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 01/01/2021 Parts I-III AND SETTLEMENT SUMMARY 12/31/2021 Date/Time Prepared: 5/26/2022 9:38 am PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 5/26/2022 9:38 am] 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. [5] Cost Report Status
[6] Date Received:
[7] As Submitted
[7] Contractor No.
[8] [N] Initial Report for this Provider CCN
[9] [N] Final Report for this Provider CCN
[10] NPR Date:
[11] Contractor's Vendor Code:
[12] [0] If line 5, column 1 is 4: Enter
[13] Number of times reopened = 0-9. Contractor use only (3) Settled with Audit number of times reopened = 0-9.

PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)

(4) Reopened (5) Amended

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

CERTIFICATION BY 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 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 01/01/2021 and ending 12/31/2021 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.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONI C	
		1	2	SI GNATURE STATEMENT	
1	Matthe	w Schuckman	Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Matthew Schuckman			2
3	Signatory Title	CF0			3
4	Date	(Dated when report is electronica			4

Cost Center Description			Title	XVIII			
		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	1, 789, 548	185, 404	0	-391, 193	1.00
2.00	Subprovi der - IPF	0	110, 818	9		176, 862	2.00
3.00	Subprovider - IRF	0	75, 798	18		-5, 619	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, 976, 164	185, 431	0	-219, 950	200. 00
The al	pove amounts represent "due to" or "due from"	the annlicable	program for th	a alament of t	he above comply	av indicated	

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDI CARE.

HOSPI 1	AL AND HOSPITAL HEALTH CARE COMPLEX	I DENTI FI C		Provi d	er CCN: 1	15-0042	Period: From 01/01/ To 12/31/	'2021 '2021	Workshe Part I Date/Ti 5/26/20	me Pre	pared:
	1.00 Hospital and Hospital Health Care Co	mal av Ada	2.00		3. 00			4. 00			
1. 00	Street: 520 SOUTH 7TH STREET	ilipi ex Auc	PO Box:								1.00
2.00	City: VINCENNES		State: IN	Zip Cod	e: 47591	Coun	ty: KNOX				2. 00
		Comp	onent Name	CCN	CBSA	Provi der			nt Syst		
				Number	Number	Туре	Certi fi ed	V,	0, or		
			1. 00	2.00	3. 00	4.00	5. 00	6. 00	7. 00	8. 00	_
	Hospital and Hospital-Based Componen	t Identif		2.00	0.00	1.00	0.00	0.00	7.00	0.00	
3.00	Hospi tal	1	ARITAN HOSPITAL	150042	99915	1	07/01/1966	N	Р	0	3. 00
4.00	Subprovi der - IPF	1	ARITAN HOSPITAL	15S042	99915 99915	4 5	01/01/1984	N N	P	0	4.00
5. 00 6. 00	Subprovi der - IRF Subprovi der - (Other)	GOOD SAMA	ARITAN - REHAB	15T042	99915	5	01/01/2001	l IN		0	5. 00 6. 00
7. 00	Swing Beds - SNF										7. 00
8.00	Swing Beds - NF										8. 00
9.00	Hospi tal -Based SNF										9.00
10. 00 11. 00	Hospi tal -Based NF Hospi tal -Based OLTC										10.00
12. 00	Hospi tal -Based HHA	GOOD SAMA	ARITAN HOME	157432	99915		06/27/1995	N	Р	N	12. 00
		CENTER									
13.00	Separately Certified ASC	0000 0444	ADLTAN LINGOLN	454507	00045		04 /04 /400 4				13.00
14. 00	Hospi tal -Based Hospi ce	TRAIL HOS	ARITAN LINCOLN	151526	99915		01/01/1984				14.00
15. 00	Hospital-Based Health Clinic - RHC	I III	DITCE								15. 00
16. 00	Hospital-Based Health Clinic - FQHC										16. 00
17. 00	Hospital-Based (CMHC) I										17. 00
18.00	Renal Dialysis Other										18. 00 19. 00
19.00	other	1					From:		To	: :	17.00
							1. 00		2. 0		
	Cost Reporting Period (mm/dd/yyyy)						01/01/2	021	12/31/	′2021	20.00
21.00	Type of Control (see instructions)						9				21. 00
						1. 00	2. 00		3. 0	00	
	Inpatient PPS Information										
22. 00	Does this facility qualify and is it disproportionate share hospital adju					Υ	N				22. 00
	§412. 106? In column 1, enter "Y" fo				`						
	facility subject to 42 CFR Section §	412. 106(c	(2) (Pickle ame								
22 01	hospital?) In column 2, enter "Y" fo			o for thi		Υ	N.				22. 01
22. 01	Did this hospital receive interim un cost reporting period? Enter in colu					Y	N				22.01
	the portion of the cost reporting pe										
	Enter in column 2, "Y" for yes or "N				ost						
22. 02	reporting period occurring on or aft Is this a newly merged hospital that					N	N				22. 02
22. 02	payments to be determined at cost re					IV	IN IN				22.02
	Enter in column 1, "Y" for yes or "N	" for no,	for the portion	n of the							
	cost reporting period prior to Octob										
	or "N" for no, for the portion of th October 1.	e cost re	porting period	on or art	er						
22. 03	Did this hospital receive a geograph	ic reclas	sification from	urban to	,	N	N		N		22. 03
	rural as a result of the OMB standar										
	adopted by CMS in FY2015? Enter in c										
	for the portion of the cost reporting in column 2, "Y" for yes or "N" for				91						
	reporting period occurring on or aft										
	Does this hospital contain at least			•							
	counted in accordance with 42 CFR 41 yes or "N" for no.	2. 105)? E	nter in column	3, "Y" fc	or						
22. 04	Did this hospital receive a geograph	ic reclas	sification from	urban to	,	N	N		N		22. 04
	rural as a result of the revised OMB										
	adopted by CMS in FY 2021? Enter in for the portion of the cost reportin										
	in column 2, "Y" for yes or "N" for				;'						
	reporting period occurring on or aft										
	Does this hospital contain at least										
	counted in accordance with 42 CFR 41 yes or "N" for no.	∠. 105)?	Enter in column	ιο, Y¨T	UI						
23. 00	Which method is used to determine Me	dicaid da	ys on lines 24	and/or 25	;		2 N				23. 00
	below? In column 1, enter 1 if date			,							
	if date of discharge. Is the method reporting period different from the				OST						
	reporting period? In column 2, ente										
					*		•				

SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DAT	ГА	Provi der C	CN: 15-0042	Peri od: From 01/01/2021	Worksheet S-2 Part I	
			NAHE 413.8! Y/N	To 12/31/2021 Worksheet A Li ne #	Date/Time Pre 5/26/2022 9:33 Pass-Through Qualification	
					Criterion Code	
			1. 00	2.00	3. 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 column column column.	85? (se umn 1. R) NAHE mn 2.	ee If column 1 MA payment	Y	Y		60.
1.01 If line 60 is yes, complete columns 2 and 3 for each instructions)			Di+ CME	23. 01		60.
	Y/N	I ME	Direct GME		Direct GME	
.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in	1. 00 N	2. 00	3. 00	4.00	5.00	61.
column 1. (see instructions) .01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.
.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.
O3 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.
O4 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61.
O5 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.
O6 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61
	Pro	gram Name	Program Cod		Unweighted Direct GME FTE Count	
		1.00	2. 00	3.00	4.00	
10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME				0.00	0.00	61
FTE unweighted count. 20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4,				0.00	0. 00	61.
the direct GME FTE unweighted count.					1.00	
ACA Provisions Affecting the Health Resources and Ser .00 Enter the number of FTE residents that your hospital	trai ned			eriod for which	0.00	62.
your hospital received HRSA PCRE funding (see instruc .01 Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog	Teachi r			o your hospital	0.00	62.
Teaching Hospitals that Claim Residents in Nonprovide			,		1	1

Health Financial Systems	GOOD S	SAMARITAN HOSPITAL		In Lie	eu of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMP	PLEX IDENTIFICATION DA	ATA Provider CC		eriod: rom 01/01/2021 o 12/31/2021	Worksheet S-2 Part I Date/Time Prep 5/26/2022 9:38	
			Unwei ghted FTEs Nonprovi der	Unwei ghted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			Si te 1. 00	2.00	3.00	
Section 5504 of the ACA Base Ye	ar FTE Residents in N	onprovider Settings				
period that begins on or after 64.00 Enter in column 1, if line 63 is in the base year period, the nuresident FTEs attributable to resettings. Enter in column 2 the resident FTEs that trained in yof (column 1 divided by (column	July 1, 2009 and before yes, or your facilinater of unweighted now chations occurring in the number of unweighted your hospital. Enter in	re June 30, 2010. ty trained residents n-primary care all nonprovider d non-primary care n column 3 the ratio	0.00			64. 00
jer (cordinir r dr vrded by (cordinir	Program Name	Program Code	Unwei ghted	Unweighted	Ratio (col. 3/	
	3	3	FTĔs Nonprovi der Si te	FTES in Hospital	(col. 3 + col. 4))	
	1. 00	2. 00	3. 00	4. 00	5.00	
65.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0. 00	0.000000 Ratio (col. 1/	65. 00
			Unwei ghted FTEs Nonprovi der Si te	FTEs in Hospital	(col. 1 + col. 2))	
			1. 00	2.00	3.00	
Section 5504 of the ACA Current	Year FTE Residents i	n Nonprovider Setting	sEffective fo	r cost reporti	ng peri ods	
beginning on or after July 1, 2			0.00	0.50	0.00000	
66.00 Enter in column 1 the number of FTEs attributable to rotations Enter in column 2 the number of FTEs that trained in your hospi (column 1 divided by (column 1	occurring in all nonp unweighted non-prima tal. Enter in column:	rovider settings. ry care resident 3 the ratio of	0.00	8. 53	0. 000000	66.00
	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col. 3/	
			FTEs Nonprovi der	FTEs in Hospital	(col. 3 + col. 4))	
			Si te		.,,	
	1.00	2.00	3. 00	4. 00	5.00	
67.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	INTERNAL MEDICINE	1400	0.00	16. 18	3 0.000000	67.00

HUSPII	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		From 01/01. To 12/31.	/2021 /2021	worksne Part I Date/Ti 5/26/20	me Pre	pared:
				1. 00	2. 00	3. 00	
70 00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does i	t contain an IPE sul	nnrovi der?	Υ			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 recent cost report filed on or before November 15, 2004? Enter "Y"	' for yes or "N" for	no. (see	N	Y	3	71. 00
	42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train resprogram in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y"						
	Column 3: If column 2 is Y, indicate which program year began durin (see instructions)						
75 00	Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or doe	es it contain an IDE		Y			75. 00
	subprovider? Enter "Y" for yes and "N" for no.			'			
76. 00	If line 75 is yes: Column 1: Did the facility have an approved GME recent cost reporting period ending on or before November 15, 2004? no. Column 2: Did this facility train residents in a new teaching pCFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column	PEnter "Y" for yes or program in accordance n 3: If column 2 is '	or "N" for e with 42 Y,	N	N	0	76. 00
	indicate which program year began during this cost reporting period	d. (see instructions)				
	Long Term Care Hospital PPS				1.0	0	
	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N		. 10.5		N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all c "Y" for yes and "N" for no. TEFRA Providers	of the cost reporting	g period? E	nter	N		81. 00
	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA?			no.	N		85.00
	Did this facility establish a new Other subprovider (excluded unit) §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital class		on		N		86.00
87. 00	1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	siffed under Section	_		N		87. 00
			1. 00)	XI) 2. 0		
90. 00	Title V and XIX Services Does this facility have title V and/or XIX inpatient hospital servi	ces? Enter "Y" for	N		Υ		90.00
91. 00	yes or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through the cost		N		Υ		91. 00
92. 00	full or in part? Enter "Y" for yes or "N" for no in the applicable Are title XIX NF patients occupying title XVIII SNF beds (dual cert	tification)? (see			N		92. 00
93. 00	instructions) Enter "Y" for yes or "N" for no in the applicable col Does this facility operate an ICF/IID facility for purposes of titl		N		N		93. 00
94. 00	"Y" for yes or "N" for no in the applicable column. Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" applicable column.	for no in the	N		N		94. 00
	If line 94 is "Y", enter the reduction percentage in the applicable		0.00)	0.0		95. 00
	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" applicable column.		N		N		96. 00
97. 00 98. 00	If line 96 is "Y", enter the reduction percentage in the applicable Does title V or XIX follow Medicare (title XVIII) for the interns a	and residents post	0. 00 N)	0. 0 Y		97.00
	stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes column 1 for title V, and in column 2 for title XIX.	or "N" for no in					
98. 01	Does title V or XIX follow Medicare (title XVIII) for the reporting C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V,		. N		Υ		98. 01
98. 02	title XIX. Does title V or XIX follow Medicare (title XVIII) for the calculati bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" f for title V, and in column 2 for title XIX.		N		Υ		98. 02
98. 03	Does title V or XIX follow Medicare (title XVIII) for a critical acreimbursed 101% of inpatient services cost? Enter "Y" for yes or "N for title V, and in column 2 for title XIX.		1 N		N		98. 03
98. 04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbur outpatient services cost? Enter "Y" for yes or "N" for no in column in column 2 for title XIX.		N		N		98. 04
98. 05	Does title V or XIX follow Medicare (title XVIII) and add back the Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 column 2 for title XIX.				Y		98. 05
98. 06	Does title V or XIX follow Medicare (title XVIII) when cost reimbur Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for column 2 for title XIX.		N		Y		98. 06
	Rural Providers Does this hospital qualify as a CAH?	vo mothed of pour	N N				105.00
	If this facility qualifies as a CAH, has it elected the all-inclusi for outpatient services? (see instructions)	. ,					106. 00
107. 00	Column 1: If line 105 is Y, is this facility eligible for cost rein training programs? Enter "Y" for yes or "N" for no in column 1. (s Column 2: If column 1 is Y and line 70 or line 75 is Y, do you transproved modical education program in the CAN's excluded. IPE and/or	see instructions) ain I&Rs in an	N				107. 00
	approved medical education program in the CAH's excluded IPF and/c Enter "Y" for yes or "N" for no in column 2. (see instructions)	or incommutal!					

	Provider C		eri od:	Worksheet S-	2
		F	rom 01/01/2021 o 12/31/2021	Date/Time Pr	
			V	5/26/2022 9: XI X	38 ar
			1.00	2.00	
8.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	CRNA fee sche	edul e? See 42	N		108
	Physi cal 1.00	Occupati onal 2.00	Speech 3.00	Respiratory 4.00	
0.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109
				1.00	
D. 00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter " complete Worksheet E, Part A, lines 200 through 218, and Wor applicable.	'Y" for yes or	"N" for no. It	f yes,	N	110
			1. 00	2.00	-
1.00 f this facility qualifies as a CAH, did it participate in t	the Frontier C	Community	N N	2.00	111
Health Integration Project (FCHIP) demonstration for this co "Y" for yes or "N" for no in column 1. If the response to co integration prong of the FCHIP demo in which this CAH is par Enter all that apply: "A" for Ambulance services; "B" for ac for tele-health services.	ost reporting olumn 1 is Y, rticipating ir	period? Enter enter the column 2.			
		1. 00	2. 00	3.00	
2.00 Did this hospital participate in the Pennsylvania Rural Heal demonstration for any portion of the current cost reporting Enter "Y" for yes or "N" for no in column 1. If column 1 is in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital cears.	peri od? s "Y", enter ne	N			111
participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information					
5.00 Is this an all-inclusive rate provider? Enter "Y" for yes or in column 1. If column 1 is yes, enter the method used (A, E in column 2. If column 2 is "E", enter in column 3 either "9 for short term hospital or "98" percent for long term care (psychiatric, rehabilitation and long term hospitals provider	3, or E only) 93" percent (includes	N			0 115
the definition in CMS Pub. 15-1, chapter 22, §2208.1. .00 Is this facility classified as a referral center? Enter "Y" "N" for no.	•	Y			11
7.00 s this facility legally-required to carry malpractice insur "Y" for yes or "N" for no.	ance? Enter	Υ			11
8.00 Is the malpractice insurance a claims-made or occurrence polif the policy is claim-made. Enter 2 if the policy is occurr			ı		118
The porrey is craim made. Enter 2 in the porrey is occur.		Premi ums	Losses	Insurance	
11 the portey 13 crafill made. Enter 2 11 the partey 13 ccan.					
		1.00 484,744	2. 00	3.00	0 118
		1.00	2.00	3.00	0 118
3.01 List amounts of malpractice premiums and paid losses: 3.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched	center other	1.00 484,744	2. 00	3.00	
8.01 List amounts of malpractice premiums and paid losses: 8.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting schedand amounts contained therein.	center other dule listing o d Harmless pro n column 1, "Y ualifies for t	than the cost centers ovision in ACA "for yes or the Outpatient	2.00	3.00	111
6.01 List amounts of malpractice premiums and paid losses: 6.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein. 7.00 DO NOT USE THIS LINE 7.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualified Hold Harmless provision in ACA \$3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.	center other dule listing of d Harmless pro n column 1, "Y ualifies for t nts? (see inst	than the cost centers ovision in ACA "for yes or the Outpatient cructions)	2.00 1.00 N	3.00	111
8.01 List amounts of malpractice premiums and paid losses: 8.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting schedand amounts contained therein. 9.00 DO NOT USE THIS LINE 9.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that question Hold Harmless provision in ACA \$3121 and applicable amendments. 9.00 Did this facility incur and report costs for high cost implation patients? Enter "Y" for yes or "N" for no. 10.00 Does the cost report contain healthcare related taxes as defined.	center other dule listing of Harmless pronocolumn 1, "Yualifies for this? (see instantable devices fined in §1903	than the cost centers ovision in ACA " for yes or the Outpatient cructions) es charged to 8(w)(3) of the	2.00 1.00 N	3.00	118 119 120
6.01 List amounts of malpractice premiums and paid losses: 6.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting schedand amounts contained therein. 7.00 DO NOT USE THIS LINE 7.00 DIs this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualified Hold Harmless provision in ACA \$3121 and applicable amendmenter in column 2, "Y" for yes or "N" for no. 8.00 Did this facility incur and report costs for high cost implated patients? Enter "Y" for yes or "N" for no. 8.00 Does the cost report contain healthcare related taxes as defact?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included.	center other dule listing of Harmless pronocolumn 1, "Yualifies for this? (see instantable devices fined in §1903	than the cost centers ovision in ACA " for yes or the Outpatient cructions) es charged to 8(w)(3) of the	2.00 1.00 N	3.00 2.00 N	118 119 120
Are malpractice premiums and paid losses: Administrative and General? If yes, submit supporting schedand amounts contained therein. OOD NOT USE THIS LINE OO Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter ir "N" for no. Is this a rural hospital with < 100 beds that qualifier in column 2, "Y" for yes or "N" for no. OOD id this facility incur and report costs for high cost implainable patients? Enter "Y" for yes or "N" for no. OOD Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information	center other dule listing of the column 1, "Y ualifies for the column start (see instantable device fined in §1903 lis "Y", enter	than the cost centers ovision in ACA "for yes or the Outpatient cructions) es charged to B(w)(3) of the er in column 2	2.00 1.00 N	3.00 2.00 N	118 119 120 122 122
B.01 List amounts of malpractice premiums and paid losses: B.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting schedand amounts contained therein. D.00 DO NOT USE THIS LINE D.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Hold Harmless provision in ACA \$3121 and applicable amendments. D.00 Did this facility incur and report costs for high cost implay patients? Enter "Y" for yes or "N" for no. D.00 Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information D.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.	center other dule listing of the dule listing of column 1, "Yualifies for the device fined in \$1903 is "Y", enter the certi	than the cost centers ovision in ACA "for yes or the Outpatient cructions) es charged to B(w)(3) of the er in column 2	2.00 1.00 N	3.00 2.00 N	118 119 120 121 122
3.01 List amounts of malpractice premiums and paid losses: 3.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting schedand amounts contained therein. 3.00 DO NOT USE THIS LINE 3.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifier in column 2, "Y" for yes or "N" for no. 3.00 Did this facility incur and report costs for high cost implay patients? Enter "Y" for yes or "N" for no. 3.00 Does the cost report contain healthcare related taxes as defact? Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information 5.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 5.00 If this is a Medicare certified kidney transplant center, enter of this is a Medicare certified heart transplant center, entered to the submit of the column 1 and termination date, if applicable, in column 2.	center other dule listing of the dule listing of the certification of th	than the cost centers ovision in ACA "for yes or the Outpatient cructions) es charged to B(w)(3) of the er in column 2 for no. If	2.00 1.00 N	3.00 2.00 N	118 118 119 120 121 122 126 126
3.01 List amounts of malpractice premiums and paid losses: 3.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting schedand amounts contained therein. 3.00 DO NOT USE THIS LINE 3.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that questioned Hold Harmless provision in ACA \$3121 and applicable amendments. The interior in column 2, "Y" for yes or "N" for no. 3.00 Did this facility incur and report costs for high cost implations? Enter "Y" for yes or "N" for no. 3.00 Does the cost report contain healthcare related taxes as defact? Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information 5.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 5.00 If this is a Medicare certified kidney transplant center, enter in column 1 and termination date, if applicable, in column 2 in column 1 and termination date, if applicable, in column 2 in column 1 and termination date, if applicable, in column 2 in column 1 and termination date, if applicable, in column 2 in column 2 in column 1 and termination date, if applicable, in column 2 in column	center other dule listing of Harmless properties for the certiful control of the certiful cer	than the cost centers ovision in ACA "for yes or the Outpatient cructions) es charged to B(w)(3) of the er in column 2 for no. If fication date	2.00 1.00 N	3.00 2.00 N	118 119 120 122 122 123
3.01 List amounts of malpractice premiums and paid losses: 3.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting schedand amounts contained therein. 7.00 DO NOT USE THIS LINE 7.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA \$3121 and applicable amendments. 8.00 Did this facility incur and report costs for high cost implation patients? Enter "Y" for yes or "N" for no. 8.00 Does the cost report contain healthcare related taxes as deformed act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. 8.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 8.00 If this is a Medicare certified kidney transplant center, enter in column 1 and termination date, if applicable, in column 2.	center other dule listing of Harmless properties for the certificant device of the certificant d	than the cost centers ovision in ACA "for yes or the Outpatient cructions) es charged to B(w)(3) of the er in column 2 for no. If fication date Fication date	2.00 H (C) 1.00 N	3.00 2.00 N	118 1119 120 122 122 121 120

Health Financial Systems	GOOD SAMAF	RITAN HOSPITAL			In Lie	u of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provider CC	N: 15-0042	Peri od:		Worksheet S-	-2
					1/01/2021 2/31/2021	Part I Date/Time Pr	epared:
						5/26/2022 9:	38 am
					1. 00	2.00	_
131.00 If this is a Medicare certified in			rti fi cati on		11.00	2.00	131. 00
date in column 1 and termination of			aatian data				122 00
132.00 If this is a Medicare certified is in column 1 and termination date,			cation date	•			132. 00
133.00 Removed and reserved							133. 00
134.00 If this is an organ procurement or		r the OPO number i	n column 1				134. 00
and termination date, if applicabl	e, in column 2.						
140.00 Are there any related organization	n or home office costs	as defined in CMS	Pub. 15-1,		N		140. 00
chapter 10? Enter "Y" for yes or '		,		S			
are claimed, enter in column 2 the	e nome office chain numi	<u>ber. (see instruct</u> 2.00	ions)		3. 00		
If this facility is part of a chair	in organization, enter		igh 143 the	name and		of the	
home office and enter the home of							4
141. 00 Name: 142. 00 Street:	Contractor's Name PO Box:	:	Contrac	tor's Nu	mber:		141. 00 142. 00
143. 00 Ci ty:	State:		Zi p Cod	e:			143. 00
	12.22.2		, <u> </u>				
144,00		1.40				1.00	111 00
144.00 Are provider based physicians' cos	sts included in workshe	et A?				Y	144. 00
					1. 00	2.00	
145.00 If costs for renal services are cl							145. 00
inpatient services only? Enter "Y'							
period? Enter "Y" for yes or "N"		TOIL TOIL TIILS COST	reporting				
146.00 Has the cost allocation methodolog	gy changed from the pre				N		146. 00
Enter "Y" for yes or "N" for no in		b. 15-2, chapter 4	0, §4020) I	f			
yes, enter the approval date (mm/d	ad/yyyy) in column 2.						
						1.00	
147.00 Was there a change in the statisti						N	147. 00
148.00 Was there a change in the order of 149.00 Was there a change to the simplifi				r no		N N	148. 00 149. 00
144. 00 was there a change to the shillpirin	ed cost irriding method	Part A	Part B		itle V	Title XIX	149.00
		1.00	2. 00		3.00	4.00	
Does this facility contain a provi or charges? Enter "Y" for yes or							
155. 00 Hospi tal	N TOT TIO TOT EACT COIL	N N	N	(366 42	N 9413	N N	155. 00
156.00 Subprovi der - IPF		N	N		N	N	156. 00
157.00 Subprovi der - IRF		N	N		N	N	157. 00
158. 00 SUBPROVI DER 159. 00 SNF		N	N		N	N	158. 00 159. 00
160.00 HOME HEALTH AGENCY		N N	N		N	N	160. 00
161. 00 CMHC			N		N	N	161. 00
						1.00	
Multicampus						1.00	
165.00 Is this hospital part of a Multica	ampus hospital that has	one or more campu	ses in diff	erent CB	SAs?	N	165. 00
Enter "Y" for yes or "N" for no.	N	C	C+-+- 7	" - CI-	CDCA	FTF /0	
	Name 0	County 1.00	2. 00	i p Code 3.00	4. 00	FTE/Campus 5.00	
166.00 If line 165 is yes, for each		1. 00	2. 50	5. 50	1. 00		00 166. 00
campus enter the name in column							
O, county in column 1, state in column 2, zip code in column 3,							
CBSA in column 4, FTE/Campus in							
column 5 (see instructions)							
						1.00	
Health Information Technology (HI	T) incentive in the Ame	rican Recovery and	l Reinvestme	ent Act		1.00	
167.00 Is this provider a meaningful user	,					Y	167. 00
168.00 If this provider is a CAH (line 10			167 is "Y"), enter	the		168. 00
reasonable cost incurred for the H 168.01 If this provider is a CAH and is r			qualify fo	r a hard	shi n	-	168. 01
exception under §413.70(a)(6)(ii)					P		100.01
169.00 If this provider is a meaningful u		and is not a CAH (line 105 is	"N"), e	nter the	9. 9	99169.00
transition factor. (see instruction	(אונ					I	I

Health Financial Systems	alth Financial Systems GOOD SAMARITAN HOSPITAL				
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFI	CATION DATA		Peri od:	Worksheet S-2	2
			From 01/01/2021	Part I	
			To 12/31/2021	Date/Time Pre	pared:
				5/26/2022 9: 3	8 am
			Begi nni ng	Endi ng	
			1. 00	2.00	
170.00 Enter in columns 1 and 2 the EHR beginning of period respectively (mm/dd/yyyy)			170. 00		
			1. 00	2.00	
171.00 If line 167 is "Y", does this provider have	any days for indiv	iduals enrolled in	N	C	171. 00
section 1876 Medicare cost plans reported or	n Wkst. S-3, Pt. I,	line 2, col. 6? Enter			
"Y" for yes and "N" for no in column 1. If o	column 1 is yes, en	ter the number of section	n		
1876 Medicare days in column 2. (see instruc	ctions)				

SPI T	Financial Systems GOOD SAMARITA AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-0042	Period: From 01/01/2021 To 12/31/2021		2 epared:
				Y/N	Date	
				1. 00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	for all NO re	esponses. Ente	r all dates in t	the	
00	Provider Organization and Operation		., .		I	۱.,
00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in c		instructions)		V//I	1.0
			1. 00	2. 00	V/I 3. 00	
00	Has the provider terminated participation in the Medicare F yes, enter in column 2 the date of termination and in colum		N N	2.00	0.00	2. 0
00	voluntary or "I" for involuntary. Is the provider involved in business transactions, includir contracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members of directors through ownership, control, or family and other relationships? (see instructions)	offices, drug ler or its of the board	N			3. 00
	Total onom por (occomment detrone)		Y/N	Туре	Date	
			1.00	2. 00	3. 00	
00	Financial Data and Reports Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" for "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	or Compiled,	Y	A		4.00
00	Are the cost report total expenses and total revenues diffe		N			5. 0
	those on the filed financial statements? If yes, submit rec	onciliation.		Y/N 1. 00	Legal Oper. 2.00	
	Approved Educational Activities			1.00	2.00	
00	Column 1: Are costs claimed for a nursing program? Column is the legal operator of the program?	2: If yes, is	s the provider	N		6. 0
00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing programs and/or allied health programs approve cost reporting period? If yes, see instructions.		ved during the	Y N		7. 00 8. 00
	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction	S.		Y		9. 0
. 00	Was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I			Y N		10.0
	Teaching Program on Worksheet A? If yes, see instructions.	• • • • • • • • • • • • • • • • • • • •			Y/N	
					1. 00	
. 00	Bad Debts Is the provider seeking reimbursement for bad debts? If yes	soo instruct	tions		Y	12. 0
	If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.			st reporting	N N	13. 0
. 00	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	nts waived? If	fyes, see ins	tructi ons.	N	14. 0
. 00	Did total beds available change from the prior cost reporti				N N	15. 0
		Y/N	rt A Date	Y/N	t B Date	+
		1.00	2.00	3. 00	4. 00	
00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through	Y	03/08/2022	Y	03/08/2022	16. 0
00	date of the PS&R Report used in columns 2 and 4 (see instructions) Was the cost report prepared using the PS&R Report for	N		N		17. 0
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) If line 16 or 17 is yes, were adjustments made to PS&R	N		N		18. 00
. 00	Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	IV		IV		10.00
. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report	N		N		19. 00

Heal th	Financial Systems GOOD SAMARIT	AN HOSPITAL		In Li∈	eu of Form CM	S-2552-10	
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-0042	Period: From 01/01/2021 To 12/31/2021	Worksheet S Part II Date/Time F 5/26/2022 S	repared:	
		Descri	pti on	Y/N	Y/N		
		()	1. 00	3. 00		
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00	
		Y/N 1.00	Date 2.00	Y/N 3.00	Date 4.00		
21. 00	Was the cost report prepared only using the provider's	N N	2.00	N N	4.00	21. 00	
	records? If yes, see instructions.						
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCI	EPT CHILDRENS H	OSPI TALS)		1. 00		
	Capital Related Cost						
22. 00 23. 00	Have assets been relifed for Medicare purposes? If yes, see Have changes occurred in the Medicare depreciation expense		ale mado dur	sing the cost	N N	22. 00 23. 00	
	reporting period? If yes, see instructions.						
24. 00	Were new leases and/or amendments to existing leases enter- If yes, see instructions	ed into during	this cost re	eporting period?	Y	24. 00	
25. 00	Have there been new capitalized leases entered into during instructions.	the cost repor	ting period?	? If yes, see	Y	25. 00	
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during thinstructions.	he cost reporti	ng period? I	f yes, see	N	26. 00	
27. 00	Has the provider's capitalization policy changed during the	yes, submit	N	27. 00			
	Copy. Interest Expense						
28. 00	Were new loans, mortgage agreements or letters of credit eleperiod? If yes, see instructions.	ntered into dur	ing the cost	t reporting	N	28. 00	
29. 00	Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see inst		bt Service F	Reserve Fund)	N	29. 00	
30. 00	Has existing debt been replaced prior to its scheduled matinstructions.		debt? If yes	s, see	N	30. 00	
31. 00	Has debt been recalled before scheduled maturity without is instructions.	ssuance of new	debt? If yes	s, see	N	31. 00	
	Purchased Services						
32. 00	Have changes or new agreements occurred in patient care se arrangements with suppliers of services? If yes, see instru	uctions.	-		N	32.00	
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 approx, see instructions.	plied pertainin	g to competi	tive bidding? If		33. 00	
	Provi der-Based Physi ci ans						
34. 00	Are services furnished at the provider facility under an a If yes, see instructions.	rrangement with	provi der-ba	ased physi ci ans?	Y	34. 00	
35. 00	If line 34 is yes, were there new agreements or amended ex physicians during the cost reporting period? If yes, see in		ts with the	provi der-based	Y	35. 00	
	physicians during the cost reporting period: it yes, see it	iisti ucti oiis.		Y/N	Date		
				1. 00	2.00		
	Home Office Costs						
36. 00 37. 00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been p	repared by the	home office?	N ?		36. 00 37. 00	
38. 00	If yes, see instructions. If line 36 is yes, was the fiscal year end of the home of					38. 00	
39. 00	the provider? If yes, enter in column 2 the fiscal year en- If line 36 is yes, did the provider render services to oth-	d of the home o	ffi ce.			39. 00	
40. 00	see instructions. If line 36 is yes, did the provider render services to the	·	,			40.00	
40.00	instructions.	Tiolile Office:				40.00	
	1.00 2.						
41. 00	Cost Report Preparer Contact Information Enter the first name, last name and the title/position	KYLE		SMI TH		41. 00	
	held by the cost report preparer in columns 1, 2, and 3, respectively.						
42. 00	Enter the employer/company name of the cost report	BLUE & CO, LLC				42. 00	
43. 00	preparer. Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7957		KCSMI TH@BLUEAN	DCO. COM	43. 00	
				•			

Heal th	Financial Systems GOOD SAMA	RITAI	N HOSPITAL	In Lieu of Form CMS-2552-10			
HOSPI TA	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provi der CCN: 15-0042	eriod: com 01/01/2021 o 12/31/2021	Worksheet S-2 Part II Date/Time Pre 5/26/2022 9:3	pared:	
		L					
			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 cos	t				43.00	
l	report preparer in columns 1 and 2, respectively.						

Health Financial Systems GOOD S
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 15-0042

				Ť	0 12/31/2021	Date/Time Prep 5/26/2022 9:38	
						I/P Days / 0/P	<u> </u>
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
		Line Number 1.00	2.00	Avai I abl e 3.00	4.00	5. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00	2.00		4. 00	5.00	1. 00
1.00	8 exclude Swing Bed, Observation Bed and	30.00	09	25, 165	0.00	U	1.00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2. 00
3.00	HMO IPF Subprovider						3. 00
4. 00	HMO IRF Subprovider						4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6. 00
7.00	Total Adults and Peds. (exclude observation		69	25, 185	0.00	0	7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	31. 00	30	10, 950	0.00	0	8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY	43. 00				0	13.00
14. 00	Total (see instructions)		99	36, 135	0.00	0	14. 00
15. 00	CAH visits					0	15. 00
16. 00	SUBPROVI DER - I PF	40. 00	20			0	16. 00
17. 00	SUBPROVI DER - I RF	41. 00	25	9, 125		0	17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20. 00	NURSING FACILITY						20. 00
21. 00	OTHER LONG TERM CARE	404.00					21. 00
22. 00	HOME HEALTH AGENCY	101. 00				0	
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	444 00	•				23. 00
24. 00	HOSPI CE	116. 00	0	0			24. 00
24. 10 25. 00	HOSPICE (non-distinct part)	30. 00					24. 10 25. 00
26. 00	CMHC - CMHC RURAL HEALTH CLINIC						25. 00 26. 00
26. 00	FEDERALLY QUALIFIED HEALTH CENTER	89. 00				0	26. 25
27. 00	Total (sum of lines 14-26)	69.00	144			U	27. 00
28. 00	Observation Bed Days		144			0	28. 00
29. 00	Ambul ance Trips					O	29. 00
30.00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days (see l'istraction)						31. 00
32. 00	Labor & delivery days (see instructions)		0	0			32. 00
32. 01	Total ancillary labor & delivery room		O				32. 01
32. 31	outpatient days (see instructions)						-2.0.
33. 00	LTCH non-covered days						33. 00
33. 01	LTCH site neutral days and discharges						33. 01

| Period: | Worksheet S-3 | From 01/01/2021 | Part | To 12/31/2021 | Date/Time Prepared: Provider CCN: 15-0042

				T	o 12/31/2021	Date/Time Pre 5/26/2022 9:3	
		I/P Days	/ O/P Visits	/ Trips	Full Time E	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
		6. 00	7. 00	Pati ents 8.00	& Residents 9.00	Payrol I 10, 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	5, 049	7.00	10, 896		10.00	1.00
1.00	8 exclude Swing Bed, Observation Bed and	3, 047	401	10, 070			1.00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	2, 821	2, 806				2. 00
3.00	HMO IPF Subprovider	90	1, 836				3. 00
4.00	HMO IRF Subprovider	130	263				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	5, 049	461	10, 896			7. 00
	beds) (see instructions)						
8. 00	INTENSIVE CARE UNIT	2, 552	0	5, 425			8. 00
9.00	CORONARY CARE UNIT						9. 00
10. 00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGI CAL INTENSIVE CARE UNIT						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)		_				12. 00
13.00		7 (04	0	942			13.00
14.00	Total (see instructions)	7, 601	461	17, 263	20. 77	1, 434. 25	•
15. 00	CAH visits	0	0	0	0.05	00.05	15.00
16.00	SUBPROVIDER - I PF	933 5, 223	410	4, 801	3. 95	30. 85	
17. 00 18. 00	SUBPROVIDER - I RF	5, 223	53	7, 092	0. 00	31. 72	17. 00 18. 00
19. 00	SUBPROVIDER 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 _l	J	O	0.00	0.00	23.00
24. 00	HOSPI CE	0	0	0	0. 00	7. 42	
24. 10	HOSPICE (non-distinct part)	J	J	465	0.00	7. 12	24. 10
25. 00	CMHC - CMHC			.00			25. 00
26. 00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	o	0	0.00	0.00	
27. 00	Total (sum of lines 14-26)				24. 72	1, 504. 24	
28. 00	Observation Bed Days		564	3, 195		,	28. 00
29. 00	Ambul ance Trips	0					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)	0	0	414			32. 00
32. 01	Total ancillary labor & delivery room			0			32. 01
	outpatient days (see instructions)						
33. 00	1	0					33. 00
33. 01	LTCH site neutral days and discharges	0					33. 01

| Period: | Worksheet S-3 | From 01/01/2021 | Part | To 12/31/2021 | Date/Time Prepared: Provider CCN: 15-0042

				To	12/31/2021	Date/Time Pre 5/26/2022 9:3	
		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 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2		C	1, 808	75	4, 051	1. 00
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)			554	641		2. 00
3.00	HMO IPF Subprovider				412		3. 00
4.00	HMO IRF Subprovider				22		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	C	1, 808	75	4, 051	14. 00
15. 00	CAH visits						15. 00
16. 00	SUBPROVIDER - I PF	0. 00	C	1	65	910	16. 00
17. 00	SUBPROVI DER - I RF	0. 00	C	336	4	479	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	0.00					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
28. 00	Observation Bed Days						
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
33. 00	outpatient days (see instructions) LTCH non-covered days			0			33. 00
	LTCH non-covered days LTCH si te neutral days and discharges			0			33. 00
33.01	LIGHT SI LE HEULT AT LAYS AND UI SCHALLYES	l l		ı o			33.01

Period: Worksheet S-3
From 01/01/2021 Part II
To 1/21/21/2021 Part/II me Propagad: Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0042

					T.	rom 01/01/2021 o 12/31/2021	Date/Time Prep	
		Wkst. A Line	Amount	Recl assi fi cati	Adj usted	Paid Hours	5/26/2022 9: 38 Average Hourly	am
		Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from Wkst. A-6)	(col.2 ± col. 3)	Salaries in col. 4	col . 5)	
		1. 00	2. 00	3.00	4.00	5. 00	6. 00	
	PART II - WAGE DATA SALARIES							
1.00	Total salaries (see	200. 00	108, 210, 873	0	108, 210, 873	3, 128, 815. 00	34. 59	1. 00
2. 00	instructions) Non-physician anesthetist Part		0	0	0	0. 00	0. 00	2. 00
	Α		, and the second	_				
3. 00	Non-physician anesthetist Part		0	0	0	0. 00	0. 00	3. 00
4.00	Physician-Part A -		190, 857	0	190, 857	1, 180. 00	161. 74	4. 00
4. 01	Administrative Physicians - Part A - Teaching		0	0	0	0. 00	0. 00	4. 01
5. 00	Physician and Non		4, 409, 936					
6. 00	Physician-Part B Non-physician-Part B for		0	0	0	0. 00	0. 00	6. 00
0.00	hospital-based RHC and FQHC					0.00	0.00	0.00
7. 00	services Interns & residents (in an	21. 00	0	0	0	0. 00	0. 00	7. 00
	approved program)	21.00	Ö					
7. 01	Contracted interns and residents (in an approved		2, 186, 999	0	2, 186, 999	39, 779. 71	54. 98	7. 01
	programs)							
8. 00	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		
10. 00	Excluded area salaries (see instructions)		37, 837, 332	0	37, 837, 332	915, 791. 00	41. 32	10. 00
	OTHER WAGES & RELATED COSTS							
11. 00	Contract Labor: Direct Patient Care		3, 176, 524	0	3, 176, 524	45, 481. 00	69. 84	11. 00
12. 00	Contract labor: Top level		0	0	0	0.00	0. 00	12. 00
	management and other management and administrative							
	services			_				
13. 00	Contract Labor: Physician-Part A - Administrative		583, 826	0	583, 826	6, 818. 00	85. 63	13. 00
14. 00	Home office and/or related		0	0	0	0. 00	0. 00	14. 00
	organization salaries and wage-related costs							
14. 01	Home office salaries		0	0	0	0.00		14. 01
14. 02 15. 00	Related organization salaries Home office: Physician Part A		0	0	_	0. 00 0. 00		14. 02 15. 00
	- Administrative		-					
16. 00	Home office and Contract Physicians Part A - Teaching		O	0	0	0. 00	0. 00	16. 00
16. 01	Home office Physicians Part A		0	0	0	0. 00	0.00	16. 01
16. 02	- Teaching Home office contract		0	0	0	0. 00	0.00	16. 02
	Physicians Part A - Teaching			_				
17. 00	WAGE-RELATED COSTS Wage-related costs (core) (see		20, 671, 328	0	20, 671, 328			17. 00
10 00	instructions)							10 00
18. 00	Wage-related costs (other) (see instructions)							18. 00
19. 00 20. 00	Excluded areas Non-physician anesthetist Part		9, 077, 461	0	9, 077, 461			19. 00 20. 00
20.00	A		O					20.00
21. 00	Non-physician anesthetist Part		0	0	0			21. 00
22. 00	Physician Part A -		21, 961	0	21, 961			22. 00
22. 01	Administrative Physician Part A - Teaching		n	0	0			22. 01
23. 00	Physician Part B		397, 795	0	397, 795			23. 00
24. 00 25. 00	Wage-related costs (RHC/FQHC) Interns & residents (in an		0	0	0			24. 00 25. 00
	approved program)		Ö					
25. 50	Home office wage-related (core)		0	0	0			25. 50
25. 51	Related organization		0	0	0			25. 51
25. 52	wage-related (core) Home office: Physician Part A		n	n	n			25. 52
02	- Administrative -		· ·					
	wage-related (core)			I	I		1	

| Peri od: | Worksheet S-3 | From 01/01/2021 | Part II | To 12/31/2021 | Date/Time Prepared: | Part II | P Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION GOOD SAMARITAN HOSPITAL Provider CCN: 15-0042

						3 12/31/2021	5/26/2022 9: 3	
		Wkst. A Line		Recl assi fi cati		Pai d Hours	Average Hourly	
		Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col.	Salaries in	col . 5)	
				A-6)	3)	col. 4		
		1.00	2. 00	3. 00	4. 00	5. 00	6. 00	
25. 53	Home office: Physicians Part A		0	0	0			25. 53
	- Teaching - wage-related							
	(core)							
27 00	OVERHEAD COSTS - DIRECT SALARII		F 000 /F1		E 000 /E1	201 014 00	20.04	27 00
26. 00	Employee Benefits Department	4. 00	5, 883, 651	•	5, 883, 651			
27. 00	Administrative & General	5. 00	7, 206, 764		7, 206, 764			
28. 00	Administrative & General under contract (see inst.)		1, 104, 719	0	1, 104, 719	5, 558. 00	198. 76	28.00
29. 00	Maintenance & Repairs	6. 00	0	0	_	0.00	0.00	29. 00
30.00	Operation of Plant	7. 00	2, 314, 574		2, 314, 574	93, 798. 00		30.00
31. 00	Laundry & Linen Service	8. 00	2, 314, 374		2, 314, 374	14, 941. 00		
32. 00	Housekeepi ng	9. 00	2, 043, 150		2, 043, 150	·		32.00
33. 00	Housekeeping under contract	7.00	2,043,130		2,043,130	0.00		33.00
33.00	(see instructions)		0	0	0	0.00	0.00	33.00
34.00	Di etary	10. 00	1, 732, 758	-1, 135, 650	597, 108	33, 172. 00	18 00	34. 00
35. 00	Di etary under contract (see	10.00	10, 049		10, 049	43.00		
00.00	instructions)		10,017		10,017	10.00	200.70	00.00
36.00	Cafeteri a	11. 00	0	1, 135, 650	1, 135, 650	63, 091. 00	18. 00	36. 00
37. 00	Maintenance of Personnel	12. 00	0	0	0	0.00		
38. 00	Nursing Administration	13. 00	2, 288, 533	0	2, 288, 533	57, 320. 00	39. 93	38. 00
39. 00	Central Services and Supply	14. 00	358, 307	0	358, 307	17, 979. 00	19. 93	39. 00
40.00	Pharmacy	15. 00	2, 911, 308	0	2, 911, 308	68, 750. 00	42. 35	40. 00
41.00	Medical Records & Medical	16. 00	3, 617, 256	0	3, 617, 256	123, 957. 00	29. 18	41.00
	Records Library							
42.00	Social Service	17. 00	475, 129	0	475, 129	13, 050. 00	36. 41	42.00
43.00	Other General Service	18. 00	0	0	0	0.00	0.00	43. 00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet S-3 | From 01/01/2021 | Part III | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | To 12/31/2 Provider CCN: 15-0042

							5/26/2022 9: 3	8 am
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col. 5)	
				Worksheet A-6)	3)	col. 4		
		1.00	2. 00	3.00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		102, 728, 706	0	102, 728, 706	3, 077, 341. 29	33. 38	1. 00
	instructions)							
2.00	Excluded area salaries (see		37, 837, 332	0	37, 837, 332	915, 791. 00	41. 32	2.00
	instructions)							
3.00	Subtotal salaries (line 1		64, 891, 374	0	64, 891, 374	2, 161, 550. 29	30. 02	3.00
	minus line 2)							
4.00	Subtotal other wages & related		3, 760, 350	0	3, 760, 350	52, 299. 00	71. 90	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		20, 693, 289	0	20, 693, 289	0.00	31. 89	5. 00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		89, 345, 013	0	89, 345, 013	2, 213, 849. 29	40. 36	6. 00
7.00	Total overhead cost (see		30, 167, 190	0	30, 167, 190	1, 087, 904. 00	27. 73	7. 00
	instructions)							

Health Financial Systems	GOOD SAMARITAN HOSPITAL	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS		Peri od: Worksheet S-3 From 01/01/2021 Part IV To 12/31/2021 Date/Time Prepared:

	To 12/31/2021	Date/Time Prep 5/26/2022 9:38	
		Amount	
		Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2. 00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	4, 692, 079	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6. 00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8. 00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	17, 153, 432	8. 02
8. 03	Health Insurance (Purchased)	0	8. 03
9. 00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	315, 112	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)	113, 829	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)	286, 821	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	213, 918	15. 00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Non cumulative portion)		1
	TAXES		
	FICA-Employers Portion Only	7, 268, 991	17. 00
	Medicare Taxes - Employers Portion Only	0	18. 00
	Unempl oyment Insurance	-5, 504	19. 00
20.00	State or Federal Unemployment Taxes	0	20. 00
	OTHER		
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see	0	21. 00
	instructions))		
	Day Care Cost and Allowances	50, 244	
	Tuition Reimbursement	79, 621	1
24. 00	Total Wage Related cost (Sum of Lines 1 -23)	30, 168, 543	24. 00
	Part B - Other than Core Related Cost		
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)		25. 00

Health Financial Systems	GOOD SAMARITAN HOSPITAL	In lie	u of Form CMS-2	2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-0042	Peri od: From 01/01/2021	Worksheet S-3	pared:
Cost Center Description		Contract Labor	Benefit Cost	
		1. 00	2. 00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identi	i fi cati on:			
1.00 Total facility's contract labor and benefit	cost	3, 176, 524	30, 168, 543	1.00

	Cost Center Description	Contract Labor	Benefit Cost	
		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	3, 176, 524	30, 168, 543	1.00
2.00	Hospi tal	3, 176, 524	30, 168, 543	2.00
3.00	Subprovi der - I PF	0	0	3.00
4.00	Subprovi der - I RF	0	0	4. 00
5.00	Subprovi der - (0ther)	0	0	5. 00
6.00	Swing Beds - SNF	0	0	6. 00
7.00	Swing Beds - NF	0	0	7. 00
8.00	Hospi tal -Based SNF			8. 00
9.00	Hospi tal -Based NF			9. 00
10.00	Hospi tal -Based OLTC			10.00
11.00	Hospi tal -Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospi tal -Based Hospi ce	0	0	13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospi tal -Based-CMHC			16.00
17. 00	Renal Di al ysi s			17.00
18. 00	0ther	0	0	18. 00

Heal th	Financial Systems		GOOD SAMARITA	AN HOSPITAL		In Lie	eu of Form CMS-2	2552-10
H0SPI 7	TAL-BASED HOSPICE IDENTIFICATION	DATA		Provi der C	CN: 15-0042	Peri od:	Worksheet S-9	
				Hoopi on CC	N. 1E 1E2/	From 01/01/2021 To 12/31/2021	PARTS I THROU Date/Time Pre	GH IV
				HOSPI CE CC	N: 15-1526	To 12/31/2021	5/26/2022 9:3	
						Hospi ce I	0,20,2022 ,10	<u> </u>
		Unduplicated		. '				
		Days						
		Title XVIII	Title XIX	Title XVIII	Title XIX	All Other	Total (sum of	
				Skilled	Nursi ng		cols. 1, 2 &	
				Nursi ng	Facility		5)	
		4 00	0.00	Facility	4.00	F 00		
	PART I - ENROLLMENT DAYS FOR CO	1.00	2.00	3.00	4.00	5. 00	6. 00	
1. 00	Hospice Continuous Home Care	JST REPURTING F	TERTODS BEGINNI	NG BEFORE OCTO	BER 1, 2015 T			1. 00
2.00	Hospice Routine Home Care			•				2.00
3.00	Hospice Inpatient Respite Care							3.00
4. 00	Hospice General Inpatient Care							4.00
5. 00	Total Hospice Days							5.00
0.00	Part II - CENSUS DATA FOR COST	REPORTING PERI	ODS BEGLNNING	BEFORE OCTOBER	1. 2015			0.00
6. 00	Number of patients receiving	THE STATE OF LINE	050 5201111110	DET GIVE GOTOBEN	1, 2010			6.00
	hospi ce care							
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							9. 00
NOTE:	Parts I and II, columns 1 and 2	also include	the days report	ted in columns	3 and 4.			
				Title XVIII	Title XIX	0ther	Total (sum of	
							col s. 1	
							through 3)	
				1. 00	2.00	3. 00	4. 00	
	PART III - ENROLLMENT DAYS FOR	COST REPORTING	PERIODS BEGIN	INING ON OR AFT	ER OCTOBER 1			
10. 00				0		0 0		10. 00
11. 00				3, 497	•	89 1, 041		11. 00
12.00				12		0 3		12.00
13.00				339		37 74		13.00
14.00	Total Hospi ce Days	N DATA FOR COO	CT DEDODTING DE	3, 848		26 1, 118		14. 00
15 00	PART IV - CONTRACTED STATISTICATION Hospice Inpatient Respite Care		SI KEPUKIING PE					15. 00
	Hospice General Inpatient Care					0 0		ı
10.00	Thospice delief at Theatrellt care			1	1	0	ı	1 10.00

	Financial Systems GOOD SAMARITAN HOSE AL UNCOMPENSATED AND INDIGENT CARE DATA Pro	ovider CCN: 15-0042	Peri od:	u of Form CMS-2 Worksheet S-10				
3P1 1/	AL UNCOMPENSATED AND INDIGENT CARE DATA	UVI UEI CCN. 13-0042	From 01/01/2021	WOLKSHEET 3-10	U			
			To 12/31/2021	Date/Time Pre	pare			
				5/26/2022 9: 3	8 am			
				1. 00				
	Uncompensated and indigent care cost computation							
00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divid	led by line 202 colum	nn 8)	0. 255593	1.			
	Medicaid (see instructions for each line)			45 (50 000	١.			
00	Net revenue from Medicaid			15, 658, 088				
00 00	Did you receive DSH or supplemental payments from Medicaid? If line 3 is yes, does line 2 include all DSH and/or supplemental	nayments from Medic	nai d2	Y	3			
00	If line 4 is no, then enter DSH and/or supplemental payments from		zai u :	' o				
00	Medical dicharges	i weareara		93, 412, 666				
00	Medicaid cost (line 1 times line 6)			23, 875, 624				
00	Difference between net revenue and costs for Medicaid program (li	ne 7 minus sum of li	nes 2 and 5; if	8, 217, 536				
	< zero then enter zero)							
	Children's Health Insurance Program (CHIP) (see instructions for	each line)						
	Net revenue from stand-alone CHIP			0				
	Stand-al one CHIP charges			0				
	Stand-alone CHIP cost (line 1 times line 10) Difference between net revenue and costs for stand-alone CHIP (li	no 11 minus Lino O	if a zoro thon	0	11			
00	enter zero)	ne ii iiiinus iine 9;	ii < zero then	U	12			
	Other state or local government indigent care program (see instru	ctions for each line	9)		l			
00	Net revenue from state or local indigent care program (Not include			0	13			
00	Charges for patients covered under state or local indigent care p	rogram (Not included	din lines 6 or	0	14			
	10)							
	State or local indigent care program cost (line 1 times line 14)			0				
. 00	Difference between net revenue and costs for state or local indig	jent care program (Li	ne 15 minus line	0	16			
	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP	and state/Local indi	gent care program	ns (saa				
	instructions for each line)	and State/Tocal Thai	gent care program	13 (300				
. 00	Private grants, donations, or endowment income restricted to fund	ling charity care		0	17			
	Government grants, appropriations or transfers for support of hos			0				
. 00	Total unreimbursed cost for Medicaid , CHIP and state and local i	ndigent care program	ns (sum of lines	8, 217, 536	19			
	8, 12 and 16)	Uni nsured	Insured	Total (col. 1				
		patients		+ col . 2)				
		1.00	2. 00	3. 00				
	Uncompensated Care (see instructions for each line)							
00	Charity care charges and uninsured discounts for the entire facil	i ty 4, 834, 1	1, 409, 331	6, 243, 484	20			
00	(see instructions)	1 225 1	1 400 221	2 444 007	21			
. 00	Cost of patients approved for charity care and uninsured discount instructions)	rs (see 1, 235, 5	576 1, 409, 331	2, 644, 907	21			
. 00	Payments received from patients for amounts previously written of	f as	0 0	0	22			
	chari ty care							
. 00	Cost of charity care (line 21 minus line 22)	1, 235, 5	576 1, 409, 331	2, 644, 907	23			
				1. 00				
00	Does the amount on line 20 column 2, include charges for patient		n of stay limit	N	24			
00	imposed on patients covered by Medicaid or other indigent care pr If line 24 is yes, enter the charges for patient days beyond the		am's lanath of	0	25			
. 00	stay limit	margent care progra	an 3 rongtii or		23			
. 00								
	Medicare reimbursable bad debts for the entire hospital complex (-		11, 016, 650 457, 120				
00	Medicare allowable bad debts for the entire hospital complex (see			703, 262				
1			1 40 040 000	1 20				
. 01 . 00	Non-Medicare bad debt expense (see instructions)	· · · · · · · · · · · · · · · · · · ·						
. 01 . 00 . 00	Non-Medicare bad debt expense (see instructions) Cost of non-Medicare and non-reimbursable Medicare bad debt exper	nse (see instructions	5)	10, 313, 388 2, 882, 172	29			
. 01 . 00 . 00 . 00	Non-Medicare bad debt expense (see instructions)	•	5)		29 30			

Heal th	Financial Systems	GOOD SAMARITAN	I HOSPI TAL		In Lie	u of Form CMS-	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	EXPENSES	Provi der CO	CN: 15-0042	Peri od:	Worksheet A	
					From 01/01/2021	Doto/Time Dro	nanad.
					Γο 12/31/2021	Date/Time Pre 5/26/2022 9:3	
	Cost Center Description	Sal ari es	Other	Total (col 1	Recl assi fi cati	Reclassi fi ed	O alli
	Soot Sonton Boodin per on	00.0.100	01	+ col . 2)	ons (See A-6)	Trial Balance	
				, 55.1 2)	0.10 (000 7. 0)	(col . 3 +-	
						col . 4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS	<u> </u>					
1.00	00100 CAP REL COSTS-BLDG & FLXT		16, 404, 265	16, 404, 26	6, 158, 828	22, 563, 093	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		95, 144	95, 14	4 0	95, 144	2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	563, 129	1, 462, 565	2, 025, 69	4 28, 704, 249	30, 729, 943	4.00
4.01	00401 COMMUNI CATI ONS	283, 462	118, 721	402, 18	-117, 830	284, 353	4. 01
4.02	00402 PURCHASING & RECEIVING	672, 983	607, 522	1, 280, 50	-296, 274	984, 231	4. 02
4.03	00403 REGI STRATI ON	1, 735, 815	739, 480	2, 475, 29	-683, 280	1, 792, 015	4. 03
4.04	00404 PATIENT ACCOUNTS	2, 628, 262	2, 633, 357	5, 261, 61	9 -967, 882	4, 293, 737	4. 04
5.00	00500 ADMINISTRATIVE & GENERAL	7, 206, 764	23, 551, 146	30, 757, 910	2, 356, 228	28, 401, 682	5. 00
7.00	00700 OPERATION OF PLANT	2, 314, 574	4, 767, 086	7, 081, 660	717, 235	6, 364, 425	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	220, 992	198, 649	419, 64	1 -117, 680	301, 961	8. 00
9.00	00900 HOUSEKEEPI NG	2, 043, 150	1, 053, 162	3, 096, 31	-807, 093	2, 289, 219	9. 00
10.00	01000 DI ETARY	1, 732, 758	1, 767, 597	3, 500, 35	-2, 497, 841	1, 002, 514	10.00
11. 00	01100 CAFETERI A	0	0		1, 906, 698	1, 906, 698	11. 00
13.00	01300 NURSI NG ADMINI STRATI ON	2, 288, 533	1, 832, 569			3, 624, 258	
14.00	01400 CENTRAL SERVICES & SUPPLY	358, 307	301, 830	660, 13	7 -99, 208	560, 929	14.00
15. 00	01500 PHARMACY	2, 911, 308	17, 669, 628	20, 580, 93	-17, 398, 990	3, 181, 946	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	3, 617, 256	1, 621, 725	5, 238, 98	1 -1, 157, 566	4, 081, 415	16. 00
17. 00	01700 SOCIAL SERVICE	0	0	(0	0	
17. 01	01701 MENTAL HEALTH OH	475, 129	385, 793	· ·		721, 130	
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	2, 186, 999	2, 186, 99		2, 186, 999	
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	1, 411, 338	672, 404	2, 083, 74	-302, 845	1, 780, 897	22. 00
23.00	02300 PARAMED ED PRGM-RADI OLOGY	0	0		0	0	23. 00
23. 01	02301 PARAMED ED PRGM-LAB	240, 212	87, 898	328, 110	-63, 887	264, 223	23. 01
	INPATIENT ROUTINE SERVICE COST CENTERS				_		
30.00	03000 ADULTS & PEDIATRICS	4, 792, 314	3, 735, 247	8, 527, 56°	1 -935, 671	7, 591, 890	30.00
31. 00	03100 I NTENSI VE CARE UNIT	3, 272, 273	2, 496, 807				
40.00	04000 SUBPROVI DER - I PF	2, 052, 405	630, 617	2, 683, 02:	-446, 187	2, 236, 835	40. 00
41. 00	04100 SUBPROVI DER - I RF	2, 034, 132	933, 821	2, 967, 95			
43.00	04300 NURSERY	338, 753	116, 835	455, 58	-85, 802	369, 786	43. 00
	ANCILLARY SERVICE COST CENTERS				1		
50. 00	05000 OPERATING ROOM	3, 247, 268	5, 707, 038	8, 954, 30	-3, 258, 793	5, 695, 513	
51. 00	05100 RECOVERY ROOM	0	0	(0	0	51.00
51. 01	05101 ENDOSCOPY	730, 592	1, 006, 275			1, 318, 462	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	1, 291, 929	425, 769	1, 717, 69	-578, 929	1, 138, 769	
53. 00	05300 ANESTHESI OLOGY	0	0		0	0	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	3, 607, 006	4, 585, 682				
55. 00	05500 RADI OLOGY-THERAPEUTI C	2, 710, 338	1, 926, 261			3, 942, 993	
60.00	06000 LABORATORY	2, 307, 337	5, 553, 526	7, 860, 86	-680, 711	7, 180, 152	1
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0 404 000	1 045 070	4 407 00	0	0	
65.00	06500 RESPI RATORY THERAPY	2, 491, 029	1, 945, 870			3, 539, 758	
	06600 PHYSI CAL THERAPY	3, 851, 462	1, 149, 889				
	06900 ELECTROCARDI OLOGY	5, 030, 178	3, 537, 154	8, 567, 33	-2, 762, 492		
	07000 ELECTROENCEPHALOGRAPHY	422 504	005.050	1 200 45	00 210	0	
70. 01	07001 NEURODI AGNOSTI CS 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	422, 506	885, 950	1, 308, 45		1, 218, 146	1
71.00	1	0	0		3, 812, 175	3, 812, 175	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		3, 550, 584	3, 550, 584	1
73.00	07300 DRUGS CHARGED TO PATIENTS	1 025 002	2 150 444	2 102 55	16, 640, 044	16, 640, 044	
75.00	07500 ASC (NON-DISTINCT PART)	1, 025, 093	2, 158, 466	3, 183, 55		1, 732, 243	
76.00	03950 MH ANCI LLARY OUTPATI ENT	0	470 F27	470 50	0 7 -3, 197	477 220	76.00
76. 01	03951 INPATIENT DIALYSIS OUTPATIENT SERVICE COST CENTERS	<u> </u>	479, 527	479, 52	7 -3, 197	476, 330	76. 01
90. 00	09000 CLINIC	77, 480	15, 610	93, 090	-14, 368	78, 722	90.00
90.00	04950 WOUND CLINIC	395, 709	1, 276, 340			1, 063, 962	
91.00	09100 EMERGENCY	4, 224, 546	2, 926, 188				
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	4, 224, 340	2, 920, 100	7, 150, 73 [,]	-9/4, 900	0, 175, 740	91.00
92.00	OTHER REIMBURSABLE COST CENTERS						72.00
96. 00		93, 968	81, 980	175, 94	3 -17, 773	158, 175	96 00
	10100 HOME HEALTH AGENCY	73, 700	01, 900		0 -17,773		101.00
101.00	SPECIAL PURPOSE COST CENTERS	<u> </u>	J	<u> </u>	<u> </u>	0	101.00
113 00	11300 I NTEREST EXPENSE		5, 754, 829	5, 754, 82	9 -5, 754, 829	0	113. 00
	11600 HOSPI CE	448, 702	286, 423				
118.00	1 1	75, 148, 992	125, 773, 644				1
. 10. 00	NONREI MBURSABLE COST CENTERS	. 5, 1 15, 772	.23, 7, 3, 044		5, 157, 013	207, 007, 047	1
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	n	0		0	n	190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	21, 890, 755	14, 509, 606	36, 400, 36	-5, 357, 281	31, 043, 080	
	19201 FP PETERSBURG	232, 381	275, 412	507, 79		434, 654	1
	19202 PEDI ATRI CS	1, 091, 031	625, 700			1, 381, 919	1
	19203 WASHINGTON PRIMARY CARE	1, 368, 298	592, 237	1, 960, 53		1, 567, 189	1
	19204 FOHC	9, 660	0	9, 660			192. 04
	07950 COMMUNITY HEALTH SERVICES	101, 264	59, 974			134, 989	
	07960 CCBHC GRANTS	1, 357, 807	779, 588				
	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	, ,	, , 550	_, _,,,,,,,	1 230, 330	.,,	

Health Financial Systems	GOOD SAMARITAN	N HOSPITAL		In Lie	eu of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der CC		Peri od:	Worksheet A	
				From 01/01/2021 To 12/31/2021	Date/Time Pre	nared:
				10 12/31/2021	5/26/2022 9:3	
Cost Center Description	Sal ari es	0ther	Total (col. 1	Recl assi fi cati	Recl assi fi ed	
			+ col . 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
					col. 4)	
	1. 00	2.00	3. 00	4. 00	5. 00	
194.02 07952 MARKETING AND PUBLIC RELATIONS	235, 800	659, 280	895, 08	-71, 030	824, 050	194. 02
194. 03 07953 MH RESIDENTIAL	485, 347	177, 676	663, 02	3 -125, 442	537, 581	194. 03
194. 04 07954 UNUSED SPACE	0	0		0	0	194. 04
194. 05 07955 MOB	0	41, 971	41, 97	1 0	41, 971	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	o		0	0	194. 08
194.09 07959 COMMUNITY MENTAL HEALTH CENTER	6, 289, 538	2, 312, 014	8, 601, 55	2 -1, 702, 331	6, 899, 221	194. 09
200.00 TOTAL (SUM OF LINES 118 through 199)	108, 210, 873	145, 807, 102	254, 017, 97	5 0	254, 017, 975	200. 00

Peri od: From 01/01/2021 To 12/31/2021

Date/Time Prepared: 5/26/2022 9:38 am

			5/26/2022 9: 38	<u>am </u>
Cost Center Description	Adjustments	Net Expenses		
	(See A-8)	For Allocation		
	6. 00	7. 00		
GENERAL SERVICE COST CENTERS				
1.00 O0100 CAP REL COSTS-BLDG & FLXT	-1, 602, 212			1. 00
2.00 O0200 CAP REL COSTS-MVBLE EQUIP	0		·	2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	-890		·	4. 00
4. 01 00401 COMMUNI CATI ONS	-58, 499	225, 854		4. 01
4. 02 00402 PURCHASI NG & RECEI VI NG	-238, 296	745, 935		4. 02
4. 03 00403 REGI STRATI ON	0	1, 792, 015		4.03
4.04 OO4O4 PATIENT ACCOUNTS	-65, 051	4, 228, 686		4.04
5.00 00500 ADMINISTRATIVE & GENERAL	-13, 485, 049	14, 916, 633		5.00
7.00 00700 OPERATION OF PLANT	-59, 859	6, 304, 566		7.00
8.00 00800 LAUNDRY & LINEN SERVICE	-12, 520			8.00
9. 00 00900 HOUSEKEEPI NG	-31, 500			9. 00
10. 00 01000 DI ETARY	0.7555			10.00
11. 00 01100 CAFETERI A	-909, 380			11. 00
13. 00 01300 NURSI NG ADMINI STRATI ON	-140, 096			13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	110,070	560, 929		14. 00
15. 00 01500 PHARMACY	-8, 042		l	15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	-48, 741		l	16. 00
17. 00 01700 SOCIAL SERVICE	-46, 741		l l	17. 00
17. 00 01700 3001 AL 3ERVICE 17. 01 01701 MENTAL HEALTH OH	· ·	1		
	-3, 845			17. 01
	10/ 245	_,,	·	21. 00
22. 00 02200 1 &R SERVI CES-OTHER PRGM COSTS APPRVD	186, 245	1, 967, 142		22. 00
23. 00 02300 PARAMED ED PRGM-RADI OLOGY	0	0		23. 00
23. 01 O2301 PARAMED ED PRGM-LAB	-37, 956	226, 267		23. 01
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS	0		l .	30. 00
31.00 03100 INTENSIVE CARE UNIT	-236			31. 00
40. 00 04000 SUBPROVI DER - 1 PF	-258, 395	1, 978, 440		40.00
41. 00 04100 SUBPROVI DER - I RF	-272	2, 448, 641		41.00
43. 00 04300 NURSERY	0	369, 786		43.00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATING ROOM	-2, 465, 491	3, 230, 022		50.00
51.00 05100 RECOVERY ROOM	0	0		51.00
51. 01 05101 ENDOSCOPY	-20, 501	1, 297, 961		51. 01
52.00 05200 DELIVERY ROOM & LABOR ROOM	-600	1, 138, 169		52.00
53. 00 05300 ANESTHESI OLOGY	0			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	-13, 612	6, 179, 093		54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	-1, 126, 990			55. 00
60. 00 06000 LABORATORY	-1, 200			60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0		l l	63. 00
65. 00 06500 RESPIRATORY THERAPY	-1, 061, 827			65. 00
66. 00 06600 PHYSI CAL THERAPY	-366	1		66. 00
69. 00 06900 ELECTROCARDI OLOGY	-3, 285, 379			69. 00
· ·	-3, 203, 379	1		
l I	-	1		70.00
70. 01 07001 NEURODI AGNOSTI CS	-5, 315			70. 01
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0		·	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0		·	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	-364, 851			73. 00
75. 00 07500 ASC (NON-DISTINCT PART)	-124, 565	1, 607, 678		75. 00
76.00 03950 MH ANCILLARY OUTPATIENT	0	0		76. 00
76. 01 03951 I NPATI ENT DI ALYSI S	-208, 995	267, 335		76. 01
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	0	78, 722	·	90.00
90. 01 04950 WOUND CLI NI C	-1, 702		l	90. 01
91. 00 09100 EMERGENCY	-1, 251, 252	4, 924, 494		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)				92.00
OTHER REIMBURSABLE COST CENTERS				
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0			96.00
101.00 10100 HOME HEALTH AGENCY	0	0		101. 00
SPECIAL PURPOSE COST CENTERS				
113. 00 11300 I NTEREST EXPENSE	0	0		113. 00
116. 00 11600 HOSPI CE	0	620, 763		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-26, 707, 240	182, 682, 409		118. 00
NONREI MBURSABLE COST CENTERS				
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFICES	0	31, 043, 080		192. 00
192. 01 19201 FP PETERSBURG		434, 654		192. 00
192. 02 19202 PEDI ATRI CS		1, 381, 919	·	192. 01
192. 03 19203 WASHINGTON PRIMARY CARE		1, 567, 189		192. 02
192.04 19204 FQHC				192. 03
		9, 660		
194. 00 07950 COMMUNITY HEALTH SERVICES	0	134, 989		194. 00
194. 01 07960 CCBHC GRANTS	0			194. 01
194.02 07952 MARKETING AND PUBLIC RELATIONS	0			194. 02
194. 03 07953 MH RESI DENTI AL	0	537, 581		194. 03

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

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

Period: From 01/01/2021 To 12/31/2021 Date/Time Prepared: 5/26/2022 9:38 am

			 5/26/2022 9: 3	8 am
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	41, 971		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, 899, 221		194. 09
200.00 TOTAL (SUM OF LINES 118 through 199)	-26, 707, 240	227, 310, 735		200. 00

Health Financial Systems RECLASSIFICATIONS | Peri od: | From 01/01/2021 | To 12/31/2021 | Worksheet A-6 | To 12/31/2021 | Date/Time Prepared: | 5/26/2022 9:38 am Provider CCN: 15-0042

					5/26/2022 9: 3
		Increases	6.1	0.11	
	Cost Center 2.00	Li ne # 3.00	Sal ary 4.00	0ther 5.00	
	A - DRUGS CHARGED TO PATIENTS		4.00	5.00	
. 00	DRUGS CHARGED TO PATIENTS	73. 00	0	16, 640, 044	
	0		0	16, 640, 044	
00	B - MEDICAL SUPPLIES CHARGED MEDICAL SUPPLIES CHARGED TO	TO PATIENTS 71.00	0	3, 812, 175	
. 00	PATIENTS	71.00	٥	3, 012, 173	
. 00	IMPL. DEV. CHARGED TO	72.00	0	3, 550, 584	
	PATI ENTS				
. 00	CENTRAL SERVICES & SUPPLY	14.00	0	50, 223	
. 00 . 00		0. 00 0. 00	0	0	
00		0.00	o	0	
00		0.00	O	0	
00		0.00	0	0	
00		0. 00 0. 00	0	0	
). 00 I. 00		0.00	0	0	
2. 00		0.00	o	0	
3. 00		0.00	0	0	
1. 00		0.00	0	0	
. 00 . 00		0. 00 0. 00	0	0	
7. 00		0.00	0	0	
3. 00		0.00	Ö	0	
9. 00		0.00	О	0	
0. 00		0.00	0	0	
1. 00 2. 00		0. 00 0. 00	0	0	
2. 00 3. 00		0.00	0	0	
4. 00		0.00	o	0	
5. 00		0.00	O	0	
5. 00		0.00	0	0	
7. 00			0	<u>0</u> 7, 412, 982	
	C - EMPLOYEE BENEFITS		<u> </u>	7,412,702	
. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	28, 739, 517	
. 00		0.00	0	0	
. 00 . 00	1	0. 00 0. 00	0	0	
. 00		0.00	ő	0	
. 00		0.00	0	0	
. 00		0.00	0	0	
. 00		0. 00 0. 00	0	0	
0. 00		0.00	0	0	
1. 00		0.00	0	0	
2. 00		0.00	0	0	
3.00		0. 00 0. 00	0	0	
4. 00 5. 00		0.00	0	0	
6. 00		0.00	ő	0 0	
7. 00		0.00	O	0	
8. 00		0.00	0	0	
9. 00		0.00	0	0	
0. 00 1. 00		0. 00 0. 00	0	0	
2. 00		0.00	ő	0	
3. 00		0.00	0	0	
4. 00		0.00	0	0	
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9. 00 0. 00 1. 00 2. 00 3. 00		0. 00 0. 00 0. 00 0. 00	0 0 0 0	0 0 0 0	
9. 00 0. 00 1. 00 2. 00 3. 00		0.00 0.00 0.00 0.00 0.00	0 0 0	0 0 0	
9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00		0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00	0 0 0 0	0 0 0 0 0 0	
9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00		0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00	0 0 0 0 0 0	0 0 0 0 0 0	
0. 00 0. 00 0. 00 2. 00 3. 00 4. 00 5. 00		0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00	0 0 0 0 0 0	0 0 0 0 0 0	

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

Period: From 01/01/2021 To 12/31/2021 Worksheet A-6 Date/Time Prepared: 5/26/2022 9:38 am

		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3. 00	4. 00	5. 00		
40.00		0.00	0	0	40. 0	00
41.00		0.00	0	0	41. (00
42.00		0.00	o	0	42.0	00
43.00		0.00	O	0	43.0	00
44.00		0.00	o	0	44.0	00
45.00		0.00	o	0	45.0	00
46.00		0.00	o	0	46.0	00
	0 — — — — —	1		28, 739, 517		
	D - INTEREST EXPENSE		-			
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	5, 754, 829	1. (00
	0 — — — — — —			5, 754, 829		
	E - INSURANCE EXPENSE		•			
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	403, 999	1. (00
	0 — — — — — —			403, 999		
	F - DIETARY RECLASS		•			
1.00	CAFETERI A	11.00	1, 135, 650	771, 048	1. (00
	0 — — — — — —	$ \top$	1, 135, 650			
	G - OB RECLASS					
1.00	ADULTS & PEDIATRICS	30.00	275, 568	33, 189	1. (00
	0 — — — — — —		275, 568	33, 189		
500.00	Grand Total: Increases		1, 411, 218	59, 755, 608	500.0	00
	'	'				

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0042

Peri od: From 01/01/2021 To 12/31/2021 Date/Ti me Prepared: 5/26/2022 9:38 am

						5/26/2022 9:	38 am
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
	A - DRUGS CHARGED TO PATIENTS	5					
1.00	PHARMACY	1500	0		· 0		1.00
	0		0	16, 640, 044			
	B - MEDICAL SUPPLIES CHARGED	TO PATIENTS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	35, 268	0		1. 00
2.00	PURCHASING & RECEIVING	4. 02	0	142	. 0		2. 00
3.00	ADMINISTRATIVE & GENERAL	5. 00		162	el ol		3. 00
4.00	OPERATION OF PLANT	7.00		1, 677	o		4.00
5.00	HOUSEKEEPI NG	9.00		29			5. 00
6.00	NURSING ADMINISTRATION	13.00		5, 622	el ol		6. 00
7.00	PHARMACY	15. 00		24, 115	1		7. 00
8. 00	ADULTS & PEDIATRICS	30.00		92, 406	1		8. 00
9. 00	INTENSIVE CARE UNIT	31.00		45, 318	1		9. 00
10. 00	SUBPROVI DER - I PF	40. 00		406	_		10.00
11. 00	SUBPROVI DER - I RF	41. 00		2, 418	1		11. 00
12. 00	NURSERY	43.00		6, 716	_		12. 00
13. 00	OPERATING ROOM	50.00		2, 416, 196			13. 00
14. 00	ENDOSCOPY	51. 01		214, 514			14. 00
15. 00	DELIVERY ROOM & LABOR ROOM	52.00		20, 242	1		15. 00
16. 00					-		16. 00
17. 00	RADI OLOGY-DI AGNOSTI C RADI OLOGY-THERAPEUTI C	54. 00 55. 00		960, 650 8, 851	_		17. 00
	LABORATORY				1		1
18.00		60.00		3, 597			18. 00
19. 00	RESPIRATORY THERAPY	65.00		197, 949	1		19. 00
20. 00	PHYSI CAL THERAPY	66.00		5, 638	1		20.00
21. 00	ELECTROCARDI OLOGY	69. 00		1, 601, 489	1		21. 00
22. 00	NEURODI AGNOSTI CS	70. 01		1, 569	1		22. 00
23. 00	ASC (NON-DISTINCT PART)	75. 00		1, 143, 217	1		23. 00
24. 00	INPATIENT DIALYSIS	76. 01		3, 197	1		24. 00
25. 00	CLINIC	90.00		17	1		25. 00
26. 00	WOUND CLINIC	90. 01		529, 977			26. 00
27. 00	EMERGENCY	91.00		91, 600	0		27. 00
	0		0	7, 412, 982			
	C - EMPLOYEE BENEFITS						
1.00	COMMUNI CATI ONS	4. 01		117, 830	0		1.00
2.00	PURCHASING & RECEIVING	4. 02		296, 132	0		2. 00
3.00	REGI STRATI ON	4. 03		683, 280	0		3. 00
4.00	PATIENT ACCOUNTS	4. 04		967, 882	. 0		4. 00
5.00	ADMINISTRATIVE & GENERAL	5. 00		1, 952, 067	0		5. 00
6.00	OPERATION OF PLANT	7. 00		715, 558	0		6. 00
7.00	LAUNDRY & LINEN SERVICE	8. 00		117, 680	0		7. 00
8.00	HOUSEKEEPI NG	9.00		807, 064	. o		8. 00
9.00	DI ETARY	10.00		591, 143	o		9. 00
10.00	NURSING ADMINISTRATION	13.00		491, 222	el ol		10.00
11. 00	CENTRAL SERVICES & SUPPLY	14.00		149, 431	o		11.00
12.00	PHARMACY	15. 00		734, 831			12. 00
13. 00	MEDICAL RECORDS & LIBRARY	16.00		1, 157, 566			13. 00
14. 00	MENTAL HEALTH OH	17. 01		139, 792			14. 00
15. 00	I&R SERVICES-OTHER PRGM	22. 00		302, 845			15. 00
10.00	COSTS APPRVD	22.00		002,010			10.00
16. 00	PARAMED ED PRGM-LAB	23. 01		63, 887	o		16. 00
17. 00	ADULTS & PEDIATRICS	30.00		1, 152, 022	1		17. 00
18. 00	INTENSIVE CARE UNIT	31.00		748, 034	1		18. 00
19. 00	SUBPROVI DER - I PF	40.00		445, 781			19. 00
20. 00	SUBPROVI DER - I RF	41.00		516, 622			20.00
21. 00	NURSERY	43.00		79, 086	1		21.00
22. 00	OPERATING ROOM	50.00		842, 597	1		22. 00
23. 00	ENDOSCOPY	51. 01		203, 891	_		23. 00
24. 00	DELIVERY ROOM & LABOR ROOM	52.00		249, 930			24. 00
25. 00	RADI OLOGY-DI AGNOSTI C	54. 00		1, 039, 333	1		25. 00
					1		1
26. 00 27. 00	RADI OLOGY-THERAPEUTI C	55. 00 60. 00		684, 755 677, 11 <i>0</i>			26. 00
27. 00	LABORATORY THERADY	60.00		677, 114	-		27. 00
28. 00	RESPIRATORY THERAPY	65.00		699, 192			28. 00
29. 00	PHYSICAL THERAPY	66.00		980, 110	1		29. 00
30.00	ELECTROCARDI OLOGY	69.00		1, 161, 003			30.00
31.00	NEURODI AGNOSTI CS	70. 01		88, 741	1		31.00
32.00	ASC (NON-DISTINCT PART)	75. 00		308, 099	1		32.00
33. 00	CLINIC	90.00		14, 351	1		33. 00
34. 00	WOUND CLINIC	90. 01		78, 110	1		34. 00
35. 00	EMERGENCY	91.00		883, 388	1		35. 00
36.00	DURABLE MEDICAL EQUIP-RENTED	96. 00		17, 773	1		36. 00
37. 00	HOSPI CE	116. 00		114, 362	1		37. 00
38. 00	PHYSICIANS' PRIVATE OFFICES	192. 00		5, 357, 281			38. 00
39. 00	FP PETERSBURG	192. 01		73, 139	1		39. 00
40. 00	PEDI ATRI CS	192. 02		334, 812	. 0		40. 00

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

Period: From 01/01/2021 To 12/31/2021 Worksheet A-6 Date/Time Prepared: 5/26/2022 9:38 am

						5/26/2022 9: 3	<u>88 am</u>
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
41.00	WASHINGTON PRIMARY CARE	192. 03		393, 346	(41. 00
42.00	COMMUNITY HEALTH SERVICES	194.00		26, 249	(42. 00
43.00	CCBHC GRANTS	194. 01		383, 383	(43. 00
44. 00	MARKETING AND PUBLIC RELATIONS	194. 02		71, 030	(D	44. 00
45.00	MH RESIDENTIAL	194. 03		125, 442	(45. 00
46.00	COMMUNITY MENTAL HEALTH	194. 09		1, 702, 331	(46. 00
	CENTER						
	0 — — — — —					7	
	D - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	5, 754, 829	11	1	1. 00
	0 — — — — —		0	5, 754, 829			
	E - INSURANCE EXPENSE	·					
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	403, 999	12	2	1. 00
	0 — — — — —			403, 999		7	
	F - DIETARY RECLASS						
1.00	DI ETARY	10.00	1, 135, 650	771, 048	(1. 00
	0 — — — — —		1, 135, 650	771, 048			
	G - OB RECLASS						ĺ
1.00	DELIVERY ROOM & LABOR ROOM	52.00	275, 568	33, 189	(1. 00
			275, 568	33, 189		1	
500.00	Grand Total: Decreases		1, 411, 218	59, 755, 608			500.00
		'			1		'

					To 12/31/2021		
	·			Acqui si ti ons		3/20/2022 9.3	o alli
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	6, 581, 448	0		0	0	1. 00
2.00	Land Improvements	10, 692, 230	34, 368		0 34, 368		2. 00
3.00	Buildings and Fixtures	169, 412, 708	2, 317, 383		0 2, 317, 383		3. 00
4.00	Building Improvements	510, 867	4, 559		0 4, 559	0	4. 00
5.00	Fi xed Equipment	0	0		0	0	5. 00
6.00	Movable Equipment	222, 593, 629	2, 009, 694		0 2, 009, 694	0	6. 00
7. 00	HIT designated Assets	0	0		0 0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	409, 790, 882	4, 366, 004		0 4, 366, 004	0	8. 00
9.00	Reconciling Items	0	0		0	0	9. 00
10. 00	Total (line 8 minus line 9)	409, 790, 882	4, 366, 004		0 4, 366, 004	0	10. 00
		Endi ng Bal ance	Fully				
			Depreciated				
		6.00	Assets 7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET		7.00				
1. 00	Land	6, 581, 448	0				1.00
2.00	Land Improvements	10, 726, 598	0				2.00
3.00	Buildings and Fixtures	171, 730, 091	0				3.00
4. 00	Building Improvements	515, 426	0				4. 00
5.00	Fixed Equipment	515, 420	0				5.00
6. 00	Movable Equipment	224, 603, 323	0				6. 00
7. 00	HIT designated Assets	224, 003, 323	0				7. 00
8.00	Subtotal (sum of lines 1-7)	414, 156, 886	0				8.00
9. 00	Reconciling Items	114, 130, 000	0				9.00
10. 00	Total (line 8 minus line 9)	414, 156, 886	0				10.00
							•

Heal th	Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provi der CO		Peri od:	Worksheet A-7	
					From 01/01/2021 To 12/31/2021		pared:
						5/26/2022 9:3	
			SU	JMMARY OF CAPI	TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
					instructions)		
		9. 00	10.00	11.00	12. 00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK			nd 2	_	_	
1.00	CAP REL COSTS-BLDG & FIXT	16, 404, 265	0		0	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	95, 14		0	2. 00
3.00	Total (sum of lines 1-2)	16, 404, 265	0	95, 14	4 0	0	3. 00
		SUMMARY 0	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	16, 404, 265				1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	95, 144				2. 00
3. 00	Total (sum of lines 1-2)	0	16, 499, 409				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		Provider Co	1	Period: From 01/01/2021 Fo 12/31/2021	Worksheet A-7 Part III Date/Time Prep 5/26/2022 9:38	
		COME	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capitalized	Gross Assets	Ratio (see	Insurance	
			Leases	for Ratio (col. 1 - col. 2)	instructions)		
		1.00	2.00	3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI	NTERS					
1.00	CAP REL COSTS-BLDG & FIXT	189, 553, 563	0	189, 553, 563	0. 457685	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	224, 603, 323	0	224, 603, 323			2.00
3.00	Total (sum of lines 1-2)	414, 156, 886		414, 156, 886			3. 00
		ALLOCA ⁻	TION OF OTHER (CAPI TAL	SUMMARY O	F CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Relate				
			d Costs	through 7)			
	DART LLL DESCRIPTION OF CARLEY COOTS OF	6.00	7. 00	8. 00	9. 00	10. 00	
1 00	PART III - RECONCILIATION OF CAPITAL COSTS CI		0	1	1/ 404 2/5	0	1 00
1. 00 2. 00	CAP REL COSTS-BLDG & FLXT CAP REL COSTS-MVBLE EQUIP	0	0		16, 404, 265	0	1. 00 2. 00
3.00	Total (sum of lines 1-2)	0	0)	14 404 245	0	3. 00
3.00	Total (Sull of Titles 1-2)	0	<u> </u>	JMMARY OF CAPI	16, 404, 265	U	3.00
			30	JIVIIVIART OF CAPT	IAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
	·		instructions)	instructions)	Capi tal -Rel ate	of cols. 9	
					d Costs (see instructions)	through 14)	
		11.00	12.00	13.00	14. 00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI		12.00	10.00	11.00	10.00	
1.00	CAP REL COSTS-BLDG & FIXT	4, 152, 617	403, 999	(0	20, 960, 881	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	95, 144			0	95, 144	2. 00
3.00	Total (sum of lines 1-2)	4, 247, 761	403, 999		0	21, 056, 025	3. 00
						·	

				T	o 12/31/2021	Date/Time Pre	pared:
				Expense Classification on	Worksheet A	5/26/2022 9: 3	8 am
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description		Amount	Cost Center		Wkst. A-7 Ref.	
1. 00	Investment income - CAP REL	1. 00 B	2. 00 -1. 602. 212	3.00 CAP REL COSTS-BLDG & FIXT	4. 00	5. 00	1. 00
	COSTS-BLDG & FIXT (chapter 2)						
2. 00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2. 00
3.00	Investment income - other (chapter 2)		0		0.00	0	3. 00
4.00	Trade, quantity, and time	В	-45, 303	PURCHASING & RECEIVING	4. 02	0	4. 00
5. 00	discounts (chapter 8) Refunds and rebates of		0		0.00	0	5. 00
<i>(</i> 00	expenses (chapter 8)		0		0.00		/ 00
6. 00	Rental of provider space by suppliers (chapter 8)		U		0.00	0	6. 00
7. 00	Tel ephone services (pay stations excluded) (chapter	В	-26, 758	OPERATION OF PLANT	7. 00	0	7. 00
	21)					_	
8. 00	Television and radio service (chapter 21)		0		0.00	0	8. 00
9.00	Parking Lot (chapter 21)	4.0.2	0 (24 214		0.00	0	9.00
10. 00	Provider-based physician adjustment	A-8-2	-9, 624, 314				10. 00
11. 00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11. 00
12. 00	Related organization	A-8-1	0			0	12. 00
13. 00	transactions (chapter 10) Laundry and linen service		0		0.00	0	13. 00
14. 00 15. 00	Cafeteria-employees and guests Rental of quarters to employee		-290, 773	CAFETERI A	11.00		
	and others		O		0.00		
16. 00	Sale of medical and surgical supplies to other than	В	-364, 851	DRUGS CHARGED TO PATIENTS	73.00	0	16. 00
17. 00	patients Sale of drugs to other than		0		0.00	0	17. 00
	pati ents		-				
18. 00	Sale of medical records and abstracts		O		0.00	0	18. 00
19. 00	Nursing and allied health education (tuition, fees,		0		0.00	0	19. 00
19. 01	books, etc.) Nursing and allied health		0		0.00	0	19. 01
	education (tuition, fees, books, etc.)						
20. 00 21. 00	Vending machines Income from imposition of	В	-25, 785 0	CAFETERI A	11. 00 0. 00	0	
21.00	interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22. 00	Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22. 00
	repay Medicare overpayments			DEODL BATODY TUEDADY	45.00		
23. 00	Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPI RATORY THERAPY	65.00		23. 00
24. 00	limitation (chapter 14) Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
24.00	therapy costs in excess of	A-0-3	0	THISTOAL THEMATT	00.00		24.00
25. 00	limitation (chapter 14) Utilization review -		0	*** Cost Center Deleted ***	114. 00		25. 00
	physicians' compensation						
26. 00	(chapter 21) Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	О	26. 00
27. 00	COSTS-BLDG & FLXT Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
	COSTS-MVBLE EQUIP						
28. 00 29. 00	Non-physician Anesthetist Physicians'assistant		0	*** Cost Center Deleted ***	19. 00 0. 00		28. 00 29. 00
30. 00	Adjustment for occupational therapy costs in excess of	A-8-3	0	*** Cost Center Deleted ***	67. 00		30. 00
	limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30. 99
31. 00	Adjustment for speech pathology costs in excess of	A-8-3	0	*** Cost Center Deleted ***	68.00		31. 00
	pathology costs in excess of limitation (chapter 14)						

From 01/01/2021 | Worksheet A-8 | To 12/31/2021 | Date/Time Prepared:

				11	0 12/31/2021	5/26/2022 9:3	
				Expense Classification on	0,20,2022 ,10	<u> </u>	
				To/From Which the Amount is			
					,		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
		1.00	2. 00	3. 00	4. 00	5. 00	
32.00	CAH HIT Adjustment for		0		0.00	0	32. 00
	Depreciation and Interest						
33.00	MISC INCOME	В		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	
33. 01	MISC INCOME	В	•	PURCHASING & RECEIVING	4. 02	0	
33. 02	MISC INCOME	В	-138	PATIENT ACCOUNTS	4. 04	0	33. 02
33. 03	MISC INCOME	В	-896, 615	ADMINISTRATIVE & GENERAL	5. 00	0	33. 03
33. 04	MISC INCOME	В	-33, 101	OPERATION OF PLANT	7. 00	0	33. 04
33.05	MISC INCOME	В	-12, 520	LAUNDRY & LINEN SERVICE	8. 00	0	33. 05
33.06	MISC INCOME	В	-31, 500	HOUSEKEEPI NG	9. 00	0	33. 06
33. 07	MISC INCOME	В	-2, 401	NURSING ADMINISTRATION	13.00	0	33. 07
33. 08	MISC INCOME	В	-120	PHARMACY	15. 00	0	33. 08
33. 09	MISC INCOME	В	-48, 741	MEDICAL RECORDS & LIBRARY	16. 00	0	33. 09
33. 10	MISC INCOME	В		PARAMED ED PRGM-LAB	23. 01	0	33. 10
33. 11	MISC INCOME	В	•	INTENSIVE CARE UNIT	31.00	0	33. 11
33. 12	MISC INCOME	В		OPERATING ROOM	50.00	0	33, 12
33. 13	MI SC I NCOME	В	•	ENDOSCOPY	51. 01	0	
33. 14	MISC INCOME	B		DELIVERY ROOM & LABOR ROOM	52. 00	0	33. 14
33. 15	MISC INCOME	B		ELECTROCARDI OLOGY	69. 00	0	
33. 16	MISC INCOME	B	•	ASC (NON-DISTINCT PART)	75. 00	0	
33. 17	MISC INCOME	В		WOUND CLINIC	90. 01	0	
33. 18	ADVERTI SI NG	A	•	ADMINISTRATIVE & GENERAL	5. 00	0	33. 18
33. 19	ADVERTI SI NG	A		MENTAL HEALTH OH	17. 01	0	
33. 20	ADVERTI SI NG	A		I&R SERVICES-OTHER PRGM	22. 00	0	33. 20
33. 20	ADVERTISING	_ ^	-13, 755	COSTS APPRVD	22.00	0	33. 20
33. 21	ADVERTI SI NG	A	_272	SUBPROVI DER – I RF	41. 00	0	33. 21
33. 21	ADVERTI SI NG	A		PHYSI CAL THERAPY	66.00	0	1
33. 23	ADVERTI SI NG	Ä		ELECTROCARDI OLOGY	69.00	0	1
33. 24	ADVERTI SI NG	A		WOUND CLINIC	90. 01	0	1
33. 25	PHYSICIAN BILLING COSTS	Ä		PATIENT ACCOUNTS	4. 04	0	33. 25
33. 26	2012 BOND ISSUE COSTS	A	•	ADMINISTRATIVE & GENERAL	5. 00	0	1
33. 27	GME CONSORTIUM FEES	A		I &R SERVICES-OTHER PRGM	22. 00	0	1
33. 21	GWE CONSORTION FEES	A	200,000	COSTS APPRVD	22.00	0	33.21
33. 28	AHA LOBBYING OFFSET	Α	10 007	ADMINISTRATIVE & GENERAL	5. 00	0	33. 28
33. 28	THA LOBBYING OFFSET	A		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	5. 00 5. 00		1
33. 29	I NDI ANA CHAMBER LOBBYI NG	A		ADMINISTRATIVE & GENERAL	5. 00 5. 00	0	1
JJ. JU	OFFSET	"	- 1, 399	ADMINISTRATIVE & GENERAL	5.00	l	33.30
33. 31	THRA LOBBYING OFFSET	A	_5_000	ADMINISTRATIVE & GENERAL	5. 00	0	33. 31
33. 32	PROVIDER ASSESSMENT FEE	A		ADMINISTRATIVE & GENERAL	5. 00	0	
33. 32	RENTAL	A		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	5. 00 5. 00	0	1
						0	
33. 34 33. 35	RENTAL RENTAL	A		OPERATING ROOM	50.00	0	
	1	A		ELECTROCARDI OLOGY	69. 00) 0	
33. 36	RENTAL	A		INPATIENT DIALYSIS	76. 01	ı	00.00
33. 37	PHYSICIAN LOAN EXPENSE	A		ADMINISTRATIVE & GENERAL	5. 00	0	
33. 38	PHYSICIAN LOAN EXPENSE	A		OPERATING ROOM	50.00	0	
33. 39	PHYSICIAN LOAN EXPENSE	A		RADI OLOGY-THERAPEUTI C	55.00	0	
33. 40	OTHER MISC FEES	В		CAFETERI A	11. 00	0	00. 10
33. 41	DONATIONS EXPENSE	В		ADMINISTRATIVE & GENERAL	5. 00	0	
33. 42	TELEPHONE OFFSET	A		COMMUNI CATI ONS	4. 01	0	33. 42
50. 00	TOTAL (sum of lines 1 thru 49)		-26, 707, 240	7			50. 00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

column 6, line 200.)
(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

⁽²⁾ Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

Peri od: From 01/01/2021 To 12/31/2021 Date/Ti me Prepared: 5/26/2022 9:38 am

							5/26/2022 9: 3	88 am
	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component		Physician/Prov ider Component Hours	
	1. 00	2.00	3.00	4.00	5. 00	6. 00	7. 00	
1. 00		ADMINISTRATIVE & GENERAL	321, 297			211, 500	2, 129	1. 00
2. 00		NURSI NG ADMI NI STRATI ON	137, 695		•	211, 500	0	
3.00		PHARMACY	23, 785			211, 500	156	3. 00
4. 00		SUBPROVIDER - IPF	282, 799		•	211, 500	240	4. 00
5. 00		OPERATING ROOM	2, 400, 990		•	246, 400	0	5. 00
6. 00		RADI OLOGY-DI AGNOSTI C	13, 612			271, 900	0	6. 00
7. 00		RADI OLOGY-THERAPEUTI C	1, 128, 820			271, 900	167	7. 00
8. 00		LABORATORY	141, 201	1, 043, 300	•	260, 300	2, 978	8. 00
9. 00		RESPI RATORY THERAPY	1, 083, 277	1, 061, 827	21, 450	211, 500	2, 778	9. 00
10. 00		ELECTROCARDI OLOGY	3, 199, 737			211, 500	270	10.00
11. 00		NEURODI AGNOSTI CS	16, 500			211, 500	110	11. 00
12. 00		ASC (NON-DISTINCT PART)	103, 850			211, 500	288	12. 00
13. 00		INPATIENT DIALYSIS	40, 560			211, 500	641	13. 00
14. 00		EMERGENCY	1, 261, 922		•	211, 500	244	14. 00
200.00	71.00	EMERGENOT	10, 156, 045	9, 469, 058		211,000	7, 231	200. 00
200.00	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	200.00
		I denti fi er	Limit	Unadjusted RCE			of Malpractice	
				Limit	Continuing	Share of col.	Insurance	
					Educati on	12		
	1. 00	2. 00	8. 00	9. 00	12. 00	13. 00	14. 00	
1. 00		ADMINISTRATIVE & GENERAL	216, 483			0	0	
2.00		NURSING ADMINISTRATION	0			0	0	
3.00		PHARMACY	15, 863			0	0	
4.00		SUBPROVIDER - IPF	24, 404			0	0	4. 00
5. 00		OPERATING ROOM	0		_	0	0	5. 00
6.00		RADI OLOGY-DI AGNOSTI C	0		-	0	0	6. 00
7.00		RADI OLOGY-THERAPEUTI C	21, 830			0	0	7. 00
8. 00		LABORATORY	372, 680			0	0	8. 00
9. 00		RESPI RATORY THERAPY	28, 268			0	0	9. 00
10.00		ELECTROCARDI OLOGY	0			0	0	10.00
11. 00		NEURODI AGNOSTI CS	11, 185			0	0	11.00
12.00		ASC (NON-DISTINCT PART)	29, 285			0	0	12.00
13.00		INPATIENT DIALYSIS	65, 179			0	0	13.00
14.00	91.00	EMERGENCY	24, 811	1, 241 40, 499	0	0	0	14. 00 200. 00
200.00	Wkst. A Line #	Cost Center/Physician	809, 988 Provi der	Adjusted RCE	RCE	Adjustment	U	200.00
	WKSt. A LITTE #	I denti fi er	Component	Limit	Di sal I owance	Auj us tillerit		
		ruentiffei	Share of col.	Limit	Di Sai i Owance			
			14					
	1. 00	2.00	15. 00	16. 00	17. 00	18. 00		
1. 00		ADMINISTRATIVE & GENERAL	0			104, 814		1. 00
2.00	13. 00	NURSING ADMINISTRATION	0	0	0	137, 695		2. 00
3.00	15. 00	PHARMACY	0	15, 863	7, 922	7, 922		3.00
4.00	40. 00	SUBPROVIDER - IPF	0	24, 404	30, 596	258, 395		4.00
5.00	50.00	OPERATING ROOM	0	0	0	2, 400, 990		5.00
6.00		RADI OLOGY-DI AGNOSTI C	0	0	0	13, 612		6.00
7.00	55. 00 RADI OLOGY-THERAPEUTI C		0	,		1, 106, 990		7. 00
8.00	60. 00 LABORATORY		0			1, 200		8. 00
9.00	65. 00 RESPI RATORY THERAPY		0	,		1, 061, 827		9. 00
10.00	69. 00 ELECTROCARDI OLOGY		0	0	_	3, 199, 737		10.00
11. 00		NEURODI AGNOSTI CS	0			5, 315		11. 00
12. 00		ASC (NON-DISTINCT PART)	0	,		74, 565		12.00
13.00		INPATIENT DIALYSIS	0			0		13.00
14.00	91.00	EMERGENCY	0		0	1, 251, 252		14.00
200.00	l		0	809, 988	155, 256	9, 624, 314		200. 00

	Financial Systems	GOOD SAMARITA				u of Form CMS-	<u> 2552-10</u>
COST A	ALLOCATION - GENERAL SERVICE COSTS		Provi der Co	CN: 15-0042 F	eriod: rom 01/01/2021 o 12/31/2021	Worksheet B Part I	
					o 12/31/2021	Date/Time Pre 5/26/2022 9:3	pared: 8 am
			CAPI TAL REI	_ATED COSTS			
	Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP		COMMUNI CATI ONS	
		for Cost Allocation			BENEFITS DEPARTMENT		
		(from Wkst A			DEPARTMENT		
		col . 7)					
	GENERAL SERVICE COST CENTERS	0	1. 00	2. 00	4. 00	4. 01	
1.00	00100 CAP REL COSTS-BLDG & FLXT	20, 960, 881	20, 960, 881				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	95, 144		95, 144			2. 00
4. 00 4. 01	00400 EMPLOYEE BENEFITS DEPARTMENT 00401 COMMUNI CATIONS	30, 729, 053 225, 854	115, 220 0	523		l e	4. 00 4. 01
4. 02	00402 PURCHASI NG & RECEI VI NG	745, 935	274, 305				4. 02
4.03	00403 REGISTRATION	1, 792, 015	267, 883	1			4. 03
4. 04 5. 00	00404 PATIENT ACCOUNTS 00500 ADMINISTRATIVE & GENERAL	4, 228, 686 14, 916, 633	1, 136, 701	5, 160			4. 04 5. 00
7. 00	00700 OPERATION OF PLANT	6, 304, 566	5, 685, 875				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	289, 441	124, 794			l e	8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	2, 257, 719 1, 002, 514	173, 612 102, 233				1
11. 00	01100 CAFETERI A	997, 318	194, 443				1
13.00	01300 NURSING ADMINISTRATION	3, 484, 162	231, 364				1
14. 00 15. 00	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	560, 929 3, 173, 904	94, 010 141, 691	427 643		l e	ı
16. 00	01600 MEDICAL RECORDS & LIBRARY	4, 032, 674	108, 537	493			
17.00	01700 SOCIAL SERVICE	717 205	(1.722	· -		0	
17. 01 21. 00	01701 MENTAL HEALTH OH 02100 I &R SERVI CES-SALARY & FRINGES APPRVD	717, 285 2, 186, 999	61, 733 240, 393			34, 180 0	17. 01 21. 00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	1, 967, 142	0	C		6, 809	22. 00
23. 00	O2300 PARAMED ED PRGM-RADI OLOGY O2301 PARAMED ED PRGM-LAB	0	0	C		0	23. 00
23. 01	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	226, 267	0	C	68, 829	0	23. 01
30. 00	03000 ADULTS & PEDIATRICS	7, 591, 890	1, 450, 795				
31.00	03100 INTENSIVE CARE UNIT 04000 SUBPROVI DER - I PF	4, 975, 492	496, 569				
40. 00 41. 00	04100 SUBPROVIDER - TPF	1, 978, 440 2, 448, 641	308, 880 407, 441	1, 402 1, 849		l	
43.00	04300 NURSERY	369, 786	0				1
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	3, 230, 022	569, 369	2, 584	930, 456	20, 290	50.00
51. 00	05100 RECOVERY ROOM	0	0	2, 304		0	51.00
51. 01	05101 ENDOSCOPY	1, 297, 961	289, 993	1			
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	1, 138, 169 0	0		,		1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	6, 179, 093	513, 442	1	_	1	
55.00	05500 RADI OLOGY-THERAPEUTI C	2, 816, 003	426, 210			4, 902	
	06000 LABORATORY 06300 BLOOD STORING, PROCESSING & TRANS.	7, 178, 952 0	172, 948 0	1		l	60. 00 63. 00
65. 00	06500 RESPI RATORY THERAPY	2, 477, 931	134, 581	611	713, 767	5, 447	65. 00
66. 00 69. 00	06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY	4, 015, 237 2, 519, 461	362, 035 430, 854				
70.00	07000 ELECTROCARDI OLOGI	2, 519, 401	430, 654	1, 950		0 10, 756	ı
70. 01	07001 NEURODI AGNOSTI CS	1, 212, 831	182, 665			l	70. 01
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	3, 812, 175 3, 550, 584	0		_	0	71. 00 72. 00
73. 00		16, 275, 193	0		Ö	o o	73. 00
75. 00	07500 ASC (NON-DISTINCT PART)	1, 607, 678	0	C		l	75. 00
76. 00 76. 01	03950 MH ANCILLARY OUTPATIENT 03951 INPATIENT DIALYSIS	0 267, 335	0 203, 377	923	_		
70.01	OUTPATIENT SERVICE COST CENTERS	207, 333	203, 377	/20		1 407	70.01
90.00	09000 CLI NI C	78, 722	53, 415			1, 226	1
90. 01 91. 00	04950 WOUND CLINIC 09100 EMERGENCY	1, 062, 260 4, 924, 494	70, 525 560, 909			1, 362 14, 298	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 721, 171	000, 707	2,010	1,210,100	11,270	92.00
07.00	OTHER REIMBURSABLE COST CENTERS	150 175	0 227	1 40	2/ 025		0, 00
	09600 DURABLE MEDICAL EQUIP-RENTED 10100 HOME HEALTH AGENCY	158, 175 0	9, 337 0	1			96. 00 101. 00
	SPECIAL PURPOSE COST CENTERS		<u> </u>				
	11300 INTEREST EXPENSE	(20.7/2	115 107	F 2.2	120 5/0	2 122	113.00
116.00)11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117)	620, 763 182, 682, 409	115, 196 15, 711, 335				116. 00 118. 00
	NONREI MBURSABLE COST CENTERS		.5, , , , , , , , , ,	, , , , , , ,	21, 571, 400		
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	12.746			190.00
) 19200 PHYSICIANS' PRIVATE OFFICES 19201 FP PETERSBURG	31, 043, 080 434, 654	3, 033, 280 87, 801	13, 768 399			192. 00 192. 01
192. 02	19202 PEDI ATRI CS	1, 381, 919	0	C	312, 619	0	192. 02
192. 03	3 19203 WASHINGTON PRIMARY CARE	1, 567, 189	161, 147	731	392, 065	0	192. 03

				, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	5/26/2022 9: 3	
		CAPI TAL REI	_ATED COSTS			
Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP		COMMUNI CATI ONS	
	for Cost			BENEFITS		
	Allocation			DEPARTMENT		
	(from Wkst A					
	col . 7)					
	0	1. 00	2.00	4. 00	4. 01	
192. 04 19204 FQHC	9, 660		0	2, 768		192. 04
194. 00 07950 COMMUNITY HEALTH SERVICES	134, 989		45	29, 016		194. 00
194. 01 07960 CCBHC GRANTS	1, 754, 012	0	0	389, 059	0	194. 01
194.02 07952 MARKETING AND PUBLIC RELATIONS	824, 050	40, 050	182	67, 565	545	194. 02
194. 03 07953 MH RESIDENTIAL	537, 581	480, 123	2, 179	139, 069	0	194. 03
194. 04 07954 UNUSED SPACE	0	482, 729	2, 191	0	0	194. 04
194. 05 07955 MOB	41, 971	0	0	0	0	194. 05
194. 06 07956 FOUNDATI ON	0	11, 043	50	0	272	194. 06
194.07 07957 KNOX COUNTY HEALTH DEPT	0	111, 665	507	0	0	194. 07
194.08 07958 INDUSTRIAL HEALTH	0	0	0	0	0	194. 08
194.09 07959 COMMUNITY MENTAL HEALTH CENTER	6, 899, 221	831, 873	3, 776	1, 802, 173	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)	227, 310, 735	20, 960, 881	95, 144	30, 844, 796	307, 076	202. 00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0042

Peri od: Worksheet B From 01/01/2021 Part I To 12/31/2021 Date/Ti me Prepared:

5/26/2022 9:38 am Cost Center Description PURCHASING & REGI STRATI ON Subtotal ADMI NI STRATI VE PATI ENT RECEI VI NG **ACCOUNTS** & GENERAL 4.03 4A. 04 5.00 4.02 4.04 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00401 COMMUNI CATI ONS 4 01 4 01 4.02 00402 PURCHASING & RECEIVING 1, 217, 042 4.02 00403 REGI STRATI ON 4.03 812 2, 564, 064 4.03 4, 988, 441 4.04 00404 PATIENT ACCOUNTS 674 4. 04 00500 ADMINISTRATIVE & GENERAL 18, 150, 076 18, 150, 076 5.00 3.034 C 5 00 7.00 00700 OPERATION OF PLANT 8, 463 12, 704, 262 1, 102, 425 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 4, 185 0 482, 308 41,853 8.00 00900 HOUSEKEEPING 0 9 00 13.887 3, 036, 478 263, 493 9 00 10.00 01000 DI ETARY 26, 196 1, 303, 725 113, 132 10.00 11.00 01100 CAFETERI A 49,823 1, 570, 321 136, 266 11.00 01300 NURSING ADMINISTRATION 4, 416, 923 383, 283 13.00 42.015 13.00 0 01400 CENTRAL SERVICES & SUPPLY 14.00 4.435 763, 421 66, 247 14.00 15.00 01500 PHARMACY 2,530 4, 157, 454 360, 767 15.00 01600 MEDICAL RECORDS & LIBRARY 5, 185, 604 16.00 349 449, 986 16.00 01700 SOCIAL SERVICE 0 17.00 0 17.00 0 0 01701 MENTAL HEALTH OH 0 950, 148 17.01 529 0 82, 450 17 01 02100 I &R SERVICES-SALARY & FRINGES APPRVD 2, 428, 483 210, 734 21.00 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 0 22.00 1,513 0 2, 379, 862 206, 515 22.00 02300 PARAMED ED PRGM-RADI OLOGY 0 23.00 C 0 23.00 23.01 02301 PARAMED ED PRGM-LAB 281 295, 377 25, 632 23.01 INPATIENT ROUTINE SERVICE COST CENTERS 113, 929 30.00 03000 ADULTS & PEDIATRICS 23, 461 221, 641 10, 882, 079 944, 303 30.00 03100 INTENSIVE CARE UNIT 31 00 21, 504 65, 778 127, 966 6, 640, 529 576, 239 31 00 40.00 04000 SUBPROVI DER - I PF 1,679 36, 237 70, 497 2, 985, 221 259, 046 40.00 04100 SUBPROVI DER - I RF 31, 378 41.00 5, 987 61,043 3, 548, 857 307, 956 41.00 10, 801 484, 750 43.00 04300 NURSERY 1,546 5, 552 42,065 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 46, 698 189, 295 368, 261 5, 356, 975 464, 857 50.00 05100 RECOVERY ROOM 51.00 51.00 0 51 01 05101 ENDOSCOPY 27 326 45, 535 88. 586 1, 963, 598 170.393 51 01 05200 DELIVERY ROOM & LABOR ROOM 52.00 5, 595 31, 570 61, 417 1, 536, 553 133, 336 52.00 05300 ANESTHESI OLOGY 53.00 53.00 0 395, 101 54.00 05400 RADI OLOGY-DI AGNOSTI C 23.305 768.870 8. 924. 254 774, 411 54.00 5, 795 05500 RADI OLOGY-THERAPEUTI C 97, 176 55.00 189.049 4, 317, 677 374, 671 55.00 06000 LABORATORY 60.00 83,600 291, 399 566, 897 8, 960, 480 777, 555 60.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 65 00 06500 RESPIRATORY THERAPY 1.099 57, 807 112 460 3, 503, 703 304, 037 65 00 06600 PHYSI CAL THERAPY 66.00 3,056 102, 715 199, 825 5, 791, 767 502, 586 66.00 06900 ELECTROCARDI OLOGY 9, 490 193, 097 375, 657 4, 982, 595 69.00 432, 370 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 70.00 C 0 07001 NEURODI AGNOSTI CS 139, 213 70 01 6.324 26, 429 1, 604, 281 70 01 51, 416 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 459, 351 14 4, 271, 547 370, 668 71.00 3, 781, 045 07200 IMPL. DEV. CHARGED TO PATIENTS 230, 461 C 328, 104 72.00 07300 DRUGS CHARGED TO PATIENTS 272, 491 530, 112 17, 077, 796 1, 481, 943 73.00 73.00 07500 ASC (NON-DISTINCT PART) 192, 709 2, 220, 759 75 00 22, 765 100, 695 195, 896 75 00 76.00 03950 MH ANCILLARY OUTPATIENT 0 76.00 03951 INPATIENT DIALYSIS 3, 966 7.715 483, 852 76.01 127 41, 987 76.01 OUTPATIENT SERVICE COST CENTERS 90 00 09000 CLINIC 347 675 156, 837 13, 610 90 00 90.01 04950 WOUND CLINIC 7,637 24, 332 47, 336 1, 327, 156 115, 165 90.01 91.00 09100 EMERGENCY 24, 171 201, 019 391, 068 7, 328, 985 635, 980 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09600 DURABLE MEDICAL EQUIP-RENTED 96.00 670 1,584 3,082 199, 815 17, 339 101.00 10100 HOME HEALTH AGENCY 0 101.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 I NTEREST EXPENSE 113.00 116.00 11600 HOSPI CE 7,860 15, 291 892, 126 77, 415 116. 00 SUBTOTALS (SUM OF LINES 1 through 117) 2, 295, 299 118.00 1, 171, 174 4, 465, 575 167, 047, 679 12, 920, 741 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 33, 921 206, 412 401, 560 41, 053, 733 3, 562, 428 192. 00 192. 01 19201 FP PETERSBURG 2, 185 4, 252 595, 962 51, 715 192. 01 86 192. 02 19202 PEDI ATRI CS 930 11, 155 21, 701 1, 728, 324 149, 977 192. 02 192. 03 19203 WASHINGTON PRIMARY CARE 187, 323 192. 03 1, 421 12, 272 23, 874 2, 158, 699 192. 04 19204 FQHC 0 12, 428 1, 078 192. 04 194. 00 07950 COMMUNITY HEALTH SERVICES 15, 224 194. 00 323 278 542 175, 437 194. 01 07960 CCBHC GRANTS 2, 951 5, 741 2, 155, 329 187, 031 194. 01 3.566 194. 02 07952 MARKETING AND PUBLIC RELATIONS 80, 910 194. 02 14 932, 406 194. 03 07953 MH RESIDENTIAL 1, 162, 748 100, 899 194. 03 1 878 651 1 267

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

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0042
From 01/01/2021
To 12/31/2021 Date/Time Prepared:

Part I Date/Time Prepared: 5/26/2022 9:38 am PURCHASING & REGISTRATION Cost Center Description PATI ENT Subtotal ADMI NI STRATI VE RECEI VI NG ACCOUNTS & GENERAL 4A. 04 4. 02 4.03 4.04 5.00 194.04 07954 UNUSED SPACE 0 484, 920 42, 079 194. 04 194. 05 07955 MOB 194. 06 07956 FOUNDATI ON 3, 642 194. 05 41, 972 986 194. 06 0 0 0 11, 365 9, 734 194. 07 194. 07 07957 KNOX COUNTY HEALTH DEPT 0 0 112, 172 194. 08 07958 INDUSTRIAL HEALTH 194. 09 07959 COMMUNITY MENTAL HEALTH CENTER 0 194. 08 O 9, 637, 561 836, 309 194. 09 3, 728 32, 861 63, 929 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 201.00 TOTAL (sum lines 118 through 201) 18, 150, 076 202. 00 1, 217, 042 2, 564, 064 4, 988, 441 227, 310, 735 202.00

Provider CCN: 15-0042

In Lieu of Form CMS-2552-10

Period:	Worksheet B
From 01/01/2021	Part
To 12/31/2021	Date/Time Prepared:
5/26/2022 9:38 am	

				10) 12/31/2021	5/26/2022 9:3	
	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	
	NERAL SERVICE COST CENTERS	1					
	100 CAP REL COSTS-BLDG & FIXT						1.00
	200 CAP REL COSTS-MVBLE EQUIP						2. 00
	400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
	0401 COMMUNI CATI ONS						4. 01
4. 02 00	0402 PURCHASING & RECEIVING						4. 02
4. 03 00	1403 REGI STRATI ON						4. 03
4.04 00	1404 PATIENT ACCOUNTS						4. 04
5.00 00	500 ADMINISTRATIVE & GENERAL						5. 00
7.00 00	700 OPERATION OF PLANT	13, 806, 687					7. 00
8.00 00	0800 LAUNDRY & LINEN SERVICE	127, 810	651, 971				8. 00
9.00 00	1900 HOUSEKEEPI NG	177, 808					9. 00
	000 DI ETARY	104, 704	2, 199		1, 620, 044		10.00
	100 CAFETERI A	199, 142	4, 183		0	1, 932, 904	1
	300 NURSI NG ADMI NI STRATI ON	236, 955		,	0	52, 483	
	400 CENTRAL SERVICES & SUPPLY	96, 282	9, 362		0	16, 462	
	500 PHARMACY	145, 115	0		0	62, 948	1
	600 MEDICAL RECORDS & LIBRARY	111, 160	0		0	113, 496	
	700 SOCIAL SERVICE	0	0	27,033	0	113, 490	17. 00
	701 MENTAL HEALTH OH	63, 225	0	100, 926	0		1
			0	100, 926	U	11, 949	1
	100 I&R SERVICES-SALARY & FRINGES APPRVD	246, 203	0	50.40	U	0	21.00
	200 I &R SERVI CES-OTHER PRGM COSTS APPRVD	0	0	52, 136	0	24, 190	
	300 PARAMED ED PRGM-RADI OLOGY	0	0	0	0	0	23. 00
	301 PARAMED ED PRGM-LAB	0	0	0	0	6, 045	23. 01
I N	PATIENT ROUTINE SERVICE COST CENTERS	1					
	000 ADULTS & PEDIATRICS	1, 485, 856		1	751, 117	154, 109	1
	100 INTENSIVE CARE UNIT	508, 569	54, 488		272, 198	84, 368	
	000 SUBPROVI DER - I PF	316, 345	14, 389	0	240, 889	58, 753	40. 00
41.00 04	100 SUBPROVI DER - I RF	417, 287	39, 063	154, 465	355, 840	60, 402	41.00
43.00 04	300 NURSERY	0	1, 483	8, 959	0	8, 291	43.00
AN	CILLARY SERVICE COST CENTERS						
50.00 05	000 OPERATING ROOM	583, 129	23, 661	200, 772	0	62, 448	50. 00
51.00 05	100 RECOVERY ROOM	0	0	0	0	0	51.00
51. 01 05	101 ENDOSCOPY	297, 001	18, 210	54, 403	0	23, 142	51. 01
52.00 05	200 DELIVERY ROOM & LABOR ROOM	0	7, 731	11, 820	0	26, 231	52. 00
	300 ANESTHESI OLOGY	0	0	0	0	0	
	400 RADI OLOGY-DI AGNOSTI C	525, 850	41, 148	113, 231	0	95, 436	
	5500 RADI OLOGY-THERAPEUTI C	436, 510		1	0	56, 897	1
	0000 LABORATORY	177, 128	0, 707		0	88, 212	1
	300 BLOOD STORING, PROCESSING & TRANS.	177, 120	0		0	00, 212	63.00
	500 RESPIRATORY THERAPY	137, 834	128	_	0	57, 582	
	600 PHYSI CAL THERAPY	370, 784	7, 081		0		
					0	102, 380	
	9900 ELECTROCARDI OLOGY	441, 267	14, 828	117, 818	U	79, 423	
	000 ELECTROENCEPHALOGRAPHY	107.070	0 25/	25 (21	U	0	
	001 NEURODI AGNOSTI CS	187, 079	9, 256	35, 621	0	13, 632	
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	
	200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	1
	300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	
	500 ASC (NON-DISTINCT PART)	0	24, 929	157, 811	0	33, 390	
	950 MH ANCILLARY OUTPATIENT	0	0	0	0	0	76. 00
	951 INPATIENT DIALYSIS	208, 292	0	0	0	0	76. 01
	TPATIENT SERVICE COST CENTERS	1		1			ļ <u>.</u> .
	0000 CLI NI C	54, 706		59, 746	0	2, 495	
	950 WOUND CLINIC	72, 230	7, 498	18, 890	0	9, 821	90. 01
91. 00 09	100 EMERGENCY	574, 465	81, 894	239, 577	0	110, 037	91.00
92. 00 09	200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OT	HER REIMBURSABLE COST CENTERS						
96.00 09	600 DURABLE MEDICAL EQUIP-RENTED	9, 563	0	0	0	3, 214	96. 00
101.00 10	100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
SP	ECIAL PURPOSE COST CENTERS						
113. 00 11	300 I NTEREST EXPENSE						113. 00
116, 00 11	600 HOSPI CE	117, 980	0	49, 060	0	14, 131	116. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	8, 430, 279			1, 620, 044		
	NREI MBURSABLE COST CENTERS	0/ 100/2//	0277010	2/7/7/007	., 020, 01.	17 10 17 70 7	
	2000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	n	0	n	n	n	190. 00
	2200 PHYSI CLANS' PRI VATE OFFI CES	3, 106, 583	22, 961	548, 722	0	361, 151	
	2201 FP PETERSBURG	89, 923		540, 722	0		192. 00
		69, 923			ol ol		
	202 PEDIATRICS	1/5 0/4			٥		192. 02
	203 WASHINGTON PRIMARY CARE	165, 041	0		0		192. 03
192. 04 19		0	0	1 1 2	0		192. 04
	950 COMMUNITY HEALTH SERVICES	10, 072	0	17, 702	0		194. 00
	960 CCBHC GRANTS	0	0	0	0		194. 01
	952 MARKETING AND PUBLIC RELATIONS	41, 018		2, 968	0		194. 02
194. 03 07	953 MH RESIDENTIAL	491, 726	0	0	0	25, 021	194. 03

Heal th Financial Systems GOOD SAMARITAN HOSPITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 15-0042 Peri od: Worksheet B

					From 01/01/2021	Part I	
					To 12/31/2021	Date/Time Pre	pared:
						5/26/2022 9: 3	8 am
	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. 04 07954	UNUSED SPACE	494, 395	0		0 0	0	194. 04
194. 05 07955	MOB	0	0		0 0	0	194. 05
194. 06 07956	FOUNDATI ON	11, 310	0		0 0	0	194. 06
194. 07 07957	KNOX COUNTY HEALTH DEPT	114, 364	0		0 0	0	194. 07
194. 08 07958	INDUSTRIAL HEALTH	0	0		0 0	0	194. 08
194. 09 07959	COMMUNITY MENTAL HEALTH CENTER	851, 976	0		0	0	194. 09
200.00	Cross Foot Adjustments						200. 00
201 00	Negative Cost Centers	0	0		0 0	0	201 00

1, 620, 044

3, 519, 281

0 201. 00 1, 932, 904 202. 00

651, 971

13, 806, 687

Cross Foot Adjustments
Negative Cost Centers
TOTAL (sum lines 118 through 201)

201.00 202.00

Provider CCN: 15-0042

				10	12/31/2021	Date/lime Pre 5/26/2022 9:3	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY		SOCIAL SERVICE	
		ADMI NI STRATI ON	SERVICES &		RECORDS &		
		13. 00	SUPPLY 14. 00	15. 00	16. 00	17. 00	
	GENERAL SERVICE COST CENTERS	10.00		10100	10.00	17.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
4. 01	00401 COMMUNI CATI ONS						4. 01
4. 02	00402 PURCHASING & RECEIVING						4. 02
4. 03	00403 REGI STRATI ON						4. 03
4.04	00404 PATIENT ACCOUNTS						4. 04
5.00	00500 ADMI NI STRATI VE & GENERAL						5. 00
7. 00 8. 00	00700 OPERATION OF PLANT						7. 00 8. 00
9. 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING						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	5, 089, 644					13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	992, 576				14. 00
15. 00	01500 PHARMACY	o	2, 361	4, 760, 974			15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	o	325	0	5, 888, 204		16. 00
17.00	01700 SOCIAL SERVICE	O	0	0	0	0	17. 00
17. 01	01701 MENTAL HEALTH OH	0	494	0	0	0	17. 01
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRVD	0	0	0	0	0	21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	166, 854	1, 412	2, 406	0	0	22. 00
23. 00	02300 PARAMED ED PRGM-RADI OLOGY	0	0	0	0	0	23. 00
23. 01	O2301 PARAMED ED PRGM-LAB	0	262	0	0	0	23. 01
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1 012 011	21 00/	(0	700 (11	0	20.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	1, 013, 911 581, 929	21, 896 20, 069	69 15	723, 611 695, 234	0	30. 00 31. 00
40. 00	04000 SUBPROVI DER – I PF	402, 741	20, 069 1, 567	6	837, 118	0	40.00
41. 00	04100 SUBPROVI DER - I RF	416, 623	5, 588	3	354, 711	0	41.00
43. 00	04300 NURSERY	57, 186	1, 443	40	113, 508	o o	43. 00
10.00	ANCILLARY SERVICE COST CENTERS	377.00	., ., .		1107000		10.00
50.00	05000 OPERATI NG ROOM	316, 302	43, 583	3, 917	425, 653	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
51. 01	05101 ENDOSCOPY	159, 623	25, 503	10, 466	0	0	51. 01
52.00	05200 DELIVERY ROOM & LABOR ROOM	229, 989	5, 222	136	0	0	52. 00
53. 00	05300 ANESTHESI OLOGY	0	0	0	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	67, 348	21, 751	72, 884	0	0	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	272, 612	5, 409	981	0	0	55. 00
60.00	06000 LABORATORY	0	78, 024	18	0	0	60.00
63. 00 65. 00	06300 BLOOD STORING, PROCESSING & TRANS. 06500 RESPIRATORY THERAPY	0	0 1, 025	0 323	0	0 0	63. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	228, 846	2, 852	748	0	0	66.00
69. 00	06900 ELECTROCARDI OLOGY	220, 040	2, 852 8, 857	17, 587	0	0	69.00
70. 00	07000 ELECTROENCEPHALOGRAPHY		0, 037	17, 307	0	Ö	70.00
70. 01	07001 NEURODI AGNOSTI CS	22, 262	5, 902	6	0	Ö	70. 01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	428, 713	o	0	Ō	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	O	215, 089	0	0	0	
	07300 DRUGS CHARGED TO PATIENTS	O	0	4, 214, 081	0	0	
75.00	07500 ASC (NON-DISTINCT PART)	230, 311	21, 246	6, 678	1, 631, 671	0	75. 00
76. 00	03950 MH ANCILLARY OUTPATIENT	0	0	0	0	0	76. 00
76. 01	03951 INPATIENT DIALYSIS	0	118	808	0	0	76. 01
00.00	OUTPATIENT SERVICE COST CENTERS		0				00.00
90.00	09000 CLI NI C 04950 WOUND CLI NI C	17.0((7 127	2 000	141 004	0	90.00
90. 01 91. 00	09100 EMERGENCY	17, 866	7, 127	3, 980	141, 884	0	
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	758, 982	22, 558	3, 008	964, 814	U	91.00
92.00	OTHER REIMBURSABLE COST CENTERS						72.00
96 00	09600 DURABLE MEDICAL EQUIP-RENTED	O	625	0	0	0	96. 00
	10100 HOME HEALTH AGENCY	o	0	o	0		101. 00
	SPECIAL PURPOSE COST CENTERS	· · · · · · · · · · · · · · · · · · ·	-				
113.00	11300 I NTEREST EXPENSE						113. 00
116.00	11600 HOSPI CE	97, 472	739	7	0		116. 00
118.00		5, 040, 857	949, 769	4, 338, 171	5, 888, 204	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	48, 787	31, 658		0		192.00
	19201 FP PETERSBURG		08 949		0		192. 01 192. 02
	2 19202 PEDIATRICS 3 19203 WASHINGTON PRIMARY CARE		868 1, 326	60, 551 18, 032	0		192. 02
	19203 WASHINGTON PRIMARY CARE		1, 326 0	18, 032	0		192. 03
	19204 FORC 07950 COMMUNITY HEALTH SERVICES		302	129	0		194. 00
	07960 CCBHC GRANTS	0	3, 328		0		194. 00
	07952 MARKETING AND PUBLIC RELATIONS	o o	13		0		194. 02
		1				•	

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2021 | Part I | To 12/31/2021 | Date/Time Prepared: | 5/26/2022 9:38 am Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS GOOD SAMARITAN HOSPITAL Provider CCN: 15-0042

					5/26/2022 9:3	8 alli
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	
	ADMI NI STRATI ON	SERVICES &		RECORDS &		
		SUPPLY		LI BRARY		
	13. 00	14.00	15. 00	16. 00	17. 00	
194. 03 07953 MH RESI DENTI AL	0	1, 753	128	0	0	194. 03
194. 04 07954 UNUSED SPACE	0	0	0	0	0	194. 04
194. 05 07955 MOB	0	0	0	0	0	194. 05
194. 06 07956 FOUNDATI ON	0	0	0	0	0	194. 06
194.07 07957 KNOX COUNTY HEALTH DEPT	0	0	0	0	0	194. 07
194. 08 07958 I NDUSTRI AL HEALTH	0	0	0	0	0	194. 08
194.09 07959 COMMUNITY MENTAL HEALTH CENTER	0	3, 479	1	0	0	194. 09
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	o	0	0	0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	5, 089, 644	992, 576	4, 760, 974	5, 888, 204	0	202. 00

Provider CCN: 15-0042

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2021 | Part I | To 12/31/2021 | Date/Time Prepared: | 5/26/2022 9:38 am

					72/31/2021	5/26/2022 9: 3	
			INTERNS &	RESI DENTS			
	Cost Center Description	MENTAL HEALTH	SERVI CES-SALAR	SERVI CES-OTHER	PARAMED ED	PARAMED ED	
		OH	Y & FRINGES		PRGM-RADI OLOGY		
	[17. 01	21. 00	22. 00	23. 00	23. 01	
1 00	GENERAL SERVICE COST CENTERS						1 00
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
4. 01	00401 COMMUNI CATI ONS						4. 01
4. 02	00402 PURCHASING & RECEIVING						4. 02
4. 03	00403 REGI STRATI ON						4. 03
4.04	00404 PATIENT ACCOUNTS						4. 04
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
7.00	00700 OPERATION OF PLANT						7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY						10.00
11. 00 13. 00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON						11. 00 13. 00
	01400 CENTRAL SERVICES & SUPPLY						14.00
15. 00	01500 PHARMACY						15. 00
	01600 MEDICAL RECORDS & LIBRARY						16. 00
17. 00	01700 SOCIAL SERVICE						17. 00
17. 01	01701 MENTAL HEALTH OH	1, 209, 192					17. 01
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	2, 885, 420				21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0		2, 833, 375			22. 00
23.00	02300 PARAMED ED PRGM-RADI OLOGY	0			0		23. 00
23. 01	02301 PARAMED ED PRGM-LAB	0				327, 316	23. 01
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		000.050	007 (50	ام		
30.00	03000 ADULTS & PEDI ATRI CS	0			0	0	30.00
31. 00	03100 I NTENSI VE CARE UNI T	(24.124	,		0	0	31.00
40. 00 41. 00	04000 SUBPROVI DER	634, 134		495, 727 0	0	0	40. 00 41. 00
43. 00	04300 NURSERY				0		43.00
43.00	ANCI LLARY SERVI CE COST CENTERS				<u> </u>		1 43.00
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	О	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	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	18, 441	18, 109	0	0	55. 00
60.00	06000 LABORATORY	0	0	0	0	327, 316	60.00
63. 00 65. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	E1 272	EO 444	0	0	63. 00 65. 00
66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY		51, 372	50, 446	0	0	66.00
69. 00	06900 ELECTROCARDI OLOGY		110, 648	108, 653	0	0	69.00
70. 00	07000 ELECTROENCEPHALOGRAPHY		0	0	Ö	Ö	70.00
70. 01	07001 NEURODI AGNOSTI CS		ő	o o	Ö	Ö	70. 01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
	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	491, 332	482, 469	0	0	75. 00
	03950 MH ANCILLARY OUTPATIENT	0		0	0	0	76. 00
76. 01	03951 I NPATI ENT DI ALYSI S	0	59, 276	58, 207	0	0	76. 01
00.00	OUTPATIENT SERVICE COST CENTERS				ام		00.00
90.00	09000 CLINIC	0		0	0	-	90.00
90. 01 91. 00	04950 WOUND CLINIC 09100 EMERGENCY	0		147, 780	0	0	90. 01 91. 00
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	150, 495	147, 700	U	0	92.00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96. 00
	10100 HOME HEALTH AGENCY	0	l e	0	O		101.00
	SPECIAL PURPOSE COST CENTERS				- 1		
113.00	11300 I NTEREST EXPENSE						113. 00
116. 00	11600 H0SPI CE	0			0		116. 00
118. 00	,	634, 134	2, 467, 196	2, 422, 694	0	327, 316	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		0	0		190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	212, 076	208, 251	0		192.00
	19201 FP PETERSBURG		0	0	0		192. 01
	19202 PEDI ATRI CS 19203 WASHI NGTON PRI MARY CARE				0		192. 02 192. 03
	19204 FOHC				٥		192. 03
	07950 COMMUNITY HEALTH SERVICES	0	0	n	n		194. 00
	07960 CCBHC GRANTS	l o	o o	0	o o		194. 01
	i i i		, ,	·	٩	·	

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2021 | Part I | To 12/31/2021 | Date/Time Prepared: | 5/26/2022 9:38 am Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS GOOD SAMARITAN HOSPITAL Provider CCN: 15-0042

					5/26/2022 9:3	<u>8 alli</u>
		INTERNS &	RESI DENTS			
		050,4,050,04,40	 		5454455 55	
Cost Center Description	MENIAL HEALIH	SERVI CES-SALAR	SERVICES-OTHER	PARAMED ED	PARAMED ED	
	OH	Y & FRINGES	PRGM COSTS	PRGM-RADI OLOGY	PRGM-LAB	
	17. 01	21. 00	22.00	23. 00	23. 01	
194.02 07952 MARKETING AND PUBLIC RELATIONS	0	0	0	0	0	194. 02
194.03 07953 MH RESIDENTIAL	0	0	0	0	0	194. 03
194. 04 07954 UNUSED SPACE	0	0	0	0	0	194. 04
194. 05 07955 MOB	0	0	0	0	0	194. 05
194. 06 07956 FOUNDATI ON	0	0	0	0	0	194. 06
194.07 07957 KNOX COUNTY HEALTH DEPT	0	0	0	0	0	194. 07
194. 08 07958 I NDUSTRI AL HEALTH	0	0	0	0	0	194. 08
194.09 07959 COMMUNITY MENTAL HEALTH CENTER	575, 058	206, 148	202, 430	0	0	194. 09
200.00 Cross Foot Adjustments		0	0	0	0	200. 00
201.00 Negative Cost Centers	0	0	0	0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	1, 209, 192	2, 885, 420	2, 833, 375	0	327, 316	202. 00

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

Daried Center Description					11	o 12/31/2021 Date/lime 5/26/2022	Prepared: 9:38 am
A PROOF Seleption Selept		Cost Center Description	Subtotal	Intern &	Total	, 3, 20, 232	
DEALERM, SERVICE COST CENTERS 24,00 55,00 26,00			F				
Adjustments							
10							
DEFERRAL SERVICE COST CHATTERS 1.00 1.			24 00		26.00		
2 00 00000 CAP REL COSTS-AVRILE FOULP 2 00 00000 CAP REL COSTS-AVRILE FOULP 3 00 00000 CARMAIN CAT MAS 4 0.0		GENERAL SERVICE COST CENTERS	21100	20.00	20.00		
4.00	1.00						1. 00
4.01 00-001 COMMANI CATTONS		1 1					•
4.0.0 BOOOD PERCENSINE & SERVICES 4.00 A.00 A.00 PERCENSINE & SERVICE 4.00 A.00 A.00 A.00 A.00 A.00 A.00 A.00							•
4.0.0 00.003 REGISTRATION		1					1
4.04 0.000 PATEENT ACCOUNTS		1					•
5.00 COSCO CARM IN STRATIVE & CEMERAL							•
2.00 0.000 DOPERATION OF PLANT		1					•
9.00 0.000 0.000 DIT FARY							•
10.00 01000 DETARY	8.00	00800 LAUNDRY & LINEN SERVICE					8. 00
11.00 11.00 CAFETERIA							l l
13.00 1300 NURSING ADMINISTRATION							•
14. 00 01400 CRITAL SERVICES & SUPPLY 15. 00 15.00 01500 MEDICAL RECORDS & LIBRARY 15. 00 15.00 01500 MEDICAL RECORDS & LIBRARY 17. 00 17.00							•
15.00 1500 PHARMARY							•
16.00 1000 MEDICAL, RECORDS & LIBRARY							I
17.00 1700 1700 18FPD (METAL HEATH OH 17.00 17.00 1700 187 SERVICES-SALARY & FRINGES APPRVD 22.00 2220 188 SERVICES-SALARY & FRINGES APPRVD 22.00 2220 188 SERVICES-OTHER PREGU COSTS APPRVD 22.00 223 00 2230 188 SERVICES-OTHER PREGU COSTS APPRVD 22.00 223 00 2230 188 SERVICES-OTHER PREGU COSTS APPRVD 23.00 23.00 2300 188 SERVICES COST CENTERS 23.00 23.00 2300 2300 188 SERVICES COST CENTERS 23.00							I
17.0 0.1701 MENTAL HEALTH OH							•
22.00 02200 IAR SERVICES-OTHER PROM COSTS APPRVD 23.00 03200 PARAMUED ED PROM-LADI 0.0000 03000 ADULTS & PEDI ATRICES 18,853,653 -1,791,612 17,062,041 30.000 03000 ADULTS & PEDI ATRICES 18,853,653 -1,791,612 17,062,041 30.000 04000 SUBPROVIDER - I FF 6,750,769 -1,000,500 5,560,795 41.000 41.000 410							•
23. 00 0300 PARAMED ED PROM-LAB 23. 01 0301 PARAMED ED PROM-LAB 23. 01 0301 PARAMED ED PROM-LAB 23. 01 1807 PARAMED ED PROM-LAB 23. 01 18. 853. 653 -1,791.612 17,062.041 30. 00 31. 00	21.00	02100 I&R SERVICES-SALARY & FRINGES APPRVD					21. 00
IMPATT ENT ROUTINE SERVICE COST CENTERS 18,853,653 -1,791,612 17,062,041 30.00 30.00 30.00 AULTS & PEDIATRICS 18,853,653 -1,791,612 17,062,041 31.00							•
30.00	23. 01						23. 01
31.00 03100 INTENSI VE CARE UNIT 10,026,403 -350,490 9,675,913 31.00 41.00 04100 SUBPROVIDER - I PF 6,750,769 -1,000,560 5,750,209 40.00 41.00 41.00 41.00 5UBPROVIDER - I PF 5,660,795 41.00	20 00		10 052 452	1 701 612	17 062 041		20.00
40.00 04000 SUBPROVI DER - I PF 6, 660, 795 71, 725 0 717, 725 41.00 0430 SUBPROVI DER - I RF 5, 660, 795 41.00 0430 SUBPROVI DER - I RF 5, 660, 795 41.00 0430 NURSERY 717, 725 0 717, 725 50 517, 724 50 70 70 70 70 70 70 70							•
1.00 0.4100 SUBPROVIDER - I RF 5,660,795 0 5,660,795 43.00 A30.00 A300 MIRSERY 717,725 0 0 717,725 43.00 A30.00 A300 DELATING ROOM 7,481,297 50.00 55.00 0.510.00 0.510.00 0.510.00 0.510.00 0.510.00 0.510.00 0.510.00 0.510.00 0.510.00 0.510.00 0.510.00 0.510.00 0.510.00 0.510.00 0.510.00 0.520.00 0.520.00 0.510.00 0.520.00 0							•
ANCILLARY SERVICE COST CENTERS 50.00 50.00 50.00 51.00 51.00 51.00 51.00 51.00 51.00 51.00 51.00 51.00 51.00 51.00 51.00 51.00 51.00 51.00 51.00 51.00 51.00 52.							•
50. 00 05000 0FEATING ROOM	43.00	04300 NURSERY	717, 725	0	717, 725		43. 00
51.00 05100 DECOVERY ROOM 0 0 0 51.00							
51.01			7, 481, 297	0			•
52.00 05200 05200 05200 05200 0530			0 722 220	0			I
53.00 05300 ANESTHESI OLOGY 0 0 0 0 53.00				0			•
54.00 05400 RADIOLOGY-DIAGNOSTIC 10, 636, 313 0 10, 636, 313 54.00			1, 931, 018	0			•
55.00 05500 RADIO LOGY-THERAPEUTI C 5, 567, 794 -36, 550 5, 531, 244 55.00 06.00 0600 LABORATORY 10, 460, 707 0 10, 460, 707 66.00 63.00 63.00 06500 BLOOD STORI NG, PROCESSI NG & TRANS. 0 0 0 0 0 0 0 0 0			10, 636, 313	o			•
63.00 63.00 63.00 65.00 65.00 65.00 65.00 66.0	55.00			-36, 550			l l
65.00 06500 RESPIRATORY THERAPY	60.00	06000 LABORATORY	10, 460, 707	0	10, 460, 707		60. 00
66.00 6600 6600 6600 6100 6			0	0	-		•
69.00 06900 06900 06900 06900 06900 06900 070000 070000 070000 070000 070000 070000 070000 0700000 070000 070000 0700000 0700000 0700000 0700000 0700000 07000000 07000000 070000000 0700000000				-101, 818			I
70.00 07000 ILECTROENCEPHALOGRAPHY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				210 201			I
70. 01 07001 NEURODI AGNOSTI CS 2, 017, 252 0 2, 017, 252 70. 01 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 5, 070, 928 0 5, 070, 928 71. 00 72. 00 72.00 MPL. DEV. CHARGED TO PATI ENTS 4, 324, 238 0 4, 324, 238 72. 00 73. 00 73.00 RUIGS CHARGED TO PATI ENTS 22, 773, 820 0 22, 773, 820 73. 00 75. 00 07500 ASC (NON-DI STI NCT PART) 5, 493, 305 -973, 801 4, 519, 504 75. 00 76. 00 03950 MH ANCI LLARY OUTPATI ENT 0 0 0 0 0 0 0 0 0			0, 314, 046				•
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 5,070,928 0 5,070,928 71. 00 72. 00 07200 MPL. DEV. CHARGED TO PATIENTS 4,324,238 0 4,324,238 0 72. 00 73. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 22,773,820 0 02,773,820 73. 00 75. 00 07500 ASC (NON-DISTINCT PART) 5,493,305 -973,801 4,519,504 75. 00 76. 00 03950 MH ANCILLARY OUTPATIENT 0 0 0 0 0 0 0 0 0			2.017.252				
73. 00 07300 DRUGS CHARGED TO PATIENTS 22, 773, 820 0 22, 773, 820 75. 00 750. 00 750. 00 750. 00 750. 00 750. 00 750. 00 750. 00 750. 00 76. 00				Ö			
75. 00	72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	4, 324, 238	0	4, 324, 238		72. 00
76. 00							
76. 01 03951 INPATIENT DIALYSIS 852,540 -117,483 735,057 76. 01 017001				1			
OUTPATI ENT SERVI CE COST CENTERS 90.00 09000 CLI NI C 287, 407 0 287, 407 90.00 90.00 09000 CLI NI C 1,721,617 0 1,721,617 90.01 91.00 09100 EMERGENCY 11,018,575 -298,275 10,720,300 91.00 92.00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 0 92.00 070 0 0 0 0 0 0 0 0		1 1	9	-1			
90. 00	76.01		852, 540	-117, 483	735, 057		76.01
90. 01	90 00		287 407	٥	287 407		90.00
91. 00				1			
96. 00				-298, 275			
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 230, 556 0 230, 556 101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 0 101. 00 SPECI AL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 114. 00 11600 HOSPI CE 1, 248, 930 0 1, 248, 930 116. 00 118. 00 SUBTOTALS (SUM OF LI NES 1 through 117) 153, 430, 286 -4, 889, 890 148, 540, 396 118. 00 NONREI MBURSABLE COST CENTERS 0 0 0 0 190. 00 190. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 49, 496, 832 -420, 327 49, 076, 505 192. 00 192. 01 19201 FP PETERSBURG 747, 472 0 747, 472 192. 01 19201 FP PETERSBURG 1, 963, 504 0 1, 963, 504 192. 02 192. 03 19203 WASHI NGTON PRI MARY CARE 2, 560, 022 0 2, 560, 022 192. 04 192. 04 19204 FOHC 13, 506 0 13, 506 192. 04	92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0			92. 00
101. 00							
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 11600 HOSPI CE 1, 248, 930 0 1, 248, 930 116.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 153, 430, 286 -4, 889, 890 148, 540, 396 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 49, 496, 832 -420, 327 49, 076, 505 192.00 192.01 192.01 FP PETERSBURG 747, 472 0 747, 472 192.01 192.01 19202 PEDI ATRI CS 1, 963, 504 0 1, 963, 504 192.02 192.03 19203 WASHI NGTON PRI MARY CARE 2, 560, 022 0 2, 560, 022 192.04 192.04 19204 FOHC 13, 506 0 13, 506 192.04 1				i i	•		
113. 00 113.00 11400 HOSPI CE	101.00		0	0	0		101.00
116. 00	112 00						112 00
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 153, 430, 286 -4, 889, 890 148, 540, 396 118. 00 NONREI MBURSABLE COST CENTERS			1 248 930	0	1 248 930		
NONREI MBURSABLE COST CENTERS 190. 00 19000 GFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 190. 00 192. 00 192.00 192.00 192.00 192.00 192.00 192.01 FP PETERSBURG 747, 472 0 747, 472 192. 01 192.01 192.02 192.02 192.02 192.02 192.02 192.02 192.03 192.03 192.03 192.03 192.03 192.03 192.03 192.04 1							
190. 00		NONREI MBURSABLE COST CENTERS	,,	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
192. 01 19201 FP PETERSBURG 747, 472 0 747, 472 192. 01 192. 02 19202 PEDI ATRI CS 1, 963, 504 0 1, 963, 504 192. 02 192. 03 19203 WASHI NGTON PRI MARY CARE 2, 560, 022 0 2, 560, 022 192. 03 192. 04 19204 FOHC 13, 506 0 13, 506 192. 04	190.00		0	0	0		190. 00
192. 02 19202 PEDI ATRI CS 1, 963, 504 0 1, 963, 504 192. 02 192. 03 19203 WASHI NGTON PRI MARY CARE 2, 560, 022 0 2, 560, 022 192. 03 192. 04 19204 FOHC 13, 506 0 13, 506 192. 04			49, 496, 832	-420, 327	49, 076, 505		I
192. 03 19203 WASHI NGTON PRI MARY CARE 2, 560, 022 0 2, 560, 022 192. 03 192. 04 19204 FOHC 13, 506 0 13, 506 192. 04				0			
192. 04 19204 FQHC 13, 506 0 13, 506 192. 04				0			
				0			
174. 00 07730 00				O			
	174.00	7/07/30/ COMMONITY TEALTH SERVICES	222, 210	<u> </u>	222, 210		1174.00

Heal th Financial Systems GOOD SAMARITAN HOSPITAL In Lieu of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0042 Period: Worksheet B

From 01/01/2021 To 12/31/2021 Part I Date/Time Prepared: 5/26/2022 9:38 am Cost Center Description Subtotal Intern & Total Residents Cost & Post Stepdown Adjustments 24.00 25.00 26.00 194. 01 07960 CCBHC GRANTS 2, 390, 352 2, 390, 352 194. 01 194.02 07952 MARKETING AND PUBLIC RELATIONS 1, 064, 369 1, 064, 369 194. 02 1, 782, 275 194. 03 07953 MH RESIDENTIAL 1, 782, 275 194. 03 194. 04 07954 UNUSED SPACE 1, 021, 394 1, 021, 394 194. 04 194. 05 07955 MOB 45, 614 45, 614 194. 05 194. 06 07956 FOUNDATION 23, 661 23, 661 194. 06 194.07 07957 KNOX COUNTY HEALTH DEPT 0 194. 07 236, 270 236, 270 194. 08 07958 I NDUSTRI AL HEALTH 194. 08

-408, 578

-5, 718, 795

11, 904, 384

221, 591, 940

0

194. 09

200.00

201. 00

202. 00

12, 312, 962

227, 310, 735

194. 09 07959 COMMUNITY MENTAL HEALTH CENTER

Cross Foot Adjustments

TOTAL (sum lines 118 through 201)

Negative Cost Centers

200.00

201.00

202.00

Health Financial Systems GOOD SAMARITAN HOSPITAL In Lieu of Form CMS-2552-10 ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0042 Peri od: Worksheet B From 01/01/2021 Part II Date/Time Prepared: 12/31/2021 5/26/2022 9:38 am CAPITAL RELATED COSTS Cost Center Description Directly BLDG & FIXT MVBLE EQUIP Subtotal **EMPLOYEE** Assigned New **BENEFITS** DEPARTMENT Capi tal Related Costs 1.00 2.00 2A 4.00 0 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 00200 CAP REL COSTS-MVBLE EQUIP 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 115, 220 523 115, 743 115, 743 4.01 00401 COMMUNI CATI ONS 0 0 0 305 00402 PURCHASING & RECEIVING 4 02 274 305 1 245 275 550 723 4.03 00403 REGI STRATI ON 267, 883 1, 216 269, 099 1,866 4.04 00404 PATIENT ACCOUNTS 2,825 5.00 00500 ADMINISTRATIVE & GENERAL 7.747 1, 136, 701 5 160 1 141 861 7.00 00700 OPERATION OF PLANT 5, 685, 875 25, 811 5, 711, 686 2, 488 8.00 00800 LAUNDRY & LINEN SERVICE 124, 794 566 125, 360 238 9.00 00900 HOUSEKEEPI NG 173, 612 788 174, 400 2, 196 01000 DI ETARY 10 00 642 464

MCRI F32 - 17. 4. 174. 1

					5/26/2022 9: 3	8 am
		CAPI TAL REI	_ATED COSTS			
Cost Center Description	Di rectl y	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
	Assigned New				BENEFI TS	
	Capi tal				DEPARTMENT	
	Related Costs					
	0	1. 00	2.00	2A	4. 00	
194.00 07950 COMMUNITY HEALTH SERVICES	0	9, 835	45	9, 880	109	194. 00
194.01 07960 CCBHC GRANTS	0	0	0	0	1, 460	194. 01
194.02 07952 MARKETING AND PUBLIC RELATIONS	0	40, 050	182	40, 232	253	194. 02
194. 03 07953 MH RESIDENTIAL	0	480, 123	2, 179	482, 302	522	194. 03
194. 04 07954 UNUSED SPACE	0	482, 729	2, 191	484, 920	0	194. 04
194. 05 07955 MOB	0	0	0	0	0	194. 05
194. 06 07956 FOUNDATI ON	0	11, 043	50	11, 093	0	194. 06
194.07 07957 KNOX COUNTY HEALTH DEPT	0	111, 665	507	112, 172	0	194. 07
194. 08 07958 I NDUSTRI AL HEALTH	0	0	0	o	0	194. 08
194.09 07959 COMMUNITY MENTAL HEALTH CENTER	0	831, 873	3, 776	835, 649	6, 761	194. 09
200.00 Cross Foot Adjustments				o		200. 00
201.00 Negative Cost Centers		0	0	o	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	0	20, 960, 881	95, 144	21, 056, 025	115, 743	202. 00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0042

Peri od: Worksheet B From 01/01/2021 Part II To 12/31/2021 Date/Time Prepared:

5/26/2022 9:38 am Cost Center Description COMMUNICATIONS PURCHASING & REGI STRATI ON PATI ENT ADMI NI STRATI VE RECEI VI NG ACCOUNTS & GENERAL 4. 01 4.03 4. 04 5.00 4.02 GENERAL SERVICE COST CENTERS 1.00 1.00 00100 CAP REL COSTS-BLDG & FLXT 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00401 COMMUNI CATI ONS 305 4 01 4 01 4.02 00402 PURCHASING & RECEIVING 276, 276 4.02 00403 REGI STRATI ON 5 4.03 184 271, 154 4.03 4.04 00404 PATIENT ACCOUNTS 6 153 0 2, 984 4. 04 23 00500 ADMINISTRATIVE & GENERAL 0 1, 150, 320 5.00 689 0 5 00 7.00 00700 OPERATION OF PLANT 1, 921 69, 873 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 0 950 0 0 2,653 8 00 5 00900 HOUSEKEEPING 0 0 9 00 16, 701 9 00 3. 152 0 10.00 01000 DI ETARY 5, 947 0 7, 170 10.00 11.00 01100 CAFETERI A 2 11, 310 0 0 0 0 0 0 8, 637 11.00 01300 NURSING ADMINISTRATION 0 13.00 24. 293 13.00 9.537 0 4, 199 01400 CENTRAL SERVICES & SUPPLY 14.00 1.007 14.00 15.00 01500 PHARMACY 574 0 22, 866 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 70 28, 521 16.00 01700 SOCIAL SERVICE 0 0 17.00 17.00 C 0 01701 MENTAL HEALTH OH 0 5, 226 17 01 34 120 17 01 02100 I &R SERVICES-SALARY & FRINGES APPRVD 0 13, 357 21.00 0 7 0 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 0 0 22.00 343 13, 089 22.00 02300 PARAMED ED PRGM-RADI OLOGY 0 23.00 0 23.00 23.01 02301 PARAMED ED PRGM-LAB 64 1,625 23.01 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 22 5, 326 12, 053 147 59, 851 30.00 6, 959 03100 INTENSIVE CARE UNIT 36, 523 31 00 13 4, 881 85 31 00 40.00 04000 SUBPROVIDER - IPF 0 381 3,834 47 16, 419 40.00 04100 SUBPROVI DER - I RF 19, 519 41.00 10 1, 359 3, 320 40 41.00 04300 NURSERY 43.00 351 587 2.666 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 20 10, 601 20,026 244 29, 463 50.00 05100 RECOVERY ROOM 51.00 0 0 0 51.00 C 4 9 6, 203 51 01 05101 ENDOSCOPY 4.817 59 10.800 51 01 05200 DELIVERY ROOM & LABOR ROOM 52.00 1, 270 3, 340 41 8, 451 52.00 05300 ANESTHESI OLOGY 0 53.00 53.00 0 9 49, 083 54.00 05400 RADI OLOGY-DI AGNOSTI C 5. 290 41, 695 191 54.00 5 5 05500 RADI OLOGY-THERAPEUTI C 55.00 1, 316 10, 280 125 23, 747 55.00 06000 LABORATORY 60.00 18, 977 30,828 375 49, 283 60.00 0 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 63.00 0 65 00 06500 RESPIRATORY THERAPY 249 74 19, 270 65 00 6 116 06600 PHYSI CAL THERAPY 4 66.00 694 10,866 132 31,855 66.00 06900 ELECTROCARDI OLOGY 2, 154 69.00 20, 428 249 27, 404 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 70.00 0 0 0 0 C 0 0 07001 NEURODI AGNOSTI CS 1, 435 70 01 2.796 34 8.824 70 01 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 104, 282 0 23, 494 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 52, 315 0 20, 796 72.00 07300 DRUGS CHARGED TO PATIENTS 351 93, 928 73.00 28, 827 73.00 07500 ASC (NON-DISTINCT PART) 75 00 5, 168 10,653 130 12, 214 75 00 0 76.00 03950 MH ANCILLARY OUTPATIENT 0 0 76.00 03951 INPATIENT DIALYSIS 76.01 29 420 2, 661 76.01 OUTPATIENT SERVICE COST CENTERS 90 00 09000 CLINIC 37 863 90 00 90.01 04950 WOUND CLINIC 1,734 2,574 31 7, 299 90.01 91 00 09100 EMERGENCY 14 5, 487 21, 266 259 40, 309 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 1, 099 09600 DURABLE MEDICAL EQUIP-RENTED 96.00 0 152 168 101.00 10100 HOME HEALTH AGENCY 0 101.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 I NTEREST EXPENSE 113.00 116.00 11600 HOSPI CE 180 831 4, 907 116. 00 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 256 265, 866 242, 722 2, 638 818, 938 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 48 7,700 21, 837 266 225, 730 192. 00 192. 01 19201 FP PETERSBURG 0 3, 278 192. 01 20 231 192. 02 19202 PEDI ATRI CS 211 1, 180 14 9, 506 192. 02 192. 03 19203 WASHINGTON PRIMARY CARE 11, 873 192. 03 0 0 322 1, 298 16 192. 04 19204 FQHC 68 192.04 0 194. 00 07950 COMMUNITY HEALTH SERVICES 29 0 965 194, 00 73 194. 01 07960 CCBHC GRANTS 0 809 312 4 11, 854 194. 01 194. 02 07952 MARKETING AND PUBLIC RELATIONS 5, 128 194. 02 C 194.03 07953 MH RESIDENTIAL 426 6, 395 194. 03 69

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

						5/26/2022 9:3	<u>8 am</u>
	Cost Center Description	COMMUNI CATI ONS	PURCHASING &	REGI STRATI ON	PATI ENT	ADMI NI STRATI VE	
			RECEI VI NG		ACCOUNTS	& GENERAL	
		4. 01	4. 02	4. 03	4. 04	5. 00	
194. 04 07954	UNUSED SPACE	0	0	0	0	2, 667	194. 04
194. 05 07955	MOB	0	0	0	0	231	194. 05
194. 06 07956	FOUNDATI ON	0	0	0	0	63	194. 06
194. 07 07957	KNOX COUNTY HEALTH DEPT	0	0	0	0	617	194. 07
194. 08 07958	INDUSTRIAL HEALTH	0	0	0	0	0	194. 08
194. 09 07959	COMMUNITY MENTAL HEALTH CENTER	0	846	3, 476	42	53, 007	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)	305	276, 276	271, 154	2, 984	1, 150, 320	202. 00

In Lieu of Form CMS-2552-10

Period:	Worksheet B
From 01/01/2021	Part II
To 12/31/2021	Date/Time Prepared:
5/26/2022 9:38 am	Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0042

) 12/31/2021	5/26/2022 9: 3	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		PLANT	LINEN SERVICE				
	T	7. 00	8. 00	9. 00	10. 00	11. 00	
	GENERAL SERVICE COST CENTERS	1					
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
4. 01	00401 COMMUNI CATI ONS						4. 01
4. 02	00402 PURCHASING & RECEIVING						4. 02
4. 03	00403 REGISTRATION						4. 03
4. 04	00404 PATI ENT ACCOUNTS						4. 04
5.00	00500 ADMINISTRATIVE & GENERAL	F 70F 004					5. 00
7.00	00700 OPERATION OF PLANT	5, 785, 984	100 7/0				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	53, 561	182, 762				8. 00
9.00	00900 HOUSEKEEPI NG	74, 514	11, 634		440 400		9. 00
10.00	01000 DI ETARY	43, 878	616		168, 683	202.070	10.00
11.00	01100 CAFETERI A	83, 454	1, 173		0	302, 969	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	99, 301	2 (24	0	0	8, 226	13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	40, 349	2, 624	3, 276	0	2, 580	14. 00
15.00	01500 PHARMACY	60, 813	0	,	0	9, 867	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	46, 584	0	_,	0	17, 790	16.00
17. 00	01700 SOCIAL SERVICE	0	0	0 104	U	0	17. 00
17. 01	01701 MENTAL HEALTH OH	26, 496	0	8, 104	U	1, 873	17. 01
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRVD	103, 176	0	0	U	0	21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0	0	4, 187	U	3, 792	22. 00
23. 00	02300 PARAMED ED PRGM-RADI OLOGY	0	0	0	0	0	23. 00
23. 01	02301 PARAMED ED PRGM-LAB	0	0	0	U	947	23. 01
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	422 470	(1.205	(O E4/	70, 200	24 155	20.00
30.00	03000 ADULTS & PEDIATRICS	622, 679	61, 395		78, 208	24, 155	30.00
31.00	03100 I NTENSI VE CARE UNI T 04000 SUBPROVI DER - I PF	213, 127	15, 274		28, 342	13, 224	31.00
40.00		132, 571	4, 034		25, 082	9, 209	40.00
41. 00	04100 SUBPROVI DER - I RF	174, 873	10, 950		37, 051	9, 468	41.00
43. 00	04300 NURSERY	0	416	719	0	1, 300	43. 00
EO 00	ANCI LLARY SERVI CE COST CENTERS	244 272	(())	1, 122	٥	0.700	EO 00
50.00	05000 OPERATING ROOM	244, 373	6, 633 0		0	9, 788	50.00
51.00	05100 RECOVERY ROOM	124 445	ū	1	0	0	51.00
51. 01	05101 ENDOSCOPY	124, 465	5, 105		0	3, 627	51. 01
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	2, 167 0		0	4, 112	52.00
53.00	05300 ANESTHESI OLOGY	1		· ·	0	14.050	53.00
54. 00	05400 RADI OLOGY - DI AGNOSTI C	220, 369	11, 535		0	14, 959	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	182, 929	1, 950		0	8, 918	55. 00
60.00	06000 LABORATORY	74, 229	0		0	13, 827	60.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	-	U	0	63. 00
65. 00	06500 RESPIRATORY THERAPY	57, 762	36		U	9, 026	65. 00
66. 00	06600 PHYSI CAL THERAPY	155, 385	1, 985		0	16, 047	66.00
69. 00	06900 ELECTROCARDI OLOGY	184, 922	4, 157	· ·	0	12, 449	69.00
70. 00 70. 01	07000 ELECTROENCEPHALOGRAPHY 07001 NEURODI AGNOSTI CS	78, 399	2, 595	0	0	0	70. 00 70. 01
70.01	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	70, 399	2, 393	2, 860 0	0	2, 137 0	70.01
	07200 IMPL. DEV. CHARGED TO PATIENTS	١	0	1	0	0	
72.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	72.00
	07500 ASC (NON-DISTINCT PART)	0	6, 988	12, 672	0	5, 234	73. 00 75. 00
76. 00	03950 MH ANCI LLARY OUTPATIENT	0	0, 900	12, 0/2	0	0, 234	76. 00
76. 00	03951 I NPATIENT DI ALYSI S	87, 289	0		0	0	76. 00 76. 01
70.01	OUTPATIENT SERVICE COST CENTERS	07, 207	0	U	<u> </u>	U	70.01
90. 00	09000 CLINIC	22, 926	0	4, 798	0	391	90. 00
90. 00	04950 WOUND CLINIC	30, 269	2, 102		0	1, 539	90. 00
91. 00	09100 EMERGENCY	240, 742	22, 957		0	17, 247	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	240, 742	22, 737	17, 230	U	17, 247	92.00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
96 00	09600 DURABLE MEDICAL EQUIP-RENTED	4, 007	0	O	0	504	96. 00
	10100 HOME HEALTH AGENCY	4,007	0		0		101. 00
101.00	SPECIAL PURPOSE COST CENTERS	<u> </u>		0	<u> </u>	0	101.00
113 00	11300 I NTEREST EXPENSE						113. 00
	11600 H0SPI CE	49, 442	0	3, 940	0	2 215	116. 00
118.00	1	3, 532, 884	176, 326		168, 683	224, 451	
110.00	NONREI MBURSABLE COST CENTERS	3, 332, 004	170, 320	230, 017	100, 003	224, 431	110.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	1, 301, 881	6, 436	44, 063	0	56, 607	
	19201 FP PETERSBURG	37, 684	0, 430 0	-4, 003 n	O O		192. 00
	19202 PEDI ATRI CS	37,004	0		٥		192. 01
	19203 WASHINGTON PRIMARY CARE	69, 164	0		٥		192. 02
	19204 FQHC	07, 104	0		٥		192. 03
	19204 FORC 07950 COMMUNITY HEALTH SERVICES	4, 221	0	1, 422	٥		192. 04 194. 00
	07960 CCBHC GRANTS	4, 221	0	1, 422	O A		194. 00 194. 01
	07960 CCBHC GRANTS 07952 MARKETING AND PUBLIC RELATIONS	١	0	238	O)		194. 01 194. 02
	07952 MARKETING AND PUBLIC RELATIONS	17, 189 206, 068	0	238	0		194. 02 194. 03
174.03	//OT TOO MIT INCOLUENTIAL	200,000	0	1 0	υ	3, 722	1174.03

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

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0042
From 01/01/2021
To 12/31/2021
Date/Time Prepared:

					5/26/2022 9:3	8 am
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. 04 07954 UNUSED SPACE	207, 187	0	0	0	0	194. 04
194. 05 07955 MOB	0	0	0	0	0	194. 05
194. 06 07956 FOUNDATI ON	4, 740	0	0	0	0	194. 06
194.07 07957 KNOX COUNTY HEALTH DEPT	47, 927	0	0	0	0	194. 07
194. 08 07958 I NDUSTRI AL HEALTH	0	0	0	0	0	194. 08
194.09 07959 COMMUNITY MENTAL HEALTH CENTER	357, 039	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)	5, 785, 984	182, 762	282, 602	168, 683	302, 969	202. 00

| Peri od: | Worksheet B | From 01/01/2021 | Part | I | To | 12/31/2021 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0042

				To	12/31/2021	Date/Time Pre 5/26/2022 9:3	
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCIAL SERVICE	O diii
		13. 00	14.00	15. 00	16. 00	17. 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						4. 02
4.03	00403 REGI STRATI ON						4. 03
4.04	00404 PATIENT ACCOUNTS						4. 04
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
7.00	00700 OPERATION OF PLANT						7.00
8. 00 9. 00	OO800 LAUNDRY & LINEN SERVICE OO900 HOUSEKEEPING						8. 00 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	376, 234					13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	148, 858				14. 00
15. 00	01500 PHARMACY	0	354	242, 538			15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	49	0	208, 168	i e	16. 00
17. 00	01700 SOCIAL SERVICE	0	0	0	0	0	
17. 01	01701 MENTAL HEALTH OH	0	74	0	0	0	17. 01
21. 00 22. 00	O2100 I &R SERVICES-SALARY & FRINGES APPRVD O2200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0 12, 334	0 212	0 123	0	0	
23. 00	02300 PARAMED ED PRGM-RADI OLOGY	12, 334	0	0	0		22. 00 23. 00
23. 00	02301 PARAMED ED PRGM-LAB		39	0	0		
20.01	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	37	<u> </u>			20.01
30.00	03000 ADULTS & PEDI ATRI CS	74, 950	3, 284	4	25, 582	0	30.00
31.00	03100 INTENSIVE CARE UNIT	43, 017	3, 010	1	24, 579	0	31. 00
40.00	04000 SUBPROVI DER - I PF	29, 771	235	0	29, 595	0	40. 00
41. 00	04100 SUBPROVI DER - I RF	30, 797	838	0	12, 540	l	
43. 00	04300 NURSERY	4, 227	216	2	4, 013	0	43. 00
EO 00	ANCILLARY SERVICE COST CENTERS O5000 OPERATING ROOM	22 202	([2/	200	15.040	0	F0 00
50. 00 51. 00	05100 RECOVERY ROOM	23, 382	6, 536 0	200 0	15, 048 0	1	
51. 00	05101 ENDOSCOPY	11, 800	3, 825	533	0	1	51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	17, 001	783	7	0	Ö	52. 00
53.00	05300 ANESTHESI OLOGY	0	0	0	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	4, 978	3, 262	3, 713	0	0	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	20, 152	811	50	0	0	55. 00
60.00	06000 LABORATORY	0	11, 702	1	0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0 16, 917	154 428	16 38	0	0	65. 00 66. 00
69. 00	06900 ELECTROCARDI OLOGY	10, 417	1, 328	896	0	0	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70. 00
70. 01	07001 NEURODI AGNOSTI CS	1, 646	885	0	0	0	70. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	64, 293	0	0	0	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	32, 258	0	0	0	
	07300 DRUGS CHARGED TO PATIENTS	0	0	214, 676	0	0	
75. 00	07500 ASC (NON-DISTINCT PART)	17, 025	3, 186	340	57, 686	l	1
76. 00 76. 01	03950 MH ANCI LLARY OUTPATI ENT	0	0	0	0	0	
76.01	03951 INPATIENT DIALYSIS OUTPATIENT SERVICE COST CENTERS	l ol	18	41		0	76. 01
90. 00	09000 CLINI C	0	1	0	0	0	90.00
90. 01	04950 WOUND CLINIC	1, 321	1, 069	203	5, 016		
91.00	09100 EMERGENCY	56, 105	3, 383	153	34, 109	l	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		·				92. 00
	OTHER REIMBURSABLE COST CENTERS						
	09600 DURABLE MEDICAL EQUIP-RENTED	0	94	0	0	•	1
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
112 00	SPECIAL PURPOSE COST CENTERS			I			112 00
	11300 INTEREST EXPENSE 11600 HOSPICE	7, 205	111	0	0	0	113. 00 116. 00
118.00		372, 628	142, 438	220, 997	208, 168		118. 00
110.00	NONREI MBURSABLE COST CENTERS	372,020	142, 430	220, 771	200, 100	0	1110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	ol	0	0	0	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	3, 606	4, 748	17, 346	0	•	192.00
192. 01	19201 FP PETERSBURG	0	12	158	0	0	192. 01
	19202 PEDI ATRI CS	0	130	3, 085	0		192. 02
	19203 WASHINGTON PRIMARY CARE	0	199	919	0		192. 03
	19204 FQHC	0	0	0	0	•	192. 04
	07950 COMMUNITY HEALTH SERVICES	0	45	7	0		194. 00
	07960 CCBHC GRANTS 07952 MARKETING AND PUBLIC RELATIONS	0	499 2	19 0	0		194. 01 194. 02
174.02	- OF TOP MARKETT NO AND TODETO RELATIONS	<u> </u>	2	U	0	1 0	1177.02

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

					5/26/2022 9:3	<u>8 am</u>
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	
	ADMI NI STRATI ON	SERVICES &		RECORDS &		
		SUPPLY		LI BRARY		
	13.00	14.00	15. 00	16.00	17. 00	
194. 03 07953 MH RESIDENTIAL	0	263	7	0	0	194. 03
194. 04 07954 UNUSED SPACE	0	0	0	0	0	194. 04
194. 05 07955 MOB	0	0	0	0	0	194. 05
194. 06 07956 FOUNDATI ON	0	0	0	0	0	194. 06
194.07 07957 KNOX COUNTY HEALTH DEPT	0	0	0	0	0	194. 07
194. 08 07958 I NDUSTRI AL HEALTH	0	0	0	0	0	194. 08
194.09 07959 COMMUNITY MENTAL HEALTH CENTER	0	522	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)	376, 234	148, 858	242, 538	208, 168	0	202. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2021 | Part II | To 12/31/2021 | Date/Time Prepared: | 5/26/2022 9:38 am Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0042

			LNITEDNIC	DECI DENTO	0 12/31/2021	5/26/2022 9:3	
			INTERNS &	RESI DENTS			
	Cost Center Description	MENTAL HEALTH	SERVI CES-SALAR	SERVI CES-OTHER	PARAMED ED	PARAMED ED	
		0H	Y & FRINGES	PRGM COSTS	PRGM-RADI OLOGY		
	GENERAL SERVICE COST CENTERS	17. 01	21.00	22.00	23. 00	23. 01	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
4. 01	00401 COMMUNI CATI ONS						4. 01
4. 02 4. 03	OO4O2 PURCHASING & RECEIVING OO4O3 REGISTRATION		•				4. 02 4. 03
4. 04	00404 PATIENT ACCOUNTS						4. 04
5.00	00500 ADMINISTRATIVE & GENERAL					•	5. 00
7.00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY		•				9. 00 10. 00
11. 00	01100 CAFETERI A						11.00
13. 00	01300 NURSI NG ADMI NI STRATI ON						13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY						14. 00
15.00	01500 PHARMACY						15. 00
	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE						16. 00 17. 00
	01700 SOCIAL SERVICE	104, 451					17. 00
	02100 &R SERVICES-SALARY & FRINGES APPRVD	C C					21. 00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	C		35, 604			22. 00
23. 00	02300 PARAMED ED PRGM-RADI OLOGY	C	1		0		23. 00
23. 01	O2301 PARAMED ED PRGM-LAB	C)			2, 933	23. 01
30. 00	O3000 ADULTS & PEDIATRICS	C	1				30.00
31. 00	03100 INTENSIVE CARE UNIT		l .				31.00
40.00	04000 SUBPROVI DER - I PF	54, 774	l				40.00
41. 00	04100 SUBPROVI DER - I RF	C	1				41. 00
43. 00	04300 NURSERY	C)				43. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM		1	1			50.00
51. 00	05100 RECOVERY ROOM		1				51.00
51. 01	05101 ENDOSCOPY	C				•	51. 01
52.00	05200 DELIVERY ROOM & LABOR ROOM	C	l .				52. 00
53.00	05300 ANESTHESI OLOGY	C	l				53.00
54. 00 55. 00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	C	l .				54. 00 55. 00
60.00	06000 LABORATORY						60.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	i c					63. 00
65.00	06500 RESPI RATORY THERAPY	C					65. 00
66. 00	06600 PHYSI CAL THERAPY	C	l .				66. 00
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	C	l .				69. 00 70. 00
70. 00	07000 ELECTROENCEPHALOGRAPHI		l .				70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	i c	l .				71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	C)				72. 00
	07300 DRUGS CHARGED TO PATIENTS	C	1				73. 00
	07500 ASC (NON-DISTINCT PART)	C	l .				75. 00 76. 00
	03950 MH ANCILLARY OUTPATIENT 03951 INPATIENT DIALYSIS		1				76.00
, 5. 01	OUTPATIENT SERVICE COST CENTERS		1				, 5. 0
90.00	09000 CLI NI C	C	1				90.00
	04950 WOUND CLINIC	C	l .				90. 01
	O9100 EMERGENCY O9200 OBSERVATION BEDS (NON-DISTINCT PART)	C	'				91. 00 92. 00
92.00	OTHER REIMBURSABLE COST CENTERS						92.00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	C					96. 00
	10100 HOME HEALTH AGENCY	C	l .				101. 00
	SPECIAL PURPOSE COST CENTERS	1	1				
	11300 I NTEREST EXPENSE						113.00
116.00	11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117)	54, 774	1	0	0	n	116. 00 118. 00
110.00	NONREI MBURSABLE COST CENTERS	J4, //4			<u> </u>		, 10.00
190. 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	C					190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	C	l .				192. 00
	19201 FP PETERSBURG	C]				192. 01
	19202 PEDIATRICS 19203 WASHINGTON PRIMARY CARE						192. 02 192. 03
	19204 FQHC						192. 03
	07950 COMMUNITY HEALTH SERVICES	C					194. 00
194. 01	07960 CCBHC GRANTS	c)		<u> </u>	<u> </u>	194. 01

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2021 | Part II | To 12/31/2021 | Date/Time Prepared: | 5/26/2022 9:38 am Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS GOOD SAMARITAN HOSPITAL Provider CCN: 15-0042

					5/26/2022 9:3	8 alli
		INTERNS &	RESI DENTS			
Cost Center Description	MENTAL HEALTH	SERVI CES-SALAR	SERVI CES-OTHER	PARAMED ED	PARAMED ED	
	OH	Y & FRINGES	PRGM COSTS	PRGM-RADI OLOGY	PRGM-LAB	
	17. 01	21. 00	22. 00	23. 00	23. 01	
194.02 07952 MARKETING AND PUBLIC RELATIONS	0					194. 02
194. 03 07953 MH RESIDENTIAL	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	49, 677					194. 09
200.00 Cross Foot Adjustments		358, 017	35, 604	. 0	2, 933	200. 00
201.00 Negative Cost Centers	0	0	C	0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	104, 451	358, 017	35, 604	· o	2, 933	202. 00

| Period: | Worksheet B | From 01/01/2021 | Part II | To | 12/31/2021 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0042

	/2022 9:38 am
Cost Center Description Subtotal Intern & Total	
Resi dents Cost & Post	
Stepdown	
Adjustments 24.00	
1. 00 O0100 CAP REL COSTS-BLDG & FIXT	1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	2. 00 4. 00
4. 01 00401 COMMUNI CATI ONS	4. 01
4. 02 00402 PURCHASI NG & RECEI VI NG 4. 03 00403 REGI STRATI ON	4. 02 4. 03
4. 04 00404 PATI ENT ACCOUNTS	4. 04
5. 00 00500 ADMI NI STRATI VE & GENERAL	5. 00
7. 00 00700 OPERATION OF PLANT 8. 00 00800 LAUNDRY & LINEN SERVICE	7. 00 8. 00
9. 00 00900 HOUSEKEEPI NG	9. 00
10. 00 01000 DI ETARY	10.00
11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMI NI STRATI ON	11. 00 13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY	14.00
15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY	15. 00 16. 00
17. 00 01700 SOCI AL SERVI CE	17. 00
17. 01 01701 MENTAL HEALTH OH	17. 01
21. 00 02100 1 &R SERVI CES-SALARY & FRI NGES APPRVD 22. 00 02200 1 &R SERVI CES-0THER PRGM COSTS APPRVD	21. 00 22. 00
23. 00 02300 PARAMED ED PRGM-RADI OLOGY	23. 00
23. 01 02301 PARAMED ED PRGM-LAB	23. 01
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 2,500,030 0 2,500,030 30.00 2,500,030	30.00
31. 00 03100 NTENSI VE CARE UNI T 910, 831 0 910, 831	31. 00
40. 00 04000 SUBPROVI DER - PF 618, 440 0 618, 440 41. 00 04100 SUBPROVI DER - RF 724, 646 0 724, 646	40. 00 41. 00
41. 00 04100 SUBPROVI DER - RF 724, 646 0 724, 646 43. 00 04300 NURSERY 14, 868 0 14, 868	43.00
ANCILLARY SERVICE COST CENTERS	
50. 00 05000 0PERATI NG ROOM 957, 880 0 957, 880 51. 00 05100 RECOVERY ROOM 0 0 0	50. 00 51. 00
51. 01 05101 ENDOSCOPY 467, 701 0 467, 701	51. 01
52. 00 05200 DELI VERY ROOM & LABOR ROOM 39, 223 0 39, 223 53. 00 05300 ANESTHESI OLOGY 0 0	52.00
53. 00 05300 ANESTHESI OLOGY	53. 00 54. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C 686, 122 0 686, 122	55. 00
60. 00 06000 LABORATORY 379, 614 0 379, 614 63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0	60. 00 63. 00
65. 00 06500 RESPI RATORY THERAPY 233, 794 0 233, 794	65. 00
66. 00 06600 PHYSI CAL THERAPY 609, 775 0 609, 775	66.00
69. 00 06900 ELECTROCARDI OLOGY 701, 676 0 701, 676 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0	69. 00 70. 00
70. 01 07001 NEURODI AGNOSTI CS 285, 562 0 285, 562	70. 01
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 192, 070 0 192, 070 72. 00 07200 1 MPL. DEV. CHARGED TO PATIENTS 105, 369 0 105, 369	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 105, 369 0 105, 369 73. 00 07300 DRUGS CHARGED TO PATIENTS 337, 782 0 337, 782	72. 00 73. 00
75. 00 07500 ASC (NON-DISTINCT PART) 132, 398 0 132, 398	75. 00
76. 00 03950 MH ANCILLARY OUTPATIENT 0 0 0 0 0 76. 01 03951 INPATIENT DIALYSIS 294, 763 0 294, 763	76. 00 76. 01
OUTPATIENT SERVICE COST CENTERS	
90. 00 09000 CLI NI C 82, 759 0 82, 759 90. 01 04950 WOUND CLI NI C 125, 945 0 125, 945	90. 00 90. 01
91. 00 09100 EMERGENCY 1, 029, 265 0 1, 029, 265	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0	92. 00
OTHER REI MBURSABLE COST CENTERS 15,506 0 15,506 96. 00 DURABLE MEDI CAL EQUI P-RENTED 15,506 0 15,506	96. 00
101. 00 10100 HOME HEALTH AGENCY 0 0 0	101. 00
SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE	113. 00
116. 00 11600 H0SPI CE 185, 045 0 185, 045	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 12,514,892 0 12,514,892	118. 00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0	190. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 4, 760, 872 0 4, 760, 872	192. 00
192. 01 19201 FP PETERSBURG 130, 884 0 130, 884	192. 01 192. 02
192. 02 19202 PEDI ATRI CS	192. 02
192. 04 19204 FQHC 78 0 78	192. 04
194. 00 07950 COMMUNI TY HEALTH SERVI CES 17, 276 0 17, 276	194. 00

Heal th Financial Systems GOOD SAMARITAN HOSPITAL In Lieu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0042 Period: Worksheet B

ALLUCATION OF	- CAPITAL RELATED COSTS		Provider Co	UN: 15-0042	Part II Date/Time Prepa 5/26/2022 9:38	
	Cost Center Description	Subtotal	Intern &	Total		

				5/26/2022 9:38 am
Cost Center Description	Subtotal	Intern &	Total	
		Residents Cost		
		& Post		
		Stepdown		
		Adjustments		
	24. 00	25. 00	26.00	
194. 01 07960 CCBHC GRANTS	21, 899	0	21, 899	194. 01
194.02 07952 MARKETING AND PUBLIC RELATIONS	64, 152	0	64, 152	194. 02
194.03 07953 MH RESIDENTIAL	699, 975	0	699, 975	194. 03
194. 04 07954 UNUSED SPACE	694, 774	0	694, 774	194. 04
194. 05 07955 MOB	231	0	231	194. 05
194. 06 07956 FOUNDATI ON	15, 896	0	15, 896	194. 06
194.07 07957 KNOX COUNTY HEALTH DEPT	160, 716	0	160, 716	194. 07
194. 08 07958 I NDUSTRI AL HEALTH	0	0	C	194. 08
194.09 07959 COMMUNITY MENTAL HEALTH CENTER	1, 307, 019	0	1, 307, 019	194. 09
200.00 Cross Foot Adjustments	396, 554	0	396, 554	200.00
201.00 Negative Cost Centers	0	0	C	201. 00
202.00 TOTAL (sum lines 118 through 201)	21, 056, 025	0	21, 056, 025	202.00

	Financial Systems	GOOD SAMARITA				u of Form CMS-	
COST A	ALLOCATION - STATISTICAL BASIS		Provi der CC		eriod: rom 01/01/2021	Worksheet B-1	
					o 12/31/2021	Date/Time Pre	pared:
						5/26/2022 9: 3	8 am
		CAPI TAL REI	LATED COSTS				
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	COMMUNI CATI ONS		
		(SQUARE FEET)	(SQUARE FEET)	BENEFITS		RECEI VI NG	
				DEPARTMENT	(NUMBER OF	(SUPPLI ES	
				(GROSS	PHONES)	COST)	
		1.00	2.00	SALARI ES)	4 01	4.00	
	CENEDAL CEDALOE COCT CENTEDO	1. 00	2.00	4. 00	4. 01	4. 02	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	884, 498		1			1 00
2. 00	00200 CAP REL COSTS-BLDG & FIXT	004, 490	884, 498				1.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	4, 862					4.00
4. 00	00400 EMPLOTEE BENEFIT IS BEPARTMENT	4, 802	4, 802				4. 00
4. 01	00401 COMMON CATTONS 00402 PURCHASING & RECEIVING	11, 575	1			18, 800, 370	1
4. 03	00403 REGI STRATI ON	11, 304				12, 541	1
4. 04	00404 PATIENT ACCOUNTS	11, 304	1			10, 417	1
5.00	00500 ADMINISTRATIVE & GENERAL	47, 966	1			46, 874	1
7. 00	00700 OPERATION OF PLANT	239, 930					1
8. 00	00800 LAUNDRY & LINEN SERVICE	5, 266					1
9. 00	00900 HOUSEKEEPI NG	7, 326				214, 527	1
10.00	01000 DI ETARY	4, 314				404, 667	
11. 00	01100 CAFETERI A	8, 205				769, 643	1
13. 00	01300 NURSI NG ADMI NI STRATI ON	9, 763					
14. 00	01400 CENTRAL SERVICES & SUPPLY	3, 967				68, 513	
15. 00	01500 PHARMACY	5, 979				39, 075	
16. 00	01600 MEDICAL RECORDS & LIBRARY	4, 580				5, 385	
17. 00	01700 SOCIAL SERVICE	0	0			0	1
17. 01	01701 MENTAL HEALTH OH	2, 605	2, 605	475, 129	251	8, 175	1
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	10, 144			0	0	21.00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0			50	23, 365	
23. 00	02300 PARAMED ED PRGM-RADIOLOGY	0	0	C	0		23. 00
23. 01	02301 PARAMED ED PRGM-LAB	0	0	240, 212	. 0	4, 340	23. 01
	INPATIENT ROUTINE SERVICE COST CENTERS			•			
30.00	03000 ADULTS & PEDI ATRI CS	61, 220	61, 220	5, 067, 882	159	362, 411	30.00
31.00	03100 INTENSIVE CARE UNIT	20, 954	20, 954	3, 272, 273	98	332, 178	31.00
40.00	04000 SUBPROVI DER - I PF	13, 034	13, 034	2, 052, 405	0	25, 941	40.00
41.00	04100 SUBPROVI DER - I RF	17, 193	17, 193	2, 034, 132	. 71	92, 488	41.00
43.00	04300 NURSERY	0	0	338, 753	0	23, 876	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	24, 026	24, 026	3, 247, 268	149	721, 377	50. 00
51.00	05100 RECOVERY ROOM	0	0	C	0	0	51.00
51. 01	05101 ENDOSCOPY	12, 237	12, 237			422, 117	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	1, 016, 361	63	86, 436	52. 00
53.00	05300 ANESTHESI OLOGY	0	0	C	0		
54.00	05400 RADI OLOGY-DI AGNOSTI C	21, 666					1
55. 00	05500 RADI OLOGY-THERAPEUTI C	17, 985					
60.00	06000 LABORATORY	7, 298					
	06300 BLOOD STORING, PROCESSING & TRANS.	0			_		1
65.00	06500 RESPI RATORY THERAPY	5, 679					65. 00
66.00	06600 PHYSI CAL THERAPY	15, 277				47, 205	
69. 00	06900 ELECTROCARDI OLOGY	18, 181	1	5, 030, 178		146, 591	1
70.00		0	0	400 500	0	0	
70. 01 71. 00	07001 NEURODI AGNOSTI CS	7, 708	7, 708			97, 684	
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0	0	_	7, 095, 914	1
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0		C	0	3, 560, 067 0	1
75. 00	07500 ASC (NON-DISTINCT PART)			1, 025, 093	0	351, 659	
76. 00	03950 MH ANCILLARY OUTPATIENT			1,025,093	0	331,039	76.00
76. 00 76. 01	03951 INPATIENT DIALYSIS	8, 582	8, 582			1, 955	
70.01	OUTPATIENT SERVICE COST CENTERS	0, 302	0, 302		3	1, 700	70.01
00 00	09000 CLINIC	2, 254	2, 254	77, 480	0	142	90.00
90. 00	04950 WOUND CLINIC	2, 976					1
91. 00	l l	23, 669				· ·	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	25,007	25,007	4, 224, 540	103	373,377	92.00
72.00	OTHER REIMBURSABLE COST CENTERS	1		l			/2.00
96 00	09600 DURABLE MEDICAL EQUIP-RENTED	394	394	93, 968	0	10 351	96. 00
	10100 HOME HEALTH AGENCY	0					101.00
	SPECIAL PURPOSE COST CENTERS				<u> </u>		1.000
113.00	11300 I NTEREST EXPENSE						113. 00
	11600 HOSPI CE	4, 861	4, 861	448, 702	23	12, 237	116. 00
118.00	i i	662, 980					1
	NONREI MBURSABLE COST CENTERS	552,760	, 332,700	, 555, 566	., 301	, . , . , . , . , . , . , . , . ,	1
190. 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	С	0	0	190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	127, 997				523, 998	
	19201 FP PETERSBURG	3, 705					192. 01
	19202 PEDI ATRI CS	0	0	1, 091, 031			192. 02
	19203 WASHINGTON PRIMARY CARE	6, 800	6, 800				192. 03
	•	<u>* </u>				·	·

Provider CCN: 15-0042

				T	o 12/31/2021	Date/Time Pre 5/26/2022 9:3	
		CAPITAL REL	ATED COSTS				
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP		COMMUNI CATI ONS		
		(SQUARE FEET)	(SQUARE FEET)	BENEFITS	(AUUMDED OF	RECEI VI NG	
				DEPARTMENT (GROSS	(NUMBER OF PHONES)	(SUPPLIES COST)	
				SALARI ES)	PHUNES)	(031)	
		1.00	2. 00	4. 00	4. 01	4. 02	
192. 04 19204	FQHC	0	0	9, 660			192. 04
194. 00 07950	COMMUNITY HEALTH SERVICES	415	415	· ·		4, 994	194. 00
194. 01 07960	CCBHC GRANTS	0	0	1, 357, 807	0	55, 084	194. 01
194. 02 07952	MARKETING AND PUBLIC RELATIONS	1, 690	1, 690	235, 800	4	217	194. 02
194. 03 07953	BMH RESIDENTIAL	20, 260	20, 260	485, 347	0	29, 014	194. 03
	UNUSED SPACE	20, 370	20, 370	0	0		194. 04
194. 05 07955	1 -	0	0	0	0		194. 05
	FOUNDATI ON	466	466		2		194. 06
	KNOX COUNTY HEALTH DEPT	4, 712	4, 712	0	0		194. 07
	INDUSTRIAL HEALTH	0	0	0	0		194. 08
	COMMUNITY MENTAL HEALTH CENTER	35, 103	35, 103	6, 289, 538	0	57, 590	194. 09
200. 00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers	00.040.004	0= 444		007.07/	4 047 040	201. 00
202. 00	Cost to be allocated (per Wkst. B, Part I)	20, 960, 881	95, 144	30, 844, 796	307, 076	1, 217, 042	202.00
203. 00	Unit cost multiplier (Wkst. B, Part I)	23. 698054	0. 107568				1
204. 00	Cost to be allocated (per Wkst. B, Part II)			115, 743	305	276, 276	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part			0. 001075	0. 135255	0. 014695	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

1. 00 2. 00 4. 00	LOCATION - STATISTICAL BASIS Cost Center Description	REGI STRATI ON (GROSS	Provi der C	Fr		Worksheet B-1 Date/Time Pre 5/26/2022 9:3	pared:
1.00 2.00 4.00	Cost Center Description		PATIENT	To	12/31/2021	Date/Time Pre 5/26/2022 9:3	pared: 8 am
1.00 2.00 4.00	Cost Center Description		PATI FNT	Doconci Li ati on		5/26/2022 9: 3	8 am
1.00 2.00 4.00	Cost Center Description		PALLENI				
1.00 2.00 4.00			ACCOUNTS	Reconciliation	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	
1.00 2.00 4.00		CHARGES)	(GROSS		(ACCUM. COST)	(SQUARE FEET)	
1.00 2.00 4.00		OTWINGES)	CHARGES)		(1000)	(SQS/IIIC TEET)	
1.00 2.00 4.00		4. 03	4. 04	5A	5. 00	7. 00	
2.00 4.00	GENERAL SERVICE COST CENTERS						
4.00	00100 CAP REL COSTS-BLDG & FLXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00
4	00400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
	00400 EMI EOTEE BENEFITTS BEFARTMENT						4. 01
	00402 PURCHASING & RECEIVING						4. 02
4. 03	00403 REGI STRATI ON	660, 027, 621					4. 03
1	00404 PATIENT ACCOUNTS	0	660, 027, 621				4. 04
1	00500 ADMINISTRATIVE & GENERAL	0	0	-18, 150, 076	209, 160, 659		5.00
1	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	0	0		12, 704, 262 482, 308		1
	00900 HOUSEKEEPING		0		3, 036, 478		
	01000 DI ETARY	l o	Ö		1, 303, 725		
	01100 CAFETERI A	O	0	0	1, 570, 321	8, 205	
	01300 NURSING ADMINISTRATION	0	0	0	4, 416, 923	9, 763	13. 00
	01400 CENTRAL SERVICES & SUPPLY	0	0	0	763, 421	3, 967	
	01500 PHARMACY	0	0	0	4, 157, 454		1
	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE		0	0	5, 185, 604 0	4, 580 0	1
	01701 MENTAL HEALTH OH		0		950, 148	_	
	02100 I&R SERVICES-SALARY & FRINGES APPRVD	l o	Ö		2, 428, 483	10, 144	
	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	o	0	o	2, 379, 862	0	
23. 00	02300 PARAMED ED PRGM-RADIOLOGY	0	0	0	0	0	23. 00
	02301 PARAMED ED PRGM-LAB	0	0	0	295, 377	0	23. 01
	INPATIENT ROUTINE SERVICE COST CENTERS	00 005 040	00 005 040	J al	40,000,070	/4.000	
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	29, 325, 343 16, 931, 150	29, 325, 343 16, 931, 150		10, 882, 079 6, 640, 529		1
	04000 SUBPROVI DER – I PF	9, 327, 474	9, 327, 474		2, 985, 221	13, 034	
4	04100 SUBPROVI DER - I RF	8, 076, 659	8, 076, 659		3, 548, 857		
	04300 NURSERY	1, 429, 086	1, 429, 086		484, 750		1
	ANCILLARY SERVICE COST CENTERS						
4	05000 OPERATING ROOM	48, 724, 660	48, 724, 660		5, 356, 975	24, 026	1
4	05100 RECOVERY ROOM 05101 ENDOSCOPY	11 720 744	11 720 744	0	1 042 500	12 227	
1	05200 DELIVERY ROOM & LABOR ROOM	11, 720, 766 8, 126, 068	11, 720, 766 8, 126, 068		1, 963, 598 1, 536, 553		1
4	05300 ANESTHESI OLOGY	0, 120, 000	0, 120, 000		1, 330, 333	Ö	
	05400 RADI OLOGY-DI AGNOSTI C	101, 735, 865	101, 735, 865	0	8, 924, 254	21, 666	
	05500 RADI OLOGY-THERAPEUTI C	25, 013, 062	25, 013, 062		4, 317, 677	17, 985	
	06000 LABORATORY	75, 006, 225	75, 006, 225	0	8, 960, 480		
	06300 BLOOD STORING, PROCESSING & TRANS. 06500 RESPIRATORY THERAPY	14, 879, 570	14 970 570		2 502 702	0 5 470	
	06600 PHYSI CAL THERAPY	26, 438, 823	14, 879, 570 26, 438, 823		3, 503, 703 5, 791, 767		
	06900 ELECTROCARDI OLOGY	49, 703, 275	49, 703, 275		4, 982, 595	·	
	07000 ELECTROENCEPHALOGRAPHY	0	0	O	0	0	
70. 01	07001 NEURODI AGNOSTI CS	6, 802, 876	6, 802, 876	0	1, 604, 281	7, 708	70. 01
1	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 911	1, 911		4, 271, 547	0	
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	70 400 007	_	3, 781, 045	0	
	07300 DRUGS CHARGED TO PATIENTS 07500 ASC (NON-DISTINCT PART)	70, 139, 207 25, 919, 018	70, 139, 207 25, 919, 018		17, 077, 796 2, 220, 759	0	73. 00 75. 00
	03950 MH ANCILLARY OUTPATIENT	25, 919, 016	25, 919, 016		2, 220, 739	0	1
1	03951 INPATIENT DIALYSIS	1, 020, 772	1, 020, 772		483, 852		
	OUTPATIENT SERVICE COST CENTERS					5, 532	1
	09000 CLI NI C	89, 313	89, 313	0	156, 837	2, 254	90.00
	04950 WOUND CLINIC	6, 263, 026	6, 263, 026		1, 327, 156		
	09100 EMERGENCY	51, 742, 256	51, 742, 256	0	7, 328, 985	23, 669	
	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92. 00
	09600 DURABLE MEDICAL EQUIP-RENTED	407, 736	407, 736	0	199, 815	394	96. 00
	10100 HOME HEALTH AGENCY	0	407, 730		0		101. 00
	SPECIAL PURPOSE COST CENTERS	1	_	,	-,		
	11300 INTEREST EXPENSE						113. 00
	11600 HOSPI CE	2, 023, 096	2, 023, 096		892, 126		116. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	590, 847, 237	590, 847, 237	-18, 150, 076	148, 897, 603	347, 343	1118. 00
	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN			0	٥		190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	53, 130, 448	53, 130, 448		41, 053, 733		
	19201 FP PETERSBURG	562, 532	562, 532		595, 962		192. 01
	19202 PEDI ATRI CS	2, 871, 198	2, 871, 198		1, 728, 324	0	192. 02
	19203 WASHINGTON PRIMARY CARE	3, 158, 822	3, 158, 822	2 0	2, 158, 699		192. 03
192.04	19204 FQHC	0	0	0	12, 428		192. 04
194.00	07950 COMMUNITY HEALTH SERVICES	71, 663	71, 663		175, 437		194. 00 194. 01
	07960 CCBHC GRANTS	759, 600	759, 600	η U	2, 155, 329	, 01	[174. UT

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

COST ALLOCATION - STATISTICAL BASIS		Provi der Co	1	Period: From 01/01/2021 To 12/31/2021	Worksheet B-1 Date/Time Pre	pared:
					5/26/2022 9: 3	
Cost Center Description	REGI STRATI ON		Reconciliation	ADMI NI STRATI VE		
	(GROSS	ACCOUNTS		& GENERAL	PLANT	
	CHARGES)	(GROSS		(ACCUM. COST)	(SQUARE FEET)	
	4.00	CHARGES)		5.00	7.00	
10.4 00 07.07.0 MARKETI NO. AND BURLLO DEL ATLONO	4. 03	4. 04	5A	5. 00	7. 00	101.00
194. 02 07952 MARKETING AND PUBLIC RELATIONS	1/7/00	0		932, 406		194. 02
194. 03 07953 MH RESI DENTI AL	167, 638	167, 638		1, 162, 748		194. 03
194. 04 07954 UNUSED SPACE	0	0	1	484, 920		194. 04
194. 05 07955 MOB	0	0	1	41, 972		194. 05
194. 06 07956 FOUNDATI ON	0	0		11, 365		194. 06
194.07 07957 KNOX COUNTY HEALTH DEPT	0	0	(112, 172		194. 07
194. 08 07958 I NDUSTRI AL HEALTH	0	0	(0		194. 08
194.09 07959 COMMUNITY MENTAL HEALTH CENTER	8, 458, 483	8, 458, 483		9, 637, 561	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, 564, 064	4, 988, 441		18, 150, 076	13, 806, 687	202. 00
203.00 Unit cost multiplier (Wkst. B, Part I	0. 003885	0. 007558		0. 086776	24. 270757	203. 00
204.00 Cost to be allocated (per Wkst. B,	271, 154	2, 984		1, 150, 320	5, 785, 984	204. 00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part	0. 000411	0. 000005		0.005500	10. 171174	205. 00
206.00 NAHE adjustment amount to be allocate	d					206. 00
(per Wkst. B-2)						
207.00 NAHE unit cost multiplier (Wkst. D,						207. 00
Parts III and IV)						[

Health Financial Systems COST ALLOCATION - STATISTICAL BASIS		GOOD SAMARITA	N HOSPITAL Provider C	CN: 15-0042	Peri od:	eu of Form CMS-2552-10 Worksheet B-1	
					From 01/01/2021 To 12/31/2021	Date/Time Pre	
	Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (HOURS OF SERVI CE)	DIETARY (PATIENT DAY:	CAFETERIA S) (MAN HOURS)	5/26/2022 9: 3 NURSI NG ADMI NI STRATI ON (DI RECT	
		8.00	9. 00	10.00	11. 00	NURSI NG) 13. 00	
	GENERAL SERVICE COST CENTERS	0.00	7. 00	10.00	11.00	10.00	
1. 00 2. 00 4. 00 4. 01 4. 02 4. 03 4. 04 5. 00 7. 00 10. 00 11. 00 13. 00 14. 00 15. 00 17. 01 22. 00 23. 00 23. 01	01701 MENTAL HEALTH OH 02100 I&R SERVICES-SALARY & FRINGES APPRVD 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	845, 567 53, 826 2, 852 5, 425 0 12, 142 0 0 0 0	65, 207 1, 784 426 0 756 599 512 0 1, 870 0 966	32, 2	888 0 2, 111, 064 0 57, 320 0 17, 979 0 68, 750 0 123, 957 0 0 13, 050 0 0 0 26, 420 0 0 0 6, 602	805, 906 0 0 0 0 0 0	14. 00 15. 00 16. 00 17. 00 17. 01 21. 00 22. 00 23. 00
30. 00	NPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	284, 055	16, 047	14, 9	70 168, 313	160, 545	30.00
31. 00	03100 INTENSIVE CARE UNIT	70, 668	4, 489	5, 4	25 92, 144	92, 144	31.00
40. 00 41. 00	04000 SUBPROVI DER	18, 662 50, 662	0 2, 862				1
43. 00	04300 NURSERY ANCILLARY SERVICE COST CENTERS	1, 923	166		0 9, 055	9, 055	43.00
50. 00	05000 OPERATING ROOM	30, 687	3, 720		0 68, 204		1
51. 00 51. 01	05100 RECOVERY ROOM 05101 ENDOSCOPY	0 23, 617	0 1, 008	l .	0 0 0 25, 275	-	
52.00	05200 DELIVERY ROOM & LABOR ROOM	10, 027	219		0 28, 649		
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0 53, 366	2, 098		0 0 104, 232	0 10, 664	
55. 00	05500 RADI OLOGY-THERAPEUTI C	9, 023	1, 103	1	0 62, 141	43, 166	
60. 00 63. 00	06000 LABORATORY 06300 BLOOD STORING, PROCESSING & TRANS.	0	963 0		0 96, 343 0 0	0	
65. 00	06500 RESPI RATORY THERAPY	166	742		0 62, 889		65. 00
66. 00 69. 00		9, 183 19, 231	1, 755 2, 183	1	0 111, 817 0 86, 744		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	12, 005 0	660 0		0 14, 888	3, 525 0	1
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72. 00
73. 00 75. 00	· · · · · · · · · · · · · · · · · · ·	32, 332	2, 924		0 36, 468	0 36, 468	
76. 00	03950 MH ANCILLARY OUTPATIENT	0	0		0 0	0	76. 00
76. 01	03951 INPATIENT DIALYSIS OUTPATIENT SERVICE COST CENTERS	0			0 0	0	76. 01
90.00	09000 CLI NI C	0	1, 107	1	0 2, 725	l .	90.00
90. 01 91. 00	04950 WOUND CLINIC 09100 EMERGENCY	9, 725 106, 211	350 4, 439	1	0 10, 726 0 120, 179		1
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	155, 211	.,		,	1.20, 111	92.00
96. 00	OTHER REIMBURSABLE COST CENTERS O9600 DURABLE MEDICAL EQUIP-RENTED	0	0	ı	0 3, 510	0	96. 00
	10100 HOME HEALTH AGENCY	0	C		0 0		101. 00
113. 0	SPECIAL PURPOSE COST CENTERS D 11300 INTEREST EXPENSE						113. 00
116. 0	11600 H0SPI CE	0	909	1	0 15, 434		116. 00
118. 0	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	815, 788	54, 657	32, 2	88 1, 563, 951	798, 181	1178.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	10.1/7		0 0		190.00
	D19200 PHYSICIANS' PRIVATE OFFICES 1 19201 FP PETERSBURG	29, 779 0	10, 167 0		0 394, 444 0 7, 305		192. 00 192. 01
192.0	2 19202 PEDI ATRI CS	0	0		0 25, 976	0	192. 02
	3 19203 WASHINGTON PRIMARY CARE 4 19204 FOHC	0 0	0		0 32, 329		192. 03 192. 04
	07950 COMMUNITY HEALTH SERVICES	0	328		0 3, 659		194. 00

COST ALLOCATION - STATISTICAL BASIS

Provi der CCN: 15-0042

Peri od: Worksheet B-1 From 01/01/2021 To 12/31/2021 Date/Time Prepared:

5/26/2022 9:38 am Cost Center Description LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A NURSI NG LINEN SERVICE (HOURS OF (PATIENT DAYS) (MAN HOURS) ADMI NI STRATI ON (POUNDS OF SERVICE) LAUNDRY) (DI RECT NURSI NG) 8.00 9.00 10.00 11.00 13.00 194. 01 07960 CCBHC GRANTS 48, 369 0 194. 01 7, 704 194. 02 07952 MARKETING AND PUBLIC RELATIONS 55 0 0 194. 02 0 0 0 0 0 194. 03 07953 MH RESIDENTIAL 0 0 194. 03 0 27, 327 194. 04 07954 UNUSED SPACE 0 0 194. 04 0 194. 05 07955 MOB 0 0 0 194. 05 194. 06 07956 FOUNDATION 0 0 0 194.06 194.07 07957 KNOX COUNTY HEALTH DEPT 0 0 194. 07 0 0 0 194. 08 07958 I NDUSTRI AL HEALTH 0 0 0 0 194. 08 194. 09 07959 COMMUNITY MENTAL HEALTH CENTER 0 0 0 0 194. 09 Cross Foot Adjustments 200.00 200. 00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 651, 971 3, 519, 281 1, 620, 044 1, 932, 904 5, 089, 644 202. 00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 0. 771046 53. 970908 50. 174802 0. 915607 6. 315431 203. 00 204.00 Cost to be allocated (per Wkst. B, 182, 762 282, 602 168, 683 302, 969 376, 234 204. 00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0. 216141 4. 333921 5. 224325 0.143515 0. 466846 205. 00 H) 206.00 NAHE adjustment amount to be allocated 206. 00 (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, 207.00 207.00 Parts III and IV)

CUST Center Description CUST Center Description CUST Center Description CUST CENTER SERVICES & COSTED SERVICES & COST		Financial Systems	GOOD SAMARITAN				u of Form CMS-	
COST Center Description	COST A	LLOCATION - STATISTICAL BASIS		Provi der Co	F	rom 01/01/2021	Worksheet B-1 Date/Time Pre	
SIRVICES A							5/26/2022 9: 3	
SUPPLY SUPPLIES OCT CITE STRUCT COST CINTERS 14.00 15.00 16.00 17.00 17.01		Cost Center Description				SOCIAL SERVICE		
CONTROL CONT						(NET CHADCES)		
COST)				REQUIS.)		(NET CHARGES)	(NET CHARGES)	
14.00 15.00 16.00 17.00 17.01			7		(TIME SIENT)			
0.000 0.00				15. 00	16. 00	17. 00	17. 01	
2.00								
0.0400 IMPOVER BENEFITS DEPARTMENT								1. 00
4. 01 00407 (20MANI CATI ONS 4 RECEIVEN 6 4.02 00402 (PRICHAST) AS RECEIVEN 6 4.03 00403 (REGISTRATI ON 4.03 00403 (REGISTRATI ON 4.04 00404) APTI EST ACCOUNTS GENERAL 5.00 00500 (A)MINISTRATI ON 4.05 00400 (A)MINISTRATI ON 4.05 00400 (A)MINISTRATI ON 4.05 00500 (A)MINISTRATION 6.05 005		•						2.00
4.02 00402 PURCHASIN S. RECELY IN IS 4.03 00403 RECISTRATION 4.04 00404 PATLENT ACCOUNTS 5.00 00500 DARM STREAT IVE & GENERAL 7.00 00500 DARM STREAT IVE & GENERAL 7.00 00500 DETARY 7.00 00500								4.00
4.03 0.0403 REGISTRATION		•						4. 01 4. 02
0.040 PATLENT ACCOUNTS								4. 02
0.000 0.0000 0.0		•						4. 04
0.000 0.0000 DEPARTION OF PLANT								5. 00
9.00 00900 HOUSEKEEPING	7.00							7. 00
10.00 01000 DIETARY		00800 LAUNDRY & LINEN SERVICE						8. 00
11.00 01100 CAFETER IA		•						9. 00
13. 00 01300 NURSIN G ADMIN STRATION 16. 428, 781 15. 00 01500 PHARMACY 16. 428, 781 15. 00 01500 PHARMACY 5.3 85 0 830 0 17. 00 01700 SOCI IAL SERVI CE 0 0 0 0 0 0 0 0 0								10.00
14. 00 01400 CENTRAL SERVICES & SUPPLY 16, 429, 781								11.00
15.00 01500 PHARMACY 39,075 18,826,607			16 420 701					13.00
16. 00 01600 MEDICAL RECORDS & LI BRARY 5. 385		•		18 826 607				15. 00
17. 00 01700 SOCIAL SERVICE				0	830			16. 00
21.00 02100 IAS ESERVICES-SOLHARY & FRI NGES APPRVD 0 0 0 0 0 0 0 0 0			1	0	1			17. 00
22.00 02200 IAS SERVICES-OTHER PROM COSTS APPRVD 23,365 9,514 0 0 0 0 0 0 0 0 0	17. 01	01701 MENTAL HEALTH OH	8, 175	0	C	0	17, 785, 957	17. 01
23.0 02300 PARAMED ED PRIGM-RADI OLOGY 0 0 0 0 0 0 0 0 0			-1	0	C	0		1
23.01 22301 PARMED ED PROM-LAB 4,340 0 0 0 0 0 0 0 0 0			1	9, 514	·	-		1
IMPATI ENT ROUTINE SERVICE COST CENTERS			-1	0				
30.00 03000 ADULTS & PEDIATRICS 362, 411 274 102 0 0 0 0 0 0 0 0 0	23. 01		4, 340	0)	0	23. 01
31.00 03100 INTENSIVE CARE UNIT 332,178 58 98 0 0 0 0 0 0 0 0 0	30 00		362 411	27.4	103	0	n	30.00
40.00 04000 04000 SUBPROVI DER - 1 PF 25, 941 24 118 0 9, 327, 474 41.00 41.00 04100 SUBPROVI DER - 1 RF 92, 488 12 50 0 0							-	
41.00		•					-	
ANCILLARY SERVICE COST CENTERS		•			50	0		
SO	43.00		23, 876	159	16	0	0	43. 00
51.00 05100 RECOVERY ROOM 0 0 0 0 0 0 0 0 0								
51.01 05101 ENDOSCOPY			1					
52.00 05200 DELI VERY ROOM & LABOR ROOM 86, 436 537 0 0 0 0 0 0 0 0 0			-1	-		-		
53.00 05300 ANESTHESI OLOGY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		•				-	_	
54. 00 05400 RADI OLOGY-DI AGNOSTI C 360, 010 288, 211 0 0 0 0 0 0 0 0 0		•	0		·	-	_	
60.00 06000 LABORATORY 1, 291, 422 72 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	54.00	•	360, 010	288, 211		0	0	
63. 00	55.00	05500 RADI OLOGY-THERAPEUTI C	89, 523	3, 880	C	0	0	55. 00
65. 00 06500 RESPI RATORY THERAPY 16, 973 1, 277 0 0 0 0 0 0 66.00 06600 PHYSI CAL THERAPY 47, 205 2, 958 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			1, 291, 422		(0		
66. 00 06600 PHYSI CAL THERAPY			I -1	ū		0		1
69. 00 06900 ELECTROCARDI OLOGY 146, 591 69, 544 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						_		
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0 0 0 0								1
70. 01 07001 NEURODI AGNOSTI CS 97, 684 22 0 0 0 0 0 71.00 MEDI CAL SUPPLIES CHARGED TO PATIENTS 7, 095, 914 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			140, 371	07, 344				
71. 00			97, 684	22		o o		1
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 16, 663, 994 0 0 0 0 75. 00 07500 ASC (NON-DISTINCT PART) 351, 659 26, 406 230 0 0 76. 00 03950 MH ANCI LLARY OUTPATIENT 0 0 0 0 0 76. 01 03951 INPATIENT DIALYSIS 1, 955 3, 197 0 0 0 OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC 142 17 0 0 0 91. 00 09100 EMERGENCY 373, 377 11, 894 136 0 0 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 OTHER REI MBURSABLE COST CENTERS 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 10, 351 0 0 0 0 OTHER REI MBURSABLE COST CENTERS 113. 00 11300 INTEREST EXPENSE 116. 00 1080 CS COST CENTERS 116. 00 11600 HOSPICE 12, 237 29 0 0 0 0 SUBTOTALS (SUM OF LINES 1 through 117) 15, 720, 242 17, 154, 696 830 0 9, 327, 474 NONREI MBURSABLE COST CENTERS				0		0	0	
75. 00		•	3, 560, 067	0	C	0		
76. 00			-1			-	-	
76. 01 03951 INPATIENT DIALYSIS 1,955 3,197 0 0 0 OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC 142 17 0 0 0 90. 01 04950 WOUND CLINIC 117,968 15,739 20 0 0 91. 00 09100 EMERGENCY 373,377 11,894 136 0 0 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 OTHER REIMBURSABLE COST CENTERS 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 10,351 0 0 0 0 OTHOR REIMBURSABLE COST CENTERS 113. 00 10100 HOME HEALTH AGENCY 0 0 0 0 0 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 12,237 29 0 0 0 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 15,720,242 17,154,696 830 0 9,327,474 NONREIMBURSABLE COST CENTERS			351, 659	26, 406	230	0		1
OUTPATI ENT SERVI CE COST CENTERS OUTPATI ENT SERVI CENTERS			1 055	2 107		0		
90. 00	70.01		1, 905	3, 197	1	, 0	0	70.01
90. 01	90. 00		142	17	(0	0	90.00
91. 00		•	1			-		
OTHER REIMBURSABLE COST CENTERS 96. 00	91.00	09100 EMERGENCY		11, 894	136	0	0	91.00
96. 00	92.00							92. 00
101. 00					T			
SPECIAL PURPOSE COST CENTERS 113.00 1 NTEREST EXPENSE 116.00 11600 HOSPI CE 12, 237 29 0 0 0 0 0 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 15, 720, 242 17, 154, 696 830 0 9, 327, 474 NONREI MBURSABLE COST CENTERS 13.00 13.00 14.00 15.00 1								
113. 00			l O	0) 0	0	101. 00
116. 00 11600 HOSPI CE 12, 237 29 0 0 0 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 15, 720, 242 17, 154, 696 830 0 9, 327, 474 NONREI MBURSABLE COST CENTERS								113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 15,720,242 17,154,696 830 0 9,327,474 NONREI MBURSABLE COST CENTERS			12, 237	29		0	0	116. 00
NONREI MBURSABLE COST CENTERS						0		
190 ON 190 ON GLET FLOWER COFFEE SHOP & CANTEEN ON ON ON ON ON		NONREI MBURSABLE COST CENTERS						
		19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(0		190. 00
						0		192. 00
						0		192. 01
								192. 02 192. 03
			21, 945	/ I, 3U4	1			192. 03
			4 994	510	١ - `	,		194. 00
		,	1 1774	210		<u>. </u>	·	

| Period: | Worksheet B-1 | From 01/01/2021 | To 12/31/2021 | Date/Time Prepared:

				T	o 12/31/2021	Date/Time Pre 5/26/2022 9:3	
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE		O dill
		SERVICES &	(COSTED	RECORDS &		OH	
		SUPPLY	REQUIS.)	LI BRARY	(NET CHARGES)	(NET CHARGES)	
		(SUPPLIES	ŕ	(TIME SPENT)	,	ĺ	
		COST)					
		14. 00	15. 00	16.00	17. 00	17. 01	
194. 01 07960	CCBHC GRANTS	55, 084	1, 490	0	0	0	194. 01
194. 02 07952	MARKETING AND PUBLIC RELATIONS	217	0	0	0	0	194. 02
194. 03 07953	MH RESIDENTIAL	29, 014	506	0	0		194. 03
194. 04 07954	UNUSED SPACE	0	0	0	0	0	194. 04
194. 05 07955		8	0	0	0		194. 05
194. 06 07956		0	0	0	0		194. 06
	KNOX COUNTY HEALTH DEPT	0	0	0	0		194. 07
-	I NDUSTRI AL HEALTH	0	0	0	0	0	194. 08
	COMMUNITY MENTAL HEALTH CENTER	57, 590	2	0	0	8, 458, 483	
200. 00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers						201. 00
202. 00	Cost to be allocated (per Wkst. B,	992, 576	4, 760, 974	5, 888, 204	0	1, 209, 192	202. 00
	Part I)						
203. 00	Unit cost multiplier (Wkst. B, Part I)	0. 060417	0. 252885				•
204. 00	Cost to be allocated (per Wkst. B,	148, 858	242, 538	208, 168	0	104, 451	204. 00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	0. 009061	0. 012883	250. 804819	0. 000000	0. 005873	205. 00
221 22	[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
I	Parts III and IV)	l l					l

		ncial Systems	GOOD SAMARITA		011 45 0040 5		u of Form CMS-2552-10
COSTA	LLOCA	TION - STATISTICAL BASIS		Provi der C		eriod: rom 01/01/2021	Worksheet B-1
					To		Date/Time Prepared:
			I NITEDNIC 0	DECLIDENTS			5/26/2022 9:38 am
			INTERNS &	RESI DENTS			
		Cost Center Description	SERVI CES-SALAR	SERVI CES-OTHER	PARAMED ED	PARAMED ED	
			Y & FRINGES	PRGM COSTS	PRGM-RADI OLOGY	PRGM-LAB	
			(ASSI GNED	(ASSI GNED		(ASSI GNED	
			TIME)	TIME)	(ASSIGNED TIME)	TIME)	
			21.00	22. 00	23. 00	23. 01	
	GENER	AL SERVICE COST CENTERS					
1.00	1	CAP REL COSTS-BLDG & FIXT					1.00
2.00	1	CAP REL COSTS-MVBLE EQUIP					2. 00
4.00		EMPLOYEE BENEFITS DEPARTMENT					4.00
4. 01 4. 02		COMMUNI CATI ONS PURCHASI NG & RECEI VI NG					4. 01 4. 02
4. 03		REGISTRATION					4. 03
4. 04	1	PATIENT ACCOUNTS					4. 04
5.00		ADMINISTRATIVE & GENERAL					5. 00
7.00		OPERATION OF PLANT					7. 00
8. 00 9. 00		LAUNDRY & LINEN SERVICE HOUSEKEEPING			•		8. 00 9. 00
10.00		DIETARY					10.00
11. 00		CAFETERI A					11. 00
13.00	01300	NURSING ADMINISTRATION					13. 00
		CENTRAL SERVICES & SUPPLY					14. 00
		PHARMACY					15.00
16. 00 17. 00		MEDICAL RECORDS & LIBRARY					16. 00 17. 00
17. 00		MENTAL HEALTH OH					17. 00
		I &R SERVICES-SALARY & FRINGES APPRVD	8, 762				21. 00
22. 00		I&R SERVICES-OTHER PRGM COSTS APPRVD		8, 762			22. 00
23. 00		PARAMED ED PRGM-RADIOLOGY			100		23. 00
23. 01		PARAMED ED PRGM-LAB				100	23. 01
30. 00		I ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	2, 745	2, 745	0	0	30.00
31. 00		INTENSIVE CARE UNIT	537	537		0	31.00
40. 00	1	SUBPROVI DER - I PF	1, 533	1, 533	1	0	40. 00
41.00	04100	SUBPROVI DER - I RF	0	0			41. 00
43.00		NURSERY	0	0	0	0	43. 00
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM	l ol	0	0	0	50.00
		RECOVERY ROOM		0			51. 00
51. 01		ENDOSCOPY	o	0	1	0	51. 01
		DELIVERY ROOM & LABOR ROOM	0	0	0	o	52. 00
53.00	1	ANESTHESI OLOGY	0	0	_	0	53. 00
	1	RADI OLOGY - DI AGNOSTI C	0	0	100	0	54.00
55. 00 60. 00		RADI OLOGY-THERAPEUTI C LABORATORY	56	56	0	0 100	55. 00 60. 00
		BLOOD STORING, PROCESSING & TRANS.		0			63.00
	1	RESPI RATORY THERAPY	156	156	1	o	65. 00
66. 00		PHYSI CAL THERAPY	0	0	_	o	66. 00
69. 00	1	ELECTROCARDI OLOGY	336	336	0	0	69. 00
70. 00 70. 01		ELECTROENCEPHALOGRAPHY NEURODI AGNOSTI CS	0	0	0	0	70. 00 70. 01
		MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	71. 00
		IMPL. DEV. CHARGED TO PATIENTS	o	0	ő	0	72. 00
		DRUGS CHARGED TO PATIENTS	0	0	0	О	73. 00
		ASC (NON-DISTINCT PART)	1, 492	1, 492		0	75. 00
76. 00		MH ANCILLARY OUTPATIENT	0	0	0	0	76.00
76. 01		INPATIENT DIALYSIS TIENT SERVICE COST CENTERS	180	180	0	0	76. 01
90. 00		CLINIC	0	0	0	0	90.00
90. 01		WOUND CLINIC	o	0	Ö		90. 01
		EMERGENCY	457	457	0	o	91. 00
92.00		OBSERVATION BEDS (NON-DISTINCT PART)					92. 00
04 00		REIMBURSABLE COST CENTERS	l	0	l o	0	04.00
		DURABLE MEDICAL EQUIP-RENTED HOME HEALTH AGENCY		0	1		96. 00 101. 00
101.00		AL PURPOSE COST CENTERS	<u> </u>		<u> </u>	<u> </u>	101.00
113.00		INTEREST EXPENSE					113. 00
	1	HOSPI CE			0	0	116. 00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7, 492	7, 492	100	100	118. 00
100 00		IMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN	l ol	0	0	0	190. 00
		PHYSICIANS' PRIVATE OFFICES	644	644	1	0	190.00
		FP PETERSBURG	0	0	0	o	192. 01
192. 02	19202	PEDI ATRI CS	0	0	0	0	192. 02
192.03	19203	WASHINGTON PRIMARY CARE	<u> </u>	0	0	0	192. 03

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0042 Peri od: Worksheet B-1 From 01/01/2021 Date/Time Prepared: 5/26/2022 9:38 am 12/31/2021 INTERNS & RESIDENTS SERVI CES-SALAR SERVI CES-OTHER PARAMED ED PARAMED ED Cost Center Description Y & FRINGES PRGM COSTS PRGM-RADI OLOGY PRGM-LAB (ASSI GNED (ASSI GNED (ASSI GNED (ASSI GNED TIME) TIME) TIME) TIME) 21.00 22.00 23.00 23. 01 192. 04 19204 FQHC 0 0 192. 04 194. 00 07950 COMMUNITY HEALTH SERVICES 0 o 194. 00 194. 01 07960 CCBHC GRANTS 0 0 0 194. 01 0 0 0 0 194. 02 07952 MARKETING AND PUBLIC RELATIONS 0 0 0 194. 02 194.03 07953 MH RESIDENTIAL 0 0 194. 03 194. 04 07954 UNUSED SPACE 0 0 194.04 0 194. 05 07955 MOB 194. 05 194. 06 07956 FOUNDATI ON 0 0 0 0 194. 06 194. 07 07957 KNOX COUNTY HEALTH DEPT 0 194. 07 Ω

0

626

2, 833, 375

323. 370806

35, 604

4.063456

626

2, 885, 420

329. 310660

40.860192

358, 017

0

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0

0.000000

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0

327, 316

2, 933

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29. 330000

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3, 273. 160000

194. 08

194. 09

200. 00

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202. 00

203. 00

204. 00

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207. 00

194. 08 07958 I NDUSTRI AL HEALTH

Part I)

Part II)

(per Wkst. B-2)

H)

200.00

201.00

202.00

203.00

204.00

205.00

206.00

207.00

194. 09 07959 COMMUNITY MENTAL HEALTH CENTER

Cross Foot Adjustments

Cost to be allocated (per Wkst. B,

Cost to be allocated (per Wkst. B,

Unit cost multiplier (Wkst. B, Part

NAHE unit cost multiplier (Wkst. D, Parts III and IV)

Unit cost multiplier (Wkst. B, Part I)

NAHE adjustment amount to be allocated

Negative Cost Centers

					rom 01/01/2021 o 12/31/2021	Part I Date/Time Pre	
			T: 41 -	V(/	11! +-1	5/26/2022 9: 3	8 am
			l little	XVIII	Hospital Costs	PPS	
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	cost center bescription	(from Wkst. B,	Adj.	Total Costs	Di sal I owance	Total Costs	
		Part I, col.	Auj .		Di Sai i Owanec		
		26)					
		1. 00	2.00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	17, 062, 041		17, 062, 041	0	17, 062, 041	30. 00
31. 00	03100 INTENSIVE CARE UNIT	9, 675, 913		9, 675, 913		9, 675, 913	31. 00
40.00	04000 SUBPROVI DER - I PF	5, 750, 209		5, 750, 209		5, 780, 805	•
41. 00	04100 SUBPROVI DER - I RF	5, 660, 795		5, 660, 795		5, 660, 795	
43. 00	04300 NURSERY	717, 725		717, 725	0	717, 725	43. 00
	ANCILLARY SERVICE COST CENTERS	7 404 007	I	7 404 007	1	7 101 007	
50.00	05000 OPERATING ROOM	7, 481, 297		7, 481, 297	0	7, 481, 297	50.00
51.00	O5100 RECOVERY ROOM O5101 ENDOSCOPY	0 700 000		2 722 226	0	0 722 220	51.00
51. 01 52. 00	05200 DELIVERY ROOM & LABOR ROOM	2, 722, 339		2, 722, 339		2, 722, 339	1
52.00	05300 ANESTHESI OLOGY	1, 951, 018		1, 951, 018		1, 951, 018 0	52. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	10, 636, 313		10, 636, 313		10, 636, 313	
55. 00	05500 RADI OLOGY-THERAPEUTI C	5, 531, 244		5, 531, 244	13, 484	5, 544, 728	1
60. 00	06000 LABORATORY	10, 460, 707		10, 460, 707	13, 404	10, 460, 707	60.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	10, 100, 707		10, 100, 707	0	0, 100, 707	63.00
65. 00	06500 RESPI RATORY THERAPY	4, 044, 678	0	4, 044, 678	o	4, 044, 678	1
66. 00	06600 PHYSI CAL THERAPY	7, 101, 763		7, 101, 763	o	7, 101, 763	66.00
69.00	06900 ELECTROCARDI OLOGY	6, 094, 745		6, 094, 745	o	6, 094, 745	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0		C	0	0	70. 00
70. 01	07001 NEURODI AGNOSTI CS	2, 017, 252		2, 017, 252	5, 315	2, 022, 567	70. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	5, 070, 928		5, 070, 928	0	5, 070, 928	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	4, 324, 238		4, 324, 238	0	4, 324, 238	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	22, 773, 820		22, 773, 820		22, 773, 820	
75. 00	07500 ASC (NON-DISTINCT PART)	4, 519, 504		4, 519, 504		4, 525, 319	1
76. 00	03950 MH ANCILLARY OUTPATIENT	0		C	0	0	76. 00
76. 01	03951 I NPATIENT DI ALYSI S	735, 057		735, 057	0	735, 057	76. 01
	OUTPATIENT SERVICE COST CENTERS		ı			007 407	
90.00	09000 CLINIC	287, 407		287, 407	0	287, 407	90.00
90. 01	04950 WOUND CLINIC	1, 721, 617		1, 721, 617	0	1, 721, 617	90. 01
91. 00 92. 00	O9100 EMERGENCY O9200 OBSERVATION BEDS (NON-DISTINCT PART)	10, 720, 300	ł .	10, 720, 300		10, 720, 300	1
92.00	OTHER REIMBURSABLE COST CENTERS	3, 868, 666		3, 868, 666		3, 868, 666	92. 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	230, 556		230, 556	O	230, 556	96. 00
	10100 HOME HEALTH AGENCY	230, 330		230, 330	٩		101.00
101.00	SPECIAL PURPOSE COST CENTERS		L				101.00
113 00	11300 I NTEREST EXPENSE						113.00
	11600 HOSPI CE	1, 248, 930		1, 248, 930		1, 248, 930	
200.00		152, 409, 062				152, 464, 272	1
201.00		3, 868, 666		3, 868, 666		3, 868, 666	1
202.00	1 1	148, 540, 396					1
		•	•	•	•		

Peri od: Worksheet C From 01/01/2021 Part I To 12/31/2021 Date/Time Prepared:

				'	12/31/2021	5/26/2022 9: 3	
			Title	XVIII	Hospi tal	PPS	
			Charges		i i		
	Cost Center Description	Inpatient	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
	·	·	·	+ col. 7)	Ratio	Inpati ent	
				·		Rati o	
		6.00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00		18, 452, 500		18, 452, 500			30. 00
31.00	03100 INTENSIVE CARE UNIT	13, 997, 030		13, 997, 030			31. 00
40.00	04000 SUBPROVI DER - I PF	9, 296, 440		9, 296, 440			40.00
41.00	04100 SUBPROVI DER - I RF	7, 970, 834		7, 970, 834	1		41.00
43.00	04300 NURSERY	1, 403, 774		1, 403, 774	1		43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	13, 507, 018	26, 011, 744	39, 518, 762	0. 189310	0. 000000	50.00
51.00	05100 RECOVERY ROOM	0	0	(0. 000000	0.000000	51.00
51. 01	05101 ENDOSCOPY	979, 209	10, 488, 290	11, 467, 499	0. 237396	0.000000	51. 01
52.00	05200 DELIVERY ROOM & LABOR ROOM	5, 871, 505	308, 823	6, 180, 328	0. 315682	0.000000	52.00
53.00	05300 ANESTHESI OLOGY	0	0	(0.000000	0.000000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	16, 022, 264	82, 653, 604	98, 675, 868	0. 107790	0.000000	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	368, 780	24, 379, 841	24, 748, 62	0. 223497	0.000000	55. 00
60.00	06000 LABORATORY	22, 216, 844	52, 789, 381	75, 006, 225	0. 139465	0.000000	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	(0. 000000	0.000000	63.00
65.00	06500 RESPI RATORY THERAPY	8, 738, 223	4, 085, 004	12, 823, 227	0. 315418	0.000000	65. 00
66.00	06600 PHYSI CAL THERAPY	15, 614, 633	10, 815, 645	26, 430, 278	0. 268698	0.000000	66. 00
69. 00	06900 ELECTROCARDI OLOGY	13, 434, 636	26, 550, 858	39, 985, 494		0.000000	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	(0.000000	0.000000	70. 00
70. 01	07001 NEURODI AGNOSTI CS	255, 242	6, 107, 581	6, 362, 823	0. 317037	0.000000	70. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 171, 479	1, 947, 719			0.000000	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	3, 046, 741	7, 739, 076	10, 785, 817	0. 400919	0.000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	19, 633, 924	55, 546, 252	75, 180, 17 <i>6</i>	0. 302923	0.000000	73. 00
75.00	07500 ASC (NON-DISTINCT PART)	65, 408	23, 843, 663	23, 909, 07	0. 189029	0.000000	75. 00
76.00	03950 MH ANCILLARY OUTPATIENT	0	0	(0. 000000	0.000000	76. 00
76. 01	03951 INPATIENT DIALYSIS	968, 719	52, 053	1, 020, 772	0. 720099	0.000000	76. 01
	OUTPATIENT SERVICE COST CENTERS						
90.00		0	89, 313	89, 313	3. 217975	0.000000	90. 00
90. 01	04950 WOUND CLINIC	56, 530	4, 190, 382	4, 246, 912	0. 405381	0.000000	90. 01
91.00	09100 EMERGENCY	10, 325, 707	41, 358, 211	51, 683, 918	0. 207420	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	5, 496, 804	9, 877, 951	15, 374, 755	0. 251625	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS						
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	407, 736	407, 736	0. 565454	0.000000	96. 00
101.00	D 10100 HOME HEALTH AGENCY	0	0	(101. 00
	SPECIAL PURPOSE COST CENTERS						
113.00	D 11300 INTEREST EXPENSE						113. 00
	0 11600 H0SPI CE	0	2, 023, 096				116. 00
200.00	,	189, 894, 244	391, 266, 223	581, 160, 467	7		200. 00
201.00	Less Observation Beds						201. 00
202.00	Total (see instructions)	189, 894, 244	391, 266, 223	581, 160, 467	7		202. 00

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

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0042
From 01/01/2021
To 12/31/2021
Date/Time Prepared:

				10 12/31/2021	5/26/2022 9: 3	
			Title XVIII	Hospi tal	PPS	70 a
	Cost Center Description	PPS Inpatient		<u> </u>		
	· ·	Rati o				
		11. 00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS					30. 00
31.00	03100 INTENSIVE CARE UNIT					31. 00
40.00	04000 SUBPROVI DER - I PF					40. 00
41.00	04100 SUBPROVI DER - I RF					41.00
43.00	04300 NURSERY					43. 00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0. 189310				50.00
51.00	05100 RECOVERY ROOM	0. 000000				51. 00
51. 01	05101 ENDOSCOPY	0. 237396				51. 01
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 315682				52. 00
53.00	05300 ANESTHESI OLOGY	0. 000000				53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 107790				54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 224042				55. 00
60.00	06000 LABORATORY	0. 139465				60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000				63.00
65.00	06500 RESPI RATORY THERAPY	0. 315418				65. 00
66.00	06600 PHYSI CAL THERAPY	0. 268698				66. 00
69. 00		0. 152424				69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000				70. 00
70. 01	07001 NEURODI AGNOSTI CS	0. 317873				70. 01
71. 00		1. 231047				71. 00
72. 00		0. 400919				72. 00
73.00		0. 302923				73. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0. 189272				75. 00
76.00	03950 MH ANCILLARY OUTPATIENT	0. 000000				76. 00
76. 01	03951 I NPATIENT DIALYSIS	0. 720099				76. 01
	OUTPATIENT SERVICE COST CENTERS					
90. 00	09000 CLI NI C	3. 217975				90. 00
90. 01		0. 405381				90. 01
91. 00		0. 207420				91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 251625				92. 00
	OTHER REIMBURSABLE COST CENTERS					
96. 00		0. 565454				96. 00
101.00	10100 HOME HEALTH AGENCY					101. 00
	SPECIAL PURPOSE COST CENTERS					
	11300 INTEREST EXPENSE					113. 00
	11600 H0SPI CE					116. 00
200.00						200. 00
201.00	· ·					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
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der C		Peri od: From 01/01/2021	Worksheet C Part I	
				To 12/31/2021	Date/Time Pre 5/26/2022 9:3	pared: 8 am
		Ti tl	e XIX	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj .		Di sal I owance		
	Part I, col.					
	26)					
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
20 00 03000 ADULTS & DEDLATRICS	17 062 041		17 042 0	11 0	17 042 041	1 20 00

					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2.00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	17, 062, 041		17, 062, 041	0	17, 062, 041	30.00
31. 00	03100 INTENSIVE CARE UNIT	9, 675, 913		9, 675, 913	0	9, 675, 913	31.00
40.00	04000 SUBPROVI DER - I PF	5, 750, 209		5, 750, 209	30, 596	5, 780, 805	40. 00
41.00	04100 SUBPROVI DER - I RF	5, 660, 795		5, 660, 795	0	5, 660, 795	41.00
43.00	04300 NURSERY	717, 725		717, 725	0	717, 725	43.00
	ANCILLARY SERVICE COST CENTERS	<u> </u>		· · · · · · · · · · · · · · · · · · ·			
50.00	05000 OPERATI NG ROOM	7, 481, 297		7, 481, 297	0	7, 481, 297	50.00
51. 00	05100 RECOVERY ROOM			0	0	0	51.00
51. 01	05101 ENDOSCOPY	2, 722, 339		2, 722, 339	0	2, 722, 339	51. 01
52. 00	05200 DELIVERY ROOM & LABOR ROOM	1, 951, 018		1, 951, 018	0	1, 951, 018	
53. 00	05300 ANESTHESI OLOGY	1,70.70.0		1, 701, 010	0	0	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	10, 636, 313		10, 636, 313	0	10, 636, 313	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	5, 531, 244		5, 531, 244	13, 484	5, 544, 728	55. 00
60. 00	06000 LABORATORY	10, 460, 707		10, 460, 707	13, 404	10, 460, 707	60.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	10, 400, 707		10, 400, 707	0	10, 400, 707	63.00
65. 00	06500 RESPIRATORY THERAPY	4, 044, 678	0	4, 044, 678	0	4, 044, 678	65. 00
66. 00	06600 PHYSI CAL THERAPY	7, 101, 763		7, 101, 763		7, 101, 763	
69. 00	06900 ELECTROCARDI OLOGY	6, 094, 745		6, 094, 745	0	6, 094, 745	
	07000 ELECTROCARDI OLOGY	0, 094, 745		0, 094, 745	0		
70.00	I I	0.047.050		0 047 050	5 045	0	70.00
70. 01	07001 NEURODI AGNOSTI CS	2, 017, 252		2, 017, 252	5, 315	2, 022, 567	70. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	5, 070, 928		5, 070, 928		5, 070, 928	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	4, 324, 238		4, 324, 238		4, 324, 238	
73. 00	07300 DRUGS CHARGED TO PATIENTS	22, 773, 820		22, 773, 820		22, 773, 820	
	07500 ASC (NON-DISTINCT PART)	4, 519, 504		4, 519, 504	5, 815	4, 525, 319	
76. 00	03950 MH ANCI LLARY OUTPATI ENT			0	0	0	76. 00
76. 01	03951 I NPATI ENT DI ALYSI S	735, 057		735, 057	0	735, 057	76. 01
	OUTPATIENT SERVICE COST CENTERS		1		_1		
90. 00	09000 CLI NI C	287, 407		287, 407	0	287, 407	90.00
90. 01	04950 WOUND CLINIC	1, 721, 617		1, 721, 617	0	1, 721, 617	90. 01
91. 00	09100 EMERGENCY	10, 720, 300		10, 720, 300	0	10, 720, 300	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	3, 868, 666		3, 868, 666		3, 868, 666	92. 00
	OTHER REIMBURSABLE COST CENTERS		1				
	09600 DURABLE MEDICAL EQUIP-RENTED	230, 556		230, 556	0	230, 556	
101.00	10100 HOME HEALTH AGENCY	C		0		0	101. 00
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE						113. 00
	11600 H0SPI CE	1, 248, 930		1, 248, 930		1, 248, 930	
200.00		152, 409, 062				152, 464, 272	
201.00		3, 868, 666		3, 868, 666		3, 868, 666	
202.00	Total (see instructions)	148, 540, 396	0	148, 540, 396	55, 210	148, 595, 606	202. 00

Peri od: Worksheet C From 01/01/2021 Part I To 12/31/2021 Date/Time Prepared:

				'	0 12/31/2021	5/26/2022 9: 3	
			Ti tl	e XIX	Hospi tal	Cost	
			Charges		·		
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
	·		·	+ col. 7)	Ratio	I npati ent	
						Ratio	
		6.00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDI ATRI CS	18, 452, 500		18, 452, 500			30. 00
31. 00	03100 I NTENSI VE CARE UNI T	13, 997, 030		13, 997, 030			31. 00
40.00	04000 SUBPROVI DER - I PF	9, 296, 440		9, 296, 440			40. 00
41. 00	04100 SUBPROVI DER - I RF	7, 970, 834		7, 970, 834			41. 00
43.00	04300 NURSERY	1, 403, 774		1, 403, 774			43. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	13, 507, 018	26, 011, 744			0. 000000	50. 00
51. 00	05100 RECOVERY ROOM	0	0	-	0.00000	0. 000000	
51. 01	05101 ENDOSCOPY	979, 209	10, 488, 290			0. 000000	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	5, 871, 505	308, 823			0. 000000	
53. 00	05300 ANESTHESI OLOGY	0	0	-	0.00000	0. 000000	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	16, 022, 264	82, 653, 604	98, 675, 868		0. 000000	
55. 00	05500 RADI OLOGY-THERAPEUTI C	368, 780	24, 379, 841	24, 748, 621		0. 000000	
60.00	06000 LABORATORY	22, 216, 844	52, 789, 381	75, 006, 225		0. 000000	60.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	-	0.00000	0. 000000	
65. 00	06500 RESPI RATORY THERAPY	8, 738, 223	4, 085, 004	12, 823, 227		0. 000000	65. 00
66. 00	06600 PHYSI CAL THERAPY	15, 614, 633	10, 815, 645			0. 000000	66. 00
69. 00	06900 ELECTROCARDI OLOGY	13, 434, 636	26, 550, 858			0. 000000	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	`	0.000000	0. 000000	
70. 01	07001 NEURODI AGNOSTI CS	255, 242	6, 107, 581	6, 362, 823		0. 000000	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 171, 479	1, 947, 719			0. 000000	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	3, 046, 741	7, 739, 076			0. 000000	
73.00	07300 DRUGS CHARGED TO PATIENTS	19, 633, 924	55, 546, 252			0. 000000	
75. 00	07500 ASC (NON-DISTINCT PART)	65, 408	23, 843, 663			0. 000000	
76. 00	03950 MH ANCI LLARY OUTPATI ENT	0	0			0. 000000	
76. 01	03951 I NPATI ENT DI ALYSI S	968, 719	52, 053	1, 020, 772	0. 720099	0. 000000	76. 01
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	89, 313	· ·		0. 000000	90.00
90. 01	04950 WOUND CLINIC	56, 530	4, 190, 382	4, 246, 912		0. 000000	90. 01
91.00	09100 EMERGENCY	10, 325, 707	41, 358, 211			0. 000000	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	5, 496, 804	9, 877, 951	15, 374, 755	0. 251625	0. 000000	92. 00
	OTHER REIMBURSABLE COST CENTERS		407 704		0.5/5/5/		
96.00	09600 DURABLE MEDI CAL EQUI P-RENTED	0	407, 736			0. 000000	
101.00	10100 HOME HEALTH AGENCY	0	0	()		101. 00
	SPECIAL PURPOSE COST CENTERS						
	11300 NTEREST EXPENSE		0.000.004	0 000 00			113. 00
	11600 HOSPI CE	100 004 011	2, 023, 096				116. 00
200.00	, ,	189, 894, 244	391, 266, 223	581, 160, 467			200.00
201.00	i i	100 004 044	201 277 222	F01 1/0 4/	,		201. 00
202.00	Total (see instructions)	189, 894, 244	391, 266, 223	581, 160, 467	1		202. 00

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

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0042
From 01/01/2021
To 12/31/2021
Date/Time Prepared:

				To 12/31/2021	Date/Time Prepa 5/26/2022 9:38	
			Title XIX	Hospi tal	Cost	
Co	ost Center Description	PPS Inpatient				
		Ratio				
LNDATLE	NT DOUTLINE CERVILOE COCT CENTERS	11.00				
	NT ROUTINE SERVICE COST CENTERS DULTS & PEDIATRICS					20.00
	NTENSIVE CARE UNIT				•	30. 00 31. 00
	JBPROVIDER - IPF					40. 00
	JBPROVIDER - IPF				•	41. 00
43. 00 04100 30 43. 00 04300 NU						43. 00
	RY SERVICE COST CENTERS				7	+3.00
	PERATING ROOM	0. 000000			F	50. 00
	ECOVERY ROOM	0. 000000				51. 00
51. 01 05101 EN		0. 000000			•	51. 01
1 1	ELIVERY ROOM & LABOR ROOM	0. 000000			•	52. 00
	NESTHESI OLOGY	0. 000000				53. 00
1 1	ADI OLOGY-DI AGNOSTI C	0. 000000				54. 00
	ADI OLOGY-THERAPEUTI C	0. 000000				55. 00
1 1	ABORATORY	0. 000000				60. 00
63. 00 06300 BL	LOOD STORING, PROCESSING & TRANS.	0. 000000			ϵ	63. 00
65. 00 06500 RE	ESPI RATORY THERAPY	0. 000000			1 6	65. 00
66. 00 06600 PH	HYSI CAL THERAPY	0. 000000			1 6	66. 00
69. 00 06900 EL	LECTROCARDI OLOGY	0. 000000			6	69. 00
70. 00 07000 EL	LECTROENCEPHALOGRAPHY	0. 000000			7	70. 00
	EURODI AGNOSTI CS	0. 000000			7	70. 01
	EDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			l l	71. 00
	MPL. DEV. CHARGED TO PATIENTS	0. 000000				72. 00
	RUGS CHARGED TO PATIENTS	0. 000000			l l	73. 00
1 1	SC (NON-DISTINCT PART)	0. 000000			•	75. 00
	H ANCILLARY OUTPATIENT	0. 000000			l l	76. 00
	NPATIENT DIALYSIS	0. 000000			7	76. 01
	ENT SERVICE COST CENTERS	0.000000				20.00
90. 00 09000 CL		0.000000				90.00
	OUND CLINIC	0.000000			·	90. 01
91. 00 09100 EM	MERGENCY BSERVATION BEDS (NON-DISTINCT PART)	0. 000000 0. 000000			•	91. 00
	EIMBURSABLE COST CENTERS	0.000000				92. 00
	JRABLE MEDICAL EQUIP-RENTED	0. 000000				96. 00
	OME HEALTH AGENCY	0.000000			•	01.00
	PURPOSE COST CENTERS					71.00
	NTEREST EXPENSE				11	13. 00
116. 00 11600 H						16. 00
	ubtotal (see instructions)					00.00
1 1	ess Observation Beds					01.00
1 1	otal (see instructions)					02.00
	•					

Health Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Li€	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITA	L COSTS			Period: From 01/01/2021 To 12/31/2021	Worksheet D Part I Date/Time Pre 5/26/2022 9:3	pared: 8 am
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col . 1 - col	•		
	26) 1, 00	2.00	2) 3, 00	4.00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4. 00	5.00	
30. 00 ADULTS & PEDIATRICS	2, 500, 030	0	2, 500, 03	0 14, 091	177. 42	30.00
31. 00 INTENSIVE CARE UNIT	910, 831	l .	910, 83			
40. 00 SUBPROVI DER - I PF	618, 440	l .			128. 81	
41. 00 SUBPROVI DER - I PF	724, 646	l .	724, 64		102.18	
43. 00 NURSERY	14, 868		14, 86		15. 78	
200.00 Total (lines 30 through 199)	4, 768, 815	l .	4, 768, 81			200.00
Cost Center Description	I npati ent	Inpatient	4, 700, 01	32, 331		200.00
cost center bescription	Program days					
	11 Ogram days	Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7.00	1			
INPATIENT ROUTINE SERVICE COST CENTERS			·			
30. 00 ADULTS & PEDI ATRI CS	5, 049	895, 794				30. 00
31.00 INTENSIVE CARE UNIT	2, 552					31. 00
40. 00 SUBPROVI DER - I PF	933	120, 180				40. 00
41. 00 SUBPROVI DER - I RF	5, 223	533, 686				41. 00
43. 00 NURSERY	0	0				43.00
200.00 Total (lines 30 through 199)	13, 757	1, 978, 141				200. 00

Health Financial Cystems	COOD CAMADIT	AN HOCDITAL		المانم	u of Form CMC	2552 10
Health Financial Systems APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	GOOD SAMARITA	Provi der C		Period: From 01/01/2021 To 12/31/2021	worksheet D Part II Date/Time Pre 5/26/2022 9:3	pared:
		Title	: XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges		t Inpatient	Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)	, and the second	ŕ	
	26)					
	1.00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	957, 880	39, 518, 762	0. 02423	6, 778, 401	164, 302	50.00
51.00 05100 RECOVERY ROOM	0	0	0.00000	0 0	0	51.00
51. 01 05101 ENDOSCOPY	467, 701	11, 467, 499	0. 04078	442, 882	18, 063	51. 01
52.00 05200 DELIVERY ROOM & LABOR ROOM	39, 223	6, 180, 328	0.00634	6 0	0	52. 00
53. 00 05300 ANESTHESI OLOGY	0	0	0.00000	0 0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	883, 828	98, 675, 868	0.00895	7, 732, 147	69, 257	54. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C	686, 122	24, 748, 621	0. 02772	298, 789	8, 284	55. 00
60. 00 06000 LABORATORY	379, 614	75, 006, 225	0.00506	9, 911, 276	50, 161	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.00000	0	0	63.00
65. 00 06500 RESPIRATORY THERAPY	233, 794	12, 823, 227	0. 01823	2, 947, 393	53, 737	65.00
66. 00 06600 PHYSI CAL THERAPY	609, 775		0. 02307	3, 082, 001	71, 105	66.00
69. 00 06900 ELECTROCARDI OLOGY	701, 676	39, 985, 494	0. 01754	8 6, 647, 669	116, 653	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0		0.00000		0	70.00
70. 01 07001 NEURODI AGNOSTI CS	285, 562	6, 362, 823	0. 04488	30, 032	1, 348	70. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	192, 070			1, 040, 758		1
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	105, 369				18, 033	1
73.00 07300 DRUGS CHARGED TO PATIENTS	337, 782					1
75. 00 07500 ASC (NON-DISTINCT PART)	132, 398					
76. 00 03950 MH ANCILLARY OUTPATIENT	0.02,070		0. 00000		0	
76. 01 03951 NPATI ENT DI ALYSI S	294, 763	1, 020, 772	l .			
OUTPATIENT SERVICE COST CENTERS		1, 5=5, 11=		,	101,011	
90. 00 09000 CLINIC	82, 759	89, 313	0. 92661	8 0	0	90.00
90. 01 04950 WOUND CLINIC	125, 945		•			
91. 00 09100 EMERGENCY	1, 029, 265		l .		l e	
92 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	566 860		•			

566, 860

15, 506

8, 127, 892

15, 374, 755

528, 016, 793

407, 736

0.036870

0.038030

2, 765, 740

55, 758, 732

92.00

0 96.00

970, 940 200. 00

101, 973

92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART)
OTHER REIMBURSABLE COST CENTERS
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED

Total (lines 50 through 199)

200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COST	TS Provider C		Period: From 01/01/2021 To 12/31/2021	Worksheet D Part III Date/Time Pre 5/26/2022 9:3	
		Title	: XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng Program Post-Stepdown Adjustments	Nursi ng Program	Allied Healt Post-Stepdow Adjustments	Allied Health Cost	All Other Medical Education Cost	
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					2.22	
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 I NTENSI VE CARE UNI T 40. 00 04000 SUBPROVI DER - I PF 41. 00 04100 SUBPROVI DER - I RF 43. 00 04300 NURSERY	0 0 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
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)	Days	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	0	0 0	5, 42 4, 80 7, 09	5 0.00 1 0.00 2 0.00 2 0.00	5, 049 2, 552 933 5, 223 0	31. 00 40. 00 41. 00 43. 00
200.00 Total (lines 30 through 199) Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00	0	32, 35	1	13, /5/	200. 00
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30.00 03000 ADULTS & PEDI ATRI CS 31.00 03100 INTENSI VE CARE UNI T 40.00 04000 SUBPROVI DER - I PF 41.00 04100 SUBPROVI DER - I RF 43.00 04300 NURSERY 200.00 Total (Lines 30 through 199)	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					30. 00 31. 00 40. 00 41. 00 43. 00 200. 00

Health Financial Systems		GOOD SAMARIT	AN HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPAT	IENT ANCILLARY SE	RVICE OTHER PAS	S Provider Co	CN: 15-0042	Peri od:	Worksheet D	
THROUGH COSTS					From 01/01/2021	Part IV	
					To 12/31/2021	Date/Time Pre	
						5/26/2022 9: 3	8 am
			Title	: XVIII	Hospi tal	PPS	
Cost Center Descripti	on	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
		Anestheti st	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adiustments		-		

			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	'	Anestheti st	Program	Program	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	1	0	0	
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	1	0	327, 316	
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	1	0	0	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	1	0	0	70. 00
70. 01	07001 NEURODI AGNOSTI CS	0	0	1	0	0	70. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1	0	0	71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	1	0	0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	0	1	0	0	73. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	1	0	0	75. 00
76. 00	03950 MH ANCILLARY OUTPATIENT	0	0	1	0	0	76. 00
76. 01	03951 I NPATIENT DIALYSIS	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			0	0	92. 00
	OTHER REIMBURSABLE COST CENTERS						
	09600 DURABLE MEDICAL EQUIP-RENTED	0	l .	1	0	0	
200.00	Total (lines 50 through 199)	0	0	1	0	327, 316	200. 00

Health Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PASS	Provider C		Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2021 To 12/31/2021	Part IV Date/Time Pre	narod:
				10 12/31/2021	5/26/2022 9: 3	8 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges		
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
	Education Cost		Cost (sum of		(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see	
					instructions)	
ANOLILIARY OFFICE OFFICE	4.00	5. 00	6. 00	7. 00	8. 00	
ANCI LLARY SERVI CE COST CENTERS	1		1	00 540 740	0.00000	
50. 00 05000 OPERATING ROOM	0	0	1	39, 518, 762	0.000000	50.00
51. 00 05100 RECOVERY ROOM	0	0	1	0	0. 000000	51.00
51. 01 05101 ENDOSCOPY	0	0	1	11, 467, 499	0.000000	51. 01
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0	1	6, 180, 328	0. 000000	52.00
53. 00 05300 ANESTHESI OLOGY	0	0	1	0	0. 000000	53.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0	0	1	98, 675, 868	0. 000000	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	1	24, 748, 621	0. 000000	55.00
60. 00 06000 LABORATORY	0	327, 316	327, 31	75, 006, 225	0. 004364	60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	1	0	0. 000000	63.00
65. 00 06500 RESPIRATORY THERAPY	0	0	1	12, 823, 227	0. 000000	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0	1	26, 430, 278	0. 000000	66. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	1	39, 985, 494	0. 000000	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	1	0	0. 000000	70.00
70. 01 07001 NEURODI AGNOSTI CS	0	0	1	6, 362, 823	0. 000000	70. 01
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1	4, 119, 198	0. 000000	71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	1	10, 785, 817	0. 000000	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	1	75, 180, 176		73. 00
75. 00 07500 ASC (NON-DISTINCT PART)	0	0	1	23, 909, 071	0. 000000	75. 00
76. 00 03950 MH ANCILLARY OUTPATIENT	0	0	1	0	0. 000000	76. 00
76. 01 03951 I NPATI ENT DI ALYSI S	0	0	1 (1, 020, 772	0. 000000	76. 01

0 0 0

0

0

0

327, 316

89, 313

407, 736

4, 246, 912 51, 683, 918 15, 374, 755

528, 016, 793

0

0

327, 316

0.000000

0.000000

0.000000

0.000000

0.000000 96.00

90.00

90. 01

91.00

92.00

200.00

OUTPATIENT SERVICE COST CENTERS
90. 00 09000 CLINIC

92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART)
OTHER REIMBURSABLE COST CENTERS
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED

Total (lines 50 through 199)

90. 01 04950 WOUND CLINIC

91.00

200.00

09100 EMERGENCY

Heal th	Financial Systems	GOOD SAMARITAN	HOSPI TAI		In lie	eu of Form CMS-2	2552-10
APPORT	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER H COSTS				Period: From 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Pre 5/26/2022 9:3	pared:
				XVIII	Hospi tal	PPS	
	Cost Center Description	Outpati ent	I npati ent	Inpati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through		Pass-Through	
		(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
		7)	10.00	x col. 10)	40.00	x col . 12)	
	ANOLULARY OFRICAS COOT OFFITTED	9. 00	10. 00	11. 00	12.00	13. 00	
	ANCILLARY SERVICE COST CENTERS		, 770 101	ı	0 004 070		
50.00	05000 OPERATI NG ROOM	0. 000000	6, 778, 401		0 9, 091, 878	i e	
51. 00	05100 RECOVERY ROOM	0. 000000	0		0 0	0	51.00
51. 01	05101 ENDOSCOPY	0. 000000	442, 882		0 3, 567, 427	0	51. 01
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 10, 694	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, 732, 147		0 28, 740, 085	•	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	298, 789		0 11, 682, 653	l	55. 00
60.00	06000 LABORATORY	0. 004364	9, 911, 276	43, 25		29, 267	60.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0	0	63. 00
65. 00	06500 RESPI RATORY THERAPY	0. 000000	2, 947, 393		0 1, 369, 945		65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 000000	3, 082, 001		0 243, 748		66. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	6, 647, 669		0 10, 875, 928	l e	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0	0	70. 00
70. 01	07001 NEURODI AGNOSTI CS	0. 000000	30, 032		0 1, 790, 585		70. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	1, 040, 758		0 909, 357		71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	1, 845, 947		0 3, 639, 126	l e	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	7, 568, 532		0 27, 393, 530	0	73. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0. 000000	5, 168		0 6, 555, 232	0	75. 00
76.00	03950 MH ANCILLARY OUTPATIENT	0. 000000	0		0	0	76. 00
76. 01	03951 I NPATIENT DIALYSIS	0. 000000	455, 722		0 29, 480	0	76. 01
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0. 000000	0		0		90. 00
90. 01	04950 WOUND CLINIC	0. 000000	9, 903		0 2, 536, 728	l e	90. 01
91.00	09100 EMERGENCY	0. 000000	4, 196, 372		0 9, 006, 504		91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	2, 765, 740		0 2, 509, 108	0	92. 00

0.000000

55, 758, 732

0 96.00 29, 267 200.00

0 126, 658, 565

0 43, 253

92. 00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)
OTHER REIMBURSABLE COST CENTERS

96. 00 O9600 DURABLE MEDICAL EQUIP-RENTED
200. 00 Total (lines 50 through 199)

Health Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider Co		Peri od: From 01/01/2021 To 12/31/2021	Worksheet D Part V Date/Time Pre 5/26/2022 9:3	pared: 8 am
		Title	XVIII	Hospi tal	PPS	
·			Charges	•	Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subj ect To		
			Ded. & Coins.			
			(see inst.)	(see inst.)		
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCI LLARY SERVI CE COST CENTERS			T		1 701 100	
50. 00 05000 OPERATING ROOM	0. 189310			0	1, 721, 183	
51. 00 05100 RECOVERY ROOM	0. 000000			0	0	51.00
51. 01 05101 ENDOSCOPY	0. 237396			0	846, 893	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 315682			0	3, 376	l
53. 00 05300 ANESTHESI OLOGY	0. 000000			0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 107790			0	3, 097, 894	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 223497	11, 682, 653		0	2, 611, 038	
60. 00 06000 LABORATORY	0. 139465			0	935, 330	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	l e		0	0	63.00
65. 00 06500 RESPI RATORY THERAPY	0. 315418			0	432, 105	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 268698			0	65, 495	•
69. 00 06900 ELECTROCARDI OLOGY	0. 152424			0	1, 657, 752	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000		l .	0	0	70.00
70. 01 07001 NEURODI AGNOSTI CS	0. 317037			0	567, 682	70. 01
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1. 231047	909, 357	•	0	1, 119, 461	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 400919		•	0 0	1, 458, 995	1
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 302923			0 27, 869	8, 298, 130	73. 00
75. 00 07500 ASC (NON-DISTINCT PART)	0. 189029		1	0	1, 239, 129	75.00
76. 00 03950 MH ANCILLARY OUTPATIENT	0. 000000		1	0	0	76.00
76. 01 03951 I NPATI ENT DI ALYSI S	0. 720099	29, 480		0 0	21, 229	76. 01
OUTPATIENT SERVICE COST CENTERS	2 217075	0	I	0	0	00 00
90. 00 09000 CLI NI C 90. 01 04950 WOUND CLI NI C	3. 217975			٦	1 020 241	90.00
• • • • • • • • • • • • • • • • • • •	0. 405381	2, 536, 728		0	1, 028, 341	90. 01
	0. 207420			0 0	1, 868, 129	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	0. 251625	2, 509, 108		0 0	631, 354	92. 00
96. 00 O9600 DURABLE MEDICAL EQUIP-RENTED	0. 565454		I	0 0	0	96. 00
200.00 Subtotal (see instructions)	0. 303434	l .		0 27, 869	27, 603, 516	
201.00 Subtotal (see Histructions) 201.00 Less PBP Clinic Lab. Services-Program		126, 658, 565		21,809	21,003,510	200.00
Only Charges						201.00
202.00 Net Charges (line 200 - line 201)		126, 658, 565		0 27, 869	27, 603, 516	202. 00

From 01/01/2021 Part V Date/Time Prepared: 5/26/2022 9:38 am 12/31/2021 Title XVIII Hospi tal PPS Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 51.00 05100 RECOVERY ROOM 0 51.00 05101 ENDOSCOPY 0 51 01 51.01 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00

0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 53. 00 | 05300 | ANESTHESI OLOGY 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 05500 RADI OLOGY-THERAPEUTI C 0 55.00 55.00 60. 00 06000 LABORATORY 0 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 63.00 63.00 06500 RESPIRATORY THERAPY 0 65 00 65 00 66.00 06600 PHYSI CAL THERAPY 0 66.00 69.00 06900 ELECTROCARDI OLOGY 0 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 0 70.00 0 07001 NEURODI AGNOSTI CS 70.01 70.01 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 73.00 8.442 07500 ASC (NON-DISTINCT PART) 75.00 0 75.00 76.00 03950 MH ANCILLARY OUTPATIENT 0 76.00 03951 INPATIENT DIALYSIS 0 76.01 76.01 0 OUTPATIENT SERVICE COST CENTERS 90 00 90 00 09000 CLI NI C 0 0 0 90.01 04950 WOUND CLINIC 0 90.01 09100 EMERGENCY 91.00 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)
OTHER REIMBURSABLE COST CENTERS 0 0 92.00 92.00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00 0 200.00 Subtotal (see instructions) 8, 442 200.00 Less PBP Clinic Lab. Services-Program 201. 00 201.00 Only Charges

0

8, 442

202.00

202.00

Net Charges (line 200 - line 201)

Heal th	Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORT	TIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der C	CN: 15-0042	Peri od:	Worksheet D	
					From 01/01/2021	Part II	
			Component	CCN: 15-S042	To 12/31/2021	Date/Time Pre 5/26/2022 9:3	pared:
			Ti +Lo	· XVIII	Subprovi der -	PPS	o alli
			11116	; AVIII	IPF	FF3	
	Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
	cost contor boson per on		(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,		(col . 1 ÷ col		column 4)	
		Part II, col.	8)	2)	onal goo	001 4	
		26)					
		1.00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	•					
50.00	05000 OPERATING ROOM	957, 880	39, 518, 762	0. 02423	39 22, 151	537	50.00
51.00	05100 RECOVERY ROOM	0	0	0.00000	00 0	0	51.00
51. 01	05101 ENDOSCOPY	467, 701	11, 467, 499	0. 04078	35 0	0	51. 01
52.00	05200 DELIVERY ROOM & LABOR ROOM	39, 223	6, 180, 328	0. 00634	16 0	0	52. 00
53.00	05300 ANESTHESI OLOGY	0	O	0.00000	00 0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	883, 828	98, 675, 868	0. 0089	55, 591	498	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	686, 122	24, 748, 621	0. 02772	24 0	0	55. 00
60.00	06000 LABORATORY	379, 614	75, 006, 225	0.0050	199, 468	1, 010	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.00000	00	0	63.00
65.00	06500 RESPI RATORY THERAPY	233, 794	12, 823, 227	0. 01823	134, 188	2, 447	65.00
66.00	06600 PHYSI CAL THERAPY	609, 775	26, 430, 278	0. 0230	71 29, 710	685	66.00
69.00	06900 ELECTROCARDI OLOGY	701, 676	39, 985, 494	0. 01754	17, 589	309	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0. 00000	00	0	70.00
70. 01	07001 NEURODI AGNOSTI CS	285, 562	6, 362, 823	0. 04488	11, 672	524	70. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	192, 070	4, 119, 198	0. 04662	28 2, 436	114	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	105, 369	10, 785, 817	0.00976	59 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	337, 782	75, 180, 176	0. 00449	188, 739	848	73. 00
75.00	07500 ASC (NON-DISTINCT PART)	132, 398	23, 909, 071	0.00553	38 0	0	75. 00
76.00	03950 MH ANCILLARY OUTPATIENT	0	0	0.00000	00	0	76.00
76. 01	03951 INPATIENT DIALYSIS	294, 763	1, 020, 772	0. 28876	55 0	0	76. 01
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	82, 759	89, 313	0. 9266	18 0	0	90. 00
90. 01	04950 WOUND CLINIC	125, 945	4, 246, 912	0. 0296	56 0	0	90. 01
91.00	09100 EMERGENCY	1, 029, 265			15 253, 344	5, 045	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	15, 374, 755	0.00000	00	0	92. 00
	OTHER REIMBURSABLE COST CENTERS						
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	15, 506			0 0		96. 00
200.00	Total (lines 50 through 199)	7, 561, 032	528, 016, 793		914, 888	12, 017	200. 00

	Financial Systems	GOOD SAMARITA			-		u of Form CMS-2	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PAS	S Provi der Co	Provider CCN: 15-0042		i od: om 01/01/2021	Worksheet D Part IV	
THROUG	H COSTS		Component	CCN: 15-S042	To	12/31/2021		
			'				5/26/2022 9: 3	8 am
			Title	XVIII	Sı	ubprovi der - I PF	PPS	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng			Allied Health	
		Anestheti st	Program	Program		Post-Stepdown		
		Cost	Post-Stepdown			Adjustments		
			Adjustments					
	ANOTHER OF THE PROPERTY OF THE	1.00	2A	2. 00		3A	3. 00	
	ANCILLARY SERVICE COST CENTERS	1 _	_	T		_1	_	
50.00	05000 OPERATI NG ROOM	0	0		0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0		0	0	0	51.00
51. 01	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	327, 316	1
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0	0	63. 00
65.00	06500 RESPIRATORY THERAPY	0	0		0	0	0	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 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0		0	0	0	71.00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0		0	U	0	72.00
75.00		0	0		0	0	0	75.00
76.00	07500 ASC (NON-DISTINCT PART) 03950 MH ANCILLARY OUTPATIENT	0			0	0	0	76.00
	03951 I NPATIENT DI ALYSI S	0	0		0	0	0	76. 00
76.01	OUTPATIENT SERVICE COST CENTERS	0			U	U	U	76.01
90. 00	09000 CLINIC		0		0	0	0	90.00
90. 00	04950 WOUND CLINIC				0	0	0	90.00
91. 00	09100 EMERGENCY				0	0	0	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		١		0	ď	0	92.00
, 2. 00	OTHER REIMBURSABLE COST CENTERS		1	·			Ü	72.00
96. 00	09600 DURABLE MEDI CAL EQUI P-RENTED	1 0	0		0	0	0	96. 00
	Total (lines 50 through 199)				O	o	-	200.00

Heal th	Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORT	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	S Provider Co		Peri od:	Worksheet D	
THROUG	H COSTS		Component (From 01/01/2021 To 12/31/2021	Part IV Date/Time Pre 5/26/2022 9:3	
			Title	XVIII	Subprovi der -	PPS	
					I PF		
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
		Education Cost		Cost (sum of		(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)		(see	
		4.00	F 00	4 00	7.00	instructions)	
	ANOLLI ADV. CEDVI OF COCT OFNITEDO	4. 00	5. 00	6. 00	7. 00	8. 00	
F0 00	ANCILLARY SERVICE COST CENTERS				00 540 740	0.00000	F0 00
50.00	05000 OPERATI NG ROOM	0	· ·		0 39, 518, 762		
51.00	05100 RECOVERY ROOM	0	0		0 0	0.000000	
51. 01	05101 ENDOSCOPY	0	0		0 11, 467, 499		
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 6, 180, 328		
53. 00	05300 ANESTHESI OLOGY	0	0		0 0	0. 000000	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 98, 675, 868		
55. 00	05500 RADI OLOGY-THERAPEUTI C	0			0 24, 748, 621	0. 000000	
60.00	06000 LABORATORY	0	327, 316	327, 31	6 75, 006, 225		
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0. 000000	
65. 00	06500 RESPI RATORY THERAPY	0	0		0 12, 823, 227	0. 000000	
66. 00	06600 PHYSI CAL THERAPY	0	0		0 26, 430, 278		
69. 00	06900 ELECTROCARDI OLOGY	0	0		0 39, 985, 494		
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0		0	0. 000000	
70. 01	07001 NEURODI AGNOSTI CS	0	0		0 6, 362, 823		
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 4, 119, 198		
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 10, 785, 817		
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 75, 180, 176		
	07500 ASC (NON-DISTINCT PART)	0	0		0 23, 909, 071	0. 000000	
76. 00	03950 MH ANCILLARY OUTPATIENT	0	0		0	0. 000000	
76. 01	03951 I NPATI ENT DI ALYSI S	0	0		0 1, 020, 772	0.000000	76. 01
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0	0		0 89, 313		
90. 01	04950 WOUND CLINIC	0	0		0 4, 246, 912		
91. 00	09100 EMERGENCY	0			0 51, 683, 918		
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 15, 374, 755	0.000000	92. 00
	OTHER REIMBURSABLE COST CENTERS		1				1
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0			0 407, 736		
200.00	Total (lines 50 through 199)	0	327, 316	327, 31	6 528, 016, 793	l	200. 00

	Financial Systems	GOOD SAMARITAN	_			u of Form CMS-2	2552-10
	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PASS	Provi der Co	CN: 15-0042	Peri od:	Worksheet D	
THROUG	SH COSTS		Component (CCN: 15-S042	From 01/01/2021 To 12/31/2021	Part IV Date/Time Pre	narod:
			Component	OCIN. 15 5042	5/26/2022 9: 3		8 am
			Title	: XVIII	Subprovi der -	PPS	
				IPF			
	Cost Center Description	Outpati ent	I npati ent	Inpati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through		Pass-Through	
		(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9. 00	10.00	11. 00	12. 00	13. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0. 000000	22, 151		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	0	51. 01
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52.00
53.00	05300 ANESTHESI OLOGY	0. 000000	0		0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	55, 591		0 3, 214	0	54. 00
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0 0	0	55. 00
60.00	06000 LABORATORY	0. 004364	199, 468	8.	70 0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0 0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0. 000000	134, 188		0 0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0. 000000	29, 710		0 0	0	66.00
69.00	06900 ELECTROCARDI OLOGY	0. 000000	17, 589		0 0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0 0	0	70. 00
70. 01	07001 NEURODI AGNOSTI CS	0. 000000	11, 672		0 0	0	70. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	2, 436		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	188, 739		0 0	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 DIALYSIS	0. 000000	0		0 0	0	76. 01
	OUTPATIENT SERVICE COST CENTERS				<u> </u>		
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	253, 344		0 3, 363	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0	l .	0 0	0	92.00
	OTHER REIMBURSABLE COST CENTERS		-				1
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0		0 0	0	96. 00
200.00	1 1		914, 888	8.	70 6, 577		200.00
				'			•

Heal th	Financial Systems	GOOD SAMARIT	AN HOSPITAL		In Lie	eu of Form CMS-	2552-10
APPORT	TONMENT OF MEDICAL, OTHER HEALTH SERVICES AND) VACCINE COST	· ·	CCN: 15-S042	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part V Date/Time Pre 5/26/2022 9:3	epared:
			Title	e XVIII	Subprovi der - I PF	PPS	
				Charges		Costs	
	Cost Center Description		PPS Reimbursed	Cost	Cost	PPS Services	
		Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subj ect To		
				Ded. & Coins.			
				(see inst.)	(see inst.)		
	T	1. 00	2.00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	0.400040					
50.00	05000 OPERATI NG ROOM	0. 189310			0	0	
51.00	05100 RECOVERY ROOM	0.000000	l .	1	0	ľ	0 00
51. 01	05101 ENDOSCOPY	0. 237396	0	1	0	0	1 0
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 315682	0		0	0	
53.00	05300 ANESTHESI OLOGY	0.000000		1	0	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 107790			0	346	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 223497	0	1	0	0	
60.00	06000 LABORATORY	0. 139465	0		0	0	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	l .	1	0	0	
65. 00	06500 RESPI RATORY THERAPY	0. 315418			0	0	00.00
66. 00	06600 PHYSI CAL THERAPY	0. 268698		1	0	0	
69. 00	06900 ELECTROCARDI OLOGY	0. 152424	0	1	0	0	1 07.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	0	1	0	0	
	07001 NEURODI AGNOSTI CS	0. 317037	0		0	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1. 231047	0	1	0	0	1 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 400919	0	1	0	0	1 , 2. 00
	07300 DRUGS CHARGED TO PATIENTS	0. 302923	0		0 434	0	
	07500 ASC (NON-DISTINCT PART)	0. 189029	l .		0	0	1
76. 00	03950 MH ANCI LLARY OUTPATI ENT	0. 000000			0	0	1 , 0, 00
76. 01	03951 I NPATI ENT DI ALYSI S	0. 720099	0	1	0 0	0	76. 01
00.00	OUTPATIENT SERVICE COST CENTERS	0.047075				_	00.00
	09000 CLINIC	3. 217975	0		0		1
	04950 WOUND CLINIC	0. 405381	0	1	0		1
91.00	09100 EMERGENCY	0. 207420		1	0		
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER RELMBURSABLE COST CENTERS	0. 251625	0	1	0 0	0	92. 00

0. 565454

6, 577

6, 577

0

434 0

434

0 96.00 1,044 200.00 201.00

1, 044 202. 00

OTHER REIMBURSABLE COST CENTERS

96.00

200. 00 201. 00

202.00

O9600 DURABLE MEDICAL EQUIP-RENTED

Subtotal (see instructions)

Less PBP Clinic Lab. Services-Program
Only Charges

Net Charges (line 200 - line 201)

Heal th Financial Systems	GOOD SAMARITA	AN HOSDITAI		In Lie	u of Form CMS-2	DEE2 10
Health Financial Systems APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND		Provi der Co	CN: 15-0042 CCN: 15-S042	Peri od:	Worksheet D Part V Date/Time Pre 5/26/2022 9:3	pared:
		Title	: XVIII	Subprovi der - I PF	PPS	
Cost Center Description	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.) 6.00	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.) 7.00				

		Cos	sts		
Cost Center	Description	Cost	Cost		
		Rei mbursed	Rei mbursed		
		Servi ces	Services Not		
		Subject To	Subject To		
		Ded. & Coins.	Ded. & Coins.		
		(see inst.)	(see inst.)		
		6. 00	7. 00		
ANCILLARY SERVICE					
50.00 05000 OPERATING R	MOOM	0	0		50. 00
51.00 05100 RECOVERY RO	OM	0	0		51.00
51. 01 05101 ENDOSCOPY		0	0		51. 01
52. 00 05200 DELI VERY RO	OM & LABOR ROOM	0	0		52.00
53. 00 05300 ANESTHESI OL	.OGY	0	0		53.00
54. 00 05400 RADI OLOGY-D	I AGNOSTI C	0	0		54.00
55. 00 05500 RADI OLOGY-T	HERAPEUTI C	0	0		55. 00
60. 00 06000 LABORATORY		0	0		60.00
63. 00 06300 BLOOD STORI	NG, PROCESSING & TRANS.	0	0		63. 00
65. 00 06500 RESPI RATORY	THERAPY	0	0		65. 00
66. 00 06600 PHYSI CAL TH	IERAPY	0	0		66. 00
69. 00 06900 ELECTROCARD	I OLOGY	0	0		69. 00
70. 00 07000 ELECTROENCE	PHALOGRAPHY	0	0		70. 00
70. 01 07001 NEURODI AGNO	STICS	0	0		70. 01
	PLIES CHARGED TO PATIENTS	0	0		71. 00
72. 00 07200 I MPL. DEV.	CHARGED TO PATIENTS	0	0		72. 00
73. 00 07300 DRUGS CHARG	ED TO PATIENTS	0	131		73. 00
75. 00 07500 ASC (NON-DI	STINCT PART)	0	0		75. 00
76.00 03950 MH ANCILLAR	*	0	0		76. 00
76. 01 03951 NPATIENT D		0	o		76. 01
OUTPATIENT SERVICE					
90. 00 09000 CLI NI C		0	0		90. 00
90. 01 04950 WOUND CLINI	C	0	0		90. 01
91. 00 09100 EMERGENCY		0	0		91. 00
92. 00 09200 OBSERVATI ON	BEDS (NON-DISTINCT PART)	0	0		92. 00
OTHER REI MBURSABL					
96. 00 09600 DURABLE MED	I CAL EQUI P-RENTED	0	0		96. 00
200.00 Subtotal (s	ee instructions)	0	131		200. 00
	inic Lab. Services-Program	0			201.00
Only Charge					
	(line 200 - line 201)	0	131		202. 00
. ,				•	•

Heal th Financial Systems GOOD SAMARITAN HOSPITAL In Lieu of Form CMS-2552-	<u>52-10</u>
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS Provider CCN: 15-0042 Period: Worksheet D From 01/01/2021 Part II	
Component CCN: 15-T042	red: am
Title XVIII Subprovider - PPS	
I RF	
Cost Center Description Capital Total Charges Ratio of Cost Inpatient Capital Costs	
Related Cost (from Wkst. C, to Charges Program (column 3 x	
(from Wkst. B, Part I, col. (col. 1 ÷ col. Charges column 4)	
Part II, col. 8) 2)	
26)	
1.00 2.00 3.00 4.00 5.00	
ANCILLARY SERVICE COST CENTERS	
	50. 00
	51. 00
	51. 01
	52. 00
	53. 00
	54. 00
	55. 00
	50. 00
	53. 00
	55.00
	66. 00
	59. 00
	70. 00
	70. 01
	71. 00
	72.00
	73.00
	75. 00
	76.00
	76. 01
OUTPATIENT SERVICE COST CENTERS	20.00
	90.00
	90. 01
	91. 00 92. 00
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 0 15, 374, 755 0. 000000 0 0 92. OTHER REIMBURSABLE COST CENTERS	12.00
	14 00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 15, 506 407, 736 0. 038030 0 0 96. 200. 00 Total (Lines 50 through 199) 7, 561, 032 528, 016, 793 11, 280, 313 257, 608 200.	96.00
200. 00 10 tal (11 lies 50 till ough 174) 1, 301, 032 320, 010, 173 11, 280, 313 237, 008 200.	JU. UU

near tn	Financial Systems	GOOD SAMARITA	AN HOSPITAL			In Lie	u of Form CMS-2	2552-10
APPORTI THROUGH	ONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER COSTS	RVICE OTHER PASS		CN: 15-0042 CCN: 15-T042	Period: From 01/01/2021 To 12/31/2021		Worksheet D Part IV Date/Time Prepared: 5/26/2022 9:38 am	
			Title	XVIII	S	Subprovider - IRF	PPS	
	Cost Center Description	Non Physician Anesthetist Cost	Nursi ng Program Post-Stepdown Adj ustments	Nursi ng Program		Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00		3A	3. 00	
	ANCILLARY SERVICE COST CENTERS							
	05000 OPERATING ROOM	0	0		0	0	0	50. 00
	D5100 RECOVERY ROOM	0	0		0	0	0	51. 00
	D5101 ENDOSCOPY	0	0		0	0	0	51. 01
	D5200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	0	52. 00
	05300 ANESTHESI OLOGY	0	0		0	0	0	53. 00
	D5400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	0	54.00
	D5500 RADI OLOGY-THERAPEUTI C	0	0		0	0	0	55. 00
	06000 LABORATORY	0	0		0	0	327, 316	60.00
	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0	0	63. 00
	06500 RESPI RATORY THERAPY	0	0		0	0	0	65. 00
	06600 PHYSI CAL THERAPY	0	0		0	0	0	66. 00
	06900 ELECTROCARDI OLOGY	0	0		0	0	0	69. 00
	07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	0	70. 00
	07001 NEURODI AGNOSTI CS	0	0		0	0	0	70. 01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	0	71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	0	0	72. 00
	D7300 DRUGS CHARGED TO PATIENTS	0	0		0	0	0	73. 00
	D7500 ASC (NON-DISTINCT PART)	0	0		0	0	0	75. 00
	03950 MH ANCI LLARY OUTPATI ENT	0	0		0	0	0	76. 00
	03951 I NPATI ENT DI ALYSI S	0	0		0	0	0	76. 01
	OUTPATIENT SERVICE COST CENTERS			ı				
	09000 CLINI C	0	0		0	0	0	90.00
	04950 WOUND CLINIC	0	0		0	0	0	90. 01
	09100 EMERGENCY		0		0	O	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		L	0		0	92. 00
	OTHER REIMBURSABLE COST CENTERS O9600 DURABLE MEDICAL EQUIP-RENTED	1 0		I		0	0	96. 00
70. UU (JYOUU DURADLE MEDICAL EQUIP-KENIED	1 0	0	I	0	0	U	J 40. UU

Heal th	Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORT	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	S Provider Co		Peri od:	Worksheet D	
THROUG	H COSTS		Component (From 01/01/2021 To 12/31/2021	Part IV Date/Time Pre 5/26/2022 9:3	
			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. C,	to Charges	
		Education Cost		Cost (sum of		(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)		(see	
					7.00	instructions)	
	ANOULL ARV CERVI OF COCT OFFITERS	4. 00	5. 00	6. 00	7. 00	8. 00	
F0 00	ANCILLARY SERVICE COST CENTERS				00 540 740	0.00000	F0 00
50.00	05000 OPERATI NG ROOM	0	· ·		0 39, 518, 762		
51.00	05100 RECOVERY ROOM	0	0		0 0	0.000000	
51. 01	05101 ENDOSCOPY	0	0		0 11, 467, 499		
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 6, 180, 328		
53.00	05300 ANESTHESI OLOGY	0	0		0 00 (75 0(0	0.000000	
54. 00	05400 RADI OLOGY - DI AGNOSTI C	0	0		0 98, 675, 868		
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 24, 748, 621	0.000000	
60.00	06000 LABORATORY	0	327, 316	327, 31	6 75, 006, 225		
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 12 022 227	0.000000	
65. 00	06500 RESPIRATORY THERAPY	0	0		0 12, 823, 227	0.000000	
66. 00	06600 PHYSI CAL THERAPY	0	0		0 26, 430, 278		
69.00	06900 ELECTROCARDI OLOGY	0	0		0 39, 985, 494		
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0.000000	
70. 01	07001 NEURODI AGNOSTI CS	0	0		0 6, 362, 823		
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 4, 119, 198		
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 10, 785, 817 0 75 180 176		
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		70, 100, 170		
	07500 ASC (NON-DISTINCT PART)	0	0		0 23, 909, 071	0.000000	
76.00	03950 MH ANCI LLARY OUTPATI ENT	0	0		0 0	0.000000	
76. 01	03951 I NPATI ENT DI ALYSI S	0	0		0 1, 020, 772	0. 000000	76. 01
00.00	OUTPATIENT SERVICE COST CENTERS				00.040	0.000000	00.00
	09000 CLINIC	0	l		0 89, 313		
90. 01	04950 WOUND CLINIC	0	0		0 4, 246, 912		
91.00	09100 EMERGENCY	0			0 51, 683, 918		
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 15, 374, 755	0.000000	92.00
0/ 00	OTHER REIMBURSABLE COST CENTERS	_	_		0 407 704	0.000000	0, 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0			0 407, 736		
200.00	Total (lines 50 through 199)	0	327, 316	327, 31	6 528, 016, 793	I	200. 00

	Financial Systems	GOOD SAMARITAN	_	011 45 0040		u of Form CMS-	2552-10
	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PASS	Provider Co	UN: 15-0042	Peri od: From 01/01/2021	Worksheet D Part IV	
THROUG	CH COSTS		Component	CCN: 15-T042	To 12/31/2021	Date/Time Pre	pared:
			Ti +Lo	: XVIII	5/26/2022 9:3 Subprovi der - PPS		8 8111
			11 11 6	XVIII	IRF	PP3	
	Cost Center Description	Outpati ent	I npati ent	Inpati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	n Charges	Pass-Through	
		(col. 6 ÷ col.	•	Costs (col.	8	Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9. 00	10. 00	11. 00	12.00	13. 00	
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATING ROOM	0. 000000	125, 469		0	0	50.00
51.00	05100 RECOVERY ROOM	0. 000000	0		0	0	51.00
51. 01	05101 ENDOSCOPY	0. 000000	15, 318		0 0	0	51. 01
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52. 00
53.00	05300 ANESTHESI OLOGY	0. 000000	0		0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	506, 805		0 2, 515	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	237		0 0	0	55. 00
60.00	06000 LABORATORY	0. 004364	909, 678	3, 97	70 943	4	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0 0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0. 000000	523, 334		0 230	0	65.00
66.00	06600 PHYSI CAL THERAPY	0. 000000	7, 362, 828		0 0	0	66. 00
69.00	06900 ELECTROCARDI OLOGY	0. 000000	117, 991		0 474	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0 0	0	70. 00
70. 01	07001 NEURODI AGNOSTI CS	0. 000000	11, 322		0 0	0	70. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	105, 830		0 0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	19, 163		0 0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	1, 170, 936		0 224	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 NPATI ENT DI ALYSI S	0. 000000	164, 508		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	246, 894		0 2, 699	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0 0	0	92. 00
	OTHER REIMBURSABLE COST CENTERS	·		•			1
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0		0 0	0	96. 00
200.00	Total (lines 50 through 199)		11, 280, 313	3, 97	7, 085	4	200. 00
		•					

	Financial Systems	GOOD SAMARITA				u of Form CMS-2	2552-10
APPORT	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provider Component (Period: From 01/01/2021 To 12/31/2021	Worksheet D Part V Date/Time Pre	pared:
			Title	: XVIII	Subprovi der -	5/26/2022 9: 3 PPS	8 am
				Cla a va a va a	IRF	C+-	
	Cost Center Description	Cost to Chargo	PPS Reimbursed	Charges Cost	Cost	Costs PPS Services	
	cost center bescription	Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C.	inst.)	Servi ces	Services Not	(366 11131.)	
		Part I, col. 9		Subject To	Subject To		
		1 41 (1, 601.)		Ded. & Coins.			
				(see inst.)	(see inst.)		
		1.00	2. 00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0. 189310	0		0 0	0	50.00
51.00	05100 RECOVERY ROOM	0. 000000	0		0	0	51.00
51. 01	05101 ENDOSCOPY	0. 237396	0		0	0	51. 01
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 315682	0		0	0	52.00
53.00	05300 ANESTHESI OLOGY	0. 000000	0		0	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 107790	2, 515		0	271	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 223497	0		0	0	55.00
60.00	06000 LABORATORY	0. 139465	943		0	132	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0		0	0	
65. 00	06500 RESPIRATORY THERAPY	0. 315418	230		0	73	
66.00	06600 PHYSI CAL THERAPY	0. 268698	0		0	0	
69. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	0. 152424	474		0 0	72	
70. 00 70. 01	07000 ELECTROENCEPHALOGRAPHY 07001 NEURODI AGNOSTI CS	0. 000000 0. 317037	0		0 0	0	70. 00 70. 01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1. 231047	0		0 0	0	71.00
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 400919			0 0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0. 302923	224		0 550	_	1
	07500 ASC (NON-DISTINCT PART)	0. 302723	0		0 0	0	1
76. 00	03950 MH ANCILLARY OUTPATIENT	0. 000000	0		0 0	0	76.00
76. 01	03951 I NPATI ENT DI ALYSI S	0. 720099			0 0	0	
. 0. 01	OUTPATIENT SERVICE COST CENTERS	3.720077			<u> </u>		1 ,0.01
90. 00	09000 CLINIC	3. 217975	0		0 0	0	90.00
	04950 WOUND CLINIC	0. 405381	Ö		0 0	Ö	
	09100 EMERGENCY	0. 207420	2, 699		0 0	560	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 251625	0		0 0	0	1
	OTHER REIMBURSABLE COST CENTERS						1
04 00	09600 DURABLE MEDICAL FOULP-RENTED	0.565454	n		0	0	1 96 00

0. 565454

7, 085

7, 085

0 96.00 1, 176 200.00 201.00

1, 176 202. 00

0 550 0

550

0

96.00

200. 00 201. 00

202.00

O9600 DURABLE MEDICAL EQUIP-RENTED

Subtotal (see instructions)

Less PBP Clinic Lab. Services-Program
Only Charges

Net Charges (line 200 - line 201)

	Financial Systems	GOOD SAMARIT				u of Form CMS-	2552-10
APPORT	TIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der	CCN: 15-0042	Peri od: From 01/01/2021	Worksheet D Part V	
			Component	CCN: 15-T042		Date/Time Pre	pared:
			T	V0/11 L		5/26/2022 9: 3	88 am
			11 11	e XVIII	Subprovi der - I RF	PPS	
		Co	sts		TIM		
	Cost Center Description	Cost	Cost				
	·	Reimbursed	Rei mbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)	_			
	AMOULLARY CERVICE COCT CENTERS	6.00	7. 00				
EO 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	1	\	0			50.00
	05100 RECOVERY ROOM		l .	0			50.00
	05100 RECOVERT ROOM						51.00
	05200 DELIVERY ROOM & LABOR ROOM						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			o			60.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	C		o			63.00
65.00	06500 RESPIRATORY THERAPY			o			65.00
66. 00	06600 PHYSI CAL THERAPY			o			66.00
69. 00	06900 ELECTROCARDI OLOGY	C		o			69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	C		0			70.00
70. 01	07001 NEURODI AGNOSTI CS	C		0			70. 01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	C)	0			71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	(C)	0			72. 00
	07300 DRUGS CHARGED TO PATIENTS	(C	16	1			73. 00
	07500 ASC (NON-DISTINCT PART)		1	0			75. 00
	03950 MH ANCILLARY OUTPATIENT	C	l l	0			76. 00
76. 01	03951 I NPATI ENT DI ALYSI S)	0			76. 01

0 0 0

0

0

0

0

0

167

167

90.00

90. 01 91. 00 92. 00

96. 00 200. 00

201. 00

202. 00

90.00

90. 01

92.00

96.00

200. 00 201. 00

202.00

OUTPATIENT SERVICE COST CENTERS

OTHER REIMBURSABLE COST CENTERS

09200 OBSERVATION BEDS (NON-DISTINCT PART)

O9600 DURABLE MEDICAL EQUIP-RENTED

Subtotal (see instructions)

Less PBP Clinic Lab. Services-Program
Only Charges

Net Charges (line 200 - line 201)

09000 CLI NI C

91. 00 09100 EMERGENCY

04950 WOUND CLINIC

Health Financial Systems	GOOD SAMARITAN HO	SPI TAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	F	Provider CCN: 15-0042	Peri od:	Worksheet D-1
			From 01/01/2021	
			To 12/31/2021	Date/Time Prepared:
				5/26/2022 9:38 am
		Title XVIII	Hospi tal	PPS

		Ti +1 o V/// /	Hospi tal	5/26/2022 9: 3 PPS	8 am
	Cost Center Description	Title XVIII	Hospi tal	PPS	
	·			1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days	s, excluding newborn)		14, 091	1.00
2.00	Inpatient days (including private room days, excluding swing-	ped and newborn days)		14, 091	2. 00
3.00	Private room days (excluding swing-bed and observation bed day	ivate room days,	0	3. 00	
4. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation be	d days)		10, 896	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room		r 31 of the cost	10, 840	5. 00
0.00	reporting period	daye, t eag becebe	. 0. 0 0001	· ·	0.00
6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December	31 of the cost	0	6. 00
7.00	reporting period (if calendar year, enter 0 on this line)		21 -6 +1+	0	7 00
7. 00	Total swing-bed NF type inpatient days (including private roor reporting period	days) through December	31 of the cost	0	7. 00
8.00	Total swing-bed NF type inpatient days (including private roor	n days) after December 3	1 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)	3 .			
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	5, 049	9. 00
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII or	alv (including private r	oom days)	0	10.00
10.00	through December 31 of the cost reporting period (see instructions)		oom days)		10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days) after	0	11. 00
40.00	December 31 of the cost reporting period (if calendar year, en				40.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	confy (including privat	e room days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI)	only (including privat	e room days)	0	13. 00
	after December 31 of the cost reporting period (if calendar ye	ear, enter O on this lin	e)		
14. 00	Medically necessary private room days applicable to the Progra	am (excluding swing-bed	days)	0	14.00
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	15. 00 16. 00
10.00	SWING BED ADJUSTMENT			0	10.00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0.00	17. 00
40.00	reporting period			0.00	10.00
18. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es after December 31 of	tne cost	0.00	18. 00
19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0.00	19. 00
	reporting period				
20. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s after December 31 of t	he cost	0.00	20. 00
21. 00	Total general inpatient routine service cost (see instructions	s)		17, 062, 041	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December	er 31 of the cost report	ing period (line	0	22. 00
00.00	5 x line 17)	04 6 11			00.00
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	3) of the cost reportin	g period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24. 00
	7 x line 19)			_	
25. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)	31 of the cost reporting	period (line 8	0	25. 00
26. 00	Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		17, 062, 041	1
	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT		,		
28. 00 29. 00	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	and observation bed ch	arges)	0	28. 00 29. 00
30.00	Semi -pri vate room charges (excluding swing-bed charges)			0	30.00
31. 00	General inpatient routine service cost/charge ratio (line 27	- line 28)		0. 000000	31.00
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	1
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	1: 00) (0.00	1
34.00	Average per diem private room charge differential (line 32 min		tions)	0. 00 0. 00	34. 00 35. 00
35. 00 36. 00	Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35)	ic 31 <i>)</i>		0.00	36.00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	17, 062, 041	
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ICTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 210. 85	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line	•		6, 113, 582	1
40.00	Medically necessary private room cost applicable to the Progra	am (line 14 x line 35)		0	40. 00
41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		6, 113, 582	41.00

Heal th	h Financial Systems GOOD SAMARITAN HOSPITAL	In Li€	eu of Form CMS-2	2552-10
COMPUT	TATION OF INPATIENT OPERATING COST Provider CCN: 15-0042 Period:	/01/2021	Worksheet D-1	
		/31/2021	Date/Time Pre	
	Title XVIII Hosp	oi tal	5/26/2022 9: 38 PPS	3 alli
		am Days	Program Cost	
	Inpatient Cost Inpatient Days Diem (col. 1 ÷ col. 2)		(col. 3 x col. 4)	
10.00		. 00	5. 00	10.00
42.00	NURSERY (title V & XIX only)	0	0	42. 00
43. 00	NTENSIVE CARE UNIT 9, 675, 913 5, 425 1, 783. 58	2, 552	4, 551, 696	43.00
44. 00 45. 00				44. 00 45. 00
46. 00				46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)			47. 00
	Cost Center Description		1. 00	
48. 00			12, 665, 097	48. 00
49. 00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions) PASS THROUGH COST ADJUSTMENTS		23, 330, 375	49. 00
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Par	ts I and	1, 324, 275	50.00
51. 00		arts II	1, 014, 193	51. 00
31.00	and IV)	11 (3 11	1,014,173	
52. 00 53. 00	, ,	and	2, 338, 468 20, 991, 907	52. 00 53. 00
55.00	medical education costs (line 49 minus line 52)	anu	20, 991, 907	33.00
F.4.00	TARGET AMOUNT AND LIMIT COMPUTATION			F.4.00
55.00	Program discharges Target amount per discharge		0.00	54. 00 55. 00
56. 00	Target amount (line 54 x line 55)		0	56. 00
57. 00 58. 00)	0	57. 00 58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounder	d by the		
60. 00	market basket Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		0.00	60. 00
61.00		unt by	0.00	61. 00
	which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the talamount (line 56), otherwise enter zero (see instructions)	rget		
62.00	Relief payment (see instructions)		0	62.00
63. 00	Allowable Inpatient cost plus incentive payment (see instructions) PROGRAM INPATIENT ROUTINE SWING BED COST		0	63. 00
64. 00		od (See	0	64. 00
4E 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period	(\$00	0	65. 00
65. 00	instructions)(title XVIII only)	(See		65.00
66. 00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only) CAH (see instructions)	. For	0	66. 00
67. 00		peri od	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting p	ori od		68. 00
00.00	(line 13 x line 20)	si i ou		00.00
69. 00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		0	69. 00
70. 00			I	70. 00
71.00				71.00
72. 00 73. 00	, ,			72. 00 73. 00
74. 00	Total Program general inpatient routine service costs (line 72 + line 73)			74. 00
75. 00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, 26, line 45)	col umn		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ line 2)			76. 00
77. 00 78. 00	, ,			77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for excess costs (from provider records)			79. 00
80. 00 81. 00		79)		80. 00 81. 00
82. 00				82. 00
83.00				83.00
84. 00 85. 00				84. 00 85. 00
86. 00	Total Program inpatient operating costs (sum of lines 83 through 85)			86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions)		3, 195	87. 00
88. 00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)		1, 210. 85	88. 00
89. 00	Observation bed cost (line 87 x line 88) (see instructions)		3, 868, 666	89.00

Health Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2021 To 12/31/2021	Date/Time Prep 5/26/2022 9:3	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital -related cost	2, 500, 030	17, 062, 041	0. 14652	6 3, 868, 666	566, 860	90.00
91.00 Nursing Program cost	0	17, 062, 041	0.00000	0 3, 868, 666	0	91.00
92.00 Allied health cost	0	17, 062, 041	0.00000	0 3, 868, 666	0	92.00
93.00 All other Medical Education	0	17, 062, 041	0. 00000	3, 868, 666	0	93. 00

Health Financial Systems	GOOD SAMARITAN HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0042	Peri od: From 01/01/2021	Worksheet D-1
	Component CCN: 15-S042	To 12/31/2021	Date/Time Prepared: 5/26/2022 9:38 am
	Title XVIII	Subprovi der -	PPS

		II the XVIII	I PF	FF3	
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days	s, excluding newborn)		4, 801	1. 00
2.00	Inpatient days (including private room days, excluding swing-			4, 801	2. 00
3. 00	Private room days (excluding swing-bed and observation bed day do not complete this line.	(s). If you have only pri	vate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		4, 801	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo		31 of the cost	0	5. 00
	reporting period				, 00
6. 00	Total swing-bed SNF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line)	om days) after becember 3	or the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private roor	n days) through December	31 of the cost	0	7. 00
	reporting period				
8. 00	Total swing-bed NF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line)	n days) after December 31	of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	933	9. 00
	newborn days) (see instructions)				
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days)	0	10. 00
11. 00	through December 31 of the cost reporting period (see instructions). Swing-bed SNF type inpatient days applicable to title XVIII or		oom davs) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, er	nter 0 on this line)			
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX	(only (including private	e room days)	0	12. 00
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX	(only (including private	room days)	0	13. 00
13.00	after December 31 of the cost reporting period (if calendar ye			O	13.00
14.00	Medically necessary private room days applicable to the Progra	am (excluding swing-bed o	lays)	0	14. 00
15. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	15.00
16. 00	SWING BED ADJUSTMENT			U	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 of	the cost	0.00	17. 00
10.00	reporting period				40.00
18. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es after December 31 of t	the cost	0.00	18. 00
19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0. 00	19. 00
	reporting period	G			
20. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s after December 31 of th	ne cost	0. 00	20. 00
21. 00	Total general inpatient routine service cost (see instructions	5)		5, 780, 805	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		ng period (line	0	22. 00
22.00	5 x line 17)	21 of the cost reporting	, nominal (line (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	U	23. 00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reportin	ng period (line	0	24. 00
05.00	7 x line 19)				05.00
25. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)	of the cost reporting	period (line 8	0	25. 00
26. 00	Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		5, 780, 805	27. 00
28. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	d and observation had cha	rges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	a and observation bed cha	ii ges)	0	
30.00	Semi -pri vate room charges (excluding swing-bed charges)			0	30. 00
31.00	General inpatient routine service cost/charge ratio (line 27	Fline 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 min	nus line 33)(see instruct	i ons)	0.00	
35. 00	Average per diem private room cost differential (line 34 x lin	, ,	·	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 a 27 minus line 36)	and private room cost dif	Terential (line	5, 780, 805	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU				
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 204. 08	
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Program			1, 123, 407 0	
	Total Program general inpatient routine service cost (line 39	,		1, 123, 407	
			·	'	

	Financial Systems	GOOD SAMARITAN	_			eu of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der CCI		Peri od: From 01/01/2021		
			Component Co		To 12/31/2021	5/26/2022 9:3	
			Title	XVIII	Subprovi der - I PF	PPS	
	Cost Center Description	Total Inpatient Costlr	Total npatient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
		1.00	2.00	3. 00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0.	00 0	0	42.00
43.00	INTENSIVE CARE UNIT	0	0	0.	00 0	0	
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44.00
46. 00	SURGI CAL INTENSI VE CARE UNIT						46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47. 00
	·					1.00	
48. 00 49. 00	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines			ie)		207, 424 1, 330, 831	
77.00	PASS THROUGH COST ADJUSTMENTS	<u> </u>		,			77.00
50. 00	Pass through costs applicable to Program inp.	atient routine se	ervices (from	Wkst. D, sur	m of Parts I and	120, 180	50.00
51. 00	Pass through costs applicable to Program inp	atient ancillary	services (fro	m Wkst. D, s	sum of Parts II	12, 887	51.00
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				133, 067	52.00
53. 00	Total Program inpatient operating cost exclu	ding capital rela	ated, non-phys	ician anestl	hetist, and	1, 197, 764	1
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					-
54. 00	Program di scharges					0	
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)					0.00	
57. 00	Difference between adjusted inpatient operat	ing cost and targ	get amount (li	ne 56 minus	line 53)	0	57. 0
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	norting period er	ndina 1006 un	udated and co	omnounded by the	0.00	
37.00	market basket	portring perrod er	idi iig 1990, up	dated and Co	Silipourided by the	0.00	39.00
60. 00 61. 00						0.00	60.00
01.00	which operating costs (line 53) are less tha	n expected costs					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	ent (see instruct	tions)			0	
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Decemb	per 31 of the	cost reporti	ina period (See	0	64.00
/E 00	instructions)(title XVIII only)					0	65. 00
65. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after beceiliber	31 Of the Co	ist reportini	g perrou (see		05.00
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line 64	1 plus line 65	(title XVI	II only). For	0	66.00
67. 00	Title V or XIX swing-bed NF inpatient routing	e costs through [December 31 of	the cost re	eporting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	e costs after Dec	cember 31 of t	he cost rep	ortina period	0	68.00
(0.00	(line 13 x line 20)		(7 1:	(0)	3 1		
69.00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69.00
70.00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c)		70.00
71. 00 72. 00	Program routine service cost (line 9 x line	, ,	ie 70 - Title 2	.)			71.00
73. 00 74. 00	Medically necessary private room cost application. Total Program general inpatient routine serv		•	ie 35)			73.00
75. 00	Capital-related cost allocated to inpatient			rksheet B, I	Part II, column		75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00 78. 00	Program capital -related costs (line 9 x line						77. 0
78. 00 79. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		ovi der records	5)			78.00
80.00	Total Program routine service costs for comp	arison to the cos			nus line 79)		80. 00 81. 00
81. 00 82. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I						82.0
83. 00	Reasonable inpatient routine service costs (see instructions)	1				83.00
84. 00 85. 00	Program inpatient ancillary services (see in Utilization review - physician compensation		s)				84. 0
86. 00	Total Program inpatient operating costs (sum	of lines 83 thro					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 ÷ l	ine 2)				88. 00
07.00	Observation bed cost (line 87 x line 88) (se	e instructions)				1 0	89.00

Health Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
		C		From 01/01/2021	D-+- /T: D	
		Component	CCN: 15-S042	To 12/31/2021	Date/Time Prep 5/26/2022 9:38	
		Title	XVIII	Subprovi der -	PPS	
				I PF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	618, 440	5, 780, 805	0. 10698	32 0	0	90. 00
91.00 Nursing Program cost	0	5, 780, 805	0.00000	0 0	0	91.00
92.00 Allied health cost	0	5, 780, 805	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	5, 780, 805	0.00000	0 0	0	93. 00

Health Financial Systems	GOOD SAMARITAN HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CC	N: 15-0042 Peri od: From 01/01/2021	Worksheet D-1
	Component C	CN: 15-T042 To 12/31/2021	Date/Time Prepared: 5/26/2022 9:38 am
	Title	XVIII Subprovider -	PPS

		II the Aviii	I RF	FF3	
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			7, 092	1. 00
2.00	Inpatient days (including private room days, excluding swing-			7, 092	
3. 00	Private room days (excluding swing-bed and observation bed day do not complete this line.	/s). If you have only pri	vate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		7, 092	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo		31 of the cost	0	5. 00
	reporting period	d) - 	11 -6 +1+		
6. 00	Total swing-bed SNF type inpatient days (including private roof reporting period (if calendar year, enter 0 on this line)	om days) after becember 3	31 of the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private roor	n days) through December	31 of the cost	0	7. 00
	reporting period				
8. 00	Total swing-bed NF type inpatient days (including private roor	n days) after December 31	I of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	5, 223	9. 00
	newborn days) (see instructions)			5, ==5	
10.00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days)	0	10. 00
11. 00	through December 31 of the cost reporting period (see instructions). Swing-bed SNF type inpatient days applicable to title XVIII or		nom days) after	o	11. 00
11.00	December 31 of the cost reporting period (if calendar year, er	nter 0 on this line)	Join days) arter	٥	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12.00
12 00	through December 31 of the cost reporting period	/ only (including private	s seem dove)	0	12 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar ye			٥	13. 00
14. 00	Medically necessary private room days applicable to the Progra		, I	0	14. 00
15. 00	Total nursery days (title V or XIX only)		-	0	15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
17. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service	es through December 31 of	the cost	0.00	17. 00
17.00	reporting period	os em ough becomber of or	1110 0031	0.00	17.00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of t	the cost	0. 00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	through Docombor 21 of	the cost	0.00	19. 00
19.00	reporting period	s through becember 31 of	the cost	0.00	19.00
20. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of th	ne cost	0. 00	20. 00
21 00	reporting period			F //O 70F	21 00
21. 00 22. 00	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through December		ng period (line	5, 660, 795 0	21. 00 22. 00
22.00	5 x line 17)	or or the cost report.	ng perred (Trie	Ĭ	22.00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	g period (line 6	0	23. 00
24. 00	x line 18) Swing-bed cost applicable to NF type services through December	21 of the cost reporting	na ported (Line	0	24. 00
24.00	7 x line 19)	31 of the cost reportin	ig perrod (Trile	٥	24.00
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
27.00	x line 20)				27.00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		0 5, 660, 795	
27.00	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT	(Trice 21 millias Trice 20)		3,000,773	27.00
	General inpatient routine service charges (excluding swing-bed	and observation bed cha	arges)		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	line 28)		0. 000000	30. 00 31. 00
32. 00	Average private room per diem charge (line 29 ÷ line 3)	1111e 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 mir	, ,	tions)	0. 00	
35. 00 36. 00	Average per diem private room cost differential (line 34 x line 35)	ne 31)		0.00	35. 00 36. 00
36.00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a	and private room cost dif	ferential (line	5, 660, 795	
27.00	27 minus line 36)			2, 555, 775	50
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	IOTHENTO.			
20 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU			700 10	38. 00
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line	•		798. 19 4, 168, 946	
40. 00	Medically necessary private room cost applicable to the Progra			0	40. 00
41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)	ļ	4, 168, 946	41. 00

	Financial Systems	GOOD SAMARITA		ON 45 0040		eu of Form CMS-	
COMPUT	ATION OF INPATIENT OPERATING COST		Provider Component (Peri od: From 01/01/2021 To 12/31/2021	Date/Time Pre	pared:
-			Title	XVIII	Subprovi der - I RF	5/26/2022 9: 3 PPS	8 alli
	Cost Center Description	Total Inpatient Cost	Total npatient Days	Average Per Diem (col. 1 col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3. 00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0.0	00 0	0	42. 00
43. 00	INTENSIVE CARE UNIT	0	0	0.0	00 0	0	43. 00
44. 00	CORONARY CARE UNIT						44. 00
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 00 46. 00
	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1 00	
48. 00	Program inpatient ancillary service cost (Wk	st D-3 col 3	line 200)			1. 00 3, 036, 310	48 00
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS			ns)		7, 205, 256	1
50.00	Pass through costs applicable to Program inp	atient routine s	services (from	Wkst. D, sum	of Parts I and	533, 686	50.00
51. 00	Pass through costs applicable to Program inpand IV)	atient ancillary	y services (fr	om Wkst. D, s	sum of Parts II	261, 578	51. 00
52. 00	Total Program excludable cost (sum of lines	50 and 51)				795, 264	52. 00
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line ! TARGET AMOUNT AND LIMIT COMPUTATION		ated, non-phy	sician anesth	netist, and	6, 409, 992	53. 00
54. 00	Program discharges					0	54.00
55. 00	Target amount per discharge					0.00	1
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operati	ing cost and tar	caet amount (1	ine 56 minus	line 53)	0 0	
58. 00	Bonus payment (see instructions)	ing cost and tai	get amount (i	The 50 minus	1111e 33)	0	
59. 00	Lesser of lines 53/54 or 55 from the cost re	0.00	59. 00				
60. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost renort und	dated by the m	arket hasket		0.00	60.00
61. 00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target						61. 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 payment	0					
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST						
	instructions)(title XVIII only)	Ü		•		0	
65. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts after Decembe	er 31 of the c	ost reporting	period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routil CAH (see instructions)	ne costs (line d	64 plus line 6	5)(title XVII	I only). For	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routing (line 12 x line 19)	e costs through	December 31 o	f the cost re	eporting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period						68. 00
69. 00							69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facil						70. 00
71. 00	Adjusted general inpatient routine service c	ost per diem (li					71. 00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applications)		(line 14 v li	ne 35)			72.00
74. 00	Total Program general inpatient routine servi		•	116 33)			74.00
75. 00	Capital -related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75. 00
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ line 2) Program capital-related costs (line 9 x line 76)						76. 00 77. 00
78. 00							78. 00
79. 00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80. 00 81. 00							80.00
82. 00							82. 00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84. 00 85. 00	Program inpatient ancillary services (see in: Utilization review - physician compensation		ns)				84. 00 85. 00
86. 00	Total Program inpatient operating costs (sum						86. 00
07.00	PART IV - COMPUTATION OF OBSERVATION BED PASS					0	07.00
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per	•	line 2)			1	87. 00 88. 00
	Observation bed cost (line 87 x line 88) (see	•	•			l e	89. 00

Health Financial Systems GOOD SAMARITAN HOSPITA				In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Period: From 01/01/2021	Worksheet D-1	
		Component (Component CCN: 15-T042		Date/Time Prepared: 5/26/2022 9:38 am	
		Title	XVIII	Subprovi der -	PPS	
				I RF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
·		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH CO	OST					
90.00 Capital -related cost	724, 646	5, 660, 795	0. 12801	1 0	0	90.00
91.00 Nursing Program cost	0	5, 660, 795	0.00000	0	0	91.00
92.00 Allied health cost	0	5, 660, 795	0.00000	0	0	92.00
93.00 All other Medical Education	0	5, 660, 795	0. 00000	0 0	0	93. 00

Health Financial Systems	GOOD SAMARITAN HOSE	PITAL	In Lieu of Form CMS-2552-10		
COMPUTATION OF INPATIENT OPERATING COST	Pro	ovider CCN: 15-0042	Peri od: From 01/01/2021	Worksheet D-1	
			To 12/31/2021	Date/Time Prepared: 5/26/2022 9:38 am	
		Title XIX	Hospi tal	Cost	

		T: +1 - VIV	11	5/26/2022 9: 3	8 am	
	Cost Center Description	Title XIX	Hospi tal	Cost		
				1. 00		
	PART I - ALL PROVIDER COMPONENTS					
1 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days	oveluding newbern)		14, 091	1.00	
1. 00 2. 00	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-l			14, 091	2.00	
3.00	Private room days (excluding swing-bed and observation bed day	14,071	3.00			
0.00	do not complete this line.	1	0.00			
4.00	Semi-private room days (excluding swing-bed and observation be	10, 896	4. 00			
5.00	Total swing-bed SNF type inpatient days (including private roo	0	5. 00			
	reporting period		, ,,,			
6. 00	Total swing-bed SNF type inpatient days (including private roof reporting period (if calendar year, enter 0 on this line)	om days) after December	31 of the cost	0	6. 00	
7.00	Total swing-bed NF type inpatient days (including private roor	n davs) through December	31 of the cost	0	7. 00	
	reporting period	3 , 3				
8.00	Total swing-bed NF type inpatient days (including private roor	n days) after December 3	1 of the cost	0	8. 00	
0.00	reporting period (if calendar year, enter 0 on this line)	the Dreamen (eveluding	owing had and	4/1	9. 00	
9. 00	Total inpatient days including private room days applicable to newborn days) (see instructions)	the Program (excluding	Swing-bed and	461	9.00	
10.00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private r	oom days)	0	10.00	
	through December 31 of the cost reporting period (see instruc					
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days) after	0	11. 00	
12. 00	December 31 of the cost reporting period (if calendar year, en Swing-bed NF type inpatient days applicable to titles V or XI)		a room days)	0	12. 00	
12.00	through December 31 of the cost reporting period	Comy (Therdaing private	e room days)	l	12.00	
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including private	e room days)	0	13. 00	
	after December 31 of the cost reporting period (if calendar ye			_		
14.00	Medically necessary private room days applicable to the Progra	am (excluding swing-bed	days)	0	14.00	
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			942	15. 00 16. 00	
10.00	SWING BED ADJUSTMENT			0	10.00	
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0.00	17. 00	
	reporting period					
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18. 00	
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0.00	19. 00	
.,. 00	reporting period	o till dagi. Dadamba. di di			17.00	
20. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of t	ne cost	0.00	20. 00	
21. 00	reporting period Total general inpatient routine service cost (see instructions	-)		17, 062, 041	21. 00	
22. 00	Swing-bed cost applicable to SNF type services through December		ng period (line		22.00	
22.00	5 x line 17)		g po ou (22.00	
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	g period (line 6	0	23. 00	
24.00	X line 18)	. 21 of the cost managet	na novind (line	0	24.00	
24. 00	Swing-bed cost applicable to NF type services through December 7 x line 19)	31 of the cost reporti	ig perrou (Trile	l	24. 00	
25. 00	Swing-bed cost applicable to NF type services after December 3	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	26. 00	
27. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(Tine 21 minus Tine 26)		17, 062, 041	27. 00	
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0	28. 00	
29. 00	Private room charges (excluding swing-bed charges)		3,	0	29. 00	
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	31. 00	
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32. 00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	aug line 22)/coo inct	tions)	0. 00 0. 00	1	
34. 00 35. 00					34. 00 35. 00	
36. 00	Private room cost differential adjustment (line 3 x line 35)			0.00	36.00	
37. 00	· · · · · · · · · · · · · · · · · · ·				37. 00	
	27 minus line 36)					
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	ICTMENTS				
20 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU		ı	1 210 05	20 00	
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line	*		1, 210. 85 558, 202	38. 00 39. 00	
40. 00	Medically necessary private room cost applicable to the Progra	•		0 330, 202	40.00	
	Total Program general inpatient routine service cost (line 39 + line 40) 558, 202 41					

CUMDIT	Financial Systems	GOOD SAMARITA	Provider C	N: 15 0042		Worksheet D	
COMPUTATION OF INPATIENT OPERATING COST			Provider Co		Period: From 01/01/2021	Worksheet D-1	
					To 12/31/2021	Date/Time Pro 5/26/2022 9:3	
		T		e XIX	Hospi tal	Cost	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Davs	Average Per Diem (col. 1	Program Days	Program Cost (col. 3 x col.	
				col . 2)		4)	
42 00	NURSERY (title V & XIX only)	1. 00 717, 725	2. 00 942	3. 00 761. 9	4. 00 2 0	5. 00	1 42.00
42.00	Intensive Care Type Inpatient Hospital Units		742	701. 7	2 0		7 42.00
43.00	INTENSIVE CARE UNIT	9, 675, 913	5, 425	1, 783. 5	8 0	(43.00
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 00 45. 00
46. 00	SURGICAL INTENSIVE CARE UNIT						46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1. 00	
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	, line 200)			569, 403	3 48.00
49. 00	Total Program inpatient costs (sum of lines	41 through 48)(see instructio	ns)		1, 127, 605	49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	atient routine	services (from	Wkst. D. sum	of Parts I and	(50.00
	[111)		•				
51. 00	Pass through costs applicable to Program inp and IV)	atient ancillar	y services (fr	om Wkst. D, s	um of Parts II	(51.00
52. 00	Total Program excludable cost (sum of lines	50 and 51)				(52.00
53. 00	Total Program inpatient operating cost exclu		lated, non-phy	sician anesth	etist, and	(53. 00
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					
54.00	Program di scharges					(54.00
	Target amount per discharge						55.00
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and ta	rget amount (L	ine 56 minus	line 53)		56.00
58. 00	Bonus payment (see instructions)	Ü			ŕ	(58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost re	mpounded by the	0.00	59.00			
60. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost report, up	dated by the m	arket basket		0. 00	60.00
61. 00	If line 53/54 is less than the lower of line	s 55, 59 or 60	enter the less	er of 50% of		(61.00
	which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						
62. 00	2.00 Relief payment (see instructions)						
63. 00	B.00 Allowable Inpatient cost plus incentive payment (see instructions) PROGRAM INPATIENT ROUTINE SWING BED COST						
64. 00	(64.00					
	instructions)(title XVIII only)						
65. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decemb	er 31 of the c	ost reporting	period (See	(65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 6	5)(title XVII	l only). For	(66. 00
<i>(</i> 7, 00	CAH (see instructions)	to through	Dogombon 21 o	f the cost wa	nanting nariad		17.00
67. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	December 31 0	i the cost re	porting period		67. 00
68. 00	00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period						68. 00
69 00	(line 13 x line 20) NO Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69.00
07.00	PART III - SKILLED NURSING FACILITY, OTHER N						3, 07, 00
70. 00 71. 00	Skilled nursing facility/other nursing facil						70.00
71.00	1 3						71. 00
73. 00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73. 00 74. 00
74. 00 75. 00							
75.00	26, line 45)	routine service	COSTS (TIOII W	OI KSHEEL B, F	art II, Corumn		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ li	. *					76. 00
77. 00 78. 00	, , , , , , , , , , , , , , , , , , ,						77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for excess costs (from provider records)						79. 00
	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81. 00 82. 00	· ·						81. 00 82. 00
83. 00	Reasonable inpatient routine service costs (see instructions)						83. 00
84.00							84. 00 85. 00
85. 00							
86. 00							86. 00
	PART IV - COMPUTATION OF OBSERVATION BED PASS						_
86. 00 87. 00 88. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions Adjusted general inpatient routine cost per)	line 2)			3, 195 1, 210. 85	

Health Financial Systems	GOOD SAMARITAN HOSPITAL			In Lieu of Form CMS-2552-10		
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Period: From 01/01/2021	Worksheet D-1	
					Date/Time Prepared: 5/26/2022 9:38 am	
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital -related cost	2, 500, 030	17, 062, 041	0. 14652	6 3, 868, 666	566, 860	90.00
91.00 Nursing Program cost	0	17, 062, 041	0.00000	0 3, 868, 666	0	91.00
92.00 Allied health cost	0	17, 062, 041	0.00000	0 3, 868, 666	0	92.00
93.00 All other Medical Education	0	17, 062, 041	0. 00000	3, 868, 666	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 01/01/2021	Worksheet D-1
	Component CCN: 15-S042	To 12/31/2021	Date/Time Prepared: 5/26/2022 9:38 am
	Title XIX	Subprovi der -	Cost

Description 1.000			II the XIX	I PF	Cost	
NAME		Cost Center Description				
INPATIENT DAYS		DADT I ALL DDOVIDED COMPONENTS			1. 00	
1.00 Inpatient days (including private room days and saving-bed days, excluding newborn)						
private room days (excluding swing-bed and observation bed days). If you have only private room days. do not complete this time. 6.00 Semi-private room days (excluding swing-bed and observation bed days) 6.00 Total swing-bed SMF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendary year, enter 0 on this line) 7.00 Total swing-bed SMF 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 MF 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 MF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 8.00 Total swing-bed MF type inpatient days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 8.00 Swing-bed SMF type inpatient days applicable to the Ite XVIII only (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 8.01 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 8.01 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) 8.02 Including private room days) 9.01 Swing-bed SMF type inpatient days applicable to services through pecember 31 of the cost reporting period (if calendar year, enter 0 on this line) 9.02 Including private room days) 9.02 Including private room days) 9.03 Including private room days) 9.04 Including private room days) 9.05 Including private room days applicable to title XVIII only (including private room days) 9.06 Including private room days applicable to title XVIII only (including private room days) 9.07 Including private room days applicable to title XVII	1.00		s, excluding newborn)		4, 801	1. 00
do not complete this line. 4. 00 Sele-private room days (sectualing saing-bed and observation bed days) through December 31 of the cost 5.00 lotal saing-bed SW type inpatient days (including private room days) after December 31 of the cost 6.00 personting period (if calendar year, enter 0 on this line) 7.00 Total saing-bed Rype inpatient days (including private room days) after December 31 of the cost 6.00 personting period (if calendar year, enter 0 on this line) 8.00 Total saing-bed Rype inpatient days (including private room days) after December 31 of the cost 6.00 personting period (if calendar year, enter 0 on this line) 9.00 Total saing-bed Rype inpatient days (including private room days) after December 31 of the cost 6.00 personting period (if calendar year, enter 0 on this line) 9.01 Total inpatient days including private room days applicable to the Program (excluding swing-bed and personally) (see instructions) 10.00 Saing-bed SW type inpatient days applicable to this exition of the program (excluding swing-bed and personally) (see instructions) 10.01 Saing-bed SW type inpatient days applicable to the Program (excluding private room days) (see instructions) 10.02 Saing-bed SW type inpatient days applicable to the SW type instructions of the cost reporting period (see instructions) 10.03 Saing-bed SW type inpatient days applicable to the SW type instructions of the cost reporting period (see instructions) 10.04 Saing-bed SW type inpatient days applicable to the SW type instructions of the cost reporting period (if calendar year, enter 0 on this line) 10.05 Saing-bed SW type instructions) 10.06 Saing-bed SW type instructions of the cost reporting period (if calendar year, enter 0 on this line) 10.07 Saing-bed SW type instructions of the cost reporting period (if calendar year, enter 0 on this line) 10.08 Saing-bed SW type instructions of the cost reporting period (if calendar year, enter 0 on this line) 10.09 Saing-bed SW type instructions of the proper instructions of the cost reporting					•	
Semi-private room days (excluding swing-bed and observation bed days) To the cost may imp-bed SNF type inpatient days (including private room days) after December 31 of the cost of control time period (if calendar year, enter 0 on this 11 ne) Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost operating period (if calendar year, enter 0 on this 11 ne) Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this 11 ne) Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this 11 ne) Total inpatient days including private room days applicable to the Program (excluding swing-bed and room days) including private room days applicable to the Program (excluding private room days) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII and y (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this 11 ne) 12.00 Swing-bed NF type inpatient days applicable to title XVIII and y (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this 11 ne) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Modically necessary private room days applicable to the Program (excluding swing-bed days) 15.00 Total nursery days (title V or XIX only) 16.00 Modically necessary private room days applicable to services through December 31 of the cost reporting period (if a rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (in a rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (in a period reporting period of the cost reporting period (in a period reporting period (in a rate for swing-bed NF services after December 31 of the cost reportin	3.00		(s). If you have only pri	vate room days,	0	3.00
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44.00 CORRINATE CARE UNIT		Financial Systems	GOOD SAMARITAN		ON 45 0040		eu of Form CMS-	
Title XIX	COMPUT	ATION OF INPATIENT OPERATING COST				From 01/01/2021	Date/Time Pre	pared:
Total Dotal Average Per Program Buys Col. 3 x col. col. col. 3 x col. col. col. col. col. col. col. col.				Titl	e XIX			o alli
1.00		Cost Center Description			Diem (col. 1	Program Days	(col. 3 x col.	
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Cost Center Description		4						46. 00
1.00								47. 00
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56.00 Target amount (IIne 54 x Tine 55) 57.00 Difference between adjusted inpatient operating cost and target amount (IIne 56 minus line 53) 57.00 Difference between adjusted inpatient operating cost and target amount (IIne 56 minus line 53) 57.00 Difference between adjusted inpatient operating period ending 1996, updated and compounded by the 0.58.00 Double on the cost reporting period ending 1996, updated and compounded by the market basket 60.00 Lesser of IInes 53/54 or 55 from prior year cost report, updated by the market basket 61.00 If I line 53/54 is less than the lower of IInes 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (IIne 53) are less than expected costs (IInes 54 x 60), or 1% of the target amount (IIne 56), otherwise enter zero (see instructions) 62.00 Relicef payment (see instructions) 63.00 Alloweble Inpatient cost plus incentive payment (see instructions) 64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (III x XVIII only). For CAM (see instructions) 65.00 Medicare swing-bed SNF inpatient routine costs (IIne 64 plus IIne 65) (III te XVIII only). For CAM (see instructions) 67.00 I Total Medicare swing-bed SNF inpatient routine costs (IIne 64 plus IIne 65) (III te XVIII only). For CAM (see instructions) 67.00 I Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (See Instructions) 68.00 IT title V or XIX swing-bed NF inpatient routine costs (IIne 67 + IIne 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (IIne 67 - IIne 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (IIne 70 - IIne 2) 69.00 Total title V or XIX swing-bed NF inpatient routine service cost (IIne 70 - IIne 2) 69.00 Total title V or XIX swing-bed NF inpatient routine service cost (IIne 70 - IIne 70) 69.00 Total Program engenal inpatient routine service costs (IIne 70 - IIne 70) 69.00 Total Program engenal inpatient routine service costs (IIne 70		Program di scharges						
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which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 0. 62.00 Relief payment (see instructions) 0. 63.00 All on Manuable Inpatient costs plus incentive payment (see instructions) PROCEAM IMPATIENT ROUTINE SWING BED COST 64.00 Action of the cost reporting period (See instructions) (Itle XVIII only) 65.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (Itle XVIII only) 66.00 Instructions) (Itle XVIII only) 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) 67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (See instructions) 67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 PART III SILLED 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 Aprised general inpatient routine service costs (fine 72 + line 73) 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 (from Worksheet B, Part II, column 26, line 45) 75.00 Captidat-related cost allocated to inpatient routine service costs (from provider records) 76.00 Per diem capital-related costs (line 75 + line 2) 77.00 Program capital-related costs (line 9 x line 76) 88.00 Apprendiction of the service cost (see instructions) 89.00 Apprendiction of the post of the cost instructions) 89.00 Apprendiction of the post of the cost instructions) 89.00 Apprendiction of the cost of the cost instruction	60.00		cost report, upd	lated by the m	arket basket		0.00	60.00
Care	61. 00							
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Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) Record Color	66. 00		ne costs (line 6	4 plus line 6	5)(title XVII	I only). For	0	66. 00
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Health Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Peri od:	Worksheet D-1	
		Component (From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 9:3	
		Ti tl	e XIX	Subprovi der - I PF	Cost	
Cost Center Description	Cost 1.00	Routine Cost (from line 21)	col umn 1 ÷ col umn 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions) 5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital-related cost	618, 440	5, 750, 209	0. 10755	1 0	0	90. 00
91.00 Nursing Program cost	0	5, 750, 209	0.00000	0	0	91. 00
92.00 Allied health cost	0	5, 750, 209	0. 00000	0	0	92.00
93.00 All other Medical Education	0	5, 750, 209	0. 00000	0 0	0	93. 00

Health Financial Systems	GOOD SAMARITAN HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0042	Peri od: From 01/01/2021	Worksheet D-1
	Component CCN: 15-T042	To 12/31/2021	Date/Time Prepared: 5/26/2022 9:38 am
	Title XIX	Subprovider -	Cost

		litie XIX	I RF	Cost	
	Cost Center Description				
	DADT I ALL DROWLDED COMPONENTS			1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days	s, excluding newborn)		7, 092	1. 00
2.00	Inpatient days (including private room days, excluding swing-			7, 092	2. 00
3.00	Private room days (excluding swing-bed and observation bed day	ys). If you have only pr	ivate room days,	0	3. 00
4. 00	do not complete this line.	ad days)		7, 092	4. 00
5.00	Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private roo		or 31 of the cost	7, 092	5. 00
0.00	reporting period	siii days) tiii dagii badaiiis	01 01 1110 0001	١	0.00
6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December	31 of the cost	0	6. 00
7.00	reporting period (if calendar year, enter 0 on this line)		04 6 11		7.00
7. 00	Total swing-bed NF type inpatient days (including private roor reporting period	n days) through December	31 of the cost	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private roor	n davs) after December 3	1 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)	<i>3</i> ,			
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	53	9. 00
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII or	alv (i neludi na privato r	coom days)	0	10. 00
10.00	through December 31 of the cost reporting period (see instructions)	tions)	ooiii days)	o	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private r	oom days) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, er			_	
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	Confy (including privat	e room days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI)	onlv (includina privat	e room davs)	0	13. 00
	after December 31 of the cost reporting period (if calendar ye	ear, enter O on this lin	ie)		
14. 00	Medically necessary private room days applicable to the Progra	am (excluding swing-bed	days)	0	
15.00	Total nursery days (title V or XIX only)			942	15.00
16. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			U	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 c	of the cost	0.00	17. 00
	reporting period				
18. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es after December 31 of	the cost	0.00	18. 00
19. 00	Medicald rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0.00	19. 00
	reporting period	<u> </u>			
20. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s after December 31 of t	he cost	0. 00	20. 00
21. 00	Total general inpatient routine service cost (see instructions	5)		5, 660, 795	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		ing period (line	0	
	5 x line 17)			ا	
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reportin	ig period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24. 00
	7 x line 19)	·			
25. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)	31 of the cost reporting	period (line 8	0	25. 00
26. 00	Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		5, 660, 795	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		· · · · · · · · · · · · · · · · · · ·		
	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	arges)	0	28. 00
29. 00 30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29. 00 30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27	: line 28)		0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)	•		0.00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00	33.00
34.00	Average per diem private room charge differential (line 32 min	nus line 33)(see instruc	tions)	0.00	34.00
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 di	fferential (line	5, 660, 795	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	JSTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			798. 19	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line			42, 304	
40.00	Medically necessary private room cost applicable to the Program			42.204	
41. 00	Total Program general inpatient routine service cost (line 39	+ 1111e 40)	l	42, 304	41.00

	Financial Systems	GOOD SAMARITA		OU 45 0040		eu of Form CMS-	
COMPUT	ATION OF INPATIENT OPERATING COST				Peri od: From 01/01/2021	Worksheet D-1	
					To 12/31/2021	5/26/2022 9:3	
			liti	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 (+; +1 - V 0 VIV and a)	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	0	42. 00
43.00	INTENSIVE CARE UNIT	0	C	0.0	0 0	0	
44. 00 45. 00	CORONARY CARE UNIT						44. 00 45. 00
46. 00	SURGICAL INTENSIVE CARE UNIT						46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1.00	
48. 00	Program inpatient ancillary service cost (Wks	st. D-3, col. 3	, line 200)			19, 163	48. 00
49. 00	Total Program inpatient costs (sum of lines a PASS THROUGH COST ADJUSTMENTS	<u> </u>		,		61, 467	
50. 00	Pass through costs applicable to Program inpa	atient routine	services (from	n Wkst. D, sum	of Parts I and	0	50.00
51. 00	Pass through costs applicable to Program inpa and IV)	atient ancillar	y services (fr	om Wkst. D, s	um of Parts II	0	51.00
52. 00 53. 00	Total Program excludable cost (sum of lines! Total Program inpatient operating cost exclu	,	lated non nh	veician anocth	atist and	0	
55.00	medical education costs (line 49 minus line !		rrated, non-pny	/SI CI all allestii	etist, and	U	33.00
E4 00	TARGET AMOUNT AND LIMIT COMPUTATION					0	- F4 00
54. 00 55. 00	Program discharges Target amount per discharge					0.00	
56.00	Target amount (line 54 x line 55)					0	56. 00
57. 00 58. 00	Difference between adjusted inpatient operati Bonus payment (see instructions)	ing cost and ta	rget amount (I	ine 56 minus	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, u	updated and co	mpounded by the	0.00	
	market basket						
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year of lines 53/54 is less than the lower of lines				the amount by	0.00	1
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target							01.00
62. 00	amount (line 56), otherwise enter zero (see i Relief payment (see instructions)	instructions)				0	62. 00
63. 00	Allowable Inpatient cost plus incentive payme	ent (see instru	ctions)			0	1
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	to through Doos	mbox 21 of the	anat manamti	na norted (Coo	0	64. 00
04.00	instructions) (title XVIII only)	ts through bece	illiber 31 of the	e cost reporti	ng perrou (see		04.00
65. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts after Decemb	er 31 of the d	cost reporting	period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 6	55)(title XVII	l only). For	0	66. 00
67. 00	9 '	e costs through	December 31 o	of the cost re	porting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine	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	e 68)		0	69. 00
	PART III - SKILLED NURSING FACILITY, OTHER NU	JRSING FACILITY	, AND ICF/IID	ONLY			
70. 00 71. 00	Skilled nursing facility/other nursing facili Adjusted general inpatient routine service co						70.00
72. 00	Program routine service cost (line 9 x line			-/			72.00
73.00	Medically necessary private room cost applica		•				73.00
74. 00 75. 00	Total Program general inpatient routine servi Capital-related cost allocated to inpatient (26, line 45)	•			art II, column		74. 00 75. 00
76. 00	Per diem capital-related costs (line 75 ÷ li						76. 00
77. 00	Program capital -related costs (line 9 x line						77. 00
78. 00 79. 00	Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess		rovi der record	ds)			78. 00 79. 00
80. 00	Total Program routine service costs for compa	arison to the c			us line 79)		80. 00
81. 00 82. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (li		,				81. 00 82. 00
82.00	Reasonable inpatient routine service cost it militation (if		* .				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
50.00	PART IV - COMPUTATION OF OBSERVATION BED PASS						33.00
87.00	Total observation bed days (see instructions)					0 00	
88. 00 89. 00	Adjusted general inpatient routine cost per of Observation bed cost (line 87 x line 88) (see					0.00	88. 00 89. 00
- *						'	

Health Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Peri od:	Worksheet D-1	
		Component (From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 9:3	
		Ti tl	e XIX	Subprovi der -	Cost	
				I RF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1. 00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital -related cost	724, 646	5, 660, 795	0. 12801	1 0	0	90.00
91.00 Nursing Program cost	0	5, 660, 795	0.00000	0 0	0	91.00
92.00 Allied health cost	0	5, 660, 795	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	5, 660, 795	0.00000	0 0	0	93. 00

Health Financial Systems GOOD SAMARITA				eu of Form CMS-2	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C		Peri od:	Worksheet D-3	
			From 01/01/2021 To 12/31/2021	Date/Time Pre	narad:
			To 12/31/2021	5/26/2022 9:3	
	Ti tl e	e XVIII	Hospi tal	PPS	O dili
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
		3	Charges	(col. 1 x col.	
				2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			8, 703, 642		30. 00
31. 00 03100 INTENSIVE CARE UNIT			6, 543, 585		31.00
40. 00 04000 SUBPROVI DER - 1 PF			0		40. 00
41. 00 04100 SUBPROVI DER - I RF			0		41.00
43. 00 04300 NURSERY					43.00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATING ROOM		0. 18931	0 6, 778, 401	1, 283, 219	50.00
51. 00 05100 RECOVERY ROOM		0.00000	00	0	51.00
51. 01 05101 ENDOSCOPY		0. 23739	96 442, 882	105, 138	51. 01
52. OO 05200 DELIVERY ROOM & LABOR ROOM		0. 31568	32 0	0	52. 00
53. 00 05300 ANESTHESI OLOGY		0.00000	00	0	53. 00
54. OO 05400 RADI OLOGY-DI AGNOSTI C		0. 10779	7, 732, 147	833, 448	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 22404	298, 789	66, 941	55. 00
60. 00 06000 LABORATORY		0. 13946	9, 911, 276	1, 382, 276	60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0.00000	00	0	63.00
65. 00 06500 RESPIRATORY THERAPY		0. 31541	2, 947, 393	929, 661	65. 00
66. 00 06600 PHYSI CAL THERAPY		0. 26869	3, 082, 001	828, 128	66. 00
69. 00 06900 ELECTROCARDI OLOGY		0. 15242	6, 647, 669	1, 013, 264	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0.00000	00	0	70. 00
70. 01 07001 NEURODI AGNOSTI CS		0. 31787	30, 032	9, 546	70. 01
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		1. 23104	1, 040, 758	1, 281, 222	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 40091	9 1, 845, 947	740, 075	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 30292	7, 568, 532	2, 292, 682	73.00
75. OO 07500 ASC (NON-DISTINCT PART)		0. 18927	72 5, 168	978	75. 00
76. 00 03950 MH ANCILLARY OUTPATIENT		0.00000	00	0	76. 00
76. 01 03951 INPATIENT DIALYSIS		0. 72009	99 455, 722	328, 165	76. 01
OUTPATIENT SERVICE COST CENTERS]
90. 00 09000 CLI NI C		3. 21797		_	
OO OI OAOFO WOUND OLINIC		0 40506	0.000	4 014	00 01

0.405381

0. 207420

0. 251625

0. 565454

9, 903

4, 196, 372 2, 765, 740

55, 758, 732 0

55, 758, 732

90. 01

91.00

92. 00

96.00

202. 00

4,014

12, 665, 097 200. 00 201. 00

870, 411 695, 929

90. 01

91.00

92.00

200. 00 201. 00

202.00

04950 WOUND CLINIC

96. 00 09600 DURABLE MEDICAL EQUIP-RENTED

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

Net charges (line 200 minus line 201)

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

09100 EMERGENCY

	Financial Systems GOOD SAMARITAN H ENT ANCILLARY SERVICE COST APPORTIONMENT		CN: 15-0042	Peri od:	u of Form CMS-2 Worksheet D-3	
			CCN: 15-S042	From 01/01/2021 To 12/31/2021	Date/Time Pre	
		·			5/26/2022 9:3	
		Titl∈	e XVIII	Subprovi der - I PF	PPS	
	Cost Center Description		Ratio of Cos	•	Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col. 2)	
			1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	0.00	
30.00	03000 ADULTS & PEDIATRICS					30.00
31.00	03100 INTENSIVE CARE UNIT					31.00
40.00	04000 SUBPROVI DER - I PF			1, 597, 235		40.00
41.00	04100 SUBPROVI DER - I RF					41.00
43.00	04300 NURSERY					43.00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATI NG ROOM		0. 18931		4, 193	1
51.00	05100 RECOVERY ROOM		0.00000		0	
51. 01	05101 ENDOSCOPY		0. 23739		0	
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY		0. 31568 0. 00000		0	
54. 00	05400 RADI OLOGY-DI AGNOSTI C		0. 10779		5, 992	
55. 00	05500 RADI OLOGY-THERAPEUTI C		0. 10779		0, 772	1
60.00	06000 LABORATORY		0. 13946		27, 819	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.		0.00000		2,,01,	1
65. 00	06500 RESPI RATORY THERAPY		0. 31541		42, 325	
66.00	06600 PHYSI CAL THERAPY		0. 26869		7, 983	
69.00	06900 ELECTROCARDI OLOGY		0. 15242		2, 681	1
70.00	07000 ELECTROENCEPHALOGRAPHY		0.00000	00	0	70.00
70. 01	07001 NEURODI AGNOSTI CS		0. 31787	73 11, 672	3, 710	70. 01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		1. 23104		2, 999	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 40091		0	
73. 00	07300 DRUGS CHARGED TO PATIENTS		0. 30292		57, 173	
75. 00	07500 ASC (NON-DISTINCT PART)		0. 18927		0	
76. 00	03950 MH ANCI LLARY OUTPATI ENT		0.00000		0	
76. 01	03951 INPATIENT DIALYSIS OUTPATIENT SERVICE COST CENTERS		0. 72009	99 0	0	76. 01
90. 00	09000 CLINIC		3. 21797	75 0	0	90.00
90.00	04950 WOUND CLINIC		0. 40538		0	
91. 00	09100 EMERGENCY		0. 40330		52, 549	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 25162	·	0 32, 347	
. 2. 00	OTHER REIMBURSABLE COST CENTERS		3. 23102			1 .2. 50
96. 00	09600 DURABLE MEDI CAL EQUI P-RENTED		0. 56545	54 0	0	96. 00
200.00				914, 888		
201.00		(line 61)		0		201.00
202.00				914, 888		202. 00

NPATIENT ANCI	LLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0042	Peri od:	Worksheet D-3	3
		Component	CCN: 15-T042	From 01/01/20 To 12/31/20		epare
		·		Cubanavi dan	5/26/2022 9: 3	3 <mark>8 am</mark>
		II ti e	e XVIII	Subprovi der I RF		
Сс	ost Center Description		Ratio of Cos	•	I npati ent	
			To Charges	Program Charges	Program Costs (col. 1 x col.	
			1.00	2. 00	2)	
	NT ROUTINE SERVICE COST CENTERS					
	DULTS & PEDI ATRI CS					30.
	NTENSI VE CARE UNI T					31.
	JBPROVI DER - I PF			F 000 4		40.
	JBPROVI DER - I RF			5, 833, 1	11	41.
	RY SERVICE COST CENTERS					43.
	PERATING ROOM		0. 1893	10 125, 4	69 23, 753	50.
	ECOVERY ROOM		0.0000		0 23, 733	1
1. 01 05101 EN			0. 2373		-1	
	ELIVERY ROOM & LABOR ROOM		0. 2373		0 3,030	
	NESTHESI OLOGY		0.0000			
	ADI OLOGY-DI AGNOSTI C		0. 1077		-1	
	ADI OLOGY-THERAPEUTI C		0. 2240		37 53	
	ABORATORY		0. 1394			
	LOOD STORING, PROCESSING & TRANS.		0.0000		0 0	
	ESPI RATORY THERAPY		0. 3154	18 523, 3	34 165, 069	65.
6. 00 06600 PH	HYSI CAL THERAPY		0. 2686	98 7, 362, 8	28 1, 978, 377	66
9. 00 06900 EL	LECTROCARDI OLOGY		0. 1524	24 117, 9	91 17, 985	69
0. 00 07000 EL	LECTROENCEPHALOGRAPHY		0.0000	00	0	70.
0. 01 07001 NE	EURODI AGNOSTI CS		0. 3178	73 11, 3	22 3, 599	70.
1.00 07100 ME	EDICAL SUPPLIES CHARGED TO PATIENTS		1. 2310	47 105, 8	30 130, 282	71.
2.00 07200 IN	MPL. DEV. CHARGED TO PATIENTS		0. 4009	19 19, 1	63 7, 683	72.
3.00 07300 DF	RUGS CHARGED TO PATIENTS		0. 3029	23 1, 170, 9	36 354, 703	73.
	SC (NON-DISTINCT PART)		0. 1892	72	0 0	75.
	H ANCILLARY OUTPATIENT		0.0000		0 0	1
	NPATIENT DIALYSIS		0. 7200	99 164, 5	08 118, 462	76.
0. 00 09000 CL	ENT SERVICE COST CENTERS		3. 2179	7.5	0 0	90.
	DUND CLINIC		0. 4053		0 0	
1. 00 09100 EN			0. 4053		٩	
	MERGENCY BSERVATION BEDS (NON-DISTINCT PART)		0. 2074		0 51, 211	
	EIMBURSABLE COST CENTERS		0. 2310	20	<u> </u>	72
	JRABLE MEDICAL EQUIP-RENTED		0. 5654	5.4	0 0	96
	otal (sum of lines 50 through 94 and 96 through 98)		0. 3034	11, 280, 3	-1	
	ess PBP Clinic Laboratory Services-Program only charge:	s (line 61)		11, 200, 3	0	201
. U 1 . UU Lt	533 FBF OFFITE LABORATORY SERVICES-FLOGRAM ONLY CHAINES	- (1111C 01)	1	1	ΥI	1201

Health Financial Systems	GOOD SAMARITAN	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provi der CO		Peri od: From 01/01/2021	Worksheet D-3	
				To 12/31/2021	Date/Time Pre 5/26/2022 9:3	pared: 8 am
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description			Ratio of Cos		Inpati ent	
			To Charges		Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS				331, 734		30. 00
31.00 03100 INTENSIVE CARE UNIT				256, 191		31. 00

	Cost Center Description	Ratio of Cost To Charges	Inpatient Program	Inpatient Program Costs	
			Charges	(col. 1 x col.	
		1.00	2. 00	2) 3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	0.00	
30.00	03000 ADULTS & PEDI ATRI CS		331, 734		30.00
31.00	03100 I NTENSI VE CARE UNI T		256, 191		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		106, 593		43.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0. 189310	241, 890	45, 792	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	51.00
51. 01	05101 ENDOSCOPY	0. 237396	16, 082	3, 818	51. 01
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 315682	395, 922	124, 985	52.00
53.00	05300 ANESTHESI OLOGY	0.000000	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 107790	273, 908	29, 525	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 223497	2, 156	482	55.00
60.00	06000 LABORATORY	0. 139465	485, 761	67, 747	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0. 315418	179, 251	56, 539	65.00
66.00	06600 PHYSI CAL THERAPY	0. 268698	108, 953	29, 275	66. 00
69.00	06900 ELECTROCARDI OLOGY	0. 152424	164, 078	25, 009	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70. 00
70. 01	07001 NEURODI AGNOSTI CS	0. 317037	4, 211	1, 335	70. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1. 231047	0	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 400919	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 302923	396, 593	120, 137	73. 00
75.00	07500 ASC (NON-DISTINCT PART)	0. 189029	0	0	75. 00
76.00	03950 MH ANCI LLARY OUTPATI ENT	0.000000	0	0	76. 00
76. 01	03951 I NPATIENT DI ALYSI S	0. 720099	7, 341	5, 286	76. 01
	OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLI NI C	3. 217975	0	0	90.00
90. 01	04950 WOUND CLINIC	0. 405381	293	119	90. 01
91.00	09100 EMERGENCY	0. 207420	283, 964	58, 900	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 251625	1, 805	454	92.00
	OTHER REIMBURSABLE COST CENTERS				
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0. 565454	0	0	96. 00
200.00			2, 562, 208		
201.00			0		201. 00
202.00	Net charges (line 200 minus line 201)		2, 562, 208		202. 00

	Financial Systems GOOD SAMARITAN	_	CN. 1E 0042	Doni		eu of Form CMS-2	
INPAII	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0042	Peri o	01/01/2021	Worksheet D-3	
		Component	CCN: 15-S042	То	12/31/2021	Date/Time Prep 5/26/2022 9:38	
		Titl	e XIX	Subj	provider - IPF	Cost	
	Cost Center Description		Ratio of Cos		npati ent	Inpati ent	
			To Charges		Program	Program Costs	
					Charges	(col. 1 x col.	
			1.00		2. 00	2) 3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS		1.00		2.00	3.00	
30. 00	03000 ADULTS & PEDIATRICS						30.00
31.00	03100 INTENSIVE CARE UNIT						31.00
	04000 SUBPROVI DER - I PF				678, 853		40.00
41.00	04100 SUBPROVI DER - I RF				070,000		41.00
	04300 NURSERY						43.00
	ANCI LLARY SERVI CE COST CENTERS		1				1
50.00	05000 OPERATING ROOM		0. 1893	10	0	0	50.00
51.00	05100 RECOVERY ROOM		0.0000		0	0	51.00
51. 01	05101 ENDOSCOPY		0. 2373	96	0	0	51. 01
52.00	05200 DELIVERY ROOM & LABOR ROOM		0. 3156	82	0	0	52.00
53.00	05300 ANESTHESI OLOGY		0.0000	00	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 1077	90	19, 923	2, 148	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C		0. 2234		0	0	
60.00	06000 LABORATORY		0. 1394		44, 861	6, 257	
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.		0.0000		0	0	
	06500 RESPI RATORY THERAPY		0. 3154		12, 552		
66.00	06600 PHYSI CAL THERAPY		0. 2686		10, 987	2, 952	
	06900 ELECTROCARDI OLOGY		0. 1524		3, 313		
	07000 ELECTROENCEPHALOGRAPHY		0.0000		070	0	
	07001 NEURODI AGNOSTI CS 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS		0. 3170 1. 2310		970 2, 299		70. 01
	07200 I MPL. DEV. CHARGED TO PATIENTS		0. 4009		2, 299	2, 630	1
	07300 DRUGS CHARGED TO PATTENTS		0. 3029		50, 602	15, 329	
	07500 ASC (NON-DISTINCT PART)		0. 1890		0,002	15, 327	1
	03950 MH ANCILLARY OUTPATIENT		0.0000		0		
	03951 I NPATI ENT DI ALYSI S		0. 7200		890		
, 0, 0,	OUTPATIENT SERVICE COST CENTERS		0.7200		0,0		70.0.
90.00	09000 CLI NI C		3. 2179	75	0	0	90.00
90. 01	04950 WOUND CLINIC		0. 4053	81	0	0	90. 01
91.00	09100 EMERGENCY		0. 2074	20	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 2516	25	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
96.00	09600 DURABLE MEDICAL EQUIP-RENTED		0. 5654	54	0	_	
200.00					146, 397	34, 929	
201.00	, ,	es (line 61)			0		201. 00 202. 00
202.00	Net charges (line 200 minus line 201)				146, 397		

	Financial Systems GOOD SAMARITAN		CN. 1E 0040	Dor: - '		eu of Form CMS-2	
INPAII	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0042	Period	: 1/01/2021	Worksheet D-3	
		Component	CCN: 15-T042		2/31/2021	Date/Time Prep 5/26/2022 9:33	
		Titl	e XIX		ovider - IRF	Cost	
	Cost Center Description		Ratio of Cos		oati ent	Inpati ent	
			To Charges		rogram	Program Costs	
				CI	narges	(col. 1 x col.	
			1.00		2. 00	2) 3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS		1.00		2.00	3.00	
	03000 ADULTS & PEDI ATRI CS						30.00
	03100 I NTENSI VE CARE UNI T						31.00
	04000 SUBPROVI DER - I PF						40.00
	04100 SUBPROVIDER - IRF				56, 391		41.00
	04300 NURSERY				,		43.00
	ANCILLARY SERVICE COST CENTERS		•				
50.00	05000 OPERATING ROOM		0. 1893	10	175	33	50.00
51.00	05100 RECOVERY ROOM		0.0000	00	0	0	51.00
51. 01	05101 ENDOSCOPY		0. 2373	96	452	107	51. 01
52.00	O5200 DELIVERY ROOM & LABOR ROOM		0. 3156	82	0	0	52.00
53.00	05300 ANESTHESI OLOGY		0.0000	00	0	0	53.00
	05400 RADI OLOGY-DI AGNOSTI C		0. 1077		4, 408		
	05500 RADI OLOGY-THERAPEUTI C		0. 2234		0	0	
	06000 LABORATORY		0. 1394		6, 506		
	06300 BLOOD STORING, PROCESSING & TRANS.		0.0000		0	0	
	06500 RESPI RATORY THERAPY		0. 3154		2, 000		
	06600 PHYSI CAL THERAPY		0. 2686		46, 295		
	06900 ELECTROCARDI OLOGY		0. 1524		840		
	07000 ELECTROENCEPHALOGRAPHY 07001 NEURODI AGNOSTI CS		0.0000		0 106		
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 3170 1. 2310		1, 676		71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 4009		65		
	07300 DRUGS CHARGED TO PATIENTS		0. 3029		6, 696		
	07500 ASC (NON-DISTINCT PART)		0. 1890		0, 0,0	0	1
	03950 MH ANCILLARY OUTPATIENT		0. 0000		0		
	03951 I NPATI ENT DI ALYSI S		0. 7200		0		
	OUTPATIENT SERVICE COST CENTERS					_	
90.00	09000 CLI NI C		3. 2179	75	0	0	90.00
90. 01	04950 WOUND CLINIC		0. 4053	81	721	292	90. 01
91.00	09100 EMERGENCY		0. 2074	20	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 2516	25	0	0	92. 00
	OTHER REIMBURSABLE COST CENTERS						4
	09600 DURABLE MEDICAL EQUIP-RENTED		0. 5654	54	0		
200.00					69, 940	19, 163	
201. 00 202. 00	Less PBP Clinic Laboratory Services-Program only charge	es (line 61)			0		201. 00
	Net charges (line 200 minus line 201)		1	1	69, 940	al .	202.00

PART A . INPATEDIT HOSPITAL SERVICES UNDER IRPS 1.00			Title XVIII	Hospi tal	5/26/2022 9: 3 PPS	8 am
No. DRAFT ALL IMPAILIBLE HOUSE TALL SERVICES HOURE FIPS NO. DRAFT ALL SERVICES HOURE FIPS NO. DRAFT ALL SERVICES HOURE FIRST DRAFT ALL SERVICES HOURS HOURE FIRST DRAFT ALL SERVICES HOURS H			II LI E AVIII	nospi tai	113	
1.00 BisS Amounts other than outlier payments for discharges occurring prior to October 1 (see 1.491.181 1.601		DADT A LINDATI ENT HOODI TALL CEDIM OF CHINDED LDDC			1. 00	
DRS amounts other than outlier payments for discharges occurring onto 10 botober 1 (see 11,491,181 1.01 1.02 1.03 1.	1 00				0	1 00
1.02 108C anounts other than outlier payments for discharges occurring on or after October 1 (see instructions) 1.02 1.03 1.03 1.04 1.05 1.04 1.05 1.0		DRG amounts other than outlier payments for discharges occurring payments	rior to October 1 (s	see	-	
1.03 10 10 10 10 10 10 10	1. 02	DRG amounts other than outlier payments for discharges occurring on	n or after October í	I (see	3, 940, 969	1. 02
1.04 Oktober 1 (see Instructions) 2.00 Oktober 1 (see Instructions) 2.00 Oktion poyents for discharges (see Instructions) 1.00 0.00	1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October			0	1. 03
2.00 Outlier payments for discharges (see Instructions) 2.00 Continger reconcilitation amount 2.00 Continger payments for discharges occurring prior to October 1 (see instructions) 170, 448 2.03	1.04	DRG for federal specific operating payment for Model 4 BPCI for dis	scharges occurring o	on or after	0	1. 04
2.02 Outlier payment for discharges cocurring prior to October 1 (see Instructions) 170, 448 2.03 2.04 Outlier payments for discharges occurring on or after October 1 (see Instructions) 170, 448 2.03 2.04 Outlier payments for discharges occurring on or after October 1 (see Instructions) 6.023 2.04 3.00 Managed Care Simulated Payments 6.023 2.04 3.00 Find Tree Medical Education Adjustment 7.00 7.00 3.00 Find Tree Medical Education Adjustment 7.00 7.00 7.00 3.00 Find Tree Tree Tree Tree Tree Tree Tree Tre		Outlier payments for discharges. (see instructions)			_	
2.03 Outlier payments for discharges occurring prior to October 1 (see instructions) 170, 448 2.03 Co.						
2.04 Outlier payments for discharges occurring on or after October 1 (see instructions) 4,603 2.04		, , ,	instructions)		-	
Managed Care Simulated Payments		, , ,			•	
Red days available divided by number of days in the cost reporting period (see instructions) 88-97 4.00		, , ,	ee mstructrons)			
Indirect_Medical_Education_Adjustment			neriod (see instru	rtions)		
or before 12/31/1996, (see instructions) or before 12/31/1996 (see instructions) 1.00 PEFC 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) 1.01 PACA \$ 5503 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) If the cook cost report straddles July 1, 2011 then see instructions affiliated programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (Mby 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 under \$ 5503 of the ACA. If the cost under \$ 5506 of ACA. (see instructions). 9.0 Sum of lines \$ Diu 6 minus lines (7 and 7.01) plus/minus lines (8, 8, 01 and 8, 02) (see 0.00 Pinstructions). 10.00 Firstructions). 10.00 Firstructions. 10.00 Treath year all outside FTE (see instructions) plus/minus lines (8, 8, 01 and 8, 02) (see 0.00 Pinstructions). 10.00 Currenty year all outside FTE (see instructions) plus/minus lines (8, 8, 01 and 8, 02) (see 0.00 Pinstructions). 10.00 Treath year all outside FTE (see instructions) plus/minus lines (8, 8, 01 and 8, 02) (see 0.00 Pinstructions). 10.00 Treath year all outside FTE (see instructions) plus/minus lines (8, 8, 01 and 8, 02) (see 0.00 Pinstructions). 10.00 Treath year all outside FTE (see instructions) plus/minus lines (8, 8, 01 and 8, 02) (see 0.00 Pinstructions). 10.00 Treath year all outside FTE (see instructions) plus/minus lines (8, 8, 01 and 8, 02) (see 0.00 Pinstructions). 10.00 Treath year all outside FTE (see instructions) plus/minus lines (8, 8, 01 and 8, 02) (see 0.00 Pinstructions). 10.00 Treath year all outside FTE (see instructions) plus/minus lines (8, 8, 01 and 8, 02) (see 0.00 Pinstructions). 10.00 Treath year all outside FTE (see instructions) plus/mi		Indirect Medical Education Adjustment				
new programs in accordance with 42 CFR 413.79(e) 7.00 MA Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) if the	5. 00		ent cost reporting p	period ending on	0.00	5. 00
7.00 MMA Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(v)(8)(2) If the cost report straddles July 1, 2011 then see instructions. 0.00 40 street of the str	6. 00		iteria for an add-or	n to the cap for	0. 00	6. 00
cost report straddles July 1, 2011 then see instructions. 8. 00 All 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). 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 under § 5503 of the ACA. If the cost under § 5506 of ACA. (see Instructions) 8. 02 Under § 5506 of ACA. (see Instructions) 8. 03 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) 9. 00 FTE count for all opathic and osteopathic programs in the current year from your records 9. 00 Current year allowable FTE (see Instructions) 9. 01 Current year allowable FTE (see Instructions) 9. 02 Current year allowable FTE count for the propram. 9. 03 Total allowable FTE count for the penul timate year if that year ended on or after September 30, 1997, otherwise enter zero. 9. 02 Sum of Ilines 12 through 14 divided by 3. 9. 03 Sum of Ilines 12 through 14 divided by 3. 9. 04 Substment for residents in initial years of the program (9, 20, 77 16, 00) 9. 05 Adjustment for residents in initial years of the program (9, 20, 77 18, 00) 9. 06 Current year resident to bed ratio (line 18 divided by Iline 4). 9. 07 Tiles 00 Current year resident to bed ratio (see instructions) 9. 08 Current year resident to bed ratio (see instructions) 1. 1808,897 22. 1809 22. 01 IME payment adjustment (see instructions) 1. 1809,897 22. 20 IME payment adjustment factor. (see instructions) 1. 1809,897 22. 20 IME payment adjustment factor. (see instructions) 20 Enter the lesser of Ilines 19 or 20 (see instructions) 21 IME payment adjustment amount - Managed Care (see Instructions) 22 IME payment adjustment amount - Managed Care (see Instructions) 23 IME add-on adjustment amount		MMA Section 422 reduction amount to the IME cap as specified under				
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).		cost report straddles July 1, 2011 then see instructions.	,,,,,	, , , , ,		
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. 01	8. 00	affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)			0.00	8. 00
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)	8. 01	The amount of increase if the hospital was awarded FTE cap slots u	nder § 5503 of the A	ACA. If the cost	0. 00	8. 01
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 11.00 12.00 12.00 13.00 14.00	8. 02	The amount of increase if the hospital was awarded FTE cap slots for	rom a closed teachin	ng hospital	0. 00	8. 02
10.00 FTE count for allopathic and osteopathic programs in the current year from your records 0.00 10.	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	
12.00 Current year allowable FTE (see instructions) 0.00 12.00 13.00 10.00 13.00 10.00		FTE count for allopathic and osteopathic programs in the current ye	ear from your record	ds		
13.00 Total allowable FTE count for the prior year. 0.00 13.00 14.00 Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, 0.00 14.00 14.00 14.00 14.00 14.00 15.00		, , ,				
14.00						
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 20.77 16.00 17.00 Adj ustment for residents displaced by program or hospital closure 0.00 17.00 24.00 25		' '				
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 20.77 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 20.00 Current year resident to bed ratio (line 18 divided by line 4). 0.233449 19.00 1	14.00		ded on or after Sept	rember 30, 1997,	0.00	14.00
16. 00 Adj ustment for residents in initial years of the program 20. 77 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 0. 00 17. 00 19. 00 Current year resident to bed ratio (line 18 divided by line 4). 0. 233449 19. 00 20. 00 Prior year resident to bed ratio (see instructions) 0. 228257 20. 00 21. 00 Enter the lesser of lines 19 or 20 (see instructions) 1, 808, 987 22. 00 22. 01 IME payment adj ustment (see instructions) 1, 808, 987 22. 00 22. 01 IME payment adj ustment - Managed Care (see instructions) 1, 808, 987 22. 01 10 Imidirect Medical Education Adj ustment for the Add-on for § 422 of the MMA 529, 952 22. 01 23. 00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0. 00 23. 00 25. 00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0. 00 25. 00 26. 00 Resident to bed ratio (divide line 25 by line 4) 0. 000000 26. 00 28. 01 IME payments a	15 00				0.00	15 00
17. 00						
18.00 Adjusted rolling average FTE count 20.77 18.00 19.00 Current year resident to bed ratio (line 18 divided by line 4). 0.233449 19.00 20.00 Prior year resident to bed ratio (see instructions) 0.228257 20.00 21.00 Enter the lesser of lines 19 or 20 (see instructions) 0.228257 21.00 22.00 IME payment adjustment (see instructions) 1,808,987 22.00 12.01 IME payment adjustment - Managed Care (see instructions) 529,952 20.01 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). 0.1ME FTE Resident Count Over Cap (see instructions) 0.00 24.00 25.00 IME FTE Resident Count Over Cap (see instructions) 0.00 25.00 26.00 Resident to bed ratio (divide line 25 by line 4) 0.000000 26.00 27.00 IME payments adjustment factor. (see instructions) 0.000000 27.00 28.01 IME add-on adjustment amount - Managed Care (see instructions) 0.28.01 29.01 Total IME payment (sum of lines 22 and 28) 1,808,987 29.00 29.01 Disproporti		, ,				
19.00 Current year resident to bed ratio (line 18 divided by line 4). 0. 233449 19. 00 20.00 Prior year resident to bed ratio (see instructions) 0. 228257 20. 00 21.00 Enter the lesser of lines 19 or 20 (see instructions) 1, 808, 987 22. 00 22.00 IME payment adjustment (see instructions) 1, 808, 987 22. 00 1 ME payment adjustment - Managed Care (see instructions) 529, 952 22. 01 1 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA 529, 952 22. 01 23.00 (f)(1)(iv)(C). 0. 00 23. 00 4.00 IME FTE Resident Count Over Cap (see instructions) 0. 00 24. 00 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 0. 00 25. 00 26.00 Resident to bed ratio (divide line 25 by line 4) 0. 000000 26. 00 27.00 IME payments adjustment factor. (see instructions) 0. 000000 27. 00 28.00 IME add-on adjustment amount (see instructions) 0. 00000 27. 00 28.01 IME add-on adjustment amount - Managed Care (see instructions) 0. 28. 00 29.01 Total IME pay						
21.00 Enter the lesser of lines 19 or 20 (see instructions) 0.228257 21.00 22.00 IME payment adjustment (see instructions) 1,808,987 22.00 1 IME payment adjustment - Managed Care (see instructions) 1,808,987 22.01 1 Imit payment adjustment for the Add-on for § 422 of the MMA 23.00 Imit rect Medical Education Adjustment for the Add-on for § 422 of the MMA 23.00 (f) (1) (iv) (c) 						
22.00 IME payment adjustment (see instructions) 1,808,987 22.00 IME payment adjustment - Managed Care (see instructions) 529,952 22.01 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). 24.00 IME FTE Resident Count Over Cap (see instructions) 0.00 24.00 17 the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 25.00 18 the amount on line 25 by line 4) 0.000000 27.00 18 payments adjustment factor. (see instructions) 0.000000 27.00 18 add-on adjustment amount (see instructions) 0.000000 28.00 18 add-on adjustment amount - Managed Care (see instructions) 0.28.01 19 add-on adjustment amount - Managed Care (see instructions) 0.28.01 10 add-on adjustment amount - Managed Care (see instructions) 0.00000 28.01 18 add-on adjustment amount - Managed Care (see instructions) 0.00000 29.01 10 add-on adjustment - Managed Care (sum of lines 22 and 28) 0.0000000 0.0000000 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 0.00000000	20.00	Prior year resident to bed ratio (see instructions)			0. 228257	20. 00
22. 01 IME payment adjustment - Managed Care (see instructions) 1 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 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	21. 00	Enter the lesser of lines 19 or 20 (see instructions)			0. 228257	21. 00
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 0.00 23.00 (f)(1)(iv)(C). 14.00 IME FTE Resident Count Over Cap (see instructions) 0.00 24.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 25.00 instructions) 26.00 Resident to bed ratio (divide line 25 by line 4) 0.000000 26.00 IME payments adjustment factor. (see instructions) 0.000000 27.00 IME payments adjustment amount (see instructions) 0.000000 27.00 IME add-on adjustment amount (see instructions) 0.000000 27.00 IME add-on adjustment amount - Managed Care (see instructions) 0.000000 27.00 IME add-on adjustment amount - Managed Care (see instructions) 0.000000 27.00 IME add-on adjustment amount - Managed Care (see instructions) 0.000000 27.00 Ime add-on adjustment amount - Managed Care (see instructions) 0.000000 27.00 Ime add-on adjustment (sum of lines 22 and 28) 1,808,987 29.00 Importionate Share Adjustment 0.0000000 Importionate Share Adjustment 0.00000000000000000000000000000000000						
23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 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 26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 28.00 IME payments adjustment factor. (see instructions) 29.00 IME payment amount (see instructions) 20.0000000 27.00 20.00 IME add-on adjustment amount (see instructions) 20.00 IME add-on adjustment amount - Managed Care (see instructions) 20.00 IME payment (sum of lines 22 and 28) 20.00 Total IME payment (sum of lines 22 and 28) 20.00 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 20.00 Disproportionate Share Adjustment 20.00 Sum of lines 30 and 31 20.00 Sum of lines 30 and 31 21.00 Sum of lines 30 and 31 22.01 Allowable disproportionate share percentage (see instructions) 23.00 Allowable disproportionate share percentage (see instructions) 24.00 IME FTE resident cap slots under 42 CFR 412.105 0.00 24.00 25.00 26.00 26.00 27.00 28.01 28.01 29.01 29.01 29.01 20.02 20.03 20.03 20.04 20.04 20.05 20.00 20.0	22. 01				529, 952	22. 01
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 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 add-on adjustment amount - Managed Care (see instructions) 29.01 Total IME payment (sum of lines 22 and 28) 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 29.01 Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 30.00 Sum of lines 30 and 31 30.00 Allowable disproportionate share percentage (see instructions)	23. 00	Number of additional allopathic and osteopathic IME FTE resident ca		FR 412. 105	0.00	23. 00
25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 25.00 instructions) Resident to bed ratio (divide line 25 by line 4) 1ME payments adjustment factor. (see instructions) 1ME add-on adjustment amount (see instructions) 28.00 IME add-on adjustment amount (see instructions) 28.01 IME add-on adjustment amount - Managed Care (see instructions) 10 28.01 Total IME payment (sum of lines 22 and 28) 10 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 10 Disproportionate Share Adjustment 29.00 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) 8.59 33.00	24 00				0.00	24 00
26.00 Resident to bed ratio (divide line 25 by line 4) 0.000000 26.00 27.00 IME payments adjustment factor. (see instructions) 0.000000 27.00 28.00 IME add-on adjustment amount (see instructions) 0.28.00 28.01 IME add-on adjustment amount - Managed Care (see instructions) 0.28.01 29.00 Total IME payment (sum of lines 22 and 28) 1,808,987 29.00 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 529,952 29.01 Disproportionate Share Adjustment 9ercentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 5.00 30.00 31.00 Percentage of Medicaid patient days (see instructions) 18.48 31.00 32.00 Sum of lines 30 and 31 23.48 32.00 33.00 Allowable disproportionate share percentage (see instructions) 8.59 33.00		If the amount on line 24 is greater than -O-, then enter the lower	of line 23 or line	24 (see		
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) 1,808,987 29.00 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 529,952 29.01 Disproportionate Share Adjustment 9ercentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 5.00 30.00 31.00 Percentage of Medicaid patient days (see instructions) 18.48 31.00 32.00 Sum of lines 30 and 31 23.48 32.00 33.00 Allowable disproportionate share percentage (see instructions) 8.59 33.00	26. 00				0. 000000	26. 00
28.00 IME add-on adjustment amount (see instructions) 28.01 IME add-on adjustment amount - Managed Care (see instructions) 29.00 Total IME payment (sum of lines 22 and 28) 29.01 Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 30.00 Percentage of Medicaid patient days (see instructions) 30.00 Sum of lines 30 and 31 30.00 Allowable disproportionate share percentage (see instructions)						
29.00 Total IME payment (sum of lines 22 and 28) 1,808,987 29.00 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 529,952 29.01 30.00 Disproportionate Share Adjustment 5.00 30.00 31.00 Percentage of SSI recipient patient days (see instructions) 5.00 30.00 32.00 Sum of lines 30 and 31 23.48 32.00 33.00 Allowable disproportionate share percentage (see instructions) 8.59 33.00	28.00	IME add-on adjustment amount (see instructions)			0	28. 00
29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 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) 529. 01 529. 01 529. 02 529. 01 529. 05	28. 01	IME add-on adjustment amount - Managed Care (see instructions)			0	28. 01
Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31.00 Percentage of Medicaid patient days (see instructions) 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 30.00 Percentage of Medicaid patient days (see instructions) 31.00 Sum of lines 30 and 31 32.48 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 32.00 Percentage of Medicaid patient days (see instructions) 33.00 Percentage of Medicaid patient days (see instructions) 34.00 Sum of lines 30 and 31 35.00 Percentage of Medicaid patient days (see instructions) 36.00 Percentage of Medicaid patient days (see instructions) 37.00 Sum of lines 30 and 31 38.00 Percentage of Medicaid patient days (see instructions)	29. 00				1, 808, 987	29. 00
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) 30.00 18.48 31.00 23.48 32.00 33.00	29. 01	1 3 9 (529, 952	29. 01
31.00 Percentage of Medicaid patient days (see instructions) 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 18.48 31.00 23.48 32.00 33.00	30.00		t days (see instruct	tions)	5. 00	30.00
33.00 Allowable disproportionate share percentage (see instructions) 8.59 33.00	31.00		. :			31.00
	32.00	Sum of lines 30 and 31			23. 48	32. 00
34.00 Disproportionate share adjustment (see instructions) 331,405 34.00						
	34. 00	טן sproportionate share adjustment (see instructions)		l	331, 405	34.00

	Financial Systems GOOD SAMARITAN ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0042	Peri od: From 01/01/2021 To 12/31/2021	u of Form CMS-2 Worksheet E Part A Date/Time Prep 5/26/2022 9:38	
		Title XVIII	Hospi tal	PPS	
			Prior to 10/1 1.00	2.00	
	Uncompensated Care Adjustment		1.00	2.00	
35. 00	Total uncompensated care amount (see instructions)		8, 290, 014, 521	7, 192, 008, 710	35.0
35. 01	Factor 3 (see instructions)		0. 000282312	0. 000242542	35. 0
35. 02		r zero on this line) (se	e 2, 340, 371	1, 744, 364	35. 0
35. 03	instructions) Pro rata share of the hospital uncompensated care payment amount of the hospital uncompensated care payment	unt (coo i netructions)	1 750 440	439, 676	35. 0
36. 00	Total uncompensated care (sum of columns 1 and 2 on line 35.0)		1, 750, 469 2, 190, 145		36.0
0. 00	Additional payment for high percentage of ESRD beneficiary dis				00.0
10.00	Total Medicare discharges (see instructions)		0		40.0
1.00	Total ESRD Medicare discharges (see instructions)		0		41.0
1. 01	Total ESRD Medicare covered and paid discharges (see instruct		0		41.0
2.00	Divide line 41 by line 40 (if less than 10%, you do not quali	fy for adjustment)	0.00		42. 0
3.00	Total Medicare ESRD inpatient days (see instructions)		0		43.0
4. 00	Ratio of average length of stay to one week (line 43 divided days)	by line 41 divided by 7	0. 000000		44.0
15. 00	Average weekly cost for dialysis treatments (see instructions)	0.00		45. 0
6. 00	Total additional payment (line 45 times line 44 times line 41		0		46.0
7. 00	Subtotal (see instructions)	•	19, 939, 758		47.0
8. 00	Hospital specific payments (to be completed by SCH and MDH, s	mall rural hospitals	19, 583, 844		48. 0
	only. (see instructions)			A	
				Amount 1.00	
19. 00	Total payment for inpatient operating costs (see instructions)		20, 469, 710	49 0
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and	•		1, 352, 730	
1.00	Exception payment for inpatient program capital (Wkst. L, Pt.			0	51.0
2. 00	Direct graduate medical education payment (from Wkst. E-4, li			868, 073	52. 0
3. 00	Nursing and Allied Health Managed Care payment			24, 316	53.0
4. 00	Special add-on payments for new technologies			99, 144	54.0
4. 01	Islet isolation add-on payment	0)		0	54.0
5. 00 6. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6' Cost of physicians' services in a teaching hospital (see intro	· ·		0	55. 0 56. 0
7. 00	Routine service other pass through costs (from Wkst. D, Pt. I		hrough 35)	0	57.0
8. 00	Ancillary service other pass through costs from Wkst. D, Pt.		g / .	43, 253	
9. 00	Total (sum of amounts on lines 49 through 58)	,		22, 857, 226	59. C
0.00	Primary payer payments			17, 514	60.0
1. 00	Total amount payable for program beneficiaries (line 59 minus	line 60)		22, 839, 712	
2. 00	Deductibles billed to program beneficiaries			1, 900, 588	
3. 00	Coinsurance billed to program beneficiaries			24, 857	
64. 00 65. 00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			252, 869 164, 365	
6. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	1
7. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	. 401. 61.6)		21, 078, 632	
8. 00	Credits received from manufacturers for replaced devices for	applicable to MS-DRGs (s	ee instructions)	0	
9. 00	Outlier payments reconciliation (sum of lines 93, 95 and 96).	(For SCH see instruction	s)	0	69.0
0. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70. C
0. 50	Rural Community Hospital Demonstration Project (§410A Demonst	ration) adjustment (see	instructions)	0	70.5
0.87	Demonstration payment adjustment amount before sequestration			0	70.8
0. 88 0. 89	SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see inst	ructions)		0	70. 8 70. 8
0.89	HSP bonus payment HVBP adjustment amount (see instructions)	i ucti ulis)		0	70. 8
0. 90	HSP bonus payment HRR adjustment amount (see instructions)			0	70. 9
0. 71	Bundled Model 1 discount amount (see instructions)			0	70. 9
0. 93	HVBP payment adjustment amount (see instructions)			-105, 104	70. 9
	HRR adjustment amount (see instructions)			-112, 186	
	Recovery of accelerated depreciation			0	70.

20, 644, 299

18, 854, 751

1, 789, 548

360, 139

0 90.00

71.00

71.01

0 71.02

71.03

72.00

72.01

0 73.00

73.01

74.00

74 01

75.00

Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)

Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and

Protested amounts (nonallowable cost report items) in accordance with

Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03

Demonstration payment adjustment amount after sequestration

Sequestration adjustment (see instructions)

Sequestration adjustment-PARHM pass-throughs

Tentative settlement (for contractor use only)

Tentative settlement-PARHM (for contractor use only)

Balance due provider/program-PARHM (see instructions)

CMS Pub. 15-2, chapter 1, §115.2 TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)

90.00 Operating Outrier amount from wkst. E, Pt. A, Trie 2, of sum of 2.03		٠Į	90.00
plus 2.04 (see instructions)			
91.00 Capital outlier from Wkst. L, Pt. I, line 2		-	,
92.00 Operating outlier reconciliation adjustment amount (see instructions)		0	92. 00
93.00 Capital outlier reconciliation adjustment amount (see instructions)		0	93. 00
94.00 The rate used to calculate the time value of money (see instructions)		0. 00	94. 00
95.00 Time value of money for operating expenses (see instructions)		0	
96.00 Time value of money for capital related expenses (see instructions)		0	96. 00
	Prior to 10/1	On/After 10/1	
	1. 00	2. 00	
HSP Bonus Payment Amount			
100.00 HSP bonus amount (see instructions)	0	0	100. 00
HVBP Adjustment for HSP Bonus Payment			
101.00 HVBP adjustment factor (see instructions)	0. 9909061528	0. 9909100000	101. 00
102.00 HVBP adjustment amount for HSP bonus payment (see instructions)	o	0	102.00
HRR Adjustment for HSP Bonus Payment	<u> </u>		
103.00 HRR adjustment factor (see instructions)	0. 9927	0. 9930	103. 00
104.00 HRR adjustment amount for HSP bonus payment (see instructions)	0		104. 00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment	<u> </u>		
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.			200.00
Cost Reimbursement			
201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201. 00
202. 00 Medi care di scharges (see i nstructions)			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 current	5 year demonst		203.00
period)	5-year demonst	I a LI OII	
204. 00 Medicare target amount	I		204. 00
205.00 Case-mix adjusted target amount (line 203 times line 204)			204. 00
206.00 Medicare inpatient routine cost cap (line 202 times line 205)			205. 00
			206.00
Adjustment to Medicare Part A Inpatient Reimbursement			207 00
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			
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)			218. 00
(line 212 minus line 213) (see instructions)			

71.00

71. 01

71.02

71. 03

72.00

72.01

73.00

73.01

74.00

74. 01

75.00

90.00

73)

Interim payments

Interim payments-PARHM

| Period: | Worksheet E | From 01/01/2021 | Part A Exhibit 4 | Date/Time Prepared: | 5/26/2022 9:38 am Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 Provider CCN: 15-0042

						0 12/31/2021	5/26/2022 9:38	
					XVIII	Hospi tal	PPS	
			Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
1.00	DRG amounts other than outlier	0 1. 00	1. 00	2.00	3.00	4.00	5. 00 0	1. 00
1.00	payments	1.00	U	0		,	U	1.00
1. 01	DRG amounts other than outlier payments for discharges	1. 01	11, 491, 181	0	11, 491, 181		11, 491, 181	1. 01
1. 02	occurring prior to October 1 DRG amounts other than outlier	1. 02	3, 940, 969	0		3, 940, 969	3, 940, 969	1. 02
	payments for discharges occurring on or after October 1							
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1. 03	0	0	C		O	1. 03
1. 04	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	C	0	0	2. 01
2. 02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2. 03	170, 448	0	170, 448	3	170, 448	2. 02
2. 03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2. 04	6, 623	0		6, 623	6, 623	2. 03
3.00	Operating outlier reconciliation	2. 01	0	0	С	0	0	3. 00
4. 00	Managed care simulated payments	3. 00	4, 520, 925	0	3, 443, 531	1, 077, 394	4, 520, 925	4. 00
	Indirect Medical Education Adj	ustment			,			
5.00	Amount from Worksheet E, Part	21. 00	0. 228257	0. 228257	0. 228257	0. 228257		5. 00
6. 00	A, line 21 (see instructions) IME payment adjustment (see	22. 00	1, 808, 987	0	1, 347, 019	461, 968	1, 808, 987	6. 00
6. 01	instructions) IME payment adjustment for managed care (see	22. 01	529, 952	0	403, 658	126, 294	529, 952	6. 01
	instructions)							
	Indirect Medical Education Adj	ustment for the	Add-on for Se	ction 422 of t	he MMA			
7.00	IME payment adjustment factor	27. 00	0. 000000	0. 000000		0. 000000		7. 00
8. 00	(see instructions) IME adjustment (see	28. 00	0	0	С	0	0	8. 00
8. 01	instructions) IME payment adjustment add on	28. 01	0	0	С	0	0	8. 01
0.00	for managed care (see instructions)	20.00	1 000 007	0	1 247 010	4/1 0/0	1 000 007	0.00
9. 00 9. 01	Total IME payment (sum of lines 6 and 8) Total IME payment for managed	29. 00 29. 01	1, 808, 987 529, 952	0				9. 00 9. 01
9.01	care (sum of lines 6.01 and 8.01)	29.01	327, 732	O	403, 030	120, 274	327, 732	9.01
	Di sproporti onate Share Adjustm							
10. 00	Allowable disproportionate share percentage (see	33. 00	0. 0859	0. 0859	0. 0859	0. 0859		10. 00
11. 00	<pre>instructions) Disproportionate share adjustment (see instructions)</pre>	34. 00	331, 405	0	246, 773	84, 632	331, 405	11. 00
11. 01	Uncompensated care payments Additional payment for high per	36.00	2, 190, 145	0 di scharges	1, 750, 469	439, 676	2, 190, 145	11. 01
12. 00	Total ESRD additional payment (see instructions)	46. 00	0	ui scriai ges 0	С	0	0	12. 00
13. 00 14. 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	47. 00 48. 00	19, 939, 758 0	0	15, 005, 890 0	4, 933, 868 0	19, 939, 758 0	13. 00 14. 00
15. 00	Total payment for inpatient operating costs (see instructions)	49. 00	20, 469, 710	0	15, 409, 548	5, 060, 162	20, 469, 710	15. 00
16. 00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50. 00	1, 352, 730	0	1, 018, 678	334, 052	1, 352, 730	16. 00

From 01/01/2021 Part A Exhibit 4 Date/Time Prepared: 5/26/2022 9:38 am 12/31/2021 Title XVIII Hospi tal W/S E, Part A Amounts (from Pre/Post Period Prior Total (Col 2 Peri od to 10/01 E, Part A) On/After 10/01 line Entitlement through 4) 4 00 0 1 00 2 00 3 00 5 00 17.00 Special add-on payments for 54.00 99, 144 66, 509 32, 635 99, 144 17.00 new technologies 17.01 Net organ aquisition cost 17.01 17.02 Credits received from 68.00 17.02 0 0 0 manufacturers for replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation 93.00 0 0 18.00 adjustment amount (see instructions) 19.00 SUBTOTAL 16, 494, 735 5, 426, 849 21, 921, 584 19.00 W/S L, line (Amounts from 0 1.00 2.00 3.00 4. 00 5.00 Capital DRG other than outlier 1, 161, 740 20.00 1.00 869, 648 292, 092 1, 161, 740 20.00 Model 4 BPCI Capital DRG other 20.01 1 01 20.01 than outlier 21.00 Capital DRG outlier payments 2.00 32, 645 30, 497 2, 148 32, 645 21.00 Model 4 BPCI Capital DRG 21.01 2.01 21.01 outlier payments Indirect medical education 22.00 5.00 0.1363 0.1363 0.1363 0.1363 22.00 percentage (see instructions) 23.00 Indirect medical education 6.00 158, 345 118, 533 39, 812 158, 345 23.00 adjustment (see instructions) 24.00 Allowable disproportionate 10.00 0.0000 0.0000 0.0000 0.0000 24.00 share percentage (see instructions) 25.00 Di sproporti onate share 11.00 0 0 25.00 0 adjustment (see instructions) 26.00 Total prospective capital 12.00 1, 352, 730 1, 018, 678 334, 052 1, 352, 730 26.00 payments (see instructions) W/S E, Part A (Amounts to E, line Part A) 5. 00 1.00 2.00 3.00 4.00 0 27.00 Low volume adjustment factor 0.000000 0.000000 27.00 28.00 Low volume adjustment 70.96 28.00 (transfer amount to Wkst. E, Pt. A. line) 29.00 Low volume adjustment 29.00 70.97 0 (transfer amount to Wkst. E, Pt. A, line) 100.00 Transfer low volume 100.00

adjustments to Wkst. E, Pt. A.

HOSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provider CO		Peri od:	Worksheet E	
					From 01/01/2021 To 12/31/2021	Part A Exhibi Date/Time Pre	pared:
			Ti +Lo	XVIII	Hospi tal	5/26/2022 9: 3 PPS	8 am
		Wkst. E, Pt.	Amt. from	Period to	Peri od on	Total (cols. 2	
		A, line	Wkst. E, Pt.	10/01	after 10/01	and 3)	
		0	1.00	2.00	3. 00	4. 00	
1. 00	DRG amounts other than outlier payments	1.00					1. 00
1. 01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1. 01	11, 491, 181	11, 491, 18	1	11, 491, 181	1. 01
1. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1. 02	3, 940, 969		3, 940, 969	3, 940, 969	1. 02
1. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	1. 03	0		0	0	1. 03
1. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	О		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	2. 01
2. 02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2. 03	170, 448	170, 44	8	170, 448	2. 02
2. 03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2. 04	6, 623		6, 623	6, 623	2. 03
3.00	Operating outlier reconciliation	2. 01	0		0 0	0	3. 00
4.00	Managed care simulated payments	3. 00	4, 520, 925	3, 443, 53	1, 077, 394	4, 520, 925	4.00
F 00	Indirect Medical Education Adjustment	21. 00	0.220257	0 22025	7 0 220257		F 00
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0. 228257	0. 22825	7 0. 228257		5. 00
6.00	IME payment adjustment (see instructions)	22. 00	1, 808, 987	1, 347, 01	9 461, 968	1, 808, 987	6. 00
6. 01	IME payment adjustment for managed care (see	22. 01	529, 952			529, 952	6. 01
	instructions)						
7.00	Indirect Medical Education Adjustment for the				0 000000		7 00
7. 00	IME payment adjustment factor (see instructions)	27. 00	0. 000000	0. 00000	0. 000000		7. 00
8.00	IME adjustment (see instructions)	28. 00	0		0 0	0	8. 00
8. 01	IME payment adjustment add on for managed	28. 01	0		0	0	8. 01
	care (see instructions)						
9. 00 9. 01	Total IME payment (sum of lines 6 and 8)	29.00	1, 808, 987	1, 347, 01			9. 00 9. 01
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	529, 952	403, 65	8 126, 294	529, 952	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage	33.00	0. 0859	0. 085	9 0. 0859		10. 00
11. 00	(see instructions) Disproportionate share adjustment (see	34.00	331, 405	246, 77	3 84, 632	331, 405	11. 00
	instructions)	0, 00	0 400 445		400 (7)	0 400 445	
11. 01	Uncompensated care payments	36.00	2, 190, 145	1, 750, 46	9 439, 676	2, 190, 145	11. 01
12. 00	Additional payment for high percentage of ESF Total ESRD additional payment (see	46.00	di scharges 0		0 0	0	12.00
12.00	instructions)	40.00			0		12.00
13.00	Subtotal (see instructions)	47. 00	19, 939, 758	15, 005, 89	0 4, 933, 868	19, 939, 758	13. 00
14. 00	Hospital specific payments (completed by SCH	48. 00	0		0 0	0	14. 00
	and MDH, small rural hospitals only.) (see instructions)						
15. 00	Total payment for inpatient operating costs (see instructions)	49. 00	20, 469, 710	15, 409, 54	5, 060, 162	20, 469, 710	15. 00
16. 00	Payment for inpatient program capital (from	50. 00	1, 352, 730	1, 018, 67	8 334, 052	1, 352, 730	16. 00
	Wkst. L, Pt. I, if applicable) Special add-on payments for new technologies	54.00	99, 144	66, 50	9 32, 635	99, 144	
17. 01 17. 02	Net organ acquisition cost Credits received from manufacturers for	68. 00	_			0	17. 01 17. 02
17.02	replaced devices for applicable MS-DRGs	00.00					17.02
18. 00	Capital outlier reconciliation adjustment amount (see instructions)	93. 00	0		0	0	18. 00
19. 00	SUBTOTAL			16, 494, 73	5, 426, 849	21, 921, 584	19. 00

Health Financial Systems	GOOD SAMARITA	N HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL ACQUIRED CONDITION (HAC)	REDUCTION CALCULATION EXHIBIT 5	XHIBIT 5 Provider CCN: 15-0042			Worksheet E 1/2021 Part A Exhibit 5 1/2021 Date/Time Prepared: 5/26/2022 9:38 am	
		Title	: XVIII	Hospi tal	PPS	
	Wkst. L, line	(Amt. from				

				Ť	0 12/31/2021	Date/Time Pre 5/26/2022 9:3	pared:
				XVIII	Hospi tal	PPS	
		Wkst. L, line	(Amt. from				
			Wkst. L)				
		0	1. 00	2. 00	3. 00	4. 00	
20. 00	Capital DRG other than outlier	1.00	1, 161, 740	869, 648		1, 161, 740	
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0	0	0	0	20. 01
21. 00	Capital DRG outlier payments	2.00	32, 645	30, 497	2, 148	32, 645	
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	0	0	0	21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 1363	0. 1363	0. 1363		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	158, 345	118, 533	39, 812	158, 345	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10.00	0. 0000	0.0000	0. 0000		24. 00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	0	0	0	0	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	1, 352, 730	1, 018, 678	334, 052	1, 352, 730	26. 00
	This is don't ensy	Wkst. E, Pt.	(Amt. from				
		A, line	Wkst. E, Pt. A)				
		0	1.00	2.00	3. 00	4. 00	
27. 00							27. 00
28.00	Low volume adjustment prior to October 1	70. 96	0	0		0	28. 00
29.00	Low volume adjustment on or after October 1	70. 97	0		0	0	29. 00
30.00	HVBP payment adjustment (see instructions)	70. 93	-105, 104	-105, 104	0	-105, 104	30. 00
30. 01	HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0	0	0	0	30. 01
31. 00	HRR adjustment (see instructions)	70. 94	-112, 186	-84, 371	-27, 815	-112, 186	31. 00
31. 01	HRR adjustment for HSP bonus payment (see instructions)	70. 91	0	0	0	0	31. 01
	1					(Amt. to Wkst.	
						E, Pt. A)	
		0	1. 00	2. 00	3. 00	4. 00	
32. 00	HAC Reduction Program adjustment (see instructions)	70. 99		163, 053	53, 990	217, 043	32. 00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100. 00

		Title XVIII	Hospi tal	5/26/2022 9: 3 PPS	8 am
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1. 00	
1.00	Medical and other services (see instructions)			8, 442	1. 00
2.00	Medical and other services reimbursed under OPPS (see instructions	s)		27, 574, 249	2. 00
3.00	OPPS payments			24, 803, 122	3. 00
4.00	Outlier payment (see instructions)			14, 557	4. 00
4. 01	Outlier reconciliation amount (see instructions)	`		0	4. 01
5. 00 6. 00	Enter the hospital specific payment to cost ratio (see instruction Line 2 times line 5	ns)		0. 000 0	5. 00 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)			0.00	8. 00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV,	col. 13, line 200		29, 267	9. 00
10.00	Organ acqui si ti ons			0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			8, 442	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
12. 00	Reasonable charges Ancillary service charges			27, 869	12 00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line	69)		27,007	13. 00
14. 00	Total reasonable charges (sum of lines 12 and 13)	,		27, 869	14. 00
	Customary charges				
15. 00	Aggregate amount actually collected from patients liable for payments			0	15. 00
16. 00	Amounts that would have been realized from patients liable for pay	yment for services or	n a chargebasis	0	16. 00
17. 00	had such payment been made in accordance with 42 CFR §413.13(e) Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17. 00
18. 00	Total customary charges (see instructions)			27. 869	18.00
19. 00	Excess of customary charges over reasonable cost (complete only in	f line 18 exceeds lir	ne 11) (see	19, 427	19. 00
	instructions)				
20. 00	Excess of reasonable cost over customary charges (complete only i	fline 11 exceeds lir	ne 18) (see	0	20. 00
21. 00	instructions) Lesser of cost or charges (see instructions)			8, 442	21. 00
21.00	Interns and residents (see instructions)			0, 442	22.00
23. 00	Cost of physicians' services in a teaching hospital (see instructi	i ons)		0	23. 00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	,		24, 846, 946	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25. 00	Deductibles and coinsurance amounts (for CAH, see instructions)	(6 0411 : 1		0	25. 00
26. 00 27. 00	Deductibles and Coinsurance amounts relating to amount on line 24 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus			4, 639, 810 20, 215, 578	26. 00 27. 00
27.00	instructions)	the sum of fittes 22	and 23] (See	20, 213, 376	27.00
28. 00	Direct graduate medical education payments (from Wkst. E-4, line	50)		752, 545	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29. 00
30.00	Subtotal (sum of lines 27 through 29)			20, 968, 123	
31. 00	Primary payer payments			4, 165	
32. 00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)			20, 963, 958	32. 00
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)			0	33. 00
34.00	Allowable bad debts (see instructions)			405, 128	34.00
35. 00	Adjusted reimbursable bad debts (see instructions)			263, 333	
36. 00	Allowable bad debts for dual eligible beneficiaries (see instructi	ions)		0	36. 00
37. 00 38. 00	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R			21, 227, 291 0	
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	38. 00 39. 00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)			· ·	39. 50
39. 97	Demonstration payment adjustment amount before sequestration			0	39. 97
39. 98	Partial or full credits received from manufacturers for replaced	devices (see instruct	i ons)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	39. 99
40.00	Subtotal (see instructions)			21, 227, 291	40.00
40. 01 40. 02	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration			0	40. 01 40. 02
40. 02	Sequestration adjustment-PARHM pass-throughs			U	40. 02
41. 00	Interim payments			21, 041, 887	41. 00
41. 01	Interim payments-PARHM				41. 01
42.00	Tentative settlement (for contractors use only)			0	42. 00
42. 01	Tentative settlement-PARHM (for contractor use only)			405 404	42. 01
43. 00 43. 01	Balance due provider/program (see instructions) Balance due provider/program-PARHM (see instructions)			185, 404	43. 00 43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordance	with CMS Pub 15-2 c	hanter 1	0	44. 00
1 7. 00	§115. 2	omo rab. 10 2, C	pto: 1,		11.00
	TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0	90. 00
91.00	Outlier reconciliation adjustment amount (see instructions)			0	91.00
92. 00 93. 00	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)			0. 00 0	92. 00 93. 00
	Total (sum of lines 91 and 93)			0	94.00
				,	

Health Financial Systems	GOOD SAMARITAN HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0042	Peri od: From 01/01/2021	Worksheet E Part B
	Component CCN: 15-S042	To 12/31/2021	Date/Time Prepared: 5/26/2022 9:38 am
	Title XVIII	Subprovi der -	PPS

Mail of an other surface (see instructions)			litle XVIII	Subprovider - IPF	PPS	
Next F - NEXICAL AND DIRECTION SERVICES		, , , , , , , , , , , , , , , , , , ,				
		PART B - MEDICAL AND OTHER HEALTH SERVICES			1. 00	
1.200 2.00	1.00				131	1. 00
0.01 Fire Payment (See Instructions)			ons)			
0.00		' '				
Infare the hospital a specific payment for cost ratio (see instructions)						
Line 2 times line 5 0 6.70		, , , , , , , , , , , , , , , , , , ,	ons)			
Transit tonal corridor payment (see Instructions)			,			
And I larry service other pass through costs from West. D. Pt. IV, col. 13, line 200						
10.00 Grgam acquist it inos 131 11.00 Total cost (sum of lines 1 and 10) (see instructions) 131 11.00 Total cost (sum of lines 1 and 10) (see instructions) 131 11.00 Total cost (sum of lines 2 and 10) 12.00			! 12 !: 200			
1.00			cor. 13, 11ne 200			
COMPUTATION OF LESSER OF COST OR CHARGES 20 20 20 20 20 20 20 2						
12.00 Ancillary service charges 434 12.00 13.00 Organ acquist tion charges (From Wist. D-4, Pt. 111, col. 4, line 69) 434 14.00 13.00 Organ acquist tion charges (sum of lines 12 and 13) 15.00 Aggregate amount actually collected From patients liable for payment for services on a charge basis 15.00 Aggregate amount actually collected From patients liable for payment for services on a charge basis 15.00 Aggregate amount actually collected From patients liable for payment for services on a charge basis 15.00 15.0		COMPUTATION OF LESSER OF COST OR CHARGES				
13.00 Organ acquisition chargées (from Wist. D-4, Pt. III. of 1. d. Inine 69) 0 13.00	12.00				42.4	10.00
14.00			a 69)			
Constraints			, 0,,			
16.00 Acount's that would have been realized from patients liable for payment for services on a chargebasis had been hade in accordance with 42 CFR \$413.13(e) 0.000000 17.00 17.00 17.00 18.10 of line 15 to line 16 (not to exceed 1.000000) 0.000000 17.00 18.10 of line 15 to line 16 (not to exceed 1.000000) 0.000000 17.00 18.10 18.00 18		Customary charges				
had such payment been made in accordance with 42 CFR §413.13(e)		1 99 9	,	9		
17.00 Ratio of line 15 to line 16 (not to exceed 1.000000) 17.00	16.00		payment for services on	n a chargebasis	0	16.00
18.00 Total customary charges (see Instructions) 4.34 18.00 19.00 Excess of customary charges over reasonable cost (complete only If line 18 exceeds line 11) (see instructions) 20.00 Excess of reasonable cost over customary charges (complete only If line 11 exceeds line 18) (see instructions) 20.00 Excess of reasonable cost over customary charges (complete only If line 11 exceeds line 18) (see instructions) 20.00 Excess of reasonable cost over customary charges (complete only If line 11 exceeds line 18) (see instructions) 20.00 Excess of cost or charges (see instructions) 22.00 Excess of cost or charges (see instructions) 23.00 Excess of cost or charges (see instructions) 25.00 25.00 Excess of cost or charges (see instructions) 25.00 26.00 Excess of cost or charges (see instructions) 26.00 Excess of cost or charges (see instruc	17. 00				0. 000000	17. 00
Instructions					434	18. 00
20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions) 131 21.00	19. 00		if line 18 exceeds lin	ne 11) (see	303	19. 00
Instructions 131 21.00 22.00 Interns and residents (see instructions) 0 22.00 23.00 Cost of physic lands' services in a teaching hospital (see instructions) 0 22.00 24.00 Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) 1,296 24.00 Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) 1,296 25.00 Deductibles and colinsurance amounts (for CAH, see instructions) 0 25.00 26.00 Deductibles and colinsurance amounts (for CAH, see instructions) 86 26.00 27.00 Subtotal ([(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions) 1,341 27.00 Subtotal ([(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions) 0 28.00 28.00 Direct graduate medical education payments (from Wkst. E-4, line 50) 0 28.00 29.00 ESRO direct medical education costs (from Wkst. E-4, line 36) 0 29.00 29.00 ESRO direct medical education costs (from Wkst. E-4, line 36) 0 29.00 29.00 ESRO direct medical education costs (from Wkst. E-4, line 36) 0 29.00 20.00 ESRO direct medical education payments (from Wkst. E-4, line 36) 0 29.00 20.00 Subtotal (sum of lines 27 through 29) 1,341 30.00 20.00 Subtotal (line 30 minus line 31) 1,341 30.00 20.00 Subtotal (line 30 minus line 31) 1,341 30.00 20.00 Composite rate ESRO (from Wkst. I-5, line 11) 0 33.00 20.00 Aljusted reinbursable bad debts (see instructions) 0 35.00 20.00 Aljusted reinbursable bad debts (see instructions) 0 39.00 20.00 Subtotal (see instructions) 0 39.00 20.00 Subtotal (see instructions) 0 39.00 20.00 Subtotal (see instructions) 0 39.00 20.00 The RADUSTMENTS (SEE INSTRUCTIONS) (SPECI FY) 0 39.90 20.00 The RADUSTMENTS (SEE INSTRUCTIONS) (SPECI FY) 0 39.90 20.00 The payment and sustment (see instructions) 0 39.90 20.00 The payment and s	20.00		if line 11 exceeds lir	ne 18) (see		20 00
22.00 Interns and residents (see instructions) 0.22.00	20.00		TI TITLE TI EXCEEUS TITL	10) (366		20.00
23.00 Cost of physicians' services in a teaching hospital (see instructions) 1,296 24.00	21. 00	Lesser of cost or charges (see instructions)			131	21. 00
24. 00 Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) 1,296 24. 00						
COMPUTATION OF RELIMBURSEMENT SETTLEMENT			CTIONS)			
25.00 Deductibles and coinsurance amounts (for CAH, see instructions) 0 25.00	24.00				1, 270	24.00
27. 00 Subtotal ([I ines 21 and 24 minus the sum of I ines 25 and 26) plus the sum of I ines 22 and 23] (see 1,341 27. 00 1.341 27. 00 1.341 27. 00 1.341 27. 00 1.341 27. 00 1.341 27. 00 1.341 27. 00 1.341 27. 00 28	25. 00				0	25. 00
Instructions			•			
28.00 Direct graduate medical education payments (From Wkst. E-4, line 50) 0 28.00 0 29.00 29.00 Sbb direct medical education costs (From Wkst. E-4, line 36) 0 29.00 30.00 Subtotal (sum of lines 27 through 29) 1,341 30.00 70 31.00 70 70 70 70 70 70 70	27.00	- · · · · · · · · · · · · · · · · · · ·	is the sum of lines 22	and 23] (see	1, 341	27.00
29.00 ESRD direct medical education costs (from Wkst. E-4, line 36) 29.00 29.00 20.0	28. 00		e 50)		0	28. 00
31.00		ESRD direct medical education costs (from Wkst. E-4, line 36)				
32.00 Subtotal (line 30 minus line 31) 1,341 32.00 ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 0 33.00 33.00 34.00 Allowable bad debts (see instructions) 0 34.00 35.00 Allowable bad debts (see instructions) 0 36.00 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 0 36.00 37.00 Subtotal (see instructions) 0 36.00 37.00 Subtotal (see instructions) 0 38.00 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 39.00 07HER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.		, ,				
ALLOWABLE RAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 33.00 Composite rate ESRD (from Wkst. I -5, line 11) 0 33.00 34.00 34.00 All owable bad debts (see instructions) 0 35.00 35.00 Adjusted reimbursable bad debts (see instructions) 0 36.00 36.00 37.00 Subtotal (see instructions) 0 36.00 37.00 Subtotal (see instructions) 1,341 37.00 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 39.00 MSP-LCC demonstration payment adjustment (see instructions) 0 39.00 39.50 91.00 0.0						
34.00 All owable bad debts (see instructions) 34.00 35.00 Adjusted reimbursable bad debts (see instructions) 0 34.00 35.00 36.00 All owable bad debts for dual eligible beneficiaries (see instructions) 0 36.00 37.00 Subtotal (see instructions) 1,341 37.00 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.50 Pi oneer ACO demonstration payment adjustment (see instructions) 9 Pi oneer ACO demonstration payment adjustment (see instructions) 9 Pi oneer ACO demonstration payment adjustment (see instructions) 9 9 9 9 9 9 9 9 9	32.00		5)		1, 541	32.00
35.00						
36.00						
37.00 Subtotal (see instructions) 1,341 37.00 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 39.00 0THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 30.00			ctions)			
39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.50 90.00 39.50 90.00 39.50 90.00 39.50 90.00 39.50 90.00 39.50 90.00 90.		· · · · · · · · · · · · · · · · · · ·	7CT 0113)			
39.50 Pi oneer ACO demonstration payment adjustment (see instructions) 39.50 39.97 39.98 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.98 39.99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 40.00 Subtotal (see instructions) 1,341 40.00 40.01 40	38. 00	MSP-LCC reconciliation amount from PS&R			0	
39. 97 Demonstration payment adjustment amount before sequestration 0 39. 97 39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39. 98 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 0 39. 99 40. 00 Subtotal (see instructions) 1, 341 40. 00 40. 01 Sequestration adjustment (see instructions) 0 40. 01 40. 02 Demonstration payment adjustment amount after sequestration 0 40. 01 40. 03 Sequestration adjustment (see instructions) 0 40. 02 40. 03 Interim payments 1, 332 41. 00 41. 00 Interim payments-PARHM pass-throughs 1, 332 41. 00 42. 01 Tentative settlement (for contractors use only) 41. 01 42. 01 Tentative settlement (for contractor use only) 42. 01 43. 01 Balance due provider/program (see instructions) 9 43. 00 44. 00 Fortested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 10 44. 00 41. 02 Tine BE COMPLETED BY CONTRACTOR 0 90. 00 90. 00 Origi		, , , , ,			0	
39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39. 98 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 0 39. 99 40. 00 Subtotal (see instructions) 1, 341 40. 00 40. 01 Sequestration adjustment (see instructions) 0 40. 01 40. 02 Demonstration payment adjustment amount after sequestration 0 40. 02 40. 03 Sequestration adjustment-PARHM pass-throughs 40. 03 41. 01 Interim payments 1, 332 41. 00 41. 01 Interim payments-PARHM 1, 332 41. 00 42. 01 Tentative settlement (for contractors use only) 42. 01 43. 00 Bal ance due provider/program (see instructions) 9 43. 00 43. 01 Bal ance due provider/program-PARHM (see instructions) 43. 01 44. 00 Solution (see instructions) 45. 01 44. 00 Solution (see instructions) 90. 00 40. 01 Outlier reconciliation adjustment amount (see instructions) 0 90. 00 90. 00 Outlier reconciliation adjustment amount (see instructions) 0 90. 00 90. 0						
39. 99 RECOVERY OF ACCELERATED DEPRECIATION 0 39. 99 40. 00 Subtotal (see instructions) 1,341 40. 00 40. 01 Demonstration payment adjustment amount after sequestration 0 40. 01 40. 03 Demonstration payment adjustment amount after sequestration 0 40. 03 41. 00 Sequestration adjustment-PARHM pass-throughs 1,332 41. 00 41. 01 Interim payments-PARHM 1,332 41. 00 42. 01 Tentative settlement (for contractors use only) 0 42. 01 43. 00 Bal ance due provider/program (see instructions) 9 43. 00 43. 01 Bal ance due provider/program-PARHM (see instructions) 9 43. 01 44. 00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 91. 0 0 44. 00 90. 00 Original outlier amount (see instructions) 0 90. 00 91. 00 The rate used to calculate the Time Value of Money 0. 00 92. 00 93. 00 Time Value of Money (see instructions) 0 93. 00		, , ,	d devices (see instruct	i ons)		
40.01 Sequestration adjustment (see instructions) 0 40.01 40.02 Demonstration payment adjustment amount after sequestration 0 40.02 40.03 Sequestration adjustment-PARHM pass-throughs 40.03 41.00 Interim payments 1,332 41.00 41.01 Interim payments-PARHM 41.01 41.01 42.00 Tentative settlement (for contractors use only) 0 42.01 43.00 Balance due provider/program (see instructions) 9 43.00 43.01 Balance due provider/program-PARHM (see instructions) 9 43.01 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, spits. 2 0 44.00 90.00 Original outlier amount (see instructions) 0 90.00 91.00 Outlier reconciliation adjustment amount (see instructions) 0 90.00 92.00 The rate used to calculate the Time Value of Money 0.00 92.00 93.00 Time Value of Money (see instructions) 0 93.00	39. 99	·	`	,	0	39. 99
40. 02 Demonstration payment adjustment amount after sequestration 40. 03 Sequestration adjustment-PARHM pass-throughs 41. 00 Interim payments 41. 01 Interim payments-PARHM 42. 00 Tentative settlement (for contractors use only) 42. 01 Tentative settlement-PARHM (for contractor use only) 43. 00 Balance due provider/program (see instructions) 43. 01 Balance due provider/program-PARHM (see instructions) 43. 01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44. 00 44. 00 Original outlier amount (see instructions) 90. 00 Original outlier amount (see instructions) 91. 00 Outlier reconciliation adjustment amount (see instructions) 92. 00 The rate used to calculate the Time Value of Money 93. 00 Time Value of Money (see instructions) 94. 0. 02 Outlier reconciliation adjustment amount (see instructions) 93. 00 Time Value of Money (see instructions) 94. 0. 02 Outlier reconciliation adjustment amount (see instructions) 95. 00 Outlier of Money (see instructions) 96. 00 Outlier of Money (see instructions) 97. 00 Outlier of Money (see instructions) 98. 00 Outlier of Money (see instructions)						
40. 03 Sequestration adjustment-PARHM pass-throughs 40. 03 41. 00 Interim payments 1, 332 41. 00 41. 01 Interim payments-PARHM 41. 01 Interim payments-PARHM 42. 00 Tentative settlement (for contractors use only) 42. 01 Tentative settlement-PARHM (for contractor use only) 42. 01 43. 00 Balance due provider/program (see instructions) 9 43. 00 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 44. 00 44. 00 44. 00 44. 00 67.						
41. 00					ı	
42.00 Tentative settlement (for contractors use only) 42.01 Tentative settlement-PARHM (for contractor use only) 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 70 BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 94.00 Og 93.00					1, 332	
42.01 Tentative settlement-PARHM (for contractor use only) 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 43.01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Og 93.00						
43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 9 43.00 43.01 44.00					0	
43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 \$\frac{115.2}{5115.2}\$ 70 BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 0 Outlier reconciliation adjustment amount (see instructions) 0 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 93.00					9	
\$115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 0 Outlier reconciliation adjustment amount (see instructions) 0 Utlier reconciliation adjustment amount (see instructions) 0 P1.00 1 The rate used to calculate the Time Value of Money 1 Time Value of Money (see instructions) 0 P3.00		· · · · · · · · · · · · · · · · · · ·				
TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 95.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions)		Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2, c	chapter 1,	o	
90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 90.00 91.00 92.00 93.00						
91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 91.00 92.00 93.00	90 00				0	90 00
92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0.00 92.00 93.00						
		The rate used to calculate the Time Value of Money				92. 00
94. 00 Total (Suiii of Titles 41 and 43)						
	74. UU	rotar (Sum Of Filics 71 dilu 43)			υĮ	74. UU

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
		From 01/01/2021	Part B
	Component CCN: 15-T042	To 12/31/2021	Date/Time Prepared:
	·		5/26/2022 9:38 am
	Title XVIII	Subprovi der -	PPS
	1	LDE	

	litle XVIII Su	ubprovider - IRF	PPS	
	DADT D. HEDLOAL AND OTHER HEALTH CERVILORS		1. 00	
1. 00	PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions)		167	1. 00
2. 00	Medical and other services (see First actions) Medical and other services reimbursed under OPPS (see instructions)		1, 172	2. 00
3. 00	OPPS payments		929	3. 00
4.00	Outlier payment (see instructions)		0	4. 00
4. 01	Outlier reconciliation amount (see instructions)		0	4. 01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0. 000	5. 00
6.00	Line 2 times line 5		0	6. 00
7. 00 8. 00	Sum of lines 3, 4, and 4.01, divided by line 6 Transitional corridor payment (see instructions)		0. 00 0	7. 00 8. 00
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		4	9. 00
10. 00			0	10. 00
11. 00			167	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable charges			
12.00			550	12.00
13. 00 14. 00			0 550	13. 00 14. 00
14.00	Total reasonable charges (sum of lines 12 and 13) Customary charges		550	14.00
15. 00	3 0	narge basis	0	15. 00
16.00			0	16.00
	had such payment been made in accordance with 42 CFR §413.13(e)	-		
17. 00	· · · · · · · · · · · · · · · · · · ·		0. 000000	17. 00
18.00	,	11) (000	550	18.00
19. 00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 1 instructions)	1) (see	383	19. 00
20. 00		8) (see	0	20. 00
	instructions)	, ,		
21. 00			167	21. 00
22. 00	· · · · · · · · · · · · · · · · · · ·		0	22. 00
23. 00			0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT		933	24. 00
25. 00			0	25. 00
26. 00		ons)	135	26. 00
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and	1 23] (see	965	27.00
	instructions)		_	
28. 00			0	28. 00
29. 00 30. 00			0 965	29. 00 30. 00
31. 00	, ,		0	31. 00
32. 00			965	32. 00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)			
33. 00			0	33. 00
34. 00	· · · · · · · · · · · · · · · · · · ·		0	34.00
35. 00 36. 00			0	35. 00 36. 00
37. 00	· · · · · · · · · · · · · · · · · · ·		965	37. 00
38. 00			0	38. 00
39. 00			0	39. 00
39. 50				39. 50
39. 97	1	,	0	39. 97
39. 98		is)	0	39. 98
39. 99 40. 00			0 965	39. 99 40. 00
40. 00			0	40. 00
40. 02			0	40. 02
40. 03				40.03
41. 00			947	41.00
41. 01				41. 01
42. 00	·		0	42.00
42. 01 43. 00	Tentative settlement-PARHM (for contractor use only) Balance due provider/program (see instructions)		18	42. 01 43. 00
43. 01	Balance due provider/program-PARHM (see instructions)		10	43. 01
44. 00	, , ,	oter 1.	0	44. 00
55	§115. 2			55
	TO BE COMPLETED BY CONTRACTOR			
	Original outlier amount (see instructions)		0	90.00
91.00			0 00	91.00
92. 00 93. 00	· · · · · · · · · · · · · · · · · · ·		0. 00 0	92. 00 93. 00
94. 00			0	94. 00
55		ı		50

Health Financial Systems GOO ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-0042

					5/26/2022 9: 38	3 am
			XVIII	Hospi tal	PPS	
		Inpatien	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		18, 094, 020		20, 175, 503	1. 00
2.00	Interim payments payable on individual bills, either		()	0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER	12/31/2021	370, 731	12/31/2021	660, 684	3. 01
3. 02	ABSOSTWENTS TO TROVIDER	12/01/2021	390, 000		205, 700	3. 02
3. 02		12/01/2021	370,000		203, 700	3. 02
3. 04						3. 04
3. 05						3. 05
3.03	Provider to Program			1		5. 05
3.50	ADJUSTMENTS TO PROGRAM		(1	0	3. 50
3. 51			d		o	3. 51
3. 52			ĺ		o	3. 52
3. 53)	o	3. 53
3.54			d)	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		760, 731		866, 384	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		18, 854, 751		21, 041, 887	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR			1		
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)					
F 01	Program to Provider TENTATIVE TO PROVIDER	Γ			1 0	F 01
5. 01 5. 02	TENTATIVE TO PROVIDER					5. 01 5. 02
5. 02			(5. 02
5.03	Provider to Program				0	5. 03
5. 50	TENTATI VE TO PROGRAM			1	1 0	5. 50
5. 51	TENTATIVE TO TROOKAW					5. 51
5. 52					0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines					5. 99
0. 77	5. 50-5. 98)					0. , ,
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					2. 30
6. 01	SETTLEMENT TO PROVIDER		1, 789, 548		185, 404	6. 01
6.02	SETTLEMENT TO PROGRAM)	0	6. 02
7.00	Total Medicare program liability (see instructions)		20, 644, 299		21, 227, 291	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
	To the second se	()	1. 00	2. 00	
8.00	Name of Contractor					8. 00

Provider CCN: 15-0042 Component CCN: 15-S042 Title XVIII

Total interim payments paid to provider 1.00			Title	XVIII	Subprovi der - I PF	PPS	
Total InterIm payments paid to provider 1.00 2.00 3.00 4.00 1.00 1.00 1.00 1.00 1.00 1.00 3.00 4.00 3.00 1.00 1.00 1.00 1.00 1.00 2.00 3.00 4.00 3.00 1.00 2.00 3.00 3.00 4.00 3.00			Inpatien	t Part A	Par	t B	
1.00			mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
InterIm payments payable on Individual bills, either substited or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "MONE" or enter a zero.				2.00		4.00	
Submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NoNE" or enter a zero	1. 00	Total interim payments paid to provider		767, 783		1, 332	1. 00
Services rendered in the cost reporting period. If none, write "MONE" or enter a zero.	2.00			C		0	2.00
write "NONE" or enter a zero 3.00 .00 List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider .01							
List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider							
amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)							
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 3.02 3.03 3.04	3.00						3.00
Dayment. If none, write "NONE" or enter a zero. (1) Program to Provider							
Program to Provider DJUSTMENTS TO PROVIDER 0 0 0 0 3 .01							
ADJUSTMENTS TO PROVIDER							
3.02	3. 01			C		0	3. 01
3.04 0 0 0 3.04 3.05	3.02			C		0	
3.05	3.03			C		0	3. 03
Provider to Program ADJUSTMENTS TO PROGRAM 0	3.04			C		0	3.04
ADJUSTMENTS TO PROGRAM	3.05			C		0	3. 05
3.51					T		
3.52 3.53 3.54 3.50		ADJUSTMENTS TO PROGRAM					
3.53 3.54 0 0 0 3.53 3.54 0 0 0 0 3.53 3.54 0 0 0 0 3.54 3.54 3.59 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) To BE COMPLETED BY CONTRACTOR							
3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) Contractor Number Contr							
Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.09 3.59 3.50-3.98) 767,783 1,332 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 767,783 1,332 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 767,783 1,332 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 767,783 1,332 4.00 Total BE COMPLETED BY CONTRACTOR				-			
3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99) Total interim payments (sum of lines 1, 2, and 3.99) Total interim payments (sum of lines 1, 2, and 3.99) Total interim payments (sum of lines 1, 2, and 3.99) Total interim payments (sum of lines 1, 2, and 3.99) Total interim payments (sum of lines 1, 2, and 3.99) Total Medicare program liability (see instructions) Total Medicare program liability (see linstructions) Total Me		Subtotal (sum of lines 2 01 2 40 minus sum of lines		-		- 1	
Total inferim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) To BE COMPLETED BY CONTRACTOR	3. 77			C			3. 77
Cransfer to Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR	4.00			767. 783		1, 332	4.00
TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider TENTATIVE TO PROVIDER 0 0 0 0 5.02 5.03				,		.,	
5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider							
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider							
Write "NONE" or enter a zero. (1) Program to Provider	5.00						5. 00
Program to Provider							
TENTATI VE TO PROVIDER							
5.02	5 O1						5 O1
Doctor Description Doctor Description Doctor Description D		TENTATIVE TO FROVIDER					
Provider to Program						- 1	
TENTATI VE TO PROGRAM		Provider to Program			II.	_	
5.52 0 0 0 5.52 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVI DER 110,818 9 6.01 6.02 SETTLEMENT TO PROGRAM 0 0 0 6.02 7.00 Total Medicare program liability (see instructions) 878,601 1,341 7.00 Contractor Number (Mo/Day/Yr) 0 1.00 2.00	5.50	TENTATI VE TO PROGRAM		C		0	5. 50
5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 110,818 9 6.01 6.02 SETTLEMENT TO PROGRAM 0 0 0 6.02 7.00 Total Medicare program liability (see instructions) 878,601 1,341 7.00 Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00	5.51			C			5. 51
5.50-5.98 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 110,818 9 6.01 6.02 SETTLEMENT TO PROGRAM 0 0 6.02 7.00 Total Medicare program liability (see instructions) 878,601 1,341 7.00				_		1	
6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 0 1.00 2.00	5. 99			C		0	5. 99
the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr)		1					
6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) SETTLEMENT TO PROGRAM	6.00	` ,					6.00
6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) 878,601 Contractor Number (Mo/Day/Yr) 0 1.00 2.00	6 01			110 010		0	6 01
7.00 Total Medicare program liability (see instructions) 878,601 1,341 7.00 Contractor Number (Mo/Day/Yr) 0 1.00 2.00				•		1	
Contractor Number NPR Date (Mo/Day/Yr) 0 1.00 2.00				-		1	
Number (Mo/Day/Yr) 0 1.00 2.00	00	1.2.2		0,0,001			00
8.00 Name of Contractor 8.00			()	1. 00	2. 00	
	8.00	Name of Contractor					8. 00

Provider CCN: 15-0042 Component CCN: 15-T042 Title XVIII

		Title	XVIII	Subprovi der - I RF	PPS	
		Inpatien	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4.00	
1.00	Total interim payments paid to provider		8, 523, 673		947	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			C		0	3. 03
3. 04			C		0	3. 04
3. 05	Durani dana ta Duranyan		C		0	3. 05
3. 50	Provider to Program ADJUSTMENTS TO PROGRAM		C		0	3. 50
3. 50	ADJUSTIMENTS TO FROGRAM		0			3. 51
3. 52			O		l ől	3. 52
3. 53			Ö		l ol	3. 53
3.54			C)	0	3. 54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		C)	0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		8, 523, 673		947	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropriate) TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after					5. 00
3.00	desk review. Also show date of each payment. If none,					5.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		C		0	5. 01
5.02			C		0	5. 02
5. 03			C		0	5. 03
5. 50	Provider to Program TENTATIVE TO PROGRAM		C		0	5. 50
5. 50	TENTATIVE TO PROGRAM		0			5. 50
5. 52			0			5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5. 99
	5. 50-5. 98)		_			
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		75, 798	1	18	6. 01
6. 02	SETTLEMENT TO PROGRAM		0 500 :7:	1	0	6. 02
7. 00	Total Medicare program liability (see instructions)		8, 599, 471		965 NPR Date	7. 00
				Contractor Number	(Mo/Day/Yr)	
		()	1. 00	2. 00	
8. 00	Name of Contractor			00	2.00	8. 00
				•		

Heal th	Financial Systems GOOD SAMARITAN	I HOSPI TAL	In Lie	u of Form CMS-	2552-10
From 01/01/2021 To 12/31/2021					epared:
		Title XVIII	Hospi tal	PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION	N			
1.00	Total hospital discharges as defined in AARA §4102 from Wkst	. S-3, Pt. I col. 15 line	e 14	i	1. 00
2.00	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, and	8 through 12, and plus f	for cost	ı	2. 00
	reporting periods beginning on or after 10/01/2013, line 32)			ı	
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			ı	3. 00
4.00	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines	1, and 8 through 12, and	d plus for cost	ı	4. 00
	reporting periods beginning on or after 10/01/2013, line 32)			ı	
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			ı	5. 00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3	line 20		ı	6. 00
7.00	CAH only - The reasonable cost incurred for the purchase of	certified HIT technology	Wkst. S-2, Pt. I	ı	7. 00
	line 168			ı	
8.00	Calculation of the HIT incentive payment (see instructions)			ı	8. 00
9.00	Sequestration adjustment amount (see instructions)			ı	9. 00
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			·	30. 00
21 00	Other Adjustment (specify)			1	21 00

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

31.00

32.00

31.00 Other Adjustment (specify)

	IPF		
	PART II - MEDICARE PART A SERVICES - IPF PPS	1.00	
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	846, 795	1.00
2.00	Net IPE PPS Outlier Payments	1, 560	2.00
3.00	Net IPF PPS ECT Payments	3, 982	3.00
4. 00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November	0.00	4. 00
	15, 2004. (see instructions)		
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by	0.00	4. 01
	program or hospital closure, that would not be counted without a temporary cap adjustment under 42		
	CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		
5.00	New Teaching program adjustment. (see instructions)	0.00	5. 00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new	0.00	6. 00
7.00	teaching program" (see instuctions)	2.05	7.00
7. 00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new	3. 95	7. 00
8. 00	teaching program" (see instructions) Intern and resident count for IPF PPS medical education adjustment (see instructions)	3. 95	8. 00
9. 00	Average Daily Census (see instructions)	13. 153425	9.00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0. 144808	
11. 00	Teaching Adjustment (line 1 multiplied by line 10).	122, 623	
12. 00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	974, 960	
13. 00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14. 00	Organ acqui si ti on (DO NOT USE THIS LINE)		14. 00
15. 00	Cost of physicians' services in a teaching hospital (see instructions)	0	15. 00
16.00	Subtotal (see instructions)	974, 960	16. 00
17.00	Primary payer payments	0	17. 00
18.00	Subtotal (line 16 less line 17).	974, 960	18. 00
19. 00	Deducti bl es	118, 644	19. 00
20.00	Subtotal (line 18 minus line 19)	856, 316	
21. 00	Coi nsurance	742	
22. 00	Subtotal (line 20 minus line 21)	855, 574	
23. 00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	34, 088	
24. 00	Adjusted reimbursable bad debts (see instructions)	22, 157	
25. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	25.00
26. 00	Subtotal (sum of lines 22 and 24)	877, 731	
27. 00	Direct graduate medical education payments (see instructions)	0	27. 00
28. 00 29. 00	Other pass through costs (see instructions)	870 0	28. 00 29. 00
30.00	Outlier payments reconciliation OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		30.00
30. 50	Pioneer ACO demonstration payment adjustment (see instructions)		30.50
30. 98	Recovery of accelerated depreciation.		30. 98
30. 99	Demonstration payment adjustment amount before sequestration		30. 99
31. 00	Total amount payable to the provider (see instructions)	878, 601	
31. 01	Sequestration adjustment (see instructions)	0	31. 01
31. 02	Demonstration payment adjustment amount after sequestration	0	31. 02
32. 00	Interim payments	767, 783	
33.00	Tentative settlement (for contractor use only)	0	33. 00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)	110, 818	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	0	35. 00
	§115. 2		
	TO BE COMPLETED BY CONTRACTOR		
50. 00	Original outlier amount from Worksheet E-3, Part II, line 2	1, 560	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52. 00	The rate used to calculate the Time Value of Money	0.00	52. 00
53. 00	Time Value of Money (see instructions)	0	53. 00
00.00	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING BEFORE THE END OF THE COVID-19		00.00
99.00	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.	0. 000000 0. 144808	1
77. U I	Calculated Teaching Adjustment Factor for the current year. (see instructions)	0. 144808	J 79. U I

Health Financial Systems	GOOD SAMARITAN HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0042		Worksheet E-3
		From 01/01/2021	
	Component CCN: 15-T042	To 12/31/2021	Date/Time Prepared:
	1. 4		5/26/2022 9:38 am
	Title XVIII	Subprovi der -	PPS
		I RF	

	IRF		
		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS	1. 00	
1.00	Net Federal PPS Payment (see instructions)	8, 410, 519	1. 00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0. 0412	2. 00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	222, 879	3.00
4.00	Outlier Payments	57, 139	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior	0.00	5. 00
	to November 15, 2004 (see instructions)		
5. 01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412. 424(d)(1)(iii)(F)(1) or (2) (see instructions)	0. 00	5. 01
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new	0.00	7.00
	teaching program" (see instructions)		
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00	8. 0
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9.0
10.00	Average Daily Census (see instructions)	19. 430137	
11. 00 12. 00	Teaching Adjustment Factor (see instructions) Teaching Adjustment (see instructions)	0. 000000 0	11. 00 12. 00
13. 00	Total PPS Payment (see instructions)	8, 690, 537	13. 0
14. 00	Nursing and Allied Health Managed Care payments (see instruction)	0, 070, 337	14. 0
15. 00	Organ acquisition (DO NOT USE THIS LINE)	O	15. 0
16. 00	Cost of physicians' services in a teaching hospital (see instructions)	0	16. 0
17. 00	Subtotal (see instructions)	8, 690, 537	
18. 00	Primary payer payments	0	18. 0
19.00	Subtotal (line 17 less line 18).	8, 690, 537	
20.00	Deducti bl es	63, 736	
21.00	Subtotal (line 19 minus line 20)	8, 626, 801	21.0
22.00	Coinsurance	38, 565	22. 0
23. 00	Subtotal (line 21 minus line 22)	8, 588, 236	
24. 00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	11, 177	
25. 00	Adjusted reimbursable bad debts (see instructions)	7, 265	
26. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	26. 0
27. 00	Subtotal (sum of lines 23 and 25)	8, 595, 501	
28. 00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28. 0
29. 00 30. 00	Other pass through costs (see instructions)	3, 970 0	29. 0 30. 0
31. 00	Outlier payments reconciliation OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31. 0
31. 50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31. 5
31. 98	Recovery of accelerated depreciation.	Ö	31. 9
31. 99	Demonstration payment adjustment amount before sequestration	Ö	31. 9
32. 00	Total amount payable to the provider (see instructions)	8, 599, 471	
32. 01	Sequestration adjustment (see instructions)	0	32. 0
32.02	Demonstration payment adjustment amount after sequestration	0	32. 0
33.00	Interim payments	8, 523, 673	33.0
34.00	Tentative settlement (for contractor use only)	0	34. 0
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	75, 798	35. 0
36. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	36. 0
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	57, 139	50. 0
51. 00	Outlier reconciliation adjustment amount (see instructions)	0	51. 0
52.00	The rate used to calculate the Time Value of Money	0.00	52. 0
53.00	Time Value of Money (see instructions)	0	53. 0
	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING BEFORE THE END OF THE COVID-19	PHE .	
99. 00	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.	0.000000	99. 0
99. 01	Calculated Teaching Adjustment Factor for the current year. (see instructions)	0. 000000	99. 0

Health Financial Systems	GOOD SAMARITAN HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0042	Peri od: Worksheet E-3 From 01/01/2021 Part VII To 12/31/2021 Date/Time Prepared:

			To 12/31/2021	Date/Time Pre 5/26/2022 9:3	
		Title XIX	Hospi tal	Cost	o ani
		TITTE XIX	I npati ent	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVIC	FS FOR TITLES V OR XI		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES	ES TON TITLES TON AL	. 02.1111 020		
1.00	Inpatient hospital/SNF/NF services		1, 127, 605		1. 00
2.00	Medical and other services		, , , , , , , , , , , , , , , , , , , ,	0	2. 00
3.00	Organ acquisition (certified transplant centers only)		o		3. 00
4.00	Subtotal (sum of lines 1, 2 and 3)		1, 127, 605	0	4. 00
5.00	Inpatient primary payer payments		O		5. 00
6.00	Outpatient primary payer payments			0	6. 00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		1, 127, 605	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges				
8.00	Routi ne servi ce charges		694, 518		8. 00
9.00	Ancillary service charges		2, 562, 208	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, 256, 726	0	12. 00
40.00	CUSTOMARY CHARGES				
13. 00	Amount actually collected from patients liable for payment for se	rvices on a charge	0	0	13. 00
14.00	basis	umant for condices on	0	0	14 00
14.00	Amounts that would have been realized from patients liable for pa a charge basis had such payment been made in accordance with 42 C		٩	Ü	14. 00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	rk 9413. 13(e)	0. 000000	0. 000000	15. 00
16. 00	Total customary charges (see instructions)		3, 256, 726	0.000000	16. 00
17. 00	Excess of customary charges over reasonable cost (complete only i	f line 16 exceeds	2, 129, 121	0	17. 00
	line 4) (see instructions)	. This is should	2, 12, 121	Ü	17.00
18. 00	Excess of reasonable cost over customary charges (complete only i	f line 4 exceeds line	o	0	18. 00
	16) (see instructions)				
19.00	Interns and Residents (see instructions)		0	0	19. 00
20.00	Cost of physicians' services in a teaching hospital (see instruct	i ons)	0	0	20. 00
21. 00	Cost of covered services (enter the lesser of line 4 or line 16)		1, 127, 605	0	21. 00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be com	pleted for PPS provid	ers.		
22. 00			0	0	
	Outlier payments		0	0	23. 00
24. 00	Program capital payments		0		24. 00
	Capital exception payments (see instructions)		0		25. 00
	Routine and Ancillary service other pass through costs		0	0	26. 00
	Subtotal (sum of lines 22 through 26)		0	0	27. 00 28. 00
28. 00	Customary charges (title V or XIX PPS covered services only) Titles V or XIX (sum of lines 21 and 27)		1 127 (05	0	28.00
29.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		1, 127, 605	U	29.00
30 00	Excess of reasonable cost (from line 18)		0	0	30. 00
31. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		1, 127, 605	0	31. 00
32. 00	Deductibles		1, 127, 005	0	32. 00
33. 00	Coinsurance		Ö	0	33. 00
	Allowable bad debts (see instructions)		Ö	0	34.00
35. 00	,		o	Ü	35. 00
36. 00			1, 127, 605	0	36. 00
37. 00			0	0	37. 00
38. 00	, , ,		1, 127, 605	0	38. 00
39.00	Direct graduate medical education payments (from Wkst. E-4)		О		39. 00
40.00			1, 127, 605	0	40. 00
41.00			1, 518, 798	0	41. 00
42.00			-391, 193	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 Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0042	Period: From 01/01/2021	Worksheet E-3
	Component CCN: 15-S042		
	Title XIX	Subprovi der -	Cost

		litle XIX	Subprovi der -	Cost	
			IPF Inpatient	Outpati ent	
			1.00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVI	CES END TITLES V ND YLY		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpati ent hospital/SNF/NF services		525, 990		1.00
2. 00	Medical and other services		020, 770	0	
3.00	Organ acquisition (certified transplant centers only)		0	١	3. 00
4. 00	Subtotal (sum of lines 1, 2 and 3)		525, 990	0	1
5. 00	Inpatient primary payer payments		0	- 1	5. 00
6.00	Outpatient primary payer payments			0	
7.00	Subtotal (line 4 less sum of lines 5 and 6)		525, 990	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e Charges]
8.00	Routine service charges		678, 853		8. 00
9.00	Ancillary service charges		146, 397	0	9. 00
10.00	Organ acquisition charges, net of revenue		0	ļ	10. 00
11. 00	Incentive from target amount computation		0	ļ	11. 00
12. 00	Total reasonable charges (sum of lines 8 through 11)		825, 250	0	12. 00
	CUSTOMARY CHARGES				
13. 00	Amount actually collected from patients liable for payment for s	ervices on a charge	0	0	13. 00
44.00	basis				44.00
14. 00	Amounts that would have been realized from patients liable for p	3	0	0	14. 00
15. 00	a charge basis had such payment been made in accordance with 42 Ratio of line 13 to line 14 (not to exceed 1.000000)	CFR 9413. 13(e)	0. 000000	0. 000000	15. 00
16. 00	Total customary charges (see instructions)		825, 250	0.000000	1
17. 00	Excess of customary charges over reasonable cost (complete only	if line 16 eveneds	299, 260	0	1
17.00	line 4) (see instructions)	II Tille 10 exceeds	277, 200	O ₁	17.00
18. 00	Excess of reasonable cost over customary charges (complete only	if line 4 exceeds line	0	0	18. 00
	16) (see instructions)	e r execede rriie		١	10.00
19. 00	Interns and Residents (see instructions)		0	0	19. 00
20.00	Cost of physicians' services in a teaching hospital (see instruc	tions)	0	0	20. 00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		525, 990	0	21. 00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be co	mpleted for PPS provide	rs.		
22. 00	Other than outlier payments		0	0	
23. 00	Outlier payments		0	0	
24. 00	Program capital payments		0	ļ	24. 00
	Capital exception payments (see instructions)		0	ļ	25. 00
26. 00	Routine and Ancillary service other pass through costs		0	0	
	Subtotal (sum of lines 22 through 26)		0	0	
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	
29. 00	, ,		525, 990	0	29. 00
20.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT				20.00
30.00	Excess of reasonable cost (from line 18)		0	0	
31. 00 32. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) Deductibles		525, 990	0	
	Coinsurance		0	0	
34. 00	Allowable bad debts (see instructions)		0	0	
	Utilization review		0	U	35. 00
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 3	3)	525, 990	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	3)	020,770	0	
38. 00	Subtotal (line 36 ± line 37)		525, 990	0	
	Direct graduate medical education payments (from Wkst. E-4)		0	١	39. 00
40. 00	Total amount payable to the provider (sum of lines 38 and 39)		525, 990	0	1
41. 00	Interim payments		349, 128	0	
42. 00	Balance due provider/program (line 40 minus line 41)		176, 862	0	
43.00	Protested amounts (nonallowable cost report items) in accordance	with CMS Pub 15-2,	0	0	1
	chapter 1, §115.2			ļ	

Health Financial Systems	GOOD SAMARITAN HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0042	Peri od: From 01/01/2021	Worksheet E-3
	Component CCN: 15-T042		
	Title XIX	Subprovi der -	Cost

		Title XIX	I RF	COST	
			Inpati ent	Outpati ent	
			1. 00	2. 00	
П	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVI	CES FOR TITLES V OR XIX		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
	Inpatient hospital/SNF/NF services		61, 467		1.0
	Medical and other services		.,	0	
	Organ acquisition (certified transplant centers only)		ol		3.0
	Subtotal (sum of lines 1, 2 and 3)		61, 467	0	
	Inpatient primary payer payments		o		5.0
00	Outpatient primary payer payments			0	6.0
00	Subtotal (line 4 less sum of lines 5 and 6)		61, 467	0	7. (
Ī	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e Charges				
00	Routine service charges		56, 391		8.0
00	Ancillary service charges		69, 940	0	9. 0
00	Organ acquisition charges, net of revenue		0		10.0
	Incentive from target amount computation		0		11. 0
	Total reasonable charges (sum of lines 8 through 11)		126, 331	0	12. (
	CUSTOMARY CHARGES				
	Amount actually collected from patients liable for payment for s	ervices on a charge	0	0	13.0
	basis			0	14. (
	Amounts that would have been realized from patients liable for p		0	0	14.
	a charge basis had such payment been made in accordance with 42 Ratio of line 13 to line 14 (not to exceed 1.000000)	CFR 9413. 13(E)	0. 000000	0. 000000	15.0
	Total customary charges (see instructions)		126, 331	0.000000	1
	Excess of customary charges over reasonable cost (complete only	if line 16 exceeds	64, 864	0	
	line 4) (see instructions)	TT TTHE TO EXCEEDS	04, 004	O	' '
00	Excess of reasonable cost over customary charges (complete only	if line 4 exceeds line	0	0	18.
	16) (see instructions)			_	
00	Interns and Residents (see instructions)		o	0	19.
00	Cost of physicians' services in a teaching hospital (see instruc	tions)	o	0	20.
00	Cost of covered services (enter the lesser of line 4 or line 16)		61, 467	0	21.
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be co	mpleted for PPS provide	rs.		
	Other than outlier payments		0	0	1
	Outlier payments		0	0	1
	Program capital payments		0		24.
	Capital exception payments (see instructions)		0	_	25.
	Routine and Ancillary service other pass through costs		0	0	
	Subtotal (sum of lines 22 through 26)		0	0	1
	Customary charges (title V or XIX PPS covered services only)		0	0	
	Titles V or XIX (sum of lines 21 and 27)		61, 467	0	29.
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	30.
	Excess of reasonable cost (from line 18) Subtate (sum of lines 10 and 20 plus 20 minus lines 5 and 6)		41 447	0	
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) Deductibles		61, 467 0	0	
	Coinsurance		0	0	1
	Allowable bad debts (see instructions)		0	0	
	Utilization review		0	U	35.
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 3	3)	61, 467	0	1
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	3)	01, 407	0	1
	Subtotal (line 36 ± line 37)		61, 467	0	
	Direct graduate medical education payments (from Wkst. E-4)		01, 407	O	39.
	Total amount payable to the provider (sum of lines 38 and 39)		61, 467	0	
- 1	Interim payments		67, 086	0	
	Balance due provider/program (line 40 minus line 41)		-5, 619	0	
00 1			5,017		
	Protested amounts (nonallowable cost report items) in accordance	with CMS Pub 15-2.	l Ol	0	43.

	RADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT EDUCATION COSTS	Provi der Co	CN: 15-0042	Period: From 01/01/2021 To 12/31/2021	Worksheet E-4 Date/Time Prep 5/26/2022 9:38	
		Title	XVIII	Hospi tal	PPS	
					1. 00	
	OMPUTATION OF TOTAL DIRECT GME AMOUNT					
	nweighted resident FTE count for allopathic and osteopathic and noteopathic and osteopathic and osteopathic and osteopathic and are set of the control of th	programs for	cost reporti	ng peri ods	0. 00	1. 00
	nweighted FTE resident cap add-on for new programs per 42 CF	R 413.79(e)(1) (see instr	ructions)	0.00	2. 00
	mount of reduction to Direct GME cap under section 422 of MM.		0.440 70 ()		0.00	3. 0
	irect GME cap reduction amount under ACA §5503 in accordance nstructions for cost reporting periods straddling 7/1/2011)	with 42 CFR	§413.79 (m).	(see	0.00	3. 0
. 00 Ac	djustment (plus or minus) to the FTE cap for allopathic and		programs due	to a Medicare	0. 00	4. 00
	ME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f) CA Section 5503 increase to the Direct GME FTE Cap (see inst		cost roporti	na nori ode	0.00	4. 0
	traddling 7/1/2011)	ructions for	cost reporti	rig per rous	0.00	4. 0
. 02 AC	CA Section 5506 number of additional direct GME FTE cap slot	s (see inst	ructions for	cost reporting	0.00	4. 02
	eriods straddling 7/1/2011) TE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 pl	us or minus	line 4 nlus l	ines 4 01 and	0.00	5. 0
4.	.02 plus applicable subscripts		•		0.00	0.00
	nweighted resident FTE count for allopathic and osteopathic	programs for	the current	year from your	0. 00	6. 00
1	ecords (see instructions) nter the lesser of line 5 or line 6				0. 00	7. 00
			Primary Care		Total	
. 00 We	eighted FTE count for physicians in an allopathic and osteop	athi c	1.00	2. 00	3. 00	8. 0
	rogram for the current year.	attiiC	0. (0.00	0.00	0.0
mι	fline 6 is less than 5 enter the amount from line 8, otherw ultiply line 8 times the result of line 5 divided by the amo		0. (0.00	0. 00	9. 0
6. 0. 00 We	eighted dental and podiatric resident FTE count for the curr	ent vear		0.00		10. 0
0. 01 Ur	nweighted dental and podiatric resident FTE count for the cu	,		0.00		10. 0
	otal weighted FTE count otal weighted resident FTE count for the prior cost reportin	~ voor (ooo	0. (0. (11. 0
	nstructions)	g year (see	0. (0.00		12. 0
	otal weighted resident FTE count for the penultimate cost re	porting	0. (0.00		13. 0
12	ear (see instructions) olling average FTE count (sum of lines 11 through 13 divided	hv 3)	0.0	0.00		14. 0
	djustment for residents in initial years of new programs	29 37.	16.			15. 0
	nweighted adjustment for residents in initial years of new p		16.			15.0
	djustment for residents displaced by program or hospital clo nweighted adjustment for residents displaced by program or h		0. (0. (16. 0 16. 0
cl	losure	00p. ta.		5. 55		
4	djusted rolling average FTE count er resident amount		16. ⁻ 112, 603. (17. 00 18. 00
4	pproved amount for resident costs		1, 821, 92		2, 782, 436	
0 00 40	dditional unweighted allopathic and osteopathic direct GME F	TE resident	can slots red	rei ved under 42	1.00	20. 0
	ec. 413.79(c)(4)	it resident	cap siots rec	Lei veu under 42	0.00	20.00
1	irect GME FTE unweighted resident count over cap (see instru					21. 0
- 1	llowable additional direct GME FTE Resident Count (see instr nter the locality adjustment national average per resident a	,	netructione)		0. 00 0. 00	1
4	ultiply line 22 time line 23	mount (see i	nstructions)		0.00	24. 0
5. 00 To	otal direct GME amount (sum of lines 19 and 24)		l 5		2, 782, 436	25. 00
			Inpatient Pai A	rt Managed Care	Total	
1=-	DARBUTATION OF PROCESS PARTY SATISFACE		1. 00	2.00	3. 00	
5. 00 Tr	OMPUTATION OF PROGRAM PATIENT LOAD npatient Days (see instructions) (Title XIX - see S-2 Part I02, column 2)	X, line	13, 7	3, 041		26. 0
	otal Inpatient Days (see instructions)		28, 62	28 28, 628		27. 0
8. 00 Ra	atio of inpatient days to total inpatient days		0. 48054	0. 106225		28. 0
	rogram direct GME amount ercent reduction for MA DGME		1, 337, 08	83 295, 564 4. 07	1, 632, 647	29. 0 29. 0
					40.000	
	eduction for direct GME payments for Medicare Advantage			12, 029	12, 029	30.00

Heal th	Financial Systems GOOD SAMARITAN	HOSPI TAL	In Lie	u of Form CMS-2	2552-10		
DI RECT	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provider CCN: 15-0042	Peri od:	Worksheet E-4			
MEDI CA	AL EDUCATION COSTS		From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 9:3			
	Title XVIII Hospital P						
				1. 00			
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITL EDUCATION COSTS)	`		OI CAL			
32. 00	Renal dialysis direct medical education costs (from Wkst. B, and 94)	Pt. I, sum of col. 20 an	d 23, lines 74	0	32. 00		
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 (lin	ne 32 ÷ line 33)		0.000000	34.00		
35.00	Medicare outpatient ESRD charges (see instructions)			0	35.00		
36.00	Medicare outpatient ESRD direct medical education costs (line			0	36.00		
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII	ONLY					
	Part A Reasonable Cost						
37. 00				31, 866, 462			
38. 00	1 3			0	38.00		
	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	39.00		
	Primary payer payments (see instructions)			17, 514			
41. 00	Total Part A reasonable cost (sum of lines 37 through 39 minu	ıs line 40)		31, 848, 948	41.00		
	Part B Reasonable Cost			07 (44 47)			
	Reasonable cost (see instructions)			27, 614, 476			
43. 00				4, 165			
44. 00	Total Part B reasonable cost (line 42 minus line 43)			27, 610, 311			
45. 00	1	44 11 45		59, 459, 259			
	Ratio of Part A reasonable cost to total reasonable cost (lin	•		0. 535643			
47.00	Ratio of Part B reasonable cost to total reasonable cost (lin ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PA			0. 464357	47. 00		
40 00	Total program GME payment (line 31)	IN D		1, 620, 618	10 00		
	Part A Medicare GME payment (line 46 x 48) (title XVIII only)	(coo instructions)		868, 073			
	Part B Medicare GME payment (line 47 x 48) (title XVIII only)	,		752, 545			
30.00	Trail b medicale one payment (Time 47 x 40) (title XVIII only)	(SEE THISTI UCTIONS)	ı	75∠, 545	1 30.00		

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

Provider CCN: 15-0042 | Period: | Worksheet G | From 01/01/2021 | To 12/31/2021 | Date/Time Prepared: 5/26/2022 9:38 am

oni y)				12/01/2021	5/26/2022 9:3	8 am
		General Fund		Endowment Fund	Plant Fund	
		1.00	Purpose Fund 2.00	3. 00	4. 00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	34, 182, 458		0	0	1.00
2. 00 3. 00	Temporary investments Notes receivable	0	0	0	0	2. 00 3. 00
4.00	Accounts receivable	73, 699, 005	0	0	0	•
5. 00	Other recei vable	12, 139, 434		0	0	
6.00	Allowances for uncollectible notes and accounts receivable	-45, 492, 511		0	0	6. 00
7.00	Inventory	3, 133, 114		0	0	7. 00
8.00	Prepai d expenses	6, 884, 472		0	0	8. 00
9. 00 10. 00	Other current assets Due from other funds	0	0	0	0	9. 00 10. 00
11. 00	Total current assets (sum of lines 1-10)	84, 545, 972		-	0	11. 00
11.00	FIXED ASSETS	01,010,772		Ψ ₁		11.00
12.00	Land	6, 581, 448	0	0	0	12. 00
13. 00	Land improvements	10, 726, 598		0	0	
14.00	Accumulated depreciation	-7, 274, 356		0	0	•
15. 00 16. 00	Buildings Accumulated depreciation	171, 730, 091 -83, 964, 363		0	0	15. 00 16. 00
17. 00	Leasehold improvements	515, 426		0	0	17. 00
18. 00	Accumulated depreciation	-393, 545		0	0	18. 00
19. 00	Fi xed equipment	110, 533, 749	0	0	0	19. 00
20.00	Accumulated depreciation	-66, 476, 676		0	0	20. 00
21. 00	Automobiles and trucks	0	_	0	0	
22. 00 23. 00	Accumulated depreciation Major movable equipment	114, 069, 574	0	0	0	22. 00 23. 00
24. 00	Accumulated depreciation	-95, 797, 751		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	26. 00
27. 00	HIT designated Assets	0	0	0	0	27. 00
28. 00	Accumulated depreciation	0	0	0	0	28. 00
29. 00 30. 00	Minor equipment-nondepreciable Total fixed assets (sum of lines 12-29)	160, 250, 195	0	0	0	
30.00	OTHER ASSETS	100, 230, 173	0	<u> </u>		30.00
31. 00	Investments	103, 733, 756	0	0	0	31. 00
32. 00	Deposits on Leases	0	0	0	0	32. 00
33. 00	Due from owners/officers	0	0	0	0	33. 00
34.00	Other assets	4, 372, 680		0	0	34.00
35. 00 36. 00	Total other assets (sum of lines 31-34) Total assets (sum of lines 11, 30, and 35)	108, 106, 436 352, 902, 603		-	0	35. 00 36. 00
00.00	CURRENT LIABILITIES	1 002, 702, 000		Ψ		00.00
37. 00	Accounts payable	2, 856, 870	0	0	0	37. 00
38. 00	Salaries, wages, and fees payable	16, 277, 897		0	0	38. 00
39. 00	Payrol I taxes payable	1, 261, 364		0	0	39. 00
40. 00 41. 00	Notes and Loans payable (short term) Deferred income	31, 761, 776 1, 206, 847		0	0	40. 00 41. 00
42. 00	Accel erated payments	1, 200, 047	0	O	O	42. 00
43. 00	Due to other funds	0	0	0	0	•
44.00	Other current liabilities	34, 157	0		0	44. 00
45. 00	Total current liabilities (sum of lines 37 thru 44)	53, 398, 911	0	0	0	45. 00
44 00	LONG TERM LIABILITIES	1 0	1 0	0	0	1 44 00
46. 00 47. 00	Mortgage payable Notes payable	0 106, 013, 119	_	0	0	
48. 00	Unsecured Loans	100,013,117	Ö	0	0	48. 00
49.00	Other long term liabilities	0	0	0	0	49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49)	106, 013, 119		0	0	1
51. 00	Total liabilities (sum of lines 45 and 50)	159, 412, 030	0	0	0	51. 00
E2 00	CAPITAL ACCOUNTS General fund balance	102 400 572				F2 00
52. 00 53. 00	Specific purpose fund	193, 490, 573	0			52. 00 53. 00
54. 00	Donor created - endowment fund balance - restricted		Ĭ	0		54. 00
55. 00	Donor created - endowment fund balance - unrestricted			0		55. 00
56. 00	Governing body created - endowment fund balance			0		56. 00
57. 00	Plant fund balance - invested in plant				0	57. 00
58. 00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58. 00
59. 00	Total fund balances (sum of lines 52 thru 58)	193, 490, 573	0	0	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	352, 902, 603		o	0	60.00
	[59]	1				

STATEMENT OF CHANGES IN FUND BALANCES

sheet (line 11 minus line 18)

Provider CCN: 15-0042

Period: Worksheet G-1 From 01/01/2021

Date/Time Prepared: 5/26/2022 9:38 am 12/31/2021 General Fund Special Purpose Fund Endowment Fund 1.00 3.00 4. 00 5. 00 2 00 1.00 Fund balances at beginning of period 186, 031, 187 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 29) 7, 459, 386 2.00 3.00 Total (sum of line 1 and line 2) 193, 490, 573 0 3.00 4.00 0 Additions (credit adjustments) (specify) 4.00 0 0 0 0 5.00 0 5.00 6.00 6.00 0 7.00 0 7.00 0 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 4-9) 10.00 Subtotal (line 3 plus line 10) 193, 490, 573 0 11.00 11.00 12.00 Deductions (debit adjustments) (specify) 12.00 00000 13.00 13.00 14.00 14.00 0 15.00 0 15.00 16.00 16.00 17.00 17.00 18.00 Total deductions (sum of lines 12-17) 18.00 Fund balance at end of period per balance 193, 490, 573 19.00 19.00 sheet (line 11 minus line 18) Endowment Fund Plant Fund 7. 00 8.00 6. 00 1.00 Fund balances at beginning of period 0 0 1.00 Net income (loss) (from Wkst. G-3, line 29) 2.00 2.00 Total (sum of line 1 and line 2) 3.00 0 0 3.00 4.00 Additions (credit adjustments) (specify) 4.00 5.00 0 5.00 0 6.00 6.00 7.00 0 7 00 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 4-9) 0 10.00 0 11.00 Subtotal (line 3 plus line 10) 0 11.00 12.00 Deductions (debit adjustments) (specify) 12.00 13.00 13.00 14.00 0 14.00 0 15.00 15.00 16.00 16.00 17.00 17.00 Total deductions (sum of lines 12-17) 18.00 18.00 0 0 19.00 Fund balance at end of period per balance 19.00

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

		To	12/31/2021	Date/Time Pre 5/26/2022 9:3	
	Cost Center Description	Inpatient	Outpati ent	Total	o diii
		1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES	<u> </u>			
	General Inpatient Routine Services				
1.00	Hospi tal	23, 239, 756		23, 239, 756	1. 00
2.00	SUBPROVI DER - I PF	9, 003, 731		9, 003, 731	2. 00
3.00	SUBPROVI DER - I RF	8, 072, 321		8, 072, 321	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				9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	40, 315, 808		40, 315, 808	10. 00
	Intensive Care Type Inpatient Hospital Services				
11. 00	INTENSIVE CARE UNIT	15, 051, 098		15, 051, 098	
12. 00	CORONARY CARE UNIT				12. 00
13. 00	BURN INTENSIVE CARE UNIT				13. 00
14. 00	SURGICAL INTENSIVE CARE UNIT				14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)				15. 00
16. 00	Total intensive care type inpatient hospital services (sum of lines	15, 051, 098		15, 051, 098	16. 00
47.00	[11-15]	55 044 004		FF 0// 00/	47.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	55, 366, 906		55, 366, 906	17. 00
18.00	Ancillary services	130, 086, 047	402, 434, 994	532, 521, 041	18. 00
19. 00	Outpati ent servi ces	10, 819, 597	49, 017, 388	59, 836, 985	
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21. 00
22. 00	HOME HEALTH AGENCY		O ₁	0	22. 00
23. 00	AMBULANCE SERVICES				23. 00
24. 00	CMHC				24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)		2 022 004	2 022 004	25. 00
26. 00	HOSPICE	0	2, 023, 096		
27. 00	DME	0	407, 736	407, 736	
27. 01 27. 02	PHYSICIAN OFFICE PROFESSIONAL FEES	2 071 445	759, 600	759, 600	27. 01 27. 02
	DI ETARY REVENUE	2, 971, 465	6, 140, 792 592, 822	9, 112, 257 592, 822	27. 02
27. 03 27. 04	GSPN IM RESDNT FACULTY PRACTIC	0	392, 022	0 392, 622	27. 03
27. 04	ADMIN	0	0	0	27. 04
27. 05	PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0	0	27. 05
27. 07	PRO FEES		0	0	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	199, 244, 015	461, 376, 428		28. 00
20.00	G-3, line 1)	177, 244, 013	401, 370, 420	000, 020, 443	20.00
	PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		254, 017, 975		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)		o		36. 00
37. 00	DEDUCT (SPECIFY)	0	Ĭ		37. 00
38. 00		0			38. 00
39. 00		0			39. 00
40. 00					40. 00
41. 00		0			41. 00
42. 00	Total deductions (sum of lines 37-41)		o		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer		254, 017, 975		43. 00
	to Wkst. G-3, line 4)		, , . , . ,		
	·		'		

	Financial Systems GOOD SAMARITAN			u of Form CMS-2	
STATE	IENT OF REVENUES AND EXPENSES	Provider CCN: 15-0042	Peri od:	Worksheet G-3	
			From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 9:3	
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, li	ne 28)		660, 620, 443	1. 00
2.00	Less contractual allowances and discounts on patients' accounts			427, 721, 142	2.00
3.00	Net patient revenues (line 1 minus line 2)			232, 899, 301	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		254, 017, 975	4. 00
5.00	Net income from service to patients (line 3 minus line 4)			-21, 118, 674	5. 00
	OTHER I NCOME				
6.00	Contributions, donations, bequests, etc			0	6.00
7.00	Income from investments			0	7. 00
8.00	Revenues from telephone and other miscellaneous communication	n servi ces		0	8. 00
9.00	Revenue from television and radio service	0	9. 00		
10.00	Purchase di scounts			0	
11. 00	Rebates and refunds of expenses			0	11. 00
12.00	Parking Lot receipts			0	
13.00	Revenue from Laundry and Linen service			0	13. 00
14.00	Revenue from meals sold to employees and guests			0	
15.00	Revenue from rental of living quarters			0	15. 00
16.00	Revenue from sale of medical and surgical supplies to other	than patients		0	
17.00	Revenue from sale of drugs to other than patients			0	17. 00
18.00	Revenue from sale of medical records and abstracts			0	
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	
21. 00	Rental of vending machines			0	
22. 00	Rental of hospital space			0	
23. 00	Governmental appropriations			6, 211, 140	
24.00	OTHER OPERATING INCOME			6, 169, 579	24. 00
24. 01	INTEREST INCOME AND DISTRIBUTIONS			5, 370, 168	24. 01
24. 02	OTHER I NCOME			2, 635, 176	
24. 03	OTHER NONOPERATING INCOME			2, 132, 422	
24.04	UNREALIZED GAIN/LOSS ON INVESTMENTS			2, 549, 672	24. 04
24. 05	OTHER INCOME AND EXPENSE			0	
24. 06	OTHER INCOME AND EXPENSE			0	
24.50	COVI D-19 PHF Fundi na			3, 509, 903	24.50

3, 509, 903 24. 50 28, 578, 060 25. 00 7, 459, 386 26. 00 0 27. 00 28 00

0 28.00 7, 459, 386 29.00

COVID-19 PHE Funding

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

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

Health Financial Systems
ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS Provider CCN: 15-0042 Peri od: Worksheet 0 From 01/01/2021 To 12/31/2021 Date/Time Prepared: 5/26/2022 9:38 am Hospi ce CCN: 15-1526

						3/20/2022 9.3	o am
		041.451.50	071155	loupzoza, ()	Hospi ce I	OURTOTAL	
		SALARI ES	OTHER	SUBTOTAL (col.	RECLASSIFI -	SUBTOTAL	
		1.00		1 plus col. 2)	CATIONS		
	Tanana	1.00	2. 00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS			1			
1.00	CAP REL COSTS-BLDG & FLXT*		0	0	0	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP*		0	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	0	0	0	3.00
4.00	ADMINISTRATIVE & GENERAL*	61, 856	255, 807	317, 663	-114, 362	203, 301	4.00
5.00	PLANT OPERATION & MAINTENANCE*		3, 224	1	0	3, 224	5. 00
6. 00	LAUNDRY & LINEN SERVICE*	0	0,	0	0	0,	6. 00
7. 00	HOUSEKEEPI NG*		0		0	0	7. 00
8. 00	DI ETARY*		0		0	0	8.00
9. 00	NURSING ADMINISTRATION*		0		0	0	9.00
			0 500	0 500	0		ł
10.00	ROUTINE MEDICAL SUPPLIES*	0	2, 590	2, 590	0	2, 590	10.00
11. 00	MEDI CAL RECORDS*	0	0	l o	0	0	11. 00
12. 00	STAFF TRANSPORTATION*	0	0	이	0	0	12. 00
13. 00	VOLUNTEER SERVICE COORDINATION*	0	0	0	0	0	13. 00
14.00	PHARMACY*	0	27	27	0	27	14. 00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	0	0	0	15. 00
16.00	OTHER GENERAL SERVICE*	o	0	ol ol	0	0	16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES						17. 00
.,, 00	DIRECT PATIENT CARE SERVICE COST CENTERS						
25. 00	INPATIENT CARE-CONTRACTED**		0	o	0	0	25. 00
26. 00	PHYSI CI AN SERVI CES**	18, 086	24, 777		0	42, 863	26.00
27. 00	NURSE PRACTITIONER**	1	24, 111	11, 419	0		27. 00
	REGISTERED NURSE**	11, 419	0	1	0	11, 419	1
28. 00		196, 929	0	196, 929	0	196, 929	28. 00
29. 00	LPN/LVN**	0	0	9	0	0	29. 00
30. 00	PHYSI CAL THERAPY**	0	0	0	0	0	30.00
31. 00	OCCUPATIONAL THERAPY**	0	0	이	0	0	31. 00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	0	32. 00
33. 00	MEDICAL SOCIAL SERVICES**	88, 323	0	88, 323	0	88, 323	33. 00
34.00	SPIRITUAL COUNSELING**	0	0	0	0	0	34.00
35.00	DI ETARY COUNSELI NG**	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER**	o	0	ol ol	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	41, 440	0	41, 440	0	41, 440	37.00
38. 00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	0	0	0	38. 00
39. 00	PATIENT TRANSPORTATION**		0		0	Ö	39. 00
40. 00	IMAGING SERVICES**		0		0	0	40.00
	LABS & DI AGNOSTI CS**		0		0	0	ł
41. 00		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 PATI ENTS**	0	0	l o	0	0	42. 50
43. 00	OUTPATIENT SERVICES**	0	0	이	0	0	43. 00
44. 00	PALLIATIVE RADIATION THERAPY**	0	0	0	0	0	44. 00
45. 00	PALLIATIVE CHEMOTHERAPY**	0	0	0	0	0	45. 00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY) **	30, 647	0	30, 647	0	30, 647	46. 00
	NONREI MBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM *	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM *	l ol	0	l ol	0	0	61.00
62. 00	FUNDRAI SI NG*	0	0	o	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
	OTHER PHYSICIAN SERVICES*		0	Ö	0	0	65.00
			0		0	0	1
66.00	RESI DENTI AL CARE*	0	0	0	0		66.00
67. 00	ADVERTI SI NG*	0	0	9	0	0	67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG*	0	0	미	0	0	68. 00
	THRI FT STORE*	0	0	0	0	0	69. 00
70. 00	NURSING FACILITY ROOM & BOARD*	0	0	0	0	0	70. 00
	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	0	0	0	71. 00
100.00	TOTAL	448, 700	286, 425	735, 125	-114, 362	620, 763	100. 00
* Tran	sfer the amounts in column 7 to Wkst. 0-5, co	lumn 1 line as	annronri ate				

^{*} 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.

				Hospi ce I	
		ADJUSTMENTS	TOTAL (col. 5		
			± col. 6)		
	T	6. 00	7. 00		
	GENERAL SERVICE COST CENTERS	1			
1.00	CAP REL COSTS-BLDG & FIXT*	0	1	1	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	0		2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0		3.00
4.00	ADMINISTRATIVE & GENERAL*	0	203, 301		4. 00
5. 00	PLANT OPERATION & MAINTENANCE*	0	3, 224		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	NURSING ADMINISTRATION*	0	0		9. 00
10. 00	ROUTINE MEDICAL SUPPLIES*	0	2, 590		10.00
11. 00	MEDI CAL 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	27		14. 00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0		15. 00
16.00	OTHER GENERAL SERVICE*	0	0		16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES				17. 00
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25. 00	INPATIENT CARE-CONTRACTED**	0	0		25. 00
26. 00	PHYSI CI AN SERVI CES**	0	42, 863		26. 00
27. 00	NURSE PRACTITIONER**	0	11, 419		27. 00
28. 00	REGI STERED NURSE**	0	196, 929		28. 00
29. 00	LPN/LVN**	0	0		29. 00
30.00	PHYSI CAL THERAPY**	0	0		30.00
31.00	OCCUPATIONAL THERAPY**	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES**	0	88, 323		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	41, 440		37. 00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0		38.00
39.00	PATI ENT TRANSPORTATION**	0	0		39.00
40.00	I MAGING SERVI CES**	0	0		40.00
41.00	LABS & DIAGNOSTICS**	0	0		41. 00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0		42. 00
42.50	DRUGS CHARGED TO PATIENTS**	0	o		42. 50
43.00	OUTPATIENT SERVICES**	0	o		43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0		44. 00
45.00	PALLIATIVE CHEMOTHERAPY**	0	o		45. 00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	30, 647		46. 00
	NONREI MBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM *	0	0		60.00
61.00	VOLUNTEER PROGRAM *	0	0		61.00
62.00	FUNDRAI SI NG*	0	0		62. 00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0		63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0		64. 00
65.00	OTHER PHYSICIAN SERVICES*	0	0		65. 00
66.00	RESI DENTI AL CARE*	0	0		66. 00
67.00	ADVERTI SI NG*	0	0		67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG*	0	0		68. 00
69. 00	THRI FT STORE*	0	o		69. 00
70.00	NURSING FACILITY ROOM & BOARD*	0	o		70. 00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)*	0	o		71. 00
	TOTAL	0	620, 763		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.

Peri od: From 01/01/2021 To 12/31/2021 Date/Time Prepared: 5/26/2022 9:38 am Hospi ce CCN: 15-1526

					Hospi ce I		
	·	SALARI ES	OTHER	SUBTOTAL (col.	RECLASSIFI -	SUBTOTAL	
				1 + col . 2)	CATI ONS		
		1.00	2. 00	3.00	4. 00	5. 00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	I NPATI ENT CARE-CONTRACTED						25. 00
26.00	PHYSI CI AN SERVI CES	16, 435	0	16, 435	0	16, 435	26. 00
27.00	NURSE PRACTITIONER	10, 376	0	10, 376	0	10, 376	27. 00
28.00	REGI STERED NURSE	178, 946	0	178, 946	0	178, 946	28. 00
29. 00	LPN/LVN	0	0	0	0	0	29. 00
30.00	PHYSI CAL THERAPY	0	0	0	0	0	30. 00
31.00	OCCUPATI ONAL THERAPY	0	0	0	0	0	31. 00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32. 00
33.00	MEDICAL SOCIAL SERVICES	80, 258	0	80, 258	0	80, 258	33. 00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DI ETARY COUNSELING	0	0	0	0	0	35. 00
36.00	COUNSELING - OTHER	0	0	0	0	0	36. 00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	37, 656	0	37, 656	0	37, 656	37. 00
38. 00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38. 00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39. 00
40.00	I MAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42. 50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44. 00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45. 00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	27, 849	0	27, 849	o	27, 849	46. 00
100.00	TOTAL *	351, 520	0	351, 520	0	351, 520	100.00

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

		ADJUSTMENTS	TOTAL (col. 5		
		ADSOSTMENTS	± col. 6)		
		6. 00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	I NPATI ENT CARE-CONTRACTED				25.00
26.00	PHYSI CI AN SERVI CES	0	16, 435		26.00
27. 00	NURSE PRACTITIONER	0	10, 376		27. 00
28. 00	REGI STERED NURSE	0	178, 946		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	80, 258		33.00
34.00	SPIRITUAL COUNSELING	0	0		34.00
35.00	DIETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	37, 656		37.00
38. 00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38. 00
39. 00	PATI ENT TRANSPORTATION	0	0		39. 00
40.00	I MAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0		42.00
42. 50	DRUGS CHARGED TO PATIENTS	0	0		42. 50
43.00	OUTPATI ENT SERVI CES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLI ATI VE CHEMOTHERAPY	0	0		45.00
	OTHER PATIENT CARE SERVICES (SPECIFY)	0	27, 849		46.00
100.00	TOTAL *	0	351, 520	1	00.00

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

Peri od: Worksheet 0-3

Provider CCN: 15-0042 From 01/01/2021 To 12/31/2021 RESPITE CARE Date/Time Prepared: 5/26/2022 9:38 am Hospi ce CCN: 15-1526 Hospi ce I

					Hospice I		
		SALARI ES	OTHER	SUBTOTAL (col.	RECLASSIFI -	SUBTOTAL	
				1 + col . 2)	CATI ONS		
		1.00	2.00	3. 00	4. 00	5. 00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25. 00	INPATIENT CARE-CONTRACTED		C	0	0	0	25. 00
26. 00	PHYSI CI AN SERVI CES	53	C	53	0	53	26. 00
27. 00	NURSE PRACTITIONER	34	C	34	0	34	27. 00
28. 00	REGI STERED NURSE	580	C	580	0	580	28. 00
29. 00	LPN/LVN	0	C	0	0	0	29. 00
30.00	PHYSI CAL THERAPY	0	C	0	0	0	30.00
31.00	OCCUPATI ONAL THERAPY	0	C	0	0	0	31. 00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	C	0	0	0	32. 00
33.00	MEDICAL SOCIAL SERVICES	260	C	260	0	260	33. 00
34.00	SPIRITUAL COUNSELING	0	C	0	0	0	34.00
35.00	DI ETARY COUNSELING	0	C	0	0	0	35.00
36.00	COUNSELING - OTHER	0	C	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	122	C	122	0	122	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	C	0	0	0	38. 00
39.00	PATIENT TRANSPORTATION	0	C	0	0	0	39. 00
40.00	I MAGING SERVICES	0	C	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	C	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	C	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	C	0	0	0	42. 50
43.00	OUTPATIENT SERVICES	0	C	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	C	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	C	0	o	0	45. 00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	90	C	90	o	90	46. 00
100.00	TOTAL *	1, 139	C	1, 139	o	1, 139	100.00
* Tran	sfer the amount in column 7 to Wkst. 0-5, col	umn 1, line 52.					

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

Transfer the amount in Corumn 7 to wast. 0-3, Corumn 1, 11he 32.							
		ADJUSTMENTS	TOTAL (col. 5				
			± col. 6)				
		6. 00	7. 00				
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25. 00	I NPATIENT CARE-CONTRACTED	0	0				
26. 00	PHYSI CI AN SERVI CES	0	53	· · · · · · · · · · · · · · · · · · ·			
27. 00	NURSE PRACTITIONER	0	34	l			
28. 00	REGI STERED NURSE	0	580	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	260	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	122	37.00			
38. 00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00			
39.00	PATI ENT TRANSPORTATION	0	0	39.00			
40.00	I MAGI NG SERVI CES	0	0	40.00			
41.00	LABS & DIAGNOSTICS	0	0	41.00			
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	42.00			
42.50	DRUGS CHARGED TO PATIENTS	0	0	42. 50			
43.00	OUTPATIENT SERVICES	0	0	43.00			
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00			
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45. 00			
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	90	46.00			
100.00	TOTAL *	0	1, 139	100. 00			
	6 11 1 7 1 11 0 5 1	4 11 50					

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

Hospi ce CCN: 15-1526 Peri od: Worksheet 0-4 From 01/01/2021 12/31/2021 To Date/Time Prepared:

5/26/2022 9:38 am Hospi ce I SUBTOTAL (col SALARI ES OTHER RECLASSI FI -SUBTOTAL 1 + col. CATI ONS 2) 1.00 2.00 5. 00 3 00 4 00 DIRECT PATIENT CARE SERVICE COST CENTERS 25.00 INPATIENT CARE-CONTRACTED 0 25.00 0 PHYSICIAN SERVICES 26.00 1,598 24.777 26, 375 26, 375 26, 00 1, 009 1, 009 NURSE PRACTITIONER 27.00 1, 009 27.00 0 28.00 REGISTERED NURSE 17, 403 0 17, 403 17, 403 28.00 29.00 LPN/LVN 29.00 30.00 PHYSI CAL THERAPY 0 0 0 30.00 0 OCCUPATIONAL THERAPY 0 31.00 0 0 0 31.00 32.00 SPEECH/LANGUAGE PATHOLOGY 32.00 33.00 MEDICAL SOCIAL SERVICES 7,805 7,805 7,805 33.00 SPIRITUAL COUNSELING 34.00 0 0 0 0 34.00 35.00 DIETARY COUNSELING 0 0 0 35.00 36.00 COUNSELING - OTHER 36.00 HOSPICE AIDE & HOMEMAKER SERVICES 37.00 37.00 3.662 3,662 3,662 38.00 DURABLE MEDICAL EQUIPMENT/OXYGEN 0 38.00 0 0 0 39. 00 PATIENT TRANSPORTATION 0 0 0 39.00 40.00 I MAGING SERVICES 0 40.00 0 LABS & DIAGNOSTICS 0000 0 0 41.00 0 41.00 MEDICAL SUPPLIES-NON-ROUTINE 0 0 42.00 0 42.00 42.50 DRUGS CHARGED TO PATIENTS 42.50 OUTPATIENT SERVICES 0 0 43.00 0 43.00 PALLIATIVE RADIATION THERAPY 44.00 C 0 0 44.00 45.00 PALLIATIVE CHEMOTHERAPY 0 C 0 0 45.00 46.00 OTHER PATIENT CARE SERVICES (SPECIFY) 2,708 2,708 0 2,708 46.00 100.00 TOTAL * 24, 777 58, 962 100. 00 58, 962 34, 185

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

		ADJUSTMENTS	TOTAL (col. 5	
			± col. 6)	
		6. 00	7.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25. 00	INPATIENT CARE-CONTRACTED	0	0	25. 00
26.00	PHYSI CI AN SERVI CES	0	26, 375	26. 00
27. 00	NURSE PRACTITIONER	0	1, 009	27. 00
28. 00	REGI STERED NURSE	0	17, 403	28. 00
29. 00	LPN/LVN	0	0	29. 00
30.00	PHYSI CAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	7, 805	33. 00
34.00	SPIRITUAL COUNSELING	0	o	34.00
35.00	DI ETARY COUNSELING	0	o	35. 00
36.00	COUNSELING - OTHER	0	o	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	3, 662	37. 00
38. 00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	o	38. 00
39.00	PATIENT TRANSPORTATION	0	o	39.00
40.00	I MAGING SERVICES	0	o	40.00
41.00	LABS & DIAGNOSTICS	0	o	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	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	PALLI ATI VE CHEMOTHERAPY	0	o	45. 00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	2, 708	46.00
100.00	TOTAL *	0	58, 962	100.00

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

Heal th	Financial Systems GOOD SAMARITAN	N HOSPITAL		In Lie	eu of Form CMS-2	2552-10
	LLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET	Provi der Co	CN: 15-0042	Peri od:	Worksheet 0-5	
	ES FOR ALLOCATION			From 01/01/2021		
		Hospi ce CCI	N: 15-1526	To 12/31/2021	Date/Time Pre	
					5/26/2022 9: 3	8 am
	D		LIOCOL CE DI DEC	Hospi ce I	TOTAL EVDENCES	
	Descriptions		HOSPICE DIRECT EXPENSES (see		TOTAL EXPENSES (sum of cols.	
			instructions		1 + 2)	
			THIS LI UC LI OHS,	WKST B PART I	1 + 2)	
				(see		
				instructions)		
			1.00	2. 00	3. 00	
	GENERAL SERVICE COST CENTERS		1.00	2.00	3.00	
1.00	CAP REL COSTS-BLDG & FLXT			0 115, 196	115, 196	1. 00
2. 00	CAP REL COSTS-MVBLE EQUIP			0 523		2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT			0 155, 644		3. 00
4. 00	ADMINISTRATIVE & GENERAL		203, 30			4. 00
5. 00	PLANT OPERATION & MAINTENANCE		3, 22			5. 00
6. 00	LAUNDRY & LINEN SERVICE		•	0 117, 780	0	6. 00
7. 00	HOUSEKEEPI NG			0 49, 060		7. 00
8. 00	DIETARY			0 47,000	47,000	8. 00
9. 00	NURSING ADMINISTRATION			0 97, 472	-	9. 00
10. 00	ROUTINE MEDICAL SUPPLIES		2, 59			10.00
11. 00	MEDI CAL RECORDS		1	0 737	3, 327	11. 00
12. 00	STAFF TRANSPORTATION		1	0	0	12. 00
13. 00	VOLUNTEER SERVICE COORDINATION			0		13. 00
14. 00	PHARMACY		2	-	34	14. 00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES		1	o '	0	15. 00
16. 00	OTHER GENERAL SERVICE			o o		16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES			0	0	17. 00
17.00	LEVEL OF CARE				0	17.00
50.00	HOSPICE CONTINUOUS HOME CARE		1	ol	0	50.00
51. 00	HOSPI CE ROUTI NE HOME CARE		351, 52		351, 520	
52. 00	HOSPICE INPATIENT RESPITE CARE		1, 13		1, 139	52. 00
53. 00	HOSPICE GENERAL INPATIENT CARE		58, 96		58, 962	
00.00	NONREI MBURSABLE COST CENTERS		1 00, 70	_	00, 702	00.00
60.00	BEREAVEMENT PROGRAM			ol	0	60. 00
61. 00	VOLUNTEER PROGRAM		1	o	0	61. 00
62. 00	FUNDRAI SI NG		1	Ö	0	62.00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			Ö	0	63. 00
64. 00	PALLIATIVE CARE PROGRAM			Ö	0	64. 00
65. 00	OTHER PHYSI CI AN SERVI CES		1	o	0	65. 00
44.00	DECLERATION SERVICES		1	-	1	44.00

66. 00 67. 00

68. 00

0 69.00 0 70.00

0 71.00

99. 00

1, 248, 930 100. 00

628, 167

620, 763

66. 00 RESI DENTI AL CARE 67. 00 ADVERTI SI NG

100. 00 TOTAL

68. 00 | TELEHEALTH/TELEMONI TORI NG

69. 00 THRIFT STORE
70. 00 NURSING FACILITY ROOM & BOARD

71. 00 OTHER NONREIMBURSABLE (SPECIFY)
99. 00 NEGATIVE COST CENTER

Health Financial Systems GOOD SAMARITAN HOSPITAL In Lieu of Form CMS-2552-							2552-10
COST A	ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE	RVICE COSTS	Provi der Co	CN: 15-0042	Peri od:	Worksheet 0-6	
					From 01/01/2021	Part I	
			Hospi ce CCI	N: 15-1526	To 12/31/2021	Date/Time Pre	pared:
			·			5/26/2022 9: 3	8 am
					Hospi ce I		
	Descriptions	TOTAL EXPENSES CA	AP REL BLDG &	CAP REL MVBL	E EMPLOYEE	SUBTOTAL	
			FIX	FOUL P	BENEFITS		
			117	2011	DEPARTMENT		
		0	1.00	2.00	3. 00	3A	
	CENEDAL CEDVICE COST CENTERS	0	1.00	2.00	3.00	3A	
	GENERAL SERVICE COST CENTERS	1 4 5 4 9 1	445 407				
1. 00	CAP REL COSTS-BLDG & FIXT	115, 196	115, 196				1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	523		5	23		2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT	155, 644	0		0 155, 644		3. 00
4.00	ADMINISTRATIVE & GENERAL	294, 847	0		0 0	294, 847	4. 00
5.00	PLANT OPERATION & MAINTENANCE	121, 204	0		0	121, 204	5. 00
6. 00	LAUNDRY & LINEN SERVICE	0	0			0	6. 00
7. 00	HOUSEKEEPI NG	49, 060	0			49, 060	7. 00
		49,000	0		0		
8. 00	DI ETARY	0	0		0	0	8. 00
9. 00	NURSING ADMINISTRATION	97, 472	0		0	97, 472	9. 00
10. 00	ROUTINE MEDICAL SUPPLIES	3, 329	0		0	3, 329	10. 00
11. 00	MEDI CAL RECORDS	0	0		0	0	11. 00
12.00	STAFF TRANSPORTATION	0	0		0 0	0	12. 00
13.00	VOLUNTEER SERVICE COORDINATION	l ol	0		0 0	0	13. 00
14. 00	PHARMACY	34	0		0	34	
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	0.	0			0	15. 00
16. 00	OTHER GENERAL SERVICE		0		0 0	0	16.00
		٩	0		0	0	
17. 00	PATIENT/RESIDENTIAL CARE SERVICES		0		<u>U</u>	U	17. 00
	LEVEL OF CARE			Т			
50. 00	HOSPICE CONTINUOUS HOME CARE	0			0	0	50. 00
51. 00	HOSPICE ROUTINE HOME CARE	351, 520			144, 777	496, 297	51. 00
52.00	HOSPICE INPATIENT RESPITE CARE	1, 139	2, 078		9 196	3, 422	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	58, 962	113, 118	5	14 10, 671	183, 265	53.00
	NONREI MBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0		0 0	0	60.00
61. 00	VOLUNTEER PROGRAM	0	0		0 0	0	61.00
62. 00	FUNDRAI SI NG		0			0	62. 00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0			0	63. 00
			0		0	_	
64. 00	PALLIATIVE CARE PROGRAM	0	0		0	0	64. 00
65. 00	OTHER PHYSICIAN SERVICES	0	0		0	0	65. 00
66. 00	RESI DENTI AL CARE	0	0		0	0	66. 00
67.00	ADVERTI SI NG	0	0		0	0	67. 00
68.00	TELEHEALTH/TELEMONI TORI NG	0	0		0 0	0	68. 00
69. 00	THRI FT STORE	o	0		0 0	0	69. 00
70. 00	NURSING FACILITY ROOM & BOARD		_			0	70. 00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)	١	0		0 0	0	71.00
99. 00	NEGATIVE COST CENTER		0		0 0	U	99. 00
	TOTAL	1, 248, 930	115, 196	_	23 155, 644	1, 248, 930	
100.00	אַ ועותב	1, 240, 930	110, 190	l 2	دی این, 044	1, 240, 930	100.00

	Trianciai Systems	GOOD SAWARTTA				d of Form CW3-	
COSTA	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE	RVICE COSIS	Provi der C	CN: 15-0042	Period: From 01/01/2021	Worksheet 0-6)
			Hospi ce CC	N: 15-1526	To 12/31/2021	Part I Date/Time Pre	nared.
			nospi ce co	10. 15 1520	10 12/31/2021	5/26/2022 9: 3	is am
					Hospi ce I	0, 20, 2022	
	Descriptions	ADMI NI STRATI VE	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	OPERATION &	LINEN SERVIC			
			MAI NTENANCE				
		4.00	5. 00	6.00	7. 00	8. 00	
	GENERAL SERVICE COST CENTERS	<u>'</u>					
1.00	CAP REL COSTS-BLDG & FLXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4. 00	ADMINISTRATIVE & GENERAL	294, 847					4. 00
5. 00	PLANT OPERATION & MAINTENANCE	37, 457	158, 661				5. 00
6.00	LAUNDRY & LINEN SERVICE	0,, 10,	100, 001		0		6.00
7. 00	HOUSEKEEPI NG	15, 161	0		64, 221		7. 00
8. 00	DI ETARY	13, 101	0		04, 221	0	
9. 00	NURSING ADMINISTRATION	30, 122	0		0	Į	9. 00
10. 00	ROUTINE MEDICAL SUPPLIES	1, 029	0		0		10.00
11. 00	MEDICAL RECORDS	1,027	0				11.00
12. 00	STAFF TRANSPORTATION	0	0		0		12.00
13. 00	VOLUNTEER SERVICE COORDINATION		0		0		13.00
14. 00	PHARMACY	11	0		0		14.00
			0		0		15. 00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0		1
	OTHER GENERAL SERVICE	0	U	()	0		16.00
17. 00		<u> </u>	U	η			17. 00
F0 00	LEVEL OF CARE	1 0		1			
50.00	HOSPICE CONTINUOUS HOME CARE	0					50.00
51.00	HOSPICE ROUTINE HOME CARE	153, 373					51.00
52.00	HOSPICE INPATIENT RESPITE CARE	1, 058	2, 862		0 1, 159	l .	
53. 00	HOSPICE GENERAL INPATIENT CARE	56, 636	155, 799	9	0 63, 062	0	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	0	66. 00
67.00	ADVERTI SI NG	0	0		0		67. 00
68.00	TELEHEALTH/TELEMONI TORI NG	0	0		0		68. 00
69. 00	THRI FT STORE	0	0)	0		69. 00
70.00	NURSING FACILITY ROOM & BOARD						70. 00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0		0 0	0	71. 00
99. 00	NEGATIVE COST CENTER		0		0 0	0	99. 00
100.00	TOTAL	294, 847	158, 661		0 64, 221	0	100.00
	•			•	*		•

Heal th	Financial Systems	GOOD SAMARITAN	I HOSPI TAL		In Lieu of Form CMS-2552-10			
	ALLOCATION - HOSPITAL-BASED HOSPICE GENERA	L SERVICE COSTS	Provi der CC	CN: 15-0042	Peri od:	Worksheet 0-6		
				15 1527	From 01/01/2021	Part I		
			Hospi ce CCN	N: 15-1526	To 12/31/2021	Date/Time Pre 5/26/2022 9:3	pared: 8 am	
					Hospi ce I	0,20,2022 7.0	o am	
	Descriptions	NURSI NG	ROUTI NE	MEDI CAL	STAFF	VOLUNTEER		
	'	ADMINI STRATION	MEDI CAL	RECORDS	TRANSPORTATI ON	SERVI CE		
			SUPPLI ES			COORDI NATI ON		
		9. 00	10.00	11. 00	12.00	13. 00		
	GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FLXT						1. 00	
2.00	CAP REL COSTS-MVBLE EQUIP						2. 00	
3.00	EMPLOYEE BENEFITS DEPARTMENT						3. 00	
4.00	ADMINISTRATIVE & GENERAL						4. 00	
5.00	PLANT OPERATION & MAINTENANCE						5. 00	
6.00	LAUNDRY & LINEN SERVICE						6. 00	
7.00	HOUSEKEEPING						7. 00	
8.00	DI ETARY						8. 00	
9.00	NURSI NG ADMI NI STRATI ON	127, 594					9. 00	
10.00	ROUTINE MEDICAL SUPPLIES	0	4, 358				10. 00	
11. 00	MEDI CAL RECORDS	0			0		11. 00	
12. 00	STAFF TRANSPORTATION	0			0		12.00	
13. 00	VOLUNTEER SERVICE COORDINATION	0			0	0	13. 00	
14. 00	PHARMACY	0			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						17. 00	
	LEVEL OF CARE		ام	ı	ما ما			
50.00	HOSPICE CONTINUOUS HOME CARE	0	0		0 0	0	50.00	
51.00	HOSPICE ROUTINE HOME CARE	118, 683	3, 960		0 0	0	51.00	
52. 00	HOSPICE INPATIENT RESPITE CARE	164	13		0 0	0	52. 00	
53. 00	HOSPICE GENERAL INPATIENT CARE	8, 747	385		0 0	0	53. 00	
(0.00	NONREI MBURSABLE COST CENTERS BEREAVEMENT PROGRAM	0			0		(0.00	
60.00		0			0	0	60.00	
61.00	VOLUNTEER PROGRAM				0	0	61.00	
62. 00	FUNDRAL SI NG				0	0	62.00	
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS				0		63.00	
64. 00 65. 00	PALLIATIVE CARE PROGRAM	0			0	0	64. 00 65. 00	
	OTHER PHYSICIAN SERVICES				0	0		
66.00	RESI DENTI AL CARE ADVERTI SI NG				0	0	66.00	
67. 00 68. 00					0	0	67.00	
69.00	TELEHEALTH/TELEMONI TORI NG THRI FT STORE					0	68. 00 69. 00	
70.00	NURSING FACILITY ROOM & BOARD					U	70.00	
70.00	OTHER NONREIMBURSABLE (SPECIFY)	0				0		
99. 00	NEGATIVE COST CENTER		0		0 0	0	99.00	
	TOTAL	127, 594	4, 358		0 0		100.00	
100.00	/ IVIAL	127, 374	4, 330	I	9	U	1100.00	

Heal th	Financial Systems	GOOD SAMARIT	AN HOSPITAL		In Lie	u of Form CMS-	2552-10
	ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SEI	RVICE COSTS	Provi der CO		Peri od: From 01/01/2021	Worksheet 0-6 Part I	
			Hospi ce CCN	N: 15-1526	To 12/31/2021	Date/Time Pre 5/26/2022 9:3	
					Hospi ce I	0,20,2022 ,10	<u> </u>
	Descriptions	PHARMACY	PHYSI CI AN	OTHER GENERA	AL PATIENT/	TOTAL	
			ADMI NI STRATI VE	SERVI CE	RESI DENTI AL		
			SERVI CES		CARE SERVICES		
	JOSUS DA LA CONTROL DE LA CONT	14. 00	15. 00	16. 00	17. 00	18. 00	
4 00	GENERAL SERVI CE COST CENTERS			1			4 00
1.00	CAP REL COSTS ANVELS FOLLD						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 6. 00	PLANT OPERATION & MAINTENANCE LAUNDRY & LINEN SERVICE						5. 00 6. 00
7. 00	HOUSEKEEPING						7.00
8. 00	DI ETARY						8.00
9.00	NURSING ADMINISTRATION						9. 00
10. 00	ROUTINE MEDICAL SUPPLIES						10.00
11. 00	MEDI CAL RECORDS						11.00
12. 00	STAFF TRANSPORTATION						12. 00
13. 00	VOLUNTEER SERVICE COORDINATION						13. 00
14. 00	PHARMACY	45					14. 00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES		0				15. 00
16. 00	OTHER GENERAL SERVICE	d			0		16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES				0		17. 00
	LEVEL OF CARE						1
50.00	HOSPICE CONTINUOUS HOME CARE	C	0		0	0	50. 00
51.00	HOSPICE ROUTINE HOME CARE	41	0		0	772, 354	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	C	0		0	8, 678	
53.00	HOSPICE GENERAL INPATIENT CARE	4	. 0		0 0	467, 898	53. 00
	NONREI MBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	C)		0	0	
61.00	VOLUNTEER PROGRAM	0)		0	0	
62.00	FUNDRAL SI NG)		0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS)		0	0	63. 00
64. 00	PALLIATIVE CARE PROGRAM)		0	0	64. 00
65. 00	OTHER PHYSICIAN SERVICES				0 0	0	65. 00 66. 00
66. 00 67. 00	RESI DENTI AL CARE 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				O .	0	1
71. 00	OTHER NONREIMBURSABLE (SPECIFY)	ر ا	o		0 0	0	1
99. 00	NEGATI VE COST CENTER		Ö	•	0 0	0	1
	TOTAL	45			0 0	_	
				1	-1	,,	

Health Financial Systems	GOOD SAMARITAN	HOSPI TAL		In Lie	u of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPICE GENE STATISTICAL BASIS	ERAL SERVICE COSTS	Provider CCN: Hospice CCN:	15-0042 15-1526	From 01/01/2021	Worksheet 0-6 Part II Date/Time Prepared: 5/26/2022 9:38 am

			Hospice CCN	l: 15-1526 T	o 12/31/2021	Date/Time Pre 5/26/2022 9:3	
					Hospi ce I		
	Cost Center Descriptions	CAP REL BLDG &	CAP REL MVBLE	EMPLOYEE	RECONCI LI ATI ON	ADMI NI STRATI VE	
	·	FLX	EQUI P	BENEFITS		& GENERAL	
		(SQUARE FEET)		DEPARTMENT		(ACCUMULATED	
		,		(GROSS		COSTS)	
				SALARI ES)			
		1.00	2.00	3. 00	4A	4. 00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FLXT	388					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		388				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT		0	438, 842			3.00
4. 00	ADMI NI STRATI VE & GENERAL		0	430, 042	-294, 847	954, 083	4. 00
				0	-274,047		
5.00	PLANT OPERATION & MAINTENANCE	0	U	0	U	121, 204	5. 00
6. 00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6. 00
7. 00	HOUSEKEEPI NG	o o	0	0	0	49, 060	7. 00
8. 00	DI ETARY	0	0	0	0	0	8. 00
9. 00	NURSING ADMINISTRATION	0	0	0	0	97, 472	9. 00
10. 00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	3, 329	10. 00
11. 00	MEDICAL RECORDS	0	0	0	0	0	11. 00
12.00	STAFF TRANSPORTATION	0	0	0	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	o	0	0	0	0	13.00
14.00	PHARMACY	l ol	o	0	0	34	14.00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	l ol	0	0	0	0	15. 00
16. 00	OTHER GENERAL SERVICE	ام	o	0	0	0	16. 00
	PATIENT/RESIDENTIAL CARE SERVICES	٥	0	Ü	0	0	17. 00
17.00	LEVEL OF CARE		۷۱		O ₁		17.00
50. 00	HOSPICE CONTINUOUS HOME CARE			0	0	0	50.00
51. 00	HOSPICE ROUTINE HOME CARE			408, 201	0	496, 297	
52. 00	HOSPICE INPATIENT RESPITE CARE	7	7	553	0	3, 422	52.00
53. 00		381	381	30, 088	0		
53.00	HOSPICE GENERAL INPATIENT CARE	381	381	30, 088	U	183, 265	53. 00
40.00	NONREI MBURSABLE COST CENTERS		٥	0	٥	0	(0.00
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61. 00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAI SI NG	0	0	0	0	0	62.00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63. 00
64. 00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64. 00
65. 00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65. 00
66. 00	RESI DENTI AL CARE	0	0	0	0	0	66. 00
67. 00	ADVERTI SI NG	0	0	0	0	0	67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG	0	0	0	0	0	68. 00
69.00	THRIFT STORE	0	0	0	0	0	69. 00
70.00	NURSING FACILITY ROOM & BOARD				0		70. 00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	l ol	O	0	0	0	71. 00
99. 00	NEGATIVE COST CENTER						99. 00
	COST TO BE ALLOCATED (per Wkst. 0-6, Pa	ırt I) 115, 196	523	155, 644		294, 847	100. 00
	UNIT COST MULTIPLIER	296. 896907	1. 347938	0. 354670		0. 309037	
	ı	,			'		1

Heal th	Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Li∈	eu of Form CMS-2	2552-10
	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL	SERVICE COSTS	Provi der C		Peri od: From 01/01/2021	Worksheet 0-6 Part II	
STATES	TICAL BASIS		Hospi ce CCI		To 12/31/2021	Date/Time Prep 5/26/2022 9:38	
					Hospi ce I		
	Cost Center Descriptions	PLANT	LAUNDRY &	HOUSEKEEPI NO		NURSI NG	
		OPERATION &	LINEN SERVICE	(SQUARE FEET		ADMI NI STRATI ON	
		MAI NTENANCE	(IN-FACILITY		DAYS)		
		(SQUARE FEET)	DAYS)			(DI RECT NURS.	
		F 00	/ 00	7.00	0.00	HRS.)	
	CENEDAL CEDALCE COCT CENTERS	5. 00	6. 00	7. 00	8. 00	9. 00	
1. 00	GENERAL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT			Γ			1. 00
2.00	CAP REL COSTS-BLDG & FIXT		-				2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3. 00
4. 00	ADMI NI STRATI VE & GENERAL						4. 00
5.00	PLANT OPERATION & MAINTENANCE	388					5. 00
6. 00	LAUNDRY & LINEN SERVICE	300					6. 00
7. 00	HOUSEKEEPI NG)	38	88		7. 00
	DI ETARY				0		8. 00
8.00							
	NURSING ADMINISTRATION	0			0	14, 018	9.00
8. 00 9. 00 10. 00		0			0	14, 018 0	9. 00 10. 00

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158, 661

408. 920103

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0 64.00

0

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127, 594 100. 00

9. 102154 101. 00

STAFF TRANSPORTATION

OTHER GENERAL SERVICE

BEREAVEMENT PROGRAM

PALLIATIVE CARE PROGRAM

OTHER PHYSICIAN SERVICES

TELEHEALTH/TELEMONI TORI NG

71.00 OTHER NONREIMBURSABLE (SPECIFY)

NEGATIVE COST CENTER

NURSING FACILITY ROOM & BOARD

VOLUNTEER PROGRAM

RESIDENTIAL CARE

FUNDRAI SI NG

ADVERTI SI NG

THRIFT STORE

101.00 UNIT COST MULTIPLIER

PHARMACY

LEVEL OF CARE

VOLUNTEER SERVICE COORDINATION

PHYSICIAN ADMINISTRATIVE SERVICES

PATIENT/RESIDENTIAL CARE SERVICES

HOSPICE CONTINUOUS HOME CARE

HOSPICE INPATIENT RESPITE CARE

HOSPICE GENERAL INPATIENT CARE NONREIMBURSABLE COST CENTERS

HOSPICE/PALLIATIVE MEDICINE FELLOWS

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

HOSPICE ROUTINE HOME CARE

12. 00 13. 00

14.00

15 00

16.00

17.00

50.00

51.00

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60.00

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69. 00

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99.00

Health Financial Systems	GOOD SAMARITAN	HOSPI TAL		In Lie	u of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPICE STATISTICAL BASIS	GENERAL SERVICE COSTS	Provider CCN:		Peri od: From 01/01/2021	Worksheet 0-6
STATISTICAL BASIS		Hospi ce CCN:	15-1526	To 12/31/2021	Date/Time Prepared:

STATES	TITCAL BASIS		Hospi ce CC	N: 15-1526	To 12/31/2021	Date/Time Pre 5/26/2022 9:3	
					Hospi ce I	0, 20, 2022 7. 0	
	Cost Center Descriptions	ROUTI NE	MEDI CAL	STAFF	VOLUNTEER	PHARMACY	
		MEDI CAL SUPPLI ES	RECORDS (PATLENT DAYS)	TRANSPORTATIO	ON SERVICE COORDINATION	(CHARGES)	
		(PATIENT DAYS)	(IAITENI DAIS)	(MI LEAGE)	(HOURS OF		
					SERVICE)		
		10.00	11. 00	12.00	13.00	14.00	
	GENERAL SERVICE COST CENTERS	1		1			
1.00	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP						1.00
2. 00 3. 00	EMPLOYEE BENEFITS DEPARTMENT						2. 00
4. 00	ADMINISTRATIVE & GENERAL						4.00
5. 00	PLANT OPERATION & MAINTENANCE						5. 00
6. 00	LAUNDRY & LINEN SERVICE						6. 00
7.00	HOUSEKEEPI NG						7. 00
8.00	DI ETARY						8. 00
9.00	NURSING ADMINISTRATION						9. 00
10. 00	ROUTINE MEDICAL SUPPLIES	5, 092					10. 00
11. 00	MEDI CAL RECORDS		0	1			11.00
12.00	STAFF TRANSPORTATION				0		12.00
13.00	VOLUNTEER SERVICE COORDINATION PHARMACY				0	4 007	13.00
14. 00 15. 00	PHYSICIAN ADMINISTRATIVE SERVICES					4, 087 0	
16. 00	OTHER GENERAL SERVICE					0	
17. 00	PATIENT/RESIDENTIAL CARE SERVICES				Ĭ	ū	17. 00
	LEVEL OF CARE	'		•			
50.00	HOSPICE CONTINUOUS HOME CARE	0	0)	0 0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	4, 627	0)	0 0	3, 679	
52.00	HOSPICE INPATIENT RESPITE CARE	15	0	1	0 0	14	
53. 00	HOSPICE GENERAL INPATIENT CARE	450	0		0 0	394	53. 00
60. 00	NONREI MBURSABLE COST CENTERS BEREAVEMENT PROGRAM			I	ol ol	0	60.00
61. 00	VOLUNTEER PROGRAM					0	
62. 00	FUNDRAI SI NG					0	
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS				0 0	0	1
64.00	PALLIATIVE CARE PROGRAM				0 0	0	64. 00
65.00	OTHER PHYSI CI AN SERVI CES				0 0	0	65. 00
66.00	RESI DENTI AL CARE				0 0	0	
67. 00	ADVERTI SI NG				0 0	0	
68. 00	TELEHEALTH/TELEMONI TORI NG				0 0	0	1
69. 00	THRIFT STORE NURSING FACILITY ROOM & BOARD				0	0	
70. 00 71. 00	OTHER NONREIMBURSABLE (SPECIFY)					0	70.00
99. 00	NEGATIVE COST CENTER	1			Ĭ	O	99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	4, 358	0	J	ما ما	45	100.00
	TICOST TO BE ALLOCATED (PET WKST. U-6, PAIL I)	4, 330	U	1	U U	43	1100.00

Health Financial Systems	GOOD SAMARITAN	HOSPI TAL	In Lie	u of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPICE GENER STATISTICAL BASIS	RAL SERVICE COSTS	Provider CCN: Hospice CCN:	From 01/01/2021	Worksheet 0-6 Part II Date/Time Prepared: 5/26/2022 9:38 am

			nospi ce co	10. 15-1520	10 12/31/2021	5/26/2022 9:3	
					Hospi ce I	5, 25, 252	
	Cost Center Descriptions	PHYSI CI AN	OTHER GENERAL	PATI ENT/		.'	
		ADMI NI STRATI VE		RESI DENTI AL			
		SERVI CES	(SPECI FY	CARE SERVICE	S		
		(PATIENT DAYS)	,	(IN-FACILITY			
		()	,	DAYS)			
		15. 00	16. 00	17. 00			
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FLXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3. 00
4. 00	ADMINISTRATIVE & GENERAL						4.00
5. 00	PLANT OPERATION & MAINTENANCE						5.00
6. 00	LAUNDRY & LINEN SERVICE						6.00
7. 00	HOUSEKEEPING						7. 00
8. 00	DI ETARY						8.00
9. 00							
	NURSING ADMINISTRATION						9. 00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11.00	MEDI CAL RECORDS						11.00
12. 00	STAFF TRANSPORTATION						12. 00
13. 00	VOLUNTEER SERVICE COORDINATION						13. 00
14. 00	PHARMACY						14. 00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	0					15. 00
16. 00	OTHER GENERAL SERVICE		0)			16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES				0		17. 00
	LEVEL OF CARE	-					
50.00	HOSPICE CONTINUOUS HOME CARE	0	l .	•			50. 00
51.00	HOSPICE ROUTINE HOME CARE	0	0)			51. 00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0)	0		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	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						64.00
65.00	OTHER PHYSICIAN SERVICES						65. 00
66.00	RESI DENTI AL CARE	0	0		0		66. 00
67. 00	ADVERTI SI NG						67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG		1				68. 00
69. 00	THRI FT STORE		1				69. 00
70. 00	NURSING FACILITY ROOM & BOARD						70.00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)	0	_		0		71. 00
	NEGATIVE COST CENTER			1			99. 00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)				0		100.00
	UNIT COST MULTIPLIER	0. 000000	0. 000000	0. 0000	20		100.00
101.00	NONII COSI MULIIFLILK	0.00000	0.00000	, U. UUUU	00		1101.00

	Financial Systems	GOOD SAMARITAN		N 45 0040		eu of Form CMS-	
	TIONMENT OF HOSPITAL-BASED HOSPICE SHARED SE OF CARE	RVICE COSIS BY	Provider CC	JN: 15-0042	Peri od: From 01/01/2021	Worksheet 0-7	
	OT CARLE		Hospi ce CCN	N: 15-1526	To 12/31/2021		pared:
					Hospi ce I	372072022 7. 3	
				Charges by	/LOC (from Provi	der Records)	
	Cost Center Descriptions	From Wkst. C, C Part I, Col. 9 line	ost to Charge Ratio	НСНС	HRHC	HI RC	
		0	1. 00	2.00	3. 00	4. 00	
	ANCILLARY SERVICE COST CENTERS						
1. 00 2. 00	PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	66. 00 67. 00	0. 268698		0	0	2. 00
3.00	SPEECH PATHOLOGY	68. 00	0. 202022				3.00
4. 00 5. 00	DRUGS CHARGED TO PATIENTS DURABLE MEDICAL EQUIP-RENTED	73. 00 96. 00	0. 302923 0. 565454		0 0	0	
6. 00	LABORATORY	60.00	0. 139465				
7. 00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71. 00	1. 231047		o o	o o	
8. 00	OTHER OUTPATIENT SERVICE COST CENTER	93. 00					8. 00
9. 00	RADI OLOGY-THERAPEUTI C	55. 00	0. 223497		0 0	0	
10.00	MH ANCI LLARY OUTPATI ENT	76. 00	0. 000000		0	0	
10. 01 11. 00	INPATIENT DIALYSIS Totals (sum of lines 1-11)	76. 01	0. 720099		0	0	10. 01 11. 00
		Charges by LOC		Shared Serv	ice Costs by LOC		
		(from Provider Records)					
	Cost Center Descriptions		col . 2)	col. 3)	xHIRC (col. 1 > col. 4)	col . 5)	
	ANOLUL ADV. CEDVI OF COCT OFFITEDS	5.00	6. 00	7. 00	8. 00	9. 00	
1. 00	ANCILLARY SERVICE COST CENTERS PHYSICAL THERAPY	0	0		0 (0	1.00
2. 00	OCCUPATIONAL THERAPY	٩	O)	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	1
6.00	LABORATORY	0	0		0	0	
7. 00 8. 00	MEDICAL SUPPLIES CHARGED TO PATIENTS OTHER OUTPATIENT SERVICE COST CENTER	0	0		0	0	7. 00 8. 00
8. 00 9. 00	RADI OLOGY-THERAPEUTI C		0		0		
10. 00	MH ANCI LLARY OUTPATIENT		0			1	1
10. 01	INPATIENT DIALYSIS	0	0		0		
	Totals (sum of lines 1-11)	1	0		0 0	0 ا	11.00

Provider CCN: 15-0042 | Period: | Worksheet 0-8 | From 01/01/2021 | To 12/31/2021 | Date/Time Prepared:

					5/26/2022 9: 3	8 am
				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
	line 11)					
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)				0.00	3. 00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line	10)		0 0		4.00
5.00	Program cost (line 3 times line 4)			0 0		5. 00
	HOSPICE ROUTINE HOME CARE					
6.00	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-7,	, col. 7,			772, 354	6. 00
	line 11)					
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)				4, 627	7. 00
8.00	Total average cost per diem (line 6 divided by line 7)				166. 92	8. 00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line	e 11)	3, 49	7 89		9. 00
10.00	Program cost (line 8 times line 9)	·	583, 71	9 14, 856		10.00
	HOSPICE INPATIENT RESPITE CARE					
11.00	Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-7,	, col. 8,			8, 678	11. 00
	line 11)					
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)				15	12.00
13.00	Total average cost per diem (line 11 divided by line 12)				578. 53	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line	e 12)	1	2 0		14.00
15.00	Program cost (line 13 times line 14)		6, 94	.2 0		15. 00
	HOSPICE GENERAL INPATIENT CARE					
16.00	Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-7,	, col . 9,			467, 898	16. 00
	line 11)					
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)				450	17. 00
18.00	Total average cost per diem (line 16 divided by line 17)				1, 039. 77	18. 00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line	e 13)	33	9 37		19. 00
20.00	Program cost (line 18 times line 19)	.	352, 48	38, 471		20.00
	TOTAL HOSPICE CARE	•		*		
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)				1, 248, 930	21. 00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)				5, 092	22. 00
23.00	Average cost per diem (line 21 divided by line 22)				245. 27	
		'		III	'	•

	Financial Systems GOOD SAMA ATION OF CAPITAL PAYMENT	Provider CCN: 15-0042	Peri od:	u of Form CMS-2 Worksheet L	2552-10
CALCUL	ATTON OF CAPITAL PAYMENT	Provider CCN: 15-0042	From 01/01/2021	Parts I-III	
			To 12/31/2021	Date/Time Pre	pared:
				5/26/2022 9: 3	8 am
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD				
	CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier			1, 161, 740	
1. 01	Model 4 BPCI Capital DRG other than outlier			0	
2.00	Capital DRG outlier payments			32, 645	
2.01	Model 4 BPCI Capital DRG outlier payments			0	
3. 00	Total inpatient days divided by number of days in the co	ost reporting period (see ins	tructi ons)	45. 85	
4.00	Number of interns & residents (see instructions)			20. 77	
5.00	Indirect medical education percentage (see instructions)			13. 63	
6. 00	<pre>Indirect medical education adjustment (multiply line 5 t 1.01)(see instructions)</pre>	by the sum of lines I and I.U	i, columns i and	158, 345	6. 00
7. 00	Percentage of SSI recipient patient days to Medicare Pa	rt A patient days (Worksheet 6	F part Aline	0.00	7. 00
7.00	30) (see instructions)	t // patront days (nor noncet i	-, pa. t /	0.00	/
8.00	Percentage of Medicaid patient days to total days (see i		0.00	8. 00	
9.00	Sum of lines 7 and 8			0.00	9. 00
10.00	Allowable disproportionate share percentage (see instruc	ctions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)			0	11. 00
12.00	Total prospective capital payments (see instructions)			1, 352, 730	12.00
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions			0	1. 00
2.00	Program inpatient ancillary capital cost (see instruction			0	
3.00	Total inpatient program capital cost (line 1 plus line 2	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 circur	nstances (see instructions)		0	2. 00
3.00	Net program inpatient capital costs (line 1 minus line 2	2)		0	3. 00
4.00	Applicable exception percentage (see instructions)			0.00	
5.00	Capital cost for comparison to payments (line 3 x line 4			0	
6.00	Percentage adjustment for extraordinary circumstances (0.00	
7.00	Adjustment to capital minimum payment level for extraord	dinary circumstances (line 2)	x line 6)	0	
8. 00	Capital minimum payment level (line 5 plus line 7)			0	
9.00	Current year capital payments (from Part I, line 12, as			0	
10.00	Current year comparison of capital minimum payment level			0	10.00
11. 00	Carryover of accumulated capital minimum payment level of Worksheet L, Part III, line 14)	over capitai payment (from pri	or year	0	11. 00
12. 00	Worksheet L, Part III, IIIIe 14) Net comparison of capital minimum payment level to capit	tal navments (line 10 plus lin	ne 11)	0	12. 00
13. 00	Current year exception payment (if line 12 is positive,			0	
14. 00	Carryover of accumulated capital minimum payment level of			0	
	(if line 12 is negative, enter the amount on this line)		. 5 50	ı	1

15.00 0 16.00 0 17.00

(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)