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(12 USC 1205 ***

ASCENSION ST. VINCENT JENNINGS

7. 1 77

In Lieu of Form CMS-2552-10

This report is	Fequired by Taw (42 USC 13939; 42 CFR 413.20(D)). Fai	Ture to report can resul	t in all interim	FORM APPROVED
payments made	since the beginning of the cost reporting period being	deemed overpayments (42	2 USC 1395g).	OMB NO. 0938-0050 EXPIRES 09-30-2025
HOSPITAL AND H AND SETTLEMENT	HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION	Provider CCN: 15-1303	Period: From 07/01/2022 To 06/30/2023	Worksheet S Parts I-III Date/Time Prepared: 11/22/2023 2:07 pm
PART I - COST	REPORT STATUS			
Provider use only	<pre>1.[X]Electronically prepared cost report 2.[]Manually prepared cost report</pre>		Date: 11/22/2	023 Time: 2:07 pm
	 [0] If this is an amended report enter the number [7] Medicare Utilization. Enter "F" for full, "L' 	of times the provider re " for low, or "N" for no	esubmitted this co	ost report
Contractor use only	 5. [1]Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended (5. Late Received: (6. Date Received: (7. Contractor No. (8. [N] Initial Report for (9. [N] Final Report for 	11.c or this Provider CCN 12.[or Code: 4 Jumn 1 is 4: Enter wes reopened = 0-9.
PART II - CERT	IFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATO	OR OR PROVIDER(S)		
ADMINISTRATIVE PROVIDED OR PR	TION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN T E ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. ROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A E ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.	FURTHERMORE, IF SERVICES	5 IDENTIFIED IN TH	IIS REPORT WERE
CERTI	FICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF	F PROVIDER(S)		
T UED	TRY CERTIFY that I have read the above contification of	tatement and that T have	avamined the acc	mpanying

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 JENNINGS (15-1303) 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	Ch	ris Hons	Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Chris Hons			2
3	Signatory Title	VP OF FINANCE			3
4	Date	11/22/2023 02:07:37 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	-30,993	-498,538	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	-22,497	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
200.00	TOTAL	0	-53,490	-498,538	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.

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Impatient PPS Information2:00Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(2) (2) (Cickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Io Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)NN222:02Is this a newly merged hospital that requires a final UCP to be determined at cost reports settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period occurring period on or after October 1. Or yes or "N" for no for the portion of the cost reporting period on or after October 1. Or yes or "N" for no for the portion of the cost reporting period or or after october 1. Or yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 1, "PT for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in colum 3, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "T for yes or "N" for no for the portion of the cost reporti	1.00	Type of Control (see instructions)						1				21.0
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adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 8.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost	2.04											22.0
for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 8.00 Which method is used to determine Medicaid days on lines 24 and/or 25 2 N 23 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost												
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counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 3.00 Which method is used to determine Medicaid days on lines 24 and/or 25 2 N 23 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost												
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below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost					-							
if date of discharge. Is the method of identifying the days in this cost						- 1		2				1 22 6
	3.00	Which method is used to determine Me						2 N				23.0
reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3.00	which method is used to determine Me below? In column 1, enter 1 if date	of admiss	ion, 2 if cens	us days,	or 3		2 N				23.0

DSPIT	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provider CC	CN: 15-1303	Period: From 07/0	1 /2022		heet S-2	2
						0/2023	Date/	1 Time Pre /2023 2:	
		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	Other edicaid days	
		1.00	2.00	3.00	4.00	5.0		6.00	
	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. If this provider is an IRF, enter the in-state	0			0		0	(24.0
	Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.				Ushon (D		Data		
					Urban/R			of Geogr .00	-
5.00	Enter your standard geographic classification (not wa		at the beg	ginning of t		2	2		26.0
	cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not we reporting period. Enter in column 1, "1" for urban of enter the effective date of the geographic reclassif If this is a sole community hospital (SCH), enter the	age) status r "2" for r ication in	ural. If ap column 2.	plicable,		2			27.0
	effect in the cost reporting period.								
					Begin 1.			ding: .00	-
5.00	Enter applicable beginning and ending dates of SCH st		cript line	36 for numb	er				36.
7.00	of periods in excess of one and enter subsequent date If this is a Medicare dependent hospital (MDH), enter		r of period	ds MDH statu	IS	C)		37.
7.01	is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for th accordance with FY 2016 OPPS final rule? Enter "Y" fo								37.
3.00	instructions) If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.								38.
					Y/			(/N .00	-
	Does this facility qualify for the inpatient 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)), (ii), or the mileage ii)? Enter	(iii)? Ent requiremer in column 2	cer in colum nts in ? "Y" for ye	ime N in S		-	N	39.
0.00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octol no in column 2, for discharges on or after October 1	ber 1. Ente	r "Y" for y			I		N	40.
						V 1.0	XVII 0 2.00		_
5 00	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymen	at for disp	ronortionat	e share in	accordance	N	N	N	45.
	with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wks	eption for	extraordina	ary circumst	ances	N	N	N	46.
7.00	Is the facility electing full federal capital payment	capital? E	nter "Y for	yes or "N'	for no.	N	N	N	47.
	Teaching Hospitals Is this a hospital involved in training residents in	approved G	ME programs	? For cost	reporting	N			56.
	periods beginning prior to December 27, 2020, enter ' cost reporting periods beginning on or after December the instructions. For column 2, if the response to co involved in training residents in approved GME progra and are you are impacted by CR 11642 (or applicable of "Y" for yes; otherwise, enter "N" for no in column 2 For cost reporting periods beginning prior to December	"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 ect GME pay	r no in colu CFR 413.78(b this hospit or penultin /ment reduct	umn 1. For)(2), see al was hate year, ion? Enter				57.
	is this the first cost reporting period during which at this facility? Enter "Y" for yes or "N" for no in residents start training in the first month of this of "N" for no in column 2. If column 2 is "Y", complete complete Wkst. D, Parts III & IV and D-2, Pt. II, if beginning on or after December 27, 2020, under 42 CFF	n column 1. cost report e Worksheet applicable	If column ing period? E-4. If co . For cost	1 is "Y", c ? Enter "Y' olumn 2 is ' reporting p	lid ' for yes o 'N", periods				

IOSPII	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		Provider CC		Period: From 07/01/2022 To 06/30/2023	11/22/2023 2:	pared
					V 1.00	XVIII XIX 0 2.00 3.00	
9.00	Are costs claimed on line 100 of Worksheet A? If yes	, comple	ete Wkst. D-2,	Pt. I.	N		59.0
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through 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? (se umn 1. CR) NAHE	ee If column 1	N			60.0
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
	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		61.0
	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.
	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) Enter the number of unweighted primary care/or						61.
	surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions). Enter the difference between the baseline primary and/or general surgery FTEs and the current year's						61.
1.06	primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.
		Pro	gram Name	Program Code	e Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
10			1.00	2.00	3.00	4.00	61
	of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Of the FTEs in line 61.05, specify each expanded				0.00		61.2
	program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.						
						1.00	
2.00	ACA Provisions Affecting the Health Resources and Ser Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruc	trained			riod for which	0.00	62.0
2.01	Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog	. Teachiı			o your hospital	0.00	62.0

	n Financial Systems TAL AND HOSPITAL HEALTH CARE COMPI		ST. VINCENT JENNINGS	CN: 15-1303	Period:	u of Form CMS-2 Worksheet S-2	
					From 07/01/2022 To 06/30/2023	Part I Date/Time Pre 11/22/2023 2:	
				Unweighted FTEs	Unweighted FTEs in	Ratio (col. 1/ (col. 1 + col.	
				Nonprovider Site	Hospital	2))	
				1.00	2.00	3.00	
	Section 5504 of the ACA Base Yea			This base yea	r is your cost r	eporting	
4.00	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 resident FTEs that trained in yo of (column 1 divided by (column	yes, or your facility ber of unweighted non- tations occurring in a number of unweighted ur hospital. Enter in	/ trained residents primary care all nonprovider non-primary care column 3 the ratio	0.0	0.00	0.000000	64.0
		Program Name	Program Code	Unweighted	Unweighted	Ratio (col. 3/	/
				FTEs Nonprovider	FTES in	(col. 3 + col. 4))	
		1.00	2.00	Site 3.00	4.00	5.00	-
5.00	Enter in column 1, if line 63	1.00	2.00	0.0			65.0
	is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			Unweighted	Unweighted	Ratio (col. 1/	
				FTEs Nonprovider Site		(col. 1 + col. 2))	
	Section 5504 of the ACA Current	Vear ETE Residents in	Nonnrovider Setting	1.00	2.00	3.00	
	beginning on or after July 1, 20		Nonprovider Secting	3Lifective		ing per rous	
5.00	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 +	ccurring in all nonpro unweighted non-primary al. Enter in column 3	ovider settings. / care resident the ratio of	0.0	0.00	0.00000	66.0
		Program Name	Program Code	Unweighted FTEs Nonprovider	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	Site 3.00	4.00	5.00	-
7.00	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						

неаlth	Financial Systems ASCENSION ST. VINCENT JEN	INTNGS		1	n lie	u of Form	CMS-2	2552-10
				Period: From 07/01		Workshee		
					/2022	Part I Date/Tim	ne Pre	pared:
						11/22/20)23 2:0	<u>)/ pm</u>
	Direct CUT in Accordance with the TV 2022 TDDC Final puls. 07 FD 400	005 400	72 (August 1)			1.00)	
68.00	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 490 For a cost reporting period beginning prior to October 1, 2022, did MAC to apply the new DGME formula in accordance with the FY 2023 IPP (August 10, 2022)?	you ob	tain permissi	on from yo		N		68.00
					1.00	2.00	3 00	
	Inpatient Psychiatric Facility PPS				1 1.00		5.00	
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it Enter "Y" for yes or "N" for no.	conta	in an IPF sub	provider?	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME t						0	71.00
	recent cost report filed on or before November 15, 2004? Enter "Y" 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train resi							
	program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y"	for ye	s or "N" for	no.				
	Column 3: If column 2 is Y, indicate which program year began during (see instructions)	tnis	cost reportir	ig period.				
75 00	Inpatient Rehabilitation Facility PPS							75 00
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does subprovider? Enter "Y" for yes and "N" for no.	17 00	ntain an IRF		N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME t recent cost reporting period ending on or before November 15, 2004?						0	76.00
	no. Column 2: Did this facility train residents in a new teaching pr	ogram	in accordance	e with 42				
	CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column indicate which program year began during this cost reporting period.							
	······································	(
	Long Term Care Hospital PPS					1.00)	
	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N"					N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of "Y" for yes and "N" for no.	the c	ost reporting	period? I	Enter	N		81.00
85 00	TEFRA Providers	Finhan		!!!!!				85 00
	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Did this facility establish a new Other subprovider (excluded unit)				r no.	N		85.00 86.00
87 00	<pre>§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital classi</pre>	fiedu	ndor coction			N		87.00
	1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		ider section					
				Approve Perman		Number Approv		
				Adjust	nent	Perman	ent	
				(Y/N 1.00		Adjustm 2.00		
88.00	Column 1: Is this hospital approved for a permanent adjustment to th amount per discharge? Enter "Y" for yes or "N" for no. If yes, compl	e TEFR	A target				0	88.00
	amount per discharge? Enter Y for yes or N for no. If yes, compi 89. (see instructions)	ete co	1. 2 and line					
	Column 2: Enter the number of approved permanent adjustments.		Wkst. A Line	Effortiv		Approv	(od	
			No.	EITECTIV	e Dale	Perman	ent	
						Adjustn Amount		
						Discha	rge	
89.00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line numb	per	1.00	2.0	0	3.00		89.00
	on which the per discharge permanent adjustment approval was based.						-	
	Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amo	unt						
	per discharge. Column 3: Enter the amount of the approved permanent adjustment to t	ha						
	TEFRA target amount per discharge.	.ne						
				V 1.00	n	XIX 2.00		
	Title V and XIX Services			1.00	5	2.00	5	
90.00	Does this facility have title V and/or XIX inpatient hospital servic yes or "N" for no in the applicable column.	es? En	ter "Y" for	N		Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost	report	either in	N		N		91.00
92.00	full or in part? Enter "Y" for yes or "N" for no in the applicable c Are title XIX NF patients occupying title XVIII SNF beds (dual certi	ficati				N		92.00
	instructions) Enter "Y" for yes or "N" for no in the applicable colu	ımn.						93.00
	Does this facility operate an ICF/IID facility for purposes of title "Y" for yes or "N" for no in the applicable column.			N		N		
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" applicable column.	for no	in the	N		N		94.00
	If line 94 is "Y", enter the reduction percentage in the applicable			0.0	0	0.00	b	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" applicable column.	tor no	in the	N		N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable	column		0.0	0	0.00	D	97.00

In Lieu of Form CMS-2552-10 Health Fi<u>nancial Systems</u> ASCENSION ST. VINCENT JENNINGS HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1303 Worksheet S-2 Period: From 07/01/2022 To 06/30/2023 Part I Date/Time Prepared: 11/22/2023 2:07 pm V XIX 1.00 2.00 98.00 Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Ν Υ 98.01 Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. Ν Υ

90.01 DOES LILLE V OF XIX FORTOW MEDICALE (LILLE XVIII) FOR the F			IN		
C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for t title XIX.	itie v, and in	Column 2 lon			
98.02 Does title V or XIX follow Medicare (title XVIII) for the c	alculation of	observation	Ν	Y	98.02
bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes					50102
for title V, and in column 2 for title XIX.					
98.03 Does title V or XIX follow Medicare (title XVIII) for a cri	tical access h	ospital (CAH)	N	N	98.03
reimbursed 101% of inpatient services cost? Enter "Y" for y	es or "N" for	no in column 1			
for title V, and in column 2 for title XIX.					
98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH			N	N	98.04
outpatient services cost? Enter "Y" for yes or "N" for no i	n column 1 for	title V, and			
in column 2 for title XIX.					
98.05 Does title V or XIX follow Medicare (title XVIII) and add b			N	Y	98.05
Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in	column 1 for t	itle V, and in			
column 2 for title XIX. 98.06 Does title V or XIX follow Medicare (title XVIII) when cost	not when and fo	n What D		N/	98.06
Pts. I through IV? Enter "Y" for yes or "N" for no in colum			N	Y	98.06
column 2 for title XIX.		v, anu m			
Rural Providers					
105.00 Does this hospital qualify as a CAH?			Y		105.00
106.00 If this facility qualifies as a CAH, has it elected the all	-inclusive met	hod of payment	N		106.00
for outpatient services? (see instructions)					
107.00 Column 1: If line 105 is Y, is this facility eligible for c	ost reimbursem	ent for I&R	Ν		107.00
training programs? Enter "Y" for yes or "N" for no in colum	n 1. (see ins	tructions)			
Column 2: If column 1 is Y and line 70 or line 75 is Y, do	you train I&R	s in an			
approved medical education program in the CAH's excluded I		unit(s)?			
Enter "Y" for yes or "N" for no in column 2. (see instruct					
108.00 Is this a rural hospital qualifying for an exception to the	CRNA tee sche	dule? See 42	N		108.00
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Physical	Occupational	Speech	Respiratory	_
	1.00	2.00	3.00	4.00	-
		Y	N	N	109.00
109.00 If this hospital qualifies as a CAH or a cost provider, are					
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y"					
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<pre>therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy. 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 applicable. 111.00 If this facility qualifies as a CAH, did it participate in 'Health Integration Project (FCHIP) demonstration for this co "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. 112.00 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 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes o in column 1. If column 1 is yes, enter the method used (A, in column 2. If column 2 is "E", enter in column 3 either " for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provide the definition in CMS Pub.15-1, chapter 22, §2208.1. 116.00 Is this facility classified as a referral center? Enter "Y" "N" for no. 117.00 Is this facility legally-required to carry malpractice insu "Y" for yes or "N" for no.</pre>	al Demonstrati "Y" for yes or rksheet E-2, 1 the Frontier C ost reporting olumn 1 is Y, rticipating in dditional beds lth Model eporting olumn 1 is pating in the ased r "N" for no B, or E only) 93" percent (includes rs) based on for yes or rance? Enter licy? Enter 1	"N" for no. If ines 200 through ommunity period? Enter enter the column 2. ; and/or "C" 1.00 N N N N Y	yes, h 215, as 1.00 N	N 2.00 3.00	111.00 111.00 112.00 0 115.00 116.00 117.00

98.00

98.01

DSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider C	1	Period: From 07/01/2022 Fo 06/30/2023		-2 repared
	Premiums	Losses	Insurance	
	1.00	2.00	2.00	
8.01 List amounts of malpractice premiums and paid losses:	1.00	2.00	3.00	0118.0
8.02 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 (and amounts contained therein. 19.00 DO NOT USE THIS LINE				119.0
20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless prosponder of the second structure of the secon	Y" for yes or the Outpatient	N	N	120.0
1.00 Did this facility incur and report costs for high cost implantable device	es charged to	Y		121.0
patients? Enter "Y" for yes or "N" for no. 2.00 Does the cost report contain healthcare related taxes as defined in §190 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter		Y	5.00	122.0
the Worksheet A line number where these taxes are included. 23.00 pid 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 n 1, enter "Y"			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 or located in a CBSA outside of the main hospital CBSA? In column 2, enter "N" for no. Certified Transplant Center Information	ganizations			
5.00 Does this facility operate a Medicare-certified transplant center? Enter	"Y" for yes	N		125.0
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 in column 1 and termination date, if applicable, in column 2.	tification date			126.0
7.00 If this is a Medicare-certified heart transplant program, enter the cert in column 1 and termination date, if applicable, in column 2.	ification date			127.0
28.00 If this is a Medicare-certified liver transplant program, enter the cert in column 1 and termination date, if applicable, in column 2.	ification date			128.0
(9.00) If this is a Medicare-certified lung transplant program, enter the certified in column 1 and termination date, if applicable, in column 2.				129.
0.00 If this is a Medicare-certified pancreas transplant program, enter the co date in column 1 and termination date, if applicable, in column 2. 1.00 If this is a Medicare-certified intestinal transplant program, enter the				130. 131.
date in column 1 and termination date, if applicable, in column 2. 2.00 If this is a Medicare-certified islet transplant program, enter the cert				132.
in column 1 and termination date, if applicable, in column 2. 33.00 Removed and reserved				133.
44.00 If this is a hospital-based organ procurement organization (OPO), enter 1 in column 1 and termination date, if applicable, in column 2. All Providers	the OPO number			134.0
10.00 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	Y	15н046	140.0
1.00 2.00 If this facility is part of a chain organization, enter on lines 141 three home office and enter the home office contractor name and contractor num	ber.			
1.00 Name: ASCENSION ST. VINCENT Contractor's Name: WPS 2.00 Street: 250 WEST 96TH STREET, SUITE 215 PO Box: 3.00 City: INDIANAPOLIS State: IN	Contracto Zip Code:	r's Number:0800		141. 142. 143.
				_
4.00 Are provider based physicians' costs included in Worksheet A?			1.00 Y	144.0
				_
5.00 If costs for renal services are claimed on Wkst. A, line 74, are the cost	ts for	1.00	2.00	145.
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 period? Enter "Y" for yes or "N" for no in column 2.	column 1 is			<u></u>
6.00 Has the cost allocation methodology changed from the previously filed cost Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter		N		146.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLE		NCENT JENNINGS Provider CC		Period		Worksheet S-	-2552-1
					7/01/2022 6/30/2023	Part I Date/Time Pr 11/22/2023 2	
						1.00	_
.47.00 was there a change in the statist	ical basis? Enter "Y" for y	yes or "N" for	no.			N 1.00	147.00
48.00 was there a change in the order o						N	148.0
49.00 was there a change to the simplif	ied cost finding method? E		es or "N" f			N	149.0
		Part A	Part B	Т	itle V	Title XIX	
		1.00	2.00		3.00	4.00	_
Does this facility contain a prov or charges? Enter "Y" for yes or							
55.00 Hospital		N	N	. (366	N	N	155.00
156.00 Subprovider - IPF		N	N		N	N	156.00
157.00 Subprovider - IRF		N	N		Ν	N	157.00
L58.00 SUBPROVIDER							158.0
L59.00 SNF		N	N		N	N	159.0
160.00 HOME HEALTH AGENCY		N	N		N	N	160.00
L61.00 СМНС			N		N	N	161.0
						1.00	_
Multicampus						2100	
.65.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no.	ampus hospital that has one	e or more campu	uses in dif	ferent CB	SAs?	N	165.00
	Name	County	State 2	zip Code	CBSA	FTE/Campus	
	0	1.00	2.00	3.00	4.00	5.00	
L66.00 If line 165 is yes, for each						0.0	00166.00
campus enter the name in column							
0, county in column 1, state in column 2, zip code in column 3,							
CBSA in column 4, FTE/Campus in							
column 5 (see instructions)							
			1 1		1		
						1.00	
Health Information Technology (HI 167.00 Is this provider a meaningful use				επτ Αςτ		Y	167.00
168.00 If this provider is a CAH (line 1				") ontor	the	T	168.00
reasonable cost incurred for the			107 15 1), chicch	che		100.00
168.01 If this provider is a CAH and is			r qualify f	or a hard	lship	N	168.01
exception under §413.70(a)(6)(ii)	? Enter "Y" for yes or "N"	for no. (see	instruction	5)	·		
169.00 If this provider is a meaningful		is not a CAH	(line 105 i	s "N"), e	nter the	0.0	00169.00
transition factor. (see instruction	ons)			Ro	ginning	Ending	_
				ве	1.00	2.00	-
170.00 Enter in columns 1 and 2 the EHR	peginning date and ending o	date for the re	eporting		1.00	2.00	170.00
period respectively (mm/dd/yyyy)							
					1.00	2.00	
171.00 If line 167 is "Y", does this pro					N		0171.00
	encountered and values of 2 pt	T line 2 co	1 67 Entor			1	
section 1876 Medicare cost plans "Y" for yes and "N" for no in col							

HOSPIT	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-1303	Period: From 07/01/2022 To 06/30/2023	Date/Time Pr	epared:
				Y/N	11/22/2023 2	:07 pm
				1.00	Date 2.00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSE General Instruction: Enter Y for all YES responses. Enter N					-
	mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS		-			_
	Provider Organization and Operation				I	
.00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in o			N		1.0
	reporting period: if yes, enter the date of the change in t	2010mm 2. (3ee	Y/N	Date	V/I	
			1.00	2.00	3.00	
.00	Has the provider terminated participation in the Medicare F yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.		N			2.0
.00	Is the provider involved in business transactions, includir contracts, with individuals or entities (e.g., chain home of or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members of of directors through ownership, control, or family and other relationships? (see instructions)	offices, drug der or its of the board	N			3.0
			Y/N	Туре	Date	
			1.00	2.00	3.00	
1.00	Financial Data and Reports Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" f or "R" for Reviewed. Submit complete copy or enter date ava Column 3. (see instructions) If no, see instructions.	for Compiled,	Y	A		4.0
5.00	Are the cost report total expenses and total revenues diffe those on the filed financial statements? If yes, submit rec		N			5.0
				Y/N 1.00	Legal Oper. 2.00	
	Approved Educational Activities					
5.00	Column 1: Are costs claimed for a nursing program? Column the legal operator of the program?	•	s the provide			6.0
7.00 3.00	Are costs claimed for Allied Health Programs? If "Y" see ir Were nursing programs and/or allied health programs approve cost reporting period? If yes, see instructions.		wed during th	e N		7.0
.00	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
L0.00	Was an approved Intern and Resident GME program initiated of cost reporting period? If yes, see instructions.		the current	Ν		10.0
1.00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	E & R in an App	proved	Ν		11.0
					Y/N 1.00	
	Bad Debts				1.00	-
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p			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	N	14.0
.5.00	Bed Complement Did total beds available change from the prior cost reporti	ing period? If	yes, see ins	tructions.	Y	15.0
			rt A		't B	
		Y/N 1.00	Date 2.00	Y/N 3.00	Date 4.00	
	PS&R Data	1.00	2.00	5.00	4.00	
.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
L9.00	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		N		19.0

Health	Financial	Systems
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HOSPIT	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-1303	Period: From 07/01/2022 To 06/30/2023		repared:
		Descr	iption	Y/N	Y/N	
			0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	EPT CHILDRENS H	OSPITALS)			
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, se				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.			•	N	23.00
24.00	Were new leases and/or amendments to existing leases enter If yes, see instructions				Y	24.00
25.00	Have there been new capitalized leases entered into during instructions.	the cost repor	rting period?	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? I	f yes, see	N	26.00
27.00	Has the provider's capitalization policy changed during th copy.	e cost reportir	ng period? If	yes, submit	N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit e period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see inst	ructions			N	29.00
30.00	Has existing debt been replaced prior to its scheduled mat instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without i instructions.	ssuance of new	debt? If yes	, see	N	31.00
	Purchased Services				1	
32.00	arrangements with suppliers of services? If yes, see instr	uctions.	-		Y	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 ap no, see instructions.	plied pertainir	ng to competi	tive bidding? If	Y	33.00
	Provider-Based Physicians					
34.00	Were services furnished at the provider facility under an	arrangement wit	th provider-b	ased physicians?	Y	34.00
35.00			nts with the	provider-based	N	35.00
	physicians during the cost reporting period? If yes, see i	nstructions.		N/ h		
				Y/N	Date	
	une office cente			1.00	2.00	
26 00	Home Office Costs Were home office costs claimed on the cost report?			V		36.00
37.00	If line 36 is yes, has a home office cost statement been p	repared by the	home office?	Y Y		37.00
38.00	If yes, see instructions. If line 36 is yes, was the fiscal year end of the home of the providers If yes, onten in column 2 the fiscal year on			Ν		38.00
39.00	the provider? If yes, enter in column 2 the fiscal year en If line 36 is yes, did the provider render services to oth see instructions.			, N		39.00
40.00	If line 36 is yes, did the provider render services to the instructions.	home office?	If yes, see	Ν		40.00
		1.	.00	2.	00	_
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	JILL		HILL		41.00
42.00	respectively. Enter the employer/company name of the cost report	ASCENSION				42.00
43.00	preparer. Enter the telephone number and email address of the cost	(317) 583-3519)	JILL.HILL1@ASC	ENSION.ORG	43.00
	report preparer in columns 1 and 2, respectively.	I				

Health	Financial Systems ASCENSION ST.	VIN	CENT JENNINGS	In Lie	u of Form CMS-	2552-10
HOSPIT	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-1303	eriod: rom 07/01/2022 o 06/30/2023		pared:
			3.00			
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position	RI	EIMBURSEMENT 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 AS	CENSION ST. VI		CN: 15-1303	Period:	u of Form CMS-2 Worksheet S-3	
11051 11	AL AND HOSTITAL MEREIN CARE COMPLEX STATISTIC		riovider e	CN. 15 1505	From 07/01/2022	Part I	
					то 06/30/2023	Date/Time Pre	
						11/22/2023 2:0 I/P Days / O/P	
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH/REH Hours	Title V	
	componente	Line No.	Not of Beas	Available	chilly KEIT Hour 5	incre v	
		1.00	2.00	3.00	4.00	5.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00	25	9,12	9,744.00	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)						
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation		25	9,12	9,744.00	0	7.00
0 00	beds) (see instructions)						0.00
8.00 9.00	INTENSIVE CARE UNIT CORONARY CARE UNIT	,					8.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,12	9,744.00	0	14.00
15.00	CAH visits		20	,	5,	0	15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF		~		0		31.00
32.00	Labor & delivery days (see instructions)		C		0		32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	-						33.00
	Temporary Expansion COVID-19 PHE Acute Care	30.00	C	1	0	_	34.00

OSPIT	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC		Provider CO		Period: From 07/01/2022 To 06/30/2023	Worksheet S-3 Part I Date/Time Pre 11/22/2023 2:	parec
		I/P Days	/ O/P Visits	/ Trips	Full Time B	Equivalents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I - STATISTICAL DATA						
.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2	183	16	40)9		1.0
	for the portion of LDP room available beds)						
.00	HMO and other (see instructions)	114	31				2.
.00	HMO IPF Subprovider	0	0				3.
.00	HMO IRF Subprovider	0	0				4.
.00	Hospital Adults & Peds. Swing Bed SNF	54	0	c.	96		5.
.00	Hospital Adults & Peds. Swing Bed NF		0	-	0		6.
.00	Total Adults and Peds. (exclude observation	237	16	50)5		7.
00	beds) (see instructions)						
.00	INTENSIVE CARE UNIT						8.
	CORONARY CARE UNIT						
0.00 L.00	BURN INTENSIVE CARE UNIT						10
	SURGICAL INTENSIVE CARE UNIT						11
2.00	OTHER SPECIAL CARE (SPECIFY)						12
4.00	NURSERY	237	16	F	0.00	48.44	13
+.00 5.00	Total (see instructions) CAH visits	-	978			40.44	14
5.10	REH hours and visits	5,704	976	35,27	0		15
5.00	SUBPROVIDER - IPF						16
7.00	SUBPROVIDER - IFF						17
3.00	SUBPROVIDER						18
9.00	SKILLED NURSING FACILITY						19
0.00	NURSING FACILITY						20
L.00	OTHER LONG TERM CARE						21
2.00	HOME HEALTH AGENCY						22
3.00	AMBULATORY SURGICAL CENTER (D.P.)						23
1.00	HOSPICE						24
4.10	HOSPICE (non-distinct part)				0		24
5.00	CMHC - CMHC						25
5.00	RURAL HEALTH CLINIC	0	0		0.00	0.00	
6.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0.00		
7.00	Total (sum of lines 14-26)	-	-		0.00	48.44	
3.00	Observation Bed Days		0	49	92		28
.00	Ambulance Trips	0	Ũ				29
00.0	Employee discount days (see instruction)				3		30
1.00	Employee discount days - IRF				0		31
2.00	Labor & delivery days (see instructions)	0	0		0		32
2.01	Total ancillary labor & delivery room	° I	Ŭ		0		32
	outpatient days (see instructions)						
3.00	LTCH non-covered days	0					33
3.01	5	Ő					33
	Temporary Expansion COVID-19 PHE Acute Care	0	0		0		34

IOSPIT	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC/	AL DATA	Provider C	CN: 15-1303	Period: From 07/01/2022 To 06/30/2023		pared
		Full Time Equivalents		Dis	charges		
	Component	Nonpaid Workers	Title V	Title XVIII		Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
L.00	PART I - STATISTICAL DATA Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2		(60 8	150	1.0
2.00	for the portion of LDP room available beds) HMO and other (see instructions)				38 11		2.0
3.00 4.00	HMO IPF Subprovider HMO IRF Subprovider				0		3.0 4.0
5.00 5.00 7.00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions)						5.0 6.0 7.0
3.00 9.00 L0.00	INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						8.0 9.0 10.0
L1.00 L2.00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						11.0 12.0
L3.00 L4.00 L5.00	NURSERY Total (see instructions) CAH visits	0.00	C		60 8	150	13.0 14.0 15.0
L5.10 L6.00	REH hours and visits SUBPROVIDER - IPF						15.1
.7.00 .8.00	SUBPROVIDER – IRF SUBPROVIDER						17.0
9.00	SKILLED NURSING FACILITY NURSING FACILITY						19. 20.
1.00 2.00 3.00	OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.)						21. 22. 23.
4.00	HOSPICE HOSPICE (non-distinct part)						24.0 24.1
5.00 6.00	CMHC - CMHC RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER	0.00					25.0 26.0 26.2
7.00	Total (sum of lines 14-26) Observation Bed Days	0.00					27.
9.00	Ambulance Trips Employee discount days (see instruction)						29. 30.
1.00 2.00 2.01	Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room						31. 32. 32.
3.00	outpatient days (see instructions) LTCH non-covered days				0		33.
33.01 34.00	LTCH site neutral days and discharges Temporary Expansion COVID-19 PHE Acute Care				0		33. 34.

Health	Financial Systems ASCENSION ST. VINCEN	T JENNINGS		In Lie	u of Form CMS-2	2552-10
HOSPIT	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-13		iod:	Worksheet S-1	0
				om 07/01/2022		
			То	06/30/2023		
					11/22/2023 2:	07 pm
					1 00	
	uncomponented and indianat any cost computation				1.00	
1.00	Uncompensated and indigent care cost computation	ided by line 202 c	0		0.183430	1.00
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 div	Tued by The 202 C	olumn 6)		0.103430	1.00
2 00	Medicaid (see instructions for each line) Net revenue from Medicaid				7 101 700	2 00
2.00					7,131,769	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?				Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplement		eaicaia?	·	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments fr	om Medicaid			0	5.00
6.00	Medicaid charges				30,124,060	6.00
7.00	Medicaid cost (line 1 times line 6)				5,525,656	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum o	flines	2 and 5; if	0	8.00
	< zero then enter zero)					
	Children's Health Insurance Program (CHIP) (see instructions fo	r each line)				
9.00	Net revenue from stand-alone CHIP				0	9.00
10.00	Stand-alone CHIP charges				0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)				0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line	9; if <	zero then	0	12.00
	enter zero)					
	Other state or local government indigent care program (see inst	ructions for each	line)			
13.00	Net revenue from state or local indigent care program (Not incl					13.00
14.00	Charges for patients covered under state or local indigent care	program (Not incl	uded in	lines 6 or	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	igent care program	(line 1	15 minus line	0	16.00
	13; if < zero then enter zero)					
	Grants, donations and total unreimbursed cost for Medicaid, CHI	P and state/local	indigent	: care program	is (see	
17 00	instructions for each line)	addaa ahaaddaa aaaa			0	17 00
	Private grants, donations, or endowment income restricted to fu				-	
	Government grants, appropriations or transfers for support of h				0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local 8. 12 and 16)	indigent care pro	grams (s	sum of lines	0	19.00
		Uninsu	ired	Insured	Total (col. 1	
		patie		patients	+ col. 2)	
		1.0		2.00	3.00	
	Uncompensated Care (see instructions for each line)	1.0	•	2100	5100	
20.00	Charity care charges and uninsured discounts for the entire fac	ility 1.7	63,352	983,844	2,747,196	20.00
20.00	(see instructions)			565,611	2,7.17,200	20.00
21.00	Cost of patients approved for charity care and uninsured discou	nts (see 3	23,452	983,844	1,307,296	21.00
	instructions)		,	,	_,,	
22.00	Payments received from patients for amounts previously written	off as	0	0	0	22.00
	charity care		-			
23.00	Cost of charity care (line 21 minus line 22)	3	23,452	983,844	1,307,296	23.00
				,	, ,	
					1.00	
24.00	Does the amount on line 20 column 2, include charges for patien	t days beyond a le	ngth of	stay limit	Ν	24.00
	imposed on patients covered by Medicaid or other indigent care	program?		-		
25.00	If line 24 is yes, enter the charges for patient days beyond th	e indigent care pr	ogram's	length of	0	25.00
	stay limit					
26.00	Total bad debt expense for the entire hospital complex (see ins	tructions)			2,491,824	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex	(see instructions)		489,134	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (s	ee instructions)			752,514	27.01
28.00	New Medianes had debt summer (see instructions)				1,739,310	28.00
	Non-Medicare bad debt expense (see instructions)				_,	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt exp	ense (see instruct	ions)		582,422	29.00
29.00 30.00		ense (see instruct	ions)			
30.00	Cost of non-Medicare and non-reimbursable Medicare bad debt exp		ions)		582,422	30.00

Health	Financial Systems AS	CENSION ST. VIN	CENT JENNINGS		In Lie	eu of Form CMS-2	2552-10
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider C		Period:	Worksheet A	
					From 07/01/2022		
					To 06/30/2023	Date/Time Pre 11/22/2023 2:	
	Cost Center Description	Salaries	Other	Total (col 1	Reclassificati		
	cost center bescription	Salaries	other	+ col. 2	ons (See A-6)		
						(col. 3 +-	
						col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT		863,984	863,98	4 0	863,984	1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	117,615	1,174,219	1,291,83	4 0	1,291,834	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	246,989	5,301,905	5,548,89		5,548,894	5.00
7.00	00700 OPERATION OF PLANT	0	816,836			816,836	
8.00	00800 LAUNDRY & LINEN SERVICE	0	42,449			42,449	8.00
9.00	00900 HOUSEKEEPING	0	493,254			493,254	9.00
10.00	01000 DIETARY	ů 0	365,894				
11.00	01100 CAFETERIA	0	0,004	505,05	0 304,480		
13.00	01300 NURSING ADMINISTRATION	284,260	18,902	303,16			
14.00	01400 CENTRAL SERVICES & SUPPLY	204,200	5,990	· · · ·		5,990	
14.00	01500 PHARMACY	222 020					15.00
16.00		233,029	509,184 0		0 0	742,213	16.00
10.00	01600 MEDICAL RECORDS & LIBRARY	0	0		0 0	0	10.00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	861,639	256,699	1,118,33	8 -2,053	1,116,285	30.00
50.00	ANCILLARY SERVICE COST CENTERS	001,039	230,099	1,110,55	o -2,033	1,110,203	50.00
50.00	05000 OPERATING ROOM	247 212	137,708	384,92	1 -25,792	359,129	50.00
54.00		247,213	600.650	,		,	
	05400 RADIOLOGY - DIAGNOSTIC	847,133	,	, , .		, ,	
60.00	06000 LABORATORY	85,050	1,793,160	1,878,21	0 0	1,878,210	
65.00	06500 RESPIRATORY THERAPY	0	0	204 65	0 0	0	65.00
66.00	06600 PHYSICAL THERAPY	9,433	372,219				
67.00	06700 OCCUPATIONAL THERAPY	0	0		0 20,204		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	20,407	20,40		· · · ·	
72.00	07200 IMPLANTABLE DEVICES CHARGED TO	0	10,365	10,36	5 0	10,365	72.00
	PATIENTS						
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
76.00	03950 ADULT MENTAL HEALTH	0	361,693	361,69	3 0	361,693	76.00
	OUTPATIENT SERVICE COST CENTERS				-	-	
88.00	08800 RURAL HEALTH CLINIC	0	0		0 0	0	88.00
91.00	09100 EMERGENCY	1,203,874	1,020,766	2,224,64	0 -1,118	2,223,522	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS						
118.00		4,136,235	14,166,284	18,302,51	9 0	18,302,519	118.00
	NONREIMBURSABLE COST CENTERS			1			
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		0 0		190.00
	19100 RESEARCH	0	0		0 0		191.00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0		0 0		192.00
	07950 OTHER NRCC	0	16,333	16,33	3 0	16,333	
	07951 SPN	0	0		0 0		194.01
194.02	07952 OUTPATIENT CLINICS	0	38	3	8 0		194.02
	07953 MARKETING	0	0		0 0		194.03
200.00	TOTAL (SUM OF LINES 118 through 199)	4,136,235	14,182,655	18,318,89	0 0	18,318,890	200.00

ECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider Co	CN: 15-1303	Period: From 07/01/2022	Worksheet A	
					то 06/30/2023	Date/Time Pr 11/22/2023 2	epared: :07 pm
	Cost Center Description	Adjustments	Net Expenses				
		(See A-8)	For Allocation				
		6.00	7.00				_
00	GENERAL SERVICE COST CENTERS	154 224	700 660				1 1 0
.00	00100 CAP REL COSTS-BLDG & FIXT	-154,324	709,660				1.0
.00	00400 EMPLOYEE BENEFITS DEPARTMENT	6,341	1,298,175				4.0
.00	00500 ADMINISTRATIVE & GENERAL	-1,569,560	3,979,334				5.0
.00	00700 OPERATION OF PLANT	0	816,836				7.0
.00	00800 LAUNDRY & LINEN SERVICE	0	42,449				8.0
.00	00900 HOUSEKEEPING	0	493,254				9.0
0.00	01000 DIETARY	0	61,414				10.0
1.00	01100 CAFETERIA	-55,196	249,284				11.0
3.00	01300 NURSING ADMINISTRATION	0	303,162				13.0
4.00	01400 CENTRAL SERVICES & SUPPLY	0	5,990				14.0
5.00	01500 PHARMACY	-9,117	733,096				15.0
6.00	I	0	0				
	INPATIENT ROUTINE SERVICE COST CENTERS						_
0.00	03000 ADULTS & PEDIATRICS	0	1,116,285				
	ANCILLARY SERVICE COST CENTERS						
0.00	05000 OPERATING ROOM	-23,557	335,572				50.0
4.00	05400 RADIOLOGY - DIAGNOSTIC	-124,053	1,323,161				54.0
0.00	06000 LABORATORY	-9,934	1,868,276				60.0
5.00	06500 RESPIRATORY THERAPY	0	0				65.0
6.00	06600 PHYSICAL THERAPY	0	361,448				66.0
7.00	06700 OCCUPATIONAL THERAPY	0	20,204				67.0
8.00	06800 SPEECH PATHOLOGY	0	0				68.0
9.00	06900 ELECTROCARDIOLOGY	0	0				69.0
1.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	-31,824	18,115	1			71.0
2.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	10,365				72.0
3.00		0	0				73.0
6.00	03950 ADULT MENTAL HEALTH	0	361,693				76.0
	OUTPATIENT SERVICE COST CENTERS		-				
	08800 RURAL HEALTH CLINIC	0	0				88.0
1.00	09100 EMERGENCY	-3,500	2,220,022				91.0
2.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.0
	SPECIAL PURPOSE COST CENTERS						
18.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	-1,974,724	16,327,795				118.0
90 00	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0				190.0
	19100 RESEARCH	0	0				191.0
	19200 PHYSICIANS' PRIVATE OFFICES	0	0				192.0
	07950 OTHER NRCC	0	16,333				192.0
	L07951 SPN	0	10,333				194.0
	207952 OUTPATIENT CLINICS	0	38				194.0
	3 07953 MARKETING	0	0				194.0
JT.U.		0	0	1			1-24.0

Health	Financial Systems	Δ	SCENSION ST. VI	NCENT JENNING	S	In Lie	u of Form CMS	-2552-10
RECLAS	SIFICATIONS			Provider (CCN: 15-1303	Period: From 07/01/2022 To 06/30/2023	Worksheet A- Date/Time Pr 11/22/2023 2	epared:
		Increases						
	Cost Center	Line #	Salary	Other				
	2.00	3.00	4.00	5.00				
	A - CAFETERIA							
1.00	CAFETERIA	11.00	0	304,480				1.00
	TOTALS		0	304,480				1
	B - MEDICAL SUPPLIES			·				1
1.00	MEDICAL SUPPLIES CHARGED TO	71.00		29,532				1.00
	PATIENTS							
2.00								2.00
3.00								3.00
4.00								4.00
			0	29,532				
	C - OCCUPATIONAL THERAPY							
1.00	OCCUPATIONAL THERAPY	67.00	500	19,704				1.00
	TOTALS		500	19,704				
500.00	Grand Total: Increases		500	353,716	1			500.00

Health	Financial Systems	A	SCENSION ST. VI	NCENT JENNING	S	In Lie	u of Form CMS	-2552-10
RECLAS	SIFICATIONS			Provider (CCN: 15-1303	Period:	Worksheet A-	6
						From 07/01/2022 To 06/30/2023	Date/Time Pr 11/22/2023 2	epared: :07 pm
		Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref	· .		
	6.00	7.00	8.00	9.00	10.00			
	A - CAFETERIA							
1.00	DIETARY	10.00	0	304,480		0		1.00
	TOTALS		0	304,480				
	B - MEDICAL SUPPLIES							
1.00	ADULTS & PEDIATRICS	30.00		2,053				1.00
2.00	OPERATING ROOM	50.00		25,792				2.00
3.00	RADIOLOGY - DIAGNOSTIC	54.00		569				3.00
4.00	EMERGENCY	91.00		1,118				4.00
			0	29,532				
	C - OCCUPATIONAL THERAPY							
1.00	PHYSICAL THERAPY	66.00	500	19,704		0		1.00
	TOTALS		500	19,704				
500.00	Grand Total: Decreases		500	353,716				500.00

1.00 2.00 3.00 Bui	TATION OF CAPITAL COSTS CENTERS RT I - ANALYSIS OF CHANGES IN CAPITAL ASSET ind ind Improvements ildings and Fixtures ilding Improvements	127,944 702,434	Provider CC Purchases 2.00 0	Acquisition Donation 3.00	Period: From 07/01/2022 To 06/30/2023 s Total 4.00		pared:
1.00 Lar 2.00 Lar 3.00 Bui	nd nd Improvements ildings and Fixtures	Balances 1.00 BALANCES 127,944 702,434		Donation	Total	Retirements	
1.00 Lar 2.00 Lar 3.00 Bui	nd nd Improvements ildings and Fixtures	Balances 1.00 BALANCES 127,944 702,434				Retirements	
1.00 Lar 2.00 Lar 3.00 Bui	nd nd Improvements ildings and Fixtures	1.00 BALANCES 127,944 702,434	2.00	3.00	4.00		
1.00 Lar 2.00 Lar 3.00 Bui	nd nd Improvements ildings and Fixtures	BALANCES 127,944 702,434	2.00	3.00	4.00	5.00	
1.00 Lar 2.00 Lar 3.00 Bui	nd nd Improvements ildings and Fixtures	127,944 702,434	0				
2.00 Lar 3.00 Bui	nd Improvements ildings and Fixtures	702,434	0				1
3.00 Bui	ildings and Fixtures				0 0	0	1.00
			0		0 0	0	2.00
/ 00 Bui	ilding Improvements	14,773,991	733,824		0 733,824	0	3.00
4.00 Bui		0	0		0 0	0	4.00
5.00 Fix	xed Equipment	1,071,086	109,615		0 109,615	0	5.00
6.00 Mov	vable Equipment	6,774,827	0		0 0	1,254,700	6.00
7.00 HII	T designated Assets	0	0		0 0	0	7.00
8.00 Sub	btotal (sum of lines 1-7)	23,450,282	843,439		0 843,439	1,254,700	8.00
9.00 Red	conciling Items	0	0		0 0	0	9.00
10.00 Tot	tal (line 8 minus line 9)	23,450,282	843,439		0 843,439	1,254,700	10.00
		Ending Balance	Fully			· · · · ·	
		5	Depreciated				
			Assets				
		6.00	7.00				
PAR	RT I - ANALYSIS OF CHANGES IN CAPITAL ASSET	BALANCES					
1.00 Lar	nd	127,944	0				1.00
2.00 Lar	nd Improvements	702,434	0				2.00
3.00 Bui	ildings and Fixtures	15,507,815	0				3.00
4.00 Bui	ilding Improvements	0	0				4.00
	xed Equipment	1,180,701	o				5.00
	vable Equipment	5,520,127	0				6.00
	T designated Assets	0	0				7.00
	btotal (sum of lines 1-7)	23,039,021	0				8.00
	conciling Items	0	0				9.00
	tal (line 8 minus line 9)	23,039,021	0				10.00

Health	Financial Systems A	SCENSION ST. VI	NCENT JENNINGS		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS				Period: From 07/01/2022	Worksheet A-7 Part II	
					To 06/30/2023		
			SU	IMMARY OF CAPI	TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	N 2, LINES 1 a					
1.00	CAP REL COSTS-BLDG & FIXT	502,388	0	361,59	6 0	0	1.00
3.00	Total (sum of lines 1-2)	502,388	0	361,59	6 0	0	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
		Capital-Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	863,984				1.00
3.00	Total (sum of lines 1-2)	0	863,984				3.00

Health	Financial Systems A	SCENSION ST. VI				u of Form CMS-2	2552-10	
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provider Co	Period: From 07/01/2022 To 06/30/2023	Worksheet A-7 Part III Date/Time Prep 11/22/2023 2:0			
		СОМ	PUTATION OF RAT	TIOS	ALLOCATION OF	OTHER CAPITAL		
	Cost Center Description		Capitalized Leases			Insurance		
		1.00	2.00	3.00	4.00	5.00		
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	23,039,021	0	23,039,02	1 1.000000	0	1.00	
3.00	Total (sum of lines 1-2)	23,039,021	0	23,039,02	1 1.000000	0	3.00	
		ALLOCA	TION OF OTHER (SUMMARY C				
	Cost Center Description	Taxes	Other Capital-Relate	Total (sum of cols. 5	Depreciation	Lease		
			d Costs	through 7)				
		6.00	7.00	8.00	9.00	10.00		
	PART III - RECONCILIATION OF CAPITAL COSTS C		1		-			
1.00	CAP REL COSTS-BLDG & FIXT	0	-		0 502,388		1.00	
3.00	Total (sum of lines 1-2)	0	°		0 502,388	0	3.00	
		SUMMARY OF CAPITAL						
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum		
			instructions)	instructions)	Capital-Relate	of cols. 9		
					d Costs (see instructions)	through 14)		
		11.00	12.00	13.00	14.00	15.00		
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	207,272	0		0 0	709,660	1.00	
3.00	Total (sum of lines 1-2)	207,272			0 0	709,660	3.00	
			1		1	,		

דצטנ	Financial Systems MENTS TO EXPENSES				Period:	u of Form CMS-2 Worksheet A-8	
					From 07/01/2022 To 06/30/2023		
				Expense Classification on	Worksheet A	11/22/2023 2:0	07 p
				To/From Which the Amount is			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center		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
	COSTS-BLDG & FIXT (chapter 2)		,				
0	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	2.00	0	1
0	Investment income - other	В	-4,558	ADMINISTRATIVE & GENERAL	5.00	0	3
0	(chapter 2) Trade, quantity, and time		0		0.00	0	2
0	discounts (chapter 8) Refunds and rebates of		0		0.00	0	5
	expenses (chapter 8)						
00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6
00	Telephone services (pay		0		0.00	0	7
	stations excluded) (chapter 21)						
00	Television and radio service (chapter 21)		0		0.00	0	8
00	Parking lot (chapter 21)		0		0.00	0	
.00	Provider-based physician adjustment	A-8-2	-156,778			0	10
.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11
.00	Related organization	A-8-1	365,840			0	12
00	transactions (chapter 10) Laundry and linen service		0		0.00	0	13
00	Cafeteria-employees and guests		-55,196	CAFETERIA	11.00	0	14
00	Rental of quarters to employee and others		0		0.00	0	15
.00	Sale of medical and surgical		0		0.00	0	16
	supplies to other than patients						
00	Sale of drugs to other than	В	-9,117	PHARMACY	15.00	0	17
00	Sale of medical records and		0		0.00	0	18
00	abstracts Nursing and allied health		0		0.00	0	19
	education (tuition, fees,		·		0.00	Ũ	
.00	books, etc.) Vending machines		0		0.00	0	20
00	Income from imposition of		0		0.00	0	21
	interest, finance or penalty charges (chapter 21)						
.00	Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22
	repay Medicare overpayments						
.00	Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPIRATORY THERAPY	65.00		23
. 00	limitation (chapter 14) Adjustment for physical	A-8-3	^	PHYSICAL THERAPY	66.00		24
	therapy costs in excess of	-0-J	0	THIJICAL THENAFT	00.00		
.00	limitation (chapter 14) Utilization review -		0	*** Cost Center Deleted ***	114.00		25
	physicians' compensation		· · · ·				
.00	(chapter 21) Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26
.00	COSTS-BLDG & FIXT Depreciation - CAP REL		^	*** Cost Center Deleted ***	2.00	~	27
	COSTS-MVBLE EQUIP					0	
00 00	Non-physician Anesthetist Physicians' assistant		0	*** Cost Center Deleted ***	19.00 0.00	0	28
00	Adjustment for occupational	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30
	therapy costs in excess of limitation (chapter 14)						
99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30
00	instructions) Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68.00		31
	pathology costs in excess of		-				
.00	limitation (chapter 14) CAH HIT Adjustment for		0		0.00	0	32
00	Depreciation and Interest ENTERTAINMENT	А	_610	ADMINISTRATIVE & GENERAL	5.00	0	33
00	2023 2:07 pm Y:\28550 - St. Vin		-012	1	5.00	U	1 22

Health	Financial Systems	AS	CENSION ST. VI	NCENT JENNINGS	In Lie	u of Form CMS-2	2552-10
ADJUST	MENTS TO EXPENSES				Period:	Worksheet A-8	
					From 07/01/2022 To 06/30/2023		
				Expense Classification or	n Worksheet A		
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	· · · · ·		Cost Center		Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.02	PROVIDER TAX ADJUSTMENT	A	-1,491,177	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.05	LOBBYING	A	-510	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	MISC REVENUE	В	-29	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	MISC REVENUE	В	-766	RADIOLOGY - DIAGNOSTIC	54.00	0	33.07
33.09	MISC REVENUE	В	-3,500	EMERGENCY	91.00	0	33.09
33.13	IC PHYSICIAN FUND	A	-391,141	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14	IC PHYSICIAN FUND	A	-75,419	EMPLOYEE BENEFITS DEPARTMEN	т 4.00	0	33.14
50.00	TOTAL (sum of lines 1 thru 49)		-1,974,724				50.00
	(Transfer to Worksheet A,		,,.				
	column 6, line 200.)						

(column 6, line 200.)
 (1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
 (2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTSProvider CCN: 15-1303Period: From 07/01/2022 To 06/30/2023Worksheet A Date/Time F 11/22/2023Line No.Cost CenterExpense ItemsAmount of Allowable CostAmount of Muscheet A SoloAmount of Allowable CostAmount of Muscheet A Solo1.002.003.004.005.00A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS ORCLAIMED VORGANIZATIONS OR1.005.00ADMINISTRATIVE & GENERAL S.00Home office - Capital Home office - Other209,755 7,853 2,427,9411.005.00ADMINISTRATIVE & GENERAL S.00Home office - Other S.002,427,941 2,312,13.014.00EMPLOYEE BENEFITS DEPARTMENT S.00SVH Chargebacks SVH Chargebacks2,751 2,751 2,70	
Line No.Cost CenterExpense ItemsAmount of Allowable CostAmount of Included in wks. A, colu 51.002.003.004.005.00A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:1.005.00ADMINISTRATIVE & GENERAL 5.00Home office - Capital Home office - Interest 2.427,941209,755 7,853 2.013.015.00ADMINISTRATIVE & GENERAL 4.00Home office - Other SVH Chargebacks2,427,941 2,312,13.025.00ADMINISTRATIVE & GENERAL 5.00Home office - Other SVH Chargebacks2,751 2,751	repared: 2:07 pm
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:1.005.00 ADMINISTRATIVE & GENERAL 5.00 ADMINISTRATIVE & GENERAL 4.00 EMPLOYEE BENEFITS DEPARTMENT 	
HOME OFFICE COSTS:1.005.00 ADMINISTRATIVE & GENERALHome Office - Capital209,7552.005.00 ADMINISTRATIVE & GENERALHome Office - Interest7,8533.005.00 ADMINISTRATIVE & GENERALHome Office - Other2,427,9413.014.00 EMPLOYEE BENEFITS DEPARTMENTSVH Chargebacks2,7513.025.00 ADMINISTRATIVE & GENERALSVH Chargebacks12,000	
1.005.00 ADMINISTRATIVE & GENERALHome office - Capital209,7552.005.00 ADMINISTRATIVE & GENERALHome office - Interest7,8533.005.00 ADMINISTRATIVE & GENERALHome office - Other2,427,9413.014.00 EMPLOYEE BENEFITS DEPARTMENTSVH Chargebacks2,7513.025.00 ADMINISTRATIVE & GENERALSVH Chargebacks12,000	
2.005.00 ADMINISTRATIVE & GENERALHome office - Interest7,8533.005.00 ADMINISTRATIVE & GENERALHome office - Other2,427,9412,312,13.014.00 EMPLOYEE BENEFITS DEPARTMENTSVH Chargebacks2,7512,73.025.00 ADMINISTRATIVE & GENERALSVH Chargebacks12,00012,000	0 1.00
3.00 5.00 ADMINISTRATIVE & GENERAL Home Office - Other 2,427,941 2,312,1 3.01 4.00 EMPLOYEE BENEFITS DEPARTMENT SVH Chargebacks 2,751 2,7 3.02 5.00 ADMINISTRATIVE & GENERAL SVH Chargebacks 12,000 12,000	0 2.00
3.014.00 EMPLOYEE BENEFITS DEPARTMENTSVH Chargebacks2,7512,73.025.00 ADMINISTRATIVE & GENERALSVH Chargebacks12,00012,000	
3.02 5.00 ADMINISTRATIVE & GENERAL SVH Chargebacks 12,000 12,0	
3.03 30.00 ADULTS & PEDIATRICS SVH Chargebacks 172,935 172,9	
3.04 15.00 PHARMACY SVH Chargebacks 17,500 17,50	
3.05 54.00 RADIOLOGY - DIAGNOSTIC SVH Chargebacks 11,004 11,00	3.05
3.06 4.00 EMPLOYEE BENEFITS DEPARTMENT Health Insurance 647,163 565,4	3.06
3.07 1.00 CAP REL COSTS-BLDG & FIXT Interest Expense 359,033 361,5	3.07
3.08 5.00 ADMINISTRATIVE & GENERAL Interest Expense 2,931	0 3.08
3.09 71.00 MEDICAL SUPPLIES CHARGED TO TRG Admin Fees - Supplies -31,824	0 3.09
3.10 5.00 ADMINISTRATIVE & GENERAL TRG ADMIN FEES - OTHER -17,886	0 3.10
3.11 0.00 0	0 3.11
4.00 0.00 0	0 4.00
5.00 TOTALS (sum of lines 1-4). Transfer column 6, line 5 to transfer column 6, line 5 to	L6 5.00
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.

nus not	been posted to worksheet Ay	corumno i ana/or i, che amoun	ie arromabie bii	oura se marcacca m coraini	or ento pare.	
				Related Organization(s) and/	or Home Office	
	Symbol (1)	Name	Percentage of	Name	Percentage of	
			Ownership		Ownership	
	1.00	2.00	3.00	4.00	5.00	
				·		1

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

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

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

i c i ilioui	Semerie under erere Auffilt					
6.00	G	ASCENSION SVH	100.00	ASCENSION SVH	100.00	6.00
7.00	G	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	HOME OFFICE				100.00
	non-financial) specify:					

(1) Use the following symbols to indicate interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.

B. Corporation, partnership, or other organization has financial interest in provider.

C. Provider has financial interest in corporation, partnership, or other organization.

D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.

E. Individual is director, officer, administrator, or key person of provider and related organization.

F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

Health Financial Systems	ASCENSION ST. VINCE	In Lie	u of Form CMS-2552-10	
STATEMENT OF COSTS OF SERVICES FROM OFFICE COSTS	RELATED ORGANIZATIONS AND HOME	Provider CCN: 15-1303	Period: From 07/01/2022 To 06/30/2023	Worksheet A-8-1 Date/Time Prepared: 11/22/2023 2:07 pm
Net Wkst. A-7 Ref.				

	Net	Wkst. A-7 Ref.		
	Adjustments			
	(col. 4 minus			
	col. 5)*			
	6.00	7.00		
	A. COSTS INCUR	RED AND ADJUSTME	NTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED	
	HOME OFFICE CO	STS:		
1.00	209,755	0		1.00
2.00	7,853	0		2.00
3.00	115,814	0		3.00
3.01	0	0		3.01
3.02	0	0		3.02
3.03	0	0		3.03
3.04	0	0		3.04
3.05	0	0		3.05
3.06	81,760	0		3.06
3.07	-2,563	11		3.07
3.08	2,931	0		3.08
3.09	-31,824	0		3.09
3.10	-17,886	0		3.10
3.11	0	0		3.11
4.00	0	0		4.00
5.00	365,840			5.00

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

nas noi	been posted to worksheet A,	COTUMITS	I anu/or	Ζ,	the amou	nt allowable	snoura	be	Indicated	In corumn	4 01	this part.	
	Related Organization(s)												
	and/or Home Office												
	,												
	Type of Business	-											
	6.00	-											
	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.

rembur	Sement under erere Aviii.	
6.00	ADMINISTRATION	6.00
7.00	ADMINISTRATION	7.00
8.00		8.00
9.00		9.00
10.00		10.00
100.00		100.00

(1) Use the following symbols to indicate interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.

B. Corporation, partnership, or other organization has financial interest in provider.

C. Provider has financial interest in corporation, partnership, or other organization.

D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.

E. Individual is director, officer, administrator, or key person of provider and related organization.

F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

In Lieu of Form CMS-2552-10 Health Financial Systems ASCENSION ST. VINCENT JENNINGS PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 15-1303 Period: Worksheet A-8-2 From 07/01/2022 то 06/30/2023 Date/Time Prepared: 11/22/2023 2:07 pm Wkst. A Line # Cost Center/Physician Total Professional Provider RCE Amount Physician/Prov Identifier ider Component Remuneration Component Component Hours 1.00 2.00 3.00 4.00 5.00 6.00 7.00 23,557 23,557 1.00 1.00 50.00 OPERATING ROOM 0 0 0 2.00 54.00 RADIOLOGY - DIAGNOSTIC 123,287 123,287 0 0 0 2.00 60.00 LABORATORY 9,934 0 0 3.00 3.00 9,934 0 0 4.00 91.00 EMERGENCY 852,991 0 852,991 0 4.00 0 5.00 0.00 0 0 0 0 5.00 6.00 0.00 0 0 0 6.00 0 0 0 7.00 0.00 0 0 0 0 7.00 0 8.00 0.00 0 0 0 0 8.00 0 9.00 0.00 0 0 0 0 9.00 10.00 0.00 0 0 0 0 10.00 1,009,769 200.00 156,778 852,991 200.00 0 Cost Center/Physician Unadjusted RCE 5 Percent of Physician Cost Wkst. A Line # Cost of Provider Identifier Limit Unadjusted RCE Memberships & Component of Malpractice Limit Continuing Share of col. Insurance Education 12 1.00 2.00 8.00 9.00 13.00 14.00 12.00 1.00 1.00 50.00 OPERATING ROOM 0 0 0 0 0 2.00 54.00 RADIOLOGY - DIAGNOSTIC 0 0 0 0 0 2.00 3.00 60.00 LABORATORY 0 0 0 0 3.00 0 0 0 0 0 91.00 EMERGENCY 0 0 4.00 4.00 0 0 0.00 5.00 0 0 0 5.00 6.00 0.00 0 0 0 0 6.00 7.00 0.00 0 0 0 0 0 7.00 0 0 0.00 0 0 8.00 0 0 8.00 0.00 0 9.00 0 0 0 9.00 0 10.00 0.00 0 0 0 0 10.00 0 200.00 200.00 0 C 0 Wkst. A Line # Cost Center/Physician Provider Adjusted RCE RCE Adjustment Identifier Component Limit Disallowance Share of col. 14 1.00 2.00 15.00 16.00 17.00 18.00 1.00 1.00 50.00 OPERATING ROOM 0 0 0 23,557 2.00 54.00 RADIOLOGY - DIAGNOSTIC 0 0 0 123,287 2.00 3.00 60.00 LABORATORY 0 0 0 9,934 3.00 91.00 EMERGENCY 0 0 0 4.00 0 4.00 0.00 5.00 0 0 0 0 5.00 6.00 0.00 0 0 0 0 6.00 7.00 0.00 0 0 0 0 7.00 0.00 0 0 0 8.00 8.00 0 0.00 0 9.00 0 0 0 9.00 10.00 0.00 0 0 0 0 10.00

0

0

0

156,778

200.00

200.00

	NABLE COST DETERMINATION FOR THERAPY SERVICES I DE SUPPLIERS	FURNISHED BY	Provider CC	N: 15-1303	Period: From 07/01/2022 To 06/30/2023 Physical Therapy	Worksheet A-8 Parts I-VI Date/Time Prep 11/22/2023 2:0 Cost	pared		
	PART I - GENERAL INFORMATION					1.00			
.00	Total number of weeks worked (excluding aides	(see instruct	ions)			50	1.0		
2.00	Line 1 multiplied by 15 hours per week					750	2.0		
8.00	Number of unduplicated days in which supervis					50	3.0		
1.00	Number of unduplicated days in which therapy nor therapist was on provider site (see instr		on provider sit	e but neith	er supervisor	90	4.0		
5.00	Number of unduplicated offsite visits - super		apists (see ins	structions)		0	5.0		
5.00	Number of unduplicated offsite visits - thera				by therapy	0	6.0		
	assistant and on which supervisor and/or ther	apist was not p	oresent during	the visit(s)) (see				
.00	instructions) Standard travel expense rate	Standard travel expense rate							
3.00	Optional travel expense rate per mile		9.57 0.00	7.0					
		Supervisors	Therapists	Assistants		Trainees			
00	Tatal hours worked	1.00	2.00	3.00	4.00	5.00	0.0		
).00 .0.00	Total hours worked AHSEA (see instructions)	429.00 110.02	1,635.00 95.67	2,354. 62.		0.00	9.0 10.0		
1.00		47.84	47.84	31.		0.00	11.0		
	one-half of column 2, line 10; column 3,								
2 00	one-half of column 3, line 10)	0	0		0		12 (
2.00	Number of travel hours (provider site) Number of travel hours (offsite)	0	0		0		12.0		
3.00		Ő	o		0		13.0		
3.01	Number of miles driven (offsite)	0	0		0		13.0		
						1 00			
	Part II - SALARY EQUIVALENCY COMPUTATION					1.00			
4.00	Supervisors (column 1, line 9 times column 1,	line 10)				47,199	14.		
5.00			156,420						
6.00					10 0 11	146,395			
7.00	Subtotal allowance amount (sum of lines 14 ar others)	350,014	17.0						
.00		10)				0	18.0		
9.00	Trainees (column 5, line 9 times column 5, line 10)								
20.00						350,014	20.0		
	If the sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater than								
	the amount from line 20. Otherwise complete	lines 21-23.							
21.00	5 5 5	1 and 2, line 9	0.00	21.0					
2.00	for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traine					0	22.0		
23.00			.5 THE LL)			350,014			
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW	ANCE AND TRAVEL	EXPENSE COMPU	TATION - PR	OVIDER SITE				
4.00	Standard Travel Allowance					2 202	24		
5.00						2,392 2,799			
6.00		sum of lines 24	and 25 for al	l others)		5,191			
7.00		for respiratory	/ therapy or su	um of lines	3 and 4 for all	1,340	27.0		
8.00	others) Total standard travel allowance and standard	traval expense	at the provide	n sito (sum	of lines 26 and	6,531	28		
0.00	27)	craver expense	at the provide	si site (sui	for times 20 and	0,551	20.0		
	Optional Travel Allowance and Optional Travel								
9.00			12, line 12)			0			
0.00			and 30 for al	1 others)		0	30.0 31.0		
2.00					y or sum of	0	32.0		
	columns 1-3, line 13 for all others)				-				
3.00						6,531			
4.00						0 0	34.0		
5.00	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA				VICES OUTSIDE PRO		, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
	Standard Travel Expense								
						0	36.		
						0	37.		
7.00		1:	1 6)			0	39.		
7.00 8.00		i or lines s and	- /						
6.00 7.00 8.00 9.00									
7.00 8.00 9.00	Standard travel expense (line 7 times the sum Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.0	Expense D1 times column	2, line 10)			0			
7.00 8.00 9.00 0.00 1.00	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	Expense D1 times column	2, line 10)			0	41.0		
7.00 8.00 9.00 0.00 1.00 2.00	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)	Expense D1 times column D3, line 10)				0	41. 42.		
7.00 8.00 9.00 0.00 1.00 2.00	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	Expense D1 times column D3, line 10) D of columns 1-3	3, line 13.01)	of the fol	lowing three line	0 0 0	41. 42.		
7.00 8.00 9.00 0.00 1.00 2.00 3.00	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 - 0 or 46, as appropriate.	Expense D1 times column D3, line 10) D of columns 1-: Effsite Services	3, line 13.01) ; Complete one			0 0 25 44, 45,	41. 42. 43.		
7.00 8.00 9.00 0.00 1.00 2.00	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 - 0 or 46, as appropriate. Standard travel allowance and standard travel	Expense D1 times column D3, line 10) D of columns 1-: Offsite Services expense (sum of	3, line 13.01) ; Complete one of lines 38 and	1 39 - see i	nstructions)	0 0 es 44, 45, 0	41. 42.		

ASONABLE COST DETERMINATION FOR THERAPY SERVICES I TSIDE SUPPLIERS	FURNISHED BY	Provider Co		Period: From 07/01/2022 To 06/30/2023	11/22/2023 2:	pared:
· · · · · · · · · · · · · · · · · · ·				Physical Therapy	Cost	
					1.00	
.00 Optional travel allowance and optional trave						46.00
	Therapists 1.00	Assistants 2.00	Aides 3.00	Trainees 4.00	<u> </u>	
PART V - OVERTIME COMPUTATION	1.00	2.00	5.00	4.00	5.00	
.00 Overtime hours worked during reporting	0.00	0.00	0.0	0.00	0.00	47.00
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)						
.00 Overtime rate (see instructions)	0.00	0.00				48.0
.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						-
.00 Percentage of overtime hours by category	0.00	0.00	0.0	0.00	0.00	50.00
(divide the hours in each column on line 47	0.00	0.00	0.0	0.00	0.00	
by the total overtime worked - column 5,						
line 47)						
.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 .00 Adjusted hourly salary equivalency amount	95.67	62.19	0.0	0.00		52.0
(see instructions)	95.07	62.19	0.0	0.00		52.0
.00 Overtime cost limitation (line 51 times line	0	0		0 0		53.0
52)	°,	0		Ŭ Ŭ		
.00 Maximum overtime cost (enter the lesser of	0	0		0 0		54.00
line 49 or line 53)						
.00 Portion of overtime already included in	0	0		0 0		55.00
hourly computation at the AHSEA (multiply						
line 47 times line 52)	0	0		0	0	56.0
.00 Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5	0	0		0 0	0	50.00
the sum of columns 1, 3, and 4 for						
respiratory therapy and columns 1 through 3						
for all others.)						
	·					
		DIUCTURNE			1.00	
Part VI - COMPUTATION OF THERAPY LIMITATION A .00 Salary equivalency amount (from line 23)	ND EXCESS COST A	ADJUSTMENT			350,014	57.0
.00 Travel allowance and expense - provider site	(from lines 33	34 or $35))$			6,531	
.00 Travel allowance and expense - Offsite service)		0,551	
.00 Overtime allowance (from column 5, line 56)		, , , , , , , , , , , , , , , , , , ,)		ů 0	
.00 Equipment cost (see instructions)					0	
.00 Supplies (see instructions)					0	
.00 Total allowance (sum of lines 57-62)					356,545	
.00 Total cost of outside supplier services (from	your records)				344,626	
.00 Excess over limitation (line 64 minus line 63		enter zero)				65.0
LINE 33 CALCULATION						
0.00 Line 26 = line 24 for respiratory therapy or					5,191	
0.01 Line 27 = line 7 times line 3 for respiratory	therapy or sum	of lines 3 a	nd 4 for all	others	1,340	
0.02 Line 33 = line 28 = sum of lines 26 and 27					6,531	100.0
LINE 34 CALCULATION		-f 1:		a tha wa	1 240	101 0
1.00 Line 27 = line 7 times line 3 for respiratory				others	1,340	101.0
1.01 Line $31 =$ line 29 for respiratory therapy or	sum of Times 29	and 50 lor a	iii otners		1,340	
1.02 Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION					1,540	101.0
	C 1'	and 20 fam a	11 othors		0	102.0
2.00 line $31 = 1$ ine 29 for respiratory therapy or	SUM OT LINES /4	and su tor a				
2.00 Line $31 =$ line 29 for respiratory therapy or 2.01 Line $32 =$ line 8 times columns 1 and 2. line				mns 1-3. line		
<pre>2.00 Line 31 = line 29 for respiratory therapy or 2.01 Line 32 = line 8 times columns 1 and 2, line 13 for all others</pre>				mns 1-3, line		102.0

	WABLE COST DETERMINATION FOR THERAPY SERVICES	GENSION ST. VI	Provider CC	CN: 15-1303	Period: From 07/01/2022 To 06/30/2023 Occupational Therapy		-3 pared:				
						1.00					
.00	PART I - GENERAL INFORMATION Total number of weeks worked (excluding aides	s) (see instruc	tions)			38	1.00				
.00	Line 1 multiplied by 15 hours per week Number of unduplicated days in which supervis			dan sita (sa	o instructions)	570	2.00				
.00	Number of unduplicated days in which therapy	assistant was				0					
.00		r therapist was on provider site (see instructions) mber of unduplicated offsite visits - supervisors or therapists (see instructions)									
.00	Number of unduplicated offsite visits - thera assistant and on which supervisor and/or the instructions)	apy assistants	(include only	visits made		0					
.00 .00	Standard travel expense rate Optional travel expense rate per mile					9.57					
.00		Supervisors	Therapists	Assistants		Trainees	0.00				
.00	Total hours worked	1.00	2.00 361.00	3.00	4.00	5.00	9.0				
0.00	AHSEA (see instructions)	0.00	90.69	62.	58 0.00		10.00				
1.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3,	45.35	45.35	31.	29		11.00				
	one-half of column 3, line 10)										
2.00	Number of travel hours (provider site) Number of travel hours (offsite)	0	0		0		12.0				
3.00	Number of miles driven (provider site)	0	0		0		13.0				
3.01	Number of miles driven (offsite)	0	0		0		13.0				
						1.00					
4.00	Part II - SALARY EQUIVALENCY COMPUTATION Supervisors (column 1, line 9 times column 1	, line 10)				0	14.0				
.00	Therapists (column 2, line 9 times column 2,	32,739									
6.00	Assistants (column 3, line 9 times column 3, Subtotal allowance amount (sum of lines 14 and	1,189 33,928									
	others)										
8.00	Aides (column 4, line 9 times column 4, line Trainees (column 5, line 9 times column 5, l	0	18.0								
0.00	Total allowance amount (sum of lines 17-19 for If the sum of columns 1 and 2 for respiratory						20.0				
	occupational therapy, line 9, is greater than										
1.00	the amount from line 20. Otherwise complete Weighted average rate excluding aides and tra		divided by su	m of columns	1 and 2 line 9	89.28	21.0				
	for respiratory therapy or columns 1 thru 3,	line 9 for all	others)		I and Z, The s						
2.00	Weighted allowance excluding aides and traine Total salary equivalency (see instructions)	ees (line 2 tim	es line 21)			50,890					
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW	ANCE AND TRAVE	L EXPENSE COMP	JTATION - PR	OVIDER SITE						
4.00	Standard Travel Allowance Therapists (line 3 times column 2, line 11)					3,628	24.0				
5.00	Assistants (line 4 times column 3, line 11)					0	25.0				
5.00 7.00	Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3				3 and 4 for all	3,628	26.0				
	others)	•									
3.00	Total standard travel allowance and standard 27)	travel expense	at the provid	er site (sum	or lines 26 and	4,394	28.0				
9.00	Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of	Expense	d 2 line 12)			0	29.0				
0.00	Assistants (column 3, line 10 times column 3		u z, The Iz)			0					
1.00	Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column:				v on cum of	0					
2.00	columns 1-3, line 13 for all others)	s I allu 2, The	13 IOI Tespin	ατοιν τηθιαρ	y of Sum of	0	32.0				
3.00 4.00	Standard travel allowance and standard trave Optional travel allowance and standard trave			d 21)		4,394	1				
5.00	Optional travel allowance and optional trave					0					
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA	NCE AND TRAVEL	EXPENSE COMPU	TATION - SER	VICES OUTSIDE PR	OVIDER SITE					
5.00	Standard Travel Expense Therapists (line 5 times column 2, line 11)					0	36.0				
7.00	Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37)					0					
9.00	Standard travel expense (line 7 times the sur		d 6)			0					
0.00	Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.0	Expense	2 line 10)			0	40.0				
L.00	Assistants (column 3, line 12.01 times column		2, THE 10)			0					
2.00	Subtotal (sum of lines 40 and 41)		2]de- 12 01			0	42.0				
3.00	Optional travel expense (line 8 times the sur Total Travel Allowance and Travel Expense - C			e of the fol	lowing three lin	0 Nes 44, 45,	43.0				
	or 46, as appropriate. Standard travel allowance and standard trave						44.0				
				u	113 LI ULLI UIS /		1 ++.0				

	ABLE COST DETERMINATION FOR THERAPY SERVICES I E SUPPLIERS	FURNISHED BY	Provider Co	CN: 15-1303	Period: From 07/01/2022 To 06/30/2023	Worksheet A-8 Parts I-VI Date/Time Pre 11/22/2023 2:	pared:
					Occupational Therapy	Cost	
						1.00	
	Optional travel allowance and standard travel					0	
6.00	Optional travel allowance and optional travel					0	46.00
		Therapists 1.00	Assistants 2.00	Aides 3.00	Trainees 4.00	<u> </u>	
	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	0.00	0.00	47.0
	Overtime rate (see instructions)	0.00	0.00				48.00
	Total overtime (including base and overtime allowance) (multiply line 47 times line 48) CALCULATION OF LIMIT	0.00	0.00	0.0	0.00		49.00
	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.0	0.00	0.00	50.00
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	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	62.58		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		55.00
6.00	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	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)		50,890 4,394 0 0 0 55,284 19,280 0	58.00 59.00 60.00 61.00 62.00 63.00
00.01	Line 26 = line 24 for respiratory therapy or Line 27 = line 7 times line 3 for respiratory Line 33 = line 28 = sum of lines 26 and 27				others		100.00 100.03 100.03
01.01	LINE 34 CALCULATION Line 27 = line 7 times line 3 for respiratory Line 31 = line 29 for respiratory therapy or				others	0	101.0
01.02	Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION					766	101.0
				11 others			•

OST ALLOCATION	1 Systems AS	SCENSION ST. VI	Provider CO	CN: 15-1303	Period:	u of Form CMS- Worksheet B	
					From 07/01/2022	Part I	
					то 06/30/2023	Date/Time Pre 11/22/2023 2:	
			CAPITAL			11/22/2023 2.	
			RELATED COSTS				
Cos	st Center Description	Net Expenses	BLDG & FIXT	EMPLOYEE	Subtotal	ADMINISTRATIVE	
		for Cost		BENEFITS		& GENERAL	
		Allocation		DEPARTMENT			
		(from Wkst A					
		col. 7)					
		0	1.00	4.00	4A	5.00	-
	SERVICE COST CENTERS	700 660	700 660				1 1
	P REL COSTS-BLDG & FIXT	709,660	709,660	1 200 1	7 5		4
	PLOYEE BENEFITS DEPARTMENT	1,298,175	0	1,298,17		4 101 015	
	MINISTRATIVE & GENERAL ERATION OF PLANT	3,979,334	62,694	79,78		4,121,815	
	JNDRY & LINEN SERVICE	816,836 42,449	64,784 771		001,010		
	JNDRY & LINEN SERVICE	42,449	14,565		0 43,220 0 507,819		
00900 HO		61,414	7,181		0 68,595	23,133	
L.00 01100 CAP		249,284	14,799		0 264,083	89,058	
	RSING ADMINISTRATION	303,162	1,684	91,82		133,772	
	NTRAL SERVICES & SUPPLY	5,990	11,807	51,02	0 17,797	6,002	
5.00 01500 PHA		733,096	6,644	75,27			
	DICAL RECORDS & LIBRARY	, , , , , , , , , , , , , , , , , , , ,	56,203	13,21	0 56,203	,	
	T ROUTINE SERVICE COST CENTERS		50,205		50,205	10,551	1
	JLTS & PEDIATRICS	1,116,285	66,579	278,34	1,461,208	492,772	1 30
	Y SERVICE COST CENTERS			· · · · ·		· · · · · ·	
0.00 05000 OPE	ERATING ROOM	335,572	52,906	79,86	468,338	157,940	50
4.00 05400 RAD	DIOLOGY - DIAGNOSTIC	1,323,161	42,875	273,65	1,639,694	552,964	54
0.00 06000 LAE	BORATORY	1,868,276	17,882	27,47	75 1,913,633	645,346	60
	SPIRATORY THERAPY	0	0		0 0	0	1 0 0
	YSICAL THERAPY	361,448	25,185	2,88			
	CUPATIONAL THERAPY	20,204	0	16	52 20,366	6,868	
	EECH PATHOLOGY	0	0		0 0	0	
	ECTROCARDIOLOGY	0	0		0 0	0	
	DICAL SUPPLIES CHARGED TO PATIENTS	18,115	0		0 18,115	6,109	
	PLANTABLE DEVICES CHARGED TO	10,365	0		0 10,365	3,495	72
	FIENTS		0				
	JGS CHARGED TO PATIENTS	0	0		0 0 361.693	121.070	
	JLT MENTAL HEALTH NT SERVICE COST CENTERS	361,693	0		0 361,693	121,976	76
	RAL HEALTH CLINIC	0	0		0 0	0	88
1.00 09100 EME		2,220,022	42,824	388,89	-	894,263	
	SERVATION BEDS (NON-DISTINCT PART)	2,220,022	42,024	500,05	0 2,051,744	054,205	92
	PURPOSE COST CENTERS				0		1 52
	STOTALS (SUM OF LINES 1 through 117)	16,327,795	489,383	1,298,17	75 16,107,518	4,042,009	1118
	URSABLE COST CENTERS		,	, ,		,,,,,,,,	
	T, FLOWER, COFFEE SHOP, & CANTEEN	0	3,672		0 3,672	1,238	190
91.00 19100 RES	SEARCH	0	0		0 0	0	191
2.00 19200 PH	SICIANS' PRIVATE OFFICES	0	0		0 0	0	192
94.00 07950 OTH	HER NRCC	16,333	0		0 16,333	5,508	194
4.01 07951 SP		0	141,141		0 141,141	47,598	
	FPATIENT CLINICS	38	75,464		0 75,502	25,462	
4.03 07953 MAF		0	0		0 0		194
0.00 Cro	oss Foot Adjustments				0		200
	gative Cost Centers		0		0 0	0	201
	TAL (sum lines 118 through 201)	16,344,166	709,660	1,298,17	16,344,166	4,121,815	120'

COST A	LLOCATION - GENERAL SERVICE COSTS		Provider C	CN: 15-1303	Period: From 07/01/2022 To 06/30/2023	Worksheet B Part I Date/Time Pre 11/22/2023 2:	
	Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	G DIETARY	CAFETERIA	
		7.00	8.00	9.00	10.00	11.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	1		1			1.00
							4.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						
5.00	00500 ADMINISTRATIVE & GENERAL	1 170 024					5.00
7.00	00700 OPERATION OF PLANT	1,178,934					7.00
8.00	00800 LAUNDRY & LINEN SERVICE	1,561	59,356		- 0		8.00
9.00	00900 HOUSEKEEPING	29,495	0	,.			9.00
10.00	01000 DIETARY	14,542	0	12,79	· · · ·	202 400	10.00
11.00	01100 CAFETERIA	29,968			0 0	383,109	
13.00	01300 NURSING ADMINISTRATION	3,410	0		0 0	18,243	
14.00	01400 CENTRAL SERVICES & SUPPLY	23,909			0 0	0	14.00
15.00	01500 PHARMACY	13,454		21,69		18,243	
16.00	01600 MEDICAL RECORDS & LIBRARY	113,812	0		0 0	0	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	134,825	59,356	32,83	L4 119,062	82,095	30.00
	ANCILLARY SERVICE COST CENTERS	1	1	1			
50.00	05000 OPERATING ROOM	107,137	0	· · ·		36,487	50.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	86,823				82,095	
60.00	06000 LABORATORY	36,212	0	2,22		9,122	60.00
65.00	06500 RESPIRATORY THERAPY	0	0		0 0	0	65.00
66.00	06600 PHYSICAL THERAPY	51,001	0	33,37	71 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 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
76.00	03950 ADULT MENTAL HEALTH	0	0		0 0	0	76.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0		0 0	0	88.00
91.00	09100 EMERGENCY	86,720	0	481,64	19 0	136,824	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS						
118.00		732,869	59,356	649,05	58 119,062	383,109	118.00
	NONREIMBURSABLE COST CENTERS	1					
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	7,435	0		0 0		190.00
	19100 RESEARCH	0			0 0		191.00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0		0 0		192.00
	07950 OTHER NRCC	0	0	59,51			194.00
	07951 SPN	285,812			0 0		194.01
	07952 OUTPATIENT CLINICS	152,818	0		0 0		194.02
	07953 MARKETING	0	0		0 0	0	194.03
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0		0 0		201.00
202.00	TOTAL (sum lines 118 through 201)	1,178,934	59,356	708,56	59 119,062	383,109	202 00

	•	ASCENSION ST. VI		N. 15 1202		u of Form CMS-	2002-10
COST A	ALLOCATION - GENERAL SERVICE COSTS		Provider CC	N: 15-1303	Period: From 07/01/2022 To 06/30/2023	Worksheet B Part I Date/Time Pre 11/22/2023 2:	
	Cost Center Description	NURSING	CENTRAL	PHARMACY	MEDICAL	Subtotal	
		ADMINISTRATION	SERVICES &		RECORDS &		
		12.00	SUPPLY	15 00	LIBRARY	24.00	
		13.00	14.00	15.00	16.00	24.00	-
1 00	GENERAL SERVICE COST CENTERS						1 1 00
1.00 4.00	00100 CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT						1.00
							5.00
5.00	00500 ADMINISTRATIVE & GENERAL						
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPING						9.00
10.00	01000 DIETARY						10.00
11.00	01100 CAFETERIA	552 000					11.00
13.00	01300 NURSING ADMINISTRATION	552,098	17 700				13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	47,708				14.00
15.00	01500 PHARMACY	0	15	1,143,27			15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0		0 188,969		16.00
~~ ~~	INPATIENT ROUTINE SERVICE COST CENTERS	200 722	2.070		0 5 005	2 600 075	
30.00	03000 ADULTS & PEDIATRICS	209,732	3,976		0 5,035	2,600,875	30.00
	ANCILLARY SERVICE COST CENTERS	50.070	=		0 0.574	004.046	
50.00	05000 OPERATING ROOM	52,376	7,989		0 9,574	894,346	
54.00	05400 RADIOLOGY - DIAGNOSTIC	0	4,647		0 48,939	2,425,173	
60.00	06000 LABORATORY	0	10		0 58,446	2,664,994	
65.00	06500 RESPIRATORY THERAPY	0	0		0 342	342	
66.00		0	364		0 3,657	609,272	
67.00	06700 OCCUPATIONAL THERAPY	0	0		0 205	27,439	
68.00	06800 SPEECH PATHOLOGY	0	0		0 0	0	
69.00	06900 ELECTROCARDIOLOGY	0	0		0 0	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	8,520		0 0	32,744	
72.00	07200 IMPLANTABLE DEVICES CHARGED TO	0	1,804		0 0	15,664	72.0
	PATIENTS						
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	1,143,27		1,143,274	
76.00		0	18		0 2,256	485,943	76.0
	OUTPATIENT SERVICE COST CENTERS				-	-	
88.00	08800 RURAL HEALTH CLINIC	0	0		0 0	0	
91.00	09100 EMERGENCY	289,990	20,365		0 60,515	4,622,070	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS						
118.00		552,098	47,708	1,143,27	188,969	15,522,136	118.00
	NONREIMBURSABLE COST CENTERS		-				
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		0 0	· · ·	190.00
	19100 RESEARCH	0	0		0 0		191.00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0		0 0		192.00
	07950 OTHER NRCC	0	0		0 0	81,352	
	107951 SPN	0	0		0 0	474,551	
	2 07952 OUTPATIENT CLINICS	0	0		0 0	253,782	
	3 07953 MARKETING	0	0		0 0		194.0
200.00						-	200.0
201.00	5	0	0		0 0	0	
202.00	TOTAL (sum lines 118 through 201)	552,098	47,708	1,143,27	74 188,969	16,344,166	202.00

COCT A	*	SCENSION ST. VINC		1202		u of Form CMS	
LOST A	LLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15	-1303	Period: From 07/01/2022 To 06/30/2023	Worksheet B Part I Date/Time Pr 11/22/2023 2	
	Cost Center Description	Intern &	Total				
		Residents Cost					
		& Post					
		Stepdown					
		Adjustments					
		25.00	26.00				
	GENERAL SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·	ł				
.00	00100 CAP REL COSTS-BLDG & FIXT						1.0
.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.
	00500 ADMINISTRATIVE & GENERAL						5.
	00700 OPERATION OF PLANT						7.
	00800 LAUNDRY & LINEN SERVICE						8.
	00900 HOUSEKEEPING						9.
	01000 DIETARY						10.
	01100 CAFETERIA						11.
	01300 NURSING ADMINISTRATION						13.
	01400 CENTRAL SERVICES & SUPPLY						14.
	01500 PHARMACY						15.
	01600 MEDICAL RECORDS & LIBRARY						16.
	INPATIENT ROUTINE SERVICE COST CENTERS						_
	03000 ADULTS & PEDIATRICS	0	2,600,875				30.
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	894,346				50.
	05400 RADIOLOGY - DIAGNOSTIC	0	2,425,173				54.
50.00	06000 LABORATORY	0	2,664,994				60.
5.00	06500 RESPIRATORY THERAPY	0	342				65.
56.00	06600 PHYSICAL THERAPY	0	609,272				66.
57.00	06700 OCCUPATIONAL THERAPY	0	27,439				67.
58.00	06800 SPEECH PATHOLOGY	0	0				68.
59.00	06900 ELECTROCARDIOLOGY	0	0				69.
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	32,744				71.
	07200 IMPLANTABLE DEVICES CHARGED TO	0	15,664				72.
2.00	PATIENTS	, i i i i i i i i i i i i i i i i i i i					
73.00	07300 DRUGS CHARGED TO PATIENTS	0	1,143,274				73.
	03950 ADULT MENTAL HEALTH	0	485,943				76.
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	0	0				88.
	09100 EMERGENCY	0	4,622,070				91.
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	4,022,070				92.
	SPECIAL PURPOSE COST CENTERS	U U					
L18.00		0	15,522,136				118.
	NONREIMBURSABLE COST CENTERS	V	15,522,150				
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	12,345				190.
		-					
	19100 RESEARCH	0	0				191.
	19200 PHYSICIANS' PRIVATE OFFICES	0	0				192.
	07950 OTHER NRCC	0	81,352				194.
	07951 SPN	0	474,551				194.
	07952 OUTPATIENT CLINICS	0	253,782				194.
.94.03	07953 MARKETING	0	0				194.
200.00	Cross Foot Adjustments	0	0				200.
201.00	Negative Cost Centers	0	0				201.
202.00		0	16,344,166				202.

ALLOCA	TION OF CAPITAL RELATED COSTS		Provider CO		Period: From 07/01/2022 To 06/30/2023	Worksheet B Part II Date/Time Pre 11/22/2023 2:	pared
			CAPITAL RELATED COSTS			11/22/2023 2.	
	Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
		0	1.00	2A	4.00	5.00	
	GENERAL SERVICE COST CENTERS	1			- 1	1	
L.00	00100 CAP REL COSTS-BLDG & FIXT						1.0
	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0		0 0		4.0
	00500 ADMINISTRATIVE & GENERAL	224,142	62,694	286,83		200,050	
7.00	00700 OPERATION OF PLANT	1,599	64,784	66,38		20,000	
3.00	00800 LAUNDRY & LINEN SERVICE	0	771	77		1,014	
9.00	00900 HOUSEKEEPING	119	14,565	14,68		11,917	
	01000 DIETARY	567	7,181	7,74		1,610	
	01100 CAFETERIA	0	14,799	14,79	9 0	6,197	
L3.00	01300 NURSING ADMINISTRATION	0	1,684	1,68	4 0	9,309	13.0
L4.00	01400 CENTRAL SERVICES & SUPPLY	0	11,807	11,80	7 0	418	14.0
	01500 PHARMACY	26,304	6,644	32,94		,	15.0
L6.00	01600 MEDICAL RECORDS & LIBRARY	0	56,203	56,20	3 0	1,319	16.0
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	6,104	66,579	72,68	3 0	34,292	30.0
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	51,048	52,906	103,95	4 0	10,991	50.0
	05400 RADIOLOGY - DIAGNOSTIC	430,536	42,875	473,41	1 0		
	06000 LABORATORY	1,068	17,882	18,95	0 0	44,909	60.0
55.00	06500 RESPIRATORY THERAPY	0	0		0 0	0	65.0
	06600 PHYSICAL THERAPY	3,527	25,185	28,71	2 0	9,141	66.0
57.00	06700 OCCUPATIONAL THERAPY	0	0		0 0	478	67.0
68.00	06800 SPEECH PATHOLOGY	0	0		0 0	0	68.
	06900 ELECTROCARDIOLOGY	0	0		0 0	0	69.
1.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3,746	0	3,74	6 0	425	71.
	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0		0 0	243	72.
	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	-	
6.00	03950 ADULT MENTAL HEALTH	701	0	70	1 0	8,488	76.
	OUTPATIENT SERVICE COST CENTERS	1				1	
	08800 RURAL HEALTH CLINIC	0	0		0 0		
	09100 EMERGENCY	18,560	42,824	61,38		62,235	
2.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92.
	SPECIAL PURPOSE COST CENTERS	1	1		1	1	
18.00		768,021	489,383	1,257,40	4 0	281,283	118.
	NONREIMBURSABLE COST CENTERS	-				1	1
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	3,672	3,67			190.
	19100 RESEARCH	0	0		0 0	-	191.
	19200 PHYSICIANS' PRIVATE OFFICES	0	0		0 0		192.
	07950 OTHER NRCC	0	0		0 0		194.
	07951 SPN	0	141,141	141,14	-	3,312	
	07952 OUTPATIENT CLINICS	0	75,464	75,46			
	07953 MARKETING	0	0		0 0	0	194.
00.00					0		200.
01.00	5		0		0 0		201.
02.00	TOTAL (sum lines 118 through 201)	768,021	709,660	1,477,68	1 0	286,836	1202

ALLOCA	TION OF CAPITAL RELATED COSTS		Provider Co	CN: 15-1303	Period: From 07/01/2022 To 06/30/2023	Worksheet B Part II Date/Time Pre 11/22/2023 2:	pared: 07 pm
	Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.00	8.00	9.00	10.00	11.00	
	GENERAL SERVICE COST CENTERS			1			
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT	87,073					7.00
8.00	00800 LAUNDRY & LINEN SERVICE	115	1,900				8.00
9.00	00900 HOUSEKEEPING	2,178	0	28,77			9.00
10.00	01000 DIETARY	1,074	0	52	· · · ·		10.00
11.00	01100 CAFETERIA	2,213	0		0 0	23,209	
13.00	01300 NURSING ADMINISTRATION	252	0		0 0	1,105	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	1,766	0		0 0	0	14.00
15.00	01500 PHARMACY	994	0	88	31 0	1,105	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	8,406	0		0 0	0	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	9,958	1,900	1,33	10,952	4,973	30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	7,913	0	2,21	.4 0	2,210	50.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	6,412	0	40	07 0	4,973	54.00
60.00	06000 LABORATORY	2,675	0	9	0 0	553	60.00
65.00	06500 RESPIRATORY THERAPY	0	0		0 0	0	65.00
66.00	06600 PHYSICAL THERAPY	3,767	0	1,35	5 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 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
76.00	03950 ADULT MENTAL HEALTH	0	0		0 0	0	76.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0		0 0	0	88.00
91.00	09100 EMERGENCY	6,405	0	19,56	62 0	8,290	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS	1					
118.00		54,128	1,900	26,36	52 10,952	23,209	118.00
	NONREIMBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	549	0		0 0		190.00
	19100 RESEARCH	0	0		0 0		191.00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0		0 0		192.00
	07950 OTHER NRCC	0	0	2,41	.7 0		194.00
	07951 SPN	21,109	0		0 0		194.01
	07952 OUTPATIENT CLINICS	11,287	0		0 0	0	194.02
194.03	07953 MARKETING	0	0		0 0	0	194.03
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0		0 0		201.00
202.00	TOTAL (sum lines 118 through 201)	87,073	1,900	28,77	10,952		202.00

	Financial Systems A ATION OF CAPITAL RELATED COSTS	SCENSION ST. VI	Provider CO	N • 15-1303	Period:	u of Form CMS- Worksheet B	
ALLOCA	ATON OF CAPITAL RELATED COSTS		FIOVIDEI CC	. IJ-1305	From 07/01/2022	Part II	
					то 06/30/2023	Date/Time Pre 11/22/2023 2:	
	Cost Center Description	NURSING	CENTRAL	PHARMACY	MEDICAL	Subtotal	
		ADMINISTRATION	SERVICES &		RECORDS &		
		12.00	SUPPLY	45.00	LIBRARY	24.00	
		13.00	14.00	15.00	16.00	24.00	
1.00	GENERAL SERVICE COST CENTERS						1.0
4.00	00100 CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT						4.0
5.00	00500 ADMINISTRATIVE & GENERAL						5.0
7.00	00700 OPERATION OF PLANT						7.0
8.00	00800 LAUNDRY & LINEN SERVICE						8.0
9.00	00900 HOUSEKEEPING						9.0
10.00	01000 DIETARY						10.0
11.00	01100 CAFETERIA						11.0
13.00	01300 NURSING ADMINISTRATION	12 250					13.0
14.00	01400 CENTRAL SERVICES & SUPPLY	12,350	13,991				14.0
15.00	01500 PHARMACY	0	15,991	55,05			15.0
16.00		0	4	55,03	0 65,928		16.0
10.00	01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	0	0		0 03,920		10.0
30.00	03000 ADULTS & PEDIATRICS	4,692	1,166		0 1,756	143,705	30.0
50.00	ANCILLARY SERVICE COST CENTERS	4,052	1,100		1,750	145,705	50.0
50.00	05000 OPERATING ROOM	1,172	2,343		0 3,339	134,136	50.0
54.00	05400 RADIOLOGY - DIAGNOSTIC	0	1,363		0 17,068	542,114	
60.00	06000 LABORATORY	0	2,000		0 20,384	87,564	
65.00	06500 RESPIRATORY THERAPY	0	0		0 119	119	
66.00	06600 PHYSICAL THERAPY	0	107		0 1,275	44,357	
67.00	06700 OCCUPATIONAL THERAPY	0	0		0 71	549	
68.00	06800 SPEECH PATHOLOGY	0	0		0 0	0	68.0
69.00	06900 ELECTROCARDIOLOGY	0	0		0 0	0	69.0
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,498		0 0	6,669	71.0
72.00	07200 IMPLANTABLE DEVICES CHARGED TO	0	529		0 0	772	
	PATIENTS						
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	55,05	59 0	55,059	73.0
76.00	03950 ADULT MENTAL HEALTH	0	5	-	0 787	9,981	76.0
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0		0 0	0	88.0
91.00	09100 EMERGENCY	6,486	5,973		0 21,129	191,464	91.0
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.0
	SPECIAL PURPOSE COST CENTERS						
118.00		12,350	13,991	55,05	59 65,928	1,216,489	118.0
400.00	NONREIMBURSABLE COST CENTERS					4 207	1100 0
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		0 0		190.0
	19100 RESEARCH	0	0		0 0		191.0
	19200 PHYSICIANS' PRIVATE OFFICES	0	0		0 0		192.0
	07950 OTHER NRCC	0	0		0 0	,	194.0
		0	0		0 0	165,562	
	207952 OUTPATIENT CLINICS	0	0		0 0	88,523	
	07953 MARKETING	0	0		0 0		194.0
200.00	5		_			-	200.0
201.00		12,250	12 001			0	
202.00) TOTAL (sum lines 118 through 201)	12,350	13,991	55,05	59 65,928	1,477,681	.1202.0

ALLOCA	ATION OF CAPITAL RELATED COSTS		Provider CCN: 15-1303		
				From 07/01/2022 Part II To 06/30/2023 Date/Time Pr	ionarod.
				To 06/30/2023 Date/Time Pr 11/22/2023 2	2:07 pm
	Cost Center Description	Intern &	Total		
		Residents Cost			
		& Post			
		Stepdown			
		Adjustments			
		25.00	26.00		_
1 00	GENERAL SERVICE COST CENTERS	1	1		1 00
1.00	00100 CAP REL COSTS-BLDG & FIXT				1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500 ADMINISTRATIVE & GENERAL				5.00
7.00	00700 OPERATION OF PLANT				7.00
8.00	00800 LAUNDRY & LINEN SERVICE				8.00
9.00	00900 HOUSEKEEPING				9.00
10.00	01000 DIETARY				10.00
11.00	01100 CAFETERIA				11.00
	01300 NURSING ADMINISTRATION				13.00
	01400 CENTRAL SERVICES & SUPPLY				14.00
15.00	01500 PHARMACY				15.00
16.00					16.00
	INPATIENT ROUTINE SERVICE COST CENTERS	1			_
30.00	03000 ADULTS & PEDIATRICS	0	143,705		30.00
	ANCILLARY SERVICE COST CENTERS		101.100		
	05000 OPERATING ROOM	0	134,136		50.00
	05400 RADIOLOGY - DIAGNOSTIC	0	542,114		54.00
	06000 LABORATORY	0	87,564		60.00
	06500 RESPIRATORY THERAPY	0	119		65.00
	06600 PHYSICAL THERAPY	0	44,357		66.00
		0	549		67.00
	06800 SPEECH PATHOLOGY	0	0		68.00
	06900 ELECTROCARDIOLOGY	0	0		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	6,669		71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO	0	772		72.00
	PATIENTS				
	07300 DRUGS CHARGED TO PATIENTS	0	55,059		73.00
76.00	03950 ADULT MENTAL HEALTH	0	9,981		76.00
	OUTPATIENT SERVICE COST CENTERS				
	08800 RURAL HEALTH CLINIC	0	0		88.00
91.00		0	191,464		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
	SPECIAL PURPOSE COST CENTERS		1 216 420		
118.00		0	1,216,489		118.00
100.00	NONREIMBURSABLE COST CENTERS		4 307		100.00
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	4,307		190.00
	19100 RESEARCH	0	0		191.00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0		192.00
	07950 OTHER NRCC	0	2,800		194.00
	L 07951 SPN	0	165,562		194.01
	207952 OUTPATIENT CLINICS	0	88,523		194.02
	3 07953 MARKETING	0	0		194.03
200.00	5	0	0		200.00
201.00	5	0	0		201.00
202.00) TOTAL (sum lines 118 through 201)	0	1,477,681		202.00

GEN 1.00 001 4.00 004 5.00 005 7.00 007 8.00 008 9.00 010 11.00 011 13.00 013 14.00 014 15.00 015 16.00 016 50.00 030 50.00 050 54.00 054 66.00 066 67.00 067 68.00 068	CATION - STATISTICAL BASIS Cost Center Description EERAL SERVICE COST CENTERS LOO CAP REL COSTS-BLDG & FIXT HOU EMPLOYEE BENEFITS DEPARTMENT SOO ADMINISTRATIVE & GENERAL O OPERATION OF PLANT SOO OPERATION OF PLANT SOO HOUSEKEEPING OO DIETARY LOO CAFETERIA SOO NURSING ADMINISTRATION HOU CENTRAL SERVICES & SUPPLY SOO MEDICAL RECORDS & LIBRARY MATIENT ROUTINE SERVICE COST CENTERS SOO OPERATING ROOM HOU RADIOLOGY - DIAGNOSTIC SOO ADULTS & PEDIATRICS CONTENT ADURATION SOO SADIOLOGY - DIAGNOSTIC	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET) 1.00 69,965 0 6,181 6,387 76 1,436 708 1,459 1,459 1,456 1,164 655 5,541 6,564	Provider Co EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES) 4.00 4,018,620 246,989 0 0 0 0 0 246,989 0 0 0 0 284,260 0 233,029 0 861,639	Reconciliation	881,620 43,220 507,819 68,595 264,083 396,673 17,797 815,018	11/22/2023 2:	1.00 4.00 5.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00
1.00 001 4.00 004 5.00 005 7.00 007 8.00 008 9.00 009 10.00 010 11.00 011 13.00 013 14.00 014 15.00 016 INP 30.00 030 50.00 050 54.00 054 66.00 066 67.00 067 68.00 068	IERAL SERVICE COST CENTERS 100 CAP REL COSTS-BLDG & FIXT 100 EMPLOYEE BENEFITS DEPARTMENT 100 ADMINISTRATIVE & GENERAL 100 OPERATION OF PLANT 100 CAPETERIA 100 DIETARY 100 CAFETERIA 100 OURSING ADMINISTRATION 100 CENTRAL SERVICES & SUPPLY 100 MEDICAL RECORDS & LIBRARY 100 MEDICAL RECORDS & LIBRARY 100 OPERATINE SERVICE COST CENTERS 100 ADULTS & PEDIATRICS 11LARY SERVICE COST CENTERS 100 OPERATING ROOM 100 RADIOLOGY - DIAGNOSTIC	RELATED COSTS BLDG & FIXT (SQUARE FEET) 1.00 69,965 0 6,181 6,387 76 1,436 708 1,459 1,459 1,459 1,459 1,164 6,554 5,541 6,564	BENEFITS DEPARTMENT (GROSS SALARIES) 4.00 4,018,620 246,989 0 0 0 0 0 246,989 0 0 0 0 246,989 0 0 0 246,989 0 0 0 246,989 0 0 233,029 0 861,639	Reconciliation 5A -4,121,815 () () () () () () () () () () () () ()	ADMINISTRATIVE & GENERAL (ACCUM. COST) 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.0	11/22/2023 2: OPERATION OF PLANT (SQUARE FEET) 7.00 57,397 76 1,436 708 1,459 166 1,164 655	07 pm 1.00 4.00 5.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00
1.00 001 4.00 004 5.00 005 7.00 007 8.00 008 9.00 009 10.00 010 11.00 011 13.00 013 14.00 014 15.00 016 INP 30.00 030 50.00 050 54.00 054 66.00 066 67.00 067 68.00 068	IERAL SERVICE COST CENTERS 100 CAP REL COSTS-BLDG & FIXT 100 EMPLOYEE BENEFITS DEPARTMENT 100 ADMINISTRATIVE & GENERAL 100 OPERATION OF PLANT 100 CAPETERIA 100 DIETARY 100 CAFETERIA 100 OURSING ADMINISTRATION 100 CENTRAL SERVICES & SUPPLY 100 MEDICAL RECORDS & LIBRARY 100 MEDICAL RECORDS & LIBRARY 100 OPERATINE SERVICE COST CENTERS 100 ADULTS & PEDIATRICS 11LARY SERVICE COST CENTERS 100 OPERATING ROOM 100 RADIOLOGY - DIAGNOSTIC	RELATED COSTS BLDG & FIXT (SQUARE FEET) 1.00 69,965 0 6,181 6,387 76 1,436 708 1,459 1,459 1,459 1,459 1,164 6,554 5,541 6,564	BENEFITS DEPARTMENT (GROSS SALARIES) 4.00 4,018,620 246,989 0 0 0 0 0 246,989 0 0 0 0 246,989 0 0 0 246,989 0 0 0 246,989 0 0 233,029 0 861,639	-4,121,815 () () () () () () () () () () () () ()	& GENERAL (ACCUM. COST) 5.00 12,222,351 881,620 43,220 507,819 68,595 264,083 396,673 17,797 815,018	OPERATION OF PLANT (SQUARE FEET) 7.00 57,397 76 1,436 708 1,459 166 1,164 655	1.0 4.0 5.0 7.0 8.0 9.0 10.0 11.0 13.0 14.0
1.00 001 4.00 004 5.00 005 7.00 007 8.00 008 9.00 009 10.00 010 11.00 011 13.00 013 14.00 014 15.00 016 INP 30.00 030 50.00 050 54.00 054 66.00 066 67.00 067 68.00 068	IERAL SERVICE COST CENTERS 100 CAP REL COSTS-BLDG & FIXT 100 EMPLOYEE BENEFITS DEPARTMENT 100 ADMINISTRATIVE & GENERAL 100 OPERATION OF PLANT 100 CAPETERIA 100 DIETARY 100 CAFETERIA 100 OURSING ADMINISTRATION 100 CENTRAL SERVICES & SUPPLY 100 MEDICAL RECORDS & LIBRARY 100 MEDICAL RECORDS & LIBRARY 100 OPERATINE SERVICE COST CENTERS 100 ADULTS & PEDIATRICS 11LARY SERVICE COST CENTERS 100 OPERATING ROOM 100 RADIOLOGY - DIAGNOSTIC	RELATED COSTS BLDG & FIXT (SQUARE FEET) 1.00 69,965 0 6,181 6,387 76 1,436 708 1,459 1,459 1,459 1,459 1,164 6,554 5,541 6,564	BENEFITS DEPARTMENT (GROSS SALARIES) 4.00 4,018,620 246,989 0 0 0 0 0 246,989 0 0 0 0 246,989 0 0 0 246,989 0 0 0 246,989 0 0 233,029 0 861,639	-4,121,815 () () () () () () () () () () () () ()	& GENERAL (ACCUM. COST) 5.00 12,222,351 881,620 43,220 507,819 68,595 264,083 396,673 17,797 815,018	PLANT (SQUARE FEET) 7.00 57,397 76 1,436 708 1,459 166 1,164 655	4.0 5.0 7.0 8.0 9.0 10.0 11.0 13.0 14.0
1.00 001 4.00 004 5.00 005 7.00 007 8.00 008 9.00 009 10.00 010 11.00 011 13.00 013 14.00 014 15.00 016 INP 30.00 030 50.00 050 54.00 054 66.00 066 67.00 067 68.00 068	IERAL SERVICE COST CENTERS 100 CAP REL COSTS-BLDG & FIXT 100 EMPLOYEE BENEFITS DEPARTMENT 100 ADMINISTRATIVE & GENERAL 100 OPERATION OF PLANT 100 CAPETERIA 100 DIETARY 100 CAFETERIA 100 OURSING ADMINISTRATION 100 CENTRAL SERVICES & SUPPLY 100 MEDICAL RECORDS & LIBRARY 100 MEDICAL RECORDS & LIBRARY 100 OPERATINE SERVICE COST CENTERS 100 ADULTS & PEDIATRICS 11LARY SERVICE COST CENTERS 100 OPERATING ROOM 100 RADIOLOGY - DIAGNOSTIC	BLDG & FIXT (SQUARE FEET) 1.00 69,965 0 6,181 6,387 76 1,436 708 1,459 166 1,164 655 5,541 6,564 5,216	BENEFITS DEPARTMENT (GROSS SALARIES) 4.00 4,018,620 246,989 0 0 0 0 0 246,989 0 0 0 0 246,989 0 0 0 246,989 0 0 0 246,989 0 0 233,029 0 861,639	-4,121,815 () () () () () () () () () () () () ()	& GENERAL (ACCUM. COST) 5.00 12,222,351 881,620 43,220 507,819 68,595 264,083 396,673 17,797 815,018	PLANT (SQUARE FEET) 7.00 57,397 76 1,436 708 1,459 166 1,164 655	4.0 5.0 7.0 8.0 9.0 10.0 11.0 13.0 14.0
1.00 001 4.00 004 5.00 005 7.00 007 8.00 008 9.00 009 10.00 010 11.00 011 13.00 013 14.00 014 15.00 016 INP 30.00 030 50.00 050 54.00 054 66.00 066 67.00 067 68.00 068	IERAL SERVICE COST CENTERS 100 CAP REL COSTS-BLDG & FIXT 100 EMPLOYEE BENEFITS DEPARTMENT 100 ADMINISTRATIVE & GENERAL 100 OPERATION OF PLANT 100 CAPETERIA 100 DIETARY 100 CAFETERIA 100 OURSING ADMINISTRATION 100 CENTRAL SERVICES & SUPPLY 100 MEDICAL RECORDS & LIBRARY 100 MEDICAL RECORDS & LIBRARY 100 OPERATINE SERVICE COST CENTERS 100 ADULTS & PEDIATRICS 11LARY SERVICE COST CENTERS 100 OPERATING ROOM 100 RADIOLOGY - DIAGNOSTIC	(SQUARE FEET) 1.00 69,965 0 6,181 6,387 76 1,436 708 1,459 166 1,164 655 5,541 6,564 5,216	BENEFITS DEPARTMENT (GROSS SALARIES) 4.00 4,018,620 246,989 0 0 0 0 0 246,989 0 0 0 0 246,989 0 0 0 246,989 0 0 0 246,989 0 0 233,029 0 861,639	-4,121,815 () () () () () () () () () () () () ()	& GENERAL (ACCUM. COST) 5.00 12,222,351 881,620 43,220 507,819 68,595 264,083 396,673 17,797 815,018	PLANT (SQUARE FEET) 7.00 57,397 76 1,436 708 1,459 166 1,164 655	4.0 5.0 7.0 8.0 9.0 10.0 11.0 13.0 14.0
1.00 001 4.00 004 5.00 005 7.00 007 8.00 008 9.00 009 10.00 010 11.00 011 13.00 013 14.00 014 15.00 016 INP 30.00 030 50.00 050 54.00 054 66.00 066 67.00 067 68.00 068	L00 CAP REL COSTS-BLDG & FIXT 100 EMPLOYEE BENEFITS DEPARTMENT 100 ADMINISTRATIVE & GENERAL 100 ADMINISTRATIVE & GENERAL 100 OPERATION OF PLANT 100 DEVATION OF PLANT 100 DETARY 100 DETARY 100 CAFETERIA 100 CENTRAL SERVICES & SUPPLY 100 PHARMACY 100 PHARMACY 100 PHARMACY 100 ADULTS & PEDIATRICS 11 ADULTS & PEDIATRICS 11 ADULTS & PEDIATRICS 11 ADULTS ROOM 100 RADIOLOGY - DIAGNOSTIC	1.00 69,965 0 6,181 6,387 76 1,436 708 1,459 166 1,164 655 5,541 6,564 5,216	DEPARTMENT (GROSS SALARIES) 4.00 4,018,620 246,989 0 0 0 0 0 284,260 0 233,029 0 861,639	-4,121,815 () () () () () () () () () () () () ()	(ACCUM. COST) 5.00 12,222,351 881,620 43,220 507,819 68,595 264,083 396,673 17,797 815,018	(SQUARE FEET) 7.00 57,397 76 1,436 708 1,459 166 1,164 655	4.0 5.0 7.0 8.0 9.0 10.0 11.0 13.0 14.0
1.00 001 4.00 004 5.00 005 7.00 007 8.00 008 9.00 009 10.00 010 11.00 011 13.00 013 14.00 014 15.00 016 INP 30.00 030 50.00 050 54.00 054 66.00 066 67.00 067 68.00 068	L00 CAP REL COSTS-BLDG & FIXT 100 EMPLOYEE BENEFITS DEPARTMENT 100 ADMINISTRATIVE & GENERAL 100 ADMINISTRATIVE & GENERAL 100 OPERATION OF PLANT 100 DEVATION OF PLANT 100 DETARY 100 DETARY 100 CAFETERIA 100 CENTRAL SERVICES & SUPPLY 100 PHARMACY 100 PHARMACY 100 PHARMACY 100 ADULTS & PEDIATRICS 11 ADULTS & PEDIATRICS 11 ADULTS & PEDIATRICS 11 ADULTS ROOM 100 RADIOLOGY - DIAGNOSTIC	69,965 0 6,181 6,387 766 1,436 708 1,459 166 1,164 655 5,541 6,564 5,216	(GROSS SALARIES) 4.00 4,018,620 246,989 0 0 0 0 0 284,260 0 233,029 0 861,639	-4,121,815 () () () () () () () () () () () () ()	5.00 5.00 5.00 5.00 5.00 43,220 507,819 68,595 264,083 396,673 17,797 815,018	7.00 57,397 76 1,436 708 1,459 166 1,164 655	4.0 5.0 7.0 8.0 9.0 10.0 11.0 13.0 14.0
1.00 001 4.00 004 5.00 005 7.00 007 8.00 008 9.00 009 10.00 010 11.00 011 13.00 013 14.00 014 15.00 016 INP 30.00 030 50.00 050 54.00 054 66.00 066 67.00 067 68.00 068	L00 CAP REL COSTS-BLDG & FIXT 100 EMPLOYEE BENEFITS DEPARTMENT 100 ADMINISTRATIVE & GENERAL 100 ADMINISTRATIVE & GENERAL 100 OPERATION OF PLANT 100 DEVATION OF PLANT 100 DETARY 100 DETARY 100 CAFETERIA 100 CENTRAL SERVICES & SUPPLY 100 PHARMACY 100 PHARMACY 100 PHARMACY 100 ADULTS & PEDIATRICS 11 ADULTS & PEDIATRICS 11 ADULTS & PEDIATRICS 11 ADULTS ROOM 100 RADIOLOGY - DIAGNOSTIC	69,965 0 6,181 6,387 766 1,436 708 1,459 166 1,164 655 5,541 6,564 5,216	4.00 4,018,620 246,989 0 0 0 0 284,260 0 233,029 0 861,639	-4,121,815 () () () () () () () () () () () () ()	<pre>12,222,351 881,620 43,220 507,819 68,595 264,083 396,673 17,797 815,018</pre>	57,397 76 1,436 708 1,459 166 1,164 655	4.0 5.0 7.0 8.0 9.0 10.0 11.0 13.0 14.0
1.00 001 4.00 004 5.00 005 7.00 007 8.00 008 9.00 009 10.00 010 11.00 011 13.00 013 14.00 014 15.00 016 INP 30.00 030 50.00 050 54.00 054 66.00 066 67.00 067 68.00 068	L00 CAP REL COSTS-BLDG & FIXT 100 EMPLOYEE BENEFITS DEPARTMENT 100 ADMINISTRATIVE & GENERAL 100 ADMINISTRATIVE & GENERAL 100 OPERATION OF PLANT 100 DEVATION OF PLANT 100 DETARY 100 DETARY 100 CAFETERIA 100 CENTRAL SERVICES & SUPPLY 100 PHARMACY 100 PHARMACY 100 PHARMACY 100 ADULTS & PEDIATRICS 11 ADULTS & PEDIATRICS 11 ADULTS & PEDIATRICS 11 ADULTS ROOM 100 RADIOLOGY - DIAGNOSTIC	69,965 0 6,181 6,387 766 1,436 708 1,459 166 1,164 655 5,541 6,564 5,216	4,018,620 246,989 0 0 0 0 284,260 0 233,029 0 861,639	-4,121,815 () () () () () () () () () () () () ()	<pre>12,222,351 881,620 43,220 507,819 68,595 264,083 396,673 17,797 815,018</pre>	57,397 76 1,436 708 1,459 166 1,164 655	4.00 5.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00
1.00 001 4.00 004 5.00 005 7.00 007 8.00 008 9.00 009 10.00 010 11.00 011 13.00 013 14.00 014 15.00 016 INP 30.00 030 50.00 050 54.00 054 66.00 066 67.00 067 68.00 068	L00 CAP REL COSTS-BLDG & FIXT 100 EMPLOYEE BENEFITS DEPARTMENT 100 ADMINISTRATIVE & GENERAL 100 ADMINISTRATIVE & GENERAL 100 OPERATION OF PLANT 100 DEVATION OF PLANT 100 DETARY 100 DETARY 100 CAFETERIA 100 CENTRAL SERVICES & SUPPLY 100 PHARMACY 100 PHARMACY 100 PHARMACY 100 ADULTS & PEDIATRICS 11 ADULTS & PEDIATRICS 11 ADULTS & PEDIATRICS 11 ADULTS ROOM 100 RADIOLOGY - DIAGNOSTIC	0 6,181 6,387 76 1,436 708 1,459 166 1,164 655 5,541 6,564 5,216	246,989 0 0 0 0 284,260 0 233,029 0 861,639	-4,121,815	881,620 43,220 507,819 68,595 264,083 396,673 17,797 815,018	76 1,436 708 1,459 166 1,164 655	4.0 5.0 7.0 8.0 9.0 10.0 11.0 13.0 14.0
4.00 004 5.00 005 7.00 007 8.00 008 9.00 009 10.00 010 11.00 011 13.00 013 14.00 014 15.00 015 16.00 016 INP 30.00 50.00 050 54.00 054 66.00 066 67.00 067 68.00 068	400 EMPLOYEE BENEFITS DEPARTMENT 500 ADMINISTRATIVE & GENERAL 700 OPERATION OF PLANT 800 LAUNDRY & LINEN SERVICE 900 HOUSEKEEPING 900 DIETARY 900 CAFETERIA 900 NURSING ADMINISTRATION 900 CENTRAL SERVICES & SUPPLY 900 PHARMACY 900 MEDICAL RECORDS & LIBRARY 901 ADULTS & PEDIATRICS 902 SERVICE COST CENTERS 900 OPERATING ROOM 900 RADIOLOGY - DIAGNOSTIC	0 6,181 6,387 76 1,436 708 1,459 166 1,164 655 5,541 6,564 5,216	246,989 0 0 0 0 284,260 0 233,029 0 861,639	-4,121,815	881,620 43,220 507,819 68,595 264,083 396,673 17,797 815,018	76 1,436 708 1,459 166 1,164 655	4.0 5.0 7.0 8.0 9.0 10.0 11.0 13.0 14.0
5.00 005/7.00 7.00 007/8.00 8.00 008/9.00 9.00 010/9 10.00 010/0 11.00 011/0 13.00 013/1 14.00 014/1 15.00 015/1 16.00 016/0 50.00 030/0 50.00 050/0 54.00 054/0 66.00 066/0 66.00 066/0 67.00 067/0 68.00 068/8	000 ADMINISTRATIVE & GENERAL 000 OPERATION OF PLANT 000 LAUNDRY & LINEN SERVICE 000 HOUSEKEEPING 000 DIETARY 000 CAFETERIA 000 NURSING ADMINISTRATION 000 CENTRAL SERVICES & SUPPLY 000 PHARMACY 000 MEDICAL RECORDS & LIBRARY ATTENT ROUTINE SERVICE COST CENTERS 000 ADULTS & PEDIATRICS 11LLARY SERVICE COST CENTERS 000 RADIOLOGY - DIAGNOSTIC	6,181 6,387 76 1,436 708 1,459 166 1,164 655 5,541 6,564 5,216	246,989 0 0 0 0 284,260 0 233,029 0 861,639	-4,121,815	881,620 43,220 507,819 68,595 264,083 396,673 17,797 815,018	76 1,436 708 1,459 166 1,164 655	5.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00
$\begin{array}{cccc} 7.00 & 0.07 \\ 8.00 & 0.08 \\ 9.00 & 0.09 \\ 10.00 & 010 \\ 11.00 & 011 \\ 13.00 & 013 \\ 14.00 & 014 \\ 15.00 & 015 \\ 16.00 & 016 \\ 100 \\ 100 \\ 50.00 & 030 \\ 50.00 & 050 \\ 54.00 & 054 \\ 60.00 & 066 \\ 67.00 & 067 \\ 68.00 & 068 \\ \end{array}$	700 OPERATION OF PLANT 800 LAUNDRY & LINEN SERVICE 900 HOUSEKEEPING 900 DIETARY 900 CAFETERIA 900 NURSING ADMINISTRATION 900 CENTRAL SERVICES & SUPPLY 900 MEDICAL RECORDS & LIBRARY 900 MEDICAL RECORDS & LIBRARY 900 ADULTS & PEDIATRICS 11LARY SERVICE COST CENTERS 900 OPERATING ROOM 900 RADIOLOGY - DIAGNOSTIC	6,387 76 1,436 708 1,459 166 1,164 655 5,541 6,564 5,216	0 0 0 284,260 0 233,029 0 861,639		881,620 43,220 507,819 68,595 264,083 396,673 17,797 815,018	76 1,436 708 1,459 166 1,164 655	7.00 8.00 9.00 10.00 11.00 13.00 14.00
$\begin{array}{cccc} 8.00 & 008 \\ 9.00 & 009 \\ 10.00 & 010 \\ 11.00 & 011 \\ 13.00 & 013 \\ 14.00 & 014 \\ 15.00 & 015 \\ 16.00 & 016 \\ \hline \textbf{INP} \\ 30.00 & 030 \\ 50.00 & 050 \\ 54.00 & 054 \\ 60.00 & 066 \\ 65.00 & 066 \\ 67.00 & 067 \\ 68.00 & 068 \\ \end{array}$	3000 LAUNDRY & LINEN SERVICE 3000 HOUSEKEEPING 3000 DIETARY 1000 CAFETERIA 3000 NURSING ADMINISTRATION 3000 CENTRAL SERVICES & SUPPLY 3000 PHARMACY 3000 MEDICAL RECORDS & LIBRARY 3001 ADULTS & PEDIATRICS 3000 OPERATING ROOM 4000 RADIOLOGY - DIAGNOSTIC	76 1,436 708 1,459 166 1,164 655 5,541 6,564	0 233,029 0 861,639	(43,220 507,819 68,595 264,083 396,673 17,797 815,018	76 1,436 708 1,459 166 1,164 655	8.00 9.00 10.00 11.00 13.00 14.00
9.00 009 10.00 010 11.00 011 13.00 013 14.00 014 15.00 015 16.00 016 10.00 016 30.00 030 ANC: 50.00 50.00 050 54.00 054 66.00 066 67.00 067 68.00 068	000 HOUSEKEEPING 000 DIETARY 000 CAFETERIA 000 NURSING ADMINISTRATION 000 CENTRAL SERVICES & SUPPLY 000 PHARMACY 000 MEDICAL RECORDS & LIBRARY 000 ADULTS & PEDIATRICS ILLARY SERVICE COST CENTERS 000 OPERATING ROOM 000 RADIOLOGY - DIAGNOSTIC	1,436 708 1,459 166 1,164 655 5,541 6,564 5,216	0 233,029 0 861,639	(507,819 68,595 264,083 396,673 17,797 815,018	1,436 708 1,459 166 1,164 655	9.00 10.00 11.00 13.00 14.00
10.00 010 11.00 011 13.00 013 14.00 014 15.00 016 10.00 016 10.00 016 10.00 030 30.00 030 50.00 050 54.00 054 66.00 066 67.00 067 68.00 068	000 DIETARY L00 CAFETERIA 300 NURSING ADMINISTRATION 100 CENTRAL SERVICES & SUPPLY 100 PHARMACY 100 MEDICAL RECORDS & LIBRARY 100 ADULTS & PEDIATRICS 11LARY SERVICE COST CENTERS 100 OPERATING ROOM 100 RADIOLOGY - DIAGNOSTIC	708 1,459 166 1,164 655 5,541 6,564 5,216	0 233,029 0 861,639	(68,595 264,083 396,673 17,797 815,018	708 1,459 166 1,164 655	10.00 11.00 13.00 14.00
11.00 011 13.00 013 14.00 014 15.00 015 16.00 016 INP 30.00 30.00 030 ANC 50.00 50.00 050 54.00 054 60.00 066 66.00 066 67.00 067 68.00 068	LOO CAFETERIA 300 NURSING ADMINISTRATION 400 CENTRAL SERVICES & SUPPLY 500 PHARMACY 500 MEDICAL RECORDS & LIBRARY 500 ADULTS & PEDIATRICS 511LARY SERVICE COST CENTERS 500 OPERATING ROOM 400 RADIOLOGY - DIAGNOSTIC	1,459 166 1,164 655 5,541 6,564 5,216	0 233,029 0 861,639	(264,083 396,673 17,797 815,018	1,459 166 1,164 655	11.0 13.0 14.0
13.00 013 14.00 014 15.00 015 16.00 016 INP 30.00 30.00 030 50.00 050 54.00 054 60.00 060 66.00 066 67.00 067 68.00 068	000 NURSING ADMINISTRATION 100 CENTRAL SERVICES & SUPPLY 100 PHARMACY 100 MEDICAL RECORDS & LIBRARY 100 ADULTS & PEDIATRICS 100 ADULTS & PEDIATRICS 100 OPERATING ROOM 100 RADIOLOGY - DIAGNOSTIC	166 1,164 655 5,541 6,564 5,216	0 233,029 0 861,639	(396,673 17,797 815,018	166 1,164 655	13.0 14.0
14.00 014 15.00 015 16.00 016 INP 30.00 30.00 030 50.00 050 54.00 054 60.00 060 66.00 066 67.00 067 68.00 068	100 CENTRAL SERVICES & SUPPLY 100 PHARMACY 100 MEDICAL RECORDS & LIBRARY 100 ADULTS & PEDIATRICS 100 ADULTS & PEDIATRICS 11LARY SERVICE COST CENTERS 100 OPERATING ROOM 100 RADIOLOGY - DIAGNOSTIC	655 5,541 6,564 5,216	0 233,029 0 861,639	(17,797 815,018	655	
15.00 015 16.00 016 INP 30.00 030 ANC 50.00 050 54.00 054 60.00 065 66.00 066 67.00 067 68.00 068	500 PHARMACY 500 MEDICAL RECORDS & LIBRARY ATIENT ROUTINE SERVICE COST CENTERS 500 ADULTS & PEDIATRICS CILLARY SERVICE COST CENTERS 500 OPERATING ROOM 500 RADIOLOGY - DIAGNOSTIC	5,541 6,564 5,216	0 861,639	(815,018	655	
INP/ 30.00 030 ANC: 050 50.00 050 54.00 060 65.00 065 66.00 066 67.00 067 68.00 068	ATIENT ROUTINE SERVICE COST CENTERS 000 ADULTS & PEDIATRICS CILLARY SERVICE COST CENTERS 000 OPERATING ROOM 100 RADIOLOGY - DIAGNOSTIC	6,564			56,203	5,541	
30.00 030 ANC: 50.00 50.00 050 54.00 054 60.00 060 65.00 065 66.00 066 67.00 067 68.00 068	000 ADULTS & PEDIATRICS CILLARY SERVICE COST CENTERS 000 OPERATING ROOM 100 RADIOLOGY - DIAGNOSTIC	5,216					16.0
ANC: 50.00 050 54.00 054 60.00 060 65.00 065 66.00 066 67.00 067 68.00 068	CILLARY SERVICE COST CENTERS 000 OPERATING ROOM 100 RADIOLOGY - DIAGNOSTIC	5,216					
50.00 050 54.00 054 60.00 060 65.00 065 66.00 066 67.00 067 68.00 068	000 OPERATING ROOM 100 RADIOLOGY - DIAGNOSTIC				1,461,208	6,564	30.0
54.00 054 60.00 060 65.00 065 66.00 066 67.00 067 68.00 068	100 RADIOLOGY - DIAGNOSTIC						
60.00 060 65.00 065 66.00 066 67.00 067 68.00 068			247,213	(,	5,216	
65.00 065 66.00 066 67.00 067 68.00 068		4,227	847,133	(,,	4,227	
66.00 066 67.00 067 68.00 068	000 LABORATORY	1,763	85,050	(1,913,633	1,763	
67.00 067 68.00 068	00 RESPIRATORY THERAPY	0 2 402	0		280 510	0	
68.00 068	000 PHYSICAL THERAPY 700 OCCUPATIONAL THERAPY	2,483	8,933 500		389,519 20,366	2,483	1
	300 SPEECH PATHOLOGY	0	000		20,300	0	
	000 ELECTROCARDIOLOGY	0	0			0	
	LOO MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(18,115	0	71.00
	200 IMPLANTABLE DEVICES CHARGED TO	0	0		10,365	0	
	PATIENTS				.,		
73.00 073	300 DRUGS CHARGED TO PATIENTS	0	0	(0	73.00
76.00 039	950 ADULT MENTAL HEALTH	0	0	(361,693	0	76.00
	PATIENT SERVICE COST CENTERS						4
	300 RURAL HEALTH CLINIC	0	0	0		0	
	LOO EMERGENCY	4,222	1,203,874	0	2,651,744	4,222	
	200 OBSERVATION BEDS (NON-DISTINCT PART)						92.0
	CIAL PURPOSE COST CENTERS	40.240	4 010 620	4 121 017	11 005 703	25 600	1110 0
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	48,248	4,018,620	-4,121,815	11,985,703	35,680	1118.00
	IREIMBURSABLE COST CENTERS	362	0		3,672	363	190.00
	LOO RESEARCH	562	0				190.00
	200 PHYSICIANS' PRIVATE OFFICES	0	0				192.00
	050 OTHER NRCC	0	0		16,333		194.0
194.01 079		13,915	0		141,141	13,915	
	052 OUTPATIENT CLINICS	7,440	0		75,502		194.0
	953 MARKETING	0	0		0		194.0
200.00	Cross Foot Adjustments		· · · ·				200.0
201.00	Negative Cost Centers						201.0
202.00	Cost to be allocated (per Wkst. B, Part I)	709,660	1,298,175		4,121,815	1,178,934	
203.00	Unit cost multiplier (Wkst. B, Part I)	10.143072	0.323040		0.337236		
204.00	Cost to be allocated (per Wkst. B, Part II)		0		286,836	87,073	204.0
205.00	Unit cost multiplier (Wkst. B, Part II)		0.000000		0.023468	1.517031	205.0
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.0
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.0

ST A	LLOCAT	ION - STATISTICAL BASIS		Provider CO	CN: 15-1303	Period: From 07/01/2022	Worksheet B-1	-
						To 06/30/2023	Date/Time Pre 11/22/2023 2:	
		Cost Center Description	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (BED DAYS AVAILABLE)	CAFETERIA (FTES)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
			8.00	9.00	10.00	11.00	13.00	
	GENER/	AL SERVICE COST CENTERS						
00	00100	CAP REL COSTS-BLDG & FIXT						1
00	00400	EMPLOYEE BENEFITS DEPARTMENT						4
00	1	ADMINISTRATIVE & GENERAL						
00		OPERATION OF PLANT						
00		LAUNDRY & LINEN SERVICE	409					8
00		HOUSEKEEPING	0	1,274				9
	1	DIETARY	0	23	9,1			1
	1	CAFETERIA	0	0		0 42		1
		NURSING ADMINISTRATION	0	0		0 2	50,650	
		CENTRAL SERVICES & SUPPLY	0	0		0 0	0	
		PHARMACY	0	39		0 2	0	
.00		MEDICAL RECORDS & LIBRARY	0	0		0 0	0	1
		IENT ROUTINE SERVICE COST CENTERS						4
.00		ADULTS & PEDIATRICS	409	59	9,1	25 9	19,241	. 30
		LARY SERVICE COST CENTERS	-			-		4
		OPERATING ROOM	0	98		0 4	4,805	
		RADIOLOGY - DIAGNOSTIC	0	18		0 9	0	-
		LABORATORY	0	4		0 1	0	-
		RESPIRATORY THERAPY	0	0		0 0	0	-
	1	PHYSICAL THERAPY	0	60		0 0	0	-
		OCCUPATIONAL THERAPY	0	0		0 0	0	
	1	SPEECH PATHOLOGY	0	0		0 0	0	-
		ELECTROCARDIOLOGY	0	0		0 0	0	
		MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	
.00	07200	IMPLANTABLE DEVICES CHARGED TO	0	0		0 0	0	72
~ ~		PATIENTS						
		DRUGS CHARGED TO PATIENTS	0	0		0 0	0	
.00		ADULT MENTAL HEALTH	0	0		0 0	0	0 70
~~		TIENT SERVICE COST CENTERS	-			0	0	
		RURAL HEALTH CLINIC	0	0		0 0	0	-
	1	EMERGENCY	0	866		0 15	26,604	
.00		OBSERVATION BEDS (NON-DISTINCT PART)						9
0 00		AL PURPOSE COST CENTERS	409	1 167	0.1	25 42	E0.6E0	111
8.00		SUBTOTALS (SUM OF LINES 1 through 117) IMBURSABLE COST CENTERS	409	1,167	9,1	25 42	50,650	177.
0 00		GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		0 0	0	19
		RESEARCH	0	0		0 0		19:
		PHYSICIANS' PRIVATE OFFICES	0	0		0 0		192
		OTHER NRCC	0	107		0 0		194
	07951		0	107		0 0		19
		OUTPATIENT CLINICS	0	0		0 0		194
		MARKETING	0	0		0 0		194
4.05		Cross Foot Adjustments	0	0		0	0	20
1.00		Negative Cost Centers						200
2.00		Cost to be allocated (per Wkst. B,	59,356	708,569	119,0	62 383,109	552,098	
		Part I)						
3.00		Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II)	145.124694 1,900				10.900257 12,350	
5.00		Unit cost multiplier (Wkst. B, Part II)	4.645477	22.589482	1.2002	19 552.595238	0.243830	20
6.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						20
7.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						20

OST 4		cial Systems AS TION - STATISTICAL BASIS		NCENT JENNINGS Provider CC	N: 15-1303	In Lieu of Form (Period: Worksheet	
	LUCA					From 07/01/2022 To 06/30/2023 Date/Time 11/22/2023	Prepar
		Cost Center Description	CENTRAL	PHARMACY	MEDICAL		5 2.07
		·	SERVICES &	(COSTED	RECORDS &		
			SUPPLY	REQUIS.)	LIBRARY		
			(COSTED		(GROSS		
			REQUIS.)		CHARGES)		
			14.00	15.00	16.00		
	GENER	AL SERVICE COST CENTERS					
.00		CAP REL COSTS-BLDG & FIXT					1
.00	1	EMPLOYEE BENEFITS DEPARTMENT					2
.00		ADMINISTRATIVE & GENERAL					
.00		OPERATION OF PLANT					
.00		LAUNDRY & LINEN SERVICE					8
.00	1	HOUSEKEEPING					
0.00	1	DIETARY					10
1.00	1	CAFETERIA					11
3.00	4	NURSING ADMINISTRATION					13
4.00			274 084				14
		CENTRAL SERVICES & SUPPLY	274,084	100			
5.00		PHARMACY	87	100	00 202 1	67	15
.6.00		MEDICAL RECORDS & LIBRARY	0	0	80,282,1	67	16
~ ~~		IENT ROUTINE SERVICE COST CENTERS	22.042	0	2 120 0	40	
0.00		ADULTS & PEDIATRICS	22,843	0	2,138,9	40	30
		LARY SERVICE COST CENTERS	45.000		1 0 0 7 1	50	
0.00		OPERATING ROOM	45,896	0	4,067,1		50
4.00		RADIOLOGY - DIAGNOSTIC	26,696	0	20,789,7		54
0.00		LABORATORY	57	0	24,828,1		60
5.00		RESPIRATORY THERAPY	0	0	145,1		65
6.00		PHYSICAL THERAPY	2,091	0	1,553,52	21	66
7.00	06700	OCCUPATIONAL THERAPY	0	0	86,93	12	67
8.00	06800	SPEECH PATHOLOGY	0	0		0	68
9.00	06900	ELECTROCARDIOLOGY	0	0		0	69
1.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	48,946	0		0	71
2.00	07200	IMPLANTABLE DEVICES CHARGED TO	10,365	0		0	72
		PATIENTS	-				
3.00	07300	DRUGS CHARGED TO PATIENTS	0	100		0	73
6.00	03950	ADULT MENTAL HEALTH	106	0	958,52	27	76
	OUTPA	TIENT SERVICE COST CENTERS					
8.00	08800	RURAL HEALTH CLINIC	0	0		0	88
1.00	09100	EMERGENCY	116,997	0	25,714,0	03	91
2.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			, ,		92
		AL PURPOSE COST CENTERS		I			
18.00		SUBTOTALS (SUM OF LINES 1 through 117)	274,084	100	80,282,1	67	118
	NONRE	IMBURSABLE COST CENTERS	,		, -,	-	
.90.00		GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		0	190
		RESEARCH	0	0		0	191
		PHYSICIANS' PRIVATE OFFICES	0	0		0	192
		OTHER NRCC	Ő	Ő		0	194
	07951		0	0		0	194
		OUTPATIENT CLINICS	0	0		0	194
		MARKETING	0	0		0	194
94.03 00.00			0	0			20
	1	Cross Foot Adjustments					20
01.00	1	Negative Cost Centers	47 700	1 142 274	100 0	c 0	
02.00		Cost to be allocated (per Wkst. B, Part I)	47,708		188,9		202
03.00		Unit cost multiplier (Wkst. B, Part I)	0.174063		0.0023	-	20
04.00		Cost to be allocated (per Wkst. B, Part II)	13,991	55,059	65,92		204
05.00		Unit cost multiplier (Wkst. B, Part II)	0.051046	550.590000	0.0008	21	20
06.00	D	NAHE adjustment amount to be allocated (per Wkst. B-2)					20
		NAHE unit cost multiplier (Wkst. D,					20
07.00)						

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CN: 15-1303 Period: From 07/01/2022 To 06/30/2023 Worksheet C Part I, Date/Time Prepared: 1/2/2023 2:07 pm Cost Center Description Total Cost (from WkSt. B, Part I, col). 260 Title XVIII Hospital Cost Impart I, 200 2,600,875 Z,600,875 0	Health Financial Systems A	SCENSION ST. VI	NCENT JENNINGS		In Lie	u of Form CMS-	2552-10
Cost Center Description Total Cost (from Wkst. B, Part I, col. 26) Therapy Limit Adj. Total Costs Total Costs Total Costs 30.00 Adyustrest (from Wkst. B, Part I, col. 26) Therapy Limit Adj. Total Costs Total Costs Total Costs 30.00 Adyustrest (from Wkst. B, Part I, col. 26) Therapy Limit Adj. Total Costs Total Costs Total Costs 30.00 Adyustrest (from Wkst. B, Part I, col. 26) Total Costs Total Costs Total Costs 30.00 Marchine Service Cost Centers 30.00 4.00 5.00 30.00 05000 OPERATING ROOM 894,346 894,346 0 50.00 66.00 06600 Laboratory 2,664,994 0 60.00 65.00 66.00 67.00 60.00 66.00 67.00 66.00 67.00 66.00 67.	COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CO		From 07/01/2022	Part I Date/Time Pre	
Cost Center Description Total Cost (from wkst. B, Part Ir, col. 26) Therapy Limit Adj. Total Costs RCE Disallowance Total Costs 30.00 Adj. Disallowance Disallowance Disallowance Disallowance Disallowance Disallowance Disallowance 30.00 30.00 4.00 5.00 Disallowance Disallowance			Title	XVIII	Hospital	Cost	
Impart I, col. 26) Adj. Disallowance 30.00 03000 ADULTS & PEDIATRICS 2,600,875 2,600,875 0 0 30.00 03000 ADULTS & PEDIATRICS 2,600,875 2,600,875 0 0 0 ANCILLARY SERVICE COST CENTERS 50.00 05400 RADIOLOGY - DIAGNOSTIC 2,425,173 2,423,173 0 0 50.00 60:00 06500 RESPIRATORY THERAPY 2,664,994 2,664,994 0 66.00 65.00 66:00 06500 RESPIRATORY THERAPY 27,439 0 27,439 0 66.00 67:00 06700 OCCUPATIONAL THERAPY 27,439 0 27,439 0 67.00 69:00 06900 ELECTROCARDIOLOGY 0 0 0 0 0 69.00 69:00 07:00 WEDICAL SUPPLIES CHARGED TO PATIENTS 32,744 32,744 0 71.00 72.00 73:00 073:00 FUNATABLE DEVICES CHARGED TO PATIENTS 1,143,274 1,143,274 0 73.00 73.00 73:00 073:00 FUNATABLE DEVICES CHARGED TO P					Costs		
$\begin{tabular}{ c c c c c c c c c c c c c c c c c c c$	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
Z6) Image: Constraint and the service cost centers 1.00 2.00 3.00 4.00 5.00 30.00 JOULTS & PEDIATRICS Z,600,875 Z,600,875 0 0 30.00 ANCILLARY SERVICE COST CENTERS Z,600,875 Z,600,875 0 0 30.00 S0.00 OS000 PERATING ROOM 894,346 894,346 0 50.00 60.00 LABORATORY Z,425,173 Z,425,173 0 0 54.00 60.00 06500 RESPIRATORY THERAPY 2,664,994 2,664,994 0 65.00 66.00 65.00 06500 PHYSICAL THERAPY 609,272 0 66.00 66.00 67.00 68.00 06800 SPECH PATHOLOGY 0 0 0 68.00 68.00 0 68.00 0 68.00 68.00 68.00 68.00 68.00 68.00 69.00 71.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 74.39		(from Wkst. B,	Adj.		Disallowance		
INPATIENT ROUTINE SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 ANCILLARY SERVICE COST CENTERS 2,600,875 0							
INPATIENT ROUTINE SERVICE COST CENTERS 2,600,875 0 0 30.00 30.00 ANCILLARY SERVICE COST CENTERS 2,600,875 0							
30.00 O3000 ADULTS & PEDIATRICS 2,600,875 2,600,875 0 0 30.00 ANCILLARY SERVICE COST CENTERS 50.00 OS000 OPERATING ROOM 894,346 894,346 0 0 50.00 054.00 O5400 RADIOLOGY - DIAGNOSTIC 2,425,173 2,425,173 0 54.00 60.00 06000 LABORATORY 2,664,994 2,664,994 0 60.00 65.00 06500 RESPIRATORY THERAPY 342 0 342 0 65.00 66.00 06600 PHYSICAL THERAPY 609,272 0 66.00 66.00 67.00 68.00 68.00 69.00 67.00 68.00 69.00 68.00 69.00 69.00 68.00 69.00 68.00 69.00 68.00 69.00 71.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 74.02,070 0 74.00 74.00 74.00 74.00 74.00 74.00 72.00 72.00 74.00 72.		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 894,346 894,346 0 0 50.00 54.00 05000 RADIOLOGY - DIAGNOSTIC 2,425,173 2,425,173 0 0 54.00 60.00 06000 LABORATORY 2,664,994 2,664,994 0 0 60.00 65.00 06500 RESPIRATORY THERAPY 342 0 342 0 66.00 66.00 06600 PHYSICAL THERAPY 609,272 0 66.00 66.00 67.00 06700 0CCUPATIONAL THERAPY 27,439 0 27,439 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 68.00 69.00 ELECTROCARDIOLOGY 0 0 0 0 69.00 71.00 71.00 72.00 69.00 72.00 72.00 72.00 72.00 72.00 72.00 73.00 73.00 73.00 73.00 73.00 73.00	INPATIENT ROUTINE SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM 894,346 894,346 0 0 50.00 54.00 05400 RADIOLOGY - DIAGNOSTIC 2,425,173 2,425,173 0 54.00 60.00 LABORATORY 2,664,994 2,664,994 0 60.00 65.00 RESPIRATORY THERAPY 342 0 342 0 65.00 66.00 06000 CCUPATIONAL THERAPY 609,272 0 609,272 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 27,439 0 27,439 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 68.00 69.00 ELECTROCARDIOLOGY 0 0 0 0 71.00 71.00 72.00 72.00 0 0 71.00 72.00 72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS 1,143,274 1,143,274 0 0 73.00 73.00 03950 ADULT MENTAL HEALTH	30.00 03000 ADULTS & PEDIATRICS	2,600,875		2,600,87	5 0	0	30.00
54.00 05400 RADIOLOGY - DIAGNOSTIC 2,425,173 0 0 54.00 60.00 06000 LABORATORY 2,664,994 2,664,994 0 0 60.00 65.00 06500 RESPIRATORY THERAPY 342 0 342 0 66.00 66.00 06600 PHYSICAL THERAPY 609,272 0 66.00 67.00 66.00 67.00 0 0 0 67.00 68.00 69,272 0 0 67.00 68.00 68.00 69.00 67.00 0 0 0 67.00 68.00 69.00 69.00 69.00 68.00 68.00 69.00 69.00 69.00 69.00 69.00 71.00 70100 MEDICAL SUPPLIES CHARGED TO PATIENTS 32,744 32,744 0 0 71.00 71.00 72.00 0 72.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 90 76.00 0	ANCILLARY SERVICE COST CENTERS						
60.00 06000 LABORATORY 2,664,994 2,664,994 0 0 60.00 65.00 06500 RESPIRATORY THERAPY 342 0 342 0 0 65.00 66.00 06600 PHYSICAL THERAPY 609,272 0 609,272 0 0 66.00 67.00 06700 0CCUPATIONAL THERAPY 27,439 0 27,439 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 68.00 69.00 06900 ELECTROCARDIOLOGY 0 0 0 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 32,744 32,744 0 0 71.00 72.00 07200 IMPLANTABLE DEVICES CHARGED TO 15,664 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 1,143,274 1,143,274 0 0 76.00 03950 ADULT MENTAL HEALTH 485,943 0 0 76.00 0 91.00 92.00 09800 RURAL HEA	50.00 05000 OPERATING ROOM	894,346		894,34	6 0	0	50.00
65.00 06500 RESPIRATORY THERAPY 342 0 342 0 65.00 66.00 06600 PHYSICAL THERAPY 609,272 0 609,272 0 0 66.00 67.00 0CCUPATIONAL THERAPY 27,439 0 27,439 0 0 67.00 68.00 06800 SPECH PATHOLOGY 0 0 0 0 68.00 69.00 06900 ELECTROCARDIOLOGY 0 0 0 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 71.00 71.00 72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS 32,744 32,744 0 0 71.00 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 1,143,274 1,143,274 0 0 76.00 03950 ADULT MENTAL HEALTH 485,943 485,943 0 0 76.00 09200 DSBROW RURAL HEALTH CLINIC 0 4,622,070 0 0 91.00 91.00 92.00 09200 DSE	54.00 05400 RADIOLOGY - DIAGNOSTIC	2,425,173		2,425,17	3 0	0	54.00
66.00 06600 PHYSICAL THERAPY 609,272 0 609,272 0 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 27,439 0 27,439 0 0 67.00 68.00 06800 SPECH PATHOLOGY 0 0 0 0 0 68.00 69.00 06900 ELECTROCARDIOLOGY 0 0 0 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 32,744 32,744 0 0 71.00 72.00 07200 IMPLANTABLE DEVICES CHARGED TO 15,664 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 1,143,274 1,143,274 0 0 73.00 73.00 03950 ADULT MENTAL HEALTH 485,943 0 0 76.00 OUTPATIENT SERVICE COST CENTERS OUTPATIENT SERVICE COST CENTERS 01.00 MERGENCY 4,622,070 4,622,070 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1,283,480	60.00 06000 LABORATORY	2,664,994		2,664,99	4 0	0	60.00
67.00 06700 OCCUPATIONAL THERAPY 27,439 0 27,439 0 0 67.00 68.00 06800 SPECH PATHOLOGY 0 0 0 0 0 0 68.00 69.00 06900 ELECTROCARDIOLOGY 0 0 0 0 0 0 69.00 71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS 32,744 32,744 0 0 71.00 72.00 07200 IMPLANTABLE DEVICES CHARGED TO 15,664 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 1,143,274 1,143,274 0 0 73.00 76.00 03950 ADULT MENTAL HEALTH 485,943 0 0 76.00 03950 ADULT MENTAL HEALTH 485,943 0 0 76.00 0100 EMERGENCY 4,622,070 0 0 91.00 92.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1,283,480 1,283,480 0 92.00 92.00 09200 BSERVATION BEDS 1,283,480 <	65.00 06500 RESPIRATORY THERAPY	342	0	34	2 0	0	65.00
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 32,744 32,744 0 0 71.00 72.00 07200 IMPLANTABLE DEVICES CHARGED TO 15,664 15,664 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 1,143,274 1,143,274 0 0 73.00 76.00 03950 ADULT MENTAL HEALTH 485,943 485,943 0 0 76.00 09100 EMERGENCY 0 0 0 0 0 91.00 92.00 92100 92.00 92.00 92.00 92.00 92.00 92.00 0 92.00 0 0 0 0 92.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1,283,480 1,283,480 0 92.00 92.00 201.00 Less Observation Beds 1,283,480 1,283,480 <	66.00 06600 PHYSICAL THERAPY	609,272	0	609,27	2 0	0	66.00
69.00 06900 ELECTROCARDIOLOGY 0 0 0 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 32,744 32,744 0 0 71.00 72.00 07200 IMPLANTABLE DEVICES CHARGED TO 15,664 15,664 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 1,143,274 1,143,274 0 0 73.00 76.00 03950 ADULT MENTAL HEALTH 485,943 485,943 0 0 76.00 04THENT SERVICE COST CENTERS 0 0 0 0 0 91.00 91.00 91.00 91.00 91.00 91.00 91.00 92.00 92.00 92.00 0 92.00 92.00 0 0 0 0 0 200.00 200.00 0 200.00 0 0 0 0 200.00 0 0 200.00 0 201.00 0 0 201.00 0 0 201.00 0 201.00 0 201.00 0 201.00 0 201.00	67.00 06700 OCCUPATIONAL THERAPY	27,439	0	27,43	9 0	0	67.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 32,744 32,744 0 0 71.00 72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS 15,664 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 1,143,274 1,143,274 0 0 73.00 76.00 03950 ADULT MENTAL HEALTH 485,943 485,943 0 0 76.00 0UTPATIENT SERVICE COST CENTERS 0 0 0 0 76.00 0 76.00 08800 RURAL HEALTH CLINIC 0 0 0 0 91.00 91.00 91.00 91.00 91.00 91.00 92.00 92.00 92.00 92.00 0 92.00 0 0 0 200.00 200.00 200.00 200.00 200.00 0 200.00 0 200.00 0 201.00 0 201.00 0 201.00 0 201.00 0 201.00 201.00 0 201.00 201.00	68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO 15,664 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 1,143,274 1,143,274 0 0 73.00 76.00 03950 ADULT MENTAL HEALTH 485,943 0 0 76.00 00TPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 0 0 76.00 09100 EMERGENCY 4,622,070 0 0 91.00 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1,283,480 1,283,480 0 0 200.00 200.00 Less Observation Beds 1,283,480 1,283,480 0 0 201.00	69.00 06900 ELECTROCARDIOLOGY	0			0 0	0	69.00
PATIENTS PATIENTS 1,143,274 0 0 73.00 73.00 07300 DRUGS CHARGED TO PATIENTS 1,143,274 1,143,274 0 0 73.00 76.00 03950 ADULT MENTAL HEALTH 485,943 0 0 76.00 OUTPATIENT SERVICE COST CENTERS 0 0 0 0 0 76.00 91.00 91.00 91.00 91.00 91.00 91.00 92.00 09200 085ErVATION BEDS (NON-DISTINCT PART) 1,283,480 1,283,480 0 92.00 92.00 00 0 0 20.00 200.00 Less Observation Beds 1,283,480 1,283,480 0 201.00	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	32,744		32,74	4 0	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS 1,143,274 1,143,274 0 0 73.00 76.00 03950 ADULT MENTAL HEALTH 485,943 485,943 0 0 76.00 OUTPATIENT SERVICE COST CENTERS 0 0 0 76.00 76.00 OUTPATIENT SERVICE COST CENTERS 0 0 0 0 88.00 09100 EMERGENCY 4,622,070 0 0 91.00 92.00 09526RVATION BEDS (NON-DISTINCT PART) 1,283,480 1,283,480 0 92.00 09200 cBSERVATION BEDS (NON-DISTINCT PART) 16,805,616 0 16,805,616 0 200.00 201.00 201.00	72.00 07200 IMPLANTABLE DEVICES CHARGED TO	15,664		15,66	4 0	0	72.00
76.00 03950 ADULT MENTAL HEALTH 485,943 0 0 76.00 OUTPATIENT SERVICE COST CENTERS 0 0 0 0 0 88.00 0 0 0 0 88.00 0	PATIENTS						
OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 88.00 91.00 09100 EMERGENCY 4,622,070 4,622,070 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1,283,480 1,283,480 0 92.00 200.00 Subtotal (see instructions) 16,805,616 0 16,805,616 0 0 200.00 201.00 Less Observation Beds 1,283,480 1,283,480 0 201.00	73.00 07300 DRUGS CHARGED TO PATIENTS	1,143,274		1,143,27	4 0	0	
88.00 08800 RURAL HEALTH CLINIC 0 0 0 88.00 91.00 09100 EMERGENCY 4,622,070 4,622,070 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1,283,480 1,283,480 0 92.00 200.00 Subtotal (see instructions) 16,805,616 0 16,805,616 0 0 200.00 201.00 Less Observation Beds 1,283,480 1,283,480 0 201.00	76.00 03950 ADULT MENTAL HEALTH	485,943		485,94	3 0	0	76.00
91.00 09100 EMERGENCY 4,622,070 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1,283,480 1,283,480 0 92.00 200.00 Subtotal (see instructions) 16,805,616 0 16,805,616 0 200.00 201.00 Less Observation Beds 1,283,480 1,283,480 0 201.00							
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1,283,480 1,283,480 0 92.00 200.00 Subtotal (see instructions) 16,805,616 0 16,805,616 0 0 200.00 201.00 Less Observation Beds 1,283,480 1,283,480 0 201.00	88.00 08800 RURAL HEALTH CLINIC	0			0 0	0	88.00
200.00 Subtotal (see instructions) 16,805,616 0 16,805,616 0 0 200.00 201.00 Less Observation Beds 1,283,480 1,283,480 0 201.00	91.00 09100 EMERGENCY	4,622,070		4,622,07	0 0	0	
201.00 Less Observation Beds 1,283,480 1,283,480 0 201.00		1,283,480		1,283,48	0	-	
		16,805,616	0	16,805,61	6 0		
202.00 Total (see instructions) 15,522,136 0 15,522,00		1,283,480		1,283,48	0		
	202.00 Total (see instructions)	15,522,136	0	15,522,13	6 0	0	202.00

Health Financial Systems	ASCENSION ST. VI	NCENT JENNINGS		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider Co	I	Period: From 07/01/2022 Fo 06/30/2023	Worksheet C Part I Date/Time Pre 11/22/2023 2:	
		Title	XVIII	Hospital	Cost	
		Charges				
Cost Center Description	Inpatient	Outpatient	+ col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	1,316,879		1,316,879	9		30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	4,067,158				50.00
54.00 05400 RADIOLOGY - DIAGNOSTIC	254,822	20,534,900				54.00
60.00 06000 LABORATORY	436,680	24,391,509				60.00
65.00 06500 RESPIRATORY THERAPY	34,083	111,112				65.00
66.00 06600 PHYSICAL THERAPY	61,353	1,492,168				66.00
67.00 06700 OCCUPATIONAL THERAPY	7,783	79,129	86,912			67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0.000000		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		0.000000		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	89,186	451,322	,			•
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	65,331	65,333	1 0.239764	0.00000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	260,215	3,473,322	3,733,53	7 0.306217	0.00000	73.00
76.00 03950 ADULT MENTAL HEALTH	0	958,527	958,52	0.506969	0.00000	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0				88.00
91.00 09100 EMERGENCY	144,419	25,569,584				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		733,634	,		0.00000	92.00
200.00 Subtotal (see instructions)	2,693,847	81,927,696	84,621,543	3		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	2,693,847	81,927,696	84,621,54	3		202.00

Health	Financial Systems	ASCENSION ST. VINC	CENT JENNINGS	In Lie	u of Form CMS-	2552-10
СОМРИТ	ATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1303	Period: From 07/01/2022 To 06/30/2023	Worksheet C Part I Date/Time Pre 11/22/2023 2:	
			Title XVIII	Hospital	Cost	
	Cost Center Description	PPS Inpatient				
		Ratio				
		11.00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS					30.00
	ANCILLARY SERVICE COST CENTERS					
	05000 OPERATING ROOM	0.000000				50.00
	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	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 IMPLANTABLE DEVICES CHARGED TO	0.000000				72.00
	PATIENTS					
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000				73.00
76.00	03950 ADULT MENTAL HEALTH	0.000000				76.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC					88.00
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	Less Observation Beds					201.00
202.00	Total (see instructions)					202.00

Health Financial Systems	ASCENSION ST. VI	NCENT JENNINGS		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 07/01/2022 To 06/30/2023	Worksheet C Part I Date/Time Pre 11/22/2023 2:	pared: 07 pm
		Titl	e XIX	Hospital	Cost	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj.		Disallowance		
	Part I, col.					
	26)					
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS			1			
30.00 03000 ADULTS & PEDIATRICS	2,600,875		2,600,87	5 0	2,600,875	30.00
ANCILLARY SERVICE COST CENTERS			1			
50.00 OFERATING ROOM	894,346		894,34		894,346	•
54.00 05400 RADIOLOGY - DIAGNOSTIC	2,425,173		2,425,17		2,425,173	
60.00 06000 LABORATORY	2,664,994		2,664,99		2,664,994	
65.00 06500 RESPIRATORY THERAPY	342	0	34		342	
66.00 06600 PHYSICAL THERAPY	609,272	0	609,27		609,272	•
67.00 06700 OCCUPATIONAL THERAPY	27,439	0	27,43	9 0	27,439	•
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0			0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	32,744		32,74		32,744	
72.00 07200 IMPLANTABLE DEVICES CHARGED TO	15,664		15,66	4 0	15,664	72.00
PATIENTS						
73.00 07300 DRUGS CHARGED TO PATIENTS	1,143,274		1,143,27		1,143,274	
76.00 03950 ADULT MENTAL HEALTH	485,943		485,94	3 0	485,943	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0			0 0	0	
91.00 09100 EMERGENCY	4,622,070		4,622,07		4,622,070	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1,283,480		1,283,48		1,283,480	
200.00 Subtotal (see instructions)	16,805,616		16,805,61		16,805,616	
201.00 Less Observation Beds	1,283,480		1,283,48		1,283,480	
202.00 Total (see instructions)	15,522,136	0	15,522,13	6 0	15,522,136	202.00

Health	Financial Systems A	SCENSION ST. VI	NCENT JENNINGS		In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 07/01/2022 To 06/30/2023	Worksheet C Part I Date/Time Pre 11/22/2023 2:	
			Titl	e XIX	Hospital	Cost	
			Charges				
	Cost Center Description	Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
		6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	1,316,879		1,316,87	9		30.00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	4,067,158				
54.00	05400 RADIOLOGY - DIAGNOSTIC	254,822	20,534,900				54.00
60.00	06000 LABORATORY	436,680	24,391,509				
65.00	06500 RESPIRATORY THERAPY	34,083	111,112	· · · ·			
66.00	06600 PHYSICAL THERAPY	61,353	1,492,168			0.00000	66.00
67.00	06700 OCCUPATIONAL THERAPY	7,783	79,129	86,91			67.00
68.00	06800 SPEECH PATHOLOGY	0	0		0.000000		
69.00	06900 ELECTROCARDIOLOGY	0	0		0.000000		
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	89,186	451,322				
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	65,331	65,33	1 0.239764	0.000000	
73.00	07300 DRUGS CHARGED TO PATIENTS	260,215	3,473,322	3,733,53	7 0.306217	0.00000	73.00
76.00	03950 ADULT MENTAL HEALTH	0	958,527	958,52	7 0.506969	0.00000	76.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0		0.000000		88.00
91.00	09100 EMERGENCY	144,419	25,569,584	25,714,00	3 0.179749	0.00000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	88,427	733,634	822,06	1 1.561295	0.00000	
200.00		2,693,847	81,927,696	84,621,54	3		200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	2,693,847	81,927,696	84,621,54	3		202.00

Health Financial Systems		ASCENSION ST. VINC		In Lieu of Form CMS-255		
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1303	Period: From 07/01/2022 To 06/30/2023	Worksheet C Part I Date/Time Prepa 11/22/2023 2:07	
			Title XIX	Hospital	Cost	
	Cost Center Description	PPS Inpatient				
		Ratio				
	1	11.00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS					30.00
	ANCILLARY SERVICE COST CENTERS					
	05000 OPERATING ROOM	0.00000				50.00
	05400 RADIOLOGY - DIAGNOSTIC	0.000000				54.00
	06000 LABORATORY	0.000000				60.00
	06500 RESPIRATORY THERAPY	0.000000				65.00
	06600 PHYSICAL THERAPY	0.000000				66.00
	06700 OCCUPATIONAL THERAPY	0.000000				67.00
	06800 SPEECH PATHOLOGY	0.000000				68.00
	06900 ELECTROCARDIOLOGY	0.000000				69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000				71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO	0.000000				72.00
	PATIENTS					
	07300 DRUGS CHARGED TO PATIENTS	0.000000				73.00
76.00	03950 ADULT MENTAL HEALTH	0.000000				76.00
	OUTPATIENT SERVICE COST CENTERS					
	08800 RURAL HEALTH CLINIC	0.000000				88.00
	09100 EMERGENCY	0.000000				91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000				92.00
200.00						00.00
201.00						01.00
202.00	Total (see instructions)				20	02.00

Health Financial Systems A	SCENSION ST. VI	NCENT JENNINGS		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT/	AL COSTS				Period: Worksheet D From 07/01/2022 Part II To 06/30/2023 Date/Time Preinformer 11/22/2023 2:	
	_		XVIII	Hospital	Cost	
Cost Center Description	Capital	Total Charges		t Inpatient	Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,	· · ·		. 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	- 1		
50.00 05000 OPERATING ROOM	134,136	, , ,			0	50.00
54.00 05400 RADIOLOGY - DIAGNOSTIC	542,114	, , ,	•		,	•
60.00 06000 LABORATORY	87,564	24,828,189	0.00352	120,755	426	60.00
65.00 06500 RESPIRATORY THERAPY	119	145,195	0.00082	10,328	8	65.00
66.00 06600 PHYSICAL THERAPY	44,357	1,553,521	0.02855	53 17,431	498	66.00
67.00 06700 OCCUPATIONAL THERAPY	549	86,912	0.00631	1,658	10	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0.00000	0 0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0.00000	0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	6,669	540,508	0.01233	27,494	339	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO	772	65,331	0.01181	.7 0	0	72.00
PATIENTS						
73.00 07300 DRUGS CHARGED TO PATIENTS	55,059	3,733,537	0.01474	139,630	2,059	73.00
76.00 03950 ADULT MENTAL HEALTH	9,981	958,527	0.01041	.3 0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0	0.0000	0 0	0	88.00
91.00 09100 EMERGENCY	191,464	25,714,003	0.00744	6 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	70,916	822,061	0.08626	6 10,841	935	92.00
200.00 Total (lines 50 through 199)	1,143,700	83,304,664		372,100	5,421	200.00

Health	Financial Systems A	SCENSION ST. VI	NCENT JENNINGS		In Lie	eu of Form CMS-2	2552-10
	APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERV THROUGH COSTS		VICE OTHER PASS Provider CCN: 15-1303		Period: From 07/01/2022 To 06/30/2023		
				XVIII	Hospital	Cost	
	Cost Center Description	Non Physician	Nursing	Nursing		Allied Health	
		Anesthetist	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
		1.00	2A	2.00	3A	3.00	
	ANCILLARY SERVICE COST CENTERS			1		1	
	05000 OPERATING ROOM	0	0		0 0	0 0	50.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	0	0		0 0	0 0	54.00
60.00	06000 LABORATORY	0	0		0 0	0 0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0		0 0	0 0	65.00
66.00	06600 PHYSICAL THERAPY	0	0		0 0	0 0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0		0 0	0 0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0		0 0	0 0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0		0 0	0 0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0 0	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO	0	0		0 0	0 0	72.00
	PATIENTS						
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0 0	73.00
76.00	03950 ADULT MENTAL HEALTH	0	0		0 0	0 0	76.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0		0 0	0 0	88.00
91.00	09100 EMERGENCY	0	0		0 0	0 0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
200.00	Total (lines 50 through 199)	0	0		0 0	0 0	200.00

Health	Financial Systems	SCENSION ST. VI	NCENT JENNINGS		In Lie	u of Form CMS-2	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE H COSTS	RVICE OTHER PASS	5 Provider Co		Period: From 07/01/2022 To 06/30/2023		
				XVIII	Hospital	Cost	
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
		Medical	(sum of cols.	Outpatient	(from Wkst. C,		
		Education Cost	1, 2, 3, and	Cost (sum of		(col. 5 ÷ col.	
			4)	cols. 2, 3,	8)	7)	
				and 4)		(see	
						instructions)	
	Γ	4.00	5.00	6.00	7.00	8.00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	0		0 4,067,158		
	05400 RADIOLOGY - DIAGNOSTIC	0	0		0 20,789,722		
	06000 LABORATORY	0	0		0 24,828,189		
	06500 RESPIRATORY THERAPY	0	0		0 145,195		65.00
	06600 PHYSICAL THERAPY	0	0		0 1,553,521		66.00
	06700 OCCUPATIONAL THERAPY	0	0		0 86,912	0.000000	
	06800 SPEECH PATHOLOGY	0	0		0 0	0.000000	68.00
	06900 ELECTROCARDIOLOGY	0	0		0 0	0.000000	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 540,508		
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0		0 65,331	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 3,733,537	0.000000	73.00
76.00	03950 ADULT MENTAL HEALTH	0	0		0 958,527	0.000000	76.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0		0 0	0.000000	88.00
91.00	09100 EMERGENCY	0	0		0 25,714,003	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 822,061	0.000000	92.00
200.00	Total (lines 50 through 199)	0	0		0 83,304,664		200.00

Health Financial System	15 A	SCENSION ST. VI	NCENT JENNINGS		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPAT THROUGH COSTS	IENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS			Period: From 07/01/2022 To 06/30/2023		
			Title	XVIII	Hospital	Cost	
Cost Cente	r Description	Outpatient	Inpatient	Inpatient	Outpatient	Outpatient	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through		Pass-Through	
		(col. 6 ÷ col.		Costs (col.	3	Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVIC		1 1		1		I	
50.00 05000 OPERATING		0.000000	0		0 0	0	50.00
54.00 05400 RADIOLOGY		0.000000	43,963		0 0	0	54.00
60.00 06000 LABORATORY		0.000000	120,755		0 0	0	60.00
65.00 06500 RESPIRATOR		0.000000	10,328		0 0	0	65.00
66.00 06600 PHYSICAL T		0.000000	17,431		0 0	0	66.00
67.00 06700 OCCUPATION	AL THERAPY	0.000000	1,658		0 0	0	67.00
68.00 06800 SPEECH PAT	HOLOGY	0.000000	0		0 0	0	68.00
69.00 06900 ELECTROCAR	DIOLOGY	0.000000	0		0 0	0	69.00
71.00 07100 MEDICAL SU	PPLIES CHARGED TO PATIENTS	0.000000	27,494		0 0	0	71.00
	E DEVICES CHARGED TO	0.000000	0		0 0	0	72.00
PATIENTS		0,000000	120 620				72.00
73.00 07300 DRUGS CHAR		0.000000	139,630		0 0	0	
76.00 03950 ADULT MENT		0.000000	0		0 0	0	76.00
OUTPATIENT SERVI		0.00000					
88.00 08800 RURAL HEAL	IH CLINIC	0.00000	0		0 0	0	
91.00 09100 EMERGENCY		0.000000	0		0 0	0	91.00
	N BEDS (NON-DISTINCT PART)	0.00000	10,841		0 0	0	92.00
200.00 Total (lin	es 50 through 199)		372,100		0 0	0	200.00

Health Financial Systems	ASCENSION ST. VI	INCENT JENNINGS		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provider C		Period: From 07/01/2022 To 06/30/2023		
		Title	XVIII	Hospital	Cost	
			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		- 1		
50.00 05000 OPERATING ROOM	0.219895		647,51		0	50.00
54.00 05400 RADIOLOGY - DIAGNOSTIC	0.116652		3,091,98		0	54.00
60.00 06000 LABORATORY	0.107337		3,960,30		0	60.00
65.00 06500 RESPIRATORY THERAPY	0.002355		20,36		0	65.00
66.00 06600 PHYSICAL THERAPY	0.392188	0	203,22	9 0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0.315710	0	23,51	5 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0.00000	0		0 0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0.00000	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.060580	0	66,16	9 0	0	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO	0.239764	0	12,67	6 0	0	72.00
PATIENTS						
73.00 07300 DRUGS CHARGED TO PATIENTS	0.306217	0	479,88	2 542	0	73.00
76.00 03950 ADULT MENTAL HEALTH	0.506969	0	537,03	0 0	0	76.00
OUTPATIENT SERVICE COST CENTERS			_			
88.00 08800 RURAL HEALTH CLINIC						88.00
91.00 09100 EMERGENCY	0.179749	0	2,926,73	9 580	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.561295	0	209,84	9 0	0	92.00
200.00 Subtotal (see instructions)		0	12,179,25	5 1,122	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	12,179,25	5 1,122	0	202.00

	SCENSION ST. VI				u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provider CO		Period: From 07/01/2022 To 06/30/2023	Worksheet D Part V Date/Time Pre 11/22/2023 2:	
			XVIII	Hospital	Cost	
		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	142, 200	0				50.00
	142,386					54.00
54.00 05400 RADIOLOGY - DIAGNOSTIC 60.00 06000 LABORATORY	360,686					60.00
65.00 06500 RESPIRATORY THERAPY	425,087					65.00
66.00 06600 PHYSICAL THERAPY	79,704					66.00
						67.00
67.00 06700 OCCUPATIONAL THERAPY 68.00 06800 SPEECH PATHOLOGY	7,424					68.00
69.00 06900 ELECTROCARDIOLOGY	0	0				69.00
	4,009	0				71.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPLANTABLE DEVICES CHARGED TO	3,039					72.00
PATIENTS	5,059	0				/2.00
73.00 07300 DRUGS CHARGED TO PATIENTS	146,948	166				73.00
76.00 03950 ADULT MENTAL HEALTH	272,258	0				76.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC						88.00
91.00 09100 EMERGENCY	526,078					91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	327,636					92.00
200.00 Subtotal (see instructions)	2,295,303	270				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)	2,295,303	270				202.00

		NCENT JENNINGS		TH LIE	u of Form CMS-2	2332-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	ID VACCINE COST	Provider C		Period:	Worksheet D	
		Common and A		From 07/01/2022		
				то 06/30/2023	11/22/2023 2:	
				Swing Beds - SNF	Cost	
			Charges		Costs	
Cost Center Description	Cost to Charge			Cost	PPS Services	
		Services (see		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						
50.00 05000 OPERATING ROOM	0.219895	0		0 0	0	50.00
54.00 05400 RADIOLOGY - DIAGNOSTIC	0.116652			0 0	0	54.00
50.00 06000 LABORATORY	0.107337	0		0 0	0	60.00
55.00 06500 RESPIRATORY THERAPY	0.002355	0		0 0	0	65.00
56.00 06600 PHYSICAL THERAPY	0.392188	0		0 0	0	66.00
57.00 06700 OCCUPATIONAL THERAPY	0.315710	0		0 0	0	67.00
58.00 06800 SPEECH PATHOLOGY	0.00000	0		0 0	0	68.00
59.00 06900 ELECTROCARDIOLOGY	0.00000	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.060580	0		0 0	0	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO	0.239764	0		0 0	0	72.00
PATIENTS						
73.00 07300 DRUGS CHARGED TO PATIENTS	0.306217	0	1	0 0	0	73.00
76.00 03950 ADULT MENTAL HEALTH	0.506969	0		0 0	0	76.00
OUTPATIENT SERVICE COST CENTERS					-	1
38.00 08800 RURAL HEALTH CLINIC						88.00
91.00 09100 EMERGENCY	0.179749	0		0 0	0	91.00
02.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.561295			0 0	0	1
200.00 Subtotal (see instructions)		0		0 0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		0		0 0	0	202.00

Health	Financial Systems A	SCENSION ST. VI	NCENT JENNINGS		In Lie	u of Form CMS-	2552-10
APPORT	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-1303	Period:	Worksheet D	
					From 07/01/2022	Part V	
			Component	CCN:15-Z303	то 06/30/2023	Date/Time Pre 11/22/2023 2:	
			Title	XVIII	Swing Beds - SNF	Cost	
		COS	sts				
	Cost Center Description	Cost	Cost				
		Reimbursed	Reimbursed				
		Services	Services Not				
		Subject To	Subject To				
			Ded. & Coins.				
		(see inst.)	(see inst.)				
	I	6.00	7.00				
	ANCILLARY SERVICE COST CENTERS	-	-	1			
	05000 OPERATING ROOM	0	0				50.00
	05400 RADIOLOGY - DIAGNOSTIC	0	0				54.00
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
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO	0	0				72.00
	PATIENTS						
	07300 DRUGS CHARGED TO PATIENTS	0	0				73.00
76.00	03950 ADULT MENTAL HEALTH	0	0				76.00
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC						88.00
	09100 EMERGENCY	0	0				91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
200.00		0	0				200.00
201.00		0					201.00
	Only Charges						
202.00	Net Charges (line 200 - line 201)	0	0				202.00

Health Financial Systems	ASCENSION ST. VI	NCENT JENNING	S		u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER P	ASS THROUGH COS		CCN: 15-1303	Period: From 07/01/2022 To 06/30/2023		
	-		le XIX	Hospital	Cost	
Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Healt Post-Stepdow Adjustments		All Other Medical Education Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS 200.00 Total (lines 30 through 199)	0		0 0	0 0 0 0	0	30.00
Cost Center Description		Total Costs (sum of cols. 1 through 3, minus col. 4) 5.00	. Days	t Per Diem (col. 5 ÷ col. 6) 7.00	Program Days	
INPATIENT ROUTINE SERVICE COST CENTERS	4.00	5.00	6.00	7.00	8.00	-
30.0003000ADULTS & PEDIATRICS200.00Total (lines 30 through 199)	0		0 90 0 90		-	30.00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS 200.00 Total (lines 30 through 199)	0					30.00 200.00

Health	Financial Systems A	SCENSION ST. VI	NCENT JENNINGS	5	In Lie	u of Form CMS-2	2552-10
	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE COSTS	RVICE OTHER PAS	5 Provider C	CN: 15-1303	Period: From 07/01/2022 To 06/30/2023		
				le XIX	Hospital	Cost	
	Cost Center Description	Non Physician	Nursing	Nursing		Allied Health	
		Anesthetist	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
		1.00	2A	2.00	3A	3.00	
	ANCILLARY SERVICE COST CENTERS	-					
	05000 OPERATING ROOM	0	0		0 0	0	50.00
	05400 RADIOLOGY - DIAGNOSTIC	0	0	D	0 0	0	54.00
	06000 LABORATORY	0	0	D	0 0	0	60.00
	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 IMPLANTABLE DEVICES CHARGED TO	0	0		0 0	0	72.00
	PATIENTS						
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
76.00	03950 ADULT MENTAL HEALTH	0	0)	0 0	0	76.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0)	0 0	0	88.00
91.00	09100 EMERGENCY	0	0)	0 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
200.00	Total (lines 50 through 199)	0	0		0 0	0	200.00

Health	Financial Systems A	SCENSION ST. VI	NCENT JENNINGS		In Lie	u of Form CMS-2	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI H COSTS	RVICE OTHER PASS	5 Provider Co		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	1, 2, 3, and	Cost (sum of		(col. 5 ÷ col.	
			4)	cols. 2, 3,	8)	7)	
				and 4)		(see	
						instructions)	
		4.00	5.00	6.00	7.00	8.00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	0		0 4,067,158		
	05400 RADIOLOGY - DIAGNOSTIC	0	0		0 20,789,722		
	06000 LABORATORY	0	0		0 24,828,189		
65.00	06500 RESPIRATORY THERAPY	0	0		0 145,195		65.00
	06600 PHYSICAL THERAPY	0	0		0 1,553,521	0.00000	66.00
	06700 OCCUPATIONAL THERAPY	0	0		0 86,912	0.00000	
	06800 SPEECH PATHOLOGY	0	0		0 0	0.000000	68.00
	06900 ELECTROCARDIOLOGY	0	0		0 0	0.000000	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 540,508		
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0		0 65,331	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 3,733,537	0.00000	73.00
76.00	03950 ADULT MENTAL HEALTH	0	0		0 958,527	0.00000	76.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0		0 0	0.00000	88.00
91.00	09100 EMERGENCY	0	0		0 25,714,003	0.00000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 822,061	0.000000	92.00
200.00	Total (lines 50 through 199)	0	0		0 83,304,664		200.00

Health Financial Systems	A	SCENSION ST. VI	NCENT JENNINGS		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/ THROUGH COSTS	OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS		-	Period: From 07/01/2022 Fo 06/30/2023	Worksheet D Part IV Date/Time Pre 11/22/2023 2:	pared: 07 pm
			-	e XIX	Hospital	Cost	
Cost Center Des	cription	Outpatient	Inpatient	Inpatient	Outpatient	Outpatient	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through		Pass-Through	
		(col. 6 ÷ col.		Costs (col. 8		Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COS	ST CENTERS	0.00000				-	
50.00 05000 OPERATING ROOM		0.000000	0		0 0	0	50.00
54.00 05400 RADIOLOGY - DIA	GNOSTIC	0.00000	39,311		0 0	0	54.00
60.00 06000 LABORATORY		0.000000	44,116		0 0	0	60.00
65.00 06500 RESPIRATORY THE		0.00000	0		0 0	0	65.00
66.00 06600 PHYSICAL THERAP		0.00000	0		0 0	0	66.00
67.00 06700 OCCUPATIONAL TH		0.00000	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOG		0.00000	0		0 0	0	68.00
69.00 06900 ELECTROCARDIOLO		0.00000	0		0 0	0	69.00
	S CHARGED TO PATIENTS	0.00000	2,289		0 0	0	71.00
72.00 07200 IMPLANTABLE DEV PATIENTS	ICES CHARGED TO	0.000000	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED T	O PATIENTS	0.000000	21,349		0 0	0	73.00
76.00 03950 ADULT MENTAL HE	ALTH	0.000000	0		0 0	0	76.00
OUTPATIENT SERVICE CO	OST CENTERS						
88.00 08800 RURAL HEALTH CL	INIC	0.000000	0		0 0	0	88.00
91.00 09100 EMERGENCY		0.000000	29,536	(0 0	0	91.00
92.00 09200 OBSERVATION BED	S (NON-DISTINCT PART)	0.000000	10,494		0 0	0	92.00
200.00 Total (lines 50	through 199)		147,095	(0 0	0	200.00

мрит	Financial Systems ASCENSION ST. VINC ATION OF INPATIENT OPERATING COST	Provider CCN: 15-1303	Period:	u of Form CMS-2 Worksheet D-1	
			From 07/01/2022 To 06/30/2023	Date/Time Pre 11/22/2023 2:0	
		Title XVIII	Hospital	Cost	
	Cost Center Description		-	1.00	
1	PART I - ALL PROVIDER COMPONENTS		1	1.00	
00	INPATIENT DAYS Inpatient days (including private room days and swing-bed day	(s excluding newborn)		997	1
00	Inpatient days (including private room days, excluding swing-			901	2
0	Private room days (excluding swing-bed and observation bed da		rivate room days,	0	3
0	do not complete this line. Semi-private room days (excluding swing-bed and observation b	(aveb bee		409	4
0	Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	54	
	reporting period		21 6 1	10	
00	Total swing-bed SNF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line)	oom days) after December	31 of the cost	42	6
00	Total swing-bed NF type inpatient days (including private roo	om days) through December	r 31 of the cost	0	7
	reporting period		01 of the cost	0	
00	Total swing-bed NF type inpatient days (including private roc reporting period (if calendar year, enter 0 on this line)	om days) after December :	SI OT LHE COSL	0	8
0	Total inpatient days including private room days applicable t	to the Program (excluding	g swing-bed and	183	9
00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII of	only (including private u	(aveb moor	54	10
00	through December 31 of the cost reporting period (see instruc		oom days)	74	
00	Swing-bed SNF type inpatient days applicable to title XVIII of		room days) after	0	11
00	December 31 of the cost reporting period (if calendar year, e 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			Ũ	
00	Swing-bed NF type inpatient days applicable to titles V or XI			0	13
00	after December 31 of the cost reporting period (if calendar y Medically necessary private room days applicable to the Progr			0	14
00	Total nursery days (title V or XIX only)			0	15
00	Nursery days (title V or XIX only)			0	16
00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to servic	ces through December 31 (of the cost		1
	reporting period	-			
.00	Medicare rate for swing-bed SNF services applicable to servic reporting period	ces after December 31 of	the cost		18
.00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 of	f the cost	250.44	19
00	reporting period	a after December 21 of	the cost	266 22	20
.00	Medicaid rate for swing-bed NF services applicable to service reporting period	es aller December 31 01	Line Cost	266.32	
	Total general inpatient routine service cost (see instruction			2,600,875	
.00	Swing-bed cost applicable to SNF type services through Decemb 5 x line 17)	per 31 of the cost report	ting period (line	0	22
.00	Swing-bed cost applicable to SNF type services after December	r 31 of the cost reportin	ng period (line 6	0	23
	x line 18)				
.00	Swing-bed cost applicable to NF type services through December 7 x line 19)	er 31 of the cost report	ing period (line	0	24
.00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	g period (line 8	0	25
.00	x line 20) Total swing-bed cost (see instructions)			250,435	26
	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		2,350,440	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		· · · · ·		
-	General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges)	ed and observation bed ch	narges)	0	28
-	Semi-private room charges (excluding swing bed charges)			0	
00	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		TIONS)	0.00	
	Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35)	iiie 31)		0.00	35
	General inpatient routine service cost net of swing-bed cost	and private room cost d	ifferential (line	2,350,440	
	27 minus line 36)			,,	1.
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				-
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ Adjusted general inpatient routine service cost per diem (see			2,608.70	38
	Program general inpatient routine service cost (line 9 x line			477,392	
-	Medically necessary private room cost applicable to the Progr			0	40
.00					41

	ATION OF INPATIENT OPERATING COST		Provider C		Period: From 07/01/2022	Worksheet D-1	
					то 06/30/2023	11/22/2023 2:	
	Cost Center Description	Total	Total	Average Per	Hospital Program Days	Cost Program Cost	
		Inpatient Cost	Inpatient Days		÷	(col. 3 x col. 4)	
		1.00	2.00	col. 2) 3.00	4.00	5.00	
.00	NURSERY (title V & XIX only)						42
.00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT						43
.00	CORONARY CARE UNIT						44
.00	BURN INTENSIVE CARE UNIT						45
	SURGICAL INTENSIVE CARE UNIT						46
.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47
						1.00	10
.00 .01	Program inpatient ancillary service cost (Wk Program inpatient cellular therapy acquisiti			TTT line 10	column 1)	86,821	1
.00	Total Program inpatient costs (sum of lines				co (umi) 1)	564,213	
	PASS THROUGH COST ADJUSTMENTS					-	
.00	Pass through costs applicable to Program inp	atient routine	services (from	n Wkst. D, sum	of Parts I and	0	50
.00	Pass through costs applicable to Program inp	atient ancillar	y services (fi	rom Wkst. D, s	um of Parts II	0	51
	and IV)		*				
00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		lated non ab	cician anacth	otict and	0	
00	medical education costs (line 49 minus line		raceu, non-phy	ysiciali allesti	etist, anu	0	33
	TARGET AMOUNT AND LIMIT COMPUTATION						
00	5 5					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	5					0	
00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	irget amount (line 56 minus	line 53)	0	
00	Trended costs (lesser of line 53 ÷ line 54,	or line 55 from	the cost repo	ortina period	endina 1996.	0.00	
	updated and compounded by the market basket)			5.			
00	Expected costs (lesser of line 53 ÷ line 54,	or line 55 fro	om prior year o	cost report, u	pdated by the	0.00	60
.00	market basket) Continuous improvement bonus payment (if line 53 \div line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise						61
	enter zero. (see instructions)		<u>-</u>		,		
00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ont (coo instru	(ctions)			0	
00	PROGRAM INPATIENT ROUTINE SWING BED COST					0	03
00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of the	e cost reporti	ng period (See	140,870	64
00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the d	cost reporting	period (See	0	65
	instructions)(title XVIII only)						
00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 6	65)(title XVII	I only); for	140,870	66
00	CAH, see instructions Title V or XIX swing-bed NF inpatient routin	e costs through	December 31 o	of the cost re	portina period	0	67
	(line 12 x line 19)						
00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after [ecember 31 of	the cost repo	rting period	0	68
00	Total title V or XIX swing-bed NF inpatient	routine costs (line 67 + line	e 68)		0	69
	PART III - SKILLED NURSING FACILITY, OTHER N						
00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c						70
00 00	Program routine service cost (line 9 x line		ine i v ÷ i i ile	<i>L</i> J			72
00	Medically necessary private room cost applic	able to Program					73
00	Total Program general inpatient routine serv	•			ant TT 7		74
00	Capital-related cost allocated to inpatient 26, line 45)	iouline service	COSTS (Trom V	worksneet B, P	ait II, Column		75
00	Per diem capital-related costs (line 75 ÷ li	ne 2)					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		provider record	ds)			78
00	Total Program routine service costs for comp				us line 79)		80
00	Inpatient routine service cost per diem limi	tation			-		81
00	Inpatient routine service cost limitation (1						82
00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in		15)				83
00	Utilization review - physician compensation		ons)				85
.00	Total Program inpatient operating costs (sum	of lines 83 th					86
00	PART IV - COMPUTATION OF OBSERVATION BED PAS Total observation bed days (see instructions					492	87
	Adjusted general inpatient routine cost per		line 2)			492 2,608.70	
00							

Health Financial Systems A	SCENSION ST. VI	NCENT JENNINGS		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period:	Worksheet D-1	
				From 07/01/2022 Fo 06/30/2023	Date/Time Pre 11/22/2023 2:	
		Title	XVIII	Hospital	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observation	Bed Pass	
				Bed Cost (from		
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	143,705	2,600,875	0.05525	3 1,283,480	70,916	90.00
91.00 Nursing Program cost	0	2,600,875	0.00000	1,283,480	0	91.00
92.00 Allied health cost	0	2,600,875	0.00000	1,283,480	0	92.00
93.00 All other Medical Education	0	2,600,875	0.00000	1,283,480	0	93.00

	Financial Systems ASCENSION ST. VINCE ATION OF INPATIENT OPERATING COST	Provider CCN: 15-1303	Period:	u of Form CMS-2 Worksheet D-1	
			From 07/01/2022 To 06/30/2023	Date/Time Pre 11/22/2023 2:	
		Title XIX	Hospital	Cost	
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS		1	1.00	
00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days	, excluding newborn)		997	1.0
00	Inpatient days (including private room days, excluding swing-b	ed and newborn days)		901	
00	Private room days (excluding swing-bed and observation bed day do not complete this line.	vs). If you have only pr	'ivate room days,	0	3.0
00	Semi-private room days (excluding swing-bed and observation be			409	
00	Total swing-bed SNF type inpatient days (including private roo reporting period	om days) through Decembe	er 31 of the cost	54	5.
00	Total swing-bed SNF type inpatient days (including private roo	om days) after December	31 of the cost	42	6.
00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room	u days) through December	31 of the cost	0	7.
	reporting period			Ũ	'.
00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	1 days) after December 3	1 of the cost	0	8.
00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	16	9.
.00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII on	ly (including private r	com dave)	0	10.
.00	through December 31 of the cost reporting period (see instruct		oom days)	0	10.
.00	Swing-bed SNF type inpatient days applicable to title XVIII on		room days) after	0	11.
.00	December 31 of the cost reporting period (if calendar year, en Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12.
~~	through December 31 of the cost reporting period	(] (i]iii		0	12
.00	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar ye			0	13.
	Medically necessary private room days applicable to the Progra			0	1 - · ·
	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT		-		
.00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 c	of the cost		17.
.00	Medicare rate for swing-bed SNF services applicable to service reporting period	es after December 31 of	the cost		18.
.00	Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	250.44	19.
.00	reporting period Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	he cost	266.32	20.
.00	reporting period Total general inpatient routine service cost (see instructions	.)		2,600,875	21.
.00	Swing-bed cost applicable to SNF type services through Decembe		ing period (line	2,000,875	22.
.00	5 x line 17) Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	a pariod (line 6	0	23.
.00	x line 18)	SI OF the cost report		0	25.
.00	Swing-bed cost applicable to NF type services through December 7 x line 19)	31 of the cost reporti	ng period (line	0	24.
.00	Swing-bed cost applicable to NF type services after December 3	1 of the cost reporting	period (line 8	0	25.
.00	x line 20) Total swing-bed cost (see instructions)			250,435	26.
.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,350,440	27.
.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0	28
	Private room charges (excluding swing-bed charges)			0	
	Semi-private room charges (excluding swing-bed charges)			0	
	General inpatient routine service cost/charge ratio (line 27 ÷	- 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 min		TIONS)	0.00	
	Average per diem private room cost differential (line 34 x lin	ie 31)		0.00	
.00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line)	0 2,350,440	1 2 0
	27 minus line 36)			2,350,440	'
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	CTMENTS			-
00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU			2 600 70	20
	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line			2,608.70 41,739	
.00	Medically necessary private room cost applicable to the Progra			41,739	
00					

MPUT	ATION OF INPATIENT OPERATING COST		Provider C	CN: 15-1303	Period: From 07/01/2022		
					то 06/30/2023	Date/Time Pre 11/22/2023 2:	
	Cost Center Description	Total	Tit] Total	e XIX Average Per	Hospital Program Days	Cost Program Cost	
		Inpatient Cost				(col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	4.2
.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units						42.
.00							43.
.00	CORONARY CARE UNIT						44.
.00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45.
	OTHER SPECIAL CARE (SPECIFY)						40.
	Cost Center Description				·	1.00	
.00	Program inpatient ancillary service cost (Wk	st. D-3. col. 3	3. line 200)			1.00	48.
.01	Program inpatient cellular therapy acquisiti			III, line 10	, column 1)	0	
.00	Total Program inpatient costs (sum of lines	41 through 48.0	01)(see instruc	tions)		79,429	49.
.00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	atient routine	services (from	1 Wkst D Su	m of Parts T and	0	50.
	III)			, su		ļ	
.00	Pass through costs applicable to Program inp and IV)	atient ancillar	y services (fr	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		lated, non-phy	/sician anest	hetist, and	0	53.
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					
.00						0	54
.00	Target amount per discharge					0.00	
.01	Permanent adjustment amount per discharge	7				0.00	
	Adjustment amount per discharge (contractor Target amount (line 54 x sum of lines 55, 55					0.00	
	Difference between adjusted inpatient operat			line 56 minus	line 53)	0	
.00	Bonus payment (see instructions)	J	, <u>,</u>		,	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, or line 55 from prior year cost report, updated by the					0.00	60
.00	market basket)					0	
	55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)						
						0	
.00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST					0	63
.00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through Dece	ember 31 of the	e cost report	ing period (See	0	64
.00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	oer 31 of the o	cost reportin	g period (See	0	65
.00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 nlus line 6	55)(title XVT	II only): for	0	66
	CAH, see instructions						
.00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	December 31 o	of the cost r	eporting period	0	67
.00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after D	ecember 31 of	the cost rep	orting period	0	68.
.00	Total title V or XIX swing-bed NF inpatient					0	69
.00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil)	1	70
.00	Adjusted general inpatient routine service of			•	,		71
.00	Program routine service cost (line 9 x line	71)					72
.00	Medically necessary private room cost applic Total Program general inpatient routine serv						73
.00	Capital-related cost allocated to inpatient 26, line 45)				Part II, column		74
.00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76
.00	Program capital-related costs (line 9 x line	76)					77
	Inpatient routine service cost (line 74 minu		noviden	1-2			78
.00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp				nus line 79)		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 (Program inpatient ancillary services (see in		15)				83
.00	Utilization review - physician compensation		ons)				84
	Total Program inpatient operating costs (sum	of lines 83 th					86
00	PART IV - COMPUTATION OF OBSERVATION BED PAS					402	0.7
.00	Total observation bed days (see instructions		14			492 2,608.70	
.00	Adjusted general inpatient routine cost per	alem time // -	· line Z)			Z.000.70	

Health Financial Systems A	SCENSION ST. VI	NCENT JENNINGS		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period:	Worksheet D-1	
			-	From 07/01/2022 Fo 06/30/2023	Date/Time Pre 11/22/2023 2:	
		Titl	e XIX	Hospital	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observation	Bed Pass	
				Bed Cost (from		
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	143,705	2,600,875	0.05525	3 1,283,480	70,916	90.00
91.00 Nursing Program cost	0	2,600,875	0.00000	1,283,480	0	91.00
92.00 Allied health cost	0	2,600,875	0.00000	1,283,480	0	92.00
93.00 All other Medical Education	0	2,600,875	0.00000	1,283,480	0	93.00

Health Financial Systems ASC	ENSION ST. VINCENT JENNINGS		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN:15-1303	Period: From 07/01/2022	Worksheet D-3	
			то 06/30/2023	Date/Time Pre 11/22/2023 2:	
	Title	XVIII	Hospital	Cost	
Cost Center Description		Ratio of Cos	t Inpatient	Inpatient	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1			
30.00 03000 ADULTS & PEDIATRICS			307,065		30.00
ANCILLARY SERVICE COST CENTERS		1		1	
50.00 05000 OPERATING ROOM		0.21989		-	50.00
54.00 05400 RADIOLOGY - DIAGNOSTIC		0.11665			
60.00 06000 LABORATORY		0.10733	,	· · · ·	
65.00 06500 RESPIRATORY THERAPY		0.00235	,		65.00
66.00 06600 PHYSICAL THERAPY		0.39218	,	· · · ·	
67.00 06700 OCCUPATIONAL THERAPY		0.31571	,	523	
68.00 06800 SPEECH PATHOLOGY		0.00000		0	68.00
69.00 06900 ELECTROCARDIOLOGY		0.00000		0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.06058		1,666	
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS		0.23976	-	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0.30621	,	42,757	
76.00 03950 ADULT MENTAL HEALTH		0.50696	69 0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC		0.00000	-	0	88.00
91.00 09100 EMERGENCY		0.17974		0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1.56129	,	· · · ·	
200.00 Total (sum of lines 50 through 94 and 96	5		372,100		
201.00 Less PBP Clinic Laboratory Services-Prog	ram only charges (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)			372,100		202.00

Health Financial Systems ASCENSION ST. VINCE				eu of Form CMS-2	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1303	Period:	Worksheet D-3	6
	Component	CCN: 15-Z303	From 07/01/2022 To 06/30/2023		naradi
	Component	CCN. 13-2303	то 06/30/2023	11/22/2023 2:	
	Title	e XVIII	Swing Beds - SNF		<u>or p</u>
Cost Center Description		Ratio of Cos		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					30.00
ANCILLARY SERVICE COST CENTERS			_		
50.00 05000 OPERATING ROOM		0.21989		0	
54.00 05400 RADIOLOGY - DIAGNOSTIC		0.11665	,		
60.00 06000 LABORATORY		0.10733	.,		
65.00 06500 RESPIRATORY THERAPY		0.00235	5 1,696	4	
66.00 06600 PHYSICAL THERAPY		0.39218	15,704	6,159	66.00
67.00 06700 OCCUPATIONAL THERAPY		0.31571	.0 2,664	841	67.00
68.00 06800 SPEECH PATHOLOGY		0.00000	0 0	0	68.00
69.00 06900 ELECTROCARDIOLOGY		0.00000		0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.06058	9,177	556	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS		0.23976	64 0	0	1.2.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0.30621	.7 14,661	4,489	73.00
76.00 03950 ADULT MENTAL HEALTH		0.50696	69 0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC		0.00000		0	00.00
91.00 09100 EMERGENCY		0.17974	9 0	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1.56129		,	
200.00 Total (sum of lines 50 through 94 and 96 through 98)			60,115		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)			60,115		202.00

Health F	inancial Systems ASCENSION S	T. VINCENT JENNINGS	5	In Lie	u of Form CMS-2	2552-10
INPATIEN	NT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1303	Period: From 07/01/2022		
				то 06/30/2023	Date/Time Pre 11/22/2023 2:	
		Tit	le XIX	Hospital	Cost	
	Cost Center Description		Ratio of Cos	t Inpatient	Inpatient	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1.00	2.00	3.00	
	NPATIENT ROUTINE SERVICE COST CENTERS		1			
	3000 ADULTS & PEDIATRICS			77,311		30.00
	NCILLARY SERVICE COST CENTERS		1	1	-	
	5000 OPERATING ROOM		0.2198		-	
	5400 RADIOLOGY - DIAGNOSTIC		0.1166	, .		
	6000 LABORATORY		0.1073		· · · ·	
	6500 RESPIRATORY THERAPY		0.0023		0	
	6600 PHYSICAL THERAPY		0.3921		0	66.00
	6700 OCCUPATIONAL THERAPY		0.3157		0	67.00
	6800 SPEECH PATHOLOGY		0.0000		0	68.00
69.00 0	6900 ELECTROCARDIOLOGY		0.0000		0	69.00
71.00 0	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.0605	30 2,289	139	71.00
72.00 0	7200 IMPLANTABLE DEVICES CHARGED TO PATIENTS		0.2397	54 0	0	72.00
73.00 0	7300 DRUGS CHARGED TO PATIENTS		0.3062	L7 21,349	6,537	
76.00 0	3950 ADULT MENTAL HEALTH		0.5069	59 0	0	76.00
	UTPATIENT SERVICE COST CENTERS					
	8800 RURAL HEALTH CLINIC		0.0000		0	
	9100 EMERGENCY		0.1797			91.00
	9200 OBSERVATION BEDS (NON-DISTINCT PART)		1.5612	95 10,494	16,384	92.00
200.00	Total (sum of lines 50 through 94 and 96 through			147,095	37,690	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)			147,095		202.00

CUL	TION OF REIMBURSEMENT SETTLEMENT	rovider CCN: 15-1303	Period: From 07/01/2022 To 06/30/2023		
		Title XVIII	Hospital	11/22/2023 2:0 Cost	07 pn
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
5	Medical and other services (see instructions)			2,295,573	
	Medical and other services reimbursed under OPPS (see instruction	ns)		0	1
	OPPS or REH payments Outlier payment (see instructions)			0	-
1	Outlier reconciliation amount (see instructions)			0	
0	Enter the hospital specific payment to cost ratio (see instructio	ons)		0.000	
))	Line 2 times line 5 Sum of lines 3, 4, and 4.01, divided by line 6			0 0.00	-
5 5	Transitional corridor payment (see instructions)			0.00	
	Ancillary service other pass through costs from Wkst. D, Pt. IV,	col. 13, line 200		0	-
	Organ acquisitions			2 205 572	10
	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES			2,295,573	11
	Reasonable charges				
	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line	(0)		0	
	Total reasonable charges (sum of lines 12 and 13)	(9)		0	-
ĺ	Customary charges				
	Aggregate amount actually collected from patients liable for pays			0	
00	Amounts that would have been realized from patients liable for pa had such payment been made in accordance with 42 CFR §413.13(e)	ayment for services of	on a chargebasis	0	16
	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	
	Total customary charges (see instructions)	if line to the line	11) ()	0	
00	Excess of customary charges over reasonable cost (complete only instructions)	if line 18 exceeds li	ne 11) (see	0	19
00	Excess of reasonable cost over customary charges (complete only	if line 11 exceeds li	ne 18) (see	0	20
~	instructions)			2 210 520	21
	Lesser of cost or charges (see instructions) Interns and residents (see instructions)			2,318,529 0	
	Cost of physicians' services in a teaching hospital (see instruc	tions)		0	1
	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			0	24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance amounts (for CAH, see instructions)			21,687	25
	Deductibles and Coinsurance amounts relating to amount on line 24	4 (for CAH, see instr	uctions)	1,516,087	
00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plu	s the sum of lines 22	and 23] (see	780,755	27
00	instructions) Direct graduate medical education payments (from Wkst. E-4, line	50)		0	28
	REH facility payment amount			-	28
	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
	Subtotal (sum of lines 27, 28, 28.50 and 29) Primary payer payments			780,755 853	
	Subtotal (line 30 minus line 31)			779,902	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES))		0	33
	Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions)			723,399	
	Adjusted reimbursable bad debts (see instructions)			470,209	
	Allowable bad debts for dual eligible beneficiaries (see instruc Subtotal (see instructions)	tions)		643,868	
	MSP-LCC reconciliation amount from PS&R			1,250,111	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
	Pioneer ACO demonstration payment adjustment (see instructions)				39
	N95 respirator payment adjustment amount (see instructions) Demonstration payment adjustment amount before sequestration			0	
	Partial or full credits received from manufacturers for replaced	devices (see instruc	tions)	0	
	RECOVERY OF ACCELERATED DEPRECIATION			0	
	Subtotal (see instructions) Sequestration adjustment (see instructions)			1,250,111 25,002	
	Demonstration payment adjustment amount after sequestration			23,002	
03	Sequestration adjustment-PARHM pass-throughs				40
	Interim payments			1,723,647	
	Interim payments-PARHM Tentative settlement (for contractors use only)			0	41
	Tentative settlement-PARHM (for contractor use only)			0	42
	Balance due provider/program (see instructions)			-498,538	
	Balance due provider/program-PARHM (see instructions) Protested amounts (nonallowable cost report items) in accordance	with CMS Pub 15-2	chapter 1	25,000	43
<i>u u u</i>	§115.2	with the run. 15-2,	chapter 1,	23,000] **
	TO BE COMPLETED BY CONTRACTOR				
					1 00
00	Original outlier amount (see instructions)			0	
00	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0 0 0.00	91

Health Financial Systems	ASCENSION ST. VINCENT JENNINGS	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1303	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

NALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED				Period: Worksheet E From 07/01/2022 Part I To 06/30/2023 Date/Time Print 11/22/2023 2		pared
		Title		Hospital	Cost	
		Inpatient	: Part A	Ра	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		540,1	27	1,723,647	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,			0	0	2.0
00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment					3.0
	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	ADJUSTMENTS TO PROVIDER			0	0	3.
02				0	0	3.
03 04				0	0	3.
04				0	0	3
05	Provider to Program			0	0	5.
50	ADJUSTMENTS TO PROGRAM			0	0	3
1				0	0	3
52				0	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)		540.1	0	0	3
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		540,1	27	1,723,647	4
	TO BE COMPLETED BY CONTRACTOR					
00	List separately each tentative settlement payment after					5
	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
01	Program to Provider TENTATIVE TO PROVIDER			0	0	5
)2	TENTALIVE TO PROVIDER			0	0	5
03				0	Ő	5
	Provider to Program			· · · · · · · · · · · · · · · · · · ·		
50	TENTATIVE TO PROGRAM			0	0	5
51				0	0	5
52 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5 5
0	5.50-5.98)			0	0	6
)1	Determined net settlement amount (balance due) based on the cost report. (1) SETTLEMENT TO PROVIDER			0	0	6
)2	SETTLEMENT TO PROVIDER		30,9	93	498,538	6
00	Total Medicare program liability (see instructions)		509,1		1,225,109	7
			,	Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	

VALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CC Component C	CN: 15-1303	Period: From 07/01/2022 To 06/30/2022		pared
		Title	XVIII	Swing Beds - SN	IF Cost	
		Inpatien	t Part A	Pa	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		176,9		0	1.0
00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	0	2.0
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.
	Program to Provider					
01	ADJUSTMENTS TO PROVIDER			0	0	
02 03				0	0	-
03				0	0	-
05				0	0	-
	Provider to Program				1	
50	ADJUSTMENTS TO PROGRAM			0	0	
51				0	0	
52				0	0	
53 54				0	0	
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	-
	3.50-3.98)					
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as		176,9	12	0	4
	appropriate) TO BE COMPLETED BY CONTRACTOR					
00	List separately each tentative settlement payment after					5
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider			-		
)1)2	TENTATIVE TO PROVIDER			0	0	
)2				0	0	
	Provider to Program			-		1 1
50	TENTATIVE TO PROGRAM			0	0	-
51				0	0	
52				0	0	-
)9)0	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	
	Determined net settlement amount (balance due) based on the cost report. (1)					6
)1	SETTLEMENT TO PROVIDER		~~ .	0	0	
)2	SETTLEMENT TO PROGRAM		22,4		0	-
00	Total Medicare program liability (see instructions)		154,4	Contractor	0 NPR Date	7
)	Number 1.00	(Mo/Day/Yr) 2.00	
00	Name of Contractor	(1.00	2.00	8.

Health Financial Systems ASCENSION ST. VINCENT JENNINGS IN L	ieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-1303 Period:	Worksheet E-1
From 07/01/20. To 06/30/20.	
	11/22/2023 2:07 pm
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 14	1.00
2.00 Medicare days (see instructions)	2.00
3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	3.00
4.00 Total inpatient days (see instructions)	4.00
5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200	5.00
6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20	6.00
7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt.	I 7.00
line 168	
8.00 Calculation of the HIT incentive payment (see instructions)	8.00
9.00 Sequestration adjustment amount (see instructions)	9.00
10.00 Calculation of the HIT incentive payment after sequestration (see instructions)	10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH	
30.00 Initial/interim HIT payment adjustment (see instructions)	30.00
31.00 Other Adjustment (specify)	31.00
32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	32.00

ATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS Provider CCN: 15-1303	Period:	worksheet E-2	
Component CCN: 15-Z303		Date/Time Pre 11/22/2023 2:	
Title XVIII			
COMDITATION OF NET COST OF COVERED SERVICES	1.00	2.00	
	142 279	0	1
	112,275		2
	15,287	0	3
Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, se	e		
instructions)			
			3
		0.00	4
	54	0	5
		0	
Utilization review - physician compensation - SNF optional method only	0	,	7
Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	157,566	0	8
Primary payer payments (see instructions)	0	0	
	157,566		
	0	0	11
	157 566	0	12
	137,300		
for hysician professional services	0		1 13
		0	14
	157,566	0	15
OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16
Pioneer ACO demonstration payment adjustment (see instructions)			16
	0		16
			10
	0		
	0		
	0	0	
	157.566		
Sequestration adjustment (see instructions)			
Demonstration payment adjustment amount after sequestration)	0	0	19
Sequestration adjustment-PARHM pass-throughs			19
	0	0	
	176,912	0	
			20
	0	0	21
	-22 /07	0	
	-22,457		22
	. 0	0	
chapter 1, §115.2			
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
			200
			-
	2 I		201
	-		201
	ine		202
200 (title XVIII swing-bed SNF))			
			203
Medicare swing-bed SNF discharges (see instructions)			204
	ent 5-year demons	cration	
			205
			206
		1	1
			207
Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines	5 1		208
and 3)			
			209
Reserved for future use Comparision of PPS versus Cost Reimbursement			210
COMPARIESTOR OF PPS VERSUS COST REIMOURSEMENT			1
	Component CCN: 15-2303 Title XVIII COMPUTATION OF NET COST OF COVERED SERVICES Inpatient routine services - swing bed-SNF (see instructions) Inpatient routine services - swing bed-SNF (see instructions) Ancillary services (from wkst. D-2, col. 3, line 200, for Part A, and sum of wkst. I Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, se instructions) Nursing and allied health payment-PARHM (see instructions) Per diem cost for interns and residents not in approved teaching program (see instructions) Program days Interns and residents not in approved teaching program (see instructions) Interns and residents not in approved teaching program (see instructions) Interns and residents not in approved teaching program (see instructions) Interns and residents not in approved teaching program (see instructions) Subtotal (sum of lines 1 through 3 plus lines 6 and 7) Primary payer payments (see instructions) Subtotal (sum of program patients (exclude amounts applicable to physician professional services) Subtotal (see instructions) OTHER ADUSTMENTS (SEE INTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions) Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions) Sequestration apyment adjustment amount before sequestration Allowable bad debts (see instructions) Sequestration digustment see instructions) Sequestration digustment (see instructions) Sequestration digustment (see instructions) Sequestration digustment (see instructions) Sequestration digustment (see instructions) Sequestration for non-claims based amounts (see instructions) Interim payments -PARMM Tentative settlement -FARMM (for contractor use only) Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21) Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21) Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21) Balance due pr	Component CON: 15-2303 From 07/01/2023 Title XVIII Swing Beds - Swing Ded-SW (See instructions) 1.00 COMPUTATION OF NET COST OF COVERED SERVICES 142.279 Inpatient routine services - swing bed-SW (See instructions) 142.279 Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Anrsing and alled health payment-PARUM (See instructions) 142.279 Ancillary services (from wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Program days 152.867 Instructions) Second Table (See instructions) 142.795 Instructions) Second Table (See instructions) 157.566 Program days Second Table (See instructions) 157.566 Subtotal (Sum of lines 1 through 3 plus lines 6 and 7) 157.566 Primary payer second	Component CON: 15-233 From 67/102021 bit for 06/30/2031 From 77/102021 bit for 06/30/2031 From 77/102021 bit for 06/30/2031 Title XVIII Swing Beds - SW Cost Cost

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	INCENT JENNINGS Provider CCN: 15-1303	Period:	Worksheet E-3	
			From 07/01/2022 To 06/30/2023		
			Uncrital	11/22/2023 2:0	07
		Title XVIII	Hospital	Cost	
				1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDIC	ARE PART A SERVICES - COST	REIMBURSEMENT		
.00	Inpatient services			564,213] 1
.00	Nursing and Allied Health Managed Care payment (see instru	ictions)		0	2
.00	Organ acquisition			0	3
.01	Cellular therapy acquisition cost (see instructions)			0	3
.00	Subtotal (sum of lines 1 through 3.01)			564,213	4
.00	Primary payer payments			0	5
.00	Total cost (line 4 less line 5). For CAH (see instructions	;)		569,855	6
	COMPUTATION OF LESSER OF COST OR CHARGES				-
.00	Reasonable charges 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
1.00	Aggregate amount actually collected from patients liable f	or payment for services on	a charge basis	0	İ 11
2.00	Amounts that would have been realized from patients liable			0	12
	had such payment been made in accordance with 42 CFR 413.1		5		
3.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.00000	13
4.00	Total customary charges (see instructions)			0	14
5.00	Excess of customary charges over reasonable cost (complete	e only if line 14 exceeds l	ine 6) (see	0	15
	instructions)				
6.00	Excess of reasonable cost over customary charges (complete	e only if line 6 exceeds li	ne 14) (see	0	16
7 00	instructions)			0	17
7.00	Cost of physicians' services in a teaching hospital (see i	nstructions)		0	17
8.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Direct graduate medical education payments (from Worksheet	E-1 line 19)		0	18
9.00	Cost of covered services (sum of lines 6, 17 and 18)			569,855	
0.00	Deductibles (exclude professional component)			69,256	
1.00	Excess reasonable cost (from line 16)			0	21
2.00	Subtotal (line 19 minus line 20 and 21)			500,599	
3.00	Coinsurance			0	23
4.00	Subtotal (line 22 minus line 23)			500,599	24
5.00	Allowable bad debts (exclude bad debts for professional se	ervices) (see instructions)		29,115	25
6.00	Adjusted reimbursable bad debts (see instructions)			18,925	26
7.00	Allowable bad debts for dual eligible beneficiaries (see i	nstructions)		25,988	27
8.00	Subtotal (sum of lines 24 and 25, or line 26)			519,524	
9.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	29
9.50	Pioneer ACO demonstration payment adjustment (see instruct	cions)		0	29
9.98	Recovery of accelerated depreciation.			0	29
9.99	Demonstration payment adjustment amount before sequestrati	on		0	29
	Subtotal (see instructions)			519,524	
0.01	Sequestration adjustment (see instructions)	_		10,390	
	Demonstration payment adjustment amount after sequestratio	on		0	1 2 2
0.03	Sequestration adjustment-PARHM			E40 137	30
1.00	Interim payments Interim payments-PARHM			540,127	31
1.01 2.00	Tentative settlement (for contractor use only)			0	31 32
				0	32
3.00	Balance due provider/program (line 30 minus lines 30.01, 3	(0, 0, 2, 3, 1) and $(3, 2)$		-30,993	
3.00	Balance due provider/program-PARHM (lines 2, 3, 18, and 26		and 32.01)	- 50, 595	33
4.00	Protested amounts (nonallowable cost report items) in acco			25,000	
	§115.2			23,000	

	Financial Systems ASCENSION ST. VI E SHEET (If you are nonproprietary and do not maintain	Provider C		Period:	u of Form CMS-2 Worksheet G	
[:] und-1 only)	ype accounting records, complete the General Fund column			rom 07/01/2022 o 06/30/2023	Date/Time Pre	pare
, iiiy)					11/22/2023 2:	
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
~ ~	CURRENT ASSETS	202 726				
00	Cash on hand in banks	293,736		-	0	1
.00	Temporary investments Notes receivable	0		-	0	2.
.00	Accounts receivable	6,483,120		0	0	4
.00	Other receivable	755,003			0	5
.00	Allowances for uncollectible notes and accounts receivable	-5,277,980			0	6
.00	Inventory	196,831) Ö	0	7
.00	Prepaid expenses	0		0	0	8
.00	Other current assets	344,845	(0 0	0	9
0.00	Due from other funds	0	(0 0	0	10
1.00	Total current assets (sum of lines 1-10)	2,795,555	(0 0	0	11
	FIXED ASSETS					
2.00	Land	127,944	(0 0	0	
3.00	Land improvements	702,434		-	0	
4.00	Accumulated depreciation	-505,713		-	0	14
	Buildings	15,507,815	1	-	0	15
6.00	Accumulated depreciation	-8,896,906	(0 0	0	16
	Leasehold improvements	0		0	0	17
	Accumulated depreciation	1 100 701		-	0	18
	Fixed equipment	1,180,701		-	0	19
	Accumulated depreciation Automobiles and trucks	-983,580		-	0	20
1.00	Accumulated depreciation	0		° °	0	21
	Major movable equipment	5,282,040		-	0	23
	Accumulated depreciation	-3,834,214		-	0	24
5.00		238,086		-	0	25
	Accumulated depreciation	-203,086		-	0	26
	HIT designated Assets	205,000		-	Ő	27
	Accumulated depreciation	0		-	0	28
	Minor equipment-nondepreciable	0		0	0	29
	Total fixed assets (sum of lines 12-29)	8,615,521		-	0	30
	OTHER ASSETS					
1.00	Investments	0	() 0	0	31
2.00	Deposits on leases	0	(0 0	0	32
3.00	Due from owners/officers	0	(0 0	0	33
4.00	Other assets	827	(0 0	0	34
5.00	Total other assets (sum of lines 31-34)	827		0 0	0	35
6.00		11,411,903	(0 0	0	36
	CURRENT LIABILITIES					4
	Accounts payable	330,833		-	0	37
	Salaries, wages, and fees payable	80,824	1	-	0	
9.00		5,397		-	0	
	Notes and loans payable (short term)	152,522	1		0	1
	Deferred income	0	(0 0	0	
2.00	Accelerated payments	0			0	42
4.00	Due to other funds Other current liabilities	2 062 126		-	0	
	Total current liabilities (sum of lines 37 thru 44)	3,963,136 4,532,712		-	0	
5.00	LONG TERM LIABILITIES	+, 332,712		0	0	1 7 7
6.00		0	(0 0	0	46
7.00	Notes payable	0		-	0	1
	Unsecured loans	0		-	Ő	
	Other long term liabilities	9,174,282	(0	0	
	Total long term liabilities (sum of lines 46 thru 49)	9,174,282		0	0	50
1.00	Total liabilities (sum of lines 45 and 50)	13,706,994		0 0	0	51
	CAPITAL ACCOUNTS					
2.00	General fund balance	-2,295,091				52
	Specific purpose fund		0			53
	Donor created - endowment fund balance - restricted			0		54
5.00				0		55
	Governing body created - endowment fund balance			0		56
7.00	Plant fund balance - invested in plant				0	
8.00	Plant fund balance - reserve for plant improvement,				0	58
	replacement, and expansion	2 205 255			-	
9.00	Total fund balances (sum of lines 52 thru 58) Total liabilities and fund balances (sum of lines 51 and	-2,295,091 11,411,903		0	0	
0.00						1 60

	· · · · · · · · · · · · · · · · · · ·	SCENSION ST. VIN				eu of Form CMS-2	
STATEM	ENT OF CHANGES IN FUND BALANCES		Provider CC	CN: 15-1303	Period: From 07/01/2022 To 06/30/2023		pared:
		General	Fund	Special	Purpose Fund	Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period	1.00	-3,656,354		4.00		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		6,449,737				2.00
3.00	Total (sum of line 1 and line 2)		2,793,383		0		3.00
4.00	Additions (credit adjustments) (specify)	0			0	0	4.00
5.00	Intercompany Transfers	-6,029,152			0	0	5.00
6.00	Contributions/Donations/Grant Revenue	449,139			0	0	6.00
7.00		0			0	0	7.00
8.00	Other	716,637			0	0	8.00
9.00	Rounding	0			0	0	9.00
10.00	Total additions (sum of line 4-9)		-4,863,376		0		10.00
11.00	Subtotal (line 3 plus line 10)		-2,069,993		0		11.00
12.00	Transfer to/from Affiliates	4,018			0	0	12.00
13.00		0			0	0	13.00
14.00		0			0	0	14.00
15.00		0			0	0	15.00
16.00	Released Capital	221,078			0	0	16.00
17.00	ROUNDING	2	225 000		0	0	17.00
18.00 19.00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance		225,098 -2,295,091		0		18.00 19.00
19.00	sheet (line 11 minus line 18)		-2,295,091		0		19.00
		Endowment Fund	Plant	Fund		1	
			7.00	0.00			
1.00	Fund balances at beginning of period	6.00	7.00	8.00	0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)	0			0		2.00
3.00	Total (sum of line 1 and line 2)	0			0		3.00
4.00	Additions (credit adjustments) (specify)		0		0		4.00
5.00	Intercompany Transfers		0				5.00
6.00	Contributions/Donations/Grant Revenue		0				6.00
7.00			0				7.00
8.00	Other		0				8.00
9.00	Rounding		0				9.00
10.00	Total additions (sum of line 4-9)	0			0		10.00
11.00	Subtotal (line 3 plus line 10)	0			0		11.00
12.00	Transfer to/from Affiliates		0				12.00
			0				13.00
13.00			0				14.00
14.00			0				
14.00 15.00			0				15.00
14.00 15.00 16.00	Released Capital		0				16.00
14.00 15.00 16.00 17.00	ROUNDING		0 0 0				16.00 17.00
14.00 15.00 16.00		0	0 0 0		0		16.00

STATE	MENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider CC	CN: 15-1303	Period: From 07/01/2022 To 06/30/2023		pared
	Cost Center Description		Inpatient	Outpatient	Total	
			1.00	2.00	3.00	
	PART I - PATIENT REVENUES					
	General Inpatient Routine Services					
1.00	Hospital		2,349,6	76	2,349,676	1.0
2.00	SUBPROVIDER - IPF					2.0
3.00	SUBPROVIDER - IRF					3.0
4.00	SUBPROVIDER					4.0
5.00	Swing bed - SNF			0	0	5.0
6.00	Swing bed - NF			0	0	6.0
7.00	SKILLED NURSING FACILITY					7.0
8.00	NURSING FACILITY					8.0
9.00	OTHER LONG TERM CARE					9.0
10.00			2,349,6	76	2,349,676	10.0
	Intensive Care Type Inpatient Hospital Services					
11.00						11.0
12.00						12.0
L3.00						13.0
14.00						14.0
L5.00						15.0
L6.00		lines		0	0	16.0
	11-15)	、 、	2 240 6	7.6	2 240 676	17 0
17.00)	2,349,6		2,349,676	
18.00			1,110,0			
19.00			233,8			19.0
	RURAL HEALTH CLINIC			0 0		20.0
21.00				0 0	0	22.0
22.00						22.0
24.00						24.0
25.00						25.0
26.00						26.0
27.00				0 0	0	27.0
28.00		to wkst	3,693,6	07 80,927,936	, v	
20.00	G-3, line 1)	co wkst.	5,055,0	00,527,550	04,021,949	20.0
	PART II - OPERATING EXPENSES					1
29.00				18,318,890		29.0
30.00				0		30.0
31.00				0		31.0
32.00				0		32.0
33.00				0		33.0
34.00				0		34.0
35.00				0		35.0
36.00	Total additions (sum of lines 30-35)			0		36.0
37.00				0		37.0
38.00				0		38.0
39.00				0		39.0
40.00				Ő		40.0
41.00				Ő		41.0
42.00	Total deductions (sum of lines 37-41)			0		42.0
43.00		2)(transfer		18,318,890		43.0
	to Wkst. G-3, line 4)			, ,		

Health	lealth Financial Systems ASCENSION ST. VINCENT JENNINGS In Lieu				
STATE	IENT OF REVENUES AND EXPENSES	Provider CCN: 15-1303	Period:	Worksheet G-3	
			From 07/01/2022		
			то 06/30/2023	Date/Time Prep 11/22/2023 2:0	
				11/22/2023 2.0	or piii
				1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, lin	e 28)		84,621,543	1.00
2.00	Less contractual allowances and discounts on patients' accoun	ts		59,390,585	2.00
3.00	Net patient revenues (line 1 minus line 2)			25,230,958	
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		18,318,890	
5.00	Net income from service to patients (line 3 minus line 4)			6,912,068	5.00
	OTHER INCOME				
6.00	Contributions, donations, bequests, etc			-3,783	
7.00	Income from investments			-716,637	
8.00	Revenues from telephone and other miscellaneous communication	services		0	
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				0	13.00
14.00	Revenue from meals sold to employees and guests			54,929	
15.00	Revenue from rental of living quarters			0	15.00
16.00	Revenue from sale of medical and surgical supplies to other t	han patients		0	16.00
17.00	Revenue from sale of drugs to other than patients			9,117	17.00
18.00	Revenue from sale of medical records and abstracts			0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
21.00	Rental of vending machines			0	
22.00	Rental of hospital space			131,820	
23.00	Governmental appropriations			0	23.00
24.00	Other Operating Income			43,303	
24.01	Other Dietary			382	
24.50	COVID-19 PHE Funding			18,538	
25.00	Total other income (sum of lines 6-24)			-462,331	
26.00	Total (line 5 plus line 25)			6,449,737	
	OTHER EXPENSES (SPECIFY)			0	
28.00				0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)		I	6,449,737	29.00