This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 09-30-2025 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 14-0046 Worksheet S Peri od: From 01/01/2023 Parts I-III AND SETTLEMENT SUMMARY 12/31/2023 Date/Time Prepared: 5/21/2024 10:06 am PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 5/21/2024 Time: 10:06 am use only] Manually prepared cost report Ilf this is an amended report enter the number of times the provider resubmitted this cost report [Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

[1] Cost Report Status
[1] As Submitted
[2] Settled without Audit
[3] Settled with Audit
[4] Date Received:
[5] To. NPR Date:
[6] 10. NPR Date:
[7] 11. Contractor's Vendor Code:
[7] 12. [8] Initial Report for this Provider CCN
[9] [8] Final Report for this Provider CCN
[10] NPR Date:
[11] 12. NPR Date:
[12] 13. NPR Date:
[13] 14. NPR Date:
[14] 15. NPR Date:
[15] 15. NPR Date:
[16] 16. NPR Date:
[17] 17. NPR Date:
[18] 17. NPR Date:
[18] 18. NPR Date:
[18] 18. NPR Date:
[18] 19. NPR

number of times reopened = 0-9.

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

(3) Settled with Audit

(4) Reopened (5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by SSM HEALTH GOOD SAMARITAN HOSPITAL (14-0046) for the cost $reporting \ period \ beginning \ 01/01/2023 \ and \ ending \ 12/31/2023 \ and \ to \ the \ best \ of \ my \ knowledge \ and \ belief, \ this$ report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

			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	-14, 907	-172, 732	0	0	1. 00
2.00	SUBPROVI DER - I PF	0	0	0		0	2. 00
3.00	SUBPROVI DER - I RF	0	976, 624	0		0	3. 00
5.00	SWING BED - SNF	0	0	0		0	5. 00
6.00	SWING BED - NF	0				0	6.00
200.00	TOTAL	0	961, 717	-172, 732	0	0	200. 00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The 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.

Contractor use only

Health Financial Systems SSM HEALTH GOOD SAMARITAN HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 14-0046 Peri od: Worksheet S-2 From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/21/2024 10:06 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 1 GOOD SAMARITAN WAY 1.00 PO Box: 1.00 2.00 City: MT. VERNON State: IL Zip Code: 62864 County: JEFFERSON 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N)

/ XVIII XIX Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: SSM HEALTH GOOD 3.00 140046 99914 07/01/1966 Ν 3.00 1 SAMARITAN HOSPITAL Subprovi der - IPF 4.00 4 00 GOOD SAMARITAN 5.00 Subprovider - IRF 14T046 99914 5 01/01/1990 Ν Ρ Р 5.00 REHABILITATION UNIT 6.00 Subprovi der - (Other) 6.00 Swi ng Beds - SNF Swi ng Beds - NF 7.00 7.00 8.00 8.00 9.00 Hospi tal -Based SNF 9.00 10.00 Hospi tal -Based NF 10.00 Hospi tal -Based OLTC 11.00 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 14.00 Hospi tal -Based Hospi ce 14 00 15.00 Hospital-Based Health Clinic - RHC 15.00 Hospital - Based Health Clinic - FQHC 16.00 16.00 17.00 Hospital -Based (CMHC) I 17.00 18.00 Renal Dialysis 18 00 19.00 Other 19.00 From: To: 1.00 2 00 20.00 Cost Reporting Period (mm/dd/yyyy) 12/31/2023 01/01/2023 20.00 21.00 Type of Control (see instructions) 21.00 1. 00 2. 00 3 00 Inpatient PPS Information 22. 00 Does this facility qualify and is it currently receiving payments for Υ N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no 22.01 Υ 22.01 for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires a final UCP to be Ν N 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to N 22 03 N N rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 22.04 Did this hospital receive a geographic reclassification from urban to 22.04 rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.

23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 23.00 3 Ν below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.

	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ATA	Provider CC	N: 14-0046	Period: From 01/		Par		
					To 12/	′31/2023		e/Ti me 1/2024	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medic HMO d	lays	Other Medica days	i d
. 00	If this provider is an IPPS hospital, enter the	1.00	2. 00	3. 00	4. 00	5.0	0 5, 478	6.00	74 2
5. 00	in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	22					93		2
						'Rural S	Date		ogr
. 00	Enter your standard geographic classification (not wa	ane) status	at the boo	inning of t		. 00	2	2. 00	2
. 00	cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not ware reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassification of this is a sole community hospital (SCH), enter the	r rural. age) status r "2" for r ication in	at the end ural. If ap column 2.	of the cos	st	2	2		2
. 00	effect in the cost reporting period.	- Trainber of							
						nni ng: . 00	E	2. 00	
. 00	Enter applicable beginning and ending dates of SCH s		cript line	36 for numb		. 00		2.00	3
. 00	of periods in excess of one and enter subsequent date If this is a Medicare dependent hospital (MDH), enter		r of period	ls MDH stati	ıs	(0		3
	is in effect in the cost reporting period.				.5	`			
	Is this hospital a former MDH that is eligible for the accordance with FY 2016 OPPS final rule? Enter "Y" for instructions)	or yes or "	N" for no.	(see					3
3. 00	If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.								3
						<u>//N</u> . 00		Y/N 2. 00	
	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii) or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octol), (ii), or the mileage ii)? Enter n adjustmen	(iii)? Ent requiremen in column 2 t? Enter "Y	er in colum its in !"Y" for ye	me nn es or	N N		N N	3
	no in column 2, for discharges on or after October 1.			C3 01 11 1	01		<u> </u>		
						1. 0			00
	Prospective Payment System (PPS)-Capital								
. 00	Does this facility qualify and receive Capital paymer with 42 CFR Section §412.320? (see instructions)	nt for disp	roporti onat	e share in	accordance	e N		N	N 4
. 00	Is this facility eligible for additional payment excepursuant to 42 CFR §412.348(f)? If yes, complete Wks. Pt. III.					N		N	N 4
	Is this a new hospital under 42 CFR §412.300(b) PPS of					N			N 4
. 00	Is the facility electing full federal capital paymen ⁻ Teaching Hospitals	ir Enter "	ı ıor yes	UI IN TOP	IIU.	N		N	N 4
	Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penul timate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter					5			
. 00		CRs) MA dir	ect GME pay	ment reduct	ion? Ente				

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 14-0046 Peri od: Worksheet S-2 From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/21/2024 10: 06 am 1. 00 2.00 3.00 59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I Ν 59.00 NAHE 413.85 Worksheet A Pass-Through Y/N Line # Qual i fi cati on Criterion Code 1.00 2.00 3.00 60.00 Are you claiming nursing and allied health education (NAHE) costs for 60.00 any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2. 60.01 If line 60 is yes, complete columns 2 and 3 for each program. (see 23.00 60.01 instructions) IME Direct GME IME Direct GME 1.00 2.00 3. 00 4.00 5.00 61.00 Did your hospital receive FTE slots under ACA 0.00 61.00 0.00 section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 61.01 Enter the average number of unweighted primary care 61.01 FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care 61.02 FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 61.03 Enter the base line FTE count for primary care 61.03 and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) 61 04 Enter the number of unweighted primary care/or 61 04 surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 61.05 Enter the difference between the baseline primary 61.05 and/or general surgery FTEs and the current year' primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)
61.06 Enter the amount of ACA §5503 award that is being 61 06 used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Unweighted IME Unweighted Program Name Program Code FTF Count Direct GME FTE Count 1.00 2. 00 3.00 4.00 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, the direct GME FTE unweighted count. 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 0.00 62.00 62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions) 62. 01 0.00 62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions) 63.00

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

	To To	12/31/2023						
			1.00					
68. 00	<u>Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, For a cost reporting period beginning prior to October 1, 2022, did you obtain permissic MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR (August 10, 2022)?</u>	n from your		68. 00				
		1.00	2.00 3.00					
70. 00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subp	rovi der? N		70. 00				
71. 00	Enter "Y" for yes or "N" for no. If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in trecent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for n 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teach program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for n Column 3: If column 2 is Y, indicate which program year began during this cost reporting (see instructions)	he most o. (see i ng o.	0	71. 00				
75. 00	Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF	Y		75. 00				
76. 00	subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in trecent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or no. Column 2: Did this facility train residents in a new teaching program in accordance CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	"N" for	N O	76. 00				
			1. 00	-				
80. 00	Long Term Care Hospital PPS Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N	80.00				
81. 00								
85. 00 86. 00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.							
87. 00	87.00 Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.							
		Approved for Permanent Adjustment (Y/N)	Number of Approved Permanent Adjustments					
88. 00	Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instructions) Column 2: Enter the number of approved permanent adjustments.	1. 00 N	2.00	0 88.00				
		Effective Date	Approved Permanent Adjustment Amount Per Discharge 3.00					
89. 00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.			9.00				
		V 1. 00	XI X 2. 00					
90. 00	Title V and XIX Services Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for	N	Υ	90.00				
	yes or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91. 00				
92. 00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see		N	92. 00				
93. 00	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 and XIX? Enter	N	N	93. 00				
94. 00	"Y" for yes or "N" for no in the applicable column. Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the	N	N	94. 00				
95. 00 96. 00	applicable column. If line 94 is "Y", enter the reduction percentage in the applicable column. Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the	0. 00 N	0. 00 N	95. 00 96. 00				
97. 00	applicable column. If line 96 is "Y", enter the reduction percentage in the applicable column.	0. 00	0.00	97. 00				

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	MARITAN HOSPIT Provider C	CN: 14-0046 F	Peri od:	worksheet S-	-2
			rom 01/01/2023 o 12/31/2023		
			V	5/21/2024 10 XI X): 06 an
			1. 00	2.00	
28.00 Does title V or XIX follow Medicare (title XVIII) for the instepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" column 1 for title V, and in column 2 for title XIX.			Y	Y	98. 0
Does title V or XIX follow Medicare (title XVIII) for the r. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for t title XIX.			Y	Y	98. (
Does title V or XIX follow Medicare (title XVIII) for the countries bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes for title V, and in column 2 for title XIX.	Y	Y	98. (
28.03 Does title V or XIX follow Medicare (title XVIII) for a cri reimbursed 101% of inpatient services cost? Enter "Y" for y for title V, and in column 2 for title XIX.	N	N	98. (
Des title V or XIX follow Medicare (title XVIII) for a CAH outpatient services cost? Enter "Y" for yes or "N" for no i in column 2 for title XIX.			N	N	98. (
Does title V or XIX follow Medicare (title XVIII) and add b Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 2 for title XIX.			Y	Y	98. (
Does title V or XIX follow Medicare (title XVIII) when cost Pts. I through IV? Enter "Y" for yes or "N" for no in column column 2 for title XIX.			Y	Y	98. (
Rural Providers 05.00Does this hospital qualify as a CAH?			N N		105.
106.00 of this facility qualifies as a CAH, has it elected the all for outpatient services? (see instructions)	-inclusive met	hod of payment			106.
07.00 Column 1: If line 105 is Y, is this facility eligible for contraining 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 approved medical education program in the CAH's excluded	n 1. (see ins you train I&R	tructions) s in an			107.
Enter "Y" for yes or "N" for no in column 2. (see instruct 07.01 If this facility is a REH (line 3, column 4, is "12"), is i reimbursement for L&R training programs? Enter "Y" for yes	ions) t eligible for	cost			107.
instructions) 08.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	CRNA fee sche	dul e? See 42	N		108.
	Physi cal	Occupati onal	Speech	Respi ratory	<u>′ </u>
09 00 of this hospital qualifies as a CAH or a cost provider are	1.00	2.00	3.00	4.00	
09.00 of 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.	1.00				
therapy services provided by outside supplier? Enter "Y"	1.00	2.00	3.00	4.00	
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	1.00 N al Demonstrati "Y" for yes or	2.00 N on project (§4 "N" for no. I	3.00 N	4. 00 N	109.
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 complete Worksheet E, Part A, Lines 200 through 218, and Wo	1.00 N al Demonstrati "Y" for yes or	2.00 N on project (§4 "N" for no. I	3.00 N 10A f yes, gh 215, as	4.00 N	109.
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 complete Worksheet E, Part A, lines 200 through 218, and Wo applicable. 11.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this compart of the response to complete the response to the	al Demonstrati "Y" for yes or rksheet E-2, I the Frontier C ost reporting olumn 1 is Y, rticipating in	on project (§4 "N" for no. I i nes 200 throu ommunity period? Enter enter the column 2.	3.00 N	4.00 N	109.
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 complete Worksheet E, Part A, lines 200 through 218, and Wo applicable. 11.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this comparting the response to contegration prong of the FCHIP demo in which this CAH is participate.	al Demonstrati "Y" for yes or rksheet E-2, I the Frontier C ost reporting olumn 1 is Y, rticipating in	on project (§4 "N" for no. I ines 200 throu ommunity period? Enter enter the column 2. ; and/or "C"	3.00 N	4. 00 N	109.
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 complete Worksheet E, Part A, lines 200 through 218, and Wo applicable. 11.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this comparties of the response to complete the response to compart the response to the respo	al Demonstrati "Y" for yes or rksheet E-2, I the Frontier C ost reporting ol umn 1 is Y, rticipating in dditional beds	on project (§4 "N" for no. I i nes 200 throu ommunity period? Enter enter the column 2. ; and/or "C"	3. 00 N 10A f yes, gh 215, as	4.00 N	110.
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 Hospit. Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable. 11.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this compart of the response to complete the response to complete the response to compart of the following the followi	al Demonstrati "Y" for yes or rksheet E-2, I the Frontier C ost reporting olumn 1 is Y, rticipating in dditional beds Ith Model eporting olumn 1 is pating in the	on project (§4 "N" for no. I ines 200 throu ommunity period? Enter enter the column 2. ; and/or "C"	3.00 N	4. 00 N	110.
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 complete Worksheet E, Part A, lines 200 through 218, and Wo applicable. 11.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this compart of the response to complete the response to compart of the response to the r	al Demonstrati "Y" for yes or rksheet E-2, I the Frontier C ost reporting olumn 1 is Y, rticipating in dditional beds Ith Model eporting olumn 1 is pating in the ased r "N" for no B, or E only) 93" percent (includes	on project (§4 "N" for no. I i nes 200 throu ommunity period? Enter enter the column 2. ; and/or "C"	3.00 N	4. 00 N	1109.
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 complete Worksheet E, Part A, lines 200 through 218, and Wo applicable. 11.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this c "Y" for yes or "N" for no in column 1. If the response to c integration prong of the FCHIP demo in which this CAH is pa Enter all that apply: "A" for Ambulance services; "B" for a for tele-health services. 12.00 Did this hospital participate in the Pennsylvania Rural Hea (PARHM) demonstration for any portion of the current cost reperiod? Enter "Y" for yes or "N" for no in column 1. If c "Y", enter in column 2, the date the hospital began participation. In column 3, enter the date the hospital ceparticipation in the demonstration, if applicable. Miscellaneous Cost Reporting Information 15.00 Is this an all-inclusive rate provider? Enter "Y" for yes o in column 1. If column 1 is yes, enter the method used (A, in column 2. If column 2 is "E", enter in column 3 either "for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provide the definition in CMS Pub. 15-1, chapter 22, §2208.1.	al Demonstrati "Y" for yes or rksheet E-2, I the Frontier C ost reporting olumn 1 is Y, rticipating in dditional beds Ith Model eporting olumn 1 is pating in the ased r "N" for no B, or E only) 93" percent (includes rs) based on	on project (§4 "N" for no. I i nes 200 throu ommunity period? Enter enter the column 2. ; and/or "C"	3.00 N	4. 00 N	1109.
for yes or "N" for no for each therapy. 10.00 Did this hospital participate in the Rural Community Hospit Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable. 11.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this c "Y" for yes or "N" for no in column 1. If the response to c integration prong of the FCHIP demo in which this CAH is pa Enter all that apply: "A" for Ambulance services; "B" for a for tele-health services. 12.00 Did this hospital participate in the Pennsylvania Rural Hea (PARHM) demonstration for any portion of the current cost reperiod? Enter "Y" for yes or "N" for no in column 1. If c "Y", enter in column 2, the date the hospital began participation. In column 3, enter the date the hospital ceparticipation in the demonstration, if applicable. Miscellaneous Cost Reporting Information 15.00 Is this an all-inclusive rate provider? Enter "Y" for yes o in column 1. If column 1 is yes, enter the method used (A, in column 2. If column 2 is "E", enter in column 3 either "for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provide	al Demonstrati "Y" for yes or rksheet E-2, I the Frontier C ost reporting olumn 1 is Y, rticipating in dditional beds Ith Model eporting olumn 1 is pating in the ased r "N" for no B, or E only) 93" percent (includes rs) based on	on project (§4 "N" for no. I i nes 200 throu ommunity period? Enter enter the column 2. ; and/or "C"	3.00 N	4. 00 N	1109. 1110. 1111. 1112. 0115.

142.	00 Street: 12800 CORPORATE HILL DRIVE	PO Box:					142. 00
143.	00 City: ST. LOUIS	State:	MO	Zi p Code:	6313	1	143. 00
						1.00	
144.	00 Are provider based physicians' cos-	ts included in Wo	rksheet A?			Υ	144. 00
					1. 00	2.00	
145.	00 If costs for renal services are cla	aimed on Wkst. A,	line 74, are th	e costs for	Υ		145. 00
	inpatient services only? Enter "Y"	for yes or "N" f	or no in column	1. If column 1 is			
	no, does the dialysis facility incl			s cost reporting			
	period? Enter "Y" for yes or "N" t						
146.	00 Has the cost allocation methodology				N		146. 00
	Enter "Y" for yes or "N" for no in			apter 40, §4020) If			
	yes, enter the approval date (mm/do	d/yyyy) in column	2.				

Health Financial Systems		SAMARITAN HOSPITA		Peri o		u of Form CMS	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provider CC			a: 01/01/2023 12/31/2023		epared:
						5/21/2024 10): 06 am
						1.00	_
147.00 Was there a change in the statisti	cal basis? Enter "Y" f	or ves or "N" for	no.			1. 00 N	147. 00
148.00 Was there a change in the order of						N	148. 00
149.00 Was there a change to the simplifi				or no.		N	149.00
		Part A	Part E	3	Title V	Title XIX	
		1. 00	2.00		3. 00	4. 00	
Does this facility contain a provi							
or charges? Enter "Y" for yes or '	N" for no for each com			3. (See 4			155 00
155.00 Hospi tal 156.00 Subprovi der - TPF		N N	N N		N N	N N	155. 00 156. 00
157. 00 Subprovi der – TRF		N N	l N		N N	N N	157. 00
158. 00 SUBPROVI DER		IV.	"		IV	IN IN	158. 00
159. 00 SNF		N	l N		N	N	159. 00
160.00 HOME HEALTH AGENCY		N N	l N		N	N N	160.00
161. 00 CMHC			N N		N	N	161. 00
		<u>'</u>					
						1.00	
Mul ti campus							
165.00 Is this hospital part of a Multica	mpus hospital that has	one or more campu	uses in dit	ferent C	BSAs?	N	165. 00
Enter "Y" for yes or "N" for no.	Name	County	State	Zip Code	CBSA	FTE/Campus	
	0	1. 00	2.00	3. 00	4. 00	5. 00	_
166.00 If line 165 is yes, for each	U	1.00	2.00	3.00	4.00		00 166. 00
campus enter the name in column							, , , , , ,
O, county in column 1, state in							
column 2, zip code in column 3,							
CBSA in column 4, FTE/Campus in							
column 5 (see instructions)							
						1.00	
Health Information Technology (HI) incentive in the Ame	erican Recovery and	d Reinvest	ment Act		1.00	
167.00 Is this provider a meaningful user				norre not		Υ	167. 00
168.00 If this provider is a CAH (line 10				/"), ente	r the		168. 00
reasonable cost incurred for the H							
168.01 If this provider is a CAH and is r					dshi p		168. 01
exception under §413.70(a)(6)(ii)?							
169.00 If this provider is a meaningful u		and is not a CAH ((line 105 i	s "N"),	enter the	0.0	00 169. 00
transition factor. (see instruction	ins)			D	egi nni ng	Endi ng	
				Ь	1. 00	2. 00	-
170.00 Enter in columns 1 and 2 the EHR k	eginning date and endi	ng date for the re	eporti na		1.00	2.00	170. 00
period respectively (mm/dd/yyyy)	egg date did end	ing data for the re	5pog				1,70,00
					4 00	2.00	
171.00 fline 167 is "Y", does this prov	idor havo any daya fan	individual a open	Lodin		1. 00 N	2.00	0 171. 00
					IV		9171.00
section 1976 Medicare cost plans r	anortad on Wkst C 2	Dt I line 2 col	62 Enta	-			1
section 1876 Medicare cost plans r "Y" for yes and "N" for no in colu							

Heal th	Financial Systems SSM HEALTH GOOD SA	AMARITAN HOSPIT	ΆΙ	In lie	u of Form CMS-:	2552-10	
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Fr		Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II		
				10 12/31/2023	5/21/2024 10:		
			iption	Y/N	Y/N		
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R		0	1. 00 N	3. 00 N	20.00	
	Report data for Other? Describe the other adjustments:			14	.,,	20.00	
		Y/N	Date	Y/N	Date		
21. 00	Was the cost report prepared only using the provider's	1. 00 N	2. 00	3. 00 N	4. 00	21. 00	
21.00	records? If yes, see instructions.					21.00	
					1. 00		
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	EPT CHILDRENS H	IOSPI TALS)				
22.00	Capital Related Cost	a i notrupti ono				1 22 00	
22. 00 23. 00	Have assets been relifed for Medicare purposes? If yes, see Have changes occurred in the Medicare depreciation expense		als made duri	na the cost		22.00	
20.00	reporting period? If yes, see instructions.	ado to appiare	ar o mado dar .	g : 0001		20.00	
24. 00	Were new leases and/or amendments to existing leases entered of the second second leases and/or amendments to existing leases entered in the second s	ed into during	this cost rep	orting period?		24. 00	
25. 00	Have there been new capitalized leases entered into during instructions.	the cost repor	ting period?	If yes, see		25. 00	
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during thinstructions.	he cost reporti	ng period? If	yes, see		26. 00	
27. 00	Has the provider's capitalization policy changed during the copy.	e cost reportir	ng period? If	yes, submit		27. 00	
	Interest Expense						
28. 00	Were new Loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.						
29. 00	00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund)						
30. 00							
31. 00	instructions. 00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see						
	instructions. Purchased Services						
32. 00		tractual		32. 00			
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 app		ng to competit	ive bidding? If		33. 00	
	no, see instructions. Provider-Based Physicians					+	
34.00		arrangement wit	h provider-ba	sed physicians?		34. 00	
35. 00	If yes, see instructions. If line 34 is yes, were there new agreements or amended exi	istina aareemer	nts with the n	rovi der-hased		35. 00	
	physicians during the cost reporting period? If yes, see in				_	33.00	
				Y/N 1. 00	Date 2.00		
	Home Office Costs			1.00	2.00		
36.00	Were home office costs claimed on the cost report?			Y		36. 00	
37. 00		repared by the	home office?	Y		37. 00	
38. 00	If yes, see instructions. If line 36 is yes , was the fiscal year end of the home of	fice different	from that of	N		38. 00	
39. 00	the provider? If yes, enter in column 2 the fiscal year end of line 36 is yes, did the provider render services to other			Y		39. 00	
	see instructions.	·					
40. 00	If line 36 is yes, did the provider render services to the instructions.	nome office?		N		40. 00	
		2.	00	+			
	Cost Report Preparer Contact Information						
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	JENNI FER		COHEN		41. 00	
42. 00	respectively. Enter the employer/company name of the cost report	SSM HEALTH				42. 00	
	preparer.			JENNI EED OOUEN	SCOMUEAL THE SCO		
43. 00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-989-3939		JENNI FER. COHEN	©SSMHEALIH. COM 	43. 00	

Heal th	Financial Systems	SSM HEALTH GOOD	SAMAR	ITAN HOSPITAL		In Li€	eu of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT	QUESTI ONNAI RE		Provider CCN	: 14-0046	Peri od:	Worksheet S-2	2
						From 01/01/2023 To 12/31/2023	Part II Date/Time Pre	nared.
						10 12/31/2023	5/21/2024 10:	06 am
				3.00)			
	Cost Report Preparer Contact Information							
41.00	Enter the first name, last name and the t	itle/position	REG	IONAL DIRECTO	R GOVERNMEN	IT		41.00
	held by the cost report preparer in colum	ns 1, 2, and 3,	REI	MBUR				
	respecti vel y.							
42. 00	Enter the employer/company name of the co	st report						42. 00
	preparer.							
43. 00	Enter the telephone number and email addr							43. 00
	report preparer in columns 1 and 2, respe	ecti vel y.						

Health Financial Systems SSM HEALTH GOOD SAMARITAN HOSPITAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN:

Provider CCN: 14-0046

In Lieu of Form CMS-2552-10

Period: Worksheet S-3

From 01/01/2023 Part I

To 12/31/2023 Date/Time Prepared: 5/21/2024 10:06 am

				'	0 12/01/2020	5/21/2024 10:	06 am
						I/P Days / O/P	
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH/REH Hours	Title V	
		Li ne No.		Avai I abl e			
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00	95	34, 675	0.00	0	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
0.00	for the portion of LDP room available beds)						0.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO I PF Subprovi der						3. 00
4.00	HMO I RF Subprovi der						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5. 00
6.00	Hospi tal Adul ts & Peds. Swing Bed NF		0.5	0.4 / 7.5		0	6. 00
7.00	Total Adults and Peds. (exclude observation		95	34, 675	0.00	0	7. 00
0.00	beds) (see instructions)	04.00	4.1	F 040	0.00		0.00
8.00	INTENSIVE CARE UNIT	31. 00	16	5, 840	0.00	0	8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)	42.00				0	12.00
13.00	NURSERY	43. 00		40 515	0.00	0	13.00
14. 00 15. 00	Total (see instructions)		111	40, 515	0.00	0	14. 00 15. 00
15. 00	CAH visits				0.00	0	15. 00
	REH hours and visits				0.00	U	
16. 00 17. 00	SUBPROVI DER - I PF SUBPROVI DER - I RF	41. 00	10	3, 650		0	16. 00 17. 00
18. 00	SUBPROVIDER - TRE	41.00	10	3, 650	,	U	17.00
19. 00	4						19. 00
20.00	SKILLED NURSING FACILITY NURSING FACILITY						20. 00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPICE						24. 00
24. 10	HOSPICE (non-distinct part)	30. 00					24. 10
25. 00	CMHC - CMHC	30.00					25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00				0	26. 25
27. 00	Total (sum of lines 14-26)	07.00	121				27. 00
28. 00	Observation Bed Days		121			0	28. 00
29. 00	Ambul ance Tri ps						29. 00
30. 00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days - IRF						31. 00
32. 00	Labor & delivery days (see instructions)		0	(32. 00
32. 01	Total ancillary labor & delivery room		Ĭ				32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days						33. 00
33. 01	LTCH site neutral days and discharges						33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30. 00	0	C		0	34.00
	· · · · · · · · · · · · · · · · · · ·		'			•	

34.00

0

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0046

Peri od: Worksheet S-3 From 01/01/2023 Part I Date/Time Prepared: 12/31/2023

5/21/2024 10:06 am Full Time Equivalents I/P Days / O/P Visits / Trips Title XVIII Component Title XIX Total All Total Interns Employees On Pati ents & Residents Payrol I 6.00 10.00 7.00 8.00 9.00 PART I - STATISTICAL DATA Hospital Adults & Peds. (columns 5, 6, 7 and 25, 208 1.00 11, 378 306 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) 4,927 5, 022 2.00 3.00 HMO IPF Subprovider 3.00 4.00 HMO IRF Subprovider 79 280 4.00 Hospital Adults & Peds. Swing Bed SNF 5.00 0 C 0 5.00 6.00 Hospital Adults & Peds. Swing Bed NF 6.00 Total Adults and Peds. (exclude observation 7.00 11, 378 306 25, 208 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8.00 1.069 37 2.551 8.00 9.00 CORONARY CARE UNIT 9.00 10.00 BURN INTENSIVE CARE UNIT 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 OTHER SPECIAL CARE (SPECIFY) 12.00 12.00 13.00 NURSERY 1,551 2,093 13.00 Total (see instructions) 1, 894 747.50 14.00 12, 447 29, 852 0.00 14.00 CAH visits 15.00 C 15.00 15.10 REH hours and visits 0 C 0 15.10 16.00 SUBPROVIDER - IPF 16.00 SUBPROVIDER - IRF 17.00 1, 236 22 2, 360 0.00 20.14 17.00 18 00 SUBPROVI DER 18 00 SKILLED NURSING FACILITY 19.00 19.00 20.00 NURSING FACILITY 20.00 OTHER LONG TERM CARE 21.00 21.00 HOME HEALTH AGENCY 22 00 22 00 23.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 24. 00 HOSPI CE 24.00 24. 10 HOSPICE (non-distinct part) 0 24. 10 CMHC - CMHC 25.00 25.00 26.00 RURAL HEALTH CLINIC 26.00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0.00 0.00 26.25 Total (sum of lines 14-26) 767.64 27.00 27.00 0.00 28 00 Observation Bed Days 585 1,012 28 00 29. 00 Ambul ance Trips 29.00 30.00 Employee discount days (see instruction) 208 30.00 Employee discount days - IRF 31.00 87 31.00 32.00 Labor & delivery days (see instructions) 74 578 32.00 Total ancillary labor & delivery room 32.01 0 32.01 outpatient days (see instructions) 33.00 33.00 LTCH non-covered days LTCH site neutral days and discharges

33.01

34.00 Temporary Expansion COVID-19 PHE Acute Care

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

34.00 Temporary Expansion COVID-19 PHE Acute Care

Provider CCN: 14-0046

Peri od: Worksheet S-3 From 01/01/2023 Part I To 12/31/2023 Date/Time Prepared:

5/21/2024 10:06 am Full Time Di scharges Equi val ents Title XVIII Total All Component Nonpai d Title V Title XIX Workers Pati ents 12.00 13.00 14.00 15.00 11.00 PART I - STATISTICAL DATA Hospital Adults & Peds. (columns 5, 6, 7 and 1.00 2,714 123 11,081 1.00 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2.00 HMO and other (see instructions) 1,032 1, 791 2.00 3.00 HMO IPF Subprovider 3.00 4.00 HMO IRF Subprovider 4.00 16 Hospital Adults & Peds. Swing Bed SNF 5.00 5 00 6.00 Hospital Adults & Peds. Swing Bed NF 6.00 Total Adults and Peds. (exclude observation 7.00 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8.00 8.00 9.00 CORONARY CARE UNIT 9.00 10.00 10.00 BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT 11.00 11.00 OTHER SPECIAL CARE (SPECIFY) 12.00 12.00 13.00 NURSERY 13.00 Total (see instructions) 11, 081 14.00 0.00 2,714 123 14.00 CAH visits 15.00 15.00 15.10 REH hours and visits 15. 10 16.00 SUBPROVIDER - IPF 16.00 SUBPROVIDER - IRF 17.00 0.00 104 2 198 17.00 18 00 SUBPROVI DER 18 00 SKILLED NURSING FACILITY 19.00 19.00 20.00 NURSING FACILITY 20.00 OTHER LONG TERM CARE 21.00 21.00 HOME HEALTH AGENCY 22 00 22 00 23.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 24. 00 HOSPI CE 24.00 24. 10 HOSPICE (non-distinct part) 24. 10 CMHC - CMHC 25.00 25 00 26.00 RURAL HEALTH CLINIC 26.00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0.00 26.25 Total (sum of lines 14-26) 0.00 27.00 27.00 28 00 Observation Bed Days 28 00 29. 00 Ambul ance Trips 29.00 30.00 Employee discount days (see instruction) 30.00 Employee discount days - IRF 31.00 31.00 32.00 Labor & delivery days (see instructions) 32.00 Total ancillary labor & delivery room 32.01 32.01 outpatient days (see instructions) 33.00 LTCH non-covered days 33.00 0 33.01 LTCH site neutral days and discharges 0 33.01

Health Financial Systems SSM HEALTH GOOD SAMARITAN HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL WAGE INDEX INFORMATION Provider CCN: 14-0046 Peri od: Worksheet S-3 From 01/01/2023 Part II 12/31/2023 Date/Time Prepared: 5/21/2024 10:06 am Wkst. A Line Amount Recl assi fi cati Adj usted Paid Hours Average Hourly on of Salaries Number Reported Sal ari es Related to Wage (col. 4 (col.2 ± col (from Wkst. Salaries in col. 5) A-6)3) col. 4 2.00 5.00 6. 00 1.00 3.00 4.00 PART II - WAGE DATA SALARI ES 1.00 200. 00 63, 241, 959 63, 241, 959 1, 550, 961. 92 40. 78 1.00 Total salaries (see instructions) 2.00 Non-physician anesthetist Part 0 0 0.00 0.00 2.00 3.00 Non-physician anesthetist Part 0 0.00 0.00 3.00 4.00 Physician-Part A -0 0.00 0.00 4.00 Administrative 4.01 Physicians - Part A - Teaching 0 0.00 0.00 4.01 Physician and Non 0 0.00 5.00 0.00 5.00 Physician-Part B Non-physician-Part B for 6.00 0.00 0.00 6.00 hospital-based RHC and FQHC servi ces 7.00 Interns & residents (in an 21.00 0 0.00 0.00 7.00 approved program) 7.01 Contracted interns and 0.00 0.00 7.01 residents (in an approved programs) Home office and/or related 8.00 1, 536, 114 0 1, 536, 114 12, 100. 22 126.95 8.00 organization personnel 9.00 44.00 0.00 0.00 9.00 2, 820, 211 2, 820, 211 10.00 Excluded area salaries (see 60, 561. 83 46.57 10.00 instructions) OTHER WAGES & RELATED COSTS 11.00 Contract labor: Direct Patient 6,608,956 6, 608, 956 59, 863. 26 110. 40 11.00 0.00 12.00 Contract labor: Top level 0 0.00 12.00 management and other management and administrative servi ces Contract Labor: Physician-Part 13.00 484, 596 484, 596 1, 221. 75 396.64 13.00 A - Administrative Home office and/or related 14.00 0.00 0.00 14.00 organization salaries and wage-related costs 160, 307. 90 9, 815, 077 9, 815, 077 14.01 Home office salaries 61. 23 14.01 14.02 Related organization salaries 0.00 0.00 14.02 15.00 Home office: Physician Part A 0 0 0.00 0.00 15.00 - Administrative Home office and Contract 0 0.00 0.00 16.00 16.00 Physicians Part A - Teaching 16.01 Home office Physicians Part A 0 0.00 0.00 16.01 Teachi ng 16. 02 Home office contract 0 0.00 0.00 16.02 Physicians <u>Part A - Teaching</u> WAGE-RELATED COSTS 37, 645, 500 17.00 Wage-related costs (core) (see 37, 645, 500 17.00 instructions) 18.00 Wage-related costs (other) 18.00 (see instructions) 19.00 Excluded areas 1, 529, 710 1, 529, 710 19.00 Non-physician anesthetist Part 20.00 C 20.00 21.00 Non-physician anesthetist Part 0 21.00 22.00 Physician Part A -22.00 0 Administrative 22.01 Physician Part A - Teaching 22 01 23.00 Physician Part B 23.00

0

0

3, 475, 648

0

0

0

0

3, 475, 648

24.00

25.00

25.50

25.51

24.00

25.00

25.50

25.51

Wage-related costs (RHC/FQHC)

Interns & residents (in an

Home office wage-related

Related organization

approved program)

(core)

MCRI F32 - 22. 2. 178. 1

40.00

41.00

42.00

Pharmacy

Records Library Social Service

43.00 Other General Service

Central Services and Supply

Medical Records & Medical

21.06

47. 26

0.00

39.00

40.00

41.00

0.00 42.00

0.00 43.00

HOSPITAL WAGE INDEX INFORMATION Provider CCN: 14-0046 Peri od: Worksheet S-3 From 01/01/2023 Part II 12/31/2023 Date/Time Prepared: 5/21/2024 10:06 am Wkst. A Line Amount Recl assi fi cati Adj usted Paid Hours Average Hourly Number on of Salaries Sal ari es Related to Wage (col. 4 Reported col . 5) (from Wkst. (col.2 ± col. Salaries in A-6)3) col. 4 2.00 1.00 5.00 6.00 3.00 4.00 25.53 Home office: Physicians Part A 0 25.53 - Teaching - wage-related (core) OVERHÉAD COSTS - DIRECT SALARIES 26.00 4 00 389, 178 389, 178 20. 99 26.00 Employee Benefits Department 18, 544, 53 27.00 Administrative & General 5.00 3, 959, 813 0 3, 959, 813 95, 525. 11 41. 45 27.00 28.00 Administrative & General under 1, 251, 571 1, 251, 571 5, 811. 61 215. 36 28.00 contract (see inst.) Maintenance & Repairs 6.00 29.00 0.00 0.00 29.00 0 Operation of Plant 1, 062, 801 0 1, 062, 801 38, 165. 48 27. 85 30.00 7.00 30.00 31.00 Laundry & Linen Service 8.00 94, 961 0 94, 961 5, 231. 26 18.15 31.00 32.00 Housekeepi ng 9.00 1, 653, 390 0 1, 653, 390 85, 963. 53 19. 23 32.00 33.00 Housekeeping under contract 0 0.00 0.00 33.00 (see instructions) 34.00 Di etary 10.00 834, 192 -567, 444 266, 748 14, 350. 83 18. 59 34.00 Di etary under contract (see instructions) 181, 955 181, 955 5, 760. 00 31. 59 35.00 35.00 36.00 0.00 Cafeteri a 11.00 567, 444 567, 444 0.00 36.00 0 Maintenance of Personnel 0.00 37.00 12.00 0 C 0.00 37.00 38.00 Nursing Administration 13.00 930, 174 930, 174 21, 179. 40 43. 92 38.00

439, 155

0

o

2, 194, 676

0

0

0

439, 155

0

0

2, 194, 676

20, 850, 76

46, 439. 04

0.00

0.00

0.00

14.00

15.00

16.00

17.00

18.00

Total overhead cost (see

instructions)

7.00

36.31

7.00

HOSPITAL WAGE INDEX INFORMATION Worksheet S-3 Part III Date/Time Prepared: Provi der CCN: 14-0046 Peri od: From 01/01/2023 To 12/31/2023 5/21/2024 10:06 am Average Hourly Worksheet A Amount Recl assi fi cati Adj usted Pai d Hours Line Number Reported on of Salaries Sal ari es Related to Wage (col. 4 (col . 2 ± col . col. 5) (from Salaries in Works<u>heet A-6)</u> 3) col. 4 1.00 5.00 6.00 2.00 3.00 4.00 PART III - HOSPITAL WAGE INDEX SUMMARY 1.00 Net salaries (see 63, 139, 371 63, 139, 371 1, 550, 433. 31 40. 72 1.00 instructions) 2.00 Excluded area salaries (see 2, 820, 211 ol 2, 820, 211 60, 561. 83 46. 57 2.00 instructions) 3.00 Subtotal salaries (line 1 60, 319, 160 0 60, 319, 160 1, 489, 871. 48 40.49 3.00 minus line 2) 4.00 Subtotal other wages & related 16, 908, 629 16, 908, 629 221, 392. 91 76.37 4.00 costs (see inst.) Subtotal wage-related costs 5.00 41, 121, 148 0 41, 121, 148 0.00 68. 17 5.00 (see inst.) Total (sum of lines 3 thru 5) 6.00 6.00 118, 348, 937 0 118, 348, 937 1, 711, 264. 39 69. 16

12, 991, 866

357, 821. 55

12, 991, 866

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

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-0046
From 01/01/2023
To 12/31/2023
Part IV
Date/Time Prepared:
5/21/2024 10:06 am

	10 12/31/2023	Date/IIMe Prep 5/21/2024 10:0	
		Amount	JO U
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		1
	RETI REMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2. 00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	1, 305, 762	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	1, 965, 469	5. 00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6. 00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8. 00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	25, 473, 396	8. 01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8. 02
8.03	Health Insurance (Purchased)	0	8. 03
9.00	Prescription Drug Plan	3, 411, 070	9. 00
10.00	Dental, Hearing and Vision Plan	1, 117, 465	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)	58, 589	11. 00
12.00	Accident Insurance (If employee is owner or beneficiary)	10, 527	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	4, 691	13. 00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	748, 445	14. 00
15. 00	'Workers' Compensation Insurance	0	15. 00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Noncumul ati ve porti on)		
	TAXES		
17. 00	FICA-Employers Portion Only	4, 657, 139	
18. 00	Medicare Taxes - Employers Portion Only	0	
19. 00	Unempl oyment Insurance	263, 563	1
20. 00	State or Federal Unemployment Taxes	0	20. 00
	OTHER		
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see	0	21. 00
	instructions))		
22. 00	Day Care Cost and Allowances	0	
23. 00	Tuition Reimbursement	159, 094	
24. 00	Total Wage Related cost (Sum of lines 1 -23)	39, 175, 210	24. 00
25 02	Part B - Other than Core Related Cost		25 00
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	l	25. 00

Health Financial Systems	SSM HEALTH GOOD SAMARITAN HOSPITAL	In Lie	u of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 14-0046	Peri od: From 01/01/2023	Worksheet S-3 Part V

		Го 12/31/2023	Date/Time Prep 5/21/2024 10:0	
	Cost Center Description	Contract Labor	Benefit Cost	
		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	6, 608, 956	39, 175, 211	1. 00
2.00	Hospi tal	6, 608, 956	37, 645, 500	2. 00
3.00	SUBPROVI DER - I PF			3. 00
4.00	SUBPROVI DER - I RF	0	1, 049, 043	4. 00
5.00	Subprovi der - (0ther)	0	0	5. 00
6.00	Swing Beds - SNF	0	0	6. 00
7.00	Swing Beds - NF	0	0	7. 00
8.00	SKILLED NURSING FACILITY			8. 00
9.00	NURSING FACILITY			9. 00
10.00	OTHER LONG TERM CARE I			10.00
11. 00	Hospi tal -Based HHA			11. 00
12. 00	AMBULATORY SURGICAL CENTER (D. P.) I			12.00
13. 00	Hospi tal -Based Hospi ce			13.00
14. 00	Hospital-Based Health Clinic RHC			14.00
15. 00	Hospital-Based Health Clinic FQHC			15. 00
16. 00	Hospi tal -Based-CMHC			16. 00
17. 00	RENAL DIALYSIS I	0	0	17. 00
18. 00	Other	0	480, 668	18. 00

	Financial Systems SSM HEALTH GOOD SAMARITA				eu of Form CMS-2			
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA Pr	rovider CC		Period: From 01/01/2023 To 12/31/2023		pared:		
					1. 00			
	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA				1.00			
	Uncompensated and Indigent Care Cost-to-Charge Ratio							
	Cost to charge ratio (see instructions)		0. 238919	1.00				
	Medicaid (see instructions for each line)				0.200717			
	Net revenue from Medicaid				17, 452, 642	2.00		
3.00	Did you receive DSH or supplemental payments from Medicaid?				N	3.00		
4.00	If line 3 is yes, does line 2 include all DSH and/or supplementa	al payment	s from Medica	ıi d?		4. 00		
5.00	If line 4 is no, then enter DSH and/or supplemental payments fro	m Medicai	d		0	5. 00		
	Medi cai d charges				153, 416, 378	6. 00		
	Medicaid cost (line 1 times line 6)				36, 654, 088			
	Difference between net revenue and costs for Medicaid program (s				19, 201, 446	8. 00		
	Children's Health Insurance Program (CHIP) (see instructions for each line)							
	Net revenue from stand-alone CHIP		0	9. 00				
	Stand-alone CHIP charges				0			
	Stand-alone CHIP cost (line 1 times line 10)				0	11. 00		
	Difference between net revenue and costs for stand-alone CHIP (s				0	12. 00		
	Other state or local government indigent care program (see instr				1			
	Net revenue from state or local indigent care program (Not inclu				0			
14. 00	Charges for patients covered under state or local indigent care 10)	program (Not included	in lines 6 or	0	14. 00		
15. 00	State or local indigent care program cost (line 1 times line 14)				0	15. 00		
	Difference between net revenue and costs for state or local indi		nrogram (see	instructions)	0			
	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line)					10.00		
	Private grants, donations, or endowment income restricted to fun				0	17. 00		
	Government grants, appropriations or transfers for support of ho				0	18. 00		
19. 00	Total unreimbursed cost for Medicaid , CHIP and state and local 8, 12 and 16)	i ndi gent			19, 201, 446	19. 00		
			Uni nsured	Insured	Total (col. 1			
			patients	pati ents	+ col . 2)			
			1.00	2. 00	3. 00			
	Uncompensated care cost (see instructions for each line)		0 044 04	744 424	9, 611, 368	20.00		
	00 Charity care charges and uninsured discounts (see instructions) 8,844,942 766,426							
21. 00	Cost of patients approved for charity care and uninsured discoun instructions)	its (see	2, 113, 22	766, 426	2, 879, 651	21. 00		
22. 00	Payments received from patients for amounts previously written o	off as		0 0	0	22. 00		

24.00 Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit

If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of

imposed on patients covered by Medicaid or other indigent care program?

29.00 | Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)

Charges for insured patients' liability (see instructions)

Cost of uncompensated care (line 23, col. 3, plus line 29)

31.00 | Total unreimbursed and uncompensated care cost (line 19 plus line 30)

Medicare reimbursable bad debts (see instructions)

Medicare allowable bad debts (see instructions)

Non-Medicare bad debt amount (see instructions)

2, 113, 225

766, 426

2, 879, 651

6, 140, 691

1, 259, 225

4, 881, 466

1, 607, 004

4, 486, 655

23, 688, 101 31. 00

818, 496

1.00

23.00

24.00

0 25.00

25 01

26.00

27.00

27.01

28.00

29.00

30.00

charity care

stay limit

25.00

25. 01

27.00

27.01

28.00

30.00

23.00 Cost of charity care (see instructions)

Bad debt amount (see instructions)

	Financial Systems	SSM HEALTH GOOD SAMA				u of Form CMS-	2552-10	
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DA	TA	Provi der CCI	N: 14-0046	Peri od: From 01/01/2023 To 12/31/2023	Worksheet S-1 Parts I & II Date/Time Pre 5/21/2024 10:	pared:	
						1. 00		
	PART II - HOSPITAL DATA					1.00		
	Uncompensated and Indigent Care Cost	to-Charge Ratio						
1.00	Cost to charge ratio (see instruction		0. 233592	1.00				
	Medicaid (see instructions for each	ine)					ĺ	
2.00	Net revenue from Medicaid	,					2.00	
3.00	Did you receive DSH or supplemental			3.00				
4.00	If line 3 is yes, does line 2 includ	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?						
5.00	If line 4 is no, then enter DSH and/			5. 00				
6.00	Medi cai d charges						6.00	
7.00	Medicaid cost (line 1 times line 6)			7. 00				
8.00							8. 00	
	Children's Health Insurance Program (CHIP) (see instructions for each line)							
9.00	Net revenue from stand-alone CHIP						9. 00	
	Stand-alone CHIP charges						10.00	
	Stand-alone CHIP cost (line 1 times						11. 00	
12.00	Difference between net revenue and c						12. 00	
	Other state or local government indig							
	Net revenue from state or local indi						13. 00	
14. 00	Charges for patients covered under s 10)	tate or local indigent ca	re program (N	lot included	in lines 6 or		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 c						16. 00	
	Grants, donations and total unreimburinstructions for each line)	·			gent care program	ns (see		
17.00	Private grants, donations, or endowm	ent income restricted to	funding chari	ty care			17. 00	
18.00	Government grants, appropriations or	transfers for support of	hospital ope	rati ons			18. 00	
19. 00	Total unreimbursed cost for Medicaid 8, 12 and 16)	, CHIP and state and Loc	al indigent c	are programs	s (sum of lines		19. 00	
				Uni nsured	Insured	Total (col. 1		
				pati ents	pati ents	+ col . 2)		
				1.00	2. 00	3.00		

		1.00	2.00	3.00			
	Uncompensated care cost (see instructions for each line)						
20.00	Charity care charges and uninsured discounts (see instructions)	8, 804, 019	763, 726	9, 567, 745	20.00		
21.00	Cost of patients approved for charity care and uninsured discounts (see	2, 056, 548	763, 726	2, 820, 274	21.00		
	instructions)						
22. 00	Payments received from patients for amounts previously written off as	0	0	0	22. 00		
	chari ty care						
23. 00	Cost of charity care (see instructions)	2, 056, 548	763, 726	2, 820, 274	23. 00		
				1. 00			
24. 00	N	24. 00					
	imposed on patients covered by Medicaid or other indigent care program?						
25. 00	25.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of						
	stay limit						
	Charges for insured patients' liability (see instructions)			0			
	Bad debt amount (see instructions)			6, 138, 378			
	Medicare reimbursable bad debts (see instructions)			817, 456			
27. 01	Medicare allowable bad debts (see instructions)			1, 257, 625			
28. 00	28.00 Non-Medicare bad debt amount (see instructions)				28. 00		
29. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see	instructions)		1, 580, 274	29.00		
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)			4, 400, 548	30.00		
31. 00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			4, 400, 548	31. 00		

Heal th	Financial Systems SSM	HEALTH GOOD SAM	ARITAN HOSPITA	AL	In Lie	u of Form CMS-2	2552-10
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	EXPENSES	Provider CC		Period: From 01/01/2023 Fo 12/31/2023	Worksheet A Date/Time Pre 5/21/2024 10:	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT		6, 824, 401	6, 824, 40		6, 824, 401	1
2.00	00200 CAP REL COSTS-MVBLE EQUIP		4, 536, 235	4, 536, 23		4, 536, 235	1
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	389, 178	22, 282, 486	22, 671, 66		22, 669, 543	1
5.00	00500 ADMINISTRATIVE & GENERAL	3, 959, 813	44, 607, 454	48, 567, 26		49, 778, 604	1
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	1, 062, 801	5, 036, 773	6, 099, 574		6, 350, 153	1
9. 00	00900 HOUSEKEEPING	94, 961 1, 653, 390	585, 397 691, 742	680, 358 2, 345, 132		673, 267 2, 299, 015	
10. 00	01000 DI ETARY	834, 192	1, 683, 639	2, 517, 83		804, 885	1
11. 00	01100 CAFETERI A	034, 172	0		1, 712, 740	1, 712, 707	1
13. 00	01300 NURSI NG ADMI NI STRATI ON	930, 174	1, 137, 548	2, 067, 722		2, 064, 950	
14. 00	01400 CENTRAL SERVICES & SUPPLY	439, 155	215, 844	654, 999		389, 747	1
15.00	01500 PHARMACY	2, 194, 676	11, 985, 192	14, 179, 868		2, 654, 497	1
16.00	01600 MEDICAL RECORDS & LIBRARY	0	27, 956	27, 956	6 0	27, 956	16.00
17.00	01700 SOCIAL SERVICE	0	2, 150	2, 150	5 -5	2, 145	17. 00
23. 00	02300 PARAMED ED PRGM-LABARATORY ED	0	71	7	1 0	71	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	17, 149, 864	4, 840, 994	21, 990, 858		22, 227, 261	
31. 00	03100 INTENSIVE CARE UNIT	2, 741, 389	1, 777, 201	4, 518, 590			
41. 00	04100 SUBPROVI DER - I RF	1, 693, 508	837, 633	2, 531, 14			
43. 00	04300 NURSERY	543, 705	0	543, 70	5 542, 471	1, 086, 176	43. 00
F0 00	ANCILLARY SERVICE COST CENTERS	0 474 444	0.007.040	10 000 00		4 007 040	
50. 00 51. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM	2, 471, 114	9, 826, 912	12, 298, 020		4, 886, 349	
51.00	05200 DELIVERY ROOM & LABOR ROOM	932, 493 3, 805, 333	242, 041 1, 029, 557	1, 174, 534 4, 834, 890		947, 916 3, 196, 156	1
53. 00	05300 ANESTHESI OLOGY	41, 877	6, 106, 228	6, 148, 10!		5, 862, 343	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 727, 545	182, 984	1, 910, 529		1, 817, 562	1
55. 00	05500 RADI OLOGY-THERAPEUTI C	1, 316, 555	691, 095	2, 007, 650		1, 820, 360	
56. 00	05600 RADI OI SOTOPE	185, 088	468, 158	653, 240		641, 682	
57. 00	05700 CT SCAN	583, 578	599, 590	1, 183, 168		1, 111, 750	1
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	240, 924	124, 498	365, 422		345, 367	1
59.00	05900 CARDI AC CATHETERI ZATI ON	933, 559	3, 140, 619	4, 074, 178		1, 475, 275	1
60.00	06000 LABORATORY	2, 498, 520	4, 025, 235	6, 523, 75	-2, 197, 030	4, 326, 725	60.00
64.00	06400 I NTRAVENOUS THERAPY	219, 219	18, 051	237, 270	-13, 664	223, 606	64.00
65.00	06500 RESPI RATORY THERAPY	1, 782, 990	620, 608	2, 403, 598	-223, 715	2, 179, 883	65.00
66.00	06600 PHYSI CAL THERAPY	1, 043, 156	186, 529	1, 229, 68		1, 219, 350	1
66. 01	03951 CLINI CAL NUTRI TI ON	156, 247	307	156, 55		156, 554	
67. 00	06700 OCCUPATI ONAL THERAPY	511, 418	47, 972	559, 390		554, 607	
68. 00	06800 SPEECH PATHOLOGY	327, 596	6, 123	333, 719		332, 964	
69. 00	06900 ELECTROCARDI OLOGY	2, 008, 707	1, 021, 294	3, 030, 00			
69. 01	06901 CARDI AC REHABI LITI ON	134, 314	618	134, 932		132, 113	
70.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	29, 765 0	12, 484 0	42, 249	9 -566 0 12, 095, 453		
	07200 IMPL. DEV. CHARGED TO PATIENTS		0		4, 527, 763	4, 527, 763	
73. 00	07300 DRUGS CHARGED TO PATIENTS	1, 180, 338	188, 095	1, 368, 433		12, 737, 183	
74. 00	07400 RENAL DIALYSIS	1, 100, 330	1, 011, 189	1, 011, 189		999, 257	
76. 00	03950 ENDOSCOPY	Ö	0		0	0	1
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	o	(0	
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	o	ō	(ol ol	0	
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	3, 606, 180	2, 090, 347	5, 696, 52	7 -330, 710	5, 365, 817	90.00
91.00	09100 EMERGENCY	2, 691, 934	2, 391, 551	5, 083, 48	-496, 378	4, 587, 107	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
	OTHER REIMBURSABLE COST CENTERS						
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	(0	0	102. 00
118.00	9 /	62, 115, 256	141, 104, 801	203, 220, 05	1, 473, 967	204, 694, 024	118. 00
46-	NONREI MBURSABLE COST CENTERS	1					1
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	40, 220	4	40, 22	4 0		190.00
	19100 RESEARCH	0	0		이		191. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	-357, 468			-357, 468	
	07950 OTHER NRB COST CENTER	657, 123	1, 991, 510	2, 648, 63	-1, 473, 967	1, 174, 666	
	07951 OTHER NRB COST CENTER	0	0	(194. 01 194. 02
	07952 NONREIMBURSABLE COST CENTER 07953 RETAIL PHARMACY	429, 360	7, 703, 779	8, 133, 13 ⁹		8, 133, 139	
200.00	1 1	63, 241, 959	150, 442, 626			213, 684, 585	
200.00	TIOTHE (SOM OF ETHES THE CHILDREN 199)	00, 271, 707	100, 442, 020	210,004,00	۷۱ ۷۱	213, 004, 303	1-00.00

Heal th	Financial Systems SSM	HEALTH GOOD SA	MARITAN HOSPITA	L	In Lie	u of Form CMS-	2552-10
	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der CCI	N: 14-0046	Peri od:	Worksheet A	
					From 01/01/2023 To 12/31/2023	Dato/Timo Dro	narodi
					10 12/31/2023	Date/Time Pre 5/21/2024 10:	
	Cost Center Description	Adjustments	Net Expenses				
			For Allocation				
	CENEDAL CEDVICE COST CENTEDS	6. 00	7. 00				
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	-500, 963	6, 323, 438				1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP	64, 045					2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	6, 698, 338					4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	-16, 898, 664	32, 879, 940				5. 00
7.00	00700 OPERATION OF PLANT	-78, 305	6, 271, 848				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	673, 267				8. 00
9.00	00900 HOUSEKEEPI NG	-2, 434	2, 296, 581				9. 00
10.00	01000 DI ETARY	0	804, 885				10.00
11. 00 13. 00	01100 CAFETERI A	-642, 662	1, 070, 045				11. 00 13. 00
14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	-319, 692 -38, 348	1, 745, 258 351, 399				14. 00
15. 00	01500 PHARMACY	-67, 079	2, 587, 418				15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	-1, 688	26, 268				16. 00
17. 00	01700 SOCIAL SERVICE	0	2, 145				17. 00
23.00	02300 PARAMED ED PRGM-LABARATORY ED	0	71				23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>					
30. 00	03000 ADULTS & PEDI ATRI CS	-5, 911, 330					30. 00
31.00	03100 NTENSI VE CARE UNI T	-1, 158, 517	2, 490, 971				31.00
41. 00 43. 00	04100 SUBPROVI DER - I RF	-169, 033 0					41.00
43.00	04300 NURSERY ANCILLARY SERVICE COST CENTERS	0	1, 086, 176				43. 00
50. 00	05000 OPERATI NG ROOM	-313, 813	4, 572, 536				50.00
51. 00	05100 RECOVERY ROOM	0.0,0.0	947, 916				51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	-3, 681	3, 192, 475				52. 00
53.00	05300 ANESTHESI OLOGY	-5, 645, 519	216, 824				53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	-2, 672	1, 814, 890				54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	-278, 060	1, 542, 300				55. 00
56. 00	05600 RADI OI SOTOPE	-148					56.00
57. 00 58. 00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	-302, 037 0	809, 713 345, 367				57. 00 58. 00
59. 00	05900 CARDIAC CATHETERIZATION	0	1, 475, 275				59.00
60.00	06000 LABORATORY	-339, 285					60.00
64. 00	06400 I NTRAVENOUS THERAPY	0	223, 606				64. 00
65.00	06500 RESPI RATORY THERAPY	-8, 445	2, 171, 438				65. 00
66. 00	06600 PHYSI CAL THERAPY	-150	1, 219, 200				66. 00
66. 01	03951 CLI NI CAL NUTRI TI ON	0	156, 554				66. 01
67. 00	06700 OCCUPATI ONAL THERAPY	0	554, 607				67. 00
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0 -362, 474	332, 964				68. 00 69. 00
69. 00	06901 CARDI AC REHABI LI TI ON	-362, 474 19, 366	2, 496, 731 151, 479				69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	-5, 762	35, 921				70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	-1, 543, 259	10, 552, 194				71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	4, 527, 763				72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	12, 737, 183				73. 00
		-22, 443	976, 814				74. 00
76. 00	03950 ENDOSCOPY	0	0				76. 00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0				77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS	0	0				78. 00
90. 00		-80, 261	5, 285, 556				90.00
91. 00	09100 EMERGENCY	-915, 551	3, 671, 556				91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	,,,,,,,,,,	3, 3, 1, 333				92. 00
	OTHER REIMBURSABLE COST CENTERS						
102.00	10200 OPIOID TREATMENT PROGRAM	0	0				102. 00
	SPECIAL PURPOSE COST CENTERS						
118. 00		-28, 830, 526	175, 863, 498				118. 00
100.00	NONREI MBURSABLE COST CENTERS		40.224				100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19100 RESEARCH	0	40, 224				190. 00 191. 00
	19100 RESEARCH 19200 PHYSI CLANS' PRI VATE OFFI CES	0	-357, 468				191.00
	07950 OTHER NRB COST CENTER	-936, 658					194. 00
	07755 OTHER NRB COST CENTER	0	0				194. 01
194. 02	07952 NONREIMBURSABLE COST CENTER	0	o				194. 02
	07953 RETAIL PHARMACY	0	8, 133, 139				194. 03
200.00	TOTAL (SUM OF LINES 118 through 199)	-29, 767, 184	183, 917, 401				200. 00

Health Financial Systems RECLASSIFICATIONS Peri od: From 01/01/2023 To 12/31/2023 Date/Ti me Prepared: 5/21/2024 10:06 am Provider CCN: 14-0046

					5/21/2024 10:	06 am
		Increases				
	Cost Center	Li ne #	Sal ary	Other		
	2. 00	3. 00	4. 00	5. 00		
	A - DRUG SUPPLY IMPLANT IV AN		_1			
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	12, 095, 453		1. 00
2 00	PATI ENTS	72.00		4 507 7/0		2 00
2. 00	I MPL. DEV. CHARGED TO	72. 00	0	4, 527, 763		2. 00
2 00	PATIENTS DRUGS CHARGED TO PATIENTS	73. 00		11 240 750		2 00
3. 00 4. 00	DRUGS CHARGED TO PATTENTS	0.00	0	11, 368, 750		3.00
5. 00		0.00	0	0		4. 00 5. 00
6. 00		0.00	0	0		6. 00
7. 00		0.00	0	0		7. 00
8. 00		0.00	0	0		8. 00
9. 00		0.00	o	0		9. 00
10. 00		0.00	o	0		10.00
11. 00		0.00	o	0		11. 00
12. 00		0.00	o	0		12.00
13. 00		0.00	o	0		13. 00
14. 00		0.00	o	0		14. 00
15. 00		0.00	o	0		15. 00
16. 00		0.00	o	0		16. 00
17. 00		0.00	o	0		17. 00
18. 00		0.00	o	0		18. 00
19. 00		0.00	o	0		19. 00
20. 00		0.00	ő	0		20.00
21. 00		0.00	ő	0		21. 00
22. 00		0.00	ő	0		22. 00
23. 00		0.00	o	0		23. 00
24. 00		0.00	Ö	0		24. 00
25. 00		0.00	ő	0		25. 00
26. 00		0.00	o	0		26. 00
27. 00		0.00	o	0		27. 00
28. 00		0.00	ő	0		28. 00
29. 00		0.00	Ö	0		29. 00
30.00		0.00	ő	0		30.00
31. 00		0.00	o	0		31.00
32. 00		0.00	o	0		32. 00
33. 00		0.00	o	0		33. 00
34. 00		0.00	0	0		34. 00
35. 00		0.00	o	0		35. 00
				27, 991, 966		
	B - DIETARY	1	-1			
1.00	CAFETERI A	11.00	567, 444	1, 145, 263		1.00
	0		567, 444	1, 145, 263		
	D - INPATIENT L&D					
1.00	ADULTS & PEDIATRICS	30.00	685, 093	359, 043		1. 00
2.00	NURSERY	43.00	380, 940	14 <u>4, 6</u> 18		2. 00
	0		1, 066, 033	503, 661		ļ
1 00	E - UTILITIES	7.00	ما	250.040		1 00
1.00	OPERATION OF PLANT	7.00	0	250, 969		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3. 00
4. 00		0.00		0 250, 969		4. 00
	F - PUMP		U_	230, 909		l
1. 00	ADULTS & PEDIATRICS	30.00	ol	206, 419		1. 00
2.00	INTENSIVE CARE UNIT	31.00	o	20, 284		2. 00
3.00	SUBPROVI DER - I RF	41.00	0	19, 457		3. 00
4. 00	NURSERY	43.00	0	16, 913		4. 00
1. 50	0			263, 073		1. 00
	G - MEDICAL PLAZA		<u> </u>	200,010		
1.00	ADMI NI STRATI VE & GENERAL	5. 00	0	1, 229, 431		1. 00
	0			1, 229, 431		
	J - ENDOSCOPY		-			
1.00	OPERATING ROOM	50.00	0	0		1. 00
	0		0	0]
500.00	Grand Total: Increases		1, 633, 477	31, 384, 363		500.00

Health Financial Systems RECLASSIFICATIONS Provider CCN: 14-0046

Peri od: From 01/01/2023 To 12/31/2023 Date/Ti me Prepared: 5/21/2024 10:06 am

						5/21/2024 10	D: 06 am
		Decreases					
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
	A - DRUG SUPPLY IMPLANT IV AN	ID BLOOD					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2, 121	0		1. 00
2.00	ADMINISTRATIVE & GENERAL	5. 00	0	13, 080	0		2. 00
3.00	OPERATION OF PLANT	7. 00	0	390	0		3. 00
4.00	LAUNDRY & LINEN SERVICE	8. 00	0	7, 091	0		4. 00
5.00	HOUSEKEEPI NG	9.00	O	45, 530	o		5. 00
6.00	DI ETARY	10.00	O	239	o		6. 00
7.00	NURSING ADMINISTRATION	13.00	o	2, 772	o		7. 00
8.00	CENTRAL SERVICES & SUPPLY	14.00	O	2, 179	O		8. 00
9.00	PHARMACY	15.00	0	11, 525, 371	o		9. 00
10.00	SOCI AL SERVI CE	17. 00	O	5	o		10.00
11.00	ADULTS & PEDIATRICS	30.00	o	1, 014, 152	o		11. 00
12. 00	INTENSIVE CARE UNIT	31.00	0	452, 714	0		12. 00
13. 00	SUBPROVI DER - I RF	41.00	0	51, 705	0		13. 00
14.00	OPERATING ROOM	50.00	0	7, 411, 677	0		14. 00
15. 00	RECOVERY ROOM	51. 00	o	226, 618	O	l e	15. 00
16. 00	DELIVERY ROOM & LABOR ROOM	52.00	0	505, 712	o		16. 00
17. 00	ANESTHESI OLOGY	53. 00	0	285, 762	o		17. 00
18. 00	RADI OLOGY-DI AGNOSTI C	54.00	o	92, 967	o		18. 00
19. 00	RADI OLOGY-THERAPEUTI C	55.00	0	187, 290	o		19. 00
20. 00	RADI OI SOTOPE	56.00	0	11, 564	o	l .	20.00
21. 00	CT SCAN	57.00	0	71, 418	o	l e e e e e e e e e e e e e e e e e e e	21. 00
22. 00	MAGNETIC RESONANCE IMAGING	58. 00	0		o	l e e e e e e e e e e e e e e e e e e e	1
22.00	(MRI)	36.00	٥	20, 055	U		22. 00
23. 00	CARDIAC CATHETERIZATION	59.00	0	2, 598, 903	o		23. 00
24. 00	LABORATORY	60.00	0	2, 197, 030	0	l I	24. 00
25. 00	INTRAVENOUS THERAPY	64. 00	ol Ol		0	l e e e e e e e e e e e e e e e e e e e	25. 00
		•	-1	13, 664	0	l .	1
26. 00	RESPI RATORY THERAPY PHYSI CAL THERAPY	65.00	0	223, 715	0		26. 00
27. 00		66.00	U	10, 335		l e	27. 00
28. 00	OCCUPATIONAL THERAPY	67.00	0	4, 783			28. 00
29. 00	SPEECH PATHOLOGY	68.00	0	755	0		29. 00
30.00	ELECTROCARDI OLOGY	69.00	0	170, 796	0		30. 00
31. 00	CARDI AC REHABI LI TI ON	69. 01	0	2, 819	0	l .	31. 00
32. 00	ELECTROENCEPHALOGRAPHY	70.00	0	566	0	l .	32. 00
33. 00	RENAL DI ALYSI S	74.00	0	11, 932	0		33. 00
34.00	CLINIC	90.00	0	329, 878	0		34. 00
35. 00	EMERGENCY	<u> </u>	•	49 <u>6, 3</u> 78			35. 00
	0		0	27, 991, 966			
	B - DI ETARY						
1.00	DI ETARY	10.00	567, 444	<u>1, 145, 2</u> 63	0		1. 00
	0		567, 444	1, 145, 263			
	D - INPATIENT L&D						
1.00	INTENSIVE CARE UNIT	31.00	244, 540	192, 132	0		1. 00
2.00	DELIVERY ROOM & LABOR ROOM	52. 00	821, 493	<u>311, 5</u> 29	0		2. 00
	0		1, 066, 033	503, 661			
	E - UTILITIES						
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	5, 014	0		1. 00
2.00	HOUSEKEEPI NG	9. 00	0	587	0		2. 00
3.00	CLINIC	90.00	0	832	0		3. 00
4.00	OTHER NRB COST CENTER	194.00	0	244, 536	0		4. 00
		T		250, 969			
	F - PUMP						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	263, 073	0		1. 00
2.00		0.00	0	0	o		2. 00
3.00		0.00	O	0	0		3. 00
4.00		0.00	0	0	O		4. 00
				263, 073			
	G - MEDICAL PLAZA		-1				
1.00	OTHER NRB COST CENTER	194.00	0	1, 229, 431	0		1. 00
	0	— — :°†	— — 	1, 229, 431	<u> </u>		1
	J - ENDOSCOPY		<u> </u>	.,, .01			
1.00	ENDOSCOPY	76.00	n	n	0		1.00
1. 50	0	— — /0. 50	— — — }	— — <u> </u>	 		1.00
500 00	Grand Total: Decreases		1, 633, 477	31, 384, 363			500.00
555.00	1 10 10 10 10 10 10 10 10 10 10 10 10 10	I	., 500, 177	3., 301, 300		ı	, 555. 55

8.00

9.00

HIT designated Assets

10.00 Total (line 8 minus line 9)

Reconciling Items

Subtotal (sum of lines 1-7)

7. 00

8.00

9.00

10.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provi der CCN: 14-0046 Peri od: Worksheet A-7 From 01/01/2023 Part I 12/31/2023 Date/Time Prepared: 5/21/2024 10:06 am Acqui si ti ons Begi nni ng Purchases Donati on Total Di sposal s and Bal ances Retirements 2.00 3.00 4. 00 1 00 5 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 590, 251 0 1.00 6, 818, 606 125, 160 2.00 Land Improvements 125, 160 0 2.00 160, 879, 485 432, 059 3.00 -233, 627 198, 432 3.00 Buildings and Fixtures 0 32, 542, 095 4.00 Building Improvements 67, 907 67, 907 0 4.00 5.00 Fixed Equipment 15, 697, 274 711, 882 711, 882 5.00 6.00 Movable Equipment 63, 536, 470 3, 660, 860 233, 627 3, 894, 487 2, 027, 042 6.00 7.00 HIT designated Assets 0 0 7.00 8.00 Subtotal (sum of lines 1-7) 280, 064, 181 4, 997, 868 0 4, 997, 868 2, 027, 042 8.00 9.00 Reconciling Items 0 9.00 4, 997, 868 4, 997, 868 2<u>, 027, 042</u> Total (line 8 minus line 9) 10.00 280, 064, 181 0 10.00 Endi ng Bal ance Fully Depreciated Assets 6.00 7.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 590, 251 0 1.00 2.00 Land Improvements 6, 943, 766 0 2. 00 161, 077, 917 3.00 Buildings and Fixtures 0 3.00 0 4.00 Building Improvements 32, 610, 002 4.00 5.00 Fi xed Equipment 16, 409, 156 0 5.00 Movable Equipment 65, 403, 915 6.00 0 6.00

283, 035, 007

283, 035, 007

0

0

RECONCILIATION OF CALLIAL COSTS CENTERS	110V1de1 CCN. 14-0040	I CI I Ou.	WOLKSHEEL A-1
		From 01/01/2023	Part II
		To 12/31/2023	Date/Time Prepared:
			5/21/2024 10 06 am

			Т	o 12/31/2023	Date/Time Pre 5/21/2024 10:	
	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 WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00 CAP REL COSTS-BLDG & FLXT	5, 798, 633	0	1, 025, 768	0	0	1. 00
2.00 CAP REL COSTS-MVBLE EQUIP	4, 536, 235	0	C	0	0	2. 00
3.00 Total (sum of lines 1-2)	10, 334, 868	0	1, 025, 768	0	0	3. 00
	SUMMARY O	F CAPITAL				
Cost Center Description	Other	Total (1) (sum				
·	Capi tal -Relate	of cols. 9				
	d Costs (see	through 14)				
	instructions)					
	14. 00	15. 00				
PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00 CAP REL COSTS-BLDG & FLXT	0	6, 824, 401				1. 00
2.00 CAP REL COSTS-MVBLE EQUIP	0	4, 536, 235				2. 00
3.00 Total (sum of lines 1-2)	0	11, 360, 636				3. 00

Heal th	n Financial Systems SSM	HEALTH GOOD SA	MARITAN HOSPIT	AL	In Lie	u of Form CMS-:	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der C		Peri od:	Worksheet A-7	
					From 01/01/2023 Fo 12/31/2023		pared:
						5/21/2024 10:	06 am
		COM	PUTATION OF RAT	TI 0S	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
			Leases	for Ratio	instructions)		
				(col. 1 - col.			
				2)			
		1.00	2.00	3. 00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C						
1.00	CAP REL COSTS-BLDG & FLXT	201, 221, 937	0	201, 221, 93	7 0. 710944	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	81, 813, 071	0	81, 813, 07°	0. 289056	0	2. 00
3.00	Total (sum of lines 1-2)	283, 035, 008	0	283, 035, 008	1. 000000	0	3. 00
		ALLOCA.	TION OF OTHER (CAPI TAL	SUMMARY O	F CAPITAL	
	Coot Conton Decemintion	Taxes	Other	Total (our of	Donnasiation	Lease	
	Cost Center Description		Capi tal -Rel ate	Total (sum of cols. 5	Depreciation	Lease	
			d Costs	through 7)			
		6. 00	7.00	8. 00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI		7.00	0.00	7.00	10.00	
1.00	CAP REL COSTS-BLDG & FLXT	0	0		5, 999, 881	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	Ō		4, 600, 280	Ō	2. 00
3. 00	Total (sum of lines 1-2)	0	Ō		10, 600, 161	Ō	3. 00
			Sl	JMMARY OF CAPI			

Interest

11. 00

323, 557

0 323, 557

Insurance (see

instructions)

12.00

0 0

Taxes (see

instructions)

13.00

0 0 0 Other

Capi tal -Rel ate d Costs (see

instructions)

14.00

0

Total (2) (sum of cols. 9

through 14)

15.00

6, 323, 438 4, 600, 280 10, 923, 718

1.00

2.00

3. 00

Cost Center Description

CAP REL COSTS-BLDG & FIXT

CAP REL COSTS-MVBLE EQUIP

Total (sum of lines 1-2)

1.00

2.00

PART III - RECONCILIATION OF CAPITAL COSTS CENTERS

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

ADJUSTMENTS TO EXPENSES Provider CCN: 14-0046 From 01/01/2023 To 12/31/2023 Date/Time Prepared:

				To	12/31/2023	Date/Time Prep 5/21/2024 10:0	oared: O6 am
				Expense Classification on		072172021 10.	30 am
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description		Amount	Cost Center		Wkst. A-7 Ref.	
1.00	Investment income - CAP REL	1.00	2.00	3.00 CAP REL COSTS-BLDG & FLXT	4. 00 1. 00	5. 00	1. 00
	COSTS-BLDG & FIXT (chapter 2)						
2. 00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
3.00	Investment income - other		0		0. 00	0	3. 00
4. 00	(chapter 2) Trade, quantity, and time		0		0. 00	0	4. 00
	discounts (chapter 8)		0				
5. 00	Refunds and rebates of expenses (chapter 8)		0		0. 00	0	5. 00
6.00	Rental of provider space by		0		0. 00	0	6. 00
7. 00	suppliers (chapter 8) Telephone services (pay	A	0	ADMINISTRATIVE & GENERAL	5. 00	0	7. 00
	stations excluded) (chapter						
8. 00	21) Television and radio service		0		0. 00	0	8. 00
0.00	(chapter 21)						0.00
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	-15, 238, 693		0. 00	0	9. 00 10. 00
11 00	adjustment				0.00		11 00
11. 00	Sale of scrap, waste, etc. (chapter 23)		0		0. 00	0	11. 00
12. 00	Related organization	A-8-1	-7, 865, 886			0	12. 00
13. 00	transactions (chapter 10) Laundry and Linen service		0		0. 00	0	13. 00
14.00	Cafeteria-employees and guests		-642, 662	CAFETERI A	11. 00	0	14.00
15. 00	Rental of quarters to employee and others		Ü		0. 00	0	15. 00
16. 00	Sale of medical and surgical supplies to other than	В	0	PHARMACY	15. 00	0	16. 00
	patients						
17. 00	Sale of drugs to other than patients	В	-67, 069	PHARMACY	15. 00	0	17. 00
18. 00	Sale of medical records and	В	-1, 688	MEDICAL RECORDS & LIBRARY	16. 00	0	18. 00
19. 00	abstracts Nursing and allied health		0		0. 00	0	19. 00
	education (tuition, fees,						
20. 00	books, etc.) Vending machines		0		0. 00	0	20. 00
21. 00	Income from imposition of interest, finance or penalty		0		0. 00	0	21. 00
	charges (chapter 21)						
22. 00	Interest expense on Medicare overpayments and borrowings to		0		0. 00	0	22. 00
	repay Medicare overpayments						
23. 00	Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPI RATORY THERAPY	65. 00		23. 00
04.00	limitation (chapter 14)			DUNCTON THE DADY			0.4.00
24. 00	Adjustment for physical therapy costs in excess of	A-8-3	U	PHYSI CAL THERAPY	66. 00		24. 00
25. 00	limitation (chapter 14) Utilization review -		0	*** Cost Center Deleted ***	114. 00		25. 00
23.00	physicians' compensation		0	cost center bereted	114.00		23.00
26. 00	(chapter 21) Depreciation - CAP REL	A	-3 142	CAP REL COSTS-BLDG & FLXT	1. 00	9	26. 00
	COSTS-BLDG & FLXT						
27. 00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-774, 495	CAP REL COSTS-MVBLE EQUIP	2. 00	9	27. 00
28. 00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19. 00		28. 00
29. 00 30. 00	Physicians' assistant Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	0. 00 67. 00	0	29. 00 30. 00
	therapy costs in excess of						
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30. 00		30. 99
31. 00	instructions) Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
51.00	pathology costs in excess of	,,,,,	0	5. 225H 17HH0E001	00.00		51.00
32. 00	limitation (chapter 14) CAH HIT Adjustment for		0		0. 00	0	32. 00
	Depreciation and Interest	P	1 042 /10	ADMINISTRATIVE & CENERAL			
33.00	MI SCELLANEOUS REVENUE	В	-1,043,019	ADMINISTRATIVE & GENERAL	5. 00	U	33. 00

Provider CCN: 14-0046

Peri od:

From 01/01/2023 12/31/2023 Date/Time Prepared: 5/21/2024 10:06 am Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Cost Center Description Basis/Code (2) Cost Center Line # Wkst. A-7 Ref. Amount 1.00 2.00 3.00 4.00 5.00 33. 01 MI SCELLANEOUS REVENUE -9, 193 OPERATION OF PLANT 7. 00 33. 01 В -2, 296 HOUSEKEEPI NG 33.02 MI SCELLANEOUS REVENUE В 9.00 33.02 33. 03 MI SCELLANEOUS REVENUE В -2 NURSING ADMINISTRATION 13.00 33.03 33.04 MI SCELLANEOUS REVENUE -185, 001 ADULTS & PEDIATRICS 30.00 33.04 В -1, 121 INTENSIVE CARE UNIT MISCELLANEOUS REVENUE 31 00 33 06 В 33 06 33.07 MI SCELLANEOUS REVENUE В -57, 823 OPERATING ROOM 50.00 33.07 33.10 MI SCELLANEOUS REVENUE В -1, 300 DELIVERY ROOM & LABOR ROOM 52.00 33.10 MI SCELLANEOUS REVENUE -1. 912RADI OLOGY-DI AGNOSTI C 33 12 В 54 00 O 33 12 MI SCELLANEOUS REVENUE -32, 732 RADI OLOGY-THERAPEUTI C 33.13 В 55.00 33.13 33.14 MI SCELLANEOUS REVENUE В -148 RADI OI SOTOPE 56.00 33.14 33. 15 MI SCELLANEOUS REVENUE В -9, 956 CT SCAN 57.00 33. 15 -23 LABORATORY MISCELLANEOUS REVENUE 33 16 60.00 33 16 В 33.18 MI SCELLANEOUS REVENUE В -4, 882 RESPI RATORY THERAPY 65.00 33.18 33. 19 MI SCELLANEOUS REVENUE В -150 PHYSICAL THERAPY 33. 19 66.00 MI SCELLANEOUS REVENUE -91 ELECTROCARDI OLOGY 69.00 33. 21 В 33. 21 MI SCELLANEOUS REVENUE 33. 22 В -5. 974 CLINIC 90.00 O 33. 22 33. 23 MARKETI NG -1, 334 ADMINISTRATIVE & GENERAL 5.00 33. 23 Α MARKETI NG -41 NURSING ADMINISTRATION 33. 24 Α 13.00 33. 24 MARKETI NG -63 ADULTS & PEDIATRICS 33, 25 30.00 0 33, 25 Α -2, 086 SUBPROVI DER - I RF 33.27 MARKETING Α 41.00 33. 27 33. 28 MARKETI NG -500 DELIVERY ROOM & LABOR ROOM 52.00 33. 28 Α -663 RADI OLOGY-DI AGNOSTI C 33. 29 MARKETI NG Α 54.00 33.29 -1, 034 RADI OLOGY-THERAPEUTI C 33.30 MARKETI NG 55.00 0 33.30 Α -1, 719 CLINIC ol 34.00 MARKETING Α 90.00 34 00 RECRUI TMENT -22, 281 ADMI NI STRATI VE & GENERAL 34.01 34.01 Α 5.00 --138 HOUSEKEEPI NG 34.02 RECRUI TMENT 9.00 34.02 Α RECRUI TMENT -317, 806 NURSING ADMINISTRATION 34.03 13.00 0 34.03 Α -46, 140 ADULTS & PEDIATRICS 34.04 RECRUI TMENT Α 30.00 34.04 -44, 780 ADMINI STRATI VE & GENERAL 35.01 GI FT В 5.00 35.01 35. 02 GI FT В -1, 843 NURSING ADMINISTRATION 13.00 35.02 -10PHARMACY GLET 36, 00 R 15.00 0 36, 00 37.00 GI FT В -520 ADULTS & PEDIATRICS 30.00 37.00 -110 INTENSIVE CARE UNIT 37. 01 GI FT В 31.00 37.01 -10|SUBPROVIDER - IRF 37.02 GI FT 41.00 37.02 В 0 -1,881 DELIVERY ROOM & LABOR ROOM 37.03 GI FT В 52.00 37.03 37.04 GI FT В -97 RADI OLOGY-DI AGNOSTI C 54.00 37.04 37.05 GI FT -294 RADI OLOGY-THERAPEUTI C 55.00 37.05 В -750 RESPIRATORY THERAPY 37.06 GLET R 65.00 0 37.06 -386 CLINIC 37.07 GI FT В 90.00 37.07 37.08 GI FT В -2, 016 EMERGENCY 91.00 37.08 -1, 040 ADMI NI STRATI VE & GENERAL 37.10 GI FT В 5.00 0 37.10 -707, 204 CAP REL COSTS-BLDG & FLXT 37.11 INTEREST Α 1.00 11 37.11 37.12 PHYSICAN PART A BENEFITS -1,862,580 EMPLOYEE BENEFITS DEPARTMENT 4.00 37.12 37.13 OTHER ADJUSTMENTS (SPECIFY) 0.00 37.13 OTHER ADJUSTMENTS (SPECIFY) 37. 15 37. 15 0 0.00 OTHER ADJUSTMENTS (SPECIFY) 37.16 0.00 37.16 OTHER ADJUSTMENTS (SPECIFY) 37.17 0.00 37.17 OTHER ADJUSTMENTS (SPECIFY) 37.18 0.00 37.18 0 (3)OTHER ADJUSTMENTS (SPECIFY) 37.19 0.00 37.19 37.20 OTHER ADJUSTMENTS (SPECIFY) 0.00 37.20 OTHER ADJUSTMENTS (SPECIFY) 37.21 0.00 37. 21 38.00 OTHER ADJUSTMENTS (SPECIFY) 0.00 38.00 OTHER ADJUSTMENTS (SPECIFY) 41.00 0.00 41.00 (3) 50.00 TOTAL (sum of lines 1 thru 49) -29, 767, 184 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.

Health Financial Systems	SSM	HEALTH GOOD SA	MARITAN HOSPITAL	In Lie	eu of Form CMS-2	2552-10
ADJUSTMENTS TO EXPENSES				Peri od:	Worksheet A-8	
				From 01/01/2023 To 12/31/2023	Date/Time Pre 5/21/2024 10:	
			Expense Classification o	Worksheet A		
			To/From Which the Amount is	to be Adjusted		
Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
cost center bescription						
	1.00	2.00	3.00	4.00	1 5.00	

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.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 14-0046

Peri od: Worksheet A-8-1 From 01/01/2023

				Го 12/31/2023 -	Date/Time Pre 5/21/2024 10:	
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUSTM	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OR	GANIZATIONS OR	CLAI MED	1
	HOME OFFICE COSTS:		T			
1. 00	1.00	CAP REL COSTS-BLDG & FLXT	HOME OFFICE	216, 754	12, 364	1.00
2.00	2. 00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	990, 018	151, 478	2. 00
3.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE - INTEREST	0	-4, 993	3. 00
4.00	4. 00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	9, 240, 771	679, 853	4. 00
4.01	5. 00	ADMINISTRATIVE & GENERAL	HOME OFFICE	21, 476, 051	36, 363, 401	4. 01
4.02	7. 00	OPERATION OF PLANT	HOME OFFICE	0	69, 112	4. 02
4.03	14. 00	CENTRAL SERVICES & SUPPLY	HOME OFFICE	0	38, 348	4. 03
4.04	71.00	MEDICAL SUPPLIES CHARGED TO	HOME OFFICE	-1, 543, 259	0	4. 04
4.05	194. 00	OTHER NRB COST CENTER	HOME OFFICE	0	936, 658	4. 05
5.00	TOTALS (sum of lines 1-4).			30, 380, 335	38, 246, 221	5. 00
	Transfer column 6, line 5 to					1
	Worksheet A-8, column 2,					1
	line 12.					
			6 11 111 1 111			

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

 not been posted to not hence in or amo I and or E, the amount arrenable cheard be that dated in coramin I or this part.						
			Related Organization(s) and/or Home Office			
Symbol (1)	Name	Percentage of	Name	Percentage of		
		Ownershi p		Ownershi p		
1. 00	2. 00	3. 00	4. 00	5. 00		
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:						

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

	Comorre undor trero mirro					
6.00	G	SSM HEALTH	100. 00 FI	RAN SISTERS	100. 00	6. 00
7. 00	G	SSM HEALTH	100. 00 FI	RAN SISTERS	100. 00	7. 00
8. 00			0.00		0. 00	8. 00
9. 00			0. 00		0. 00	9. 00
10.00			0. 00		0. 00	10.00
100.00	G. Other (financial or	CHURCH				100.00
	non-financial) specify:					

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

			5/21/2024 10: 0	<u>6 am</u>
	Net	Wkst. A-7 Ref.		
	Adjustments			
	(col. 4 minus			
	col. 5)*			
	6. 00	7. 00		
	A. COSTS INCUR	RED AND ADJUSTN	MENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED	
	HOME OFFICE CO	STS:		
1.00	204, 390	9		1.00
2.00	838, 540	9		2.00
3.00	4, 993	11		3.00
4.00	8, 560, 918	0		4.00
4.01	-14, 887, 350	0		4. 01
4.02	-69, 112	0		4. 02
4.03	-38, 348	0		4. 03
4.04	-1, 543, 259	0		4. 04
4. 05	-936, 658	1		4. 05
5. 00	-7, 865, 886	1		5. 00
			bescripts as appropriate) are transferred in detail to Workshoot A. column 6. Lines as	

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

 	cordinate i diferenti di conditti di remane e cindi di conditti di cindi parti	
Related Organization(s)		
and/or Home Office		
Type of Business		
6. 00		
B. INTERRELATIONSHIP TO RELA	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	HOME OFFICE	6.00
7.00	SSM HOSPITALS	7.00
8.00		8.00
9.00		9.00
10.00		10.00
100.00		100.00

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- $\hbox{B. Corporation, partnership, or other organization has financial interest in provider}.$
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

Health Financial Systems		ems SSI	M HEALTH GOOD S	SAMARITAN HOSPI	TAL	In Lieu of Form CMS-2552-10		
	R BASED PHYSIC		Provi der CCN: 14-0046		Peri od: Worksheet A-8-2			
						From 01/01/2023	3	
						Γο 12/31/2023	B Date/Time Pre 5/21/2024 10:	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
	MRSt. A LITTO "	I denti fi er	Remuneration	Component	Component		ider Component	
		1 40	Tromanor a cr orr	00poritorit	ooporiorit		Hours	
	1. 00	2.00	3.00	4.00	5. 00	6. 00	7. 00	
1.00		ADMINISTRATIVE & GENERAL	98, 260	98, 260		211, 500		1. 00
2.00		ADULTS & PEDIATRICS	5, 709, 136					2. 00
3.00		INTENSIVE CARE UNIT	1, 179, 046				214	3. 00
4.00	41. 00	SUBPROVIDER - IRF	251, 050				965	4. 00
5. 00		OPERATING ROOM	255, 990				0	
6.00	53. 00	ANESTHESI OLOGY	5, 645, 519	1			0	6. 00
7. 00		RADI OLOGY-THERAPEUTI C	244, 000				0	7. 00
8.00		CT SCAN	292, 081	292, 081	0	271, 900	0	8. 00
9. 00	60.00	LABORATORY	339, 262	339, 262	2		0	9. 00
10.00	65. 00	RESPI RATORY THERAPY	2, 813	2, 813	0	211, 500	0	10.00
11. 00	69. 00	ELECTROCARDI OLOGY	502, 298	238, 432	263, 866	211, 500	1, 376	11. 00
12. 00	69. 01	CARDIAC REHABILITION	-6, 351	-26, 112	19, 761	211, 500	128	12. 00
13. 00	70.00	ELECTROENCEPHALOGRAPHY	11, 050	1, 700	9, 350	211, 500	52	13. 00
14. 00	74. 00	RENAL DIALYSIS	67, 830	-14, 500	82, 330	197, 500	478	14. 00
15. 00	90.00	CLINIC	72, 182	72, 182	0	197, 500	0	15. 00
16. 00	91.00	EMERGENCY	966, 993	854, 326	112, 667	197, 500	563	16. 00
200.00			15, 631, 159	14, 894, 049	737, 110		4, 087	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE				Physician Cost	
		I denti fi er	Limit	Unadjusted RCE	Memberships &	Component	of Mal practice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1. 00	2. 00	8.00	9. 00	12. 00	13.00	14.00	
1.00		ADMINISTRATIVE & GENERAL	0				0	
2.00		ADULTS & PEDIATRICS	29, 530					
3. 00		INTENSIVE CARE UNIT	21, 760			0	0	
4. 00		SUBPROVIDER - IRF	84, 113	1			0	
5. 00		OPERATING ROOM	0) C	0	0	0	5. 00
6.00		ANESTHESI OLOGY	0	· ·	_		0	
7. 00		RADI OLOGY-THERAPEUTI C	0	l C	·	-	0	
8. 00		CT SCAN	0	l C	0		0	
9. 00	60. 00	LABORATORY	0	l C	0	0	0	9. 00
10. 00		RESPI RATORY THERAPY	0	· ·	0	0	0	10. 00
11. 00		ELECTROCARDI OLOGY	139, 915				0	11. 00
12. 00		CARDIAC REHABILITION	13, 015		0	0	0	12. 00
13. 00		ELECTROENCEPHALOGRAPHY	5, 288	264	0	0	0	13. 00
14. 00		RENAL DIALYSIS	45, 387	2, 269	0	0	0	14. 00
15. 00		CLI NI C	0	1	1	0	0	15. 00
16. 00	91. 00	EMERGENCY	53, 458					
200.00			392, 466				0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		ldenti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	4.00	0.00	14	47.00	47.00	10.00		
1 00	1.00	2.00	15. 00	16. 00	17. 00	18.00		1 00
1.00		ADMINISTRATIVE & GENERAL ADULTS & PEDIATRICS	0				1	1.00
2.00				1				2.00
3.00		INTENSIVE CARE UNIT	0	1				3. 00
4.00		SUBPROVI DER - I RF	0	1		1		4.00
5.00		OPERATING ROOM	0	·	1		1	5. 00
6.00		ANESTHESI OLOGY	0	l .	0			6.00
7. 00		RADI OLOGY-THERAPEUTI C CT SCAN	0			244, 000		7. 00
8.00			0	1	-			8. 00
9.00		LABORATORY			0			9.00
10.00		RESPIRATORY THERAPY	0	l .	_	_, _, _		10.00
11. 00		ELECTROCARDI OLOGY CARDI AC REHABI LI TI ON		139, 915		362, 383		11.00
12. 00 13. 00		ELECTROENCEPHALOGRAPHY		1				12. 00 13. 00
				1				
14.00		RENAL DIALYSIS CLINIC		1			1	14.00
15. 00 16. 00		EMERGENCY		1	_	,		15. 00 16. 00
200.00	91.00	LINENGLING					1	200.00
200.00	I	I	1	y 37∠, 400) 344, 044	10, 230, 093	I	200.00

Peri od:

Worksheet B

COST ALLOCATION - GENERAL SERVICE COSTS

From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/21/2024 10:06 am CAPITAL RELATED COSTS Cost Center Description Net Expenses BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Subtotal for Cost **BENEFITS** DEPARTMENT Allocation (from Wkst A col. 7) 1.00 2.00 4. 00 4A GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 6, 323, 438 6, 323, 438 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 4, 600, 280 4, 600, 280 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 29, 367, 881 159, 749 29, 527, 630 4.00 00500 ADMINISTRATIVE & GENERAL 77. 905 1, 860, 281 35, 670, 176 5 00 32, 879, 940 852, 050 5 00 7.00 00700 OPERATION OF PLANT 6, 271, 848 1,011,850 2, 412, 842 499, 293 10, 195, 833 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 673, 267 69, 760 44, 612 787, 639 8.00 00900 HOUSEKEEPI NG 2, 296, 581 162, 669 4, 453 776, 746 3, 240, 449 9.00 9.00 10.00 01000 DI ETARY 804.885 125, 316 996, 562 10 00 62, 804 3, 557 11.00 01100 CAFETERI A 1,070,045 164, 048 266, 580 1,500,673 11.00 01300 NURSING ADMINISTRATION 171, 931 436, 986 2, 385, 298 13.00 1, 745, 258 31, 123 13.00 01400 CENTRAL SERVICES & SUPPLY 351, 399 206, 311 14.00 812 558, 522 14.00 15.00 01500 PHARMACY 2, 587, 418 55, 421 1,460 1, 031, 037 3, 675, 336 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 26, 268 66, 512 92, 780 16.00 C 01700 SOCIAL SERVICE 56, 996 17.00 2, 145 0 0 59, 141 17.00 10, 500 02300 PARAMED ED PRGM-LABARATORY ED 23.00 71 0 10, 571 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 919, 612 25, 614, 250 30.00 03000 ADULTS & PEDIATRICS 16, 315, 931 8, 378, 707 30.00 31.00 03100 INTENSIVE CARE UNIT 2, 490, 971 287, 325 12, 960 1, 172, 995 3, 964, 251 31.00 04100 SUBPROVI DER - I RF 41.00 2, 329, 860 148, 117 44, 531 795, 593 3, 318, 101 41.00 04300 NURSERY 43.00 1,086,176 17, 571 84 434, 389 1, 538, 220 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 4, 572, 536 532, 946 374, 094 1, 160, 905 6, 640, 481 50.00 51.00 05100 RECOVERY ROOM 947, 916 1, 385, 992 438, 076 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 3, 192, 475 158, 486 38, 199 1, 401, 778 4, 790, 938 52.00 05300 ANESTHESI OLOGY 53.00 216, 824 4, 200 24, 373 19,673 265,070 53.00 3, 047, 117 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 814, 890 367, 356 53, 288 811, 583 54.00 05500 RADI OLOGY-THERAPEUTI C 55.00 1,542,300 84, 246 618, 504 2, 245, 050 55.00 729, 057 05600 RADI OI SOTOPE 641, 534 571 86, 952 56, 00 56,00 57.00 05700 CT SCAN 809, 713 63, 279 69, 463 274, 159 1, 216, 614 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 139, 152 58 00 345, 367 35, 618 113.184 633, 321 58 00 2, 110, 136 59.00 05900 CARDI AC CATHETERI ZATI ON 1, 475, 275 108, 036 88, 248 438, 577 59.00 06000 LABORATORY 145, 771 1, 173, 780 60.00 3, 987, 440 63, 122 5, 370, 113 60.00 06400 I NTRAVENOUS THERAPY 22, 214 102, 987 64.00 223, 606 348.807 64.00 33.819 06500 RESPIRATORY THERAPY 24, 150 3, 067, 038 65.00 2, 171, 438 837, 631 65.00 66.00 06600 PHYSI CAL THERAPY 1, 219, 200 61, 360 1,063 490,064 1, 771, 687 66.00 66.01 03951 CLINICAL NUTRITION 156, 554 73, 403 229, 957 66.01 06700 OCCUPATIONAL THERAPY 56, 487 851, 661 67 00 554 607 308 240 259 67 00 68.00 06800 SPEECH PATHOLOGY 332, 964 11, 173 562 153, 901 498, 600 68.00 69.00 06900 ELECTROCARDI OLOGY 2, 496, 731 287, 440 36, 859 943, 670 3, 764, 700 69.00 06901 CARDIAC REHABILITION 69.01 151, 479 7, 332 63,099 221, 910 69.01 07000 ELECTROENCEPHALOGRAPHY 35 921 70 00 21, 312 13, 983 71, 437 70 00 221 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 10, 552, 194 C 10, 552, 194 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 4, 527, 763 4, 527, 763 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 12, 737, 183 0 788 554, 511 13, 292, 482 73.00 07400 RENAL DIALYSIS 74 00 976, 814 Ω 0 0 976, 814 74 00 76.00 03950 ENDOSCOPY 0 0 0 76.00 0 07700 ALLOGENEIC HSCT ACQUISITION 0 77.00 0 0 0 77.00 07800 CAR T-CELL IMMUNOTHERAPY 0 78.00 0 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 5, 285, 556 52, 090 39, 565 1, 694, 147 7, 071, 358 90.00 91 00 09100 EMERGENCY 3, 671, 556 255, 677 5, 368 1, 264, 644 5, 197, 245 91 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 0 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 0 102.00 SPECIAL PURPOSE COST CENTERS 175, 863, 498 3, 791, 176 28, 998, 316 174, 485, 344 118. 00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 6, 283, 702 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 40, 224 23, 346 535 18, 895 83, 000 190. 00 191. 00 19100 RESEARCH 0 191.00 0 0 192.00 19200 PHYSI CLANS' PRI VATE OFFI CES 5, 923 -357, 468 180, 867 0 -170, 678 192, 00 194.00 07950 OTHER NRB COST CENTER 238, 008 1, 182, 601 194. 00 10, 467 625, 416 308, 710 194. 01 07951 OTHER NRB COST CENTER 0 C 0 0 194. 01 194. 02 07952 NONREI MBURSABLE COST CENTER C 0 0 194, 02 194. 03 07953 RETAIL PHARMACY 8, 133, 139 C 2, 286 201, 709 8, 337, 134 194. 03 200.00 Cross Foot Adjustments 0 200.00 201.00 Negative Cost Centers 0 201.00 TOTAL (sum lines 118 through 201) 4, 600, 280 183, 917, 401 202. 00 202.00 183, 917, 401 6, 323, 438 29, 527, 630

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0046

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2023 | Part I | To 12/31/2023 | Date/Time Prepared: | 5/21/2024 | 10: 06 am

						5/21/2024 10:	
	Cost Center Description	ADMI NI STRATI VE		LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	PLANT	LINEN SERVICE	0.00	10.00	
	OFNEDAL CEDIU OF COST OFNITEDO	5. 00	7. 00	8. 00	9. 00	10. 00	
1 00	GENERAL SERVICE COST CENTERS	1		I			1 00
1.00	00100 CAP REL COSTS-BLDG & FIXT					ļ	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00
4. 00 5. 00	00500 ADMINISTRATIVE & GENERAL	35, 670, 176				ļ	4. 00 5. 00
7. 00	00700 OPERATION OF PLANT	2, 450, 426	12, 646, 259			ļ	7.00
8. 00	00800 LAUNDRY & LINEN SERVICE	189, 298	205, 174				8.00
9. 00	00900 HOUSEKEEPING	778, 797	478, 433		4, 497, 679	ļ	9.00
10. 00	01000 DI ETARY	239, 510	184, 714		69, 448	1, 490, 234	1
11. 00	01100 CAFETERI A	360, 666	482, 486		181, 404	1, 470, 234	1
13. 00	01300 NURSI NG ADMI NI STRATI ON	573, 273	91, 537		34, 416	0	
14. 00	01400 CENTRAL SERVICES & SUPPLY	134, 233	71,007	j o	01, 110	0	1
15. 00	01500 PHARMACY	883, 316	163, 000	,	61, 284	0	
16. 00	01600 MEDICAL RECORDS & LIBRARY	22, 298	195, 619		73, 548	0	
17. 00	01700 SOCIAL SERVICE	14, 214	167, 632	1	63, 026	0	1
23. 00	02300 PARAMED ED PRGM-LABARATORY ED	2, 541	30, 882	1		0	
	INPATIENT ROUTINE SERVICE COST CENTERS	, , , , , ,			,		
30.00	03000 ADULTS & PEDI ATRI CS	6, 156, 033	2, 704, 702	925, 079	1, 016, 907	1, 166, 206	30.00
31.00	03100 INTENSIVE CARE UNIT	952, 752	845, 062			118, 018	1
41.00	04100 SUBPROVI DER - I RF	797, 459	435, 632	86, 607	163, 787	109, 181	41.00
43.00	04300 NURSERY	369, 690	51, 679	76, 809	19, 430	96, 829	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	1, 595, 947	1, 567, 464	0	589, 330	0	50. 00
51. 00	05100 RECOVERY ROOM	333, 104	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 151, 435	466, 128	0	175, 253	0	52. 00
53.00	05300 ANESTHESI OLOGY	63, 706	12, 353	0	4, 644	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	732, 332	1, 080, 443	0	406, 221	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	539, 566	0	0	0	0	
56. 00	05600 RADI 01 S0T0PE	175, 219	0	0	0	0	
57. 00	05700 CT SCAN	292, 396	186, 113		69, 974	0	1
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	152, 210	104, 758		39, 387	0	
59. 00	05900 CARDI AC CATHETERI ZATI ON	507, 142	317, 749		119, 466	0	1
60. 00	06000 LABORATORY	1, 290, 631	428, 732		161, 193	0	
64. 00	06400 I NTRAVENOUS THERAPY	83, 831	65, 335		24, 564	0	1
65. 00	06500 RESPI RATORY THERAPY	737, 120	71, 029		26, 705	0	
66. 00	06600 PHYSI CAL THERAPY	425, 800	180, 468		67, 852	0	
66. 01	03951 CLINICAL NUTRITION	55, 267	0		0	0	
67. 00	06700 OCCUPATI ONAL THERAPY	204, 685	166, 137		62, 463	0	
68. 00	06800 SPEECH PATHOLOGY	119, 832	32, 861	1	12, 355	0	1
69. 00	06900 ELECTROCARDI OLOGY	904, 793	845, 400	1	317, 851	0	
69. 01	06901 CARDI AC REHABI LITI ON	53, 333	0		22 547	0	
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	17, 169	62, 681	0	23, 567	0	
71.00	07200 IMPL. DEV. CHARGED TO PATTENTS	2, 536, 072 1, 088, 184	0		0	0	
73. 00	07300 DRUGS CHARGED TO PATIENTS	3, 194, 662	0		0	0	
74. 00	07400 RENAL DIALYSIS	234, 764	0		0	0	1
76. 00	03950 ENDOSCOPY	254, 704	0		0	0	
	07700 ALLOGENEIC HSCT ACQUISITION	l o	0	0	0	0	
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	l o	_	_	- 1	-	
70.00	OUTPATIENT SERVICE COST CENTERS	<u>ا</u>		1	٥	0	70.00
90. 00	09000 CLINIC	1, 699, 502	153, 205	0	57, 601	0	90.00
91. 00	09100 EMERGENCY	1, 249, 085	751, 981				1
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1,217,000	70.770.	Ĭ	202,720	١	92.00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102. 00
	SPECIAL PURPOSE COST CENTERS	-1			-1	-	
118.00		33, 362, 293	12, 529, 389	1, 182, 111	4, 453, 739	1, 490, 234	118.00
	NONREI MBURSABLE COST CENTERS	,					
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	19, 948	68, 665	0	25, 816	0	190. 00
191.00	19100 RESEARCH	0	0	0	0	0	191. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	17, 419	0	6, 549	0	192. 00
	07950 OTHER NRB COST CENTER	284, 222	30, 786	0	11, 575	0	194. 00
	07951 OTHER NRB COST CENTER	ol	0	0	o		194. 01
	07952 NONREIMBURSABLE COST CENTER		0	0	o		194. 02
	07953 RETAIL PHARMACY	2, 003, 713	0	0	o		194. 03
200.00						- 1	200.00
201.00		o	0	0	О	0	201. 00
202.00	TOTAL (sum lines 118 through 201)	35, 670, 176	12, 646, 259	1, 182, 111	4, 497, 679	1, 490, 234	202.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0046

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2023 | Part I | To 12/31/2023 | Date/Time Prepared: | 5/21/2024 | 10: 06 am

					5/21/2024 10:	06 am
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVICES &		RECORDS &	
	11 00	12.00	SUPPLY	15.00	LI BRARY	
GENERAL SERVICE COST CENTERS	11. 00	13. 00	14. 00	15. 00	16. 00	
1.00 00100 CAP REL COSTS-BLDG & FIXT						1. 00
2. 00 00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00 OO400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00 00500 ADMI NI STRATI VE & GENERAL						5. 00
7. 00 O0700 OPERATION OF PLANT						7. 00
8.00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A	2, 525, 229					11.00
13.00 01300 NURSING ADMINISTRATION	42, 515	3, 127, 039				13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	20, 072	0	712, 827			14.00
15. 00 01500 PHARMACY	100, 312	0	0	4, 883, 248		15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	0	0	0	384, 245	16. 00
17. 00 01700 SOCI AL SERVI CE	0	0	0	0	0	17. 00
23. 00 O2300 PARAMED ED PRGM-LABARATORY ED	0	0	0	0	0	23. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	815, 210	1, 110, 152	59, 252	271, 668	31, 252	30.00
31. 00 03100 INTENSI VE CARE UNI T	114, 123	262, 183	26, 337	37, 597	3, 897	31.00
41. 00 04100 SUBPROVI DER - RF	77, 405	124, 043	3, 083	6, 266	3, 001	41.00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	42, 263	92, 046	0	0	1, 988	43. 00
50. 00 05000 OPERATING ROOM	112, 947	186, 554	253, 451	936, 836	52, 655	50. 00
51. 00 05100 RECOVERY ROOM	42, 621	102, 285	13, 507	4, 286	7, 577	51. 00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	136, 382	309, 547	30, 153	92, 604	11, 671	52.00
53. 00 05300 ANESTHESI OLOGY	1, 914	307, 347	17, 038	574, 299	17, 256	53. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	78, 961	12, 239	5, 536	48, 904	12, 770	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	60, 176	40, 582	9, 946	85, 685	2, 355	55. 00
56. 00 05600 RADI 0I SOTOPE	8, 460	40, 302	689	112, 749	6, 076	56. 00
57. 00 05700 CT SCAN	26, 674	55	4, 258	159, 796	42, 616	57. 00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	11, 012	192	1, 196	11, 063	7, 353	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	42, 670	51, 431	78, 426	14, 022	24, 807	59. 00
60. 00 06000 LABORATORY	114, 200	0	130, 996	3, 858	45, 462	60. 00
64. 00 06400 I NTRAVENOUS THERAPY	10, 020	21, 923	815	4, 266	559	64. 00
65. 00 06500 RESPIRATORY THERAPY	81, 495	857	13, 191	33, 678	7, 653	65. 00
66. 00 06600 PHYSI CAL THERAPY	47, 680	0	616	1, 286	4, 415	66. 00
66. 01 03951 CLINI CAL NUTRI TI ON	7, 142	0	0	0	13	66. 01
67. 00 06700 OCCUPATI ONAL THERAPY	23, 375	O	277	1, 980	1, 984	67.00
68.00 06800 SPEECH PATHOLOGY	14, 973	o	45	O	1, 122	68. 00
69. 00 06900 ELECTROCARDI OLOGY	91, 812	131, 550	10, 184	847, 886	14, 086	69. 00
69. 01 06901 CARDI AC REHABI LI TI ON	6, 139	20, 049	168	980	415	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	1, 360	0	34	1, 612	120	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	7, 787	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	5, 246	72. 00
73.00 O7300 DRUGS CHARGED TO PATIENTS	53, 950	134, 919	5, 350	7, 103	35, 852	73. 00
74. 00 07400 RENAL DI ALYSI S	0	0	711	61	1, 181	74. 00
76. 00 03950 ENDOSCOPY	0	0	0	0	0	76. 00
77. 00 07700 ALLOGENEI C HSCT ACQUI SITI ON	0	0	0	0	0	77. 00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0	U	0	U	0	78. 00
OUTPATIENT SERVICE COST CENTERS	1/4 020	204 044	10 022	1 550 000	7 401	00.00
90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY	164, 828	286, 964	18, 032	1, 559, 999	7, 491	90.00
	123, 040	239, 155	29, 536	64, 764	25, 585	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) OTHER REIMBURSABLE COST CENTERS						92. 00
102.00 10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102. 00
SPECIAL PURPOSE COST CENTERS	<u> </u>	U _I	U	<u> </u>	0	102.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	2, 473, 731	3, 126, 726	712, 827	4, 883, 248	384, 245	118 00
NONREIMBURSABLE COST CENTERS	2,473,731	3, 120, 720	712,027	4, 003, 240	304, 243	110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 838	0	0	0	0	190. 00
191. 00 19100 RESEARCH	0	o	Ö	0		191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	313	0	0		192. 00
194. 00 07950 OTHER NRB COST CENTER	30, 035	0	o	ol		194. 00
194. 01 07951 OTHER NRB COST CENTER	0	o	Ö	o		194. 01
194. 02 07952 NONREI MBURSABLE COST CENTER	o	O	0	0		194. 02
194.03 07953 RETAIL PHARMACY	19, 625	o	О	o	0	194. 03
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	o	0	0	О		201. 00
202.00 TOTAL (sum lines 118 through 201)	2, 525, 229	3, 127, 039	712, 827	4, 883, 248	384, 245	202. 00

| Period: | Worksheet B | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 14-0046

					Fo 12/31/2023	Date/Time Pre 5/21/2024 10:	
	Cost Center Description	SOCIAL SERVICE	PARAMED ED PRGM-LABARATOR	Subtotal	Intern & Residents Cost	Total	OG alli
			Y ED		& Post Stepdown		
		17.00	22.00	24.00	Adjustments	24 00	
	GENERAL SERVICE COST CENTERS	17. 00	23. 00	24. 00	25. 00	26. 00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUI P						2.00
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						4. 00 5. 00
7. 00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9. 00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A						10.00
13. 00	01300 NURSI NG ADMI NI STRATI ON						13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY						14. 00
15. 00	01500 PHARMACY						15. 00
16. 00 17. 00	01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE	304, 013	,				16. 00 17. 00
23. 00	02300 PARAMED ED PRGM-LABARATORY ED	304,013					23. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS						20.00
30.00	03000 ADULTS & PEDIATRICS	237, 911	1			40, 108, 622	
31.00	03100 NTENSIVE CARE UNIT	24, 076	1	6, 759, 636		6, 759, 636	
41. 00 43. 00	04100 SUBPROVI DER - I RF 04300 NURSERY	22, 273 19, 753	1	5, 146, 838 2, 308, 707		5, 146, 838 2, 308, 707	
10.00	ANCILLARY SERVICE COST CENTERS	17,700	,ı	2,000,70	, i	2,000,707	10.00
50.00	05000 OPERATING ROOM	C	1	11, 935, 665		11, 935, 665	
51.00	05100 RECOVERY ROOM	C		1, 889, 372		1, 889, 372	
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	C		7, 164, 111 956, 280		7, 164, 111 956, 280	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	Č	o o	5, 424, 523		5, 424, 523	
55. 00	05500 RADI OLOGY-THERAPEUTI C	C	o	2, 983, 360		2, 983, 360	
56.00	05600 RADI OI SOTOPE	C		1, 032, 250		1, 032, 250	
57. 00 58. 00	05700 CT SCAN 05800 MAGNETIC RESONANCE I MAGING (MRI)			1, 998, 496 960, 492		1, 998, 496 960, 492	1
59. 00	05900 CARDI AC CATHETERI ZATI ON		1	3, 265, 849		3, 265, 849	1
60.00	06000 LABORATORY	C		7, 600, 790		7, 600, 790	1
64. 00	06400 NTRAVENOUS THERAPY	C		560, 120		560, 120	
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY			4, 038, 766 2, 499, 804		4, 038, 766 2, 499, 804	
66. 01	03951 CLINICAL NUTRITION	i c	1	292, 379		292, 379	
67. 00	06700 OCCUPATI ONAL THERAPY	C	1	1, 312, 562	2 0	1, 312, 562	
68. 00	06800 SPEECH PATHOLOGY	C	1	679, 788		679, 788	
69. 00 69. 01	06900 ELECTROCARDI OLOGY 06901 CARDI AC REHABI LI TI ON	C		6, 928, 262 302, 994		6, 928, 262 302, 994	1
70. 00	07000 ELECTROENCEPHALOGRAPHY		ol ol	177, 980		177, 980	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	C	1 -1	13, 096, 053	3 O	13, 096, 053	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	C	0			5, 621, 193	
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS			16, 724, 318 1, 213, 53		16, 724, 318 1, 213, 531	
76. 00	03950 ENDOSCOPY	Č	1	1, 210, 00		0	1
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	C	1	-	o o	0	
78. 00	O7800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS	C) 0	(0	0	78. 00
90. 00	09000 CLINIC		ol	11, 018, 980	ol lo	11, 018, 980	90.00
91. 00	09100 EMERGENCY	C	1	7, 963, 119		7, 963, 119	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92. 00
100.00	OTHER REIMBURSABLE COST CENTERS 10200 OPIOID TREATMENT PROGRAM	T C	ol ol	,	ol ol	0	102.00
102.00	SPECIAL PURPOSE COST CENTERS		n Ol	(oj oj	0	102. 00
118.00		304, 013	55, 605	171, 964, 840	0	171, 964, 840	118. 00
	NONREI MBURSABLE COST CENTERS				-		1.05
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19100 RESEARCH	C	1	199, 267	0	199, 267	190. 00 191. 00
	19100 RESEARCH 19200 PHYSICIANS' PRIVATE OFFICES		1	-146, 39 ⁷	7 0	-146, 397	
194.00	07950 OTHER NRB COST CENTER		ol ol	1, 539, 219		1, 539, 219	194. 00
	07951 OTHER NRB COST CENTER	C	이	(194. 01
	07952 NONREIMBURSABLE COST CENTER 07953 RETAIL PHARMACY			10, 360, 472		0 10, 360, 472	194. 02
200.00	1 1		<u></u>	10, 300, 472			200. 00
201.00	Negative Cost Centers	c	ol ől		ol ől	0	201. 00
202.00	TOTAL (sum lines 118 through 201)	304, 013	55, 605	183, 917, 401	ı o	183, 917, 401	202. 00

Provider CCN: 14-0046

Peri od:

ALLOCATION OF CAPITAL RELATED COSTS

Part II

From 01/01/2023 Date/Time Prepared: 12/31/2023 5/21/2024 10:06 am CAPITAL RELATED COSTS Cost Center Description Directly BLDG & FIXT MVBLE EQUIP Subtotal **EMPLOYEE** Assigned New **BENEFITS** DEPARTMENT Capi tal Related Costs 1.00 2.00 2A 4.00 0 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 159, 749 159, 749 159, 749 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 0 0 852,050 77, 905 929, 955 10,066 5.00 00700 OPERATION OF PLANT 2, 702 7 00 1, 011, 850 3, 424, 692 7 00 2, 412, 842 00800 LAUNDRY & LINEN SERVICE 8.00 69, 760 69, 760 241 8.00 9.00 00900 HOUSEKEEPI NG 0 162, 669 4, 453 167, 122 4, 203 9.00 01000 DI ETARY 0 62, 804 3, 557 10 00 66 361 678 10 00 01100 CAFETERI A 11.00 0 164, 048 164,048 1, 442 11.00 13.00 01300 NURSING ADMINISTRATION 59, 019 31, 123 171, 931 262, 073 2, 365 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 38 812 850 1, 116 14.00 01500 PHARMACY 55 421 319 954 5, 579 15 00 263.073 15 00 1,460 16.00 01600 MEDICAL RECORDS & LIBRARY 0 66, 512 C 66, 512 0 16.00 01700 SOCIAL SERVICE 0 56, 996 0 56, 996 0 17.00 17.00 02300 PARAMED ED PRGM-LABARATORY ED 10, 500 10,500 23.00 23.00 0 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 109, 347 919, 612 0 1, 028, 959 45, 318 30.00 03100 INTENSIVE CARE UNIT 12, 960 31.00 4,660 287, 325 304, 945 6, 347 31.00 04100 SUBPROVIDER - IRF 44, 531 4, 305 41.00 41.00 148, 117 192.648 0 04300 NURSERY 43.00 0 17, 571 84 17,655 2, 350 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 107, 340 532, 946 374, 094 1,014,380 6, 282 50.00 05100 RECOVERY ROOM 51.00 2.370 51.00 0 05200 DELIVERY ROOM & LABOR ROOM 38 199 52.00 0 158, 486 196, 685 7, 585 52 00 05300 ANESTHESI OLOGY 0 4, 200 28, 573 106 53.00 24, 373 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 367, 356 53, 288 420, 644 4, 391 54.00 05500 RADI OLOGY-THERAPEUTI C 84, 246 117, 906 3, 347 55.00 33,660 55.00 56.00 05600 RADI OI SOTOPE 0 571 571 470 56.00 05700 CT SCAN 63, 279 69, 463 132, 742 57.00 0 1,483 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 35, 618 139, 152 174, 770 612 58.00 05900 CARDIAC CATHETERIZATION 108.036 59 00 167 88. 248 196, 451 2.373 59 00 60.00 06000 LABORATORY 145, 771 63, 122 208, 893 6, 351 60.00 06400 I NTRAVENOUS THERAPY 64.00 0 22, 214 22, 214 557 64.00 06500 RESPIRATORY THERAPY 180.476 65.00 122, 507 24, 150 33, 819 4.532 65, 00 06600 PHYSI CAL THERAPY 66.00 684 61, 360 1,063 63, 107 2,652 66.00 66.01 03951 CLINICAL NUTRITION 0 397 66.01 06700 OCCUPATIONAL THERAPY 56, 487 308 56, 795 67.00 0 1.300 67.00 06800 SPEECH PATHOLOGY 11, 173 11, 735 68.00 562 833 68.00 69.00 06900 ELECTROCARDI OLOGY 180, 525 287, 440 36, 859 504, 824 5, 106 69.00 69.01 06901 CARDIAC REHABILITION 7, 332 7, 332 341 69.01 07000 ELECTROENCEPHALOGRAPHY 0 21, 312 21. 533 70.00 221 76 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 C 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 C 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0 0 0 788 788 3,000 73.00 07400 RENAL DIALYSIS 74 00 74 00 Ω 0 0 0 76.00 03950 ENDOSCOPY 0 0 0 0 76.00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0 0 77.00 77.00 C 07800 CAR T-CELL IMMUNOTHERAPY 78.00 78.00 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 1,041,268 52.090 39, 565 1, 132, 923 9, 167 90.00 09100 EMERGENCY 91.00 255, 677 5.368 261, 045 6,843 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 0 102. 00 SPECIAL PURPOSE COST CENTERS 11, 997, 166 SUBTOTALS (SUM OF LINES 1 through 117) 1, 922, 288 6, 283, 702 3, 791, 176 <u>156, 886</u> 118. 00 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 102 190. 00 0 23, 346 535 23.881 191. 00 19100 RESEARCH 0 0 191.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 5, 923 235, 654 0 192,00 48.864 180, 867 194.00 07950 OTHER NRB COST CENTER 1, 180, 810 10, 467 625, 416 1, 816, 693 1, 670 194. 00 0 194. 01 194. 01 07951 OTHER NRB COST CENTER 194. 02 07952 NONREI MBURSABLE COST CENTER 0 194. 02 0 194. 03 07953 RETAIL PHARMACY 0 C 2, 286 2.286 1, 091 194, 03 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 201.00 159, 749 202. 00 4, 600, 280 14, 075, 680 202.00 TOTAL (sum lines 118 through 201) 3, 151, 962 6, 323, 438

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0046

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: | 5/21/2024 | 10: 06 am | Date/Time Prepared: | Date/Tim

SOUTH Continue C							5/21/2024 10:	06 am_
FRIENDL SERVICE COST DENTERS		Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
EREBEAL SERVICE COST CENTERS 1 00 000100 APR ELL COSTS-AURLE EDUTY 2 00 00000 APR ELL COSTS-AURLE EDUTY 3 00 00000 AURLE COSTS-AURLE EDUTY 4 00 00000 AURLES ARE COSTS AURLE EDUTY 5 00 00000 AURLES ARE COSTS AURLES AURL		·	& GENERAL	PLANT	LINEN SERVICE			
0.0100 0.0100 0.024 PRIL CESISS WINE FOUR 0.0100 0.024 0.024 0.0100 0.024 0.0100 0.024 0.02			5. 00	7. 00	8. 00	9. 00	10.00	
2 00		GENERAL SERVICE COST CENTERS						
0.000 DATE OF BEWEFT IS EPPARTWET 0.000 0.000 DATE OF MINISTRATION 0.000 0.000 DATE OF MINISTRATION 0.000	1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
0.000 DATE OF BEWEFT IS EPPARTWET 0.000 0.000 DATE OF MINISTRATION 0.000 0.000 DATE OF MINISTRATION 0.000	2.00	00200 CAP REL COSTS-MVBLE EQUIP					1	2.00
0.0000 OBSORD ABBIN ISTRATIVE & GENERAL 94,000 0.000 0.00000 0.00000 0.00000 0.00000 0.00000 0.0000000 0.00000000							1	
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10.00 01000 DETARY 6, 312 51,005 0 5,000 129,388 10.00 13.							1	
11.00 0 11000 (ARETERIA) 9.505 133.227 0 13.066 0 111.00 14.00 14.00 0 14.00		l I					400.050	
13.00 01300 MURSINS ADMINISTRATION 15.108 25.276 0 2,479 0 13.00								
14. 00 01-000 PARAMACY 23. 280 0 0 0 14. 00		l l				,		
15.00 0 10500 PIARABRACY		l l		25, 276	0	2, 479		
10. 00 01000 MEDICAL RECORDS & LIBRARY 588 54, 016 0 5,298 0 10,00 02300 02000 PARAMED FD PROM-LABARATORY FD 67 8,527 0 8336 0 23,00 17,00 02300 PARAMED FD PROM-LABARATORY FD 67 8,527 0 8336 0 23,00 17,	14.00	01400 CENTRAL SERVICES & SUPPLY	3, 538	0	0	0	0	14. 00
17.00 01700 PARAMED ED PRIGULABANATIONY ED 67 8,527 0 83.0 022.0	15.00	01500 PHARMACY	23, 280	45, 009	0	4, 414	0	15. 00
Description	16.00	01600 MEDICAL RECORDS & LIBRARY	588	54, 016	0	5, 298	0	16. 00
Description	17. 00	01700 SOCIAL SERVICE	375	46, 288	0	4, 540	0	17. 00
INPATI ENT ROUTINE SERVICE COST CENTERS 10.2,181			· · · · · · · · · · · · · · · · · · ·		1		0	
30.00 03000 ADULTS & PEDI ATRICS 102,181 746,840 103,020 73,246 101,232 30.00 101,000 101 101 101,000 101,00							_	
31 00 03100 INTENSIVE CARE UNIT 25, 110 2233, 345 10, 425 22, 885 10, 244 31, 00 410 04100 SUBPROVID DEF 17, 79 9477 41, 00 430 04300 NURSERY 9, 743 114, 270 8, 554 11, 490 8, 405 43, 00 43, 00 NURSERY 14, 00 8, 405 43, 00 43, 00 NURSERY 14, 00 05000 OFFICIAL THE STREET 14, 270 0 0 0 0 0 0 0 0 0	30 00		162 191	746 840	103 020	73 246	101 232	30 00
14. 00 04100 SUBPROVIDER - IRF			1					
ABOOD MARCHELARY SERVICE COST CERTERS								
ANCILLARY SERVICE COST CENTERS			1					
50.00 050000 0FEATH NO. ROOM	43.00		9, 743	14, 270	8, 554	1, 400	8, 405	43.00
15.10			,					
1.00 0.05200 0.05200 0.05200 0.05200 0.05200 0.05300 0.05300 0.05300 0.05300 0.05300 0.05300 0.05300 0.05300 0.05300 0.05300 0.05500 0.0	50. 00	l l		432, 819	0	42, 448		50.00
1.679 3.411 0 3.35 0 53.0	51.00	05100 RECOVERY ROOM	8, 779	0	0	0	0	51.00
94.00 05400 RADIO LOGY-DI AGNOSTIC 19, 300 298, 339 0 29, 259 0 54, 00 055.00 05500 RADIO LOGY-THERAPEUTIC 14, 220 0 0 0 0 55, 00 05600 RADIO LOGY-THERAPEUTIC 14, 220 0 0 0 0 0 55, 00 05700 C5700 C7500	52.00	05200 DELIVERY ROOM & LABOR ROOM	30, 346	128, 711	0	12, 623	0	52.00
94.00 05400 RADIO LOGY-DI AGNOSTIC 19, 300 298, 339 0 29, 259 0 54, 00 055.00 05500 RADIO LOGY-THERAPEUTIC 14, 220 0 0 0 0 55, 00 05600 RADIO LOGY-THERAPEUTIC 14, 220 0 0 0 0 0 55, 00 05700 C5700 C7500	53.00		1		0		0	53.00
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66. 01 03951 CLI NI CAL NUTRI TI ON		l l				, , ,		
67. 00 06700 06CUPATI ONAL THERAPY 5, 394 45, 875 0 4, 499 0 67. 00 68. 00 06800 SPECH PATHOLOGY 33, 158 9, 074 0 890 0 68. 00 69. 01 06900 ELECTROCARDI OLOGY 23, 846 233, 438 0 22, 894 0 69. 00 69. 01 06901 CARDI AC REHABI LITION 1, 406 0 0 0 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 66, 838 0 0 0 0 0 0 72. 00 07200 IMPL DEV. CHARGED TO PATI ENTS 84, 195 0 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 84, 195 0 0 0 0 0 0 74. 00 07400 RENAL DI ALVSIS 6, 187 0 0 0 0 0 0 75. 00 07300 DRUGS CHARGED TO PATI ENTS 84, 195 0 0 0 0 0 0 76. 00 03950 ENDOSCOPY 0 0 0 0 0 0 0 0 77. 00 07700 ALLOGENEIC HASCED TO PATI ENTS 84, 195 0 0 0 0 0 0 0 78. 00 07300 CART E-CELL I IMMUNOTHERAPY 0 0 0 0 0 0 0 0 78. 00 07300 CART E-CELL I IMMUNOTHERAPY 0 0 0 0 0 0 0 79. 00 09000 CLINIC 32, 919 207, 642 0 20, 364 0 91. 00 79. 00 09000 OSERWATI ON BEDS (NON-DISTINCT PART) 92. 00 79. 00 09000 OSERWATI ON BEDS (NON-DISTINCT PART) 92. 00 79. 00 09000 OSERWATI ON BEDS (NON-DISTINCT PART) 92. 00 79. 00 09000 OSERWATI ON BEDS (NON-DISTINCT PART) 92. 00 79. 00 09000 OSERWATI ON BEDS (NON-DISTINCT PART) 92. 00 79. 00 09000 OSERWATI ON BEDS (NON-DISTINCT PART) 92. 00 79. 00 09000 OSERWATI ON BEDS (NON-DISTINCT PART) 92. 00 79. 00 09000 OSERWATI ON BEDS (NON-DISTINCT PART) 92. 00 79. 00 09000 OSERWATI ON BEDS (NON-DISTINCT PART) 92. 00 79. 00 09000 OSERWATI ON BEDS (NON-DISTINCT PART) 92. 00 79. 00 09000 OSERWATI ON BEDS (NON-DISTINCT PART) 92. 00 79. 00 09000 OSERWATI ON BEDS (NON-DISTINCT PART) 92. 00 79. 00 09000 OSERWATI ON BEDS (NON-DISTINCT PART) 92. 00 79. 00 09000 OSERWATI ON BEDS (NON-DISTINCT PART) 92. 00 79. 00 09000 OSERWATI ON BE		l l						
68.00 06800 SPECH PATHOLOGY 3, 158 9, 074 0 890 0 68.00 69.00 06900 ELECTROCARDIOLOGY 23, 846 233, 438 0 22, 894 0 69.00 69.01 06901 CARDIAC REHABILITION 1, 406 0 0 0 0 0 70.00 07000 ELECTROENCEPHALOGRAPHY 452 17, 308 0 1, 697 0 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 66, 838 0 0 0 0 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 28, 679 0 0 0 0 0 0 73.00 07300 DRUGS CHARGED TO PATIENTS 84, 195 0 0 0 0 0 0 74.00 07400 RENAL DIALYSIS 6, 187 0 0 0 0 0 0 75.00 07300 DRUGS CHARGED TO PATIENTS 84, 195 0 0 0 0 0 0 76.00 03950 ENDOSCOPY 0 0 0 0 0 0 0 0 76.00 03950 ENDOSCOPY 0 0 0 0 0 0 0 77.00 07000 ALIGENEIC FISCAL CAULISITION 0 0 0 0 0 0 0 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 0 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 0 79.00 09000 CLINIC CENTERS 79.00 09000 CLINIC CENTERS 79.00 09000 DEBROENCY 32, 919 207, 642 0 20, 364 0 91.00 79.00 09000 ELROSCOPY 0 0 0 0 0 0 70.00 09100 EMERGENCY 32, 919 207, 642 0 20, 364 0 91.00 70.00 09100 EMERGENCY 32, 919 207, 642 0 20, 364 0 91.00 70.00 09100 DID TREATMENT PROGRAM 0 0 0 0 0 0 70.00 09000 010 TREATMENT PROGRAM 0 0 0 0 0 70.00 0100 0100 0100 0100 0100 0100 70.00 0100 0100 0100 0100 0100 0100 70.00 0100 0100 0100 0100 0100 0100 70.00 0100 0100 0100 0100 0100 0100 70.00 0100 0100 0100 0100 0100 0100 70.00 0100 0100 0100 0100 0100 0100 70.00 0100 0100 0100 0100 0100 0100 0100 70.00 0100 0100 0100 0100 0100 0100 0100 0100 70.00 0100 0100 0100 0100 0100 0100 0100 0100 0100 70.00 0100 0100 0100 0100 0100 0100 0				-	_	_		
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70. 00 07000 ELECTROENCEPHALOGRAPHY 452 17, 308 0 1, 697 0 70. 00 71. 00 7100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 66, 838 0 0 0 0 0 71. 00 72. 00 07200 MPL. DEV. CHARGED TO PATIENTS 28, 679 0 0 0 0 0 0 73. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 84, 195 0 0 0 0 0 0 73. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 0 0 0 0 0 0 0 0 0	69.00	06900 ELECTROCARDI OLOGY	23, 846	233, 438	0	22, 894	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	69. 01	06901 CARDIAC REHABILITION	1, 406	0	0	ol	0	69. 01
71. 00		l l	1	17 308	0	1 697	0	
72. 00 07200 MPLC DEV CHARGED TO PATIENTS 28, 679 0 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 84, 195 0 0 0 0 0 0 74. 00 07400 RENAL DIALYSIS 6, 187 0 0 0 0 0 0 0 76. 00 03950 ENDOSCOPY 0 0 0 0 0 0 0 0 0 77. 00 07700 ALLOGENEI C HSCT ACQUISITION 0 0 0 0 0 0 0 0 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 0 0 79. 00 07900 CLINIC 0 0 0 0 0 0 0 0 90. 00 09100 EMERGENCY 0 0 0 0 0 0 0 0 91. 00 09100 EMERGENCY 0 0 0 0 0 0 0 0 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 0 0 102. 00 07000 OD 0 0 0 0 0 0 0 103. 00 07000 OD 07000 OD 0 0 0 0 104. 00 07000 OD 07000 OD 0 0 0 0 105. 00 07000 OD 07000 OD 0 0 0 0 0 107. 00 07000 OD 0 0 0 0 0 0 0 108. 00 07000 OD 07000 OD 0 0 0 0 0 109. 00 07000 OD 07000 OD 0 0 0 0 0 0 109. 00 07000 OD 07000 OD 0 0 0 0 0 0 109. 00 07000 OD 07000 OD 0 0 0 0 0 0 109. 00 07000 OD 07000 OD 0 0 0 0 0 0 109. 00 07000 OD 07000 OD 0 0 0 0 0 0 109. 00 07000 OD 07000 OD 0 0 0 0 0 109. 00 07000 OD 07000 OD 0 0 0 0 0 109. 00 07000 OD 07000 OD 0 0 0 0 109. 00 07000 OD 07000 OD 0 0 0 0 0 109. 00 07000 OD 07000 OD 0 0 0 0 109. 00 07000 OD 07000 OD 0 0 0 0 109. 00 07000 OD 07000 OD 0 0 0 109. 00 07000 OD 07000 OD 0 0 0 0 109. 00 07000 OD 07000 OD 0 0 0 109. 00 07000 OD 07000 OD 0 0 0 0 109. 00 07000 OD 07000 OD 0 0 0 0 109. 00 07000 OD 07000 OD 0 0 0 109. 00 0700				.,, 555	j ,	., 0,,		
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74. 00 07400 RENAL DIALYSIS 6, 187 0 0 0 0 0 74. 00 76. 00 03950 ENDOSCOPY 0 0 0 0 0 0 0 76. 00 77. 00 07700 ALLOGENEI C HSCT ACQUI SITI ON 0 0 0 0 0 0 0 77. 00 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 0 78. 00 OUTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLINIC 44, 790 42, 304 0 4, 149 0 90. 00 91. 00 09100 EMERGENCY 32, 919 207, 642 0 20, 364 0 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 92. 00 OTHER REI MBURSABLE COST CENTERS 102. 00 10200 OPI OID TREATMENT PROGRAM 0 0 0 0 0 0 0 102. 00 SPECI AL PURPOSE COST CENTERS 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 879, 197 3, 459, 703 131, 644 320, 793 129, 358 118. 00 NNONRI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 526 18, 960 0 1, 859 0 190. 00 191. 00 19100 RESEARCH 0 0 0 0 0 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 4, 810 0 472 0 192. 00 194. 00 07950 OTHER NRB COST CENTER 7, 491 8, 501 0 834 0 194. 01 194. 01 07951 OTHER NRB COST CENTER 7, 491 8, 501 0 834 0 194. 01 194. 02 07952 NONREI MBURSABLE COST CENTER 7, 491 8, 501 0 834 0 194. 01 194. 02 07952 NONREI MBURSABLE COST CENTER 0 0 0 0 0 0 0 194. 01 194. 02 07952 NONREI MBURSABLE COST CENTER 0 0 0 0 0 0 0 194. 02 194. 03 07953 RETAL L PHARMACY 52, 807 0 0 0 0 0 194. 03 200. 00 0 0 Cross Foot Adjustments 0 200. 00 201. 00 Negative Cost Centers 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			1	0		U		
76. 00 03950 ENDOSCOPY 0 0 0 0 0 0 76. 00 77. 00 7700 ALLOGENEIC HSCT ACQUISITION 0 0 0 0 0 0 0 77. 00 78. 00 78. 00 78. 00 078. 00 0 0 0 0 0 0 0 0 0		l l	1	Ü	0	U		
77. 00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0 0 0 0 77. 00 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 78. 00 0 0 0 0 0 0 0 0 0			1	0	0	O		
78.00				0	0	0		
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90. 00	78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78. 00
91. 00 09100 EMERGENCY 32, 919 207, 642 0 20, 364 0 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 92. 00 OTHER REI MBURSABLE COST CENTERS		OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY 32, 919 207, 642 0 20, 364 0 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 92. 00 OTHER REI MBURSABLE COST CENTERS	90.00	09000 CLI NI C	44, 790	42, 304	0	4, 149	0	90. 00
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 92. 00 0THER REIMBURSABLE COST CENTERS 102. 00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 0 0 0 102. 00 0 0 0 0 0 0 0 0 0								
OTHER REI MBURSABLE COST CENTERS 102.00 10200 OPI 0I D TREATMENT PROGRAM O O O O O 102.00			02, 717	207,012	Ĭ	20,001	,	
102. 00 10200 OPI OI D TREATMENT PROGRAM O O O O O O O O O								92.00
SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 879, 197 3, 459, 703 131, 644 320, 793 129, 358 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 526 18, 960 0 1, 859 0 190. 00 191. 00 19100 RESEARCH 0 0 0 0 0 0 191. 00 192. 00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 4, 810 0 472 0 192. 00 194. 00 194. 00 194. 00 195. 00			1 0		ı o			100 00
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 879, 197 3, 459, 703 131, 644 320, 793 129, 358 118. 00	102.00		l U		0	l U	0	102.00
NONRET MBURSABLE COST CENTERS 190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 526 18,960 0 1,859 0 190.00 191.00 19100 RESEARCH 0 0 0 0 0 0 191.00 192.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 4,810 0 472 0 192.00 194.00 197.0			,					
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 526 18,960 0 1,859 0 190. 00 191. 00 19100 RESEARCH 0 0 0 0 0 0 191. 00 192. 00 192.	118. 00		879, 197	3, 459, 703	131, 644	320, 793	129, 358	118. 00
191. 00 19100 RESEARCH								
191. 00 19100 RESEARCH	190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	526	18, 960	0	1, 859	0	190. 00
192. 00 1920			1	0				
194. 00 07950 OTHER NRB COST CENTER 7, 491 8, 501 0 834 0 194. 00 194. 01 194. 02 07951 OTHER NRB COST CENTER 0 0 0 0 194. 01 194. 02 07952 NONREI MBURSABLE COST CENTER 0 0 0 0 0 194. 02 194. 03 07953 RETAIL PHARMACY 52, 807 0 0 0 0 194. 03 200. 00 0 0 0 0 0 0 0 0				4 810		_		
194. 01 07951 OTHER NRB COST CENTER 0 0 0 0 0 194. 01 194. 02 07952 NONREI MBURSABLE COST CENTER 0 0 0 0 0 194. 02 194. 03 07953 RETAIL PHARMACY 52, 807 0 0 0 0 0 194. 03 200. 00 Negative Cost Centers 0 0 0 0 0 0 0 0 0 0 0 201. 00								
194. 02 07952 NONREI MBURSABLE COST CENTER 0 0 0 0 194. 02 194. 03 07953 RETAI L PHARMACY 52, 807 0 0 0 0 194. 03 200. 00 Cross Foot Adjustments 200. 00 201. 00 Negative Cost Centers 0 0 0 0 0 0 0 201. 00			7, 491	0, 301]	034		
194. 03 07953 RETAIL PHARMACY 52,807 0 0 0 194.03 200. 00 Cross Foot Adjustments 200.00 201. 00 Negative Cost Centers 0 0 0 0 0 0			0	0] 0	0		
200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 0 0 0 0 0 201.00			0	0	'l 0	이		
201.00 Negative Cost Centers 0 0 0 0 201.00			52, 807	0	0	0	0	
	200.00	Cross Foot Adjustments					i	
	201.00	Negative Cost Centers	l ol	0	0	ol	0	201. 00
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In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2023 Part II
To 12/31/2023 Date/Time Prepared:
5/21/2024 10:06 am Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 14-0046

			10) 12/31/2023	5/21/2024 10:	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVICES &		RECORDS &	
	11.00	13. 00	SUPPLY 14.00	15. 00	LI BRARY 16. 00	
GENERAL SERVICE COST CENTERS	11.00	13.00	14.00	13.00	10.00	
1. 00 00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00 00500 ADMINISTRATIVE & GENERAL						5. 00
7. 00 00700 OPERATION OF PLANT						7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY						9. 00 10. 00
11. 00 01100 CAFETERI A	321, 288					11.00
13. 00 01300 NURSING ADMINISTRATION	5, 409	312, 710				13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY	2, 554	0	8, 058			14. 00
15. 00 01500 PHARMACY	12, 762	0	0	410, 998		15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	0	0	0	126, 414	1
17. 00 01700 SOCIAL SERVICE	0	0	0	0	0	17. 00
23. 00 O2300 PARAMED ED PRGM-LABARATORY ED	0	0	0	0	0	23. 00
30.00 O3000 ADULTS & PEDIATRICS	103, 729	111, 018	670	22, 865	10, 300	30.00
31. 00 03100 NTENSI VE CARE UNI T	14, 519	26, 219	298	3, 164	1, 284	1
41. 00 04100 SUBPROVI DER - I RF	9, 848	12, 405	35	527	989	41. 00
43. 00 04300 NURSERY	5, 377	9, 205	0	0	655	43. 00
ANCILLARY SERVICE COST CENTERS	_					
50. 00 05000 OPERATI NG ROOM	14, 370	18, 656	2, 863	78, 849	17, 127	50.00
51. 00 05100 RECOVERY ROOM	5, 422	10, 229	153	361	2, 497	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	17, 351 244	30, 955 0	341 193	7, 794 48, 336	3, 847 5, 688	52. 00 53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	10, 046	1, 224	63	4, 116	4, 209	
55. 00 05500 RADI OLOGY-THERAPEUTI C	7, 656	4, 058	112	7, 212	776	
56. 00 05600 RADI OI SOTOPE	1, 076	0	8	9, 490	2, 002	56. 00
57.00 05700 CT SCAN	3, 394	5	48	13, 449	14, 046	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 401	19	14	931	2, 424	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	5, 429	5, 143	887	1, 180	8, 176	1
60. 00 06000 LABORATORY	14, 529	0	1, 481	325	14, 984	
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY	1, 275 10, 368	2, 192 86	9 149	359 2, 834	184 2, 522	64. 00 65. 00
66. 00 06600 PHYSI CAL THERAPY	6, 066	0	7	108	1, 455	1
66. 01 03951 CLINI CAL NUTRI TI ON	909	o	Ó	0	4	66. 01
67.00 06700 OCCUPATIONAL THERAPY	2, 974	О	3	167	654	67. 00
68. 00 06800 SPEECH PATHOLOGY	1, 905	0	1	0	370	68. 00
69. 00 06900 ELECTROCARDI OLOGY	11, 681	13, 155	115	71, 362	4, 643	
69. 01 06901 CARDI AC REHABI LI TI ON	781	2, 005	2	82	137	69. 01
70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	173	0	0	136	40 2, 566	70. 00 71. 00
72. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	2, 300 1, 729	
73. 00 07300 DRUGS CHARGED TO PATIENTS	6, 864	13, 492	60	598	11, 816	
74.00 07400 RENAL DIALYSIS	0	0	8	5	389	
76. 00 03950 ENDOSCOPY	0	0	0	0	0	76. 00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78. 00
90. 00 09000 CLINIC	20, 970	28, 697	204	131, 297	2, 469	90.00
91. 00 09100 EMERGENCY	15, 654	23, 916	334	5, 451	2, 469 8, 432	1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	15, 054	25, 710	334	3, 431	0, 432	92.00
OTHER REIMBURSABLE COST CENTERS						
102.00 10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102. 00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	314, 736	312, 679	8, 058	410, 998	126, 414	118. 00
NONREI MBURSABLE COST CENTERS	004	ما	0	ما		100 00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 191.00 19100 RESEARCH	234	0	0	0		190. 00 191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	31	0	0		191.00
194. 00 07950 OTHER NRB COST CENTER	3, 821	0	0	0		194. 00
194. 01 07951 OTHER NRB COST CENTER	0	ol	Ö	ol		194. 01
194.02 07952 NONREIMBURSABLE COST CENTER	0	О	0	О		194. 02
194. 03 07953 RETAI L PHARMACY	2, 497	0	0	0	0	194. 03
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	0 050	0		201. 00
202.00 TOTAL (sum lines 118 through 201)	321, 288	312, 710	8, 058	410, 998	126, 414	J2U2. UU

Peri od:

Worksheet B

From 01/01/2023 Part II Date/Time Prepared: 12/31/2023 5/21/2024 10:06 am Cost Center Description SOCIAL SERVICE PARAMED ED Intern & Subtotal Total PRGM-LABARATOR Residents Cost Y ED & Post Stepdown Adjustments 17.00 23.00 24.00 25.00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11 00 11 00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16 00 16 00 17.00 01700 SOCIAL SERVICE 108, 199 17.00 02300 PARAMED ED PRGM-LABARATORY ED 23.00 19, 930 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 84,673 2, 594, 051 2, 594, 051 30.00 03100 INTENSIVE CARE UNIT 8, 569 667, 354 0 667, 354 31.00 31.00 41.00 04100 SUBPROVI DER - I RF 7,927 400, 910 0 400, 910 41.00 04300 NURSERY 43.00 7,030 0 43 00 84, 644 84,644 ANCILLARY SERVICE COST CENTERS 1, 669, 855 50.00 05000 OPERATING ROOM 1, 669, 855 0 50.00 51.00 05100 RECOVERY ROOM 00000000000000000000000000 29, 811 0 29, 811 51.00 05200 DELIVERY ROOM & LABOR ROOM 436, 238 436, 238 52 00 52 00 53.00 05300 ANESTHESI OLOGY 88, 565 88, 565 53.00 05400 RADI OLOGY-DI AGNOSTI C 791, 591 791, 591 54.00 0 0 0 0 0 0 0 0 0 54.00 05500 RADI OLOGY-THERAPEUTI C 155, 287 155, 287 55.00 55.00 05600 RADI OI SOTOPE 56.00 18, 235 18, 235 56.00 57.00 05700 CT SCAN 229, 304 229, 304 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58 00 215, 946 215, 946 58 00 59.00 05900 CARDIAC CATHETERIZATION 329, 349 329, 349 59.00 06000 LABORATORY 60 00 410, 571 410, 571 60 00 06400 INTRAVENOUS THERAPY 48, 809 48, 809 64.00 64.00 06500 RESPIRATORY THERAPY 65.00 241, 931 241, 931 65.00 06600 PHYSI CAL THERAPY 139, 336 66.00 139, 336 66,00 03951 CLINICAL NUTRITION 66.01 2,767 2, 767 66.01 67.00 06700 OCCUPATIONAL THERAPY 117, 661 0 0 117, 661 67.00 06800 SPEECH PATHOLOGY 27, 966 27, 966 68.00 68.00 06900 ELECTROCARDI OLOGY 891, 064 891, 064 69.00 69 00 69.01 06901 CARDIAC REHABILITION 12,086 0 0 0 12,086 69.01 70.00 07000 ELECTROENCEPHALOGRAPHY 41, 415 41, 415 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 69, 404 71.00 69, 404 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 30, 408 30, 408 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 120, 813 0 120, 813 73.00 74.00 07400 RENAL DIALYSIS 6, 589 6, 589 74.00 03950 ENDOSCOPY 76.00 C 0 76.00 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0 0 77.00 07800 CAR T-CELL IMMUNOTHERAPY 78.00 0 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 1, 416, 970 0 1, 416, 970 90.00 91.00 09100 EMERGENCY 0 582,600 0 582,600 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0 92.00 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 102.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)
NONREI MBURSABLE COST CENTERS 108, 199 0 11, 871, 530 0 11, 871, 530 118. 00 118.00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 45, 562 0 45, 562 190. 00 191. 00 19100 RESEARCH 0 0 0 191.00 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 0 240, 967 240, 967 192. 00 194.00 07950 OTHER NRB COST CENTER 1, 839, 010 194. 00 1, 839, 010 194. 01 07951 OTHER NRB COST CENTER 0 0 0 194. 01 194. 02 07952 NONREI MBURSABLE COST CENTER 0 0 0 194. 02 0 194. 03 07953 RETAIL PHARMACY 0 58. 681 58, 681 194. 03 200.00 Cross Foot Adjustments 19, 930 19,930 0 19, 930 200. 00 201.00 Negative Cost Centers 0 201.00 202.00 TOTAL (sum lines 118 through 201) 108, 199 19, 930 14, 075, 680 14, 075, 680 202. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS In Lieu of Form CMS-2552-10
Worksheet B-1 SSM HEALTH GOOD SAMARITAN HOSPITAL Provider CCN: 14-0046

COST Center Description						Т	o 12/31/2023	Date/Time Pre 5/21/2024 10:	
SOURCE FEET GOULLAN WALLES SERIENT SALVER STATE				CAPITAL RE	LATED COSTS			372172024 10.	00 4111
SOURCE FEET GOULLAN WALLES SERIENT SALVER STATE			Cook Cooker December of	DIDC & FLVT	MANDLE FOLLO	EMDL OVEE	D	ADMINI CEDATINE	
CARDENS CARDEN			Cost Center Description				Reconciliation		
SALARIES)				(SGOTINE TEET)	(BOLLAN VALUE)				
						(GROSS		,	
SERERAL SERVICE COST CENTERS 1.0				1 00				5.00	
DITION OF PREL COSTS:-BLICA FIRTY 388, 4279 10, 334, 868 42, 862, 788 35, 670, 176 148, 417, 003 00, 000		CENED	AL SERVICE COST CENTERS	1.00	2.00	4.00	5A	5.00	
2.00 00000 CAP REL DOSTS-MURLE EDUIP 10,334,986 2 00 00000 CAP REL DOSTS-MURLE POULP 2 00 00000 CAP REL DOSTS-MURLE POULP 5 1,737 175,000 3,699,813 -35,670,176 18,417,000 5 00 00000 CAP REL DOSTS-MURLE POULP 5 1,934 175,000 3,699,813 -35,670,176 18,417,000 5 00 00000 CAP REL DOSTS-MURLE POULP 4 775,736 10,004 1,633,390 0 3,746,249 9 00 00000 CAP REL DOSTS-MURLE POULP 7 1,000 CAP RE	1.00			385, 425					1.00
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8.00 000000 LAMIDRY & LINEN SERVICE					1				•
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10.00 01000 IETARY									1
13.00 01300 MURSI NG ABMINI STRATION 1,897 386,257 930,174 0 2,385,298 12.00	10.00				1				1
14 00 01400 CENTRAL SERVICES & SUPPLY 0 1,824 439,155 0 558,522 14.00					1				1
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MINISTRATE SERVICE COST CENTERS									1
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51.00 0500 RECOVERY ROOM & LABOR ROOM 0 0 922, 493 0 1,385,992 51.00 0500 DELIVERY ROOM & LABOR ROOM 9,660 8.516 2,983,840 0 4,790,988 52.00 53.00 05200 ANESTHESI DLOGY 2.56 54,756 41,877 0 265,070 53.00 54.00 54.00 54.00 64.00 64.00 64.00 64.00 65.00 65.00 65.00 ANESTHESI DLOGY 0 189,264 1,316,555 0 2,245,050 55.00 05500 RADI OLOGY-THERAPEUTI 0 189,264 1,316,555 0 2,245,050 55.00 05700 CT SCAN 3,867 156,053 583,578 0 1,216,614 57.00 05700 CT SCAN 3,867 156,053 583,578 0 1,216,614 57.00 05700 CT SCAN 6,885 199,256 933,559 0 2,110,136 59.00 05900 CARDI AC CATHETERI ZATI ON 6,585 199,256 933,559 0 2,110,136 59.00 05900 CARDI AC CATHETERI ZATI ON 6,585 199,256 933,559 0 2,110,136 59.00 06000 RESPIRATORY THERAPY 1,354 0 219,219 0 348,807 44.00 06400 INTRAVEROUS THERAPY 1,354 0 219,219 0 3,488,807 44.00 06600 PHYSI GLA. THERAPY 3,740 2,388 1,043,156 0 1,771,687 66.00 06600 PHYSI GLA. THERAPY 3,443 693 511,418 0 851,601 67.00 06700 OCCUPATIONAL THERAPY 3,443 693 511,418 0 851,601 67.00 06700 OCCUPATIONAL THERAPY 3,443 693 511,418 0 851,601 67.00 06700 OCCUPATIONAL THERAPY 3,443 693 511,418 0 851,601 67.00 06700 OCCUPATIONAL THERAPY 3,443 693 511,418 0 851,601 67.00 06700 OCCUPATIONAL THERAPY 3,443 693 511,418 0 851,601 67.00 06700 OCCUPATIONAL THERAPY 3,443 693 511,418 0 851,601 67.00 06700 OCCUPATIONAL THERAPY 3,443 693 511,418 0 851,601 67.00 06700 OCCUPATIONAL THERAPY 3,443 693 511,418 0 851,601 07.00 0700 OCCUPATIONAL THERAPY 3,443 693 511,418 0 851,601 07.00 0700 OCCUPATIONAL THERAPY 3,443 693 511,418 0 07.00 07.00 0700 0700 0700 0700 0700 0700 0700 0700 0700 0700 0700 0700 0700 0700	EO 00			22.404	040 421	2 471 114		4 440 401	 EO 00
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76. 00 03950 ENDOSCOPY 0 0 0 0 0 0 76. 00 77. 00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0 0 0 0 77. 00 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 0 00TPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC 3,175 88,885 3,606,180 0 7,071,358 90. 00 91. 00 09000 CLINIC 15,584 12,059 2,691,934 0 5,197,245 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 92. 00 07HER REIMBURSABLE COST CENTERS 102. 00 10200 OPIOI D TREATMENT PROGRAM 0 0 0 0 0 0 102. 00 SPECIAL PURPOSE COST CENTERS 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 383,003 8,517,153 61,726,078 -35,670,176 138,815,168 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 1,423 1,203 40,220 0 83,000 191. 00 19100 RESEARCH 0 0 0 0 0 191. 00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 361 406,332 0 170,678 0 192. 00 194. 00 07950 OTHER NRB COST CENTER 638 1,405,044 657,123 0 1,182,601 194. 00 194. 01 07951 OTHER NRB COST CENTER 0 0 0 0 0 0 194. 02 07952 NONREI MBURSABLE COST CENTER 0 0 0 0 0 194. 02 07952 OTHER NRB COST CENTER 0 0 0 0 0 194. 02 07952 OTHER NRB COST CENTER 0 0 0 0 0 194. 02 07952 OTHER NRB COST CENTER 0 0 0 0 0 194. 02 07952 OTHER NRB COST CENTER 0 0 0 0 0 194. 02 07952 OTHER NRB COST CENTER 0 0 0 0 0 194. 02 07952 OTHER NRB COST CENTER 0 0 0 0 194. 02 07952 OTHER NRB COST CENTER 0 0 0 0 194. 02 07952 OTHER NRB COST CENTER 0 0 0 0 194. 02 07952 OTHER NRB COST CENTER 0 0 0 0 194. 03 07953 RETAIL PHARMACY 0 5,136 429,360 0 8,337,134 194. 03 07953 OTHER NRB COST CENTER 0 0 0 0 194. 02 07952 OTHER NRB COST CENTER 0 0 0 0 194. 02 07952 OTHER NRB COST CENTER 0 0 0 0 194. 03 07953 OTHER NRB COST CENTER 0 0				0	1, 771	1, 180, 338	0		
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OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 3,175 88,885 3,606,180 0 7,071,358 90.00 91.00 09100 EMERGENCY 15,584 12,059 2,691,934 0 5,197,245 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 00 00 0 0 0 00 00 0				O	0	Ō	0		
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SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 383,003 8,517,153 61,726,078 -35,670,176 138,815,168 118.00	,2,00								72.00
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 383,003 8,517,153 61,726,078 -35,670,176 138,815,168 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 1,423 1,203 40,220 0 83,000 190. 00 191. 00 191. 00 19200 PHYSICI ANS' PRI VATE OFFICES 361 406,332 0 170,678 0 192. 00 194. 00 194. 00 194. 00 195. 00	102.00			0	0	0	0	0	102. 00
NONREI MBURSABLE COST CENTERS 190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 1,423 1,203 40,220 0 83,000 190.00 191.00 191.00 191.00 192.00 1	440.00			200 000	0 547 450	/4 70/ 070	05 (70 47)	400 045 4/0	140.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 1, 423 1, 203 40, 220 0 83, 000 190. 00 191. 00 191. 00 19100 RESEARCH 0 0 0 0 0 0 191. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 361 406, 332 0 170, 678 0 192. 00 194. 00 07950 OTHER NRB COST CENTER 638 1, 405, 044 657, 123 0 1, 182, 601 194. 00 194. 01 07951 OTHER NRB COST CENTER 0 0 0 0 0 194. 01 194. 01 194. 02 07952 NONREI MBURSABLE COST CENTER 0 0 0 0 0 194. 01 194. 02 07952 RETAIL PHARMACY 0 5, 136 429, 360 0 8, 337, 134 194. 03 200. 00 Cross Foot Adjustments 201. 00 Negative Cost Centers 202. 00 Cost to be allocated (per Wkst. B, 6, 323, 438 4, 600, 280 29, 527, 630 35, 670, 176 202. 00	118. UC			383, 003	8,517,153	61, 726, 078	-35, 670, 176	138, 815, 168]118.00
191.00 19100 RESEARCH 0 0 0 0 0 191.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 361 406, 332 0 170, 678 0 192.00 194.00 107950 OTHER NRB COST CENTER 638 1, 405, 044 657, 123 0 1, 182, 601 194.00 194.01 194.02 07952 OTHER NRB COST CENTER 0 0 0 0 0 194.01 194.02 07952 NONREI MBURSABLE COST CENTER 0 0 0 0 0 0 194.01 194.02 194.03 07953 RETAIL PHARMACY 0 5, 136 429, 360 0 8, 337, 134 194.02 194.02 194.02 194.02 194.02 194.02 194.02 194.02 194.03	190.00			1. 423	1. 203	40. 220	0	83.000	190. 00
194. 00 07950 OTHER NRB COST CENTER 638 1, 405, 044 657, 123 0 1, 182, 601 194. 00 194. 01 07951 OTHER NRB COST CENTER 0 0 0 0 194. 02 07952 NONREI MBURSABLE COST CENTER 0 0 0 194. 03 07953 RETAIL PHARMACY 0 5, 136 429, 360 0 200. 00 Cross Foot Adjustments 200. 00 201. 00 Negative Cost Centers 202. 00 202. 00 Cost to be allocated (per Wkst. B, 6, 323, 438 4, 600, 280 29, 527, 630 35, 670, 176 202. 00	191.00	19100	RESEARCH		i e		0	0	191. 00
194. 01 07951 OTHER NRB COST CENTER 0 0 0 0 0 0 194. 01 194. 02 07952 NONREI MBURSABLE COST CENTER 0 0 0 0 0 0 194. 02 194. 03 07953 RETAIL PHARMACY 0 5, 136 429, 360 0 8, 337, 134 194. 03 200. 00 Cross Foot Adjustments Negative Cost Centers 202. 00 Cost to be allocated (per Wkst. B, 6, 323, 438 4, 600, 280 29, 527, 630 35, 670, 176 202. 00					1				1
194. 02 07952 NONREIMBURSABLE COST CENTER 0 0 0 0 0 194. 02 194. 03 07953 RETAIL PHARMACY 0 5, 136 429, 360 0 8, 337, 134 194. 03 200. 00 Cross Foot Adjustments 201. 00 Negative Cost Centers 202. 00 Cost to be allocated (per Wkst. B, 6, 323, 438 4, 600, 280 29, 527, 630 35, 670, 176 202. 00				638	1, 405, 044	657, 123	0		
194. 03 07953 RETAIL PHARMACY 0 5, 136 429, 360 0 8, 337, 134 194. 03 200. 00 Cross Foot Adjustments 201. 00 Negative Cost Centers 202. 00 Cost to be allocated (per Wkst. B, 6, 323, 438 4, 600, 280 29, 527, 630 35, 670, 176 202. 00					0	0			1
200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 6,323,438 4,600,280 29,527,630 35,670,176 202.00					5, 136	429, 360	O		
202.00 Cost to be allocated (per Wkst. B, 6,323,438 4,600,280 29,527,630 35,670,176 202.00	200.00		Cross Foot Adjustments						200. 00
		1				00 505		05 /5	
	202.00	ľ		6, 323, 438	4, 600, 280	29, 527, 630		35, 6/0, 176	202.00
		1)· - · - · /	1	1	1	1	1	<u> </u>

Heal th Financi	al Systems SSM	HEALTH GOOD SA	MARITAN HOSPITA	AL	In Lie	u of Form CMS-2	2552-10
COST ALLOCATIO	ON - STATISTICAL BASIS		Provi der CO		Period: From 01/01/2023	Worksheet B-1	
					Γο 12/31/2023		
		CAPITAL REL	LATED COSTS				
C	ost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		1.00	2.00	4.00	5A	5. 00	
204. 00 C	nit cost multiplier (Wkst. B, Part I) ost to be allocated (per Wkst. B, art II)	16. 406403	0. 445122	0. 469790 159, 74		0. 240336 940, 021	
	nit cost multiplier (Wkst. B, Part I)			0. 00254:	2	0. 006334	205. 00
	AHE adjustment amount to be allocated per Wkst. B-2)						206. 00
	AHE unit cost multiplier (Wkst. D, arts III and IV)						207. 00

In Lieu of Form CMS-2552-10 Health Financial Systems SSM HEALTH GOOD SAMARITAN HOSPITAL COST ALLOCATION - STATISTICAL BASIS Provider CCN: 14-0046 Peri od: Worksheet B-1 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/21/2024 10:06 am Cost Center Description OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A LINEN SERVICE PLANT (SQUARE FEET) (TOTAL PATIENT (GROSS (SQUARE FEET) (TOTAL PATIENT DAYS) SALARI ES) DAYS) 7.00 11. 00 10.00 8.00 9.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 7.00 00700 OPERATION OF PLANT 262,080 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 4.252 32, 212 8.00 00900 HOUSEKEEPI NG 9.00 9, 915 247, 913 9.00 10.00 01000 DI ETARY 3,828 3,828 32, 212 10.00 01100 CAFETERI A 9,999 9, 999 55, 247, 624 11.00 11.00 01300 NURSING ADMINISTRATION 1, 897 1, 897 0 930, 174 13.00 C 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY C 0 439, 155 14.00 15.00 01500 PHARMACY 3, 378 3.378 2, 194, 676 15.00 o 01600 MEDICAL RECORDS & LIBRARY 0 16.00 4.054 4.054 0 16.00 01700 SOCIAL SERVICE 0 17.00 3,474 3, 474 0 17.00 02300 PARAMED ED PRGM-LABARATORY ED 640 640 0 23.00 23.00 NPATIENT ROUTINE SERVICE COST CENTERS 17, 834, 957 25, 208 30.00 03000 ADULTS & PEDLATRICS 56 052 25, 208 56 052 30.00 31.00 03100 INTENSIVE CARE UNIT 17, 513 2, 551 17, 513 2, 551 2, 496, 849 31.00 41.00 04100 SUBPROVIDER - IRF 9,028 2, 360 9,028 2, 360 1, 693, 508 41.00 43.00 04300 NURSERY 1,071 2,093 1,071 2,093 924, 645 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 32, 484 32, 484 2, 471, 114 50.00 51.00 05100 RECOVERY ROOM 0 932, 493 51.00 C 0 05200 DELIVERY ROOM & LABOR ROOM 2, 983, 840 52 00 9 660 Ω 9,660 52 00 53.00 05300 ANESTHESI OLOGY 256 0 256 41,877 53.00 05400 RADI OLOGY-DI AGNOSTI C 22, 391 22, 391 0 1, 727, 545 54.00 54.00 05500 RADI OLOGY-THERAPEUTI C 55.00 0 0 1, 316, 555 55.00 0 0 56 00 05600 RADI OI SOTOPE Ω 185, 088 0 0 56.00 57.00 05700 CT SCAN 3.857 0 3,857 583, 578 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 2, 171 240, 924 58.00 2, 171 0 0 0 0 0 0 58.00 05900 CARDIAC CATHETERIZATION 59.00 6.585 0 6.585 933, 559 59.00 06000 LABORATORY 8, 885 0 8.885 2, 498, 520 60.00 60 00 64.00 06400 INTRAVENOUS THERAPY 1, 354 0 1, 354 219, 219 64.00 1, 782, 990 06500 RESPIRATORY THERAPY 65.00 1,472 1, 472 65.00 66, 00 06600 PHYSI CAL THERAPY 3,740 0 3, 740 1, 043, 156 66, 00 03951 CLINICAL NUTRITION 66.01 0 C 156, 247 66.01 67.00 06700 OCCUPATIONAL THERAPY 3, 443 3, 443 511, 418 67.00 68.00 06800 SPEECH PATHOLOGY 681 681 0 327, 596 68.00 06900 ELECTROCARDI OLOGY 2,008,707 69.00 0 69.00 17, 520 17, 520 06901 CARDIAC REHABILITION 69.01 Ω \cap 134, 314 69.01 70.00 07000 ELECTROENCEPHALOGRAPHY 1, 299 1, 299 0 0 0 29, 765 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 C 07200 I MPL. DEV. CHARGED TO PATIENTS 72.00 72.00 0 0 0 0 07300 DRUGS CHARGED TO PATIENTS 73.00 0 C 0 1, 180, 338 73.00 74.00 07400 RENAL DIALYSIS 0 0 74.00 0 0 03950 ENDOSCOPY 0 0 76.00 76.00 0 07700 ALLOGENEIC HSCT ACQUISITION 0 0 77 00 C 0 0 77 00 07800 CAR T-CELL IMMUNOTHERAPY 78.00 0 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 3.175 0 3.175 3, 606, 180 90.00 91.00 09100 EMERGENCY 15, 584 15, 584 2, 691, 934 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 0 102. 00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 259, 658 32, 212 245, 491 32, 212 54, 120, 921 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 40, 220 190. 00 1, 423 1, 423 191. 00 19100 RESEARCH 0 0 191.00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 361 0 361 0 192.00 194. 00 07950 OTHER NRB COST CENTER 0 638 Ω 638 657, 123 194. 00 194. 01 07951 OTHER NRB COST CENTER 0 0 0 C 0 194. 01 194. 02 07952 NONREI MBURSABLE COST CENTER 0 0 194. 02 C 0 194. 03 07953 RETAIL PHARMACY 0 0 429, 360 194. 03 200 00 Cross Foot Adjustments 200 00 201.00 Negative Cost Centers 201.00 4, 497, 679 1, 490, 234 2, 525, 229 202. 00 202.00 Cost to be allocated (per Wkst. B, 12, 646, 259 1, 182, 111 Part I)

48. 253430

3, 491, 974

36, 697846

131, 644

18. 142167

323, 958

46. 263318

129, 358

0.045707 203.00

321, 288 204. 00

Part II)

Unit cost multiplier (Wkst. B, Part I)

Cost to be allocated (per Wkst. B,

203.00

204.00

Heal th Finar	ncial Systems SSM	HEALTH GOOD SA	MARITAN HOSPITA	AL	In Lie	u of Form CMS-2	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provi der CO		Period: From 01/01/2023	Worksheet B-1	
					Го 12/31/2023 	Date/Time Pre 5/21/2024 10:	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		PLANT	LINEN SERVICE	(SQUARE FEET)	(TOTAL PATIENT	(GROSS	
		(SQUARE FEET)	(TOTAL PATIENT		DAYS)	SALARI ES)	
			DAYS)				
		7. 00	8. 00	9. 00	10.00	11. 00	
205. 00	Unit cost multiplier (Wkst. B, Part	13. 324077	4. 086800	1. 30674	4. 015833	0. 005815	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

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 14-0046 Peri od: Worksheet B-1 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/21/2024 10:06 am Cost Center Description NURSI NG CENTRAL PHARMACY MEDI CAL SOCIAL SERVICE ADMI NI STRATI ON SERVICES & (COSTED RECORDS & **SUPPLY** REQUIS.) LI BRARY (TOTAL PATIENT (DI RECT NURS. (COSTED (GROSS DAYS) CHARGES) HRS.) REQUIS.) 17.00 13.00 14.00 15.00 16.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11 00 11 00 01300 NURSING ADMINISTRATION 13.00 568, 974 13.00 11, 955, 324 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 15.00 01500 PHARMACY 0 239, 248 15.00 01600 MEDICAL RECORDS & LIBRARY 719, 763, 223 16 00 0 16.00 C 17.00 01700 SOCIAL SERVICE 0 0 32, 212 17.00 02300 PARAMED ED PRGM-LABARATORY ED 23.00 0 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 201, 995 993, 768 13, 310 58, 525, 079 25, 208 30.00 03100 INTENSIVE CARE UNIT 47, 705 441, 720 1,842 7, 297, 502 2, 551 31.00 31.00 41.00 04100 SUBPROVI DER - I RF 22, 570 51, 705 307 5, 620, 534 2, 360 41.00 04300 NURSERY 16, 748 2,093 43 00 43.00 C 3.723.575 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 33, 944 4, 250, 776 45, 899 98, 806, 118 50.00 0 51.00 05100 RECOVERY ROOM 18, 611 226, 529 210 14, 188, 587 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 505, 712 4.537 21, 855, 255 52 00 52 00 56, 323 0 53.00 05300 ANESTHESI OLOGY 285, 762 28, 137 32, 315, 437 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 23, 913, 952 54.00 2.227 92, 841 2.396 54.00 05500 RADI OLOGY-THERAPEUTI C 4, 411, 017 55.00 7.384 166, 804 4. 198 0 55.00 05600 RADI OI SOTOPE 11, 377, 558 56.00 11, 564 5.524 0 56.00 57.00 05700 CT SCAN 10 71, 418 7,829 79, 805, 150 0 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58 00 35 20,055 542 13, 770, 222 58.00 46, 454, 822 59.00 05900 CARDIAC CATHETERIZATION 1, 315, 351 687 59.00 9.358 0 60 00 06000 LABORATORY 2, 197, 030 189 85, 135, 298 0 60.00 06400 INTRAVENOUS THERAPY 3, 989 1, 046, 106 64.00 13,664 209 0 64.00 65.00 06500 RESPIRATORY THERAPY 156 221, 234 1,650 14, 331, 789 0 65.00 06600 PHYSI CAL THERAPY 8, 267, 833 66.00 0 10, 335 63 0 66.00 66.01 03951 CLINICAL NUTRITION 0 C 23, 661 0 66.01 06700 OCCUPATIONAL THERAPY 67.00 0 4,654 97 3, 714, 448 0 67.00 06800 SPEECH PATHOLOGY 755 2, 100, 940 68.00 C 68.00 06900 ELECTROCARDI OLOGY 170, 796 69.00 23, 936 41, 541 26, 377, 877 Λ 69.00 3, 648 2, 819 69.01 06901 CARDIAC REHABILITION 48 777, 975 0 69.01 70.00 07000 ELECTROENCEPHALOGRAPHY 79 224, 900 70.00 566 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0 C 0 14, 582, 309 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 9, 824, 333 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 24, 549 89, 721 348 67, 139, 055 0 73.00 74.00 07400 RENAL DIALYSIS 11, 932 2, 211, 858 74.00 3 0 0 03950 ENDOSCOPY 0 76.00 0 0 76.00 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0 0 77.00 07800 CAR T-CELL IMMUNOTHERAPY 78.00 0 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 52, 214 302, 436 76, 430 14, 028, 556 0 90.00 91.00 43, 515 09100 EMERGENCY 495, 377 3, 173 47, 911, 477 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 0 102.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)
NONREI MBURSABLE COST CENTERS 568, 917 11, 955, 324 239, 248 719, 763, 223 32, 212 118. 00 118.00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 C 0 190, 00 191. 00 19100 RESEARCH 0 0 0 0 191.00 0 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 57 0 0 0 192.00 194.00 07950 OTHER NRB COST CENTER 0 0 194 00 0 Ω 194. 01 07951 OTHER NRB COST CENTER 0 0 0 0 0 194. 01 194. 02 07952 NONREI MBURSABLE COST CENTER 0 0 0 194. 02 0 194. 03 07953 RETAIL PHARMACY 0 C 0 0 0 194. 03 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 3, 127, 039 712.827 4.883.248 304, 013 202. 00 384, 245 Part I) 9. 437880 203. 00 203.00 5. 495926 0.059624 20. 410821 0.000534 Unit cost multiplier (Wkst. B, Part I)

Health Finar	ncial Systems SSM	HEALTH GOOD SAMARITAN HOSPITAL			In Lieu of Form CMS-2552-10			
COST ALLOCA	TION - STATISTICAL BASIS		Provi der CO	CN: 14-0046	Peri od: From 01/01/2023	Worksheet B-1		
					To 12/31/2023	Date/Time Pre 5/21/2024 10:		
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY		SOCIAL SERVICE		
		ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &			
			SUPPLY	REQUI S.)	LI BRARY	(TOTAL PATIENT		
		(DI RECT NURS.	(COSTED		(GROSS	DAYS)		
		HRS.)	REQUIS.)		CHARGES)			
		13.00	14. 00	15. 00	16.00	17. 00		
204.00	Cost to be allocated (per Wkst. B,	312, 710	8, 058	410, 99	126, 414	108, 199	204. 00	
	Part II)							
205.00	Unit cost multiplier (Wkst. B, Part	0. 549603	0. 000674	1. 71787	0. 000176	3. 358966	205. 00	
	[11]							
206. 00	NAHE adjustment amount to be allocated						206. 00	
	(per Wkst. B-2)							
207.00	NAHE unit cost multiplier (Wkst. D,						207. 00	
	Parts III and IV)							

In Lieu of Form CMS-2552-10 Health Financial Systems SSM HEALTH GOOD SAMARITAN HOSPITAL COST ALLOCATION - STATISTICAL BASIS Provider CCN: 14-0046 Peri od: Worksheet B-1 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/21/2024 10:06 am Cost Center Description PARAMED ED PRGM-LABARATOR Y ED (ASSI GNED TIME) 23.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11 00 11 00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16 00 16 00 17.00 01700 SOCIAL SERVICE 17.00 02300 PARAMED ED PRGM-LABARATORY ED 23.00 100 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 30.00 03100 INTENSIVE CARE UNIT 0 31.00 31.00 41.00 04100 SUBPROVI DER - I RF 0 41.00 04300 NURSERY 0 43.00 43 00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 51.00 05100 RECOVERY ROOM 00000000 51.00 05200 DELIVERY ROOM & LABOR ROOM 52 00 52 00 53.00 05300 ANESTHESI OLOGY 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 54.00 05500 RADI OLOGY-THERAPEUTI C 55.00 55.00 05600 RADI OI SOTOPE 56.00 56.00 57.00 05700 CT SCAN 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 58.00 59.00 05900 CARDIAC CATHETERIZATION 59.00 06000 LABORATORY 60 00 100 60 00 64.00 06400 I NTRAVENOUS THERAPY 0000000000000000 64.00 06500 RESPIRATORY THERAPY 65.00 65.00 06600 PHYSI CAL THERAPY 66.00 66,00 66.01 03951 CLINICAL NUTRITION 66.01 67.00 06700 OCCUPATIONAL THERAPY 67.00 68.00 06800 SPEECH PATHOLOGY 68.00 06900 ELECTROCARDI OLOGY 69.00 69.00 69.01 06901 CARDIAC REHABILITION 69.01 70.00 07000 ELECTROENCEPHALOGRAPHY 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 71.00 72.00 07200 I MPL. DEV. CHARGED TO PATIENTS 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 73.00 74.00 07400 RENAL DIALYSIS 74.00 03950 ENDOSCOPY 76.00 76.00 77.00 07700 ALLOGENEIC HSCT ACQUISITION 77.00 07800 CAR T-CELL IMMUNOTHERAPY 78.00 0 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 90.00 91.00 09100 EMERGENCY 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 0 102.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)
NONREI MBURSABLE COST CENTERS 100 118.00 118.00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190.00 191. 00 19100 RESEARCH 0 191.00 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 192.00 194.00 07950 OTHER NRB COST CENTER 194. 00 194. 01 07951 OTHER NRB COST CENTER 0 194.01 194. 02 194. 02 07952 NONREI MBURSABLE COST CENTER 0 194. 03 07953 RETAIL PHARMACY 0 194. 03 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201. 00 202.00 Cost to be allocated (per Wkst. B, 55.605 202.00 Part I)

556, 050000

203.00

Unit cost multiplier (Wkst. B, Part I)

203.00

Heal th Fin	ancial Systems SSM	M HEALTH GOOD SAM	IARITAN HOSPITAL	In Lie	u of Form CN	IS-2552-10
COST ALLOC	ATION - STATISTICAL BASIS		Provider CCN: 14-0046	Peri od: From 01/01/2023	Worksheet E	
				To 12/31/2023	Date/Time F 5/21/2024	
	Cost Center Description	PARAMED ED				
		PRGM-LABARATOR				
		Y ED				
		(ASSI GNED				
		TIME)				
		23. 00				
204.00	Cost to be allocated (per Wkst. B,	19, 930				204. 00
	Part II)					
205.00	Unit cost multiplier (Wkst. B, Part	199. 300000				205. 00
	11)					
206.00	NAHE adjustment amount to be allocated	0				206. 00
	(per Wkst. B-2)					
207. 00	NAHE unit cost multiplier (Wkst. D,	0. 000000				207. 00
	Parts III and IV)					

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 14-0046 Peri od: Worksheet C From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/21/2024 10:06 am Title XVIII Hospi tal PPS Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs from Wkst. B, Adj Di sal I owance Part I, col. 26) 4. 00 1.00 2.00 3.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 30 00 03000 ADULTS & PEDIATRICS 40, 108, 622 40, 108, 622 26, 780 40, 135, 402 03100 INTENSIVE CARE UNIT 6, 759, 636 6, 759, 636 26, 278 6, 785, 914 31.00 31.00 04100 SUBPROVI DER - I RF 41.00 5, 146, 838 5, 146, 838 60, 675 5, 207, 513 41.00 04300 NURSERY 43.00 2, 308, 707 2, 308, 707 2, 308, 707 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 11, 935, 665 50.00 11, 935, 665 11, 935, 665 50.00 51.00 05100 RECOVERY ROOM 1, 889, 372 1, 889, 372 0 1, 889, 372 51.00 05200 DELIVERY ROOM & LABOR ROOM 7, 164, 111 52 00 7, 164, 111 7, 164, 111 52.00 53.00 05300 ANESTHESI OLOGY 956, 280 956, 280 0 956, 280 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 5, 424, 523 5, 424, 523 0 0 0 5, 424, 523 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 2, 983, 360 2, 983, 360 2, 983, 360 55.00 05600 RADI OI SOTOPE 56,00 1,032,250 1, 032, 250 1,032,250 56.00 57.00 05700 CT SCAN 1, 998, 496 1, 998, 496 1, 998, 496 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 960, 492 960, 492 0 0 0 0 0 960, 492 58.00 05900 CARDIAC CATHETERIZATION 59 00 3 265 849 3 265 849 3, 265, 849 59 00 60.00 06000 LABORATORY 7, 600, 790 7, 600, 790 7, 600, 790 60.00 06400 I NTRAVENOUS THERAPY 560, 120 560, 120 560, 120 64.00 64.00 06500 RESPIRATORY THERAPY 65.00 4, 038, 766 4, 038, 766 4, 038, 766 65.00 06600 PHYSI CAL THERAPY 2, 499, 804 2, 499, 804 2, 499, 804 66 00 66 00 66. 01 03951 CLINICAL NUTRITION 292, 379 0 292, 379 0 292, 379 66.01 67.00 06700 OCCUPATIONAL THERAPY 1, 312, 562 1, 312, 562 0 1, 312, 562 67.00 68 00 06800 SPEECH PATHOLOGY 679.788 679 788 O 679, 788 68 00 69.00 06900 ELECTROCARDI OLOGY 6, 928, 262 6, 928, 262 123, 951 7, 052, 213 69.00 06901 CARDIAC REHABILITION 302, 994 302, 994 6,746 309, 740 69.01 69.01 70.00 07000 ELECTROENCEPHALOGRAPHY 177, 980 177, 980 4, 062 182, 042 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71 00 13, 096, 053 13, 096, 053 13, 096, 053 71 00 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 5, 621, 193 5, 621, 193 0 5, 621, 193 72.00 07300 DRUGS CHARGED TO PATIENTS 16, 724, 318 16, 724, 318 16, 724, 318 73.00 73.00 0 1, 213, 531 36, 943 74.00 07400 RENAL DIALYSIS 1, 213, 531 1, 250, 474 74.00 76.00 03950 ENDOSCOPY 0 76.00 0 0 0 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0 0 77.00 07800 CAR T-CELL IMMUNOTHERAPY 78.00 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 90.00 09000 CLI NI C 11, 018, 980 11, 018, 980 11, 018, 980 09100 EMERGENCY 7, 963, 119 7, 963, 119 59, 209 8, 022, 328 91.00 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1, 549, 089 1, 549, 089 1, 549, 089 92.00 OTHER REIMBURSABLE COST CENTERS 0 102. 00 102. 00 10200 OPI OI D TREATMENT PROGRAM 200.00 Subtotal (see instructions) 173, 513, 929 173, 513, 929 344, 644 173, 858, 573 200. 00 201.00 Less Observation Beds 1, 549, 089 1, 549, 089 1, 549, 089 201. 00 172, 309, 484 202. 00 202.00 Total (see instructions) 171, 964, 840 171, 964, 840 344.644

Provider CCN: 14-0046

Peri od:

COMPUTATION OF RATIO OF COSTS TO CHARGES

From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/21/2024 10:06 am Title XVIII Hospi tal PPS Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other TFFRA + col . 7) Ratio Inpati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 56, 892, 325 03000 ADULTS & PEDIATRICS 56, 892, 325 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 7, 297, 502 7, 297, 502 31.00 04100 SUBPROVI DER - I RF 41.00 5, 620, 534 5, 620, 534 41.00 43.00 04300 NURSERY 3, 723, 575 3, 723, 575 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 46, 044, 526 52, 761, 592 98, 806, 118 0.120799 0.000000 50.00 51.00 05100 RECOVERY ROOM 4, 948, 273 9, 240, 314 14, 188, 587 0.133161 0.000000 51.00 05200 DELIVERY ROOM & LABOR ROOM 2, 806, 040 0. 327798 19, 049, 215 21, 855, 255 0.000000 52.00 52.00 0.029592 53.00 05300 ANESTHESI OLOGY 16, 574, 687 15, 740, 750 32, 315, 437 0.000000 53 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 6, 585, 562 17, 328, 390 23, 913, 952 0.226835 0.000000 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 1, 536, 705 2, 874, 312 4, 411, 017 0.676343 0.000000 55.00 05600 RADI OI SOTOPE 2,604,226 8, 773, 332 0.090727 0.000000 56,00 11, 377, 558 56.00 57.00 05700 CT SCAN 26, 180, 795 53, 624, 355 79, 805, 150 0.025042 0.000000 57 00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 3, 594, 773 10, 175, 449 13, 770, 222 0.069751 0.000000 58.00 59.00 05900 CARDIAC CATHETERIZATION 23, 861, 854 22, 592, 968 46, 454, 822 0.070302 0.000000 59.00 06000 LABORATORY 37, 684, 199 47, 451, 099 85, 135, 298 0.089279 60.00 0.000000 60 00 64.00 06400 I NTRAVENOUS THERAPY 2,754 1,043,352 1, 046, 106 0. 535433 0.000000 64.00 06500 RESPIRATORY THERAPY 1, 693, 476 14, 331, 789 0. 281805 0.000000 65.00 12, 638, 313 65.00 06600 PHYSI CAL THERAPY 4, 434, 259 3, 833, 574 8, 267, 833 0.000000 66.00 0.302353 66.00 12. 357001 66.01 03951 CLINICAL NUTRITION 186 23, 475 23, 661 0.000000 66.01 67.00 06700 OCCUPATIONAL THERAPY 2, 559, 820 1, 154, 628 3, 714, 448 0.353367 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 1, 272, 265 828, 675 2, 100, 940 0.323564 0.000000 68.00 69 00 06900 ELECTROCARDI OLOGY 11, 741, 574 14, 636, 303 26, 377, 877 0 000000 69 00 0 262654 69.01 06901 CARDIAC REHABILITION 1,008 776, 967 777, 975 0.389465 0.000000 69.01 07000 ELECTROENCEPHALOGRAPHY 210,600 14, 300 224, 900 0.791374 0.000000 70.00 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 10, 504, 408 4,077,901 14, 582, 309 0.898078 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 6, 035, 059 3, 789, 274 72.00 9, 824, 333 0.572170 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 26, 953, 187 40, 185, 868 67, 139, 055 0. 249100 0.000000 73.00 74.00 07400 RENAL DIALYSIS 2, 168, 357 43, 501 2, 211, 858 0.548648 0.000000 74.00 76 00 03950 ENDOSCOPY 0 0.000000 0 000000 76 00 0 07700 ALLOGENEIC HSCT ACQUISITION 0 77.00 0 0.000000 0.000000 77.00 07800 CAR T-CELL IMMUNOTHERAPY 0 0.000000 0.000000 78.00 78.00 OUTPATIENT SERVICE COST CENTERS 90 00 13, 702, 153 14 028 556 0 785468 326 403 0.000000 90 00 09000 CLI NI C 91.00 09100 EMERGENCY 13, 703, 079 34, 208, 398 47, 911, 477 0.166205 0.000000 91.00 365, 312 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1, 267, 442 1, 632, 754 0. 948758 0.000000 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 102. 00 10200 OPI OI D TREATMENT PROGRAM 102.00 200.00 Subtotal (see instructions) 355, 115, 335 364, 647, 888 719, 763, 223 200.00 201.00 Less Observation Beds 201.00 202.00 Total (see instructions) 355, 115, 335 364, 647, 888 719, 763, 223 202.00

| In Lieu of Form CMS-2552-10 | Period: Worksheet C | From 01/01/2023 Part I | To 12/31/2023 Date/Time Prepared: 5/21/2024 10:06 am

				5/21/2024 10:06 am
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30.00
31. 00 03100 I NTENSI VE CARE UNIT				31.00
41. 00 04100 SUBPROVI DER - I RF				41.00
43. 00 04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATING ROOM	0. 120799			50.00
51. 00 05100 RECOVERY ROOM	0. 133161			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 327798			52. 00
53. 00 05300 ANESTHESI OLOGY	0. 029592			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 226835			54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 676343			55. 00
56. 00 05600 RADI 0I SOTOPE	0. 090727			56. 00
57. 00 05700 CT SCAN	0. 025042			57. 00
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 069751			58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 070302			59. 00
60. 00 06000 LABORATORY	0. 089279			60.00
64. 00 06400 I NTRAVENOUS THERAPY	0. 535433			64. 00
65. 00 06500 RESPIRATORY THERAPY	0. 281805			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 302353			66.00
66. 01 03951 CLI NI CAL NUTRI TI ON	12. 357001			66. 01
67. 00 06700 OCCUPATI ONAL THERAPY	0. 353367			67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 323564			68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 267353			69.00
69. 01 06901 CARDI AC REHABI LI TI ON	0. 398136			69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 809435			70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 898078			71. 00
72. 00 07100 MEDICAL SUFFEI ES CHARGED TO PATIENTS	0. 572170			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 372170			73. 00
74. 00 07400 RENAL DI ALYSI S	0. 565350			74.00
74. 00 07400 RENAL DI ALYSI S 76. 00 03950 ENDOSCOPY				I
	0.000000			76.00
77. 00 07700 ALLOGENEI C HSCT ACQUISITION	0.000000			77. 00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0. 000000			78. 00
OUTPATIENT SERVICE COST CENTERS	0.7054(0			00.00
90. 00 09000 CLI NI C	0. 785468			90.00
91. 00 09100 EMERGENCY	0. 167441			91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0. 948758			92. 00
OTHER REIMBURSABLE COST CENTERS				400.00
102. 00 10200 OPI OI D TREATMENT PROGRAM				102. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds 202.00 Total (see instructions)				201. 00
202.00 Total (see instructions)				202. 00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 14-0046 Peri od: Worksheet C From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/21/2024 10:06 am Title XIX Hospi tal PPS Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs from Wkst. B, Adj Di sal I owance Part I, col. 26) 4. 00 1.00 2.00 3.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 30 00 03000 ADULTS & PEDIATRICS 40, 108, 622 40, 108, 622 26, 780 40, 135, 402 03100 INTENSIVE CARE UNIT 6, 759, 636 6, 759, 636 26, 278 6, 785, 914 31.00 31.00 04100 SUBPROVI DER - I RF 41.00 5, 146, 838 5, 146, 838 60, 675 5, 207, 513 41.00 04300 NURSERY 43.00 2, 308, 707 2, 308, 707 2, 308, 707 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 11, 935, 665 50.00 11, 935, 665 11, 935, 665 50.00 51.00 05100 RECOVERY ROOM 1, 889, 372 1, 889, 372 0 1, 889, 372 51.00 05200 DELIVERY ROOM & LABOR ROOM 7, 164, 111 52 00 7, 164, 111 7, 164, 111 52.00 53.00 05300 ANESTHESI OLOGY 956, 280 956, 280 0 956, 280 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 5, 424, 523 5, 424, 523 0 0 0 5, 424, 523 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 2, 983, 360 2, 983, 360 2, 983, 360 55.00 05600 RADI OI SOTOPE 56,00 1,032,250 1, 032, 250 1,032,250 56.00 57.00 05700 CT SCAN 1, 998, 496 1, 998, 496 1, 998, 496 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 960, 492 960, 492 0 0 0 0 0 960, 492 58.00 05900 CARDIAC CATHETERIZATION 59 00 3 265 849 3 265 849 3, 265, 849 59 00 60.00 06000 LABORATORY 7, 600, 790 7, 600, 790 7, 600, 790 60.00 06400 I NTRAVENOUS THERAPY 560, 120 560, 120 560, 120 64.00 64.00 06500 RESPIRATORY THERAPY 65.00 4, 038, 766 4, 038, 766 4, 038, 766 65.00 06600 PHYSI CAL THERAPY 2, 499, 804 2, 499, 804 2, 499, 804 66 00 66 00 66. 01 03951 CLINICAL NUTRITION 292, 379 0 292, 379 0 292, 379 66.01 67.00 06700 OCCUPATIONAL THERAPY 1, 312, 562 1, 312, 562 0 1, 312, 562 67.00 68 00 06800 SPEECH PATHOLOGY 679.788 679 788 O 679, 788 68 00 69.00 06900 ELECTROCARDI OLOGY 6, 928, 262 6, 928, 262 123, 951 7, 052, 213 69.00 06901 CARDIAC REHABILITION 302, 994 302, 994 6,746 309, 740 69.01 69.01 70.00 07000 ELECTROENCEPHALOGRAPHY 177, 980 177, 980 4, 062 182, 042 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71 00 13, 096, 053 13, 096, 053 13, 096, 053 71 00 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 5, 621, 193 5, 621, 193 0 5, 621, 193 72.00 07300 DRUGS CHARGED TO PATIENTS 16, 724, 318 16, 724, 318 16, 724, 318 73.00 73.00 0 1, 213, 531 36, 943 74.00 07400 RENAL DIALYSIS 1, 213, 531 1, 250, 474 74.00 76.00 03950 ENDOSCOPY 0 76.00 0 0 0 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0 0 77.00 07800 CAR T-CELL IMMUNOTHERAPY 78.00 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 90.00 09000 CLI NI C 11, 018, 980 11, 018, 980 11, 018, 980 09100 EMERGENCY 7, 963, 119 7, 963, 119 59, 209 8, 022, 328 91.00 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1,549,089 1, 549, 089 1, 549, 089 92.00 OTHER REIMBURSABLE COST CENTERS 0 102. 00 102. 00 10200 OPI OI D TREATMENT PROGRAM 200.00 Subtotal (see instructions) 173, 513, 929 173, 513, 929 344, 644 173, 858, 573 200. 00 201.00 Less Observation Beds 1, 549, 089 1, 549, 089 1, 549, 089 201. 00 172, 309, 484 202. 00 202.00 Total (see instructions) 171, 964, 840 171, 964, 840 344.644

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 14-0046 Peri od: Worksheet C From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/21/2024 10:06 am Title XIX Hospi tal PPS Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other TFFRA + col . 7) Ratio Inpati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 56, 892, 325 03000 ADULTS & PEDIATRICS 56, 892, 325 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 7, 297, 502 7, 297, 502 31.00 04100 SUBPROVI DER - I RF 41.00 5, 620, 534 5, 620, 534 41.00 43.00 04300 NURSERY 3, 723, 575 3, 723, 575 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 46, 044, 526 52, 761, 592 98, 806, 118 0.120799 0.000000 50.00 51.00 05100 RECOVERY ROOM 4, 948, 273 9, 240, 314 14, 188, 587 0.133161 0.000000 51.00 05200 DELIVERY ROOM & LABOR ROOM 2, 806, 040 0. 327798 19, 049, 215 21, 855, 255 0.000000 52.00 52.00 0.029592 53.00 05300 ANESTHESI OLOGY 16, 574, 687 15, 740, 750 32, 315, 437 0.000000 53 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 6, 585, 562 17, 328, 390 23, 913, 952 0.226835 0.000000 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 1, 536, 705 2, 874, 312 4, 411, 017 0.676343 0.000000 55.00 05600 RADI OI SOTOPE 2,604,226 8, 773, 332 0.090727 0.000000 56,00 11, 377, 558 56.00 57.00 05700 CT SCAN 26, 180, 795 53, 624, 355 79, 805, 150 0.025042 0.000000 57 00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 3, 594, 773 10, 175, 449 13, 770, 222 0.069751 0.000000 58.00 59.00 05900 CARDIAC CATHETERIZATION 23, 861, 854 22, 592, 968 46, 454, 822 0.070302 0.000000 59.00 06000 LABORATORY 37, 684, 199 47, 451, 099 85, 135, 298 0.089279 60.00 0.000000 60 00 64.00 06400 I NTRAVENOUS THERAPY 2,754 1,043,352 1, 046, 106 0. 535433 0.000000 64.00 06500 RESPIRATORY THERAPY 1, 693, 476 14, 331, 789 0. 281805 0.000000 65.00 12, 638, 313 65.00 06600 PHYSI CAL THERAPY 4, 434, 259 3, 833, 574 8, 267, 833 0.000000 66.00 0.302353 66.00 12. 357001 66.01 03951 CLINICAL NUTRITION 186 23, 475 23, 661 0.000000 66.01 67.00 06700 OCCUPATIONAL THERAPY 2, 559, 820 1, 154, 628 3, 714, 448 0.353367 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 1, 272, 265 828, 675 2, 100, 940 0.323564 0.000000 68.00 69 00 06900 ELECTROCARDI OLOGY 11, 741, 574 14, 636, 303 26, 377, 877 0 000000 69 00 0 262654 69.01 06901 CARDIAC REHABILITION 1,008 776, 967 777, 975 0.389465 0.000000 69.01 07000 ELECTROENCEPHALOGRAPHY 210,600 14, 300 224, 900 0.791374 0.000000 70.00 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 10, 504, 408 4,077,901 14, 582, 309 0.898078 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 6, 035, 059 3, 789, 274 72.00 9, 824, 333 0.572170 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 26, 953, 187 40, 185, 868 67, 139, 055 0. 249100 0.000000 73.00 74.00 07400 RENAL DIALYSIS 2, 168, 357 43, 501 2, 211, 858 0.548648 0.000000 74.00 76 00 03950 ENDOSCOPY 0 0.000000 0 000000 76 00 0 07700 ALLOGENEIC HSCT ACQUISITION 0 77.00 0 0.000000 0.000000 77.00 07800 CAR T-CELL IMMUNOTHERAPY 0 0.000000 0.000000 78.00 78.00 OUTPATIENT SERVICE COST CENTERS 90 00 13, 702, 153 14 028 556 0 785468 326 403 0.000000 90 00 09000 CLI NI C 91.00 09100 EMERGENCY 13, 703, 079 34, 208, 398 47, 911, 477 0.166205 0.000000 91.00 365, 312 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1, 267, 442 1, 632, 754 0. 948758 0.000000 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 102. 00 10200 OPI OI D TREATMENT PROGRAM 102.00 200.00 Subtotal (see instructions) 355, 115, 335 364, 647, 888 719, 763, 223 200.00 201.00 Less Observation Beds 201.00 202.00 Total (see instructions) 355, 115, 335 364, 647, 888 719, 763, 223 202.00

| Period: | Worksheet C | From 01/01/2023 | Part | | Date/Time Prepared: | 5/21/2024 | 10: 06 am

					5/21/2024 10:06 am
			Title XIX	Hospi tal	PPS
	Cost Center Description	PPS Inpatient			
		Ratio			
		11.00			
I NPA	ATIENT ROUTINE SERVICE COST CENTERS				
30.00 0300	00 ADULTS & PEDIATRICS				30.00
31.00 0310	OO INTENSIVE CARE UNIT				31.00
41.00 0410	00 SUBPROVIDER - IRF				41.00
43.00 0430	00 NURSERY				43.00
ANCI	ILLARY SERVICE COST CENTERS				
50.00 0500	OO OPERATING ROOM	0. 120799			50.00
51.00 0510	OO RECOVERY ROOM	0. 133161			51.00
52.00 0520	OO DELIVERY ROOM & LABOR ROOM	0. 327798			52. 00
53.00 0530	00 ANESTHESI OLOGY	0. 029592			53. 00
54.00 0540	00 RADI OLOGY-DI AGNOSTI C	0. 226835			54.00
	00 RADI OLOGY-THERAPEUTI C	0. 676343			55. 00
	00 RADI OI SOTOPE	0. 090727			56.00
	00 CT SCAN	0. 025042			57.00
	OO MAGNETIC RESONANCE IMAGING (MRI)	0. 069751			58.00
	OO CARDI AC CATHETERI ZATI ON	0. 070302			59. 00
1	OO LABORATORY	0. 089279			60.00
	OO I NTRAVENOUS THERAPY	0. 535433			64. 00
	00 RESPI RATORY THERAPY	0. 281805			65. 00
1	00 PHYSI CAL THERAPY	0. 302353			66. 00
	51 CLINI CAL NUTRITION	12. 357001			66. 01
1	OO OCCUPATIONAL THERAPY	0. 353367			67. 00
	00 SPEECH PATHOLOGY	0. 323564			68. 00
	00 ELECTROCARDI OLOGY	0. 267353			69. 00
	01 CARDI AC REHABI LI TI ON	0. 398136			69. 01
	OO ELECTROENCEPHALOGRAPHY	0. 809435			70.00
	00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 898078			71. 00
1	00 IMPL. DEV. CHARGED TO PATIENTS	0. 572170			72.00
	OO DRUGS CHARGED TO PATIENTS	0. 249100			73. 00
	00 RENAL DIALYSIS	0. 565350			74. 00
	50 ENDOSCOPY	0. 000000			76.00
	OO ALLOGENEIC HSCT ACQUISITION	0. 000000			77. 00
	OO CAR T-CELL IMMUNOTHERAPY	0. 000000			78.00
	PATIENT SERVICE COST CENTERS	0.000000			78.00
	00 CLINIC	0. 785468			90.00
	OOLEMERGENCY	0. 763466			91.00
		0. 167441			92.00
	OO OBSERVATION BEDS (NON-DISTINCT PART)	0. 948/58			92.00
	ER REIMBURSABLE COST CENTERS OO OPIOID TREATMENT PROGRAM				102.00
200.00					102.00
	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201. 00
202. 00	Total (see instructions)	1			202. 00

Heal th Financial Systems SSM HEALTH GOOD CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICALD ONLY | In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: | To 12/31/2024 | Date/Time Prepared: | Date/Time Prepared: | Da Provider CCN: 14-0046

					10 12/31/2023	5/21/2024 10:0	
			Ti tl	e XIX	Hospi tal	PPS	00 4
	Cost Center Description	Total Cost		Operating Cos		Operating Cost	
	'	(Wkst. B, Part	(Wkst. B, Part	Net of Capita	Reduction	Reduction	
		1, col. 26)		Cost (col. 1		Amount	
			ŕ	col . 2)			
		1.00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	11, 935, 665	1, 669, 855	10, 265, 81	0 0	0	50. 00
51.00	05100 RECOVERY ROOM	1, 889, 372	29, 811	1, 859, 56	1 0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	7, 164, 111	436, 238	6, 727, 87	3 0	0	52.00
53.00	05300 ANESTHESI OLOGY	956, 280	88, 565	867, 71	5 0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	5, 424, 523	791, 591	4, 632, 93	2 0	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	2, 983, 360	155, 287	2, 828, 07	3 0	0	55. 00
56.00	05600 RADI OI SOTOPE	1, 032, 250	18, 235	1, 014, 01	5 0	0	56. 00
57.00	05700 CT SCAN	1, 998, 496	229, 304	1, 769, 19	2 0	0	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	960, 492	215, 946	744, 54	6 0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	3, 265, 849	329, 349	2, 936, 50	0	0	59. 00
60.00	06000 LABORATORY	7, 600, 790	410, 571	7, 190, 21	9 0	0	60.00
64.00	06400 I NTRAVENOUS THERAPY	560, 120	48, 809	511, 31	1 0	0	64.00
65.00	06500 RESPIRATORY THERAPY	4, 038, 766	241, 931			0	65. 00
66. 00	06600 PHYSI CAL THERAPY	2, 499, 804	139, 336			o	66. 00
66. 01	03951 CLINICAL NUTRITION	292, 379	2, 767	289, 61	2 0	o	66. 01
67. 00	06700 OCCUPATI ONAL THERAPY	1, 312, 562	117, 661			o	67. 00
68. 00	06800 SPEECH PATHOLOGY	679, 788	27, 966			o	68. 00
69. 00	06900 ELECTROCARDI OLOGY	6, 928, 262	891, 064			o	69. 00
69. 01	06901 CARDI AC REHABI LI TI ON	302, 994	12, 086			o	69. 01
70. 00	07000 ELECTROENCEPHALOGRAPHY	177, 980	41, 415	1		o	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	13, 096, 053	69, 404	1		0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	5, 621, 193	30, 408			0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	16, 724, 318	120, 813			Ö	73. 00
	07400 RENAL DIALYSIS	1, 213, 531	6, 589			Ö	74. 00
76. 00	03950 ENDOSCOPY	0	0,007	1,200,71	0	0	76. 00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		0 0	Ö	77. 00
	07800 CAR T-CELL IMMUNOTHERAPY	0	0	1	0 0		78. 00
70.00	OUTPATIENT SERVICE COST CENTERS			1	<u> </u>	0	70.00
90.00	09000 CLINIC	11, 018, 980	1, 416, 970	9, 602, 01	0 0	0	90. 00
91. 00	09100 EMERGENCY	7, 963, 119					91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 549, 089					92. 00
, 2. 00	OTHER REIMBURSABLE COST CENTERS	., ., ., .,	.00, 121	., ., ., .,			1 2.00
102, 00	10200 OPI OI D TREATMENT PROGRAM	0	0		0 0	0	102. 00
200.00	l	119, 190, 126	8, 224, 692	1			200. 00
201.00		1, 549, 089		1			201. 00
202.00		117, 641, 037					202. 00
	1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		2, .= ., 0, .	1,,	-1	,	. = . = 2

Heal th Financial Systems SSM HEALTH GOOD CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICALD ONLY | In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: 5/21/2024 10:06 am Provider CCN: 14-0046

						5/21/2024 10:	06 am
				e XIX	Hospi tal	PPS	
	Cost Center Description		Total Charges				
		Capital and	(Worksheet C,				
		Operating Cost			6		
		Reduction	8)	/ col. 7)			
		6.00	7. 00	8. 00			
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATI NG ROOM	11, 935, 665	98, 806, 118	0. 12079	99		50.00
51.00	05100 RECOVERY ROOM	1, 889, 372	14, 188, 587	0. 13316	51		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	7, 164, 111	21, 855, 255	0. 32779	98		52. 00
53.00	05300 ANESTHESI OLOGY	956, 280	32, 315, 437	0. 02959	92		53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	5, 424, 523	23, 913, 952	0. 22683	35		54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	2, 983, 360	4, 411, 017	0. 67634	13		55. 00
56.00	05600 RADI OI SOTOPE	1, 032, 250	11, 377, 558	0. 09072	27		56. 00
57.00	05700 CT SCAN	1, 998, 496	79, 805, 150	0. 02504	12		57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	960, 492	13, 770, 222	0.06975	51		58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	3, 265, 849	46, 454, 822	0. 07030)2		59. 00
60.00	06000 LABORATORY	7, 600, 790	85, 135, 298		79		60.00
64.00	06400 I NTRAVENOUS THERAPY	560, 120	1, 046, 106		33		64. 00
65.00	06500 RESPIRATORY THERAPY	4, 038, 766	14, 331, 789	l .			65. 00
66. 00	06600 PHYSI CAL THERAPY	2, 499, 804	8, 267, 833				66. 00
66. 01	03951 CLINI CAL NUTRI TI ON	292, 379	23, 661				66. 01
67. 00	06700 OCCUPATI ONAL THERAPY	1, 312, 562	3, 714, 448				67. 00
68. 00	06800 SPEECH PATHOLOGY	679, 788	2, 100, 940				68. 00
69. 00	06900 ELECTROCARDI OLOGY	6, 928, 262	26, 377, 877				69. 00
69. 01	06901 CARDI AC REHABI LI TI ON	302, 994	777, 975				69. 01
70. 00	07000 ELECTROENCEPHALOGRAPHY	177, 980	224, 900				70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	13, 096, 053	14, 582, 309				71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	5, 621, 193	9, 824, 333				72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	16, 724, 318	67, 139, 055				73. 00
	07400 RENAL DIALYSIS	1, 213, 531	2, 211, 858				74. 00
76.00	03950 ENDOSCOPY	1, 210, 001	2, 211, 000	1			76.00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	Ö				77. 00
	07800 CAR T-CELL IMMUNOTHERAPY	0	Ö				78. 00
70.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>		0.00000	,o		70.00
90. 00	09000 CLINI C	11, 018, 980	14, 028, 556	0. 78546	.8		90.00
	09100 EMERGENCY	7, 963, 119	47, 911, 477				91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 549, 089	1, 632, 754				92. 00
72.00	OTHER REIMBURSABLE COST CENTERS	1, 547, 007	1,032,734	0. 74073	70		72.00
102 00	10200 OPI OI D TREATMENT PROGRAM	0	0	0.00000	00		102. 00
200.00		119, 190, 126			,0		200. 00
201.00		1, 549, 089	040, 227, 207	•			201. 00
201.00		117, 641, 037	-	1			202. 00
202.00	Trotal (Title 200 IIII lius Title 201)	117,041,037	040, 227, 201	I	I		1202.00

Health Financial Systems S	SM HEALTH GOOD SA	AMARITAN HOSPIT	AL	In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITA	AL COSTS	Provi der C		Period: From 01/01/2023 To 12/31/2023		
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col . 1 - col			
	26)		2)			
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	2, 594, 051	0	2, 594, 05	1 26, 220	98. 93	30.00
31.00 INTENSIVE CARE UNIT	667, 354		667, 35	4 2, 551	261. 60	31.00
41. 00 SUBPROVI DER - I RF	400, 910	0	400, 91	2, 360	169. 88	41.00
43. 00 NURSERY	84, 644		84, 64	4 2, 093	40. 44	43.00
200.00 Total (lines 30 through 199)	3, 746, 959		3, 746, 95	9 33, 224		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 & PEDI ATRI CS	11, 378	1, 125, 626				30.00
31.00 INTENSIVE CARE UNIT	1, 069	279, 650				31. 00
41. 00 SUBPROVI DER - I RF	1, 236					41. 00
43. 00 NURSERY	0	1	1			43.00
200.00 Total (lines 30 through 199)	13, 683	1, 615, 248	8			200. 00

0

1, 416, 970

8, 224, 692

582, 600

100.121

0

14, 028, 556

47, 911, 477

1, 632, 754

646, 229, 287

0.000000

0.000000

0.101006

0.012160

0.061320

0

1, 104

6, 464, 687

107, 242, 747

134, 269

0 77.00

0 78.00

90 00

91.00

92.00

112

1, 346, 497 200. 00

78.611

8, 233

07700 ALLOGENEIC HSCT ACQUISITION

92. 00 | 09200 | OBSERVATI ON BEDS (NON-DISTINCT PART)

Total (lines 50 through 199)

07800 CAR T-CELL IMMUNOTHERAPY

09000 CLI NI C

09100 EMERGENCY

OUTPATIENT SERVICE COST CENTERS

77.00

78.00

91.00

Health Financial Sy	ystems	SSM HEALTH GOOD SAMAR	ITAN HOSPITAL	In Lieu	u of Form CMS-2552-10
ADDODTI ONMENT OF I	NDATIENT DOUTINE CED	DVICE OTHER DACK THROHOL COSTS	Drovi dor CCN, 14 0046	Dori od:	Workshoot D

Health Financial Systems SS	M HEALTH GOOD SA	MARITAN HOSPIT	AL	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER F	ASS THROUGH COS		F	Period: From 01/01/2023 To 12/31/2023	5/21/2024 10:	
			XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng		Allied Health	All Other	
	Program	Program	Post-Stepdown		Medi cal	
	Post-Stepdown		Adjustments		Education Cost	
	Adjustments					
	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0) c	0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0) (0	0	31.00
41. 00 04100 SUBPROVI DER - RF	0	0) c	0	0	41.00
43. 00 04300 NURSERY	0	0	ol c	0	0	43.00
200.00 Total (lines 30 through 199)	0	l c) c	0	0	200. 00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem (col.	Inpati ent	
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,		·		
	instructions)	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	26, 220	0.00	11, 378	30. 00
31.00 03100 INTENSIVE CARE UNIT		0	2, 551	0.00	1, 069	31.00
41. 00 04100 SUBPROVI DER - RF	0	0	2, 360	0.00	1, 236	41.00
43. 00 04300 NURSERY		0	2, 093	0.00	0	43.00
200.00 Total (lines 30 through 199)			33, 224		13, 683	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						31.00
41. 00 04100 SUBPROVI DER - RF						41.00
43. 00 04300 NURSERY						43. 00
200.00 Total (lines 30 through 199)						200.00
	1	I				1=30.00

| Peri od: | Worksheet D | From 01/01/2023 | Part IV | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2024 | Date/Time Prepared: | Date/Time P Health Financial Systems SSM HEALTH GOOD SAMARITAN HOSPITAL APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: Provider CCN: 14-0046 THROUGH COSTS

					10 12/31/2023	5/21/2024 10:	
			Ti tl e	: XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	·	Anestheti st	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
		1.00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	0		0	0	
51. 00	05100 RECOVERY ROOM	0	0		0	0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	
53.00	05300 ANESTHESI OLOGY	0	0		0 0	0	00.00
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
56. 00	05600 RADI OI SOTOPE	0	0		0 0	0	
57. 00	05700 CT SCAN	0	0		0	0	
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0	0	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	59. 00
60.00	06000 LABORATORY	0	0		0	55, 605	
64.00	06400 I NTRAVENOUS THERAPY	0	0		0	0	64. 00
65.00	06500 RESPI RATORY THERAPY	0	0		0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0		0 0	0	66. 00
66. 01	03951 CLINICAL NUTRITION	0	0		0 0	0	66. 01
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0		0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0		0 0	0	69. 00
69. 01	06901 CARDIAC REHABILITION	0	0		0 0	0	69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73. 00
74.00	07400 RENAL DIALYSIS	0	0		0 0	0	74. 00
76.00	03950 ENDOSCOPY	0	0		0	0	76. 00
77.00	07700 ALLOGENEIC HSCT ACQUISITION	o	0		0	0	77. 00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	0		0 0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0		0 (0	90.00
91.00	09100 EMERGENCY	0	0		0 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
200.00	Total (lines 50 through 199)	0	0		0	55, 605	200. 00

In Lieu of Form CMS-2552-10 Health Financial Systems SSM HEALTH GOOD SAMARITAN HOSPITAL APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 14-0046 Peri od: Worksheet D From 01/01/2023 To 12/31/2023 THROUGH COSTS Part IV Date/Time Prepared: 5/21/2024 10:06 am Title XVIII Hospi tal All Other Cost Center Description Total Cost Total Total Charges Ratio of Cost to Charges Medi cal (from Wkst. C, (sum of cols. Outpati ent Education Cost 1, 2, 3, and Cost (sum of Part I, col. l(col. 5 ÷ col 4) 8) col s. 2, 3, 7) and 4) (see instructions) 4.00 5.00 6.00 7. 00 8.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 98, 806, 118 0.00000050.00 00000000000000000000000000000 05100 RECOVERY ROOM 0 0 14, 188, 587 0.000000 51.00 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 21, 855, 255 0.000000 52.00 53. 00 05300 ANESTHESI OLOGY 0 0 32, 315, 437 0.000000 53 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 23, 913, 952 0.000000 54.00 55. 00 05500 RADI OLOGY-THERAPEUTI C 4, 411, 017 0.000000 55.00 56.00 05600 RADI OI SOTOPE 0 0 11, 377, 558 0.000000 56 00 0 57.00 05700 CT SCAN 0 79, 805, 150 0.000000 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 13, 770, 222 0.000000 58.00 05900 CARDIAC CATHETERIZATION 59.00 0 46, 454, 822 0.000000 59.00 06000 LABORATORY 55, 605 85, 135, 298 60 00 55, 605 0.000653 60 00 64.00 06400 I NTRAVENOUS THERAPY C 0 1, 046, 106 0.000000 64.00 06500 RESPIRATORY THERAPY 0 14, 331, 789 0.000000 65.00 0 65.00 8, 267, 833 06600 PHYSI CAL THERAPY 0 0.000000 66.00 0 66,00 0 03951 CLINICAL NUTRITION 66.01 Ω 23, 661 0.000000 66.01 67.00 06700 OCCUPATIONAL THERAPY C 0 3, 714, 448 0.000000 67.00 06800 SPEECH PATHOLOGY 2, 100, 940 0.000000 68.00 68.00 06900 ELECTROCARDI OLOGY 0 26, 377, 877 0.000000 69.00 69.00 06901 CARDIAC REHABILITION 0 777, 975 69.01 0 0.000000 69.01 70.00 07000 ELECTROENCEPHALOGRAPHY 224, 900 0.000000 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 14, 582, 309 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 9, 824, 333 0.000000 72.00

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78.00

90.00

91 00

92.00

200.00

07300 DRUGS CHARGED TO PATIENTS

07700 ALLOGENEIC HSCT ACQUISITION

07800 CAR T-CELL IMMUNOTHERAPY

OUTPATIENT SERVICE COST CENTERS

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

Total (lines 50 through 199)

07400 RENAL DIALYSIS

03950 ENDOSCOPY

09000 CLI NI C

91. 00 | 09100 | EMERGENCY

73.00

74.00

76.00

77.00

78.00

90.00

200.00

Health Financial Systems	SSM HEALTH GOOD SAMAR	RITAN HOSPITAL	In Lie	u of Form CMS-2552-10
ADDODTI ONMENT OF INDATI ENT/OUTDATI ENT	ANCLILADY CEDVICE OTHER DACC	Dravidor CCN, 14 0046	Doni od.	Waskahaat D

Peri od: From 01/01/2023 To 12/31/2023 APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Worksheet D Part IV THROUGH COSTS Date/Time Prepared: 5/21/2024 10:06 am Title XVIII Hospi tal PPS Outpati ent Cost Center Description Outpati ent Inpatient Inpati ent Outpati ent Program Ratio of Cost Program Program Program to Charges Pass-Through Pass-Through Charges Charges $(col. 6 \div col$ Costs (col. 8 Costs (col. 7) x col. 10) x col. 12) 13.00 9.00 10.00 11.00 12.00 ANCILLARY SERVICE COST CENTERS 17, 270, 338 50.00 05000 OPERATING ROOM 0.000000 22, 455, 554 50.00 0 0 51.00 05100 RECOVERY ROOM 0.000000 2, 146, 321 3, 263, 982 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 15, 642 0 52.00 4,572 0 52.00 05300 ANESTHESI OLOGY 0.000000 3, 462, 665 2, 791, 400 53.00 0 53.00 0.000000 7, 780, 702 05400 RADI OLOGY-DI AGNOSTI C 3, 242, 553 54.00 0 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 420 0 336, 970 0 55.00 56.00 05600 RADI OI SOTOPE 0.000000 850, 094 2, 398, 541 0 56.00 11, 617, 631 57.00 05700 CT SCAN 0.000000 0 16, 613, 573 0 57 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58.00 0.000000 1, 406, 404 3, 599, 848 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 0.000000 0 59.00 60.00 06000 LABORATORY 0.000653 15, 509, 252 10, 128 7, 561, 051 4, 937 60.00 06400 I NTRAVENOUS THERAPY 453, 374 64.00 64 00 0.000000 0 0 65.00 06500 RESPIRATORY THERAPY 0.000000 5,003,181 0 79, 111 0 65.00 06600 PHYSI CAL THERAPY 0 66.00 0.000000 2, 137, 262 38, 868 0 66.00 03951 CLINICAL NUTRITION 0 66 01 0.000000 0 66 01 06700 OCCUPATI ONAL THERAPY 67.00 0.000000 1, 111, 018 6,000 0 67.00 06800 SPEECH PATHOLOGY 0.000000 409, 523 5, 840 0 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 11, 712, 856 13, 558, 365 69.00 0 06901 CARDIAC REHABILITION 0 0.000000 69 01 69 01 0 0 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 91,000 2,600 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 4, 519, 267 1, 410, 642 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 2, 599, 919 0 1, 565, 632 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 0 18, 498, 340 73.00 73.00 11, 118, 638 0 0 74.00 07400 RENAL DIALYSIS 0.000000 1, 233, 487 11, 215 0 74.00 03950 ENDOSCOPY 0.000000 0 0 76.00 76.00 0 07700 ALLOGENEIC HSCT ACQUISITION 0 77.00 77.00 0.000000 0 0 07800 CAR T-CELL IMMUNOTHERAPY 78.00 78.00 0.000000 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0.000000 1, 104 489, 937 91.00 09100 EMERGENCY 0.000000 6, 464, 687 0 9, 218, 772 0 91.00 92. 00 | 09200 | OBSERVATI ON BEDS (NON-DISTINCT PART) 0

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Total (lines 50 through 199)

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 14-0046 Peri od: Worksheet D From 01/01/2023 Part V Date/Time Prepared: 12/31/2023 5/21/2024 10:06 am Title XVIII Hospi tal PPS Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Ratio From Services (see Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1.00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 120799 17, 270, 338 2, 086, 240 50.00 51.00 05100 RECOVERY ROOM 0. 133161 3, 263, 982 0 0 434, 635 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 1, 499 52 00 0.327798 4, 572 52 00 2, 791, 400 0 0 53.00 05300 ANESTHESI OLOGY 0.029592 82,603 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 226835 7, 780, 702 1, 764, 936 54.00 336, 970 55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 227, 907 0.676343 55 00 0 56.00 05600 RADI OI SOTOPE 0.090727 2, 398, 541 217, 612 56.00 57.00 05700 CT SCAN 0.025042 16, 613, 573 416, 037 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 58.00 0.069751 3, 599, 848 0 251, 093 58.00 0 05900 CARDI AC CATHETERI ZATI ON 0.070302 59 00 59 00 0 60.00 06000 LABORATORY 0.089279 7, 561, 051 675, 043 60.00 06400 INTRAVENOUS THERAPY 0.535433 0 0 0 0 0 0 0 0 242, 751 64.00 453, 374 64.00 06500 RESPIRATORY THERAPY 0. 281805 79, 111 0 22, 294 65.00 65.00 0 06600 PHYSI CAL THERAPY 66.00 0.302353 38, 868 11, 752 66.00 66.01 03951 CLINICAL NUTRITION 12. 357001 0 0 66.01 6,000 2, 120 06700 OCCUPATI ONAL THERAPY 0. 353367 67.00 67.00 06800 SPEECH PATHOLOGY 0. 323564 5, 840 0 1, 890 68.00 68.00 06900 ELECTROCARDI OLOGY 0 69 00 0.262654 13, 558, 365 3, 561, 159 69 00 69. 01 06901 CARDIAC REHABILITION 0. 389465 69.01 0 07000 ELECTROENCEPHALOGRAPHY 0. 791374 0 0 2,058 70.00 2,600 70.00 1, 410, 642 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0.898078 0 1, 266, 867 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 1, 565, 632 O 895, 808 72.00 0.572170 0 72 00 07300 DRUGS CHARGED TO PATIENTS 0. 249100 18, 498, 340 492 29, 194 4, 607, 936 73.00 73.00 07400 RENAL DIALYSIS 74.00 0.548648 11, 215 0 0 6, 153 74.00 03950 ENDOSCOPY 0.000000 0 76.00 0 76.00 C 0 07700 ALLOGENEIC HSCT ACQUISITION 77.00 0.000000 C 0 0 0 77.00 07800 CAR T-CELL IMMUNOTHERAPY 0.000000 78.00 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 0. 785468 489, 937 384, 830 90.00 0 91.00 09100 EMERGENCY 0. 166205 9, 218, 772 0 0 1, 532, 206 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0. 948758 186, 289 0 176, 743 92.00 200.00 Subtotal (see instructions) 492 29, 194 200.00 107, 145, 962 18, 872, 172 201.00 Less PBP Clinic Lab. Services-Program 0 201. 00 Only Charges 202.00 Net Charges (line 200 - line 201) 107, 145, 962 492 29, 194 18, 872, 172 202. 00

In Lieu of Form CMS-2552-10 Health Financial Systems SSM HEALTH GOOD SAMARITAN HOSPITAL APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 14-0046 Peri od: Worksheet D From 01/01/2023 Part V 12/31/2023 Date/Time Prepared: 5/21/2024 10:06 am Title XVIII Hospi tal PPS Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 7.00 6.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 51.00 05100 RECOVERY ROOM 0000000000000000000000 0 51.00 52. 00 05200 DELIVERY ROOM & LABOR ROOM 0 52 00 05300 ANESTHESI OLOGY 0 53.00 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 05500 RADI OLOGY-THERAPEUTI C 55.00 0 55.00 05600 RADI OI SOTOPE 0 56.00 56.00 57. 00 05700 CT SCAN 0 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 58.00 58.00 05900 CARDIAC CATHETERIZATION 0 59 00 59 00 60.00 06000 LABORATORY 0 60.00 64.00 06400 I NTRAVENOUS THERAPY 0 64.00 06500 RESPIRATORY THERAPY 65.00 0 65.00 Ol 06600 PHYSI CAL THERAPY 66.00 66.00 66.01 03951 CLINICAL NUTRITION 0 66.01 06700 OCCUPATI ONAL THERAPY 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 0 68.00 06900 ELECTROCARDI OLOGY 0 69.00 69.00 69. 01 06901 CARDIAC REHABILITION 0 69.01 07000 ELECTROENCEPHALOGRAPHY 0 70.00 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 72.00 Ω 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 73.00 07400 RENAL DIALYSIS 74.00 0 0 0 74.00 76.00 03950 ENDOSCOPY 0 76.00 07700 ALLOGENEIC HSCT ACQUISITION 77.00 0 77.00 07800 CAR T-CELL IMMUNOTHERAPY 0 78.00 78.00 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 90.00 0 91.00 09100 EMERGENCY 0 Ω 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 C 92.00 Subtotal (see instructions) 200.00 7, 272 200. 00 123

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Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

Only Charges

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Component CCR: 14+T046				CN: 14-0046	Peri od:	Worksheet D	2552-10
Cost Center Description			Component			Date/Time Pre	pared: 06 am
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70. 00							1
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72. 00							
73. 00 07300 DRUGS CHARGED TO PATIENTS 120, 813 67, 139, 055 0.001799 195, 496 352 73 74. 00 07400 RENAL DI ALYSI S 6, 589 2, 211, 858 0.002979 24, 092 72 74 75 75 75 75 75 75 75							1
74. 00							1
76. 00							
77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 0.000000 0 0 77 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0.000000 0 0 78. 00 0.000000 0 0 78. 00 0.000000 0 0 0 0 0 0							1
78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0.000000 0 0 78 00 00 0000000 0 0 0 78 00 0000000 0 0 0		0					77. 00
OUTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C 1, 416, 970 14, 028, 556 0. 101006 0 0 90 91. 00 09100 EMERGENCY 582, 600 47, 911, 477 0. 012160 53, 174 647 91		1	_			0	1
90. 00 09000 CLI NI C 1,416,970 14,028,556 0.101006 0 0 90 09100 EMERGENCY 582,600 47,911,477 0.012160 53,174 647 91				0.0000	<u> </u>		70.00
91. 00 09100 EMERGENCY 582, 600 47, 911, 477 0. 012160 53, 174 647 91		1, 416, 970	14, 028, 556	0. 10100	0	0	90.00
						-	1
	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1, 632, 754	1			
200.00 Total (Lines 50 through 199) 8, 124, 571 646, 229, 287 2, 547, 964 44, 735 200		8, 124, 571		1		44, 735	200.00

	LIEAL THE GOOD, CA	MADITAN JOSDIT			C.E. ONG	0550 40
Health Financial Systems SSM APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS				Period: From 01/01/2023 To 12/31/2023		pared:
		Title	: XVIII	Subprovi der - I RF	PPS	
Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursi ng Program	Allied Health Post-Stepdown Adjustments	Allied Health	
	1.00	2A	2.00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0		0 0	0	
51.00 05100 RECOVERY ROOM	0	0		0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	52. 00
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0	00.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0	00.00
56. 00 05600 RADI OI SOTOPE	0	0		0 0	1 0	56.00
57. 00 05700 CT SCAN	0	0		0 0	1	57. 00
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0			0 0	0	00.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0			0 0	0	07.00
60. 00 06000 LABORATORY 64. 00 06400 NTRAVENOUS THERAPY	0			0 0	55, 605	
	0			0 0	0	1 0 00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY					0	00.00
66. 01 03951 CLI NI CAL NUTRI TI ON						66. 01
67. 00 06700 OCCUPATIONAL THERAPY						67.00
68. 00 06800 SPEECH PATHOLOGY						68.00
69. 00 06900 ELECTROCARDI OLOGY						
69. 01 06901 CARDI AC REHABI LI TI ON					١	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY					١	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS					١	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS						1
73. 00 07300 DRUGS CHARGED TO PATIENTS						1
74. 00 07400 RENAL DI ALYSI S					ا ا	74.00
76. 00 03950 ENDOSCOPY					ا ا	76.00
77. 00 07700 ALLOGENEIC HSCT ACQUISITION					م ا	77. 00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY		1			ol ő	1
OUTDATIENT SERVICE COST CENTERS	<u>. </u>					1

0 0 0

0

0 91.00

0 92.00 55,605 200.00

0

0 0 0

90.00

90. 00 09000 CLI NI C

91. 00 09100 EMERGENCY

07700 ALLOGENEIC HSCT ACQUISITION 07800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS

92. 00 | 09200 | 085ERVATION BEDS (NON-DISTINCT PART) 200. 00 | Total (lines 50 through 199)

APPOR	Financial Systems SSM FIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE CH COSTS		Component (CN: 14-0046 CCN: 14-T046	Period: From 01/01/2023 To 12/31/2023	wof Form CMS-2 Worksheet D Part IV Date/Time Pre 5/21/2024 10:	pared:
			Title	e XVIII	Subprovi der - I RF	PPS	
	Cost Center Description	All Other	Total Cost	Total Outpatient	Total Charges (from Wkst. C,	Ratio of Cost to Charges	
		Medical Education Cost	(sum of cols. 1, 2, 3, and	Cost (sum of		(col. 5 ÷ col.	
		Ludcati on cost	4)	col s. 2, 3,	8)	7)	
			'/	and 4)		(see	
						instructions)	
		4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0			0 98, 806, 118	0.000000	50.00
51.00	05100 RECOVERY ROOM	0	0		0 14, 188, 587	0.000000	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	1	0 21, 855, 255	0.000000	
53.00	05300 ANESTHESI OLOGY	0	0	1	0 32, 315, 437	0. 000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 23, 913, 952	0. 000000	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 4, 411, 017	0. 000000	
56. 00	05600 RADI OI SOTOPE	0	0	1	0 11, 377, 558	0. 000000	
57. 00	05700 CT SCAN	0	0	1	0 79, 805, 150	0. 000000	
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	1	0 13, 770, 222	0. 000000	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	1	0 46, 454, 822	0. 000000	
60.00	06000 LABORATORY	0	,			0. 000653	
64.00	06400 I NTRAVENOUS THERAPY	0	0		0 1, 046, 106	0.000000	
65.00	06500 RESPI RATORY THERAPY	0	0		0 14, 331, 789	0.000000	
66.00	06600 PHYSI CAL THERAPY	0	0		0 8, 267, 833	0.000000	
66. 01	03951 CLINICAL NUTRITION	0	0		0 23, 661	0.000000	
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0 3, 714, 448	0.000000	
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0			0 2, 100, 940 0 26, 377, 877	0. 000000 0. 000000	
69. 00	06901 CARDI AC REHABI LI TI ON	0			0 26, 377, 877 0 777, 975	0.000000	
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 224, 900		
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0		0 14, 582, 309	0.000000	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 9, 824, 333	0.000000	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	•	0 67, 139, 055	0.000000	
74. 00	07400 RENAL DIALYSIS	0	0	•	0 2, 211, 858	0. 000000	
76. 00	03950 ENDOSCOPY	0	0		0 2,211,030	0. 000000	
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	Ö		0 0	0. 000000	
78. 00	1	0	_		0 0	0. 000000	
	OUTPATIENT SERVICE COST CENTERS		-	I.	-		1
90.00	09000 CLI NI C	0	0		0 14, 028, 556	0. 000000	90.00
91.00	09100 EMERGENCY	0	0		0 47, 911, 477	0.000000	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 1, 632, 754	0.000000	92.00
200.00	1 1	0	55, 605	55, 60			200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	HEALTH GOOD SAM RVICE OTHER PASS	Provi der C	CN: 14-0046 I	Period: From 01/01/2023	u of Form CMS-2 Worksheet D Part IV	
THROUGH COSTS		Component		To 12/31/2023	Date/Time Pre 5/21/2024 10:	pared: 06 am
		Title	xVIII	Subprovi der - I RF	PPS	
Cost Center Description	Outpati ent	I npati ent	Inpatient	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.		Costs (col. 8	3	Costs (col. 9	
	7)	10.00	x col. 10)	40.00	x col . 12)	
ANGLILLARY CERVICE COCT CENTERS	9. 00	10. 00	11.00	12. 00	13. 00	
ANCILLARY SERVICE COST CENTERS 50.00 OFFRATING ROOM	0.000000	2, 247	1	0 0	0	50.00
	0. 000000	-	1	-	0	
51. 00 05100 RECOVERY ROOM 52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	1
53. 00 05300 ANESTHESI OLOGY	0. 000000	0	1	0 0	0	1
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0. 000000	22, 912	1	0 0	0	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	22, 712	1	0 0	0	55. 00
56. 00 05600 RADI 0I SOTOPE	0. 000000	7, 188	1		0	1
57. 00 05700 CT SCAN	0. 000000	37, 052			0	57. 00
58. 00 05800 MAGNETIC RESONANCE MAGING (MRI)	0. 000000	0 0	1	o o	0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	0	l .	o o	0	
60. 00 06000 LABORATORY	0. 000653	256, 381	1		0	1 0 / 1 0 0
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000	200,001		ol ol	0	
65. 00 06500 RESPIRATORY THERAPY	0. 000000	195, 018		ol ol	0	
66. 00 06600 PHYSI CAL THERAPY	0. 000000	696, 601	1	ol ol	0	1
66. 01 03951 CLI NI CAL NUTRI TI ON	0. 000000	0)	o o	0	66. 01
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	700, 683	:	o	0	1
68. 00 06800 SPEECH PATHOLOGY	0. 000000	258, 020)	o o	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	13, 213	:	o o	0	69. 00
69. 01 06901 CARDI AC REHABI LI TI ON	0. 000000	0)	0 0	0	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0)	0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	82, 485		0 0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	3, 402	(0 0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	195, 496	,	0 0	0	73. 00
74. 00 07400 RENAL DI ALYSI S	0. 000000	24, 092	(0 0	0	74. 00
76. 00 03950 ENDOSCOPY	0. 000000	0		0	0	
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0)	0	0	77. 00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0	(0 0	0	78. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0. 000000	0	1	0	0	
91. 00 09100 EMERGENCY	0. 000000	53, 174	1	0 0	0	,
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0	1	0 0	0	
200.00 Total (lines 50 through 199)	1	2, 547, 964	16	7l Ol	Λ.	200.00

Health Financial Systems	SSM HEALTH GOOD SA	MARITAN HOSPIT	AL	In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPI	TAL COSTS	Provi der C		Period: From 01/01/2023 To 12/31/2023	Date/Time Pre	pared:
		Ti tl	e XIX	Hospi tal	5/21/2024 10: PPS	uo alli
Cost Center Description	Capital Related Cost (from Wkst. B,	Swing Bed Adjustment	Reduced Capi tal Rel ated Cost	Total Patient Days	Per Diem (col. 3 / col. 4)	
	Part II, col.		(col . 1 - col . 2)			
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	2, 594, 051		_, _, ,			
31.00 INTENSIVE CARE UNIT	667, 354		667, 35			
41. 00 SUBPROVI DER - I RF	400, 910		400, 910			
43. 00 NURSERY	84, 644		84, 64		•	
200.00 Total (lines 30 through 199)	3, 746, 959		3, 746, 95	9 33, 224		200. 00
Cost Center Description	I npati ent	Inpatient				
	Program days	Program				
		Capital Cost				
		(col. 5 x col. 6)				
	6, 00	7.00	1			
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00				
30. 00 ADULTS & PEDIATRICS	306	30, 273				30.00
31.00 INTENSIVE CARE UNIT	37					31.00
41. 00 SUBPROVI DER - I RF	22					41. 00
43. 00 NURSERY	1, 551	62, 722	2			43.00
200.00 Total (lines 30 through 199)	1, 916	106, 411				200. 00

Capital Related Cost (From Wisst. B, Part II, col. Part II	Cost Center Description	Capi tal		Ratio of Cost	Inpatient	Capital Costs	
Crom WKSt. B, Part II, col. 26)	cost center bescription		(from Wkst C	to Charges			
Part II, col. 26)							
1.00 2.00 3.00 4.00 5.00					onal goo	001 4	
NOTE CONTRIVENCE COST CENTERS Service		•	-,				
50. 00			2. 00	3.00	4. 00	5. 00	
51.00 05100 RECOVERY ROOM 29.811 14.188,587 0.002101 0 0 51.00 052.00 052.00 05200 052.00 052.00 052.00 052.00 052.00 052.00 052.00 052.00 052.00 052.00 052.00 052.00 052.00 052.00 052.00 052.00 052.00 052.00 052.00 053.00 053.00 053.00 055.00 053.00 055.00 05	ANCILLARY SERVICE COST CENTERS						
52.00 05200 DELI VERY ROOM & LABOR ROOM 436, 238 21, 855, 255 0. 019960 0 0 52.00	50. 00 05000 OPERATI NG ROOM	1, 669, 855	98, 806, 118	0. 016900	0	0	50.00
53.00 05300 ANESTHESI OLOGY 88, 565 32, 315, 437 0.002741 0 0 53.00	51.00 05100 RECOVERY ROOM	29, 811	14, 188, 587	0. 002101	0	0	51.00
54. 00 05400 RADI OLOGY_DI AGNOSTI C 791, 591 23, 913, 952 0.033102 0 0 54. 00 055. 00 05500 RADI OLOGY_THERAPEUTI C 155, 287 4, 411, 017 0.035204 0 0 55. 00 05600 RADI OLOGY_THERAPEUTI C 155, 287 4, 411, 017 0.035204 0 0 55. 00 05700 CT SCAN 229, 304 79, 805, 150 0.002873 0 0 57. 00 05700 CT SCAN 229, 304 79, 805, 150 0.002873 0 0 57. 00 05900 CARDI AC CATHETERI ZATI ON 329, 349 46, 454, 822 0.007090 0 0 59. 00 06000 LABORATORY 410, 571 85, 135, 298 0.004823 0 0 60. 00 64. 00 06400 INTRAVENOUS THERAPY 48, 809 1, 046, 106 0.046658 0 0 64. 00 06600 RESPI RATORY THERAPY 241, 931 14, 331, 789 0.016881 0 0 65. 00 06600 PHYSI CAL THERAPY 139, 336 8, 267, 833 0.016853 0 0 66. 00 06600 PHYSI CAL THERAPY 117, 661 3, 714, 448 0.031677 0 0 67. 00 06900 CARDI AC REHABI LI TI ON 27, 767 23, 661 0.116943 0 0 65. 00 66. 00 06900 ELECTROCARDI OLOGY 27, 966 2, 100, 940 0.013311 0 0 69. 00 6900 ELECTROCARDI OLOGY 891, 064 24, 577, 975 0.015315 0 0 69. 01 071, 00 07000 ELECTROCARDI OLOGY 0.000000 0 0.000000 0 0.000000 0	52.00 05200 DELIVERY ROOM & LABOR ROOM	436, 238	21, 855, 255	0. 019960	0	0	52. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C 155, 287 4, 411, 017 0. 0.35204 0 0 55. 00 56. 00 05600 RADI OLOGY-THERAPEUTI C 18, 235 1, 377, 558 0. 001603 0 0 55. 00 57. 00 05700 CT SCAN 229, 304 79, 805, 150 0. 002873 0 0 55. 00 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 215, 946 13, 770, 222 0. 015682 0 0 58. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 329, 349 46, 454, 822 0. 007090 0 0 59. 00 64. 00 0600 LABORATORY 410, 571 85, 135, 298 0. 004823 0 0 66. 00 65. 00 0600 LABORATORY 48, 809 1, 046, 106 0. 046658 0 0 64. 00 65. 00 06500 RESPI RATORY THERAPY 241, 931 14, 331, 789 0. 016881 0 0 65. 00 66. 00 06600 PLASTICAL THERAPY 139, 336 8, 267, 833 0. 016853 0 0 66. 00 66. 01 03951 CLI NI CAL NUTRI TI ON 2, 767 23, 661 0. 116943 0 0 66. 01 67. 00 06700 OCCUPATI ONAL THERAPY 117, 661 3, 714, 448 0. 031677 0 0 67. 00 69. 00 06900 ELECTROCARDI OLOGY 891, 064 26, 377, 877 0. 033781 0 0 69. 00 69. 01 06901 CARDI AC REHABI LI TI ON 12, 866 777, 975 0. 015535 0 0 69. 01 70. 00 07000 ELECTROCARDI OLOGY 891, 064 26, 377, 877 0. 033781 0 0 69. 01 71. 00 07000 ELECTROENCEPHAL OGRAPHY 14, 14, 15 224, 900 0. 184149 0 0 70. 00 71. 00 07000 ELECTROENCEPHAL OGRAPHY 14, 14, 15 224, 900 0. 184149 0 0 70. 00 71. 00 07000 ELECTROENCEPHAL OGRAPHY 14, 14, 15 224, 900 0. 184149 0 0 71. 00 71. 00 07000 ELECTROENCEPHAL OGRAPHY 14, 14, 15 224, 900 0. 184149 0 0 72. 00 71. 00 07000 ELECTROENCEPHAL OGRAPHY 14, 14, 15 224, 900 0. 184149 0 0 72. 00 71. 00 07000 ELECTROENCEPHAL DRIENTS 120, 813 67, 139, 055 0. 001759 0 0 73. 00 74. 00 07300 DRUGS CHARGED TO PATI ENTS 120, 813 67, 139, 055 0. 001799 0 0 74. 00 75. 00 07000 ELECTROENCEPHAL DRIENTS 120, 813 67, 139, 055 0. 001799 0 0 74. 00 76. 00 07000 ELECTROENCEPHAL DRIENTS 120, 813 67, 139, 055 0. 001799 0 0 74. 00 07000 07000 ELECTROENCEPHAL DRIENTS 120, 813 67, 139, 055 0. 001799 0 0 74. 00 07000 07000 ELECTROENCEPHAL DRIENTS 120, 813 67, 139, 055 0. 001799 0 0 74. 00 07000 07000 ELECTROENCEPHAL DRIENTS 140, 810, 810, 810, 810, 810, 810, 810, 81	53. 00 05300 ANESTHESI OLOGY	88, 565	32, 315, 437	0. 002741	0	0	53. 00
56. 00 05600 RADI OI SOTOPE 18, 235 11, 377, 558 0. 001603 0 0 56. 00	54. 00 05400 RADI OLOGY-DI AGNOSTI C	791, 591	23, 913, 952	0. 033102	0	0	54.00
57. 00 05700 CT SCAN 229, 304 79, 805, 150 0.002873 0 0 57. 00 58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 215, 946 13, 770, 222 0.015682 0 0 58. 00 59. 00 05900 CARDIA C CATHETERI ZATION 329, 349 46, 454, 822 0.007090 0 0 0.00000 60. 00 06000 LABORATORY 410, 571 85, 135, 298 0.004823 0 0 60. 00 64. 00 06400 INTRAVENOUS THERAPY 48, 809 1, 046, 106 0.046658 0 0 64. 00 65. 00 06500 RESPIRATORY THERAPY 241, 931 14, 331, 789 0.016881 0 0 65. 00 66. 01 03951 CLI NI CAL NUTRI TI ON 2, 767 23, 661 0.116943 0 0 66. 01 67. 00 06700 OCCUPATI ONAL THERAPY 117, 661 3, 714, 448 0.031677 0 0 67. 00 69. 00 06900 ELECTROCARDI OLOGY 891, 064 26, 377, 877 0.033781 0 0 68. 00 69. 01 06901 CARDIA C REHABILITION 12, 086 777, 775 0.015335 0 0 69. 01 70. 00 07000 ELECTROCENCEPHALOGRAPHY 41, 415 224, 900 0.184149 0 0.70. 00 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 69, 404 14, 582, 309 0.004759 0 0 71. 00 71. 00 07400 RENAL DIALYSIS 69, 404 14, 582, 309 0.004759 0 0 72. 00 74. 00 07400 RENAL DIALYSIS 69, 404 14, 582, 309 0.004759 0 0 73. 00 75. 00 07500 LINCS CHARGED TO PATIENTS 120, 813 67, 139, 055 0.001799 0 0 74. 00 76. 00 07500 CARDIA C REHABILITION 0 0 0 0.000000 0 0 77. 00 77. 00 07700 ALLOGENET C HSCT ACQUISITION 0 0 0.000000 0 0 77. 00 77. 00 07700 CALDIAC C REHABILITION 0 0 0 0.000000 0 0 78. 00 77. 00 07700 CALDIAC C REHABILITION 0 0 0 0.000000 0 0 0.000000 0 77. 00 07700 ALLOGENET C HSCT ACQUISITION 0 0 0.000000 0 0 0.000000 0	55. 00 05500 RADI OLOGY-THERAPEUTI C	155, 287	4, 411, 017	0. 035204	0	0	55. 00
58. 00	56. 00 05600 RADI 0I SOTOPE	18, 235	11, 377, 558	0. 001603	0	0	56. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON 329, 349 46, 454, 822 0. 007090 0 0 59. 00 60. 00 60.00 0 60000 LABORATORY 410, 571 85, 135, 298 0. 004823 0 0 60. 0	57. 00 05700 CT SCAN	229, 304	79, 805, 150	0. 002873	0	0	57. 00
60.00 06000 LABORATORY 410, 571 85, 135, 298 0.004823 0 0 60.00 64.00 06400 INTRAVENOUS THERAPY 48, 809 1, 046, 106 0.046658 0 0 64.00 65.00 65.00 66500 RESPI RATORY THERAPY 241, 931 14, 331, 789 0.016881 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 139, 336 8, 267, 833 0.016853 0 0 66.01 03951 CLI NI CAL NUTRI TI ON 2, 767 23, 661 0.116943 0 0 66.01 06700 0CCUPATI ONAL THERAPY 117, 661 3, 714, 448 0.031677 0 0 67.00 06800 SPEECH PATHOLOGY 27, 966 2, 100, 940 0.013311 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 891, 064 26, 377, 877 0.033781 0 0 69.00 69.01 06901 CARDI AC REHABI LITI ON 12, 086 777, 975 0.015535 0 0 69.01 07000 ELECTROCARDI OLOGY 41, 4115 224, 900 0.184149 0 0 70.00 70.00 07000 ELECTROCARDI OLOGAPHY 41, 415 224, 900 0.184149 0 0 70.00 70.00 70.00 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 69, 404 14, 582, 309 0.004759 0 0 71.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 30, 408 9, 824, 333 0.003095 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 120, 813 67, 139, 055 0.001799 0 0 74.00 75.00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 0.000000 0 0 74.00 75.00 07500 CAR T-CELL IMMUNOTHERAPY 0 0 0.000000 0 0 75.00 07500 07	58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	215, 946	13, 770, 222	0. 015682	0	0	58. 00
64. 00	59. 00 05900 CARDI AC CATHETERI ZATI ON	329, 349	46, 454, 822	0.007090	0	0	59. 00
65. 00 06500 RESPIRATORY THERAPY 241, 931 14, 331, 789 0. 016881 0 0 65. 00 660. 00 66	60. 00 06000 LABORATORY	410, 571	85, 135, 298	0. 004823	0	0	60.00
66. 00	64. 00 06400 I NTRAVENOUS THERAPY	48, 809	1, 046, 106	0. 046658	0	0	64. 00
66. 01 03951 CLINICAL NUTRITION 2, 767 23, 661 0.116943 0 0 66. 01 67. 00 06700 OCCUPATIONAL THERAPY 117, 661 3, 714, 448 0.031677 0 0 67. 00 68. 00 06800 SPECH PATHOLOGY 27, 966 2, 100, 940 0.013311 0 0 68. 00 69. 00 69. 00 ELECTROCARDIOLOGY 891, 064 26, 377, 877 0.033781 0 0 69. 00 69. 01 06901 CARDIAC REHABILITION 12, 086 777, 975 0.015535 0 0 69. 01 070. 00 07000 ELECTROENCEPHALOGRAPHY 41, 415 224, 900 0.184149 0 0 70. 00 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 69, 404 14, 582, 309 0.004759 0 0 71. 00 072. 00 07200 I MPL. DEV. CHARGED TO PATIENTS 30, 408 9, 824, 333 0.003095 0 0 72. 00 07300 DRUGS CHARGED TO PATIENTS 120, 813 67, 139, 055 0.001799 0 0 73. 00 07400 RENAL DI ALYSIS 6, 589 2, 211, 858 0.002979 0 0 74. 00 07400 RENAL DI ALYSIS 6, 589 2, 211, 858 0.002979 0 0 74. 00 07500 CAR T-CELL IMMUNOTHERAPY 0 0 0.000000 0 0 0 0.000000 0 0 0 0.000000	65. 00 06500 RESPIRATORY THERAPY	241, 931	14, 331, 789	0. 016881	0	0	65. 00
67. 00 06700 0CCUPATI ONAL THERAPY 117, 661 3,714,448 0.031677 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 27,966 2,100,940 0.013311 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 891,064 26,377,877 0.033781 0 0 69.00 69.01 06901 CARDI AC REHABI LI TI ON 12,086 777,975 0.015535 0 0 69.01 70.00 07000 ELECTROENCEPHALOGRAPHY 411,415 224,900 0.184149 0 0 70.00 71.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 69,404 14,582,309 0.004759 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 30,408 9,824,333 0.003095 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 120,813 67,139,055 0.001799 0 0 73.00 74.00 07400 RENAL DI ALYSI S 6,589 2,211,858 0.002979 0 0 74.00 75.00 77.00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 0.000000 0 0 77.00 07800 CAR T-CELL I IMMUNOTHERAPY 0 0 0.000000 0 0 0.000000 0	66. 00 06600 PHYSI CAL THERAPY	139, 336	8, 267, 833	0. 016853	0	0	66. 00
68. 00	66. 01 03951 CLI NI CAL NUTRI TI ON	2, 767	23, 661	0. 116943	0	0	66. 01
69. 00 06900 ELECTROCARDI OLOGY 891, 064 26, 377, 877 0. 033781 0 0 69. 00 69. 01 06901 CARDI AC REHABI LI TI ON 12, 086 777, 975 0. 015535 0 0 69. 01 70. 00 70. 00 70. 00 ELECTROENCEPHALOGRAPHY 41, 415 224, 900 0. 184149 0 0 70. 00 70. 00 71. 00 71. 00 71. 00 71. 00 72. 00 72. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 74	67. 00 06700 OCCUPATI ONAL THERAPY	117, 661	3, 714, 448	0. 031677	0	0	67. 00
69. 01	68. 00 06800 SPEECH PATHOLOGY	27, 966	2, 100, 940	0. 013311	0	0	68. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY 11, 415 224, 900 0. 184149 0 0 70. 00 71. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 69, 404 14, 582, 309 0. 004759 0 0 71. 00 72. 00 72. 00 MPL. DEV. CHARGED TO PATI ENTS 30, 408 9, 824, 333 0. 003095 0 0 72. 00 73. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 120, 813 67, 139, 055 0. 001799 0 0 73. 00 74. 00 0. 000000 0 0 74. 00 0. 000000 0 0 74. 00 0. 000000 0 0 74. 00 0. 000000 0 0 76. 00 0. 000000 0 0 76. 00 0. 000000 0 0 77. 00 0. 000000 0 0 0. 000000 0	69. 00 06900 ELECTROCARDI OLOGY	891, 064	26, 377, 877	0. 033781	0	0	69. 00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 69, 404 14, 582, 309 0.004759 0 0 71. 00 72. 00 72. 00 73. 00 73. 00 73. 00 73. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 75. 00 7	69. 01 06901 CARDI AC REHABI LI TI ON	12, 086	777, 975	0. 015535	0	0	69. 01
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 30, 408 9, 824, 333 0.003095 0 0 72. 00 73. 00 73. 00 73. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 75. 00	70. 00 07000 ELECTROENCEPHALOGRAPHY	41, 415	224, 900	0. 184149	0	0	70. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 120, 813 67, 139, 055 0.001799 0 0 73. 00 74. 00 74. 00 74. 00 74. 00 74. 00 75.	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	69, 404	14, 582, 309	0. 004759	0	0	71. 00
74. 00 07400 RENAL DI ALYSI S 0,589 2,211,858 0.002979 0 0 74. 00 76. 00 03950 ENDOSCOPY 0 0 0.000000 0 0 76. 00 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 0.000000 0 0 0 77. 00 07800 CAR T-CELL I MMUNOTHERAPY 0 0 0.000000 0 0 0 0 0	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	30, 408	9, 824, 333	0. 003095	0	0	72. 00
76. 00	73.00 07300 DRUGS CHARGED TO PATIENTS	120, 813	67, 139, 055	0. 001799	0	0	73. 00
77. 00 07700 ALLOGENEI C HSCT ACQUI SITION 0 0.000000 0 0.77. 00 07800 CAR T-CELL I MMUNOTHERAPY 0 0.000000 0 0.000000 0 0	74.00 07400 RENAL DIALYSIS	6, 589	2, 211, 858	0. 002979	0	0	74. 00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0.000000 0 0 78. 00 00 00 00 00 00 00 00 00 00 00 00 00	76. 00 03950 ENDOSCOPY	0	0	0.000000	0	0	76. 00
OUTPATI ENT SERVICE COST CENTERS 90. 00 09000 CLINIC 1,416,970 14,028,556 0.101006 0 0 90.00 91. 00 09100 EMERGENCY 582,600 47,911,477 0.012160 0 0 91.00	77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0	77. 00
90. 00 09000 CLI NI C 1,416,970 14,028,556 0.101006 0 0 90.00 91.00 09100 EMERGENCY 582,600 47,911,477 0.012160 0 91.00	78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	0.000000	0	0	78. 00
91.00 09100 EMERGENCY 582,600 47,911,477 0.012160 0 91.00	OUTPATIENT SERVICE COST CENTERS						
					0	0	
92.00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 100, 121 1, 632, 754 0.061320 0 0 92.00		582, 600	47, 911, 477	0. 012160	0	0	
		•			0		
200.00 Total (lines 50 through 199) 8,224,692 646,229,287 0 0 200.00	200.00 Total (lines 50 through 199)	8, 224, 692	646, 229, 287	1	0) O	200. 00

ealth Financial Systems	SSM HEALTH GOOD SAMAR	ITAN HOSPITAL	In Lie	u of Form CMS-2552-10

Health Financial Systems	SSM HEALTH GOOD SA	MARITAN HOSPIT	AL	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	R PASS THROUGH COS		F	Period: From 01/01/2023 To 12/31/2023	Date/Time Pre 5/21/2024 10:	
			e XIX	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng		Allied Health	All Other	
	Program	Program	Post-Stepdown		Medi cal	
	Post-Stepdown		Adjustments		Education Cost	
	Adjustments					
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0) C	0	0	00.00
31.00 03100 INTENSIVE CARE UNIT	0	0)	0	0	31.00
41. 00 04100 SUBPROVI DER - I RF	0	0) c	0	0	41.00
43. 00 04300 NURSERY	0	0) c	0	0	43.00
200.00 Total (lines 30 through 199)	0	l o	o c	0	0	200. 00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem (col.	Inpati ent	
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
	instructions)					
	4.00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0	26, 220	0.00	306	30.00
31.00 03100 INTENSIVE CARE UNIT		0	2, 551	0.00	37	31.00
41. 00 04100 SUBPROVI DER - I RF	0		2, 360	0.00	22	41.00
43. 00 04300 NURSERY		0	2, 093	0.00	1, 551	43.00
200.00 Total (lines 30 through 199)			1			200.00
Cost Center Description	I npati ent	-			,	
, and the second	Program					
	Pass-Through					
	Cost (col. 7 x					
	col . 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
31. 00 03100 INTENSIVE CARE UNIT	0					31.00
41. 00 04100 SUBPROVI DER - RF	0					41.00
43. 00 04300 NURSERY	0	ŀ				43. 00
200.00 Total (lines 30 through 199)	0	l .				200.00
200.00 10tal (11103 00 till ough 177)	1	I				1200.00

| Peri od: | Worksheet D | From 01/01/2023 | Part IV | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2024 | Date/Time Prepared: | Date/Time P
 Heal th Financial
 Systems
 SSM HEALTH GOOD SAMARITAN HOSPITAL

 APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY
 SERVICE OTHER PASS
 Provider CCN:
 Provider CCN: 14-0046 THROUGH COSTS

				10 12/31/2023	5/21/2024 10:	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	Anesthetist	Program	Program	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
	1.00	2A	2. 00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS						F0 00
50. 00 05000 0PERATI NG ROOM	0	0		0	0	50.00
51. 00 05100 RECOVERY ROOM	0	0		0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM 53.00 05300 ANESTHESI OLOGY	0	0		0	0	52. 00 53. 00
	0	0		0	0	54.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0	0	55.00
56. 00 05500 RADI OLOGY - THERAPEUTI C	0	0		0	0	56.00
57. 00 05700 CT SCAN	0	0		0	0	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0		0	0	58.00
59. 00 05900 CARDIAC CATHETERIZATION		0		0	0	59.00
60. 00 06000 LABORATORY		0		0	55, 605	
64. 00 06400 NTRAVENOUS THERAPY		0		0	0 55, 605	64.00
65. 00 06500 RESPIRATORY THERAPY		0		0	0	65.00
66. 00 06600 PHYSI CAL THERAPY		0		0	0	66.00
66. 01 03951 CLI NI CAL NUTRI TI ON		0		0		66. 01
67. 00 06700 OCCUPATI ONAL THERAPY		0		0	0	67.00
68. 00 06800 SPEECH PATHOLOGY		0		0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY		0		0 0	0	69.00
69. 01 06901 CARDI AC REHABI LI TI ON		0		0	Ö	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY		0		0	0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0		0	0	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS		0		0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73. 00
74. 00 07400 RENAL DI ALYSI S		0		0 0	Ö	74.00
76. 00 03950 ENDOSCOPY	0	0		0 0	Ö	76.00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0		0 0	0	77. 00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0	0		0	0	78. 00
OUTPATIENT SERVICE COST CENTERS	-1	·	I .			
90. 00 09000 CLI NI C	0	0		0 0	0	90.00
91. 00 09100 EMERGENCY	0	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92. 00
200.00 Total (lines 50 through 199)	0	0		0 0	55, 605	200. 00

In Lieu of Form CMS-2552-10 Health Financial Systems SSM HEALTH GOOD SAMARITAN HOSPITAL APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 14-0046 Peri od: Worksheet D From 01/01/2023 To 12/31/2023 THROUGH COSTS Part IV Date/Time Prepared: 5/21/2024 10:06 am Title XIX Hospi tal Ratio of Cost Cost Center Description All Other Total Cost Total Total Charges to Charges Medi cal (from Wkst. C, (sum of cols. Outpati ent Education Cost 1, 2, 3, and Cost (sum of Part I, col. l(col. 5 ÷ col 8) 4) col s. 2, 3, 7) and 4) (see instructions) 4.00 5.00 6.00 7. 00 8.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 98, 806, 118 0.00000050.00 00000000000000000000000000000 05100 RECOVERY ROOM 0 0 14, 188, 587 0.000000 51.00 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 21, 855, 255 0.000000 52.00 53. 00 05300 ANESTHESI OLOGY 0 0 32, 315, 437 0.000000 53 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 23, 913, 952 0.000000 54.00 55. 00 05500 RADI OLOGY-THERAPEUTI C 4, 411, 017 0.000000 55.00 56.00 05600 RADI OI SOTOPE 0 0 11, 377, 558 0.000000 56 00 0 57.00 05700 CT SCAN 0 79, 805, 150 0.000000 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 13, 770, 222 0.000000 58.00 05900 CARDIAC CATHETERIZATION 59.00 0 46, 454, 822 0.000000 59.00 06000 LABORATORY 55, 605 85, 135, 298 60 00 55, 605 0.000653 60 00 64.00 06400 I NTRAVENOUS THERAPY C 0 1, 046, 106 0.000000 64.00 06500 RESPIRATORY THERAPY 0 14, 331, 789 0.000000 65.00 0 65.00 8, 267, 833 06600 PHYSI CAL THERAPY 0 0.000000 66.00 0 66,00 0 03951 CLINICAL NUTRITION 66.01 Ω 23, 661 0.000000 66.01 67.00 06700 OCCUPATIONAL THERAPY C 0 3, 714, 448 0.000000 67.00 06800 SPEECH PATHOLOGY 2, 100, 940 0.000000 68.00 68.00 06900 ELECTROCARDI OLOGY 0 26, 377, 877 0.000000 69.00 69.00 06901 CARDIAC REHABILITION 0 777, 975 69.01 0 0.000000 69.01 70.00 07000 ELECTROENCEPHALOGRAPHY 224, 900 0.000000 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 14, 582, 309 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 9, 824, 333 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0.000000 73.00 Ω 67, 139, 055 73 00 74.00 07400 RENAL DIALYSIS 0 0 2, 211, 858 0.000000 74.00 03950 ENDOSCOPY 76.00 0.000000 76.00 07700 ALLOGENEIC HSCT ACQUISITION 0 77.00 0 0 0.000000 77.00 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0.000000 78.00 OUTPATIENT SERVICE COST CENTERS

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92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

Total (lines 50 through 199)

91. 00 | 09100 | EMERGENCY

Heal th	Financial Systems SS	M HEALTH GOOD SAM	ARITAN HOSPIT	AL	In Lie	eu of Form CMS-2	2552-10
	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE H COSTS	RVICE OTHER PASS	Provider Co		Period: From 01/01/2023 To 12/31/2023		
				e XIX	Hospi tal	PPS	
	Cost Center Description	Outpatient Ratio of Cost to Charges	Inpatient Program Charges	Inpatient Program Pass-Through		Outpatient Program Pass-Through	
		(col. 6 ÷ col.		Costs (col. 8	3	Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9. 00	10. 00	11. 00	12.00	13. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0. 000000	0		0	0	50.00
51. 00	05100 RECOVERY 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 ANESTHESI OLOGY	0. 000000	0		0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	0		0	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0	0	55. 00
56.00	05600 RADI OI SOTOPE	0. 000000	0		0 0	0	56. 00
57.00	05700 CT SCAN	0. 000000	0		0 0	0	57. 00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000	0		0 0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0 0	0	59. 00
60.00	06000 LABORATORY	0. 000653	0		0	0	60.00
64.00	06400 I NTRAVENOUS THERAPY	0. 000000	0		0	0	64.00

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65. 00 06500 RESPIRATORY THERAPY

06600 PHYSI CAL THERAPY

06800 SPEECH PATHOLOGY

06900 ELECTROCARDI OLOGY

07400 RENAL DIALYSIS

03950 ENDOSCOPY

09000 CLI NI C

91. 00 09100 EMERGENCY

03951 CLINICAL NUTRITION

06700 OCCUPATI ONAL THERAPY

06901 CARDIAC REHABILITION

07000 ELECTROENCEPHALOGRAPHY

07100 MEDICAL SUPPLIES CHARGED TO PATIENTS

07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS

07700 ALLOGENEIC HSCT ACQUISITION 07800 CAR T-CELL IMMUNOTHERAPY

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

Total (lines 50 through 199)

OUTPATIENT SERVICE COST CENTERS

66.00

66. 01

67.00

68.00

69.00

69. 01

70.00

72.00

73.00

74.00

77.00

78.00

Health Financial Systems SSM APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA		MARITAN HOSPIT		Peri od:	eu of Form CMS-2 Worksheet D	2552-10
ATTOMICE OF THE ATTOMIC CONTROL OF THE ATTOMIC	2 00010		CCN: 14-T046	From 01/01/2023 To 12/31/2023	Part II	pared:
		Ti tl	e XIX	Subprovi der -	5/21/2024 10: PPS	06 am
Cost Center Description	Capi tal	Total Charges	Dotin of Con	I RF t I npati ent	Capital Costs	
cost center bescription		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,	Part I, col.			column 4)	
	Part II, col.	8)	2)	. Charges	COLUMN 4)	
	26)	0)	2)			
	1.00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
50. 00 05000 OPERATING ROOM	1, 669, 855	98, 806, 118	0. 01690	00 0	0	50.00
51. 00 05100 RECOVERY ROOM	29, 811				Ö	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	436, 238				0	
53. 00 05300 ANESTHESI OLOGY	88, 565				0	
54. 00 05400 RADI OLOGY - DI AGNOSTI C	791, 591				0	
55. 00 05500 RADI OLOGY-THERAPEUTI C	155, 287				0	
56. 00 05600 RADI 0I SOTOPE	18, 235				0	
57. 00 05700 CT SCAN	229, 304				0	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	215, 946		l .		0	1
59. 00 05900 CARDIAC CATHETERIZATION	329, 349				Ö	
60. 00 06000 LABORATORY	410, 571	85, 135, 298				
64. 00 06400 I NTRAVENOUS THERAPY	48, 809					
65. 00 06500 RESPIRATORY THERAPY	241, 931		•	-	Ö	1
66. 00 06600 PHYSI CAL THERAPY	139, 336				Ö	
66. 01 03951 CLI NI CAL NUTRI TI ON	2, 767				0	
67. 00 06700 OCCUPATI ONAL THERAPY	117, 661	1			Ö	
68. 00 06800 SPEECH PATHOLOGY	27, 966				o o	
69. 00 06900 ELECTROCARDI OLOGY	891, 064				Ö	
69. 01 06901 CARDI AC REHABILITION	12, 086				Ö	
70. 00 07000 ELECTROENCEPHALOGRAPHY	41, 415				o o	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	69, 404				0	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	30, 408					1
73. 00 07300 DRUGS CHARGED TO PATIENTS	120, 813				0	
74. 00 07400 RENAL DIALYSIS	6, 589				Ö	
76. 00 03950 ENDOSCOPY	0,007	2,211,000			0	
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0	ĺ			Ö	
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0	١	0. 00000		0	1
OUTPATIENT SERVICE COST CENTERS			0.0000	,0		70.00
90. 00 09000 CLINIC	1, 416, 970	14, 028, 556	0. 10100	06 0	0	90. 00
91. 00 09100 EMERGENCY	582, 600					1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0					
		646, 229, 287		- 1	, -	, 50

Heal th Financial Systems	SSM HEALTH GOOD SA				eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILL THROUGH COSTS	ARY SERVICE UTHER PAS	S Provider C	CN: 14-0046	Peri od: From 01/01/2023	Worksheet D Part IV	
THROUGH COSTS		Component	CCN: 14-T046	To 12/31/2023	Date/Time Pre	
		-			5/21/2024 10:	06 am
		liti	e XIX	Subprovi der - I RF	PPS	
Cost Center Description	Non Physician	Nursi ng	Nursi ng		Allied Health	
	Anesthetist	Program	Program	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
	1.00	2A	2. 00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS		_			_	4
50. 00 05000 OPERATING ROOM	C	1	1	0 0	0	
51. 00 05100 RECOVERY ROOM	C	0	2	0 0	ή	
52. 00 05200 DELIVERY ROOM & LABOR ROOM			2	0	0	
53. 00 05300 ANESTHESI OLOGY			2	0	0	
54. 00 05400 RADI OLOGY - DI AGNOSTI C			2	0	0	
55. 00 05500 RADI OLOGY-THERAPEUTI C			2	0	0	
56. 00 05600 RADI 01 SOTOPE			(0	0	
57. 00 05700 CT SCAN			(0	0	
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)			(0	
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY			(Ί	
64. 00 06400 I NTRAVENOUS THERAPY			(55, 605 0	
65. 00 06500 RESPI RATORY THERAPY						
66. 00 06600 PHYSI CAL THERAPY			()			66.00
66. 01 03951 CLI NI CAL NUTRI TI ON						
67. 00 06700 OCCUPATIONAL THERAPY						1
68. 00 06800 SPEECH PATHOLOGY						
69. 00 06900 ELECTROCARDI OLOGY						
69. 01 06901 CARDI AC REHABI LI TI ON						
70. 00 07000 ELECTROENCEPHALOGRAPHY						1
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATI	FNTS C					
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	2.113			0 0		
73. 00 07300 DRUGS CHARGED TO PATIENTS				o o	ol ö	
74. 00 07400 RENAL DI ALYSI S				ol o	ol o	1
76. 00 03950 ENDOSCOPY				0 0	ol o	1
77. 00 07700 ALLOGENEIC HSCT ACQUISITION		o		ol o	ا ا	77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY		o		0 0	o	78. 00
OUTDATIENT SERVICE COST CENTERS	•			•		

0 0 0

0

0 91.00

55, 605 200. 00

0

0 0 0

90.00

92. 00 0

90.00

91.00

200.00

09000 CLI NI C

09100 EMERGENCY

07700 ALLOGENEIC HSCT ACQUISITION 07800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

Total (lines 50 through 199)

	FIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE SH COSTS	RVICE OTHER PASS			Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Pre 5/21/2024 10:	pared: 06 am
			Ti tl	e XIX	Subprovi der – I RF	PPS	
	Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
		4. 00	5. 00	6.00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0		0 98, 806, 118	0.000000	50.00
51. 00	05100 RECOVERY ROOM	0	0		0 14, 188, 587	0.000000	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 21, 855, 255	0.000000	
53. 00	05300 ANESTHESI OLOGY	0	0		0 32, 315, 437	0. 000000	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 23, 913, 952	0. 000000	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 4, 411, 017	0. 000000	
56. 00	05600 RADI OI SOTOPE	0	0		0 11, 377, 558	0. 000000	
57. 00	05700 CT SCAN	0	0		0 79, 805, 150	0. 000000	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0 13, 770, 222	0. 000000	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 46, 454, 822	0. 000000	
60. 00	06000 LABORATORY	0	55, 605			0. 000653	
64. 00	06400 I NTRAVENOUS THERAPY	0	0		0 1, 046, 106	0. 000000	
65. 00	06500 RESPI RATORY THERAPY	0	0		0 14, 331, 789	0. 000000	
66. 00	06600 PHYSI CAL THERAPY	0	0		0 8, 267, 833	0. 000000	
66. 01	03951 CLINICAL NUTRITION	0	0		0 23, 661	0. 000000	
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		0 3, 714, 448	0. 000000	
68. 00	06800 SPEECH PATHOLOGY	0	0		0 2, 100, 940	0. 000000	
69. 00	06900 ELECTROCARDI OLOGY	0	0		0 26, 377, 877	0. 000000	
69. 01	06901 CARDI AC REHABI LI TI ON	0	0		0 777, 975		
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 224, 900	0.000000	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 14, 582, 309	0.000000	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 9, 824, 333	0.000000	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 67, 139, 055	0.000000	
74.00	07400 RENAL DIALYSIS	0	0		0 2, 211, 858	0.000000	
76. 00	03950 ENDOSCOPY	0	0		0	0.000000	
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0			0 0	0.000000	
78. 00		0	0		0 0	0. 000000	78. 00
90. 00	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC	0	0		0 14, 028, 556	0. 000000	90.00
90.00	09100 EMERGENCY	0			0 47, 911, 477		
91.00		0			0 47, 911, 477		
フノ・いし	U72UU UD3LKVAIIUN DED3 (NUN-DI3IINUI PAKI)	1 0	ı U	1	0 1,032,734	0.000000	7∠. UU

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	HEALTH GOOD SAM VICE OTHER PASS		CN: 14-0046	Period: From 01/01/2023	u of Form CMS-2 Worksheet D Part IV	2552 10
THROUGH COSTS		Component		To 12/31/2023	Date/Time Pre 5/21/2024 10:	pared: 06 am
		Ti tl	e XIX	Subprovider - IRF	PPS	
Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.		Costs (col. 8	3	Costs (col. 9	
	7)		x col . 10)		x col . 12)	
	9. 00	10. 00	11. 00	12. 00	13. 00	
ANCILLARY SERVICE COST CENTERS	0.00000		,	ما ما		
50. 00 05000 OPERATING ROOM	0. 000000	C		0	0	
51. 00 05100 RECOVERY ROOM	0. 000000	C	1	0 0	0	
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0. 000000	C	1	0 0	0	02.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	C	1	0 0	0	
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0. 000000	C	1	0 0	0	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	C	1	0 0	0	
56. 00 05600 RADI OI SOTOPE	0. 000000	C	1	0 0	0	
57. 00 05700 CT SCAN 58. 00 05800 MAGNETIC RESONANCE MAGING (MRI)	0. 000000 0. 000000	C	1	0 0	ū	57.00
		C	1		0	
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	0. 000000 0. 000653	C		0 0	0	
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000	C		0 0	0	
65. 00 06500 RESPIRATORY THERAPY	0. 000000	C	1	0 0	0	
66. 00 06600 PHYSI CAL THERAPY	0. 000000	C	1	0 0	0	
66. 01 03951 CLI NI CAL NUTRI TI ON	0. 000000	C		0 0	0	
67. 00 06700 OCCUPATIONAL THERAPY	0. 000000	C		0 0	0	
68. 00 06800 SPEECH PATHOLOGY	0. 000000	C		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	C		0 0	0	
69. 01 06901 CARDI AC REHABI LI TI ON	0. 000000			0 0	0	1
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	C	1	0 0	0	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	C	1	0 0	0	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	Ċ		o o	0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	C	1	o o	0	
74. 00 07400 RENAL DIALYSIS	0. 000000	Ċ		o o	0	1
76. 00 03950 ENDOSCOPY	0. 000000	C		o o	0	
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	C		o o	0	
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	C		o o	0	1
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0. 000000	C		0 0	0	90.00
91. 00 09100 EMERGENCY	0. 000000	C		0 0	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	C	ol	0 0	0	

Health Financial Systems	SSM HEALTH GOOD SAMARITAN HOS	PLTAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der	CCN: 14-0046	Peri od: From 01/01/2023	Worksheet D-1
				Date/Time Prepared: 5/21/2024 10:06 am
	Ti	tle XVIII	Hospi tal	PPS

			10 12/01/2020	5/21/2024 10:	06 am
		Title XVIII	Hospi tal	PPS	
	Cost Center Description				
				1. 00	
	PART I - ALL PROVIDER COMPONENTS				
	I NPATI ENT DAYS		-		
1.00	Inpatient days (including private room days and swing-bed days			26, 220	1. 00
2.00	Inpatient days (including private room days, excluding swing-b			26, 220	2. 00
3.00	Private room days (excluding swing-bed and observation bed day	/s). If you have only pr	ivate room days,	0	3. 00
4 00	do not complete this line.			05 000	4 00
4.00	Semi-private room days (excluding swing-bed and observation be			25, 208	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room	om days) through Decembe	r 31 of the cost	01	5. 00
	reporting period		04 6 11		, 00
6.00	Total swing-bed SNF type inpatient days (including private room	om days) after December	31 of the cost	0	6. 00
7 00	reporting period (if calendar year, enter 0 on this line)	daya) through December	21 of the cost	0	7 00
7. 00	Total swing-bed NF type inpatient days (including private room reporting period	r days) till odgir becelliber	31 OF THE COST	J 0 1	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room	days) after December 2	1 of the cost	0	8. 00
8.00	reporting period (if calendar year, enter 0 on this line)	days) at tel becember 3	i oi the cost	J 0 1	0.00
9. 00	Total inpatient days including private room days applicable to	the Program (eveluding	swing had and	11, 378	9. 00
7.00	newborn days) (see instructions)	the frogram (excruding	Swifig-bed and	11, 370	7. 00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII or	alv (including private r	nom days)	o	10. 00
10.00	through December 31 of the cost reporting period (see instruct		Join days)	١	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		nom davs) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, er		dayo, areo.	1	
12.00	Swing-bed NF type inpatient days applicable to titles V or XI)		e room days)	0	12. 00
	through December 31 of the cost reporting period	3 (3)			
13.00	Swing-bed NF type inpatient days applicable to titles V or XI)	only (including private	e room days)	0	13.00
	after December 31 of the cost reporting period (if calendar ye				
14.00	Medically necessary private room days applicable to the Progra			0	14.00
15.00	Total nursery days (title V or XIX only)		,	0	15. 00
16.00	Nursery days (title V or XIX only)			0	16. 00
	SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0.00	17. 00
	reporting period				
18.00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18.00
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0.00	19.00
	reporting period				
20. 00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	he cost	0. 00	20. 00
	reporting period				
21. 00	Total general inpatient routine service cost (see instructions			40, 135, 402	
22. 00	Swing-bed cost applicable to SNF type services through December	er 31 of the cost report	ing period (line	0	22. 00
22.00	5 x line 17)	21 -6 +6++		,	22.00
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	g period (iine o	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December	21 of the cost reporti	ng ported (line	0	24. 00
24.00	7 x line 19)	31 of the cost reporti	ng perrou (Trile	J 0 1	24.00
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	neriod (line 8	0	25. 00
20.00	x line 20)	or or the cost reporting	perrou (rriie o	١	20.00
26. 00	Total swing-bed cost (see instructions)			o	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		40, 135, 402	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0	28. 00
29.00	Private room charges (excluding swing-bed charges)		J ,	0	
30.00	Semi -pri vate room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 -	- line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33.00
34.00	Average per diem private room charge differential (line 32 mir	nus line 33)(see instruc	tions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x lin		•	0.00	
36.00	Private room cost differential adjustment (line 3 x line 35)	•		0	36. 00
37.00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	40, 135, 402	37.00
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 530. 72	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line	38)		17, 416, 532	39. 00
40.00	Medically necessary private room cost applicable to the Progra	•		0	40. 00
41.00	Total Program general inpatient routine service cost (line 39	+ line 40)		17, 416, 532	41. 00

MPUT	Financial Systems SSM ATION OF INPATIENT OPERATING COST	HEALTH GOOD SAN	Provi der CO		Peri od:	worksheet D-1	
					From 01/01/2023 To 12/31/2023		pare
			Title	XVIII	Hospi tal	PPS	00 0
	Cost Center Description	Total Inpatient Costl	Total npatient Days			Program Cost (col. 3 x col.	
		1.00	2.00	col . 2) 3.00	4.00	4) 5. 00	-
. 00	NURSERY (title V & XIX only)	0	0		_		42.
	Intensive Care Type Inpatient Hospital Units						
. 00	INTENSIVE CARE UNIT	6, 785, 914	2, 551	2, 660. 1	1, 069	2, 843, 647	1
. 00	CORONARY CARE UNIT						44. 45.
. 00 . 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						46.
	OTHER SPECIAL CARE (SPECIFY)						47
	Cost Center Description				<u> </u>		
						1. 00	1.0
. 00 . 01	Program inpatient ancillary service cost (Wk Program inpatient cellular therapy acquisiti			III lino 10	column 1)	21, 702, 945 0	1
. 00	Total Program inpatient costs (sum of lines				COLUMN 1)	41, 963, 124	
. 00	PASS THROUGH COST ADJUSTMENTS	+1 till oagil +0.0	1) (300 111311 40	ti ons)		11, 700, 124	177
. 00	Pass through costs applicable to Program inp	atient routine s	services (from	Wkst. D, sum	of Parts I and	1, 405, 276	50
	[111]						l
. 00	Pass through costs applicable to Program inp and IV)	atient ancillary	y services (fr	om Wkst. D, s	sum of Parts II	1, 356, 625	51
. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				2, 761, 901	52
. 00	Total Program inpatient operating cost exclu		ated, non-phy	sician anesth	etist, and	39, 201, 223	
	medical education costs (line 49 minus line						
	TARGET AMOUNT AND LIMIT COMPUTATION						١.
	Program di scharges					0	
. 00 . 01	Target amount per discharge Permanent adjustment amount per discharge					0. 00 0. 00	
. 01	Adjustment amount per discharge (contractor	use only)				0.00	
. 00	Target amount (line 54 x sum of lines 55, 55					0.00	1
. 00	Difference between adjusted inpatient operat	ing cost and tar	get amount (I	ine 56 minus	line 53)	0	57
. 00	Bonus payment (see instructions)					0	
. 00	Trended costs (lesser of line 53 ÷ line 54,		the cost repo	rting period	endi ng 1996,	0.00	59
. 00	updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54,		n nrior vear c	ost renort i	indated by the	0.00	60
. 00	market basket)	01 11110 33 1101	ii piroi year e	ost report, t	ipaatea by the	0.00	
. 00	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	ser of 50% of th	ne amount by w	hich operatir	g costs (İine	0	61
. 00	enter zero. (see instructions) Relief payment (see instructions)					0	62
	Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)			Ö	
	PROGRAM INPATIENT ROUTINE SWING BED COST						
. 00	Medicare swing-bed SNF inpatient routine cos	ts through Decer	mber 31 of the	cost reporti	ng period (See	0	64
. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	to after Decembe	or 21 of the c	act rapartina	norial (Soc	0	65
. 00	instructions)(title XVIII only)	ts after beceiling	er 31 or the C	ost reporting	perrou (see	0	00
. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line 6	64 plus line 6	5)(title XVII	I only); for	0	66
	CAH, see instructions						
. 00	Title V or XIX swing-bed NF inpatient routin	e costs through	December 31 o	f the cost re	porting period	0	67
. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	e costs after Na	ecember 31 of	the cost reno	rting period	0	68
. 50	(line 13 x line 20)	5 50515 di toi De		о созт герс	ig por rou		
. 00	Total title V or XIX swing-bed NF inpatient					0	69
	PART III - SKILLED NURSING FACILITY, OTHER N						ļ
. 00 . 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c	-		• •			70
. 00	Program routine service cost (line 9 x line		ne /o = IIIIè	<i>-)</i>			72
. 00	Medically necessary private room cost applic		(line 14 x li	ne 35)			73
. 00	Total Program general inpatient routine serv			•			74
. 00	Capital-related cost allocated to inpatient	routine service	costs (from W	orksheet B, F	art II, column		75
. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76
00	Program capital-related costs (line 9 x line						77
	Inpatient routine service cost (line 74 minu	•					78
. 00	Aggregate charges to beneficiaries for exces			•			79
	Total Program routine service costs for comp		ost limitation	(line 78 mir	us line 79)		80
. 00 . 00	Inpatient routine service cost per diem limi						81
. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (82
. 00	Program inpatient ancillary services (see in		-,				84
. 00	Utilization review - physician compensation		ns)				85
. 00	Total Program inpatient operating costs (sum	of lines 83 th					86
00	PART IV - COMPUTATION OF OBSERVATION BED PAS					4 040	ļ
	Total observation bed days (see instructions)				1, 012	87
. 00 . 00	Adjusted general inpatient routine cost per	diem (line 27 ·	line 2)			1, 530. 72	90

Health Financial Systems SSM	HEALTH GOOD SA	MARITAN HOSPITA	AL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 01/01/2023 To 12/31/2023	Date/Time Pre 5/21/2024 10:0	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	2, 594, 051	40, 135, 402	0. 06463	1, 549, 089	100, 121	90.00
91.00 Nursing Program cost	0	40, 135, 402	0. 000000	1, 549, 089	0	91.00
92.00 Allied health cost	0	40, 135, 402	0. 000000	1, 549, 089	0	92.00
93.00 All other Medical Education	0	40, 135, 402	0. 000000	1, 549, 089	0	93. 00

Health Financial Systems	SSM HEALTH GOOD SAMAR	RITAN HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0046	Peri od: From 01/01/2023	Worksheet D-1
		Component CCN: 14-T046	To 12/31/2023	Date/Time Prepared: 5/21/2024 10:06 am
		Title XVIII	Subprovi der -	PPS

		II the Aviii	I RF	FF3	
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			2, 360	
2.00	Inpatient days (including private room days, excluding swing-berivate room days (excluding swing-bed and observation bed day			2, 360	
3.00	do not complete this line.	75). IT you have only pri	vate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		2, 360	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo	om days) through December	31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private roo	om days) after December 3	21 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	om days) arter becember e	or or the cost	Ö	0.00
7.00	Total swing-bed NF type inpatient days (including private room	n days) through December	31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private room	n davs) after December 31	of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	days) arter becember 31	of the cost	O	0.00
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	1, 236	9. 00
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII or	alv. (i poludi pa pri voto ro	om days)	0	10. 00
10.00	through December 31 of the cost reporting period (see instructions)		Joili days)	U	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private ro	oom days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, er Swing-bed NF type inpatient days applicable to titles V or XI)		room days)	0	12. 00
12.00	through December 31 of the cost reporting period	t only (frictually private	e room days)	U	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XI)			0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar ye	•	, i	0	14. 00
15. 00	Medically necessary private room days applicable to the Progra Total nursery days (title V or XIX only)	dii (excluding swing-bed c	lays)	0	15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
47.00	SWING BED ADJUSTMENT		2.11	0.00	47.00
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 of	tne cost	0.00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of t	he cost	0.00	18. 00
19. 00	reporting period	through December 21 of	the cost	0.00	19. 00
19.00	Medicaid rate for swing-bed NF services applicable to services reporting period	s through becember 31 or	the cost	0.00	19.00
20. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of th	ne cost	0. 00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions	:)		5, 207, 513	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		ng period (line	0, 207, 010	22. 00
	5 x line 17)	04 6 11			
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reportir	ng period (line	0	24. 00
25 00	7 x line 19))1 -6 thtt!		0	25 00
25. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)	or the cost reporting	period (line 8	0	25. 00
26. 00	Total swing-bed cost (see instructions)			0	
27. 00	General inpatient routine service cost net of swing-bed cost (PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		5, 207, 513	27. 00
28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed cha	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)		3 ,	0	
30.00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 =	lino 20)		0. 000000	30.00
31. 00 32. 00	Average private room per diem charge (line 29 ÷ line 3)	- ITTIE 26)		0.00000	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34.00	Average per diem private room charge differential (line 32 mir	, ,	i ons)	0.00	
35. 00 36. 00	Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35)	ne 31)		0.00	35. 00 36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost dif	ferential (line	5, 207, 513	
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			2, 206. 57	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line	38)		2, 727, 321	39. 00
40.00	Medically necessary private room cost applicable to the Program	•		0	40.00
41. 00	Total Program general inpatient routine service cost (line 39	+ 11116 40)	I	2, 727, 321	41.00

111-4-	Figure 1 Contains	IFALTIL COOR CA	MADI TAN HOCDI TA		1 1:-	£ F CNC	2552 40
	Financial Systems SSM I ATION OF INPATIENT OPERATING COST	HEALTH GOOD SA	Provider CCI		Period: From 01/01/2023	u of Form CMS-: Worksheet D-1	
			Component Co	CN: 14-T046	To 12/31/2023	Date/Time Pre 5/21/2024 10:	
			Title	XVIII	Subprovi der - I RF	PPS	
	Cost Center Description	Total npati ent Cost	Total Inpatient Days D	Average Per iem (col. 1 col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3. 00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0. (00 0	0	42.00
43.00	INTENSIVE CARE UNIT	0	0	0.0	00 0	0	
	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 00 45. 00
	SURGICAL INTENSIVE CARE UNIT						46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1. 00	
	Program inpatient ancillary service cost (Wks					777, 377	
	Program inpatient cellular therapy acquisitio				column 1)	0	
49. 00	Total Program inpatient costs (sum of lines 4 PASS THROUGH COST ADJUSTMENTS	I through 48.0	I)(see Instruct	i ons)		3, 504, 698	49. 00
50.00	Pass through costs applicable to Program inpa	tient routine	services (from	Wkst. D, sun	of Parts I and	209, 972	50.00
51. 00	III) Pass through costs applicable to Program inpa	tient anciller	v sarvicas (foo	m Wks+ D -	um of Darte II	44, 902	51.00
o 1. UU	and IV)	nent anciliar	y services (Tro	m wkst. D, S	oun OF PALES II	44, 902	31.00
52. 00	Total Program excludable cost (sum of lines 5					254, 874	
53. 00	Total Program inpatient operating cost exclud medical education costs (line 49 minus line 5		lated, non-phys	ician anesth	etist, and	3, 249, 824	53. 00
	TARGET AMOUNT AND LIMIT COMPUTATION	2)					1
	Program di scharges					0	
	Target amount per discharge Permanent adjustment amount per discharge					0. 00 0. 00	
	Adjustment amount per discharge (contractor u	se only)				0.00	
	Target amount (line 54 x sum of lines 55, 55.				50)	0	
57. 00 58. 00	Difference between adjusted inpatient operati Bonus payment (see instructions)	ng cost and ta	rget amount (II	ne 56 minus	line 53)	0	
59. 00	Trended costs (lesser of line 53 ÷ line 54, o	r line 55 from	the cost repor	ting period	endi ng 1996,	0. 00	
60. 00	updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54,	or line 55 fro	m prior year co	st report, ι	pdated by the	0. 00	60.00
61. 00	market basket) Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise					0	61. 00
62. 00	enter zero. (see instructions) Relief payment (see instructions)					0	62. 00
	Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST	nt (see instru	ctions)			0	
64. 00	Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only)	s through Dece	mber 31 of the	cost reporti	ng period (See	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine cost instructions) (title XVIII only)	s after Decemb	er 31 of the co	st reportino	period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routing	e costs (line	64 plus line 65)(title XVII	I only); for	0	66. 00
67. 00	CAH, see instructions Title V or XIX swing-bed NF inpatient routine	costs through	December 31 of	the cost re	porting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)	costs after D	ecember 31 of t	he cost repo	orting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient r PART III – SKILLED NURSING FACILITY, OTHER NU					0	69. 00
	Skilled nursing facility/other nursing facili	ty/ICF/IID rou	tine service co	st (line 37)			70. 00
	Adjusted general inpatient routine service co		ine 70 ÷ line 2)			71.00
	Program routine service cost (line 9 x line 7 Medically necessary private room cost applica	•	(line 14 x lin	e 35)			72.00
74. 00	Total Program general inpatient routine servi	ce costs (line	72 + line 73)	ŕ			74. 00
75. 00	Capital-related cost allocated to inpatient related		costs (from Wo	rksheet B, F	art II, column		75. 00
	Per diem capital-related costs (line 75 ÷ lin Program capital-related costs (line 9 x line						76. 00 77. 00
78. 00	Inpatient routine service cost (line 74 minus	line 77)					78. 00
	Aggregate charges to beneficiaries for excess Total Program routine service costs for compa			* .	us lina 70\		79. 00 80. 00
	Inpatient routine service costs for compa		SSC Trim tati Off	(. 1 110 / 0 IIII I	11110 17)		81.00
82.00	Inpatient routine service cost limitation (li		•				82.00
83. 00 84. 00	Reasonable inpatient routine service costs (see ins		S)				83.00
	Utilization review - physician compensation (ns)				85. 00
86. 00	Total Program inpatient operating costs (sum	of lines 83 th					86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions)	THROUGH COST				0	87. 00
67.00	(22 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2						

Health Financial Systems SS	M HEALTH GOOD SA	MARITAN HOSPITA	AL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
		Component (CCN: 14-T046	From 01/01/2023 To 12/31/2023	Date/Time Pre 5/21/2024 10:	pared: 06 am
		Title	XVIII	Subprovi der - I RF	PPS	
Cost Center Description						
					1.00	
89.00 Observation bed cost (line 87 x line 88) (s	ee instructions)				0	89. 00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	400, 910	5, 207, 513	0. 07698	7 0	0	90. 00
91.00 Nursing Program cost	0	5, 207, 513	0.00000	0 0	0	91.00
92.00 Allied health cost	0	5, 207, 513	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	5, 207, 513	0. 00000	0 0	0	93. 00

Health Financial Systems	SSM HEALTH GOOD SAMARITAN HOSPITAL	In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 14-004	From 01/01/2023	Worksheet D-1 Date/Time Prep5/21/2024 10:0	
	Title XIX	Hospi tal	PPS	
Cost Center Description				

Cost Center Description Title XIX Hospital	PPS	
DADT I ALL DROWDER COMPONENTS		
DART I ALL DROWLDED COMPONENTS	1. 00	
PART I - ALL PROVIDER COMPONENTS		
I NPATI ENT DAYS		
1.00 Inpatient days (including private room days and swing-bed days, excluding newborn)	26, 220	1.00
2.00 Inpatient days (including private room days, excluding swing-bed and newborn days)	26, 220	2.00
3.00 Private room days (excluding swing-bed and observation bed days). If you have only private room days,	0	3.00
do not complete this line.		
4.00 Semi-private room days (excluding swing-bed and observation bed days)	25, 208	4.00
5.00 Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	0	5.00
reporting period		
6.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6.00
reporting period (if calendar year, enter 0 on this line)		
7.00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
reporting period		
8.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
reporting period (if calendar year, enter 0 on this line)		
9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and	306	9. 00
newborn days) (see instructions)		
10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10. 00
through December 31 of the cost reporting period (see instructions)	_	
11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11. 00
December 31 of the cost reporting period (if calendar year, enter 0 on this line)		40.00
12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12. 00
through December 31 of the cost reporting period		40.00
13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13. 00
after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		44.00
14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00 Total nursery days (title V or XIX only)	2, 093	
16.00 Nursery days (title V or XIX only)	1, 551	16. 00
SWING BED ADJUSTMENT		
17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0.00	17. 00
reporting period		40.00
18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0.00	18. 00
reporting period		40.00
19.00 Medicald rate for swing-bed NF services applicable to services through December 31 of the cost	0.00	19. 00
reporting period	0.00	20.00
20.00 Medical d rate for swing-bed NF services applicable to services after December 31 of the cost	0. 00	20. 00
reporting period	40 125 402	21 00
21.00 Total general inpatient routine service cost (see instructions)	40, 135, 402	
22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22. 00
23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23. 00
x line 18)	۷	23.00
24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24. 00
7 x line 19)	۷	24.00
25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
x line 20)	٥	25.00
26.00 Total swing-bed cost (see instructions)	0	26. 00
27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	40, 135, 402	27. 00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	10, 100, 102	27.00
28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
29. 00 Pri vate room charges (excluding swing-bed charges)	Ö	29. 00
30. 00 Semi -pri vate room charges (excluding swing-bed charges)	ő	30.00
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	
32.00 Average private room per diem charge (line 29 ÷ line 3)	0.00	32. 00
33. 00 Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	
34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	
35. 00 Average per diem private room cost differential (line 34 x line 31)	0.00	35. 00
36. 00 Private room cost differential adjustment (line 3 x line 35)	0.00	36. 00
37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line	40, 135, 402	37. 00
27 minus line 36)	70, 130, 402	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY		
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00 Adjusted general inpatient routine service cost per diem (see instructions)	1, 530. 72	38. 00
39. 00 Program general inpatient routine service cost (line 9 x line 38)	468, 400	39. 00
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	408, 400	40. 00
41.00 Total Program general inpatient routine service cost (line 39 + line 40)	468, 400	
so protein and general impatront routine service cost (The SV Filling 40)	130, 400	11.00

)MPU I	ATION OF INPATIENT OPERATING COST		Provi der Co	CN: 14-0046	Peri od:	Worksheet D-1	
					From 01/01/2023 To 12/31/2023		
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
		1.00	2. 00	3.00	4. 00	5. 00	
. 00	NURSERY (title V & XIX only)	2, 308, 707	2, 093	1, 103.		1, 710, 846	42.
00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	/ 70E 014	2 551	2 ((0	10 37	00.424	1 42
00	CORONARY CARE UNIT	6, 785, 914	2, 551	2, 660.	37	98, 424	43. 44.
00	BURN INTENSIVE CARE UNIT						45.
00	SURGICAL INTENSIVE CARE UNIT						46.
00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.
	cost center bescription					1.00	
00	Program inpatient ancillary service cost (Wks					0	
01	3				, column 1)	0	
00	Total Program inpatient costs (sum of lines 4 PASS THROUGH COST ADJUSTMENTS	41 through 48.0	i)(see instruc	tions)		2, 277, 670	49.
00	Pass through costs applicable to Program inpa	atient routine	services (from	Wkst. D, su	m of Parts I and	102, 674	50.
00	Dass through costs applicable to Drogram input	ationt and	v condess (C	om Wka+ D	cum of Dont- !!		E4
00	Pass through costs applicable to Program inpa and IV)	atrent ancillar	y services (fr	Om WKST. D,	Sum OF Parts II	0	51
00	Total Program excludable cost (sum of lines !					102, 674	
00	Total Program inpatient operating cost exclude	9 1	lated, non-phy	sician anest	hetist, and	2, 174, 996	53
	medical education costs (line 49 minus line 5 TARGET AMOUNT AND LIMIT COMPUTATION	52)					
00	Program di scharges					0	54
00	, 3					0.00	
01 02	Permanent adjustment amount per discharge Adjustment amount per discharge (contractor u	ise only)				0.00	
00	Target amount (line 54 x sum of lines 55, 55.					0.00	
00	Difference between adjusted inpatient operati	ng cost and ta	rget amount (I	ine 56 minus	line 53)	0	
00	Bonus payment (see instructions) Trended costs (lesser of line 53 ÷ line 54, o	or lino 55 from	the cost rope	rting ported	andina 1006	0.00	
	updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54,		•	0 .	3	0.00	
	market basket)			•	,		
00	Continuous improvement bonus payment (if line 55.01, or line 59, or line 60, enter the less 53) are less than expected costs (lines 54 x	ser of 50% of t	he amount by w	hich operati	ng costs (İine	0	61
	enter zero. (see instructions)		Ü			_	
00	Relief payment (see instructions) Allowable Inpatient cost plus incentive payme	ent (see instru	ctions)			0 0	
00	PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see mistru	etrons)				03
00	Medicare swing-bed SNF inpatient routine cost	ts through Dece	mber 31 of the	cost report	ing period (See	0	64
00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cost	ts after Decemb	er 31 of the c	ost reportin	g period (See	0	65
00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routing</pre>	ne costs (line	64 plus line 6	5)(title XVI	II only); for	0	66
00	CAH, see instructions Title V or XIX swing-bed NF inpatient routing	e costs through	December 31 o	f the cost r	eporting period	0	67
00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	e costs after D	ecember 31 of	the cost rep	orting period	0	68
00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NU					0	69
00	Skilled nursing facility/other nursing facili		•)		70
00	Adjusted general inpatient routine service co	ost per diem (I					71
00	Program routine service cost (line 9 x line 3 Medically necessary private room cost applications)		(line 14 v li	ne 35)			72 73
00	Total Program general inpatient routine servi		•	00)			74
00	Capital -related cost allocated to inpatient	routine service	costs (from W	orksheet B,	Part II, column		75
00	26, line 45) Per diem capital-related costs (line 75 ÷ lin	ne 2)					76
00	Program capital -related costs (line 9 x line	,					77
00	Inpatient routine service cost (line 74 minus		rovi don r '	c)			78
00	Aggregate charges to beneficiaries for excess Total Program routine service costs for compa			· .	nus line 79)		79 80
00	Inpatient routine service cost per diem limit			,o 70 mil	. = ,		81
00	Inpatient routine service cost limitation (li		•				82
00	Reasonable inpatient routine service costs (see inspream inpatient ancillary services (see inspream inpatient)		5)				83
00			ns)				85
00			rough 85)				86
00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions)					1, 012	0.7
(1()	LIOTAL ODSELVATION DEG GAVS (SEE INSTITUTIONS					1 1117	1 8/

Health Financial Systems SSM	HEALTH GOOD SA	MARITAN HOSPITA	AL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2023 To 12/31/2023	Date/Time Pre 5/21/2024 10:0	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	2, 594, 051	40, 135, 402	0. 064632	1, 549, 089	100, 121	90.00
91.00 Nursing Program cost	0	40, 135, 402	0.000000	1, 549, 089	0	91.00
92.00 Allied health cost	0	40, 135, 402	0. 000000	1, 549, 089	0	92.00
93.00 All other Medical Education	0	40, 135, 402	0. 000000	1, 549, 089	0	93. 00

Health Financial Systems	SSM HEALTH GOOD SAMARITAN HOSPITAL	In Lie	eu of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 14-00	Peri od: From 01/01/2023	Worksheet D-1
	Component CCN: 14-To	146 To 12/31/2023	Date/Ti me Prepared: 5/21/2024 10:06 am
	Title XIX	Subprovider -	PPS

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22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 Feneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 Feneral inpatient routine service charges (excluding swing-bed and observation bed charges) 28.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Average private room per diem charge (line 29 + line 3) 30.00 Average semi-private room per diem charge (line 29 + line 3) 30.00 Average per diem private room per diem charge (line 30 + line 4) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 Private room cost differential adjustment (line 3 x line 35) 30.00 Private room cost differential adjustment (line 3 x line 35) 30.00 Private room cost differential adjustment (line 3 x line 35) 30.00 Average per general inpatient routine service cost per diem (see instructions) 30.00 Program general inpatient routine service cost per diem (see instructions) 30.00 Average general inpatient routine service cost per diem (see instructions) 30.00 Average general inpatient routine service cost per diem (see instructions) 30.00 Average general inpatient routine service cost per diem (see instructions) 30.00 Average general inpatient routine service cost per diem (see instructions) 30.00 Average per diem private room cost applicable to the Program (line 14 x line 35) 30.00 Average per diem private room cost diem per volument of the cost		reporting period				
5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Average private room per diem charge (line 29 + line 3) 30.00 Average semi-private room per diem charge (line 30 + line 34) 40.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 Private room cost differential adjustment (line 3 x line 35) 30.00 Proprivate room cost differential adjustment (line 3 x line 35) 30.00 Proprivate room cost differential species of the swing-bed cost and private room cost differential (line 5, 207, 513) 31.00 General inpatient routine service cost per diem (see instructions) 32.00 Average per diem private room cost differential (line 3 x line 35) 33.00 Average per diem private room cost differential (line 3 x line 35) 34.00 Average per diem private room cost differential (line 3 x line 35) 35.00 Average per diem private room cost differential (line 3 x line 35) 36.00 Average per diem private room cost differential (line 3 x line 35) 37.00 General inpatient routine service cost per diem (see instructions) 48.50 Adjusted general inpatient routine service cost per diem (see instructions) 48.50 Adjusted general inpatient routine service cost per diem (see instructions)				ing popied (Line		1
23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 Private room DIFFERENTIAL ADJUSTMENT 28.00 Private room charges (excluding swing-bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room per diem charge (line 29 + line 3) 30.00 Vaerage private room per diem charge (line 29 + line 3) 30.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 30.00 Vaerage per diem private room cost differential (line 32 minus line 33) 30.00 Vaerage per diem private room cost differential (line 32 minus line 33) 30.00 Vaerage per diem private room cost differential (line 32 minus line 33) 30.00 Vaerage per diem private room cost differential (line 32 minus line 33) 30.00 Vaerage per diem private room cost differential (line 32 minus line 33) 30.00 Vaerage per diem private room cost differential (line 32 minus line 33) 30.00 Vaerage per diem private room cost differential (line 32 minus line 35) 30.00 Vaerage per diem private room cost differential (line 32 minus line 35) 30.00 Vaerage per diem private room cost differential (line 32 minus line 35) 30.00 Vaerage per diem private room cost differential (line 32 minus line 35) 30.00 Vaerage per diem private room cost differential (line 32 minus line 35) 30.00 Vaerage per diem private room cost differential (line 32 minus line 35) 30.00 Vaerage semi-private room cost differential (line 32 minus line 35) 30.00 Vaerage per diem private room cost differential (line 32 minus line 35) 30.00 Vaerage semi-private room cost differential (line 32 minu	22.00		er 31 of the cost reporti	ing period (iine	ا ا	22.00
24. 00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26. 00 Total swing-bed cost (see instructions) 27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28. 00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29. 00 Private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 31. 00 General inpatient routine service cost/charge ratio (line 27 ± line 28) 32. 00 Average private room per diem charge (line 29 ± line 3) 33. 00 Average semi-private room charge differential (line 30 ± line 4) 35. 00 Average per diem private room cost differential (line 30 ± line 31) 36. 00 Average per diem private room cost differential (line 34 x line 31) 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3 x line 35) 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3 x line 35) 37. 00 Average per diem private room cost differential (line 3 x line 35) 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 5, 207, 513) 38. 00 Adjusted general inpatient routine service cost per diem (see instructions) 38. 00 Adjusted general inpatient routine service cost per diem (see instructions) 48. 545 39. 00 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	g period (line 6	o ¹	23. 00
7 x line 19) 25. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26. 00 Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 9. 00 Private room charges (excluding swing-bed charges) 9. 00 9.	24.00		- 24	(1:		24.00
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26. 00 Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 7. 27. 00 Seneral inpatient routine service charges (excluding swing-bed and observation bed charges) 8. 00 Private room charges (excluding swing-bed charges) 9. 00 Semi-private room charges (excluding swing-bed charges) 10 Seneral inpatient routine service cost/charge ratio (line 27 ÷ line 28) 11 Observation of the complete of the comple	25. 00		31 of the cost reporting	period (line 8	0	25. 00
27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 5, 207, 513 PRI VATE ROOM DIFFERENTIAL ADJUSTMENT 28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 0 28. 00 Private room charges (excluding swing-bed charges) 0 29. 00 30. 00 Semi-private room charges (excluding swing-bed charges) 0 30. 00 31. 00 General inpatient routine service cost/charge ratio (line 27 + line 28) 0.000000 31. 00 32. 00 Average private room per diem charge (line 29 + line 3) 0.0 0. 32. 00 33. 00 Average per diem private room charge differential (line 30 + line 4) 0.0 0. 33. 00 34. 00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 0.0 0. 34. 00 35. 00 Average per diem private room cost differential (line 34 x line 31) 0.0 0.0 35. 00 36. 00 Private room cost differential adjustment (line 3 x line 35) 0 36. 00 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 5, 207, 513) 37. 00 27 minus line 36) PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38. 00 Adjusted general inpatient routine service cost (line 9 x line 38) 2, 206. 57 38. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 48, 545 39. 00 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	27.00					24 00
PRI VATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Pri vate room charges (excluding swing-bed charges) 30.00 Semi-pri vate room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 32.00 Average pri vate room per diem charge (line 29 + line 3) 33.00 Average semi-pri vate room per diem charge (line 30 + line 4) 34.00 Average per diem pri vate room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem pri vate room cost differential (line 34 x line 31) 36.00 Pri vate room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 5, 207, 513) 37.00 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 48, 545 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 28.00 29.00 29.00 29.00 29.00 30.00 30.00 30.00 30.00 30.00 30.00 31.00 31.00 29.00 31.00 29.00 31.00 32.0			Tine 21 minus line 26)			
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30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 32.00 Average semi-private room per diem charge (line 30 + line 4) 32.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 32.00 Average per diem private room cost differential (line 34 x line 31) 33.00 Average per diem private room cost differential (line 34 x line 31) 34.00 Average per diem private room cost differential (line 3 x line 35) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 5, 207, 513) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 48,545 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)			and observation bed cha	arges)		
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35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 5, 207, 513 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 48,545 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00						1
36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 48,545 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)			, ,	tions)		1
37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38. 00 Adjusted general inpatient routine service cost per diem (see instructions) 2, 206. 57 38. 00 Program general inpatient routine service cost (line 9 x line 38) 48, 545 39. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40. 00		, ,	le 31)			1
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 2, 206. 57 38.00 Program general inpatient routine service cost (line 9 x line 38) 48, 545 49.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00			and private room cost di	fferential (line		1
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 48,545 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		27 minus line 36)	·	·		
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 2,206.57 38.00 Program general inpatient routine service cost (line 9 x line 38) 48,545 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00			ISTMENTS			
39.00 Program general inpatient routine service cost (line 9 x line 38) 48,545 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	38. 00				2. 206. 57	38. 00
41.00 lotal Program general inpatient routine service cost (line 39 + line 40) 48,545 41.00						40.00
	41.00	liotal Program general inpatient routine service cost (line 39	+ IIne 40)	l	48, 545	41.00

PUT	ATION OF INPATIENT OPERATING COST		Provi der C	CCN: 14-0046	Peri od: From 01/01/2023	Worksheet D-1	
			Component	CCN: 14-T046	To 12/31/2023	Date/Time Pre 5/21/2024 10:	
			Ti tl	le XIX	Subprovi der -	PPS	uo aiii
	Cost Center Description	Total	Total	Average Per	IRF Program Days	Program Cost	
	le de la companya de la companya de la companya de la companya de la companya de la companya de la companya de		Inpatient Days	Diem (col. 1		(col. 3 x col.	
		1.00	2.00	3.00	4. 00	4) 5. 00	
00	NURSERY (title V & XIX only)	0	(0. (00 0		42. 0
00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	0		0.0	00 0	0	43.0
	CORONARY CARE UNIT						44.0
	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. C
	OTHER SPECIAL CARE (SPECIFY)						47. 0
	Cost Center Description					1. 00	
00	Program inpatient ancillary service cost (Wks	st. D-3, col. 3	3, line 200)			0	48. 0
	Program inpatient cellular therapy acquisition	•			, column 1)	0	
00	Total Program inpatient costs (sum of lines a PASS THROUGH COST ADJUSTMENTS	41 through 48.0	OI)(see Instruc	ctions)		48, 545	49.0
00	Pass through costs applicable to Program inpa	atient routine	services (from	n Wkst. D, sur	m of Parts I and	3, 737	50.0
00	III) Pass through costs applicable to Program inpa	atient ancillar	rv services (fi	rom Wkst D	sum of Parts II	0	51. 0
	and IV)		y scrvices (II	om with D _i 3	Jam Of Falts II	_	
00	Total Program excludable cost (sum of lines !	,	alatad - '	vol al · · · · ·	hotiot	3, 737	
00	Total Program inpatient operating cost exclude medical education costs (line 49 minus line !		erated, non-phy	ısıcıan anesti	netist, and	44, 808	53. (
00	TARGET AMOUNT AND LIMIT COMPUTATION	•					
	Program discharges Target amount per discharge					0 0. 00	
	Permanent adjustment amount per discharge					0.00	
	Adjustment amount per discharge (contractor					0.00	
	Target amount (line 54 x sum of lines 55, 55. Difference between adjusted inpatient operations)			line 56 minus	Line 53)	0	1
00	Bonus payment (see instructions)	o .			ŕ	0	58.
00	Trended costs (lesser of line 53 ÷ line 54, of updated and compounded by the market basket)	or line 55 from	m the cost repo	orting period	endi ng 1996,	0. 00	59.
00	Expected costs (lesser of line 53 ÷ line 54, market basket)	or line 55 fro	om prior year o	cost report, (updated by the	0.00	60.
00	Continuous improvement bonus payment (if line 55.01 , or line 59 , or line 60 , enter the less 53) are less than expected costs (lines 54 x	ser of 50% of t	the amount by w	which operatio	ng costs (line	0	61.
00	enter zero. (see instructions) Relief payment (see instructions)					0	62.
00	Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	uctions)			0	1 .
	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of the	e cost reporti	ing period (See	0	64.
00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decemb	per 31 of the d	cost reportino	g period (See	0	65.
00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routio	ne costs (line	64 plus line 6	55)(title XVII	II only); for	0	66.
00	CAH, see instructions Title V or XIX swing-bed NF inpatient routing	e costs through	n December 31 d	of the cost re	eporting period	0	67.
00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine	e costs after [December 31 of	the cost repo	orting period	0	68.
00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NU					0	69.
	Skilled nursing facility/other nursing facili)		70.
00	Adjusted general inpatient routine service co Program routine service cost (line 9 x line		ine 70 ÷ line	2)			71. 72.
	Medically necessary private room cost applications		m (line 14 x li	ne 35)			73.
00	Total Program general inpatient routine servi	•			Dart II aclima		74.
00	Capital-related cost allocated to inpatient a 26, line 45)		= COSIS (TEOM)	vorksneet B, F	raitii, COIUMN		75.
00 00	Per diem capital-related costs (line 75 ÷ line Program capital-related costs (line 9 x line	,					76. 77.
	Inpatient routine service cost (line 74 minus						78.
00	Aggregate charges to beneficiaries for excess			•	nuc line 70)		79.
	Total Program routine service costs for comparing the routine service cost per diem limit		JUST TIMITATION	i (iiile /8 MH	iius IIIIe /9)		80. 81.
00	Inpatient routine service cost limitation (li	ne 9 x line 81	•				82.
00	Reasonable inpatient routine service costs (ns)				83. 84.
	Program inpatient ancillary services (see insultilization review - physician compensation		ons)				85.
	Total Program inpatient operating costs (sum	of lines 83 th					86.
00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions)					0	87.
) diem (line 27 =	0)			0. 00	1 -

Health Financial Systems	SSM	HEALTH GOOD SA	MARITAN HOSPITA	AL	In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST			Provi der CC		Peri od:	Worksheet D-1	
			Component (CCN: 14-T046	From 01/01/2023 To 12/31/2023		pared: 06 am
			Ti tl	e XIX	Subprovi der - I RF	PPS	
Cost Center Description							
						1. 00	
89.00 Observation bed cost (line 87 x	ine 88) (se	e instructions)				0	89. 00
Cost Center Description		Cost	Routine Cost	column 1 ÷	Total	Observation	
			(from line 21)	column 2	Observati on	Bed Pass	
					Bed Cost (from	Through Cost	
					line 89)	(col. 3 x col.	
						4) (see	
						instructions)	
		1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PA	ASS THROUGH (COST					
90.00 Capital -related cost		400, 910	5, 207, 513	0. 07698	7 0	0	90. 00
91.00 Nursing Program cost		0	5, 207, 513	0.00000	0 0	0	91.00
92.00 Allied health cost		0	5, 207, 513	0. 00000	0 0	0	92.00
93.00 All other Medical Education		0	5, 207, 513	0. 00000	0 0	0	93. 00

Health Financial Systems	SSM HEALTH GOOD SAMAI	<u>RLIAN HOSPI</u>	IAL	In Lie	eu of Form CMS-:	<u> 2552-10</u>
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provi der	CCN: 14-0046	Peri od:	Worksheet D-3	
				From 01/01/2023		
				To 12/31/2023	Date/Time Pre	pared:
					5/21/2024 10:	06 am
		Ti tl	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.	
				Ŭ	2)	
			1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30 00 03000 ADULTS & PEDLATRICS				20 234 764		1 30 00

	COST Centre Description	T- Characa	D	D C+-	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00		2)	
	ANDATI SHT. DOUTLING OFFINI OF COOT OFFITEDO	1. 00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS		00 004 7/4		
	03000 ADULTS & PEDI ATRI CS		20, 234, 764		30. 00
	03100 I NTENSI VE CARE UNI T		2, 816, 815		31. 00
	04100 SUBPROVI DER - I RF		0		41. 00
	04300 NURSERY				43. 00
	ANCI LLARY SERVI CE COST CENTERS			T	
	05000 OPERATING ROOM	0. 120799	22, 455, 554		
	05100 RECOVERY ROOM	0. 133161	2, 146, 321	285, 806	
	05200 DELIVERY ROOM & LABOR ROOM	0. 327798	15, 642		52. 00
	05300 ANESTHESI OLOGY	0. 029592	3, 462, 665		53.00
	05400 RADI OLOGY-DI AGNOSTI C	0. 226835	3, 242, 553	735, 525	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 676343	420	284	55. 00
56. 00	05600 RADI OI SOTOPE	0. 090727	850, 094	77, 126	56. 00
57. 00	05700 CT SCAN	0. 025042	11, 617, 631	290, 929	57.00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 069751	1, 406, 404	98, 098	58. 00
	05900 CARDI AC CATHETERI ZATI ON	0. 070302	0	0	59. 00
60. 00	06000 LABORATORY	0. 089279	15, 509, 252	1, 384, 651	60.00
64. 00	06400 INTRAVENOUS THERAPY	0. 535433	0	0	64.00
65. 00	06500 RESPI RATORY THERAPY	0. 281805	5, 003, 181	1, 409, 921	65. 00
	06600 PHYSI CAL THERAPY	0. 302353	2, 137, 262	646, 208	66. 00
	03951 CLINICAL NUTRITION	12. 357001	0	0	66. 01
	06700 OCCUPATI ONAL THERAPY	0. 353367	1, 111, 018	392, 597	67. 00
	06800 SPEECH PATHOLOGY	0. 323564	409, 523		68. 00
	06900 ELECTROCARDI OLOGY	0. 267353	11, 712, 856		69. 00
	06901 CARDIAC REHABILITION	0. 398136	0	0	69. 01
	07000 ELECTROENCEPHALOGRAPHY	0. 809435	91, 000	73, 659	70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 898078	4, 519, 267		
	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 572170	2, 599, 919		
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 249100	11, 118, 638	2, 769, 653	73. 00
	07400 RENAL DIALYSIS	0. 565350	1, 233, 487	697, 352	74. 00
	03950 ENDOSCOPY	0.000000	0	0	76. 00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0.000000	0	l 0	77. 00
	07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS				
	09000 CLI NI C	0. 785468	1, 104	867	90.00
	09100 EMERGENCY	0. 167441	6, 464, 687		
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 948758	134, 269		
200.00	Total (sum of lines 50 through 94 and 96 through 98)		107, 242, 747		
201. 00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201. 00
202.00	Net charges (line 200 minus line 201)		107, 242, 747		202. 00
		'		1	

	Financial Systems SSM HEALTH G ENT ANCILLARY SERVICE COST APPORTIONMENT	GOOD SAMARITAN HOSPIT Provider C	CN: 14-0046	Peri od:	eu of Form CMS-2 Worksheet D-3	
			CCN: 14-T046	From 01/01/2023 To 12/31/2023	Date/Time Pre	
		Ti +1 c	e XVIII	Subprovi der -	5/21/2024 10: PPS	06 am
		11 11 6	e valli	I RF	PPS	
	Cost Center Description		Ratio of Cos To Charges	Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
	INDATIENT DOUTINE CEDVICE COCT CENTEDS		1.00	2. 00	3. 00	
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS		I		I	30.
31. 00	03100 I NTENSI VE CARE UNI T					31.
41. 00	04100 SUBPROVI DER – I RF			1, 862, 652		41.
	04300 NURSERY			1, 002, 032		43.
3.00	ANCI LLARY SERVI CE COST CENTERS				l .	75.
0.00	05000 OPERATI NG ROOM		0. 1207	99 2, 247	271	50.
1. 00	05100 RECOVERY ROOM		0. 1331	·	0	
2. 00	05200 DELIVERY ROOM & LABOR ROOM		0. 3277		0	
3. 00	05300 ANESTHESI OLOGY		0. 02959		0	1
4. 00	05400 RADI OLOGY-DI AGNOSTI C		0. 22683	35 22, 912	5, 197	54.
5. 00	05500 RADI OLOGY-THERAPEUTI C		0. 6763	43 0	0	55.
6. 00	05600 RADI 0I SOTOPE		0. 09072	27 7, 188	652	56.
7. 00	05700 CT SCAN		0. 0250	42 37, 052	928	57.
8. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)		0. 0697		0	58.
9. 00	05900 CARDI AC CATHETERI ZATI ON		0. 07030		0	59.
0.00	06000 LABORATORY		0. 0892	79 256, 381	22, 889	60.
4. 00	06400 I NTRAVENOUS THERAPY		0. 5354		0	64.
5. 00	06500 RESPI RATORY THERAPY		0. 28180		54, 957	
6. 00	06600 PHYSI CAL THERAPY		0. 3023!		210, 619	
6. 01	03951 CLI NI CAL NUTRI TI ON		12. 35700		0	
7. 00	06700 OCCUPATI ONAL THERAPY		0. 3533	·	247, 598	
8. 00	06800 SPEECH PATHOLOGY		0. 3235		83, 486	
9. 00	06900 ELECTROCARDI OLOGY		0. 2673		3, 533	
9. 01	06901 CARDI AC REHABI LI TI ON		0. 3981		0	
0.00	07000 ELECTROENCEPHALOGRAPHY		0. 8094		0	
1.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 8980		74, 078	
2.00	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 5721		1, 947	
3.00	07300 DRUGS CHARGED TO PATIENTS		0. 24910		48, 698	
4.00	07400 RENAL DI ALYSI S		0. 5653!		13, 620	
6.00	03950 ENDOSCOPY		0.00000		0	
7.00	07700 ALLOGENEIC HSCT ACQUISITION		0.00000		0	
8. 00	07800 CAR T-CELL IMMUNOTHERAPY		0.0000	00	0	78.
00	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC		0.7054	68 0	0	90.
	09100 EMERGENCY		0. 7854 0. 1674		8, 904	
	09200 DRSERVATION REDS (NON-DISTINCT PART)		0. 1674			

92.00 | 09200 | SERVATION BEDS (NON-DISTINCT PART)
200.00 | Total (sum of lines 50 through 94 and 96 through 98)
201.00 | Less PBP Clinic Laboratory Services-Program only charges (line 61)
202.00 | Net charges (line 200 minus line 201)

0. 948758

92.00

0 777, 377 200. 00 201. 00 202.00

	Title XVIII Hospital	5/21/2024 10: PPS	Jo alli
		1. 00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS	1	4 00
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurring prior to October 1 (see	19, 799, 316	1. 00 1. 01
1. 02	Instructions) DRG amounts other than outlier payments for discharges occurring on or after October 1 (see	6, 724, 949	1. 02
1.03	instructions) DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October	0	1. 03
1. 04	1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after	0	1. 04
2.00	October 1 (see instructions) Outlier payments for discharges. (see instructions)		2. 00
2. 01 2. 02	Outlier reconciliation amount Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2. 01 2. 02
2. 02	Outlier payments for discharges occurring prior to October 1 (see instructions)	281, 916	2. 02
2. 04	Outlier payments for discharges occurring on or after October 1 (see instructions)	58, 564	2. 04
3.00	Managed Care Simulated Payments	0	3. 00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	108. 23	4. 00
Г 00	Indirect Medical Education Adjustment		г оо
5. 00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending or before 12/31/1996. (see instructions)	0.00	5. 00
5. 01	FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions)	0.00	5. 01
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for	0.00	6. 00
()(new programs in accordance with 42 CFR 413.79(e)	0.00	/ 2/
6. 26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)	0.00	6. 26
7. 00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7. 00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the	0.00	7. 01
7.00	cost report straddles July 1, 2011 then see instructions.		7 00
7. 02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural	0.00	7. 02
	track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)		
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for	0.00	8. 00
	affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12,		
0.01	1998), and 67 FR 50069 (August 1, 2002).	0.00	0.01
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. 01
8. 02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital	0.00	8. 02
	under § 5506 of ACA. (see instructions)		
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. 21
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	0.00	9. 00
7. 00	minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)		7. 00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	
12. 00 13. 00	Current year allowable FTE (see instructions) Total allowable FTE count for the prior year.	0.00	12. 00 13. 00
14. 00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997,		
	otherwise enter zero.		
15. 00			15. 00
	Adjustment for residents in initial years of the program (see instructions)		16.00
17. 00 18. 00	Adjustment for residents displaced by program or hospital closure Adjusted rolling average FTE count	1	17. 00 18. 00
	Current year resident to bed ratio (line 18 divided by line 4).	0. 000000	
20.00	Prior year resident to bed ratio (see instructions)	0. 000000	20. 00
21. 00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	
22. 00 22. 01	IME payment adjustment (see instructions) IME payment adjustment - Managed Care (see instructions)	0 0	22. 00 22. 01
22.01	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA	0	22.01
23. 00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105	0.00	23. 00
	(f)(1)(iv)(C).		
24. 00	IME FTE Resident Count Over Cap (see instructions)	0.00	
25. 00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see	0.00	25. 00
26. 00	instructions) Resident to bed ratio (divide line 25 by line 4)	0. 000000	26. 00
27. 00	IME payments adjustment factor. (see instructions)	0. 000000	
	IME add-on adjustment amount (see instructions)	0	28. 00
28. 01	IME add-on adjustment amount - Managed Care (see instructions)	0	28. 01
29. 00 29. 01	Total LME payment (sum of lines 22 and 28)	0	29. 00 29. 01
∠7. U1	Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment	0	∠7. ∪1
30. 00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	5. 10	30. 00
31. 00	Percentage of Medicaid patient days (see instructions)	22. 81	31. 00
32. 00		27. 91	
33. 00 34. 00	Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions)	12. 24 811, 643	
	15. op. opor a share and adjustment (see that detroils)	1 011,043	J 7. 00

Heal th	Financial Systems SSM HEALTH GOOD SAMA	DITAN HAZDITAI	Inlie	u of Form CMS-2	2552_10
	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 14-0046	Peri od: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Pre 5/21/2024 10:	pared:
		Title XVIII	Hospi tal	PPS	
			Prior to 10/1		
			1. 00	2. 00	
	Uncompensated Care Payment Adjustment				
35. 00	Total uncompensated care amount (see instructions)			5, 938, 006, 757	35. 00
35. 01	Factor 3 (see instructions)		0. 000152934	0. 000151862	35. 01
35. 02	Hospital UCP, including supplemental UCP (see instructions)		1, 051, 327	901, 757	35. 02
35. 03	Pro rata share of the hospital UCP, including supplemental UC	P (see instructions)	786, 335	226, 671	
36.00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)		1, 013, 006		36. 00
	Additional payment for high percentage of ESRD beneficiary di	scharges (lines 40 throu	*		
40. 00	Total Medicare discharges (see instructions)		0		40. 00
41. 00	Total ESRD Medicare discharges (see instructions)		0		41.00
41. 01	Total ESRD Medicare covered and paid discharges (see instruct		0		41. 01
42.00	Divide line 41 by line 40 (if less than 10%, you do not quali	fy for adjustment)	0.00		42. 00
43.00	Total Medicare ESRD inpatient days (see instructions)		0		43. 00
44. 00	Ratio of average length of stay to one week (line 43 divided	by line 41 divided by 7	0. 000000		44. 00
45.00	days)	`	0.00		45 00
45. 00	Average weekly cost for dialysis treatments (see instructions		0.00		45. 00
46. 00	Total additional payment (line 45 times line 44 times line 41	.01)	00 (00 004		46.00
47. 00	Subtotal (see instructions)		28, 689, 394		47. 00
48. 00	Hospital specific payments (to be completed by SCH and MDH, s	maii rurai nospitais	0		48. 00
	only. (see instructions)			Amount	
				1. 00	
49. 00	Total payment for inpatient operating costs (see instructions)		28, 689, 394	49. 00
50. 00	Payment for inpatient program capital (from Wkst. L, Pt. I an			2, 057, 927	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, li			0	52.00
53. 00	Nursing and Allied Health Managed Care payment	,		0	53.00
54. 00	Special add-on payments for new technologies			30, 601	
54. 01	Islet isolation add-on payment			0	54. 01
55. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6	9)		0	55. 00
55. 01	Cellular therapy acquisition cost (see instructions)	-,		0	55. 01
56. 00	Cost of physicians' services in a teaching hospital (see intr	uctions)		0	56.00
57. 00	Routine service other pass through costs (from Wkst. D, Pt. I		nrough 35).	0	57.00
58. 00	Ancillary service other pass through costs from Wkst. D, Pt.		3,	10, 128	
59. 00	Total (sum of amounts on lines 49 through 58)	, ,		30, 788, 050	59.00
60.00	Primary payer payments			2, 883	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus	line 60)		30, 785, 167	61.00
62. 00	Deductibles billed to program beneficiaries	,		3, 064, 456	
63.00	Coinsurance billed to program beneficiaries			118, 734	
64.00	Allowable bad debts (see instructions)			783, 440	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			509, 236	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		707, 280	
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	,		28, 111, 213	
68. 00	Credits received from manufacturers for replaced devices for	applicable to MS-DRGs (se	ee instructions)	0	68. 00
69. 00	Outlier payments reconciliation (sum of lines 93, 95 and 96).	(For SCH see instructions	s)	0	69. 00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70. 00

70.50

70. 75

70.87

70. 88

70.89

70.90

70. 91

70. 92

70. 93

70.94

0 70.95

-16, 425

-47, 368

70.50 Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)

N95 respirator payment adjustment amount (see instructions)

SCH or MDH volume decrease adjustment (contractor use only)

HSP bonus payment HVBP adjustment amount (see instructions)

HSP bonus payment HRR adjustment amount (see instructions)
Bundled Model 1 discount amount (see instructions)

70.93 | HVBP payment adjustment amount (see instructions)

HRR adjustment amount (see instructions)

70.95 Recovery of accelerated depreciation

 ${\tt Demonstration}\ \ {\tt payment}\ \ {\tt adjustment}\ \ {\tt amount}\ \ {\tt before}\ \ {\tt sequestration}$

Pioneer ACO demonstration payment adjustment amount (see instructions)

70. 88 70. 89

ONLOUL	ATION OF REIMBURSEMENT SETTLEMENT Provide	er CCN: 1		Peri od: From 01/01/2023 To 12/31/2023	Date/Time Prep 5/21/2024 10:0	pared:
		itle XV		Hospi tal	PPS Amount	
			FFT	(yyyy) 0	1. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column	0		0	1.00	70. 96
70. 70	the corresponding federal year for the period prior to 10/1)	٠		O	١	70.70
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column	0		0	0	70. 97
	the corresponding federal year for the period ending on or after 10/1)					
70. 98	Low Volume Payment-3			0	0	70. 98
70. 99	HAC adjustment amount (see instructions)				0	70. 99
71. 00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)				28, 047, 420	71. 00
71. 01	Sequestration adjustment (see instructions)				560, 948	71. 01
71. 02	Demonstration payment adjustment amount after sequestration				0	71. 02
71. 03	Sequestration adjustment-PARHM pass-throughs					71. 03
72. 00	Interim payments				27, 501, 379	1
72. 01	Interim payments-PARHM					72. 01
73.00	Tentative settlement (for contractor use only)				0	73.00
73. 01	Tentative settlement-PARHM (for contractor use only)				14 007	73. 01
74. 00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 72)	na			-14, 907	74. 00
74. 01	73) Balance due provider/program-PARHM (see instructions)					74. 01
75. 00	Protested amounts (nonallowable cost report items) in accordance with				935, 474	•
73.00	CMS Pub. 15-2, chapter 1, §115.2				755, 474	73.00
	TO BE COMPLETED BY CONTRACTOR (Lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03				0	90.00
	plus 2.04 (see instructions)					
91.00	Capital outlier from Wkst. L, Pt. I, line 2				0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)				0	92. 00
93.00	Capital outlier reconciliation adjustment amount (see instructions)				0	93. 00
94.00	The rate used to calculate the time value of money (see instructions)				0.00	94. 00
95.00	Time value of money for operating expenses (see instructions)				0	95. 00
96.00	Time value of money for capital related expenses (see instructions)				0	96. 00
					On/After 10/1	
	LICE B. D. L.A. L.			1. 00	2. 00	
100.00	HSP Bonus Payment Amount					100 00
100.00	HSP bonus amount (see instructions)			0	0	100. 00
101 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions)			0. 000000000	0. 0000000000	101 00
	HVBP adjustment amount for HSP bonus payment (see instructions)			0.000000000		101.00
102.00	HRR Adjustment for HSP Bonus Payment				U	102.00
103 00	HRR adjustment factor (see instructions)			0.0000		
					0 00001	103 00
	HRR adjustment amount for HSP bonus payment (see instructions)			0.0000		
	HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (\$410A Demonstration)	Adi ustme	ent	0.0000		103. 00 104. 00
200.00	Rural Community Hospital Demonstration Project (§410A Demonstration) A			0.0000	0	104. 00
200. 00	Rural Community Hospital Demonstration Project (§410A Demonstration) A Is this the first year of the current 5-year demonstration period unde			0.0000	0	
200. 00	Rural Community Hospital Demonstration Project (§410A Demonstration) A			0.0000	0	104. 00
201. 00	Rural Community Hospital Demonstration Project (§410A Demonstration) A Is this the first year of the current 5-year demonstration period undo Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			0.000	0	104. 00
201. 00 202. 00	Rural Community Hospital Demonstration Project (§410A Demonstration) A Is this the first year of the current 5-year demonstration period undo Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions)			0.0000	0	104. 00 200. 00 201. 00 202. 00
201. 00 202. 00	Rural Community Hospital Demonstration Project (§410A Demonstration) A Is this the first year of the current 5-year demonstration period undo Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions)	er the 2	21st	0	0	104. 00 200. 00 201. 00
201. 00 202. 00	Rural Community Hospital Demonstration Project (§410A Demonstration) A Is this the first year of the current 5-year demonstration period under Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year)	er the 2	21st	0	0	104. 00 200. 00 201. 00 202. 00
201. 00 202. 00 203. 00	Rural Community Hospital Demonstration Project (§410A Demonstration) A Is this the first year of the current 5-year demonstration period under Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first yeaperiod)	er the 2	21st	0	0 tration	200. 00 201. 00 202. 00 203. 00
201. 00 202. 00 203. 00 204. 00	Rural Community Hospital Demonstration Project (§410A Demonstration) A Is this the first year of the current 5-year demonstration period under Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first yeaperiod) Medicare target amount	er the 2	21st	0	tration	200. 00 201. 00 202. 00 203. 00 204. 00
201. 00 202. 00 203. 00 204. 00 205. 00	Rural Community Hospital Demonstration Project (§410A Demonstration) A Is this the first year of the current 5-year demonstration period under Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first yesperiod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204)	er the 2	21st	0	tration	200. 00 201. 00 202. 00 203. 00 204. 00 205. 00
201. 00 202. 00 203. 00 204. 00 205. 00	Rural Community Hospital Demonstration Project (§410A Demonstration) A Is this the first year of the current 5-year demonstration period under Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year) period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205)	er the 2	21st	0	tration	200. 00 201. 00 202. 00 203. 00 204. 00
201. 00 202. 00 203. 00 204. 00 205. 00 206. 00	Rural Community Hospital Demonstration Project (§410A Demonstration) A Is this the first year of the current 5-year demonstration period under Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first yeaperiod) 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	er the 2	21st	0	tration	201. 00 202. 00 203. 00 204. 00 205. 00 206. 00
201. 00 202. 00 203. 00 204. 00 205. 00 206. 00	Rural Community Hospital Demonstration Project (§410A Demonstration) A Is this the first year of the current 5-year demonstration period under Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first years) 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 instructions)	ear of t	21st	0	tration	201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00
201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00	Rural Community Hospital Demonstration Project (§410A Demonstration) A Is this the first year of the current 5-year demonstration period under Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year) 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 instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)	ear of t	21st	0	tration	201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00
201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00	Rural Community Hospital Demonstration Project (§410A Demonstration) A Is this the first year of the current 5-year demonstration period under Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year) 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 instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) Adjustment to Medicare IPPS payments (see instructions)	ear of t	21st	0	tration	201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00
201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00	Rural Community Hospital Demonstration Project (§410A Demonstration) A Is this the first year of the current 5-year demonstration period under Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year) 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 instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) Adjustment to Medicare IPPS payments (see instructions) Reserved for future use	ear of t	21st	0	tration	104. 00 200. 00 201. 00 202. 00 203. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00
201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00	Rural Community Hospital Demonstration Project (§410A Demonstration) A Is this the first year of the current 5-year demonstration period under Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year) 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 instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) Adjustment to Medicare IPPS payments (see instructions)	ear of t	21st	0	tration	201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00
201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00	Rural Community Hospital Demonstration Project (§410A Demonstration) A Is this the first year of the current 5-year demonstration period undo Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year) 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 instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions)	ear of t	21st	0	tration	104. 00 200. 00 201. 00 202. 00 203. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00
201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00	Rural Community Hospital Demonstration Project (§410A Demonstration) A Is this the first year of the current 5-year demonstration period under Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year) 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 instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) 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	ear of t	21st	0	tration	201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00
201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00 212. 00 213. 00	Rural Community Hospital Demonstration Project (§410A Demonstration) A Is this the first year of the current 5-year demonstration period undo Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year) Demonstration Target Amount Limitation (N/A in first year) 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 instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) 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 Total adjustment to Medicare Part A IPPS payments (from line 211)	ear of t	the currer	0	tration	201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00 212. 00
201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 210. 00 211. 00 212. 00 213. 00	Rural Community Hospital Demonstration Project (§410A Demonstration) A Is this the first year of the current 5-year demonstration period undo Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first years) 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 instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare Part A IPPS payments (from line 211) Low-volume adjustment (see instructions)	ear of t	the currer	0	tration	201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00 212. 00 213. 00

Health Financial Systems

SSM HEALTH GOOD SAMARITAN HOSPITAL

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0046

Period:
From 01/01/2023
To 12/31/2023

Part A Exhibit 4
Date/Time Prepared:
5/21/2024 10: 06 am

Provider CCN: 14-0046

Period From CMS-2552-10

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/21/2024 10: 06 am

Pre/Post Period Prior Period Total (Col 2)

Line F. Part A)
Fortitlement to 10/01 On/After 10/01 through 4)

				Title	XVIII	Hospi tal	5/21/2024 10:0 PPS	Jo alli
		W/S F. Part A	Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement		On/After 10/01	through 4)	
		0	1.00	2.00	3.00	4. 00	5. 00	
1.00	DRG amounts other than outlier	1. 00	0	0	0	0	0	1. 00
	payments							
1. 01	DRG amounts other than outlier	1. 01	19, 799, 316	0	19, 799, 316		19, 799, 316	1. 01
	payments for discharges							
1 02	occurring prior to October 1	1 02	4 724 040	0		4 724 040	4 724 040	1 02
1. 02	DRG amounts other than outlier	1. 02	6, 724, 949	0		6, 724, 949	6, 724, 949	1. 02
	payments for discharges occurring on or after October							
	1							
1. 03	DRG for Federal specific	1. 03	0	0	0		0	1. 03
1.00	operating payment for Model 4	1.00	Ğ	o o	Ĭ		Ŭ	1.00
	BPCI occurring prior to							
	October 1							
1.04	DRG for Federal specific	1. 04	o	0		0	0	1. 04
	operating payment for Model 4							
	BPCI occurring on or after							
	October 1							
2.00	Outlier payments for	2. 00						2. 00
0.04	discharges (see instructions)	0.00						0.01
2. 01	Outlier payments for	2. 02	0	0	0	0	0	2. 01
2 02	discharges for Model 4 BPCI	2.02	201 01/	0	201 014		201 014	2 02
2. 02	Outlier payments for discharges occurring prior to	2. 03	281, 916	U	281, 916		281, 916	2. 02
	October 1 (see instructions)							
2. 03	Outlier payments for	2. 04	58, 564	0		58, 564	58, 564	2. 03
2.00	discharges occurring on or	2.01	30, 30 1	Ü		00,001	55, 551	2.00
	after October 1 (see							
	instructions)							
3.00	Operating outlier	2. 01	o	0	0	0	0	3.00
	reconciliation							
4.00	Managed care simulated	3. 00	0	0	0	0	0	4. 00
	payments							
	Indirect Medical Education Adju							
5. 00	Amount from Worksheet E, Part	21. 00	0. 000000	0. 000000	0. 000000	0. 000000		5. 00
	A, line 21 (see instructions)	22.00	0	0	_	0	0	4 00
6. 00	IME payment adjustment (see instructions)	22.00	٥	U	٥	0	U	6. 00
6. 01	IME payment adjustment for	22. 01	0	0	_	0	0	6. 01
0.01	managed care (see	22.01	Ğ	O		0	J	0.01
	instructions)							
	Indirect Medical Education Adju	ustment for the	Add-on for Se	ction 422 of t	he MMA			
7.00	IME payment adjustment factor	27. 00	0. 000000	0. 000000	0. 000000	0. 000000		7. 00
	(see instructions)							
8.00	IME adjustment (see	28. 00	0	0	0	0	0	8. 00
	instructions)		_	_	_	_	_	
8. 01	IME payment adjustment add on	28. 01	0	0	0	0	0	8. 01
	for managed care (see instructions)							
9. 00	Total IME payment (sum of	29. 00	0	0	0	0	0	9. 00
7.00	lines 6 and 8)	29.00	U U	0	0	0	U	7.00
9. 01	Total IME payment for managed	29. 01	0	0	0	0	0	9. 01
,, , ,	care (sum of lines 6.01 and	27.0.	Š	· ·	Ĭ		Ü	,, ,,
	8. 01)							
	Disproportionate Share Adjustme	ent						
10.00	Allowable disproportionate	33.00	0. 1224	0. 1224	0. 1224	0. 1224		10. 00
	share percentage (see							
	instructions)							
11. 00	Di sproporti onate share	34.00	811, 643	0	605, 859	205, 784	811, 643	11. 00
11 01	adjustment (see instructions)	27, 00	1 012 007	0	70/ 225	22/ /71	1 012 007	11 01
11. 01	Uncompensated care payments	36.00	1, 013, 006	0	786, 335	226, 671	1, 013, 006	11.01
12. 00	Additional payment for high per Total ESRD additional payment	rcentage of ESE 46.00	beneficiary	<u>ai scnarges</u> 0	0	0	0	12. 00
12.00	(see instructions)	40.00	۷	U			ا	12.00
13. 00	Subtotal (see instructions)	47. 00	28, 689, 394	0	21, 473, 426	7, 215, 968	28, 689, 394	13. 00
14. 00	Hospital specific payments	48. 00	0	0	0	0	0	14. 00
	(completed by SCH and MDH,		ا	· ·			ا	. ==
	small rural hospitals only.)							
	(see instructions)							
15. 00	Total payment for inpatient	49. 00	28, 689, 394	0	21, 473, 426	7, 215, 968	28, 689, 394	15. 00
	operating costs (see							
	instructions)							
16. 00	Payment for inpatient program	50. 00	2, 057, 927	0	1, 530, 140	527, 787	2, 057, 927	16. 00
	capital (from Wkst. L, Pt. I,							
	if applicable)	I	ı l		I	I		l

Peri od:

From 01/01/2023 Part A Exhibit 4 12/31/2023 Date/Time Prepared: 5/21/2024 10:06 am Title XVIII Hospi tal W/S E, Part A Amounts (from Pre/Post Period Prior Total (Col 2 Peri od On/After 10/01 Part A) to 10/01 line Entitlement through 4) 4 00 0 1 00 2 00 3 00 5 00 17.00 Special add-on payments for 54.00 30, 601 30, 601 30,601 17.00 new technologies 17.01 Net organ aquisition cost 17.01 17.02 Credits received from 68.00 17.02 0 0 0 manufacturers for replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation 93.00 0 0 18.00 adjustment amount (see instructions) 19.00 SUBTOTAL 23, 034, 167 7, 743, 755 30, 777, 922 19.00 W/S L, line (Amounts from 0 1.00 2.00 3.00 4. 00 5. 00 Capital DRG other than outlier 20.00 1.00 2,009,385 1, 488, 807 520, 578 2,009,385 20.00 Model 4 BPCI Capital DRG other 20.01 1 01 20 01 than outlier 21.00 Capital DRG outlier payments 2.00 48, 542 41, 333 7, 209 48, 542 21.00 Model 4 BPCI Capital DRG 21.01 2.01 21.01 outlier payments Indirect medical education 22.00 5.00 0.0000 0.0000 0.0000 0.0000 22.00 percentage (see instructions) 23.00 Indirect medical education 6.00 0 23.00 adjustment (see instructions) 24.00 Allowable disproportionate 10.00 0.0000 0.0000 0.0000 0.0000 24.00 share percentage (see instructions) 25.00 Di sproporti onate share 11.00 0 0 25.00 0 adjustment (see instructions) 26.00 Total prospective capital 12.00 2,057,927 1, 530, 140 527, 787 2, 057, 927 26.00 payments (see instructions) W/S E, Part A (Amounts to E, line Part A) 5. 00 1.00 2.00 3.00 4.00 0 27.00 Low volume adjustment factor 0.000000 0.000000 27.00 28.00 Low volume adjustment 70.96 28.00 (transfer amount to Wkst. E, Pt. A. line) 29.00 Low volume adjustment 70.97 0 29.00 (transfer amount to Wkst. E, Pt. A, line) 100.00 Transfer low volume 100.00

adjustments to Wkst. E, Pt. A.

Provider CCN: 14-0046

Peri od:

From 01/01/2023

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Part A Exhibit 5

Date/Time Prepared: 12/31/2023 5/21/2024 10:06 am Hospi tal Title XVIII PPS Period to Total (cols. 2 Wkst. E, Pt. Amt. from Peri od on 10/01 A. line Wkst. E, Pt. after 10/01 and 3) A) 2.00 3. 00 0 4.00 1.00 1.00 DRG amounts other than outlier payments 1.00 1. 00 DRG amounts other than outlier payments for 19, 799, 316 19, 799, 316 1.01 1.01 19, 799, 316 1.01 discharges occurring prior to October 1 6, 724, 949 1.02 DRG amounts other than outlier payments for 1.02 6, 724, 949 6, 724, 949 1.02 discharges occurring on or after October 1 1.03 DRG for Federal specific operating payment 1.03 C 1.03 0 for Model 4 BPCI occurring prior to October DRG for Federal specific operating payment 1.04 1.04 0 1.04 for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for discharges (see 2.00 2.00 instructions) 2.01 Outlier payments for discharges for Model 4 2.02 2.01 **BPCI** 2 02 Outlier payments for discharges occurring 2 03 281, 916 281, 916 281, 916 2 02 prior to October 1 (see instructions) Outlier payments for discharges occurring on 2.03 2.04 58, 564 58, 564 58, 564 2.03 or after October 1 (see instructions) 3.00 Operating outlier reconciliation 2.01 0 3.00 Managed care simulated payments 4.00 3.00 0 4.00 Indirect Medical Education Adjustment 5.00 Amount from Worksheet E, Part A, line 21 21.00 0.000000 0.000000 0.000000 5.00 (see instructions) IME payment adjustment (see instructions) 6.00 22.00 0 0 0 6.00 IME payment adjustment for managed care (see 0 6.01 22.01 0 0 6.01 instructions) Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 7.00 IME payment adjustment factor (see 27. 00 0.000000 0.000000 0.000000 7.00 instructions) 8 00 IME adjustment (see instructions) 28 00 8 00 0 0 0 0 8.01 IME payment adjustment add on for managed 28.01 0 0 8.01 care (see instructions) Total IME payment (sum of lines 6 and 8) 29.00 9.00 C 0 9.00 Total IME payment for managed care (sum of 9.01 29.01 C 0 9.01 lines 6.01 and 8.01) Disproportionate Share Adjustment 10.00 Allowable disproportionate share percentage 33.00 0.1224 0.1224 0.1224 10.00 (see instructions) 11.00 Disproportionate share adjustment (see 34.00 811.643 605, 859 205. 784 811.643 11.00 instructions) 11.01 1.013.006 1, 013, 006 Uncompensated care payments 36, 00 786, 335 226, 671 11.01 Additional payment for high percentage of ESRD beneficiary discharges 12.00 Total ESRD additional payment (see 46. 00 12.00 instructions) 47.00 28, 689, 394 13 00 28, 689, 394 21, 473, 426 7, 215, 968 Subtotal (see instructions) 13 00 14.00 Hospital specific payments (completed by SCH 48.00 14.00 and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs 49.00 28, 689, 394 21, 473, 426 7, 215, 968 28, 689, 394 15.00 15.00 (see instructions) 2, 057, 927 16.00 Payment for inpatient program capital (from 50 00 1 530 140 527.787 2.057.927 16.00 Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for new technologies 54.00 30, 601 30, 601 30, 601 17.00 17.01 Net organ acquisition cost 17.01 Credits received from manufacturers for 68.00 0 17.02 17.02 0 replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment 93.00 18.00 0 amount (see instructions) 19.00 **SUBTOTAL** 23, 034, 167 7, 743, 755 30, 777, 922 19.00

Health Financial Systems SSM	HEALTH GOOD SA	MARITAN HOSPIT	AL	In Lie	u of Form CMS-2	2552-10
HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provider Co		Period: From 01/01/2023 To 12/31/2023		pared:
		Title	: 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	2, 009, 385	1, 488, 80	7 520, 578	2, 009, 385	20.00
20.01 Model 4 BPCI Capital DRG other than outlier	1. 01	0		0 0	0	20. 01
21.00 Capital DRG outlier payments	2. 00	48, 542	41, 33	7, 209	48, 542	21.00
21.01 Model 4 BPCI Capital DRG outlier payments	2. 01	0		0 0	0	21. 01
22.00 Indirect medical education percentage (see	5. 00	0.0000	0.000	0.0000		22. 00
instructions)						
23.00 Indirect medical education adjustment (see instructions)	6. 00	0		0 0	0	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	2, 057, 927	1, 530, 14	527, 787	2, 057, 927	26. 00
(This is deticated)	Wkst. E, Pt.	(Amt. from				
	A, line	Wkst. E, Pt.				
	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	-16, 425		0 -16, 425	-16, 425	30.00
30.01 HVBP payment adjustment for HSP bonus	70. 90	0		0 0	0	30. 01
payment (see instructions)						
31.00 HRR adjustment (see instructions)	70. 94	-47, 368	-21, 81	3 -25, 555	-47, 368	31.00
31.01 HRR adjustment for HSP bonus payment (see	70. 91	0		0 0	0	31. 01
instructions)					(Amt. to Wkst.	
					E, Pt. A)	
1	0	1. 00	2.00	3. 00	4. 00	
32.00 HAC Reduction Program adjustment (see instructions)	70. 99			0 0	0	32. 00
100.00 Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100. 00
•	•	:	:	,	•	

Health Financial Systems	SSM HEALTH GOOD SAMAF	RITAN HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0046	Peri od: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/21/2024 10:06 am
		T1 11 \000111		

	Ti ti	e XVIII	Hospi tal	5/21/2024 10: 0 PPS	06 am	
				1. 00		
	PART B - MEDICAL AND OTHER HEALTH SERVICES					
1.00	Medical and other services (see instructions)			7, 395	1.00	
2. 00 3. 00	Medical and other services reimbursed under OPPS (see instructions) OPPS or REH payments			18, 867, 235 18, 049, 571	2. 00 3. 00	
4. 00	Outlier payment (see instructions)			46, 404	4. 00	
4.01						
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0. 000	5. 00	
6. 00 7. 00	Line 2 times line 5 Sum of lines 3, 4, and 4.01, divided by line 6			0 0. 00	6. 00 7. 00	
8. 00	Transitional corridor payment (see instructions)			0.00	8. 00	
9. 00	Ancillary service other pass through costs including REH direct graduate	medical educa	ation costs from	4, 937	9. 00	
	Wkst. D, Pt. IV, col. 13, line 200					
10.00	Organ acquisitions			7 205	10.00	
11. 00	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES			7, 395	11. 00	
	Reasonable charges					
12.00	Ancillary service charges			29, 686		
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			0	13.00	
14. 00	Total reasonable charges (sum of lines 12 and 13) Customary charges			29, 686	14. 00	
15. 00	Aggregate amount actually collected from patients liable for payment for	services on	a charge basis	0	15. 00	
16. 00	Amounts that would have been realized from patients liable for payment f		9	0	16. 00	
	had such payment been made in accordance with 42 CFR §413.13(e)					
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	17. 00	
18. 00 19. 00	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete only if line	18 exceeds Lin	ne 11) (see	29, 686 22, 291	18. 00 19. 00	
.,. 00	instructions)	no encodas i i	, (555	22,271	. ,	
20. 00	Excess of reasonable cost over customary charges (complete only if line	11 exceeds li	ne 18) (see	0	20. 00	
21. 00	instructions) Lesser of cost or charges (see instructions)			7, 395	21. 00	
22. 00	Interns and residents (see instructions)			7, 343	22. 00	
23. 00	Cost of physicians' 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)			18, 100, 912	24. 00	
25. 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	25. 00	
26. 00	Deductibles and coinsurance amounts (for CAH, see instructions) Deductibles and Coinsurance amounts relating to amount on line 24 (for C	AH. see instr	uctions)	3, 251, 034	26. 00	
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the su			14, 857, 273		
00.00	instructions)				00.00	
28. 00 28. 50	Direct graduate medical education payments (from Wkst. E-4, line 50) REH facility payment amount (see instructions)			0	28. 00 28. 50	
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29. 00	
30.00	· · · · · · · · · · · · · · · · · · ·			14, 857, 273		
31.00	Primary payer payments			3, 140		
32. 00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)			14, 854, 133	32. 00	
33. 00				0	33. 00	
	Allowable bad debts (see instructions)			474, 185		
35. 00				308, 220		
36.00				403, 582 15, 162, 353		
37. 00 38. 00				15, 162, 353	38.00	
39. 00				0	39. 00	
39. 50	, , , , , , , , , , , , , , , , , , , ,				39. 50	
39. 75	N95 respirator payment adjustment amount (see instructions)			0	39. 75	
39. 97 39. 98	Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replaced devices	(see instruc	tions)	0	39. 97 39. 98	
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	(300 111311 00	5115)	0	39. 99	
40.00	Subtotal (see instructions)			15, 162, 353	40. 00	
40. 01	Sequestration adjustment (see instructions)			303, 247	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			15, 031, 838	41. 00	
41. 01	Interim payments-PARHM				41. 01	
42. 00	Tentative settlement (for contractors use only)			0	42.00	
42. 01	Tentative settlement-PARHM (for contractor use only)			170 700	42. 01	
43. 00 43. 01	Balance due provider/program (see instructions) Balance due provider/program-PARHM (see instructions)			-172, 732	43. 00 43. 01	
44. 00	Protested amounts (nonallowable cost report items) in accordance with CM	S Pub. 15-2,	chapter 1,	0	44. 00	
	§115. 2					
00 00	TO BE COMPLETED BY CONTRACTOR Original publicar amount (see instructions)		T	0	90. 00	
90. 00 91. 00	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)			0	90.00	
92. 00	, , ,			0. 00	92.00	
93. 00	Time Value of Money (see instructions)			0	93. 00	

Health Financial Systems	SSM HEALTH GOOD SAMA	RITAN HOSPITAL	In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0046	Peri od:	Worksheet E	
			From 01/01/2023		
			To 12/31/2023	Date/Time Pre	
				5/21/2024 10:	06 am
		Title XVIII	Hospi tal	PPS	
				1. 00	
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				0	200. 00

Part I

Peri od:

From 01/01/2023 Date/Time Prepared: 12/31/2023 5/21/2024 10:06 am Title XVIII Hospi tal PPS Part B Inpatient Part A mm/dd/yyyy mm/dd/yyyy Amount Amount 1.00 2.00 3.00 4.00 1.00 Total interim payments paid to provider 27, 501, 379 15, 077, 401 1. 00 2.00 Interim payments payable on individual bills, either 2.00 submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 3.00 List separately each retroactive lump sum adjustment 3.00 amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3.01 ADJUSTMENTS TO PROVIDER 0 0 3.01 0 3.02 0 3.02 3.03 0 3.03 0 3.04 0 Ω 3.04 3.05 0 0 3.05 Provider to Program 08/01/2023 3.50 ADJUSTMENTS TO PROGRAM 45, 563 3.50 0 3.51 0 3.51 0 3.52 0 3.52 0 3.53 0 3.53 0 3.54 Λ 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 0 -45, 563 3.99 3.50-3.98) 27, 501, 379 15, 031, 838 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropri ate) TO BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after 5.00 desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 TENTATIVE TO PROVIDER 0 0 5.01 5.02 0 0 5.02 0 5.03 0 5.03 Provider to Program 5.50 TENTATI VE TO PROGRAM 0 0 5.50 5.51 0 0 5. 51 0 5.52 0 5.52 5. 99 0 Subtotal (sum of lines 5.01-5.49 minus sum of lines 0 5.99 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on 6.00 the cost report. (1) SETTLEMENT TO PROVIDER 6.01 0 6.01 14, 907 6 02 SETTLEMENT TO PROGRAM 172, 732 6.02 7.00 Total Medicare program liability (see instructions) 27, 486, 472 14, 859, 106 7.00 Contractor NPR Date (Mo/Day/Yr) Number

0

1 00

2 00

8.00

8.00 Name of Contractor

| In Lieu of Form CMS-2552-10 | Period: | Worksheet E-1 | From 01/01/2023 | Part | | Date/Time Prepared: 5/21/2024 10:06 am | PPS Health Financial Systems SSM HEALT ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 14-0046 Component CCN: 14-T046

		Title	XVIII	Subprovider - IRF	PPS	
		Inpatien	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4. 00	
1. 00 2. 00	Total interim payments paid to provider Interim payments payable on individual bills, either		2, 303, 00	9	0	1. 00 2. 00
	submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero					
3. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate					3. 00
	for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider		ı	al		
3. 01	ADJUSTMENTS TO PROVIDER			0	0	3. 01
3. 02 3. 03				0		3. 02 3. 03
3. 03				0		3. 04
3. 05				o	l ol	3. 05
	Provider to Program			-1		
3.50	ADJUSTMENTS TO PROGRAM			0	0	3.50
3.51				0	0	3. 51
3. 52				0	0	3. 52
3. 53				0	0	3. 53
3. 54 3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3. 54 3. 99
3. 99	3. 50-3. 98)			U .	U	3. 99
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		2, 303, 00	9	0	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as		, ,			
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR		1			
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER			ol	0	5. 01
5. 02				Ö	Ö	5. 02
5.03				0	0	5.03
	Provider to Program					
5. 50	TENTATI VE TO PROGRAM			0	0	5. 50
5. 51				0	0	5. 51
5. 52 5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5. 52 5. 99
6. 00	5.50-5.98) Determined net settlement amount (balance due) based on			O		6. 00
5. 00	the cost report. (1)					0.00
6. 01	SETTLEMENT TO PROVI DER		976, 62	4	0	6. 01
6. 02	SETTLEMENT TO PROGRAM			0	0	6. 02
7. 00	Total Medicare program liability (see instructions)		3, 279, 63		0	7. 00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		()	1. 00	2. 00	
8.00	Name of Contractor					8. 00

Heal th	Financial Systems SSM HEALTH GOOD SAMA	ARITAN HOSPITAL	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 14-0046	Peri od: From 01/01/2023 To 12/31/2023	Worksheet E-1 Part II Date/Time Pre 5/21/2024 10:	epared:
		Title XVIII	Hospi tal	PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				4
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION	l			1
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.	S-3, Pt. I col. 15 line	2 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 I	ine 20			6. 00
7. 00	CAH only - The reasonable cost incurred for the purchase of cline 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				1
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
	Other Adjustment (specify)				31.00
	Balance due provider (line 8 (or line 10) minus line 30 and l	ine 31) (see instruction	15)		32 00

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

Health Financial Systems	SSM HEALTH GOOD SAMARITAN HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0046	Peri od: From 01/01/2023	Worksheet E-3
	Component CCN: 14-T046		
	Title XVIII	Subprovi der -	PPS
		I RF	

	IRF		
		1. 00	
	PART III - MEDICARE PART A SERVICES - IRF PPS	1.00	
1.00	Net Federal PPS Payment (see instructions)	2, 209, 693	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	2. 5000	2. 00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	1, 106, 172	3.00
4.00	Outlier Payments	48, 248	4. 00
5. 00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0. 00	5. 00
5. 01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412. 424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	5. 01
6.00	New Teaching program adjustment. (see instructions)	0.00	6. 00
7. 00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0. 00	7. 00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00	8. 00
9. 00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9. 00
10.00	Average Daily Census (see instructions)	6. 465753	
11.00	Teaching Adjustment Factor (see instructions)	0. 000000	
12.00	Teaching Adjustment (see instructions)	0	12.00
13.00	Total PPS Payment (see instructions)	3, 364, 113	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		15. 00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17. 00	Subtotal (see instructions)	3, 364, 113	17.00
18. 00	Primary payer payments	0	18. 00
19. 00	Subtotal (line 17 less line 18).	3, 364, 113	
20. 00	Deducti bl es	12, 756	
21. 00	Subtotal (line 19 minus line 20)	3, 351, 357	
22. 00	Coi nsurance	6, 000	
23. 00	Subtotal (line 21 minus line 22)	3, 345, 357	
24. 00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	1, 600	
25. 00	Adjusted reimbursable bad debts (see instructions)	1, 040	25. 00
26. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)	1, 600	
27. 00	Subtotal (sum of lines 23 and 25)	3, 346, 397	27. 00
28. 00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28. 00
29. 00	Other pass through costs (see instructions)	167 0	29. 00
30.00	Outlier payments reconciliation	0	30. 00 31. 00
31. 00 31. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31. 50
31. 98	Pioneer ACO demonstration payment adjustment (see instructions) Recovery of accelerated depreciation.	0	31. 98
31. 99	Demonstration payment adjustment amount before sequestration	0	31. 99
32. 00	Total amount payable to the provider (see instructions)	3, 346, 564	
32. 01	Sequestration adjustment (see instructions)	66, 931	32. 01
32. 02	Demonstration adjustment amount after sequestration	00, 731	32. 02
33. 00	Interim payments	2, 303, 009	33. 00
34.00	Tentative settlement (for contractor use only)	0	34. 00
35. 00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	976, 624	35. 00
36. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	30, 936	36. 00
	\$115. 2 TO BE COMPLETED BY CONTRACTOR		
50. 00	TO BE COMPLETED BY CONTRACTOR Original outlier amount from Wkst. E-3, Pt. III, line 4	48, 248	50. 00
51.00	Outlier reconciliation adjustment amount (see instructions)	40, 240	51.00
52. 00	The rate used to calculate the Time Value of Money	•	52. 00
53. 00	Time Value of Money (see instructions)	0.00	53. 00
55. 66	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE THE COVID-19 PHE)		33.00
99. 00	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.	0. 000000	99 00
	Calculated Teaching Adjustment Factor for the current year. (see instructions)	0. 000000	
	The second section of the section of the sect	3. 000000	, , , , , , ,

Heal th	Financial Systems SSM HEALTH GOOD SA	MARITAN HOSPITAL	In Lie	u of Form CMS-2	552-10
				Worksheet E-5	
			From 01/01/2023 To 12/31/2023	Date/Time Prep 5/21/2024 10:0	oared: 06 am
		Title XVIII		PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR				
1.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or su	ım of 2.03 plus 2.04 (see i	nstructions)	0	1.00
2.00	Capital outlier from Wkst. L, Pt. I, line 2			0	2.00
3.00	Operating outlier reconciliation adjustment amount (see ins	structions)		0	3.00
4.00	Capital outlier reconciliation adjustment amount (see instr	ructions)		0	4.00
5.00	The rate used to calculate the time value of money (see ins	structions)		0.00	5.00
6.00	Time value of money for operating expenses (see instruction	ns)		0	6.00
7. 00	Time value of money for capital related expenses (see instr	ructi ons)		0	7. 00

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

Provider CCN: 14-0046

| Period: | Worksheet G | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: 5/21/2024 | 10:06 am |

oni y)					5/21/2024 10:	06 am
		General Fund	Speci fi c	Endowment Fund	Plant Fund	
		1.00	Purpose Fund 2.00	3. 00	4. 00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	-3, 938	0	_	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3. 00 4. 00	Notes receivable Accounts receivable	71, 376, 774		0	0 0	3. 00 4. 00
5. 00	Other recei vable	2, 399, 398	0	0	0	ı
6. 00	Allowances for uncollectible notes and accounts receivable	-40, 963, 984	0	0	0	
7. 00	Inventory	4, 762, 396	Ö	0	Ö	7. 00
8.00	Prepai d expenses	784, 065	Ō	0	0	
9.00	Other current assets	0	0	0	0	9. 00
10.00	Due from other funds	0	0	0	0	10. 00
11.00	Total current assets (sum of lines 1-10)	38, 354, 711	0	0	0	11. 00
	FI XED ASSETS		_	_		
12.00	Land	590, 251	0	_	0	12.00
13.00	Land improvements	6, 943, 766	0 0	_	0	13.00
14. 00 15. 00	Accumulated depreciation Buildings	-5, 926, 917 160, 843, 428	0	_	0 0	14. 00 15. 00
	Accumulated depreciation	-66, 083, 718	_	_	0	16.00
17. 00	Leasehold improvements	19, 336, 297	0		0	17. 00
	Accumulated depreciation	-10, 044, 146	Ö	0	Ö	18.00
	Fi xed equipment	16, 409, 156	O	0	0	19.00
20.00	Accumulated depreciation	-11, 829, 481	0	0	0	20.00
21.00	Automobiles and trucks	314, 614	0	0	0	21. 00
	Accumulated depreciation	-256, 001	0	0	0	22. 00
	Major movable equipment	72, 894, 587	0		0	23. 00
	Accumulated depreciation	-55, 161, 413	0	0	0	24. 00
	Minor equipment depreciable	0	0	0	0	25. 00
	Accumulated depreciation	0	0	0	0 0	26.00
	HIT designated Assets Accumulated depreciation	0		0	0	27. 00 28. 00
	Mi nor equi pment-nondepreci abl e	0		0	0	29.00
	Total fixed assets (sum of lines 12-29)	128, 030, 423	Ö	0	_	30.00
	OTHER ASSETS	1 1 2 7 2 2 2 7 1 2 2	-			
31.00	Investments	4, 937, 562	0	0	0	31.00
32.00	Deposits on Leases	0	0	0	0	32. 00
	Due from owners/officers	0	0	0	0	33. 00
34. 00	Other assets	5, 203, 089		0	0	34.00
	Total other assets (sum of lines 31-34)	10, 140, 651	1, 283, 181	0	0	35.00
36. 00	Total assets (sum of lines 11, 30, and 35) CURRENT LIABILITIES	176, 525, 785	1, 283, 181	0	0	36. 00
37. 00	Accounts payable	565, 947, 688	0	0	0	37. 00
	Salaries, wages, and fees payable	5, 634, 574	0	_	0	38.00
	Payroll taxes payable	137, 946	Ö	0	Ö	39.00
	Notes and Loans payable (short term)	794, 278	O	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accel erated payments	0				42. 00
43.00	Due to other funds	0	0	0	0	
	Other current liabilities	265, 145			_	
45. 00	Total current liabilities (sum of lines 37 thru 44)	572, 779, 631	0	0	0	45. 00
44 00	LONG TERM LIABILITIES	1 0	0		0	1 44 00
46. 00 47. 00	Mortgage payable Notes payable			0	-	
48. 00	Unsecured Loans	0			0	48. 00
49. 00	Other long term liabilities	-481, 362, 309			Ö	49. 00
50. 00	Total long term liabilities (sum of lines 46 thru 49)	-481, 362, 309			-	50.00
51.00	Total liabilities (sum of lines 45 and 50)	91, 417, 322		0		
	CAPI TAL ACCOUNTS					
52.00	CAPITAL ACCOUNTS					52.00
52.00	General fund balance	85, 108, 463				
53.00	General fund balance Specific purpose fund	85, 108, 463	1, 283, 181			53.00
53. 00 54. 00	General fund balance Specific purpose fund Donor created - endowment fund balance - restricted	85, 108, 463		0		53. 00 54. 00
53. 00 54. 00 55. 00	General fund balance Specific purpose fund Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted	85, 108, 463				53. 00 54. 00 55. 00
53. 00 54. 00 55. 00 56. 00	General fund balance Specific purpose fund Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted Governing body created - endowment fund balance	85, 108, 463		0		53. 00 54. 00 55. 00 56. 00
53. 00 54. 00 55. 00 56. 00 57. 00	General fund balance Specific purpose fund Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted Governing body created - endowment fund balance Plant fund balance - invested in plant	85, 108, 463		0	0	53. 00 54. 00 55. 00 56. 00 57. 00
53. 00 54. 00 55. 00 56. 00	General fund balance Specific purpose fund Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted Governing body created - endowment fund balance Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement,	85, 108, 463		0	0	53. 00 54. 00 55. 00 56. 00 57. 00 58. 00
53. 00 54. 00 55. 00 56. 00 57. 00	General fund balance Specific purpose fund Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted Governing body created - endowment fund balance Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement, replacement, and expansion	85, 108, 463 85, 108, 463	1, 283, 181	0 0 0	-	53. 00 54. 00 55. 00 56. 00 57. 00
53. 00 54. 00 55. 00 56. 00 57. 00 58. 00	General fund balance Specific purpose fund Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted Governing body created - endowment fund balance Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement,		1, 283, 181 1, 283, 181	0 0 0	0	53. 00 54. 00 55. 00 56. 00 57. 00 58. 00

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES SSM HEALTH GOOD SAMARITAN HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 14-0046

				-	To 12/31/2023	Date/Time Prep 5/21/2024 10:0	
		General	Fund	Special P	urpose Fund	Endowment Fund	oo aiii
				•	·		
		1.00	2. 00	3. 00	4. 00	5. 00	
1.00	Fund balances at beginning of period		141, 613, 282		1, 062, 787		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		43, 682, 704		4 0/0 707		2.00
3.00	Total (sum of line 1 and line 2)	100 107 501	185, 295, 986		1, 062, 787		3. 00
4.00	RELEATED ORG TRANSFERS	-100, 187, 524		220, 39		0	4. 00
5.00	CORPORATE OFFICE GAIN ON INVESTMENTS	0				0	5. 00
6. 00 7. 00	TRANSFER FROM OTHER RELATED ORGANIZA)		0	6. 00 7. 00
8.00	TRANSFERS FROM OTHER FUNDS)		0	8. 00
9. 00	DONATIONS)		0	9. 00
10.00	Total additions (sum of line 4-9)		-100, 187, 524	`	220, 395		10. 00
11. 00	Subtotal (line 3 plus line 10)		85, 108, 462		1, 283, 182		11. 00
12.00	Deductions (debit adjustments) (specify)	0	05, 100, 402		1, 203, 102	0	12. 00
13. 00	capecity))		0	13. 00
14. 00						0	14. 00
15. 00				ì		0	15. 00
16. 00		0		ì	ol .	ő	16. 00
17. 00		0				0	17. 00
18. 00	Total deductions (sum of lines 12-17)]	0		0		18. 00
19. 00	Fund balance at end of period per balance		85, 108, 462		1, 283, 182		19. 00
	sheet (line 11 minus line 18)						
		Endowment Fund	PI ant	Fund			
1.00	Te	6. 00	7. 00	8. 00			
1.00	Fund balances at beginning of period	0		(1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	O O	0	(3. 00
4.00	RELEATED ORG TRANSFERS CORPORATE OFFICE		0				4. 00 5. 00
5.00	GAIN ON INVESTMENTS		0				6. 00
6. 00 7. 00	TRANSFER FROM OTHER RELATED ORGANIZA		0				7. 00
8.00	TRANSFERS FROM OTHER FUNDS	1	0				7. 00 8. 00
9. 00	DONATIONS		0				9. 00
10. 00	Total additions (sum of line 4-9)		O	,			10. 00
11. 00	Subtotal (line 3 plus line 10)						11. 00
12. 00	Deductions (debit adjustments) (specify)		0	· `			12. 00
13. 00	Seader one (dear t adjustments) (specify)		0				13. 00
14. 00			0				14. 00
15. 00			0				15. 00
16. 00		1	0			İ	16. 00
17. 00		1	0			İ	17. 00
18.00	Total deductions (sum of lines 12-17)	0					18.00
19. 00	Fund balance at end of period per balance	0		(19.00
	sheet (line 11 minus line 18)						

		1.00	2. 00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	60, 615, 900		60, 615, 900	1.00
2.00	SUBPROVI DER - I PF				2. 00
3.00	SUBPROVI DER - I RF	5, 620, 534		5, 620, 534	3.00
4.00	SUBPROVI DER				4. 00
5.00	Swing bed - SNF	0		0	5. 00
6.00	Swing bed - NF	0		0	6. 00
7.00	SKILLED NURSING FACILITY				7. 00
8.00	NURSING FACILITY				8. 00
9. 00	OTHER LONG TERM CARE				9. 00
10. 00	Total general inpatient care services (sum of lines 1-9)	66, 236, 434		66, 236, 434	10. 00
10.00	Intensive Care Type Inpatient Hospital Services	00, 200, 101		00, 200, 101	10.00
11. 00	INTENSIVE CARE UNIT	7, 297, 502		7, 297, 502	11. 00
12. 00	CORONARY CARE UNIT	7,277,302		1, 271, 302	12. 00
13. 00	BURN INTENSIVE CARE UNIT				13. 00
14. 00	SURGICAL INTENSIVE CARE UNIT				14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)				15. 00
16. 00	Total intensive care type inpatient hospital services (sum of lines	7, 297, 502		7, 297, 502	16. 00
10.00	11-15)	1, 291, 302		1, 291, 302	16.00
17. 00		73, 533, 936		73, 533, 936	17. 00
	Total inpatient routine care services (sum of lines 10 and 16)		215 5/0 00/		
18.00	Ancillary services	267, 086, 606	315, 569, 896	582, 656, 502	18.00
19. 00	Outpatient services	14, 394, 794	49, 177, 991	63, 572, 785	
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21. 00
22. 00	HOME HEALTH AGENCY				22. 00
23. 00	AMBULANCE SERVICES				23. 00
24. 00	CMHC				24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00
26. 00	HOSPICE				26. 00
27. 00	EMPLOYEE CHARGES	3, 753, 477	9, 621, 867	13, 375, 344	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	358, 768, 813	374, 369, 754	733, 138, 567	28. 00
	G-3, line 1)				
	PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		213, 684, 585		29. 00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35. 00
36.00	Total additions (sum of lines 30-35)		ol		36. 00
37. 00	DEDUCT (SPECIFY)	0			37. 00
38. 00		ا			38. 00
39. 00					39. 00
40. 00					40. 00
41. 00					41. 00
42. 00	Total deductions (sum of lines 37-41)		٥		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer		213, 684, 585		43. 00
43.00	to Wkst. G-3, line 4)		213, 004, 363		43.00

		SAMARITAN HOSPITAL		u of Form CMS-2	
STATEN	ENT OF REVENUES AND EXPENSES	Provider CCN: 14-0046	Peri od: From 01/01/2023	Worksheet G-3	
			To 12/31/2023	Date/Time Pre 5/21/2024 10:	
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3			733, 138, 567	1. 00
2.00	Less contractual allowances and discounts on patients' a	ccounts		506, 650, 248	
3.00	Net patient revenues (line 1 minus line 2)			226, 488, 319	
4.00	Less total operating expenses (from Wkst. G-2, Part II,			213, 684, 585	4. 00
5.00	Net income from service to patients (line 3 minus line 4	.)		12, 803, 734	5. 00
	OTHER I NCOME				
6.00	Contributions, donations, bequests, etc			2, 636, 259	6. 00
7.00	Income from investments			588, 059	7. 00
8.00	Revenues from telephone and other miscellaneous communic	ation services		0	8. 00
9.00	Revenue from television and radio service			0	9. 00
10.00	Purchase di scounts			-520	10. 00
11. 00	Rebates and refunds of expenses			0	11. 00
12.00	Parking lot receipts			0	12. 00
13.00	Revenue from Laundry and Linen service			0	13. 00
14.00	Revenue from meals sold to employees and guests			642, 384	14.00
15.00	Revenue from rental of living quarters			0	15. 00
16.00	Revenue from sale of medical and surgical supplies to ot	her than patients		0	16. 00
17.00	Revenue from sale of drugs to other than patients			0	17. 00
18.00	Revenue from sale of medical records and abstracts			0	18. 00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00
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			391, 485	22. 00
23.00	Governmental appropriations			0	23. 00
24.00	OTHER INCOME			10 054 104	04.00

18, 854, 104 24. 00

0 24. 50 23, 111, 771 25. 00 35, 915, 505 26. 00 -7, 767, 199 27. 00 -7, 767, 199 28. 00 43, 682, 704 29. 00

0 24. 50

24. 00 OTHER INCOME

24.50 COVID-19 PHE Funding
25.00 Total other income (sum of lines 6-24)
26.00 Total (line 5 plus line 25)
27.00 NON OPERATING EXPENSES

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

	Financial Systems SSM HEALTH GOC ATION OF CAPITAL PAYMENT	DD SAMARITAN HOSPITAL	Peri od:	u of Form CMS-2	2002-
ALCUI	LATION OF CAPITAL PAYMENT	Provider CCN: 14-0046	From 01/01/2023	Worksheet L Parts I-III	
			To 12/31/2023	Date/Time Pre	pared
				5/21/2024 10:	06 am
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD			1.00	
	CAPITAL FEDERAL AMOUNT				
. 00	Capital DRG other than outlier			2, 009, 385	1. (
. 01	Model 4 BPCI Capital DRG other than outlier			0	1
2. 00	Capital DRG outlier payments			48, 542	2. (
. 01	Model 4 BPCI Capital DRG outlier payments			0	2.
. 00	Total inpatient days divided by number of days in the o	cost reporting period (see inst	ructions)	78. 21	3.
. 00	Number of interns & residents (see instructions)			0.00	4.
. 00	Indirect medical education percentage (see instructions			0.00	5.
. 00	Indirect medical education adjustment (multiply line 5 1.01) (see instructions)	by the sum of lines 1 and 1.01	, columns 1 and	0	6.
00	Percentage of SSI recipient patient days to Medicare Pa 30) (see instructions)	art A patient days (Worksheet E	E, part A line	0. 00	7.
. 00	Percentage of Medicaid patient days to total days (see	instructions)		0.00	8.
. 00	Sum of lines 7 and 8			0.00	9.
0. 00	Allowable disproportionate share percentage (see instru	uctions)		0.00	10.
1. 00	Disproportionate share adjustment (see instructions)			0	11.
2. 00	Total prospective capital payments (see instructions)			2, 057, 927	12.
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST			1.00	
. 00	Program inpatient routine capital cost (see instruction			0	1.
. 00	Program inpatient ancillary capital cost (see instructi			0	2.
. 00	Total inpatient program capital cost (line 1 plus line			0	3.
. 00	Capital cost payment factor (see instructions)			0	4.
. 00	Total inpatient program capital cost (line 3 x line 4)			0	5.
	PART III - COMPUTATION OF EXCEPTION PAYMENTS			1. 00	
. 00	Program inpatient capital costs (see instructions)			0	1.
. 00	Program inpatient capital costs (see instructions)	imetances (see instructions)		0	
. 00	Net program inpatient capital costs (line 1 minus line			0	
00	Applicable exception percentage (see instructions)	- /		0.00	
. 00	Capital cost for comparison to payments (line 3 x line	4)		0.00	1
. 00	Percentage adjustment for extraordinary circumstances (0.00	
. 00	Adjustment to capital minimum payment level for extraor		(line 6)	0.00	
3. 00	Capital minimum payment level (line 5 plus line 7)	, , , , , , , , , , , , , , , , , , ,	,	0	8.
		!!!! ->		ŭ	0.

9.00

0 10.00

11.00

14.00

0 12.00

0 13.00

0

0 15.00

0 16.00 0 17.00

Current year capital payments (from Part I, line 12, as applicable)

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

16.00 Current year operating and capital costs (see instructions)

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

17.00 | Current year exception offset amount (see instructions)

Worksheet L, Part III, line 14)

10.00 | Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)

Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)

Current year exception payment (if line 12 is positive, enter the amount on this line)

Carryover of accumulated capital minimum payment level over capital payment for the following period

11.00 | Carryover of accumulated capital minimum payment level over capital payment (from prior year

9.00

12.00

13.00