provided in compliance with such laws and regulations. SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR ELECTRONI C CHECKBOX SIGNATURE STATEMENT 2 1 have read and agree with the above certification 1 statement. I certify that I intend my electronic Matt Schuckman γ signature on this certification be the legally binding equivalent of my original signature. 2 Signatory Printed Name Matt Schuckman 3 Signatory Title CEO 3 4 Date (Dated when report is electronica

regarding the provision of health care services, and that the services identified in this cost report were

			Title XVIII				
		Title V	Part A	Part B	HI T	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	1, 542, 317	107, 702	0	-379, 260	1.00
2.00	SUBPROVIDER - IPF	0	13, 941	988		299, 205	2.00
3.00	SUBPROVIDER - IRF	0	-713	-35		-11, 285	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
10.00	FAMILY PRACTICE 120 I	0		0		0	10.00
200.00	TOTAL	0	1, 555, 545	108, 655	0	-91, 340	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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

	AL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DATA	Provid	AL der CO	CN: 1		Period: From 01/01/		of For Workshe Part I		
							To 12/31/		Date/Ti 4/11/20		
	1.00	2.00		3.00			L	. 00	4/11/20)24 3. 1	
 -	Hospital and Hospital Health Care Co										
)	Street: 520 SOUTH 7TH STREET City: VINCENNES	PO Box: State: IN	Zip Cod	le: 475	591	Count	y: KNOX				1
-		Component Name	CCN	CB	SA	Provi der	Date		nt Syst		
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)	Subprovider - (Other)										6
))	Swing Beds - SNF Swing Beds - NF										8
)	Hospital - Based SNF										9
0	Hospital-Based NF										10
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0	•	CENTER	13/432	799	10		00/21/1990	IN			'2
0	Separately Certified ASC										13
0	Hospi tal -Based Hospi ce	GOOD SAMARITAN LINCOLN TRAIL HOSPICE	151526	999	715		01/01/1984				14
0	Hospital-Based Health Clinic - RHC	GOOD SAMARITAN FAMILY	158577	999	915		12/27/2023	Ν	0	0	15
		PRACTICE 120									
0	Hospital-Based Health Clinic - FQHC Hospital-Based (CMHC) I										16
0	Renal Dialysis										18
	Other										19
							From: 1.00				-
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1 2 3 4	Does this facility qualify and is it disproportionate share hospital adju §412.106? In column 1, enter "Y" fo facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fo Did this hospital receive interim UC this cost reporting period? Enter in for the portion of the cost reportin 1. Enter in column 2, "Y" for yes or cost reporting period occurring on o instructions) Is this a newly merged hospital that determined at cost report settlement 1, "Y" for yes or "N" for no, for th period prior to October 1. Enter in for the portion of the cost reportin Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in co 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. Did this hospital receive a geograph 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 Dees this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Did this hospital receive a geograph 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	stment, in accordance w r yes or "N" for no. Is 412.106(c)(2)(Pickle am r yes or "N" for no. Ps, including supplemen column 1, "Y" for yes g period occurring prio "N" for no for the por r after October 1. (see requires a final UCP to ? (see instructions) En e portion of the cost r column 2, "Y" for yes o g period on or after Oc ic reclassification fro ds for delineating stat olumn 1, "Y" for yes or g period prior to Octobe no for the portion of th en October 1. (see inst 100 but not more than 4 2.105)? Enter in column ic reclassification fro delineations for stati column 1, "Y" for yes o g period prior to Octobe no for the portion of ti en October 1. (see inst 100 but not more than 4 2.105)? Enter in column	ith 42 CF this endment tal UCPs, or "N" for r to Octo tion of t be ter in co eporting r "N" for er 1. Ent ne cost ructions) 99 beds (3, "Y" for er 1. Ent te cost ructions) 99 beds (n 3, "Y"	for or no ober he of umn ono oreas no reas for as for		Y Y N	N				22 22 22 22 22
1 2 3 4	Does this facility qualify and is it disproportionate share hospital adju §412.106? In column 1, enter "Y" fo facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fo Did this hospital receive interim UC this cost reporting period? Enter in for the portion of the cost reporting 1. Enter in column 2, "Y" for yes or cost reporting period occurring on o instructions) Is this a newly merged hospital that determined at cost report settlement 1, "Y" for yes or "N" for no, for th period prior to October 1. Enter in for the portion of the cost reportin Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in co for the portion of the cost reportin n column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital receive a geograph rural as a result of the revised OMB adopted by CMS in FY 2015? Enter in co for the portion of the cost reportin n for the portion of the cost reportin 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. Which method is used to determine Me below? In column 1, enter 1 if date	stment, in accordance w r yes or "N" for no. Is 412.106(c)(2)(Pickle am r yes or "N" for no. Ps, including supplemen column 1, "Y" for yes g period occurring prio "N" for no for the por r after October 1. (see requires a final UCP tr ? (see instructions) En e portion of the cost re column 2, "Y" for yes o g period on or after Oc ds for delineating stat olumn 1, "Y" for yes or g period on or after oc ds for delineating stat olumn 1, "Y" for yes or g period prior to Octob no for the portion of tl er October 1. (see inst 100 but not more than 4' 2.105)? Enter in column ic reclassification froi delineations for statis column 1, "Y" for yes o g period prior to Octob no for the portion of tl er October 1. (see inst 100 but not more than 4' 2.105)? Enter in column dic reclassification froi delineations for statis	ith 42 CF this endment tal UCPs, or "N" for r to Octo tion of t obe ter in co eporting r "N" for tober 1. m urban t istical a "N" for er 1. Ent he cost ructions) 79 beds (n 3, "Y" and/or 2 us days,	FR for no ober he olumn no, ro reas no reas for as for 25 or 3		Y Y N	N N N N				22 22 22 22
4	Does this facility qualify and is it disproportionate share hospital adju §412.106? In column 1, enter "Y" fo facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fo Did this hospital receive interim UC this cost reporting period? Enter in for the portion of the cost reporting 1. Enter in column 2, "Y" for yes or cost reporting period occurring on o instructions) Is this a newly merged hospital that determined at cost report settlement 1, "Y" for yes or "N" for no, for th period prior to October 1. Enter in for the portion of the cost reporting Did this hospital receive a geograph 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 reporting period occurring on or aft Does this hospital receive a geograph rural as a result of the revised OMB adopted by CMS in FY2015? Enter in c for the portion of the cost reporting in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital receive a geograph rural as a result of the revised OMB adopted by CMS in FY 2021? Enter in for the portion of the cost reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Which method is used to determine Me	stment, in accordance w r yes or "N" for no. Is 412.106(c)(2)(Pickle am r yes or "N" for no. Ps, including supplemen column 1, "Y" for yes g period occurring prio "N" for no for the por r after October 1. (see requires a final UCP t. ? (see instructions) En e portion of the cost re column 2, "Y" for yes o g period on or after Oc ic reclassification from ds for delineating stat olumn 1, "Y" for yes or g period prior to Octobe no for the portion of t er October 1. (see inst 100 but not more than 4 2.105)? Enter in column ic reclassification from delineations for stati- column 1, "Y" for yes or g period prior to Octobe no for the portion of t er October 1. (see inst 100 but not more than 4 2.105)? Enter in column dicaid days on lines 24 of admission, 2 if censi	ith 42 CF this endment tal UCPs, or "N" for r to Octo tion of t obe ter in co eporting r "N" for tober 1. m urban t istical a "N" for er 1. Ent he cost ructions) 99 beds (a, "Y" f m urban t stical ar r "N" for er 1. Ent he cost ructions) 99 beds (h 3, "Y"	FR for no ober he olumn no, ro reas no reas for as for 25 or 3		Y Y N	N N N N				222 222 222 222 222 222 222 222 222 22

HOSPI TAL AND H	II Systems GOOD S DSPITAL HEALTH CARE COMPLEX IDENTIFICATION D.	SAMARITAN HO	Provider CC	N: 15-0042	Peri od:		Worksh	rm CMS- leet S-2	
					From 01/0 To 12/3	1/2023 1/2023		ime Pre	
		In-State	In-State	Out-of	Out-of	Medi ca		<u>:024 3:1</u>)ther	17 pm
		Medicaid	Medicaid	State Madi agi d	State	HMO da		di cai d	
		paid days	el i gi bl e unpai d	Medicaid paid days	Medicaid eligible			days	
		1.00	days		unpai d				_
4.00 If this	provider is an IPPS hospital, enter the	1.00	2.00 112	3.00	4.00	<u>5.00</u> 1,	963	<u>6.00</u> 416	5 24.0
in-stat	. Medicaid paid days in column 1, in-state								
	eligible unpaid days in column 2, tate Medicaid paid days in column 3,								
	tate Medicaid eligible unpaid days in column aid HMO paid and eligible but unpaid days in								
column	, and other Medicaid days in column 6.								
	provider is an IRF, enter the in-state paid days in column 1, the in-state	17	32	0	6		181		25.0
Medi cai	eligible unpaid days in column 2,								
	tate Medicaid days in column 3, out-of-state eligible unpaid days in column 4, Medicaid								
	and eligible but unpaid days in column 5.				Usels are (D		Data	6 0	
					Urban/R			r Geogr 00	-
	ur standard geographic classification (not w orting period. Enter "1" for urban or "2" fo		at the be	ginning of	the	2			26.0
7.00 Enter y	ur standard geographic classification (not w	age) status			st	2			27.0
	g period. Enter in column 1, "1" for urban o e effective date of the geographic reclassif			pplicable,					
5.00 If this	is a sole community hospital (SCH), enter th			CH status i	n	0			35.0
effect	n the cost reporting period.				Begi ni	ni ng:	End	i ng:	
(00 Enter a	nliable beginning and anding datas of SCILs	tatua Suba	orint line	24 for pur	1. (00	2.	00	24.0
	plicable beginning and ending dates of SCH s ds in excess of one and enter subsequent dat		scriptiine	36 FOF NUM	ber				36.
	is a Medicare dependent hospital (MDH), ente fect in the cost reporting period.	er the numbe	er of perio	ds MDH stat	us	1			37.
	hospital a former MDH that is eligible for t	he MDH tran	nsitional p	ayment in					37.
accorda i nstruc	ce with FY 2016 OPPS final rule? Enter "Y" f ions)	"or yes or "	N" for no.	(see					
8.00 If line	37 is 1, enter the beginning and ending date				01/01,	/2023	12/31	/2023	38.0
	than 1, subscript this line for the number o bsequent dates.	of periods i	n excess o	f one and					
					Y/			/N 00	-
	s facility qualify for the inpatient hospita				ume N			N	39.0
	s in accordance with 42 CFR §412.101(b)(2)(i r yes or "N" for no. Does the facility meet				mn				
accorda	ce with 42 CFR 412.101(b)(2)(i), (ii), or (i				es				
or "N" 0.00 Is this	or no. (see instructions) hospital subject to the HAC program reductio	n adjustmer	nt? Enter "	Y" for yes	or N			Y	40.0
"N" for	no in column 1, for discharges prior to Octo lumn 2, for discharges on or after October 1	ber 1. Ente	er "Y" for						
	duin 2, for discharges on of after october i		Tuctions)			V	XVIII	XI X	
Prospec	ive Payment System (PPS)-Capital					1.00	2.00	3.00	
5.00 Does th	s facility qualify and receive Capital payme	ent for disp	proporti ona	te share in	accordance	e N	N	N	45.0
	CFR Section §412.320? (see instructions) facility eligible for additional payment exc	eption for	extraordin	arv circums	tances	N	N	N	46.0
pursuan	to 42 CFR §412.348(f)? If yes, complete Wks								
Pt. III 7.00 Is this	a new hospital under 42 CFR §412.300(b) PPS	capital? E	nter "Y fo	r yes or "N	" for no.	N	N	N	47.0
	acility electing full federal capital paymen Hospitals	it? Enter "	Y" for yes	or "N" for	no.	N	N	N	48.0
6.00 Is this	a hospital involved in training residents in					Y	Y	1	56.0
	beginning prior to December 27, 2020, enter orting periods beginning on or after Decembe								
1005110	ructions. For column 2, if the response to c	olumn 1 is	"Y", or if	this hospi	tal was				
the ins	in training residents in approved GME progr you are impacted by CR 11642 (or applicable					.			
the ins involve	yes; otherwise, enter "N" for no in column 2		•	-					
the ins involve and are "Y" for	reporting periods beginning prior to Decemb the first cost reporting period during which				5	Y			57.0
the ins involve and are "Y" for 7.00 For cos				1 is "Y",	di d				
the ins i nvol ve and are "Y" for 7.00 For cos is this at this	facility? Enter "Y" for yes or "N" for no i			2 Entrain 11					
the ins involve and are "Y" for 7.00 For cos is this at this residen		cost report	ing period)r.			
the ins involve and are "Y" for 7.00 For cos is this at this residen "N" for complete	facility? Enter "Y" for yes or "N" for no i s start training in the first month of this no in column 2. If column 2 is "Y", complet Wkst. D, Parts III & IV and D-2, Pt. II, if	cost report e Worksheet applicable	ing period E-4. If c For cost	olumn 2 is reporting	"N", periods	or.			
the ins involve and are "Y" for 7.00 For cos is this at this residen "N" for complet beginni which m	facility? Enter "Y" for yes or "N" for no i s start training in the first month of this no in column 2. If column 2 is "Y", complet	cost report e Worksheet applicable R 413.77(e on duty, i	ing period E-4. If c For cost)(1)(iv) a f the resp	olumn 2 is reporting nd (v), reg onse to lin	"N", periods ardless of e 56 is "Y"				

		N HOSPI TAL		In Lieu	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION D	ATA	Provider CC		eriod: rom 01/01/2023	Worksheet S-2 Part I	
				0 12/31/2023		
				V	XVIII XIX	/ piii
58.00 If line 56 is yes, did this facility elect cost reir	hurcomo	nt for physici	anc' convione		2.00 3.00	58.00
defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	compl e	te Wkst. D-5.				
59.00 Are costs claimed on line 100 of Worksheet A? If ye	es, comp	lete Wkst. D-2	, Pt. I. NAHE 413.85	Worksheet A	Pass-Through	59.00
			Y/N	Li ne #	Qualification	
					Cri teri on Code	
			1.00	2.00	3.00	
60.00 Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413			Y	Y		60.00
instructions) Enter "Y" for yes or "N" for no in co	olumn 1.	lf column 1				
is "Y", are you impacted by CR 11642 (or subsequent adjustment? Enter "Y" for yes or "N" for no in colu		E MA payment				
60.01 If line 60 is yes, complete columns 2 and 3 for each	n progra	m. (see		23. 01	1	60. 01
instructions)	Y/N	IME	Direct GME	IME	Direct GME	
	17 1		DITECTOME	T WIL	DITECT GWL	
61.00 Did your hospital receive FTE slots under ACA	1.00 N	2.00	3.00	4.00	5.00	61.00
section 5503? Enter "Y" for yes or "N" for no in	IN IN			0.00	0.00	01.00
column 1. (see instructions) 61.01 Enter the average number of unweighted primary care						61.01
FTEs from the hospital's 3 most recent cost reports						01.01
ending and submitted before March 23, 2010. (see instructions)						
61.02 Enter the current year total unweighted primary care	e					61.02
FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of						
ACA). (see instructions)						
61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for						61.03
determining compliance with the 75% test. (see						
instructions) 61.04 Enter the number of unweighted primary care/or						61.04
surgery allopathic and/or osteopathic FTEs in the						01.01
current cost reporting period. (see instructions). 61.05 Enter the difference between the baseline primary						61.05
and/or general surgery FTEs and the current year's						01100
primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)	e					
61.06 Enter the amount of ACA §5503 award that is being						61.06
used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						
	Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME	
				TIME FIE COUNT	FTE Count	
		1.00	2.00	3.00	4.00	(1.10
61.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents				0.00	0.00	61.10
for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the						
program code. Enter in column 3, the IME FTE						
unweighted count. Enter in column 4, the direct GME FTE unweighted count.						
61. 20 Of the FTEs in line 61.05, specify each expanded				0.00	0.00	61.20
program specialty, if any, and the number of FTE residents for each expanded program. (see						
instructions) Enter in column 1, the program name.						
Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4,	ו					
the direct GME FTE unweighted count.						
					1.00	
ACA Provisions Affecting the Health Resources and Se						
62.00 Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instru		d in this cost	reporting per	iod for which	0.00	62.00
62.01 Enter the number of FTE residents that rotated from	a Teach			o your hospital	0.00	62.01
during in this cost reporting period of HRSA THC pro Teaching Hospitals that Claim Residents in Nonprovid			ns)			
63.00 Has your facility trained residents in nonprovider s	setti ngs	during this c			N	63.00
"Y" for yes or "N" for no in column 1. If yes, compl	ete lin	es 64 through	67. (see instr	ructions)		

alth Financial Systems SPITAL AND HOSPITAL HEALTH CARE COMPL		SAMARITAN I DATA	Provider CC		Period:	u of Form CMS-: Worksheet S-2	
					rom 01/01/2023 To 12/31/2023		
				Unwei ghted FTEs	Unweighted FTEs in	Ratio (col. 1/ (col. 1 +	
				Nonprovider	Hospital	col. 2))	
				Site	incopi cui		
				1.00	2.00	3.00	
Section 5504 of the ACA Base Year				This base yea	r is your cost	reporting	
 period that begins on or after Ju 00 Enter in column 1, if line 63 is in the base year period, the numl resident FTEs attributable to rossettings. Enter in column 2 the resident FTEs that trained in you of (column 1 divided by (column 1 	yes, or your facili per of unweighted no tations occurring in number of unweighte ur hospital. Enter i	ity trained on-primary n all nonpr ed non-prim in column 3	d residents care rovider mary care 3 the ratio	0.0	0 0.00	0. 000000	64.00
	Program Name		am Code	Unweighted	Unwei ghted	Ratio (col.	
				FTEs	FTEs in	3/ (col. 3 +	
				Nonprovi der	Hospi tal	col. 4))	
_	1 00		00	Si te	4.00	F 00	-
.00 Enter in column 1, if line 63	1.00	2	. 00	3.00	4.00 0 0.00	5.00 0.000000	65.00
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)				Unweighted	Unweighted	Ratio (col.	
				FTEs Nonprovider Site 1.00	FTEs in Hospital	1/ (col . 1 + col . 2)) 3.00	_
Section 5504 of the ACA Current	Year FTE Residents	in Nonprovi	der Setting				
beginning on or after July 1, 20	10	•		,			
b.00 Enter in column 1 the number of a FTEs attributable to rotations or Enter in column 2 the number of a FTEs that trained in your hospita (column 1 divided by (column 1 +	ccurring in all non unweighted non-prima al. Enter in column	provider se ary care re 3 the rati	ettings. esident oof	0. 1	7 18.30	0. 009204	66.00
	Program Name		am Code	Unweighted	Unwei ghted	Ratio (col.	
	5			FTĔs	FTEsin	3/ (col. 3 +	
				Nonprovi der	Hospi tal	col. 4))	
	1.00	-	. 00	Si te 3.00	4.00	5.00	-
2.00 Enter in column 1, the program	NTERNAL MEDICINE	1400	. 00	0.4			67 0
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							

Heal th	Financial Systems GOOD SAMARITAN HOSPITAL		١n	Li eu	ı of Form	n CMS-2	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CO	CN: 15-0042	Period: From 01/01/2	2023	Workshe Part I	et S-2	
			o 12/31/		Date/Ti		
					4/11/20	24 3:1	7 pm
	Direct CME in Accordance with the EV 2022 LDDC Einel Dule 07 ED 4004E 44	070 (August 1	0 2022)		1.0	0	
68.00	<u>Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-44</u> For a cost reporting period beginning prior to October 1, 2022, did you c MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Fir (August 10, 2022)?	btain permissi	on from yo				68.00
			-	1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				2.00	5.00	
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it cont Enter "Y" for yes or "N" for no.	ain an IPF sul	oprovi der?	Y			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teachi			Ν	Y	5	71.00
	recent cost report filed on or before November 15, 2004? Enter "Y" for y 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents						
	program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for y	es or "N" for	no.				
	Column 3: If column 2 is Y, indicate which program year began during this (see instructions)	cost reportin	ng period.				
75 00	Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or does it c			Y			75 00
75.00	subprovider? Enter "Y" for yes and "N" for no.	contain an IRF		Ŷ			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teachi recent cost reporting period ending on or before November 15, 2004? Enter			Ν	N	0	76.00
	no. Column 2: Did this facility train residents in a new teaching program	in accordance	e with 42				
	CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If indicate which program year began during this cost reporting period. (see						
	ind cate winen program year began darring tin's cost reporting period. (see		/]				
	Long Term Care Hospital PPS				1.0	0	
	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for				N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the "Y" for yes and "N" for no.	cost reporting	g period? E	nter	N		81.00
05 00	TEFRA Providers						05 00
	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter Did this facility establish a new Other subprovider (excluded unit) under			no.	N		85.00 86.00
07 00	§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.	under costi en			N		87.00
87.00	Is this hospital an extended neoplastic disease care hospital classified 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	under section			IN		87.00
			Approved Permane		Number Appro		
			Adjustme		Permar	nent	
			(Y/N) 1.00		Adjustr 2.0		
88.00	Column 1: Is this hospital approved for a permanent adjustment to the TEF	5	N		2.0		88.00
	amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete c 89. (see instructions)	col. 2 and line	9				
	Column 2: Enter the number of approved permanent adjustments.		ECC				
		Wkst. A Line No.	Effecti Date	ve	Appro Permar		
					Adjust		
					Amount Di scha		
80.00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line number	1.00	2.00		3.0		89.00
69.00	on which the per discharge permanent adjustment approval was based.	0.0				0	69.00
	Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount						
	per di scharge.						
	Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.						
			V 1.00		XI) 2. 0		
	Title V and XIX Services					0	
90.00	Does this facility have title V and/or XIX inpatient hospital services? E yes or "N" for no in the applicable column.	inter "Y" for	N		Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost repor		N		Y		91.00
92.00	full or in part? Enter "Y" for yes or "N" for no in the applicable column Are title XIX NF patients occupying title XVIII SNF beds (dual certificat				Ν		92.00
93 NU	instructions) Enter "Y" for yes or "N" for no in the applicable column. Does this facility operate an ICF/IID facility for purposes of title V ar	nd XIX2 Entor	N		N		93.00
	"Y" for yes or "N" for no in the applicable column.						
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for r applicable column.	o in the	N		N		94.00
	If line 94 is "Y", enter the reduction percentage in the applicable colum		0.00		0.0	0	95.00
	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for r applicable column.		N		N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable colum	ın.	0.00		0.0	0	97.00

ealth Financial Systems GOOD SAMARITAN I HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 1		Period:	Worksheet S-2	2
			From 01/01/2023 To 12/31/2023	Date/Time Pro	
			V	4/11/2024 3: XI X	17 pm
			1.00	2.00	
18.00 Does title V or XIX follow Medicare (title XVIII) for the intestepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for column 1 for title V, and in column 2 for title XIX.		•	N	Y	98.00
8.01 Does title V or XIX follow Medicare (title XVIII) for the report C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for titl title XIX.				Y	98.0
28.02 Does title V or XIX follow Medicare (title XVIII) for the cald bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or			Ν	Y	98.02
for title V, and in column 2 for title XIX. 8.03 Does title V or XIX follow Medicare (title XVIII) for a critic reimbursed 101% of inpatient services cost? Enter "Y" for yes				Ν	98.0
for title V, and in column 2 for title XIX. 8.04 Does title V or XIX follow Medicare (title XVIII) for a CAH re- outpatient services cost? Enter "Y" for yes or "N" for no in o			N	N	98.0
in column 2 for title XIX. 28.05 Does title V or XIX follow Medicare (title XVIII) and add back Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in col				Y	98.0
 column 2 for title XIX. 28.06 Does title V or XIX follow Medicare (title XVIII) when cost represented by the second second			Ν	Y	98.0
Rural Providers 05.00Does this hospital qualify as a CAH? 06.00If this facility qualifies as a CAH, has it elected the all-in	nclusive method	of paymer	N N		105.0 106.0
for outpatient services? (see instructions) 07.00 Column 1: If line 105 is Y, is this facility eligible for cost training programs? Enter "Y" for yes or "N" for no in column Column 2: If column 1 is Y and line 70 or line 75 is Y, do ye	1. (see instru ou train I&Rs i	ctions) n an	Ν		107. 0
approved medical education program in the CAH's excluded IPF Enter "Y" for yes or "N" for no in column 2. (see instruction 07.01 If this facility is a REH (line 3, column 4, is "12"), is it e reimbursement for I&R training programs? Enter "Y" for yes or	ns) eligible for co	st			107.0
instructions) 08.001s this a rural hospital qualifying for an exception to the CA					
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	RNA fee schedul	e? See 42	2 N		108.0
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Physi cal Oc	ccupati onal	Speech	Respiratory	108.0
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.				Respiratory 4.00 N	
CFR Section §412.113(c). Enter "Y" for yes or "N" for no. 09.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y"	Physical 0c 1.00	ccupati onal 2.00	Speech 3.00	4.00 N	
CFR Section §412.113(c). Enter "Y" for yes or "N" for no. 09.00 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.	Physical Oc 1.00 N N Demonstration for yes or "N	ccupational 2.00 N project (§ " for no.	Speech 3.00 N 1410A	4.00	
CFR Section §412.113(c). Enter "Y" for yes or "N" for no. 09.00 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. 10.00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter "Y" complete Worksheet E, Part A, Lines 200 through 218, and Works	Physical Oc 1.00 N N Demonstration for yes or "N	ccupational 2.00 N project (§ " for no.	Speech 3.00 N i410A If yes, bugh 215, as	4.00 N 1.00 N	109.0
CFR Section §412.113(c). Enter "Y" for yes or "N" for no. 09.00 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. 10.00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter "Y" complete Worksheet E, Part A, lines 200 through 218, and Works applicable.	Physical Oc 1.00 N N N Demonstration " "for yes or "N sheet E-2, line e Frontier Comm t reporting per umn 1 is Y, ent icipating in co	ccupational 2.00 N project (§ " for no. s 200 thrc unity iod? Enter er the lumn 2.	Speech 3.00 N i410A If yes, bugh 215, as 1.00 N	4.00 N	109. 0 1109. 0
CFR Section §412.113(c). Enter "Y" for yes or "N" for no. 09.00 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. 10.00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter "Y' complete Worksheet E, Part A, lines 200 through 218, and Works applicable. 11.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this cost "Y" for yes or "N" for no in column 1. If the response to coluin integration prong of the FCHIP demo in which this CAH is partiEnter all that apply: "A" for Ambulance services; "B" for additional content of the content of the content of the content of the column content of the content of	Physical Oc 1.00 N N N Demonstration " "for yes or "N sheet E-2, line e Frontier Comm t reporting per umn 1 is Y, ent icipating in co	ccupational 2.00 N project (§ " for no. s 200 thrc unity iod? Enter er the lumn 2.	Speech 3.00 N i410A If yes, bugh 215, as 1.00 N	4.00 N 1.00 N	109. 0 1109. 0
 CFR Section §412.113(c). Enter "Y" for yes or "N" for no. 09.00 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. 10.00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter "Y' complete Worksheet E, Part A, Lines 200 through 218, and Works applicable. 11.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this cost "Y" for yes or "N" for no in column 1. If the response to color integration prong of the FCHIP demo in which this CAH is partient Enter all that apply: "A" for Ambulance services; "B" for addi for tele-health services. 12.00 Did this hospital participate in the Pennsylvania Rural Health (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y", enter in column 2, the date the hospital began participate demonstration. In column 3, enter the date the hospital cease participation in the demonstration, if applicable. 	Physical Oc 1.00 N N Demonstration "for yes or "N sheet E-2, line e Frontier Comm t reporting per umn 1 is Y, ent icipating in co itional beds; a h Model orting umn 1 is ting in the	project (§ " for no. s 200 thrc uni ty i od? Enter er the I umn 2. nd/or "C"	Speech 3.00 N i410A If yes, bugh 215, as 1.00 N	4.00 N 1.00 N 2.00	109. 0 110. 0 111. 0
 CFR Section §412.113(c). Enter "Y" for yes or "N" for no. 09.00 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. 10.00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter "Y' complete Worksheet E, Part A, lines 200 through 218, and Works applicable. 11.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this cost "Y" for yes or "N" for no in column 1. If the response to coluintegration prong of the FCHIP demo in which this CAH is participate in the for tele-health services. 12.00 Did this hospital participate in the Pennsylvania Rural Health (PARHM) demonstration for any portion of the current cost reporting eriod? Enter "Y" for yes or "N" for yes or "N" for no in column 1. If colum 1. If colum 1. If column 2. the date the hospital began participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information 15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or 'in column 2. If column 2 is "E", enter in column 3 either "93" for short term hospital or "98" percent for long term care (in psychiatric, rehabilitation and long term hospitals providers) 	Physical Oc 1.00 N N N Demonstration " "for yes or "N sheet E-2, line e Frontier Comm t reporting per umn 1 is Y, enticipating in co icipating in co itional beds; a h Model orting umn 1 is ting in the ed "N" for no or E only) " percent ncludes	ccupational 2.00 N project (§ " for no. s 200 thro s 200 thro i od? Enter er the l umn 2. nd/or "C" 1.00	Speech 3.00 N i410A If yes, bugh 215, as 1.00 N	4.00 N 1.00 N 2.00 3.00	109.0
 CFR Section §412.113(c). Enter "Y" for yes or "N" for no. 09.00 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. 10.00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter "Y' complete Worksheet E, Part A, lines 200 through 218, and Works applicable. 11.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this cost "Y" for yes or "N" for no in column 1. If the response to colu integration prong of the FCHIP demo in which this CAH is partification prong of the FCHIP demo in which this CAH is part Enter all that apply: "A" for Ambulance services; "B" for addifor tele-health services. 12.00 Did this hospital participate in the Pennsyl vania Rural Health (PARHM) demonstration for any portion of the current cost reporting the date the hospital began participate demonstration. In column 3, enter the date the hospital cease participation in the demonstration, if applicable. 15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "in column 1. If column 2. if column 2. is "E", enter in column 3 either "93" for short term hospital or "98" percent for long term care (in the current cost center). 	Physical Oc 1.00 N N Image: Constraint on the second secon	ccupational 2.00 N project (§ " for no. s 200 thrc unity iod? Enter er the lumn 2. nd/or "C" <u>1.00</u> N	Speech 3.00 N i410A If yes, bugh 215, as 1.00 N	4.00 N 1.00 N 2.00 3.00	109. 0 109. 0 110. 0

ealth Financial Systems OSPITAL AND HOSPITAL HEALTH CARE	GOOD SAMARITAN HO	Provider CCI		eriod: rom 01/01/2023	u of Form CMS Worksheet S Part I Date/Time P 4/11/2024 3	-2 repared:
			Premi ums	Losses	Insurance	
18.01 List amounts of malpractice	promitime and paid Lossos:		<u>1.00</u> 483,019	2.00	3.00	0118.01
			403, 017	0		0110.01
19 02 Are mal practice promiume an	d paid losses reported in a cost cer	tor other t	han the	1.00 N	2.00	118.02
Administrative and General? and amounts contained there	If yes, submit supporting schedule			N		
§3121 and applicable amendm "N" for no. Is this a rural	qualifies for the Outpatient Hold Ha ents? (see instructions) Enter in cc hospital with < 100 beds that quali ACA §3121 and applicable amendments? ves or "N" for no	lumn 1, "Y" fies for th	for yes or ne Outpatient	Ν	Ν	119.00 120.00
21.00 Did this facility incur and	report costs for high cost implanta	bl e devi ces	s charged to	Y		121.00
Act?Enter "Y" for yes or "N	n healthcare related taxes as define " for no in column 1. If column 1 is			Y	5.00	122.00
23.00 Did the facility and/or its	where these taxes are included. subproviders (if applicable) purcha unting, tax preparation, bookkeeping			Y	N	123.00
management/consulting servi for yes or "N" for no. If column 1 is "Y", were th professional services expen located in a CBSA outside o "N" for no.	ces, from an unrelated organization? e majority of the expenses, i.e., gr ses, for services purchased from unr f the main hospital CBSA? In column	In column reater than related orga	1, enter "Y" 50% of total nizations			
	a Medicare-certified transplant cent		Y" for yes	N		125.00
6.00 If this is a Medicare-certi	er certification date(s) (mm/dd/yyyy fied kidney transplant program, ente		fication date			126.00
27.00 If this is a Medicare-certi	date, if applicable, in column 2. fied heart transplant program, enter	the certif	ication date			127.00
8.00 If this is a Medicare-certi	date, if applicable, in column 2. fied liver transplant program, enter	the certif	ication date			128.00
9.00 If this is a Medicare-certi	date, if applicable, in column 2. fied lung transplant program, enter date, if applicable, in column 2.	the certifi	cation date			129.00
30.00 If this is a Medicare-certi	fied pancreas transplant program, en ation date, if applicable, in column		ti fi cati on			130.00
1.00 If this is a Medicare-certi	fied intestinal transplant program, ation date, if applicable, in column	enter the c	certi fi cati on			131.00
32.00 If this is a Medicare-certi	fied islet transplant program, enter date, if applicable, in column 2.		ication date			132.00
33.00 Removed and reserved						133.00
in column 1 and termination	organ procurement organization (OPC date, if applicable, in column 2.), enter th	ne OPO number			134.00
chapter 10? Enter "Y" for y	ization or home office costs as defi es or "N" for no in column 1. If yes n 2 the home office chain number. (s	, and home	office costs	N		140.00
1.00	a chain organization, enter on line			3.00 me and address	of the home	_
office and enter the home o	ffice contractor name and contractor				S. the holde	
41.00Name: 42.00Street:	Contractor's Name: PO Box:		Contractor	s Number:		141.00 142.00
13. 00/Ci ty:	State:		Zip Code:			143.00
					1.00	
44.00 Are provider based physicia	ns' costs included in Worksheet A?				1.00 Y	144.00
				1.00	2.00	_
inpatient services only? En	are claimed on Wkst. A, line 74, ar ter "Y" for yes or "N" for no in col ity include Medicare utilization for	umn 1. lf c	olumn 1 is	1.00	2.00	145.00
period? Enter "Y" for yes			. 0	N		146.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provi	ider CC	N: 15-0042		eri od:		Worksheet S-	2
					Fr Tc		/01/2023 /31/2023		
								1.00	
47.00 Was there a change in the statist	cal basis? Enter "Y"	for ves or "	'N" for	no				N 1.00	147.0
48.00Was there a change in the order o								N	148.0
49.00 Was there a change to the simplif					for r	no.		N	149.0
		Part		Part			tle V	Title XIX	
		1. (2.00		-	. 00	4.00	
Does this facility contain a prov or charges? Enter "Y" for yes or		omponent for	Part A	and Part			CFR §41	3. 13)	
55.00Hospital		N		N			N	N	155.0
56.00 Subprovider - IPF 57.00 Subprovider - IRF		N		N N			N N	N N	156. C
58. 00 SUBPROVI DER		IN IN		IN			IN	IN IN	158.0
59. 00 SNF		N		N			Ν	N	159.0
60.00HOME HEALTH AGENCY		N		N			N	N	160.0
61.00 CMHC				N			Ν	N	161.0
								1.00	
Multicampus								1	_
55.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	ampus hospital that ha	as one or mor	re campi	uses in d	i ffere	ent CB	SAs?	N	165. (
	Name	Count		State	Zip		CBSA	FTE/Campus	_
	0	1.00		2.00	3.	00	4.00	5.00	
66.00 If line 165 is yes, for each campus enter the name in column								0.0	0166.0
0, county in column 1, state in									
column 2, zip code in column 3,									
CBSA in column 4, FTE/Campus in									
column 5 (see instructions)									
								1.00	-
Health Information Technology (HI						Act			
67.00 Is this provider a meaningful use								Y	167.0
68.00 If this provider is a CAH (line 10			er (line	e 167 is	"Y"),	enter	the		168.0
reasonable cost incurred for the l					£		- l- 1		1100
68.01 If this provider is a CAH and is exception under §413.70(a)(6)(ii)'						a nard	sni p		168. C
69.00 If this provider is a meaningful transition factor. (see instruction	user (line 167 is "Y")					N"), ei	nter the	9.9	9169. (
	·					Begi	nni ng	Endi ng	
						1	. 00	2.00	
70.00 Enter in columns 1 and 2 the EHR period respectively (mm/dd/yyyy)	beginning date and end	ling date for	the re	eporti ng					170.0
						1	. 00	2.00	-
71.00 If line 167 is "Y", does this prov	ider have any dave fo	n individual	s enrol	lledin		1	. 00 N		0171.0
section 1876 Medicare cost plans		Pt. I, line	e 2, col	I. 6? Ent			IN		

SPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0042	Period: From 01/01/2023 To 12/31/2023		
				10 12/31/2023	4/11/2024 3:	
				Y/N	Date	
				1.00	2.00	_
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSE			ton all datas in	+ h a	_
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format.		esponses. Em		the	
	COMPLETED BY ALL HOSPITALS					_
	Provider Organization and Operation					
00	Has the provider changed ownership immediately prior to the	beainnina of	the cost	N		1.
	reporting period? If yes, enter the date of the change in c			5)		
			Y/N	Date	V/I	
			1.00	2.00	3.00	
00	Has the provider terminated participation in the Medicare P		N			2.
	yes, enter in column 2 the date of termination and in colum	n 3, "V" for				
	voluntary or "I" for involuntary.					
00	Is the provider involved in business transactions, includin		N			3.
	contracts, with individuals or entities (e.g., chain home o					
	or medical supply companies) that are related to the provid					
	officers, medical staff, management personnel, or members o					
	of directors through ownership, control, or family and othe	r similar				
	relationships? (see instructions)		Y/N	Tupo	Date	_
			1.00	Type 2.00	3.00	
	Financial Data and Reports		1.00	2.00	5.00	
00	Column 1: Were the financial statements prepared by a Cert	ified Public	Y	А		4
	Accountant? Column 2: If yes, enter "A" for Audited, "C" f	for Compiled.				
	or "R" for Reviewed. Submit complete copy or enter date ava					
	column 3. (see instructions) If no, see instructions.					
00	Are the cost report total expenses and total revenues diffe	rent from	N			5
	those on the filed financial statements? If yes, submit rec	onciliation.				
				Y/N	Legal Oper.	
				1.00	2.00	
	Approved Educational Activities					
00	Column 1: Are costs claimed for a nursing program? Column	2: If yes, i	s the provide	er N		6
	the legal operator of the program?					_
00	Are costs claimed for Allied Health Programs? If "Y" see in			Y		7
00	Were nursing programs and/or allied health programs approve	d and/or rene	wed during th	ne N		8.
	cost reporting period? If yes, see instructions.			N/		
00	Are costs claimed for Interns and Residents in an approved		cal education	ו Y		9
00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated o		the current	Y		10
00	cost reporting period? If yes, see instructions.	i renewed in	the current	I		
00	Are GME cost directly assigned to cost centers other than I	& Rinan An	nroved	Ν		11
00	Teaching Program on Worksheet A? If yes, see instructions.	a k in an Ap	proved	IN		1
					Y/N	
					1.00	-
	Bad Debts					
00	Is the provider seeking reimbursement for bad debts? If yes	. see instruc	tions.		Y	12
00	If line 12 is yes, did the provider's bad debt collection p	olicy change	during this o	cost reporting	Ν	13
	period? If yes, submit copy.	5 5	J I	. 5		
00	If line 12 is yes, were patient deductibles and/or coinsura	nce amounts w	aived? If yes	s, see	Ν	14
	instructions.					
-	Bed Complement					
00	Did total beds available change from the prior cost reporti			structions.	N	15
			t A	Par		_
	-	Y/N	Date	Y/N	Date	_
	DS&D Data	1.00	2.00	3.00	4.00	
00	PS&R Data Was the cost report prepared using the PS&R Report only?	Y	03/08/2024	Y	03/08/2024	16
00	If either column 1 or 3 is yes, enter the paid-through	I	03/00/2024	I	037 007 2024	10
	date of the PS&R Report used in columns 2 and 4 . (see					
	instructions)					
00	Was the cost report prepared using the PS&R Report for	Ν		Ν		17
	totals and the provider's records for allocation? If					
	either column 1 or 3 is yes, enter the paid-through date					
	in columns 2 and 4. (see instructions)					
	If line 16 or 17 is yes, were adjustments made to PS&R	Ν		Ν		18
00	Report data for additional claims that have been billed					
00						
00	but are not included on the PS&R Report used to file this I			1		1
00	but are not included on the PS&R Report used to file this cost report? If yes, see instructions.					
00	but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R	Ν		N		19
	cost report? If yes, see instructions.	Ν		Ν		19

	TAN HOSPITAL			eu of Form CN	
OSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CC	N: 15-0042	Period: From 01/01/2023 To 12/31/2023		Prepare
	Descri	ntion	Y/N	Y/N	<u>3. 17 pi</u>
	0		1.00	3.00	
0.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.
	Y/N	Date	Y/N	Date	
	1.00	2.00	3.00	4.00	
. 00 Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	CEPT CHILDRENS H	OSPI TALS)		1 11 00	
Capital Related Cost					
2.00 Have assets been relifed for Medicare purposes? If yes, se				N	22
8.00 Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	e due to apprais	als made du	uring the cost	N	23
I. 00 Were new Leases and/or amendments to existing Leases enter If yes, see instructions	red into during	this cost r	reporting period?	Y	24
5.00 Have there been new capitalized leases entered into during instructions.	g the cost repor	ting period	d?lfyes, see	Y	25
 00 Were assets subject to Sec. 2314 of DEFRA acquired during to instructions. 	the cost reporti	ng period?	lf yes, see	N	26
7.00 Has the provider's capitalization policy changed during the copy.	he cost reportin	ıg period? I	fyes, submit	N	27
Interest Expense .00 Were new Loans, mortgage agreements or letters of credit e	entered into dur	ing the cor	at reporting	N N	28
period? If yes, see instructions.		0			
00 Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see inst	tructions	N	29		
.00 Has existing debt been replaced prior to its scheduled man instructions.	-	-		N	30
.00 Has debt been recalled before scheduled maturity without i instructions. Purchased Services	issuance of new	debt? If ye	es, see	N	31
.00 Have changes or new agreements occurred in patient care se		d through d	contractual	N	32
arrangements with suppliers of services? If yes, see instr .00 If line 32 is yes, were the requirements of Sec. 2135.2 ap no, see instructions.		g to compet	titive bidding? It	f	33
Provider-Based Physicians .00 Were services furnished at the provider facility under an	arrangement wit	h provider.	based physicians	ł Y	34
If yes, see instructions.	0	·		Y	35
.00 If line 34 is yes, were there new agreements or amended exphysicians during the cost reporting period? If yes, see i	i nstructi ons.		•	T	30
			Y/N 1.00	Date 2.00	
Home Office Costs			NI	1	
.00 Were home office costs claimed on the cost report? .00 If line 36 is yes, has a home office cost statement been p	prepared by the	home office	€?		36
If yes, see instructions. .00 If line 36 is yes , was the fiscal year end of the home of					38
the provider? If yes, enter in column 2 the fiscal year er .00 If line 36 is yes, did the provider render services to oth			es,		39
see instructions. .00 If line 36 is yes, did the provider render services to the	e home office?	lf yes, see	e		40
i nstructi ons.					
	1. (00	2.	00	
Cost Report Preparer Contact Information .00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	KYLE		SMI TH		41
respectivel y.					42
2.00 Enter the employer/company name of the cost report preparer.	BLUE & CO, LLC				1 12

Heal th	Financial Systems GOOD SAMA	RITAN HOSPITAL		In Lieu	u of Form CMS-2	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CC		Period:	Worksheet S-2	
				rom 01/01/2023 o 12/31/2023	Date/Time Pre 4/11/2024 3:1	pared: 7 pm
		3.0	0			
	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					
	respectively.					
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
	report preparer in columns 1 and 2, respectively.					

	Financial Systems TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	GOOD SAMARITA	Provi der CO	CN· 15-0042	Peri od:	u of Form CMS-2 Worksheet S-3	
					From 01/01/2023 To 12/31/2023	Part I Date/Time Pre	pared:
						4/11/2024 3:1 I/P Days /	/pm
						0/P Visits /	
						Tri ps	
	Component	Worksheet A	No. of Beds	Bed Days	CAH/REH Hours	Title V	
		Line No.	2.00	Available	4.00	F 00	
	PART I – STATI STI CAL DATA	1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30, 00	69	25, 18	5 0.00	0	1.0
	8 exclude Swing Bed, Observation Bed and					-	
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2.0
. 00	HMO I PF Subprovi der						3.0
. 00	HMO I RF Subprovi der						4.0
. 00 . 00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF					0	
. 00	Total Adults and Peds. (exclude observation		69	25, 18	0.00	-	
. 00	beds) (see instructions)		07	25,10	0.00	0	/.(
. 00	I NTENSI VE CARE UNI T	31.00	30	10, 95	0.00	0	8.0
. 00	CORONARY CARE UNIT						9. (
0. OO	BURN INTENSIVE CARE UNIT						10.0
1.00	SURGICAL INTENSIVE CARE UNIT						11. (
2.00	OTHER SPECIAL CARE (SPECIFY)						12.0
3.00	NURSERY	43.00				0	
4.00	Total (see instructions)		99	36, 13	0.00		14.0
5.00	CAH visits				0.00	0	
5.10 6.00	REH hours and visits SUBPROVIDER - IPF	40.00	20	7,30	0.00	0	
7.00	SUBPROVIDER - IRF	40.00	20			0	
8.00	SUBPROVI DER	41.00	20	7,12		0	18.0
9.00	SKILLED NURSING FACILITY						19.0
0.00	NURSING FACILITY						20.0
1.00	OTHER LONG TERM CARE						21. (
2.00	HOME HEALTH AGENCY	101.00				0	22.0
3.00	AMBULATORY SURGICAL CENTER (D. P.)						23.0
4.00	HOSPICE	116.00	0		0		24.
4.10	HOSPICE (non-distinct part)	30.00					24.
5.00	CMHC - CMHC						25.
5.00	FAMILY PRACTICE 120	88.00				0	
5.25 7.00	FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26)	89.00	144			0	26. 27.
3.00	Observation Bed Days		144			0	
9.00	Ambulance Trips					0	20.
). 00). 00	Employee discount days (see instruction)						30.
1.00	Employee discount days - IRF						31.0
2.00	Labor & delivery days (see instructions)		0		0		32.0
2. 01	Total ancillary labor & delivery room						32.0
	outpatient days (see instructions)						
3.00	LTCH non-covered days						33.0
3.01	LTCH site neutral days and discharges		_			-	33.0
4.00	Temporary Expansion COVID-19 PHE Acute Care	30.00	0		0	0	34.0

	Financial Systems TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	GOOD SAMARITAN	Provi der CC	N· 15-0042	Peri od:	u of Form CMS-: Worksheet S-3	
103111	AL AND HOST THE HEALTH OAKE COMPLEX STATISTIC				From 01/01/2023 To 12/31/2023	Part I	pared:
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I – STATISTICAL DATA				-		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	4, 497	405	9, 71	3		1.00
	8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	3, 537	2, 230				2.00
3.00	HMO I PF Subprovider	537	1, 464				3.00
4.00	HMO IRF Subprovider	533	219				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 beds) (see instructions)	4, 497	405	9, 71			7.00
8.00	INTENSIVE CARE UNIT	1, 988	0	4, 81	2		8.00
9.00 10.00	CORONARY CARE UNIT						9.00
11.00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		0	81	6		13.00
14.00	Total (see instructions)	6, 485	405	15, 34	-	1, 368. 63	
15.00	CAH visits	0	0		0	1,000,00	15.00
15.10	REH hours and visits	0	0		0		15.10
16.00	SUBPROVIDER - IPF	532	357	4, 32	3 3. 98	28.66	16.00
17.00	SUBPROVIDER - IRF	4, 578	17	6, 25	2 0.00	29. 53	17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0		0 0.00	0.00	
23.00	AMBULATORY SURGICAL CENTER (D. P.)				0 0 00	0.10	23.00
24.00 24.10	HOSPICE	0	0	40	0 0.00	8. 12	24.00 24.10
25.00	HOSPICE (non-distinct part) CMHC - CMHC			40	4		24.10
26.00	FAMILY PRACTICE 120	0	0		6 0.00	0.06	•
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0.00		
27.00	Total (sum of lines 14-26)	0	0		43.55		•
28.00	Observation Bed Days		476	2, 55		.,	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	416	87			32.00
32.01	Total ancillary labor & delivery room				0		32.01
	outpatient days (see instructions)						
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0		0		34.00

OSPI 1	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider C	CN: 15-0042	Period: From 01/01/2023 To 12/31/2023	Worksheet S-3 Part I Date/Time Pre 4/11/2024 3:1	pare
		Full Time		Dis	charges		
	Component	Equi val ents Nonpai d	Title V	Title XVIII	Title XIX	Total All	
	component	Workers	nue v		II LIE AIA	Patients	
		11.00	12.00	13.00	14.00	15.00	
	PART I – STATISTICAL DATA						
. 00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	1, 69	90 94	4, 032	1.
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
00	for the portion of LDP room available beds) HMO and other (see instructions)			70	9 860		2.
00	HMO IPF Subprovider				282		3.
00	HMO I RF Subprovi der				18		4
00	Hospital Adults & Peds. Swing Bed SNF				10		5
00	Hospital Adults & Peds. Swing Bed SM Hospital Adults & Peds. Swing Bed NF						6
00	Total Adults and Peds. (exclude observation						7
00	beds) (see instructions)						´
00	INTENSIVE CARE UNIT						8
00	CORONARY CARE UNIT						9
. 00	BURN INTENSIVE CARE UNIT						10
. 00	SURGICAL INTENSIVE CARE UNIT						11
. 00	OTHER SPECIAL CARE (SPECIFY)						12
8.00	NURSERY						13
. 00	Total (see instructions)	0.00	0	1, 69	90 94	4, 032	
. 00	CAH visits						15
5. 10	REH hours and visits						15
. 00	SUBPROVIDER - IPF	0.00	0		37 63	818	
. 00	SUBPROVIDER - IRF	0.00	0	30)2 1	407	17
. 00	SUBPROVIDER						18
. 00	SKILLED NURSING FACILITY						19
0.00	NURSING FACILITY						20
. 00	OTHER LONG TERM CARE	0.00					21
. 00	HOME HEALTH AGENCY	0.00					22
. 00	AMBULATORY SURGICAL CENTER (D. P.) HOSPICE	0.00					23
. 10	HOSPICE (non-distinct part)	0.00					24
. 00	CMHC - CMHC						25
. 00	FAMILY PRACTICE 120	0.00					26
. 25	FEDERALLY QUALIFIED HEALTH CENTER	0,00					26
. 00	Total (sum of lines 14-26)	0.00					27
3.00	Observation Bed Days						28
. 00	Ambulance Trips						29
. 00	Employee discount days (see instruction)						30
. 00	Employee discount days - IRF						31
. 00	Labor & delivery days (see instructions)						32
. 01	Total ancillary labor & delivery room						32
	outpatient days (see instructions)						
. 00	LTCH non-covered days				0		33
3. 01	LTCH site neutral days and discharges				0		33
4.00	Temporary Expansion COVID-19 PHE Acute Care						34

	Financial Systems AL WAGE INDEX INFORMATION		GOOD SAMARITA	Provider C		eriod: rom 01/01/2023		pare
		Wkst. A Line Number	Amount Reported	Reclassificat ion of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	PART II - WAGE DATA	1.00	2.00	3.00	4.00	5.00	6.00	
	SALARI ES				1			
00	Total salaries (see instructions)	200.00	110, 193, 141	0	110, 193, 141	2, 935, 332. 00	37.54	1
00	Non-physician anesthetist Part		0	0	0	0.00	0.00	2
00	A Non-physician anesthetist Part		0	0	0	0.00	0.00	3
00	B Physician-Part A -		0	0	0	0.00	0.00	4
	Administrative		-	_	_			
01 00	Physicians - Part A - Teaching Physician and Non		0 9, 092, 375	-	-	0. 00 36, 359. 00		
	Physician-Part B							
00	Non-physician-Part B for hospital-based RHC and FQHC services		21, 835					
00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7
01	Contracted interns and residents (in an approved		3, 615, 557	0	3, 615, 557	82, 326. 00	43. 92	7
	programs) Home office and/or related organization personnel		0	0	0	0.00	0.00	
00 . 00	SNF Excluded area salaries (see	44.00	0 25, 752, 706	0 1, 572, 092	0 27, 324, 798	0. 00 678, 943. 00		
	instructions)		20,702,700		21,021,170	0.07,710100	10120	
00	OTHER WAGES & RELATED COSTS Contract Labor: Direct Patient		4, 236, 110	0	4, 236, 110	90, 077. 00	47.03	11
00	Care		0	0	0	0.00	0.00	1.
00	Contract Labor: Top Level management and other management and administrative		0			0.00	0.00	
00	services Contract Labor: Physician-Part		638, 804	0	638, 804	4, 485. 00	142. 43	13
	A - Administrative Home office and/or related organization salaries and		0	0	0	0.00	0.00	14
01	wage-related costs					0.00		
	Home office salaries Related organization salaries		0	0	0	0. 00 0. 00		
	Home office: Physician Part A		0	0	0			
00	- Administrative Home office and Contract		0	0	0	0.00	0.00	16
01	Physicians Part A - Teaching Home office Physicians Part A		0			0.00	0.00	14
01	- Teaching		0		0	0.00	0.00	
02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16
00	WAGE-RELATED COSTS Wage-related costs (core) (see		20, 866, 469	0	20, 866, 469			1 17
	instructions)		., , ,					
00	Wage-related costs (other) (see instructions)							18
00 00	Excluded areas Non-physician anesthetist Part		6, 528, 587 0	0	6, 528, 587 0			19
	A Non-physician anesthetist Part		0	0	0			21
00	B Physician Part A - Administrative		0	0	0			22
	Physician Part A - Teaching		0	0	0			22
	Physician Part B Wage-related costs (RHC/FQHC)		797, 867 5, 149	0 0	797, 867 5, 149			23
	Interns & residents (in an		0	0	0			25
50	approved program) Home office wage-related		0	0	о			25
	(core) Related organization		0	 ∩	 ∩			25
	wage-related (core)		0					
. 52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25

Heal th	Financial Systems		GOOD SAMARI TA	AN HOSPITAL		In Lie	u of Form CMS-2	2552-10
	AL WAGE INDEX INFORMATION			Provider C		Period: From 01/01/2023 To 12/31/2023	Worksheet S-3 Part II	pared:
		Wkst. A Line Number	Amount Reported	Reclassificat	Adjusted Salaries	Paid Hours Related to	Average Hourly Wage	
		Number	Reported	Salaries	$(col.2 \pm col)$		(col. 4 ÷	
				(from Wkst.	3)	col. 4	col. 5)	
				A-6)	3)	001. 4	001. 3)	
		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)							
	OVERHÉAD COSTS - DI RECT SALARI							
26.00	Employee Benefits Department	4.00	6, 006, 745					
27.00	Administrative & General	5.00	7, 853, 050		7, 853, 05			
28.00	Administrative & General under		1, 249, 762	0	1, 249, 76	8, 828. 00	141.57	28.00
	contract (see inst.)							
29.00	Maintenance & Repairs	6.00	0	0		0 0.00		29.00
30.00	Operation of Plant	7.00	2, 576, 329		2, 576, 32			
31.00	Laundry & Linen Service	8.00	239, 763		239, 76			
32.00	Housekeeping	9.00	2, 339, 766	0	2, 339, 76			
33.00	Housekeeping under contract		0	0		0 0.00	0.00	33.00
24.00	(see instructions)	10.00	1 00/ 110	1 401 040	FOF 20	21 002 00	22.00	24.00
34.00	Dietary	10.00	1, 906, 448	-1, 401, 049	505, 39			34.00 35.00
35.00	Dietary under contract (see instructions)		0	0		0 0.00	0.00	35.00
36.00	Cafeteri a	11.00	0	1, 401, 049	1, 401, 04	74, 394. 00	10 02	36.00
37.00	Maintenance of Personnel	12.00	0	1, 401, 049		0 74, 394.00	0.00	
38.00	Nursing Administration	13.00	2, 284, 261		2, 284, 26			
39.00	Central Services and Supply	13.00	386, 217		386, 21			39.00
40.00	Pharmacy	14.00	3, 202, 203		3, 202, 20			40.00
40.00	Medical Records & Medical	16.00	4, 038, 556		4, 038, 55			
41.00	Records Library	10.00	4,000,000		4,030,55	123, 434.00	52.72	-1.00
42.00	Social Service	17.00	345, 494	0	345, 49	7, 166. 00	48 21	42.00
	Other General Service	18.00	010, 171			0 0.00		43.00
.0.00			0		1	-1 0.00	5.00	

Heal th	Financial Systems		GOOD SAMARI TA	AN HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPI	FAL WAGE INDEX INFORMATION			Provider C		Period: From 01/01/2023 To 12/31/2023		pared:
		Worksheet A	Amount	Recl assi fi cat	Adj usted	Paid Hours	Average	
		Line Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
				Sal ari es	(col.2 ± col.	Salaries in	(col. 4 ÷	
				(from	3)	col. 4	col. 5)	
				Worksheet				
				A-6)				
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY			_			
1.00	Net salaries (see		98, 713, 136	0	98, 713, 13	6 2, 825, 010. 00	34.94	1.00
	instructions)							
2.00	Excluded area salaries (see		25, 752, 706	1, 572, 092	27, 324, 79	8 678, 943. 00	40. 25	2.00
	instructions)							
3.00	Subtotal salaries (line 1		72, 960, 430	-1, 572, 092	71, 388, 33	8 2, 146, 067. 00	33.26	3.00
	minus line 2)							
4.00	Subtotal other wages & related		4, 874, 914	0	4, 874, 91	4 94, 562. 00	51.55	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		20, 866, 469	0	20, 866, 46	9 0.00	29.23	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		98, 701, 813	-1, 572, 092	97, 129, 72	1 2, 240, 629. 00	43.35	6.00
7.00	Total overhead cost (see		32, 428, 594	0	32, 428, 59	4 1, 076, 966. 00	30. 11	7.00
	instructions)							
								•

Heal th	n Financial Systems	GOOD SAMARI TAN	HOSPI TAL			In Lie	eu of Form CMS-2	2552-10
	TAL WAGE RELATED COSTS		Provi der	CCN: 15-0		Period: From 01/01/2023 To 12/31/2023		pared:
							Amount Reported	
							1.00	
	PART IV - WAGE RELATED COSTS						1.00	
	Part A - Core List							
	RETI REMENT COST							
1.00	401K Employer Contributions						0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contr	ibution					0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (se	e instructions)					4, 563, 535	3.00
4.00	Qualified Defined Benefit Plan Cost (see i	nstructions)					0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External	Organi zati on)						
5.00	401K/TSA Plan Administration fees						0	5.00
6.00	Legal /Accounting/Management Fees-Pension P	lan					0	6.00
7.00	Employee Managed Care Program Administrati	on 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 Th						0	
8.02	Health Insurance (Self Funded with a Third	Party Administrat	or)				14, 610, 500	8.02
8.03	Health Insurance (Purchased)						0	8.03
9.00	Prescription Drug Plan						0	9.00
10.00	Juli Juli Juli Juli Juli Juli Juli Juli						293, 116	
11.00							112, 135	
12.00							0	
13.00							228, 469	
14.00		wner or beneficiar	y)				0	
15.00							591, 201	
16.00	Retirement Health Care Cost (Only current	year, not the extr	aordi nary 🛛	accrual r	requi re	d by FASB 106.	0	16.00
	Noncumulative portion)							
47 00	TAXES						7 570 045	47.00
	FICA-Employers Portion Only						7, 573, 845	
18.00							0	
19.00							0	
20.00	State or Federal Unemployment Taxes						0	20.00
21 00	OTHER Executive Deferred Compensation (Other Tha	- Dati manant Cast					2(2()	01 00
21.00	instructions))	n Retirement Cost	Reported of	n Tines I	throu	gn 4 above. (se	26, 266	21.00
22.00							199,005	22 00
	Tuition Reimbursement						0	
	Total Wage Related cost (Sum of lines 1 -2	3)					28, 198, 072	
250	Part B - Other than Core Related Cost	-,					20, 1.0, 012	
25.00	OTHER WAGE RELATED COSTS (SPECIFY)							25.00

Heal th	Financial Systems	GOOD SAMARI TAN	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPI	TAL CONTRACT LABOR AND BENEFIT COST		Provider CC	N: 15-0042	Period: From 01/01/2023	Worksheet S-3 Part V	
					To 12/31/2023	Date/Time Pre	
						4/11/2024 3:1	7 pm
	Cost Center Description				Contract	Benefit Cost	
					Labor	0.00	
					1.00	2.00	
	PART V - Contract Labor and Benefit Cost						
	Hospital and Hospital-Based Component Identif						
1.00	Total facility's contract labor and benefit of	cost			4, 236, 110		1.00
2.00	Hospi tal				4, 236, 110	28, 198, 072	2.00
3.00	SUBPROVIDER - IPF				0	0	3.00
4.00	SUBPROVIDER - IRF				0	0	4.00
5.00	Subprovider - (Other)				0	0	5.00
6.00	Swing Beds - SNF				0	0	6.00
7.00	Swing Beds - NF				0	0	7.00
8.00	SKILLED NURSING FACILITY						8.00
9.00	NURSING FACILITY						9.00
10.00	OTHER LONG TERM CARE I						10.00
11.00	Hospital-Based HHA				0	0	11.00
12.00	AMBULATORY SURGICAL CENTER (D. P.) I						12.00
13.00	Hospi tal -Based Hospi ce				0	0	13.00
14.00	Hospital-Based Health Clinic RHC				0	0	14.00
15.00	Hospital-Based Health Clinic FQHC						15.00
16.00	Hospital-Based-CMHC						16.00
17.00	RENAL DIALYSIS I						17.00
18.00	Other				0	0	18.00

Heal th	Financial Systems	GOOD SAMARI TA	AN HOSPITAL		In Li	eu of Form CMS-	2552-10
HOSPI T	AL-BASED RHC/FQHC STATISTICAL DATA		Provider C		Period:	Worksheet S-	3
			Component		rom 01/01/2023 o 12/31/2023		epared: 17 pm
					RHC I	Cost	
					1	. 00	-
1 00	Clinic Address and Identification						1 00
1.00	Street		Ci	ty	406 N. 1ST, S State	UITE C ZIP Code	1.00
				00	2.00	3.00	
2.00	City, State, ZIP Code, County		VINCENNES			N 47591	2.00
						1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for rura	al or "U" for u			(3.00
					Award 00	Date 2.00	
	Source of Federal Funds			<u> </u>	00	2.00	
4.00	Community Health Center (Section 330(d), PHS						4.00
5.00	Migrant Health Center (Section 329(d), PHS A						5.00
6.00 7.00	Health Services for the Homeless (Section 34 Appalachian Regional Commission	U(d), PHS ACT)					6.00 7.00
8.00	Look-Alikes						8.00
9.00	OTHER (SPECIFY)						9.00
					1.00	2.00	
10.00	Does this facility operate as other than a h	ospital-based F	RHC or FQHC? E	nter "Y" for	N		10.00
	yes or "N" for no in column 1. If yes, indic 2. (Enter in subscripts of line 11 the type o hours.)						
		Sund	day	Mor	nday	Tuesday	
		from	to	from	to	from	
	Facility hours of operations (1)	1.00	2.00	3.00	4.00	5.00	
11.00				08: 30	16: 30	08: 30	11.00
					1.00	0.00	
12.00	Have you received an approval for an excepti	on to the produ	ictivity stand	ard?	1.00 N	2.00	12.00
	Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.	d in CMS Pub. 1 umn 1. If yes,	100-04, chapte enter in colu	r 9, section mn 2 the	N	(
13.01	If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoli separate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered c comprised exclusively of new consolidated RH)? Enter "Y" f dated RHC group RHC grouping. onsolidated RHC	for yes or "N" bings and comp Consolidated Cs in the grou	for no. If lete a RHC groupings		C) 13.01
	,		d'		er name	CCN	
14.00				1.	00	2.00	14.00
14.00	RHC/FQHC name, CCN	Y/N	V	XVIII	XIX	Total Visits	14.00
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00

Health Financial Systems	GOOD SAMARIT.	AN HOSPI TAL		In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider C	CN: 15-0042	Period:	Worksheet S-8	3
		Component	CCN: 15-8577	From 01/01/2023 To 12/31/2023		
		_		RHC I	Cost	
		Cou	unty			
		4.	00			
2.00 City, State, ZIP Code, County		KNOX				2.00
	Tuesday	Wednesday		Thursday		
	to	from	to	from	to	
	6.00	7.00	8.00	9.00	10.00	
Facility hours of operations (1)						
11.00 CLINIC	16: 30	08: 30	16: 30	08: 30	16: 30	11.00
	Fri	day	Sa	turday		
	from	to	from	to		
	11.00	12.00	13.00	14.00		
Facility hours of operations (1)						
11.00 CLINIC	08: 30	16: 30				11.00

lealth Financial Systems		GOOD SAMARIT				u of Form CMS-2	
HOSPITAL-BASED HOSPICE IDENTIFICAT	ION DATA		Provider C Hospice CC	CN: 15-0042 N: 15-1526	Period: From 01/01/2023 To 12/31/2023		GH IV pared:
					Hospi ce I		
	Unduplicated Days						
	Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of cols. 1, 2 & 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART I - ENROLLMENT DAYS FOR	COST REPORTING	PERIODS BEGINN	ING BEFORE OCT	DBER 1, 2015			
 Hospice Continuous Home Care Hospice Routine Home Care Hospice Inpatient Respite Ca Hospice General Inpatient Ca Total Hospice Days 	are are						1.00 2.00 3.00 4.00 5.00
Part II - CENSUS DATA FOR CO		ODS BEGINNING	BEFORE OCTOBE	<u>7 1, 2015</u>			
6.00 Number of patients receiving hospice care							6.00
7.00 Total number of unduplicated Continuous Care hours billat to Medicare							7.00
B.00 Average Length of Stay (line / line 6)	è 5						8.00
9.00 Unduplicated census count							9.00
IOTE: Parts I and II, columns 1 and	d 2 also include	the days repor	ted in columns	3 and 4.			
			Title XVIII	Title XIX	Other	Total (sum of cols. 1 through 3)	
			1.00	2.00	3.00	4.00	
PART III - ENROLLMENT DAYS F		G PERIODS BEGI	NNING ON OR AF	TER OCTOBER 1			4
10.00 Hospice Continuous Home Care 11.00 Hospice Routine Home Care			0 3, 274		0 0 81 56	3, 511	11.00
12.00 Hospice Inpatient Respite Ca			5		0 0		12.00
13.00 Hospice General Inpatient Ca 14.00 Total Hospice Days			166 3, 445	1	0 0 81 56	3, 682	13.00 14.00
PART IV - CONTRACTED STATIST		ST REPORTING P					
15.00 Hospice Inpatient Respite Ca 16.00 Hospice General Inpatient Ca			0		0 0 0 0		
is so mospice ceneral inpatrent of			1 0	I	9	0	1 10.00

Health Financial Systems	GOOD SAMARITAN HOSPITAL	In Lieu	u of Form CMS-2552-10
HOSPI TAL UNCOMPENSATED AND I NDI GENT CARE DATA	Provi der CCN: 15-0042	From 01/01/2023	Worksheet S-10 Parts I & II Date/Time Prepared:

	4/11/2024	3:17 pm
12/31/2023	Date/Time	Prepared:
01/01/2023		

				471172024 5.1			
				1.00			
	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA			1.00			
	Uncompensated and Indigent Care Cost-to-Charge Ratio						
1.00	Cost to charge ratio (see instructions)			0. 261462	1.00		
	Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid			16, 346, 949	2.00		
3.00	Did you receive DSH or supplemental payments from Medicaid?			Y	3.00		
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental paymen	ts from Medicai	d?	Y	4.00		
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medica	i d		0	5.00		
6.00	Medi cai d charges			102, 501, 350	6.00		
7.00	Medicaid cost (line 1 times line 6)			26, 800, 208	7.00		
8.00	Difference between net revenue and costs for Medicaid program (see instr	uctions)		10, 453, 259	8.00		
	Children's Health Insurance Program (CHIP) (see instructions for each li	ne)					
9.00	Net revenue from stand-alone CHIP			0	9.00		
10.00	Stand-al one CHIP charges			0	10.00		
11.00	Stand-alone CHIP cost (line 1 times line 10)			0			
12.00				0	12.00		
	Other state or local government indigent care program (see instructions			-			
13.00	Net revenue from state or local indigent care program (Not included on l				13.00		
14.00	Charges for patients covered under state or local indigent care program	(Not included in	n lines 6 or	0	14.00		
15 00	10)			0	15 00		
15.00	State or local indigent care program cost (line 1 times line 14)		notructions)	0	15.00 16.00		
16.00	Difference between net revenue and costs for state or local indigent car Grants, donations and total unreimbursed cost for Medicaid, CHIP and sta				16.00		
	instructions for each line)	terrocar murger	it calle progra	and (See			
17.00		rity care		0	17.00		
18.00	Government grants, appropriations or transfers for support of hospital o	5		0			
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent		(sum of lines	10, 453, 259			
	8, 12 and 16)	our o programo		107 1007 207			
		Uni nsured	Insured	Total (col. 1			
		patients	patients	+ col. 2)			
		1.00	2.00	3.00			
	Uncompensated care cost (see instructions for each line)						
20.00	Charity care charges and uninsured discounts (see instructions)	5, 136, 749	585, 357				
21.00	Cost of patients approved for charity care and uninsured discounts (see	1, 343, 065	555, 752	1, 898, 817	21.00		
	instructions)						
22.00	Payments received from patients for amounts previously written off as	0	0	0	22.00		
22.00	charity care	1 242 0/5		1 000 017	22.00		
23.00	Cost of charity care (see instructions)	1, 343, 065	555, 752	1, 898, 817	23.00		
				1.00			
24 00	Does the amount on line 20 col. 2, include charges for patient days beyo	nd a length of	stav limit	N 1.00	24.00		
24.00	imposed on patients covered by Medicaid or other indigent care program?	nu a rengti or :	stay minit	IN	24.00		
25.00	If line 24 is yes, enter the charges for patient days beyond the indigen	t care program's	s length of	0	25.00		
20.00	stay limit	t care program.	s rength of	0	20.00		
25.01	Charges for insured patients' liability (see instructions)			40, 086	25.01		
26.00							
27.00							
27.01				285, 977 439, 965			
28.00	Non-Medicare bad debt amount (see instructions)			12, 953, 187	28.00		
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see	instructions)		3, 540, 754	29.00		
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)			5, 439, 571	30.00		
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			15, 892, 830	31.00		
				-			

Health Financial Systems	GOOD SAMARITAN HOSPITAL	In Lie	In Lieu of Form CMS-2552-10		
HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0042	Period:	Worksheet S-10		

	worksneet S-TU	
1/2023	Parts I & II	

10110	Ju.	WOT KSHOOL	5 1	0
From	01/01/2023			
То	12/31/2023			
		4/11/2024	3: 1	7 pm

				4/11/2024 3:1	7 piii
				1.00	
	PART II - HOSPITAL DATA				
	Uncompensated and Indigent Care Cost-to-Charge Ratio				
1.00	Cost to charge ratio (see instructions)			0. 246763	1.00
	Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid				2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?				3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental paymen		d?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medica	id			5.00
6.00	Medi cai d charges				6.00
7.00	Medicaid cost (line 1 times line 6)				7.00
8.00	Difference between net revenue and costs for Medicaid program (see instru				8.00
0 00	Children's Health Insurance Program (CHIP) (see instructions for each lin	ne)			0.00
9.00	Net revenue from stand-al one CHIP				9.00
10.00	Stand-allone CHIP charges				10.00
11.00 12.00	Stand-alone CHIP cost (line 1 times line 10)	uationa)			11.00 12.00
12.00	Difference between net revenue and costs for stand-alone CHIP (see instructions) Other state or local government indigent care program (see instructions)				12.00
13.00	Net revenue from state or local indigent care program (Net included on I				13.00
14.00	Charges for patients covered under state or local indigent care program		n lines 6 or		14.00
14.00	10)		11 111163 0 01		14.00
15.00	State or local indigent care program cost (line 1 times line 14)				15.00
16.00	Difference between net revenue and costs for state or local indigent card	e program (see	instructions)		16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and sta		,	ms (see	
	instructions for each line)	g-			
17.00	Private grants, donations, or endowment income restricted to funding cha	rity care			17.00
18.00	Government grants, appropriations or transfers for support of hospital o	perations			18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent	care programs	(sum of lines		19.00
	8, 12 and 16)				
		Uni nsured	Insured	Total (col. 1	
		patients	patients	+ col. 2)	
		1.00	2.00	3.00	
~ ~ ~	Uncompensated care cost (see instructions for each line)	E 404 754	574 005	5 740 504	
20.00	Charity care charges and uninsured discounts (see instructions)	5, 136, 756	576, 825		
21.00	Cost of patients approved for charity care and uninsured discounts (see	1, 267, 561	547, 128	1, 814, 689	21.00
22.00	instructions) Payments received from patients for amounts previously written off as	0	0	0	22.00
22.00	charity care	0	0	0	22.00
23.00	Cost of charity care (see instructions)	1, 267, 561	547, 128	1, 814, 689	23 00
20100		1/20//001	0177120	1/011/00/	20100
				1.00	
24.00	Does the amount on line 20 col. 2, include charges for patient days beyo	nd a length of	stay limit	N	24.00
	imposed on patients covered by Medicaid or other indigent care program?	5	5		
25.00	If line 24 is yes, enter the charges for patient days beyond the indigen	t care program'	s length of	0	25.00
	stay limit		-		
25.01	Charges for insured patients' liability (see instructions)			39, 426	25.01
26.00	Bad debt amount (see instructions)			13, 265, 240	26.00
27.00	Medicare reimbursable bad debts (see instructions)			274, 451	
27.01	Medicare allowable bad debts (see instructions)			422, 232	
28.00	Non-Medicare bad debt amount (see instructions)			12, 843, 008	
				0 047 070	29.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see	instructions)		3, 316, 960	
30.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see Cost of uncompensated care (line 23, col. 3, plus line 29) Total unreimbursed and uncompensated care cost (line 19 plus line 30)	instructions)		3, 316, 960 5, 131, 649 5, 131, 649	30.00

ECLAS	Financial Systems SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	N HOSPITAL Provider CC		eriod: rom 01/01/2023	u of Form CMS-2 Worksheet A	
				T		Date/Time Pre	
	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cat	4/11/2024 3:1 Recl assi fi ed	/ pm
				+ col. 2)	ions (See	Trial Balance	
					A-6)	(col. 3 +-	
	-	1.00	2.00	3.00	4.00	<u>col. 4)</u> 5.00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	0.00	1.00	0.00	
. 00	00100 CAP REL COSTS-BLDG & FIXT		16, 347, 994	16, 347, 994	5, 562, 128	21, 910, 122	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		40, 088	40, 088	0	40, 088	2.00
. 00	00400 EMPLOYEE BENEFI TS DEPARTMENT	669, 803	1, 803, 871	2, 473, 674		28, 415, 231	4.00
. 01 . 02	00401 COMMUNI CATI ONS 00402 PURCHASI NG & RECEI VI NG	324, 521 762, 616	101, 988 715, 135	426, 509 1, 477, 751	-101, 382 -304, 631	325, 127 1, 173, 120	4.01 4.02
. 03	00403 REGI STRATI ON	1, 806, 704	651, 282	2, 457, 986	-634, 841	1, 823, 145	4.03
. 04	00404 PATIENT ACCOUNTS	2, 443, 101	2, 410, 422	4, 853, 523	-744, 901	4, 108, 622	4.04
. 00	00500 ADMI NI STRATI VE & GENERAL	7, 853, 050	29, 385, 627	37, 238, 677	-2, 397, 324	34, 841, 353	5. OC
. 00	00700 OPERATION OF PLANT	2, 576, 329	5, 865, 649	8, 441, 978	-741, 119	7, 700, 859	7.00
8.00 9.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	239, 763 2, 339, 766	214, 533 961, 216	454, 296 3, 300, 982	-114, 864 -706, 736	339, 432 2, 594, 246	8.00 9.00
0.00	01000 DI ETARY	1, 906, 448	1, 991, 080	3, 897, 528		887, 887	10.00
1.00	01100 CAFETERI A	0	0	0	2, 461, 366	2, 461, 366	11.00
3.00	01300 NURSING ADMINISTRATION	2, 284, 261	2, 624, 086	4, 908, 347	-417, 349	4, 490, 998	13.00
4.00	01400 CENTRAL SERVICES & SUPPLY	386, 217	324, 699	710, 916		600, 644	14.00
5.00 6.00	01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY	3, 202, 203 4, 038, 556	21, 113, 178 1, 682, 897	24, 315, 381 5, 721, 453	-20, 736, 541 -1, 117, 243	3, 578, 840 4, 604, 210	15.00 16.00
7.00	01700 SOCIAL SERVICE	4,038,550	1,002,097	5,721,455	-1, 117, 243	4,004,210	17.00
	01701 MENTAL HEALTH OH	345, 494	324, 659	670, 153	-85, 298	584, 855	
1. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	3, 615, 557	3, 615, 557	19, 182	3, 634, 739	21.00
2.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	2,002,388	1, 110, 500	3, 112, 888	-434, 724	2, 678, 164	22.00
3.00	02300 PARAMED ED PRGM-RADI OLOGY	0	0	0	0	0	23.00
3. 01	02301 PARAMED ED PRGM-LAB	278, 171	65, 249	343, 420	-51, 895	291, 525	23.01
0. 00	03000 ADULTS & PEDIATRICS	7, 681, 380	8, 233, 679	15, 915, 059	-2, 140, 034	13, 775, 025	30.00
1.00	03100 I NTENSI VE CARE UNI T	3, 479, 331	1, 714, 551	5, 193, 882	-663, 026	4, 530, 856	31.00
0.00	04000 SUBPROVI DER – I PF	2, 236, 192	1, 052, 463	3, 288, 655	-453, 517	2, 835, 138	40.00
1.00	04100 SUBPROVIDER - IRF	1, 993, 493	752, 228	2, 745, 721	-465, 566	2, 280, 155	41.00
3.00		0	0	0	309, 790	309, 790	43.00
0.00	ANCI LLARY SERVI CE COST CENTERS	3, 308, 341	6, 078, 551	9, 386, 892	-3, 520, 491	5, 866, 401	50.00
1.00	05100 RECOVERY ROOM	0,000,011	0,070,001	0,000,072	0, 020, 1,1	0,000,101	51.00
1. 01	05101 ENDOSCOPY	845, 525	1, 117, 860	1, 963, 385	-350, 289	1, 613, 096	51.01
2.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	187, 235	187, 235	52.00
3.00 4.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	2,861,645	2, 111, 345	4, 972, 990 11, 331, 835	-526, 706	4, 446, 284 8, 993, 164	53.00 54.00
5.00	05500 RADI OLOGY-THERAPEUTI C	4, 961, 683 2, 937, 306	6, 370, 152 3, 250, 609	6, 187, 915	-2, 338, 671 -683, 233	5, 504, 682	55.00
0.00	06000 LABORATORY	2, 441, 210	6, 019, 748	8, 460, 958	-534, 759	7, 926, 199	60.00
3.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
5.00	06500 RESPI RATORY THERAPY	2, 724, 194	2, 460, 357	5, 184, 551	-990, 261	4, 194, 290	
6.00	06600 PHYSI CAL THERAPY	5, 788, 311	1, 617, 130	7, 405, 441		6,029,455	66.00
0.00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	5, 104, 267 0	3, 176, 018 0	8, 280, 285 0	-2, 098, 916 0	6, 181, 369 0	69.00 70.00
0.00	07001 NEURODI AGNOSTI CS	889, 678	1, 139, 699	2,029,377	-183, 261	1, 846, 116	
1. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	3, 675, 266	3, 675, 266	71.00
2.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	4, 249, 606	4, 249, 606	
'3.00 '5.00	07300 DRUGS CHARGED TO PATI ENTS 07500 ASC (NON-DI STI NCT PART)	1 221 011	0 2, 638, 082	0 3, 859, 093	19, 923, 050	19, 923, 050	73.00 75.00
6.00	03950 MH ANCILLARY OUTPATIENT	1, 221, 011	2,030,082	3, 639, 093 0	-1, 744, 672 0	2, 114, 421 0	76.00
6. 01	03951 I NPATI ENT DI ALYSI S	93, 493	383, 376	476, 869	-19, 466	457, 403	76.01
	OUTPATIENT SERVICE COST CENTERS						1
8. 00	08800 FAMILY PRACTICE 120	1, 593, 927	624, 829	2, 218, 756		24, 307	88.00
0.00		157, 578	29, 962	187, 540	-28, 709	158, 831	90.00
0.01 1.00	04950 WOUND CLINIC 09100 EMERGENCY	372, 480 4, 702, 789	1, 260, 767 3, 366, 786	1, 633, 247 8, 069, 575	-622, 903 -1, 026, 568	1, 010, 344 7, 043, 007	90.01 91.00
2.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	4,702,707	3, 300, 700	0,007,070	1, 020, 300	7,043,007	92.00
	OTHER REIMBURSABLE COST CENTERS						
	09600 DURABLE MEDICAL EQUIP-RENTED	95, 066	82, 051	177, 117	-18, 497	158, 620	
01.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
13 00	SPECIAL PURPOSE COST CENTERS		5, 029, 545	5, 029, 545	-5, 029, 545	0	113.00
	11600 HOSPI CE	515, 690	522, 975	1, 038, 665		881, 815	
18.00		89, 463, 981	150, 382, 473	239, 846, 454		243, 300, 498	
	NONREIMBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	-		190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	13, 455, 912	7, 728, 341 148, 824	21, 184, 253	-1, 312, 678	19, 871, 575	
	19201 FP PETERSBURG 19202 PEDI ATRI CS	130, 307 920, 415	148, 824 576, 325	279, 131 1, 496, 740	-23, 708 -296, 727	255, 423 1, 200, 013	
	19202 PEDIATRICS	1, 426, 504	531,865	1, 498, 740	-290, 727 -310, 985	1, 647, 384	
		.,,					
	19204 FQHC	0	282, 420	282, 420	-282, 492	- 72 132, 184	192.04

Health Financial Systems	GOOD SAMARI TA	N HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	F EXPENSES	Provider C		Period:	Worksheet A	
				From 01/01/2023 To 12/31/2023		nared
					4/11/2024 3:1	
Cost Center Description	Sal ari es	Other		Recl assi fi cat		
			+ col. 2)	ions (See	Trial Balance	
				A-6)	(col. 3 +-	
					col. 4)	
	1.00	2.00	3.00	4.00	5.00	
194. 01 07960 CCBHC GRANTS	1, 011, 558	1, 275, 532	2, 287, 090	-301, 143	1, 985, 947	194.01
194.0207952 MARKETING AND PUBLIC RELATIONS	260, 331	563, 141	823, 472	2 -59, 377	764, 095	194.02
194. 03 07953 MH RESIDENTIAL	274, 107	88, 609	362, 71	6 -64, 279	298, 437	194.03
194.0407954 UNUSED SPACE	0	0	(0 0	0	194.04
194. 05 07955 MOB	160	36, 545	36, 70	5 -47	36, 658	194.05
194. 06 07956 FOUNDATI ON	0	0	(0 0	0	194.06
194.0707957 KNOX COUNTY HEALTH DEPT	0	0	(0 0	0	194.07
194. 08 07958 I NDUSTRI AL HEALTH	0	0	(0 0	0	194.08
194.0907959 COMMUNITY MENTAL HEALTH CENTER	3, 131, 825	1, 125, 474	4, 257, 299	-782, 154	3, 475, 145	194.09
194. 10 07951 BEI RHAUS BUI LDI NG	0	116, 137	116, 13	7 0	116, 137	194.10
200.00 TOTAL (SUM OF LINES 118 through 199)	110, 193, 141	162, 890, 283	273, 083, 42	4 0	273, 083, 424	200. 00

	ADJUSTMENTS OF TRIAL BALANCE O	0	Provider CCN	 Period: From 01/01/2023 To 12/31/2023	Worksheet A Date/Time Pre	epare
Cost Cost	er Description	Adjustments	Net Expenses		4/11/2024 3: 1	
COST CENT	er beschiptron	(See A-8)	For			
	_	. ,	Allocation			
		6.00	7.00			
.00 GENERAL SERVICE	OSTS-BLDG & FIXT	-1, 603, 625	20, 306, 497			1.
	OSTS-MVBLE EQUIP	0000, 020	40, 088			2.
. 00 00400 EMPLOYEE	BENEFITS DEPARTMENT	-610	28, 414, 621			4.
01 00401 COMMUNI CA		-114, 387	210, 740			4.
02 00402 PURCHASI N		-392, 942 0	780, 178			4.
03 00403 REGI STRAT 04 00404 PATI ENT A		-177, 024	1, 823, 145 3, 931, 598			4.
	ATIVE & GENERAL	-15, 156, 746	19, 684, 607			5.
00 00700 OPERATI ON	OF PLANT	-43, 681	7, 657, 178			7.
00 00800 LAUNDRY 8		0	339, 432			8.
00 00900 HOUSEKEEP 0. 00 01000 DI ETARY	ING	-33, 311	2, 560, 935			9.
. 00 01100 DIETARY		0 1, 233, 900–	887, 887 1, 227, 466			10.
. 00 01300 NURSING A		-177, 435	4, 313, 563			13.
	ERVICES & SUPPLY	0	600, 644			14.
00 01500 PHARMACY		-262, 168	3, 316, 672			15.
	ECORDS & LI BRARY	-113, 529	4, 490, 681			16.
.00 01700 SOCIAL SE .01 01701 MENTAL HE		0 -19, 215	0 565, 640			17.
	CES-SALARY & FRINGES APPRVD	-19,215	3, 634, 739			21.
	CES-OTHER PRGM COSTS APPRVD	168,000	2, 846, 164			22
. 00 02300 PARAMED E		0	0			23
. 01 02301 PARAMED E		-18, 819	272, 706			23
0.00 03000 ADULTS &	NE SERVICE COST CENTERS	2 440 422	10 104 202			30.
. 00 03100 INTENSIVE		-3, 668, 633 0	10, 106, 392 4, 530, 856			31.
. 00 04000 SUBPROVI D		-45	2, 835, 093			40
. 00 04100 SUBPROVI D	ER – IRF	-146	2, 280, 009			41
. 00 04300 NURSERY		0	309, 790			43.
. 00 05000 OPERATING	CE COST CENTERS	-1, 700, 407	4 145 004			
. 00 05100 RECOVERY		-1, 700, 407	4, 165, 994 0			50.
. 01 05101 ENDOSCOPY		0	1, 613, 096			51.
	ROOM & LABOR ROOM	0	187, 235			52.
00 05300 ANESTHESI		-3, 789, 393	656, 891			53
. 00 05400 RADI OLOGY . 00 05500 RADI OLOGY		-1, 397, 945	7, 595, 219			54 55
. 00 05500 RADI OLOGY . 00 06000 LABORATOR		-2, 414, 035 -421, 909	3, 090, 647 7, 504, 290			60
	RING, PROCESSING & TRANS.	0	0			63
. 00 06500 RESPI RATO	RY THERAPY	-1, 786, 820	2, 407, 470			65
. 00 06600 PHYSI CAL		-1, 867, 392	4, 162, 063			66
. 00 06900 ELECTROCA		-3, 186, 831	2, 994, 538			69
. 00 07000 ELECTROEN . 01 07001 NEURODI AG		0 -806, 192	0 1, 039, 924			70
	UPPLIES CHARGED TO PATIENTS	000, 172	3, 675, 266			71
	. CHARGED TO PATIENTS	0	4, 249, 606			72
. 00 07300 DRUGS CHA		-395, 348	19, 527, 702			73
. 00 07500 ASC (NON-		-75, 786	2, 038, 635			75
. 00 03950 MH ANCILL . 01 03951 INPATIENT		0 -208, 995	0 248, 408			76
	I CE COST CENTERS	-200, 773	240, 400			- ''
. 00 08800 FAMILY PR		0	24, 307			88
. 00 09000 CLINIC		0	158, 831			90
. 01 04950 WOUND CLI		-17, 500	992, 844			90
. 00 09100 EMERGENCY	ON BEDS (NON-DISTINCT PART)	-1, 266, 599	5, 776, 408			91 92
	BLE COST CENTERS					- 72
	EDI CAL EQUI P-RENTED	0	158, 620			96
1.0010100 HOME HEAL		0	0			101
SPECIAL PURPOSE		0				1110
3. 00 11300 NTEREST 6. 00 11600 HOSPI CE	EAFEINSE	0	0 881, 815			113
	(SUM OF LINES 1 through 117)	-42, 183, 368				118
NONREI MBURSABLE			, , ,			
0.0019000GIFT, FLC	WER, COFFEE SHOP & CANTEEN	0	0			190
2. 00 19200 PHYSI CI AN		0	19, 871, 575			192
2. 01 19201 FP PETERS		0	255, 423			192
2. 02 19202 PEDI ATRI 0 2. 03 19203 WASHI NGTO		0	1, 200, 013 1, 647, 384			192 192
2. 04 19204 FQHC		0	-72			192
4. 00 07950 COMMUNI TY	HEALTH SERVICES	0	132, 184			194
4.0107960 CCBHC GRA		0	1, 985, 947			194

Health Financial Systems	GOOD SAMARI TA	AN HOSPITAL		In Lieu	ı of Form CMS-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL	BALANCE OF EXPENSES	Provider CO	CN: 15-0042	Period:	Worksheet A
				From 01/01/2023 To 12/31/2023	Date/Time Prepared: 4/11/2024 3:17 pm
Cost Center Description	Adjustments	Net Expenses			
	(See A-8)	For			
		Allocation			
	6.00	7.00			
194.0207952 MARKETING AND PUBLIC RELATION	S 0	764, 095			194.02
194.0307953 MH RESIDENTIAL	0	298, 437			194.03
194.0407954 UNUSED SPACE	0	0			194.04
194.0507955 MOB	0	36, 658			194.05
194. 06 07956 FOUNDATI ON	0	0			194.06
194.0707957 KNOX COUNTY HEALTH DEPT	0	0			194.07
194.0807958 INDUSTRIAL HEALTH	0	0			194.08
194.0907959 COMMUNITY MENTAL HEALTH CENTER	R O	3, 475, 145			194.09
194. 10 07951 BEI RHAUS BUI LDI NG	0	116, 137			194.10
200.00 TOTAL (SUM OF LINES 118 through	gh 199) -42, 183, 368	230, 900, 056			200.00

	Financial Systems SIFICATIONS		GOOD SAMARIT	Provider CCN: 15-0042 Period: From 01	In Lieu of Form CMS-2552-10 Worksheet A-6 /01/2023 /31/2023 Date/Time Prepared:
		Increases			4/11/2024 3:17 pm
	Cost Center 2.00	Li ne # 3.00	Sal ary 4. 00	<u>0ther</u> 5.00	
1.00	A - DRUGS CHARGED TO PATI ENTS DRUGS CHARGED TO PATI ENTS O	<u> </u>	0	<u>19, 923, 050</u> 19, 923, 050	1.00
1.00	B - MEDI CAL SUPPLI ES CHARGED MEDI CAL SUPPLI ES CHARGED TO	T0 PATIENTS 71.00	0	3, 675, 266	1.00
2.00	PATIENTS I MPL. DEV. CHARGED TO PATIENTS	72.00	0	4, 249, 606	2.00
$\begin{array}{c} 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 20.\ 00\\ 21.\ 00\\ 22.\ 00\\ 23.\ 00\\ 24.\ 00\\ \end{array}$		0.00 0.00			$\begin{array}{c} 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 20.\ 00\\ 21.\ 00\\ 22.\ 00\\ 23.\ 00\\ 24.\ 00\\ \end{array}$
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 20.\ 00\\ 21.\ 00\\ 22.\ 00\\ 23.\ 00\\ 24.\ 00\\ 25.\ 00\\ 26.\ 00\\ 27.\ 00\\ 28.\ 00\\ 25.\ 00\\ 26.\ 00\\ 27.\ 00\\ 30.\ 00\\ 31.\ 00\\ 32.\ 00\\ 33.\ 00\\ 33.\ 00\\ 34.\ 00\\ 35.\ 00\\ 36.\ 00\\ 37.\ 00\\ 38.\ 00\\ 39.\ 00\\ 41.\ 00\\ 41.\ 00\\ \end{array}$	C - EMPLOYEE BENEFITS EMPLOYEE BENEFITS DEPARTMENT	$\begin{array}{c} 4.\ 00\\ 0.\ 00\ 0.\ 00\\ 0.\ 00\ 0.\ 00\\ 0.\ 00\ 0.\ 00\ 0.\ 00\ 0.\ 0.\ 00\ 0.\ 0.$			$\begin{array}{c} 1.00\\ 2.00\\ 3.00\\ 4.00\\ 4.00\\ 5.00\\ 6.00\\ 7.00\\ 8.00\\ 9.00\\ 10.00\\ 11.00\\ 12.00\\ 13.00\\ 14.00\\ 15.00\\ 16.00\\ 17.00\\ 18.00\\ 19.00\\ 20.00\\ 21.00\\ 22.00\\ 23.00\\ 24.00\\ 25.00\\ 26.00\\ 27.00\\ 28.00\\ 29.00\\ 30.00\\ 31.00\\ 32.00\\ 33.00\\ 34.00\\ 35.00\\ 35.00\\ 36.00\\ 37.00\\ 38.00\\ 39.00\\ 39.00\\ 39.00\\ 41.00\\ \end{array}$

 GOOD
 SAMARI TAN
 HOSPI TAL
 In
 Lieu
 of
 Form
 CMS-2552-10

 Provider
 CCN:
 15-0042
 Period: From
 Worksheet
 A-6

					From 01/01/2023 To 12/31/2023	Date/Time Prepared: 4/11/2024 3:17 pm
		Increases				
	Cost Center	Line #	Sal ary	Other		
	2.00	3.00	4.00	5.00		
43.00		0.00	0	0		43.00
44.00		0.00	0	0		44.00
45.00		0.00	0	0		45.00
46.00		0.00	0	0		46.00
47.00		0.00	0	0		47.00
48.00		0.00	0	0		48.00
49.00		0.00	0	0		49.00
	0		0	26, 017, 558		
	D - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	5,029,545		1.00
	0		0	5, 029, 545		
	E - INSURANCE EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	532, 583		1.00
	0		0	532, 583		
	F - DIETARY RECLASS					
1.00	CAFETERI A	11.00	1, 401, 049	1,060,317		1.00
	0		1, 401, 049	1,060,317		
	G – OB RECLASS					
1.00	NURSERY	43.00	278, 493	31, 297		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	168, 319	18, 916		2.00
	0		446, 812	50, 213		
	H - RESIDENT RECLASS					
1.00	I &R SERVICES-SALARY &	21.00	0	19, 182		1.00
	FRINGES APPRVD					
	0		0	19, 182		
	I - RHC RECLASS					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	1, 572, 092	<u>177, 9</u> 55		1.00
	TOTALS		1, 572, 092	177, 955		
500.00	Grand Total: Increases		3, 419, 953	60, 735, 275		500.00

GOOD SAMARI TAN HOSPI TAL

Heal th	Financial Systems		GOOD SAMARITA	AN HOSPITAL			In Lie	eu of Form CM	MS-2552-10
RECLAS	SI FI CATI ONS			Provi der	CCN: 15-0042	Peri oc	l:)1/01/2023	Worksheet	A-6
							2/31/2023	B Date/Time	
		Decreases				I.,		4/11/2024	3:17 pm
	Cost Center	Line #	Sal ary	0ther	Wkst. A-7 Re	f.			
	6.00	7.00	8.00	9.00	10.00				
1.00	A - DRUGS CHARGED TO PATIENT: PHARMACY	15.00	0	19, 923, 050		0			1.00
	0		0	19, 923, 050		-			
1 00	B - MEDICAL SUPPLIES CHARGED		ol	74.00	1	0			1.00
1.00 2.00	EMPLOYEE BENEFITS DEPARTMENT PURCHASING & RECEIVING	4.00 4.02	0	76, 00 ⁻ 464		0			1.00 2.00
3.00	ADMI NI STRATI VE & GENERAL	5.00	0	1		0			3.00
4.00	OPERATION OF PLANT	7.00	0	2, 868		0			4.00
5.00 6.00	HOUSEKEEPI NG CENTRAL SERVI CES & SUPPLY	9.00 14.00	0	48 2, 408		0			5.00 6.00
7.00	PHARMACY	15.00	Ö	65, 329		0			7.00
8.00	ADULTS & PEDIATRICS	30.00	0	147, 168		0			8.00
9.00 10.00	I NTENSI VE CARE UNI T SUBPROVI DER – I PF	31.00 40.00	0	53, 338 1, 336		0			9.00 10.00
11.00	SUBPROVI DER – I RF	41.00	0	10, 190		0			11.00
12.00	OPERATING ROOM	50.00	0	2, 694, 80		0			12.00
13.00 14.00	ENDOSCOPY RADI OLOGY-DI AGNOSTI C	51.01 54.00	0	146, 96 1, 249, 990		0			13.00 14.00
15.00	RADI OLOGY-THERAPEUTI C	55.00	0	15, 49		0			15.00
16.00	LABORATORY	60.00	0	6, 388		0			16.00
17.00		65.00	0	203, 70		0			17.00
18.00 19.00	PHYSI CAL THERAPY ELECTROCARDI OLOGY	66.00 69.00	0	88, 949 1, 135, 87		0			18.00 19.00
20.00	NEURODI AGNOSTI CS	70.01	0	1, 97		0			20.00
21.00	ASC (NON-DI STI NCT PART)	75.00	0	1, 387, 04		0			21.00
22.00 23.00	INPATIENT DIALYSIS WOUND CLINIC	76. 01 90. 01	0	2, 36 ⁻ 538, 84 ⁻		0			22.00 23.00
24.00	EMERGENCY	91.00	0	93, 313	3	0			24.00
			0	7, 924, 872	2				
1.00	C - EMPLOYEE BENEFITS COMMUNICATIONS	4.01		101, 382		0			1.00
2.00	PURCHASI NG & RECEI VI NG	4. 02		304, 16		0			2.00
3.00	REGI STRATI ON	4.03		634, 84		0			3.00
4.00 5.00	PATI ENT ACCOUNTS ADMI NI STRATI VE & GENERAL	4.04 5.00		744, 90 ⁻ 1, 864, 724		0			4.00 5.00
6.00	OPERATION OF PLANT	7.00		738, 25		0			6.00
7.00	LAUNDRY & LINEN SERVICE	8.00		114, 864		0			7.00
8.00 9.00	HOUSEKEEPI NG DI ETARY	9.00 10.00		706, 688 548, 275		0			8.00 9.00
10.00	NURSING ADMINISTRATION	13.00		417, 349		0			10.00
11.00	CENTRAL SERVICES & SUPPLY	14.00		107, 864		0			11.00
12.00 13.00	PHARMACY MEDICAL RECORDS & LIBRARY	15.00 16.00		748, 162 1, 117, 243		o			12.00 13.00
14.00	MENTAL HEALTH OH	17.01		85, 298		0			14.00
15.00	I&R SERVICES-OTHER PRGM	22.00		434, 724	4	0			15.00
16.00	COSTS APPRVD PARAMED ED PRGM-LAB	23.01		51, 89	5	0			16.00
17.00	ADULTS & PEDIATRICS	30.00		1, 495, 84		0			17.00
18.00	INTENSIVE CARE UNIT	31.00		609, 688		0			18.00
19.00 20.00	SUBPROVI DER – I PF SUBPROVI DER – I RF	40.00 41.00		452, 18 ⁻ 455, 37(0			19.00 20.00
20.00	OPERATI NG ROOM	50.00		825, 690		0			20.00
22.00	ENDOSCOPY	51.01		203, 322		0			22.00
23.00 24.00	ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C	53.00 54.00		526, 700 1, 088, 681		0			23.00 24.00
24.00	RADI OLOGY-THERAPEUTI C	55.00		667, 738		0			24.00
26.00	LABORATORY	60.00		528, 37 ⁻	1	0			26.00
27.00 28.00	RESPI RATORY THERAPY PHYSI CAL THERAPY	65.00 66.00		786, 550		0			27.00 28.00
28.00	ELECTROCARDI OLOGY	69.00		1, 287, 03 963, 04		o			28.00
30.00	NEURODI AGNOSTI CS	70.01		181, 284		0			30.00
31.00	ASC (NON-DI STI NCT PART)	75.00		357, 63		0			31.00
32.00 33.00	INPATIENT DIALYSIS FAMILY PRACTICE 120	76.01 88.00		17, 105 444, 402		0			32.00 33.00
34.00	CLINIC	90.00		28, 70		0			34.00
35.00		90.01		84,062		0			35.00
36.00 37.00	EMERGENCY DURABLE MEDICAL EQUIP-RENTED	91.00 96.00		933, 255 18, 49		0			36.00 37.00
38.00	HOSPI CE	116.00		156, 850		õ			38.00
39.00	PHYSI CI ANS' PRI VATE OFFI CES	192.00		3, 062, 72	ō	0			39.00
40.00 41.00	FP PETERSBURG PEDI ATRI CS	192.01 192.02		23, 708 296, 72		0			40.00 41.00
41.00	WASHINGTON PRIMARY CARE	192.02		310, 98		0			41.00
43.00	FQHC	192.04		282, 492		0			43.00

Heal th	Financial Systems		GOOD SAMARITA	N HOSPI TAL		In Lieu	u of Form CMS	-2552-10
RECLASSI FI CATI ONS				Provider C	CN: 15-0042	Peri od:	Worksheet A-6	
						From 01/01/2023 To 12/31/2023	Date/Time Pr	oparod
						10 12/31/2023	4/11/2024 3:	17 pm
		Decreases						
	Cost Center	Line #	Sal ary		Wkst. A-7 Ref	· .		
	6.00	7.00	8.00	9.00	10.00			
44.00	COMMUNITY HEALTH SERVICES	194.00		20, 454		0		44.00
45.00	CCBHC GRANTS	194.01		301, 143		0		45.00
46.00	MARKETING AND PUBLIC	194.02		59, 377		0		46.00
	RELATIONS							
47.00	MH RESIDENTIAL	194.03		64, 279		0		47.00
	MOB	194.05		47		0		48.00
49.00	COMMUNITY MENTAL HEALTH	194.09		762, 972		0		49.00
	CENTER							
	0		0	26, 017, 558				
	D – INTEREST EXPENSE							
1.00	INTEREST EXPENSE	113.00	0	5, 029, 545	1	1		1.00
	0		0	5, 029, 545				
	E – I NSURANCE EXPENSE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	532, 583	1	2		1.00
	0		0	532, 583				
	F - DIETARY RECLASS							
1.00	DI ETARY	10.00	1, 401, 049	1, 060, 317		0		1.00
	0	T	1, 401, 049	1,060,317				
	G – OB RECLASS							
1.00	ADULTS & PEDIATRICS	30.00	446, 812	50, 213		0		1.00
2.00		0.00	0	0		0		2.00
	0		446, 812	50, 213		7		
	H - RESIDENT RECLASS							
1.00	COMMUNITY MENTAL HEALTH	194.09	0	19, 182		0		1.00
	CENTER							
	0			19, 182		7		
	I - RHC RECLASS							
1.00	FAMILY PRACTICE 120	88.00	<u>1, 572, 0</u> 92	<u>177, 9</u> 55		0		1.00
	TOTALS		1, 572, 092	177, 955				
500.00	Grand Total: Decreases		3, 419, 953	60, 735, 275				500.00

Health Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Lie	eu of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider CCN: 15-0042		Period: From 01/01/2023 To 12/31/2023		pared:
		Acqui si ti ons		S	1/1/2021 0.1	
	Begi nni ng	Purchases	Donati on	Total	Disposals and	
	Bal ances				Retirements	
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES					
1.00 Land	6, 581, 448	0		0 0	0	1.00
2.00 Land Improvements	10, 726, 598	128, 122		0 128, 122	0	2.00
3.00 Buildings and Fixtures	173, 358, 126	4, 588, 431		0 4, 588, 431	0	3.00
4.00 Building Improvements	515, 426	0		0 0	36, 239	4.00
5.00 Fixed Equipment	0	0		0 0	0	5.00
6.00 Movable Equipment	229, 887, 189	0		0 0	97, 334	6.00
7.00 HIT designated Assets	0	0		0 0	0	7.00
8.00 Subtotal (sum of lines 1-7)	421, 068, 787	4, 716, 553		0 4, 716, 553	133, 573	8.00
9.00 Reconciling Items	0	0		0 0	0	9.00
10.00 Total (line 8 minus line 9)	421, 068, 787	4, 716, 553		0 4, 716, 553	133, 573	10.00
	Endi ng	Fully				
	Bal ance	Depreciated				
		Assets				
	6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1.00 Land	6, 581, 448	0				1.00
2.00 Land Improvements	10, 854, 720	0				2.00
3.00 Buildings and Fixtures	177, 946, 557	0				3.00
4.00 Building Improvements	479, 187	0				4.00
5.00 Fixed Equipment	0	0				5.00
6.00 Movable Equipment	229, 789, 855	0				6.00
7.00 HIT designated Assets	0	0				7.00
8.00 Subtotal (sum of lines 1-7)	425, 651, 767	0				8.00
9.00 Reconciling Items	0	0				9.00
10.00 Total (line 8 minus line 9)	425, 651, 767	0				10.00

Heal th	Financial Systems	GOOD SAMARITAN HOSPITAL			In Lieu of Form CMS-2552-10			
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 01/01/2023 To 12/31/2023		pared:	
		SUMMARY OF CAPITAL						
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)		
		9.00	10.00	11.00	12.00	13.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WOR		AN 2, LINES 1 a	and 2	-			
1.00	CAP REL COSTS-BLDG & FIXT	16, 347, 994	0		0 0	0	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	40, 08		0	2.00	
3.00	Total (sum of lines 1-2)	16, 347, 994		40, 08	8 0	0	3.00	
		SUMMARY O	F CAPITAL					
	Cost Center Description	Other	Total (1)	1				
		Capi tal -Rel at	(sum of cols.					
		ed Costs (see	9 through 14)					
		instructions)	-					
		14.00	15.00					
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN	/N 2, LINES 1 a	and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	16, 347, 994				1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	0	40, 088				2.00	
3.00	Total (sum of lines 1-2)	0	16, 388, 082				3.00	

Health Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Lie	u of Form CMS-2	552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C	1	Period: From 01/01/2023 Fo 12/31/2023	Worksheet A-7 Part III Date/Time Prep 4/11/2024 3:1	
	COMPUTATION OF RATIOS			ALLOCATION OF	OTHER CAPI TAL	
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
		Leases	for Ratio	instructions)		
			(col. 1 - col. 2)			
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS C		2.00	0.00	1.00	0.00	
1.00 CAP REL COSTS-BLDG & FIXT	195, 861, 912	0	195, 861, 912	0. 460146	0	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	229, 789, 855	0	229, 789, 85			2.00
3.00 Total (sum of lines 1-2)	425, 651, 767	0	425, 651, 76			3.00
	ALLOCATION OF OTHER CAPITAL SUMMARY OF CAP				F CAPITAL	
Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease	
		Capi tal -Rel at				
		ed Costs	through 7)		10.00	
PART III - RECONCILIATION OF CAPITAL COSTS C	6.00	7.00	8.00	9.00	10.00	
1.00 CAP REL COSTS-BLDG & FIXT		0		16, 347, 994	0	1.00
2.00 CAP REL COSTS-MUBLE EQUIP	0			0 0	0	2.00
3.00 Total (sum of lines 1-2)	0	0		16, 347, 994	Ő	3.00
	SUMMARY OF CAPITAL					
Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)	
		(see	instructions)	Capi tal -Rel at		
		instructions)		ed Costs (see instructions)	9 through 14)	
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS C						
1.00 CAP REL COSTS-BLDG & FIXT	3, 425, 920			0 0	20, 306, 497	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	40, 088		(0 0	10,000	2.00
3.00 Total (sum of lines 1-2)	3, 466, 008	532, 583	(0 0	20, 346, 585	3.00

Heal th	Fi nan	ici al	Systems
AD JUST	MENTS	TO	FXPENSES

ADJUS II	MENTS TO EXPENSES			Provider CCN: 15-0042	Period: From 01/01/2023 To 12/31/2023	Worksheet A-8 Date/Time Pre 4/11/2024 3:1	pared:
			То	Expense Classification c From Which the Amount is			
						W	
	Cost Center Description	Basi s/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Li ne #	Wkst. A-7 <u>Ref.</u> 5.00	
1.00	Investment income - CAP REL	B		P REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		OCA	P REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		О		0.00	0	3.00
4.00	(chapter 2) Trade, quantity, and time discounts (chapter 8)	В	-239, 303 PU	IRCHASI NG & RECEI VI NG	4. 02	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	В	-28, 004 OP	ERATION OF PLANT	7.00	0	7.00
8.00	Television and radio service (chapter 21)		О		0.00	0	8.00
	Parking lot (chapter 21) Provider-based physician	A-8-2	0 -21, 812, 842		0.00	0 0	9. 00 10. 00
11.00	adjustment Sale of scrap, waste, etc. (abantan 22)		0		0.00	0	11.00
12.00	(chapter 23) Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
	Cafeteria-employees and guests Rental of quarters to employee and others		-407, 651 CA 0	FETERI A	11.00 0.00	0 0	
16.00	Sale of medical and surgical supplies to other than	В	-395, 348 DR	UGS CHARGED TO PATIENTS	73.00	0	16.00
17.00	patients Sale of drugs to other than		О		0.00	0	17.00
18.00	patients Sale of medical records and abstracts		0		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 education (tuition, fees, books, etc.)		О		0.00	0	19. 01
19. 02	Nursing and allied health education (tuition, fees, books, etc.)		0		0. 00	0	19. 02
19. 03	Nursing and allied health education (tuition, fees, books, etc.)		О		0.00	0	19. 03
	Vending machines Income from imposition of interest, finance or penalty	В	-35, 503 CA 0	FETERI A	11.00 0.00	0 0	20. 00 21. 00
22.00	charges (chapter 21) Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22.00
23.00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	ORE	SPI RATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of	A-8-3	ОРН	IYSI CAL THERAPY	66.00		24.00
25.00	limitation (chapter 14) Utilization review - physicians' compensation		0**	* Cost Center Deleted **	* 114.00		25.00
26.00	(chapter 21) Depreciation - CAP REL		OCA	P REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	COSTS-BLDG & FIXT Depreciation - CAP REL COSTS-MVBLE EQUIP		OCA	P REL COSTS-MVBLE EQUIP	2.00	0	27.00

Heal th	Fi nanc	i al	Systems
AD JUST	MENTS T	TO F	XPENSES

ealth Financial Systems		GOOD SAMARITA	AN HOSPITAL	In Lie	u of Form CMS-:	2552-10
ADJUSTMENTS TO EXPENSES			Provider CCN: 15-0042	Period:	Worksheet A-8	3
				From 01/01/2023		
				To 12/31/2023	Date/Time Pre 4/11/2024 3:1	
· · · · · · · · · · · · · · · · · · ·			Expense Classification or	Workshoot A	4/11/2024 3.1	
			To/From Which the Amount is			
			TO/TTOIL WITCH THE AMOUNT TS	to be Aujusteu		
Cost Center Description	Basi s/Code	Amount	Cost Center	Line #	Wkst. A-7	
	(2)	0.00	0.00	1.00	Ref.	
	1.00	2.00	3.00	4.00	5.00	
28.00 Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant		0		0.00	0	
30.00 Adjustment for occupational	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
therapy costs in excess of						
limitation (chapter 14)						
30.99 Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30.99
instructions)						
31.00 Adjustment for speech	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
pathology costs in excess of						
limitation (chapter 14)						
32.00 CAH HIT Adjustment for		0		0.00	0	32.00
Depreciation and Interest						
33. 00 MISC INCOME	В	-610	EMPLOYEE BENEFITS DEPARTMEN	т 4.00	O	33.00
33. 01 MISC INCOME	B		PURCHASING & RECEIVING	4. 02	Ő	
33. 02 MISC INCOME	B		PATIENT ACCOUNTS	4.04	Ő	
33. 03 MISC INCOME	B		ADMI NI STRATI VE & GENERAL	5.00	0	
33. 04 MISC INCOME	B		OPERATION OF PLANT	7.00	0	
33. 05 MISC INCOME	B			9.00	0	
			HOUSEKEEPING		-	
33. 06 MISC INCOME	В	-219, 219		15.00	0	
33. 07 MISC INCOME	В		MEDI CAL RECORDS & LI BRARY	16.00	0	
33. 09 MISC INCOME	В	-2,000	I&R SERVICES-OTHER PRGM	22.00	0	33.09
	-		COSTS APPRVD		_	
33. 10 MISC INCOME	В		PARAMED ED PRGM-LAB	23.01	0	
33.11 MISC INCOME	В		SUBPROVIDER - IPF	40.00	0	
33.12 MISC INCOME	В		OPERATING ROOM	50.00	0	
33.13 MISC INCOME	В	-504, 722	RADI OLOGY-DI AGNOSTI C	54.00	0	33.13
33.14 MISC INCOME	В	-22, 821	LABORATORY	60.00	0	33.14
33.15 MISC INCOME	В	-1, 271	RESPI RATORY THERAPY	65.00	0	33.15
33.16 MISC INCOME	В	-35, 449	PHYSI CAL THERAPY	66.00	0	33.16
33.17 MISC INCOME	В	-96, 027	ELECTROCARDI OLOGY	69.00	0	33.17
33. 18 MISC INCOME	В	-17,500	WOUND CLINIC	90.01	0	33. 18
33. 19 ADVERTI SI NG	Ā		ADMINISTRATIVE & GENERAL	5.00	0	
33. 20 ADVERTI SI NG	A		MENTAL HEALTH OH	17.01	Ő	
33. 21 ADVERTI SI NG	A		SUBPROVI DER – I RF	41.00	0	
33. 22 ADVERTI SI NG	A		RADI OLOGY-DI AGNOSTI C	54.00	Ő	
33. 23 ADVERTISING	A		PHYSICAL THERAPY	66.00	0	
	A				0	
				69.00		
33. 25 PHYSI CI AN BILLING COSTS	A		PATIENT ACCOUNTS	4.04		
33. 26 2012 BOND I SSUE COSTS	A		ADMI NI STRATI VE & GENERAL	5.00	0	
33.27 GME CONSORTIUM FEES	A		I &R SERVICES-OTHER PRGM	22.00	0	33.27
			COSTS APPRVD			
33. 28 AHA LOBBYING OFFSET	A		ADMI NI STRATI VE & GENERAL	5.00	0	
33. 29 I HA LOBBYING OFFSET	A		ADMINISTRATIVE & GENERAL	5.00	0	
33. 30 INDIANA CHAMBER LOBBYING	A	- 196	ADMINISTRATIVE & GENERAL	5.00	0	33.30
OFFSET						
33.31 HRA LOBBYING OFFSET	A		ADMINISTRATIVE & GENERAL	5.00	0	
33. 32 PROVIDER ASSESSMENT FEE	A	-12, 796, 585	ADMINISTRATIVE & GENERAL	5.00	0	
33. 33 RENTAL	A	-539, 823	ADMINISTRATIVE & GENERAL	5.00	C	33.33
33. 34 RENTAL	A	-19, 620	OPERATING ROOM	50.00	0	33.34
33. 35 RENTAL	A		ELECTROCARDI OLOGY	69.00	0	
33. 36 RENTAL	A		INPATIENT DIALYSIS	76.01	0	
33. 37 PHYSICIAN LOAN EXPENSE	A		ADMI NI STRATI VE & GENERAL	5.00	Ő	1
33. 38 PHYSICIAN LOAN EXPENSE	A		I &R SERVICES-OTHER PRGM	22.00	0	
			COSTS APPRVD	22.00	0	55.50
33. 39 PHYSICIAN LOAN EXPENSE	A		OPERATING ROOM	50.00	C	33.39
	A		RADI OLOGY-THERAPEUTI C	55.00		
33. 41 PHYSI CLAN LOAN EXPENSE	В		ANESTHESI OLOGY	53.00	0	
33. 42 PHYSI CI AN LOAN EXPENSE	В		NEURODI AGNOSTI CS	70.01	0	
33. 43 OTHER MISC FEES	В		CAFETERIA	11.00	0	
33. 44 DONATIONS EXPENSE	В		ADMINISTRATIVE & GENERAL	5.00	0	
33.45 TELEPHONE OFFSET	A		COMMUNI CATI ONS	4. 01	0	
33.46 340B OFFSET	В	-41, 978	PHARMACY	15.00	0	
33. 47 OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33.47
(3)	1	i		1		1

Health Financial Systems	GOOD SAMARITA	AN HOSPITAL	In Lieu of Form CMS-2552-10			
ADJUSTMENTS TO EXPENSES				Period: From 01/01/2023	Worksheet A-8	;
				To 12/31/2023		pared: 7 pm
			Expense Classification o			
			To/From Which the Amount is	s to be Adjusted		
Cost Center Description	Basi s/Code	Amount	Cost Center	Line #	Wkst. A-7	
	(2)	Amount		Erno "	Ref.	
	1.00	2.00	3.00	4.00	5.00	
50.00 TOTAL (sum of lines 1 thru 49)		-42, 183, 368				50.00
(Transfer to Worksheet A,						
column 6, line 200.)						

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

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

	Financial Syste R BASED PHYSIC		GOOD SAMARI		CCN: 15-0042 F	In Lie Period:	u of Form CMS- Worksheet A-8	
						From 01/01/2023 To 12/31/2023		
	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		ADMI NI STRATI VE & GENERAL	261, 771	17, 771	244,000	211, 500	2, 193	1.00
2.00		NURSING ADMINISTRATION	177, 435			211, 500	0	2.00
3.00		PHARMACY	18, 969			211, 500	177	3.00
4.00		MEDICAL RECORDS & LIBRARY	85, 827		22, 500	211, 500	150	4.00
5.00		ADULTS & PEDIATRICS	3, 668, 633			211, 500	0	5.00
6.00	50.00	OPERATING ROOM	1, 627, 263			246, 400	50	6.00
7.00		ANESTHESI OLOGY	3, 724, 393			246, 400	0	7.00
8.00	54.00	RADI OLOGY-DI AGNOSTI C	892, 984	892, 984	0	271, 900	0	8.00
9.00	55.00	RADI OLOGY-THERAPEUTI C	2, 417, 310	2, 368, 035	49, 275	271, 900	219	9.00
10.00	60.00	LABORATORY	444, 766	312, 766	132,000	260, 300	365	10.00
11.00	65.00	RESPI RATORY THERAPY	1, 808, 949	1, 785, 549	23, 400	211, 500	247	11.00
12.00	66.00	PHYSICAL THERAPY	1, 831, 817	1, 831, 817	0	211, 500	0	12.00
13.00	69.00	ELECTROCARDI OLOGY	3, 093, 168	3, 083, 168	10, 000	211, 500	90	13.00
14.00	70. 01	NEURODI AGNOSTI CS	795, 954	779, 454	16, 500	211, 500	96	14.00
15.00	75.00	ASC (NON-DISTINCT PART)	103, 850	68, 750	35, 100	211, 500	276	15.00
16.00		I NPATI ENT DI ALYSI S	40, 560	0	40, 560	211, 500	637	16.00
17.00	91.00	EMERGENCY	1, 274, 225	1, 235, 225	39, 000	211, 500	75	17.00
200.00			22, 267, 874	21, 629, 070	638, 804			200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of		Physician Cost	
		I denti fi er	Limit	Unadjusted RCE			of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
	1 00	2.00	0.00	0.00	Education	12	14.00	
1.00	1.00 E.00	2.00 ADMI NI STRATI VE & GENERAL	8.00 222,990	9.00 11,150	12.00	13.00 0	14.00	1.00
2.00		NURSING ADMINISTRATION	222, 990				0	2.00
3.00		PHARMACY	17, 998			0	0	3.00
4.00		MEDICAL RECORDS & LIBRARY	15, 252	763	-	0	0	4.00
5.00		ADULTS & PEDIATRICS	0		-	0	0	5.00
6.00		OPERATING ROOM	5, 923		0	0	0	6.00
7.00		ANESTHESI OLOGY	0,720		0	0	0	7.00
8.00		RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	8.00
9.00		RADI OLOGY-THERAPEUTI C	28, 628	1, 431	0	0	0	9.00
10.00	60.00	LABORATORY	45, 678	2, 284	0	0	0	10.00
11.00	65.00	RESPI RATORY THERAPY	25, 116	1, 256	0	0	0	11.00
12.00	66.00	PHYSI CAL THERAPY	0	0	0	0	0	12.00
13.00		ELECTROCARDI OLOGY	9, 151	458	0	0	0	13.00
14.00		NEURODI AGNOSTI CS	9, 762	488	0	0	0	14.00
15.00		ASC (NON-DISTINCT PART)	28, 064	1, 403		0	0	15.00
16.00		INPATIENT DIALYSIS	64, 772	3, 239	0	0	0	16.00
17.00	91.00	EMERGENCY	7,626		0	0	0	17.00
200.00			480, 960			0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		Identifier	Component Share of col.	Limit	Di sal I owance			
			14					
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00		ADMI NI STRATI VE & GENERAL	0					1.00
2.00		NURSING ADMINISTRATION	0		0			2.00
3.00	15.00	PHARMACY	0	17, 998	971	971		3.00
4.00	16.00	MEDICAL RECORDS & LIBRARY	0	15, 252	7, 248	70, 575		4.00
5.00	30.00	ADULTS & PEDIATRICS	0		0	3, 668, 633		5.00
6.00	50.00	OPERATING ROOM	0	5, 923	1, 577	1, 621, 340		6.00
7.00	53.00	ANESTHESI OLOGY	0	0	0	3, 724, 393		7.00
8.00	54.00	RADI OLOGY-DI AGNOSTI C	0	0	0	892, 984		8.00
9.00		RADI OLOGY-THERAPEUTI C	0	28, 628	20, 647	2, 388, 682		9.00
10.00		LABORATORY	0			399, 088		10.00
11.00		RESPI RATORY THERAPY	0			1, 785, 549		11.00
12.00		PHYSICAL THERAPY	0		-	1, 831, 817		12.00
13.00		ELECTROCARDI OLOGY	0		849	3, 084, 017		13.00
14.00		NEURODI AGNOSTI CS	0		6, 738	786, 192		14.00
15.00		ASC (NON-DI STI NCT PART)	0			75, 786		15.00
16.00		I NPATI ENT DI ALYSI S	0		0	0		16.00
17.00	91.00	EMERGENCY	0					17.00 200.00
200.00	l	I	0	480, 960	183, 772	21, 812, 842		200.00

$\begin{array}{ccccc} 1. & 00 & 0\\ 2. & 00 & 0\\ 4. & 00 & 0\\ 4. & 01 & 0\\ 4. & 02 & 0\\ 4. & 03 & 0\\ 4. & 04 & 0\\ 5. & 00 & 0\\ 7. & 00 & 0 \end{array}$	Cost Center Description ENERAL SERVICE COST CENTERS 10100 CAP REL COSTS-BLDG & FIXT 10200 CAP REL COSTS-MVBLE EQUIP 10400 EMPLOYEE BENEFITS DEPARTMENT 10401 COMMUNICATIONS 10402 PURCHASING & RECEIVING 10403 REGISTRATION	Net Expenses for Cost Allocation (from Wkst A col. 7) 0 20, 306, 497 40, 088 28, 414, 621	CAPI TAL REI BLDG & FI XT 1.00 20, 306, 497	ATED COSTS MVBLE EQUI P 2.00	EMPLOYEE BENEFI TS DEPARTMENT	4/11/2024 3: 1 COMMUNI CATI ON S	7 pm
$\begin{array}{ccccc} 1. & 00 & 0\\ 2. & 00 & 0\\ 4. & 00 & 0\\ 4. & 01 & 0\\ 4. & 02 & 0\\ 4. & 03 & 0\\ 4. & 04 & 0\\ 5. & 00 & 0\\ 7. & 00 & 0 \end{array}$	ENERAL SERVICE COST CENTERS 10100 CAP REL COSTS-BLDG & FIXT 10200 CAP REL COSTS-MVBLE EQUIP 10400 EMPLOYEE BENEFITS DEPARTMENT 10401 COMMUNICATIONS 10402 PURCHASING & RECEIVING 10403 REGISTRATION	for Cost Allocation (from Wkst A col. 7) 0 20, 306, 497 40, 088	1.00		BENEFI TS		
$\begin{array}{ccccc} 1. & 00 & 0\\ 2. & 00 & 0\\ 4. & 00 & 0\\ 4. & 01 & 0\\ 4. & 02 & 0\\ 4. & 03 & 0\\ 4. & 04 & 0\\ 5. & 00 & 0\\ 7. & 00 & 0 \end{array}$	0100 CAP REL COSTS-BLDG & FIXT 0200 CAP REL COSTS-MVBLE EQUIP 0400 EMPLOYEE BENEFITS DEPARTMENT 0401 COMMUNI CATIONS 0402 PURCHASING & RECEIVING 0403 REGISTRATION	0 20, 306, 497 40, 088		2.00			
$\begin{array}{ccccc} 1. & 00 & 0\\ 2. & 00 & 0\\ 4. & 00 & 0\\ 4. & 01 & 0\\ 4. & 02 & 0\\ 4. & 03 & 0\\ 4. & 04 & 0\\ 5. & 00 & 0\\ 7. & 00 & 0 \end{array}$	0100 CAP REL COSTS-BLDG & FIXT 0200 CAP REL COSTS-MVBLE EQUIP 0400 EMPLOYEE BENEFITS DEPARTMENT 0401 COMMUNI CATIONS 0402 PURCHASING & RECEIVING 0403 REGISTRATION	40, 088	20, 306, 497	2.00	4.00	4. 01	
$\begin{array}{cccc} 2.\ 00 & 0 \\ 4.\ 00 & 0 \\ 4.\ 01 & 0 \\ 4.\ 02 & 0 \\ 4.\ 03 & 0 \\ 4.\ 04 & 0 \\ 5.\ 00 & 0 \\ 7.\ 00 & 0 \end{array}$	0200 CAP REL COSTS-MVBLE EQUIP 0400 EMPLOYEE BENEFITS DEPARTMENT 0401 COMMUNI CATIONS 0402 PURCHASING & RECEIVING 0403 REGISTRATION	40, 088					1.00
4.03 0 4.04 0 5.00 0 7.00 0	0403 REGI STRATI ON	210, 740 780, 178	111, 623 0	40, 088 220 0 525	28, 526, 464 84, 525		2.00 4.00 4.01 4.02
5.00 0 7.00 0		1, 823, 145	259, 520	512			4.02
	0404 PATI ENT ACCOUNTS 0500 ADMI NI STRATI VE & GENERAL	3, 931, 598 19, 684, 607		0 2, 174			4.04 5.00
0.00 10	0700 OPERATION OF PLANT 0800 LAUNDRY & LINEN SERVICE	7, 657, 178 339, 432		10, 874 239		16, 932 0	7.00 8.00
	10900 HOUSEKEEPING	2, 560, 935		332			9.00
	1000 DI ETARY	887, 887	87, 769	173			
	1100 CAFETERIA 1300 NURSI NG ADMI NI STRATI ON	1, 227, 466 4, 313, 563		394 442		2, 799 2, 659	11.00
	1400 CENTRAL SERVICES & SUPPLY	600, 644		180			
		3, 316, 672		271			
	11600 MEDI CAL RECORDS & LI BRARY 11700 SOCI AL SERVI CE	4, 490, 681 0	105, 149 0	208 C		6, 577 0	16.00
17.01 0	1701 MENTAL HEALTH OH	565, 640	59, 806	118		12, 314	17.01
	2100 I & R SERVICES-SALARY & FRINGES APPRVD 2200 I & R SERVICES-OTHER PRGM COSTS APPRVD	3, 634, 739 2, 846, 164	232, 888 0	460 C		0 4, 758	21.00 22.00
	2300 PARAMED ED PRGM-RADI OLOGY	2, 040, 104	0	0		4,750	23.00
	2301 PARAMED ED PRGM-LAB	272, 706	0	C	72, 452	0	23.01
	NPATIENT ROUTINE SERVICE COST CENTERS	10, 106, 392	1, 040, 650	2, 054	1, 884, 316	28, 547	30.00
31.00 0	3100 I NTENSI VE CARE UNI T	4, 530, 856	481, 066	950	906, 227	13, 434	
	4000 SUBPROVI DER - I PF	2, 835, 093		591			40.00
	14100 SUBPROVI DER – I RF 14300 NURSERY	2, 280, 009 309, 790		779 473			1
A	NCILLARY SERVICE COST CENTERS						
	15000 OPERATING ROOM 15100 RECOVERY ROOM	4, 165, 994 0	551, 594 0	1, 089 0		20, 571 0	50.00 51.00
	15101 ENDOSCOPY	1, 613, 096		555	-	3, 638	1
52.00 0	5200 DELIVERY ROOM & LABOR ROOM	187, 235	144, 775	286	43, 840	3, 219	52.00
	15300 ANESTHESI OLOGY 15400 RADI OLOGY-DI AGNOSTI C	656, 891 7, 595, 219	0 497, 413	0 982			
	5500 RADI OLOGY-THERAPEUTI C	3, 090, 647		815			54.00
60.00 0	6000 LABORATORY	7, 504, 290		331	635, 838	4, 758	60.00
	6300 BLOOD STORI NG, PROCESSI NG & TRANS. 6500 RESPI RATORY THERAPY	0 2, 407, 470	0 130, 380	0 257	-	0 5, 458	
	6600 PHYSI CAL THERAPY	4, 162, 063		1, 285			
69.00 0	6900 ELECTROCARDI OLOGY	2, 994, 538				11, 335	69.00
	7000 ELECTROENCEPHALOGRAPHY 7001 NEURODI AGNOSTI CS	0 1, 039, 924	0 176, 962	0 349	-	0 2, 799	
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 675, 266		349 C		2, 799	71.00
	7200 IMPL. DEV. CHARGED TO PATIENTS	4, 249, 606		C	0 O	0	72.00
	7300 DRUGS CHARGED TO PATIENTS	19, 527, 702	0	0	210.025	0	73.00 75.00
	17500 ASC (NON-DISTINCT PART) 13950 MH ANCILLARY OUTPATIENT	2, 038, 635 0	0			0	76.00
76.01 0	3951 I NPATI ENT DI ALYSI S	248, 408	197, 027	389	-	280	1
	UTPATIENT SERVICE COST CENTERS	24, 307		C	5, 687	0	88.00
	18800 FAMILY PRACTICE 120 19000 CLINIC	24, 307 158, 831	0 51, 748				
90.01 0	14950 WOUND CLINIC	992, 844	68, 324	135	97, 016	1, 399	90.01
	9100 EMERGENCY 9200 OBSERVATION BEDS (NON-DISTINCT PART)	5, 776, 408	543, 398	1, 073	1, 224, 888	14, 134	91.00 92.00
	THER REIMBURSABLE COST CENTERS						92.00
96.00 0	9600 DURABLE MEDICAL EQUIP-RENTED	158, 620					96.00
	0100 HOME HEALTH AGENCY PECIAL PURPOSE COST CENTERS	0	0	C	0 0	0	101.00
	1300 INTEREST EXPENSE						113.00
116.001	1600 HOSPI CE	881, 815				3, 219	116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	201, 117, 130	15, 540, 349	30, 679	22, 717, 864	249, 930	118.00
	ONREIMBURSABLE COST CENTERS 9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C	0	0	190.00
192.001	9200 PHYSI CLANS' PRI VATE OFFI CES	19, 871, 575	2, 619, 073		3, 914, 210	40, 716	192.00
	9201 FP PETERSBURG 9202 PEDI ATRI CS	255, 423 1, 200, 013		168 C			192. 01 192. 02

Health Financial Systems	GOOD SAMARI TA	AN HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CO		Period: From 01/01/2023 To 12/31/2023		
		CAPI TAL REL	LATED COSTS			
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFI TS DEPARTMENT	COMMUNI CATI ON S	
	0	1.00	2.00	4.00	4.01	
192.03 19203 WASHINGTON PRIMARY CARE	1, 647, 384	156, 116	30	8 371, 547	0	192.03
192.04 19204 FQHC	-72	0		0 0	0	192.04
194.0007950 COMMUNITY HEALTH SERVICES	132, 184	9, 528	1	9 30, 745	560	194.00
194.0107960 CCBHC GRANTS	1, 985, 947	0		0 263, 470	0	194.01
194.0207952 MARKETING AND PUBLIC RELATIONS	764, 095	38, 799	7	7 67, 806	840	194.02
194.0307953 MH RESIDENTIAL	298, 437	465, 133	91	8 71, 394	0	194.03
194.0407954 UNUSED SPACE	0	467,659	92	3 0	0	194.04
194.0507955 MOB	36, 658	0		0 42	0	194.05
194. 06 07956 FOUNDATI ON	0	10, 699	2	1 0	420	194.06
194.0707957 KNOX COUNTY HEALTH DEPT	0	108, 179	21	4 0	0	194.07
194. 08 07958 I NDUSTRI AL HEALTH	0	0		0 0	0	194.08
194.0907959 COMMUNITY MENTAL HEALTH CENTER	3, 475, 145	805, 902	1, 59	1 815, 715	0	194.09
194. 10 07951 BEI RHAUS BUI LDI NG	116, 137	0		0 0	0	194.10
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)	230, 900, 056	20, 306, 497	40, 08	8 28, 526, 464	295, 265	202.00

COST A	Financial Systems LLOCATION - GENERAL SERVICE COSTS	GOOD SAMARITA	Provi der CCI	N: 15-0042 Pe Fr	riod: om 01/01/2023	u of Form CMS-2 Worksheet B Part I	
				То	12/31/2023	Date/Time Pre 4/11/2024 3:1	pared:
	Cost Center Description	PURCHASING &	REGI STRATI ON	PATI ENT	Subtotal	ADMI NI STRATI V	
		RECEI VI NG 4. 02	4.03	ACCOUNTS 4.04	4A. 04	E & GENERAL 5.00	
	GENERAL SERVICE COST CENTERS	4. 02	4.03	4.04	4A. 04	5.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 4.01	00400 EMPLOYEE BENEFITS DEPARTMENT 00401 COMMUNI CATIONS						4.00 4.01
4.01	00402 PURCHASING & RECEIVING	1, 247, 874					4.01
4.03	00403 REGI STRATI ON	521	2, 559, 450				4.03
4.04	00404 PATIENT ACCOUNTS	617	0	4, 574, 842			4.04
5.00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	6, 187	0	0	22, 865, 895	22, 865, 895	5.00
7.00 8.00	00800 LAUNDRY & LINEN SERVICE	12, 790 4, 989	0	0	13, 877, 169 528, 007	1, 525, 295 58, 035	7.00 8.00
9.00	00900 HOUSEKEEPI NG	13, 377	0	0	3, 357, 429	369, 028	9.00
10.00	01000 DI ETARY	24, 202	0	0	1, 132, 647	124, 494	10.00
11.00		67, 092	0	0	1,862,313	204, 694	11.00
13.00 14.00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	274 6, 845	0	0	5, 136, 038 800, 318	564, 522 87, 966	13.00 14.00
15.00	01500 PHARMACY	1, 710	0	0	4, 294, 444	472, 020	
16.00	01600 MEDICAL RECORDS & LIBRARY	377	0	0	5, 654, 874	621, 550	
17.00	01700 SOCIAL SERVICE	0	0	0	0	0	17.00
17.01 21.00	01701 MENTAL HEALTH OH 02100 I&R SERVICES-SALARY & FRINGES APPRVD	139	0	0	728, 004 3, 868, 087	80, 018	17.01
21.00	02200 I &R SERVICES-SALART & FRINGES APPRVD	3, 638	0	0	3, 376, 102	425, 157 371, 081	21.00
23.00	02300 PARAMED ED PRGM-RADIOLOGY	0	0	0	0	0	23.00
23.01	02301 PARAMED ED PRGM-LAB	177	0	0	345, 335	37, 957	23.01
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	20.074	10/ 115	225 050	12 444 707	1 477 750	20.00
30.00 31.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	30, 274 21, 317	126, 415 49, 033	225, 958 87, 644	13, 444, 606 6, 090, 527	1, 477, 750 669, 434	30.00 31.00
40.00	04000 SUBPROVI DER – I PF	1, 662	36, 648	65, 506	3, 821, 176	420, 001	40.00
41.00	04100 SUBPROVI DER – I RF	5, 640	31, 245	55, 849	3, 297, 823	362, 477	41.00
43.00	04300 NURSERY	0	4, 917	8, 788	636, 050	69, 911	43.00
50.00	ANCILLARY SERVICE COST CENTERS	52, 379	174, 128	311, 243	6, 138, 688	674, 728	50.00
51.00	05100 RECOVERY ROOM	52, 577	0	0	0, 130, 000	074,720	51.00
51.01	05101 ENDOSCOPY	38, 805	52, 527	93, 889	2, 303, 675	253, 206	51.01
52.00	05200 DELIVERY ROOM & LABOR ROOM	3, 424	8, 135	14, 541	405, 455	44, 565	
53.00 54.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0 E0 943	32, 319	57, 767	1, 492, 321	164,027	53.00 54.00
54.00 55.00	05500 RADI OLOGY-THERAPEUTI C	50, 862 6, 327	451, 717 108, 350	807, 409 193, 668	10, 709, 216 4, 582, 940	1, 177, 093 503, 729	55.00
60.00	06000 LABORATORY	89, 563	322, 779	576, 945	9, 302, 053	1, 022, 426	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00		998 3, 133	48, 681	87, 014	3, 389, 802	372, 587	65.00
66.00 69.00	06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY	14, 423	104, 298 174, 753	186, 426 312, 359	6, 624, 278 5, 255, 092	728, 101 577, 608	66.00 69.00
	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0,200,072		70.00
	07001 NEURODI AGNOSTI CS	2, 863	24, 941	44, 581	1, 524, 145	167, 525	70.01
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	410, 668	13, 104	23, 422	4, 122, 460	453, 116	
72.00 73.00	07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	258, 720 0	50, 415 368, 779	90, 114 659, 167	4, 648, 855 20, 555, 648	510, 974 2, 259, 353	
	07500 ASC (NON-DI STI NCT PART)	29, 734	115, 011	205, 575	2, 706, 980	2, 237, 333	
76.00	03950 MH ANCI LLARY OUTPATI ENT	0	0	0	0	0	76.00
76.01	03951 I NPATI ENT DI ALYSI S	173	3, 985	7, 123	481, 736	52, 950	76.01
88.00	OUTPATIENT SERVICE COST CENTERS 08800 FAMILY PRACTICE 120	0	184	329	30, 507	3, 353	88.00
90.00	09000 CLINIC	18		881	254, 515	27,975	90.00
90.01	04950 WOUND CLINIC	8, 639	21, 199	37, 892	1, 227, 448	134, 914	90.01
91.00	09100 EMERGENCY	24, 160	227, 108	405, 941	8, 217, 110	903, 175	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
96 00	OTHER REIMBURSABLE COST CENTERS 09600 DURABLE MEDICAL EQUIP-RENTED	371	1, 797	3, 212	197, 825	21, 744	96.00
	10100 HOME HEALTH AGENCY	0	0	0, 2.2	0		101.00
	SPECIAL PURPOSE COST CENTERS	1					
	11300 INTEREST EXPENSE	001	(100	11 500	1 150 140		113.00
118.00	11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117)	881 1, 197, 969	6, 489 2, 559, 450	11, 599 4, 574, 842	1, 150, 140 190, 437, 733	126, 416 18, 418, 490	
	NONREIMBURSABLE COST CENTERS	1,177,707	2, 337, 430	4, 374, 042	170, 437, 733	10, 410, 470	110.00
110.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
190.00		40.000	0	0	26, 490, 764	2, 911, 728	192.00
190. 00 192. 00	19200 PHYSICIANS' PRIVATE OFFICES	40, 020					100
190. 00 192. 00 192. 01	19200 PHYSI CLANS' PRI VATE OFFI CES 19201 FP PETERSBURG	119	0	0	374, 710		192.01
190. 00 192. 00 192. 01 192. 02	19200 PHYSI CI ANS' PRI VATE OFFI CES 19201 FP PETERSBURG 19202 PEDI ATRI CS	119 2, 598	0	0	1, 445, 141	158, 841	192.02
190. 00 192. 00 192. 01 192. 02 192. 03	19200 PHYSI CLANS' PRI VATE OFFI CES 19201 FP PETERSBURG	119	0 0 0	0 0 0		158, 841 239, 324	192.02
190.00 192.00 192.01 192.03 192.03 192.04 194.00	19200 PHYSI CI ANS' PRI VATE OFFI CES 19201 FP PETERSBURG 19202 PEDI ATRI CS 19203 WASHI NGTON PRI MARY CARE 19204 FQHC 07950 COMMUNI TY HEALTH SERVI CES	119 2, 598 2, 022 0 80	0 0 0 0	0 0 0 0	1, 445, 141 2, 177, 377 -72 173, 116	158, 841 239, 324 0 19, 028	192.02 192.03 192.04 194.00
190.00 192.00 192.01 192.03 192.03 192.04 194.00 194.01	19200 PHYSI CI ANS' PRI VATE OFFI CES 19201 FP PETERSBURG 19202 PEDI ATRI CS 19203 WASHI NGTON PRI MARY CARE 19204 FQHC	119 2, 598 2, 022 0			1, 445, 141 2, 177, 377 -72	158, 841 239, 324 0	192.02 192.03 192.04 194.00 194.01

Health Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CO	CN: 15-0042	Period: From 01/01/2023	Worksheet B Part I	
				To 12/31/2023		
Cost Center Description	PURCHASI NG & RECEI VI NG	REGI STRATI ON	PATI ENT ACCOUNTS	Subtotal	ADMI NI STRATI V E & GENERAL	
	4. 02	4.03	4.04	4A. 04	5.00	
194.0307953 MH RESIDENTIAL	992	0		0 836, 874	91, 984	194.03
194.0407954 UNUSED SPACE	0	0		0 468, 582	51, 504	194.04
194. 05 07955 MOB	0	0		0 36, 700	4,034	194.05
194. 06 07956 FOUNDATI ON	0	0		0 11, 140	1, 224	194.06
194.0707957 KNOX COUNTY HEALTH DEPT	0	0		0 108, 393	11, 914	194.07
194. 08 07958 I NDUSTRI AL HEALTH	0	0		0 0	0	194.08
194.0907959 COMMUNITY MENTAL HEALTH CENTER	2,652	0		0 5, 101, 005	560, 672	194.09
194. 10 07951 BEI RHAUS BUI LDI NG	29	0		0 116, 166	12, 768	194.10
200.00 Cross Foot Adjustments				0		200.00
201.00 Negative Cost Centers	0	0		0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	1, 247, 874	2, 559, 450	4, 574, 84	230, 900, 056	22, 865, 895	202.00

	I Financial Systems ALLOCATION - GENERAL SERVICE COSTS	GOOD SAMARITA	N HOSPITAL Provider CO		riod: om 01/01/2023		epared:
	Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		7.00	8.00	9.00	10.00	11.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401 COMMUNI CATI ONS						4.01
4.02	00402 PURCHASING & RECEIVING						4.02
4.03 4.04	00403 REGI STRATI ON 00404 PATI ENT ACCOUNTS						4.03 4.04
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT	15, 402, 464					7.00
8.00	00800 LAUNDRY & LINEN SERVICE	142, 582	728, 624				8.00
9.00	00900 HOUSEKEEPI NG	198, 359	30, 670		1 1/0 05/		9.00
10.00	01000 DI ETARY 01100 CAFETERI A	103, 511	2,480		1, 460, 956	2 222 41E	10.00
11.00 13.00	01300 NURSING ADMINISTRATION	235, 453 264, 343	6, 875 0		0 0	2, 332, 415 59, 337	
14.00	01400 CENTRAL SERVICES & SUPPLY	107, 410	12, 155	-	0	17,946	
15.00	01500 PHARMACY	161, 887	0		0	78, 011	
16.00	01600 MEDICAL RECORDS & LIBRARY	124, 008	0		0	139, 441	1
17.00	01700 SOCIAL SERVICE	0	0		0	0	
17.01 21.00	01701 MENTAL HEALTH OH 02100 I &R SERVICES-SALARY & FRINGES APPRVD	70, 533 274, 659	0		0	8, 049 71	17.01
21.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	274,059	0		0	40, 489	1
23.00	02300 PARAMED ED PRGM-RADI OLOGY	0	0		0	0	1
23.01	02301 PARAMED ED PRGM-LAB	0	0	0	0	7, 705	23.01
	INPATIENT ROUTINE SERVICE COST CENTERS			L			
30.00	03000 ADULTS & PEDIATRICS	1, 227, 300	220, 726		683, 890	170, 896	
31.00 40.00	03100 I NTENSI VE CARE UNI T 04000 SUBPROVI DER – I PF	567, 350 352, 908	38, 978 12, 826		243, 013 218, 318	100, 970 66, 959	1
41.00	04100 SUBPROVI DER – I RF	465, 517	35, 354		315, 735	68, 992	1
43.00		282, 511	50, 807		0	39, 338	1
	ANCI LLARY SERVICE COST CENTERS	1 1					
50.00	05000 OPERATING ROOM	650, 527	28, 183		0	77, 455	
51.00 51.01	05100 RECOVERY ROOM 05101 ENDOSCOPY	0 331, 329	0 16, 704	-	0	0 28, 214	
52.00	05200 DELIVERY ROOM & LABOR ROOM	170, 741	30, 707	90, 243	0	23, 214	
53.00	05300 ANESTHESI OLOGY	0	0	0	0	16, 958	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	586, 628	43, 532		0	125, 748	
55.00	05500 RADI OLOGY-THERAPEUTI C	486, 961	6, 842		0	68, 298	
60.00 63.00	06000 LABORATORY 06300 BLOOD STORING, PROCESSING & TRANS.	197, 600 0	0		0	108, 845 0	1
65.00	06500 RESPIRATORY THERAPY	153, 764	1, 597	-	0	71, 636	1
66.00	06600 PHYSI CAL THERAPY	767, 495	13,900		0	145, 136	1
69.00	06900 ELECTROCARDI OLOGY	492, 268	15, 807	182, 789	0	93, 855	
	07000 ELECTROENCEPHALOGRAPHY	0	0	-	0	-	70.00
	07001 NEURODI AGNOSTI CS	208, 702	7,839	51, 552	0	23, 210	
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	1
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	1
75.00		0	25, 508	161, 674	0	43, 309	
76.00	03950 MH ANCI LLARY OUTPATI ENT	0	0	0	0	0	
76.01	03951 I NPATI ENT DI ALYSI S	232, 366	0	0	0	1, 916	76.01
88.00	OUTPATIENT SERVICE COST CENTERS 08800 FAMILY PRACTICE 120	0	0	0	0	0	88.00
90.00	09000 CLINIC	61, 029	48		0	4, 869	
90.01	04950 WOUND CLINIC	80, 578	11, 299		0	11, 890	1
	09100 EMERGENCY	640, 861	88, 430	236, 531	0	137, 731	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
96 00	OTHER REIMBURSABLE COST CENTERS 09600 DURABLE MEDICAL EQUIP-RENTED	10, 668	0	0	0	3 547	96.00
	10100 HOME HEALTH AGENCY	10,008	0		0		101.00
	SPECIAL PURPOSE COST CENTERS	-			-		
	11300 INTEREST EXPENSE						113.00
		131, 616	0		0		116.00
118.00	D SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	9, 781, 464	701, 267	3, 147, 788	1, 460, 956	1, 803, 572	118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	3, 088, 828	27, 357		0	349, 527	1
192. Oʻ	19201 FP PETERSBURG	100, 316	0	0	0	5, 210	192.01
	2 19202 PEDI ATRI CS	0	0	0	0		192.02
	19203 WASHINGTON PRIMARY CARE	184, 117	0		0		192.03
	4 19204 FQHC 07950 COMMUNI TY HEALTH SERVI CES	0 11, 237	0	15, 836	0		192.04 194.00
	107960 CCBHC GRANTS	0	0	3, 089	0		194.00
	07952 MARKETING AND PUBLIC RELATIONS	45, 758	0	0	0		194.02

Health Financial Systems	GOOD SAMARI TA	AN HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATI ON - GENERAL SERVI CE COSTS		Provider C	CN: 15-0042	Period: From 01/01/2023 To 12/31/2023		
Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DI ETARY	CAFETERI A	
	7.00	8.00	9.00	10.00	11.00	
194.0307953 MH RESIDENTIAL	548, 559	0		0 0	15, 882	194.03
194. 04 07954 UNUSED SPACE	551, 538	0		0 0	0	194.04
194. 05 07955 MOB	0	0		0 0	0	194.05
194. 06 07956 FOUNDATI ON	12, 617	0		0 0	0	194.06
194.0707957 KNOX COUNTY HEALTH DEPT	127, 582	0		0 0	0	194.07
194. 08 07958 I NDUSTRI AL HEALTH	0	0		0 0	0	194.08
194.0907959 COMMUNITY MENTAL HEALTH CENTER	950, 448	0		0 0	0	194.09
194. 10 07951 BEI RHAUS BUI LDI NG	0	0	58, 01	0 0	0	194.10
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)	15, 402, 464	728, 624	3, 955, 48	6 1, 460, 956	2, 332, 415	202.00

2.00 00200 GAP REL COSTS-MARLE EQUIP 4.00 00407 [CMMMICATIONS INFORMATION INF	Health Financial Systems		GOOD SAMARITA	N HOSPITAL		In Lie	u of Form CMS-	2552-10
Chief Center Description Auministration Central Supervision PMRMACY PECORD 5 EVALUATION 5 1000 Control Control Control Controls 13.00 14.00 15.00 16.00 17.00	COST ALLOCATION - GENERAL SE	RVICE COSTS		Provider C		rom 01/01/2023	Part I	
ADM NI STRATTO SERVICES & SUPURTS PEORES & SUPURTS SERVICE LIEMAGY 10.00 CENERAL SERVICE COST CENTERS 13.00 14.00 15.00 13.00 10.00<					Т	o 12/31/2023		
N SUPPRY LIBBORY SUPPRY LIBBORY 1000 CAP FEL COST CHTERE 17.00 4.00	Cost Center Desc	ription			PHARMACY			
BATIRAL STRUCT CAST CANTERS 1 1.00 OCTOOL (AP REL COSTS AVELE EQUIP) 2 2.00 COSTS AVELE EQUIP 4 2.01 OCTOOL (AP REL COSTS AVELE EQUIP) 4 4.01 OVERTIC COSTS AVELE EQUIP 4 4.01 OVERTIC COSTS AVELE EQUIP 4 4.01 OVERTIC COSTS AVELE EQUIP 4 4.02 OVERTIC COSTS AVELE EQUIP 4 4.01 OVERTIC COSTS AVELE EQUIP 4 4.02 OVERTIC COSTS AVELE EQUIP 4 4.02 OVERTIC COSTS AVELE EQUIP 4 4.02 OVERTIC COSTS AVELE EQUIP 5 4.03 OVERTIC COSTS AVELE EQUIP 5 4.04 OVERTIC COSTS AVELE EQUIP 5 4.04 OVERTIC COSTS AVELE EQUIP 5 4.04 OVERTIC COSTS AVELE EQUIP 6 4.05 OVERTIC COSTS AVELE EQUIP 6 4.00 OVERTIC COSTS AVELE EQUIP 1 0 4.00 OVERTIC COSTS AVELE EQUIP 1 0 0 4.010 <t< td=""><td></td><td></td><td>N</td><td>SUPPLY</td><td></td><td>LI BRARY</td><td></td><td></td></t<>			N	SUPPLY		LI BRARY		
1:00 DOTION CAPE REL COSTS - BLICK & FITXT 1.00 0:00 DODOC APPRIL COSTS - BLICK & FITXT 1.00 0:00 DEPLOYEE SEMEETTS DEPARTNENT 1.00 0:00 DEPLOYEE SEMEETTS DEPARTNENT 1.00 0:00 DEPLOYEE SEMEETTS DEPARTNENT 4.00 0:00 DEPLOYEE SEMEETTS DEPARTNENT 0.01 0:00 DEPLOYEE SEMEETTS DEPARTNENT 0.02 0:00 DEPLOYEE SEMEETTS SEMERTS 0.00 0:00 DEPLOYEE SEMEETTS SEMERTS 0.00 0:00 DEPLOYEE SEMEETTS SEMERTS	GENERAL SERVICE COST C	FNTERS	13.00	14.00	15.00	16.00	17.00	
4.00 00400 DMELOPEE BURFETTS DEPARTMENT 4.0 4.00 10400 MARLINARIA & MORTHVING 4.0 4.00 READD MARLINARIA & MORTHVING 4.0 4.00 READD MARLINARIA & MORTHVING 4.0 4.00 READD MARLINARIA & MORTHVING 4.0 5.00 COSCOLADMINI STRATIVE & GENERAL 5.0 5.00 CORDEL CALERAVICE 5.0 5.00 DITOD (APETERIA A 0.0 0.0 5.00 DITOD (APETERIA A DITOD (APETERIA A 0.0 0.0 5.00 DITOD (APETERIA A DITOD (APETERIA A 0.0 0.0 0.0 5.00 DITOD (APETERIA A <t< td=""><td>1.00 00100 CAP REL COSTS-BL</td><td>DG & FIXT</td><td></td><td></td><td></td><td></td><td></td><td>1.00</td></t<>	1.00 00100 CAP REL COSTS-BL	DG & FIXT						1.00
4. 01 0401_COMUNIT CATURS 4.0 4. 02 0402_PERCMASING & RECEIVING 4.0 4. 02 0402_PERCMASING & RECEIVING 4.0 4. 03 00003_PERCMASING & RECEIVING 7.00 6. 00 00000_PERATION 6.00 7. 00 0000_PERATION 6.00 0.00 0000_PERATION 6.00 0.00 0000_PERATION 6.00 0.00 00000_PERATION 6.00 0.00 00000_PERATION 6.00 0.00 00000_PERATION 6.00 0.00 00000_PERATION 6.00 1.000 0000_PERATION 6.00 0.00 0000_PERATION 6.00 0.00 0000_PERATION 6.00 0.00 000_PERATION 6.00 0.00 000_PERATION 000_PERATION 0.00 000_PERATION 00_PERATION 0.00 000_PERATION 00_PERATION 0.00 000_PERATION 00_PERATION 0.00 000_PERATION 00_PERATION 0.00 00_PERATION 00_PERATION <								2.00
4. 03 00403 BEGISTRATION 4. 0 4. 04 00407 PATENT ACOUNTS 4. 0 5. 00 00500 ADMIRTSATIVE & GEBERALL 5. 0 7. 00 07000 DEPROFINATION OF PLANT 6. 024, 240 8. 00 00500 ADMIRTSATIVE & GEBERALL 7. 00 13. 00 01500 CAPERTATION OF TARY 0 0. 0660 14. 00 011000 CAPERTATION OF TARY 0 1. 066, 642 1. 066, 642 14. 00 011000 CAPERTATIAN OF TARY 0 1. 066, 642 1. 066, 642 15. 00 DIGOD (PHARMACY 0 1. 3. 00 1. 3. 00 1. 066, 574, 827 1. 066, 642 16. 00 DIARDO (PHARMACY 0 1. 3. 00 1. 060, 00 0 0 0 0 1. 100 0 0 0 1. 100, 000 1. 100, 000 1. 100, 000 1. 100, 000 0	4. 01 00401 COMMUNI CATI ONS							4.01
4. 0.0 00404 PATTERT ACCOUNTS 4. 0.0 5.00 00500 OPERATION OF PLANT 5. 0.0 6.00 00700 OPERATION OF PLANT 5. 0.0 6.00 00700 OPERATION OF PLANT 5. 0.0 6.00 00700 OPERATION OF PLANT 6. 0.024,200 10.00 01000 DITTAW MO 10.00 11.00 01100 OLITARY 11.00 11.01 010 OLITARY 11.00		EIVING						4.02
7. 00 00/000 (PERATINO OF PLANT 7. 00 8. 00 000000 (NUSKEREPI NG 9. 00 00000 (NUSKEREPI NG 9. 00 00000 (NUSKEREPI NG 9. 00 00000 (NUSKEREPI NG 10. 00	4.04 00404 PATIENT ACCOUNTS							4.04
8. 00 000000 LAUNERY & LINN SERVICE 9. 00 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>5.00</td></t<>								5.00
10. 00 01000 [D LETARY 10. 00 01000 [D LETARY 10. 00 1	8.00 00800 LAUNDRY & LI NEN							8.00
11.00 01100 CAFETERIA 11.00 13.00 0 0 0 0 0 0 17.00 0<								9.00
14.00 01400 CENTRAL SERVICES & SUPPLY 0 1,068,642 4 15.00 01500 PHARMACY 0 362 0 6,574,827 16,00 17.01 01701 MENTAL HEALTH OH 0								11.00
15. C0 0 0 1, 445 5, 041, 869 4 16. C0 0 0 0 0 0 0 16. 00 17. 00 01700 SOCIAL SERVICE 0 0 0 0 0 0 17. 00 0 0 0 0 0 0 17. 00 0 <td></td> <td></td> <td></td> <td>1 069 642</td> <td></td> <td></td> <td></td> <td>13.00</td>				1 069 642				13.00
17.00 01700 SOCIAL SERVICE 0 <t< td=""><td></td><td>& JUFFLI</td><td>-</td><td></td><td>5, 041, 869</td><td></td><td></td><td>15.00</td></t<>		& JUFFLI	-		5, 041, 869			15.00
17. 01 D1701 MEMTAL HEALTH 0H 0 134 0		& LI BRARY	0		-		(16.00
22.00 02200 is SERVICES-OTHER PROM COSTS APPRVD 269, 721 3, 499 2, 065 0 0 23.0 023.00 PRAMEDE DE PRGAL-RAB 0 171 0 0 0 23.0 0123.01 PRAMEDE DE PRGAL-LAB 0 171 0 0 0 23.0 0100 03000 AULTS & PEDIATRICS 1.106, 058 29, 120 228 874, 484 0 30.0 0 30.0 <td></td> <td></td> <td>0</td> <td>-</td> <td>-</td> <td>0</td> <td></td> <td></td>			0	-	-	0		
22.00 [02300] PARAMED ED REGU-RADIOLOGY 0 0 0 0 23.00 23.01 [02300] PARAMED ED REGU-LAB 0 171 0 0 23.01 1000 [0300] CALDIS & PERCEL-LAB 1.166.058 29.120 228 674.484 0 30.00 31.00 [0300] CALDIS & PERCEL-LAB 1.166.058 29.120 228 674.484 0 30.00 31.00 [0300] CALDIS & PERVICE COST CENTERS 254.592 0 52.64.777 0 43.00 ANCILLARY SERVICE COST CENTERS 254.992 0 52.00 0 0 0 0 0 0 51.00 55.00 53.00 53.00 53.00 53.00 53.00 55.00 51.00 51.00 51.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.0			-	0		Ű		
23.01 D2301 PARAMED ED PRGM-LAB 0 171 0 0 0 23.0 30.00 03000 ADULTS & PEDIATRICS 1.106.058 29.120 22.8 87.4.484 0 30.0 31.00 03000 INTENSIVE CARE INT 672.618 20.505 225 74.4.931 0 31.00 40.00 OVADOU SUBPROVIDER - 1 FF 446.055 1.598 0 817.805 0 40.00 41.00 O 4000 SUBPROVIDER - 1 FF 459.598 5.425 1.901 526.310 0 41.00 43.00 O 5000 OPECATI NG ROMEN 254.592 0 0 0 0 0 51.00 51.00 51.00 51.00 51.00 51.00 51.00 51.00 51.00 51.00 51.00 51.00 52.00 62.00 60.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00				3, 499 0				
30. 00 000000 NULTS & PEDIATINCS 1.106.058 29,120 228 874,494 0 90.00 31. 00 03000 NULTS & PEDIATINCS 1.706.058 255 744.931 0 31.00 40. 00 040000 SUBPROVIDER - IPF 446.055 1.598 0 817.805 0 40.00 41.00 041000 SUBPROVIDER - IPF 456.592 0 521 64.777 0 43.00 40.00 03000 RESPRICE COST CENTERS	23.01 02301 PARAMED ED PRGM-	LAB	0	171	0	0	(23.01
31.00 03100 INTENSI VE CARE UNIT 672,618 20,505 25 744,931 0 31.00 40.00 040000 SUBPROVIDER - IPF 446,055 1,598 0 817,805 0 40.00 41.00 SUBONOVERSERV 254,592 0 52 64,777 0 43.00 ANCILLARY SERVICE COST CENTERS 396,857 50.933 3,655 275,301 0 51.00 50.00 50.00 50.00 50.00 50.00 51.00 51.00 51.00 51.00 51.00 51.00 51.00 51.00 51.00 52.00 52.00 52.00 52.00 52.00 52.00 52.00 52.00 54.00 53.00 53.00 53.00 53.00 54.00 54.00 54.00 54.00 53.00 54.00 54.00 54.00 54.00 54.00 56.00 66.00 <td< td=""><td></td><td></td><td>1, 106, 058</td><td>29, 120</td><td>228</td><td>874, 484</td><td></td><td>30.00</td></td<>			1, 106, 058	29, 120	228	874, 484		30.00
41.00 00 0100 SUBPROVI DER - 1 RF 459, 598 5, 425 1, 901 526, 310 0 43.00 04300 NURSERY 254, 592 0 52 64, 777 0 33.00 50.00 05000 OPERATI NG ROOM 395, 857 50.383 3, 655 275, 301 0 50.00 51.00 DS100 RECOVERY ROOM 187, 947 37, 326 145 0 0 51.00 53.00 55.00 53.00 55.00 53.00 55.00	31.00 03100 INTENSIVE CARE U	NIT	672, 618	20, 505	25	744, 931	(31.00
43. 00 043.00 04582RY 0 52 64,777 0 43. 00 ANCILLARY SERVICE COST CENTERS 50. 00 05000 0PERATING ROOM 395,857 50. 303 3,655 275,301 0 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 52.00 52.00 52.00 52.00 52.00 52.00 52.00 53.00 53.00 0 0 0 53.00 53.00 50.00 55.0					-			
50. 00 05000 0PERATI NG ROOM 395, 857 50, 383 3, 655 275, 301 0 50, 00 51. 00 05100 ECOVERY ROOM 0 0 0 0 0 51. 00 05101 ENDORECOVERY ROOM 187, 947 37, 326 145 0 0 0 52. 00 05200 DELLVERY ROOM 183, 873 3, 293 32 0 0 0 0 53. 00 05300 MSSIM ABOR NOSTIC 86, 338 48, 924 113, 680 0 0 55. 00 55.00 05500 RADI CLOCY - THERAPEUTI C 304, 109 6, 686 1, 480 0 0 66. 00 60: 00 06000 RESPI RATORY THERAPY 0 86, 150 111 0 0 66. 00 66: 00 06500 RESPI RATORY THERAPY 247, 947 3, 014 19, 909 0 66. 00 66: 00 06600 ELECTROCARDI QLOGY 0 13, 873 354 0 0 70. 00 70: 00 00000 ELECTROCARDI QLOGY 0 13, 873 354 0 0 70. 00 70: 00 00000 ELECTROCARDI QLOGY 0 0 0 0 70. 00 71: 00 001	43. 00 04300 NURSERY							
51:00 OS 100 RECOVERY ROOM O O O O O S1:00		CENTERS	395, 857	50, 383	3, 655	275, 301	(50.00
52.00 D5200 DELIVERY ROOM 153,873 3,293 32 0 0 52.00 53.00 05300 ANESTHESI OLOGY 0 0 0 0 0 53.00 54.00 05400 RADIOLOGY-DIAGNOSTI C 86.338 48.924 113.680 0 55.00 05.00 D5500 RADIOLOGY-THERAPEUTI C 304,109 6.086 1,480 0 65.00 06.00 D6000 LOGONO LABORATORY 0 86,150 11 0 60.00 66.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 70.00 70.00 70.00 70.00	51.00 05100 RECOVERY ROOM		0	0	0	0	(51.00
53. 00 00 0 </td <td></td> <td>LABOR ROOM</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>		LABOR ROOM						
55.00 05500 RADI OLOGY-THERAPEUTI C 304, 109 6, 086 1, 480 0 55.00 60.00 DABORATORY 0 86, 150 11 0 60.00 63.00 06300 DABORATORY 0 86, 150 11 0 60.00 65.00 06500 RESPI RATORY THERAPY 0 960 488 0 66.00 66.00 06500 RESPI RATORY THERAPY 0 960 488 0 66.00 66.00 06500 RESPI RATORY THERAPY 0 13, 873 354 0 66.00 67.00 06000 HSECRADEANERPHY 0 0 0 0 67.00 70.00 070000 ELCTROENCEPHALOGRAPHY 0 0 0 70.00	53. 00 05300 ANESTHESI OLOGY		0	0	0	0	(53.00
60.00 06000 LABORATORY 0 86, 150 11 0 60.00 63.00 06300 BLOD STORI NG, PROCESSI NG & TRANS. 0 0 0 0 63.00 65.00 06500 RESPIRATORY THERAPY 0 960 488 0 65.00 66.00 066000 PHYSI CAL THERAPY 247, 947 3, 014 19, 909 0 66.00 67.00 00000 ELCTROCARDI OLOGY 0 13, 873 354 0 69.00 70.00 07001 NEURODI AGNOSTI CS 22, 454 2, 754 8 0 70.00 71.00 072001 INPL DEV. CHARGED TO PATI ENTS 395, 017 0 0 72.00 72.00 07300 DRUGS CHARGED TO PATI ENTS 248, 861 0 0 72.00 75.00 07300 DRUGS CHARGED TO PATI ENTS 248, 861 0 0 75.00 76.00 03950 MH ANCI LLARY OUTPATI ENT 288, 509 28, 601 3, 648 1, 781, 357 76.00 76.00 03950 MH ANCI LLARY OUTPATI ENT 1								
65.00 06500 RESPIRATORY THERAPY 0 960 488 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 247,947 3,014 19,909 0 66.00 67.00 06000 ELECTROCARDI OLOGY 0 13,873 354 0 0 69.00 70.01 07001 REUROBLACOSTICS 22,454 2,754 8 0 0 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 395,017 0 0 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 0 0 0 72.00	60.00 06000 LABORATORY				11		(60.00
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70. 01 07001 NEURODI AGNOSTI CS 22, 454 2, 754 8 0 0 70. 0 71. 00 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 395, 017 0 0 71. 00 72. 00 O7200 IMPL. DEV. CHARGED TO PATI ENTS 0 248, 861 0 0 72. 00 73. 00 O7300 DRUGS CHARCED TO PATI ENTS 0 0 4, 563, 323 0 0 73. 00 75. 00 O7500 ASC (NON-DI STI NCT PART) 288, 509 28, 601 3, 648 1, 781, 357 0 76. 00 76. 01 03951 INPATI ENT DI ALYSIS 12, 765 166 540 0 76. 00 001PATI ENT SERVICE COST CENTERS 12, 765 166 540 0 76. 00 70. 00 70. 00 70. 00 76. 00 76. 00 76. 00 76. 00 76. 00 76. 00 76. 00 76. 00 76. 00 76. 00 76. 00 76. 00 76. 00 76. 00 76. 00 76. 00 76. 00 76. 00						0		
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 248,861 0 0 72.00 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 4,563,323 0 0 73.00 <	70. 01 07001 NEURODI AGNOSTI CS			2, 754	8	0		70.01
73.00 07300 DRUGS CHARGED TO PATIENTS 0 4, 563, 323 0 73.00 75.00 07500 ASC (NON-DISTINCT PART) 288, 509 28, 601 3, 648 1, 781, 357 0 75.00 76.00 03950 MH ANCI LLARY OUTPATIENT 0 0 0 0 0 0 76.00 76.01 03951 INPATIENT DIALYSIS 12, 765 166 540 0 76.00 00TPATIENT SERVICE COST CENTERS 0 0 0 0 0 76.00 00100 08800 FAMILY PRACTICE 120 0 0 0 88.00 88.00 99.00 90.00 92.00			0		0	0		
76.00 03950 MH ANCI LLARY OUTPATI ENT 0 0 0 0 0 76.00 76.01 03951 INPATI ENT DI ALYSI S 12,765 166 540 0 0 76.00 OUTPATI ENT SERVICE COST CENTERS 0 <th< td=""><td></td><td></td><td>0</td><td></td><td>4, 563, 323</td><td>0</td><td></td><td></td></th<>			0		4, 563, 323	0		
76. 01 03951 NPATI ENT DI ALYSI S 12, 765 166 540 0 0 76. 01 OUTPATI ENT SERVICE COST CENTERS 0 <			288, 509	28, 601	3, 648	1, 781, 357		
88.00 08800 FAMILY PRACTICE 120 0			12, 765	166	540	0		
90.00 09000 CLINIC 0 18 0 0 90.00 90.00 90.01 04950 WOUND CLINIC 18,698 8,310 3,993 194,330 0 90.00 91.00 09100 EMERGENCY 917,505 23,239 2,784 1,295,532 0 91.00 92.00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 917,505 23,239 2,784 1,295,532 0 91.00 90.01 0 09600 DURABLE MEDI CAL EQUI P-RENTED 0 357 0 0 0 96.00 96.00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 357 0 0 0 96.00 101.00 HOME HEALTH AGENCY 0 0 0 0 0 0 101.00 101.00 HOME HEALTH AGENCY 0 0 0 0 0 101.00 101.00 113.00 I 13600 I NTREST EXPENSE 126,405 847 6 0			0	0	0	0	(
91.00 09100 EMERGENCY 917, 505 23, 239 2, 784 1, 295, 532 0 91.00 92.00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 917, 505 23, 239 2, 784 1, 295, 532 0 92.00 92.00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 917, 505 23, 239 2, 784 1, 295, 532 0 92.00 96.00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 357 0 0 0 96.00 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 0 101.00 SPECI AL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 126, 405 847 6 0 116.00 116.00 11600 HOSPI CE 126, 405 847 6 0 118.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 5, 971, 049 1, 020, 638 4, 718, 327 6, 574, 827 0 118.00 NONREL MBURSABLE COST CENTERS 190.00 I9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0		120	0			0		
92.00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 92.00 0THER REI MBURSABLE COST CENTERS 92.00 96.00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 357 0 0 0 96.00 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 101.00 SPECI AL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 11300 1130.01 1140.00 1160.00 1160.00 105PI CE 116.00 1160.00 1160.00 1160.00 1160.00 1180.00 0 0 0 0 100.00 NONREI MBURSABLE COST CENTERS 190.00 0 0 0 0 0 0 0 0 0 0 190.00 190.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
96.00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 357 0 0 96.00 101.00 HOME HEALTH AGENCY 0 101.00 0 0 101.00 0 0 101.00 0 0 113.00 1130.00 1140.00 116.00 116.00 0 116.00 0 116.00 0 116.00 116.00 116.00 118.00 118.00 118.00 118.00 118.00 118.00 </td <td></td> <td>(NON-DISTINCT PART)</td> <td>917, 505</td> <td>23, 239</td> <td>2, 784</td> <td>1, 295, 532</td> <td>(</td> <td>91.00</td>		(NON-DISTINCT PART)	917, 505	23, 239	2, 784	1, 295, 532	(91.00
101.00 HOME HEALTH AGENCY 0 0 0 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 113.00 INTREST EXPENSE 113.00 11300 INTREST EXPENSE 113.00 113.00 1140.00 101.00 113.00 1130.01 1140.00 116.00 1160.01 1180.00 1180.00 1180.00 1180.00 1180.00 1180.00 1180.00 1180.00 1180.00 1180.00 1180.00 1180.00 1180.00 1190.00 1900.00 0 0 0 0 190.00 190.00 190.00 190.00 0 0 0 0 0				253				
113.00 11300 INTEREST EXPENSE 113.00 113.00 116.00 11600 HOSPI CE 126,405 847 6 0 0 116.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 5,971,049 1,020,638 4,718,327 6,574,827 0 118.00 NONREI MBURSABLE COST CENTERS 190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 190.00								
116.00 HOSPI CE 126,405 847 6 0 116.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 5,971,049 1,020,638 4,718,327 6,574,827 0 118.00 NONREI MBURSABLE COST CENTERS 190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190.00	SPECIAL PURPOSE COST C	ENTERS						
SUBTOTALS SUBTOTALS SUM OF LINES 1 through 117) 5, 971, 049 1, 020, 638 4, 718, 327 6, 574, 827 0 118. 00 NONREI MBURSABLE COST CENTERS 0 0 0 0 190.00 190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190.00			126, 405	847	6	0	(
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 190.00	118.00 SUBTOTALS (SUM O				4, 718, 327	6, 574, 827		
			0	0	0	0	(190 00
	192.00 19200 PHYSI CI ANS' PRI V		53, 191	38, 495	258, 358		(192.00
192.01 FP PETERSBURG 0 115 1, 134 0 0 192.02 192.02 PEDI ATRI CS 0 2, 499 45, 159 0 0 192.02			0			0		
192. 03 19203 WASHI NGTON PRI MARY CARE 0 1, 945 18, 803 0 0 192. 03	192.03 19203 WASHI NGTON PRI MA	RY CARE	0	1, 945	18, 803	0	(192.03
192.04 FOHC 0 0 0 0 0 0 192.04 194.00 07950 COMMUNI TY HEALTH SERVICES 0 77 88 0 0 194.00		SERVICES	0			0) 192.04) 194.00
194. 01 07960 CCBHC GRANTS 0 1, 312 0 0 0 194. 01			0					

Health Financial Systems	GOOD SAMARI TA	AN HOSPITAL	In Lieu of Form CMS-2552-10			
COST ALLOCATI ON - GENERAL SERVI CE COSTS		Provider CO	CN: 15-0042	Period: From 01/01/2023 To 12/31/2023		
Cost Center Description	NURSI NG ADMI NI STRATI O N	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	
	13.00	14.00	15.00	16.00	17.00	
194.0207952 MARKETING AND PUBLIC RELATIONS	0	28		0 0	0 19	94.02
194. 03 07953 MH RESI DENTI AL	0	954		0 0	0 19	94.03
194. 04 07954 UNUSED SPACE	0	0		0 0	0 19	94.04
194. 05 07955 MOB	0	0		0 0	0 19	94.05
194. 06 07956 FOUNDATI ON	0	0		0 0	0 19	94.06
194.0707957 KNOX COUNTY HEALTH DEPT	0	0		0 0	0 19	94.07
194. 08 07958 I NDUSTRI AL HEALTH	0	0		0 0	0 19	94.08
194.0907959 COMMUNITY MENTAL HEALTH CENTER	0	2, 551		0 0	0 19	94.09
194. 10 07951 BEI RHAUS BUI LDI NG	0	28		0 0	0 19	94.10
200.00 Cross Foot Adjustments					20	00.00
201.00 Negative Cost Centers	0	0		0 0	0 20	01.00
202.00 TOTAL (sum lines 118 through 201)	6, 024, 240	1, 068, 642	5, 041, 8	69 6, 574, 827	0 20	02.00

OST A	Financial Systems LLOCATION - GENERAL SERVICE COSTS	GOOD SAMARIT	Provi der C	F	Period: from 01/01/2023 fo 12/31/2023	u of Form CMS-: Worksheet B Part I Date/Time Pre 4/11/2024 3:1	epared:
			I NTERNS &	RESI DENTS		1.1.1.2021.011	
	Cost Center Description	MENTAL HEALTH OH	SERVI CES-SALA RY & FRI NGES	SERVICES-OTHE R PRGM COSTS	PARAMED ED PRGM-RADI OLOG	PARAMED ED PRGM-LAB	
		17.01	21.00	22.00	Y 23.00	23.01	
	GENERAL SERVICE COST CENTERS	1	1	1	1		
. 00 . 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00
. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
. 01	00401 COMMUNI CATI ONS						4.0
. 02	00402 PURCHASI NG & RECEI VI NG						4.0
. 03 . 04	00403 REGI STRATI ON 00404 PATI ENT ACCOUNTS						4.0
. 04 . 00	00500 ADMINI STRATI VE & GENERAL						5.0
. 00	00700 OPERATION OF PLANT						7.0
. 00	00800 LAUNDRY & LINEN SERVICE						8.0
. 00	00900 HOUSEKEEPI NG						9.0
	01000 DI ETARY 01100 CAFETERI A						10.0
	01300 NURSI NG ADMI NI STRATI ON						13.0
	01400 CENTRAL SERVICES & SUPPLY						14.0
	01500 PHARMACY						15.0
	01600 MEDICAL RECORDS & LIBRARY						16.0
	01700 SOCIAL SERVICE 01701 MENTAL HEALTH OH	992, 312					17.0
	02100 I &R SERVICES-SALARY & FRINGES APPRVD	992, 312					21.0
	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD			4, 143, 541			22.0
	02300 PARAMED ED PRGM-RADIOLOGY	C			0		23.0
3.01	02301 PARAMED ED PRGM-LAB	C				391, 168	23.0
0. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	C	883, 453	801, 367	0	0	30.0
	03100 I NTENSI VE CARE UNI T					0	
	04000 SUBPROVI DER – I PF	670, 285				0	
	04100 SUBPROVI DER – I RF	C				0	
3.00		C	0	C	0	0	43.0
0.00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM	C	0	C	0	0	50.0
	05100 RECOVERY ROOM	C				0	
	05101 ENDOSCOPY	C	156, 943			0	
	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY		14, 551	0 13, 199	-	0	
	05400 RADI OLOGY-DI AGNOSTI C		8, 315			0	
	05500 RADI OLOGY-THERAPEUTI C	C	48, 850			0	55.0
	06000 LABORATORY	C	0			391, 168	
	06300 BLOOD STORING, PROCESSING & TRANS.	0				0	
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY		39, 496	35, 826		0	1 001 0
	06900 ELECTROCARDI OLOGY	C	32, 220	-	-	0	
	07000 ELECTROENCEPHALOGRAPHY	C	0	C	0	0	
	07001 NEURODI AGNOSTI CS	C	0	0	0	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS				0	0	
	07300 DRUGS CHARGED TO PATIENTS				0	0	
	07500 ASC (NON-DI STINCT PART)	C	0	C C	0	0	
	03950 MH ANCILLARY OUTPATIENT	C	0	C	0	0	
6. 01	03951 I NPATI ENT DI ALYSI S	C	64, 440	58, 453	0	0	76. C
8.00	OUTPATIENT SERVICE COST CENTERS 08800 FAMILY PRACTICE 120	0		0	0	0	88.0
	09000 CLINIC			d d	0	0	90.0
	04950 WOUND CLINIC	C	0	C	0	0	
	09100 EMERGENCY	C	1, 149, 528	1, 042, 720	0	0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	<u> </u>		1			92.0
	09600 DURABLE MEDICAL EQUIP-RENTED	C	0	C	0	0	96.0
01. 00	10100 HOME HEALTH AGENCY	C	0	C	0	0	101.0
10.00	SPECIAL PURPOSE COST CENTERS						1110 0
	11300 I NTEREST EXPENSE 11600 HOSPI CE	0			0	0	113. C
18.00		670, 285	2, 766, 768	2, 509, 694		391, 168	
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	C	0	0	-		190.0
	19200 PHYSI CLANS' PRI VATE OFFI CES 19201 FP PETERSBURG		730, 668	662, 778	0		192.0 192.0
	19201 PETERSBURG 19202 PEDI ATRI CS						192.0
	19203 WASHINGTON PRIMARY CARE			d d	0		192.0
72.03		1	1	1	1		

Health Financial Systems	GOOD SAMARI TAN HOSPI TAL			In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C		Period:	Worksheet B		
				From 01/01/2023 To 12/31/2023		narod	
				10 12/31/2023	4/11/2024 3:1		
		INTERNS &	RESI DENTS				
Cost Center Description	MENTAL HEALTH				PARAMED ED		
	OH	RY & FRINGES	R PRGM COSTS	PRGM-RADI OLOG	PRGM-LAB		
	17.01	21.00	22.00	Y 23.00	23.01		
194.0007950 COMMUNI TY HEALTH SERVICES	17.01	21.00	22.00	23.00		194.00	
194. 01 07960 CCBHC GRANTS	0					194.00	
194. 02 07952 MARKETING AND PUBLIC RELATIONS	0	0				194.02	
194. 03 07953 MH RESIDENTIAL	0	0		0		194.03	
194. 04 07954 UNUSED SPACE	0	0		0		194.04	
194. 05 07955 MOB	0	0		0	0	194.05	
194. 06 07956 FOUNDATI ON	0	0	(0 0	0	194.06	
194.0707957 KNOX COUNTY HEALTH DEPT	0	0	(0 0	0	194.07	
194. 08 07958 I NDUSTRI AL HEALTH	0	0	(0 0	0	194.08	
194.0907959 COMMUNITY MENTAL HEALTH CENTER	322, 027	1, 070, 538	971, 069	9 0	0	194.09	
194. 10 07951 BEI RHAUS BUI LDI NG	0	0	(0 0	0	194.10	
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)	992, 312	4, 567, 974	4, 143, 54	0	391, 168	202.00	

alth Financial Systems ST ALLOCATION - GENERAL SERVICE COSTS	GOOD SAMARITA	Provider CO	N. 15-0042	In Lieu of Form CM Period: Worksheet	
ST ALLOSATION GENERAL SERVICE COSTS				From 01/01/2023 Part I	
Cost Center Description	Subtotal	Intern &	Total	To 12/31/2023 Date/Time 4/11/2024	3:17 pm
cost center bescription	Subtotal	Residents	Total		
		Cost & Post			
		Stepdown			
	24.00	Adjustments 25.00	26.00	-	
GENERAL SERVICE COST CENTERS	24.00	23.00	20.00		
00 00100 CAP REL COSTS-BLDG & FIXT					1.
00 00200 CAP REL COSTS-MVBLE EQUIP					2.
00 00400 EMPLOYEE BENEFITS DEPARTMENT					4.
01 00401 COMMUNI CATI ONS 02 00402 PURCHASI NG & RECEI VI NG					4.
03 00403 REGI STRATI ON					4.
04 00404 PATIENT ACCOUNTS					4.
00 00500 ADMINI STRATI VE & GENERAL					5.
00 00700 OPERATION OF PLANT					7.
00 00800 LAUNDRY & LI NEN SERVI CE 00 00900 HOUSEKEEPI NG					8. 9.
. 00 01000 DI ETARY					10.
. 00 01100 CAFETERI A					11.
. 00 01300 NURSING ADMINISTRATION					13.
. 00 01400 CENTRAL SERVICES & SUPPLY					14.
					15.
. 00 01600 MEDICAL RECORDS & LIBRARY . 00 01700 SOCIAL SERVICE					16. 17.
. 01 01701 MENTAL HEALTH OH					17.
. 00 02100 I &R SERVICES-SALARY & FRINGES	APPRVD				21.
.00 02200 I&R SERVICES-OTHER PRGM COSTS					22.
. 00 02300 PARAMED ED PRGM-RADIOLOGY					23.
. 01 02301 PARAMED ED PRGM-LAB					23.
00 03000 ADULTS & PEDIATRICS	21, 568, 653	-1, 684, 820	19, 883, 83	22	30.
00 03100 INTENSIVE CARE UNIT	9, 442, 431		9, 377, 02		30.
00 04000 SUBPROVIDER - IPF	7, 466, 181		6, 827, 93		40.
00 04100 SUBPROVIDER - IRF	5, 710, 634	0	5, 710, 63	34	41.
. 00 04300 NURSERY	1, 547, 358	0	1, 547, 35	58	43.
ANCI LLARY SERVI CE COST CENTERS	8, 462, 291	0	8, 462, 29	21	50.
. 00 05100 RECOVERY ROOM	0,402,271	0	0,402,2	0	51.
. 01 05101 ENDOSCOPY	3, 515, 017	-299, 304	3, 215, 71	13	51.
. 00 05200 DELIVERY ROOM & LABOR ROOM	922, 685		922, 68		52.
. 00 05300 ANESTHESI OLOGY	1, 701, 056		1, 673, 30		53.
. 00 05400 RADI OLOGY-DI AGNOSTI C . 00 05500 RADI OLOGY-THERAPEUTI C	13, 020, 957 6, 119, 365	-15, 857 -93, 161	13, 005, 10 6, 026, 20		54. 55.
00 06000 LABORATORY	11, 161, 265	- 93, 101	11, 161, 26		60
00 06300 BLOOD STORING, PROCESSING & T		0	11, 101, 20	0	63
00 06500 RESPI RATORY THERAPY	4, 104, 005	-75, 322	4, 028, 68	33	65
00 06600 PHYSI CAL THERAPY	8, 714, 374	0	- 1 - 1 -		66
00 06900 ELECTROCARDI OLOGY	6, 693, 092	-61, 446	6, 631, 64	46	69
00 07000 ELECTROENCEPHALOGRAPHY 01 07001 NEURODI AGNOSTI CS	2,008,189	0	2,008,18		70
00 07100 MEDICAL SUPPLIES CHARGED TO P			4, 970, 59		70.
00 07200 I MPL. DEV. CHARGED TO PATIENT			5, 408, 69		72
00 07300 DRUGS CHARGED TO PATIENTS	27, 378, 324	0	27, 378, 32	24	73
00 07500 ASC (NON-DISTINCT PART)	5, 337, 121	0	5, 337, 12		75
00 03950 MH ANCI LLARY OUTPATI ENT	0			0	76
01 03951 I NPATI ENT DI ALYSI S OUTPATI ENT SERVI CE COST CENTERS	905, 332	-122, 893	782, 43	34	76
00 08800 FAMILY PRACTICE 120	33, 860	0	33, 86	50	88
00 09000 CLINIC	411, 125		411, 12		90
01 04950 WOUND CLINIC	1, 711, 002		1, 711, 00		90
00 09100 EMERGENCY	14, 655, 146	-2, 192, 248	12, 462, 89	78	91
00 09200 OBSERVATI ON BEDS (NON-DI STI NC	T PART)	0			92
OTHER REIMBURSABLE COST CENTERS 00 09600 DURABLE MEDICAL EQUIP-RENTED	234, 141	0	234, 14	11	96
1.00 109600 DURABLE MEDICAL EQUIP-RENTED	234, 141	0	∠34, 12	0	101
SPECIAL PURPOSE COST CENTERS	0			-1	
3. 00 11300 I NTEREST EXPENSE					113
5. 00 11600 HOSPI CE	1, 620, 726		1, 620, 72		116
3.00 SUBTOTALS (SUM OF LINES 1 thr	ough 117) 174, 823, 613	-5, 276, 462	169, 547, 15	51	118
NONREI MBURSABLE COST CENTERS					100
0.00 19000 GIFT, FLOWER, COFFEE SHOP & C 2.00 19200 PHYSICIANS' PRIVATE OFFICES	ANTEEN 0 35, 342, 457		33, 949, 01	0	190. 192.
2. 00 19200 PHYSICIANS PRIVATE OFFICES 2. 01 19201 FP PETERSBURG	35, 342, 457 522, 671		33, 949, 0		192.
2. 02 19202 PEDI ATRI CS	1, 676, 218		1, 676, 21		192.
2. 03 19203 WASHINGTON PRIMARY CARE	2, 657, 080		2, 657, 08		192
	49,012		49, 01		192.

Health Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Lieu of Form CMS-2552-10		
COST ALLOCATI ON - GENERAL SERVI CE COSTS		Provider CC	N: 15-0042	Period: From 01/01/2023 To 12/31/2023	Worksheet B Part I Date/Time Prepared: 4/11/2024 3:17 pm	
Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total			
	24.00	25.00	26.00			
194.0007950 COMMUNITY HEALTH SERVICES	206, 682	0	206, 68	32	194.00	
194.0107960 CCBHC GRANTS	2, 555, 712	0	2, 555, 7	12	194.01	
194.0207952 MARKETING AND PUBLIC RELATIONS	1, 021, 848	0	1, 021, 84	18	194.02	
194. 03 07953 MH RESIDENTIAL	1, 494, 253	0	1, 494, 25	53	194.03	
194.0407954 UNUSED SPACE	1,071,624	0	1,071,62	24	194.04	
194. 05 07955 MOB	40, 734	0	40, 73	34	194.05	
194. 06 07956 FOUNDATI ON	24, 981	0	24, 98	31	194.06	
194.0707957 KNOX COUNTY HEALTH DEPT	247, 889	0	247, 88	39	194.07	
194. 08 07958 I NDUSTRI AL HEALTH	0	0		0	194.08	
194.0907959 COMMUNITY MENTAL HEALTH CENTER	8, 978, 310	-2,041,607	6, 936, 70	03	194.09	
194. 10 07951 BEI RHAUS BUI LDI NG	186, 972	0	186, 9	12	194.10	
200.00 Cross Foot Adjustments	0	0		0	200.00	
201.00 Negative Cost Centers	0	0		0	201.00	
202.00 TOTAL (sum lines 118 through 201)	230, 900, 056	-8, 711, 515	222, 188, 54	11	202.00	

_OCA	Financial Systems TION OF CAPITAL RELATED COSTS		Provider CC	F	In Lieu eriod: rom 01/01/2023 o 12/31/2023	Worksheet B Part II Date/Time Pre	pare
			CAPI TAL REL	ATED COSTS		4/11/2024 3:1	7 pm
	Cost Center Description	Di rectl y Assi gned New Capi tal	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
		Related Costs	1.00	2.00	2A	4.00	
	GENERAL SERVICE COST CENTERS	0	1.00	2.00	ZA	4.00	
	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1. 2.
	00400 EMPLOYEE BENEFITS DEPARTMENT	0	111, 623	220	111, 843	111, 843	
)1	00401 COMMUNI CATI ONS	0	0	0	0	331	4.
)2)3	00402 PURCHASI NG & RECEI VI NG 00403 REGI STRATI ON	0	265, 741 259, 520	525 512		779 1, 845	4. 4.
04	00404 PATIENT ACCOUNTS	0	0	0.12		2, 494	4.
	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	0	1, 101, 214	2, 174		8,018	
00 00	00800 LAUNDRY & LINEN SERVICE	0	5, 508, 364 120, 898	10, 874 239	5, 519, 238 121, 137	2, 630 245	
	00900 HOUSEKEEPI NG	0	168, 192	332	168, 524	2, 389	
	01000 DI ETARY	0	87, 769	173		516	
	01100 CAFETERIA 01300 NURSING ADMINISTRATION	0	199, 645 224, 141	394 442		1, 430 2, 332	
	01400 CENTRAL SERVICES & SUPPLY	0	91, 075	180		394	
	01500 PHARMACY	0	137, 267	271	137, 538	3, 269	
	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	0	105, 149 0	208	105, 357	4, 123 0	16
	01701 MENTAL HEALTH OH	0	59, 806	118	59, 924	353	
	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	232, 888	460		0	21
	02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD 02300 PARAMED ED PRGM-RADI OLOGY	0	0	0		2,044	
	02301 PARAMED ED PRGM-LAB	0	0	0		284	23
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	0	1, 040, 650 481, 066	2, 054 950		7, 386 3, 552	
	04000 SUBPROVIDER - IPF	0	299, 237	591	299, 828	2, 283	
	04100 SUBPROVI DER – I RF	0	394, 721	779		2, 035	
00	04300 NURSERY	0	239, 546	473	240, 019	284	43.
00	ANCI LLARY SERVI CE COST CENTERS	0	551, 594	1, 089	552, 683	3, 378	50.
	05100 RECOVERY ROOM	0	0	0	0	0	51
	05101 ENDOSCOPY 05200 DELIVERY ROOM & LABOR ROOM	0	280, 940	555		863	51
	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	0	144, 775 0	286	145, 061 0	172 2, 922	52 53
	05400 RADI OLOGY-DI AGNOSTI C	0	497, 413	982	498, 395	5,066	
	05500 RADI OLOGY-THERAPEUTI C	0	412, 904	815		2,999	
	06000 LABORATORY 06300 BLOOD STORING, PROCESSING & TRANS.	0	167, 549 0	331	167, 880 0	2, 492	60 63
	06500 RESPI RATORY THERAPY	0	130, 380	257	130, 637	2, 781	
	06600 PHYSI CAL THERAPY	0	650, 774	1, 285		5, 910	
	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	0	417, 403	824	418, 227	5, 211 0	
	07001 NEURODI AGNOSTI CS	0	176, 962	349	177, 311	908	
00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	
	07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	1
	07500 ASC (NON-DISTINCT PART)	0	0	0	0	1, 247	75
00	03950 MH ANCILLARY OUTPATIENT	0	0	0	0	0	76
	03951 INPATIENT DIALYSIS OUTPATIENT SERVICE COST CENTERS	0	197, 027	389	197, 416	95	76
	08800 FAMILY PRACTICE 120	0	0	0	ol	22	88
	09000 CLI NI C	0	51, 748	102	51, 850	161	
	04950 WOUND CLINIC	0	68, 324	135		380	
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	543, 398	1, 073	544, 471	4, 802	91
	OTHER REIMBURSABLE COST CENTERS				<u> </u>		1 12
	09600 DURABLE MEDI CAL EQUI P-RENTED	0	9, 046			97	
	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	101
	11300 INTEREST EXPENSE						113
5. 00	11600 HOSPI CE	0	111, 600				116
. 00		0	15, 540, 349	30, 679	15, 571, 028	89, 049	118
	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	o	0	0	ol	0	190
	19200 PHYSI CLANS' PRI VATE OFFICES	0	2, 619, 073	5, 170		15, 367	
	19201 FP PETERSBURG	0	85, 060	168			192.
	19202 PEDI ATRI CS	1		0			192.

Health Financial Systems GOOD SAMARITAN HOSPITAL				In Lie	Lieu of Form CMS-2552-10		
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC		Period: From 01/01/2023 To 12/31/2023			
		CAPI TAL REL	ATED COSTS				
Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT		
	0	1.00	2.00	2A	4.00		
192.04 19204 FQHC	0	0		0 0	0	192.04	
194.0007950 COMMUNITY HEALTH SERVICES	0	9, 528	1	9 9, 547	121	194.00	
194.0107960 CCBHC GRANTS	0	0	(0 0	1, 033	194.01	
194.0207952 MARKETING AND PUBLIC RELATIONS	0	38, 799	7	7 38, 876	266	194.02	
194.03 07953 MH RESIDENTIAL	0	465, 133	91	8 466, 051	280	194.03	
194.0407954 UNUSED SPACE	0	467, 659	92	3 468, 582	0	194.04	
194.0507955 MOB	0	0		0 0	0	194.05	
194. 06 07956 FOUNDATI ON	0	10, 699	2	1 10, 720	0	194.06	
194.0707957 KNOX COUNTY HEALTH DEPT	0	108, 179	21	4 108, 393	0	194.07	
194. 08 07958 I NDUSTRI AL HEALTH	0	0		0 0	0	194.08	
194.0907959 COMMUNITY MENTAL HEALTH CENTER	0	805, 902	1, 59	1 807, 493	3, 198	194.09	
194. 10 07951 BEI RHAUS BUI LDI NG	0	0		0 0	0	194.10	
200.00 Cross Foot Adjustments				0		200.00	
201.00 Negative Cost Centers		0	(0 0	0	201.00	
202.00 TOTAL (sum lines 118 through 201)	0	20, 306, 497	40, 08	8 20, 346, 585	111, 843	202.00	

8.00 00800 LAUNDRY & LINEN SERVICE 0 1,068 0 2, 9.00 00900 HOUSEKEEPING 6 2,863 0 0 17, 10.00 DI ETARY 1 5,179 0 0 6, 11.00 O1100 CAFETERIA 3 14,357 0 0 9, 13.00 O1300 NURSI NG ADMI NI STRATI ON 3 59 0 0 2, 14.00 O1400 CENTRAL SERVI CES & SUPPLY 1 1,465 0 0 4, 15.00 01500 PHARMACY 5 366 0 0 22, 16.00 01600 MEDI CAL RECORDS & LI BRARY 7 81 0 0 30, 17.00 01700 SOCI AL SERVI CES SALARY & FRI NGES APPRVD 0 0 0 3, 21.00 02100 I & SERVI CES-SALARY & FRI NGES APPRVD 0 0 0 20, 20, 20, 20, 20, 20, 20, 20, 20, 20, 20, 20, 20, <th>3:17 pm TIV AL 1.00 2.00 4.00 4.01 4.02 4.03 4.04</th>	3:17 pm TIV AL 1.00 2.00 4.00 4.01 4.02 4.03 4.04
S RECEI VI NG ACCOUNTS E & GENERAL 1.00 00100 CAP REL COST CENERAL SERVICE COST COST CENERAL CENERAL CENERAL SERVICE COST CENERAL	AL 1.00 2.00 4.01 4.01 4.02 4.03 4.04 759 5.00 229 7.00 824 8.00 959 9.00 059 10.00 962 11.00 473 13.00 281 14.00 971 15.00 281 14.00 971 15.00 281 14.00 971 15.00 281 14.00 971 15.00 281 14.00 971 15.00 281 14.00 0 17.00 894 17.01 690 21.00 0 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 24.00 25.
4.01 4.02 4.03 4.04 5.00 GENERAL SERVICE COST CENTERS	1.00 2.00 4.01 4.02 4.03 4.04 759 5.00 229 7.00 824 8.00 959 9.00 059 11.00 473 13.00 281 14.00 971 15.00 281 16.00 0 77.00 894 15.00 248 16.00 0 17.00 894 17.00 894 22.00 0 23.00
1.00 00100 CAP REL COSTS-BLDG & FLXT 2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.01 00401 COMMUNICATIONS 331 4.02 00402 PURCHASING & RECEIVING 3 267,048 4.03 00403 REGISTRATION 6 112 261,995 4.04 00404 PATI ENT ACCOUNTS 7 132 0 2,633 5.00 00500 ADMINI STRATI VE & GENERAL 29 1,324 0 0 1,112, 7.00 00700 OPERATION OF PLANT 19 2,737 0 0 74, 8.00 00800 LAUNRY & LINEN SERVICE 0 1,068 0 02,7,7 10.00 01000 DI ETARY 1 5,179 0 0,6, 11.00 01100 CAFETERI A 3 14,357 0 9, 14.00 01400 CENTRAL SERVICES & SUPPLY 1 1,465 0 0	2.00 4.00 4.01 4.02 4.03 4.04 759 5.00 229 7.00 824 8.00 959 9.00 059 10.00 962 11.00 473 13.00 281 14.00 971 15.00 248 16.00 0 17.00 894 17.01 690 21.00 0 59 22.00 0 23.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP	2.00 4.00 4.01 4.02 4.03 4.04 759 5.00 229 7.00 824 8.00 959 9.00 059 10.00 962 11.00 473 13.00 281 14.00 971 15.00 248 16.00 0 17.00 894 17.01 690 21.00 0 59 22.00 0 23.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 331 4.01 00401 COMMUNI CATI ONS 331 4.02 00402 PURCHASI NG & RECI VI NG 3 4.03 00403 REGI STRATI ON 6 4.04 004044 PATI ENT ACCOUNTS 7 132 0 2,633 5.00 00500 ADMI NI STRATI VE & GENERAL 29 1,324 0 0 1,112, 7.00 00700 OPERATI ON OF PLANT 19 2,737 0 0 74, 8.00 00800 LAUNDRY & LI NEN SERVI CE 0 1,068 0 2, 9.00 00900 HOUSEKEEPI NG 6 2,863 0 17, 10.00 DIO00 DI ETARY 1 5,179 0 6, 11.00 O1100 CAFETERI A 3 14,357 0 9, 13.00 D1300 NURSI NG ADMI NI STRATI ON 3 59 0 0 27, 14.00 O1400 CENTRAL SERVI CES & SUPPLY 1 1,465 0 0 2	4.00 4.01 4.02 4.03 4.04 759 5.00 229 7.00 824 8.00 959 9.00 059 11.00 473 13.00 281 14.00 971 15.00 248 16.00 0 71.00 894 17.01 690 22.00 0 23.00
4.01 00401 COMMUNI CATI ONS 331 4.02 00402 PURCHASI NG & RECEI VI NG 3 267,048 4.03 00403 REGI STRATI ON 6 112 261,995 4.04 00404 PATI ENT ACCOUNTS 7 132 0 2,633 5.00 00500 ADMI NI STRATI VE & GENERAL 29 1,324 0 0 1,112, 7.00 00700 OPERATI ON OF PLANT 19 2,737 0 0 74, 8.00 00800 LAUNDRY & LI NEN SERVI CE 0 1,068 0 2, 9.00 00900 HOUSEKEEPI NG 6 2,863 0 0 17, 10.00 01000 DI ETARY 1 5,179 0 0 6, 11.00 01100 CAFETERI A 3 14,357 0 9, 2, 13.00 01300 NURSI NG ADMI NI STRATI ON 3 59 0 0 2, 14.00 CHARMACY 5 366 0 2, 2, 1, 4,	4.02 4.03 4.04 759 5.00 824 8.00 959 9.00 059 10.00 962 211.00 473 13.00 281 14.00 971 15.00 248 16.00 0 77.00 894 17.01 690 22.00 0 23.00
4.03 00403 REGISTRATION 6 112 261,995 4.04 00404 PATIENT ACCOUNTS 7 132 0 2,633 5.00 00500 ADMINISTRATIVE & GENERAL 29 1,324 0 0 1,112, 7.00 00700 PERATION OF PLANT 19 2,737 0 0 74, 8.00 00800 LAUNDRY & LINEN SERVICE 0 1,068 0 0 2, 9.00 0900 HOUSEKEEPING 6 2,863 0 0 17, 10.00 01000 DI ETARY 1 5,179 0 0 6, 11.00 01100 CAFETERIA 3 14,357 0 0 9, 13.00 01300 NURSI NG ADMINISTRATION 3 59 0 0 27, 14.00 01400 CENTRAL SERVICES & SUPPLY 1 1,465 0 0 22, 16.00 01600 MEDICAL SERVICE 0 0 0 30, 30, 17.00 01700 <td< td=""><td>4.03 4.04 759 5.00 229 7.00 824 8.00 959 9.00 059 10.00 962 11.00 473 13.00 281 14.00 971 15.00 248 16.00 0 17.00 894 17.01 690 21.00 059 22.00 0 23.00</td></td<>	4.03 4.04 759 5.00 229 7.00 824 8.00 959 9.00 059 10.00 962 11.00 473 13.00 281 14.00 971 15.00 248 16.00 0 17.00 894 17.01 690 21.00 059 22.00 0 23.00
4. 04 00404 PATI ENT ACCOUNTS 7 132 0 2, 633 5. 00 00500 ADMI NI STRATI VE & GENERAL 29 1, 324 0 0 1, 112, 7. 00 00700 OPERATI ON OF PLANT 19 2, 737 0 0 74, 8. 00 00800 LAUNDRY & LINEN SERVICE 0 1, 068 0 0 2, 2, 9. 00 00900 HOUSEKEEPI NG 6 2, 863 0 0 17, 10. 00 DI ETARY 1 5, 179 0 0 6, 11. 00 01100 CAFETERI A 3 14, 357 0 0 27, 14. 00 01400 CENTRAL SERVI CES & SUPPLY 1 1, 465 0 0 27, 14. 00 01400 CENTRAL SERVI CES & SUPPLY 1 1, 465 0 0 24, 15. 00 01500 PHARMACY 5 366 0 0 22, 16. 00 01600 MEDI CAL RECORDS & LI BRARY 7 81 0 0 3,	4.04 759 5.00 229 7.00 824 8.00 959 9.00 959 10.00 962 11.00 473 13.00 281 14.00 971 15.00 248 16.00 0 17.00 894 17.01 690 21.00 0 23.00
5.00 00500 ADMINISTRATIVE & GENERAL 29 1, 324 0 0 1, 112, 7.00 00700 OPERATION OF PLANT 19 2, 737 0 0 74, 8.00 00800 LAUNDRY & LINEN SERVICE 0 1, 068 0 2, 9.00 00900 HOUSEKEEPING 6 2, 863 0 0 17, 10.00 DI ETARY 1 5, 179 0 0 6, 11.00 O1300 NURSING ADMINISTRATION 3 14, 357 0 0 9, 13.00 01300 NURSING ADMINISTRATION 3 59 0 0 27, 14.00 01400 CENTRAL SERVICES & SUPPLY 1 1, 465 0 0 22, 15.00 01500 PHARMACY 5 366 0 0 22, 16.00 01600 MEDICAL RECORDS & LI BRARY 7 81 0 0 30, 17.01 01701 MENTAL HEALTH OH 14 30 0 0 3, 11.00	759 5.00 229 7.00 824 8.00 959 9.00 059 10.00 962 11.00 473 13.00 281 14.00 971 15.00 248 16.00 0 17.00 894 17.01 690 21.00 059 22.00 0 23.00
8.00 00800 LAUNDRY & LINEN SERVICE 0 1,068 0 2, 9.00 00900 HOUSEKEEPING 6 2,863 0 17, 10.00 DI ETARY 1 5,179 0 0 6, 11.00 O1100 CAFETERIA 3 14,357 0 0 9, 13.00 O1300 NURSI NG ADMI NI STRATI ON 3 59 0 0 2, 14.00 O1400 CENTRAL SERVICES & SUPPLY 1 1,465 0 0 4, 15.00 01500 PHARMACY 5 366 0 0 22, 16.00 01600 MEDI CAL RECORDS & LI BRARY 7 81 0 0 30, 17.00 01700 SOCI AL SERVICE 0 0 0 30, 31, 30,	824 8.00 959 9.00 059 10.00 962 11.00 473 13.00 281 14.00 971 15.00 248 16.00 0 17.00 894 17.01 690 21.00 059 22.00 0 23.00
9.00 00900 HOUSEKEEPING 6 2,863 0 0 17, 10.00 DI ETARY 1 5,179 0 0 6, 11.00 OTADO DI ETARY 1 5,179 0 0 6, 11.00 OTADO DI ETARY 3 14,357 0 0 9, 13.00 DTADO CAFETERIA 3 14,357 0 0 27, 14.00 OTADO CENTRAL SERVICES & SUPPLY 1 1,465 0 0 27, 15.00 OTADO PHARMACY 5 366 0 0 22, 16.00 OTADO SOCIAL SERVICE 0 0 0 30, 17.00 OTADO SOCIAL SERVICE 0 0 0 30, 17.00 OTADO SOCIAL SERVICE 0 0 0 30, 17.00 OTADO SOCIAL SERVICES SALARY & FRINGES APPRVD 0 0 0 20, 20, 20, 20, 20, 20, 20, 20, <td>959 9.00 059 10.00 962 11.00 473 13.00 281 14.00 971 15.00 248 16.00 0 17.00 894 17.01 690 21.00 059 22.00 0 23.00</td>	959 9.00 059 10.00 962 11.00 473 13.00 281 14.00 971 15.00 248 16.00 0 17.00 894 17.01 690 21.00 059 22.00 0 23.00
10.00 DI ETARY 1 5, 179 0 0 6, 11.00 D1100 CAFETERIA 3 14, 357 0 0 9, 13.00 D1300 NURSI NG ADMI NI STRATI ON 3 59 0 0 27, 14.00 D1400 CENTRAL SERVI CES & SUPPLY 1 1, 465 0 0 4, 15.00 D1500 PHARMACY 5 366 0 0 22, 16.00 D1600 MEDI CAL RECORDS & LI BRARY 7 81 0 0 30, 17.00 D1700 SOCI AL SERVI CE 0 0 0 0 30, 17.01 MENTAL HEALTH OH 14 30 0 0 3, 21.00 O2100 I & SERVI CES-OTHER PRGM COSTS APPRVD 0 0 0 18, 23.00 D2300 PARAMED ED PRGM-RADI OLOGY 0 0 0 0	059 10.00 962 11.00 473 13.00 281 14.00 971 15.00 248 16.00 0 17.01 690 21.00 059 22.00 0 23.00
11.00 01100 CAFETERIA 3 14,357 0 0 9, 13.00 01300 NURSING ADMINISTRATION 3 59 0 0 27, 14.00 01400 CENTRAL SERVICES & SUPPLY 1 1,465 0 0 4, 15.00 01500 PHARMACY 5 366 0 0 22, 16.00 01600 MEDICAL RECORDS & LIBRARY 7 81 0 0 30, 17.00 01700 SOCIAL SERVICE 0 0 0 0 31, 31, 30, 31, 30, 30, 30, 31, 30, 30, </td <td>962 11.00 473 13.00 281 14.00 971 15.00 248 16.00 0 17.00 894 17.01 690 21.00 059 22.00 0 23.00</td>	962 11.00 473 13.00 281 14.00 971 15.00 248 16.00 0 17.00 894 17.01 690 21.00 059 22.00 0 23.00
13.00 01300 NURSI NG ADMI NI STRATI ON 3 59 0 27, 14.00 01400 CENTRAL SERVI CES & SUPPLY 1 1,465 0 0 4, 15.00 01500 PHARMACY 5 366 0 0 22, 16.00 01600 MEDI CAL RECORDS & LI BRARY 7 81 0 0 30, 17.00 01700 SOCI AL SERVI CE 0 0 0 0 14 30 0 0 3, 17.01 01701 MENTAL HEALTH OH 14 30 0 0 3,	473 13.00 281 14.00 971 15.00 248 16.00 0 17.00 894 17.01 690 21.00 059 22.00 0 23.00
15.00 01500 PHARMACY 5 366 0 0 22, 16.00 01600 MEDICAL RECORDS & LI BRARY 7 81 0 0 30, 17.00 01700 SOCI AL SERVICE 0 0 0 0 1 17.01 01701 MENTAL HEALTH OH 14 30 0 0 3, 21.00 0200 I & SERVICES-SALARY & FRINGES APPRVD 0 0 0 20, 22.00 02200 I & SERVICES-OTHER PRGM COSTS APPRVD 5 778 0 0 18, 23.00 02300 PARAMED ED PRGM-RADI OLOGY 0 0 0 0 0	971 15.00 248 16.00 0 17.00 894 17.01 690 21.00 059 22.00 0 23.00
16.00 01600 MEDI CAL RECORDS & LI BRARY 7 81 0 30, 17.00 01700 SOCI AL SERVI CE 0 0 0 0 17.01 01701 MENTAL HEALTH OH 14 30 0 0 3, 21.00 02100 I & R SERVI CES-SALARY & FRI NGES APPRVD 0 0 0 20, 22.00 02200 I & R SERVI CES-OTHER PRGM COSTS APPRVD 5 778 0 0 18, 23.00 02300 PARAMED ED PRGM-RADI OLOGY 0 0 0 0	248 16.00 0 17.00 894 17.01 690 21.00 059 22.00 0 23.00
17.00 01700 SOCI AL SERVICE 0 0 0 17.01 01701 MENTAL HEALTH OH 14 30 0 0 3, 21.00 02100 I &R SERVI CES-SALARY & FRI NGES APPRVD 0 0 0 20, 22.00 02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD 5 778 0 0 18, 23.00 02300 PARAMED ED PRGM-RADI OLOGY 0 0 0 0	0 17.00 894 17.01 690 21.00 059 22.00 0 23.00
17. 01 01701 MENTAL HEALTH OH 14 30 0 3, 21. 00 02100 I & R SERVI CES-SALARY & FRI NGES APPRVD 0 0 0 20, 22. 00 02200 I & R SERVI CES-OTHER PRGM COSTS APPRVD 5 778 0 0 18, 23. 00 02300 PARAMED ED PRGM-RADI OLOGY 0 0 0 0	89417.0169021.0005922.00023.00
22. 00 02200 I &R SERVICES-OTHER PRGM COSTS APPRVD 5 778 0 0 18, 23. 00 02300 PARAMED ED PRGM-RADI OLOGY 0 0 0 0 18,	059 22.00 0 23.00
23.00 02300 PARAMED ED PRGM-RADIOLOGY 0 0 0	0 23.00
	20.01
INPATIENT ROUTINE SERVICE COST CENTERS	
	915 30.00
	578 31.00
	439 40.00 640 41.00
	402 43.00
ANCI LLARY SERVICE COST CENTERS	
	836 50.00
51.00 05100 RECOVERY ROOM 0	0 51.00 322 51.01
	169 52.00
	982 53.00
	284 54.00
	514 55.00 757 60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0 0	0 63.00
	132 65.00
	433 66.00
	109 69.00
	0 70.00 153 70.01
	051 71.00
	867 72.00
73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 37, 747 374 109,	
75.00 07500 ASC (NON-DISTINCT PART) 0 6,363 11,772 117 14, 76.00 03950 MH ANCILLARY OUTPATIENT 0 0 0 0 0	480 75.00 0 76.00
	577 76.01
OUTPATIENT SERVICE COST CENTERS	
	163 88.00
	361 90.00 566 90.01
	953 91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	92.00
OTHER REIMBURSABLE COST CENTERS	
	058 96.00
101.00 10100 HOME HEALTH AGENCY O	0 101.00
113.00 I 11300 I NTEREST EXPENSE	113.00
	152 116. 00
	341 118.00
NONREI MBURSABLE COST CENTERS 190.00 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0	0 190.00
	686 192.00
192.01 19201 FP PETERSBURG 0 25 0 0 2,	004 192. 01
	730 192. 02
	647 192.03
192.04 19204 FQHC 0 0 0 194.00 07950 COMMUNITY HEALTH SERVICES 1 17 0 0	0 192.04 926 194.00
	039 194.00
	662 194. 02

Health Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C	CN: 15-0042	Period: From 01/01/2023	Worksheet B Part II	
				To 12/31/2023	Date/Time Pre	
					4/11/2024 3:1	7 pm
Cost Center Description	COMMUNI CATI ON	PURCHASING &	REGI STRATI O	I PATI ENT	ADMI NI STRATI V	
	S	RECEI VI NG		ACCOUNTS	E & GENERAL	
	4. 01	4.02	4.03	4.04	5.00	
194. 03 07953 MH RESI DENTI AL	0	212		0 0	4, 476	194.03
194.0407954 UNUSED SPACE	0	0		0 0	2, 506	194.04
194. 05 07955 MOB	0	0		0 0	196	194.05
194. 06 07956 FOUNDATI ON	0	0		0 0	60	194.06
194.0707957 KNOX COUNTY HEALTH DEPT	0	0		0 0	580	194.07
194.0807958 INDUSTRIAL HEALTH	0	0		0 0	0	194.08
194.0907959 COMMUNITY MENTAL HEALTH CENTER	0	568		0 0	27, 285	194.09
194. 10 07951 BEI RHAUS BUI LDI NG	0	6		0 0	621	194.10
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	1	0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	331	267, 048	261, 99	2,633	1, 112, 759	202.00

	Financial Systems TION OF CAPITAL RELATED COSTS	GOOD SAMARITA	AN HOSPITAL Provider C	CN: 15-0042 P	In Lie	u of Form CMS-2 Worksheet B	2552-10
ALLOG/	THE REAL SOLUTION				rom 01/01/2023	Part II	pared:
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPING	DI ETARY	CAFETERI A	
		PLANT 7.00	LINEN SERVICE 8.00	9.00	10.00	11.00	
	GENERAL SERVICE COST CENTERS	7.00	8.00	9.00	10.00	11.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 4.01	00400 EMPLOYEE BENEFITS DEPARTMENT 00401 COMMUNICATIONS						4.00 4.01
4.02	00402 PURCHASI NG & RECEI VI NG						4.02
4.03	00403 REGI STRATI ON						4.03
4.04	00404 PATIENT ACCOUNTS						4.04
5.00 7.00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	5, 598, 853					5.00 7.00
8.00	00800 LAUNDRY & LI NEN SERVICE	51, 829					8.00
9.00	00900 HOUSEKEEPI NG	72, 104					9.00
10.00	01000 DI ETARY 01100 CAFETERI A	37,627	603			214 422	10.00
11.00 13.00	01300 NURSI NG ADMI NI STRATI ON	85, 588 96, 090			0	314, 633 8, 004	•
14.00	01400 CENTRAL SERVICES & SUPPLY	39, 044	2, 954		Ő	2, 421	14.00
15.00	01500 PHARMACY	58, 847	0		0	10, 523	•
16.00 17.00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	45, 077 0	0	2, 373 0	0	18, 810 0	16.00
17.00	01701 MENTAL HEALTH OH	25, 639		7, 241	0	1, 086	
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	99, 839	0	0	0	10	1
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0	0	5, 527	0	5, 462	•
23.00 23.01	02300 PARAMED ED PRGM-RADI OLOGY 02301 PARAMED ED PRGM-LAB	0	0	0	0	0 1, 039	23.00 23.01
23.01	INPATIENT ROUTINE SERVICE COST CENTERS	0	0	<u> </u>	0	1,039	23.01
30.00	03000 ADULTS & PEDIATRICS	446, 128	53, 652	44, 498	67, 706	23, 053	30.00
31.00	03100 I NTENSI VE CARE UNI T	206, 234	9, 474		24,059	13, 620	1
40.00 41.00	04000 SUBPROVI DER – I PF 04100 SUBPROVI DER – I RF	128, 283 169, 217			21, 614 31, 258	9, 033 9, 307	•
43.00	04300 NURSERY	109, 217			0	5, 306	•
	ANCILLARY SERVICE COST CENTERS						1
50.00	05000 OPERATING ROOM	236, 469	6, 850		0	10, 448	50.00
51.00 51.01	05100 RECOVERY ROOM 05101 ENDOSCOPY	0 120, 439	0 4,060	-	0	0 3, 806	
52.00	05200 DELIVERY ROOM & LABOR ROOM	62, 065	7, 464			3, 207	52.00
53.00	05300 ANESTHESI OLOGY	0	0	0	0	2, 288	•
54.00	05400 RADI OLOGY-DI AGNOSTI C	213, 241	10, 581		0	16, 963	•
55.00 60.00	05500 RADI OLOGY-THERAPEUTI C 06000 LABORATORY	177, 012 71, 828	1, 663 0		0	9, 213 14, 683	•
63.00	06300 BLOOD STORI NG, PROCESSI NG & TRANS.	0	0		0	0	1
65.00	06500 RESPI RATORY THERAPY	55, 894	388		0	9, 663	•
66.00 69.00	06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY	278, 987 178, 941	3, 379 3, 842		0	19, 578 12, 661	•
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0		70.00
70.01	07001 NEURODI AGNOSTI CS	75, 864	1, 905	3, 536	0		70.01
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	
72.00 73.00	07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS	0		0	0	0	
75.00	07500 ASC (NON-DI STINCT PART)	0	6, 200	11, 089	0	5, 842	
76.00	03950 MH ANCILLARY OUTPATIENT	0	0	0	0	0	
76.01	03951 I NPATI ENT DI ALYSI S OUTPATI ENT SERVI CE COST CENTERS	84, 466	0	0	0	258	76.01
88.00	08800 FAMILY PRACTICE 120	0	0	0	0	0	88.00
90.00	09000 CLINIC	22, 184	12	4, 298	-	657	90.00
90.01	04950 WOUND CLINIC	29, 290				1, 604	
91.00 92.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	232, 955	21, 494	16, 223	0	18, 579	91.00 92.00
92.00	OTHER REIMBURSABLE COST CENTERS			1			92.00
96.00	09600 DURABLE MEDI CAL EQUI P-RENTED	3, 878	0	0	0		96.00
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
113 00	SPECIAL PURPOSE COST CENTERS			1			113.00
	11600 HOSPI CE	47, 843	0	4, 549	о	2, 560	116.00
118.00		3, 555, 596	170, 453	215, 902	144, 637	243, 293	118.00
100.00	NONREI MBURSABLE COST CENTERS						100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0 1, 122, 804	6, 650	50, 121	0		190.00 192.00
	19201 FP PETERSBURG	36, 465		0	0		192.00
192.02	19202 PEDI ATRI CS	0	0	0	0	3, 315	192.02
	19203 WASHINGTON PRIMARY CARE	66, 927	0	0	0		192.03
	19204 FQHC 07950 COMMUNI TY HEALTH SERVI CES	0 4,085		1, 086 0	0		192.04 194.00
	07960 CCBHC GRANTS	0	0	212	0	7, 168	194.01
194.02	07952 MARKETING AND PUBLIC RELATIONS	16, 633	0	0	0	1, 162	194.02

Health Financial Systems	GOOD SAMARI TA	AN HOSPITAL		In Lie	u of Form CMS-2552-1	10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		Period: From 01/01/2023 To 12/31/2023	Worksheet B Part II Date/Time Prepared	
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPING	DI ETARY	4/11/2024 3:17 pm CAFETERIA	_
	PLANT	LINEN SERVICE	HOUSEREEFTING	DIEMAN	on Erenn	
	7.00	8.00	9.00	10.00	11.00	
194.0307953 MH RESIDENTIAL	199, 403	0		0 0	2, 142 194. C)3
194.0407954 UNUSED SPACE	200, 486	0		0 0	0 194.0)4
194. 05 07955 MOB	0	0		0 0	0 194.0)5
194. 06 07956 FOUNDATI ON	4, 586	0		0 0	0 194.0)6
194.0707957 KNOX COUNTY HEALTH DEPT	46, 377	0		0 0	0 194.0)7
194. 08 07958 I NDUSTRI AL HEALTH	0	0		0 0	0 194.0)8
194.0907959 COMMUNITY MENTAL HEALTH CENTER	345, 491	0		0 0	0 194.0)9
194. 10 07951 BEI RHAUS BUI LDI NG	0	0	3, 97	9 0	0 194. 1	10
200.00 Cross Foot Adjustments					200.0)0
201.00 Negative Cost Centers	0	0		0 0	0 201.0)0
202.00 TOTAL (sum lines 118 through 201)	5, 598, 853	177, 103	271, 30	0 144, 637	314, 633 202. 0)0

Health Financial Systems	GOOD SAMARI TA	N HOSPI TAL		In Lie	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		eriod: rom 01/01/2023	Worksheet B Part II
				0 12/31/2023	Date/Time Prepared: 4/11/2024 3:17 pm
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL
	ADMI NI STRATI O N	SERVICES & SUPPLY		RECORDS & LI BRARY	SERVI CE
GENERAL SERVICE COST CENTERS	13.00	14.00	15.00	16.00	17.00
1. 00 00100 CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT					2.00 4.00
4. 01 00401 COMMUNI CATI ONS					4.00
4. 02 00402 PURCHASI NG & RECEI VI NG 4. 03 00403 REGI STRATI ON					4. 02 4. 03
4. 04 00403 REGISTRATION 4. 04 00404 PATIENT ACCOUNTS					4.03
5. 00 00500 ADMINI STRATI VE & GENERAL 7. 00 00700 OPERATI ON OF PLANT					5.00 7.00
8.00 00800 LAUNDRY & LINEN SERVICE					8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY					9.00 10.00
11. 00 01100 CAFETERI A					11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY	358, 544	144 754			13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY 15. 00 01500 PHARMACY	0	144, 754 223			14.00 15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	49 0			16.00
17.00 01700 SOCIAL SERVICE 17.01 01701 MENTAL HEALTH OH	0	18		-	0 17.00 0 17.01
21.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0	-	-	0 21.00
22.00 02200 I &R SERVICES-OTHER PRGM COSTS APPRVD 23.00 02300 PARAMED ED PRGM-RADIOLOGY	16, 053 0	474 0		-	0 22.00 0 23.00
23. 01 02301 PARAMED ED PRGM-LAB	0	23	C	0	0 23.01
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	65, 829	3, 945	11	27, 416	0 30.00
31. 00 03100 I NTENSI VE CARE UNI T	40, 032	2, 778			0 31.00
40. 00 04000 SUBPROVI DER - I PF 41. 00 04100 SUBPROVI DER - I RF	26, 548 27, 354	217 735	0 89		0 40.00 0 41.00
43.00 04300 NURSERY	15, 152	0	2	2, 031	0 43.00
ANCI LLARY SERVICE COST CENTERS 50.00 05000 0PERATI NG ROOM	23, 560	6, 825	171	8, 631	0 50.00
51.00 05100 RECOVERY ROOM 51.01 05101 ENDOSCOPY	0 11, 186	0 5, 056	-	-	0 51.00 0 51.01
52.00 05200 DELIVERY ROOM & LABOR ROOM	9, 158	446		0	0 51.01
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	0 5, 139	0 6, 627	0 5, 322		0 53.00 0 54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	18, 100	824			0 55.00
60. 00 06000 LABORATORY 63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	11, 670 0		0	0 60.00 0 63.00
65. 00 06500 RESPIRATORY THERAPY	0	130			0 65.00
66. 00 06600 PHYSI CAL THERAPY 69. 00 06900 ELECTROCARDI OLOGY	14, 757	408 1, 879		0	0 66.00 0 69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	1, 879		0	0 69.00 0 70.00
70. 01 07001 NEURODI AGNOSTI CS 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	1, 336	373 53, 505		Ŭ	0 70.01 0 71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	33, 711		-	0 72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 75. 00 07500 ASC (NON-DISTINCT PART)	0 17, 171	0 3, 874			0 73.00 0 75.00
76. 00 03950 MH ANCI LLARY OUTPATI ENT	0	3, 874	C	0	0 76.00
76. 01 03951 I NPATI ENT DI ALYSI S OUTPATI ENT SERVI CE COST CENTERS	760	22	25	0	0 76.01
88.00 08800 FAMILY PRACTICE 120	0	0		-	0 88.00
90. 00 09000 CLINIC 90. 01 04950 WOUND CLINIC	0 1, 113	2 1, 126	0 187		0 90.00 0 90.01
91. 00 09100 EMERGENCY	54, 607	3, 148			0 91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) OTHER REI MBURSABLE COST CENTERS					92.00
96.00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	48			0 96.00
101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0	C	0	0 101.00
113.00 11300 INTEREST EXPENSE					113.00
116.00 11600 HOSPICE 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	7, 523 355, 378	115 138, 251			0 116.00 0 118.00
NONREL MBURSABLE COST CENTERS		130, 231	220, 910	200, 123	0 110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSI CLANS' PRI VATE OFFICES	0 3, 166	0 5, 215		-	0 190. 00 0 192. 00
192.01 19201 FP PETERSBURG	3, 100	16	53	0	0 192.01
192. 02 19202 PEDI ATRI CS 192. 03 19203 WASHI NGTON PRI MARY CARE	0	338 263			0 192. 02 0 192. 03
192.04 19204 FQHC	0	0	C		0 192.04
194.00 07950 COMMUNI TY HEALTH SERVI CES 194.01 07960 CCBHC GRANTS	0	10 178		0	0 194.00 0 194.01
יארי אונטט ווטטע ארוויט	<u>ا</u> ا	1/0		u U	0[174.01

Health Financial Systems	GOOD SAMARI TA	AN HOSPITAL		In Lieu of Form CMS-2552-10			
ALLOCATION OF CAPITAL RELATED COSTS		Provider CO	CN: 15-0042	Period: From 01/01/2023	Worksheet B Part II		
				To 12/31/2023		pared:	
				-	4/11/2024 3:1	7 pm	
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCI AL		
	ADMI NI STRATI O	SERVICES &		RECORDS &	SERVI CE		
	N	SUPPLY		LI BRARY			
	13.00	14.00	15.00	16.00	17.00		
194.0207952 MARKETING AND PUBLIC RELATIONS	0	4		0 0	0	194.02	
194.0307953 MH RESIDENTIAL	0	129		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	
194.0707957 KNOX COUNTY HEALTH DEPT	0	0		0 0	0	194.07	
194. 08 07958 I NDUSTRI AL HEALTH	0	0		0 0	0	194.08	
194.0907959 COMMUNITY MENTAL HEALTH CENTER	0	346		0 0	0	194.09	
194, 10 07951 BEI RHAUS BUI LDI NG	0	4		0 0	0	194, 10	
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)	358, 544	144, 754	236, 00	206, 125		202.00	

	inancial Systems ON OF CAPITAL RELATED COSTS	GOOD SAMARITA	Provider C		Period: From 01/01/2023	u of Form CMS- Worksheet B Part II	2002-1
					o 12/31/2023		
			I NTERNS &	RESI DENTS			
	Cost Center Description	MENTAL HEALTH	SERVI CES-SALA	SERVI CES-OTHE	PARAMED ED	PARAMED ED	
		OH	RY & FRINGES	R PRGM COSTS	PRGM-RADI OLOG Y	PRGM-LAB	
		17.01	21.00	22.00	23.00	23.01	
	ENERAL SERVICE COST CENTERS 0100 CAP REL COSTS-BLDG & FIXT	1		1			1.0
2.00 0	0200 CAP REL COSTS-MVBLE EQUIP						2.0
	0400 EMPLOYEE BENEFITS DEPARTMENT 0401 COMMUNI CATI ONS						4.0
	0402 PURCHASI NG & RECEI VI NG						4.0
	0403 REGI STRATI ON						4.0
	0404 PATI ENT ACCOUNTS 0500 ADMI NI STRATI VE & GENERAL						4.0
	0700 OPERATION OF PLANT						7.0
	0800 LAUNDRY & LINEN SERVICE						8.0
	0900 HOUSEKEEPI NG 1000 DI ETARY						9.0
	1100 CAFETERI A						11.0
	1300 NURSING ADMINISTRATION						13.0
	1400 CENTRAL SERVICES & SUPPLY						14.0
	1500 PHARMACY 1600 MEDI CAL RECORDS & LI BRARY						15.0
	1700 SOCI AL SERVI CE						17.0
	1701 MENTAL HEALTH OH	98, 199					17.0
	2100 I &R SERVICES-SALARY & FRINGES APPRVD 2200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0		48, 499			21.0
	2300 PARAMED ED PRGM-RADIOLOGY	0		40, 499	0		22.0
23.01 0	2301 PARAMED ED PRGM-LAB	0			_	3, 231	
	NPATIENT ROUTINE SERVICE COST CENTERS		1	1			
	3000 ADULTS & PEDIATRICS 3100 INTENSIVE CARE UNIT	0					30.0
	4000 SUBPROVI DER – I PF	66, 333					40.0
	4100 SUBPROVIDER - IRF	0					41.0
	4300 NURSERY NCI LLARY SERVI CE COST CENTERS	0					43.0
	5000 OPERATI NG ROOM	0					50.0
	5100 RECOVERY ROOM	0					51.0
	5101 ENDOSCOPY 5200 DELIVERY ROOM & LABOR ROOM	0					51.0
	5300 ANESTHESI OLOGY	0					53.0
54.00 0	5400 RADI OLOGY-DI AGNOSTI C	0					54.0
	5500 RADI OLOGY-THERAPEUTI C	0					55.0
	6000 LABORATORY 6300 BLOOD STORING, PROCESSING & TRANS.	0					60. C
	6500 RESPIRATORY THERAPY	0					65.0
6.00 0	6600 PHYSI CAL THERAPY	0					66.0
	6900 ELECTROCARDI OLOGY 7000 ELECTROENCEPHALOGRAPHY	0					69.0 70.0
	7001 NEURODI AGNOSTI CS	0					70.0
1	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0					71.0
	7200 IMPL. DEV. CHARGED TO PATIENTS	0					72.0
	7300 DRUGS CHARGED TO PATIENTS 7500 ASC (NON-DISTINCT PART)						73.0
6.00 0	3950 MH ANCILLARY OUTPATIENT	0					76.0
	3951 INPATIENT DIALYSIS	0					76.0
	UTPATIENT SERVICE COST CENTERS 8800 FAMILY PRACTICE 120	0					88.0
	9000 CLINIC	0					90.0
	4950 WOUND CLINIC	0					90.0
	9100 EMERGENCY 9200 OBSERVATION BEDS (NON-DISTINCT PART)	0					91.0
	THER REIMBURSABLE COST CENTERS	1	1	1			72.0
96.00 0	9600 DURABLE MEDI CAL EQUI P-RENTED	0					96.0
	0100 HOME HEALTH AGENCY	0		I			101.0
	PECIAL PURPOSE COST CENTERS 1300 INTEREST EXPENSE						113.0
	1600 HOSPI CE	0					116.0
18.00	SUBTOTALS (SUM OF LINES 1 through 117)	66, 333	0	C	0	0	118.0
	ONREIMBURSABLE COST CENTERS			1			100 0
	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0					190.0 192.0
	9200 PHYSICIANS' PRIVATE DEFICES						
192.001	9200 PHYSI CLANS' PRI VATE OFFI CES 9201 FP PETERSBURG	0					192.0
192. 00 1 192. 01 1 192. 02 1		0					

Health Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Lieu of Form CMS-2552-10			
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		Period:	Worksheet B		
				From 01/01/2023 To 12/31/2023	Part II Date/Time Pre 4/11/2024 3:1		
		I NTERNS &	RESI DENTS				
Cost Center Description	MENTAL HEALTH OH	SERVI CES-SALA RY & FRI NGES			PARAMED ED PRGM-LAB		
				Y	-		
	17.01	21.00	22.00	23.00	23.01		
194.0007950 COMMUNITY HEALTH SERVICES	0					194.00	
194.0107960 CCBHC GRANTS	0					194.01	
194.0207952 MARKETING AND PUBLIC RELATIONS	0					194.02	
194.0307953 MH RESIDENTIAL	0					194.03	
194.0407954 UNUSED SPACE	0					194.04	
194.0507955 MOB	0					194.05	
194. 06 07956 FOUNDATI ON	0					194.06	
194.0707957 KNOX COUNTY HEALTH DEPT	0					194.07	
194. 08 07958 I NDUSTRI AL HEALTH	0					194.08	
194.0907959 COMMUNITY MENTAL HEALTH CENTER	31, 866					194.09	
194. 10 07951 BEI RHAUS BUI LDI NG	0					194.10	
200.00 Cross Foot Adjustments		353, 887	48, 49	9 0	3, 231	200.00	
201.00 Negative Cost Centers	0	0		0 0	0	201.00	
202.00 TOTAL (sum lines 118 through 201)	98, 199	353, 887	48, 49	9 0		202.00	

LLUCA	Financial Systems TION OF CAPITAL RELATED COSTS	0000 0/ 11/ 11/	AN HOSPITAL Provider CC	N: 15_0042	Period: Worksheet	MS-2552- B
	TION OF CAPITAL RELATED COSTS			N. 15-0042	From 01/01/2023 Part II	
					To 12/31/2023 Date/Time 4/11/2024	3: 17 pm
	Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown	Total		
		24.00	Adjustments	24.00		
	GENERAL SERVICE COST CENTERS	24.00	25.00	26.00		
1	00100 CAP REL COSTS-BLDG & FIXT					1. (
	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT					2.0
	00400 COMMUNI CATI ONS					4.0
	00402 PURCHASI NG & RECEI VI NG					4. (
	00403 REGI STRATI ON					4.0
						4.0
	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT					5.0
	00800 LAUNDRY & LINEN SERVICE					8.0
. 00	00900 HOUSEKEEPI NG					9. (
	01000 DI ETARY					10. (
	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON					11. (
	01400 CENTRAL SERVICES & SUPPLY					14.
	01500 PHARMACY					15.0
1	01600 MEDICAL RECORDS & LIBRARY					16. (
1	01700 SOCIAL SERVICE					17.
1	01701 MENTAL HEALTH OH 02100 I&R SERVICES-SALARY & FRINGES APPRVD					17.
	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD					22.
3.00	02300 PARAMED ED PRGM-RADI OLOGY					23.
	02301 PARAMED ED PRGM-LAB					23.
H	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	1, 873, 820	0	1, 873, 82	20	30.
	03100 I NTENSI VE CARE UNI T	863, 028	0	863, 02		30.
	04000 SUBPROVI DER – I PF	607, 479	0	607, 47		40.
1	04100 SUBPROVI DER – I RF	694, 440	0	694, 44		41.
H	04300 NURSERY	391, 989	0	391, 98	39	43.
	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM	922, 572	0	922, 57	72	50.0
	05100 RECOVERY ROOM	0	0		0	51.0
	05101 ENDOSCOPY	456, 892	0	456, 89		51.
	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	237, 511 16, 533	0	237, 51 16, 53		52. 53.
	05400 RADI OLOGY-DI AGNOSTI C	884, 087	0	884, 08		54.
5.00	05500 RADI OLOGY-THERAPEUTI C	665, 183	0	665, 18		55.
	06000 LABORATORY	374, 483	0	374, 48		60.
	06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06500 RESPI RATORY THERAPY	0 225, 496	0	225, 49		63. 65.
	06600 PHYSI CAL THERAPY	1, 034, 194	0	1, 034, 19		66.
9.00	06900 ELECTROCARDI OLOGY	682, 587	0	682, 58		69.
	07000 ELECTROENCEPHALOGRAPHY	0	0	075 7	0	70.
	07001 NEURODI AGNOSTI CS 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	275, 711 164, 799	0	275, 71 164, 79		70.
	07200 IMPL. DEV. CHARGED TO PATIENTS	119, 154	0	119, 15		72.
3.00	07300 DRUGS CHARGED TO PATIENTS	361, 735	0	361, 73		73.
	07500 ASC (NON-DI STI NCT PART)	134, 172	0	134, 17		75.
1	03950 MH ANCI LLARY OUTPATI ENT 03951 I NPATI ENT DI ALYSI S	0 286, 068	0	286, 06	0	76. 76.
	OUTPATIENT SERVICE COST CENTERS	200,000	U U	200, 00	00	/0.
	08800 FAMILY PRACTICE 120	204	0	20)4	88.
	09000 CLINIC	80, 581	0	80, 58		90.
	04950 WOUND CLINIC 09100 EMERGENCY	122, 945 1, 009, 640	0	122, 94		90. 91.
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 009, 040	0	1, 009, 64		91.
	OTHER REIMBURSABLE COST CENTERS					
	09600 DURABLE MEDI CAL EQUI P-RENTED	14, 888	0	14, 88		96.
	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0		0	101.
	11300 INTEREST EXPENSE		Ι			113.
16.00	11600 HOSPI CE	181, 952	0	181, 95	52	116.
18.00		12, 682, 143	0	12, 682, 14	43	118.
	NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	<u></u>		0	100
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0 4, 037, 108	0	4, 037, 10	0	190. 192.
		T, UJ7, 100	U			
92.00		124.627	0	124, 62	27	192.
92.00 92.01 92.02	19201 FP PETERSBURG 19202 PEDI ATRI CS 19203 WASHI NGTON PRI MARY CARE	124, 627 14, 996	0 0	124, 62 14, 99		192. 192. 192.

Health Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Lieu of Form CMS-2552-10		
ALLOCATION OF CAPITAL RELATED COSTS		Provider C	CN: 15-0042	Period: From 01/01/2023 To 12/31/2023		
Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total			
	24.00	25.00	26.00			
194.0007950 COMMUNI TY HEALTH SERVICES	15, 134	0	15, 1	34	194.00	
194.0107960 CCBHC GRANTS	20, 922	0	20, 9	22	194.01	
194.0207952 MARKETING AND PUBLIC RELATIONS	61, 610	0	61, 6	10	194.02	
194. 03 07953 MH RESIDENTIAL	672, 693	0	672, 6	93	194.03	
194.0407954 UNUSED SPACE	671, 574	0	671, 5	74	194.04	
194.0507955 MOB	196	0	1	96	194.05	
194. 06 07956 FOUNDATI ON	15, 366	0	15, 3	66	194.06	
194.0707957 KNOX COUNTY HEALTH DEPT	155, 350	0	155, 3	50	194.07	
194. 08 07958 I NDUSTRI AL HEALTH	0	0	1	0	194.08	
194.0907959 COMMUNITY MENTAL HEALTH CENTER	1, 216, 247	0	1, 216, 2	47	194.09	
194. 10 07951 BEI RHAUS BUI LDI NG	4, 610	0	4,6	10	194.10	
200.00 Cross Foot Adjustments	405, 617	0	405, 6	17	200.00	
201.00 Negative Cost Centers	0	0		0	201.00	
202.00 TOTAL (sum lines 118 through 201)	20, 346, 585	0	20, 346, 5	85	202.00	

	Financial Systems NLLOCATION - STATISTICAL BASIS	GOOD SAMARITA	AN HOSPITAL Provider CO		eriod:	u of Form CMS-: Worksheet B-1	
					rom 01/01/2023 o 12/31/2023	Date/Time Pre 4/11/2024 3:1	
		CAPI TAL REI	LATED COSTS				
	Cost Center Description	BLDG & FI XT (SQUARE FEET)	MVBLE EQUI P (SQUARE FEET)	EMPLOYEE BENEFI TS DEPARTMENT (GROSS SALARI ES)	COMMUNI CATI ON S (NUMBER OF PHONES)	PURCHASI NG & RECEI VI NG (SUPPLI ES COST)	
		1.00	2.00	4.00	4. 01	4.02	
1.00 2.00 4.00 4.01 4.02 4.03 4.03	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00401 COMMUNICATIONS 00402 PURCHASING & RECEIVING 00403 REGISTRATION 00404 PATIENT ACCOUNTS	884, 498 4, 862 0 11, 575 11, 304 0	884, 498 4, 862 0 11, 575 11, 304 0	109, 523, 338 324, 521 762, 616 1, 806, 704 2, 443, 101	2, 110 20 37 45	20, 434, 501 8, 536 10, 111	4.04
	00500 ADMI NI STRATI VE & GENERAL 00700 OPERATI ON OF PLANT 00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	47, 966 239, 930 5, 266 7, 326 3, 823 8, 696 9, 763 3, 967 5, 979	239, 930 5, 266 7, 326 3, 823 8, 696 9, 763 3, 967 5, 979	7, 853, 050 2, 576, 329 239, 763 2, 339, 766 505, 399 1, 401, 049 2, 284, 261 386, 217 3, 202, 203	121 0 37 20 19 7 32	101, 321 209, 439 81, 699 219, 056 396, 318 1, 098, 658 4, 487 112, 089 28, 006	8.00 9.00 10.00 11.00 13.00 14.00 15.00
17.01 21.00 22.00 23.00 23.01	01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE 01701 MENTAL HEALTH OH 02100 I &R SERVI CES-SALARY & FRI NGES APPRVD 02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD 02300 PARAMED ED PRGM-RADI OLOGY 02301 PARAMED ED PRGM-LAB I NPATI ENT ROUTI NE SERVI CE COST CENTERS	4, 580 0 2, 605 10, 144 0 0 0	0 2,605 10,144 0 0 0	4, 038, 556 0 345, 494 2, 002, 388 0 278, 171	0 88 0 34 0 0	6, 169 0 2, 284 0 59, 569 0 2, 906	17.00 17.01 21.00 22.00 23.00 23.01
31.00 40.00 41.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF 04300 NURSERY ANCILLARY SERVICE COST CENTERS	45, 328 20, 954 13, 034 17, 193 10, 434	20, 954 13, 034 17, 193	3, 479, 331 2, 236, 192	96 0 74	495, 749 349, 076 27, 212 92, 354 0	31.00 40.00 41.00
50.00	05000 OPERATI NG ROOM	24, 026	24, 026	3, 308, 341	147	857, 729	50.00
51.00 51.01 52.00 53.00	05100 RECOVERY ROOM 05101 ENDOSCOPY 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	0 12, 237 6, 306 0	12, 237 6, 306 0	0 845, 525 168, 319 2, 861, 645	0	0 635, 443 56, 064 0	52.00 53.00
60.00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C 06000 LABORATORY 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06500 RESPI RATORY THERAPY	21, 666 17, 985 7, 298 0 5, 679	17, 985 7, 298 0	2, 937, 306	37 34 0	832, 891 103, 613 1, 466, 637 0 16, 348	60.00 63.00
66. 00 69. 00	06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07001 NEURODI AGNOSTI CS	28, 346 18, 181 0 7, 708	28, 346 18, 181 0	5, 788, 311 5, 104, 267 0 889, 678	62 81 0	51, 304 236, 181 0 46, 886	66.00 69.00 70.00
71.00 72.00 73.00 75.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07500 ASC (NON-DISTINCT PART) 03950 MH ANCILLARY OUTPATIENT 03951 I NPATIENT DIALYSIS	0 0 0 0 0 0 8, 582	0 0 0 0	0 0 0 1, 221, 011 0 93, 493	0 0 0 0	6, 724, 882 4, 236, 655 0 486, 903 0 2, 825	71.00 72.00 73.00 75.00 76.00
90. 00 90. 01	OUTPATI ENT SERVICE COST CENTERS 08800 FAMILY PRACTICE 120 09000 CLINIC 04950 WOUND CLINIC	0 2, 254 2, 976	2, 254	21, 835 157, 578 372, 480	10 10	0 301 141, 467	90.00 90.01
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS 09600 DURABLE MEDICAL EQUIP-RENTED	23, 669		4, 702, 789 95, 066		395, 624 6, 070	91.00 92.00 96.00
101.00 113.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE	0	0	0	0	0	101.00 113.00
118.00	11600 HOSPI CE SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	4, 861 676, 897		515, 690 87, 222, 086	1, 786	19, 617, 286	116.00 118.00 190.00
192.00 192.01	19200 GFFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CLANS' PRI VATE OFFI CES 19201 FP PETERSBURG 19202 PEDI ATRI CS	0 114, 080 3, 705 0	114, 080 3, 705	15, 028, 004 130, 307	0	655, 352 1, 951	•

Health Financial Systems	GOOD SAMARI TA	AN HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider C	F	Period: From 01/01/2023 To 12/31/2023	Worksheet B-1 Date/Time Pre 4/11/2024 3:1	pared:
	CAPI TAL REI	ATED COSTS				
Cost Center Description	BLDG & FI XT (SQUARE FEET)	, , , , , , , , , , , , , , , , , , ,	EMPLOYEE BENEFI TS DEPARTMENT (GROSS SALARI ES)	COMMUNI CATI ON S (NUMBER OF PHONES)	RECEI VI NG (SUPPLI ES COST)	
	1.00	2.00	4.00	4.01	4.02	
192. 03 19203 WASHI NGTON PRI MARY CARE 192. 04 19204 FQHC	6, 800 0	0	1, 426, 504 (0 0	0	192. 03 192. 04
194. 00 07950 COMMUNI TY HEALTH SERVI CES 194. 01 07960 CCBHC GRANTS	415	415	118, 041 1, 011, 558			194.00 194.01
194.0207952 MARKETING AND PUBLIC RELATIONS	1, 690	1, 690				194.02
194. 03 07953 MH RESIDENTIAL	20, 260					194.03
194. 04 07954 UNUSED SPACE	20, 370		(194.04
194. 05 07955 MOB	0		160	0		194.05
194. 06 07956 FOUNDATI ON	466	466	C	3	0	194.06
194.0707957 KNOX COUNTY HEALTH DEPT	4, 712	4, 712	0	0 0	0	194.07
194. 08 07958 I NDUSTRI AL HEALTH	0	0	0	0 0	0	194.08
194.0907959 COMMUNITY MENTAL HEALTH CENTER	35, 103	35, 103	3, 131, 825	0	43, 427	194.09
194. 10 07951 BEI RHAUS BUI LDI NG	0	0	(C	0	477	194.10
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)	20, 306, 497	40, 088	28, 526, 464	295, 265	1, 247, 874	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	22. 958217	0. 045323	0. 260460	139. 936019	0. 061067	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)			111, 843	331	267, 048	204.00
205.00 Unit cost multiplier (Wkst. B, Part			0. 001021	0. 156872	0. 013068	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

Health Financial Systems COST ALLOCATION - STATISTICAL BASIS	GOOD SAMARITA		N: 15 0042 D	In Lie	u of Form CMS-2	
CUST ALLOCATION - STATISTICAL BASIS		Provider CC	F	rom 01/01/2023 o 12/31/2023	Worksheet B-1 Date/Time Pre 4/11/2024 3:1	pared:
Cost Center Description	REGI STRATI ON (GROSS CHARGES)	PATI ENT ACCOUNTS (GROSS CHARGES)	Reconciliatio n	ADMI NI STRATI V E & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
	4.03	4.04	5A	5.00	7.00	
GENERAL SERVICE COST CENTERS						1 00
1. 00 00100 CAP REL COSTS-BLDG & FIXT 2. 00 00200 CAP REL COSTS-MVBLE EQUIP 4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 4. 01 00401 COMMUNI CATI ONS 4. 02 00402 PURCHASI NG & RECEI VI NG 4. 03 00403 REGI STRATI ON 4. 04 00404 PATI ENT ACCOUNTS 5. 00 00500 ADMI NI STRATI VE & GENERAL 7. 00 00700 OPERATI ON OF PLANT 8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY 17. 00 01700 SOCI AL SERVI CE 17 01700 MENTAL UF ALTU OU	648, 458, 527 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	648, 458, 527 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	-22, 865, 895 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	13, 877, 169 528, 007 3, 357, 429 1, 132, 647 1, 862, 313 5, 136, 038 800, 318 4, 294, 444 5, 654, 874 0	568, 861 5, 266 7, 326 3, 823 8, 696 9, 763 3, 967 5, 979 4, 580 0	$\begin{array}{c} 1. 00\\ 2. 00\\ 4. 00\\ 4. 01\\ 4. 02\\ 4. 03\\ 4. 04\\ 5. 00\\ 7. 00\\ 8. 00\\ 9. 00\\ 10. 00\\ 11. 00\\ 13. 00\\ 14. 00\\ 15. 00\\ 16. 00\\ 17. 00\\ 17. 01\\ \end{array}$
17.01 01701 MENTAL HEALTH OH 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0		2, 605 10, 144	17.01 21.00
22. 00 02200 FAR SERVICES-SALART & TRINGLS AFRAD 22. 00 02200 FARAMED ED PRGM-RADIOLOGY 23. 00 02300 PARAMED ED PRGM-LAB INPATIENT ROUTINE SERVICE COST CENTERS	000000000000000000000000000000000000000	0 0 0 0	0	3, 376, 102 0	00,144	21.00 22.00 23.00 23.01
30. 00 03000 ADULTS & PEDI ATRI CS	32, 027, 998	32, 027, 998	0		45, 328	30.00
31. 00 03100 I NTENSI VE CARE UNI T	12, 422, 932	12, 422, 932	0		20, 954	
40. 00 04000 SUBPROVI DER - I PF 41. 00 04100 SUBPROVI DER - I RF	9, 285, 009 7, 916, 191	9, 285, 009 7, 916, 191	0 0		13, 034 17, 193	40.00 41.00
43. 00 04300 NURSERY	1, 245, 687	1, 245, 687	0		10, 434	43.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 0PERATI NG ROOM 51. 00 05100 RECOVERY ROOM	44, 116, 643 0	44, 116, 643 0	0 0		24, 026 0	50.00 51.00
51.01 05101 ENDOSCOPY	13, 308, 153	13, 308, 153	0		12, 237	51.01
52. 00 05200 DELIVERY ROOM & LABOR ROOM	2,061,064	2,061,064	0	405, 455	6, 306	52.00
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	8, 188, 147 114, 449, 658	8, 188, 147 114, 449, 658	0		0 21, 666	53.00 54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	27, 451, 180	27, 451, 180	0		17, 985	55.00
60. 00 06000 LABORATORY	81, 778, 189	81, 778, 189	0	.,,	7, 298	60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	10 000 717	0		0	63.00 65.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	26, 424, 681	12, 333, 717 26, 424, 681	0	3, 389, 802 6, 624, 278	5, 679 28, 346	
69. 00 06900 ELECTROCARDI OLOGY	44, 274, 847	44, 274, 847	0		18, 181	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0		0	70.00
70. 01 07001 NEURODI AGNOSTI CS 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	6, 319, 021 3, 319, 868	6, 319, 021 3, 319, 868	0	1, 524, 145 4, 122, 460	7, 708 0	70. 01 71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	12, 773, 053	12, 773, 053	0	4, 648, 855	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	93, 432, 655	93, 432, 655	0	20, 555, 648	0	73.00
75.00 07500 ASC (NON-DISTINCT PART)	29, 138, 855	29, 138, 855	0	2, 706, 980	0	75.00
76.00 03950 MH ANCI LLARY OUTPATI ENT 76.01 03951 I NPATI ENT DI ALYSI S	1,009,629	0 1,009,629	0	0 481, 736	0 8, 582	76. 00 76. 01
OUTPATIENT SERVICE COST CENTERS	1,007,027	., 007, 027			0, 302	
88.00 08800 FAMILY PRACTICE 120	46, 689	46, 689	0		0	88.00
90. 00 09000 CLINIC 90. 01 04950 WOUND CLINIC	124, 872 5, 370, 889	124, 872	0		2, 254	90.00
90. 01 04950 WOUND CLINIC 91. 00 09100 EMERGENCY	57, 539, 520	5, 370, 889 57, 539, 520	0		2, 976 23, 669	90. 01 91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	07,007,020	0770077020		0,2,0	20,007	92.00
OTHER REIMBURSABLE COST CENTERS	455 200	455 200		107.005	204	0/ 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 101. 00 10100 HOME HEALTH AGENCY	455, 308 0	455, 308 0	0		394	96.00 101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE 116.00 11600 HOSPICE 118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	1, 644, 072 648, 458, 527	1, 644, 072 648, 458, 527	0 -22, 865, 895	1, 150, 140 167, 571, 838		113. 00 116. 00 118. 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	26, 490, 764	114, 080	192.00
192. 01 19201 FP PETERSBURG	0	0	0	374, 710		192.01
192. 02 19202 PEDI ATRI CS 192. 03 19203 WASHI NGTON PRI MARY CARE	0	0	0	1, 445, 141 2, 177, 377		192.02 192.03
192. 04 19204 FQHC	0	0	72		0	192.04
194. 00 07950 COMMUNI TY HEALTH SERVICES	0	0	0	173, 116		194.00

Health Financial Systems	GOOD SAMARI TA	N HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider C	CN: 15-0042	Period:	Worksheet B-1	
				From 01/01/2023 To 12/31/2023		pared: 7 pm
Cost Center Description	REGI STRATI ON	PATI ENT		D ADMI NI STRATI V	OPERATION OF	
	(GROSS	ACCOUNTS	n	E & GENERAL	PLANT	
	CHARGES)	(GROSS CHARGES)		(ACCUM. COST)	(SQUARE FEET)	
	4.03	4, 04	5A	5.00	7.00	
194.0107960 CCBHC GRANTS	0	0	0,1	0 2, 250, 781		194.01
194.0207952 MARKETING AND PUBLIC RELATIONS	0	0		0 871, 646	1, 690	194.02
194.0307953 MH RESIDENTIAL	0	0		0 836, 874	20, 260	194.03
194. 04 07954 UNUSED SPACE	0	0		0 468, 582	20, 370	194.04
194. 05 07955 MOB	0	0		0 36, 700		194.05
194. 06 07956 FOUNDATI ON	0	0		0 11, 140		194.06
194.07 07957 KNOX COUNTY HEALTH DEPT	0	0		0 108, 393		194.07
194. 08 07958 I NDUSTRI AL HEALTH	0	0		0 0		194.08
194.0907959 COMMUNI TY MENTAL HEALTH CENTER	0	0		0 5, 101, 005		
194. 10 07951 BEI RHAUS BUI LDI NG	0	0		0 116, 166	0	194.10
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	2 550 450	4 574 040		22 0/5 005	15 400 4/4	201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	2, 559, 450	4, 574, 842		22, 865, 895	15, 402, 464	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	0. 003947	0. 007055		0. 109914	27.075971	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	261, 995	2, 633		1, 112, 759	5, 598, 853	204.00
205.00 Unit cost multiplier (Wkst. B, Part	0. 000404	0. 000004		0.005349	9.842216	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

	inancial Systems LOCATION - STATISTICAL BASIS	GOOD SAMARITA	N HOSPITAL Provider CC		Period:	u of Form CMS-2 Worksheet B-1	
					From 01/01/2023 To 12/31/2023	Date/Time Pre 4/11/2024 3:1	
	Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (HOURS OF SERVI CE)	DI ETARY (PATI ENT DAYS)	CAFETERIA (MAN HOURS)	NURSI NG ADMI NI STRATI O N (DI RECT NURSI NG)	
		8.00	9.00	10.00	11.00	13.00	
	ENERAL SERVICE COST CENTERS 0100 CAP REL COSTS-BLDG & FIXT						1.00
$\begin{array}{cccccccccccccccccccccccccccccccccccc$	0200 CAP REL COSTS-MVBLE EQUI P 0400 EMPLOYEE BENEFITS DEPARTMENT 0401 COMMUNI CATIONS 0402 PURCHASI NG & RECEI VI NG 0403 REGI STRATI ON 0404 PATI ENT ACCOUNTS 0500 ADMI NI STRATI VE & GENERAL 0700 OPERATION OF PLANT 0800 LAUNDRY & LI NEN SERVI CE 0900 HOUSEKEEPI NG 1000 DI ETARY 1100 CAFETERI A 1300 NURSI NG ADMI NI STRATI ON 1400 CENTRAL SERVI CES & SUPPLY 1500 PHARMACY 1600 MEDI CAL RECORDS & LI BRARY 1700 SOCI AL SERVI CE 1701 MENTAL HEALTH OH 2100 I & SERVI CES-SALARY & FRI NGES APPRVD 2300 PARAMED ED PRGM-RADI OLOGY 2301 PARAMED ED PRGM-LAB	849, 322 35, 751 2, 891 8, 014 0 14, 168 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	70, 437 1, 742 411 0 763 603 616 0 1, 880 0 1, 880 0 1, 435 0 0		9 0 2, 076, 592 0 52, 829 0 15, 978 0 69, 455 0 124, 147 0 0 7, 166 0 63 0 36, 048 0 0 0 6, 860	805, 136 0 0 0 0 0 36, 048 0 0	$\begin{array}{c} 2.\ 00\\ 4.\ 00\\ 4.\ 01\\ 4.\ 02\\ 4.\ 03\\ 4.\ 04\\ 5.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 01\\ 21.\ 00\\ \end{array}$
	NPATIENT ROUTINE SERVICE COST CENTERS 3000 ADULTS & PEDIATRICS	257, 289	11, 553	13, 54	2 152, 152	147, 824	30.00
31.00 03	3100 I NTENSI VE CARE UNI T	45, 435	4, 072	4, 81	2 89, 895	89, 895	31.00
	4000 SUBPROVI DER – I PF 4100 SUBPROVI DER – I RF	14, 951 41, 210	0 3, 054	4, 32 6, 25		59, 615 61, 425	1
43.00 04	4300 NURSERY	59, 223	2, 659		0 35, 023		•
	NCILLARY SERVICE COST CENTERS 5000 OPERATING ROOM	32, 852	2, 983		0 68, 960	52, 906	50.00
	5100 RECOVERY ROOM	0	2, 703		0 00, 700	0	51.00
	5101 ENDOSCOPY	19, 471	1,018		0 25, 119	25, 119	
	5200 DELIVERY ROOM & LABOR ROOM 5300 ANESTHESIOLOGY	35, 794 0	1, 607 0		0 21, 168 0 15, 098	20, 565 0	52.00 53.00
	5400 RADI OLOGY-DI AGNOSTI C	50, 743	2, 029		0 111, 956	11, 539	•
	5500 RADI OLOGY-THERAPEUTI C	7, 975	1, 171		0 60, 807	40, 644	55.00
	6000 LABORATORY 6300 BLOOD STORING, PROCESSING & TRANS.	0	944 0		0 96,907 0 0	0	60.00 63.00
	6500 RESPIRATORY THERAPY	1, 862	674		0 63, 779		•
66.00 06	6600 PHYSI CAL THERAPY	16, 203	2, 931		0 129, 217	33, 138	66.00
	6900 ELECTROCARDI OLOGY 7000 ELECTROENCEPHALOGRAPHY	18, 425	3, 255 0		0 83,561 0 0	0	
	7000 ELECTROENCEPHALOGRAPHY 7001 NEURODI AGNOSTI CS	9, 137	918		0 20, 664	3, 001	•
71.00 07	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
	7200 IMPL. DEV. CHARGED TO PATIENTS 7300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	72.00
	7500 ASC (NON-DISTINCT PART)	29, 733	2, 879		0 38, 559		
	3950 MH ANCI LLARY OUTPATIENT	0	0		0 0	0	
	3951 INPATIENT DIALYSIS UTPATIENT SERVICE COST CENTERS	0	0		0 1, 706	1, 706	76.01
	8800 FAMILY PRACTICE 120	0	0		0 0	0	88.00
	9000 CLINIC	56	1, 116		0 4, 335	0	90.00
	4950 WOUND CLINIC 9100 EMERGENCY	13, 171 103, 079	348 4, 212		0 10, 586 0 122, 624		
	9200 OBSERVATION BEDS (NON-DISTINCT PART)	103, 079	4, 212		122, 024	122, 024	91.00
01	THER REIMBURSABLE COST CENTERS		1				
	9600 DURABLE MEDICAL EQUIP-RENTED 0100 HOME HEALTH AGENCY	0	0		0 3, 158 0 0		96.00 101.00
SF	PECIAL PURPOSE COST CENTERS						1
	1300 I NTEREST EXPENSE 1600 HOSPI CE		1, 181		0 16, 894	16, 894	113.00
118.001	SUBTOTALS (SUM OF LINES 1 through 117)	817, 433	56, 054	28, 92			
NC	ONREI MBURSABLE COST CENTERS				, , , , , , , , , , , , , , , , , , , ,		1
	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	12 012		0 0		190.00
	9200 PHYSI CLANS' PRI VATE OFFI CES 9201 FP PETERSBURG	31, 889 0	13, 013 0		0 311, 189 0 4, 639		192.00 192.01
	9202 PEDI ATRI CS	0	0		0 21, 882	0	192.02
	9203 WASHI NGTON PRI MARY CARE	0	0		0 31, 619		192.03
192.04	9204 FQHC	0	282		0 29, 601	0	192.04

Health Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider C		Period: From 01/01/2023	Worksheet B-1	
				To 12/31/2023	Date/Time Pre 4/11/2024 3:1	
Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	
	LINEN SERVICE (POUNDS OF	(HOURS OF SERVICE)	(PATI ENT DAYS)	(MAN HOURS)	ADMINISTRATIO N	
	LAUNDRY)	JERVICE)	DATS		(DI RECT	
	EAGNER(T)				NURSI NG)	
	8.00	9.00	10.00	11.00	13.00	
194.0007950 COMMUNI TY HEALTH SERVICES	0	0		0 2, 792		194.00
194.0107960CCBHC GRANTS	0	55		0 47, 310		194.01
194.0207952MARKETING AND PUBLIC RELATIONS	0	0		0 7,666		194.02
194. 03 07953 MH RESIDENTIAL	0	0		0 14, 140		194.03
194.0407954 UNUSED SPACE	0	0		0 0		194.04
194.0507955 MOB	0	0		0 0		194.05
194. 06 07956 FOUNDATI ON	0	0		0 0		194.06
194. 07 07957 KNOX COUNTY HEALTH DEPT	0	0		0 0		194.07
194. 08 07958 I NDUSTRI AL HEALTH	0	0		0 0		194.08
194.0907959 COMMUNITY MENTAL HEALTH CENTER	0	0		0 0		194.09
194.10 07951 BEIRHAUS BUILDING 200.00 Cross Foot Adjustments	0	1, 033		0 0	0	194. 10 200. 00
200.00Cross Foot Adjustments201.00Negative Cost Centers						200.00
202.00 Cost to be allocated (per Wkst. B,	728, 624	3, 955, 486	1, 460, 95	6 2, 332, 415	6, 024, 240	
Part I)	720, 024	3, 755, 400	1,400,95	2, 332, 413	0, 024, 240	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	0.857889	56. 156367	50, 50143	5 1. 123194	7, 482264	203.00
204.00 Cost to be allocated (per Wkst. B,	177, 103				358, 544	
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part	0. 208523	3. 851669	4. 99972	3 0. 151514	0. 445321	205.00
11)						
206.00 NAHE adjustment amount to be allocated						206.00
(per Wkst. B-2)						0.07 0.0
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

Health Financial Systems COST ALLOCATION - STATISTICAL BASIS	GOOD SAMARITA	N HOSPITAL	CN: 15-0042 P	In Lie eriod:	u of Form CMS-: Worksheet B-1	
			F	rom 01/01/2023 o 12/31/2023		
Cost Center Description	CENTRAL SERVI CES & SUPPLY (SUPPLI ES COST)	PHARMACY (COSTED REQUI S.)	MEDI CAL RECORDS & LI BRARY (TI ME SPENT)	SOCI AL SERVI CE (NET CHARGES)	4/11/2024 3:1 MENTAL HEALTH OH (NET CHARGES)	/ pm
	14.00	15.00	16.00	17.00	17.01	
GENERAL SERVI CE COST CENTERS 1. 00 00100 CAP REL COSTS-BLDG & FIXT 2. 00 00200 CAP REL COSTS-BLDG & FIXT 2. 00 00200 CAP REL COSTS-BLDG & FIXT 4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 4. 01 00401 COMMUNI CATI ONS 4 4 4. 02 00402 PURCHASI NG & RECEI VI NG 4. 03 00403 REGI STRATI ON 4. 04 00404 PATI ENT ACCOUNTS 5. 00 00500 ADMI NI STRATI VE & GENERAL 7. 00 00700 OPERATI ON OF PLANT 8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 9. 00 00900 HOUSEKEEPI NG 10. 00 01000 10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY	18, 192, 787 28, 006 6, 169 0 2, 284 0 59, 569 0	22, 028, 426 0 0 0 9, 021 0	812 0 0 0 0 0 0	0 0 0 0 0	0 0 0	$\begin{array}{c} 1.00\\ 2.00\\ 4.00\\ 4.01\\ 4.02\\ 4.03\\ 4.04\\ 5.00\\ 7.00\\ 8.00\\ 9.00\\ 10.00\\ 11.00\\ 13.00\\ 14.00\\ 15.00\\ 16.00\\ 17.01\\ 121.00\\ 22.00\\ 23.00\\ 23.00\\ 10.01\\ 10.01\\ 10.01\\ 10.01\\ 10.00\\ 10.01\\ 10.01\\ 10.00\\ 10.01\\ 10.00\\ 10.01\\ 10.00$
23. 01 02301 PARAMED ED PRGM-LAB INPATI ENT ROUTI NE SERVICE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRICS 31. 00 03100 INTENSI VE CARE UNIT 40. 00 04000 SUBPROVI DER - I PF 41. 00 04100 SUBPROVI DER - I RF 43. 00 04300 NURSERY	2,906 495,749 349,076 27,212 92,354 0	0 	108 92 101 65	0 0 0 0	0 0 9, 333, 957 0	23.01 30.00 31.00 40.00 41.00 43.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM 51. 00 05100 RECOVERY ROOM 51. 01 05101 ENDOSCOPY 52. 00 05200 DELI VERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C 55. 00 05500 RADI OLOGY-THERAPEUTI C 60. 00 06000 LABORATORY 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 65. 00 06500 RESPI RATORY THERAPY 66. 00 066000 PHYSI CAL THERAPY 69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROCARDI OLOGY 70. 01 07001 NEURODI AGNOSTI CS 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 73. 00 07300 DRUGS CHARGED TO PATI ENTS 75. 00 07500 ASC (NON-DI STI NCT PART) 76. 00 03950 MH ANCI LLA	857, 729 0 635, 443 56, 064 0 832, 891 103, 613 1, 466, 637 0 16, 348 51, 304 236, 181 0 46, 886 6, 724, 882 4, 236, 655 0 486, 903 0 2, 825 0 301 141 467	15, 971 0 633 139 0 496, 679 6, 465 49 0 2, 134 86, 983 1, 547 0 37 0 19, 937, 599 15, 937 0 2, 361 0 0 2, 361				66.00 69.00 70.00 70.01 71.00 72.00 73.00 75.00 76.01 88.00 90.00
90. 01 04950 WOUND CLINIC 91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0THER REI MBURSABLE COST CENTERS 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	141, 467 395, 624 6, 070	17, 446 12, 164	160	0	0	90. 01 91. 00 92. 00 96. 00
101.00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0				101.00
113. 00 11300 NTEREST EXPENSE 116. 00 11600 HOSPI CE 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	14, 424 17, 375, 572	26 20, 614, 835		-		113. 00 116. 00 118. 00
190. 00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 192. 01 19201 FP PETERSBURG 192. 02 19202 PEDI ATRI CS 192. 03 19203 WASHI NGTON PRI MARY CARE 192. 04 19204 FOHC	0 655, 352 1, 951 42, 539 33, 113 0	0 1, 128, 794 4, 956 197, 303 82, 152 0	0 0 0 0	0 0 0 0	0 0 0 0	190. 00 192. 00 192. 01 192. 02 192. 03 192. 04

Health Financi	ial Systems	GOOD SAMARITAN HOSPITAL			In Lieu of Form CMS-2552-10			
COST ALLOCATI	ON - STATISTICAL BASIS		Provi der CCN: 15-0042		Peri od: From 01/01/2023 To 12/31/2023 Uate/Time Prepa 4/11/2024 3:17			
C	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCI AL	MENTAL HEALTH		
		SERVICES &	(COSTED	RECORDS &	SERVI CE	OH		
		SUPPLY	REQUIS.)	LI BRARY	(NET CHARGES)	(NET CHARGES)		
		(SUPPLIES		(TIME SPENT)				
		COST)	15.00	1/ 00	17.00	17.01		
104 0007050 0	COMMUNITY HEALTH SERVICES	14.00 1,306	15.00 384	16.00	17.00	17.01	194.00	
194. 00 07950 C		22, 336	304 2	0	0		194.00	
	IARKETING AND PUBLIC RELATIONS	22, 330	2	0	0		194.01	
	IH RESIDENTIAL	16, 239	0	0	0		194.02	
194. 04 07954 U		10, 237	0	0	0		194.04	
194.0507955 M		0	0	0	0		194.05	
194.0607956 F		0	0	0	0		194.06	
194.0707957 K	NOX COUNTY HEALTH DEPT	0	0	0	0	0	194.07	
194.0807958 I	NDUSTRI AL HEALTH	0	0	0	0	0	194.08	
194.0907959 C	COMMUNITY MENTAL HEALTH CENTER	43, 427	0	0	0	4, 484, 373	194.09	
	BEI RHAUS BUI LDI NG	477	0	0	0	0	194.10	
	Cross Foot Adjustments						200.00	
	legative Cost Centers						201.00	
	Cost to be allocated (per Wkst. B, Part I)	1, 068, 642	5, 041, 869	6, 574, 827	0	992, 312	202.00	
203.00 U	Jnit cost multiplier (Wkst. B, Part I)	0. 058740	0. 228880	8, 097. 077586	0. 000000	0. 071811	203.00	
	Cost to be allocated (per Wkst. B, Part II)	144, 754	236, 065	206, 125	0	98, 199	204.00	
	Jnit cost multiplier (Wkst. B, Part 1)	0. 007957	0. 010716	253. 848522	0. 000000	0. 007106	205.00	
206.00 N	AHE adjustment amount to be allocated (per Wkst. B-2)						206. 00	
207.00 N	IAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00	

	Financial Systems LLOCATION - STATISTICAL BASIS	GOOD SAMARIT			Period: From 01/01/2023	u of Form CMS-2552-1 Worksheet B-1
					To 12/31/2023	Date/Time Prepared: 4/11/2024 3:17 pm
		INTERNS &	RESI DENTS			4/11/2024 3.17 pm
	Cost Center Description	SERVI CES-SALA RY & FRI NGES (ASSI GNED TI ME)	SERVI CES-OTHE R PRGM COSTS (ASSI GNED TI ME)	PARAMED ED PRGM-RADI OLOO Y (ASSI GNED TI ME)	PARAMED ED G PRGM-LAB (ASSI GNED TI ME)	
	CENEDAL CEDVICE COST CENTERS	21.00	22.00	23.00	23.01	
1 00	GENERAL SERVICE COST CENTERS	1				1.0
17.01 21.00 22.00 23.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00401 COMMUNI CATIONS 00402 PURCHASING & RECEIVING 00403 REGISTRATION 00404 PATIENT ACCOUNTS 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01701 MENTAL HEALTH OH 02100 I & R SERVICES-SALARY & FRINGES APPRVD 02200 I & SERVICES-OTHER PRGM COSTS APPRVD 02300 PARAMED ED PRGM-RADIOLOGY	4, 395	4, 395		0	1.0 2.0 4.0 4.0 4.0 4.0 5.0 7.0 8.0 9.0 9.0 10.0 11.0 13.0 14.0 15.0 16.0 17.0 21.0 22.0 23.0 23.0
23.01	02301 PARAMED ED PRGM-LAB I NPATI ENT ROUTI NE SERVI CE COST CENTERS				100	23.0
30.00	03000 ADULTS & PEDI ATRI CS	850			0 0	30.0
31.00 40.00 41.00 43.00	03100 NTENSI VE CARE UNI T 04000 SUBPROVI DER – I PF 04100 SUBPROVI DER – I RF 04300 NURSERY	33 322 0 0	322 0		0 0 0 0 0 0 0 0	31. 0 40. 0 41. 0 43. 0
43.00	ANCI LLARY SERVICE COST CENTERS			<u>'</u>	0 0	40.0
	05000 OPERATING ROOM	C			0 0	50.0
	05100 RECOVERY ROOM	0			0 0	51.0
51.01 52.00	05101 ENDOSCOPY 05200 DELIVERY ROOM & LABOR ROOM	151 0			0 0	51.0 52.0
53.00	05300 ANESTHESI OLOGY	14			0 0	53.0
	05400 RADI OLOGY-DI AGNOSTI C	8			0 0	54.0
	05500 RADI OLOGY-THERAPEUTI C	47	47	,	0 0	55.0
	06000 LABORATORY	C			0 100	60.0
	06300 BLOOD STORING, PROCESSING & TRANS.	C			0 0	63.0
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	38			0 0	65. 0 66. 0
69.00	06900 ELECTROCARDI OLOGY	31			0 0	69.0
70.00	07000 ELECTROENCEPHALOGRAPHY	C	0		0 0	70.0
70. 01	07001 NEURODI AGNOSTI CS	C	0		0 0	70.0
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS		0		0 0	71.0
	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS					72. 0 73. 0
	07500 ASC (NON-DI STI NCT PART)				0 0	75.0
76.00	03950 MH ANCILLARY OUTPATIENT	C	0		0 0	76.0
76.01	03951 I NPATI ENT DI ALYSI S	62	62		0 0	76.0
00.00	OUTPATIENT SERVICE COST CENTERS			J		
90.00	08800 FAMILY PRACTICE 120 09000 CLINIC		0	1		88. 0 90. 0
	04950 WOUND CLINIC		0		0 0	90.0
91.00	09100 EMERGENCY	1, 106	1, 106		0 0	91.0
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)					92.0
	OTHER REIMBURSABLE COST CENTERS	-	-	1	-	
	09600 DURABLE MEDI CAL EQUI P-RENTED	0			0 0	96.0
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	C	0	<u>'</u>	0 0	101.0
113.00	11300 INTEREST EXPENSE					113.0
	11600 HOSPI CE				0 0	116.0
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	2,662	2,662		0 100	118.0
4.0-	NONREI MBURSABLE COST CENTERS	1		1		
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	C 702			0 0	190.0
	19200 PHYSI CLANS' PRI VATE OFFI CES 19201 FP PETERSBURG	703	703			192. 0 192. 0
197 11				1	~U	1172.0

Health Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Lie	u of Form CMS-2	552-10
COST ALLOCATION - STATISTICAL BASIS		Provider C	1	Period: From 01/01/2023 Fo 12/31/2023	Worksheet B-1 Date/Time Prep 4/11/2024 3:17	
	INTERNS &	RESI DENTS				
Cost Center Description	SERVI CES-SALA RY & FRI NGES (ASSI GNED TI ME)	R PRGM COSTS (ASSI GNED TI ME)	PARAMED ED PRGM-RADI OLOG Y (ASSI GNED TI ME)	(ASSI GNED TI ME)		
	21.00	22.00	23.00	23.01		
192. 03 19203 WASHI NGTON PRI MARY CARE 192. 04 19204 FQHC	0	0				192.03 192.04
194. 00 07950 COMMUNI TY HEALTH SERVICES	0			0		194.00
194. 01 07960 CCBHC GRANTS	0			0		194.01
194. 02 07952 MARKETING AND PUBLIC RELATIONS	0	0		0		194.02
194. 03 07953 MH RESIDENTIAL	0	0		0		194.03
194. 04 07954 UNUSED SPACE	0	0		0		194.04
194. 05 07955 MOB	0	0		0		194.05
194. 06 07956 FOUNDATI ON	0	0		0		194.06
194.0707957 KNOX COUNTY HEALTH DEPT	0	0		0		194.07
194. 08 07958 I NDUSTRI AL HEALTH	0	0		0 0		194.08
194.0907959 COMMUNITY MENTAL HEALTH CENTER	1, 030	1, 030		0 0		194.09
194. 10 07951 BEI RHAUS BUI LDI NG	0	0		0 0		194.10
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)	4, 567, 974	4, 143, 541	(391, 168		202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	1, 039. 356997	942. 785210	0. 000000	3, 911. 680000		203.00
204.00 Cost to be allocated (per Wkst. B,	353, 887	48, 499	(3, 231		204.00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part	80. 520364	11. 035040	0.00000	32. 310000		205.00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)			(0 0		206.00
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)			0.00000	0. 000000		207.00

Health Financial Systems		GOOD SAMARITA	AN HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHA	RGES		Provider C		Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Pre 4/11/2024 3:1	pared: 7 pm
			Title	XVIII	Hospi tal	PPS	<u>, bui</u>
					Costs		
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST	CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS		19, 883, 833		19, 883, 83	3 0	19, 883, 833	30.00
31.00 03100 INTENSIVE CARE UNIT		9, 377, 020		9, 377, 02		9, 377, 020	
40. 00 04000 SUBPROVI DER – I PF		6, 827, 931		6, 827, 93		6, 827, 931	
41.00 04100 SUBPROVIDER - IRF		5, 710, 634		5, 710, 63		5, 710, 634	
43.00 04300 NURSERY		1, 547, 358		1, 547, 35		1, 547, 358	
ANCI LLARY SERVICE COST CENTERS	5	., ,		.,		., ,	
50.00 05000 OPERATI NG ROOM		8, 462, 291		8, 462, 29	1 1, 577	8, 463, 868	50.00
51.00 05100 RECOVERY ROOM		0			0 0	0	51.00
51.01 05101 ENDOSCOPY		3, 215, 713		3, 215, 71	3 0	3, 215, 713	•
52.00 05200 DELIVERY ROOM & LABOR RO	OM	922, 685		922, 68		922, 685	
53.00 05300 ANESTHESI OLOGY		1,673,306		1, 673, 30		1,673,306	
54.00 05400 RADI OLOGY-DI AGNOSTI C		13,005,100		13,005,10		13,005,100	•
55.00 05500 RADI OLOGY-THERAPEUTI C		6,026,204		6, 026, 20		6, 046, 851	•
60. 00 06000 LABORATORY		11, 161, 265		11, 161, 26		11, 247, 587	
63.00 06300 BLOOD STORING, PROCESSIN	G & TRANS.	0			0 0	0	
65. 00 06500 RESPI RATORY THERAPY		4, 028, 683	0	4, 028, 68		4, 028, 683	•
66. 00 06600 PHYSI CAL THERAPY		8, 714, 374	0	8, 714, 37		8, 714, 374	
69. 00 06900 ELECTROCARDI OLOGY		6, 631, 646	-	6, 631, 64		6, 632, 495	
70.00 07000 ELECTROENCEPHALOGRAPHY		0		-,,	0 0	0	
70. 01 07001 NEURODI AGNOSTI CS		2,008,189		2, 008, 18	6,738	2,014,927	
71. 00 07100 MEDICAL SUPPLIES CHARGED	TO PATIENTS	4, 970, 593		4, 970, 59		4, 970, 593	
72.00 07200 I MPL. DEV. CHARGED TO PA		5, 408, 690		5, 408, 69		5, 408, 690	
73. 00 07300 DRUGS CHARGED TO PATIENT		27, 378, 324		27, 378, 32		27, 378, 324	
75. 00 07500 ASC (NON-DI STINCT PART)		5, 337, 121		5, 337, 12		5, 344, 157	
76. 00 03950 MH ANCI LLARY OUTPATIENT		0,007,121			0 0	0,011,107	
76. 01 03951 I NPATI ENT DI ALYSI S		782, 439		782, 43		782, 439	
OUTPATIENT SERVICE COST CENTER	25	762, 167		102,10	/	702, 107	70.01
88.00 08800 FAMILY PRACTICE 120		33, 860		33, 86	0 0	33, 860	88.00
90. 00 09000 CLINIC		411, 125		411, 12		411, 125	
90. 01 04950 WOUND CLINIC		1, 711, 002		1, 711, 00		1, 711, 002	
91. 00 09100 EMERGENCY		12, 462, 898		12, 462, 89		12, 494, 272	
92.00 09200 OBSERVATION BEDS (NON-DI	STINCT PART)	4, 138, 541		4, 138, 54		4, 138, 541	
OTHER REIMBURSABLE COST CENTER		1, 100, 011		1, 100, 01	•	1, 100, 011	/2.00
96. 00 09600 DURABLE MEDICAL EQUIP-RE		234, 141		234, 14	1 0	234, 141	96 00
101.00 10100 HOME HEALTH AGENCY		201, 111			0		101.00
SPECIAL PURPOSE COST CENTERS		0		1	-	0	
113. 00 11300 I NTEREST EXPENSE							113.00
116. 00 11600 HOSPI CE		1, 620, 726		1, 620, 72	6	1, 620, 726	
200.00 Subtotal (see instructio	ins)	173, 685, 692	0			173, 840, 235	
201.00 Less Observation Beds	- /	4, 138, 541	0	4, 138, 54		4, 138, 541	
202.00 Total (see instructions)		169, 547, 151	0				
	I			,,			=

Health Financial Systems	GOOD SAMARI TA			In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Pre 4/11/2024 3:1	epared: 7 pm
			e XVIII	Hospi tal	PPS	
Cost Center Description	I npati ent	<u>Charges</u> Outpati ent	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA I npati ent Rati o	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS	T					
30. 00 03000 ADULTS & PEDI ATRI CS	18, 723, 934		18, 723, 93			30.00
31.00 03100 I NTENSI VE CARE UNI T	12, 422, 932		12, 422, 93			31.00
40.00 04000 SUBPROVI DER - I PF	9, 285, 009		9, 285, 00			40.00
41.00 O4100 SUBPROVIDER - IRF	7, 916, 191		7, 916, 19			41.00
43.00 04300 NURSERY	1, 245, 687		1, 245, 68	/		43.00
ANCI LLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM	15 112 024	20,002,007	44 116 64	0 101016	0,000000	50.00
50. 00 05000 0PERATING ROOM 51. 00 05100 RECOVERY ROOM	15, 113, 836	29, 002, 807		3 0. 191816 0 0. 000000	0. 000000 0. 000000	
51. 01 05101 ENDOSCOPY	0 1, 206, 777	0 12, 101, 376			0.000000	
52.00 05200 DELIVERY ROOM & LABOR ROOM	2,031,744	29, 320			0. 000000	
53. 00 05300 ANESTHESI OLOGY	2, 031, 744	5, 991, 032			0.000000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	16, 982, 883	97, 466, 775			0.000000	1
55. 00 05500 RADI OLOGY-THERAPEUTI C	876, 922	26, 574, 258			0.000000	
60. 00 06000 LABORATORY	21, 790, 847	59, 987, 342			0.000000	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	21, 790, 847	59,967,342 0		0. 000000	0.000000	
65. 00 06500 RESPIRATORY THERAPY	8, 600, 839	3, 732, 878			0.000000	
66. 00 06600 PHYSI CAL THERAPY	14, 551, 640	11, 873, 041			0.000000	1
69. 00 06900 ELECTROCARDI OLOGY	15, 513, 561	28, 761, 286			0.000000	
70. 00 07000 ELECTROENCEPHALOGRAPHY	13, 313, 301	20, 701, 200		0. 000000	0. 000000	
70. 01 07001 NEURODI AGNOSTI CS	243, 470	6,075,551			0.000000	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 743, 931	1, 575, 937			0.000000	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	3, 103, 281	9, 669, 772			0. 000000	
73. 00 07300 DRUGS CHARGED TO PATIENTS	16, 614, 831	76, 817, 824			0.000000	
75. 00 07500 ASC (NON-DISTINCT PART)	309, 932	28, 828, 923			0, 000000	
76.00 03950 MH ANCILLARY OUTPATIENT	0	0		0. 000000	0. 000000	
76. 01 03951 I NPATI ENT DI ALYSI S	951, 401	58, 228	1,009,62		0. 000000	1
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 FAMILY PRACTICE 120	833	45, 856	46, 68	9		88.00
90. 00 09000 CLINIC	129	124, 743			0.000000	90.00
90. 01 04950 WOUND CLINIC	66, 558	5, 304, 331	5, 370, 88	9 0. 318570	0.000000	90.01
91.00 09100 EMERGENCY	11, 659, 417	45, 880, 103	57, 539, 52	0 0. 216597	0. 000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	4, 394, 991	8, 909, 073	13, 304, 06	4 0. 311073	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS						
96.00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	455, 308	455, 30	8 0. 514247	0. 000000	96.00
101.00 10100 HOME HEALTH AGENCY	0	0		0		101.00
SPECIAL PURPOSE COST CENTERS						
113.0011300 INTEREST EXPENSE						113.00
116. 00 11600 HOSPI CE	0	1, 644, 072				116.00
200.00 Subtotal (see instructions)	187, 548, 691	460, 909, 836	648, 458, 52	7		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	187, 548, 691	460, 909, 836	648, 458, 52	7		202.00

Health Financial Systems	GOOD SAMARI TAN	N HOSPI TAL	In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0042	Peri od:	Worksheet C	
			From 01/01/2023	Part I	
			To 12/31/2023	Date/Time Pre 4/11/2024 3:1	
		Title XVIII	Hospi tal	47 117 2024 S. 1 PPS	7 piii
Cost Center Description	PPS Inpatient			110	
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
31.00 03100 INTENSIVE CARE UNIT					31.00
40. 00 04000 SUBPROVI DER – I PF					40.00
41. 00 04100 SUBPROVI DER – I RF					41.00
43.00 04300 NURSERY					43.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATI NG ROOM	0. 191852				50.00
51.00 05100 RECOVERY ROOM	0. 000000				51.00
51.01 05101 ENDOSCOPY	0. 241635				51.01
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 447674				52.00
53.00 05300 ANESTHESI OLOGY	0. 204357				53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 113632				54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 220277				55.00
60. 00 06000 LABORATORY	0. 137538				60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000				63.00
65. 00 06500 RESPI RATORY THERAPY	0. 326640				65.00
66.00 06600 PHYSI CAL THERAPY	0. 329782				66.00
69. 00 06900 ELECTROCARDI OLOGY	0. 149803				69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000				70.00
70. 01 07001 NEURODI AGNOSTI CS	0. 318867				70.01
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT					71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 423445				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 293027				73.00
75. 00 07500 ASC (NON-DI STINCT PART)	0. 183403				75.00
76. 00 03950 MH ANCI LLARY OUTPATIENT	0. 000000				76.00
76. 01 03951 I NPATI ENT DI ALYSI S	0. 774977				76.01
OUTPATIENT SERVICE COST CENTERS	0.774777				70.01
88. 00 08800 FAMILY PRACTICE 120					88.00
90. 00 09000 CLINIC	3. 292371				90.00
90. 01 04950 WOUND CLINIC	0. 318570				90.01
91. 00 09100 EMERGENCY	0. 217142				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS					12.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0. 514247				96.00
101.00 10100 HOME HEALTH AGENCY	0.017247				101.00
SPECIAL PURPOSE COST CENTERS					1 3 1. 00
113. 00 11300 I NTEREST EXPENSE					113.00
116. 00 11600 HOSPI CE					116.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					200.00
202.00 Total (see instructions)					201.00
	I I				1202.00

Health Financial Systems COMPUTATION OF RATIO OF COSTS TO CHARGES		GOOD SAMARITA	Provi der C	°N· 15_0042	Peri od:	2552-10	
COMPUTATION	OF RATIO OF COSTS TO CHARGES		Provider C	CN. 15-0042	From 01/01/2023	Worksheet C Part I	
					To 12/31/2023	Date/Time Pre	pared:
						4/11/2024 3:1	7 pm
			111	e XIX	<u>Hospi tal</u> Costs	Cost	
	Cost Center Description	Total Cost	Therapy Limit	Total Costs		Total Costs	
	cost center bescription	(from Wkst.	Adj.		Di sal I owance	10121 00313	
		B, Part I,	, ag i		bi our ronarioo		
		col. 26)					
		1.00	2.00	3.00	4.00	5.00	
	ENT ROUTINE SERVICE COST CENTERS						
	ADULTS & PEDIATRICS	19, 883, 833		19, 883, 83		19, 883, 833	
	INTENSIVE CARE UNIT	9, 377, 020		9, 377, 02		9, 377, 020	
	SUBPROVIDER - IPF	6, 827, 931		6, 827, 93		6, 827, 931	
	SUBPROVIDER - IRF	5, 710, 634		5, 710, 63		5, 710, 634	
	NURSERY	1, 547, 358		1, 547, 35	58 0	1, 547, 358	43.00
	LARY SERVICE COST CENTERS	0.1/0.001		0.110.00	4 577		
	OPERATING ROOM	8, 462, 291		8, 462, 29		8, 463, 868	
	RECOVERY ROOM ENDOSCOPY	0		2 215 71	0 0	0	
		3, 215, 713		3, 215, 71		3, 215, 713	
	DELIVERY ROOM & LABOR ROOM ANESTHESIOLOGY	922, 685 1, 673, 306		922, 68 1, 673, 30		922, 685 1, 673, 306	•
	RADI OLOGY-DI AGNOSTI C	13, 005, 100		13, 005, 10		13, 005, 100	
	RADI OLOGY-THERAPEUTI C	6, 026, 204		6, 026, 20		6, 046, 851	
	LABORATORY	11, 161, 265		11, 161, 26		11, 247, 587	
	BLOOD STORING, PROCESSING & TRANS.	0		11,101,20	0 0	0	•
	RESPI RATORY THERAPY	4, 028, 683	0	4, 028, 68		4, 028, 683	•
	PHYSI CAL THERAPY	8, 714, 374	0	8, 714, 37		8, 714, 374	•
	ELECTROCARDI OLOGY	6, 631, 646	-	6, 631, 64		6, 632, 495	•
70.00 07000	ELECTROENCEPHALOGRAPHY	0			0 0	0	70.00
70.01 07001	NEURODI AGNOSTI CS	2,008,189		2, 008, 18	6, 738	2, 014, 927	70.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4, 970, 593		4, 970, 59	93 0	4, 970, 593	71.00
	IMPL. DEV. CHARGED TO PATIENTS	5, 408, 690		5, 408, 69	90 0	5, 408, 690	
	DRUGS CHARGED TO PATIENTS	27, 378, 324		27, 378, 32		27, 378, 324	
	ASC (NON-DISTINCT PART)	5, 337, 121		5, 337, 12	21 7, 036	5, 344, 157	
	MH ANCILLARY OUTPATIENT	0			0 0	0	
	INPATIENT DIALYSIS	782, 439		782, 43	39 0	782, 439	76.01
	FIENT SERVICE COST CENTERS	00.040					
	FAMILY PRACTICE 120	33, 860		33, 86		33, 860	
		411, 125		411, 12		411, 125	
	WOUND CLINIC EMERGENCY	1, 711, 002 12, 462, 898		1, 711, 00		1, 711, 002 12, 494, 272	•
	OBSERVATION BEDS (NON-DISTINCT PART)	4, 138, 541		12, 462, 89 4, 138, 54		4, 138, 541	•
	REIMBURSABLE COST CENTERS	4, 130, 341		4, 130, 34	+ 1	4, 130, 341	92.00
	DURABLE MEDICAL EQUIP-RENTED	234, 141		234, 14	1 0	234, 141	96.00
	HOME HEALTH AGENCY	0		204,14	0		101.00
	AL PURPOSE COST CENTERS						101100
	INTEREST EXPENSE						113.00
116.0011600		1, 620, 726		1, 620, 72	26	1, 620, 726	
	Subtotal (see instructions)	173, 685, 692	0			173, 840, 235	
							001 00
	Less Observation Beds	4, 138, 541		4, 138, 54	11	4, 138, 541	201.00

COMPUTATI O	N OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2023	Worksheet C Part I	
					To 12/31/2023	Date/Time Pre 4/11/2024 3:1	epared: 7 pm
	,			e XIX	Hospi tal	Cost	1
	Cost Center Description	I npati ent	Charges Outpatient	Total (col d	6 Cost or Other	TEFRA	
	bost benter beschiption	inpatrent	outputtent	+ col. 7)	Ratio	Inpatient	
						Rati o	
	THENT DOUTINE CEDULAE AACT ACHTERC	6.00	7.00	8.00	9.00	10.00	
	ATIENT ROUTINE SERVICE COST CENTERS	18, 723, 934		18, 723, 93	4		30.00
	DO INTENSIVE CARE UNIT						30.00
	DO SUBPROVI DER – I PF	12, 422, 932 9, 285, 009		12, 422, 93 9, 285, 00			40.00
	DO SUBPROVIDER - IRF	7, 916, 191		7, 916, 19			40.00
	DO NURSERY	1, 245, 687		1, 245, 68			41.00
	LLARY SERVICE COST CENTERS	1, 245, 007		1, 245, 00	/		43.00
	DO OPERATING ROOM	15, 113, 836	29,002,807	44, 116, 64	3 0. 191816	0.000000	50.00
	DO RECOVERY ROOM	0	0		0, 000000	0.000000	
	D1 ENDOSCOPY	1, 206, 777	12, 101, 376	13, 308, 15		0.000000	
	DO DELIVERY ROOM & LABOR ROOM	2,031,744	29, 320			0.000000	
53.00 0530	DO ANESTHESI OLOGY	2, 197, 115	5, 991, 032			0.000000	
	DO RADI OLOGY-DI AGNOSTI C	16, 982, 883	97, 466, 775			0.000000	
	DO RADI OLOGY-THERAPEUTI C	876, 922	26, 574, 258			0,000000	
60.00 0600	DO LABORATORY	21, 790, 847	59, 987, 342			0.000000	60.00
3.00 0630	DO BLOOD STORING, PROCESSING & TRANS.	0	0		0 0. 000000	0.000000	63.00
	DO RESPIRATORY THERAPY	8, 600, 839	3, 732, 878	12, 333, 71	7 0. 326640	0.000000	65.00
6. 00 0660	DO PHYSI CAL THERAPY	14, 551, 640	11, 873, 041	26, 424, 68	1 0. 329782	0.000000	66.00
69.00 0690	DO ELECTROCARDI OLOGY	15, 513, 561	28, 761, 286	44, 274, 84	7 0. 149784	0.000000	69.00
70.00 0700	DO ELECTROENCEPHALOGRAPHY	0	0		0 0. 000000	0.000000	70.00
70.01 0700	D1 NEURODI AGNOSTI CS	243, 470	6, 075, 551	6, 319, 02	0. 317801	0.000000	70.01
1.00 0710	DO MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 743, 931	1, 575, 937	3, 319, 86	8 1. 497226	0.000000	71.00
72.00 0720	DO IMPL. DEV. CHARGED TO PATIENTS	3, 103, 281	9, 669, 772	12, 773, 05	3 0. 423445	0.000000	72.00
	DO DRUGS CHARGED TO PATIENTS	16, 614, 831	76, 817, 824	93, 432, 65	5 0. 293027	0.00000	73.00
	DO ASC (NON-DISTINCT PART)	309, 932	28, 828, 923	29, 138, 85		0.00000	
	50 MH ANCILLARY OUTPATIENT	0	0		0 0. 000000	0.000000	
	51 I NPATI ENT DI ALYSI S	951, 401	58, 228	1, 009, 62	9 0. 774977	0.00000	76.01
	PATIENT SERVICE COST CENTERS						
	DO FAMILY PRACTICE 120	833	45, 856			0.000000	
		129	124, 743			0.000000	
	50 WOUND CLINIC	66, 558	5, 304, 331			0.000000	
	DO EMERGENCY	11, 659, 417	45, 880, 103			0.000000	
	DO OBSERVATION BEDS (NON-DISTINCT PART) ER REIMBURSABLE COST CENTERS	4, 394, 991	8, 909, 073	13, 304, 06	4 0. 311073	0. 000000	92.00
	DO DURABLE MEDICAL EQUIP-RENTED	0	455, 308	455, 30	8 0. 514247	0. 000000	96.00
	DO HOME HEALTH AGENCY	0	455, 506		0.514247	0.000000	101.00
	CIAL PURPOSE COST CENTERS	0	0	I			101.00
	DO INTEREST EXPENSE						113.00
	DO HOSPI CE	0	1, 644, 072	1, 644, 07	2		116.00
200.00	Subtotal (see instructions)	187, 548, 691	460, 909, 836				200.00
201.00	Less Observation Beds	107, 040, 071	100, 707, 000	010, 400, 02	·		200.00
		1		1	1		

Health Financial Systems	GOOD SAMARI TAN	HOSPI TAL	In Lieu	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0042	Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Pre 4/11/2024 3:1	
		Title XIX	Hospi tal	Cost	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
31.00 03100 INTENSIVE CARE UNIT					31.00
40. 00 04000 SUBPROVIDER - IPF					40.00
41. 00 04100 SUBPROVI DER – I RF					41.00
43. 00 04300 NURSERY					43.00
ANCI LLARY SERVICE COST CENTERS					+5.00
50. 00 05000 OPERATING ROOM	0. 000000				50.00
51. 00 05100 RECOVERY ROOM	0. 000000				51.00
51. 01 05101 ENDOSCOPY	0. 000000				51.01
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52.00
53.00 05300 ANESTHESI OLOGY	0. 000000				53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000				55.00
60. 00 06000 LABORATORY	0. 000000				60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000				63.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000				66.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000				69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 000000				70.00
70. 01 07001 NEURODI AGNOSTI CS	0. 000000				70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
75. 00 07500 ASC (NON-DI STI NCT PART)	0. 000000				
					75.00
76. 00 03950 MH ANCI LLARY OUTPATI ENT	0. 000000				76.00
76.01 03951 I NPATI ENT DI ALYSI S	0. 000000				76.01
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 FAMILY PRACTICE 120	0. 000000				88.00
90. 00 09000 CLINIC	0. 000000				90.00
90. 01 04950 WOUND CLINIC	0. 000000				90.01
91. 00 09100 EMERGENCY	0. 000000				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000				92.00
OTHER REIMBURSABLE COST CENTERS					
96.00 09600 DURABLE MEDI CAL EQUI P-RENTED	0. 000000				96.00
101.00 10100 HOME HEALTH AGENCY					101.00
SPECIAL PURPOSE COST CENTERS					1
113. 00 11300 I NTEREST EXPENSE					1113.00
116. 00 11600 HOSPI CE					116.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					200.00
202.00 Total (see instructions)					201.00
	1				1202.00

Health Financial Systems	GOOD SAMARI TA	AN HOSPITAL		In Lieu of Form CMS-2552-10			
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CA	PITAL COSTS	Provider C		Period: From 01/01/2023 Fo 12/31/2023		epared: 7 pm	
		Title	XVIII	Hospi tal	PPS		
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem		
	Related Cost	Adjustment	Capi tal	Days	(col. 3 /		
	(from Wkst.		Related Cost		col. 4)		
	B, Part II,		(col. 1 -				
	col. 26)		col. 2)				
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30. 00 ADULTS & PEDIATRICS	1, 873, 820	0	1, 873, 820	12, 266	152.77	30.00	
31.00 INTENSIVE CARE UNIT	863, 028		863, 028	3 4, 812	179.35	31.00	
40.00 SUBPROVIDER - IPF	607, 479	0	607, 479	9 4, 323	140. 52	40.00	
41.00 SUBPROVIDER - IRF	694, 440	0	694, 440	0 6, 252	111.07	41.00	
43.00 NURSERY	391, 989		391, 989	9 816	480.38	43.00	
200.00 Total (lines 30 through 199)	4, 430, 756		4, 430, 756	5 28, 469		200.00	
Cost Center Description	I npati ent	I npati ent					
	Program days	Program					
		Capital Cost					
		(col. 5 x					
		col. 6)					
	6.00	7.00					
INPATIENT ROUTINE SERVICE COST CENTERS							
30. 00 ADULTS & PEDIATRICS	4, 497		1			30.00	
31.00 INTENSIVE CARE UNIT	1, 988	356, 548	6			31.00	
40. 00 SUBPROVIDER - IPF	532	74, 757				40.00	
41.00 SUBPROVIDER - IRF	4, 578	508, 478				41.00	
43.00 NURSERY	0	0				43.00	
200.00 Total (lines 30 through 199)	11, 595	1, 626, 790				200.00	

Health Financial Systems	GOOD SAMARITAN HOSPITAL In Lieu of Form						
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT.	AL COSTS	Provider C		Period: From 01/01/2023 To 12/31/2023		pared: 7 pm	
			XVIII	Hospi tal	PPS		
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs		
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x		
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)		
	B, Part II,	col. 8)	col. 2)				
	col. 26)						
	1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATI NG ROOM	922, 572					50.00	
51.00 05100 RECOVERY ROOM	0	-	0. 00000		0	51.00	
51.01 05101 ENDOSCOPY	456, 892				14, 681		
52.00 05200 DELIVERY ROOM & LABOR ROOM	237, 511				584		
53. 00 05300 ANESTHESI OLOGY	16, 533				0	53.00	
54.00 05400 RADI OLOGY-DI AGNOSTI C	884, 087	114, 449, 658	0.00772	7, 593, 466	58, 660		
55. 00 05500 RADI OLOGY-THERAPEUTI C	665, 183	27, 451, 180			808	55.00	
60. 00 06000 LABORATORY	374, 483	81, 778, 189			40, 042		
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.00000		0	63.00	
65. 00 06500 RESPI RATORY THERAPY	225, 496	12, 333, 717	0. 01828	2, 613, 422	47, 781	65.00	
66. 00 06600 PHYSI CAL THERAPY	1, 034, 194	26, 424, 681	0. 03913	2, 812, 793	110, 084	66.00	
69.00 06900 ELECTROCARDI OLOGY	682, 587	44, 274, 847	0. 01541	7 7, 096, 121	109, 401	69.00	
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0. 00000	0 0	0	70.00	
70. 01 07001 NEURODI AGNOSTI CS	275, 711	6, 319, 021	0. 04363	34, 184	1, 492	70.01	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	164, 799	3, 319, 868	0. 04964	0 739, 555	36, 712	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	119, 154	12, 773, 053	0. 00932	1, 596, 093	14, 890	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	361, 735	93, 432, 655	0. 00387	2 5, 616, 702	21, 748	73.00	
75.00 07500 ASC (NON-DISTINCT PART)	134, 172	29, 138, 855	0. 00460	05 212	1	75.00	
76.00 03950 MH ANCILLARY OUTPATIENT	0	0	0. 00000	0 0	0	76.00	
76. 01 03951 I NPATI ENT DI ALYSI S	286, 068	1, 009, 629	0. 28334	409, 165	115, 933	76.01	
OUTPATIENT SERVICE COST CENTERS			•			1	
88.00 08800 FAMILY PRACTICE 120	204	46, 689	0. 00436	9 0	0	88.00	
90. 00 09000 CLINIC	80, 581	124, 872	0. 64530	09 0	0	90.00	
90.01 04950 WOUND CLINIC	122, 945	5, 370, 889	0. 02289	7, 783	178	90.01	
91.00 09100 EMERGENCY	1,009,640	57, 539, 520	0. 01754	4, 485, 503	78, 707	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	390, 008	13, 304, 064	0. 02931	5 2,003,004	58, 718	92.00	
OTHER REIMBURSABLE COST CENTERS				•		1	
96.00 09600 DURABLE MEDI CAL EQUI P-RENTED	14, 888	455, 308	0. 03269	09 0	0	96.00	
200.00 Total (lines 50 through 199)	8, 459, 443	597, 220, 702		50, 043, 229	832, 221	200.00	

Health Financial Systems	GOOD SAMARI TA	AN HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER P	ASS THROUGH COS			Period: From 01/01/2023 To 12/31/2023	Date/Time Pre 4/11/2024 3:1	
			e XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng		h Allied Health	All Other	
	Program	Program	Post-Stepdow		Medi cal	
	Post-Stepdown		Adj ustments		Educati on	
	Adjustments				Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						-
30. 00 03000 ADULTS & PEDI ATRI CS	0	C		0 0	0	
31.00 03100 INTENSIVE CARE UNIT	0	C		0 0	0	
40. 00 04000 SUBPROVI DER – I PF	0	C		0 0	0	
41.00 04100 SUBPROVIDER – IRF	0	C		0 0	0	
43. 00 04300 NURSERY	0	C		0 0	0	1 101 00
200.00 Total (lines 30 through 199)	0	C)	0 0		200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patien		I npati ent	
	Adjustment	(sum of cols.	Days	(col. 5 ÷	Program Days	
	Amount (see	1 through 3,		col. 6)		
		minus col. 4)				
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS				- (-
30. 00 03000 ADULTS & PEDI ATRI CS	0	C	1 12,20		4, 497	
31.00 03100 INTENSIVE CARE UNIT		C	4,81		1, 988	
40. 00 04000 SUBPROVI DER – I PF	0	C	4, 32		532	
41.00 04100 SUBPROVI DER – I RF	0	C	6, 25		4, 578	
43. 00 04300 NURSERY		C	81		0	
200.00 Total (lines 30 through 199)		C	28, 46	o9	11, 595	200.00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7					
	x col. 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS	-					_
30. 00 03000 ADULTS & PEDI ATRI CS	0					30.00
31.00 03100 INTENSIVE CARE UNIT	0					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	0					43.00
200.00 Total (lines 30 through 199)	0					200.00

Health Financial Systems	GOOD SAMARITA	In Lie	u of Form CMS-:	2552-10			
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SET THROUGH COSTS	RVICE OTHER PAS			То	n 01/01/2023 12/31/2023	4/11/2024 3:1	pared: 7 pm
		Title	XVIII		Hospi tal	PPS	
Cost Center Description	Non Physician	Nursi ng	Nursi ng			Allied Health	
	Anesthetist	Program	Program	Po	st-Stepdown		
	Cost	Post-Stepdown		A	djustments		
		Adjustments			-		
	1.00	2A	2.00		3A	3.00	
ANCILLARY SERVICE COST CENTERS							
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	391, 168	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0	0	63.00
65.00 06500 RESPI RATORY THERAPY	0	0		0	0	0	65.00
66.00 06600 PHYSI CAL THERAPY	0	0		0	0	0	66.00
69.00 06900 ELECTROCARDI OLOGY	0	0		0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	0	70.00
70. 01 07001 NEURODI AGNOSTI CS	0	0		0	o	0	70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	o	0	73.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0		0	0	0	75.00
76.00 03950 MH ANCI LLARY OUTPATI ENT	0	0		0	0	0	76.00
76. 01 03951 I NPATI ENT DI ALYSI S	0	0)	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS		`					
88.00 08800 FAMILY PRACTICE 120	0	0		0	0	0	88.00
90. 00 09000 CLINIC	0	0		0	o	0	90.00
90. 01 04950 WOUND CLINIC	0	0		0	o	0	90.01
91.00 09100 EMERGENCY	0	0		0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0		0	92.00
OTHER REIMBURSABLE COST CENTERS				- 1		-	
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	0		0	0	0	96.00
200.00 Total (lines 50 through 199)	0	-		0	Ō		
				'	- 1		•

Health Financial Systems	GOOD SAMARI TA	AN HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEA THROUGH COSTS	RVICE OTHER PAS	S Provider C		Period: From 01/01/2023 To 12/31/2023	Date/Time Pre	pared:
		Title	XVIII	Hospi tal	4/11/2024 3:1 PPS	7 pm
Cost Center Description	All Other	Total Cost	Total	Total Charges		
cost center bescription	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Education	1, 2, 3, and	Cost (sum of	•	(col. 5 ÷	
	Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
	0051		and 4)	001.0)	(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATI NG ROOM	0	0		0 44, 116, 643	0.00000	50.00
51.00 05100 RECOVERY ROOM	0	0		0 0	0.000000	51.00
51.01 05101 ENDOSCOPY	0	0		0 13, 308, 153	0.000000	51.01
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 2,061,064	0. 000000	52.00
53.00 05300 ANESTHESI OLOGY	0	0		0 8, 188, 147	0. 000000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 114, 449, 658	0. 000000	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 27, 451, 180	0. 000000	55.00
60. 00 06000 LABORATORY	0	391, 168	391, 16	81, 778, 189	0.004783	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0.000000	63.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 12, 333, 717	0.000000	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 26, 424, 681	0.000000	66.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 44, 274, 847	0.000000	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	1	0 0	0. 000000	70.00
70. 01 07001 NEURODI AGNOSTI CS	0	0	1	0 6, 319, 021	0. 000000	70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1	0 3, 319, 868	0. 000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 12, 773, 053	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 93, 432, 655	0.000000	73.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0		0 29, 138, 855	0.000000	75.00
76.00 03950 MH ANCILLARY OUTPATIENT	0	0		0 0	0.00000	76.00
76. 01 03951 I NPATI ENT DI ALYSI S	0	0		0 1,009,629	0.00000	76.01
OUTPATIENT SERVICE COST CENTERS		-	-			
88.00 08800 FAMILY PRACTICE 120	0	0		0 46, 689		
90. 00 09000 CLINIC	0	0		0 124, 872	0.000000	
90. 01 04950 WOUND CLINIC	0	0		0 5, 370, 889		
91.00 09100 EMERGENCY	0	-		0 57, 539, 520		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 13, 304, 064	0. 000000	92.00
OTHER REIMBURSABLE COST CENTERS	1					
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0			0 455, 308		
200.00 Total (lines 50 through 199)	0	391, 168	391, 16	58 597, 220, 702		200.00

Health Financial Systems	GOOD SAMARI TAN	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVICE OTHER PASS			Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV	pared:
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Outpati ent	Inpati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷		Costs (col.	8	Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 000000	5, 824, 453		0 9, 089, 991	0	50.00
51.00 05100 RECOVERY ROOM	0. 000000	0		0 0	0	51.00
51. 01 05101 ENDOSCOPY	0. 000000	427, 611		0 3, 692, 702	0	51.01
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	5,064		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	7, 593, 466		0 30, 950, 516	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	33, 326		0 13, 180, 466	0	55.00
60. 00 06000 LABORATORY	0. 004783	8, 744, 772	41, 82	7, 190, 947	34, 394	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0 0	0	63.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	2, 613, 422		0 1, 277, 294	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	2, 812, 793		0 689, 105	0	66.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	7, 096, 121		0 12, 432, 256	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0 0	0	70.00
70. 01 07001 NEURODI AGNOSTI CS	0. 000000	34, 184		0 1, 724, 693	0	70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	739, 555		0 673, 163	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	1, 596, 093		0 3, 782, 807	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.000000	5, 616, 702		0 38, 487, 586	0	73.00
75.00 07500 ASC (NON-DISTINCT PART)	0.000000	212		0 8, 134, 770	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	409, 165		0 14, 215	0	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 FAMILY PRACTICE 120	0.000000	0		0 0	0	88.00
90. 00 09000 CLINIC	0. 000000	0		0 2,334	0	90.00
90. 01 04950 WOUND CLINIC	0. 000000	7, 783		0 2,070,088	0	90.01
91. 00 09100 EMERGENCY	0. 000000	4, 485, 503		0 8, 863, 784	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	2,003,004		0 1, 565, 489		92.00
OTHER REIMBURSABLE COST CENTERS		, ,	L	, , , , , , , , , , , , , , , , , , , ,		
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0. 000000	0		0 0	0	96.00
200.00 Total (lines 50 through 199)		50,043,229	41, 82	143, 822, 206	34, 394	

Health Financial Systems	GOOD SAMARI TA				u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provider C	CN: 15-0042	Period: From 01/01/2023 To 12/31/2023		pared: 7 pm
		Title	e XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	Charge Ratio	Reimbursed	Reimbursed	Reimbursed	(see inst.)	
	From	Services (see		Services Not		
	Worksheet C,	inst.)	Subject To	Subject To		
	Part I, col.		Ded. & Coins			
	9		(see inst.)			
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS			1	-		
50. 00 05000 OPERATI NG ROOM	0. 191816			0 0	1, 743, 606	•
51.00 05100 RECOVERY ROOM	0. 000000			0 0	0	
51.01 05101 ENDOSCOPY	0. 241635			0 0	892, 286	1
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 447674			0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 204357			0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 113632			0 0	3, 516, 969	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 219524			0 0	2, 893, 429	
60. 00 06000 LABORATORY	0. 136482			0 0	981, 435	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000			0 0	0	
65. 00 06500 RESPI RATORY THERAPY	0. 326640			0 0	417, 215	
66. 00 06600 PHYSI CAL THERAPY	0. 329782			0 0	227, 254	66.00
69. 00 06900 ELECTROCARDI OLOGY	0. 149784			0 0	1, 862, 153	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			0 0	0	70.00
70. 01 07001 NEURODI AGNOSTI CS	0. 317801	1, 724, 693		0 0	548, 109	•
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1. 497226			0 0	1, 007, 877	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 423445			0 0	1, 601, 811	
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 293027	38, 487, 586		0 10, 864	11, 277, 902	73.00
75.00 07500 ASC (NON-DISTINCT PART)	0. 183162	8, 134, 770		0 0	1, 489, 981	75.00
76.00 03950 MH ANCILLARY OUTPATIENT	0. 000000			0 0	0	76.00
76. 01 03951 I NPATI ENT DI ALYSI S	0. 774977	14, 215		0 0	11, 016	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 FAMILY PRACTICE 120						88.00
90. 00 09000 CLINIC	3. 292371	2, 334		0 0	7,684	90.00
90. 01 04950 WOUND CLINIC	0. 318570			0 0	659, 468	90.01
91. 00 09100 EMERGENCY	0. 216597			0 163	1, 919, 869	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 311073	1, 565, 489		0 0	486, 981	92.00
OTHER REIMBURSABLE COST CENTERS		-				
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0. 514247	0		0 0	0	
200.00 Subtotal (see instructions)		143, 822, 206		0 11,027	31, 545, 045	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		143, 822, 206	1	0 11,027	31, 545, 045	202.00

Heal th Fi	inancial Systems	GOOD SAMARITA	N HOSPI TAL		In Lieu	u of Form CMS-	-2552-10
APPORTI O	DNMENT OF MEDICAL, OTHER HEALTH SERVICES ANI	D VACCINE COST	Provider C		Peri od: From 01/01/2023 To 12/31/2023	Worksheet D Part V Date/Time Pr 4/11/2024 3:	epared: 17 pm
			Title	XVIII	Hospi tal	PPS	
		Cos	ts				
	Cost Center Description	Cost	Cost				
		Reimbursed	Reimbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.					
		(see inst.)	(see inst.)				
		6.00	7.00				
	NCILLARY SERVICE COST CENTERS						
	5000 OPERATING ROOM	0	0				50.00
51.00 05	5100 RECOVERY ROOM	0	0				51.00
51.01 05	5101 ENDOSCOPY	0	0				51.01
52.00 05	5200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
53.00 05	5300 ANESTHESI OLOGY	0	0				53.00
54.00 05	5400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
55.00 05	5500 RADI OLOGY-THERAPEUTI C	0	0				55.00
60.00 06	6000 LABORATORY	0	0				60,00
	6300 BLOOD STORING, PROCESSING & TRANS.	0	0				63.00
	6500 RESPIRATORY THERAPY	0	0				65.00
	6600 PHYSI CAL THERAPY	0	0				66.00
	6900 ELECTROCARDI OLOGY	0	0				69.00
	7000 ELECTROENCEPHALOGRAPHY	0	0				70.00
	7001 NEURODI AGNOSTI CS	0	0				70.01
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
	7200 I MPL. DEV. CHARGED TO PATIENTS	0	0				72.00
	7300 DRUGS CHARGED TO PATIENTS	0	3, 183				73.00
	7500 ASC (NON-DI STINCT PART)	0	3, 103	1			75.00
	3950 MH ANCI LLARY OUTPATIENT	0	0				76.00
	3951 I NPATI ENT DI ALYSI S	0	0				76.01
	JTPATIENT SERVICE COST CENTERS	0	0	1			/0.01
	B800 FAMILY PRACTICE 120			1			88.00
	9000 CLINIC	0	0				90.00
	4950 WOUND CLINIC	0	0				90.00
	9100 EMERGENCY	0	35				90.01
		0	35	1			91.00
	9200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
	9600 DURABLE MEDI CAL EQUI P-RENTED	0	0				96.00
200.00	Subtotal (see instructions)	0	3, 218				200.00
201.00	Less PBP Clinic Lab. Services-Program	0					201.00
	Only Charges Net Charges (line 200 - line 201)		0.010				
202.00		0	3, 218	1			202.00

Health Financial Systems	GOOD SAMARI TA	AN HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS		CCN: 15-S042	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part II Date/Time Pre 4/11/2024 3:1	pared: 7 pm
			e XVIII	Subprovider -	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)			
	col. 26)					
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS	1	1	1			
50.00 05000 OPERATI NG ROOM	922, 572				265	
51.00 05100 RECOVERY ROOM	0		0.00000		0	51.00
51.01 05101 ENDOSCOPY	456, 892				0	51.01
52.00 05200 DELIVERY ROOM & LABOR ROOM	237, 511				0	52.00
53. 00 05300 ANESTHESI OLOGY	16, 533				0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	884, 087	114, 449, 658			125	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	665, 183	27, 451, 180	0. 02423	31 0	0	55.00
60. 00 06000 LABORATORY	374, 483	81, 778, 189			632	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.0000	0 0	0	63.00
65. 00 06500 RESPI RATORY THERAPY	225, 496	12, 333, 717	0. 01828	33 25, 379	464	65.00
66. 00 06600 PHYSI CAL THERAPY	1,034,194	26, 424, 681	0. 03913	37 7, 373	289	66.00
69. 00 06900 ELECTROCARDI OLOGY	682, 587	44, 274, 847	0. 01541	7 11, 463	177	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0.0000	0 0	0	70.00
70. 01 07001 NEURODI AGNOSTI CS	275, 711	6, 319, 021	0. 04363	32 4, 127	180	70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	164, 799	3, 319, 868	0. 04964	1, 845	92	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	119, 154	12, 773, 053	0. 00932	29 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	361, 735	93, 432, 655	0.00387	90, 869	352	73.00
75.00 07500 ASC (NON-DISTINCT PART)	134, 172	29, 138, 855	0.00460	05 0	0	75.00
76.00 03950 MH ANCILLARY OUTPATIENT	0	0	0.0000	0 0	0	76.00
76.01 03951 INPATIENT DIALYSIS	286, 068	1,009,629	0. 28334	0 0	0	76.01
OUTPATIENT SERVICE COST CENTERS	· · ·					
88.00 08800 FAMILY PRACTICE 120	204	46, 689	0.00436	09 0	0	88.00
90. 00 09000 CLINIC	80, 581	124, 872	0. 64530)9 0	0	90.00
90. 01 04950 WOUND CLINIC	122, 945				0	90.01
91. 00 09100 EMERGENCY	1,009,640				2,967	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0				0	92.00
OTHER REIMBURSABLE COST CENTERS	ı — — — — — — — — — — — — — — — — — — —					
96.00 09600 DURABLE MEDI CAL EQUI P-RENTED	14, 888	455, 308	0.03269	09 0	0	96.00
200.00 Total (lines 50 through 199)	8,069,435			476, 859	5, 543	200.00

Health Financial Systems	GOOD SAMARI TA	AN HOSPITAL		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PAS	S Provider C	CN: 15-0042	Peri od:	Worksheet D	
THROUGH COSTS			001 45 0040	From 01/01/2023		
		Component	CCN: 15-S042	To 12/31/2023	B Date/Time Pre 4/11/2024 3:1	
		Title	e XVIII	Subprovider -	PPS	
				I PF		
Cost Center Description	Non Physician		Nursi ng		Allied Health	
	Anestheti st	Program	Program	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
	1.00	Adjustments 2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS	1.00	ZA	2.00	3A	3.00	
50. 00 05000 OPERATI NG ROOM	0	0		0 (0	50.00
51. 00 05100 RECOVERY ROOM	0			0		51.00
51. 01 05101 ENDOSCOPY	0			0 0		51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0			0		52.00
53. 00 05300 ANESTHESI OLOGY	0			0 0		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0			0 0		54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 0		55.00
60. 00 06000 LABORATORY	0	0		0	391, 168	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0		63.00
65. 00 06500 RESPI RATORY THERAPY	0	0)	0 0	0	65.00
66.00 06600 PHYSI CAL THERAPY	0	0		0 (ol o	66.00
69.00 06900 ELECTROCARDI OLOGY	0	0)	0 (0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 (o o	70.00
70. 01 07001 NEURODI AGNOSTI CS	0	0)	0 (0 0	70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0)	0 (0 0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 (0 0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0 0	73.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0		0 (0 0	75.00
76.00 03950 MH ANCILLARY OUTPATIENT	0	0		0 (0 0	76.00
76. 01 03951 I NPATI ENT DI ALYSI S	0	0		0 (0 0	76.01
OUTPATIENT SERVICE COST CENTERS	1		1		1	
88.00 08800 FAMILY PRACTICE 120	0	0		0 (0 0	88.00
90. 00 09000 CLINIC	0	0		0 (0	90.00
90. 01 04950 WOUND CLINIC	0	0		0 (0	90.01
91. 00 09100 EMERGENCY	0	0		0 (0 0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	-		0 0	-	96.00
200.00 Total (lines 50 through 199)	0	0	1	0 0	391, 168	∠UU. UU

Heal th	Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Lie	u of Form CMS-2	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PAS	S Provider C		Period:	Worksheet D	
THROUG	GH COSTS		Component		From 01/01/2023 To 12/31/2023	Part IV	norod.
			component (CCN: 15-S042	To 12/31/2023	Date/Time Pre 4/11/2024 3:1	7 nm
			Title	XVIII	Subprovider -	PPS	/ piii
					IPF		
	Cost Center Description	All Other	Total Cost	Total	Total Charges		
		Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
		Educati on	1, 2, 3, and	Cost (sum of		(col. 5 ÷	
		Cost	4)	cols. 2, 3,	col. 8)	col. 7)	
				and 4)		(see	
						instructions)	
		4.00	5.00	6.00	7.00	8.00	
50.00	ANCI LLARY SERVICE COST CENTERS				0 44 444 440	0.00000	50.00
50.00	05000 OPERATING ROOM	0	0		0 44, 116, 643	0.000000	
51.00	05100 RECOVERY ROOM	0	0		0 0	0.000000	
51.01	05101 ENDOSCOPY	0	0		0 13, 308, 153	0.000000	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 2,061,064	0.000000	
53.00	05300 ANESTHESI OLOGY	0	0		0 8, 188, 147	0.000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 114, 449, 658	0.000000	
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	201 1	0 27, 451, 180	0.000000	
60.00 63.00	06000 LABORATORY 06300 BLOOD STORING, PROCESSING & TRANS.	0	391, 168	391, 16		0.004783	
65.00	06500 RESPIRATORY THERAPY	0	0		0 0 0 12, 333, 717	0.000000	
66.00	06600 PHYSI CAL THERAPY	0	0		0 12, 333, 717	0.000000	
69.00	06900 ELECTROCARDI OLOGY	0	0		0 28, 424, 881 0 44, 274, 847	0.000000	
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 44,274,847	0.000000	•
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 6, 319, 021	0.000000	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 3, 319, 868	0.000000	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 12, 773, 053	0.000000	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 93, 432, 655	0.000000	
75.00	07500 ASC (NON-DI STINCT PART)	0	0		0 29, 138, 855	0.000000	
76.00	03950 MH ANCI LLARY OUTPATIENT	0	0		0 27, 150, 055	0.000000	
76.01	03951 I NPATI ENT DI ALYSI S	0	0		0 1,009,629	0.000000	
70.01	OUTPATIENT SERVICE COST CENTERS	<u> </u>	0		1,007,027	0.000000	1 /0.01
88.00	08800 FAMILY PRACTICE 120	0	0		0 46, 689	0.000000	88.00
90.00	09000 CLINIC	0	0		0 124, 872	0.000000	
90.01	04950 WOUND CLINIC	0	0		0 5, 370, 889	0.000000	
91.00	09100 EMERGENCY	0	0		0 57, 539, 520		
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 13, 304, 064	0.000000	
	OTHER REIMBURSABLE COST CENTERS						1
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0 455, 308	0.000000	96.00
200.00		0	391, 168				200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS Provider CN: 15-0042 Component CCN: 15-0042 To 12/31/2023 Part IV part V Date/Time Prepared: 11/12/204 3:17 pm	Health Financial Systems	GOOD SAMARI TAN	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
ANOODITION Component CN: 15-S042 To 12/31/2023 Date/Time Prepared: 4/11/2024 3:17 pm Image: Construction of Constructin of Construction of Constructin of Construction of Cons		RVICE OTHER PASS	Provider C	CN: 15-0042			
ANCI LLARY SERVICE COST CENTERS Outpatient Ratio of Cost (col. 6) Inpatient Program Charges (col. 7) Inpatient Program Charges Outpatient Program Charges 50. 00 05000 0FERATING ROOM 0.000000 0 0 0 0 0 50.00 51. 00 05100 0EEATING ROOM 0.000000 0 0 0 51.00 52. 00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0 0 0 52.00 53. 00 05300 ANESTIESI OLOGY 0.000000 0 0 0 52.00 50. 00 054.00 DABORATORY 0.000000 0 0 0 0 0 63.00 65. 00 06500 RESPIRATORY THERAPY 0.000000 0 0 </td <td>THROUGH COSTS</td> <td></td> <td>Component</td> <td>CCN: 15-S042</td> <td></td> <td></td> <td>nared</td>	THROUGH COSTS		Component	CCN: 15-S042			nared
ANCILLARY SERVICE COST CENTERS Outpati ent Ratio of Cost to Charges (col. 6 + col. 7) Inpati ent Program Charges Inpati ent Program Charges Outpati ent Program Charges Program Charges Program Charges <td></td> <td></td> <td>•</td> <td></td> <td></td> <td></td> <td></td>			•				
Cost Center Description Outpatient Ratio of Cost to Charges (col. 6 * eol. 7) Inpatient Program (Carges) Inpatient Program (Carges) Outpatient Program (Carges) Program (Carges) Outpatient Program (Carges) Program (Carges) Outpatient Program (Carges) Program (Carges) Outpatient Program (Carges) Outpatient Program (Carges) Outpatient Program (Carges) Outpatient Carges Program (Carges) Outpatient Carges Program (Carges) Outpatient Carges Outpatient Program (Carges) Outpatient Carges Outpatient Ca			Title	e XVIII		PPS	
ANCILLARY SERVICE COST CENTERS Ratio of Cost to Charges (Call 6 + coll 7)) Program (Charges Costs (coll 8)) Program (Charges Costs (coll 8)) Program (Charges Costs (coll 9)) Program (Charg							
to Charges (col. Charges (col. Pass-Through Costs Charges (col. Pass-Through Costs Pass <th< td=""><td>Cost Center Description</td><td></td><td></td><td></td><td></td><td></td><td></td></th<>	Cost Center Description						
Image: constraint of the second se							
Image: col. 7) x col. 10) x col. 12) 9.00 10.00 11.00 12.00 13.00 50.00 05000 OPERATI NG ROOM 0.000000 12.660 0 0 0 50.00 51.00 05100 RECOVERY ROOM 0.000000 0 0 0 51.00 51.01 05100 RECOVERY ROOM 0.000000 0 0 0 51.01 52.00 05200 DELI VERY ROOM & LABOR ROOM 0.000000 0 0 0 52.00 53.00 05300 ANESTHESI OLGGY 0.000000 0 0 0 53.00 54.00 05400 RADI OLOGY-THERAPEUTI C 0.000000 0 0 0 53.00 65.00 06500 RADI OLOGY-THERAPEUTI C 0.000000 0 0 0 63.00 65.00 06500 RADI OLOGY-THERAPEUTI C 0.000000 0 0 0 63.00 65.00 06500 RESPI RATORY THERAPEUT 0.000000 0 0 0 65.00 66.00 06500 RESPI RA			chai yes				
ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM 0.000000 12.00 13.00 51.00 05100 RECVIER COST CENTERS 0 0 0 0 50.00 51.01 05101 RENOSCOPY 0.000000 0 0 0 51.00 52.00 05200 DELI VERY ROOM & LABOR ROOM 0.000000 0 0 0 53.00 53.00 05300 ANSTHESI OLOGY 0.000000 0 0 0 53.00 54.00 05400 RADI OLOGY-THERAPEUTI C 0.000000 0 0 0 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 0 0 0 55.00 60.00 06300 BADOR STORI NG, PROCESSI NG & TRANS. 0.000000 0 0 0 63.00 66.00 63.00 66.00 65.00 66.00 65.00 66.00 65.00 66.00 65.00 66.00 66.00 69.00 66.00 69.00 66.00					0		
ANCI LLARY SERVICE COST CENTERS 50.00 OS000 PPERATING ROM 0.000000 12,660 0 0 0 50.00 51.00 OS100 RECOVERY ROOM 0.000000 0 0 0 51.00 51.01 OS101 ENDOSCOPY 0.000000 0 0 0 51.01 52.00 OS200 DELI VERY ROOM & LABOR ROOM 0.000000 0 0 0 51.01 52.00 OS200 DELI VERY ROOM & LABOR ROOM 0.000000 0 0 0 53.00 53.00 OS400 RABI OLOGY - JAGNOSTI C 0.000000 0 0 0 53.00 55.00 OS500 RADI OLOGY - THERAPEUTI C 0.000000 0 0 0 55.00 60.00 D6000 D STORI NG, PROCESSI NG & TRANS. 0.000000 0 0 66.00 318 2 60.00 65.00 O6500 RESPI RATORY THERAPY 0.000000 7.373 0 0 66.00 66.00 66.00 66.00 66.00 67.00 0 77.00 0			10.00		12.00		
50.00 05000 0PERATI NG ROOM 0.000000 12,660 0 0 0 50.00 51.00 05100 RECOVERY ROOM 0.000000 0 0 0 51.00 51.01 ENDOSCOPY 0.000000 0 0 0 51.00 52.00 DELI VERY ROOM & LABOR ROOM 0.000000 0 0 0 52.00 53.00 05300 ANESTHESI OLOGY 0.000000 0 0 0 53.00 54.00 O5400 RADI OLOGY-DI AGNOSTI C 0.000000 0 0 0 55.00 0 05000 LABORATORY 0.000000 0 0 0 55.00 0 06400 LABORATORY 0.004783 137,955 6660 318 2 60.00 65.00 G6500 RESPI RATORY THERAPY 0.000000 7,373 0 0 65.00 64.00 06900 ELECTROCARDI OLOGY 0.000000 7,373 0 0 66.00 </td <td>ANCILLARY SERVICE COST CENTERS</td> <td>,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,</td> <td>10100</td> <td>11100</td> <td>12100</td> <td>10100</td> <td></td>	ANCILLARY SERVICE COST CENTERS	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	10100	11100	12100	10100	
51.01 05101 ENDOSCOPY 0.000000 0 0 0 0 51.01 52.00 05200 DELI VERY ROM & LABOR ROM 0.000000 0 0 0 52.00 53.00 05300 ANESTHESI OLOGY 0.000000 0 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 0 0 0 55.00 60.00 06000 LABORATORY 0.004783 137,955 660 318 2 60.00 63.00 06300 BLODD STORI NG, PROCESSI NG & TRANS. 0.000000 0 0 0 65.00 65.00 06500 RESPI RATORY THERAPY 0.000000 7,373 0 0 65.00 65.00 06400 PHYSI CAL THERAPY 0.000000 7,373 0 0 66.00 69.00 06400 ELECTROCARDI OLOGY 0.000000 11,463 0 0 70.00 70.00 ELECTROCARDI OLOGY 0.000000 0 0 0 71.00 71.00 07001 NEUROLALGRADENHY		0. 000000	12, 660	1	0 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0 0 0 52.00 53.00 05300 ANESTHESI OLOGY 0.000000 0 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 16,119 0 0 0 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 0 0 0 55.00 60.00 06000 LABORATORY 0.04783 137,955 660 318 2 60.00 65.00 06500 RESPI RATORY THERAPY 0.000000 25,379 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0.000000 7,373 0 0 66.00 69.00 ELECTROCARDI OLOGY 0.000000 11,463 0 <	51.00 05100 RECOVERY ROOM	0. 000000	0		0 0	0	51.00
53.00 05300 ANESTHESI OLOGY 0.000000 0 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 16,119 0 0 0 55.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 0 0 0 0 55.00 60.00 06000 LABORATORY 0.04783 137,955 660 318 2 60.00 63.00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0.000000 0 0 0 63.00 65.00 06500 RESPI RATORY THERAPY 0.000000 25,379 0 0 66.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 7,373 0 0 66.00 69.00 07000 ELECTROCARDI OLOGY 0.000000 11,463 0 0 70.00 70.01 NEURODI AGNOSTI CS 0.000000 4,127 0 0 70.01 71.00 0700 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.000000 0 0 0 72.00 72.0	51.01 05101 ENDOSCOPY	0. 000000	0		0 0	0	51.01
54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 16, 119 0 0 0 55.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 0 0 0 0 55.00 60.00 06000 LABORATORY 0.004783 137, 955 660 318 2 60.00 63.00 06300 BLODD STORI NG, PROCESSI NG & TRANS. 0.000000 0 0 0 63.00 65.00 06600 PHYSI CAL THERAPY 0.000000 25, 379 0 0 66.00 66.00 06600 PHYSI CAL THERAPY 0.000000 7, 373 0 0 69.00 67.00 06900 ELECTROCARDI OLOGY 0.000000 11, 463 0 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 4, 127 0 0 70.01 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.000000 1, 845 0 0 72.00 73.00 07300 DRGS CHARGED TO PATI ENTS 0.000000 0 0 0	52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52.00
55.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 0 0 0 0 0 0 55.00 60.00 06000 LABORATORY 0.004783 137,955 6660 318 2 60.00 63.00 06300 BLODD STORING, PROCESSING & TRANS. 0.000000 0 0 0 0 63.00 65.00 06500 RESPI RATORY THERAPY 0.000000 25,379 0 0 0 65.00 66.00 06900 ELECTROCARDI OLOGY 0.000000 7,373 0 0 0 69.00 070.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 11,463 0 0 0 70.00 70.01 NEURODI AGNOSTI CS 0.000000 0 0 0 0 70.01 70.01 70.01 70.01 70.01 70.01 70.01 70.01 70.01 70.01 70.01 70.01 70.01 70.01 70.01 70.01 70.01 70.01 70.01 <td>53.00 05300 ANESTHESI OLOGY</td> <td>0. 000000</td> <td>0</td> <td></td> <td>0 0</td> <td>0</td> <td>53.00</td>	53.00 05300 ANESTHESI OLOGY	0. 000000	0		0 0	0	53.00
60.00 06000 LABORATORY 0.004783 137,955 660 318 2 60.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 0 0 0 0 63.00 65.00 06500 RESPI RATORY THERAPY 0.000000 25,379 0 0 0 65.00 66.00 PHYSICAL THERAPY 0.000000 7,373 0 0 0 66.00 69.00 ELECTROCARDIOLOGY 0.000000 11,463 0 0 0 70.00 70.00 FLECTROENCEPHALOGRAPHY 0.000000 4,127 0 0 70.00 70.01 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 1,845 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 0 0 0 73.00 75.00 07500 <td>54.00 05400 RADI OLOGY-DI AGNOSTI C</td> <td>0. 000000</td> <td>16, 119</td> <td></td> <td>0 0</td> <td>0</td> <td>54.00</td>	54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	16, 119		0 0	0	54.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 0 0 0 0 63.00 65.00 06500 RESPIRATORY THERAPY 0.000000 25,379 0 0 0 65.00 66.00 06600 PHYSICAL THERAPY 0.000000 7,373 0 0 0 66.00 69.00 06900 ELECTROCARDIOLOGY 0.000000 11,463 0 0 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0 0 0 0 70.00 70.10 NEURODI AGNOSTICS 0.000000 4,127 0 0 0 71.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.000000 1,845 0 0 72.00 72.00 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 0 0 72.00 72.00 72.00 72.00 72.00 73.00 73.00 73.00 73.00 73.00 73.00 75.00 75.00			0			0	55.00
65.00 06500 RESPIRATORY THERAPY 0.000000 25,379 0 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0.000000 7,373 0 0 0 66.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 11,463 0 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0 0 0 70.00 70.01 07001 NEURODI AGNOSTI CS 0.000000 4,127 0 0 0 71.00 71.00 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.000000 1,845 0 0 72.00 73.00 DRUGS CHARGED TO PATI ENTS 0.000000 0 0 73.00			137, 955	6	60 318	2	
66.00 06600 PHYSI CAL THERAPY 0.000000 7,373 0 0 66.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 11,463 0 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0 0 0 0 70.00 70.01 NEURODI AGNOSTI CS 0.000000 4,127 0 0 0 71.00 71.00 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.000000 1,845 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 0 0 0 73.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 90,869 0 244 0 73.00 75.00 07500 ASC (NON-DI STI NCT PART) 0.000000 0 0 0 0 75.00 76.00 03950 MH ANCI LLARY OUTPATI ENT 0.000000 0 0 0 0 76.00 76.01 03951			0		0 0	0	
69.00 06900 ELECTROCARDIOLOGY 0.000000 11,463 0 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0 0 0 0 70.00 70.01 07001 NEURODIAGNOSTICS 0.000000 4,127 0 0 0 70.01 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 1,845 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 90,869 0 244 0 73.00 75.00 07500 ASC (NON-DISTINCT PART) 0.000000 0 0 0 75.00 76.00 03950 MH ANCILLARY OUTPATIENT 0.000000 0 0 0 76.00 76.01 03951 INPATIENT DIALYSIS 0.000000 0 0 0 76.01						0	
70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0 0 0 0 0 70.00 70.01 NEURODI AGNOSTI CS 0.000000 4, 127 0 0 0 70.01 71.00 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.000000 1, 845 0 0 0 71.00 72.00 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 0 0 0 72.00 73.00 O7300 DRUGS CHARGED TO PATI ENTS 0.000000 0 0 0 73.00 75.00 O7500 ASC (NON-DI STI NCT PART) 0.000000 0 0 0 75.00 76.00 03950 MH ANCI LLARY OUTPATI ENT 0.000000 0 0 0 0 76.00 76.01 03951 INPATI ENT DI ALYSI S 0.000000 0 0 0 76.01					-	Ũ	
70. 01 07001 NEURODI AGNOSTI CS 0.000000 4, 127 0 0 0 70. 01 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 1, 845 0 0 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 90, 869 0 244 0 73. 00 75. 00 OS500 ASC (NON-DI STI NCT PART) 0.000000 0 0 0 0 75. 00 76. 00 03950 MH ANCI LLARY OUTPATI ENT 0.000000 0 0 0 0 76. 00 76. 01 03951 INPATI ENT DI ALYSIS 0.000000 0 0 0 0 76. 01							
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.000000 1,845 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 90,869 0 244 0 73.00 75.00 07500 ASC (NON-DI STI NCT PART) 0.000000 0 0 0 75.00 76.00 03950 MH ANCI LLARY OUTPATI ENT 0.000000 0 0 0 76.00 76.01 03951 INPATI ENT DI ALYSI S 0.000000 0 0 0 0 76.01			-			-	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 90,869 0 244 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 76.00 76.01 03951 INPATIENT DIALYSIS 0.000000 0 0 0 0 76.01					-	-	
73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 90,869 0 244 0 73.00 75.00 07500 ASC (NON-DISTINCT PART) 0.000000 0 0 0 75.00 76.00 03950 MH ANCILLARY OUTPATIENT 0.000000 0 0 0 76.00 76.01 03951 INPATIENT DIALYSIS 0.000000 0 0 0 76.01					0		
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 INPATIENT DIALYSIS 0.000000 0 0 0 0 76.01			0		-		
76.00 03950 MH_ANCI LLARY_OUTPATI ENT 0.000000 0 0 0 0 76.00 76.01 03951 I NPATI ENT_DI ALYSI S 0.000000 0 0 0 0 0 76.00			90, 869			-	
76. 01 03951 INPATIENT DIALYSIS 0. 00000 0 0 0 0 76. 01			0			-	
OUTPATIENT SERVICE COST CENTERS		0.000000	0		0 0	0	76.01
88.00 08800 FAMILY PRACTICE 120 0.000000 0 0 0 88.00		0.00000	0		0	0	00 00
90. 00 09000 CLINIC 0. 000000 0 0 0 0 0 90. 00			-			-	
90. 00 19000 CLINIC 0 0 90. 00 0 90. 00 90.			0				
91. 00 09100 EMERGENCY 0. 000000 169, 069 0 3, 924 0 91. 00			169 060		0 3 024	-	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0. 000000 0 0 0 0 0 0 0 92. 00							
OTHER REIMBURSABLE COST CENTERS		0.000000	0	1		0	/2.00
96.00 09600 DURABLE MEDI CAL EQUI P-RENTED 0.000000 0 0 0 0 96.00		0, 000000	0		0 0	0	96.00
200.00 Total (lines 50 through 199) 476, 859 660 4, 486 2 200.00			-			-	

Heal th Fina	ncial Systems	GOOD SAMARIT.	AN HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTI ONME	ENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-0042	Period:	Worksheet D	
			Component	CCN: 15-S042	From 01/01/2023 To 12/31/2023	Part V Date/Time Pre	narod
			component	CCN. 15-5042	10 12/31/2023	4/11/2024 3:1	7 pm
			Title	e XVIII	Subprovider -	PPS	
					' I PF		
				Charges		Costs	
	Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
		Charge Ratio	Reimbursed	Reimbursed	Reimbursed	(see inst.)	
		From	Services (see	Servi ces	Services Not		
		Worksheet C,	inst.)	Subject To	Subject To		
		Part I, col.		Ded. & Coins			
		9		(see inst.)			
		1.00	2.00	3.00	4.00	5.00	
	LLARY SERVICE COST CENTERS		-	1		-	
	O OPERATING ROOM	0. 191816			0 0	0	
	O RECOVERY ROOM	0. 000000			0 0	0	
	1 ENDOSCOPY	0. 241635			0 0	0	
	O DELIVERY ROOM & LABOR ROOM	0. 447674			0 0	0	
	0 ANESTHESI OLOGY	0. 204357	0		0 0	0	
	0 RADI OLOGY-DI AGNOSTI C	0. 113632			0 0	0	
	0 RADI OLOGY-THERAPEUTI C	0. 219524			0 0	0	
	O LABORATORY	0. 136482			0 0	43	
	0 BLOOD STORING, PROCESSING & TRANS.	0. 000000			0 0	0	
	O RESPIRATORY THERAPY	0. 326640			0 0	0	
	O PHYSI CAL THERAPY	0. 329782			0 0	0	
	0 ELECTROCARDI OLOGY	0. 149784	0		0 0	0	
	O ELECTROENCEPHALOGRAPHY	0.00000			0 0	0	
	1 NEURODI AGNOSTI CS	0. 317801	0		0 0	0	
	O MEDI CAL SUPPLIES CHARGED TO PATIENTS	1. 497226			0 0	0	
	O I MPL. DEV. CHARGED TO PATIENTS O DRUGS CHARGED TO PATIENTS	0. 423445			0 0 0 215	0	
		0. 293027	244			71	
	O ASC (NON-DISTINCT PART) O MH ANCILLARY OUTPATIENT	0. 183162			0 0	0	
	IINPATIENT DIALYSIS	0.00000	0		0 0	0	
	ATIENT SERVICE COST CENTERS	0. 774977	0	1	0 0	0	76.01
	O FAMILY PRACTICE 120			1			88.00
	O CLINIC	3. 292371	0		0 0	0	
		0. 318570			0 0	0	
	O EMERGENCY	0. 216597			0 0	850	
	O OBSERVATION BEDS (NON-DISTINCT PART)	0. 210597			0 0	0	
	R REIMBURSABLE COST CENTERS	0.311073	0	1	0 0	0	92.00
	O DURABLE MEDICAL EQUIP-RENTED	0. 514247	0		0 0	0	96.00
200.00	Subtotal (see instructions)	0. 514247	4, 486		0 215	-	200.00
200.00	Less PBP Clinic Lab. Services-Program		4,400		0 215	904	200.00
201.00	Only Charges				0		201.00
202.00	Net Charges (line 200 - line 201)		4, 486		0 215	964	202.00
202.00		1	-,400	1	215	704	1202.00

Health Financial Systems	GOOD SAMARI TAI	N HOSPI TAL		In Lieu	u of Form CMS-2552-	<u>!-10</u>
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider Concernent	CN: 15-0042 CCN: 15-S042	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part V Date/Time Prepare 4/11/2024 3:17 pm	
		Title	XVIII	Subprovider -	PPS	
	Cost					
Cost Center Description	Cost Reimbursed Services Subject To Ded. & Coins. I (see inst.) 6,00	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.) 7.00				
ANCI LLARY SERVI CE COST CENTERS			1			
50. 00 05000 OPERATI NG ROOM 51. 00 05100 RECOVERY ROOM 51. 01 05101 ENDOSCOPY 52. 00 05200 DELI VERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C 55. 00 05500 RADI OLOGY-THERAPEUTI C 60. 00 06000 LABORATORY 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 65. 00 06600 PHYSI CAL THERAPY 66. 00 06600 PHYSI CAL THERAPY 69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROCARDI OLOGY 70. 01 07001 NEURODI AGNOSTI CS 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 73. 00 07300 DRUGS CHARGED TO PATI ENTS 75. 00 07500 ASC (NON-DI STI NCT PART) 76. 01 03950 MH ANCI LLARY OUTPATI ENT 76. 01 <t< td=""><td></td><td>0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0</td><td></td><td></td><td>51. 52. 53. 54. 55. 60. 63. 65. 66. 69. 70. 70. 71. 72. 73. 75. 76.</td><td>. 00 . 00 . 01 . 00 . 00 . 00 . 00 . 00</td></t<>		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			51. 52. 53. 54. 55. 60. 63. 65. 66. 69. 70. 70. 71. 72. 73. 75. 76.	. 00 . 00 . 01 . 00 . 00 . 00 . 00 . 00
OUTPATI ENT SERVICE COST CENTERS 88. 00 08800 FAMILY PRACTICE 120 90. 00 09000 CLINIC 90. 01 04950 WOUND CLINIC 91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0 0 0 0	0 0 0 0			90. 90. 91.	. 00 . 00 . 01 . 00 . 00
OTHER REIMBURSABLE COST CENTERS 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 200.00 Subtotal (see instructions) 201.00 Less PBP Clinic Lab. 201.00 Net Charges Net Charges 202.00 Net Charges	0 0 0 0	0 63 63			96. 200. 201. 202.	. 00 . 00 . 00

Health Financial Systems	GOOD SAMARI TA	AN HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS	Provider C Component		Period: From 01/01/2023 To 12/31/2023	Worksheet D Part II Date/Time Pre 4/11/2024 3:1	pared: 7 pm
			× XVIII	Subprovider -	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)			
	col. 26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	L					
50.00 05000 OPERATI NG ROOM	922, 572				422	
51.00 05100 RECOVERY ROOM	0		0.00000		0	51.00
51.01 05101 ENDOSCOPY	456, 892	13, 308, 153			357	51.01
52.00 05200 DELIVERY ROOM & LABOR ROOM	237, 511	2, 061, 064			0	52.00
53. 00 05300 ANESTHESI OLOGY	16, 533				0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	884, 087	114, 449, 658			2, 887	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	665, 183				0	55.00
60. 00 06000 LABORATORY	374, 483				3, 923	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0		0.00000		0	63.00
65. 00 06500 RESPI RATORY THERAPY	225, 496				15, 306	65.00
66. 00 06600 PHYSI CAL THERAPY	1, 034, 194		0. 03913		256, 659	
69. 00 06900 ELECTROCARDI OLOGY	682, 587	44, 274, 847			1, 228	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0.0000		0	70.00
70. 01 07001 NEURODI AGNOSTI CS	275, 711	6, 319, 021	0. 04363		123	70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	164, 799	3, 319, 868	0. 04964	10 90, 696	4, 502	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	119, 154	12, 773, 053	0. 00932	29 700	7	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	361, 735	93, 432, 655	0.00387	985, 238	3, 815	73.00
75.00 07500 ASC (NON-DISTINCT PART)	134, 172	29, 138, 855	0. 00460	05 0	0	75.00
76.00 03950 MH ANCILLARY OUTPATIENT	0	0	0.00000	0 0	0	76.00
76.01 03951 INPATIENT DIALYSIS	286, 068	1, 009, 629	0. 28334	40 96, 281	27, 280	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 FAMILY PRACTICE 120	204	46, 689	0.00436	59 0	0	88.00
90. 00 09000 CLINIC	80, 581	124, 872	0. 64530	09 0	0	90.00
90.01 04950 WOUND CLINIC	122, 945	5, 370, 889	0. 02289	0	0	90.01
91.00 09100 EMERGENCY	1,009,640	57, 539, 520	0. 01754	93, 257	1, 636	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	13, 304, 064	0. 00000	0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS						1
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	14, 888	455, 308	0. 03269	99 0	0	96.00
200.00 Total (lines 50 through 199)	8, 069, 435	597, 220, 702		10, 004, 833	318, 145	200.00

Health Financial Systems	GOOD SAMARI TA	AN HOSPITAL		In Lie	eu of Form CMS-3	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PAS	S Provider C	CN: 15-0042	Peri od:	Worksheet D	
THROUGH COSTS			001 45 5040	From 01/01/2023		
		Component	CCN: 15-T042	To 12/31/2023	B Date/Time Pre 4/11/2024 3:1	
		Title	XVIII	Subprovider -	PPS	<u>, bui</u>
				I RF		
Cost Center Description	Non Physi ci an		Nursi ng		Allied Health	
	Anesthetist	Program	Program	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
	1.00	Adjustments	0.00		0.00	
ANCILLARY SERVICE COST CENTERS	1.00	2A	2.00	3A	3.00	
50. 00 05000 OPERATING ROOM	0		1	0 (0 0	50.00
51. 00 05100 RECOVERY ROOM	0			0		
51. 01 05101 ENDOSCOPY	0			0		
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0		
53. 00 05300 ANESTHESI OLOGY	0			0		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0			0		
55. 00 05500 RADI OLOGY-THERAPEUTI C	0			0		
60. 00 06000 LABORATORY	0			0	391, 168	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0				0 0	•
65. 00 06500 RESPI RATORY THERAPY	0					
66. 00 06600 PHYSI CAL THERAPY	0					
69. 00 06900 ELECTROCARDI OLOGY	0			0 0		
70. 00 07000 ELECTROENCEPHALOGRAPHY	0			0 0		
70. 01 07001 NEURODI AGNOSTI CS	0			0 0		
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0		
72, 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 (
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 (
75.00 07500 ASC (NON-DI STINCT PART)	0	0		0 0	ol o	
76.00 03950 MH ANCI LLARY OUTPATI ENT	0	0		0 0	ol o	
76. 01 03951 I NPATI ENT DI ALYSI S	0	0		0 (0 0	•
OUTPATIENT SERVICE COST CENTERS			•	!		1
88.00 08800 FAMILY PRACTICE 120	0	0		0 (0 0	88.00
90. 00 09000 CLINIC	0	0		0 (o o	90.00
90.01 04950 WOUND CLINIC	0	0		0 (o o	90.01
91.00 09100 EMERGENCY	0	0		0 0	o o	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
96.00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	0		0 (0 0	
200.00 Total (lines 50 through 199)	0	0		0 (391, 168	200.00

Health Financial Systems	GOOD SAMARI TA	AN HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PAS	S Provider C		Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2023		
		component	CCN: 15-T042	To 12/31/2023	Date/Time Pre 4/11/2024 3:1	
		Title	XVIII	Subprovider -	PPS	
			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	I RF		
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
	Cost	4)	cols. 2, 3,	col. 8)	col. 7)	
			and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS	1					
50.00 O5000 OPERATI NG ROOM	0	0		0 44, 116, 643		
51.00 05100 RECOVERY ROOM	0	0		0 0	0. 000000	
51.01 05101 ENDOSCOPY	0	0		0 13, 308, 153	0. 000000	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 2, 061, 064	0.000000	
53. 00 05300 ANESTHESI OLOGY	0	0		0 8, 188, 147	0.000000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 114, 449, 658	0.000000	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 27, 451, 180		
60. 00 06000 LABORATORY	0	391, 168				
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0.000000	
65. 00 06500 RESPI RATORY THERAPY	0	0		0 12, 333, 717	0.000000	
66. 00 06600 PHYSI CAL THERAPY	0	0		0 26, 424, 681	0.000000	
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 44, 274, 847	0.000000	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0.000000	
70. 01 07001 NEURODI AGNOSTI CS	0	0		0 6, 319, 021	0.000000	
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0		0 3, 319, 868	0.000000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 12, 773, 053	0.000000	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 93, 432, 655	0.000000	
75.00 07500 ASC (NON-DI STI NCT PART)	0	0		0 29, 138, 855	0.000000	
76.00 03950 MH ANCI LLARY OUTPATIENT	0	0		0 1 000 (20	0.000000	
76. 01 03951 INPATIENT DIALYSIS	0	0		0 1, 009, 629	0.000000	76.01
OUTPATIENT SERVICE COST CENTERS 88.00 08800 FAMILY PRACTICE 120	0	0		0 46, 689	0. 000000	88.00
90. 00 09000 CLINIC	0	0		0 46, 689 0 124, 872	0.000000	
90. 01 04950 WOUND CLINIC	0	0		0 5, 370, 889		
91. 00 09100 EMERGENCY	0	0		0 57, 539, 520		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 13, 304, 064		
OTHER REIMBURSABLE COST CENTERS	0	0	l	0 13, 304, 064	0.00000	72.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0 455, 308	0. 000000	96.00
200.00 Total (lines 50 through 199)	0					200.00
	0	571,100	1 571, TC	577,220,702		200.00

Health Financial Systems	GOOD SAMARI TAN	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	Provider C	CN: 15-0042	Peri od:	Worksheet D	
THROUGH COSTS		Component	CCN: 15-T042	From 01/01/2023 To 12/31/2023	Part IV Date/Time Pre	pared:
					4/11/2024 3:1	
		Title	XVIII	Subprovider -	PPS	
Cost Center Description	Outpatient	Inpati ent	Inpati ent	I RF Outpati ent	Outpati ent	
cost center bescription	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷	g	Costs (col.		Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 000000	20, 176		0 0	0	50.00
51.00 05100 RECOVERY ROOM	0. 000000	0		0 0	0	51.00
51.01 05101 ENDOSCOPY	0. 000000	10, 411		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	373, 671		0 0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0 0	0	55.00
60. 00 06000 LABORATORY	0. 004783	856, 821	4,09		0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0 0	0	63.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	837, 151		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	6, 557, 973		0 0	0	66.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	79, 630		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	2, 828		0 0	0	70.01
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0. 000000	90, 696		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	700		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	985, 238		0 0	0	73.00
75.00 07500 ASC (NON-DISTINCT PART)	0. 000000	0		0 0	0	75.00
76. 00 03950 MH ANCI LLARY OUTPATI ENT	0. 000000	0		0 0	0	76.00
76. 01 03951 I NPATI ENT DI ALYSI S	0. 000000	96, 281		0 0	0	76.01
0UTPATI ENT SERVI CE COST CENTERS 88. 00 08800 FAMI LY PRACTI CE 120	0. 000000	0		0 0	0	88.00
88. 00 08800 FAMILY PRACTICE 120 90. 00 09000 CLINIC	0. 000000	0		0 978	-	90.00
90.00 09000 CLINIC 90.01 04950 WOUND CLINIC	0. 000000	0		0 9/8	0	90.00
90. 01 04930 WOOND CETNIC 91. 00 09100 EMERGENCY	0. 000000	93, 257		0 0	0	90.01
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	93, 237			0	91.00
OTHER REIMBURSABLE COST CENTERS	0.000000	0	l	0 0	0	72.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0		0 0	0	96.00
200.00 Total (lines 50 through 199)	0.000000	10,004,833			-	200.00
	1 I.	,,	1,0		U U	

Health Financial Systems	GOOD SAMARITA			In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provider C	CN: 15-0042	Peri od:	Worksheet D	
		Composit	CON 15 TO 40	From 01/01/2023	Part V	
		component	CCN: 15-T042	To 12/31/2023	Date/Time Pre 4/11/2024 3:1	7 nm
		Title	XVIII	Subprovider -	PPS	<u>/ piii</u>
				I RF		
			Charges		Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	Charge Ratio	Reimbursed	Reimbursed	Reimbursed	(see inst.)	
	From	Services (see	Servi ces	Services Not		
	Worksheet C,	inst.)	Subject To			
	Part I, col.		Ded. & Coins			
	9		(see inst.)			
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0. 191816			0 0	0	
51.00 05100 RECOVERY ROOM	0. 000000	0		0 0	0	51.00
51.01 05101 ENDOSCOPY	0. 241635	0		0 0	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 447674	0		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 204357	0		0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 113632	0		0 0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 219524	0		0 0	0	55.00
60. 00 06000 LABORATORY	0. 136482	0		0 0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0 0	0	63.00
65.00 06500 RESPI RATORY THERAPY	0. 326640	0		0 0	0	65.00
66.00 06600 PHYSI CAL THERAPY	0. 329782	0		0 0	0	66.00
69. 00 06900 ELECTROCARDI OLOGY	0. 149784	0		0 0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0 0	0	70.00
70. 01 07001 NEURODI AGNOSTI CS	0. 317801	0		0 0	0	70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1. 497226	0		0 0	0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 423445	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 293027	0		0 974	0	73.00
75.00 07500 ASC (NON-DISTINCT PART)	0. 183162	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. 774977	0		0 0	0	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 FAMILY PRACTICE 120						88.00
90. 00 09000 CLINIC	3. 292371	978		0 0	3, 220	90.00
90. 01 04950 WOUND CLINIC	0. 318570	0		0 0	0	90.01
91.00 09100 EMERGENCY	0. 216597	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 311073	0		0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS			·			
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0. 514247	0		0 0	0	96.00
200.00 Subtotal (see instructions)		978		0 974	3, 220	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)	1	978	1	0 974		202.00

Health Financial Systems	GOOD SAMARI TA	AN HOSPITAL		In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES ANI	D VACCINE COST	Provider C Component	CN: 15-0042 CCN: 15-T042	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part V Date/Time Prepared: 4/11/2024 3:17 pm
		Title	e XVIII	Subprovider -	PPS
	Cos				
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			
ANCILLARY SERVICE COST CENTERS	0.00	7.00	1		
Altert SLANT CL COST CLIVIERS 50. 00 05000 OPERATI NG ROOM 51. 00 05100 RECOVERY ROOM 51. 01 05101 ENDOSCOPY 52. 00 05200 DELI VERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C 55. 00 05500 RADI OLOGY-THERAPEUTI C 60. 00 06000 LABORATORY 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY 69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROCARDI OLOGY 70. 01 07001 NEURODI AGNOSTI CS 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 73. 00 07300 RUGS CHARGED TO PATI ENTS 75. 00 07500 ASC (NON-DI STI NCT PART) 76. 01 03950 MH ANCI LLARY OUT		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			50.00 51.01 52.00 53.00 54.00 55.00 60.00 63.00 65.00 66.00 69.00 70.00 70.01 71.00 72.00 73.00 75.00 75.00 76.00
OUTPATI ENT SERVI CE COST CENTERS 88. 00 08800 FAMI LY PRACTI CE 120 90. 00 09000 CLI NI C 90. 01 04950 WOUND CLI NI C 91. 00 090400 CULINI C	0	0			88. 00 90. 00 90. 01
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	0	0			91.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED 200.00 Subtotal (see instructions) 201.00 Less PBP Clinic Lab. Services-Program 0nl y Charges	0 0 0	0 285	1		96.00 200.00 201.00
202.00 Net Charges (line 200 - line 201)	0	285			202.00

	Financial Systems GOOD SAMARITAN ATION OF INPATIENT OPERATING COST GOOD SAMARITAN	Provider CCN: 15-0042	Period: From 01/01/2023	u of Form CMS-2 Worksheet D-1		
			To 12/31/2023	Date/Time Pre		
		Title XVIII	Hospi tal	4/11/2024 3:1 PPS	7 pm	
	Cost Center Description			1.00		
	PART I - ALL PROVIDER COMPONENTS			1.00		
00	INPATIENT DAYS Inpatient days (including private room days and swing-bed day	ve oveluding nowhern)	1	12, 266	1	
00	Inpatient days (including private room days and swing-bed da Inpatient days (including private room days, excluding swing-			12, 200	2	
00	Private room days (excluding swing-bed and observation bed d	ays). If you have only p	rivate room days,	0	3	
00	do not complete this line. Semi-private room days (excluding swing-bed and observation l	hed days)		9, 713	4	
00	Total swing-bed SNF type inpatient days (including private re		er 31 of the cost		5	
~~	reporting period		01 -6 the sect	0		
00	Total swing-bed SNF type inpatient days (including private reporting period (if calendar year, enter 0 on this line)	com days) after becember	31 OF THE COST	0	6	
00	Total swing-bed NF type inpatient days (including private roo	om days) through Decembe	er 31 of the cost	0	7	
00	reporting period Total swing-bed NF type inpatient days (including private row	om davs) after December	31 of the cost	0	8	
00	reporting period (if calendar year, enter 0 on this line)	om days) arter becember	ST OF the cost	0		
00	Total inpatient days including private room days applicable	to the Program (excludir	ig swing-bed and	4, 497	9	
. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII o	only (including private	room days)	0	10	
	through December 31 of the cost reporting period (see instru	ctions)	3,			
. 00	Swing-bed SNF type inpatient days applicable to title XVIII of December 31 of the cost reporting period (if calendar year, of		room days) after	0	11	
. 00	Swing-bed NF type inpatient days applicable to titles V or X	IX only (including priva	te room days)	0	12	
00	through December 31 of the cost reporting period		t	0	1.1	
. 00	Swing-bed NF type inpatient days applicable to titles V or X after December 31 of the cost reporting period (if calendar			0	13	
	Medically necessary private room days applicable to the Prog			0	14	
	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	15 16	
. 00	SWING BED ADJUSTMENT			0		
. 00	Medicare rate for swing-bed SNF services applicable to servi	ces through December 31	of the cost	0.00	17	
. 00	reporting period 0 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost					
	reporting period			0.00		
. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	es through December 31 d	or the cost	0.00	19	
. 00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of	the cost	0.00	20	
. 00	reporting period Total general inpatient routine service cost (see instruction	ns)		19, 883, 833	21	
	Swing-bed cost applicable to SNF type services through Decem	2	ting period (line		22	
00	5 x line 17) Swing-bed cost applicable to SNF type services after December	r 21 of the cost reporti	na poriod (line A	0	23	
. 00	x line 18)	1 31 01 the cost report	ng period (inne o	0	23	
. 00	Swing-bed cost applicable to NF type services through December	er 31 of the cost report	ing period (line	0	24	
5. 00	7 x line 19) Swing-bed cost applicable to NF type services after December	31 of the cost reportin	a period (line 8	0	25	
	x line 20)	· · · · · · · · · ·	5 1 2 2 2			
b. 00 7. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		0 19, 883, 833	26 27	
. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			17,005,055	21	
	General inpatient routine service charges (excluding swing-be	ed and observation bed o	harges)	0	28	
	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29 30	
	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.000000		
	Average private room per diem charge (line 29 ÷ line 3)			0.00		
. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33	
	Average per diem private room charge differential (line 32 mi		ictions)	0.00		
	Average per diem private room cost differential (line 34 x li	ine 31)		0.00	35	
	Private room cost differential adjustment (line 3 x line 35)			0	36	
. 00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost c	utterential (line	19, 883, 833	37	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY					
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD.			4 (01 -=		
	Adjusted general inpatient routine service cost per diem (ser			1,621.05		
	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Prog			7, 289, 862 0	39 40	
), ()()						

MPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-		Worksheet D-1	
		To 12/31/20	23 Date/Time Pre	
	Title XVIII	Hospi tal	4/11/2024 3:1 PPS	i / pr
Cost Center Description Total		age Per Program Day		
I npati ent Cost		(col. 1 ol. 2)	23 Date/Time Prep 4/11/2024 3: 17 PPS 5 Program Cost (col. 3 x col. 4) 5.00 0 0 0 0 38 3, 873, 956 1.00 11, 496, 809 0 22, 660, 627 1.00 11, 043, 555 1.874, 047 1, 917, 602 20, 743, 025 0 0 0 0 0 0 0 0 0 0 0 0 0	
1.00		3. 00 4. 00	Worksheet D-1 Date/Time Prep 4/11/2024 3: 17 PPS Program Cost (col. 3 x col. 4) 5.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 1.00 11,496,809 0 022,660,627 0 0 1,043,555 1 874,047 1,917,602 20,743,025 0	
.00 NURSERY (title V & XIX only) 0	0	0.00	0 0	42
Intensive Care Type Inpatient Hospital Units 00 INTENSIVE CARE UNIT 9, 377, 020	4, 812	1, 948. 67 1, 9	88 3 873 956	43
00 CORONARY CARE UNIT	4,012	1, 940. 07	5, 675, 750	44
. OO BURN INTENSIVE CARE UNIT				45
00 SURGI CAL I NTENSI VE CARE UNI T				46
00 OTHER SPECIAL CARE (SPECIFY) Cost Center Description				47
· · · · · · · · · · · · · · · · · · ·				
.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3		line 10 column 1)	11, 496, 809	
.01 Program inpatient cellular therapy acquisition cost (Worksh .00 Total Program inpatient costs (sum of lines 41 through 48.0			22 660 627	48
PASS THROUGH COST ADJUSTMENTS		/	22,000,027	1
.00 Pass through costs applicable to Program inpatient routine	services (from Wkst	. D, sum of Parts I a	ind 1, 043, 555	50
00 Pass through costs applicable to Program inpatient ancillar	w sorvicos (from Wk	st D sum of Parts I	1 974 047	51
and IV)	y services (ITOII WK	St. D, Sum OF Parts I	1 074,047	
.00 Total Program excludable cost (sum of lines 50 and 51)				
.00 Total Program inpatient operating cost excluding capital re	lated, non-physicia	n anesthetist, and	20, 743, 025	53
medical education costs (line 49 minus line 52) TARGET AMOUNT AND LIMIT COMPUTATION				
. 00 Program di scharges			0	
.00 Target amount per discharge				
.01 Permanent adjustment amount per discharge .02 Adjustment amount per discharge (contractor use only)				
.00 Target amount (line 54 x sum of lines 55, 55.01, and 55.02)				
.00 Difference between adjusted inpatient operating cost and ta	rget amount (line 5	6 minus line 53)		
.00 Bonus payment (see instructions)	the east reporting	noriad anding 1004		
.00 Trended costs (lesser of line 53 ÷ line 54, or line 55 from updated and compounded by the market basket)	the cost reporting	period ending 1996,	0.00	59
.00 Expected costs (lesser of line 53 ÷ line 54, or line 55 fro	m prior year cost r	eport, updated by the	0.00	60
<pre>market basket) OD Continuous improvement bonus payment (if line 53 ÷ line 54 55.01, or line 59, or line 60, enter the lesser of 50% of t</pre>	he amount by which	operating costs (İine		61
53) are less than expected costs (lines 54 x 60), or 1 % of enter zero. (see instructions)	the target amount	(line 56), otherwise		
.00 Relief payment (see instructions)			0	62
.00 Allowable Inpatient cost plus incentive payment (see instru	ictions)		0	63
PROGRAM INPATIENT ROUTINE SWING BED COST .00 Medicare swing-bed SNF inpatient routine costs through Dece	mbor 21 of the cost	reporting pariod (Sc		4
instructions) (title XVIII only)	inder 31 of the cost	reporting period (se	e U	04
.00 Medicare swing-bed SNF inpatient routine costs after Decemb	er 31 of the cost r	eporting period (See	0	65
instructions) (title XVIII only)	(1 plup lipp (E) (ti	the Will entry. for		66
.00 Total Medicare swing-bed SNF inpatient routine costs (line CAH, see instructions	o4 prus rine o3)(ti	tre viri only), for		
.00 Title V or XIX swing-bed NF inpatient routine costs through	December 31 of the	cost reporting perio	od 0	67
(line 12 x line 19) .00 Title V or XIX swing-bed NF inpatient routine costs after [locombor 21 of the c	act conarting pariod		68
(line 13 x line 20)	ecember 51 01 the c	JSt Tepor ting period		
.00 Total title V or XIX swing-bed NF inpatient routine costs (0	69
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY .00 Skilled nursing facility/other nursing facility/ICF/IID rou		Line 27)		1 70
.00 Skilled nursing facility/other nursing facility/ICF/IID rou .00 Adjusted general inpatient routine service cost per diem (1		The ST)		70
.00 Program routine service cost (line 9 x line 71)				72
.00 Medically necessary private room cost applicable to Program)		73
00 Total Program general inpatient routine service costs (line 00 Capital-related cost allocated to inpatient routine service	-	eet B Part II colum	n	74
26, line 45)				'`
00 Per diem capital-related costs (line 75 ÷ line 2)				76
00 Program capital-related costs (line 9 x line 76) 00 Inpatient routine service cost (line 74 minus line 77)				77
00 Aggregate charges to beneficiaries for excess costs (from p	orovider records)			79
00 Total Program routine service costs for comparison to the c		e 78 minus line 79)		80
00 Inpatient routine service cost per diem limitation	>			81
00 Inpatient routine service cost limitation (line 9 x line 81 00 Reasonable inpatient routine service costs (see instruction	-			82
.00 Program inpatient ancillary services (see instructions)	-,			84
.00 Utilization review - physician compensation (see instructio				85
.00 Total Program inpatient operating costs (sum of lines 83 th PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST	rough 85)			86
.00 Total observation bed days (see instructions)			2, 553	87
	line 2)		1, 621. 05	

Health Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period:	Worksheet D-1	
				From 01/01/2023 To 12/31/2023	Date/Time Pre 4/11/2024 3:1	pared: 7 pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description						
					1.00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions))			4, 138, 541	89.00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	1, 873, 820	19, 883, 833	0.09423	4, 138, 541	390, 008	90.00
91.00 Nursing Program cost	0	19, 883, 833	0.00000	4, 138, 541	0	91.00
92.00 Allied health cost	0	19, 883, 833	0.0000	4, 138, 541	0	92.00
93.00 All other Medical Education	0	19, 883, 833	0.00000	4, 138, 541	0	93.00

MPUTA	TION OF INPATIENT OPERATING COST	Provider CCN: 15-0042 Component CCN: 15-S042 Title XVIII	Peri od: From 01/01/2023 To 12/31/2023 Subprovi der -	u of Form CMS-2 Worksheet D-1 Date/Time Pre 4/11/2024 3:1 PPS	pare
	Cost Center Description		IPF		
ľ	PART I - ALL PROVIDER COMPONENTS			1.00	
	NPATIENT DAYS				1
00	Inpatient days (including private room days and swing-bed day			4, 323	
	Inpatient days (including private room days, excluding swing-			4, 323	
	Private room days (excluding swing-bed and observation bed da do not complete this line.	ys). If you have only p	rivate room days,	0	3.
	Semi-private room days (excluding swing-bed and observation b	ed days)		4, 323	4.
00	Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	0	5
	reporting period Tatal amina had SNE turns insations days (including animate as		21 - 6 + +	0	
	Total swing-bed SNF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line)	om days) after December	31 of the cost	0	6
	Total swing-bed NF type inpatient days (including private roo	m days) through Decembe	r 31 of the cost	0	7
	reporting period				
	Total swing-bed NF type inpatient days (including private roo reporting period (if calendar year, enter 0 on this line)	m days) after December :	31 of the cost	0	8
	Total inpatient days including private room days applicable t	o the Program (excluding	a swing-bed and	532	9
	newborn days) (see instructions)	5 .			
	Swing-bed SNF type inpatient days applicable to title XVIII o		room days)	0	10
	through December 31 of the cost reporting period (see instruc Swing-bed SNF type inpatient days applicable to title XVIII o		room days) after	0	11
	December 31 of the cost reporting period (if calendar year, e		augo) area	Ũ	
	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including priva	te room days)	0	12
	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI	X only (including prive	te room days)	0	13
	after December 31 of the cost reporting period (if calendar y	5 (51	<i>,</i>	0	
. 00	Medically necessary private room days applicable to the Progr	am (excluding swing-bed	days)	0	14
	Total nursery days (title V or XIX only)			0	
	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16
. 00 [Medicare rate for swing-bed SNF services applicable to servic	es through December 31	of the cost	0.00	17
	reporting period Medicare rate for swing-bed SNF services applicable to servic	as after December 21 of	the cost	0.00	10
	reporting period	es al tel December 31 01	the cost	0.00	
. 00	Medicaid rate for swing-bed NF services applicable to service	s through December 31 o	f the cost	0.00	19
	reporting period Medicaid rate for swing-bed NF services applicable to service	s ofter December 21 of	the cost	0.00	20
	reporting period	s arter becember 31 01	the cost	0.00	20
. 00	Total general inpatient routine service cost (see instruction			6, 827, 931	21
	Swing-bed cost applicable to SNF type services through Decemb	er 31 of the cost repor	ting period (line	0	22
	5 x line 17) Swing-bed cost applicable to SNF type services after December	31 of the cost reportion	na period (line A	0	23
	x line 18)			Ũ	20
	Swing-bed cost applicable to NF type services through Decembe	r 31 of the cost report	ing period (line	0	24
	7 x line 19) Swing-bed cost applicable to NF type services after December	31 of the cost reporting	n period (line 8	0	25
	x line 20)		5 per ce (-	
	Total swing-bed cost (see instructions)			0	
	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(The 21 minus The 26)		6, 827, 931	27
	General inpatient routine service charges (excluding swing-be	d and observation bed c	harges)	0	28
00	Private room charges (excluding swing-bed charges)			0	
	Semi-private room charges (excluding swing-bed charges)			0	
	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3)	÷ TThe 28)		0.000000	
	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
00	Average per diem private room charge differential (line 32 mi		ctions)	0.00	
	Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 2 x line 25)	ne 31)		0.00	35
	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost	and private room cost d	ifferential (line		30
	27 minus line 36)				́
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				-
-	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ Adjusted general inpatient routine service cost per diem (see		Ι	1, 579. 44	38
	Program general inpatient routine service cost (line 9 x line			840, 262	
. 00	Medically necessary private room cost applicable to the Progr	am (line 14 x line 35)		0	40
. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		840, 262	1 41

	Financial Systems ATION OF INPATIENT OPERATING COST	GOOD SAMARITA		CCN: 15-0042	Peri od:	u of Form CMS- Worksheet D-1	
			Component	CCN: 15-S042	From 01/01/2023 To 12/31/2023		epare
				e XVIII	Subprovi der -	4/11/2024 3:1 PPS	
			11 11		I PF	PP3	
	Cost Center Description	Total	Total	Average Per		Program Cost	
		Inpatient Cost	Inpatient Days	Diem (col. ÷ col. 2)	1	(col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	-
	NURSERY (title V & XIX only)	0		0.			42.
	Intensive Care Type Inpatient Hospital Units						1
	I NTENSI VE CARE UNI T CORONARY CARE UNI T	0	(0.	00 0	0	43. 44.
	BURN I NTENSI VE CARE UNI T						44.
	SURGI CAL I NTENSI VE CARE UNI T						46.
. 00	OTHER SPECIAL CARE (SPECIFY)						47.
	Cost Center Description					1.00	
. 00	Program inpatient ancillary service cost (Wk	st D-3 col 3	line 200)			1.00 103,090	48
. 01	Program inpatient cellular therapy acquisiti	on cost (Worksh	neet D-6, Part	III, line 10), column 1)	0	
. 00 🛛	Total Program inpatient costs (sum of lines					943, 352	49
	PASS THROUGH COST ADJUSTMENTS						1 50
	Pass through costs applicable to Program inp III)	atient routine	services (Tro	OM WKST. D, SL	im of Parts I and	74, 757	50
	Pass through costs applicable to Program inp	atient ancillar	ry services (f	rom Wkst. D,	sum of Parts II	6, 203	51
	and IV)		· ·				
	Total Program excludable cost (sum of lines					80, 960	
	Total Program inpatient operating cost exclu medical education costs (line 49 minus line		elated, non-pr	iysi ci an anest	thetist, and	862, 392	53.
	TARGET AMOUNT AND LIMIT COMPUTATION	52)				1	
	Program di scharges					0	54
	Target amount per discharge					0.00	
	Permanent adjustment amount per discharge					0.00	
	Adjustment amount per discharge (contractor Target amount (line 54 x sum of lines 55, 55					0.00	
	Difference between adjusted inpatient operat			line 56 minus	sline 53)	0	
	Bonus payment (see instructions)					0	
00	Trended costs (lesser of line 53 ÷ line 54,	or line 55 from	n the cost rep	orting period	l ending 1996,	0.00	59
	updated and compounded by the market basket)					0.00	
	Expected costs (lesser of line 53 ÷ line 54, market basket)	or time 55 fro	om prior year	cost report,	updated by the	0.00	60
. 00	Continuous improvement bonus payment (if lin 55.01, or line 59, or line 60, enter the les					0	61
	53) are less than expected costs (lines 54 x						
	enter zero. (see instructions)		<u>.</u>	(
	Relief payment (see instructions)					0	
	Allowable Inpatient cost plus incentive paym	ent (see instru	ictions)			0	63
	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of th	e cost report	ing period (See	0	64
	instructions)(title XVIII only)	to thiough boot					
	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	per 31 of the	cost reportir	ng period (See	0	65
	instructions)(title XVIII only) Total Medicare swing bod SNE inpatient routi	no coste (lino	64 plus lipo	45) (+i +l o XV/I	II only). for	0	66
	Total Medicare swing-bed SNF inpatient routi CAH, see instructions	ne costs (ITHE	or prus rine	osych ne XVI	TT UTTY), TUT		66
	Title V or XIX swing-bed NF inpatient routin	e costs through	December 31	of the cost r	reporting period	0	67
00	(line 12 x line 19)	a anata -Et-	acombor 01 (+ + + + + + + + + + + + + + + + + + +	onting real ad		1 10
. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs arter L	ecember: 31 01	the cost rep	or tring period	0	68
	Total title V or XIX swing-bed NF inpatient					0	69
- E	PART III - SKILLED NURSING FACILITY, OTHER N				~		
	Skilled nursing facility/other nursing facil				()		70
	Adjusted general inpatient routine service c Program routine service cost (line 9 x line		ine /u ÷ line	: 2)			71
	Medically necessary private room cost applic		n (line 14 x l	ine 35)			73
	Total Program general inpatient routine serv	•		·			74
	Capital-related cost allocated to inpatient	routine service	e costs (from	Worksheet B,	Part II, column		75
	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76
	Program capital-related costs (line 9 x line						77
00	Inpatient routine service cost (line 74 minu	s line 77)					78
	Aggregate charges to beneficiaries for exces						79
	Total Program routine service costs for comp		cost limitatio	on (line 78 mi	nus line 79)		80
	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I)				81
	Reasonable inpatient routine service costs (82
	Program inpatient ancillary services (see in		,				84
	Utilization review - physician compensation		ons)				85
	Total Program inpatient operating costs (sum	of lines 83 th	nrough 85)				86
	PART IV - COMPUTATION OF OBSERVATION BED PAS	TUDOLICU COCT	2				

Health Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO	CN: 15-0042	Period: From 01/01/2023	Worksheet D-1	
		Component (CCN: 15-SO42	To 12/31/2023		
		Title XVIII Subprovider -		PPS		
Cost Center Description						
					1.00	
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						88.00
89.00 Observation bed cost (line 87 x line 88) (se)			0	89.00	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	607, 479	6, 827, 931	0. 0889	70 0	0	90.00
91.00 Nursing Program cost	0	6, 827, 931	0.0000	0 00	0	91.00
92.00 Allied health cost	0	6, 827, 931	0.0000	0 00	0	92.00
93.00 All other Medical Education	0	6, 827, 931	0.0000	0 00	0	93.00

	Financial Systems GOOD SAMARITAN ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0042	Peri od:	u of Form CMS-2 Worksheet D-1	
		Component CCN: 15-T042	From 01/01/2023 To 12/31/2023	Date/Time Pre 4/11/2024 3:1	
		Title XVIII	Subprovider -	PPS	7 pili
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS		I	1.00	
	INPATIENT DAYS				
00	Inpatient days (including private room days and swing-bed days			6, 252	
00 00	Inpatient days (including private room days, excluding swing Private room days (excluding swing-bed and observation bed o		rivate room davs.	6, 252 0	
	do not complete this line.			-	
00	Semi-private room days (excluding swing-bed and observation			6, 252	
00	Total swing-bed SNF type inpatient days (including private r reporting period	room days) through Decemb	er 31 of the cost	0	5
00	Total swing-bed SNF type inpatient days (including private r	room days) after December	31 of the cost	0	6
	reporting period (if calendar year, enter 0 on this line)				
00	Total swing-bed NF type inpatient days (including private ro reporting period	oom days) through Decembe	r 31 of the cost	0	7
00	Total swing-bed NF type inpatient days (including private ro	oom days) after December	31 of the cost	0	8
	reporting period (if calendar year, enter 0 on this line)	/			
00	Total inpatient days including private room days applicable newborn days) (see instructions)	to the Program (excluding	g swing-bed and	4, 578	9
. 00	Swing-bed SNF type inpatient days applicable to title XVIII	only (including private	room days)	0	10
	through December 31 of the cost reporting period (see instru				
. 00	Swing-bed SNF type inpatient days applicable to title XVIII December 31 of the cost reporting period (if calendar year,	5 (51	room days) after	0	11
. 00	Swing-bed NF type inpatient days applicable to titles V or X		te room days)	0	12
	through December 31 of the cost reporting period				
. 00	Swing-bed NF type inpatient days applicable to titles V or >			0	13
. 00	after December 31 of the cost reporting period (if calendar Medically necessary private room days applicable to the Proc			0	14
. 00	Total nursery days (title V or XIX only)			0	
. 00	Nursery days (title V or XIX only)			0	16
. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to servi	ces through December 31	of the cost	0.00	1 17
	reporting period	eee through becombol et		0.00	
. 00	Medicare rate for swing-bed SNF services applicable to servi	ces after December 31 of	the cost	0.00	18
. 00	reporting period Medicaid rate for swing-bed NF services applicable to servic	ces through December 31 o	f the cost	0.00	19
	reporting period				
. 00	Medicaid rate for swing-bed NF services applicable to servic reporting period	ces after December 31 of	the cost	0.00	20
. 00	Total general inpatient routine service cost (see instruction	ons)		5, 710, 634	21
. 00	Swing-bed cost applicable to SNF type services through Decem		ting period (line		
00	5 x line 17)			0	0.00
. 00	Swing-bed cost applicable to SNF type services after December x line 18)	er 31 of the cost report	ng period (line a	0	23
. 00	Swing-bed cost applicable to NF type services through Decemb	per 31 of the cost report	ing period (line	0	24
00	7 x line 19) Swing had cast applicable to NE type carvices after December	21 of the cost reportin	a pariod (line 9	0	25
6. 00	Swing-bed cost applicable to NF type services after December x line 20)	ST OF THE COST TEPOTETH		0	25
b. 00	Total swing-bed cost (see instructions)			0	
. 00	General inpatient routine service cost net of swing-bed cost	t (line 21 minus line 26)		5, 710, 634	27
. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-b	ped and observation bed c	harges)	0	28
	Private room charges (excluding swing-bed charges)		iai goo)	0	
. 00	Semi-private room charges (excluding swing-bed charges)			0	30
. 00	General inpatient routine service cost/charge ratio (line 27	7 ÷ line 28)		0.00000	
. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
. 00	Average per diem private room charge differential (line 32 m		ctions)	0.00	
. 00	Average per diem private room cost differential (line 34 x l			0.00	
	Private room cost differential adjustment (line 3 x line 35)		66	0	
. 00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	i and private room cost d	irrerential (line	5, 710, 634	37
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD		1		
	Adjusted general inpatient routine service cost per diem (se			913. 41 4, 181, 591	
0. 00	Program general inpatient routine service cost (line 9 x lin Medically necessary private room cost applicable to the Prog			4, 101, 371	

	Financial Systems ATION OF INPATIENT OPERATING COST	GOOD SAMARITA		CN: 15-0042	In Lie Period:	u of Form CMS-2 Worksheet D-1	
COMPUT	ATTON OF INFAILENT OPERATING COST			CCN: 15-0042 CCN: 15-T042	From 01/01/2023 To 12/31/2023	Date/Time Pre	epared:
			Title	e XVIII	Subprovider -	4/11/2024 3:1 PPS	7 pm
	Cost Contor Description	Total	Total	Average Per	I RF	Program Cost	
	Cost Center Description	Inpatient Cost	Inpatient Days	Diem (col. ÷ col. 2)	1	(col. 3 x col. 4)	
42 00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	42.00
42.00	Intensive Care Type Inpatient Hospital Unit	S				1	
43.00 44.00	INTENSIVE CARE UNIT CORONARY CARE UNIT	0	C	0.	00 00	0	43.00
44.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGI CAL I NTENSI VE CARE UNI T						46.00
47.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.00
	· · ·					1.00	
48.00 48.01	Program inpatient ancillary service cost (W Program inpatient cellular therapy acquisit	/kst. D-3, col. 3 ion cost (Workst	3, line 200) Deet D-6 - Part	III line 10) column 1)	3, 135, 327	
49.00					, corami 1)	7, 316, 918	
F0 00	PASS THROUGH COST ADJUSTMENTS	nationt routing	convious (fro	m Wkat D a	m of Dorto I on	E00 470	
50.00	Pass through costs applicable to Program in	ipatient routine	services (iro	m WKSI. D, SI	im of Parts I and	508, 478	50.00
51.00	Pass through costs applicable to Program in and IV)	patient ancillar	ry services (f	rom Wkst. D,	sum of Parts II	322, 243	51.00
52.00	Total Program excludable cost (sum of lines		alatad are al		botict ord	830, 721	
53.00	Total Program inpatient operating cost excl medical education costs (line 49 minus line		elated, non-pn	ysician anest	inetist, and	6, 486, 197	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION						-
54.00 55.00	Program discharges Target amount per discharge					0.00	
55.01	Permanent adjustment amount per discharge					0.00	55.01
55.02	Adjustment amount per discharge (contractor					0.00	
56.00 57.00	Target amount (line 54 x sum of lines 55, 5 Difference between adjusted inpatient opera			line 56 minus	sline 53)	0	
58.00	Bonus payment (see instructions)	and to			, , , , , , , , , , , , , , , , , , , ,	0	
59.00	Trended costs (lesser of line 53 ÷ line 54,		m the cost rep	orting period	l endi ng 1996,	0.00	59.00
60.00	updated and compounded by the market basket Expected costs (lesser of line 53 ÷ line 54 market basket)		om prior year	cost report,	updated by the	0.00	60.00
61.00	Continuous improvement bonus payment (if li 55.01, or line 59, or line 60, enter the le 53) are less than expected costs (lines 54	esser of 50% of t	the amount by	which operati	ng costs (line	0	61.00
62.00	enter zero. (see instructions) Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive pay	ment (see instru	uctions)			0	
64.00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine co	sts through Dece	ember 31 of th	e cost report	ing period (See	0	64.00
65.00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine co	sts after Decemb	per 31 of the	cost reportir	ng period (See	0	65.00
66.00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient rout CAH, see instructions	ine costs (line	64 plus line	65)(title XVI	<pre>II only); for</pre>	0	66.00
67.00		ne costs through	n December 31	of the cost r	reporting period	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routi (line 13 x line 20)	ne costs after [December 31 of	the cost rep	oorting period	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER	NURSING FACILITY	, AND ICF/IID	ONLY		0	69.00
70.00	Skilled nursing facility/other nursing faci	lity/ICF/IID rou	utine service	cost (line 37	/)		70.00
71.00 72.00	Adjusted general inpatient routine service Program routine service cost (line 9 x line		ine /U ÷ line	2)			71.00
73.00	Medically necessary private room cost appli		m (line 14 x l	ine 35)			73.00
74.00 75.00	Total Program general inpatient routine ser Capital-related cost allocated to inpatient	•			Part II, column		74.00 75.00
76.00	26, line 45) Per diem capital-related costs (line 75 ÷ l	ine 2)					76.00
77.00	Program capital -related costs (line 9 x lin						77.00
78.00	Inpatient routine service cost (line 74 min	,		45)			78.00
79.00 80.00	Aggregate charges to beneficiaries for exce Total Program routine service costs for com				nus line 79)		79.00
81.00	Inpatient routine service cost per diem lim	•		(1110 /0 m			81.00
	Inpatient routine service cost limitation (82.00
82.00	Reasonable inpatient routine service costs	•	ns)				83.00 84.00
83.00	Program innationt ancillary convision (and i						
83. 00 84. 00	Program inpatient ancillary services (see i Utilization review - physician compensation		ons)				85.00
83.00 84.00	Utilization review - physician compensation	(see instruction of lines 83 th					

Health Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 01/01/2023	Worksheet D-1	
			CCN: 15-T042	To 12/31/2023		
		Title	XVIII	Subprovider - IRF	PPS	
Cost Center Description						
					1.00	
88.00 Adjusted general inpatient routine cost per	diem (line 27	÷line 2)			0.00	88.00
89.00 Observation bed cost (line 87 x line 88) (se	e instructions)			0	89.00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	694, 440	5, 710, 634	0. 12160	05 0	0	90.00
91.00 Nursing Program cost	0	5, 710, 634	0.0000	0 00	0	91.00
92.00 Allied health cost	0	5, 710, 634	0.0000	0 00	0	92.00
93.00 All other Medical Education	0	5, 710, 634	0.0000	0 00	0	93.00

MPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0042	Period: From 01/01/2023	Worksheet D-1	
			To 12/31/2023	4/11/2024 3:1	
	Cost Center Description	Title XIX	Hospi tal	Cost	
	PART I - ALL PROVIDER COMPONENTS			1.00	
00	I NPATI ENT DAYS			12.244	
00 00	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing-			12, 266 12, 266	
00	Private room days (excluding swing-bed and observation bed da		rivate room days,	0	
00	do not complete this line. Semi-private room days (excluding swing-bed and observation b	aveb boo		9, 713	4
00	Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	9, 713	
00	reporting period	am dava) aftar Daaambar	21 of the east	0	
00	Total swing-bed SNF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line)	oom days) arter December	31 of the cost	0	6
00	Total swing-bed NF type inpatient days (including private roo	om days) through Decembe	r 31 of the cost	0	7
00	reporting period Total swing-bed NF type inpatient days (including private roo	om davs) after December	31 of the cost	0	8
	reporting period (if calendar year, enter 0 on this line)			Ū	
00	Total inpatient days including private room days applicable 1 newborn days) (see instructions)	to the Program (excludin	g swing-bed and	405	9
. 00	Swing-bed SNF type inpatient days applicable to title XVIII o	only (including private	room days)	0	10
00	through December 31 of the cost reporting period (see instruc			0	1 1 1
. 00	Swing-bed SNF type inpatient days applicable to title XVIII of December 31 of the cost reporting period (if calendar year, e		room days) arter	0	11
. 00	Swing-bed NF type inpatient days applicable to titles V or XI		te room days)	0	12
00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI	X only (including priva	te room days)	0	13
	after December 31 of the cost reporting period (if calendar y	year, enter O on this li	ne)	-	
	Medically necessary private room days applicable to the Progr Total nursery days (title V or XIX only)	ram (excluding swing-bed	days)	0 816	14
	Nursery days (title V or XIX only)			010	
	SWING BED ADJUSTMENT				
. 00	Medicare rate for swing-bed SNF services applicable to servic reporting period	ces through December 31	of the cost	0.00	17
. 00	Medicare rate for swing-bed SNF services applicable to servic reporting period	ces after December 31 of	the cost	0.00	18
. 00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 c	f the cost	0.00	19
. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	es after December 31 of	the cost	0.00	20
. 00	reporting period Total general inpatient routine service cost (see instruction))		19, 883, 833	21
	Swing-bed cost applicable to SNF type services through Decemb		ting period (line		
	5 x line 17)				
. 00	Swing-bed cost applicable to SNF type services after December x line 18)	- 31 OF THE COST REPORT	ng period (line 6	0	23
. 00	Swing-bed cost applicable to NF type services through Decembe	er 31 of the cost report	ing period (line	0	24
. 00	7 x line 19) Swing-bed cost applicable to NF type services after December	31 of the cost reportin	g period (line 8	0	25
. 00	x line 20) Total swing-bed cost (see instructions)			0	26
	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		19, 883, 833	
00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	and observation had a	hanges)	0	1 20
	Private room charges (excluding swing-bed charges)		nai yes)	0	
. 00	Semi-private room charges (excluding swing-bed charges)			0	30
	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.000000	
. 00 . 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mi	nus line 33)(see instru	ctions)	0.00 0.00	
	Average per diem private room cost differential (line 34 x li			0.00	
	Private room cost differential adjustment (line 3 x line 35)	-		0	
. 00	General inpatient routine service cost net of swing-bed cost	and private room cost d	ifferential (line	19, 883, 833	37
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
<u> </u>	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD.		Т		
	Adjusted general inpatient routine service cost per diem (see			1,621.05	
	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progr			656, 525 0	
				0	

MPUTATION OF INPATIENT OPERATING COST			neet D-1
	То		ime Prepa
	Title XIX	Hospi tal	2 <u>024 3:17</u> Cost
Cost Center Description Total	Total Average Per F	Program Days Progra	m Cost
Inpatient	Inpatient Diem (col. 1		3 X
<u> </u>	Days ÷ col. 2) 2.00 3.00	4.00 5.	
00 NURSERY (title V & XIX only) 1,547,35		0	0
Intensive Care Type Inpatient Hospital Units			
00 INTENSIVE CARE UNIT 9, 377, 02 00 CORONARY CARE UNIT 9, 377, 02	0 4, 812 1, 948. 67	0	0 4
00 BURN I NTENSI VE CARE UNI T			
00 SURGI CAL I NTENSI VE CARE UNI T			4
00 OTHER SPECIAL CARE (SPECIFY)			4
Cost Center Description		1.	00
00 Program inpatient ancillary service cost (Wkst. D-3, col.			460, 663 4
01 Program inpatient cellular therapy acquisition cost (Works			0 4
00 Total Program inpatient costs (sum of lines 41 through 48 PASS THROUGH COST ADJUSTMENTS	.01)(see instructions)	1,	117, 188
00 Pass through costs applicable to Program inpatient routing	e services (from Wkst. D. sum o	f Parts L and	0 5
00 Pass through costs applicable to Program inpatient ancill	ary services (from Wkst. D, sum	of Parts II	0 5
and IV) .00 Total Program excludable cost (sum of lines 50 and 51)			0 5
00 Total Program inpatient operating cost excluding capital	related, non-physician anestheti	st, and	0 5
medical education costs (line 49 minus line 52)			
TARGET AMOUNT AND LIMIT COMPUTATION 00 Program di scharges			0 5
00 Target amount per discharge			0.00 5
01 Permanent adjustment amount per discharge			0.00 5
02 Adjustment amount per discharge (contractor use only)			0.00 5
00 Target amount (line 54 x sum of lines 55, 55.01, and 55.0. 00 Difference between adjusted inpatient operating cost and		ne 53)	0 5
.00 Bonus payment (see instructions)			0 5
00 Trended costs (lesser of line 53 ÷ line 54, or line 55 fr	om the cost reporting period end	di ng 1996,	0.00 5
updated and compounded by the market basket) .00 Expected costs (lesser of line 53 ÷ line 54, or line 55 f	rom prior year cast report und	ated by the	0.00
market basket)	Tom prior year cost report, upua	ated by the	0.00
00 Continuous improvement bonus payment (if line 53 ÷ line 5 55.01, or line 59, or line 60, enter the lesser of 50% of 53) are less than expected costs (lines 54 x 60), or 1 %	the amount by which operating of	costs (line	0 6
enter zero. (see instructions) 00 Relief payment (see instructions)			0 6
.00 Allowable Inpatient cost plus incentive payment (see inst	ructions)		0 6
PROGRAM INPATIENT ROUTINE SWING BED COST			
.00 Medicare swing-bed SNF inpatient routine costs through De instructions)(title XVIII only)	cember 31 of the cost reporting	period (See	0 6
.00 Medicare swing-bed SNF inpatient routine costs after Dece	mber 31 of the cost reporting pe	eriod (See	0 6
instructions)(title XVIII only)			
.00 Total Medicare swing-bed SNF inpatient routine costs (line CAH, see instructions	e 64 plus line 65)(title XVIII (only); for	0 6
.00 Title V or XIX swing-bed NF inpatient routine costs throu	gh December 31 of the cost repo	rting period	0 6
(line 12 x line 19)	-		
.00 Title V or XIX swing-bed NF inpatient routine costs after	December 31 of the cost report	ng period	0 6
(line 13 x line 20) .00 Total title V or XIX swing-bed NF inpatient routine costs	(line 67 + line 68)		0 6
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILI	· · · · · · · · · · · · · · · · · · ·		
.00 Skilled nursing facility/other nursing facility/ICF/IID r			
00 Adjusted general inpatient routine service cost per diem00 Program routine service cost (line 9 x line 71)	(THE /U ÷ THE 2)		-
00 Medically necessary private room cost applicable to Progra	am (line 14 x line 35)		1
00 Total Program general inpatient routine service costs (li			-
00 Capital-related cost allocated to inpatient routine servi- 26, line 45)	ce costs (trom Worksheet B, Par	t II, column	7
00 Per diem capital-related costs (line 75 ÷ line 2)			
00 Program capital-related costs (line 9 x line 76)			
00 Inpatient routine service cost (line 74 minus line 77)	provider records)		-
00 Aggregate charges to beneficiaries for excess costs (from 00 Total Program routine service costs for comparison to the		line 79)	8
00 Inpatient routine service cost per diem limitation			8
00 Inpatient routine service cost limitation (line 9 x line			8
00 Reasonable inpatient routine service costs (see instruction)00 Program inpatient ancillary services (see instructions)	ons)		8
.00 Utilization review - physician compensation (see instructions)	i ons)		8
00 Total Program inpatient operating costs (sum of lines 83	through 85)		
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 00 Total observation bed days (see instructions)	Γ		2 552 4
			2, 553 8

Health Financial Systems	GOOD SAMARI TA	AN HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period:	Worksheet D-1	
				From 01/01/2023 To 12/31/2023	Date/Time Pre 4/11/2024 3:1	pared: 7 pm
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description						
					1.00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions))			4, 138, 541	89.00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	1, 873, 820	19, 883, 833	0.09423	4, 138, 541	390, 008	90.00
91.00 Nursing Program cost	0	19, 883, 833	0.0000	0 4, 138, 541	0	91.00
92.00 Allied health cost	0	19, 883, 833	0.00000	0 4, 138, 541	0	92.00
93.00 All other Medical Education	0	19, 883, 833	0.00000	4, 138, 541	0	93.00

MPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0042	Peri od:	Worksheet D-1	
		Component CCN: 15-SO42	From 01/01/2023 To 12/31/2023	Date/Time Pre 4/11/2024 3:1	
		Title XIX	Subprovider - IPF	Cost	
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS				
	Inpatient days (including private room days and swing-bed day			4, 323	
	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed days)		rivato room dave	4, 323 0	2
0	do not complete this line.	ays). If you have only p	i i vate i ooni uays,	0	
00	Semi-private room days (excluding swing-bed and observation I	bed days)		4, 323	4
00	Total swing-bed SNF type inpatient days (including private re	oom days) through Decemb	er 31 of the cost	0	5
	reporting period		04		
00	Total swing-bed SNF type inpatient days (including private reporting period (if calendar year, enter 0 on this line)	oom days) after December	31 of the cost	0	6
00	Total swing-bed NF type inpatient days (including private roo	om davs) through Decembe	r 31 of the cost	0	7
	reporting period	<i>y</i> , <i>c</i>		-	
00	Total swing-bed NF type inpatient days (including private roo	om days) after December	31 of the cost	0	8
20	reporting period (if calendar year, enter 0 on this line)	to the Dreason (avaludin	a owing had and	257	9
00	Total inpatient days including private room days applicable newborn days) (see instructions)	to the Program (excluding	y swilly-bed and	357	`
00	Swing-bed SNF type inpatient days applicable to title XVIII (only (including private	room days)	0	10
	through December 31 of the cost reporting period (see instrue	ctions)			
00	Swing-bed SNF type inpatient days applicable to title XVIII of		room days) after	0	11
00	December 31 of the cost reporting period (if calendar year, of Swing-bed NF type inpatient days applicable to titles V or X		to room days)	0	12
00	through December 31 of the cost reporting period	TX only (Therading priva	te room uays)	0	12
00	Swing-bed NF type inpatient days applicable to titles V or X	IX only (including priva	te room days)	0	13
	after December 31 of the cost reporting period (if calendar				
	Medically necessary private room days applicable to the Prog	ram (excluding swing-bed	days)	0	
	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			816 0	
	SWING BED ADJUSTMENT		I	0	
	Medicare rate for swing-bed SNF services applicable to service	ces through December 31	of the cost	0.00	17
	reporting period				
00	Medicare rate for swing-bed SNF services applicable to service reporting period	ces after December 31 of	the cost	0.00	1 18
00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 o	f the cost	0.00	19
	reporting period				
00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of	the cost	0.00	20
00	reporting period	70)		(007 001	21
	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decem	·	ting period (line	6, 827, 931 0	
. 00	5 x line 17)		ting period (init	0	22
. 00	Swing-bed cost applicable to SNF type services after December	r 31 of the cost reporti	ng period (line 6	0	23
	x line 18)			-	
00	Swing-bed cost applicable to NF type services through December 7×1 (ine 19)	er 31 of the cost report	ing period (line	0	24
. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reportin	a period (line 8	0	25
	x line 20)		,	0	_ `
	Total swing-bed cost (see instructions)			0	
	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		6, 827, 931	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	od and observation bod c	bargos)	0	28
	Private room charges (excluding swing-bed charges)	ed and observation bed c		0	
	Semi-private room charges (excluding swing-bed charges)			0	
	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.000000	
	Average private room per diem charge (line 29 ÷ line 3)			0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mi	inus line 33)(see instru	ctions)	0.00 0.00	
	Average per diem private room cost differential (line 34 x li			0.00	
	Private room cost differential adjustment (line 3 x line 35)			0.00	36
	General inpatient routine service cost net of swing-bed cost	and private room cost d	ifferential (line	6, 827, 931	
	27 minus line 36)				1
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD.	ILISTMENTS			1
	Adjusted general inpatient routine service cost per diem (see			1, 579. 44	38
	Program general inpatient routine service cost (line 9 x line			563, 860	
	Medically necessary private room cost applicable to the Progr	ram (line 14 x line 35)		0	40
	Total Program general inpatient routine service cost (line 34	$0 + 1 i p_0 (0)$		563, 860	1 1-

	Financial Systems TION OF INPATIENT OPERATING COST	GOOD SAMARITA		CN: 15-0042	Period:	u of Form CMS-: Worksheet D-1	
				CCN: 15-S042	From 01/01/2023 To 12/31/2023		epared
			Ti tl	e XIX	Subprovider -	Cost	7 piii
	Cost Center Description	Total I npati ent	Total I npati ent	Average Per Diem (col.	0 5	Program Cost (col. 3 x	
		Cost 1.00	Days 2.00	÷ col. 2) 3.00	4.00	col. 4) 5.00	
2.00	NURSERY (title V & XIX only)	0					42.0
1	ntensive Care Type Inpatient Hospital Units			I	<u>_</u>	1	1
	INTENSIVE CARE UNIT	0	C	0.	00 0	0	
	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44.0
	SURGI CAL I NTENSI VE CARE UNI T						46.0
7.00 (OTHER SPECIAL CARE (SPECIFY)						47.0
	Cost Center Description					1.00	
3. 00 F	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	3. line 200)			27, 179	48.
3. 01 F	Program inpatient cellular therapy acquisiti	on cost (Worksł	neet D-6, Part	III, line 10), column 1)	0	
	Total Program inpatient costs (sum of lines	41 through 48.(01)(see instru	ctions)		591, 039	49.
-	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	ationt routing	services (fro	m Wkst D si	m of Parts I and	0	50.
			Services (III	m wkst. D, St			30.
1.00 F	Pass through costs applicable to Program inp	atient ancilla	ry services (f	rom Wkst. D,	sum of Parts II	0	51.0
	and IV) Tatal Dragnam avaludable cost (sum of lines	EQ and E1)				0	52.
	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		elated, non-ph	vsician anest	thetist. and		
	medical education costs (line 49 minus line	5 1	or a coa, non pr	Jor or arr arros	chotrot, and		
	TARGET AMOUNT AND LIMIT COMPUTATION						
	Program discharges Target amount per discharge					0.00	
	Permanent adjustment amount per discharge					0.00	
	Adjustment amount per discharge (contractor	use only)				0.00	
	Target amount (line 54 x sum of lines 55, 55					0	
	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	arget amount (line 56 minus	s line 53)	0	
	Trended costs (lesser of line 53 ÷ line 54,	or line 55 from	n the cost ren	ortina period	d ending 1996	0.00	
l	updated and compounded by the market basket)			0.1	0		
r	Expected costs (lesser of line 53 ÷ line 54, market basket)					0.00	
Ę	Continuous improvement bonus payment (if lin 55.01, or line 59, or line 60, enter the les 53) are less than expected costs (lines 54 x enter zero. (see instructions)	ser of 50% of t	the amount by	which operati	ng costs (line	0	61.
	Relief payment (see instructions)					0	62.
8.00 /	Allowable Inpatient cost plus incentive paym	ent (see instru	uctions)			0	63.
. 00 🛽	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of th	e cost report	ting period (See	0	64.
	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decemb	per 31 of the	cost reportin	ng period (See	0	65.
	instructions)(title XVIII only)	no costs (lino	64 plus lips	4E) (+; + o V)/	ll only), for	0	64
(Total Medicare swing-bed SNF inpatient routi CAH, see instructions		·		3,	0	
	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	n December 31	of the cost i	reporting period	0	67.
	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)				porting period	0	
P	Total title V or XIX swing-bed NF inpatient ART III - SKILLED NURSING FACILITY, OTHER N	JRSING FACILITY	, AND ICF/IID	ONLY	- `	0	
	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c				()		70.
	Program routine service cost (line 9 x line		ine /o ÷ ine	-)			72.
. 00	Medically necessary private room cost applic	able to Program					73.
00 0	Total Program general inpatient routine serv Capital-related cost allocated to inpatient 26, line 45)	•			Part II, column		74.
00 F	Per diem capital-related costs (line 75 ÷ li						76
	Program capital-related costs (line 9 x line						77.
	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		provi den inecor	ds)			78.
	Total Program routine service costs for comp				nus line 79)		80
. 00 I	Inpatient routine service cost per diem limi	tation					81.
	Inpatient routine service cost limitation (I						82.
	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in		15)				83. 84.
	Utilization review - physician compensation		ons)				85.
. 00 📘	Total Program inpatient operating costs (sum	of lines 83 th					86.
ID.	PART IV - COMPUTATION OF OBSERVATION BED PAS	S THROUGH COST				1	

Health Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 01/01/2023	Worksheet D-1	
		Component (CCN: 15-SO42	To 12/31/2023		
		Ti tl	e XIX	Subprovider - IPF	Cost	
Cost Center Description						
					1.00	
88.00 Adjusted general inpatient routine cost per	diem (line 27	÷line 2)			0.00	88.00
89.00 Observation bed cost (line 87 x line 88) (se	e instructions)			0	89.00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	607, 479	6, 827, 931	0. 08897	70 0	0	90.00
91.00 Nursing Program cost	0	6, 827, 931	0.0000	0 0	0	91.00
92.00 Allied health cost	0	6, 827, 931	0.0000	0 0	0	92.00
93.00 All other Medical Education	0	6, 827, 931	0.0000	0 0	0	93.00

MPUT	Financial Systems GOOD SAMARITAN ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0042	Peri od:	u of Form CMS-2 Worksheet D-1	
		Component CCN: 15-T042	From 01/01/2023 To 12/31/2023	Date/Time Pre 4/11/2024 3:1	
		Title XIX	Subprovider -	Cost	, bu
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS				
	Inpatient days (including private room days and swing-bed da			6, 252	1
	Inpatient days (including private room days, excluding swing			6, 252	2
00	Private room days (excluding swing-bed and observation bed d do not complete this line.	lays). If you have only p	rivate room days,	0	3
00	Semi-private room days (excluding swing-bed and observation	bed days)		6, 252	4
00	Total swing-bed SNF type inpatient days (including private r		er 31 of the cost		5
	reporting period				
00	Total swing-bed SNF type inpatient days (including private r	room days) after December	31 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private ro	om davis) through Decombo	r 21 of the cost	0	7
50	reporting period	ioni days) thi ough becenibe	I SI UI LINE CUSL	0	'
00	Total swing-bed NF type inpatient days (including private ro	oom days) after December	31 of the cost	0	8
	reporting period (if calendar year, enter 0 on this line)				
00	Total inpatient days including private room days applicable	to the Program (excludin	g swing-bed and	17	9
. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII	anly (including private	reem deve)	0	10
00	through December 31 of the cost reporting period (see instru		room uays)	0	
00	Swing-bed SNF type inpatient days applicable to title XVIII		room days) after	0	11
	December 31 of the cost reporting period (if calendar year,		5		
. 00	Swing-bed NF type inpatient days applicable to titles V or X	(IX only (including priva	te room days)	0	12
00	through December 31 of the cost reporting period	(IV only (including prive	ta naam daya)	0	11
	Swing-bed NF type inpatient days applicable to titles V or X after December 31 of the cost reporting period (if calendar			0	13
00	Medically necessary private room days applicable to the Prog	ram (excluding swing-bed	davs)	0	14
	Total nursery days (title V or XIX only)			816	
	Nursery days (title V or XIX only)			0	16
	SWING BED ADJUSTMENT	and through December 21	of the east	0.00	1 1 7
. 00	Medicare rate for swing-bed SNF services applicable to servi reporting period	ces through December 31	or the cost	0.00	
. 00	Medicare rate for swing-bed SNF services applicable to servi	ces after December 31 of	the cost	0.00	18
	reporting period				
. 00	Medicaid rate for swing-bed NF services applicable to servic	es through December 31 o	f the cost	0.00	19
. 00	reporting period Medicaid rate for swing-bed NF services applicable to servic	os after December 21 of	the cost	0.00	20
	reporting period	es al tel December 31 01	the cost	0.00	20
	Total general inpatient routine service cost (see instructio	ns)		5, 710, 634	21
00	Swing-bed cost applicable to SNF type services through Decem	ber 31 of the cost repor	ting period (line	0	22
	5 x line 17)				
	Swing-bed cost applicable to SNF type services after Decembe x line 18)	er 31 of the cost reporti	ng period (line 6	0	23
	Swing-bed cost applicable to NF type services through Decemb	er 31 of the cost report	ina period (line	0	24
	7 x line 19)			-	- ·
	Swing-bed cost applicable to NF type services after December	31 of the cost reportin	g period (line 8	0	25
	x line 20)			0	
	Total swing-bed cost (see instructions)	(line 21 minus line 26)		0 5, 710, 634	
	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	CITIC ZI IIITIUS ITTIC 20)		5, 710, 034	27
	General inpatient routine service charges (excluding swing-b	ed and observation bed c	harges)	0	28
00	Private room charges (excluding swing-bed charges)			0	29
	Semi -private room charges (excluding swing-bed charges)			0	
	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0.000000	
	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
	Average per diem private room charge differential (line 32 m		ctions)	0.00	
	Average per diem private room cost differential (line 34 x l			0.00	
00	Private room cost differential adjustment (line 3 x line 35)			0	36
	General inpatient routine service cost net of swing-bed cost	and private room cost d	ifferential (line	5, 710, 634	37
	27 minus line 36)				1
	PART II – HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD.	JUSTMENTS			1
	Adjusted general inpatient routine service cost per diem (se			913.41	38
	Program general inpatient routine service cost (line 9 x lin			15, 528	
	Medically necessary private room cost applicable to the Prog	ram (line 14 x line 35)		0	
	Total Program general inpatient routine service cost (line 3			15, 528	1 4 1

ealth Financial Systems COMPUTATION OF INPATIENT OPERATING COST	GOOD SAWARTTA	N HOSPITAL Provider C	CN: 15-0042	Period:	u of Form CMS-: Worksheet D-1	
			CCN: 15-T042	From 01/01/2023 To 12/31/2023		epared:
		Ti tl	e XIX	Subprovider -	Cost	7 piii
Cost Center Description	Total I npati ent Cost	Total Inpatient Days	Average Per Diem (col. ÷ col. 2)	0 5	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
I2.00 NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Un	0 its		0.	00 0	0	42.0
3. 00 INTENSIVE CARE UNIT	0	C	0.	00 0	0	43.0
4.00 CORONARY CARE UNIT						44.0
I5. 00 BURN INTENSIVE CARE UNIT I6. 00 SURGICAL INTENSIVE CARE UNIT						45.0
17. 00 OTHER SPECIAL CARE (SPECIFY)						47.0
Cost Center Description					1.00	
8.00 Program inpatient ancillary service cost	(Wkst. D-3, col. 3	, line 200)			23, 769	48.0
8.01 Program inpatient cellular therapy acquis	sition cost (Worksh	eet D-6, Part), column 1)	0	48.0
19.00 Total Program inpatient costs (sum of lir	nes 41 through 48.C	01)(see instru	ctions)		39, 297	49.0
PASS THROUGH COST ADJUSTMENTS 50.00 Pass through costs applicable to Program	inpatient routine	services (fro	m Wkst. D. s	um of Parts I and	0	50.0
111)						
1.00 Pass through costs applicable to Program	inpatient ancillar	y services (f	rom Wkst. D,	sum of Parts II	0	51.0
and IV) 52.00 Total Program excludable cost (sum of lin	nes 50 and 51)				0	52.0
3.00 Total Program inpatient operating cost ex	cluding capital re	lated, non-ph	ysi ci an anes	thetist, and	0	
medical education costs (line 49 minus li TARGET AMOUNT AND LIMIT COMPUTATION	ne 52)					-
54.00 Program di scharges					0	54.0
5.00 Target amount per discharge					0.00	
55.01 Permanent adjustment amount per discharge					0.00	
5.02 Adjustment amount per discharge (contract 6.00 Target amount (line 54 x sum of lines 55,					0.00	
7.00 Difference between adjusted inpatient ope			line 56 minu	s line 53)	0	
8.00 Bonus payment (see instructions)				1	0	
59.00 Trended costs (lesser of line 53 ÷ line 5 updated and compounded by the market bask		i the cost rep	orting perio	a enaling 1996,	0.00	59.0
0.00 Expected costs (lesser of line 53 ÷ line market basket)		m prior year	cost report,	updated by the	0.00	60.0
01.00 Continuous improvement bonus payment (if 55.01, or line 59, or line 60, enter the 53) are less than expected costs (lines 5 anter zore (cost instructions)	lesser of 50% of t	he amount by	which operat	ng costs (line	0	61.0
enter zero. (see instructions) 2.00 Relief payment (see instructions)					0	62.0
03.00 Allowable Inpatient cost plus incentive p PROGRAM INPATIENT ROUTINE SWING BED COST	payment (see instru	icti ons)			0	63.0
04.00 Medicare swing-bed SNF inpatient routine instructions)(title XVIII only)	costs through Dece	mber 31 of th	e cost repor	ting period (See	0	64.0
55.00 Medicare swing-bed SNF inpatient routine instructions)(title XVIII only)	costs after Decemb	er 31 of the	cost reporti	ng period (See	0	65.0
66.00 Total Medicare swing-bed SNF inpatient ro CAH, see instructions		•	, ,	3,	0	
57.00 Title V or XIX swing-bed NF inpatient rou (line 12 x line 19)						
88.00 Title V or XIX swing-bed NF inpatient rou (line 13 x line 20)				borting period	0	
p9.00 Total title V or XIX swing-bed NF inpatie PART III - SKILLED NURSING FACILITY, OTHE 70.00 Skilled nursing facility/other nursing facility/other	R NURSING FACILITY	, AND ICF/IID	ONLY	7)	0	69.0 70.0
71.00 Adjusted general inpatient routine service				• /		71.0
2.00 Program routine service cost (line 9 x li	ne 71)					72.0
 3.00 Medically necessary private room cost app 4.00 Total Program general inpatient routine s 	0		,			73.0
5.00 Capital-related cost allocated to inpatie 26, line 45)	ent routine service			Part II, column		75. C
6.00 Per diem capital-related costs (line 75 ÷ 7.00 Program capital-related costs (line 9 x l						76.0
8.00 Inpatient routine service cost (line 74 m						78.0
9.00 Aggregate charges to beneficiaries for ex						79.0
30.00 Total Program routine service costs for c 31.00 Inpatient routine service cost per diem	•	ost limitatio	n (line 78 m	nus line 79)		80. C
82.00 Inpatient routine service cost per drem a)				82.0
33.00 Reasonable inpatient routine service cost	s (see instruction					83.0
84.00 Program inpatient ancillary services (see 85.00 Utilization review - physician compensati		ne)				84.0
35.00 Utilization review - physician compensati 36.00 Total Program inpatient operating costs (85.0 86.0
o. oo jiotai Fiogram Inpatrent operating costs (

Health Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 01/01/2023	Worksheet D-1	
		Component (To 12/31/2023		
		Titl	e XIX	Subprovider - IRF	Cost	
Cost Center Description						
					1.00	
88.00 Adjusted general inpatient routine cost per	diem (line 27 ·	÷line 2)			0.00	88.00
89.00 Observation bed cost (line 87 x line 88) (se	e instructions)			0	89.00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	694, 440	5, 710, 634	0. 12160	05 0	0	90.00
91.00 Nursing Program cost	0	5, 710, 634	0.0000	0 00	0	91.00
92.00 Allied health cost	0	5, 710, 634	0.0000	0 00	0	92.00
93.00 All other Medical Education	0	5, 710, 634	0.0000	0 00	0	93.00

ealth Financial Systems GOOD SAMARITAN H		011 15 0010		u of Form CMS-2	
NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0042	Period: From 01/01/2023	Worksheet D-3	8
			To 12/31/2023		nared.
			10 12/01/2020	4/11/2024 3:1	
	Title	e XVIII	Hospi tal	PPS	•
Cost Center Description		Ratio of Cos	t Inpatient	Inpati ent	
·		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
				col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS			8, 220, 511		30.0
1. 00 03100 INTENSIVE CARE UNIT			5, 171, 709		31.0
0.00 04000 SUBPROVIDER - IPF			0		40.0
1.00 04100 SUBPROVIDER - IRF			0		41.0
3. 00 04300 NURSERY					43.0
ANCILLARY SERVICE COST CENTERS					
0.00 05000 OPERATING ROOM		0. 1918	52 5, 824, 453	1, 117, 433	50.0
1.00 05100 RECOVERY ROOM		0.0000	0 00	0	51.0
1. 01 05101 ENDOSCOPY		0. 2416	35 427, 611	103, 326	51.0
2.00 05200 DELIVERY ROOM & LABOR ROOM		0. 4476	74 5,064	2, 267	52.0
3. 00 05300 ANESTHESI OLOGY		0. 2043	57 0	0	53.0
4. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1136		862, 861	54.0
5. 00 05500 RADI OLOGY-THERAPEUTI C		0. 2202	77 33, 326		
0. 00 06000 LABORATORY		0. 1375		1, 202, 738	
3. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0.0000		0	
5. 00 06500 RESPI RATORY THERAPY		0. 3266		853, 648	65.0
6. 00 06600 PHYSI CAL THERAPY		0. 3297			
9.00 06900 ELECTROCARDI OLOGY		0. 14980		1,063,020	
0.00 07000 ELECTROENCEPHALOGRAPHY		0.0000		0	
0. 01 07001 NEURODI AGNOSTI CS		0. 3188		10, 900	
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		1. 4972			
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 4234			
3.00 07300 DRUGS CHARGED TO PATI ENTS		0. 2930			
5.00 07500 ASC (NON-DI STINCT PART)		0. 18340		39	
76. 00 03950 MH ANCI LLARY OUTPATI ENT		0.0000			
76. 01 03951 I NPATI ENT DI ALYSI S		0. 7749		-	
OUTPATIENT SERVICE COST CENTERS		0.7717	107,100	017,070	/0.0
18. 00 08800 FAMILY PRACTICE 120		0.0000	20	0	88.0
0. 00 09000 CLINIC		3. 2923		0	
0. 01 04950 WOUND CLINIC		0. 3185			
0. 01 04930 WOND CEINIC		0. 2171			
22. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 3110			
OTHER REIMBURSABLE COST CENTERS		0.5110	, 5, 2, 003, 004	023,000	1 /2.0
06. 00 09600 DURABLE MEDICAL EQUIP-RENTED		0. 5142	47 0	0	96.0
200.00 Total (sum of lines 50 through 94 and 96 through 98)		0. 5142	50, 043, 229		
201.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)		50, 043, 229	11,470,009	200.0
202.00 Net charges (line 200 minus line 201)			50, 043, 229		201.0
Dz. 00 met charges (The 200 minus The 201)		I	50, 045, 229	l	1202.0

NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0042	Peri od:	Worksheet D-3	
		001 45 0040	From 01/01/2023		
	Component	CCN: 15-S042	To 12/31/2023	Date/Time Pre 4/11/2024 3:1	
	Title	e XVIII	Subprovider -	PPS	<u> </u>
			I PF		
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	5	Program Costs	
			Charges	(col. 1 x	
		1.00	2.00	col. 2)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	-
0. 00 03000 ADULTS & PEDI ATRICS					30
1. 00 03100 I NTENSI VE CARE UNI T					31
0. 00 04000 SUBPROVI DER – I PF			948, 536		40.
1. 00 04100 SUBPROVI DER – I RF			,		41.
3. 00 04300 NURSERY					43.
ANCI LLARY SERVICE COST CENTERS					
0.00 05000 OPERATING ROOM		0. 1918	52 12, 660	2, 429	50.
1.00 05100 RECOVERY ROOM		0.0000	00 0	0	51.
1. 01 05101 ENDOSCOPY		0. 2416	35 0	0	51.
2.00 05200 DELIVERY ROOM & LABOR ROOM		0. 4476		0	
3. 00 05300 ANESTHESI OLOGY		0. 2043		0	
4. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1136			
5. 00 05500 RADI OLOGY-THERAPEUTI C		0. 2202		0	
0. 00 06000 LABORATORY		0. 1375		18, 974	
3. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0.0000		0	
5. 00 06500 RESPI RATORY THERAPY		0. 3266		8, 290	
6. 00 06600 PHYSI CAL THERAPY		0. 3297		2, 431	
9. 00 06900 ELECTROCARDI OLOGY		0. 14980		1, 717	
0. 00 07000 ELECTROENCEPHALOGRAPHY		0.0000		0	
0. 01 07001 NEURODI AGNOSTI CS		0. 3188		1, 316	
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 2.00 07200 IMPL. DEV. CHARGED TO PATIENTS		1. 4972 0. 4234		2, 762 0	
3. 00 07300 DRUGS CHARGED TO PATIENTS		0. 29302		26, 627	
5. 00 07500 ASC (NON-DISTINCT PART)		0. 2930		20,027	
6. 00 03950 MH ANCI LLARY OUTPATI ENT		0. 00000		0	
6. 01 03951 I NPATI ENT DI ALYSI S		0. 7749		0	
OUTPATIENT SERVICE COST CENTERS		0.7717		0	- / 0.
8. 00 08800 FAMILY PRACTICE 120		0.0000	00	0	88.
0. 00 09000 CLINIC		3. 2923	71 0	0	90.
0. 01 04950 WOUND CLINIC		0. 3185		0	90.
1.00 09100 EMERGENCY		0. 2171	42 169, 069	36, 712	91.
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 3110	73 0	0	92.
OTHER REIMBURSABLE COST CENTERS		1			
6. 00 09600 DURABLE MEDI CAL EQUI P-RENTED		0. 5142		0	
00.00 Total (sum of lines 50 through 94 and 96 through 98)			476, 859	103, 090	
01.00 Less PBP Clinic Laboratory Services-Program only cha	rges (line 61)		0		201.
02.00 Net charges (line 200 minus line 201)		1	476, 859		202.

NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0042	Peri od:	Worksheet D-3	3
	Component	CCN: 15-T042	From 01/01/2023 To 12/31/2023	Date/Time Pre	epare
				4/11/2024 3:1	
	Title	e XVIII	Subprovider - IRF	PPS	
Cost Center Description		Ratio of Cos		I npati ent	
·		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
				col. 2)	
		1.00	2.00	3.00	-
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 0. 00 03000 ADULTS & PEDI ATRI CS					30.
1. 00 03100 INTENSIVE CARE UNIT					30
0. 00 04000 SUBPROVI DER - I PF					40
1. 00 04000 SUBPROVIDER - TPF			5, 788, 915		40.
3. 00 04100 SUBPROVIDER - TRF			5, 766, 915		41
ANCI LLARY SERVI CE COST CENTERS					43
D. 00 05000 OPERATING ROOM		0. 19185	20, 176	3, 871	50
1. 00 05100 RECOVERY ROOM		0. 00000		0,0,1	
1. 01 05101 ENDOSCOPY		0. 24163		2, 516	
2. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 44767		0	
3. 00 05300 ANESTHESI OLOGY		0. 20435		0	
4. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 11363		42, 461	54
5. 00 05500 RADI OLOGY-THERAPEUTI C		0. 22027		0	
D. 00 06000 LABORATORY		0. 13753		117, 845	60
3. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0.00000	0 0	0	
5. 00 06500 RESPI RATORY THERAPY		0. 32664	40 837, 151	273, 447	65.
6. 00 06600 PHYSI CAL THERAPY		0. 32978	6, 557, 973	2, 162, 701	66.
9. 00 06900 ELECTROCARDI OLOGY		0. 14980	79, 630	11, 929	69.
D. 00 07000 ELECTROENCEPHALOGRAPHY		0.00000	0 0	0	70.
0. 01 07001 NEURODI AGNOSTI CS		0. 31886	57 2, 828	902	70.
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		1. 49722	90, 696	135, 792	71.
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 42344	15 700	296	72
3.00 07300 DRUGS CHARGED TO PATIENTS		0. 29302	985, 238	288, 701	73.
5.00 07500 ASC (NON-DISTINCT PART)		0. 18340	03 0	0	
6.00 03950 MH ANCILLARY OUTPATIENT		0.00000		0	
6. 01 03951 I NPATI ENT DI ALYSI S		0. 77497	96, 281	74, 616	76.
OUTPATIENT SERVICE COST CENTERS			-	-	
8.00 08800 FAMILY PRACTICE 120		0.00000		0	
D. 00 09000 CLINIC		3. 29237		0	
0. 01 04950 WOUND CLINIC		0. 31857		0	1
1.00 09100 EMERGENCY		0. 21714		20, 250	
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 31107	73 0	0	92.
OTHER REI MBURSABLE COST CENTERS		0.54.62		2	
6.00 09600 DURABLE MEDICAL EQUIP-RENTED	0)	0. 51424		0	
00.00 Total (sum of lines 50 through 94 and 96 through 9			10, 004, 833	3, 135, 327	
01.00 Less PBP Clinic Laboratory Services-Program only c	narges (IIne 61)		10 004 000		201
02.00 Net charges (line 200 minus line 201)			10, 004, 833		202

Health Financial Systems GOOD SAMARITAN HO	SPI TAL		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT P	Provider C	CN: 15-0042	Peri od:	Worksheet D-3	
			From 01/01/2023		
			To 12/31/2023	Date/Time Pre 4/11/2024 3:1	
	Ti +1	e XIX	Hospi tal	4/11/2024 3.1 Cost	7 pili
Cost Center Description	11 11	Ratio of Cos		Inpatient	
		To Charges	Program	Program Costs	
		10 charges	Charges	(col. 1 x	
			charges	col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	0.00	
30. 00 03000 ADULTS & PEDI ATRI CS			286, 030		30.00
31. 00 03100 I NTENSI VE CARE UNI T			264, 452		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			457, 099		43.00
ANCI LLARY SERVI CE COST CENTERS			437,077		45.00
50. 00 05000 OPERATING ROOM		0. 1918	16 248, 928	47, 748	50.00
51. 00 05100 RECOVERY ROOM		0.0000		47,740	51.00
51. 01 05101 ENDOSCOPY		0. 2416		4, 526	
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 2410		4, 520	52.00
53. 00 05300 ANESTHESI OLOGY		0. 2043		0	53.00
54. 00 05400 RADI 0L0GY-DI AGNOSTI C		0. 2043		42, 200	
55. 00 05500 RADI 0L0GY-THERAPEUTI C		0. 1130		42,200	
60. 00 06000 LABORATORY		0. 2193		67, 584	60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 0000		07, 584	63.00
65. 00 06500 RESPIRATORY THERAPY		0. 3266		49, 217	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 3200		34, 748	
69. 00 06900 ELECTROCARDI OLOGY		0. 3297		30, 140	
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 0000		30, 140	•
70. 01 07000 ELECTROENCEPHALOGRAPHY 70. 01 07001 NEURODI AGNOSTI CS		0. 3178		1, 811	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		1. 4972		0	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 4234		0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 4234		94, 897	
75. 00 07500 DR0GS CHARGED TO PATTENTS 75. 00 07500 ASC (NON-DI STINCT PART)		0. 2930		1, 442	75.00
76. 00 03950 MH ANCI LLARY OUTPATIENT		0. 1831		1, 442	•
				-	
76. 01 03951 INPATIENT DIALYSIS		0.7749	77 14, 718	11, 406	76.01
		0 7252	24	0	00.00
88.00 08800 FAMILY PRACTICE 120		0. 7252		0	
90. 00 09000 CLINIC		3. 2923		66	•
90. 01 04950 WOUND CLINIC		0.3185		341	90.01
91.00 09100 EMERGENCY		0. 2165		71, 522	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 3110	73 4, 259	1, 325	92.00
		0 5140	47	2	
96.00 09600 DURABLE MEDICAL EQUIP-RENTED		0. 5142		0	
200.00 Total (sum of lines 50 through 94 and 96 through 98)	(1) (7)		2, 286, 886	460, 663	
201.00 Less PBP Clinic Laboratory Services-Program only charges ((II ne 61)		0		201.00
202.00 Net charges (line 200 minus line 201)		I	2, 286, 886		202.00

NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0042	Peri od:	Worksheet D-3	3
			From 01/01/2023		
	Component	CCN: 15-S042	To 12/31/2023	Date/Time Pre 4/11/2024 3:1	
	Ti tl	e XIX	Subprovider -	Cost	F
Cost Center Description		Ratio of Cos	I PF st I npati ent	Inpatient	
cost center bescription		To Charges		Program Costs	
		10 charges	Charges	(col. 1 x	
			charges	col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
0. 00 03000 ADULTS & PEDI ATRI CS					30.
1. 00 03100 INTENSIVE CARE UNIT					31.
0. 00 04000 SUBPROVI DER – I PF			514, 329		40.
1. 00 04100 SUBPROVI DER – I RF					41.
3. 00 04300 NURSERY					43.
ANCI LLARY SERVI CE COST CENTERS			1/		-
0. 00 05000 OPERATING ROOM		0. 1918		0	
1. 00 05100 RECOVERY ROOM		0.0000		0	
1. 01 05101 ENDOSCOPY		0.2416		0	
2. 00 05200 DELI VERY_ROOM_&_LABOR_ROOM 3. 00 05300 ANESTHESI OLOGY		0. 4476		0	
3. 00 05300 ANESTHESI OLOGY 4. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 2043		1, 715	
5. 00 05500 RADI OLOGY-THERAPEUTI C		0. 1130		0	
0. 00 06000 LABORATORY		0. 2195		4, 639	
3. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 00000		4,039	
5. 00 06500 RESPIRATORY THERAPY		0. 3266		3, 106	
6. 00 06600 PHYSI CAL THERAPY		0. 3297		2,745	
9. 00 06900 ELECTROCARDI OLOGY		0. 1497		376	
0. 00 07000 ELECTROENCEPHALOGRAPHY		0.0000		0	
0. 01 07001 NEURODI AGNOSTI CS		0. 3178		234	
1. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		1. 4972		2,608	
2. 00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 4234		0	
3. 00 07300 DRUGS CHARGED TO PATIENTS		0. 29302		11, 234	
5. 00 07500 ASC (NON-DI STINCT PART)		0, 1831		0	
6. 00 03950 MH ANCI LLARY OUTPATI ENT		0.0000		0	
6. 01 03951 I NPATI ENT DI ALYSI S		0. 7749		522	
OUTPATIENT SERVICE COST CENTERS					1
8.00 08800 FAMILY PRACTICE 120		0. 7252	24 0	0	88.
0. 00 09000 CLINIC		3. 2923	71 0	0	90.
0. 01 04950 WOUND CLINIC		0. 3185	70 0	0	90.
1.00 09100 EMERGENCY		0. 2165		0	
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 3110	73 0	0	92.
OTHER REIMBURSABLE COST CENTERS					
6. 00 09600 DURABLE MEDI CAL EQUI P-RENTED		0. 5142			
00.00 Total (sum of lines 50 through 94 and 96 through 98)			110, 915	27, 179	
01.00 Less PBP Clinic Laboratory Services-Program only cha	rges (line 61)		0		201.
02.00 Net charges (line 200 minus line 201)			110, 915		202.

NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0042	Peri od:	Worksheet D-3	3
			From 01/01/2023		
	Component	CCN: 15-T042	To 12/31/2023	Date/Time Pre 4/11/2024 3:1	
	Ti tl	e XIX	Subprovider -	Cost	- p
			I RF		
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
		1.00	2.00	<u>col.2)</u> 3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	-
30. 00 03000 ADULTS & PEDI ATRI CS					30.0
31. 00 03100 I NTENSI VE CARE UNI T					31.
10. 00 04000 SUBPROVI DER – I PF					40.0
1. 00 04100 SUBPROVIDER - IRF			59, 995		41.0
13. 00 04300 NURSERY					43.
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATI NG ROOM		0. 1918	16 186	36	50.
51.00 05100 RECOVERY ROOM		0.0000	0 00	0	51.
51. 01 05101 ENDOSCOPY		0. 24163	35 481	116	51.
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 4476			
53. 00 05300 ANESTHESI OLOGY		0. 2043		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 11363			
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 21952		0	
50. 00 06000 LABORATORY		0. 13648			
53.00 06300 BLOOD STORING, PROCESSING & TRANS.		0.0000			
55. 00 06500 RESPI RATORY THERAPY		0. 32664		695	
66.00 06600 PHYSI CAL THERAPY		0. 32978			
59.00 06900 ELECTROCARDI OLOGY		0. 14978		134	
70.00 07000 ELECTROENCEPHALOGRAPHY		0.0000		-	
70. 01 07001 NEURODI AGNOSTI CS 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS		0.31780			
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		1. 49722 0. 42344			
73. 00 07200 DRUGS CHARGED TO PATIENTS		0. 29302			
75. 00 07500 ASC (NON-DI STINCT PART)		0. 29302			
76. 00 03950 MH ANCILLARY OUTPATIENT		0. 00000		-	
76. 01 03951 INPATIENT DIALYSIS		0. 7749			
OUTPATIENT SERVICE COST CENTERS		0.7717		Ŭ	1 /0.1
38. 00 08800 FAMILY PRACTICE 120		0. 72522	24 0	0	88.0
20. 00 09000 CLINIC		3. 2923	71 0	0	90.
PO. 01 04950 WOUND CLINIC		0. 3185	70 767	244	90.
P1. 00 09100 EMERGENCY		0. 21659	97 0	0	91.
02.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 3110	73 0	0	92.
OTHER REIMBURSABLE COST CENTERS			-		
P6. 00 09600 DURABLE MEDI CAL EQUI P-RENTED		0. 51424		-	
200.00 Total (sum of lines 50 through 94 and 96 through 9			74, 408	23, 769	
201.00 Less PBP Clinic Laboratory Services-Program only	charges (line 61)		0		201.
202.00 Net charges (line 200 minus line 201)			74, 408		202.

1. Instructions) 1. Instructions) 3, b4, 79 1.0 1.00 DBB anount 5 other than outling payment for Model 4 BPCI for discharges occurring prior to 0ctober 0 1.0 1.01 DBB for Faderal specific operating payment for Model 4 BPCI for discharges occurring on or after Dictober 0 1.0 1.02 DBB for Faderal specific operating payment for Model 4 BPCI (see instructions) 0 1.0 1.03 DBB for Faderal specific operating payment for Model 4 BPCI (see instructions) 0 2.0 1.04 DBB for Faderal Specific operating payment for Model 4 BPCI (see instructions) 0 2.0 2.00 Duttine rescontine for discharges occurring on or after october 1 (see instructions) 0 2.0 2.00 Duttine rescontine Adjustment for qualifing hospitals under Si31 of the CAA 2021 (see instructions) 0 0.00 5.0 5.00 FTE cap adjustment for qualifing hospitals under Si31 of the CAA 2021 (see instructions) 0.00 5.0<	ealth Financial Systems GOOD SAMARITAN	N HOSPI TAL	In Lieu	u of Form CMS-2	2552-10
Initial XVIII Hospital PPS 0 Beff A LHWAT HAY LogSPLAGE SUMPER LPPS 1.00 1.00 0.00	ALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0042	From 01/01/2023	Part A Date/Time Pre	
Dest A LIBATE INFORME TASE INFORMED FIPS 100 Bik Remuts Other than Outlier payments for discharges occurring prior to October 1 (see Instructions) 11, 200, 397 10 100 Bik Remuts Other than Outlier payments for discharges occurring on arter October 1 (see Instructions) 10, 200, 397 10 101 Bik For referal specific operating payment for Woold 4 BECL for discharges occurring on arter October October 1 (see instructions) 0 10 102 Outlier payments for discharges. Covering on on after October October 1 (see instructions) 0 0 103 Dis For referal specific operating payment for Voold 4 EPCL (see instructions) 0 0 0 103 Distribut State (see instructions) 0		Title XVIII	Hospi tal		
1.00 Bio Amounts Other than Outlier payments for discharges occurring prior to October 1 (see 1.0 0.0 </th <th></th> <th></th> <th></th> <th>1.00</th> <th></th>				1.00	
1.01 Bids anounts other than outlier payments for discharges occurring prior to 0ctober 1 (see instructions) 11, 200, 329 10, 200, 329 1.02 Disc mounts offer than outlier payments for discharges occurring on or after october 1 (see instructions) 3, 554, 795 10, 00, 10, 10, 10, 10, 10, 10, 10, 10,				0	1 00
Instructions) 0.06 0.07 0.01	.01 DRG amounts other than outlier payments for discharges occu	rring prior to October 1	(see	-	1.00
1 (See instructions) 0 00	.02 DRG amounts other than outlier payments for discharges occu	rring on or after October	- 1 (see	3, 554, 795	1. 02
Decoder 1 (see instructions) 2.0 Outlier reconcilizion amount 2.0 2.01 Quitier reconcilizion amount 2.0 2.01 Quitier reconcilizion amount 2.0 2.01 Quitier payment for discharges for Middl & BCO (see Instructions) 2.0 2.01 Quitier payments for discharges cocurring on a fiter October 1 (see Instructions) 5.17.27 2.00 Wanged Care Simulated Payments 6.478.802 3.00 Bed days avail lable divided by number of days in the cost reporting period (see instructions) 6.478.802 5.00 FEE count for allopathic and osteopathic programs for the most recent cost reporting period (see instructions) 0.00 6.00 FEE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in according with the NE (see as specified under 42 CIK \$412.105(f) (1)(1)(9)(0)(2) (1) fte cost report strandles of the NE (see as specified under 42 CIK \$412.105(f) (1)(1)(9)(0)(2) (1) fte cost report strandles and secondance with 42 CIK \$413.78(o) 0.00 7.0 7.01 Ma Section resource discusses) to the NE (see as specified under 42 CIK \$412.105(f) (1)(1)(9)(0)(2) (1) fte cost report strandles on discusses) to the NE (see as specified under 42 CIK \$412.105(f) (1)(1)(9)(0)(2) (1) fte cost report strandles on discusses) to the NE (see instructions) 0.00 7.02<	1 (see instructions)	-		0	1.03
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2.04 Outlier psysents for discharges occurring on or after October 1 (see Instructions) 0 0.0 <td< td=""><td></td><td>-</td><td></td><td>-</td><td></td></td<>		-		-	
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6.26 Rural track program FTE cap limitation adjustment after the cap-building window closed under \$127 of the CAA 2071 (see instructions) 0.00 6.2 7.00 MAA Section 422 reduction amount to the IME cap as specified under 42 CFR \$142.105(f)(1)(iv)(B)(1) 0.00 7.0 7.01 ACA \$5503 reduction amount to the IME cap as specified under 42 CFR \$142.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions. 0.00 7.0 7.04 Adjustment (increase or decrease) to the hospital's rural track programs in accordance with 413.75(b) and 87 FR 49057 (August 10, 2022) (see instructions) 0.00 7.0 8.00 Adjustment (increase or decrease) to the FTE count for all opathic and osteopathic programs for artifiliated programs in accordance with 42 CFR \$13.75(b). 13.79(c) 2(1)(v). 64 FR 20340 (May 12. 1978), and 67 FR 20056 (August 1, 2002). 0.00 8.0 8.01 The amount of increase if the hospital was awarded FTE cap slots under \$126 of the CAA 2021 (see instructions) 0.00 8.0 8.21 The amount of increase if the hospital was awarded FTE cap slots under \$126 of the CAA 2021 (see instructions) 0.00 8.0 9.00 Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8.01 through 8.27 (see Instructions) 0.00 10.00 10.00 FTE count for railopathic and osteopathic programs. 0.00	0.00 FTE count for allopathic and osteopathic programs that meet				5.01 6.00
7.01 ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)	26 Rural track program FTE cap limitation adjustment after the	cap-building window clos	sed under §127 of	0.00	6. 26
7.02 Adjustment (increase or decrease) to the hospital's rural track program FIE limitation(s) for rural track for Weidrare G&E affiliated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions) 0.00 7.02 8.0 Adjustment (increase or decrease) to the FIE count for allopathic and osteopathic programs for accordance with 42 CFR 413.75(b), 413.79(c)(2)(1'v), 54 FR 26340 (May 12, 1998), and 67 FR 50060 (August 1, 2002). 0.00 8.0 8.0 Adjustment (increase or decrease) to the FIE count for allopathic and osteopathic programs for accordance with 42 CFR 413.75(b), 413.79(c)(2)(1'v), 54 FR 26340 (May 12, 1998), and 67 FR 50060 (August 1, 2002). 0.00 8.0 8.01 The amount of increase if the hospital was awarded FTE cap slots under \$1503 of the ACA 11 fthe cost programs in accordance with 41.87 (See instructions) 0.00 8.0 8.02 The amount of increase if the hospital was awarded FTE cap slots under \$150 of the CAA 2021 (see instructions) 0.00 8.0 9.03 Sum of Flines 5 and 5.01, plus line 6, plus lines 8.0 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plusor minus line 7.01, plus or minus line 7.02, plusor minus line 7.02, plusor minus line 7.02, plusor minus line 7.01, plus or minus line 7.02, plusor minus line 7.01, plus or minus line 7.02, plusor minus line 7.01, plus or minus line 7.01, plus or minus line 7.01, plus or minus line 7.02, pluson minus l	0.01 ACA § 5503 reduction amount to the IME cap as specified und				7.00 7.01
8.00 Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002). 0.00 <td>Adjustment (increase or decrease) to the hospital's rural t track programs with a rural track for Medicare GME affiliat</td> <td></td> <td></td> <td>0.00</td> <td>7. 02</td>	Adjustment (increase or decrease) to the hospital's rural t track programs with a rural track for Medicare GME affiliat			0.00	7. 02
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. 0.00 8.0 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) 0.00 8.0 8.21 The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions) 0.00 8.2 9.00 Sum of lines S and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions) 0.00 9.0 9.00 FTE count for allopathic and osteopathic programs in the current year from your records 0.00 10.0 11.00 FTE count for the peni limate year if that year ended on or after September 30, 1997, otherwise enter zero. 0.00 14.0 15.00 Sum of lines 12 through 14 divided by 3. 0.00 15.0 10.00 Adjustment for residents in initial years of the program (see instructions) 3.140, 276 22.0 10.00 Prior year resident to bed ratio (see instructions) 0.43542 19.0 10.00 Enter the lesser of lines 19 or 20 (see instructions) 3.140, 276 22.0 10.00 Prior year resident to bed ratio (see instructions) 1.435,044 19.0	8.00 Adjustment (increase or decrease) to the FTE count for allo affiliated programs in accordance with 42 CFR 413.75(b), 41			0.00	8. 00
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16.00Adjustment for residents in initial years of the program (see instructions)39.5816.017.00Adjustment for residents displaced by program or hospital closure0.0017.008.00Adjusted rolling average FTE count39.5818.019.00Current year resident to bed ratio (line 18 divided by line 4).0.43542419.020.00Prior year resident to bed ratio (see instructions)0.43851120.021.00Enter the lesser of lines 19 or 20 (see instructions)3,140,27622.022.01IME payment adjustment (see instructions)1,435,04422.022.01IMmore of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.1050.0023.00Number of addit tonal allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.1050.0024.00IME FTE Resident Count Over Cap (see instructions)0.0000025.00If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see0.0027.00IME payment adjustment factor. (see instructions)0.00000026.00Resident to bed ratio (divide line 25 by line 4)0.00000027.00IME payment (sum of lines 22 and 28)0.1435,04428.01IME add-on adjustment amount (see instructions)0.28.029.00Total IME payment (sum of lines 22.01 and 28.01)1,435,04429.00Disproportionate Share Adjustment1,435,04420.01Derentage of SI recipient patient days to Medicare Part A patient days (see instructions)3,140,27629.01 <td></td> <td></td> <td></td> <td>0.00</td> <td>15.00</td>				0.00	15.00
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24.00IME FTE Resident Count Over Cap (see instructions)0.0024.025.00If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see0.0025.025.00If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see0.0025.026.00Resident to bed ratio (divide line 25 by line 4)0.00000026.027.00IME payments adjustment factor. (see instructions)0.00000027.028.00IME add-on adjustment amount (see instructions)028.028.01IME add-on adjustment amount - Managed Care (see instructions)028.029.00Total IME payment (sum of lines 22 and 28)3,140,27629.029.01Total IME payment - Managed Care (sum of lines 22.01 and 28.01)1,435,04429.0Disproportionate Share Adjustment30.00Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)4.2530.031.00Percentage of Medicaid patient days (see instructions)4.2530.031.032.00Sum of lines 30 and 3123.0732.032.0	3.00 Number of additional allopathic and osteopathic IME FTE res		CFR 412.105	0.00	23.00
25.00If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see0.0025.026.00Resident to bed ratio (divide line 25 by line 4)0.00000026.027.00IME payments adjustment factor. (see instructions)0.00000027.028.00IME add-on adjustment amount (see instructions)028.029.01IME payment (sum of lines 22 and 28)3,140,27629.029.01Total IME payment - Managed Care (see instructions)1,435,04429.01Disproportionate Share Adjustment28.01 and 28.01)1,435,04430.00Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)4.2530.031.00Percentage of Medicaid patient days (see instructions)18.8231.032.00Sum of lines 30 and 3123.0732.0				0.00	24.00
26.00Resident to bed ratio (divide line 25 by line 4)0.00000026.027.00IME payments adjustment factor. (see instructions)0.00000027.028.00IME add-on adjustment amount (see instructions)028.028.01IME add-on adjustment amount - Managed Care (see instructions)028.029.00Total IME payment - Managed Care (sum of lines 22 and 28)3,140,27629.029.01Total IME payment - Managed Care (sum of lines 22.01 and 28.01)1,435,04429.029.01Disproportionate Share Adjustment90.0028.0130.0031.00Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)4.2530.032.00Sum of lines 30 and 3123.0732.0	5.00 If the amount on line 24 is greater than -O-, then enter th	e lower of line 23 or lin	ne 24 (see		
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29. 01Total IME payment - Managed Care (sum of lines 22.01 and 28.01)1,435,04429. 0Disproportionate Share Adjustment30. 00Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)4. 2530. 031. 00Percentage of Medicaid patient days (see instructions)18. 8231. 032. 00Sum of lines 30 and 3123. 0732. 0	,				
30.00Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)4.2530.031.00Percentage of Medicaid patient days (see instructions)18.8231.032.00Sum of lines 30 and 3123.0732.0	9.01 Total IME payment - Managed Care (sum of lines 22.01 and 28	. 01)			
32.00 Sum of Lines 30 and 31 23.07 32.0	0.00 Percentage of SSI recipient patient days to Medicare Part A	patient days (see instru	uctions)		
	12.00 Sum of lines 30 and 31 13.00 Allowable disproportionate share percentage (see instruction	ns)			

CALCU	Financial Systems GOOD SAMARITAN ATION OF REIMBURSEMENT SETTLEMENT	HOSPITAL Provider CCN: 15-0042	Peri od:	u of Form CMS-2 Worksheet E	2002-10
CALCOL		11001061 0010. 13-0042	From 01/01/2023 To 12/31/2023	Part A Date/Time Pre	pared:
				4/11/2024 3:1	7 pm
		Title XVIII	Hospi tal	PPS	
				1.00	
34.00	Disproportionate share adjustment (see instructions)			304, 325	34.00
				On/After 10/1	
	Uncompensated Care Payment Adjustment		1.00	2.00	
35.00	Total uncompensated care amount (see instructions)		0	5, 938, 006, 757	35.00
35.01	Factor 3 (see instructions)		0. 00000000	0. 000224628	35.0
35.02	Hospital UCP, including supplemental UCP (see instructions)		1, 611, 996	1, 333, 843	35.02
35.03	Pro rata share of the hospital UCP, including supplemental U	ICP (see instructions)	1, 205, 684	335, 283	
36.00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)	icohorgoo (lipoo 40 thro	1, 540, 967		36.00
40.00	Additional payment for high percentage of ESRD beneficiary d Total Medicare discharges (see instructions)	rischarges (Trhes 40 thro	0 (ugil 46)		40.00
41.00	Total ESRD Medicare discharges (see instructions)		0		41.00
41.01	Total ESRD Medicare covered and paid discharges (see instruc	tions)	0		41.01
42.00					42.00
43.00					43.00
44.00	Ratio of average length of stay to one week (line 43 divided	I by line 41 divided by 7	0. 000000		44.00
45.00	days) Average weekly cost for dialysis treatments (see instruction))	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 4		0.00		46.00
47.00	Subtotal (see instructions)		19, 791, 974		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH,	small rural hospitals	18, 406, 092		48.00
	only. (see instructions)				
				Amount	
49.00	Total payment for inpatient operating costs (see instruction	()		1.00 21,227,018	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I a	<i>·</i>	e)	1, 452, 950	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt			0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, I	ine 49 see instructions)		1, 667, 740	52.00
53.00	Nursing and Allied Health Managed Care payment			15, 220	53.00
54.00	Special add-on payments for new technologies			8, 048	54.00
54.01	Islet isolation add-on payment	(0)		0	54.0 [°] 55.00
55.00 55.01	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cellular therapy acquisition cost (see instructions)	69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see int	ructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt.		through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 11 line 200)	0 /	41, 826	58.00
59.00	Total (sum of amounts on lines 49 through 58)			24, 412, 802	59.00
60.00	Primary payer payments			0	60.00
61.00 62.00	Total amount payable for program beneficiaries (line 59 minu Deductibles billed to program beneficiaries	is The 60)		24, 412, 802 1, 916, 008	61.00 62.00
63.00	Coinsurance billed to program beneficiaries			20, 767	63.00
64.00	Allowable bad debts (see instructions)			122, 662	
65.00	Adjusted reimbursable bad debts (see instructions)			79, 730	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see ins	structions)		22, 908	
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			22, 555, 757	67.00
68.00	Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96)			0	68.00 69.00
69.00 70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		115)	0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demons	stration) adjustment (see	instructions)	0	70.50
70.75	N95 respirator payment adjustment amount (see instructions)		/	0	70.75
70. 87	Demonstration payment adjustment amount before sequestration	1		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)			0	70.8
70.89	Pioneer ACO demonstration payment adjustment amount (see ins	structions)			70.89
70. 90 70. 91	HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions)			0	70.9 70.9
70.91	Bundled Model 1 discount amount (see instructions)			0	70.92
70.92	HVBP payment adjustment amount (see instructions)			-35, 672	70.93
70.94	HRR adjustment amount (see instructions)			-71, 273	70.94
	Recovery of accelerated depreciation				70.95

	Financial Systems GOOD SAMARITAN ATION OF REIMBURSEMENT SETTLEMENT	Provi der C	CN: 15-0042	Peri od:	u of Form CMS-2 Worksheet E	
				From 01/01/2023 To 12/31/2023	Part A Date/Time Pre	
		Title	XVIII	Hospi tal	4/11/2024 3:1 PPS	7 pm
		in the		(уууу)	Amount	
				0	1.00	
0.96	Low volume adjustment for federal fiscal year (yyyy) (Enter i	n column O		0	0	70.96
	the corresponding federal year for the period prior to 10/1)					
0.97	Low volume adjustment for federal fiscal year (yyyy) (Enter i			0	0	70.9
0 00	the corresponding federal year for the period ending on or af	ter 10/1)		0	0	70.9
0. 98 0. 99	Low Volume Payment-3 HAC adjustment amount (see instructions)			0	0 54, 034	
	Amount due provider (line 67 minus lines 68 plus/minus lines	69 & 70)			22, 394, 778	
	Sequestration adjustment (see instructions)				447, 896	
1. 02	Demonstration payment adjustment amount after sequestration				0	71.0
	Sequestration adjustment-PARHM pass-throughs					71.0
	Interim payments				20, 404, 565	
1	Interim payments-PARHM					72.0
	Tentative settlement (for contractor use only)				0	73.0
	Tentative settlement-PARHM (for contractor use only) Balance due provider/program (line 71 minus lines 71.01, 71.0	12 72 and			1, 542, 317	
4.00	73)	2, 72, 414			1, 542, 517	/ 4. 00
74.01	Balance due provider/program-PARHM (see instructions)					74.0
75.00	Protested amounts (nonallowable cost report items) in accorda	nce with			326, 853	75.0
	CMS Pub. 15-2, chapter 1, §115.2					
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)	- 6 0 00	1		0	00.0
0.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum plus 2.04 (see instructions)	OF 2.03			0	90.0
1.00	Capital outlier from Wkst. L, Pt. I, line 2				0	91.0
	Operating outlier reconciliation adjustment amount (see instr	uctions)			0	92.0
	Capital outlier reconciliation adjustment amount (see instruct				0	93.0
94.00	The rate used to calculate the time value of money (see instr	uctions)			0.00	
	Time value of money for operating expenses (see instructions)				0	
96.00	Time value of money for capital related expenses (see instruc	tions)		D.1	0	96.00
				Prior to 10/1		
	HSP Bonus Payment Amount			1.00	2.00	
	HSP Bonus Payment Amount HSP bonus amount (see instructions)				2.00	100. 0
00.00	HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment			1.00	2.00	100. 0
00. 00 01. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions)			1.00 0 1.0000000000	2.00 0 0.9899650703	101. 0
00.00 01.00 02.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction	s)		1.00	2.00 0 0.9899650703	101.0
100. 00 101. 00 102. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment	s)		1.00 0 1.000000000 0	2.00 0 0.9899650703 0	102.0
00.00 01.00 02.00 03.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions)			1.00 0 1.000000000 0 0.9951	2.00 0.9899650703 0 0.9954	101. 0 102. 0 103. 0
00.00 01.00 02.00 03.00 04.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions)	Istment	1.00 0 1.000000000 0	2.00 0.9899650703 0 0.9954	101. 0 102. 0 103. 0
00.00 01.00 02.00 03.00 04.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions)) ration) Adju		1.00 0 1.000000000 0 0.9951	2.00 0.9899650703 0 0.9954 0	101. 0 102. 0 103. 0 104. 0
00.00 01.00 02.00 03.00 04.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst) ration) Adju		1.00 0 1.000000000 0 0.9951	2.00 0.9899650703 0 0.9954 0	101. 0 102. 0 103. 0 104. 0
00.00 01.00 02.00 03.00 04.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement) ration) Adju riod under		1.00 0 1.000000000 0 0.9951	2.00 0.9899650703 0 0.9954 0	101. 0 102. 0 103. 0 104. 0
00. 00 01. 00 02. 00 03. 00 04. 00 200. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin) ration) Adju riod under		1.00 0 1.000000000 0 0.9951	2.00 0.9899650703 0 0.9954 0	101. 0 102. 0 103. 0 104. 0 200. 0
00. 00 01. 00 02. 00 03. 00 04. 00 200. 00 201. 00 202. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions)) ration) Adju riod under		1.00 0 1.000000000 0 0.9951	2.00 0.9899650703 0.9954 0	101. 0 102. 0 103. 0 104. 0 200. 0 201. 0 202. 0
00. 00 01. 00 02. 00 03. 00 04. 00 200. 00 201. 00 202. 00 203. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions)) ration) Adju riod under e 49)	the 21st	1.00 0 1.000000000 0 0.9951 0	2.00 0.9899650703 0.9954 0	101. 0 102. 0 103. 0 104. 0 200. 0 201. 0 202. 0
00. 00 01. 00 02. 00 03. 00 04. 00 200. 00 201. 00 202. 00 203. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions)) ration) Adju riod under e 49)	the 21st	1.00 0 1.000000000 0 0.9951 0	2.00 0.9899650703 0.9954 0	101. 0 102. 0 103. 0 104. 0 200. 0 201. 0 202. 0
00.00 01.00 02.00 03.00 04.00 200.00 200.00 201.00 203.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in) ration) Adju riod under e 49)	the 21st	1.00 0 1.000000000 0 0.9951 0	2.00 0.9899650703 0 0.9954 0	101. 0 102. 0
00.00 01.00 02.00 03.00 04.00 00.00 01.00 02.00 03.00 04.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period)) ration) Adju riod under e 49)	the 21st	1.00 0 1.000000000 0 0.9951 0	2.00 0.9899650703 0 0.9954 0	101. 0 102. 0 103. 0 104. 0 200. 0 201. 0 202. 0 203. 0 203. 0
00.00 01.00 02.00 03.00 04.00 00.00 01.00 02.00 03.00 03.00 04.00 05.00 06.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205)) ration) Adju riod under e 49) first year	the 21st	1.00 0 1.000000000 0 0.9951 0	2.00 0.9899650703 0 0.9954 0	101. 0 102. 0 103. 0 104. 0 200. 0 201. 0 202. 0 203. 0 203. 0 204. 0 205. 0
00.00 01.00 02.00 03.00 04.00 00.00 01.00 02.00 03.00 04.00 05.00 06.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement) ration) Adju riod under e 49) first year	the 21st	1.00 0 1.000000000 0 0.9951 0	2.00 0.9899650703 0 0.9954 0	101. 0 102. 0 103. 0 104. 0 200. 0 201. 0 202. 0 203. 0 203. 0 205. 0 206. 0
00.00 01.00 02.00 03.00 04.00 00.00 01.00 02.00 03.00 03.00 04.00 05.00 06.00 07.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst) ration) Adju riod under e 49) first year ructions)	the 21st	1.00 0 1.000000000 0 0.9951 0	2.00 0.9899650703 0.9954 0	101. 0 102. 0 103. 0 104. 0 200. 0 201. 0 203. 0 203. 0 204. 0 205. 0 206. 0 207. 0
00.00 01.00 02.00 03.00 04.00 00.00 02.00 03.00 03.00 05.00 06.00 07.00 08.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HVBP adjustment for HSP Bonus Payment HRR adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A,) ration) Adju riod under e 49) first year ructions)	the 21st	1.00 0 1.000000000 0 0.9951 0	2.00 0.9899650703 0 0.9954 0	101. 0 102. 0 103. 0 104. 0 200. 0 201. 0 202. 0 203. 0 204. 0 205. 0 206. 0 207. 0 208. 0
00.00 01.00 02.00 03.00 04.00 00.00 01.00 02.00 03.00 04.00 05.00 06.00 07.00 08.00 09.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions)) ration) Adju riod under e 49) first year ructions)	the 21st	1.00 0 1.000000000 0 0.9951 0	2.00 0.9899650703 0 0.9954 0	101. 0 102. 0 103. 0 104. 0 200. 0 201. 0 202. 0 203. 0 204. 0 205. 0 206. 0 206. 0 207. 0 208. 0 209. 0
00.00 01.00 02.00 03.00 04.00 00.00 02.00 03.00 03.00 05.00 06.00 07.00 08.00 09.00 10.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use) ration) Adju riod under e 49) first year ructions)	the 21st	1.00 0 1.000000000 0 0.9951 0	2.00 0.9899650703 0 0.9954 0	101. 0 102. 0 103. 0 104. 0 200. 0 201. 0 202. 0 203. 0 203. 0 204. 0 205. 0 206. 0 206. 0 207. 0 208. 0 209. 0 209. 0
00.00 01.00 02.00 03.00 04.00 200.00 201.00 202.00 203.00 204.00 205.00 206.00 206.00 207.00 208.00 209.00 210.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions)) ration) Adju riod under e 49) first year ructions)	the 21st	1.00 0 1.000000000 0 0.9951 0	2.00 0.9899650703 0 0.9954 0	101. 0 102. 0 103. 0 104. 0 200. 0 201. 0 202. 0 203. 0
00.00 01.00 02.00 03.00 04.00 20.000	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions)) ration) Adju riod under e 49) first year first year ructions) line 59)	the 21st	1.00 0 1.000000000 0 0.9951 0	2.00 0.9899650703 0 0.9954 0 strati on	101. 0 102. 0 103. 0 104. 0 200. 0 201. 0 202. 0 203. 0 203. 0 204. 0 205. 0 206. 0 206. 0 207. 0 208. 0 209. 0 209. 0 210. 0
00.00 01.00 02.00 03.00 04.00 200.00 201.00 203.00 203.00 205.00 205.00 206.00 206.00 206.00 206.00 207.00 208.00 209.00 211.00 211.00 211.00 211.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement) ration) Adju riod under e 49) first year ructions) line 59) 211)	of the curre	1.00 0 1.000000000 0 0.9951 0	2.00 0.9899650703 0 0.9954 0 strati on	101. 0 102. 0 103. 0 104. 0 200. 0 201. 0 202. 0 203. 0 203. 0 205. 0 205. 0 205. 0 206. 0 207. 0 208. 0 209. 0 210. 0

	Financial Systems LUME CALCULATION EXHIBIT 4		GOOD SAMARITA		CN: 15-0042	Peri od: From 01/01/2023 To 12/31/2023	u of Form CMS-2 Worksheet E Part A Exhibi Date/Time Pre 4/11/2024 3:1	t 4 parec
					XVIII	Hospi tal	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	r Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
00	DRG amounts other than outlier	1.00	0	0		0 0	0	1.0
01	payments DRG amounts other than outlier payments for discharges	1.01	11, 200, 339	0	11, 200, 33	39	11, 200, 339	1.0
02	occurring prior to October 1 DRG amounts other than outlier payments for discharges	1.02	3, 554, 795	0		3, 554, 795	3, 554, 795	1.
03	occurring on or after October 1 DRG for Federal specific	1.03	0	0		0	0	1.
00	operating payment for Model 4 BPCI occurring prior to October 1	1.00		0		0		
04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.
00	Outlier payments for discharges (see instructions)	2.00						2.
01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0		0 0	0	
02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	51, 272	0	51, 27	/2	51, 272	2.
03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	Ο	0		0	0	2.
00	Operating outlier reconciliation	2.01	0	0		0 0	0	3.
00	Managed care simulated payments	3.00	6, 742, 802	0	4, 968, 74	1, 774, 060	6, 742, 802	4.
00	Indirect Medical Education Adju Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0. 435424	0. 435424	0. 43542	0. 435424		5.
00	IME payment adjustment (see instructions)	22.00	3, 140, 276	0	2, 383, 72	23 756, 553	3, 140, 276	6.
01	IME payment adjustment for managed care (see instructions)	22.01	1, 435, 044	0	1, 057, 47	78 377, 566	1, 435, 044	6.
	Indirect Medical Education Adju	ustment for th	e Add-on for Se	ection 422 of	the MMA			1
00	IME payment adjustment factor (see instructions)	27.00	0. 000000	0. 000000		0. 000000		7
00	IME adjustment (see instructions)	28.00	0	0		0 0	0	
)1	IME payment adjustment add on for managed care (see instructions)	28.01	0	0		0 0	0	8
00	Total IME payment (sum of lines 6 and 8)	29.00	3, 140, 276	0			3, 140, 276	
)1	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	1, 435, 044	0	1, 057, 47	78 377, 566	1, 435, 044	9.
	Disproportionate Share Adjustme				1			
00	Allowable disproportionate share percentage (see instructions)	33.00	0. 0825	0. 0825	0. 082	0. 0825		10.
	Disproportionate share adjustment (see instructions)	34.00	304, 325	0			304, 325	
01	Uncompensated care payments Additional payment for high per		1, 540, 967 RD beneficiary		1		1, 540, 967	
00	Total ESRD additional payment (see instructions) Subtotal (see instructions)	46.00 47.00	0 19, 791, 974	0		0 0 25 4, 719, 949	0 19, 791, 974	
00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	48.00	0	0)	0 4, 719, 949	19, 791, 974 0	
00	(see instructions) Total payment for inpatient operating costs (see instructions)	49.00	21, 227, 018	0	16, 129, 50	5, 097, 515	21, 227, 018	15.

	Financial Systems DLUME CALCULATION EXHIBIT 4		GOOD SAMARITA	Provi der C	CN: 15-0042	Peri od:	u of Form CMS-: Worksheet E	
						From 01/01/2023 To 12/31/2023	Date/Time Pre 4/11/2024 3:1	pared
	,				XVIII	Hospi tal	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prion to 10/01	r Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
6. 00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1, 452, 950	0	1, 095, 08	30 357, 870	1, 452, 950	16. C
	Special add-on payments for new technologies	54.00	8, 048	0	8, 04	48 0	8, 048	17. C
7.01	Net organ aquisition cost							17.0
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0		0 0	0	17.0
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0		0 0	0	18. C
19 00	SUBTOTAL			0	17, 232, 63	5, 455, 385	22, 688, 016	19 0
7.00		W/S L, line	(Amounts from L)		11,202,00	0,100,000	22,000,010	17.0
		0	1.00	2.00	3.00	4.00	5.00	
20. 00 20. 01	Capital DRG other than outlier Model 4 BPCI Capital DRG other than outlier		1, 107, 849 0	0		36 273, 863 0 0	1, 107, 849 0	
1.00	Capital DRG outlier payments	2.00	9, 423	0	8, 39	76 1, 027	9, 423	21.0
1. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	0		0 0	-	
2.00	Indirect medical education percentage (see instructions)	5.00	0. 3030	0. 3030				22.0
23.00	Indirect medical education adjustment (see instructions)	6.00	335, 678	0	252, 69	98 82, 980	335, 678	23.0
4. 00	Allowable disproportionate share percentage (see instructions)	10.00	0. 0000	0. 0000	0.000	0.0000		24.0
5.00	Disproportionate share adjustment (see instructions)	11.00	0	0		0 0	0	25.0
6. 00	Total prospective capital payments (see instructions)	12.00	1, 452, 950	0	1, 095, 08	30 357, 870	1, 452, 950	26. (
		W/S E, Part A	(Amounts to					
		line	E, Part A)					
7 06		0	1.00	2.00	3.00	4.00	5.00	07.
7.00 8.00	Low volume adjustment factor Low volume adjustment (transfer amount to Wkst. E,	70. 96			0. 00000	0.000000	0	27. (28. (
9. 00	Pt. A, line) Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 97				0	0	29. (
00.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100. 0

OSPI 1	FAL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	5 Provider CC	-	Period: From 01/01/2023 To 12/31/2023		pared:
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt.	Period to 10/01	Hospital Period on after 10/01	Total (cols. 2 and 3)	
		0	A) 1.00	2.00	3.00	4.00	
. 00 . 01	DRG amounts other than outlier payments DRG amounts other than outlier payments for	1. 00 1. 01	11, 200, 339	11, 200, 33		11, 200, 339	1. 00 1. 01
. 02	discharges occurring prior to October 1 DRG amounts other than outlier payments for	1.02	3, 554, 795		3, 554, 795	3, 554, 795	1.02
. 03	discharges occurring on or after October 1 DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	1.03	0	(D	0	1.03
04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after	1.04	0		0	0	1.04
. 00	October 1 Outlier payments for discharges (see instructions)	2.00					2.00
01	Outlier payments for discharges for Model 4 BPCI	2.02	0	(0 0	0	2.01
02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	51, 272	51, 27	2	51, 272	2.02
03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	0		0	0	2.03
00 00	Operating outlier reconciliation Managed care simulated payments	2. 01 3. 00	0 6, 742, 802	(4, 968, 74	0 0 2 1, 774, 060	0 6, 742, 802	3.00 4.00
00	Indirect Medical Education Adjustment Amount from Worksheet E, Part A, line 21	21.00	0. 435424	0. 43542	4 0. 435424		5.00
00	(see instructions) IME payment adjustment (see instructions)	22.00	3, 140, 276	2, 383, 72		3, 140, 276	6.00
01	IME payment adjustment for managed care (see instructions)		1, 435, 044	1, 057, 478	8 377, 566	1, 435, 044	6. 01
00	Indirect Medical Education Adjustment for the IME payment adjustment factor (see	27.00	0. 000000	0. 00000	0.000000		7.00
00	Instructions) IME adjustment (see instructions)	28.00	0.000000			0	8.00
01	IME payment adjustment add on for managed care (see instructions)	28.00	0	(0 0	0	8.00
00 01	Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 00 29. 01	3, 140, 276 1, 435, 044	2, 383, 72 1, 057, 47		3, 140, 276 1, 435, 044	9.00 9.01
	Disproportionate Share Adjustment		II				
. 00	Allowable disproportionate share percentage (see instructions)	33.00	0. 0825	0. 082	5 0. 0825		10.00
. 00	Disproportionate share adjustment (see instructions)	34.00	304, 325	231, 00	7 73, 318	304, 325	11.00
. 01	Uncompensated care payments Additional payment for high percentage of ESI	36.00 RD beneficiary	1, 540, 967 di scharges	1, 205, 684	4 335, 283	1, 540, 967	11.01
2. 00		46.00	0	(0 0	0	12.00
8. 00 . 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see	47.00 48.00	19, 791, 974 0	15, 072, 02 (5 4, 719, 949 0 0	19, 791, 974 0	13.00 14.00
. 00	instructions) Total payment for inpatient operating costs	49.00	21, 227, 018	16, 129, 503	3 5, 097, 515	21, 227, 018	15.00
. 00	(see instructions) Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1, 452, 950	1, 095, 080	0 357, 870	1, 452, 950	16.00
7.00 7.01	Special add-on payments for new technologies Net organ acquisition cost	54.00	8, 048	8, 04	8 0	8, 048	17.00 17.01
7. 02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	(0 0	0	17.01
3. 00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	(0 0	0	18.00
9.00	SUBTOTAL			17, 232, 63	1 5, 455, 385	22, 688, 016	19. OC

	Financial Systems	GOOD SAMARI TA			In Lie	u of Form CMS-2	2552-10
HOSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	ATION EXHIBIT 5			Period: From 01/01/2023 To 12/31/2023		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, 107, 849	833, 98	36 273, 863	1, 107, 849	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1. 01	0		0 0	0	20.01
	Capital DRG outlier payments	2.00	9, 423	8, 39	76 1, 027	9, 423	21.00
	Model 4 BPCI Capital DRG outlier payments	2.01	0		0 0	0	
	Indirect medical education percentage (see instructions)	5.00	0. 3030	0. 303	0. 3030	_	22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	335, 678	252, 69	98 82, 980	335, 678	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10. 00	0.0000	0.000	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, 452, 950	1, 095, 08	30 357, 870	1, 452, 950	26.00
		Wkst. E, Pt. A, line	(Amt. from 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	-35,672		0 -35,672	-35, 672	30.00
	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	-71, 273	-54, 92	-16, 352	-71, 273	31.00
	HRR adjustment for HSP bonus payment (see instructions)	70. 91	0		0 0	0	
						(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			0 54, 034	54, 034	32.00
	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

Interview Interview Interview Interview Interview 1.00 Marcial and allow particle 1.00 1.00 1.00 1.00 1.00 Marcial and allow particle 1.00 1.00 1.00 1.00 1.00 Marcial and allow particle 1.00<		Financial Systems GOOD SAMARITAN HOS ATION OF REIMBURSEMENT SETTLEMENT Pr	SPITAL rovider CCN: 15-0042	Peri od:	u of Form CMS-2 Worksheet E	2552-10
Ites Ites Ites Picture 100 100 100 100 101 Martin and number services relations (see instructions) 3, 218 1, 00 101 Martin and number services relations (see instructions) 2, 1, 1, 00 2, 1, 1, 00 2, 1, 1, 00 2, 1, 1, 00 2, 1, 1, 00 2, 1, 1, 00 2, 1, 1, 00 2, 1, 1, 00 2, 1, 1, 00 2, 1, 1, 00 2, 1, 1, 00 2, 1, 1, 00 2, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1,				From 01/01/2023 To 12/31/2023		pared:
Notical and other services (see instructions) 3.76 1.00 Marked and other services (see instructions) 31,510,61,20 0.00 Description of the services (see instructions) 31,510,61,20 0.00 Description of the services (see instructions) 31,510,61,20 0.00 Description of the services (see instructions) 0,000,50 0.00 File payment (see instructions) 0,000,50 0.00 File payment (see instructions) 0,000,50 0.00 File payment (see instructions) 0,000,70 0.00 File payment (see instructions) 0,000,700,700,700,700,700,700,700,700,7			Title XVIII	Hospi tal		7 pm
MAT B METCL METCL MAT C 10 Medical and other services (see instructions) 3.218 1.00 200 Medical and other services (see instructions) 31.05.05 2.00 200 Medical and other services (see instructions) 31.05.05 2.00 4.01 Outlier record listion means (see instructions) 4.01 5.00 Direct record listion means (see instructions) 0.00 5.00 Direct record listion 0.00 6.00 Trans tore of the append (see instructions) 0.00 7.00 Sare of lines 1.4, and 4.01, divide by line 6 0.00 6.00 Organ sequent stions 1.116 200 0.00 7.00 Sare of lines 1.3, and 100 (see instructions) 3.218 1.00 10.01 Distal cost (see of lines 1.2 and 13) 0.00						
1.00 Recical and other services (see instructions) 3, 218 1.00 2.00 Model and other services (relations) 3, 218 1.00 3.00 Dorth er paysent (resonal historic teris) 3, 218 1.00 3.00 Dorth er paysent (resonal historic teris) 0, 0, 0, 0, 0, 0, 0, 0, 0, 0, 0, 0, 0, 0		PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
3.00 OPS or RED payment (see Instructions) 22,512,22 3.00 4.00 Outline record liablen amount (see instructions) 0 4.01 4.01 Outline record liablen amount (see instructions) 0 4.01 4.01 Outline record liablen amount (see instructions) 0 4.01 6.01 Outline record liablen amount (see instructions) 0 0 7.00 Sam of lines 3, 4, and 4.01, divided by line 6 0.00 0	1.00				3, 218	1.00
4.00 butil er pagment (see instructions) 1, 997 4.00 0.10 butil er reconcil latis mount (see instructions) 0.000 5.00 1.00 butil er reconcil latis mount (see instructions) 0.000 5.00 1.00 butil er reconcil latis mount (see instructions) 0.000 5.00 1.00 butil er pagment (see instructions) 0.000 5.00 1.00 butil er pagment (see instructions) 0.000 6.00 1.00 Degan acquisitions 3.10 0.00 6.00 1.00 Degan acquisition (see instructions) 0.00 7.00			ons)			
4.01 Dutlier resonant lation amount (see instructions) 0 4.01 0.00 Extension 0.00 5.00 0.00 Finant inclusion 0.00 0.00 Finant inclusion		1.5				
6.00 Line 2 lines 1 lines 3. and 4.01, divided by line 6 0 0 0.00 7.00 Sare of Times 3.4, and 4.01, divided by line 6 0.00 0.00 8.00 Lines 1.10 and corridor payment (see instructions) 0.00 0.00 9.00 Maximum Analysis Costs Including RFI direct graduate medical education costs from 3.4, 194 0.00 9.00 Organ acquistions 0.10, 00 0.00 0.00 9.00 Organ acquistion charges (sum of Times 1.2 and 13.0) 110, 227 12.00 9.00 Organ acquistion charges (sum of Times 1.2 and 13.0) 110, 227 12.00 10.00 Organ acquistion charges (sum of Times 1.2 and 13.0) 110, 227 14.00 11.000 Time 1.00 Time 1.00 110, 227 14.00 12.00 Resconder charges (sum of Times 1.2 and 13.0) 0.000000 110, 227 13.00 Argoregate acount actually collected from patientic 1.1 alid 6 for payment for services on a charge basis 0 15.00 14.00 Decases of castomary charges (see instructions) 0.000000 0.000000 110, 227 10.00 Extension of castomary charges (see instructions) 0.00000 0.000000 110, 227 0.000000 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td>1</td>						1
7.00 Sam of lines 3, 4, and 4.01, divided by line 6 0.00			i ons)			
8.00 Transitional corridor pagement (see instructions) 0 0.00					-	1
Ukst. D. PF. IV, col. 13, line 20 0		Transitional corridor payment (see instructions)			0	1
10. 00 Organ acquisitions 0 10. 00 Income Cost (sum of lines 1 and 10) (see instructions) 3.111 10. 00 Organ acquisitions 3.111 11.00 Cost (sum of lines 1 and 10) (see instructions) 3.111 10. 00 Organ acquisitions 11.001 Cost (sum of lines 1 and 10) (see instructions) 11.001 13. 00 Organ acquisitions that would have been realized from patients liable for payment for services on a charge basis (see instructions) 11.002 11.001 10. 00 Anounts that would have been realized from patients liable for payment for services on a charge basis (see instructions) 0 0.0000000 10. 00 Exesses of customary charges (sum of lines 12 and 13). 0 0.000000 11.002 10. 00 Exesses of customary charges (see instructions) 0 0.000000 0.000000 10. 00 Exesses of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see 0.000000 10. 00 Instructions) 0.2000 0.2000 0.2000 20. 00 Instructions) 0.2000 0.2000 0.2000 0.2000 20. 00 Instructions) 0.2000 0.2000 0.2000 0.2000 0.2000	9.00		graduate medical educ	ation costs from	34, 394	9.00
11.00 Total cost (sum of lines 1 and 10) (see instructions) 3,211 11.00 00 Monthal Section Cost of CARRES 11.00 12.00 01.01 March 11.00 DESCENCE 11.00 12.00 12.00 Anci Liney Service Charges 11.00 12.00 13.00 Aggregate amount actually collected from patients liable for payment for services on a chargebasis 0 16.00 15.00 Aggregate amount actually collected from patients liable for payment for services on a chargebasis 0 16.00 10.01 Diration for finit 5 (in the secced 1.00000) 0.000000 10.00 0.000000 11.027 18.00 10.01 Diration for finit 5 (in the secced 1.00000) 0.000000 0.000000 10.00 10.00 11.0027 18.00 10.01 Diration for finit 5 (in the secced 1.00000) 0.0000000 0.0000000 0.00000000000 10.00000000000000000000000000000000000	10.00				0	10.00
Reasonable (charges) Interpretation (charges) <thinterpretation (charges)<="" th=""> <thinterpretatio< td=""><td></td><td>Total cost (sum of lines 1 and 10) (see instructions)</td><td></td><td></td><td>3, 218</td><td>1</td></thinterpretatio<></thinterpretation>		Total cost (sum of lines 1 and 10) (see instructions)			3, 218	1
12.00 Ancillary service charges 11.027 12.00 Construction acquisition charges (rom Wist. D-4, Pt. 111, col. 4, line 69) 11.027 12.00 13.00 10.02 13.00 10.02 13.00 11.027 14.00 13.00 11.027 14.00 13.00 11.027 14.00 13.00 11.027 14.00 13.00 14.00 13.00 14.00 13.02 14.00 13.02 14.00 13.02 14.00 13.02 14.00 13.02 14.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td>-</td>						-
13.00 Organ acquisition charges (cam of lines 12 and 13) 0 13.00 0.0 Outsteary charges (cam of lines 12 and 13) 11.027 14.00 Outsteary charges (cam of lines 12 and 13) 11.027 15.00 Agregate anount actually collected from patients i lable for payment for services on a chargebasis 0 16.00 Amounts that would have been neal i na condance with AL (FR \$413.16) 16.00 16.00 Total customary charges (see instructions) 0.00000017.00 18.00 Total customary charges (see instructions) 0.0000017.00 19.00 Excess of reasonable cost over customary charges (see instructions) 0 0.0000017.00 10.01 Excess of reasonable cost over customary charges (see instructions) 0 2.00 2.00 10.01 Excess of reasonable cost over customary charges (see instructions) 0 2.00	12.00				11,027	12.00
Customary charges Current 10:00 Aggregate anount actually collected from patients liable for payment for services on a charge basis had such payment been made in accurdance with 42 (FR §41.313(e) 0 15.00 10:00 Ratic of line 15 to line 16 (not to exceed 1.000000) 0 0.0000000 16.00 10:00 Ratic of line 15 to line 16 (not to exceed 1.000000) 0 0.0000000 16.00 10:00 Ratic of line 15 to line 16 (not to exceed 1.000000) 0 0.0000000 16.00 10:00 Resceed Control 10000000 0.00000000 16.00 0.00000000000000000000000000000000000	13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line	e 69)			
15:00 Aggregate amount actually collected from patients iiable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §433.13(e) 0 15:00 16:00 Amounts that would have been realized from patients iiable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §433.13(e) 0 16:00 18:00 Total customary charges (see instructions) 0 0.000000 17:00 18:00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions) 0 20:00 20:00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions) 0 22:00 21:00 Lesser of cost or charges (see instructions) 0 22:00 0 0 22:00 23:00 Cost of physicians' services in a teaching hospital (see instructions) 0 22:00 0 28:49,114 24:00 26:00 Deductibles and coinsurance amounts (for CM, see instructions) 5:90,451 25:00 25:00 25:00 25:00 25:00 25:00 28:101 28:104 28:102 28:102 28:102 28:102 28:102 28:102 28:102 28:102 28:102 28:102 <t< td=""><td>14.00</td><td></td><td></td><td></td><td>11, 027</td><td>14.00</td></t<>	14.00				11, 027	14.00
In ad such payment been made in accordance with 42 CFR \$413.13(e) 0 10.00 Ratio of line 15 to line 16 (not be exceed 1.000000) 0.000000 18.00 Total customary charges (see instructions) 0.000000 10.00 Excees of customary charges (see instructions) 0.000000 10.00 Excees of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see 0.000000 11.00 Instructions) 0.01000 12.00 Interns of readings (see instructions) 0.01000 13.00 Excees of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see 0.000000 13.00 Excees of reasonable cost over customary charges (see instructions) 0.01000 14.00 Total prospective payment (see instructions) 0.025.00 15.00 Deductibles and coinsurance anounts (for CAH, see instructions) 0.025.00 15.00 Deductible send coinsurance anounts (for CAH, see instructions) 0.028.50 15.00 Differet radulate medical education payments (from Wkst. E-4, line 30) 0.028.50 10.00 Prieret graduate medical education costs (from Wkst. E-4, line 30) 2.000 10.01 Prieret graduate medical education costs (from Wkst. E-4, line 30) 2.000 10.01 Prieret graduate medical education costs (from Wkst. E-4, line 30) 2.000.21, 8.00, 2.00, 2.00, 2.00, 2.00, 2.00, 2.00, 2.00, 2.00, 2.00, 2.00, 2.00, 2.00,	15.00	Aggregate amount actually collected from patients liable for pay			0	15.00
17. CO Patio of line 15 to line 16 (not to exceed 1.00000) 0.000000 17. 00 18.00 Total customary charges (see Instructions) 0.10027 18.00 19. 00 Excess of customary charges (see instructions) 11.027 18.00 20. 00 Excess of charges (see instructions) 3.218 0.00000 17. 00 20. 00 Excess of charges (see instructions) 3.218 0.00000 20.00 21.00 Interns and residents (see instructions) 0.23.00 0.00000 21.00 0.00000 22.00 23.00 Cost of physic lans' services in a teaching to amount on line 24 (for CAH, see instructions) 0.00000 22.00 24. 00 Deductible sand coinsurance amounts (for GAH, see instructions) 0.000000 20.00 25. 00 Deductible sand coinsurance amounts (form Wkst. E-4, line 50) 1.70.1,48 28.00 29. 00 Direct graduate medical education costs (from Wkst. E-4, line 36) 24.863.299 24.863.299 20.00 Subtotal ((line 20 minus line 31) 24.865.218 20.00 30.00 20.00 Subtotal (Line 30 minus line 31) 24.865.218 20.00 30.00 30.00 20.00 <td< td=""><td>16.00</td><td></td><td>payment for services o</td><td>on a chargebasis</td><td>0</td><td>16.00</td></td<>	16.00		payment for services o	on a chargebasis	0	16.00
18.00 Total customary charges (see instructions) 11,027 18.00 Fixees of customary charges (see instructions) 7.809 19.00 19.00 Excess of customary charges over reasonable cost (complete only if line 11 exceeds line 13) (see instructions) 2.00 0.00 2.00 2.00 2.00 2.00 2.00 2.00 0.00 2.0	17 00				0 00000	17 00
instructions) 0 20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions) 0 20.00 10.00 Lesses of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions) 0 20.00 20.00 Excess of reasonable cost or charges (see instructions) 0 20.00 0 20.00 Interns and residents (see instructions) 0 23.00 21.00 Deductibles and coinsurance amounts (for CAH, see instructions) 0 25.30, 0481 (26.00 20.00 Deductibles and coinsurance amounts (for CAH, see instructions) 0 25.30, 0481 (26.00 22.00 Direct graduate medical education payments (from Wst. E-4, line 50) 1, 701, 438 (28.00 28.50 20.00 Subtotal (sum of lines 27, 28, 28.50 and 29) 1, 701, 438 (28.00 29.00 24.863, 29.30 0 29.00 24.863, 28.93 20.00 24.863, 28.93 20.00 24.863, 28.93 20.00 24.863, 28.93 20.00 24.863, 28.93 20.00 24.863, 28.93 20.00 24.863, 28.93 20.00 24.863, 28.93 20.00 24.863, 28.93 20.00 24.863, 28.93 20.00 24.863, 28.93 20.00		, , ,				
20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions) 0 20.00 21.00 Lesser of cost or charges (see instructions) 3.218 21.00 22.00 Interns and residents (see instructions) 23.00 23.00 23.00 Cost of physiclans' services in a teaching hospital (see instructions) 23.00 23.00 25.00 Deductibles and coinsurance amounts (for CAH, see instructions) 5.390,481 24.00 26.00 Deductibles and coinsurance amounts (for CAH, see instructions) 5.390,481 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) 1.701,482 28.00 28.00 Direct graduate medical education costs (from Wkst. E-4, line 36) 0.29.00 24.863,289 30.00 30.00 Subtotal (line 30 minus line 31) 24.863,289 33.00 7.771 31.00 31.00 Addinest (see instructions) 24,863,289 33.00 30.00 33.00 31.00 Addinest (see instructions) 194,727 35.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.	19.00		if line 18 exceeds li	ne 11) (see	7, 809	19.00
instructions) instructions) 3.218 21.00 Linterns and residents (see instructions) 0.200 22.00 Interns and residents (see instructions) 0.200 23.00 Cost of physicians' services in a teaching hospital (see instructions) 0.21.00 24.00 Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) 28.549,114 25.00 Deductibles and coinsurance amounts (for CAH, see instructions) 5.00 26.00 Deductibles and coinsurance amounts (for CAH, see instructions) 5.390,412 26.00 Direct graduate medical education payments (from Wkst. E-4, line 50) 1.701,438 28.60 27.00 Subtal (line S1, 28, 28, 50 and 29) 1.701,438 28.60 24.863,289 30.00 20.00 Subtal (line S1, 28, 28, 50 and 29) 24.486,218 2.00 24.863,289 30.00 31.00 Depusiter rate ESN (from Wkst. E-4, line 36) 24.866,218 30.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 3	20.00		ifline 11 exceeds li	ne 18) (see	0	20.00
22.00 Interns and residents (see instructions) 0 02.00 23.00 Cost of physicla sis services in a teaching hospital (see instructions) 0 23.00 24.00 Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) 28.549,114 24.00 25.00 Deductibles and coinsurance amounts (for CAH, see instructions) 0 25.00 28.549,114 24.00 25.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions) 5.390,481 26.00 28.00 Direct graduate medical education payments (from Wkst. E-4, line 36) 0 28.00 24.803,289 0.00 24.803,289 0.00 24.803,289 0.00 24.803,289 0.00 24.803,289 0.00 24.803,289 0.00 0.250,07 0.00 0.0100 0.0100 0.010000000000000000000000000000000000		instructions)				
23.00 Cost of physiclans' services in a traching hospital (see instructions) 0 0 23.00 24.00 Total prospective payment figures 3, 4, 40.1, 8 and 9) 28, 549, 114 24.00 25.00 Deductibles and coinsurance amounts (for CAH, see instructions) 0 25.00 25.00 Deductibles and Coinsurance amounts (for CAH, see instructions) 5.300, 481 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) 23.161, 851 27.00 28.00 Direct graduate medical education payments (from Wkst. E-4, line 50) 1, 701, 438 28.00 29.01 ESK0 direct medical education costs (from Wkst. E-4, line 36) 24, 863, 289 30.00 30.00 Subtotal (sum of lines 27, 28, 28.50 and 29) 24, 863, 289 30.00 7, 701 31.00 31.00 Primary payer payments 24, 865, 218 32.00 30.00 7, 701 31.00 32.00 Composite rate ESR0 (from Kkst. I-5, line 11) 0 0 33.00 7, 701 31.00 33.00 Composite rate ESR0 (from Kkst. I-5, line 11) 0 0 33.00 29, 505, 503, 93 37.00 30.00 </td <td></td> <td>0</td> <td></td> <td></td> <td></td> <td></td>		0				
24.00 Total prospective payment (sum of lines 3, 4, 40, 8 and 9) 28,549,114 24.00 25.00 Deductibles and coinsurance amounts (for CAH, see instructions) 0 25.00 0.00 Deductibles and coinsurance amounts (for CAH, see instructions) 0 25.00 0.00 Deductibles and coinsurance amounts (for CAH, see instructions) 5.300, 412 20.00 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) 23, 161, 851 27.00 28.00 Direct graduate medical education payments (from Wkst. E-4, line 30) 1, 701, 438 28.00 29.00 ESRD direct medical education costs (from Wkst. E-4, line 36) 0 29.00 0.00 Subtotal (sum of lines 27, 28, 28.50 and 29) 14.663, 289 30.00 0.01 Openciste rate ESRD (from Wkst. I-5.1 line 11) 0 31.00 33.00 0.00 ALLOWABLE BAD DEBTS (EXCLUPE EAD DEBTS FOR PROFESSIONAL SERVICES) 32.00 33.00 30.00 Allowable bad debts (see instructions) 14.72 35.00 0.01 Allowable bad debts (see instructions) 154, 566 36.00 39.00 <td></td> <td></td> <td>ctions)</td> <td></td> <td>-</td> <td></td>			ctions)		-	
25.00 Deductibles and coinsurance amounts (for CAH, see instructions) 0 25.00 5.390, 481 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) 23, 161, 851 27.00 28.00 Direct graduate medical education payments (from Wkst. E-4, line 50) 1, 701, 438 28.00 28.50 29.00 ERH facility payment amount (see instructions) 24, 863, 289 30.00 29.00 30.00 Subtotal (line 30 minus line 31) 24, 863, 289 30.00 7, 071 31.00 31.00 Composite rate ESR0 (from Wst. 1-5, line 11) 0 33.00 31.00 Composite rate ESR0 (from Wst. 1-5, line 11) 0 33.00 32.00 SUbtotal (see instructions) 194, 721 35.00 39.00 33.00 Composite rate ESR0 (from Wst. 1-5, line 11) 0 30.00 39.00 33.00 Composite rate SRN (from Wst. 1-5, line 11) 0 30.00 39.00 39.00 34.00 Adjusted red medursable bad debts (see instructions) 194, 721 35.00 39.00 35.00 Adjusted red medursable bad debts (see instructions) 25, 050, 939 37.00 39.90 35.00 Morener ACO demonstration payment adjustment amo	24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	,		28, 549, 114	24.00
26.00 Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions) 5.390, 481 26.00 27.00 Subtotal [(ines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions) 1.701, 438 28.00 28.00 Direct graduate medical education payments (from Wkst. E-4, line 50) 1.701, 438 28.00 29.00 ESRD direct medical education costs (from Wkst. E-4, line 36) 0 29.00 20.00 Subtotal (Sum 30 minus line 31) 24,863,289 30.00 31.00 Primary payer payments 7.071 31.00 20.00 Subtotal (Sum 85.1 ine 11) 0 34.00 30.00 Composite rate ESRO (from Wkst. 1-5, line 11) 0 34.00 31.00 Composite rate ESRO (from Wkst. 1-5, line 11) 0 34.00 32.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 154,566 36.00 33.00 Allowable bad moustration payment amount (see instructions) 154,566 36.00 39.00 39.00 Subtotal (See instructions) 154,566 36.00 39.00 39.00 39.00 Observertal estable bad debts for dual eligible beneficiaries (see instructions)	25 00				0	25.00
instructions) 1,701,438,28,00 28,50 28,00 28,50 28,01 28,02 29,00 25,00 28,00 28,00 28,00 24,863,288 20,00 24,863,288 24,862,28 25,050,939		, , ,	24 (for CAH, see instr	ructions)	-	1
28:00 Direct graduate medical education payments (from Wkst. E-4, line 50) 1,701,433 28.00 28.50 28:00 ESRD direct medical education costs (from Wkst. E-4, line 36) 24.863,283 30.00 30:00 Subtotal (sum of lines 27, 28, 28.50 and 29) 24,863,283 30.00 31:00 Subtotal (sum of lines 27, 28, 28.50 and 29) 24,856,218 32.00 31:00 Subtotal (line 30 minus line 31) 24,856,218 32.00 31:00 Composite rate ESRD (from Wkst. I-5, line 11) 0 33.00 30:00 Allowable bad debts (see instructions) 194,721 35.00 31:00 Minwable bad debts (see instructions) 154,566 30.00 32:00 Minwable bad debts (see instructions) 25,050,939 37.00 33:00 MSP-LCC reconciliation amount from PS&R -771 38.00 33:00 MSP-LCC reconciliation amount from seitructions) 39.50 39.50 39:00 MSP-LCC reconciliation amount before sequestration 39.57 39.75 39:75 MSP respirator payment adj ustment amount defore sequestration 39.57 39.97	27.00		us the sum of lines 22	and 23] (see	23, 161, 851	27.00
28.50 REH facility payment amount (see instructions) 28.50 00 ESED direct medical eduction costs (from Wkst. E-4, line 36) 0 29.00 01.00 Primary payer payments 24, 863, 289 30.00 01.00 Primary payer payments 24, 863, 289 30.00 01.00 Primary payer payments 24, 863, 289 30.00 01.00 Primary payer payments 24, 865, 218 32.00 01.00 ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 31.00 33.00 01.00 Allowable bad debts (see instructions) 194, 721 35.00 01.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 194, 721 35.00 01.00 Ottotal (see instructions) 154, 566 36.00 39.00 01.00 Ottotal (see instructions) 194, 721 37.00 39.00 01.00 Ottotal (see instructions) 194, 721 37.00 39.00 03.00 MSP-LCC reconciliation amount from PS&R 7 71 38.00 03.97 PonoerACO demonstration payment adj ustm	28 00		e 50)		1 701 438	28 00
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33.00 Composite rate ESR0 (from Wkst. 1-5, line 11) 0 33.00 34.00 All owable bad debts (see instructions) 299,570 34.00 35.00 Adjusted reimbursable bad debts (see instructions) 194,721 35.00 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 154,566 36.00 37.00 Subtotal (see instructions) 154,566 36.00 38.00 MSP-LCC reconciliation amount from PS&R -71 38.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.50 39.51 N95 respirator payment adjustment amount (see instructions) 0 39.50 39.75 N95 respirator payment adjustment amount before sequestration 0 39.90 39.99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.90 40.01 Sequestration adjustment (see instructions) 0 39.90 41.00 Demonstration payment adjustment amount after sequestration 0 40.03 40.01 Sequestration adjustment amount after sequestration 0 40.03 41.01 Interim payments 24,442,288 41.00 41.01 In		Subtotal (line 30 minus line 31)				
34.00Allowable bad debts (see instructions)299,57034.0035.00Adjusted reimbursable bad debts (see instructions)194,72135.0036.00Allowable bad debts (see instructions)194,72135.0036.00Allowable bad debts (see instructions)194,72135.0037.00Subtotal (see instructions)25,050,93937.0039.00OTHER ADUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)-7138.0039.00OTHER ADUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)039.0039.75N95 respirator payment adjustment amount before sequestration39.7539.97Demonstration payment adjustment (see instructions)039.9739.98Partial or full credits received from manufacturers for replaced devices (see instructions)039.9839.99RECOVERY OF ACCELERATED DEPRECIATION039.9740.00Subtotal (see instructions)0501,02040.0140.01Sequestration adjustment (see instructions)0501,02040.0240.02Demonstration payment adjustment amount after sequestration0501,02040.0241.01Interim payments24,442,28841.0042.0041.01Interim payments24,442,28841.0042.0042.01Tentative settlement (for contractor use only)42.0142.0043.00Balance due provider/program.PARHM (see instructions)43.0042.0143.01Balance due provider/program.PARHM (see instructions)43.0043.0141	33 00		S)		0	33 00
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39.75N95 respirator payment adjustment amount (see instructions)039.7539.97Demonstration payment adjustment amount before sequestration039.9739.98Partial or full credits received from manufacturers for replaced devices (see instructions)039.9739.99RECOVERY OF ACCELERATED DEPRECIATION039.9840.00Subtotal (see instructions)25,051,01040.0040.01Sequestration adjustment (see instructions)501,02040.0140.02Demonstration payment adjustment amount after sequestration040.0241.00Interim payments41.0040.0241.00Interim payments-PARHM24,442,28841.0041.01Interim payments-PARHM64.00342.0142.00Tentative settlement (for contractors use only)042.0143.00Balance due provider/program (see instructions)107,70243.0043.01Balance due provider/program (see instructions)44.0044.0044.00Ortiginal outlier amount (see instructions)090.0090.00Original outlier amount (see instructions)090.0090.00Original outlier amount (see instructions)091.0091.00Outlier reconciliation adjustment amount (see instructions)091.0092.00The rate used to calculate the Time Value of Money0.0092.00					0	
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40.00Subtotal (see instructions)25,051,01040.0040.01Sequestration adjustment (see instructions)501,02040.0140.02Demonstration payment adjustment amount after sequestration040.0240.03Sequestration adjustment-PARHM pass-throughs40.0341.00Interim payments24,442,28841.0041.01Interim payments-PARHM24,442,28841.0142.00Tentative settlement (for contractors use only)042.0042.01Tentative settlement-PARHM (for contractor use only)42.0143.00Bal ance due provider/program (see instructions)107,70243.0044.00Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.2044.0070BE COMPLETED BY CONTRACTOR090.0090.00Original outlier amount (see instructions)091.0092.00The rate used to calculate the Time Value of Money0.0092.00			d devices (see instruc	tions)	-	
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41.00Interim payments24,442,28841.0041.01Interim payments-PARHM41.0142.00Tentative settlement (for contractors use only)042.0042.01Tentative settlement-PARHM (for contractor use only)042.0143.00Balance due provider/program (see instructions)107,70243.0043.01Balance due provider/program-PARHM (see instructions)107,70243.0044.00Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, S115.2044.0070BE COMPLETED BY CONTRACTOR090.0090.00Original outlier amount (see instructions)091.0092.00The rate used to calculate the Time Value of Money0.0092.00					0	
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42.01Tentative settlement-PARHM (for contractor use only)42.0143.00Balance due provider/program (see instructions)107,70243.01Balance due provider/program-PARHM (see instructions)43.0144.00Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,044.00Sil15.2107,702TO BE COMPLETED BY CONTRACTOR090.00Original outlier amount (see instructions)091.00Outlier reconciliation adjustment amount (see instructions)092.00The rate used to calculate the Time Value of Money0.00					-	
43.00 Balance due provider/program (see instructions) 107,702 43.00 43.01 Balance due provider/program-PARHM (see instructions) 43.01 44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 §115.2 TO BE COMPLETED BY CONTRACTOR 0 90.00 Original outlier amount (see instructions) 0 91.00 Outlier reconciliation adjustment amount (see instructions) 0 92.00 The rate used to calculate the Time Value of Money 0.00					0	
44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, <u>\$115.2</u> <u>10 BE COMPLETED BY CONTRACTOR</u> 90.00 44.00 90.00 Original outlier amount (see instructions) 0 91.00 Outlier reconciliation adjustment amount (see instructions) 0 92.00 The rate used to calculate the Time Value of Money 0.00					107, 702	
§115.2TO BE COMPLETED BY CONTRACTOR90.0091.0091.0092.0092.00					-	
TO BE COMPLETED BY CONTRACTOR90.00Original outlier amount (see instructions)090.0091.00Outlier reconciliation adjustment amount (see instructions)091.0092.00The rate used to calculate the Time Value of Money0.0092.00	44.00		e with CMS Pub. 15-2,	cnapter 1,	0	44.00
91.00Outlier reconciliation adjustment amount (see instructions)091.0092.00The rate used to calculate the Time Value of Money0.0092.00		TO BE COMPLETED BY CONTRACTOR				1
92.00 The rate used to calculate the Time Value of Money 0.00 92.00		8				
	93.00	Time Value of Money (see instructions)			0	

Health Financial Systems	GOOD SAMARITAN H	HOSPI TAL	In Lieu	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0042	Peri od:	Worksheet E	
			From 01/01/2023 To 12/31/2023	Date/Time Pro 4/11/2024 3:	epared: 17 pm
		Title XVIII	Hospi tal	PPS	
				1.00	
94.00 Total (sum of lines 91 and 93)				(94.00
				1.00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days				(200.00

	Financial Systems GOOD SAMARITAN ATION OF REIMBURSEMENT SETTLEMENT GOOD SAMARITAN	HOSPI TAL Provi der CCN: 15-0042	In Lie Period: From 01/01/2023	u of Form CMS-2 Worksheet E Part B	2552-10
		Component CCN: 15-SO42	To 12/31/2023	Date/Time Pre 4/11/2024 3:1	
		Title XVIII	Subprovider -	PPS	
				1.00	
1.00	PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions)			63	1.00
2.00	Medical and other services reimbursed under OPPS (see instruct	ctions)		962	
3.00 4.00	OPPS or REH payments Outlier payment (see instructions)			2, 509 0	3.00 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 instru Line 2 times line 5	ictions)		0.000 0	
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
8.00 9.00	Transitional corridor payment (see instructions) Ancillary service other pass through costs including REH dire	ect graduate medical edu	cation costs from	0	8.00 9.00
10.00	Wkst. D, Pt. IV, col. 13, line 200	0		0	10.00
10. 00 11. 00	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)			0 63	
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges				
12.00	Ancillary service charges			215	12.00
13.00 14.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	ine 69)		0	
14.00	Total reasonable charges (sum of lines 12 and 13) Customary charges		l	215	14.00
15.00 16.00	Aggregate amount actually collected from patients liable for Amounts that would have been realized from patients liable for			0	15.00 16.00
10.00	had such payment been made in accordance with 42 CFR §413.130		on a chargebasi s	0	10.00
17.00 18.00	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions)			0.000000 215	
19.00	Excess of customary charges over reasonable cost (complete or	nly if line 18 exceeds l	ine 11) (see	152	
20.00	instructions) Excess of reasonable cost over customary charges (complete or	ly if line 11 exceeds l	ing 18) (see	0	20.00
20.00	instructions)	If y ff fffle ff exceeds f	The To) (see	0	20.00
21.00 22.00	Lesser of cost or charges (see instructions) Interns and residents (see instructions)			63 0	
22.00	Cost of physicians' services in a teaching hospital (see inst	tructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			2, 511	24.00
	Deductibles and coinsurance amounts (for CAH, see instruction			0	
26.00 27.00	Deductibles and Coinsurance amounts relating to amount on lin Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)			441 2, 133	
	instructions)				
28.00 28.50	Direct graduate medical education payments (from Wkst. E-4, I REH facility payment amount (see instructions)	ine 50)		0	28.00 28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36))		0	29.00
30.00 31.00	Subtotal (sum of lines 27, 28, 28.50 and 29) Primary payer payments			2, 133 0	
32.00	Subtotal (line 30 minus line 31)			2, 133	
33.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI Composite rate ESRD (from Wkst. 1-5, line 11)	CES)		0	33.00
34.00	Allowable bad debts (see instructions)			1, 556	34.00
35.00 36.00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst	tructions)		1, 011 0	
37.00	Subtotal (see instructions)			3, 144	37.00
38.00 39.00	MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
39.50	Pioneer ACO demonstration payment adjustment (see instruction	ıs)		-	39.50
39. 75 39. 97	N95 respirator payment adjustment amount (see instructions) Demonstration payment adjustment amount before sequestration			0	
39.98	Partial or full credits received from manufacturers for repla	aced devices (see instru	ctions)	0	39.98
39. 99 40. 00	RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions)			0 3, 144	39.99 40.00
40.01	Sequestration adjustment (see instructions)			63	40. 01
40. 02 40. 03	Demonstration payment adjustment amount after sequestration Sequestration adjustment-PARHM pass-throughs			0	40. 02 40. 03
41.00	Interim payments			2, 093	41.00
41.01 42.00	Interim payments-PARHM Tentative settlement (for contractors use only)			0	41.01 42.00
42.01	Tentative settlement-PARHM (for contractor use only)			000	42.01
43.00 43.01	Balance due provider/program (see instructions) Balance due provider/program-PARHM (see instructions)			988	43.00 43.01
44.00	Protested amounts (nonallowable cost report items) in accorda	ance with CMS Pub. 15-2,	chapter 1,	0	
	\$115.2 TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount (see instructions)			0	
	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0 0.00	91.00
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Health Financial Systems	GOOD SAMARI TAN	HOSPI TAL	In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0042	Period: From 01/01/2023	Worksheet E Part B	
		Component CCN: 15-SO42		Date/Time Pre 4/11/2024 3:1	
		Title XVIII	Subprovider - IPF	PPS	
		•			
				1.00	
93.00 Time Value of Money (see instructions)				C	93.00
94.00 Total (sum of lines 91 and 93)				C	94.00
				1.00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days					200.00

CALCULATION OF RETROUGSERNT SETTLEMENT Protocols Pertocols Pertocols Component Octs To M2 To To T273/2023 Pertocols Pert		Financial Systems GOOD SAMARITAN			u of Form CMS-2	2552-10
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31.00 Primary payer payments 0 31.00 32.00 Subtotal (line 30 minus line 31) 755 32.00 ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 0 33.00 Composite rate ESR0 (from Wkst. 1-5, line 11) 0 33.00 33.00 Composite rate ESR0 (from Wkst. 1-5, line 11) 0 34.00 34.00 34.00 Allowable bad debts (see instructions) 0 34.00 35.00 Adjusted reimbursable bad debts (see instructions) 0 36.00 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 0 36.00 36.00 MSP-LCC reconciliation amount from PS&R 0 38.00 37.50 PS respirator payment adjustment amount (see instructions) 39.90 39.97 39.75 N95 respirator payment adjustment amount before sequestration 0 39.97 39.99 RecoVERY of ACCLEREATED DEPRECIATION 0 39.99 40.01 Sequestration adjustment amount after sequestration 0 39.97 39.99 RecoVERY of ACCLEREATED DEPRECIATION 0 40.02 40.01 Sequestration adjustment amount after sequestration <	29.00	ESRD direct medical education costs (from Wkst. E-4, line 36))		0	
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39.75N95 respirator payment adjustment amount (see instructions)039.7539.97Demonstration payment adjustment amount before sequestration039.9739.98Partial or full credits received from manufacturers for replaced devices (see instructions)039.9839.99RECOVERY OF ACCELERATED DEPRECIATION039.9840.00Subtotal (see instructions)039.9940.01Sequestration adjustment (see instructions)1540.0040.02Demonstration payments adjustment amount after sequestration040.0241.00Interim payments77541.0041.01Interim payments-PARHM pass-throughs41.0141.0142.00Tentative settlement (for contractor us only)42.0042.0043.00Balance due provider/program (see instructions)-3543.0044.00Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, o44.0090.00Original outlier amount (see instructions)090.0091.00Outlier reconciliation adjustment amount (see instructions)091.00			、 、		0	
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39.99RECOVERY OF ACCELERATED DEPRECIATION039.9940.00Subtotal (see instructions)75540.0040.01Sequestration adjustment (see instructions)1540.0140.02Demonstration payment adjustment amount after sequestration040.0240.03Sequestration adjustment-PARHM pass-throughs40.0341.00Interim payments77541.0041.01Interim payments-PARHM41.0142.00Tentative settlement (for contractors use only)42.0043.00Bal ance due provider/program (see instructions)-3543.01Bal ance due provider/program (see instructions)-3544.00Frotested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 044.0044.00For Dested amount (see instructions)090.00Original outlier amount (see instructions)090.0091.00Outlier reconciliation adjustment amount (see instructions)091.00						
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40.02Demonstration payment adjustment amount after sequestration040.0240.03Sequestration adjustment-PARHM pass-throughs40.0341.00Interim payments77541.01Interim payments-PARHM42.00Tentative settlement (for contractors use only)042.01Tentative settlement (for contractor use only)043.00Balance due provider/program (see instructions)-3543.01Balance due provider/program-PARHM (see instructions)-3544.00Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.2090.00Original outlier amount (see instructions)091.00Outlier reconciliation adjustment amount (see instructions)091.00091.00					-	
40.03Sequestration adjustment-PARHM pass-throughs40.0341.00Interim payments77541.00Interim payments77541.01Interim payments-PARHM41.0142.00Tentative settlement (for contractors use only)42.0142.01Tentative settlement-PARHM (for contractor use only)42.0143.00Balance due provider/program (see instructions)-3543.01Balance due provider/program-PARHM (see instructions)-3544.00Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.2044.00Original outlier amount (see instructions)090.00Original outlier amount (see instructions)091.00Outlier reconciliation adjustment amount (see instructions)091.00091.00						
41.00Interim payments77541.0041.01Interim payments-PARHM41.0142.00Tentative settlement (for contractors use only)042.0042.01Tentative settlement-PARHM (for contractor use only)42.0143.00Bal ance due provider/program (see instructions)-3543.0043.01Bal ance due provider/program-PARHM (see instructions)-3543.0044.00Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, S115.2044.0090.00Original outlier amount (see instructions)090.0091.00Outlier reconciliation adjustment amount (see instructions)091.00					0	
42.00Tentative settlement (for contractors use only)042.0042.01Tentative settlement-PARHM (for contractor use only)42.0143.00Bal ance due provider/program (see instructions)-3543.01Bal ance due provider/program-PARHM (see instructions)-3544.00Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, S115.2044.00Original outlier amount (see instructions)090.00Original outlier amount (see instructions)091.00Outlier reconciliation adjustment amount (see instructions)0					775	
42.01Tentative settlement-PARHM (for contractor use only)42.0143.00Balance due provider/program (see instructions)-3543.01Balance due provider/program-PARHM (see instructions)-3544.00Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.244.0070BE COMPLETED BY CONTRACTOR90.0090.00Original outlier amount (see instructions)091.00Outlier reconciliation adjustment amount (see instructions)0					0	
43.00 Balance due provider/program (see instructions) -35 43.00 43.01 Balance due provider/program-PARHM (see instructions) -35 43.00 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 5115.2 TO BE COMPLETED BY CONTRACTOR 90.00 90.00 Original outlier amount (see instructions) 0 91.00 Outlier reconciliation adjustment amount (see instructions) 0					0	
44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, <u>\$115.2</u> <u>10 BE COMPLETED BY CONTRACTOR</u> 90.00 0 90.00 90.00 Original outlier amount (see instructions) 0 utlier reconciliation adjustment amount (see instructions) 0 91.00 0 90.00		Balance due provider/program (see instructions)			-35	
§115.2 TO BE COMPLETED BY CONTRACTOR 90.00 91.00 0utlier reconciliation adjustment amount (see instructions) 0 91.00			ance with CMS Pub 15-2	chapter 1.	Ο	
90.00Original outlier amount (see instructions)090.0091.00Outlier reconciliation adjustment amount (see instructions)091.00		§115. 2				
91.00 Outlier reconciliation adjustment amount (see instructions) 0 91.00	90 00				0	90 00
92.00 The rate used to calculate the Time Value of Money 0.00 92.00					0	91.00
	92.00	The rate used to calculate the Time Value of Money			0.00	92.00

Health Financial Systems	GOOD SAMARI TAN	HOSPI TAL	In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0042	Period: From 01/01/2023	Worksheet E Part B	
		Component CCN: 15-TO42		Date/Time Pre 4/11/2024 3:1	
		Title XVIII	Subprovider -	PPS	
				1	
				1.00	
93.00 Time Value of Money (see instructions)				0	
94.00 Total (sum of lines 91 and 93)				0	94.00
				1.00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days					200.00

NALY	n Financial Systems GOOD SAMARITA SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider C	CN: 15-0042	Period: From 01/01/2023 To 12/31/2023		pared:
		Title	XVIII	Hospi tal	PPS	
		I npati en	t Part A		тв	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00 2.00 3.00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate		18, 672, 8	81 0	22, 656, 670 0	1.00 2.00 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	09/06/2023	367, 1	00 12/31/2023	1, 345, 918	3.0
3. 02		12/31/2023	1, 364, 5		439, 700	3.0
3. 03				0	0	3.0
3.04				0	0	3.0
8. 05	Provider to Program			0	0	3.0
8.50	ADJUSTMENTS TO PROGRAM			0	0	3.5
. 51				0	0	3.5
. 52				0	0	3.5
3.53				0	0	3.5
8.54 8.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		1, 731, 6	0	0 1, 785, 618	3.5
. 77	3. 50-3. 98)		1,751,0	04	1, 703, 010	J. 7
. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E–3, line and column as appropriate)		20, 404, 5	65	24, 442, 288	4.0
	TO BE COMPLETED BY CONTRACTOR					
. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.(
	Program to Provider					
. 01	TENTATI VE TO PROVIDER			0	0	5.0
. 02				0	0	5.C
. 05	Provider to Program		I	5	0	5.0
. 50	TENTATI VE TO PROGRAM			0	0	5.5
. 51				0	0	5.5
. 52 . 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5. ! 5. 9
. 99	5. 50-5. 98)			0	0	5.
. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. (
. 01	SETTLEMENT TO PROVIDER		1, 542, 3	17	107, 702	6. (
. 02 . 00	SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions)		21, 946, 8	U 82	0 24, 549, 990	6. 7.
. 00			21, 940, 8	Contractor	24,549,990 NPR Date	7.
				Number	(Mo/Day/Yr)	
		()	1.00	2.00	

IALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		CN: 15-0042 CCN: 15-S042	Period: From 01/01/2023 To 12/31/2023		parec 7 pm
		Title	e XVIII	Subprovider -	PPS	
		Inpatier	nt Part A		rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
00	Tatal interim poymente peid te provider	1.00	2.00	3.00	4.00	1. (
00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		518, 9	0	2,093	2. (
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3.
01	ADJUSTMENTS TO PROVIDER			0	0	3.
02				0	0	3.
03 04				0	0	3. 3.
04				0	0	3.
	Provider to Program		1	-		
50	ADJUSTMENTS TO PROGRAM			0	0	3.
51				0	0	3
52 53				0	0	3
53 54				0	0	3
99	Subtotal (sum of lines 3.01–3.49 minus sum of lines 3.50–3.98)			0	0	3
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as		518, 9	84	2, 093	4
	appropriate) TO BE COMPLETED BY CONTRACTOR					
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5
	Program to Provider					
D1	TENTATI VE TO PROVI DER			0	0	5
22				0	0	5
23	Provider to Program			0	0	5
50	TENTATI VE TO PROGRAM			0	0	5
51				0	0	5
52				0	0	5
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	5
00	Determined net settlement amount (balance due) based on the cost report. (1)					6
01 02	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM		13, 9	41	988	6
02 00	Total Medicare program liability (see instructions)		532, 9	25	3, 081	6 7
00			552, 7	Contractor	NPR Date	/
				Number	(Mo/Day/Yr)	
			0	1.00	2.00	

IALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CO	CN: 15-0042 CCN: 15-T042	Period: From 01/01/202 To 12/31/202		pare
		Title	XVIII	Subprovider - IRF		F
		I npati en	t Part A		nrt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
	Tabal intenin normate said to provide	1.00	2.00	3.00	4.00	1
00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		7, 687, 8	0	775 0	1. 2.
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3.
01	ADJUSTMENTS TO PROVIDER			0	0	3.
02				0	0	3.
03				0	0	3.
04				0	0	3
05	Dravidar to Dragram			0	0	3
50	Provider to Program ADJUSTMENTS TO PROGRAM			0	0	3
50 51				0	0	3
52				0	0	
53				0	0	3
54				0	0	3
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	0	3
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		7, 687, 8	12	775	4
	TO BE COMPLETED BY CONTRACTOR					
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5
	Program to Provider					
01	TENTATI VE TO PROVIDER			0	0	5
02 03				0	0	5
03	Provider to Program			0	0	1 5
50	TENTATI VE TO PROGRAM			0	0	5
51				0	0	5
52				0	0	5
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	5
00	Determined net settlement amount (balance due) based on the cost report. (1)					6
01	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM		-	0 13	0	6
02 00	Total Medicare program liability (see instructions)		7, 687, 0		35 740	6
00			7,007,0	Contractor	NPR Date	-
				Number	(Mo/Day/Yr)	
		()	1.00	2.00	

Heal th	Financial Systems GOOD SAMARITAN	HOSPI TAL	In Lie	u of Form CMS-	-2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0042	Period: From 01/01/2023	Worksheet E- Part II	1
			To 12/31/2023		
		Title XVIII	Hospi tal	PPS	
				1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				_
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst	. S-3, Pt. I col. 15 lin	e 14		1.00
2.00	Medicare days (see instructions)				2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4.00	Total inpatient days (see instructions)				4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3	line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of line 168	certified HIT technology	Wkst. S-2, Pt. I		7.00
8.00	Calculation of the HIT incentive payment (see instructions)				8.00
9.00	Sequestration adjustment amount (see instructions)				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
31.00	Other Adjustment (specify)				31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and	line 31) (see instructio	ns)		32.00

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0042	Period: From 01/01/2023	Worksheet E-3 Part II	
		Component CCN: 15-S042	To 12/31/2023		
		Title XVIII	Subprovider - IPF	PPS	
			-	1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS				
00	Net Federal IPF PPS Payments (excluding outlier, ECT, and	medical education payments)	536, 349	1
00	Net IPF PPS Outlier Payments			0	2
00	Net IPF PPS ECT Payments		с. н. н.	2, 301	3
00	Unweighted intern and resident FTE count in the most rece 15, 2004. (see instructions)	nt cost report filed on or i	perore November	0.00	4
01	Cap increases for the unweighted intern and resident FTE	count for residents that we	re displaced by	0.00	4
01	program or hospital closure, that would not be counted wi			0.00	
	CFR §412. 424(d) (1) (i i i) (F) (1) or (2) (see instructions)	thout a temperary sup aujus			
00	New Teaching program adjustment. (see instructions)			0.00	5
00	Current year's unweighted FTE count of I&R excluding FTEs	in the new program growth	period of a "new	0.00	6
	teaching program" (see instuctions)				
00	Current year's unweighted I&R FTE count for residents wit	hin the new program growth	period of a "new	3. 98	7
	teaching program" (see instuctions)				
00	Intern and resident count for IPF PPS medical education a	djustment (see instructions))	3. 98	8
00	Average Daily Census (see instructions)			11.843836	
. 00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised	to the power of .5150 -1}.		0. 160906	
. 00 . 00	Teaching Adjustment (line 1 multiplied by line 10).	11)		86, 302	
. 00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and Nursing and Allied Health Managed Care payment (see instr	-		624, 952 0	12
00	Organ acquisition (DO NOT USE THIS LINE)			0	14
00	Cost of physicians' services in a teaching hospital (see	instructions)		0	1
. 00	Subtotal (see instructions)			624, 952	
. 00	Primary payer payments			021, 702	17
. 00	Subtotal (line 16 less line 17).			624, 952	
. 00	Deducti bl es			86, 356	
. 00	Subtotal (line 18 minus line 19)			538, 596	20
. 00	Coinsurance			0	2
	Subtotal (line 20 minus line 21)			538, 596	
. 00	Allowable bad debts (exclude bad debts for professional s	ervices) (see instructions)		6, 993	
. 00	Adjusted reimbursable bad debts (see instructions)			4, 545	
. 00	Allowable bad debts for dual eligible beneficiaries (see	instructions)		1, 462	
. 00	Subtotal (sum of lines 22 and 24)			543, 141	20
. 00	Direct graduate medical education payments (see instructi	ons)		0	2
00	Other pass through costs (see instructions) Outlier payments reconciliation			660 0	2
00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	3
50	Pioneer ACO demonstration payment adjustment (see instruc	tions)		0	30
98	Recovery of accel erated depreciation.			Ő	30
99	Demonstration payment adjustment amount before sequestrat	i on		0	30
. 00	Total amount payable to the provider (see instructions)			543, 801	3.
. 01	Sequestration adjustment (see instructions)			10, 876	3.
. 02	Demonstration payment adjustment amount after sequestrati	on		0	31
. 00	Interim payments			518, 984	
. 00	Tentative settlement (for contractor use only)			0	33
. 00	Balance due provider/program (line 31 minus lines 31.01,			13, 941	
. 00	Protested amounts (nonallowable cost report items) in acc	ordance with CMS Pub. 15-2,	chapter 1,	0	35
	§115.2 TO BE COMPLETED BY CONTRACTOR				
. 00	Original outlier amount from Worksheet E-3, Part II, line	2		0	50
. 00	Outlier reconciliation adjustment amount (see instruction			0	5
. 00	The rate used to calculate the Time Value of Money	<i>.</i> ,		0.00	
. 00	Time Value of Money (see instructions)			0.00	53
	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 COVID-19 PHE)	AND BEGINNING ON OR BEFORE	MAY 11, 2023 (TH		
	Teaching Adjustment Factor for the cost reporting period				

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0042	Period:	Worksheet E-3	
		Component CCN: 15-T042	From 01/01/2023 To 12/31/2023		
		Title XVIII	Subprovider - IRF	PPS	
				1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS			1.00	
. 00	Net Federal PPS Payment (see instructions)			7, 661, 357	1 1.
. 00	Medicare SSI ratio (IRF PPS only) (see instructions)			0. 0225	2.
00	Inpatient Rehabilitation LIP Payments (see instructions)			144, 034	3
00	Outlier Payments			106, 520	
00	Unweighted intern and resident FTE count in the most receipto November 15, 2004 (see instructions)	ent cost reporting period e	nding on or prior	0.00	5
01	Cap increases for the unweighted intern and resident FTE	count for residents that we	re displaced by	0.00	5
01	program or hospital closure, that would not be counted w			0.00	
	CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)				
00	New Teaching program adjustment. (see instructions)			0.00	6
00	Current year's unweighted FTE count of I&R excluding FTE	s in the new program growth	period of a "new	0.00	7
~~	teaching program" (see instructions)			0.00	
00	Current year's unweighted I&R FTE count for residents wi teaching program" (see instructions)	thin the new program growth	period of a new	0.00	8
00	Intern and resident count for IRF PPS medical education a	adiustment (see instructions		0.00	9
. 00	Average Daily Census (see instructions)			17. 128767	
. 00	Teaching Adjustment Factor (see instructions)			0.000000	11
2. 00	Teaching Adjustment (see instructions)			0	12
. 00	Total PPS Payment (see instructions)			7, 911, 911	
. 00	Nursing and Allied Health Managed Care payments (see ins	truction)		0	
. 00	Organ acquisition (DO NOT USE THIS LINE)	·		0	15
. 00 . 00	Cost of physicians' services in a teaching hospital (see Subtotal (see instructions)	Instructions)		0 7, 911, 911	
. 00	Primary payer payments			7, 911, 911	
0.00	Subtotal (line 17 less line 18).			7, 911, 911	
0. 00	Deducti bl es			67, 200	
. 00	Subtotal (line 19 minus line 20)			7, 844, 711	2
2.00	Coinsurance			10, 800	
. 00	Subtotal (line 21 minus line 22)			7, 833, 911	
. 00	Allowable bad debts (exclude bad debts for professional s	services) (see instructions)		9, 184	
. 00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see	instructions)		5, 970 1, 600	
. 00 . 00	Subtotal (sum of lines 23 and 25)			7, 839, 881	2
3.00	Direct graduate medical education payments (from Wkst. E	-4, line 49)		0	
. 00	Other pass through costs (see instructions)	. ,		4, 098	20
0. 00	Outlier payments reconciliation			0	30
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	31
. 50	Pioneer ACO demonstration payment adjustment (see instru-	ctions)		0	
. 98 . 99	Recovery of accelerated depreciation. Demonstration payment adjustment amount before sequestra	tion		0	-
2.00	Total amount payable to the provider (see instructions)			7, 843, 979	
	Sequestration adjustment (see instructions)			156, 880	
2. 02	Demonstration payment adjustment amount after sequestrat	i on		0	
. 00	Interim payments			7, 687, 812	33
. 00	Tentative settlement (for contractor use only)			0	
. 00	Balance due provider/program (line 32 minus lines 32.01,	· · · · · ·		-713	
o. 00	Protested amounts (nonallowable cost report items) in act §115.2	cordance with CMS Pub. 15-2,	chapter 1,	0	36
	TO BE COMPLETED BY CONTRACTOR				
. 00	Original outlier amount from Wkst. E-3, Pt. III, line 4			106, 520	50
. 00	Outlier reconciliation adjustment amount (see instruction	ns)		0	51
2.00	The rate used to calculate the Time Value of Money			0.00	
3.00	Time Value of Money (see instructions)			0	53
	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020	U AND BEGINNING ON OR BEFORE	MAY 11, 2023 (TH	E END OF THE	
. 00	COVID-19 PHE) Teaching Adjustment Factor for the cost reporting period	immodiately preceding Febru	2020	0.000000	
		THE ALELY DIRCROUND FROM	arv 27. 2020.	0.00000	1 90

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0042	Period: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part VII Date/Time Pre 4/11/2024 3:1	pared
		Title XIX	Hospi tal	Cost	
			Inpatient 1.00	Outpatient 2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SE	RVICES FOR TITLES V OR		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES				1
. 00	Inpatient hospital/SNF/NF services		1, 117, 188		1.0
. 00	Medical and other services			0	2.0
. 00	Organ acquisition (certified transplant programs only)		0		3.0
. 00	Subtotal (sum of lines 1, 2 and 3)		1, 117, 188	0	
. 00	Inpatient primary payer payments		0	0	5.0
. 00 . 00	Outpatient primary payer payments Subtotal (line 4 less sum of lines 5 and 6)		1, 117, 188	0	
. 00	COMPUTATION OF LESSER OF COST OR CHARGES		1, 117, 100	0	, <i>'</i> .c
	Reasonable Charges				1
. 00	Routi ne servi ce charges		1, 007, 581		8.0
. 00	Ancillary service charges		2, 286, 886	0	9.0
00 .C	Organ acquisition charges, net of revenue		0		10. C
1.00	Incentive from target amount computation		0		11.0
2.00	Total reasonable charges (sum of lines 8 through 11)		3, 294, 467	0	12.0
	CUSTOMARY CHARGES				1 1 2 2
3.00	Amount actually collected from patients liable for payment for	or services on a charge	0	0	13.0
4.00	basis Amounts that would have been realized from patients liable fo	r navment for services	on 0	0	14.0
4.00	a charge basis had such payment been made in accordance with			0	14.0
5.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0, 000000	0.000000	15.0
6.00	Total customary charges (see instructions)		3, 294, 467	0	
7.00	Excess of customary charges over reasonable cost (complete on	ly if line 16 exceeds	2, 177, 279	0	17.0
	line 4) (see instructions)				
B. 00	Excess of reasonable cost over customary charges (complete on	ly if line 4 exceeds li	ne 0	0	18.0
	16) (see instructions)			0	10.0
9.00 0.00	Interns and Residents (see instructions) Cost of physicians' services in a teaching hospital (see inst	rusti and)	0	0	
1.00	Cost of covered services (enter the lesser of line 4 or line		1, 117, 188	0	
1.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be			0	21.0
2.00	Other than outlier payments		0	0	22.0
3.00	Outlier payments		0	0	
4.00	Program capital payments		0		24.0
5.00	Capital exception payments (see instructions)		0		25.0
6.00	Routine and Ancillary service other pass through costs		0	0	
7.00	Subtotal (sum of lines 22 through 26)		0	0	
8.00	Customary charges (title V or XIX PPS covered services only)		0	0	
9.00	Titles V or XIX (sum of lines 21 and 27) COMPUTATION OF REIMBURSEMENT SETTLEMENT		1, 117, 188	0	29.0
D. 00	Excess of reasonable cost (from line 18)		0	0	30.0
1.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	1, 117, 188	0	
2.00	Deducti bl es	,	0	0	
3.00	Coinsurance		0	0	33.0
4.00	Allowable bad debts (see instructions)		0	0	34.0
5.00	Utilization review		0		35.0
6.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 an	id 33)	1, 117, 188	0	
7.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
B. 00	Subtotal (line 36 ± line 37)		1, 117, 188	0	
9.00 0.00	Direct graduate medical education payments (from Wkst. E-4) Total amount payable to the provider (sum of lines 38 and 39)		1 117 100	0	39.0 40.0
1.00	Interim payments		1, 117, 188 1, 496, 448	0	
2.00	Balance due provider/program (line 40 minus line 41)		-379, 260	0	1
3.00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub 15-2	-379,200	0	
	chapter 1, §115.2		Ĭ	Ŭ	

ALCULA	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0042	Period:	Worksheet E-3	;
		Component CCN: 15-SO42	From 01/01/2023 To 12/31/2023	Part VII Date/Time Pre 4/11/2024 3:1	
		Title XIX	Subprovider -	Cost	<u>, b</u>
			I npati ent	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SE COMPUTATION OF NET COST OF COVERED SERVICES	RVICES FOR TITLES V OR 2	XIX SERVICES		-
	Inpatient hospital/SNF/NF services		591,039		1 1
	Medical and other services		571,057	0	
	Organ acquisition (certified transplant programs only)		0	Ũ	3
00	Subtotal (sum of lines 1, 2 and 3)		591, 039	0	4
00	Inpatient primary payer payments		0		5
	Outpatient primary payer payments			0	
	Subtotal (line 4 less sum of lines 5 and 6)		591, 039	0	7
	COMPUTATION OF LESSER OF COST OR CHARGES				-
	Reasonable Charges Routine service charges		514, 329		1 8
	Ancillary service charges		110, 915	0	
	Organ acquisition charges, net of revenue		0	Ũ	10
	Incentive from target amount computation		0		11
. 00	Total reasonable charges (sum of lines 8 through 11)		625, 244	0	12
	CUSTOMARY CHARGES				
8.00	Amount actually collected from patients liable for payment fo	or services on a charge	0	0	13
~~	basis		0	1 1	
. 00	Amounts that would have been realized from patients liable for a charge basis had such payment been made in accordance with		on 0	0	14
. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0. 000000	0.000000	15	
	Total customary charges (see instructions)	625, 244	0.000000		
	Excess of customary charges over reasonable cost (complete on	34, 205	0		
	line 4) (see instructions)	5			
3. 00	Excess of reasonable cost over customary charges (complete on	ly if line 4 exceeds li	ne 0	0	18
	16) (see instructions)			_	
	Interns and Residents (see instructions)		0	0	
	Cost of physicians' services in a teaching hospital (see inst Cost of covered services (enter the lesser of line 4 or line		0 591, 039	0	
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be			0	
	Other than outlier payments		0	0	22
	Outlier payments		0	0	
	Program capital payments		0		24
5.00	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	
	Customary charges (title V or XIX PPS covered services only)		0	0	1
0.00	Titles V or XIX (sum of lines 21 and 27)		591, 039	0	29
0. 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Excess of reasonable cost (from line 18)		0	0	30
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6		591, 039	0	
	Deductiblies	· /	0	0	
	Coinsurance		0	0	
	Allowable bad debts (see instructions)		0	0	
	Utilization review	0		35	
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 an	591, 039	0		
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0		
	Subtotal (line 36 ± line 37)	591, 039	0		
	Direct graduate medical education payments (from Wkst. E-4) Total amount payable to the provider (sum of lines 38 and 39)		E01 020	0	39
	Interim payments		591, 039 291, 834	0	
	Balance due provider/program (line 40 minus line 41)		291, 834 299, 205	0	
	Protested amounts (nonallowable cost report items) in accorda	ince with CMS Pub 15-2	299, 203	0	
	chapter 1, §115.2		Ŭ	0	1

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0042	Period: From 01/01/2023	Worksheet E-3 Part VII	3
		Component CCN: 15-T042	To 12/31/2023	Date/Time Pre 4/11/2024 3:1	
		Title XIX	Subprovider - IRF	Cost	
			Inpatient	Outpati ent	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH S	EDVICES EOD TITLES V OD		2.00	-
	COMPUTATION OF NET COST OF COVERED SERVICES	ERVICES FOR THEES V OR	ATA SERVICES		1
00	Inpati ent hospi tal /SNF/NF servi ces		39, 297		1 ·
00	Medical and other services			0	
00	Organ acquisition (certified transplant programs only)		0		:
00	Subtotal (sum of lines 1, 2 and 3)		39, 297	0	
00	Inpatient primary payer payments		0	0	
00 00	Outpatient primary payer payments		39, 297	0	
00	Subtotal (line 4 less sum of lines 5 and 6) COMPUTATION OF LESSER OF COST OR CHARGES		39,297	0	1
	Reasonabl e Charges				1
00	Routine service charges		59, 995		18
00	Ancillary service charges		74, 408	0	
. 00	Organ acquisition charges, net of revenue		0		10
. 00	Incentive from target amount computation		0		1
. 00	Total reasonable charges (sum of lines 8 through 11)		134, 403	0	12
. 00	CUSTOMARY CHARGES	for convices on a charge	0	0	11:
. 00	Amount actually collected from patients liable for payment f basis	or services on a charge	0	0	'`
. 00	Amounts that would have been realized from patients liable f	on 0	0	14	
	a charge basis had such payment been made in accordance with				
. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0. 000000	0.000000	1!	
. 00	Total customary charges (see instructions)	134, 403 95, 106	0		
. 00		customary charges over reasonable cost (complete only if line 16 exceeds			
00	line 4) (see instructions)			0	1
. 00	Excess of reasonable cost over customary charges (complete o 16) (see instructions)	only if the 4 exceeds if	ne 0	0	18
. 00	Interns and Residents (see instructions)		0	0	10
. 00	Cost of physicians' services in a teaching hospital (see ins	structions)	0	0	
. 00	Cost of covered services (enter the lesser of line 4 or line	e 16)	39, 297	0	2
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only b	e completed for PPS prov	i ders.		
. 00	Other than outlier payments		0	0	
. 00	Outlier payments		0	0	1 -
. 00	Program capital payments		0		2
. 00	Capital exception payments (see instructions) Routine and Ancillary service other pass through costs		0	0	2
. 00	Subtotal (sum of lines 22 through 26)		0	0	
. 00	Customary charges (title V or XIX PPS covered services only)		0	0	
. 00	Titles V or XIX (sum of lines 21 and 27)		39, 297	0	20
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
. 00	Excess of reasonable cost (from line 18)		0	0	
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and	6)	39, 297	0	
	Deductibles		0	0	
. 00 . 00	Coinsurance Allowable bad debts (see instructions)		0	0	
. 00	Utilization review	0	0	3!	
. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 a	39, 297	0		
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0		
. 00	Subtotal (line 36 ± line 37)	39, 297	0		
	Direct graduate medical education payments (from Wkst. E-4)		0		30
. 00	Total amount payable to the provider (sum of lines 38 and 39	2)	39, 297	0	
. 00	Interim payments		50, 582	0	
. 00	Balance due provider/program (line 40 minus line 41)	anco with CMS Dub 15 0	-11, 285	0	
. 00	Protested amounts (nonallowable cost report items) in accord chapter 1, §115.2	iance with two Pub 15-2,	0	0	43

MEDICAL EDUCATION COSTS Free Original Free Original Data The Present of the Presen		Financial Systems GOOD SAMARITAN H				u of Form CMS-2			
To To 12/31/2023 DetorTime Programs Ti Ha XVIII Hospital PPS Ti Ha XVIII Hospital PPS COMPUTATION OF TOTAL DIRCT CMF ANDIMI 1.00 1.00 1.00 Unweighted resident FIE count for allopathic and osteopathic programs for cost reporting periods 0.00 1.01 FIE cap adjustment under \$313 of the CAX 2021 (see instructions) 0.00			Provider C	CN: 15-0042	Period: From 01/01/2023	Worksheet E-4			
Title XVIII Hospital PPS 0 Unweighted Fieldorf TRECOUNT for allopath C and osteopath C programs for cost reporting periods ording on or borors December 31. 1996. 1.00 1.00 0.00 Unweighted Fieldorf Fieldorf C aut for allopath C and osteopath C programs for cost reporting periods ording on or borors December 31. 1996. 0.00 1.00 0.01 Direcign adjustment under 5131 of the CAX 2021 (see instructions) 0.00 2.26 0.02 Rural Track program Fit C call ill and vindore factor factor with 42 CFR 5413.79 (m). (see instructions for cost reporting periods stradiling 7/1/2011) 0.00 3.00 2.03 Direct GBC cap reduction amount under AAX 5503 in cural track FIE Limitation(S) for rural track dwold capter 10, access or decrease) to the hospital's rural track FIE Limitation(S) for rural track dwold capter 10, access or decrease) to the hospital's rural track FIE Limitation (S) cost reporting periods stradiling 7/1/2011) 0.00 4.00 0.02 Advise field field on all creat GRE FIE cap slots (see instructions for cost reporting periods stradiling 7/1/2011) 0.00 4.00 1.04 Advise field field field on all creat GRE FIE cap slots under 512 of the CAA 2021 (see instructions) 0.00 4.00 2.04 Advise field field field on all opathic and osteopathic programs for the current year instructions) 0.00 0.00	WEDICA	L EDUCATION COSTS				Date/Time Pre			
COMPUTATION OF TOTAL DIFFCT CMF AMOUNT 1.00 1.00 Unweighted resident FTE count for all quathic and ostoopathic programs for cost reporting periods 0.00 1.00 1.01 Unweighted resident FTE count for all quathic and ostoopathic programs for cost reporting periods 0.00 1.00 1.01 FTE cap adjustment under \$313 of the CAA 2021 (see instructions) 0.00 2.00 2.26 Raral track program FTE cap limitation adjustment after the cap-building window closed under \$127 of the CAA 2013 (see instructions) 0.00 3.00 3.00 Anount of reduction to Direct QME Cap under section 422 of MA 0.00 3.00 3.01 Adjustment (furcesee or decrease) to the hospital's rural track for long QME FATI Status agreement (status for instructions) 0.00 4.00 4.00 Adjustment (furcesee or decrease) to the hospital's rural track for cost reporting periods 0.00 4.00 4.01 Straddling 7/1/2011 Straddling 7/1/2011 0.00 4.00 4.00 4.02 FR stratter for short for all quathic and osteopathic programs due to a Medicare 0.00 4.00 4.01 Straddling 7/1/2011 Straddling 7/1/2011 0.00 0.00 4.00			Title	XVIII	Hospi tal		<u>/ pm</u>		
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multiplyline 8 times the result of line 5 divided by the amount on line 6. For cost reporting periods beginning on or after October 1, 2022, or of Kwrksheet S-2, Part I, line 68, is "Y", see instructions.0.0010.0010.01Weighted dental and podiatric resident FTE count for the current year Unweighted fet Count0.0010.0010.01Total weighted FTE count0.000.0011.0012.00Total weighted resident FTE count for the prior cost reporting year (see using the for resident FTE count for the penultimate cost reporting year (see instructions)0.000.0013.0013.00Total weighted resident FTE count for the penultimate cost reporting year (see instructions)0.000.0014.0014.00Rolling average FTE count (sum of lines 11 through 13 divided by 3).0.000.0014.0015.00Adjustment for residents displaced by program or hospital closure0.000.0016.0016.01Unweighted adjustment for residents displaced by program or hospital closure0.000.0016.0117.00Addi sted rolling average FTE count closure24.8718.2217.0018.01Per resident amount closure126,519.57126,519.5718.0019.00Approved amount for resident costs3.146,5422.305.1875.451,72920.00Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(C) (4)0.0020.0020.00Additional unweighted resident count over cap (see instructions)0.0021.0021.00Dire	0 00		iso			0.00	0.00		
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12.00Total weighted resident FTE count for the prior cost reporting year (see instructions)0.0012.0013.00Total weighted resident FTE count for the penultimate cost reporting year (see instructions)0.000.0014.00Rolling average FTE count (sum of lines 11 through 13 divided by 3).0.000.0014.0015.01Unweighted adjustment for residents in initial years of new programs24.8718.2215.0016.00Adjustment for residents displaced by program or hospital closure0.000.0016.0016.01Unweighted adjustment for residents displaced by program or hospital0.000.0016.0017.00Adjustent for resident singlaced by program or hospital0.000.0018.0117.00Adjustent for resident amount126,519.57126,519.5718.0018.01Per resident amount13.10126,519.57126,519.5718.0019.00Approved amount for resident costs3.146,5422.305.1875.451,72920.00Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 420.0020.0021.00Direct GME FTE unweighted resident count over cap (see instructions)0.0021.0023.00Enter the locality adjustment national average per resident amount (see instructions)0.0023.0024.00Multiply line 22 time line 230.400.0023.0024.00Multiply line 22 time line 230.24.00			rrent year	0					
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22. 00Allowable additional direct GME FTE Resident Count (see instructions)0. 0022. 0023. 00Enter the locality adjustment national average per resident amount (see instructions)0. 0023. 0024. 00Multiply line 22 time line 23024. 00									
23.00Enter the locality adjustment national average per resident amount (see instructions)0.0023.0024.00Multiply line 22 time line 23024.00									
24.00 Multiply line 22 time line 23 0 24.00				instructions					
							1		
						5, 451, 729			

Health Financial Systems GOOD SAMARITA	N HOSPI TAL		In Lie	eu of Form CMS-2	2552-10		
DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provider C	CN: 15-0042	Period:	Worksheet E-4			
MEDICAL EDUCATION COSTS			From 01/01/2023 To 12/31/2023		nared		
				4/11/2024 3:1			
	Title	e XVIII	Hospi tal	PPS			
		I npati ent	Managed Care	Total			
		Part A	2.00	2.00			
COMPUTATION OF PROGRAM PATIENT LOAD		1.00	2.00	3.00			
26.00 Inpatient Days (see instructions) (Title XIX - see S-2 Part	- IX line	11, 5	95 4, 607	,	26.00		
3. 02, column 2)		, .	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		20100		
27.00 Total Inpatient Days (see instructions)		25, 9	73 25, 973		27.00		
28.00 Ratio of inpatient days to total inpatient days		0. 4464	25 0. 177377		28.00		
29.00 Program direct GME amount		2, 433, 7	88 967, 011	3, 400, 799	29.00		
29.01 Percent reduction for MA DGME			3. 27		29.01		
30.00 Reduction for direct GME payments for Medicare Advantage			31, 621				
31.00 Net Program direct GME amount				3, 369, 178	31.00		
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TI				1.00			
EDUCATION COSTS FOR ESRD COMPOSITE RATE - TI	ILE AVIII UNL	I (NURSING PI	KUGKAWI AND PARAWI	EDICAL			
32.00 Renal dialysis direct medical education costs (from Wkst. E	Pt I sum	of col 20 a	nd 23 lines 74	0	32.00		
and 94)	, ,	01 0011 20 4	la 20, 11100 / 1		02.00		
33.00 Renal dialysis and home dialysis total charges (Wkst. C, Pt	20 Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)						
34.00 Ratio of direct medical education costs to total charges (I	ine 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 (li		35)		0	36.00		
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVI	II ONLY						
Part A Reasonable Cost							
37.00 Reasonable cost (see instructions)	``			30, 920, 897			
38.00 Organ acquisition and HSCT acquisition costs (see instructi				0			
39.00 Cost of physicians' services in a teaching hospital (see in 40.00 Primary payer payments (see instructions)	istructions)			0			
40.00 Primary payer payments (see fistractions) 41.00 Total Part A reasonable cost (sum of lines 37 through 39 mi	nuc Line (0)			30, 920, 897			
Part B Reasonable Cost	nus i ne 40)			30, 920, 897	41.00		
42.00 Reasonable cost (see instructions)				31, 552, 795	42 00		
43.00 Primary payer payments (see instructions)				7,071			
44.00 Total Part B reasonable cost (line 42 minus line 43)				31, 545, 724			
45.00 Total reasonable cost (sum of lines 41 and 44)				62, 466, 621			
46.00 Ratio of Part A reasonable cost to total reasonable cost (I	ine 41 ÷ line	45)		0. 494999			
47.00 Ratio of Part B reasonable cost to total reasonable cost (I				0. 505001			
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND							
48.00 Total program GME payment (line 31)				3, 369, 178	48.00		
49.00 Part A Medicare GME payment (line 46 x 48) (title XVIII onl	y) (see instr	uctions)		1, 667, 740			
50.00 Part B Medicare GME payment (line 47 x 48) (title XVIII onl	y) (see instr	uctions)		1, 701, 438	50 00		

Health Financial Systems G	u of Form CMS-2	552-10		
OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT	Worksheet E-5			
	Date/Time Prepared: 4/11/2024 3:17 pm			
	Title XVIII		PPS	
			1.00	
TO BE COMPLETED BY CONTRACTOR				
1.00 Operating outlier amount from Wkst. E, Pt. A, I	ine 2, or sum of 2.03 plus 2.04 (see	instructions)	0	1.00
2.00 Capital outlier from Wkst. L, Pt. I, line 2			0	2.00
3.00 Operating outlier reconciliation adjustment amo	unt (see instructions)		0	3.00
4.00 Capital outlier reconciliation adjustment amoun	t (see instructions)		0	4.00
5.00 The rate used to calculate the time value of mo	ney (see instructions)		0.00	5.00
6.00 Time value of money for operating expenses (see		0	6.00	
7.00 Time value of money for capital related expense		0	7.00	

	E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column	Provider C		eriod: rom 01/01/2023 p 12/31/2023	Worksheet G Date/Time Pre 4/11/2024 3:1	
		General Fund	Speci fi c Purpose Fund	Endowment Fund	Plant Fund	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
00	Cash on hand in banks	9, 836, 656	0	0	0	1 1.0
00	Temporary investments	0	0	0	0	2.0
00	Notes receivable	0	0	0	0	3.0
00	Accounts receivable	85, 557, 266	0	0	0	4.0
00 00	Other receivable Allowances for uncollectible notes and accounts receivable	10, 862, 706 -53, 765, 157	0	0	0	5.0
00	Inventory	2, 862, 111	0	0	0	7.0
00	Prepaid expenses	6, 780, 863	0	0	0	8.0
00	Other current assets	0	0	0	0	9. (
	Due from other funds	0	0	0	0	10. (
	Total current assets (sum of lines 1-10)	62, 134, 445	0	0	0	11. (
	FI XED ASSETS Land	6, 581, 448	0	0	0	12.0
	Land improvements	10, 854, 720	0	0	0	13. (
	Accumulated depreciation	-8, 008, 840	0	0	0	
	Buildings	177, 946, 557	0	0	0	15.
	Accumulated depreciation	-96, 690, 066	0	0	0	16.
	Leasehold improvements	479, 187	0	0	0	17.
	Accumulated depreciation	-388, 297	0	0	0	18.
	Fixed equipment	118, 340, 313		0	0	19.
	Accumulated depreciation Automobiles and trucks	-74, 563, 196	0	0	0	20. 21.
	Accumulated depreciation	0	0	0	0	21.
	Major movable equipment	111, 449, 542	0	0	0	23.
	Accumulated depreciation	-97, 287, 930	0	0	0	24.
. 00	Minor equipment depreciable	0	0	0	0	25.
	Accumulated depreciation	0	0	0	0	26.
	HIT designated Assets	0	0	0	0	27.
	Accumulated depreciation	0	0	0	0	28. 29.
	Minor equipment-nondepreciable Total fixed assets (sum of lines 12-29)	148, 713, 438		0	0	30.
	OTHER ASSETS	110/ 10/ 100				
. 00	Investments	81, 967, 631	0	0	0	31.
	Deposits on leases	0	0	0	0	32.
	Due from owners/officers	0	0	0	0	33.
	Other assets	6, 969, 298		0	0	34.
	Total other assets (sum of lines 31-34) Total assets (sum of lines 11, 30, and 35)	88, 936, 929 299, 784, 812	0	0	0	35. 36.
	CURRENT LIABILITIES	277, 704, 012	0	0	0	1 30.
	Accounts payable	1, 730, 130	0	0	0	37.
. 00	Sal ari es, wages, and fees payable	11, 939, 837	0	0	0	38.
	Payroll taxes payable	-35, 742	0	0	0	
	Notes and Loans payable (short term)	5, 801, 744	0	0	0	
	Deferred income	72, 147	0	0	0	41.
	Accelerated payments Due to other funds	0	0	0	0	
	Other current liabilities	449, 752	-	0	0	
	Total current liabilities (sum of lines 37 thru 44)	19, 957, 868		0	0	
	LONG TERM LIABILITIES					
	Mortgage payable	0	0	0	0	46.
	Notes payable	101, 384, 447	0	0	0	
	Unsecured Loans	0	0	0	0	
	Other long term liabilities Total long term liabilities (sum of lines 46 thru 49)	-250, 957	0	0	0	49. 50.
	Total liabilities (sum of lines 45 and 50)	101, 133, 490 121, 091, 358		0	0	50.
00	CAPITAL ACCOUNTS	121,071,330	0	0	0	1 51
. 00	General fund balance	178, 693, 454				52.
. 00	Specific purpose fund		0			53.
	Donor created - endowment fund balance - restricted			0		54
	Donor created - endowment fund balance - unrestricted			0		55
	Governing body created - endowment fund balance			0	-	56
	Plant fund balance - invested in plant				0	57
. 00	Plant fund balance - reserve for plant improvement,				0	58
~ ~	replacement, and expansion Total fund balances (sum of lines 52 thru 58)	178, 693, 454	0	0	0	59
. 00						1 07

Heal th	Financial Systems	GOOD SAMARI TA	N HOSPI TAL		In Lie	u of Form CMS-	2552-10
STATE	IENT OF CHANGES IN FUND BALANCES		Provider CC	CN: 15-0042	Period: From 01/01/2023 To 12/31/2023	Worksheet G- Date/Time Pr 4/11/2024 3:	epared:
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance	2, 254, 597 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2, 254, 597 178, 693, 454 2, 254, 597 178, 693, 454				5.00 6.00 7.00 8.00 9.00 10.00 11.00 0 13.00 14.00 15.00 16.00
	sheet (line 11 minus line 18)	Endowment Fund	PI ant	Fund	_		
1 00	Fund hal anneas at having an an anniad	6.00	7.00	8.00	0		1.00
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions	0	0 0 0 0 0		0		1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0 0 0	0 0 0 0 0 0 0		0 0 0 0		10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00

AIEMENI OF PAIIENI	REVENUES AND OPERATING EXPENSES	Provider C	CN: 15-0042	Period: From 01/01/2023 To 12/31/2023	Worksheet G-2 Parts I & II Date/Time Pre 4/11/2024 3:1	pared:
Cost Cen	ter Description		I npati ent	Outpati ent	Total	
			1.00	2.00	3.00	
PART I - PATIE						-
	ent Routine Services			1		
00 Hospital			29, 234, 6		29, 234, 656	
00 SUBPROVIDER -			8, 421, 6		8, 421, 632	
00 SUBPROVIDER -	I RF		7, 986, 9	55	7, 986, 955	
00 SUBPROVI DER	-					4.00
00 Swing bed - SM				0	0	
00 Swing bed - NF				0	0	
DO SKILLED NURSIN						7.00
DO NURSING FACILI						8.00
DO OTHER LONG TEP			45 (40.0	40	45 (40.040	9.0
	inpatient care services (sum of lines 1-9)		45, 643, 2	43	45, 643, 243	10.0
	Type Inpatient Hospital Services		10 074 7	(0	10 074 7/0	111 0
. 00 I NTENSI VE CARE			13, 374, 7	68	13, 374, 768	
. 00 CORONARY CARE						12.0
. 00 BURN I NTENSI VE						13.0
. 00 SURGI CAL I NTEN						14.0
00 OTHER SPECIAL	, ,	m of Linco	10 074 7	(0	12 274 740	15.0
	e care type inpatient hospital services (su	m or tines	13, 374, 7	68	13, 374, 768	16.0
11-15) .00 Total inpatier	t routine care services (sum of lines 10 an	d 14)	59, 018, 0	11	59, 018, 011	17.0
.00 Ancillary serv		u 10)				
.00 Andriary serv .00 Outpatient ser			117,036,8		513, 979, 244	
. 00 FAMILY PRACTIC			12, 241, 3		66, 706, 282 3, 407, 975	
			60, 8	07 3, 347, 168 0 0		
. OO HOME HEALTH AC	IFIED HEALTH CENTER			0 0	0	21.0
. 00 AMBULANCE SERV				0	0	23.0
. 00 AMBULANCE SERV	TGES					23.0
	GICAL CENTER (D.P.)					24.0
. 00 HOSPICE	GICKE CENTER (D.T.)			0 1, 644, 072	1, 644, 072	
. 00 DME				0 455, 308	455, 308	
.01 PHYSICIAN OFFI	СF		1, 834, 6			
. 02 PROFESSIONAL F			4, 114, 0		23, 047, 862	
. 03 DI ETARY REVENU			1, 111, 0	0 790, 746	790, 746	
	revenues (sum of lines 17-27)(transfer colu	mn 3 to Wkst	194, 305, 7			
G-3, line 1)			.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	020,000,00	, 20, 010, 100	20.0
PART II - OPER	ATING EXPENSES			I		
.00 Operating expe	nses (per Wkst. A, column 3, line 200)			273, 083, 424		29.0
. 00 ADD (SPECIFY)				0		30.0
. 00				0		31.0
. 00				0		32.0
. 00				0		33.0
. 00				0		34.0
. 00				0		35.0
.00 Total addition	s (sum of lines 30-35)			0		36.0
. 00 DEDUCT (SPECIF				0		37.0
. 00				0		38.0
. 00				0		39.0
. 00				0		40.0
. 00				0		41.0
	ns (sum of lines 37-41)			0		42.0
	g expenses (sum of lines 29 and 36 minus li	ne 42)(transfer		273, 083, 424		43.00
to Wkst. G-3,	0 1 1					

STATEMENT OF REVENUES AND EXPENSES Drew der CON: 15-0042 Provider CON: 15-0042 Provider CON: 15-0042 Provider CON: 15-0042 Provider CON: 15-0042 Worksheet G-3 1.00 Total patient revenues (from Wkst. G-2, Part I, column 3, line 28) 1.00	Heal th	Financial Systems	GOOD SAMARITAN H	IOSPI TAI	Inlie	u of Form CMS-2	2552-10
From 01/01/2023 To 12/31/2023 Date/Time Prepared: 4/11/2024 3: 17 pm 1.00 Total patient revenues (from Wkst. G-2, Part I, column 3, line 28) 1.00 2.00 Less contractual all owances and discounts on patients' accounts 475, 716, 411 2, 00 3.00 Net patient revenues (line 1 minus line 2) 244, 929, 657 3.00 4.00 Less total operating expenses (from Wkst. G-2, Part II, line 43) 273, 083, 424 4.00 5.00 Net income from investments 0 6.00 0.01 1.00 6.00 Contributions, donations, bequests, etc 0 7.00 0 0 0.00 Purchase discounts 0 1.00 1.00 1.00 0.00 Revenue from telephone and other miscellaneous communication services 0 7.00 0.01 Revenue from telephone and other miscellaneous communication services 0 1.00 0.01 Revenue from meals sold to employees and guests 0 1.00 0.02 Pervnue from meals sold to employees and guests 0 14.00 0.00 Revenue from meals sold to employees and abstracts 0 16.00							
Image: 1.00 Total patient revenues (from Wkst. G-2, Part I, column 3, line 28) 1.00 1.00 Less contractual allowances and discounts on patients' accounts 475,716,411 2.00 2.00 Less contractual allowances and discounts on patients' accounts 475,716,411 2.00 3.00 Net patient revenues (line minus line 2) 244,929,057 3.00 4.00 Less total operating expenses (from Wkst. G-2, Part II, line 43) 273,083,424 4.00 5.00 Net income from investments 0 6.00 Contributions, donations, bequests, etc 0 7.00 8.00 Revenue from telephone and other miscellaneous communication services 0 9.00 9.00 Revenue from television and radio service 0 10.00 10.00 Purchase discounts 0 10.00 11.00 Revenue from leavisto 0 11.00 12.00 Revenue from meals sold to employees and guests 0 14.00 13.00 Revenue from sele of medical and surgical supplies to other than patients 0 16.00 13.00 Revenue from sele of drugs to other than patients 0					From 01/01/2023		
Image: 1.00 Image: 1.00 1.00 Total patient revenues (from Wkst. G-2, Part I, column 3, line 28) 720, 645, 648 1.00 2.00 Less contractual allowances and discounts on patients' accounts 475, 716, 411 2.00 2.00 Less total operating expenses (from Wkst. G-2, Part II, line 43) 244, 929, 057 3.00 0.00 Less total operating expenses (from Wkst. G-2, Part II, line 43) 273, 083, 924 4.00 0.01 Less total operating expenses (from Wkst. G-2, Part II, line 43) 273, 083, 924 4.00 0.01 Income from investments 0 6.00 0 0.01 Income from investments 0 6.00 0 1.00 0.00 Puenchase discounts 0 1.00 1.00 1.00 0.00 Puenchase discounts 0 1.00 1.00 1.00 0.00 Revenue from lelephone and other miscell aneous communication services 0 1.00 0.00 Revenues from lelephone and other miscell aneous communication services 0 1.00 0.00 Revenues from aneals sol di to employees and guests 0					To 12/31/2023	Date/Time Pre	
1.00 Total patient revenues (from Wist. G-2, Part I, column 3, line 28) 720, 645, 648 1.00 2.00 Less contractual allowances and discounts on patients' accounts 475, 716, 411 2.00 3.00 Net patient revenues (line 1 minus line 2) 244, 929, 057 3.00 4.00 Less total operating expenses (from Wkst. G-2, Part II, line 43) 273, 083, 424 4.00 0.00 Income from service to patients (line 3 minus line 4) -28, 154, 367 5.00 0.01 Income from investments 0 6.00 0 6.00 0.00 Revenue from telephone and other miscel laneous communication services 0 8.00 9.00 0.00 Revenue from telephone and other miscel laneous communication services 0 9.00 11.00 0.00 Purchase discounts 0 12.00 13.00 13.00 10.00 13.00 13.00 0.01 Revenue from meals sold to employees and guests 0 13.00 14.00 0.00 Revenue from sel of medical and surgical supplies to other than patients 0 15.00 0.00 Revenue from sale of fuels						4/11/2024 3:1	/pm
1.00 Total patient revenues (from Wist. G-2, Part I, column 3, line 28) 720, 645, 648 1.00 2.00 Less contractual allowances and discounts on patients' accounts 475, 716, 411 2.00 3.00 Net patient revenues (line 1 minus line 2) 244, 929, 057 3.00 4.00 Less total operating expenses (from Wkst. G-2, Part II, line 43) 273, 083, 424 4.00 0.00 Income from service to patients (line 3 minus line 4) -28, 154, 367 5.00 0.01 Income from investments 0 6.00 0 6.00 0.00 Revenue from telephone and other miscel laneous communication services 0 8.00 9.00 0.00 Revenue from telephone and other miscel laneous communication services 0 9.00 11.00 0.00 Purchase discounts 0 12.00 13.00 13.00 10.00 13.00 13.00 0.01 Revenue from meals sold to employees and guests 0 13.00 14.00 0.00 Revenue from sel of medical and surgical supplies to other than patients 0 15.00 0.00 Revenue from sale of fuels						1 00	
2.00 Less contractual allowances and discounts on patients' accounts 475,716,411 2.00 3.00 Net patient revenues (line 1 minus line 2) 244,492,057 3.00 4.00 Less total operating expenses (from Wkst. G-2, Part II, Line 43) -28,154,367 5.00 0.01 Net income from service to patients (line 3 minus line 4) -28,154,367 5.00 0.01 Contributions, donations, bequests, etc 0 6.00 6.00 0.01 Income from investments 0 7.00 8.00 Revenues from telephone and other miscellaneous communication services 0 9.00 0.00 Purchase di scounts 0 10.00 10.00 10.00 Parking lot receipts 0 11.00 12.00 Parking lot receipts 0 13.00 13.00 Revenue from rental of living quarters 0 15.00 16.00 Revenue from sale of drugs to other than patients 0 16.00 17.00 Revenue from sale of medical and surgical supplies to other than patients 0 16.00 10.00 Revenue from sale of medica	1 00	Total patient revenues (from Wkst G-2 Part I	column 3 lin	a 28)			1 00
3.00 Net patient revenues (line 1 minus line 2) 244,929,057 3.00 4.00 Less total operating expenses (from Wkst. 6-2, Part II, Line 43) -28,154,367 5.00 0THER INCOME -28,154,367 5.00 0.00 Income from service to patients (line 3 minus line 4) -28,154,367 5.00 0.01 Income from investments 0 6.00 0.00 Revenue from telephone and other miscellaneous communication services 0 8.00 9.00 Pevenue from telephone and radio service 0 9.00 10.00 Purchase di scounts 0 10.00 11.00 Revenue from television and radio service 0 10.00 10.00 Purchase di scounts 0 11.00 11.00 Revenue from meals sold to employees and guests 0 12.00 12.00 Revenue from sale of medical and surgical supplies to other than patients 0 14.00 13.00 Revenue from sale of medical records and abstracts 0 15.00 14.00 Revenue from sale of medical records and canteen 0 21.00							
4.00 Less total operating expenses (from Wkst, 6-2, Part II, line 43) 273,083,424 4.00 5.00 Net income from service to patients (line 3 minus line 4) -28,154,367 5.00 6.00 Contributions, donations, bequests, etc 0 6.00 6.00 0.01 Income from investments 0 6.00 7.00 8.00 Revenues from telephone and other miscellaneous communication services 0 9.00 9.00 Revenue from television and radio service 0 9.00 10.00 Purchase discounts 10.00 11.00 12.00 Parking lot receipts 0 12.00 13.00 Revenue from rental of living quarters 0 13.00 14.00 Revenue from sale of medical and surgical supplies to other than patients 0 15.00 15.00 Revenue from sale of medical records and abstracts 0 18.00 10.00 Revenue from sale of medical records and abstracts 0 19.00 10.00 Revenue from sale of medical records and abstracts 0 21.00 10.00 Revenue from sale of medi							
5.00Net income from service to patients (line 3 minus line 4)-28, 154, 3675.00OTHER INCOMEOTHER INCOME06.000Income from investments07.008.00Revenue from telephone and other miscellaneous communication services07.009.00Revenues from telephone and other miscellaneous communication services09.0010.00Purchase discounts010.0011.00Rebates and refunds of expenses011.0012.00Parking lot receipts012.0013.00Revenue from meals sold to employees and guests013.0014.00Revenue from sale of medical and surgical supplies to other than patients017.0018.00Revenue from sale of medical records and abstracts018.0019.00Tuition (fees, sale of textbooks, uniforms, etc.)019.0019.0010.00Retrail appropriations4.420.48923.0022.00Governmental appropriations9.20,0921.0024.00THER DESTINGUE & DISTRIBUTIONS2.100,00024.0424.00THER NOMPERATING INCOME4.1,59724.0024.00THER NOMPERATING INCOME4.1,59724.0024.00THER NOMPERATING INCOME4.1,59724.0025.00TOTHER NOMPERATING INCOME4.1,59724.0026.00TOTHER DESTINENTS2,100,00024.0427.00TOTHER NOMPERATING INCOME41.197824.0526.00TOTHER REVENUE41			Part II line	43)			
OTHER INCOME06.00Contributions, donations, bequests, etc07.00Income from investments08.00Revenues from television and radio service09.00Revenue form television and radio service09.00Revenue from television and radio service010.00Purchase discounts011.00Rebates and refunds of expenses012.00Parking lot receipts012.00Revenue from laundry and linen service012.00Revenue from meals solid to employees and guests013.00Revenue from rental of living quarters016.00Revenue from sale of medical and surgical supplies to other than patients010.00Revenue from sale of drugs to other than patients010.00Revenue from sale of drugs to other than patients010.00Revenue from sale of fextbooks, uniforms, etc.)010.00Revenue from gifts, flowers, coffee shops, and canteen020.00Revental appropriations4,420,48921.00Governmental appropriations4,420,48922.00Governmental appropriations2,068,78524.00UHER NONOPERATING INCOME4,000,00224.01INTER DEFARTING INCOME4,000,00224.02UHER NONOPERATING INCOME4,1,79724.03OTHER NONOPERATING INCOME4,1,79724.04UNREALIZED GAIN/LOSS ON INVESTMENTS2,000,00025.00Total other expenses (sum of line 27 and subscripts) <td></td> <td></td> <td></td> <td>10)</td> <td></td> <td></td> <td></td>				10)			
6 00 Contributions, donations, bequests, etc 0 6.00 7.00 Income from investments 0 7.00 8.00 Revenues from telephone and other miscel laneous communication services 0 8.00 9.00 Revenues from telephone and radio service 0 9.00 10.00 Purchase discounts 0 10.00 11.00 Rebates and refunds of expenses 0 11.00 12.00 Parking lot receipts 0 12.00 13.00 Revenue from laundry and linen service 0 13.00 14.00 Revenue from sale of medical radius urgical supplies to other than patients 0 14.00 15.00 Revenue from sale of medical recrofts and abstracts 0 18.00 10.00 Revenue from sale of fudgs to other than patients 0 18.00 10.00 Revenue from sale of fudgs to abstracts 0 19.00 10.00 Revenue from ing ifts, flowers, coffee shops, and canteen 0 22.00 10.00 Rental of hospital space 0 22.00 20.00 Governmental appropriations 4.420,489 23.00 21	0.00					20/101/00/	0.00
7.00 Income from investments 0 7.00 8.00 Revenues from telephone and other miscellaneous communication services 0 8.00 9.00 Revenues from television and radio service 0 9.00 10.00 Purchase discounts 0 10.00 11.00 Rebates and refunds of expenses 0 10.00 12.00 Parking lot receipts 0 12.00 13.00 Revenue from meals sold to employees and guests 0 13.00 14.00 Revenue from sale of medical and surgical supplies to other than patients 0 15.00 15.00 Revenue from sale of medical records and abstracts 0 17.00 10.00 Tuition (fees, sale of textbooks, uniforms, etc.) 0 19.00 20.00 Revenue from gifts, flowers, coffee shops, and canteen 0 20.00 21.00 Rental of vending machines 0 12.00 22.00 Rental of nospital space 0 21.00 23.00 Governmental appropriations 4.420,489 23.00 24.00 OTHER NONDERATING INCOME 9.209,941 4.011 24.00	6,00					0	6.00
9.00 Revenue from television and radio service 0 9.00 10.00 Purchase di scounts 0 10.00 11.00 Rebates and refunds of expenses 0 11.00 12.00 Parking lot receipts 0 12.00 13.00 Revenue from meals sold to employees and guests 0 13.00 14.00 Revenue from meals sold to employees and guests 0 14.00 15.00 Revenue from sale of medical and surgical supplies to other than patients 0 16.00 17.00 Revenue from sale of medical records and abstracts 0 17.00 18.00 Revenue from gifts, flowers, coffee shops, and canteen 0 21.00 22.00 Rental of vending machines 0 18.00 22.00 Rental of hospital space 0 21.00 23.00 Governmental appropriations 4,420,489 23.00 24.01 UTRERST INCOME 6,421,597 24.00 24.02 OTHER INCOME 2,058,785 24.02 24.03 OTHER NONDERATING INCOME 2,058,785 24.02 24.04 OTHER INCOME 2,058,785						0	
10.00 Purchase discounts 0 10.00 11.00 Rebates and refunds of expenses 0 11.00 12.00 Parking I of receipts 0 12.00 13.00 Revenue from laundry and Linen service 0 13.00 14.00 Revenue from rental of Living quarters 0 14.00 15.00 Revenue from sale of medical and surgical supplies to other than patients 0 16.00 16.00 Revenue from sale of medical excords and abstracts 0 17.00 18.00 Revenue from sale of textbooks, uniforms, etc.) 0 19.00 10.00 Revalue from gifts, flowers, coffee shops, and canteen 0 20.00 10.00 Revalue from gifts, flowers, coffee shops, and canteen 0 21.00 10.00 Governmental appropriations 4,420,489 23.00 22.00 Rental of hospital space 0 21.00 24.00 OTHER OPERATING INCOME 9,290,941 24.01 24.02 OTHER NOMPERATING INCOME 2,058,785 24.02 24.03 OTHER NONPERATING INCOME 2,058,785 24.02 24.04 UNREALI	8.00	Revenues from telephone and other miscellaneou	us communication	servi ces		0	8.00
11.00 Rebates and refunds of expenses 0 11.00 12.00 Parking lot receipts 0 12.00 13.00 Revenue from laundry and linen service 0 13.00 14.00 Revenue from meals sold to employees and guests 0 14.00 15.00 Revenue from sale of medical and surgical supplies to other than patients 0 16.00 16.00 Revenue from sale of medical records and abstracts 0 17.00 18.00 Revenue from gifts, flowers, coffee shops, and canteen 0 19.00 10.00 Rental of vending machines 0 19.00 20.00 Rental of vending machines 0 20.00 21.00 Rental of hospital space 0 22.00 22.00 Rental of hospital space 0 22.00 23.00 Governmental appropriations 9, 29.09 (1 24.01 2.058, 785 24.00 24.01 INTEREST ING INCOME 9, 290, 941 (24.01 2.058, 785 24.02 24.02 OTHER NONDERATING INCOME 2, 058, 785 24.02 24.03 OTHER NONDERATING INCOME 2, 058, 785 24.02	9.00	Revenue from television and radio service				0	9.00
12.00 Parking lot receipts 0 12.00 13.00 Revenue from laundry and linen service 0 13.00 14.00 Revenue from meals sold to employees and guests 0 13.00 15.00 Revenue from rental of living quarters 0 14.00 16.00 Revenue from sale of medical and surgical supplies to other than patients 0 15.00 16.00 Revenue from sale of medical records and abstracts 0 16.00 17.00 Revenue from gifts, flowers, coffee shops, and canteen 0 18.00 19.00 Revenue from gifts, flowers, coffee shops, and canteen 0 21.00 22.00 Rental of hospital space 0 21.00 23.00 Governmental appropriations 4,420,489 23.00 24.00 OTHER OPERATING INCOME 9,290,941 24.01 24.01 INTEREST INCOME & DISTRIBUTIONS 9,290,941 24.01 24.02 OTHER NORDERATING INCOME 2,000,000 24.02 24.03 OTHER NORDERATING INCOME 2,100,000 24.03 24.04 UNREALIZED GAIN/LOSS ON INVESTMENTS 2,100,000 24.04	10.00	Purchase di scounts				0	10.00
13.00 Revenue from laundry and Linen service 0 13.00 14.00 Revenue from meals sold to employees and guests 0 14.00 15.00 Revenue from meals sold to employees and guests 0 14.00 15.00 Revenue from rental of living quarters 0 14.00 16.00 Revenue from sale of medical and surgical supplies to other than patients 0 16.00 17.00 Revenue from sale of drugs to other than patients 0 17.00 18.00 Revenue from gifts, flowers, coffee shops, and canteen 0 18.00 12.00 Rental of vending machines 0 21.00 22.00 Rental of hospital space 0 22.00 23.00 Governmental appropriations 4,420,489 23.00 24.00 OTHER NONOPERATING INCOME 9,290,941 24.01 24.01 INTEREST INCOME & DI STRIBUTIONS 2,100,000 24.02 24.03 OTHER NONOPERATING INCOME 1,106,405 24.02 24.04 UNREALIZED GAI N/LOSS ON INVESTMENTS 2,100,000 24.04 25.00 Total other income (sum of lines 6-24) 26,569,621 25.00 </td <td>11.00</td> <td>Rebates and refunds of expenses</td> <td></td> <td></td> <td></td> <td>0</td> <td>11.00</td>	11.00	Rebates and refunds of expenses				0	11.00
14.00 Revenue from meals sold to employees and guests 0 14.00 15.00 Revenue from rental of living quarters 0 15.00 16.00 Revenue from sale of medical and surgical supplies to other than patients 0 16.00 17.00 Revenue from sale of medical records and abstracts 0 16.00 19.00 Tuition (fees, sale of textbooks, uniforms, etc.) 0 19.00 20.00 Revenue from gifts, flowers, coffee shops, and canteen 0 20.00 21.00 Rental of vending machines 0 21.00 23.00 Governmental appropriations 4,420,489 23.00 24.00 OTHER OPERATING INCOME 9,290,941 24.01 24.02 OTHER INCOME 9,290,941 24.01 24.03 OTHER NONOPERATING INCOME 1,106,405 24.02 24.04 UINREALIZED GAIN/LOSS ON INVESTMENTS 2,100,000 24.04 24.05 OTHER REVENUE 1,29,426 40.5 25.00 Total other income (sum of lines 6-24) 26,569,621 25.00 26.00 Total (line 5 plus line 25) -1,584,746 26.00 27.00	12.00	Parking lot receipts				0	12.00
15.00 Revenue from rental of living quarters 0 15.00 16.00 Revenue from sale of medical and surgical supplies to other than patients 0 16.00 17.00 Revenue from sale of drugs to other than patients 0 17.00 18.00 Revenue from sale of medical records and abstracts 0 17.00 19.00 Tuition (fees, sale of textbooks, uniforms, etc.) 0 19.00 20.00 Revenue from gifts, flowers, coffee shops, and canteen 0 20.00 21.00 Rental of hospital space 0 21.00 22.00 Rental of hospital space 0 22.00 23.00 Governmental appropriations 4, 420, 489 23.00 24.00 OTHER OPERATING INCOME 9, 290, 941 24.01 24.02 OTHER NONOPERATING INCOME 2, 058, 785 24.02 24.03 OTHER NONOPERATING INCOME 2, 058, 785 24.02 24.04 UNREALIZED GAIN/LOSS ON INVESTMENTS 2, 100, 000 24.04 24.05 Total other income (sum of lines 6-24) 26, 569, 621 25.00 25.00 Total other income (sum of lines 6-24) 26, 569, 621 25	13.00	Revenue from Laundry and Linen service				0	13.00
16.00 Revenue from sale of medical and surgical supplies to other than patients 0 16.00 17.00 Revenue from sale of drugs to other than patients 0 17.00 18.00 Revenue from sale of medical records and abstracts 0 17.00 19.00 Tuition (fees, sale of medical records and abstracts 0 18.00 19.00 Revenue from gifts, flowers, coffee shops, and canteen 0 20.00 21.00 Rental of vending machines 0 21.00 22.00 Rental of hospital space 0 22.00 24.00 OTHER OPERATING INCOME 0 4,420,489 24.01 INTEREST INCOME & DISTRIBUTIONS 9,290,941 24.01 24.02 OTHER NONOPERATING INCOME 2,058,785 24.02 24.01 UNREALIZED GAIN/LOSS ON INVESTMENTS 2,058,785 24.02 24.02 OTHER REVENUE 2,100,000 24.04 24.03 OTHER REVENUE 1,106,405 24.02 24.50 COVID-19 PHE Funding 1,129,426 24.05 25.00 Total other income (sum of lines 6-24) 26,569,621 25.00 27.00 <t< td=""><td>14.00</td><td>Revenue from meals sold to employees and guest</td><td>ts</td><td></td><td></td><td>0</td><td>14.00</td></t<>	14.00	Revenue from meals sold to employees and guest	ts			0	14.00
17.00 Revenue from sale of drugs to other than patients 0 17.00 18.00 Revenue from sale of medical records and abstracts 0 18.00 19.00 Tuition (fees, sale of textbooks, uniforms, etc.) 0 18.00 20.00 Revenue from gifts, flowers, coffee shops, and canteen 0 20.00 21.00 Rental of vending machines 0 21.00 22.00 Rental of hospital space 0 22.00 24.00 OTHER OPERATING INCOME 4,420,489 23.00 24.00 OTHER OPERATING INCOME 6,421,597 24.00 24.01 INTEREST INCOME & DISTRIBUTIONS 9,290,941 24.01 24.02 OTHER NONOPERATING INCOME 2,058,785 24.02 24.03 OTHER NONOPERATING INCOME 2,100,000 24.03 24.04 UNREALIZED GAIN/LOSS ON INVESTMENTS 2,100,000 24.03 24.05 OTHER REVENUE 41,978 24.05 25.00 Total other income (sum of lines 6-24) 26,569,621 25.00 26.00 Total (line 5 plus line 25) -1,584,746 26.00 27.00 OTHER EXPENSES (SPECIFY	15.00	Revenue from rental of living quarters				0	15.00
18.00 Revenue from sale of medical records and abstracts 0 18.00 19.00 Tuition (fees, sale of textbooks, uniforms, etc.) 0 19.00 20.00 Revenue from gifts, flowers, coffee shops, and canteen 0 20.00 21.00 Rental of vending machines 0 20.00 22.00 Rental of hospital space 0 22.00 33.00 Governmental appropriations 4,420,489 23.00 24.00 OTHER OPERATING INCOME 6,421,597 24.00 24.01 INTEREST INCOME & DISTRIBUTIONS 9,290,941 24.01 24.02 OTHER NONOPERATING INCOME 2,058,785 24.02 24.03 OTHER NONOPERATING INCOME 2,000 24.00 24.05 OTHER NONOPERATING INCOME 2,000,000 24.04 24.05 OTHER NONOPERATING INCOME 2,000,000 24.04 24.05 OTHER NONOPERATING INCOME 2,000 24.03 24.05 OTHER REVENUE 2,100,000 24.04 24.05 OTHER REVENUE 24.05 24.05 25.00 Total other income (sum of lines 6-24) 26,569,621 25	16.00	Revenue from sale of medical and surgical supp	olies to other th	han patients		0	16.00
19.00 Tuition (fees, sale of textbooks, uniforms, etc.) 0 19.00 20.00 Revenue from gifts, flowers, coffee shops, and canteen 0 20.00 21.00 Rental of vending machines 0 21.00 22.00 Rental of hospital space 0 21.00 23.00 Governmental appropriations 4,420,489 23.00 24.00 OTHER OPERATING INCOME 6,421,597 24.00 24.01 INTEREST INCOME & DISTRIBUTIONS 9,290,941 24.01 24.02 OTHER INCOME 2,058,785 24.02 24.03 OTHER NONOPERATING INCOME 2,058,785 24.02 24.04 UNREALIZED GAIN/LOSS ON INVESTMENTS 2,100,000 24.04 24.05 OTHER REVENUE 2,058,785 24.02 24.05 OTHER REVENUE 1,106,405 24.03 24.05 OTHER REVENUE 1,129,426 24.50 25.00 Total other income (sum of lines 6-24) 26,569,621 25.00 27.00 OTAL (line 5 plus line 25) -1,584,746 26.00 27.00 0 27.00 0 27.00	17.00					0	17.00
20.00 Revenue from gifts, flowers, coffee shops, and canteen 0 20.00 21.00 Rental of vending machines 0 21.00 22.00 Rental of hospital space 0 22.00 23.00 Governmental appropriations 4,420,489 23.00 24.00 OTHER OPERATING INCOME 6,421,597 24.00 24.01 INTEREST INCOME & DISTRIBUTIONS 9,290,941 24.01 24.02 OTHER INCOME 2,058,785 24.02 24.03 OTHER NONOPERATING INCOME 2,058,785 24.02 24.04 UNREALIZED GAIN/LOSS ON INVESTMENTS 2,100,000 24.04 24.05 OTHER REVENUE 2,100,000 24.04 24.05 OTHER REVENUE 1,106,405 24.05 24.05 OTHER REVENUE 2,100,000 24.04 24.05 OTHER REVENUE 2,500 24.05 24.50 COVID-19 PHE Funding 26,569,621 25.00 25.00 Total other income (sum of lines 6-24) -1,584,746 26.00 26.00 Total other expenses (sum of line 27 and subscripts) 0 27.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td>0</td> <td></td>						0	
21.00 Rental of vending machines 0 21.00 22.00 Rental of hospital space 0 22.00 23.00 Governmental appropriations 4,420,489 23.00 24.00 OTHER OPERATING INCOME 6,421,597 24.00 24.01 INTEREST INCOME & DISTRIBUTIONS 9,290,941 24.01 24.02 OTHER NONOPERATING INCOME 2,058,785 24.02 24.03 OTHER NONOPERATING INCOME 1,106,405 24.03 24.04 UNREALIZED GAIN/LOSS ON INVESTMENTS 2,100,000 24.04 24.05 OTHER REVENUE 2,100,000 24.05 24.05 OTHER REVENUE 1,129,426 24.50 25.00 Total other income (sum of lines 6-24) 26,569,621 25.00 26.00 Total other expenses (sum of line 27 and subscripts) 0 27.00			,			0	
22.00 Rental of hospital space 0 22.00 23.00 Governmental appropriations 4,420,489 23.00 24.00 OTHER OPERATING INCOME 6,421,597 24.00 24.01 INTEREST INCOME & DISTRIBUTIONS 9,290,941 24.01 24.02 OTHER INCOME 2,058,785 24.02 24.03 OTHER NONOPERATING INCOME 1,106,405 24.03 24.04 UNREALIZED GAIN/LOSS ON INVESTMENTS 2,100,000 24.04 24.05 OTHER REVENUE 2,100,000 24.05 24.50 COVID-19 PHE Funding 1,129,426 24.50 25.00 Total other income (sum of lines 6-24) 26,569,621 25.00 26.00 Total other expenses (SECIFY) 0 27.00 28.00 28.00 Total other expenses (sum of line 27 and subscripts) 0 28.00			d canteen			-	
23.00 Governmental appropriations 4,420,489 23.00 24.00 OTHER OPERATING INCOME 6,421,597 24.00 24.01 INTEREST INCOME & DISTRIBUTIONS 9,290,941 24.01 24.02 OTHER INCOME 2,058,785 24.02 24.03 OTHER NONOPERATING INCOME 2,058,785 24.02 24.04 UNREALIZED GAIN/LOSS ON INVESTMENTS 2,100,000 24.04 24.05 OTHER REVENUE 2,100,000 24.04 25.00 Total other income (sum of lines 6-24) 1,129,426 24.50 26.00 Total (line 5 plus line 25) -1,584,746 26.00 27.00 OTHER EXPENSES (SPECIFY) 0 27.00 28.00 Total other expenses (sum of line 27 and subscripts) 0 28.00	21.00					0	
24.00 OTHER OPERATING INCOME 6,421,597 24.00 24.01 INTEREST INCOME & DISTRIBUTIONS 9,290,941 24.01 24.02 OTHER INCOME 2,058,785 24.02 24.03 OTHER NONOPERATING INCOME 1,106,405 24.03 24.04 UNREALIZED GAIN/LOSS ON INVESTMENTS 2,100,000 24.04 24.05 OTHER REVENUE 2,100,000 24.04 24.05 OTHER REVENUE 1,129,426 24.50 25.00 Total other income (sum of lines 6-24) 26,569,621 25.00 26.00 Total (line 5 plus line 25) -1,584,746 26.00 27.00 OTHER EXPENSES (SPECIFY) 0 27.00 28.00 Total other expenses (sum of line 27 and subscripts) 0 28.00						-	
24. 01 INTEREST INCOME & DISTRIBUTIONS 9, 290, 941 24. 01 24. 02 OTHER INCOME 2, 058, 785 24. 02 24. 03 OTHER NONOPERATING INCOME 1, 106, 405 24. 03 24. 04 UNREALIZED GAIN/LOSS ON INVESTMENTS 2, 100, 000 24. 04 24. 05 OTHER REVENUE 2, 100, 000 24. 04 24. 05 OTHER REVENUE 1, 129, 426 24. 05 25. 00 Total other income (sum of lines 6-24) 26, 569, 621 25. 00 26. 00 Total (line 5 plus line 25) -1, 584, 746 26. 00 27. 00 OTHER EXPENSES (SPECIFY) 0 27. 00 27. 00 28. 00 Total other expenses (sum of line 27 and subscripts) 0 28. 00							
24. 02 OTHER INCOME 2, 058, 785 24. 02 24. 03 OTHER NONOPERATING INCOME 1, 106, 405 24. 03 24. 04 UNREALIZED GAIN/LOSS ON INVESTMENTS 2, 100, 000 24. 04 24. 05 OTHER REVENUE 21, 00, 000 24. 05 24. 05 OTHER REVENUE 1, 129, 426 24. 05 25. 00 Total other income (sum of lines 6-24) 26, 569, 621 25. 00 26. 00 Total (line 5 plus line 25) -1, 584, 746 26. 00 27. 00 OTHER EXPENSES (SPECIFY) 0 27. 00 28. 00 Total other expenses (sum of line 27 and subscripts) 0 28. 00							
24.03 OTHER NONOPERATING INCOME 1,106,405 24.03 24.04 UNREALIZED GAIN/LOSS ON INVESTMENTS 2,100,000 24.04 24.05 OTHER REVENUE 24.05 41,978 24.05 24.50 COVID-19 PHE Funding 1,129,426 24.50 25.00 Total other income (sum of lines 6-24) 26,569,621 25.00 26.00 Total other expenses (SPECIFY) 0 27.00 28.00 Total other expenses (sum of line 27 and subscripts) 0 28.00							
24.04 UNREALIZED GAIN/LOSS ON INVESTMENTS 2,100,000 24.04 24.05 OTHER REVENUE 24.05 24.50 COVID-19 PHE Funding 1,129,426 24.50 25.00 Total other income (sum of lines 6-24) 26,569,621 25.00 26.00 Total (line 5 plus line 25) 27.00 0THER EXPENSES (SPECIFY) 0 27.00 28.00 Total other expenses (sum of line 27 and subscripts) 0 28.00 28.00							
24.05OTHER REVENUE41,97824.0524.50COVID-19 PHE Funding1,129,42624.5025.00Total other income (sum of lines 6-24)26,569,62125.0026.00Total (line 5 plus line 25)-1,584,74626.0027.00OTHER EXPENSES (SPECIFY)027.0028.00Total other expenses (sum of line 27 and subscripts)028.00							
24.50 C0VID-19 PHE Funding 1, 129, 426 24.50 25.00 Total other income (sum of lines 6-24) 26, 569, 621 25.00 26.00 Total (line 5 plus line 25) -1, 584, 746 26.00 27.00 OTHER EXPENSES (SPECI FY) 0 27.00 28.00 Total other expenses (sum of line 27 and subscripts) 0 28.00							
25.00 Total other income (sum of lines 6-24) 26,569,621 25.00 26.00 Total (line 5 plus line 25) -1,584,746 26.00 27.00 OTHER EXPENSES (SPECIFY) 0 27.00 28.00 Total other expenses (sum of line 27 and subscripts) 0 28.00							
26.00 Total (line 5 plus line 25) -1,584,746 26.00 27.00 OTHER EXPENSES (SPECIFY) 0 27.00 28.00 Total other expenses (sum of line 27 and subscripts) 0 28.00							
27.00 OTHER EXPENSES (SPECIFY) 0 27.00 28.00 Total other expenses (sum of line 27 and subscripts) 0 28.00							
28.00Total other expenses (sum of line 27 and subscripts)028.00							
						-	
23. 00 pixet rincome (or ross) rol the period (rine zo minus rine zo) -1, 584, 740 29. 00							
	29.00	Iner income (or ross) for the period (The 26 h	iii iius II ne 28)		I	-1, 384, 746	29.00

ANALYSI	S OF HOSPITAL-BASED HOSPICE COSTS		Provider C		eriod: rom 01/01/2023	Worksheet O	
			Hospi ce CC		o 12/31/2023	Date/Time Pre 4/11/2024 3:1	
		SALARI ES	OTHER	SUBTOTAL	Hospi ce I RECLASSI FI -	SUBTOTAL	
				(col. 1 plus	CATIONS		
		1.00	2.00	<u>col.2)</u> 3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS				· · · · · ·		
	CAP REL COSTS-BLDG & FIXT*		0	-	-	0	
1	CAP REL COSTS-MVBLE EQUIP*		0	0	-	0	
	EMPLOYEE BENEFITS DEPARTMENT*	0	156, 850			156, 850	
	ADMINISTRATIVE & GENERAL* PLANT OPERATION & MAINTENANCE*	61, 870	280, 600 9, 943	342, 470 9, 943		185, 620 9, 943	
	LAUNDRY & LINEN SERVICE*	0	9, 943 O	7, 743	0	9, 943	
	HOUSEKEEPI NG*	0	0		0	0	
	DI ETARY*	0	0	Ö	0 0	0	1
00.0	NURSI NG ADMI NI STRATI ON*	0	0	0	0	0	9.1
0.00 I	ROUTINE MEDICAL SUPPLIES*	0	51, 541	51, 541	0	51, 541	10.
1.00	MEDI CAL RECORDS*	0	0	0	0	0	11.
2.00	STAFF TRANSPORTATI ON*	0	0	0	0	0	12.
	VOLUNTEER SERVICE COORDINATION*	0	0	0	0	0	
	PHARMACY*	0	26	26	0	26	
	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	0	0	0	
1	OTHER GENERAL SERVICE*	0	0	0	0	0	
	PATIENT/RESIDENTIAL CARE SERVICES						17.
	DI RECT PATIENT CARE SERVICE COST CENTERS	1	0	0	ol	0	25.
	PHYSICIAN SERVICES**	19,068	24, 014	43, 082		43, 082	
1	NURSE PRACTITIONER**	5, 016	24,014	5, 016		5,016	
1	REGI STERED NURSE**	245, 111	0	245, 111		245, 111	
	LPN/LVN**	0	0	0	0	0	
0.00	PHYSI CAL THERAPY**	0	0	0	0	0	30.
1.00	OCCUPATIONAL THERAPY**	0	0	0	0	0	31.
2.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	0	32.
1	MEDI CAL SOCI AL SERVI CES**	128, 880	0	128, 880	0	128, 880	
1	SPI RI TUAL COUNSELI NG**	0	0	0	0	0	
	DI ETARY COUNSELI NG**	0	0	0	0	0	
	COUNSELING - OTHER**	0	0		0	0	
	HOSPICE AIDE & HOMEMAKER SERVICES**	55, 746	0	55, 746	0	55, 746	
	DURABLE MEDI CAL EQUI PMENT/OXYGEN** PATI ENT TRANSPORTATI ON**	0	0		0	0	
	IMAGING SERVICES**	0	0		0	0	
	LABS & DI AGNOSTI CS**	0	0	0	0	0	
	MEDI CAL SUPPLI ES-NON-ROUTI NE**	0	0	Ő	0 0	0	
	DRUGS CHARGED TO PATIENTS**	0	0	0	0	0	
3.00 0	OUTPATI ENT SERVI CES**	0	0	0	0	0	43.
4.00 H	PALLIATIVE RADIATION THERAPY**	0	0	0	0	0	44.
	PALLIATIVE CHEMOTHERAPY**	0	0	0	0	0	
	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0	0	0	0	46.
	NONREI MBURSABLE COST CENTERS	1		1	1		
	BEREAVEMENT PROGRAM *	0	0	-	-	0	
	VOLUNTEER PROGRAM *	0	0	0	0	0	
	FUNDRALSING*	0	0	0	0	0	
	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	0	0	0	
	PALLIATIVE CARE PROGRAM* OTHER PHYSICIAN SERVICES*		0			0	1
	RESIDENTIAL CARE*		0			0	1
	ADVERTI SI NG*		0			0	1
	TELEHEALTH/TELEMONI TORI NG*	0	0		0	0	
	THRI FT STORE*	0	0		0	0	
	NURSING FACILITY ROOM & BOARD*	0	0	o o	0	0	
	OTHER NONREI MBURSABLE (SPECI FY)*	0	0	0	o o	0	
	TOTAL	515, 691	522, 974	1, 038, 665	-156, 850	881, 815	

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

	inancial Systems S OF HOSPITAL-BASED HOSPICE COSTS		Provider CCN:	15-0042	Peri od:	Worksheet O
			Hospice CCN:	15-1526	From 01/01/2023 To 12/31/2023	Date/Time Prepa
					Hospi ce I	4/11/2024 3:17
		ADJUSTMENTS	TOTAL (col. 5		Hospice i	
		6.00	<u>± col. 6)</u> 7.00			
G	ENERAL SERVICE COST CENTERS	6.00	7.00			
	CAP REL COSTS-BLDG & FIXT*	0	0			
0 0	CAP REL COSTS-MVBLE EQUIP*	0	0			
DO E	EMPLOYEE BENEFITS DEPARTMENT*	0	156, 850			
	ADMI NI STRATI VE & GENERAL*	0	185, 620			
	PLANT OPERATION & MAINTENANCE*	0	9, 943			
	LAUNDRY & LINEN SERVICE*	0	0			
	HOUSEKEEPI NG*	0	0			
	DI ETARY*	0	0			
	NURSENG ADMENTSTRATION* ROUTENE MEDICAL SUPPLIES*	0	•			1
	MEDICAL SUPPLIES	0	51, 541			1
	STAFF TRANSPORTATION*	0	0			1
	/OLUNTEER SERVICE COORDINATION*	0	0			1
	PHARMACY*	0	26			1
	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0			1
	OTHER GENERAL SERVICE*	0	0			1
00 F	PATI ENT/RESI DENTI AL CARE SERVI CES					1
D	IRECT PATIENT CARE SERVICE COST CENTERS					
00 1	NPATIENT CARE-CONTRACTED**	0	0			2
	PHYSICIAN SERVICES**	0	43, 082			2
	NURSE PRACTITIONER**	0	5, 016			2
	REGI STERED NURSE**	0	245, 111			2
	_PN/LVN**	0	0			2
	PHYSICAL THERAPY**	0	0			3
	DCCUPATIONAL THERAPY**	0	0			3
	SPEECH/LANGUAGE PATHOLOGY**	0	120,000			3
	/EDICAL SOCIAL SERVICES** SPIRITUAL COUNSELING**	0	128, 880 0			
	DI ETARY COUNSELING**	0	0			
	COUNSELING - OTHER**	0	0			
	HOSPICE AIDE & HOMEMAKER SERVICES**	0	55, 746			
	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0			3
	PATIENT TRANSPORTATION**	0	Ő			
	MAGING SERVICES**	0	0			4
00 1	_ABS & DI AGNOSTI CS**	0	0			4
00 1	/EDICAL SUPPLIES-NON-ROUTINE**	0	0			4
	DRUGS CHARGED TO PATI ENTS**	0	0			4
	DUTPATIENT SERVICES**	0	0			4
	PALLIATIVE RADIATION THERAPY**	0	0			4
	PALLIATIVE CHEMOTHERAPY**	0	0			4
	OTHER PATIENT CARE SERVICES (SPECIFY) **	0	0			4
	ONREI MBURSABLE COST CENTERS		0			
	BEREAVEMENT PROGRAM * /OLUNTEER PROGRAM *	0	0			6
	FUNDRAL SI NG*	0	0			
	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0			
	PALLIATIVE CARE PROGRAM*	0	0			6
	THER PHYSICIAN SERVICES*	0	0			6
	RESIDENTIAL CARE*	0	0			6
	ADVERTI SI NG*	0	0			6
	FELEHEALTH/TELEMONI TORI NG*	0	0			6
	THRI FT STORE*	0	ő			6
	NURSING FACILITY ROOM & BOARD*	0	Ő			7
	OTHER NONREI MBURSABLE (SPECI FY)*	0	0			7
	FOTAL		881, 815			10

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

Heal th	Financial Systems	GOOD SAMARITA	N HOSPI TAL		In Lie	u of Form CMS-2	2552-10
ANALYS	IS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPIC	E ROUTINE HOME	Provider C	CN: 15-0042	Peri od:	Worksheet 0-2	
CARE			Hospi ce CCI	N: 15-1526	From 01/01/2023 To 12/31/2023	Date/Time Pre 4/11/2024 3:1	
					Hospi ce I		
		SALARI ES	OTHER	SUBTOTAL	RECLASSI FI -	SUBTOTAL	
				(col. 1 +	CATI ONS		
				col . 2)			
		1.00	2.00	3.00	4.00	5.00	
	DI RECT PATI ENT CARE SERVI CE COST CENTERS	T		1			
25.00	I NPATI ENT CARE-CONTRACTED						25.00
26.00	PHYSI CI AN SERVI CES	18, 182	0	18, 18	32 0	18, 182	
27.00	NURSE PRACTI TI ONER	4, 783	0	4, 78	3 0	4, 783	27.00
28.00	REGI STERED NURSE	233, 727	0	233, 72	.7 0	233, 727	28.00
29.00	LPN/LVN	0	0		0 0	0	29.00
30.00	PHYSI CAL THERAPY	0	0		0 0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0		0 0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		0 0	0	32.00
33.00	MEDI CAL SOCI AL SERVI CES	122, 895	0	122, 89	05 0	122, 895	33.00
34.00	SPI RI TUAL COUNSELI NG	0	0		0 0	0	34.00
35.00	DI ETARY COUNSELI NG	0	0		0 0	0	35.00
36.00	COUNSELING - OTHER	0	0		0 0	0	36.00

35.00	DIETARY 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	53, 157	0	53, 157	0	53, 157	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATI ENT TRANSPORTATI ON	0	0	0	0	0	39.00
40.00	I MAGI NG SERVI CES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATI ENT SERVI CES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	432, 744	0	432, 744	0	432, 744	100.00
* Tran	sfer the amount in column 7 to Wkst. 0-5, col	umn 1, line 51					

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

		ADJUSTMENTS	TOTAL (col. 5		
			± col. 6)		
		6.00	7.00		
	SERVICE COST CENTERS				
25.00 INPATIENT CARE-CONTR	RACTED				25.00
26.00 PHYSI CLAN SERVI CES		0	18, 182	2	26.00
27.00 NURSE PRACTITIONER		0	4, 783		27.00
28.00 REGI STERED NURSE		0	233, 727		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 PATH		0	0		32.00
33.00 MEDICAL SOCIAL SERVI		0	122, 895		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 & HOMEN		0	53, 157		37.00
38.00 DURABLE MEDICAL EQUI		0	0		38.00
39.00 PATI ENT TRANSPORTATI	ON	0	0		39.00
40.00 I MAGI NG SERVICES		0	0		40.00
41.00 LABS & DIAGNOSTICS		0	0		41.00
42.00 MEDICAL SUPPLIES-NON		0	0		42.00
42.50 DRUGS CHARGED TO PAT	TI ENTS	0	0		42.50
43.00 OUTPATIENT SERVICES		0	0		43.00
44.00 PALLIATIVE RADIATION		0	0		44.00
45.00 PALLIATIVE CHEMOTHER		0	0		45.00
46.00 OTHER PATIENT CARE S	SERVICES (SPECIFY)	0	0		46.00
100.00 TOTAL *		0	432, 744		100.00
* Transfer the amount in co	olumn 7 to Wkst. 0-5, col	umn 1, line 51			

Health Financial Systems	GOOD SAMARI TAN	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPIC	E INPATIENT	Provider CC	N: 15-0042	Period:	Worksheet 0-3	
RESPITE CARE		Hospi ce CCN	l: 15-1526	From 01/01/2023 To 12/31/2023	Date/Time Pre 4/11/2024 3:1	pared: 7 pm
				Hospi ce I		
	SALARI ES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSI FI - CATI ONS	SUBTOTAL	
	1.00	2.00	3.00	4.00	5.00	
DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00 INPATIENT CARE-CONTRACTED		0		0 0	0	
26.00 PHYSICIAN SERVICES	26	0		26 0	26	26.00
27.00 NURSE PRACTITIONER	7	0		7 0	7	27.00
28.00 REGI STERED NURSE	333	0	3	33 0	333	
29.00 LPN/LVN	0	0		0 0	0	
30. 00 PHYSI CAL THERAPY	0	0		0 0	0	30.00
31.00 OCCUPATIONAL THERAPY	0	0		0 0	0	31.00
32.00 SPEECH/LANGUAGE PATHOLOGY	0	0		0 0	0	32.00
33.00 MEDICAL SOCIAL SERVICES	175	0	1	75 0	175	33.00
34.00 SPI RI TUAL COUNSELI NG	0	0		0 0	0	34.00
35.00 DI ETARY COUNSELI NG	0	0		0 0	0	35.00
36.00 COUNSELING - OTHER	0	0		0 0	0	36.00
37.00 HOSPICE AIDE & HOMEMAKER SERVICES	76	0		76 0	76	37.00
38.00 DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		0 0	0	38.00
39.00 PATI ENT TRANSPORTATI ON	0	0		0 0	0	39.00
40.00 I MAGI NG SERVI CES	0	0		0 0	0	40.00
41.00 LABS & DIAGNOSTICS	0	0		0 0	0	41.00
42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE	0	0		0 0	0	42.00
42.50 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	42.50
43.00 OUTPATIENT SERVICES	0	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)	0	0		0 0	0	46.00
100. 00 TOTAL *	617	0	6	17 0	617	100.00

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

	ADJUSTMENTS	TOTAL (col. 5		
		± col. 6)		
	6.00	7.00		
DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00 INPATIENT CARE-CONTRACTED	0	0		5.00
26.00 PHYSICIAN SERVICES	0	26		6.00
27.00 NURSE PRACTITIONER	0	7		7.00
28.00 REGI STERED NURSE	0	333		8.00
29.00 LPN/LVN	0	0		9.00
30. 00 PHYSI CAL THERAPY	0	0	30	0.00
31. 00 OCCUPATI ONAL THERAPY	0	0	31	1.00
32.00 SPEECH/LANGUAGE PATHOLOGY	0	0	32	2.00
33.00 MEDICAL SOCIAL SERVICES	0	175	33	3.00
34.00 SPIRITUAL COUNSELING	0	0	34	4.00
35. 00 DI ETARY COUNSELI NG	0	0	35	5.00
36.00 COUNSELING - OTHER	0	0	36	6.00
37.00 HOSPICE AIDE & HOMEMAKER SERVICES	0	76	37	7.00
38.00 DURABLE MEDI CAL EQUI PMENT/OXYGEN	0	0	38	8.00
39. 00 PATI ENT TRANSPORTATI ON	0	0	39	9.00
40. 00 I MAGI NG SERVI CES	0	0	40	0.00
41.00 LABS & DIAGNOSTICS	0	0	41	1.00
42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE	0	0	42	2.00
42.50 DRUGS CHARGED TO PATIENTS	0	0	42	2.50
43.00 OUTPATIENT SERVICES	0	0	43	3.00
44.00 PALLIATIVE RADIATION THERAPY	0	0	44	4.00
45.00 PALLIATIVE CHEMOTHERAPY	0	0	45	5.00
46.00 OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46	6.00
100.00 TOTAL *	0	617	100	0.00
* Transfer the amount in column 7 to Wkst. 0-5, col	umn 1, line 52			

Health Financial Systems	GOOD SAMARI TAN				u of Form CMS-2	
ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR	HOSPICE GENERAL	Provider CC		Period:	Worksheet 0-4	
INPATIENT CARE		Hospi ce CCN		From 01/01/2023 To 12/31/2023	Date/Time Pre 4/11/2024 3:1	pared: 7 pm
				Hospi ce I		
	SALARI ES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSI FI - CATI ONS	SUBTOTAL	
	1.00	2.00	3.00	4.00	5.00	
DIRECT PATIENT CARE SERVICE COST CENTER	S					
25.00 INPATIENT CARE-CONTRACTED		0		0 0	0	
26.00 PHYSI CI AN SERVI CES	860	24, 014	24, 87	74 0	24, 874	26.00
27.00 NURSE PRACTITIONER	226	0	22		226	27.00
28.00 REGI STERED NURSE	11, 051	0	11, 05	51 0	11, 051	28.00
29.00 LPN/LVN	0	0		0 0	0	
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	
33.00 MEDICAL SOCIAL SERVICES	5, 810	0	5, 81	0 0	5, 810	33.00
34.00 SPI RI TUAL COUNSELI NG	0	0		0 0	0	34.00
35. 00 DI ETARY COUNSELI NG	0	0		0 0	0	35.00
36.00 COUNSELING - OTHER	0	0		0 0	0	36.00
37.00 HOSPICE AIDE & HOMEMAKER SERVICES	2, 513	0	2, 51	13 0	2, 513	37.00
38.00 DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		0 0	0	38.00
39.00 PATIENT TRANSPORTATION	0	0		0 0	0	39.00
40.00 I MAGI NG SERVI CES	0	0		0 0	0	40.00
41.00 LABS & DIAGNOSTICS	0	0		0 0	0	41.00
42.00 MEDI CAL SUPPLI ES-NON-ROUTI NE	0	0		0 0	0	42.00
42.50 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	42.50
43.00 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)	0	0		0 0	0	46.00
100.00 TOTAL *	20, 460	24, 014	44,47	74 0	44, 474	100.00

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

		ADJUSTMENTS	TOTAL (col. 5	
			± col. 6)	
		6.00	7.00	
	DI RECT PATIENT CARE SERVICE COST CENTERS			
25.00	I NPATI ENT CARE-CONTRACTED	0	0	25.00
26.00	PHYSI CI AN SERVI CES	0	24, 874	26.00
27.00	NURSE PRACTITIONER	0	226	27.00
28.00	REGI STERED NURSE	0	11, 051	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	5, 810	33.00
34.00	SPI RI TUAL COUNSELI NG	0	0	34.00
35.00	DI ETARY COUNSELI NG	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	2, 513	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	I MAGI NG SERVI CES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATI ENT SERVI CES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	44, 474	100.00
* Trar	nsfer the amount in column 7 to Wkst. 0-5, col	umn 1, line 53		

Heal th	Financial Systems GOOD SAMARITA	AN HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST A	LLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET	Provider C		Peri od:	Worksheet 0-5	
EXPENS	ES FOR ALLOCATION			From 01/01/2023		
		Hospi ce CC	N: 15-1526	To 12/31/2023	Date/Time Pre 4/11/2024 3:1	
				Hospi ce I	4/11/2024 5.1	<u>, bui</u>
	Descriptions		HOSPI CE	GENERAL	TOTAL	
			DI RECT	SERVI CE	EXPENSES (sum	
			EXPENSES (see	EXPENSES FROM	of cols. 1 +	
			instructions)	WKST B PART I	2)	
				(see		
				instructions)		
	1		1.00	2.00	3.00	
	GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT			0 111, 600		1.00
2.00	CAP REL COSTS-MVBLE EQUIP			220		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT		156, 85			3.00
4.00	ADMI NI STRATI VE & GENERAL		185, 62		331, 011	4.00
5.00	PLANT OPERATION & MAINTENANCE		9, 94			5.00
6.00	LAUNDRY & LINEN SERVICE			0 0	-	6.00
7.00	HOUSEKEEPING			66, 321	66, 321	7.00
8.00	DI ETARY		1	0 0	0	8.00
9.00	NURSI NG ADMI NI STRATI ON			0 126, 405		9.00
10.00	ROUTI NE MEDI CAL SUPPLI ES		51, 54		52, 388	
11.00	MEDI CAL RECORDS			0 0		11.00
12.00	STAFF TRANSPORTATION			2	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION PHARMACY				0	13.00
14.00 15.00			2	6 6 0	32	14.00 15.00
15.00 16.00	PHYSI CI AN ADMI NI STRATI VE SERVI CES OTHER GENERAL SERVI CE			0 0		16.00
	PATI ENT/RESI DENTI AL CARE SERVI CES			0		17.00
17.00	LEVEL OF CARE			0	0	17.00
50.00	HOSPICE CONTINUOUS HOME CARE			D	0	50.00
51.00	HOSPI CE ROUTI NE HOME CARE		432, 74		432, 744	
52.00	HOSPICE INPATIENT RESPITE CARE		61		617	
53.00	HOSPICE GENERAL INPATIENT CARE		44, 47		44, 474	53.00
00100	NONREI MBURSABLE COST CENTERS		1,,		,	00.00
60.00	BEREAVEMENT PROGRAM			C	0	60.00
61.00	VOLUNTEER PROGRAM) C	0	61.00
62.00	FUNDRAI SI NG			C	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			D	0	63.00
64.00	PALLIATIVE CARE PROGRAM			C	0	64.00
65.00	OTHER PHYSICIAN SERVICES			D	0	65.00
66.00	RESIDENTIAL CARE			C	0	66.00
67.00	ADVERTI SI NG			C	0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG			C	0	68.00
69.00	THRI FT STORE			C	0	69.00
70.00	NURSING FACILITY ROOM & BOARD			C	0	70.00
	OTHER NONREIMBURSABLE (SPECIFY)			C	0	71.00
	NEGATI VE COST CENTER			C	0	99.00
100.00	TOTAL		881, 81	5 738, 911	1, 620, 726	100.00

COST A								2552-10
	LLOCATI ON - HOSPI TAL-BASED HOSPI CE GENERAL S	ERVICE COSTS	Provider C Hospice CC			riod: om 01/01/2023 12/31/2023	Worksheet 0-6 Part I Date/Time Pre 4/11/2024 3:1	pared:
						Hospi ce I		
	Descriptions	TOTAL EXPENSES	CAP REL BLDG & FIX	CAP REL MVBL EQUI P	LE	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL	
		0	1.00	2.00		3.00	3A	
	GENERAL SERVICE COST CENTERS					I	-	
1.00	CAP REL COSTS-BLDG & FIXT	111, 600	111, 600					1.00
2.00	CAP REL COSTS-MVBLE EQUIP	220	,		20			2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	313, 355	0		0	313, 355		3.00
4.00	ADMI NI STRATI VE & GENERAL	331, 011	0		0	010,000	331, 011	4.00
5.00	PLANT OPERATION & MAINTENANCE	141, 559	0		0	0	141, 559	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0		0	0	0	6.00
7.00	HOUSEKEEPING	66, 321	0		0	0	66, 321	7.00
8.00	DI ETARY	00, 321	0		0	0	00, 321	8.00
9.00	NURSI NG ADMI NI STRATI ON	126, 405	0		0	0	126, 405	9.00
10.00	ROUTI NE MEDI CAL SUPPLI ES	52, 388	0		0	0	52, 388	10.00
10.00	MEDICAL RECORDS	0	0		0	0	52, 300	11.00
12.00	STAFF TRANSPORTATION	0	0		0	0	0	12.00
		0	0		0	0	-	
13.00	VOLUNTEER SERVICE COORDINATION	0	0		0	0	0	13.00
14.00		32	0		0	0	32 0	14.00
15.00	PHYSI CI AN ADMI NI STRATI VE SERVI CES	-	0		0	0	-	15.00
16.00	OTHER GENERAL SERVICE	0	0		0	0	0	16.00
17.00	PATI ENT/RESI DENTI AL CARE SERVI CES		0		0		0	17.00
50.00	HOSPICE CONTINUOUS HOME CARE	0		1		0	0	50.00
51.00	HOSPICE CONTINUOUS HOME CARE	432, 744				298, 802	731, 546	
52.00	HOSPICE ROUTINE HOME CARE	432, 744	2, 013		4	298, 802	3, 060	
52.00	HOSPICE THPATTENT RESPICE CARE	44, 474	109, 587		4	14, 127	168, 404	
55.00	NONREIMBURSABLE COST CENTERS	44, 474	109, 367	Z	10	14, 127	100, 404	55.00
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
63.00 64.00	PALLIATIVE CARE PROGRAM	0	0		0	0	0	64.00
64.00 65.00		0	0		0	0	0	
	OTHER PHYSICIAN SERVICES	0	0		0	0	-	65.00
66.00	RESIDENTIAL CARE	0	0		0	0	0	66.00
67.00	ADVERTI SI NG	0	0		0	0	0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG	0	0		U	0	0	68.00
69.00	THRIFT STORE	0	0		U	0	0	69.00
	NURSING FACILITY ROOM & BOARD	0	-			_	0	70.00
	OTHER NONREI MBURSABLE (SPECI FY)	0	0		0	0	0	71.00
	NEGATI VE COST CENTER	0	0	-	0	0	1 (00	99.00
100.00	IUIAL	1, 620, 726	111, 600	2	20	313, 355	1, 620, 726	100.00

Heal th	n Financial Systems	GOOD SAMARI TA	AN HOSPITAL			In Lieu	u of Form CMS	5-2!	552-10
COST	ALLOCATI ON - HOSPI TAL-BASED HOSPI CE GENERAL	SERVI CE COSTS	Provider C Hospice CC	CN: 15-0042 N: 15-1526		eriod: com 01/01/2023 0 12/31/2023	Worksheet O Part I Date/Time P 4/11/2024 3:	rep	ared: pm
				_		Hospi ce I			
	Descriptions	ADMI NI STRATI V E & GENERAL	PLANT OPERATION & MAINTENANCE	LAUNDRY & LINEN SERVIO		HOUSEKEEPI NG	DI ETARY		
		4.00	5.00	6.00		7.00	8.00		
	GENERAL SERVICE COST CENTERS								
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL PLANT OPERATION & MAINTENANCE LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY	331, 011 36, 332 0 17, 022 0	177, 891 C C		0	83, 343 0		0	1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00
9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00	NURSI NG ADMI NI STRATI ON ROUTI NE MEDI CAL SUPPLI ES MEDI CAL RECORDS STAFF TRANSPORTATI ON VOLUNTEER SERVI CE COORDI NATI ON PHARMACY PHYSI CI AN ADMI NI STRATI VE SERVI CES OTHER GENERAL SERVI CE	32, 442 13, 446 0 0 0 8 0 0 0 0 0				0 0 0 0 0 0 0			9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00
50. 00 51. 00 52. 00 53. 00	HOSPI CE CONTI NUOUS HOME CARE HOSPI CE ROUTI NE HOME CARE HOSPI CE I NPATI ENT RESPI TE CARE	0 187, 754 785 43, 222	3, 209 174, 682		0	1, 504 81, 839		0	50. 00 51. 00 52. 00 53. 00
71.00 99.00	BEREAVEMENT PROGRAM VOLUNTEER PROGRAM FUNDRAI SI NG HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS PALLI ATI VE CARE PROGRAM OTHER PHYSI CI AN SERVI CES RESI DENTI AL CARE ADVERTI SI NG TELEHEALTH/TELEMONI TORI NG THRI FT STORE NURSI NG FACI LI TY ROOM & BOARD	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	C C C C C C C C C C C C C C C C C C C		0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 83, 343		0	60.00 61.00 62.00 63.00 64.00 65.00 66.00 67.00 68.00 69.00 70.00 71.00 99.00

Heal th	Financial Systems	GOOD SAMARI TAN	N HOSPI TAL		In Lie	u of Form CMS-	2552-10
	ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL S	ERVICE COSTS	Provider C	CN: 15-0042	Period: Worksheet)
				45 4504	From 01/01/2023		
			Hospi ce CC	N: 15-1526	To 12/31/2023	Date/Time Pre 4/11/2024 3:1	2 nm
					Hospi ce I	17 117 202 1 0.1	
	Descriptions	NURSI NG	ROUTI NE	MEDI CAL	STAFF	VOLUNTEER	
	•	ADMI NI STRATI O	MEDI CAL	RECORDS	TRANSPORTATI 0	SERVI CE	
		N	SUPPLI ES		Ν	COORDI NATI ON	
		9.00	10.00	11.00	12.00	13.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMI NI STRATI VE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DI ETARY						8.00
9.00	NURSI NG ADMI NI STRATI ON	158, 847					9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	65, 834				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						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0		0 0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	151, 469	62, 777		0 0	0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	214	89		0 0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	7, 164	2, 968		0 0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0			0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0		
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	66.00
67.00	ADVERTI SI NG	0			0	0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG	0			0	0	
69.00	THRI FT STORE	0			0	0	
70.00							70.00
71.00	OTHER NONREI MBURSABLE (SPECI FY)	0			0	-	
	NEGATI VE COST CENTER	0	0		0 0		
100.00	D TOTAL	158, 847	65, 834		0 0	0	100.00

Heal th	Financial Systems	GOOD SAMARI TA	N HOSPI TAL		In Lie	u of Form CMS-	2552-10
	ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL S		Provider CC Hospice CCI		Period: From 01/01/2023 To 12/31/2023	Worksheet 0-6 Part I Date/Time Pre	epared:
					Hospi ce I	4/11/2024 3:1	/pm
	Descriptions	PHARMACY	PHYSI CI AN ADMI NI STRATI V E SERVI CES	OTHER GENERA SERVI CE		TOTAL	
		14.00	15.00	16.00	17.00	18.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMI NI STRATI VE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00							8.00
9.00 10.00	NURSI NG ADMI NI STRATI ON						9.00 10.00
11.00	ROUTI NE MEDI CAL SUPPLI ES MEDI CAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
12.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY	40					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	40	0				15.00
16.00	OTHER GENERAL SERVICE	0	0		0		16.00
17.00	PATI ENT/RESI DENTI AL CARE SERVI CES	Ŭ			0		17.00
	LEVEL OF CARE	11					
50.00	HOSPICE CONTINUOUS HOME CARE	0	0		0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	38	0		0	1, 133, 584	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	1	0 0	8, 861	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	2	0		0 0	478, 281	53.00
	NONREI MBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0			0	0	
61.00	VOLUNTEER PROGRAM	0			0	0	
62.00	FUNDRAI SI NG	0			0	0	
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	
64.00	PALLIATIVE CARE PROGRAM	0			0	0	
65.00	OTHER PHYSICIAN SERVICES	0			0	0	00100
66.00	RESIDENTIAL CARE	0	0		0 0	0	
67.00	ADVERTI SI NG	0			0	0	
68.00 69.00	TELEHEALTH/TELEMONI TORI NG THRI FT STORE	0			0	0	
70.00	NURSING FACILITY ROOM & BOARD				U I	0	
	OTHER NONREIMBURSABLE (SPECIFY)		0		0 0	0	
99.00	NEGATI VE COST CENTER		0			0	1 / 11 00
	TOTAL	40	0		0 0	1, 620, 726	
			0	I	-	., 525, 720	1.50.00

	Financial Systems	GOOD SAMARI TA				u of Form CMS-:	
	LLOCATION - HOSPITAL-BASED HOSPICE GENE	RAL SERVICE COSTS	Provider C		Peri od:	Worksheet 0-6)
STATI S	TICAL BASIS		Hospi ce CCI		From 01/01/2023 To 12/31/2023		nared
			1030100 001	1. 10 1020	10 12/01/2020	4/11/2024 3:1	7 pm
			_		Hospi ce I		
	Cost Center Descriptions	CAP REL BLDG	CAP REL MVBLE	EMPLOYEE		ADMI NI STRATI V	
		& FIX	EQUI P	BENEFITS	N	E & GENERAL	
		(SQUARE FEET)	(DOLLAR	DEPARTMENT		(ACCUMULATED	
			VALUE)	(GROSS		COSTS)	
		1.00	2.00	SALARI ES)	4.0	4.00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4A	4.00	
1.00	CAP REL COSTS-BLDG & FIXT	388					1.00
2.00	CAP REL COSTS-BEDG & TTXT	500	388				2.00
2.00	EMPLOYEE BENEFITS DEPARTMENT	0		513, 66	.0		3.00
4.00	ADMI NI STRATI VE & GENERAL	0		515,00	0 -331,011	1, 289, 715	4.00
4.00 5.00	PLANT OPERATION & MAINTENANCE	0	0		0 -331,011	141, 559	5.00
6.00	LAUNDRY & LINEN SERVICE	0			0 0	0	6.00
7.00	HOUSEKEEPING	0			0 0	66, 321	7.00
8.00	DI ETARY	0			0 0	00, 321	8.00
9.00	NURSI NG ADMI NI STRATI ON	0	0		0 0	126, 405	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0		0 0	52, 388	
11.00	MEDI CAL RECORDS	0	0		0 0	0	11.00
12.00	STAFF TRANSPORTATION	0	0		0 0	0	
13.00	VOLUNTEER SERVICE COORDINATION	0	0		0 0	0	
14.00	PHARMACY	0	0		0 0	32	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0 0	0	•
16.00	OTHER GENERAL SERVICE	0	0		0 0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0	0	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE				0 0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			489, 81	2 0	731, 546	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	7		69			
53.00	HOSPICE GENERAL INPATIENT CARE	381	381	23, 15	0 8	168, 404	53.00
	NONREI MBURSABLE COST CENTERS		1	1			
60.00	BEREAVEMENT PROGRAM	0			0 0		60.00
61.00	VOLUNTEER PROGRAM	0			0 0	-	61.00
62.00	FUNDRALSING	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
66.00 67.00	RESI DENTI AL CARE ADVERTI SI NG	0	0		0 0	0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG	0	0		0 0	0	68.00
68.00 69.00	THRIFT STORE				0 0		69.00
70.00	NURSING FACILITY ROOM & BOARD				0 0		70.00
70.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0		0 0	0	
	NEGATI VE COST CENTER				0		99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Pa	art I) 111,600	220	313, 35	5	331,011	
	UNIT COST MULTIPLIER	287. 628866				0. 256654	
	1	1			I.		

Heal th	Financial Systems	GOOD SAMARI TA	AN HOSPITAL		In Lie	u of Form CMS-2	2552-10
	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL S TICAL BASIS	SERVICE COSTS	Provider C Hospice CC		Period: From 01/01/2023 To 12/31/2023		pared:
					Hospi ce I		
	Cost Center Descriptions	PLANT OPERATI ON &	LAUNDRY & LINEN SERVICE	HOUSEKEEPIN (SQUARE FEET	G DI ETARY	NURSI NG ADMI NI STRATI O	
		MAI NTENANCE (SQUARE FEET)	(IN-FACILITY DAYS)		DAYS)	N (DI RECT NURS. HRS.)	
		5.00	6.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS		•	·		•	
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE	388					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0				6.00
7.00	HOUSEKEEPI NG	0		3	88		7.00
8.00	DI ETARY	0			0 0		8.00
9.00	NURSING ADMINISTRATION	0			0	16, 297	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0			0	0	10.00
11.00	MEDI CAL RECORDS	0			0	0	11.00
12.00	STAFF TRANSPORTATION	0			0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	0	13.00
14.00	PHARMACY	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	PATI ENT/RESI DENTI AL CARE SERVI CES	0			0		17.00
	LEVEL OF CARE				-		
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					15, 540	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	7	-		7 0		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	381	0	3	81 0	735	53.00
	NONREI MBURSABLE COST CENTERS	1	1	1		1	
60.00	BEREAVEMENT PROGRAM	0			0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0	0	61.00
62.00	FUNDRAI SI NG	0			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	0	64.00
65.00	OTHER PHYSI CI AN SERVI CES	0			0	0	65.00
66.00	RESI DENTI AL CARE	0	0		0 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	THRIFT STORE	0			0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD					_	70.00
71.00	OTHER NONREI MBURSABLE (SPECI FY)	0	0		0 0	0	71.00
	NEGATIVE COST CENTER	177 001	0		43 0	150 047	99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I UNIT COST MULTIPLIER) 177, 891 458. 481959		05,5		100/01/	
101.00	UNIT COST MULTIPLIER	400.401999	0.00000	214.0015	40 U. UUUUU	9.747009	101.00

Heal th	n Financial Systems	GOOD SAMARI TAN	I HOSPI TAL		In Lie	u of Form CMS-	2552-10
	ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE STICAL BASIS	ERVICE COSTS	Provider C Hospice CC		Period: From 01/01/2023 To 12/31/2023	Worksheet 0-6 Part II Date/Time Pre 4/11/2024 3:1	epared:
					Hospi ce I		/ p
	Cost Center Descriptions	ROUTI NE MEDI CAL SUPPLI ES (PATI ENT DAYS)	MEDI CAL RECORDS (PATI ENT DAYS)	STAFF TRANSPORTATI N (MI LEAGE)	VOLUNTEER	PHARMACY (CHARGES)	
		10.00	11.00	12.00	13.00	14.00	
	GENERAL SERVICE COST CENTERS						
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ \end{array}$	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL PLANT OPERATION & MAINTENANCE LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY NURSING ADMINISTRATION ROUTINE MEDICAL SUPPLIES MEDICAL RECORDS STAFF TRANSPORTATION VOLUNTEER SERVICE COORDINATION PHARMACY PHYSICIAN ADMINISTRATIVE SERVICES OTHER GENERAL SERVICE	3, 682	0		0 0 0 0 0 0 0 0 0 0	6, 107 0 0	15.00
50.00		0	0		0 0	0	50.00
51.00		3, 511	0		0 0	5.824	
52.00	HOSPICE INPATIENT RESPITE CARE	5	0		0 0	8	52.00
53.00		166	0		0 0	275	53.00
	NONREI MBURSABLE COST CENTERS	· · ·		•			
100.0	VOLUNTEER PROGRAM FUNDRAI SI NG HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS PALLI ATI VE CARE PROGRAM OTHER PHYSI CI AN SERVI CES RESI DENTI AL CARE ADVERTI SI NG TELEHEALTH/TELEMONI TORI NG THRI FT STORE NURSI NG FACI LI TY ROOM & BOARD	65, 834 17. 879957	0 0. 000000	0. 0000	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	61.00 62.00 63.00 64.00 65.00 66.00 67.00 68.00 69.00 70.00 71.00 99.00 100.00

Heal th	Financial Systems	GOOD SAMARIT.	AN HOSPITAL		In Lie	u of Form CMS	-2552-10
	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL SI	ERVICE COSTS	Provider C	CN: 15-0042	Period:	Worksheet 0-	6
STATI S	TI CAL BASI S		Hospi ce CC	N: 15-1526	From 01/01/2023 To 12/31/2023	Part II Date/Time Pr	epared:
						4/11/2024 3:	17 pm
	Cost Center Descriptions	PHYSI CI AN	OTHER GENERAL	PATI ENT/	Hospi ce I		
	Cost center bescriptions	ADMI NI STRATI V	SERVI CE	RESI DENTI AL			
		E SERVICES	(SPECI FY	CARE SERVICE			
		(PATI ENT	BASIS)	(IN-FACILIT			
		DAYS)		DAYS)			
		15.00	16.00	17.00			_
	GENERAL SERVICE COST CENTERS		1	1			1
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00 4.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00 5.00	ADMINISTRATIVE & GENERAL PLANT OPERATION & MAINTENANCE						4.00 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						9.00
10.00	ROUTI NE MEDI CAL SUPPLI ES						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	PHYSI CI AN ADMI NI STRATI VE SERVI CES	0					15.00
16.00	OTHER GENERAL SERVICE		0				16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				0		17.00
	LEVEL OF CARE			1			_
50.00	HOSPICE CONTINUOUS HOME CARE	0					50.00
51.00	HOSPICE ROUTINE HOME CARE	0	-		-		51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0			0		52.00
53.00		0	0)	0		53.00
60, 00	NONREIMBURSABLE COST CENTERS BEREAVEMENT PROGRAM		0	1			60.00
61.00	VOLUNTEER PROGRAM						61.00
62.00	FUNDRAI SI NG						62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS						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		0				67.00
68.00	TELEHEALTH/TELEMONI TORI NG		0				68.00
69.00	THRI FT STORE		0				69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREI MBURSABLE (SPECI FY)	0	0		0		71.00
99.00	NEGATI VE COST CENTER						99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)		0	0.0000	0		100.00
101.00	UNIT COST MULTIPLIER	0. 000000	0. 000000	0.0000	UU		101.00

Heal th	Financial Systems	GOOD SAMARI T	AN HOSPITAL		In Lie	u of Form CMS-2	2552-10
	IONMENT OF HOSPITAL-BASED HOSPICE SHARED SER	VICE COSTS BY	Provider C	CN: 15-0042	Peri od:	Worksheet 0-7	
LEVEL	OF CARE		Hospi ce CC	N: 15-1526	From 01/01/2023 To 12/31/2023		
					Hospi ce I		
				Charges by	LOC (from Provi	der Records)	
	Cost Center Descriptions	From Wkst. C, Part I, Col.	Cost to Charge Ratio	НСНС	HRHC	HI RC	
		9 line					
		0	1.00	2.00	3.00	4.00	
1 00	ANCI LLARY SERVICE COST CENTERS	((00	0 000700		2		1 4 99
1.00 2.00	PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	66.00 67.00			0 0	0	1.00
2.00	SPEECH PATHOLOGY	68.00					3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00			0 0	0	
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00			0 0	0	•
6.00	LABORATORY	60.00	0. 136482		0 0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	1. 497226		0 0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00					8.00
9.00	RADI OLOGY-THERAPEUTI C	55.00			0 0	0	
10.00	MH ANCI LLARY OUTPATI ENT	76.00			0 0	0	
10. 01 11. 00	INPATIENT DIALYSIS	76.01	0. 774977		0 0	0	10.01 11.00
11.00	Totals (sum of lines 1–11)	Charges by		Shared Serv	ce Costs by LOC		11.00
		LOC (from		Sharea Servi	100 00313 by 200		
		Provi der					
		Records)					
	Cost Center Descriptions	HGI P	HCHC (col. 1			HGIP (col. 1	
		F 00	x col. 2)	x col. 3)	x col. 4)	x col. 5)	
	ANCILLARY SERVICE COST CENTERS	5.00	6.00	7.00	8.00	9.00	
1.00	PHYSICAL THERAPY	0	0		0 0	0	1.00
2.00	OCCUPATIONAL THERAPY		0		0	0	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	
6.00	LABORATORY	0	0		0 0	0	
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	
8.00	OTHER OUTPATIENT SERVICE COST CENTER						8.00
9.00	RADI OLOGY-THERAPEUTI C MH ANCI LLARY OUTPATI ENT	0			0 0 0 0	0	
10. 00 10. 01	INPATIENT DIALYSIS				0 0		•
	Totals (sum of lines 1-11)		0		0 0	-	•
		I	. 0	I	S ₁ 0	. 0	1 11.00

ALCULA	ATION OF HOSPITAL-BASED HOSPICE PER DIEM COST	Provider C	CN: 15-0042	Peri od:	Worksheet 0-8	
		Hospi ce CC	N: 15-1526	From 01/01/2023 To 12/31/2023		
				Hospi ce I		
			TITLE XVIII MEDICARE	TITLE XIX MEDICAID	TOTAL	
			1.00	2.00	3.00	
	HOSPICE CONTINUOUS HOME CARE					
	Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst.	0-7, col. 6,			0	1.
	line 11)					
	Total unduplicated days (Wkst. S-9, col. 4, line 10)				0	
	Total average cost per diem (line 1 divided by line 2)				0.00	
	Unduplicated program days (Wkst. S-9 col. as appropriate, ${\sf I}$	ine 10)		0 0		4.
	Program cost (line 3 times line 4)			0 0		5.
	HOSPICE ROUTINE HOME CARE				-	
	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst.	0-7, col. 7,			1, 133, 584	6.
	line 11)					
	Total unduplicated days (Wkst. S-9, col. 4, line 11)				3, 511	
	Total average cost per diem (line 6 divided by line 7)				322.87	
	Unduplicated program days (Wkst. S-9, col. as appropriate,	line 11)	3, 2			9.
	Program cost (line 8 times line 9)		1, 057, 0	76 58, 439		10.
	HOSPICE INPATIENT RESPITE CARE					
	Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst.	0-7, col. 8,			8, 861	11.
	line 11)					
	Total unduplicated days (Wkst. S-9, col. 4, line 12)				5	
	Total average cost per diem (line 11 divided by line 12)				1, 772. 20	
	Unduplicated program days (Wkst. S-9, col. as appropriate,	line 12)		5 0		14
	Program cost (line 13 times line 14)		8,8	61 0		15
	HOSPICE GENERAL INPATIENT CARE		1		1	
	Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst.	0-7, col. 9,			478, 281	16
	line 11)					
	Total unduplicated days (Wkst. S-9, col. 4, line 13)				166	
	Total average cost per diem (line 16 divided by line 17)				2, 881. 21	
	Unduplicated program days (Wkst. S-9, col. as appropriate,	line 13)		66 0		19
	Program cost (line 18 times line 19)		478, 2	81 0		20
	TOTAL HOSPICE CARE		1			
	Total cost (sum of line 1 + line 6 + line 11 + line 16)				1, 620, 726	
	Total unduplicated days (Wkst. S-9, col. 4, line 14)				3, 682	
3.00	Average cost per diem (line 21 divided by line 22)				440. 18	23

ALCULATION OF CAPITAL PAYMENT	F	Period: From 01/01/2023 To 12/31/2023	Worksheet L Parts I-III Date/Time Pre	nare
		0 12/31/2023	4/11/2024 3:1	
	Title XVIII	Hospi tal	PPS	
		-	1.00	
PART I - FULLY PROSPECTIVE METHOD			1.00	
CAPITAL FEDERAL AMOUNT				1
00 Capital DRG other than outlier			1, 107, 849	1 1.
01 Model 4 BPCI Capital DRG other than outlie	c c c c c c c c c c c c c c c c c c c		0	
00 Capital DRG outlier payments			9, 423	
01 Model 4 BPCI Capital DRG outlier payments			0	
	days in the cost reporting period (see instru	uctions)	42.19	
00 Number of interns & residents (see instruc	tions)	,	39. 58	4.
00 Indirect medical education percentage (see	instructions)		30. 30	5.
00 Indirect medical education adjustment (mul	tiply line 5 by the sum of lines 1 and 1.01,	columns 1 and	335, 678	6
1.01) (see instructions)				_
00 Percentage of SSI recipient patient days t 30) (see instructions)	o Medicare Part A patient days (Worksheet E,	part A line	0.00	7
00 Percentage of Medicaid patient days to tot	al days (see instructions)		0.00	
00 Sum of lines 7 and 8			0.00	
.00 Allowable disproportionate share percentag			0.00	
.00 Disproportionate share adjustment (see ins			0	1
.00 Total prospective capital payments (see in	structions)		1, 452, 950	12
		-	1.00	
PART II - PAYMENT UNDER REASONABLE COST				
00 Program inpatient routine capital cost (se			0	
00 Program inpatient ancillary capital cost (0	2
00 Total inpatient program capital cost (line			0	
00 Capital cost payment factor (see instructi			0	
00 Total_inpatient_program_capital_cost (line	3 x line 4)		0	5
			1.00	
PART III - COMPUTATION OF EXCEPTION PAYMEN				
00 Program inpatient capital costs (see instr			0	
00 Program inpatient capital costs for extrao 00 Net program inpatient capital costs (line	3		0	
00 Net program inpatient capital costs (line 00 Applicable exception percentage (see instr			0.00	
00 Capital cost for comparison to payments (1			0.00	
00 Percentage adjustment for extraordinary ci			0.00	
	for extraordinary circumstances (line 2 x	line 6)	0.00	
00 Capital minimum payment level (line 5 plus	3		0	
00 Current year capital payments (from Part I			0	-
	payment level to capital payments (line 8 l	ess line 9)	0	10
.00 Carryover of accumulated capital minimum p Worksheet L, Part III, line 14)	ayment level over capital payment (from prio	r year	0	11.
	evel to capital payments (line 10 plus line	11)	0	12
.00 Current year exception payment (if line 12			0	
.00 Carryover of accumulated capital minimum p			0	
(if line 12 is negative, enter the amount				
.00 Current year allowable operating and capit			0	15
. Oo jourrent year arrowabre operating and capit				
.00 Current year operating and capital costs (.00 Current year exception offset amount (see	see instructions)		0	16 17

	Financial Systems IS OF HOSPITAL-BASED RHC/FQHC COSTS	GOOD SAMARITA	Provi der C	N. 15-0042	Peri od:	u of Form CMS-2 Worksheet M-1	
	IS OF HOST THE BASED KHOT THE COSTS			5N. 13 0042	From 01/01/2023	WOLKSHEET M 1	
			Component (CCN: 15-8577	To 12/31/2023	Date/Time Pre 4/11/2024 3:1	
					RHC I	Cost	
		Compensati on	Other Costs		1 Recl assi fi cat	Recl assi fi ed	
				+ col. 2)	i ons	Trial Balance	
						(col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS	1.00	2.00	0.00	1.00	0.00	
. 00	Physi ci an	8, 977	137	9, 11	4 0	9, 114	1.00
2.00	Physician Assistant	2, 283	0			2, 283	
3.00	Nurse Practitioner	1, 993	0			1, 993	3.00
1.00	Visiting Nurse	0	0		0 0	0	4.00
5.00	Other Nurse	6, 695	0	6, 69	95 0	6, 695	5.00
. 00	Clinical Psychologist	0	0		0 0	0	6.00
. 00	Clinical Social Worker	0	0		0 0	0	7.00
7. 10	Marriage and Family Therapist						7.10
7. 11	Mental Health Counselor						7.1
3. 00	Laboratory Techni ci an	0	0		0 0	0	8.0
9.00	Other Facility Health Care Staff Costs	0	0		0 0	0	9.00
0.00	Subtotal (sum of lines 1 through 9)	19, 948	137	20, 08	35 0	20, 085	10.0
1.00	Physician Services Under Agreement	0	1, 850	1, 85	50 0	1,850	11.0
2.00	Physician Supervision Under Agreement	0	0		0 0	0	12.0
3.00	Other Costs Under Agreement	0	0		0 0	0	13.0
4.00	Subtotal (sum of lines 11 through 13)	0	1, 850	1, 85	50 0	1, 850	14.0
5.00	Medical Supplies	0	0		0 0	0	15.0
6.00	Transportation (Health Care Staff)	0	0		0 0	0	16.0
7.00	Depreciation-Medical Equipment	0	0		0 0	0	17.0
8.00	Professional Liability Insurance	0	0		0 0	0	18.0
9.00	Other Health Care Costs	0	0		0 0	0	19.0
0.00	Allowable GME Costs						20.0
21.00	Subtotal (sum of lines 15 through 20)	0	0		0 0	0	21.0
22.00	Total Cost of Health Care Services (sum of	19, 948	1, 987	21, 93	35 0	21, 935	22.0
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0		0 0	0	23.0
24.00	Dental	0	0		0 0	0	
25.00	Optometry	0	0		0 0	0	
25.01	Tel eheal th	0	0		0 0	0	25.0
5. 02	Chronic Care Management	0	0		0 0	0	
6.00	All other nonreimbursable costs	0	0		0 0	0	
7.00	Nonallowable GME costs		-				27.0
8.00	Total Nonreimbursable Costs (sum of lines 23	0	0		0 0	0	28.0
	through 27)						-
29.00	FACILITY OVERHEAD	0	173	17	73 0	173	29.0
30.00	Facility Costs Administrative Costs	0 1, 889	444, 714			2, 199	
30.00 31.00	Total Facility Overhead (sum of lines 29 and		444, 714 444, 887			2, 199 2, 372	
01. UU	30)	1, 889	444,887	440, /	-444, 404	2,312	31.0
32.00	Total facility costs (sum of lines 22, 28	21, 837	446, 874	468, 7 ⁻	-444, 404	24, 307	32.0
	and 31)	21,037	440,074	400,7	-444, 404	24, 307	52.0

	Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Lieu	of Form CMS	-2552-10
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C	CN: 15-0042	Peri od:	Worksheet M-	1
			Component	CCN: 15-8577	From 01/01/2023 To 12/31/2023	Date/Time Pr 4/11/2024 3:	
					RHC I	Cost	
		Adjustments	Net Expenses		· · ·		
			for				
			Allocation				
			(col. 5 +				
		6.00	col. 6) 7.00	-			
	FACILITY HEALTH CARE STAFF COSTS	0.00	7.00				
1.00	Physi ci an	0	9, 114				1.00
2.00	Physician Assistant	0		1			2.00
3.00	Nurse Practitioner	0	1, 993				3.00
4.00	Visiting Nurse	0	.,,,,,	1			4.00
5.00	Other Nurse	0	6, 695				5.00
6.00	Clinical Psychologist	0	0,0,0	1			6.00
7.00	Clinical Social Worker	0	C	1			7.00
7.10	Marriage and Family Therapist	Ū					7.10
7.11	Mental Health Counselor						7.11
8.00	Laboratory Techni ci an	0	C				8.00
9.00	Other Facility Health Care Staff Costs	0	C				9.00
10.00	Subtotal (sum of lines 1 through 9)	0	20, 085				10.00
11.00	Physician Services Under Agreement	0	1, 850				11.00
12.00	Physician Supervision Under Agreement	0	C				12.00
13.00	Other Costs Under Agreement	0	C				13.00
	Subtotal (sum of lines 11 through 13)	0	1, 850				14.00
15.00	Medical Supplies	0	C	1			15.00
	Transportation (Health Care Staff)	0	C				16.00
	Depreciation-Medical Equipment	0	C				17.00
	Professional Liability Insurance	0	C				18.00
	Other Health Care Costs	0	C				19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	C				21.00
22.00	Total Cost of Health Care Services (sum of	0	21, 935				22.00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES						
	Pharmacy	0					23.00
	Dental	0	C				24.00
25.00	Optometry	0	C				25.00
	Tel eheal th	0	C				25.01
25.02	Chronic Care Management	0	C	1			25.02
26.00	All other nonreimbursable costs	0	C				26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	C				28.00
	through 27)						-
20.00	FACILITY OVERHEAD	0	470				
	Facility Costs	0					29.00
30.00	Administrative Costs	0	-,	1			30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	2, 372				31.00
32.00	Total facility costs (sum of lines 22, 28	0	24, 307				32.00
JZ. 00	and 31)	0	24, 307				1 32.00

	Financial Systems	GOOD SAMARITA			In Lie	u of Form CMS-2	2552-1
ALLOCA	ATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQH	C SERVI CES	Provider C		Period:	Worksheet M-2	
			Component		From 01/01/2023 To 12/31/2023		nared
			component	CON. 13 03/7		4/11/2024 3:1	
			_		RHC I	Cost	
		Number of FTE	Total Visits	Productivity	Mi ni mum	Greater of	
		Personnel		Standard (1)	Visits (col.	col. 2 or	
					1 x col. 3)	col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VI SI TS AND PRODUCTI VI TY						
	Positions		-				
. 00	Physi ci an	0.04		4,200			1.0
2.00	Physician Assistant	0.01	6	2,100			2.0
. 00	Nurse Practitioner	0.01	0	2, 100		010	3.0
. 00	Subtotal (sum of lines 1 through 3)	0.06			210		
. 00	Visiting Nurse	0.00				0	5.0
. 00	Clinical Psychologist	0.00				0	6.0
. 00	Clinical Social Worker	0.00				0	7.0
. 01	Medical Nutrition Therapist (FQHC only)	0.00				0	7.0
. 02	Diabetes Self Management Training (FQHC	0.00	0			0	7.0
7.03	only)						7.0
7.03 7.04	Marriage and Family Therapist Mental Health Counselor						7.0
. 04 8. 00	Total FTEs and Visits (sum of lines 4	0.06	4			210	
5.00	through 7)	0.00	0			210	0.0
9.00	Physician Services Under Agreements		0			0	9.0
. 00	Thysreran services under Agreements					0	7.0
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE	TO HOSPI TAL-BASI	ED RHC/FQHC SE	RVI CES			
0.00	Total costs of health care services (from	Wkst. M-1, col.	7, line 22)			21, 935	10.0
1.00	Total nonreimbursable costs (from Wkst. M-	-1, col. 7, line	28)			0	11. (
2.00	Cost of all services (excluding overhead)	(sum of lines 10	and 11)			21, 935	12. (
3.00	Ratio of hospital-based RHC/FQHC services	(line 10 divided	by line 12)			1.000000	13. (
4.00	Total hospital-based RHC/FQHC overhead - ((from Worksheet.	M-1, col. 7, I	ine 31)		2, 372	14.(
5.00		lity (see instru	ctions)			9, 553	
	Total overhead (sum of lines 14 and 15)					11, 925	
7.00							17.(
8.00						11, 925	
	Overhead applicable to hospital-based RHC/					11, 925	
0 00	Total allowable cost of bespital based DHC	C/FOLIC comulace (our of Linco 1	0 and 10)		22 040	1 20

 20.00
 Total allowable cost of hospital -based RHC/FQHC services (sum of lines 10 and 19)
 33,860
 20.00

alth Financial Systems GOOD SAMARITAN H ALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 15-0042	Peri od:	u of Form CMS-2 Worksheet M-3	
ERVICES	Component CCN: 15-8577	From 01/01/2023 To 12/31/2023	Date/Time Pre 4/11/2024 3:1	pare
	Title XVIII	RHC I	4/11/2024 3.1 Cost	/ piii
DETERMINATION OF DATE FOR HOSPITAL DASED DUC/FOUR SERVICES			1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES 00 Total Allowable Cost of hospital-based RHC/FQHC Services (from	Wkst M 2 lipo 20)		33, 860	1.
00 Cost of injections/infusions and their administration (from Wk	· · · · · ·		33, 800	2.
00 Total allowable cost excluding injections/infusions (line 1 mi			33, 860	3.
00 Total Visits (from Wkst. M-2, column 5, line 8)			210	4.
00 Physicians visits under agreement (from Wkst. M-2, column 5, l	ine 9)		0	5.
00 Total adjusted visits (line 4 plus line 5)			210	6.
00 Adjusted cost per visit (line 3 divided by line 6)			161.24	7.
		Cal cul ati on		
		Rate Period	Rate Period 1	
		N/A	(01/01/2023	
			through	
			12/31/2023)	
		1.00	2.00	
00 Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.	6 or your contractor)	0.00	126.00	8.
00 Rate for Program covered visits (see instructions)		0.00	126.00	9.
CALCULATION OF SETTLEMENT				
0.00 Program covered visits excluding mental health services (from		0	0	
I.00 Program cost excluding costs for mental health services (line	•	0	0	
2.00 Program covered visits for mental health services (from contra		0	0	12
3.00 Program covered cost from mental health services (line 9 x lin		0	0	13
4.00 Limit adjustment for mental health services (see instructions) 5.00 Graduate Medical Education Pass Through Cost (see instructions)		0	0	14. 15.
5.00 Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	·	0	0	16.
5.01 Total program charges (see instructions)(from contractor's rec		0	0	16.
5. 02 Total program preventive charges (see instructions)(from provi			0	16.
5.03 Total program preventive costs ((line 16.02/line 16.01) times	-		Ő	16.
5.04 Total Program non-preventive costs ((line 16 minus lines 16.03	-		0	16.
(Titles V and XIX see instructions.)	, , ,			
5.05 Total program cost (see instructions)		0	0	16.
7.00 Primary payer amounts			0	17.
B.00 Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		0	18.
records)				
9.00 Beneficiary coinsurance for RHC/FQHC services (see instruction	is) (from contractor		0	19.
records)	>		0	0
0.00 Net program cost excluding injections/infusions (see instructi			0	20.
I.OO Program cost of vaccines and their administration (from Wkst. I.50 Total program IOP OPPS payments (see instructions)	M-4, ITTTE 16)		0	21
1.55 Total program IOP Costs (see instructions)				21
1.60 Program IOP coinsurance (see instructions)				21
2.00 Total reimbursable Program cost (sum of lines 20, 21, 21.50, m	inus line 21 60)		0	
B. 00 Allowable bad debts (see instructions)			0	
8. 01 Adjusted reimbursable bad debts (see instructions)			Ő	
1.00 Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		0	
5. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	,		0	25
5.50 Pioneer ACO demonstration payment adjustment (see instructions	.)		0	25.
5.99 Demonstration payment adjustment amount before sequestration			0	25.
5.00 Net reimbursable amount (see instructions)			0	26.
5.01 Sequestration adjustment (see instructions)			0	26
5.02 Demonstration payment adjustment amount after sequestration			0	26
7.00 Interim payments			0	27
3.00 Tentative settlement (for contractor use only)			0	28.
	12 27 and 28)		0	29.
0.00 Balance due component/program (line 26 minus lines 26.01, 26.0).00 Protested amounts (nonallowable cost report items) in accordan			0	30.