This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 03-31-2022 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-0042 Worksheet S Peri od: From 01/01/2020 Parts I-III AND SETTLEMENT SUMMARY 12/31/2020 Date/Time Prepared: 7/29/2021 2:33 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 7/29/2021 2:33 pm Manually prepared cost report use only] If this is an amended report enter the number of times the provider resubmitted this cost report] Medicare Utilization. Enter "F" for full or "L" for low. [1] Cost Report Status 6. Date Received: 7. Contractor No. (2) Settled without Audit 8. [N] Initial Report for this Provider CCN (3) Settled with Audit 9. [N] Final Report for this Provider CCN (10. NPR Date: 11. Contractor's Vendor Code: 4. (2. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9. Contractor use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened (5) Amended

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 01/01/2020 and ending 12/31/2020 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.

[X]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) THOM COOK
Officer or Administrator of Provider(s)

CFO

Title

(Dated when report is electronically signed.)
Date

			Title XVIII				
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	854, 381	222, 911	0	-627, 042	1.00
2.00	Subprovider - IPF	0	112, 819	65		167, 674	2.00
3.00	Subprovider - IRF	0	40, 781	0		-53, 787	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	1, 007, 981	222, 976	0	-513, 155	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.

roporting portions in our amin 2, officer in the food of							
	In-State	In-State	Out-of	Out-of	Medi cai d	Other	
	Medi cai d	Medi cai d	State	State	HMO days	Medi cai d	
	pai d days	eligible	Medi cai d	Medi cai d		days	
		unpai d	pai d days	eligible			
		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 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 ir column 5, and other Medicaid days in column 6.		996	321	176	1, 217	0	24.00

Health Financial Systems GOOD SA HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	MARITAN H	OSPITAL Provider CO	`N: 15_0042	Peri od:	In Lie	u of Form Workshee		2-10
THOST THE AND HOST THE HEALTH GARL COMMERCE TRENTITION OF		i i ovi dei oc	N. 13 0042	From 01/0	01/2020 31/2020	Part I Date/Tim		
	In-State Medicaid paid days	In-State Medicaid eligible unpaid days 2.00	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medica HMO da	aid Oth ays Medi da	ner cai d	<u> </u>
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, 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.	21			63		0		5. 00
					Rural S 00	Date of 2.00		
26.00 Enter your standard geographic classification (not wa cost reporting period. Enter "1" for urban or "2" for		s at the be	ginning of		2			6. 00
27.00 Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifi	ge) status "2" for i cation in	rural. If a column 2.	ppl i cabl e,		2			7. 00
35.00 If this is a sole community hospital (SCH), enter the effect in the cost reporting period.	number of	f periods S	CH status i	n	0			5. 00
					ni ng: 00	Endi n 2. 00		
36.00 Enter applicable beginning and ending dates of SCH st of periods in excess of one and enter subsequent date	s.	•					36	6. 00
37.00 If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period.		•		us	1			7. 00
37.01 Is this hospital a former MDH that is eligible for th accordance with FY 2016 OPPS final rule? Enter "Y" fo instructions)	r yes or '	'N" for no.	(see					7. 01
38.00 If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.				01/01	/2020	12/31/2	2020 38	8. 00
					/N 00	Y/N 2. 00		
39.00 Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet t accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions)	, (ii), on he mileage	r (iii)? En e requireme	ter in colu nts in	mn	N	N	39	9. 00
40.00 Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.	er 1. Ente	er "Y" for		-	Y	Y		0. 00
					1. 00	XVIII 2.00	XI X 3. 00	
Prospective Payment System (PPS)-Capital 45.00 Does this facility qualify and receive Capital paymen	ıt for disp	oroporti ona	te share in	accordanc	e N	N	N 45	5. 00
with 42 CFR Section §412.320? (see instructions) 46.00 Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst					N	N	N 46	6. 00
Pt. III. 47.00 Is this a new hospital under 42 CFR §412.300(b) PPS c 48.00 Is the facility electing full federal capital payment					N N	N N		7. 00 8. 00
Teaching Hospitals 56.00 Is this a hospital involved in training residents in "N" for no in column 1. If column 1 is "Y", are you i						Y	56	6. 00
GME payment reduction? Enter "Y" for yes or "N" for 1f line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y"	no in colu eriod duri yes or "N h of this	umn 2. ng which r V" for no i cost repor	esidents in n column 1. ting period	approved If column ? Enter "	1 Y"		57	7. 00
"N", complete Wkst. D, Parts III & IV and D-2, Pt. II 58.00 If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, chapter 21, \$2148? If yes,	, if appli oursement 1	cable. for physici			N		58	8. 00
59.00 Are costs claimed on line 100 of Worksheet A? If yes			, Pt. I. NAHE 413.8 Y/N		heet A ne #	Pass-Thr Qualific Criter Code	ough ation ion	9. 00
40.00 Are you digital and all the little to	(NIALIE)	-to f	1.00		00	3.00)	0.00
60.00 Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in colis "Y", are you impacted by CR 11642 (or subsequent C adjustement? Enter "Y" for yes or "N" for no in colu	85? (see umn 1. I1 R) NAHE M	f column 1	Y		Y		60	0. 00
60.01 If line 60 is yes, complete columns 2 and 3 for each instructions)		(see			23. 01	1	60	0. 01

| North | Nort Health Financial SystemsGOOD SAMARHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA GOOD SAMARITAN HOSPITAL Provider CCN: 15-0042 Peri od: From 01/01/2020 To 12/31/2020 Y/N IME Direct GME IME

S		1.00	2. 00	3. 00	4. 00	5. 00	
	Did your hospital receive FTE slots under ACA	N			0.00	0. 00	61.00
C	section 5503? Enter "Y" for yes or "N" for no in						
61 01 F	column 1. (see instructions) Enter the average number of unweighted primary care						61. 01
	TEs from the hospital's 3 most recent cost reports						0
	ending and submitted before March 23, 2010. (see						
1	nstructions)						
	Enter the current year total unweighted primary care TE count (excluding OB/GYN, general surgery FTEs,						61. 02
	and primary care FTEs added under section 5503 of						
	ACA). (see instructions)						
	inter 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 nstructions)						
1	Enter the number of unweighted primary care/or						61. 04
	surgery allopathic and/or osteopathic FTEs in the						
	current cost reporting period (see instructions).						
	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's						61.05
	orimary care and/or general surgery FTE counts (line						
	of 0.04 minus line 61.03). (see instructions)						
	inter 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)	Pro	ogram Name	Program Code	Unweighted	Unwei ghted	
			ogi alli Hallic	Trogram oode	IME FTE Count	Direct GME	
						FTE Count	
(1.10.0	OC 11 - ETE - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -		1. 00	2.00	3. 00	4. 00	(1.10
	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents				0.00	0.00	61. 10
	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 TE unweighted count.						
1	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				0.00	0.00	01120
	residents for each expanded program. (see						
	nstructions) Enter in column 1, the program name.						
	Enter in column 2, the program code. Enter in column B, the IME FTE unweighted count. Enter in column 4,						
	the direct GME FTE unweighted count.						
ΙΔ.	CA Draviai and Affording the Health Decourage and Co		Adminiatration	(UDCA)		1. 00	
	ACA Provisions Affecting the Health Resources and Sei Enter the number of FTE residents that your hospital				iod for which	0.00	62. 00
	our hospital received HRSA PCRE funding (see instruc			reporting per	rod for will cir	0.00	02.00
	inter the number of FTE residents that rotated from a				your hospital	0. 00	62. 01
	during in this cost reporting period of HRSA THC prog			ns)			
	eaching Hospitals that Claim Residents in Nonprovide las your facility trained residents in nonprovider se			ost reporting	neriod2 Enter	N	63. 00
	Y" for yes or "N" for no in column 1. If yes, comple					14	03.00
			<u>J</u>	Unwei ghted	Unweighted	Ratio (col.	
				FTEs	FTEs in	1/ (col. 1 +	
				Nonprovi der Si te	Hospi tal	col. 2))	
				1.00	2. 00	3. 00	
	Section 5504 of the ACA Base Year FTE Residents in No	onprovi	der Settings				
S	period that begins on or after July 1, 2009 and before	re June	30, 2010.				
р			and the second second second	0.00	0.00		64 00
64. 00 Ei	inter in column 1, if line 63 is yes, or your facilit			0.00	0. 00	0. 000000	04.00
64. 00 Ei	n the base year period, the number of unweighted nor	n-pri ma	ry care	0.00	0.00	0. 000000	04.00
64. 00 Ei i i re	n the base year period, the number of unweighted nor resident FTEs attributable to rotations occurring in	n-prima all no	ry care nprovi der	0.00	0.00	0. 000000	04.00
64. 00 Ei i i ri si	n the base year period, the number of unweighted nor	n-prima all no d non-p	ry care nprovider rimary care	0.00	0.00	0.00000	04.00

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 01/01/2020 Part I 12/31/2020 Date/Time Prepared: 7/29/2021 2:33 pm 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 4. 27 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 INTERNAL MEDICINE 1400 0.00 6. 46 0.000000 67.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)

	1.00	2.00	3.00	
Inpatient Psychiatric Facility PPS				
70.00 Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovide	? 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 mos	N	Y	1	71.00
recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (se	:			
42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching				
program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no.				
Column 3: If column 2 is Y, indicate which program year began during this cost reporting perior	l.			
(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
subprovider? Enter "Y" for yes and "N" for no.				

	<u>'</u> T	0 12/31/		Date/Ti 7/29/20	me Pre 21 2:3	pared: 3 pm
			1.00	2.00	3. 00	
	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes on column 2: Did this facility train residents in a new teaching program in accordance CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y indicate which program year began during this cost reporting period. (see instructions)	or "N" for with 42 ,	N N	N N	0	76. 00
	Long Term Care Hospital PPS		-	1. (00	
80. 00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		I	N		80.00
81. 00	Is this a LTCH co-located within another hospital for part or all of the cost reporting "Y" for yes and "N" for no. TEFRA Providers	peri od? I	Enter	N		81.00
86. 00	Is this a new hospital under 42 CFR Section $$413.40(f)(1)(i)$ TEFRA? Enter "Y" for yes Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Sectic $$413.40(f)(1)(ii)$? Enter "Y" for yes and "N" for no.	r no.	N		85. 00 86. 00	
87. 00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			N		87.00
	Title V and XIX Services	1. 00)	2. C		
	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N		Y		90.00
91. 00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N		Υ		91.00
92. 00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N		92.00
	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		N		93.00
	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		N		94.00
	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 in the applicable column.	0.00 N	1	O. (N		95. 00 96. 00
98. 00	If line 96 is "Y", enter the reduction percentage in the applicable column. Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	0. 00 N		0. (Y		97. 00 98. 00
98. 01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		Υ		98. 01
98. 02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		Υ		98. 02
	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		N		98. 03
	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		N		98.04
	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		Υ		98. 05
	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Rural Providers	N		Y		98.06
	Does this hospital qualify as a CAH? If this facility qualifies as a CAH, has it elected the all-inclusive method of payment	N N				105. 00 106. 00
	for outpatient services? (see instructions) Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for L&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train L&Rs in an approved medical education program in the CAH's excluded LPF and/or LRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N				107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N				108. 00

date in column 1 and termination date, if applicable, in column 2.

OSPITAL AND HOSPITAL HEALTH CARE COMPL	GOOD SAMARITA EX IDENTIFICATION DATA	Provi der CC	CN: 15-0042			of Form CMS Worksheet S- Part I Date/Time Pr	2 epared:
						7/29/2021 2:	33 pm
					1. 00	2. 00	+
32.00 If this is a Medicare certified i in column 1 and termination date,			ication date		1.00	2. 00	132.00
33.00 Removed and reserved 34.00 If this is an organ procurement o and termination date, if applicab		the OPO number	in column 1				133. 0 134. 0
All Providers 40.00 Are there any related organization chapter 10? Enter "Y" for yes or are claimed, enter in column 2 the	"N" for no in column 1. If	f yes, and home	office cost	ts	N		140. 0
1.00	2. (•	11 0110)		3. 00		
If this facility is part of a cha office and enter the home office	contractor name and contra					of the home	
41. 00 Name:	Contractor's Name:		Contrac	tor's Nu	mber:		141.0
42. 00 Street: 43. 00 Ci ty:	PO Box: State:		Zi p Code	۵٠			142. C
43. 00 01 ty.	State.		Zi p cou	· .			143.0
						1. 00	
44.00 Are provider based physicians' co	sts included in Worksheet	A?				Υ	144.0
15 001.6					1.00	2. 00	4.5
45.00 f costs for renal services are cinpatient 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 ir clude Medicare utilizatior for no in column 2. gy changed from the previo n column 1. (See CMS Pub.	n column 1. If n for this cost ously filed cos	column 1 is reporting t report?	f	N		145. (
Many areas and approved a second	<u></u>						
						1 00	
47.00Was there a change in the statist	ical basis? Enter "Y" for	yes or "N" for	no.			1. 00 N	147. C
48.00 Was there a change in the order o	f allocation? Enter "Y" fo	or yes or "N" f	or no.				
	f allocation? Enter "Y" fo	or yes or "N" f nter "Y" for y	or no. es or "N" fo			N N N	148.0
48.00 Was there a change in the order o	f allocation? Enter "Y" fo	or yes or "N" f Enter "Y" for y Part A	or no. es or "N" fo Part B		itle V	N N N Title XIX	148.0
48.00Was there a change in the order o 49.00Was there a change to the simplif	f allocation? Enter "Y" foiged cost finding method? E	or yes or "N" f Enter "Y" for y Part A 1.00	or no. es or "N" fo Part B 2.00	Т	3. 00	N N N Title XIX 4.00	148.0
48.00 Was there a change in the order o 49.00 Was there a change to the simplif Does this facility contain a prov	f allocation? Enter "Y" for ied cost finding method? E	Part A 1.00 n exemption from	or no. es or "N" fo Part B 2.00 om the appli	cation c	3.00 f the low	N N N Title XIX 4.00 er of costs	148. (
48.00 Was there a change in the order of 49.00 Was there a change to the simpliful Does this facility contain a provor charges? Enter "Y" for yes or	f allocation? Enter "Y" for ied cost finding method? E	Part A 1.00 n exemption from	or no. es or "N" fo Part B 2.00 om the appli	cation c	3.00 f the low	N N N Title XIX 4.00 er of costs 3.13)	148. (
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Does this facility contain a provor charges? Enter "Y" for yes or IRF 68.00 Subprovider - IRF 68.00 SUBPROVIDER 69.00 SNF 69.00 SNF 69.00 CMHC Multicampus Multicampus S5.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no.	f allocation? Enter "Y" for ied cost finding method? Enter that qualifies for an "N" for no for each compose ampus hospital that has or	or yes or "N" f Enter "Y" for y Part A 1.00 n exemption froment for Part A N N N N N N N N N N N N N N N N N N N	or no. es or "N" for Part B 2.00 om the appli A and Part B N N N N N N uses in diff	T cation c. (See 4	3.00 If the Lowe 2 CFR §41: N N N N N N BSAs?	N N N N Title XIX 4.00 er of costs 3.13) N N N N N	148. (149. (149. (155. (156. (157. (159. (160. (161. (
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Health Financial Systems					
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTI				Worksheet S-2 Part I Date/Time Pre	
				7/29/2021 2:3	3 pm
			Begi nni ng	Endi ng	
			1. 00	2. 00	
170.00 Enter in columns 1 and 2 the EHR beginning period respectively (mm/dd/yyyy)			170. 00		
			1. 00	2. 00	
171.00 If line 167 is "Y", does this provider has section 1876 Medicare cost plans reported "Y" for yes and "N" for no in column 1. I 1876 Medicare days in column 2. (see insti	N on	0	171. 00		

Health Financial Systems GOOD SAMARITAN HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 15-0042 Period: Worksheet S-2 From 01/01/2020 Part II Date/Time Prepared: 12/31/2020 7/29/2021 2:33 pm Date 1. 00 2.00 General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Provider Organization and Operation 1 00 Has the provider changed ownership immediately prior to the beginning of the cost N 1 00 reporting period? If yes, enter the date of the change in column 2. (see instructions) Y/N Date V/I 1.00 2.00 3.00 2.00 Has the provider terminated participation in the Medicare Program? If 2.00 Ν yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary. 3.00 Is the provider involved in business transactions, including management Ν 3.00 contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions) Y/N Туре Date 1.00 3.00 2.00 Financial Data and Reports Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, 4.00 Υ 4.00 Α or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues different from 5.00 Ν 5.00 those on the filed financial statements? If yes, submit reconciliation. Y/N Legal Oper 1. 00 2.00 Approved Educational Activities 6.00 Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is Ν 6.00 the legal operator of the program? 7.00 Are costs claimed for Allied Health Programs? If "Y" see instructions. 7.00 Were nursing school and/or allied health programs approved and/or renewed during the 8.00 Ν 8.00 cost reporting period? If yes, see instructions. 9.00 Are costs claimed for Interns and Residents in an approved graduate medical education 9.00 program in the current cost report? If yes, see instructions. . Was an approved Intern and Resident GME program initiated or renewed in the current 10.00 10.00 cost reporting period? If yes, see instructions. 11.00 Are GME cost directly assigned to cost centers other than I & R in an Approved N 11.00 Teaching Program on Worksheet A? If yes, see instructions Y/N 1.00 Bad Debts 12.00 Is the provider seeking reimbursement for bad debts? If yes, see instructions γ 12.00 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting Ν 13.00 period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions. Ν 14.00 Bed Complement 15.00 Did total beds available change from the prior cost reporting period? If yes, see instructions Ν 15.00 Part A Part B Y/N Y/N Date Date 3.00 1.00 2.00 4.00 PS&R Data 04/22/2021 04/22/2021 Was the cost report prepared using the PS&R Report only? Υ 16.00 If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) 17 00 Was the cost report prepared using the PS&R Report for N 17.00 totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) 18.00 If line 16 or 17 is yes, were adjustments made to PS&R 18.00 Ν 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.
19.00 If line 16 or 17 is yes, were adjustments made to PS&R N N 19.00 Report data for corrections of other PS&R Report information? If yes, see instructions.

Heal th Fi	nancial Systems GOOD SAMARIT	AN HOSPITAL		In Lie	u of Form CM	S-2552-10			
	AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CN: 15-0042	Period: From 01/01/2020 To 12/31/2020	Worksheet S Part II	6-2 Prepared:			
			iption	Y/N	Y/N				
20. 00 I f	fline 16 or 17 is yes, were adjustments made to PS&R		0	1. 00 N	3. 00 N	20.00			
	eport data for Other? Describe the other adjustments:			IN	IV	20.00			
		Y/N	Date	Y/N	Date				
04 00 144		1.00	2. 00	3.00	4. 00	21.00			
	as the cost report prepared only using the provider's ecords? If yes, see instructions.	N		N		21.00			
					1. 00				
	MPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	EPT CHILDRENS	HOSPI TALS)						
	pital Related Cost	- !+			N.				
	ave assets been relifed for Medicare purposes? If yes, se ave changes occurred in the Medicare depreciation expense			ring the cost	N N	22. 00 23. 00			
	eporting period? If yes, see instructions.	Tring the cost		20.00					
	ere new leases and/or amendments to existing leases enter f yes, see instructions	eporting period?	Υ	24. 00					
	ave there been new capitalized leases entered into during	g the cost repo	rting period	? If yes, see	Υ	25. 00			
26.00 We	nstructions. ere assets subject to Sec. 2314 of DEFRA acquired during t	he cost report	ing period?	If yes, see	N	26. 00			
27. 00 Ha	nstructions. as the provider's capitalization policy changed during th	ne cost reporti	ng period? I	f yes, submit	N	27. 00			
Ιn	opy. Iterest Expense	entared into du	uri ng the cos	t roporting	N	28. 00			
ре	ere new loans, mortgage agreements or letters of credit e eriod? If yes, see instructions. d the provider have a funded depreciation account and/or		N	29.00					
	reated as a funded depreciation account? If yes, see inst		ebt Service	keserve runu)	IV	29.00			
30. 00 Ha	as existing debt been replaced prior to its scheduled mat nstructions.	s, see	N	30. 00					
i n	as debt been recalled before scheduled maturity without instructions.	ssuance of new	debt? If ye	s, see	N	31.00			
32.00 Ha	nrchased Services ave changes or new agreements occurred in patient care se		ed through c	ontractual	N	32. 00			
33.00 I f	rrangements with suppliers of services? If yes, see instr fline 32 is yes, were the requirements of Sec. 2135.2 ap o, see instructions.		ng to compet	itive bidding? If		33. 00			
	ovi der-Based Physi ci ans								
	re services furnished at the provider facility under an a	arrangement wit	h provi der-b	ased physicians?	Υ	34.00			
35.00 I f	f yes, see instructions. f line 34 is yes, were there new agreements or amended ex		ents with the	provi der-based	Υ	35.00			
ph	nysicians during the cost reporting period? If yes, see i	nstructions.		Y/N	Date				
				1.00	2. 00				
	me Office Costs								
37. 00 I f	ere home office costs claimed on the cost report? fline 36 is yes, has a home office cost statement been p	prepared by the	home office	? N		36. 00 37. 00			
38. 00 I f	f yes, see instructions. Fline 36 is yes , was the fiscal year end of the home of			f		38. 00			
39.00 I f	ne provider? If yes, enter in column 2 the fiscal year en fline 36 is yes, did the provider render services to oth			S,		39. 00			
40. 00 I f	ee instructions. f line 36 is yes, did the provider render services to the nstructions.	e home office?	If yes, see			40. 00			
	The first one.								
		1.	00	2.	00				
	st Report Preparer Contact Information	lou E		CMI TII		44.00			
he	nter the first name, last name and the title/position eld by the cost report preparer in columns 1, 2, and 3, espectively.	KYLE		SMI TH		41.00			
42. 00 En	espectivery. hter the employer/company name of the cost report reparer.	BLUE & CO, LLC				42. 00			
43. 00 En	nter the telephone number and email address of the cost eport preparer in columns 1 and 2, respectively.	317-713-7957		KCSMI TH@BLUEAN	DCO. COM	43. 00			

Health Financial Systems GOOD SAMAR	TAN HOSPITAL	In Lieu of Form CMS-2552-10			
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der CCN: 15-0042	Peri od: Worksheet S-	2		
		From 01/01/2020 Part II To 12/31/2020 Date/Time Pr	onarod:		
		7/29/2021 2:			
	3. 00				
Cost Report Preparer Contact Information					
41.00 Enter the first name, last name and the title/position	DI RECTOR		41.00		
held by the cost report preparer in columns 1, 2, and 3,					
respecti vel y.					
42.00 Enter the employer/company name of the cost report			42.00		
preparer.					
43.00 Enter the telephone number and email address of the cost			43. 00		
report preparer in columns 1 and 2, respectively.					

| Period: | Worksheet S-3 | From 01/01/2020 | Part | To 12/31/2020 | Date/Time Prepared: Health Financial Systems GOOD SA HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 15-0042

						To 12/31/2020	Date/Time Pre 7/29/2021 2:3	
							1/P Days /	J piii
							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, 25	0.00	0	1.00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days) (see instructions for col. 2							
2 00	for the portion of LDP room available beds)							2 00
2.00	HMO and other (see instructions)							2.00
3.00	HMO IPF Subprovider							3.00
4.00	HMO IRF Subprovider						0	4. 00 5. 00
5.00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF							
6. 00 7. 00	Total Adults and Peds. (exclude observation			40	25.25	4 0 00		
7.00	beds) (see instructions)			69	25, 25	0.00	0	7.00
8. 00	INTENSIVE CARE UNIT	31. 00		30	10, 98	0.00	0	8.00
9. 00	CORONARY CARE UNIT	31.00		30	10, 90	0.00	U	9.00
10.00	BURN INTENSIVE CARE UNIT							10.00
11. 00	SURGICAL INTENSIVE CARE UNIT							11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)							12.00
13. 00	NURSERY	43.00					0	
14. 00	Total (see instructions)	43.00		99	36, 23	0.00		14.00
15. 00	CAH visits			,,	30, 23	0.00	Ö	
16. 00	SUBPROVI DER - I PF	40. 00		20	7, 32	1	Ö	16.00
17. 00	SUBPROVI DER - I RF	41. 00		25			o o	17.00
18. 00	SUBPROVI DER	111.00		20	,,,,,			18.00
19. 00	SKILLED NURSING FACILITY							19.00
20.00	NURSING FACILITY							20.00
21. 00	OTHER LONG TERM CARE							21.00
22. 00	HOME HEALTH AGENCY	101. 00					0	22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)							23.00
24.00	HOSPI CE	116. 00		0		0		24.00
24. 10	HOSPICE (non-distinct part)	30.00						24. 10
25.00	CMHC - CMHC							25. 00
26.00	RURAL HEALTH CLINIC							26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	26. 25
27.00	Total (sum of lines 14-26)			144				27.00
28. 00	Observation Bed Days						0	
29. 00	Ambul ance Trips							29. 00
30.00	Employee discount days (see instruction)							30.00
31.00	Employee discount days - IRF							31.00
32.00	Labor & delivery days (see instructions)			0	(O		32.00
32. 01	Total ancillary labor & delivery room							32. 01
	outpatient days (see instructions)							
33.00	LTCH non-covered days							33.00
33. 01	LTCH site neutral days and discharges		l		I	1	I	33. 01

					0 12/31/2020	7/29/2021 2: 3	
		I/P Davs	/ O/P Visits	/ Trips	Full Time	Equi val ents	<u> </u>
						1	
	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	6, 321	363	12, 046			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, 175	2, 667				2.00
3. 00	HMO IPF Subprovi der	281	1, 782				3.00
4.00	HMO IRF Subprovider	483	178				4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6. 00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7. 00	Total Adults and Peds. (exclude observation	6, 321	363	12, 046			7. 00
	beds) (see instructions)						
8. 00	INTENSIVE CARE UNIT	3, 648	62	6, 301			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)		F./	000			12.00
13.00	NURSERY	0.040	56	930		1 405 75	13.00
14.00	Total (see instructions)	9, 969	481 0	19, 277	8. 14	1, 435. 75	1
15. 00 16. 00	CAH visits	1, 379	394	0 4, 639	2. 58	22.24	15. 00 16. 00
17. 00	SUBPROVIDER - IPF SUBPROVIDER - IRF	5, 377	394 21	4, 639 6, 447	0.00		•
18.00	SUBPROVI DER	3, 377	21	0, 447	0.00	29.00	18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	o o	O	0	0.00	0.00	23. 00
24. 00	HOSPI CE	0	0	0	0.00	6. 74	1
24. 10	HOSPICE (non-distinct part)	o _l	O	388		0.74	24. 10
25. 00	CMHC - CMHC			300			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)	Ĭ	J	Ü	10. 72		
28. 00	Observation Bed Days		436	2, 557	10.72	1,001.70	28.00
29. 00	Ambul ance Trips	0	.00	2,007			29. 00
30.00	Employee discount days (see instruction)			0			30.00
31. 00	Employee discount days - IRF			0			31.00
32. 00	Labor & delivery days (see instructions)	o	48	110			32.00
32. 01	Total ancillary labor & delivery room			0			32. 01
	outpatient days (see instructions)			_			
33.00	LTCH non-covered days	0					33.00
33. 01	LTCH site neutral days and discharges	o					33. 01

					12/31/2020	7/29/2021 2: 3	
	·	Full Time		Di sch	arges		
		Equi val ents			_		
	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	2, 453	102	4, 855	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)			498	699		2.00
3. 00	HMO IPF Subprovider				358		3.00
4. 00	HMO IRF Subprovider				12		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6. 00
7.00	Total Adults and Peds. (exclude observation						7. 00
	beds) (see instructions)						
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	2, 453	102	4, 855	
15. 00	CAH visits						15. 00
16. 00	SUBPROVI DER - I PF	0.00	0		62	792	16. 00
17. 00	SUBPROVI DER - I RF	0.00	0	377	2	451	17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY	0.00					22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE	0.00					24.00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27. 00	Total (sum of lines 14-26)	0.00					27. 00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance Trips						29. 00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32. 00	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33. 00	LTCH non-covered days			0			33.00
33. 01	LTCH site neutral days and discharges			0	l		33. 01

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION GOOD SAMARITAN HOSPITAL Provider CCN: 15-0042

		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	7/29/2021 2:3 Average Hourly Wage (col. 4 ÷ col. 5)	3 pm
		1. 00	2. 00	A-6) 3.00	4.00	5. 00	6. 00	
	PART II - WAGE DATA SALARIES							İ
1.00	Total salaries (see	200. 00	103, 341, 470	0	103, 341, 470	3, 129, 835. 00	33. 02	1.00
2. 00	instructions) Non-physician anesthetist Part		0	0	0	0. 00	0. 00	2. 00
3. 00	Non-physician anesthetist Part B		0	0	0	0. 00	0. 00	3. 00
4. 00	Physician-Part A - Administrative		118, 625	0	118, 625	644. 00	184. 20	4. 00
4. 01 5. 00	Physicians - Part A - Teaching Physician and Non		0 4, 434, 009	0		0. 00 22, 694. 00	0. 00 195. 38	
6. 00	Physician-Part B Non-physician-Part B for hospital-based RHC and FQHC		0	0	0	0. 00	0. 00	6. 00
7. 00	services Interns & residents (in an approved program)	21. 00	0	0	0	0. 00	0. 00	7. 00
7. 01	Contracted interns and residents (in an approved		857, 653	О	857, 653	15, 600. 00	54. 98	7. 01
8. 00	programs) Home office and/or related organization personnel		0	0	0	0. 00	0. 00	8. 00
9. 00	SNF	44. 00	0	0	-	0. 00	0.00	
10. 00	Excluded area salaries (see instructions) OTHER WAGES & RELATED COSTS		35, 245, 075	0	35, 245, 075	855, 690. 00	41. 19	10.00
11. 00	Contract Labor: Direct Patient		1, 165, 304	0	1, 165, 304	17, 239. 00	67. 60	11. 00
12. 00	Care Contract labor: Top level management and other management and administrative		0	0	0	0. 00	0. 00	12. 00
13. 00	services Contract Labor: Physician-Part A - Administrative		507, 431	0	507, 431	5, 941. 00	85. 41	13.00
14. 00	Home office and/or related organization salaries and		0	0	0	0. 00	0. 00	14. 00
14. 01	wage-related costs Home office salaries		0	0	О	0. 00	0. 00	14. 01
14. 02	Related organization salaries		0	1	_	0. 00	0.00	
15. 00	Home office: Physician Part A - Administrative		0	0	0	0. 00	0. 00	15. 00
16. 00	Home office and Contract Physicians Part A - Teaching		0	0	0	0. 00	0. 00	16. 00
16. 01	Home office Physicians Part A - Teaching		0	0	0	0. 00	0.00	16. 01
16. 02	Home office contract Physicians Part A - Teaching		0	0	0	0. 00	0.00	16. 02
17. 00	WAGE-RELATED COSTS Wage-related costs (core) (see		20, 123, 842	0	20, 123, 842			17. 00
18. 00	instructions) Wage-related costs (other) (see instructions)							18. 00
19. 00 20. 00	Excluded areas Non-physician anesthetist Part		8, 274, 851	0	8, 274, 851			19.00 20.00
21. 00	A Non-physician anesthetist Part		0	0	0			21.00
22. 00	B Physician Part A -		12, 693	0	12, 693			22. 00
22. 01	Administrative Physician Part A - Teaching		0	0	0			22. 01
23. 00 24. 00 25. 00	Physician Part B Wage-related costs (RHC/FQHC) Interns & residents (in an		460, 054 0 0	0 0	460, 054 0 0			23.00 24.00 25.00
25. 50	approved program) Home office wage-related		0	0	0			25. 50
25. 51	(core) Related organization		0	0	0			25. 51
25. 52	wage-related (core) Home office: Physician Part A - Administrative -		0	О	0			25. 52
-	wage-related (core)							

Hear th	Financiai Systems		GOOD SAMARITA	AN HUSPITAL		In Lie	U OF FORM CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION			Provi der C	CN: 15-0042	Peri od:	Worksheet S-3	
						From 01/01/2020		
						To 12/31/2020		
				5		1 5	7/29/2021 2: 3	3 pm
		Wkst. A Line	Amount	Reclassi fi cat		Pai d Hours	Average	
		Number	Reported	i on of	Sal ari es	Related to	Hourly Wage	
				Sal ari es	(col.2 ± col		(col. 4 ÷	
				(from Wkst.	3)	col. 4	col. 5)	
				A-6)				
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
25. 53		1	0	0	1	0		25. 53
	- Teaching - wage-related							
	(core)							
	OVERHEAD COSTS - DIRECT SALARI	ES						
26.00	Employee Benefits Department	4.00	5, 451, 958	0	5, 451, 95	8 276, 832. 00	19. 69	26.00
27.00	Administrative & General	5.00	7, 107, 356	0	7, 107, 35	6 198, 100. 00	35. 88	27.00
28.00	Administrative & General under		1, 145, 401	0	1, 145, 40	10, 340. 00	110. 77	28. 00
	contract (see inst.)							
29.00	Maintenance & Repairs	6.00	0	0)	0.00	0.00	29.00
30.00	Operation of Plant	7.00	2, 270, 238	0	2, 270, 23	91, 880. 00	24. 71	30.00
31.00	Laundry & Linen Service	8.00	215, 736	0	215, 73	6 15, 290. 00	14. 11	31.00
32.00	Housekeepi ng	9.00	2, 089, 015	0	2, 089, 01	5 133, 640. 00	15. 63	32.00
33.00	Housekeeping under contract		0	l o		0.00	0.00	33.00
	(see instructions)							
34.00	Dietary	10.00	1, 674, 977	-1, 127, 487	547, 49	0 32, 936. 00	16. 62	34.00
35.00	Di etary under contract (see		0	0		0.00	0.00	35.00
	instructions)							
36.00	Cafeteri a	11.00	0	1, 127, 487	1, 127, 48	67, 827. 00	16. 62	36.00
37.00	Maintenance of Personnel	12.00	0	0		0.00	0.00	37.00
38.00	Nursing Administration	13.00	2, 332, 664	l o	2, 332, 66	4 64, 250. 00	36. 31	38.00
39. 00	Central Services and Supply	14. 00	367, 400	l .	367, 40	· ·	l .	•
40.00	Pharmacy	15. 00	2, 911, 505	l .	2, 911, 50	· ·	l	
41. 00	Medical Records & Medical	16. 00	3, 552, 741	l .	3, 552, 74	· ·	l	41.00
41.00	Records Library	10.00	5, 552, 741	l	3, 332, 74	120, 710.00	\ \frac{27.77}{}	71.00
42 00	Social Service	17. 00	525, 313	١	525, 31	3 15, 611. 00	33 65	42.00
	Other General Service	18.00	·	l		0 0.00	l	43.00
43.00	Totaler deficial Service	10.00	U	ı	4	υ ₁ υ. υυ	0.00	1 43.00

HOSPI 1	AL WAGE INDEX INFORMATION			Provi der C		Period: From 01/01/2020 To 12/31/2020	Worksheet S-3 Part III Date/Time Prep 7/29/2021 2:33	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, 195, 209	0	99, 195, 20	9 3, 101, 881. 00	31. 98	1.00
	instructions)							
2.00	Excluded area salaries (see		35, 245, 075	0	35, 245, 07	5 855, 690. 00	41. 19	2.00
	instructions)							
3.00	Subtotal salaries (line 1		63, 950, 134	0	63, 950, 13	4 2, 246, 191. 00	28. 47	3.00
	minus line 2)							
4.00	Subtotal other wages & related		1, 672, 735	0	1, 672, 73	5 23, 180. 00	72. 16	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		20, 136, 535	0	20, 136, 53	5 0.00	31. 49	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		85, 759, 404	l e	85, 759, 40		•	
7.00	Total overhead cost (see		29, 644, 304	0	29, 644, 30	4 1, 124, 584. 00	26. 36	7.00
	instructions)							

Health Financial Systems	GOOD SAMARITAN HOSPITAL	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0042	Peri od: Worksheet S-3 From 01/01/2020 Part IV To 12/31/2020 Date/Time Prepared:

PART IV - WAGE RELATED COSTS 1.00		10 12/31/2020	7/29/2021 2: 3	
PART I V - WAGE RELATED COSTS				
PART I V - WAGE RELATED COSTS Part A - Core List RETIREMENT COST 401K Employer Contributions 0 1.00 2.00 3.00 401K Employer Contributions 0 2.00 3.00 401K Employer Contributions 0 2.00 3.00 400K Employer Contributions 0 2.00 3.00 400K Employer Contributions 0 2.00 3.00 40.00			Reported	
Part A - Core List			1.00	
RETIREMENT COST		PART IV - WAGE RELATED COSTS		
1.00		Part A - Core List		
2.00		RETI REMENT COST		
3.00 Nonqualified Defined Benefit Plan Cost (see instructions) 4.717,816 3.00 Valuation Va	1.00	401K Employer Contributions	0	1.00
A 00 PLAN ADMIN IN STRATIVE COSTS (Paid to External Organization) 5.00 A 01K/TSA Plan Admin Instration fees 0 5.00 Legal /Accounting/Management Fees-Pension Plan 0 6.00 Control 0 0 0 0 0 0 0 0 0	2.00	Tax Sheltered Annuity (TSA) Employer Contribution	ol	2.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization) ORACTSA Plan Administration fees ORACTSA Plan Plan Plan Plan Plan Plan Plan Plan	3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	4, 717, 816	3.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization) ORACTSA Plan Administration fees ORACTSA Plan Plan Plan Plan Plan Plan Plan Plan	4.00	Qualified Defined Benefit Plan Cost (see instructions)	ol	4.00
Column C		PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
Employee Managed Care Program Administration Fees 0 7.00	5.00	401K/TSA Plan Administration fees	0	5.00
HEALTH AND INSURANCE COST	6.00	Legal /Accounting/Management Fees-Pension Plan	0	6.00
Real th Insurance (Purchased or Self Funded) Real th Insurance (Self Funded without a Third Party Administrator) Real th Insurance (Self Funded without a Third Party Administrator) Real th Insurance (Self Funded with a Third Party Administrator) Real th Insurance (Self Funded with a Third Party Administrator) Real th Insurance (Self Funded with a Third Party Administrator) Real th Insurance (Self Funded with a Third Party Administrator) Real th Insurance (Furchased) Real th Insurance (Purchased) Real th Insurance (Pu	7.00	Employee Managed Care Program Administration Fees	0	7.00
Heal th Insurance (Self Funded without a Third Party Administrator) 15,466,820 8.02 Heal th Insurance (Self Funded without a Third Party Administrator) 15,466,820 8.02 Heal th Insurance (Purchased) 0 8.03 Heal th Insurance (Purchased) 0 8.03 Heal th Insurance (Purchased) 0 8.03 Prescription Drug Plan 0 9.00 10.00 Dental , Hearing and Vision Plan 313,988 10.00 11.00 Life Insurance (If employee is owner or beneficiary) 156,927 11.00 12.00 Accident Insurance (If employee is owner or beneficiary) 0 12.00 13.00 Disability Insurance (If employee is owner or beneficiary) 0 14.00 15.00 Workers' Compensation Insurance (If employee is owner or beneficiary) 0 14.00 16.00 Workers' Compensation Insurance 196,984 15.00 17.00 Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 16.00 Non-cumulative portion) 17.00 17.00 Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 16.00 Non-cumulative portion) 0 18.00 17.00 Exacutive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions) 0 18.00 17.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions) 0 22.00 10.00 23.00 Tuition Reimbursement 254,214 23.00 10.01 24.00 24.00 24.00 10.02 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 25.00 26.00 26.00 26.00 26.00 26.00 26.00 26.00 26.00 26.00 26.00 26.00 26.00 26.00 26.00 26.00 26.00 26.00 26.00 26.00 26.00 26.00 26.00 26.				
Heal th Insurance (Self Funded with a Third Party Administrator) 15, 466, 820 8.03 Heal th Insurance (Purchased) 0 8.03 0.00 0	8.00		0	8.00
8. 03 Heal th Insurance (Purchased) 0 0 0 0 0 0 0 0 0	8. 01		0	
9. 00 Prescription Drug Plan 0 9. 00 10. 00 10. 00 10. 00 10. 10. 00 10. 10. 00 10. 10. 00 10. 10. 00 10. 10. 00 10. 10. 00 10. 10. 00 10. 10. 00 10. 10. 00 10. 10. 00 10. 10. 00 10. 10. 00 10. 10. 00 10. 10. 00 1			15, 466, 820	
10.00 Dental, Hearing and Vision Plan 313,988 10.00 11.00 Life Insurance (If employee is owner or beneficiary) 156,927 11.00 12.00 Accident Insurance (If employee is owner or beneficiary) 12.00 13.00 Disability Insurance (If employee is owner or beneficiary) 323,938 13.00 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14.00 15.00 Workers' Compensation Insurance 196,984 15.00 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 Non cumulative portion 16.00 Non cumulative portion 17.00 18.00 Medicare Taxes - Employers Portion Only 6,936,071 17.00 19.00 Unemployment Insurance 453,766 19.00 20.00 State or Federal Unemployment Taxes 0 OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances 50,915 22.00 23.00 Tuit ion Reimbursement 254,214 23.00 Part B - Other than Core Related Cost 24.00 Part B - Other than Core Related Cost 20.00 Contact			0	8. 03
11.00	9.00		0	9.00
12.00			313, 988	
13.00 Disability Insurance (If employee is owner or beneficiary) 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 15.00 'Workers' Compensation Insurance 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES 17.00 FICA-Employers Portion Only 18.00 Medicare Taxes - Employers Portion Only 19.00 Unemployment Insurance 20.00 State or Federal Unemployment Taxes 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see Oinstructions)) 22.00 Day Care Cost and Allowances 23.00 Tuition Reimbursement 24.00 Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost			156, 927	11.00
Long-Term Care Insurance (If employee is owner or beneficiary) 15.00 16.00 Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES 17.00 FICA-Employers Portion Only Medicare Taxes - Employers Portion Only 19.00 Unemployment Insurance 20.00 State or Federal Unemployment Taxes OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost			-	
15.00 'Workers' Compensation Insurance 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES 17.00 FICA-Employers Portion Only 18.00 Medicare Taxes - Employers Portion Only 19.00 Unemployment Insurance 20.00 State or Federal Unemployment Taxes 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances 23.00 Tuition Reimbursement 254, 214 250 Day Care Belated cost (Sum of Lines 1 -23) 24.00 Part B - Other than Core Related Cost			323, 938	
Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES 17. 00 FICA-Employers Portion Only 18. 00 Medicare Taxes - Employers Portion Only 19. 00 Unemployment Insurance 20. 00 State or Federal Unemployment Taxes 21. 00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22. 00 Day Care Cost and Allowances 33. 00 Tuition Reimbursement 24. 00 Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost			7	
Non cumulative portion TAXES To Taxes			196, 984	
TAXES	16.00		0	16.00
17.00 FICA-Employers Portion Only 6,936,071 17.00 18.00 Medicare Taxes - Employers Portion Only 0 18.00 19.00 Unemployment Insurance 453,766 19.00 20.00 OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances 50,915 22.00 23.00 Tuition Reimbursement 254,214 23.00 24.00 Part B - Other than Core Related Cost 24.00 Part B - Other than Core Related Cost 25.00 26.00 26.00 26.00 27.00				
18.00 Medicare Taxes - Employers Portion Only 0 18.00 19.00 Unemployment Insurance 453,766 19.00 20.00 State or Federal Unemployment Taxes 0 20.00 OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 0 21.00 22.00 Day Care Cost and Allowances 50,915 22.00 23.00 Tuition Reimbursement 254,214 23.00 24.00 Total Wage Related cost (Sum of Lines 1 -23) 28,871,439 24.00 Part B - Other than Core Related Cost				
19.00 Unempl oyment Insurance 453, 766 20.00 State or Federal Unempl oyment Taxes 0 20.00 OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances 50,915 22.00 Tuition Reimbursement 254,214 23.00 Total Wage Related cost (Sum of Lines 1 -23) 28,871,439 Part B - Other than Core Related Cost				
20.00 State or Federal Unemployment Taxes 0 OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances 50,915 22.00 Tuition Reimbursement 254,214 23.00 Total Wage Related cost (Sum of Lines 1 -23) 28,871,439 Part B - Other than Core Related Cost				
OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances 750,915 22.00 Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost 21.00 21.00 22.00 22.00 23.00 25.00 24.00 25.00 25.00 26.00 27.00 28.871,439 28.871,439 29.00 29.00 20				
21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances Tuition Reimbursement 250, 915 22.00 Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost	20. 00		0	20. 00
instructions)) 22.00 Day Care Cost and Allowances Tuition Reimbursement 24.00 Total Wage Related cost (Sum of lines 1 -23) Part B - Other than Core Related Cost 1 Instructions) 22.00 23.00 25.			_	
22.00 Day Care Cost and Allowances 50, 915 22.00 23.00 Tuition Reimbursement 254, 214 23.00 24.00 Total Wage Related cost (Sum of lines 1 -23) 28, 871, 439 24.00 Part B - Other than Core Related Cost 24.00	21. 00) 0	21.00
23.00 Tuition Reimbursement 254, 214 23.00 24.00 Total Wage Related cost (Sum of lines 1 -23) 28, 871, 439 Part B - Other than Core Related Cost 24.00				
24.00 Total Wage Related cost (Sum of lines 1 -23) Part B - Other than Core Related Cost 28,871,439 24.00			·	
Part B - Other than Core Related Cost				
	24.00		28, 8/1, 439	24.00
25.00 UTHER WAGE RELATED COSTS (SPECIFY) 25.00	25 00			25 00
	25.00	OTHER WAGE RELATED COSTS (SPECIFT)	l	, ∠5.00

Health Financial Systems	GOOD SAMARITAN HOSPITAL	In Lieu of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST		Peri od: Worksheet S-3 From 01/01/2020 Part V To 12/31/2020 Date/Time Prepared:

		То	12/31/2020	Date/Time Pre 7/29/2021 2:3	
	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		1, 165, 304		1. 00
2. 00	Hospi tal		1, 165, 304	28, 871, 439	
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
	Hospi tal -Based HHA		0	0	
	Separately Certified ASC				12.00
	Hospi tal -Based Hospi ce		0	0	
	Hospital-Based Health Clinic RHC				14.00
	Hospital-Based Health Clinic FQHC				15.00
16. 00	Hospi tal -Based-CMHC				16.00
	Renal Di al ysi s				17.00
18. 00	Other Other		0	0	18. 00

Heal th	Financial Systems		GOOD SAMARIT	AN HOSPITAL		In Lie	u of Form CMS-2	2552-10
	TAL-BASED HOSPICE IDENTIFICATION	I DATA		Provider C		Peri od: From 01/01/2020 To 12/31/2020	Worksheet S-9 PARTS I THROU	IGH IV
				nospi ce cc	N. 15-1520	10 12/31/2020	7/29/2021 2:3	
						Hospi ce I		
		Undupl i cated						
		Days	T: +1 - VIV	T: +1 - \(\lambda \tau \tau \tau \tau \tau \tau \tau \ta	T: +1 - VIV	ALL 0+6	T-+-! (6	
		Title XVIII	Title XIX	Title XVIII Skilled	Title XIX Nursing	All Other	Total (sum of cols. 1, 2 &	
				Nursi ng	Facility		5)	
				Facility	lacitity		3)	
		1. 00	2. 00	3.00	4.00	5. 00	6. 00	
	PART I - ENROLLMENT DAYS FOR CO	OST REPORTING	PERIODS BEGINN	ING BEFORE OCT	OBER 1, 2015			
1.00	Hospice Continuous Home Care							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 Part II - CENSUS DATA FOR COST	DEDODTI NO DED	LODS BECLINITING	DEEUDE UCTUBEI	D 1 2015			5.00
6. 00	Number of patients receiving	KLFOKIING FLK	I ODS BEGINNING	BLIOKE OCTOBE	1, 2015			6.00
0.00	hospi ce care							0.00
7.00	Total number of unduplicated							7.00
	Continuous Care hours billable							
	to Medicare							
8. 00	Average Length of Stay (line 5							8. 00
0.00	/ line 6)							0.00
9. 00	Unduplicated census count	-1 !!	<u> </u>		2 4			9.00
NOTE:	Parts I and II, columns 1 and 2	arso include	the days repor					
				Title XVIII	Title XIX	0ther	Total (sum of	
							col s. 1	
				1.00	2.00	3.00	through 3)	
	PART III - ENROLLMENT DAYS FOR	COST DEDODTIN	C DEDIANS DECI	1.00	2.00		4. 00	
10. 00	Hospice Continuous Home Care	COST KLFOKITIN	G FERIODS BEGI	T ON OR AL	ILK OCTOBER I	0 0	0	10.00
11. 00	Hospice Routine Home Care			4. 987		30 152	_	11.00
12. 00	Hospice Inpatient Respite Care			5	i '	0 2	7	12.00
13.00	1			326		15 40	381	13.00
14.00	Total Hospice Days			5, 318		45 194	5, 557	14.00
	PART IV - CONTRACTED STATISTICA		ST REPORTING P	ERIODS BEGINNII	NG ON OR AFTE			
	Hospice Inpatient Respite Care			0		0 0		15.00
16.00	Hospice General Inpatient Care			0		0 0	0	16. 00

		PITAL ovider CCN: 15-004	2 P	eri od:	u of Form CMS-2 Worksheet S-1	
	THE GROOM ENGINED THAT CENT CHILE BITTY	0 V I GC 0 0 V I C 0 0 V		om 01/01/2020		
			To	12/31/2020	Date/Time Pre	pared
					7/29/2021 2:3	3 piii
					1. 00	
00	Uncompensated and indigent care cost computation	dad by Lina 202 a	alma	0)	0.255205	1 1 0
. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided caid (see instructions for each line)	ded by fine 202 C	or unim	8)	0. 255285	1.0
2. 00	Net revenue from Medicaid				11, 815, 671	2.0
3. 00	Did you receive DSH or supplemental payments from Medicaid?				Υ	3.0
. 00	If line 3 is yes, does line 2 include all DSH and/or supplemental		edi cai	d?	Υ	4.0
. 00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid charges		0 81, 878, 579	5.0 6.0		
. 00	Medicaid cost (line 1 times line 6)				20, 902, 373	7.0
. 00	Difference between net revenue and costs for Medicaid program (1)	ine 7 minus sum o	fline	es 2 and 5; if	9, 086, 702	8.0
	< zero then enter zero)			· 		
	Children's Health Insurance Program (CHIP) (see instructions for	each line)				
. 00	Net revenue from stand-alone CHIP				0	9.0
0.00	Stand-alone CHIP charges Stand-alone CHIP cost (line 1 times line 10)				0	10. C
2. 00	Difference between net revenue and costs for stand-alone CHIP (1)	ine 11 minus line	9: if	<pre>< zero then</pre>	Ö	12.0
	enter zero)					
	Other state or local government indigent care program (see instru					
3.00	Net revenue from state or local indigent care program (Not included the state of local indigent care program (Not include	ded on lines 2, 5	or 9)	- 1: /	0	13.0
4. 00	Charges for patients covered under state or local indigent care 10)	program (Not incl	uaea i	n lines 6 or	0	14.0
5. 00	State or local indigent care program cost (line 1 times line 14)				0	15.0
6. 00	Difference between net revenue and costs for state or local indig		(Line	e 15 minus line		16.0
	13; if < zero then enter zero)					
	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line)	and state/local i	i ndi ge	ent care progra	ms (see	
7. 00	Private grants, donations, or endowment income restricted to fund	ding charity care			0	17. C
8.00	Government grants, appropriations or transfers for support of hos					
				(()	0	
9. 00	Total unreimbursed cost for Medicaid , CHIP and state and local			(sum of lines	9, 086, 702	18. 0 19. 0
			grams	(sum of lines	9, 086, 702 Total (col. 1	
	Total unreimbursed cost for Medicaid , CHIP and state and local	indigent care pro Uninsu patien	grams red its	I nsured pati ents	9, 086, 702 Total (col. 1 + col. 2)	
	Total unreimbursed cost for Medicaid , CHIP and state and local 8, 12 and 16)	i ndi gent care pro	grams red its	Insured	9, 086, 702 Total (col. 1	
9. 00	Total unreimbursed cost for Medicaid , CHIP and state and local	indigent care proj Uninsui patien 1.00	grams red its	I nsured pati ents	9, 086, 702 Total (col. 1 + col. 2) 3.00	19. 0
9. 00	Total unreimbursed cost for Medicaid , CHIP and state and local 8, 12 and 16) Uncompensated Care (see instructions for each line)	indigent care proj Uninsui patien 1.00	grams red nts	Insured patients 2.00	9, 086, 702 Total (col. 1 + col. 2) 3.00	19.0
0. 00	Total unreimbursed cost for Medicaid , CHIP and state and local 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discounts.	Uni nsuipati en 1.00	grams red nts	Insured patients 2.00	9, 086, 702 Total (col. 1 + col. 2) 3.00	20.0
9. 00 0. 00 1. 00	Total unreimbursed cost for Medicaid , CHIP and state and local 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discouninstructions)	Uni nsur pati en 1.00 Lity 7,84 ts (see 2,00	grams red nts 0 0,747	Insured patients 2.00 1,120,098	9, 086, 702 Total (col. 1 + col. 2) 3.00 8, 960, 845 3, 121, 723	19. C 20. C 21. C
9. 00 0. 00 1. 00	Total unreimbursed cost for Medicaid, CHIP and state and local 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discouninstructions) Payments received from patients for amounts previously written or	Uni nsur pati en 1.00 Lity 7,84 ts (see 2,00	grams red nts 0	Insured pati ents 2.00	9, 086, 702 Total (col. 1 + col. 2) 3.00 8, 960, 845 3, 121, 723	19. C 20. C 21. C
9. 00	Total unreimbursed cost for Medicaid , CHIP and state and local 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discouninstructions) Payments received from patients for amounts previously written or charity care	Uni nsu	grams red nts 0 0,747	Insured patients 2.00 1,120,098	9, 086, 702 Total (col. 1 + col. 2) 3. 00 8, 960, 845 3, 121, 723 11, 900	20. 0 21. 0 22. 0
9. 00 0. 00 1. 00 2. 00	Total unreimbursed cost for Medicaid , CHIP and state and local 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discouninstructions) Payments received from patients for amounts previously written or charity care	Uni nsu	grams red ots 0 0,747 01,625 9,640	I nsured pati ents 2.00 1,120,098 2,260	9, 086, 702 Total (col. 1 + col. 2) 3. 00 8, 960, 845 3, 121, 723 11, 900 3, 109, 823	20. C 21. C 22. C
9. 00 0. 00 1. 00 2. 00 3. 00	Total unreimbursed cost for Medicaid , CHIP and state and local 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facilities (see instructions) Cost of patients approved for charity care and uninsured discountinstructions) Payments received from patients for amounts previously written or charity care Cost of charity care (line 21 minus line 22)	Uni nsurpati en 1.00 Lity 7,84 ts (see 2,00 ff as 1,99	grams red ats 0 -0,747 11,625 9,640 11,985	Insured patients 2.00 1,120,098 1,120,098 2,260 1,117,838	9, 086, 702 Total (col. 1 + col. 2) 3. 00 8, 960, 845 3, 121, 723 11, 900 3, 109, 823	20. C 21. C 22. C 23. C
9. 00 0. 00 1. 00 2. 00 3. 00	Total unreimbursed cost for Medicaid , CHIP and state and local 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facilicate (see instructions) Cost of patients approved for charity care and uninsured discountinstructions) Payments received from patients for amounts previously written or charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient	Uni nsurpati en 1.00 Ii ty 7,84 ts (see 2,00 ff as 1,99	grams red ats 0 -0,747 11,625 9,640 11,985	Insured patients 2.00 1,120,098 1,120,098 2,260 1,117,838	9, 086, 702 Total (col. 1 + col. 2) 3. 00 8, 960, 845 3, 121, 723 11, 900 3, 109, 823	20. C 21. C 22. C 23. C
9. 00 0. 00 1. 00 2. 00 3. 00	Total unreimbursed cost for Medicaid , CHIP and state and local 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facilities (see instructions) Cost of patients approved for charity care and uninsured discountinstructions) Payments received from patients for amounts previously written or charity care Cost of charity care (line 21 minus line 22)	Uni nsu pati en 1.00 lity 7,84 ts (see 2,00 ff as 1,99 days beyond a lerrogram?	grams red ots 0, 0,747 01,625 9,640 01,985	Insured patients 2.00 1,120,098 2,260 1,117,838	9, 086, 702 Total (col. 1 + col. 2) 3. 00 8, 960, 845 3, 121, 723 11, 900 3, 109, 823	20. C 21. C 22. C 23. C
9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00	Total unreimbursed cost for Medicaid , CHIP and state and local 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discountinstructions) Payments received from patients for amounts previously written or charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care piffline 24 is yes, enter the charges for patient days beyond the	Uni nsui pati en 1.00 lity 7,84 ts (see 2,00 ff as 1,99 days beyond a lei rogram? indigent care pro	grams red ots 0, 0,747 01,625 9,640 01,985	Insured patients 2.00 1,120,098 2,260 1,117,838	9, 086, 702 Total (col. 1 + col. 2) 3.00 8, 960, 845 3, 121, 723 11, 900 3, 109, 823	20. C 21. C 22. C 23. C 24. C 25. C
9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00	Total unreimbursed cost for Medicaid , CHIP and state and local 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facilities (see instructions) Cost of patients approved for charity care and uninsured discountinstructions) Payments received from patients for amounts previously written or charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care pilf line 24 is yes, enter the charges for patient days beyond the stay limit Total bad debt expense for the entire hospital complex (see instimedicare reimbursable bad debts for the entire hospital complex	Uninsumpation Uninsumpation 1.00 Iity 7,84 ts (see 2,00 ff as 1,99 days beyond a learogram? indigent care productions) (see instructions)	grams red hts 0 0,747 01,625 9,640 01,985 ngth c	Insured patients 2.00 1,120,098 2,260 1,117,838	9, 086, 702 Total (col. 1 + col. 2) 3. 00 8, 960, 845 3, 121, 723 11, 900 3, 109, 823 1. 00 N	20. C 21. C 22. C 23. C 24. C 25. C 26. C
9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 7. 01	Total unreimbursed cost for Medicaid , CHIP and state and local 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written or charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care provided in the stay limit total bad debt expense for the entire hospital complex (see instant Medicare allowable bad debts for the entire hospital complex (see	Uninsumpation Uninsumpation 1.00 Iity 7,84 ts (see 2,00 ff as 1,99 days beyond a learogram? indigent care productions) (see instructions)	grams red hts 0 0,747 01,625 9,640 01,985 ngth c	Insured patients 2.00 1,120,098 2,260 1,117,838	9, 086, 702 Total (col. 1 + col. 2) 3. 00 8, 960, 845 3, 121, 723 11, 900 3, 109, 823 1. 00 N 0 13, 979, 271 750, 314 1, 154, 329	20. C 21. C 22. C 23. C 24. C 25. C 26. C 27. C 27. C
9. 00 0. 00 11. 00 12. 00 14. 00 15. 00 16. 00 17. 01 18. 00	Total unreimbursed cost for Medicaid , CHIP and state and local 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discountinstructions) Payments received from patients for amounts previously written or charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care provided in the stay limit total bad debt expense for the entire hospital complex (see instance) Medicare reimbursable bad debts for the entire hospital complex (see Medicare allowable bad debt spense (see instructions)	Uninsumpatien 1.00 Iity 7,84 ts (see 2,00) ff as 1,99 days beyond a learogram? indigent care productions) (see instructions)	grams red hts 0 0,747 01,625 9,640 01,985 ngth coogram'	Insured patients 2.00 1,120,098 2,260 1,117,838	9, 086, 702 Total (col. 1 + col. 2) 3.00 8, 960, 845 3, 121, 723 11, 900 3, 109, 823 1.00 N 0 13, 979, 271 750, 314 1, 154, 329 12, 824, 942	20. 0 21. 0 22. 0 23. 0 24. 0 25. 0 26. 0 27. 0 27. 0 28. 0
20. 00 21. 00 22. 00 23. 00	Total unreimbursed cost for Medicaid , CHIP and state and local 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written or charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care provided in the stay limit total bad debt expense for the entire hospital complex (see instant Medicare allowable bad debts for the entire hospital complex (see	Uninsumpatien 1.00 Iity 7,84 ts (see 2,00) ff as 1,99 days beyond a learogram? indigent care productions) (see instructions)	grams red hts 0 0,747 01,625 9,640 01,985 ngth coogram'	Insured patients 2.00 1,120,098 2,260 1,117,838	9, 086, 702 Total (col. 1 + col. 2) 3. 00 8, 960, 845 3, 121, 723 11, 900 3, 109, 823 1. 00 N 0 13, 979, 271 750, 314 1, 154, 329	20. 0 21. 0 22. 0 23. 0 24. 0 25. 0 26. 0 27. 0 28. 0 29. 0

	n Financial Systems	GOOD SAMARITAN		CN. 1E 0042 D		u of Form CMS-2	2552-10
RECLA	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der CO		eriod: rom 01/01/2020	Worksheet A	
				T		Date/Time Pre	pared:
	Cost Contan Decemintion	Colorios	O+hon	Total (col 1	Dool agai fi agt	7/29/2021 2: 3	3 pm
	Cost Center Description	Sal ari es	Other	+ col . 2)	Reclassificat ions (See	Reclassified Trial Balance	
				1 (01. 2)	A-6)	(col. 3 +-	
					,	col . 4)	
		1. 00	2. 00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1. 00	00100 CAP REL COSTS-BLDG & FLXT		18, 044, 284			24, 074, 225	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		95, 145			95, 145	2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00401 COMMUNI CATLONS	626, 130	1, 896, 503			29, 374, 892	4.00
4. 01 4. 02	00401 COMMUNICATIONS 00402 PURCHASING & RECEIVING	276, 769 667, 262	111, 689 573, 059			279, 251 969, 218	4. 01 4. 02
4. 02	00402 PORCHASTING & RECEIVING	1, 511, 097	537, 986			1, 528, 508	4.02
4. 04	00404 PATIENT ACCOUNTS	2, 370, 700	2, 087, 874			3, 896, 163	4. 04
5.00	00500 ADMINISTRATIVE & GENERAL	7, 107, 356	23, 259, 633			28, 149, 508	5.00
7.00	00700 OPERATION OF PLANT	2, 270, 238	4, 364, 217	6, 634, 455	-660, 003	5, 974, 452	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	215, 736	205, 777	•		317, 566	8.00
9. 00	00900 HOUSEKEEPI NG	2, 089, 015	982, 189			2, 292, 822	9. 00
10.00	01000 DI ETARY	1, 674, 977	1, 924, 813			993, 647	10.00
11. 00 13. 00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON	0 2, 332, 664	0 1, 606, 086	·	_, -, -, -, -, -,	2, 046, 292 3, 183, 549	11. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	367, 400	308, 230			5, 163, 549 591, 777	14.00
15. 00	01500 PHARMACY	2, 911, 505	18, 692, 287	•		3, 225, 676	
16. 00	01600 MEDICAL RECORDS & LIBRARY	3, 552, 741	1, 679, 674			4, 189, 034	
17.00	01700 SOCIAL SERVICE	0	0	0		0	17.00
17. 01	01701 MENTAL HEALTH OH	525, 313	342, 802	868, 115	-143, 672	724, 443	17. 01
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	857, 653		l	857, 653	21.00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	1, 245, 712	711, 627	1, 957, 339	-335, 314	1, 622, 025	
23. 00	02300 PARAMED ED PRGM-RADI OLOGY	000 057	70,001	0	0	0	23.00
23. 01	O2301 PARAMED ED PRGM-LAB I NPATI ENT ROUTI NE SERVI CE COST CENTERS	233, 957	79, 831	313, 788	-58, 215	255, 573	23. 01
30. 00	03000 ADULTS & PEDIATRICS	4, 446, 561	2, 205, 395	6, 651, 956	-987, 587	5, 664, 369	30.00
31. 00	03100 NTENSI VE CARE UNI T	3, 183, 737	1, 546, 188			3, 928, 274	
40.00	04000 SUBPROVI DER - I PF	2, 006, 922	599, 015				40.00
41.00	04100 SUBPROVI DER - I RF	1, 594, 965	698, 748			1, 796, 862	41.00
43.00	04300 NURSERY	294, 776	101, 637	396, 413	-76, 521	319, 892	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	3, 057, 616	5, 591, 627	8, 649, 243		5, 239, 814	50.00
51. 00 51. 01	05100 RECOVERY ROOM 05101 ENDOSCOPY	751, 774	992, 223	0 1, 743, 997		0 1, 268, 492	51. 00 51. 01
52. 00	05200 DELIVERY ROOM & LABOR ROOM	1, 258, 162	393, 037			1, 208, 492	1
53.00	05300 ANESTHESI OLOGY	0	0	0		0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 579, 864	3, 717, 741	7, 297, 605	-1, 819, 288	5, 478, 317	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	2, 550, 937	1, 852, 636			3, 755, 469	55.00
60.00	06000 LABORATORY	2, 253, 807	5, 603, 492		· .	7, 195, 388	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0		0	63.00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	2, 360, 272 3, 714, 916	1, 652, 479 1, 088, 055			3, 173, 579 3, 855, 184	65. 00 66. 00
69.00		5, 230, 152	3, 324, 663				
70.00	1 1	0, 230, 132	0, 324, 003	0, 334, 019	2, 754, 675	0,777,720	70.00
70. 01	07001 NEURODI AGNOSTI CS	452, 485	216, 665	669, 150	-78, 603	590, 547	70. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	4, 036, 742	4, 036, 742	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0		3, 970, 233	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	17, 729, 102	17, 729, 102	73.00
75.00	07500 ASC (NON-DISTINCT PART)	1, 059, 520	1, 947, 679	3, 007, 199	-1, 236, 364	1, 770, 835	75.00
76. 00 76. 01	03950 MH ANCILLARY OUTPATIENT 03951 INPATIENT DIALYSIS	0	0 491, 821	0 491, 821	-4, 415	0 487, 406	76. 00 76. 01
, 0. 01	OUTPATIENT SERVICE COST CENTERS	<u> </u>	471,021	471,021	-4,415	407, 400	, , , , , , , ,
90.00	09000 CLINIC	86, 719	17, 007	103, 726	-16, 580	87, 146	90.00
90. 01	04950 WOUND CLINIC	393, 276	1, 738, 502			930, 815	90.01
91.00	09100 EMERGENCY	3, 589, 323	2, 801, 123	6, 390, 446	-872, 105	5, 518, 341	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
0, 00	OTHER REIMBURSABLE COST CENTERS	07.000	70.000	1/1 100	47.1	111 (22	
	09600 DURABLE MEDI CAL EQUI P-RENTED	87, 883	73, 220			144, 629	96.00
101.00	D10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0		0	U	101. 00
113 0	11300 INTEREST EXPENSE		5, 921, 611	5, 921, 611	-5, 921, 611	0	113.00
	11600 HOSPI CE	438, 842	432, 030			776, 871	
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	72, 371, 081	121, 367, 953				
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	1	· ·		190.00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	21, 058, 309	14, 542, 904			30, 598, 704	
	1 19201 FP PETERSBURG	251, 821	126, 530 826, 281			320, 967 1 781 084	
	2 19202 PEDIATRICS 3 19203 WASHINGTON PRIMARY CARE	1, 345, 787 1, 321, 765	826, 281 636, 213	2, 172, 068 1, 957, 978		1, 781, 084 1, 590, 631	
	0 07950 COMMUNITY HEALTH SERVICES	342	6, 888				194.00
	1 07960 CCBHC GRANTS	258, 500	155, 704		l	357, 020	
	207952 MARKETING AND PUBLIC RELATIONS	224, 378	542, 138			707, 250	
	<u> </u>		,				

Health Financial Systems	GOOD SAMARITAN	I HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	F EXPENSES	Provi der CO		Peri od:	Worksheet A	
				From 01/01/2020 To 12/31/2020	Date/Time Pre	narad.
				To 12/31/2020	7/29/2021 2: 3	
Cost Center Description	Sal ari es	Other	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. 03 07953 MH RESIDENTIAL	458, 120	167, 915	626, 03	5 -129, 882	496, 153	194. 03
194. 04 07954 UNUSED SPACE	0	0		0	0	194. 04
194. 05 07955 MOB	0	30, 491	30, 49	1 0	30, 491	194. 05
194. 06 07956 FOUNDATI ON	0	0		0	0	194. 06
194.07 07957 KNOX COUNTY HEALTH DEPT	O	0		0	0	194. 07
194. 08 07958 I NDUSTRI AL HEALTH	o	0		0	0	194. 08
194.09 07959 COMMUNITY MENTAL HEALTH CENTER	6, 051, 367	2, 117, 256	8, 168, 62	-1, 611, 920	6, 556, 703	194. 09
200.00 TOTAL (SUM OF LINES 118 through 199)	103, 341, 470	140, 520, 273	243, 861, 74	3 0	243, 861, 743	200. 00

Health Financial Systems	GOOD SAMARITA	AN HOSPITAL	In Lieu of Form CMS	S-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CCN: 15-0042	Period: Worksheet A	
			From 01/01/2020 To 12/31/2020 Date/Time P	repared:
			7/29/2021 2	
Cost Center Description	Adjustments (See A-8)	Net Expenses For		
	(See A-0)	Allocation		
	6. 00	7. 00		
GENERAL SERVICE COST CENTERS	2 275 040	21 700 254		1 00
1.00 00100 CAP REL COSTS-BLDG & FIXT 2.00 00200 CAP REL COSTS-MVBLE EQUIP	-2, 275, 869 0	1		1.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	-830			4.00
4. 01 00401 COMMUNI CATI ONS	0	2,7,201		4. 01
4. 02 00402 PURCHASI NG & RECEI VI NG 4. 03 00403 REGI STRATI ON	-181, 016			4. 02
4. 04 00404 PATIENT ACCOUNTS	-61, 274	1, 528, 508 3, 834, 889		4. 03
5. 00 00500 ADMINI STRATI VE & GENERAL	-12, 727, 715			5. 00
7.00 O0700 OPERATION OF PLANT	-48, 299			7. 00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG	-10, 732			8. 00 9. 00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY	-31, 608 0			10.00
11. 00 01100 CAFETERI A	-991, 534			11.00
13.00 01300 NURSING ADMINISTRATION	-37, 171			13. 00
14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY	01 021	1		14.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	-91, 021 -66, 162			15. 00 16. 00
17. 00 01700 SOCIAL SERVICE	00, 102	0		17. 00
17.01 01701 MENTAL HEALTH OH	-1, 075			17. 01
21. 00 02100 &R SERVI CES-SALARY & FRINGES APPRVD	120 205	857, 653		21.00
22. 00 02200 1&R SERVICES-OTHER PRGM COSTS APPRVD 23. 00 02300 PARAMED ED PRGM-RADIOLOGY	-120, 395	1, 501, 630 0		22. 00
23. 01 02301 PARAMED ED PRGM-LAB	-35, 788	1 -1		23. 01
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS	0			30.00
31. 00 03100 I NTENSI VE CARE UNI T 40. 00 04000 SUBPROVI DER - I PF	0 -405, 415	-111		31. 00 40. 00
41. 00 04100 SUBPROVI DER - I RF	0			41.00
43. 00 04300 NURSERY	0	319, 892		43. 00
ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM	-2, 131, 523	3, 108, 291		50.00
51. 00 05100 RECOVERY ROOM	-2, 131, 323	1		51.00
51. 01 05101 ENDOSCOPY	Ö	1		51. 01
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	1, 073, 687		52.00
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	-36, 630	0 5, 441, 687		53. 00 54. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C	-1, 268, 528			55.00
60. 00 06000 LABORATORY	0	1 ' '		60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	-867, 008 -1, 466	1		65. 00 66. 00
69. 00 06900 ELECTROCARDI OLOGY	-3, 671, 337			69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
70. 01 07001 NEURODI AGNOSTI CS	-89, 451			70. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	4, 036, 742 3, 970, 233		71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	-300, 191			73.00
75.00 07500 ASC (NON-DISTINCT PART)	-83, 876			75.00
76. 00 03950 MH ANCI LLARY OUTPATIENT	0	I -1		76.00
76. 01 03951 INPATIENT DIALYSIS OUTPATIENT SERVICE COST CENTERS	-202, 523	284, 883		76. 01
90. 00 09000 CLINIC	0	87, 146		90.00
90. 01 04950 WOUND CLINIC	-806	930, 009		90. 01
91. 00 09100 EMERGENCY	-1, 253, 253	4, 265, 088		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS				92.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	144, 629		96.00
101.00 10100 HOME HEALTH AGENCY	0	0		101. 00
SPECIAL PURPOSE COST CENTERS	^			112 00
113. 00 11300 INTEREST EXPENSE 116. 00 11600 HOSPI CE	0 -29			113. 00 116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-26, 992, 525			118.00
NONREI MBURSABLE COST CENTERS				
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			190.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES 192.01 19201 FP PETERSBURG	0			192. 00 192. 01
192. 02 19202 PEDI ATRI CS	ő	1 277/171		192. 02
192. 03 19203 WASHINGTON PRIMARY CARE	0	1, 590, 631		192. 03
194. 00 07950 COMMUNITY HEALTH SERVICES	0	7, 118		194.00
194.01 07960 CCBHC GRANTS 194.02 07952 MARKETING AND PUBLIC RELATIONS	0	357, 020 707, 250		194. 01 194. 02
194. 03 07953 MH RESIDENTIAL	ő			194. 02
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Health Financial Systems GOOD SAMARITAN HOSPITAL In Lieu of Form CMS-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES Provider CCN: 15-0042 Period: From 01/01/2020 To 12/31/2020 Date/Time Prepared: 7/29/2021 2:33 pm

Cost Center Description	Adjustments	Net Expenses	
	(See A-8)	For	
		Allocation	
	6. 00	7. 00	
194. 04 07954 UNUSED SPACE	0	0	194. 04
194. 05 07955 MOB	0	30, 491	194. 05
194. 06 07956 FOUNDATI ON	0	0	194. 06
194.07 07957 KNOX COUNTY HEALTH DEPT	0	0	194. 07
194. 08 07958 I NDUSTRI AL HEALTH	0	0	194. 08
194.09 07959 COMMUNITY MENTAL HEALTH CENTER	0	6, 556, 703	194. 09
200.00 TOTAL (SUM OF LINES 118 through 199)	-26, 992, 525	216, 869, 218	200.00

					7/29/2021 2	
		Increases		0.1		
	Cost Center 2.00	Li ne # 3.00	Sal ary 4. 00	0ther 5.00		
	A - DRUGS CHARGED TO PATIENTS		4.00	5.00		
1.00	DRUGS CHARGED TO PATIENTS	73. 00		17, 729, 102		1.00
2.00		0.00	0	0		2.00
	0	TO DATI FAITO	0	17, 729, 102		_
1. 00	B - MEDICAL SUPPLIES CHARGED MEDICAL SUPPLIES CHARGED TO	71. 00	ol	4, 036, 742		1.00
1.00	PATI ENTS	71.00		4, 030, 742		1.00
2.00	IMPL. DEV. CHARGED TO	72. 00	О	3, 970, 233		2. 00
0.00	PATIENTS	14.00		40.050		2.00
3. 00 4. 00	CENTRAL SERVICES & SUPPLY	14. 00 0. 00	0	49, 853 0		3. 00 4. 00
5. 00		0.00	0	O		5.00
6.00		0. 00	0	0		6.00
7. 00		0. 00	0	0		7. 00
8. 00 9. 00		0. 00 0. 00	0	0		8. 00 9. 00
10.00		0.00	o	0		10.00
11. 00		0. 00	O	0		11.00
12.00		0. 00	0	0		12.00
13.00		0.00	0	0		13.00
14. 00 15. 00		0. 00 0. 00	0	0		14. 00 15. 00
16. 00		0.00	0	o		16.00
17.00		0. 00	0	0		17.00
18.00		0.00	0	0		18.00
19. 00 20. 00		0. 00 0. 00	0	0		19. 00 20. 00
21. 00		0.00	o	0		21.00
22. 00		0. 00	0	0		22.00
23. 00		0. 00	0	0		23. 00
24. 00		0.00	0	0		24. 00
25. 00		0.00	0	<u>0</u> 8, 056, 828		25. 00
	C - EMPLOYEE BENEFITS			07 0007 020		
1. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	26, 879, 866		1.00
2. 00 3. 00		0. 00 0. 00	0	0		2. 00 3. 00
4. 00		0.00	0	0		4.00
5.00		0.00	0	0		5. 00
6. 00		0.00	0	0		6.00
7. 00 8. 00		0. 00 0. 00	0	0		7. 00 8. 00
9. 00		0.00	o	0		9.00
10.00		0. 00	O	0		10.00
11. 00		0. 00	0	0		11.00
12. 00 13. 00		0. 00 0. 00	0	0		12. 00 13. 00
14. 00		0.00	0	0		14.00
15. 00		0. 00	Ö	Ö		15. 00
16.00		0. 00	0	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	Ö	0		20.00
21.00		0.00	0	0		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	0	0		25. 00
26.00		0.00	0	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
29. 00 30. 00		0.00	0	0		30.00
31. 00		0. 00	Ö	0		31.00
32.00		0. 00	o	0		32.00
33.00		0.00	0	0		33.00
34. 00 35. 00		0. 00 0. 00	0	0		34. 00 35. 00
36. 00		0. 00	o	0		36.00
37.00		0. 00	0	0		37.00
38.00		0.00	0	0		38.00
39. 00 40. 00		0. 00 0. 00	0	0		39. 00 40. 00
.5. 50	I .	0.00	9	<u> </u>		1 70.00

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

RECLASSIFICATIONS Provider CCN: 15-0042 Period: From 01/01/2020 To 12/31/2020 Date/Time Prepared:

					То	12/31/2020	Date/Time Pro 7/29/2021 2:3	epared:
		Increases	,				172772021 2.	Jo piii
	Cost Center	Li ne #	Sal ary	0ther				
	2. 00	3. 00	4. 00	5. 00				
41.00		0.00	0	0				41.00
42.00		0. 00	0	0				42.00
43.00		0.00	0	0				43.00
44.00		0. 00	0	0				44.00
45.00		0. 00	0	0				45. 00
46.00		0.00	0	0				46.00
	0		0	26, 879, 866				
	D - INTEREST EXPENSE							
1. 00	CAP REL COSTS-BLDG & FLXT	1. 00	0	5, 652, 975				1.00
2. 00	PATI ENT ACCOUNTS	4. 04	0	<u>268, 6</u> 36				2.00
	0		0	5, 921, 611				
	E - INSURANCE EXPENSE							
1.00	CAP REL COSTS-BLDG & FIXT	1.00		37 <u>6, 9</u> 66				1.00
	0		0	376, 966	1			
	F - DIETARY RECLASS							
1.00	CAFETERI A	<u>11.</u> 00	<u>1, 127, 4</u> 87	91 <u>8, 8</u> 05				1.00
	0		1, 127, 487	918, 805				
	G - OB RECLASS							
1. 00	ADULTS & PEDI ATRI CS	30. 00	27 <u>8, 6</u> 83	2 <u>6, 6</u> 74				1.00
	0		278, 683	26, 674				
500.00	Grand Total: Increases		1, 406, 170	59, 909, 852				500.00

Peri od: From 01/01/2020 To 12/31/2020 Date/Time Prepared: 7/29/2021 2: 33 pm

		Doorsoos				1/29/2021 2:	J DIII
	Coot Conton	Decreases	Colomi	O+hon	Wka+ A 7 Daf	1	
	Cost Center	Li ne #	Sal ary		Wkst. A-7 Ref.		
	6.00 A - DRUGS CHARGED TO PATIENTS	7.00	8. 00	9. 00	10. 00		
1 00				17 (70 000			1 00
1.00	PHARMACY	15. 00		17, 672, 898	0	¥	1.00
2. 00	NURSING ADMINISTRATION	1300		5 <u>6, 204</u>	0		2. 00
	0	TO DATI FUTO	0	17, 729, 102			_
4 00	B - MEDICAL SUPPLIES CHARGED		ما	07.407		I	1
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	27, 607	0		1.00
2. 00	ADMINISTRATIVE & GENERAL	5. 00		563	0		2.00
3.00	OPERATION OF PLANT	7. 00		1, 493	0		3. 00
4. 00	HOUSEKEEPI NG	9. 00		9	0		4. 00
5.00	NURSING ADMINISTRATION	13. 00		63, 834	0		5.00
6. 00	PHARMACY	15. 00		17, 696	0		6. 00
7. 00	ADULTS & PEDIATRICS	30. 00		102, 958	0		7. 00
8.00	INTENSIVE CARE UNIT	31.00		44, 995	0		8. 00
9.00	SUBPROVIDER - IPF	40.00		234	0		9.00
10.00	SUBPROVI DER - I RF	41. 00		2, 172	0		10.00
11.00	NURSERY	43.00		5, 753	0		11.00
12.00	OPERATING ROOM	50.00		2, 580, 986	0		12.00
13.00	ENDOSCOPY	51. 01		279, 069	0		13.00
14.00	DELIVERY ROOM & LABOR ROOM	52. 00		17, 993	0		14.00
15. 00	RADI OLOGY-DI AGNOSTI C	54.00		838, 526	0		15.00
16. 00	RADI OLOGY-THERAPEUTI C	55. 00		10, 650	0		16.00
17. 00	LABORATORY	60. 00		5, 033	0	1	17. 00
18. 00	RESPIRATORY THERAPY	65. 00		219, 014	Ö		18.00
19. 00	PHYSI CAL THERAPY	66. 00		12, 431	Ö	*	19.00
20. 00	ELECTROCARDI OLOGY	69. 00		1, 662, 239	0		20.00
21. 00	NEURODI AGNOSTI CS	70. 01		1, 002, 239	0	1	21.00
	ASC (NON-DISTINCT PART)						22.00
22. 00	,	75. 00		950, 049	_	1	1
23.00	I NPATI ENT DI ALYSI S	76. 01		4, 415	0	1	23.00
24.00	WOUND CLINIC	90. 01		1, 127, 664	0	1	24.00
25. 00	EMERGENCY	91.00		7 <u>9, 5</u> 56	0		25. 00
	0		0	8, 056, 828			_
	C - EMPLOYEE BENEFITS				_	T	4
1.00	COMMUNI CATI ONS	4. 01		109, 207	0		1.00
2.00	PURCHASING & RECEIVING	4. 02		271, 103	0		2. 00
3.00	REGI STRATI ON	4. 03		520, 575	0		3. 00
4. 00	PATIENT ACCOUNTS	4. 04		831, 047	0		4. 00
5. 00	ADMINISTRATIVE & GENERAL	5. 00		1, 839, 952	0	i .	5. 00
6. 00	OPERATION OF PLANT	7. 00		658, 510			6.00
7. 00	LAUNDRY & LINEN SERVICE	8. 00		103, 947	0	1	7. 00
8.00	HOUSEKEEPI NG	9. 00		778, 373	0		8. 00
9.00	DI ETARY	10. 00		559, 851	0		9. 00
10.00	NURSING ADMINISTRATION	13. 00		635, 163	0		10.00
11.00	CENTRAL SERVICES & SUPPLY	14. 00		133, 706	0		11.00
12.00	PHARMACY	15. 00		687, 522	0		12.00
13.00	MEDICAL RECORDS & LIBRARY	16. 00		1, 043, 381	0		13.00
14.00	MENTAL HEALTH OH	17. 01		143, 672	0		14.00
15.00	I&R SERVICES-OTHER PRGM	22. 00		335, 314	0		15.00
	COSTS APPRVD						
16.00	PARAMED ED PRGM-LAB	23. 01		58, 215	0		16.00
17.00	ADULTS & PEDIATRICS	30.00		1, 189, 986	0		17. 00
18.00	INTENSIVE CARE UNIT	31. 00		756, 656	0		18.00
19.00	SUBPROVIDER - IPF	40.00		423, 414	0		19.00
20.00	SUBPROVI DER - I RF	41. 00		494, 679	0		20.00
21. 00	NURSERY	43. 00		70, 768	Ö		21.00
22. 00	OPERATING ROOM	50. 00		828, 443	Ö	¥	22. 00
23. 00	ENDOSCOPY	51. 01		196, 436	Ö	1	23. 00
24. 00	DELIVERY ROOM & LABOR ROOM	52. 00		254, 162	Ö	¥	24.00
25. 00	RADI OLOGY-DI AGNOSTI C	54. 00		980, 762	0	1	25. 00
	RADI OLOGY-THERAPEUTI C	55. 00			0	1	26.00
26.00	LABORATORY			637, 454		1	1
27. 00	l .	60.00		656, 878		1	27.00
28. 00	RESPIRATORY THERAPY	65.00		620, 158	0	1	28.00
29. 00	PHYSI CAL THERAPY	66.00		935, 356	0	1	29.00
30.00	ELECTROCARDI OLOGY	69. 00		1, 092, 656	0	1	30.00
31.00	NEURODI AGNOSTI CS	70. 01		76, 714	0	1	31.00
32.00	ASC (NON-DISTINCT PART)	75. 00		286, 315	0	1	32.00
33. 00	CLI NI C	90. 00		16, 580	0	1	33.00
34.00	WOUND CLINIC	90. 01		73, 299	0	1	34.00
35.00	EMERGENCY	91. 00		792, 549	0	1	35.00
36.00	DURABLE MEDICAL EQUIP-RENTED	96. 00		16, 474	0	1	36.00
37.00	HOSPI CE	116. 00		94, 001	0	•	37.00
38.00	PHYSICIANS' PRIVATE OFFICES	192. 00		5, 002, 509	0		38. 00
39.00	FP PETERSBURG	192. 01		57, 384	0		39.00
40.00	PEDI ATRI CS	192. 02		390, 984	0		40.00
41.00	WASHINGTON PRIMARY CARE	192. 03		367, 347	0		41.00
	•	- 1					

Health Financial Systems RECLASSIFICATIONS GOOD SAMARITAN HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 15-0042

Peri od: Worksheet A-6 From 01/01/2020 To 12/31/2020 Date/Time Prepared: 7/29/2021 2:33 pm

						1/29/2021 2: 3	<u>3 pm</u>
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10.00		
42.00	COMMUNITY HEALTH SERVICES	194. 00		112	0		42.00
43.00	CCBHC GRANTS	194. 01		57, 184	0		43.00
44. 00	MARKETING AND PUBLIC RELATIONS	194. 02		59, 266	0		44.00
45.00	MH RESIDENTIAL	194. 03		129, 882	0		45.00
46.00	COMMUNITY MENTAL HEALTH	194. 09		1, 611, 920	0		46.00
	CENTER						
				<u>26, 879, 866</u>		1	
	D - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113. 00	0	5, 921, 611	11		1.00
2.00		0.00	О	0	0		2.00
	0 — — — — —			5, 921, 611		1	
	E - INSURANCE EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	376, 966	12		1.00
	0 = = = = =			376, 966		1	
	F - DIETARY RECLASS						
1.00	DI ETARY	10.00	1, 127, 487	918, 805	0		1.00
	0 — — — — —		1, 127, 487	918, 805		1	
	G - OB RECLASS						
1.00	DELIVERY ROOM & LABOR ROOM	52.00	278, 683	26, 674	0		1.00
			278, 683	26, 674		1	
500.00	Grand Total: Decreases		1, 406, 170	59, 909, 852		1	500.00
	•						

					To 12/31/20	20 Date/Time Pre 7/29/2021 2:3	epared:
				Acqui si ti ons		172772021 2:0	Jo piii
		Beginning	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES					
1.00	Land	6, 581, 448	0		0	0 0	1.00
2.00	Land Improvements	10, 609, 282	82, 948		0 82, 9	48 0	2.00
3.00	Buildings and Fixtures	163, 818, 192	5, 594, 516		0 5, 594, 5	16 0	3.00
4.00	Building Improvements	850, 562	30, 100		0 30, 1	00 369, 795	4.00
5.00	Fixed Equipment	0	0		0	0 0	5.00
6.00	Movable Equipment	218, 389, 269	12, 079, 989		0 12, 079, 9	7, 875, 629	6.00
7.00	HIT designated Assets	0	0		0	0 0	7.00
8.00	Subtotal (sum of lines 1-7)	400, 248, 753	17, 787, 553		0 17, 787, 5	8, 245, 424	8.00
9.00	Reconciling Items	0	0		0	0 0	9.00
10.00	Total (line 8 minus line 9)	400, 248, 753	17, 787, 553		0 17, 787, 5	8, 245, 424	10.00
		Endi ng	Fully				
		Bal ance	Depreci ated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE		_				
1. 00	Land	6, 581, 448	0				1.00
2.00	Land Improvements	10, 692, 230	0				2.00
3.00	Buildings and Fixtures	169, 412, 708	0				3.00
4. 00	Building Improvements	510, 867	0				4.00
5.00	Fi xed Equi pment	0	0				5.00
6. 00	Movable Equipment	222, 593, 629	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	409, 790, 882	0				8.00
9.00	Reconciling Items	0	0				9.00
10. 00	Total (line 8 minus line 9)	409, 790, 882	0				10.00

Health Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Lieu of Form CMS-2552-10			
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der Co	CN: 15-0042	Peri od: From 01/01/2020	Worksheet A-7 Part II		
					Date/Time Pre	pared:	
		SII	JMMARY OF CAP	ΙΤΔΙ	7/29/2021 2: 3	3 pili	
		30	NINIMARCE OF CALL	ITAL			
Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see		
				(see	instructions)		
				instructions)			
	9. 00	10. 00	11. 00	12.00	13. 00		
PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUI	MN 2, LINES 1 a	and 2				
1.00 CAP REL COSTS-BLDG & FLXT	18, 044, 284	0		0	0	1.00	
2.00 CAP REL COSTS-MVBLE EQUIP	95, 145	0		0 0	0	2.00	
3.00 Total (sum of lines 1-2)	18, 139, 429	0		0 0	0	3.00	
	SUMMARY 0	F CAPITAL					
Cost Center Description	0ther	Total (1)					
	Capi tal -Rel at						
	ed Costs (see	9 through 14)					
	instructions)						
	14.00	15. 00					

					(1
					instructions)		
		9. 00	10. 00	11. 00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLU	MN 2, LINES 1 a	and 2			
1.00	CAP REL COSTS-BLDG & FIXT	18, 044, 284	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	95, 145	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	18, 139, 429	0	0	0	0	3.00
SUMMARY OF CAPITAL							
	Cost Center Description	Other	Total (1)				
		Capi tal -Relat	(sum of cols.				
		ed Costs (see	9 through 14)				
		instructions)					
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLU	MN 2, LINES 1 a	and 2			
1.00	CAP REL COSTS-BLDG & FLXT	0	18, 044, 284			l	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	95, 145			ļ	2.00
3.00	Total (sum of lines 1-2)	0	18, 139, 429				3.00
		,					•

Heal th	n 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 01/01/2020 To 12/31/2020	Worksheet A-7 Part III Date/Time Pre 7/29/2021 2:3	pared:
		COMF	PUTATION OF RA	TI 0S	ALLOCATION OF	OTHER CAPITAL	·
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
			Leases	for Ratio	instructions)		
				(col. 1 -			
				col . 2)			
		1. 00	2. 00	3. 00	4. 00	5. 00	
4 00	PART III - RECONCILIATION OF CAPITAL COSTS C			107 107 05	0 45/040		
1.00	CAP REL COSTS-BLDG & FLXT	187, 197, 253					1.00
2.00	CAP REL COSTS-MVBLE EQUIP	222, 593, 629					2.00
3. 00	Total (sum of lines 1-2)	409, 790, 882		107/770/00			3. 00
		ALLUCA	TION OF OTHER (LAPITAL	SUMMARY U	OF CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Rel at	cols. 5			
			ed Costs	through 7)			
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00	CAP REL COSTS-BLDG & FLXT	0	0		0 18, 044, 284		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		95, 145		2.00
3. 00	Total (sum of lines 1-2)	0	0		0 18, 139, 429	0	3.00
			Sl	JMMARY OF CAPI	TAL		
	Cost Center Description	Interest	Insurance	Taxes (see	0ther	Total (2)	
			(see	instructions)	Capi tal -Rel at	(sum of cols.	
			instructions)		ed Costs (see	9 through 14)	
					instructions)		
		11. 00	12. 00	13.00	14. 00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C						
1.00	CAP REL COSTS-BLDG & FLXT	3, 377, 106	l		0	, , , , , , , , ,	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	ľ		0		2.00
3.00	Total (sum of lines 1-2)	3, 377, 106	376, 966		0 0	21, 893, 501	3.00

From 01/01/2020 12/31/2020 Date/Time Prepared: 7/29/2021 2:33 pm 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 -2, 275, 869 CAP 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 -10, 390 PURCHASING & RECEIVING 4.02 4.00 discounts (chapter 8) 5.00 Refunds and rebates of 5.00 0.00 expenses (chapter 8) Rental of provider space by 6.00 0.00 6.00 suppliers (chapter 8) 7.00 Tel ephone services (pay В -27, 601 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 -9, 502, 816 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 -269, 167 CAFETERI A 14.00 11.00 14.00 15.00 Rental of quarters to employee 0.00 15.00 and others Sale of medical and surgical -300, 191 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 В -46, 606 CAFETERI A 11 00 20.00 21.00 Income from imposition of 0.00 21.00 interest, finance or penalty charges (chapter 21) Interest expense on Medicare 22.00 0 00 ol 22.00 overpayments and borrowings to repay Medicare overpayments 23.00 Adjustment for respiratory ORESPIRATORY THERAPY 65.00 23.00 A-8-3 therapy costs in excess of limitation (chapter 14) 24.00 Adjustment for physical OPHYSICAL THERAPY 24.00 A-8-3 66.00 therapy costs in excess of limitation (chapter 14) Utilization review 0 *** Cost Center Deleted *** 25.00 25.00 114.00 physicians' compensation (chapter 21) OCAP REL COSTS-BLDG & FIXT 26.00 Depreciation - CAP REL 1.00 26.00 COSTS-BLDG & FLXT 27.00 Depreciation - CAP REL OCAP REL COSTS-MVBLE EQUIP 2.00 27.00 COSTS-MVBLE EQUIP Non-physician Anesthetist Physicians' assistant 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: Peri od: From 01/01/2020 To 12/31/2020 Date/Time Prepared: 7/29/2021 2:33 pm Worksheet A-8

						7/29/2021 2:3	3 pm
				Expense Classification on	Worksheet A		
				To/From Which the Amount is			
					,		
	Cost Center Description	Basis/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
	oost conten bescription	(2)	runoarre	COST CONTEN	Li iio "	Ref.	
			2. 00	3.00	4 00		
04.00		1.00		3.00	4. 00	5. 00	04.00
31. 00	Adjustment for speech	A-8-3	0	*** Cost Center Deleted ***	68. 00		31.00
	pathology costs in excess of						
	limitation (chapter 14)						
32.00	CAH HIT Adjustment for		0		0.00	0	32.00
	Depreciation and Interest						
33.00	MISC INCOME	В	-830	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33.00
33. 01	MISC INCOME	В		ł	4. 02	0	33. 01
	l .			PURCHASING & RECEIVING	1	U	
33. 02	MI SC I NCOME	В		PATIENT ACCOUNTS	4. 04	0	33. 02
33. 03	MISC INCOME	В	-965, 314	ADMINISTRATIVE & GENERAL	5. 00	0	33. 03
33.04	MISC INCOME	В	-20, 698	OPERATION OF PLANT	7. 00	0	33.04
33. 05	MISC INCOME	В	-10, 732	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		NURSING ADMINISTRATION	1	0	33. 07
	1			i i	13. 00	-	
33. 08	MI SC I NCOME	В		PHARMACY	15. 00	0	33. 08
33. 09	MISC INCOME	В	-66, 162	MEDICAL RECORDS & LIBRARY	16. 00	0	33. 09
33. 10	MISC INCOME	В	-8, 808	I&R SERVICES-OTHER PRGM	22. 00	0	33. 10
				COSTS APPRVD			
33. 11	MISC INCOME	В	-35, 788	PARAMED ED PRGM-LAB	23. 01	0	33. 11
33. 12	MISC INCOME	В		OPERATING ROOM	50.00	0	33. 12
	1			i i		-	
33. 13	1	В		RADI OLOGY-DI AGNOSTI C	54. 00	0	33. 13
33. 14	MISC INCOME	В	-189, 712	ELECTROCARDI OLOGY	69. 00	0	33. 14
33. 15	MISC INCOME	В	-150	ASC (NON-DISTINCT PART)	75. 00	0	33. 15
33. 16	MISC INCOME	В	-1, 756	WOUND CLINIC	90. 01	0	33. 16
33. 17	MISC INCOME	В		HOSPI CE	116.00	0	33. 17
33. 18	ADVERTI SI NG	Ā		ADMINISTRATIVE & GENERAL	5. 00	0	33. 18
	1			i l	1	-	
33. 19	ADVERTI SI NG	A		MENTAL HEALTH OH	17. 01	0	33. 19
33. 20	ADVERTI SI NG	A	-1, 466	PHYSI CAL THERAPY	66. 00	0	33. 20
33. 21	ADVERTI SI NG	A	-44	NEURODI AGNOSTI CS	70. 01	0	33. 21
33. 22	PHYSICIAN BILLING COSTS	A	-60, 108	PATIENT ACCOUNTS	4. 04	0	33. 22
33. 23	2012 BOND ISSUE COSTS	A	45, 855	ADMINISTRATIVE & GENERAL	5. 00	0	33. 23
33. 24	GME CONSORTIUM FEES	A		I &R SERVI CES-OTHER PRGM	22. 00	0	33. 24
33. 24	OWE CONSORTION LEES	_ ^	200,000		22.00	O	33.24
00.05	ALIA LODDVIANO OFFICET		40.007	COSTS APPRVD	F 00		00.05
33. 25	AHA LOBBYING OFFSET	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 25
33. 26	IHA LOBBYING OFFSET	Α	-4, 482	ADMINISTRATIVE & GENERAL	5. 00	0	33. 26
33. 27	INDIANA CHAMBER LOBBYING	A	-184	ADMINISTRATIVE & GENERAL	5. 00	0	33. 27
	OFFSET						
33. 28	IHRA LOBBYING OFFSET	A	-5.000	ADMINISTRATIVE & GENERAL	5. 00	0	33. 28
33. 29	PROVI DER ASSESSMENT FEE	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 29
		•		1		-	
33. 30	l .	В		ADMINISTRATIVE & GENERAL	5. 00	0	33. 30
33. 31	RENTAL	В		OPERATING ROOM	50. 00	0	33. 31
33. 32	RENTAL	В	-1, 920	ELECTROCARDI OLOGY	69. 00	0	33. 32
	RENTAL	В	-202, 523	INPATIENT DIALYSIS	76. 01	0	
33. 34		A		ADMINISTRATIVE & GENERAL	5. 00	0	
		1		1	1	0	
33. 35	PHYSICIAN LOAN EXPENSE	A		ADMINISTRATIVE & GENERAL	5. 00	-	
	PHYSICIAN LOAN EXPENSE	A		OPERATING ROOM	50. 00	0	
33. 37	PHYSICIAN LOAN EXPENSE	A		RADI OLOGY-THERAPEUTI C	55. 00	0	
33. 38	PHYSICIAN LOAN EXPENSE	A	-20, 000	ELECTROCARDI OLOGY	69. 00	0	33. 38
33. 40	OTHER REVENUE	В		I&R SERVICES-OTHER PRGM	22. 00	0	33. 40
				COSTS APPRVD		Ĭ	
33. 41	OTHER MISC FEES	В	_675 761	CAFETERI A	11. 00	0	33. 41
	1			1	1	-	
33. 42	DONATIONS EXPENSE	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 42
50.00	TOTAL (sum of lines 1 thru 49)		-26, 992, 525				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						
(1) D-	scription all chapter referen			- CMC Dub 1F 1			

⁽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.

					'	0 12/31/2020	7/29/2021 2:3	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	у (р.іі.
		I denti fi er	Remuneration	Component	Component		ider Component	
				'	•		Hours	
	1. 00	2.00	3. 00	4. 00	5. 00	6. 00	7. 00	
1.00	5. 00	ADMINISTRATIVE & GENERAL	204, 181	20, 181	184, 000	211, 500	1, 496	1.00
2.00	13. 00	NURSING ADMINISTRATION	5, 392	192	5, 200	211, 500	40	2.00
3.00	15. 00	PHARMACY	19, 166	11, 666	7, 500	211, 500	108	3.00
4.00	40. 00	SUBPROVI DER - I PF	429, 819	368, 349	61, 470	211, 500	240	4.00
5.00		OPERATING ROOM	2, 073, 549	1, 992, 709	80, 840	246, 400	361	5.00
6.00		RADI OLOGY-DI AGNOSTI C	885	885	0	211, 500	0	6.00
7. 00	55. 00	RADI OLOGY-THERAPEUTI C	1, 268, 790	1, 241, 665	27, 125	271, 900	155	7.00
8.00	60. 00	LABORATORY	140, 001	0	140, 001	211, 500	2, 682	8.00
9. 00		RESPIRATORY THERAPY	879, 008		12, 000	271, 900	290	9.00
10.00		ELECTROCARDI OLOGY	3, 464, 077	3, 454, 472	9, 605	211, 500	43	10.00
11. 00		NEURODI AGNOSTI CS	97, 847	79, 847	18, 000	211, 500	83	11.00
12.00		ASC (NON-DISTINCT PART)	113, 011	75, 010	38, 001	211, 500	288	12.00
13. 00		INPATIENT DIALYSIS	36, 807	0	36, 807	211, 500	375	13.00
14.00		WOUND CLINIC	-950		0	211, 500	0	14.00
15. 00	91. 00	EMERGENCY	1, 292, 050		38, 797	211, 500	424	15.00
200.00			10, 023, 633	9, 364, 287	659, 346		6, 585	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of		Physician Cost	
		l denti fi er	Li mi t	Unadjusted RCE			of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
	1.00	0.00	0.00	0.00	Educati on	12	44.00	
1 00	1.00	2.00	8.00	9. 00	12. 00	13. 00	14. 00	1 00
1.00		ADMINISTRATIVE & GENERAL	152, 117	7, 606	0		0	1.00
2.00		NURSING ADMINISTRATION	4, 067	203	0		0	2.00
3. 00		PHARMACY	10, 982	549	0	0	0	3.00
4.00		SUBPROVI DER - I PF	24, 404	1, 220	0	0	0	4.00
5.00		OPERATING ROOM	42, 765	2, 138	0	0	0	5.00
6.00		RADI OLOGY - DI AGNOSTI C	0	0	0	0	0	6.00
7. 00		RADI OLOGY-THERAPEUTI C	20, 262	1, 013	0	0	0	7.00
8. 00		LABORATORY	272, 713	13, 636	0	0	0	8.00
9.00		RESPIRATORY THERAPY	37, 909	1, 895	0	0	0	9.00
10.00		ELECTROCARDI OLOGY	4, 372	219	0	0	0	10.00
11.00		NEURODI AGNOSTI CS	8, 440	422	0	0	0	11.00
12.00		ASC (NON-DISTINCT PART)	29, 285	1, 464	0	0	0	12.00
13.00		I NPATI ENT DI ALYSI S	38, 131	1, 907	0	0	0	13.00
14.00		WOUND CLINIC	~	0	0	0	0	14.00
15. 00 200. 00	91.00	EMERGENCY	43, 113	2, 156	0	0	0	15.00
	Wkst. A Line #	Cost Center/Physician	688, 560 Provi der	34, 428 Adjusted RCE	RCE	Adjustment	U	200.00
	WKSt. A LITTE #	I denti fi er	Component	Limit	Di sal I owance	Auj us tillerit		
		ruentiffer	Share of col.	LIIIII	DI Sai i Owance			
			14					
	1. 00	2.00	15. 00	16. 00	17. 00	18. 00		
1. 00		ADMI NI STRATI VE & GENERAL	0		31, 883	52, 064		1. 00
2. 00		NURSING ADMINISTRATION	ا م	4, 067	1, 133	1, 325		2. 00
3. 00		PHARMACY	o o	10, 982	0	11, 666		3. 00
4. 00		SUBPROVI DER - I PF	l ő	24, 404	37, 066			4. 00
5. 00		OPERATING ROOM	Ö		· ·			5. 00
6. 00		RADI OLOGY-DI AGNOSTI C	Ö	· ·	0	885		6. 00
7. 00		RADI OLOGY-THERAPEUTI C	Ö		6, 863	1, 248, 528		7. 00
8. 00		LABORATORY	Ö	· ·	0, 000	0		8. 00
9. 00		RESPIRATORY THERAPY	Ö	' '	ő	867, 008		9. 00
10.00		ELECTROCARDI OLOGY	Ö		5, 233	3, 459, 705		10.00
11. 00		NEURODI AGNOSTI CS	Ö		9, 560	89, 407		11. 00
12. 00		ASC (NON-DISTINCT PART)	Ö		8, 716	83, 726		12.00
13. 00		INPATIENT DIALYSIS	l ő	38, 131	0, 710	00,720		13. 00
14. 00		WOUND CLINIC	Ö		0	-950		14. 00
15. 00		EMERGENCY	Ö		ő	1, 253, 253		15.00
200.00	, 00		o o	· ·				200.00
		,						

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0042

					To	12/31/2020	Date/Time Pre 7/29/2021 2:3	
				CAPI TAL REI	ATED COSTS		772772021 2.3	5 piii
		Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	COMMUNI CATI ON	
		Cost Center Description	for Cost	BLDG & FIXI	MVBLE EQUIP	BENEFITS	S	
			Allocation			DEPARTMENT		
			(from Wkst A					
			col. 7) 0	1. 00	2.00	4. 00	4. 01	
	GENER	AL SERVICE COST CENTERS	-					
1.00		CAP REL COSTS-BLDG & FIXT	21, 798, 356	21, 798, 356				1.00
2. 00 4. 00	1	CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT	95, 145 29, 374, 062	119, 823	95, 145 523	29, 494, 408		2.00 4.00
4. 01		COMMUNI CATI ONS	279, 251	0	0	79, 473	358, 724	4. 01
4. 02		PURCHASING & RECEIVING	788, 202			191, 602		4. 02
4. 03 4. 04		REGISTRATION PATIENT ACCOUNTS	1, 528, 508			433, 907		4. 03 4. 04
5.00		ADMINISTRATIVE & GENERAL	3, 834, 889 15, 421, 793		5, 160	680, 739 2, 040, 856		5.00
7. 00		OPERATION OF PLANT	5, 926, 153			651, 892		7. 00
8.00		LAUNDRY & LINEN SERVICE	306, 834	129, 780		61, 948		8.00
9. 00 10. 00		HOUSEKEEPI NG DI ETARY	2, 261, 214 993, 647	180, 548 0	788 0	599, 854 157, 210		9. 00 10. 00
11. 00	1	CAFETERI A	1, 054, 758	_	1, 347	323, 755		
13.00		NURSING ADMINISTRATION	3, 146, 378			669, 817		
14. 00 15. 00	1	CENTRAL SERVICES & SUPPLY PHARMACY	591, 777	97, 766		105, 498 836, 030		
16. 00		MEDICAL RECORDS & LIBRARY	3, 134, 655 4, 122, 872	147, 352 112, 874	493	1, 020, 159		
17. 00		SOCIAL SERVICE	0	0		0	0	17. 00
17. 01	1	MENTAL HEALTH OH	723, 368			150, 842	34, 581	17. 01
21. 00 22. 00		I&R SERVICES-SALARY & FRINGES APPRVD I&R SERVICES-OTHER PRGM COSTS APPRVD	857, 653 1, 501, 630	249, 998 0	1, 091 0	0 357, 702	0 7, 685	21. 00 22. 00
23. 00		PARAMED ED PRGM-RADIOLOGY	1, 501, 630	0	0	337, 702	7,085	23.00
23. 01	02301	PARAMED ED PRGM-LAB	219, 785	0	0	67, 180	0	23. 01
20.00		I ENT ROUTI NE SERVI CE COST CENTERS	F // 1 0/0	4 500 7/0	/ FOE	4 05/ 040	05.040	00.00
30. 00 31. 00		ADULTS & PEDIATRICS INTENSIVE CARE UNIT	5, 664, 369 3, 928, 274	1, 508, 760 516, 409		1, 356, 840 914, 201	25, 360 15, 523	
40. 00		SUBPROVI DER - I PF	1, 776, 874	321, 221	1, 402	576, 282	0	40.00
41.00		SUBPROVI DER - I RF	1, 796, 862			457, 989		
43. 00		NURSERY LARY SERVICE COST CENTERS	319, 892	0	0	84, 644	0	43.00
50.00		OPERATING ROOM	3, 108, 291	592, 118	2, 584	877, 985	23, 054	50.00
51.00		RECOVERY ROOM	0	0	0	0	0	51.00
51. 01 52. 00		ENDOSCOPY DELIVERY ROOM & LABOR ROOM	1, 268, 492	301, 580 0		215, 870		
53.00		ANESTHESI OLOGY	1, 073, 687 0	0	- 1	281, 254 0	10, 298	53.00
54. 00		RADI OLOGY-DI AGNOSTI C	5, 441, 687	533, 956	2, 331	1, 027, 947	10, 298	
55.00		RADI OLOGY-THERAPEUTI C	2, 486, 941	443, 238		732, 494		
60. 00 63. 00		LABORATORY BLOOD STORING, PROCESSING & TRANS.	7, 195, 388 0	179, 858 0	785 0	647, 174 0	6, 763	60. 00 63. 00
65. 00		RESPI RATORY THERAPY	2, 306, 571	139, 958	- 1	677, 745		
66. 00	1	PHYSI CAL THERAPY	3, 853, 718			1, 066, 727		
69. 00 70. 00		ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY	2, 128, 583	448, 069 0	1, 956 0	1, 501, 822	13, 064 0	
70. 00		NEURODI AGNOSTI CS	501, 096	_	829	129, 930	3, 381	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4, 036, 742	0	0	0	0	71.00
72.00		IMPL. DEV. CHARGED TO PATIENTS	3, 970, 233	0	0	0	0	72.00
73. 00 75. 00		DRUGS CHARGED TO PATIENTS ASC (NON-DISTINCT PART)	17, 428, 911 1, 686, 959	0	0	304, 238	0	73. 00 75. 00
76. 00		MH ANCILLARY OUTPATIENT	0	0	Ö	001, 200	Ö	76.00
76. 01		INPATIENT DIALYSIS	284, 883	211, 502	923	0	461	76. 01
90. 00		TIENT SERVICE COST CENTERS CLINIC	87, 146	55, 550	242	24, 901	1, 691	90.00
90. 00		WOUND CLINIC	930, 009			112, 928		90.00
91. 00		EMERGENCY	4, 265, 088			1, 030, 663		
92. 00		OBSERVATION BEDS (NON-DISTINCT PART)						92.00
96. 00		REIMBURSABLE COST CENTERS DURABLE MEDICAL EQUIP-RENTED	144, 629	9, 710	42	25, 235	0	96.00
		HOME HEALTH AGENCY	0			0		101.00
440.5		AL PURPOSE COST CENTERS						440.00
		I NTEREST EXPENSE HOSPI CE	776, 842	119, 799	523	126, 012		113. 00 116. 00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	174, 423, 097			20, 601, 345		
	NONRE	MBURSABLE COST CENTERS						
		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	12.740	0		190.00
		PHYSICIANS' PRIVATE OFFICES FP PETERSBURG	30, 598, 704 320, 967	3, 154, 472 91, 309	13, 769 399	6, 046, 839 72, 310		192. 00 192. 01
		PEDI ATRI CS	1, 781, 084			386, 439		192.02
192. 03	19203	WASHINGTON PRIMARY CARE	1, 590, 631	167, 585	731	379, 541		192. 03

Health Financial Systems	GOOD SAMARITAN HOSPITAL	In Lieu	of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS	Provi der CCN: 15-0042	From 01/01/2020 To 12/31/2020	Worksheet B Part I Date/Time Prepared:

						7/29/2021 2: 3	
			CAPI TAL REL	ATED COSTS			
	Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	COMMUNICATION	
		for Cost			BENEFITS	S	
		Allocation			DEPARTMENT		
		(from Wkst A					
		col. 7)					
		0	1.00	2.00	4. 00	4. 01	
194. 00 07950	COMMUNITY HEALTH SERVICES	7, 118	10, 228	45	98	461	194. 00
194. 01 07960	CCBHC GRANTS	357, 020	0	0	74, 227	0	194. 01
194. 02 07952	MARKETING AND PUBLIC RELATIONS	707, 250	41, 650	182	64, 429	768	194. 02
194. 03 07953	MH RESIDENTIAL	496, 153	499, 305	2, 179	131, 548	0	194. 03
194. 04 07954	UNUSED SPACE	0	502, 016	2, 191	0	0	194.04
194. 05 07955	MOB	30, 491	0	0	0	0	194. 05
194. 06 07956	FOUNDATI ON	0	11, 485	50	0	307	194. 06
194. 07 07957	KNOX COUNTY HEALTH DEPT	0	116, 127	507	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	6, 556, 703	865, 110	3, 776	1, 737, 632	0	194. 09
200. 00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers		0	0	0	0	201.00
202. 00	TOTAL (sum lines 118 through 201)	216, 869, 218	21, 798, 356	95, 145	29, 494, 408	358, 724	202. 00

				Io	12/31/2020	Date/lime Pre 7/29/2021 2:3	
	Cost Center Description	PURCHASING &	REGI STRATI ON	PATI ENT	Subtotal	ADMI NI STRATI V	J DIII
	·	RECEI VI NG		ACCOUNTS		E & GENERAL	
	[4. 02	4. 03	4. 04	4A. 04	5. 00	
1 00	GENERAL SERVICE COST CENTERS						1 00
1. 00 2. 00	OO100 CAP REL COSTS-BLDG & FIXT OO200 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	1, 269, 234					4. 02
4. 03	00403 REGI STRATI ON	593	2, 248, 650				4. 03
4.04	00404 PATIENT ACCOUNTS	767	0	4, 523, 772			4. 04
5.00	00500 ADMINISTRATIVE & GENERAL	4, 892	0	0	18, 680, 946		
7. 00	00700 OPERATION OF PLANT	10, 326	0	0	12, 546, 750		7.00
8. 00	00800 LAUNDRY & LINEN SERVICE	5, 807	0	0	504, 935		
9. 00 10. 00	00900 HOUSEKEEPI NG	13, 106 28, 573	0	0	3, 061, 350		
11. 00	01000 DI ETARY 01100 CAFETERI A	58, 012	0	0	1, 180, 813 1, 749, 321		
13. 00	01300 NURSING ADMINISTRATION	15, 325	0	Ö	4, 076, 252	l .	
	01400 CENTRAL SERVI CES & SUPPLY	6, 130	o	Ö	802, 981	75, 688	
	01500 PHARMACY	4, 108	0	0	4, 128, 782		
16.00	01600 MEDICAL RECORDS & LIBRARY	368	0	0	5, 265, 834	496, 352	16. 00
17. 00	01700 SOCIAL SERVICE	0	0	0	0	0	17. 00
17. 01	01701 MENTAL HEALTH OH	271	0	0	973, 542		17. 01
	02100 I &R SERVI CES-SALARY & FRI NGES APPRVD	0	0	0	1, 108, 742		
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	3, 412	0	0	1, 870, 429		
23. 00	02300 PARAMED ED PRGM-RADI OLOGY	0	0	0	207 175	0	
23. 01	02301 PARAMED ED PRGM-LAB INPATIENT ROUTINE SERVICE COST CENTERS	210	0	0	287, 175	27, 069	23. 01
30. 00	03000 ADULTS & PEDIATRICS	26, 142	111, 835	225, 005	8, 924, 896	841, 252	30.00
31. 00	03100 I NTENSI VE CARE UNI T	21, 566	58, 017	116, 726	5, 572, 970		
40. 00	04000 SUBPROVI DER – I PF	1, 598	31, 440	63, 256	2, 772, 073		1
41.00	04100 SUBPROVI DER - I RF	5, 607	26, 663	53, 643	2, 777, 706		
43.00	04300 NURSERY	1, 351	4, 923	9, 904	420, 714	39, 656	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	43, 091	141, 709	285, 110	5, 073, 942	478, 265	
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
51. 01	05101 ENDOSCOPY	26, 973	38, 025	76, 505	1, 932, 911	182, 194	
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	5, 217	18, 853	37, 932	1, 427, 241	134, 530 0	52. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	19, 220	306, 837	616, 956	7, 959, 232		
55. 00	05500 RADI OLOGY-THERAPEUTI C	6, 295	82, 180	165, 342	3, 924, 265		55. 00
60.00	06000 LABORATORY	161, 202	258, 622	520, 333	8, 970, 125		1
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500 RESPI RATORY THERAPY	4, 314	49, 893	100, 381	3, 285, 621	309, 699	65. 00
66. 00	06600 PHYSI CAL THERAPY	3, 741	87, 496	176, 036	5, 570, 011		66. 00
69. 00	06900 ELECTROCARDI OLOGY	9, 499	138, 535	278, 724	4, 520, 252		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	2 200	10 027	20, 201	004.004	0	70.00
70. 01 71. 00	07001 NEURODI AGNOSTI CS 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	2, 289 276, 093	19, 037 15, 186	38, 301 30, 554	884, 826 4, 358, 575		1
	07200 IMPL. DEV. CHARGED TO PATIENTS	270, 664	36, 831	74, 103	4, 351, 831		1
	07300 DRUGS CHARGED TO PATIENTS	270,001	305, 987	615, 627	18, 350, 525		
75. 00	07500 ASC (NON-DISTINCT PART)	23, 786	76, 873	154, 665	2, 246, 521	211, 755	
76.00	03950 MH ANCILLARY OUTPATIENT	0	0	0	0		1
76. 01	03951 I NPATI ENT DI ALYSI S	144	3, 670	7, 384	508, 967	47, 975	76. 01
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	29	338	681	170, 578		
90. 01	04950 WOUND CLINIC	6, 664	16, 072	32, 336	1, 173, 363		
	09100 EMERGENCY	20, 262	164, 921	331, 811	6, 415, 364	604, 706	
92.00	O9200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS				0		92.00
96 00	09600 DURABLE MEDICAL EQUIP-RENTED	3, 729	1, 522	3, 062	187, 929	17 714	96.00
	10100 HOME HEALTH AGENCY	0,727	0	0,002	07, 727		101.00
	SPECIAL PURPOSE COST CENTERS	<u> </u>	<u> </u>	<u> </u>			
113.00	11300 NTEREST EXPENSE						113.00
116.00	11600 H0SPI CE	1, 212	7, 980	16, 056	1, 052, 113	99, 171	116. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	1, 092, 588	2, 003, 445	4, 030, 433	159, 070, 403	13, 232, 970	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	130, 676	180, 466	363, 087	40, 544, 574		
	19201 FP PETERSBURG	790	2, 197	4, 420	492, 392		192. 01
	19202 PEDI ATRI CS 19203 WASHI NGTON PRI MARY CARE	27, 694	12, 199 10, 836	24, 543	2, 235, 187		
	07950 COMMUNITY HEALTH SERVICES	11, 629 138	10, 836	21, 802	2, 182, 755 18, 088		192.03
	07960 CCBHC GRANTS	580	0	0	431, 827		
	07952 MARKETING AND PUBLIC RELATIONS	115	ol	0	814, 394		194. 01
	07953 MH RESIDENTIAL	1, 685	1, 628	3, 276	1, 135, 774		
	07954 UNUSED SPACE	0	0	0	504, 207		194. 04

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

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0042
From 01/01/2020
To 12/31/2020
Date/Time Prepared:

					7/29/2021 2: 3	3 pm
Cost Center Description	PURCHASI NG &	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. 05 07955 MOB	0	0	0	30, 491	2, 874	194. 05
194. 06 07956 FOUNDATI ON	0	0	0	11, 842	1, 116	194.06
194.07 07957 KNOX COUNTY HEALTH DEPT	0	0	0	116, 634	10, 994	194. 07
194. 08 07958 I NDUSTRI AL HEALTH	0	0	0	0	0	194. 08
194.09 07959 COMMUNITY MENTAL HEALTH CENTER	3, 339	37, 879	76, 211	9, 280, 650	874, 785	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, 269, 234	2, 248, 650	4, 523, 772	216, 869, 218	18, 680, 946	202. 00

					7/29/2021 2:3	3 pm
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
	PLANT	LINEN SERVICE				
	7. 00	8. 00	9. 00	10.00	11. 00	
GENERAL SERVICE COST CENTERS	•		<u> </u>	•		
1.00 O0100 CAP REL COSTS-BLDG & FLXT						1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4. 00 O0400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
4. 01 O0401 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 PATIENT ACCOUNTS						4.04
5. 00 00500 ADMINI STRATI VE & GENERAL						5.00
7. 00 00700 OPERATION OF PLANT	13, 729, 394					7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE	127, 094	470 424				8. 00
	1	679, 624	0 574 040			
9. 00 00900 HOUSEKEEPI NG	176, 812	44, 488	3, 571, 210			9. 00
10. 00 01000 DI ETARY	0	9, 081	93, 025	1, 394, 221		10.00
11. 00 01100 CAFETERI A	302, 145	0	22, 397	0	2, 238, 752	11.00
13.00 01300 NURSING ADMINISTRATION	235, 629	0	0	0	68, 270	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	95, 743	9, 440	40, 366	n	22, 475	14.00
15. 00 01500 PHARMACY	144, 302	7, 110	31, 616	o o	74, 178	15. 00
	1	0		0		
16. 00 01600 MEDI CAL RECORDS & LI BRARY	110, 538	0	30, 210	O ₁	134, 857	16.00
17. 00 01700 SOCI AL SERVI CE	0	0	0	O	0	17. 00
17.01 01701 MENTAL HEALTH OH	62, 871	12, 998	96, 619	0	16, 588	17. 01
21.00 02100 L&R SERVICES-SALARY & FRINGES APPRVD	244, 824	0	0	0	0	21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	54, 169	ol	19, 961	22.00
23. 00 02300 PARAMED ED PRGM-RADI OLOGY	0	0	0.7.07	ň	0	23. 00
23. 01 02301 PARAMED ED PRGM-LAB	0	0	0	0		23. 00
	1 0	U	U	<u> </u>	7, 044	23.01
INPATIENT ROUTINE SERVICE COST CENTERS			-			
30. 00 03000 ADULTS & PEDI ATRI CS	1, 477, 538	234, 088	878, 479	645, 199	198, 429	30.00
31.00 03100 INTENSIVE CARE UNIT	505, 722	82, 775	268, 242	275, 366	113, 119	31.00
40. 00 04000 SUBPROVI DER - 1 PF	314, 574	0	ol	198, 204	71, 525	40.00
41. 00 04100 SUBPROVI DER - I RF	414, 951	38, 812	158, 653	275, 452	66, 038	41.00
43. 00 04300 NURSERY	0	1, 697	9, 219	273, 432	9, 089	43. 00
		1, 097	9, 219	U _I	9, 009	43.00
ANCILLARY SERVICE COST CENTERS				_1		
50.00 05000 OPERATING ROOM	579, 865	23, 512	200, 426	0	72, 642	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0	51.00
51. 01 05101 ENDOSCOPY	295, 339	18, 417	53, 284	0	27, 967	51.01
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	10, 377	12, 240	ol	31, 043	52.00
53. 00 05300 ANESTHESI OLOGY	0	.0,0,,	0	n	0.70.0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	522, 906	44, 840	166, 727	٥	111, 043	54.00
· · · · · · · · · · · · · · · · · · ·	1			0		
55. 00 05500 RADI OLOGY-THERAPEUTI C	434, 066	3, 037	0	o _l	66, 379	55.00
60. 00 06000 LABORATORY	176, 136	0	50, 575	0	104, 063	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65. 00 06500 RESPIRATORY THERAPY	137, 062	246	38, 023	0	67, 796	65.00
66. 00 06600 PHYSI CAL THERAPY	368, 709	7, 218	96, 515	ol	114, 297	66.00
69. 00 06900 ELECTROCARDI OLOGY	438, 796	12, 801	146, 934	0	95, 546	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	12,001	110, 701	o o	70, 010	70.00
		0.050	07.000	0		
70. 01 07001 NEURODI AGNOSTI CS	186, 032	9, 259	37, 293	0	14, 364	70. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00 07500 ASC (NON-DISTINCT PART)	0	23, 532	156, 362	o	40, 182	75.00
76. 00 03950 MH ANCILLARY OUTPATIENT	0	0	0	Ö	0	76. 00
		0		- 1		
76. 01 03951 I NPATI ENT DI ALYSI S	207, 126	0	0	0	0	76. 01
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	54, 400	5	57, 711	0	3, 601	90.00
90. 01 04950 WOUND CLINIC	71, 825	5, 849	18, 490	0	11, 416	90.01
91. 00 09100 EMERGENCY	571, 249	61, 647	236, 626	ol	127, 928	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		,			• • •	92.00
OTHER REIMBURSABLE COST CENTERS				<u> </u>		72.00
	9, 509	0		ام	2 (00	04 00
	1	0	0	0	3, 608	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	117, 320	0	48, 336	ol	14, 895	116 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)		65/L 110		1, 394, 221	1, 708, 343	
	0, 303, 083	654, 119	3,002,037	1, 374, 221	1, 100, 343	110.00
NONREI MBURSABLE COST CENTERS			-1	.1		100 5-
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	3, 089, 191	25, 505	548, 099	0	410, 196	
192. 01 19201 FP PETERSBURG	89, 420	0	o	ol		192. 01
192. 02 19202 PEDI ATRI CS	n	n	n	n	33, 021	
192. 03 19203 WASHINGTON PRIMARY CARE	164, 117	n	١	o o	34, 123	
		0	17 440	9		
194. 00 07950 COMMUNITY HEALTH SERVICES	10, 016	0	17, 449	٥		194.00
194. 01 07960 CCBHC GRANTS	0	0	0	0	8, 456	194. 01
194.02 07952 MARKETING AND PUBLIC RELATIONS	40, 788	0	3, 125	0	8, 355	194. 02
194. 03 07953 MH RESI DENTI AL	488, 973	0	0	0	27, 155	194.03
194. 04 07954 UNUSED SPACE	491, 628	0	0	o		194. 04
	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			-1		

Health Financial Systems	GOOD SAMARITAN HOSPITAL	In Lieu of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS	Provi der CCN: 15-0042	From 01/01/2020 Part I
		To 12/31/2020 Date/Time Prepared:

						7/29/2021 2:3	3 pm
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		PLANT	LINEN SERVICE				
		7. 00	8. 00	9. 00	10.00	11. 00	
194. 05 07	7955 MOB	0	0	0	0	0	194. 05
194. 06 07	7956 FOUNDATI ON	11, 247	0	0	0	0	194.06
194. 07 07	7957 KNOX COUNTY HEALTH DEPT	113, 724	0	0	0	0	194. 07
194. 08 07	7958 INDUSTRIAL HEALTH	0	0	0	0	0	194. 08
194. 09 07	7959 COMMUNITY MENTAL HEALTH CENTER	847, 207	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)	13, 729, 394	679, 624	3, 571, 210	1, 394, 221	2, 238, 752	202.00

Peri od: Worksheet B From 01/01/2020 Part I To 12/31/2020 Date/Ti me Prepared: 7/29/2021 2:33 pm

						7/29/2021 2:3	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCI AL	
		ADMI NI STRATI O N	SERVICES & SUPPLY		RECORDS & LI BRARY	SERVI CE	
		13. 00	14. 00	15. 00	16.00	17. 00	
	GENERAL SERVICE COST CENTERS						
	DO100 CAP REL COSTS-BLDG & FLXT						1.00
	DO200 CAP REL COSTS-MVBLE EQUIP DO400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
	00400 EMPEOTEE BENEFITTS BEFARTMENT						4. 00
	00402 PURCHASING & RECEIVING						4. 02
	00403 REGI STRATI ON						4. 03
1	00404 PATIENT ACCOUNTS						4. 04
	DO500 ADMINISTRATIVE & GENERAL						5. 00
1	00700 OPERATION OF PLANT						7. 00
	00800 LAUNDRY & LINEN SERVICE						8.00
	00900 HOUSEKEEPI NG						9.00
	D1000 DI ETARY D1100 CAFETERI A						10.00
	D1300 NURSING ADMINISTRATION	4, 764, 374					13.00
	01400 CENTRAL SERVICES & SUPPLY	4, 704, 374	1, 046, 693				14.00
1	D1500 PHARMACY		3, 820	4, 771, 873			15.00
1	01600 MEDICAL RECORDS & LIBRARY	O	343	0	6, 038, 134		16.00
	01700 SOCIAL SERVICE	O	0	0	0	0	17. 00
17. 01	01701 MENTAL HEALTH OH	0	252	0	0	0	17. 01
1	D2100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	107, 283	3, 173	7, 760	0	0	22. 00
	D2300 PARAMED ED PRGM-RADIOLOGY	0	0	0	0	0	23.00
	D2301 PARAMED ED PRGM-LAB	0	195	0	0	0	23. 01
	NPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	1, 066, 457	24, 308	111	1, 254, 985	0	30.00
	D3100 NTENSI VE CARE UNIT	607, 958	20, 052	24	602, 737	0	
	04000 SUBPROVI DER - I PF	377, 339	1, 486	24	647, 942	0	40.00
	04100 SUBPROVI DER – I RF	354, 919	5, 214	2	376, 711	0	41.00
43.00	04300 NURSERY	48, 850	1, 256	15	103, 326	0	43.00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	296, 304	40, 067	5, 647	499, 411	0	1
	D5100 RECOVERY ROOM	0	0	0	0	0	51.00
	D5101 ENDOSCOPY	150, 308	25, 080	387	0	0	51.01
	D5200 DELIVERY ROOM & LABOR ROOM D5300 ANESTHESIOLOGY	166, 840	4, 851 0	119 0	0	0	52. 00 53. 00
	D5400 RADI OLOGY-DI AGNOSTI C	58, 695	17, 871	58, 760	0	0	54.00
	D5500 RADI OLOGY-THERAPEUTI C	254, 741	5, 853	886	0	0	55.00
	D6000 LABORATORY	0	149, 890	315	o	0	60.00
63.00	D6300 BLOOD STORING, PROCESSING & TRANS.	O	0	0	О	0	63.00
	06500 RESPIRATORY THERAPY	0	4, 011	746	0	0	65.00
1	D6600 PHYSI CAL THERAPY	207, 090	3, 479	783	0	0	66.00
	D6900 ELECTROCARDI OLOGY	0	8, 833	17, 992	0	0	69.00
	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
	07001 NEURODI AGNOSTI CS	19, 679	2, 128	5	0	0	70.01
	D7100 MEDICAL SUPPLIES CHARGED TO PATIENTS D7200 IMPL. DEV. CHARGED TO PATIENTS	0	256, 702 251, 670	0	0	0	71. 00 72. 00
	D7300 DRUGS CHARGED TO PATTENTS	0	231, 670	4, 214, 051	0	0	73.00
	07500 ASC (NON-DISTINCT PART)	215, 959	22, 117	6, 591	1, 407, 821	0	75.00
	03950 MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
	D3951 INPATIENT DIALYSIS	o	134	1, 048	О	0	76. 01
	OUTPAȚIENT SERVICE COST CENTERS						
	09000 CLI NI C	0	27	0	0	0	90.00
	04950 WOUND CLINIC	16, 721	6, 196	3, 086	258, 316	0	90. 01
	09100 EMERGENCY	687, 549	18, 840	2, 740	886, 885	0	
	D9200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92.00
	09600 DURABLE MEDICAL EQUIP-RENTED	0	3, 468	0	0	0	96.00
	10100 HOME HEALTH AGENCY		0, 400	Ö	ő		101.00
	SPECIAL PURPOSE COST CENTERS	<u> </u>	<u> </u>	<u> </u>	<u> </u>		
	11300 NTEREST EXPENSE						113.00
116. 00 1	11600 HOSPI CE	80, 054	1, 127	19	0		116. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	4, 716, 746	882, 443	4, 321, 111	6, 038, 134	0	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	47, 628	121, 506		0		192.00
	19201 FP PETERSBURG	0	735	2, 778	0		192. 01 192. 02
	19202 PEDLATRICS 19203 WASHINGTON PRIMARY CARE		25, 750 10, 813	91, 695 35, 726			192. 02
	07950 COMMUNITY HEALTH SERVICES		10, 813	35, 726	0		194.00
	07950 COMMON THE TEACHT SERVICES	0	539	164	0		194.00
	07952 MARKETING AND PUBLIC RELATIONS	o	107	0	ol		194. 02
	D7953 MH RESIDENTIAL	o	1, 566	O	o		194. 03
		'					

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

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0042
From 01/01/2020
To 12/31/2020
Date/Time Prepared:

					7/29/2021 2:3	3 pm
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. 04 07954 UNUSED SPACE	0	0	0	0	0	194. 04
194. 05 07955 MOB	0	0	0	0	0	194. 05
194. 06 07956 FOUNDATI ON	0	0	0	0	0	194.06
194.07 07957 KNOX COUNTY HEALTH DEPT	0	0	0	0	0	194. 07
194. 08 07958 I NDUSTRI AL HEALTH	o	0	0	o	0	194. 08
194.09 07959 COMMUNITY MENTAL HEALTH CENTER	o	3, 105	0	o	0	194. 09
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	o	0	0	o	0	201.00
202.00 TOTAL (sum lines 118 through 201)	4, 764, 374	1, 046, 693	4, 771, 873	6, 038, 134	0	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS | Peri od: | Worksheet B | From 01/01/2020 | Part I | To 12/31/2020 | Date/Time Prepared: Provider CCN: 15-0042

			Т	o 12/31/2020	Date/Time Pre 7/29/2021 2:3	
		INTERNS &	RESI DENTS		772772021 2.0	J piii
Cost Contor Doscription	MENTAL HEALTH	SERVI CES-SALA	SEDVICES OTHE	PARAMED ED	PARAMED ED	
Cost Center Description	OH	RY & FRINGES	R PRGM COSTS	PRGM-RADI OLOG	PRGM-LAB	
				Υ		
CENEDAL CEDVICE COST CENTEDS	17. 01	21. 00	22. 00	23. 00	23. 01	
GENERAL SERVICE COST CENTERS 1. 00 00100 CAP REL COSTS-BLDG & FLXT						1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUI P						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 OO404 PATIENT ACCOUNTS 5. 00 OO500 ADMINISTRATIVE & GENERAL		•				4. 04 5. 00
7. 00 00700 OPERATION OF PLANT						7.00
8. 00 00800 LAUNDRY & LI NEN SERVI CE						8.00
9. 00 00900 HOUSEKEEPI NG						9.00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A						11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON						13.00
14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY						14. 00 15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY						16.00
17. 00 01700 SOCI AL SERVI CE						17. 00
17. O1 O17O1 MENTAL HEALTH OH	1, 254, 635					17. 01
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	C	1, 458, 075				21.00
22. 00 02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD	C		2, 239, 080			22.00
23. 00 02300 PARAMED ED PRGM-RADI OLOGY 23. 01 02301 PARAMED ED PRGM-LAB				0		23.00
23. 01 O2301 PARAMED ED PRGM-LAB I NPATI ENT ROUTI NE SERVI CE COST CENTERS					321, 483	23. 01
30. 00 03000 ADULTS & PEDIATRICS	C	533, 450	819, 189	0	0	30.00
31.00 03100 INTENSIVE CARE UNIT		57, 952	88, 993	0	0	31.00
40. 00 04000 SUBPROVI DER - PF	569, 042	1	1		0	40.00
41. 00 04100 SUBPROVI DER - I RF 43. 00 04300 NURSERY					0	41.00 43.00
ANCILLARY SERVICE COST CENTERS		,	0	<u> </u>	0	43.00
50. 00 05000 OPERATING ROOM	C	0	0	0	0	50.00
51. 00 05100 RECOVERY ROOM	C	0	_	_		51.00
51. 01 05101 ENDOSCOPY 52. 00 05200 DELIVERY ROOM & LABOR ROOM			0	_	0	51. 01 52. 00
53. 00 05300 ANESTHESI OLOGY			0	_	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		Ö	Ö	_	Ö	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	C	20, 803	31, 946	0	0	55.00
60. 00 06000 LABORATORY	C	0	1			60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		21 205	0	_	0	63.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY		31, 205	47, 919 0		0	65. 00 66. 00
69. 00 06900 ELECTROCARDI OLOGY		47, 550	1	_	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0	1	0		70.00
70. 01 07001 NEURODI AGNOSTI CS	C	0	0	0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS			0	0	0	
73. 00 07300 DRUGS CHARGED TO PATIENTS			0	0	0	1
75. 00 07500 ASC (NON-DISTINCT PART)		221, 405	339, 998	0	Ö	1
76.00 03950 MH ANCILLARY OUTPATIENT		0	0	0	0	
76. 01 03951 I NPATI ENT DI ALYSI S	C	16, 345	25, 101	0	0	76. 01
90. 00 09000 CLI NI C			0	0	0	90.00
90. 01 04950 WOUND CLINIC			Ö	0		90.00
91. 00 09100 EMERGENCY	C	91, 014	139, 764	0		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS		J				0, 00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 101. 00 10100 HOME HEALTH AGENCY	C		1			96. 00 101. 00
SPECIAL PURPOSE COST CENTERS		,	0	0	0	1101.00
113. 00 11300 I NTEREST EXPENSE						113. 00
116. 00 11600 HOSPI CE	5.00.010	1 070 105	0 404 450	0		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	569, 042	1, 370, 405	2, 104, 450	0	321, 483	j 118. 00
NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		0	0	0	0	190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES		87, 670	1	_		192.00
192. 01 19201 FP PETERSBURG		0	0			192. 01
192. 02 19202 PEDI ATRI CS	C	0	0	0		192. 02
192.03 19203 WASHINGTON PRIMARY CARE 194.00 07950 COMMUNITY HEALTH SERVICES			0	0		192.03
194.00 07950 COMMUNITY HEALTH SERVICES 194.01 07960 CCBHC GRANTS			0	0		194. 00 194. 01
31/07/00/005110 010/11/10	1		1 0	ı	<u> </u>	1. 7 7. 01

GOOD SAMARITAN HOSPITAL Health Financial Systems In Lieu of Form CMS-2552-10 COST ALLOCATION - GENERAL SERVICE COSTS Worksheet B Provi der CCN: 15-0042 Peri od: From 01/01/2020 To 12/31/2020

Part I Date/Time Prepared: 7/29/2021 2:33 pm INTERNS & RESIDENTS MENTAL HEALTH SERVICES-SALA SERVICES-OTHE PARAMED ED PARAMED ED Cost Center Description RY & FRINGES R PRGM COSTS PRGM-RADI OLOG PRGM-LAB ОН 17. 01 21. 00 22.00 23.00 23. 01 194.02 07952 MARKETING AND PUBLIC RELATIONS 194.03 07953 MH RESIDENTIAL 0 194. 02 0 194. 03 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 194. 04 07954 UNUSED SPACE 0 194.04 0 194. 05 07955 MOB 0 194.05 194.06 07956 FOUNDATION 194.07 07957 KNOX COUNTY HEALTH DEPT 194.08 07958 INDUSTRIAL HEALTH 0 0 0 194.06 0 0 0 194. 07 0 194.08 0 0 194. 09 07959 COMMUNITY MENTAL HEALTH CENTER 685, 593 0 0 194. 09 200.00 Cross Foot Adjustments 0 0 0 200.00 0 201.00 201.00 Negative Cost Centers 0

1, 254, 635

1, 458, 075

2, 239, 080

321, 483 202. 00

TOTAL (sum lines 118 through 201)

202.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS | Peri od: | Worksheet B | From 01/01/2020 | Part I | To 12/31/2020 | Date/Time Prepared: Provider CCN: 15-0042

					To	Date/Time Pr 7/29/2021 2:	
		Cost Center Description	Subtotal	Intern &	Total	, , , , , , , , , , , , , , , , , , , ,	,
				Residents Cost & Post			
				Stepdown			
				Adjustments			
	CENED	AL SERVICE COST CENTERS	24. 00	25. 00	26. 00		
1. 00		CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	1	EMPLOYEE BENEFITS DEPARTMENT					4.00
4. 01 4. 02	1	COMMUNI CATIONS PURCHASING & RECEIVING					4. 01 4. 02
4. 03	1	REGI STRATI ON					4. 03
4. 04		PATIENT ACCOUNTS					4. 04
5. 00 7. 00	4	ADMINISTRATIVE & GENERAL OPERATION OF PLANT					5. 00 7. 00
8. 00	1	LAUNDRY & LINEN SERVICE					8.00
9. 00	00900	HOUSEKEEPI NG					9. 00
10.00	1	DI ETARY					10.00
11. 00 13. 00	1	CAFETERIA NURSI NG ADMI NI STRATI ON					11.00
14. 00		CENTRAL SERVICES & SUPPLY					14.00
15. 00	01500	PHARMACY					15. 00
16.00		MEDICAL RECORDS & LIBRARY SOCIAL SERVICE					16.00
17. 00 17. 01		MENTAL HEALTH OH					17. 00 17. 01
21. 00	1	I&R SERVICES-SALARY & FRINGES APPRVD					21.00
22. 00	1	I&R SERVICES-OTHER PRGM COSTS APPRVD					22. 00
23. 00	1	PARAMED ED PRGM-RADIOLOGY					23.00
23. 01		PARAMED ED PRGM-LAB ENT ROUTINE SERVICE COST CENTERS					23. 01
30.00		ADULTS & PEDIATRICS	16, 898, 381	-1, 352, 639	15, 545, 742		30.00
31.00		INTENSIVE CARE UNIT	8, 721, 213	-146, 945	8, 574, 268		31.00
40. 00 41. 00		SUBPROVI DER - I PF SUBPROVI DER - I RF	6, 102, 703 4, 730, 282	-889, 201 0	5, 213, 502 4, 730, 282		40. 00 41. 00
43.00	1	NURSERY	633, 822	0	633, 822		43.00
	ANCI L	LARY SERVICE COST CENTERS	, .				
50.00		OPERATI NG ROOM	7, 270, 081	0	7, 270, 081		50.00
51. 00 51. 01		RECOVERY ROOM ENDOSCOPY	0 2, 685, 887	0	0 2, 685, 887		51. 00 51. 01
52. 00	1	DELIVERY ROOM & LABOR ROOM	1, 787, 241	Ö	1, 787, 241		52.00
53.00		ANESTHESI OLOGY	0	0	0		53.00
54. 00 55. 00	1	RADI OLOGY-DI AGNOSTI C RADI OLOGY-THERAPEUTI C	9, 690, 303 5, 111, 873	0 -52, 749	9, 690, 303 5, 059, 124		54. 00 55. 00
60.00	1	LABORATORY	10, 618, 102	-52, 749	10, 618, 102		60.00
63.00		BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
65.00		RESPI RATORY THERAPY	3, 922, 328	-79, 124	3, 843, 204		65.00
66. 00 69. 00	1	PHYSI CAL THERAPY ELECTROCARDI OLOGY	6, 893, 126 5, 787, 798	0 -120, 570	6, 893, 126 5, 667, 228		66. 00 69. 00
70.00		ELECTROENCEPHALOGRAPHY	0,707,770	-120, 370	0,007,220		70.00
70. 01	07001	NEURODI AGNOSTI CS	1, 236, 989	o	1, 236, 989		70. 01
71.00		MEDICAL SUPPLIES CHARGED TO PATIENTS	5, 026, 112	0	5, 026, 112		71.00
72. 00 73. 00	4	IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	5, 013, 700 24, 294, 278	0	5, 013, 700 24, 294, 278		72. 00 73. 00
75. 00		ASC (NON-DISTINCT PART)	4, 892, 243	-561, 403	4, 330, 840		75. 00
		MH ANCILLARY OUTPATIENT	0	0	0		76.00
76. 01		INPATIENT DIALYSIS TIENT SERVICE COST CENTERS	806, 696	-41, 446	765, 250		76. 01
90.00		CLINIC	302, 401	ol	302, 401		90.00
90. 01	04950	WOUND CLINIC	1, 675, 862	O	1, 675, 862		90. 01
91.00		EMERGENCY	9, 844, 312	-230, 778	9, 613, 534		91.00
92. 00		OBSERVATION BEDS (NON-DISTINCT PART) REIMBURSABLE COST CENTERS		0			92.00
96. 00		DURABLE MEDICAL EQUIP-RENTED	222, 228	0	222, 228		96.00
101. 00		HOME HEALTH AGENCY	0	0	0		101.00
112 0		AL PURPOSE COST CENTERS INTEREST EXPENSE					113.00
		HOSPI CE	1, 413, 035	o	1, 413, 035		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	145, 580, 996	-3, 474, 855			118. 00
100 5		IMBURSABLE COST CENTERS	-1				100.00
	1	GIFT, FLOWER, COFFEE SHOP & CANTEEN PHYSICIANS' PRIVATE OFFICES	0 49, 151, 007	0 -222, 300	0 48, 928, 707		190. 00 192. 00
		FP PETERSBURG	640, 829	-222, 300 0	48, 928, 707 640, 829		192.00
192. 0	2 19202	PEDI ATRI CS	2, 596, 339	0	2, 596, 339		192. 02
		WASHINGTON PRIMARY CARE	2, 633, 278	0	2, 633, 278		192.03
		COMMUNITY HEALTH SERVICES CCBHC GRANTS	47, 398 481, 690	0	47, 398 481, 690		194. 00 194. 01
	1	1	,	<u> </u>			1

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

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0042
From 01/01/2020
To 12/31/2020
Date/Time Prepared:

				7/29/2021 2: 3	
Cost Center Description	Subtotal	Intern &	Total		
		Resi dents			
		Cost & Post			
		Stepdown			
		Adjustments			
	24. 00	25. 00	26. 00		
194.02 07952 MARKETING AND PUBLIC RELATIONS	943, 533	0	943, 533		194. 02
194. 03 07953 MH RESIDENTIAL	1, 760, 525	0	1, 760, 525		194. 03
194. 04 07954 UNUSED SPACE	1, 043, 361	0	1, 043, 361		194. 04
194. 05 07955 MOB	33, 365	0	33, 365		194. 05
194. 06 07956 FOUNDATI ON	24, 205	0	24, 205		194.06
194.07 07957 KNOX COUNTY HEALTH DEPT	241, 352	0	241, 352		194. 07
194. 08 07958 I NDUSTRI AL HEALTH	0	0	0		194. 08
194.09 07959 COMMUNITY MENTAL HEALTH CENTER	11, 691, 340	0	11, 691, 340		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)	216, 869, 218	-3, 697, 155	213, 172, 063		202. 00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2020 | Part | I | To | 12/31/2020 | Date/Time Prepared: | Pare | Pa Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0042

					Io	12/31/2020	Date/lime Pre 7/29/2021 2:3	
				CAPI TAL REI	LATED COSTS		7,2,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	<u>Б.</u>
			5	DI DO A FLIVE	10/01 5 50/// 0		EMBL 0)/EE	
		Cost Center Description	Directly Assigned New	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
			Capi tal				DEPARTMENT	
			Related Costs				BEI 7 III TIMEIT	
			0	1. 00	2.00	2A	4. 00	
		AL SERVICE COST CENTERS						
1. 00 2. 00		CAP REL COSTS-BLDG & FLXT CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4. 00		EMPLOYEE BENEFITS DEPARTMENT	0	119, 823	523	120, 346	120, 346	4.00
4. 01		COMMUNI CATI ONS	ő	0		0	324	4. 01
4. 02		PURCHASING & RECEIVING	0	285, 265	1, 245	286, 510	782	4. 02
4. 03	1	REGI STRATI ON	0	278, 586		279, 802	1, 771	4. 03
4. 04	1	PATIENT ACCOUNTS	0	1 102 117		1 107 277	2, 778	4. 04
5. 00 7. 00		ADMINISTRATIVE & GENERAL OPERATION OF PLANT	0	1, 182, 117 5, 913, 049		1, 187, 277 5, 938, 860	8, 330 2, 661	5. 00 7. 00
8. 00	1	LAUNDRY & LINEN SERVICE	ő	129, 780		130, 346	253	8.00
9. 00		HOUSEKEEPI NG	0	180, 548		181, 336	2, 448	9. 00
10.00	1	DI ETARY	0	0	-	0	642	10.00
11.00	1	CAFETERI A	0	308, 529		309, 876	1, 321	11.00
13. 00 14. 00	1	NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	0	240, 608 97, 766		241, 658 98, 193	2, 734 431	13. 00 14. 00
15. 00		PHARMACY	o	147, 352		147, 995	3, 412	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	O	112, 874		113, 367	4, 164	
17. 00		SOCIAL SERVICE	0	0		0	0	17. 00
17. 01	1	MENTAL HEALTH OH	0	64, 200		64, 480	616	17. 01
21. 00 22. 00			0	249, 998	1, 091	251, 089	0 1, 460	21. 00 22. 00
23. 00		PARAMED ED PRGM-RADIOLOGY	0	0		0	1, 460	23. 00
23. 01		PARAMED ED PRGM-LAB	ő	0	_	o	274	23. 01
	I NPAT	IENT ROUTINE SERVICE COST CENTERS						
30.00	1	ADULTS & PEDIATRICS	0	1, 508, 760		1, 515, 345	5, 538	30.00
31.00		I NTENSI VE CARE UNI T	0	516, 409		518, 663	3, 731	31.00
40. 00 41. 00		SUBPROVI DER – I PF SUBPROVI DER – I RF	0	321, 221 423, 720		322, 623 425, 569	2, 352 1, 869	40. 00 41. 00
43. 00		NURSERY	o	423, 720		423, 307	345	43.00
		LARY SERVICE COST CENTERS	-					
50.00		OPERATING ROOM	0	592, 118		594, 702	3, 584	50.00
51.00		RECOVERY ROOM	0	201 500	_	0	0	51.00
51. 01 52. 00		ENDOSCOPY DELIVERY ROOM & LABOR ROOM	0	301, 580 0		302, 896 0	881 1, 148	51. 01 52. 00
53. 00		ANESTHESI OLOGY	ő	0		Ö	0	53.00
54.00	1	RADI OLOGY-DI AGNOSTI C	0	533, 956	2, 331	536, 287	4, 196	54.00
55.00	1	RADI OLOGY-THERAPEUTI C	0	443, 238		445, 173	2, 990	55.00
60. 00 63. 00		LABORATORY BLOOD STORING, PROCESSING & TRANS.	0	179, 858	1	180, 643	2, 641	60. 00 63. 00
65.00	1	RESPIRATORY THERAPY	0	0 139, 958	_	140, 569	0 2, 766	65.00
66. 00		PHYSI CAL THERAPY	ő	376, 500		378, 143	4, 354	
69.00		ELECTROCARDI OLOGY	0	448, 069		450, 025		69.00
		ELECTROENCEPHALOGRAPHY	0	0		0		70. 00
	1	NEURODI AGNOSTI CS	0	189, 963		190, 792		70. 01
71. 00 72. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	71. 00 72. 00
73. 00		DRUGS CHARGED TO PATIENTS	ő	0	l ő	o	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	1, 242	
76. 00		MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76. 01		I NPATI ENT DI ALYSI S	0	211, 502	923	212, 425	0	76. 01
90. 00		TIENT SERVICE COST CENTERS	n n	55, 550	242	55, 792	102	90. 00
90. 01		WOUND CLINIC	ő	73, 343		73, 663	461	
91.00		EMERGENCY	O	583, 320		585, 866	4, 207	91.00
92.00		OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
0, 00		REIMBURSABLE COST CENTERS	ام	0.740	1	0.750	400	0, 00
		DURABLE MEDICAL EQUIP-RENTED HOME HEALTH AGENCY	0	9, 710 0	1	9, 752 0		96. 00 101. 00
101.00		AL PURPOSE COST CENTERS	<u> </u>	0	<u> </u>	<u> </u>	0	101.00
113.00		INTEREST EXPENSE						113. 00
		HOSPI CE	0	119, 799		120, 322		116. 00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	16, 339, 069	71, 316	16, 410, 385	84, 085	118. 00
100 00		IMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN		^	0	ما	0	190. 00
		PHYSICIANS' PRIVATE OFFICES		3, 154, 472		3, 168, 241	24, 645	
		FP PETERSBURG	Ö	91, 309		91, 708		192. 01
		PEDI ATRI CS	o	0		0		192. 02
		WASHINGTON PRIMARY CARE	0	167, 585		168, 316		192. 03
194.00	ηυ/950	COMMUNITY HEALTH SERVICES	<u> </u> 0	10, 228	45	10, 273	0	194. 00

GOOD SAMARITAN HOSPITAL Health Financial Systems In Lieu of Form CMS-2552-10 ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 15-0042 Worksheet B Peri od: From 01/01/2020

Part II Date/Time Prepared: 7/29/2021 2:33 pm 12/31/2020 CAPITAL RELATED COSTS Di rectly BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Cost Center Description Subtotal Assigned New **BENEFITS** DEPARTMENT Capi tal Related Costs 1.00 2.00 2A 4.00 303 194. 01 263 194. 02 194. 01 07960 CCBHC GRANTS 0 0 0 0 0 0 194. 02 07952 MARKETING AND PUBLIC RELATIONS 194. 03 07953 MH RESIDENTIAL 41, 650 182 41, 832 537 194. 03 499, 305 2, 179 501, 484 194. 04 07954 UNUSED SPACE 194. 05 07955 MOB 194. 06 07956 FOUNDATI ON 502, 016 2, 191 504, 207 0 194.04 0 194. 05 0 0 194.06 11, 485 50 11, 535

116, 127

865, 110

21, 798, 356

507

3, 776

95, 145

116, 634

868, 886

21, 893, 501

0 194. 07

0 194.08

200.00

0 201.00

7, 092 194. 09

120, 346 202. 00

194. 07 07957 KNOX COUNTY HEALTH DEPT

194. 09 07959 COMMUNITY MENTAL HEALTH CENTER

Cross Foot Adjustments

Negative Cost Centers

TOTAL (sum lines 118 through 201)

194. 08 07958 I NDUSTRI AL HEALTH

200.00

201.00

202.00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2020 Part II
To 12/31/2020 Date/Time Prepared: 7/29/2021 2:33 pm

				, , ,		7/29/2021 2:3	
	Cost Center Description	COMMUNI CATI ON	PURCHASING &	REGI STRATI ON	PATI ENT ACCOUNTS	ADMINISTRATIV E & GENERAL	
		S 4. 01	RECEI VI NG 4. 02	4. 03	4. 04	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
4. 01	00401 COMMUNI CATI ONS	324					4. 01
4. 02	00402 PURCHASING & RECEIVING	3	287, 295	1			4. 02
4. 03	00403 REGISTRATION	5	134	1	0.050		4. 03
4. 04	00404 PATIENT ACCOUNTS	24	174		2, 959	l	4.04
5. 00 7. 00	00500 ADMINISTRATIVE & GENERAL	24 18	1, 107		0	1, 196, 738 75, 757	5. 00 7. 00
8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	0	2, 337 1, 314	1	0	3, 049	8.00
9. 00	00900 HOUSEKEEPI NG	5	2, 966	1	0	18, 484	9.00
10.00	01000 DI ETARY	1	6, 468	1	0		10.00
11. 00	01100 CAFETERI A	3	13, 131		0	10, 562	11.00
13. 00	01300 NURSI NG ADMI NI STRATI ON	3	3, 469		0	24, 612	13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	1	1, 387		0	4, 848	14.00
15.00	01500 PHARMACY	5	930		0	24, 930	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	8	83	O	0	31, 795	16.00
17.00	01700 SOCI AL SERVI CE	0	0	0	0	0	17. 00
17. 01	01701 MENTAL HEALTH OH	31	61	0	0	5, 878	17. 01
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	6, 695	21.00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	7	772	0	0	11, 294	22. 00
23.00	02300 PARAMED ED PRGM-RADIOLOGY	0	0		0	0	23.00
23. 01	02301 PARAMED ED PRGM-LAB	0	47	0	0	1, 734	23. 01
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDI ATRI CS	23	5, 917		155	53, 889	30.00
31. 00	03100 I NTENSI VE CARE UNI T	14	4, 881		81	33, 650	31.00
40.00	04000 SUBPROVI DER - I PF	0	362	1	44	16, 738	1
41. 00	04100 SUBPROVI DER - I RF	10	1, 269	1	37	16, 772	41.00
43. 00	04300 NURSERY	0	306	617	7	2, 540	43.00
FO 00	ANCI LLARY SERVI CE COST CENTERS	21	0.754	17 740	107	20.727	
50. 00 51. 00	05000 OPERATING ROOM	21	9, 754	17, 748	197	30, 636	50.00
	05100 RECOVERY ROOM	0	(105	0	0	1	51.00
51. 01 52. 00	O5101 ENDOSCOPY O5200 DELI VERY ROOM & LABOR ROOM	4	6, 105 1, 181	4, 762 2, 361	53 26	11, 671 8, 618	51. 01 52. 00
53. 00	05300 ANESTHESI OLOGY	9	1, 101	2, 301	20	0,010	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	9	4, 351		264	l	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	5	1, 425	1	114	23, 695	1
60.00	06000 LABORATORY	6	36, 489	1	359	54, 162	60.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.		00, 107		0	0 1, 132	63.00
65. 00	06500 RESPI RATORY THERAPY	6	977	6, 249	69	19, 839	65.00
66.00	06600 PHYSI CAL THERAPY	4	847	1	121	33, 632	66.00
69.00	06900 ELECTROCARDI OLOGY	12	2, 150	1	192	1	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70. 01	07001 NEURODI AGNOSTI CS	3	518	2, 384	26	5, 343	70. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	62, 497	1, 902	21	26, 317	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	61, 266	4, 613	51	26, 276	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0	,	425	110, 800	
	07500 ASC (NON-DISTINCT PART)	0	5, 384	9, 628	107	13, 564	
76. 00	03950 MH ANCILLARY OUTPATIENT	0	0	0	0		76.00
76. 01	03951 NPATI ENT DI ALYSI S	0	33	460	5	3, 073	76. 01
	OUTPATIENT SERVICE COST CENTERS					4 000	
90.00	09000 CLINIC	2	1 500	42	0	,	90.00
90. 01	04950 WOUND CLINIC	2	1, 508	1	22		•
91.00	09100 EMERGENCY	15	4, 586	20, 655	229	38, 736	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92.00
06 00	09600 DURABLE MEDICAL EQUIP-RENTED	l	844	191	2	1, 135	96.00
	10100 HOME HEALTH AGENCY		044	1	0		101.00
101.00	SPECIAL PURPOSE COST CENTERS	ı o		<u> </u>			1101.00
113 00	11300 I NTEREST EXPENSE						113.00
	11600 HOSPI CE	3	274	999	11	6 353	116.00
118. 00	1	269	247, 311		2, 618		
	NONREI MBURSABLE COST CENTERS	207	217,011	20.7002	2,010	0177070	
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	51	29, 579	22, 602	251	244, 885	
	19201 FP PETERSBURG	0	179		3		192. 01
	19202 PEDI ATRI CS] 3	6, 269	1	17	13, 496	
192. 03	19203 WASHINGTON PRIMARY CARE	0	2, 632	1, 357	15	13, 179	192. 03
	07950 COMMUNITY HEALTH SERVICES	0	31	0	0		194. 00
	07960 CCBHC GRANTS		131	1	0		194. 01
	07952 MARKETING AND PUBLIC RELATIONS	1	26		0		194. 02
	07953 MH RESIDENTIAL	0	381	1	2		194. 03
194. 04	07954 UNUSED SPACE	0	0	0	0	3, 044	194. 04

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

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0042
From 01/01/2020
To 12/31/2020
To 12/31/2020
To 7/29/2021 2: 33 pm

						7/29/2021 2:3	3 pm
	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. 05 07955	MOB	0	0	0	0	184	194. 05
194. 06 07956	FOUNDATI ON	0	0	0	0	72	194.06
194. 07 07957	KNOX COUNTY HEALTH DEPT	0	0	0	0	704	194. 07
194. 08 07958	INDUSTRIAL HEALTH	0	0	0	0	0	194. 08
194. 09 07959	COMMUNITY MENTAL HEALTH CENTER	0	756	4, 744	53	56, 037	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	287, 295	281, 712	2, 959	1, 196, 738	202.00

	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	7/29/2021 2: 3 CAFETERIA	
	cost center bescription	PLANT	LINEN SERVICE				
	GENERAL SERVICE COST CENTERS	7. 00	8. 00	9. 00	10. 00	11. 00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE 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 00404 PATI ENT ACCOUNTS						4. 03
4. 04 5. 00	00500 ADMINISTRATIVE & GENERAL						4. 04 5. 00
7. 00	00700 OPERATION OF PLANT	6, 019, 633					7.00
8. 00	00800 LAUNDRY & LINEN SERVICE	55, 724	190, 686				8.00
9.00	00900 HOUSEKEEPI NG	77, 523	12, 482	295, 244			9.00
10.00	01000 DI ETARY	0	2, 548	7, 691	24, 480		10.00
11. 00	01100 CAFETERI A	132, 475	0		0	469, 220	1
13.00	01300 NURSI NG ADMI NI STRATI ON	103, 311	0	0	0	14, 309	1
	01400 CENTRAL SERVICES & SUPPLY	41, 978	2, 649		0	4, 711	1
	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	63, 269	0		O O	15, 547 28, 265	15. 00 16. 00
17. 00	01700 SOCIAL SERVICE	48, 465 0	0	2, 490	0	26, 203	17.00
	01701 MENTAL HEALTH OH	27, 566	3, 647	7, 988	0	3, 477	17. 01
21. 00	02100 &R SERVICES-SALARY & FRINGES APPRVD	107, 343	0	0	0	0	21.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	4, 478	0	4, 184	22. 00
23.00	02300 PARAMED ED PRGM-RADIOLOGY	0	0	-	0	0	23. 00
23. 01	02301 PARAMED ED PRGM-LAB	0	0	0	0	1, 476	23. 01
	INPATIENT ROUTINE SERVICE COST CENTERS	(17 00 1	(5 (30	70 (07	44 000		
	03000 ADULTS & PEDIATRICS	647, 824	65, 678		11, 329	41, 589	1
31. 00 40. 00	03100 I NTENSI VE CARE UNI T 04000 SUBPROVI DER - I PF	221, 733 137, 925	23, 225 0	22, 176 0	4, 835 3, 480	23, 709 14, 991	31.00 40.00
41. 00	04100 SUBPROVI DER - TPF	181, 935	10, 890	-	4, 836	13, 841	1
43. 00	04300 NURSERY	0	476		4, 030	1, 905	1
	ANCILLARY SERVICE COST CENTERS					.,	
50.00	05000 OPERATING ROOM	254, 241	6, 597	16, 570	0	15, 225	50.00
51.00	05100 RECOVERY ROOM	0	0		0	0	
51. 01	05101 ENDOSCOPY	129, 491	5, 167		0	5, 862	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	2, 912		0	6, 506	1
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	229, 268	12 501	12 704	O O	0	
55. 00	05500 RADI OLOGY-THERAPEUTI C	190, 316	12, 581 852	13, 784	0	23, 273 13, 912	1
60.00	06000 LABORATORY	77, 227	0	· -	0	21, 811	1
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		o	0	ı
65.00	06500 RESPI RATORY THERAPY	60, 095	69	3, 143	0	14, 209	65.00
66.00	06600 PHYSI CAL THERAPY	161, 660	2, 025	7, 979	0	23, 956	66. 00
69.00	06900 ELECTROCARDI OLOGY	192, 390	3, 592		0	20, 026	1
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70. 01 71. 00	07001 NEURODI AGNOSTI CS 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	81, 565	2, 598	3, 083	0	3, 011	1
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	71. 00 72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	1
	07500 ASC (NON-DISTINCT PART)	0	6, 603		o	8, 422	
	03950 MH ANCILLARY OUTPATIENT	0	0		0	0	
76. 01	03951 INPATIENT DIALYSIS	90, 814	0	0	0	0	76. 01
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	23, 852	1	4, 771	0	755	
	04950 WOUND CLINIC	31, 492	1, 641		0	2, 393	1
91.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	250, 463	17, 297	19, 563	0	26, 812	91. 00 92. 00
92.00	OTHER REIMBURSABLE COST CENTERS						92.00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	4, 169	0	0	0	756	96. 00
	10100 HOME HEALTH AGENCY	0	0		o		101.00
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE						113.00
	11600 HOSPI CE	51, 439	0		0		116. 00
118. 00	3 /	3, 675, 553	183, 530	248, 230	24, 480	358, 055	1118.00
100 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		0	0	0	0	190. 00
	19000 PHYSI CLANS' PRI VATE OFFI CES	1, 354, 451	7, 156	_	0		190.00
	19201 FP PETERSBURG	39, 206	7, 130		0		192.01
	19202 PEDI ATRI CS	0	0	· -	o o		192.02
	19203 WASHINGTON PRIMARY CARE	71, 957	0	0	o	7, 152	192. 03
194.00	07950 COMMUNITY HEALTH SERVICES	4, 391	0	1, 443	О	2	194. 00
	07960 CCBHC GRANTS	0	0	0	0		194. 01
	07952 MARKETING AND PUBLIC RELATIONS	17, 883	0	258	0		194. 02
	07953 MH RESIDENTIAL	214, 389	0		0		194. 03
194.04	07954 UNUSED SPACE	215, 553	0	0	0	0	194. 04

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

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0042
From 01/01/2020
To 12/31/2020
Date/Time Prepared:

						7/29/2021 2: 3	3 pm
Cost Ce	nter Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		PLANT	LINEN SERVICE				
		7. 00	8. 00	9. 00	10.00	11. 00	
194. 05 07955 MOB		0	0	0	0	0	194. 05
194. 06 07956 FOUNDAT	ON	4, 931	0	0	0	0	194.06
194. 07 07957 KNOX CO	JNTY HEALTH DEPT	49, 862	0	0	0	0	194. 07
194. 08 07958 I NDUSTR	AL HEALTH	0	0	0	0	0	194. 08
194. 09 07959 COMMUNI	Y MENTAL HEALTH CENTER	371, 457	0	0	0	0	194. 09
200.00 Cross F	oot Adjustments						200.00
201.00 Negati v	e Cost Centers	0	0	0	O	0	201.00
202.00 TOTAL (sum lines 118 through 201)	6, 019, 633	190, 686	295, 244	24, 480	469, 220	202.00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2020 Part II
To 12/31/2020 Date/Time Prepared: 7/29/2021 2:33 pm

					12/31/2020	7/29/2021 2:3	
Cost	Center Description	NURSI NG ADMI NI STRATI O	CENTRAL SERVICES &	PHARMACY	MEDICAL RECORDS &	SOCI AL SERVI CE	
		N	SUPPLY		LI BRARY	SERVICE	
		13. 00	14. 00	15. 00	16. 00	17. 00	
	VICE COST CENTERS EL COSTS-BLDG & FIXT						1.00
	EL COSTS-BEDG & TTAT						2.00
1 1	YEE BENEFITS DEPARTMENT						4.00
4. 01 00401 COMMUI							4. 01
4. 02 00402 PURCH	ASING & RECEIVING						4. 02
4. 03 00403 REGI S							4.03
4. 04 00404 PATI EI							4.04
	ISTRATIVE & GENERAL						5.00
1 1	TION OF PLANT RY & LINEN SERVICE						7. 00 8. 00
9. 00 00900 HOUSEI							9.00
10. 00 01000 DI ETAI							10.00
11. 00 01100 CAFETI							11.00
	NG ADMINISTRATION	390, 096					13.00
14. 00 01400 CENTRA	AL SERVICES & SUPPLY	0	157, 535				14.00
15. 00 01500 PHARM		0	575	259, 277			15.00
1 1	AL RECORDS & LIBRARY	0	52	0	228, 697		16.00
17. 00 01700 SOCI AI		0	0	0	0	0	1
17. 01 01701 MENTAL		0	38		0	0	
	ERVICES-SALARY & FRINGES APPRVD ERVICES-OTHER PRGM COSTS APPRVD	0 8, 784	0 478	0 422	0	0	
	ED ED PRGM-RADIOLOGY	0, 764	0	422	0	0	
1 1	ED ED PRGM-LAB		29		0	0	
	OUTINE SERVICE COST CENTERS	<u> </u>	27	<u> </u>	<u> </u>		20.0.
	S & PEDIATRICS	87, 318	3, 658	6	47, 533	0	30.00
31. 00 03100 I NTENS	SIVE CARE UNIT	49, 778	3, 018	1	22, 829	0	31.00
	OVIDER - IPF	30, 896	224	1	24, 541	0	40.00
1 1	OVIDER - IRF	29, 060	785	0	14, 268	0	1
43. 00 04300 NURSEI		4, 000	189	1	3, 914	0	43.00
	ERVICE COST CENTERS	24.261	4 020	207	10 015	0	FO 00
50. 00 05000 OPERA 51. 00 05100 RECOVI		24, 261	6, 030 0	307 0	18, 915	0	1
51. 01 05101 ENDOS		12, 307	3, 775	21	0	0	
	ERY ROOM & LABOR ROOM	13, 660	730	6	Ö	0	
53. 00 05300 ANESTI		0	0	Ö	o	0	
54. 00 05400 RADI 01	LOGY-DI AGNOSTI C	4, 806	2, 690	3, 193	0	0	54.00
55. 00 05500 RADI 01	LOGY-THERAPEUTI C	20, 858	881	48	0	0	55.00
60. 00 06000 LABORA		0	22, 559	17	0	0	60.00
	STORING, PROCESSING & TRANS.	0	0	0	0	0	
1 1	RATORY THERAPY	0	604	41	0	0	
66. 00 06600 PHYSI (16, 956	524	43	0	0	1
	ROCARDI OLOGY ROENCEPHALOGRAPHY	0	1, 329 0	978 0	0	0	
70. 00 07000 LEECTI		1, 611	320	0	0	0	
	AL SUPPLIES CHARGED TO PATIENTS	0	38, 638		0	0	
	DEV. CHARGED TO PATIENTS	l ol	37, 877		o	0	
	CHARGED TO PATIENTS	O	0	228, 968	0	0	
75.00 07500 ASC (I	NON-DISTINCT PART)	17, 682	3, 329	358	53, 322	0	
	CILLARY OUTPATIENT	0	0	0	0	0	
76. 01 03951 I NPAT		0	20	57	0	0	76. 01
	SERVI CE COST CENTERS		4		ما	0	00.00
90. 00 09000 CLI NI (90. 01 04950 WOUND		1 2(0	933	0	0.704	0	
91. 00 09100 EMERGI		1, 369 56, 295	2, 835		9, 784 33, 591	0	
	VATION BEDS (NON-DISTINCT PART)	30, 243	2, 033	147	33, 341	0	92.00
	URSABLE COST CENTERS						72.00
	LE MEDICAL EQUIP-RENTED	0	522	0	0	0	96.00
101.00 10100 HOME I		O	0		0	0	101.00
SPECIAL PUR	POSE COST CENTERS						
113. 00 11300 I NTERI							113. 00
116. 00 11600 HOSPI		6, 555	170		0		116. 00
	TALS (SUM OF LINES 1 through 117)	386, 196	132, 816	234, 786	228, 697	0	118. 00
	ABLE COST CENTERS		0		اه		100 00
	FLOWER, COFFEE SHOP & CANTEEN	2 000	10 207	17 400	0		190.00
192. 00 19200 PHYSIC	CLANS' PRIVATE OFFICES	3, 900	18, 287 111	17, 408 151	0		192. 00 192. 01
192. 01 19201 FP PE 192. 02 19202 PEDI A			3, 875		0		192.01
	NGTON PRIMARY CARE		1, 627		0		192. 02
	NOTON TRAMMART CARE NITY HEALTH SERVICES		1, 027		ol		194.00
194. 01 07960 CCBHC		0	81	9	ő		194. 01
194. 02 07952 MARKE	TING AND PUBLIC RELATIONS	0	16	О	o	0	194. 02
194. 03 07953 MH RES	SI DENTI AL	0	236	0	0	0	194. 03

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

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0042
From 01/01/2020
To 12/31/2020
Date/Time Prepared:

					7/29/2021 2:3	3 pm
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. 04 07954 UNUSED SPACE	0	0	0	0	0	194.04
194. 05 07955 MOB	0	0	0	0	0	194.05
194. 06 07956 FOUNDATI ON	0	0	0	0	0	194.06
194.07 07957 KNOX COUNTY HEALTH DEPT	0	0	0	0	0	194. 07
194. 08 07958 I NDUSTRI AL HEALTH	o	0	0	0	0	194. 08
194.09 07959 COMMUNITY MENTAL HEALTH CENTER	o	467	0	0	0	194. 09
200.00 Cross Foot Adjustments					1	200.00
201.00 Negative Cost Centers	o	0	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	390, 096	157, 535	259, 277	228, 697	0	202. 00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2020 | Part | I | To | 12/31/2020 | Date/Time Prepared: | Pare | Pa Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0042

				1	0 12/31/2020	Date/lime Pr 7/29/2021 2:	
			INTERNS &	RESI DENTS			
	Cook Cooks Doors at a	MENTAL HEALTH	CEDVI CEC CALA	CERVI CEC OTHE	DADAMED ED	DADAMED ED	
	Cost Center Description	OH	SERVICES-SALA RY & FRINGES	R PRGM COSTS	PARAMED ED PRGM-RADIOLOG	PARAMED ED PRGM-LAB	
				11 1110 00010	Υ Υ	1 110111 2713	
	OFFICE OF A STATE OF A	17. 01	21. 00	22.00	23. 00	23. 01	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	1	I	I			1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
4. 01	00401 COMMUNI CATI ONS						4. 01
4. 02	00402 PURCHASING & RECEIVING						4. 02
4. 03	00403 REGI STRATI ON						4. 03
4. 04	00404 PATIENT ACCOUNTS						4.04
5. 00 7. 00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT						5. 00 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8.00
9. 00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A						11.00
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON						13.00
15. 00							14. 00 15. 00
16. 00	1						16.00
17. 00	1						17. 00
17. 01	01701 MENTAL HEALTH OH	113, 782					17. 01
	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	365, 127				21.00
22. 00		0		31, 879			22.00
23. 00 23. 01	O2300 PARAMED ED PRGM-RADI OLOGY O2301 PARAMED ED PRGM-LAB	0			0	3, 560	23. 00
20.01	INPATIENT ROUTINE SERVICE COST CENTERS		1			0,000	20.01
30.00	03000 ADULTS & PEDIATRICS	0)				30.00
31.00	1	0	l .				31.00
40. 00 41. 00		51, 609	l .				40. 00 41. 00
	04300 NURSERY		1				43.00
	ANCILLARY SERVICE COST CENTERS						
50.00		0)				50.00
51. 00 51. 01	O5100 RECOVERY ROOM O5101 ENDOSCOPY	0					51. 00 51. 01
52. 00							52.00
53. 00	1	0					53.00
54.00		0					54.00
55.00		0					55.00
60. 00 63. 00	06000 LABORATORY 06300 BLOOD STORING, PROCESSING & TRANS.	0					60. 00 63. 00
65. 00							65.00
66. 00	1	0					66.00
69. 00		0					69. 00
	07000 ELECTROENCEPHALOGRAPHY	0					70.00
	07001 NEURODI AGNOSTI CS 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0					70. 01 71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS						72.00
	07300 DRUGS CHARGED TO PATIENTS	0					73.00
	07500 ASC (NON-DISTINCT PART)	0					75.00
	03950 MH ANCILLARY OUTPATIENT	0	1				76.00
76. 01	03951 INPATIENT DIALYSIS OUTPATIENT SERVICE COST CENTERS	1 0					76. 01
90.00	09000 CLINIC	0)				90.00
90. 01		0					90. 01
	09100 EMERGENCY	0)				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92.00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	1 0)				96.00
	10100 HOME HEALTH AGENCY	0					101.00
	SPECIAL PURPOSE COST CENTERS	1		ı			
	0 11300 INTEREST EXPENSE						113.00
118.00	11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117)	51, 609	o	0	0	(116. 00 118. 00
. 10. 00	NONREI MBURSABLE COST CENTERS	31,007					1 13.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0					190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	1				192.00
	1 19201 FP PETERSBURG 2 19202 PEDI ATRI CS	0					192. 01 192. 02
	3 19203 WASHINGTON PRIMARY CARE						192. 02
	07950 COMMUNITY HEALTH SERVICES						194. 00
194. 01	1 07960 CCBHC GRANTS	0) <u> </u>				194. 01

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2020 | Part II | To 12/31/2020 | Date/Time Prepared: | 7/29/2021 2:33 pm Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS GOOD SAMARITAN HOSPITAL Provider CCN: 15-0042

					1/29/2021 2: 3	3 pm
		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	
194.02 07952 MARKETING AND PUBLIC RELATIONS	0					194. 02
194. 03 07953 MH RESI DENTI AL	0					194. 03
194. 04 07954 UNUSED SPACE	0					194. 04
194. 05 07955 MOB	0					194. 05
194. 06 07956 FOUNDATI ON	0					194. 06
194.07 07957 KNOX COUNTY HEALTH DEPT	0					194. 07
194. 08 07958 I NDUSTRI AL HEALTH	0					194. 08
194.09 07959 COMMUNITY MENTAL HEALTH CENTER	62, 173					194. 09
200.00 Cross Foot Adjustments		365, 127	31, 879	0	3, 560	200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	113, 782	365, 127	31, 879	0	3, 560	202. 00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2020 | Part | I | To | 12/31/2020 | Date/Time Prepared: | Pare | Pa Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0042

				11		2021 2:33 pm
Cost Center	Description	Subtotal	Intern &	Total	,, ., -, .,	
	·		Resi dents			
			Cost & Post			
			Stepdown			
		24. 00	Adjustments 25.00	26. 00		
GENERAL SERVICE CO	OST CENTERS	24.00	23.00	20.00		
1. 00 00100 CAP REL COST						1.00
2.00 00200 CAP REL COST	S-MVBLE EQUIP					2. 00
4. 00 00400 EMPLOYEE BEN						4.00
4. 01 00401 COMMUNI CATI C	•					4. 01
4. 02 00402 PURCHASI NG &						4. 02
4. 03 00403 REGI STRATI ON 4. 04 00404 PATI ENT ACCO						4. 03 4. 04
5. 00 00500 ADMI NI STRATI	•					5.00
7. 00 00700 OPERATION OF						7. 00
8.00 00800 LAUNDRY & LI						8. 00
9. 00 00900 HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A	NI CTRATION					11.00
13.00 01300 NURSI NG ADMI 14.00 01400 CENTRAL SERV						13. 00 14. 00
15. 00 01500 PHARMACY	TICES & SUPPLY					15.00
16. 00 01600 MEDICAL RECO	ORDS & LIBRARY					16.00
17. 00 01700 SOCIAL SERVI						17. 00
17.01 01701 MENTAL HEALT	TH OH					17. 01
	S-SALARY & FRINGES APPRVD					21.00
	5-OTHER PRGM COSTS APPRVD					22. 00
23. 00 02300 PARAMED ED P	•					23.00
23. 01 02301 PARAMED ED P	SERVICE COST CENTERS					23. 01
30. 00 03000 ADULTS & PED		2, 572, 436	0	2, 572, 436		30.00
31. 00 03100 NTENSI VE CA	•	939, 590	0			31.00
40. 00 04000 SUBPROVI DER	•	609, 724	0			40.00
41. 00 04100 SUBPROVI DER	- IRF	717, 596	0	717, 596		41.00
43. 00 04300 NURSERY		15, 062	0	15, 062		43.00
ANCI LLARY SERVI CE		000 700		000 700		
50. 00 05000 OPERATING RO		998, 788	0			50.00
51. 00 05100 RECOVERY ROC 51. 01 05101 ENDOSCOPY	JIVI	487, 400	0			51.00 51.01
52. 00 05200 DELI VERY ROO	OM & LABOR ROOM	38, 169	0			52.00
53. 00 05300 ANESTHESI OLO		0	0	0		53.00
54. 00 05400 RADI OLOGY-DI	AGNOSTI C	921, 273	0	921, 273		54.00
55. 00 05500 RADI 0L0GY-TH	IERAPEUTI C	710, 561	0	,		55.00
60. 00 06000 LABORATORY		432, 486	0	432, 486		60.00
	IG, PROCESSI NG & TRANS.	0	0	0		63.00
65. 00 06500 RESPI RATORY 66. 00 06600 PHYSI CAL THE		248, 636	0	248, 636		65. 00 66. 00
69. 00 06900 ELECTROCARDI		641, 202 733, 616	0	641, 202 733, 616		69.00
70. 00 07000 ELECTROENCEP		733, 010	0			70.00
70. 01 07001 NEURODI AGNOS		291, 784	0			70. 01
	PLIES CHARGED TO PATIENTS	129, 375	0			71.00
72.00 07200 I MPL. DEV. C		130, 083	0	130, 083		72. 00
73. 00 07300 DRUGS CHARGE		378, 516	0	378, 516		73.00
75.00 07500 ASC (NON-DIS 76.00 03950 MH ANCILLARY	,	132, 568 0	0	132, 568 0		75. 00 76. 00
76. 01 03951 I NPATI ENT DI	•	306, 887	0	306, 887		76.00
OUTPATIENT SERVICE		300, 007		300,007		70.01
90. 00 09000 CLINIC		86, 358	0	86, 358		90.00
90.01 04950 WOUND CLINIC	;	134, 063	0	134, 063		90. 01
91.00 09100 EMERGENCY		1, 061, 299	0			91.00
92. 00 09200 0BSERVATI ON			0			92. 00
96. 00 OTHER REI MBURSABLE MEDI		17, 474	0	17, 474		96.00
101. 00 10100 HOME HEALTH		17, 474	0	· ·		101. 00
SPECIAL PURPOSE CO		<u> </u>	J			101.00
113. 00 11300 I NTEREST EXP						113. 00
116. 00 11600 HOSPI CE		193, 759	0	193, 759		116.00
	SUM OF LINES 1 through 117)	12, 928, 705	0	12, 928, 705		118. 00
NONREI MBURSABLE CO		-1	=1	-		100.05
190. 00 19000 GLFT, FLOWER		0	0			190.00
192. 00 19200 PHYSI CI ANS' 192. 01 19201 FP PETERSBUR		5, 022, 739 136, 807	0	5, 022, 739 136, 807		192. 00 192. 01
192. 01 19201 FP PETERSBUR 192. 02 19202 PEDI ATRI CS		38, 668	0	38, 668		192.01
192. 03 19203 WASHINGTON P	PRIMARY CARE	269, 725	0	269, 725		192.02
194. 00 07950 COMMUNITY HE		16, 268	0	16, 268		194.00
194.01 07960 CCBHC GRANTS	<u> </u>	4, 903	0			194. 01

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

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0042
From 01/01/2020
To 12/31/2020
Date/Time Prepared:

			11	7/29/2021 2:3	
Cost Center Description	Subtotal	Intern &	Total		
		Residents			
		Cost & Post			
		Stepdown			
		Adjustments			
	24. 00	25. 00	26. 00		
194.02 07952 MARKETING AND PUBLIC RELATIONS	66, 947	0	66, 947		194. 02
194. 03 07953 MH RESI DENTI AL	729, 782	0	729, 782		194. 03
194. 04 07954 UNUSED SPACE	722, 804	0	722, 804		194. 04
194. 05 07955 MOB	184	0	184		194. 05
194. 06 07956 FOUNDATI ON	16, 538	0	16, 538		194. 06
194.07 07957 KNOX COUNTY HEALTH DEPT	167, 200	0	167, 200		194. 07
194. 08 07958 I NDUSTRI AL HEALTH	0	0	0		194. 08
194.09 07959 COMMUNITY MENTAL HEALTH CENTER	1, 371, 665	0	1, 371, 665		194. 09
200.00 Cross Foot Adjustments	400, 566	0	400, 566		200.00
201.00 Negative Cost Centers	0	0	0		201.00
202.00 TOTAL (sum lines 118 through 201)	21, 893, 501	o	21, 893, 501		202.00

Cash ALLICATION - SIAITSTICAL BASS Provide CC. 11-0025 To 17-17-202 To		Financial Systems	GUUD SAMARI I		011 45 0040 5		u or Form CMS-2	
COSE CONTON DESCRIPTION	COST A	ALLOCATION - STATISTICAL BASIS		Provider C			Worksheet B-1	
Cost Centur Description							Date/Time Pre	pared:
COUNTY COUNTY COU			0401741 051	ATER COOTS			7/29/2021 2: 3	3 pm
SOURCE FEET SOURCE FEET SOURCE FOR SUPPRINCE S			CAPITAL REI	LATED COSTS				
SOURCE FEET SOURCE FEET SOURCE FOR SUPPRINCE S		Cost Center Description	BLDG & FLYT	MVRIE FOILD	EMPLOYEE	COMMUNICATION	DIIDCHASING &	
DEBERBAL SERVICE COST CENTERS 1.00 2.00 4.00 4.00 1.0		cost center bescription						
Control Cont			(SQUARE TELT)	(SQUARE TEET)				
CALESTAL SERVICE COST CENTRIS 1.00							7	
DEFENDENT SERVICE ONLY CHARGES 1.00 2.00 4.00 4.01 4.02 1.00 1.								
1.00			1. 00	2.00		4. 01	4. 02	
2.00		GENERAL SERVICE COST CENTERS						
4.00 0.0000 DEMICUNEE BEKENT IS DEPARTMENT 4.862			884, 498					
4.01					1			
4.02 0.00402 PURCHASING & RECEIVING 11,575 11,575 11,575 11,004 13,1007 38 8,705 4.004 4.004 30,00403 PURCHASING 11,304 11,507 38 8,705 4.004								
4.03 00409 SEGISTRATION 11,304 11,3104 1,511,079 38 87,058 4,04 00409 APTIENT ACCOUNTS 0 0 0.273,07,070 48 11,256 4,04 0.0409 APTIENT ACCOUNTS 17,766 5,00 0.0000 ADMINISTRATIVE A CONTROL 229,939 229,939 227,232,338 172 151,477 17,766 5,00 0.0000 ADMINISTRATIVE A CONTROL 229,939 229,939 227,232,338 172 151,477 17,766 5,00 0.0000 ADMINISTRATIVE A CONTROL 229,939 229,939 227,232,338 172 171,766 5,00 0.0000 ADMINISTRATIVE A CONTROL 229,939 229,939 229,939 229,939 229,939 229,939 229,939 23			_	_			10 (10 005	
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5.00 0.0500 CAMIN INSTRATIVE & CENTERAL 47, 966		1						
2.00 0.0700 0.0700 0.0FEATION 0.0F PLATE 239, 930 2.29, 930 2.270, 238 127 151, 147 17.00 7.00 0.0700 0.085, 178 8.00 0.0800 0.085, 178 8.00 0.085, 178 9.00 0.085, 178 9.00 9			_	_				1
B.00 ORGOL (LANDRY & LINEN SERVICE 5, 266 7, 326 215, 736 0 85, 178 8 00 00 00 00 ORGEREPIN 7, 326 7, 326 0 0 547, 400 9 419, 130 10 00 11, 100 010 00 OETARY 7 0 0 547, 400 9 419, 130 10 00 11, 100 010 00 OETARY 7 10 00 010 00 01 11, 127, 487 17 17 00 100 00 01 11, 100 010 00 0			1					
9.00 0.0900 MOUSEKEEPING			1					1
10.00 01000 DETARY			1					
11.00 0 1100 CAFETERIA 12,519 12,519 1,127,487 19 850,961 11,00 130 130 01300 (MUSSING AMUNISTRATION) 7,763 7,763 2,332,664 20 224,779 13,00 130 140 1								
14.00 01400 (ENTIRAL SERVICES & SUPPLY 3, 967 5, 979 5, 979 5, 979 5, 979 1, 10, 10 10, 10			12, 519	12, 519	1			
15.00 01500 PHARMACY 5.979 5.979 2.911,505 39 60,227 15.00 17.00								
16.00 10400 MEDICAL RECORDS & LIBRARY 4, 580	14.00	01400 CENTRAL SERVICES & SUPPLY	3, 967	3, 967	367, 400	9	89, 914	14.00
17.00 01700 SOCIAL SERVICE 0	15.00	01500 PHARMACY	5, 979	5, 979	2, 911, 505	39	60, 257	15.00
17.0 01701 MENTAL HEALTH OH 2,605 2,605 525,313 225 3,980 17.01	16.00	01600 MEDICAL RECORDS & LIBRARY	4, 580	4, 580	3, 552, 741	59	5, 405	16.00
21.00 02100 BAT SERVI CES-SALARY & FRINGES APPROV 10, 144 10, 144 10, 144 70 0 0 0 1, 245, 712 50 50, 055 52, 20 02300 PARAMED ED PROBI-ABAI OLOGY 0 0 0 233, 957 0 0 0, 0 23, 00 03000 030000 030000 030000 030000 030000 030000 030000	17.00	01700 SOCIAL SERVICE	0	0) (0	0	17. 00
22 00 02200 RAT SERVICES-OTHER PROM COSTS APPRVD 0 0 0 1,245,712 50 50.055 22.00 23.00 02300 PARAMED ED PROM-LADA 0 0 0 233,957 0 3,077 23.01			2, 605			225	3, 980	17. 01
23. 00 02300 PARAMED ED PROM-LABB 0 0 233,957 0 3,077 23.00		1	10, 144	10, 144		, I		
33.0 02301 PARAMED ED PROM_LAB 0 0 233,957 0 3,077 23.01						50		
INPATIENT ROUTINE SERVICE COST CENTERS						0		
30.00 03000 ADULTS & PEDIATRIC S 61,220 61,220 64,725,244 165 383,474 30.00 40.00 04000 SURPROVIDER - I PF 13,034 13,034 2,006,922 0 23,448 40.00 41.00 04100 SURPROVIDER - I PF 17,193 17,	23. 01		0	0	233, 957	0	3, 077	23.01
31.00 03100 INTERSIVE CARE UNIT 20,954 20,954 3,183,737 101 316,343 31.00	20.00		(1.220	(1.220	4 705 044	1/5	202 474	20.00
40.00 04000 04000 04000 04000 04							-	
11.00 0410								
ABOOK ABOO			1	1				
ANCILLARY SERVICE COST CENTERS			1	1				
50.00	10.00				271,770	,	17,011	10.00
12, 237 12, 237 751, 774 27 395, 663 51. 01	50.00		24, 026	24, 026	3, 057, 616	150	632, 088	50.00
S2.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 979, 479 67 76, 534 52.00	51.00	05100 RECOVERY ROOM	0	0) (0	0	51.00
S3.00 05300 AIRSTHESI OLOGY 0 0 0 0 0 53.00	51.01	05101 ENDOSCOPY	12, 237	12, 237	751, 774	27	395, 663	51.01
54.00 05400 RADI OLOGY-DI AGNOSTI C 21, 666 21, 666 3, 579, 864 67 281, 936 54.00	52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	979, 479	67	76, 534	52.00
55.00 05500 ABDI OLOGY-THERAPEUTIC 17, 985 17, 985 2, 550, 937 38 92, 342 55.00			_	_	1	_		
60.00 06000 LABORATORY 7, 298 7, 298 2, 253, 807 44 2, 364, 643 60.00								1
63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0 63.00 65.00 06500 RESPIRATORY THERAPY 5,679 5,679 2,360,272 40 63.283 65.00 66.00 06600 PHYSI CAL THERAPY 15,277 15,277 3,714,916 27 54,882 66.00 69.00 06600 PHYSI CAL THERAPY 15,277 15,277 3,714,916 27 54,882 66.00 69.00 06600 PHYSI CAL THERAPY 18,181 18,181 5,230,152 85 139,346 69.00 69.00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 0 0 70.00 70.00 10ECTROENCEPHALOGRAPHY 0 0 0 0 0 0 0 0 0								
65.00 06500 RESPIRATORY THERAPY 5, 679 5, 679 2, 360, 272 40 63, 283 65.00 66.00 06600 PHYSI CAL THERAPY 15, 277 15, 277 3, 714, 916 27 54, 882 66.00 6900 06900 ELECTROCARDI OLOGY 18, 181 18, 181 18, 181 52, 30, 152 85 139, 346 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								
66. 00 06600 PHYSI CAL THERAPY 15, 277 15, 277 3, 714, 916 27 54, 882 66, 00 69. 00 06900 ELECTROCARDIOLOGY 18, 181 18, 181 52, 30, 152 85 139, 346 69, 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						-		
69, 00 0,000 CLECTROCARD OLOGY 18, 181 18, 181 5, 230, 152 85 139, 346 69, 00 70. 00 00 00 00 00 00								
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 70. 00 70. 01 07001 BEURODI AGNOSTI CS 7, 708 7, 708 452, 485 22 33, 578 70. 01 70. 00 70. 01 07010 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 4, 049, 804 71. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 3, 970, 317 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 348, 913 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 0 76. 01 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 76. 01 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 76. 01 07500 ASC (NON-DISTINCT PART) 0 0 0 0 76. 01 07500 ASC (NON-DISTINCT PART) 0 0 0 0 76. 01 07500 ASC (NON-DISTINCT PART) 0 0 0 0 76. 01 07500 ASC (NON-DISTINCT PART) 0 0 0 0 76. 01 07500 ASC (NON-DISTINCT PART) 0 0 0 0 77. 01 07500 ASC (NON-DISTINCT PART) 0 0 0 0 78. 01 07500 ASC (NON-DISTINCT PART) 0 0 0 0 79. 00 07500 07500 07500 07500 0 0 79. 00 07500 07500 07500 07500 0 0 79. 00 07500 07500 07500 07500 0 0 79. 00 07500 07500 07500 0 0 0 79. 00 07500 07500 07500 0 0 0 79. 00 07500 07500 07500 0 0 0 79. 00 07500 07500 07500 0 0 0 79. 00 07500 07500 07500 0 0 0 79. 00 07500 07500 07500 0 0 0 79. 00 07500 07500 07500 0 0 0 79. 00 07500 07500 07500 0 0 79. 00 07500 07500 07500 0 0 0 79. 00 07500 07500 07500 0 0 79. 00 07500 07500 07500 0 79. 00 07500 07500 07500 0 79. 00 07500 07500 07500 0 79. 00 07500 07500 07500 0 79. 00 07500 07500 07500 07500 07								1
70. 01 0701 NEURODI AGNOSTI CS 7, 708 7, 708 452, 485 22 33, 578 70. 01 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 0 4, 049, 804 71. 00 72. 00 07200 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 0 3, 970, 317 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 3, 970, 317 72. 00 75. 00 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 1, 059, 520 0 348, 913 75. 00 76. 00 03951 MPATIENT DI ALYSIS 8, 582 8, 582 0 3 2, 110 76. 01 76.								1
71. 00			_	_	1	_	_	1
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 3, 970, 317 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 73. 00 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 0 0 0					1			1
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 73. 00			1	_		_		
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76. 00		1	0	l o	1, 059, 520	o o		
76. 01 03951 INPATIENT DIALYSIS 8,582 8,582 0 3 2,110 76. 01			0	0				
90. 00 09000 CLI NI C 2, 254 2, 254 86, 719 11 427 90. 00 90. 01 04950 WOUND CLI NI C 2, 976 2, 976 393, 276 11 97, 755 90. 01 91. 00 09100 EMERGENCY 23, 669 23, 669 3, 589, 323 109 297, 220 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 92. 00 09400 DURABLE MEDI CAL EQUI P-RENTED 394 394 87, 883 0 54, 703 96. 00 101. 00 ODE MERGENCY ODE M		1	8, 582	8, 582	:	3		
90. 01 04950 WOUND CLINIC 2, 976 2, 976 23, 669 33, 276 11 97, 755 90. 01 91. 00 09100 EMERGENCY 23, 669 23, 669 3, 589, 323 109 297, 220 91. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92. 00 070 OBSERVATION BEDS (NON-DISTINCT PART) 92. 01 19201 FP PETERSBURG 92. 00 070 OBSERVATION BEDS (NON-DISTINCT PART) 92. 01 19201 FP PETERSBURG 92. 00 070 OBSERVATION BEDS (NON-DISTINCT PART) 92. 01 19201 FP PETERSBURG 93. 705 SERVATION BEDS (NON-DISTINCT PART) 92. 01 19202 PEDIATRICS 0 0 0 1, 345, 787 21 406, 231 192. 02		OUTPATIENT SERVICE COST CENTERS						
91. 00	90.00		2, 254	2, 254			427	90.00
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 92. 00 OTHER REIMBURSABLE COST CENTERS 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 394 394 87, 883 0 54, 703 96. 00 101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 0 0 SPECI AL PURPOSE COST CENTERS 113. 00 113. 00 11300 INTEREST EXPENSE 113. 00 116. 00 11600 HOSPI CE 4, 861 4, 861 438, 842 24 17, 781 116. 00 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 662, 980 662, 980 71, 744, 951 1, 935 16, 026, 853 119. 00 1900 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 127, 997 127, 997 21, 058, 309 368 1, 916, 862 192. 00 192. 01 19201 FP PETERSBURG 3, 705 251, 821 0 11, 590 192. 01 192. 02 19202 PEDI ATRI CS 0 0 0 1, 345, 787 21 406, 231 192. 02 192. 00 19200 PEDI ATRI CS 0 0 0 0 0 0 100. 00 100. 00 100. 00 100. 00 100. 00 100. 00 100. 00 100. 00 100. 00 100. 00 100. 00 100. 00 100. 00 100. 00 100. 00 100. 00 100. 00 100. 00 100. 00 100. 00			1	1				
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96. 00	92. 00							92.00
101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113. 00 11600 HOSPI CE SUBTOTALS (SUM OF LINES 1 through 117) 662, 980 662, 980 71, 744, 951 11, 935 16, 026, 853 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	04 00		1 004	1 204	07.000		E 4 700	0, 00
SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 14, 861 4, 861 438, 842 24 17, 781 116. 00 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 662, 980 662, 980 71, 744, 951 1, 935 16, 026, 853 118. 00 NONREI MBURSABLE COST CENTERS 100 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 190. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 127, 997 127, 997 21, 058, 309 368 1, 916, 862 192. 00 192. 01 19201 FP PETERSBURG 3, 705 3, 705 251, 821 0 11, 590 192. 01 192. 02 19202 PEDI ATRI CS 0 0 0 1, 345, 787 21 406, 231 192. 02 192. 02 192. 02 192. 03 192. 04 192. 04 192. 04 192. 05			1	l .				
113. 00	101.00		0	0	ή (η <u></u> Ο	0	1101.00
116. 00 11600 HOSPI CE SUBTOTALS (SUM OF LINES 1 through 117) 662, 980 662, 980 71, 744, 951 1, 935 16, 026, 853 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 127, 997 127, 997 21, 058, 309 368 1, 916, 862 192. 00 192. 01 19201 FP PETERSBURG 3, 705 3, 705 251, 821 0 11, 590 192. 01 192. 02 19202 PEDI ATRI CS 0 0 1, 345, 787 21 406, 231 192. 02	112 00			I				112 00
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 662, 980 662, 980 71, 744, 951 1, 935 16, 026, 853 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 190. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 127, 997 127, 997 21, 058, 309 368 1, 916, 862 192. 00 192. 01 19201 FP PETERSBURG 3, 705 3, 705 251, 821 0 11, 590 192. 01 192. 02 19202 PEDI ATRI CS 0 0 1, 345, 787 21 406, 231 192. 02		1	/ QA1	/ QA1	138 813	24	17 791	
NONRE MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190. 00 192. 00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 127, 997 127, 997 21, 058, 309 368 1, 916, 862 192. 00 192. 01 19201 FP PETERSBURG 3, 705 3, 705 251, 821 0 11, 590 192. 01 192. 02 19202 PEDI ATRI CS 0 0 1, 345, 787 21 406, 231 192. 02		1	· ·					
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 127, 997 127, 997 21, 058, 309 368 1, 916, 862 192. 00 192. 01 19201 FP PETERSBURG 3, 705 3, 705 251, 821 0 11, 590 192. 01 192. 02 19202 PEDI ATRI CS 0 0 1, 345, 787 21 406, 231 192. 02	110.00		002, 700	002, 700	1 , 1, , 144, 751	1, 733	10, 020, 003	1. 10. 00
192. 00 PHYSI CI ANS' PRI VATE OFFI CES 127, 997 127, 997 21, 058, 309 368 1, 916, 862 192. 00 192. 01 19201 FP PETERSBURG 3, 705 3, 705 251, 821 0 11, 590 192. 01 192. 02 19202 PEDI ATRI CS 0 0 1, 345, 787 21 406, 231 192. 02	190 00		0	0) 0	Ω	190. 00
192. 01 19201 FP PETERSBURG 3, 705 3, 705 251, 821 0 11, 590 192. 01 192. 02 19202 PEDI ATRI CS 0 0 1, 345, 787 21 406, 231 192. 02			127. 997		1	_		
192. 02 19202 PEDI ATRI CS 0 0 1, 345, 787 21 406, 231 192. 02								
			0	0				
			6, 800	6, 800				

| Peri od: | Worksheet B-1 | From 01/01/2020 | To 12/31/2020 | Date/Ti me Prepared:

				1	o 12/31/2020	Date/lime Pre 7/29/2021 2:3	
		CAPI TAL REL	ATED COSTS			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	, p
	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		SALARI ES)			
404 00 0705	COMMUNITY HEALTH CERVACES	1. 00	2.00	4. 00	4. 01	4. 02	104.00
	COMMUNITY HEALTH SERVICES	415	415		-		194.00
	CCBHC GRANTS	1 (00	1 (00	258, 500			194. 01
	MARKETING AND PUBLIC RELATIONS MH RESIDENTIAL	1, 690	·	-			194. 02 194. 03
	UNUSED SPACE	20, 260			0	•	194. 03
194. 04 07955		20, 370	20, 370	0	0		194.04
	5 FOUNDATION	466	466	0	0		194.05
	KNOX COUNTY HEALTH DEPT	4, 712			0		194.00
	BINDUSTRIAL HEALTH	4, 712	4, /12	0	0		194. 07
	COMMUNITY MENTAL HEALTH CENTER	35, 103	35, 103	6, 051, 367	0		194. 09
200.00	Cross Foot Adjustments	55, 105	00, 100	0,001,007	J		200.00
201.00	Negative Cost Centers						201.00
202. 00	Cost to be allocated (per Wkst. B,	21, 798, 356	95, 145	29, 494, 408	358, 724	1, 269, 234	
	Part I)	1, 110, 220	,	=1,,	333, 12.	.,,	
203. 00	Unit cost multiplier (Wkst. B, Part I)	24. 644890	0. 107569	0. 287147	153. 694944	0. 068172	203. 00
204.00	Cost to be allocated (per Wkst. B,			120, 346	324	287, 295	204.00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part			0. 001172	0. 138817	0. 015431	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

Hearth Financial Systems	GUUD SAMARI TAI		ON 45 0040 D		u or form CMS-2	
COST ALLOCATION - STATISTICAL BASIS		Provi der CO		eriod: rom 01/01/2020	Worksheet B-1	
			To		Date/Time Pre	pared:
					7/29/2021 2:3	
Cost Center Description	REGI STRATI ON	PATI ENT	Reconciliatio		OPERATION OF	
	(GROSS	ACCOUNTS	n	E & GENERAL	PLANT	
	CHARGES)	(GROSS		(ACCUM. COST)	(SQUARE FEET)	
		CHARGES)				
	4. 03	4. 04	5A	5. 00	7. 00	
GENERAL SERVICE COST CENTERS						1 00
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						4.00
4. 01 00401 COMMUNI CATI ONS						4.01
4. 02 00402 PURCHASI NG & RECEI VI NG	(04 407 0/0					4.02
4. 03 00403 REGI STRATI ON	624, 437, 869	(04 407 0/0				4.03
4. 04 O0404 PATIENT ACCOUNTS	0	624, 437, 869		400 400 070		4.04
5. 00 00500 ADMI NI STRATI VE & GENERAL	0	0	-18, 680, 946	198, 188, 272	F/O 0/1	5.00
7. 00 00700 OPERATION OF PLANT	0	0	0	12, 546, 750		7.00
8. 00 00800 LAUNDRY & LI NEN SERVI CE	0	0	0	504, 935		8.00
9. 00 00900 HOUSEKEEPI NG	0	0	0	3, 061, 350	7, 326	9.00
10. 00 01000 DI ETARY		0	0	1, 180, 813	12 510	10.00
11. 00 01100 CAFETERI A	0	0	0	1, 749, 321	12, 519	11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON		0	0	4, 076, 252 802, 981	9, 763	1
14. 00 01400 CENTRAL SERVICES & SUPPLY 15. 00 01500 PHARMACY		0	0		3, 967	ł
16. 00 01600 MEDI CAL RECORDS & LI BRARY		0	0	4, 128, 782 5, 265, 834	5, 979 4, 580	16.00
17. 00 01700 SOCI AL SERVI CE		0	0	5, 205, 654	4, 380	17.00
17. 01 01700 SOCIAL SERVICE 17. 01 01701 MENTAL HEALTH OH		0		973, 542	2, 605	17.00
21. 00 02100 1 &R SERVI CES-SALARY & FRINGES APPRVD		0	0	1, 108, 742	10, 144	
22. 00 02200 1 &R SERVICES-SALARY & FRINGES APPRVD		0	0	1, 108, 742	10, 144	21.00
23. 00 02300 PARAMED ED PRGM-RADI OLOGY		0	0	1, 070, 427	0	23.00
23. 01 02300 PARAMED ED PRGM-RADI OLOGI 23. 01 02301 PARAMED ED PRGM-LAB		0	0	287, 175	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	<u> </u>	U _I	207, 173	0	23.01
30. 00 03000 ADULTS & PEDIATRICS	31, 056, 575	31, 056, 575	O	8, 924, 896	61, 220	30.00
31. 00 03100 NTENSI VE CARE UNI T	16, 111, 220	16, 111, 220		5, 572, 970		
40. 00 04000 SUBPROVI DER - I PF	8, 730, 989	8, 730, 989		2, 772, 073	13, 034	40.00
41. 00 04100 SUBPROVI DER - IRF	7, 404, 201	7, 404, 201		2, 772, 073		41.00
43. 00 04300 NURSERY	1, 367, 007	1, 367, 007	0	420, 714	17, 143	43.00
ANCI LLARY SERVI CE COST CENTERS	1, 307, 007	1, 307, 007	<u> </u>	420, 714	0	45.00
50. 00 05000 OPERATING ROOM	39, 352, 712	39, 352, 712	0	5, 073, 942	24, 026	50.00
51. 00 05100 RECOVERY ROOM	07,002,712	07,002,712	Ö	0, 0, 0, 7, 12	0	51.00
51. 01 05101 ENDOSCOPY	10, 559, 652	10, 559, 652	Ö	1, 932, 911	12, 237	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	5, 235, 619	5, 235, 619	Ö	1, 427, 241	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0,200,017	o	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	85, 195, 272	85, 195, 272	0	7, 959, 232	21, 666	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	22, 821, 465	22, 821, 465	0	3, 924, 265	17, 985	1
60. 00 06000 LABORATORY	71, 819, 620	71, 819, 620	o	8, 970, 125	7, 298	ł
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65. 00 06500 RESPIRATORY THERAPY	13, 855, 191	13, 855, 191	0	3, 285, 621	5, 679	65.00
66. 00 06600 PHYSI CAL THERAPY	24, 297, 613	24, 297, 613	0	5, 570, 011	15, 277	66.00
69. 00 06900 ELECTROCARDI OLOGY	38, 471, 199	38, 471, 199		4, 520, 252		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	ı
70. 01 07001 NEURODI AGNOSTI CS	5, 286, 474	5, 286, 474	0	884, 826	7, 708	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4, 217, 208	4, 217, 208	0	4, 358, 575	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	10, 228, 109	10, 228, 109	0	4, 351, 831	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	84, 972, 671	84, 972, 671	0	18, 350, 525	0	73.00
75.00 07500 ASC (NON-DISTINCT PART)	21, 347, 778	21, 347, 778	0	2, 246, 521	0	75.00
76.00 03950 MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01 03951 INPATIENT DIALYSIS	1, 019, 180	1, 019, 180	0	508, 967	8, 582	76. 01
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	93, 959	93, 959	0	170, 578	2, 254	90.00
90.01 04950 WOUND CLINIC	4, 463, 175	4, 463, 175	0	1, 173, 363	2, 976	90. 01
91. 00 09100 EMERGENCY	45, 798, 619	45, 798, 619	0	6, 415, 364	23, 669	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	422, 599	422, 599	0	187, 929	394	96.00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113. 00
116. 00 11600 HOSPI CE	2, 216, 085	2, 216, 085	0	1, 052, 113	4, 861	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	556, 344, 192	556, 344, 192	-18, 680, 946	140, 389, 457	347, 343	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	50, 115, 535	50, 115, 535	0	40, 544, 574	127, 997	
192. 01 19201 FP PETERSBURG	610, 077	610, 077	0	492, 392		192. 01
192. 02 19202 PEDI ATRI CS	3, 387, 560	3, 387, 560	0	2, 235, 187		192. 02
192.03 19203 WASHINGTON PRIMARY CARE	3, 009, 250	3, 009, 250	0	2, 182, 755		192. 03
194.00 07950 COMMUNITY HEALTH SERVICES	0	0	0	18, 088		194.00
194. 01 07960 CCBHC GRANTS	0	0	0	431, 827		194. 01
194.02 07952 MARKETING AND PUBLIC RELATIONS	0	0	0	814, 394	1, 690	194. 02

Health Financial Systems	GOOD SAMARITAN HOSPITAL	In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS		Period: Worksheet B-1 From 01/01/2020
		To 12/31/2020 Date/Time Prepared:

				T T	o 12/31/2020	Date/Time Pre 7/29/2021 2:3	
	Cost Center Description	REGI STRATI ON	PATI ENT	Reconciliatio	ADMI NI STRATI V	OPERATION OF	3 piii
	Sect Conten Boson Ptron	(GROSS	ACCOUNTS	n	E & GENERAL	PLANT	
		CHARGES)	(GROSS		(ACCUM. COST)	(SQUARE FEET)	
			CHARGES)		, , , ,	,	
		4. 03	4. 04	5A	5. 00	7. 00	
194. 03 07953	MH RESIDENTIAL	452, 112	452, 112	0	1, 135, 774	20, 260	194. 03
194. 04 07954	UNUSED SPACE	0	0	0	504, 207	20, 370	194. 04
194. 05 07955	MOB	0	0	0	30, 491	0	194. 05
194. 06 07956	FOUNDATI ON	0	0	0	11, 842	466	194. 06
194. 07 07957	KNOX COUNTY HEALTH DEPT	0	0	0	116, 634	4, 712	194. 07
194. 08 07958	INDUSTRIAL HEALTH	0	0	0	0	0	194. 08
194. 09 07959	COMMUNITY MENTAL HEALTH CENTER	10, 519, 143	10, 519, 143	0	9, 280, 650	35, 103	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)	2, 248, 650	4, 523, 772		18, 680, 946	13, 729, 394	202. 00
203. 00	Unit cost multiplier (Wkst. B, Part I)	0. 003601	0. 007245		0. 094259	24. 134884	203.00
204. 00	Cost to be allocated (per Wkst. B, Part II)	281, 712	2, 959		1, 196, 738	6, 019, 633	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	0. 000451	0. 000005		0. 006038	10. 581905	205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

	Financial Systems	GOOD SAMARITA				u of Form CMS-2	
COST A	LLOCATION - STATISTICAL BASIS		Provi der CCI	N: 15-0042	Peri od: From 01/01/2020	Worksheet B-1	
					To 12/31/2020	Date/Time Pre 7/29/2021 2:3	
	Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	<u> </u>
		LINEN SERVICE	(HOURS OF SERVICE)	(PATI ENT	(MAN HOURS)	ADMI NI STRATI O	
		(POUNDS OF LAUNDRY)	SERVICE)	DAYS)		N (DI RECT	
		,				NURSI NG)	
	GENERAL SERVICE COST CENTERS	8. 00	9. 00	10. 00	11.00	13. 00	
1. 00	00100 CAP REL COSTS-BLDG & FIXT	T			T		1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
1. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
. 01	00401 COMMUNI CATI ONS						4. 01
. 02	00402 PURCHASING & RECEIVING						4. 02
l. 03 l. 04	OO4O3 REGI STRATI ON OO4O4 PATI ENT ACCOUNTS						4. 03 4. 04
5. 00	00500 ADMI NI STRATI VE & GENERAL						5.00
7. 00	00700 OPERATION OF PLANT						7. 00
3. 00	00800 LAUNDRY & LINEN SERVICE	880, 078					8. 00
. 00	00900 HOUSEKEEPI NG	57, 610	68, 564				9. 00
	01000 DI ETARY	11, 760	1, 786	32, 63			10.00
	01100 CAFETERI A	0	430		0 2, 106, 925	024 270	11.00
	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	0 12, 224	0 775		0 64, 250 0 21, 152	834, 278 0	13. 00 14. 00
	01500 PHARMACY	12, 224	607		0 69, 810	0	15.00
	01600 MEDICAL RECORDS & LIBRARY		580		0 126, 916	0	16.00
	01700 SOCIAL SERVICE	o	0		0 0	0	17. 00
	01701 MENTAL HEALTH OH	16, 832	1, 855		0 15, 611	0	17. 01
	02100 &R SERVICES-SALARY & FRINGES APPRVD	0	0		0 0	0	21.00
	02200 1 & R SERVICES-OTHER PRGM COSTS APPRVD 02300 PARAMED ED PRGM-RADIOLOGY	0	1, 040		0 18, 786 0 0	18, 786 0	
	02301 PARAMED ED PRGM-RADIOLOGI		o		0 6, 629	0	
.0. 0.	INPATIENT ROUTINE SERVICE COST CENTERS	1 3	<u> </u>		0,027		20.0.
30. 00	03000 ADULTS & PEDIATRICS	303, 132	16, 866	15, 10	186, 745	186, 745	
	03100 I NTENSI VE CARE UNI T	107, 189	5, 150	6, 44		106, 458	
10.00	04000 SUBPROVI DER - I PF	0	0	4, 63		66, 075	
41. 00 43. 00	04100 SUBPROVI DER - RF 04300 NURSERY	50, 260 2, 197	3, 046 177	6, 44	.7 62, 149 0 8, 554	62, 149 8, 554	41. 00 43. 00
13.00	ANCILLARY SERVICE COST CENTERS	2, 197	177		0 6, 334	6, 554	43.00
0.00	05000 OPERATI NG ROOM	30, 447	3, 848		0 68, 365	51, 885	50.00
1.00	05100 RECOVERY ROOM	0	0		0 0	0	51.00
	05101 ENDOSCOPY	23, 849	1, 023		0 26, 320	26, 320	
2.00	05200 DELIVERY ROOM & LABOR ROOM	13, 438	235		0 29, 215	29, 215	
3.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0 58, 066	0 3, 201		0 0 104, 504	0 10, 278	53.00
	05500 RADI OLOGY-THERAPEUTI C	3, 933	3, 201		0 62, 470	44, 607	•
0.00	06000 LABORATORY	0, 733	971		0 97, 935	44, 667	
3. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0	63.00
5. 00	06500 RESPI RATORY THERAPY	318	730		0 63, 804	0	65.00
	06600 PHYSI CAL THERAPY	9, 347	1, 853		0 107, 567	36, 263	
	06900 ELECTROCARDI OLOGY	16, 576	2, 821		0 89, 920	0	69.00
	07000 ELECTROENCEPHALOGRAPHY 07001 NEURODI AGNOSTI CS	11, 990	0 716		0 0 13, 518	0 3, 446	70. 00 70. 01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	11, 990	710		0 13, 318	3, 440	71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS		Ö		0 0	0	
	07300 DRUGS CHARGED TO PATIENTS		Ö		0 0	0	
5. 00	07500 ASC (NON-DISTINCT PART)	30, 473	3, 002		0 37, 816	37, 816	75. 00
	03950 MH ANCILLARY OUTPATIENT	0	0		0	0	
6. 01	03951 INPATIENT DIALYSIS OUTPATIENT SERVICE COST CENTERS	0	0		0 0	0	76. 01
	WILLEAU FINE SERVILE LUST LENTERS						

SPARREL SERVICE DOST OFWERS			LAUNDRY)				(DI RECT NURSI NG)	
0.00 0.000 CAR PEL COSTS-BURD & FINT 0.00			8. 00	9. 00	10.00	11.00		
2.00 DODDOCAP REL COSTS -MANUEL EQUIP 2.00 DODDOCAP REL COSTS -MANUEL EQUIP 3.00 D								
4 - 00 DOSCO LAURANCY AS IN A RECEIVED ING 4 - 0.0 4 - 00 COSTO COMMINICATIONS 4 - 0.0 4 - 00 COSTO COSTO COSTO COSTO COSTO 5 - 00 COSTO COSTO COSTO COSTO COSTO COSTO 5 - 00 COSTO COST								
4.01 00-001 COMMUNICATIONS								
4. 0.0 00000 PRINCHASTING A PRICHAMS 4. 0.0 00000 PRISCHASTING 4. 0.0 00000 PRISCHAST STATE OF STATE O		1 1						
4.04 0.040 ATTENT ACCOUNTS								
5.00								
0.0000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.0000000 0.00000000		1 1						
8.00 00800 LAURINDRY & LINEN SERVICE 880,078 8.00 000 00000 CONSECREPTING 57,010 68,564 9.00 10.00 10000 CONSECREPTING 11.760 47.90 0.00 0.00 2.106,925 834,278 13.00 13.00 10300 MINCRI NG AURINISTRATION 0.00 4.00 0.00 4.250 834,278 13.00 13.00 10300 MINCRI NG AURINISTRATION 0.00 0.00 0.00 0.00 0.00 15.00 10.								
9.00 0.090		1 1	880 078					
11.00 0100 CAFETERIA 0 430 0 2,106,925 11.00 14.00 01400 CAFETERIA 0 0 0 0 0 0 14.00 01400 CENTRAL SERVICES & SUPPLY 12,224 775 0 21,152 0 14.00 16.00 01400 CENTRAL SERVICES & SUPPLY 12,224 775 0 21,152 0 14.00 16.00 01400 CENTRAL SERVICES & SUBPLY 0 0 600 0 0 15,611 0 17.00 16.00 01400 CENTRAL SERVICES & SUBPRY 0 0 0 0 0 12,691 0 0 0 17.01 01701 URTHAL HEALTH OH 16,832 1,885 0 0 15,611 0 17.01 17.01 01701 URTHAL HEALTH OH 16,832 1,885 0 0 0 0 0 0 17.01 01701 URTHAL HEALTH OH 16,832 1,885 0 0 0 0 0 0 18.786 18,786 18,786 23,000 23.00 0200 PARAMED ED PROBLES PREVO 0 0 0 0 0 0 0 23.00 0200 PARAMED ED PROBLES PREVO 0 0 0 0 0 0 0 23.00 0200 PARAMED ED PROBLES PREVO 0 0 0 0 0 0 0 0 23.00 0200 DARAMED ED PROBLES PREVO 0 0 0 0 0 0 0 0 0				68, 564				
13.00 01300 NIRES ING ADMIN STRATION 0 0 64, 250 834, 278 13.00			11, 760	1, 786	32, 632			10.00
14. 00 01400 [CRITTAL SERVICES & SUPPLY 12.224 775 0 21.152 0 14. 00 16. 00 01600 [MEDICAL RECORDS & LIBRARY 0 560 0 126. 916 0 16. 00 17. 01 01700 [MENTAL HEALTH CLAFF & FRINCES APPRIVO 0 0 0 0 0 0 17. 01 01700 [MENTAL HEALTH CLAFF & FRINCES APPRIVO 0 0 0 0 0 0 23. 00 03000 [RASARED ED PROM-RADIOLOGYS APPRIVO 0 0 0 0 0 0 0 23. 00 03000 [RASARED ED PROM-RADIOLOGYS APPRIVO 0 0 0 0 0 0 0 23. 00 03000 [RASARED ED PROM-RADIOLOGYS APPRIVO 0 0 0 0 0 0 0 0 23. 00 03000 [RASARED ED PROM-RADIOLOGYS APPRIVO 0 0 0 0 0 0 0 0 0 24. 00 03000 [RASARED ED PROM-RADIOLOGYS APPRIVO 0 0 0 0 0 0 0 0 0			0					
15.00 01500 PHARMACY 0 500 0 09,910 0 15.00 17.00		1 1	12 224		0			
16.00 01000 MEDICAL RECORDS & LIBRARY 0 590 0 120,916 0 1.0 0.0 0 0 0 17.0 0.170 0.070		1 1	12, 224		0		-	
17.00 01700 SOCIAL SERVICE 0 0 0 0 0 17.00		1 1	o				-	
21.00			0				0	
22.00 02000 LAR SERVICES-OTHER PROM COSTS APPRVD 0 1,040 0 18,786 22.00 23.00 02300 PARAMED ED PROGN-LABO 0 0 0 0 0 0 0 0 0			16, 832	1, 855	0	15, 611	-	
23.00 02300 PARAMED ED PRICH-RADIOLOGY 0 0 0 0 6,629 0 23.00			0	-	0	10.70/	-	
23.01 PARAMED ED PROM-LAB O O O O O O O O O		1 1	0			18, 786		
INPATI ENT ROUTI NE SERVI CE COST CENTERS 303, 132 16, 866 15, 101 186, 745 186, 745 31. 00 31. 00 30100 ADULTS & PEDITATIC S 303, 132 16, 866 15, 101 186, 745 31. 00 31. 00 30100 INTERSIVE CARE UNIT 107, 189 5, 150 6, 445 106, 458 31. 00 40. 00 4000 SUBPROVIDER - 1 PF 0 0 0 0 4, 639 67, 313 66, 6075 40. 00 40. 00 4000 SUBPROVIDER - 1 PF 50, 260 3, 046 6, 447 62, 149 62, 149 41. 00 41. 00 40. 00			0	-	_	6 629		
13.1 0.0 0.3100 INTERSIVE CARE UNIT 107, 189 5,150 6,448 106,488 31.0 0 41.0 0 0.400 SUBPROVI DER - IPF 0.0 0.46,39 67,313 66,075 40.0 41.0 0 41.0	20.0.		<u> </u>	<u> </u>	<u> </u>	0, 02.7		20.0.
0.0 0.0 0.0000 SUBPROVI DER - I PF 50, 260 3, 046 6.47 6.47 6.21 49 6.21 49 41, 00 41, 00 0.4300 0.0		1 1						
41.00 04100 SUBPROVI DER - I RF 50, 260 3,046 6,447 62,149 62,149 41.00			107, 189					
A3. 00 04300 NURSERY 2, 197 177 0 8, 554 8, 554 3. 00			0 E0 240	-				
ANCIL LARY SERVICE COST CENTERS 50.00								
50.00	10.00		2, 177	177	9	0, 00 1	0,001	10.00
10 10 10 10 10 10 10 10	50.00		30, 447	3, 848	0	68, 365	51, 885	50.00
52.00 05200 DELLYERY ROOM & LABOR ROOM 13,438 235 0 29,215 29,215 52.00		1 1	0	-		-	-	
53.00 08300 ANESTHESI OLOGY 0 0 0 0 53.00		1 1						
54.00 05400 RADIOLOGY-DI AGNOSTIC 58,066 3,201 0 104,504 10,278 54.00		1 1	13, 438					
55.00 05500 RADIOLOGY-THERAPEUTI C 3,933 0 0 62,470 44,607 55.00		1 1	58, 066	-	-	-	-	
63.00 06300 BLOOD STORI NG PROCESSING & TRANS. 0 0 0 0 0 0 0 0 0					0			
65.00 0650			0	971	-	97, 935	-	
66.00 06600 PHYSI CAL THERAPY 9, 347 1, 853 0 107, 567 36, 263 66. 00 69.00 06900 ELECTROCARDI OLOGY 16, 576 2, 821 0 89, 920 0 69. 00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0 0 70.01 07001 NEURODI AGNOSTI CS 11, 990 716 0 13, 518 3, 446 70. 01 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 0 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 0 0 73.00 07300 ROUGE CHARGED TO PATI ENTS 0 0 0 0 0 0 0 75.00 07500 ASC (NON-DIST) INCT PART) 30, 473 3, 002 0 37, 816 37, 816 57, 500 76.00 03950 MH ANCI LLARY OUTPATI ENT 0 0 0 0 0 0 0 0 76.01 03951 IMPATIENT DI ALYSIS 0 0 0 0 0 0 0 76.01 0000000000000000000000000000000000			0	-	_	0		
69.00					-		-	
70.00 07000 LECTROENCEPHALOGRAPHY 0 0 0 0 0 0 0 70.00		1 1			-			
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 73. 00 073. 00 073. 00 07500		1 1	0			0		
72.00 07200 IMPL DEV CHARGED TO PATIENTS 0 0 0 0 0 72.00			11, 990	716	0	13, 518	3, 446	70. 01
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 73. 00 75. 00 07500 ASC (NON-DISTINCT PART) 30, 473 3,002 0 37, 816 37, 816 75. 00 03950 MRANCILLARY OUTPATIENT 0 0 0 0 0 0 0 0 0			0		-	0	-	
75. 00 07500 ASC (NON-DISTINCT PART) 30,473 3,002 0 37,816 37,816 75.00 76.00 03950 MH ANCILLARY OUTPATIENT 0 0 0 0 0 0 0 76.00 76.00 03951 INPATIENT DI ALYSIS 0 0 0 0 0 0 0 0 0			0			0		
76. 00 03950 MH ANCI LLARY OUTPATIENT 0 0 0 0 0 0 76. 00 76. 00 76. 00 76. 00 76. 00 76. 00 0 0 0 0 0 0 76. 00 76. 00 76. 00 76. 00 0 0 0 0 0 0 0 0 0			30 473	- 1		37 816	-	
76. 01 03951 INPATIENT DIALYSIS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								
90. 00		03951 INPATIENT DIALYSIS	0	0	0	0	0	76. 01
90. 01				4 400		9 999		
91. 00								
92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 92. 00 OTHER REI MBURSABLE COST CENTERS 96. 00 O9600 DURABLE MEDI CAL EQUI P-RENTED O O O O O O O O O								
OTHER REIMBURSABLE COST CENTERS 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 3, 396 0 96. 00 101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 0 0 0 101. 00 0 0 0 0 0 0 0 0 0			77,030	4, 545		120, 373	120, 373	
101.00 10100 HOME HEALTH AGENCY 0 0 0 0 0 101.00		OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 0 928 0 14,018 14,018 116.00 1		1 1						
113. 00 11300 INTEREST EXPENSE	101.00		0	0	0	0	0	101. 00
116. 00	113 00							113 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 847,051 57,646 32,632 1,607,749 825,938 118.00		1 1	0	928	0	14, 018	14, 018	
190. 00 19000 GFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 386, 041 8, 340 192. 00 192. 01 19200 PHYSI CI ANS' PRI VATE OFFI CES 33, 027 10, 523 0 386, 041 8, 340 192. 00 192. 01 19201 FP PETERSBURG 0 0 0 8, 557 0 192. 01 192. 02 19202 PEDI ATRI CS 0 0 0 31, 077 0 192. 02 192. 03 19203 WASHI NGTON PRI MARY CARE 0 0 0 32, 114 0 192. 03 194. 00 07950 COMMUNI TY HEALTH SERVI CES 0 335 0 10 0 194. 00		SUBTOTALS (SUM OF LINES 1 through 117)	847, 051					
192. 00		NONREI MBURSABLE COST CENTERS						
192. 01 1920 FP PETERSBURG 0 0 0 8, 557 0 192. 01 192. 02 1920 PEDI ATRI CS 0 0 0 31, 077 0 192. 02 192. 03 1920 WASHI NGTON PRI MARY CARE 0 0 0 32, 114 0 192. 03 194. 00 07950 COMMUNI TY HEALTH SERVI CES 0 335 0 10 0 194. 00			0	0	0	0		
192. 02 19202 PEDI ATRI CS 0 0 0 31, 077 0 192. 02 192. 03 19203 WASHI NGTON PRI MARY CARE 0 0 0 32, 114 0 192. 03 194. 00 07950 COMMUNI TY HEALTH SERVI CES 0 335 0 10 0 194. 00		1 1	33, 027	10, 523	0			
192. 03 19203 WASHI NGTON PRI MARY CARE 0 0 0 32, 114 0 192. 03 194. 00 07950 COMMUNI TY HEALTH SERVI CES 0 335 0 10 0 194. 00			0	0				
194.00 07950 COMMUNITY HEALTH SERVICES 0 335 0 10 0 194.00			o	-	0			
194. 01 07960 CCBHC GRANTS 0 0 7, 958 0 194. 01	194.00	07950 COMMUNITY HEALTH SERVICES	0			10		
	194. 01	07960 CCBHC GRANTS	0	0	0	7, 958	0	194. 01

				T	0 12/31/2020	Date/Time Pre 7/29/2021 2:3	
	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. 02 07952	MARKETING AND PUBLIC RELATIONS	0	60	0	7, 863	0	194. 02
194. 03 07953	MH RESIDENTIAL	0	0	0	25, 556	0	194. 03
194. 04 07954	UNUSED SPACE	0	0	0	0	0	194. 04
194. 05 07955		0	0	0	0	0	194. 05
194. 06 07956	FOUNDATI ON	0	0	0	0	0	194. 06
	KNOX COUNTY HEALTH DEPT	0	0	0	0		194. 07
	INDUSTRIAL HEALTH	0	0	0	0		194. 08
	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,	679, 624	3, 571, 210	1, 394, 221	2, 238, 752	4, 764, 374	202. 00
	Part I)						
203. 00	Unit cost multiplier (Wkst. B, Part I)	0. 772232	52. 085788			5. 710775	
204. 00	Cost to be allocated (per Wkst. B,	190, 686	295, 244	24, 480	469, 220	390, 096	204. 00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	0. 216669	4. 306108	0. 750184	0. 222704	0. 467585	205. 00
	[11]						
206. 00	NAHE adjustment amount to be allocated						206. 00
007.00	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)			l			

	LOCATION - STATISTICAL BASIS	GOOD SAWARI TAR	Provi der Co	CN: 15-0042 P	eri od:	Worksheet B-1	
				F	rom 01/01/2020		
						7/29/2021 2: 3	3 pm
	Cost Center Description	CENTRAL SERVI CES &	PHARMACY (COSTED	MEDICAL RECORDS &	SOCI AL SERVI CE	MENTAL HEALTH OH	
		SUPPLY	REQUIS.)	LI BRARY	(NET CHARGES)	(NET CHARGES)	
		(SUPPLI ES	ŕ	(TIME SPENT)	,	ì	
		COST)	45.00	1/ 00	47.00	47.04	
G	ENERAL SERVICE COST CENTERS	14. 00	15. 00	16. 00	17. 00	17. 01	
	0100 CAP REL COSTS-BLDG & FLXT						1.00
	0200 CAP REL COSTS-MVBLE EQUIP						2.00
	0400 EMPLOYEE BENEFITS DEPARTMENT 0401 COMMUNI CATIONS						4. 00 4. 01
	0401 COMMONICATIONS 0402 PURCHASING & RECEIVING						4.01
	0403 REGI STRATI ON						4. 03
1	0404 PATIENT ACCOUNTS						4. 04
	0500 ADMINISTRATIVE & GENERAL 0700 OPERATION OF PLANT						5. 00 7. 00
	0800 LAUNDRY & LINEN SERVICE						8.00
9. 00 0	0900 HOUSEKEEPI NG						9. 00
	1000 DI ETARY						10.00
	1100 CAFETERIA 1300 NURSING ADMINISTRATION						11. 00 13. 00
	1400 CENTRAL SERVICES & SUPPLY	16, 512, 601					14.00
15. 00 0	1500 PHARMACY	60, 257	20, 096, 839				15.00
	1600 MEDICAL RECORDS & LIBRARY	5, 405	0	70, 125			16.00
	1700 SOCIAL SERVICE 1701 MENTAL HEALTH OH	0 3, 980	0	0	0	19, 250, 132	17. 00 17. 01
	2100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0	Ö	0	0	21.00
22. 00 0	2200 I&R SERVICES-OTHER PRGM COSTS APPRVD	50, 055	32, 680	0	0	0	22.00
	2300 PARAMED ED PRGM-RADI OLOGY	0	0	0	0	0	23.00
	2301 PARAMED ED PRGM-LAB NPATIENT ROUTINE SERVICE COST CENTERS	3, 077	0	0	0	0	23. 01
	3000 ADULTS & PEDI ATRI CS	383, 474	468	14, 575	0	0	30.00
	3100 INTENSIVE CARE UNIT	316, 343	99				31.00
	4000 SUBPROVI DER - I PF 4100 SUBPROVI DER - I RF	23, 448 82, 251	99 9				40. 00 41. 00
	4300 NURSERY	19, 814	62	.,			43.00
A	NCILLARY SERVICE COST CENTERS						
	5000 OPERATING ROOM 5100 RECOVERY ROOM	632, 088	23, 781 0	5, 800 0	0	_	50. 00 51. 00
	5100 RECOVERT ROOM 5101 ENDOSCOPY	395, 663	1, 630		0	0	51.00
	5200 DELIVERY ROOM & LABOR ROOM	76, 534	502	0	0	0	52.00
	5300 ANESTHESI OLOGY	0	0	0		0	53.00
	5400 RADI OLOGY-DI AGNOSTI C 5500 RADI OLOGY-THERAPEUTI C	281, 936 92, 342	247, 469 3, 730			0	54. 00 55. 00
	6000 LABORATORY	2, 364, 643	1, 327	Ö	0	ő	60.00
	6300 BLOOD STORING, PROCESSING & TRANS.	O	0	0	0	0	63.00
1	6500 RESPI RATORY THERAPY	63, 283	3, 142		0	0	65.00
	6600 PHYSI CAL THERAPY 6900 ELECTROCARDI OLOGY	54, 882 139, 346	3, 297 75, 773	0	0	0	66. 00 69. 00
70.00 0	7000 ELECTROENCEPHALOGRAPHY	0	0	Ö	0	0	70.00
	7001 NEURODI AGNOSTI CS	33, 578	19	0	0	0	70. 01
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS 7200 IMPL. DEV. CHARGED TO PATIENTS	4, 049, 804 3, 970, 317	0	0	0	0	71. 00 72. 00
	7300 DRUGS CHARGED TO PATIENTS	3, 770, 317	17, 747, 568	0	0	0	73.00
	7500 ASC (NON-DISTINCT PART)	348, 913	27, 758	16, 350	0	0	75.00
1	3950 MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
	3951 INPATIENT DIALYSIS UTPATIENT SERVICE COST CENTERS	2, 110	4, 415	0	0	0	76. 01
90.00	9000 CLI NI C	427	0	0	0	0	90.00
	4950 WOUND CLINIC	97, 755	12, 998				90. 01
	9100 EMERGENCY 9200 OBSERVATION BEDS (NON-DISTINCT PART)	297, 220	11, 538	10, 300	0	0	91. 00 92. 00
	THER REIMBURSABLE COST CENTERS						72.00
	9600 DURABLE MEDICAL EQUIP-RENTED	54, 703	0	0			96.00
	0100 HOME HEALTH AGENCY PECIAL PURPOSE COST CENTERS	0	0	0	0	0	101. 00
	1300 INTEREST EXPENSE						113.00
	1600 HOSPI CE	17, 781	79	0	0		116.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	13, 921, 429	18, 198, 443	70, 125	0	8, 730, 989	118.00
	ONREIMBURSABLE COST CENTERS 9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		0		1	0	190. 00
	9200 PHYSICIANS' PRIVATE OFFICES	1, 916, 862	1, 349, 368	l 0	0		190.00
192. 01 1	9201 FP PETERSBURG	11, 590	11, 700		0	0	192. 01
	9202 PEDI ATRI CS	406, 231	386, 176		0		192.02
	9203 WASHINGTON PRIMARY CARE 7950 COMMUNITY HEALTH SERVICES	170, 585 2, 029	150, 462 0	1	0		192. 03 194. 00
	7960 CCBHC GRANTS	8, 502	690		_		194. 00

Health Financial Systems	GOOD SAMARITAN HOSPITAL	In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Provi der CCN: 15-0042	Peri od: Worksheet B-1

					rom 01/01/2020 o 12/31/2020	Date/Time Pre	
	Cost Contar Decement on	CENTRAL	PHARMACY	MEDI CAL	SOCI AL	7/29/2021 2: 3	3 pm
	Cost Center Description	SERVICES &	(COSTED	RECORDS &	SERVI CE	MENTAL HEALTH OH	
		SUPPLY	REQUIS.)	LI BRARY	(NET CHARGES)	(NET CHARGES)	
		(SUPPLIES	KLQUI 3.)	(TIME SPENT)	(NET CHARGES)	(NET CHARGES)	
		COST)		(IIWL SELNI)			
		14. 00	15. 00	16.00	17. 00	17. 01	
194 02 07	952 MARKETING AND PUBLIC RELATIONS	1, 683	13.00	10.00	17.00		194. 02
	953 MH RESIDENTIAL	24, 710	0	l o	0		194. 03
	954 UNUSED SPACE	24, 710	0	٥	0		194. 04
194. 05 07		0	0		0		194. 05
	956 FOUNDATION	0	0		0		194. 06
	957 KNOX COUNTY HEALTH DEPT	0	0		0		194. 07
	958 I NDUSTRI AL HEALTH	0	0		0		194. 07
	959 COMMUNITY MENTAL HEALTH CENTER	48, 980	0		0	10, 519, 143	
200. 00	Cross Foot Adjustments	46, 700	U	٦	U	10, 517, 143	200.00
201. 00	Negative Cost Centers						201.00
201.00	Cost to be allocated (per Wkst. B,	1, 046, 693	4, 771, 873	6, 038, 134	0	1, 254, 635	1
202.00	Part I)	1, 040, 693	4, 771, 673	0,030,134	U	1, 254, 655	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 063388	0. 237444	86. 105298	0.000000	0. 065175	203.00
204.00	Cost to be allocated (per Wkst. B,	157, 535	259, 277	228, 697	0	113, 782	204.00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	0. 009540	0. 012901	3. 261276	0.000000	0. 005911	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)						

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0042 Peri od: Worksheet B-1 From 01/01/2020 12/31/2020 Date/Time Prepared: 7/29/2021 2:33 pm INTERNS & RESIDENTS Cost Center Description SERVI CES-SALA | SERVI CES-OTHE PARAMED ED PARAMED ED RY & FRINGES R PRGM COSTS PRGM-RADI OLOG PRGM-I AB (ASSI GNED (ASSI GNED (ASSI GNED TIME) TIME) (ASSI GNED TIME) TIME) 21. 00 22. 00 23.00 23. 01 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00401 COMMUNI CATI ONS 4.01 4 01 4.02 00402 PURCHASING & RECEIVING 4.02 4.03 00403 REGI STRATI ON 4.03 00404 PATIENT ACCOUNTS 4 04 4 04 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9 00 9 00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11.00 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 14 00 14 00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 01700 SOCIAL SERVICE 17 00 17 00 17.01 01701 MENTAL HEALTH OH 17.01 02100 I&R SERVICES-SALARY & FRINGES APPRVD 3, 925 21.00 21.00 22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 3, 925 22.00 02300 PARAMED ED PRGM-RADIOLOGY 100 23 00 23 00 02301 PARAMED ED PRGM-LAB 23.01 100 23.01 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 1, 436 1, 436 C 0 30.00 0 03100 INTENSIVE CARE UNIT 31.00 156 156 0 31.00 04000 SUBPROVI DER - I PF 40.00 944 944 0 0 40.00 04100 SUBPROVI DER - I RF 0 0 41 00 0 41.00 04300 NURSERY
ANCILLARY SERVICE COST CENTERS 43.00 0 0 0 0 43.00 50.00 05000 OPERATING ROOM 50.00 0 0 05100 RECOVERY ROOM 0 0 0 51.00 0 51.00 0 05101 ENDOSCOPY 0 51.01 0 51.01 0 05200 DELIVERY ROOM & LABOR ROOM 0 0 52.00 0 52.00 0 53.00 05300 ANESTHESI OLOGY 0 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 100 0 54.00 55 00 05500 RADI OLOGY-THERAPEUTI C 56 0 56 0 55.00 60.00 06000 LABORATORY 0 C 0 100 60.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 63.00 0 06500 RESPIRATORY THERAPY 84 84 0 65.00 65.00 06600 PHYSI CAL THERAPY 0 0 0 66.00 C 66,00 69.00 06900 ELECTROCARDI OLOGY 128 128 0 69.00 0 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 70.00 C 0 0 07001 NEURODI AGNOSTI CS 70 01 C 70 01 71.00 |07100|MEDICAL SUPPLIES CHARGED TO PATIENTS 0 C 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 72.00 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 73.00 C 07500 ASC (NON-DISTINCT PART) 0 75.00 596 596 75.00 76.00 03950 MH ANCILLARY OUTPATIENT 0 C 0 0 76.00 03951 INPATIENT DIALYSIS 76.01 44 44 0 76.01 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 0 0 90.00 04950 WOUND CLINIC 0 0 0 90.01 90.01 91.00 09100 EMERGENCY 245 245 0 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92 00 92.00 OTHER REIMBURSABLE COST CENTERS 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00 0 0 0 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 116.00 SUBTOTALS (SUM OF LINES 1 through 117)
NONREIMBURSABLE COST CENTERS 118.00 3,689 3,689 100 100 118.00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190.00 0 0 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 236 236 0 0 192.00 192. 01 19201 FP PETERSBURG 0 0 192.01 0 C 192. 02 19202 PEDI ATRI CS 0 0 0 192.02 192. 03 19203 WASHINGTON PRIMARY CARE 0 0 0 192.03

| Peri od: | Worksheet B-1 | From 01/01/2020 | To 12/31/2020 | Date/Time Prepared: Provider CCN: 15-0042

						7/29/2021 2: 33 pm
		INTERNS &	RESI DENTS			
	Cost Center Description		SERVI CES-OTHE		PARAMED ED	
		RY & FRINGES	R PRGM COSTS	PRGM-RADI OLOG	PRGM-LAB	
		(ASSI GNED	(ASSI GNED	Y	(ASSI GNED	
		TIME)	TIME)	(ASSI GNED	TIME)	
				TIME)		
		21. 00	22. 00	23. 00	23. 01	
	COMMUNITY HEALTH SERVICES	0	0	0	0	194. 00
	CCBHC GRANTS	0	0	0	0	194. 01
•	MARKETING AND PUBLIC RELATIONS	0	0	0	0	194. 02
	MH RESIDENTIAL	0	0	0	0	194. 03
	UNUSED SPACE	0	0	0	0	194. 04
194. 05 07955	The state of the s	0	0	0	0	194. 05
194. 06 07956	FOUNDATI ON	0	0	0	0	194. 06
194. 07 07957	KNOX COUNTY HEALTH DEPT	0	0	0	0	194. 07
194. 08 07958	INDUSTRIAL HEALTH	0	0	0	0	194. 08
194. 09 07959	COMMUNITY MENTAL HEALTH CENTER	0	0	0	0	194. 09
200.00	Cross Foot Adjustments					200. 00
201. 00	Negative Cost Centers					201.00
202. 00	Cost to be allocated (per Wkst. B,	1, 458, 075	2, 239, 080	0	321, 483	202. 00
	Part I)					
203.00	Unit cost multiplier (Wkst. B, Part I)	371. 484076	570. 466242	0.000000	3, 214. 830000	203. 00
204.00	Cost to be allocated (per Wkst. B,	365, 127	31, 879	0	3, 560	204.00
	Part II)					
205.00	Unit cost multiplier (Wkst. B, Part	93. 025987	8. 122038	0. 000000	35. 600000	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	Period: Worksheet C		
		From 01/01/2020 Part		

						Date/Time Prepared: 7/29/2021 2:33 pm		
			Ti +l o	XVIII	Hospi tal	PPS	3 piii	
			11116	AVIII	Costs			
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs		
	cost center beserretron	(from Wkst.	Adj .	10101 00313	Di sal I owance	10141 00313		
		B, Part I,	Auj .		Di Sai i Owanice			
		col . 26)						
		1. 00	2. 00	3. 00	4. 00	5. 00		
	INPATIENT ROUTINE SERVICE COST CENTERS		2.00	0.00	00	0.00		
30. 00	03000 ADULTS & PEDIATRICS	15, 545, 742		15, 545, 742	O	15, 545, 742	30.00	
31. 00	03100 I NTENSI VE CARE UNI T	8, 574, 268		8, 574, 268		8, 574, 268		
40. 00	04000 SUBPROVI DER – I PF	5, 213, 502		5, 213, 502		5, 250, 568		
41. 00	04100 SUBPROVI DER - I RF	4, 730, 282		4, 730, 282		4, 730, 282	41.00	
	04300 NURSERY	633, 822		633, 822		633, 822	43.00	
43.00	ANCILLARY SERVICE COST CENTERS	033, 022		033, 022	٠	033, 022	45.00	
50.00	05000 OPERATING ROOM	7, 270, 081		7, 270, 081	38, 075	7, 308, 156	50.00	
51. 00	05100 RECOVERY ROOM	0		7, 270, 001		7, 300, 130	51.00	
51. 00	05101 ENDOSCOPY	2, 685, 887		2, 685, 887		2, 685, 887	51.00	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	1, 787, 241		1, 787, 241	1	1, 787, 241	52.00	
53. 00	05300 ANESTHESI OLOGY	1, 707, 241		1, 707, 241	1	1, 707, 241	53.00	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	9, 690, 303		9, 690, 303	1 "	9, 690, 303	54.00	
55. 00	05500 RADI OLOGY-THERAPEUTI C	5, 059, 124		5, 059, 124	1	5, 065, 987	55.00	
60. 00	06000 LABORATORY	10, 618, 102		10, 618, 102		10, 618, 102	60.00	
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	10, 618, 102		10, 016, 102		10, 018, 102	63.00	
65. 00	06500 RESPIRATORY THERAPY	3, 843, 204	0	3, 843, 204		3, 843, 204	65.00	
66. 00	06600 PHYSI CAL THERAPY	6, 893, 126	0	6, 893, 126		6, 893, 126		
69. 00	06900 ELECTROCARDI OLOGY	5, 667, 228	U	5, 667, 228		5, 672, 461	69.00	
70. 00	07000 ELECTROENCEPHALOGRAPHY	5,007,220		3,007,220	0, 233	5, 672, 461	70.00	
70. 00	07000 EEECTROENCEPHALOGRAPHI	1, 236, 989		1, 236, 989	i	1, 246, 549		
70.01	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	5, 026, 112		5, 026, 112	, , , , , ,	5, 026, 112		
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS	5, 028, 112				5, 013, 700		
73. 00	07300 DRUGS CHARGED TO PATIENTS	24, 294, 278		5, 013, 700 24, 294, 278		24, 294, 278		
75. 00	07500 ASC (NON-DISTINCT PART)	4, 330, 840		4, 330, 840		4, 339, 556		
76. 00	03950 MH ANCILLARY OUTPATIENT	4, 330, 640		4, 330, 640		4, 339, 330	76.00	
76. 00 76. 01	1	765, 250			١			
76.01	03951 INPATIENT DIALYSIS OUTPATIENT SERVICE COST CENTERS	/65, 250		765, 250	y U	765, 250	76.01	
90. 00	09000 CLINIC	302, 401		302, 401	ol	302, 401	90.00	
90.00	04950 WOUND CLINIC	1, 675, 862		1, 675, 862		1, 675, 862	90.00	
	09100 EMERGENCY	9, 613, 534		9, 613, 534		9, 613, 534		
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 722, 080		2, 722, 080		2, 722, 080		
92.00	OTHER REIMBURSABLE COST CENTERS	2, 722, 000		2, 722, 000		2, 122, 000	92.00	
06 00	09600 DURABLE MEDICAL EQUIP-RENTED	222, 228		222, 228	l ol	222, 228	96. 00	
	10100 HOME HEALTH AGENCY	222, 228		222, 220	1		101.00	
101.00	SPECIAL PURPOSE COST CENTERS	J O		C		U	101.00	
113 00								
	11600 HOSPI CE	1, 413, 035		1, 413, 035		1, 413, 035	113.00	
200.00	1	144, 828, 221	0			144, 933, 734		
200.00	, , , , , , , , , , , , , , , , , , , ,	2, 722, 080	U	2, 722, 080		2, 722, 080		
201.00	i i	142, 106, 141	0		l l	142, 211, 654		
202.00	Total (see Histi detions)	142, 100, 141	O	142, 100, 141	105, 513	142, 211, 004	1202.00	

Date/Time Prepared: 12/31/2020 7/29/2021 2:33 pm Title XVIII Hospi tal PPS Charges Total (col. 6 Cost or Other Cost Center Description Inpati ent Outpati ent TEFRA + col. 7) Ratio I npati ent Ratio 6. 00 7.00 8.00 9.00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 25, 411, 336 30.00 03000 ADULTS & PEDIATRICS 25, 411, 336 30.00 31.00 03100 INTENSIVE CARE UNIT 16, 111, 220 16, 111, 220 31.00 04000 SUBPROVI DER - I PF 8, 730, 989 8, 730, 989 40.00 40.00 41.00 04100 SUBPROVI DER - I RF 7, 404, 201 7, 404, 201 41.00 04300 NURSERY 1, 367, 007 43.00 1, 367, 007 43.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 18, 747, 538 20, 605, 174 39, 352, 712 0 184742 0.000000 50.00 05100 RECOVERY ROOM 0.000000 0.000000 51.00 51.00 10, 559, 652 1, 160, 799 9, 398, 853 0. 254354 0.000000 51.01 05101 ENDOSCOPY 51.01 52.00 05200 DELIVERY ROOM & LABOR ROOM 5, 031, 496 204, 123 5, 235, 619 0.341362 0.000000 52.00 53.00 05300 ANESTHESI OLOGY 0.000000 0.000000 53.00 85, 195, 272 0. 113742 14, 532, 436 05400 RADI OLOGY-DI AGNOSTI C 0.000000 54 00 54.00 70, 662, 836 55.00 05500 RADI OLOGY-THERAPEUTI C 545, 037 22, 276, 428 22, 821, 465 0.221683 0.000000 55.00 47, 979, 070 71, 819, 620 60 00 06000 LABORATORY 23, 840, 550 0.147844 0.000000 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 63.00 0.000000 63.00 0 06500 RESPIRATORY THERAPY 11, 086, 916 2, 768, 275 13, 855, 191 65.00 0.277384 0.000000 65 00 06600 PHYSI CAL THERAPY 15, 221, 681 9,075,932 24, 297, 613 0. 283696 0.000000 66.00 66.00 69.00 06900 ELECTROCARDI OLOGY 15, 470, 378 23, 000, 821 38, 471, 199 0.147311 0.000000 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 0.000000 0.000000 70.00 5, 286, 474 70.01 07001 NEURODI AGNOSTI CS 171, 222 5, 115, 252 0. 233991 0.000000 70.01 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 2, 265, 245 1, 951, 963 4, 217, 208 1.191810 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 4, 904, 278 5, 323, 831 10, 228, 109 0.490188 0.000000 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 21, 531, 646 73 00 63, 441, 025 84, 972, 671 0.285907 0.000000 73.00 75.00 07500 ASC (NON-DISTINCT PART) 114, 163 21, 233, 615 21, 347, 778 0.202871 0.000000 75.00 03950 MH ANCILLARY OUTPATIENT 76.00 0.000000 0.000000 76.00 03951 INPATIENT DIALYSIS 991.859 27. 321 1, 019, 180 0.750849 0.000000 76.01 76.01 OUTPATIENT SERVICE COST CENTERS 90 00 09000 CLI NI C 250 93, 709 93, 959 3.218436 0.000000 90.00 04950 WOUND CLINIC 90.01 104, 446 4, 358, 729 4, 463, 175 0.375487 0.000000 90.01 91 00 09100 EMERGENCY 10 551 708 35, 246, 911 45 798 619 0.209909 0.000000 91 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 1, 700, 230 4, 256, 596 5, 956, 826 0.456968 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 0 422, 599 422, 599 0.525860 0.000000 96.00 101.00 10100 HOME HEALTH AGENCY 0 101.00 Ω SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 2 216 085 2 216 085 116 00 200.00 Subtotal (see instructions) 206, 996, 631 349, 659, 148 556, 655, 779 200.00 201.00 Less Observation Beds 201.00

206, 996, 631

349, 659, 148

556, 655, 779

202.00

202.00

Total (see instructions)

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	From 01/01/2020	Worksheet C Part I Date/Time Prepared: 7/29/2021 2:33 pm

				10 12/31/2020	7/29/2021 2:3	∍pared: 33 nm
			Title XVIII	Hospi tal	PPS	70 PIII
	Cost Center Description	PPS Inpatient		<u> </u>		
	·	Ratio				
		11. 00				
	PATIENT ROUTINE SERVICE COST CENTERS					
	OOO ADULTS & PEDIATRICS					30.00
	100 INTENSIVE CARE UNIT					31.00
	000 SUBPROVI DER - I PF					40.00
	100 SUBPROVI DER - I RF					41.00
	300 NURSERY					43.00
	CILLARY SERVICE COST CENTERS					4
	OOO OPERATING ROOM	0. 185709				50.00
	100 RECOVERY ROOM	0. 000000				51.00
	101 ENDOSCOPY	0. 254354				51. 01
	200 DELIVERY ROOM & LABOR ROOM	0. 341362				52.00
	300 ANESTHESI OLOGY	0. 000000				53.00
	400 RADI OLOGY-DI AGNOSTI C	0. 113742				54.00
	500 RADI OLOGY-THERAPEUTI C	0. 221983				55.00
	000 LABORATORY	0. 147844				60.00
	300 BLOOD STORING, PROCESSING & TRANS.	0. 000000				63.00
	500 RESPI RATORY THERAPY	0. 277384				65.00
	600 PHYSI CAL THERAPY	0. 283696				66.00
	900 ELECTROCARDI OLOGY	0. 147447				69.00
	000 ELECTROENCEPHALOGRAPHY	0. 000000				70.00
	001 NEURODI AGNOSTI CS	0. 235800				70. 01
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1. 191810				71.00
	200 IMPL. DEV. CHARGED TO PATIENTS	0. 490188				72.00
	300 DRUGS CHARGED TO PATIENTS	0. 285907				73.00
	500 ASC (NON-DISTINCT PART)	0. 203279				75.00
	950 MH ANCILLARY OUTPATIENT	0.000000				76.00
	951 I NPATI ENT DI ALYSI S	0. 750849				76. 01
	TPATIENT SERVICE COST CENTERS	2 242424				
	000 CLINIC	3. 218436				90.00
	950 WOUND CLINIC	0. 375487				90. 01
	100 EMERGENCY	0. 209909				91.00
	200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 456968				92.00
	HER REIMBURSABLE COST CENTERS 600 DURABLE MEDICAL EQUIP-RENTED	0. 505040				0, 00
	100 HOME HEALTH AGENCY	0. 525860				96.00
	ECIAL PURPOSE COST CENTERS					101.00
	300 INTEREST EXPENSE					113.00
	600 HOSPI CE					116.00
200.00	Subtotal (see instructions)					200.00
201.00	Less Observation Beds					200.00
201.00	Total (see instructions)					201.00
202.00	Total (See Histinctions)	1				1202.00

					o 12/31/2020	Date/Time Pre 7/29/2021 2:3	pared:
			Ti tl	e XIX	Hospi tal	Cost	<u> </u>
			<u> </u>		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	15, 545, 742	l .	15, 545, 742		15, 545, 742	
	03100 INTENSIVE CARE UNIT	8, 574, 268		8, 574, 268		8, 574, 268	
40.00	04000 SUBPROVI DER - I PF	5, 213, 502		5, 213, 502		5, 250, 568	1
	04100 SUBPROVI DER - I RF	4, 730, 282	l	4, 730, 282		4, 730, 282	1
43.00	04300 NURSERY	633, 822		633, 822	2 0	633, 822	43. 00
	ANCILLARY SERVICE COST CENTERS		l				
50. 00	05000 OPERATI NG ROOM	7, 270, 081		7, 270, 081		7, 308, 156	
	05100 RECOVERY ROOM	0		(0	0	51.00
51. 01	05101 ENDOSCOPY	2, 685, 887		2, 685, 887		2, 685, 887	51.01
	05200 DELIVERY ROOM & LABOR ROOM	1, 787, 241		1, 787, 241		1, 787, 241	
53.00	05300 ANESTHESI OLOGY	0 (00 000		0	-	0	53.00
54.00	05400 RADI OLOGY - DI AGNOSTI C	9, 690, 303		9, 690, 303		9, 690, 303	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	5, 059, 124		5, 059, 124		5, 065, 987	55.00
60.00	06000 LABORATORY	10, 618, 102		10, 618, 102		10, 618, 102 0	
63. 00 65. 00	06300 BLOOD STORING, PROCESSING & TRANS. 06500 RESPIRATORY THERAPY	3, 843, 204	0	3, 843, 204		3, 843, 204	63. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	6, 893, 126	1	6, 893, 126		6, 893, 126	
69. 00	06900 ELECTROCARDI OLOGY	5, 667, 228	0	5, 667, 228		5, 672, 461	1
70. 00	07000 ELECTROENCEPHALOGRAPHY	3,007,220		3,007,220	3, 233	0, 072, 401	70.00
	07001 NEURODI AGNOSTI CS	1, 236, 989		1, 236, 989	9, 560	1, 246, 549	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	5, 026, 112	l	5, 026, 112		5, 026, 112	
	07200 I MPL. DEV. CHARGED TO PATIENTS	5, 013, 700	l	5, 013, 700		5, 013, 700	
	07300 DRUGS CHARGED TO PATIENTS	24, 294, 278	l .	24, 294, 278		24, 294, 278	
	07500 ASC (NON-DISTINCT PART)	4, 330, 840		4, 330, 840		4, 339, 556	
76. 00	03950 MH ANCILLARY OUTPATIENT	0		(0	0	1
	03951 I NPATI ENT DI ALYSI S	765, 250		765, 250	ol	765, 250	1
	OUTPATIENT SERVICE COST CENTERS				· · · · · ·		
90.00	09000 CLI NI C	302, 401		302, 401	0	302, 401	90.00
90. 01	04950 WOUND CLINIC	1, 675, 862		1, 675, 862	el ol	1, 675, 862	90. 01
91.00	09100 EMERGENCY	9, 613, 534		9, 613, 534	o	9, 613, 534	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 722, 080		2, 722, 080		2, 722, 080	92.00
	OTHER REIMBURSABLE COST CENTERS						
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	222, 228		222, 228	0	222, 228	96.00
101.00	10100 HOME HEALTH AGENCY	0		C)	0	101. 00
	SPECIAL PURPOSE COST CENTERS						
	11300 I NTEREST EXPENSE						113.00
	11600 H0SPI CE	1, 413, 035	ł	1, 413, 035		1, 413, 035	
200.00		144, 828, 221	0	, . = . , = = .		144, 933, 734	
201.00		2, 722, 080		2, 722, 080		2, 722, 080	
202. 00	Total (see instructions)	142, 106, 141	0	142, 106, 141	105, 513	142, 211, 654	202.00

| Peri od: | Worksheet C | From 01/01/2020 | Part I | Date/Time Prepared: |

					0 12/31/2020	7/29/2021 2:3	
			Ti tl	e XIX	Hospi tal	Cost	о рііі
			Charges	0 //.	1100p1 tui	0001	
	Cost Center Description	I npati ent	Outpati ent	Total (col 6	Cost or Other	TEFRA	
	ocat contain book i per an	patront	output ont	+ col . 7)	Ratio	Inpatient	
				' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '		Ratio	
		6. 00	7. 00	8.00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS	2.22			1. 20		
30.00	03000 ADULTS & PEDIATRICS	25, 411, 336		25, 411, 336			30.00
31.00	03100 INTENSIVE CARE UNIT	16, 111, 220		16, 111, 220			31.00
40.00	04000 SUBPROVI DER - I PF	8, 730, 989		8, 730, 989			40.00
41.00	04100 SUBPROVI DER - I RF	7, 404, 201		7, 404, 201			41.00
43. 00	04300 NURSERY	1, 367, 007		1, 367, 007			43.00
	ANCILLARY SERVICE COST CENTERS	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		., .,			
50.00	05000 OPERATING ROOM	18, 747, 538	20, 605, 174	39, 352, 712	0. 184742	0.000000	50.00
51. 00	05100 RECOVERY ROOM	0	0			0. 000000	
51. 01	05101 ENDOSCOPY	1, 160, 799	9, 398, 853	10, 559, 652		0. 000000	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	5, 031, 496	204, 123		1	0. 000000	
53. 00	05300 ANESTHESI OLOGY	0	0			0. 000000	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	14, 532, 436	70, 662, 836			0. 000000	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	545, 037	22, 276, 428			0.000000	55.00
60.00	06000 LABORATORY	23, 840, 550	47, 979, 070			0. 000000	60.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	25, 640, 550	47, 777, 070		1	0.000000	63.00
65.00	06500 RESPIRATORY THERAPY	11, 086, 916	2, 768, 275		1	0. 000000	65.00
66. 00	06600 PHYSI CAL THERAPY	15, 221, 681	9, 075, 932			0. 000000	66.00
69. 00	06900 ELECTROCARDI OLOGY	15, 470, 378	23, 000, 821			0. 000000	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	13, 470, 376	23,000,821		1	0.000000	
70.00	07000 ELECTROENCEPHALOGRAFITI	171, 222	5, 115, 252	1		0.000000	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 265, 245	1, 951, 963			0.000000	
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS	4, 904, 278	5, 323, 831			0.000000	
73.00	07300 DRUGS CHARGED TO PATIENTS	21, 531, 646			1	0.000000	
75.00	07500 ASC (NON-DISTINCT PART)	114, 163	63, 441, 025			0.000000	
76. 00	03950 MH ANCILLARY OUTPATIENT	114, 103	21, 233, 615 0		1	0.000000	
76. 00	03951 I NPATI ENT DI ALYSI S	991, 859	27, 321			0.000000	
76.01	OUTPATIENT SERVICE COST CENTERS	991, 009	21, 321	1,019,100	0.750649	0.000000	76.01
90. 00	09000 CLINIC	250	93. 709	93, 959	3. 218436	0. 000000	90.00
90.00	04950 WOUND CLINIC	104, 446	4, 358, 729			0.000000	90.00
91.00	09100 EMERGENCY	10, 551, 708	35, 246, 911			0.000000	91.00
91.00		1, 700, 230	4, 256, 596			0.000000	91.00
92.00	O9200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	1, 700, 230	4, 250, 590	5, 950, 820	0. 450908	0.000000	92.00
04 00	09600 DURABLE MEDICAL EQUIP-RENTED		422 F00	422 500	0 505040	0.000000	04 00
96.00		0	422, 599			0. 000000	96.00
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0	0			101. 00
112 00							112 00
	11300 INTEREST EXPENSE		2 24/ 225	2 21/ 225			113.00
	11600 HOSPI CE	0	2, 216, 085		1		116.00
200.00	,	206, 996, 631	349, 659, 148	556, 655, 779			200.00
201.00	1 · · · · · · · · · · · · · · · · · · ·	00/ 00/ 101	0.40 (50 1.10	FF/ /FF 330			201.00
202.00	Total (see instructions)	206, 996, 631	349, 659, 148	556, 655, 779	Ί Ι		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	Period: Worksheet C From 01/01/2020 Part I To 12/31/2020 Date/Time Prepared: 7/29/2021 2:33 nm

			10 12/31/2020 D	/29/2021 2:33 pm
		Title XIX	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
INDATIENT BOUTINE CERVI OF COCT CENTERS	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				20.00
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
31. 00 03100 INTENSIVE CARE UNIT				31.00
40. 00 04000 SUBPROVI DER - 1 PF				40.00
41. 00 04100 SUBPROVI DER - RF				41.00
43. 00 04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS	0.00000			
50. 00 05000 OPERATING ROOM	0. 000000			50.00
51. 00 05100 RECOVERY ROOM	0. 000000			51.00
51. 01 05101 ENDOSCOPY	0. 000000			51. 01
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0. 000000			52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000			55.00
60. 00 06000 LABORATORY	0. 000000			60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000			63.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000			65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			70.00
70. 01 07001 NEURODI AGNOSTI CS	0. 000000			70. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.00
75.00 07500 ASC (NON-DISTINCT PART)	0. 000000			75.00
76.00 03950 MH ANCILLARY OUTPATIENT	0. 000000			76.00
76. 01 03951 I NPATI ENT DI ALYSI S	0. 000000			76. 01
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	0. 000000			90.00
90. 01 04950 WOUND CLINIC	0. 000000			90. 01
91. 00 09100 EMERGENCY	0. 000000			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92.00
OTHER REIMBURSABLE COST CENTERS				
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000			96.00
101.00 10100 HOME HEALTH AGENCY				101. 00
SPECIAL PURPOSE COST CENTERS				
113. 00 11300 INTEREST EXPENSE				113.00
116. 00 11600 HOSPI CE				116.00
200.00 Subtotal (see instructions)				200.00
201.00 Less Observation Beds				201.00
202.00 Total (see instructions)				202.00

Health Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITA	L COSTS	Provi der C	1	Period: From 01/01/2020 Fo 12/31/2020		pared: 3 pm
		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, 572, 436	0	2, 572, 436			
31.00 INTENSIVE CARE UNIT	939, 590		939, 590	6, 301	149. 12	31.00
40. 00 SUBPROVI DER - I PF	609, 724	0	609, 72	4, 639	131. 43	40.00
41. 00 SUBPROVI DER - I RF	717, 596	0	717, 596	6, 447	111. 31	41.00
43. 00 NURSERY	15, 062		15, 062	930	16. 20	43.00
200.00 Total (lines 30 through 199)	4, 854, 408		4, 854, 408	32, 920		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x				
		col. 6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	6, 321					30.00
31.00 INTENSIVE CARE UNIT	3, 648					31.00
40. 00 SUBPROVI DER - I PF	1, 379	181, 242				40.00
41. 00 SUBPROVI DER - I RF	5, 377	598, 514				41.00
43. 00 NURSERY	0	0				43.00
200.00 Total (lines 30 through 199)	16, 725	2, 437, 253				200.00

Health Financial Systems		GOOD SAMARITAN	HOSPI TAL		In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT	ANCILLARY SERVICE CAPITA	L COSTS	Provi der	CCN: 15-0042	From 01/01/2020	Worksheet D Part II Date/Time Prepared: 7/29/2021 2:33 pm

Cost Center Description		TOWNENT OF THE ATTENT AND LEARN SERVICE GALLIA	12 00313	Trovider C		From 01/01/2020 To 12/31/2020	Date/Time Pre 7/29/2021 2:3	pared: 3 pm
Rel ated Cost (From Wkst. C. Part I, col. 1 + col. 2)								
CFORM WEST B, Part II, Col . 2) Col . 2) Charges Col umn 4)		Cost Center Description						
B. Part II, col 26								
COL 26) COL 26) COL 200 COL 3.00 4.00 5.00 COL 2.00 COL						Charges	column 4)	
1.00 2.00 3.00 4.00 5.00 6.00				col. 8)	col . 2)			
ANCILLARY SERVICE COST CENTERS 998, 788 39, 352, 712 0.025380 8, 285, 382 210, 283 50.00 51.00 05100 PEROTING ROOM 0 0 0.000000 0 0 51.00 51.00 51.00 05101 ENDOSCOPY 487, 400 10, 559, 662 0.046157 603, 148 27, 840 51.01 52.00 05200 DELI VERY ROOM & LABOR ROOM 38, 169 5, 235, 619 0.007290 14, 248 104 52.00 53.00 05300 ANESTHESI OLOGY 0 0 0.000000 0 0 0.53.00 0.000000 0 0 0.000000 0								
50.00		T	1. 00	2.00	3. 00	4. 00	5. 00	
51. 00 05100 RECOVERY ROOM	F0 00		000 700	00 050 740	1 0 00500	0 005 000		
51. 01 05101 ENDOSCOPY 487, 400 10, 559, 652 0. 046157 603, 148 27, 840 51. 01				39, 352, 712	l .	· · · · · · · · · · · · · · · · · · ·		
52.00 05200 DELIVERY ROOM & LABOR ROOM 38, 169 5, 235, 619 0.007290 14, 248 104 52.00			_	0	l .			
53. 00 05300 ANESTHESI OLOGY 0 0.000000 0 0.000000 53. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 921, 273 85, 195, 272 0.010814 7, 516, 902 81, 288 54. 00 65. 00 05500 RADI OLOGY-THERAPEUTI C 710, 561 22, 821, 465 0.031136 357, 220 11, 122 55. 00 60. 00 06000 LABORATORY 432, 486 71, 819, 620 0.06002 12, 547, 860 75, 563 60. 00 63. 00 06500 BLOOD STORI NG, PROCESSI NG & TRANS. 0 0 0.000000 0 0.000000 0 63. 00 65. 00 06500 RESPI RATORY THERAPY 248, 636 13, 855, 191 0.017945 4, 827, 722 86, 633 65. 00 66. 00 06600 PHYSI CAL THERAPY 641, 202 24, 297, 613 0.026390 3, 718, 907 98, 142 66. 00 69. 00 ELECTROCARDI OLOGY 733, 616 38, 471, 199 0.019069 7, 233, 176 137, 929 69. 00					l .	· ·		1
54. 00 05400 RADI OLOGY-DI AGNOSTI C 921, 273 85, 195, 272 0. 010814 7, 516, 902 81, 288 54. 00 05500 RADI OLOGY-THERAPEUTI C 710, 561 22, 821, 465 0. 031136 357, 220 11, 122 55. 00 06. 00 06000 LABORATORY 432, 486 71, 819, 620 0. 006002 12, 547, 860 75, 563 60. 00 63. 00 06500 RESPI RATORY THERAPY 248, 636 13, 855, 191 0. 017945 4, 827, 722 86, 633 65. 00 06500 RESPI RATORY THERAPY 641, 202 24, 297, 613 0. 026390 3, 718, 907 98, 142 66. 00 06900 ELECTROCARDI OLOGY 733, 616 38, 471, 199 0. 019069 7, 233, 176 137, 929 69, 00 07000 ELECTROENCEPHALOGRAPHY 0 0. 0000000 0 0. 0000000 0								
55. 00 05500 RADI OLOGY-THERAPEUTI C 710, 561 22, 821, 465 0. 031136 357, 220 11, 122 55. 00 60. 00 0. 06000 LABORATORY 432, 486 71, 819, 620 0. 006002 12, 547, 860 75, 563 60. 00 63. 00 0. 6300 BLOOD STORING, PROCESSING & TRANS. 0 0. 000000 0 0. 63. 00 0. 006002 0. 006002 12, 547, 860 75, 563 60. 00 0. 006002 0. 006002 12, 547, 860 75, 563 60. 00 0. 006002 12, 547, 860 75, 563 60. 00 0. 006002 12, 547, 860 75, 563 60. 00 0. 006002 12, 547, 860 75, 563 60. 00 0. 006002 12, 547, 860 75, 563 60. 00 0. 006002 12, 547, 860 75, 563 60. 00 0. 006002 12, 547, 860 75, 563 60. 00 0. 006002 12, 547, 860 75, 563 60. 00 0. 006002 12, 547, 860 12				Ĭ	l .		_	1
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69. 00			·			· · · · · · · · · · · · · · · · · · ·	·	
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0.000000 0 70. 00 70. 01 07001 NEURODI AGNOSTI CS 291, 784 5, 286, 474 0.055194 43, 808 2, 418 70. 01 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 129, 375 4, 217, 208 0.030678 1, 162, 115 35, 651 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 130, 083 10, 228, 109 0.012718 2, 585, 234 32, 879 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 378, 516 84, 972, 671 0.004455 9, 910, 884 44, 153 73. 00 75. 00 07500 ASC (NON-DISTINCT PART) 132, 568 21, 347, 778 0.006210 0 0 75. 00 76. 01 03950 MH ANCI LLARY OUTPATIENT 0 0 0.000000 0 0 76. 00 76. 01 03951 INPATIENT DI ALYSI S 306, 887 1, 019, 180 0.301112 643, 014 193, 619 76. 01 <t< td=""><td></td><td></td><td>·</td><td></td><td></td><td>· · · · · · · · · · · · · · · · · · ·</td><td></td><td></td></t<>			·			· · · · · · · · · · · · · · · · · · ·		
70. 01 07001 NEURODI AGNOSTI CS 291, 784 5, 286, 474 0. 055194 43, 808 2, 418 70. 01 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 129, 375 4, 217, 208 0. 030678 1, 162, 115 35, 651 71. 00 72. 00 07200 MPL. DEV. CHARGED TO PATI ENTS 130, 083 10, 228, 109 0. 012718 2, 585, 234 32, 879 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 378, 516 84, 972, 671 0. 004455 9, 910, 884 44, 153 73. 00 75. 00 07500 ASC (NON-DI STI NCT PART) 132, 568 21, 347, 778 0. 006210 0 0. 000000 0 0 75. 00 76. 00 03950 MH ANCI LLARY OUTPATI ENT 0 0 0. 0000000 0 0 0. 000000 0			733, 616	38, 471, 199			137, 929	
71. 00	70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0. 00000	0 0	0	70.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 130, 083 10, 228, 109 0. 012718 2, 585, 234 32, 879 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 378, 516 84, 972, 671 0. 004455 9, 910, 884 44, 153 73. 00 75. 00 07500 ASC (NON-DISTINCT PART) 132, 568 21, 347, 778 0. 006210 0 0 0. 000000 0 0 0. 000000 0	70. 01	07001 NEURODI AGNOSTI CS	291, 784	5, 286, 474	0. 05519	43, 808	2, 418	70. 01
73. 00 07300 DRUGS CHARGED TO PATIENTS 378, 516 84, 972, 671 0.004455 9, 910, 884 44, 153 73. 00 75. 00 07500 ASC (NON-DISTINCT PART) 132, 568 21, 347, 778 0.006210 0 0 0.000000 0 0 0.000000 0	71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	129, 375	4, 217, 208	0. 03067	8 1, 162, 115	35, 651	71.00
75. 00 07500 ASC (NON-DISTINCT PART) 132, 568 21, 347, 778 0.006210 0 0 75. 00 76. 0	72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	130, 083	10, 228, 109	0. 01271	8 2, 585, 234	32, 879	72.00
76. 00	73.00	07300 DRUGS CHARGED TO PATIENTS	378, 516	84, 972, 671	0.00445	9, 910, 884	44, 153	73.00
76. 01 03951 NPATI ENT DI ALYSI S 306, 887 1, 019, 180 0. 301112 643, 014 193, 619 76. 01 0UTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C 86, 358 93, 959 0. 919103 0 0 0 0 90. 01 04950 WOUND CLI NI C 134, 063 4, 463, 175 0. 030038 11, 663 350 90. 01 91. 00 09100 EMERGENCY 1, 061, 299 45, 798, 619 0. 023173 5, 522, 642 127, 976 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 450, 436 5, 956, 826 0. 075617 812, 948 61, 473 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 17, 474 422, 599 0. 041349 0 0 96. 00 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 17, 474 422, 599 0. 041349 0 0 96. 00 97. 01 09700 0. 00700 0. 00700 0. 00700 0. 00700 0. 00700 98. 02 00 09700 0. 00700 0. 00700 0. 00700 0. 00700 99. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	75.00	07500 ASC (NON-DISTINCT PART)	132, 568	21, 347, 778	0. 00621	0 0	0	75. 00
OUTPATIENT SERVICE COST CENTERS 90.00 O9000 CLINIC 86,358 93,959 0.919103 0 0 0.00	76.00	03950 MH ANCILLARY OUTPATIENT	0	0	0.00000	0 0	0	76.00
90. 00 09000 CLI NI C 86, 358 93, 959 0. 919103 0 0 90. 00	76. 01	03951 INPATIENT DIALYSIS	306, 887	1, 019, 180	0. 30111	2 643, 014	193, 619	76. 01
90. 01 04950 WOUND CLINIC 134, 063 4, 463, 175 0. 030038 11, 663 350 90. 01 91. 00 91. 00 91. 00 92. 00 085ERVATI ON BEDS (NON-DISTINCT PART) 450, 436 5, 956, 826 0. 075617 812, 948 61, 473 92. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 17, 474 422, 599 0. 041349 0 0 96. 00 96. 00 96. 00 0. 075617 0. 030038 11, 663 350 90. 01 91. 00 91. 00 92. 00 92. 00 92. 00 93. 00 0. 075617 0		OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY 1, 061, 299 45, 798, 619 0. 023173 5, 522, 642 127, 976 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 450, 436 5, 956, 826 0. 075617 812, 948 61, 473 92. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 17, 474 422, 599 0. 041349 0 0 96. 00 96. 00 096. 0	90.00	09000 CLI NI C	86, 358	93, 959	0. 91910	0	0	90.00
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 450, 436 5, 956, 826 0. 075617 812, 948 61, 473 92. 00 OTHER REIMBURSABLE COST CENTERS 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 17, 474 422, 599 0. 041349 0 0 96. 00	90. 01	04950 WOUND CLINIC	134, 063	4, 463, 175	0. 03003	8 11, 663	350	90. 01
OTHER REI MBURSABLE COST CENTERS 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 17, 474 422, 599 0. 041349 0 0 96. 00	91.00	09100 EMERGENCY	1, 061, 299	45, 798, 619	0. 02317	3 5, 522, 642	127, 976	91.00
OTHER REI MBURSABLE COST CENTERS 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 17, 474 422, 599 0. 041349 0 0 96. 00	92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	450, 436	5, 956 <u>,</u> 826	0. 07561	7 812, 948	61, 473	92.00
200. 00 Total (Lines 50 through 199) 8, 330, 974 495, 414, 941 65, 796, 873 1, 227, 423 200. 00	96.00					9 0	_	
	200.00	Total (lines 50 through 199)	8, 330, 974	495, 414, 941		65, 796, 873	1, 227, 423	200.00

Health Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER P	ASS THROUGH COS			Period: From 01/01/2020 To 12/31/2020	Date/Time Pre 7/29/2021 2:3	epared:
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursi ng School	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 & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 40. 00 04000 SUBPROVIDER - IPF 41. 00 04100 SUBPROVIDER - IRF	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
43. 00 04300 NURSERY	0	0)	0	0	
200.00 Total (lines 30 through 199)	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 & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT	0	0	6, 30	0. 00	3, 648	31.00
40. 00 04000 SUBPROVI DER - I PF	0	0	4, 63			
41. 00 04100 SUBPROVI DER - I RF	0	0	6, 44			
43. 00 04300 NURSERY		0	93			
200.00 Total (lines 30 through 199)		0	32, 92	20	16, 725	200.00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 40. 00 04000 SUBPROVI DER - PF	0 0					30.00 31.00 40.00
41. 00 04100 SUBPROVI DER - RF	0					41.00
43.00 04300 NURSERY 200.00 Total (Lines 30 through 199)	0					43. 00 200. 00

Health Financial Systems	GOOD SAMARITAN HOSPITAL	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT A	NCILLARY SERVICE OTHER PASS Provider CCN: 15-0042	Period: Worksheet D
THROUGH COSTS		From 01/01/2020 Part IV

Hikoudii 60313			-	To 12/31/2020	Date/Time Pre 7/29/2021 2:3	pared: 3 pm
		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						
50.00 05000 OPERATING ROOM	0	0	(0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	(0	0	51.00
51. 01 05101 ENDOSCOPY	0	0	(0	0	51.01
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	(0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0	(0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	(0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	(0	0	55.00
60. 00 06000 LABORATORY	0	0	(0	321, 483	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	(0	0	63.00
65. 00 06500 RESPI RATORY THERAPY	0	0	(0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0	(0	0	66.00
69. 00 06900 ELECTROCARDI OLOGY	0	0	(0	0	69. 00
70. 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 I NPATI ENT DI ALYSI S	0	0	(0	0	76. 01
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0	(0	0	90.00
90. 01 04950 WOUND CLINIC	0	0	(0	0	90. 01
91. 00 09100 EMERGENCY	0	0	(0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			O	0	92.00
OTHER REIMBURSABLE COST CENTERS						
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0			0	0	
200.00 Total (lines 50 through 199)	0	0	(0 C	321, 483	200.00

Health Financial Systems	GOOD SAMARITAN HOSPITAL	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0042	Peri od: Worksheet D From 01/01/2020 Part IV To 12/31/2020 Date/Time Prepared:

ANCILLARY SERVICE COST CENTERS A.00 5.00 6.00 7.00 85.00 55.00	111100511 00010			Т	o 12/31/2020	Date/Time Pre 7/29/2021 2:3	
Medical Education Cost Sum of Cols. Cost (sum of Co			Title	XVIII	Hospi tal		
Education Cost	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
Cost 4) Col s 2, 3, and 4) Col s 2, 3, and 4) Col 7 (see instructions)		Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
ANCILLARY SERVICE COST CENTERS			1, 2, 3, and		C, Part I,		
ANCI LLARY SERVI CE COST CENTERS		Cost	4)		col. 8)		
ANCI LLARY SERVI CE COST CENTERS S. 00 6.00 7.00 8.00				and 4)			
ANCILLARY SERVICE COST CENTERS							
50. 00 05000 OPERATI NC ROOM 0 0 0 0 39, 352, 712 0.000000 50. 00		4. 00	5.00	6. 00	7. 00	8. 00	
51.00 05100 RECOVERY ROOM 0 0 0 0 0 0 0 0 0			1	1	00 050 740		
51. 01 05101 ENDOSCOPY 0 0 0 0 10,559,652 0.000000 51. 01		0	1	ľ	39, 352, 712		
52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0 5, 235, 619 0.000000 52.00		0	0	0	0		
53. 00 05300 ANESTHESI OLOGY 0 0 0 0 0.000000 53. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 85, 195, 272 0.000000 54. 00 55. 00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 22, 821, 465 0.000000 55. 00 60. 00 06000 LABORATORY 0 321, 483 321, 483 71, 819, 620 0.004476 60. 00 63. 00 06500 BLOOD STORI NG, PROCESSI NG & TRANS. 0 0 0 0.000000 63. 00 66. 00 06600 PESPI RATORY THERAPY 0 0 0 13, 855, 191 0.000000 65. 00 66. 00 06600 PEYSI CAL THERAPY 0 0 0 24, 297, 613 0.000000 66. 00 06900 ELECTROCARDI OLOGY 0 0 0 38, 471, 199 0.000000 70. 00 70. 01 07000 BELOCTROENCEPHALOGRAPHY 0 0 0 <td< td=""><td></td><td>0</td><td>0</td><td>0</td><td></td><td></td><td></td></td<>		0	0	0			
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 85, 195, 272 0.000000 54. 00 55. 00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 22, 821, 465 0.00000 55. 00 60. 00 06000 LABORATORY 0 321, 483 321, 483 321, 483 71, 819, 620 0.00476 60. 00 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0 0 0 0.000000 65. 00 0.000000 0 0.000000 65. 00 0.000000 65. 00 0.000000 0 0 0.000000 65. 00 0.000000 0 0 0.000000 65. 00 0 0 0 0 0.000000 65. 00 0 0 0 0.000000 66. 00 0 0 0 0 0 0.000000 66. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 </td <td></td> <td>0</td> <td>0</td> <td>0</td> <td></td> <td></td> <td></td>		0	0	0			
55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 22, 821, 465 0.000000 0.00000 0.00000 0.00000 0.00000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.000000 0.0000000 0.0000000 0.0000000 0.00000000		0	0	0	0		
60. 00 06000 LABORATORY 0 321, 483 321, 483 71, 819, 620 0.004476 60. 00 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0 0 0 0 0.000000 65. 00 06500 RESPIRATORY THERAPY 0 0 0 0 13, 855, 191 0.000000 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 24, 297, 613 0.000000 66. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 38, 471, 199 0.000000 69. 00 70. 00 07000 ELECTROCARDI OLOGY 0 0 0 0 0 0.000000 71. 00 07001 NEURODI AGNOSTI CS 0 0 0 0 5, 286, 474 0.000000 70. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 0 4, 217, 208 0.000000 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 42, 277, 71 0.000000 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 84, 972, 671 0.000000 73. 00 75. 00 07500 ASC (NON-DI STI NCT PART) 0 0 0 0 0 0.000000 76. 01 76. 01 03951 INPATI ENT DI ALYSI S 0 0 0 0 0 0, 000000 76. 01 90. 00 09000 CLI NI C 0 0 0 0 4, 463, 175 0.000000 90. 01 91. 00 09100 EMERGENCY 0 0 0 0 44, 463, 175 0.000000 90. 01 91. 00 09100 EMERGENCY 0 0 0 0 44, 463, 175 0.000000 90. 01 91. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 422, 599 0.000000 96. 00		0	0	0			
63. 00		0	0	004 400			
65. 00 06500 RESPIRATORY THERAPY 0 0 0 0 13, 855, 191 0.000000 65. 00 660. 00 06600 PHYSI CAL THERAPY 0 0 0 0 24, 297, 613 0.000000 66. 00 0 0.000000 06. 00 0 0 0		0	321, 483	321, 483	/1, 819, 620		
66. 00		0	0	0	10.055.101		
69. 00 06900 ELECTROCARDI OLOGY 0 0 0 38, 471, 199 0.000000 69. 00 70. 00 70.00 70.00 70.00 70.00 ELECTROENCEPHALOGRAPHY 0 0 0 0 0.000000 70. 0		0	0	0	· · ·		
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0 0 0 0	· · · · · · · · · · · · · · · · · · ·	0	0	0	· · ·		
70. 01 07001 NEURODI AGNOSTI CS 0 0 0 5, 286, 474 0.000000 70. 01 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 4, 217, 208 0.000000 71. 00 72. 00 07200 MPL. DEV. CHARGED TO PATI ENTS 0 0 0 10, 228, 109 0.000000 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 84, 972, 671 0.000000 73. 00 75. 00 07500 ASC (NON-DI STI NCT PART) 0 0 0 0 21, 347, 778 0.000000 76. 00 76. 00 0.0000000 76. 00 0.000000000000000000000000000000		0	0	0	38, 4/1, 199		
71. 00		0	0	0	U F 207 474		
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 10, 228, 109 0.000000 72. 00 73. 00 73. 00 73. 00 73. 00 73. 00 74. 00 0 0 0 0 0 0 0.000000 73. 00 75. 00	· · · · · · · · · · · · · · · · · · ·	0	0	0			
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 84, 972, 671 0.000000 73. 00 75. 00 75. 00 75. 00 75. 00 75. 00 75. 00 76. 00 0 0 0 0 0 0 0.000000 75. 00 76. 00 76. 00 0 0 0 0 0 0 0 0 0		0	0				
75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 21, 347, 778 0.000000 75. 00 76. 00 03950 MH ANCILLARY OUTPATIENT 0 0 0 0 0.000000 76. 00 76. 00 03951 NPATIENT DIALYSIS 0 0 0 1, 019, 180 0.000000 76. 01 000000 000000 0000000 0000000 000000		0	0				
76. 00 03950 MH ANCI LLARY OUTPATIENT 0 0 0 0 0 0.000000 76. 00 76. 00 0 0 0.000000 76. 00 0 0 0.000000 76. 00 0 0 0.000000 76. 00 0 0 0.000000 76. 00 0 0 0.000000 76. 01 0 0 0 0 0 0.000000 76. 01 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	l l	0					
76. 01 03951 INPATIENT DIALYSIS 0 0 0 1,019,180 0.000000 76. 01 0UTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC 0 0 0 93,959 0.000000 90. 00 90. 01 045,798,619 0.000000 90. 01 045,798,619 0.000000 91. 00 0 0 45,798,619 0.000000 91. 00 00 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0					
OUTPATIENT SERVICE COST CENTERS OUTP		0	_	1	_		
90. 00 09000 CLINIC 0 0 93,959 0.000000 90.00			0		1,017,100	0.000000	70.01
90. 01		0	0		93 959	0.000000	90 00
91. 00 09100 EMERGENCY 0 0 45, 798, 619 0.000000 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 5, 956, 826 0.000000 92. 00 00000000000000000000000000000000		0			·		
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 0 0 5, 956, 826 0.000000 92. 00		0	0	١	·		
OTHER REI MBURSABLE COST CENTERS 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 422,599 0.000000 96.00		0	0	١	·		
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 422, 599 0. 000000 96. 00					3, 755, 626	0.00000	72.00
		0	0	0	422, 599	0. 000000	96. 00
				-	·		

Health Financial Systems	GOOD SAMARITAN	I HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SET THROUGH COSTS	RVICE OTHER PASS	Provi der CC		Period: From 01/01/2020 To 12/31/2020		
		Title	XVIII	Hospi tal	PPS	<u> </u>
Cost Center Description	Outpatient Ratio of Cost	Inpatient Program	Inpatient Program	Outpatient Program	Outpatient Program	
	to Charges (col. 6 ÷	Charges	Pass-Through Costs (col. 8		Pass-Through 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	8, 285, 382		0 6, 751, 542	0	50.00
51.00 05100 RECOVERY ROOM	0. 000000	0		0	0	51.00
51. 01 05101 ENDOSCOPY	0. 000000	603, 148		0 3, 213, 977	0	51.01
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	14, 248		0 8, 491	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. 000000	7, 516, 902		0 26, 417, 214	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	357, 220		0 11, 341, 006	0	55.00
60. 00 06000 LABORATORY	0. 004476	12, 547, 860	56, 16	4 5, 943, 635	26, 604	60.00
(2 00 0/200 DI 00D CTODING DEOCECCING & TRANS	0 000000					(2.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provi der CCN: 15-0042 Worksheet D From 01/01/2020 Part V Date/Time Prepared: 12/31/2020 7/29/2021 2:33 pm Title XVIII Hospi tal PPS 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.) 1.00 2.00 5.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 0. 184742 6, 751, 542 1, 247, 293 50.00 05100 RECOVERY ROOM 0 0.000000 51.00 0 51.00 0 05101 ENDOSCOPY 0 51.01 0. 254354 3, 213, 977 817, 488 51.01 2, 899 05200 DELIVERY ROOM & LABOR ROOM 0.341362 8, 491 0 52.00 53.00 05300 ANESTHESI OLOGY 0.000000 0 0 53.00 0 0 0. 113742 0 3, 004, 747 54.00 05400 RADI OLOGY-DI AGNOSTI C 26, 417, 214 54.00 0 0 55.00 05500 RADI OLOGY-THERAPEUTI C 0. 221683 11, 341, 006 2, 514, 108 55.00 60.00 06000 LABORATORY 0. 147844 5, 943, 635 0 0 0 878, 731 60.00 0 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 63.00 C 63.00 0 06500 RESPIRATORY THERAPY 1, 225, 739 0 340,000 65.00 0.277384 65.00 66.00 06600 PHYSI CAL THERAPY 0.283696 143, 471 40, 702 66.00 06900 ELECTROCARDI OLOGY 0 69.00 0.147311 11, 061, 497 0 0 1, 629, 480 69.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0 70 00 70 00 0 07001 NEURODI AGNOSTI CS 70.01 0. 233991 1, 643, 209 0 384, 496 70.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 1. 191810 1, 016, 676 0 0 1, 211, 685 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0. 490188 2, 323, 193 0 0 1, 138, 801 72.00 07300 DRUGS CHARGED TO PATIENTS 73 00 0 285907 32, 581, 966 220 21, 821 9, 315, 412 73 00 75.00 07500 ASC (NON-DISTINCT PART) 0. 202871 5, 821, 933 0 0 1, 181, 101 75.00 03950 MH ANCILLARY OUTPATIENT 0.000000 0 0 76.00 76.00 0 03951 INPATIENT DIALYSIS 76.01 0.750849 19, 515 0 0 14,653 76.01 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 3. 218436 277 0 892 90.00 04950 WOUND CLINIC 0. 375487 2, 369, 499 0 0 889, 716 90.01 90.01 09100 EMERGENCY 0. 209909 7, 828, 759 1, 643, 327 91.00 91.00 0 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0.456968 2,075,810 92.00 948, 579 92.00 OTHER REIMBURSABLE COST CENTERS 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0. 525860 0 0 96.00 200.00 121, 787, 409 21, 821 27, 204, 110 200. 00 Subtotal (see instructions) 220 201.00 Less PBP Clinic Lab. Services-Program 0 201.00 Only Charges 202.00 Net Charges (line 200 - line 201) 121, 787, 409 220 21, 821 27, 204, 110 202. 00

Health Financial Systems	GOOD SAMARITAN	In Lieu	u of Form CMS-2552-10	
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provi der CCN: 15-0042	From 01/01/2020	Worksheet D Part V Date/Time Prepared:

					To 12/31/2020	Date/Time Pro	
			Title	XVIII	Hospi tal	PPS	
	·	Cos	ts				
	Cost Center Description	Cost	Cost				
		Rei mbursed	Rei mbursed				
			Services Not				
		Subject To	Subject To				
			Ded. & Coins.				
		(see inst.)	(see inst.)				
	ANOLILIADY CERVICE COCT CENTERS	6. 00	7. 00				
FO 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM						50.00
	05100 RECOVERY ROOM	0	0				51.00
	05100 RECOVERY ROOM	0	0				51.00
	05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
	05300 ANESTHESI OLOGY		0				53.00
	05400 RADI OLOGY-DI AGNOSTI C		0				54.00
	05500 RADI OLOGY-THERAPEUTI C		0				55.00
	06000 LABORATORY		0				60.00
	06300 BLOOD STORING, PROCESSING & TRANS.		0				63.00
	06500 RESPIRATORY THERAPY		0				65.00
	06600 PHYSI CAL THERAPY		0				66.00
	06900 ELECTROCARDI OLOGY		0				69.00
	07000 ELECTROENCEPHALOGRAPHY		0				70.00
	07001 NEURODI AGNOSTI CS	ol	0				70. 01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	0				71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	o	0				72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	63	6, 239				73.00
75.00	07500 ASC (NON-DISTINCT PART)	O	0				75.00
	03950 MH ANCILLARY OUTPATIENT	0	0				76.00
76. 01	03951 INPATIENT DIALYSIS	0	0				76. 01
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0	0				90.00
	04950 WOUND CLINIC	0	0				90. 01
	09100 EMERGENCY	0	0				91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
	OTHER REIMBURSABLE COST CENTERS						
	09600 DURABLE MEDICAL EQUIP-RENTED	0	0				96.00
200.00	,	63	6, 239				200.00
201.00		0					201.00
202.00	Only Charges	(3)	4 220				202.00
202.00	Net Charges (line 200 - line 201)	63	6, 239	[202.00

Real th Financial Systems							
Component CCN: 15-S042 From 01/01/2020 Date/Time Prepared: 77/29/2021 2: 33 mm	Health Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Lie	u of Form CMS-2	2552-10
Component CCN: 15-S042 To 12/31/2020 Date/Time Prepared: 7/29/2021 2: 33 pm	APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der C	CN: 15-0042			
Cost Center Description				45 0040	From 01/01/2020		
Capital Related Cost (From Wisst. B, Part II)			Component	LCN: 15-S042	10 12/31/2020		parea:
Cost Center Description			Ti +l c	Y\/	Subprovi der -		3 piii
Capital Charges Ratio of Cost Inpatient Capital Costs (From Wkst. B, Part I), col. 2) Charges Col. 26) Charges Col. 20 Charges			11116	AVIII		113	
Rel ated Cost (From Wkst. C, Part I, col. 2)	Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
Col. 26 Col. 8 Col. 2 Col. 1 Col. 2 Col. 1 Col. 2 Col. 2 Col. 2 Col. 4 Col. 2 Col. 2 Col. 2 Col. 4 Col. 2							
B. Part II, col 26							
ANCILLARY SERVICE COST CENTERS		, ·			3		
1.00 2.00 3.00 4.00 5.00			,	,			
50.00			2. 00	3.00	4.00	5. 00	
51.00 05100 RECOVERY ROOM 0 0 0 0 0 0 0 0 0	ANCILLARY SERVICE COST CENTERS			•			
51. 01 05101 ENDOSCOPY 487, 400 10, 559, 652 0. 046157 0 0 51. 01	50. 00 05000 OPERATING ROOM	998, 788	39, 352, 712	0. 02538	11, 821	300	50.00
52.00 05200 DELI VERY ROOM & LABOR ROOM 38, 169 5, 235, 619 0.007290 0 0 52.00	51.00 05100 RECOVERY ROOM	0	0	0. 00000	0 0	0	51.00
53. 00 05300 ANESTHESI OLOGY 0 0 0.000000 0 0 53. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 921, 273 85, 195, 272 0.010814 54, 755 592 54. 00 60. 00 06500 RADI OLOGY-THERAPEUTI C 710, 561 22, 821, 465 0.031136 0 0.55. 00 60. 00 06000 LABORATORY 432, 486 71, 819, 620 0.006022 209, 228 1, 260 60. 00 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0 0.000000 0 0.63. 00 65. 00 06500 RESPI RATORY THERAPY 248, 636 13, 855, 191 0.0117945 94, 541 1, 697 65. 00 66. 00 06600 PHYSI CAL THERAPY 641, 202 24, 297, 613 0.026390 24, 225 639 66. 00 69. 00 06900 ELECTROCARDI OLOGY 733, 616 38, 471, 199 0.019069 14, 109 269 69. 00 70. 00 07000 ELECTROCARDI OLOGY 733, 616 38, 471, 199 0.019069 14, 109 269 69. 00 70. 01 07001 NEURODI AGNOSTI CS 291, 784 5, 286, 474 0.055194 0 0.70. 01 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 129, 375 4, 217, 208 0.030678 5, 089 156 71. 00 72. 00 07300 DRUGS CHARGED TO PATIENTS 130, 083 10, 228, 109 0.012718 0 0.72. 00 75. 00 07300 DRUGS CHARGED TO PATIENTS 378, 516 84, 972, 671 0.004455 313, 585 1, 397 73. 00 75. 00 07500 ASC (NON-DISTINCT PART) 132, 568 21, 347, 778 0.006210 0 0.75. 00 76. 01 03951 INPATIENT DI LAUSIS 306, 887 1, 019, 180 0.301112 0 0 76. 01 90. 01 04950 WOUND CLI NI C 86, 358 93, 959 0.919103 0 0.90. 01 90. 01 04950 WOUND CLI NI C 346, 34, 463, 175 0.030038 0 0.90. 01 91. 00 09100 EMERGENCY 1, 661, 299 45, 798, 619 0.023173 219, 966 5, 097 92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 0 5, 956, 826 0.000000 0 0 96. 00 90. 01 09400 DURABLE MEDI CAL EQUI P-RENTED 17, 474 422, 599 0.041349 0 0 96. 00	51. 01 05101 ENDOSCOPY	487, 400	10, 559, 652	0. 04615	0	0	51.01
54. 00 05400 RADI OLOGY-DI AGNOSTI C 921, 273 85, 195, 272 0. 010814 54, 755 592 54. 00 05500 RADI OLOGY-THERAPEUTI C 710, 561 22, 821, 465 0. 031136 0 0 55. 00 06000 LABORATORY 432, 486 71, 819, 620 0. 006022 209, 228 1, 260 60. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0 0. 0. 0000000 0 0 63. 00 06500 RESPI RATORY THERAPY 248, 636 13, 855, 191 0. 017945 94, 541 1, 697 65. 00 06600 PHYSI CAL THERAPY 641, 202 24, 297, 613 0. 026390 24, 225 639 66. 00 06900 ELECTROCARDI OLOGY 733, 616 38, 471, 199 0. 019069 14, 109 269 69. 00 07000 ELECTROCARDI OLOGY 733, 616 38, 471, 199 0. 019069 14, 109 269 69. 00 07000 ELECTROENCEPHALOGRAPHY 0 0.000000 0 0 70. 01 07001 NEURODI AGNOSTI CS 291, 784 5, 286, 474 0. 055194 0 0 70. 01 07001 NEURODI AGNOSTI CS 291, 784 5, 286, 474 0. 055194 0 0 70. 01 07001 NEURODI AGNOSTI CS 291, 784 5, 286, 474 0. 055194 0 0 70. 01 07000 IMPL. DEV. CHARGED TO PATI ENTS 130, 083 10, 228, 109 0. 012718 0 0 72. 00 07300 DRUGS CHARGED TO PATI ENTS 130, 083 10, 228, 109 0. 012718 0 0 72. 00 07500 IMPL. DEV. CHARGED TO PATI ENTS 378, 516 84, 972, 671 0. 004455 313, 585 1, 397 73. 00 07500 IASC (NON-DI STI NCT PART) 132, 568 21, 347, 778 0. 006210 0 0 75. 00 03950 IM HACI LLARY OUTPATI ENT 0 0 0 0. 000000 0 0 0 0. 000000 0 0 0	52.00 05200 DELIVERY ROOM & LABOR ROOM	38, 169	5, 235, 619	0. 00729	0 0	0	52.00
55.00 05500 RADI OLOGY-THERAPEUTI C 710, 561 22, 821, 465 0.031136 0 0 0 0 0 0 0 0 0	53. 00 05300 ANESTHESI OLOGY	0	0	0. 00000	00	0	53.00
60. 00 06000 LABORATORY 60. 00 06000 LABORATORY 60. 00 060000 BLOOD STORING, PROCESSING & TRANS. 0 0 0. 0000000 0 0 063. 00 06500 BLOOD STORING, PROCESSING & TRANS. 0 0 0. 0000000 0 0 063. 00 06500 RESPIRATORY THERAPY 248, 636 13, 855, 191 0. 017945 94, 541 1, 697 65. 00 06600 PHYSI CAL THERAPY 641, 202 24, 297, 613 0. 026390 24, 225 639 66. 00 06900 ELECTROCARDIOLOGY 733, 616 38, 471, 199 0. 019069 14, 109 269 69. 00 07000 ELECTROCARDIOLOGY 733, 616 38, 471, 199 0. 019069 14, 109 269 69. 00 07000 ELECTROCEPHALOGRAPHY 0 0 0. 0000000 0 0 0 070. 00 070. 00 07000 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 129, 375 4, 217, 208 0. 030678 5, 089 156 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 130, 083 10, 228, 109 0. 012718 0 0 0 72. 00 07300 DRUGS CHARGED TO PATI ENTS 130, 083 10, 228, 109 0. 012718 0 0 0 72. 00 07500 ASC (NON-DISTINCT PART) 132, 568 21, 347, 778 0. 006210 0 0 75. 00 07500 ASC (NON-DISTINCT PART) 132, 568 21, 347, 778 0. 006210 0 0 75. 00 07500 ASC (NON-DISTINCT PART) 132, 568 21, 347, 778 0. 006210 0 0 0 0. 000000 0 0 0 0 0. 000000 0 0 0 0 0. 000000	54. 00 05400 RADI OLOGY-DI AGNOSTI C	921, 273	85, 195, 272	0. 01081	4 54, 755	592	54.00
63. 00	55. 00 05500 RADI OLOGY-THERAPEUTI C	710, 561	22, 821, 465	0. 03113	6 0	0	55.00
65. 00	60. 00 06000 LABORATORY	432, 486	71, 819, 620	0. 00602	209, 228	1, 260	60.00
66. 00 06600 PHYSI CAL THERAPY 641, 202 24, 297, 613 0. 026390 24, 225 639 66. 00 69. 00 06900 ELECTROCARDI OLOGY 733, 616 38, 471, 199 0. 019069 14, 109 269 69. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0. 0000000 0 0. 70. 00 70. 01 07001 NEURODI AGNOSTI CS 291, 784 5, 286, 474 0. 055194 0 0 70. 01 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 129, 375 4, 217, 208 0. 030678 5, 089 156 71. 00 72. 00 07200 IMPL DEV. CHARGED TO PATI ENTS 130, 083 10, 228, 109 0. 012718 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 378, 516 84, 972, 671 0. 004455 313, 585 1, 397 73. 00 75. 00 07500 ASC (NON-DI STI NCT PART) 132, 568 21, 347, 778 0. 006210 0 0 75. 00 76. 00 03950 MH ANCI LLARY OUTPATIENT 0 0 0. 0000000 0 0 76. 00 76. 01 001TPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C 86, 358 93, 959 0. 919103 0 0 90. 01 91. 00 09100 EMERGENCY 1, 061, 299 45, 798, 619 0. 033038 0 0 90. 01 91. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 5, 956, 826 0. 000000 0 0 96. 00 OTHER REI MBURSABLE COST CENTERS 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 17, 474 422, 599 0. 041349 0 0 96. 00	63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0. 00000	0 0	0	63.00
69. 00	65. 00 06500 RESPIRATORY THERAPY	248, 636	13, 855, 191	0. 01794	94, 541	1, 697	65.00
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0.0000000 0 70. 00 70. 01 07001 NEURODI AGNOSTI CS 291, 784 5, 286, 474 0.055194 0 0 70. 01 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 129, 375 4, 217, 208 0.030678 5, 089 156 71. 00 72. 00 07200 IMPLA. DEV. CHARGED TO PATI ENTS 130, 083 10, 228, 109 0.012718 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 378, 516 84, 972, 671 0.004455 313, 585 1, 397 73. 00 75. 00 07500 ASC (NON-DI STI NCT PART) 132, 568 21, 347, 778 0.006210 0 0 75. 00 76. 01 03950 MH ANCI LLARY OUTPATI ENT 0 0 0.000000 0 0 76. 00 76. 01 03951 INPATI ENT DI ALYSI S 306, 887 1, 019, 180 0.301112 0 0 76. 01 90. 01 09000<	66. 00 06600 PHYSI CAL THERAPY	641, 202	24, 297, 613	0. 02639	24, 225	639	66.00
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0 0 0 0	69. 00 06900 ELECTROCARDI OLOGY	733, 616	38, 471, 199	0. 01906	9 14, 109	269	69.00
71. 00	70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0. 00000	0 0	0	70.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 130, 083 10, 228, 109 0.012718 0 0 72. 00 7300 07300 DRUGS CHARGED TO PATIENTS 378, 516 84, 972, 671 0.004455 313, 585 1, 397 73. 00 75. 00 07500 ASC (NON-DISTINCT PART) 132, 568 21, 347, 778 0.006210 0 0 0.000000 0 0 0.000000 0	70. 01 07001 NEURODI AGNOSTI CS	291, 784	5, 286, 474	0. 05519	04	0	70. 01
73. 00 07300 DRUGS CHARGED TO PATIENTS 378, 516 84, 972, 671 0.004455 313, 585 1, 397 73. 00 75. 00 0.0000000 0.0000000 0.000000 0.00000000	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	129, 375	4, 217, 208	0. 03067	78 5, 089	156	71.00
75. 00 07500 ASC (NON-DISTINCT PART) 132, 568 21, 347, 778 0.006210 0 0 75. 00 76. 00 0.000000 0 0 76. 00 0.000000 0 0 76. 00 0.000000 0 0 76. 00 0.000000 0 0 0.000000 0	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	130, 083	10, 228, 109	0. 01271	8 0	0	72.00
76. 00	73.00 07300 DRUGS CHARGED TO PATIENTS	378, 516	84, 972, 671	0. 00445	313, 585	1, 397	73.00
76. 01 03951 NPATI ENT DI ALYSI S 306, 887 1, 019, 180 0. 301112 0 0 76. 01 OUTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C 86, 358 93, 959 0. 919103 0 0 0 0 90. 01 04950 WOUND CLI NI C 134, 063 4, 463, 175 0. 030038 0 0 0 91. 00 09100 EMERGENCY 1, 061, 299 45, 798, 619 0. 023173 219, 966 5, 097 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 5, 956, 826 0. 000000 0 0 OTHER REI MBURSABLE COST CENTERS 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 17, 474 422, 599 0. 041349 0 0 96. 00	75.00 07500 ASC (NON-DISTINCT PART)	132, 568	21, 347, 778	0. 00621	0 0	0	75.00
OUTPATI ENT SERVI CE COST CENTERS 90.00 O9000 CLI NI C 86, 358 93, 959 0.919103 0 0 90.00	76.00 03950 MH ANCILLARY OUTPATIENT	0	0	0. 00000	0 0	0	76.00
90. 00 09000 CLI NI C 86, 358 93, 959 0. 919103 0 0 90. 00 90. 00 90. 01	76.01 03951 INPATIENT DIALYSIS	306, 887	1, 019, 180	0. 30111	2 0	0	76. 01
90. 01 04950 WOUND CLINIC 134, 063 4, 463, 175 0. 030038 0 0 90. 01 91. 00 09100 EMERGENCY 1, 061, 299 45, 798, 619 0. 023173 219, 966 5, 097 91. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 5, 956, 826 0. 000000 0 0 92. 00 OTHER REIMBURSABLE COST CENTERS 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 17, 474 422, 599 0. 041349 0 0 96. 00	OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY 1, 061, 299 45, 798, 619 0.023173 219, 966 5, 097 91. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 0 5, 956, 826 0.000000 0 0 92. 00 0THER REI MBURSABLE COST CENTERS 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 17, 474 422, 599 0.041349 0 0 96. 00 0 96. 00 0 0 0 0 0 0 0 0 0	90. 00 09000 CLI NI C	86, 358	93, 959	0. 91910	0	0	90.00
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 0 5, 956, 826 0.000000 0 0 92. 00		134, 063	4, 463, 175	0. 03003	0 8	0	90. 01
OTHER REI MBURSABLE COST CENTERS 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 17, 474 422, 599 0.041349 0 0 96.00	91. 00 09100 EMERGENCY	1, 061, 299	45, 798, 619	0. 02317	219, 966	5, 097	91.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 17, 474 422, 599 0. 041349 0 0 96. 00		0	5, 956, 826	0. 00000	00	0	92.00
200. 00 Total (lines 50 through 199) 7, 880, 538 495, 414, 941 947, 319 11, 407 200. 00						_	
	200.00 Total (lines 50 through 199)	7, 880, 538	495, 414, 941		947, 319	11, 407	200.00

	Financial Systems	GOOD SAMARITA				n Lieu	of Form CMS-2	2552-10
	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEIGH COSTS	RVICE OTHER PAS	S Provider Co	CN: 15-0042	Period: From 01/01	/2020	Worksheet D Part IV	
THROUG	on COSTS		Component	CCN: 15-S042		/2020	Date/Time Pre 7/29/2021 2:3	
			Title	XVIII	Subprovi d	ler -	PPS	<u>o p</u>
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied He		Allied Health	
		Anestheti st	School	School	Post-Ste			
		Cost	Post-Stepdown		Adj ustm	ents		
		4.00	Adjustments	0.00	0.4		2.00	
	ANCILLARY SERVICE COST CENTERS	1. 00	2A	2. 00	3A		3. 00	
50. 00	05000 OPERATING ROOM	0	0		O	O	0	50.00
51.00	05100 RECOVERY ROOM	0	0		0		0	51.00
51. 01	05101 ENDOSCOPY	0	0		0	0	0	51.01
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	o	0	52.00
53.00	05300 ANESTHESI OLOGY	0	0		0	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0	0	0	55.00
60.00	06000 LABORATORY	0	0		0	0	321, 483	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0	0	63.00
65. 00	06500 RESPI RATORY THERAPY	0	0		0	0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	0		0	0	0	66.00
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	0	69. 00 70. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	o o	Ö		Ö	o	0	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0		0	0	0	75. 00
76.00	03950 MH ANCILLARY OUTPATIENT	0	0		0	0	0	76.00
76. 01	03951 I NPATI ENT DI ALYSI S	0	0		0	0	0	76. 01
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLI NI C	0	0		0	0	0	90.00
90. 01	04950 WOUND CLINIC	0	0		0	0	0	90. 01
	09100 EMERGENCY	0	0		0	O	0	91.00
92. 00	O9200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	0			0		0	92.00
96 00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0	0	0	96.00
70.00	Total (lines 50 through 199)	0			0	0	321, 483	

Health Financial Systems	GOOD SAMARITA	AN HOSPLTAL		Inlie	u of Form CMS-2	2552_10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER			CN: 15-0042	Peri od:	Worksheet D	2002 10
THROUGH COSTS	WIGE STILK TAS			From 01/01/2020 To 12/31/2020	Part IV	pared:
		Title	XVIII	Subprovi der -	PPS	<u> </u>
				I PF		
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		(col. 5 ÷	
	Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
			and 4)		(see	
					instructions)	
	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0	0		0 39, 352, 712	0. 000000	
51. 00 05100 RECOVERY ROOM	0	0		0 0	0. 000000	
51. 01 05101 ENDOSCOPY	0	0		0 10, 559, 652	0. 000000	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0		5, 235, 619	0. 000000	
53. 00 05300 ANESTHESI OLOGY	0	0		0	0. 000000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 85, 195, 272	0. 000000	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		22, 821, 465	0.000000	
60. 00 06000 LABORATORY	0	321, 483	321, 48		0. 004476	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0.000000	
65. 00 06500 RESPI RATORY THERAPY	0	0		0 13, 855, 191	0.000000	
66. 00 06600 PHYSI CAL THERAPY	0	0		24, 297, 613	0.000000	
69. 00 06900 ELECTROCARDI OLOGY	0	0		38, 471, 199	0.000000	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 5 207 474	0.000000	
70. 01 07001 NEURODI AGNOSTI CS	0	0		5, 286, 474	0.000000	
71.00 O7100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 4, 217, 208	0.000000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 10, 228, 109 0 84, 972, 671	0. 000000 0. 000000	
73. 00 07300 DROGS CHARGED TO PATTENTS 75. 00 07500 ASC (NON-DISTINCT PART)	0	0		- 1,,	0.000000	
76. 00 03950 MH ANCILLARY OUTPATIENT	0	0		0 21, 347, 778 0 0	0.000000	
76. 00 03950 MH ANCILLARY OUTPATTENT 76. 01 03951 INPATLENT DIALYSIS	0	0		-		
OUTPATIENT SERVICE COST CENTERS	U	U		0 1, 019, 180	0.000000	76.01
90. 00 09000 CLINIC	0	0		93, 959	0. 000000	90.00
90. 01 04950 WOUND CLINIC	0	0		0 4, 463, 175	0.000000	
91. 00 09100 EMERGENCY	0	0		0 45, 798, 619		
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0			0.000000	
OTHER REIMBURSABLE COST CENTERS	U	U		5, 956, 826	0.000000	72.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	0		0 422, 599	0. 000000	06 00
200.00 Total (lines 50 through 199)	0	-			0.000000	200.00
200.00 Total (Tries 50 till ough 177)	ا	321, 403	321,40	0 475, 414, 741	I	1200.00

	Financial Systems	GOOD SAMARITAN			In Lie	u of Form CMS-2	2552-10
	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PASS	Provi der C	CN: 15-0042	Peri od:	Worksheet D	
THROUG	GH COSTS		0	0011 45 6040	From 01/01/2020		
			Component	CCN: 15-S042	To 12/31/2020	Date/Time Pre 7/29/2021 2:3	parea:
			Title	XVIII	Subprovi der -	PPS	о рііі
					IPF		
	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	11, 821		0	0	50.00
51.00	05100 RECOVERY ROOM	0. 000000	0		0	0	51.00
51. 01	05101 ENDOSCOPY	0. 000000	0		0	0	51.01
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	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. 000000	54, 755		0 1, 895	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0 0	0	55.00
60.00	06000 LABORATORY	0. 004476	209, 228	93	37 282	1	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0 0	0	63.00
65.00	06500 RESPI RATORY THERAPY	0. 000000	94, 541		0 0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0. 000000	24, 225		0 0	0	66.00
69.00	06900 ELECTROCARDI OLOGY	0. 000000	14, 109		0 300	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0 0	0	70.00
70. 01	07001 NEURODI AGNOSTI CS	0. 000000	0		0 0	0	70. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	5, 089		0 0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	313, 585		0 1, 669	0	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0. 000000	0		0 0	0	75.00
76.00	03950 MH ANCILLARY OUTPATIENT	0. 000000	0		0 0	0	76.00
76. 01	03951 I NPATIENT DI ALYSIS	0. 000000	0		0 0	0	76. 01
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	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	219, 966		0 3, 362	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	1	0 0	0	96.00
200.00	Total (lines 50 through 199)		947, 319	93	7, 508	1	200. 00

	Financial Systems ONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provider CO		Period: From 01/01/2020 To 12/31/2020	Worksheet D Part V Date/Time Pre 7/29/2021 2:3	epared:
			Title	XVIII	Subprovi der - I PF	PPS	
				Charges	I PF	Costs	
	Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	oost denter beserretten	Charge Ratio	Rei mbursed	Rei mbursed	Rei mbursed	(see inst.)	
		From	Services (see	Servi ces	Servi ces Not	(300 11131.)	
		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	
P	ANCILLARY SERVICE COST CENTERS						
	D5000 OPERATING ROOM	0. 184742	0		0 0	0	50.00
51.00	D5100 RECOVERY ROOM	0. 000000	0		0 0	0	51.00
51.01	D5101 ENDOSCOPY	0. 254354	0		0 0	0	51. 01
	D5200 DELIVERY ROOM & LABOR ROOM	0. 341362	0		0 0	0	52.00
53.00	D5300 ANESTHESI OLOGY	0. 000000	0		0 0	0	53.00
54.00	D5400 RADI OLOGY-DI AGNOSTI C	0. 113742	1, 895		0 0	216	54.00
1	D5500 RADI OLOGY-THERAPEUTI C	0. 221683	0		0 0	0	55.00
1	06000 LABORATORY	0. 147844	282		0 0	42	60.00
1	D6300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0 0	0	
1	06500 RESPI RATORY THERAPY	0. 277384	0		0 0	0	
1	06600 PHYSI CAL THERAPY	0. 283696	0		0 0	0	
1	06900 ELECTROCARDI OLOGY	0. 147311	300		0 0	44	
1	07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0 0	0	
1	07001 NEURODI AGNOSTI CS	0. 233991	0		0	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1. 191810	0		0	0	
	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 490188	0		0 0	0	
	07300 DRUGS CHARGED TO PATIENTS	0. 285907	1, 669		0 705	477	
	07500 ASC (NON-DISTINCT PART)	0. 202871	0		0 0	0	
	03950 MH ANCILLARY OUTPATIENT	0.000000	0		0 0	0	
	03951 INPATIENT DIALYSIS	0. 750849	U		0 0	0	76. 01
	DUTPATIENT SERVICE COST CENTERS D9000 CLINIC	2 210424	0		0 0	0	00.00
	04950 WOUND CLINIC	3. 218436 0. 375487	0			0	
	09100 EMERGENCY	0. 375487	3, 362		0 75	706	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 209909	3, 302		0 75	708	1
	OTHER REIMBURSABLE COST CENTERS	0.430900	U		<u>U</u>	0	92.00
	09600 DURABLE MEDICAL EQUIP-RENTED	0. 525860	0		ol ol	0	96.00
200.00	Subtotal (see instructions)	0. 323000	7, 508		780	-	200.00
201.00	Less PBP Clinic Lab. Services-Program		7, 300		0 700		201.00
231.00	Only Charges			'			201.00

PORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provider Component	CN: 15-0042 CCN: 15-S042	Peri od: From 01/01/2020 To 12/31/2020	Worksheet D Part V Date/Time Pro 7/29/2021 2:3	epared 33 pm
		Title	XVIII	Subprovi der - I PF	PPS	
	Cos					
Cost Center Description	Cost Reimbursed	Cost Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS						
0. 00 05000 OPERATING ROOM	0					50.
. 00 05100 RECOVERY ROOM	0					51.
. 01 05101 ENDOSCOPY	0	0				51.
1.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.
6. 00 05300 ANESTHESI OLOGY	0	0				53.
. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.
6. 00 05500 RADI OLOGY-THERAPEUTI C	0	0				55.
0. 00 06000 LABORATORY	0	0				60.
00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0				63.
6. 00 06500 RESPIRATORY THERAPY	0	0				65.
0. 00 06600 PHYSI CAL THERAPY	0	0				66.
2. 00 06900 ELECTROCARDI OLOGY 2. 00 07000 ELECTROENCEPHALOGRAPHY	0	0				69. 70.
D. 01 07000 ELECTROENCEPHALOGRAPHY	0					70.
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		•			71.
2. 00 07100 MEDICAL SUPPLIES CHARGED TO PATTENTS	0					72.
3. 00 07200 TWIFE. BEV. CHARGED TO PATTENTS	0	202				73.
5. 00 07500 ASC (NON-DISTINCT PART)	0	0				75.
0. 00 03950 MH ANCILLARY OUTPATIENT	0	ĺ				76.
0. 01 03951 I NPATI ENT DI ALYSI S	0					76.
OUTPATIENT SERVICE COST CENTERS						1
0.00 09000 CLINIC	0	0				90.
0. 01 04950 WOUND CLINIC	0	O				90.
. 00 09100 EMERGENCY	0	16				91.
. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.
OTHER REIMBURSABLE COST CENTERS						
. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0				96.
0.00 Subtotal (see instructions)	0					200.
11.00 Less PBP Clinic Lab. Services-Program	0					201.
Only Charges						
2.00 Net Charges (line 200 - line 201)	0	218				202.

Heal th Fina	ncial Systems	GOOD SAMARITA	AN HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTI ONME	ENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der C	CN: 15-0042	Peri od:	Worksheet D	
					From 01/01/2020		
			Component	CCN: 15-T042	To 12/31/2020	Date/Time Pre	pared:
			Ti +l o	: XVIII	Subprovi der -	7/29/2021 2: 3 PPS	3 piii
			IIIIe	: AVIII	I RF	PFS	
	Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
	cost center beserretron	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)	onal ges	COT GIIIIT 1)	
		col . 26)	COI. 0)	COI. 2)			
		1. 00	2.00	3.00	4.00	5. 00	
ANCL	LLARY SERVICE COST CENTERS	1. 00	2.00	0.00	1.00	0.00	
	O OPERATING ROOM	998, 788	39, 352, 712	0. 02538	37, 986	964	50.00
	O RECOVERY ROOM	0		•		0	51.00
	1 ENDOSCOPY	487, 400	_				
	O DELIVERY ROOM & LABOR ROOM	38, 169				0	52.00
	O ANESTHESI OLOGY	0		1		0	53.00
	O RADI OLOGY-DI AGNOSTI C	921, 273	_				54.00
	O RADI OLOGY-THERAPEUTI C	710, 561					55.00
	O LABORATORY	432, 486					
	O BLOOD STORING, PROCESSING & TRANS.	432, 400				0,027	63.00
	O RESPIRATORY THERAPY	248, 636					
	O PHYSI CAL THERAPY	641, 202					66.00
	O ELECTROCARDI OLOGY	733, 616					69.00
	O ELECTROENCEPHALOGRAPHY	733, 010				2,311	
	1 NEURODI AGNOSTI CS	291, 784	_				
	O MEDICAL SUPPLIES CHARGED TO PATIENTS	129, 375					71.00
	O IMPL. DEV. CHARGED TO PATIENTS	130, 083					72.00
	O DRUGS CHARGED TO PATTENTS	378, 516					73.00
	O ASC (NON-DISTINCT PART)	132, 568				0, 121	75.00
	OMH ANCILLARY OUTPATIENT	132, 300				0	76.00
	1 INPATIENT DIALYSIS	306, 887	1, 019, 180	l .			
	ATIENT SERVICE COST CENTERS	300, 667	1,019,160	0.3011	12 73, 212	22, 047	76.01
	O CLINIC	86, 358	93, 959	0. 91910	03	0	90.00
	O WOUND CLINIC	134, 063				0	90.00
	O EMERGENCY	1, 061, 299					
	O OBSERVATION BEDS (NON-DISTINCT PART)	1,001,299					1
	R REIMBURSABLE COST CENTERS	ı U	0, 900, 820	0.00000	0	<u> </u>	72.00
	O DURABLE MEDICAL EQUIP-RENTED	17, 474	422, 599	0. 04134	19 0	0	96.00
200. 00	Total (lines 50 through 199)	7, 880, 538		l .	11, 667, 353	ı	
200.00	Total (Tries 30 till ough 177)	1,000,000	1 470, 414, 741	I	11,007,333	200,772	₁ 200.00

	Financial Systems	GOOD SAMARITA			-		u of Form CMS-2	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PAS	SS Provider C	CN: 15-0042		eriod: com 01/01/2020	Worksheet D Part IV	
THROUG	H COSTS		Component	CCN: 15-T042	To			pared:
			· ·				7/29/2021 2:3	3 pm
			Title	: XVIII	S	Subprovi der – I RF	PPS	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Η,	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							
50.00	05000 OPERATING ROOM	0	0		0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0		0	0	0	51.00
51.01	05101 ENDOSCOPY	0	0		0	0	0	51.01
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	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	0	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0	0	0	55.00
60.00	06000 LABORATORY	0	0		0	0	321, 483	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0	0	63.00
65.00	06500 RESPI RATORY THERAPY	0	0		0	0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	0		0	0	0	66.00
69.00	06900 ELECTROCARDI OLOGY	0	0		0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	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	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	0	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0		0	0	0	75.00
	03950 MH ANCILLARY OUTPATIENT	0	0		0	0	0	76.00
76. 01	03951 I NPATI ENT DI ALYSI S	0	0		0	0	0	76. 01
	OUTPATIENT SERVICE COST CENTERS		T .	1				
90.00	09000 CLINIC	0	0		0	0	0	90.00
	04950 WOUND CLINIC	0	0		0	0	0	90.01
91.00	09100 EMERGENCY	0	0		0	O	0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0		0	92.00
04 00	OTHER REIMBURSABLE COST CENTERS					ما	0	04 00
96. 00 200. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0		1	0	0	0 321, 483	
	Total (lines 50 through 199)	1 0	1 0	1	U	U	321,483	IZUU. UU

Health Financial Systems	GOOD SAMARITA	AN HOSDITAL		Inlio	u of Form CMS-2	neen 10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEE			°N: 15 0042	Peri od:	Worksheet D	2552-10
THROUGH COSTS	WICE OTHER PAS	55 Frovider C		From 01/01/2020		
THROUGH CUSTS		'	CCN: 15-T042	To 12/31/2020	Date/Time Pre 7/29/2021 2:3	pared: 3 pm
		Title	XVIII	Subprovi der -	PPS	
				I RF		
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	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)		(see	
					instructions)	
	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0			0 39, 352, 712	0.000000	
51. 00 05100 RECOVERY ROOM	0	0		0	0.000000	
51. 01 05101 ENDOSCOPY	0	0	'	0 10, 559, 652	0. 000000	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	,	5, 235, 619	0. 000000	
53. 00 05300 ANESTHESI OLOGY	0	0		0	0.000000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 85, 195, 272	0.000000	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	(0 22, 821, 465	0. 000000	
60. 00 06000 LABORATORY	0	321, 483	321, 48	3 71, 819, 620	0. 004476	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	(0	0.000000	
65. 00 06500 RESPI RATORY THERAPY	0	0	(0 13, 855, 191	0.000000	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0	(0 24, 297, 613	0.000000	
69. 00 06900 ELECTROCARDI OLOGY	0	0	(0 38, 471, 199	0.000000	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	(0	0.000000	70.00
70. 01 07001 NEURODI AGNOSTI CS	0	0	(5, 286, 474	0.000000	70. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 4, 217, 208	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 10, 228, 109	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 84, 972, 671	0.000000	73.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0		0 21, 347, 778	0.000000	75.00
76.00 03950 MH ANCILLARY OUTPATIENT	0	0	(0	0.000000	76.00
76. 01 03951 I NPATI ENT DI ALYSI S	0	0		0 1, 019, 180	0.000000	76. 01
OUTPATIENT SERVICE COST CENTERS	•	•				1
90. 00 09000 CLI NI C	0	0	(93, 959	0.000000	90.00
90. 01 04950 WOUND CLINIC	0	0		0 4, 463, 175	0.000000	90. 01
91. 00 09100 EMERGENCY	0	0		0 45, 798, 619	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		5, 956, 826	0. 000000	92.00
OTHER REIMBURSABLE COST CENTERS						1
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0 422, 599	0.000000	96.00
200.00 Total (lines 50 through 199)	0		321, 48		l	200.00
	•		' '		'	

Health Financial Systems	GOOD SAMARITAN		011 45 0040		u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY	SERVICE OTHER PASS	Provi der C	CN: 15-0042	Peri od: From 01/01/2020	Worksheet D Part IV	
THROUGH COSTS		Component	CCN: 15-T042	To 12/31/2020		nared:
		Component	0011. 13 1042	10 12/31/2020	7/29/2021 2: 3	
		Title	XVIII	Subprovi der -	PPS	
				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 ÷	, and the second	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	37, 986		0 0	0	50.00
51.00 05100 RECOVERY ROOM	0. 000000	0		0 0	0	51.00
51. 01 05101 ENDOSCOPY	0. 000000	23, 079		0 1	0	51.01
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	. 0	1	0 1	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. 000000	423, 416		0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	4, 069		0 44	0	55.00
60. 00 06000 LABORATORY	0. 004476	1, 001, 214			1	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0 0	0	63.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	878, 125		0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	7, 780, 416		0 0	0	66.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	131, 695		0 0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0.7070		0 0	Ö	70.00
70. 01 07001 NEURODI AGNOSTI CS	0. 000000	3, 960			Ö	70.01
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	102, 657		0 113		71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	1, 784		0 0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	1, 149, 602		0 322	0	73.00
75. 00 07500 ASC (NON-DISTINCT PART)	0. 000000	1, 147, 002		0 0	0	75.00
76. 00 03950 MH ANCILLARY OUTPATIENT	0. 000000	0			0	76.00
76. 01 03951 INPATIENT DIALYSIS	0. 000000	75, 212		0 0	0	76.00
OUTPATIENT SERVICE COST CENTERS	0.000000	75, 212		0 0	0	70.01
90. 00 09000 CLINIC	0.000000	0		0 0	0	90.00
90. 01 04950 WOUND CLI NI C	0. 000000	0	•	0 0	0	90.00
91. 00 09100 EMERGENCY	0.000000	54, 138		0 3, 042		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	04, 136		0 3,042	0	
OTHER REIMBURSABLE COST CENTERS	0.000000	0		0 0	0	1 72.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0		0 0	0	96.00
200.00 Total (lines 50 through 199)	0.000000	11, 667, 353	1	-		200.00
200.00 10tal (111163 30 till ough 177)	ı	11,007,333	1 4,40	5,013	1	1200.00

	Financial Systems ONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CC Component C		Period: From 01/01/2020 To 12/31/2020	Worksheet D Part V Date/Time Pre 7/29/2021 2:3	epared:
			Title	XVIII	Subprovi der -	PPS	
				Charges	I RF	Costs	
	Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	cost center bescription	Charge Ratio	Rei mbursed	Rei mbursed	Rei mbursed	(see inst.)	
		From	Services (see	Servi ces	Servi ces Not	(300 11131.)	
		Worksheet C,	inst.)	Subject To	Subject To		
		Part I, col.	11131.7	Ded. & Coins.			
		9		(see inst.)	(see inst.)		
		1. 00	2. 00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0. 184742	0		0 0	0	50.00
	05100 RECOVERY ROOM	0. 000000	0		0 0	0	51.00
51. 01	05101 ENDOSCOPY	0. 254354	1		0 0	0	51. 01
	05200 DELIVERY ROOM & LABOR ROOM	0. 341362	1		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. 113742	0		0	0	54.00
	05500 RADI OLOGY-THERAPEUTI C	0. 221683	44		0	10	55.00
	06000 LABORATORY	0. 147844	290		0	43	
	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0	0	
	06500 RESPI RATORY THERAPY	0. 277384	0		0	0	
	06600 PHYSI CAL THERAPY	0. 283696	0		0	0	00.00
	06900 ELECTROCARDI OLOGY	0. 147311	0		0	0	
	07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0	0	1 . 0. 00
	07001 NEURODI AGNOSTI CS	0. 233991	0		0	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1. 191810	113		0	135	1
	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 490188	0		0	0	
	07300 DRUGS CHARGED TO PATIENTS	0. 285907	322		0 488	92	
	07500 ASC (NON-DISTINCT PART)	0. 202871	0		0	0	
1	03950 MH ANCILLARY OUTPATIENT	0. 000000	0		0 0	0	
	03951 I NPATI ENT DI ALYSI S	0. 750849	U		0 0	0	76. 01
	DUTPATIENT SERVICE COST CENTERS 09000 CLINIC	2 210424	0		0 0	0	00.00
	04950 WOUND CLINIC	3. 218436 0. 375487	0		0 0	0	
	09100 EMERGENCY	0. 375467	1		0 0	639	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 209909			0 0	039	1
	OTHER REIMBURSABLE COST CENTERS	0. 400908	<u> </u>		<u>υ</u> υ	0	72.00
	09600 DURABLE MEDICAL EQUIP-RENTED	0. 525860	0		0 0	0	96.00
200.00	Subtotal (see instructions)	0. 323600	3, 813		0 488	-	200.00
201.00	Less PBP Clinic Lab. Services-Program		3,013		0 400	717	201.00
201.00	Only Charges						251.00
	ioni y ondi gos	I .					

	Financial Systems	GOOD SAMARITA				of Form CMS-	2552-10
APPORT	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provi der C	CN: 15-0042	Peri od: From 01/01/2020	Worksheet D Part V	
			Component	CCN: 15-T042	To 12/31/2020	Date/Time Pre 7/29/2021 2:3	epared: 33 pm
			Title	× XVIII	Subprovi der - I RF	PPS	
			sts				
	Cost Center Description	Cost	Cost				
		Rei mbursed	Rei mbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
	ANCILLARY SERVICE COST CENTERS	6. 00	7. 00				_
	05000 OPERATING ROOM	0	0				50.00
	05100 RECOVERY ROOM		0	1			51.00
	05100 RECOVERY ROOM 05101 ENDOSCOPY		ľ	l .			51.00
	05200 DELIVERY ROOM & LABOR ROOM	0					52.00
	05200 DELIVERT ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	0					53.00
	05400 RADI OLOGY-DI AGNOSTI C	0		1			54.00
	05500 RADI OLOGY-THERAPEUTI C	0		1			55.00
	06000 LABORATORY	0		1			60.00
	06300 BLOOD STORING, PROCESSING & TRANS.						63.00
	06500 RESPIRATORY THERAPY	0	1				65.00
	06600 PHYSI CAL THERAPY	0		•			66.00
	06900 ELECTROCARDI OLOGY	0	1				69.00
	07000 ELECTROENCEPHALOGRAPHY	0					70.00
	07000 RELECTROENCEL MALOGRAFITI	0	1				70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	ĺ				71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	ĺ				72.00
	07300 DRUGS CHARGED TO PATIENTS	0	140	1			73.00
	07500 ASC (NON-DISTINCT PART)		0	1			75.00
	03950 MH ANCILLARY OUTPATIENT	0					76.00
	03951 I NPATI ENT DI ALYSI S	0	l e	1			76. 01
70.01	OUTPATIENT SERVICE COST CENTERS						70.0.
90.00	09000 CLI NI C	0	0				90.00
	04950 WOUND CLINIC	0		•			90. 01
	09100 EMERGENCY	0		1			91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	O	1			92.00
	OTHER REIMBURSABLE COST CENTERS						
	09600 DURABLE MEDICAL EQUIP-RENTED	0	0				96.00
200.00	Subtotal (see instructions)	0	l .				200.00
201.00	Less PBP Clinic Lab. Services-Program	0					201.00
	Only Charges	1					

140

202.00

202.00

Only Charges Net Charges (line 200 - line 201)

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 01/01/2020	Worksheet D-1
			Date/Time Prepared: 7/29/2021 2:33 pm
	Title XVIII	Hospi tal	PPS
Cost Center Description			

Cost Center Description 1.00 1.01 1.02 1.03 1.04 1.05 1.06 1.06 1.06 1.07 1.07 1.07 1.07 1.07 1.08			Title XVIII	Hospi tal	7/29/2021 2: 3 PPS	3 pm
NAMELIE LOWS NAME		Cost Center Description	THE AVIII	1103pi tui	113	
INPATIENT DAYS		DADT I ALL DROWNED COMPONENTO			1. 00	
Ingatient days (including private room days and swing-bed days, excluding newborn) 14,033 1,00 2,00 1,00						
1. Inpatt ent days (including private room days, excluding saing-bed and newborn days) 14,003 2.00	1. 00		rs. excludina newborn)		14, 603	1.00
do not complete this line. do not complete this line. do not complete this line. Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost of the cost reporting period (if calendar year, enter 0 on this line) Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Total swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and next days) (see Instructions) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after the cost reporting period (if calendar year, enter 0 on this line) 10. Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 11. Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12. Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) 13. Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) 14. Swing-bed NF type inpatient days applicable to swing-bed NF type inpatient days ap	2.00				14, 603	2.00
	3.00		ys). If you have only pr	ivate room days,	0	3.00
Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) through December 31 of the cost reporting period (including private room days) through December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including period (including private room days) after December 31 of the cost reporting period (including period (including private room days) after December 31 of the cost reporting period (including period (including private room days) after December 31 of the cost reporting period (including period (inc	4 00	·	and daysa)		12.046	4 00
reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost or reporting period (if calendar year, enter 0 on this line) 8.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9.00 Total inputient days including private room days after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 10.00 Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and nesborn days) (see Instructions) 11.00 Swing-bed SNF type inputient days applicable to title XVIII only (including private room days) 12.00 Swing-bed SNF type inputient days applicable to title XVIII only (including private room days) 13.00 Swing-bed SNF type inputient days applicable to title XVIII only (including private room days) 14.00 Swing-bed SNF type inputient days applicable to title XVIII only (including private room days) 15.00 Swing-bed SNF type inputient days applicable to title XVIII only (including private room days) 16.00 Swing-bed SNF type inputient days applicable to title SV or XX anly (including private room days) 17.00 Swing-bed SNF type inputient days applicable to title SV or XX anly (including private room days) 18.00 Modically necessary private room days applicable to the Program (excluding swing-bed days) 18.00 Modically necessary private room days applicable to the Program (excluding swing-bed days) 18.00 Namerov days (title V or XX anly) 18.00 Namerov days (ti				r 31 of the cost		
reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost 7.00 Toporting period (if calendar) year, enter 0 on this line) 8.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost 7.00 Toporting period (if calendar) year, enter 0 on this line) 9.00 Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 5.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 5.00 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 XXX only (including private room days) 14.00 Modically necessary private room days applicable to titles V or XXX only (including private room days) 15.00 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days) 16.00 Nursery days (title V or XXX only) 17.00 Modically necessary private room days applicable to the Program (excluding swing-bed days) 18.00 Nursery days (title V or XXX only) 19.00 Modically necessary private room days applicable to the Program (excluding swing-bed days) 19.00 Modically necessary private room days applicable to services through December 31 of the cost 19.00 Modical processary private room days applicable to services after December 31 of the cost 19.00 Modical processary private room days applicable to services after December 31 of the cost 19.00 Modical processary days (title V or XXX only) 19.00 Modical processary days (title V or XXX only) 19.00 Modical processary days (title V or XXX only) 19.00 Modical processary days (title V or XXX only) 19.00 Modical processary days (title V or XXX only) 19.00 Modical processary days (title V or XXX only) 19.00 Modical processary days (title V or X	3.00		om days) thi ough becembe	or or the cost		3.00
7.00 Total swing-bed NF type inpatient days (including private room days) shrough December 31 of the cost preporting period (if calendar year, enter 0 on this line) 10 total inpatient days including private room days applicable to the Program (excluding swing-bed and private room days applicable to the Program (excluding swing-bed and private room days applicable to the Program (excluding swing-bed and private room days applicable to the Program (excluding swing-bed and private room days) 10 to 0.00 through December 31 of the cost reporting period (see instructions) 11.00 Swing-bed SNF type inpatient days applicable to the Title XVIII only (including private room days) after 11.00 Swing-bed SNF type inpatient days applicable to title XVII only (including private room days) after 12.00 Swing-bed NF type inpatient days applicable to title XVII only (including private room days) 12.00 Swing-bed NF type inpatient days applicable to title XVII only (including private room days) 12.00 Swing-bed NF type inpatient days applicable to title XVII only (including private room days) 12.00 Swing-bed NF type inpatient days applicable to title XVII only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) 14.00 Swing-bed MF type inpatient days applicable to title XVIII only (including private room days) 15.00 Total nursery days (title V or XVIX only) 16.00 Swing-bed MF type inpatient days applicable to the Program (excluding Swing-bed days) 17.00 Swing-bed Swin	6.00	Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	0	6. 00
reporting period No Total swing-bed NF type inpatient days (including private room days) after becember 31 of the cost 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 newborn days) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 12.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 0 becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 Swing-bed SNF type inpatient days applicable to titles Vior XIX only (including private room days) after 0 through becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Medically necessary private room days applicable to titles V or XIX only (including private room days) 15.00 Total nursery days (title V or XIX only) 16.00 Nurser days (title V or XIX only) 17.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 18.00 Medical care rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 18.00 Medical care rate for swing-bed SNF services applicable to services after December 31 of the cost 19.00 Medical or rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medical or rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medical or rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medical or rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medical or rate for swing-bed NF services after December 31 of the cost reporting period (line swing-b						
7. Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if cal endar year, enter 0 on this line) 7. Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 7. Do Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after some days applicable to title XVIII only (including private room days) after some days) after some days applicable to title XVIII only (including private room days) after some days applicable to title XVIII only (including private room days) after some days) after some days applicable to title XVIII only (including private room days) after some days) after some days applicable to title XVIII only (including private room days) after some days) after some days applicable to title xVIII only (including private room days) some days applicable to title xVIII only (including private room days) some days after seeme of the cost reporting period some days applicable to titles vor XIX only (including private room days) some days after seeme after seem	7. 00		m days) through December	31 of the cost	0	7.00
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PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY 70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 1.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	ol e	69. 00
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	8	81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions)		82. 00 83. 00
83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions)		84. 00
85.00 Utilization review - physician compensation (see instructions)	8	85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST	8	86. 00
	557 8	87. 00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1,064	. 56 8	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions) 2,722,	טאטן צ	84. UU

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 01/01/2020 To 12/31/2020	Date/Time Pre 7/29/2021 2:3	pared: 3 pm
		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, 572, 436	15, 545, 742	0. 16547	5 2, 722, 080	450, 436	90.00
91.00 Nursing School cost	0	15, 545, 742	0.00000	0 2, 722, 080	0	91.00
92.00 Allied health cost	0	15, 545, 742	0.00000	0 2, 722, 080	0	92.00
93.00 All other Medical Education	O	15, 545, 742	0. 00000	0 2, 722, 080	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 01/01/2020	Worksheet D-1
	Component CCN: 15-S042		
	Title XVIII	Subprovi der -	PPS
		I PF	

PART I ALL PROVIDER COMPONENTS 1.00			I PF		
MARTILL IONS MART		Cost Center Description		1 00	
		DART I ALL DROVIDED COMPONENTS		1.00	
Inpatient days (including private room days and swing-bed days, excluding newborn)					
Injustiont days (including private room days)	1.00		vborn)	4, 639	1.00
do not complete this line. 4. 05 Sella-private room days (sectualing swing-bed and observation bed days) 1. 05 Total swing-bed SW type inpatient days (including private room days) after December 31 of the cost cost reporting period (if calendar year, enter 0 on this line) 7. 00 Total swing-bed W type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7. 00 Total swing-bed W type inpatient days (including private room days) through December 31 of the cost cost on the cost reporting period (if calendar year, enter 0 on this line) 8. 00 Total swing-bed W type inpatient days (including private room days) through December 31 of the cost cost on the line) 9. 00 Total lineater days including private room days after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 10. 00 Saing-bed SW type inpatient days applicable to the Program (excluding swing-bed and newbork) (see instructions) 10. 00 Saing-bed SW type inpatient days applicable to the swing-bed				•	2.00
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PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,131.83 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38) 1,560,794 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00					
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41. 00 Total Program general impatrent routine service cost (Time 39 + Time 40)		1	ne 35)		
	41.00	Tiotal Frogram general impatrent routine service cost (Tine 39 + Tine 40)		1, 200, 794	41.00

	Financial Systems	GOOD SAMARITA				u of Form CMS-2	
COMPU	TATION OF INPATIENT OPERATING COST			CN: 15-0042	Peri od: From 01/01/2020	Worksheet D-1	
		Component CCN: 15-S042 To 12/31/2020				7/29/2021 2: 3	pared: 3 pm
			Titl€	e XVIII	Subprovi der - I PF	PPS	
	Cost Center Description	Total Inpatient	Total Inpati ent	Average Per Diem (col.	Program Days	Program Cost (col. 3 x	
		Cost	Days	÷ col . 2)		col . 4)	
42 00	NURSERY (title V & XIX only)	1. 00 0	2.00	3. 00	4. 00 00 0	5. 00	42.00
	Intensive Care Type Inpatient Hospital Units						1
43. 00 44. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT	0	C	0.	00 0	0	43. 00 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					1. 00	
48. 00				`		216, 427	•
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(see instructi	ons)		1, 777, 221	49.00
50. 00	Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D, s	um of Parts I and	181, 242	50.00
51. 00	Pass through costs applicable to Program inp	atient ancillar	y services (f	rom Wkst. D,	sum of Parts II	12, 344	51.00
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				193, 586	52.00
53. 00	Total Program inpatient operating cost exclu	ding capital re	elated, non-ph	ysician anes	thetist, and	1, 583, 635	
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					1
54. 00 55. 00	Program discharges Target amount per discharge						54. 00 55. 00
56.00	Target amount (line 54 x line 55)					0	56.00
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	57. 00 58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996,	updated and	compounded by the	0.00	59. 00
60.00	1					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					0	61.00
	amount (line 56), otherwise enter zero (see				or the target		,,,,,,,
62. 00 63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instru	ıcti ons)			0	62. 00 63. 00
64 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of th	e cost renor	ting period (See	0	64.00
	instructions) (title XVIII only)	Ü		•			
65. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decemb	per 31 of the	cost reporti	ng perioa (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line	64 plus line	65)(title XV	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	reporting period	0	67.00
68. 00	<pre>(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin</pre>	e costs after [December 31 of	the cost re	porting period	0	68. 00
69 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (line 67 ± lin	e 68)		0	69. 00
	PART III - SKILLED NURSING FACILITY, OTHER N	JRSING FACILITY	, AND ICF/IID	ONLY		0	1
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c				7)		70.00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic	,	. (lino 14 v l	ino 2E)			72. 00 73. 00
74. 00	Total Program general inpatient routine serv						74.00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	e costs (from	Worksheet 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 80. 00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp	,		*.	inus lina 70)		79. 00 80. 00
81. 00	Inpatient routine service cost per diem limi	tati on		(TING 70 III	inds tine 17)		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
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions					0	87. 00
88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷				0.00	88. 00
89. 00	Observation bed cost (line 87 x line 88) (se	e instructions)	1			0	89.00

Health Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST				Peri od:	Worksheet D-1	
				From 01/01/2020		
		Component (LCN: 15-S042	To 12/31/2020	Date/Time Pre 7/29/2021 2:3	
		Title	XVIII	Subprovi der -	PPS	о рііі
				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						
90.00 Capital-related cost	609, 724	5, 250, 568	0. 11612	25 0	0	90.00
91.00 Nursing School cost	0	5, 250, 568	0. 00000	00	0	91.00
92.00 Allied health cost	0	5, 250, 568	0.00000	00	0	92.00
93.00 All other Medical Education	0	5, 250, 568	0.00000	00	0	93.00

Health Financial Systems	GOOD SAMARITAN HOSPITAL	In Lieu	of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0042	Peri od: From 01/01/2020	Worksheet D-1
	Component CCN: 15-T042		
	Title XVIII	Subprovi der -	PPS
		IRF	

		II the Aviii	I RF	FF3			
	Cost Center Description						
	PART I - ALL PROVIDER COMPONENTS			1. 00			
	INPATIENT DAYS						
1.00	Inpatient days (including private room days and swing-bed day			6, 447	1.00		
2.00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed da			6, 447	2.00		
3. 00	do not complete this line.	ys). If you have only priv	ate room days,	0	3. 00		
4.00	Semi-private room days (excluding swing-bed and observation bed days)						
5.00	Total swing-bed SNF type inpatient days (including private ro	om days) through December	31 of the cost	0	5.00		
6. 00	reporting period Total swing-bed SNF type inpatient days (including private ro	om days) after December 3	l of the cost	0	6. 00		
0.00	reporting period (if calendar year, enter 0 on this line)	om days) arter becember 3	or the cost	O	0.00		
7. 00	Total swing-bed NF type inpatient days (including private roo	m days) through December 3	31 of the cost	0	7. 00		
8. 00	reporting period Total swing-bed NF type inpatient days (including private roo	m days) after December 31	of the cost	0	8. 00		
0.00	reporting period (if calendar year, enter 0 on this line)	iii days) arter becember sr	or the cost	J	0.00		
9. 00	Total inpatient days including private room days applicable t	o the Program (excluding s	swing-bed and	5, 377	9.00		
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private rea	om dave)	0	10. 00		
10.00	through December 31 of the cost reporting period (see instruc		Jili days)	U	10.00		
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private ro	om days) after	0	11.00		
12. 00	December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to titles V or XI		room days)	0	12. 00		
12.00	through December 31 of the cost reporting period	A only (frictually private	1 doill days)	U	12.00		
13.00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including private	room days)	0	13.00		
14. 00	after December 31 of the cost reporting period (if calendar y Medically necessary private room days applicable to the Progr	ear, enter 0 on this line))	0	14. 00		
15. 00	Total nursery days (title V or XIX only)	all (excluding swing-bed da	iys)	0	15.00		
16. 00	Nursery days (title V or XIX only)			0			
17. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service	as through Dasambar 21 of	the cost	0.00	17 00		
17.00	reporting period	es through December 31 of	the cost	0.00	17. 00		
18. 00	Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of th	ne cost	0. 00	18.00		
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	s through Dosombor 21 of	the cost	0.00	19. 00		
19.00	reporting period	s through becember 31 of	lile cost	0.00	19.00		
20. 00	Medicaid rate for swing-bed NF services applicable to service	s after December 31 of the	e cost	0. 00	20.00		
21. 00	reporting period Total general inpatient routine service cost (see instruction	5)		4, 730, 282	21. 00		
22. 00	Swing-bed cost applicable to SNF type services through Decemb		ng period (line	0	22. 00		
22.00	5 x line 17)	21 -6		0	22.00		
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	perrod (Trie 6	0	23. 00		
24. 00	Swing-bed cost applicable to NF type services through Decembe	r 31 of the cost reporting	period (line	0	24.00		
25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December	31 of the cost reporting a	period (line 8	0	25. 00		
25.00	x line 20)	or the cost reporting p	perrod (Trile 0	J	23.00		
26.00	Total swing-bed cost (see instructions)	(1)		0	26.00		
27. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(IIne 21 minus IIne 26)		4, 730, 282	27.00		
28. 00	General inpatient routine service charges (excluding swing-be	d and observation bed chai	ges)	0	28.00		
29. 00	Private room charges (excluding swing-bed charges)			0			
30. 00 31. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	· lino 20)		0. 000000	30. 00 31. 00		
32. 00	Average private room per diem charge (line 29 ÷ line 3)	- 111le 20)		0.00000			
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	nus line 33)(see instructi	ons)	0. 00			
35.00	Average per diem private room cost differential (line 34 x li	ne 31)		0. 00	35.00		
36.00	Private room cost differential adjustment (line 3 x line 35)			0	36.00		
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost dif	erential (line	4, 730, 282	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			733. 72	38.00		
39. 00	Program general inpatient routine service cost (line 9 x line	38)		3, 945, 212			
40.00	Medically necessary private room cost applicable to the Progr	,		0 2 045 212	40.00		
41.00	Total Program general inpatient routine service cost (line 39	+ ITHE 40)		3, 945, 212	41.00		

Heal th	Financial Systems	GOOD SAMARITA	N HOSPITAL		In Lie	u of Form CMS-	2552-10	
COMPUT	TATION OF INPATIENT OPERATING COST			CN: 15-0042	Peri od: From 01/01/2020	Worksheet D-1		
					Date/Time Pre 7/29/2021 2:3			
	Title XVIII Subprovider - IRF				PPS			
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. ÷ col. 2)	Program Days	Program Cost (col. 3 x		
		1.00	2.00	3.00	4. 00	col . 4) 5.00		
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	C	0.	00 0	0	42. 00	
43.00	INTENSIVE CARE UNIT	0	C	0.	00 0	0	43.00	
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 00 45. 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: Total Program inpatient costs (sum of lines	st. D-3, col. 3	, line 200)	one)		3, 200, 951	48.00	
49.00	PASS THROUGH COST ADJUSTMENTS	41 through 48)(see instructi	ons)		7, 146, 163	49.00	
50.00	Pass through costs applicable to Program inp	atient routine	servi ces (fro	m Wkst. D, su	um of Parts I and	598, 514	50.00	
51. 00	<pre> </pre>	atient ancillar	y services (f	rom Wkst. D,	sum of Parts II	273, 253	51.00	
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				871, 767	52.00	
53. 00	Total Program inpatient operating cost exclusion		lated, non-ph	ysician anest	thetist, and	6, 274, 396	1	
	medical education costs (line 49 minus line ETARGET AMOUNT AND LIMIT COMPUTATION	52)					-	
54.00	Program di scharges					0	54.00	
55.00							55. 00 56. 00	
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and ta	rget amount (line 56 minus	s line 53)	0	57.00	
58.00	Bonus payment (see instructions)					0		
59. 00	.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the 0.00 market basket							
60.00								
61. 00	which operating costs (line 53) are less that					0	61.00	
42.00	amount (line 56), otherwise enter zero (see instructions)							
	62.00 Relief payment (see instructions) 63.00 Allowable Inpatient cost plus incentive payment (see instructions)							
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of th	e cost report	ting period (See	0	64. 00	
65. 00	instructions)(title XVIII only)						65. 00	
	instructions) (title XVIII only)			•				
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)		·		•		66.00	
67. 00	Title V or XIX swing-bed NF inpatient routing (line 12 x line 19)	e costs through	December 31	of the cost r	reporting period	0	67. 00	
68. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	e costs after D	ecember 31 of	the cost rep	porting period	0	68. 00	
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00	
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facil				7)		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 x l	ine 35)			72.00 73.00	
74.00	Total Program general inpatient routine serv	ice costs (line	72 + line 73)	5		74.00	
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	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 minus						77. 00 78. 00	
79. 00	Aggregate charges to beneficiaries for excess	s costs (from p			70)		79.00	
80. 00 81. 00	Total Program routine service costs for companient routine service cost per diem limi		ost limitatio	n (IINe /8 mi	nus line /9)		80. 00 81. 00	
82.00	Inpatient routine service cost limitation (ine 9 x line 81	* .				82. 00	
83. 00 84. 00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in:		s)				83. 00 84. 00	
85.00	Utilization review - physician compensation	(see instructio					85.00	
86. 00	Total Program inpatient operating costs (sum		rough 85)				86. 00	
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions					0	87. 00	
88.00	Adjusted general inpatient routine cost per observation bed cost (line 87 x line 88) (see	•	line 2)				88. 00 89. 00	
07.00	lopser Agricult ped cost (Title 01 x Title 00) (26	c manuchons)				0	J 07.00	

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-T042	From 01/01/2020 To 12/31/2020	Date/Time Pre 7/29/2021 2:3	
		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	
					instructions)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	717, 596	4, 730, 282	0. 15170	0	0	90.00
91.00 Nursing School cost	0	4, 730, 282	0. 00000	00	0	91.00
92.00 Allied health cost	0	4, 730, 282	0. 00000	00	0	92.00
93.00 All other Medical Education	0	4, 730, 282	0. 00000	00 0	0	93.00

Health Financial Systems	GOOD SAMARITAN HOSPITAL	In Lie	u of Form CMS-2	552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0042	From 01/01/2020	Worksheet D-1 Date/Time Prep 7/29/2021 2:33	
	Title XIX	Hospi tal	Cost	<u> </u>
Cost Center Description				

		Ti tle XIX	Hospi tal	7/29/2021 2:3 Cost	3 pm		
	Cost Center Description	THE XIX	поэрт саг	'			
	PART I - ALL PROVIDER COMPONENTS			1. 00			
	I NPATI ENT DAYS				1		
1. 00							
2. 00 3. 00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed da		sivata room days	14, 603 0	2.00		
3.00	do not complete this line.	ys). If you have only pr	ivate room days,	U	3.00		
4.00	Semi-private room days (excluding swing-bed and observation bed days)						
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost 0						
6. 00	reporting period Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	0	6.00		
0.00	reporting period (if calendar year, enter 0 on this line)	om days) arter becomber	of the cost	O	0.00		
7. 00	Total swing-bed NF type inpatient days (including private roo	m days) through December	31 of the cost	0	7. 00		
8. 00	reporting period Total swing-bed NF type inpatient days (including private roo	m days) after December 3	21 of the cost	0	8. 00		
8.00	reporting period (if calendar year, enter 0 on this line)	iii days) arter beceiiber s	or or the cost	O	0.00		
9. 00	Total inpatient days including private room days applicable t	o the Program (excluding	swing-bed and	363	9. 00		
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private r	soom days)	0	10.00		
10.00	through December 31 of the cost reporting period (see instruc		oom days)	Ü	10.00		
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		oom days) after	0	11.00		
40.00	December 31 of the cost reporting period (if calendar year, e				40.00		
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period	x only (including privat	te room days)	0	12.00		
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			_			
14. 00 15. 00	Medically necessary private room days applicable to the Progr Total nursery days (title V or XIX only)	am (excluding swing-bed	days)	0 930			
	Nursery days (title V or XIX only)			56			
	SWING BED ADJUSTMENT						
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	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		
10.00	reporting period	es arter becomber or or	1110 0031	0.00	10.00		
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 t	he cost	0. 00	20.00		
20.00	reporting period	S ditter becomber of or		0.00	20.00		
21.00	Total general inpatient routine service cost (see instruction			15, 545, 742			
22. 00	Swing-bed cost applicable to SNF type services through Decemb 5×1 line 17)	er 31 of the cost report	ing period (line	0	22. 00		
23. 00	,	31 of the cost reportir	ng period (line 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 reporti	ng period (line	0	24.00		
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)	(1) 21 1 2()		0			
27.00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(Tine 21 minus Tine 26)		15, 545, 742	27.00		
28. 00	General inpatient routine service charges (excluding swing-be	d and observation bed ch	narges)	0	28. 00		
29. 00			_	0			
30.00	Semi-private room charges (excluding swing-bed charges)	. Line 20)		0			
31. 00 32. 00	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3)	÷ Tine 28)		0. 000000 0. 00			
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	1		
34. 00	Average per diem private room charge differential (line 32 mi	nus line 33)(see instru	rtions)	0.00			
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)	/		0.00	36.00		
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line		1		
	27 minus line 36)						
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	USTMENTS			1		
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 064. 56	38.00		
39. 00	Program general inpatient routine service cost (line 9 x line			386, 435	1		
	Medically necessary private room cost applicable to the Progr	•		0			
	Total Program general inpatient routine service cost (line 39			386, 435			

	Financial Systems	GOOD SAMARITAI		ON 45 0040 5		u of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der C	F	eriod: rom 01/01/2020 o 12/31/2020	Date/Time Pre	pared:
			Ti +I	e XIX	Hospi tal	7/29/2021 2:3 Cost	3 pm
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		I npati ent	I npati ent	Diem (col. 1		(col . 3 x	
		Cost	Days	÷ col. 2)		col. 4)	
40.00	MUDGEDY (1111 - M. o. MIV 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	633, 822	930	681. 53	56	38, 166	42.00
43.00	INTENSIVE CARE UNIT	8, 574, 268	6, 301	1, 360, 78	62	84, 368	43.00
44. 00	CORONARY CARE UNIT	3, 3, 1, 233	3, 55 .	., 555. 75	52	0.7000	44.00
45.00	BURN INTENSIVE CARE UNIT						45. 00
46.00	SURGICAL INTENSIVE CARE UNIT						46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1. 00	
48. 00	Program inpatient ancillary service cost (Wk	st D-3 col 3	Line 200)			550, 601	48. 00
	Total Program inpatient costs (sum of lines			ons)		1, 059, 570	
	PASS THROUGH COST ADJUSTMENTS	g , ,		,			
50.00	Pass through costs applicable to Program inp	atient routine	servi ces (fro	m Wkst. D, sum	of Parts I and	0	50.00
F1 00		-4:4:	(6	WI+ D -	£ D 11		51.00
51. 00	Pass through costs applicable to Program inpland IV)	atrent andiriar	y services (ii	OIII WKSt. D, S	um or Parts II	0	51.00
52. 00	Total Program excludable cost (sum of lines	50 and 51)				o	52.00
53.00	Total Program inpatient operating cost exclu		lated, non-phy	ysician anesth	etist, and	0	
	medical education costs (line 49 minus line	52)					
F4 00	TARGET AMOUNT AND LIMIT COMPUTATION					0	F4 00
	Program discharges Target amount per discharge					0.00	
56. 00	Target amount (line 54 x line 55)					0.00	56.00
	Difference between adjusted inpatient operat	ing cost and ta	rget amount (ine 56 minus	line 53)	Ō	
58.00	Bonus payment (see instructions)	-				0	58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996, i	updated and co	mpounded by the	0.00	59. 00
60. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost report un	dated by the i	markat haskat		0.00	60.00
	If line 53/54 is less than the lower of line				the amount by	0.00	61.00
011.00	which operating costs (line 53) are less tha						01.00
	amount (line 56), otherwise enter zero (see	instructions)			Ü		62. 00
	62.00 Relief payment (see instructions) 63.00 Allowable Inpatient cost plus incentive payment (see instructions)						
63.00	0	63. 00					
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of the	e cost reporti	na period (See	0	64.00
	instructions)(title XVIII only)	· ·		•			
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the (cost reporting	period (See	0	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	no costs (lino	64 plus lino	45) (+i +l	Lonly) For	0	66. 00
00.00	CAH (see instructions)	ile costs (Title	04 prus rine i	os)(title xvii	i diliy). Toi		00.00
67.00	Title V or XIX swing-bed NF inpatient routin	e costs through	December 31	of the cost re	porting period	0	67.00
	(line 12 x line 19)	_					
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	routine costs (line 67 ± line	. 68)		0	69. 00
07.00	PART III - SKILLED NURSING FACILITY, OTHER NI						07.00
70.00	Skilled nursing facility/other nursing facil						70. 00
71.00	Adjusted general inpatient routine service c		ine 70 ÷ line	2)			71.00
72.00	Program routine service cost (line 9 x line	,	(Line 14 v Li	no 2E)			72.00
73. 00 74. 00	Medically necessary private room cost applic Total Program general inpatient routine serv	•	•				73. 00 74. 00
75. 00	Capital -related cost allocated to inpatient	•			art II, column		75.00
	26, line 45)		•				
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	,	rovi den inecon	ds)			78.00
80.00	Total Program routine service costs for comp	, ,		,	us line 79)		80.00
81.00	Inpatient routine service cost per diem limi		_				81.00
82.00	Inpatient routine service cost limitation (I		•				82.00
83. 00 84. 00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in		5)				83. 00 84. 00
85.00	Utilization review - physician compensation		ns)				85.00
86.00	Total Program inpatient operating costs (sum	•					86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST					
87.00	Total observation bed days (see instructions	•	lino 2)			2, 557	87.00
88. 00 89. 00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se		rine 2)			1, 064. 56 2, 722, 080	
57.00	(3e					2, , 22, 000	1 37. 30

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 01/01/2020 To 12/31/2020	Date/Time Pre 7/29/2021 2:3	pared: 3 pm
		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, 572, 436	15, 545, 742	0. 16547	5 2, 722, 080	450, 436	90.00
91.00 Nursing School cost	0	15, 545, 742	0.00000	0 2, 722, 080	0	91.00
92.00 Allied health cost	0	15, 545, 742	0.00000	0 2, 722, 080	0	92.00
93.00 All other Medical Education	0	15, 545, 742	0. 00000	0 2, 722, 080	0	93.00

Health Financial Systems	GOOD SAMARITAN HOSPITAL	In Lieu	ı of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0042	Peri od: From 01/01/2020	Worksheet D-1
	Component CCN: 15-S042		
	Title XIX	Subprovi der -	Cost
		I PF	

		I tro XIX	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 day			4, 639	1.00
2. 00 3. 00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed da		nom dave	4, 639 0	2. 00 3. 00
3.00	do not complete this line.	ys). If you have only private it	Juli uays,	U	3.00
4.00	Semi-private room days (excluding swing-bed and observation b	ed days)		4, 639	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			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) after becember 31 of tr	ne cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private roo	m days) through December 31 of t	the cost	0	7. 00
	reporting period	3 ,			
8. 00	Total swing-bed NF type inpatient days (including private roo	m days) after December 31 of the	e cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable t	o the Program (eycluding swing-h	ned and	394	9. 00
7. 00	newborn days) (see instructions)	o the riogram (exercating swring t	ocu ana	374	7.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private room days	s)	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 o December 31 of the cost reporting period (if calendar year, e		s) arter	0	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI		days)	0	12. 00
	through December 31 of the cost reporting period				
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI		days)	0	13.00
14. 00	after December 31 of the cost reporting period (if calendar y Medically necessary private room days applicable to the Progr			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)				16.00
	SWING BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to servic	es through December 31 of the co	ost	0. 00	17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of the cost	t l	0.00	18. 00
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to service	s through December 31 of the cos	st	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			5, 213, 502	
22. 00	Swing-bed cost applicable to SNF type services through Decemb 5×1 ine 17)	er 31 of the cost reporting peri	od (IIne	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting period	d (line 6	0	23. 00
	x line 18)		1		
24. 00	Swing-bed cost applicable to NF type services through Decembe 7×1 ine 19)	r 31 of the cost reporting perio	od (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting period	(Line 8	0	25. 00
20.00	x line 20)	or or the boot roper tring porrou	(11110		20.00
	Total swing-bed cost (see instructions)			0	26.00
27. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(Tine 21 minus Tine 26)		5, 213, 502	27.00
28. 00	General inpatient routine service charges (excluding swing-be	d and observation bed charges)		0	28. 00
29. 00	Pri vate 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 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	
34. 00	Average per diem private room charge differential (line 32 mi	nus line 33)(see instructions)		0. 00	
35.00	Average per diem private room cost differential (line 34 x li			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 differenti	al (line	5, 213, 502	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	instructions)		1, 123. 84	
39.00	Program general inpatient routine service cost (line 9 x line			442, 793	
40. 00 41. 00	Medically necessary private room cost applicable to the Progr Total Program general inpatient routine service cost (line 39	,		0 442, 793	
11.00	1. State		ı	172, 175	11.00

Heal th	Financial Systems	GOOD SAMARITA	N HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUT	TATION OF INPATIENT OPERATING COST			CN: 15-0042	Peri od: From 01/01/2020	Worksheet D-1	
				CCN: 15-S042	To 12/31/2020	7/29/2021 2: 3	
			litl	e XIX	Subprovi der - IPF	Cost	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. ÷ col. 2)		Program Cost (col. 3 x col. 4)	
42.00	NUDCEDY (ALALA VIII VIII VIII VIII VIII VIII VIII	1. 00	2. 00	3. 00	4.00	5. 00	42.00
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	C	0.0	00 0	0	42.00
43. 00 44. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT	0	C	0.0	00 0	0	43. 00 44. 00
45.00	BURN INTENSIVE CARE UNIT						45.00
	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
47.00	Cost Center Description						47.00
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	3, line 200)			1. 00 28, 937	48. 00
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS			ons)		471, 730	49. 00
50.00	Pass through costs applicable to Program inp	atient routine	servi ces (fro	m Wkst. D, su	m of Parts I and	0	50.00
51. 00		atient ancillar	y services (f	rom Wkst. D,	sum of Parts II	0	51.00
52. 00	and IV) Total Program excludable cost (sum of lines					0	
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line	0 .	elated, non-ph	ysician anest	hetist, and	0	53. 00
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	line 53)	0	56. 00 57. 00
58.00	Bonus payment (see instructions)					0	58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost re market basket	porting period	ending 1996,	updated and c	ompounded by the	0.00	59. 00
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year					0. 00 0	1
01.00	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 Relief payment (see instructions)					0	
63. 00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	uctions)			0	63.00
64. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts through Dece	ember 31 of th	e cost report	ing period (See	0	64.00
65. 00	1	ts after Decemb	per 31 of the	cost reportin	g period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line	64 plus line	65)(title XVI	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	December 31	of the cost r	eporting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after D	December 31 of	the cost rep	orting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NI Skilled nursing facility/other nursing facil)		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 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient	•		•	Part II, column		74. 00 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	76)					77. 00
78. 00 79. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		orovi der recor	ds)			78. 00 79. 00
	Total Program routine service costs for comp	arison to the c			nus line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I		1)				81. 00 82. 00
83.00	Reasonable inpatient routine service costs (see instruction					83.00
84. 00 85. 00	Program inpatient ancillary services (see in Utilization review - physician compensation		ons)				84. 00 85. 00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS	of lines 83 th					86. 00
87. 00	Total observation bed days (see instructions)				0	
88. 00 89. 00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se					0. 00 0	88. 00 89. 00
		ŕ			'	-	

Health Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST				Peri od:	Worksheet D-1	
		Component (From 01/01/2020 To 12/31/2020		pared: 3 pm
		Ti tl	e XIX	Subprovi der - I PF	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	609, 724	5, 213, 502	0. 11695	51 0	0	90.00
91.00 Nursing School cost	0	5, 213, 502	0.00000	0 0	0	91.00
92.00 Allied health cost	0	5, 213, 502	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	5, 213, 502	0.00000	0 0	0	93.00

Health Financial Systems	GOOD SAMARITAN HOSPITAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0042	Peri od: From 01/01/2020	Worksheet D-1
	Component CCN: 15-T042		
	Title XIX	Subprovi der -	Cost
		IRF	

		I RF		
	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, ex	cluding newborn)	6, 447	1. 00
2.00	Inpatient days (including private room days, excluding swing-bed at	nd newborn days)	6, 447	2.00
3.00	Private room days (excluding swing-bed and observation bed days).	If you have only private room days,	0	3.00
	do not complete this line.	,		
4.00	Semi-private room days (excluding swing-bed and observation bed day		6, 447	4.00
5.00	Total swing-bed SNF type inpatient days (including private room day reporting period	ys) through becember 31 or the cost	0	5. 00
6. 00	Total swing-bed SNF type inpatient days (including private room da	vs) after December 31 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	ys) arter becomber or or the east	G	0.00
7.00	Total swing-bed NF type inpatient days (including private room days	s) through December 31 of the cost	0	7.00
	reporting period			
8.00	Total swing-bed NF type inpatient days (including private room days	s) 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 (oveluding swing had and	21	9. 00
7. 00	newborn days) (see instructions)	Trogram (excruding swing-bed and	21	9.00
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 (0	11.00
10.00	December 31 of the cost reporting period (if calendar year, enter of		0	10.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only through December 31 of the cost reporting period	y (including private room days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only	v (including private room days)	0	13. 00
	after December 31 of the cost reporting period (if calendar year,		_	
14.00	Medically necessary private room days applicable to the Program (e.	xcluding swing-bed days)	0	14.00
15. 00	Total nursery days (title V or XIX only)		930	
16. 00	Nursery days (title V or XIX only)		56	16. 00
17. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to services the	rough Docombor 21 of the cost	0.00	17. 00
17.00	reporting period	rough becember 31 of the cost	0.00	17.00
18. 00	Medicare rate for swing-bed SNF services applicable to services af	ter December 31 of the cost	0. 00	18. 00
	reporting period			
19. 00	Medicaid rate for swing-bed NF services applicable to services three	ough December 31 of the cost	0. 00	19. 00
20.00	reporting period	or December 21 of the cost	0.00	20. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services after reporting period	er beceiiber 31 of the cost	0.00	20.00
21. 00	Total general inpatient routine service cost (see instructions)		4, 730, 282	21. 00
22.00	Swing-bed cost applicable to SNF type services through December 31	of the cost reporting period (line	0	22.00
	5 x line 17)			
23. 00	Swing-bed cost applicable to SNF type services after December 31 o	f the cost reporting period (line 6	0	23. 00
24. 00	x line 18) Swing-bed cost applicable to NF type services through December 31 (of the cost reporting period (line	0	24. 00
21.00	7 x line 19)	or the dost reporting period (inhe	0	21.00
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 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line	21 minus Line 24)	0 4, 730, 282	
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	21 IIII lius 11 lie 20)	4, 730, 202	27.00
28. 00	General inpatient routine service charges (excluding swing-bed and	observation bed charges)	0	28. 00
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	e 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)	ine 22) (acc instructions)	0.00	
34. 00 35. 00	Average per diem private room charge differential (line 32 minus l Average per diem private room cost differential (line 34 x line 31)		0. 00 0. 00	
36.00	Private room cost differential adjustment (line 3 x line 35)	,	0.00	36.00
37. 00	General inpatient routine service cost net of swing-bed cost and p	rivate room cost differential (line	-	37.00
	27 minus line 36)			
	PART II - HOSPITAL AND SUBPROVIDERS ONLY			
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMEN			
38. 00	Adjusted general inpatient routine service cost per diem (see inst	ructions)	733. 72	
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line 38) Medically necessary private room cost applicable to the Program (ine 14 v line 35)	15, 408 0	39. 00 40. 00
	Total Program general inpatient routine service cost (line 39 + li	*	15, 408	
	1 3 3 2 2 3 3 2 3 3 3 3 3 3 3 3 3 3 3 3		.5, .66	

Heal th	Financial Systems	GOOD SAMARITA	N HOSPITAL		In Lie	u of Form CMS-2	<u> 2552-10</u>
COMPUT	TATION OF INPATIENT OPERATING COST				Peri od: From 01/01/2020	Worksheet D-1	
				CCN: 15-T042	To 12/31/2020	7/29/2021 2: 3	
			litl	e XIX	Subprovi der - I RF	Cost	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42.00	NUDCEDY (ALALA VIII VIII VIII VIII VIII VIII VIII	1. 00	2. 00	3. 00	4.00	5. 00	42.00
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	C	0.0	0	0	42.00
43. 00 44. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT	0	C	0. 0	0	0	43. 00 44. 00
45.00	BURN INTENSIVE CARE UNIT						45. 00
	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
47.00	Cost Center Description						47.00
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	3, line 200)			1. 00 35, 048	48. 00
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS			ons)		50, 456	1
50.00	Pass through costs applicable to Program inp	atient routine	servi ces (fro	m Wkst. D, su	m of Parts I and	0	50.00
51. 00		atient ancillar	y services (f	rom Wkst. D,	sum of Parts II	0	51.00
52. 00	and IV) Total Program excludable cost (sum of lines					0	52.00
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		elated, non-ph	ysician anest	hetist, and	0	53. 00
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	line 53)	0	56. 00 57. 00
58.00	Bonus payment (see instructions)					0	58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost re market basket	porting period	endi ng 1996,	updated and c	ompounded by the	0.00	59. 00
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line				the amount by	0. 00 0	60. 00 61. 00
01.00	which operating costs (line 53) are less tha	n expected cost				0	01.00
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	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through Dece	ember 31 of th	e cost report	ing period (See	0	64.00
65. 00	, , , , , , , , , , , , , , , , , , , ,	ts after Decemb	per 31 of the	cost reportin	g period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line	64 plus line	65)(title XVI	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	December 31	of the cost r	eporting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after D	December 31 of	the cost rep	orting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NI Skilled nursing facility/other nursing facil)		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 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient	•		•	Part II column		74. 00 75. 00
	26, line 45)		, , , , , , , , , , , , , , , , , , , ,	nor noneet by	a c rr, corami		
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line	. *					76. 00 77. 00
78. 00 79. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		rovidor rocor	rde)			78. 00 79. 00
	Total Program routine service costs for comp				nus line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I		1)				81. 00 82. 00
83.00	Reasonable inpatient routine service costs (see instruction					83.00
84. 00 85. 00	Program inpatient ancillary services (see in Utilization review - physician compensation		ons)				84. 00 85. 00
	Total Program inpatient operating costs (sum	of lines 83 th					86.00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions					0	87. 00
88. 00 89. 00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se					0. 00 0	88. 00 89. 00
57.00	(3e)	oti doti olis)			ļ	· ·	1 07.00

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-T042	From 01/01/2020 To 12/31/2020	Date/Time Pre 7/29/2021 2:3	
		Ti tl	e XIX	Subprovi der -	Cost	
				I RF		
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	717, 596	4, 730, 282	0. 15170	0	0	90.00
91.00 Nursing School cost	0	4, 730, 282	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	4, 730, 282	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	4, 730, 282	0. 00000	0 0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		CN: 15-0042	Peri od: From 01/01/2020 To 12/31/2020		pared
	Title	XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cos To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2) 3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
03000 ADULTS & PEDIATRICS 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			11, 595, 640 9, 019, 748 0 69, 767		30. 0 31. 0 40. 0 41. 0 43. 0
ANCI LLARY SERVI CE COST CENTERS		1			1 75.0
50. 00 05000 0PERATI NG ROOM 51. 00 05100 RECOVERY ROOM		0. 18570 0. 00000			1
51. 01 05101 ENDOSCOPY		0. 2543		153, 413	51.0
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 34136		4, 864	
53. 00 05300 ANESTHESI OLOGY		0.00000			1
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 11374			
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 22198			1
50.00 06000 LABORATORY 53.00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 14784 0. 00000			1
55. 00 06500 RESPIRATORY THERAPY		0. 27738		l ~	
6. 00 06600 PHYSI CAL THERAPY		0. 28369			
9. 00 06900 ELECTROCARDI OLOGY		0. 1474			1
0. 00 07000 ELECTROENCEPHALOGRAPHY		0.00000			1
0. 01 07001 NEURODI AGNOSTI CS		0. 23580		10, 330	70.
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		1. 1918	1, 162, 115	1, 385, 020	71. (
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 49018			
3.00 07300 DRUGS CHARGED TO PATIENTS		0. 28590		2, 833, 591	
75. 00 07500 ASC (NON-DISTINCT PART)		0. 2032			1 .
76. OO 03950 MH ANCILLARY OUTPATIENT		0.00000		0	
76. 01 03951 INPATIENT DIALYSIS OUTPATIENT SERVICE COST CENTERS		0. 75084	49 643, 014	482, 806	76.0
00. 00 09000 CLINIC		3. 21843	36 0	0	90. (
0. 01 04950 WOUND CLINIC		0. 37548			
91. 00 09100 EMERGENCY		0. 20990			
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 45696	68 812, 948	371, 491	92.
OTHER REIMBURSABLE COST CENTERS				1	
26. 00 09600 DURABLE MEDICAL EQUIP-RENTED		0. 52586			
Total (sum of lines 50 through 94 and 96 th			65, 796, 873		
201.00 Less PBP Clinic Laboratory Services-Program	only charges (line 61)		0		201.

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

65, 796, 873

201. 00 202. 00

202.00

	Systems GOOD SAMARITAL ARY SERVICE COST APPORTIONMENT	Provider C	CN: 15 0042	Peri od:	u of Form CMS-: Worksheet D-3	
INPATTENT ANCILI	LART SERVICE COST APPORTIONWENT	Provider C	CN. 15-0042	From 01/01/2020	WOLKSHEEL D-3)
		'	CCN: 15-S042	To 12/31/2020	7/29/2021 2: 3	
		Title	e XVIII	Subprovi der - I PF	PPS	
Cos	t Center Description		Ratio of Cos		I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col . 1 x	
			1.00	2.00	col . 2)	
LNDATLENT	DOLLTI ME CEDVI CE COCT CENTEDO		1.00	2. 00	3. 00	
	ROUTINE SERVICE COST CENTERS _TS & PEDIATRICS			0		30.00
				0		
	ENSIVE CARE UNIT PROVIDER - IPF			_		31.00
	PROVIDER - IPF			2, 313, 220		41.00
43. 00 04300 NUR				0		43.00
	SERVI CE COST CENTERS					43.00
	RATING ROOM		0. 18570	09 11, 821	2, 195	50.00
	OVERY ROOM		0. 00000		2, 193	•
51. 01 05101 END			0. 25435		0	
	VERY ROOM & LABOR ROOM		0. 34136		0	
53. 00 05300 ANE	STHEST OLOGY		0. 00000		0	
	OLOGY-DI AGNOSTI C		0. 11374		6, 228	
	OLOGY-THERAPEUTI C		0. 22198		0, 220	1
60. 00 06000 LAB			0. 14784		30, 933	
	DD STORING, PROCESSING & TRANS.		0.00000		0	1
1 1	PI RATORY THERAPY		0. 27738		26, 224	1
1 1	SI CAL THERAPY		0. 28369		6, 873	
69. 00 06900 ELE			0. 14744		2, 080	
	CTROENCEPHALOGRAPHY		0.00000		0	
	RODI AGNOSTI CS		0. 23580		0	1
	CAL SUPPLIES CHARGED TO PATIENTS		1. 1918		6, 065	71.0
	L. DEV. CHARGED TO PATIENTS		0. 49018		0	1
	GS CHARGED TO PATLENTS		0. 28590		89, 656	73.00
75. 00 07500 ASC	(NON-DISTINCT PART)		0. 20327	79 0	0	75.0
76.00 03950 MH A	ANCI LLARY OUTPATIENT		0.00000	00	0	76.0
76. 01 03951 I NP	ATLENT DIALYSIS		0. 75084	19 0	0	76.0
OUTPATI EN	T SERVICE COST CENTERS					
90.00 09000 CLII	VI C		3. 21843	36 0	0	90.00
90. 01 04950 WOUI	ND CLINIC		0. 37548	37 0	0	90.0
91. 00 09100 EMEI	RGENCY		0. 20990	219, 966	46, 173	91.00
	ERVATION BEDS (NON-DISTINCT PART)		0. 45696	0 88	0	92.00
	MBURSABLE COST CENTERS					
	ABLE MEDICAL EQUIP-RENTED		0. 52586		0	
	al (sum of lines 50 through 94 and 96 through 98)			947, 319	216, 427	
	s PBP Clinic Laboratory Services-Program only charg	jes (line 61)		0		201.00
202.00 Net	charges (line 200 minus line 201)			947, 319		202.00

NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0042	Peri od:	Worksheet D-3	3
		0011 45 7040	From 01/01/2020	5	
	Component	CCN: 15-T042	To 12/31/2020	Date/Time Pre 7/29/2021 2:3	
	Titl€	e XVIII	Subprovi der - I RF	PPS	
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
		1.00	2.00	col . 2)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2. 00	3. 00	
0.00 03000 ADULTS & PEDIATRICS			0		30.0
1. 00 03100 NTENSI VE CARE UNI T			0		31.0
0. 00 04000 SUBPROVI DER - PF			0		40.0
1. 00 04100 SUBPROVI DER - I RF			6, 237, 319		41.0
3. 00 04300 NURSERY					43.0
ANCILLARY SERVICE COST CENTERS		•			
0.00 05000 OPERATING ROOM		0. 18570	09 37, 986	7, 054	50.0
1.00 05100 RECOVERY ROOM		0.0000	00	0	51.0
1. 01 05101 ENDOSCOPY		0. 2543	· ·	5, 870	51.0
2.00 05200 DELIVERY ROOM & LABOR ROOM		0. 3413	52 0	0	1
3. 00 05300 ANESTHESI OLOGY		0.00000		0	
4. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1137		48, 160	
5. 00 05500 RADI OLOGY-THERAPEUTI C		0. 22198	· ·		
0. 00 06000 LABORATORY		0. 1478		148, 023	
3. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0.00000		0	
5. 00 06500 RESPI RATORY THERAPY 6. 00 06600 PHYSI CAL THERAPY		0. 27738	· ·	243, 578	
9. 00 06900 PHYSICAL THERAPY 9. 00 06900 ELECTROCARDI OLOGY		0. 2836 0. 1474		2, 207, 273 19, 418	
0. 00 07000 ELECTROENCEPHALOGRAPHY		0. 00000	· ·	19,418	1
0. 01 07001 NEURODI AGNOSTI CS		0. 23580		934	
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		1. 1918		122, 348	
2. 00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 49018	·	874	1
3. 00 07300 DRUGS CHARGED TO PATIENTS		0. 28590		328, 679	
5.00 07500 ASC (NON-DISTINCT PART)		0. 2032		0	
6.00 03950 MH ANCILLARY OUTPATIENT		0.00000	00	0	76. C
6.01 03951 INPATIENT DIALYSIS		0. 7508	49 75, 212	56, 473	76. C
OUTPAȚI ENT SERVI CE COST CENTERS					
0. 00 09000 CLI NI C		3. 2184		0	90.0
0. 01 04950 WOUND CLINIC		0. 37548		0	90.0
1. 00 09100 EMERGENCY		0. 20990	· ·	11, 364	
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 4569	68 0	0	92.0
OTHER REIMBURSABLE COST CENTERS		0.5050	(0)		٠, ،
6.00 09600 DURABLE MEDICAL EQUIP-RENTED		0. 5258		2 200 051	
00.00 Total (sum of lines 50 through 94 and 96 through 98) 01.00 Less PBP Clinic Laboratory Services-Program only char	acc (line (1)		11, 667, 353	3, 200, 951	200. 0
or our cress egg citore taboratory services-prodram only char					

	Financial Systems	GOOD SAMARITAN				u of Form CMS-2	
I NPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT		Provider C		Peri od: From 01/01/2020	Worksheet D-3	
					To 12/31/2020	Date/Time Pre	
			Ti +I	e XIX	Hospi tal	7/29/2021 2:3 Cost	3 piii
	Cost Center Description		11 (1	Ratio of Cos		Inpati ent	
	2001 201101 20001 pt 011			To Charges	Program	Program Costs	
				9	Charges	(col . 1 x	
					3	col . 2)	
				1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS				334, 473		30.00
31.00	03100 INTENSIVE CARE UNIT				249, 846		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				91, 830		43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM			0. 18474		59, 906	
	05100 RECOVERY ROOM			0.00000		1	
51. 01	05101 ENDOSCOPY			0. 25435	· ·		
52.00	05200 DELIVERY ROOM & LABOR ROOM			0. 34136			
53.00	05300 ANESTHESI OLOGY			0.00000		0	
	05400 RADI OLOGY-DI AGNOSTI C			0. 11374			
55.00	05500 RADI OLOGY-THERAPEUTI C			0. 22168			
60.00	06000 LABORATORY			0. 14784	· ·		
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.			0.00000		0	63.00
65. 00	06500 RESPI RATORY THERAPY			0. 27738			65.00
66.00	06600 PHYSI CAL THERAPY			0. 28369			
69.00	06900 ELECTROCARDI OLOGY			0. 14731	· ·		
70.00	07000 ELECTROENCEPHALOGRAPHY			0.00000		0	70.00
	07001 NEURODI AGNOSTI CS			0. 23399	· ·	l	70. 01
				1. 19181		0	71. 00 72. 00
				0. 49018		107.000	
	07300 DRUGS CHARGED TO PATIENTS 07500 ASC (NON-DISTINCT PART)			0. 28590			73. 00 75. 00
	03950 MH ANCILLARY OUTPATIENT			0. 20287 0. 00000	· ·	1	76.00
76. 00 76. 01				0. 00000		0 445	1
/O. UI	03951 INPATIENT DIALYSIS OUTPATIENT SERVICE COST CENTERS			U. 75084	9 11, 274	8, 465	76.01
90. 00				3. 21843	6 0	0	90.00
	04000 CLINIC			3. 21843			90.00

0. 375487

0. 209909

0. 456968

0. 525860

4, 852

1, 694

254, 471

2, 483, 151

2, 483, 151

90.01

91.00 92.00

201. 00 202. 00

0 96.00 550,601 200.00

1, 822

53, 416 774

90. 01

91.00

92.00

201.00

202.00

04950 WOUND CLINIC

09100 EMERGENCY
09200 OBSERVATION BEDS (NON-DISTINCT PART)
OTHER REINBURSABLE COST CENTERS

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

Net charges (line 200 minus line 201)

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

	inancial Systems GOOD SAMARITAN H IT ANCILLARY SERVICE COST APPORTIONMENT		CN: 15-0042	Peri od:	u of Form CMS-2 Worksheet D-3	
	7 THO ELIN GENT GENT GENT GENT GENT GENT GENT GEN			From 01/01/2020		
		Component	CCN: 15-S042	To 12/31/2020	Date/Time Pre 7/29/2021 2:3	
		Ti tl	e XIX	Subprovi der - I PF	Cost	
	Cost Center Description		Ratio of Cos		I npati ent	
			To Charges		Program Costs	
				Charges	(col . 1 x	
			1.00	2.00	col . 2) 3.00	
LA	NPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
	3000 ADULTS & PEDIATRICS			0		30.0
	3100 INTENSIVE CARE UNIT			Ö	I	31.0
	4000 SUBPROVI DER - I PF			575, 212	I	40.0
1	4100 SUBPROVI DER - I RF			0,0,2.2	I	41.0
	4300 NURSERY			o	I	43.0
	NCILLARY SERVICE COST CENTERS		•			
	5000 OPERATING ROOM		0. 1847	42 0	0	50.0
51.00 05	5100 RECOVERY ROOM		0.0000	00 0	0	51.0
	5101 ENDOSCOPY		0. 2543	54 208	53	51.0
52.00 05	5200 DELIVERY ROOM & LABOR ROOM		0. 3413	62 0	0	52.0
	ANESTHESI OLOGY		0.0000		0	
	RADI OLOGY-DI AGNOSTI C		0. 1137			54.0
	5500 RADI OLOGY-THERAPEUTI C		0. 2216		0	
- 1	5000 LABORATORY		0. 1478		5, 620	
	6300 BLOOD STORING, PROCESSING & TRANS. 6500 RESPIRATORY THERAPY		0. 0000 0. 2773		0	
	6600 PHYSI CAL THERAPY		0. 2773		2, 950 2, 641	
	5900 ELECTROCARDI OLOGY		0. 2838		414	1
	7000 ELECTROENCEPHALOGRAPHY		0.1473		0	1
	7001 NEURODI AGNOSTI CS		0. 2339		192	
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS		1. 1918		2, 322	
	7200 IMPL. DEV. CHARGED TO PATIENTS		0. 4901		0	
	7300 DRUGS CHARGED TO PATIENTS		0. 2859		12, 259	73.0
	7500 ASC (NON-DISTINCT PART)		0. 2028	71 0	0	75. C
76. 00 03	3950 MH ANCILLARY OUTPATIENT		0. 0000	00 0	0	76. C
	3951 I NPATI ENT DI ALYSI S		0. 7508	49 754	566	76. C
	JTPATIENT SERVICE COST CENTERS					
- 1	9000 CLINIC		3. 2184		0	
4	4950 WOUND CLINIC		0. 3754		0	
	9100 EMERGENCY		0. 2099		0	1
	P200 OBSERVATION BEDS (NON-DISTINCT PART) THER REIMBURSABLE COST CENTERS		0. 4569	68 0	0	92.0
	PRODUCTION OF THE PRODUCT OF THE PRO		0. 5258	60 0	0	96.0
200. 00 09	Total (sum of lines 50 through 94 and 96 through 98)		0. 5258	124, 254	28, 937	
200.00	Less PBP Clinic Laboratory Services-Program only charges	(line 61)		124, 234		201. 0
202.00	Net charges (line 200 minus line 201)	(1110 01)		124, 254		202. 0

Health Financial Systems INPATIENT ANCILLARY SERVICE		RITAN HOSPITAL Provider C	CN: 15-0042	Peri od:	u of Form CMS-: Worksheet D-3	
THE ANOTEEN TOE	GOST ALTORITONIMENT	Trovider 6	ON: 15 0042	From 01/01/2020		,
			CCN: 15-T042	To 12/31/2020	7/29/2021 2: 3	
		Ti tl	e XIX	Subprovi der - I RF	Cost	
Cost Center Des	cri pti on		Ratio of Cos		I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col . 1 x	
			1.00	2.00	col . 2) 3.00	
INPATIENT ROUTINE SER	VICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDI AT				0		30.0
31. 00 03100 NTENSI VE CARE				0		31.0
40. 00 04000 SUBPROVI DER - I				0		40.0
41. 00 04100 SUBPROVI DER - I				100, 517		41. 0
43. 00 04300 NURSERY				0		43.0
ANCILLARY SERVICE COS	T CENTERS					10.0
50. 00 05000 OPERATING ROOM	T SERVERO		0. 18474	12 311	57	50.0
51.00 05100 RECOVERY ROOM			0.00000		0	1
51. 01 05101 ENDOSCOPY			0. 25435		205	
52.00 05200 DELIVERY ROOM &	LABOR ROOM		0. 34136		0	1
53. 00 05300 ANESTHESI OLOGY			0. 00000	00	0	53.0
54. 00 05400 RADI OLOGY-DI AGN	OSTI C		0. 11374	7, 856	894	54.0
55. 00 05500 RADI OLOGY-THERA	PEUTI C		0. 22168	33 0	0	55. C
60. 00 06000 LABORATORY			0. 14784	11, 597	1, 715	60.0
63. 00 06300 BLOOD STORI NG,			0. 00000	00	0	
65. 00 06500 RESPI RATORY THE			0. 27738		989	
66. 00 06600 PHYSI CAL THERAP			0. 28369		23, 411	1
69. 00 06900 ELECTROCARDI OLO			0. 14731		221	
70.00 07000 ELECTROENCEPHAL			0. 00000		0	
70. 01 07001 NEURODI AGNOSTI C			0. 23399		44	1
71. 00 07100 MEDI CAL SUPPLI E			1. 19181		3, 561	
72.00 07200 I MPL. DEV. CHAR			0. 49018		56	
73.00 07300 DRUGS CHARGED T			0. 28590		3, 412	
75.00 07500 ASC (NON-DISTIN 76.00 03950 MH ANCILLARY OU			0. 20287		0	
76.00 03950 MH ANCILLARY 00 76.01 03951 INPATIENT DIALY			0. 75084		0	
OUTPATIENT SERVICE CO			0. 73062	19 0	U	70.0
90. 00 09000 CLINIC	JOI CENTERS		3. 21843	36 0	0	90.0
90. 01 04950 WOUND CLINIC			0. 37548		483	
91. 00 09100 EMERGENCY			0. 20990		0	1
92. 00 09200 OBSERVATION BED	S (NON-DISTINCT PART)		0. 45696		0	1
OTHER REIMBURSABLE CO			0. 45070	J.S., O		1 /2.0
96. 00 09600 DURABLE MEDICAL			0. 52586	50 0	0	96.0
	ines 50 through 94 and 96 through 9	8)		124, 664	35, 048	
	Laboratory Services-Program only c			0	22, 2.0	201.0
	ne 200 minus line 201)	3 ([124, 664		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	Peri od: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 7/29/2021 2:33 pm

				To 12/31/2020	Date/Time Pre 7/29/2021 2:3	
No. DRF A - IMPATIBAT MOSPITAL SERVICES UNDER IPPS			Title XVIII	Hospi tal		<u> </u>
No. DRF A - IMPATIBAT MOSPITAL SERVICES UNDER IPPS					1 00	
1.00 BisS Amounts ofther than outli ier Payments for discharges occurring prior to October 1 (see 1, 203.464 1, 20		PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			1.00	
Instructions) 1. 00 DRG moments other than outlier payments for discharges occurring on or after October 1 (see Instructions) 1. 00 DRG for Federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0.		DRG Amounts Other than Outlier Payments			0	1
1.02 BRG amounts other than outlier payment for discharges occurring on or after October 1 (see instructions) 0.02 1.02	1. 01		ing prior to October 1	(see	14, 203, 464	1. 01
Instructions	1 02	1	ing on or after October	1 (see	6 476 774	1 02
1 (see instructions) 1.04 00	1.02		ring on or arter october	1 (300	0, 170, 771	1.02
1.04 October 1 (see instructions) 2.00 Outlier payements for discharges (see instructions) 2.00 Outlier payements for discharges (see instructions) 2.00 Outlier payements for discharges (see instructions) 3.00 0.0	1.03		or discharges occurring	prior to October	0	1.03
October 1 (see instructions) 2.00 Outlier payments for discharges (see instructions) 2.00 2.01 Outlier payments for discharges (see instructions) 3.00 2.01 2.02 2.01 2.0	1 04	1 ` '	or discharges occurring	on or after	0	1 04
2.01 Outlier reconciliation assuming 0 2.01	1.04		or discharges occurring	on or arter	O	1.04
2.02 2.03 Outlier payment for discharges for Model 4 BPCI (see instructions) 1,897 2.03 2.04 2.04 2.05					_	
2.03 Outlier payments for discharges occurring or on offero Ctober 1 (see instructions) 11,897 2.04			i ana)			1
2.04 Outlier payments for discharges occurring on or after October 1 (see instructions) 11,911 2.04					-	
Red days available divided by number of days in the cost reporting period (see instructions) 90.95 4.00		, , ,	•		· ·	
Indirect Medical Education Adjustment Country of all opathic and osteopathic programs for the most recent cost reporting period ending of or before 12/31/1996. (see Instructions)	3.00		,			3.00
FTE count for all opathic and osteopathic programs for the most recent cost reporting period ending of or before 12/31/19/96, (see instructions) 0.00 6.00	4.00		rting period (see instru	uctions)	90. 95	4.00
or before 12/31/1996, (see Instructions) 0. 0FE count for all lopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e) 7. 00 MMA Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(1) 8. 00 ACA \$5503 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions. 8. 00 Adjustment (Increase or decrease) to the FTE count for all opathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1999), and 67 FR 50069 (August 1, 2002). 8. 01 The amount of increase if the hospital was awarded FTE cap slots under \$5503 of the ACA. If the cost report straddles July 1, 2011, see instructions. 8. 02 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under \$5506 of ACA. (see instructions) 9. 05 Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8, 01 and 8, 02) (see 0.00 10.00 Instructions) 10. 00 FTE count for allopathic and osteopathic programs in the current year from your records 0.00 10.00 FTE count for residents in dental and pod atric programs. 10. 00 Criteriut year all lowable FTE count for the prior year. 10. 00 Criteriut year all lowable FTE count for the prior year. 10. 00 Sum of lines 5 plus with the program of the program of the program and the program of t	5 00		t recent cost reporting	port od opding or	0.00	5 00
6.00 FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e) 7.00 7.00 7.00 7.01 ACA \$5.503 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) If the 0.00 7.00 7.01 7.01 7.00	5.00		t recent cost reporting	perrod endring on	0.00	3.00
7.00 MMA Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) if the cost report straddles July 1, 2011 then see instructions. 0.00 40 street of the cost report straddles July 1, 2011 then see instructions. 0.00 40 street of the cost report straddles July 1, 2011 then see instructions. 0.00 40 street of the cost report straddles July 1, 2011 then see instructions. 0.00 8.00 8.00 Alj ustment (increase or decrease) to the FTE count for all opathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b). 413.79(c)(2)(iv). 64 FR 26340 (May 12, 1998), and 67 FR 50009 (August 1, 2002). 0.00 8.00 8.01 The amount of increase if the hospital was awarded FTE cap slots under \$5500 of ACA. (see Instructions) 0.00 8.01 9.00 Instructions Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see 0.00 9.00 10.00 FTE count for all opathic and osteopathic programs in the current year from your records 0.00 1.00 10.00 FTE count for all owable FTE (see instructions) 0.00 1.00 11.00 Current year allowable FTE count for the prior year. 0.00 1.00 12.00 Current year allowable FTE count for the program or hospital closure 0.00 1.00	6.00	FTE count for allopathic and osteopathic programs that meet t	he criteria for an add-o	on to the cap for	0.00	6.00
ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(8)(2) if the cost report straddles July 1, 2011 then see instructions.						
cost report straddles July 1, 2011 then see instructions. 8. 00 Adjustment (increase or decreases) to the FTE count for all opathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002). 8. 01 The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions. 8. 02 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions) 9. 00 Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see 0.00 9.00 instructions) 10. 00 FTE count for all opathic and osteopathic programs in the current year from your records 0.00 11.00 FTE count for residents in dental and podiatric programs. 0.00 11.00 Current year allowable FTE (see instructions) 13. 00 Total allowable FTE count for the penul timate year if that year ended on or after September 30, 1997, 0.00 14.00 Total allowable FTE count for the penul timate year if that year ended on or after September 30, 1997, 0.00 14.00 Total allowable FTE count for the penul timate year if that year ended on or after September 30, 1997, 0.00 14.00 Total allowable FTE count for the penul timate year if that year ended on or after September 30, 1997, 0.00 14.00 Total allowable FTE count for the penul timate year if that year ended on or after September 30, 1997, 0.00 14.00 Total allowable FTE count for the penul timate year if that year ended on or after September 30, 1997, 0.00 14.00 Total allowable graverage FTE count for the program 8. 14 16.00 Algustment for residents in initial years of the program 9. 0.00 15.00 Total allowable FTE count for the program 9. 0.00 15.00 Total allowable FTE count for the program 9. 0.00 15.00 Total 30		•				•
Agl Justment (Increase or decrease) to the FIE count for al lopathic and osteopathic programs for affiliated programs in accordance with 42 CER 413.75(b). 413.79(c)(2)(1)/, 64 FR 26340 (Way 12.1998), and 67 FR 50069 (August 1, 2002).	7.01		42 CFR 9412. 105(1)(1)(1	V)(B)(2) II the	0.00	7.01
1998 , and 67 FR 50000 (August 1, 2002).	8.00		thic and osteopathic pro	ograms for	0.00	8.00
8. 01 The amount of Increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report stradies July 1, 2011, see instructions. 20.00 8. 01			79(c)(2)(iv), 64 FR 263	40 (May 12,		
report straddles July 1, 2011, see instructions.	0 01		ats under & EEO2 of the	ACA If the cost	0.00	0.01
B. 02 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	6.01		ots under 9 5505 of the	ACA. II the cost	0.00	0.01
9.00 Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see 0.00 9.00 10.00 FTE count for all opathic and osteopathic programs in the current year from your records 0.00 10.00 10.00 FTE count for residents in dental and podiatric programs. 0.00 12.00 13.00 13.00 14.00	8. 02					8. 02
Instructions						
10.00 FTE count for allopathic and osteopathic programs in the current year from your records 0.00 10.00	9. 00					9.00
11.00 FTE count for residents in dental and podiatric programs. 0.00 11.00 12.00 12.00 13.00 15.00 1	10.00		ent vear from vour reco	rds	0.00	10.00
13.00 Total allowable FTE count for the prior year. 0.00 Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero. 0.00 14.00			ont year trom year tees.			
14.00 Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero. 15.00 Sum of lines 12 through 14 divided by 3. 0.00 15.00 16.00 Adjustment for residents in initial years of the program 8.14 16.00 17.00 Adjustment for residents displaced by program or hospital closure 0.00 17.00 18.00 Adjustment for residents displaced by program or hospital closure 0.00 17.00 18.00 Adjustment for residents displaced by program or hospital closure 0.00 17.00 18.00 Adjustment for resident to bed ratio (line 18 divided by line 4). 0.89500 19.	12.00	Current year allowable FTE (see instructions)			0. 00	12.00
Otherwise enter zero. Sum of lines 12 through 14 divided by 3. 0.00 15.00 15.00 16.00 Adj ustment for residents in initial years of the program 8.14 16.00 17.00 Adj ustment for residents displaced by program or hospital closure 0.00 17.00 17.00 Adj ustment for residents displaced by program or hospital closure 0.00 17.00 17.00 18.00 Adj ustment for residents displaced by program or hospital closure 0.00 17.00 18.00 Adj ustment for residents displaced by program or hospital closure 0.00 17.00 18.00 19.00		• •				
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16. 00 Adj ustment for residents in initial years of the program 8. 14 16. 00 17. 00 Adj ustment for residents displaced by program or hospital closure 0. 00 17. 00 18. 00 Adj ustment for residents displaced by program or hospital closure 8. 14 18. 00 18. 00 Adj ustment for residents displaced by program or hospital closure 0. 00 17. 00 19. 00 Current year resident to bed ratio (see instructions) 0. 089500 19. 00 20. 00 Prior year resident to bed ratio (see instructions) 0. 091905 20. 00 21. 00 Enter the lesser of lines 19 or 20 (see instructions) 986, 241 22. 00 22. 01 IME payment adj ustment (see instructions) 986, 241 22. 00 22. 01 IME payment adj ustment - Managed Care (see instructions) 20. 01 10 Indirect Medical Education Adj ustment for the Add-on for § 422 of the MMA 20. 01 23. 00 (f)(1)(iv)(C). 0. 00 24. 00 IME FTE Resident Count Over Cap (see instructions) 0. 00 25. 00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 0. 00 26. 00 Resi dent to bed ratio (divide line 25 by line 4)<	15. 00				0. 00	15.00
18.00 Adjusted rolling average FTE count 8.14 18.00 19.00 Current year resident to bed ratio (line 18 divided by line 4). 0.089500 19.00 20.00 Prior year resident to bed ratio (see instructions) 0.091905 20.00 21.00 Enter the lesser of lines 19 or 20 (see instructions) 0.089500 21.00 22.01 IME payment adjustment (see instructions) 986, 241 22.00 22.01 IME payment adjustment - Managed Care (see instructions) 201, 986 23.00 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA 23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 0.00 23.00 (f)(1)(iv)(c). 0.1 0.00 24.00 25.00 1f the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 25.00 26.00 Resident to bed ratio (divide line 25 by line 4) 0.000000 26.00 27.00 IME payments adjustment amount (see instructions) 0.000000 27.00 28.01 IME add-on adjustment amount (see instructions) 0.000000 27.00 29.01 Total IME payment - Managed Care (sum of lines 2	16.00	,			8. 14	16.00
19.00 Current year resident to bed ratio (line 18 divided by line 4). 0.089500 19.00 20.00 Prior year resident to bed ratio (see instructions) 0.091905 20.00 21.00 Enter the lesser of lines 19 or 20 (see instructions) 0.089500 21.00 22.00 IME payment adjustment (see instructions) 986, 241 22.00 22.01 IME payment adjustment - Managed Care (see instructions) 201, 986 22.01 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA 23.00 20.00 23.00 24.00 IME FTE Resident Count Over Cap (see instructions) 0.00 24.00 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 0.00 25.00 26.00 Resident to bed ratio (divide line 25 by line 4) 0.000000 26.00 27.00 IME payments adjustment factor. (see instructions) 0.00000 27.00 28.01 IME add-on adjustment amount (see instructions) 0.00000 27.00 28.01 IME add-on adjustment amount - Managed Care (see instructions) 0.28.01 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 201,986			sure			
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(f)(1)(iv)(C). 24.00 IME FTE Resident Count Over Cap (see instructions) 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 28.00 IME add-on adjustment amount (see instructions) 28.01 IME add-on adjustment amount (see instructions) 29.00 IME add-on adjustment amount - Managed Care (see instructions) 29.00 Total IME payment (sum of lines 22 and 28) 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 30.00 Sum of lines 30 and 31 31.00 Allowable disproportionate share percentage (see instructions) 6.84 33.00	22.00			SED 412 105	0.00	1 22 20
24.00 IME FTE Resident Count Over Cap (see instructions) 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 28.00 IME add-on adjustment amount (see instructions) 28.01 IME add-on adjustment amount - Managed Care (see instructions) 29.00 IME payment (sum of lines 22 and 28) 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 29.01 Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 30.00 Sum of lines 30 and 31 30.00 Allowable disproportionate share percentage (see instructions)	23.00		ent cap slots under 42 (JFR 412. 105	0.00	23.00
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27. 00 IME payments adjustment factor. (see instructions) 0.000000 27. 00 28. 00 IME add-on adjustment amount (see instructions) 0 28. 00 28. 01 IME add-on adjustment amount - Managed Care (see instructions) 0 28. 01 29. 00 Total IME payment (sum of lines 22 and 28) 986, 241 29. 00 29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 201, 986 29. 01 Disproportionate Share Adjustment 986, 241 29. 01 30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 4. 88 30. 00 31. 00 Percentage of Medicaid patient days (see instructions) 16. 49 31. 00 32. 00 Sum of lines 30 and 31 21. 37 32. 00 33. 00 Allowable disproportionate share percentage (see instructions) 6. 84 33. 00	0, 00	1				
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Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31.00 Percentage of Medicaid patient days (see instructions) 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 34.88 30.00 16.49 31.00 21.37 32.00 33.00 Allowable disproportionate share percentage (see instructions) 6.84 33.00		,	,			
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31.00 Percentage of Medicaid patient days (see instructions) 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 16.49 31.00 21.37 32.00 6.84 33.00	20.00		atlant days (lest)	ati ana)	4 00	20.00
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33.00 Allowable disproportionate share percentage (see instructions) 6.84 33.00						1
)			1
	34. 00	Disproportionate share adjustment (see instructions)			353, 632	34.00

CALCUI	Financial Systems GOOD SAMARITAN ATION OF REIMBURSEMENT SETTLEMENT	HOSPITAL Provider CCN: 15-0042	Peri od:	u of Form CMS-2 Worksheet E	ZJJZ-11
0712002	ATTOM OF RETHINGROLLIETT SETTEMENT	17007467 55% 15 5612	From 01/01/2020 To 12/31/2020	Part A	
		Title XVIII	Hospi tal	PPS	
			Prior to 10/1		
	Uncompensated Care Adjustment		1. 00	2. 00	
35. 00	Total uncompensated care amount (see instructions)		0	8, 290, 014, 521	35.00
35. 01	Factor 3 (see instructions)		0. 000000000	0. 000282312	
35. 02	Hospital uncompensated care payment (If line 34 is zero, ente	er zero on this line) (se	ee 2, 050, 815	2, 340, 371	35. 02
25 02	instructions)		1 525 210	F00, 000	25 00
	Pro rata share of the hospital uncompensated care payment amount Total uncompensated care (sum of columns 1 and 2 on line 35.0	,	1, 535, 310 2, 125, 212		35. 03 36. 00
30. 00	Additional payment for high percentage of ESRD beneficiary di				30.00
40. 00	Total Medicare discharges, excluding MS-DRGs 652, 682, 683, 6		0		40.00
	instructions)				
41. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 6	683, 684 an 685. (see	0		41.00
41. 01	instructions) Total ESPD Modicare covered and paid discharges evaluding MS	DDCc 652 692 692 694	1 0		41.01
+ I. UI	Total ESRD Medicare covered and paid discharges excluding MS- lan 685. (see instructions)	-שונטס טטע, טסט, סטיוש-	· "		41.0
42. 00	Divide line 41 by line 40 (if less than 10%, you do not quali	ify for adjustment)	0.00		42.00
43. 00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 68	82, 683, 684 an 685. (see	9 0		43.00
	instructions)				
44. 00	Ratio of average length of stay to one week (line 43 divided	by line 41 divided by 7	0. 000000		44.00
45. 00	days) Average weekly cost for dialysis treatments (see instructions	e)	0.00		45.00
46. 00	Total additional payment (line 45 times line 44 times line 41		0.00		46.00
47. 00	Subtotal (see instructions)	,	24, 199, 131		47.00
48. 00	Hospital specific payments (to be completed by SCH and MDH, s	small rural hospitals	25, 631, 657		48.00
	only. (see instructions)			A	
				Amount 1.00	
49. 00	Total payment for inpatient operating costs (see instructions	s)		25, 475, 512	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I ar)	1, 668, 826	1
51. 00	Exception payment for inpatient program capital (Wkst. L, Pt.	. III, see instructions)		0	51.00
52. 00	Direct graduate medical education payment (from Wkst. E-4, li	ine 49 see instructions).		430, 471	
53.00	Nursing and Allied Health Managed Care payment			14, 973	•
54.00	Special add-on payments for new technologies			143, 296	1
54. 01 55. 00	Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6	(0)		0	
56.00	Cost of physicians' services in a teaching hospital (see intr			0	
57. 00	Routine service other pass through costs (from Wkst. D, Pt. I		through 35).	0	
58. 00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 11 line 200)		56, 164	58.00
59. 00	Total (sum of amounts on lines 49 through 58)			27, 789, 242	59.00
	Primary payer payments			4, 562	
61.00	Total amount payable for program beneficiaries (line 59 minus	s line 60)		27, 784, 680	
62.00	Deductibles billed to program beneficiaries			2, 429, 196	
53.00	Coinsurance billed to program beneficiaries			25, 696	1
54. 00 55. 00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			365, 951 237, 868	
56.00	Allowable bad debts for dual eligible beneficiaries (see inst	tructions)		135, 130	
57.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			25, 567, 656	
68. 00	Credits received from manufacturers for replaced devices for	applicable to MS-DRGs (s	see instructions)	0	
59. 00	Outlier payments reconciliation (sum of lines 93, 95 and 96).	.(For SCH see instruction	ns)	0	69.00
70. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	1
70. 50	Rural Community Hospital Demonstration Project (§410A Demonst	, ,	instructions)	0	
70. 87 70. 88	Demonstration payment adjustment amount before sequestration			0	
70. 88 70. 89	SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see inst	tructions)		0	70.8
70. 90	HSP bonus payment HVBP adjustment amount (see instructions)			-1, 374	1
70. 91	HSP bonus payment HRR adjustment amount (see instructions)			-7, 440	
	Bundled Model 1 discount amount (see instructions)			0	
70. 92				-	•
70. 92	HVBP payment adjustment amount (see instructions)			-41, 100	70. 9
70. 92 70. 93 70. 94	1			-144, 910	

alth Financial Systems GOOD SAMA	ARITAN HOSPITAL		In Lieu	u of Form CMS-:	255
LCULATION OF REIMBURSEMENT SETTLEMENT	Provi der C	F	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Pre 7/29/2021 2:3	epar
	Title	XVIII	Hospi tal	PPS	,5 p
			(уууу)	Amount	
			0	1. 00	
.96 Low volume adjustment for federal fiscal year (yyyy) (E	Enter in column O		0	0	70
the corresponding federal year for the period prior to	10/1)				
0.97 Low volume adjustment for federal fiscal year (yyyy) (E			0	0	70
the corresponding federal year for the period ending or	n or after 10/1)				۱.,
0.98 Low Volume Payment-3				0	
0.99 HAC adjustment amount (see instructions)	11 (0 0 70)			270, 928	
.00 Amount due provider (line 67 minus lines 68 plus/minus	Tines 69 & 70)			25, 101, 904	
.01 Sequestration adjustment (see instructions)	4!			165, 673	
.02 Demonstration payment adjustment amount after sequestra	ation			0	1 '
.03 Sequestration adjustment-PARHM pass-throughs				24, 081, 850	7 7:
.00 Interim payments .01 Interim payments-PARHM				24, 061, 630	7
.00 Tentative settlement (for contractor use only)				0	
.01 Tentative settlement-PARHM (for contractor use only)				U	Ί,
.00 Balance due provider/program (line 71 minus lines 71.01	1 71 02 72 and			854, 381	
73)	1, 71.02, 72, and			034, 301	′
.01 Balance due provider/program-PARHM (see instructions)					7
.00 Protested amounts (nonallowable cost report items) in a	accordance with			570, 675	
CMS Pub. 15-2, chapter 1, §115.2	accordance with			370,073	′
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					1
Operating outlier amount from Wkst. E, Pt. A, line 2, c	or sum of 2.03			0	9
plus 2.04 (see instructions)					
.00 Capital outlier from Wkst. L, Pt. I, line 2				0	9
.00 Operating outlier reconciliation adjustment amount (see	e instructions)			0	9
00 Capital outlier reconciliation adjustment amount (see i	nstructions)			0	9
.00 The rate used to calculate the time value of money (see	e instructions)			0.00	9
.00 Time value of money for operating expenses (see instruc	ctions)			0	9
.00 Time value of money for capital related expenses (see i	nstructions)			0	9
				On/After 10/1	
			1. 00	2. 00	╄
HSP Bonus Payment Amount					4
0.00 HSP bonus amount (see instructions)			804, 328	270, 067	_110
HVBP Adjustment for HSP Bonus Payment			1 0010110050	0.00000/4500	4
1.00 HVBP adjustment factor (see instructions)			1. 0013449050	0. 9909061528	
2.00 HVBP adjustment amount for HSP bonus payment (see instr	ructions)		1, 082	-2, 456	110
HRR Adjustment for HSP Bonus Payment			0.0000	0.0007	4.0
3.00 HRR adjustment factor (see instructions)	ioti ana)		0. 9932	0. 9927	
4.00 HRR adjustment amount for HSP bonus payment (see instru		io+mon+	-5, 469	-1, 971	110
Rural Community Hospital Demonstration Project (§410A D					1201
0.00 Is this the first year of the current 5-year demonstrat	tion period under	the ZIST			200
Century Cures Act? Enter "Y" for yes or "N" for no.					4
Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. I	L line 40)				20
1.00 Medicare inpatient service costs (from wkst. D-1, Pt. 1 2.00 Medicare discharges (see instructions)	1, 1111e 49)				20
13.00 Case-mix adjustment factor (see instructions)					20
a managa man gurua unchi raciul lace lla luctiula l			1		140

	1.00	2. 00	
HSP Bonus Payment Amount	1.00	2.00	
100.00 HSP bonus amount (see instructions)	804, 328	270, 067	100 00
HVBP Adjustment for HSP Bonus Payment	00 17 020	2.0700.	1.00.00
101.00 HVBP adjustment factor (see instructions)	1. 0013449050	0. 9909061528	101.00
102.00 HVBP adjustment amount for HSP bonus payment (see instructions)	1, 082		102.00
HRR Adjustment for HSP Bonus Payment	,	, , , , ,	
103.00 HRR adjustment factor (see instructions)	0. 9932	0. 9927	103.00
104.00 HRR adjustment amount for HSP bonus payment (see instructions)	-5, 469	-1, 971	104.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00 Is this the first year of the current 5-year demonstration period under the 21st			200.00
Century Cures Act? Enter "Y" for yes or "N" for no.		ļ	
Cost Reimbursement			
201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00 Medicare discharges (see instructions)		ļ	202.00
203.00 Case-mix adjustment factor (see instructions)			203. 00
Computation of Demonstration Target Amount Limitation (N/A in first year of the curren	t 5-year demons	trati on	
peri od)			
204.00 Medicare target amount			204. 00
205.00 Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00 Medicare inpatient routine cost cap (line 202 times line 205)			206. 00
Adjustment to Medicare Part A Inpatient Reimbursement			
207.00 Program reimbursement under the §410A Demonstration (see instructions)			207. 00
208.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00 Adjustment to Medicare IPPS payments (see instructions)			209. 00
210.00 Reserved for future use			210.00
211.00 Total adjustment to Medicare IPPS payments (see instructions)			211. 00
Comparision of PPS versus Cost Reimbursement	1		4
212.00 Total adjustment to Medicare Part A IPPS payments (from line 211)			212. 00
213.00 Low-volume adjustment (see instructions)			213. 00
218.00 Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement)		ļ	218. 00
(line 212 minus line 213) (see instructions)		ļ	

Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 | Peri od: | Worksheet E | From 01/01/2020 | Part A Exhi bit 4 | To | 12/31/2020 | Date/Time Prepared: Provider CCN: 15-0042

							7/29/2021 2:3	3 pm
	·				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	1. 00	0	0	0	0	0	1.00
1. 01	payments DRG amounts other than outlier payments for discharges	1. 01	14, 203, 464	0	14, 203, 464		14, 203, 464	1. 01
1. 02	occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	6, 476, 774	0		6, 476, 774	6, 476, 774	1. 02
1. 03	1 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 discharges (see instructions)	2. 00						2. 00
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	0	0	0	0	0	2. 01
2. 02	Outlier payments for discharges occurring prior to	2. 03	41, 897	0	41, 897		41, 897	2. 02
2. 03	October 1 (see instructions) Outlier payments for discharges occurring on or after October 1 (see	2.04	11, 911	0		11, 911	11, 911	2. 03
3. 00	instructions) Operating outlier	2. 01	0	0	0	0	0	3. 00
4. 00	reconciliation Managed care simulated payments	3. 00	4, 235, 401	0	3, 132, 889	1, 102, 512	4, 235, 401	4. 00
	Indirect Medical Education Adju	ustment						
5. 00	Amount from Worksheet E, Part A, line 21 (see instructions)	21. 00	0. 089500	0. 089500	0. 089500	0. 089500		5. 00
6. 00	IME payment adjustment (see instructions)	22. 00	986, 241	0	677, 364	308, 877	986, 241	6. 00
6. 01	IME payment adjustment for managed care (see	22. 01	201, 986	0	149, 407	52, 579	201, 986	6. 01
	instructions) Indirect Medical Education Adju	ustment for the	Add-on for Se	ection 422 of t	the MMA			
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	O	0	0	O	0	8. 01
9. 00	Total IME payment (sum of lines 6 and 8)	29. 00	986, 241	0	677, 364	308, 877	986, 241	9. 00
9. 01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	201, 986	0	149, 407	52, 579	201, 986	9. 01
	Disproportionate Share Adjustmo	ent						
10.00	Allowable disproportionate share percentage (see instructions)	33. 00	0. 0684	0. 0684	0. 0684	0. 0684		10.00
11. 00	Disproportionate share adjustment (see instructions)	34. 00	353, 632	0	242, 879	110, 753	353, 632	11.00
11. 01	Uncompensated care payments Additional payment for high per	36.00	2,125,212 RD beneficiary	di scharges	1, 535, 310	589, 902	2, 125, 212	11. 01
12. 00	Total ESRD additional payment (see instructions)	46. 00	0	0 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	24, 199, 131 25, 631, 657	0	16, 700, 914 0	7, 498, 217 0	24, 199, 131 0	ı
15. 00	(see instructions) Total payment for inpatient operating costs (see instructions)	49. 00	25, 475, 512	0	17, 924, 716	7, 550, 796	25, 475, 512	15. 00

LOW VC	DLUME CALCULATION EXHIBIT 4					Period: From 01/01/2020 To 12/31/2020	Date/Time Pre 7/29/2021 2:3	pared:
					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	
16. 00	Payment for inpatient program	50.00	1, 668, 826	2.00			1, 668, 826	16. 00
	capital (from Wkst. L, Pt. I, if applicable)				1,171,00			
17. 00	Special add-on payments for new technologies	54. 00	143, 296	0		0 143, 296	143, 296	
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
18. 00	Capital outlier reconciliation adjustment amount (see linstructions)		О	0		0 0	0	18. 00
19. 00	1			0	19, 099, 28	8, 188, 351	27, 287, 634	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, 574, 757 0	0	1, 107, 59	2 467, 165 0 0	1, 574, 757 0	20.00
21. 00 21. 01	Capital DRG outlier payments Model 4 BPCI Capital DRG outlier payments	2. 00 2. 01	20, 528 0	0	15, 25	5, 277 0 0	20, 528 0	21. 00 21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0467	0. 0467	0. 046	0. 0467		22.00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	73, 541	0	51, 72	21, 817	73, 541	23. 00
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, 668, 826	O	1, 174, 56	494, 259	1, 668, 826	26. 00
		W/S E, Part A line	(Amounts to E, Part A)					
	T	0	1. 00	2. 00	3. 00	4. 00	5. 00	
27. 00 28. 00	Low volume adjustment factor Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 96			0. 00000	0.000000	0	27. 00 28. 00
29. 00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 97				0	0	29. 00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100. 00

From 01/01/2020 Part A Exhibit 5 Date/Time Prepared: 7/29/2021 2:33 pm 12/31/2020 Hospi tal Title XVIII PPS 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 14, 203, 464 14, 203, 464 14, 203, 464 1.01 discharges occurring prior to October 1 1 02 DRG amounts other than outlier payments for 1 02 6.476.774 6, 476, 774 6, 476, 774 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 2.00 instructions) 2.01 Outlier payments for discharges for Model 4 2.02 0 2.01 **BPCI** 41, 897 2.02 41, 897 41, 897 2.02 Outlier payments for discharges occurring 2.03 prior to October 1 (see instructions) Outlier payments for discharges occurring on 2.03 2.04 11, 911 11, 911 11, 911 2.03 or after October 1 (see instructions) 3.00 Operating outlier reconciliation 2.01 3.00 Managed care simulated payments 4, 235, 401 3, 132, 889 1, 102, 512 4, 235, 401 4.00 3.00 4.00 Indirect Medical Education Adjustment 5.00 Amount from Worksheet E, Part A, line 21 21.00 0.089500 0.089500 0.089500 5.00 (see instructions) 6.00 IME payment adjustment (see instructions) 22.00 986, 241 677, 364 308, 877 986, 241 6.00 6.01 IME payment adjustment for managed care (see 22.01 201, 986 149, 407 52, 579 201, 986 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) 8.00 IME adjustment (see instructions) 28.00 0 8.00 0 0 IME payment adjustment add on for managed O 28 01 0 8 01 8 01 Ω care (see instructions) 9.00 Total IME payment (sum of lines 6 and 8) 29.00 986, 241 677, 364 308, 877 986, 241 9.00 149, 407 Total IME payment for managed care (sum of 9.01 29.01 201, 986 52, 579 201, 986 9.01 lines 6.01 and 8.01) Disproportionate Share Adjustment 10.00 Allowable disproportionate share percentage 33.00 0.0684 0.0684 0.0684 10.00 (see instructions) 11.00 Di sproporti onate share adjustment (see 34.00 353, 632 242, 879 110, 753 353, 632 11.00 instructions) 589, 902 11.01 36 00 2, 125, 212 1, 535, 310 2, 125, 212 Uncompensated care payments 11.01 Additional payment for high percentage of ESRD beneficiary discharges 12.00 Total ESRD additional payment (see 46.00 12.00 instructions) 16, 700, 914 47.00 24, 199, 131 7.498.217 24, 199, 131 13.00 Subtotal (see instructions) 13.00 14.00 Hospital specific payments (completed by SCH 48.00 25, 631, 657 17, 522, 949 8, 108, 708 25, 631, 657 14.00 and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs 8, 008, 664 25, 475, 512 15 00 49 00 25 475 512 17 466 848 15 00 (see instructions) 16.00 Payment for inpatient program capital (from 50.00 1, 668, 826 1, 174, 567 494, 259 1,668,826 16.00 Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for new technologies 54.00 143, 296 0 143, 296 143, 296 17.00 17.01 Net organ acquisition cost 17.01 17.02 Credits received from manufacturers for 68.00 0 0 Λ 17.02 replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment 93.00 0 18.00 amount (see instructions) 19.00 SUBTOTAL 18. 641. 415 8, 646, 219 27, 287, 634 19.00

Heal th	Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	ATION EXHIBIT 5	Provider C		Period: From 01/01/2020 To 12/31/2020		pared:
			Ti tl e	e XVIII	Hospi tal	PPS	
		Wkst. L, line	(Amt. from				
			Wkst. L)				
		0	1.00	2.00	3. 00	4. 00	
20.00	Capital DRG other than outlier	1. 00	1, 574, 757	1, 107, 59	2 467, 165	1, 574, 757	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1. 01	(0	0	20. 01
21.00	Capital DRG outlier payments	2. 00	20, 528	15, 25	1 5, 277	20, 528	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2. 01	(0	0	21.01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0467	0. 046	0. 0467		22. 00
23. 00	Indirect medical education adjustment (see	6. 00	73, 541	51, 72	4 21, 817	73, 541	23. 00

	instructions)						
24.00	Allowable disproportionate share percentage	10. 00	0. 0000	0.0000	0. 0000		24.00
	(see instructions)						
25.00	Disproportionate share adjustment (see	11. 00	0	0	0	0	25. 00
	instructions)						
26. 00	Total prospective capital payments (see	12. 00	1, 668, 826	1, 174, 567	494, 259	1, 668, 826	26. 00
	instructions)						
		Wkst. E, Pt.	(Amt. from				
		A, line	Wkst. E, Pt.				
			A)				
		0	1. 00	2. 00	3. 00	4. 00	
27. 00							27. 00
28. 00	Low volume adjustment prior to October 1	70. 96	0	0		0	
29. 00	Low volume adjustment on or after October 1	70. 97	0		0	0	29. 00
30. 00	HVBP payment adjustment (see instructions)	70. 93	-41, 100	19, 102	-60, 202	-41, 100	30.00
30. 01	HVBP payment adjustment for HSP bonus	70. 90	-1, 374	1, 082	-2, 456	-1, 374	30. 01
21 00	payment (see instructions)	70.04	144 010	0/ 504	40.007	144 010	21 00
31.00	HRR adjustment (see instructions)	70. 94	-144, 910	· ·			
31. 01	HRR adjustment for HSP bonus payment (see instructions)	70. 91	-7, 440	-5, 469	-1, 971	-7, 440	31. 01
	Thisti detrons)					(Amt. to	
						Wkst. E, Pt.	
						A)	
		0	1. 00	2. 00	3. 00	4. 00	
32. 00	HAC Reduction Program adjustment (see	70. 99		185, 595	85, 333	270, 928	32.00
	instructions)						
100.00	Transfer HAC Reduction Program adjustment to		Υ				100.00
	Wkst. E, Pt. A.						
						-	

Health Financial Systems	GOOD SAMARITAN HOSPITAL	In Lieu	of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0042	Peri od: From 01/01/2020 To 12/31/2020	Worksheet E Part B Date/Time Prepared: 7/29/2021 2:33 pm

		Title XVIII	Hospi tal	7/29/2021 2: 3 PPS	3 pm
	DADT D. MEDICAL AND OTHER HEALTH CERVICES			1. 00	
1. 00	PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions)			6, 302	1.00
2. 00	Medical and other services (see Fristraetrons)	ns)		27, 177, 506	
3.00	OPPS payments			25, 099, 101	
4.00	Outlier payment (see instructions)			35, 877	
4. 01	Outlier reconciliation amount (see instructions)			0	
5.00	Enter the hospital specific payment to cost ratio (see instruction	ons)		0.000	
6. 00 7. 00	Line 2 times line 5			0.00	
8. 00	Sum of lines 3, 4, and 4.01, divided by line 6 Transitional corridor payment (see instructions)			0.00	1
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV,	col. 13. line 200		26, 604	
10.00	Organ acquisitions			0	1
11.00	Total cost (sum of lines 1 and 10) (see instructions)			6, 302	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
10.00	Reasonable charges			22.041	10.00
12. 00 13. 00	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line	60)		22, 041 0	
14. 00	Total reasonable charges (sum of lines 12 and 13)	04)		22, 041	
00	Customary charges			22/011	1 00
15.00	Aggregate amount actually collected from patients liable for pay	ment for services on	a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for p	ayment for services o	on a chargebasis	0	16. 00
47.00	had such payment been made in accordance with 42 CFR §413.13(e)			0 000000	47.00
17. 00 18. 00	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions)			0. 000000 22, 041	
19. 00	Excess of customary charges over reasonable cost (complete only	if line 18 exceeds li	ne 11) (see	15, 739	
17.00	instructions)	TT TIME TO CACCCUS TT	110 11) (300	10,707	17.00
20.00	Excess of reasonable cost over customary charges (complete only	if line 11 exceeds li	ne 18) (see	0	20.00
	instructions)				
21. 00	Lesser of cost or charges (see instructions)			6, 302	1
	Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see instruc	tions)		0 0	
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	ti ons)		25, 161, 582	1
2 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			207 1017 002	200
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)			0	25. 00
26.00	Deductibles and Coinsurance amounts relating to amount on line 2			4, 722, 796	1
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus	s the sum of lines 22	2 and 23] (see	20, 445, 088	27. 00
28. 00	<pre>instructions) Direct graduate medical education payments (from Wkst. E-4, line</pre>	50)		324, 697	28. 00
	ESRD direct medical education costs (from Wkst. E-4, line 36)	50)		324, 097	
30.00	Subtotal (sum of lines 27 through 29)			20, 769, 785	
31.00	Pri mary payer payments			3, 850	31.00
32.00	Subtotal (line 30 minus line 31)			20, 765, 935	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)			0 766, 401	
	Adjusted reimbursable bad debts (see instructions)			498, 161	
	Allowable bad debts for dual eligible beneficiaries (see instruc	tions)		400, 976	
37.00	Subtotal (see instructions)			21, 264, 096	
	MSP-LCC reconciliation amount from PS&R			-28	
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
39. 50 39. 97	Prioneer ACO demonstration payment adjustment (see instructions)			_	39.50
39. 97 39. 98	Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replaced	devices (see instruc	ctions)	0	1
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	acvices (see institut	, (1 0113)	0	
	Subtotal (see instructions)			21, 264, 124	1
40. 01	Sequestration adjustment (see instructions)			140, 343	40. 01
40. 02	Demonstration payment adjustment amount after sequestration			0	
	Sequestration adjustment-PARHM pass-throughs			20 202 2=-	40. 03
	Interim payments			20, 900, 870	
41.01	Interim payments-PARHM Tentative settlement (for contractors use only)			0	41.01
42. 01					42.01
43.00	Balance due provider/program (see instructions)			222, 911	1
43. 01	Balance due provider/program-PARHM (see instructions)				43. 01
44.00	Protested amounts (nonallowable cost report items) in accordance	with CMS Pub. 15-2,	chapter 1,	0	44.00
	§115. 2				-
90 00	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)			0	90.00
	Outlier reconciliation adjustment amount (see instructions)			0	1
	The rate used to calculate the Time Value of Money			0.00	
	Time Value of Money (see instructions)			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	Provider CCN: 15-0042	Peri od:	Worksheet E
	Component CCN: 15-S042	From 01/01/2020 To 12/31/2020	
	30mponent 30m 15 3012	10 12/01/2020	7/29/2021 2: 33 pm
	Title XVIII	Subprovi der -	PPS

		itle XVIII	Subprovi der -	PPS	
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1. 00	
1. 00	Medical and other services (see instructions)			218	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			1, 484	2.00
3.00	OPPS payments			2, 889	
4.00	Outlier payment (see instructions)			0	
4. 01 5. 00	Outlier reconciliation amount (see instructions)			0 0. 000	
6. 00	Enter the hospital specific payment to cost ratio (see instructions) Line 2 times line 5			0.000	1
7. 00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
8. 00	Transitional corridor payment (see instructions)			0	
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col.	13, line 200		1	9. 00
10.00	Organ acqui si ti ons			0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			218	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES				1
12. 00	Reasonable charges Ancillary service charges			780	12.00
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			0	1
	Total reasonable charges (sum of lines 12 and 13)			780	
	Customary charges				
15. 00	Aggregate amount actually collected from patients liable for payment		~	0	
16. 00	Amounts that would have been realized from patients liable for paymer	nt for services (on a chargebasis	0	16. 00
17 00	had such payment been made in accordance with 42 CFR §413.13(e)			0.000000	17.00
17. 00 18. 00	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions)			0. 000000 780	1
19. 00	Excess of customary charges over reasonable cost (complete only if li	ne 18 exceeds L	ine 11) (see	562	
	instructions)		, (555		.,
20.00	Excess of reasonable cost over customary charges (complete only if li	ne 11 exceeds I	ine 18) (see	0	20.00
	instructions)				
21. 00	Lesser of cost or charges (see instructions)			218	
	Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see instructions	e)		0	22. 00 23. 00
	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	>)		2, 890	
21.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			2,070	21.00
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)			0	25.00
	Deductibles and Coinsurance amounts relating to amount on line 24 (for			461	26.00
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the	e sum of lines 2	2 and 23] (see	2, 647	27. 00
28. 00	<pre>instructions) Direct graduate medical education payments (from Wkst. E-4, line 50)</pre>			0	28.00
	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	1
	Subtotal (sum of lines 27 through 29)			2, 647	1
	Primary payer payments			0	1
	Subtotal (line 30 minus line 31)			2, 647	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
	Composite rate ESRD (from Wkst. I-5, line 11)			0	
	Allowable bad debts (see instructions)			0	
	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions	e)		0	
	Subtotal (see instructions)	>)		2, 647	
	MSP-LCC reconciliation amount from PS&R			· ·	38.00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)			1	39. 50
39. 97	Demonstration payment adjustment amount before sequestration			0	
39. 98	Partial or full credits received from manufacturers for replaced devi	ces (see instru	ctions)	0	
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	
40. 00 40. 01	Subtotal (see instructions) Sequestration adjustment (see instructions)			2, 647 17	1
40. 01	Demonstration payment adjustment amount after sequestration			0	1
	Sequestration adjustment-PARHM pass-throughs				40.03
	Interim payments			2, 565	
41.01	Interim payments-PARHM				41.01
	Tentative settlement (for contractors use only)			0	
42. 01	Tentative settlement-PARHM (for contractor use only)				42. 01
43.00	Balance due provider/program (see instructions)			65	
43. 01	Balance due provider/program-PARHM (see instructions)	n CMS Dub 1E 2	chapter 1	_	43.01
44. 00	Protested amounts (nonallowable cost report items) in accordance with §115.2	1 UNO PUD. 10-2,	chapter I,	0	44.00
	TO BE COMPLETED BY CONTRACTOR				1
90.00	Original outlier amount (see instructions)			0	90.00
91. 00	Outlier reconciliation adjustment amount (see instructions)			0	
	The rate used to calculate the Time Value of Money			0.00	1
93.00	Time Value of Money (see instructions)			0	
94.00	Total (sum of lines 91 and 93)		l	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	Peri od: From 01/01/2020	Worksheet E
	Component CCN: 15-T042		Date/Time Prepared: 7/29/2021 2:33 pm
	Title XVIII	Subprovi der -	PPS

	litle XVIII	Subprovi der - I RF	PPS	
			1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		1.00	
1.00	Medical and other services (see instructions)		140	1.00
2. 00	Medical and other services reimbursed under OPPS (see instructions)		918	2.00
3. 00	OPPS payments		820	3.00
4.00	Outlier payment (see instructions)		0	4.00
4. 01 5. 00	Outlier reconciliation amount (see instructions) Enter the hospital specific payment to cost ratio (see instructions)		0.000	4. 01 5. 00
6. 00	Line 2 times line 5		0.000	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)		0	8. 00
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		1	9. 00
10.00			0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES		140	11.00
	Reasonable charges			
12.00	-		488	12.00
13.00			0	13.00
14.00			488	14.00
45.00	Customary charges			45.00
15. 00 16. 00	1 3 3	•	0	15. 00 16. 00
10.00	Amounts that would have been realized from patients liable for payment for services had such payment been made in accordance with 42 CFR §413.13(e)	on a chargebasis	٥	10.00
17. 00			0. 000000	17.00
18. 00	· · · · · · · · · · · · · · · · · · ·		488	18. 00
19. 00		ine 11) (see	348	19. 00
00.00	instructions)	1 10)		00.00
20. 00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds linstructions)	ine 18) (see	0	20.00
21. 00			140	21.00
22. 00	· · · · · · · · · · · · · · · · · · ·		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00			821	24.00
25.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		0	25 00
25. 00 26. 00	,	ructions)	0 109	25. 00 26. 00
27. 00	9		852	27.00
27.00	instructions)	.2 dia 20] (300	002	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28. 00
29. 00			0	29. 00
30.00	, ,		852	30.00
31. 00 32. 00			0 852	31. 00 32. 00
32.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		032	32.00
33.00			0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35. 00	, ,		0	35.00
36.00	· · · · · · · · · · · · · · · · · · ·		0 852	36.00
37. 00 38. 00			0	37. 00 38. 00
39. 00			Ö	39.00
39. 50				39. 50
39. 97			0	39. 97
39. 98	· · · · · · · · · · · · · · · · · · ·	icti ons)	0	39. 98
39. 99 40. 00			0 852	39. 99 40. 00
40. 00			652	40.00
40. 02			Ö	40. 02
40. 03				40.03
41. 00			846	
41. 01				41.01
42. 00 42. 01	,		0	42.00
43. 00	, ,,,		0	42. 01 43. 00
43. 01				43. 01
44. 00		chapter 1,	0	44.00
	§115. 2	·		
00.00	TO BE COMPLETED BY CONTRACTOR		-	00.00
90.00	, ,		0	90.00
91. 00 92. 00	· · · · · · · · · · · · · · · · · · ·		0.00	91. 00 92. 00
93. 00			0.00	93.00
	Total (sum of lines 91 and 93)		o	94.00

Health Financial Systems GOOD ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Peri od: Worksheet E-1
From 01/01/2020 Part I
To 12/31/2020 Date/Time Prepared: 7/29/2021 2:33 pm Provider CCN: 15-0042

					7/29/2021 2: 3	3 pm
	<u> </u>		XVIII	Hospi tal	PPS	
		Inpatien	it Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		23, 780, 323	3	20, 285, 633	1.00
2. 00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for		()	0	2.00
	services rendered in the cost reporting period. If none, write "NONE" or enter a zero					
3. 00	List separately each retroactive lump sum adjustment					3. 00
3.00	amount based on subsequent revision of the interim rate					3.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER	12/31/2020	243, 427	12/31/2020	567, 937	3. 01
3. 02		09/04/2020	58, 100		47, 300	3. 02
3. 03					0	3. 03
3. 04					l	3. 04
3. 05			1		O	3. 05
	Provider to Program			'		
3.50	ADJUSTMENTS TO PROGRAM		()	0	3.50
3.51					0	3.51
3.52					0	3.52
3.53					0	3.53
3.54					0	3.54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		301, 527	7	615, 237	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		24, 081, 850)	20, 900, 870	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR		T			
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)					
E 01	Program to Provider TENTATIVE TO PROVIDER				0	5. 01
5. 01 5. 02	TENTATIVE TO PROVIDER					5. 01
5. 02						5. 02
5.05	Provider to Program			<u>'</u>	U	5.05
5. 50	TENTATI VE TO PROGRAM			1	0	5. 50
5. 51	TENTATI VE TO TROGRAM					5. 51
5. 52						5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines					5. 99
3. 77	5. 50-5. 98)					3. 77
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		854, 381		222, 911	6. 01
6. 02	SETTLEMENT TO PROGRAM		(0	6. 02
7. 00	Total Medicare program liability (see instructions)		24, 936, 231		21, 123, 781	7. 00
	,		.,, 20	Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
			0	1. 00	2.00	
8. 00	Name of Contractor					8. 00

Health Financial Systems	GOOD	SAMARI TAN	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
ANALYSIS OF PAYMENTS TO PROVIDERS FOR	SERVICES RENDERED		Provi der CCN: 15-0042	Peri od: From 01/01/2020	Worksheet E-1 Part I	
			Component CCN: 15-S042	To 12/31/2020	Date/Time Pre 7/29/2021 2:3	
			Title XVIII	Subprovi der -	PPS	
				I PF		
			Inpatient Part A	Par	t B	

		litie	XVIII	Subprovider -	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	
1.00	Total interim payments paid to provider		996, 314		2, 565	1. 0
2.00	Interim payments payable on individual bills, either		C		0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
3. 00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment					3. 0
3.00	amount based on subsequent revision of the interim rate					3.0
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER		C		0	3.0
3. 02			C		0	3. 02
3. 03			C		0	3. 0
3. 04 3. 05			C		0 0	3.0
3.05	Provider to Program		С)	U	3. 0!
3. 50	ADJUSTMENTS TO PROGRAM		C		0	3. 50
3. 51	ADSOSTMENTS TO TROOKAWI					3.5
3. 52			C		0	3. 5:
3. 53			C		0	3. 5
3.54			C		0	3.54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		C		0	3. 9
	3. 50-3. 98)		00/ 04/		0.545	
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		996, 314		2, 565	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)					
	Program to Provider				_	
5. 01	TENTATI VE TO PROVI DER		C		0	5.0
5. 02 5. 03			(0 0	5. 02 5. 03
5. 03	Provider to Program			<u>/ </u>	0	5.0.
5. 50	TENTATI VE TO PROGRAM		C		0	5. 50
5. 51			C		0	5. 5
5. 52			C		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		C)	0	5. 9
	5. 50-5. 98)					
6. 00	Determined net settlement amount (balance due) based on					6. 00
6. 01	the cost report. (1) SETTLEMENT TO PROVIDER		112 010		65	4 0
6. 01	SETTLEMENT TO PROVIDER		112, 819 (05	6. 0°
7. 00	Total Medicare program liability (see instructions)		1, 109, 133		2, 630	7.00
	Trotal mod. od. o program readerity (odo enote dottollo)		1, 107, 100	Contractor	NPR Date	,. 00
				Number	(Mo/Day/Yr)	
		()	1. 00	2. 00	
8. 00	Name of Contractor	l				8.00

Health Financial Systems	GOOD SAMARITAN	HOSPI TAL	In Lieu	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO PROVIDERS FOR S	SERVI CES RENDERED	Provi der CCN: 15-0042	Peri od: From 01/01/2020	Worksheet E-1 Part I
		Component CCN: 15-T042	To 12/31/2020	Date/Time Prepared: 7/29/2021 2:33 pm
		Title XVIII	Subprovi der -	PPS
			IRF	
		Inpatient Part A	Par	t B

		Titl∈	xVIII	Subprovi der - I RF	PPS	
		Inpatier	it Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1. 00	Total interim payments paid to provider		8, 182, 772	2	846	1. 00
2.00	Interim payments payable on individual bills, either		C)	0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none, write "NONE" or enter a zero					
3. 00	List separately each retroactive lump sum adjustment					3. 00
3.00	amount based on subsequent revision of the interim rate					3.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER		C		0	3. 01
3. 02			C		0	3. 02
3. 03 3. 04					0 0	3. 03 3. 04
3. 04						3. 04
3. 03	Provider to Program			'	0	3.03
3. 50	ADJUSTMENTS TO PROGRAM				0	3. 50
3. 51)	0	3. 51
3.52			[c)	0	3. 52
3. 53			C		0	3. 53
3. 54			C		0	3.54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		C)	0	3. 99
4. 00	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99)		8, 182, 772	,	846	4. 00
4.00	(transfer to Wkst. E or Wkst. E-3, line and column as		0, 102, 772	-	040	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) Program to Provider					
5. 01	TENTATIVE TO PROVIDER	T			1 0	5. 01
5. 01	TENTATIVE TO PROVIDER					5. 02
5. 03					l ő	5. 03
	Provider to Program	'		•		
5.50	TENTATI VE TO PROGRAM		C)	0	5. 50
5. 51			C		0	5. 51
5. 52			C		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		C)	0	5. 99
4 00	[5.50-5.98] Determined net settlement amount (balance due) based on					6. 00
6. 00	the cost report. (1)					0.00
6. 01	SETTLEMENT TO PROVIDER		40, 781		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		, , , , , , , , , , , , , , , , , , ,		l ol	6. 02
7. 00	Total Medicare program liability (see instructions)		8, 223, 553	3	846	7. 00
				Contractor	NPR Date	
			2	Number	(Mo/Day/Yr)	
9.00	Name of Contractor		0	1. 00	2. 00	0.00
8. 00	Name of Contractor	I		I	1	8. 00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-0042 From 01/01/2020 To 12/31/2020 Date/Time Prepared: 7/29/2021 2: 33 pm Title XVIII Hospital PPS To 12/31/2020 To 12/31/2020 To 12/31/2020 To 12/31/2020 To 12/31/2020 To 12/31/2021 Date/Time Prepared: 7/29/2021 2: 33 pm Title XVIII Hospital PPS 1.00 To BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION 1.00 Total hospital discharges as defined in AARA \$4102 from Wkst. S-3, Pt. I col. 15 line 14 2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12 3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12 5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 6.00 6.00
To 12/31/2020 Date/Time Prepared: 7/29/2021 2: 33 pm Title XVIII Hospital PPS TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION 1.00 Total hospital discharges as defined in AARA \$4102 from Wkst. S-3, Pt. I col. 15 line 14 2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12 3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12 4.00 5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 5.00
Title XVIII Hospital PPS TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION 1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14 2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12 3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12 4.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION 1.00 Total hospital discharges as defined in AARA \$4102 from Wkst. S-3, Pt. I col. 15 line 14 2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12 3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12 5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 5.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION 1.00 Total hospital discharges as defined in AARA \$4102 from Wkst. S-3, Pt. I col. 15 line 14 2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12 3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12 5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 5.00
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION 1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14 1.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12 2.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 3.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12 4.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 5.00
Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14 2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12 3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12 5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 5.00
2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12 2.00 3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 3.00 4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12 4.00 5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 5.00
3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12 5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 5.00
4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12 5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 5.00
5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 5.00
6.00 Total bospital charity care charges from Wkst S.10 col. 2 Lino 20
7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I 7.00 line 168
8.00 Calculation of the HIT incentive payment (see instructions)
9.00 Sequestration adjustment amount (see instructions) 9.00
10.00 Calculation of the HIT incentive payment after sequestration (see instructions)
INPATIENT HOSPITAL SERVICES UNDER THE LIPPS & CAH
30.00 Initial/interim HIT payment adjustment (see instructions) 30.00
31.00 Other Adjustment (specify) 31.00
32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions) 32.00

Н	ealth Financial Systems	GOOD SAMARITAN HOSPITAL	In Lie	u of Form CMS-2	2552-10
C	ALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0042	Peri od: From 01/01/2020	Worksheet E-3	
		Component CCN: 15-S042			
_		Title XVIII	Subprovi der -	PPS	
_			IPF		

	I PF		
		1. 00	
PART II - MEDICARE PART A SERVICES - IPF PPS		1.00	
.00 Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education paymen	ts)	1, 199, 410	1.0
.00 Net IPF PPS Outlier Payments		23, 863	2.0
.00 Net IPF PPS ECT Payments		0	3.0
.00 Unweighted intern and resident FTE count in the most recent cost report filed on o	r before November	0.00	4. C
15, 2004. (see instructions)			
Cap increases for the unweighted intern and resident FTE count for residents that uprogram or hospital closure, that would not be counted without a temporary cap adju		0. 00	4. C
CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		0.00	
New Teaching program adjustment. (see instructions)		0.00	5.0
.00 Current year's unweighted FTE count of I&R excluding FTEs in the new program growth	n period or a new	0. 00	6.0
teaching program" (see instuctions) Ourrent year's unweighted I&R FTE count for residents within the new program growth teaching program" (see instuctions)	h period of a "new	2. 58	7.0
.00 Intern and resident count for IPF PPS medical education adjustment (see instruction	ns)	2. 58	8. 0
.00 Average Daily Census (see instructions)		12. 674863	
0.00 Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1	}	0. 100118	
1.00 Teaching Adjustment (line 1 multiplied by line 10).	,	120. 083	11.0
2.00 Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)		1, 343, 356	12.0
3.00 Nursing and Allied Health Managed Care payment (see instruction)		0	13.0
4. 00 Organ acquisition (DO NOT USE THIS LINE)		ĭ	14. (
5.00 Cost of physicians' services in a teaching hospital (see instructions)		0	15.
b. 00 Subtotal (see instructions)		1, 343, 356	
7.00 Primary payer payments		0	17.
8.00 Subtotal (line 16 less line 17).		1, 343, 356	18.
2.00 Deductibles		135, 080	
0.00 Subtotal (line 18 minus line 19)		1, 208, 276	
1.00 Coinsurance		102, 432	
2.00 Subtotal (line 20 minus line 21)		1, 105, 844	
3.00 Allowable bad debts (exclude bad debts for professional services) (see instructions	5)	14, 956	
4.00 Adjusted reimbursable bad debts (see instructions)		9, 721	24.
5.00 Allowable bad debts for dual eligible beneficiaries (see instructions)		4, 110	25.
5.00 Subtotal (sum of lines 22 and 24)		1, 115, 565	-
7.00 Direct graduate medical education payments (see instructions)		0	27.
3.00 Other pass through costs (see instructions)		937	28.
9.00 Outlier payments reconciliation		0	29.
D. OO OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		ő	30.
0.50 Pioneer ACO demonstration payment adjustment (see instructions)		o l	30.
Demonstration payment adjustment amount before sequestration		0	30.
1.00 Total amount payable to the provider (see instructions)		1, 116, 502	
.01 Sequestration adjustment (see instructions)		7, 369	
.02 Demonstration payment adjustment amount after sequestration		0	31.
2.00 Interim payments		996, 314	32.
8.00 Tentative settlement (for contractor use only)		0	33.
4.00 Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)		112, 819	34.
5.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-	2, chapter 1,	0	35.
§115. 2			
TO BE COMPLETED BY CONTRACTOR On Original outlier amount from Worksheet E-3, Part II, line 2	T	23, 863	50.
			50. 51.
1.00 Outlier reconciliation adjustment amount (see instructions)		0 0. 00	
2.00 The rate used to calculate the Time Value of Money 3.00 Time Value of Money (see instructions)			52. (53. (
5. 50 Time value of money (see first actions)	I	υĮ	JJ.

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 01/01/2020	Worksheet E-3
	Component CCN: 15-T042		
	Title XVIII	Subprovi der -	PPS
		IRF	

	IRF	113	
		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS	1.00	
1. 00	Net Federal PPS Payment (see instructions)	8, 155, 761	1.00
2. 00	Medicare SSI ratio (IRF PPS only) (see instructions)	0. 0351	2. 00
3. 00	Inpatient Rehabilitation LIP Payments (see instructions)	167, 193	3. 00
4.00	Outlier Payments	46, 378	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 teaching program" (see instructions)	0.00	7. 00
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)	17. 614754	
11. 00	Teaching Adjustment Factor (see instructions)	0. 000000	
12.00	Teaching Adjustment (see instructions)	0	12.00
13.00	Total PPS Payment (see instructions)	8, 369, 332	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 17. 00		0 8, 369, 332	16. 00 17. 00
18.00	Subtotal (see instructions) Primary payer payments	0, 309, 332	18.00
19. 00		8, 369, 332	
20.00	Deducti bl es	87, 252	20.00
21. 00	Subtotal (line 19 minus line 20)	8, 282, 080	21.00
22. 00		12, 936	
23. 00	Subtotal (line 21 minus line 22)	8, 269, 144	23. 00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	7, 021	24.00
25. 00		4, 564	25.00
26. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)	1, 408	26.00
27.00	Subtotal (sum of lines 23 and 25)	8, 273, 708	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)	4, 481	29. 00
30.00	Outlier payments reconciliation	0	30.00
31.00		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)	8, 278, 189	
32. 01	Sequestration adjustment (see instructions)	54, 636	
32. 02	Demonstration payment adjustment amount after sequestration	0 100 770	32. 02
33.00		8, 182, 772	33.00
34. 00 35. 00	Tentative settlement (for contractor use only) Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	0 40, 781	34. 00 35. 00
36. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	40, 781	36. 00
	TO BE COMPLETED BY CONTRACTOR		
	Original outlier amount from Wkst. E-3, Pt. III, line 4	46, 378	
	Outlier reconciliation adjustment amount (see instructions)	0	51.00
	The rate used to calculate the Time Value of Money		52.00
53.00	Time Value of Money (see instructions)	0	53.00

Health Financial Systems	GOOD SAMARITAN HOSPITAL	In Lieu	of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0042	From 01/01/2020 To 12/31/2020	Worksheet E-3 Part VII Date/Time Prepared: 7/29/2021 2:33 pm

			0 12/31/2020	7/29/2021 2: 3	
		Title XIX	Hospi tal	Cost	
			Inpatient	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		1, 059, 570		1.00
2.00	Medical and other services			0	2.00
3.00	gan acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		1, 059, 570	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)		1, 059, 570	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES				1
	Reasonabl e Charges				
8.00	Routi ne servi ce charges		676, 149		8.00
9.00	Ancillary service charges		2, 483, 151	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)		3, 159, 300	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
45.00	a charge basis had such payment been made in accordance with	42 CFR §413.13(e)	0.000000	0.000000	45.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0. 000000	1
16. 00 17. 00	Total customary charges (see instructions)	ly if line 14 evenede	3, 159, 300	0	
17.00	Excess of customary charges over reasonable cost (complete on line 4) (see instructions)	ry ir rine 16 exceeds	2, 099, 730	Ü	17.00
18. 00	Excess of reasonable cost over customary charges (complete on	Ly if line 4 exceeds line	0	0	18.00
10.00	16) (see instructions)	Ty IT TITLE 4 exceeds ITTLE	0	U	10.00
19. 00	Interns and Residents (see instructions)		0	0	19.00
		ructions)	0	0	
	Cost of covered services (enter the lesser of line 4 or line		1, 059, 570	0	
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be				1
22. 00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27. 00	Subtotal (sum of lines 22 through 26)		0	0	27. 00
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	28. 00
29. 00	Titles V or XIX (sum of lines 21 and 27)		1, 059, 570	0	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				1
30.00	Excess of reasonable cost (from line 18)		0	0	
31. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	1, 059, 570	0	
	Deducti bl es		0	0	
33. 00	Coinsurance		0	0	
34.00	Allowable bad debts (see instructions)		0	0	
35.00	Utilization review	4 22)	1 050 570	0	35.00
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	a 33)	1, 059, 570	0	
37. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		1 050 570	0	
38. 00 39. 00			1, 059, 570	0	38.00
	Direct graduate medical education payments (from Wkst. E-4)		1, 059, 570	0	
40.00	Total amount payable to the provider (sum of lines 38 and 39) Interim payments		1, 686, 612	0	
41.00	Balance due provider/program (line 40 minus line 41)		-627, 042	0	
43. 00		nce with CMS Pub 15-2	-027, 042	0	
45.00	chapter 1, §115.2	nee with one rub 13-2,		U	1 43.00
	10.0pto, 3110.2		1 1		1

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 01/01/2020	Worksheet E-3
	Component CCN: 15-S042		
	Title XIX	Subprovi der -	Cost
		I PF	

		ii tie xix	Subprovider -	COST	
			I PF I npati ent	Outpati ent	
	DADT VIII CALCULATION OF DEIMPHREMENT ALL OTHER HEALTH SERVICES E	OD TITLES V OD VI	1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES F	UR TITLES V UR AT	X SERVICES		
1 00	COMPUTATION OF NET COST OF COVERED SERVICES Inpatient hospital/SNF/NF services		471 720		1 00
1.00			471, 730	0	1.00
2.00	Medical and other services			Ü	2.00
3. 00 4. 00	Organ acquisition (certified transplant centers only) Subtotal (sum of lines 1, 2 and 3)		471 720	0	3. 00 4. 00
4. 00 5. 00			471, 730 0	Ü	5. 00
6. 00	Inpatient primary payer payments		U	0	6.00
7. 00	Outpatient primary payer payments Subtotal (line 4 less sum of lines 5 and 6)		471 720	0	7. 00
7.00	COMPUTATION OF LESSER OF COST OR CHARGES		471, 730	0	7.00
	Reasonable Charges				
8. 00	Routine service charges		575, 212		8. 00
9. 00	Ancillary service charges		1	0	9.00
10.00	Organ acquisition charges, net of revenue		124, 254	U	10.00
11. 00	Incentive from target amount computation				11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		699, 466	0	12.00
12.00	CUSTOMARY CHARGES		099, 400	U	12.00
13. 00	Amount actually collected from patients liable for payment for service	os on a chargo	O	0	13. 00
13.00	basis	es on a charge	٩	U	13.00
14. 00	Amounts that would have been realized from patients liable for paymen	t for sarvices or		0	14. 00
14.00	a charge basis had such payment been made in accordance with 42 CFR §		'	U	14.00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	413. 13(6)	0, 000000	0. 000000	15. 00
16. 00	Total customary charges (see instructions)		699, 466	0.000000	16.00
17. 00	Excess of customary charges over reasonable cost (complete only if li	ne 16 exceeds	227, 736	0	17. 00
17.00	line 4) (see instructions)	ne to execeds	227, 730	O	17.00
18. 00		ne 4 exceeds line	9	0	18. 00
10.00	16) (see instructions)	ne i execedo iin		O	10.00
19. 00	Interns and Residents (see instructions)		0	0	19. 00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21. 00		,	471, 730	0	21. 00
200	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be complet	ed for PPS provid			21.00
22. 00	Other than outlier payments		0	0	22. 00
23.00			0	0	23. 00
24.00			0		24.00
	Capital exception payments (see instructions)		0		25. 00
26.00	Routine and Ancillary service other pass through costs		0	0	26. 00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27. 00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28. 00
29.00	Titles V or XIX (sum of lines 21 and 27)		471, 730	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		•		
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)		471, 730	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)		471, 730	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		471, 730	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)		471, 730	0	40.00
41.00	Interim payments		304, 056	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		167, 674	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with	CMS Pub 15-2,	0	0	43.00
	chapter 1, §115.2				

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 01/01/2020	Worksheet E-3 Part VII
	Component CCN: 15-T042	To 12/31/2020	Date/Time Prepared: 7/29/2021 2:33 pm
	Title XIX	Subprovi der -	Cost
		IRF	

	Title .	^1 ^	I RF	COST	
			I npati ent	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TIT	IFS V OR XI		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES	LLO V OK XI	X OLIVIOLO		
1. 00	Inpati ent hospi tal /SNF/NF services		50, 456		1.00
2. 00	Medical and other services		00, 100	0	2. 00
3.00	Organ acquisition (certified transplant centers only)		0	Ü	3.00
4. 00	Subtotal (sum of lines 1, 2 and 3)		50, 456	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)		50, 456	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges				
8.00	Routine service charges		100, 512		8.00
9.00	Ancillary service charges		124, 664	0	9. 00
10.00	Organ acquisition charges, net of revenue		O		10.00
11.00	Incentive from target amount computation		o		11. 00
12.00	Total reasonable charges (sum of lines 8 through 11)		225, 176	0	12.00
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on	a charge	0	0	13.00
	basis				
14. 00	Amounts that would have been realized from patients liable for payment for		0	0	14.00
	a charge basis had such payment been made in accordance with 42 CFR §413.13	B(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)		225, 176	0	16.00
17. 00	Excess of customary charges over reasonable cost (complete only if line 16	exceeds	174, 720	0	17. 00
10 00	line 4) (see instructions)			0	10.00
18. 00	Excess of reasonable cost over customary charges (complete only if line 4 e	exceeds iine	0	0	18. 00
19. 00	16) (see instructions) Interns and Residents (see instructions)		0	0	19. 00
20. 00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21. 00	Cost of covered services (enter the lesser of line 4 or line 16)		50, 456	0	21.00
21.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for	DDS provid	 	0	21.00
22 00	Other than outlier payments	115 provid	0	0	22. 00
23. 00			o	0	23. 00
	Program capital payments		o	_	24. 00
25. 00			o		25. 00
26. 00	Routine and Ancillary service other pass through costs		o	0	26. 00
27.00			o	0	27. 00
28.00	Customary charges (title V or XIX PPS covered services only)		o	0	28. 00
29.00	Titles V or XIX (sum of lines 21 and 27)		50, 456	0	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
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)		50, 456	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)		50, 456	0	36.00
37.00	, , ,		0	0	37.00
38. 00	Subtotal (line 36 ± line 37)		50, 456	0	38. 00
39. 00			0		39. 00
40.00			50, 456	0	40.00
41. 00			104, 243	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		-53, 787	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS F	'up 15-2,	0	0	43. 00
	chapter 1, §115.2		1		

	Financial Systems GOOD SAMARITAN				u of Form CMS-2	2552-10
	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provi der CO		Peri od: From 01/01/2020	Worksheet E-4	
INIEDI GA	L EDUCATION COSTS			To 12/31/2020	Date/Time Prep 7/29/2021 2:33	
		Title	XVIII	Hospi tal	PPS	
					1. 00	
1 00	COMPUTATION OF TOTAL DIRECT GME AMOUNT	programa for		ing poriodo	0, 00	1. 00
1. 00	Unweighted resident FTE count for allopathic and osteopathic ending on or before December 31, 1996.	programs ron	cost report	ing periods	0.00	1.00
2. 00	Unweighted FTE resident cap add-on for new programs per 42 CF		(1) (see inst	ructions)	0.00	2.00
3. 00 3. 01	Amount of reduction to Direct GME cap under section 422 of MN Direct GME cap reduction amount under ACA \$5503 in accordance		2 8413 79 (m)	(500	0. 00 0. 00	3. 00 3. 01
0.01	instructions for cost reporting periods straddling 7/1/2011)				0.00	0.01
4. 00	Adjustment (plus or minus) to the FTE cap for allopathic and GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f)		programs due	to a Medicare	0. 00	4. 00
4. 01	ACA Section 5503 increase to the Direct GME FTE Cap (see inst		r cost report	ing periods	0.00	4. 01
4 02	straddling 7/1/2011)	es (see inst	tructions for	cost reporting	0.00	4 02
4. 02	ACA Section 5506 number of additional direct GME FTE cap slot periods straddling 7/1/2011)	is (see ms)	tructions for	cost reporting	0. 00	4. 02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 pl	us or minus	line 4 plus	lines 4.01 and	0. 00	5. 00
6. 00	4.02 plus applicable subscripts Unweighted resident FTE count for allopathic and osteopathic	programs for	r the current	vear from vour	0. 00	6. 00
	records (see instructions)	p. og. amo . o.		your rrom your		
7. 00	Enter the lesser of line 5 or line 6		Primary Care	e Other	0.00 Total	7. 00
			1.00	2.00	3. 00	
8. 00	Weighted FTE count for physicians in an allopathic and osteop	oathi c	0.0	0.00	0. 00	8. 00
9. 00	program for the current year. If line 6 is less than 5 enter the amount from line 8, otherw	vi se	0. 0	0. 00	0. 00	9. 00
	multiply line 8 times the result of line 5 divided by the amo					
10. 00	6. Weighted dental and podiatric resident FTE count for the curr	ent vear		0.00		10.00
10. 01	Unweighted dental and podiatric resident FTE count for the cu			0.00		10. 01
11. 00 12. 00	Total weighted FTE count Total weighted resident FTE count for the prior cost reportir	na voor (coo	0. 0 0. 0			11. 00 12. 00
12.00	instructions)	ig year (see	0.0	0.00		12.00
13.00	Total weighted resident FTE count for the penultimate cost re	eporti ng	0.0	0.00		13. 00
14. 00	year (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided	d by 3).	0. 0	0. 00		14. 00
15.00	Adjustment for residents in initial years of new programs	,	6. 4	4. 27		15.00
15. 01 16. 00	Unweighted adjustment for residents in initial years of new padjustment for residents displaced by program or hospital clo		6. 4 0. 0			15. 01 16. 00
16. 01	Unweighted adjustment for residents displaced by program or h		0. 0			16. 00
47.00	closure		, ,	4 07		47.00
17. 00 18. 00	1 3 1 1 3 1 1 1 1		6. 4 106, 854. 8			17. 00 18. 00
	Approved amount for resident costs		690, 28		1, 146, 552	
					1. 00	
20. 00	Additional unweighted allopathic and osteopathic direct GME F	TE resident	cap slots re	ceived under 42		20.00
21 00	Sec. 413.79(c)(4)	unti ons)	-		0.00	21 00
21.00	Direct GME FTE unweighted resident count over cap (see instru Allowable additional direct GME FTE Resident Count (see instr				0.00	21. 00 22. 00
	Enter the locality adjustment national average per resident a		nstructions)		106, 854. 87	
	Multiply line 22 time line 23 Total direct GME amount (sum of lines 19 and 24)				1 144 553	24.00
23.00	Total direct GME allount (Sull of Titles 19 and 24)		Inpatient	Managed Care	1, 146, 552 Total	25. 00
			Part A	0 00		
	COMPUTATION OF PROGRAM PATIENT LOAD		1. 00	2. 00	3. 00	
26. 00	Inpatient Days (see instructions) (Title XIX - see S-2 Part I	X, line	16, 72	2, 939		26. 00
27. 00	3.02, column 2) Total Inpatient Days (see instructions)		29, 54	29, 543		27. 00
28. 00	Ratio of inpatient days to total inpatient days		0. 56612			28.00
29. 00	Program di rect GME amount		649, 09	114, 061	763, 152	29. 00
	Percent reduction for MA DGME		l .	7.00		29. 01
29. 01 30. 00	Reduction for direct GME payments for Medicare Advantage			7, 984	7, 984	30.00

	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provider CCN: 15-0042	Peri od:	Worksheet E-4	
MEDI CA	L EDUCATION COSTS		From 01/01/2020 To 12/31/2020	Date/Time Prep 7/29/2021 2:3	
		Title XVIII	Hospi tal	PPS	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITL	E VILLE ONLY (NUDSENC S	CHOOL AND DADAMED	1.00	
	EDUCATION COSTS)	E AVIII ONLY (NORSING 3	CHOOL AND PARAMED	ICAL	
32.00	Renal dialysis direct medical education costs (from Wkst. B,	Pt I sum of col 20 a	nd 23 lines 74	0	32.00
	and 94)	,	,	-	
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt.	I, col. 8, sum of lines	74 and 94)	0	33.00
34.00	Ratio of direct medical education costs to total charges (lir	ne 32 ÷ line 33)	ŕ	0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)			0	35.00
36.00	00 Medicare outpatient ESRD direct medical education costs (line 34 x line 35)				36.00
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII	ONLY			
	Part A Reasonable Cost				
	Reasonable cost (see instructions)			36, 077, 752	
	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)			0	38.00
	Cost of physicians' services in a teaching hospital (see inst	ructi ons)		0	39. 00
	Primary payer payments (see instructions)			4, 562	
41. 00	Total Part A reasonable cost (sum of lines 37 through 39 minu	ıs line 40)		36, 073, 190	41.00
	Part B Reasonable Cost				
	Reasonable cost (see instructions)			27, 213, 174	
	Primary payer payments (see instructions)			.,	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)			27, 209, 324	
45.00	Total reasonable cost (sum of lines 41 and 44)			63, 282, 514	
46.00	Ratio of Part A reasonable cost to total reasonable cost (lir			0. 570034	
	Ratio of Part B reasonable cost to total reasonable cost (lir			0. 429966	47.00
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PA	KI B		755 1/0	40.00
	Total program GME payment (line 31)	(!t		755, 168	
	Part A Medicare GME payment (line 46 x 48) (title XVIII only)			430, 471	
5U. UU	Part B Medicare GME payment (line 47 x 48) (title XVIII only)	(see instructions)		324, 697	ou. 00

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 Per Fro

Peri od: From 01/01/2020 To 12/31/2020 Date/Time Prepared: 7/29/2021 2:33 pm

					7/29/2021 2: 3	3 pm
		General Fund	Speci fi c	Endowment	Plant Fund	
		1.00	Purpose Fund 2.00	Fund 3. 00	4. 00	
	CURRENT ASSETS	1, 00	2.00	0.00		
1.00	Cash on hand in banks	33, 102, 557	0	0	0	
2.00	Temporary investments	0	0	0	0	1
3. 00	Notes receivable	0	0	0	0	
4.00	Accounts receivable	81, 006, 681	0	0	0	
5.00	Other receivable	4, 096, 276		0	0	
6. 00 7. 00	Allowances for uncollectible notes and accounts receivable Inventory	-50, 099, 025 3, 342, 820		0	0	
8. 00	Prepai d expenses	6, 111, 834		0	0	
9. 00	Other current assets	0, 111, 001	o o	Ö	0	
10.00	Due from other funds	Ö	0	O	0	
11.00	Total current assets (sum of lines 1-10)	77, 561, 143	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	6, 581, 448	0	0	0	
13.00	Land improvements	10, 692, 230		0	0	
14. 00	Accumulated depreciation	-6, 845, 015		0	0	1
15.00	Bui I di ngs	169, 412, 708		0	0	
16.00	Accumulated depreciation	-78, 270, 314	0	0	0	
17. 00 18. 00	Leasehold improvements Accumulated depreciation	510, 867	0	0	0	
19.00	Fixed equipment	2, 305, 485	_	0	0	
20.00	Accumulated depreciation	2, 303, 403		0	0	
21.00	Automobiles and trucks	0	0	0	0	
22. 00	Accumulated depreciation	Ö	0	O	0	
23.00	Major movable equipment	220, 303, 501	0	0	0	
24.00	Accumul ated depreciation	-153, 829, 892	0	0	0	24.00
25.00	Mi nor equi pment depreci abl e	0	0	0	0	25.00
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	0	0	0	0	
30. 00	Total fixed assets (sum of lines 12-29) OTHER ASSETS	170, 861, 018	0	0	0	30.00
31. 00	Investments	97, 140, 693	0	0	0	31.00
32.00	Deposits on Leases	77, 140, 079	0	0	0	
33.00	Due from owners/officers	0	o o	Ö	0	
34.00	Other assets	5, 267, 433	0	O	0	
35.00	Total other assets (sum of lines 31-34)	102, 408, 126		0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	350, 830, 287	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	4, 211, 671	0	0	0	
38.00	Sal ari es, wages, and fees payable	15, 016, 211	0	0	0	
39.00	Payroll taxes payable (chart tarm)	4, 124, 901	0	0	0	
40. 00 41. 00	Notes and Loans payable (short term) Deferred income	33, 829, 350 503, 456		0	0	
42.00	Accel erated payments	003, 430		U	U	42.00
43. 00	Due to other funds	0	0	0	0	
44. 00	Other current liabilities	34, 158	0	0	0	
45. 00	Total current liabilities (sum of lines 37 thru 44)	57, 719, 747		0		1
	LONG TERM LIABILITIES					1
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	107, 079, 354	0	0	0	
48.00	Unsecured Loans	0	0	0	0	1
49. 00	Other long term liabilities	0	0	0	0	
50.00	Total long term liabilities (sum of lines 46 thru 49)	107, 079, 354		0	0	1
51. 00	Total liabilities (sum of lines 45 and 50)	164, 799, 101	0	0	0	51.00
52. 00	CAPITAL ACCOUNTS General fund balance	186, 031, 186				52.00
53.00	Specific purpose fund	100,031,100	0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			Ö		56.00
	Plant fund balance - invested in plant				0	
57.00	Plant fund balance - reserve for plant improvement,				0	
57. 00 58. 00	Traite rand barance reserve for praire rimprovement,					1
	replacement, and expansion			l		l
58. 00 59. 00	replacement, and expansion Total fund balances (sum of lines 52 thru 58)	186, 031, 186		0	0	1
58. 00	repl acement, and expansion	186, 031, 186 350, 830, 287		0 0	0	

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES Peri od: From 01/01/2020 Provi der CCN: 15-0042 Worksheet G-1

					To 12/31/2020	Date/Time Pre 7/29/2021 2:3	pared: 3 pm
		General	Fund	Special P	Purpose Fund	Endowment Fund	
		1. 00	2. 00	3. 00	4. 00	5. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 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) ROUNDING 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	0 2 0 0 0 0 0 0	2. 00 175, 859, 803 10, 171, 381 186, 031, 184 2 186, 031, 186		4.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00
	sheet (line 11 minus line 18)	Endowment		Fund			171.00
		Fund	Trant	T dila			
		6. 00	7. 00	8. 00			
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) ROUNDING	0	0 0 0 0 0		0		1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17)	0 0	0 0 0 0 0		0		10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0			0		19. 00

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

		10	5 12/31/2020	Date/lime Pre 7/29/2021 2:3				
	Cost Center Description	Inpatient	Outpati ent	Total	<u>Б</u>			
	'	1.00	2. 00	3. 00				
	PART I - PATIENT REVENUES							
	General Inpatient Routine Services							
1.00	Hospi tal	26, 778, 343		26, 778, 343	1.00			
2.00	SUBPROVI DER - I PF	8, 730, 989		8, 730, 989	2.00			
3.00	SUBPROVI DER - I RF	7, 404, 201		7, 404, 201	3.00			
4. 00	SUBPROVI DER				4. 00			
5. 00	Swing bed - SNF	0		0	5.00			
6. 00	Swing bed - NF	0		0	6. 00			
7.00	SKILLED NURSING FACILITY				7. 00			
8.00	NURSING FACILITY				8.00			
9.00	OTHER LONG TERM CARE	40.010.500		40 010 500	9.00			
10. 00	Total general inpatient care services (sum of lines 1-9)	42, 913, 533		42, 913, 533	10. 00			
11. 00	Intensive Care Type Inpatient Hospital Services INTENSIVE CARE UNIT	16, 111, 220		16, 111, 220	11. 00			
12. 00	CORONARY CARE UNIT	10, 111, 220		10, 111, 220	12.00			
13. 00	BURN INTENSIVE CARE UNIT				13.00			
14. 00	SURGICAL INTENSIVE CARE UNIT				14.00			
15. 00	OTHER SPECIAL CARE (SPECIFY)				15.00			
16. 00	Total intensive care type inpatient hospital services (sum of lines	16, 111, 220		16, 111, 220	16. 00			
10.00	11-15)	10, 111, 220		10, 111, 220	10.00			
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	59, 024, 753		59, 024, 753	17. 00			
18. 00	Ancillary services	135, 615, 244	303, 064, 517	438, 679, 761	18. 00			
19. 00	Outpati ent servi ces	12, 356, 634	43, 955, 945	56, 312, 579	19.00			
20. 00	RURAL HEALTH CLINIC	0	0	0	20.00			
21. 00	FEDERALLY QUALIFIED HEALTH CENTER	O	o	0	21. 00			
22. 00	HOME HEALTH AGENCY		o	0	22.00			
23. 00	AMBULANCE SERVICES]	_	23. 00			
24. 00	CMHC				24. 00			
25. 00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00			
26. 00	HOSPI CE	0	2, 216, 085	2, 216, 085	26. 00			
27. 00	DME	0	422, 599	422, 599	27. 00			
27. 01	PHYSI CI AN OFFI CE	6, 874, 440	61, 265, 554	68, 139, 994	27. 01			
27. 02	PROFESSIONAL FEES	0	9, 562, 546	9, 562, 546	27. 02			
27. 03	DI ETARY REVENUE	0	675, 761	675, 761	27. 03			
27. 04	FACULTY RESIDENCY BILLINGS	0	0	0	27. 04			
27. 05	ADMI N	0	120	120	27. 05			
28.00	Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst.	213, 871, 071	421, 163, 127	635, 034, 198	28.00			
	G-3, line 1)							
	PART II - OPERATING EXPENSES							
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		243, 861, 743		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	7	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)(transfe	er	243, 861, 743		43.00			
	to Wkst. G-3, line 4)	1						

	_	RITAN HOSPITAL		u of Form CMS-2	2552-10
STATEM	ENT OF REVENUES AND EXPENSES	Provi der CCN: 15-0042	Peri od:	Worksheet G-3	
			From 01/01/2020 To 12/31/2020	Date/Time Pre 7/29/2021 2:3	
			,	1. 00	
1. 00	Total patient revenues (from Wkst. G-2, Part I, column			635, 034, 198	
2.00	Less contractual allowances and discounts on patients'	accounts		414, 021, 254	
3.00	Net patient revenues (line 1 minus line 2)			221, 012, 944	1
4.00	Less total operating expenses (from Wkst. G-2, Part II,			243, 861, 743	
5.00	Net income from service to patients (line 3 minus line	4)		-22, 848, 799	5.00
	OTHER I NCOME				
6. 00	Contributions, donations, bequests, etc			0	
7.00	Income from investments			0	
8. 00	Revenues from telephone and other miscellaneous communi	cation services		0	
9. 00	Revenue from television and radio service			0	
10.00	Purchase di scounts			0	
11. 00	Rebates and refunds of expenses			0	
	Parking lot receipts			0	
	Revenue from Laundry and Linen service			0	
	Revenue from meals sold to employees and guests			0	
	Revenue from rental of living quarters			0	1
	Revenue from sale of medical and surgical supplies to o	other than patients		0	
	Revenue from sale of drugs to other than patients			0	
	Revenue from sale of medical records and abstracts			0	
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	
	Revenue from gifts, flowers, coffee shops, and canteen			0	
	Rental of vending machines			0	
	Rental of hospital space			0	00
23.00	Governmental appropriations			4, 890, 119	23. 00
24.00	OTHER REVENUE			5, 372, 857	24.00
24. 01	INVESTMENT INCOME			5, 828, 713	24. 01
24. 02	INTERCOMPANY TRANSFERS			2, 661, 825	24. 02
24. 03	OTHER NONOPERATING			1, 649, 415	24. 03
24.50	COVI D-19 PHE Fundi ng			12, 617, 251	24. 50
25.00	Total other income (sum of lines 6-24)			33, 020, 180	25.00
26.00	Total (line 5 plus line 25)			10, 171, 381	26.00
27.00	OTHER EXPENSES (SPECIFY)			0	27. 00

27.00 0

0 28.00

10, 171, 381 29. 00

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)

27.00 OTHER EXPENSES (SPECIFY)

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0

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438, 841

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432,030

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870, 871

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0 61.00

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0 63.00

0 64.00

0 66.00

0 67 00

0

0 69.00

0 70.00

0 71.00

776, 869 100. 00

62.00

65.00

68.00

60.00

61.00

62.00

63.00

64.00

65.00

66.00

67 00

68.00

69 00

70.00

100.00 TOTAL

BEREAVEMENT PROGRAM *

PALLIATIVE CARE PROGRAM*

OTHER PHYSICIAN SERVICES*

TELEHEALTH/TELEMONI TORI NG*

71.00 OTHER NONREIMBURSABLE (SPECIFY)*

NURSING FACILITY ROOM & BOARD*

HOSPICE/PALLIATIVE MEDICINE FELLOWS*

VOLUNTEER PROGRAM *

RESIDENTIAL CARE*

FUNDRAI SI NG*

ADVERTI SI NG*

THRIFT STORE*

^{*} Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.

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

				Hospi ce	e I	
		ADJUSTMENTS	TOTAL (col. 5			
			± col. 6)			
		6. 00	7. 00			
4 00	GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT*	0	0			1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	0			2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0			3.00
4. 00	ADMI NI STRATI VE & GENERAL*	-27	340, 295			4.00
5. 00	PLANT OPERATION & MAINTENANCE*	0	2, 953			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	2, 549			10.00
11.00	MEDICAL RECORDS*	0	0			11.00
12.00	STAFF TRANSPORTATION*	0	0			12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0			13.00
14.00	PHARMACY*	0	79			14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0			15.00
16. 00 17. 00	OTHER GENERAL SERVICE*	0	0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES					17. 00
25 00	DI RECT PATIENT CARE SERVICE COST CENTERS		0			25.00
25. 00	I NPATI ENT CARE-CONTRACTED**	0	0			25.00
26. 00	PHYSI CI AN SERVI CES**	0	20, 751			26.00
27. 00	NURSE PRACTITIONER**	0	7, 778			27.00
28. 00 29. 00	REGI STERED NURSE**	0	232, 200 0			28. 00
30.00	LPN/LVN**	0	ŭ,			29.00
	PHYSI CAL THERAPY**	0	0			30.00
31.00	OCCUPATIONAL THERAPY**	0	0			31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	02 240			32.00
33. 00 34. 00	MEDICAL SOCIAL SERVICES**	0	93, 269			33. 00 34. 00
35. 00	SPIRITUAL COUNSELING** DIETARY COUNSELING**	0	0			35.00
36. 00	COUNSELING - OTHER**	0	0			36.00
37. 00		0	41 470			
38.00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	41, 670			37. 00 38. 00
39. 00	DURABLE MEDI CAL EQUI PMENT/OXYGEN**	0	0			
	PATIENT TRANSPORTATION**	0	0			39.00
40. 00 41. 00	I MAGING SERVICES**	0	0			40.00
41.00	LABS & DI AGNOSTI CS**	0	-			41. 00 42. 00
42. 00	MEDICAL SUPPLIES-NON-ROUTINE** DRUGS CHARGED TO PATIENTS**	0	0			42. 50
42. 50	OUTPATIENT SERVICES**	0	0			43. 00
44. 00	PALLIATIVE RADIATION THERAPY**	· ·	0			44.00
45. 00	PALLIATIVE CHEMOTHERAPY**	0 0	0			45. 00
	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	-			
46. 00	NONREI MBURSABLE COST CENTERS	U	35, 298			46. 00
40.00	BEREAVEMENT PROGRAM *	ام	0			40.00
60. 00 61. 00	VOLUNTEER PROGRAM *	0	0			60.00
62.00	FUNDRAI SI NG*	0	0			61. 00 62. 00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0			63.00
		· ·	0			
64. 00 65. 00	PALLIATIVE CARE PROGRAM* OTHER PHYSICIAN SERVICES*	0	0			64. 00 65. 00
		- 1				
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	THRIFT STORE*	0	0			69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0			70.00
71.00	OTHER NONREI MBURSABLE (SPECI FY)*	0	774 040			71.00
100.00	/ IUIAL	-27	776, 842			100.00

^{*} 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.

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38, 761

36.00 0

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42.50

44.00

45.00

46.00 402, 561 100. 00

44.00	PALLIATIVE RADIATION THERAPY	o	
45.00	PALLI ATI VE CHEMOTHERAPY	0	
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	27, 238	
100.00	TOTAL *	314, 454	

* 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 I NPATI ENT CARE-CONTRACTED			25. 0
26. 00 PHYSI CI AN SERVI CES	0	20, 751	26. 0
27. 00 NURSE PRACTITIONER	0	7, 235	27. 0
28. 00 REGI STERED NURSE	0	215, 986	28. 0
29. 00 LPN/LVN	0	0	29. 0
30. 00 PHYSI CAL THERAPY	0	o	30.00
31. 00 OCCUPATI ONAL THERAPY	0	o	31. 0
32. 00 SPEECH/LANGUAGE PATHOLOGY	0	o	32. 0
33.00 MEDICAL SOCIAL SERVICES	0	86, 756	33.0
34. 00 SPIRITUAL COUNSELING	0	o	34. 0
35. 00 DIETARY COUNSELING	0	0	35. 0
36. 00 COUNSELING - OTHER	0	0	36.0
37.00 HOSPICE AIDE & HOMEMAKER SERVICES	0	38, 761	37. 0
38. OO DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.0
39. 00 PATIENT TRANSPORTATION	0	0	39.0
40.00 I MAGING SERVICES	0	0	40.0
41. 00 LABS & DI AGNOSTI CS	0	0	41. 0
42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE	0	0	42. 0
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	44.0
45. 00 PALLI ATI VE CHEMOTHERAPY	0	0	45. 0
46.00 OTHER PATIENT CARE SERVICES (SPECIFY)	0	33, 072	46. 0
100. 00 TOTAL *	0	402, 561	100.00

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

35.00

36.00

37.00

38.00

39.00

40.00

41.00

42.00

42.50

43.00

DIETARY COUNSELING

COUNSELING - OTHER

IMAGING SERVICES

LABS & DIAGNOSTICS

OUTPATIENT SERVICES

PATIENT TRANSPORTATION

HOSPICE AIDE & HOMEMAKER SERVICES

DURABLE MEDICAL EQUIPMENT/OXYGEN

MEDICAL SUPPLIES-NON-ROUTINE

DRUGS CHARGED TO PATIENTS

Health Financial Systems	GOOD SAMARITAN	I HOSPITAL		In Lie	u of Form CMS-2	2552-10
ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSP	ICE INPATIENT	Provi der CCI	N: 15-0042	Peri od:	Worksheet 0-3	
RESPITE CARE		Hospi ce CCN:	15-1526	From 01/01/2020 To 12/31/2020		
				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						
25. 00 I NPATI ENT CARE-CONTRACTED		0		0	0	
26. 00 PHYSI CI AN SERVI CES	0	0		0	0	
27. 00 NURSE PRACTITIONER	8	2		10 0	10	
28. 00 REGI STERED NURSE	241	52	2	93 0	293	1
29. 00 LPN/LVN	0	0		0	0	29. 00
30. 00 PHYSI CAL THERAPY	0	0		0	0	30.00
31. 00 OCCUPATI ONAL THERAPY	0	0		0	0	31.00
32.00 SPEECH/LANGUAGE PATHOLOGY	0	0		0	0	32.00
33.00 MEDICAL SOCIAL SERVICES	97	21	1	18 0	118	
34. 00 SPI RI TUAL COUNSELI NG	0	0		0	0	
35. 00 DIETARY COUNSELING	0	0		0	0	35.00
36. 00 COUNSELING - OTHER	0	0		0	0	36.00
37.00 HOSPICE AIDE & HOMEMAKER SERVICES	43	9		52 0	52	37.00
38. 00 DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		0	0	38.00
39. 00 PATIENT TRANSPORTATION	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	0	41.00
42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE	0	0		0 0	0	42.00
42.50 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	42.50
43. 00 OUTPATIENT SERVICES	0	O		0	0	43.00
44.00 PALLIATIVE RADIATION THERAPY	0	O		0 0	0	44.00
45.00 PALLIATIVE CHEMOTHERAPY	0	0		0 0	0	45.00
46.00 OTHER PATIENT CARE SERVICES (SPECIFY)	26	6		32 0	32	46.00
100 00 10141 *	1 415	വ	E	05 0	I ENE	100 00

90

505 100.00

		ADJUSTMENTS	TOTAL (col. 5	
			± col . 6)	
		6. 00	7. 00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25.00	I NPATI ENT CARE-CONTRACTED	0	0	25. 00
26.00	PHYSI CI AN SERVI CES	0	0	26. 00
27.00	NURSE PRACTITIONER	0	10	27. 00
28.00	REGI STERED NURSE	0	293	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	118	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	52	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	PALLI ATI VE CHEMOTHERAPY	0	0	45. 00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	32	46. 00
100.00	TOTAL *	0	505	100.00

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

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

Heal th	Financial Systems	GOOD SAMARITAN	N HOSPI TAL		In Lie	u of Form CMS-2	2552-10
ANALYS	SIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPIC	E GENERAL	Provi der CC		Peri od:	Worksheet 0-4	
INPATI	ENT CARE				rom 01/01/2020		
			Hospi ce CCN	: 15-1526 T	Γo 12/31/2020	Date/Time Pre	
					Hooni oo I	7/29/2021 2: 3	3 pm
		SALARI ES	OTHER	SUBTOTAL	Hospi ce I RECLASSI FI -	SUBTOTAL	
		SALAKIES	UTHER		CATIONS	SUBTUTAL	
				(col . 1 +	CATTONS		
		1. 00	2.00	col. 2) 3.00	4.00	5. 00	
	DIRECT PATIENT CARE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
25. 00	I NPATI ENT CARE CONTRACTED		Λ	(0	25. 00
26. 00	PHYSI CI AN SERVI CES	0	0	(0	26.00
27. 00	NURSE PRACTITIONER	439	94	533		533	27.00
28.00	REGISTERED NURSE	13, 112	2, 809	15, 92		15, 921	28.00
29. 00	LPN/LVN	13, 112	2, 609	13, 72		15, 721	29.00
30.00	PHYSI CAL THERAPY	0	0	(0	30.00
31. 00	OCCUPATIONAL THERAPY	0	0	(0	31.00
32. 00	SPEECH/LANGUAGE PATHOLOGY	0	0	(0	32.00
33. 00	MEDICAL SOCIAL SERVICES	5, 267	1, 128	6, 395		6, 395	
34. 00	SPIRITUAL COUNSELING	5, 207	1, 120	0, 390		0, 393	34.00
35. 00	DI ETARY COUNSELING	0	0	(0	35.00
36. 00	COUNSELING - OTHER	0	0	(0	36.00
		2 252	504	2 05		2 057	
37.00	HOSPICE AIDE & HOMEMAKER SERVICES DURABLE MEDICAL EQUIPMENT/OXYGEN	2, 353	504	2, 857		2, 857	37.00
38. 00 39. 00		0	0	(0	38.00
	PATIENT TRANSPORTATION	0	0	(0	39.00
40.00	I MAGING SERVICES	0	0	(0	40.00
41.00	LABS & DI AGNOSTI CS	U	0	(0	41.00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	0	(0	42.00
42. 50	DRUGS CHARGED TO PATIENTS	0	0	(0	42.50
43.00	OUTPATIENT SERVICES	0	0	(0	43.00
	PALLIATIVE CHEMOTHERAPY	0	0	(0	44.00

0

2, 194

387

4, 922

0 45.00 2,194 46.00 27,900 100.00

45.00 PALLIATIVE CHEMOTHERAPY
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	0	25. 00
26. 00	PHYSI CI AN SERVI CES	0	0	26.00
27. 00	NURSE PRACTITIONER	0	533	27.00
28. 00	REGI STERED NURSE	0	15, 921	28.00
29. 00	LPN/LVN	0	13, 721	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	6, 395	33.00
34. 00	SPI RI TUAL COUNSELI NG	0	0	34.00
35.00	DI ETARY COUNSELI NG	0	o	35.00
36. 00	COUNSELING - OTHER	0	o	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	2, 857	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	o	38.00
39.00	PATIENT TRANSPORTATION	0	o	39.00
40.00	I MAGI NG SERVI CES	0	o	40.00
41.00	LABS & DIAGNOSTICS	0	o	41.00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	o	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	o	42.50
43.00	OUTPATIENT SERVICES	0	o	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	o	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	o	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	2, 194	46.00
100.00	TOTAL *	0	27, 900	100.00

1, 807

^{100.00} TOTAL * 22,978 * 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 HOSPITAL		In Lie	u of Form CMS-2	552-10
COST ALLOCATION - DETERMINATION OF HOSPITAL-BASED F	HOSPICE NET Provider C		Period: From 01/01/2020	Worksheet 0-5	
EXPENSES FOR ALLOCATION	Hospi ce CC		o 12/31/2020	Date/Time Prep 7/29/2021 2:33	oared: 3 pm
			Hospi ce I		
Descriptions Descriptions		HOSPI CE	GENERAL	TOTAL	
		DI RECT	SERVI CE	EXPENSES (sum	
			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 & FLXT			119, 799	119, 799	1.00
2.00 CAP REL COSTS-MVBLE EQUIP		0	523	523	2.00
3.00 EMPLOYEE BENEFITS DEPARTMENT		(154, 949	154, 949	3.00

Health FinancialSystemsGOOD SAMARITAN HOSPITALCOST ALLOCATION - HOSPITAL-BASED HOSPICE GENERALSERVICE COSTSProvider In Lieu of Form CMS-2552-10 Peri od: Worksheet 0-6
From 01/01/2020 Part I
To 12/31/2020 Date/Time Prepared: 7/29/2021 2: 33 pm Provider CCN: 15-0042 Hospi ce CCN: 15-1526

						1/27/2021 2.3	J PIII
					Hospi ce I		
	Descriptions	TOTAL		CAP REL MVBLE		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	119, 799					1.00
2.00	CAP REL COSTS-MVBLE EQUIP	523		523			2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	154, 949	0	C	154, 949		3.00
4.00	ADMINISTRATIVE & GENERAL	454, 361	0	C	0	454, 361	4.00
5.00	PLANT OPERATION & MAINTENANCE	120, 273	0	d c	0	120, 273	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	l c	0	0	6.00
7.00	HOUSEKEEPI NG	48, 336	0	l c	0	48, 336	7. 00
8.00	DI ETARY	0	0	l c	0	0	8. 00
9.00	NURSI NG ADMI NI STRATI ON	80, 054	0		0	80, 054	9.00
10.00	ROUTINE MEDICAL SUPPLIES	3, 676	l .		0	3, 676	10.00
11. 00	MEDI CAL RECORDS	0	0	l c	0	0	11.00
12. 00	STAFF TRANSPORTATION	0	0	d	0	0	12.00
13. 00	VOLUNTEER SERVICE COORDINATION	0	0		0	0	13.00
14. 00	PHARMACY	98	0		0	98	14.00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0		o o	0	15. 00
16. 00	OTHER GENERAL SERVICE	0			0	0	16.00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES					0	17.00
17.00	LEVEL OF CARE	1	· · · · · ·		1		17.00
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	402, 561			144, 130	546, 691	51.00
52. 00	HOSPICE INPATIENT RESPITE CARE	505	11, 875	52		12, 627	52.00
53. 00	HOSPICE GENERAL INPATIENT CARE	27, 900				146, 919	53.00
33.00	NONREI MBURSABLE COST CENTERS	21,700	107, 724	771	10, 024	140, 717	33.00
60.00	BEREAVEMENT PROGRAM	0	0	C	0	0	60.00
61. 00	VOLUNTEER PROGRAM	0	٥			0	61.00
62. 00	FUNDRAI SI NG	0	٥			0	62.00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0				0	63.00
64. 00	PALLIATIVE CARE PROGRAM					0	64.00
65. 00	OTHER PHYSICIAN SERVICES					0	65.00
66. 00	RESI DENTI AL CARE				0	0	66.00
67. 00	ADVERTI SI NG					0	67.00
68. 00	TELEHEALTH/TELEMONI TORI NG	0			0	0	68.00
69.00	THRIFT STORE					0	69.00
		0	U	1	U	_	
70.00	NURSING FACILITY ROOM & BOARD					0	70.00
71.00	OTHER NONREI MBURSABLE (SPECIFY)	0				0	71. 00 99. 00
99.00	NEGATIVE COST CENTER	1 412 025	110 700	C	_	1 412 025	
100.00	TOTAL	1, 413, 035	119, 799	523	154, 949	1, 413, 035	1100.00

Health FinancialSystemsGOOD SAMARITAN HOSPITALCOST ALLOCATION - HOSPITAL-BASED HOSPICE GENERALSERVICE COSTSProvider

			nospi ce cc	N. 13-1320	10 12/31/2020	7/29/2021 2:3	
					Hospi ce I	772772021 210	50 р
	Descriptions	ADMI NI STRATI V	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	·	E & GENERAL	OPERATION &	LINEN SERVIC	E		
			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	454, 361					4.00
5.00	PLANT OPERATION & MAINTENANCE	57, 003	177, 276				5. 00
6.00	LAUNDRY & LINEN SERVICE	0	0		0		6.00
7.00	HOUSEKEEPI NG	22, 909	0		71, 245		7. 00
8.00	DI ETARY	0	0		0	C	8.00
9.00	NURSI NG ADMI NI STRATI ON	37, 941	0		0		9. 00
10.00	ROUTINE MEDICAL SUPPLIES	1, 742	0		0		10.00
11.00	MEDI CAL RECORDS	0	0		0		11.00
12.00	STAFF TRANSPORTATION	0	0		0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0		0		13.00
14.00	PHARMACY	46	0		0		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0		15.00
16.00	OTHER GENERAL SERVICE	0	0		0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0)	0		17. 00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0					50.00
51.00	HOSPICE ROUTINE HOME CARE	259, 103					51.00
52.00	HOSPICE INPATIENT RESPITE CARE	5, 985	17, 573		0 7, 062		
53.00	HOSPICE GENERAL INPATIENT CARE	69, 632	159, 703		0 64, 183	C	53.00
	NONREI MBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0)	0		60.00
61. 00	VOLUNTEER PROGRAM	0	0)	0		61.00
62. 00	FUNDRAI SI NG	0	0)	0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0)	0		63.00
64. 00	PALLIATIVE CARE PROGRAM	0	0)	0		64.00
65. 00	OTHER PHYSICIAN SERVICES	0	0)	0		65. 00
66. 00	RESI DENTI AL CARE	0	0)	0	C	
67.00	ADVERTI SI NG	0	0)	0		67. 00
68.00	TELEHEALTH/TELEMONI TORI NG	0	0)	0		68. 00
69. 00	THRI FT STORE	0	0)	0		69. 00
70. 00	NURSING FACILITY ROOM & BOARD					1	70.00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)	0	0)	0	C	
	NEGATI VE COST CENTER	0	0)	0 0		, , , , , , , , ,
100.00	TOTAL	454, 361	177, 276	p	0 71, 245	į C	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS Provider CCN: 15-0042 Peri od: Worksheet 0-6 From 01/01/2020 Part I Date/Time Prepared: Hospi ce CCN: 15-1526 12/31/2020 7/29/2021 2:33 pm 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 117, 995 9.00 9.00 ROUTINE MEDICAL SUPPLIES 5, 418 10.00 10.00 11.00 MEDICAL RECORDS 0 0 11.00 12.00 STAFF TRANSPORTATION 0 12.00 0 VOLUNTEER SERVICE COORDINATION 0 0 13.00 0 13.00 14.00 PHARMACY 0 0 14.00 PHYSICIAN ADMINISTRATIVE SERVICES 0 15.00 15.00 0 0 16.00 OTHER GENERAL SERVICE 0 0 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, 754 5,040 51.00 51.00 0 52.00 HOSPICE INPATIENT RESPITE CARE 152 0 52.00 53.00 HOSPICE GENERAL INPATIENT CARE 8,089 371 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

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0 100.00

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66.00

67 00

68.00

69.00

70.00

100.00 TOTAL

OTHER PHYSICIAN SERVICES

TELEHEALTH/TELEMONI TORI NG

71.00 OTHER NONREIMBURSABLE (SPECIFY)

NURSING FACILITY ROOM & BOARD

RESIDENTIAL CARE

ADVERTI SI NG

THRIFT STORE

99. 00 NEGATI VE COST CENTER

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS Provider CCN: 15-0042 Peri od: Worksheet 0-6 From 01/01/2020 Part I Hospi ce CCN: 15-1526 12/31/2020 Date/Time Prepared: To 7/29/2021 2:33 pm Hospi ce I PHARMACY PHYSI CI AN OTHER GENERAL PATI ENT/ TOTAL Descriptions ADMI NI STRATI V SERVI CE RESI DENTI AL E SERVICES CARE SERVICES 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 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 9.00 ROUTINE MEDICAL SUPPLIES 10.00 10.00 11.00 MEDICAL RECORDS 11.00 12.00 STAFF TRANSPORTATION 12.00 VOLUNTEER SERVICE COORDINATION 13.00 13.00 14.00 PHARMACY 144 14.00 PHYSICIAN ADMINISTRATIVE SERVICES 15.00 0 0 15.00 16.00 OTHER GENERAL SERVICE 0 0 16.00 PATIENT/RESIDENTIAL CARE SERVICES 17.00 0 17.00 LEVEL OF CARE HOSPICE CONTINUOUS HOME CARE 50.00 0 0 50.00 0 HOSPICE ROUTINE HOME CARE 920, 722 51.00 51.00 134 0 52.00 HOSPICE INPATIENT RESPITE CARE 0 0 0 43, 406 52.00 53.00 HOSPICE GENERAL INPATIENT CARE 10 0 448, 907 53.00 NONREIMBURSABLE COST CENTERS BEREAVEMENT PROGRAM 60.00 0 0 0 60.00 0 VOLUNTEER PROGRAM 61.00 0 0 0 0 0 0 0 61.00 62.00 FUNDRAI SI NG 0 62.00 0 0 63.00 HOSPICE/PALLIATIVE MEDICINE FELLOWS 0 63.00 0 PALLIATIVE CARE PROGRAM 64.00 0 64.00 65.00 OTHER PHYSICIAN SERVICES 0 65.00 RESIDENTIAL CARE 0 66.00 0 0 0 66.00 67 00 ADVERTI SI NG 0 0 67.00 0 TELEHEALTH/TELEMONI TORI NG 68.00 0 68.00 0 69.00 THRIFT STORE 0 0 69.00

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1, 413, 035 100. 00

70.00

71.00 Ω

NURSING FACILITY ROOM & BOARD

71.00 OTHER NONREIMBURSABLE (SPECIFY)

99. 00 NEGATI VE COST CENTER

70.00

100.00 TOTAL

Health Financial Systems	GOOD SAMARIT	AN HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL S	SERVICE COSTS	Provi de	CCN: 15-0042	Peri od:	Worksheet 0-6	
STATISTICAL BASIS		Hospi ce	CCN: 15-1526	From 01/01/2020 To 12/31/2020		pared: 3 pm
				Hospi ce I		
Cost Center Descriptions	CAP REL BLDG	CAP REL MVI	BLE 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						

	Cost Center Descriptions	CAP REL BLDG & FLX	CAP REL MVBLE EQUI P	EMPLOYEE BENEFITS	RECONCILIATIO	ADMINISTRATIV E & GENERAL	
		(SQUARE FEET)	(DOLLAR	DEPARTMENT	IN	(ACCUMULATED	
		(SQUARE TEET)	VALUE)	(GROSS		COSTS)	
			V/LOL)	SALARI ES)		00010)	
		1. 00	2.00	3.00	4A	4. 00	
	GENERAL SERVICE COST CENTERS	1					
1.00	CAP REL COSTS-BLDG & FLXT	686					1.00
2. 00	CAP REL COSTS-MVBLE EQUIP		686				2.00
3. 00	EMPLOYEE BENEFITS DEPARTMENT	0		438, 842			3.00
4.00	ADMINISTRATIVE & GENERAL	0	0	0	-454, 361	958, 674	4.00
5. 00	PLANT OPERATION & MAINTENANCE	0	0	0	0	120, 273	5. 00
6. 00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7. 00	HOUSEKEEPI NG	0	0	0	0	48, 336	7. 00
8. 00	DI ETARY	0	0	0	0	0	8. 00
9. 00	NURSING ADMINISTRATION		0	0	0	80, 054	9. 00
	ROUTINE MEDICAL SUPPLIES		0	0	0	3, 676	10.00
	MEDI CAL RECORDS		0	0	0	0	11. 00
	STAFF TRANSPORTATION		0	0	0	0	12.00
	VOLUNTEER SERVICE COORDINATION		0	0	0	0	13. 00
	PHARMACY		0	0	0	98	
	PHYSICIAN ADMINISTRATIVE SERVICES			0	0	0	15. 00
	OTHER GENERAL SERVICE			0	0	0	16. 00
	PATI ENT/RESI DENTI AL CARE SERVI CES				ő	0	17. 00
17.00	LEVEL OF CARE				<u> </u>	0	17.00
50 00	HOSPICE CONTINUOUS HOME CARE			0	0	0	50.00
	HOSPICE ROUTINE HOME CARE			408, 201		546, 691	
	HOSPICE INPATIENT RESPITE CARE	68	68			12, 627	
	HOSPICE GENERAL INPATIENT CARE	618				146, 919	
	NONREI MBURSABLE COST CENTERS				-1		
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
	VOLUNTEER PROGRAM	0	0	0	0	0	61. 00
	FUNDRAI SI NG	0	0	0	0	0	62.00
	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64. 00
	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65. 00
	RESI DENTI AL CARE	0	0	0	0	0	66. 00
	ADVERTI SI NG	0	0	0	0	0	67. 00
	TELEHEALTH/TELEMONI TORI NG	0	0	0	0	0	68. 00
	THRI FT STORE		0	0	0	0	69. 00
	NURSING FACILITY ROOM & BOARD				0	<u> </u>	70. 00
	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	
	NEGATI VE COST CENTER		Ĭ	Ĭ	Ĭ		99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I	119, 799	523	154, 949		454, 361	
	UNIT COST MULTIPLIER	174. 634111				0. 473947	
	1	.,	0.702071	1 0.00000		0	

Health Financial Systems		GOOD	SAMARI TAN	HOSPI TAL				In Lieu	of Form C	MS-2552-10
COST ALLOCATION - HOSPITAL-BASED STATISTICAL BASIS	HOSPICE GENERAL	SERVI CE	COSTS	Provi der	CCN:	15-0042	Perion From	od: 01/01/2020	Worksheet Part II	0-6
STATE DIGITS				Hospi ce (CCN:	15-1526	To	12/31/2020	Date/Time	Prepared:

SIAIIS	TITCAL BASIS		Hospi ce CC	N: 15-1526	To 12/31/2020	Date/Time Pre 7/29/2021 2:3	
					Hospi ce I		
	Cost Center Descriptions	PLANT OPERATION & MAINTENANCE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (IN-FACILITY DAYS)	HOUSEKEEPING (SQUARE FEET		NURSING ADMINISTRATIO N (DIRECT NURS. HRS.)	
		5. 00	6. 00	7. 00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS	<u>'</u>			-		
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL PLANT OPERATION & MAINTENANCE LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY NURSING ADMINISTRATION ROUTINE MEDICAL SUPPLIES MEDICAL RECORDS STAFF TRANSPORTATION VOLUNTEER SERVICE COORDINATION PHARMACY PHYSICIAN ADMINISTRATIVE SERVICES OTHER GENERAL SERVICE	686 0 0 0 0 0 0 0 0 0	0	68	0 0 0 0 0 0 0 0 0 0	14, 018 0 0 0 0 0 0	1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00
50. 00 51. 00 52. 00 53. 00	LEVEL OF CARE HOSPICE CONTINUOUS HOME CARE HOSPICE ROUTINE HOME CARE HOSPICE INPATIENT RESPITE CARE HOSPICE GENERAL INPATIENT CARE	68 618	0	1	8 0 8 0	0 13, 039 18 961	50. 00 51. 00 52. 00 53. 00
100.00	NONREIMBURSABLE COST CENTERS BEREAVEMENT PROGRAM VOLUNTEER PROGRAM FUNDRAISING HOSPICE/PALLIATIVE MEDICINE FELLOWS PALLIATIVE CARE PROGRAM OTHER PHYSICIAN SERVICES RESIDENTIAL CARE ADVERTISING TELEHEALTH/TELEMONITORING THRIFT STORE NURSING FACILITY ROOM & BOARD OTHER NONREIMBURSABLE (SPECIFY) NEGATIVE COST CENTER COST TO BE ALLOCATED (per Wkst. 0-6, Part I	0 0 0 0 0 0 0 0 0 0 0 0 177, 276 258, 419825	0 0 0. 000000	71, 24		0 0 0 0 117, 995	

	Financial Systems	GOOD SAMARITAN	_			u of Form CMS-	
	ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL S	SERVICE COSTS	Provi der C		Period: From 01/01/2020	Worksheet 0-6	
STATES	STATISTICAL BASIS		Hospi ce CC		To 12/31/2020		epared:
			'			7/29/2021 2:3	3 pm
					Hospi ce I		
	Cost Center Descriptions	ROUTI NE	MEDI CAL	STAFF	VOLUNTEER	PHARMACY	
		MEDI CAL	RECORDS	TRANSPORTATI ((CHARGES)	
		SUPPLI ES	(PATI ENT	N (MILEAGE)	COORDI NATI ON		
		(PATI ENT DAYS)	DAYS)	(MI LEAGE)	(HOURS OF SERVICE)		
		10. 00	11. 00	12.00	13. 00	14.00	
	GENERAL SERVICE COST CENTERS	10.00	11.00	12.00	13.00	14.00	
1. 00	CAP REL COSTS-BLDG & FLXT	Τ		Ι			1.00
2. 00	CAP REL COSTS-MVBLE EQUIP						2.00
3. 00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4. 00	ADMI NI STRATI VE & GENERAL						4.00
5. 00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6,00
7.00	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	5, 557					10.00
11.00	MEDI CAL RECORDS		C				11.00
12.00	STAFF TRANSPORTATION				0		12.00
13.00	VOLUNTEER SERVICE COORDINATION				0 0		13.00
14.00	PHARMACY				0 0	5, 557	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES				0 0	0	
16.00	OTHER GENERAL SERVICE				0 0	0	1 10.00
17. 00	PATI ENT/RESI DENTI AL CARE SERVI CES						17. 00
	LEVEL OF CARE						1
50.00	HOSPICE CONTINUOUS HOME CARE	0	C		0	0	
51.00	HOSPICE ROUTINE HOME CARE	5, 169	C		0	5, 169	1
52.00	HOSPICE INPATIENT RESPITE CARE	7	C		0	7	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	381	C)	0 0	381	53.00
(0.00	NONREI MBURSABLE COST CENTERS				ما		
60.00	BEREAVEMENT PROGRAM			•	0 0	0	00.00
61.00	VOLUNTEER PROGRAM			•	0 0	0	61.00
62.00	FUNDRAL SI NG				0 0	0	02.00

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69. 00 70. 00

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63.00 HOSPICE/PALLIATIVE MEDICINE FELLOWS
64.00 PALLIATIVE CARE PROGRAM

OTHER PHYSICIAN SERVICES

69. 00 THRIFT STORE
70. 00 NURSING FACILITY ROOM & BOARD
71. 00 OTHER NONE BURSABLE (SPECIFY)

100.00 COST TO BE ALLOCATED (per Wkst. 0-6, Part I)
101.00 UNIT COST MULTIPLIER

68. 00 | TELEHEALTH/TELEMONI TORI NG

66. 00 RESIDENTIAL CARE

ADVERTI SI NG

99.00 NEGATIVE COST CENTER

65.00

67.00

Health Financial Systems	GOOD SAMARITA	N HOSPITAL	In Lie	u of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED I STATISTICAL BASIS	HOSPICE GENERAL SERVICE COSTS	Provi der CCN: 15-0042 Hospi ce CCN: 15-1526		

Cost Center Descriptions	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
ADMINISTRATIV E SERVICE RESIDENTIAL CARE SERVICES (SPECIFY (SPECIFY (SPECIFY (DAYS)) 15.00 16.00 17.00	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00
CARE SERVICES (PATIENT DAYS) DAYS) DAYS)	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00
CPATI ENT DAYS DAYS DAYS	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00
DAYS DAYS	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00
DAYS DAYS	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00
15.00	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00
GENERAL SERVI CE COST CENTERS	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00
1. 00	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00
2.00	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00
3.00	3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00
4.00 ADMINISTRATIVE & GENERAL 5.00 PLANT OPERATION & MAINTENANCE 6.00 LAUNDRY & LINEN SERVICE 7.00 HOUSEKEEPING 8.00 DI ETARY 9.00 NURSING ADMINISTRATION 10.00 ROUTINE MEDICAL SUPPLIES 11.00 MEDICAL RECORDS 12.00 STAFF TRANSPORTATION 13.00 VOLUNTEER SERVICE COORDINATION 14.00 PHARMACY 15.00 PHYSICIAN ADMINISTRATIVE SERVICES 17.00 OTHER GENERAL SERVICE 17.00 PATIENT/RESIDENTIAL CARE SERVICES 18.00 DIEVEL OF CARE 50.00 HOSPICE CONTINUOUS HOME CARE	4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00
5. 00	5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00
6. 00	6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00
7. 00	7. 00 8. 00 9. 00 10. 00 11. 00 12. 00
8. 00	8. 00 9. 00 10. 00 11. 00 12. 00
9. 00	9. 00 10. 00 11. 00 12. 00
10. 00	10.00 11.00 12.00
11. 00	11. 00 12. 00
12. 00 STAFF TRANSPORTATION 13. 00 VOLUNTEER SERVICE COORDINATION 14. 00 PHARMACY 15. 00 PHYSICIAN ADMINISTRATIVE SERVICES 5, 557 16. 00 OTHER GENERAL SERVICE 0 17. 00 PATIENT/RESIDENTIAL CARE SERVICES 0 LEVEL OF CARE 50. 00 HOSPICE CONTINUOUS HOME CARE 0 0 0	12.00
12. 00 STAFF TRANSPORTATION 13. 00 VOLUNTEER SERVICE COORDINATION 14. 00 PHARMACY 15. 00 PHYSICIAN ADMINISTRATIVE SERVICES 5, 557 0 16. 00 OTHER GENERAL SERVICE 0 OTHER GENERAL SERVICES 0 OTHER GENERAL SERVICES 0 OTHER GENERAL CARE SERVICES 0 OTHER GENERAL SERVICES 0 OTHER GENERAL CARE SERVICES 0 OTHER GENERAL SERVICES 0 OTHER GENERAL SERVICES OTHER GENERAL SERVICES	
13. 00	
14. 00	13.00
15. 00	14.00
16. 00 OTHER GENERAL SERVI CE	15.00
17. 00 PATI ENT/RESI DENTI AL CARE SERVI CES 0 LEVEL OF CARE 50. 00 HOSPI CE CONTI NUOUS HOME CARE 0 0 0	•
LEVEL OF CARE 50. 00 HOSPI CE CONTI NUOUS HOME CARE 0 0	16.00
50. 00 HOSPICE CONTINUOUS HOME CARE 0 0	17. 00
	50.00
51.00 HOSPICE ROUTINE HOME CARE 5,169 0	51.00
52.00 HOSPICE INPATIENT RESPITE CARE 7 0 0	52.00
53.00 HOSPICE GENERAL INPATIENT CARE 381 0 0	53.00
NONREI MBURSABLE COST CENTERS	
60.00 BEREAVEMENT PROGRAM 0	60.00
61.00 VOLUNTEER PROGRAM 0	61.00
62. 00 FUNDRAI SI NG 0	62.00
63. 00 HOSPICE/PALLIATIVE MEDICINE FELLOWS 0	63.00
64. 00 PALLIATIVE CARE PROGRAM 0	64.00
65. 00 OTHER PHYSI CI AN SERVI CES 0	65. 00
66. 00 RESI DENTI AL CARE 0 0 0	66.00
67. 00 ADVERTI SI NG 0	67.00
68. 00 TELEHEALTH/TELEMONI TORI NG	68.00
69. 00 THRIFT STORE 0	69.00
70.00 NURSING FACILITY ROOM & BOARD	70.00
71.00 OTHER NONREIMBURSABLE (SPECIFY) 0 0 0	71.00
99.00 NEGATIVE COST CENTER	99.00
100.00 COST TO BE ALLOCATED (per Wkst. 0-6, Part I) 0 0 0	
101. 00 UNIT COST MULTIPLIER 0. 000000 0. 000000 0. 000000	100.00

Health Financial Systems	GOOD SAMARIT	AN HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF HOSPITAL-BASED HOSPICE SHARED LEVEL OF CARE	SERVICE COSTS BY	Provi der Co		Period: From 01/01/2020	Worksheet 0-7	
LEVEL OF SIME		Hospi ce CCI	N: 15-1526	To 12/31/2020	Date/Time Pre 7/29/2021 2:3	pared: 3 pm
				Hospi ce I		
			Charges by	LOC (from Provi	der Records)	
Cost Center Descriptions	From Wkst. C, Part I, Col.	Cost to Charge Ratio	HCHC	HRHC	HI RC	

			5.1d. geo 27 2		ue. 1.000. ue,	
Cost Center Descriptions	From Wkst. C.	Cost to	HCHC	HRHC	HI RC	
	Part I, Col.	Charge Ratio				
	9 line					
	0	1.00	2. 00	3. 00	4. 00	
ANCILLARY SERVICE COST CENTERS						
1. 00 PHYSI CAL THERAPY	66. 00		0	0	0	
2. 00 OCCUPATI ONAL THERAPY	67. 00					2.00
3. 00 SPEECH PATHOLOGY	68.00			0		3.00
4.00 DRUGS CHARGED TO PATIENTS 5.00 DURABLE MEDICAL EQUIP-RENTED	73. 00 96. 00		0	0	0	4. 00 5. 00
6. 00 LABORATORY	60.00			0	0	1
7. 00 MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00			0		
8. 00 OTHER OUTPATIENT SERVICE COST CENTER	93.00			0	0	8.00
9. 00 RADI OLOGY-THERAPEUTI C	55. 00		0	0	0	
10.00 MH ANCILLARY OUTPATIENT	76.00			0	0	10.00
10. 01 I NPATI ENT DI ALYSI S	76. 01	0. 750849		0	0	10.01
11.00 Totals (sum of lines 1-11)						11.00
	Charges by		Shared Service	Costs by LOC		
	LOC (from					
	Provi der					
	Records)	110110 6 1 4	LUDUIQ () 4		1101.5 () 4	
Cost Center Descriptions	HGI P	HCHC (col. 1	HRHC (col. 1	HIRC (col. 1	HGIP (col. 1	
	5. 00	x col. 2) 6.00	x col. 3) 7.00	x col. 4) 8.00	x col. 5) 9.00	
ANCILLARY SERVICE COST CENTERS	3.00	0.00	7.00	8.00	7.00	
1. 00 PHYSI CAL THERAPY	0	0	0	0	0	1.00
2. 00 OCCUPATI ONAL THERAPY				J		2.00
3. 00 SPEECH PATHOLOGY						3.00
4. 00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	4.00
5. 00 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	5.00
6. 00 LABORATORY	0	0	0	0	0	6.00
7.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	7. 00
8.00 OTHER OUTPATIENT SERVICE COST CENTER						8. 00
9. 00 RADI OLOGY-THERAPEUTI C	0	0	-	0	0	
10.00 MH ANCILLARY OUTPATIENT	0	0	-	0	0	
10. 01 INPATIENT DIALYSIS	0	0	-		· ·	
11.00 Totals (sum of lines 1-11)	1	0	0	0	0	11. 00

		nospi ce cci	. 15-1520 1	0 12/31/2020	7/29/2021 2:3	pareu. 3 pm
				Hospi ce I		
			TITLE XVIII	TITLE XIX	TOTAL	
			MEDI CARE	MEDI CAI D		
			1. 00	2. 00	3. 00	
	HOSPICE CONTINUOUS HOME CARE					
1. 00	Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-	7, col. 6,			0	1.00
0.00	line 11)				0	0.00
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)				0	2.00
3.00	Total average cost per diem (line 1 divided by line 2)	10)			0. 00	3.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, lin	e 10)	C	1		4.00
5. 00	Program cost (line 3 times line 4)		C) 0		5.00
/ 00	HOSPICE ROUTINE HOME CARE	71 7			020 722	/ 00
6. 00	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-line 11)	7, COI. 7,			920, 722	6. 00
7. 00					F 140	7. 00
7. 00 8. 00	Total unduplicated days (Wkst. S-9, col. 4, line 11)				5, 169	8.00
9. 00	Total average cost per diem (line 6 divided by line 7)	no 11)	4, 987	, 20	178. 12	9.00
10.00	Unduplicated program days (Wkst. S-9, col. as appropriate, li	ne II)	4, 987 888, 284			10.00
10.00	Program cost (line 8 times line 9) HOSPICE INPATIENT RESPITE CARE		888, 284	5, 344		10.00
11. 00	Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-	7 001 0			43, 406	11. 00
11.00	line 11)	7, COI. 6,			43, 400	11.00
12. 00	Total unduplicated days (Wkst. S-9, col. 4, line 12)	•			7	12.00
13. 00	Total average cost per diem (line 11 divided by line 12)				6, 200. 86	13.00
14. 00	Unduplicated program days (Wkst. S-9, col. as appropriate, li	ne 12)	E	0	0, 200. 00	14.00
	Program cost (line 13 times line 14)	110 12)	31, 004	-		15. 00
13.00	HOSPICE GENERAL INPATIENT CARE		31,004	rı <u> </u>		13.00
16 00	Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-	7 col 9			448, 907	16.00
	line 11)	,, ,,			110,707	10.00
17. 00	Total unduplicated days (Wkst. S-9, col. 4, line 13)				381	17. 00
18. 00	Total average cost per diem (line 16 divided by line 17)				1, 178. 23	18.00
19. 00	Unduplicated program days (Wkst. S-9, col. as appropriate, li	ne 13)	326	15	.,	19.00
20. 00	Program cost (line 18 times line 19)		384, 103	17, 673		20.00
	TOTAL HOSPICE CARE			,		
21. 00	Total cost (sum of line 1 + line 6 + line 11 + line 16)				1, 413, 035	21.00
	Total unduplicated days (Wkst. S-9, col. 4, line 14)				5, 557	1
23.00						

	Health Financial Systems GOOD SAMARITAN HOSPITAL In Lieu CALCULATION OF CAPITAL PAYMENT Provider CCN: 15-0042 Period: From 01/01/2020 From 12/31/2020 From 12							
		Title XVIII	Hospi tal	7/29/2021 2: 3 PPS				
				1. 00				
	PART I - FULLY PROSPECTIVE METHOD							
	CAPITAL FEDERAL AMOUNT							
1. 00	Capital DRG other than outlier			1, 574, 757	1.00			
1. 01	Model 4 BPCI Capital DRG other than outlier			0				
2.00	Capital DRG outlier payments			20, 528	1			
2. 01	Model 4 BPCI Capital DRG outlier payments			0				
3.00	Total inpatient days divided by number of days in the cost re	eporting period (see inst	ructions)	50. 43				
4.00	Number of interns & residents (see instructions)			8. 14				
5.00	Indirect medical education percentage (see instructions)	E ! 1 1 01		4. 67	5.00			
6. 00	Indirect medical education adjustment (multiply line 5 by the 1.01) (see instructions)	e sum or lines I and I.UI	, corumns i and	73, 541	6. 00			
7. 00	Percentage of SSI recipient patient days to Medicare Part A p 30) (see instructions)	0.00	7. 00					
8. 00	Percentage of Medicaid patient days to total days (see instru	0. 00	8. 00					
9. 00					1			
10.00	Allowable disproportionate share percentage (see instructions	0. 00 0. 00						
11. 00	Disproportionate share adjustment (see instructions)	0.00						
12. 00	Total prospective capital payments (see instructions)	1, 668, 826						
				1. 00				
	PART II - PAYMENT UNDER REASONABLE COST							
1.00	Program inpatient routine capital cost (see instructions)			0				
2.00	Program inpatient ancillary capital cost (see instructions)			0				
3.00	Total inpatient program capital cost (line 1 plus line 2)			0				
4.00	Capital cost payment factor (see instructions)	0						
5. 00	Total inpatient program capital cost (line 3 x line 4)			0	5. 00			
				1. 00				
	PART III - COMPUTATION OF EXCEPTION PAYMENTS							
1.00	Program inpatient capital costs (see instructions)			0	1.00			
2.00	Program inpatient capital costs for extraordinary circumstand	ces (see instructions)		0	2.00			
3.00	Net program inpatient capital costs (line 1 minus line 2)			0	3.00			
4.00	Applicable exception percentage (see instructions)			0.00	4. 00			
5.00	Capital cost for comparison to payments (line 3 x line 4)			0	5. 00			
6.00	Percentage adjustment for extraordinary circumstances (see in	nstructions)		0.00	6. 00			
7.00	Adjustment to capital minimum payment level for extraordinary	y circumstances (line 2 x	:line 6)	0	7. 00			
8.00	Capital minimum payment level (line 5 plus line 7)			0				
9.00	Current year capital payments (from Part I, line 12, as appli			0				
10.00	Current year comparison of capital minimum payment level to o			0				
11. 00	Carryover of accumulated capital minimum payment level over	capital payment (from pri	or year	0	11.00			
10.00	Worksheet L, Part III, line 14)		- 11)	_	10.00			
12.00	Net comparison of capital minimum payment level to capital pa			0				
13. 00 14. 00	Current year exception payment (if line 12 is positive, enter		,	0	1			
14.00	Carryover of accumulated capital minimum payment level over of (if line 12 is negative, enter the amount on this line)	zapitai payiilent non the n	orrowing period		14.00			

(if line 12 is negative, enter the amount on this line)

15.00 Current year allowable operating and capital payment (see instructions)

16.00 Current year operating and capital costs (see instructions)

17.00 Current year exception offset amount (see instructions)

17.00

0 15.00

0 16.00