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

ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

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 ASCENSION ST. VINCENT MERCY (15-1308) for the cost reporting period beginning 07/01/2022 and ending 06/30/2023 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	ELECTRONIC	
	1		2	SIGNATURE STATEMENT	
1	Christ	topher Hons	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	Christopher Hons			2
3	Signatory Title	VP OF FINANCE			3
4	Date	11/22/2023 02:20:17 PM			4

			Title	XVIII			
		Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	-43,908	-329,382	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	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	-43,908	-329,382	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.

	AL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DATA	Provid	ler CCN:		Period: From 07/01/ To 06/30/	2022 2023	Workshe Part I Date/Ti 11/22/2	me Pre	pared
	1.00	2.00		3.00		4	1.00			
~~	Hospital and Hospital Health Care Co		-							1 1 0
.00	Street: 1331 SOUTH A ST.	PO Box:	zin cod	o. 46026	Count					1.0
.00	City: ELWOOD	State: IN Component Name	CCN	e: 46036 CBSA	Provider	Date	Pavme	nt Syst	om (P	2.0
		componente ivame	Number	Number		Certified		, 0, or		
							V	XVIII		1
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Componer		-	1						
.00	Hospital	ASCENSION ST. VINCENT	151308	26900	1	07/01/2001	Ν	0	0	3.0
.00	Subprovider – IPF	MERCY								4.0
.00	Subprovider – IRF									5.0
.00	Subprovider - (Other)									6.0
.00	Swing Beds - SNF	ASCENSION ST. VINCENT	15z308	26900		07/01/2001	N	0	N	7.0
		MERCY SWING								
.00	Swing Beds - NF									8.0
.00	Hospital-Based SNF									9.0
	Hospital-Based NF									10.0
1.00	Hospital-Based OLTC Hospital-Based HHA									11.0
3.00										13.0
	Hospital-Based Hospice									14.0
	Hospital-Based Health Clinic - RHC									15.0
	Hospital-Based Health Clinic - FQHC									16.0
	Hospital-Based (CMHC) I									17.0
3.00	Renal Dialysis									18.0
9.00	Other					From:		То		19.0
						1.00		2.0		1
0.00	Cost Reporting Period (mm/dd/yyyy)					07/01/20	)22	06/30,		20.0
1.00	Type of Control (see instructions)					1				21.0
				-	1 00	2.00		2 (		-
	Inpatient PPS Information				1.00	2.00		3.0	00	
2.00	Does this facility qualify and is it	currently receiving pa	vments fo	r	N	N				22.0
	disproportionate share hospital adju									
	§412.106? In column 1, enter "Y" fo	r yes or "N" for no. Is	this							
	facility subject to 42 CFR Section §	412.106(c)(2)(Pickle am	endment							
2 01	hospital?) In column 2, enter "Y" fo Did this hospital receive interim UC		tal ucoc	for	N	N				22.0
2.01	this cost reporting period? Enter in				IN	IN				22.
	for the portion of the cost reportir									
	1. Enter in column 2, "Y" for yes or									
	cost reporting period occurring on c	r after October 1. (see								
	instructions)									
2.02	Is this a newly merged hospital that determined at cost report settlement			1	N	N				22.
	1, "Y" for yes or "N" for no, for th			lumn						
	period prior to October 1. Enter in			no,						
	for the portion of the cost reportir									
2.03	Did this hospital receive a geograph				N	N		N		22.
	rural as a result of the OMB standar									
	adopted by CMS in FY2015? Enter in c for the portion of the cost reportir									
	in column 2, "Y" for yes or "N" for			-						
	reporting period occurring on or aft	er October 1. (see inst	ructions)							
		100 but not more than 4	99 beds (							
	Does this hospital contain at least		3, "Y" f	or						
	counted in accordance with 42 CFR 41	.2.105)? Enter in column	,							22.
. 04	counted in accordance with 42 CFR 41 yes or "N" for no.		m urban t							44.
2.04	counted in accordance with 42 CFR 41 yes or "N" for no. Did this hospital receive a geograph	ic reclassification fro								
2.04	counted in accordance with 42 CFR 41 yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OME	ic reclassification fro delineations for stati	stical ar	eas						
2.04	counted in accordance with 42 CFR 41 yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OME adopted by CMS in FY 2021? Enter in for the portion of the cost reportir	ic reclassification fro delineations for stati column 1, "Y" for yes o g period prior to Octob	stical ar r "N" for er 1. Ente	eas no						
2.04	counted in accordance with 42 CFR 41 yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OME adopted by CMS in FY 2021? Enter in for the portion of the cost reportir in column 2, "Y" for yes or "N" for	ic reclassification fro delineations for stati column 1, "Y" for yes o g period prior to Octob no for the portion of t	stical ar r "N" for er 1. Ent he cost	eas no						
2.04	counted in accordance with 42 CFR 41 yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OME adopted by CMS in FY 2021? Enter in for the portion of the cost reportir in column 2, "Y" for yes or "N" for reporting period occurring on or aft	ic reclassification fro delineations for stati column 1, "Y" for yes o g period prior to Octob no for the portion of t er October 1. (see inst	stical ar r "N" for er 1. Ent he cost ructions)	eas no er						
2.04	counted in accordance with 42 CFR 41 yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OME adopted by CMS in FY 2021? Enter in for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least	ic reclassification fro delineations for stati column 1, "Y" for yes o g period prior to Octob no for the portion of t er October 1. (see inst 100 but not more than 4	stical ard r "N" for er 1. Ent he cost ructions) 99 beds (3	eas no er						
2.04	counted in accordance with 42 CFR 41 yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OME adopted by CMS in FY 2021? Enter in for the portion of the cost reportir in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41	ic reclassification fro delineations for stati column 1, "Y" for yes o g period prior to Octob no for the portion of t er October 1. (see inst 100 but not more than 4	stical ard r "N" for er 1. Ent he cost ructions) 99 beds (3	eas no er						
	counted in accordance with 42 CFR 41 yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OME adopted by CMS in FY 2021? Enter in for the portion of the cost reportir in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no.	ic reclassification fro delineations for stati column 1, "Y" for yes o g period prior to Octob no for the portion of t er October 1. (see inst 100 but not more than 4 2.105)? Enter in colum	stical are r "N" for er 1. Ente he cost ructions) 99 beds (7 n 3, "Y"	eas no er as for		2 N				
	counted in accordance with 42 CFR 41 yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OME adopted by CMS in FY 2021? Enter in for the portion of the cost reportir in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Which method is used to determine Me	tic reclassification fro delineations for stati column 1, "Y" for yes o g period prior to Octob no for the portion of t er October 1. (see inst 100 but not more than 4 2.105)? Enter in colum dicaid days on lines 24	stical are r "N" for er 1. Ente he cost ructions) 99 beds (7 n 3, "Y" and/or 2	eas no er as for		2 N				23.
	counted in accordance with 42 CFR 41 yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OME adopted by CMS in FY 2021? Enter in for the portion of the cost reportir in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no.	ic reclassification fro delineations for stati column 1, "Y" for yes o g period prior to Octob no for the portion of t ter October 1. (see inst 100 but not more than 4 2.105)? Enter in colum dicaid days on lines 24 of admission, 2 if cens of identifying the days	stical ard r "N" for er 1. Ent he cost ructions) 99 beds ( n 3, "Y" and/or 2 us days, in this	eas no er as for 5 5 7 7		2 N				

IOSPIT	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provider CC	CN: 15-1308	Period:	1 /2022		eet S-2	2
					From 07/0 To 06/3	0/2022	Part I Date/T 11/22/		
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medica HMO da	id C lys Me	other dicaid days	
	1	1.00	2.00	3.00	4.00	5.00		6.00	
	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days 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	0			0		0	C	24.0
	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.				Ushan (D		Date of	6.0000	
					Urban/R			r Geogr 00	-
6.00	Enter your standard geographic classification (not wa		at the beg	ginning of t		1			26.0
	cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not we reporting period. Enter in column 1, "1" for urban of enter the effective date of the geographic reclassif If this is a sole community hospital (SCH), enter the	age) status r "2" for r ication in	ural. If ap column 2.	oplicable,		1			27.0
5.00	effect in the cost reporting period.			Status II					
					Beginn 1.(			ing: 00	_
6.00	Enter applicable beginning and ending dates of SCH st		cript line	36 for numb					36.
7.00	of periods in excess of one and enter subsequent date If this is a Medicare dependent hospital (MDH), enter		r of period	ds MDH statu	IS	0			37.
7.01	is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for th accordance with FY 2016 OPPS final rule? Enter "Y" fo								37.
8.00	instructions) If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.								38.
	· ·				Y/			/N 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 (i or "N" for no. (see instructions)	), (ii), or the mileage ii)? Enter	(iii)? Ent requiremen in column 2	cer in colum nts in ? "Y" for ye	ime N in S			N	39.
0.00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octol no in column 2, for discharges on or after October 1	ber 1. Ente	r "Y" for y				r	N	40.
						V 1.00	XVIII 2.00		
5.00	<b>Prospective Payment System (PPS)-Capital</b> Does this facility qualify and receive Capital payment	nt for disp	roportionat	ce share in	accordance	N	N	N	45.
6.00	with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst					N	N	N	46.
	Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS of					N	N	N	47.
0.00	Is the facility electing full federal capital payment Teaching Hospitals	L: Enter	i i or yes	UT N TOP	110.	N	N	N	48.
	Is this a hospital involved in training residents in periods beginning prior to December 27, 2020, enter cost reporting periods beginning on or after December	"Y" for yes r 27, 2020, olumn 1 is	or "N" for under 42 C "Y", or if prior year	r no in colu CFR 413.78(k this hospit or penultin	umn 1. For (2), see al was nate year,	N			56.
5.00	the instructions. For column 2, if the response to co involved in training residents in approved GME progra and are you are impacted by CR 11642 (or applicable of "V" for your otherwise order "V" for points and and applicable of	CRs) MA dir	ect GME pay				1	1	
	involved in training residents in approved GME progra	CRS) MA dir er 27, 2020 residents n column 1. cost report e Worksheet applicable R 413.77(e	, if line 5 in approvec If column ing period? E-4. If cc . For cost )(1)(iv) ar	56, column 1 d GME progra 1 is "Y", c ? Enter "Y' olumn 2 is ' reporting p nd (v), rega	ums trained lid for yes or N", periods urdless of				57.

IOSPIT	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ТА	Provider CC		Period: From 07/01/2 To 06/30/2	2023	Worksheet S-2 Part I Date/Time Prep 11/22/2023 2:2	pared:
					-	V 1 00	XVIII XIX 2.00 3.00	
9.00	Are costs claimed on line 100 of Worksheet A? If yes	. compl	ete Wkst. D-2	Pt. I.		N N	2.00 3.00	59.00
				NAHE 413.85 Y/N	Worksheet Line #	•	Pass-Through Qualification Criterion Code	
			-	1.00	2.00		3.00	
	Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in col is "Y", are you impacted by CR 11642 (or subsequent C adjustment? Enter "Y" for yes or "N" for no in colum	85? (s umn 1. CR) NAHE	ee If column 1	N				60.0
		Y/N	IME	Direct GME	IME		Direct GME	
		1.00	2.00	3.00	4.00		5.00	
51.01	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) Enter the current year total unweighted primary care	N				0.00		61.00 61.03
	FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see							61.0
	instructions) Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).							61.0
	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)							61.0
	eare of general surgery. (see instructions)	Pro	ogram Name	Program Cod			Unweighted	
					FTE Cour	nt	Direct GME FTE Count	
			1.00	2.00	3.00		4.00	
	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Of the FTEs in line 61.05, specify each expanded					0.00		61.1
	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	
2 00	ACA Provisions Affecting the Health Resources and Ser	vices A	dministration	(HRSA)	niod for th'	ch	0.00	62.0
	Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruc Enter the number of FTE residents that rotated from a	tions)						62.0
	during in this cost reporting period of HRSA THC prog Teaching Hospitals that Claim Residents in Nonprovide			15)				

	AL AND HOSPITAL HEALTH CARE COMPL	EX IDENIIFICATION DA	TA Provider C		Period: From 07/01/2022	Worksheet S-2 Part I	
					го 06/30/2023	11/22/2023 2:	20 pm
				Unweighted FTEs Nonprovider	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	1
				Site	2.00	2.00	-
	Section 5504 of the ACA Base Yea	r ETE Posidents in No	opprovider Settings-	1.00	2.00	3.00	
	period that begins on or after J			This base year	is your cost i	eporting	
4.00	Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to ro settings. Enter in column 2 the resident FTEs that trained in yo of (column 1 divided by (column	yes, or your facilit per of unweighted nor tations occurring in number of unweighted ur hospital. Enter ir	ty trained residents n-primary care all nonprovider d non-primary care n column 3 the ratio	0.0	0.00	0.000000	64.0
1		Program Name	Program Code	Unweighted	Unweighted	Ratio (col. 3/	,
				FTES	FTEs in	(col. 3 + col.	
				Nonprovider	Hospital	4))	
				Site			
		1.00	2.00	3.00	4.00	5.00	
	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.0 Unweighted FTEs Nonprovider	0 0.00 Unweighted FTEs in Hospital	0.000000 Ratio (col. 1/ (col. 1 + col. 2))	
				Site 1.00	2.00	3.00	-
I	Section 5504 of the ACA Current	Year FTF Residents in	Nonprovider Setting				
	beginning on or after July 1, 20	10	-	-			
	Enter in column 1 the number of FTES attributable to rotations o Enter in column 2 the number of FTES that trained in your hospit (column 1 divided by (column 1 +	ccurring in all nonpr unweighted non-primar al. Enter in column 3	rovider settings. ry care resident 3 the ratio of	0.0	0 0.00	0.00000	66.0
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	-	1.00	2.00	3.00	4.00	5.00	1
	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column	1.00	2.00	0.0			67.0

	Financial Systems         ASCENSION ST. VINCENT M           CAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA         Provi			I Period: From 07/01, To 06/30,	/2022	u of For Workshe Part I Date/Ti	et S-2 me Pre	pared:
						11/22/2		20 pm
68.00	<b>Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 490</b> For a cost reporting period beginning prior to October 1, 2022, did MAC to apply the new DGME formula in accordance with the FY 2023 IPP (August 10, 2022)?	you ob	tain permissi	on from yo		1.0		68.00
					1.00	2.00	3.00	
70.00	<b>Inpatient Psychiatric Facility PPS</b> Is this facility an Inpatient Psychiatric Facility (IPF), or does it	conta	in an IPF sub	provider?	N			70.00
	Enter "Y" for yes or "N" for no. If line 70 is yes: Column 1: Did the facility have an approved GME t recent cost report filed on or before November 15, 2004? Enter "Y" 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train resi program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" Column 3: If column 2 is Y, indicate which program year began during (see instructions)	eachin for ye dents for ye	g program in s or "N" for in a new teac s or "N" for	the most no. (see hing no.			0	71.00
75.00	<b>Inpatient Rehabilitation Facility PPS</b> Is this facility an Inpatient Rehabilitation Facility (IRF), or does	; it co	ntain an IRF		N			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 t recent cost reporting period ending on or before November 15, 2004? no. Column 2: Did this facility train residents in a new teaching pr CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column indicate which program year began during this cost reporting period.	Enter ogram 3: If	"Y" for yes o in accordance column 2 is N	or "N" for with 42 ',			0	76.00
					-	1.0	)0	
80.00	Long Term Care Hospital PPS Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N"	' for n	0			N	1	80.00
	Is this a LTCH co-located within another hospital for part or all of "Y" for yes and "N" for no. TEFRA Providers			period? E	nter	N		81.00
86.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Did this facility establish a new Other subprovider (excluded unit) §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.	under	42 CFR Sectio		no.	N		85.00 86.00
87.00	Is this hospital an extended neoplastic disease care hospital classi 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	fied u	nder section			N		87.00
				Approved Perman Adjustm (Y/N) 1.00	ent Ient )	Numbe Appro Perma Adjust 2.0	oved nent ments	
88.00	Column 1: Is this hospital approved for a permanent adjustment to th amount per discharge? Enter "Y" for yes or "N" for no. If yes, compl 89. (see instructions) Column 2: Enter the number of approved permanent adjustments.	ne TEFR ete co	A target 1. 2 and line		,	2.0		88.00
			Wkst. A Line No.	Effective	Date	Appro Perma Adjust Amount Disch	nent ment Per	
80.00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line numb	on	1.00	2.00	)	3.0		89.00
89.00	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 amo per discharge. Column 3: Enter the amount of the approved permanent adjustment to t TEFRA target amount per discharge.	ount	0.0				0	89.00
				V		XI		
	Title V and XIX Services			1.00		2.0	00	
90.00	Does this facility have title V and/or XIX inpatient hospital servic yes or "N" for no in the applicable column.	es? En	ter "Y" for	N		Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost full or in part? Enter "Y" for yes or "N" for no in the applicable c			N		Y		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certi	ficati				Y		92.00
93.00	instructions) Enter "Y" for yes or "N" for no in the applicable colu Does this facility operate an ICF/IID facility for purposes of title		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
	applicable column. If line 94 is "Y", enter the reduction percentage in the applicable Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" applicable column.			0.00 N	)	0.0 N		95.00 96.00
97.00							97.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C		eriod:	Worksheet S	-2	
			rom 07/01/2022 o 06/30/2023	Part I Date/Time P		
			V	11/22/2023	2:20 pm	
			1.00	XIX 2.00	_	
08.00 Does title V or XIX follow Medicare (title XVIII) for the in stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" 1 column 1 for title V, and in column 2 for title XIX.			N	Y	98.0	
98.01 Does title V or XIX follow Medicare (title XVIII) for the re C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for ti title XIX.	itle V, and in	column 2 for	N	Y	98.0	
Does title V or XIX follow Medicare (title XVIII) for the cabed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes of for title V, and in column 2 for title XIX.	or "N" for no	in column 1	N	Y	98.0	
for title V, and in column 2 for title XIX.	reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in colu for title V, and in column 2 for title XIX. .04 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of					
outpatient services cost? Enter "Y" for yes or "N" for no ir in column 2 for title XIX.	title V, and	N	N	98.		
38.05 Does title V or XIX follow Medicare (title XVIII) and add ba Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in a column 2 for title XIX.	itle V, and in		Y	98.		
98.06 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.	r wkst. D, V, and in	N	Y	98.		
Rural Providers L05.00 Does this hospital qualify as a CAH?			Y		105.	
.06.00 If this facility qualifies as a CAH, has it elected the all- for outpatient services? (see instructions)			N		106.	
.07.00 Column 1: If line 105 is Y, is this facility eligible for co training programs? Enter "Y" for yes or "N" for no in column Column 2: If column 1 is Y and line 70 or line 75 is Y, do approved medical education program in the CAH's excluded IF	n 1. (see ins you train I&R PF and/or IRF	tructions) s in an	N		107.	
Enter "Y" for yes or "N" for no in column 2. (see instructions 108.00 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		N		108.	
	Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00	y	
L09.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y	Y	Y	N	109.	
					_	
				1 00	_	
10.00 Did this hospital participate in the Rural Community Hospita Demonstration)for the current cost reporting period? Enter ' complete Worksheet E, Part A, lines 200 through 218, and Wor applicable.	'Y" for yes or	"N" for no. I	f yes,	1.00 N	110.	
Demonstration)for the current cost reporting period? Enter ' complete Worksheet E, Part A, lines 200 through 218, and Wor	'Y" for yes or	"N" for no. I	f yes, gh 215, as	N	110.	
Demonstration)for the current cost reporting period? Enter ' complete Worksheet E, Part A, lines 200 through 218, and Wor applicable.	'Y" for yes or rksheet E-2, 1 the Frontier C ost reporting olumn 1 is Y, rticipating in	"N" for no. I ines 200 throu period? Enter enter the column 2.	f yes,			
<ul> <li>Demonstration) for the current cost reporting period? Enter ' complete Worksheet E, Part A, lines 200 through 218, and Wor applicable.</li> <li>11.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this con "Y" for yes or "N" for no in column 1. If the response to con integration prong of the FCHIP demo in which this CAH is participate all that apply: "A" for Ambulance services; "B" for account of the service of the serv</li></ul>	'Y" for yes or rksheet E-2, 1 the Frontier C ost reporting olumn 1 is Y, rticipating in	"N" for no. I ines 200 throu period? Enter enter the column 2.	f yes, gh 215, as 1.00	N		
Demonstration)for the current cost reporting period? Enter ' complete Worksheet E, Part A, lines 200 through 218, and Wor applicable.	'Y" for yes or rksheet E-2, 1 the Frontier C ost reporting olumn 1 is Y, rticipating in dditional beds lth Model eporting olumn 1 is pating in the	"N" for no. I ines 200 throu period? Enter enter the column 2. ; and/or "C"	f yes, gh 215, as	N 2.00	111.	
<ul> <li>Demonstration)for the current cost reporting period? Enter ' complete Worksheet E, Part A, lines 200 through 218, and Wor applicable.</li> <li>11.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this completer and the provide the the sequence of the the the sequence of the the sequence of the the sequence of the the the the sequence of the the the sequence of the the the the sequence of the the the the sequence of the the the sequence of the the the sequence of the the the the sequence of the the the sequence of the the the the sequence of the the the sequence of the the t</li></ul>	'Y" for yes or rksheet E-2, 1 the Frontier C ost reporting olumn 1 is Y, rticipating in dditional beds lth Model eporting olumn 1 is pating in the ased	"N" for no. I ines 200 throug period? Enter enter the column 2. ; and/or "C" 1.00	f yes, gh 215, as	N 2.00	111.	
<pre>Demonstration)for the current cost reporting period? Enter ' complete worksheet E, Part A, lines 200 through 218, and wor applicable.  111.00 If this facility qualifies as a CAH, did it participate in t Health Integration Project (FCHIP) demonstration for this co "Y" for yes or "N" for no in column 1. If the response to co integration prong of the FCHIP demo in which this CAH is par Enter all that apply: "A" for Ambulance services; "B" for ac for tele-health services.  112.00 Did this hospital participate in the Pennsylvania Rural Heal (PARHM) demonstration for any portion of the current cost re period? Enter "Y" for yes or "N" for no in column 1. If co "Y", enter in column 2, the date the hospital began particip demonstration. In column 3, enter the date the hospital cee participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or in column 1. If column 1 is yes, enter the method used (A, E in column 2. If column 2 is "E", enter in column 3 either "S for short term hospital or "98" percent for long term care ( psychiatric, rehabilitation and long term hospitals provider </pre>	'Y" for yes or rksheet E-2, 1 the Frontier C ost reporting olumn 1 is Y, rticipating in dditional beds lth Model eporting olumn 1 is obting in the ased r "N" for no 3, or E only) 33" percent (includes	"N" for no. I ines 200 throug period? Enter enter the column 2. ; and/or "C" 1.00	f yes, gh 215, as	N 2.00	111.	
<pre>complete worksheet E, Part A, lines 200 through 218, and wor applicable. 111.00 If this facility qualifies as a CAH, did it participate in t Health Integration Project (FCHIP) demonstration for this co "Y" for yes or "N" for no in column 1. If the response to co integration prong of the FCHIP demo in which this CAH is par Enter all that apply: "A" for Ambulance services; "B" for ac for tele-health services. 112.00 Did this hospital participate in the Pennsylvania Rural Heal (PARHM) demonstration for any portion of the current cost re period? Enter "Y" for yes or "N" for no in column 1. If co "Y", enter in column 2, the date the hospital began particip demonstration. In column 3, enter the date the hospital cea participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or in column 1. If column 1 is yes, enter the method used (A, E in column 2. If column 2 is "E", enter in column 3 either "S for short term hospital or "98" percent for long term care ( psychiatric, rehabilitation and long term hospitals provider the definition in CMS Pub.15-1, chapter 22, §2208.1. 116.00 Is this facility classified as a referral center? Enter "Y"</pre>	'Y" for yes or rksheet E-2, 1 the Frontier C ost reporting olumn 1 is Y, rticipating in dditional beds lth Model eporting olumn 1 is pating in the ased r "N" for no 3, or E only) 33" percent (includes rs) based on	"N" for no. I ines 200 throug period? Enter enter the column 2. ; and/or "C" 1.00 N	f yes, gh 215, as	N 2.00	110. 111. 111. 112. 0115. 116.	
<pre>Demonstration)for the current cost reporting period? Enter ' complete worksheet E, Part A, lines 200 through 218, and wor applicable. L11.00 If this facility qualifies as a CAH, did it participate in t Health Integration Project (FCHIP) demonstration for this co "Y" for yes or "N" for no in column 1. If the response to co integration prong of the FCHIP demo in which this CAH is par Enter all that apply: "A" for Ambulance services; "B" for ac for tele-health services. L12.00 Did this hospital participate in the Pennsylvania Rural Heal (PARHM) demonstration for any portion of the current cost re period? Enter "Y" for yes or "N" for no in column 1. If co "Y", enter in column 2, the date the hospital began particip demonstration. In column 3, enter the date the hospital ce participation in the demonstration L15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or in column 1. If column 1 is yes, enter the method used (A, E in column 2. If column 1 is "E", enter in column 3 either "' for short term hospital or "98" percent for long term care ( psychiatric, rehabilitation and long term hospitals provider the definition in CMS Pub.15-1, chapter 22, §2208.1.</pre>	'Y" for yes or rksheet E-2, 1 the Frontier C ost reporting olumn 1 is Y, rticipating in dditional beds lth Model eporting olumn 1 is pating in the ased r "N" for no 3, or E only) 93" percent (includes rs) based on for yes or	"N" for no. I ines 200 through period? Enter enter the column 2. ; and/or "C" 1.00 N	f yes, gh 215, as	N 2.00	111. 112. 0115.	

alth Financial Systems ASCENSION ST. VIN DSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CO	CN: 15-1308	Period: From 07/01/202 To 06/30/202		5-2 Prepared
	1	Premiums	Losses	Insurance	
10.01 List smaller of malanating and maid larger		1.00	2.00	3.00	0 1 1 0 (
L8.01 List amounts of malpractice premiums and paid losses:		162,8	557	0	0118.0
			1.00	2.00	
18.02 Are malpractice premiums and paid losses reported in a cost control Administrative and General? If yes, submit supporting schedul and amounts contained therein. 19.00 DO NOT USE THIS LINE			Ν		118.0
20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold H §3121 and applicable amendments? (see instructions) Enter in o "N" for no. Is this a rural hospital with < 100 beds that qual Hold Harmless provision in ACA §3121 and applicable amendments Enter in column 2, "Y" for yes or "N" for no.	column 1, "Y lifies for tl	' for yes or ne Outpatient		Ν	120.0
21.00 Did this facility incur and report costs for high cost implant	table device	s charged to	Y		121.0
patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain healthcare related taxes as defir Act?Enter "Y" for yes or "N" for no in column 1. If column 1				5.00	122.0
the Worksheet A line number where these taxes are included. 23.00 Did the facility and/or its subproviders (if applicable) purch services, e.g., legal, accounting, tax preparation, bookkeepir management/consulting services, from an unrelated organizatior for yes or "N" for no.	ng, payroll,	and/or			123.0
If column 1 is "Y", were the majority of the expenses, i.e., or professional services expenses, for services purchased from un located in a CBSA outside of the main hospital CBSA? In column "N" for no. Certified Transplant Center Information	related org	anizations			
25.00 Does this facility operate a Medicare-certified transplant cer		'Y" for yes	N		125.0
and "N" for no. If yes, enter certification date(s) (mm/dd/yyy 26.00 If this is a Medicare-certified kidney transplant program, ent		ification dat	te		126.0
in column 1 and termination date, if applicable, in column 2. 7.00 If this is a Medicare-certified heart transplant program, ente	er the certi	fication date	2		127.0
in column 1 and termination date, if applicable, in column 2. 28.00 If this is a Medicare-certified liver transplant program, ente	er the certi	fication date	2		128.0
in column 1 and termination date, if applicable, in column 2. 29.00 If this is a Medicare-certified lung transplant program, enter?	r the certif	ication date			129.0
in column 1 and termination date, if applicable, in column 2. 30.00 If this is a Medicare-certified pancreas transplant program, e		rtification			130.0
date in column 1 and termination date, if applicable, in colum 1.00 If this is a Medicare-certified intestinal transplant program.	, enter the o	certification	1		131.
date in column 1 and termination date, if applicable, in colum 32.00 If this is a Medicare-certified islet transplant program, ent		fication date	2		132.
in column 1 and termination date, if applicable, in column 2. 33.00 Removed and reserved 34.00 If this is a hospital-based organ procurement organization (OF		ne OPO number	~		133.0 134.0
in column 1 and termination date, if applicable, in column 2. All Providers					
0.00 Are there any related organization or home office costs as def chapter 10? Enter "Y" for yes or "N" for no in column 1. If ye are claimed, enter in column 2 the home office chain number.	es, and home	office costs	5 Y	15н046	140.
1.00 2.00			3.00	1	
If this facility is part of a chain organization, enter on lin home office and enter the home office contractor name and com		er.			141
1.00 Name:ASCENSION ST. VINCENTContractor's Name: WPS2.00 Street:250 WEST 96TH STREET SUITE 215PO Box:3.00 City:INDIANAPOLISState:			or's Number: 08		141. 142. 143.
3.00 City: INDIANAPOLIS  State: IN		Zip Code	- 40	5260	145.
				1.00	
4.00 Are provider based physicians' costs included in Worksheet A?				Y	144.
			1.00	2.00	-
5.00 If costs for renal services are claimed on Wkst. A, line 74, a inpatient services only? Enter "Y" for yes or "N" for no in co no, does the dialysis facility include Medicare utilization fo	olumn 1. If (	column 1 is			145.
period? Enter "Y" for yes or "N" for no in column 2. 6.00 Has the cost allocation methodology changed from the previous Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15- yes, enter the approval date (mm/dd/yyyy) in column 2.			F N		146.

Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	ASCENSION ST. V X IDENTIFICATION DATA	Provider CC	N: 15-1308	Period:		u of Form CMS Worksheet S-	
					/01/2022 /30/2023	Part I Date/Time Pr 11/22/2023 2	
						1.00	_
147.00 was there a change in the statist	cal basis? Enter "Y" for	yes or "N" for	no.			N	147.00
148.00 was there a change in the order of						N	148.00
149.00 was there a change to the simplif	ed cost finding method? En	nter "Y" for ye	es or "N" fo	or no.		N	149.00
		Part A	Part B		tle V	Title XIX	
		1.00	2.00		3.00	4.00	
Does this facility contain a prov or charges? Enter "Y" for yes or '							
L55.00 Hospital		N	N	. (566	N	N	155.00
156.00 Subprovider - IPF		N	N		N	N	156.00
157.00 Subprovider - IRF		N	N		N	N	157.00
158.00 SUBPROVIDER							158.00
159.00 SNF		N	N		N	N	159.00
160.00 HOME HEALTH AGENCY		N	N		N	N	160.00
L61.00 СМНС			N		N	N	161.00
						1.00	-
Multicampus						1.00	
L65.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	ampus hospital that has one	e or more campu	uses in dif	ferent CB	SAS?	N	165.00
	Name	County	State 2	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						0.0	0166.00
campus enter the name in column 0, county in column 1, state in							
column 2, zip code in column 3,							
CBSA in column 4, FTE/Campus in							
column 5 (see instructions)							
	L. L.						
uselah zefermatien zeeheeleen (uz	n du constitue du stre sucode		d Badayaata			1.00	
Health Information Technology (HI 167.00 Is this provider a meaningful user				ent Act		Y	167.00
168.00 If this provider is a CAH (line 10				') enter	the	1	168.00
reasonable cost incurred for the H			207 10 1	, encer			100.00
168.01 If this provider is a CAH and is r	not a meaningful user, does	s this provider			ship		168.01
exception under §413.70(a)(6)(ii)							
169.00 If this provider is a meaningful u		is not a CAH (	(line 105 is	s "N"), ei	nter the	0.0	00169.00
transition factor. (see instruction	ons)						_
					inning	Ending	-
170 00 setter in columns 1 and 2 the sup l	entering data and ending .				1.00	2.00	170.00
170.00 Enter in columns 1 and 2 the EHR b period respectively (mm/dd/yyyy)	eginning date and ending d	date for the re	eporting				170.00
					1.00	2.00	_
							0171.00
171.00 If line 167 is "Y", does this prov	ider have anv davs for ind	dividuals enrol	lled in		N		01/1.00

IOSPIT	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-1308	Period: From 07/01/2022 To 06/30/2023	Date/Time Pr	epared:
				Y/N	11/22/2023 2 Date	:20 pm
				1.00	2.00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSE General Instruction: Enter Y for all YES responses. Enter M mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS			er all dates in t	he	
.00	Provider Organization and Operation Has the provider changed ownership immediately prior to the			N		1.0
	reporting period? If yes, enter the date of the change in o	column 2. (see	Y/N	Date	V/I	
			1.00	2.00	3.00	1
.00	Has the provider terminated participation in the Medicare I yes, enter in column 2 the date of termination and in colur voluntary or "I" for involuntary.		N			2.0
.00	Is the provider involved in business transactions, includin contracts, with individuals or entities (e.g., chain home of or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members of of directors through ownership, control, or family and other relationships? (see instructions)	offices, drug der or its of the board	N			3.0
			Y/N	Туре	Date	
	stored a set and second		1.00	2.00	3.00	
.00	Financial Data and Reports Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" to or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	for Compiled, ailable in	Y	A		4.0
.00	Are the cost report total expenses and total revenues different those on the filed financial statements? If yes, submit reconcisional statements of the statement of the stateme		N			5.0
			1	Y/N 1.00	Legal Oper. 2.00	
.00	Approved Educational Activities Column 1: Are costs claimed for a nursing program? Column	2. Tf ves in	the provide	r N		6.0
.00	the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see in			N		7.0
.00	Were nursing programs and/or allied health programs approve cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved		-			8.0
0.00	program in the current cost report? If yes, see instruction was an approved Intern and Resident GME program initiated of	ns.		N		10.0
1.00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than : Teaching Program on Worksheet A? If yes, see instructions.	I & R in an App	proved	Ν		11.0
					Y/N 1.00	
2.00	Bad Debts Is the provider seeking reimbursement for bad debts? If yes	s, see instruct	tions.		Y	12.0
3.00	If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.	policy change of	during this c		N	13.0
4.00	If line 12 is yes, were patient deductibles and/or coinsura instructions. Bed Complement	ance amounts wa	aived? If yes	, see	N	14.0
5.00	Did total beds available change from the prior cost report				Y	15.0
			rt A		t B	
		Y/N 1.00	Date 2.00	Y/N 3.00	Date 4.00	
	PS&R Data	1				
5.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	10/06/2023	Y	10/06/2023	16.0
.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		Ν		17.0
3.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		Ν		18.0
9.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		Ν		19.0

Health	Financial	Systems
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In Lieu of Form CMS-2552-10

Health	Financial Systems ASCENSION ST.			In Lie	<u>u of Form CM</u>	<u>S-2552-10</u>		
HOSPIT	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-1308	Period: From 07/01/2022 To 06/30/2023		repared:		
		Descr	iption	Y/N	Y/N			
			0	1.00	3.00			
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	Ν	20.00		
		Y/N	Date	Y/N	Date			
		1.00	2.00	3.00	4.00			
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00		
					1.00			
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	EPT CHILDRENS H	OSPITALS)					
	Capital Related Cost							
22.00 23.00	Have assets been relifed for Medicare purposes? If yes, see Have changes occurred in the Medicare depreciation expense		sals made dur	ing the cost	N	22.00		
	reporting period? If yes, see instructions.			-				
24.00	Were new leases and/or amendments to existing leases enterous If yes, see instructions	ed into during	this cost re	porting period?	Ν	24.00		
25.00	Have there been new capitalized leases entered into during instructions.	the cost repo	rting period?	'If yes, see	Ν	25.00		
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the instructions.	he cost report	ing period? I	f yes, see	Ν	26.00		
27.00	Has the provider's capitalization policy changed during the copy.	e cost reporti	ng period? If	yes, submit	Ν	27.00		
	Interest Expense					28.00		
28.00	3.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.							
29.00	Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see inst	•	ebt Service R	eserve Fund)	Ν	29.00		
30.00								
31.00								
	Purchased Services							
32.00	Have changes or new agreements occurred in patient care se arrangements with suppliers of services? If yes, see instru		ed through co	ontractual	Ν	32.00		
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions.		ng to competi	tive bidding? If	Ν	33.00		
	Provider-Based Physicians							
34.00	Were services furnished at the provider facility under an a	arrangement wi	th provider-b	ased physicians?	Y	34.00		
35 00	If yes, see instructions. If line 34 is yes, were there new agreements or amended ex	isting agreemen	nts with the	provider-based	N	35.00		
55.00	physicians during the cost reporting period? If yes, see in					33.00		
				Y/N	Date			
	Home Office Costs			1.00	2.00			
36 00	Were home office costs claimed on the cost report?			Y		36.00		
	If line 36 is yes, has a home office cost statement been p	repared by the	home office?			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 If line 36 is yes, did the provider render services to othe			, N		39.00		
40.00	see instructions. If line 36 is yes, did the provider render services to the	home office?	If yes, see	Ν		40.00		
	instructions.							
	Cost Depart Departs Contact To formation	1	.00	2.	00			
41 00	Cost Report Preparer Contact Information	3711		11711		41.00		
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	JILL		HILL		41.00		
42.00	respectively. Enter the employer/company name of the cost report	ASCENSION				42.00		
43.00	preparer. Enter the telephone number and email address of the cost	(317) 583-3519	9	JILL.HILL1@ASC	ENSION.ORG	43.00		
	report preparer in columns 1 and 2, respectively.	I				II		

Health	Financial Systems ASCENSION ST.	VINCENT MERCY	In Lie	In Lieu of Form CMS-2552-			
HOSPIT	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1308	Period: From 07/01/2022 To 06/30/2023		pared:		
		3.00					
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title/position	MANAGER OF REIMBURSEMENT			41.00		
	held by the cost report preparer in columns 1, 2, and 3,						
	respectively.						
42.00	Enter the employer/company name of the cost report				42.00		
	preparer.						
43.00	Enter the telephone number and email address of the cost				43.00		
	report preparer in columns 1 and 2, respectively.						

		ASCENSION ST. V		N. 1E 1200	Period:	u of Form CMS-2 Worksheet S-3	
HOSPII	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CO	LN: 15-1308	From 07/01/2022		
					то 06/30/2023	Date/Time Pre	
						11/22/2023 2:	
						I/P Days / O/P Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH/REH Hours	Title V	
		Line No.		Available	,		
		1.00	2.00	3.00	4.00	5.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed. Observation Bed and	30.00	18	6,57	24,672.00	0	1.00
	Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation		18	6,57	24,672.00	0	7.00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	31.00	0		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	DETOXIFICATION INTENSIVE CARE UNIT	35.00	0		0.00	0	
13.00	NURSERY		10	C 53	24 672 00	0	13.00
14.00 15.00	Total (see instructions) CAH visits		18	6,57	24,672.00	0	14.00
15.10	REH hours and visits					0	15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						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						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00	10			0	
27.00	Total (sum of lines 14-26)		18			0	27.00
28.00	Observation Bed Days					0	20.00
29.00 30.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction) Employee discount days - IRF						30.00
32.00	Labor & delivery days (see instructions)		0		0		32.00
32.00	Total ancillary labor & delivery room		0		~		32.00
32.01	outpatient days (see instructions)						52.01
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		0	0	34.00

OSPIT	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC		Period: From 07/01/2022 To 06/30/2023	Worksheet S-3 Part I Date/Time Pre 11/22/2023 2:	pare
		I/P Days	/ O/P Visits	/ Trips	Full Time B	Equivalents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I - STATISTICAL DATA	· · · · · ·					
.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2	262	19	1,02	8		1.
	for the portion of LDP room available beds)						
.00	HMO and other (see instructions)	427	101				2.
.00	HMO IPF Subprovider	0	0				3.
.00	HMO IRF Subprovider	0	0				4.
.00	Hospital Adults & Peds. Swing Bed SNF	0	0	6			5.
.00	Hospital Adults & Peds. Swing Bed NF		0		0		6.
.00	Total Adults and Peds. (exclude observation	262	19	1,09	0		7.
	beds) (see instructions)				-		
.00	INTENSIVE CARE UNIT	0	0		0		8
.00	CORONARY CARE UNIT						9
0.00	BURN INTENSIVE CARE UNIT						10
1.00	SURGICAL INTENSIVE CARE UNIT						11
2.00	DETOXIFICATION INTENSIVE CARE UNIT	0	0		0		12
3.00	NURSERY						13
.00	Total (see instructions)	262	19	1,09		62.60	
5.00	CAH visits	5,094	397	30,98	6		15
.10	REH hours and visits						15
.00	SUBPROVIDER - IPF						16
.00	SUBPROVIDER - IRF						17
.00	SUBPROVIDER						18
.00	SKILLED NURSING FACILITY						19
.00	NURSING FACILITY						20
.00	OTHER LONG TERM CARE						21
.00	HOME HEALTH AGENCY						22
.00	AMBULATORY SURGICAL CENTER (D.P.)						23
.10	HOSPICE				0		24
.00	HOSPICE (non-distinct part) CMHC - CMHC				0		24
5.00							25
5.25	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER	0	0		0.00	0.00	
7.00		0	0		0.00	62.60	
3.00	Total (sum of lines 14-26) Observation Bed Days		0	23		02.00	28
.00	Ambulance Trips	0	0	25	4		20
		0			0		
0.00	Employee discount days (see instruction)				0		30
2.00	Employee discount days - IRF	~	0		0		31
	Labor & delivery days (see instructions)	0	0		0		
2.01	Total ancillary labor & delivery room				V		32
3.00	outpatient days (see instructions) LTCH non-covered days	0					33
3.00	LTCH non-covered days LTCH site neutral days and discharges	0					33
							1 33

OSPIT	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CO		Period: From 07/01/2022 To 06/30/2023	Worksheet S-3 Part I Date/Time Pre 11/22/2023 2:	pared
		Full Time		Disc	charges	11/22/2023 2.	
	Component	Equivalents Nonpaid	Title V	Title XVIII	Title XIX	Total All	
	component	Workers	THERE V			Patients	
		11.00	12.00	13.00	14.00	15.00	
00	PART I - STATISTICAL DATA			r	7	262	1 1 0
.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and		0	5	7 9	263	1.0
	Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)						
.00	HMO and other (see instructions)				8 23		2.0
.00	HMO IPF Subprovider			5	0 23		3.0
.00	HMO IPF Subprovider HMO IRF Subprovider				0		4.0
					0		1
.00	Hospital Adults & Peds. Swing Bed SNF						5.0
	Hospital Adults & Peds. Swing Bed NF						6.0
.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.
.00							8.
.00	INTENSIVE CARE UNIT						0. 9.
	CORONARY CARE UNIT						
0.00	BURN INTENSIVE CARE UNIT						10.
1.00	SURGICAL INTENSIVE CARE UNIT						11.
2.00	DETOXIFICATION INTENSIVE CARE UNIT						12.
3.00	NURSERY	0.00	0	-	7	262	13.
4.00	Total (see instructions)	0.00	0	5	7 9	263	
5.00	CAH visits						15.
5.10	REH hours and visits						15.
6.00	SUBPROVIDER - IPF						16.
7.00	SUBPROVIDER - IRF						17.
8.00	SUBPROVIDER						18.
9.00	SKILLED NURSING FACILITY						
0.00	NURSING FACILITY						20.
1.00	OTHER LONG TERM CARE						1
2.00	HOME HEALTH AGENCY						22.
3.00	AMBULATORY SURGICAL CENTER (D.P.)						23.
4.00	HOSPICE						24.
4.10	HOSPICE (non-distinct part)						24.
5.00	CMHC - CMHC						25.
6.00	RURAL HEALTH CLINIC	0.00					26.
6.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.
7.00	Total (sum of lines 14-26)	0.00					27.
8.00	Observation Bed Days						28.
9.00	Ambulance Trips						29.
0.00	Employee discount days (see instruction)						30.
1.00	Employee discount days - IRF						31.
2.00	Labor & delivery days (see instructions)						32.
2.01	Total ancillary labor & delivery room						32.
2 00	outpatient days (see instructions)						22
3.00	LTCH non-covered days				0		33.
3.01	LTCH site neutral days and discharges				0		33.

Health	Financial Systems ASCENSION ST. VIN	CENT MERCY		In Lie	eu of Form CMS-2	2552-10	
	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CC		Period:	Worksheet S-1	.0	
				From 07/01/2022	Date /Time Dra	nonod.	
				то 06/30/2023	Date/Time Pre 11/22/2023 2:	20 pm	
					1.00		
1 00	Uncompensated and indigent care cost computation		202 1	0)	0.266442	1 1 00	
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 di Medicaid (see instructions for each line)	Ivided by Iii	ne 202 column	8)	0.266442	1.00	
2.00	Net revenue from Medicaid				1,254,004	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 supplement	ntal payments	s from Medica	id?		4.00	
5.00	If line 4 is no, then enter DSH and/or supplemental payments f	From Medicai	d		0	5.00	
6.00	Medicaid charges				20,109,114		
7.00	Medicaid cost (line 1 times line 6)				5,357,913		
8.00	Difference between net revenue and costs for Medicaid program	(line 7 min	us sum of lin	es 2 and 5; if	4,103,909	8.00	
	< zero then enter zero)	ion oach lind				-	
9.00	Children's Health Insurance Program (CHIP) (see instructions f Net revenue from stand-alone CHIP	or each line	2)		0	9.00	
10.00					0		
11.00	Stand-alone CHIP cost (line 1 times line 10)				0		
12.00		(line 11 mi	nus line 9; i	f < zero then	0	•	
	enter zero)		,				
	Other state or local government indigent care program (see ins						
13.00	Net revenue from state or local indigent care program (Not inc				0		
14.00	Charges for patients covered under state or local indigent car	re program (I	Not included	in lines 6 or	0	14.00	
15.00	10) State or local indigent care program cost (line 1 times line 1	(4)			0	15.00	
16.00	Difference between net revenue and costs for state or local ir		program (lin	e 15 minus line			
20.00	13; if < zero then enter zero)	argene care	program (rm	e 10 minuto 111e	, i i i i i i i i i i i i i i i i i i i		
	Grants, donations and total unreimbursed cost for Medicaid, CH	IIP and state	e/local indig	ent care progra	ns (see	1	
47.00	instructions for each line)	<u> </u>	•.			1 4 - 00	
17.00	Private grants, donations, or endowment income restricted to f				0		
19.00				(sum of lines	4,103,909		
15.00	8, 12 and 16)	ar margene v	care programs	(3011 01 111163	4,105,505	15.00	
			Uninsured	Insured	Total (col. 1		
			patients	patients	+ col. 2)		
	the second state of the se		1.00	2.00	3.00		
20.00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire fa	cility	879,19	4 667,965	1,547,159	20.00	
20.00	(see instructions)	actificy	079,15	4 007,905	1, 547, 155	20.00	
21.00		ounts (see	234,25	4 667,965	902,219	21.00	
	instructions)		- , -	,			
22.00		n off as		0 0	0	22.00	
	charity care				000.010		
23.00	Cost of charity care (line 21 minus line 22)		234,25	4 667,965	902,219	23.00	
					1.00		
24.00	Does the amount on line 20 column 2, include charges for patie	ent days bevo	ond a length	of stav limit	N 1.00	24.00	
200	imposed on patients covered by Medicaid or other indigent care		ona a rengen	or ocay rimre		2	
25.00			care program	's length of	0	25.00	
	stay limit						
26.00					1,557,339		
27.00		294,958 453,781					
27.01	. Medicare allowable bad debts for the entire hospital complex (see instructions) Non-Medicare bad debt expense (see instructions)						
28.00		(nense (see ·	instructions		1,103,558 452,857		
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)				L,355.0/6	1 30.00	
	Total unreimbursed and uncompensated care (line 23 column 3 plus line 29)	line 30)			1,355,076 5,458,985		

Health	Financial Systems	ASCENSION ST. VI				u of Form CMS-	2552-10
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	F EXPENSES	Provider C		Period:	Worksheet A	
					From 07/01/2022 To 06/30/2023	Date/Time Pre	narod.
					10 00/30/2023	11/22/2023 2:	
	Cost Center Description	Salaries	Other	Total (col. 1	Reclassificati	Reclassified	
		Suru: 105	o chici	+ col. 2)	ons (See A-6)	Trial Balance	
						(col. 3 +-	
						col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS				-		
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT		1,293,263	1,293,26	3 0	1,293,263	1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP		436,687	436,68	7 0	436,687	2.00
3.00	00300 OTHER CAPITAL RELATED COSTS		0		0 0	0	
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	133,417	1,349,207	1,482,62		1,482,624	
5.00	00500 ADMINISTRATIVE & GENERAL	298,393	5,990,538			6,288,931	
7.00	00700 OPERATION OF PLANT	0	1,100,649	1,100,64		1,100,649	
8.00	00800 LAUNDRY & LINEN SERVICE	0	0		0 47,147	47,147	
9.00	00900 HOUSEKEEPING	0	610,442	610,44	· · · ·	563,295	
10.00	01000 DIETARY	0	494,465	494,46		57,980	
11.00	01100 CAFETERIA	0	0		0 436,485	436,485	
13.00	01300 NURSING ADMINISTRATION	61,511	8,698	70,20		70,209	
15.00	01500 PHARMACY	295,468	2,720,231	3,015,69		3,015,498	
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0		0 0	0	
17.00	01700 SOCIAL SERVICE	74,277	49,826	124,10	3 0	124,103	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	783,855	314,799			1,098,462	
31.00	03100 INTENSIVE CARE UNIT	0	0		0 0	0	
35.00	02040 DETOXIFICATION INTENSIVE CARE UNIT	0	0		0 0	0	35.00
	ANCILLARY SERVICE COST CENTERS	474 000	204.000	0.05 .00		242 572	
50.00	05000 OPERATING ROOM	471,086	394,609				
54.00	05400 RADIOLOGY-DIAGNOSTIC	878,130	99,671	977,80	1 -2,725	975,076	1
56.00	05600 RADIOISOTOPE	0	0		0 0	0	
57.00	05700 CT SCAN	0	0		0 0	0	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	1 250 210	1 250 21	0 0	0	
60.00	06000 LABORATORY	0	1,358,319			1,358,319	
65.00	06500 RESPIRATORY THERAPY	584,715	20,306			605,021	
66.00	06600 PHYSICAL THERAPY	16,555	573,144			589,699	
67.00	06700 OCCUPATIONAL THERAPY	4,078	78,016			82,094	
68.00		3,446	23,136	26,58	2 0	26,582	
69.00 70.00	06900 ELECTROCARDIOLOGY	0	0		0 0	0	
70.00	07000 ELECTROENCEPHALOGRAPHY	0	62 210	62 21	0 671,068	-	
72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPLANTABLE DEVICES CHARGED TO	0	62,310 450,097			733,378	1
72.00	PATIENTS	0	430,097	450,09	/ 0	450,097	/2.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	2,120	2,12	0 0	2,120	73.00
76.00	03610 SLEEP LAB	19,258	603			19,861	
76.01	03480 ONCOLOGY	227,164	36,406	· · · ·		263,570	
70.01	OUTPATIENT SERVICE COST CENTERS	227,104	50,400	205,57	0 0	205,570	10.01
90.00	09000 CLINIC	277,238	32,681	309,91	9 -9.647	300,272	90.00
91.00	09100 EMERGENCY	1,202,052	1,189,271	· · · ·	,	,	1
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1,202,032	1,105,271	2,331,32	5 0,100	2,505,145	92.00
52.00	SPECIAL PURPOSE COST CENTERS	I					52.00
118.00		5,330,643	18,689,494	24,020,13	7 0	24,020,137	118 00
110.00	NONREIMBURSABLE COST CENTERS	5,550,015	10,000,101	21,020,15		21,020,137	110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190.00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0		0 0		192.00
	07950 MARKETING	0	0		0 0		194.00
	07951 FOUNDATION	0	0		0 0		194.01
	07952 CLINIC	0	0		0 0		194.02
	07953 VACANT	ő	0		0 0		194.03
200.00		5,330,643	18,689,494	24,020,13	· · ·		
	····· (···· ··· ······················	-,,	,,,	, 020,20		, 020,207	

RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	F EXPENSES	Provider CCN	1: 15-1308	Period: From 07/01/2022 To 06/30/2023	Worksheet A Date/Time Pr	enared:
	Cost Conton Description	Adjustmonts	Not Exponsos			11/22/2023 2	
	Cost Center Description		Net Expenses For Allocation				
		6.00	7.00				
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	-149,364	1,143,899				1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP	0	436,687				2.00
3.00	00300 OTHER CAPITAL RELATED COSTS	0	0				3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	105,709	1,588,333				4.00
5.00	00500 ADMINISTRATIVE & GENERAL	-1,167,962	5,120,969				5.00
7.00	00700 OPERATION OF PLANT	1,107,502	1,100,649				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	47,147				8.00
9.00	00900 HOUSEKEEPING	0	563,295				9.00
10.00	01000 DIETARY	0					10.00
		60 867	57,980				
11.00	01100 CAFETERIA	-60,867	375,618				11.00
13.00	01300 NURSING ADMINISTRATION	-2,380	67,829				13.00
15.00		-30,005	2,985,493				15.00
16.00		0	0				16.00
17.00		0	124,103				17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	-258,400	840,062				30.00
31.00	03100 INTENSIVE CARE UNIT	0	0				31.00
35.00	02040 DETOXIFICATION INTENSIVE CARE UNIT	0	0				35.00
	ANCILLARY SERVICE COST CENTERS		· · · · ·				
50.00	05000 OPERATING ROOM	0	213,572				50.00
54.00		-49,554	925,522				54.00
56.00		0	0				56.00
57.00		0	0				57.00
58.00		0	0				58.00
60.00	06000 LABORATORY	0	1,358,319				60.00
65.00		0	605,021				65.00
66.00	06600 PHYSICAL THERAPY	0	589,699				66.00
		0					
67.00		0	82,094				67.00
68.00	06800 SPEECH PATHOLOGY	0	26,582				68.00
69.00		0	0				69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	-71,301	662,077				71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO	0	450,097				72.00
	PATIENTS						
73.00		0	2,120				73.00
76.00		0	19,861				76.00
76.01	03480 ONCOLOGY	0	263,570				76.01
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	300,272				90.00
91.00	09100 EMERGENCY	0	2,385,143				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS						
118.00		-1,684,124	22,336,013				118.00
	NONREIMBURSABLE COST CENTERS	_,,.	,:::,:::				
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190.00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0				192.00
	007950 MARKETING	0	0				192.00
		0	-				
		0	0				194.0
	2 07952 CLINIC	0	0				194.02
	3 07953 VACANT	0	0				194.03
	) TOTAL (SUM OF LINES 118 through 199)	-1,684,124	22,336,013				200.00

Health	Financial Systems		ASCENSION ST.	VINCENT MERCY		In Lie	u of Form CMS-	-2552-10
RECLAS	SIFICATIONS			Provider C	CN: 15-1308	Period: From 07/01/2022 To 06/30/2023	Worksheet A- Date/Time Pro 11/22/2023 2	epared:
		Increases						
	Cost Center	Line #	Salary	Other				
	2.00	3.00	4.00	5.00				
	A - CAFETERIA							
1.00	CAFETERIA	11.00	0	436,485				1.00
	TOTALS		0	436,485				
	B – Laundry							1
1.00	LAUNDRY & LINEN SERVICE	8.00		47,147				1.00
			0	47,147				
	D - Billable Med Supplies							1
1.00	MEDICAL SUPPLIES CHARGED TO	71.00		671,068				1.00
	PATIENTS							
2.00								2.00
3.00								3.00
4.00								4.00
5.00								5.00
6.00								6.00
			0	671,068				
500.00	Grand Total: Increases		0	1,154,700				500.00

Health	Financial Systems		ASCENSION ST.	VINCENT MERCY		In Lieu of Form CMS-25		
RECLAS	SIFICATIONS	ATIONS Provider CC		CCN: 15-1308	Period: From 07/01/2022 To 06/30/2023		epared:	
		Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref	·.		
	6.00	7.00	8.00	9.00	10.00			
	A - CAFETERIA							
1.00	DIETARY	10.00	0	436,485	5	0		1.00
	TOTALS		0	436,485	5			
	B – Laundry	· · · · · · · · · · · · · · · · · · ·						
1.00	HOUSEKEEPING	9.00		47,147	7			1.00
		1	0	47,147	7	7		
	D - Billable Med Supplies			· · ·				
1.00	PHARMACY	15.00		201	L			1.00
2.00	ADULTS & PEDIATRICS	30.00		192	2			2.00
3.00	OPERATING ROOM	50.00		652,123	3			3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00		2,725	5			4.00
5.00	EMERGENCY	91.00		6,180				5.00
6.00	CLINIC	90.00		9,647				6.00
			0	671,068		1		
500.00	Grand Total: Decreases		0	1,154,700				500.00

Health	Financial Systems	ASCENSION ST. V	INCENT MERCY		_	In Lie	u of Form CMS-2	2552-10
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provider CO	Provider CCN: 15-1308		riod: om 07/01/2022 06/30/2023		pared:
			Acquisitions		15			
		Beginning	Purchases	Donation		Total	Disposals and	
		Balances					Retirements	
		1.00	2.00	3.00		4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET							
1.00	Land	465,381	0		0	0	0	1.00
2.00	Land Improvements	821,276	0		0	0	0	2.00
3.00	Buildings and Fixtures	13,353,069	0		0	0	0	3.00
4.00	Building Improvements	9,930,186	367,460		0	367,460	0	4.00
5.00	Fixed Equipment	4,532,699	144,249		0	144,249	0	5.00
6.00	Movable Equipment	8,023,060	0		0	0	1,051,993	6.00
7.00	HIT designated Assets	0	0		0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	37,125,671	511,709		0	511,709	1,051,993	8.00
9.00	Reconciling Items	0	0		0	0	0	9.00
10.00	Total (line 8 minus line 9)	37,125,671	511,709		0	511,709	1,051,993	10.00
		Ending Balance	Fully				· · ·	
		-	Depreciated					
			Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	BALANCES						
1.00	Land	465,381	0					1.00
2.00	Land Improvements	821,276	0					2.00
3.00	Buildings and Fixtures	13,353,069	0					3.00
4.00	Building Improvements	10,297,646	0					4.00
5.00	Fixed Equipment	4,676,948	0					5.00
6.00	Movable Equipment	6,971,067	0					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	36,585,387	0					8.00
9.00	Reconciling Items	0	0					9.00
10.00	Total (line 8 minus line 9)	36,585,387	0					10.00

Health	Financial Systems	ASCENSION ST. \	VINCENT MERCY		In Lieu of Form CMS-2552-1			
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provider C		Period:	Worksheet A-7		
					From 07/01/2022 Fo 06/30/2023		narodi	
					10 00/30/2023	11/22/2023 2:		
			SL	JMMARY OF CAPI	TAL			
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see			
					instructions)	,		
		9.00	10.00	11.00	12.00	13.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORK							
1.00	NEW CAP REL COSTS-BLDG & FIXT	900,781		392,25	3 0	229		
2.00	NEW CAP REL COSTS-MVBLE EQUIP	369,086	67,601		0 0	0	2.00	
3.00	Total (sum of lines 1-2)	1,269,867	67,601	392,25	3 0	229	3.00	
		SUMMARY O	F CAPITAL					
	Cost Center Description		Total (1) (sum					
		Capital-Relate						
		d Costs (see	through 14)					
		instructions)						
		14.00	15.00					
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1,293,263				1.00	
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	436,687				2.00	
3.00	Total (sum of lines 1-2)	0	1,729,950				3.00	

Health Financial Systems	ASCENSION ST. \	VINCENT MERCY		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider Co	CN: 15-1308	Period: From 07/01/2022 To 06/30/2023	Worksheet A-7 Part III Date/Time Prep 11/22/2023 2:2	pared:
	COME	PUTATION OF RAT	TIOS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capitalized	Gross Assets		Insurance	
		Leases	for Ratio	instructions)		
			(col. 1 - col			
	1.00	2.00	2)	4.00	5.00	
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS		0	20 (14 2)	0 000450	0	1 00
1.00 NEW CAP REL COSTS-BLDG & FIXT 2.00 NEW CAP REL COSTS-MVBLE EQUIP	29,614,320		29,614,32		0	1.00 2.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)	6,971,067		6,971,06		0	
3.00   Iotal (sum of lines 1-2)	36,585,387		36,585,38		· · · · · · · · · · · · · · · · · · ·	3.00
	ALLOCA	TION OF OTHER O	CAPITAL	SUMMARY U	F CAPITAL	
Cost Center Description	Taxes	Other	Total (sum o	f Depreciation	Lease	
		Capital-Relate	cols. 5			
		d Costs	through 7)			
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS	CENTERS					
1.00 NEW CAP REL COSTS-BLDG & FIXT	0	0		0 900,781	0	1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	0	0		0 369,086	67,601	2.00
3.00 Total (sum of lines 1-2)	0	0		0 1,269,867	67,601	3.00
		SU	JMMARY OF CAP	ITAL		
Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
		instructions)		) Capital-Relate		
				d Costs (see	through 14)	
				instructions)	J ,	
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS	CENTERS					
1.00 NEW CAP REL COSTS-BLDG & FIXT	242,889	0	22	29 0	1,143,899	1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	0	0		0 0	436,687	2.00

	Financial Systems MENTS TO EXPENSES				Period: From 07/01/2022	Worksheet A-8	2552-10
					To 06/30/2023	Date/Time Pre 11/22/2023 2::	
				Expense Classification of To/From Which the Amount is			
	Cost Center Description	Basis/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Line # 4.00	Wkst. A-7 Ref. 5.00	
00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	В	-146,584	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter		C	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
0	2) Investment income - other	В	-5,113	ADMINISTRATIVE & GENERAL	5.00	0	3.00
0	(chapter 2) Trade, quantity, and time discounts (chapter 8)		C		0.00	0	4.00
0	Refunds and rebates of		C		0.00	0	5.00
0	expenses (chapter 8) Rental of provider space by		C		0.00	0	6.00
C	suppliers (chapter 8) Telephone services (pay stations excluded) (chapter	В	-12,383	ADMINISTRATIVE & GENERAL	5.00	0	7.00
)	21) Television and radio service		C		0.00	0	8.00
0 00	(chapter 21) Parking lot (chapter 21) Provider-based physician	A-8-2	0 -307,954		0.00	0 0	9.00 10.00
00	adjustment Sale of scrap, waste, etc.		C		0.00	0	11.00
00	(chapter 23) Related organization	A-8-1	601,059			0	12.00
00	transactions (chapter 10) Laundry and linen service		C		0.00	0	
0 0	Cafeteria-employees and guests Rental of quarters to employee and others	В	-60,867 C	CAFETERIA	11.00 0.00	0 0	
0	Sale of medical and surgical supplies to other than		C		0.00	0	16.00
0	patients Sale of drugs to other than patients	В	-30,005	PHARMACY	15.00	0	17.00
0	Sale of medical records and abstracts		C		0.00	0	18.00
0	Nursing and allied health education (tuition, fees,		C		0.00	0	19.00
00	books, etc.) Vending machines		C		0.00	0	
0	Income from imposition of interest, finance or penalty charges (chapter 21)		C		0.00	0	21.00
0	Interest expense on Medicare overpayments and borrowings to		C		0.00	0	22.00
0	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	C	RESPIRATORY THERAPY	65.00		23.00
0	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	C	PHYSICAL THERAPY	66.00		24.00
0	limitation (chapter 14) Utilization review - physicians' compensation		C	*** Cost Center Deleted ***	114.00		25.00
0	(chapter 21) Depreciation - NEW CAP REL		C	NEW CAP REL COSTS-BLDG &	1.00	0	26.00
00	COSTS-BLDG & FIXT Depreciation - NEW CAP REL		C	FIXT NEW CAP REL COSTS-MVBLE	2.00	0	27.00
0	COSTS-MVBLE EQUIP Non-physician Anesthetist		C	EQUIP *** Cost Center Deleted ***			28.00
00 00	Physicians' assistant Adjustment for occupational therapy costs in excess of	A-8-3	C C	OCCUPATIONAL THERAPY	0.00 67.00	0	29.00 30.00
99	limitation (chapter 14) Hospice (non-distinct) (see		C	ADULTS & PEDIATRICS	30.00		30.99
00	instructions) Adjustment for speech pathology costs in excess of	A-8-3	C	SPEECH PATHOLOGY	68.00		31.00

Health	Financial Systems		ASCENSION ST.	VINCENT MERCY	In Lie	u of Form CMS-2	2552-10
ADJUST	MENTS TO EXPENSES			Provider CCN: 15-1308	Period:	Worksheet A-8	
					From 07/01/2022 To 06/30/2023		
				Expense Classification of			
				To/From Which the Amount i	s to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
32.00	CAH HIT Adjustment for		0		0.00	0	32.00
	Depreciation and Interest						
33.00	Admin Revenue	В	-36	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.06	Lobbying	A	-510	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.11	Med Affairs Admin	A	-17,452	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	Provider Tax	A	-1,575,182	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	Advertising	A	-2,100	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.16	Physician Fund Expense	A	-126,997	ADMINISTRATIVE & GENERAL	5.00	0	33.16
50.00	TOTAL (sum of lines 1 thru 49)		-1,684,124				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

Health	Financial Systems	ASCENSION ST.	VINCENT MERCY	In Lie	eu of Form CMS-	2552-10
STATEM	ENT OF COSTS OF SERVICES FROM COSTS	RELATED ORGANIZATIONS AND HO	ME Provider CCN: 15-1308	Period: From 07/01/2022 To 06/30/2023		pared:
	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTM HOME OFFICE COSTS:	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED O	RGANIZATIONS OR	CLAIMED	
1.00	5.00	ADMINISTRATIVE & GENERAL	Home Office - Capital	277,922	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	Home Office - Interest	10,405	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	Home Office - Other	3,387,978	3,069,433	3.00
3.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	SVH CHARGEBACKS	2,751	2,751	3.01
3.02	15.00	PHARMACY	SVH CHARGEBACKS	4,000	4,000	3.02
3.03	54.00	RADIOLOGY-DIAGNOSTIC	SVH CHARGEBACKS	11,004	11,004	3.03
3.04		RESPIRATORY THERAPY	SVH CHARGEBACKS	3,744		3.04
3.05	91.00	EMERGENCY	SVH CHARGEBACKS	13,100	13,100	3.05
3.06	4.00	EMPLOYEE BENEFITS DEPARTMENT	Health Insurance	836,732	731,023	3.06
3.07	1.00	NEW CAP REL COSTS-BLDG & FIX	Interest Expense	389,473	392,253	3.07
3.08	5.00	ADMINISTRATIVE & GENERAL	Interest Expense	3,179	0	3.08
3.09		MEDICAL SUPPLIES CHARGED TO	TRG Admin Fees - Supplies	-71,301	0	3.09
3.10		NURSING ADMINISTRATION	TRG Admin Fees - Contracted	-2,380		3.10
3.11		ADMINISTRATIVE & GENERAL	TRG Admin Fees - Other	-38,240	0	3.11
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			4,828,367	4,227,308	5.00

\* 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.

1145 1100	been posted to worksheet A,	corumns i unu/or 2, che umou	ic arrowable si	ourd be marcated in corumn 4	or this part.	
				Related Organization(s) and/	or Home Office	
	Symbol (1)	Name	Percentage of	Name	Percentage of	
			Ownership		Ownership	
	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.

i c mour	Semerre under crere Aviiii					
6.00	G	ASCENSION SVH	1.00	ASCENSION SVH	1.00	6.00
7.00	G	ASCENSION	1.00	ASCENSION	1.00	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	HOME OFFICE				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.

Health Financial Systems	ASCENSION ST. VIN	CENT MERCY	In Lie	u of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES I	FROM RELATED ORGANIZATIONS AND HOME	Provider CCN: 15-1308	Period: From 07/01/2022	Worksheet A-8-1
				Date/Time Prepared:

					11/22/2023 2:	20 pm
	Net	Wkst. A-7 Ref.				
	Adjustments					
	(col. 4 minus					
	col. 5)*					
	6.00	7.00				
			ENTS REQUIRED AS A RESULT OF	RANSACTIONS WITH RELATED O	RGANIZATIONS OR CLAIMED	
	HOME OFFICE CO					
1.00	277,922					1.00
2.00	10,405					2.00
3.00	318,545					3.00
3.01	0	0				3.01
3.02		0				3.02
3.02		0				3.03
3.03	0	0				
	0	0				3.04
3.05	0	0				3.05
3.06	105,709					3.06
3.07	-2,780					3.07
3.08	3,179	0				3.08
3.09	-71,301	0				3.09
3.10	-2,380	0				3.10
3.11	-38,240	0				3.11
4.00	0	0				4.00
5.00	601,059					5.00

\* 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.

nas not	been posted to worksheet A,	COTUMITS I a	10/01 <sup>-</sup> 2	, the	amount	allowable	Should	be	Indicated	In column	4 01	this part.	
	Related Organization(s)												
	and/or Home Office												
	Type of Business												
	6.00												
	B. INTERRELATIONSHIP TO RELA	TED ORGANIZA	TION(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.

rembur	Sement under erere Aviii.	
6.00	ADMINISTRATION	6.00
7.00	ADMINISTRATION	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.

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 Syste	ems	ASCENSION ST.	VINCENT MERCY		In Lie	eu of Form CMS-	2552-10
PROVIDE	R BASED PHYSIC	IAN ADJUSTMENT		Provider C	CN: 15-1308	Period: From 07/01/2022 To 06/30/2023	B Date/Time Pre	epared:
	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	11/22/2023 2: Physician/Prov ider Component Hours	20 pm
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00		ADULTS & PEDIATRICS	258,400	258,400		0.00		1.00
2.00		RADIOLOGY-DIAGNOSTIC	49,554	49,554			-	2.00
3.00		EMERGENCY	1,012,599	0	1,012,59	-	0	3.00
4.00	0.00	Energener	1,012,555	0	1,012,00		0	4.00
5.00	0.00		0	ů 0			0	5.00
6.00	0.00		0	0			0	6.00
7.00	0.00		0	0			0	7.00
8.00	0.00		0	0			0	8.00
9.00	0.00		0	0			0	9.00
10.00	0.00		0	0			0	10.00
200.00	0.00		1,320,553	307,954	1,012,59		0	
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provider	Physician Cost	200.00
	WKSL. A LINE #	Identifier		Unadjusted RCE			of Malpractice	
		Identifier	LIMIT	Limit	Continuing	Share of col.	Insurance	
				LIMIC	Education	12	Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00		ADULTS & PEDIATRICS	0	0		0 0		1.00
2.00		RADIOLOGY-DIAGNOSTIC	0	0			0	2.00
3.00		EMERGENCY	0	Ő			0	3.00
4.00	0.00		0	0			0	4.00
5.00	0.00		0	ů 0			0	
6.00	0.00		0	ů 0			0	6.00
7.00	0.00		0	ů 0			0	7.00
8.00	0.00		0	0			0	8.00
9.00	0.00		0	0			0	9.00
10.00	0.00		0	0			0	
200.00	0.00		0	0			0	
	Wkst. A Line #	Cost Center/Physician	Provider	Adjusted RCE	RCE	Adjustment	0	200.00
	WRSC. A LINE $\pi$	Identifier	Component	Limit	Disallowance	Aujustillerit		
		Identifier	Share of col.	LIMIC	DISallowance			
			14					
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00		ADULTS & PEDIATRICS	0	0		258,400		1.00
2.00		RADIOLOGY-DIAGNOSTIC	0	0		49,554		2.00
3.00		EMERGENCY	0	0		0 0		3.00
4.00	0.00		0	0 0				4.00
5.00	0.00		0	0				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		0	0				9.00
10.00	0.00		0	0				10.00
200.00	0.00		0	0		307,954		200.00
200.00			1 0	0	,	507,954	1	200.00

	NABLE COST DETERMINATION FOR THERAPY SERVICES DE SUPPLIERS	FURNISHED BY	Provider CC	CN: 15-1308	Period: From 07/01/2022 To 06/30/2023	Worksheet A-8 Parts I-VI Date/Time Pre 11/22/2023 2::	pared
					Physical Therapy		
						1.00	
	PART I - GENERAL INFORMATION					1.00	
.00	Total number of weeks worked (excluding aides	s) (see instruc	tions)			50	1.0
.00	Line 1 multiplied by 15 hours per week	on on thoronto	+ was on provi	dan sita (se	, instructions)	750	2.
.00 .00	Number of unduplicated days in which supervis Number of unduplicated days in which therapy					178	-
.00	nor therapist was on provider site (see inst		on provider Si		supervisor	1/0	
.00	Number of unduplicated offsite visits - super					0	5.
.00	Number of unduplicated offsite visits - thera assistant and on which supervisor and/or the					0	6.
	instructions)	apist was not	present during	the visit(s	(see		
.00	Standard travel expense rate					9.57	7.
.00	Optional travel expense rate per mile					0.00	8.
		Supervisors 1.00	Therapists 2.00	Assistants 3.00	Aides 4.00	Trainees 5.00	
.00	Total hours worked	2,047.00					9.
0.00	AHSEA (see instructions)	110.02	95.67	62.	19 0.00	0.00	10.
1.00		47.84	47.84	31.	10		11.
	one-half of column 2, line 10; column 3, one-half of column 3, line 10)						
2.00		0	0		0		12.
2.01		0	0		0		12
	Number of miles driven (provider site)	0	0		0		13
3.01	Number of miles driven (offsite)	0	0		0		13
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
1.00	, , , , , , , , , , , , , , , , , , , ,					225,211	
5.00						161,587 229,979	
7.00			ratory therapy	or lines 14	-16 for all	616,777	
	others)	10 10 101 10501	racory enerupy	or rines 1	10 101 411	010,777	
3.00						0	18
9.00				a. 17 and 10	fer all athemal	0	19
0.00	Total allowance amount (sum of lines 17-19 for If the sum of columns 1 and 2 for respiratory						20
	occupational therapy, line 9, is greater than						
				innes ZI and	22 and enter on		
	the amount from line 20. Otherwise complete					line 23	
1.00	Weighted average rate excluding aides and tra	ainees (line 17	divided by su				21.
	Weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3,	ainees (line 17 line 9 for all	divided by su others)			1ine 23	
2.00	Weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and trained	ainees (line 17 line 9 for all	divided by su others)			line 23	22
2.00	Weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW	ainees (line 17 line 9 for all ees (line 2 tim	divided by su others) es line 21)	m of columns	1 and 2, line 9	1ine 23 0.00 0	22
2.00 3.00	Weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance	ainees (line 17 line 9 for all ees (line 2 tim	divided by su others) es line 21)	m of columns	1 and 2, line 9	<b>1ine 23</b> 0.00 0 616,777	22 23
2.00 3.00 4.00	Weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11)	ainees (line 17 line 9 for all ees (line 2 tim	divided by su others) es line 21)	m of columns	1 and 2, line 9	1ine 23 0.00 0 616,777 2,153	22 23 24
2.00 3.00 4.00 5.00	Weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11)	ainees (line 17 line 9 for all ees (line 2 tim MANCE AND TRAVE	divided by su others) les line 21) L EXPENSE COMP	m of columns UTATION – PR	1 and 2, line 9	<b>1ine 23</b> 0.00 616,777 2,153 5,536	22 23 24 25
2.00 3.00 4.00 5.00	Weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11)	ainees (line 17 line 9 for all ees (line 2 tim AANCE AND TRAVE sum of lines 2	divided by su others) les line 21) L EXPENSE COMP 4 and 25 for a	m of columns UTATION - PR	ovider Site	1ine 23 0.00 0 616,777 2,153	22 23 24 25 26
2.00 3.00 4.00 5.00 5.00 7.00	Weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others)	ainees (line 17 line 9 for all ees (line 2 tim MANCE AND TRAVE sum of lines 2 for respirator	divided by su others) les line 21) L EXPENSE COMP 4 and 25 for a y therapy or s	m of columns UTATION - PR 11 others) um of lines	<b>OVIDER SITE</b> 3 and 4 for all	<b>1 ine 23</b> 0.00 0 616,777 2,153 5,536 7,689 2,134	22 23 24 25 26 27
2.00 3.00 4.00 5.00 5.00 7.00	Weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traine Total salary equivalency (see instructions) <b>PART III - STANDARD AND OPTIONAL TRAVEL ALLOW</b> <b>Standard Travel Allowance</b> Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard	ainees (line 17 line 9 for all ees (line 2 tim MANCE AND TRAVE sum of lines 2 for respirator	divided by su others) les line 21) L EXPENSE COMP 4 and 25 for a y therapy or s	m of columns UTATION - PR 11 others) um of lines	<b>OVIDER SITE</b> 3 and 4 for all	<b>1 ine 23</b> 0.00 0 616,777 2,153 5,536 7,689 2,134	22 23 24 25 26 27
2.00 3.00 5.00 5.00 7.00 3.00	Weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel	ainees (line 17 line 9 for all es (line 2 tim ANCE AND TRAVE sum of lines 2 for respirator travel expense Expense	divided by su others) les line 21) L EXPENSE COMP 4 and 25 for a y therapy or s at the provid	m of columns UTATION - PR 11 others) um of lines	<b>OVIDER SITE</b> 3 and 4 for all	1ine 23 0.00 0 616,777 2,153 5,536 7,689 2,134 9,823	22 23 24 25 26 27 28
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2.00 3.00 4.00 5.00 5.00 7.00 8.00 9.00 0.00	Weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 3, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3,	ainees (line 17 line 9 for all es (line 2 tim ANCE AND TRAVE sum of lines 2 for respirator travel expense <u>Expense</u> of columns 1 an , line 12)	divided by su others) les line 21) L EXPENSE COMP 4 and 25 for a y therapy or s at the provid d 2, line 12 )	m of columns UTATION - PR 11 others) um of lines er site (sum	<b>OVIDER SITE</b> 3 and 4 for all	line 23 0.00 0 616,777 2,153 5,536 7,689 2,134 9,823 0 0 0	22 23 24 25 26 27 28 28 29 30
2.00 3.00 4.00 5.00 5.00 7.00 3.00 3.00 9.00 0.00 L.00	Weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traine Total salary equivalency (see instructions) <b>PART III - STANDARD AND OPTIONAL TRAVEL ALLOW</b> <b>Standard Travel Allowance</b> Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) <b>Optional Travel Allowance and Optional Travel</b> Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or	ainees (line 17 line 9 for all ees (line 2 tim ANCE AND TRAVE sum of lines 2 for respirator travel expense Expense of columns 1 an , line 12) sum of lines 2	divided by su others) les line 21) <b>L EXPENSE COMP</b> 4 and 25 for a y therapy or s at the provid d 2, line 12 ) 9 and 30 for a	m of columns UTATION - PR 11 others) um of lines er site (sum 11 others)	1 and 2, line 9 OVIDER SITE 3 and 4 for all 1 of lines 26 and	<b>1 ine 23</b> 0.00 0 616,777 2,153 5,536 7,689 2,134 9,823 0 0 0 0 0	22 23 24 25 26 27 28 29 30 31
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 9.00 0.00 1.00 2.00	<pre>Weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns)</pre>	ainees (line 17 line 9 for all ees (line 2 tim ANCE AND TRAVE sum of lines 2 for respirator travel expense Expense of columns 1 an , line 12) sum of lines 2	divided by su others) les line 21) <b>L EXPENSE COMP</b> 4 and 25 for a y therapy or s at the provid d 2, line 12 ) 9 and 30 for a	m of columns UTATION - PR 11 others) um of lines er site (sum 11 others)	1 and 2, line 9 OVIDER SITE 3 and 4 for all 1 of lines 26 and	line 23 0.00 0 616,777 2,153 5,536 7,689 2,134 9,823 0 0 0	22 23 24 25 26 27 28 29 30 31
2.00 3.00 4.00 5.00 5.00 7.00 3.00 3.00 9.00 0.00 L.00	<pre>Weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel</pre>	ainees (line 17 line 9 for all ees (line 2 tim AANCE AND TRAVE sum of lines 2 for respirator travel expense Expense of columns 1 an , line 12) sum of lines 2 s 1 and 2, line l expense (line	divided by su others) les line 21) L EXPENSE COMP 4 and 25 for a y therapy or s at the provid d 2, line 12 ) 9 and 30 for a 13 for respir	m of columns UTATION - PR 11 others) um of lines er site (sun 11 others) atory therap	1 and 2, line 9 OVIDER SITE 3 and 4 for all 1 of lines 26 and	<b>1 ine 23</b> 0.00 0 616,777 2,153 5,536 7,689 2,134 9,823 0 0 0 0 0	22 23 24 25 26 27 28 30 31 32 33
2.00 3.00 5.00 5.00 7.00 3.00 9.00 1.00 2.00 3.00	<pre>Weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave</pre>	ainees (line 17 line 9 for all es (line 2 tim ANCE AND TRAVE sum of lines 2 for respirator travel expense Expense of columns 1 an , line 12) sum of lines 2 s 1 and 2, line l expense (line expense (sum	divided by su others) les line 21) L EXPENSE COMP 4 and 25 for a y therapy or s at the provid d 2, line 12 ) 9 and 30 for a 13 for respir 28) of lines 27 an	m of columns UTATION - PR 11 others) um of lines er site (sum 11 others) atory therap d 31)	1 and 2, line 9 OVIDER SITE 3 and 4 for all 1 of lines 26 and	1ine 23 0.00 0 616,777 2,153 5,536 7,689 2,134 9,823 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34.
	<pre>Weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3; Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and standard trave</pre>	ainees (line 17 line 9 for all es (line 2 tim ANCE AND TRAVE sum of lines 2 for respirator travel expense Expense of columns 1 an , line 12) sum of lines 2 s 1 and 2, line l expense (line expense (sum expense (sum	divided by su others) les line 21) L EXPENSE COMP 4 and 25 for a y therapy or s at the provid d 2, line 12 ) 9 and 30 for a 13 for respir 28) of lines 27 an of lines 31 an	m of columns UTATION - PR Il others) um of lines er site (sum ll others) atory therap d 31) d 32)	1 and 2, line 9 OVIDER SITE 3 and 4 for all 1 of lines 26 and 1 y or sum of	line 23 0.00 0 616,777 2,153 5,536 7,689 2,134 9,823 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	22 23 24 25 26 27 28 29 30 31 32 33 34
	<pre>Weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and optional trave</pre>	ainees (line 17 line 9 for all es (line 2 tim ANCE AND TRAVE sum of lines 2 for respirator travel expense Expense of columns 1 an , line 12) sum of lines 2 s 1 and 2, line l expense (line expense (sum expense (sum	divided by su others) les line 21) L EXPENSE COMP 4 and 25 for a y therapy or s at the provid d 2, line 12 ) 9 and 30 for a 13 for respir 28) of lines 27 an of lines 31 an	m of columns UTATION - PR Il others) um of lines er site (sum ll others) atory therap d 31) d 32)	1 and 2, line 9 OVIDER SITE 3 and 4 for all 1 of lines 26 and 1 y or sum of	line 23 0.00 0 616,777 2,153 5,536 7,689 2,134 9,823 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	22 23 24 25 26 27 28 29 30 31 32 33 34
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2.00 3.00	<pre>Weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Ditonal travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and standard trave Ditonal travel allowance and standard trave Ditonal travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and standard trave Ditonal travel allowance and standard trave Ditonal travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and standard trave Ditonal travel allowance and standard trave Ditonal travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and standard trave Ditonal travel allowance and standard trave Ditonal travel allowance and standard trave Optional travel allowance and standard trave Ditonal travel allowance and standard trave Ditonal trave allowance and optional trave Ditonal trave allowance and optional trave Ditonal trave allowance and piter Ditonal trave allowance and piter Ditonal trave all</pre>	ainees (line 17 line 9 for all ees (line 2 tim ANCE AND TRAVE sum of lines 2 for respirator travel expense f columns 1 an , line 12) sum of lines 2 s 1 and 2, line l expense (line l expense (sum l expense (sum	divided by su others) les line 21) L EXPENSE COMP 4 and 25 for a y therapy or s at the provid d 2, line 12 ) 9 and 30 for a 13 for respir 28) of lines 27 an of lines 31 an EXPENSE COMPU	m of columns UTATION - PR Il others) um of lines er site (sum ll others) atory therap d 31) d 32)	1 and 2, line 9 OVIDER SITE 3 and 4 for all 1 of lines 26 and 1 y or sum of	1ine 23 0.00 0 616,777 2,153 5,536 7,689 2,134 9,823 0 0 0 0 0 0 0 0 0 0 0 0 0	22 23 24 25 26 27 28 30 31 32 33 34 35 36
.00 .00 .00 .00 .00 .00 .00 .00 .00 .00	<pre>Weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns 3 Subtotal (line 29 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense Therapists (line 5 times column 3, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum Optional Travel Allowance and Optional Travel</pre>	ainees (line 17 line 9 for all ees (line 2 tim ANCE AND TRAVE sum of lines 2 for respirator travel expense bf columns 1 an , line 12) sum of lines 2 s 1 and 2, line l expense (line l expense (sum expense (sum NCE AND TRAVEL	divided by su others) les line 21) <b>L EXPENSE COMP</b> 4 and 25 for a y therapy or s a the provid d 2, line 12 ) 9 and 30 for a 13 for respir 28) of lines 27 an of lines 31 an <b>EXPENSE COMPU</b> d 6)	m of columns UTATION - PR Il others) um of lines er site (sum ll others) atory therap d 31) d 32)	1 and 2, line 9 OVIDER SITE 3 and 4 for all 1 of lines 26 and 1 y or sum of	1ine 23 0.00 0 616,777 2,153 5,536 7,689 2,134 9,823 0 0 0 0 0 0 0 0 0 0 0 0 0	22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39
.00 .00 .00 .00 .00 .00 .00 .00 .00 .00	<pre>Weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns 3, Subtotal (line 29 for all others) Standard travel allowance and standard trave Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense Therapists (line 5 times column 3, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum Optional Travel Allowance and Optional Travel</pre>	Ainees (line 17 line 9 for all ees (line 2 tim ANCE AND TRAVE sum of lines 2 for respirator travel expense of columns 1 an , line 12) sum of lines 2 s 1 and 2, line l expense (line l expense (sum l expense (sum (sum (sum (sum (sum (sum (sum (sum	divided by su others) les line 21) <b>L EXPENSE COMP</b> 4 and 25 for a y therapy or s a the provid d 2, line 12 ) 9 and 30 for a 13 for respir 28) of lines 27 an of lines 31 an <b>EXPENSE COMPU</b> d 6)	m of columns UTATION - PR Il others) um of lines er site (sum ll others) atory therap d 31) d 32)	1 and 2, line 9 OVIDER SITE 3 and 4 for all 1 of lines 26 and 1 y or sum of	1ine 23           0.00           0           616,777           2,153           5,536           7,689           2,134           9,823           0	222 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 8 39 40
2.00 3.00 5.00 5.00 3.00 3.00 3.00 2.00 3.00	<pre>Weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel allowance and standard trave Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense Therapists (line 5 times column 3, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.04 Assistants (column 3, line 12.01 times column Subtotal (sum of lines 40 and 41)</pre>	Ainees (line 17 line 9 for all es (line 2 tim ANCE AND TRAVE sum of lines 2 for respirator travel expense of columns 1 an , line 12) sum of lines 2 s 1 and 2, line l expense (line l expense (sum l expe	divided by su others) les line 21) L EXPENSE COMPL 4 and 25 for a y therapy or s at the provid d 2, line 12 ) 9 and 30 for a 13 for respir 28) of lines 27 an of lines 31 an EXPENSE COMPU d 6) 2, line 10)	m of columns UTATION - PR Il others) um of lines er site (sum ll others) atory therap d 31) d 32)	1 and 2, line 9 OVIDER SITE 3 and 4 for all 1 of lines 26 and 1 y or sum of	1ine 23           0.00           0           0.00           0           2,153           5,536           7,689           2,134           9,823           0 <td>222 23 24 25 26 27 28 30 31 32 33 34 35 36 37 38 39 40 41 42</td>	222 23 24 25 26 27 28 30 31 32 33 34 35 36 37 38 39 40 41 42
2.00 3.00	<pre>Weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense Therapists (line 6 times column 2, line 11) Assistants (line 6 times column 2, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum Optional Travel Allowance and optional Travel Therapists (sum of columns 1 and 2, line 12.0 Assistants (column 3, line 12.01 times column Subtotal (sum of lines 40 and 41) Optional travel expense (line 8 times the sum Subtotal (sum of lines 40 and 41)</pre>	ainees (line 17 line 9 for all ees (line 2 tim ANCE AND TRAVE for respirator travel expense <b>Expense</b> of columns 1 an , line 12) sum of lines 2 s 1 and 2, line l expense (line expense (sum expense (sum expense (sum expense (sum travel expense (sum expense (sum travel expense (sum trave	divided by su others) les line 21) L EXPENSE COMP 4 and 25 for a y therapy or s at the provid d 2, line 12 ) 9 and 30 for a 13 for respir 28) of lines 27 an of lines 31 an EXPENSE COMPU d 6) 2, line 10) 3, line 13.01)	m of columns UTATION - PR 11 others) um of lines er site (sum 11 others) atory therap d 31) d 32) TATION - SER	<pre>&gt; 1 and 2, line 9 OVIDER SITE 3 and 4 for all 1 of lines 26 and 1 y or sum of VICES OUTSIDE PRC</pre>	1ine 23           0.00           0           0.616,777           2,153           5,536           7,689           2,134           9,823           0	222 23 24 25 26 27 28 29 300 31 32 33 34 35 36 37 38 39 40 41
2.00 3.00 5.00 7.00 3.00 7.00 3.00 5.00 7.00 3.00 5.00 7.00 3.00 5.00 7.00 3.00 5.00 7.00 3.00	<pre>Weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense Therapists (line 6 times column 2, line 11) Assistants (line 6 times column 2, line 12) Standard travel expense (line 7 times the sum Optional Travel Allowance and optional Trave Therapists (sum of columns 1 and 2, line 12.0 Assistants (column 3, line 12.01 times column Subtotal (sum of lines 40 and 41) Optional travel expense (line 8 times the sum Total Travel Allowance and Travel Expense - CON Standard Travel Allowance and Travel Standard Travel Allowance and Standard Travel Subtotal (sum of lines 40 and 41)</pre>	ainees (line 17 line 9 for all ees (line 2 tim ANCE AND TRAVE for respirator travel expense <b>Expense</b> of columns 1 an , line 12) sum of lines 2 s 1 and 2, line l expense (line expense (sum expense (sum expense (sum expense (sum travel expense (sum expense (sum travel expense (sum trave	divided by su others) les line 21) L EXPENSE COMP 4 and 25 for a y therapy or s at the provid d 2, line 12 ) 9 and 30 for a 13 for respir 28) of lines 27 an of lines 31 an EXPENSE COMPU d 6) 2, line 10) 3, line 13.01)	m of columns UTATION - PR 11 others) um of lines er site (sum 11 others) atory therap d 31) d 32) TATION - SER	<pre>&gt; 1 and 2, line 9 OVIDER SITE 3 and 4 for all 1 of lines 26 and 1 y or sum of VICES OUTSIDE PRC</pre>	1ine 23           0.00           0           0.616,777           2,153           5,536           7,689           2,134           9,823           0	222 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42
2.00 3.00 5.00 5.00 7.00 3.00 3.00 5.00 5.00 5.00 5.00 5.00 5	<pre>Weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns 3, Subtotal (line 29 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Allowance and optional trave Dytional travel allowance and optional trave Optional travel allowance and optional trave Optional travel allowance and optional trave Optional travel allowance and optional trave Dytional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense Therapists (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.0 Assistants (column 3, line 12.01 times column Subtotal (sum of lines 40 and 41) Optional travel expense (line 8 times the sum Total Travel Allowance and Travel Expense - Co or 46, as appropriate.</pre>	ainees (line 17 line 9 for all ees (line 2 tim ANCE AND TRAVE for respirator travel expense of columns 1 an , line 12) sum of lines 2 s 1 and 2, line l expense (line l expense (sum expense (sum NCE AND TRAVEL n of lines 5 an Expense D1 times columns 1 3, line 10) n of columns 1- offsite Service	divided by su others) les line 21) L EXPENSE COMP 4 and 25 for a y therapy or s at the provid d 2, line 12 ) 9 and 30 for a 13 for respir 28) of lines 27 an of lines 27 an of lines 31 an EXPENSE COMPU d 6) 2, line 10) 3, line 13.01) s; Complete on	m of columns UTATION - PR Il others) um of lines er site (sun ll others) atory therap d 31) d 32) TATION - SER	<pre>&gt; 1 and 2, line 9 OVIDER SITE 3 and 4 for all 1 of lines 26 and y or sum of VICES OUTSIDE PRO NUTCES OU</pre>	1ine 23           0.00           0           0.616,777           2,153           5,536           7,689           2,134           9,823           0	222 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42

	Financial Systems ABLE COST DETERMINATION FOR THERAPY SERVICES	ASCENSION ST. VI FURNISHED BY	Provider C	CN: 15-1308	Period:	u of Form CMS-2 Worksheet A-8	
	E SUPPLIERS				From 07/01/2022 Fo 06/30/2023	Parts I-VI	pared
				F	hysical Therapy	Cost	
						1.00	
6.00	Optional travel allowance and optional trave			d 43 - see in		0	46.0
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
7.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.0	0.00	0.00	47.0
8.00	Overtime rate (see instructions)	0.00	0.00	0.0	0.00		48.0
9.00	Total overtime (including base and overtime	0.00	0.00				49.0
9.00	allowance) (multiply line 47 times line 48)	0.00	0.00	0.0	0.00		49.0
	CALCULATION OF LIMIT				1		
0.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.0	0.00	0.00	50.0
.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.0	0.00	0.00	51.0
	DETERMINATION OF OVERTIME ALLOWANCE	05 67	C2 10	0.0	0.00		5.2
.00	Adjusted hourly salary equivalency amount (see instructions)	95.67	62.19				52.0
.00	Overtime cost limitation (line 51 times line 52)	0	0		0 0		53.0
.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0		0 0		54.0
.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0		0 0		55.0
.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3	0	0		0 0	0	56.
	for all others.)						
						1.00	
00	Part VI - COMPUTATION OF THERAPY LIMITATION A	IND EXCESS COST A	ADJUSTMENT			616 777	
7.00	Salary equivalency amount (from line 23)	(from 14mor 22	24 25))			616,777	
.00	Travel allowance and expense - provider site			``		9,823	
.00	Travel allowance and expense - Offsite servic	es (trom lines	44, 45, Or 46	)		0	
.00	Overtime allowance (from column 5, line 56)					0	60.
.00	Equipment cost (see instructions)					0	61.
.00	Supplies (see instructions)					0	
.00	Total allowance (sum of lines 57-62)					626,600	
.00	Total cost of outside supplier services (from	n your records)				550,783	64.
.00	Excess over limitation (line 64 minus line 63	3 - if negative,	enter zero)			0	65.
	LINE 33 CALCULATION						
0.00	Line 26 = line 24 for respiratory therapy or	sum of lines 24	and 25 for a	ll others		7,689	100.
0.01	Line 27 = line 7 times line 3 for respiratory	/ therapy or sum	of lines 3 a	nd 4 for all o	others	2,134	100.
	Line 33 = line 28 = sum of lines 26 and 27	••				9,823	
	Line 34 CALCULATION Line 27 = line 7 times line 3 for respiratory	/ therapy or sum	of lines 3 a	und 4 for all o	others	2,134	101.
1.00	Line 31 = line 29 for respiratory therapy or						101.
						2,134	
01.01	Line 34 = sum of lines 27 and 31					· · · · · ·	
)1.01 )1.02	LINE 35 CALCULATION			77			102
01.01 01.02	LINE 35 CALCULATION Line 31 = line 29 for respiratory therapy or					0	102.0
01.01 01.02	LINE 35 CALCULATION				nns 1-3, line	0	102. 102.

01511	NABLE COST DETERMINATION FOR THERAPY SERVICES DE SUPPLIERS	FURNISHED BY	Provider CC	N: 15-1308	Period: From 07/01/2022 To 06/30/2023 Occupational Therapy	Worksheet A-8- Parts I-VI Date/Time Prep 11/22/2023 2:2 Cost	pared
						1.00	
.00	<b>PART I - GENERAL INFORMATION</b> Total number of weeks worked (excluding aide	s) (see instruct	ions)			49	1.0
.00	Line 1 multiplied by 15 hours per week		. 10113 /			735	
.00	Number of unduplicated days in which supervi Number of unduplicated days in which therapy nor therapist was on provider site (see inst	assistant was c		•		224 0	
.00	Number of unduplicated offsite visits - supe Number of unduplicated offsite visits - ther assistant and on which supervisor and/or the instructions)	rvisors or thera apy assistants (	include only	visits made b		0 0	5.0 6.0
.00	Standard travel expense rate					9.57	
.00	Optional travel expense rate per mile					0.00	8.0
		Supervisors 1.00	Therapists 2.00	Assistants 3.00	Aides 4.00	Trainees 5.00	
.00	Total hours worked	0.00	1,414.00	0.0		0.00	9.0
0.00		0.00	90.69	0.0		0.00	
1.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	45.35	45.35	0.0	00		11.0
2.00		0	0		0		12.0
	Number of travel hours (offsite) Number of miles driven (provider site)	0	0		0		12.0
	Number of miles driven (provider site)	0	0		0		13.0
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION					1.00	
4.00	Supervisors (column 1, line 9 times column 1	, line 10)				0	14.0
	Therapists (column 2, line 9 times column 2,					128,236	
6.00			atomi thomani	on lines 14	16 for all	128 226	
7.00	others)	ia is for respir	atory therapy	or lines 14-	-16 TOP all	128,236	17.1
8.00	Aides (column 4, line 9 times column 4, line	10)				0	18.0
	Trainees (column 5, line 9 times column 5, 1				C 11 11 1	0	
0.00	Total allowance amount (sum of lines 17-19 for If the sum of columns 1 and 2 for respiratory	/ therapy or col	128,236 1000gy or	20.0			
	occupational therapy, line 9, is greater than	n line 2, make n					
1.00	the amount from line 20. Otherwise complete Weighted average rate excluding aides and tr		divided by sur	n of columns	1 and 2 line 9	0.00	21 (
1.00	for respiratory therapy or columns 1 thru 3,				i and 2, The J	0.00	21.0
2.00	5 5	ees (line 2 time	es line 21)			0	
3.00	Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW	ANCE AND TRAVEL	EXPENSE COMPL			128,236	23.0
	Standard Travel Allowance				WIDER SITE		
	Therapists (line 3 times column 2, line 11)					10,158	
5.00	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or	sum of lines 24	land 25 for a	11 others)		0 10,158	25.0
	Standard travel expense (line 7 times line 3				and 4 for all	2,144	
	others)	,					
8.00	27)		at the provide	er site (sum	of lines 26 and	12,302	28.0
	<b>Optional Travel Allowance and Optional Trave</b> Therapists (column 2, line 10 times the sum		1 2 line 12 )			0	29.0
9.00	,					°.	
9.00 0.00	Assistants (column 3, line 10 times column 3		<i>z</i> , me <i>z</i> ,			0	30.0
0.00 1.00	Subtotal (line 29 for respiratory therapy or	, line 12) sum of lines 29	) and 30 for a			0	31.0
0.00	Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column	, line 12) sum of lines 29	) and 30 for a		vor sum of		31.0
0.00 1.00	Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others)	, line 12) sum of lines 29 s 1 and 2, line	) and 30 for a 13 for respira		vor sum of	0	31.0 32.0
0.00 1.00 2.00 3.00 4.00	Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave	, line 12) sum of lines 29 s 1 and 2, line l expense (line l expense (sum c	) and 30 for a 13 for respira 28) of lines 27 and	atory therapy d 31)	vorsumof	0 0 12,302 0	31.0 32.0 33.0 34.0
0.00 1.00 2.00 3.00 4.00	Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional trave	, line 12) sum of lines 29 s 1 and 2, line l expense (line l expense (sum o l expense (sum o	) and 30 for a 13 for respira 28) of lines 27 and of lines 31 and	atory therapy d 31) d 32)		0 0 12,302 0 0	31.0 32.0 33.0 34.0
0.00 1.00 2.00 3.00 4.00	Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA	, line 12) sum of lines 29 s 1 and 2, line l expense (line l expense (sum o l expense (sum o	) and 30 for a 13 for respira 28) of lines 27 and of lines 31 and	atory therapy d 31) d 32)		0 0 12,302 0 0	31.0 32.0 33.0 34.0
0.00 1.00 2.00 3.00 4.00 5.00 6.00	Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Expense Therapists (line 5 times column 2, line 11)	, line 12) sum of lines 29 s 1 and 2, line l expense (line l expense (sum o l expense (sum o	) and 30 for a 13 for respira 28) of lines 27 and of lines 31 and	atory therapy d 31) d 32)		0 0 12,302 0 0 <b>WIDER SITE</b> 0	31.0 32.0 33.0 34.0 35.0 36.0
0.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00	Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and optional trave <b>Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW</b> <b>Standard Travel Expense</b> Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11)	, line 12) sum of lines 29 s 1 and 2, line l expense (line l expense (sum o l expense (sum o	) and 30 for a 13 for respira 28) of lines 27 and of lines 31 and	atory therapy d 31) d 32)		0 0 12,302 0 0 VVIDER SITE 0 0 0	31.0 32.0 33.0 34.0 35.0 36.0 37.0
0.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00	Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and optional trave <b>Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW</b> <b>Standard Travel Expense</b> Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37)	, line 12) sum of lines 29 s 1 and 2, line l expense (line l expense (sum c NCE AND TRAVEL	and 30 for a 13 for respira 28) of lines 27 and f lines 31 and EXPENSE COMPUT	atory therapy d 31) d 32)		0 0 12,302 0 0 <b>VVIDER SITE</b> 0 0 0 0	31.0 32.0 33.0 34.0 35.0 36.0 37.0 38.0
0.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00	Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and optional trave <b>Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW</b> <b>Standard Travel Expense</b> Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11)	, line 12) sum of lines 29 s 1 and 2, line l expense (line l expense (sum of l expense (sum of NCE AND TRAVEL	and 30 for a 13 for respira 28) of lines 27 and f lines 31 and EXPENSE COMPUT	atory therapy d 31) d 32)		0 0 12,302 0 0 VVIDER SITE 0 0 0	31.0 32.0 33.0 34.0 35.0 36.0 37.0 38.0
0.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 0.00	Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional trave <b>Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW</b> <b>Standard Travel Expense</b> Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum <b>Optional Travel Allowance and Optional Trave</b> Therapists (sum of columns 1 and 2, line 12.	, line 12) sum of lines 29 s 1 and 2, line l expense (line l expense (sum c expense (sum c NCE AND TRAVEL n of lines 5 and Expense D1 times column	and 30 for a 13 for respira 28) of lines 27 and f lines 31 and EXPENSE COMPUT	atory therapy d 31) d 32)		0 0 12,302 0 <b>VVIDER SITE</b> 0 0 0 0 0 0 0 0	31.( 32.( 33.( 34.( 35.( 35.( 37.( 38.( 39.( 40.(
0.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 0.00 1.00	Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional trave <b>Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW</b> <b>Standard Travel Expense</b> Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum <b>Optional Travel Allowance and Optional Trave</b> Therapists (sum of columns 1 and 2, line 12. Assistants (column 3, line 12.01 times column	, line 12) sum of lines 29 s 1 and 2, line l expense (line l expense (sum c expense (sum c NCE AND TRAVEL n of lines 5 and Expense D1 times column	and 30 for a 13 for respira 28) of lines 27 and f lines 31 and EXPENSE COMPUT	atory therapy d 31) d 32)		0 0 12,302 0 <b>VIDER SITE</b> 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	31.0 32.0 34.0 35.0 36.0 37.0 38.0 39.0 40.0 41.0
0.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 0.00 1.00 2.00	Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional trave <b>Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW</b> <b>Standard Travel Expense</b> Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum <b>Optional Travel Allowance and Optional Trave</b> Therapists (sum of columns 1 and 2, line 12. Assistants (column 3, line 12.01 times column Subtotal (sum of lines 40 and 41)	, line 12) sum of lines 29 s 1 and 2, line l expense (line l expense (sum of expense (sum of INCE AND TRAVEL m of lines 5 and Expense D1 times column n 3, line 10)	and 30 for a 13 for respira 28) of lines 27 and f lines 31 and EXPENSE COMPUT 6) 2, line 10)	atory therapy d 31) d 32)		0 0 12,302 0 0 <b>VIDER SITE</b> 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	31.( 32.( 33.( 34.( 35.( 35.( 37.( 38.( 39.( 40.( 41.( 42.(
0.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 0.00 1.00 2.00	Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard Travel Allowance and Optional Trave Therapists (sum of columns 1 and 2, line 12.4 Assistants (column 3, line 12.01 times column Subtotal (sum of lines 40 and 41) Optional travel expense (line 8 times the sum	, line 12) sum of lines 29 s 1 and 2, line l expense (line l expense (sum of l expense (sum of <b>INCE AND TRAVEL</b> m of lines 5 and <b>Expense</b> D1 times column n 3, line 10) m of columns 1-3	and 30 for a 13 for respira 28) of lines 27 and f lines 31 and EXPENSE COMPUT 4 6) 2, line 10) 3, line 13.01)	atory therapy d 31) d 32) FATION - SERV	TCES OUTSIDE PRO	0 0 12,302 0 0 VIDER SITE 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	31.0 32.0 34.0 35.0 36.0 37.0 38.0 39.0 40.0 41.0
0.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 0.00 1.00 2.00 3.00	Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional trave <b>Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW</b> <b>Standard Travel Expense</b> Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum <b>Optional Travel Allowance and Optional Trave</b> Therapists (sum of columns 1 and 2, line 12. Assistants (column 3, line 12.01 times column Subtotal (sum of lines 40 and 41)	, line 12) sum of lines 29 s 1 and 2, line l expense (line l expense (sum of l expense (sum of l expense (sum of <b>Expense</b> D1 times column h 3, line 10) m of columns 1-3 <b>Offsite Services</b>	and 30 for a 13 for respira 28) of lines 27 and f lines 31 and EXPENSE COMPUT 4 6) 2, line 10) 3, line 13.01) ; Complete one	atory therapy d 31) d 32) FATION - SERV	VICES OUTSIDE PRO	0 0 12,302 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42.

	ABLE COST DETERMINATION FOR THERAPY SERVICES I E SUPPLIERS	URNISHED BY	Provider Co	CN: 15-1308	Period: From 07/01/2022 To 06/30/2023	Worksheet A-8 Parts I-VI Date/Time Pre 11/22/2023 2:	pared:
					Occupational Therapy	Cost	
						1.00	
.00	Optional travel allowance and standard travel	expense (sum	of lines 39 an	d 42 - see ir	nstructions)	0	45.0
5.00	Optional travel allowance and optional travel			d 43 - see ir		0	46.0
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
.00	<b>PART V - OVERTIME COMPUTATION</b> Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.0	0.00	0.00	47.0
.00	Overtime rate (see instructions)	0.00	0.00	0.0	0.00		48.0
.00	Total overtime (including base and overtime	0.00	0.00				49.0
	allowance) (multiply line 47 times line 48)						
	CALCULATION OF LIMIT	0.00	0.00	0.0		0.00	50.0
0.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.0	0.00	0.00	50.0
.00	-	0.00	0.00	0.0	0.00	0.00	51.0
	DETERMINATION OF OVERTIME ALLOWANCE						
.00	Adjusted hourly salary equivalency amount	90.69	0.00	0.0	0.00		52.0
.00	(see instructions) Overtime cost limitation (line 51 times line	0	0		0 0		53.0
.00	52) Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0		0 0		54.0
.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0		0 0		55.0
.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0		0 0	0	56.0
		I		I			
	Part VI - COMPUTATION OF THERAPY LIMITATION A	ND EXCESS COST				1.00	
.00	Salary equivalency amount (from line 23)		ADJUJIHENT			128,236	57.0
.00 .00 .00 .00	Travel allowance and expense - provider site Travel allowance and expense - Offsite servic Overtime allowance (from column 5, line 56) Equipment cost (see instructions) Supplies (see instructions)			)		12,302 0 0 0 0	58.0 59.0 60.0 61.0
.00	Total allowance (sum of lines 57-62)					140,538	
	Total cost of outside supplier services (from					78,016	
.00	Excess over limitation (line 64 minus line 63	- if negative	, enter zero)			0	65.
0 00	LINE 33 CALCULATION Line 26 = line 24 for respiratory therapy or	sum of lines 2	1 and 25 for a	11 others		10,158	100
	Line $27 = 1$ ine 7 times line 3 for respiratory				others	2,144	
	Line 33 = 1ine 28 = sum of 1ines 26 and 27 LINE 34 CALCULATION					12,302	
1 00	Line 27 = line 7 times line 3 for respiratory	therapy or su	m of lines 3 a	nd 4 for all	others	2,144	101.0
1.00	Line 31 = line 29 for respiratory therapy or					0	101.
1.01	Line $34 = sum of lines 27 and 31$					2,144	101.
1.01							
1.01 1.02	LINE 35 CALCULATION	sum of lines 2	9 and 30 for a	11 others		0	102.0
1.01 1.02 2.00					umns 1-3, line		102. 102.

	NABLE COST DETERMINATION FOR THERAPY SERVICES DE SUPPLIERS	FURNISHED BY	Provider CC	EN: 15-1308	Period: From 07/01/2022 To 06/30/2023 Speech Pathology	Date/Time Prep 11/22/2023 2:2	pared:		
						1.00			
	PART I - GENERAL INFORMATION		-						
.00	Total number of weeks worked (excluding aides	s) (see instruc	tions)			48	1.0		
.00	Line 1 multiplied by 15 hours per week Number of unduplicated days in which supervis	on on thoronic	t was on provi	don cito (co	a instructions)	720 57	2.0		
.00	Number of unduplicated days in which therapy					0	4.0		
	nor therapist was on provider site (see inst		on provider of	te sut herei	Supervisor	Ŭ			
.00	Number of unduplicated offsite visits - super					0	5.0		
.00	Number of unduplicated offsite visits - there					0	6.0		
	assistant and on which supervisor and/or the instructions)	rapist was not	present during	the visit(s	(see				
.00	Standard travel expense rate					9.57	7.0		
.00	Optional travel expense rate per mile					0.00	8.0		
		Supervisors	Therapists	Assistants		Trainees			
.00	Total hours worked	1.00	2.00	3.00	4.00	5.00	9.0		
0.00		0.00	992.00 87.17		00 0.00				
1.00		43.59	43.59		00	0.00	11.0		
	one-half of column 2, line 10; column 3,								
2 00	one-half of column 3, line 10)		~				12 0		
	Number of travel hours (provider site) Number of travel hours (offsite)	0	0		0		12.0		
	Number of miles driven (provider site)	0	0		0		13.0		
	Number of miles driven (offsite)	0	0		0		13.0		
						1.00			
1 00	Part II - SALARY EQUIVALENCY COMPUTATION Supervisors (column 1, line 9 times column 1	ling 10)				0	14.0		
5.00						86,473			
6.00						0	16.0		
7.00	Subtotal allowance amount (sum of lines 14 am	nd 15 for respi	ratory therapy	or lines 14	-16 for all	86,473	17.0		
	others)								
8.00						0	18.0 19.0		
0.00			therany or lin	es 17 and 18	for all others)	86,473			
0.00	If the sum of columns 1 and 2 for respiratory						2010		
	occupational therapy, line 9, is greater than		no entries on	lines 21 and	22 and enter on	line 23			
1 00	the amount from line 20. Otherwise complete Weighted average rate excluding aides and tra	<u>lines 21-23.</u>	divided by cu	m of columns	1 and 2 line 0	0.00	21 0		
1.00	for respiratory therapy or columns 1 thru 3,				1 aliu 2, Tille 9	0.00	21.0		
2.00						(			
	Total salary equivalency (see instructions)								
3.00						0 86,473			
3.00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW	ANCE AND TRAVE	L EXPENSE COMP	UTATION - PR	OVIDER SITE	-			
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance	ANCE AND TRAVE	L EXPENSE COMP	UTATION - PR	OVIDER SITE	86,473	23.0		
4.00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11)	ANCE AND TRAVE	L EXPENSE COMP	UTATION - PR	OVIDER SITE	86,473	23.0		
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11)				OVIDER SITE	86,473	23.0 24.0 25.0		
4.00 5.00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11)	sum of lines 2	4 and 25 for a	ll others)		86,473 2,485 0	23.0 24.0 25.0 26.0		
4.00 5.00 6.00 7.00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others)	sum of lines 2 for respirator	4 and 25 for a y therapy or s	ll others) um of lines	3 and 4 for all	86,473 2,485 0 2,485 545	23.0 24.0 25.0 26.0 27.0		
4.00 5.00 6.00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard	sum of lines 2 for respirator	4 and 25 for a y therapy or s	ll others) um of lines	3 and 4 for all	86,473 2,485 0 2,485	23.0 24.0 25.0 26.0 27.0		
4.00 5.00 6.00 7.00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others)	sum of lines 2 for respirator travel expense	4 and 25 for a y therapy or s	ll others) um of lines	3 and 4 for all	86,473 2,485 0 2,485 545	23.0 24.0 25.0 26.0 27.0		
4.00 5.00 6.00 7.00 8.00 9.00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWStandard Travel AllowanceTherapists (line 3 times column 2, line 11)Assistants (line 4 times column 3, line 11)Subtotal (line 24 for respiratory therapy orStandard travel expense (line 7 times line 3others)Total standard travel allowance and standard27)Optional Travel Allowance and Optional TravelTherapists (column 2, line 10 times the sum of	sum of lines 2 for respirator travel expense <b>Expense</b> of columns 1 an	4 and 25 for a y therapy or s at the provid	ll others) um of lines	3 and 4 for all	86,473 2,485 0 2,485 545	23.0 24.0 25.0 26.0 27.0 28.0 29.0		
4.00 5.00 6.00 7.00 8.00 9.00 0.00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWStandard Travel AllowanceTherapists (line 3 times column 2, line 11)Assistants (line 4 times column 3, line 11)Subtotal (line 24 for respiratory therapy orStandard travel expense (line 7 times line 3others)Total standard travel allowance and standard27)Optional Travel Allowance and Optional TravelTherapists (column 2, line 10 times the sum 0Assistants (column 3, line 10 times column 3	sum of lines 2 for respirator travel expense <b>Expense</b> of columns 1 an , line 12)	4 and 25 for a y therapy or s at the provid d 2, line 12 )	ll others) um of lines er site (sum	3 and 4 for all	86,473 2,485 0 2,485 545 3,030 0 0 0	23.0 24.0 25.0 26.0 27.0 28.0 29.0 30.0		
4.00 5.00 6.00 7.00 8.00 9.00 0.00 1.00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or	sum of lines 2 for respirator travel expense <b>Expense</b> of columns 1 an , line 12) sum of lines 2	4 and 25 for a y therapy or s at the provid d 2, line 12 ) 9 and 30 for a	ll others) um of lines er site (sum ll others)	3 and 4 for all of lines 26 and	86,473 2,485 0 2,485 545 3,030 0 0 0 0	23.0 24.0 25.0 26.0 27.0 28.0 29.0 30.0 31.0		
4.00 5.00 6.00 7.00 8.00 9.00 0.00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns)	sum of lines 2 for respirator travel expense <b>Expense</b> of columns 1 an , line 12) sum of lines 2	4 and 25 for a y therapy or s at the provid d 2, line 12 ) 9 and 30 for a	ll others) um of lines er site (sum ll others)	3 and 4 for all of lines 26 and	86,473 2,485 0 2,485 545 3,030 0 0 0	23.0 24.0 25.0 26.0 27.0 28.0 29.0 30.0 31.0		
4.00 5.00 6.00 7.00 8.00 9.00 0.00 1.00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others)	sum of lines 2 for respirator travel expense Df columns 1 an , line 12) sum of lines 2 s 1 and 2, line	4 and 25 for a y therapy or s at the provid d 2, line 12 ) 9 and 30 for a 13 for respir	ll others) um of lines er site (sum ll others)	3 and 4 for all of lines 26 and	86,473 2,485 0 2,485 545 3,030 0 0 0 0 0 0 0 0 0	23.0 24.0 25.0 26.0 27.0 28.0 29.0 30.0 31.0 32.0		
4.00 5.00 6.00 7.00 8.00 9.00 0.00 1.00 2.00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel	sum of lines 2 for respirator travel expense <b>Expense</b> of columns 1 an , line 12) sum of lines 2 s 1 and 2, line l expense (line	4 and 25 for a y therapy or s at the provid d 2, line 12 ) 9 and 30 for a 13 for respir 28)	ll others) um of lines er site (sum 	3 and 4 for all of lines 26 and	86,473 2,485 0 2,485 545 3,030 0 0 0 0	23.0 24.0 25.0 26.0 27.0 28.0 30.0 31.0 32.0 33.0		
4.00 5.00 6.00 7.00 8.00 9.00 0.00 1.00 2.00 3.00 4.00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel allowance and standard trave columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional trave	sum of lines 2 for respirator travel expense <b>Expense</b> of columns 1 an , line 12) sum of lines 2 s 1 and 2, line l expense (line expense (sum expense (sum	4 and 25 for a y therapy or s at the provid d 2, line 12 ) 9 and 30 for a 13 for respir 28) of lines 27 an of lines 31 an	ll others) um of lines er site (sum ll others) atory therap d 31) d 32)	3 and 4 for all of lines 26 and y or sum of	86,473 2,485 0 2,485 545 3,030 0 0 0 0 0 0 3,030 0 0 0 0 0 0 0 0	23.0 24.0 25.0 26.0 27.0 28.0 30.0 31.0 32.0 33.0 34.0		
4.00 5.00 6.00 7.00 8.00 9.00 0.00 1.00 2.00 3.00	<ul> <li>PART III - STANDARD AND OPTIONAL TRAVEL ALLOW</li> <li>Standard Travel Allowance</li> <li>Therapists (line 3 times column 2, line 11)</li> <li>Assistants (line 4 times column 3, line 11)</li> <li>Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others)</li> <li>Total standard travel allowance and standard 27)</li> <li>Optional Travel Allowance and Optional Travel</li> <li>Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3 subtotal (line 29 for respiratory therapy or Optional travel allowance and standard travel expense (line 8 times columns 1-3, line 13 for all others)</li> <li>Standard travel allowance and standard trave</li> <li>Optional travel allowance and standard trave</li> <li>Optional travel allowance and potional trave</li> </ul>	sum of lines 2 for respirator travel expense <b>Expense</b> of columns 1 an , line 12) sum of lines 2 s 1 and 2, line l expense (line expense (sum expense (sum	4 and 25 for a y therapy or s at the provid d 2, line 12 ) 9 and 30 for a 13 for respir 28) of lines 27 an of lines 31 an	ll others) um of lines er site (sum ll others) atory therap d 31) d 32)	3 and 4 for all of lines 26 and y or sum of	86,473 2,485 0 2,485 545 3,030 0 0 0 0 0 0 3,030 0 0 0 0 0 0 0 0	23.0 24.0 25.0 26.0 27.0 28.0 30.0 31.0 32.0 33.0 34.0		
4.00 5.00 6.00 7.00 8.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum 6 Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional trave Standard Travel AND OPTIONAL TRAVEL ALLOWA	sum of lines 2 for respirator travel expense <b>Expense</b> of columns 1 an , line 12) sum of lines 2 s 1 and 2, line l expense (line expense (sum expense (sum	4 and 25 for a y therapy or s at the provid d 2, line 12 ) 9 and 30 for a 13 for respir 28) of lines 27 an of lines 31 an	ll others) um of lines er site (sum ll others) atory therap d 31) d 32)	3 and 4 for all of lines 26 and y or sum of	86,473 2,485 0 2,485 545 3,030 0 0 0 3,030 0 0 3,030 0 0 0 <b>&gt;VIDER SITE</b>	23.0 24.0 25.0 26.0 27.0 28.0 30.0 31.0 32.0 33.0 33.0 33.0 35.0		
4.00 5.00 6.00 7.00 8.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum 6 Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and standard trave Ditional travel allowance and optional trave Ditional travel allowance and standard trave Ditional travel allowance and standard trave Ditional trave Ditional trave D	sum of lines 2 for respirator travel expense <b>Expense</b> of columns 1 an , line 12) sum of lines 2 s 1 and 2, line l expense (line expense (sum expense (sum	4 and 25 for a y therapy or s at the provid d 2, line 12 ) 9 and 30 for a 13 for respir 28) of lines 27 an of lines 31 an	ll others) um of lines er site (sum ll others) atory therap d 31) d 32)	3 and 4 for all of lines 26 and y or sum of	86,473 2,485 0 2,485 545 3,030 0 0 0 0 0 0 3,030 0 0 0 0 0 0 0 0	23. ( 24. ( 25. ( 26. ( 27. ( 28. ( 29. ( 30. ( 31. ( 33. ( 33. ( 33. ( 35. ( 36. ( 36. (		
4.00 5.00 6.00 7.00 8.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and ptional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11)	sum of lines 2 for respirator travel expense <b>Expense</b> of columns 1 an , line 12) sum of lines 2 s 1 and 2, line l expense (line expense (sum expense (sum	4 and 25 for a y therapy or s at the provid d 2, line 12 ) 9 and 30 for a 13 for respir 28) of lines 27 an of lines 31 an	ll others) um of lines er site (sum ll others) atory therap d 31) d 32)	3 and 4 for all of lines 26 and y or sum of	86,473 2,485 0 2,485 545 3,030 0 0 0 0 0 0 0 0 0 0 0 0 0	23.0 24.0 25.0 26.0 27.0 28.0 29.0 30.0 31.0 32.0 33.0 33.0 34.0 35.0 34.0 35.0 34.0 35.0		
4.00 5.00 6.00 7.00 8.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Defional travel allowance and standard trave Optional travel allowance and optional trave Defional travel allowance and standard trave Optional travel allowance and standard trave Defional travel allowance and optional trave Defines (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum	sum of lines 2 for respirator travel expense of columns 1 an , line 12) sum of lines 2 s 1 and 2, line l expense (line l expense (sum l expense (sum l expense (sum l expense (sum	4 and 25 for a y therapy or s at the provid d 2, line 12 ) 9 and 30 for a 13 for respir 28) of lines 27 an of lines 31 an EXPENSE COMPU	ll others) um of lines er site (sum ll others) atory therap d 31) d 32)	3 and 4 for all of lines 26 and y or sum of	86,473 2,485 0 2,485 545 3,030 0 0 0 0 0 0 0 0 0 0 0 0 0	23.0 24.0 25.0 26.0 27.0 28.0 29.0 30.0 31.0 32.0		
4.00 5.00 6.00 7.00 8.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense Therapists (line 5 times column 3, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum Optional Travel Allowance and Optional Travel	sum of lines 2 for respirator travel expense of columns 1 an , line 12) sum of lines 2 s 1 and 2, line l expense (line l expense (sum NCE AND TRAVEL	4 and 25 for a y therapy or s at the provid d 2, line 12 ) 9 and 30 for a 13 for respir 28) of lines 27 an of lines 31 an EXPENSE COMPU d 6)	ll others) um of lines er site (sum ll others) atory therap d 31) d 32)	3 and 4 for all of lines 26 and y or sum of	86,473 2,485 0 2,485 545 3,030 0 0 0 0 0 0 0 0 0 0 0 0 0	23.0 24.0 25.0 26.0 27.0 28.0 30.0 31.0 32.0 33.0 33.0 33.0 33.0 33.0 33.0 33		
4.00 5.00 6.00 7.00 8.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and standard trave Dotional travel allowance and standard trave Dotional travel allowance and standard trave Dotional travel allowance and standard trave Optional travel allowance and standard trave Dotional travel allowance and standard trave Dotional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense Therapists (line 5 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum Optional Travel Allowance and Optional Trave Therapists (sum of columns 1 and 2, line 12.000000000000000000000000000000000000	sum of lines 2 for respirator travel expense <b>Expense</b> of columns 1 an , line 12) sum of lines 2 s 1 and 2, line l expense (line l expense (sum expense (sum <b>INCE AND TRAVEL</b> n of lines 5 an <b>Expense</b> D1 times column	4 and 25 for a y therapy or s at the provid d 2, line 12 ) 9 and 30 for a 13 for respir 28) of lines 27 an of lines 31 an EXPENSE COMPU d 6)	ll others) um of lines er site (sum ll others) atory therap d 31) d 32)	3 and 4 for all of lines 26 and y or sum of	86,473 2,485 0 2,485 545 3,030 0 0 0 0 0 0 0 0 0 0 0 0 0	23.0 24.0 25.0 26.0 27.0 28.0 30.0 31.0 32.0 33.0 33.0 34.0 35.0 36.0 37.0 38.0 39.0 40.0		
4.00 5.00 6.00 7.00 8.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 0.00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWStandard Travel AllowanceTherapists (line 3 times column 2, line 11)Assistants (line 4 times column 3, line 11)Subtotal (line 24 for respiratory therapy orStandard travel expense (line 7 times line 3others)Total standard travel allowance and standard27)Optional Travel Allowance and Optional TravelTherapists (column 2, line 10 times the sum dAssistants (column 3, line 10 times column 3Subtotal (line 29 for respiratory therapy orOptional travel expense (line 8 times column 3Subtotal (line 29 for respiratory therapy orOptional travel allowance and standard travecolumns 1-3, line 13 for all others)Standard travel allowance and standard traveOptional travel allowance and standard traveOptional travel allowance and standard traveDytional travel allowance and standard traveDytional travel allowance and standard traveOptional travel allowance and standard traveOptional travel allowance and optional travePart IV - STANDARD AND OPTIONAL TRAVEL ALLOWStandard Travel ExpenseTherapists (line 5 times column 2, line 11)Assistants (line 6 times column 3, line 11)Subtotal (sum of lines 36 and 37)Standard travel expense (line 7 times the surOptional Travel Allowance and Optional TraveTherapists (sum of columns 1 and 2, line 12.0Assistants (column 3, line 12.01 times column	sum of lines 2 for respirator travel expense <b>Expense</b> of columns 1 an , line 12) sum of lines 2 s 1 and 2, line l expense (line l expense (sum expense (sum <b>INCE AND TRAVEL</b> n of lines 5 an <b>Expense</b> D1 times column	4 and 25 for a y therapy or s at the provid d 2, line 12 ) 9 and 30 for a 13 for respir 28) of lines 27 an of lines 31 an EXPENSE COMPU d 6)	ll others) um of lines er site (sum ll others) atory therap d 31) d 32)	3 and 4 for all of lines 26 and y or sum of	86,473 2,485 0 2,485 545 3,030 0 0 0 0 0 0 0 0 0 0 0 0 0	23.0 24.0 25.0 26.0 27.0 28.0 29.0 30.0 31.0 32.0 33.0 33.0 35.0 36.0 37.0 38.0 39.0 40.0 41.0		
4.00 5.00 6.00 7.00 8.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 0.00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel allowance and standard trave Columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and optional trave Data travel allowance and optional trave Optional travel allowance and optional trave Optional travel expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum Optional Travel Allowance and Optional Trave Therapists (sum of columns 1 and 2, line 12.01 Assistants (column 3, line 12.01 times column Subtotal (sum of lines 40 and 41)	sum of lines 2 for respirator travel expense of columns 1 an , line 12) sum of lines 2 s 1 and 2, line l expense (line l expense (sum l expense (sum l expense (sum l expense (sum l expense (sum l expense (sum l expense column b of lines 5 an Expense 1 times column h 3, line 10)	4 and 25 for a y therapy or s at the provid d 2, line 12 ) 9 and 30 for a 13 for respir 28) of lines 27 an of lines 31 an EXPENSE COMPU d 6) 2, line 10)	ll others) um of lines er site (sum ll others) atory therap d 31) d 32)	3 and 4 for all of lines 26 and y or sum of	86,473 2,485 0 2,485 545 3,030 0 0 0 0 0 0 0 0 0 0 0 0 0	23.0 24.0 25.0 26.0 27.0 28.0 30.0 31.0 32.0 33.0 33.0 34.0 35.0 36.0 37.0 38.0 39.0 40.0		
4.00 5.00 6.00 7.00 8.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 0.00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel allowance and standard trave Columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and optional trave Data travel allowance and optional trave Optional travel allowance and optional trave Optional travel expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum Optional Travel Allowance and Optional Trave Therapists (sum of columns 1 and 2, line 12.01 Assistants (column 3, line 12.01 times column Subtotal (sum of lines 40 and 41)	sum of lines 2 for respirator travel expense of columns 1 an , line 12) sum of lines 2 s 1 and 2, line l expense (line l expense (sum l expense (sum l expense (sum NCE AND TRAVEL n of lines 5 an Expense D1 times column n 3, line 10) m of columns 1-	4 and 25 for a y therapy or s at the provid d 2, line 12 ) 9 and 30 for a 13 for respir 28) of lines 27 an of lines 31 an EXPENSE COMPU d 6) 2, line 10) 3, line 13.01)	ll others) um of lines er site (sum ll others) atory therap d 31) d 32) TATION - SER	3 and 4 for all of lines 26 and y or sum of <b>VICES OUTSIDE PRC</b>	86,473 2,485 0 2,485 545 3,030 0 0 0 0 0 0 0 0 0 0 0 0 0	23.0 24.0 25.0 26.0 27.0 28.0 29.0 30.0 31.0 32.0 33.0 35.0 34.0 35.0 36.0 37.0 38.0 39.0 40.0 41.0		
4.00 5.00 6.00 7.00 8.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 0.00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/ Standard Travel Expense Therapists (line 6 times column 3, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.0 Assistants (column 3, line 12.01 times column Subtotal (sum of lines 40 and 41) Optional travel expense (line 8 times the sum Total Travel Allowance and Travel Expense - C or 46, as appropriate.	sum of lines 2 for respirator travel expense of columns 1 an , line 12) sum of lines 2 s 1 and 2, line l expense (line l expense (sum NCE AND TRAVEL n of lines 5 an Expense D1 times column h 3, line 10) m of columns 1- offsite Service	4 and 25 for a y therapy or s at the provid d 2, line 12 ) 9 and 30 for a 13 for respir 28) of lines 27 an of lines 27 an of lines 31 an EXPENSE COMPU d 6) 2, line 10) 3, line 13.01) s; Complete on	<pre>11 others) um of lines er site (sum 11 others) atory therap d 31) d 32) TATION - SER e of the fol</pre>	3 and 4 for all of lines 26 and y or sum of VICES OUTSIDE PRO	86,473 2,485 0 2,485 545 3,030 0 0 0 0 0 0 0 0 0 0 0 0 0	23.1 24.1 25.1 26.1 27.1 28.1 29.1 30.1 31.1 32.1 33.1 34.1 35.1 34.1 35.1 34.1 35.1 40.1 41.1 42.1		

REASON	Financial Systems ABLE COST DETERMINATION FOR THERAPY SERVICES E SUPPLIERS	ASCENSION ST. VI FURNISHED BY	Provider C	CN: 15-1308	Period: From 07/01/2022	worksheet A-8 Parts I-VI	
					то 06/30/2023	Date/Time Pre 11/22/2023 2:	
					Speech Pathology		
						1.00	
6.00	Optional travel allowance and optional trave	l expense (sum o	f lines 42 an	d 43 - see i	nstructions)	0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
17 00	PART V - OVERTIME COMPUTATION	0.00	0.00	0.0	0.00	0.00	47.00
7.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or	0.00	0.00	0.0	0.00	0.00	47.00
	equal to or greater than 2,080, do not						
	complete lines 48-55 and enter zero in each						
	column of line 56)						
8.00	Overtime rate (see instructions)	0.00	0.00	0.0	0.00		48.0
9.00	Total overtime (including base and overtime	0.00	0.00	0.0	0.00		49.0
	allowance) (multiply line 47 times line 48)						
0.00	CALCULATION OF LIMIT Percentage of overtime hours by category	0.00	0.00	0.0	0.00	0.00	50.0
0.00	(divide the hours in each column on line 47	0.00	0.00	0.0	0.00	0.00	50.00
	by the total overtime worked - column 5,						
	line 47)						
1.00	Allocation of provider's standard work year	0.00	0.00	0.0	0.00	0.00	51.0
	for one full-time employee times the						
	percentages on line 50) (see instructions)						
2.00	DETERMINATION OF OVERTIME ALLOWANCE Adjusted hourly salary equivalency amount	87.17	0.00	0.0	0.00		52.0
2.00	(see instructions)	07.17	0.00	0.0	0.00		32.0
3.00	Overtime cost limitation (line 51 times line	0	0		0 0		53.0
	52)						
4.00	Maximum overtime cost (enter the lesser of	0	0		0 0		54.0
	line 49 or line 53)						
5.00	Portion of overtime already included in	0	0		0 0		55.0
	hourly computation at the AHSEA (multiply line 47 times line 52)						
6.00	Overtime allowance (line 54 minus line 55 -	0	0		0 0	0	56.0
	if negative enter zero) ( Enter in column 5						
	the sum of columns 1, 3, and 4 for						
	respiratory therapy and columns 1 through 3						
	for all others.)						
						1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION A	ND EXCESS COST A	ADJUSTMENT				
7.00	Salary equivalency amount (from line 23)	(C				86,473	
8.00	Travel allowance and expense - provider site	• /	, , , ,	``		3,030	
9.00	Travel allowance and expense - Offsite servic Overtime allowance (from column 5, line 56)	ces (trom lines 4	44, 45, Or 46	)		0	
1.00	Equipment cost (see instructions)					0	
2.00	Supplies (see instructions)					0	
	Total allowance (sum of lines 57-62)					89,503	
4.00	Total cost of outside supplier services (from	n your records)				23,136	
5.00	Excess over limitation (line 64 minus line 63		enter zero)				65.0
	LINE 33 CALCULATION						]
	Line 26 = line 24 for respiratory therapy or					2,485	
	Line 27 = line 7 times line 3 for respiratory	/ therapy or sum	of lines 3 a	nd 4 for all	others		100.0
00.02	Line 33 = line 28 = sum of lines 26 and 27					3,030	100.0
01 00	LINE 34 CALCULATION	( thorapy on cum	of lines 2 a	nd 4 for all	othone	E4E	101 0
	Line 27 = line 7 times line 3 for respiratory Line 31 = line 29 for respiratory therapy or				others		101.0 101.0
	Line $34 = \text{sum of lines } 27 \text{ and } 31$	Juli OF THES 29		ULIEIS			101.0
	LINE 35 CALCULATION						101.0
02.00	Line 31 = line 29 for respiratory therapy or	sum of lines 29	and 30 for a	11 others		0	102.0
	Line 32 = line 8 times columns 1 and 2, line				umns 1-3, line		102.0
	13 for all others						
02.02	Line 35 = sum of lines 31 and 32					0	102.

COST A		ASCENSION ST. V				u of Form CMS-2	2332-10
	LLOCATION - GENERAL SERVICE COSTS		Provider CC		Period: From 07/01/2022 To 06/30/2023	Worksheet B Part I Date/Time Pre 11/22/2023 2:	
			CAPITAL REL	ATED COSTS			
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	NEW BLDG & FIXT	NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		0	1.00	2.00	4.00	4A	
	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT	1,143,899	1,143,899				1.00
2.00	00200 NEW CAP REL COSTS-BLDG & PIXT	436,687	1,145,655	436,68	7		2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	1,588,333	0		, 0 1,588,333		4.00
5.00	00500 ADMINISTRATIVE & GENERAL	5,120,969	353,254	28		5,565,699	•
7.00	00700 OPERATION OF PLANT	1,100,649	221,574	5,38		1,327,606	•
8.00	00800 LAUNDRY & LINEN SERVICE	47,147	13,624		0 0	60,771	8.00
9.00	00900 HOUSEKEEPING	563,295	8,304		0 0	571,599	9.00
10.00	01000 DIETARY	57,980	22,593	10,57	6 0	91,149	10.00
11.00	01100 CAFETERIA	375,618	14,328		0 0	389,946	11.00
	01300 NURSING ADMINISTRATION	67,829	14,064	22,37	8 18,798	123,069	13.00
	01500 PHARMACY	2,985,493	12,705	62,12	2 90,299	3,150,619	15.00
	01600 MEDICAL RECORDS & LIBRARY	0	19,316		0 0	19,316	
	01700 SOCIAL SERVICE	124,103	3,482		0 22,700	150,285	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	840,062	56,951	22,95	2 239,555	1,159,520	30.00
	03100 INTENSIVE CARE UNIT	040,002	50,951		0 239,333	1,139,320	31.00
	02040 DETOXIFICATION INTENSIVE CARE UNIT	0	0		0 0	0	•
	ANCILLARY SERVICE COST CENTERS	0	0		0	0	55.00
	05000 OPERATING ROOM	213,572	76,433	111,01	7 143,970	544,992	50.00
	05400 RADIOLOGY-DIAGNOSTIC	925,522	49,068	149,84		1,392,799	
	05600 RADIOISOTOPE	0	0		0 0	0	56.00
57.00	05700 CT SCAN	0	0		0 0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	58.00
60.00	06000 LABORATORY	1,358,319	21,487		0 0	1,379,806	60.00
65.00	06500 RESPIRATORY THERAPY	605,021	16,773	13,14		813,637	
66.00	06600 PHYSICAL THERAPY	589,699	50,408		0 5,059	645,166	
67.00	06700 OCCUPATIONAL THERAPY	82,094	1,780		0 1,246	85,120	1
	06800 SPEECH PATHOLOGY	26,582	0		0 1,053	27,635	
	06900 ELECTROCARDIOLOGY	0	0		0 0	0	69.00
	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	662,077	0		0 0	662,077	1
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	450,097	0		0 0	450,097	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2,120	0		0 0	2,120	73.00
	03610 SLEEP LAB	19,861	7,140		9 5,885	32,935	
	03480 ONCOLOGY	263,570	3,384		0 69,424	336,378	
	OUTPATIENT SERVICE COST CENTERS	· · · · · ·				,	1
90.00	09000 CLINIC	300,272	14,152		0 84,727		
	09100 EMERGENCY	2,385,143	70,585	38,93	7 367,362	2,862,027	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
	SPECIAL PURPOSE COST CENTERS						
118.00		22,336,013	1,051,405	436,68	7 1,588,333	22,243,519	1118.00
	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,316		0 0	2 216	190.00
192 00	19200 PHYSICIANS' PRIVATE OFFICES	0	78,947		0 0 0 0		190.00
	07950 MARKETING	0	7,189				192.00
	07951 FOUNDATION	0	3,042		0 0		194.00
	07952 CLINIC	0	3,042		0 0		194.02
	07953 VACANT	0	ő		0 0	0	194.03
						0	200.00
194.03	Cross Foot Adjustments	-	0		0 0		200.00 201.00

COST A	ALLOCATION - GENERAL SERVICE COSTS	_	Provider Co	CN: 15-1308	Period: From 07/01/2022 To 06/30/2023	Worksheet B Part I Date/Time Pre 11/22/2023 2:	
	Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVIC	HOUSEKEEPING E	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS			_			
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL	5,565,699					5.00
7.00	00700 OPERATION OF PLANT	440,603	1,768,209				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	20,169	42,332	123,27	2		8.00
9.00	00900 HOUSEKEEPING	189,701	25,801		0 787,101		9.00
10.00	01000 DIETARY	30,250	70,200		0 0	191,599	10.00
11.00	01100 CAFETERIA	129,414	44,521		0 0	0	11.00
13.00	01300 NURSING ADMINISTRATION	40,844	43,700		0 1,263	0	13.00
15.00	01500 PHARMACY	1,045,624	39,476		0 0	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	6,411	60,019	1	0 2,578	0	16.00
17.00	01700 SOCIAL SERVICE	49,876	10,819	1	0 421	0	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS	· · · · · ·					
30.00	03000 ADULTS & PEDIATRICS	384,819	176,958	123,27	2 306,244	191,599	30.00
31.00	03100 INTENSIVE CARE UNIT	0	0		0 0	0	1
35.00	02040 DETOXIFICATION INTENSIVE CARE UNIT	0	0		0 0	0	35.00
	ANCILLARY SERVICE COST CENTERS						1
50.00	05000 OPERATING ROOM	180,871	237,493		0 99,275	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	462,239	152,464		0 58,713	0	54.00
56.00	05600 RADIOISOTOPE	0	0		0 0	0	56.00
57.00	05700 CT SCAN	0	0		0 0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	58.00
60.00	06000 LABORATORY	457,927	66,766		0 12,416	0	60.00
65.00	06500 RESPIRATORY THERAPY	270,028	52,118		0 5,156	0	65.00
66.00	06600 PHYSICAL THERAPY	214,116	156,627		0 22,096	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	28,249	5,531		0 0	0	67.00
68.00	06800 SPEECH PATHOLOGY	9,171	0		0 0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0		0 0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	219,729	0		0 0	0	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO	149,377	0		0 0	0	72.00
	PATIENTS	· · · · ·					
73.00	07300 DRUGS CHARGED TO PATIENTS	704	0	1	0 54,241	0	73.00
76.00	03610 SLEEP LAB	10,930	22,184	1	0 1,210	0	76.00
76.01	03480 ONCOLOGY	111,636	10,515	1	0 2,683	0	76.01
	OUTPATIENT SERVICE COST CENTERS					·	
90.00	09000 CLINIC	132,469	43,974		0 74,864	0	90.00
91.00	09100 EMERGENCY	949,844	219,321	1	0 145,520	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			1			92.00
	SPECIAL PURPOSE COST CENTERS						
118.00		5,535,001	1,480,819	123,27	786,680	191,599	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,101	10,302		0 0	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	26,201	245,301		0 0		192.00
	07950 MARKETING	2,386			0 0	0	194.00
194.01	07951 FOUNDATION	1,010			0 421	0	194.01
194.02	07952 CLINIC	0	0		0 0		194.02
	07953 VACANT	0	0		0 0		194.03
200.00		1					200.00
201.00		0	0		0 0	0	201.00
201.00							

COST A	LLOCAT	TION - GENERAL SERVICE COSTS		Provider CC	EN: 15-1308	Period: From 07/01/2022 To 06/30/2023		
		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			11.00	13.00	15.00	16.00	17.00	
		AL SERVICE COST CENTERS						1
1.00		NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00		NEW CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT						2.00
4.00 5.00		ADMINISTRATIVE & GENERAL						4.00
7.00		OPERATION OF PLANT						7.00
8.00		LAUNDRY & LINEN SERVICE						8.00
9.00	1 1	HOUSEKEEPING						9.00
10.00	1 1	DIETARY						10.00
11.00	1 1	CAFETERIA	563,881					11.00
13.00	1 1	NURSING ADMINISTRATION	10,069	218,945				13.00
15.00	01500	PHARMACY	30,208	0	4,265,92	27		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0		0 88,324		16.00
17.00	01700	SOCIAL SERVICE	10,069	4,941		0 0	226,411	17.00
	INPAT:	IENT ROUTINE SERVICE COST CENTERS	r	· · · · · · · · · · · · · · · · · · ·			1	
30.00		ADULTS & PEDIATRICS	100,693	55,169		0 3,644	219,605	30.00
31.00		INTENSIVE CARE UNIT	0	0		0 0	0	31.00
35.00		DETOXIFICATION INTENSIVE CARE UNIT	0	0		0 0	0	35.00
F0 00		LARY SERVICE COST CENTERS	60.416	21 627		0 15 200	0	50.00
50.00	1 1	OPERATING ROOM	60,416	31,627		0 15,209	0	50.00
54.00 56.00		RADIOLOGY-DIAGNOSTIC RADIOISOTOPE	90,624	128		0 19,812	0	54.00
57.00		CT SCAN	0	0		0 0	0	56.00
58.00	1 1	MAGNETIC RESONANCE IMAGING (MRI)	0	0			0	58.00
60.00	1	LABORATORY	0	0		0 13,180	0	60.00
65.00		RESPIRATORY THERAPY	60,416	22,374		0 3,210	0	65.00
66.00		PHYSICAL THERAPY	00,120	0		0 3,482	0	66.00
67.00	1 1	OCCUPATIONAL THERAPY	0	0		0 689	0	67.00
68.00		SPEECH PATHOLOGY	0	0		0 156	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		0 0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO	0	0		0 0	0	72.00
		PATIENTS						
73.00		DRUGS CHARGED TO PATIENTS	0	0	4,265,92		0	73.00
76.00		SLEEP LAB	0	0		0 161	0	76.00
76.01		ONCOLOGY	30,208	14,352		0 1,880	0	76.01
90.00		TIENT SERVICE COST CENTERS	40,277	15,517		0 1,992	0	90.00
90.00		EMERGENCY	130,901	74,837		0 24,909	-	•
92.00		OBSERVATION BEDS (NON-DISTINCT PART)	130,901	74,057		24,505	0,000	92.00
52.00		AL PURPOSE COST CENTERS						52.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	563.881	218.945	4,265,92	88.324	226,411	118.00
110.00		IMBURSABLE COST CENTERS	500,001	220,010	.,200,01			
190.00		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190.00
		PHYSICIANS' PRIVATE OFFICES	0	0		0 0		192.00
		MARKETING	0	0		0 0	0	194.00
194.01	07951	FOUNDATION	0	0		0 0		194.01
		CLINIC	0	0		0 0		194.02
		VACANT	0	0		0 0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers TOTAL (sum lines 118 through 201)	0 563,881	0 218,945		0 0 27 88,324		201.00
202.00					4,265,92			

OST ALLOCA	TION - GENERAL SERVICE COSTS		Provider CC	N: 15-1308	Period:	Worksheet B
					From 07/01/2022	Part I
					то 06/30/2023	Date/Time Prepar 11/22/2023 2:20
	Cost Center Description	Subtotal	Intern &	Total		11, 11, 10, 1010
		R	esidents Cost			
			& Post			
			Stepdown			
	-	24.00	Adjustments	26.00		
CENE		24.00	25.00	26.00		
	RAL SERVICE COST CENTERS					1
	D NEW CAP REL COSTS BEDG & FIXT					
	0 EMPLOYEE BENEFITS DEPARTMENT					
	0 ADMINISTRATIVE & GENERAL					
	O OPERATION OF PLANT					
	0 LAUNDRY & LINEN SERVICE					8
	0 HOUSEKEEPING					
	0 DIETARY					10
	0 CAFETERIA					11
.00 0130	0 NURSING ADMINISTRATION					13
	0 PHARMACY					15
.00 0160	0 MEDICAL RECORDS & LIBRARY					16
	0 SOCIAL SERVICE					17
	FIENT ROUTINE SERVICE COST CENTERS	I				
	0 ADULTS & PEDIATRICS	2,721,523	0	2,721,5	23	30
.00 0310	0 INTENSIVE CARE UNIT	0	0		0	31
.00 0204	0 DETOXIFICATION INTENSIVE CARE UNIT	0	0		0	35
ANCI	LLARY SERVICE COST CENTERS					
.00 0500	0 OPERATING ROOM	1,169,883	0	1,169,8	83	50
.00 0540	0 RADIOLOGY-DIAGNOSTIC	2,176,779	0	2,176,7	79	54
.00 0560	0 RADIOISOTOPE	0	0		0	56
.00 0570	0 CT SCAN	0	0		0	57
.00 0580	MAGNETIC RESONANCE IMAGING (MRI)	0	0		0	58
.00 0600	0 LABORATORY	1,930,095	0	1,930,0	95	60
.00 0650	0 RESPIRATORY THERAPY	1,226,939	0	1,226,9	39	65
.00 0660	0 PHYSICAL THERAPY	1,041,487	0	1,041,4	87	66
.00 0670	0 OCCUPATIONAL THERAPY	119,589	0	119,5	89	67
.00 0680	0 SPEECH PATHOLOGY	36,962	0	36,9	62	68
.00 0690	0 ELECTROCARDIOLOGY	0	0		0	69
.00 0700	0 ELECTROENCEPHALOGRAPHY	0	0		0	70
.00 0710	0 MEDICAL SUPPLIES CHARGED TO PATIENTS	881,806	0	881,8	06	71
.00 0720	0 IMPLANTABLE DEVICES CHARGED TO	599,474	0	599,4	74	72
	PATIENTS					
	0 DRUGS CHARGED TO PATIENTS	4,322,992	0	4,322,9	92	73
	0 SLEEP LAB	67,420	0	67,4		76
	0 ONCOLOGY	507,652	0	507,6	52	76
	ATIENT SERVICE COST CENTERS		- 1			
.00 0900		708,244	0	708,2		90
	0 EMERGENCY	4,414,165	0	4,414,1	.65	91
	O OBSERVATION BEDS (NON-DISTINCT PART)		0			92
	IAL PURPOSE COST CENTERS	21 025 010	0	21 025 0	10	
8.00	SUBTOTALS (SUM OF LINES 1 through 117)	21,925,010	0	21,925,0	10	118
	EIMBURSABLE COST CENTERS	14 710		14 -	10	10
	0 GIFT, FLOWER, COFFEE SHOP & CANTEEN	14,719	0	14,7		190 192
	0 PHYSICIANS' PRIVATE OFFICES	350,449	0	350,4		
	0 MARKETING	31,911	0	31,9		194
	1 FOUNDATION	13,924	0	13,9	0	194
4.02 0795		0	0		0	194
4.03 0795		0	0		0	194
0.00	Cross Foot Adjustments	0	0		0	200
01.00 02.00	Negative Cost Centers TOTAL (sum lines 118 through 201)	0	0	22.226.6	0	201
	1000 (SUM 1306S 118 through 201)	22,336,013	0	22,336,0	123	202

	· · · · · · · · · · · · · · · · · · ·	ASCENSION ST. V		45 4200		u of Form CMS-2	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider CC	N: 15-1308	Period: From 07/01/2022 To 06/30/2023	Worksheet B Part II Date/Time Pre 11/22/2023 2:2	
			CAPITAL REL	ATED COSTS			
	Cost Center Description	Directly Assigned New Capital Related Costs	NEW BLDG & FIXT	NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
	GENERAL SERVICE COST CENTERS	0	1.00	2.00	2A	4.00	
	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0		0 0	0	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	277,922	353,254	28	631,460	0	5.00
7.00	00700 OPERATION OF PLANT	0	221,574	5,38	226,957	0	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	13,624		0 13,624	0	8.00
9.00	00900 HOUSEKEEPING	0	8,304		0 8,304	0	9.00
10.00	01000 DIETARY	0	22,593	10,57	76 33,169	0	10.00
11.00	01100 CAFETERIA	0	14,328		0 14,328	0	11.00
13.00	01300 NURSING ADMINISTRATION	0	14,064	22,37	78 36,442	0	13.00
	01500 PHARMACY	0	12,705	62,12	74,827	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	19,316		0 19,316	0	16.00
17.00	01700 SOCIAL SERVICE	0	3,482		0 3,482	0	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	0	56,951	22,95		0	30.00
	03100 INTENSIVE CARE UNIT	0	0		0 0	0	31.00
35.00	02040 DETOXIFICATION INTENSIVE CARE UNIT	0	0		0 0	0	35.00
50.00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	0	76,433	111,01	7 187,450	0	50.00
	05400 RADIOLOGY-DIAGNOSTIC	0	49,068	149,84		0	54.00
	05600 RADIOLOGI-DIAGNOSTIC	0	49,008	149,04	0 0	0	56.00
	05700 CT SCAN	0	0			0	57.00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	58.00
	06000 LABORATORY	0	21,487		0 21,487	0	60.00
	06500 RESPIRATORY THERAPY	0	16,773	13,14		0	65.00
	06600 PHYSICAL THERAPY	0	50,408	,_	0 50,408	0	66.00
	06700 OCCUPATIONAL THERAPY	0	1,780		0 1,780	0	67.00
	06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
	06900 ELECTROCARDIOLOGY	0	0		0 0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
	07200 IMPLANTABLE DEVICES CHARGED TO	0	0		0 0	0	72.00
	PATIENTS						
	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
	03610 SLEEP LAB	0	7,140	4	9 7,189	0	76.00
76.01	03480 ONCOLOGY	0	3,384		0 3,384	0	76.01
~~ ~~	OUTPATIENT SERVICE COST CENTERS		44.450		0 44450		
	09000 CLINIC	0	14,152	20.02	0 14,152	0	90.00
	09100 EMERGENCY	0	70,585	38,93		0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	277,922	1,051,405	436,68	1,766,014	0	118.00
110.00	NONREIMBURSABLE COST CENTERS	211,522	1,031,403	430,00	1,700,014	0	1110.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,316		0 3,316	0	190.00
	19200 PHYSICIANS' PRIVATE OFFICES	0	78,947		0 78,947		192.00
	07950 MARKETING	0	7,189		0 7,189		194.00
	07951 FOUNDATION	0	3,042		0 3,042		194.01
	07952 CLINIC	0	0,042		0 0		194.02
	07953 VACANT	0	0		0 0		194.03
			Ű				
200.00	Cross Foot Adjustments				01		200.00
			0		0 0		200.00

ALLOCA	TION OF CAPITAL RELATED	COSTS		Provider C		Period: From 07/01/2022 To 06/30/2023	Worksheet B Part II Date/Time Pre 11/22/2023 2:	epared: 20 pm
	Cost Center Descr	iption	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CE							
1.00	00100 NEW CAP REL COSTS	-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS	-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS	DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE &	GENERAL	631,460					5.00
7.00	00700 OPERATION OF PLAN	т	49,988	276,945				7.00
8.00	00800 LAUNDRY & LINEN S	ERVICE	2,288	6,630	22,54	2		8.00
9.00	00900 HOUSEKEEPING		21,522	4,041		0 33,867		9.00
10.00	01000 DIETARY		3,432	10,995		0 0	47,596	10.00
11.00	01100 CAFETERIA		14,683	6,973		0 0	0	11.00
13.00	01300 NURSING ADMINISTR	ATION	4,634	6,844		0 54	0	
15.00	01500 PHARMACY		118,636			0 0	0	
16.00	01600 MEDICAL RECORDS &	LTBRARY	727	9,400		0 111	ů 0	1
17.00	01700 SOCIAL SERVICE	LIDIARI	5,659	1,694		0 18	0	
17.00	INPATIENT ROUTINE SERVI	CE COST CENTERS	5,055	1,054		0 10	0	17.00
30.00	03000 ADULTS & PEDIATRI		43,659	27,716	22,54	2 13,178	47,596	30.00
31.00	03100 INTENSIVE CARE UN		43,039	0		0 13,178	47,590	1
	02040 DETOXIFICATION IN		0	0		0 0	0	
55.00	ANCILLARY SERVICE COST		0	0		0 0	0	35.00
50.00	05000 OPERATING ROOM	CENTERS	20.521	37,197		0 4,272	0	50.00
54.00		TIC	. , .	,			0	
	05400 RADIOLOGY-DIAGNOS	IIC	52,443	23,880		0 2,526	-	54.00
56.00	05600 RADIOISOTOPE		0	0		0 0	0	
57.00	05700 CT SCAN		0	0		0 0	0	57.00
58.00	05800 MAGNETIC RESONANC	E IMAGING (MRI)	51 054	10 457		0 0	0	58.00
60.00	06000 LABORATORY		51,954	10,457		0 534	0	60.00
65.00	06500 RESPIRATORY THERA	PY	30,636	8,163		0 222	0	65.00
66.00	06600 PHYSICAL THERAPY		24,292	24,532		0 951	0	66.00
67.00	06700 OCCUPATIONAL THER	APY	3,205	866		0 0	0	67.00
68.00	06800 SPEECH PATHOLOGY		1,041	0		0 0	0	
69.00	06900 ELECTROCARDIOLOGY		0	0		0 0	0	
70.00	07000 ELECTROENCEPHALOG		0	0		0 0	0	
71.00	07100 MEDICAL SUPPLIES		24,929	0		0 0	0	71.00
72.00	07200 IMPLANTABLE DEVIC	ES CHARGED TO	16,948	0		0 0	0	72.00
	PATIENTS							
73.00	07300 DRUGS CHARGED TO	PATIENTS	80	0		0 2,334	0	
76.00	03610 SLEEP LAB		1,240			0 52	0	
76.01	03480 ONCOLOGY		12,666	1,647		0 115	0	76.01
	OUTPATIENT SERVICE COST	CENTERS	1					
90.00	09000 CLINIC		15,029	6,887		0 3,221	0	
91.00	09100 EMERGENCY		107,764	34,351		0 6,261	0	91.00
92.00	09200 OBSERVATION BEDS	(NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CE	NTERS						
118.00	SUBTOTALS (SUM OF	LINES 1 through 117)	627,976	231,931	22,54	2 33,849	47,596	118.00
	NONREIMBURSABLE COST CE	NTERS						
	19000 GIFT, FLOWER, COF		125	1,614		0 0		190.00
192.00	19200 PHYSICIANS' PRIVA	TE OFFICES	2,973	38,422		0 0		192.00
	07950 MARKETING		271	3,498		0 0	0	194.00
	07951 FOUNDATION		115	1,480		0 18		194.01
	07952 CLINIC		0	0		0 0		194.02
	07953 VACANT		0	0		0 0		194.03
200.00		ments	Ĭ				Ŭ	200.00
								200.00
201.00	Negative (ost (en	ters				0 0	0	1/01 01

1.00 $002$ 2.00 $002$ 4.00 $004$ 5.00 $002$ 7.00 $002$ 8.00 $003$ 9.00 $003$ 9.00 $012$ 11.00 $012$ 13.00 $012$ 17.00 $012$ 30.00 $033$ 31.00 $033$ 35.00 $022$ 56.00 $055$ 58.00 $055$ 58.00 $055$ 55.00 $056$ 57.00 $055$ 56.00 $056$ 57.00 $055$ 58.00 $058$ 60.00 $066$ 67.00 $056$ 68.00 $066$ 67.00 $056$ 68.00 $066$	Cost Center Description  VERAL SERVICE COST CENTERS  100 NEW CAP REL COSTS-BLDG & FIXT 200 NEW CAP REL COSTS-MVBLE EQUIP 400 EMPLOYEE BENEFITS DEPARTMENT 500 ADMINISTRATIVE & GENERAL 700 OPERATION OF PLANT 800 LAUNDRY & LINEN SERVICE 900 HOUSEKEEPING 900 DIETARY 100 CAFETERIA 800 NURSING ADMINISTRATION 900 PHARMACY 500 MEDICAL RECORDS & LIBRARY 700 SOCIAL SERVICE 94 TENT ROUTINE SERVICE COST CENTERS 900 ADULTS & PEDIATRICS 100 INTENSIVE CARE UNIT 94 DETOXIFICATION INTENSIVE CARE UNIT 11 14 DETOXIFICATION INTENSIVE CARE UNIT 11 14 DETOXIFICATION INTENSIVE CARE UNIT 11 14 15 14 15 15 15 15 15 15 15 15 15 15 15 15 15	CAFETERIA 11.00 35,984 643 1,928 0 6,426 0 0 3,855 5,783	NURSING ADMINISTRATION 13.00 48,617 0 0 1,097 12,250 0 0 7,023 28	PHARMACY  15.00  201,574  (0)  (0)  (0)  (0)  (0)  (0)  (0)  (0	RECORDS & LIBRARY 16.00 29,554 0 29,554 0 1,218 0 0 0 0	SOCIAL SERVICE 17.00 12,593 12,214 0 0 0	1.00 2.00 4.00 5.00 7.00 8.00 9.00 10.00 11.00 13.00 15.00 16.00 17.00 30.00 31.00
1.00 $002$ 2.00 $002$ 4.00 $004$ 5.00 $002$ 7.00 $002$ 8.00 $003$ 9.00 $003$ 9.00 $012$ 11.00 $012$ 13.00 $012$ 17.00 $012$ 30.00 $033$ 31.00 $033$ 35.00 $022$ 56.00 $055$ 58.00 $055$ 58.00 $055$ 55.00 $056$ 57.00 $055$ 56.00 $056$ 57.00 $055$ 58.00 $058$ 60.00 $066$ 67.00 $056$ 68.00 $066$ 67.00 $056$ 68.00 $066$	100       NEW CAP REL COSTS-BLDG & FIXT         200       NEW CAP REL COSTS-MVBLE EQUIP         400       EMPLOYEE BENEFITS DEPARTMENT         500       ADMINISTRATIVE & GENERAL         700       OPERATION OF PLANT         300       LAUNDRY & LINEN SERVICE         900       HOUSEKEEPING         900       DIETARY         100       CAFETERIA         300       NURSING ADMINISTRATION         500       MEDICAL RECORDS & LIBRARY         700       SOCIAL SERVICE <b>PATIENT ROUTINE SERVICE COST CENTERS</b> 900       ADULTS & PEDIATRICS         100       INTENSIVE CARE UNIT         940       DETOXIFICATION INTENSIVE CARE UNIT <b>TILLARY SERVICE COST CENTERS</b> 900       PRATING ROOM         400       RADIOLOGY-DIAGNOSTIC	35,984 643 1,928 0 6,426 0 0 3,855	48,617 0 0 1,097 12,250 0 0 7,023	201,574	4 29,554 0 1,218 0 0 0 0	12,593 12,214 0 0	2.00 4.00 5.00 7.00 8.00 9.00 10.00 11.00 13.00 15.00 16.00 17.00 30.00 31.00
1.00 $002$ 2.00 $002$ 4.00 $004$ 5.00 $002$ 7.00 $002$ 8.00 $003$ 9.00 $003$ 9.00 $012$ 11.00 $012$ 13.00 $012$ 17.00 $012$ 30.00 $033$ 31.00 $033$ 35.00 $022$ 56.00 $055$ 58.00 $055$ 58.00 $055$ 55.00 $056$ 57.00 $055$ 56.00 $056$ 57.00 $055$ 58.00 $058$ 60.00 $066$ 67.00 $056$ 68.00 $066$ 67.00 $056$ 68.00 $066$	100       NEW CAP REL COSTS-BLDG & FIXT         200       NEW CAP REL COSTS-MVBLE EQUIP         400       EMPLOYEE BENEFITS DEPARTMENT         500       ADMINISTRATIVE & GENERAL         700       OPERATION OF PLANT         300       LAUNDRY & LINEN SERVICE         900       HOUSEKEEPING         900       DIETARY         100       CAFETERIA         300       NURSING ADMINISTRATION         500       MEDICAL RECORDS & LIBRARY         700       SOCIAL SERVICE <b>PATIENT ROUTINE SERVICE COST CENTERS</b> 900       ADULTS & PEDIATRICS         100       INTENSIVE CARE UNIT         940       DETOXIFICATION INTENSIVE CARE UNIT <b>TILLARY SERVICE COST CENTERS</b> 900       PRATING ROOM         400       RADIOLOGY-DIAGNOSTIC	643 1,928 0 6,426 0 0 0 3,855	0 0 1,097 12,250 0 0 7,023		29,554 0 1,218 0 0 0 0	12,214 0 0	2.00 4.00 5.00 7.00 8.00 9.00 10.00 11.00 13.00 15.00 16.00 17.00 30.00 31.00
2.00         002           4.00         004           5.00         003           5.00         003           5.00         003           5.00         003           8.00         003           10.00         012           13.00         013           15.00         013           17.00         013           30.00         033           31.00         032           50.00         056           54.00         055           58.00         055           58.00         056           60.00         066           65.00         056           65.00         056           65.00         056           65.00         056           65.00         056           65.00         056           65.00         056           65.00         056           65.00         056           65.00         056           65.00         056           65.00         056           65.00         056           65.00         056           65.00	2000 NEW CAP REL COSTS-MVBLE EQUIP 400 EMPLOYEE BENEFITS DEPARTMENT 500 ADMINISTRATIVE & GENERAL 700 OPERATION OF PLANT 500 LAUNDRY & LINEN SERVICE 500 HOUSEKEEPING 500 DIETARY 100 CAFETERIA 500 NURSING ADMINISTRATION 500 PHARMACY 500 SOCIAL SERVICE 500 ADULTS & PEDIATRICS 100 INTENSIVE CARE UNIT 500 DETOXIFICATION INTENSIVE CARE UNIT 500 DETOXIFICATION INTENSIVE CARE UNIT 500 PERATING ROOM 500 RADIOLOGY-DIAGNOSTIC	643 1,928 0 6,426 0 0 0 3,855	0 0 1,097 12,250 0 0 7,023		29,554 0 1,218 0 0 0 0	12,214 0 0	2.00 4.00 5.00 7.00 8.00 9.00 10.00 11.00 13.00 15.00 16.00 17.00 30.00 31.00
$\begin{array}{ccccc} 4.00 & 0.04 \\ 5.00 & 0.07 \\ 5.00 & 0.07 \\ 8.00 & 0.07 \\ 8.00 & 0.07 \\ 9.00 & 0.07 \\ 10.00 & 0.17 \\ 11.00 & 0.17 \\ 13.00 & 0$	400 EMPLOYEE BENEFITS DEPARTMENT 500 ADMINISTRATIVE & GENERAL 700 OPERATION OF PLANT 500 LAUNDRY & LINEN SERVICE 500 HOUSEKEEPING 500 DIETARY 100 CAFETERIA 500 NURSING ADMINISTRATION 500 PHARMACY 500 SOCIAL SERVICE 500 ADULTS & PEDIATRICS 500 ADULTS & PEDIATRICS 500 ADULTS & PEDIATRICS 500 INTENSIVE CARE UNIT 500 DETOXIFICATION INTENSIVE CARE UNIT 500 DETAILING ROOM 500 RADIOLOGY-DIAGNOSTIC	643 1,928 0 6,426 0 0 0 3,855	0 0 1,097 12,250 0 0 7,023		29,554 0 1,218 0 0 0 0	12,214 0 0	4.00 5.00 7.00 8.00 9.00 10.00 11.00 13.00 15.00 16.00 17.00 30.00 31.00
$\begin{array}{cccccccccccccccccccccccccccccccccccc$	500       ADMINISTRATIVE & GENERAL         700       OPERATION OF PLANT         800       LAUNDRY & LINEN SERVICE         900       HOUSEKEEPING         900       DIETARY         100       CAFETERIA         800       NURSING ADMINISTRATION         900       PHARMACY         900       MEDICAL RECORDS & LIBRARY         900       ADULTS & PEDIATRICS         900       ADULTS & PEDIATRICS         940       DETOXIFICATION INTENSIVE CARE UNIT         910       PERATING ROOM         900       PRATING ROOM         900       RADIOLOGY-DIAGNOSTIC	643 1,928 0 6,426 0 0 0 3,855	0 0 1,097 12,250 0 0 7,023		29,554 0 1,218 0 0 0 0	12,214 0 0	5.00 7.00 8.00 9.00 10.00 11.00 13.00 15.00 16.00 17.00 30.00 31.00
7.00         007           8.00         008           9.00         009           10.00         010           11.00         011           13.00         012           15.00         012           15.00         012           15.00         012           17.00         013           30.00         033           31.00         033           35.00         026           54.00         056           54.00         055           55.00         055           66.00         066           67.00         055           66.00         066           67.00         055           68.00         066           69.00         065	700 OPERATION OF PLANT 800 LAUNDRY & LINEN SERVICE 900 HOUSEKEEPING 900 DIETARY 100 CAFETERIA 900 NURSING ADMINISTRATION 900 PHARMACY 900 MEDICAL RECORDS & LIBRARY 900 SOCIAL SERVICE 941ENT ROUTINE SERVICE COST CENTERS 900 ADULTS & PEDIATRICS 100 INTENSIVE CARE UNIT 940 DETOXIFICATION INTENSIVE CARE UNIT 911 912 912 912 912 912 912 912	643 1,928 0 6,426 0 0 0 3,855	0 0 1,097 12,250 0 0 7,023		29,554 0 1,218 0 0 0 0	12,214 0 0	7.00 8.00 9.00 10.00 11.00 13.00 15.00 16.00 17.00 30.00 31.00
8.00         008           9.00         009           10.00         010           11.00         011           13.00         012           15.00         012           17.00         012           17.00         013           30.00         030           31.00         033           35.00         026           50.00         055           54.00         055           58.00         055           58.00         055           66.00         066           67.00         065           66.00         066           67.00         065           68.00         066           69.00         065	3000       LAUNDRY & LINEN SERVICE         3000       HOUSEKEEPING         3000       DIETARY         1000       CAFETERIA         3000       NURSING ADMINISTRATION         3000       NURSING ADMINISTRATION         5000       PHARMACY         5000       MEDICAL RECORDS & LIBRARY         7000       SOCIAL SERVICE <b>2ATIENT ROUTINE SERVICE COST CENTERS</b> 3000       ADULTS & PEDIATRICS         1000       INTENSIVE CARE UNIT         2400       DETOXIFICATION INTENSIVE CARE UNIT         211LARY SERVICE COST CENTERS         3000       OPERATING ROOM         4000       RADIOLOGY-DIAGNOSTIC	643 1,928 0 6,426 0 0 0 3,855	0 0 1,097 12,250 0 0 7,023		29,554 0 1,218 0 0 0 0	12,214 0 0	8.00 9.00 10.00 11.00 13.00 15.00 16.00 17.00 30.00 31.00
9.00         009           10.00         010           11.00         011           13.00         013           15.00         012           16.00         012           17.00         013           30.00         030           31.00         033           35.00         020           56.00         055           58.00         055           58.00         055           55.00         056           60.00         060           65.00         056           65.00         056           65.00         056           65.00         056           65.00         056           65.00         066           65.00         066           65.00         066           67.00         065           68.00         068           69.00         065	000       HOUSEKEEPING         000       DIETARY         100       CAFETERIA         000       NURSING ADMINISTRATION         000       PHARMACY         000       MEDICAL RECORDS & LIBRARY         000       SOCIAL SERVICE         2001       ADULTS & PEDIATRICS         1000       ADULTS & PEDIATRICS         1001       INTENSIVE CARE UNIT         2014       SERVICE COST CENTERS         000       PERATING ROOM         400       RADIOLOGY-DIAGNOSTIC	643 1,928 0 6,426 0 0 0 3,855	0 0 1,097 12,250 0 0 7,023		29,554 0 1,218 0 0 0 0	12,214 0 0	9.00 10.00 11.00 13.00 15.00 16.00 17.00 30.00 31.00
10.00         010           11.00         012           13.00         013           15.00         013           16.00         016           17.00         013           30.00         030           31.00         032           35.00         020           56.00         056           57.00         055           58.00         056           60.00         066           65.00         066           65.00         066           66.00         066           67.00         055           68.00         066           69.00         065	000 DIETARY 100 CAFETERIA 300 NURSING ADMINISTRATION 500 PHARMACY 500 MEDICAL RECORDS & LIBRARY 700 SOCIAL SERVICE 241ENT ROUTINE SERVICE COST CENTERS 500 ADULTS & PEDIATRICS 100 INTENSIVE CARE UNIT 500 DETOXIFICATION INTENSIVE CARE UNIT 500 PERATING ROOM 400 RADIOLOGY-DIAGNOSTIC	643 1,928 0 6,426 0 0 0 3,855	0 0 1,097 12,250 0 0 7,023		29,554 0 1,218 0 0 0 0	12,214 0 0	10.00 11.00 13.00 15.00 16.00 17.00 30.00 31.00
11.00         01:           13.00         01:           15.00         01:           15.00         01:           17.00         01:           30.00         03:           31.00         03:           35.00         02:           ANC         55:           50.00         05:           57:00         05:           58:00         05:           60:00         06:           67:00         05:           66:00         06:           67:00         05:           68:00         06:           69:00         06:	100 CAFETERIA 300 NURSING ADMINISTRATION 500 PHARMACY 500 MEDICAL RECORDS & LIBRARY 700 SOCIAL SERVICE <b>PATIENT ROUTINE SERVICE COST CENTERS</b> 5000 ADULTS & PEDIATRICS 100 INTENSIVE CARE UNIT 500 DETOXIFICATION INTENSIVE CARE UNIT 511 CARE UNIT 512 CARE UNIT 512 CARE UNIT 512 CARE UNIT 513 CARE UNIT 514 CARE UNIT 514 CARE UNIT 515 CAR	643 1,928 0 6,426 0 0 0 3,855	0 0 1,097 12,250 0 0 7,023		29,554 0 1,218 0 0 0 0	12,214 0 0	11.00 13.00 15.00 16.00 17.00 30.00 31.00
13.00         01:           15.00         01:           15.00         01:           16.00         01:           17.00         01:           30.00         03:           31.00         03:           35.00         02:           50.00         05:           54.00         05:           57.00         05:           58.00         05:           60.00         06:           65.00         05:           66.00         06:           67.00         05:           68.00         06:           69.00         06:	3000       NURSING ADMINISTRATION         5000       PHARMACY         5000       MEDICAL RECORDS & LIBRARY         7000       SOCIAL SERVICE <b>PATENT ROUTINE SERVICE COST CENTERS</b> 0000       ADULTS & PEDIATRICS         1000       INTENSIVE CARE UNIT         240       DETOXIFICATION INTENSIVE CARE UNIT <b>TILLARY SERVICE COST CENTERS</b> 000       OPERATING ROOM         400       RADIOLOGY-DIAGNOSTIC	643 1,928 0 6,426 0 0 0 3,855	0 0 1,097 12,250 0 0 7,023		29,554 0 1,218 0 0 0 0	12,214 0 0	13.00 15.00 16.00 17.00 30.00 31.00
15.00         015           16.00         014           17.00         017           17.00         017           30.00         033           31.00         033           35.00         020           54.00         050           54.00         055           56.00         056           57.00         055           58.00         056           60.00         066           65.00         065           66.00         066           67.00         056           68.00         066           69.00         066	500 PHARMACY 500 MEDICAL RECORDS & LIBRARY 700 SOCIAL SERVICE <b>PATIENT ROUTINE SERVICE COST CENTERS</b> 100 ADULTS & PEDIATRICS 100 INTENSIVE CARE UNIT 104 DETOXIFICATION INTENSIVE CARE UNIT 11LARY SERVICE COST CENTERS 100 OPERATING ROOM 100 RADIOLOGY-DIAGNOSTIC	1,928 0 6,426 0 0 3,855	0 0 1,097 12,250 0 0 7,023		29,554 0 1,218 0 0 0 0	12,214 0 0	15.00 16.00 17.00 30.00 31.00
16.00         016           17.00         017           30.00         033           31.00         032           35.00         023           50.00         056           54.00         054           55.00         056           54.00         054           55.00         055           56.00         056           57.00         055           58.00         056           60.00         066           65.00         066           67.00         065           68.00         066           69.00         066	500       MEDICAL RECORDS & LIBRARY         700       SOCIAL SERVICE <b>PATIENT ROUTINE SERVICE COST CENTERS</b> 100       ADULTS & PEDIATRICS         100       INTENSIVE CARE UNIT         1040       DETOXIFICATION INTENSIVE CARE UNIT         21LLARY SERVICE COST CENTERS         100       PRATING ROOM         400       RADIOLOGY-DIAGNOSTIC	0 6,426 0 0 3,855	0 1,097 12,250 0 0 7,023		29,554 0 1,218 0 0 0 0	12,214 0 0	16.00 17.00 30.00 31.00
17.00         017           30.00         033           31.00         033           35.00         023           50.00         056           54.00         056           54.00         055           55.00         056           57.00         055           58.00         056           65.00         066           65.00         066           66.00         066           67.00         065           68.00         068           69.00         065	700       SOCIAL SERVICE         PATIENT ROUTINE SERVICE COST CENTERS         000       ADULTS & PEDIATRICS         100       INTENSIVE CARE UNIT         040       DETOXIFICATION INTENSIVE CARE UNIT         21LLARY SERVICE COST CENTERS         000       PERATING ROOM         400       RADIOLOGY-DIAGNOSTIC	6,426 0 0 3,855	12,250 0 0 7,023	(	0     0       1,218     0       0     0       0     0	12,214 0 0	17.00 30.00 31.00
INI           30.00         030           31.00         032           35.00         020           ANC         050           50.00         050           54.00         055           55.00         055           58.00         055           60.00         060           65.00         066           65.00         066           67.00         065           68.00         066           69.00         065	Description         Reduting         Service         COST         CENTERS           000         ADULTS & PEDIATRICS         100         INTENSIVE         CARE         UNIT           040         DETOXIFICATION         INTENSIVE         CARE         UNIT           010         DETOXIFICATION         INTENSIVE         CARE         UNIT           010         PERATING         ROOM         1000         RADIOLOGY-DIAGNOSTIC	6,426 0 0 3,855	12,250 0 0 7,023	(	0 1,218 0 0 0 0	12,214 0 0	30.00 31.00
30.00         030           31.00         031           35.00         020           ANC         050           50.00         050           54.00         056           57.00         055           58.00         056           57.00         055           58.00         056           60.00         066           65.00         065           66.00         066           67.00         055           68.00         066           69.00         065	000 ADULTS & PEDIATRICS 100 INTENSIVE CARE UNIT 040 DETOXIFICATION INTENSIVE CARE UNIT CILLARY SERVICE COST CENTERS 000 OPERATING ROOM 400 RADIOLOGY-DIAGNOSTIC	00	007,023	(		0	31.00
31.00         03:           35.00         020           ANK         050           50.00         050           54.00         055           56.00         056           57.00         055           58.00         056           60.00         066           65.00         065           66.00         066           67.00         057           68.00         066           69.00         066	100 INTENSIVE CARE UNIT 040 DETOXIFICATION INTENSIVE CARE UNIT CILLARY SERVICE COST CENTERS 000 OPERATING ROOM 400 RADIOLOGY-DIAGNOSTIC	00	007,023	(		0	31.00
35.00         020           ANC         50.00         050           54.00         050         050           57.00         055         57.00         055           58.00         056         66.00         066           66.00         065         66.00         065           67.00         055         66.00         065           68.00         066         66.00         066           69.00         066         69.00         066	040 DETOXIFICATION INTENSIVE CARE UNIT CILLARY SERVICE COST CENTERS 000 OPERATING ROOM 400 RADIOLOGY-DIAGNOSTIC	3,855	7,023				35.00
50.00         050           54.00         054           56.00         056           57.00         055           58.00         058           60.00         066           65.00         066           66.00         066           67.00         065           68.00         066           69.00         066	000 OPERATING ROOM 400 RADIOLOGY-DIAGNOSTIC			(	) 5.085	0	1
54.00         054           56.00         056           57.00         057           58.00         058           60.00         066           65.00         066           66.00         066           67.00         067           68.00         068           69.00         068	400 RADIOLOGY-DIAGNOSTIC			(	) 5.085	0	
56.00       056         57.00       057         58.00       058         60.00       066         65.00       066         66.00       066         67.00       067         68.00       068         69.00       068		5,783	28		3,000	U U	50.00
57.00       057         58.00       058         60.00       060         65.00       065         66.00       066         67.00       067         68.00       068         69.00       068         69.00       068	500 RADTOTSOTOPE	0	20	(	6,624	0	54.00
58.00       058         60.00       060         65.00       065         66.00       066         67.00       067         68.00       068         69.00       068         69.00       068		0	0	(	0 0	0	56.00
60.00         060           65.00         069           66.00         069           67.00         067           68.00         068           69.00         068	700 CT SCAN	0	0	(	0 0	0	57.00
65.00       065         66.00       066         67.00       067         68.00       068         69.00       068	MAGNETIC RESONANCE IMAGING (MRI)	0	0	(	) 0	0	58.00
66.00       060         67.00       067         68.00       068         69.00       069	DOO LABORATORY	0	0	(	4,407	0	60.00
67.00 067 68.00 068 69.00 069	500 RESPIRATORY THERAPY	3,855	4,968	(	1,073	0	65.00
68.00 068 69.00 069	600 PHYSICAL THERAPY	0	0	(	1,164	0	66.00
69.00 069	700 OCCUPATIONAL THERAPY	0	0	(	230	0	67.00
	800 SPEECH PATHOLOGY	0	0	(	52	0	68.00
/0.00  0/0	900 ELECTROCARDIOLOGY	0	0	(		0	69.00
71 00 071	000 ELECTROENCEPHALOGRAPHY	0	0	(		0	70.00
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(		0	71.00
72.00 072	200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	(		0	72.00
73.00 073	300 DRUGS CHARGED TO PATIENTS	0	0	201,574	1	0	73.00
	510 SLEEP LAB	0	0	201, 57-	54	0	76.00
	480 ONCOLOGY	1,928	3,187	(		0	76.01
	TPATIENT SERVICE COST CENTERS	2,020	5,201		025		
	DOO CLINIC	2,570	3,446	(	0 666	0	90.00
91.00 091	100 EMERGENCY	8,353	16,618	(	8,352	379	91.00
92.00 092	200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPE	ECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	35,984	48,617	201,574	4 29,554	12,593	118.00
	REIMBURSABLE COST CENTERS						
	000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(	) 0		190.00
	200 PHYSICIANS' PRIVATE OFFICES	0	0	(	2 O		192.00
	950 MARKETING	0	0	(	0		194.00
	951 FOUNDATION	0	0	(	1 <u>0</u>		194.01
	952 CLINIC	0	0	(			194.02
	953 VACANT	0	0	(	0		194.03
200.00	Cross Foot Adjustments			,			200.00 201.00
201.00 202.00	Negative Cost Centers	0	0	(	4 29,554		12111 101

LLOCATION	ancial Systems A		Provider C	CN: 15-1308	Period:	Worksheet B
					From 07/01/2022 To 06/30/2023	Part II Date/Time Prepare
					то 06/30/2023	11/22/2023 2:20 p
	Cost Center Description	Subtotal	Intern &	Total		
			Residents Cost			
			& Post			
			Stepdown			
	-	24.00	Adjustments	26.00		
CENT		24.00	25.00	26.00		
	ERAL SERVICE COST CENTERS					1
	00 NEW CAP REL COSTS-BLDG & FIXT					2
	00 EMPLOYEE BENEFITS DEPARTMENT					4
	00 ADMINISTRATIVE & GENERAL					5
						7
	00 OPERATION OF PLANT					
	00 LAUNDRY & LINEN SERVICE					8
	00 HOUSEKEEPING					9.
	DO DIETARY					10
						11
	00 NURSING ADMINISTRATION					13
	00 PHARMACY					15
	00 MEDICAL RECORDS & LIBRARY					16
	00 SOCIAL SERVICE					17
	ATIENT ROUTINE SERVICE COST CENTERS	266 702		200 7		
	00 ADULTS & PEDIATRICS	266,702	0	· · · ·		30
	00 INTENSIVE CARE UNIT	0	0		0	31
	40 DETOXIFICATION INTENSIVE CARE UNIT	0	0		0	35
	ILLARY SERVICE COST CENTERS				1	
	00 OPERATING ROOM	265,403	0	,		50
	00 RADIOLOGY-DIAGNOSTIC	290,194	0	290,1		54
	00 RADIOISOTOPE	0	0		0	56
	DO CT SCAN	0	0		0	57
	00 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0	58
	00 LABORATORY	88,839	0	88,8		60
	00 RESPIRATORY THERAPY	78,837	0	78,8	37	65
	00 PHYSICAL THERAPY	101,347	0	101,3	47	66
57.00 0670	00 OCCUPATIONAL THERAPY	6,081	0	6,0	81	67.
8.00 0680	00 SPEECH PATHOLOGY	1,093	0	1,0	93	68
9.00 0690	00 ELECTROCARDIOLOGY	0	0		0	69.
0.00 0700	00 ELECTROENCEPHALOGRAPHY	0	0		0	70
1.00 0710	00 MEDICAL SUPPLIES CHARGED TO PATIENTS	24,929	0	24,9	29	71
2.00 0720	00 IMPLANTABLE DEVICES CHARGED TO	16,948	0	16,9	48	72
	PATIENTS					
3.00 0730	00 DRUGS CHARGED TO PATIENTS	203,988	0	203,9	88	73.
6.00 0361	10 SLEEP LAB	12,010	0	12,0	10	76
6.01 0348	30 ONCOLOGY	23,556	0	23,5	56	76
OUTF	PATIENT SERVICE COST CENTERS					
0.00 0900		45,971	0	45,9	71	90
	D0 EMERGENCY	291,600	0	291,6	00	91
2.00 0920	00 OBSERVATION BEDS (NON-DISTINCT PART)		0			92
	CIAL PURPOSE COST CENTERS			-		
18.00	SUBTOTALS (SUM OF LINES 1 through 117)	1,717,498	0	1,717,4	98	118
	REIMBURSABLE COST CENTERS					
	00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,055	0	5,0		190
	00 PHYSICIANS' PRIVATE OFFICES	120,342	0			192
	50 MARKETING	10,958	0			194
	51 FOUNDATION	4,655	0			194
94.02 0795		0	0		0	194
94.03 0795		0	0		Ő	194
00.00	Cross Foot Adjustments	0	0		0	200
01.00	Negative Cost Centers	0	0		0	201

		cial Systems TON - STATISTICAL BASIS	ASCENSION ST.	Provider Co		Period:	u of Form CMS-2 Worksheet B-1	
						rom 07/01/2022 o 06/30/2023	Date/Time Pre	
			CAPITAL RE	LATED COSTS			11/22/2023 2:	20 p
				1				
		Cost Center Description	NEW BLDG & FIXT	NEW MVBLE EQUIP	EMPLOYEE BENEFITS	Reconciliation	ADMINISTRATIVE & GENERAL	
			(SQUARE	(DIRECT COST)	DEPARTMENT		(ACCUM.	
			FEET)		(GROSS		COST)	
			1.00	2.00	SALARIES) 4.00	5A	5.00	-
	GENER	AL SERVICE COST CENTERS	1.00	2.00	4.00	JA	5.00	
.00		NEW CAP REL COSTS-BLDG & FIXT	116,959					] 1
.00		NEW CAP REL COSTS-MVBLE EQUIP		436,687				2
.00		EMPLOYEE BENEFITS DEPARTMENT	0	0	5,197,226		10 770 214	4
.00 .00		ADMINISTRATIVE & GENERAL OPERATION OF PLANT	36,119 22,655		298,393		16,770,314 1,327,606	
.00		LAUNDRY & LINEN SERVICE	1,393				60,771	
00		HOUSEKEEPING	849			0 0	571,599	
0.00		DIETARY	2,310		(	0 0	91,149	
.00	01100	CAFETERIA	1,465	0	(	0 0	389,946	11
3.00		NURSING ADMINISTRATION	1,438		61,511		123,069	
5.00		PHARMACY	1,299		295,468		3,150,619	
5.00		MEDICAL RECORDS & LIBRARY	1,975		(		19,316	
7.00		SOCIAL SERVICE IENT ROUTINE SERVICE COST CENTERS	356		74,277	0	150,285	17
0.00		ADULTS & PEDIATRICS	5,823	22,952	783,855	0	1,159,520	30
.00		INTENSIVE CARE UNIT	0		(		0	
.00	02040	DETOXIFICATION INTENSIVE CARE UNIT	0	0	(	0 0	0	3!
		LARY SERVICE COST CENTERS		1		T		
).00		OPERATING ROOM	7,815		471,086		544,992	
.00		RADIOLOGY-DIAGNOSTIC	5,017		878,130		1,392,799	
.00		RADIOISOTOPE CT SCAN	0	0			0	
.00		MAGNETIC RESONANCE IMAGING (MRI)	0	0			0	
0.00		LABORATORY	2,197	0	(	0 0	1,379,806	
5.00	06500	RESPIRATORY THERAPY	1,715		584,715	0	813,637	
5.00	06600	PHYSICAL THERAPY	5,154	0	16,555	5 O	645,166	66
7.00	1	OCCUPATIONAL THERAPY	182		4,078		85,120	
8.00		SPEECH PATHOLOGY	0	0	3,446		27,635	
9.00			0	0			0	
0.00		ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENTS	0				662,077	
2.00		IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0			450,097	
	0.200	PATIENTS						
3.00	07300	DRUGS CHARGED TO PATIENTS	0	0	(	0 0	2,120	7
5.00		SLEEP LAB	730		19,258		32,935	
.01		ONCOLOGY	346	0	227,164	0	336,378	7
00		CLINIC	1,447	0	277,238	3 0	399,151	
		EMERGENCY	7,217		,			
		OBSERVATION BEDS (NON-DISTINCT PART)	.,		_,_0_,000		2,002,027	92
		AL PURPOSE COST CENTERS	1					
.8.00		SUBTOTALS (SUM OF LINES 1 through 117)	107,502	436,687	5,197,226	5 -5,565,699	16,677,820	]118
		IMBURSABLE COST CENTERS		1				Į
		GIFT, FLOWER, COFFEE SHOP & CANTEEN	339	0			- ,	
		PHYSICIANS' PRIVATE OFFICES MARKETING	8,072 735				78,947 7,189	
		FOUNDATION	311			-	3,042	
		CLINIC	0		(	-		194
		VACANT	0		(	0 0		194
0.00		Cross Foot Adjustments						200
1.00		Negative Cost Centers						201
2.00		Cost to be allocated (per Wkst. B,	1,143,899	436,687	1,588,333	3	5,565,699	202
		Part I)	0 780242	1 000000	0 205617		0 221070	20.
03.00		Unit cost multiplier (Wkst. B, Part I)	9.780342	1.000000	0.305612	2	0.331878	
04.00	1	Cost to be allocated (per Wkst. B, Part II)					631,460	204
05.00		Unit cost multiplier (Wkst. B, Part			0.00000		0.037653	20
		II)						
06.00		NAHE adjustment amount to be allocated						206
		(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,						207
07.00								

JST #	ALLOCAT	ION - STATISTICAL BASIS		Provider CC	CN: 15-1308	Period: From 07/01/2022 To 06/30/2023	Worksheet B-1 Date/Time Pre 11/22/2023 2:	epare
		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (HOURS OF SERVICE)	G DIETARY (PATIENT DAYS)	CAFETERIA (FTE)	
			7.00	8.00	9.00	10.00	11.00	
~ ~		AL SERVICE COST CENTERS	1	1				
.00		NEW CAP REL COSTS-BLDG & FIXT						1.
.00 .00		NEW CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT						2.
.00		ADMINISTRATIVE & GENERAL						5.
.00		OPERATION OF PLANT	58,185					7.
.00		LAUNDRY & LINEN SERVICE	1,393					8.
.00		HOUSEKEEPING	849		14,96	51		9.
00.0		DIETARY	2,310	-		0 1,028		10.
.00		CAFETERIA	1,465			0 0	56	11.
3.00	01300	NURSING ADMINISTRATION	1,438	0	2	.4 0	1	13.
5.00	01500	PHARMACY	1,299	0		0 0	3	15.
5.00	01600	MEDICAL RECORDS & LIBRARY	1,975	0	4	9 0	0	16.
7.00	01700	SOCIAL SERVICE	356	0		8 0	1	17.
	INPAT	IENT ROUTINE SERVICE COST CENTERS						
0.00		ADULTS & PEDIATRICS	5,823				10	
.00		INTENSIVE CARE UNIT	0			0 0	0	
.00		DETOXIFICATION INTENSIVE CARE UNIT	0	0		0 0	0	35
		LARY SERVICE COST CENTERS				-		
.00		OPERATING ROOM	7,815	-			6	
.00		RADIOLOGY-DIAGNOSTIC	5,017		,		9	54
.00		RADIOISOTOPE	0			0 0	0	
.00		CT SCAN	0	-		0 0	0	57
.00		MAGNETIC RESONANCE IMAGING (MRI)	2 107	0		0 0	0	
.00			2,197		23		0	60
.00		RESPIRATORY THERAPY	1,715		42	-	6	65
.00		PHYSICAL THERAPY OCCUPATIONAL THERAPY	5,154		42	0 0	0	66
.00		SPEECH PATHOLOGY	182			0 0	0	68
.00		ELECTROCARDIOLOGY		0		0 0	0	69
.00		ELECTROENCEPHALOGRAPHY		0		0 0	0	
.00		MEDICAL SUPPLIES CHARGED TO PATIENTS		0		0 0	0	
.00		IMPLANTABLE DEVICES CHARGED TO		0		0 0	0	
	0.200	PATIENTS		, i i i i i i i i i i i i i i i i i i i		с С		1.5
.00	07300	DRUGS CHARGED TO PATIENTS	C	0	1,03	31 0	0	73
.00	03610	SLEEP LAB	730	0		3 0	0	76
.01		ONCOLOGY	346			51 0	3	76
	OUTPA	TIENT SERVICE COST CENTERS						
.00	09000	CLINIC	1,447	0	1,42	23 0	4	90
.00	09100	EMERGENCY	7,217	0	2,76	66 0	13	91
.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92
	SPECI	AL PURPOSE COST CENTERS	1					
8.00		SUBTOTALS (SUM OF LINES 1 through 117)	48,728	1,028	14,95	1,028	56	118
		IMBURSABLE COST CENTERS		1	1		-	
		GIFT, FLOWER, COFFEE SHOP & CANTEEN	339			0 0		190
		PHYSICIANS' PRIVATE OFFICES	8,072			0 0		192
		MARKETING	735			0 0		194
		FOUNDATION	311			8 0		194
		CLINIC	0			0 0		194
+.0: ).00		VACANT Cross Foot Adjustments		0		0	0	194 200
L.00		Negative Cost Centers						200
2.00		Cost to be allocated (per Wkst. B,	1,768,209	123,272	787,10	191,599	563,881	
	<b>'</b>	Part I)	1,700,209	123,272	/0/,10	191,399	202,001	202
3.00		Unit cost multiplier (Wkst. B, Part I)	30.389430	119.914397	52.61018	186.380350	10,069.303571	203
4.00		Cost to be allocated (per Wkst. B,	276,945					
		Part II)	2,0,545				55,504	1
5.00	)	Unit cost multiplier (Wkst. B, Part II)	4.759732	21.928016	2.26368	46.299611	642.571429	205
6.00	)	NAHE adjustment amount to be allocated (per Wkst. B-2)						206
7.00	)	NAHE unit cost multiplier (Wkst. D,						207
		Parts III and IV)	1	1		1		1

		cial Systems ION - STATISTICAL BASIS	ASCENSION ST. \	Provider CC	N: 15-1308	Period:	u of Form CMS-2552 Worksheet B-1
						From 07/01/2022 To 06/30/2023	Date/Time Prepare 11/22/2023 2:20 p
		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	
			13.00	15.00	16.00	17.00	
	GENER	AL SERVICE COST CENTERS	10.00	201000	20100	2.100	
.00		NEW CAP REL COSTS-BLDG & FIXT					1
.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2
.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4
.00	00500	ADMINISTRATIVE & GENERAL					5
00	00700	OPERATION OF PLANT					7
.00	00800	LAUNDRY & LINEN SERVICE					8
.00	00900	HOUSEKEEPING					9
00.0	01000	DIETARY					10
.00	01100	CAFETERIA					11
3.00	01300	NURSING ADMINISTRATION	80,242				13
5.00		PHARMACY	0	100			15
5.00		MEDICAL RECORDS & LIBRARY	0	0	68,057,87		16
7.00		SOCIAL SERVICE	1,811	0		0 4,990	17
		IENT ROUTINE SERVICE COST CENTERS					
		ADULTS & PEDIATRICS	20,219	0	2,807,56		30
		INTENSIVE CARE UNIT	0	0		0 0	31
5.00		DETOXIFICATION INTENSIVE CARE UNIT	0	0		0 0	35
		LARY SERVICE COST CENTERS	44 504		44 - 4 - 00		
0.00		OPERATING ROOM	11,591	0	11,717,02		50
		RADIOLOGY-DIAGNOSTIC	47	0	15,263,20		54
.00		RADIOISOTOPE	0	0		0 0	56
.00		CT SCAN	0	0		0 0	57
.00	1	MAGNETIC RESONANCE IMAGING (MRI)	0	0	10 154 20	0 0	58
00.0			0	0	10,154,20		60
5.00	1	RESPIRATORY THERAPY	8,200	0	2,473,08		65
5.00		PHYSICAL THERAPY	0	0	2,682,71		66
7.00		OCCUPATIONAL THERAPY	0	0	530,80		67
3.00		SPEECH PATHOLOGY	0	0	120,06	0	68
	1		0	0		0 0	69
0.00 1.00	1	ELECTROENCEPHALOGRAPHY	0	0		0 0	70
2.00		MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	71
2.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0		0	12
3.00	07300	DRUGS CHARGED TO PATIENTS	0	100		0	73
5.00		SLEEP LAB	0	0	124,04	9 0	76
		ONCOLOGY	5,260	0	1,448,49		76
.01	-	TIENT SERVICE COST CENTERS	5,200	U U	1,440,45	0	//
00		CLINIC	5,687	0	1,534,55	1 0	90
		EMERGENCY	27,427	0	19,202,11		91
		OBSERVATION BEDS (NON-DISTINCT PART)	27,127	Ű	13,202,11	150	92
		AL PURPOSE COST CENTERS	1	I			
8.00		SUBTOTALS (SUM OF LINES 1 through 117)	80,242	100	68,057,87	3 4,990	118
	NONRE:	IMBURSABLE COST CENTERS	· · · · ·				
0.00		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	190
		PHYSICIANS' PRIVATE OFFICES	0	0		0 0	192
		MARKETING	0	0		0 0	194
4.01	07951	FOUNDATION	0	0		0 0	194
		CLINIC	0	0		0 0	194
		VACANT	0	0		0 0	194
0.00		Cross Foot Adjustments					200
1.00		Negative Cost Centers					201
2.00		Cost to be allocated (per Wkst. B,	218,945	4,265,927	88,32	4 226,411	202
-		Part I)			-		
03.00	1	Unit cost multiplier (Wkst. B, Part I)	2.728559		0.00129		203
04.00		Cost to be allocated (per Wkst. B,	48,617	201,574	29,55	4 12,593	204
		Part II)					
05.00		Unit cost multiplier (Wkst. B, Part	0.605880	2,015.740000	0.00043	4 2.523647	205
		II)					
	1	NAHE adjustment amount to be allocated					206
06.00							
06.00		(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,					207

Health	Financial Systems	ASCENSION ST. V				u of Form CMS-2	2552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider Co		Period: From 07/01/2022 To 06/30/2023	Worksheet C Part I Date/Time Pre 11/22/2023 2:	
			Title	XVIII	Hospital	Cost	
					Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	2,721,523		2,721,52	23 0	0	30.00
31.00	03100 INTENSIVE CARE UNIT	0			0 0	0	31.00
35.00	02040 DETOXIFICATION INTENSIVE CARE UNIT	0			0 0	0	35.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	1,169,883		1,169,88	33 0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,176,779		2,176,7		0	54.00
56.00	05600 RADIOISOTOPE	0			0 0	0	56.00
57.00	05700 CT SCAN	0			0 0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0			0 0	0	58.00
60.00	06000 LABORATORY	1,930,095		1,930,09	95 0	0	60.00
65.00	06500 RESPIRATORY THERAPY	1,226,939	0	1,226,93	39 0	0	65.00
66.00	06600 PHYSICAL THERAPY	1,041,487	0	1,041,48		0	66.00
67.00	06700 OCCUPATIONAL THERAPY	119,589	0	119,58		0	67.00
68.00	06800 SPEECH PATHOLOGY	36,962	0	36,90		0	68.00
69.00	06900 ELECTROCARDIOLOGY	0		· · · · ·	0 0	0	69.00
	07000 ELECTROENCEPHALOGRAPHY	0			0 0	0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	881,806		881,80	06 0	0	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	599,474		599,42	74 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	4,322,992		4,322,99	02 0	0	73.00
76.00	03610 SLEEP LAB	67,420		67,42	20 0	0	76.00
76.01	03480 ONCOLOGY	507,652		507,6	52 0	0	76.01
	OUTPATIENT SERVICE COST CENTERS						1
90.00	09000 CLINIC	708,244		708,24	14 0	0	90.00
91.00	09100 EMERGENCY	4,414,165		4,414,10	55 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	480,994		480,99	94	0	92.00
200.00		22,406,004	0			0	200.00
201.00	Less Observation Beds	480,994		480,99	94	0	201.00
202.00	Total (see instructions)	21,925,010	0	21,925,0	LO 0	0	202.00

Health Financial Systems	ASCENSION ST. V		CN 15 1200		eu of Form CMS-	2552-1
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-1308	Period: From 07/01/2022	Worksheet C Part I	
				To 06/30/2023	Date/Time Pre	
					11/22/2023 2:	20 pm
			e XVIII	Hospital	Cost	
		Charges		<u> </u>		
Cost Center Description	Inpatient	Outpatient		6 Cost or Other	TEFRA	
			+ col. 7)	Ratio	Inpatient Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	0.00	9.00	10.00	
30.00 03000 ADULTS & PEDIATRICS	2,261,445		2,261,4	15		30.00
31.00 03100 INTENSIVE CARE UNIT	2,201,443		2,201,4	0		31.00
35.00 02040 DETOXIFICATION INTENSIVE CARE UNIT	0			0		35.00
ANCILLARY SERVICE COST CENTERS	0		I	0	1	1 33.00
50.00 05000 OPERATING ROOM	552,827	11,164,194	11,717,0	0.099845	0.00000	50.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	527,496	14,735,710				
56.00 05600 RADIOISOTOPE	0	C	,,_	0 0.000000		
57.00 05700 CT SCAN	0	Č	)	0 0.000000		
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	C	)	0 0.000000	0.00000	58.0
60.00 06000 LABORATORY	847,855	9,306,347	10,154,2	0.190078	0.00000	60.0
65.00 06500 RESPIRATORY THERAPY	488,793	1,984,290			0.00000	65.0
66.00 06600 PHYSICAL THERAPY	148,293	2,534,422	2,682,7	0.388221	0.00000	66.0
67.00 06700 OCCUPATIONAL THERAPY	75,652	455,156	530,8	0.225296	0.00000	67.0
68.00 06800 SPEECH PATHOLOGY	14,712	105,354	120,0	66 0.307847	0.00000	68.0
69.00 06900 ELECTROCARDIOLOGY	0	C	)	0.000000	0.00000	69.0
70.00 07000 ELECTROENCEPHALOGRAPHY	0	C		0 0.000000	0.00000	70.0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	350,305	2,313,088	2,663,3	93 0.331084	0.00000	71.0
72.00 07200 IMPLANTABLE DEVICES CHARGED TO	7,687	69,603	77,2	90 7.756165	0.00000	72.0
PATIENTS						
73.00 07300 DRUGS CHARGED TO PATIENTS	750,363	10,739,136				
76.00 03610 SLEEP LAB	0	124,049	· · · ·			
76.01 03480 ONCOLOGY	2,893	1,445,597	1,448,4	90 0.350470	0.00000	76.0
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	8,005	1,526,546				
91.00 09100 EMERGENCY	349,609	18,852,507				
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	33,120	513,000	· · ·		0.00000	
200.00 Subtotal (see instructions)	6,419,055	75,868,999	82,288,0	54		200.0
201.00 Less Observation Beds	6 410 055	75 969 000	02 200 0	- 4		201.0
202.00 Total (see instructions)	6,419,055	75,868,999	82,288,0	54		202.0

Health Financial Systems				In Lieu of Form CMS-25		
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1308	Period: From 07/01/2022 To 06/30/2023	Worksheet C Part I Date/Time Pre 11/22/2023 2:		
		Title XVIII	Hospital	Cost		
Cost Center Description	PPS Inpatient					
	Ratio					
	11.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS					30.00	
31.00 03100 INTENSIVE CARE UNIT					31.00	
35.00 02040 DETOXIFICATION INTENSIVE CARE UN	IT				35.00	
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0.00000				50.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.00000				54.00	
56.00 05600 RADIOISOTOPE	0.00000				56.0	
57.00 05700 CT SCAN	0.00000				57.0	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000				58.0	
60.00 06000 LABORATORY	0.000000				60.00	
65.00 06500 RESPIRATORY THERAPY	0.000000				65.0	
66.00 06600 PHYSICAL THERAPY	0.000000				66.0	
67.00 06700 OCCUPATIONAL THERAPY	0.000000				67.0	
68.00 06800 SPEECH PATHOLOGY	0.000000				68.0	
69.00 06900 ELECTROCARDIOLOGY	0.000000				69.00	
70.00 07000 ELECTROENCEPHALOGRAPHY	0.000000				70.0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATI	ENTS 0.000000				71.0	
72.00 07200 IMPLANTABLE DEVICES CHARGED TO	0.000000				72.00	
PATIENTS						
73.00 07300 DRUGS CHARGED TO PATIENTS	0.000000				73.00	
76.00 03610 SLEEP LAB	0.000000				76.0	
76.01 03480 ONCOLOGY	0.000000				76.0	
OUTPATIENT SERVICE COST CENTERS					1	
90.00 09000 CLINIC	0.000000				90.00	
91.00 09100 EMERGENCY	0.000000				91.0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT P					92.0	
200.00 Subtotal (see instructions)					200.0	
201.00 Less Observation Beds					201.0	
202.00 Total (see instructions)					202.00	

Health F	inancial Systems	ASCENSION ST. V	INCENT MERCY		In Lie	u of Form CMS-	2552-10
COMPUTAT	TION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 07/01/2022 To 06/30/2023	Worksheet C Part I Date/Time Pre 11/22/2023 2:	
			Titl	e XIX	Hospital	Cost	
					Costs		
	Cost Center Description	(from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
	NPATIENT ROUTINE SERVICE COST CENTERS	1		1			
	3000 ADULTS & PEDIATRICS	2,721,523		2,721,52	23 0	2,721,523	
	3100 INTENSIVE CARE UNIT	0			0 0	0	
	2040 DETOXIFICATION INTENSIVE CARE UNIT	0			0 0	0	35.00
	NCILLARY SERVICE COST CENTERS	T			-		
	5000 OPERATING ROOM	1,169,883		1,169,88		1,169,883	
	5400 RADIOLOGY-DIAGNOSTIC	2,176,779		2,176,77	<sup>'9</sup> 0	2,176,779	
	5600 RADIOISOTOPE	0			0 0	0	
	5700 CT SCAN	0			0 0	0	
	5800 MAGNETIC RESONANCE IMAGING (MRI)	0			0 0	0	
	6000 LABORATORY	1,930,095		1,930,09		1,930,095	
	6500 RESPIRATORY THERAPY	1,226,939	0	1,226,93		1,226,939	
	6600 PHYSICAL THERAPY	1,041,487	0	1,041,48		1,041,487	
	6700 OCCUPATIONAL THERAPY	119,589	0	119,58		119,589	
	6800 SPEECH PATHOLOGY	36,962	0	36,96	0	36,962	
	6900 ELECTROCARDIOLOGY	0			0 0	0	00.00
	7000 ELECTROENCEPHALOGRAPHY	0		0.01.0/		0	
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	881,806 599,474		881,80 599,47		881,806	
	7200 IMPLANTABLE DEVICES CHARGED TO PATIENTS					599,474	
	7300 DRUGS CHARGED TO PATIENTS	4,322,992		4,322,99		4,322,992	
	3610 SLEEP LAB	67,420		67,42		67,420	
	3480 ONCOLOGY	507,652		507,65	0	507,652	76.01
	UTPATIENT SERVICE COST CENTERS						
	9000 CLINIC	708,244		708,24		708,244	
	9100 EMERGENCY	4,414,165		4,414,16		4,414,165	
	9200 OBSERVATION BEDS (NON-DISTINCT PART)	480,994	•	480,99		480,994	
200.00	Subtotal (see instructions)	22,406,004	0	,,.		22,406,004	
201.00	Less Observation Beds	480,994	•	480,99		480,994	
202.00	Total (see instructions)	21,925,010	0	21,925,01	0 0	21,925,010	202.00

	ASCENSION ST. V		CN 15 1200	In Lie Period:	u of Form CMS-	2552-1
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-1308	From 07/01/2022	Worksheet C Part I	
				то 06/30/2023	Date/Time Pre	epared
			e XIX	Hospital	11/22/2023 2: Cost	20 pm
		Charges		nosprear	030	
Cost Center Description	Inpatient	Outpatient	Total (col.	6 Cost or Other	TEFRA	
			+ col. 7)	Ratio	Inpatient	
					Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	2,261,445		2,261,4	45		30.0
31.00 03100 INTENSIVE CARE UNIT	0			0		31.0
35.00 02040 DETOXIFICATION INTENSIVE CARE UNIT	0			0		35.0
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	552,827	11,164,194				
54.00 05400 RADIOLOGY-DIAGNOSTIC	527,496	14,735,710	15,263,20			
6.00 05600 RADIOISOTOPE	0	0		0 0.000000		
7.00 05700 CT SCAN	0	0		0 0.000000	0.00000	
8.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0.000000	0.00000	
50.00 06000 LABORATORY	847,855	9,306,347				
55.00 06500 RESPIRATORY THERAPY	488,793	1,984,290			0.00000	
56.00 06600 PHYSICAL THERAPY	148,293	2,534,422			0.00000	
57.00 06700 OCCUPATIONAL THERAPY	75,652	455,156	· · · ·			
8.00 06800 SPEECH PATHOLOGY	14,712	105,354	120,0		0.00000	
59.00 06900 ELECTROCARDIOLOGY	0	0		0 0.000000		
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0.000000		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	350,305	2,313,088	2,663,3	0.331084		
72.00 07200 IMPLANTABLE DEVICES CHARGED TO	7,687	69,603	77,2	7.756165	0.00000	72.0
PATIENTS						
73.00 07300 DRUGS CHARGED TO PATIENTS	750,363	10,739,136				
76.00 03610 SLEEP LAB	0	124,049				
'6.01 03480 ONCOLOGY	2,893	1,445,597	1,448,49	0.350470	0.00000	76.
OUTPATIENT SERVICE COST CENTERS	I					
0.00 09000 CLINIC	8,005					
01.00 09100 EMERGENCY	349,609	18,852,507				
02.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	33,120	513,000	· · · ·		0.00000	
200.00 Subtotal (see instructions)	6,419,055	75,868,999	82,288,0	54		200.
201.00 Less Observation Beds						201.
202.00 Total (see instructions)	6,419,055	75,868,999	82,288,0	54		202.0

	Financial Systems	ASCENSION ST. VI			u of Form CMS-	2552-10
СОМРИТ	ATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1308	Period: From 07/01/2022 To 06/30/2023	Worksheet C Part I Date/Time Pre 11/22/2023 2	
			Title XIX	Hospital	Cost	
	Cost Center Description	PPS Inpatient				
		Ratio				
	1	11.00				
	INPATIENT ROUTINE SERVICE COST CENTERS					_
	03000 ADULTS & PEDIATRICS					30.00
31.00	03100 INTENSIVE CARE UNIT					31.00
35.00	02040 DETOXIFICATION INTENSIVE CARE UNIT					35.00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.00000				50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.00000				54.00
56.00	05600 RADIOISOTOPE	0.00000				56.00
57.00	05700 CT SCAN	0.00000				57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.00000				58.00
60.00	06000 LABORATORY	0.000000				60.00
65.00	06500 RESPIRATORY THERAPY	0.000000				65.00
66.00	06600 PHYSICAL THERAPY	0.000000				66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000				67.00
	06800 SPEECH PATHOLOGY	0.000000				68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000				69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000				70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000				71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO	0.000000				72.00
	PATIENTS					
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000				73.00
76.00	03610 SLEEP LAB	0.000000				76.00
76.01	03480 ONCOLOGY	0.000000				76.01
	OUTPATIENT SERVICE COST CENTERS	· · · · · ·				
90.00	09000 CLINIC	0.000000				90.00
	09100 EMERGENCY	0.000000				91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000				92.00
200.00						200.00
201.00						201.00
202.00						202.00

54.00       05400       RADIOLOGY-DIAGNOSTIC       290,194       15,263,206       0.019013       78,555       1,494       54.00         55.00       05600       RADIOISOTOPE       0       0       0.000000       0       55.00         58.00       05800       MAGNETIC RESONANCE IMAGING (MRI)       0       0       0.000000       0       58.00         60.00       06000       LABORATORY       88,839       10,154,202       0.008749       179,756       1,573       60.0         65.00       06500       RESPIRATORY THERAPY       78,837       2,473,083       0.031878       93,348       2,976       65.0         66.00       06600       PHYSICAL THERAPY       101,347       2,682,715       0.037778       31,455       1,188       66.0         67.00       06700       OCCUPATIONAL THERAPY       6,081       530,808       0.011456       20,062       230       67.0         68.00       06900       ELECTROCARDIOLOGY       0       0       0.000000       0       0       69.00         70.00       07000       ELECTROCARDIOLOGY       0       0       0.000000       0       70.0         71.00       07100       MELTROCARDIOLOGY       1,093	Health Financial Systems	ASCENSION ST.	VINCENT MERCY		In Lie	u of Form CMS-2	2552-10
Cost Center Description         Capital Related Cost (from wkst. B, Part II, col. 20)         Total Charges (arges)         Ratio of Cost to Charges (col. 1 + col. 8)         Impatient Program (col. 1 + col. 2)         Copital Costs (column 3 x column 4)           AMCILLARY SERVICE COST CENTERS         200         3.00         4.00         5.00           50.00         05000 (PERATING ROM         265,403         11,717,021         0.022651         97,224         2,202         50.0           54.00         05400 (RADIOLOGY-DIAGNOSTIC         290,194         15,263,206         0.019013         78,555         1,494         54.0           56.00         05500 (CT SCAN         0         0         0.000000         0         57.0           05000 (DABORATORY         88,839         10,154,202         0.008749         179,756         1,573         60.0           65.00         06500 RESPIRATORY THERAPY         78,837         2,473,083         0.031878         93,348         2,976         65.00           65.00         06600 PHYSICAL THERAPY         6,081         530,808         0.011456         20,062         230         67.0           00000 CLOCROCADIOLOGY         0         0         0.000000         0         0         0.000000         0         68.0         0.01456         20	APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS	Provider C		From 07/01/2022	Part II Date/Time Pre	
ANCILLARY SERVICE COST CENTERS         Related Cost (from wkst. B, 26)         (from wkst. C, 26)         to charges (col. 1 + col. 26)         Program (column 4)         (column 4)           50.00         05000         OPERATING ROOM         2.00         3.00         4.00         5.00           50.00         05000         OPERATING ROOM         265,403         11,717,021         0.022651         97,224         2,202         50.0           56.00         05600         RADIOIGOY-DIAGNOSTIC         290,194         15,263,206         0.0109013         78,555         1,494         54.0           58.00         05600         RADIOISOTOPE         0         0         0.000000         0         58.0           58.00         05600         RESPIRATORY         88,839         10,154,202         0.008749         179,756         1,573         60.0           66.00         06600         PRSPIRATORY THERAPY         78,837         2,473,083         0.031878         93,348         2,976         51,573         60.0         60.0         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.01						Cost	
ANCILLARY SERVICE COST CENTERS         (from wkst. B, Part II, col. 26)         Part I, col. 8)         (col. 1 + col. 8)         (col. 1 + col. 2)         (col. m 4)           50.00         05000         OPERATING ROOM         2.00         3.00         4.00         5.00           50.00         05000         OPERATING ROOM         265,403         11,717,021         0.022651         97,224         2,202         50.0           56.00         05000         OPERATING ROOM         265,403         11,717,021         0.022651         97,224         2,202         50.0           56.00         05000         OS000 OPERATING ROOM         265,403         11,717,021         0.022651         97,224         2,202         50.0           56.00         05000         OS700 CT SCAN         0         0         0.000000         0         55.0           05000         D6500         RESPIRATORY THERAPY         78,837         2,473,083         0.031878         93,348         2,976         65.0           66.00         O6500         RESPIRATORY THERAPY         101,347         2,682,715         0.037778         31,455         1,188         66.0           67.00         06700         OCULATIONAL THERAPY         10,93         120,066         0.099103	Cost Center Description	Capital	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
Part II, col. 260         80         20         1           ACTLLARY SERVICE COST CENTERS         1.000         2.00         3.00         4.00         5.00           S0.00         05400         PRATING ROOM         265,403         11,717,021         0.022651         97,224         2,202         50.00           S6.00         05400         RADIOLOGY-DIAGNOSTIC         290,194         15,263,206         0.019013         78,555         1.494         54.00           S6.00         05600         RADIOLOGY-DIAGNOSTIC         290,194         15,263,206         0.000000         0         57.00           S7.00         05700 CT SCAN         0         0         0.000000         0         58.00           05800         MAGNETIC RESONANCE IMAGING (MRI)         0         0         0.000749         179,756         1,573         60.00         58.00         05600 RESPIRATORY THERAPY         78,837         2,473,083         0.031878         93,348         2,976         65.00         65.00         06500 SPEECH PATHOLOGY         1,01,347         2,682,715         0.031878         2,930         27         68.00         6900         69.00         10,009103         2,930         27         68.00         68.00         68.00         0.0000000							
26)         1.00         2.00         3.00         4.00         5.00           ANCTLLARY SERVICE COST CENTERS           50.00         05000         OPERATING ROOM         265,403         11,717,021         0.022651         97,224         2,202         50.0           54.00         05400         RADILLARY SERVICE COST CENTERS         290,194         15,263,206         0.019013         78,555         1,494         54.0           56.00         05700         CT SCAN         0         0         0.000000         0         57.0           05700         05700         CT SCAN         0         0         0.000000         0         57.0           05000         04500         RAGNTORY         88,839         10,154,202         0.008749         179,756         1,573         60.0           06000         06500         RESPIRATORY THERAPY         101,347         2,682,715         0.037778         31,455         1,188         66.0         67.00         66000         0         0         0         0         0         60000         680.0         15.00,803         0.011456         20,062         230         27         68.0           66.00         066000         SPEECH PATHOLOGY         1,		(from Wkst. B,	Part I, col.	$(col. 1 \div col$	. Charges	column 4)	
Inclusion         Inclusion <t< td=""><td></td><td>Part II, col.</td><td>8)</td><td>2)</td><td></td><td></td><td></td></t<>		Part II, col.	8)	2)			
ANCILLARY SERVICE COST CENTERS           50.00         05000         OPERATING ROM         265,403         11,717,021         0.022651         97,224         2,202         50.0           54.00         05400         RADIOLGGY-DIAGNOSTIC         290,194         15,263,206         0.019013         78,555         1,494         54.0           057.00         05700         CT SCAN         0         0         0.000000         0         056.0           050.00         06500         RADITISCTOPE         0         0         0.000000         0         057.0           057.00         05700         CT SCAN         0         0         0.000000         0         058.0           060.00         06000         LABORATORY         88,839         10,154,202         0.008749         179,756         1,573         60.0           061.00         DESDERATORY THERAPY         78,837         2,473,083         0.031878         93,348         2,976         65.0           06500         RESPIRATORY THERAPY         10,1347         2,682,715         0.03778         31,455         1,188         66.0           69.00         06900         ELECTROCARDIOLOGY         1,093         120,066         0.009103         2,930		26)					
50.00       05000       OPERATING ROOM       265,403       11,717,021       0.022651       97,224       2,202       50.0         54.00       05400       RADIOLOGY-DIAGNOSTIC       290,194       15,263,206       0.019013       78,555       1,494       54.0         56.00       05700       CT SCAN       0       0.000000       0       057.0         05800       MAGNETIC RESONANCE IMAGING (MRI)       0       0.000000       0       58.0         060.00       LABORATORY       88,839       10,154,202       0.008749       179,756       1,573         060.00       LABORATORY       78,837       2,473,083       0.031878       93,348       2,976       65.00         06500       RESPIRATORY THERAPY       78,837       2,473,083       0.031878       93,348       2,976       65.00         06000       OCUPATIONAL THERAPY       78,837       2,473,083       0.031878       29.30       27       67.00         68.00       SPEECH PATHOLOGY       1,093       120,066       0.0011456       20,062       230       67.0         68.00       GEECR CARDIOLOGY       0       0.000000       0       0       70.0         71.00       O7100       MEDICAL SUPPLI		1.00	2.00	3.00	4.00	5.00	
54.00       05400       RADIOLOGY-DIAGNOSTIC       290,194       15,263,206       0.019013       78,555       1,494       54.00         55.00       05600       RADIOLOGY-DIAGNOSTIC       0       0       0.000000       0       56.00         57.00       05700       CT SCAN       0       0       0.000000       0       57.00         65.00       05800       MAGNETIC RESONANCE IMAGING (MRI)       0       0.000000       0       58.00         60.00       06000       LABORATORY       THERAPY       78,837       2,473,083       0.031878       93,348       2,976       65.00         65.00       06500       RESPIRATORY THERAPY       101,347       2,682,715       0.037778       31,455       1,188       66.00         66.00       06600       PHYSICAL THERAPY       6,081       530,808       0.011456       20,062       230       67.0         67.00       06600       SPECH PATHOLOGY       1,093       120,066       0.09013       2,930       27       68.0         68.00       06800       SPECH PATHOLOGY       0       0       0.000000       0       69.00         70.00       07000       ELCTROCARDIOLOGY       0       0       0.00000		1	1	1	- 1		
56.00       05600       RADIOISOTOPE       0       0       0.000000       0       56.00         57.00       05700       CT SCAN       0       0       0.000000       0       57.00         58.00       MAGNETIC RESONANCE IMAGING (MRI)       0       0       0.000000       0       57.00         60.00       O6000       LABORATORY       88,839       10,154,202       0.008749       179,756       1,573       60.00         65.00       06500       RESPIRATORY THERAPY       78,837       2,473,083       0.031878       93,348       2,976       65.00         66.00       06600       PHYSICAL THERAPY       101,347       2,682,715       0.037778       31,455       1,188       66.0         67.00       0C700       OCCUPATIONAL THERAPY       6,081       530,808       0.011456       20,062       230       67.0         68.00       06800       SPEECH PATHOLOGY       1,093       120,066       0.000100       0							50.00
57.00       05700       CT SCAN       0       0       0.000000       0       0       57.00         58.00       05800       MAGNETIC RESONANCE IMAGING (MRI)       0       0       0.000000       0       0       58.00         60.00       LABORATORY       88,839       10,154,202       0.008749       179,756       1,573       60.0         65.00       RESPIRATORY THERAPY       78,837       2,473,083       0.031878       93,348       2,976       65.00         66.00       06000       PHYSICAL THERAPY       101,347       2,682,715       0.037778       31,455       1,188       66.00         67.00       06700       OCCUPATIONAL THERAPY       6,081       530,808       0.011456       20,062       230       67.0         68.00       06800       FEECH PATHOLOGY       1,093       120,066       0.009103       2,930       27       68.0         69.00       OF100       MEDICAL SUPPLIES CHARGED TO PATIENTS       24,929       2,663,393       0.009360       67,077       628       71.0         72.00       07200       IMPLANTABLE DEVICES CHARGED TO       16,948       77,290       0.219278       1,921       421       72.0         76.00       03610 <td>54.00 05400 RADIOLOGY-DIAGNOSTIC</td> <td>290,194</td> <td>15,263,206</td> <td></td> <td></td> <td>1,494</td> <td></td>	54.00 05400 RADIOLOGY-DIAGNOSTIC	290,194	15,263,206			1,494	
58.00       05800       MAGNETIC RESONANCE IMAGING (MRI)       0       0       0.000000       0       0       58.00         60.00       06000       LABORATORY       88,839       10,154,202       0.008749       179,756       1,573       60.0         65.00       06500       RESPIRATORY THERAPY       78,837       2,473,083       0.031878       93,348       2,976       65.0         66.00       0HYSICAL THERAPY       101,347       2,682,715       0.037778       31,455       1,188       66.0         67.00       0CCUPATIONAL THERAPY       6,081       530,808       0.011456       20,062       230       67.0         68.00       06800       SPEECH PATHOLOGY       1,093       120,066       0.009103       2,930       27       68.0         69.00       0F000       ELECTROCARDIOLOGY       0       0       0.000000       0       69.0       69.0         71.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENTS       24,929       2,663,393       0.009360       67,077       628       71.0         72.00       07200       IMPLANTABLE DEVICES CHARGED TO PATIENTS       24,929       2,663,393       0.009360       67,077       628       73.0       73.00       0.00		0	0			0	56.00
60.00       06000       LABORATORY       88,839       10,154,202       0.008749       179,756       1,573       60.0         65.00       06500       RESPIRATORY THERAPY       78,837       2,473,083       0.031878       93,348       2,976       65.0         66.00       06600       PHYSICAL THERAPY       101,347       2,682,715       0.037778       31,455       1,188       66.0         67.00       06700       OCCUPATIONAL THERAPY       6,081       530,808       0.011456       20,062       230       67.0         68.00       06800       SPEECH PATHOLOGY       1,093       120,066       0.009103       2,930       27       68.0         69.00       06900       ELECTROCARDIOLOGY       0       0       0.000000       0       69.0         70.00       07000       ELECTROCARDIOLOGY       0       0       0.000000       0       0       70.0         71.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENTS       24,929       2,663,393       0.009360       67,077       62.8       71.0         73.00       07300       DRUAS CHARGED TO PATIENTS       203,988       11,489,499       0.017754       179,488       3,187       73.0         76.01 <td>57.00 05700 CT SCAN</td> <td>0</td> <td>0</td> <td>0.0000</td> <td>0 0</td> <td>0</td> <td>57.00</td>	57.00 05700 CT SCAN	0	0	0.0000	0 0	0	57.00
65.00       06500       RESPIRATORY THERAPY       78,837       2,473,083       0.031878       93,348       2,976       65.0         66.00       06600       PHYSICAL THERAPY       101,347       2,682,715       0.037778       31,455       1,188       66.0         67.00       06700       OCCUPATIONAL THERAPY       6,081       530,808       0.011456       20,062       230       67.0         68.00       06800       SPEECH PATHOLOGY       1,093       120,066       0.09103       2,930       27       68.0         69.00       06900       ELECTROCARDIOLOGY       0       0       0.000000       0       69.0         71.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENTS       24,929       2,663,393       0.009360       67,077       628       71.0         72.00       07200       IMPLANTABLE DEVICES CHARGED TO       16,948       77,290       0.219278       1,921       421       72.0         73.00       07300       DRUGS CHARGED TO PATIENTS       203,988       11,489,499       0.017754       179,488       3,187       73.0         76.01       03480       ONCOLGY       23,556       1,448,490       0.016262       0       0       76.0	58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.00000	0 0	0	58.00
66.00       06600       PHYSICAL THERAPY       101,347       2,682,715       0.037778       31,455       1,188       66.0         67.00       06700       OCCUPATIONAL THERAPY       6,081       530,808       0.011456       20,062       230       67.0         68.00       06800       SPEECH PATHOLOGY       1,093       120,066       0.009103       2,930       27       68.0         69.00       06900       ELECTROCARDIOLOGY       0       0       0.000000       0       69.0         70.00       07000       ELECTROCENCEPHALOGRAPHY       0       0       0.000000       0       0       70.00         71.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENTS       24,929       2,663,393       0.009360       67,077       62.8       71.00         72.00       07200       IMPLANTABLE DEVICES CHARGED TO       16,948       77,290       0.219278       1,921       421       72.00         73.00       03610       SLEEP LAB       12,010       124,049       0.096817       0       0       73.00         76.00       03610       SLEEP LAB       12,010       124,049       0.017754       179,488       3,187       73.0         76.00       09000<	60.00 06000 LABORATORY	88,839	10,154,202	0.00874	9 179,756	1,573	60.00
67.00       06700       OCCUPATIONAL THERAPY       6,081       530,808       0.011456       20,062       230       67.0         68.00       06800       SPEECH PATHOLOGY       1,093       120,066       0.009103       2,930       27       68.0         69.00       06900       ELECTROCARDIOLOGY       0       0       0.000000       0       0       69.0         70.00       07000       ELECTROCARDIOLOGY       0       0       0.000000       0       0       69.0         70.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENTS       24,929       2,663,393       0.009360       67,077       62.8       71.0         72.00       07200       IMPLANTABLE DEVICES CHARGED TO PATIENTS       203,988       11,489,499       0.017754       1,921       421       72.0         73.00       07300       DRUGS CHARGED TO PATIENTS       203,988       11,489,499       0.017754       179,488       3,187       73.0         76.00       03610       SLEEP LAB       12,010       124,049       0.096817       0       0       76.0         76.01       03480       ONCOLOGY       23,556       1,448,490       0.016262       0       0       76.0         90.0	65.00 06500 RESPIRATORY THERAPY	78,837	2,473,083	0.03187	/8 93,348	2,976	65.00
68.00       06800       SPEECH PATHOLOGY       1,093       120,066       0.009103       2,930       27       68.0         69.00       06900       ELECTROCARDIOLOGY       0       0       0.000000       0       69.0         70.00       07000       ELECTROENCEPHALOGRAPHY       0       0       0.000000       0       0       70.0         71.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENTS       24,929       2,663,393       0.009360       67,077       628       71.0         72.00       07200       IMPLANTABLE DEVICES CHARGED TO       16,948       77,290       0.219278       1,921       421       72.0         73.00       07300       DRUGS CHARGED TO PATIENTS       203,988       11,489,499       0.017754       179,488       3,187       73.0         76.00       03610       SLEEP LAB       12,010       124,049       0.096817       0       0       76.0         03640       ONCOLOGY       23,556       1,448,490       0.016262       0       0       76.0         09000       CLINIC       45,971       1,534,551       0.029957       1,162       35       90.0         91.00       09100       EMERGENCY       291,600	66.00 06600 PHYSICAL THERAPY	101,347	2,682,715	0.03777	8 31,455	1,188	66.00
69.00       06900       ELECTROCARDIOLOGY       0       0       0.000000       0       0       69.0         70.00       07000       ELECTROENCEPHALOGRAPHY       0       0       0.000000       0       0       70.0         71.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENTS       24,929       2,663,393       0.009360       67,077       628       71.0         72.00       07200       IMPLANTABLE DEVICES CHARGED TO       16,948       77,290       0.219278       1,921       421       72.0         73.00       07300       DRUGS CHARGED TO PATIENTS       203,988       11,489,499       0.017754       179,488       3,187       73.0         76.00       03610       SLEEP LAB       12,010       124,049       0.096817       0       0       76.0         03480       ONCOLOGY       23,556       1,448,490       0.016262       0       0       76.0         090.00       CLINIC       45,971       1,534,551       0.029957       1,162       35       90.0         91.00       09100       EMERGENCY       291,600       19,202,116       0.015186       0       0       91.0         92.00       09200       OBSERVATION BEDS (NON-DISTINCT PA	67.00 06700 OCCUPATIONAL THERAPY	6,081	530,808	0.01145	20,062	230	67.00
70.00         07000         ELECTROENCEPHALOGRAPHY         0         0         0.000000         0         0         70.00           71.00         07100         MEDICAL SUPPLIES CHARGED TO PATIENTS         24,929         2,663,393         0.009360         67,077         628         71.0           72.00         07200         IMPLANTABLE DEVICES CHARGED TO         16,948         77,290         0.219278         1,921         421         72.0           73.00         07300         DRUGS CHARGED TO PATIENTS         203,988         11,489,499         0.017754         179,488         3,187         73.0           76.01         03610         SLEEP LAB         12,010         124,049         0.096817         0         0         76.0           03480         ONCOLOGY         23,556         1,448,490         0.016262         0         0         76.0           04000         CLINIC         45,971         1,534,551         0.029957         1,162         35         90.0           91.00         09100         EMERGENCY         291,600         19,202,116         0.015186         0         0         91.0           92.00         09200         OBSERVATION BEDS (NON-DISTINCT PART)         47,136         546,120	68.00 06800 SPEECH PATHOLOGY	1,093	120,066	0.00910	2,930	27	68.00
71.00         07100         MEDICAL SUPPLIES CHARGED TO PATIENTS         24,929         2,663,393         0.009360         67,077         628         71.0           72.00         07200         IMPLANTABLE DEVICES CHARGED TO         16,948         77,290         0.219278         1,921         421         72.0           73.00         07300         DRUGS CHARGED TO PATIENTS         203,988         11,489,499         0.017754         179,488         3,187         73.0           76.00         03610         SLEEP LAB         12,010         124,049         0.096817         0         0         76.0           76.01         03480         ONCOLOGY         23,556         1,448,490         0.016262         0         0         76.0           90.00         09000         CLINIC         45,971         1,534,551         0.029957         1,162         35         90.0           91.00         09100         EMERGENCY         291,600         19,202,116         0.015186         0         0         91.0           92.00         09200         OBSERVATION BEDS (NON-DISTINCT PART)         47,136         546,120         0.086311         0         0         92.0	69.00 06900 ELECTROCARDIOLOGY	0	0	0.00000	0 0	0	69.00
72.00       07200       IMPLANTABLE DEVICES CHARGED TO       16,948       77,290       0.219278       1,921       421       72.0         73.00       07300       DRUGS CHARGED TO PATIENTS       203,988       11,489,499       0.017754       179,488       3,187       73.0         76.00       03610       SLEEP LAB       12,010       124,049       0.096817       0       0       76.0         70.00       03480       ONCOLOGY       23,556       1,448,490       0.016262       0       0       76.0         70.00       09000       CLINIC       45,971       1,534,551       0.029957       1,162       35       90.0         91.00       09100       EMERGENCY       291,600       19,202,116       0.015186       0       0       91.0         92.00       09200       OBSERVATION BEDS (NON-DISTINCT PART)       47,136       546,120       0.086311       0       0       92.0	70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0.00000	0 0	0	70.00
PATIENTS         PATIENTS           73.00         07300         DRUGS CHARGED TO PATIENTS         203,988         11,489,499         0.017754         179,488         3,187         73.0           76.00         03610         SLEEP LAB         12,010         124,049         0.096817         0         0         60.0           76.01         03480         ONCOLOGY         23,556         1,448,490         0.016262         0         0         76.0           00TPATIENT SERVICE COST CENTERS         0         009000         CLINIC         45,971         1,534,551         0.029957         1,162         35         90.0         91.00         91.00         9100         EMERGENCY         291,600         19,202,116         0.015186         0         0         91.00         92.0           92.00         09200         OBSERVATION BEDS (NON-DISTINCT PART)         47,136         546,120         0.086311         0         0         92.0	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	24,929	2,663,393	0.00936	67,077	628	71.00
73.00       07300       DRUGS CHARGED TO PATIENTS       203,988       11,489,499       0.017754       179,488       3,187       73.0         76.00       03610       SLEEP LAB       12,010       124,049       0.096817       0       0       76.0         76.01       03480       ONCOLOGY       23,556       1,448,490       0.016262       0       0       76.0         00TPATIENT SERVICE COST CENTERS       00000       CLINIC       45,971       1,534,551       0.029957       1,162       35       90.0         91.00       09100       EMERGENCY       291,600       19,202,116       0.015186       0       0       91.0         92.00       09200       OBSERVATION BEDS (NON-DISTINCT PART)       47,136       546,120       0.086311       0       0       92.0	72.00 07200 IMPLANTABLE DEVICES CHARGED TO	16,948	77,290	0.21927	78 1,921	421	72.00
76.00         03610         SLEEP LAB         12,010         124,049         0.096817         0         0         76.00           76.01         03480         ONCOLOGY         23,556         1,448,490         0.016262         0         0         76.0           OUTPATIENT SERVICE COST CENTERS         0         45,971         1,534,551         0.029957         1,162         35         90.0           91.00         09100         EMERGENCY         291,600         19,202,116         0.015186         0         0         91.0           92.00         09200         OBSERVATION BEDS (NON-DISTINCT PART)         47,136         546,120         0.086311         0         0         92.0	PATIENTS		,				
76.01         03480         ONCOLOGY         23,556         1,448,490         0.016262         0         0         76.0           OUTPATIENT SERVICE COST CENTERS         00000         CLINIC         45,971         1,534,551         0.029957         1,162         35         90.0         91.00         09100         EMERGENCY         291,600         19,202,116         0.015186         0         0         91.00         92.00         09200         OBSERVATION BEDS (NON-DISTINCT PART)         47,136         546,120         0.086311         0         0         92.00	73.00 07300 DRUGS CHARGED TO PATIENTS	203,988	11,489,499	0.01775	4 179,488	3,187	73.00
OUTPATIENT SERVICE COST CENTERS           90.00         09000         CLINIC         45,971         1,534,551         0.029957         1,162         35         90.0           91.00         09100         EMERGENCY         291,600         19,202,116         0.015186         0         0         91.0           92.00         09200         OBSERVATION BEDS (NON-DISTINCT PART)         47,136         546,120         0.086311         0         0         92.0	76.00 03610 SLEEP LAB	12,010	124,049	0.09681	.7 0	0	76.00
90.00         09000         CLINIC         45,971         1,534,551         0.029957         1,162         35         90.0           91.00         09100         EMERGENCY         291,600         19,202,116         0.015186         0         0         91.0           92.00         09200         OBSERVATION BEDS (NON-DISTINCT PART)         47,136         546,120         0.086311         0         0         92.0	76.01 03480 ONCOLOGY	23,556	1,448,490	0.01626	0	0	76.01
91.00         09100         Emergency         291,600         19,202,116         0.015186         0         0         91.0           92.00         09200         OBSERVATION BEDS (NON-DISTINCT PART)         47,136         546,120         0.086311         0         0         92.0	OUTPATIENT SERVICE COST CENTERS						1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 47,136 546,120 0.086311 0 0 92.0	90.00 09000 CLINIC	45,971	1,534,551	0.02995	7 1,162	35	90.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 47,136 546,120 0.086311 0 0 92.0	91.00 09100 EMERGENCY	291,600			6 0	0	91.00
	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	47,136			.1 0	0	92.00
	200.00 Total (lines 50 through 199)	1,497,932			752,978	13,961	200.00

Health	Financial Systems	ASCENSION ST.	/INCENT MERCY		In Lie	eu of Form CMS-2	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE H COSTS	RVICE OTHER PASS			Period: From 07/01/2022 To 06/30/2023		
			Title	XVIII	Hospital	Cost	
	Cost Center Description	Non Physician	Nursing	Nursing	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	-					
	05000 OPERATING ROOM	0	0		0 0	0	50.00
	05400 RADIOLOGY-DIAGNOSTIC	0	0		0 0	0	54.00
	05600 RADIOISOTOPE	0	0		0 0	0	56.00
57.00	05700 CT SCAN	0	0		0 0	0	57.00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	58.00
60.00	06000 LABORATORY	0	0		0 0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0		0 0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0		0 0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0		0 0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	1	0 0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	1	0 0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	1	0 0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1	0 0	0	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO	0	0		0 0	0	72.00
	PATIENTS						
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	1	0 0	0	73.00
76.00	03610 SLEEP LAB	0	0	1	0 0	0	76.00
76.01	03480 ONCOLOGY	0	0		0 0	0	76.01
	OUTPATIENT SERVICE COST CENTERS	•					1
90.00	09000 CLINIC	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	0	200.00

Health	Financial Systems	ASCENSION ST. \	/INCENT MERCY		In Lie	u of Form CMS-2	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF H COSTS	RVICE OTHER PASS			Period: From 07/01/2022 To 06/30/2023		
				XVIII	Hospital	Cost	
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
		Medical	(sum of cols.		(from Wkst. C,		
		Education Cost		Cost (sum of		(col. 5 ÷ col.	
			4)	cols. 2, 3,	8)	7)	
				and 4)		(see	
						instructions)	
		4.00	5.00	6.00	7.00	8.00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	0		0 11,717,021		
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0		0 15,263,206		
56.00	05600 RADIOISOTOPE	0	0		0 0	0.000000	
57.00	05700 CT SCAN	0	0		0 0	0.000000	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0.000000	
60.00	06000 LABORATORY	0	0		0 10,154,202		
65.00	06500 RESPIRATORY THERAPY	0	0		0 2,473,083		
66.00	06600 PHYSICAL THERAPY	0	0		0 2,682,715		
67.00	06700 OCCUPATIONAL THERAPY	0	0		0 530,808		
68.00	06800 SPEECH PATHOLOGY	0	0		0 120,066		
69.00	06900 ELECTROCARDIOLOGY	0	0		0 0	0.000000	
	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0.000000	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 2,663,393		
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0		0 77,290	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 11,489,499	0.000000	73.00
76.00	03610 SLEEP LAB	0	0		0 124,049	0.000000	76.00
76.01	03480 ONCOLOGY	0	0		0 1,448,490	0.000000	76.01
	OUTPATIENT SERVICE COST CENTERS						1
90.00	09000 CLINIC	0	0		0 1,534,551	0.000000	90.00
91.00	09100 EMERGENCY	0	0		0 19,202,116	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 546,120		92.00
200.00	Total (lines 50 through 199)	0	0		0 80,026,609		200.00

Health	Financial Systems	ASCENSION ST. V	INCENT MERCY		In Lie	u of Form CMS-2	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE H COSTS	RVICE OTHER PASS	Provider Co	CN: 15-1308	Period: From 07/01/2022 To 06/30/2023	Worksheet D Part IV Date/Time Pre 11/22/2023 2:	
			Title	XVIII	Hospital	Cost	
	Cost Center Description	Outpatient	Inpatient	Inpatient	Outpatient	Outpatient	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through		Pass-Through	
		(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0.000000	97,224		0 0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	78,555		0 0	0	54.00
56.00	05600 RADIOISOTOPE	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 IMAGING (MRI)	0.000000	0		0 0	0	58.00
60.00	06000 LABORATORY	0.000000	179,756		0 0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.000000	93,348		0 0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	31,455		0 0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	20,062		0 0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	2,930		0 0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0		0 0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0		0 0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	67,077		0 0	0	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO	0.000000	1,921		0 0	0	72.00
	PATIENTS						
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	179,488		0 0	0	73.00
76.00	03610 SLEEP LAB	0.000000	0		0 0	0	76.00
76.01	03480 ONCOLOGY	0.000000	0		0 0	0	76.01
	OUTPATIENT SERVICE COST CENTERS						]
90.00	09000 CLINIC	0.000000	1,162		0 0	0	90.00
91.00	09100 EMERGENCY	0.000000	0		0 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0		0 0	0	92.00
200.00	Total (lines 50 through 199)		752,978		0 0	0	200.00

Health Financial Systems	ASCENSION ST.	VINCENT MERCY		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Period: From 07/01/2022 To 06/30/2023	Worksheet D Part V Date/Time Pre 11/22/2023 2:	
		Title	XVIII	Hospital	Cost	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Services	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins			
	1.00	2.00	(see inst.)	(see inst.)	5 00	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS	0.000045		1 (22 0)	7	0	50.00
50.00 ODERATING ROOM	0.099845		1,622,85		0	
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.142616		2,457,55	0	0	54.00
56.00 05600 RADIOISOTOPE	0.00000			0 0	0	56.00
57.00 05700 CT SCAN	0.00000			0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.00000			0 0	0	58.00
60.00 06000 LABORATORY	0.190078	0	1,774,05		0	60.00
65.00 06500 RESPIRATORY THERAPY	0.496117	0	385,98		0	65.00
66.00 06600 PHYSICAL THERAPY	0.388221	0	482,21		0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0.225296		77,35		0	67.00
68.00 06800 SPEECH PATHOLOGY	0.307847		22,94	-	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0.00000			0 0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.00000			0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.331084		329,73		0	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	7.756165	0	31,83	38 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.376256	0	2,321,21	.3 81	0	73.00
76.00 03610 SLEEP LAB	0.543495	0	77	2 0	0	76.00
76.01 03480 ONCOLOGY	0.350470	0	20,27	78 0	0	76.01
OUTPATIENT SERVICE COST CENTERS						1
90.00 09000 CLINIC	0.461532	0	141,51	4 134	0	90.00
91.00 09100 EMERGENCY	0.229879	0	2,031,90	09 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.880748	0	87,15	5 0	0	92.00
200.00 Subtotal (see instructions)		0	11,787,37	7 215	0	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges				0 0		201.00
202.00 Net Charges (line 200 - line 201)		0	11,787,37	215	0	202.00

	ASCENSION ST.				u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-1308	Period: From 07/01/2022 To 06/30/2023	Worksheet D Part V Date/Time Pre 11/22/2023 2:	epared: 20 pm
		Title	2 XVIII	Hospital	Cost	
	COS	sts				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Services	Services Not				
	Subject To	Subject To				
	Ded. & Coins.					
	(see inst.)	(see inst.)	-			
	6.00	7.00				
ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM	102.024	0				50.00
	162,034					50.00
54.00 05400 RADIOLOGY-DIAGNOSTIC 56.00 05600 RADIOISOTOPE	350,487					54.00
57.00 05700 CT SCAN	0					57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0					57.00
60.00 06000 LABORATORY	337,208					60.00
65.00 06500 RESPIRATORY THERAPY	191,496					65.00
66.00 06600 PHYSICAL THERAPY	187,205					66.00
67.00 06700 OCCUPATIONAL THERAPY	17,428					67.00
68.00 06800 SPEECH PATHOLOGY	7,063					68.00
69.00 06900 ELECTROCARDIOLOGY	7,003					69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0					70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	109,170					71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO	246,941					72.00
PATIENTS	240, 341		·			12.00
73.00 07300 DRUGS CHARGED TO PATIENTS	873,370	30				73.00
76.00 03610 SLEEP LAB	420					76.00
76.01 03480 ONCOLOGY	7,107					76.01
OUTPATIENT SERVICE COST CENTERS	.,	-	1			
90.00 09000 CLINIC	65,313	62	2			90.00
91.00 09100 EMERGENCY	467,093					91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	76,762					92.00
200.00 Subtotal (see instructions)	3,099,097		2			200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
001y Charges 202.00 Net Charges (line 200 - line 201)	3,099,097	92				202.00

Health Financial Systems	ASCENSION ST.	VINCENT MERCY		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider Co		Period: From 07/01/2022	Worksheet D Part V	
		Component		To 06/30/2023	Date/Time Pre	
			XVIII	Swing Dode CNG	11/22/2023 2:	20 pm
			Charges	Swing Beds - SNF	Cost Costs	
Cost Center Description	Cost to Charge	DDS Raimhursad		Cost	PPS Services	
cost center bescription		Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Services	Services Not		
	Part I, col. 9		Subject To	Subject To		
	,			. Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS	1					
50.00 05000 OPERATING ROOM	0.099845			0 0	0	
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.142616			0 0	0	51100
56.00 05600 RADIOISOTOPE	0.000000			0 0	0	
57.00 05700 CT SCAN	0.00000			0 0	0	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000			0 0	0	
60.00 06000 LABORATORY	0.190078	0		0 0	0	00.00
65.00 06500 RESPIRATORY THERAPY	0.496117	0		0 0	0	00.00
66.00 06600 PHYSICAL THERAPY	0.388221	0		0 0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0.225296	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0.307847	0		0 0	0	
69.00 06900 ELECTROCARDIOLOGY	0.000000			0 0	0	
70.00 07000 ELECTROENCEPHALOGRAPHY	0.00000			0 0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.331084			0 0	0	1.1.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	1.120102	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.376256	0		0 0	0	73.00
76.00 03610 SLEEP LAB	0.543495			0 0	0	
76.01 03480 ONCOLOGY	0.350470			0 0	0	
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0.461532	0		0 0	0	90.00
91.00 09100 EMERGENCY	0.229879	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.880748	0		0 0	0	92.00
200.00 Subtotal (see instructions)		0		0 0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00   Net Charges (line 200 - line 201)		0		0 0	0	202.00

Health Financial Systems	ASCENSION ST.			In Lie	u of Form CMS-2552-2
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	O VACCINE COST	Provider C	CN: 15-1308	Period:	Worksheet D
		Component	CCN: 15-Z308	From 07/01/2022 To 06/30/2023	
		component	CCN. 13-2308	10 00/30/2023	11/22/2023 2:20 pm
		Title	2 XVIII	Swing Beds - SNF	
	COS	sts			
Cost Center Description	Cost	Cost			
	Reimbursed	Reimbursed			
	Services	Services Not			
	Subject To	Subject To			
	Ded. & Coins.				
	(see inst.)	(see inst.)	-		
	6.00	7.00			
ANCILLARY SERVICE COST CENTERS	0				
50.00 05000 OPERATING ROOM	0				50.0
54.00 05400 RADIOLOGY-DIAGNOSTIC	0				54.0
56.00 05600 RADIOISOTOPE	0				56.0
57.00 05700 CT SCAN	0				57.0
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0				58.0
60.00 06000 LABORATORY	0	0			60.0
65.00 06500 RESPIRATORY THERAPY	0	0			65.0
66.00 06600 PHYSICAL THERAPY	0	0			66.0
67.00 06700 OCCUPATIONAL THERAPY	0	0			67.0
68.00 06800 SPEECH PATHOLOGY	0	0			68.0
69.00 06900 ELECTROCARDIOLOGY	0	0			69.0
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0			70.0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			71.0
72.00 07200 IMPLANTABLE DEVICES CHARGED TO	0	0			72.0
PATIENTS					
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0			73.0
76.00 03610 SLEEP LAB	0	0			76.0
76.01 03480 ONCOLOGY	0	0			76.0
OUTPATIENT SERVICE COST CENTERS					
90.00 09000 CLINIC	0	C			90.0
91.00 09100 EMERGENCY	0	( C			91.0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	( C			92.0
200.00 Subtotal (see instructions)	0	C			200.0
201.00 Less PBP Clinic Lab. Services-Program	0				201.0
Only Charges					
202.00 Net Charges (line 200 - line 201)	0	( C			202.0

Health Financial Sys	tems	ASCENSION ST.				u of Form CMS-	2552-10
APPORTIONMENT OF INP	ATIENT ROUTINE SERVICE OTHER	PASS THROUGH COS			Period: From 07/01/2022 To 06/30/2023	Worksheet D Part III Date/Time Pre 11/22/2023 2:	
			Titl	e XIX	Hospital	Cost	
Cost Cer	ter Description	Nursing	Nursing	Allied Health	Allied Health	All Other	
		Program	Program	Post-Stepdown	n Cost	Medical	
		Post-Stepdown Adjustments		Adjustments		Education Cost	
		1A	1.00	2A	2.00	3.00	
INPATIENT ROUT	TINE SERVICE COST CENTERS						
30.00 03000 ADULTS &		0	0	)	0 0	0	30.00
31.00 03100 INTENSIV	'E CARE UNIT	0	0		0 0	0	31.00
35.00 02040 DETOXIFI	CATION INTENSIVE CARE UNIT	0	0		0 0	0	35.00
200.00 Total (1	ines 30 through 199)	0	0		0 0	0	200.00
Cost Cer	ter Description	Swing-Bed	Total Costs	Total Patient	Per Diem (col.	Inpatient	
		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	
	TINE SERVICE COST CENTERS				- T.		
30.00 03000 ADULTS &		0	0	1,26			
31.00 03100 INTENSIV			0		0.00		
	CATION INTENSIVE CARE UNIT		0		0.00		
	ines 30 through 199)		0	1,26	2	19	200.00
Cost Cer	ter Description	Inpatient					
		Program					
		Pass-Through					
		Cost (col. 7 x					
		col. 8)					
		9.00					
	TINE SERVICE COST CENTERS	-					
30.00 03000 ADULTS &		0					30.00
31.00 03100 INTENSIV		0					31.00
	CATION INTENSIVE CARE UNIT	0					35.00
200.00  Total (1	ines 30 through 199)	0					200.00

Health	Financial Systems	ASCENSION ST.	INCENT MERCY			u of Form CMS-2	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE H COSTS	RVICE OTHER PAS			Period: From 07/01/2022 To 06/30/2023	Worksheet D Part IV Date/Time Pre 11/22/2023 2:	
				e XIX	Hospital	Cost	
	Cost Center Description	Non Physician	Nursing	Nursing	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						
50.00	05000 OPERATING ROOM	0	0		0 0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0		0 0	0	54.00
56.00	05600 RADIOISOTOPE	0	0		0 0	0	56.00
57.00	05700 CT SCAN	0	0		0 0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	58.00
60.00	06000 LABORATORY	0	0		0 0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	)	0 0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0		0 0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0		0 0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0		0 0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO	0	0	)	0 0	0	72.00
	PATIENTS						
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
76.00	03610 SLEEP LAB	0	0	)	0 0	0	76.00
76.01	03480 ONCOLOGY	0	0	)	0 0	0	76.01
	OUTPATIENT SERVICE COST CENTERS						1
90.00	09000 CLINIC	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	0	200.00

Health	Financial Systems	ASCENSION ST.	INCENT MERCY		In Lie	u of Form CMS-2	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF H COSTS	RVICE OTHER PASS			Period: From 07/01/2022 To 06/30/2023		
				e XIX	Hospital	Cost	
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
		Medical	(sum of cols.		(from Wkst. C,		
		Education Cost		Cost (sum of		(col. 5 ÷ col.	
			4)	cols. 2, 3,	8)	7)	
				and 4)		(see	
						instructions)	
		4.00	5.00	6.00	7.00	8.00	
	ANCILLARY SERVICE COST CENTERS	-	-				
	05000 OPERATING ROOM	0	0		0 11,717,021		
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0		0 15,263,206		
56.00	05600 RADIOISOTOPE	0	0		0 0	0.000000	
57.00	05700 CT SCAN	0	0		0 0	0.000000	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0.000000	
60.00	06000 LABORATORY	0	0		0 10,154,202		
65.00	06500 RESPIRATORY THERAPY	0	0		0 2,473,083		
66.00	06600 PHYSICAL THERAPY	0	0		0 2,682,715		
67.00	06700 OCCUPATIONAL THERAPY	0	0		0 530,808		
68.00	06800 SPEECH PATHOLOGY	0	0		0 120,066		
69.00	06900 ELECTROCARDIOLOGY	0	0		0 0	0.000000	
	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0.000000	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 2,663,393		
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0		0 77,290	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 11,489,499	0.000000	73.00
76.00	03610 SLEEP LAB	0	0		0 124,049	0.000000	76.00
76.01	03480 ONCOLOGY	0	0		0 1,448,490	0.000000	76.01
	OUTPATIENT SERVICE COST CENTERS	·	-	•		•	1
90.00	09000 CLINIC	0	0		0 1,534,551	0.000000	90.00
91.00	09100 EMERGENCY	0	0		0 19,202,116	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 546,120		92.00
200.00	Total (lines 50 through 199)	0	0		0 80,026,609		200.00

Health	Financial Systems	ASCENSION ST. VI	INCENT MERCY		In Lie	u of Form CMS-2	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEA H COSTS	RVICE OTHER PASS	Provider Co		Period: From 07/01/2022 To 06/30/2023	Worksheet D Part IV Date/Time Pre 11/22/2023 2:	pared: 20 pm
			Titl	e XIX	Hospital	Cost	
	Cost Center Description	Outpatient	Inpatient	Inpatient	Outpatient	Outpatient	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through		Pass-Through	
		(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
	ANCILLARY SERVICE COST CENTERS	1					
50.00	05000 OPERATING ROOM	0.000000	41,842		0 0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	41,828		0 0	0	54.00
56.00	05600 RADIOISOTOPE	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 IMAGING (MRI)	0.00000	0		0 0	0	58.00
60.00	06000 LABORATORY	0.000000	44,147		0 0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.000000	19,190		0 0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	4,766		0 0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0		0 0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0		0 0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.00000	0		0 0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.00000	0		0 0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0		0 0	0	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO	0.000000	0		0 0	0	72.00
	PATIENTS						
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	22,872		0 0	0	73.00
76.00	03610 SLEEP LAB	0.00000	0		0 0	0	76.00
76.01	03480 ONCOLOGY	0.00000	0		0 0	0	76.01
	OUTPATIENT SERVICE COST CENTERS						1
90.00	09000 CLINIC	0.000000	0		0 0	0	90.00
91.00	09100 EMERGENCY	0.000000	47,078		0 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0		0 0	0	92.00
200.00	Total (lines 50 through 199)		221,723		0 0	0	200.00

MPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-1308	Period: From 07/01/2022	Worksheet D-1	_
			To 06/30/2023	Date/Time Prep 11/22/2023 2:2	
		Title XVIII	Hospital	Cost	
	Cost Center Description			1.00	-
	PART I - ALL PROVIDER COMPONENTS			1.00	
	INPATIENT DAYS	······································		1 224	
00 00	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing-			1,324 1,262	2
00	Private room days (excluding swing-bed and observation bed da		rivate room days,	1,202	
	do not complete this line.			1 000	
00 00	Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro		ar 31 of the cost	1,028 23	
00	reporting period	on days) through becent	er si or the cost	23	
00	Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	39	6
~~	reporting period (if calendar year, enter 0 on this line)	m days) through December	n 21 of the cost	0	
00	Total swing-bed NF type inpatient days (including private roo reporting period	m days) through becembe	r si or the cost	0	7
00	Total swing-bed NF type inpatient days (including private roo	m days) after December	31 of the cost	0	8
	reporting period (if calendar year, enter 0 on this line)				
00	Total inpatient days including private room days applicable t newborn days) (see instructions)	ο τηε Program (excluding	g swing-bed and	262	9
.00	Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private	room days)	0	10
	through December 31 of the cost reporting period (see instruc				
.00	Swing-bed SNF type inpatient days applicable to title XVIII o December 31 of the cost reporting period (if calendar year, e		room days) after	0	11
.00	Swing-bed NF type inpatient days applicable to titles V or XI		te room days)	0	12
	through December 31 of the cost reporting period				
.00	Swing-bed NF type inpatient days applicable to titles V or XI			0	13
.00	after December 31 of the cost reporting period (if calendar y Medically necessary private room days applicable to the Progr			0	14
	Total nursery days (title V or XIX only)		,.,	0	15
.00	Nursery days (title V or XIX only)			0	16
00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to servic	es through December 31	of the cost		117
.00	reporting period	es through becember 51			1 1
.00	Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost		18
.00	reporting period Medicaid rate for swing-bed NF services applicable to service	s through December 31 o	f the cost	250.44	19
.00	reporting period Medicaid rate for swing-bed NF services applicable to service	s after December 31 of	the cost	266.32	20
.00	reporting period	S arter becember 51 of		200.52	
	Total general inpatient routine service cost (see instruction			2,721,523	
.00	Swing-bed cost applicable to SNF type services through Decemb	er 31 of the cost repor	ting period (line	0	22
.00	5 x line 17) Swing-bed cost applicable to SNF type services after December	31 of the cost reporti	ng period (line 6	0	23
	x line 18)			-	
.00	Swing-bed cost applicable to NF type services through Decembe	r 31 of the cost report	ing period (line	0	24
.00	7 x line 19) Swing-bed cost applicable to NF type services after December	31 of the cost reporting	a period (line &	0	25
	x line 20)	and and about opportunity	,	Ű	
	Total swing-bed cost (see instructions)			127,443	
	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(Inne 21 minus line 26)		2,594,080	27
	General inpatient routine service charges (excluding swing-be	d and observation bed c	harges)	0	28
.00	Private room charges (excluding swing-bed charges)		-	0	29
	Semi-private room charges (excluding swing-bed charges)	· line 28)		0	30
	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3)	- THE 20)		0.000000 0.00	
.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
	Average per diem private room charge differential (line 32 mi		ctions)	0.00	
1	Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35)	ne 31)		0.00	35
	General inpatient routine service cost net of swing-bed cost	and private room cost d	ifferential (line	0 2,594,080	
	27 minus line 36)	,		_,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	UCTATINE			-
.00	<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ</b> Adjusted general inpatient routine service cost per diem (see			2,055.53	2.5
	Program general inpatient routine service cost (line 9 x line			538,549	
	Medically necessary private room cost applicable to the Progr			0	40
00	Total Program general inpatient routine service cost (line 39	+ line 40)		538,549	41

OMPUT	Financial Systems ATION OF INPATIENT OPERATING COST		Provider C	CN: 15-1308	Period: From 07/01/2022	Worksheet D-1	
					то 06/30/2023		
	Cost Conton Deconintion	Total		XVIII	Hospital	Cost	
	Cost Center Description	Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1		Program Cost (col. 3 x col.	
				col. 2)		4)	
2 00	NURSERY (title V & VIV enly)	1.00	2.00	3.00	4.00	5.00	42.0
2.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	<u> </u>					42.0
3.00	INTENSIVE CARE UNIT	0	0	0.	00 0	0	43.0
4.00	CORONARY CARE UNIT						44.
5.00	BURN INTENSIVE CARE UNIT						45.
	SURGICAL INTENSIVE CARE UNIT DETOXIFICATION INTENSIVE CARE UNIT	0	l o	0.	00 0	0	46. 47.
100	Cost Center Description		· · · · ·				
						1.00	
8.00 8.01	Program inpatient ancillary service cost (Wks Program inpatient cellular therapy acquisition			TTT line 10	column 1)	224,200	
9.00	Total Program inpatient costs (sum of lines a				, corumn 1)	762,749	
	PASS THROUGH COST ADJUSTMENTS			,			
0.00	Pass through costs applicable to Program inpa	atient routine	services (from	ı Wkst. D, su	m of Parts I and	0	50.
1.00	III) Pass through costs applicable to Program inpa	atient ancillar	rv services (fr	om Wkst D	sum of Parts II	0	51.
1.00	and IV)		y services (ii	om wkst. D,		Ŭ	51.
2.00	Total Program excludable cost (sum of lines					0	
3.00	Total Program inpatient operating cost exclu		elated, non-phy	sician anest	hetist, and	0	53.
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					
4.00	Program discharges					0	54.
	Target amount per discharge					0.00	
5.01	Permanent adjustment amount per discharge					0.00	
	Adjustment amount per discharge (contractor Target amount (line 54 x sum of lines 55, 55					0.00	
	Difference between adjusted inpatient operat			ine 56 minus	line 53)	0	
3.00	Bonus payment (see instructions)	5	5		-	0	58.
9.00	Trended costs (lesser of line 53 ÷ line 54,	or line 55 from	1 the cost repo	orting period	ending 1996,	0.00	59.
0.00	updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54,	or line 55 fro	m prior year o	ost report	undated by the	0.00	60.
	market basket)	of the 55 fre	in prior year c	.031 100010,	apuacea by the	0.00	00.
1.00	0	61.					
2 00	enter zero. (see instructions)					0	62.
	Relief payment (see instructions) Allowable Inpatient cost plus incentive payme	ent (see instru	uctions)			0	
	PROGRAM INPATIENT ROUTINE SWING BED COST		,			-	
4.00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of the	e cost report	ing period (See	0	64.
5 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	ts after Decemb	per 31 of the c	ost reportin	n neriod (See	0	65.
	instructions)(title XVIII only)					Ŭ	0.5.
6.00	Total Medicare swing-bed SNF inpatient routin	ne costs (line	64 plus line 6	5)(title XVI	II only); for	0	66.
7.00	CAH, see instructions Title V or XIX swing-bed NF inpatient routing	a costs through	December 31 c	of the cost r	enorting period	0	67.
7.00	(line 12 x line 19)	e costs through	I December 31 (		eporting period	0	07.
8.00	Title V or XIX swing-bed NF inpatient routing	e costs after D	December 31 of	the cost rep	orting period	0	68.
0 00	(line 13 x line 20)	noutino costo (	line 67 . line	68)		0	69.
9.00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NU					0	69.
0.00	Skilled nursing facility/other nursing facil				)		70.
L.00	Adjusted general inpatient routine service co		ine 70 ÷ line	2)			71.
2.00	Program routine service cost (line 9 x line 3 Medically necessary private room cost application		1 (line 1/ v )	ne 35)			72.
4.00	Total Program general inpatient routine serv						73.
5.00	Capital-related cost allocated to inpatient				Part II, column		75.
c	26, line 45)	2)					
5.00 7.00	Per diem capital-related costs (line 75 ÷ lin Program capital-related costs (line 9 x line						76.
	Inpatient routine service cost (line 74 minus						78.
.00	Aggregate charges to beneficiaries for exces	s costs (from p					79.
.00	Total Program routine service costs for compa		cost limitation	n (line 78 mi	nus line 79)		80
.00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (1						81. 82.
.00	Reasonable inpatient routine service cost (						83.
1.00	Program inpatient ancillary services (see in	structions)					84.
5.00	Utilization review - physician compensation						85.
5.00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		irougn 85)				86.
7.00	Total observation bed days (see instructions)					234	87.
3.00	Adjusted general inpatient routine cost per	diem (line 27 ÷				2,055.53	88.
	Observation bed cost (line 87 x line 88) (see	instructions)				480,994	89.

Health Financial Systems	ASCENSION ST.	VINCENT MERCY		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 07/01/2022	Worksheet D-1	
				го 06/30/2023	Date/Time Pre 11/22/2023 2:	
	_	Title	XVIII	Hospital	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observation	Bed Pass	
				Bed Cost (from		
				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	266,702	2,721,523	0.09799	7 480,994	47,136	90.00
91.00 Nursing Program cost	0	2,721,523	0.00000	480,994	0	91.00
92.00 Allied health cost	0	2,721,523	0.00000	480,994	0	92.00
93.00 All other Medical Education	0	2,721,523	0.00000	480,994	0	93.00

MPUT	Financial Systems ASCENSION ST. VINC ASCENSION OF INPATIENT OPERATING COST	Provider CCN: 15-1308	Period: From 07/01/2022	u of Form CMS-2 Worksheet D-1	
			To 06/30/2023	Date/Time Prep 11/22/2023 2:2	
	Cost Conton Description	Title XIX	Hospital	Cost	- · r
	Cost Center Description			1.00	
1	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				-
00	Inpatient days (including private room days and swing-bed days	, excluding newborn)		1,324	1
00	Inpatient days (including private room days, excluding swing-be			1,262	
00	Private room days (excluding swing-bed and observation bed days	s). If you have only pr	rivate room days,	0	3
00	do not complete this line. Semi-private room days (excluding swing-bed and observation be	d davs)		1,028	4
00	Total swing-bed SNF type inpatient days (including private roo		er 31 of the cost	23	
	reporting period				
00	Total swing-bed SNF type inpatient days (including private roo reporting period (if calendar year, enter 0 on this line)	m days) after December	31 of the cost	39	6
00	Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	0	7
	reporting period				
00	Total swing-bed NF type inpatient days (including private room	days) after December 3	1 of the cost	0	8
00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	19	9
	newborn days) (see instructions)		, swing-beu allu	19	"
.00	Swing-bed SNF type inpatient days applicable to title XVIII on		room days)	0	10
00	through December 31 of the cost reporting period (see instruct		nom dave) after	0	11
.00	Swing-bed SNF type inpatient days applicable to title XVIII on December 31 of the cost reporting period (if calendar year, en		oom days) atter	0	11
.00	Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12
	through December 31 of the cost reporting period				
.00	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar years)			0	13
.00	Medically necessary private room days applicable to the Program			0	14
.00	Total nursery days (title V or XIX only)			0	15
.00	Nursery days (title V or XIX only)			0	16
00	<b>SWING BED ADJUSTMENT</b> Medicare rate for swing-bed SNF services applicable to service:	s through December 31 c	of the cost		17
.00	reporting period	s through becember si t			1/
.00	Medicare rate for swing-bed SNF services applicable to service: reporting period	s after December 31 of	the cost		18
.00	Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	250.44	19
.00	reporting period Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	he cost	266.32	20
	reporting period			200102	
	Total general inpatient routine service cost (see instructions			2,721,523	
.00	Swing-bed cost applicable to SNF type services through Decembe 5 x line 17)	r 31 of the cost report	ing period (line	0	22
.00	Swing-bed cost applicable to SNF type services after December :	31 of the cost reportin	a period (line 6	0	23
	x line 18)			-	
.00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24
.00	7 x line 19) Swing-bed cost applicable to NF type services after December 3:	1 of the cost reporting	period (line 8	0	25
	x line 20)		, ,	°	
	Total swing-bed cost (see instructions)			127,443	
	General inpatient routine service cost net of swing-bed cost ( PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	ine 21 minus line 26)		2,594,080	27
	General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0	28
.00	Private room charges (excluding swing-bed charges)			0	29
	Semi-private room charges (excluding swing-bed charges)	7.1		0	30
	General inpatient routine service cost/charge ratio (line 27 ÷ Average private room per diem charge (line 29 ÷ line 3)	iine 28)		0.000000	
	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
	Average per diem private room charge differential (line 32 min	us line 33)(see instruc	tions)	0.00	
.00	Average per diem private room cost differential (line 34 x line			0.00	35
	Private room cost differential adjustment (line 3 x line 35)	nd notivata	fforontial (liter	0	36
.00	General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	nu private room cost di	iierential (line	2,594,080	3/
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS				-
-	Adjusted general inpatient routine service cost per diem (see			2,055.53	
-	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Program			39,055	40
.00					

OMPUT	Financial Systems ATION OF INPATIENT OPERATING COST		Provider C	CN: 15-1308	Period: From 07/01/2022	Worksheet D-1	
					To 06/30/2023		
	Cost Conton Deceminting	<b>T</b> 2+2]		e XIX	Hospital	Cost	1
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1		Program Cost (col. 3 x col.	
		-		col. 2)		4)	
2 00	NURCERY (title V & VIV enly)	1.00	2.00	3.00	4.00	5.00	42.4
2.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units						42.0
3.00	INTENSIVE CARE UNIT	0	C	0.	0 00	0	43.0
4.00	CORONARY CARE UNIT						44.0
5.00	BURN INTENSIVE CARE UNIT						45.
	SURGICAL INTENSIVE CARE UNIT DETOXIFICATION INTENSIVE CARE UNIT	0	c c	0.	00 0	0	46.
1.00	Cost Center Description		v				
						1.00	
8.00 8.01	Program inpatient ancillary service cost (Wk Program inpatient cellular therapy acquisition			TTT line 10	column 1)	49,332	
9.00	Total Program inpatient costs (sum of lines				, corumn 1)	88,387	
	PASS THROUGH COST ADJUSTMENTS	in ough fore	(0000 111001 40				1.5.
0.00	Pass through costs applicable to Program inp	atient routine	services (from	ı Wkst. D, su	n of Parts I and	0	50.
1.00	III) Pass through costs applicable to Program inp	ationt ancillar	w convicos (fr	om wkst D	sum of Parts II	0	51.
1.00	and IV)	actence anci ital	y services (II	UNI WKSC. D,	Sum OF Parts II	0	51.
2.00	Total Program excludable cost (sum of lines	50 and 51)				0	52.
3.00	Total Program inpatient operating cost exclu		elated, non-phy	vsician anest	netist, and	0	53.
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					
4.00	Program discharges					0	54.
	Target amount per discharge					0.00	
5.01	Permanent adjustment amount per discharge					0.00	
	Adjustment amount per discharge (contractor Target amount (line 54 x sum of lines 55, 55					0.00	
	Difference between adjusted inpatient operat			ine 56 minus	line 53)	0	
3.00	Bonus payment (see instructions)					0	
9.00	Trended costs (lesser of line 53 ÷ line 54,	or line 55 from	the cost repo	orting period	ending 1996,	0.00	59.
0.00	updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54,	on line EE fra	m prior voor	oct roport	undated by the	0.00	60.
0.00	market basket)	of the 55 fre	nii pi tot year c	Jost report,	apuateu by the	0.00	00.
1.00	0	61.					
2 00	enter zero. (see instructions)					0	62.
	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instru	uctions)			0	
	PROGRAM INPATIENT ROUTINE SWING BED COST		,			-	
4.00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of the	e cost report	ing period (See	0	64.
5.00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decemb	per 31 of the d	ost reportin	n period (See	0	65.
	instructions)(title XVIII only)				g pe: .ou (bee	Ĵ	0.5.
6.00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 6	5)(title XVI	II only); for	0	66.
7.00	CAH, see instructions Title V or XIX swing-bed NF inpatient routin	o costs through	Docombor 31	f the cost r	porting poriod	0	67.
7.00	(line 12 x line 19)	e costs through	I December ST (		eporting period	0	07.
8.00	Title V or XIX swing-bed NF inpatient routing	e costs after 🛛	December 31 of	the cost rep	orting period	0	68.
0 00	(line 13 x line 20)	moutino costo (	line 67 . line	68)			60
9.00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NO					0	69.
0.00	Skilled nursing facility/other nursing facil				)		70.
1.00	Adjusted general inpatient routine service c		ine 70 ÷ line	2)			71.
2.00	Program routine service cost (line 9 x line Medically necessary private room cost applic		$(\lim_{n \to \infty} 1/\sqrt{1+1})$	no 35)			72.
4.00	Total Program general inpatient routine serv						73.
5.00	Capital-related cost allocated to inpatient				Part II, column		75.
	26, line 45)						
5.00 7.00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76.
	Inpatient routine service cost (line 74 minu						78.
.00	Aggregate charges to beneficiaries for exces		provider record	ls)			79.
.00	Total Program routine service costs for comp		cost limitation	ı (line 78 mi	nus line 79)		80.
00	Inpatient routine service cost per diem limi						81. 82.
.00 .00	Inpatient routine service cost limitation () Reasonable inpatient routine service costs (						82.
1.00	Program inpatient ancillary services (see in		,				84.
5.00	Utilization review - physician compensation						85.
6.00	Total Program inpatient operating costs (sum		rough 85)				86.
7.00	<b>PART IV - COMPUTATION OF OBSERVATION BED PASS</b> Total observation bed days (see instructions					234	87.
3.00	Adjusted general inpatient routine cost per		line 2)			2,055.53	
						480,994	

Health Financial Systems	ASCENSION ST.	VINCENT MERCY		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider Co		Period:	Worksheet D-1	
			•	From 07/01/2022 To 06/30/2023	Date/Time Pre 11/22/2023 2:	
	_	Titl	e XIX	Hospital	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observation	Bed Pass	
				Bed Cost (from		
				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						
90.00 Capital-related cost	266,702	2,721,523	0.09799	7 480,994	47,136	90.00
91.00 Nursing Program cost	0	2,721,523	0.00000	0 480,994	0	91.00
92.00 Allied health cost	0	2,721,523	0.00000	0 480,994	0	92.00
93.00 All other Medical Education	0	2,721,523	0.00000	0 480,994	0	93.00

Health Financial Systems ASCENSION ST. VIN		CNI 15 1202		eu of Form CMS-	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1308	Period: From 07/01/2022	Worksheet D-3	•
			To 06/30/2023		pared
				11/22/2023 2:	
	Title	XVIII	Hospital	Cost	
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges		Program Costs	
			Charges	(col. 1 x col.	
		1.00		2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS           30.00         ADULTS & PEDIATRICS		1	E20 0E	7	30.0
			528,857		30.0
					35.0
35.00 02040 DETOXIFICATION INTENSIVE CARE UNIT ANCILLARY SERVICE COST CENTERS				/	35.0
50.00 OSOOO OPERATING ROOM		0.0998	45 97,224	9,707	50.0
54.00 05400 RADIOLOGY-DIAGNOSTIC		0.1426			
56.00 05600 RADIOISOTOPE		0.0000		0 0	
57.00 05700 CT SCAN		0.0000			
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0.0000			
60.00 06000 LABORATORY		0.1900		-	
65.00 06500 RESPIRATORY THERAPY		0.4961			
66.00 06600 PHYSICAL THERAPY		0.3882			
67.00 06700 OCCUPATIONAL THERAPY		0.2252	- ,		
68.00 06800 SPEECH PATHOLOGY		0.3078			
69.00 06900 ELECTROCARDIOLOGY		0.0000			
70.00 07000 ELECTROENCEPHALOGRAPHY		0.0000			
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.3310		22,208	
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS		7.7561	· · · ·		
73.00 07300 DRUGS CHARGED TO PATIENTS		0.3762	· · · ·		
76.00 03610 SLEEP LAB		0.5434	· · · ·		
76.01 03480 ONCOLOGY		0.3504	70 0	ol o	76.0
OUTPATIENT SERVICE COST CENTERS				1	
00.00 09000 CLINIC		0.4615	32 1,162	2 536	90.0
91.00 09100 EMERGENCY		0.2298	79 (	0 0	91.0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0.8807	48 0	0 0	92.0
200.00 Total (sum of lines 50 through 94 and 96 through 98)			752,978	3 224,200	200.0
201.00 Less PBP Clinic Laboratory Services-Program only charges	6 (line 61)		(		201.0
202.00 Net charges (line 200 minus line 201)			752,978	3	202.0

lealth Financial Systems ASCENSION ST. VINC	Provider C	CNI 15 1200	Do 7	iod:	worksheet D-3	
INPAILENT ANCILLARY SERVICE CUST APPORTIONMENT	Provider Co	CN: 12-1308		'10d: m 07/01/2022		
	Component (	CCN: 15-Z308	To	06/30/2023	Date/Time Pre	pared
					11/22/2023 2:	20 pm
	Title	XVIII		ng Beds – SNF		
Cost Center Description		Ratio of Cos	-	Inpatient	Inpatient	
		To Charges		Program	Program Costs	
				Charges	(col. 1 x col.	
		1.00		2.00	2)	
TUDATTENT POULTNE CERVICE COST CENTERS		1.00		2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS						30.0
31.00 03100 INTENSIVE CARE UNIT						31.0
35.00 02040 DETOXIFICATION INTENSIVE CARE UNIT						35.0
ANCILLARY SERVICE COST CENTERS						
50.00 OS000 OPERATING ROOM		0.0998	45	0	0	50.0
54.00 05400 RADIOLOGY-DIAGNOSTIC		0.1426	-	0	0	
56.00 05600 RADIOISOTOPE		0.0000		0	0	
57.00 05700 CT SCAN		0.0000		0	0	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0.0000		0	0	
50.00 06000 LABORATORY		0.1900		0	0	
55.00 06500 RESPIRATORY THERAPY		0.4961	17	0	0	65.0
56.00 06600 PHYSICAL THERAPY		0.3882	21	0	0	66.0
57.00 06700 OCCUPATIONAL THERAPY		0.2252	96	0	0	67.0
58.00 06800 SPEECH PATHOLOGY		0.3078	47	0	0	68.0
59.00 06900 ELECTROCARDIOLOGY		0.0000	00	0	0	69.0
70.00 07000 ELECTROENCEPHALOGRAPHY		0.0000	00	0	0	70.0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.3310	84	0	0	71.0
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS		7.7561	65	0	0	72.0
73.00 07300 DRUGS CHARGED TO PATIENTS		0.3762	56	0	0	73.0
76.00 03610 SLEEP LAB		0.5434	95	0	0	76.0
76.01 03480 ONCOLOGY		0.3504	70	0	0	76.0
OUTPATIENT SERVICE COST CENTERS						
00.00 09000 CLINIC		0.4615	32	0	0	
01.00 09100 EMERGENCY		0.2298	-	0	0	1
02.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0.8807	48	0	0	
200.00 Total (sum of lines 50 through 94 and 96 through 98)				0	0	200.
201.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)			0		201.0
202.00 Net charges (line 200 minus line 201)				0		202.0

	. VINCENT MERCY	CNI 15 1200		u of Form CMS-	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1308	Period: From 07/01/2022	Worksheet D-3	
			To 06/30/2023	Date/Time Pre	pared
				11/22/2023 2:	
	Titl	e XIX	Hospital	Cost	
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges		Program Costs	
			Charges	(col. 1 x col.	
		1.00	2.00	2)	
THRATTENT ROUTING CERVICE COOT CENTERS		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS           30.00         ADULTS & PEDIATRICS		1	E 9 200		30.0
31.00 03100 INTENSIVE CARE UNIT			58,300		31.0
			0		35.0
35.00 02040 DETOXIFICATION INTENSIVE CARE UNIT ANCILLARY SERVICE COST CENTERS			0		35.0
50.00 OPERATING ROOM		0.0998	45 41,842	4,178	50.0
54.00 05400 RADIOLOGY-DIAGNOSTIC		0.1426			
56.00 05600 RADIOLOGY DIAGNOSTIC		0.0000		0	
57.00 05700 CT SCAN		0.0000		0	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0.0000		0	
50.00 06000 LABORATORY		0.1900		, o	
55.00 06500 RESPIRATORY THERAPY		0.4961	,		
56.00 06600 PHYSICAL THERAPY		0.3882			
57.00 06700 OCCUPATIONAL THERAPY		0.2252		0	
58.00 06800 SPEECH PATHOLOGY		0.3078		0	
59.00 06900 ELECTROCARDIOLOGY		0.0000		0	
70.00 07000 ELECTROENCEPHALOGRAPHY		0.0000		0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.3310		0	
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS		7.7561		0	
73.00 07300 DRUGS CHARGED TO PATIENTS		0.3762		8,606	73.0
76.00 03610 SLEEP LAB		0.5434	,	0	
76.01 03480 ONCOLOGY		0.3504		0	76.0
OUTPATIENT SERVICE COST CENTERS				-	1
90.00 09000 CLINIC		0.4615	32 0	0	90.0
01.00 09100 EMERGENCY		0.2298	79 47,078	10,822	91.0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0.8807	48 0	0	92.0
200.00 Total (sum of lines 50 through 94 and 96 through 98	8)		221,723	49,332	200.0
201.00 Less PBP Clinic Laboratory Services-Program only cl			0		201.0
202.00 Net charges (line 200 minus line 201)			221,723		202.0

			From 07/01/2022 To 06/30/2023		
		Title XVIII	Hospital	11/22/2023 2:: Cost	20 pm
			Ποσρττατ	031	
r	ART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
	Medical and other services (see instructions)			3,099,189	1.0
0	Medical and other services reimbursed under OPPS (see instruction	is)		0	2.0
	DPPS or REH payments Dutlier payment (see instructions)			0	3.0
	Dutlier reconciliation amount (see instructions)			0	
	Enter the hospital specific payment to cost ratio (see instructio	ons)		0.000	
-	Line 2 times line 5 Sum of lines 3, 4, and 4.01, divided by line 6			0 0.00	
	Transitional corridor payment (see instructions)			0.00	
	Ancillary service other pass through costs from Wkst. D, Pt. IV,	col. 13, line 200		0	9.
	Organ acquisitions Fotal cost (sum of lines 1 and 10) (see instructions)			0 3,099,189	10.
	COMPUTATION OF LESSER OF COST OR CHARGES			5,055,105	1 11.
	easonable charges				
	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line	69)		0	
	Total reasonable charges (sum of lines 12 and 13)	05)		0	
	Customary charges				
	Aggregate amount actually collected from patients liable for paym Amounts that would have been realized from patients liable for pa			0	
	nad such payment been made in accordance with 42 CFR §413.13(e)	services c	in a chargebasis	0	10.
	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	
	Fotal customary charges (see instructions) Excess of customary charges over reasonable cost (complete only i	f line 18 exceeds li	ne 11) (see	0	
-	instructions)			Ũ	1.0.0
	Excess of reasonable cost over customary charges (complete only i	f line 11 exceeds li	ne 18) (see	0	20.0
	instructions) Lesser of cost or charges (see instructions)			3,130,181	21.
00 :	Interns and residents (see instructions)			0	22.
	Cost of physicians' services in a teaching hospital (see instruct Fotal prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	cions)		0	-
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	24.
	Deductibles and coinsurance amounts (for CAH, see instructions)			30,419	
	Deductibles and Coinsurance amounts relating to amount on line 24 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus			1,974,315 1,125,447	
	instructions)			1,129,447	27.
	Direct graduate medical education payments (from Wkst. E-4, line	50)		0	
	REH facility payment amount ESRD direct medical education costs (from Wkst. E-4, line 36)			0	28.
00	Subtotal (sum of lines 27, 28, 28.50 and 29)			1,125,447	
	Primary payer payments Subtotal (line 30 minus line 31)			489 1,124,958	-
	LLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)			1,124,930	52.
	Composite rate ESRD (from Wkst. I-5, line 11)			0	
	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			441,581 287,028	
	Allowable bad debts for dual eligible beneficiaries (see instruct	ions)		387,309	
	Subtotal (see instructions)			1,411,986	
	MSP-LCC reconciliation amount from PS&R DTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
	Pioneer ACO demonstration payment adjustment (see instructions)			0	39.
	v95 respirator payment adjustment amount (see instructions)			0	
	Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replaced	devices (see instruc	tions)	0	
	RECOVERY OF ACCELERATED DEPRECIATION	devices (see instruc		0	
	Subtotal (see instructions)			1,411,986	1
	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration			28,240 0	
	Sequestration adjustment-PARHM pass-throughs			U	40.
	Interim payments			1,713,128	
	Interim payments-PARHM Fentative settlement (for contractors use only)			0	41.
	Tentative settlement-PARHM (for contractor use only)			0	42.
00	Balance due provider/program (see instructions)			-329,382	
	Balance due provider/program-PARHM (see instructions) Protested amounts (nonallowable cost report items) in accordance	with CMS pub 15-2	chanter 1	25,000	43.
	§115.2	with the Pub. 13-2,	chapter 1,	23,000	
Т	O BE COMPLETED BY CONTRACTOR				
	Driginal outlier amount (see instructions)			0	
	Jutlier reconciliation adjustment amount (see instructions)				
00 0	Dutlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0 0.00	

Health Financial Systems	ASCENSION ST. VINCENT MERCY	In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1308	Period: From 07/01/2022 To 06/30/2023		
	Title XVIII	Hospital	Cost	
			1.00	
MEDICARE PART B ANCILLARY COSTS 200.00 Part B Combined Billed Days			0	200.00

NALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC	CN: 15-1308	Period: From 07/01/2022 To 06/30/2023		pared
			XVIII	Hospital	Cost	
		Inpatien	t Part A	Pai	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
.00	Total interim payments paid to provider		733,7	71	1,645,128	1.0
.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	0	2.0
.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.0
	Program to Provider					
.01	ADJUSTMENTS TO PROVIDER			0 08/25/2022	68,000	3.0
.02				0	0	3.0
.03				0	0	3.0
.04				0	0	3.( 3.(
.05	Provider to Program			0	0	5.0
.50	ADJUSTMENTS TO PROGRAM			0	0	3.
.51				0	0	3.
.52				0	0	3.
.53				0	0	3.
.54				0	0	3.5
.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	68,000	3.9
.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as		733,7	71	1,713,128	4.
	appropriate) TO BE COMPLETED BY CONTRACTOR					
.00	List separately each tentative settlement payment after					5.0
	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.
	Program to Provider					
.01	TENTATIVE TO PROVIDER			0	0	5.0
.02				0	0	5. 5.
.05	Provider to Program			0	0	5.
.50	TENTATIVE TO PROGRAM			0	0	5.
.50				0	0	5.
.52				0	0	5.
.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	5.
.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.
.01	SETTLEMENT TO PROVIDER			0	0	6.
.02	SETTLEMENT TO PROGRAM		43,9		329,382	6.
.00	Total Medicare program liability (see instructions)		689,8		1,383,746	7.
				Contractor Number 1.00	NPR Date (Mo/Day/Yr) 2.00	
.00	Name of Contractor	(		1.00	2.00	8.

IALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC Component C			eriod: com 07/01/2022 o 06/30/2023	Worksheet E-1 Part I Date/Time Pre 11/22/2023 2:	pared
		Title	XVIII	Sw	ing Beds - SNF	Cost	
		Inpatient	t Part A		Par	tВ	
		mm/dd/yyyy	Amount		mm/dd/yyyy	Amount	
		1.00	2.00		3.00	4.00	
00	Total interim payments paid to provider			0		0	1.0
00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0		0	2.0
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.
	Program to Provider						
01	ADJUSTMENTS TO PROVIDER			0		0	
02				0		0	
03 04				0		0	
04				0		0	
0.5	Provider to Program	I					1 .
50	ADJUSTMENTS TO PROGRAM			0		0	3
51				0		0	-
52				0		0	-
53				0		0	
54 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0		0	-
19	3.50-3.98)			0		0	
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as			0		0	4
	appropriate)						
00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after						5
,0	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						
	Program to Provider			-			ł.,
)1 )2	TENTATIVE TO PROVIDER			0 0		0	
)2 )3				0		0	
	Provider to Program			U		0	1
50	TENTATIVE TO PROGRAM			0		0	5
51				0		0	
52				0		0	-
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0		0	
)0 )1	Determined net settlement amount (balance due) based on the cost report. (1) SETTLEMENT TO PROVIDER			0		0	6
)1 )2	SETTLEMENT TO PROVIDER			0		0	
)2 )0	Total Medicare program liability (see instructions)			0		0	-
				Ū	Contractor Number	NPR Date (Mo/Day/Yr)	
		0			1.00	2.00	

Health	Financial Systems ASCENSION ST.	VINCENT MERCY	In Lie	u of Form CMS	-2552-10		
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1308	Period: From 07/01/2022 To 06/30/2023		repared:		
		Title XVIII	Hospital	Cost			
				1.00			
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS						
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULAT				_		
1.00	00 Total hospital discharges as defined in AARA §4102 from wkst. S-3, Pt. I col. 15 line 14						
2.00	Medicare days (see instructions)		2.00				
3.00	00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2						
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.				6.00		
7.00	CAH only - The reasonable cost incurred for the purchase on the loss of the purchase of the loss of the purchase of the loss of the purchase o	of certified HIT technology	Wkst. S-2, Pt. I		7.00		
8.00	Calculation of the HIT incentive payment (see instructions	5)			8.00		
9.00	Sequestration adjustment amount (see instructions)				9.00		
10.00	Calculation of the HIT incentive payment after sequestration	on (see instructions)			10.00		
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH						
	<pre>Initial/interim HIT payment adjustment (see instructions)</pre>				30.00		
	Other Adjustment (specify)				31.00		
32.00	Balance due provider (line 8 (or line 10) minus line 30 ar	nd line 31) (see instruction	is)		32.00		

LCULA	TION OF REIMBURSEMENT SETTLEMENT - SWING BEDS P	rovider CCN: 15-1308	Period:	Worksheet E-2	
	с	omponent CCN:15-Z308	From 07/01/2022 To 06/30/2023	Date/Time Pre 11/22/2023 2:	pare 20 p
		Title XVIII	Swing Beds - SNF		
			Part A 1.00	<u>Part B</u> 2.00	
C	OMPUTATION OF NET COST OF COVERED SERVICES		1.00	2.00	
	Inpatient routine services - swing bed-SNF (see instructions)		0	0	1 1
оо   1	Inpatient routine services - swing bed-NF (see instructions)				2
	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A			0	3
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-	-bed pass-through, see			
	instructions)				
	Nursing and allied health payment-PARHM (see instructions) Per diem cost for interns and residents not in approved teaching	n nnognam (coo		0.00	3
	instructions)	g program (see		0.00	4
	Program days		0	0	5
	Interns and residents not in approved teaching program (see inst	ructions)		0	
)0 (L	Jtilization review - physician compensation - SNF optional metho	od only	0		7
	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		0	0	
	Primary payer payments (see instructions)		0	0	-
	Subtotal (line 8 minus line 9)		0	0	
	Deductibles billed to program patients (exclude amounts applicab professional services)	oie to physician	0	0	11
	Subtotal (line 10 minus line 11)		0	0	12
	Coinsurance billed to program patients (from provider records) (	exclude coinsurance	0	0	
	for physician professional services)	exertude corrisul anec	Ŭ	0	1 - 3
	80% of Part B costs (line 12 x 80%)			0	14
.00 s	Subtotal (see instructions)		0	0	15
.00 o	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16
	Pioneer ACO demonstration payment adjustment (see instructions)				16
	Rural community hospital demonstration project (§410A Demonstrat	tion) payment	0		16
	adjustment (see instructions)			0	1.0
	Demonstration payment adjustment amount before sequestration Allowable bad debts (see instructions)		0	0	
	Adjusted reimbursable bad debts (see instructions)		0	0	
	Allowable bad debts for dual eligible beneficiaries (see instruc	tions)	0	0	
	Total (see instructions)		0	ů 0	
	Sequestration adjustment (see instructions)		0	0	
.02 [	Demonstration payment adjustment amount after sequestration)		0	0	19
.03   5	Sequestration adjustment-PARHM pass-throughs				19
	Sequestration for non-claims based amounts (see instructions)		0	0	
	Interim payments		0	0	
	Interim payments-PARHM				20
	Tentative settlement (for contractor use only)		0	0	
	<pre>Fentative settlement-PARHM (for contractor use only) Balance due provider/program (line 19 minus lines 19.01, 19.02,</pre>	10.25 + 20 - 20 + 21	0	0	21
	Balance due provider/program-PARHM (see instructions)	19.23, 20, and 21)	0	0	22
	Protested amounts (nonallowable cost report items) in accordance	with CMS Pub. 15-2.	0	0	
	chapter 1, §115.2		Ŭ	Ũ	
	ural Community Hospital Demonstration Project (§410A Demonstrat	ion) Adjustment			]
	Is this the first year of the current 5-year demonstration perio	od under the 21st			200
	Century Cures Act? Enter "Y" for yes or "N" for no.				
	<b>Cost Reimbursement</b> Medicare swing-bed SNF inpatient routine service costs (from Wks	t D 1 Dt TT line			201
	66 (title XVIII hospital))	st. D-1, Pt. 11, The			201
	Medicare swing-bed SNF inpatient ancillary service costs (from W	vkst D-3 col 3 lin	۵		202
	200 (title XVIII swing-bed SNF))		C		100
	rotal (sum of lines 201 and 202)				203
	Medicare swing-bed SNF discharges (see instructions)				204
	Computation of Demonstration Target Amount Limitation (N/A in fi	rst year of the curre	nt 5-year demonst	ration	
	period)				
	Medicare swing-bed SNF target amount	- 1 204)			205
	Medicare swing-bed SNF inpatient routine cost cap (line 205 time				206
	djustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursem Program reimbursement under the §410A Demonstration (see instruction)				207
	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2,	-	1		207
	and 3)	con I, Sum OF THES	-		200
	Adjustment to Medicare swing-bed SNF PPS payments (see instructi	ions)			209
).00 F	Reserved for future use	-			210
	Comparision of PPS versus Cost Reimbursement				
	Fotal adjustment to Medicare swing-bed SNF PPS payment (line 209	) plus line 210) (see			215

			From 07/01/2022 To 06/30/2023		
		Title XVIII	Hospital	11/22/2023 2:2 Cost	20
			nosprear		
				1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICAF	RE PART A SERVICES - COST	REIMBURSEMENT		
00	Inpatient services			762,749	1
00	Nursing and Allied Health Managed Care payment (see instruct	tions)		0	2
00	Organ acquisition			0	3
01	Cellular therapy acquisition cost (see instructions)			0	3
.00	Subtotal (sum of lines 1 through 3.01)			762,749	4
.00	Primary payer payments				
.00	Total cost (line 4 less line 5). For CAH (see instructions)			770,376	6
ſ	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges				1
.00	Routine service charges			0	7
.00	Ancillary service charges			0	8
	Organ acquisition charges, net of revenue			ő	
	Total reasonable charges			Ő	10
	Customary charges				
	Aggregate amount actually collected from patients liable for	r payment for services on	a charge basis	0	11
2.00	Amounts that would have been realized from patients liable	for payment for services of	on a charge basis	0	12
ľ	had such payment been made in accordance with 42 CFR 413.13	(e)			
	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.00000	
	Total customary charges (see instructions)			0	14
5.00	Excess of customary charges over reasonable cost (complete o	only if line 14 exceeds li	ne 6) (see	0	15
c	instructions)		142 (		1 1
5.00	Excess of reasonable cost over customary charges (complete (	only if line 6 exceeds lin	ie 14) (see	0	16
7 00	instructions) Cost of physicians' services in a teaching hospital (see in:	(tructions)		0	17
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		I	0	1 1/
	Direct graduate medical education payments (from Worksheet )	F-4 line 49)		0	18
	Cost of covered services (sum of lines 6, 17 and 18)			770,376	
	Deductibles (exclude professional component)			74,364	
	Excess reasonable cost (from line 16)			0	21
	Subtotal (line 19 minus line 20 and 21)			696,012	22
3.00	Coinsurance			0	23
4.00	Subtotal (line 22 minus line 23)			696,012	24
5.00	Allowable bad debts (exclude bad debts for professional serv	vices) (see instructions)		12,200	25
	Adjusted reimbursable bad debts (see instructions)			7,930	26
	Allowable bad debts for dual eligible beneficiaries (see in	structions)		7,604	
	Subtotal (sum of lines 24 and 25, or line 26)			703,942	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	29
	Pioneer ACO demonstration payment adjustment (see instruction	ons)		0	29
	Recovery of accelerated depreciation.			0	
1	Demonstration payment adjustment amount before sequestration	n		0 702 042	
1	Subtotal (see instructions)			703,942 14,079	
	Sequestration adjustment (see instructions)				30
	Demonstration payment adjustment amount after sequestration Sequestration adjustment-PARHM			0	30
	Interim payments			733,771	
	Interim payments-PARHM			133,111	31
	Tentative settlement (for contractor use only)			0	
	Tentative settlement-PARHM (for contractor use only)			0	32
	Balance due provider/program (line 30 minus lines 30.01, 30	.02. 31. and 32)		-43,908	
	Balance due provider/program-PARHM (lines 2, 3, 18, and 26,		and 32.01)	.5,500	33
	Protested amounts (nonallowable cost report items) in accord			25,000	

CUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1308	Period:	Worksheet E-3	
			From 07/01/2022 To 06/30/2023	Part VII Date/Time Pre 11/22/2023 2:	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	VICES FOR TITLES V OR X	IX SERVICES		-
	COMPUTATION OF NET COST OF COVERED SERVICES		00 207		1 1 0
0	Inpatient hospital/SNF/NF services Medical and other services		88,387	0	1.00
0	Organ acquisition (certified transplant programs only)		0	0	3.00
0	Subtotal (sum of lines 1, 2 and 3)		88,387	0	
0	Inpatient primary payer payments		0	-	5.00
0	Outpatient primary payer payments			0	6.0
0	Subtotal (line 4 less sum of lines 5 and 6)		88,387	0	7.0
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges				
0	Routine service charges		58,300		8.0
0	Ancillary service charges		221,723	0	
	Organ acquisition charges, net of revenue		0		10.0
	Incentive from target amount computation		0	0	11.0
00	Total reasonable charges (sum of lines 8 through 11)		280,023	0	12.0
00	CUSTOMARY CHARGES Amount actually collected from patients liable for payment for	services on a charge	0	0	13.0
00	basis	services on a charge	0	0	13.0
00	Amounts that would have been realized from patients liable for	payment for services of	on 0	0	14.0
	a charge basis had such payment been made in accordance with 4			-	
00	Ratio of line 13 to line 14 (not to exceed 1.000000)	2	0.000000	0.00000	15.0
00	Total customary charges (see instructions)		280,023	0	16.0
00	Excess of customary charges over reasonable cost (complete onl	ly if line 16 exceeds	191,636	0	17.0
	line 4) (see instructions)				
00	Excess of reasonable cost over customary charges (complete onl	ly if line 4 exceeds lir	1e 0	0	18.0
~	16) (see instructions)		0	0	10 0
	Interns and Residents (see instructions) Cost of physicians' services in a teaching hospital (see instr	uctions)	0	0	19.0
	Cost of covered services (enter the lesser of line 4 or line 1		88,387	0	20.0
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be			0	21.0
	Other than outlier payments		0	0	22.0
	Outlier payments		0	0	
	Program capital payments		0	-	24.0
00	Capital exception payments (see instructions)		0		25.0
00	Routine and Ancillary service other pass through costs		0	0	
00	Subtotal (sum of lines 22 through 26)		0	0	
	Customary charges (title V or XIX PPS covered services only)		0	0	28.0
00	Titles V or XIX (sum of lines 21 and 27)		88,387	0	29.0
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
00	Excess of reasonable cost (from line 18)		0	0	
00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	)	88,387	0	
	Deductibles		0	0	
	Coinsurance Allowable bad debts (see instructions)		0	0	
00	Utilization review		0	0	35.0
00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	1 33)	88,387	0	
00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	/	0	0	
	Subtotal (line 36 $\pm$ line 37)		88,387	0	38.0
00	Direct graduate medical education payments (from Wkst. E-4)		0	Ũ	39.0
	Total amount payable to the provider (sum of lines 38 and 39)		88,387	0	40.0
	Interim payments		88,387	0	41.0
00	Balance due provider/program (line 40 minus line 41)		0	0	42.0
00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub 15-2,	0	0	43.0
	chapter 1, §115.2				1

	E SHEET (If you are nonproprietary and do not maintain	Provider C	CN: 15-1308	Period: From 07/01/2022	Worksheet G	
nd-t ly)	ype accounting records, complete the General Fund column			From 07/01/2022 Γο 06/30/2023	Date/Time Pre	pare
.,,,		General Fund	Specific	Endowment Fund	11/22/2023 2: Plant Fund	20
			Purpose Fund			
		1.00	2.00	3.00	4.00	
00	CURRENT ASSETS Cash on hand in banks	450	57,94	2 0	0	1
00	Temporary investments	430	57,54		0	
00	Notes receivable	0		0 0	0	
00	Accounts receivable	7,229,394		0 0	0	4
00	Other receivable	465,044		0 0	0	
00	Allowances for uncollectible notes and accounts receivable	-4,818,220		0 0	0	1 1
)0 )0	Inventory Prepaid expenses	489,650			0	8
00	Other current assets	0			0	
00	Due from other funds	0			0	10
00	Total current assets (sum of lines 1-10)	3,366,318	57,94	2 0	0	11
	FIXED ASSETS	, ,				
.00	Land	465,381		0 0	0	
.00	Land improvements	821,276		0 0	0	
.00	Accumulated depreciation	-508,444		0 0	0	14
.00	Buildings	13,353,069			0	15
.00	Accumulated depreciation Leasehold improvements	-8,699,122 10,297,646			0	10
.00	Accumulated depreciation	-6,629,081			0	18
.00		4,676,948			0	19
.00	Accumulated depreciation	-2,911,191		0 0	0	
.00	Automobiles and trucks	0		0 0	0	2
.00	Accumulated depreciation	0		0 0	0	22
.00	Major movable equipment	6,835,629		0 0	0	23
.00	Accumulated depreciation	-5,823,057		0 0	0	24
.00	Minor equipment depreciable	135,437		0 0	0	2
.00	Accumulated depreciation	-135,437		0	0	26
.00	HIT designated Assets Accumulated depreciation	0			0	
.00	Minor equipment-nondepreciable	0			0	1
.00	Total fixed assets (sum of lines 12-29)	11,879,054			0	
	OTHER ASSETS		1	-1 -1	-	
.00	Investments	0		0 0	0	3:
.00	Deposits on leases	0		0 0	0	32
.00	Due from owners/officers	0		0 0	0	
.00	Other assets	12,640		0 0	0	34
.00	Total other assets (sum of lines 31-34)	12,640		0	0	
.00	Total assets (sum of lines 11, 30, and 35) CURRENT LIABILITIES	15,258,012	57,94	2 0	0	36
.00		942,754		0 0	0	37
.00	Salaries, wages, and fees payable	621,899		0	0	
.00	Payroll taxes payable	0		0 0	0	
.00	Notes and loans payable (short term)	0		0 0	0	4(
.00	Deferred income	0		0 0	0	
.00	Accelerated payments	0				42
.00	Due to other funds	2,504,758		0 0	0	
.00	Other current liabilities Total current liabilities (sum of lines 37 thru 44)	930,070			0	
.00	LONG TERM LIABILITIES	4,999,481		0 0	0	43
.00	Mortgage payable	0			0	40
.00	Notes payable	9,878,344		0	ů 0	
.00	Unsecured loans	0		o ol	0	
.00	Other long term liabilities	11,938		0 0	0	
.00	Total long term liabilities (sum of lines 46 thru 49)	9,890,282		0 0	0	
.00	Total liabilities (sum of lines 45 and 50)	14,889,763		0 0	0	51
~~	CAPITAL ACCOUNTS	260, 240	1	1		1
.00	General fund balance	368,249				52
.00	Specific purpose fund Donor created - endowment fund balance - restricted		57,94			53
.00	Donor created - endowment fund balance - restricted			0		5
.00	Governing body created - endowment fund balance			0		56
.00	Plant fund balance - invested in plant				0	
.00	Plant fund balance - reserve for plant improvement,				0	
	replacement, and expansion				Ũ	
.00	Total fund balances (sum of lines 52 thru 58)	368,249			0	
.00	Total liabilities and fund balances (sum of lines 51 and	15,258,012	57,94		0	60

STATE	IENT OF CHANGES IN FUND BALANCES		Provider Co		Period: From 07/01/2022 To 06/30/2023	Worksheet G-1 Date/Time Pre 11/22/2023 2:	pared:
		General	Fund	Special F	Purpose Fund	Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period	1.00	1,727,276		63,989		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,657,271		00,000		2.00
3.00	Total (sum of line 1 and line 2)		3,384,547		63,989		3.00
4.00	Transfer to/from Affiliates	-3,282,032	5,501,511		0	0	4.00
5.00	Temporary Restricted	0		252,91	.6	0	5.00
6.00		0		,	0	0	6.00
7.00	Released Operating	265,736		2	0	0 0	7.00
8.00	Other	0		7,30		0	8.00
9.00	Rounding	0		.,	0	0	9.00
10.00	Total additions (sum of line 4-9)	Ŭ	-3,016,296		260,236	, i i i i i i i i i i i i i i i i i i i	10.00
11.00	Subtotal (line 3 plus line 10)		368,251		324,225		11.00
12.00	Deductions (debit adjustments) (specify)	0	500,251		0	0	12.00
13.00	beddeerons (debre ddjusemenes) (speerry)	0			Ő	0	13.00
14.00		0			0	0	14.00
15.00	Released Operating	0		266,28	3	0	15.00
16.00		0		200,20	0	0	16.0
17.00	Rounding	2			0	0	17.00
18.00	Total deductions (sum of lines 12-17)	2	2		266,283	-	18.00
19.00	Fund balance at end of period per balance		368,249		57,942		19.00
19.00	sheet (line 11 minus line 18)		500,245		57,542		15.00
		Endowment Fund	Plant	Fund	_		
		6.00	7.00	8.00	_		
1.00	Fund balances at beginning of period	0.00	7.00	0.00	0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)	, i i i i i i i i i i i i i i i i i i i					2.00
3.00	Total (sum of line 1 and line 2)	0			0		3.00
4.00	Transfer to/from Affiliates	Ŭ	0		Ŭ,		4.00
5.00	Temporary Restricted		ů 0				5.00
5.00			0				6.00
7.00	Released Operating		ů 0				7.0
3.00	Other		0				8.0
9.00	Rounding		0				9.0
10.00	Total additions (sum of line 4-9)	0	Ŭ		0		10.0
L1.00	Subtotal (line 3 plus line 10)	0			0		11.0
L2.00	Deductions (debit adjustments) (specify)	Ŭ	0		Ŭ,		12.0
L3.00	beddeerons (debre ddjusemenes) (speerry)		0				13.0
4.00			0				14.0
15.00	Released Operating		0				15.00
			0				16.00
16 00	Rounding		0				17.00
		1 1	0		1		L ΤΥ.Ο(
17.00					0		10 00
16.00 17.00 18.00 19.00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance	0			0		18.00

STATEM	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider CC	EN: 15-1308	Perio From To	od: 07/01/2022 06/30/2023	Worksheet G-2 Parts I & II Date/Time Pre 11/22/2023 2:	pare
	Cost Center Description		Inpatient	0	utpatient	Total	
			1.00		2.00	3.00	
	PART I - PATIENT REVENUES						
	General Inpatient Routine Services						
.00	Hospital		2,626,0	87		2,626,087	1.
.00	SUBPROVIDER - IPF						2.
3.00	SUBPROVIDER - IRF						3.
1.00	SUBPROVIDER						4.
.00	Swing bed - SNF			0		0	5.
5.00	Swing bed - NF			0		0	6.
.00	SKILLED NURSING FACILITY						7.
3.00	NURSING FACILITY						8.
0.00	OTHER LONG TERM CARE						9.
.00.00	Total general inpatient care services (sum of lines 1-9)		2,626,0	87		2,626,087	10.
	Intensive Care Type Inpatient Hospital Services						
1.00	INTENSIVE CARE UNIT			0		0	11.
2.00	CORONARY CARE UNIT						12.
.3.00	BURN INTENSIVE CARE UNIT						13
4.00	SURGICAL INTENSIVE CARE UNIT						14
5.00	DETOXIFICATION INTENSIVE CARE UNIT			0		0	-
.6.00	Total intensive care type inpatient hospital services (sum o	f lines		0		0	16
	11-15)						
7.00	Total inpatient routine care services (sum of lines 10 and 1	6)	2,626,0			2,626,087	
.00	Ancillary services		3,766,8		54,613,144	58,380,021	
.9.00	Outpatient services		390,7		20,891,213	21,281,947	19.
20.00	RURAL HEALTH CLINIC			0	0	0	20.
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0	0	0	21.
2.00	HOME HEALTH AGENCY						22.
23.00	AMBULANCE SERVICES						23.
4.00	СМНС						24.
25.00	AMBULATORY SURGICAL CENTER (D.P.)						25.
26.00	HOSPICE			0	0	0	26.
27.00	OTHER (SPECIFY)	2	6 700 6	0	75 504 257	0	27.
28.00	Total patient revenues (sum of lines 17-27)(transfer column	3 to Wkst.	6,783,6	98	75,504,357	82,288,055	28.
	G-3, line 1)						
0 00	PART II - OPERATING EXPENSES			1	24 020 127		20
9.00	Operating expenses (per Wkst. A, column 3, line 200)			~	24,020,137		29.
0.00	ADD (SPECIFY)			0			30.
31.00				0			31
32.00				0			32
3.00				0			33
4.00				0			34 35
	Total additions (sum of lines 20 25)			U	0		35
6.00	Total additions (sum of lines 30-35)			0	0		36
7.00	DEDUCT (SPECIFY)			0			-
8.00				0			38
9.00				-			39
0.00				0			40
1.00	Tatal deductions (our of lines 27 (1))			0			41
2.00	Total deductions (sum of lines 37-41)	(2) (+			0		42
3.00	Total operating expenses (sum of lines 29 and 36 minus line to Wkst. G-3, line 4)	42)(transter			24,020,137		43

Health	Financial Systems	ASCENSION ST. VIN	CENT MERCY	In Lie	u of Form CMS-2	2552-10
	IENT OF REVENUES AND EXPENSES		Provider CCN: 15-1308	Period: From 07/01/2022	Worksheet G-3	
				To 06/30/2023	Date/Time Pre	pared:
					11/22/2023 2:	20 pm
				-	1.00	
1.00	Total patient revenues (from Wkst. G-2, Par	t I, column 3, line	28)		82,288,055	1.00
2.00	Less contractual allowances and discounts o				56,920,175	2.00
3.00	Net patient revenues (line 1 minus line 2)				25,367,880	3.00
4.00	Less total operating expenses (from Wkst. G	-2, Part II, line 4	43)		24,020,137	4.00
5.00	Net income from service to patients (line 3	minus line 4)			1,347,743	5.00
	OTHER INCOME					
6.00	Contributions, donations, bequests, etc				-17,500	6.00
7.00	Income from investments				0	7.00
8.00	Revenues from telephone and other miscellan	eous communication	services		0	8.00
9.00	Revenue from television and radio service				0	9.00
10.00	Purchase discounts				0	10.00
11.00	Rebates and refunds of expenses				0	11.00
12.00	Parking lot receipts				0	12.00
13.00	Revenue from laundry and linen service				0	13.00
14.00	Revenue from meals sold to employees and gu	lests			60,867	
15.00					0	15.00
16.00	Revenue from sale of medical and surgical s		nan patients		0	16.00
17.00	Revenue from sale of drugs to other than pa				29,773	
18.00	Revenue from sale of medical records and ab				0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms,				0	19.00
20.00	Revenue from gifts, flowers, coffee shops,	and canteen			0	20.00
21.00					0	21.00
22.00					56,939	
23.00	Governmental appropriations				0	23.00
24.00	Other Revenue				70,568	
24.01	Net assets released from restrictions				548	24.01
24.03	State Program Revenue				108,333	24.03
24.50	COVID-19 PHE Funding				0	24.50
25.00					309,528	25.00
	Total (line 5 plus line 25)				1,657,271	
27.00	OTHER EXPENSES (SPECIFY)				0	27.00
28.00	Total other expenses (sum of line 27 and su				0	28.00
29.00	Net income (or loss) for the period (line 2	6 minus line 28)			1,657,271	29.00