ASCENSION ST. VINCENT WARRICK

In Lieu of Form CMS-2552-10

This report is required by law (42 U				FORM APPROVED	
payments made since the beginning of	the cost reporting period being	deemed overpayments (4	2 USC 1395g).	OMB NO. 0938-	0050
				EXPIRES 09-30	-2025
HOSPITAL AND HOSPITAL HEALTH CARE COM	MPLEX COST REPORT CERTIFICATION	Provider CCN: 15-1325	Period:	Worksheet S	
AND SETTLEMENT SUMMARY			From 07/01/2022		
			то 06/30/2023	Date/Time Pre 11/24/2023 3:	
PART I - COST REPORT STATUS					
Provider 1. [X] Electronically	prepared cost report		Date: 11/24/2	023 Time: 3	:50 pm
use only 2.[]Manually prepa	red cost report				
	amended report enter the number zation. Enter "F" for full, "L'			ost report	
Contractor 5. [1] Cost Report St (1) As Submitted	7. Contractor No.	11.	NPR Date: Contractor's Vendo	r Code:	4
(2) Settled without(3) Settled with Au	Audit 8. [N] Initial Report fo dit 9. [N] Final Report for	this Provider CCN 12.		es reopened =	
(4) Reopened					
(5) Amended					
PART II - CERTIFICATION BY A CHIEF F	INANCIAL OFFICER OR ADMINISTRATO	OR OR PROVIDER(S)			
MISREPRESENTATION OR FALSIFICATION O			PUNISHABLE BY CRIM	IINAL. CIVIL AN	ID

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ASCENSION ST. VINCENT WARRICK (15-1325) 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	Zach	Zirkelbach	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	Zach Zirkelbach			2
3	Signatory Title	VP OF FINANCE			3
4	Date	11/24/2023 03:50:42 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	-34,842	-254,629	0	0	1.00
2.00	SUBPROVIDER - IPF	0	30,159	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
4.00	SUBPROVIDER (OTHER)						4.00
5.00	SWING BED - SNF	0	-53,479	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
200.00	TOTAL	0	-58,162	-254,629	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.

	I Financial Systems FAL AND HOSPITAL HEALTH CARE COMPLEX	ASCENSION ST. N IDENTIFICATION DATA		ler CCN:		Period: From 07/01/ To 06/30/	2022		et S-2	pare
	1.00	2.00		3.00		4	1.00	11/24/2	2023 3:	50 pr
	Hospital and Hospital Health Care Co									
00	Street:1116 MILLIS AVE	PO Box:								1.
00	City: BOONEVILLE	State: IN		e: 47601		y: WARRICK	Dayma			2.
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified		ent Syst		
			Number	Number	Type	Certifieu	V	, O, or XVIII		-
		1.00	2.00	3.00	4.00	5.00	6.00		8.00	1
	Hospital and Hospital-Based Componer		2.00	5100	1100	5100	0.00	11.00	0.00	
00	Hospital	ASCENSION ST. VINCENT	151325	21780	1	03/01/2005	N	0	0	3.
		WARRICK								
00	Subprovider - IPF	ST. VINCENT WARRICK -	15M325	21780	4	03/01/2005	N	P	0	4.
~ ~		PSYCH UNIT								-
00	Subprovider - IRF									5.
00 00	Subprovider - (Other) Swing Beds - SNF		157225	21700		02/01/2005	N	0	N	6.
00	Swing Beas - SNF	ST. VINCENT WARRICK - SWING BED	15z325	21780		03/01/2005	Ν	0	N	7.
00	Swing Beds - NF	SWING BED								8.
00	Hospital-Based SNF									9.
.00	•									10.
.00										11.
.00				1						12.
.00	•									13.
.00	Hospital-Based Hospice									14.
.00	Hospital-Based Health Clinic - RHC									15.
.00										16.
.00										17.
.00	Renal Dialysis									18.
.00	Other									19.
						From: 1.00		T0 2.0		-
00	Cost Reporting Period (mm/dd/yyyy)					07/01/20	022	06/30		20
	Type of Control (see instructions)					1		00,00,	2020	21
					1.00	2.00		3.0	00	1
	Inpatient PPS Information									
.00					N	N				22.
	disproportionate share hospital adju	istment, in accordance	with 42 CF	र						
	§412.106? In column 1, enter "Y" fo									
	facility subject to 42 CFR Section §		nendment							
01	hospital?) In column 2, enter "Y" fo Did this hospital receive interim UC			for	N					22.
.01	this cost reporting period? Enter in				N	N				22.
	for the portion of the cost reportin									
	1. Enter in column 2, "Y" for yes or									
	cost reporting period occurring on c									
	instructions)		-							
.02	Is this a newly merged hospital that	requires a final UCP	to be		Ν	N				22.
	determined at cost report settlement	? (see instructions) E	nter in co	lumn						
	1, "Y" for yes or "N" for no, for th									
	period prior to October 1. Enter in			no,						1
	for the portion of the cost reportir									
	Did this hospital receive a geograph				Ν	N		N		22
.03										
.03	rural as a result of the OMB standar	- 7		10						
.03	adopted by CMS in FY2015? Enter in c									
.03	adopted by CMS in FY2015? Enter in c for the portion of the cost reportir	ng period prior to Octo	per 1. Ent	er						
.03	adopted by CMS in FY2015? Enter in c for the portion of the cost reportir in column 2, "Y" for yes or "N" for	ng period prior to Octo no for the portion of	per 1. Ente the cost							
. 03	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	ng period prior to Octo no for the portion of er October 1. (see ins	per 1. Ento the cost tructions)							
03	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 Does this hospital contain at least	ng period prior to Octo no for the portion of er October 1. (see ins 100 but not more than	per 1. Ent the cost tructions) 499 beds (a	as						
03	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	ng period prior to Octo no for the portion of er October 1. (see ins 100 but not more than	per 1. Ent the cost tructions) 499 beds (a	as						
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0361	TAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ATA	Provider CC	N: 15-1325	Period:	1 /2022		ieet S-2	2
					From 07/03 To 06/30	0/2022	Part 1 Date/1 11/24/	L Fime Pre /2023 3:	eparec :50 pm
		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	aid d ays Me	Other edicaid days	
00	If this provider is an IDDC bespitel opton the	1.00	2.00	3.00	4.00	5.00) ()	6.00	24
4.00	in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state		0		0		0		24.
	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.				under (2)		Dete	6 6 6 6 6 6 6	
					Urban/R			it Geogr .00	-
5.00			at the beg	inning of t		1			26.
	cost reporting period. Enter "1" for urban or "2" fo Enter your standard geographic classification (not w reporting period. Enter in column 1, "1" for urban o enter the effective date of the geographic reclassif	age) status r "2" for r ication in	ural. If ap column 2.	plicable,		1			27
.00	If this is a sole community hospital (SCH), enter th effect in the cost reporting period.	e number of	perious sc	H SLALUS II		0			55
					Beginn 1.0			ing: .00	-
.00	Enter applicable beginning and ending dates of SCH s		cript line	36 for numb					36
.00	of periods in excess of one and enter subsequent dat If this is a Medicare dependent hospital (MDH), ente		r of period	ls MDH statu	s	0			37
	is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for t accordance with FY 2016 OPPS final rule? Enter "Y" f	he MDH tran	sitional pa	uyment in					37
.00	instructions)	s of MDH st	atus. If li	ne 37 is					38
					Y/			/N	
.00	Does this facility qualify for the inpatient hospita 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) Is this hospital subject to the HAC program reductio), (ii), or the mileage ii)? Enter	(iii)? Ent requiremen in column 2	er in colum its in "Y" for ye	n s			<u>. 00</u> N	39
	"N" for no in column 1, for discharges prior to Octo no in column 2, for discharges on or after October 1	ber 1. Ente	r "Y" for y						
						V 1.00	XVII:) 2.00		
.00	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital payme	nt for disp	roportionat	e share in	accordance	N	N	N	45
.00	with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exc pursuant to 42 CFR §412.348(f)? If yes, complete Wks					N	N	N	46
	Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS Is the facility electing full federal capital paymen					N	N	N	47
						N			56
.00	Teaching Hospitals Is this a hospital involved in training residents in periods beginning prior to December 27, 2020, enter cost reporting periods beginning on or after Decembe the instructions. For column 2, if the response to c involved in training residents in approved GME progr and are you are impacted by CR 11642 (or applicable "Y" for yes; otherwise, enter "N" for no in column 2	approved G "Y" for yes r 27, 2020, olumn 1 is ams in the CRs) MA dir	or "N" for under 42 C "Y", or if prior year	no in colu FR 413.78(b this hospit or penultim	mn 1. For)(2), see al was ate year,				
.00	Teaching Hospitals Is this a hospital involved in training residents in periods beginning prior to December 27, 2020, enter cost reporting periods beginning on or after Decembe the instructions. For column 2, if the response to c involved in training residents in approved GME progr and are you are impacted by CR 11642 (or applicable "Y" for yes; otherwise, enter "N" for no in column 2	approved G "Y" for yes r 27, 2020, olumn 1 is ams in the CRS) MA dir er 27, 2020 residents n column 1. cost report e Worksheet applicable R 413.77(e on duty, i ete column	or "N" for under 42 C "Y", or if prior year ect GME pay , if line 5 in approved If column ing period? E-4. If co . For cost)(1)(iv) an f the respo 2, and comp	no in colu FR 413.78(b this hospit or penultim ment reduct G6, column 1 I GME progra 1 is "Y", c Enter "Y" remorting p id (v), rega onse to line blete Worksh	<pre>mn 1. For)(2), see al was ate year, ion? Enter , is yes, ms trained id for yes or N", eriods rdless of 56 is "Y" eet E-4.</pre>				57

105P11	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provider CC		Period: From 07/01/2 To 06/30/2		Worksheet S-2 Part I Date/Time Prep 11/24/2023 3: XVIII XIX	pared:
						1.00		
59.00	Are costs claimed on line 100 of Worksheet A? If yes	, compl	ete Wkst. D-2	Pt. I. NAHE 413.85	Worksheet	N	Pass-Through	59.00
				Y/N	Line #		Qualification Criterion Code	
				1.00	2.00		3.00	
0.00	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. R) NAHE	ee If column 1	N				60.00
		Y/N	IME	Direct GME	IME		Direct GME	
		1.00	2.00	3.00	4.00		5.00	
	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	N				0.00	0.00	61.00
1.02	instructions) Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)							61.02
	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)							61.0
	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions). Enter the difference between the baseline primary							61.0
1.06	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							61.0
	care or general surgery. (see instructions)	Pro	ogram Name	Program Code	Unweighted	TMF	Unweighted	
					FTE Cour		Direct GME FTE Count	
1 10	of the FTFE in line (1.05, encoder and any measure		1.00	2.00	3.00	0.00	4.00	61.1
	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.					0.00		
1.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.					0.00	0.00	61.20
						-	1.00	
2.00	ACA Provisions Affecting the Health Resources and Ser Enter the number of FTE residents that your hospital				riod for whi	ch	0.00	62.00
	your hospital received HRSA PCRE funding (see instruct Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog	tions) Teachi	ng Health Cent	cer (THC) into				62.01
	Teaching Hospitals that Claim Residents in Nonprovide			13/				

	I Financial Systems TAL AND HOSPITAL HEALTH CARE COMPL		ST. VINCENT WARRICK		In Lie Period:	Worksheet S-2	
				· · · · · · · · · · · · · · · · · · ·	From 07/01/2022 To 06/30/2023	Part I Date/Time Pre 11/24/2023 3:	
				Unweighted FTEs	Unweighted FTEs in	Ratio (col. 1/ (col. 1 + col.	1
				Nonprovider Site		2))	
				1.00	2.00	3.00	-
	Section 5504 of the ACA Base Yea						
.00	period that begins on or after J 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	yes, or your facilit ber of unweighted non tations occurring in	y trained residents -primary care all nonprovider	0.0	0.00	0.00000	64.0
	resident FTEs that trained in yo	ur hospital. Enter in	column 3 the ratio				
	of (column 1 divided by (column				Unwataktad	Datio (col 2/	
		Program Name	Program Code	Unweighted FTEs	Unweighted FTEs in	Ratio (col. 3/ (col. 3 + col.	
				Nonprovider		4))	
				Site			
		1.00	2.00	3.00	4.00	5.00	1
.00	Enter in column 1, if line 63			0.0	0.00	0.00000	65.0
	trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			Unweighted	Unweighted	Ratio (col. 1/	
				FTES Nonprovider Site		(col. 1 + col. 2))	_
	Section 5504 of the ACA Current	Voor ETE Bosidonts in	Nonprovider Setting	1.00	2.00	3.00	
	beginning on or after July 1, 20		Nonprovider Secting	SEffective		ng per rous	
.00	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 +	unweighted non-primar ccurring in all nonpr unweighted non-primar al. Enter in column 3	ovider settings. y care resident the ratio of	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
.00	Enter in column 1, the program	1.00	2.00	0.0			67.0
	name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3						

неаlth	Financial Systems ASCENSION ST. VINCENT WA	RRTCK		т	n Lieu	ı of Fori	n CMS-2	2552-10
			N:15-1325 P	eriod:		Workshe		
				rom 07/01		Part I		
			1	o 06/30	/2025	Date/Ti 11/24/2	023 3:	50 pm
					ĺ	1.0	0	
	Direct GME in Accordance with the EY 2023 TPPS Final Rule, 87 FR 490	65-490)72 (August 10	. 2022)		1.0	0	
68.00	For a cost reporting period beginning prior to October 1, 2022, did	you ob	tain permissi	on from yo		N		68.00
					1 00	2.00	2 00	
	Innatient Psychiatric Facility PPS				1.00	2.00	3.00	
70.00		conta	in an IPF sub	provider?	Y			70.00
	Enter "Y" for yes or "N" for no.							
/1.00					N	N	0	71.00
	42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train resi	dents	in a new teac	hing				
	(see instructions)	this	cost reporting	g period.				
	Inpatient Rehabilitation Facility PPS							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does	it co	ontain an IRF		N			75.00
76 00		eachin	a program in ·	the most	N	N	0	76.00
10.00							0	10100
				,				
	······································	(****			<u>'</u>			
	Long Term Care Hospital DDS					1.0	0	
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N"	for n	10.			N		80.00
	Is this a LTCH co-located within another hospital for part or all of			period? E	nter	N		81.00
85.00		Enter	' "Y" for yes (or "N" for	no.	N		85.00
	Did this facility establish a new Other subprovider (excluded unit)							86.00
87 00	§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.	find	under costion			N		87.00
87.00	1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	i ieu u	inder section			IN		87.00
				Approved		Number		
				Perman Adjustn		Appro Permar		
				(Y/N		Adjust		
				1.00)	2.0		
88.00	Column 1: Is this hospital approved for a permanent adjustment to th	ete co	A target				0	88.00
	89. (see instructions)							
	Column 2: Enter the number of approved permanent adjustments.		Viliant A Lina	Effective	Data			
				ETTECTIVE	e Date	Appro Perman		
						Adjust	ment	
						Amount Discha		
			1.00	2.00)	3.0		
89.00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line numb	er	0.00					89.00
	beginning date) for the permanent adjustment to the TEFRA target amo	unt						
	per discharge.							
		he						
				V		XIX	<	
	Title V and VTV Complete			1.00)	2.0	0	
90.00		es? En	iter "Y" for	N		Y		90.00
	yes or "N" for no in the applicable column.							
91.00	Is this hospital reimbursed for title V and/or XIX through the cost full or in part? Enter "V" for yes or "N" for no in the applicable of	report	: either in	N		N		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certi	ficati				N		92.00
02.00	instructions) Enter "Y" for yes or "N" for no in the applicable colu							02.00
93.00	D HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1325 if CME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August J cost reporting period beginning prior to October 1, 2022, did you obtain permiss or apply the in DOME formula in accordance with the FY 2023 IPPS Final Rule, 87 F store 10, 2022)? ient Psychiatric Facility PPS is facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF su "" for yes or "N" for no. ne 70 is yes: column 1: Did the facility have an approved GWE teaching program in t cost report filed on or before November 15, 20047 Enter "N" for yes or "N" for an in accordance with 42 CFR 124.242 (d) (1)(1)(1)(D)? Enter "N" for yes or "N" for n 3: If column 2 is Y, indicate which program year began during this cost report instructions? instructions Column 1: Did the facility have an approved GWE teaching program in t cost report of this facility train residents in a new teaching program in accordanc 12.424 (d)(1)(1)(1)(0)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is facility and Inpatient Rebabilitation Facility (IRF), or does it contain an IRF ovider" Enter "V" for yes and "N" for no. 12.424 (d)(1)(1)(1)(0)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is a long term care hospital (LCHO)? Enter "Y" for yes and "N" for no. 13: LTC for located within another hospital for part or all of the cost report is a long term care hospital (LCHO)? Enter "Y" for yes and "N" for no. 140(F)(1)(1)? Enter "Y" for yes and "N" for no. 15 shospital an extended neolalist disease care hospital classified under 42 CFR Secti 40(F)(1)(1)? Enter "Y" for yes or "N" for no. 140(1)(8)(vi)? Enter "Y" for yes or "N" for no. 15 sentructions) n 1: Is this hospital approved permanent adjustment to the 140(F)(1)(8)(vi)? Enter "Y" for yes or "N" for no. 140(1)(8)(vi)? Ente			N		N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N"	for no	in the	N		Ν		94.00
95 00	applicable column. If line 94 is "Y", enter the reduction percentage in the applicable	co1		0.00	,	0.0	0	95.00
	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N"			N 0.00	,	0.0 N	U	95.00
	applicable column.							
97.00	If line 96 is "Y", enter the reduction percentage in the applicable	column	1.	0.00)	0.0	U	97.00

	Financial Systems ASCENSION ST. VI AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CO	N: 15-1325	In Lie Period:	Worksheet S-	-2
037172	A AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA			From 07/01/2022 To 06/30/2023	Part I	repared
				V 1.00	XIX	_
00.86	Does title V or XIX follow Medicare (title XVIII) for the i	nterns and res	idents post	1.00 N	2.00 Y	98.0
	stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" column 1 for title V, and in column 2 for title XIX.	for yes or "N"	for no in			
c	Does title V or XIX follow Medicare (title XVIII) for the r C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for t title XIX.			N	Y	98.0
ł	Does title V or XIX follow Medicare (title XVIII) for the c bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes for title V, and in column 2 for title XIX.			N	Y	98.0
98.03 I	Does title V or XIX follow Medicare (title XVIII) for a cri reimbursed 101% of inpatient services cost? Enter "Y" for y for title V, and in column 2 for title XIX.			L	N	98.0
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH Dutpatient services cost? Enter "Y" for yes or "N" for no i in column 2 for title XIX.	reimbursed 10 n column 1 for	1% of title V, and	N	N	98.0
98.05 I	Does title V or XIX follow Medicare (title XVIII) and add b Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 2 for title XIX.	ack the RCE di column 1 for t	sallowance on itle V, and ir	N	Y	98.0
98.06 I	Does title V or XIX follow Medicare (title XVIII) when cost Pts. I through IV? Enter "Y" for yes or "N" for no in colum column 2 for title XIX.			N	Y	98.0
	Rural Providers					_
	Does this hospital qualify as a CAH?			Y		105.0
	If this facility qualifies as a CAH, has it elected the all for outpatient services? (see instructions)	-inclusive met	nod of payment	I N		106.
L07.00	Column 1: If line 105 is Y, is this facility eligible for c training programs? Enter "Y" for yes or "N" for no in colum Column 2: If column 1 is Y and line 70 or line 75 is Y, do	n 1. (see ins	tructions)	N		107.
	approved medical education program in the CAH's excluded I		unit(s)?			
.08.00	Enter "Y" for yes or "N" for no in column 2. (see instruct Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		dule? See 42	Ν		108.
		Physical	Occupationa		Respiratory	<u>,</u>
09.00	If this hospital qualifies as a CAH or a cost provider, are	1.00 Y	2.00 Y	3.00 Y	4.00 N	109.
1	therapy services provided by outside supplier? Enter "Y"					
	for yes or "N" for no for each therapy.					
	for yes or "N" for no for each therapy.				1.00	_
L10.00 [for yes or "N" for no for each therapy. Did this hospital participate in the Rural Community Hospit Demonstration)for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable.	"Y" for yes or	"N" for no. 1	f yes,	1.00 N	110.
L10.00	Did this hospital participate in the Rural Community Hospit Demonstration)for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo	"Y" for yes or	"N" for no. 1	f yes,		110.
110.00 	Did this hospital participate in the Rural Community Hospit Demonstration)for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo	"Y" for yes or rksheet E-2, 1 the Frontier Co ost reporting olumn 1 is Y, o rticipating in	"N" for no. 1 ines 200 throu period? Enter enter the column 2.	if yes, Igh 215, as	N	
	Did this hospital participate in the Rural Community Hospit Demonstration)for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable. If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this c "Y" for yes or "N" for no in column 1. If the response to c integration prong of the FCHIP demo in which this CAH is pa Enter all that apply: "A" for Ambulance services; "B" for a	"Y" for yes or rksheet E-2, 1 the Frontier Co ost reporting olumn 1 is Y, o rticipating in	"N" for no. 1 ines 200 throu period? Enter enter the column 2. ; and/or "C"	f yes, igh 215, as	N 2.00	
10.00 t	Did this hospital participate in the Rural Community Hospit Demonstration)for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable. If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this c "Y" for yes or "N" for no in column 1. If the response to c integration prong of the FCHIP demo in which this CAH is pa Enter all that apply: "A" for Ambulance services; "B" for a	"Y" for yes or rksheet E-2, 1 the Frontier C ost reporting olumn 1 is Y, o rticipating in dditional beds	"N" for no. 1 ines 200 throu period? Enter enter the column 2.	if yes, igh 215, as	N	111.
	Did this hospital participate in the Rural Community Hospit Demonstration)for the current cost reporting period? Enter complete worksheet E, Part A, lines 200 through 218, and wo applicable. If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this c "Y" for yes or "N" for no in column 1. If the response to c integration prong of the FCHIP demo in which this CAH is pa Enter all that apply: "A" for Ambulance services; "B" for a for tele-health services. Did this hospital participate in the Pennsylvania Rural Hea (PARHM) demonstration for any portion of the current cost r period? Enter "Y" for yes or "N" for no in column 1. If c "Y", enter in column 2, the date the hospital began partici demonstration. In column 3, enter the date the hospital ce participation in the demonstration, if applicable.	"Y" for yes or rksheet E-2, 1 the Frontier Co ost reporting p olumn 1 is Y, o rticipating in dditional beds lth Model eporting olumn 1 is pating in the	"N" for no. 1 ines 200 throu period? Enter enter the column 2. ; and/or "C" 1.00	f yes, igh 215, as	N 2.00	111.
	Did this hospital participate in the Rural Community Hospit Demonstration)for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable. If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this c "V" for yes or "N" for no in column 1. If the response to c integration prong of the FCHIP demo in which this CAH is pa Enter all that apply: "A" for Ambulance services; "B" for a for tele-health services. Did this hospital participate in the Pennsylvania Rural Hea (PARHM) demonstration for any portion of the current cost r period? Enter "Y" for yes or "N" for no in column 1. If c "Y", enter in column 2, the date the hospital began partici demonstration. In column 3, enter the date the hospital ce participation in the demonstration, if applicable. Viscellaneous Cost Reporting Information	"Y" for yes or rksheet E-2, 1 the Frontier Co ost reporting p olumn 1 is Y, o rticipating in dditional beds lth Model eporting olumn 1 is pating in the ased	"N" for no. 1 ines 200 throu period? Enter enter the column 2. ; and/or "C" 1.00 N	f yes, igh 215, as	N 2.00	111.
.10.00 [[] .11.00] .12.00 [] .15.00]	Did this hospital participate in the Rural Community Hospit Demonstration)for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable. If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this c "Y" for yes or "N" for no in column 1. If the response to c integration prong of the FCHIP demo in which this CAH is pa Enter all that apply: "A" for Ambulance services; "B" for a for tele-health services. Did this hospital participate in the Pennsylvania Rural Hea (PARHM) demonstration for any portion of the current cost r period? Enter "Y" for yes or "N" for no in column 1. If c "Y", enter in column 2, the date the hospital began partici demonstration. In column 3, enter the date the hospital ce participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information Is this an all-inclusive rate provider? Enter "Y" for yes o in column 1. If column 1 is yes, enter the method used (A, in column 2. If column 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 provide	"Y" for yes or rksheet E-2, 1 the Frontier C ost reporting p olumn 1 is Y, o rticipating in dditional beds lth Model eporting olumn 1 is pating in the ased r "N" for no B, or E only) 93" percent (includes	"N" for no. 1 ines 200 throu period? Enter enter the column 2. ; and/or "C" 1.00	f yes, igh 215, as	N 2.00	111.
	Did this hospital participate in the Rural Community Hospit Demonstration)for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable. If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this c "Y" for yes or "N" for no in column 1. If the response to c integration prong of the FCHIP demo in which this CAH is pa Enter all that apply: "A" for Ambulance services; "B" for a for tele-health services. Did this hospital participate in the Pennsylvania Rural Hea (PARHM) demonstration for any portion of the current cost r period? Enter "Y" for yes or "N" for no in column 1. If c "Y", enter in column 2, the date the hospital began partici demonstration. In column 3, enter the date the hospital ce participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information Is this an all-inclusive rate provider? Enter "Y" for yes o in column 1. If column 1 is yes, enter the method used (A, in column 2. If column 2 is "E", enter in column 3 either " for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provide the definition in CMS Pub.15-1, chapter 22, §2208.1. Is this facility classified as a referral center? Enter "Y"	"Y" for yes or rksheet E-2, 1 the Frontier Co ost reporting p olumn 1 is Y, o rticipating in dditional beds lth Model eporting olumn 1 is pating in the ased r "N" for no B, or E only) 93" percent (includes rs) based on	"N" for no. 1 ines 200 throu period? Enter enter the column 2. ; and/or "C" 1.00 N	f yes, igh 215, as	N 2.00	 110.0 111.0 111.0 1111.0 1112.0 0 1115.0 1116.0
	Did this hospital participate in the Rural Community Hospit Demonstration)for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable. If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this c "Y" for yes or "N" for no in column 1. If the response to c integration prong of the FCHIP demo in which this CAH is pa Enter all that apply: "A" for Ambulance services; "B" for a for tele-health services. Did this hospital participate in the Pennsylvania Rural Hea (PARHM) demonstration for any portion of the current cost r period? Enter "Y" for yes or "N" for no in column 1. If c "y", enter in column 2, the date the hospital began partici demonstration. In column 3, enter the date the hospital ce participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information Is this an all-inclusive rate provider? Enter "Y" for yes o in column 1. If column 1 is yes, enter the method used (A, in column 2. If column 2 is "E", enter in column 3 either " for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provide the definition in CMS Pub.15-1, chapter 22, §2208.1. Is this facility classified as a referral center? Enter "Y" "N" for no. Is this facility legally-required to carry malpractice insu	"Y" for yes or rksheet E-2, 1 the Frontier Co ost reporting o olumn 1 is Y, o rticipating in dditional beds lth Model eporting olumn 1 is pating in the ased r "N" for no B, or E only) 93" percent (includes rs) based on for yes or	"N" for no. 1 ines 200 throu period? Enter enter the column 2. ; and/or "C" 1.00 N	f yes, igh 215, as	N 2.00	0 115.
L10.00 L11.00 L11.00 L112.00 L115.00 L115.00 L115.00	Did this hospital participate in the Rural Community Hospit Demonstration)for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable. If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this c "Y" for yes or "N" for no in column 1. If the response to c integration prong of the FCHIP demo in which this CAH is pa Enter all that apply: "A" for Ambulance services; "B" for a for tele-health services. Did this hospital participate in the Pennsylvania Rural Hea (PARHM) demonstration for any portion of the current cost r period? Enter "Y" for yes or "N" for no in column 1. If c "Y", enter in column 2, the date the hospital began partici demonstration. In column 3, enter the date the hospital ce participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information Is this an all-inclusive rate provider? Enter "Y" for yes o in column 1. If column 1 is yes, enter the method used (A, in column 2. If column 2 is "E", enter in column 3 either " for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provide the definition in CMS Pub.15-1, chapter 22, §2208.1. Is this facility classified as a referral center? Enter "Y"	"Y" for yes or rksheet E-2, 1 the Frontier Co ost reporting p olumn 1 is Y, or rticipating in dditional beds lth Model eporting olumn 1 is pating in the ased r "N" for no B, or E only) 93" percent (includes rs) based on for yes or rance? Enter	"N" for no. 1 ines 200 throu period? Enter enter the column 2. ; and/or "C" 1.00 N	f yes, igh 215, as	N 2.00	1111. 1112. 0115. 1116.

ealth Financial Systems ASCENSION ST. VINCENT WARRICK OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider C	CN: 15-1325	Period: From 07/01/2022 To 06/30/2023	Worksheet S Part I	repared
	Premiums	Losses	Insurance	
18.01List amounts of malpractice premiums and paid losses:	1.00	2.00	3.00	0118.0
to or the set and the set of the	127,0		-	
18.02 Are malpractice premiums and paid losses reported in a cost center other	than the	1.00 N	2.00	118.0
Administrative and General? If yes, submit supporting schedule listing c and amounts contained therein. 19.00DO NOT USE THIS LINE		N		119.0
20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless pro §3121 and applicable amendments? (see instructions) Enter in column 1, "Y "N" for no. Is this a rural hospital with < 100 beds that qualifies for t Hold Harmless provision in ACA §3121 and applicable amendments? (see inst Enter in column 2, "Y" for yes or "N" for no.	(" for yes or the Outpatient		Ν	120.0
21.00 Did this facility incur and report costs for high cost implantable device patients? Enter "Y" for yes or "N" for no.	es charged to	Y		121.0
22.00 Does the cost report contain healthcare related taxes as defined in §1903 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", ente the worksheet A line number where these taxes are included.			5.04	122.0
23.00 Did the facility and/or its subproviders (if applicable) purchase profess services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, management/consulting services, from an unrelated organization? In column for yes or "N" for no.	and/or			123.0
If column 1 is "Y", were the majority of the expenses, i.e., greater than professional services expenses, for services purchased from unrelated org located in a CBSA outside of the main hospital CBSA? In column 2, enter " "N" for no.	anizations			
Certified Transplant Center Information 25.00 Does this facility operate a Medicare-certified transplant center? Enter	"Y" for yes	N		125.
and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 If this is a Medicare-certified kidney transplant program, enter the cert	ification dat	e		126.0
in column 1 and termination date, if applicable, in column 2. 27.00 If this is a Medicare-certified heart transplant program, enter 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, enter 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 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, enter the ce date in column 1 and termination date, if applicable, in column 2.	ertification			130.
(1.00) If this is a Medicare-certified intestinal transplant program, enter the date in column 1 and termination date, if applicable, in column 2.	certificatior	1		131.
2.00 If this is a Medicare-certified islet transplant program, enter the certi in column 1 and termination date, if applicable, in column 2.	fication date	2		132.
33.00Removed and reserved 34.00If this is a hospital-based organ procurement organization (OPO), enter t	ha ODO numbar			133. 134.
in column 1 and termination date, if applicable, in column 2.				
All Providers 40.00 Are there any related organization or home office costs as defined in CMS chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home are claimed, enter in column 2 the home office chain number. (see instruc	e office costs	5 Y	15н046	140.0
1.00 2.00 If this facility is part of a chain organization, enter on lines 141 thro		3.00	of the	
home office and enter the home office contractor name and contractor numb		name and address	of the	
1.00 Name: ASCENSION ST. VINCENT HEALTH CONTRACTOR'S Name: WPS 12.00 Street:250 WEST 96TH STREET, SUITE 215 PO Box:	Contract	or's Number:080	01	141. 142.
13.00 City: INDIANAPOLIS State: IN	Zip Code	462	60	143.
			1.00	_
14.00 Are provider based physicians' costs included in Worksheet A?			Y	144.0
		1.00	2.00	_
15.00 If costs for renal services are claimed on Wkst. A, line 74, are the cost inpatient services only? Enter "Y" for yes or "N" for no in column 1. If no, does the dialysis facility include Medicare utilization for this cost	column 1 is	1.00	2.00	145.
period? Enter "Y" for yes or "N" for no in column 2. 46.00 Has the cost allocation methodology changed from the previously filed cos Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter	st report?	N		146.

OSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provider CC	CN: 15-1325		: 07/01/2022 06/30/2023	Worksheet S- Part I Date/Time Pr 11/24/2023 3	epared:
						1.00	4.47.04
47.00 was there a change in the statist						N	147.0
48.00 was there a change in the order of						N	148.0
49.00 was there a change to the simplif	ed cost finding method? El						149.0
		Part A 1.00	Part B 2.00		<u>ritle V</u> 3.00	Title XIX 4.00	_
Does this facility contain a prov	den that qualifies for an			ication o			_
or charges? Enter "Y" for yes or '							
55.00 Hospital	in for no for each compone		N). (300 +	N	N	155.0
56.00 Subprovider – IPF		N	N		N	N	156.0
57.00 Subprovider - IRF		N	N		N	N	157.0
58.00 SUBPROVIDER							158.0
59.00 SNF		N	N		N	N	159.0
60.00 HOME HEALTH AGENCY		N	N		N	N	160.0
61.00 СМНС			N		Ν	N	161.0
						1.00	
Multicampus						1	
65.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	impus hospital that has one	e or more campu	uses in dif	ferent C	BSAs?	N	165.0
	Name	County	State	Zip Code	CBSA	FTE/Campus	
	0	1.00	2.00	3.00	4.00	5.00	
66.00 If line 165 is yes, for each						0.0	00166.0
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)							
						1.00	-
Health Information Technology (HI) incentive in the Americ	an Pecovery and	d Reinvestr	ent Act		1.00	
67.00 Is this provider a meaningful user						Y	167.0
68.00 If this provider is a CAH (line 10					r the		168.0
reasonable cost incurred for the H				,,			
68.01 If this provider is a CAH and is r	ot a meaningful user, does	s this provider	[•] qualify f	or a har	dship	N	168.0
exception under §413.70(a)(6)(ii)	'Enter "Y" for yes or "N"	for no. (see i	instruction	s)			
69.00 If this provider is a meaningful ι		is not a CAH ((line 105 i	s "N"),	enter the	0.0	00169.0
transition factor. (see instruction	ons)				_ <u>.</u>		_
				Be	eginning	Ending	_
	and and an along the state of the	data far iti			1.00	2.00	170.0
70.00 Enter in columns 1 and 2 the EHR b period respectively (mm/dd/yyyy)	eginning date and ending (uate for the re	eporting				170.0
					1 00	2.00	_
71.00 If line 167 is "Y", does this prov	viden have any days for in	dividuale opral	llod in		1.00 N	2.00	0171.0
				.	N		01/1.0
section 1876 Medicare cost plans i	'eported on WKSt. S-3. Pt.	I, THE Z. CO	I. U: ENLET				

IOSPIT	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-1325	Period: From 07/01/2022 To 06/30/2023		
					11/24/2023 3	
				Y/N 1.00	Date	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSE	MENT OUESTION		1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter M mm/dd/yyyy format.			er all dates in t	the	
	COMPLETED BY ALL HOSPITALS Provider Organization and Operation					_
.00	Has the provider changed ownership immediately prior to the	e beginning of	the cost	N		1.0
	reporting period? If yes, enter the date of the change in a		instructions)			
			Y/N	Date 2.00	V/I 3.00	
.00	Has the provider terminated participation in the Medicare H	Program? If	1.00 N	2.00	5.00	2.0
	yes, enter in column 2 the date of termination and in colur voluntary or "I" for involuntary.	nn 3, "V" for				
.00	Is the provider involved in business transactions, includin contracts, with individuals or entities (e.g., chain home or 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	Y			3.00
			Y/N	Туре	Date	
			1.00	2.00	3.00	
00	Financial Data and Reports	bified public				
.00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" 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 rec		N			5.0
			I	Y/N 1.00	Legal Oper. 2.00	
0.0	Approved Educational Activities	2 = 6				
.00	Column 1: Are costs claimed for a nursing program? Column the legal operator of the program?	2: If yes, 19	s the provide	r N		6.0
.00 .00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing programs and/or allied health programs approve		ved during the	N N		7.0
.00	cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction		cal education	N		9.0
.0.00	Was an approved Intern and Resident GME program initiated of cost reporting period? If yes, see instructions.	or renewed in t		Ν		10.0
1.00	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	N	Y/N	11.0
					1.00	
	Bad Debts					
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection provider's bad debt collection provider 2. The second provider of the provider of the second provider of the se			ost reporting	Y N	12.0 13.0
.4.00	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or coinsura instructions.	ance amounts wa	aived? If yes	, see	Ν	14.0
F 00	Bed Complement	1				1
5.00	Did total beds available change from the prior cost report		yes, see ins t A		N t B	15.0
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
c	PS&R Data		10/00/2022		10/06/2022	10.0
6.00	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
7.00	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
8.00	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 I	Financial Systems ASCENSION ST. V	/INCENT WARRICK		In Lie	u of Form CM	5-2552-10
HOSPITA	L AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C		Period: From 07/01/2022 To 06/30/2023		repared:
		Descr	iption	Y/N	Y/N	<u>5.50 pm</u>
			0	1.00	3.00	
	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
	Report data for other: Describe the other dajustments.	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	N	2.00	N		21.00
	records? If yes, see instructions.					
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	EPT CHILDRENS H	IOSPITALS)			
	Capital Related Cost	. instructions			N	22.00
23.00	Have assets been relifed for Medicare purposes? If yes, se Have changes occurred in the Medicare depreciation expense		als made duri	ng the cost	N N	22.00 23.00
24.00	reporting period? If yes, see instructions. were new leases and/or amendments to existing leases enter If yes, see instructions	ed into during	this cost repo	orting period?	Ν	24.00
25.00	Have there been new capitalized leases entered into during instructions.	If yes, see	Ν	25.00		
26.00	were assets subject to Sec.2314 of DEFRA acquired during t instructions.	he cost reporti	ing period? If	yes, see	Ν	26.00
27.00 H	has the provider's capitalization policy changed during th copy.	e cost reportir	ng period? If	yes, submit	Ν	27.00
	Interest Expense were new loans, mortgage agreements or letters of credit e	ntered into dur	ing the cost	reporting	N	28.00
1	period? If yes, see instructions. Did the provider have a funded depreciation account and/or		-		Y	29.00
1	treated as a funded depreciation account? If yes, see inst Has existing debt been replaced prior to its scheduled mat	ructions		-	N	30.00
-	instructions.	-				
	Has debt been recalled before scheduled maturity without i instructions. Purchased Services	ssuance of new	debt? If yes,	see	N	31.00
32.00 H	Have changes or new agreements occurred in patient care se		ed through con	tractual	N	32.00
33.00	arrangements with suppliers of services? If yes, see instr If line 32 is yes, were the requirements of Sec. 2135.2 ap		ng to competit	ive bidding? If	Ν	33.00
	no, see instructions. Provider-Based Physicians					
	were services furnished at the provider facility under an	arrangement wit	ch provider-ba	sed physicians?	Y	34.00
35.00	If yes, see instructions. If line 34 is yes, were there new agreements or amended ex physicians during the cost reporting period? If yes, see i		nts with the p	rovider-based	Y	35.00
	physicians during the cost reporting period: 11 yes, see 1			Y/N	Date	
	Home Office Costs			1.00	2.00	_
	Were home office costs claimed on the cost report?			Y		36.00
37.00	If line 36 is yes, has a home office cost statement been p	orepared by the	home office?	Y		37.00
38.00	If yes, see instructions. If line 36 is yes , was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year en			Ν		38.00
39.00	If line 36 is yes, did the provider render services to oth see instructions.			Ν		39.00
40.00	instructions.	home office?	If yes, see	Ν		40.00
			22		0.0	
-	Cost Report Preparer Contact Information	1.	00	2.	00	
41.00						
42.00	respectively. Enter the employer/company name of the cost report	ASCENSION				42.00
	preparer. Enter the telephone number and email address of the cost	(317)-583-3519	1	JILL.HILL1@ASC	ENSTON ORG	43.00
	report preparer in columns 1 and 2, respectively.	(311)-303-3318		SILL.IIILLIGASC		

Health	Financial Systems ASCENSION ST. V	/INC	ENT WARRICK	In Lie	u of Form CMS-	2552-10
HOSPIT	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	_	Provider CCN: 15-1325	riod: om 07/01/2022 06/30/2023		pared:
			3.00			
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position	REI	IMBURSEMENT MANAGER			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.					

	Financial Systems A: TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC/	SCENSION ST. VI AL DATA	Provider CC	N: 15-1325	Period:	u of Form CMS-2 Worksheet S-3	
					From 07/01/2022 To 06/30/2023	Part I Date/Time Pre 11/24/2023 3:	
						I/P Days / O/P Visits / Trips	
	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH/REH Hours	Title V	
	PART I - STATISTICAL DATA	1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00	25	9,12	5 10,344.00	0	1.00
	8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	50100		5,12			
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	
7.00	Total Adults and Peds. (exclude observation		25	9,12	5 10,344.00	0	7.00
	beds) (see instructions)	24.00					
8.00	INTENSIVE CARE UNIT	31.00	0		0.00	0	8.00
9.00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	,					10.0
L1.00	SURGICAL INTENSIVE CARE UNIT						11.0
12.00	OTHER SPECIAL CARE (SPECIFY)						12.0
13.00	NURSERY						13.0
14.00	Total (see instructions)		25	9,12	5 10,344.00	0	14.0
15.00	CAH visits			,		0	15.0
15.10	REH hours and visits						15.1
16.00	SUBPROVIDER - IPF	40.00	10	3,65	0	0	16.0
17.00	SUBPROVIDER - IRF	41.00	0		0	0	17.0
18.00	SUBPROVIDER	42.00	0		0	0	18.0
19.00	SKILLED NURSING FACILITY						19.0
20.00	NURSING FACILITY OTHER LONG TERM CARE						20.0
22.00	HOME HEALTH AGENCY						22.0
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.0
24.00	HOSPICE						24.0
24.10	HOSPICE (non-distinct part)	30.00					24.1
25.00	CMHC - CMHC						25.0
26.00	RURAL HEALTH CLINIC						26.0
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.2
27.00	Total (sum of lines 14-26)		35				27.0
28.00	Observation Bed Days					0	
29.00	Ambulance Trips						29.0
30.00	Employee discount days (see instruction)						30.0
31.00	Employee discount days - IRF Labor & delivery days (see instructions)		0		0		32.0
32.00	Total ancillary labor & delivery room		0				32.0
	outpatient days (see instructions)						52.0.
33.00	LTCH non-covered days						33.0
33.01	LTCH site neutral days and discharges						33.0
3/ 00	Temporary Expansion COVID-19 PHE Acute Care	30.00	0		0	0	34.0

OSPIT	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	CN: 15-1325	Period: From 07/01/2022 To 06/30/2023		pare
		I/P Days	/ O/P Visits / Trips		Full Time I	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				.1		
.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2	208	18	43	1		1.
00	for the portion of LDP room available beds)	100	FC				1
.00	HMO and other (see instructions) HMO IPF Subprovider	108 404	56 0				2.
.00		404	0				3.
.00	HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF	485	0	1 10	r.		5.
.00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF	400	0	1,15 11			6
.00	Total Adults and Peds. (exclude observation beds) (see instructions)	693	18	1,69			7.
.00	INTENSIVE CARE UNIT	0	0		0		8
.00	CORONARY CARE UNIT	-	-		-		9
0.00	BURN INTENSIVE CARE UNIT						10
.00	SURGICAL INTENSIVE CARE UNIT						11
2.00	OTHER SPECIAL CARE (SPECIFY)						12
3.00	NURSERY						13
1.00	Total (see instructions)	693	18	1,69	0.00	59.01	
5.00	CAH visits	6,072	335	25,94		55101	15
5.10	REH hours and visits	0,012	555	20,0			15
.00	SUBPROVIDER - IPF	1,159	0	1,81	.2 0.00	11.23	
.00	SUBPROVIDER - IRF	2,200	0	2,02	0 0.00		
3.00	SUBPROVIDER	Ŭ	0		0 0.00	0.00	
9.00	SKILLED NURSING FACILITY		Ű		0.00	0.00	19
).00	NURSING FACILITY						20
.00	OTHER LONG TERM CARE						21
.00	HOME HEALTH AGENCY						22
.00	AMBULATORY SURGICAL CENTER (D.P.)						23
1.00	HOSPICE						24
.10	HOSPICE (non-distinct part)				0		24
.00	CMHC - CMHC				-		25
5.00	RURAL HEALTH CLINIC						26
5.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0.00	0.00	
7.00	Total (sum of lines 14-26)	-	-		0.00	70.24	
.00	Observation Bed Days		0	45			28
.00	Ambulance Trips	0	-		-		29
.00	Employee discount days (see instruction)	-		3	5		30
.00	Employee discount days - IRF				0		31
2.00	Labor & delivery days (see instructions)	0	0		Ő		32
2.01	Total ancillary labor & delivery room	ů,	Ŭ		0		32
	outpatient days (see instructions)				Ŭ.		52
3.00	LTCH non-covered days	0					33
3.01	LTCH site neutral days and discharges	Ő					33
	Temporary Expansion COVID-19 PHE Acute Care	Ő	0		0		34

OSPIT	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider C	CN: 15-1325	Period: From 07/01/2022 To 06/30/2023	Worksheet S-3 Part I Date/Time Pre 11/24/2023 3:	pared
		Full Time		Dis	charges		
	Component	Equivalents Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
	PART I - STATISTICAL DATA	1		1			
.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2		0		57 6	135	1.0
	for the portion of LDP room available beds)				20 14		
.00	HMO and other (see instructions)				30 14 0		2.0
.00	HMO IPF Subprovider HMO IRF Subprovider				0		3.0
.00	Hospital Adults & Peds. Swing Bed SNF				0		5.0
.00	Hospital Adults & Peds. Swing Bed SNF						6.0
.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.0
.00	INTENSIVE CARE UNIT						8.0
.00	CORONARY CARE UNIT						9.0
0.00	BURN INTENSIVE CARE UNIT						10.
1.00	SURGICAL INTENSIVE CARE UNIT						11.
2.00	OTHER SPECIAL CARE (SPECIFY)						12.
3.00	NURSERY						13.
4.00	Total (see instructions)	0.00	0		57 6	135	
5.00	CAH visits						15.
5.10	REH hours and visits	0.00			0.1	127	15.
6.00	SUBPROVIDER - IPF	0.00	0		81 0 0 0	127	
7.00 8.00	SUBPROVIDER - IRF	0.00	0		0 0	0	
8.00 9.00	SUBPROVIDER SKILLED NURSING FACILITY	0.00	0		0	0	10.
0.00	NURSING FACILITY						20.
1.00	OTHER LONG TERM CARE						20.
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						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)				0		22
3.00	LTCH non-covered days				0		33.
3.01	LTCH site neutral days and discharges Temporary Expansion COVID-19 PHE Acute Care			1	V		33.

Health	Financial Systems ASCENSION ST. VINCEN	NT WARRICK		In Lie	u of Form CMS-2	2552-10	
		Provider CC	CN: 15-1325	Period:	Worksheet S-1	0	
				From 07/01/2022			
				то 06/30/2023	Date/Time Pre		
					11/24/2023 3:	so pili	
					1.00		
	Uncompensated and indigent care cost computation				1.00		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 div	ided by li	ne 202 column	8)	0.290380	1.00	
	Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid				251,668	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	al payment	s from Medica	id?		4.00	
5.00	If line 4 is no, then enter DSH and/or supplemental payments fr	om Medicai	d		0	5.00	
6.00	Medicaid charges				12,654,520	6.00	
7.00	Medicaid cost (line 1 times line 6)				3,674,620	7.00	
8.00	Difference between net revenue and costs for Medicaid program (line 7 min	us sum of lin	es 2 and 5; if	3,422,952	8.00	
	< zero then enter zero)						
0 00	Children's Health Insurance Program (CHIP) (see instructions fo	r each line	e)		0	0.00	
9.00 10.00	Net revenue from stand-alone CHIP Stand-alone CHIP charges				0	9.00	
11.00	Stand-alone CHIP cost (line 1 times line 10)						
12.00	Difference between net revenue and costs for stand-alone CHIP (lino 11 mi	nus lino 9. i	f < zero then	0	12.00	
12.00	enter zero)	TILLE II IIII	nus inte 9, i		0	12.00	
	Other state or local government indigent care program (see inst	ructions for	or each line)				
13.00	Net revenue from state or local indigent care program (Not incl				0	13.00	
14.00	Charges for patients covered under state or local indigent care				0	14.00	
	10)						
15.00	State or local indigent care program cost (line 1 times line 14				0	15.00	
16.00	Difference between net revenue and costs for state or local ind	ligent care	program (lin	e 15 minus line	0	16.00	
	13; if < zero then enter zero)		(7 7 1 1)	-			
	Grants, donations and total unreimbursed cost for Medicaid, CHI	P and state	e/local indig	ent care progra	ns (see		
17 00	instructions for each line) Private grants, donations, or endowment income restricted to fu	Inding char	ity caro		0	17.00	
	Government grants, appropriations or transfers for support of h				0	18.00	
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local			(sum of lines	3,422,952		
	8, 12 and 16)			(
			Uninsured	Insured	Total (col. 1		
			patients	patients	+ col. 2)		
			1.00	2.00	3.00		
20.00	Uncompensated Care (see instructions for each line)		502.40	7 215 250	000 746	20.00	
20.00	Charity care charges and uninsured discounts for the entire fac (see instructions)	ility	583,48	7 315,259	898,746	20.00	
21.00		ints (soo	169,43	3 315,259	484,692	21.00	
21.00	instructions)	11123 (366	105,45	5 515,255	404,052	21.00	
22.00		off as		0 0	0	22.00	
	charity care			-			
23.00	Cost of charity care (line 21 minus line 22)		169,43	3 315,259	484,692	23.00	
	1				1.00		
24.00	Does the amount on line 20 column 2, include charges for patien		ond a length	of stay limit	N	24.00	
25 00	imposed on patients covered by Medicaid or other indigent care					25 00	
25.00	If line 24 is yes, enter the charges for patient days beyond th	ie indigent	care program	's length of	0	25.00	
26.00	stay limit 26.00 Total bad debt expense for the entire hospital complex (see instructions)						
27.00	Medicare reimbursable bad debts for the entire hospital complex (see his				1,058,294 124,214		
27.00					191,098		
28.00	Non-Medicare bad debt expense (see instructions)	ice motrue	c10/13/		867,196		
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt exp	ense (see	instructions)		318,700		
30.00		(803,392		
	Total unreimbursed and uncompensated care cost (line 19 plus li	ne 30)			4,226,344		

CLASSI	FICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	EXPENSES	Provider Co	CN: 15-1325	Period: From 07/01/2022 To 06/30/2023		epare 50 p
	Cost Center Description	Salaries	Other	Total (col. + col. 2)	1 Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	ENERAL SERVICE COST CENTERS						
	0100 CAP REL COSTS-BLDG & FIXT		0		0 0	0	1
00 00	0200 CAP REL COSTS-MVBLE EQUIP		153,003	153,00	03 0	153,003	2
00 00	0300 OTHER CAP REL COSTS		0		0 0	0	3
00 00	0400 EMPLOYEE BENEFITS DEPARTMENT	140,858	1,422,804	1,563,60	52 0	1,563,662	4
02 00	0560 PURCHASING RECEIVING AND STORES	0	16,706	16,70	06 0	16,706	5 5
03 00	0580 CASHIERING/ACCOUNTS RECEIVABLE	425	19,717	20,14	42 0	20,142	5
04 00	0590 OTHER ADMINISTRATIVE AND GENERAL	362,097	5,396,187	5,758,28	-190,595	5,567,689	5
	0700 OPERATION OF PLANT	0	1,119,799			1,119,799	
	0800 LAUNDRY & LINEN SERVICE	0	23,417			23,417	
	0900 HOUSEKEEPING	o	334,553			334,553	
	1000 DIETARY	0	498,621				
	1100 CAFETERIA	0	0	,	0 281,624		
	1300 NURSING ADMINISTRATION	163,281	137,347	300,62		,	
	1400 CENTRAL SERVICE & SUPPLY	100,101	0	500,01	0 0	0	
	1500 PHARMACY	245,852	-23,102	222,75	50 0	222,750	
	1600 MEDICAL RECORDS & LIBRARY	215,052	23,102	,,,	0 0	0	
	1700 SOCIAL SERVICE	0	0		0 0	0	
	NPATIENT ROUTINE SERVICE COST CENTERS	V	0	1	0 0	0	1 1
	3000 ADULTS & PEDIATRICS	1,005,494	94,726	1,100,22	20 0	1,100,220	30
	3100 INTENSIVE CARE UNIT	1,005,454	0,720	1,100,22	0 0	0	
	4000 SUBPROVIDER - IPF	898,153	913,462	1,811,61	° °	1,811,615	
	4100 SUBPROVIDER - IRF	0,155	015,402	1,011,01		0	
	4200 SUBPROVIDER	0	0		0 0	0	
	NCILLARY SERVICE COST CENTERS	0	0		0 0	0	42
	5000 OPERATING ROOM	329,841	559,274	889,11	-87,195	801,920	50
	5100 RECOVERY ROOM	525,041	555,274	005,1	0 00,100	001,520	
	5200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	
	5300 ANESTHESIOLOGY	0	0		0 0	0	
	5400 RADIOLOGY DIAGNOSTIC	751 622		1 210 0	0 0	1,310,057	
		751,622	558,435	1,310,05	0	1,510,057	
	5900 CARDIAC CATHETERIZATION 6000 LABORATORY	110 967	1 277 704	1 407 6	0 0	, °	
		119,867	1,377,794			1,497,661	
	6500 RESPIRATORY THERAPY	263,790	17,200			280,990	
	6600 PHYSICAL THERAPY	23,817	298,503	322,32			
	6700 OCCUPATIONAL THERAPY	0	0		0 131,028		
	6800 SPEECH PATHOLOGY	0	0		0 6,363		
	6900 ELECTROCARDIOLOGY	0	0	40.7	0 0	0	
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	40,788				
	7200 IMPL. DEV. CHARGED TO PATIENTS	0	31,786				
	7300 DRUGS CHARGED TO PATIENTS	0	228,143	228,14	43 0	228,143	73
	JTPATIENT SERVICE COST CENTERS	-1		1		-	
	9000 CLINIC	0	0		0 0		90
	9100 EMERGENCY	1,043,647	1,216,880	2,260,52	27 0	2,260,527	
	9200 OBSERVATION BEDS (NON-DISTINCT PART)						92
	PECIAL PURPOSE COST CENTERS						
3.00	SUBTOTALS (SUM OF LINES 1 through 117)	5,348,744	14,436,043	19,784,78	37 0	19,784,787	1118
	ONREIMBURSABLE COST CENTERS						-
	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190
	7950 OTHER NRCC - PHYSICIAN CLINIC	0	2,220			2,220	
	7951 OTHER NRCC - WIC	446,170	198,180	644,35	50 0	644,350	
1.0207	7952 OTHER NRCC - PUBLIC RELATIONS	0	0		0 0		194
1.0307	7953 OTHER NRCC - DR. OFFICE	0	0		0 0	0	194
1.04 07	7954 OTHER NRCC - MARKETING	0	0		0 0	0	194
0.00	TOTAL (SUM OF LINES 118 through 199)	5,794,914	14,636,443	20,431,35	57 0	20,431,357	land

ECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (OF EXPENSES	Provider C	CN: 15-1325	Period:	Worksheet A	
					From 07/01/2022 To 06/30/2023	Date/Time Prep	
	Cost Center Description	Adjustments	Net Expenses			11/24/2023 3:5	0 pii
		(See A-8)	For Allocation				
		6.00	7.00	1			
	GENERAL SERVICE COST CENTERS						
.00	00100 CAP REL COSTS-BLDG & FIXT	60,184	60,184				1.0
.00	00200 CAP REL COSTS-MVBLE EQUIP	-124,297	28,706				2.0
.00	00300 OTHER CAP REL COSTS	0	0				3.
.00	00400 EMPLOYEE BENEFITS DEPARTMENT	128,806	1,692,468				4.
.02	00560 PURCHASING RECEIVING AND STORES	-13	16,693				5.
.03	00580 CASHIERING/ACCOUNTS RECEIVABLE	0	20,142				5.
.04	00590 OTHER ADMINISTRATIVE AND GENERAL	-733,455	4,834,234				5.
.00	00700 OPERATION OF PLANT	-60	1,119,739				7.
.00	00800 LAUNDRY & LINEN SERVICE	0	23,417				8.
.00	00900 HOUSEKEEPING	0	334,553				9.
0.00	01000 DIETARY	-8	216,989				10.0
1.00	01100 CAFETERIA	-51,329	230,295				11.0
3.00	01300 NURSING ADMINISTRATION	-2,507	488,716				13.0
4.00	01400 CENTRAL SERVICE & SUPPLY	0	0				14.0
5.00	01500 PHARMACY	0	222,750				15.
6.00	01600 MEDICAL RECORDS & LIBRARY	0		1			16.
7.00	01700 SOCIAL SERVICE	0	0				17.
	INPATIENT ROUTINE SERVICE COST CENTERS						
0.00	03000 ADULTS & PEDIATRICS	0	1,100,220				30.
	03100 INTENSIVE CARE UNIT	0					31.
	04000 SUBPROVIDER - IPF	0	1,811,615				40.
	04100 SUBPROVIDER - IRF	0		1			41.
	04200 SUBPROVIDER	0	0				42.
	ANCILLARY SERVICE COST CENTERS						
0.00	05000 OPERATING ROOM	-228,211	. 573,709				50.0
1.00	05100 RECOVERY ROOM	0	0				51.0
2.00	05200 DELIVERY ROOM & LABOR ROOM	0	0				52.0
3.00	05300 ANESTHESIOLOGY	0	0				53.0
4.00	05400 RADIOLOGY-DIAGNOSTIC	-84,333	1,225,724				54.
9.00	05900 CARDIAC CATHETERIZATION	0	0				59.0
0.00		-1,316	1,496,345				60.0
5.00	06500 RESPIRATORY THERAPY	0	280,990				65.0
6.00	06600 PHYSICAL THERAPY	-27,864	157,065				66.0
7.00	06700 OCCUPATIONAL THERAPY	0	131,028				67.
8.00	06800 SPEECH PATHOLOGY	0	6,363				68.
9.00	06900 ELECTROCARDIOLOGY	0	0				69.
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	-28,905					71.0
2.00		0					72.0
	07300 DRUGS CHARGED TO PATIENTS	0					73.
	OUTPATIENT SERVICE COST CENTERS						
0.00	09000 CLINIC	0	0				90.
	09100 EMERGENCY	-1,981	-				91.
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				92.
	SPECIAL PURPOSE COST CENTERS						
18.00		-1,095,289	18,689,498			1	118.
	NONREIMBURSABLE COST CENTERS	, ,,====	, .,,				
90.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0			1	190.
	07950 OTHER NRCC - PHYSICIAN CLINIC	0					194.
	07951 OTHER NRCC - WIC	0					194.
	07952 OTHER NRCC - PUBLIC RELATIONS	0					194.
	07953 OTHER NRCC - DR. OFFICE	0	, i i i i i i i i i i i i i i i i i i i				194.
	07954 OTHER NRCC - MARKETING	0	0				194.
	TOTAL (SUM OF LINES 118 through 199)	-1,095,289					200.

Health	Financial Systems	A	SCENSION ST. V	INCENT WARRICK	(In Lie	u of Form CMS	-2552-10
RECLAS	SIFICATIONS			Provider (CCN: 15-1325	Period: From 07/01/2022 To 06/30/2023	Worksheet A- Date/Time Pr 11/24/2023 3	epared:
		Increases						
	Cost Center	Line #	Salary	Other				
	2.00	3.00	4.00	5.00				
	A – Nursing Admin Salaries							
1.00	NURSING ADMINISTRATION	13.00	190,595	0				1.00
	TOTALS	†	190,595	0				
	B - Cafeteria Expense							
1.00	CAFETERIA	11.00		281,624				1.00
			0	281,624				
	C - Supplies and Implantable	Devices		· · · · ·				
1.00	MEDICAL SUPPLIES CHARGED TO	71.00		87,195				1.00
	PATIENTS			,				
			0	87,195				
	D - Therapy Costs		· · · · · ·	· · · · · ·				
1.00	OCCUPATIONAL THERAPY	67.00	11,418	119,610				1.00
2.00	SPEECH PATHOLOGY	68.00	1,291	5,072				2.00
			12,709	124,682				
500.00	Grand Total: Increases		203,304	493,501				500.00
	1		, , , , , , , , , , , , , , , , , ,	,	1			

Health	Financial Systems	A	SCENSION ST. VI	NCENT WARRICK	[In Lie	u of Form CMS	-2552-10
RECLAS	SIFICATIONS			Provider (CCN: 15-1325	Period:	Worksheet A-	6
						From 07/01/2022 To 06/30/2023	Date/Time Pr 11/24/2023 3	
		Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref	· .		
	6.00	7.00	8.00	9.00	10.00			
	A – Nursing Admin Salaries							
1.00	OTHER ADMINISTRATIVE AND	5.04	190,595	0		0		1.00
	GENERAL							
	TOTALS		190,595					
	B - Cafeteria Expense		· · ·					1
1.00	DIETARY	10.00		281,624				1.00
				281,624				1
	C - Supplies and Implantable	Devices		,				1
1.00	OPERATING ROOM	50.00		87,195				1.00
				87,195		-		1
	D - Therapy Costs	I						
1.00	PHYSICAL THERAPY	66.00	12,709	124,682				1.00
2.00			,					2.00
		\vdash $$ $+$	12,709	124,682	<u> </u>	-		
500 00	Grand Total: Decreases		203,304	493,501		-		500.00

Health	Financial Systems A	SCENSION ST. VI	NCENT WARRICK			In Lie	u of Form CMS-2	2552-10
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provider Co		То	od: 07/01/2022 06/30/2023		pared:
				Acquisition	s			
		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 ASSE							
1.00	Land	808,762	0		0	0	0	1.00
2.00	Land Improvements	0	0		0	0	0	2.00
3.00	Buildings and Fixtures	14,381,172	555,311		0	555,311	0	3.00
4.00	Building Improvements	164,374	30,428		0	30,428	0	4.00
5.00	Fixed Equipment	10,551,278	0		0	0	1,661,585	5.00
6.00	Movable Equipment	0	0		0	0	0	6.00
7.00	HIT designated Assets	0	0		0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	25,905,586	585,739		0	585,739	1,661,585	8.00
9.00	Reconciling Items	0	0		0	0	0	9.00
10.00	Total (line 8 minus line 9)	25,905,586	585,739		0	585,739	1,661,585	10.00
		Ending Balance	Fully					
		5	Depreciated					
			Assets					
		6.00	7.00	1				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES						
1.00	Land	808,762	0					1.00
2.00	Land Improvements	0	0					2.00
3.00	Buildings and Fixtures	14,936,483	0					3.00
4.00	Building Improvements	194,802	0					4.00
5.00	Fixed Equipment	8,889,693	0					5.00
6.00	Movable Equipment	0	0					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	24,829,740	0					8.00
9.00	Reconciling Items	0	0					9.00
10.00	Total (line 8 minus line 9)	24,829,740	0					10.00
		,,	-	1				

Health Financial Systems ASCENSION ST. VINCENT WARRICK In Lieu of Form CMS-25									
RECONC	ILIATION OF CAPITAL COSTS CENTERS	Provider CCN: 15-1325			Period:	Worksheet A-7			
					From 07/01/2022 To 06/30/2023		nared		
					10 00, 50, 2025	11/24/2023 3:			
			SU	JMMARY OF CAPI	TAL				
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see			
					instructions)	instructions)			
		9.00	10.00	11.00	12.00	13.00			
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2					
1.00	CAP REL COSTS-BLDG & FIXT	0	0		0 0	0	1.00		
2.00	CAP REL COSTS-MVBLE EQUIP	0	28,706	124,29	7 0	0	2.00		
3.00	Total (sum of lines 1-2)	0	28,706	124,29	7 0	0	3.00		
		SUMMARY O	F CAPITAL						
	Cost Center Description	Other	Total (1) (sum						
		Capital-Relate							
		d Costs (see							
		instructions)							
		14.00	15.00						
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2					
1.00	CAP REL COSTS-BLDG & FIXT	0	0				1.00		
2.00	CAP REL COSTS-MVBLE EQUIP	0	153,003				2.00		
3.00	Total (sum of lines 1-2)	0	153,003				3.00		

Health	Financial Systems	SCENSION ST. VI	INCENT WARRICK		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS	Provider CCN: 15-1325			Period: From 07/01/2022 To 06/30/2023		pared:
		СОМІ	PUTATION OF RAT	ALLOCATION OF	OTHER CAPITAL		
	Cost Center Description	Gross Assets	Capitalized	Gross Assets	Ratio (see	Insurance	
			Leases	for Ratio	instructions)		
				(col. 1 - col			
				2)			
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C						
1.00	CAP REL COSTS-BLDG & FIXT	15,745,245		15,745,24			1.00
2.00	CAP REL COSTS-MVBLE EQUIP	9,084,495		9,084,49		0	2.00
3.00	Total (sum of lines 1-2)	24,829,740	0	24,829,74	0 1.000000	0	3.00
		ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL					
	Cost Center Description	Taxes	Other	Total (sum o	f Depreciation	Lease	
	···· · · · · · · · · · · · · · · · · ·		Capital-Relate				
			d Costs	through 7)			
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00	CAP REL COSTS-BLDG & FIXT	0	0		0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 0	28,706	2.00
3.00	Total (sum of lines 1-2)	0	0		0 0	28,706	3.00
			SU	JMMARY OF CAPI	TAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
		2) Capital-Relate		
					d Costs (see	through 14)	
					instructions)	chi ough 11)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C						
1.00	CAP REL COSTS-BLDG & FIXT	60,184	0		0 0	60,184	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	00,101	0		0 0	28,706	2.00
3.00	Total (sum of lines 1-2)	60,184	-		0 0	88,890	3.00
5.00		00,104	0	I	0	00,000	5.00

	Financial Systems MENTS TO EXPENSES	AS	SCENSION SI. V	INCENT WARRICK Provider CCN: 15-1325	Period:	u of Form CMS-2 Worksheet A-8	
					From 07/01/2022 To 06/30/2023	Date/Time Pre	pared
				Expense Classification o	n Worksheet A	11/24/2023 3:	50 pm
				To/From Which the Amount is			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
.00	Investment income - CAP REL	1.00 B	2.00	3.00 CAP REL COSTS-BLDG & FIXT	4.00	5.00	1.0
	COSTS-BLDG & FIXT (chapter 2)	D	-				
.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		C	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.0
.00	Investment income - other (chapter 2)	В	-24	OTHER ADMINISTRATIVE AND	5.04	0	3.0
.00	Trade, quantity, and time		C	GENERAL	0.00	0	4.0
.00	discounts (chapter 8) Refunds and rebates of		C		0.00	0	5.0
	expenses (chapter 8)		-				
.00	Rental of provider space by suppliers (chapter 8)		C		0.00	0	6.0
.00	Telephone services (pay stations excluded) (chapter		C		0.00	0	7.0
	21)						
.00	Television and radio service (chapter 21)		C		0.00	0	8.0
.00	Parking lot (chapter 21) Provider-based physician	A-8-2	0 -313,010		0.00	0	
	adjustment	A-0-2					
1.00	Sale of scrap, waste, etc. (chapter 23)		C		0.00	0	11.0
2.00	Related organization	A-8-1	910,835			0	12.0
3.00	transactions (chapter 10) Laundry and linen service		C		0.00	0	13.
4.00	Cafeteria-employees and guests Rental of quarters to employee	В	-51,329	CAFETERIA	11.00 0.00		
	and others		Ū.				
5.00	Sale of medical and surgical supplies to other than		C		0.00	0	16.0
7.00	patients Sale of drugs to other than		C		0.00	0	17.0
	patients		-				
8.00	Sale of medical records and abstracts		C		0.00	0	18.0
9.00	Nursing and allied health		C		0.00	0	19.0
	education (tuition, fees, books, etc.)						
0.00	Vending machines Income from imposition of	В	-8	DIETARY	10.00 0.00		
1.00	interest, finance or penalty				0.00	Ŭ	
2.00	charges (chapter 21) Interest expense on Medicare		C		0.00	0	22.0
	overpayments and borrowings to repay Medicare overpayments						
3.00	Adjustment for respiratory	A-8-3	C	RESPIRATORY THERAPY	65.00		23.0
	therapy costs in excess of limitation (chapter 14)						
4.00	Adjustment for physical therapy costs in excess of	A-8-3	C	PHYSICAL THERAPY	66.00		24.0
	limitation (chapter 14)						
5.00	Utilization review - physicians' compensation		C	*** Cost Center Deleted ***	114.00		25.0
5.00	(chapter 21) Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.0
5.00	COSTS-BLDG & FIXT		U	CAP REL COSTS-BLDG & FIXT	1.00		
7.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		C	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.0
8.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***			28.0
9.00	Physicians' assistant Adjustment for occupational	A-8-3	0	OCCUPATIONAL THERAPY	0.00 67.00		29.0
	therapy costs in excess of limitation (chapter 14)						
0.99	Hospice (non-distinct) (see		C	ADULTS & PEDIATRICS	30.00		30.9
1.00	instructions) Adjustment for speech	A-8-3	ſ	SPEECH PATHOLOGY	68.00		31.0
	pathology costs in excess of		ŭ				
2.00	limitation (chapter 14) CAH HIT Adjustment for		C		0.00	0	32.0
	Depreciation and Interest						

Health	Financial Systems	AS	CENSION ST. V	INCENT WARRICK	In Lie	eu of Form CMS-2	2552-10
ADJUST	MENTS TO EXPENSES			Provider CCN: 15-1325	Period: From 07/01/2022	Worksheet A-8	
					то 06/30/2023	Date/Time Pre 11/24/2023 3:	
				Expense Classification (
				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	
33.00	Other Admin-Medical Records	В		OTHER ADMINISTRATIVE AND	5.04		33.00
			.,	GENERAL			
33.01	Miscellaneous Lab Revenue	В	-850	LABORATORY	60.00	0	33.01
33.02	Fitness Club Revenue	В	-27,864	PHYSICAL THERAPY	66.00	0	33.02
33.03	ED Revenue	В	-1,981	EMERGENCY	91.00	0	33.03
33.04	Physician Fund	A	-42,771	OTHER ADMINISTRATIVE AND	5.04	0	33.04
				GENERAL			
33.05	Late Penalty Fees	A	-13	PURCHASING RECEIVING AND	5.02	0	33.05
				STORES			
33.06	Sponsorship, Marketing,	A	-1,899	OTHER ADMINISTRATIVE AND	5.04	0	33.06
33.07	Charity Other Miscellaneous Revenue		6 600	GENERAL	F 04	0	22.07
33.07	other Miscellaneous Revenue	В	-6,600	OTHER ADMINISTRATIVE AND	5.04	0	33.07
33 08	Other Miscellaneous Revenue	В	-60	OPERATION OF PLANT	7.00	0	33.08
33.11	Provider Tax Expense	В		OTHER ADMINISTRATIVE AND	5.04		33.11
55.11		5	, ,	GENERAL	5101	Ů	55.11
33.13	Unnecessary Borrowing	А		CAP REL COSTS-BLDG & FIXT	1.00	11	33.13
33.15	Lobbying Offset	A	,	OTHER ADMINISTRATIVE AND	5.04		
				GENERAL			
50.00	TOTAL (sum of lines 1 thru 49)		-1,095,289				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 WARRICK	In Lie	u of Form CMS-	2552-10			
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HO	ME Provider CCN: 15-1325	Period:	Worksheet A-8	-1			
OFFICE	COSTS			From 07/01/2022 To 06/30/2023		pared:			
					11/24/2023 3:				
	Line No.	Cost Center	Expense Items	Amount of	Amount				
				Allowable Cost					
		Wks. A, column							
					5				
	1.00	2.00	3.00	4.00	5.00				
		MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED O	RGANIZATIONS OR	CLAIMED				
4 00	HOME OFFICE COSTS:	I		200.074		1 00			
1.00		OTHER ADMINISTRATIVE AND GEN		299,274	0	1.00			
2.00		OTHER ADMINISTRATIVE AND GEN			0	2.00			
3.00		OTHER ADMINISTRATIVE AND GEN		73	0	3.00			
3.01		OTHER ADMINISTRATIVE AND GEN		3,182,389		3.01			
3.02		EMPLOYEE BENEFITS DEPARTMENT		1,019,553		3.02			
3.03			Interest Expense	123,416		3.03			
3.04			Interest Expense	0	124,297	3.04			
3.05		OTHER ADMINISTRATIVE AND GEN		1,007	0	3.05			
3.06			TRG Admin Fees - Supplies	-28,905	0	3.06			
3.07		NURSING ADMINISTRATION	TRG Admin Fees - Contracted	-2,507	0	3.07			
3.08	5.04	OTHER ADMINISTRATIVE AND GEN	TRG Admin Fees - Other	-16,889	0	3.08			
4.00	0.00			0	0	4.00			
5.00	TOTALS (sum of lines 1-4).			4,586,202	3,675,367	5.00			
	Transfer column 6, line 5 to								
	Worksheet A-8, column 2,								
	line 12.								

* 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	s not	been	posted t	to works	sneet	А,	columns	Τā	and/or	٠z,	the	amoun	t allowable	should be	e indicated in co	1umn 4	of this part.	
														Relate	ed Organization(s) and/o	r Home Office	
			Symbo	ol (1)					Name	5			Percentage d	of	Name	1	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.

	Semeric under crere straff					
6.00	В	Ascension SVH	100.00	Ascension SVH	100.00	6.00
7.00	В	Ascension	100.00	Ascension	100.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or					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. VINC	ENT WARRICK	In Lieu of Form CMS-2552-1			
STATEMENT OF COSTS OF SERVICES OFFICE COSTS	FROM RELATED ORGANIZATIONS AND HOME		Period: From 07/01/2022 To 06/30/2023	Worksheet A-8-1 Date/Time Prepared:		

					11/24/2023 3	:50 pm
	Net	Wkst. A-7 Ref.				
	Adjustments					
	(col. 4 minus					
	col. 5)*					
	6.00	7.00				
	A. COSTS INCUR	RED AND ADJUST	MENTS REQUIRED AS A RESULT OF TRA	NSACTIONS WITH RELATED C	ORGANIZATIONS OR CLAIMED	
	HOME OFFICE CO					
1.00	299,274	0				1.00
2.00	8,791	0				2.00
3.00	73	0				3.00
3.01	522,066	0				3.01
3.02	128,806	0				3.02
3.03	123,416	11				3.03
3.04	-124,297	11				3.04
3.05	1,007					3.05
3.06	-28,905					3.06
3.07	-2,507					3.07
3.08	-16,889					3.08
4.00	0	0				4.00
5.00	910,835	Ĩ				5.00
5.00				6 · · · · · · · · · · · · · · · · · · ·		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.

Related Organization(s)		
and/or Home Office		
Type of Business		
6.00		
B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HOME OFFICE:	
· · · · · ·		

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

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

6.00	Home Office	6.00
7.00	Home Office	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. V	/INCENT WARRICK		In Lie	eu of Form CMS-	2552-10
	R BASED PHYSIC				CCN: 15-1325	Period: Worksheet A- From 07/01/2022 To 06/30/2023 Date/Time Pr 11/24/2023 3		epared: 50 pm
	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Prov ider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00		OPERATING ROOM	164,423	18,958				1.00
2.00		OPERATING ROOM	209,253	209,253	,		-	
3.00	0.00		205,255	203,233			0	
4.00		RADIOLOGY-DIAGNOSTIC	84,333	84,333			0	
5.00		LABORATORY	466	466			0	
6.00		EMERGENCY	1,103,844	400	1,103,84		0	
7.00	0.00		1,103,844	0	1,103,04		0	
8.00	0.00		0	0			0	
9.00	0.00	1	0	0			0	
10.00	0.00		0	0			0	
200.00	0.00		1,562,319	313,010	1,249,30		0	
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE			Provider	Physician Cost	
	WKSL. A LINE #	Identifier	Limit	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		OPERATING ROOM	0.00	0		0 0		1.00
2.00		OPERATING ROOM	0	0			0	
3.00	0.00	4	0	0			0	1
4.00		RADIOLOGY-DIAGNOSTIC	0	0			0	
5.00		LABORATORY	0	ů 0			0	
6.00		EMERGENCY	0	0			0	
7.00	0.00		0	0			0	
8.00	0.00		0	0			0	
9.00	0.00		0	0			0	
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
	WKSC. A LINE #	Identifier	Component Share of col.	Limit	Disallowance	Aujustillent		
			14					
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	50.00	OPERATING ROOM	0	0		18,958		1.00
2.00	50.00	OPERATING ROOM	0	0		209,253		2.00
3.00	0.00		0	0		0 0		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0		84,333		4.00
5.00	60.00	LABORATORY	0	0		466		5.00
6.00	91.00	EMERGENCY	0	0		0 0		6.00
7.00	0.00		0	0		0 0		7.00
8.00	0.00		0	0		0 0		8.00
9.00	0.00	1	0	0		0 0		9.00
10.00	0.00	1	0	0		0 0		10.00
200.00	0.00		0	0		313,010		200.00
		1		i v	I		1	

	NABLE COST DETERMINATION FOR THERAPY SERVICES DE SUPPLIERS	FURNISHED BY	Provider CCN	: 15-1325	Period: From 07/01/20 To 06/30/20 Physical Ther	022 P 023 D 1	Vorksheet A-8- Parts I-VI Date/Time Prep L <u>1/24/2023 3:5</u> Cost	pared:
					Inforcar mer			
	PART I - GENERAL INFORMATION						1.00	
L.00	Total number of weeks worked (excluding aides	s) (see instruct	ions)				50	1.00
2.00	Line 1 multiplied by 15 hours per week	~	750 49	2.00				
3.00 4.00	Number of unduplicated days in which supervision Number of unduplicated days in which therapy		49	4.0				
	nor therapist was on provider site (see inst		Ũ					
5.00	Number of unduplicated offsite visits - supe						0	5.0
5.00	Number of unduplicated offsite visits - thera assistant and on which supervisor and/or the						0	6.0
	instructions)		reserve during t					
7.00	Standard travel expense rate						9.57	7.0
3.00	Optional travel expense rate per mile	Supervisors	Therapists	Assistants	Aides	_	0.00 Trainees	8.0
		1.00	2.00	3.00	4.00		5.00	
9.00	Total hours worked	2,306.00	646.00			.00	0.00	9.0
L0.00	· · · · · ·	110.02	95.67			.00	0.00	
L1.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3,	47.84	47.84	0.	00			11.0
	one-half of column 3, line 10)							
	Number of travel hours (provider site)	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 (offsite)	0	0		0			13.0
							1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						1.00	
L4.00	Supervisors (column 1, line 9 times column 1	, line 10)					253,706	14.0
	Therapists (column 2, line 9 times column 2,						61,803	
L6.00 L7.00			atomy thomany	n lines 14	16 for all		0 315,509	16.0 17.0
17.00	others)	iu 15 ioi iespii	atory therapy t	n THES 14	-10 101 all		515,509	17.0
L8.00							0	18.0
) Trainees (column 5, line 9 times column 5, line 10)) Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)							19.0
20.00	If the sum of columns 1 and 2 for respiratory						315,509	20.0
	occupational therapy, line 9, is greater than	line 2, make n						
21 00	the amount from line 20. Otherwise complete Weighted average rate excluding aides and tra		divided by sum	of columns	1 and 2 line	e 9	0.00	21.0
	for respiratory therapy or columns 1 thru 3,				1 and 2, 1110		0.00	21.0
22.00	5	ees (line 2 time	s line 21)				0	
23.00	Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW	ANCE AND TRAVEL	EXPENSE COMPLIT	ATTON - PR	OVIDER STTE		315,509	23.0
	Standard Travel Allowance			AILON IN	OVIDER SITE			
	Therapists (line 3 times column 2, line 11)						2,344	
25.00		sum of lines 24					0	25.0
		Julii 01 111163 24	and 25 for all	others)			2 3/1	
26.00	Standard travel expense (line / times line 3	for respiratory			3 and 4 for al	11	2,344 469	
27.00	others)		therapy or sum	of lines			469	27.0
	others) Total standard travel allowance and standard		therapy or sum	of lines				27.0
27.00	others)	travel expense	therapy or sum	of lines			469	27.0
27.00 28.00 29.00	others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Trave Therapists (column 2, line 10 times the sum	travel expense Expense of columns 1 and	therapy or sun at the provider	of lines			469 2,813 0	27.0 28.0 29.0
27.00 28.00 29.00 30.00	others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Trave Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3	travel expense Expense of columns 1 and , line 12)	therapy or sum at the provider 2, line 12)	n of lines site (sum			469 2,813 0 0	27.0 28.0 29.0 30.0
27.00 28.00 29.00	others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or	travel expense Expense of columns 1 and , line 12) sum of lines 29	therapy or sum at the provider 2, line 12) and 30 for all	of lines site (sum others)	of lines 26 a		469 2,813 0	27.0 28.0 29.0 30.0 31.0
27.00 28.00 29.00 30.00 31.00 32.00	others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum 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)	travel expense Expense of columns 1 and , line 12) sum of lines 29 s 1 and 2, line	therapy or sum at the provider 2, line 12) and 30 for all 13 for respirat	of lines site (sum others)	of lines 26 a		469 2,813 0 0 0 0 0 0	27.0 28.0 29.0 30.0 31.0 32.0
27.00 28.00 29.00 30.00 31.00 32.00	others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum 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	travel expense Expense of columns 1 and , line 12) sum of lines 29 s 1 and 2, line l expense (line	therapy or sum at the provider 2, line 12) and 30 for all 13 for respirat 28)	of lines site (sum others) cory therap	of lines 26 a		469 2,813 0 0 0 0 0 2,813	27.0 28.0 29.0 30.0 31.0 32.0 33.0
27.00 28.00 29.00 30.00 31.00 32.00 33.00 34.00	others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3 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	travel expense Expense of columns 1 and , line 12) sum of lines 29 5 1 and 2, line l expense (line l expense (sum o	therapy or sum at the provider 2, line 12) and 30 for all 13 for respirat 28) f lines 27 and	of lines site (sum others) cory therap	of lines 26 a		469 2,813 0 0 0 0 0 2,813 0	27.0 28.0 29.0 30.0 31.0 32.0 33.0 34.0
27.00 28.00 29.00 30.00 31.00 32.00 33.00 34.00	others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum 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	travel expense Expense of columns 1 and , line 12) sum of lines 29 s 1 and 2, line l expense (line l expense (sum o l expense (sum o	therapy or sum at the provider 2, line 12) and 30 for all 13 for respirat 28) f lines 27 and f lines 31 and	others) others) otherap 31) 32)	n of lines 26 a	and	469 2,813 0 0 0 0 0 2,813 0 0 0	27.0 28.0 29.0 30.0 31.0 32.0 33.0 34.0
27.00 28.00 29.00 30.00 31.00 32.00 33.00 34.00 35.00	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 ALLOW/ Standard Travel Expense	travel expense Expense of columns 1 and , line 12) sum of lines 29 s 1 and 2, line l expense (line l expense (sum o l expense (sum o	therapy or sum at the provider 2, line 12) and 30 for all 13 for respirat 28) f lines 27 and f lines 31 and	others) others) otherap 31) 32)	n of lines 26 a	and	469 2,813 0 0 0 0 2,813 0 0 CDER SITE	27.0 28.0 30.0 31.0 32.0 33.0 34.0 35.0
27.00 28.00 29.00 30.00 31.00 32.00 33.00 34.00 35.00	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 Optional travel allowance and optional trave Deart IV - STANDARD AND OPTIONAL TRAVEL ALLOW/ Standard Travel Expense Therapists (line 5 times column 2, line 11)	travel expense Expense of columns 1 and , line 12) sum of lines 29 s 1 and 2, line l expense (line l expense (sum o l expense (sum o	therapy or sum at the provider 2, line 12) and 30 for all 13 for respirat 28) f lines 27 and f lines 31 and	others) others) otherap 31) 32)	n of lines 26 a	and	469 2,813 0 0 0 2,813 0 0 0 IDER SITE	27.0 28.0 30.0 31.0 32.0 33.0 34.0 35.0 36.0
27.00 28.00 29.00 30.00 31.00 32.00 33.00 34.00 35.00	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 ALLOW/ Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11)	travel expense Expense of columns 1 and , line 12) sum of lines 29 s 1 and 2, line l expense (line l expense (sum o l expense (sum o	therapy or sum at the provider 2, line 12) and 30 for all 13 for respirat 28) f lines 27 and f lines 31 and	others) others) otherap 31) 32)	n of lines 26 a	and	469 2,813 0 0 0 0 2,813 0 0 CDER SITE	27.0 28.0 30.0 31.0 32.0 33.0 33.0 35.0 36.0 37.0
27.00 28.00 29.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00	others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Trave Therapists (column 2, line 10 times the sum 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 2, line 11) Assistants (line 6 times 36 and 37) Standard travel expense (line 7 times the sum	travel expense Expense of columns 1 and , line 12) sum of lines 29 s 1 and 2, line l expense (line l expense (sum o l expense (s	therapy or sum at the provider 2, line 12) and 30 for all 13 for respirat 28) f lines 27 and f lines 31 and EXPENSE COMPUTA	others) others) otherap 31) 32)	n of lines 26 a	and	469 2,813 0 0 0 2,813 0 0 0 IDER SITE 0 0 0	27.0 28.0 29.0 30.0 31.0 32.0 33.0 34.0 35.0 36.0 37.0 38.0
27.00 28.00 29.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00 38.00 39.00	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 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 expense (line 7 times the sum Optional Travel Allowance and Optional Travel	travel expense Expense of columns 1 and , line 12) sum of lines 29 5 1 and 2, line 1 expense (line 1 expense (sum o 1 expense (sum o 1 expense (sum o 1 expense (sum o 1 expense 5 and Expense	therapy or sum at the provider 2, line 12) and 30 for all 13 for respirat 28) f lines 27 and f lines 31 and EXPENSE COMPUTA	others) others) otherap 31) 32)	n of lines 26 a	and	469 2,813 0 0 0 2,813 0 0 0 IDER SITE 0 0 0 0 0 0	27.0 28.0 30.0 31.0 32.0 33.0 34.0 35.0 36.0 37.0 38.0 39.0
227.00 29.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00 38.00 39.00	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 optional 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) Subtotal (sum of lines 36 and 37) Standard travel Allowance and Optional Trave Therapists (sum of columns 1 and 2, line 12.0	travel expense Expense of columns 1 and , line 12) sum of lines 29 s 1 and 2, line l expense (line l expense (sum o l expense (sum o NCE AND TRAVEL I m of lines 5 and Expense D1 times column	therapy or sum at the provider 2, line 12) and 30 for all 13 for respirat 28) f lines 27 and f lines 31 and EXPENSE COMPUTA	others) others) otherap 31) 32)	n of lines 26 a	and	469 2,813 0 0 0 2,813 0 0 0 EDER SITE 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	27.00 28.00 30.00 31.00 32.00 33.00 35.00 36.00 37.00 38.00 39.00 40.00
227.00 28.00 29.00 30.00 31.00 32.00 33.00 33.00 34.00 35.00 36.00 38.00 38.00 39.00 40.00 41.00	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 Allowance and Optional Trave Therapists (sum of columns 1 and 2, line 12.0	travel expense Expense of columns 1 and , line 12) sum of lines 29 s 1 and 2, line l expense (line l expense (sum o l expense (sum o NCE AND TRAVEL I m of lines 5 and Expense D1 times column	therapy or sum at the provider 2, line 12) and 30 for all 13 for respirat 28) f lines 27 and f lines 31 and EXPENSE COMPUTA	others) others) otherap 31) 32)	n of lines 26 a	and	469 2,813 0 0 0 2,813 0 0 0 IDER SITE 0 0 0 0 0 0	27.0 28.0 30.0 31.0 32.0 33.0 34.0 35.0 36.0 37.0 38.0 39.0 40.0
227.00 28.00 29.00 30.00 31.00 32.00 33.00 33.00 34.00 35.00 36.00 38.00 38.00 39.00 40.00 41.00	others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Trave Therapists (column 2, line 10 times the sum 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 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 12.0 Assistants (column 3, line 12.01 times column Subtotal (sum of lines 40 and 41) Optional travel expense (line 8 times the sum	travel expense Expense of columns 1 and , line 12) sum of lines 29 s 1 and 2, line l expense (line l expense (sum o l expense (sum o l expense (sum o l expense (sum o l expense column of lines 5 and Expense l times column n 3, line 10) n of columns 1-3	therapy or sum at the provider 2, line 12) and 30 for all 13 for respirat 28) f lines 27 and f lines 31 and EXPENSE COMPUTA 6) 2, line 10) , line 13.01)	others) others) cory therap 31) 32) TION - SER	y or sum of	and PROVI	469 2,813 0 0 0 0 2,813 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	27.0 28.0 29.0 30.0 31.0 32.0 33.0 34.0 35.0 36.0 37.0 38.0 39.0 40.0 41.0 42.0
27.00 29.00 30.00 31.00 32.00 33.00 44.00 35.00 36.00 37.00 38.00 39.00 40.00 11.00 12.00	others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Trave Therapists (column 2, line 10 times the sum 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 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 12.0 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	travel expense Expense of columns 1 and , line 12) sum of lines 29 s 1 and 2, line l expense (line l expense (sum o l expense (sum o l expense (sum o l expense (sum o l expense column of lines 5 and Expense l times column n 3, line 10) n of columns 1-3	therapy or sum at the provider 2, line 12) and 30 for all 13 for respirat 28) f lines 27 and f lines 31 and EXPENSE COMPUTA 6) 2, line 10) , line 13.01)	others) others) cory therap 31) 32) TION - SER	y or sum of	and PROVI	469 2,813 0 0 0 0 2,813 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	27.0 28.0 30.0 31.0 32.0 33.0 34.0 35.0 36.0 37.0 38.0 39.0 40.0 41.0 42.0
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 1.00 2.00	others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum 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 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 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 Allowance and Travel Expense - C or 46, as appropriate.	travel expense Expense of columns 1 and , line 12) sum of lines 29 5 1 and 2, line 1 expense (line 1 expense (sum o 1 of lines 5 and Expense 1 times column 1 3, line 10) n of columns 1-3 offsite Services	therapy or sum at the provider 2, line 12) and 30 for all 13 for respirat 28) f lines 27 and f lines 31 and EXPENSE COMPUTA 6) 2, line 10) , line 13.01) ; Complete one	of lines others) ory therap 31) 32) TION - SER of the fol	of lines 26 a by or sum of VICES OUTSIDE	and PROVI	469 2,813 0 0 2,813 0 0 2,813 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	27.0 28.0 30.0 31.0 32.0 33.0 34.0 35.0 35.0 37.0 38.0 39.0 40.0 41.0 42.0

	ABLE COST DETERMINATION FOR THERAPY SERVICES E SUPPLIERS	FURNISHED BY	Provider CC		Period: From 07/01/2022 To 06/30/2023	Date/Time Pre 11/24/2023 3:	pared:
					Physical Therapy	Cost	
						1.00	
5.00	Optional travel allowance and optional trave						46.00
		Therapists	Assistants	Aides	Trainees	Total	
	PART V - OVERTIME COMPUTATION	1.00	2.00	3.00	4.00	5.00	
	Overtime hours worked during reporting	0.00	0.00	0.0	0.00	0.00	47.00
.00	period (if column 5, line 47, is zero or	0.00	0.00	0.0	0.00	0.00	47.0
	equal to or greater than 2,080, do not						
	complete lines 48-55 and enter zero in each						
	column of line 56)						
3.00	Overtime rate (see instructions)	0.00	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) CALCULATION OF LIMIT						
0.00	Percentage of overtime hours by category	0.00	0.00	0.0	0.00	0.00	50.0
	(divide the hours in each column on line 47	0.00	0.00	0.0	0.00	0.00	50.0
	by the total overtime worked - column 5,						
	line 47)						
L.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)						
	DETERMINATION OF OVERTIME ALLOWANCE	05.67	0.00	0.0	0 00		52.0
2.00	Adjusted hourly salary equivalency amount (see instructions)	95.67	0.00	0.0	0.00		52.0
3.00	Overtime cost limitation (line 51 times line	0	0		0 0		53.0
	52)	Ŭ	0		0 0		55.0
1.00	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)				-		
5.00	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	ADJUSTMENT				
	Salary equivalency amount (from line 23)	(from 1:000 22	24			315,509	
	Travel allowance and expense - provider site Travel allowance and expense - Offsite service			`		2,813 0	
0.00	Overtime allowance (from column 5, line 56)		44, 45, 01 40)		0	
00	Equipment cost (see instructions)					0	
2.00	Supplies (see instructions)					0	
	Total allowance (sum of lines 57-62)					318,322	
	Total cost of outside supplier services (from	vour records)				149,686	
	Excess over limitation (line 64 minus line 63		enter zero)				65.0
	LINE 33 CALCULATION						1
0.00	Line 26 = line 24 for respiratory therapy or	sum of lines 24	and 25 for a	11 others		2,344	100.0
	Line 27 = line 7 times line 3 for respiratory	/ therapy or sum	ı of lines 3 a	nd 4 for all	others		100.0
0 02	Line 33 = line 28 = sum of lines 26 and 27					2,813	100.0
.01	LINE 34 CALCULATION						
	Line 27 = line 7 times line 3 for respiratory				others		101.0
)1.00		sum of lines 29	and 30 for a	II others			101.0
)1.00)1.01	Line 31 = line 29 for respiratory therapy or					469	101.0
)1.00)1.01	Line 34 = sum of lines 27 and 31						
01.00 01.01 01.02	Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION			11			
1.00 1.01 1.02 2.00	Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION Line 31 = line 29 for respiratory therapy or				mag 1 2 14	0	102.0
01.00 01.01 01.02	Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION				mns 1-3, line	0	

	DE SUPPLIERS				Period: From 07/01/2022 To 06/30/2023 Occupational Therapy		pared					
						1.00						
00	PART I - GENERAL INFORMATION Total number of weeks worked (excluding aide	s) (see instruc	tions)			49	1.0					
00	Line 1 multiplied by 15 hours per week	s) (see mistruc	croits)			735						
00	Number of unduplicated days in which supervis	sor or therapis	t was on provi	der site (see	instructions)	123	3.0					
00	Number of unduplicated days in which therapy		on provider si	te but neithe	r supervisor	0	4.0					
00	nor therapist was on provider site (see inst Number of unduplicated offsite visits - supe		anists (soo in	structions)		0	5.0					
00	Number of unduplicated offsite visits - supe				v therapy	0	6.0					
	assistant and on which supervisor and/or the					-						
~~	instructions)					0.57						
00 00	Standard travel expense rate Optional travel expense rate per mile					9.57						
00	operonal eraver expense race per inne	Supervisors	Therapists	Assistants	Aides	Trainees	0.1					
00	Tetal have verted	1.00	2.00	3.00	4.00	5.00						
00	Total hours worked AHSEA (see instructions)	6.00 99.76	2,452.00 90.69	0.0		0.00	9.0 10.0					
.00		45.35	45.35	0.0		0100	11.0					
	one-half of column 2, line 10; column 3,											
00	one-half of column 3, line 10) Number of travel hours (provider site)	0	0		0		12.0					
.00	1 7	0	0		0		12.0					
	Number of miles driven (provider site)	0	0		0		13.					
.01	Number of miles driven (offsite)	0	0		0		13.					
						1.00						
	Part II - SALARY EQUIVALENCY COMPUTATION					1100						
.00							14.					
.00						222,372	15. 16.					
.00			ratory therapy	or lines 14-	16 for all	222,971						
	others)					, -						
.00						0	18. 19.					
.00			therapy or lin	es 17 and 18	for all others)	222,971						
.00	If the sum of columns 1 and 2 for respiratory	y therapy or co	Tumns 1-3 for	physical there	apy, speech path		20.					
	occupational therapy, line 9, is greater than		no entries on [:]	lines 21 and 2	22 and enter on	line 23						
00	the amount from line 20. Otherwise complete Weighted average rate excluding aides and tr		divided by su	m of columns	1 and 2 line 9	0.00	21					
					i unu i, rine s	0.00						
.00		ees (line 2 tim	es line 21)		for respiratory therapy or columns 1 thru 3, line 9 for all others)							
.00			0									
					THE STTE	0 222,971						
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOU Standard Travel Allowance	NANCE AND TRAVE		JTATION - PRO	VIDER SITE	-						
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11)	NANCE AND TRAVE		JTATION - PRO	VIDER SITE	222,971	23.					
.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)		L EXPENSE COMP		VIDER SITE	222,971 5,578 0	23. 24. 25.					
.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	sum of lines 2	4 and 25 for a	ll others)		222,971 5,578 0 5,578	23. 24. 25. 26.					
.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)		222,971 5,578 0	23. 24. 25. 26.					
.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	222,971 5,578 0 5,578	23. 24. 25. 26. 27.					
.00 .00 .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)	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	222,971 5,578 0 5,578 1,177	23. 24. 25. 26. 27.					
.00 .00 .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 Trave	sum of lines 2 for respirator travel expense l Expense	4 and 25 for a y therapy or s at the provid	ll others) um of lines 3	and 4 for all	222,971 5,578 0 5,578 1,177	23. 24. 25. 26. 27. 28.					
.00 .00 .00 .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 TraveTherapists (column 2, line 10 times the sumAssistants (column 3, line 10 times column 3	sum of lines 2 for respirator travel expense l Expense 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 3 er site (sum)	and 4 for all	222,971 5,578 0 5,578 1,177 6,755 0 0	23. 24. 25. 26. 27. 28. 29. 30.					
.00 .00 .00 .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 Trave Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or	sum of lines 2 for respirator travel expense 1 Expense 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 3 er site (sum 11 others)	and 4 for all of lines 26 and	222,971 5,578 0 5,578 1,177 6,755 0 0 0 0	23. 24. 25. 26. 27. 28. 29. 30. 31.					
.00 .00 .00 .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 Trave Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column	sum of lines 2 for respirator travel expense 1 Expense 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 3 er site (sum 11 others)	and 4 for all of lines 26 and	222,971 5,578 0 5,578 1,177 6,755 0 0	23. 24. 25. 26. 27. 28. 29.					
.00 .00 .00 .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 Trave Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others)	sum of lines 2 for respirator travel expense 1 Expense of 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 respire	ll others) um of lines 3 er site (sum 11 others)	and 4 for all of lines 26 and	222,971 5,578 0 5,578 1,177 6,755 0 0 0 0	23. 24. 25. 26. 27. 28. 29. 30. 31. 32.					
.00 .00 .00 .00 .00 .00 .00 .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 Trave Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3 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	sum of lines 2 for respirator travel expense 1 Expense of columns 1 an , line 12) sum of lines 2 s 1 and 2, line l expense (line 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	ll others) um of lines 3 er site (sum ll others) atory therapy d 31)	and 4 for all of lines 26 and	222,971 5,578 0 5,578 1,177 6,755 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34.					
.00 .00 .00 .00 .00 .00 .00 .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 Trave Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3 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	sum of lines 2 for respirator travel expense I Expense 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 3 er site (sum ll others) atory therapy d 31) d 32)	and 4 for all of lines 26 and or sum of	222,971 5,578 0 5,578 1,177 6,755 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	23. 24. 25. 26. 27. 28. 30. 31. 32. 33. 34.					
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.00 .00 .00 .00 .00 .00 .00 .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 Trave Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3 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 Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/ Standard Travel Expense	sum of lines 2 for respirator travel expense I Expense 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 3 er site (sum ll others) atory therapy d 31) d 32)	and 4 for all of lines 26 and or sum of	222,971 5,578 0 5,578 1,177 6,755 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	23. 24. 25. 26. 27. 28. 30. 31. 32. 33. 34. 35.					
	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 Trave Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3 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 standard trave Optional travel allowance and standard trave Ditional trave trave Ditional trave allowance and standard trave Ditional trave Ditional trave allowance and standard trave Ditional trave D	sum of lines 2 for respirator travel expense I Expense 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 3 er site (sum ll others) atory therapy d 31) d 32)	and 4 for all of lines 26 and or sum of	222,971 5,578 0 5,578 1,177 6,755 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37.					
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	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 Trave Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3 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 standard trave Optional travel allowance and standard trave Defional travel allowance and standard 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 1 Expense of columns 1 an , line 12) sum of lines 2 s 1 and 2, line l expense (line l expense (sum expense (sum l expense (sum mof lines 5 an	L EXPENSE COMPU 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 3 er site (sum ll others) atory therapy d 31) d 32)	and 4 for all of lines 26 and or sum of	222,971 5,578 0 5,578 1,177 6,755 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	23. 24. 25. 26. 27. 28. 30. 31. 32. 33. 34. 35. 36. 37. 38.					
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	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 Trave Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3 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 standard trave Optional travel allowance and standard trave Ditional travel allowance and standard trave Optional travel allowance and optional trave Ditional travel allowance and optional trave Optional travel allowance and optional trave Dational 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 expense (sum expense (sum ANCE AND TRAVEL m of lines 5 an 1 Expense OI times column n 3, line 10)	L EXPENSE COMPU 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 3 er site (sum ll others) atory therapy d 31) d 32)	and 4 for all of lines 26 and or sum of	222,971 5,578 0 5,578 1,177 6,755 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42.					
	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 Trave Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3 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 standard trave Optional travel allowance and standard trave Ditional 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 Trave Therapists (sum of columns 1 and 2, line 12. 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)	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 expense (sum expense (sum ANCE AND TRAVEL m of lines 5 an 1 Expense O1 times column n 3, line 10) m of columns 1-	L EXPENSE COMPU 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 3 er site (sum ll others) atory therapy d 31) d 32) TATION - SERV	and 4 for all of lines 26 and or sum of ICES OUTSIDE PRC	222,971 5,578 0 5,578 1,177 6,755 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42.					
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	ABLE COST DETERMINATION FOR THERAPY SERVICES I E SUPPLIERS	FURNISHED BY	Provider Co	Provider CCN. 13-1323		Worksheet A-8 Parts I-VI Date/Time Pre 11/24/2023 3:	pared:
					Occupational Therapy	Cost	
						1.00	
	Optional travel allowance and standard travel					0	45.00
6.00	Optional travel allowance and optional travel					0	46.00
		Therapists 1.00	Assistants 2.00	Aides 3.00	Trainees 4.00	Total 5.00	
	PART V - OVERTIME COMPUTATION	1.00	2.00	5.00	4.00	5.00	
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.	0.00	0.00	47.0
	Overtime rate (see instructions)	0.00	0.00				48.0
	Total overtime (including base and overtime allowance) (multiply line 47 times line 48) CALCULATION OF LIMIT	0.00	0.00	0.	00 0.00		49.00
	(divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.	0.00	0.00	50.00
1.00	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.	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE			-			
	Adjusted hourly salary equivalency amount (see instructions) Overtime cost limitation (line 51 times line	90.69	0.00		00 0.00		52.0
	Maximum overtime cost (enter the lesser of	0	0		0 0		54.0
5.00	line 49 or line 53) Portion of overtime already included in hourly computation at the AHSEA (multiply	0	0		0 0		55.0
5.00	line 47 times line 52) 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
						1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION A	ND EXCESS COST	ADJUSTMENT				
8.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00	Salary equivalency amount (from line 23) 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) Total allowance (sum of lines 57-62) Total cost of outside supplier services (from Excess over limitation (line 64 minus line 63 LINE 33 CALCULATION	es (from lines your records)	44, 45, or 46)		222,971 6,755 0 0 0 229,726 124,637 0	58.0 59.0 60.0 61.0 62.0 63.0
	Line 26 = line 24 for respiratory therapy or	sum of lines ?	4 and 25 for a	11 others		5,578	100.0
00.01 00.02	Line 27 = line 7 times line 3 for respiratory Line 33 = line 28 = sum of lines 26 and 27				others	1,177 6,755	100.0
01.00	LINE 34 CALCULATION Line 27 = line 7 times line 3 for respiratory				others	1,177	
01.02	Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION	Sum of lines 2	9 and 30 tor a	iii otners		0 1,177	101.0 101.0
02.00	Line 31 = line 29 for respiratory therapy or Line 32 = line 8 times columns 1 and 2, line				umns 1-3, line		102.0 102.0
	13 for all others	-			-		

	DE SUPPLIERS	FURNISHED BY	Provider CC	N:15-1325	Period: From 07/ To 06/	30/2023	Worksheet A-8 Parts I-VI Date/Time Pre 11/24/2023 3: Cost	pared:	
							1.00		
	PART I - GENERAL INFORMATION						1.00		
.00	Total number of weeks worked (excluding aides	s) (see instruct	ions)				18	1.0	
.00	Line 1 multiplied by 15 hours per week						270	2.0	
.00	Number of unduplicated days in which supervis		20 0	3.0					
.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)								
.00	Number of unduplicated offsite visits - super		apists (see in	structions)			0	5.0	
.00	Number of unduplicated offsite visits - there	apy assistants (include only	isits made		у	0	6.0	
	assistant and on which supervisor and/or the	rapist was not p	oresent during	the visit(s	s)) (see				
.00	instructions) Standard travel expense rate						9.57	7.0	
.00	Optional travel expense rate per mile						0.00		
	operonal eraver expense race per mille	Supervisors	Therapists	Assistants	s Ai	des	Trainees	0.1	
		1.00	2.00	3.00	4.	00	5.00		
.00	Total hours worked	0.00	188.00		.00	0.00	0.00		
0.00	· ·	0.00	87.17		.00	0.00	0.00		
1.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3,	43.59	43.59	0	.00			11.0	
	one-half of column 3, line 10)								
2.00	Number of travel hours (provider site)	0	0		0			12.	
	Number of travel hours (offsite)	0	0		0			12.	
3.00	Number of miles driven (provider site) Number of miles driven (offsite)	0	0		0			13. 13.	
5.01	Number of miles driven (offsite)	0	0		0			15.	
						ŀ	1.00		
	Part II - SALARY EQUIVALENCY COMPUTATION								
4.00								14.	
5.00							16,388		
5.00 7.00	Assistants (column 3, line 9 times column 3, Subtotal allowance amount (sum of lines 14 ar		atory therany	or lines 1/	1-16 for a	11	0 16,388	16.	
.00	others)	iu 15 ioi respii	atory therapy	of thes r	+-10 101 a		10,500	17.	
8.00	Aides (column 4, line 9 times column 4, line	10)					0	18.	
9.00							0 16,388		
0.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others) If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pat							20.	
	occupational therapy, line 9, is greater than						ology or		
				ines 21 and	1 22 and e	nter on	line 23		
	the amount from line 20. Otherwise complete		o entries on	ines 21 and	1 22 and e	nter on	line 23		
1.00		lines 21-23. ainees (line 17	divided by sur				1ine 23 87.17	21.	
	Weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3,	lines 21-23. ainees (line 17 line 9 for all	divided by sur others)				87.17		
2.00	Weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traine	lines 21-23. ainees (line 17 line 9 for all	divided by sur others)				87.17 23,536	22.	
	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)	lines 21-23. ainees (line 17 line 9 for all ees (line 2 time	divided by sur others) es line 21)	n of columns	5 1 and 2,	line 9	87.17	22.	
2.00	Weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traine	lines 21-23. ainees (line 17 line 9 for all ees (line 2 time	divided by sur others) es line 21)	n of columns	5 1 and 2,	line 9	87.17 23,536	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 Standard Travel Allowance	lines 21-23. ainees (line 17 line 9 for all ees (line 2 time	divided by sur others) es line 21)	n of columns	5 1 and 2,	line 9	87.17 23,536 23,536	22. 23.	
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)	lines 21-23. ainees (line 17 line 9 for all ees (line 2 time MANCE AND TRAVEL	divided by sur others) es line 21) . EXPENSE COMP L	n of columns JTATION – PF	5 1 and 2,	line 9	87.17 23,536 23,536 	22. 23. 24. 25.	
2.00 3.00 4.00 5.00 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) Subtotal (line 24 for respiratory therapy or	lines 21-23. ainees (line 17 line 9 for all ees (line 2 time VANCE AND TRAVEL sum of lines 24	divided by sur others) es line 21) . EXPENSE COMPL and 25 for a	n of columns JTATION - PF	s 1 and 2,	line 9	87.17 23,536 23,536 872 0 872	22. 23. 24. 25. 26.	
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2.00 3.00 4.00 5.00 5.00 7.00 8.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00	<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>	<pre>lines 21-23. ainees (line 17 line 9 for all ees (line 2 time VANCE AND TRAVEL sum of lines 24 for respiratory travel expense f columns 1 and , line 12) sum of lines 29 s 1 and 2, line l expense (line l expense (sum of l expense (sum of lines 5 and Expense</pre>	divided by sur others) as line 21) EXPENSE COMPL and 25 for a therapy or su at the provide 12, line 12) and 30 for a 13 for respira 28) of lines 27 and f lines 31 and EXPENSE COMPUT	n of columns JTATION - PF Il others) um of lines er site (sur Il others) atory therag d 31) d 32)	s 1 and 2, ROVIDER SI 3 and 4 f n of lines	line 9 TE for all 26 and of	87.17 23,536 23,536 872 0 872 191 1,063 0 0 0 0 1,063 0 0 VIDER SITE 0 0 0 0	22. 23. 24. 25. 26. 27. 28. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39.	
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00 5.00	<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 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 ALLOW/ 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 Travel Therapists (sum of columns 1 and 2, line 12.0</pre>	<pre>lines 21-23. ainees (line 17 line 9 for all ees (line 2 time VANCE AND TRAVEL sum of lines 24 for respiratory travel expense l Expense of columns 1 and , line 12) sum of lines 29 s 1 and 2, line l expense (sum of l expense (sum of l expense</pre>	divided by sur others) as line 21) EXPENSE COMPL and 25 for a therapy or su at the provide 12, line 12) and 30 for a 13 for respira 28) of lines 27 and f lines 31 and EXPENSE COMPUT	n of columns JTATION - PF Il others) um of lines er site (sur Il others) atory therag d 31) d 32)	s 1 and 2, ROVIDER SI 3 and 4 f n of lines	line 9 TE for all 26 and of	87.17 23,536 23,536 872 0 872 191 1,063 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. 35. 36. 37. 38. 39. 40.	
2.00 3.00 5.00 5.00 7.00 3.00 9.00 1.00 2.00 3.00 4.00 5.00 5.00 5.00	<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 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 (column 3, line 12.01 times column Subtotal (sum of lines 40 and 41)</pre>	<pre>lines 21-23. ainees (line 17 line 9 for all ees (line 2 time VANCE AND TRAVEL sum of lines 24 for respiratory travel expense travel expense f columns 1 and , line 12) sum of lines 25 s 1 and 2, line l expense (sum of lexpense (sum of lexpense (sum of lexpense (sum of lexpense (sum of lexpense (sum of lexpense (sum of lexpe</pre>	divided by sur others) es line 21) • EXPENSE COMPU • and 25 for a / therapy or su at the provide 12, line 12) • and 30 for a 13 for respira 28) of lines 27 and f lines 31 and EXPENSE COMPU 4 6) 2, line 10)	n of columns JTATION - PF Il others) um of lines er site (sur Il others) atory therag d 31) d 32)	s 1 and 2, ROVIDER SI 3 and 4 f n of lines	line 9 TE for all 26 and of	87.17 23,536 23,536 872 0 872 191 1,063 0 0 0 1,063 0 0 VIDER SITE 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. 35. 36. 37. 38. 39. 40. 41. 42.	
2.00 3.00 5.00 5.00 7.00 3.00 3.00 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 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 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 (column 3, line 12.01 times column Subtotal (sum of columns 1 and 2, line 12.04 Assistants (column 3, line 20, line 12.05 Standard travel expense (line 7 times the sum Optional travel expense (line 7 times the sum Optional travel expense (line 8 times column Subtotal (sum of lines 40 and 41) Optional travel expense (line 8 times the sum</pre>	<pre>lines 21-23. ainees (line 17 line 9 for all ees (line 2 time VANCE AND TRAVEL sum of lines 24 for respiratory travel expense of columns 1 and , line 12) sum of lines 29 s 1 and 2, line l expense (line l expense (line l expense (sum of l expense (sum of l expense)) t imes column n 3, l ine 10) m of columns 1-3</pre>	divided by sur others) as line 21) EXPENSE COMPL and 25 for a therapy or su at the provide 12, line 12) and 30 for a 13 for respira 28) of lines 27 and fines 31 and EXPENSE COMPUT 16) 2, line 10) 3, line 13.01)	n of columns JTATION - PF 11 others) um of lines er site (sur 11 others) atory therap 131) 132) TATION - SEF	s 1 and 2, ROVIDER SI 3 and 4 f n of lines by or sum RVICES OUT	line 9 TE or all 26 and of SIDE PRO	87.17 23,536 23,536 872 0 872 191 1,063 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. 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 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>	<pre>lines 21-23. ainees (line 17 line 9 for all ees (line 2 time VANCE AND TRAVEL sum of lines 24 for respiratory travel expense of columns 1 and , line 12) sum of lines 29 s 1 and 2, line l expense (line l expense (line l expense (sum of l expense (sum of l expense)) t imes column n 3, l ine 10) m of columns 1-3</pre>	divided by sur others) as line 21) EXPENSE COMPL and 25 for a therapy or su at the provide 12, line 12) and 30 for a 13 for respira 28) of lines 27 and fines 31 and EXPENSE COMPUT 16) 2, line 10) 3, line 13.01)	n of columns JTATION - PF 11 others) um of lines er site (sur 11 others) atory therap 131) 132) TATION - SEF	s 1 and 2, ROVIDER SI 3 and 4 f n of lines by or sum RVICES OUT	line 9 TE or all 26 and of SIDE PRO	87.17 23,536 23,536 872 0 872 191 1,063 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. 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 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 12.0 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.</pre>	<pre>lines 21-23. ainees (line 17 line 9 for all ees (line 2 time /ANCE AND TRAVEL ////////////////////////////////////</pre>	divided by sur others) as line 21) EXPENSE COMPL and 25 for a therapy or su at the provide 12, line 12) and 30 for a 13 for respira 28) of lines 27 and f lines 27 and f lines 31 and EXPENSE COMPUT 4 6) 2, line 10) 3, line 13.01) ; Complete one	n of columns TTATION - PR Il others) um of lines er site (sur Il others) atory therap d 31) d 32) TATION - SER A of the fol	s 1 and 2, ROVIDER SI 3 and 4 f n of lines by or sum RVICES OUT	line 9 TE or all 26 and of SIDE PRO	87.17 23,536 23,536 872 0 872 191 1,063 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. 35. 36. 37. 38. 39. 40. 41. 42.	

	ABLE COST DETERMINATION FOR THERAPY SERVICES	FURNISHED BY	Provider CC	CN: 15-1325	Period: From 07/01/2022 To 06/30/2023	Worksheet A-8 Parts I-VI Date/Time Pre 11/24/2023 3:	pared:
	· · · · · · · · · · · · · · · · · · ·				Speech Pathology	Cost	
						1.00	
5.00	Optional travel allowance and optional trave		f lines 42 an	d 43 - see in	structions)	0	46.0
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
	Overtime hours worked during reporting	0.00	0.00	0.0	0.00	0.00	47.0
	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) Overtime rate (see instructions)	0.00	0.00	0.0	0.00		48.0
	Total overtime (including base and overtime	0.00	0.00				49.0
	allowance) (multiply line 47 times line 48)	0.00	0.00	0.0	0.00		49.0
	CALCULATION OF LIMIT						1
	Percentage of overtime hours by category	0.00	0.00	0.0	0.00	0.00	50.0
	(divide the hours in each column on line 47						
	by the total overtime worked - column 5,						
	line 47)						
	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)						
	DETERMINATION OF OVERTIME ALLOWANCE	07.17	0.00				1 52 /
	Adjusted hourly salary equivalency amount (see instructions)	87.17	0.00	0.0	0.00		52.0
	Overtime cost limitation (line 51 times line	0	0		0 0		53.0
	52)	0	U		0		55.0
	Maximum overtime cost (enter the lesser of	0	0		0 0		54.0
	line 49 or line 53)	, i i i i i i i i i i i i i i i i i i i	Ũ		° °		
	Portion of overtime already included in	0	0		0 0		55.0
	hourly computation at the AHSEA (multiply						
	line 47 times line 52)						
	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	ADJUSTMENT				
	Salary equivalency amount (from line 23)					23,536	57.
	Travel allowance and expense - provider site					1,063	
	Travel allowance and expense - Offsite servic	ces (from lines	44, 45, or 46)		0	
	Overtime allowance (from column 5, line 56)					0	
	Equipment cost (see instructions)					0	
	Supplies (see instructions)					0	
	Total allowance (sum of lines 57-62)					24,599	
	Total cost of outside supplier services (from					9,533	
	Excess over limitation (line 64 minus line 63	3 - if negative,	enter zero)			0	65.
- H	LINE 33 CALCULATION	sum of lines 24	and 25 fam a	11 others			100
	Line 26 = line 24 for respiratory therapy or Line 27 = line 7 times line 3 for respiratory				othors		100. 100.
	Line $33 = 1$ ine $28 = $ sum of 1 ines 26 and 27	/ cherapy of Sum	of times 5 a	110 4 101 all	others	1,063	
	LINE 34 CALCULATION					1,005	100.
	Line 27 = line 7 times line 3 for respiratory	/ therapy or sum	of lines 3 a	nd 4 for all	others	101	101.
1 00	Line $31 = 1$ ine 29 for respiratory therapy or				others		101.
		Sum Of THIES 25	and 50 101 d	Unici 5			101.
1.01						191	1-0
1.01 1.02	Line 34 = sum of lines 27 and 31						
1.01 1.02	LINE 35 CALCULATION	sum of lines 20	and 30 for a	11 others		0	102
1.01 1.02 2.00	L INE 35 CALCULATION Line 31 = line 29 for respiratory therapy or				mns 1-3 line		102.
L.01 L.02 2.00 2.01	LINE 35 CALCULATION				mns 1-3, line		102. 102.

OST AL	LOCATION - GENERAL SERVICE COSTS		Provider CC	CN: 15-1325	Period: From 07/01/2022 To 06/30/2023	Worksheet B Part I Date/Time Pre 11/24/2023 3:	
			CAPITAL REL	ATED COSTS		11/24/2023 3.	
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	PURCHASING RECEIVING AND STORES	
		<u>col. 7)</u>	1.00	2.00	4.00	5.02	
c	GENERAL SERVICE COST CENTERS	0	1.00	2.00	4.00	5.02	
	00100 CAP REL COSTS-BLDG & FIXT	60,184	60,184				1.0
.00	00200 CAP REL COSTS-MVBLE EQUIP	28,706		28,70	06		2.0
.00 0	00400 EMPLOYEE BENEFITS DEPARTMENT	1,692,468	569	27	1,693,308		4.0
.02 0	00560 PURCHASING RECEIVING AND STORES	16,693	1,069	51	0 0	18,272	5.0
.03 0	00580 CASHIERING/ACCOUNTS RECEIVABLE	20,142	1,912	91	.2 127	0	5.0
.04 0	00590 OTHER ADMINISTRATIVE AND GENERAL	4,834,234	7,975	3,80	51,362	0	5.0
	00700 OPERATION OF PLANT	1,119,739	4,377	2,08	38 0	0	7.0
	00800 LAUNDRY & LINEN SERVICE	23,417	448	21		0	8.0
-	00900 HOUSEKEEPING	334,553	1,089	52		83	9.0
-	01000 DIETARY	216,989	2,543	1,21		0	10.0
	01100 CAFETERIA	230,295	925	44		0	11.0
	01300 NURSING ADMINISTRATION	488,716	212	10	· · · · ·	0	13.0
	01400 CENTRAL SERVICE & SUPPLY	0	689	32		0	14.0
	D1500 PHARMACY	222,750	974	46	· · · ·	18	15.0
	01600 MEDICAL RECORDS & LIBRARY	0	1,445	68		0	16.0
	01700 SOCIAL SERVICE	0	0		0 0	0	17.0
	INPATIENT ROUTINE SERVICE COST CENTERS	1 100 220	7 550	2.60	201 121	<u> </u>	20.0
	03000 ADULTS & PEDIATRICS	1,100,220	7,550	3,60	301,131	8,293	30.0
	03100 INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	1 011 615	5 276	2 54	54 268,984	0	31.0 40.0
	04100 SUBPROVIDER - IPF	1,811,615	5,376	2,56	0 0	6,867 0	40.0
	04200 SUBPROVIDER	0	0		0 0	0	42.0
	ANCILLARY SERVICE COST CENTERS	U 0	V		0 0		72.0
	05000 OPERATING ROOM	573,709	4,752	2,26	98,783	482	50.0
	05100 RECOVERY ROOM	0	0	_,	0 0	0	51.0
	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.0
	05300 ANESTHESIOLOGY	0	0		0 0	0	53.0
	05400 RADIOLOGY-DIAGNOSTIC	1,225,724	3,646	1,73	225,100	356	
	05900 CARDIAC CATHETERIZATION	0	0		0 0	0	59.
0.00	06000 LABORATORY	1,496,345	1,902	90	35,898	154	60.0
5.00	06500 RESPIRATORY THERAPY	280,990	767	36	6 79,001	220	65.0
6.00	D6600 PHYSICAL THERAPY	157,065	2,130	1,01	.6 3,327	911	66.
7.00	06700 OCCUPATIONAL THERAPY	131,028	1,257	59	3,420	0	67.
8.00	06800 SPEECH PATHOLOGY	6,363	33	1	.6 387	0	68.
9.00	06900 ELECTROCARDIOLOGY	0	0		0 0	0	69.
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	99,078	0		0 0	0	71.
	07200 IMPL. DEV. CHARGED TO PATIENTS	31,786	0		0 0	0	72.0
3.00	07300 DRUGS CHARGED TO PATIENTS	228,143	0		0 0	0	73.
	DUTPATIENT SERVICE COST CENTERS						
	09000 CLINIC	0	0		0 0	0	
	09100 EMERGENCY	2,258,546	2,824	1,34	312,556	461	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.0
	SPECIAL PURPOSE COST CENTERS	10 000 400	E4 464	25.05	1 550 600	17.015	110
18.00	SUBTOTALS (SUM OF LINES 1 through 117)	18,689,498	54,464	25,97	1,559,686	17,845	1118.0
	NONREIMBURSABLE COST CENTERS		244	1/			100 /
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 07950 OTHER NRCC - PHYSICIAN CLINIC	0 2,220	344 3,281	16 1,56			190.0 194.0
	07950 OTHER NRCC - PHYSICIAN CLINIC	644,350	5,281	1,50	0 133,622		194.
	07951 OTHER NRCC - WIC 07952 OTHER NRCC - PUBLIC RELATIONS	044,350	0		0 133,622		194.
	07953 OTHER NRCC - POBLIC RELATIONS	0	2,095	99	° I		194. 194.
94 034		0	2,095	95			194.
	17951 OTHER NRCC - MARKETTNC	∩					
94.04	07954 OTHER NRCC - MARKETING	0	0		0 0		
	07954 OTHER NRCC - MARKETING Cross Foot Adjustments Negative Cost Centers	0	0				200. 201.

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 15-1325		Period: From 07/01/2022 To 06/30/2023	Worksheet B Part I Date/Time Pre 11/24/2023 3:	
	Cost Center Description	CASHIERING/ACC OUNTS RECEIVABLE	Subtotal	OTHER ADMINISTRATIV AND GENERAL	OPERATION OF E PLANT	LAUNDRY & LINEN SERVICE	
		5.03	5A.03	5.04	7.00	8.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.0
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.0
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.0
5.02	00560 PURCHASING RECEIVING AND STORES						5.0
5.03	00580 CASHIERING/ACCOUNTS RECEIVABLE	23,093					5.0
5.04	00590 OTHER ADMINISTRATIVE AND GENERAL	0	4,897,375	4,897,37	5		5.0
7.00	00700 OPERATION OF PLANT	0	1,126,204				7.0
8.00	00800 LAUNDRY & LINEN SERVICE	0	24,079	,	,, .	47,498	
9.00	00900 HOUSEKEEPING	0	336,245			3,677	9.0
10.00	01000 DIETARY	0	220,745			0	
11.00	01100 CAFETERIA	0	231,661			0	11.0
13.00	01300 NURSING ADMINISTRATION	0	595,010			0	13.0
14.00	01400 CENTRAL SERVICE & SUPPLY	0	1,018			0	14.0
15.00	01500 PHARMACY	0	297,835			ů 0	15.0
16.00	01600 MEDICAL RECORDS & LIBRARY	0	2,134		, .	0	16.0
17.00	01700 SOCIAL SERVICE	0	2,134		0 0	0	17.0
17.00	INPATIENT ROUTINE SERVICE COST CENTERS	•	, i i i i i i i i i i i i i i i i i i i	/	0	0	17.0
30.00	03000 ADULTS & PEDIATRICS	1,414	1,422,209	482,39	1 257,146	10,058	30.0
31.00	03100 INTENSIVE CARE UNIT	1,414	1,422,203	402,35	0 237,140	10,050	31.0
40.00	04000 SUBPROVIDER - IPF	1,471	2,096,877	711,22	7 183,110	8,217	40.0
41.00	04100 SUBPROVIDER - IRF	1,4/1	2,090,077	/11,22	0 105,110	0,217	41.0
42.00	04200 SUBPROVIDER	0	0		0 0	0	42.0
+2.00	ANCILLARY SERVICE COST CENTERS	0			0 0	0	42.0
50.00	05000 OPERATING ROOM	1,345	681,338	231,09	9 161,860	5,193	50.0
51.00	05100 RECOVERY ROOM	1, 545	001,550		0 101,000	0,100	51.0
52.00	05200 DELIVERY ROOM & LABOR ROOM	0				0	52.0
53.00	05300 ANESTHESIOLOGY	0				0	53.0
54.00	05400 RADIOLOGY-DIAGNOSTIC	7,686	1,464,251	496,65	1 124,190	5,675	
59.00	05900 CARDIAC CATHETERIZATION	7,000	1,404,201	450,05	0 124,130	0,075	59.0
60.00	06000 LABORATORY	3,918	1,539,124	522,04	6 64,782	1,705	60.0
65.00	06500 RESPIRATORY THERAPY	612	361,956			1,703	65.0
66.00	06600 PHYSICAL THERAPY	317	164,766			2,003	66.0
67.00	06700 OCCUPATIONAL THERAPY	247	136,551		· · · · ·	1,381	
68.00	06800 SPEECH PATHOLOGY	18	6,817			57	68.0
69.00	06900 ELECTROCARDIOLOGY	18	0,017		0 1,113	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	170			Ŭ Ŭ	0	71.0
	07200 IMPL. DEV. CHARGED TO PATIENTS		99,248			0	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	105 991	31,891			0	72.0
/3.00		991	229,134	77,71	0	0	73.0
90.00	OUTPATIENT SERVICE COST CENTERS	0				0	00.0
90.00		, v	2,580,533	075 27		-	90.0
	09100 EMERGENCY	4,799	2,000,000	875,27	7 96,182	9,532	
92.00							92.0
110 04	SPECIAL PURPOSE COST CENTERS	33,003	10 547 001	4 620 72	7 1 212 207	47 400	110 0
118.00		23,093	18,547,001	4,629,73	7 1,313,387	47,498	1110.0
100 04	NONREIMBURSABLE COST CENTERS		FOR	17	2 11 734	<u>^</u>	190.0
		0	508				
	07950 OTHER NRCC - PHYSICIAN CLINIC	0	7,066				194.0
	107951 OTHER NRCC - WIC	0	778,399	264,02	0 0		194.0
	2 07952 OTHER NRCC - PUBLIC RELATIONS	0	0		0 77 770		194.0
	3 07953 OTHER NRCC - DR. OFFICE	0	3,094	1,04	9 71,350		194.0
	4 07954 OTHER NRCC - MARKETING	0	C		0 0	0	194.0
200.00			C				200.0
201.00		0	0 19,336,068		0 0	0 47,498	201.0
202.00		23,093		4,897,37	5 1,508,194		

20317	ALLOCATION - GENERAL SERVICE COSTS		Provider CC	F	Period: From 07/01/2022	Worksheet B Part I	narodi
					Го 06/30/2023	Date/Time Pre 11/24/2023 3:	
	Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICE &	
		0.00	10.00	11 00	12.00	SUPPLY	
	CENERAL SERVICE COST CENTERS	9.00	10.00	11.00	13.00	14.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-BEDG & FIXT						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.02	00560 PURCHASING RECEIVING AND STORES						5.02
5.02	00580 CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590 OTHER ADMINISTRATIVE AND GENERAL						5.04
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPING	491,071					9.00
10.00	01000 DIETARY	0	382,220				10.00
11.00	01100 CAFETERIA	2,939	0	344,685	5		11.00
13.00	01300 NURSING ADMINISTRATION	0	0	19,402			13.00
14.00	01400 CENTRAL SERVICE & SUPPLY	0	0	(0	24,839	1
15.00	01500 PHARMACY	7,905	0	9,917	7 0	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	1,622	0	(0	16.00
17.00	01700 SOCIAL SERVICE	0	0	(0	0	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						1
30.00	03000 ADULTS & PEDIATRICS	168,942	209,045	65,248	3 243,424	0	30.00
31.00	03100 INTENSIVE CARE UNIT	0	0	(0 0	0	31.00
40.00	04000 SUBPROVIDER - IPF	108,339	173,175	59,990	142,282	0	40.00
41.00	04100 SUBPROVIDER - IRF	0	0	(0 0	0	41.00
42.00	04200 SUBPROVIDER	0	0	(0 0	0	42.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	14,847	0	21,165	65,657	0	50.00
51.00	05100 RECOVERY ROOM	0	0	(0 0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	(0 0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	(0 0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	24,272	0	41,70	5 0	0	54.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	(0 0	0	59.00
60.00	06000 LABORATORY	18,800	0	14,803		0	60.00
65.00	06500 RESPIRATORY THERAPY	4,510	0	17,187		0	65.00
66.00	06600 PHYSICAL THERAPY	11,716	0	133		0	66.00
67.00	06700 OCCUPATIONAL THERAPY	8,057	0	47		0	67.00
68.00	06800 SPEECH PATHOLOGY	345	0	64	4 0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	(0 0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(0 0	24,839	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(-	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	(0 10	0	73.00
00.00	OUTPATIENT SERVICE COST CENTERS		A			^	00.00
90.00	09000 CLINIC	0	0	(52 72)		0	90.00
91.00	09100 EMERGENCY	64,405	0	53,736	5 254,869	0	91.00
02 00							92.00
92.00	SPECIAL PURPOSE COST CENTERS	436,699	202 220	202 021	714 122	24 020	110 00
	CURTOTALS (CUM OF LINES 1 +brough 117)	430.099	382,220	303,825	5 714,123	24,039	118.00
92.00 118.00		,					
118.00	NONREIMBURSABLE COST CENTERS		ol	(0	190 00
118.00	NONREIMBURSABLE COST CENTERS	0	0	(0 0		190.00
118.00 190.00 194.00	NONREIMBURSABLE COST CENTERS D 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN D 07950 OTHER NRCC - PHYSICIAN CLINIC	0 42,565	0 0	((10 %)	$\begin{pmatrix} 0 \\ 0 \\ 0 \\ 0 \\ 0 \\ 0 \\ 0 \\ 0 \\ 0 \\ 0 $	0	194.00
118.00 190.00 194.00 194.03	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 07950 OTHER NRCC - PHYSICIAN CLINIC 107951 OTHER NRCC - WIC	0	0 0 0	((40,860	0 0 0 109,326	0 0	194.00 194.01
118.00 190.00 194.00 194.00 194.02	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 07950 OTHER NRCC - PHYSICIAN CLINIC 107951 OTHER NRCC - WIC 207952 OTHER NRCC - PUBLIC RELATIONS	0 42,565 11,807 0	0 0 0 0	((40,860 (0 0 0 0 109,326 0 0	0 0 0	194.00 194.01 194.02
118.00 190.00 194.00 194.00 194.00 194.00	NONREIMBURSABLE COST CENTERS 19000 GJFT, FLOWER, COFFEE SHOP & CANTEEN 07950 OTHER NRCC - PHYSICIAN CLINIC 107951 OTHER NRCC - WIC 207952 OTHER NRCC - PUBLIC RELATIONS 307953 OTHER NRCC - DR. OFFICE	0 42,565	0 0 0 0	40,860 (0 (0) (0)	0 0 0 0 0 109,326 0 0 0 0	0 0 0 0	194.00 194.01 194.02 194.03
118.00 190.00 194.00 194.00 194.00 194.00 194.00	NONREIMBURSABLE COST CENTERS 19000 GJFT, FLOWER, COFFEE SHOP & CANTEEN 07950 OTHER NRCC - PHYSICIAN CLINIC 107951 OTHER NRCC - WIC 207952 OTHER NRCC - PUBLIC RELATIONS 307953 OTHER NRCC - DR. OFFICE 407954 OTHER NRCC - MARKETING	0 42,565 11,807 0	0 0 0 0 0 0	(40,860 (((0 0 0 0 0 109,326 0 0 0 0 0 0	0 0 0 0 0	194.00 194.01 194.02 194.03 194.04
118.00 190.00 194.00 194.00 194.00 194.00 194.00 194.00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 07950 OTHER NRCC - PHYSICIAN CLINIC 107951 OTHER NRCC - WIC 07952 OTHER NRCC - PUBLIC RELATIONS 307953 OTHER NRCC - DR. OFFICE 407954 OTHER NRCC - MARKETING Cross Foot Adjustments Cross Foot Adjustments	0 42,565 11,807 0		40,860 (((((0 0 0 0 0 109,326 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0	194.00 194.01 194.02 194.03 194.04 200.00
118.00 190.00 194.00 194.00 194.00 194.00 194.00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 07950 OTHER NRCC - PHYSICIAN CLINIC 07951 OTHER NRCC - WIC 07952 OTHER NRCC - PUBLIC RELATIONS 07953 OTHER NRCC - DR. OFFICE 07954 OTHER NRCC - MARKETING 0 Cross Foot Adjustments 0 Negative Cost Centers	0 42,565 11,807 0	0 0 0 0 0 0 382,220	40,860 ((((((344,68)		0 0 0 0 0	194.00 194.02 194.02 194.02 194.02 200.00 201.00

11/24/2023 3:50 pm Y:\27200 - St. Vincent Warrick\300 - Medicare Cost Report\20230630\HFS\20230630 Warrick.mcrx

JST <i>F</i>	ALLOCATION - GENERAL SERVICE COSTS		Provider C	CN: 15-1325	Period: From 07/01/202 To 06/30/202		
	Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVI	CE Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		15.00	16.00	17.00	24.00	25.00	
	GENERAL SERVICE COST CENTERS						
00	00100 CAP REL COSTS-BLDG & FIXT] 1
00	00200 CAP REL COSTS-MVBLE EQUIP						2
00	00400 EMPLOYEE BENEFITS DEPARTMENT						4
02	00560 PURCHASING RECEIVING AND STORES						5
03	00580 CASHIERING/ACCOUNTS RECEIVABLE						5
04	00590 OTHER ADMINISTRATIVE AND GENERAL						5
00	00700 OPERATION OF PLANT						7
00	00800 LAUNDRY & LINEN SERVICE						8
00	00900 HOUSEKEEPING						9
.00	01000 DIETARY						10
.00	01100 CAFETERIA						1
.00	01300 NURSING ADMINISTRATION						13
.00	01400 CENTRAL SERVICE & SUPPLY						14
.00	01500 PHARMACY	449,842					1
.00	01600 MEDICAL RECORDS & LIBRARY	0	53,684	ļ			16
.00	01700 SOCIAL SERVICE	0	C		0		17
	INPATIENT ROUTINE SERVICE COST CENTERS						
00	03000 ADULTS & PEDIATRICS	80	3,289)	0 2,861,83	32 0) 3(
00	03100 INTENSIVE CARE UNIT	0	C		0	0 0) 31
.00	04000 SUBPROVIDER - IPF	22	3,421	-	0 3,486,66	50 0) 40
.00	04100 SUBPROVIDER - IRF	0	C)	0	0 0) 41
.00	04200 SUBPROVIDER	0	C)	0	0 0) 42
	ANCILLARY SERVICE COST CENTERS			1			
.00		1,345	3,127	1	0 1,185,63		
.00		0	C	1	0	0 0	
.00		0	C)	0	0 0	1 22
.00		0	17 055		0	0 0	1
.00		991	17,855		0 2,175,59		
.00		0	0 111			0 0	1 .
.00		61	9,111		0 2,170,43		1 .
.00	06500 RESPIRATORY THERAPY 06600 PHYSICAL THERAPY	0	1,423 737		0 541,87		
.00		0	573				
00		0	43		0 236,15 0 10,75		
.00		0	43		0 10,7		
.00		0	396		0 158,14	°	
.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	244		0 42,95		
.00		446,491	2,305		0 755,64		
	OUTPATIENT SERVICE COST CENTERS		2,000				-
.00	09000 CLINIC	0	C		0	0 0	0 90
	09100 EMERGENCY	852	11,160		0 3,946,54	•	91
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		,		- , , -		92
	SPECIAL PURPOSE COST CENTERS						
3.00	0 SUBTOTALS (SUM OF LINES 1 through 11	7) 449,842	53,684	-	0 17,879,99	98 0) 118
	NONREIMBURSABLE COST CENTERS						
0.00	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	C		0 12,40		190
	0 07950 OTHER NRCC - PHYSICIAN CLINIC	0	C		0 163,76) 194
	107951 OTHER NRCC - WIC	0	C		0 1,204,42) 194
4.02	207952OTHER NRCC - PUBLIC RELATIONS	0	C		0) 194
	3 07953 OTHER NRCC - DR. OFFICE	0	C		0 75,49) 194
	407954OTHER NRCC - MARKETING	0	C		0) 194
0.00							200
1.00		0	C		0	0 0	201
	0 TOTAL (sum lines 118 through 201)	449,842	53,684	4	0 19,336,06	1	202

OST AL	LOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-1325	Period: From 07/01/2022 To 06/30/2023	Worksheet B Part I Date/Time Prepar 11/24/2023 3:50
	Cost Center Description	<u>Total</u> 26.00			
	GENERAL SERVICE COST CENTERS	20.00			
	00100 CAP REL COSTS-BLDG & FIXT				
	00200 CAP REL COSTS-MVBLE EQUIP				
	00400 EMPLOYEE BENEFITS DEPARTMENT				
	00560 PURCHASING RECEIVING AND STORES				
	00580 CASHIERING/ACCOUNTS RECEIVABLE				
	00590 OTHER ADMINISTRATIVE AND GENERAL				
	00700 OPERATION OF PLANT				
	00800 LAUNDRY & LINEN SERVICE				
	00900 HOUSEKEEPING				
	01000 DIETARY				1
	01100 CAFETERIA				1
	01300 NURSING ADMINISTRATION				1
1	01400 CENTRAL SERVICE & SUPPLY				
	01500 PHARMACY				1
	01600 MEDICAL RECORDS & LIBRARY				1
	01700 SOCIAL SERVICE				1
	INPATIENT ROUTINE SERVICE COST CENTERS	2 0 01 0 2 2			
	03000 ADULTS & PEDIATRICS	2,861,832			3
	03100 INTENSIVE CARE UNIT	0			3
	04000 SUBPROVIDER - IPF	3,486,660			4
	04100 SUBPROVIDER - IRF	0			4
	04200 SUBPROVIDER	0			4
	ANCILLARY SERVICE COST CENTERS				
1	05000 OPERATING ROOM	1,185,631			5
	05100 RECOVERY ROOM	0			5
	05200 DELIVERY ROOM & LABOR ROOM	0			5
3.00	05300 ANESTHESIOLOGY	0			5
	05400 RADIOLOGY-DIAGNOSTIC	2,175,590			5
9.00	05900 CARDIAC CATHETERIZATION	0			5
0.00	06000 LABORATORY	2,170,432			6
5.00	06500 RESPIRATORY THERAPY	541,872			6
6.00	06600 PHYSICAL THERAPY	307,785			6
7.00	06700 OCCUPATIONAL THERAPY	236,152			6
8.00	06800 SPEECH PATHOLOGY	10,751			6
9.00	06900 ELECTROCARDIOLOGY	0			6
1.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	158,146			7
2.00	07200 IMPL. DEV. CHARGED TO PATIENTS	42,952			7
	07300 DRUGS CHARGED TO PATIENTS	755,649			7
	OUTPATIENT SERVICE COST CENTERS				
	09000 CLINIC	0			9
	09100 EMERGENCY	3,946,546			9
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	, , , , , , , , , , , , , , , , , , , ,			9
	SPECIAL PURPOSE COST CENTERS				
18.00		17,879,998			11
	NONREIMBURSABLE COST CENTERS				
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	12,404			19
	07950 OTHER NRCC - PHYSICIAN CLINIC	163,761			19
	07951 OTHER NRCC - WIC	1,204,412			19
	07952 OTHER NRCC - PUBLIC RELATIONS	1,204,412			19
	07953 OTHER NRCC - DR. OFFICE	75,493			19
	07955 OTHER NRCC - MARKETING	, , , , , , , , , , , , , , , , , , ,			19
00.00		0			20
JU.UU		0			
01.00	Negative Cost Centers				20

Cost Center Description Directly Assigned New Related Costs CAPITAL RELATED COSTS Subtotal EMPLoYEE BENDOTES 1.00 00000 (CAP REL COSTS-HIDE & FIXT Related Costs 0 1.00 2.00 2A 4.00 1.00 00000 (CAP REL COSTS-HIDE & FIXT Related Costs 0 1.00 2.00 2A 4.00 1.00 00000 (CAP REL COSTS-HIDE & FIXT Related Costs 0 1.00 556 271 840 840 5.03 1.00 00580 (CAP REL COSTS-WALE EQUIPN COSTSO COSTSO CONTS RECEIVAGE 0 1.912 3.22 2.824 0 5.03 1.00 000000 (CAP REL COSTS-WALE EQUIPN COSTSO COSTSO			SCENSION ST. VI				u of Form CMS-2	2552-10
Cost Center Description Directly Assigned New Pailed Cost BLD & FIXT (Note: Cost Centers) BLD & FIXT (Note: Cost Centers) BLD & FIXT (Note: Cost Centers) 1.00 02.00 2.00	ALLOCA	TION OF CAPITAL RELATED COSTS		Provider CO	CN: 15-1325		Date/Time Pre	pared: 50 pm
Assigned New Neilling Assigned New Neilling Belieted Cost DepArtment 0.00 00.000 (2AP REL COST-HUNG & FIXT 0 2.00 2.00 2.00 2.00 2.00 0.00 00.000 (2AP REL COST-HUNG & FIXT 0 559 271 8.40 8.40 4.00 0.00 00.000 (2AP REL COST-HUNG & AD STORES 0 1.06 559 271 8.40 8.40 5.03 00.500 (2A) (2A) (2A) (2A) (2A) (2A) (2A) (2A)				CAPITAL REL	ATED COSTS			
GENERAL SERVICE COST CENTES 1 0.000100 CAP REL COSTS-BLOG & FLIXT 0 2.00 0.0000 CAP REL COSTS-BLOG & FLIXT 2.00 0.000100 CAP REL COSTS-SHUELE GUIP 0 5.69 2.71 840 5.00 0.00000 CAP REL COSTS-SHUELE GUIP 0 5.69 2.02 2.824 0 5.00 0.00000 CAPIERLIX COSTS-MUSE EGUIP 0 1.066 5.10 1.757 0 5.00 0.00000 CAPIERLIX COSTS-MUSE EGUIP 0 1.000 1.000 0.0000 6.000 6.00 8.00 0.00000 CAPIERLIX APPLAT 313.506 4.337 2.084 312.00 7.00 7.000 6.000 8.00 8		Cost Center Description	Assigned New Capital Related Costs				BENEFITS DEPARTMENT	
1.00 00100 CAP REL COST-BLOG & FLYT 1.00 0200 CAP REL COST-SHUG & FLYT 1.00 0.00 00400 EMPLOYE BENETTS DEPARTMENT 0 569 271 840 840 4.00 0.00 00500 CAP REL COST-SHUG AND STORES 0 1.069 510 0536 2.524 0 5.03 0.0100 CMFH. ADMISTRATATY E AND GENERAL 344,846 7.975 2.304 356,652.426 5.0 0.00 00500 LANINGEY & LINEN SERVICE 0 1.445 2.24 316,607 0 5.00 0.00 0000 OND ONGESEEFINA ADMINISTRATION 5.715 2.12 1.010 6.028 53 1.30 0.1000 OITETAN CAFTRAL SERVICE & SUPPLY 0 689 329 1.018 0 1.400 0.1000 OIDETAL SERVICE & SUPPLY 0 689 2.91 1.018 0 1.000 0.1000 OIDETAL SERVICE & SUPPLY 0 689 2.91 0.0 0 0 0 0 0 0 0 0 0 0 0		CENEDAL SERVICE COST CENTERS	0	1.00	2.00	2A	4.00	
2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00400 FAP Control Control 5.01 1.579 050 9500 9500 9500 9510 1.579 0500 5.01 0.5700 9500 9510 1.579 0500 5.01 0.5700 9500 9500 5.04 00590 01500 9510 1.579 0500 9500	1.00							1.00
5.02 00560 UNCLASTING RECEIVENG AND STORES 0 1,069 5.10 1,579 0.570 0570								2.00
5.03 00580 CASHEERING/ACCOUNTS RECEIVABLE 0 1,912 912 2,824 0 5.03 5.04 00580 OTHER ADMINISTRATIVE AND GENERAL 344,845 7,797 3,804 336,564 256 5.0 7.00 00700 OPERATION OF PLANT 3313,506 4,377 2,088 3319,971 0 7.00 0.00 00000 LAUNDRY & LINEN SERVICE 0 448 214 6662 0 8.0 9.00 00900 IDTEAMY 2,341 2,353 1,018 0 10.0 10.00 10.00 1.069 0 10.0 10.00 01000 UNESING ADMINISTRATION 5,715 212 101 6,028 31.0 13.0 11.00 01300 UNESING ADMINISTRATION 5,715 212 101 6,028 15.0 15.0 10.00 01400 UNESING ADMINISTRATION -8,725 2,754 464 -6,936 21.5 15.0 10.00 0100 DITEAMY -8,612 7,056 7,550 3,600 18,177 150 30.0 10.00 000 DITEMSING CADST ENTERMONTINE SERVICE COST CENTERS 0	4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	569	27	71 840	840	4.00
5.04 00590 (THER ADDIVESTRATIVE AND GENERAL 344, 845 7, 975 3, 804 356, 624 26 5.0 8.00 00800 (LAUNORY & LINEN SERVICE 0 448 214 662 0 8.0 9.00 00900 (MUSEKGEPING) 0 1,089 520 1,609 0 9.0 10.00 01000 (CAFFTERIA 0 225 441 1,366 0 14.0 11.00 01000 (CAFFTERIA 0 325 441 1,366 0 14.0 11.00 01000 (CAFFTERIA CAFFTERIA 0 14.4 6.028 33 14.0 11.00 01000 (DETRAL SERVICE & SUPPLY 0 6.474 6.98 2.1.1 0 16.0 15.00 16.0 16.00 16.0 <td>5.02</td> <td></td> <td>0</td> <td>1,069</td> <td>51</td> <td>LO 1,579</td> <td>0</td> <td>5.02</td>	5.02		0	1,069	51	LO 1,579	0	5.02
7.00 00700 OPERATION OF PLANT 313,506 4,377 2.088 319,971 0 7.00 0.00 00900 HOUSEKREPING 0 1,089 520 1,609 0 9.00 0.00 01000 CATEREPING 2,341 2,543 1,213 6,097 0 10.0 11.00 01300 URSING AMINISTRATION 5,715 212 101 6,028 533 13.0 13.00 01300 URSING AMINISTRATION 5,715 212 101 6,028 53 13.0 13.00 01400 CENTRAL SERVICE & SUPPLY -8,424 974 464 -6,986 37 15.00 01400 DENTARE SERVICE OST CENTERS - - 0			0		-	, -		
8.00 00800 LAUNDRY & LINEN SERVICE 0 0 448 24 662 0 8.0 9.00 00900 HUSEKEEPING 0 9.00 9.0 10.00 01000 DIETARY (1.600 HUSEKEEPING 0 9.0 10.00 01000 CAETERIA 0 925 441 1,366 01 1.0 11.00 01000 CAETERIA 0 925 441 1,366 01 1.0 11.00 01000 CHETRAL SERVICE & SUPPLY 0 669 329 1,01.8 01 41.0 15.00 01500 PHARMACY - 8.424 974 664 -6.986 37 15.0 17.00 01000 MUDELCAL RECORDS & LIBRARY 0 1.45 669 2.134 01 60.0 17.00 01700 SOCIAL SERVICE SUPPLY 0 0 1.45 669 2.134 01 60.0 17.00 01700 SOCIAL SERVICE SERVICE 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								
9.00 00900 HOUSEREEPING 0 9.00 1.0689 520 1.609 0 9.00 110.00 01000 CAFEREPIN 2.341 2.543 1.213 6.097 0 10.0 110.0 CAFETERIA 0 925 441 1.366 0 11.0 13.0 01300 UNRSING ADMINISTRATION 5.715 212 101 6.028 53 13.0 13.0 01400 CENTRAL SERVICE & SUPPLY 0.0689 329 1.018 0 14.0 14.0 14.0 01400 CENTRAL SERVICE & SUPPLY 0.1464 -6.386 37 15.0 01500 MEDICAL RECORDS & LIBRARY 0 1.445 689 32.9 1.018 0 14.0 16.0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			313,506		-			
10.00 01000 DETERMY 2,341 2,543 1,213 6,097 0 10.0 13.00 0100 CAFETERAT 0,925 441 1,366 11.0 13.00 0100 CHETRAL SERVICE & SUPLY 0 669 329 1,018 13.0 15.00 01500 PHARMACY -8,424 974 464 -6,986 37 15.0 17.00 01700 SOCTAL SERVICE 0 0 0 0 17.0 01000 SOLFACK SERVICE 0 0 0 0 0 17.0 01000 SUBFORVIDER - IPF 62,227 5,376 2,564 70,167 134 40.0 04000 SUBFORVIDER - IFF 0 0 0 0 0 42.0 04200 SUBFORVIDER - IFF 62,227 5,376 2,564 70,167 134 40.0 04100 04100 SUBFORVIDER - IFF 0 0 0 0 0 42.0 05000 OPECATING ROOM 118,766 4,752 2,267 125,785 49 50.0 51.00 05000 DELOCARER MOM 118,766 4,752 <td< td=""><td></td><td></td><td>0</td><td></td><td></td><td></td><td></td><td></td></td<>			0					
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13.00 01300 NURSING ADMINISTRATION 5,715 2.12 101 6,028 53 13.00 13.00 01500 PHARMACY 689 329 1.018 0 14.0 15.00 01500 PHARMACY -8,424 974 464 -6,986 37 15.00 10.00 NEGUCE KORS & LIBRARY 0 1,445 6689 2,134 0 16.0 17.00 SOCIAL SERVICE COST CENTERS - 0 0 0 0 0 0 31.00 03000 ADULTS & PEDIATRICS 7,026 7,550 3,601 18,177 150 30.00 31.00 04100 SUBROVIDER - IPF 62,227 5,376 2,564 70.167 134 40.0 04100 SUBROVIDER - IRF 0 0 0 0 0 0 0 42.0 05100 SUBORVIDER - IRF 118,766 4,752 2,267 125,785 49 50.00 52.0 00 0000 0 0 0 0 0 0 52.0 01000 ROULARY SERVICE COST CENTERS <t< td=""><td></td><td></td><td>2,341</td><td></td><td></td><td></td><td></td><td></td></t<>			2,341					
14.00 01400 CENTRAL SERVICE & SUPPLY 0 668 329 1.018 0 15.0 15.00 01500 MEDTCAL RECORDS & LIBRARY -8,424 974 464 -6,986 37 15.0 10.00 01700 MEDTCAL RECORDS & LIBRARY 0 1,445 669 2,134 0 17.0 INPATIENT ROUTINE SERVICE COST CENTES INPATIENT ROUTINE SERVICE COST CENTES 0 0.00 0.00 0 0 31.00 0.00 0.00 0 0 0 14.00 0.00 0.00 0			5 715				-	
15.00 01500 PHARMACY -8.424 974 46.44 -6.986 37 15.00 10.00 NOD MEDICAL SERVICE 0			3,713			· · · ·		
16.00 01600 NETCOLAL RECORDS & LIBRARY 0 1,445 689 2,134 0 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 3000 ADULTS & PEDIATRICS 7,026 7,550 3,601 18,177 150 30.0 30.00 3000 INTENSIVE CARE UNIT 0			-8 424					
17.00 01700 SOCTAL SERVICE 0 <td></td> <td></td> <td></td> <td>-</td> <td></td> <td></td> <td></td> <td></td>				-				
INPATIENT ROUTINE SERVICE COST CENTERS			-					
30:00 30000 ADULTS & PEDLATRICS 7,026 7,550 3,601 18,177 150 30.0 40:00 04000 SUBPROVIDER - IFF 62,227 5,376 2,564 70,167 134 40.0 41.00 04100 SUBPROVIDER - IFF 62,227 5,376 2,564 70,167 134 40.0 41.00 04100 SUBPROVIDER - IFF 62,227 5,376 2,564 70,167 134 40.0 AUCLLARY SERVICE COST CENTERS 0 0 0 0 0 0 0 0 0 0 0 42.0 051.00 OS200 DELIVERY ROOM LABOR ROOM 0 0 0 0 0 0 0 53.0 05300 ARSTHESIOLOGY 0 0 0 0 0 0 53.0 546 12,547 364.63 3.646 1,739 374.068 125 54.0 0500 CRADIA CATHETERIZATION 0 0 0 0 0 <t< td=""><td></td><td></td><td>-</td><td>-</td><td></td><td></td><td></td><td></td></t<>			-	-				
40.00 004000 SUBPROVIDER - IPF 62,227 5,376 2,564 70,167 134 40.0 41.00 04100 SUBPROVIDER - IRF 0	30.00		7,026	7,550	3,60	18,177	150	30.00
41.00 04100 SUBPROVIDER - IRF 0 <td>31.00</td> <td>03100 INTENSIVE CARE UNIT</td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td>0</td> <td>31.00</td>	31.00	03100 INTENSIVE CARE UNIT	0	0		0 0	0	31.00
42.00 04200 SUBPROVIDER 0	40.00	04000 SUBPROVIDER - IPF	62,227	5,376	2,50	54 70,167	134	40.00
ANCZLLARY SERVICE COST CENTERS 0 <th< td=""><td>41.00</td><td>04100 SUBPROVIDER - IRF</td><td>0</td><td>0</td><td></td><td>-</td><td></td><td></td></th<>	41.00	04100 SUBPROVIDER - IRF	0	0		-		
50.00 05000 0FRATING ROOM 118,766 4,752 2,267 125,785 49 50.00 51.00 05000 RECOVERY ROOM 0	42.00		0	0		0 0	0	42.00
51.00 COUNT COUNT <th< td=""><td>50.00</td><td></td><td>110 700</td><td>4 750</td><td>2.20</td><td>105 705</td><td>10</td><td>50.00</td></th<>	50.00		110 700	4 750	2.20	105 705	10	50.00
52.00 DELVERY ROOM & LABOR ROOM 0 0 0 0 0 0 53.00 053.00 053.00 ANESTHESIOLOGY 0			118,766	4,752	2,20			1
53.00 05300 AMESTHESIDLOGY 0 0 0 0 0 53.0 54.00 05400 RADIOLOGY-DIAGNOSTIC 368,683 3,646 1,739 374,068 112 54.00 05900 CARDIAL CATHETERIZATION 0 0 0 0 0 0 0 0 53.0 06.00 06000 LABORATORY 0 1,902 907 2,809 18 60.0 061.00 06000 CARDIAC CATHETERIZATION 0 1,902 907 2,809 18 60.0 66.00 6600 PHYSICAL THERAPY 1,1363 767 366 12,496 39 65.0 66.00 6600 54.41 2 66.0 66.00 6600 54.01 630 65.0 6600 54.01 53.0 67.0 63.0 650.0 650.0 650.0 650.0 650.0 650.0 650.0 650.0 650.0 67.0 67.0 67.0 67.0 67.0 67.0			0	0		Ŭ Ŭ	-	
54.00 05400 RADIOLOGY-DIAGNOSTIC 368,683 3,646 1,739 374,068 112 54.0 59.00 05000 CARDIAC CATHETERIZATION 0 0 0 0 0 59.0 60.00 06000 LABORATORY 0 1,902 907 2,809 18 60.0 0500 RESPIRATORY THERAPY 2,295 2,130 1,016 5,441 2 66.0 06100 OCCUPATIONAL THERAPY 2,295 2,130 1,016 5,441 2 66.0 06200 OCCUPATIONAL THERAPY 0 1,257 599 1,856 2 67.0 68.0 68.0 69.0 68.0 68.0 69.0 69.0 69.0 69.0 69.0 69.0 69.0 0 0 0 0 72.0 73.0 07100 MPL DEV. CHARGED TO PATIENTS 0 0 0 0 0 73.0 73.0 0100 OUTPATIENT SERVICE COST CENTERS 0 0 0 0 0 90.0 91.0 91.0 91.0 91.0			0	0		0 0	-	
59.00 05900 CARDIAC CATHETERIZATION 0			368 683	3 646	1 73	39 374 068	-	
60.00 06000 LABORATORY 0 1,902 907 2,809 18 60.00 65.00 06500 RESPIRATORY THERAPY 11,363 767 366 12,496 39 65.0 66.00 06600 PHSICAL THERAPY 2,295 2,130 1,016 5,441 2 66.0 67.00 06700 OCCUPATIONAL THERAPY 0 1,257 599 1,856 2 67.0 68.00 SPECH PATHOLOGY 0 33 16 49 0 68.0 0 06900 ELECTROCARDIOLOGY 0 0 0 0 67.0 07100 MOTICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 72.0 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 72.0 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 90.0 91.00 19000 ELECTROCARDIDOLOGY 36,219 2,824 1,347			· · · · · · · · · · · · · · · · · · ·	5,040	1,7.			
65.00 06500 RESPIRATORY THERAPY 11,363 767 366 12,496 39 65.0 66.00 06600 PHYSICAL THERAPY 2,295 2,130 1,016 5,441 2 66.0 67.00 06700 OCCUPATIONAL THERAPY 0 1,257 599 1,856 2 67.0 68.00 06800 SPEECH PATHOLOGY 0 33 16 49 0 68.0 069.00 ELECTROCARDIOLOGY 0 <td></td> <td></td> <td>0</td> <td>1,902</td> <td>9(</td> <td>Ŭ Ŭ</td> <td></td> <td></td>			0	1,902	9(Ŭ Ŭ		
66.00 06600 PHYSICAL THERAPY 2,295 2,130 1,016 5,441 2 66.00 67.00 0CCUPATIONAL THERAPY 0 1,257 599 1,856 2 67.00 68.00 06800 SPECH PATHOLOGY 0 33 16 49 0 68.00 069.00 06900 LECTROCARDIOLOGY 0 0 0 0 68.00 0 0 0 68.00 0 0 0 68.00 0 0 0 0 68.00 0 0 0 0 68.00 0 0 0 0 68.00 0 <td></td> <td></td> <td>11.363</td> <td></td> <td></td> <td>,</td> <td></td> <td></td>			11.363			,		
68.00 06800 SPEECH PATHOLOGY 0 33 16 49 0 68.00 69.00 06900 ELECTROCARDIOLOGY 0								66.00
69.00 06900 ELECTROCARDIOLOGY 0 <td>67.00</td> <td>06700 OCCUPATIONAL THERAPY</td> <td>0</td> <td>1,257</td> <td>59</td> <td>99 1,856</td> <td>2</td> <td>67.00</td>	67.00	06700 OCCUPATIONAL THERAPY	0	1,257	59	99 1,856	2	67.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 72.00 0 0 0 0 0 0 72.00 0 0 0 0 0 0 0 72.00 0 0 0 0 0 0 0 0 0 0 72.00 73.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 73.00 7	68.00	06800 SPEECH PATHOLOGY	0	33	1	L6 49	0	68.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 73.00 0000 CUTPATIENT SERVICE COST CENTERS 0 <	69.00	06900 ELECTROCARDIOLOGY	0	0		0 0	0	69.00
73.00 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 73.00 OUTPATIENT SERVICE COST CENTERS 0 <td></td> <td></td> <td>0</td> <td>0</td> <td></td> <td>-</td> <td>0</td> <td>71.00</td>			0	0		-	0	71.00
OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 0			0	0				
90.00 09000 CLINIC 0	73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
91.00 09100 EMERGENCY 36,219 2,824 1,347 40,390 152 91.00 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0 92.00 92.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 1,264,562 54,464 25,978 1,345,004 714 118.00 NONREIMBURSABLE COST CENTERS 190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 344 164 508 0 190.00 194.00 07950 OTHER NRCC - PHYSICIAN CLINIC 166 3,281 1,565 5,012 0 194.00 194.01 07951 OTHER NRCC - PUBLIC RELATIONS 0 0 0 0 194.00 194.02 07952 OTHER NRCC - DR. OFFICE 0 2,095 999 3,094 0 194.00 194.03 07954 OTHER NRCC - MARKETING 0 0 0 194.00 194.04 07954 OTHER NRCC - DR. OFFICE 0 2,095 999 3,094 0 194.00 <td>00.00</td> <td></td> <td></td> <td>0</td> <td></td> <td></td> <td>0</td> <td>00.00</td>	00.00			0			0	00.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 1,264,562 54,464 25,978 1,345,004 774 118.00 NONREIMBURSABLE COST CENTERS 118.00 190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 344 164 508 0 190.00 190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 344 1,565 5,012 0 194.00 194.00 07950 OTHER NRCC - PHYSICIAN CLINIC 166 3,281 1,565 5,012 0 194.00 194.01 07951 OTHER NRCC - WIC 59,755 0 0 0 194.00 194.02 07952 OTHER NRCC - PUBLIC RELATIONS 0 0 0 194.00 194.04 07954 OTHER NRCC - DR. OFFICE 0 2,095 999 3,094 194.00 194.04 07954 OTHER NRCC - MARKETING 0					1 2			
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 1,264,562 54,464 25,978 1,345,004 774 118.00 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 344 164 508 0 190.00 194.00 07950 OTHER NRCC - PHYSICIAN CLINIC 166 3,281 1,565 5,012 0 194.00 194.01 07951 OTHER NRCC - WIC 59,755 0 0 59,755 66 194.00 194.02 07952 OTHER NRCC - PUBLIC RELATIONS 0 0 0 194.00 194.03 07953 OTHER NRCC - DR. OFFICE 0 2,095 999 3,094 0 194.00 194.04 07954 OTHER NRCC - MARKETING 0 0 0 194.00 194.04 07954 OTHER NRCC - MARKETING 0 0 0 194.00 194.04 07954 OTHER NRCC - MARKETING 0			50,219	2,024	1,54	+7 40,390	152	
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 1,264,562 54,464 25,978 1,345,004 774 118.00 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 344 164 508 0 190.00 194.00 07950 OTHER NRCC - PHYSICIAN CLINIC 166 3,281 1,565 5,012 0 194.00 194.01 07951 OTHER NRCC - WIC 59,755 0 0 59,755 66 194.00 194.02 07952 OTHER NRCC - PUBLIC RELATIONS 0 0 0 194.00 194.03 07953 OTHER NRCC - DR. OFFICE 0 2,095 999 3,094 0 194.00 194.04 07954 OTHER NRCC - MARKETING 0 0 0 0 194.00 194.04 07954 OTHER NRCC - MARKETING 0 0 0 194.00 194.04 07954 OTHER NRCC - MARKETING 0 0 0 0	52.00		I I			0		52.00
NORREIMBURSABLE COST CENTERS 190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 344 164 508 0 190.00 194.00 07950 OTHER NRCC - PHYSICIAN CLINIC 166 3,281 1,565 5,012 0 194.00 194.01 07951 OTHER NRCC - WIC 59,755 0 0 59,755 66 194.00 194.02 07952 OTHER NRCC - PUBLIC RELATIONS 0 0 0 194.00 194.03 07953 OTHER NRCC - DR. OFFICE 0 2,095 999 3,094 0 194.00 194.04 07954 OTHER NRCC - MARKETING 0 0 0 194.00 194.04 07954 OTHER NRCC - MARKETING 0 0 0 194.00 194.04 07954 OTHER NRCC - MARKETING 0 0 0 200.00 200.00 Cross Foot Adjustments 0 0 0 200.00 201.00 0 0 0 0 201.00 <td>118.00</td> <td></td> <td>1,264,562</td> <td>54.464</td> <td>25.97</td> <td>1,345,004</td> <td>774</td> <td>118.00</td>	118.00		1,264,562	54.464	25.97	1,345,004	774	118.00
190.00 190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 344 164 508 0 190.00 194.00 07950 OTHER NRCC - PHYSICIAN CLINIC 166 3,281 1,565 5,012 0 194.00 194.01 07951 OTHER NRCC - WIC 59,755 0 0 59,755 66 194.00 194.02 07952 OTHER NRCC - PUBLIC RELATIONS 0 0 0 194.00 194.03 07953 OTHER NRCC - DR. OFFICE 0 2,095 999 3,094 0 194.00 194.04 07954 OTHER NRCC - MARKETING 0 0 0 194.00 194.04 07954 OTHER NRCC - MARKETING 0 0 0 194.00 194.04 07954 OTHER NRCC - MARKETING 0 0 0 194.00 200.00 Cross Foot Adjustments 0 0 0 200.00 200.00 201.00 0 0 0 0 201.00 0 <td< td=""><td>00</td><td></td><td>_,,</td><td></td><td></td><td>_,_,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,</td><td></td><td>1</td></td<>	00		_,,			_,_,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		1
194.00 07950 OTHER NRCC - PHYSICIAN CLINIC 166 3,281 1,565 5,012 0 194.00 194.01 07951 OTHER NRCC - WIC 59,755 0 0 59,755 66 194.00 194.02 07952 OTHER NRCC - PUBLIC RELATIONS 0 0 0 0 194.00 194.03 07953 OTHER NRCC - DR. OFFICE 0 2,095 999 3,094 0 194.00 194.04 07954 OTHER NRCC - MARKETING 0 0 0 194.00 194.04 07954 OTHER NRCC - MARKETING 0 0 0 194.00 200.00 Cross Foot Adjustments 0 0 0 200.00 201.00 0 0 0 201.00	190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		16	54 508	0	190.00
194.01 07951 OTHER NRCC - WIC 59,755 0 0 59,755 66 194.0 194.02 07952 OTHER NRCC - PUBLIC RELATIONS 0 0 0 0 194.0 194.03 07953 OTHER NRCC - DR. OFFICE 0 2,095 999 3,094 0 194.0 194.04 07954 OTHER NRCC - MARKETING 0 0 0 194.0 200.00 Cross Foot Adjustments 0 0 0 200.0 201.00 Negative Cost Centers 0 0 0 0 201.00	194.00	07950 OTHER NRCC - PHYSICIAN CLINIC		3,281	1,50	55 5,012	0	194.00
194.02 07952 OTHER NRCC - PUBLIC RELATIONS 0 0 0 0 194.02 194.03 07953 OTHER NRCC - DR. OFFICE 0 2,095 999 3,094 0 194.02 194.04 07954 OTHER NRCC - MARKETING 0 0 0 194.02 194.02 200.00 Cross Foot Adjustments 0 0 0 200.02 0 0 200.02 201.00 Negative Cost Centers 0 0 0 0 201.02	194.01	07951 OTHER NRCC - WIC	59,755					
194.04 07954 OTHER NRCC - MARKETING 0 0 0 194.04 200.00 Cross Foot Adjustments 0 0 200.00			0	0		0 0		
200.00 Cross Foot Adjustments 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0 201.00			0	2,095	99		0	194.03
201.00 Negative Cost Centers 0 0 0 0 201.00			0	0		0 0		
		5				0		200.00
202.00 IUTAL (SUM TIMES IIS THYOUGH 201) 1,324,483 60,184 28,706 1,413,373 840 202.00			1 334 433	0	20 -	0 0		
	202.00		1,324,483	60,184	28,70	ב,413,373 און 1,413	840	202.00

ALLOC	ATION OF CAPITAL RELATED COSTS		Provider C		Period: From 07/01/2022 To 06/30/2023	Worksheet B Part II Date/Time Pre 11/24/2023 3:	pared: 50 pm
	Cost Center Description	PURCHASING RECEIVING AND STORES	CASHIERING/ACC OUNTS RECEIVABLE	OTHER ADMINISTRATIV AND GENERAL	e OPERATION OF	LAUNDRY & LINEN SERVICE	
		5.02	5.03	5.04	7.00	8.00	
	GENERAL SERVICE COST CENTERS	1		1			
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.02	00560 PURCHASING RECEIVING AND STORES	1,579					5.02
5.03	00580 CASHIERING/ACCOUNTS RECEIVABLE	0	2,824		~		5.03
5.04	00590 OTHER ADMINISTRATIVE AND GENERAL	C		356,65			5.04
7.00	00700 OPERATION OF PLANT	0					7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0		59		4,774	
9.00	00900 HOUSEKEEPING	7		0,00		370	9.00
10.00	01000 DIETARY	0		5,15		0	10.00
11.00	01100 CAFETERIA	C		3,12		0	11.00
13.00	01300 NURSING ADMINISTRATION	C		1 .,		0	13.00
14.00	01400 CENTRAL SERVICE & SUPPLY	C			5 5,413	0	14.00
15.00	01500 PHARMACY	2	0	7,35		0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	C			3 11,346	0	16.00
17.00	01700 SOCIAL SERVICE	C	0 0		0 0	0	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	716		, .	0 59,297	1,011	
31.00	03100 INTENSIVE CARE UNIT	0	-		0 0	0	31.00
40.00	04000 SUBPROVIDER - IPF	593		. , .		826	
41.00	04100 SUBPROVIDER - IRF	C			0 0	0	41.00
42.00	04200 SUBPROVIDER	0	0 0)	0 0	0	42.00
F0 00	ANCILLARY SERVICE COST CENTERS	42	1.00	10.02	0 27 225		1 50 00
50.00	05000 OPERATING ROOM	42		· · · ·	-	522	50.00
51.00	05100 RECOVERY ROOM		-		0 0	0	51.00
52.00 53.00	05200 DELIVERY ROOM & LABOR ROOM				0 0	0	52.00
	05300 ANESTHESIOLOGY				0 20 620	-	
54.00	05400 RADIOLOGY-DIAGNOSTIC	31			8 28,638	570	
59.00	05900 CARDIAC CATHETERIZATION	0	-		0 0	0	59.00
60.00	06000 LABORATORY	13		,		171	60.00
65.00	06500 RESPIRATORY THERAPY	19		,		0	65.00
66.00	06600 PHYSICAL THERAPY	79		,.		201	66.00
67.00	06700 OCCUPATIONAL THERAPY	0		,		139	
68.00	06800 SPEECH PATHOLOGY					6	68.0
69.00	06900 ELECTROCARDIOLOGY				0 0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS			· · · ·		0	71.00
72.00							72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	L C	0 122	5,66	0 0	0	73.00
90.00	OUTPATIENT SERVICE COST CENTERS	C		J	0	0	90.00
90.00	09000 CLINIC 09100 EMERGENCY	40	-	62 74		958	
91.00		40	585	63,74	0 22,180	928	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS		I	I			92.00
118.0		1,542	2,824	337,15	9 302,866	1 771	118.00
110.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	1, 542	2,024	1 357,15	5 502,800	4,//4	1110.00
100 0	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		1	3 2,704	0	190.00
	07950 OTHER NRCC - PHYSICIAN CLINIC		-	17			194.00
	LO7951 OTHER NRCC - WIC	37		19,22			194.00
	207952 OTHER NRCC - WIC	57		19,22	0		194.02
	07952 OTHER NRCC - POBLIC RELATIONS		-	-	6 16,453		194.02
	107955 OTHER NRCC - DR. OFFICE			1	6 16,453		194.0
					0	0	200.00
200.0		-			0	0	200.00
		, U	// U	1	0 0	0	1201.00
201.0		1,579	2,824	356,65	0 347,789	4,774	

ALLOC	ATION OF CAPITAL RELATED COSTS		Provider CC		Period: From 07/01/2022 To 06/30/2023	Worksheet B Part II Date/Time Pre 11/24/2023 3:	
	Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICE & SUPPLY	
		9.00	10.00	11.00	13.00	14.00	
	GENERAL SERVICE COST CENTERS						1
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.02 5.03	00560 PURCHASING RECEIVING AND STORES						5.02
5.05	00580 CASHIERING/ACCOUNTS RECEIVABLE 00590 OTHER ADMINISTRATIVE AND GENERAL						5.04
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPING	18,847					9.00
10.00	01000 DIETARY	10,047	31,520				10.00
11.00	01100 CAFETERIA	113	0	14,46	7		11.00
13.00	01300 NURSING ADMINISTRATION	0	0	81			13.00
14.00	01400 CENTRAL SERVICE & SUPPLY	0	0		0 0	6,456	
15.00	01500 PHARMACY	303	0	41		0,150	
16.00	01600 MEDICAL RECORDS & LIBRARY	62	0		0 0	0	
17.00	01700 SOCIAL SERVICE	0	0		0 0	0	
	INPATIENT ROUTINE SERVICE COST CENTERS	· · · · ·			<u> </u>		
30.00	03000 ADULTS & PEDIATRICS	6,483	17,239	2,74	0 6,875	0	30.00
31.00	03100 INTENSIVE CARE UNIT	0	0		0 0	0	
40.00	04000 SUBPROVIDER - IPF	4,158	14,281	2,51	.8 4,019	0	40.00
41.00	04100 SUBPROVIDER - IRF	0	0		0 0	0	41.00
42.00	04200 SUBPROVIDER	0	0		0 0	0	42.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	570	0	88	8 1,854	0	50.00
51.00	05100 RECOVERY ROOM	0	0		0 0	0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	
53.00	05300 ANESTHESIOLOGY	0	0		0 0	0	
54.00	05400 RADIOLOGY-DIAGNOSTIC	932	0	1,75		0	
59.00	05900 CARDIAC CATHETERIZATION	0	0		0 0	0	
60.00	06000 LABORATORY	722	0	62		0	1 00.00
65.00	06500 RESPIRATORY THERAPY	173	0	72		0	
66.00	06600 PHYSICAL THERAPY	450	0		6 0	0	
67.00	06700 OCCUPATIONAL THERAPY	309	0		0 0	0	
68.00	06800 SPEECH PATHOLOGY	13	0		3 0	0	
69.00	06900 ELECTROCARDIOLOGY	0	0		0 0	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	6,456	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	U		0 0	0	73.00
90.00	OUTPATIENT SERVICE COST CENTERS	0	0		0 0	0	90.00
90.00	09100 EMERGENCY	2,472	0	2,25	с -	0	
92.00		2,472	0	2,23	7,190	0	92.00
52.00	SPECIAL PURPOSE COST CENTERS						52.00
118.00		16,760	31,520	12,75	2 20,169	6 456	118.00
	NONREIMBURSABLE COST CENTERS	20,.00	51,520	,75	20,200	0,100	1
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190.00
	07950 OTHER NRCC - PHYSICIAN CLINIC	1,634	0		0 0		194.00
	1 07951 OTHER NRCC - WIC	453	0	1,71	.5 3,088	0	194.01
	2 07952 OTHER NRCC - PUBLIC RELATIONS	0	0		0 0	0	194.02
	3 07953 OTHER NRCC - DR. OFFICE	0	0		0 0		194.03
	4 07954 OTHER NRCC - MARKETING	0	0		0 0		194.04
200.00	Cross Foot Adjustments						200.00
		0	0		0 0	0	201.00
201.00		U U	0			0	

LIBRARY LIBRARY LIBRARY September Adjustments Adjustments 00 00100 (CAP REL COST CENTERS 15.00 17.00 24.00 25.00 100 00100 (CAP REL COST SHDG & FINT (COST) 15.00 17.00 24.00 25.00 100 00400 EMPLOYCE BENEFITS DEPARITMENT (COST) 16.00 17.00 24.00 24.00 25.00 100 00400 EMPLOYCE BENEFITS DEPARITMENT (COST) 16.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 13.595 0 1<		ON OF CAPITAL RELATED COSTS		Provider C	CN: 15-1325	Period: From 07/01/2022 To 06/30/2023	Worksheet B Part II Date/Time Pre 11/24/2023 3:	
Description Description 00 00100100102 PR RL COSTS-ENDEG & FIXT 000 004000 PRUVCEE BINERIS DEDG & FIXT 000 004000 PRUVCEE BINERIS DEDG & FIXT 000 00560 PURCHASING RECEIVING AND STORES 005560 PURCHASING RECEIVING AND STORES 005560 PURCHASING RECEIVING AND STORES 000 00500 OLIVES REPERVE 00 007000 DEPEATION OF PLANT 000 00500 OLIVESKEEPING 000 00000 OLIVESKEEPING 000 00000 OLIVESKEEPING 000 0000 OLIVESKEEPING 000 0000 OLIVESKEEPING 000 0000 0000 OLIVESKEEPING 000 0000 000 00 0 000 0000 0000 OLIVESKEEPING 000 0000 0000 OLIVESKEEPING 000 0000 000 00 0 000 0000 0000 000 0 000 0000 0000 000 0 000 0000 0000 0 000 0000 0000 0 000 0000 0000 0 000 0000 0 000 0000 0 000 0000 0 000 0		Cost Center Description	PHARMACY	RECORDS &	SOCIAL SERVI		Residents Cost & Post	
1.00 0100 CAP REL COST-SHUG & FIXT 1.00 02000 CAP REL COST-SHUG & FIXT 1.00 0400 EMPLOYEE BENETI'S DEPARTMENT 1.00 02000 CAPRICASI'S RECEIVABLE 1.00 00000 CASHEERING/ACCOUNTS RECEIVABLE 1.00 00000 CASHEERING/ACCOUNTS RECEIVABLE 1.00 00000 CHAR ADMINISTRATIVE AND GENERAL 1.00 00000 CHANGES AL DEPART 1.00 01000 CEFTARY 1.00 01000 CEFTARY 1.00 01000 CEFTARY 1.00 01000 CEFTARY 1.00 01000 CEFTARY 1.00 01000 CEFTARY 1.00 01000 CETTARY 1.00 0100 CETTARY 1.			15.00	16.00	17.00	24.00	25.00	
0.00 0.00 <td< td=""><td>GE</td><td>NERAL SERVICE COST CENTERS</td><td></td><td></td><td></td><td></td><td></td><td></td></td<>	GE	NERAL SERVICE COST CENTERS						
0.00 04000 EMPLOYCE BENEFITS DEPARTMENT 0 00 00560 CASHIEERING ACCOUNTS RECEIVABLE 0 0.00 00580 CASHIEERING ACCOUNTS RECEIVABLE 0 0.00 00500 DERATATIVE AND GENERAL 0 0.00 00700 OPERATION OF PLANT 0 0.00 00800 HOUNDRY & LINEW SERVICE 0 0.00 00000 DIOSENCEATINE SERVICE & SUPPLY 5 0.00 01000 DEFARY 0 13,595 0.00 01000 DEFARY 0 13,595 0.00 01000 DEFARY 0 0 0.00 01000 DEFARY 0 0 0.00 01000 DEFARY 0 0 0 0.00 01000 DEFARY 0 0 0 0 0.00 01000 DEFARY 0 145,828 0 145,828 0.00 00 0 0 0 0 0	00 00	100 CAP REL COSTS-BLDG & FIXT						1
02 00560 PURCHASTNG RECEIVING AND STORES 00580 CASHERERNG/ACCOUNTS RECEIVABLE 04 00590 OTHER ADMINISTRATIVE AND GENERAL 00 00700 OPERATION OF PLANT 00 00900 LAUNDRY & LINEN SERVICE 00 00900 OURSEKEEPING 00 00900 CHERARD SAMURISTRATION 100 01000 CHERARD SERVICE & SUPPLY 100 01000 CHERARD SERVICE & SUPPLY 100 01000 CHERARD SERVICE OST CENTERS 100 01000 CHERARD SERVICE COST CENTERS 100 03000 ADULTS & PEDIATRICS 100 04000 SUBPROVIDER - IPF 00 0300 OBPROVIDER - IFF 00 0300 OBPROVIDER - IFF 00 0300 OPENATING ROOM 100 0400 SUBPROVIDER - IFF 00 0300 OPENATING ROOM 100 0400 SUBPROVIDER - IFF 00 0500 OPENATING ROOM 100 0400 SUBPROVIDER - IFF 00 0500 OPENATING ROOM 100 0400 SUBPROVIDER - IFF 100 0500 OPENATING ROOM 100 0400 SUBPROVIDER - IFF 100 0500 OPENATING ROOM 100 0500 0ENTERSIVE COST CENTERS 100 0500	00 00	200 CAP REL COSTS-MVBLE EQUIP						2
03 00580 CASHIERING/ACCOUNTS RECEIVABLE 04 00590 OPTRA ADVINISTRATIVE AND GENERAL 00 00700 OPERATION OF PLANT 00 00800 HOUSEKEEPING 00 00800 HOUSEKEEPING 00 01000 DETARY 00 01000 DETARY 00 01000 CAFFTERIA 00 0000 CATA SERVICE COST CENTERS 00 000 0 0 0 00 0 0 00 0	00 00	0400 EMPLOYEE BENEFITS DEPARTMENT						4
04 00590 OTHER ADMINISTRATIVE AND GENERAL 00 00500 LAUNDRY & LINEN SERVICE 00 00500 LAUNDRY & LINEN SERVICE 00 01000 DEFARITON OF PLANT 00 01000 DEFARITON SERVICE 00 0100 CAPTRAL SERVICE & SUPPLY 00 0100 DEFARAL SERVICE 0 00 0100 DEFARAL SERVICE COST CENTERS INPATTEM TOUTIME SERVICE COST CENTERS 00 03000 ADULTS & PEDIATRICS 2 834 0 148,828 00 03000 SUBPROVIDER - 1PF 0 0 0 0 0 0 00 03000 SUBPROVIDER - 1PF 0 867 0 131,763 00 04000 SUBPROVIDER - 1PF 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 <t< td=""><td>00 20</td><td>560 PURCHASING RECEIVING AND STORES</td><td></td><td></td><td></td><td></td><td></td><td>5</td></t<>	00 20	560 PURCHASING RECEIVING AND STORES						5
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000 00000 HOUSEKEEPING Image: Constraint of the second	00 00	0800 LAUNDRY & LINEN SERVICE						8
00 0100 CAFETERIA 00 01300 NURSING ADMINISTRATION 01400 Impact Administration 01400 Impact Administration 0100 Impact Administration 00 Impact Administratid 00 Impact Administratid 00								9
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THPATIENT ROUTINE SERVICE COST CENTERS 000 03000 ADULTS & PEDIATRICS 2 834 0 148,828 001 03100 INTENSIVE CARE UNIT 0 0 0 0 001 04000 SUBPROVIDER - IPF 0 867 0 191,763 001 04100 SUBPROVIDER - IRF 0 0 0 0 00100 GENERATING ROOM 26 793 0 184,849 000 05000 OPERATING ROOM 0 0 0 0 000 05100 RECOVERY ROOM 0 0 0 0 0 000 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0 0 000 05300 ANESTHESIOLOGY 0 0 0 0 0 0 000 05400 RABORATCATHETESIOLOGY 1 2,309 0 60,102 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 2,204						0		17
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00 05000 OPERATING ROOM 26 793 0 184,849 00 05100 RECOVERY ROOM & 0 0 0 0 00 05200 DELIVERY ROOM & 0 0 0 0 00 05200 DELIVERY ROOM & 0 0 0 0 00 05200 DARDIOLOGY-DIAGNOSTIC 19 4,514 0 447,735 00 05000 CARDIAC CATHETERIZATION 0 0 0 0 00 06400 LABORATORY 1 2,309 0 60,102 00 06500 RESPIRATORY THERAPY 0 187 0 27,204 00 06600 OCUPATIONAL THERAPY 0 145 0 15,743 00 06600 DECTR PATHOLOGY 0 10 0 0 00 06300 DELCTRO CARDIAL CHERAPY 0 145 0 15,743 00 06000 LECTROCARDIOLOGY	.00 04	200 SUBPROVIDER	0	C		0 0	0	42
00 05100 RECOVERY ROOM 0 0 0 0 00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0 00 05300 ARSTHESIDLOGY 0 0 0 0 00 05400 ANDIOLOGY-DIAGNOSTIC 19 4,514 0 447,735 00 05000 CARDIAC CATHETERIZATION 0 0 0 0 00 06000 LABORATORY 1 2,309 0 60,102 00 066000 LABORATORY 0 187 0 27,204 00 066000 OCCUPATIONAL THERAPY 0 145 0 15,743 00 066000 CARDIOLOGY 0 10 0 0 00 06700 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 100 9,029 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 8,712 584 0 15,078 00 00000 CLINIC	AN	ICILLARY SERVICE COST CENTERS						1
00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0 00 05300 ANESTHESIOLOGY 0 <td< td=""><td>.00 05</td><td>5000 OPERATING ROOM</td><td>26</td><td>793</td><td></td><td>0 184,849</td><td>0</td><td>50</td></td<>	.00 05	5000 OPERATING ROOM	26	793		0 184,849	0	50
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00 06900 ELECTROCARDIOLOGY 0			0	145		0 15,743	0	67
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 100 0 9,029 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 62 0 863 00 07300 DRUGS CHARGED TO PATIENTS 8,712 584 0 15,078 00TPATIENT SERVICE COST CENTERS 0 0 0 0 0 00 09000 CLINIC 0 0 0 0 00 09100 EMERGENCY 17 2,828 0 142,819 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 17 2,828 0 1,273,597 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 8,777 13,595 0 1,273,597 NONREIMBURSABLE COST CENTERS NONREIMBURSABLE COST CENTERS 0.00 0 0 0 3,225 0.00 0750 OTHER NRCC - PHYSICIAN CLINIC 0 0 0 3,225 <			0	11	-	0 509	0	
00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 62 0 863 00 07300 DRUGS CHARGED TO PATIENTS 8,712 584 0 15,078 00 09000 CLINIC 0 0 0 0 00 09100 EMERGENCY 17 2,828 0 142,819 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 17 2,828 0 1,273,597 00 09200 OBSERVATION BEDS (SUM OF LINES 1 through 117) 8,777 13,595 0 1,273,597 NONREIMBURSABLE COST CENTERS 0.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 3,225 0.00 07550 OTHER NRCC - PHYSICIAN CLINIC 0 0 0 3,225 0.01 07951 OTHER NRCC - PUBLIC RELATIONS 0 0 0 0 0.02 07952 OTHER NRCC - PUBLIC RELATIONS 0 0 0 0 0.03 07954 OTHER NRCC - MAR			0			0 0	0	1 .
07300 DRUGS CHARGED TO PATIENTS 8,712 584 0 15,078 001741ENT SERVICE COST CENTERS 0 <t< td=""><td></td><td></td><td>0</td><td></td><td></td><td></td><td>0</td><td></td></t<>			0				0	
OUTPATIENT SERVICE COST CENTERS 00 09000 CLINIC 0 0 0 00 09100 EMERGENCY 17 2,828 0 142,819 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 17 2,828 0 142,819 SPECIAL PURPOSE COST CENTERS 5 5 0 1,273,597 13,595 0 1,273,597 NONREIMBURSABLE COST CENTERS 5 0 1,273,597 13,595 0 1,273,597 NONREIMBURSABLE COST CENTERS 5 0 0 0 3,225 0.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 3,225 1.01 07950 OTHER NRCC - PHYSICIAN CLINIC 0 0 0 32,587 1.01 07951 OTHER NRCC - VIC 0 0 0 0 0 1.02 07952 OTHER NRCC - PUBLIC RELATIONS 0 0 0 0 0 0 1.03 07954 <t< td=""><td></td><td></td><td>-</td><td></td><td></td><td></td><td>0</td><td></td></t<>			-				0	
00 09000 CLINIC 0 0 0 0 00 09100 EMERGENCY 17 2,828 0 142,819 09200 DBSERVATION BEDS (NON-DISTINCT PART) 17 2,828 0 142,819 SPECIAL PURPOSE COST CENTERS SPECIAL PURPOSE COST CENTERS NONREIMBURSABLE COST CENTERS NONREIMBURSABLE COST CENTERS 0 0 0 3,225 0 0 0 32,587 4.00 0 0 0 0 0 0 0 0 0 0 0 0 0 32,587 4.0107951 OTHER NRCC - PHYSICIAN CLINIC 0 0 0 0 0			8,712	584	+	0 15,078	0	73
OO OBJOU EMERGENCY 17 2,828 0 142,819 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 17 2,828 0 142,819 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 8,777 13,595 0 1,273,597 NONREIMBURSABLE COST CENTERS U <thu< th=""> <thu< th=""> <thu< th=""></thu<></thu<></thu<>					1			4.
09200 OBSERVATION BEDS (NON-DISTINCT PART) O O SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 8,777 13,595 0 1,273,597 NONRETEMBURSABLE COST CENTERS NONRETENBURSABLE COST CENTERS 0.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 3,225 0.00 0 OTHER NRCC - PHYSICIAN CLINIC 0 0 32,587 4.00 07950 OTHER NRCC - PUBLIC RELATIONS 0 0 84,341 4.02 07952 OTHER NRCC - PUBLIC RELATIONS 0 0 0 4.03 07953 OTHER NRCC - DR. OFFICE 0 0 19,623 4.04 07954 OTHER NRCC - MARKETING 0 0 0 0.00 Cross Foot Adjustments 0 0 0 0						°		90
SPECIAL PURPOSE COST CENTERS SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 8,777 13,595 0 1,273,597 NONREIMBURSABLE COST CENTERS NONREIMBURSABLE COST CENTERS 0.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 3,225 0.01 07950 OTHER NRCC - PHYSICIAN CLINIC 0 0 32,587 4.01 07951 OTHER NRCC - PUBLIC RELATIONS 0 0 84,341 4.02 07952 OTHER NRCC - DR. OFFICE 0 0 0 0 4.03 07953 OTHER NRCC - DR. OFFICE 0 0 0 0 4.04 07954 OTHER NRCC - MARKETING 0 0 0 0 00 0 0 0 0 0 0 0			17	2,828	5	U 142,819		91
SUBTOTALS (SUM OF LINES 1 through 117) 8,777 13,595 0 1,273,597 NONREIMBURSABLE COST CENTERS							0	92
NONREIMBURSABLE COST CENTERS 0.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 3,225 0.00 O7950 OTHER NRCC - PHYSICIAN CLINIC 0 0 32,587 0.01 07951 OTHER NRCC - WIC 0 0 0 84,341 0.02 07952 OTHER NRCC - PUBLIC RELATIONS 0 0 0 0 0.03 07953 OTHER NRCC - MARKETING 0 0 0 0 1.03 07954 OTHER NRCC - MARKETING 0 0 0 0 0.04 07954 OTHER NRCC - MARKETING 0 0 0 0 0.04 07954 OTHER NRCC - MARKETING 0 0 0 0			0 777	12 505		0 1 272 507		1110
0.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 3,225 4.00 07950 OTHER NRCC - PHYSICIAN CLINIC 0 0 32,587 4.01 07951 OTHER NRCC - WIC 0 0 0 84,341 4.02 07952 OTHER NRCC - PUBLIC RELATIONS 0 0 0 0 4.03 07953 OTHER NRCC - MARKETING 0 0 19,623 0.04 07954 OTHER NRCC - MARKETING 0 0 0 0.00 Cross Foot Adjustments 0 0 0 0			8,///	13,595	1	U 1,2/3,59/	0	118
1.00 07950 OTHER NRCC - PHYSICIAN CLINIC 0 0 32,587 1.01 07951 OTHER NRCC - WIC 0 0 84,341 1.02 07952 OTHER NRCC - PUBLIC RELATIONS 0 0 0 1.03 07953 OTHER NRCC - DR. OFFICE 0 0 0 1.04 07954 OTHER NRCC - MARKETING 0 0 0 0.00 Cross Foot Adjustments 0 0 0		NIKELMOUKSABLE CUSI CENIEKS	0	·	1	0 2.225	<u>^</u>	1100
4.01 07951 OTHER NRCC - WIC 0 0 84,341 4.02 07952 OTHER NRCC - PUBLIC RELATIONS 0 0 0 0 4.03 07953 OTHER NRCC - DR. OFFICE 0 0 0 19,623 4.04 07954 OTHER NRCC - MARKETING 0 0 0 0 0.00 Cross Foot Adjustments 0 0 0 0								190
1.02 07952 OTHER NRCC - PUBLIC RELATIONS 0 0 0 1.03 07953 OTHER NRCC - DR. OFFICE 0 0 0 19,623 1.04 07954 OTHER NRCC - MARKETING 0 0 0 0 0.00 Cross Foot Adjustments 0 0 0 0			0	(194
4.03 07953 OTHER NRCC - DR. OFFICE 0 0 19,623 4.04 07954 OTHER NRCC - MARKETING 0 0 0 0.00 Cross Foot Adjustments 0 0 0			0	(0 84,341		194
1.04 07954 OTHER NRCC - MARKETING 0 0 0 0.00 Cross Foot Adjustments 0 0 0			0	(0 10 000		194
0.00 Cross Foot Adjustments 0			0	(U 19,623		194
			0	C		U 0		194
				-		0		200
I.00 Negative cost centers 0 <td></td> <td>Negative Cost Centers</td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td></td> <td>201</td>		Negative Cost Centers	0	0		0 0		201

ALLOCATIO	ON OF CAPITAL RELATED COSTS		Provider CCN: 15-1325	Period: From 07/01/2022	Worksheet B Part II
				то 06/30/2023	Date/Time Prepared 11/24/2023 3:50 pm
	Cost Center Description	Total	·		
GE	NERAL SERVICE COST CENTERS	26.00			
	100 CAP REL COSTS-BLDG & FIXT				1.
	200 CAP REL COSTS-MVBLE EQUIP				2.
	400 EMPLOYEE BENEFITS DEPARTMENT				4.
	560 PURCHASING RECEIVING AND STORES				5.
	0580 CASHIERING/ACCOUNTS RECEIVABLE				5.
	0590 OTHER ADMINISTRATIVE AND GENERAL				5.
	0700 OPERATION OF PLANT				7.
	0800 LAUNDRY & LINEN SERVICE				8.
	0900 HOUSEKEEPING				9.
	.000 DIETARY				10.
	100 CAFETERIA				11.
	300 NURSING ADMINISTRATION				13.
	400 CENTRAL SERVICE & SUPPLY				14.
	500 PHARMACY				15.
	.600 MEDICAL RECORDS & LIBRARY				16.
	.700 SOCIAL SERVICE				17.
	PATIENT ROUTINE SERVICE COST CENTERS	I			
	000 ADULTS & PEDIATRICS	148,828			30.
	100 INTENSIVE CARE UNIT	110,020			31.
	000 SUBPROVIDER - IPF	191,763			40.
	100 SUBPROVIDER - IRF	191,709			41.
	200 SUBPROVIDER	0			42.
	CILLARY SERVICE COST CENTERS				
	000 OPERATING ROOM	184,849			50.
	100 RECOVERY ROOM	104,045			51.
	200 DELIVERY ROOM & LABOR ROOM	0			52.
	300 ANESTHESIOLOGY	0			53.
	400 RADIOLOGY-DIAGNOSTIC	447,735			54.
	900 CARDIAC CATHETERIZATION	1,755			59.
	5000 LABORATORY	60,102			60.
	5500 RESPIRATORY THERAPY	29,075			65.
	600 PHYSICAL THERAPY	27,204			66.
	000 OCCUPATIONAL THERAPY	15,743			67.
	5800 SPEECH PATHOLOGY	509			68.
	5900 ELECTROCARDIOLOGY	000			69.
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	9,029			71.
	200 IMPL. DEV. CHARGED TO PATIENTS	863			72.
	300 DRUGS CHARGED TO PATIENTS	15,078			72.
	TPATIENT SERVICE COST CENTERS	15,070			/
	0000 CLINIC	0			90.
	0100 ELINIC 0100 EMERGENCY	142,819			90.
		142,019			92.
	2000 OBSERVATION BEDS (NON-DISTINCT PART)				92.
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	1,273,597			118.
	NREIMBURSABLE COST CENTERS	1,273,397			110.
	0000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,225			190.
	2950 OTHER NRCC - PHYSICIAN CLINIC	32,587			190.
					194.
	7951 OTHER NRCC - WIC	84,341			
194.0207	7952 OTHER NRCC - PUBLIC RELATIONS	10 (22)			194.
194.0307	7953 OTHER NRCC - DR. OFFICE	19,623			194.
	'954 OTHER NRCC - MARKETING	0			194.
200.00	Cross Foot Adjustments	0			200.
201.00	Negative Cost Centers	0			201.
202.00	TOTAL (sum lines 118 through 201)	1,413,373			202.

	Financial Systems A LLOCATION - STATISTICAL BASIS	SCENSION ST. V	Provider CO	CN: 15-1325 P	eriod:	worksheet B-1	
				F	rom 07/01/2022 o 06/30/2023		
		CAPITAL REL	ATED COSTS			11/24/2023 3:	50 pm
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS	PURCHASING RECEIVING AND STORES (COST OF	CASHIERING/ACC OUNTS RECEIVABLE (GROSS	
		1.00	2.00	SALARIES) 4.00	SUPPLIES) 5.02	CHARGES) 5.03	
	GENERAL SERVICE COST CENTERS	1.00	2.00	4.00	5.02	5.05	
	00100 CAP REL COSTS-BLDG & FIXT	75,527					1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		75,527				2.00
1	00400 EMPLOYEE BENEFITS DEPARTMENT	714	714	5,654,056			4.00
5.02 5.03	00560 PURCHASING RECEIVING AND STORES 00580 CASHIERING/ACCOUNTS RECEIVABLE	1,342 2,400	1,342 2,400	425	7,961	61,574,515	5.02
	00590 OTHER ADMINISTRATIVE AND GENERAL	10,006	10,006	171,502	0	01, 574, 515	1
	00700 OPERATION OF PLANT	5,493	5,493	0	-	0	
8.00	00800 LAUNDRY & LINEN SERVICE	562	562	0	0	0	8.00
9.00	00900 HOUSEKEEPING	1,367	1,367	0	36	0	9.00
	01000 DIETARY	3,191	3,191	0	0	0	10.00
	01100 CAFETERIA 01300 NURSING ADMINISTRATION	1,161	1,161 266	353,876	0	0	11.00
	01400 CENTRAL SERVICE & SUPPLY	865	865	0	0	0	14.00
	01500 PHARMACY	1,222		245,852	8	0	15.00
	01600 MEDICAL RECORDS & LIBRARY	1,813	1,813	0	0	0	16.00
	01700 SOCIAL SERVICE	0	0	0	0	0	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS	0.475	0.475	1 005 404	2 612	2 771 002	1 20 00
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	9,475	9,475	1,005,494	3,613	3,771,882	1
	04000 SUBPROVIDER - IPF	6,747	6,747	898,153	2,992	3,922,725	
	04100 SUBPROVIDER - IRF	0	0	0		0	1
42.00	04200 SUBPROVIDER	0	0	0	0	0	42.00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM 05100 RECOVERY ROOM	5,964	5,964	329,841	210	3,586,320	
	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	
	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	4,576	4,576	751,622	155	20,486,822	54.00
	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
	06000 LABORATORY	2,387	2,387	119,867	67	10,447,831	1
	06500 RESPIRATORY THERAPY 06600 PHYSICAL THERAPY	963 2,673	963 2,673	263,790 11,108		1,631,876 845,575	1
	06700 OCCUPATIONAL THERAPY	1,577	1,577	11,418		657,548	
	06800 SPEECH PATHOLOGY	41	41	1,291		48,979	
	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	454,047	
	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	280,050 2,643,130	
	OUTPATIENT SERVICE COST CENTERS	0	0	0	0	2,043,130	1 / 5.00
	09000 CLINIC	0	0	0	0	0	90.00
	09100 EMERGENCY	3,544	3,544	1,043,647	201	12,797,730	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	68,349	68,349	5,207,886	7,775	61,574,515	118 00
	NONREIMBURSABLE COST CENTERS	00,549	00,549	3,207,880	7,775	01, 374, 313	1110.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	432	432	0	0	0	190.00
	07950 OTHER NRCC - PHYSICIAN CLINIC	4,117	4,117	0	0		194.00
	07951 OTHER NRCC - WIC	0	0	446,170			194.01
	07952 OTHER NRCC - PUBLIC RELATIONS	0	0	0	0		194.02
	07953 OTHER NRCC - DR. OFFICE 07954 OTHER NRCC - MARKETING	2,629	2,629	0	-		194.03
200.00		0	0	0	0	Ů	200.00
201.00	5						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	60,184	28,706	1,693,308	18,272	23,093	202.00
203.00 204.00	Unit cost multiplier (Wkst. B, Part I)	0.796854	0.380076	0.299486 840			203.00
205.00	Part II)			0.000149			
205.00	II)			0.0001+3	0.130342	0.00040	205.00
	(per Wkst. B-2)						
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

OST AL	Financial Systems / LOCATION - STATISTICAL BASIS		INCENT WARRICK Provider C		Period:	u of Form CMS- Worksheet B-1	
					rom 07/01/2022 o 06/30/2023	Date/Time Pre 11/24/2023 3:	
	Cost Center Description	Reconciliatior	ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF	HOUSEKEEPING (MINUTES OF SERVICE)	
		5.04	(ACCUM. COST)		LAUNDRY)		<u> </u>
		5A.04	5.04	7.00	8.00	9.00	-
	ENERAL SERVICE COST CENTERS	1	1				1 1
	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						2
	00400 EMPLOYEE BENEFITS DEPARTMENT						4
	00560 PURCHASING RECEIVING AND STORES						5
	00580 CASHIERING/ACCOUNTS RECEIVABLE						5
	00590 OTHER ADMINISTRATIVE AND GENERAL	-4,897,375	14,438,693				5
	00700 OPERATION OF PLANT	4,057,575	1,126,204		,		7
	00800 LAUNDRY & LINEN SERVICE		24,079				8
	00900 HOUSEKEEPING		336,245			48,455	
	01000 DIETARY		220,745				
	01100 CAFETERIA		231,661	1,161		290	
	01300 NURSING ADMINISTRATION		595,010			0	1
	01400 CENTRAL SERVICE & SUPPLY	0	1,018			0	1
	01500 PHARMACY	0	297,835		-	780	
	01600 MEDICAL RECORDS & LIBRARY	0	2,134			160	
	01700 SOCIAL SERVICE	0	0			0	
	INPATIENT ROUTINE SERVICE COST CENTERS						1 - '
	03000 ADULTS & PEDIATRICS	0	1,422,209	9,475	2,295	16,670	30
	03100 INTENSIVE CARE UNIT	0	0	(0	
	04000 SUBPROVIDER - IPF	0	2,096,877	6,747	1,875	10,690	
	04100 SUBPROVIDER - IRF	0	0	0,11		0	
	04200 SUBPROVIDER	0	0		0	0	
-	NCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	681,338	5,964	1,185	1,465	50
	05100 RECOVERY ROOM	0	0	(_,0	
)5200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	
	05300 ANESTHESIOLOGY	0			0	0	53
	05400 RADIOLOGY-DIAGNOSTIC	0	1,464,251	4,576	1,295	2,395	
	5900 CARDIAC CATHETERIZATION	0	0) 0	0	
0.00	06000 LABORATORY	0	1,539,124	2,387	389	1,855	60
5.00 0	06500 RESPIRATORY THERAPY	0	361,956	963	0	445	65
5.00 0	06600 PHYSICAL THERAPY	0	164,766	2,673	457	1,156	66
7.00 0	06700 OCCUPATIONAL THERAPY	0	136,551	1,577	315	795	67
3.00 0	06800 SPEECH PATHOLOGY	0	6,817	41	13	34	68
9.00 0	06900 ELECTROCARDIOLOGY	0	0 0	0	0 0	0	69
1.00 0	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	99,248	(0 0	0	71
)7200 IMPL. DEV. CHARGED TO PATIENTS	0	31,891	. c	0 0	0	72
3.00 0	07300 DRUGS CHARGED TO PATIENTS	0	229,134	(c	0 0	0	73
0	OUTPATIENT SERVICE COST CENTERS						
	09000 CLINIC	C				0	
1.00 0	09100 EMERGENCY	C	2,580,533	3,544	2,175	6,355	91
2.00 0	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92
S	PECIAL PURPOSE COST CENTERS						
.00	SUBTOTALS (SUM OF LINES 1 through 117)	-4,897,375	13,649,626	48,394	10,838	43,090	118
	IONREIMBURSABLE COST CENTERS						
	L9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	C	508				190
	07950 OTHER NRCC - PHYSICIAN CLINIC	0	7,066			4,200	
	07951 OTHER NRCC - WIC	0	778,399		-	1,165	
	07952 OTHER NRCC - PUBLIC RELATIONS	0	0	0	-		194
	07953 OTHER NRCC - DR. OFFICE	0	3,094	2,629	0		194
	07954 OTHER NRCC - MARKETING	0	0 0	0	0 0	0	194
0.00	Cross Foot Adjustments						200
1.00	Negative Cost Centers						201
02.00	Cost to be allocated (per Wkst. B,		4,897,375	1,508,194	47,498	491,071	202
	Part I)					10 10 15	000
03.00	Unit cost multiplier (Wkst. B, Part I)		0.339184				
04.00	Cost to be allocated (per Wkst. B,		356,650	347,789	4,774	18,847	204
	Part II)		0.001555			0 0000	
05.00	Unit cost multiplier (Wkst. B, Part		0.024701	6.258350	0.440487	0.388959	205
06.00	II) NAHE adjustment amount to be allocated						206
00.00	(per Wkst. B-2)						200
07.00	NAHE unit cost multiplier (Wkst. D,						207
	Parts III and IV)	1	1	1			1.11

COST A	Financial Systems A LLOCATION - STATISTICAL BASIS	ASCENSION ST. VI		CN: 15-1325	Period:	u of Form CMS- Worksheet B-1	
					From 07/01/2022 To 06/30/2023	Date/Time Pre 11/24/2023 3:	pared
	Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (MANHOURS)	NURSING ADMINISTRATIC (NURSING HOURS)	CENTRAL ON SERVICE & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
		10.00	11.00	13.00	14.00	15.00	
	GENERAL SERVICE COST CENTERS	1 1		1			
1.00 2.00 4.00 5.02 5.03 5.04 7.00 8.00 9.00 10.00 11.00 13.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00560 PURCHASING RECEIVING AND STORES 00580 CASHIERING/ACCOUNTS RECEIVABLE 00590 OTHER ADMINISTRATIVE AND GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION	15,163 0	134,305 7,560				1.0 2.0 4.0 5.0 5.0 7.0 8.0 9.0 10.0 11.0 13.0
	01400 CENTRAL SERVICE & SUPPLY	0	7,500	07,41	0 100		14.0
	01500 PHARMACY	0	3,864		0 0	229,772	
16.00	01600 MEDICAL RECORDS & LIBRARY	0	Ć		0 0	0	
17.00	01700 SOCIAL SERVICE	0	0		0 0	0	17.0
20 00	INPATIENT ROUTINE SERVICE COST CENTERS	× 202	25 423	10.07	28 0	/1	20.0
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	8,293	25,423			41	
	04000 SUBPROVIDER - IPF	6,870	23,375			11	
41.00	04100 SUBPROVIDER - IRF	0	Ć		0 0	0	41.0
42.00	04200 SUBPROVIDER	0			0 0	0	42.0
	ANCILLARY SERVICE COST CENTERS		9 245		7.5	697	50.0
	05000 OPERATING ROOM 05100 RECOVERY ROOM	0	8,247		75 0 0 0	687 0	
	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	
	05300 ANESTHESIOLOGY	0	C		0 0	0	53.0
	05400 RADIOLOGY-DIAGNOSTIC	0	16,250		0 0	506	
59.00 60.00	05900 CARDIAC CATHETERIZATION 06000 LABORATORY	0	(E 769		0 0	0 31	
	06500 RESPIRATORY THERAPY	0	5,768 6,697		-	0	
	06600 PHYSICAL THERAPY	0	52		0 0	0	
	06700 OCCUPATIONAL THERAPY	0	185		0 0	0	
		0	25		0 0	0	
	06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0 0 100	0	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	(0 0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	C		0 0	228,061	73.0
	OUTPATIENT SERVICE COST CENTERS			.1		-	
	09000 CLINIC 09100 EMERGENCY	0)	·	0 0 55 0	0	90.0 91.0
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	20,938	20,86	000	455	92.0
	SPECIAL PURPOSE COST CENTERS	1 I		1			
118.00		15,163	118,384	58,46	52 100	229,772	118.0
100 00	NONREIMBURSABLE COST CENTERS			,		0	100 0
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 07950 OTHER NRCC - PHYSICIAN CLINIC	0	(0 0		190.0
	07951 OTHER NRCC - WIC	0	15,921	8,95	-		194.0
194.02	07952 OTHER NRCC - PUBLIC RELATIONS	0	Ċ)	0 0	0	194.0
	07953 OTHER NRCC - DR. OFFICE	0	0		0 0		194.0
194.04 200.00	07954 OTHER NRCC - MARKETING Cross Foot Adjustments	0	(0	0	194.0
201.00	Negative Cost Centers						201.0
202.00	Part I)	382,220	344,685				
203.00 204.00		25.207413 31,520	2.566435 14,467	1		1.957776 8,777	203.0
205.00	Unit cost multiplier (Wkst. B, Part II)	2.078744	0.107718	0.34499	64.560000	0.038199	
206.00	(per Wkst. B-2)						206.0
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.0

ST ALLOCAT	TION - STATISTICAL BASIS		Provider CCN: 15-	1325 Period: From 07/01/2022	Worksheet B-1
				To 06/30/2023	Date/Time Prepare 11/24/2023 3:50 p
	Cost Center Description	MEDICAL	SOCIAL SERVICE	I	
		RECORDS &			
		LIBRARY (GROSS	(TIME SPENT)		
		CHARGES)			
		16.00	17.00		
	AL SERVICE COST CENTERS				
	CAP REL COSTS-BLDG & FIXT				1
	CAP REL COSTS-MVBLE EQUIP				2
	EMPLOYEE BENEFITS DEPARTMENT				4
	PURCHASING RECEIVING AND STORES				5
	CASHIERING/ACCOUNTS RECEIVABLE OTHER ADMINISTRATIVE AND GENERAL				5
	OPERATION OF PLANT				7
	LAUNDRY & LINEN SERVICE				8
	HOUSEKEEPING				9
	DIETARY				10
	CAFETERIA				11
	NURSING ADMINISTRATION				13
	CENTRAL SERVICE & SUPPLY				14
	PHARMACY				15
.00 01600	MEDICAL RECORDS & LIBRARY	61,574,515			16
	SOCIAL SERVICE	0	0		17
	IENT ROUTINE SERVICE COST CENTERS	2 774 000			
1 1	ADULTS & PEDIATRICS	3,771,882	0		30
	INTENSIVE CARE UNIT	2 022 725	0		31
	SUBPROVIDER - IPF SUBPROVIDER - IRF	3,922,725	0		40
	SUBPROVIDER - IKF	0	0		41
	LARY SERVICE COST CENTERS		0		
	OPERATING ROOM	3,586,320	0		50
.00 05100	RECOVERY ROOM	0	0		51
.00 05200	DELIVERY ROOM & LABOR ROOM	0	0		52
.00 05300	ANESTHESIOLOGY	0	0		53
	RADIOLOGY-DIAGNOSTIC	20,486,822	0		54
1	CARDIAC CATHETERIZATION	0	0		59
	LABORATORY	10,447,831	0		60
	RESPIRATORY THERAPY	1,631,876			65
	PHYSICAL THERAPY	845,575	0		66
	OCCUPATIONAL THERAPY	657,548	0		67
	SPEECH PATHOLOGY ELECTROCARDIOLOGY	48,979	0		68 69
	MEDICAL SUPPLIES CHARGED TO PATIENTS	454,047	0		71
	IMPL. DEV. CHARGED TO PATIENTS	280,050	-		71
	DRUGS CHARGED TO PATIENTS	2,643,130	0		73
	TIENT SERVICE COST CENTERS	2,015,150			
.00 09000		0	0		90
.00 09100	EMERGENCY	12,797,730	0		91
	OBSERVATION BEDS (NON-DISTINCT PART)				92
	AL PURPOSE COST CENTERS	04			
.00	SUBTOTALS (SUM OF LINES 1 through 117)	61,574,515	0		118
	IMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190
	OTHER NRCC - PHYSICIAN CLINIC	0	0		190
	OTHER NRCC - WIC	0	0		194
	OTHER NRCC - PUBLIC RELATIONS	0	o		194
	OTHER NRCC - DR. OFFICE	0	0		194
	OTHER NRCC - MARKETING	0	0		194
0.00	Cross Foot Adjustments				200
.00	Negative Cost Centers				201
2.00	Cost to be allocated (per Wkst. B,	53,684	0		202
	Part I)				_
.00	Unit cost multiplier (Wkst. B, Part I)		0.000000		203
1.00	Cost to be allocated (per Wkst. B,	13,595	0		204
	Part II)	0.000001	0.000000		205
5.00	Unit cost multiplier (Wkst. B, Part II)	0.000221	0.000000		205
5.00	NAHE adjustment amount to be allocated				206
5.00	(per Wkst. B-2)				200
7.00	NAHE unit cost multiplier (Wkst. D,				207
	Parts III and IV)	1	1 1		1-07

Health Financial Systems	ASCENSION ST. VI	INCENT WARRICK		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider Co		Period: From 07/01/2022 To 06/30/2023		
		Title	XVIII	Hospital	Cost	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs		Total Costs	
	(from Wkst. B,	Adj.		Disallowance		
	Part I, col.					
	26)	2.00	2.00	1.00	F 00	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	2 0 6 1 0 2 2		2 0 0 1 0		2 061 022	20.00
30.00 03000 ADULTS & PEDIATRICS 31.00 03100 INTENSIVE CARE UNIT	2,861,832		2,861,8	0	2,861,832	1
31.00 03100 INTENSIVE CARE UNIT 40.00 04000 SUBPROVIDER - IPF	2 486 660		2 496 6		0	
	3,486,660		3,486,6	0 0	3,486,660 0	1
41.00 04100 SUBPROVIDER - IRF 42.00 04200 SUBPROVIDER	0			0 0	0	
ANCILLARY SERVICE COST CENTERS	0			0 0	0	42.00
50.00 05000 OPERATING ROOM	1,185,631		1,185,6	0	1,185,631	50.00
51.00 05100 RECOVERY ROOM	1,105,051		1,105,0		1,105,051	1
52.00 05200 DELIVERY ROOM & LABOR ROOM	0				0	1
53.00 05300 ANESTHESIOLOGY	0			0 0	0	1
54.00 05400 RADIOLOGY-DIAGNOSTIC	2,175,590		2,175,5	0	2,175,590	
59.00 05900 CARDIAC CATHETERIZATION	0			0 0	0	1
60.00 06000 LABORATORY	2,170,432		2,170,4	32 0	2,170,432	
65.00 06500 RESPIRATORY THERAPY	541,872	0	541,8		541,872	
66.00 06600 PHYSICAL THERAPY	307,785	0	307,7		307,785	
67.00 06700 OCCUPATIONAL THERAPY	236,152	0	236,1		236,152	67.00
68.00 06800 SPEECH PATHOLOGY	10,751	0	10,7	51 0	10,751	68.00
69.00 06900 ELECTROCARDIOLOGY	0			0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	158,146		158,14	16 0	158,146	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	42,952		42,9	52 0	42,952	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	755,649		755,64	19 0	755,649	73.00
OUTPATIENT SERVICE COST CENTERS	_			_		
90.00 09000 CLINIC	0			0 0	0	
91.00 09100 EMERGENCY	3,946,546		3,946,54		3,946,546	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	632,928		632,92		632,928	
200.00 Subtotal (see instructions)	18,512,926	0	18,512,92		18,512,926	
201.00 Less Observation Beds	632,928		632,9		632,928	
202.00 Total (see instructions)	17,879,998	0	17,879,9	98 0	17,879,998	202.00

	1 Financial Systems A TATION OF RATIO OF COSTS TO CHARGES	SCENSION ST. VI	Provider C	CN+ 15_1325	In Lieu of Form CMS Period: Worksheet C		-2332-10
COMPO	TATION OF RATIO OF COSTS TO CHARGES		FIOVICEI C	CN. 13-1325	From 07/01/2022	Part I	
					то 06/30/2023	Date/Time Pre	epared:
						11/24/2023 3:	:50 pm
				XVIII	Hospital	Cost	
	Cost Conton Decemintion	Tunationt	Charges	Tatal (asl	C cret an other	TEED 4	
	Cost Center Description	Inpatient	Outpatient	+ col. 7	6 Cost or Other Ratio	TEFRA Inpatient	
				+ (01.7)	Kallo	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		1,912,154		1,912,1	54		30.00
31.00		1,012,101			0		31.00
40.00		3,922,725		3,922,7	25		40.00
41.00		0		5,522,7	0		41.00
42.00		0			0		42.00
	ANCILLARY SERVICE COST CENTERS			1			
50.00		0	3,586,320	3,586,3	20 0.330598	0.00000	50.00
51.00	05100 RECOVERY ROOM	0	0		0 0.000000	0.00000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0.000000	0.00000	52.00
53.00	05300 ANESTHESIOLOGY	0	0		0 0.000000	0.00000	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	425,945	20,060,877	20,486,8	0.106195	0.00000	54.00
59.00	05900 CARDIAC CATHETERIZATION	0	0		0 0.000000	0.00000	59.00
60.00	06000 LABORATORY	1,334,395	9,113,436	10,447,8	0.207740	0.00000	60.00
65.00	06500 RESPIRATORY THERAPY	199,964	1,431,912	1,631,8	76 0.332055	0.00000	65.00
66.00	06600 PHYSICAL THERAPY	275,455	570,120	845,5	75 0.363995	0.00000	66.00
67.00	06700 OCCUPATIONAL THERAPY	423,782	233,766	657,5	48 0.359140	0.00000	
68.00		21,777	27,202	48,9			
69.00	06900 ELECTROCARDIOLOGY	0	0		0 0.000000	0.00000	
71.00		162,171	291,876				
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	280,050	280,0		0.00000	
73.00		1,174,576	1,468,554	2,643,1	30 0.285892	0.00000	0 73.00
	OUTPATIENT SERVICE COST CENTERS						_
90.00		0	0		0 0.00000		
91.00		203,820	12,593,910				
92.00		51,522	1,808,206			0.00000	
200.0		10,108,286	51,466,229	61,574,5	15		200.00
201.0							201.00
202.0	0 Total (see instructions)	10,108,286	51,466,229	61,574,5	15		202.00

	,	ASCENSION ST. VIN			u of Form CMS-	2552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1325	Period: From 07/01/2022 To 06/30/2023	Worksheet C Part I Date/Time Pre 11/24/2023 3:	pared: 50 pm
			Title XVIII	Hospital	Cost	
	Cost Center Description	PPS Inpatient				
		Ratio				
		11.00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
	03000 ADULTS & PEDIATRICS					30.00
	03100 INTENSIVE CARE UNIT					31.00
	04000 SUBPROVIDER - IPF					40.00
41.00	04100 SUBPROVIDER - IRF					41.00
42.00	04200 SUBPROVIDER					42.00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.330598				50.00
51.00	05100 RECOVERY ROOM	0.000000				51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000				52.00
53.00	05300 ANESTHESIOLOGY	0.000000				53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.106195				54.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000				59.00
60.00	06000 LABORATORY	0.207740				60.00
65.00	06500 RESPIRATORY THERAPY	0.332055				65.00
66.00	06600 PHYSICAL THERAPY	0.363995				66.00
67.00	06700 OCCUPATIONAL THERAPY	0.359140				67.00
	06800 SPEECH PATHOLOGY	0.219502				68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000				69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.348303				71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.153373				72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.285892				73.00
	OUTPATIENT SERVICE COST CENTERS					1
90.00	09000 CLINIC	0.000000				90.00
	09100 EMERGENCY	0.308379				91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.340334				92.00
200.00						200.00
201.00						201.00
202.00						202.00

Health Financial Systems	ASCENSION ST. VI	INCENT WARRICK		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider Co		Period: From 07/01/2022 To 06/30/2023	Worksheet C Part I Date/Time Pre 11/24/2023 3:	
		Titl	e XIX	Hospital	Cost	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	,		Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1	1	- 1		
30.00 03000 ADULTS & PEDIATRICS	2,861,832		2,861,83	32 0	2,861,832	
31.00 03100 INTENSIVE CARE UNIT	0			0 0	0	
40.00 04000 SUBPROVIDER - IPF	3,486,660		3,486,60	50 0	3,486,660	
41.00 04100 SUBPROVIDER - IRF	0			0 0	0	
42.00 04200 SUBPROVIDER	0			0 0	0	42.00
ANCILLARY SERVICE COST CENTERS		1				
50.00 OFERATING ROOM	1,185,631		1,185,63	31 0	1,185,631	
51.00 05100 RECOVERY ROOM	0			0 0	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0			0 0	0	
53.00 05300 ANESTHESIOLOGY	0			0 0	0	
54.00 05400 RADIOLOGY-DIAGNOSTIC	2,175,590		2,175,59	90 0	2,175,590	
59.00 05900 CARDIAC CATHETERIZATION	0			0 0	0	
60.00 06000 LABORATORY	2,170,432		2,170,4		2,170,432	
65.00 06500 RESPIRATORY THERAPY	541,872		541,8		541,872	
66.00 06600 PHYSICAL THERAPY	307,785		307,78		307,785	
67.00 06700 OCCUPATIONAL THERAPY	236,152	0	236,1		236,152	
68.00 06800 SPEECH PATHOLOGY	10,751	0	10,7	51 0	10,751	
69.00 06900 ELECTROCARDIOLOGY	0			0 0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	158,146		158,14		158,146	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	42,952		42,9		42,952	
73.00 07300 DRUGS CHARGED TO PATIENTS	755,649		755,64	19 0	755,649	73.00
OUTPATIENT SERVICE COST CENTERS	1	1	1	-1 -	-	
90.00 09000 CLINIC	0			0 0	0	
91.00 09100 EMERGENCY	3,946,546		3,946,54		3,946,546	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	632,928		632,92		632,928	
200.00 Subtotal (see instructions)	18,512,926		18,512,92		18,512,926	
201.00 Less Observation Beds	632,928		632,92		632,928	
202.00 Total (see instructions)	17,879,998	0	17,879,99	98 0	17,879,998	202.00

	Financial Systems A	SCENSION ST. VI	Provider C	CN: 15-1325	Period:	u of Form CMS- Worksheet C	2222-10
COM 0	TATION OF NATIO OF COSTS TO CHARGES		i i ovider et	CN. 15 1525	From 07/01/2022	Part I	
					то 06/30/2023	Date/Time Pre	epared:
					ussuits]	11/24/2023 3:	:50 pm
			Charges	e XIX	Hospital	Cost	
	Cost Center Description	Inpatient	Outpatient	Total (col	6 Cost or Other	TEFRA	
	cost center beschiption	Inpactenc	outpatrent	+ col. 7	Ratio	Inpatient	
					Racio	Ratio	
		6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS	I					
30.00	03000 ADULTS & PEDIATRICS	1,912,154		1,912,1	54		7 30.00
31.00	03100 INTENSIVE CARE UNIT	0			0		31.00
40.00	04000 SUBPROVIDER - IPF	3,922,725		3,922,7	25		40.00
41.00	04100 SUBPROVIDER - IRF	0			0		41.00
42.00	04200 SUBPROVIDER	0			0		42.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	3,586,320	3,586,3	20 0.330598	0.00000	50.00
51.00	05100 RECOVERY ROOM	0	0		0 0.000000	0.00000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0.000000		
53.00	05300 ANESTHESIOLOGY	0	0		0 0.000000		
54.00	05400 RADIOLOGY-DIAGNOSTIC	425,945	20,060,877	20,486,8			
59.00	05900 CARDIAC CATHETERIZATION	0	0		0 0.000000		
60.00	06000 LABORATORY	1,334,395	9,113,436				
65.00	06500 RESPIRATORY THERAPY	199,964	1,431,912			0.00000	
66.00	06600 PHYSICAL THERAPY	275,455	570,120				
67.00	06700 OCCUPATIONAL THERAPY	423,782	233,766			0.00000	
68.00	06800 SPEECH PATHOLOGY	21,777	27,202	48,9		0.00000	
69.00	06900 ELECTROCARDIOLOGY	0	0		0 0.000000		
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	162,171	291,876				
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	280,050	· · · ·			
73.00	07300 DRUGS CHARGED TO PATIENTS	1,174,576	1,468,554	2,643,1	30 0.285892	0.00000	73.00
	OUTPATIENT SERVICE COST CENTERS		-	1			
90.00	09000 CLINIC	0	0		0.000000		
91.00	09100 EMERGENCY	203,820	12,593,910				
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	51,522	1,808,206			0.00000	
200.00		10,108,286	51,466,229	61,574,5	12		200.00
201.00		10 100 555	F4 466 555				201.00
202.00) Total (see instructions)	10,108,286	51,466,229	61,574,5	12		202.00

42.00 04200 SUBPROVIDER 42.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.000000 50.00 51.00 05100 RECOVERY ROOM 0.000000 51.00 52.00 52.00 DS100 DELIVERY ROOM & LABOR ROOM 0.000000 52.00 52.00 53.00 DS300 ANESTHESIOLOGY 0.000000 53.00 54.00 54.00 DS400 RADIOLOGY-DIAGNOSTIC 0.000000 59.00 60.00 65.00 O6000 LABORATORY 0.000000 59.00 60.00 65.00 06000 LABORATORY 0.000000 60.00 60.00 65.00 06000 PHYSICAL THERAPY 0.000000 60.00 65.00 66.00 06700 OCUPATIONAL THERAPY 0.000000 66.00 67.00 68.00 SPECH PATHOLOGY 0.000000 66.00 67.00 67.00 67.00 69.00 OF900 ELECTROCARDIOLOGY 0.000000 69.00 69.00 <t< th=""><th>Health</th><th>Financial Systems A</th><th>ASCENSION ST. VIN</th><th>CENT WARRICK</th><th>In Lie</th><th>u of Form CMS-</th><th>2552-10</th></t<>	Health	Financial Systems A	ASCENSION ST. VIN	CENT WARRICK	In Lie	u of Form CMS-	2552-10
Cost Center Description PPS Inpatient Ratio Number Service Cost Centers 30.00 11.00 11.00 11.00 31.00 31.00 31.00 0.00 03000 ADULTS & PEDIATRICS 31.00 31.00 31.00 0.100 04000 SUBPROVIDER - IFF 40.00 41.00 42.00 AULIO 04100 SUBPROVIDER - IFF 40.000 42.00 42.00 AKTLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.000000 51.00 51.00 05100 RECOVERY ROOM 0.000000 51.00 52.00 52.00 05200 DELIVERY ROOM 0.000000 53.00 53.00 53.00 05300 ANESTHESIOLOGY 0.000000 53.00 59.00 65.00 06500 RESPIRATORY THERAPY 0.000000 59.00 66.00 06600 PHYSICAL THERAPY 0.000000 65.00 66.00 06600 RESPIRATORY THERAPY 0.000000 65.00 66.00 06600 PHYSICAL THERAPY 0.000000 69.00 67.00 06500 SPEECH PATHOLOGY 0.000000 69.00	COMPUT	ATION OF RATIO OF COSTS TO CHARGES			From 07/01/2022 To 06/30/2023	Part I Date/Time Pre	pared: 50 pm
Image: state in the service cost centers 30.00				Title XIX	Hospital	Cost	
Intervent 11.00 30.00 03000 ADULTS & PEDIATRICS 30.00 31.00 031000 INTENSIVE CARE UNIT 31.00 41.00 04100 SUBPROVIDER - IFF 40.00 42.00 042000 SUBPROVIDER - IRF 42.00 42.00 05000 OPERATING ROOM 50.000 51.00 051000 PERATING ROOM 0.000000 52.00 05200 DELIVERY ROOM 0.000000 51.00 05100 RECOVERY ROOM 0.000000 53.00 05300 ARSTHESIGLOGY 0.000000 53.00 05300 CARDIAC CATHETERIZATION 0.000000 59.00 05500 RESPIRATORY THERAPY 0.000000 66.00 06500 RESPIRATORY THERAPY 0.000000 61.00 06500 RESPIRATORY THERAPY 0.000000 66.00 06600 PHYSICAL THERAPY 0.000000 67.00 06700 CCUPATIONAL THERAPY 0.000000 67.00 06700 CCUPATIONAL THERAPY 0.000000 68.00 06800 SPECH PATHOLOGY 0.000000 69.00 000000 68.00 69.00 00		Cost Center Description					
INPATIENT ROUTINE SERVICE COST CENTERS 30.00							
30.00 03000 ADULTS & PEDIATRICS 30.00 31.00 03100 INTENSIVE CARE UNIT 31.00 40.00 04000 SUBPROVIDER - IFF 41.00 42.00 AUDONUDER 1FF ACTILARY SERVICE COST CENTERS 42.00 ACTILARY SERVICE COST CENTERS 50.00 ACTILARY SERVICE COST CENTERS 51.00 51.00 05100 RECOVERY ROOM 0.000000 52.00 05200 DELIVERY ROOM & 0.000000 52.00 53.00 05400 RADETHESIDLOGY 0.000000 53.00 54.00 05400 RADETARDSTIC 0.000000 54.00 05400 RADIOGO-DIAGNOSTIC 0.000000 54.00 0.60000 06500 RESPIRATORY THERAPY 0.000000 65.00 06500 RESPIRATORY THERAPY 0.000000 65.00 06500 RESPIRATORY THERAPY 0.000000 66.00 66.00 06600 PHYSICAL THERAPY 0.000000 67.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 67.00 67.00 06000 SPECH PATHOLOGY 0.0000000 72.00 73.00 <td></td> <td>1</td> <td>11.00</td> <td></td> <td></td> <td></td> <td></td>		1	11.00				
31.00 03100 INTENSIVE CARE UNIT 31.00 40.00 04000 SUBPROVIDER - IPF 40.00 41.00 04200 SUBPROVIDER - IRF 41.00 42.00 4200 SUBPROVIDER 42.00 ANCILLARY SERVICE COST CENTERS 42.00 50.00 50.00 50.00 50.00 51.00 05100 RECOVERY ROOM 0.000000 52.00 05200 DELIVERY NOM & LABOR ROOM 0.000000 53.00 05300 ANSTHESIOLOGY 0.000000 54.00 05400 CARDIACGY + 0.000000 53.00 59.00 CARDIAC CATHETERIZATION 0.000000 59.00 66.00 MASICAL THERAPY 0.000000 66.00 66.00 G600 PHSTACL THERAPY 0.000000 67.00 67.00 06700 CCUPATIONAL THERAPY 0.000000 68.00 68.00 06600 FESTRATORY THERAPY 0.000000 69.00 69.00 06500 RESPIRATORY THERAPY 0.000000 69.00 61.00 06600 HSTACL THERAPY 0.0000000 69.0			1 1				
40.00 04000 SUBPROVIDER - IFF 40.00 41.00 04100 SUBPROVIDER - IFF 41.00 42.00 42.00 42.00 ANCILLARY SERVICE COST CENTERS 42.00 ANCILLARY SERVICE COST CENTERS 50.00 50.00 05000 0PERATING ROOM 0.000000 51.00 51.00 50.00 51.00 52.00 05200 DELIVERY ROOM 0.000000 51.00 53.00 05300 ANESTHESIDLOGY 0.000000 53.00 54.00 05400 RADIOLOGY-DIAGNOSTIC 0.000000 59.00 65.00 06500 CARDIAC CATHETERIZATION 0.000000 59.00 66.00 06600 PHYSICAL THERAPY 0.000000 65.00 65.00 06500 RESPIRATORY THERAPY 0.000000 67.00 68.00 06600 PHYSICAL THERAPY 0.000000 68.00 0 06300 SEECH PATHOLOGY 0.000000 68.00 71.00 7100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 73.00 72.00 07300 IMPL.							
41.00 04100 SUBPROVIDER - IRF 41.00 42.00 04200 SUBPROVIDER 42.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 PERATING ROOM 0.000000 51.00 51.00 05100 RECOVERY ROOM 0.000000 51.00 52.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 52.00 53.00 05300 ANSTHESIOLOGY 0.000000 53.00 54.00 05400 RADIOLOGY-DIAGNOSTIC 0.000000 54.00 59.00 05500 CARDIAC CATHETERIZATION 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 CCUPATIONAL THERAPY 0.000000 67.00 68.00 SPECH PATHOLOGY 0.000000 68.00 71.00 MDICLAL SUPPLIES CHARGED TO PATIENTS 0.000000 71.00 71.00 MDICLAL SUPPLIES CHARGED TO PATIENTS 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS		03100 INTENSIVE CARE UNIT					
42.00 04200 SUBPROVIDER 42.00 ANCTLLARY SERVICE COST CENTERS 42.00 ANCTLLARY SERVICE COST CENTERS 50.00 05100 PERATING ROOM 0.000000 51.00 05100 RECOVERY ROOM 0.000000 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 53.00 53.00 05400 RASTHESIOLOGY 0.000000 53.00 54.00 05400 RADIOLOGY-DIAGNOSTIC 0.000000 54.00 05400 CARDIAC CATHETERIZATION 0.000000 59.00 60.00 D6500 CARDIAC CATHETERIZATION 0.000000 60.00 65.00 06500 RESPIRATORY THERAPY 0.000000 65.00 66.00 D6600 PHYSICAL THERAPY 0.000000 66.00 66.00 G6000 PHYSICAL THERAPY 0.000000 67.00 68.00 OB600 ELECTROCARDIOLOGY 0.000000 68.00 69.00 CLUPATIENT SERVICE COST CENTERS 0.000000 71.00 71.00 OTJO	40.00	04000 SUBPROVIDER - IPF					40.00
ANCILLARY SERVICE COST CENTERS 50.00 05000 PERATING ROM 0.000000 50.00 51.00 05100 RECOVERY ROOM 0.000000 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 52.00 53.00 05300 ANESTHESIOLOGY 0.000000 53.00 54.00 05400 RADIOLOGY-DIAGNOSTIC 0.000000 54.00 59.00 06900 CARDIAC CATHETERIZATION 0.000000 60.00 66.00 06000 LABORATORY 0.000000 60.00 65.00 06500 RESPIRATORY THERAPY 0.000000 60.00 66.00 06500 RESPIRATORY THERAPY 0.000000 66.00 67.00 06700 OCCUPATIONAL THERAPY 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 0.000000 67.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 72.00 73.00 09000 CLINIC 0.000000 </td <td>41.00</td> <td>04100 SUBPROVIDER - IRF</td> <td></td> <td></td> <td></td> <td></td> <td>41.00</td>	41.00	04100 SUBPROVIDER - IRF					41.00
50.00 05000 OPERATING ROOM 0.000000 50.00 51.00 05100 RECOVERY ROOM 0.000000 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 52.00 53.00 05300 ANESTHESIOLOGY 0.000000 53.00 54.00 05400 RADIOLOGY-DIAGNOSTIC 0.000000 59.00 69.00 CARDIAC CATHETERIZATION 0.000000 60.00 65.00 06500 RESPIRATORY THERAPY 0.000000 60.00 66.00 06600 PHYSICAL THERAPY 0.000000 66.00 67.00 06500 RESPIRATORY THERAPY 0.000000 67.00 67.00 06500 RECHATHOLOGY 0.000000 68.00 69.00 06800 SPECH PATHOLOGY 0.000000 68.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS </td <td>42.00</td> <td>04200 SUBPROVIDER</td> <td></td> <td></td> <td></td> <td></td> <td>42.00</td>	42.00	04200 SUBPROVIDER					42.00
51.00 05100 RECOVERY ROOM 0.000000 51.00 52.00 D5200 DELIVERY ROM & LABOR ROOM 0.000000 52.00 53.00 O5300 ANESTHESIOLOGY 0.000000 53.00 54.00 D5400 RADLOGY-DIAGNOSTIC 0.000000 54.00 59.00 O5900 CARDIAC CATHETERIZATION 0.000000 60.00 60.00 D6000 LABORATORY 0.000000 60.00 65.00 D6500 RESPIRATORY THERAPY 0.000000 66.00 67.00 O6700 OCCUPATIONAL THERAPY 0.000000 66.00 67.00 O6800 SPECH PATHOLOGY 0.000000 68.00 69.00 OES00 RESPIRATORY TO PATIENTS 0.000000 68.00 69.00 OF200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 72.00 71.00 MDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 72.00 73.00 DUTATIENT SERVICE COST CENTERS 90.00 90.00 91.00 O9100 EMERGENCY 0.000000		ANCILLARY SERVICE COST CENTERS					
52.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 53.00 53.00 05300 ANESTHESIOLOGY 0.000000 53.00 54.00 05400 RADIOLOGY-DIAGNOSTIC 0.000000 54.00 59.00 05900 CARDIAC CATHETERIZATION 0.000000 59.00 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 66.00 68.00 06800 SPECH PATHOLOGY 0.000000 68.00 69.00 06900 ELECTROCARDIOLOGY 0.000000 71.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 72.00 73.00 DRUGS CHARGED TO PATIENTS 0.000000 72.00 73.00 DRUGS CHARGED TO PATIENTS 0.000000 72.00 73.00 DRUGS CHARGED TO PATIENTS 0.000000	50.00	05000 OPERATING ROOM	0.000000				50.00
53.00 05300 ANESTHESIOLOGY 0.000000 53.00 54.00 05400 RADIOLOGY-DIAGNOSTIC 0.000000 54.00 59.00 05900 CARDIAC CATHETERIZATION 0.000000 59.00 60.00 06000 LABORATORY 0.000000 60.00 65.00 06500 RESPIRATORY THERAPY 0.000000 60.00 66.00 06600 PHYSICAL THERAPY 0.000000 66.00 67.00 06700 OCUPATIONAL THERAPY 0.000000 66.00 68.00 06800 SPECH PATHOLOGY 0.000000 68.00 69.00 06900 ELECTROCARDIOLOGY 0.000000 68.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 72.00 73.00 09000 CLINIC 0.000000 90.00 91.00 091000 ENERGENCY<	51.00	05100 RECOVERY ROOM	0.000000				51.00
54.00 05400 RADIOLOGY-DIAGNOSTIC 0.000000 54.00 59.00 05900 CARDIAC CATHETERIZATION 0.000000 59.00 60.00 06000 LABORATORY 0.000000 60.00 65.00 06500 RESPIRATORY THERAPY 0.000000 66.00 66.00 06600 PHYSICAL THERAPY 0.000000 66.00 67.00 06700 OCCUPATIONAL THERAPY 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 0.000000 68.00 69.00 06800 SPEECH PATHOLOGY 0.000000 68.00 71.00 O7100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 73.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 73.00 73.00 90.00 91.00 99000 CLINIC 0.000000 91.00 92.00 <td< td=""><td>52.00</td><td>05200 DELIVERY ROOM & LABOR ROOM</td><td>0.000000</td><td></td><td></td><td></td><td>52.00</td></td<>	52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000				52.00
59.00 05900 CARDIAC CATHETERIZATION 0.000000 59.00 60.00 06000 LABORATORY 0.000000 60.00 65.00 06500 RESPIRATORY THERAPY 0.000000 65.00 66.00 06600 PHYSICAL THERAPY 0.000000 65.00 67.00 06700 OCCUPATIONAL THERAPY 0.000000 66.00 67.00 06700 OCCUPATIONAL THERAPY 0.000000 67.00 68.00 6800 SPECH PATHOLOGY 0.000000 68.00 69.00 06900 ELECTROCARDIOLOGY 0.000000 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 72.00 73.00 DUTPATIENT SERVICE COST CENTERS 0.000000 73.00 90.00 09100 CLINIC 0.000000 91.00 91.00 09100 EMERGENCY 0.000000 91.00 92.00 0BSERVATION BEDS (NON-DISTINCT PART) 0.000000 92.00 90.100 Less observation Beds 201	53.00	05300 ANESTHESIOLOGY	0.000000				53.00
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 68.00 SPEECH PATHOLOGY 0.000000 67.00 69.00 G6900 ELECTROCARDIOLOGY 0.000000 69.00 71.00 O7100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 72.00 73.00 DOTPATIENT SERVICE COST CENTERS 0.000000 73.00 90.00 O9100 EMERGENCY 0.000000 90.00 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 91.00 92.00 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 92.00 201.00 Less observation Beds 201.00 201.00	54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000				54.00
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 68.00 SPEECH PATHOLOGY 0.000000 67.00 69.00 G6900 ELECTROCARDIOLOGY 0.000000 69.00 71.00 O7100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 72.00 73.00 DOTPATIENT SERVICE COST CENTERS 0.000000 73.00 90.00 O9100 EMERGENCY 0.000000 90.00 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 91.00 92.00 Subtotal (see instructions) 200.00 201.00 201.00	59.00	05900 CARDIAC CATHETERIZATION	0.000000				59.00
66.00 06600 PHYSICAL THERAPY 0.000000 66.00 67.00 06700 OCCUPATIONAL THERAPY 0.000000 67.00 68.00 06800 SPECH PATHOLOGY 0.000000 68.00 69.00 06900 ELECTROCARDIOLOGY 0.000000 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 72.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 73.00 00.00 INUS CHARGED TO PATIENTS 0.000000 73.00 00.00 OPUTPATIENT SERVICE COST CENTERS 90.00 90.00 90.00 90.00 09100 EMERGENCY 0.000000 91.00 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 91.00 90.00 Subtotal (see instructions) 200.00 201.00 201.00			0.000000				60.00
66.00 06600 PHYSICAL THERAPY 0.000000 66.00 67.00 06700 OCCUPATIONAL THERAPY 0.000000 67.00 68.00 06800 SPECH PATHOLOGY 0.000000 68.00 69.00 06900 ELECTROCARDIOLOGY 0.000000 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 72.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 73.00 00.00 INUS CHARGED TO PATIENTS 0.000000 73.00 00.00 OPUTPATIENT SERVICE COST CENTERS 90.00 90.00 90.00 90.00 09100 EMERGENCY 0.000000 91.00 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 91.00 90.00 Subtotal (see instructions) 200.00 201.00 201.00	65.00	06500 RESPIRATORY THERAPY	0.000000				65.00
68.00 06800 SPEECH PATHOLOGY 0.000000 68.00 69.00 06900 ELECTROCARDIOLOGY 0.000000 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 73.00 00100 CLINIC 0.000000 90.00 90.00 09000 CLINIC 90.000 91.00 09100 EMERGENCY 0.000000 91.00 92.00 082020 0BSERVATION BEDS (NON-DISTINCT PART) 0.000000 92.00 200.00 Subtotal (see instructions) 200.00 201.00 201.00	66.00		0.000000				66.00
68.00 06800 SPECH PATHOLOGY 0.000000 68.00 69.00 06900 ELECTROCARDIOLOGY 0.000000 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 72.00 73.00 DRUGS CHARGED TO PATIENTS 0.000000 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 73.00 00100 CLINIC 0.000000 90.00 90.00 09000 CLINIC 90.00 91.00 09000 CLINIC 91.00 92.00 08200 0BSERVATION BEDS (NON-DISTINCT PART) 0.000000 92.00 200.00 Subtotal (see instructions) 200.00 201.00 201.00	67.00	06700 OCCUPATIONAL THERAPY	0.000000				67.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 73.00 00100 DRUGS CHARGED TO PATIENTS 0.000000 73.00 00100 DRUGS CHARGED TO PATIENTS 0.000000 73.00 00100 DEVENTION SERVICE COST CENTERS 0.000000 90.00 90.00 09100 EMERGENCY 0.000000 90.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 92.00 200.00 Subtotal (see instructions) 200.00 201.00 201.00							68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 73.00 0UTPATIENT SERVICE COST CENTERS 0.000000 90.00 90.00 90.00 O9100 EMERGENCY 0.000000 90.00 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0.000000 92.00 201.00 Subtotal (see instructions) 200.00 201.00 201.00	69.00	06900 ELECTROCARDIOLOGY	0.000000				69.00
73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 73.00 OUTPATIENT SERVICE COST CENTERS 0.000000 0.000000 90.00 90.00 09000 CLINIC 0.000000 90.00							71.00
73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 73.00 OUTPATIENT SERVICE COST CENTERS 0.000000 0.000000 90.00 90.00 09000 CLINIC 0.000000 90.00	72.00	07200 IMPL, DEV, CHARGED TO PATIENTS	0.00000				72.00
OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 0.000000 90.00 91.00 09100 EMERGENCY 0.000000 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 92.00 200.00 Subtotal (see instructions) 200.00 201.00 201.00							73.00
90.00 09000 CLINIC 0.000000 90.00 91.00 09100 EMERGENCY 0.000000 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 92.00 200.00 Subtotal (see instructions) 200.00 201.00 201.00							
91.00 09100 EMERGENCY 0.000000 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 92.00 200.00 Subtotal (see instructions) 200.00 200.00 201.00	90.00		0.000000				90.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 92.00 200.00 Subtotal (see instructions) 200.00 200.00 201.00							
200.00Subtotal (see instructions)200.00201.00Less Observation Beds201.00							
201.00 Less Observation Beds 201.00							

Health Financial Systems	SCENSION ST. V	INCENT WARRICK		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provider C	CN: 15-1325	Period: From 07/01/2022 To 06/30/2023	Worksheet D Part II Date/Time Pre 11/24/2023 3:	
			XVIII	Hospital	Cost	
Cost Center Description	Capital	Total Charges		t Inpatient	Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,		$(col. 1 \div col$. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS	r	1				
50.00 05000 OPERATING ROOM	184,849	3,586,320			0	
51.00 05100 RECOVERY ROOM	0	0	0.0000	0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0.0000		0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0.0000	0 0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	447,735	20,486,822	0.02185	5 85,494	1,868	54.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0.0000	0 0	0	59.00
60.00 06000 LABORATORY	60,102	10,447,831	0.00575	3 89,450	515	60.00
65.00 06500 RESPIRATORY THERAPY	29,075	1,631,876	0.01781	.7 47,959	854	65.00
66.00 06600 PHYSICAL THERAPY	27,204	845,575	0.03217	2 12,236	394	66.00
67.00 06700 OCCUPATIONAL THERAPY	15,743	657,548	0.02394	2 17,118	410	67.00
68.00 06800 SPEECH PATHOLOGY	509	48,979	0.01039	4,947	51	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0.0000	0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	9,029	454,047	0.01988	31,732	631	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	863	280,050	0.00308	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	15,078	2,643,130	0.00570	86,802	495	73.00
OUTPATIENT SERVICE COST CENTERS						1
90.00 09000 CLINIC	0	0	0.0000	0 0	0	90.00
91.00 09100 EMERGENCY	142,819	12,797,730	0.01116	14,011	156	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	32,915	1,859,728	0.01769	5,004	89	92.00
200.00 Total (lines 50 through 199)	965,921			394,753	5,463	200.00

Health	Finar	cial Systems	ASCENSION ST. V	INCENT WARRICK		In Lie	u of Form CMS-2	2552-10
APPORT THROUG		NT OF INPATIENT/OUTPATIENT ANCILLARY SEI FS	RVICE OTHER PAS			Period: From 07/01/2022 To 06/30/2023		pared: 50 pm
				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	
		LARY SERVICE COST CENTERS						
	1	OPERATING ROOM	0	0		0 0	0	50.00
		RECOVERY ROOM	0	0		0 0	0	51.00
	•	DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
		ANESTHESIOLOGY	0	0		0 0	0	53.00
		RADIOLOGY-DIAGNOSTIC	0	0		0 0	0	54.00
	•	CARDIAC CATHETERIZATION	0	0		0 0	0	59.00
		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
	06900	ELECTROCARDIOLOGY	0	0		0 0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
		TIENT SERVICE COST CENTERS						
		CLINIC	0	0		0 0	0	50.00
		EMERGENCY	0	0		0 0	0	91.00
	4	OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	
200.00		Total (lines 50 through 199)	0	0		0 0	0	200.00

Health	Financial Systems	ASCENSION ST. VI	INCENT WARRICK		In Lie	u of Form CMS-2	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE H COSTS	RVICE OTHER PASS	S Provider C		Period: From 07/01/2022 To 06/30/2023		
			Title	XVIII	Hospital	Cost	
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
		Medical	(sum of cols.	Outpatient	(from Wkst. C,		
		Education Cost		Cost (sum of		(col. 5 ÷ col.	
			4)	cols. 2, 3,	8)	7)	
				and 4)		(see	
		4.00	5.00	C 00	7.00	instructions)	
		4.00	5.00	6.00	7.00	8.00	
	ANCILLARY SERVICE COST CENTERS	0	0		0 2 596 220	0,00000	50.00
	05000 OPERATING ROOM	0	0		0 3,586,320		
	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0.000000	
	05300 ANESTHESIOLOGY	0	0		0 0	0.000000	
	05400 RADIOLOGY-DIAGNOSTIC	0	0		0 20,486,822		
		0	0		0 20,460,622	0.000000	59.00
	05900 CARDIAC CATHETERIZATION	0	0		0 10 447 821		
	06000 LABORATORY 06500 RESPIRATORY THERAPY	0	0		0 10,447,831		
		0	0		0 1,631,876		
	06600 PHYSICAL THERAPY 06700 OCCUPATIONAL THERAPY	0	0		0 845,575		
	06800 SPEECH PATHOLOGY	0			0 657,548 0 48,979		
	06900 ELECTROCARDIOLOGY	0			40,979	0.000000	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			0 454,047		
	07200 IMPL. DEV. CHARGED TO PATIENTS	0			0 280,050		
	07300 DRUGS CHARGED TO PATIENTS	0			0 2,643,130		73.00
75.00	OUTPATIENT SERVICE COST CENTERS	0	0		2,043,130	0.000000	73.00
90.00	09000 CLINIC	0	0		0 0	0.000000	90.00
	09100 EMERGENCY	0			0 12,797,730		
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0 1,859,728		
200.00		0			0 55,739,636		200.00
200.00	l liocar (lines so cillougil 199)	0	0	1	J JJ,739,030	I I	200.00

Health Financial Systems	ASCENSION ST. VI	NCENT WARRICK		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEE THROUGH COSTS	RVICE OTHER PASS			Period: From 07/01/2022 To 06/30/2023	Worksheet D Part IV Date/Time Pre 11/24/2023 3:	
		Title XVIII		Hospital	Cost	
Cost Center Description	Outpatient	Inpatient	Inpatient	Outpatient	Outpatient	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	5	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	0		0 0	0	
51.00 05100 RECOVERY ROOM	0.000000	0		0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.000000	0		0 0	0	52.00
53.00 05300 ANESTHESIOLOGY	0.000000	0		0 0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.000000	85,494		0 0	0	54.00
59.00 05900 CARDIAC CATHETERIZATION	0.000000	0		0 0	0	59.00
60.00 06000 LABORATORY	0.000000	89,450		0 0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0.000000	47,959		0 0	0	65.00
66.00 06600 PHYSICAL THERAPY	0.000000	12,236		0 0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0.000000	17,118		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0.000000	4,947		0 0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0.000000	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	31,732		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.000000	86,802		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS		· · · · · · · · · · · · · · · · · · ·				1
90.00 09000 CLINIC	0.000000	0		0 0	0	90.00
91.00 09100 EMERGENCY	0.000000	14,011		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	5,004		0 0	0	92.00
200.00 Total (lines 50 through 199)		394,753		0 0	0	200.00

Health Financial Systems	SCENSION ST. V	INCENT WARRICK		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 11/24/2023 3:	
		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	Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0.330598	0	793,25	7 0	0	50.00
51.00 05100 RECOVERY ROOM	0.000000	0		0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.000000	0		0 0	0	52.00
53.00 05300 ANESTHESIOLOGY	0.000000	0		0 0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.106195	0	5,337,75	0 0	0	54.00
59.00 05900 CARDIAC CATHETERIZATION	0.000000	0		0 0	0	59.00
60.00 06000 LABORATORY	0.207740	0	1,876,55	9 0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0.332055	0	383,53	7 0	0	65.00
66.00 06600 PHYSICAL THERAPY	0.363995	0	190,68	7 0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0.359140	0	78,63	3 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0.219502	0	6,34	2 0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0.000000	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.348303	0	62,47	4 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.153373	0	65,88	2 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.285892	0	298,06	6 394	0	73.00
OUTPATIENT SERVICE COST CENTERS						1
90.00 09000 CLINIC	0.000000	0		0 0	0	90.00
91.00 09100 EMERGENCY	0.308379	0	2,108,08	9 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.340334	0	178,76		0	92.00
200.00 Subtotal (see instructions)		0	11,380,03		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	11,380,03	9 394	0	202.00

Health Financial Systems	ASCENSION ST. V	INCENT WARRICK		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES	AND VACCINE COST	Provider Co		Period: From 07/01/2022 To 06/30/2023	Worksheet D Part V Date/Time Pre 11/24/2023 3:	
			XVIII	Hospital	Cost	
	CO	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		-	1			4
50.00 OPERATING ROOM	262,249	0				50.00
51.00 05100 RECOVERY ROOM	0	0				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
53.00 05300 ANESTHESIOLOGY	0	0				53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	566,842	0				54.00
59.00 05900 CARDIAC CATHETERIZATION	0	0				59.00
60.00 06000 LABORATORY	389,836					60.00
65.00 06500 RESPIRATORY THERAPY	127,355	0				65.00
66.00 06600 PHYSICAL THERAPY	69,409	0				66.00
67.00 06700 OCCUPATIONAL THERAPY	28,240	0				67.00
68.00 06800 SPEECH PATHOLOGY	1,392	0				68.00
69.00 06900 ELECTROCARDIOLOGY	0	0				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	21,760	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	10,105	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	85,215	113				73.00
OUTPATIENT SERVICE COST CENTERS	·					1
90.00 09000 CLINIC	0	0				90.00
91.00 09100 EMERGENCY	650,090	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	60,839	0				92.00
200.00 Subtotal (see instructions)	2,273,332	113				200.00
201.00 Less PBP Clinic Lab. Services-Progra						201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)	2,273,332	113				202.00

Health Financial Systems A	SCENSION ST. V	INCENT WARRICK		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS		CN: 15-1325 CCN: 15-M325	Period: From 07/01/2022 To 06/30/2023		
		Title	e XVIII	Subprovider - IPF	PPS	<u>30 pm</u>
Cost Center Description	Capital	Total Charges		t Inpatient	Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	$(col. 1 \div col$. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS	1	1				
50.00 05000 OPERATING ROOM	184,849	3,586,320			0	50.00
51.00 05100 RECOVERY ROOM	0	0	0.0000		0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0.0000		0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0.0000		0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	447,735	20,486,822		,	859	54.00
59.00 05900 CARDIAC CATHETERIZATION	0	, o	0.0000		0	59.00
60.00 06000 LABORATORY	60,102			. ,		60.00
65.00 06500 RESPIRATORY THERAPY	29,075			,		65.00
66.00 06600 PHYSICAL THERAPY	27,204	,				66.00
67.00 06700 OCCUPATIONAL THERAPY	15,743					67.00
68.00 06800 SPEECH PATHOLOGY	509	48,979			40	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0.0000		0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	9,029	· · · ·		,	443	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	863	280,050			0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	15,078	2,643,130	0.00570	216,597	1,236	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	0	0.0000		0	90.00
91.00 09100 EMERGENCY	142,819	12,797,730	0.01116	50 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1,000,120			0	92.00
200.00 Total (lines 50 through 199)	933,006	55,739,636		640,026	4,854	200.00

Health	Financial Systems	ASCENSION ST. V	INCENT WARRICK		In Lie	u of Form CMS-2	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEP	RVICE OTHER PASS	S Provider Co	CN: 15-1325	Period:	Worksheet D	
THROUG	IH COSTS		Component	ссм:15-м325	From 07/01/2022 To 06/30/2023	Part IV Date/Time Pre	narodi
			component	CCN. 13-M323	10 00/30/2023	11/24/2023 3:	
			Title	XVIII	Subprovider -	PPS	
					IPF		
	Cost Center Description	Non Physician		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	
51.00	05100 RECOVERY ROOM	0	0		0 0	0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	
53.00	05300 ANESTHESIOLOGY	0	0		0 0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0		0 0	0	54.00
59.00	05900 CARDIAC CATHETERIZATION	0	0		0 0	0	59.00
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	
68.00	06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0		0 0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
	OUTPATIENT SERVICE COST CENTERS	1					
90.00	09000 CLINIC	0	0		0 0	0	
91.00	09100 EMERGENCY	0	0		0 0	0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	
200.00	Total (lines 50 through 199)	0	0		0 0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS Provider CCN: 15-1325 component CCN: 15-M325 Period: From 07/01/2022 To 06/30/2023 Worksheet D Part TV Date/Time Prepared: To Date/Time Prepare	Health Financial Systems	ASCENSION ST. V	INCENT WARRICK		In Lie	u of Form CMS-	2552-10
Ancode Cost 3 Component CCN: 15-M325 To 06/30/2023 Date/Time Prepared: 11/24/2023 3: 50 pm Cost Center Description All Other Medical Education Cost Total Cost (sum of cols. 1, 2, 3, and 4) Subprovider - IPF PPS ANCILLARY SERVICE COST CENTERS Total Cost (see instructions) Total Cost (see instructions) Total Cost (see instructions) Total Cost (see instructions) Ratio of Cost (cols. 2, 3, and 4) Total Charges (cols. 2, 6, 4) Ratio of Cost (cols. 2, 6, 4) Cost Contracts (cols. 2, 6, 4) Total Charges (cols. 2, 6, 4) Ratio of Cost (cols. 2, 6, 4) Cost (cols. 2, 6, 4) Cost (cols. 2, 6, 4) Cost (cols. 2, 6, 4) Ratio of Cost (cols. 2, 6, 4) Cost (cols. 2, 6, 6) Cost (cols. 2, 6, 6) Cost (cols. 2, 6, 6) Cost (cols. 2, 6)		RVICE OTHER PAS	S Provider C				
All other Medical Education Cost Total Cost (sum of cols. 1, 2, 3, and 4) Total Cost (sum of cols. 2, 3, and 4) Total Charges (from Wst. C, 0 ls. 2, 3, and 4) Ratio of Cost to Charges (col. 5 + col. 7) (see instructions) ANCILLARY SERVICE COST CENTERS 4.00 5.00 6.00 7.00 8.00 ACCILLARY SERVICE COST CENTERS 0 0 0 0 0.000000 50.00 50.00 05000 (PERATING ROOM 00 (DR ECOVERY ROOM 00 (DR ECOVERY ROOM 00 (DR ECOVERY ROOM 00 (DR COVERY ROOM) 0 0 0 0.000000 0 50.00 52.00 05300 (RADIAC CATHER ROOM 00 (DR ADDIAG CATHER ROOM) 0 0 0 0.000000 0 50.00 53.00 05300 (ARBIAC CATHETERIZATION 00 (DR OD (LABORATORY) 0 0 0 0.000000 0 53.00 59.00 06500 (ABORATORY) 0 0 0 0 0 0.000000 54.00 59.00 05300 (ARDIAC CATHETERIZATION 0 0 0 0 0.000000 55.00 0.000000 55.00 66.00 06500 (RESPIRATORY THERAPY 0 0 0 0 0			Component			Date/Time Pre	
All Other Medical Education Cost Total Cost (sum of cols. 4.00 Total Cost (sum of cols. 4.00 Total Cost (sum of cols. 4.00 Total Cost (sum of cols. 4.00 Total Charges (see instructions) Ratio of Cost (see instructions) ANCILLARY SERVICE COST CENTERS 4.00 5.00 6.00 7.00 8.00 Soudo 05200 OPERATING ROOM 51.00 05200 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM 00 0 0 0.0000000 50.00 51.00 05200 OPERATING ROOM 52.00 0 0 0 0.000000 51.00 05200 DELIVERY ROOM & LABOR ROOM 51.00 0 0 0 0 0.000000 51.00 05200 DELIVERY ROOM & LABOR ROOM 51.00 0 0 0 0 0.000000 52.00 53.00 05200 CARDIAC CATHETERIZATION 00000 CARDIAC CATHETERIZATION 66.00 0 0 0 0.000000 59.00 66.00 06600 PHYSICAL THERAPY 0 0 0 0 0.000000 66.00 66.00 06800 SPEECH PATHOLOGY 0 0 0 0.000000 67.00 00000 0 <t< td=""><td></td><td></td><td>Title</td><td>XVIII</td><td></td><td>PPS</td><td></td></t<>			Title	XVIII		PPS	
Medical Education Cost (sum of cols. 1, 2, 3, and 4) Outpatient Cost (sum of cols. 2, 3, and 4) (from wkst. C, Part I, col. 8) (col. 5 + col. 7) ANCILLARY SERVICE COST CENTERS 4.00 5.00 6.00 7.00 8.00 ANCILLARY SERVICE COST CENTERS 0 0 0 0.000000 0 0.0000000 0 0.00000000000000000000000000000000000				7			
Education Cost 1, 2, 3, and 4) Cost (sum of cols. 2, 3, and 4) Part I, col. 8) (col. 5 + col. 7) (see instructions) ANCILLARY SERVICE COST CENTERS 4.00 5.00 6.00 7.00 8.00 S0.00 05000 OPERATING ROOM 0 0 0 0.000000 50.00 S1.00 05100 RECOVERY ROOM 0 0 0 0 0.000000 52.00 S2.00 DELIVEY ROOM & LABOR ROOM 0 0 0 0 0.000000 52.00 S3.00 ANDIDLOGY - DIAGNOSTIC 0 0 0 0.000000 53.00 S4.00 0 0 0 0 0 0.000000 53.00 S4.00 0.06000 LABORATORY 0 0 0 0.000000 59.00 S9.00 0.5000 CARDIAC CATHETERIZATION 0 0 0 0.000000 59.00 66.00 MASIAL THERAPY 0 0 0 0 0.000000 66.00 66.00 MASIAL THERAPY 0 <td< td=""><td>Cost Center Description</td><td></td><td></td><td></td><td></td><td></td><td></td></td<>	Cost Center Description						
ANCILLARY SERVICE COST CENTERS 4.00 5.00 6.00 7.00 8.00 50.00 05000 OPERATING ROOM 0 0 0 3,586,320 0.000000 50.00 50.00 05000 OPERATING ROOM 0 0 0 0 0.000000 51.00 51.00 05100 RECOVERY ROOM 0 0 0 0 0.000000 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0 0.000000 52.00 53.00 05300 ANESTHESIDLOGY 0 0 0 0 0.000000 53.00 54.00 05400 RADIOLOGY-DIAGNOSTIC 0 0 0 0.000000 59.00 06000 LABORATORY 0 0 0 0 0.000000 59.00 05000 CARDIAC CATHETERIZATION 0 0 0 0.000000 59.00 06000 LABORATORY 0 0 0 0.000000 65.00 65.00 06500 RESPIRATORY THERAPY </td <td></td> <td></td> <td>x</td> <td></td> <td></td> <td></td> <td></td>			x				
ANCILLARY SERVICE COST CENTERS 4.00 5.00 6.00 7.00 8.00 50.00 05000 OPERATING ROOM 0 0 0 3,586,320 0.000000 51.00 51.00 05100 RECOVERY ROOM 0 0 0 0.000000 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0.000000 51.00 54.00 05300 ANESTHESIOLOGY 0 0 0 0.000000 52.00 54.00 05400 RADIOLOGY-DIAGNOSTIC 0 0 0 0.000000 53.00 59.00 05900 CARDIAC CATHETERIZATION 0 0 0 0.000000 54.00 0 0 0 0 0 0 0.000000 50.00 66.00 06600 RESPIRATORY 0 0 0 0.000000 65.00 67.00 06700 OCCUPATIONAL THERAPY 0 0 0 0.000000 67.00 <		Education Cost	, , . ,				
ANCILLARY SERVICE COST CENTERS 4.00 5.00 6.00 7.00 8.00 50.00 05000 OPERATING ROM 0 0 0.000000 50.00 51.00 05100 RECOVERY ROOM 0 0 0.000000 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0.000000 52.00 53.00 05300 ANESTHESIOLOGY 0 0 0 0.000000 52.00 54.00 05400 RADIOLOGY-DIAGNOSTIC 0 0 0 0.000000 54.00 59.00 05900 CARDIAC CATHETERIZATION 0 0 0 0.000000 59.00 60.00 LABORATORY 0 0 0 0 0.000000 65.00 66.00 06500 RESPIRATORY THERAPY 0 0 0 0.00000 65.00 66.00 66.00 66.00 67.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 6			4)		8)		
ANCILLARY SERVICE COST CENTERS 4.00 5.00 6.00 7.00 8.00 ANCILLARY SERVICE COST CENTERS				and 4)			
ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 0 0 0.000000 51.00 51.00 05200 DELIVERY ROOM 0 0 0 0.000000 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0.000000 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0.000000 52.00 53.00 05300 ANESTHESIOLOGY 0 0 0.000000 53.00 54.00 05400 RADILLAGY THERING 0 0 0 0.000000 54.00 59.00 05400 CARDIAC CATHETERIZATION 0 0 0 0.000000 59.00 60.00 06500 RESPIRATORY THERAPY 0 0 0 0 0.000000 65.00 66.00 66.00 657,548 0.000000 65.00 66.00 66.00 66.00 66.00 66.00 69.00 0 0 0 0.000000 67.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
50.00 05000 OPERATING ROOM 0 0 3,586,320 0.000000 50.00 51.00 05100 RECOVERY ROOM 0 0 0 0.000000 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0.000000 51.00 52.00 05300 ANESTHESIOLOGY 0 0 0 0.000000 53.00 54.00 05400 RADIOLOGY-DIAGNOSTIC 0 0 0 0.000000 54.00 59.00 05900 CARDIAC CATHETERIZATION 0 0 0 0.000000 59.00 60.00 06000 LABORATORY 0 0 0 0.000000 60.00 65.00 06500 RESPIRATORY THERAPY 0 0 0 0.000000 65.00 66.00 06600 PHSICAL THERAPY 0 0 0 0.000000 66.00 67.00 06700 0 0 0 0 0 67.00		4.00	5.00	6.00	7.00	8.00	
51.00 05100 RECOVERY ROOM 0 0 0 0.000000 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0.000000 52.00 53.00 05300 ANESTHESIOLOGY 0 0 0 0.000000 53.00 54.00 05400 RADIOLOGY-DIAGNOSTIC 0 0 0 0.000000 54.00 59.00 05900 CARDIAC CATHETERIZATION 0 0 0 0.000000 59.00 60.00 06000 LABORATORY 0 0 0 0.000000 60.00 65.00 06500 RESPIRATORY THERAPY 0 0 0 10,447,831 0.000000 65.00 66.00 PHYSICAL THERAPY 0 0 0 845,575 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 0.000000 68.00 69.00 06900 ELCTROCARDIOLOGY 0 0 0 0.000000 71.00 71.00 07100 MEDIAL SUPPLIES CHARGED TO PATIENTS		-		1			
52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0.000000 52.00 53.00 05300 ANESTHESIOLOGY 0 0 0 0.000000 53.00 54.00 05400 RADIOLOGY-DIAGNOSTIC 0 0 0 0.000000 54.00 59.00 05900 CARDIAC CATHETERIZATION 0 0 0 0.000000 59.00 60.00 06000 LABORATORY 0 0 0 0.000000 69.00 65.00 06500 RESPIRATORY THERAPY 0 0 0 1.631,876 0.000000 65.00 66.00 06600 PHYSICAL THERAPY 0 0 0 845,575 0.000000 66.00 67.00 06700 OCUPATIONAL THERAPY 0 0 0 48,979 0.000000 68.00 68.00 SPEECH PATHOLOGY 0 0 0 0 0.000000 68.00 69.00 ELETROCARDIOLOGY 0 0 0 0 0.000000 71.00 71.00 OTION ME		0	0		0 3,586,320		
53.00 05300 ANESTHESIOLOGY 0 0 0.000000 53.00 54.00 05400 RADIOLOGY-DIAGNOSTIC 0 0 0 20,486,822 0.000000 54.00 59.00 05900 CARDIAC CATHETERIZATION 0 0 0 0.000000 59.00 60.00 06000 LABORATORY 0 0 0 0.000000 60.00 65.00 06500 RESPIRATORY THERAPY 0 0 0 10,447,831 0.000000 65.00 66.00 06600 PHYSICAL THERAPY 0 0 0 845,575 0.000000 65.00 67.00 06700 OCUPATIONAL THERAPY 0 0 0 64.00 67.00 66.00 66.00 66.00 67.00 65.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 67.00 66.00 67.00 68.00 68.00 69.00 71.00 69.00 68.00 69.00 71.00 71.00 71.00 71.00 71.00 72.00 72.00 72.00		0	0		0 0		
54.00 05400 RADIOLOGY-DIAGNOSTIC 0 0 20,486,822 0.000000 54.00 59.00 05900 CARDIAC CATHETERIZATION 0 0 0 0.000000 59.00 60.00 06000 LABORATORY 0 0 0 0.000000 60.00 65.00 06500 RESPIRATORY THERAPY 0 0 0 1,631,876 0.000000 65.00 66.00 06600 PHYSICAL THERAPY 0 0 0 845,575 0.000000 67.00 67.00 06700 OCUPATIONAL THERAPY 0 0 0 845,575 0.000000 67.00 68.00 06800 SPECH PATHOLOGY 0 0 0 485,575 0.000000 68.00 69.00 06900 ELECTROCARDIOLOGY 0 0 0 0.000000 71.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0.000000 72.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 280,050 0.000000		0	0		0 0		
59.00 05900 CARDIAC CATHETERIZATION 0 0 0 0.000000 59.00 60.00 06000 LABORATORY 0 0 0 10,447,831 0.000000 60.00 65.00 06500 RESPIRATORY THERAPY 0 0 0 1,631,876 0.000000 65.00 66.00 06600 PHYSICAL THERAPY 0 0 0 845,575 0.000000 65.00 67.00 06700 OCCUPATIONAL THERAPY 0 0 0 845,575 0.000000 67.00 68.00 06800 SPECH PATHOLOGY 0 0 0 48,979 0.000000 68.00 69.00 06900 ELECTROCARDIOLOGY 0 0 0 0.000000 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 280,050 0.000000 72.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 2.643,130 0.000000 72.00 73.00 07000 CLINIC 0 0 0 2.643,1		0	0		0 0		
60.00 06000 LABORATORY 0 0 10,447,831 0.00000 60.00 65.00 06500 RESPIRATORY THERAPY 0 0 0 1,631,876 0.00000 65.00 66.00 06600 PHYSICAL THERAPY 0 0 0 845,575 0.000000 66.00 67.00 06700 OCCUPATIONAL THERAPY 0 0 0 845,575 0.000000 66.00 68.00 06800 SPECH PATHOLOGY 0 0 0 48,979 0.000000 67.00 69.00 06900 ELECTROCARDIDLOGY 0 0 0 0.000000 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0.000000 73.00 90.00 OJ3		0	0		0 20,486,822		
65.00 06500 RESPIRATORY THERAPY 0 0 1,631,876 0.000000 65.00 66.00 06600 PHYSICAL THERAPY 0 0 0 845,575 0.000000 66.00 67.00 06700 OCCUPATIONAL THERAPY 0 0 0 845,575 0.000000 66.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 67.00 68.00 69.00 65.7,548 0.000000 67.00 69.00 06800 SPEECH PATHOLOGY 0 0 0 0.000000 68.00 69.00 06900 ELECTROCARDIOLOGY 0 0 0 0.000000 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 2.643,130 0.000000 72.00 73.00 09000 CLINIC 0 0 0 0.000000 72.00 <td>59.00 05900 CARDIAC CATHETERIZATION</td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td>0.00000</td> <td>59.00</td>	59.00 05900 CARDIAC CATHETERIZATION	0	0		0 0	0.00000	59.00
66.00 06600 PHYSICAL THERAPY 0 0 845,575 0.000000 66.00 67.00 06700 OCCUPATIONAL THERAPY 0 0 0 657,548 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 48,979 0.000000 68.00 69.00 06900 ELECTROCARDIOLOGY 0 0 0 0.000000 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 454,047 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 280,050 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 2,643,130 0.000000 72.00 90.00 09000 CLINIC 0 0 0 0.000000 90.00 91.00 09100 EMERGENCY 0 0 0 0.000000 91.00 92.00	60.00 06000 LABORATORY	0	0		0 10,447,831	0.00000	60.00
67.00 06700 OCCUPATIONAL THERAPY 0 0 657,548 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 48,979 0.000000 68.00 69.00 06900 ELECTROCARDIOLOGY 0 0 0 0 0.000000 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 454,047 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 280,050 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 2,643,130 0.000000 72.00 90.00 09000 CLINIC 0 0 0 0.000000 90.00 91.00 09100 EMERGENCY 0 0 0 0.000000 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 1,859,728 0.000000 92.00	65.00 06500 RESPIRATORY THERAPY	0	0		0 1,631,876	0.00000	65.00
68.00 06800 SPEECH PATHOLOGY 0 0 48,979 0.000000 68.00 69.00 06900 ELECTROCARDIOLOGY 0 0 0 0 0.000000 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 454,047 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 280,050 0.000000 72.00 73.00 07300 RUGS CHARGED TO PATIENTS 0 0 0 2,643,130 0.000000 72.00 90.00 09000 CLINIC 0 0 0 0.000000 90.00 91.00 09100 EMERGENCY 0 0 0 0.000000 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 1,859,728 0.000000 92.00	66.00 06600 PHYSICAL THERAPY	0	0		0 845,575	0.00000	66.00
69.00 06900 ELECTROCARDIOLOGY 0 0 0 0 0.000000 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 454,047 0.000000 71.00 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 280,050 0.000000 72.00 73.00 OTUGS CHARGED TO PATIENTS 0 0 0 2,643,130 0.000000 72.00 70.00 09000 CLINIC 0 0 0 0.000000 90.00 91.00 09100 EMERGENCY 0 0 0 0.000000 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 1,859,728 0.000000 92.00	67.00 06700 OCCUPATIONAL THERAPY	0	0		0 657,548	0.00000	67.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 454,047 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 280,050 0.000000 72.00 73.00 DRUGS CHARGED TO PATIENTS 0 0 0 2,643,130 0.000000 73.00 OUTPATIENT SERVICE COST CENTERS 90.00 CLINIC 0 0 0 0.000000 90.00 91.00 09100 EMERGENCY 0 0 0 0.000000 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 1,859,728 0.000000 92.00	68.00 06800 SPEECH PATHOLOGY	0	0		0 48,979	0.00000	68.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 280,050 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 2,643,130 0.000000 73.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 0 0 0 0.000000 90.00 91.00 09100 EMERGENCY 0 0 0 12,797,730 0.000000 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 1,859,728 0.000000 92.00	69.00 06900 ELECTROCARDIOLOGY	0	0		0 0	0.000000	69.00
73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 2,643,130 0.000000 73.00 OUTPATIENT SERVICE COST CENTERS 0 0 0 0 0.000000 73.00 90.00 09000 CLINIC 0 0 0 0.000000 90.00 91.00 90.00 91.00 92.00<	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 454,047	0.00000	71.00
OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 0 0 0.00 90.00 91.00 09100 EMERGENCY 0 0 0.000000 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 1,859,728 0.000000 92.00	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 280,050	0.00000	72.00
OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 0 0 0.00 90.00 91.00 09100 EMERGENCY 0 0 0.000000 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 1,859,728 0.000000 92.00	73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 2.643.130	0.00000	73.00
90.00 09000 CLINIC 0 0 0 0.00000 90.00 91.00 09100 EMERGENCY 0 0 0 12,797,730 0.000000 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 1,859,728 0.000000 92.00			<u> </u>		, , , , , , , , , , , , , , , , , , , ,		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 1,859,728 0.000000 92.00		0	0		0 0	0.00000	1 90.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 1,859,728 0.000000 92.00		0			0 12.797.730		
		0					
	200.00 Total (lines 50 through 199)	0			0 55,739,636		200.00

Health Financial Systems	ASCENSION ST. VI	NCENT WARRICK		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEE THROUGH COSTS	RVICE OTHER PASS		CN: 15-1325 CCN: 15-M325	Period: From 07/01/2022 To 06/30/2023	Worksheet D Part IV Date/Time Pre 11/24/2023 3:	
			XVIII	Subprovider - IPF	PPS	
Cost Center Description	Outpatient Ratio of Cost	Inpatient Program	Inpatient Program	Outpatient Program	Outpatient Program	
	to Charges (col. 6 ÷ col. 7)	Charges	Pass-Through Costs (col. x col. 10)		Pass-Through Costs (col. 9 x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0.000000	0		0 0	0	
51.00 05100 RECOVERY ROOM	0.000000	0		0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.000000	0		0 0	0	52.00
53.00 05300 ANESTHESIOLOGY	0.000000	0		0 0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.000000	39,300		0 0	0	54.00
59.00 05900 CARDIAC CATHETERIZATION	0.000000	0		0 0	0	59.00
60.00 06000 LABORATORY	0.000000	344,465		0 0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0.000000	9,429		0 0	0	65.00
66.00 06600 PHYSICAL THERAPY	0.000000	3,385		0 0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0.000000	715		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0.000000	3,883		0 0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0.000000	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	22,252		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.000000	216,597		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0.000000	0		0 0	0	
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	
200.00 Total (lines 50 through 199)		640,026		0 0	0	200.00

Health	Financial Systems A	SCENSION ST. V	INCENT WARRICK		In Lie	u of Form CMS-2	2552-10
APPORT	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-1325	Period:	Worksheet D	
			Compositor	CON 15 4225	From 07/01/2022	Part V	
			Component	CCN:15-M325	то 06/30/2023	Date/Time Pre 11/24/2023 3:	pared: 50 pm
			Title	XVIII	Subprovider -	PPS	
					IPF		
				Charges		Costs	
	Cost Center Description		PPS Reimbursed		Cost	PPS Services	
		Ratio From	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			
	05000 OPERATING ROOM	0.330598			0 0	0	50.00
	05100 RECOVERY ROOM	0.00000			0 0	0	51.00
	05200 DELIVERY ROOM & LABOR ROOM	0.000000			0 0	0	52.00
	05300 ANESTHESIOLOGY	0.000000			0 0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.106195			0 0	0	54.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0		0 0	0	59.00
60.00	06000 LABORATORY	0.207740	0		0 0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.332055	0		0 0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.363995	0		0 0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.359140	0		0 0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.219502	0		0 0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0		0 0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.348303	0	1	0 0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.153373	0		0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.285892	0		0 0	0	73.00
	OUTPATIENT SERVICE COST CENTERS						1
90.00	09000 CLINIC	0.000000	0		0 0	0	90.00
91.00	09100 EMERGENCY	0.308379	0		0 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.340334	0		0 0	0	92.00
200.00			0		0 0	0	200.00
201.00					0 0		201.00
	Only Charges						
202.00			0		0 0	0	202.00

Health Financial Systems	A	SCENSION ST. V	INCENT WARRICK		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL,	APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND		Provider Component	CN: 15-1325 CCN: 15-M325	Period: From 07/01/2022 To 06/30/2023	Worksheet D Part V Date/Time Pre 11/24/2023 3:	
			Title	XVIII	Subprovider -	PPS	
		60	sts		IPF		
Cost Center D	escription	Cost Reimbursed Services Subject To Ded. & Coins.	Cost Reimbursed Services Not Subject To	-			
		(see inst.)	(see inst.)				
		6.00	7.00				
ANCILLARY SERVICE C	OST CENTERS						
50.00 05000 OPERATING ROO	М	0	0				50.00
51.00 05100 RECOVERY ROOM		0	0				51.00
52.00 05200 DELIVERY ROOM	& LABOR ROOM	0	0				52.00
53.00 05300 ANESTHESIOLOG	Y	0	0				53.00
54.00 05400 RADIOLOGY-DIA	GNOSTIC	0	0				54.00
59.00 05900 CARDIAC CATHE	TERIZATION	0	0				59.00
60.00 06000 LABORATORY		0	0				60.00
65.00 06500 RESPIRATORY T	HERAPY	0	0				65.00
66.00 06600 PHYSICAL THER	APY	0	0				66.00
67.00 06700 OCCUPATIONAL	THERAPY	0	0				67.00
68.00 06800 SPEECH PATHOL	OGY	0	0				68.00
69.00 06900 ELECTROCARDIO	LOGY	0	0				69.00
71.00 07100 MEDICAL SUPPL	IES CHARGED TO PATIENTS	0	0				71.00
72.00 07200 IMPL. DEV. CH		0	0				72.00
73.00 07300 DRUGS CHARGED		0	0				73.00
OUTPATIENT SERVICE	COST CENTERS						
90.00 09000 CLINIC		0	0				90.00
91.00 09100 EMERGENCY		0	0				91.00
92.00 09200 OBSERVATION B	• · · · · · · · · · · · · · · · · · · ·	0	0				92.00
	instructions)	0	0				200.00
201.00 Less PBP Clin Only Charges	ic Lab. Services-Program	0	1				201.00
	line 200 - line 201)	0	0				202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-1325 Component CCN: 15-2325 Period: From 07/01/2022 To 06/30/2023 Worksheet D Date/Time Prepared: 1/2/2023 3:50 pm Cost Center Description Cost to charge worksheet c, Part I, col 9 Services (see inst.) Services Not Subject To 06.4 & Coins. (see inst.) Cost Provider CN: 15-1325 Provider V Date/Time Prepared: 1.00 Services (see inst.) Services (see inst.) Services Not Subject To 06.4 & Coins. (see inst.) Provider CN: 15-1325 Provider CN: 15-1325 Provider V Date/Time Prepared: 1.00 Cost Center Description ACTILARY SERVICE COST CENTERS Services (see inst.) Cost Services Not Subject To 00 (DELIVERY ROOM & LABOR ROOM 0.000000 0<	Health Financial Systems A	SCENSION ST. V	INCENT WARRICK		In Lie	u of Form CMS-	2552-10
ANCTLLARY SERVICE COST CENTERS Cost Control Cost Cost Cost Control Cost Cost Cost Cost Cost Cost Cost Cost	APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C				
ARCILLARY SERVICE COST CENTERS Cost Cost Cost Cost Cost Cost Cost Cost 50.00 05000 OPERATING ROOM 0.330598 0			Component				nanad.
ANCTLLARY SERVICE COST CENTERS Cost to Charges Cost center Description ANCTLLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 50.00 05000 OPERATING ROOM 0.330598 0 0 0 0 5.00 51.00 051000 RECOVERY ROOM 0.300598 0 0 0 0 5.00 52.00 053000 ANESTHESIOLOGY 0.000000 0 0 0 5.00 53.00 05400 RADICAGAR ROOM 0.330598 0 0 0 0 5.00 54.00 052000 DELIVERY ROOM 0.000000 0 0 0 51.00 51.00 05400 RADICGY PROOM 0.000000 0 0 0 53.00 54.00 05400 RADICGY PLAGNOSTIC 0.106195 0 0 0 54.00 50.00 05700 CARDIAC CATHERERIZATION 0.000000 0 0 0 66.00 65.00 60.00 065000 LABORATORY 0.227740 0 0 0			component	CCN: 15-2525	10 06/30/2023	11/24/2023 3:	
Cost Center Description Cost to Charge PR elimbursed Ratio From Worksheet C, Part I, col. 9 Services (see inst.) Cost Reimbursed Services (see inst.) Cost Reimbursed Services (see inst.) PP S services (see inst.) ANCILLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 50.00 05100 RECOVER ROOM 0.330598 0 0 0 0 5.00 51.00 05100 RECOVER ROOM 0.000000 0 0 0 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0 0 0 52.00 54.00 05400 RADIOLOGY-DIAGNOSTIC 0.106195 0 0 0 53.00 59.00 05000 LABORATORY 0.332055 0 0 0 66.00 66.00 06000 PHYSICAL THERAPY 0.332055 0 0 0 66.00 66.00 06000 PHYSICAL THERAPY 0.332055 0 0 0 66.00 66.00 06500 RESPIRATORY THERAPY 0.332055 0 0 0 66.00			Title	XVIII	Swing Beds - SNF		
ANCILLARY SERVICE COST CENTERS Ratio From Worksheet C, Part I, col. 9 Services (see inst.) Reimbursed Services Not Subject To Ded. & Coins. (see inst.) (see inst.) 50.00 05000 (PERATING ROM 0.330598 0 0 0 0 50.00 50.00 05000 (PERATING ROM 0.330598 0 0 0 0 0 50.00 50.00 05000 (PERATING ROM 0.330598 0 0 0 0 0 51.00 51.00 05000 peltvery Room & LABOR ROOM 0.000000 0 0 0 0 0 0 0 0 0 51.00 52.00 05300 ANESTHESIOLOGY 0.000000 0 </td <td></td> <td></td> <td></td> <td>Charges</td> <td></td> <td>Costs</td> <td></td>				Charges		Costs	
ANCILLARY SERVICE COST CENTERS inst.) Services Subject To Ded. & Coins. (see inst.) Services Subject To Ded. & Coins. (see inst.) AMCILLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 AMCILLARY SERVICE COST CENTERS 0.330598 0 0 0 0 0 50.00 05200 PERATING ROOM 0.330598 0 0 0 0 0 52.00 05200 DELIVERY ROOM 0.000000 0	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
Ancillary Service cost centers Subject To Subject To		Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
ANCILLARY SERVICE COST CENTERS Ded. & Coins. (see inst.) Ded. & Coins. (see inst.) ANCILLARY SERVICE COST CENTERS 05000 0PERATING ROOM 0.330598 0		Worksheet C,	inst.)	Services			
ANCTLLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 50.00 05000 OPERATING ROOM 0.330598 0 0 0 0 50.00 51.00 05000 OPERATING ROOM 0.0330598 0 0 0 0 50.00 51.00 05100 RECOVERY ROOM 0.000000 0 0 0 51.00 52.00 05300 ANESTHESIOLOGY 0.000000 0 0 0 53.00 54.00 05400 RADIOLOGY-DIAGNOSTIC 0.106195 0 0 0 54.00 05000 LABORATORY 0.207740 0 0 0 59.00 06100 LABORATORY 0.363995 0 0 0 66.00 06700 CCULATIONAL THERAPY 0.363995 0 0 0 66.00 06700 OCULATIONAL THERAPY 0.363995 0 0 0 66.00 06700 OCULATIONAL THERAPY 0.351914 0 0 0 70.00 </td <td></td> <td>Part I, col. 9</td> <td></td> <td></td> <td></td> <td></td> <td></td>		Part I, col. 9					
ANCILLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 ANCILLARY SERVICE COST CENTERS 0							
ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.330598 0 0 0 0 51.00 51.00 05100 RECOVERY ROOM 0.000000 0 0 0 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0 0 0 0 52.00 53.00 05300 ANESTHESIOLOGY 0.000000 0 0 0 53.00 54.00 05400 RADIOLOGY-DIAGNOSTIC 0.106195 0 0 0 53.00 59.00 05900 CARDIAC CATHETERIZATION 0.000000 0 0 0 59.00 0 0 0 59.00 0 0 59.00 0 0 59.00 0 0 0 59.00 0 0 59.00 0 0 0 59.00 0 0 0 0 0 0 59.00 0 0 0 0 0 0 0 0 0 0 0 0 0							
50.00 05000 OPERATING ROOM 0.330598 0 <th0< td=""><td></td><td>1.00</td><td>2.00</td><td>3.00</td><td>4.00</td><td>5.00</td><td></td></th0<>		1.00	2.00	3.00	4.00	5.00	
51.00 05100 RECOVERY ROOM 0.000000 0 0 0 51.00 52.00 D5200 DELIVERY ROOM & LABOR ROOM 0.000000 0 0 0 0 52.00 53.00 OS200 ANESTHESIOLOGY 0.000000 0 0 0 0 53.00 54.00 OS400 RABINLOGY-DIAGNOSTIC 0.106195 0 0 0 53.00 59.00 OS500 CARDIAC CATHETERIZATION 0.000000 0 0 0 59.00 60.00 LABORATORY 0.32055 0 0 0 66.00 65.00 OG600 PHYSICAL THERAPY 0.3359140 0 0 0 67.00 66.00 OG700 OCUPATIONAL THERAPY 0.3159140 0 0 0 68.00 69.00 GE4CH PATHOLOGY 0.219502 0 0 0 69.00 71.00 71.00 OT100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.348303 0 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
52.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0 0 0 52.00 53.00 05300 ANESTHESIDLOGY 0.000000 0 0 0 53.00 54.00 OS400 RADIOLOGY-DIAGNOSTIC 0.106195 0 0 0 54.00 59.00 OS900 CARDIAC CATHETERIZATION 0.000000 0 0 0 54.00 60.00 06000 LABORATORY 0.207740 0 0 0 60.00 65.00 06500 RESPIRATORY THERAPY 0.332055 0 0 0 66.00 66.00 06700 OCCUPATIONAL THERAPY 0.359140 0 0 0 67.00 06700 06200 LECTROCARDIOLOGY 0.219502 0 0 0 68.00 69.00 06900 ELECTROCARDIOLOGY 0.2328373 0 0 0 71.00 71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.133373 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.138379 <					0 0	-	
53.00 05300 ANESTHESIOLOGY 0.000000 0 0 0 53.00 54.00 05400 RADIOLOGY-DIAGNOSTIC 0.106195 0 0 0 54.00 59.00 05900 CARDIAC CATHETERIZATION 0.000000 0 0 0 59.00 60.00 LABORATORY 0.207740 0 0 0 60.00 65.00 06500 RESPIRATORY THERAPY 0.332055 0 0 0 65.00 66.00 06700 OCUPATIONAL THERAPY 0.359140 0 0 0 66.00 67.00 06700 OCUPATIONAL THERAPY 0.359140 0 0 0 68.00 69.00 06900 ELECTROCARDIOLOGY 0.219502 0 0 0 69.00 0 69.00 0 69.00 0 0 0 0 71.00 71.00 71.00 71.00 71.00 71.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 <td></td> <td></td> <td></td> <td></td> <td>0 0</td> <td>, i i i i i i i i i i i i i i i i i i i</td> <td></td>					0 0	, i i i i i i i i i i i i i i i i i i i	
54.00 05400 RADIOLOGY-DIAGNOSTIC 0.106195 0 0 0 54.00 59.00 05900 CARDIAC CATHETERIZATION 0.000000 0 0 0 59.00 60.00 06000 LABORATORY 0.207740 0 0 0 60.00 65.00 06500 RESPIRATORY THERAPY 0.332055 0 0 0 66.00 66.00 06600 PHYSICAL THERAPY 0.332055 0 0 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 0.353995 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0.219502 0 0 0 68.00 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.348303 0 0 0 71.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.153373 0 0 0 72.00 73.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.285892 0 0 0 0 73.00 00.00 09000					0 0	0	
59.00 05900 CARDIAC CATHETERIZATION 0.000000 0					0 0	0	
60.00 06000 LABORATORY 0.207740 0<	54.00 05400 RADIOLOGY-DIAGNOSTIC				0 0	0	
65.00 06500 RESPIRATORY THERAPY 0.332055 0 0 0 65.00 66.00 06600 PHYSICAL THERAPY 0.363995 0 0 0 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 0.359140 0 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0.219502 0 0 0 68.00 69.00 06900 ELECTROCARDIOLOGY 0.000000 0 0 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.348303 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.153373 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.285892 0 0 0 73.00 90.00 09000 CLINIC 0.000000 0 0 0 90.00 90.00 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.340334 0 0 0 200.00 920.00 </td <td>59.00 05900 CARDIAC CATHETERIZATION</td> <td>0.000000</td> <td>0</td> <td></td> <td>0 0</td> <td>0</td> <td>59.00</td>	59.00 05900 CARDIAC CATHETERIZATION	0.000000	0		0 0	0	59.00
66.00 06600 PHYSICAL THERAPY 0.363995 0 0 0 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 0.359140 0 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0.219502 0 0 0 0 68.00 69.00 06900 ELECTROCARDIOLOGY 0.000000 0 0 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.348303 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.153373 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.285892 0 0 0 0 73.00 00400 CLINIC 0.000000 0 0 0 0 90.00 91.00 91.00 91.00 91.00 91.00 92.00 0 0 0 0 92.00 200.00 200.00 200.00 200.00 200.00 200.00 200.00 200.00 201.00 201.00<	60.00 06000 LABORATORY	0.207740	0		0 0	0	60.00
67.00 06700 OCCUPATIONAL THERAPY 0.359140 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0.219502 0 0 0 68.00 69.00 06900 ELECTROCARDIOLOGY 0.000000 0 0 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.348303 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.153373 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.285892 0 0 0 0 73.00 00.00 0100 CLINIC 0.000000 0 0 0 0 90.00 91.00 91.00 91.00 91.00 91.00 91.00 92.00 0 0 0 0 92.00 90.00 Subtotal (see instructions) 0 0 0 0 0 201.00 201.00 Subtotal (see instructions) 0 0 0 201.00 201.00 201.00	65.00 06500 RESPIRATORY THERAPY	0.332055	0		0 0	0	65.00
68.00 06800 SPEECH PATHOLOGY 0.219502 0 0 0 68.00 69.00 06900 ELECTROCARDIOLOGY 0.000000 0 0 0 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.348303 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.153373 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.1285892 0 0 0 73.00 OUTPATIENT SERVICE COST CENTERS 0.000000 0 0 0 0 90.00 90.00 09000 CLINIC 0.000000 0 0 0 90.00 91.00 92.00 90.00 91.00 92.00 92.00 0 0 0 92.00 0 0 0 0 92.00 92.00 OBSERVATION BEDS (NON-DISTINCT PART) 0.340334 0 0 0 0 201.00 201.00 Less PBP Clinic Lab. Services-Program Only Charges 0 0 0 0	66.00 06600 PHYSICAL THERAPY	0.363995	0		0 0	0	66.00
69.00 06900 ELECTROCARDIOLOGY 0.000000 0 0 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.348303 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.153373 0 0 0 72.00 73.00 DRUGS CHARGED TO PATIENTS 0.153373 0 0 0 73.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 0 0 0 90.00 91.00 09100 EMERGENCY 0.308379 0 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.340334 0 0 0 92.00 200.00 Subtotal (see instructions) 0 0 0 0 201.00 201.00 Less PBP Clinic Lab. Services-Program 0 0 0 201.00 201.00	67.00 06700 OCCUPATIONAL THERAPY	0.359140	0		0 0	0	67.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.348303 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.153373 0 0 0 0 72.00 73.00 DRUGS CHARGED TO PATIENTS 0.153373 0 0 0 0 73.00 OUTPATIENT SERVICE COST CENTERS 90.00 09100 CLINIC 0.000000 0 0 0 90.00 90.00 91.00 90.00 91.00 92.00 08SERVATION BEDS (NON-DISTINCT PART) 0.340334 0 0 0 0 92.00 0 0 0 0 92.00 0 0 0 0 0 0 92.00 0 0 0 0 0 92.00 <	68.00 06800 SPEECH PATHOLOGY	0.219502	0		0 0	0	68.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.153373 0 0 0 0 72.00 73.00 DRUGS CHARGED TO PATIENTS 0.285892 0 0 0 0 73.00 OUTPATIENT SERVICE COST CENTERS 90.00 09100 CLINIC 0.000000 0 0 0 90.00 90.00 90.00 91.00 92.00 0 0 0 91.00 92.00 0 0 0 92.00 92.00 058ERVATION BEDS (NON-DISTINCT PART) 0.340334 0 0 0 92.00 92.00 0 0 0 0 200.00 201.00	69.00 06900 ELECTROCARDIOLOGY	0.00000	0		0 0	0	69.00
73.00 07300 DRUGS CHARGED TO PATIENTS 0.285892 0 0 0 0 73.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 0.000000 0 0 0 90.00 90.00 91.00 09100 EMERGENCY 0.308379 0 0 0 92.00 92.00 058ERVATION BEDS (NON-DISTINCT PART) 0.340334 0 0 0 92.00 92.00 0 0 0 200.00 200.00 Subtotal (see instructions) 0 0 0 0 200.00 201.00	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.348303	0		0 0	0	71.00
OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 0.000000 0 0 0 0 90.00 91.00 09100 EMERGENCY 0.308379 0 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.340334 0 0 0 92.00 200.00 Subtotal (see instructions) 0 0 0 200.00 201.00 Less PBP Clinic Lab. Services-Program 0 0 201.00	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.153373	0		0 0	0	72.00
90.00 09000 CLINIC 0.000000 0 0 0 0 0 90.00 91.00 91.00 91.00 91.00 91.00 91.00 92.00 00 0 0 0 0 0 0 91.00 91.00 92.00 00 0 0 0 92.00 0 0 0 0 0 92.00 92.00 0 0 0 0 0 92.00 92.00 92.00 0 0 0 0 92.00 92.00 0 0 0 0 0 92.00	73.00 07300 DRUGS CHARGED TO PATIENTS	0.285892	0		0 0	0	73.00
91.00 09100 EMERGENCY 0.308379 0 0 0 0 91.00 92.00 085ERVATION BEDS (NON-DISTINCT PART) 0.308379 0 0 0 0 92.00 92.00 0 0 0 92.00 0 0 92.00 0 0 0 92.00 0 0 0 92.00 0 0 0 92.00 200.00 200.00 200.00 200.00 201.00	OUTPATIENT SERVICE COST CENTERS						1
92.00 200.000BSERVATION BEDS (NON-DISTINCT PART)0.340334000092.00200.00 201.00Subtotal (see instructions) Less PBP Clinic Lab. Services-Program Only Charges00000200.000Only Charges000000000	90.00 09000 CLINIC	0.00000	0		0 0	0	90.00
200.00 201.00Subtotal (see instructions)0000200.00201.00Less PBP Clinic Lab. Services-Program000201.00Only Charges00201.0000	91.00 09100 EMERGENCY	0.308379	0		0 0	0	91.00
201.00 Less PBP Clinic Lab. Services-Program 0 0 201.00 Only Charges 0 201.00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.340334	0		0 0	0	92.00
Only Charges	200.00 Subtotal (see instructions)		0		0 0	0	200.00
	201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
202.00 Net Charges (line 200 - line 201) 0 0 0 0 0 0 202.00	Only Charges						
	202.00 Net Charges (line 200 - line 201)		0		0 0	0	202.00

Health	Financial Systems A	SCENSION ST. V	INCENT WARRICK		In Lie	u of Form CMS-	2552-10
APPORT	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-1325	Period:	Worksheet D	
					From 07/01/2022	Part V	
			Component o	CCN:15-Z325	то 06/30/2023	Date/Time Pre 11/24/2023 3:	
			Title	XVIII	Swing Beds - SNF	Cost	
		Co	sts				
	Cost Center Description	Cost	Cost				
		Reimbursed	Reimbursed				
		Services	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
		6.00	7.00				
	ANCILLARY SERVICE COST CENTERS	1					
	05000 OPERATING ROOM	0	0				50.00
	05100 RECOVERY ROOM	0	0				51.00
	05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
	05300 ANESTHESIOLOGY	0	0				53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0				54.00
59.00	05900 CARDIAC CATHETERIZATION	0	0				59.00
60.00	06000 LABORATORY	0	0				60.00
65.00	06500 RESPIRATORY THERAPY	0	0				65.00
66.00	06600 PHYSICAL THERAPY	0	0				66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0				67.00
68.00	06800 SPEECH PATHOLOGY	0	0				68.00
69.00	06900 ELECTROCARDIOLOGY	0	0				69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0				73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0				90.00
91.00	09100 EMERGENCY	0	0				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
200.00	Subtotal (see instructions)	0	0				200.00
201.00	Less PBP Clinic Lab. Services-Program	0					201.00
	Only Charges						
202.00	Net Charges (line 200 - line 201)	0	0				202.00

Health Financial Systems	ASCENSION ST. VIN			In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTH	ER PASS THROUGH COSTS			Period: From 07/01/2022 To 06/30/2023	Date/Time Pre 11/24/2023 3:	
			e XIX	Hospital	Cost	
Cost Center Description	Nursing	Nursing		h Allied Health	All Other	
	Program	Program	Post-Stepdow		Medical	
	Post-Stepdown		Adjustments		Education Cost	
	Adjustments					
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS	0	0	J	0	0	20.00
30.00 03000 ADULTS & PEDIATRICS	0	0		0 0	-	
31.00 03100 INTENSIVE CARE UNIT	0	0		0 0	0	
40.00 04000 SUBPROVIDER - IPF	0	0		0 0	0	
41.00 04100 SUBPROVIDER - IRF	0	0		0 0	0	
42.00 04200 SUBPROVIDER	0	0	2	0 0	0	1 .2.00
200.00 Total (lines 30 through 199)	0	0		0 0		200.00
Cost Center Description	Swing-Bed	Total Costs (sum of cols.		t Per Diem (col.	Inpatient	
		··· · · · ·	Days	5 ÷ col. 6)	Program Days	
		1 through 3, minus col. 4)				
	instructions) r 4.00	<u>5.00</u>	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS	4.00	5.00	0.00	7.00	0.00	
30.00 03000 ADULTS & PEDIATRICS	0	0	88	7 0.00	18	30.00
31.00 03100 INTENSIVE CARE UNIT	, i i i i i i i i i i i i i i i i i i i	0		0.00		
40.00 04000 SUBPROVIDER - IPF	0	0	1,81			
41.00 04100 SUBPROVIDER - IRF	Ő	0	1,01	0 0.00	0	
42.00 04200 SUBPROVIDER	Ő	0		0 0.00	-	
200.00 Total (lines 30 through 199)		0	2,69			200.00
Cost Center Description	Inpatient					200100
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	0					30.00
						31.00
31.00 03100 INTENSIVE CARE UNIT	0					1 21.00
	0					
	0 0 0					40.00
40.00 04000 SUBPROVIDER - IPF	0 0 0 0					40.00 41.00 42.00

Health	Finan	cial Systems	ASCENSION ST. V	INCENT WARRICK		In Lie	u of Form CMS-2	2552-10
APPORT THROUG		NT OF INPATIENT/OUTPATIENT ANCILLARY SEI FS	RVICE OTHER PAS			Period: From 07/01/2022 To 06/30/2023		pared: 50 pm
				Titl	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	
		LARY SERVICE COST CENTERS						
	•	OPERATING ROOM	0	0		0 0	0	50.00
		RECOVERY ROOM	0	0		0 0	0	51.00
	•	DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
		ANESTHESIOLOGY	0	0		0 0	0	53.00
		RADIOLOGY-DIAGNOSTIC	0	0		0 0	0	54.00
	•	CARDIAC CATHETERIZATION	0	0		0 0	0	59.00
		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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
		TIENT SERVICE COST CENTERS						
		CLINIC	0	0		0 0	0	50.00
		EMERGENCY	0	0		0 0	0	91.00
	4	OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	
200.00		Total (lines 50 through 199)	0	0		0 0	0	200.00

Health	Financial Systems	ASCENSION ST. V	INCENT WARRICK		In Lie	u of Form CMS-2	2552-10
	APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI THROUGH COSTS		S Provider C		Period: From 07/01/2022 To 06/30/2023		
			Titl	e XIX	Hospital	Cost	
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
		Medical	(sum of cols.	Outpatient	(from Wkst. C,		
		Education Cost		Cost (sum of		(col. 5 ÷ col.	
			4)	cols. 2, 3,	8)	7)	
				and 4)		(see	
		4.00	5.00			instructions)	
	····	4.00	5.00	6.00	7.00	8.00	
	ANCILLARY SERVICE COST CENTERS				2 506 220	0.00000	50.00
	05000 OPERATING ROOM	0	0		0 3,586,320		50.00
	05100 RECOVERY ROOM	0	0		0 0	0.00000	51.00
	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0.00000	
	05300 ANESTHESIOLOGY	0	0			0.00000	
	05400 RADIOLOGY-DIAGNOSTIC	0	0		0 20,486,822		
	05900 CARDIAC CATHETERIZATION	0	0		0 0	0.00000	59.00
	06000 LABORATORY	0	0		0 10,447,831		60.00
	06500 RESPIRATORY THERAPY	0	0		0 1,631,876		65.00
	06600 PHYSICAL THERAPY	0	0		0 845,575		
	06700 OCCUPATIONAL THERAPY	0	0		0 657,548		
	06800 SPEECH PATHOLOGY	0	0		0 48,979		68.00
	06900 ELECTROCARDIOLOGY	0	0		0 0	0.00000	69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 454,047		
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 280,050		
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 2,643,130	0.000000	73.00
	OUTPATIENT SERVICE COST CENTERS		-	1	-1 -		
	09000 CLINIC	0	0		0 0	0.00000	
	09100 EMERGENCY	0	0		0 12,797,730		91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 1,859,728		
200.00	Total (lines 50 through 199)	0	0		0 55,739,636		200.00

Health Financial Systems	ASCENSION ST. VI	NCENT WARRICK		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEE THROUGH COSTS	RVICE OTHER PASS			Period: From 07/01/2022 To 06/30/2023		
		Titl	e XIX	Hospital	Cost	
Cost Center Description	Outpatient	Inpatient	Inpatient	Outpatient	Outpatient	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Throug	5	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	0		0 0	0	50.00
51.00 05100 RECOVERY ROOM	0.000000	0		0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.000000	0		0 0	0	52.00
53.00 05300 ANESTHESIOLOGY	0.000000	0		0 0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.000000	13,735		0 0	0	54.00
59.00 05900 CARDIAC CATHETERIZATION	0.000000	0		0 0	0	59.00
60.00 06000 LABORATORY	0.000000	22,903		0 0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0.000000	3,516		0 0	0	65.00
66.00 06600 PHYSICAL THERAPY	0.000000	1,689		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	0.000000	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.000000	12,546		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS		· · · · ·				1
90.00 09000 CLINIC	0.000000	0		0 0	0	90.00
91.00 09100 EMERGENCY	0.000000	24,928		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)		79,317		0 0	0	200.00

Health Financial Systems	SCENSION ST. V	INCENT WARRICK		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-1325	Period: From 07/01/2022 To 06/30/2023	Worksheet D Part V Date/Time Pre 11/24/2023 3:	
		Titl	e XIX	Hospital	Cost	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed		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	. Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0.330598	0	51,69	07 0	0	50.00
51.00 05100 RECOVERY ROOM	0.000000	0		0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.000000	0		0 0	0	52.00
53.00 05300 ANESTHESIOLOGY	0.000000	0		0 0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.106195	0	170,29	9 0	0	54.00
59.00 05900 CARDIAC CATHETERIZATION	0.000000	0		0 0	0	59.00
60.00 06000 LABORATORY	0.207740	0	116,77	2 0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0.332055	0	9,06	5 0	0	65.00
66.00 06600 PHYSICAL THERAPY	0.363995	0	1,95	64 0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0.359140	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0.219502	0		0 0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0.000000	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.348303	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.153373	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.285892	0	20,14	4 0	0	73.00
OUTPATIENT SERVICE COST CENTERS	1		· · · · · · · · · · · · · · · · · · ·			
90.00 09000 CLINIC	0.000000	0		0 0	0	90.00
91.00 09100 EMERGENCY	0.308379	0	261,80	0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.340334	0	32,41	.5 0	0	92.00
200.00 Subtotal (see instructions)		0	664,14	6 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	664,14	16 0	0	202.00

Health Financial Systems A	SCENSION ST. V	INCENT WARRICK		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider Co		Period: From 07/01/2022 To 06/30/2023	Worksheet D Part V Date/Time Pre 11/24/2023 3	
		Titl	e XIX	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 OFERATING ROOM	17,091	0				50.00
51.00 05100 RECOVERY ROOM	0	0				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
53.00 05300 ANESTHESIOLOGY	0	0				53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	18,085	0				54.00
59.00 05900 CARDIAC CATHETERIZATION	0	0				59.00
60.00 06000 LABORATORY	24,258	0				60.00
65.00 06500 RESPIRATORY THERAPY	3,010	0				65.00
66.00 06600 PHYSICAL THERAPY	711	0				66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0				67.00
68.00 06800 SPEECH PATHOLOGY	0	0				68.00
69.00 06900 ELECTROCARDIOLOGY	0	0				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	5,759	0				73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	0				90.00
91.00 09100 EMERGENCY	80,734	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	11,032	0				92.00
200.00 Subtotal (see instructions)	160,680	0				200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0					201.00
202.00 Net Charges (line 200 - line 201)	160,680	0				202.00

	Financial Systems ASCENSION ST. VIN ATION OF INPATIENT OPERATING COST	Provider CCN: 15-1325	Period:	Worksheet D-1	
			From 07/01/2022 To 06/30/2023	Date/Time Pre	
		Title XVIII	Hospital	11/24/2023 3: Cost	<u> </u>
	Cost Center Description				
				1.00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
00	Inpatient days (including private room days and swing-bed day	/s, excluding newborn)		2,152	1
00	Inpatient days (including private room days, excluding swing-	-bed and newborn days)		887	2
00	Private room days (excluding swing-bed and observation bed da	ays). If you have only p	rivate room days,	0	3
00	do not complete this line.	and dave)		421	4
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	431 577	5
00	reporting period	577			
00	Total swing-bed SNF type inpatient days (including private ro	578	6		
	reporting period (if calendar year, enter 0 on this line)				
00	Total swing-bed NF type inpatient days (including private roo	om days) through Decembe	r 31 of the cost	55	7
00	reporting period Total swing-bed NF type inpatient days (including private roo	m dave) after Decomber	and the cost	55	8
00	reporting period (if calendar year, enter 0 on this line)	in days) areer becember .	DI UI LILE CUSC	ĴĴ	0
00	Total inpatient days including private room days applicable t	to the Program (excluding	g swing-bed and	208	9
	newborn days) (see instructions)	_	_		
0.00	Swing-bed SNF type inpatient days applicable to title XVIII of		room days)	243	10
.00	through December 31 of the cost reporting period (see instruc Swing-bed SNF type inpatient days applicable to title XVIII of	-	coom dave) after	242	11
1.00	December 31 of the cost reporting period (if calendar year, e		oom days) arter	242	1 11
2.00	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				
3.00	Swing-bed NF type inpatient days applicable to titles V or XI			0	13
1 00	after December 31 of the cost reporting period (if calendar) Medically necessary private room days applicable to the Progr			0	14
	Total nursery days (title V or XIX only)	am (excluding swing bed	uuys)	0	
	Nursery days (title V or XIX only)			-	16
	SWING BED ADJUSTMENT				
7.00	Medicare rate for swing-bed SNF services applicable to service	ces through December 31 (of the cost		17
8.00	reporting period Medicare rate for swing-bed SNF services applicable to servic	cas after December 31 of	the cost		18
	reporting period				
9.00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 o	f the cost	250.44	19
	reporting period	C 1 2 1 2			
0.00	Medicaid rate for swing-bed NF services applicable to service reporting period	es after December 31 of t	the cost	250.44	20
1 00	Total general inpatient routine service cost (see instruction	15)		2,861,832	21
	Swing-bed cost applicable to SNF type services through Decemb		ting period (line	2,001,052	
	5 x line 17)		5		
3.00	Swing-bed cost applicable to SNF type services after December	r 31 of the cost reporti	ng period (line 6	0	23
4 00	x line 18)	an 21 of the cost nonent	ing partial (line	12 774	24
+.00	Swing-bed cost applicable to NF type services through December 7 x line 19)	er si of the cost report	ing period (Tine	13,774	24
5.00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	13,774	25
	x line 20)			,	
	Total swing-bed cost (see instructions)			1,630,676	
7.00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		1,231,156	27
8 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	and observation had cl	parges)	0	28
	Private room charges (excluding swing-bed charges)		lai ges)	0	29
	Semi-private room charges (excluding swing-bed charges)			0	30
	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0.000000	31
	Average private room per diem charge (line 29 ÷ line 3)			0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
	Average per diem private room charge differential (line 32 mi Average per diem private room cost differential (line 34 x li		LIONS)	0.00	
	Private room cost differential adjustment (line 3 x line 35)	ine Jij		0.00	
7.00	General inpatient routine service cost net of swing-bed cost	and private room cost d	ifferential (line	1,231,156	
	27 minus line 36)			. , , , , ,	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				-
0.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ			1 207 00	20
	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line			1,387.99 288,702	
	Medically necessary private room cost applicable to the Progr				40
	, , , , , , , , , , , , , , , , , , ,				

IPUT	ATION OF INPATIENT OPERATING COST		Provider C	CN: 15-1325	Period: From 07/01/2022	Worksheet D-1	
					то 06/30/2023	Date/Time Pre 11/24/2023 3:	
		_		e XVIII	Hospital	Cost	
	Cost Center Description	Total Inpatient CostI	Total Inpatient Days			Program Cost (col. 3 x col.	
		1.00	2.00	col. 2) 3.00	4.00	4)	
00	NURSERY (title V & XIX only)						42.
	Intensive Care Type Inpatient Hospital Units			1			
		0	C	0.	00 0	0	
00 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44
	SURGICAL INTENSIVE CARE UNIT						45
	OTHER SPECIAL CARE (SPECIFY)						47
	Cost Center Description						
			71 000			1.00	
00 01	Program inpatient ancillary service cost (We Program inpatient cellular therapy acquisit			TTT line 10	column 1)	97,166 0	
00	Total Program inpatient costs (sum of lines				, corumn 1)	385,868	
00	PASS THROUGH COST ADJUSTMENTS	ii chrough ioroi				505,000	
00	Pass through costs applicable to Program inp	oatient routine s	services (from	n Wkst. D, su	m of Parts I and	0	50
~~	III)				C - - - -		-1
00	Pass through costs applicable to Program inp and IV)	batient ancillary	/ services (Ti	rom wkst. D,	sum of Parts II	0	51
00	Total Program excludable cost (sum of lines	50 and 51)				0	52
00	Total Program inpatient operating cost exclu		ated, non-phy	/sician anest	hetist, and	0	53
	medical education costs (line 49 minus line	52)					
~~	TARGET AMOUNT AND LIMIT COMPUTATION						
00	Program discharges					0 0.00	
00 01	Target amount per discharge Permanent adjustment amount per discharge					0.00	
	Adjustment amount per discharge (contractor	use only)				0.00	
00	Target amount (line 54 x sum of lines 55, 55					0	
00	Difference between adjusted inpatient operat	ting cost and tar	get amount (line 56 minus	line 53)	0	57
00	Bonus payment (see instructions)					0	
00	Trended costs (lesser of line 53 ÷ line 54,		the cost repo	orting period	ending 1996,	0.00	59
00	updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54		nrior year (ost renort	undated by the	0.00	60
00	market basket)		i pi ioi yeai (tost report,	upuacea by the	0.00	
00	Continuous improvement bonus payment (if lin 55.01, or line 59, or line 60, enter the les 53) are less than expected costs (lines 54 >	sser of 50% of th	ne amount by w	vhich operati	ng costs (line	0	61
	enter zero. (see instructions)		-				
		ant (can instruct	tions)			0	
00	Allowable Inpatient cost plus incentive pays PROGRAM INPATIENT ROUTINE SWING BED COST	ient (see instruc	LIONS)			0	63
00	Medicare swing-bed SNF inpatient routine cos	sts through Decem	ber 31 of the	e cost report	ing period (See	337,282	64
	instructions)(title XVIII only)						
00	Medicare swing-bed SNF inpatient routine cos	sts after Decembe	er 31 of the o	cost reportin	g period (See	335,894	65
00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient rout	ina costa (lina A	A plus line (5)(+i+lo VVT	TT only): for	673,176	66
00	CAH, see instructions		of plus line (II ONIY), TOT	075,170	
00	Title V or XIX swing-bed NF inpatient routir	ne costs through	December 31 d	of the cost r	eporting period	0	67
	(line 12 x line 19)						
00	Title V or XIX swing-bed NF inpatient routir	ne costs after De	ecember 31 of	the cost rep	orting period	0	68
00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (1	ine 67 + line	- 68)		0	69
	PART III - SKILLED NURSING FACILITY, OTHER N						1 33
00	Skilled nursing facility/other nursing facil	lity/ICF/IID rout	ine service o	cost (line 37)		70
00	Adjusted general inpatient routine service of		ne 70 ÷ line	2)			71
00	Program routine service cost (line 9 x line		(line 14 ···]	no 25)			72
00 00	Medically necessary private room cost applic Total Program general inpatient routine serv						73
00	Capital-related cost allocated to inpatient	•			Part II, column		75
	26, line 45)				,		
00	Per diem capital-related costs (line 75 ÷ li						76
00	Program capital-related costs (line 9 x line						77
00 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		ovider record	15)			78
00	Total Program routine service costs for com				nus line 79)		80
00	Inpatient routine service cost per diem limit				/		81
00	Inpatient routine service cost limitation (1				82
00	Reasonable inpatient routine service costs (5)				83
00	Program inpatient ancillary services (see in						84
00	Utilization review - physician compensation						85
00	Total Program inpatient operating costs (sur PART IV - COMPUTATION OF OBSERVATION BED PAS		ougn 85)				86
00						456	87
00	Adjusted general inpatient routine cost per		line 2)			1,388.00	
00							

Health Financial Systems	ASCENSION ST. V	INCENT WARRICK		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 11/24/2023 3:	
		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						
90.00 Capital-related cost	148,828	2,861,832	0.05200	4 632,928	32,915	90.00
91.00 Nursing Program cost	0	2,861,832	0.00000	0 632,928	0	91.00
92.00 Allied health cost	0	2,861,832	0.00000	0 632,928	0	92.00
93.00 All other Medical Education	0	2,861,832	0.00000	0 632,928	0	93.00

MPUT	Financial Systems ASCENSION ST. VING ATION OF INPATIENT OPERATING COST	Provider CCN: 15-1325	Period:	u of Form CMS-2 Worksheet D-1	
		Component CCN:15-M325	From 07/01/2022 To 06/30/2023	Date/Time Pre 11/24/2023 3:	
		Title XVIII	Subprovider - IPF	PPS	30
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	INPATIENT DAYS				
00	Inpatient days (including private room days and swing-bed day			1,812	
00	Inpatient days (including private room days, excluding swing-			1,812	
00	Private room days (excluding swing-bed and observation bed da do not complete this line.	ays). If you have only pr	ivate room days,	0	3
00	Semi-private room days (excluding swing-bed and observation b	bed davs)		1,812	4
00	Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	_,	
	reporting period				
00	Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line)	om dave) through Decomber	21 of the cost	0	-
0	Total swing-bed NF type inpatient days (including private roc reporting period	om days) through becember	SI OI LHE COSL	0	'
00	Total swing-bed NF type inpatient days (including private roc	om davs) after December 3	1 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	to the Program (excluding	swing-bed and	1,159	9
00	newborn days) (see instructions)				
.00	Swing-bed SNF type inpatient days applicable to title XVIII of through December 31 of the cost reporting period (see instruct		oun days)	0	10
.00	Swing-bed SNF type inpatient days applicable to title XVIII of		oom days) after	0	11
	December 31 of the cost reporting period (if calendar year, e			-	
.00	Swing-bed NF type inpatient days applicable to titles V or XI \ensuremath{NF}	IX only (including privat	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 XI after December 31 of the cost reporting period (if calendar y			0	13
.00	Medically necessary private room days applicable to the Progr			0	14
.00	Total nursery days (title V or XIX only)	Tam (excluding swing bed	uuysy	0	
.00	Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT				
.00	Medicare rate for swing-bed SNF services applicable to servic	ces through December 31 c	of the cost		17
.00	reporting period Medicare rate for swing-bed SNF services applicable to servic	cos often December 21 of	the cost		18
.00	reporting period	ces alter becember 51 01	the cost		1 10
.00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 of	the cost	250.44	19
	reporting period	-			
.00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of t	he cost	250.44	20
.00	reporting period Total general inpatient routine service cost (see instructior			3,486,660	21
.00	Swing-bed cost applicable to SNF type services through Decemb		ing period (line	3,480,000	
	5 x line 17)		ing period (The	0	
.00	Swing-bed cost applicable to SNF type services after December	r 31 of the cost reportin	g period (line 6	0	23
	x line 18)				
.00	Swing-bed cost applicable to NF type services through December	er 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	31 of the cost reporting	neriod (line 8	0	25
.00	x line 20)	Si or the cost reporting		0	23
.00	Total swing-bed cost (see instructions)			0	26
.00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		3,486,660	27
00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	. I I			
.00 .00	General inpatient routine service charges (excluding swing-be	ed and observation bed cr	larges)	0	
.00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	
.00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0.000000	
.00	Average private room per diem charge (line 29 ÷ line 3)	-		0.00	
.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
.00	Average per diem private room charge differential (line 32 mi		tions)	0.00	
.00 .00	Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35)	ine 31)		0.00	
.00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	0 3,486,660	
.00	27 minus line 36)	and private room cost un		5,700,000	''
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	JUSTMENTS			
	Adjusted general inpatient routine service cost per diem (see	e instructions)		1,924.21	
.00 .00 .00		e instructions) e 38)		1,924.21 2,230,159 0	39

PUT	ATION OF INPATIENT OPERATING COST		Provider C	CN: 15-1325	Period: From 07/01/2022	Worksheet D-1	L
			Component	ссм:15-м325	To 06/30/2023		
			Title	XVIII	Subprovider -	11/24/2023 3: PPS	50
	Cont. Conton Decemintion				IPF	Durana Cart	_
	Cost Center Description	Total Inpatient CostI	Total npatient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	+
	NURSERY (title V & XIX only)						42
	Intensive Care Type Inpatient Hospital Units	0	0	0	00 0	0	
00 00	INTENSIVE CARE UNIT CORONARY CARE UNIT	0	U	0.	00 0	0	4
00	BURN INTENSIVE CARE UNIT						4
00	SURGICAL INTENSIVE CARE UNIT						4
00	OTHER SPECIAL CARE (SPECIFY)						4
	Cost Center Description					1.00	+
)0	Program inpatient ancillary service cost (Wk	st. D-3. col. 3.	line 200)			150,877	4
)1	Program inpatient cellular therapy acquisiti			III, line 10	, column 1)	0	
00	Total Program inpatient costs (sum of lines	41 through 48.01)(see instruc	tions)	· · ·	2,381,036	4
	PASS THROUGH COST ADJUSTMENTS						
00	Pass through costs applicable to Program inp III)	atient routine s	ervices (from	ı Wkst. D, su	m of Parts I and	0	5
00	Pass through costs applicable to Program inp	atient ancillarv	services (fr	om Wkst. D.	sum of Parts IT	4,854	5
-	and IV)					.,	
00	Total Program excludable cost (sum of lines					4,854	
00	Total Program inpatient operating cost exclu		ated, non-phy	sician anest	hetist, and	2,376,182	5
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	525				<u> </u>	
	Program discharges					0	5
00	Target amount per discharge					0.00	
)1	Permanent adjustment amount per discharge					0.00	
)2)0	Adjustment amount per discharge (contractor Target amount (line 54 x sum of lines 55, 55					0.00	
	Difference between adjusted inpatient operat		get amount (1	ine 56 minus	line 53)	0	
00	Bonus payment (see instructions)	5	J (,	0	5
00	Trended costs (lesser of line 53 ÷ line 54,		the cost repo	orting period	ending 1996,	0.00	5
00	updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54,		nnion voon	oct roport	undated by the	0.00	
00	market basket)	of the 55 from	prior year c	ost report,	upualeu by the	0.00	" "
00	Continuous improvement bonus payment (if lin 55.01, or line 59, or line 60, enter the les 53) are less than expected costs (lines 54 x enter zero. (see instructions)	ser of 50% of th	e amount by w	hich operati	ng costs (line	0	6
00	Relief payment (see instructions)					0	6
	Allowable Inpatient cost plus incentive paym	ent (see instruc	tions)			0	0 6
	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Decem	her 31 of the	cost report	ing period (See	0	6
	instructions)(title XVIII only)	-					
00	Medicare swing-bed SNF inpatient routine cos	ts after Decembe	r 31 of the c	ost reportin	g period (See	0	6
00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi</pre>	ne costs (line 6	4 nlus line f	5)(+i+le XVT	TT only): for	0	6
	CAH, see instructions				,,,,		
00	Title V or XIX swing-bed NF inpatient routin	e costs through	December 31 c	of the cost r	eporting period	0	6
20	(line 12 x line 19)	a costa after a	combon 21 of	the cost as	orting pariod	_	
00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e cosis aiter De	Cellinel. 2T OL	the cost rep	or cring period	0	68
00	Total title V or XIX swing-bed NF inpatient	routine costs (1	<u>ine 67 +</u> line	68)		0	6
	PART III - SKILLED NURSING FACILITY, OTHER N						
00	Skilled nursing facility/other nursing facil)		7
00 00	Adjusted general inpatient routine service c Program routine service cost (line 9 x line		ne /v ÷ line	۷)			7
	Medically necessary private room cost applic		(line 14 x li	ne 35)			7
00	Total Program general inpatient routine serv	ice costs (line	72 + line 73)				7
00	Capital-related cost allocated to inpatient	routine service	costs (from w	orksheet B,	Part II, column		7
00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					7
00	Program capital-related costs (line 75 ÷ 11 Program capital-related costs (line 9 x line						7
00	Inpatient routine service cost (line 74 minu	s line 77)					7
00	Aggregate charges to beneficiaries for exces				1		7
	Total Program routine service costs for comp Inpatient routine service cost per diem limi		st limitatior	i (inne 78 mi	nus line 79)		8
	Inpatient routine service cost per diem fimi Inpatient routine service cost limitation (1						8
00	Reasonable inpatient routine service costs (8
00	Program inpatient ancillary services (see in						84
00	Utilization review - physician compensation						8
	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PAS		ougn 85)			<u> </u>	8
	Total observation bed days (see instructions					0	8
	Adjusted general inpatient routine cost per		1			0.00	

Health Financial Systems	ASCENSION ST. V	INCENT WARRICK		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO	CN: 15-1325	Period:	Worksheet D-1	
		Component o	CCN:15-M325	From 07/01/2022 To 06/30/2023	Date/Time Pre 11/24/2023 3:	
		Title	XVIII	Subprovider -	PPS	
Cost Center Description	Cont Control Description					
Cost Center Description					1 00	
					1.00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions)				0	89.00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observation	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	$(col. 3 \times col.$	
					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	0	3,486,660	0.0000	0 00	0	90.00
91.00 Nursing Program cost	0	3,486,660		0 00	0	91.00
92.00 Allied health cost	0	3,486,660			0	92.00
93.00 All other Medical Education	0	3,486,660			0	93.00
	-			1	-	

OMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-1325	Period: From 07/01/2022 To 06/30/2023	Worksheet D-1 Date/Time Prep 11/24/2023 3:	pare
		Title XIX	Hospital	Cost	50 pi
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	INPATIENT DAYS				
.00	Inpatient days (including private room days and swing-bed day			2,152	
.00 .00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed da		rivato room dave	887 0	2
.00	do not complete this line.	ys). If you have only p	Ivace Ioom uays,	0	
.00	Semi-private room days (excluding swing-bed and observation b	ed days)		431	4
.00	Total swing-bed SNF type inpatient days (including private ro	om days) through Decembe	er 31 of the cost	1,155	5
00	reporting period Total swing-bed SNF type inpatient days (including private ro	om dave) after Decomber	21 of the cost	0	6
.00	reporting period (if calendar year, enter 0 on this line)	on days) arter becember	SI OI LIE COSL	0	0
.00	Total swing-bed NF type inpatient days (including private roo	m days) through December	r 31 of the cost	110	7
	reporting period				
.00	Total swing-bed NF type inpatient days (including private roo	m days) after December 3	31 of the cost	0	8
.00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable t	o the Program (excluding	swing-bed and	18	9
	newborn days) (see instructions)		g swing bed and	10	
00.0	Swing-bed SNF type inpatient days applicable to title XVIII o		room days)	0	10
1.00	through December 31 of the cost reporting period (see instruc				11
1.00	Swing-bed SNF type inpatient days applicable to title XVIII o December 31 of the cost reporting period (if calendar year, e		room days) atter	0	11
2.00	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				
3.00	Swing-bed NF type inpatient days applicable to titles V or XI			0	13
4.00	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)	am (excluding swing bed	uays)	0	15
	Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT				
7.00	Medicare rate for swing-bed SNF services applicable to servic reporting period	es through December 31 d	of the cost		17
8.00	Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost		18
	reporting period				
9.00	Medicaid rate for swing-bed NF services applicable to service	s through December 31 of	f the cost	250.44	19
0.00	reporting period Medicaid rate for swing-bed NF services applicable to service	s after December 31 of t	the cost	250.44	20
0.00	reporting period	s arter becember 51 01		230.44	20
1.00	Total general inpatient routine service cost (see instruction	s)		2,861,832	21
2.00		er 31 of the cost report	ting period (line	0	22
2 00	5 x line 17)	21 of the cost mount:	a mariad (line (22
3.00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reportin	ig period (line 6	0	23
4.00	Swing-bed cost applicable to NF type services through Decembe	r 31 of the cost report	ing period (line	27,548	24
	7 x line 19)				
5.00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	g period (line 8	0	25
6.00	x line 20) Total swing-bed cost (see instructions)			1,630,676	26
	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		1,231,156	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
	General inpatient routine service charges (excluding swing-be	d and observation bed cl	narges)		28
	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29
	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0.000000	
	Average private room per diem charge (line 29 ÷ line 3)	-		0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
	Average per diem private room charge differential (line 32 mi		ctions)	0.00	
	Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35)	ile JL)		0.00	35
	General inpatient routine service cost net of swing-bed cost	and private room cost d [.]	ifferential (line	1,231,156	
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
3.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ Adjusted general inpatient routine service cost per diem (see			1,387.99	20
	Program general inpatient routine service cost (line 9 x line			24,984	
	Medically necessary private room cost applicable to the Progr			0	40
	Total Program general inpatient routine service cost (line 39			24,984	11

OMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-1325		Period: From 07/01/2022 To 06/30/2023		pare	
				le XIX	Hospital	11/24/2023 3: Cost	50 p
	Cost Center Description	Total Inpatient CostI	Total	Average Per Diem (col. 1	Program Days	Program Cost (col. 3 x col.	
		1.00	2.00	col. 2) 3.00	4.00	4)	
.00	NURSERY (title V & XIX only)						42.
	Intensive Care Type Inpatient Hospital Units					-	
	INTENSIVE CARE UNIT	0	C	0.	00 0	0	
.00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44.
	SURGICAL INTENSIVE CARE UNIT						46
	OTHER SPECIAL CARE (SPECIFY)						47
	Cost Center Description						
.00	Program inpatient ancillary service cost (Wk		1ima 200)			1.00	48
01	Program inpatient cellular therapy acquisiti			TTT line 10	column 1)	19,274	1
00	Total Program inpatient costs (sum of lines				, соташт 1)	44,258	
	PASS THROUGH COST ADJUSTMENTS		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			,	1
.00	Pass through costs applicable to Program inp	atient routine s	ervices (from	n Wkst. D, su	m of Parts I and	0	50
00	III)	ationt ancillan	convices (f	om What D	sum of Donte II	0	F1
.00	Pass through costs applicable to Program inp and IV)	atient ancillary	services (Ti	'om wkst. D,	sum of Parts II	0	51
.00	Total Program excludable cost (sum of lines	50 and 51)				0	52
00	Total Program inpatient operating cost exclu		ated, non-phy	/sician anest	hetist, and	0	
	medical education costs (line 49 minus line	52)					1
00	TARGET AMOUNT AND LIMIT COMPUTATION					0	A
00	Program discharges Target amount per discharge					0.00	
01	Permanent adjustment amount per discharge					0.00	
02	Adjustment amount per discharge (contractor	use only)				0.00	55
	Target amount (line 54 x sum of lines 55, 55					0	
	Difference between adjusted inpatient operat	ing cost and tar	get amount (line 56 minus	line 53)	0	
00	Bonus payment (see instructions) Trended costs (lesser of line 53 ÷ line 54,	on line EE from	the cost rong	nting pariod	onding 1006	0 0.00	
00	updated and compounded by the market basket)		the cost repo	biting period	enung 1990,	0.00	59
00	Expected costs (lesser of line 53 ÷ line 54,		prior year o	cost report,	updated by the	0.00	60
	market basket)			-			
00	Continuous improvement bonus payment (if lin 55.01, or line 59, or line 60, enter the les 53) are less than expected costs (lines 54 x enter zero. (see instructions)	ser of 50% of th	e amount by w	which operati	ng costs (line	0	61
	Relief payment (see instructions)					0	
00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instruc	tions)			0	63
00		ts through Decem	ber 31 of the	cost report	ing period (See	0	64
	instructions)(title XVIII only)	to through becch			ing period (bee	Ŭ	° .
00	Medicare swing-bed SNF inpatient routine cos	ts after Decembe	er 31 of the o	cost reportin	g period (See	0	65
00	instructions)(title XVIII only)		4				
.00	Total Medicare swing-bed SNF inpatient routi CAH. see instructions	ne costs (line 6	4 plus line 6	S)(title XVI	11 only); for	0	66
.00	Title V or XIX swing-bed NF inpatient routin	e costs through	December 31 d	of the cost r	eportina period	0	67
,	(line 12 x line 19)	-					
.00	Title V or XIX swing-bed NF inpatient routin	e costs after De	cember 31 of	the cost rep	orting period	0	68
00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (1	ine 67 1 1in	68)		0	69
. 00	PART III - SKILLED NURSING FACILITY, OTHER N					0	109
.00	Skilled nursing facility/other nursing facil)		70
00	Adjusted general inpatient routine service of		ne 70 ÷ line	2)			71
00	Program routine service cost (line 9 x line		(line 14]	no 25)			72
00 00	Medically necessary private room cost applic Total Program general inpatient routine serv						73
00	Capital-related cost allocated to inpatient				Part II, column		75
	26, line 45)			7	,		
00	Per diem capital-related costs (line 75 ÷ li						76
00 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77
00	Aggregate charges to beneficiaries for exces		ovider record	ls)			78
00	Total Program routine service costs for comp				nus line 79)		80
00	Inpatient routine service cost per diem limi						81
00	Inpatient routine service cost limitation (1						82
00	Reasonable inpatient routine service costs (() ()				83
00 00	Program inpatient ancillary services (see in Utilization review - physician compensation		(2)				84
	Total Program inpatient operating costs (sum						86
	PART IV - COMPUTATION OF OBSERVATION BED PAS						1
	Total observation bed days (see instructions						87
.00	Adjusted general inpatient routine cost per	diem (line 27 ÷	line 2)			1,388.00	
	Observation bed cost (line 87 x line 88) (se	A dimensional and the second sec				632,928	

Health Financial Systems	ASCENSION ST. V	INCENT WARRICK		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 11/24/2023 3:	
			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	COST					
90.00 Capital-related cost	148,828	2,861,832	0.05200	4 632,928	32,915	90.00
91.00 Nursing Program cost	0	2,861,832	0.00000	0 632,928	0	91.00
92.00 Allied health cost	0	2,861,832	0.00000	0 632,928	0	92.00
93.00 All other Medical Education	0	2,861,832	0.00000	0 632,928	0	93.00

Health Financial Systems ASCENSION ST. VINC					u of Form CMS-2	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1325	Period:		Worksheet D-3	
				n 07/01/2022	Date/Time Pre	nanad.
			То	06/30/2023	11/24/2023 3:	
	Title	e XVIII		Hospital	Cost	<u>50 piii</u>
Cost Center Description		Ratio of Cos	st	Inpatient	Inpatient	
		To Charges		Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
		1.00		2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS				253,442		30.00
31.00 03100 INTENSIVE CARE UNIT				0		31.00
40.00 O4000 SUBPROVIDER - IPF				0		40.00
41.00 04100 SUBPROVIDER - IRF				0		41.00
42.00 O4200 SUBPROVIDER				0		42.00
ANCILLARY SERVICE COST CENTERS		1				
50.00 05000 OPERATING ROOM		0.3305		0	0	
51.00 05100 RECOVERY ROOM		0.0000		0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0.0000		0	0	52.00
53.00 05300 ANESTHESIOLOGY		0.0000		0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC		0.1061		85,494	9,079	
59.00 05900 CARDIAC CATHETERIZATION		0.0000		0	0	
60.00 06000 LABORATORY		0.2077		89,450	18,582	
65.00 06500 RESPIRATORY THERAPY		0.3320		47,959	15,925	
66.00 06600 PHYSICAL THERAPY		0.3639		12,236	4,454	
67.00 06700 OCCUPATIONAL THERAPY		0.3591		17,118	6,148	
68.00 06800 SPEECH PATHOLOGY		0.2195		4,947	1,086	
69.00 06900 ELECTROCARDIOLOGY		0.0000		0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.3483		31,732	11,052	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0.1533		0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0.2858	92	86,802	24,816	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC		0.0000		0	0	
91.00 09100 EMERGENCY		0.3083		14,011	4,321	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0.3403	34	5,004		92.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)				394,753		200.00
201.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)			0		201.00
202.00 Net charges (line 200 minus line 201)				394,753		202.00

42.00 04200 SUBPROVIDER 42.00 ANCILLARY SERVICE COST CENTERS ANCILLARY SERVICE COST CENTERS ANCILLARY SERVICE COST CENTERS 0.00 05000 0PERATING ROOM 0.000000 0 51.00 51.00 05100 RECOVERY ROOM 0.000000 0 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0 53.00 53.00 05300 ANESTHESIOLOGY 0.106195 39,300 4,173 54.00 05400 RADILACY TAKNOSTIC 0.106195 39,300 4,173 54.00 059.00 OS500 CADIAC CATHETERIZATION 0.000000 0 0 66.00 06600 LABORATORY 0.332055 9,429 3,131 65.00 66.00 06600 PHYSICAL THERAPY 0.363995 3,385 1,232 66.00 66.00 06600 PHYSICAL THERAPY 0.348303 22,222 7,750 71.00 67.00 06500 CECTROCARDIOLOGY 0.153373 0 0 72.00 <tr< th=""><th>Health Financial Systems</th><th>ASCENSION ST. VINCENT WARRICK</th><th></th><th>In Lie</th><th>eu of Form CMS-</th><th>2552-10</th></tr<>	Health Financial Systems	ASCENSION ST. VINCENT WARRICK		In Lie	eu of Form CMS-	2552-10
Component CCN: 15-M325 To 06/30/2023 Date/Time Prepared: 11/24/2023 3:50 pm Title XVIII Subprovider - IPF PPS Cost Center Description Ratio of Cost To Charges Inpatient Program Costs (col. 1 x col. 2) 30.00 30.00 03000 Adults & PEDIATRICS 1.00 2.00 3.00 30.00 03000 SubPROVIDER - IRF 2,502,189 40.00 41.00 04100 SubPROVIDER - IRF 2,502,189 40.00 42.00 AVOID SubPROVIDER - IRF 0.330598 0 050.00 0.00 05000 OPERATING ROOM 0.330598 0 050.00 50.00 0.00 05000 OPERATING ROOM 0.330598 0 050.00 53.00 0.00 05000 OPERATING ROOM 0.330598 0 0 53.00 0.00 05000 OPERATING ROOM 0.3300598 0 0 53.00 0.00 05000 OPERATING ROOM 0.000000 0	INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1325			
Intervention Title XVIII Subprovider - IPF Intrad/2023 3:50 pm Cost Center Description Ratio of Cost To charges Inpatient Program (charges Inpatient Program Costs (col. 1 x col. 2) Inpatient Program Costs (col. 1 x col. 2) Inpatient Program Costs (col. 1 x col. 2) 30.00 30.00 03000 ADULTS & PEDIATRICS 30.00 30.00 30.00 30.00 10.00 040.00 SUBPROVIDER - IFF 2, 502,189 40.00 40.00 40.00 O4200 SUBPROVIDER - IFF 2, 502,189 40.00 40.00 O4200 SUBPROVIDER - IFF 0.330598 0 0 50.00 05000 OPERATING ROOM 0.330598 0 0 50.00 51.00 05000 DELIVERY ROOM 0.000000 0 52.00 53.00 61.00 05000 CARDAC CATHERIZATION NOM 0.000000 0 0 53.00 59.00 05000 CARDAC CATHERIZATION 0.000000 0 0 53.00 66.00 065000 RADICOCOVERATION 0.000000 0 0 53.00 66.00 06600 PHYSICAL THERAPY		Common and	CON 15 N225	From 07/01/2022	Data /Time Due	
Title XVIII Subprovider - TPF PPS Cost Center Description Ratio of Cost To Charges Inpatient Program Charges Inpatient Program Charges Inpatient Program Charges Inpatient Program Charges Inpatient Cost (col. 1 x col. 2) Inpatient Program Charges Inpatient Cost (col. 1 x col. 2) Inpatient Cost (col. 1 x col. 2) Inpatient Program Charges Inpatient Cost (col. 1 x col. 2) Inpatient (cost (col. 1 x col. 2) Inpatient (cost cost (cost (col. 1 x col. 2) Inp		Component	CCN: 15-M325	10 06/30/2023	11/24/2023 3:	50 pm
Cost Center Description Ratio of Cost To Charges Inpatient Program (charges Inpatient Program (cal. 1 x col. 2) INPATIENT ROUTINE SERVICE COST CENTERS 1.00 2.00 3.00 30.00 03000 ADULTS & PEDIATRICS 3.00 3.00 31.00 03000 SUBPROVIDER - IPF 2,502,189 40.00 41.00 04100 SUBPROVIDER - IRF 2,502,189 40.00 42.00 05000 PEATING ROM 0.330598 0 50.00 50.00 05000 AADULTS ROM 0.000000 0 51.00 50.00 05000 ADULTS ROM 0.000000 0 51.00 61.00 05000 ADULTS ROM 0.000000 0 51.00 50.00 05400 REATING ROM 0.000000 0 53.00 50.00 05400 RADICS CATHERIZATION 0.000000 0 53.00 50.00 05400 RADIC CATHERIZATION 0.000000 0 53.00 60.00 06000 LABORATORY 0.332055 9,429 3.131 65.00 60.00 05000 CADIACATHERIZATION 0.363995		Title	e XVIII	Subprovider -		
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201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00			0.5405		, v	
				0		201.00
	202.00 Net charges (line 200 minus line 201			640,026		202.00

	Financial Systems	ASCENSION ST. VINCE				Lieu of Form		
INPATI	IENT ANCILLARY SERVICE COST APPORTIONMENT		Provider C	CN: 15-1325	Period: From 07/01/2	Workshee	et D-3	\$
			Component	CCN:15-Z325	To 06/30/2		e Pre	nared.
			•			11/24/20		
			Title		Swing Beds -		Cost	
	Cost Center Description			Ratio of Cos				
				To Charges		Program (
					Charges	(col. 1 x	col.	
						2)		
				1.00	2.00	3.00		_
20.00	INPATIENT ROUTINE SERVICE COST CENTERS			1				30.00
30.00								
31.00								31.00
40.00	04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF							40.00
41.00								41.00
42.00	04200 SUBPROVIDER							42.00
50.00	ANCILLARY SERVICE COST CENTERS			0.3305	0.0	0	0	50.00
	05100 RECOVERY ROOM			0.0000		0	0	
52.00	05200 DELIVERY ROOM & LABOR ROOM			0.0000		0	0	
53.00	05300 ANESTHESIOLOGY			0.0000		0	0	
54.00	05400 RADIOLOGY-DIAGNOSTIC			0.1061		475	3,236	
59.00	05900 CARDIAC CATHETERIZATION			0.0000		47.5	0,230	
60.00	06000 LABORATORY			0.2077		760 3	4,850	
65.00	06500 RESPIRATORY THERAPY			0.3320	,		8,424	
66.00	06600 PHYSICAL THERAPY			0.3639			4,795	
67.00	06700 OCCUPATIONAL THERAPY			0.3591			7,111	
68.00	06800 SPEECH PATHOLOGY			0.2195	,		2,634	
69.00	06900 ELECTROCARDIOLOGY			0.0000		0	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	s		0.3483		-	3,640	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	-		0.1533		0	0	
73.00				0.2858	-	264 6	4,401	
	OUTPATIENT SERVICE COST CENTERS			012000		2011 0	.,	
90.00				0.0000	00	0	0	90.00
91.00	09100 EMERGENCY			0.3083		0	0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0.3403	-	818	2,661	
200.00					762,			200.00
201.00			(line 61)			0	, ,=	201.00
202.00					762,	160		202.00

Health Financial Systems ASCENSION ST. VINC					u of Form CMS-2	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1325		riod:	Worksheet D-3	
				om 07/01/2022	Date/Time Pre	nonod.
			То	06/30/2023	11/24/2023 3:	
	Titl	le XIX		Hospital	Cost	<u>50 pm</u>
Cost Center Description		Ratio of Cos	st	Inpatient	Inpatient	
		To Charges		Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
		1.00		2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS				23,312		30.00
31.00 03100 INTENSIVE CARE UNIT				0		31.00
40.00 O4000 SUBPROVIDER - IPF				0		40.00
41.00 04100 SUBPROVIDER - IRF				0		41.00
42.00 04200 SUBPROVIDER				0		42.00
ANCILLARY SERVICE COST CENTERS		1				
50.00 05000 OPERATING ROOM		0.3305		0	0	
51.00 05100 RECOVERY ROOM		0.0000		0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0.0000		0	0	52.00
53.00 05300 ANESTHESIOLOGY		0.0000		0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC		0.1061		13,735	1,459	
59.00 05900 CARDIAC CATHETERIZATION		0.0000		0	0	
60.00 06000 LABORATORY		0.2077		22,903	4,758	
65.00 06500 RESPIRATORY THERAPY		0.3320		3,516	1,168	
66.00 06600 PHYSICAL THERAPY		0.3639		1,689	615	
67.00 06700 OCCUPATIONAL THERAPY		0.3591		0	0	67.00
68.00 06800 SPEECH PATHOLOGY		0.2195		0	0	68.00
69.00 06900 ELECTROCARDIOLOGY		0.0000		0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.3483		0	0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0.1533		0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0.2858	92	12,546	3,587	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC		0.0000		0	0	
91.00 09100 EMERGENCY		0.3083		24,928	7,687	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0.3403	34	0	0	
200.00 Total (sum of lines 50 through 94 and 96 through 98)				79,317	19,274	
201.00 Less PBP Clinic Laboratory Services-Program only charges	; (line 61)			0		201.00
202.00 Net charges (line 200 minus line 201)				79,317		202.00

Health Financial Systems	ASCENSION ST. VINCENT WARRICK			In Lie	u of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1325		iod:	Worksheet D-3	
	Component	ссм:15-м325	Fro	m 07/01/2022 06/30/2023	Date/Time Pre	narod.
	component	CCN. 13-M323	10	00/30/2023	11/24/2023 3:	
	Titl	e XIX	Su	ıbprovider -	Cost	
				IPF		
Cost Center Description		Ratio of Cos		Inpatient	Inpatient	
		To Charges		Program	Program Costs	
				Charges	(col. 1 x col.	
		1.00		2.00	2) 3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00		2.00	5.00	
30.00 03000 ADULTS & PEDIATRICS						30.00
31.00 03100 INTENSIVE CARE UNIT						31.00
40.00 04000 SUBPROVIDER - IPF				0		40.00
41.00 04100 SUBPROVIDER - IRF				0		41.00
42.00 04200 SUBPROVIDER						42.00
ANCILLARY SERVICE COST CENTERS			_			
50.00 05000 OPERATING ROOM		0.3305	98	0	0	50.00
51.00 05100 RECOVERY ROOM		0.0000	00	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0.0000	00	0	0	52.00
53.00 05300 ANESTHESIOLOGY		0.0000	00	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC		0.1061	95	0	0	54.00
59.00 05900 CARDIAC CATHETERIZATION		0.0000	00	0	0	59.00
60.00 06000 LABORATORY		0.2077	40	0	0	
65.00 06500 RESPIRATORY THERAPY		0.3320	55	0	0	65.00
66.00 06600 PHYSICAL THERAPY		0.3639	95	0	0	00.00
67.00 06700 OCCUPATIONAL THERAPY		0.3591		0	0	
68.00 06800 SPEECH PATHOLOGY		0.2195		0	0	
69.00 06900 ELECTROCARDIOLOGY		0.0000		0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	5	0.3483		0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0.1533		0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0.2858	92	0	0	73.00
OUTPATIENT SERVICE COST CENTERS		0.0000	0.0		2	
90.00 09000 CLINIC		0.0000		0	0	
91.00 09100 EMERGENCY		0.3083		0	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0.3403	34	0	0	02.00
200.00 Total (sum of lines 50 through 94 ar				0	0	200.00
201.00 Less PBP Clinic Laboratory Services- 202.00 Net charges (line 200 minus line 201				0		201.00
202.00 Net charges (line 200 minus line 201	L)	I		0		202.00

CUL	Financial Systems ASCENSION ST. VINCENT N ATION OF REIMBURSEMENT SETTLEMENT Pro	vider CCN: 15-1325	Period: From 07/01/2022 To 06/30/2023	u of Form CMS-2 Worksheet E Part B Date/Time Pre	
				11/24/2023 3:	
		Title XVIII	Hospital	Cost	
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
0 0	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instructions	5)		2,273,445	
0	OPPS or REH payments	5)		0	
0	Outlier payment (see instructions)			0	
1	Outlier reconciliation amount (see instructions)			0	1 .
0	Enter the hospital specific payment to cost ratio (see instructior Line 2 times line 5	ns)		0.000	
0	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
0	Transitional corridor payment (see instructions)			0	
0	Ancillary service other pass through costs from Wkst. D, Pt. IV, o	col. 13, line 200		0	-
	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)			0 2,273,445	
00	COMPUTATION OF LESSER OF COST OR CHARGES			2,275,445	1 - 1
	Reasonable charges				
	Ancillary service charges			0	
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 6 Total reasonable charges (sum of lines 12 and 13)	69)		0	
00	Customary charges			0	1 14
00	Aggregate amount actually collected from patients liable for payme			0	15
00	Amounts that would have been realized from patients liable for pay	yment for services	on a chargebasis	0	16
00	had such payment been made in accordance with 42 CFR §413.13(e) Ratio of line 15 to line 16 (not to exceed 1.000000)			0.00000	1 1 7
00	Total customary charges (see instructions)			0.0000000000000000000000000000000000000	
00	Excess of customary charges over reasonable cost (complete only if	f line 18 exceeds l	ine 11) (see	0	
	instructions)				
00	Excess of reasonable cost over customary charges (complete only if instructions)	f line 11 exceeds l	ine 18) (see	0	20
00	Lesser of cost or charges (see instructions)			2,296,179	21
	Interns and residents (see instructions)			0	
	Cost of physicians' services in a teaching hospital (see instruction	ions)		0	
00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	24
00	Deductibles and coinsurance amounts (for CAH, see instructions)			26,360	25
00	Deductibles and Coinsurance amounts relating to amount on line 24	(for CAH, see inst	ructions)	1,862,080	
00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus	the sum of lines 2	2 and 23] (see	407,739	27
00	instructions) Direct graduate medical education payments (from Wkst. E-4, line 5	50)		0	28
50	REH facility payment amount	50)		0	28
	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
00	Subtotal (sum of lines 27, 28, 28.50 and 29)			407,739	
00 00	Primary payer payments Subtotal (line 30 minus line 31)			283 407,456	
00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)			407,430	1 32
	Composite rate ESRD (from Wkst. I-5, line 11)			0	33
00	Allowable bad debts (see instructions)			137,684	
00 00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructi	ions)		89,495 100,533	
	Subtotal (see instructions)			496,951	
00	MSP-LCC reconciliation amount from PS&R			0	38
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	1
50 75	Pioneer ACO demonstration payment adjustment (see instructions) N95 respirator payment adjustment amount (see instructions)			0	39
75 97	Demonstration payment adjustment amount before sequestration			0	
98	Partial or full credits received from manufacturers for replaced of	devices (see instru	ctions)	0	39
99	RECOVERY OF ACCELERATED DEPRECIATION			0	
00	Subtotal (see instructions)			496,951	
01 02	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration			9,939	
	Sequestration adjustment-PARHM pass-throughs			-	40
	Interim payments			741,641	
	Interim payments-PARHM Tentative settlement (for contractors use only)			0	41
00	Tentative settlement-PARHM (for contractor use only)			0	42
00	Balance due provider/program (see instructions)			-254,629	
01	Balance due provider/program-PARHM (see instructions)	• • • • · · -			43
00	Protested amounts (nonallowable cost report items) in accordance v	with CMS Pub. 15-2,	chapter 1,	25,000	44
	§115.2 TO BE COMPLETED BY CONTRACTOR				
00	Original outlier amount (see instructions)			0	90
	Outlier reconciliation adjustment amount (see instructions)			0	
00					
00 00	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)			0.00	

Health Financial Systems	ASCENSION ST. VINCENT WARRICK	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1325	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

	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1325	Period: From 07/01/2022	Worksheet E Part B	
		Component CCN: 15-M325	то 06/30/2023	Date/Time Pre 11/24/2023 3:	
		Title XVIII	Subprovider - IPF	PPS	
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				1
00 00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instruct	tions)		0	
00	OPPS or REH payments			0	3
00 01	Outlier payment (see instructions) Outlier reconciliation amount (see instructions)			0	
00	Enter the hospital specific payment to cost ratio (see instructions)	ctions)		0.000	
00	Line 2 times line 5			0	
00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
00 00	Transitional corridor payment (see instructions) Ancillary service other pass through costs from Wkst. D, Pt. 1	TV col 13 line 200		0	
.00	Organ acquisitions	IV, COI. IS, THE 200		0	1 7
	Total cost (sum of lines 1 and 10) (see instructions)			0	11
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges				-
	Ancillary service charges			0	12
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, li	ine 69)			13
	Total reasonable charges (sum of lines 12 and 13)			0	14
	Customary charges Aggregate amount actually collected from patients liable for p	payment for services on	a charge basis	0	1
	Amounts that would have been realized from patients liable for	r payment for services o			16
.00	had such payment been made in accordance with 42 CFR 413.13(6 Ratio of line 15 to line 16 (not to exceed 1.000000)	e)		0.00000	1.
	Total customary charges (see instructions)				
	Excess of customary charges over reasonable cost (complete on	ly if line 18 exceeds li	ne 11) (see		1
0.00	instructions)	ly if line 11 eyeeede li	no 19) (coo	0	20
.00	Excess of reasonable cost over customary charges (complete on instructions)	Ty IT THE IT exceeds IT	lie 10) (See	0	20
	Lesser of cost or charges (see instructions)			0	
	Interns and residents (see instructions)				22
	Cost of physicians' services in a teaching hospital (see instr Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	ructions)			23
Ì	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
	Deductibles and coinsurance amounts (for CAH, see instructions				2
	Deductibles and Coinsurance amounts relating to amount on line Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) p			0	1
	instructions)	•			
	Direct graduate medical education payments (from Wkst. E-4, li	ine 50)		0	28
	REH facility payment amount ESRD direct medical education costs (from Wkst. E-4, line 36)			0	28
	Subtotal (sum of lines 27, 28, 28.50 and 29)			0	
	Primary payer payments			0	
	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVIC	res)		0	32
	Composite rate ESRD (from Wkst. I-5, line 11)			0	33
	Allowable bad debts (see instructions)			0	
	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		0	
	Subtotal (see instructions)			0	
	MSP-LCC reconciliation amount from PS&R			0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions	s)		0	39
	N95 respirator payment adjustment amount (see instructions)	<i></i>		0	
.97	Demonstration payment adjustment amount before sequestration			0	39
	Partial or full credits received from manufacturers for replace RECOVERY OF ACCELERATED DEPRECIATION	ced devices (see instruc	tions)	0	
	Subtotal (see instructions)			0	
	Sequestration adjustment (see instructions)			0	
	Demonstration payment adjustment amount after sequestration			0	
	Sequestration adjustment-PARHM pass-throughs Interim payments			0	40
	Interim payments-PARHM				4
.00	Tentative settlement (for contractors use only)			0	4
	Tentative settlement-PARHM (for contractor use only) Balance due provider/program (see instructions)			0	42
	Balance due provider/program (see instructions) Balance due provider/program-PARHM (see instructions)			0	43
	Protested amounts (nonallowable cost report items) in accordar	nce with CMS Pub. 15-2,	chapter 1,	0	44
	§115.2 TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount (see instructions)			0	90
				0	
.00	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0.00	

Health Financial Systems	ASCENSION ST. VINC	ENT WARRICK	In Lie	u of Form CMS	-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-1325	Period:	Worksheet E	
		Component CCN: 15-M325	From 07/01/2022 To 06/30/2023		enared:
		•	10 00,00,2020	11/24/2023 3	:50 pm
		Title XVIII	Subprovider -	PPS	
			IPF		
				1.00	
94.00 Total (sum of lines 91 and 93)				(94.00
				1.00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days					200.00

NALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC		Period: From 07/01/2022 To 06/30/2023		pared
			XVIII	Hospital	Cost	
		Inpatient	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
.00 .00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		314,9	40 0	741,641 0	1.(2.(
.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3.0
.01	ADJUSTMENTS TO PROVIDER	02/16/2023	45,8	00	0	3.
.02			- , -	0	0	3.
.03				0	0	3.
.04				0	0	3.
.05				0	0	3.
. 50	Provider to Program ADJUSTMENTS TO PROGRAM			0	0	3.
51	ADJUSTMENTS TO PROGRAM			0	0	3
52				Ő	0	3
53				0	0	3.
.54				0	0	3.
.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		45,8		0	3.
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		360,7	40	741,641	4.
	TO BE COMPLETED BY CONTRACTOR	I				
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					5
01	TENTATIVE TO PROVIDER			0	0	5
02				0	0	5
03				0	0	5
	Provider to Program				-	_
50 51	TENTATIVE TO PROGRAM			0	0	5
51 52				0	0	5 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		34,8		254,629	6
00	Total Medicare program liability (see instructions)		325,8		487,012	7
				Contractor Number	NPR Date (Mo/Day/Yr)	
00	Name of Contractor	0		1.00	2.00	8

.00 I s s .00 L a f p	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider ADJUSTMENTS TO PROVIDER		XVIII t Part A <u>Amount</u> 2.00 1,189,0	mm/dd/yyyy 3.00	11/24/2023 3: PPS PPS TT B Amount 4.00 0 0 0 0 0 0 0 0 0) 1.) 2. 3.
.00 I s s .00 L a f f P .01 A .02 .03 .04	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider	mm/dd/yyyy	Amount 2.00	Par mm/dd/yyyy 3.00 19 0	Amount 4.00 0 0	3.
.00 I s s .00 L a f f P .01 A .02 .03 .04	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider		2.00	3.00 19 0 0	4.00	3.
.00 I s s .00 L a f f P .01 A .02 .03 .04	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider	1.00		0	0000	3.
.00 I s s .00 L a f f P .01 A .02 .03 .04	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider		1,189,0	0	0	3.
a f .01 .02 .03 .04	amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					
.01 A .02 .03 .04						-
02 03 04	AUJUSIMENTS TO PROVIDER) 3.
03 04						
04				0	0	
-				0	0	
05				0	0	
	Provider to Program		<u> </u>	0		-
	ADJUSTMENTS TO PROGRAM			0	0) 3
51				0	0	
52				0	0	
53				0	0	
54				0	0	
99 s	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	0	
т 00 (Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,189,0	19	0) 4
	O BE COMPLETED BY CONTRACTOR			1		
00 L c w	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5
	Program to Provider			2	1	4 -
-	TENTATIVE TO PROVIDER			0	0	
02				0	0	
	Provider to Program			V	0	<u>'</u> '
	TENTATIVE TO PROGRAM			0	0) 5
50 1				0	0	
52				0	0	
	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	
	5.50-5.98)			~		1 1
00 0	Determined net settlement amount (balance due) based on the cost report. (1)					6
	SETTLEMENT TO PROVIDER		30,1	59	0	
	SETTLEMENT TO PROGRAM			0	0	
	Total Medicare program liability (see instructions)		1,219,1	78	0	
			,,-	Contractor Number	NPR Date (Mo/Day/Yr)	
		()	1.00	2.00	

NALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC Component C		Period: From 07/01/2022 To 06/30/2023		pare
			XVIII	Swing Beds - SN		
		Inpatient	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		835,54		0	1.
.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.
.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.
01	Program to Provider	02 (16 (2022	0.6 4	20		
01 02	ADJUSTMENTS TO PROVIDER	02/16/2023	96,40	0	0	-
02				0	0	-
04				0	0	
05				0	0	
	Provider to Program					
50	ADJUSTMENTS TO PROGRAM			0	0	
51				0	0	
52 53				0	0	
55 54				0	0	
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		96,40	-	0	
	3.50-3.98)					
00	Total interim payments (sum of lines 1, 2, and 3.99)		931,94	44	0	4
	(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)					
	TO BE COMPLETED BY CONTRACTOR					
00	List separately each tentative settlement payment after					1 5
	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
01	Program to Provider			0	0	5
02				0	0	
03				0	0	
	Provider to Program	· · ·				
50	TENTATIVE TO PROGRAM			0	0	
51				0	0	
52 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	-
99 00	5.50-5.98) Determined net settlement amount (balance due) based on			0	0	6
	the cost report. (1)					
01	SETTLEMENT TO PROVIDER		F.2. 41	0	0	
02	SETTLEMENT TO PROGRAM		53,4		0	
00	Total Medicare program liability (see instructions)		878,4	Contractor	NPR Date	7
				Number	(Mo/Day/Yr)	
		0		1.00	2.00	

Health	Financial Systems ASCENSION ST. VIN	CENT WARRICK	In Lie	u of Form CMS-	2552-10	
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1325	Period:	Worksheet E-1		
			From 07/01/2022 To 06/30/2023	Part II Date/Time Pre	nared	
			10 00/ 50/ 2025	11/24/2023 3:		
		Title XVIII	Hospital	Cost		
				1.00		
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS					
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION	-				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.	. S-3, Pt. I col. 15 line	e 14		1.00	
2.00					2.00	
3.00					3.00	
4.00					4.00	
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00	
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 1				6.00	
7.00	CAH only - The reasonable cost incurred for the purchase of c line 168	certified HIT technology	Wkst. S-2, Pt. I		7.00	
8.00	Calculation of the HIT incentive payment (see instructions)				8.00	
9.00	Sequestration adjustment amount (see instructions)				9.00	
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00	
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH					
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00	
31.00	Other Adjustment (specify)				31.00	
32.00	Balance due provider (line 8 (or line 10) minus line 30 and 1	line 31) (see instructior	is)		32.00	

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS Pro	vider CCN: 15-1325	Period:	Worksheet E-2	
	Com	ponent CCN:15-Z325	From 07/01/2022 To 06/30/2023	Date/Time Pre 11/24/2023 3:	
		Title XVIII	Swing Beds - SNF		
			Part A	Part B	
			1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES Inpatient routine services - swing bed-SNF (see instructions)		679,908	0	1 1.
.00	Inpatient routine services - swing bed-SWF (see instructions)		079,900	0	2.
.00	Ancillary services (from wkst. D-3, col. 3, line 200, for Part A, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-be			0	3.
01	instructions) Nursing and allied health payment-PARHM (see instructions)				3.
00	per diem cost for interns and residents not in approved teaching (instructions)	orogram (see		0.00	
00	Program days		485	0	5
00	Interns and residents not in approved teaching program (see instru			0	
00	Utilization review - physician compensation - SNF optional method	only	0		7
00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		903,878	0	-
00	Primary payer payments (see instructions)		0	0	9
.00	Subtotal (line 8 minus line 9) Deductibles billed to program patients (exclude amounts applicable	to physician	903,878 0	0	10 11
.00	professional services)	e co physician	0	0	1 11
2.00	Subtotal (line 10 minus line 11)		903,878	0	12
	Coinsurance billed to program patients (from provider records) (ex for physician professional services)	clude coinsurance	7,485	0	13
.00	80% of Part B costs (line 12 x 80%)			0	14
.00	Subtotal (see instructions)		896,393	0	15
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
	Pioneer ACO demonstration payment adjustment (see instructions)				16
	Rural community hospital demonstration project (§410A Demonstration adjustment (see instructions)	on) payment	0		16
	Demonstration payment adjustment amount before sequestration Allowable bad debts (see instructions)		0	0	16 17
	Adjusted reimbursable bad debts (see instructions)		0	0	
	Allowable bad debts for dual eligible beneficiaries (see instruct:	ions)	0	0	
	Total (see instructions)		896,393	0	19
	Sequestration adjustment (see instructions)		17,928	0	19
.02	Demonstration payment adjustment amount after sequestration)		0	0	19
	Sequestration adjustment-PARHM pass-throughs				19
	Sequestration for non-claims based amounts (see instructions)		0	0	19
	Interim payments		931,944	0	
	Interim payments-PARHM			0	20
	Tentative settlement (for contractor use only) Tentative settlement-PARHM (for contractor use only)		0	0	21
	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19	25 20 and 21)	-53,479	0	
	Balance due provider/program-PARHM (see instructions)	, 20, and 21)	55,475	0	22
	Protested amounts (nonallowable cost report items) in accordance v	vith CMS Pub. 15-2,	0	0	
	chapter 1, §115.2				
	Rural Community Hospital Demonstration Project (§410A Demonstration	on) Adjustment			
0.00	Is this the first year of the current 5-year demonstration period	under the 21st			200
	Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement				
	Medicare swing-bed SNF inpatient routine service costs (from Wkst	D-1. Pt. TT line			201
	66 (title XVIII hospital))	,,			
2.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wk	st. D-3, col. 3, lin	e		202
	200 (title XVIII swing-bed SNF))				
	Total (sum of lines 201 and 202)				203
1.00	Medicare swing-bed SNF discharges (see instructions) Computation of Demonstration Target Amount Limitation (N/A in firs	t year of the curre	nt 5-year demonst		204
	period)				
	Medicare swing-bed SNF target amount	1 204)			205
	Medicare swing-bed SNF inpatient routine cost cap (line 205 times Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursemer				206
	Program reimbursement under the §410A Demonstration (see instruct				207
	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, co		1		208
	and 3)	, 3000 01 11003	-		
	Adjustment to Medicare swing-bed SNF PPS payments (see instruction	ıs)			209
	Reserved for future use Comparision of PPS versus Cost Reimbursement				210
	COMPARISION OF PPS VARSUS COST RAIMbursement				

ALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-1325	Period: From 07/01/2022 To 06/30/2023	Worksheet E-3 Part V Date/Time Prep 11/24/2023 3:	par
		Title XVIII	Hospital	Cost	
			-	1.00	
				1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICA	ARE PART A SERVICES - COS	I REIMBURSEMENT	205 060	1
.00	Inpatient services			385,868	
00	Nursing and Allied Health Managed Care payment (see instruc	ctions)		0	2
00	Organ acquisition			0	3
01	Cellular therapy acquisition cost (see instructions) Subtotal (sum of lines 1 through 3.01)			-	4
00				385,868 0	5
00	Primary payer payments			389,727	6
00	Total cost (line 4 less line 5). For CAH (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES)		509,727	0
	Reasonable charges				
.00	Routine service charges			0	7
.00	Ancillary service charges			0	8
00	Organ acquisition charges, net of revenue			0	9
0.00	Total reasonable charges			0	10
	Customary charges			0	1 10
.00	Aggregate amount actually collected from patients liable for	or navment for services on	a charge basis	0	11
.00	Amounts that would have been realized from patients liable			0	12
	had such payment been made in accordance with 42 CFR 413.1.		on a charge sasts	Ű	
.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.00000	13
	Total customary charges (see instructions)			0	14
.00	Excess of customary charges over reasonable cost (complete	only if line 14 exceeds 1	ine 6) (see	0	15
	instructions)	,		-	
5.00	Excess of reasonable cost over customary charges (complete	only if line 6 exceeds li	ne 14) (see	0	16
	instructions)	-			
7.00	Cost of physicians' services in a teaching hospital (see in	nstructions)		0	17
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
	Direct graduate medical education payments (from Worksheet	E-4, line 49)			18
.00	Cost of covered services (sum of lines 6, 17 and 18)			389,727	
.00	Deductibles (exclude professional component)			61,129	
00	Excess reasonable cost (from line 16)			0	21
.00	Subtotal (line 19 minus line 20 and 21)			328,598	
.00	Coinsurance			0	23
.00	Subtotal (line 22 minus line 23)			328,598	
	Allowable bad debts (exclude bad debts for professional se	rvices) (see instructions)		6,078	
	Adjusted reimbursable bad debts (see instructions)			3,951	
	Allowable bad debts for dual eligible beneficiaries (see in	nstructions)		4,594	
	Subtotal (sum of lines 24 and 25, or line 26)			332,549	
.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	29
.50	Pioneer ACO demonstration payment adjustment (see instruct	ions)		0	29
.98	Recovery of accelerated depreciation.			0	29
.99	Demonstration payment adjustment amount before sequestration	on		222 5 42	29
.00	Subtotal (see instructions)			332,549	
.01	Sequestration adjustment (see instructions)			6,651	
	Demonstration payment adjustment amount after sequestration	TI		0	30
.03	Sequestration adjustment-PARHM			260 740	30
00	Interim payments			360,740	
01	Interim payments-PARHM			_	31
.00	Tentative settlement (for contractor use only)			0	32
2.01	Tentative settlement-PARHM (for contractor use only)	0.02 21 and 22		24 042	32
	Balance due provider/program (line 30 minus lines 30.01, 30		and 22 01)	-34,842	33
	Balance due provider/program-PARHM (lines 2, 3, 18, and 26			25 000	
.00	Protested amounts (nonallowable cost report items) in acco	iuance with CMS PUD. 15-2,	chapter I,	25,000	34

.00 .00 .00 .00		Component CCN: 15-M325		Part II	
.00 .00 .00 .00		Component CCN. 13-M323	From 07/01/2022 To 06/30/2023	Date/Time Prep 11/24/2023 3:5	
.00 .00 .00 .00		Title XVIII	Subprovider - IPF	PPS	<u> </u>
.00 .00 .00 .00				1.00	
00 00 00 01	PART II - MEDICARE PART A SERVICES - IPF PPS			1100	
00 00 01	Net Federal IPF PPS Payments (excluding outlier, ECT, and me	edical education payments)		1,198,727] 1
00 01	Net IPF PPS Outlier Payments			92,892	
01	Net IPF PPS ECT Payments			0	
01	Unweighted intern and resident FTE count in the most recent	cost report filed on or b	efore November	0.00	4
	15, 2004. (see instructions)	unt for residents that was	a dianlagad bu	0.00	
	Cap increases for the unweighted intern and resident FTE couprogram or hospital closure, that would not be counted with			0.00	4
	CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	out a temporary cap aujust	ment under 42		
	New Teaching program adjustment. (see instructions)			0.00	
	Current year's unweighted FTE count of I&R excluding FTEs in	n the new program growth p	eriod of a "new	0.00	
	teaching program" (see instuctions)				
00	Current year's unweighted I&R FTE count for residents within	n the new program growth p	eriod of a "new	0.00	
	teaching program" (see instuctions)				
	Intern and resident count for IPF PPS medical education adju	ustment (see instructions)		0.00	
	Average Daily Census (see instructions)			4.964384	
	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to	o the power of $.5150 - 1$.		0.000000	
	Teaching Adjustment (line 1 multiplied by line 10).				1
	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11) Nursing and Allied Health Managed Care payment (see instruct			1,291,619	
	5 5 1 5 1			0	$\begin{vmatrix} 1 \\ 1 \end{vmatrix}$
	Organ acquisition (DO NOT USE THIS LINE) Cost of physicians' services in a teaching hospital (see ins	structions)		0	
	Subtotal (see instructions)	structions)		1,291,619	
	Primary payer payments			1,251,015	
	Subtotal (line 16 less line 17).			1,291,619	
	Deductibles			78,328	
	Subtotal (line 18 minus line 19)			1,213,291	
.00	Coinsurance			0	2
.00	Subtotal (line 20 minus line 21)			1,213,291	2
	Allowable bad debts (exclude bad debts for professional serv	vices) (see instructions)		47,336	
	Adjusted reimbursable bad debts (see instructions)			30,768	
	Allowable bad debts for dual eligible beneficiaries (see ins	structions)		41,476	
	Subtotal (sum of lines 22 and 24)	_		1,244,059	
	Direct graduate medical education payments (see instructions	s)		0	2
	Other pass through costs (see instructions)			0	2
	Outlier payments reconciliation OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	2
	Pioneer ACO demonstration payment adjustment (see instruction	one)		0	3
	Recovery of accelerated depreciation.	0113)		0	
	Demonstration payment adjustment amount before sequestration	n		ő	
	Total amount payable to the provider (see instructions)			1,244,059	
	Sequestration adjustment (see instructions)			24,881	
.02	Demonstration payment adjustment amount after sequestration			0	
.00	Interim payments			1,189,019	3
	Tentative settlement (for contractor use only)			0	3
	Balance due provider/program (line 31 minus lines 31.01, 31.			30,159	
	Protested amounts (nonallowable cost report items) in accord	dance with CMS Pub. 15-2,	chapter 1,	0	3
	§115.2				
	TO BE COMPLETED BY CONTRACTOR Original outlier amount from Worksheet E-3, Part II, line 2			02 002	-
	Ouriginal outlier amount from worksneet E-3, Part II, line 2 Outlier reconciliation adjustment amount (see instructions)			92,892	5
	The rate used to calculate the Time Value of Money			0 0.00	
	Time Value of Money (see instructions)			0.00	
Ī	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AN THE COVID-19 PHE)	ND BEGINNING ON OR BEFORE	MAY 11, 2023 (THE		
	Teaching Adjustment Factor for the cost reporting period imm	mediately preceding Februa	ry 29, 2020.	0.000000	9

	TION OF REIMBURSEMENT SETTLEMENT P	Provider CCN: 15-1325	Period:	Worksheet E-3	
			From 07/01/2022 To 06/30/2023	Part VII Date/Time Pre 11/24/2023 3:	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
- 1			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVI	ICES FOR TITLES V OR X	IX SERVICES		-
	COMPUTATION OF NET COST OF COVERED SERVICES Inpatient hospital/SNF/NF services		44,258		1.
	Medical and other services		44,230	160,680	2.
	Organ acquisition (certified transplant programs only)		0	100,080	3.
	Subtotal (sum of lines 1, 2 and 3)		44,258	160,680	
	Inpatient primary payer payments		0	,	5.
	Outpatient primary payer payments			0	6.
	Subtotal (line 4 less sum of lines 5 and 6)		44,258	160,680	7.
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges				
	Routine service charges		3,569		8.
	Ancillary service charges		79,317	664,146	
	Organ acquisition charges, net of revenue		0		10.
	Incentive from target amount computation		0	CCA 140	11.
- E	Total reasonable charges (sum of lines 8 through 11)		82,886	664,146	1 12.
- H	CUSTOMARY CHARGES Amount actually collected from patients liable for payment for s	sorvicos on a chargo	0	0	13
	basis	services on a charge	0	0	1.2.
	Amounts that would have been realized from patients liable for	navment for services o	on 0	0	14.
	a charge basis had such payment been made in accordance with 42			0	
	Ratio of line 13 to line 14 (not to exceed 1.000000)	5	0.000000	0.000000	15
0	Total customary charges (see instructions)		82,886	664,146	16
0	Excess of customary charges over reasonable cost (complete only	if line 16 exceeds	38,628	503,466	17
	line 4) (see instructions)				
	Excess of reasonable cost over customary charges (complete only	if line 4 exceeds lir	1e 0	0	18
	16) (see instructions)			0	
	Interns and Residents (see instructions)		0	0	19
	Cost of physicians' services in a teaching hospital (see instruc		44.259	0	20
	Cost of covered services (enter the lesser of line 4 or line 16) PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be co		44,258	160,680	21
	Other than outlier payments	bilipreted for PPS provi	0	0	22
	Outlier payments		0	0	23
	Program capital payments		0	Ũ	24
	Capital exception payments (see instructions)		0		25
	Routine and Ancillary service other pass through costs		0	0	
	Subtotal (sum of lines 22 through 26)		0	0	27
0	Customary charges (title V or XIX PPS covered services only)		0	0	28
	Titles V or XIX (sum of lines 21 and 27)		44,258	160,680	29
- H	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
	Excess of reasonable cost (from line 18)		0	0	
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		44,258	160,680	
	Deductibles		0	0	-
	Coinsurance		0	0	
0	Allowable bad debts (see instructions) Utilization review		0	0	34 35
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 3	33)	44,258	160,680	
0			, 238 0	100,000	37
0	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIEV)		44.950	160,680	
0	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Subtotal (line 36 ± line 37)		44.758		
000000000000000000000000000000000000000	Subtotal (line 36 ± line 37)		44,258	100,000	
	Subtotal (line 36 ± line 37) Direct graduate medical education payments (from Wkst. E-4)		44,258 0 44,258	160,680	39
000000000000000000000000000000000000000	Subtotal (line 36 ± line 37)		0 44,258		39 40
	Subtotal (line 36 ± line 37) Direct graduate medical education payments (from Wkst. E-4) Total amount payable to the provider (sum of lines 38 and 39)		0	160,680	39 40

	SHEET (If you are nonproprietary and do not maintain pe accounting records, complete the General Fund column	Provider CO		Period: From 07/01/2022	Worksheet G	
nly)	pe accounting records, comprete the General Fund Cordinin			To 06/30/2023	Date/Time Pre 11/24/2023 3:	
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
-		1.00	2.00	3.00	4.00	
	CURRENT ASSETS Cash on hand in banks	556,122		0 0	0	1.
	Temporary investments	0		0 0	0	
	Notes receivable	0		0 0	0	-
	Accounts receivable	8,650,930		0 0	0	
	Other receivable Allowances for uncollectible notes and accounts receivable	0 -4,886,017		0 0	0	
	Inventory	261,142			0	-
	Prepaid expenses	0		0 0	0	
	Other current assets	0		0 0	0	9
	Due from other funds	0		0 0	0	
	Total current assets (sum of lines 1-10)	4,582,177		0 0	0	11
	FIXED ASSETS	000 700			0	1 1 2
	Land Land improvements	808,762		0 0	0	
	Accumulated depreciation	0		0 0	0	
	Buildings	14,936,483		0 0	0	
.00 /	Accumulated depreciation	-11,229,433		0 0	0	16
	Leasehold improvements	194,802		0 0	0	
	Accumulated depreciation	-143,933		0 0	0	
	Fixed equipment Accumulated depreciation	8,889,693 -7,873,317			0	
	Automobiles and trucks	-7,873,317			0	
	Accumulated depreciation	0		0 0	ů 0	22
	Major movable equipment	0		0 0	0	23
	Accumulated depreciation	0		0 0	0	24
	Minor equipment depreciable	0		0 0	0	
	Accumulated depreciation	0		0 0	0	1
	HIT designated Assets Accumulated depreciation	0		0 0	0	
	Minor equipment-nondepreciable	0			0	
	Total fixed assets (sum of lines 12-29)	5,583,057		0 0	0	
C	OTHER ASSETS					
	Investments	0		0 0	0	
	Deposits on leases	0		0 0	0	
	Due from owners/officers Other assets	0		0 0	0	
	Total other assets (sum of lines 31-34)	0		0 0	0	-
	Total assets (sum of lines 11, 30, and 35)	10,165,234		0 0	0 0	
-	CURRENT LIABILITIES	- , , -		-1 -1	-	
	Accounts payable	167,658		0 0	0	
	Salaries, wages, and fees payable	0		0 0	0	
	Payroll taxes payable Notes and loans payable (short term)	E2 420		0 0	0	
	Deferred income	52,429			0	
	Accelerated payments	0			0	42
	Due to other funds	0		0 0	0	43
	Other current liabilities	8,169,584		0 0	0	1
	Total current liabilities (sum of lines 37 thru 44)	8,389,671		0 0	0	45
	ONG TERM LIABILITIES	0			0	1.0
	Mortgage payable Notes payable	0		0 0	0	
	Unsecured loans	0		o o	0	
	Other long term liabilities	50,867		0 0	0	
.00 -	Total long term liabilities (sum of lines 46 thru 49)	50,867		0 0	0	
	Total liabilities (sum of lines 45 and 50)	8,440,538		0 0	0	51
	CAPITAL ACCOUNTS	1 724 606		1		1 6 2
	General fund balance Specific purpose fund	1,724,696		0		52
	Donor created - endowment fund balance - restricted			Γ́		54
	Donor created - endowment fund balance - unrestricted			0		55
	Governing body created - endowment fund balance			0		56
.00 li	Plant fund balance - invested in plant				0	
	Plant fund balance - reserve for plant improvement,				0	58
	replacement, and expansion	1 734 666			^	
	Total fund balances (sum of lines 52 thru 58) Total liabilities and fund balances (sum of lines 51 and	1,724,696 10,165,234			0	59 60
.00	iocar mastricles and fund satances (Sum OF FINES ST dilu	10,100,234	1	<u> </u>	0	1 00

Special Pu	From 07/01/2022 To 06/30/2023	Date/Time Prep 11/24/2023 3:5	
Special Pl	Purpose Fund	Endowment Fund	
.00 3.00	4.00	5.00	
,420,406 ,156,365 ,576,771 () () () () () () () () () () () () ()	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0	1.0 2.0 3.0 4.0 5.0 6.0 7.0 8.0 9.0 11.0 12.0 13.0 14.0 15.0 14.0 15.0 14.0 15.0 19.0
Plant Fund	_		
.00 8.00			
	0		1.0 2.0 3.0 4.0 5.0 6.0 7.0 8.0 9.0
0 0 0 0 0 0 0	0		10. 11. 12. 13. 14. 15. 16. 17. 18.

Health Financial Systems ASCENSION ST. VINCEN STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES F		Provider C	CN 1 1 1225	In Lie Period:	eu of Form CMS-2552 Worksheet G-2	
	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider Co	LN: 15-1325	From 07/01/2022 To 06/30/2023	Parts I & II	pared:
	Cost Center Description		Inpatient	Outpatient	Total	
			1.00	2.00	3.00	
	PART I - PATIENT REVENUES					-
	General Inpatient Routine Services					
1.00	Hospital		1,918,70		1,918,760	
2.00	SUBPROVIDER - IPF		3,922,72		3,922,725	
3.00	SUBPROVIDER - IRF			0	0	
4.00	SUBPROVIDER			0	0	
5.00	Swing bed - SNF			0	0	
6.00	Swing bed - NF			0	0	6.00
7.00	SKILLED NURSING FACILITY					7.00
8.00	NURSING FACILITY					8.00
9.00	OTHER LONG TERM CARE					9.00
10.00	Total general inpatient care services (sum of lines 1-9)		5,841,48	35	5,841,485	10.00
	Intensive Care Type Inpatient Hospital Services		1			
11.00	INTENSIVE CARE UNIT			0	0	
12.00	CORONARY CARE UNIT					12.00
13.00	BURN INTENSIVE CARE UNIT					13.00
14.00	SURGICAL INTENSIVE CARE UNIT					14.00
15.00	OTHER SPECIAL CARE (SPECIFY)					15.00
16.00	Total intensive care type inpatient hospital services (sum o	flines		0	0	16.00
	11-15)					
17.00	Total inpatient routine care services (sum of lines 10 and 1	6)	5,841,48		5,841,485	•
18.00	Ancillary services		4,023,30		40,964,703	
19.00	Outpatient services		255,40			•
20.00	RURAL HEALTH CLINIC			0 0	-	
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0 0	0	21.00
22.00	HOME HEALTH AGENCY					22.00
23.00	AMBULANCE SERVICES					23.00
24.00	СМНС					24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)					25.00
26.00	HOSPICE					26.00
27.00	OTHER (SPECIFY)			0 0	0	
28.00	Total patient revenues (sum of lines 17-27)(transfer column	3 to Wkst.	10,120,3	12 51,384,974	61,505,286	28.00
	G-3, line 1)					-
20.00	PART II - OPERATING EXPENSES		1	20 421 257		20.00
29.00	Operating expenses (per Wkst. A, column 3, line 200)			20,431,357		29.00
30.00	ADD (SPECIFY)			0		30.00
31.00				0		31.00
32.00				0		32.00
33.00				0		33.00
34.00				0		34.00
35.00	Tetal additions (our of lines 20.25)			0		35.00
36.00	Total additions (sum of lines 30-35)			0		36.00
37.00	DEDUCT (SPECIFY)			0		37.00
				0		38.00
38.00				0		39.00
38.00 39.00						
38.00 39.00 40.00				0		40.00
38.00 39.00 40.00 41.00				0		41.00
38.00 39.00 40.00	Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line	42) (tax 5 5		0 0 0 20,431,357		•

Health Financial Systems ASCENSION ST. VINCENT WARRICK In Lieu of						
-	FATEMENT OF REVENUES AND EXPENSES Provider CCN: 15-1325 Period:					
			From 07/01/2022			
			то 06/30/2023	Date/Time Prep 11/24/2023 3::		
				11/21/2023 31		
				1.00		
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, lin	e 28)		61,505,286	1.00	
2.00	Less contractual allowances and discounts on patients' accoun	ts		43,101,092	2.00	
3.00	Net patient revenues (line 1 minus line 2)			18,404,194	3.00	
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		20,431,357	4.00	
5.00	Net income from service to patients (line 3 minus line 4)			-2,027,163	5.00	
	OTHER INCOME					
6.00	Contributions, donations, bequests, etc			0	6.00	
7.00	Income from investments			0	7.00	
8.00	Revenues from telephone and other miscellaneous communication	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				51,329	14.00 15.00	
15.00		h		0	16.00	
16.00 17.00	Revenue from sale of medical and surgical supplies to other t Revenue from sale of drugs to other than patients	nan patients		0	17.00	
17.00	Revenue from sale of medical records and abstracts			0	17.00	
19.00				0	19.00	
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00	
21.00	Rental of vending machines			8	20.00	
22.00	Rental of hospital space			0	22.00	
23.00	Governmental appropriations			0	23.00	
24.00	Other Operating Revenue			681,696		
24.01	Exercise Revenue			27,864		
24.06	Building Rent			14,196		
24.11	Physician Clinic			85,896		
24.50				9,809		
	Total other income (sum of lines 6-24)			870,798		
26.00				-1,156,365		
27.00	OTHER EXPENSES (SPECIFY)			_,,0	27.00	
28.00	Total other expenses (sum of line 27 and subscripts)			0	28.00	
29.00	Net income (or loss) for the period (line 26 minus line 28)			-1,156,365	29.00	