| Health Financial Systems | ASCENSI ON ST. | VINCENT | JENNI NGS | Inlie | u of Form CMS-2552-10 | | | | |
|--|--|------------------------|----------------------------------|---|--|--|--|--|--|
| | law (42 USC 1395g; 42 CFR 413.20(b) | | | | | | | | |
| | inning of the cost reporting period | | | | OMB NO. 0938-0050 EXPIRES 03-31-2022 | | | | |
| HOSPITAL AND HOSPITAL HEALTH AND SETTLEMENT SUMMARY | H CARE COMPLEX COST REPORT CERTIFIC | ATION Pro | ovider CCN: 15-1303 | Period: From 07/01/2021 To 06/30/2022 | Worksheet S Parts I-III Date/Time Prepared: 11/28/2022 12:17 pm | | | | |
| PART I - COST REPORT STATUS | | | | | | | | | |
| | ronically prepared cost report | | | Date: 11/28/20 | D22 Time: 12:17 pm | | | | |
| | lly prepared cost report | | | | | | | | |
| 3.[0] fth 4.[F]Medic | is is an amended report enter the r are Utilization. Enter "F" for full | number of or "L" fo | times the provider re or low. | esubmitted this co | ost report | | | | |
| | Report Status 6. Date Received: | | | PR Date: | | | | | |
| use only (1) As Subi | mitted | port for th | nis Provider CCN 12 [| Contractor's Vendo | r Code: 4 | | | | |
| | d with Audit 9. [N] Final Repor | t for this | s Provider CCN | number of tim | es reopened = 0-9. | | | | |
| (4) Reopen | | | | | | | | | |
| (5) Amende | | | | | | | | | |
| | - | | | | | | | | |
| | A CHIEF FINANCIAL OFFICER OR ADMINI | | | | | | | | |
| | ICATION OF ANY INFORMATION CONTAINE | | | | | | | | |
| | AND/OR I MPRI SONMENT UNDER FEDERAL | | | | | | | | |
| | H THE PAYMENT DIRECTLY OR INDIRECTL S AND/OR IMPRISONMENT MAY RESULT. | Y OF A KIC | KBACK OR WERE UTHERW | ISE ILLEGAL, CRIM | IINAL, CIVIL AND | | | | |
| | | | | | | | | | |
| CERTIFICATION BY CH | IEF FINANCIAL OFFICER OR ADMINISTRA | TOR OF PRO | OVI DER(S) | | | | | | |
| I HEREBY CERTIFY th | at I have read the above certificat | ion stater | nent and that I have | examined the acco | ompanyi ng | | | | |
| electronically file | d or manually submitted cost report | and submi | tted cost report and | I the Balance Shee | et and | | | | |
| | e and Expenses prepared by ASCENSIC | | | | | | | | |
| | /01/2021 and ending 06/30/2022 and | | | | | | | | |
| | correct, complete and prepared fro | | | | | | | | |
| | 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 | | | | | | | | |
| | nce with such laws and regulations. | | ervices identified in | this cost report | were | | | | |
| | nce with such laws and regulations. | | | | | | | | |
| SIGNATURE OF CHIEF FIN | IANCIAL OFFICER OR ADMINISTRATOR | CHECKBOX | | ELECTRONI C | | | | | |
| | 1 | 2 | SI GN | ATURE STATEMENT | | | | | |
| 1 | | | I have read and agre | | | | | | |
| | hris Hons | Y | statement. I certify | | | | | | |
| | | | | | | | | | |

| | | | signature on this certification be the legally binding equivalent of my original signature. | |
|---|------------------------|------------------------|--|---|
| 2 | Signatory Printed Name | Chris Hons | | 2 |
| 3 | Signatory Title | VP OF FINANCE | | 3 |
| 4 | Date | 11/28/2022 12:17:04 PM | | 4 |
| | | | | |

| | | | Title | XVIII | | | |
|--------|-------------------------------|---------|----------|-----------|------|-----------|--------|
| | Cost Center Description | 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 | Hospi tal | 0 | -25, 279 | -282, 263 | 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 | 2, 615 | 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 | -22, 664 | -282, 263 | 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 valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 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.

| SPI | TAL AND HOSPITAL HEALTH CARE COMPLEX | DENIIFICATION DATA | | ler CCN: 1 | | Period: From 07/01/ To 06/30/ | 2021 2022 | Workshe Part I Date/Ti <u>11/28/2</u> | me Pre | pared |
|----------------|--|---|--|---|-------------|-------------------------------------|--------------|--|--------|---|
| | 1.00 | 2.00 | | 3.00 | | L | 4.00 | | | |
| 00 | Hospital and Hospital Health Care Co Street: 301 HENRY STREET | PO Box: | - | | | | | | | 1 |
| 00 00 | City: NORTH VERNON | State: IN | Zin Cod | e: 47265 | Count | y: JENNINGS | | | | 1. |
| 00 | orty. North VERNON | Component Name | CCN | CBSA | Provi der | | Pavme | nt Syst | em (P. | 2. |
| | | | Number | Number | Туре | Certified | | 0, or | | |
| | | | | | | | V | XVIII | XIX | |
| | | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | 6.00 | 7.00 | 8.00 | |
| ~~ | Hospital and Hospital-Based Componen | | 454000 | 00045 | | 07/04/400/ | N | 0 | 0 | |
| 00 | Hospi tal | ASCENSION ST. VINCENT JENNINGS | 151303 | 99915 | 1 | 07/01/1996 | Ν | 0 | 0 | 3. |
| 00 | Subprovider - IPF | SENNINGS | | | | | | | | 4. |
| 00 | Subprovider - IRF | | | | | | | | | 5. |
| 00 | Subprovider - (Other) | | | | | | | | | 6. |
| 00 | Swing Beds - SNF | ASCENSION ST. VINCENT | 15Z303 | 99915 | | 07/05/1991 | Ν | 0 | N | 7. |
| | | JENNINGS SWING | | | | | | | | |
| 00 | Swing Beds - NF | | | | | | | | | 8. |
| 00 . 00 | Hospi tal -Based SNF Hospi tal -Based NF | | | | | | | | | 9. |
| 00 | Hospital - Based OLTC | | | | | | | | | 111. |
| 00 | Hospi tal -Based HHA | | | | | | | | | 12 |
| 00 | Separately Certified ASC | | | | | | | | | 13. |
| 00 | Hospi tal -Based Hospi ce | | | | | | | | 1 | 14. |
| 00 | Hospital-Based Health Clinic - RHC | | | | | | | | | 15 |
| 00 | Hospital-Based Health Clinic - FQHC | | | | | | | | | 16 |
| 00 | Hospital-Based (CMHC) I | | | | | | | | | 17 |
| 00 | Renal Dialysis | | | | | | | | | 18 |
| 00 | Other | | | | | From: | | To | | 19 |
| | | | | | | 1.00 | | 2. (| | 1 |
| 00 | Cost Reporting Period (mm/dd/yyyy) | | | | | 07/01/20 | 021 | 06/30 | | 20. |
| 00 | Type of Control (see instructions) | | | | | 1 | | | | 21 |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | 1.00 | 2.00 | | 3. (| 00 | |
| | Inpatient PPS Information | | | | | | | 3. (| 00 | |
| 00 | Does this facility qualify and is it | currently receiving pa | /ments for | - | 1.00 N | 2.00 N | | 3. (| 00 | 22 |
| 00 | Does this facility qualify and is it disproportionate share hospital adju | stment, in accordance wi | th 42 CFI | 2 | | | | 3. (| 00 | 22 |
| 00 | Does this facility qualify and is it disproportionate share hospital adju §412.106? In column 1, enter "Y" fo | stment, in accordance wi r yes or "N" for no. Is | th 42 CFI this | 2 | | | | 3. (| 00 | 22 |
| 00 | Does this facility qualify and is it disproportionate share hospital adju | stment, in accordance wi r yes or "N" for no. Is 412.106(c)(2)(Pickle ame | th 42 CFI this | - | | | | 3. (| 00 | 22 |
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| HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA | TA I | Provider CC | CN: 15-1303 | Period: From 07/01 To 06/30 | 1/2021 1/2022 | Vorkshe Part I Date/Ti 11/28/2 | me Pre | |
| | In-State Medicaid paid days | In-State Medicaid eligible unpaid days | Out-of State Medi cai d pai d days | Out-of State Medicaid eligible unpaid | Medicai HMO day | d 0 s Mec c | ther li cai d lays | _ |
| 24.00 If this provider is an IPPS hospital, enter the | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | 0 | <u>). 00</u> C | 24.00 |
| in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5. | 0 | 0 | | 0 | | 0 | | 25. 00 |
| | | | | Urban/Ru 1.0 | | 2. 0 | | - |
| 26.00 Enter your standard geographic classification (not wa | | at the beg | jinning of t | | 2 | | | 26.00 |
| cost reporting period. Enter "1" for urban or "2" for 27.00 Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifi 25.00 If this is a cale community hereit (SCI) | age) status ~ "2" for r cation in d | ural. If ap column 2. | pplicable, | | 2 | | | 27.00 |
| 35.00 If this is a sole community hospital (SCH), enter the effect in the cost reporting period. | e number of | periods su | H Status Ir | | 0 | | | 35.00 |
| | | | | Begi nn 1. 0 | | Endi 2. (| | _ |
| 36.00 Enter applicable beginning and ending dates of SCH st | | cript line | 36 for numb | | | 2.0 | | 36.00 |
| of periods in excess of one and enter subsequent date 37.00 If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period. | | r of perioc | is MDH statu | IS | 0 | | | 37.00 |
| 37.01 Is this hospital a former MDH that is eligible for th accordance with FY 2016 OPPS final rule? Enter "Y" fo instructions) | | | | | | | | 37.01 |
| 38.00 If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates. | | | | | | | | 38.00 |
| | | | | Y/M 1.0 | | Y/ 2.0 | | - |
| 39.00 Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet t accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions) |), (İi), or the mileage i)? Enter | (iii)? Ent requiremer in column 2 | ter in colum nts in 2 "Y" for ye | me N in ?S | | N | | 39.00 |
| 40.00 Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1. | per 1. Ente | r "Y" for y | | | | N | | 40.00 |
| | | | | | V 1.00 | XVIII 2.00 | XI X 3.00 | - |
| Prospective Payment System (PPS)-Capital 45.00 Does this facility qualify and receive Capital paymer | t for diam | conorti onst | o sharo in | accordance | N | | N | 45.00 |
| with 42 CFR Section §412.320? (see instructions) 46.00 Is this facility eligible for additional payment exce | eption for | extraordi na | ary circumst | ances | N | N N | N | 45.00 |
| pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III. | t. L, Pt. I | II and Wkst | . L-1, Pt. | I through | | | | |
| 47.00 Is this a new hospital under 42 CFR §412.300(b) PPS of 48.00 Is the facility electing full federal capital payment | | | | | N N | N N | N N | 47.00 48.00 |
| 56.00 Is this a hospital involved in training residents in "N" for no in column 1. For column 2, if the response was involved in training residents in approved GME pr | "N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? | | | | | | | |
| 57.00 If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y "N", complete Wkst. D, Parts III & IV and D-2, Pt. II | period duri ryes or "N th of this (", complete | " for no ir cost report e Worksheet | n column 1. ing period? | If column 1 P Enter "Y" | | | | 57.00 |
| 58.00 If line 56 is yes, did this facility elect cost reimb | oursement f | or physicia | ans' service | es as | N | | | 58.00 |
| defined in CMS Pub. 15-1, chapter 21, §2148? If yes, 59.00 Are costs claimed on line 100 of Worksheet A? If yes | | | Pt. I. | | N | | | 59.00 |

| Image: The construction of the second seco | | Financial Systems ASCENSION AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA | | NCENT JENNINGS Provider C | CN: 15-1303 P | Period: | Worksheet S-2 | |
|---|-------|---|---|--|--------------------|--------------------------------|----------------------------------|--------|
| Nummer Nummer Program Nummer Program Desc. Thrus 35.00 Are you claiming purshing and allied health education (Nulls) costs for any programs that meet the criteria under 42 CR 413.85? (see the "Y", ure you impacted by GR 1164.10 routsoppoint CD Well MA payment and usteement? Enter 'Y', for yes or "W" for no in column 2. N N N 3.00 10.00 1.00 2.00 3.00 4.00 0.00 5.00 11.00 1.00 2.00 3.00 4.00 0.00 <t< td=""><td></td><td></td><td></td><td></td><td></td><td>rom 07/01/2021 o 06/30/2022</td><td>Date/Time Pre</td><td></td></t<> | | | | | | rom 07/01/2021 o 06/30/2022 | Date/Time Pre | |
| V/N Line # Obal IF call 0.00 Are you claiming oursing and allied health inducation (MMP) costs for any programs, that ment the criteria under 42 CR 413.85° (See Instructions). Enter 'V' for yes or 'N' for no in cours. If focum 1 1.00 2.00 3.00 1.00 Y/N Line # Direct OME N | | | | | NAHE 413.85 | Worksheet A | 11/28/2022 12 Pass-Through | :17 pr |
| 0.00 Are you claiming nursing and allied health education (NAME) costs for any programs that meet the oriter is under 42 CPR 4185 7 (see instructions). Enter "Y" for yes or "K" for no in column 1. If column | | | | | | | Qualification Criterion Code | |
| any programs: that neet the criteria under 42 CR 413.657 (see Instructions). Enter "V" for vision of "V" for not in cuium 1. If column 1 is "V", are you impacted by CR 11642 (ar subsequent CR) MME MA payment nd untermited intermited by CR 11642 (ar subsequent CR) MME MA payment nd untermited intermited by CR 11642 (ar subsequent CR) MME MA payment nd untermited intermited by CR 11642 (ar subsequent CR) MME MA payment nd untermited intermited by CR 11642 (ar subsequent CR) MME MA payment nd untermited intermited by CR 11642 (ar subsequent CR) MME MA payment nd untermited intermited by CR 11642 (ar subsequent CR) MME MA payment nd untermited into the hospital is a sost record cost reports ending and subal tick before Narch 23, 2010. (see instructions) N 0 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 1.01 Enter the average number of unweighted primary care FTEs from the hospital is 3 most record to stoppath is and primary care FTE count for primary care painfor general surgery residents, which is used for instructions). See instructions) N N 0 0.00 0.00 0.00 1.02 Enter the amute of unweighted primary care painfor general surgery residents, which is used for instructions). See instructions) Program Name Program Code Unweighted IME FTE counts (are information stoppath is an on one intervior surgery allopath card/or general surgery FTE counts (line in 0.00 fine the amute of FTE is in 1 in column 3, the is used for primary care and/or general surgery residents (line in 0.00 fine the amute of FTE is in 1 in column 4, the direct CME instructions). Enter in column 3, the is used in column 4, the onerestoppet subsect to the column 4, the direct | | | | | 1.00 | 2.00 | 3.00 | - |
| Y/N INE Direct GNE IME Direct GNE IME Direct GNE 1.00 2.00 3.00 4.000 5.000 0.00 <td></td> <td>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</td> <td>85? (s umn 1. CR) NAHE</td> <td>see If column 1</td> <td>N</td> <td></td> <td></td> <td>60. (</td> | | 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 | 85? (s umn 1. CR) NAHE | see If column 1 | N | | | 60. (|
| 1.00 Did your hospital receive FIE slots under ACA section S503 Enter ''' For yos or 'N' for no in column. 1. (see instructions) 0.00 0.00 1.01 Ditter the average number of unweighted primary care FIE's from the bospital's 3 most recent cost reports mading and ead must be average number of unweighted primary care FIE's added under section 5503 of ACA. (see instructions) 0.00 0.00 1.02 Enter the average number of unweighted primary care fifts added under section 5503 of ACA. (see instructions) 0.00 0.00 1.03 Enter the number of unweighted primary care fifts and/or general surgery FIE's in the current veel of the primary care or general surgery. FIE's in the current veel fifts of the current veel's primary care and/or general surgery. (see instructions). 0.00 2.00 3.00 1.05 Enter the author of unweighted primary care/or surgery fifts and the current veel's primary care or general surgery. (see instructions). Program Name Program Code Inweighted IME Difference between the baseline primary care of fifts and/or fifts that are nonprimary care of adver general surgery. (see instructions) is the trip of the fifts in line 61.05, specify each new program to a surgery. The count of the program code. Ther in column 3, the program name. Enter in column 2, the program code. Enter in column 3, the NE FIE unweighted count. Enter in column 4, the direct GUE FIE's in the subtro of FIE residents that your hospital trained in this cost reporting period for which the direct GUE FIE residents that your hospital train of in this cost reporting period for which fies in the oroutin 4, the direct GUE FIE residents that you | | adjustement? Enter Y for yes or N for no in colu | | IME | Direct GME | IME | Direct GME | |
| section 5503 ² Enter 'Y' for yes or 'N' for no in column 1, 6se instructions) inter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see Instructions) inter the average number of unweighted primary care ending and submitted before March 23, 2010. (see Instructions) inter the average number of unweighted primary care end primary care FTEs from 2014 unweighted primary care and/or general surgery residents, which is used for determining compliance with the 755 test. (see instructions) inter the average from 2016 test is the set of the primary care fTEs from 2016 test is the set of the primary care fTEs the set in the transport of the test is the primary care and/or general surgery FTEs and the current year's primary care and/or general surgery FTE submit are nonprimary and/or general surgery FTEs that are nonprimary used for cap relief and/or FTE from 516 (see instructions) Program Name Program Code Unweighted ML Unweighted Count. 1.00 Of the FTEs in line 61.05, specify each new program special ty, if any, and the number of FTE residents for each new program. Gese instructions) into column 1, the program name. Enter in column 2, the program code. Enter in column 3, the HE FTE unweighted count. Enter in column 4, the direct GBE unweighted GBE FTE unweighted count in the program name. Enter in column 2, the program code. Enter in column 4, the direct GBE FTE unweighted count in the scot reporting period for which your hospital received MESA DEE for more of HESA PRE for goram. Gese instructions) 1.00 AcA Provisions Affecting the Mealth Resou | | | | 2.00 | 3.00 | | | |
| 1.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see Instructions) Image: Section 2010 (see Instructions) 1.02 Enter the current year total unweighted primary care and primary care fTEs double and subject yEs, and primary care fTEs count for primary care instructions) Image: Section 2010 (see Instructions) 1.03 Enter the base line FC count for primary care and/or general surgery residents, which is used for determining compliance with the 7% test. (see Instructions) Image: Section 2010 (see Instructions) Image: Section 2010 (see Instructions) 1.04 Enter the amount of ALG \$5503 aver determining compliance \$45503 aver springery allogathic and/or estepathic fTEs in the 0. Enter the amount of ALG \$5503 aver springery care and/or general surgery if E counts (line of 0.0 min us line of 0.3). (see Instructions) Program Name Program Code Unweighted IME (see Count 1.00 2.00 3.00 4.00 1.10 Of the FTEs in line 61.05, specify each new program special ty, 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 GUE FTE unweighted count. Enter in column 4, the direct GUE Tre unweighted count. Enter in column 4, the direct GME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Enter | | section 5503? Enter "Y" for yes or "N" for no in | N | | | 0.00 | 0.00 | 61.0 |
| 1.02 Enter the current year total unweighted primary care FFE count (excluding QBC/W), general surgery FFEs, and primary care FFEs added under section 5503 of ACA). (see instructions) 1.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75s test. (see instructions) Image: Compliance with test. (see instructions) Image: Compliance with the 75s test. (see instructions) Image: Compliance with test. (see instructions) Image: Com | | 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 | | | | | | 61. (|
| 1.03 Exter the base line FTE count for primary care and/or general surgery residents, which is sued for determining compliance with the 75% test. (see instructions). Instructions) Instructions) 1.04 Enter the number of unweighted primary care/or surgery allogabtic and/or general surgery FTEs in the current cost reporting period (see instructions). Instructions) Instructions) 1.05 Enter the amount of Ack 5503 anard that is being used for cap relief and/or TTEs that are nonprimary care and/or general surgery. (see instructions) Program Name Program Code Unweighted HIE Unweighte | | 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 | | | | | | 61. (|
| 1.04 Enter the number of uneeighted primary care/or surgery allopathic cand/or ostropathic FTEs in the current cost reporting period. (see instructions). Image: Content of the current of the current year's primary care and/or general surgery FTEs and the current year's primary care and/or general surgery (see instructions) Image: Content of the current year's primary care and/or general surgery (see instructions) 0.6 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care and/or general surgery. (see instructions) Program Name Program Code Unweighted IME Unweighted IME Count of the Count of the current year's primary care or general surgery. (see instructions) 1.00 ft for each new program, (see instructions) Program Name Program Code Unweighted IME Unweighted IME Count of the Count of the current year's primary care and/or general surgery. (see instructions) Image: Count of the current year's primary care and/or general surgery. (see instructions) Program Name Program Code Unweighted IME Unweighted IME Unweighted IME Unweighted IME Count of the Current is column 2, the program name. Enter in column 3, the IME FTE Image: Count 1, the program name. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Enter in column 4, the direct GME FTE unwe | | Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see | | | | | | 61. (|
| current cost reporting period. (see instructions). Image: Construction of the baseline primary primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) Image: Construction of Constructi | | Enter the number of unweighted primary care/or | | | | | | 61.0 |
| 1.06 Enter the anount of ACA §5503 award that is being used for cap relief and/or FIEs that are nonprimary care or general surgery. (see instructions) Program Name Program Code Unweighted IME Unweight | | current cost reporting period. (see instructions). Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line | | | | | | 61. |
| Image: Construction of the State o | | Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary | | | | | | 61. |
| 1.10 Of the FTEs in line 61.05, specify each new program special ty, if any, and the number of FTE residents in column 1, the program name. Enter in column 2, the program code. Enter in column 4, the direct GME FTE unweighted count. 0.00 0 1.20 Of the FTEs in line 61.05, specify each expanded program special ty, if any, and the number of FTE residents for each expanded program special ty, if any, and the number of FTE residents for each expanded program code. Enter in column 1, the program name. 0.00 0 20 Of the HTEs in line 61.05, specify each expanded program special ty, if any, and the number of FTE residents that user in column 4, the direct GME FTE unweighted count. 0.00 0 20 Of the IME FTE unweighted count. 1.00 ACA Provisions Affecting the Heal th Resources and Services Administration (HRSA) 1.00 2.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions) 1.00 2.01 Enter the number of FTE residents in nonprovider Settings 1.00 3.00 Has your facility trained residents in nonprovider Settings 0.00 0.00 3.00 Has your facility trained residents in nonprovider Settings. 0.00 0.00 0.00 <td></td> <td></td> <td>Pro</td> <td>ogram Name</td> <td>Program Code</td> <td></td> <td>Direct GME FTE</td> <td></td> | | | Pro | ogram Name | Program Code | | Direct GME FTE | |
| special ty, 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. Enter in column 4, the direct GME instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 4, the direct GME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Enter in column 4, it column 5, the IME FTE unweighted count. Enter in column 4, graduated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA PCRE funding (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings 3.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions) Section 5504 of the ACA Base Year FTE Residents in Nonprovider SettingsThis base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. 4.00 Enter in column 1, iff line 63 is yes, or your facility trained residents [0.00] 0.00[0.000] | | | | 1.00 | 2.00 | | | |
| ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 2.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions) Cost in the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions) Cost in the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions) Cost in the number of FTE residents in nonprovider Settings 3.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter N N "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions) Ratio (col. (col. 1 + column 1) Section 5504 of the ACA Base Year FTE Residents in Nonprovider SettingsThis base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. 0.00 0.00 0.00 | 1. 20 | 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 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, | | | | | | 61. |
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| 2.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions) 0 | | ACA Provisions Affecting the Health Decourses and Cor | | Administration | (HDSA) | | 1.00 | |
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| Teaching Hospitals that Claim Residents in Nonprovider Settings 8.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions) Unweighted Unweighted FTEs FTEs in Nonprovider FTEs FTEs in Nonprovider Hospital 2) Site 1.00 2.00 Section 5504 of the ACA Base Year FTE Residents in Nonprovider SettingsThis base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. 0.00 0.00 0.00 | 2. 01 | Enter the number of FTE residents that rotated from a | Teachi | | | your hospital | 0.00 | 62. |
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| H. 00 Enter in column 1, if line 63 is yes, or your facility trained residents 0.00 0.00 0.000 | | | | | | | | |
| resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio | . 00 | Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted non resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted | y trair -primar all nor non-pr | ned residents ry care nprovider rimary care | 0.00 | 0. 00 | 0. 000000 | 64. |

| SPITAL AND HOSPITAL HEALTH CARE COMPL | EX IDENTIFICATION DA | TA Provider (| | riod: om 07/01/2021 | Worksheet S-2 Part I | |
|---|---|---|--|-----------------------------------|---|---------|
| | | | Tc | | | |
| | Program Name | Program Code | Unweighted | Unweighted | Ratio (col. 3/ | |
| | Ŭ | | FTĔs | FTEsin | (col. 3 + col. | |
| | | | Nonprovider Site | Hospi tal | 4)) | |
| | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | - |
| .00 Enter in column 1, if line 63 | | 2100 | 0.00 | 0.00 | | 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 FTEs Nonprovider | Unweighted FTEs in Hospital | Ratio (col. 1/ (col. 1 + col. 2)) | |
| | | | Si te | | | |
| Section 5504 of the ACA Current | Voor ETE Posidonts i | n Nonnrovidor Sottin | 1.00 | 2.00 | 3.00 | |
| beginning on or after July 1, 20 | | n Nonprovider Settin | gsEffective fo | | ing perious | |
| FTEs attributable to rotations of Enter in column 2 the number of t FTEs that trained in your hospita (column 1 divided by (column 1 + | unweighted non-primar al. Enter in column 3 | ry care resident 3 the ratio of | Unweighted FTEs Nonprovider Site | Unweighted FTEs in Hospital | Ratio (col. 3/ (col. 3 + col. 4)) | |
| - | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | - |
| .00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 3 divided by (column 3 + column 4)). (see instructions) | | | 0.00 | 0.00 | 0. 000000 |) 67. C |
| | | | | 1.00 | 0 2.00 3.00 | |
| Inpatient Psychiatric Facility P | | PF), or does it con | tain an IPF subp | rovider? N | | 70. (|
| .00 s this facility an Inpatient Ps | | | ing program in t | he most | 0 | 71. (|
| .00 Is this facility an Inpatient Psy Enter "Y" for yes or "N" for no. .00 If line 70 is yes: Column 1: Did recent cost report filed on or be 42 CFR 412.424(d)(1)(iii)(c)) Col program in accordance with 42 CFI Column 3: If column 2 is Y, india (see instructions) | efore November 15, 20 Lumn 2: Did this faci R 412.424 (d)(1)(iii) | DO4? Enter "Y" for lity train residents)(D)? Enter "Y" for | s in a new teach yes or "N" for n | i ng p. | | |
| Enter "Y" for yes or "N" for no. .00 If line 70 is yes: Column 1: Did recent cost report filed on or be 42 CFR 412.424(d)(1)(iii)(c)) Col program in accordance with 42 CFI Column 3: If column 2 is Y, indic | efore November 15, 20 Jumn 2: Did this faci R 412.424 (d)(1)(iii) cate which program ye y PPS | 004? Enter "Y" for y lity train residents (D)? Enter "Y" for y ear began during this | s in a new teach yes or "N" for n s cost reporting | i ng p. | | 75.0 |

| Health Financial Systems ASCENSION ST. V | NCENT JENNINGS | 5 | In Lie | u of Form CMS- | 2552-10 | |
|--|---|-------------------------|---|---|------------------|--|
| HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider C | CN: 15-1303 | Period: From 07/01/2021 To 06/30/2022 | Worksheet S-2 Part I Date/Time Pre 11/28/2022 12 | epared: | |
| | | I | | 1.00 | | |
| Long Term Care Hospital PPS 80.00 Is this a long term care hospital (LTCH)? Enter "Y" for ye 81.00 Is this a LTCH co-located within another hospital for part "Y" for yes and "N" for no. | | | g period? Enter | N N | 80. 00 81. 00 | |
| TEFRA Providers85.00Is this a new hospital under 42 CFR Section §413.40(f)(1)(i)86.00Did this facility establish a new Other subprovider (exclude) | | | | N | 85.00 86.00 | |
| §413. 40(f)(1)(ii)? Enter "Y" for yes and "N" for no. 87. 00 Is this hospital an extended neoplastic disease care hospital 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. | al classified | under section | | N | 87.00 | |
| | | | V 1.00 | XI X 2.00 | - | |
| Title V and XIX Services 90.00 Does this facility have title V and/or XIX inpatient hospi | al services? E | nter "Y" for | N | Y | 90.00 | |
| yes or "N" for no in the applicable column. 91.00 Is this hospital reimbursed for title V and/or XIX through full or in part? Enter "Y" for yes or "N" for no in the app | N | N | 91.00 | | | |
| 92.00 Are title XIX NF patients occupying title XVIII SNF beds (instructions) Enter "Y" for yes or "N" for no in the applic | lual certificat | | | Ν | 92.00 | |
| 93.00 Does this facility operate an ICF/IID facility for purposes "Y" for yes or "N" for no in the applicable column. | | d XIX? Enter | N | N | 93.00 | |
| 94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, applicable column. | | | N | N | 94.00 | |
| 95.00 If line 94 is "Y", enter the reduction percentage in the applicable column. 96.00 Does title V or XIX reduce operating cost? Enter "Y" for year applicable column. | | | 0. 00 N | 0.00 N | 95.00 96.00 | |
| 97.00 If line 96 is "Y", enter the reduction percentage in the ap 98.00 Does title V or XIX follow Medicare (title XVIII) for the is stepdown adjustments on Wkst. B, Pt. 1, col. 25? Enter "Y" | 7.00 If line 96 is "Y", enter the reduction percentage in the applicable column. 8.00 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. 98.01 Does title V or XIX follow Medicare (title XVIII) for the r C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for | | | | Y | 98. 01 | |
| title XIX. 98.02 Does title V or XIX follow Medicare (title XVIII) for the obed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes | | | Ν | Y | 98. 02 | |
| 98.03 Does title V, and in column 2 for title XIX. 98.03 Does title V or XIX follow Medicare (title XVIII) for a cri reimbursed 101% of inpatient services cost? Enter "Y" for y | | | N 1 | Ν | 98.03 | |
| for title V, and in column 2 for title XIX. 98.04 Does title V or XIX follow Medicare (title XVIII) for a CAI outpatient services cost? Enter "Y" for yes or "N" for no in the content of the title XVIII for a CAI outpatient services cost? | | | Ν | Ν | 98.04 | |
| <pre>in column 2 for title XIX. 98.05 Does title V or XIX follow Medicare (title XVIII) and add H Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in</pre> | | | | Y | 98.05 | |
| column 2 for title XIX. 98.06 Does title V or XIX follow Medicare (title XVIII) when cost Pts. I through IV? Enter "Y" for yes or "N" for no in colum column 2 for title XIX. | | | N | Y | 98.06 | |
| Rural Providers 105.00Does this hospital qualify as a CAH? | | | Y | | 105.00 | |
| 106.00 If this facility qualifies as a CAH, has it elected the all for outpatient services? (see instructions) 107.00 Column 1: If line 105 is Y, is this facility eligible for o | | | t N N | | 106.00 107.00 | |
| training programs? Enter "Y" for yes or "N" for no in colur Column 2: If column 1 is Y and line 70 or line 75 is Y, do approved medical education program in the CAH's excluded I Enter "Y" for yes or "N" for no in column 2. (see instruct | nn 1. (see ins you train I&R PF and/or IRF | structions) As in an | | | | |
| 108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no. | | edul e? See 42 | Ν | | 108.00 | |
| | Physi cal 1.00 | Occupationa 2.00 | I Speech 3.00 | Respi ratory 4.00 | - | |
| 109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy. | | N | N | N | 109.00 | |
| | | | | 1.00 | _ | |
| 110.00 Did this hospital participate in the Rural Community Hospi Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable. | "Y" for yes or | "N" for no. | lf yes, | N | 110.00 | |

| SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provid | ler CCN: 15-1303 | Peri od: | Worksheet S- | 2 |
|--|---|----------------------------------|--------------|----------------------|
| | | From 07/01/2021 To 06/30/2022 | | |
| | | | 1172072022 | |
| I.00 If this facility qualifies as a CAH, did it participate in the Fronti Health Integration Project (FCHIP) demonstration for this cost report "Y" for yes or "N" for no in column 1. If the response to column 1 is integration prong of the FCHIP demo in which this CAH is participatin Enter all that apply: "A" for Ambulance services; "B" for additional for tele-health services. | ting period? Enter s Y, enter the ng in column 2. | 1.00 N | 2.00 | 111. (|
| | 1.00 | 2.00 | 3.00 | _ |
| 2.00 Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", ent in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information | N | 2.00 | 0.00 | 112. (|
| 5.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for in column 1. If column 1 is yes, enter the method used (A, B, or E on in column 2. If column 2 is "E", enter in column 3 either "93" percen for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based the definition in CMS Pub. 15-1, chapter 22, §2208.1. | nl y) nt on | | | 0115. |
| 5.00 s this facility classified as a referral center? Enter "Y" for yes o "N" for no. | or N | | | 116. |
| 7.001 this facility legally-required to carry malpractice insurance? Ent "Y" for yes or "N" for no. | ter Y | | | 117. |
| 3. 00 Is the malpractice insurance a claims-made or occurrence policy? Ente if the policy is claim-made. Enter 2 if the policy is occurrence. | er 1 | 2 | | 118. |
| in the portey is crann-made. Enter 2 in the portey is occurrence. | Premi ums | Losses | Insurance | |
| | | | | |
| | 1.00 | 2.00 | 3.00 | _ |
| 3.01 List amounts of malpractice premiums and paid losses: | 106, 9 | 965 | 0 | 0118. |
| | | 1.00 | 2.00 | _ |
| 3. 02 Are malpractice premiums and paid losses reported in a cost center ot Administrative and General? If yes, submit supporting schedule listi and amounts contained therein. 5. 00 DO NOT USE THIS LINE 5. 00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless \$3121 and applicable amendments? (see instructions) Enter in column 1 "N" for no. Is this a rural hospital with < 100 beds that qualifies f Hold Harmless provision in ACA \$3121 and applicable amendments? (see | ng cost centers s provision in ACA I, "Y" for yes or For the Outpatien | | N | 118. 119. 120. |
| Enter in column 2, "Y" for yes or "N" for no. 1.00Did this facility incur and report costs for high cost implantable de | evices charged to | Y | | 121. |
| patients? Enter "Y" for yes or "N" for no. 2.00Does the cost report contain healthcare related taxes as defined in § | \$1903(w)(3) of th | e Y | 5.00 | 122. |
| Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", the Worksheet A line number where these taxes are included. Transplant Center Information | | | | _ |
| 5.00 Does this facility operate a transplant center? Enter "Y" for yes and | d "N" for no. If | N | | 125. |
| yes, enter certification date(s) (mm/dd/yyyy) below. b.00 If this is a Medicare certified kidney transplant center, enter the c | certification dat | e | | 126 |
| in column 1 and termination date, if applicable, in column 2. 7.00 If this is a Medicare certified heart transplant center, enter the ce | ertification date | | | 127 |
| in column 1 and termination date, if applicable, in column 2. 3.00 If this is a Medicare certified liver transplant center, enter the ce | ertification date | | | 128. |
| in column 1 and termination date, if applicable, in column 2. 0.00 If this is a Medicare certified lung transplant center, enter the cer | tification date | in | | 129. |
| column 1 and termination date, if applicable, in column 2. 0.00 f this is a Medicare certified pancreas transplant center, enter the | e certification | | | 130. |
| date in column 1 and termination date, if applicable, in column 2. 0.00 If this is a Medicare certified intestinal transplant center, enter t | the certification | | | 131. |
| date in column 1 and termination date, if applicable, in column 2. | | | | 132. |
| 2.00 If this is a Medicare certified islet transplant center, enter the ce | | | | 133. |
| | nber in column 1 | | | 134. |

| IOSPITAL AND HOSPITAL HEALTH CARE COMPLE | | | ENT JENNINGS Provider CC | CN: 15-13C | | riod: om 07/01/20 | Worksheet S- | repared: |
|---|---|--|---|-----------------------------------|----------|---------------------------|--------------|--------------------|
| 1.00 | | 2.00 | | | | 3.00 | | |
| If this facility is part of a cha | | | | | he nam | e and addres | ss of the | |
| home office and enter the home of 41.00 Name: ASCENSION ST. VINCENT | Contractor name Contractor's Na | | tractor numbe | | coctor! | s Number: 08 | 9001 | 141.00 |
| 41. OUNTILE: ASCENSION ST. VINCENT 42. 00 Street: 250 WEST 96TH STREET, SUIT | | ame: wPS | | Cont | actor | S Number: 08 | 8001 | 141.00 |
| 43. 00 City: INDIANAPOLIS | State: | IN | | Zin | Code: | 4 | 6260 | 142.00 |
| | otato. | | | | Jouc. | | | 110.00 |
| | | | | | | | 1.00 | |
| 44.00 Are provider based physicians' cos | sts included in Works | sheet A? | | | | | Y | 144.00 |
| | | | | | | | | _ |
| | | | | | | 1.00 | 2.00 | |
| 45.00 If costs for renal services are clipatient services only? Enter "Y" no, does the dialysis facility imperiod? Enter "Y" for yes or "N" 46.00 Has the cost allocation methodologication methodologication and the cost allocation methodologication of the service and the cost allocation (methodologication) and the cost and the cost allocation (methodologication) and the cost /li> | ' for yes or "N" for clude Medicare utiliz for no in column 2. gy changed from the p n column 1. (See CMS | no in co zation fo previousl Pub. 15– | olumn 1. lf o or this cost y filed cost | column 1 reportin t report? | g | Ν | | 145. 00 146. 00 |
| yes, enter the approval date (mm/o | uu/yyyy) in corunn 2. | | | | | | | |
| | | | | | | | 1.00 | - |
| 47.00Was there a change in the statisti | cal basis? Enter "Y" | ' for yes | s or "N" for | no. | | | N 1.00 | 147.0 |
| 48.00 Was there a change in the order of | °allocation? Enter " | 'Y" for y | es or "N" fo | or no. | | | N | 148. 0 |
| 49.00 Was there a change to the simplifi | ed cost finding meth | nod? Ente | | | | | N | 149. 0 |
| | | | Part A | Part | | Title V | Title XIX | _ |
| | | | 1.00 | 2.0 | | 3.00 | 4.00 | |
| Does this facility contain a prov | | | | | | | | |
| or charges? Enter "Y" for yes or 55.00Hospital | N FOR NO FOR EACH C | componen | N | And Part | B. (5 | <u>ee 42 CFR 9</u> 4 N | 413.13) N | 155. 0 |
| 56.00 Subprovider - IPF | | | N | N | | N | N | 156.0 |
| 57.00Subprovider - IRF | | | Ν | N | | Ν | N | 157.0 |
| 58. 00 SUBPROVI DER | | | | | | | | 158. 0 |
| 59. 00 SNF | | | N | N | | N | N | 159. 0 |
| 60. 00 HOME HEALTH AGENCY | | | N | N | | N | N | 160. 0 |
| 61.00 CMHC | | | | N | | N | N | 161.0 |
| | | | | | | | 1.00 | - |
| Multicampus | | | | | | | | |
| 65.00 Is this hospital part of a Multica | ampus hospital that h | nas one o | or more campu | uses in d | i fferer | nt CBSAs? | N | 165. 0 |
| Enter "Y" for yes or "N" for no. | | _ | | | | | | _ |
| | Name | | County | State | | | | _ |
| 66.00 If line 165 is yes, for each | 0 | | 1.00 | 2.00 | 3.0 | 0 4.00 | | 00 166. 0 |
| 0. county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) | | | | | | | 0.1 | |
| | | | | | | | 1.00 | |
| Health Information Technology (HI | Γ) incentive in the A | Ameri can | Recovery and | d Reinves | tment | Act | | |
| 67.001s this provider a meaningful use 68.001f this provider is a CAH (line 10 reasonable cost incurred for the 1 | 05 is "Y") and is a m | neani ngfu | ul user (line | | | enter the | Y | 167. 0 168. 0 |
| 68.01 If this provider is a CAH and is i | not a meaningful user | r, does t | this provider | | | hardshi p | N | 168. 0 |
| exception under §413.70(a)(6)(ii) | | | | | | | | |
| 69.00 If this provider is a meaningful u | | ') and is | s not a CAH (| (line 105 | is "N' | '), enter th | ne 0. | 00169. 0 |
| transition factor. (see instruction | JIIS) | | | | | Begi nni ng | Endi ng | |
| | | | | | - | 1. 00 | 2.00 | - |
| 70.00 Enter in columns 1 and 2 the EHR I | beginning date and en | nding dat | te for the re | eporting | | 1.00 | 2.00 | 170. 0 |
| period respectively (mm/dd/yyyy) | | | | | | | | |
| | | | | | | | | |
| | | | | | ł | 1.00 | 2.00 | |

In Lieu of Form CMS-2552-10 Health Financial Systems ASCENSION ST. VINCENT JENNINGS HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 15-1303 Peri od. Worksheet S-2 From 07/01/2021 Part II 06/30/2022 Date/Time Prepared: То 11/28/2022 12:17 pm Y/N Date 1.00 2.00 General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Provider Organization and Operation 1.00 Has the provider changed ownership immediately prior to the beginning of the cost Ν 1.00 reporting period? If yes, enter the date of the change in column 2. (see instructions) V/I Y/N Date 1.00 2.00 3.00 Has the provider terminated participation in the Medicare Program? If 2.00 Ν 2 00 yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary. Is the provider involved in business transactions, including management 3.00 Ν 3.00 contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions) Y/N Date Туре 1.00 2.00 3.00 Financial Data and Reports Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, 4.00 Y А 4.00 or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions. 5.00 Are the cost report total expenses and total revenues different from Ν 5.00 those on the filed financial statements? If yes, submit reconciliation. Y/N Legal Oper 1.00 2.00 Approved Educational Activities Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider Ν 6.00 6.00 is the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see instructions. 7.00 Ν 7 00 8.00 Were nursing programs and/or allied health programs approved and/or renewed during the Ν 8.00 cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved graduate medical education 9 00 Ν 9.00 program in the current cost report? If yes, see instructions. Was an approved Intern and Resident GME program initiated or renewed in the current 10.00 Ν 10.00 cost reporting period? If yes, see instructions. 11.00 Are GME cost directly assigned to cost centers other than I & R in an Approved Ν 11.00 Teaching Program on Worksheet A? If yes, see instructions Y/N 1.00 Bad Debts 12.00 Is the provider seeking reimbursement for bad debts? If yes, see instructions. Y 12.00 13.00 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting Ν 13.00 period? If yes, submit copy. 14.00 If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions. Ν 14.00 Bed Complement 15.00 Did total beds available change from the prior cost reporting period? If yes, Υ 15.00 see instructions. Part B Part A Y/N Date Y/N Date 1.00 2.00 3.00 4.00 PS&R Data Was the cost report prepared using the PS&R Report only? 10/07/2022 10/07/2022 16.00 Υ γ 16.00 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) 17.00 Was the cost report prepared using the PS&R Report for Ν Ν 17.00 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) 18.00 If line 16 or 17 is yes, were adjustments made to PS&R Ν Ν 18.00 Report data for additional claims that have been billed but are not included on the PS&R Report used to file this

 cost report? If yes, see instructions.
 19.00 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.

Ν

19.00

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| Heal th | Financial Systems ASCENSION ST. V | TINCENT JENNING | S . | In Lie | u of Form CMS | -2552-10 | | |
|---------|--|-------------------|----------------|---|---|----------|--|--|
| HOSPI T | AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider (| CCN: 15-1303 | Period: From 07/01/2021 To 06/30/2022 | Worksheet S- Part II Date/Time Pr 11/28/2022 1 | repared: | | |
| | | Descr | ription | 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: | | | Ν | Ν | 20.00 | | |
| | | Y/N | Date | Y/N | Date | | | |
| | | 1.00 | 2.00 | 3.00 | 4.00 | | | |
| 21.00 | Was the cost report prepared only using the provider's records? If yes, see instructions. | N | | N | | 21.00 | | |
| | | -1 | - | | 1 00 | | | |
| | CONDUCTED BY COST DELNDUDGED AND TEEDA HOCDUTALC ONLY (EVO | | | | 1.00 | | | |
| | COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC Capital Related Cost | LEPT CHILDRENS | HUSPITALS) | | | _ | | |
| 22.00 | Have assets been relifed for Medicare purposes? If yes, se | o instructions | | | N | 22.00 | | |
| | | | | ng the east | | | | |
| 23.00 | Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions. | Ū | Ν | 23.00 | | | | |
| 24.00 | Were new leases and/or amendments to existing leases enter If yes, see instructions | orting period? | Y | 24.00 | | | | |
| 25.00 | Have there been new capitalized leases entered into during instructions. | g the cost repo | rting period? | lf yes, see | Ν | 25.00 | | |
| 26.00 | Were assets subject to Sec. 2314 of DEFRA acquired during t | the cost report | ing period? If | yes, see | Ν | 26.00 | | |
| 27.00 | instructions. Has the provider's capitalization policy changed during th | ne cost reporti | ng period?lf | yes, submit | Ν | 27.00 | | |
| | copy. Interest Expense | | 51 | J . | | _ | | |
| 28.00 | Were new loans, mortgage agreements or letters of credit e | entered into du | ring the cost | reporting | N | 28.00 | | |
| 29.00 | period? If yes, see instructions. Did the provider have a funded depreciation account and/or | serve Fund) | Ν | 29.00 | | | | |
| | treated as a funded depreciation account? If yes, see inst | | | | | | | |
| 30. 00 | Has existing debt been replaced prior to its scheduled mat instructions. | | Ν | 30.00 | | | | |
| 31.00 | Has debt been recalled before scheduled maturity without i instructions. | ssuance of new | debt? If yes, | see | Ν | 31.00 | | |
| | Purchased Services | | | | | | | |
| 32.00 | Have changes or new agreements occurred in patient care se | ervi ces furni sh | ed through con | tractual | Y | 32.00 | | |
| 33. 00 | arrangements with suppliers of services? If yes, see instr If line 32 is yes, were the requirements of Sec. 2135.2 ap | | ng to competit | ive bidding? If | Y | 33.00 | | |
| | no, see instructions. Provider-Based Physicians | · · | | | | _ | | |
| 34 00 | Are services furnished at the provider facility under an a | arrangement wit | h provider-bas | ed_physicians? | Y | 34.00 | | |
| | If yes, see instructions. | Ū. | | | | | | |
| 35.00 | If line 34 is yes, were there new agreements or amended exphysicians during the cost reporting period? If yes, see i | | nts with the p | | Y | 35.00 | | |
| | | | | Y/N | Date | | | |
| | | | | 1.00 | 2.00 | | | |
| | Home Office Costs | | | | | _ | | |
| | Were home office costs claimed on the cost report? | | | Y | | 36.00 | | |
| 37.00 | If line 36 is yes, has a home office cost statement been p If yes, see instructions. | prepared by the | home office? | Y | | 37.00 | | |
| 38.00 | If line 36 is yes, was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year er | ffice different | from that of | Ν | | 38.00 | | |
| 39.00 | If line 36 is yes, did the provider render services to oth | | | Ν | | 39.00 | | |
| 40.00 | see instructions. If line 36 is yes, did the provider render services to the | e home office? | lf yes, see | Ν | | 40.00 | | |
| | i nstructi ons. | | | | | | | |
| | | 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 | | |
| 12 00 | respectively. | ASCENSION | | | | 12 00 | | |
| 42.00 | Enter the employer/company name of the cost report preparer. | ASCENSI ON | | | | 42.00 | | |
| 43.00 | Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively. | N/A | | JI LL. HI LL1@ASCI | ENSI ON. ORG | 43.00 | | |
| | | | | i i | | | | |

| Heal th | Financial Systems ASC | ENSION ST. | VI NC | ENT JENNINGS | | In Lie | u of Form CMS-: | 2552-10 |
|---------|---|-------------|-------|---------------|--------|----------------------------------|-----------------|------------------|
| HOSPI T | AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUEST | FI ONNAI RE | | Provider CCN | | Period: | Worksheet S-2 | |
| | | | | | | From 07/01/2021 To 06/30/2022 | | pared: :17 pm |
| | | | | | | | | |
| | | | | 3.0 | 0 | | | |
| | Cost Report Preparer Contact Information | | | | | | | |
| 41.00 | Enter the first name, last name and the title/ | 'position | RE | IMBURSEMENT M | ANAGER | | | 41.00 |
| | held by the cost report preparer in columns 1, | 2, and 3, | | | | | | |
| | respecti vel y. | | | | | | | |
| 42.00 | Enter the employer/company name of the cost re | port | | | | | | 42.00 |
| | preparer. | | | | | | | |
| 43.00 | Enter the telephone number and email address o | of the cost | | | | | | 43.00 |
| | report preparer in columns 1 and 2, respective | el y. | | | | | | |

| | Financial Systems AS | SCENSION ST. VI AL DATA | Provider C | | Period: | u of Form CMS-2 Worksheet S-3 | |
|--|---|----------------------------|-------------|-----------------------|----------------------------------|--|---|
| 103111 | AL AND HOST THE HEALTH CARE COMPLEX STATISTIC. | | | SN. 13-1303 | From 07/01/2021 To 06/30/2022 | Part I Date/Time Pre 11/28/2022 12 | pared: |
| | | | | | | I/P Days / O/P Visits / Trips | |
| | Component | Worksheet A Line Number | No. of Beds | Bed Days Available | CAH Hours | Title V | |
| | | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| 1.00 | Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) | 30. 00 | 25 | 9, 1: | 25 15, 360. 00 | 0 | 1.00 |
| 3.00 4.00 5.00 6.00 7.00 | HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation | | 25 | 9, 1: | 25 15, 360. 00 | 0 | 3.00 4.00 5.00 6.00 7.00 |
| 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 | INTENSI VE CARE UNI T CORONARY CARE UNI T BURN INTENSI VE CARE UNI T SURGI CAL INTENSI VE CARE UNI T OTHER SPECI AL CARE (SPECI FY) NURSERY | | 23 | 2, 1. | 10, 500. 00 | 0 | 8.00 9.00 10.00 11.00 12.00 13.00 |
| 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00 23. 00 24. 00 | Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.) HOSPICE | | 25 | 9, 1: | 25 15, 360. 00 | 0 0 | 14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00 22.00 23.00 24.00 |
| 24.00 24.10 25.00 26.00 26.25 27.00 28.00 29.00 30.00 31.00 32.00 | HUSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) | 30. 00 88. 00 89. 00 | 25 0 | | 0 | 0 0 0 | 24.00 24.10 25.00 26.02 27.00 28.00 29.00 30.00 31.00 32.01 |
| 33. 00 33. 01 | LTCH non-covered days LTCH si te neutral days and discharges | | | | | | 33. 00 33. 01 |

| HOSPI 1 | AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC | AL DATA | Provider CC | | Period: From 07/01/2021 To 06/30/2022 | Worksheet S-3 Part I Date/Time Pre 11/28/2022 12 | pared: |
|---|--|---------------|--------------|-----------------------|---|---|---|
| | | I/P Days | / O/P Visits | / Trips | Full Time E | Equi val ents | |
| | Component | Title XVIII | Title XIX | Total All Patients | Total Interns & Residents | Employees On Payroll | |
| | | 6.00 | 7.00 | 8.00 | 9.00 | 10.00 | |
| 1.00 | Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) | 305 | 11 | 64 | 10 | | 1.00 |
| 2.00 3.00 | HMO and other (see instructions) HMO IPF Subprovider | 170 0 | 43 0 | | | | 2.00 3.00 |
| 4.00 5.00 | HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF | 0 7 | 0 0 | | 39 | - | 4.00 |
| 6.00 | Hospital Adults & Peds. Swing Bed NF | | 0 | | 0 | | 6.00 |
| 7.00 | Total Adults and Peds. (exclude observation beds) (see instructions) | 312 | 11 | 67 | '9 | | 7.00 |
| 8.00 9.00 10.00 11.00 12.00 | INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) | | | | | | 8.00 9.00 10.00 11.00 12.00 |
| 13.00 14.00 15.00 16.00 17.00 | NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF | 312 6, 415 | 11 1, 056 | | | 52. 51 | 13.00 14.00 15.00 16.00 17.00 |
| 18.00 19.00 20.00 21.00 22.00 | SUBPROVI DER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY | | | | | | 18.00 19.00 20.00 21.00 22.00 |
| 23.00 24.00 24.10 25.00 | AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC | | | | 0 | | 23.00 24.00 24.10 25.00 |
| 26.00 26.25 27.00 | RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) | 0 0 | 0 0 | | 0 0.00 0 0.00 0.00 | | 26. 25 27. 00 |
| 28.00 29.00 30.00 31.00 | Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF | 0 | 0 | | 0 | | 28.00 29.00 30.00 31.00 |
| 32. 00 32. 01 | Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) | 0 | 0 | | 0 | | 32. 00 32. 01 |
| 33. 00 33. 01 | LTCH non-covered days LTCH site neutral days and discharges | 0 0 | | | | | 33. 00 33. 01 |

| HOSPI 1 | AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC | AL DATA | Provider CO | CN: 15-1303 | Period: From 07/01/2021 To 06/30/2022 | Worksheet S-3 Part I Date/Time Pre 11/28/2022 12 | pared: |
|---|--|--------------------------------------|-------------|-------------|---|---|--|
| | | Full Time Equivalents | | Di s | charges | | |
| | Component | Nonpai d | Title V | Title XVIII | Title XIX | Total All | |
| | | Workers | | 10.00 | 44.00 | Patients | |
| 1 00 | | 11.00 | 12.00 | 13.00 | 14.00 | 15.00 | 1.00 |
| 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 20.00 21.00 22.00 23.00 24.00 24.00 24.00 25.00 26.00 26.00 28.00 29.00 30.00 31.00 | Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSI VE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IPF SUBPROVIDER - IPF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF | 0.00 0.00 0.00 0.00 0.00 | 0 | | 99 9 57 14 0 0 99 9 | 209 | 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 11.00 13.00 14.00 15.00 14.00 15.00 14.00 20.00 21.00 22.00 23.00 24.10 25.00 26.00 24.00 25.00 26.00 27.00 28.00 20.00 21.00 20.00 20.00 21.00 20.0 |
| 32. 00 32. 01 33. 00 | Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days LTCH site neutral days and discharges | | | | 0 | | 31. 0 32. 0 32. 0 33. 0 33. 0 |

| Heal th | Financial Systems ASCENSION ST. VINCE | NT JENNINGS | | In Li€ | eu of Form CMS-2 | 2552-10 | | |
|----------------|--|--------------|---------------|--|---|---------|--|--|
| | AL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CC | CN: 15-1303 | Peri od: | Worksheet S-1 | | | |
| | | | | From 07/01/2021 | | | | |
| | | | | To 06/30/2022 | | | | |
| | | | | | 11/28/2022 12 | :17 pm | | |
| | | | | | 1.00 | | | |
| | Uncompensated and indigent care cost computation | | | | 1.00 | | | |
| 1.00 | Cost to charge ratio (Worksheet C, Part I line 202 column 3 di | vided by li | ne 202 column | 8) | 0. 243965 | 1 1.00 | | |
| | Medicaid (see instructions for each line) | | | | | | | |
| 2.00 | Net revenue from Medicaid | | | | 6, 660, 781 | 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 supplemen | tal payments | s from Medica | i d? | Y | 4.00 | | |
| 5.00 | If line 4 is no, then enter DSH and/or supplemental payments f | rom Medicai | d | | 0 | 5.00 | | |
| 6.00 | Medi cai d charges | | | | 25, 877, 750 | 6.00 | | |
| 7.00 | Medicaid cost (line 1 times line 6) | | | | 6, 313, 265 | 7.00 | | |
| 8.00 | Difference between net revenue and costs for Medicaid program | (line 7 min | us sum of lin | es 2 and 5; if | 0 | 8.00 | | |
| | < zero then enter zero) | | | | | | | |
| | Children's Health Insurance Program (CHIP) (see instructions for | or each line | e) | | 1 | | | |
| 9.00 | Net revenue from stand-alone CHIP | | | | 0 | | | |
| 10.00 | Stand-alone CHIP charges | | | | 0 | 10.00 | | |
| 11.00 | Stand-alone CHIP cost (line 1 times line 10) | | | | 0 | | | |
| 12.00 | Difference between net revenue and costs for stand-alone CHIP | (line 11 mi | nus line 9; i | f < zero then | 0 | 12.00 | | |
| | enter zero) | | | | | | | |
| 12 00 | Other state or local government indigent care program (see ins | | | <u>`````````````````````````````````````</u> | 0 | 12.00 | | |
| 13.00 | Net revenue from state or local indigent care program (Not inc | | | | 0 | | | |
| 14.00 | Charges for patients covered under state or local indigent car | e program (i | Not included | in lines 6 or | 0 | 14.00 | | |
| 15 00 | 10) State on least indigent care program cost (line 1 times line 1 | | | | 0 | 15.00 | | |
| 15.00 16.00 | State or local indigent care program cost (line 1 times line 1 Difference between net revenue and costs for state or local in | | nrogrom (lin | o 1E minuo lino | | | | |
| 10.00 | 13; if < zero then enter zero) | urgent care | program (TT | | 0 | 10.00 | | |
| | Grants, donations and total unreimbursed cost for Medicaid, CH | IP and state | e/local india | ent care progra | IL SEE | | | |
| | instructions for each line) | | erroeur rhurg | cht cure progra | 13 (300 | | | |
| 17.00 | Private grants, donations, or endowment income restricted to f | unding char | itv care | | 0 | 17.00 | | |
| 18,00 | Government grants, appropriations or transfers for support of | | | | 0 | • | | |
| 19.00 | Total unreimbursed cost for Medicaid, CHIP and state and loca | l indigent | care programs | (sum of lines | 0 | 19.00 | | |
| | 8, 12 and 16) | | | - | | | | |
| | | | Uni nsured | Insured | Total (col. 1 | | | |
| | | | patients | patients | + col. 2) | | | |
| | | | 1.00 | 2.00 | 3.00 | | | |
| 20.00 | Uncompensated Care (see instructions for each line) | | 1 100 10 | 4 (05 5(2 | 1 000 /07 | 20.00 | | |
| 20.00 | Charity care charges and uninsured discounts for the entire fa | CITITY | 1, 128, 12 | 695, 563 | 1, 823, 687 | 20.00 | | |
| 21.00 | (see instructions) Cost of patients approved for charity care and uninsured disco | unto (coo | 275 27 | 2 405 542 | 970, 786 | 21.00 | | |
| 21.00 | instructions) | unts (see | 275, 22 | .3 695, 563 | 970, 780 | 21.00 | | |
| 22.00 | Payments received from patients for amounts previously written | off as | | 0 0 | 0 | 22.00 | | |
| 22.00 | charity care | 011 43 | | 0 | | 22.00 | | |
| 23.00 | Cost of charity care (line 21 minus line 22) | | 275, 22 | .3 695, 563 | 970, 786 | 23 00 | | |
| 20100 | | | 270722 | 0,0,000 | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | 20100 | | |
| | | | | | | | | |
| 24.00 | Does the amount on line 20 column 2, include charges for patie | nt days bey | ond a length | of stay limit | N | 24.00 | | |
| | imposed on patients covered by Medicaid or other indigent care | | Ũ | 5 | | | | |
| 25.00 | If line 24 is yes, enter the charges for patient days beyond t | he indigent | care program | 's length of | 0 | 25.00 | | |
| | stay limit | | | | | | | |
| 26.00 | Total bad debt expense for the entire hospital complex (see in | | | | 2, 760, 370 | | | |
| 27.00 | Medicare reimbursable bad debts for the entire hospital comple | | | | 315, 962 | | | |
| 27.01 | Medicare allowable bad debts for the entire hospital complex (| see instruc | tions) | | 486, 096 | | | |
| 28.00 | Non-Medicare bad debt expense (see instructions) | | | | 2, 274, 274 | | | |
| 29.00 | Cost of non-Medicare and non-reimbursable Medicare bad debt ex | pense (see | instructions) | | 724, 977 | | | |
| 30.00 | Cost of uncompensated care (line 23 column 3 plus line 29) | | | | 1, 695, 763 | | | |
| 31.00 | Total unreimbursed and uncompensated care cost (line 19 plus l | ıne 30) | | | 1, 695, 763 | 31.00 | | |
| | | | | | | | | |

| RECLAS | SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF | EXPENSES | Provider CO | | Period: | Worksheet A | |
|--------------|---|-------------|-------------------------|---------------|----------------------------------|--------------------------------|---------|
| | | | | | From 07/01/2021 To 06/30/2022 | Date/Time Pre 11/28/2022 12 | pared: |
| | Cost Center Description | Sal ari es | Other | Total (col. 1 | Reclassi fi cati | | |
| | | | | + col. 2) | ons (See A-6) | Trial Balance | |
| | | | | | | (col. 3 +- | |
| | | | | | | col. 4) | |
| | | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| 1.00 | GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT | | 799, 954 | 799, 95 | 4 0 | 799, 954 | 1 1.00 |
| 4.00 | 00400 EMPLOYEE BENEFITS DEPARTMENT | 65, 209 | 1, 188, 405 | 1, 253, 61 | | , | |
| 4.00 5.00 | 00500 ADMINI STRATI VE & GENERAL | 297,066 | 4, 983, 045 | 5, 280, 11 | | 5, 280, 111 | |
| | 00700 OPERATION OF PLANT | 297,000 | 4, 983, 043 744, 921 | 744, 92 | | | |
| 7.00 | | 0 | | | | 744, 921 | |
| 8.00 | 00800 LAUNDRY & LINEN SERVICE | 0 | 45, 723 | | | 45, 723 | |
| 9.00 | 00900 HOUSEKEEPI NG | 0 | 474, 598 | | | 474, 598 | |
| | 01000 DI ETARY | 0 | 298, 527 | 298, 52 | | | |
| 11.00 | 01100 CAFETERI A | 0 | 0 | | 0 236, 106 | | |
| | 01300 NURSING ADMINISTRATION | 286, 741 | 16, 377 | 303, 11 | | | |
| | 01400 CENTRAL SERVICES & SUPPLY | 0 | 20, 124 | 20, 12 | | | |
| 15.00 | 01500 PHARMACY | 216, 045 | 490, 214 | 706, 25 | | 706, 259 | |
| 16.00 | 01600 MEDICAL RECORDS & LIBRARY | 0 | 0 | | 0 0 | 0 | 16.00 |
| | I NPATI ENT ROUTI NE SERVI CE COST CENTERS | | | | | | |
| 30.00 | 03000 ADULTS & PEDIATRICS | 977, 919 | 141, 919 | 1, 119, 83 | 8 -17 | 1, 119, 821 | 30.00 |
| | ANCI LLARY SERVI CE COST CENTERS | | | | | | |
| | 05000 OPERATI NG ROOM | 253, 053 | 164, 884 | 417, 93 | | | |
| | 05400 RADI OLOGY - DI AGNOSTI C | 752, 095 | 594, 246 | | | | |
| | 06000 LABORATORY | 75, 307 | 1, 957, 279 | 2, 032, 58 | 6 0 | | |
| 65.00 | 06500 RESPI RATORY THERAPY | 0 | 0 | | 0 0 | 0 | |
| | 06600 PHYSI CAL THERAPY | 203, 010 | 14, 813 | 217, 82 | 3 -37, 792 | 180, 031 | 66.00 |
| 67.00 | 06700 OCCUPATI ONAL THERAPY | 0 | 0 | | 0 37, 792 | 37, 792 | 67.00 |
| 68.00 | 06800 SPEECH PATHOLOGY | 0 | 0 | | 0 0 | 0 | 68.00 |
| 69.00 | 06900 ELECTROCARDI OLOGY | 0 | 0 | | 0 0 | 0 | 69.00 |
| 71.00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 28, 147 | 28, 14 | 7 21, 805 | 49, 952 | 71.00 |
| 72.00 | 07200 IMPLANTABLE DEVICES CHARGED TO | 0 | 10, 209 | 10, 20 | 9 0 | 10, 209 | 72.00 |
| | PATIENTS | | | | | | |
| 73.00 | 07300 DRUGS CHARGED TO PATIENTS | 0 | 0 | | 0 0 | 0 | 73.00 |
| 76.00 | 03950 ADULT MENTAL HEALTH | 0 | 410, 416 | 410, 41 | 6 0 | 410, 416 | 76.00 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | _ | |
| | 08800 RURAL HEALTH CLINIC | 0 | 0 | | 0 0 | 0 | 88.00 |
| 91.00 | 09100 EMERGENCY | 1, 434, 686 | 1, 212, 532 | 2, 647, 21 | 8 -1, 814 | 2, 645, 404 | 91.00 |
| 92.00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | | | | | | 92.00 |
| | SPECIAL PURPOSE COST CENTERS | | | | | | |
| 118.00 | | 4, 561, 131 | 13, 596, 333 | 18, 157, 46 | 4 0 | 18, 157, 464 | 118.00 |
| | NONREIMBURSABLE COST CENTERS | | | | | | |
| | 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN | 0 | 0 | | 0 0 | 0 | 190.00 |
| | 19100 RESEARCH | 0 | 0 | | 0 0 | | 191.00 |
| 192.00 | 19200 PHYSI CLANS' PRI VATE OFFI CES | 0 | 0 | | 0 0 | 0 | 192.00 |
| 194.00 | 07950 OTHER NRCC | О | 15, 183 | 15, 18 | 3 0 | 15, 183 | 194.00 |
| 194.01 | 07951 SPN | О | 0 | | 0 0 | 0 | 194.01 |
| 194.02 | 07952 OUTPATIENT CLINICS | О | 0 | | 0 0 | 0 | 194. 02 |
| | 07953 MARKETI NG | 0 | 0 | | 0 0 | 0 | 194.03 |
| 194.03 | | | 0 | | | | |

| RECLAS | Financial Systems AS SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O | F EXPENSES | Provider CC | CN: 15-1303 | From 07/01/2021 To 06/30/2022 | Worksheet A Date/Time Prepared: 11/28/2022 12:17 pm |
|--------|--|----------------------------------|--|-------------|----------------------------------|---|
| | Cost Center Description | Adjustments (See A-8) 6.00 | Net Expenses For Allocation 7.00 | | | |
| | GENERAL SERVICE COST CENTERS | 0.00 | 7.00 | | | |
| 1.00 | 00100 CAP REL COSTS-BLDG & FIXT | -344,006 | 455, 948 | | | 1.00 |
| 4.00 | 00400 EMPLOYEE BENEFITS DEPARTMENT | 38, 680 | 1, 292, 294 | | | 4, 00 |
| 5.00 | 00500 ADMI NI STRATI VE & GENERAL | 976, 345 | 6, 256, 456 | | | 5.00 |
| 7.00 | 00700 OPERATION OF PLANT | 0 | 744, 921 | | | 7.00 |
| 8.00 | 00800 LAUNDRY & LINEN SERVICE | 0 | 45, 723 | | | 8.00 |
| 9.00 | 00900 HOUSEKEEPI NG | 0 | 474, 598 | | | 9.00 |
| 10.00 | 01000 DI ETARY | 0 | 62, 421 | | | 10.00 |
| | 01100 CAFETERIA | -50, 533 | 185, 573 | | | 11.00 |
| | 01300 NURSI NG ADMI NI STRATI ON | 0,000 | 303, 118 | | | 13.00 |
| | 01400 CENTRAL SERVICES & SUPPLY | 0 | 20, 124 | | | 14.00 |
| | 01500 PHARMACY | - 10, 485 | 695, 774 | | | 15.00 |
| | 01600 MEDICAL RECORDS & LIBRARY | - 10, 403 | 0,73,774 | | | 16.00 |
| 10.00 | INPATIENT ROUTINE SERVICE COST CENTERS | 0 | 0 | | | 10.00 |
| 30.00 | 03000 ADULTS & PEDI ATRI CS | 154, 143 | 1, 273, 964 | | | 30.00 |
| 50.00 | ANCI LLARY SERVICE COST CENTERS | 104,140 | 1,273,704 | | | |
| 50.00 | 05000 OPERATING ROOM | -21,689 | 376, 514 | | | 50.00 |
| | 05400 RADIOLOGY - DIAGNOSTIC | -79, 472 | 1, 266, 629 | | | 54.00 |
| 60.00 | 06000 LABORATORY | -3, 926 | 2, 028, 660 | | | 60.00 |
| 65.00 | 06500 RESPI RATORY THERAPY | 5, 720 | 2, 020, 000 | | | 65.00 |
| | 06600 PHYSI CAL THERAPY | -121 | 179, 910 | | | 66.00 |
| 67.00 | 06700 OCCUPATI ONAL THERAPY | 0 | 37, 792 | | | 67.00 |
| | 06800 SPEECH PATHOLOGY | 0 | 0 | | | 68.00 |
| | 06900 ELECTROCARDI OLOGY | 0 | 0 | | | 69.00 |
| 71.00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | -24, 200 | 25, 752 | | | 71.00 |
| | 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS | 0 | 10, 209 | | | 72.00 |
| 73.00 | 07300 DRUGS CHARGED TO PATIENTS | 0 | 0 | | | 73.00 |
| 76.00 | 03950 ADULT MENTAL HEALTH | 0 | 410, 416 | | | 76.00 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | |
| 88.00 | 08800 RURAL HEALTH CLINIC | 0 | 0 | | | 88.00 |
| 91.00 | 09100 EMERGENCY | 0 | 2, 645, 404 | | | 91.00 |
| 92.00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | | | | | 92.00 |
| | SPECIAL PURPOSE COST CENTERS | | | | | |
| 118.00 | SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS | 634, 736 | 18, 792, 200 | | | 118.00 |
| 190.00 | 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN | 0 | 0 | | | 190.00 |
| 191.00 | 19100 RESEARCH | 0 | 0 | | | 191.00 |
| 192.00 | 19200 PHYSICIANS' PRIVATE OFFICES | 0 | 0 | | | 192.00 |
| | 07950 OTHER NRCC | 0 | 15, 183 | | | 194.00 |
| 194.01 | 07951 SPN | 0 | 0 | | | 194. 01 |
| 194.02 | 07952 OUTPATIENT CLINICS | 0 | 0 | | | 194. 02 |
| | 07953 MARKETI NG | 0 | o | | | 194. 03 |
| 200.00 | TOTAL (SUM OF LINES 118 through 199) | 634, 736 | 18, 807, 383 | | | 200.00 |

| RECLASSI FI CATI ONS Provi der CCN: 15-1303 Peri d: From 07/01/2021 To 06/30/2022 Worksheet A-6 Date/Time Prepared: 11/28/2022 12:17 pm Image: Cost Center Line # Sal ary Other 0 | Heal th | Financial Systems | A | SCENSION ST. V | INCENT JENNING | S | In Lieu of Form CMS-2552- | | |
|--|---------|-------------------------------|-----------|----------------|----------------|--------------|---------------------------|--------------|---------|
| Increases Cost Center Line # Sal ary Other 2.00 3.00 4.00 5.00 A - CAFETERI A Image: Careform of the state | RECLAS | SI FI CATI ONS | | | Provider (| CCN: 15-1303 | From 07/01/2021 | Date/Time Pr | epared: |
| 2.00 3.00 4.00 5.00 A - CAFETERIA 11.00 0 236,106 1.00 1.00 CAFETERIA 0 236,106 1.00 B - MEDI CAL SUPPLI ES 0 236,106 1.00 NO0 MEDI CAL SUPPLI ES 1.00 0 21,805 1.00 2.00 3.00 71.00 21,805 2.00 3.00 2.00 0 21,805 4.00 4.00 3.00 4.00 0 21,805 1.00 1.00 1.00 1.00 0 21,805 1.00 1.00 1.00 | | | Increases | | | | | | |
| A - CAFETERIA 11.00 0 236, 106 1.00 TOTALS 0 236, 106 1.00 1.00 B - MEDI CAL SUPPLI ES 0 236, 106 1.00 MEDI CAL SUPPLI ES CHARGED TO 71.00 21, 805 1.00 9ATI ENTS 0 21, 805 1.00 2.00 0 21, 805 1.00 0 21, 805 1.00 1.00 0 21, 805 1.00 2.00 0 21, 805 1.00 0 21, 805 1.00 3.00 4.00 0 21, 805 1.00 0 0 21, 805 1.00 1.00 0 21, 805 1.00 | | Cost Center | Line # | Salary | 0ther | | | | |
| 1.00 CAFETERIA | | 2.00 | 3.00 | 4.00 | 5.00 | | | | |
| TOTALS 0 236, 106 B - MEDI CAL SUPPLI ES 1.00 MEDI CAL SUPPLI ES CHARGED TO 71.00 21, 805 PATI ENTS 2.00 3.00 0 21, 805 C - OCCUPATI ONAL THERAPY RECLASS 0 21, 805 1.00 0 21, 805 1.00 1.00 0 21, 805 1.00 1.00 0 21, 805 1.00 1.00 0 21, 805 1.00 | | A – CAFETERIA | | | | | | | |
| B - MEDI CAL SUPPLI ES 1. 00 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 71. 00 21, 805 1. 00 2. 00 2. 00 3. 00 2. 00 3. 00 1. 00 1. 00 1. 00 1. 00 1. 00 | 1.00 | CAFETERI A | 11.00 | 0 | 236, 106 | | | | 1.00 |
| 1.00 MEDI CAL SUPPLI ES CHARGED TO 71.00 21,805 1.00 2.00 3.00 | | TOTALS | | 0 | 236, 106 | | | | |
| 2. 00 3. 00 - - - - - 2. 00 3. 00 3. 00 3. 00 4. 00 3. 00 4. 00 4. 00 4. 00 4. 00 4. 00 4. 00 1. 00 0 21, 805 1. 00 | | B - MEDICAL SUPPLIES | | | | | | | 1 |
| 2.00 3.00 4.00 C - OCCUPATI ONAL THERAPY RECLASS 1.00 0 0 0 0 21,805 2.00 3.00 4.00 1.00 0 0 21,805 1.00 0 0 2,570 2,570 2,570 2,570 2,570 1.00 | 1.00 | MEDICAL SUPPLIES CHARGED TO | 71.00 | | 21, 805 | | | | 1.00 |
| 3. 00 3. 00 4. 00 4. 00 4. 00 4. 00 1. 00 35, 222 2, 570 1. 00 1. 00 | | PATI ENTS | | | | | | | |
| 4.00 | 2.00 | | | | | | | | 2.00 |
| C - OCCUPATI ONAL THERAPY RECLASS 1.00 0 21, 805 1.00 0 21, 805 | 3.00 | | | | | | | | 3.00 |
| C - OCCUPATI ONAL THERAPY RECLASS 1.00 OCCUPATI ONAL THERAPY 67.00 35,222 2,570 1.00 35,222 2,570 35,222 2,570 1.00 | 4.00 | L | | | | | | | 4.00 |
| 1.00 OCCUPATI ONAL THERAPY 67.00 35,222 2,570 1.00 35,222 2,570 35,222 2,570 1.00 < | | | | 0 | 21, 805 | | | | |
| 35, 222 2, 570 | | C - OCCUPATIONAL THERAPY RECL | ASS | | | | | | |
| | 1.00 | OCCUPATI ONAL THERAPY | 67.00 | 35, 222 | 2,570 | | | | 1.00 |
| 500_00 Grand Total : Increases 35 222 260_481 500_00 | | | | 35, 222 | 2, 570 | | | | |
| | 500.00 | Grand Total: Increases | | 35, 222 | 260, 481 |] | | | 500.00 |

| Heal th | Financial Systems | A | SCENSION ST. V | INCENT JENNING | S | In Lie | u of Form CMS | -2552-10 |
|---------|-------------------------------|-----------|----------------|----------------|---------------|----------------------------------|------------------------------|---------------------|
| RECLAS | SEFECATIONS | | | Provider (| CCN: 15-1303 | Peri od: | Worksheet A- | 6 |
| | | | | | | From 07/01/2021 To 06/30/2022 | Date/Time Pr 11/28/2022 1 | epared: 2:17 pm_ |
| | | Decreases | | | | | | |
| | Cost Center | Line # | Sal ary | 0ther | Wkst. A-7 Ref | · . | | |
| | 6.00 | 7.00 | 8.00 | 9.00 | 10.00 | | | |
| | A – CAFETERIA | | | | | | | |
| 1.00 | DI ETARY | 10.00 | 0 | 236, 106 | | 0 | | 1.00 |
| | TOTALS | | 0 | 236, 106 | | | | |
| | B - MEDICAL SUPPLIES | | | | | | | |
| 1.00 | ADULTS & PEDIATRICS | 30.00 | | 17 | | | | 1.00 |
| 2.00 | OPERATING ROOM | 50.00 | | 19, 734 | | | | 2.00 |
| 3.00 | RADIOLOGY - DIAGNOSTIC | 54.00 | | 240 | | | | 3.00 |
| 4.00 | EMERGENCY | 91.00 | | 1, 814 | | | | 4.00 |
| | | | 0 | 21, 805 | | | | |
| | C - OCCUPATIONAL THERAPY RECL | LASS | | | | | | |
| 1.00 | PHYSI CAL THERAPY | 66.00 | 35, 222 | 2, 570 | | | | 1.00 |
| | | | 35, 222 | 2, 570 | | | | |
| 500.00 | Grand Total: Decreases | | 35, 222 | 260, 481 | | | | 500.00 |

| RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 15-1303 Period: From 07/07/201 To 06/30/2022 Worksheet A-7 Part I Date/Time Prepared: 11/28/2022 12: 17 pm PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 0 0 4.00 5.00 1.00 2.00 3.00 4.00 5.00 2.00 1.00 2.00 0 0 0 2.00 3.00 4.00 5.00 1.00 2.00 3.00 4.00 5.00 1.00 2.00 1.00 2.00 3.00 4.00 5.00 1.00 1.02 0 0 0 0 1.00 2.00 Land 1.027,944 0 | Heal th | Health Financial Systems ASCENSION ST. VINCENT JENNINGS In Lieu of Form CMS-2552 | | | | | | | | | |
|--|---------|--|------------------|----------------|-------------|-----|---------------|-------------------------|--------|--|--|
| Beginning Balances Purchases Donation Total Disposal s and Retirements 1.00 2.00 3.00 4.00 5.00 PART 1 - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 127,944 0 0 0 0 0 1.00 2.00 Land Inprovements 539,531 162,903 0 12.00 2.00 3.00 Building Improvements 0 0 0 0 2.00 3.00 Building Improvements 0 0 0 0 2.00 5.00 Fixed Equipment 1,027,481 43,605 0 43,605 0 5.00 6.00 Movable Equipment 6,330,541 444,286 0 64.00 7.00 11 designated Assets 0 0 0 0 0 7.00 0 0 7.00 10.00 Total (line 8 minus line 9) 22,889,839 650,794 0 650,794 90,351 8.00 10.00 Land Inprovements< | | | | Provider CO | CN: 15-1303 | Fro | om 07/01/2021 | Part I Date/Time Pre | pared: | | |
| Balances Retirements 1.00 2.00 3.00 4.00 5.00 1.00 Land 127,944 0 0 0 1.00 2.00 Land Improvements 127,944 0 0 0 1.00 3.00 Buildings and Fixtures 139,531 162,903 0 120 4.00 Building Improvements 0 0 0 0 0 0 0 0 4.00 5.00 Fixed Equipment 1,027,481 43,605 0 43,605 0 6.00 7.00 6.00 < | | | | Acqui si ti on | | | | | | | |
| PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 2.00 3.00 4.00 5.00 2.00 Land 0 0 0 0 0 1.00 2.00 Land Improvements 539, 531 162, 903 0 162, 903 0 2.00 3.00 Buildings and Fixtures 14, 864, 342 0 0 0 0 4.00 5.00 Fixed Equipment 1, 027, 481 43, 605 0 43, 605 0 5.00 6.00 Movable Equipment 6, 330, 541 444, 286 0 444, 286 0 0 0 0 7.00 8.00 Subtotal (sum of lines 1-7) 22, 889, 839 650, 794 0 650, 794 90, 351 8.00 9.00 Reconciling Items 0 0 0 0 0 0 90, 351 8.00 10.00 Total (line 8 minus line 9) 22, 889, 839 650, 794 0 650, 794 90, 351 10.00 | | | Begi nni ng | Purchases | Donati on | | Total | Disposals and | | | |
| PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 0 | | | | | | | | | | | |
| 1.00 Land 127,944 0 0 0 0 0 0 1.00 2.00 Land Improvements 539,531 162,903 0 162,903 0 2.00 3.00 Buil dings and Fixtures 14,864,342 0 0 0 90,351 3.00 4.00 Buil ding Improvements 0 0 0 0 0 4.00 5.00 Fixed Equipment 1,027,481 43,605 0 43,605 0 6.00 6.00 Movable Equipment 6,330,541 444,286 0 | | | | 2.00 | 3.00 | | 4.00 | 5.00 | | | |
| 2.00 Land Improvements 539,531 162,903 0 162,903 0 2.00 3.00 Buil dings and Fixtures 14,864,342 0 0 0 90,351 3.00 4.00 Buil ding improvements 0 | | | | | | | | | | | |
| 3.00 Buildings and Fixtures 14,864,342 0 | 1.00 | | | | | 0 | 0 | | | | |
| 4.00 Building Improvements 0 0 0 0 0 0 4.00 5.00 Fixed Equipment 1,027,481 43,605 0 43,605 0 5.00 6.00 Movable Equipment 6,330,541 444,286 0 444,286 0 6.00 7.00 HIT designated Assets 0 | 2.00 | Land Improvements | | | | 0 | 162, 903 | 0 | 2.00 | | |
| 5.00 Fixed Equipment 1,027,481 43,605 0 43,605 0 5.00 6.00 Movable Equipment 6,330,541 444,286 0 444,286 0 6.00 7.00 HIT designated Assets 0 0 0 0 0 0 0 7.00 8.00 Subtotal (sum of lines 1-7) 22,889,839 650,794 0 650,794 0 0 0 0 9.00 9.00 Reconciling Items 0 0 0 0 0 0 9.00 | | | 14, 864, 342 | 0 | | 0 | 0 | 90, 351 | | | |
| 6.00 Movable Equipment 6, 330, 541 444, 286 0 444, 286 0 6.00 7.00 HIT designated Assets 0 | | | 0 | 0 | | 0 | 0 | 0 | | | |
| 7.00 HIT designated Assets 0 0 0 0 0 0 7.00 8.00 Subtotal (sum of lines 1-7) 22,889,839 650,794 0 650,794 90,351 8.00 9.00 Reconciling items 0 0 0 0 0 0 0 9.00 10.00 Total (line 8 minus line 9) 22,889,839 650,794 0 650,794 90,351 10.00 PART 1 - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 127,944 0 1.00 2.00 Land Improvements 702,434 0 3.00 3.00 Building and Fixtures 14,773,991 3.00 3.00 5.00 Fixed Equipment 1,071,086 5.00 5.00 6.00 Moxable Equipment 6,774,827 6.00 5.00 7.00 HIT designated Assets 0 0 7.00 9.00 Reconciling Items 0 0 9.00 | 5.00 | Fixed Equipment | 1, 027, 481 | 43, 605 | | 0 | 43, 605 | 0 | 5.00 | | |
| 8.00 Subtotal (sum of lines 1-7) 22,889,839 650,794 0 650,794 0 | 6.00 | | 6, 330, 541 | 444, 286 | | 0 | 444, 286 | 0 | 6.00 | | |
| 9.00 Reconciling Items 0 0 0 0 0 9.00 10.00 Total (line 8 minus line 9) 22,889,839 650,794 0 650,794 90,351 10.00 Image: the state of the | 7.00 | HIT designated Assets | 0 | 0 | | 0 | 0 | 0 | 7.00 | | |
| 10.00 Total (line 8 minus line 9) 22,889,839 650,794 0 650,794 90,351 10.00 Ending Balance Fully Depreciated Assets Assets 6.00 7.00 7.00 PART 1 - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 6.00 7.00 7.00 1.00 1.00 Land mprovements 702,434 0 2.00 3.00 3.00 Buildings and Fixtures 14,773,991 0 3.00 4.00 5.00 Fixed Equipment 1,071,086 0 5.00 5.00 6.00 7.00 4.00 6.00 Subtotal (sum of lines 1-7) 23,450,282 0 0 7.00 9.00 9.00 | 8.00 | Subtotal (sum of lines 1-7) | 22, 889, 839 | 650, 794 | | 0 | 650, 794 | 90, 351 | 8.00 | | |
| PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCEs 1.00 1.0 | 9.00 | Reconciling Items | 0 | 0 | | 0 | 0 | 0 | 9.00 | | |
| PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 1.00 Land 1.00 2.00 1.00 2.00 3.00 9.00 <t< td=""><td>10.00</td><td>Total (line 8 minus line 9)</td><td>22, 889, 839</td><td>650, 794</td><td></td><td>0</td><td>650, 794</td><td>90, 351</td><td>10.00</td></t<> | 10.00 | Total (line 8 minus line 9) | 22, 889, 839 | 650, 794 | | 0 | 650, 794 | 90, 351 | 10.00 | | |
| PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 6.00 7.00 1.00 Land 127,944 0 1.00 2.00 Land Improvements 702,434 0 2.00 3.00 Buildings and Fixtures 14,773,991 0 3.00 4.00 Building Improvements 0 0 4.00 5.00 Fixed Equipment 1,071,086 0 5.00 6.00 Movable Equipment 6,774,827 0 6.00 7.00 HIT designated Assets 0 0 7.00 7.00 9.00 Reconciling Items 0 0 9.00 9.00 | | | Endi ng Bal ance | Fully | | | | | | | |
| 6.00 7.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 127,944 0 1.00 2.00 Land 127,944 0 2.00 3.00 Buildings and Fixtures 702,434 0 2.00 4.00 Building Improvements 0 0 3.00 5.00 Fixed Equipment 1,071,086 0 4.00 6.00 Movable Equipment 6,774,827 0 6.00 7.00 HIT designated Assets 0 0 7.00 8.00 Subtotal (sum of lines 1-7) 23,450,282 0 8.00 9.00 Reconciling Items 0 0 9.00 | | | - | Depreciated | | | | | | | |
| PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 127,944 0 1.00 2.00 Land Improvements 702,434 0 2.00 3.00 Buildings and Fixtures 14,773,991 0 3.00 4.00 Building Improvements 0 0 4.00 5.00 Fixed Equipment 1,071,086 0 5.00 6.00 Movable Equipment 6,774,827 0 6.00 7.00 HIT designated Assets 0 0 7.00 8.00 9.00 8.00 9.00 | | | | Assets | | | | | | | |
| 1.00 Land 127,944 0 1.00 2.00 Land Improvements 702,434 0 2.00 3.00 Buildings and Fixtures 14,773,991 0 3.00 4.00 Building Improvements 0 0 4.00 5.00 Fixed Equipment 1,071,086 0 5.00 6.00 Movable Equipment 6,774,827 0 6.00 7.00 HIT designated Assets 0 0 7.00 8.00 Subtotal (sum of lines 1-7) 23,450,282 0 8.00 9.00 Reconciling Items 0 0 9.00 | | | 6.00 | 7.00 | | | | | | | |
| 2.00 Land Improvements 702,434 0 2.00 3.00 Buildings and Fixtures 14,773,991 0 3.00 4.00 Building Improvements 0 0 4.00 5.00 Fixed Equipment 1,071,086 0 5.00 6.00 Movable Equipment 6,774,827 0 6.00 7.00 HIT designated Assets 0 0 7.00 8.00 Subtotal (sum of lines 1-7) 23,450,282 0 8.00 9.00 Reconciling Items 0 0 9.00 | | PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE | BALANCES | | | | | | | | |
| 3.00 Buildings and Fixtures 14,773,991 0 3.00 4.00 Building Improvements 0 0 4.00 5.00 Fixed Equipment 1,071,086 0 5.00 6.00 Movable Equipment 6,774,827 0 6.00 7.00 HIT designated Assets 0 0 7.00 8.00 Subtotal (sum of lines 1-7) 23,450,282 0 8.00 9.00 Reconciling Items 0 0 9.00 | 1.00 | Land | 127, 944 | 0 | | | | | 1.00 | | |
| 4.00 Building Improvements 0 0 4.00 5.00 Fixed Equipment 1,071,086 0 5.00 6.00 Movable Equipment 6,774,827 0 6.00 7.00 HIT designated Assets 0 0 7.00 8.00 Subtotal (sum of lines 1-7) 23,450,282 0 8.00 9.00 Reconciling Items 0 0 9.00 | 2.00 | Land Improvements | 702, 434 | 0 | | | | | 2.00 | | |
| 5.00 Fixed Equipment 1,071,086 0 5.00 6.00 Movable Equipment 6,774,827 0 6.00 7.00 HIT designated Assets 0 0 7.00 8.00 Subtotal (sum of lines 1-7) 23,450,282 0 8.00 9.00 Reconciling Items 0 0 9.00 | 3.00 | Buildings and Fixtures | 14, 773, 991 | 0 | | | | | 3.00 | | |
| 6.00 Movable Equipment 6,774,827 0 6.00 7.00 HIT designated Assets 0 0 7.00 8.00 Subtotal (sum of lines 1-7) 23,450,282 0 8.00 9.00 Reconciling Items 0 0 9.00 | 4.00 | Building Improvements | 0 | 0 | | | | | 4.00 | | |
| 7.00 HIT designated Assets 0 0 7.00 8.00 Subtotal (sum of lines 1-7) 23,450,282 0 8.00 9.00 Reconciling Items 0 0 9.00 | 5.00 | Fixed Equipment | 1, 071, 086 | 0 | | | | | 5.00 | | |
| 8.00 Subtotal (sum of lines 1-7) 23,450,282 0 8.00 9.00 | 6.00 | Movable Equipment | 6, 774, 827 | 0 | | | | | 6.00 | | |
| 9.00 Reconciling Items 0 0 9.00 | 7.00 | HIT designated Assets | 0 | 0 | | | | | 7.00 | | |
| 9.00 Reconciling Items 0 0 9.00 | 8.00 | Subtotal (sum of lines 1-7) | 23, 450, 282 | 0 | | | | | 8.00 | | |
| 10.00 Total (Line 8 minus Line 9) 23.450.282 0 10.00 | 9.00 | | 0 | 0 | | | | | 9.00 | | |
| | 10.00 | Total (line 8 minus line 9) | 23, 450, 282 | 0 | | | | | 10.00 | | |

| Heal th | Financial Systems AS | SCENSION ST. VI | NCENT JENNINGS | | In Lieu of Form CMS-25 | | |
|---------|---|-------------------|----------------|----------------|---|-----------------------------|-------|
| RECONO | CILIATION OF CAPITAL COSTS CENTERS | | Provider CC | | Period: From 07/01/2021 To 06/30/2022 | | |
| | | | | | | 11/28/2022 12 | 17 pm |
| | | | SU | JMMARY 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 WOR | SHEET A, COLUM | N 2, LINES 1 a | nd 2 | | | |
| 1.00 | CAP REL COSTS-BLDG & FIXT | 455, 948 | 0 | 344, 00 | 6 0 | 0 | 1.00 |
| 3.00 | Total (sum of lines 1-2) | 455, 948 | 0 | 344, 00 | 6 0 | 0 | 3.00 |
| | | SUMMARY O | F CAPITAL | | | | |
| | Cost Center Description | Other | Total (1) (sum | | | | |
| | | Capi tal -Rel ate | of cols. 9 | | | | |
| | | d Costs (see | through 14) | | | | |
| | | instructions) | | | | | |
| | | 14.00 | 15.00 | | | | |
| | PART II - RECONCILIATION OF AMOUNTS FROM WORK | SHEET A, COLUM | | | | | |
| 1.00 | CAP REL COSTS-BLDG & FIXT | 0 | 799, 954 | | | | 1.00 |
| 3.00 | Total (sum of lines 1-2) | 0 | 799, 954 | | | | 3.00 |

| Health Financial Systems AS | SCENSION ST. VI | NCENT JENNINGS | | In Lie | u of Form CMS-2 | 2552-10 |
|---|--|------------------------------------|---|---|---|---------|
| RECONCILIATION OF CAPITAL COSTS CENTERS | | Provider C | F | Period: From 07/01/2021 To 06/30/2022 | Worksheet A-7 Part III Date/Time Prep 11/28/2022 12: | |
| | COMI | PUTATION OF RAT | FI OS | ALLOCATION OF | OTHER CAPITAL | |
| Cost Center Description | Gross Assets | Capi tal i zed Leases | Gross Assets for Ratio (col. 1 - col. | Ratio (see instructions) | Insurance | |
| | | | 2) | 4.00 | | |
| PART III - RECONCILIATION OF CAPITAL COSTS CE | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| 1.00 CAP REL COSTS-BLDG & FLXT | 23, 450, 283 | 0 | 23, 450, 283 | 1.000000 | 0 | 1.00 |
| 3.00 Total (sum of lines 1-2) | 23, 450, 283 | | 23, 450, 283 | | | 3.00 |
| | ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL | | | | | |
| Cost Center Description | Taxes | Other Capital-Relate d Costs | Total (sum of cols.5 through 7) | Depreciation | Lease | |
| | 6.00 | 7.00 | 8,00 | 9,00 | 10,00 | |
| PART III - RECONCILIATION OF CAPITAL COSTS CE | | 7.00 | 0.00 | 7.00 | 10.00 | |
| 1.00 CAP REL COSTS-BLDG & FIXT | 0 | 0 | 0 | 455, 948 | 0 | 1.00 |
| 3.00 Total (sum of lines 1-2) | 0 | 0 | 0 | 455, 948 | 0 | 3.00 |
| | | SL | JMMARY OF CAPIT | TAL | | |
| Cost Center Description | Interest | Insurance (see | | | Total (2) (sum | |
| | | instructions) | instructions) | Capi tal -Rel ate | | |
| | | | | d Costs (see instructions) | through 14) | |
| | 11.00 | 12.00 | 13.00 | 14.00 | 15.00 | |
| PART III - RECONCILIATION OF CAPITAL COSTS CE | - | 1 | | | | |
| 1.00 CAP REL COSTS-BLDG & FIXT | 0 | - | | | 455, 948 | 1.00 |
| 3.00 Total (sum of lines 1-2) | 0 | 0 | (| 0 0 | 455, 948 | 3.00 |

| Heal th | Fi nan | ci a | l Systems |
|---------|--------|------|-----------|
| AD JUST | MENTS | TO | EXPENSES |

ASCENSION ST VINCENT JENNINGS

| Health Financial Systems | AS | CENSION ST. VI | NCENT JENNINGS | In Lie | eu of Form CMS-2 | 2552-10 |
|---|-----------------|----------------|-----------------------------|----------------------------------|---|----------------|
| ADJUSTMENTS TO EXPENSES | | | Provider CCN: 15-1303 | Peri od: | Worksheet A-8 | |
| | | | | From 07/01/2021 To 06/30/2022 | | pared: |
| | | | Expense Classification or | Workshoot A | 11/28/2022 12 | 17 pm |
| | | | To/From Which the Amount is | | | |
| | | | | , | | |
| | | | | | | |
| | | | | | | |
| Cost Center Description | Basi s/Code (2) | Amount | Cost Center | Line # | Wkst. A-7 Ref. | |
| | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | 1 00 |
| 1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2) | В | -340, 103 | CAP REL COSTS-BLDG & FIXT | 1.00 | 11 | 1.00 |
| 2.00 Investment income - CAP REL | | C | *** Cost Center Deleted *** | 2.00 | 0 | 2.00 |
| COSTS-MVBLE EQUIP (chapter 2) | | 0.000 | | 5.00 | | 0.00 |
| 3.00 Investment income - other (chapter 2) | В | -8,090 | ADMINISTRATIVE & GENERAL | 5.00 | 0 | 3.00 |
| 4.00 Trade, quantity, and time | | C | | 0.00 | 0 | 4.00 |
| discounts (chapter 8) | | | | | | F 00 |
| 5.00 Refunds and rebates of expenses (chapter 8) | | C | | 0.00 | 0 | 5.00 |
| 6.00 Rental of provider space by | | C | | 0.00 | 0 | 6.00 |
| suppliers (chapter 8) | | | | | | |
| 7.00 Tel ephone services (pay stations excluded) (chapter | | C | | 0.00 | 0 | 7.00 |
| 21) | | | | | | |
| 8.00 Tel evi si on and radi o servi ce | | C | | 0.00 | 0 | 8.00 |
| (chapter 21) 9.00 Parking lot (chapter 21) | | C | | 0.00 | 0 | 9.00 |
| 10. 00 Provi der-based physici an | A-8-2 | -112, 205 | | 0.00 | 0 | 10.00 |
| adjustment | | | | | | |
| 11.00 Sale of scrap, waste, etc. (chapter 23) | | C | | 0.00 | 0 | 11.00 |
| 12.00 Related organization | A-8-1 | 2, 766, 657 | , | | 0 | 12.00 |
| transactions (chapter 10) | | _ | | | | |
| 13.00 Laundry and Linen service14.00 Cafeteria-employees and guest | s B | -50 533 | CAFETERI A | 0.00 11.00 | | 13.00 14.00 |
| 15.00 Rental of quarters to employe | | -30, 333 C | | 0.00 | | 15.00 |
| and others | | _ | | | | |
| 16.00 Sale of medical and surgical supplies to other than | | C | | 0.00 | 0 | 16.00 |
| patients | | | | | | |
| 17.00 Sale of drugs to other than | | C | | 0.00 | 0 | 17.00 |
| patients 18.00 Sale of medical records and | | C | | 0.00 | 0 | 18.00 |
| abstracts | | C | | 0.00 | 0 | 18.00 |
| 19.00 Nursing and allied health | | C | | 0.00 | 0 | 19.00 |
| education (tuition, fees, books, etc.) | | | | | | |
| 20. 00 Vendi ng machi nes | | C | | 0.00 | 0 | 20.00 |
| 21.00 Income from imposition of | | C | | 0.00 | 0 | 21.00 |
| interest, finance or penalty | | | | | | |
| 22.00 Interest expense on Medicare | | C | | 0.00 | 0 | 22.00 |
| overpayments and borrowings t | o | | | | | |
| 23.00 Adjustment for respiratory | A-8-3 | | | (5.00 | | 23.00 |
| therapy costs in excess of | A-0-3 | L. L. | RESPI RATORY THERAPY | 65.00 | | 23.00 |
| limitation (chapter 14) | | | | | | |
| 24.00 Adjustment for physical | A-8-3 | C | PHYSICAL THERAPY | 66.00 | | 24.00 |
| therapy costs in excess of limitation (chapter 14) | | | | | | |
| 25.00 Utilization review - | | C | *** Cost Center Deleted *** | 114.00 | | 25.00 |
| physicians' compensation | | | | | | |
| (chapter 21) 26.00 Depreciation - CAP REL | | C | CAP REL COSTS-BLDG & FIXT | 1.00 | 0 | 26.00 |
| COSTS-BLDG & FIXT | | | | | , i i i i i i i i i i i i i i i i i i i | 201 00 |
| 27.00 Depreciation - CAP REL | | C | *** Cost Center Deleted *** | 2.00 | 0 | 27.00 |
| COSTS-MVBLE EQUIP 28.00 Non-physician Anesthetist | | C | *** Cost Center Deleted *** | 19.00 | | 28.00 |
| 29.00 Physicians' assistant | | C | | 0.00 | | 29.00 |
| 30.00 Adjustment for occupational | A-8-3 | C | OCCUPATI ONAL THERAPY | 67.00 | | 30.00 |
| therapy costs in excess of limitation (chapter 14) | | | | | | |
| 30. 99 Hospice (non-distinct) (see | | С | ADULTS & PEDIATRICS | 30.00 | | 30. 99 |
| instructions) | | | | | | |
| 31.00 Adjustment for speech | A-8-3 | C | SPEECH PATHOLOGY | 68.00 | | 31.00 |
| pathology costs in excess of limitation (chapter 14) | | | | | | |
| 32.00 CAH HIT Adjustment for | | C | | 0.00 | 0 | 32.00 |
| Depreciation and Interest | Δ | 0 740 | | E OO | | 22 00 |
| 33. 00 BAD DEBT | A | -3, /48 | ADMINISTRATIVE & GENERAL | 5.00 | | 33.00 |

| Health Financial Systems | AS | CENSION ST. VI | NCENT JENNINGS | In Lieu of Form CMS-2552-10 | | |
|--------------------------------------|-----------------|----------------|-----------------------------|----------------------------------|----------------------------------|--------|
| ADJUSTMENTS TO EXPENSES | | | Provider CCN: 15-1303 | Peri od: | Worksheet A-8 | |
| | | | | From 07/01/2021 To 06/30/2022 | Date/Time Prep 11/28/2022 12: | |
| | | | Expense Classification o | n Worksheet A | | |
| | | | To/From Which the Amount is | s to be Adjusted | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| Cost Center Description | Basi s/Code (2) | Amount | Cost Center | Line # | Wkst. A-7 Ref. | |
| | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| 33.01 PERSONAL PROPERTY TAX | A | 155, 231 | ADULTS & PEDIATRICS | 30.00 | 0 | 33.01 |
| 33. 02 ENTERTAI NMENT | А | -909 | ADMINISTRATIVE & GENERAL | 5.00 | 0 | 33. 02 |
| 33. 03 ENTERTAI NMENT | А | -121 | PHYSICAL THERAPY | 66.00 | 0 | 33.03 |
| 33.04 PROMOTIONAL ITEMS | А | -544 | ADULTS & PEDIATRICS | 30.00 | 0 | 33.04 |
| 33.05 PROVIDER TAX ADJUSTMENT | А | -1, 119, 075 | ADMI NI STRATI VE & GENERAL | 5.00 | 0 | 33.05 |
| 33. 06 LOBBYI NG | A | -493 | ADMI NI STRATI VE & GENERAL | 5.00 | 0 | 33.06 |
| 33.07 MISC REVENUE | В | -922 | ADMI NI STRATI VE & GENERAL | 5.00 | 0 | 33.07 |
| 33.09 MISC REVENUE | В | -10, 485 | PHARMACY | 15.00 | 0 | 33.09 |
| 33.15 IC PHYSICIAN FUND | A | -639, 380 | ADMI NI STRATI VE & GENERAL | 5.00 | 0 | 33. 15 |
| 33.16 PROMOTIONAL ITEMS | A | -544 | ADULTS & PEDIATRICS | 30.00 | 0 | 33. 16 |
| 50.00 TOTAL (sum of lines 1 thru 49) | | 634, 736 | | | | 50.00 |
| (Transfer to Worksheet A, | | | | | | |
| column 6, line 200.) | | | | | | |

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

A. Costs - if cost, including applicable overhead, can be determined.
 B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

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

| Heal th | Financial Systems | ASCENSION ST. V | INCENT JENNINGS | In Lie | eu of Form CMS-: | 2552-10 |
|---------|---|-------------------------------|------------------------------|----------------------------------|--------------------------------|---------|
| | ENT OF COSTS OF SERVICES FROM | RELATED ORGANIZATIONS AND HOM | | Peri od: | Worksheet A-8 | -1 |
| OFFICE | COSTS | | | From 07/01/2021 To 06/30/2022 | Date/Time Pre 11/28/2022 12 | |
| | Line No. | Cost Center | Expense Items | Amount of | Amount | |
| | | | | Allowable Cost | | |
| | | | | | Wks. A, column | |
| | 1.00 | 2.00 | 2.00 | 4.00 | 5 | |
| | | | 3.00 | 4.00 | 5.00 | |
| | A. COSTS INCURRED AND ADJUSTM HOME OFFICE COSTS: | MENTS REQUIRED AS A RESULT OF | TRANSACTIONS WITH RELATED OF | RGANIZATIONS OR | CLAIMED | |
| 1.00 | | ADMINISTRATIVE & GENERAL | HOME OFFICE - CAPITAL | 240, 379 | 0 | 1.00 |
| 2.00 | | | HOME OFFICE - INTEREST | 6, 332 | | 2.00 |
| 3.00 | | | HOME OFFICE - OTHER | 5, 636, 339 | | 3.00 |
| 3.01 | | | SVH CHARGEBACKS | 2, 751 | 2, 751 | 3.01 |
| 3.02 | | | SVH CHARGEBACKS | 12,000 | | 3.02 |
| 3.03 | | | SVH CHARGEBACKS | 172, 935 | | 3.03 |
| 3.04 | | | SVH CHARGEBACKS | 17, 500 | | |
| 3.05 | | - | SVH CHARGEBACKS | 11,004 | | 3.05 |
| 3.06 | 4,00 | EMPLOYEE BENEFITS DEPARTMENT | HEALTH INSURANCE | 685,095 | | 3.06 |
| 3.07 | 1.00 | CAP REL COSTS-BLDG & FIXT | INTEREST EXPENSE | 340, 103 | 344,006 | 3.07 |
| 3.08 | 5.00 | ADMINISTRATIVE & GENERAL | INTEREST EXPENSE | 1, 758 | | 3.08 |
| 3.09 | 71.00 | MEDICAL SUPPLIES CHARGED TO | TRG ADMIN FEES - SUPPLIES | -24, 200 | 0 | 3.09 |
| 4.00 | 5.00 | ADMINISTRATIVE & GENERAL | TRG ADMIN FEES - OTHER | -43, 997 | 0 | 4.00 |
| 5.00 | TOTALS (sum of lines 1-4). | | | 7, 057, 999 | 4, 291, 342 | 5.00 |
| | Transfer column 6, line 5 to | | | | | |
| | Worksheet A-8, column 2, | | | | | |
| | line 12. | | | | | |

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

| | | | | Related Organization(s) and/ | or Home Office | | | |
|--|------------|------|---------------|------------------------------|----------------|--|--|--|
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | Symbol (1) | Name | Percentage of | Name | Percentage of | | | |
| | | | Ownershi p | | Ownershi p | | | |
| | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | | | |
| | | | | | | | | |

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

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

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

| I EI IIIDUI | | | | | | |
|-------------|-------------------------|---------------|--------|---------------|--------|--------|
| 6.00 | G | ASCENSION SVH | 100.00 | ASCENSION SVH | 100.00 | 6.00 |
| 7.00 | G | ASCENSI ON | 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 | ENT JENNINGS | In Lieu of Form CMS-2552-10 | | |
|---|---------------------------|-----------------------|-----------------------------|---------------------|--|
| STATEMENT OF COSTS OF SERVICES FROM RELAT | ED ORGANIZATIONS AND HOME | Provider CCN: 15-1303 | Peri od: | Worksheet A-8-1 | |
| OFFICE COSTS | | | From 07/01/2021 | | |
| | | | To 06/30/2022 | Date/Time Prepared: | |
| | | | | 11/28/2022 12:17 pm | |

| | Net | Wkst. A-7 Ref. | |
|------|----------------|--|-------|
| | Adjustments | | |
| | (col. 4 minus | 5 | |
| | col. 5)* | | |
| | 6.00 | 7.00 | |
| | | IRRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED | |
| | HOME OFFICE CO | | |
| 1.00 | 240, 379 | | 1.00 |
| 2.00 | 6, 332 | | 2.00 |
| 3.00 | 2, 551, 608 | 8 0 | 3.00 |
| 3.01 | 0 | 0 0 | 3. 01 |
| 3.02 | 0 | 0 0 | 3. 02 |
| 3.03 | 0 | 0 0 | 3. 03 |
| 3.04 | 0 | 0 0 | 3.04 |
| 3.05 | 0 | 0 0 | 3. 05 |
| 3.06 | 38, 680 | 0 0 | 3.06 |
| 3.07 | -3, 903 | 13 11 | 3.07 |
| 3.08 | 1, 758 | 8 0 | 3. 08 |
| 3.09 | -24, 200 | o o | 3. 09 |
| 4.00 | -43, 997 | 7 0 | 4.00 |
| 5.00 | 2, 766, 657 | 7 | 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

| nu. | 5 110 | L DOON POSTOU LO MORKSHOOL A, | | | | | | |
|-----|-------|---|--|--|--|--|--|--|
| | | Rel ated Organi zati on(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

| i ei iibui | Sement under title AVIII. | | | | | | | | |
|------------|--|--------|--|--|--|--|--|--|--|
| 6.00 | ADMI NI STRATI ON | 6.00 | | | | | | | |
| 7.00 | ADMI NI STRATI ON | 7.00 | | | | | | | |
| 8.00 | | 8.00 | | | | | | | |
| 9.00 | | 9.00 | | | | | | | |
| 10.00 | | 10.00 | | | | | | | |
| 100.00 | | 100.00 | | | | | | | |
| (1) 100 | (1) lies the following symbols to indicate interpolationship to related engenizations: | | | | | | | | |

(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 organi zati on.

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 provi der

| Heal th | Fi nanci a | I Systems | |
|---------|------------|-----------|--|
| | | | |

ASCENSION ST. VINCENT JENNINGS

In Lieu of Form CMS-2552-10

| PROVIDER BASED PHYSICIAN ADJUSTMENT | | | Provi der 0 | CCN: 15-1303 | Period: From 07/01/2021 To 06/30/2022 | | 3-2 epared: | |
|-------------------------------------|----------------|-------------------------------------|-----------------------|----------------------------|---|---------------|---|--------|
| | Wkst. A Line # | Cost Center/Physician Identifier | Total Remuneration | Professi onal Component | Provider Component | RCE Amount | Physician/Prov ider Component Hours | |
| | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | 6.00 | 7.00 | |
| 1.00 | 5.00 | ADMI NI STRATI VE & GENERAL | 7, 118 | 7, 118 | 0 | 0 | 0 | 1.00 |
| 2.00 | 30.00 | ADULTS & PEDIATRICS | 0 | 0 | 0 | 0 | 0 | 2.00 |
| 3.00 | 50.00 | OPERATING ROOM | 21, 689 | 21, 689 | 0 | 0 | 0 | 3.00 |
| 4.00 | 54.00 | RADIOLOGY – DIAGNOSTIC | 79, 472 | 79, 472 | 0 | 0 | 0 | 4.00 |
| 5.00 | 60.00 | LABORATORY | 3, 926 | 3, 926 | 0 | 0 | 0 | 5.00 |
| 6.00 | 91.00 | EMERGENCY | 1, 001, 620 | 0 | 1,001,620 | 0 | 0 | 6.00 |
| 7.00 | 0.00 | | 0 | 0 | 0 | 0 | 0 | 7.00 |
| 8.00 | 0.00 | | 0 | 0 | 0 | 0 | 0 | 8.00 |
| 9.00 | 0.00 | | 0 | 0 | 0 | 0 | 0 | 9.00 |
| 10.00 | 0.00 | | 0 | 0 | 0 | 0 | 0 | 10.00 |
| 200.00 | | | 1, 113, 825 | 112, 205 | 1,001,620 | | 0 | 200.00 |
| | Wkst. A Line # | Cost Center/Physician | Unadjusted RCE | 5 Percent of | Cost of | Provi der | Physician Cost | |
| | | I denti fi er | Limit | Unadjusted RCE | | Component | of Malpractice | |
| | | | | Limit | Conti nui ng | Share of col. | Insurance | |
| | | | | | Educati on | 12 | | |
| | 1.00 | 2.00 | 8.00 | 9.00 | 12.00 | 13.00 | 14.00 | |
| 1.00 | | ADMINISTRATIVE & GENERAL | 0 | - | 0 | - | °, | 1.00 |
| 2.00 | | ADULTS & PEDIATRICS | 0 | - | 0 | 0 | 0 | 2.00 |
| 3.00 | | OPERATING ROOM | 0 | 0 | 0 | 0 | 0 | 3.00 |
| 4.00 | | RADIOLOGY - DIAGNOSTIC | 0 | 0 | 0 | 0 | 0 | 4.00 |
| 5.00 | | LABORATORY | 0 | 0 | 0 | 0 | 0 | 5.00 |
| 6.00 | | EMERGENCY | 0 | 0 | 0 | 0 | 0 | 6.00 |
| 7.00 | 0.00 | | 0 | 0 | 0 | 0 | 0 | 7.00 |
| 8.00 | 0.00 | | 0 | 0 | 0 | 0 | 0 | 8.00 |
| 9.00 | 0.00 | | 0 | 0 | 0 | 0 | 0 | 9.00 |
| 10.00 | 0.00 | | 0 | 0 | 0 | 0 | 0 | 10.00 |
| 200.00 | | | 0 | 0 | 0 | 0 | 0 | 200.00 |
| | Wkst. A Line # | Cost Center/Physician | Provi der | Adjusted RCE | RCE | Adjustment | | |
| | | Identifier | Component | Limit | Di sal I owance | | | |
| | | | Share of col. 14 | | | | | |
| | 1,00 | 2.00 | 15.00 | 16.00 | 17.00 | 18.00 | | |
| 1.00 | | ADMI NI STRATI VE & GENERAL | 0 | | 0 | | | 1.00 |
| 2.00 | | ADULTS & PEDIATRICS | 0 | 0 | 0 | ,,,,,,, | | 2.00 |
| 3.00 | | OPERATI NG ROOM | 0 | 0 | 0 | 21, 689 | | 3.00 |
| 4.00 | | RADI OLOGY - DI AGNOSTI C | 0 | 0 | 0 | 79, 472 | | 4.00 |
| 5.00 | | LABORATORY | 0 | 0 | 0 | 3, 926 | | 5.00 |
| 6.00 | | EMERGENCY | 0 | 0 | | 3, 720 N | | 6.00 |
| 7.00 | 0.00 | | 0 | 0 | 0 | 0 | | 7.00 |
| 8.00 | 0.00 | | | 0 | | 0 0 | | 8.00 |
| 9.00 | 0.00 | | 0 | 0 | | 0 | | 9.00 |
| 10.00 | 0.00 | | 0 | 0 | | 0 | | 10,00 |
| 200.00 | 0.00 | | 0 | 0 | 0 | 112, 205 | | 200.00 |
| 200.00 | I | | 1 0 | 0 | | 1 112,200 | I | 200.00 |

ASCENSION ST. VINCENT JENNINGS

In Lieu of Form CMS-2552-10

| COST ALLOCA | ATION - GENERAL SERVICE COSTS | | Provider CO | | Peri od: | Worksheet B | |
|-------------|--|--------------|---------------|---------------------------------------|--------------------------------|-------------------|---------|
| | | | | | rom 07/01/2021 0 06/30/2022 | | narad |
| | | | | | 0 00/ 30/ 2022 | 11/28/2022 12 | :17 pm |
| | | | CAPI TAL | | | | |
| | | | RELATED COSTS | | | | |
| | Cost Center Description | Net Expenses | BLDG & FIXT | EMPLOYEE | Subtotal | ADMI NI STRATI VE | |
| | | for Cost | | BENEFITS | | & GENERAL | |
| | | Allocation | | DEPARTMENT | | | |
| | | (from Wkst A | | | | | |
| | | col. 7) | | | | | |
| | | 0 | 1.00 | 4.00 | 4A | 5.00 | |
| | RAL SERVICE COST CENTERS | 155 0.10 | 155 0.10 | | | 1 | |
| | 0 CAP REL COSTS-BLDG & FIXT | 455, 948 | 455, 948 | | | | 1.00 |
| | O EMPLOYEE BENEFITS DEPARTMENT | 1, 292, 294 | 0 | | | | 4.00 |
| | O ADMINISTRATIVE & GENERAL | 6, 256, 456 | | | | | 5.00 |
| | O OPERATION OF PLANT | 744, 921 | 41, 623 | | | | 7.00 |
| | O LAUNDRY & LINEN SERVICE | 45, 723 | 495 | | | | |
| | O HOUSEKEEPI NG | 474, 598 | 9, 358 | | 100/ 700 | | • |
| | 0 DI ETARY | 62, 421 | 4, 614 | | | | |
| | | 185, 573 | | | | | |
| | O NURSI NG ADMI NI STRATI ON | 303, 118 | 1, 082 | | | | |
| | 0 CENTRAL SERVICES & SUPPLY | 20, 124 | | | 27, 710 | | • |
| | 0 PHARMACY | 695, 774 | | | | | |
| | O MEDI CAL RECORDS & LI BRARY | 0 | 36, 110 | (| 36, 110 | 18, 548 | 16.00 |
| | TIENT ROUTINE SERVICE COST CENTERS | 1 070 0/1 | 10.77/ | | 1 507 000 | 000 744 | |
| | O ADULTS & PEDIATRICS | 1, 273, 964 | 42, 776 | 281, 090 | 1, 597, 830 | 820, 711 | 30.00 |
| | LLARY SERVICE COST CENTERS | 376, 514 | 33, 992 | 72, 73 | 483, 243 | 240.010 | 50.00 |
| | 0 RADIOLOGY - DIAGNOSTIC | 1, 266, 629 | 27, 547 | | | | 54.00 |
| | 0 LABORATORY | 2, 028, 660 | 11, 489 | | | | • |
| | 0 RESPIRATORY THERAPY | 2, 020, 000 | 11, 469 | 21,040 | | | |
| | 0 PHYSI CAL THERAPY | 179, 910 | 16, 181 | 48, 228 | ° | | • |
| | 0 OCCUPATIONAL THERAPY | 37, 792 | 0,131 | | | | • |
| | O SPEECH PATHOLOGY | 37, 792 | 0 | | | | |
| | 0 ELECTROCARDI OLOGY | 0 | 0 | (| - | | |
| 71.00 0710 | O MEDICAL SUPPLIES CHARGED TO PATIENTS | 25, 752 | 0 | | 25, 752 | - | |
| | O IMPLANTABLE DEVICES CHARGED TO | 10, 209 | 0 | | 10, 209 | | • |
| 72.00 0720 | PATIENTS | 10, 209 | 0 | | 10, 209 | 5, 244 | /2.00 |
| 73.00 0730 | O DRUGS CHARGED TO PATIENTS | 0 | 0 | (| | 0 | 73.00 |
| | O ADULT MENTAL HEALTH | 410, 416 | 0 | (| 410, 416 | | |
| | ATIENT SERVICE COST CENTERS | 110/110 | | · · · · · · · · · · · · · · · · · · · | 110/110 | 210,000 | 1 0.00 |
| | O RURAL HEALTH CLINIC | 0 | 0 | (| 0 0 | 0 | 88.00 |
| | 0 EMERGENCY | 2, 645, 404 | 27, 514 | 412, 382 | 3, 085, 300 | 1, 584, 738 | |
| | O OBSERVATION BEDS (NON-DISTINCT PART) | | | | 0 | | 92.00 |
| SPEC | AL PURPOSE COST CENTERS | | | | | | 1 |
| 118.00 | SUBTOTALS (SUM OF LINES 1 through 117) | 18, 792, 200 | 314, 424 | 1, 292, 294 | 18, 650, 676 | 6, 301, 632 | 118.00 |
| NONR | EIMBURSABLE COST CENTERS | | | | | | 1 |
| 190.001900 | OGIFT, FLOWER, COFFEE SHOP, & CANTEEN | 0 | 2, 359 | (| 2, 359 | 1, 212 | 190.00 |
| 191.001910 | | 0 | 0 | (| 0 0 | 0 | 191.00 |
| 192.001920 | 0 PHYSI CI ANS' PRI VATE OFFI CES | 0 | 0 | (| 0 0 | 0 | 192.00 |
| 194.000795 | O OTHER NRCC | 15, 183 | 0 | (| 15, 183 | | 194.00 |
| 194.010795 | 1 SPN | 0 | 90, 680 | (| 90, 680 | 46, 577 | 194.01 |
| 194.020795 | 2 OUTPATIENT CLINICS | 0 | 48, 485 | (| 48, 485 | 24, 904 | 194. 02 |
| 194.030795 | 3 MARKETI NG | 0 | 0 | (| 0 0 | 0 | 194. 03 |
| 200.00 | Cross Foot Adjustments | | | | 0 | | 200. 00 |
| 201.00 | Negative Cost Centers | | 0 | (| 0 0 | | 201.00 |
| 202.00 | TOTAL (sum lines 118 through 201) | 18, 807, 383 | 455, 948 | 1, 292, 294 | 18, 807, 383 | 6, 382, 124 | 202.00 |
| | | | | | | | |

| Heal th | Financial Systems AS | SCENSION ST. VI | NCENT JENNINGS | | In Lie | u of Form CMS- | 2552-10 |
|----------------|--|-----------------------|----------------------------|---------------|---|---|---------|
| | ALLOCATION - GENERAL SERVICE COSTS | | Provider C | CN: 15-1303 | Period: From 07/01/2021 To 06/30/2022 | Worksheet B Part I Date/Time Pre 11/28/2022 12 | |
| | Cost Center Description | OPERATION OF PLANT | LAUNDRY & LINEN SERVICE | HOUSEKEEPI NO | | CAFETERI A | |
| | 1 | 7.00 | 8.00 | 9.00 | 10.00 | 11.00 | |
| | GENERAL SERVICE COST CENTERS | 1 | 1 | 1 | | | |
| 1.00 | 00100 CAP REL COSTS-BLDG & FIXT | | | | | | 1.00 |
| 4.00 | 00400 EMPLOYEE BENEFITS DEPARTMENT | | | | | | 4.00 |
| 5.00 | 00500 ADMI NI STRATI VE & GENERAL | 4 400 545 | | | | | 5.00 |
| 7.00 | 00700 OPERATION OF PLANT | 1, 190, 545 | | | | | 7.00 |
| 8.00 | 00800 LAUNDRY & LINEN SERVICE | 1,576 | | | | | 8.00 |
| 9.00 | 00900 HOUSEKEEPING | 29, 786 | | | | | 9.00 |
| 10.00 | 01000 DI ETARY | 14, 686 | | 9, 26 | | 205 544 | 10.00 |
| 11.00 | 01100 CAFETERIA | 30, 263 | | | 0 0 | 325, 546 | |
| 13.00 14.00 | 01300 NURSI NG ADMI NI STRATI ON | 3, 443 | | | - | 21, 231 | |
| | 01400 CENTRAL SERVICES & SUPPLY | 24, 144 | | 10.0 | 0 0 | 0 | |
| 15.00 | | 13, 586 | | 19, 84 | | 14, 154 | |
| 16.00 | 01600 MEDI CAL RECORDS & LI BRARY | 114, 933 | 0 | | 0 0 | 0 | 16.00 |
| 30, 00 | 03000 ADULTS & PEDIATRICS | 136, 152 | 0 | 55, 89 | 125, 413 | 70, 771 | 30,00 |
| 30.00 | ANCI LLARY SERVICE COST CENTERS | 130, 132 | 0 | 55, 6 | 125, 415 | 70, 771 | 30.00 |
| 50.00 | 05000 OPERATING ROOM | 108, 192 | 471 | 306, 89 | 98 0 | 28, 308 | 50.00 |
| 54.00 | 05400 RADI OLOGY - DI AGNOSTI C | 87,678 | | | | 63, 694 | • |
| 60.00 | 06000 LABORATORY | 36, 569 | | 23, 8 | | 7,077 | • |
| 65.00 | 06500 RESPIRATORY THERAPY | 00,007 | 0 | 20,0 | 0 0 | 0 | |
| 66.00 | 06600 PHYSI CAL THERAPY | 51, 503 | | 19, 84 | 12 0 | 21, 231 | |
| 67.00 | 06700 OCCUPATI ONAL THERAPY | 01,000 | 0 | 17,0 | 0 0 | 0 | |
| 68.00 | 06800 SPEECH PATHOLOGY | 0 | 0 | | 0 0 | 0 | |
| 69.00 | 06900 ELECTROCARDI OLOGY | 0 | 0 | | 0 0 | 0 | |
| 71.00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 0 | | 0 0 | 0 | |
| 72.00 | 07200 I MPLANTABLE DEVICES CHARGED TO PATIENTS | 0 | 0 | | 0 0 | 0 | • |
| 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 | 1 | | 1 | | | |
| 88.00 | 08800 RURAL HEALTH CLINIC | 0 | - | | 0 0 | 0 | |
| 91.00 | 09100 EMERGENCY | 87, 574 | 0 | 300, 28 | 33 0 | 99, 080 | • |
| 92.00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | | | | | | 92.00 |
| | SPECIAL PURPOSE COST CENTERS | 710.005 | 74 500 | | | 0.05 544 | |
| 118.00 | | 740, 085 | 71, 533 | 779, 47 | 79 125, 413 | 325, 546 | 118.00 |
| 100.00 | NONREIMBURSABLE COST CENTERS | 7, 509 | 0 | 1 | 0 0 | 0 | 190.00 |
| | 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN | 7, 509 | | | 0 0 | | 190.00 |
| | 19100 RESEARCH 19200 PHYSI CLANS' PRI VATE OFFI CES | | 0 | | 0 0 | | 191.00 |
| | 07950 OTHER NRCC | | 0 | 53, 90 | - | | 194.00 |
| | 07950 0112k NKCC | 288, 628 | | 55, 90 | 0 0 | | 194.00 |
| | 07951 OUTPATIENT CLINICS | 154, 323 | | | 0 0 | | 194.02 |
| | 07952 001FATTENT CENTCS | 154, 525 | | | | | 194.02 |
| 200.00 | | | l | | | 0 | 200.00 |
| 200.00 | 5 | 0 | 0 | | 0 0 | Ω | 201.00 |
| 202.00 | 5 | 1, 190, 545 | 71, 533 | 833, 38 | 34 125, 413 | 325, 546 | |
| | | | | | | | |

| From 07/01/2021 Date/Time Price Part I Date/Time Price Description PMRMACY ADM IN STRATION SERVICES a SUPPLY PHARMACY EVENTSAL PHARMACY RECORDS & LIBRARY Description Service 100 00100 CAP REL COST CENTERS 33.00 14.00 15.00 24.00 100 00100 CAP REL COST SUPPLY 0 16.00 24.00 00000 EMPLOYEE ENERTIS DECARTNENT 0 0 0 0 0 000000 DIFARM 000000 DIFARM 0 0 0 0 0 000000 DIFARM 00100 CAP REL COST CENTERS 0 0 0 0 0 0 0 10:00 000000 DIFTARY 607.878 660.087 1 201 169.591 11:00 01000 CHAMINISTRATION 607.878 60.087 1 201.221 1 11:00 01000 CHAMINISTRATION 607.81 209.134 5.970 0 5.48 3.027.41 11:00 01000 CHAMINISTRATION 73.126 1 6.7.28 3.027.41 10:00 <th></th> <th></th> <th>SCENSION ST. VII</th> <th></th> <th></th> <th></th> <th>u of Form CMS-</th> <th>2552-10</th> | | | SCENSION ST. VII | | | | u of Form CMS- | 2552-10 |
|--|--------|-----------------------------------|------------------|-------------|-------------|-------------|---|--------------------|
| Cost Center Description NRSING DMINISTRATION CENTRAL SERVICES PHARMACY ACTION SERVICES MEDICAL RECORDS & LIBRARY Subtotal RECORDS & LIBRARY 100 GOTOQ CAP REL COST S-BLDG & FIXT 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 CAP REL COSTS-BLDG & FIXT 4.00 0 15.00 16.00 24.00 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 0 <td>COST A</td> <td>LLOCATION - GENERAL SERVICE COSTS</td> <td></td> <td>Provider CC</td> <td>CN: 15-1303</td> <td></td> <td>Worksheet B Part I Date/Time Pre 11/28/2022 12</td> <td>epared: 2:17 pm</td> | COST A | LLOCATION - GENERAL SERVICE COSTS | | Provider CC | CN: 15-1303 | | Worksheet B Part I Date/Time Pre 11/28/2022 12 | epared: 2:17 pm |
| SUPPLY LIBRARY 100 OTION CAR REL COST CENTERS 13.00 14.00 15.00 16.00 24.00 100 OTION CAR REL COST CENTERS 0 16.00 16.00 24.00 100 OTION CAR REL COST CENTERS 0 <td< td=""><td></td><td>Cost Center Description</td><td></td><td></td><td>PHARMACY</td><td></td><td></td><td></td></td<> | | Cost Center Description | | | PHARMACY | | | |
| GENERAL SERVICE COST CENTERS Image: Cost of the co | | | ADMINI STRATI UN | | | | | |
| 1.00 00100 CAP REL COSTS-BLOG & FIXT | | | 13.00 | 14.00 | 15.00 | 16.00 | 24.00 | |
| 4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT | | | 1 1 | | | | | _ |
| 5. 00 00500 ADMIN STRATIVE & GENERAL | | | | | | | | 1.00 |
| 7. 00 00700 0PERATION OF PLANT 80.00 00800 LUNEWS SERVICE 9.00 00900 HUSEKEEPING 11.00 011000 CAFETERIA 609, 878 13.00 01000 CAFETERIA 609, 878 13.00 OTOOD (MEDICAL RECORDS & SUPPLY) 0 66, 087 15.00 01500 MARMACY 0 22 1, 201, 213 10.00 OTOOD OPEDATINE SERVICE COST CENTERS 00 05000 PRATIENT ROUTINE SERVICE COST CENTERS 00 05000 PRATIENT ROUTINE SERVICE COST CENTERS | | | | | | | | 4.00 |
| 8. 00 00000 LAUNDRY & LINEN SERVICE | | | | | | | | 5.00 |
| 9, 00 0000 HOUSEKEEPING 11.00 01100 CAFETERIA 13.00 01300 NURSING ADMINISTRATION 01300 NURSING ADMINISTRATION 01300 NURSING ADMINISTRATION 001500 PERATING EXPLOSES & SUPPLY 0 002 1, 201, 213 000 0000 MEDICAL RECORDS & LIBRARY 0 0 0 0 0 0 0 0 0 0 0 0 0 | | | | | | | | 7.00 |
| 10:000 01000 DETARY 0 11:00 01100 CAFETERIA 609, 878 13:00 01300 NURSI KG ADMI NI STRATI ON 609, 878 14:00 01400 CENTRAL, SERVICES & SUPPLY 0 606, 087 15:00 01500 PHARMACY 0 22 1, 201, 213 16:00 0000 AUDICAL RECORDS & LIBRARY 0 0 0 10:001 DICAL RECORDS & LIBRARY 0 0 0 169, 591 10:001 DICAL RECORDS & LIBRARY 0 0 0 5, 548 3, 027, 41 10:001 DICAL RECORDS & LIBRARY 0 0 0 5, 548 3, 027, 41 40:001 LARY SERVICE COST CENTERS | | | | | | | | 8.00 |
| 11 00 0100 CAPETERIA 609, 878 13 00 01300 NURSI NG ADMIN ISTATI ON 609, 878 14 00 01400 CENTRAL SERVI CES & SUPPLY 0 15 00 01500 PLARMACY 0 22 16 00 1600, MEDI CAL, RECORDS & LI BRARY 0 0 169, 591 10 00 000 ADULTS & PEDI ATRICS 209, 134 5, 970 0 5, 648 3, 027, 41 ANCI LLARY SERVI CE COST CENTERS | | | | | | | | 9.00 |
| 13:00 013:00 NURSI NG ADMI NI STRATI ON 609, 878 66, 087 14:00 01400 CENTRAL SERVI CES & SUPPLY 0 22 1, 201, 213 16:00 01500 PHARMACY 0 22 1, 201, 213 16:00 01500 FARMACY 0 0 169, 591 INPATIENT ROUTINE SERVICE COST CENTERS 209, 134 5, 970 0 5, 548 3, 027, 41 ANCILLARY SERVICE COST CENTERS 0 16, 287 0 10, 224 1, 274, 96 50:00 05000 PEATI ING ROOM 73, 126 16, 287 0 10, 224 1, 274, 96 51:00 0 6000 LABORATORY 0 98 0 52, 296 3, 240, 66 66:00 06000 LABORATORY 0 0 0 326 32 67:00 0 0 0 2, 786 0 0 0 326 32 68:00 06000 SPECEL PATHOLOGY 0 0 0 0 0 1, 201, 213 1, 201, 213 1, 201, 213 1, 201, 213 1, 201, 214 | | | | | | | | 10.00 |
| 14.00 CHTRAL SERVICES & SUPPLY 0 66,087 15.00 01500 PHARMACY 0 22 1,201,213 16.00 01600 MEDICAL RECORDS & LIBRARY 0 0 169,591 INPATIENT ROUTINE SERVICE COST CENTERS 209,134 5,970 0 5,548 3,027,41 ANCILLARY SERVICE COST CENTERS 73,126 16,287 0 10,224 1,274,96 54.00 05000 ORDO OPERATING ROOM 73,126 16,287 0 10,224 1,274,96 54.00 06000 RESPIRATORY THOR TORY THERAPY 0 98 0 52,296 3,240,66 65.00 06500 RESPIRATORY THERAPY 0 0 0 2,796 465,69 7.00 00 0 0 2,796 465,69 0 0 0 0 0 0 1,201,213 0 1,201,213 0 1,201,213 0 1,201,213 0 1,201,213 0 1,201,213 0 1,201,213 0 1,201,213 0 1,201,213 0 1,201,213 0 1,201,213 < | 11.00 | 01100 CAFETERI A | | | | | | 11.00 |
| 15.00 01500 PHARMACY 0 0 22 1, 201, 213 0 16.00 0 0000 0 0 0 0 169, 591 19.00 03000 ADULTS & PEDIATRICS 209, 134 5, 970 0 5, 548 3, 027, 41 ANCILLARY SERVICE COST CENTERS | 13.00 | 01300 NURSING ADMINISTRATION | 609, 878 | | | | | 13.00 |
| 16:00 DI GOD MEDI CAL RECORDS & LI BRARY 0 0 0 169, 591 INPATI ENT ROUTI NE SERVI CE COST CENTERS 209, 134 5, 970 0 5, 548 3, 027, 41 ANCI LLARY SERVI CE COST CENTERS | 14.00 | 01400 CENTRAL SERVICES & SUPPLY | 0 | 66, 087 | | | | 14.00 |
| INPATI ENT ROUTI NE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDI ATR CS 209, 134 5, 970 0 5, 548 3, 027, 41 ANCILLARY SERVICE COST CENTERS 50.00 05000 [PRATI NG ROOM 73, 126 16, 287 0 10, 224 1, 274, 96 50.00 06000 [AbOURGY - DI AGNOSTIC 0 4, 672 0 44, 818 2, 530, 65 60.00 06000 [RESPI RATORY HERAPY 0 98 0 52, 296 3, 240, 66 65.00 06600 [PHYSI CAL THERAPY 0 0 0 326 322 66.00 06600 PHYSI CAL THERAPY 0 510 0 2,796 445, 69 67.00 06700 [OCCUPATI ONAL THERAPY 0 0 0 0 0 68.00 68000 [SBECEN PATHOLOGY 0 0 0 0 0 71.00 07100 [LICAL SUPPLIES CHARGED TO PATI ENTS 0 9, 120 0 0 1, 201, 21 75.00 07200 [IMPLANTABLE DEVICES CHARGED TO PATI ENTS 0 0 1, 201, 21 | 15.00 | 01500 PHARMACY | 0 | 22 | 1, 201, 2 | 13 | | 15.00 |
| INPATI ENT ROUTI NE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDI ATR CS 209, 134 5, 970 0 5, 548 3, 027, 41 ANCILLARY SERVICE COST CENTERS 50.00 05000 [PRATI NG ROOM 73, 126 16, 287 0 10, 224 1, 274, 96 50.00 06000 [AbOURGY - DI AGNOSTIC 0 4, 672 0 44, 818 2, 530, 65 60.00 06000 [RESPI RATORY HERAPY 0 98 0 52, 296 3, 240, 66 65.00 06600 [PHYSI CAL THERAPY 0 0 0 326 322 66.00 06600 PHYSI CAL THERAPY 0 510 0 2,796 445, 69 67.00 06700 [OCCUPATI ONAL THERAPY 0 0 0 0 0 68.00 68000 [SBECEN PATHOLOGY 0 0 0 0 0 71.00 07100 [LICAL SUPPLIES CHARGED TO PATI ENTS 0 9, 120 0 0 1, 201, 21 75.00 07200 [IMPLANTABLE DEVICES CHARGED TO PATI ENTS 0 0 1, 201, 21 | 16.00 | 01600 MEDI CAL RECORDS & LI BRARY | 0 | 0 | | 0 169, 591 | | 16.00 |
| ANCI LLARY SERVICE COST CENTERS 50.00 05000 (DPERATI NG ROOM 73, 126 16, 287 0 10, 224 1, 274, 96 50.00 05400 (RADI OLOGY - DI AGNOSTI C 0 4, 672 0 44, 818 2, 530, 65 60.00 06500 (RESPI RATORY THERAPY 0 98 0 52, 296 3, 240, 66 65.00 06500 (PERYSI CAL THERAPY 0 0 0 326 32 66.00 06600 (PHYSI CAL THERAPY 0 0 0 2, 796 445, 69 67.00 06700 (OCCUPATI ONAL THERAPY 0 0 0 0 2, 796 456, 69 68.00 06800 SPECH PATHOLOGY 0 1, 217, 213 0 1, 217, 21 0 1, 201, 213 0 1, 201, 213 1, 201, 213 1, 201, 213 0 | | | | | | | | 1 |
| ANCILLARY SERVICE COST CENTERS 50.00 05000 DERATING ROOM 73,126 16,287 0 10,224 1,274,96 50.00 05400 RADIOLOGY - DI AGNOSTI C 0 4,672 0 44,818 2,530,65 60.00 DABORATORY 0 98 0 52,296 3,240,66 65.00 O6600 PHYSI CAL THERAPY 0 0 0 326 32 66.00 06600 CUPATIONAL THERAPY 0 0 0 2,796 445,69 67.00 O6700 OCUPATIONAL THERAPY 0 0 0 0 2,796 456,60 68.00 O6800 SPEECH PATHOLOGY 0 0 0 0 0 0 0 0 0 0 1,79,95 0 0 0 0 1,201,213 0 1,201,213 0 1,201,21 1,621,622,84 0 1,621,622,84 0 1,621,622,84 0 1,621,623,85 1,623,923,00 1,621,623,93 0 | 30.00 | 03000 ADULTS & PEDIATRICS | 209, 134 | 5, 970 | | 0 5,548 | 3, 027, 419 | 30.00 |
| 50.00 DSO00 DPERATINC ROOM 73, 126 16, 287 0 10, 224 1, 274, 96 54.00 05400 RADIOLOGY - DIAGNOSTIC 0 4, 672 0 44, 818 2, 530, 65 60.00 06000 LABORATORY 0 98 0 52, 296 3, 240, 66 65.00 06500 RESPI RATORY THERAPY 0 0 0 326 322 66.00 06700 DCUPATIONAL THERAPY 0 0 0 2,796 465,69 67.00 06700 DCUPATIONAL THERAPY 0 0 0 2,796 465,69 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 0 69.00 60500 DECTROCARDIOLOGY 0 0 0 0 1, 201, 213 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 1, 201, 213 0 1, 201, 213 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 1, 201, 213 0 1, 201, 213 76.00 08800 RURA | | | | | | | | |
| 54.00 05400 RADI OLOGY - DI AGNOSTI C 0 4,672 0 44,818 2,530,65 60.00 06000 LABORATORY 0 98 0 52,296 3,240,66 60.00 06000 PHSI RATORY THERAPY 0 0 0 326 322 66.00 06000 PHYSI CAL THERAPY 0 0 0 2,796 465,69 67.00 06000 CCUPATI ONAL THERAPY 0 0 0 0 0 0 68.00 06000 ELECTROCARDI OLOGY 0 0 0 0 0 0 69.00 06900 ELECTROCARDI OLOGY 0 0 0 0 48,09 72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATI ENTS 0 1,201,213 0 1,201,21 73.00 07300 RUGS CHARGED TO PATI ENTS 0 0 1,201,213 0 1,201,21 74.00 09100 EMERGENCY 327,618 26,903 0 51,688 5,563,18 92.00 09200 IOBSERVATI ON BEDS (NON-DI STI NCT PART) 327,618 26,903 0 1,09,591 <td< td=""><td>50.00</td><td></td><td>73, 126</td><td>16, 287</td><td></td><td>0 10.224</td><td>1, 274, 962</td><td>50.00</td></td<> | 50.00 | | 73, 126 | 16, 287 | | 0 10.224 | 1, 274, 962 | 50.00 |
| 60.00 06000 LABORATORY 0 98 0 52, 296 3, 240, 66 65.00 06500 RESPI RATORY THERAPY 0 0 0 326 32 64.00 06600 PHYSI CAL THERAPY 0 510 0 2,796 4465, 69 67.00 06700 0CCUPATI ONAL THERAPY 0 0 0 274 72, 80 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 69.00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 1, 201, 21 0 1, 201, 21 0 1, 201, 21 0 1, 201, 21 0 1, 201, 21 0 1, 201, 21 0 1, 201, 21 0 1, 201, 21 0 1, 201, 21 0 1, 201, 21 0 1, 201, 21 0 1, 201, 21 0 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>•</td> | | | | | | | | • |
| 65.00 06500 RESPIRATORY THERAPY 0 0 326 32 66.00 06600 PHYSI CAL THERAPY 0 510 0 2,796 465,69 67.00 0500 0000000 0 0 274 72,80 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 69.00 06900 ELECTROCARDIOLOGY 0 0 0 0 71.00 MDI CAL SUPPLIES CHARGED TO PATI ENTS 0 9,120 0 48.09 72.00 07200 IMPLANTABLE DEVICES CHARGED TO 0 2,505 0 0 17,95 PATI ENTS 0 0 0 1,201,213 0 1,201,21 76.00 03905 ADULT MENTAL HEALTH 0 0 0 0 1,621 622,84 00 09100 EMERGENCY 327,618 26,903 0 51,688 5,563,18 92.00 09200 DBSES (NON-DI STI INCT PART) 327,618 | | | 0 | | | | | • |
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| 68.00 06800 SPECH PATHOLOGY 0 0 0 69.00 06900 ELECTROCARDI OLOGY 0 0 0 0 71.00 OT100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 9,120 0 0 48,09 72.00 O7200 IMPLANTABLE DEVICES CHARGED TO 0 2,505 0 0 17,95 73.00 DRUGS CHARGED TO PATIENTS 0 0 1,201,213 0 1,201,213 03950 ADULT MENTAL HEALTH 0 0 0 0 622,84 0UTPATI ENT SERVICE COST CENTERS 0 0 0 0 0 0 88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 0 0 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 327,618 26,903 0 51,688 5,563,18 92.00 09200 PURSE MEURSABLE COST CENTERS 5 5 0 0 0 0 0 190.00 <td></td> <td></td> <td>0</td> <td></td> <td></td> <td>2///0</td> <td></td> <td></td> | | | 0 | | | 2///0 | | |
| 69.00 06900 ELECTROCARDIOLOGY 0 0 0 71.00 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 9,120 0 0 48,09 72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS 0 2,505 0 0 17,95 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 1,201,213 0 1,201,213 76.00 03950 ADULT MENTAL HEALTH 0 0 0 1,621 622,84 0UTPATIENT SERVICE COST CENTERS 0 <t< td=""><td></td><td></td><td>0</td><td>-</td><td></td><td></td><td>12,002</td><td></td></t<> | | | 0 | - | | | 12,002 | |
| 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 9, 120 0 0 48,09 72.00 07200 IMPLANTABLE DEVICES CHARGED TO 0 2,505 0 0 17,95 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 1,201,213 0 1,201,21 76.00 03950 ADULT MENTAL HEALTH 0 0 0 1,621 622,84 0UTPATIENT SERVICE COST CENTERS 0 0 0 0 0 60 0 0 1,621 622,84 0UTPATIENT SERVICE COST CENTERS 327,618 26,903 0 51,688 5,563,18 92.00 OBSERVATION BEDS (NON-DI STINCT PART) 327,618 26,903 0 51,688 5,563,18 92.00 OBSERVATION BEDS (SUM OF LINES 1 through 117) 609,878 66,087 1,201,213 169,591 18,065,81 180.00 Ignos Gift, FLOWER, COFFEE SHOP, & CANTEEN 0 0 0 0 191.00 19000 | | | 0 | - | | - | 0 | |
| 72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS 0 2,505 0 0 17,95 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 1,201,213 0 1,201,213 76.00 03950 JAULT MENTAL HEALTH 0 0 0 1,621 622.84 OUTPATIENT SERVICE COST CENTERS 0 0 0 0 0 1,621 622.84 001704 DERGENCY 0 | | | 0 | Ŭ | | 0 | - | |
| PATIENTS PATIENTS O O 1, 201, 213 O 1, 201, 213 O 1, 201, 21 622, 84 O 1, 621 622, 84 622, 84 0 622, 84 0 1, 621 622, 84 622, 84 0 1, 621 622, 84 0 1, 621 622, 84 0 1, 621 622, 84 0 1, 621 622, 84 0 1, 621 622, 84 0 1, 621 622, 84 0 1, 621 622, 84 0 1, 621 622, 84 0 1, 621 622, 84 0 1, 621 622, 84 0 | | | 0 | | | - | | |
| 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 1, 201, 213 0 1, 201, 21 76.00 03950 ADULT MENTAL HEALTH 0 0 0 1, 621 622, 84 0UTPATIENT SERVICE COST CENTERS 0 0 0 0 0 0 0 0 88.00 08800 RURAL HEALTH CLINIC 0 | 72.00 | | 0 | 2, 505 | | 0 0 | 17, 958 | 72.00 |
| 76.00 03950 ADULT MENTAL HEALTH 0 0 1, 621 622, 84 0UTPATI ENT SERVICE COST CENTERS 0 <t< td=""><td>70.00</td><td></td><td></td><td></td><td>1 001 0</td><td>10 0</td><td>1 001 010</td><td>72 00</td></t<> | 70.00 | | | | 1 001 0 | 10 0 | 1 001 010 | 72 00 |
| OUTPATI ENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 91.00 09100 EMERGENCY 327, 618 26, 903 0 51, 688 5, 563, 18 92.00 OBSERVATI ON BEDS (NON-DI STINCT PART) SPECI AL PURPOSE COST CENTERS 5 | | | 0 | | 1, 201, 2 | | | |
| 88.00 08800 RURAL HEALTH CLINIC 0 | 76.00 | | 0 | 0 | | 0 1,621 | 622, 843 | 76.00 |
| 91.00 09100 EMERGENCY 327, 618 26, 903 0 51, 688 5, 563, 18 92.00 OBSERVATI ON BEDS (NON-DI STINCT PART) SUBTOTALS (SUM OF LINES 1 through 117) 609, 878 66, 087 1, 201, 213 169, 591 18, 065, 81 NONREI MBURSABLE COST CENTERS 118.00 NONREI MBURSABLE COST CENTERS 190.00 GI FT, FLOWER, COFFEE SHOP, & CANTEEN 0 0 0 11, 08 191.00 19100 RESEARCH 0 0 0 0 192.00 07950 OTHER NRCC 0 0 0 0 194.00 07950 OTHEN NRCC 0 0 0 0 194.02 07952 OUTPATI ENT CLINICS 0 0 0 227, 71 194.02 07952 MARKETI NG 0 0 0 227, 71 194.02 07953 MARKETI NG 0 0 0 227, 71 194.03 07953 MARKETI NG < | ~~ ~~ | | | a | | | | |
| 92.00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) Image: constraint of the state of th | | | - | Ŭ | | | 0 | |
| SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 609, 878 66, 087 1, 201, 213 169, 591 18, 065, 81 NONREL MBURSABLE COST CENTERS 190.00 19000 GI FT, FLOWER, COFFEE SHOP, & CANTEEN 0 0 0 11, 08 191.00 19100 RESEARCH 0 0 0 0 0 0 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 0 194.00 07950 OTHER NRCC 0 0 0 0 0 0 76, 88 194.02 07952 OUTPATI ENT CLINICS 0 0 0 0 227, 71 194.03 07953 MAKETI NG 0 0 0 0 0 0 227, 71 194.03 07953 MAKETI NG 0 0 0 0 0 0 0 0 0 0 0 0 227, 71 | | | 327, 618 | 26, 903 | | 0 51,688 | 5, 563, 184 | |
| SUBTOTALS SUBTOTALS SUM OF LINES 1 through 117 609, 878 66, 087 1, 201, 213 169, 591 18, 065, 81 NONREI MBURSABLE COST CENTERS 0 0 0 11, 08 190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 0 0 0 11, 08 191.00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 0 0 11, 08 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 0 0 0 194.00 07950 OTHER NRCC 0 0 0 0 425, 88 194.01 07951 SPN 0 0 0 0 227, 71 194.02 07952 OUTPATI ENT CLINICS 0 0 0 0 227, 71 194.03 07953 MARKETI NG 0 0 | 92.00 | | | | | | | 92.00 |
| NONREI MBURSABLE COST CENTERS 0 0 0 0 11,08 190.00 GI FT, FLOWER, COFFEE SHOP, & CANTEEN 0 0 0 11,08 191.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 194.00 07950 OTHER NRCC 0 0 0 76,88 194.01 07951 SPN 0 0 0 425,88 194.02 07952 OUTPATI ENT CLI NI CS 0 0 0 227,71 194.03 07953 MARKETI NG 0 0 0 227,71 194.03 07953 Cross Foot Adj ustments 0 0 0 0 | | | | | | | | |
| 190.00 GI FT, FLOWER, COFFEE SHOP, & CANTEEN 0 0 0 11,08 191.00 19100 RESEARCH 0 0 0 0 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 194.00 07950 OTHER NRCC 0 0 0 0 76, 88 194.01 07951 SPN 0 0 0 425, 88 194.02 07952 OUTPATI ENT CLI NI CS 0 0 0 227, 71 194.03 07953 MARKETI NG 0 0 0 0 200.00 Cross Foot Adj ustments 0 0 0 0 0 | 118.00 | | 609, 878 | 66, 087 | 1, 201, 2 | 13 169, 591 | 18, 065, 819 | 118.00 |
| 191.00 19100 RESEARCH 0 0 0 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 194.00 07950 OTHER NRCC 0 0 0 76, 88 194.01 07951 SPN 0 0 0 425, 88 194.02 07952 OUTPATI ENT CLINICS 0 0 0 227, 71 194.03 07953 MARKETI NG 0 0 0 227, 71 | | | | | | | | |
| 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 194.00 07950 OTHER NRCC 0 0 0 76,88 194.01 07951 SPN 0 0 0 425,88 194.02 07952 OUTPATI ENT CLINICS 0 0 0 227,71 194.03 07953 MARKETI NG 0 0 0 227,71 200.00 Cross Foot Adjustments 0 0 0 0 | | | - | | | | | 190.00 |
| 194.00 07950 OTHER NRCC 0 0 0 76,88 194.01 07951 SPN 0 0 0 425,88 194.02 07952 OUTPATI ENT CLINICS 0 0 0 227,71 194.03 07953 MARKETING 0 0 0 0 200.00 Cross Foot Adjustments 0 0 0 0 | | | - | - | | | | 191.00 |
| 194.01 07951 SPN 0 0 0 425, 88 194.02 07952 OUTPATI ENT CLINICS 0 0 0 227, 71 194.03 07953 MARKETI NG 0 0 0 227, 71 200.00 Cross Foot Adjustments 0 0 0 0 | | | 0 | 0 | | 0 0 | | 192.00 |
| 194.02 07952 OUTPATI ENT CLINICS 0 0 0 227, 71 194.03 07953 MARKETING 0 0 0 0 200.00 Cross Foot Adjustments 0 0 0 0 | | | 0 | 0 | | 0 0 | 76, 887 | 194.00 |
| 194.03 07953 MARKETI NG 0 0 0 200.00 Cross Foot Adjustments 0 0 0 0 | 194.01 | 07951 SPN | 0 | 0 | | 0 0 | 425, 885 | 194.01 |
| 194.03 07953 MARKETI NG 0 0 0 200.00 Cross Foot Adjustments 0 0 0 0 | 194.02 | 07952 OUTPATIENT CLINICS | 0 | 0 | | 0 0 | 227, 712 | 194.02 |
| 200.00 Cross Foot Adjustments | 194.03 | 07953 MARKETI NG | 0 | 0 | | 0 0 | 0 | 194.03 |
| | | | | | | | | 200.00 |
| | | 5 | 0 | 0 | | 0 0 | | 201.00 |
| | | 5 | 609, 878 | 66, 087 | 1, 201, 2 | 13 169.591 | | |

| Heal th | Financial Systems | ASCENSION ST. VINC | CENT JENNINGS | | In Lieu of Fo | rm CMS-2552-10 |
|---------|--|--|----------------|------------|--|----------------|
| | LOCATION - GENERAL SERVICE COSTS | | Provider CCN | l: 15-1303 | Period: Worksh From 07/01/2021 Part I To 06/30/2022 Date/T | ime Prepared: |
| | Cost Center Description | Intern & Residents Cost & Post Stepdown Adjustments 25.00 | Total 26.00 | | 11/28/ | 2022 12:17 pm |
| | GENERAL SERVICE COST CENTERS | 23.00 | 20.00 | | | |
| | 00100 CAP REL COSTS-BLDG & FIXT | | | | | 1.00 |
| | 00400 EMPLOYEE BENEFITS DEPARTMENT | | | | | 4.00 |
| | 00500 ADMINI STRATI VE & GENERAL | | | | | 5.00 |
| | 00700 OPERATION OF PLANT | | | | | 7.00 |
| | 00800 LAUNDRY & LINEN SERVICE | | | | | 8.00 |
| | 00900 HOUSEKEEPING | | | | | 9.00 |
| | 01000 DI ETARY | | | | | 10.00 |
| | 01100 CAFETERI A | | | | | 11.00 |
| | 01300 NURSI NG ADMI NI STRATI ON | | | | | 13.00 |
| | 01400 CENTRAL SERVICES & SUPPLY | | | | | 14.00 |
| | 01500 PHARMACY | | | | | 15.00 |
| | 01600 MEDICAL RECORDS & LIBRARY | | | | | 16.00 |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | | | 10.00 |
| | 03000 ADULTS & PEDI ATRI CS | 0 | 3, 027, 419 | | | 30.00 |
| | ANCI LLARY SERVICE COST CENTERS | - | | | | |
| | 05000 OPERATING ROOM | 0 | 1, 274, 962 | | | 50.00 |
| | 05400 RADIOLOGY - DIAGNOSTIC | 0 | 2, 530, 652 | | | 54.00 |
| | 06000 LABORATORY | 0 | 3, 240, 668 | | | 60.00 |
| 65.00 | 06500 RESPI RATORY THERAPY | 0 | 326 | | | 65.00 |
| | 06600 PHYSI CAL THERAPY | 0 | 465, 693 | | | 66.00 |
| 67.00 | 06700 OCCUPATI ONAL THERAPY | 0 | 72, 802 | | | 67.00 |
| 68.00 | 06800 SPEECH PATHOLOGY | 0 | 0 | | | 68.00 |
| 69.00 | 06900 ELECTROCARDI OLOGY | 0 | 0 | | | 69.00 |
| 71.00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 48, 099 | | | 71.00 |
| 72.00 | 07200 IMPLANTABLE DEVICES CHARGED TO | 0 | 17, 958 | | | 72.00 |
| | PATIENTS | | | | | |
| | 07300 DRUGS CHARGED TO PATIENTS | 0 | 1, 201, 213 | | | 73.00 |
| | 03950 ADULT MENTAL HEALTH | 0 | 622, 843 | | | 76.00 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | |
| | 08800 RURAL HEALTH CLINIC | 0 | 0 | | | 88.00 |
| | 09100 EMERGENCY | 0 | 5, 563, 184 | | | 91.00 |
| | 09200 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS | 0 | | | | 92.00 |
| 118.00 | SUBTOTALS (SUM OF LINES 1 through 117) | 0 | 18,065,819 | | | 118.00 |
| | NONREI MBURSABLE COST CENTERS | U U | 10,005,019 | | | 110.00 |
| | 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN | 0 | 11, 080 | | | 190.00 |
| | 19100 RESEARCH | 0 | 0 | | | 191.00 |
| | 19200 PHYSI CLANS' PRI VATE OFFI CES | 0 | 0 | | | 192.00 |
| | 07950 OTHER NRCC | 0 | 76, 887 | | | 194.00 |
| | 07951 SPN | 0 | 425, 885 | | | 194.00 |
| | 07952 OUTPATIENT CLINICS | 0 | 227, 712 | | | 194.02 |
| | 07953 MARKETI NG | 0 | 0 | | | 194.03 |
| 200.00 | Cross Foot Adjustments | 0 | o | | | 200.00 |
| 201.00 | Negative Cost Centers | 0 | o | | | 201.00 |
| 202.00 | TOTAL (sum lines 118 through 201) | 0 | 18, 807, 383 | | | 202.00 |
| | | · · | | | | ' |

| Heal th | Fina | inci | al | Syste | ems | | |
|---------|------|------|-----|-------|-----|------|----|
| | | OF | CAE | | DEL | ATED | CC |

ASCENSION ST. VINCENT JENNINGS In Lieu of Form CMS-2552-10

| | TTION OF CAPITAL RELATED COSTS | DELIISI ON ST. VI | Provi der C | | eri od: | Worksheet B | 2332-10 |
|--------|---|-------------------|---------------|-------------|----------------|-------------------|---------|
| ALLOUF | THON OF CALLINE RELATED COSTS | | | | rom 07/01/2021 | Part II | |
| | | | | T | | Date/Time Pre | pared: |
| | | | | | | 11/28/2022 12 | :17 pm |
| | | | CAPI TAL | | | | |
| | Cast Castas Description | Discontinu | RELATED COSTS | 0 | | | |
| | Cost Center Description | Directly | BLDG & FIXT | Subtotal | EMPLOYEE | ADMI NI STRATI VE | |
| | | Assigned New | | | BENEFI TS | & GENERAL | |
| | | Capital | | | DEPARTMENT | | |
| | | Related Costs | 1.00 | 2A | 4.00 | 5.00 | |
| | GENERAL SERVICE COST CENTERS | 0 | 1.00 | ZA | 4.00 | 5.00 | |
| 1.00 | 00100 CAP REL COSTS-BLDG & FIXT | | | | | | 1.00 |
| 4.00 | 00400 EMPLOYEE BENEFITS DEPARTMENT | 0 | 0 | 0 | 0 | | 4.00 |
| 5.00 | 00500 ADMI NI STRATI VE & GENERAL | 251, 975 | - | - | 0 | | 5.00 |
| 7.00 | 00700 OPERATION OF PLANT | 1, 599 | | | 0 | , | 7.00 |
| 8.00 | 00800 LAUNDRY & LINEN SERVICE | 0 | | | 0 | | 8.00 |
| 9.00 | 00900 HOUSEKEEPING | 119 | | | 0 | | 9.00 |
| 10.00 | 01000 DI ETARY | 567 | | | 0 | 1, 577 | 10.00 |
| 11.00 | 01100 CAFETERIA | 0 | | | 0 | | |
| | | 0 | | | 0 | | • |
| 13.00 | 01300 NURSI NG ADMI NI STRATI ON | 2, 825 | | | - | ., | 13.00 |
| 14.00 | 01400 CENTRAL SERVICES & SUPPLY | 0 | 1,000 | | 0 | | 14.00 |
| 15.00 | 01500 PHARMACY | 28, 826 | | | 0 | | • |
| 16.00 | 01600 MEDI CAL RECORDS & LI BRARY | 0 | 36, 110 | 36, 110 | 0 | 849 | 16.00 |
| 20.00 | INPATIENT ROUTINE SERVICE COST CENTERS | 22.040 | 40.77/ | 15 744 | 0 | 27 502 | 1 20 00 |
| 30.00 | 03000 ADULTS & PEDI ATRI CS ANCI LLARY SERVI CE COST CENTERS | 22, 968 | 42, 776 | 65, 744 | 0 | 37, 583 | 30.00 |
| 50.00 | 05000 OPERATING ROOM | 53, 931 | 33, 992 | 87, 923 | 0 | 11, 366 | 50.00 |
| 54.00 | 05400 RADI OLOGY - DI AGNOSTI C | 454, 984 | | | 0 | | • |
| 60.00 | 06000 LABORATORY | 2, 136 | | | 0 | | |
| 65.00 | 06500 RESPIRATORY THERAPY | 3, 252 | | 3, 252 | 0 | | 65.00 |
| 66.00 | 06600 PHYSI CAL THERAPY | 3,232 | | | 0 | - | 66.00 |
| 67.00 | 06700 OCCUPATI ONAL THERAPY | | | | 0 | -, | 67.00 |
| 68.00 | 06800 SPEECH PATHOLOGY | | - | 0 | 0 | | 68.00 |
| 69.00 | 06900 ELECTROCARDI OLOGY | | - | 0 | 0 | 0 | 69.00 |
| 71.00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 7, 596 | - | 7, 596 | 0 | - | |
| 71.00 | | 7, 590 | | 7, 590 | 0 | 606 | |
| 72.00 | 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS | 0 | 0 | 0 | 0 | 240 | /2.00 |
| 73.00 | 07300 DRUGS CHARGED TO PATIENTS | 0 | | 0 | 0 | 0 | 73.00 |
| 76.00 | 03950 ADULT MENTAL HEALTH | 701 | | 701 | 0 | - | • |
| 70.00 | OUTPATIENT SERVICE COST CENTERS | 701 | 0 | 701 | 0 | 9,000 | /0.00 |
| 88.00 | 08800 RURAL HEALTH CLINIC | 0 | 0 | 0 | 0 | 0 | 88.00 |
| 91.00 | 09100 EMERGENCY | 22, 365 | | - | 0 | | |
| 91.00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 22, 303 | 27, 314 | 49, 879 | 0 | 12, 371 | 92.00 |
| 92.00 | SPECIAL PURPOSE COST CENTERS | | | 0 | | | 92.00 |
| 118.00 | | 853, 844 | 314, 424 | 1, 168, 268 | 0 | 288, 570 | 118 00 |
| 110.00 | NONREIMBURSABLE COST CENTERS | 033, 044 | 314,424 | 1, 100, 200 | 0 | 200, 370 | 1110.00 |
| 190 00 | 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN | 0 | 2, 359 | 2, 359 | 0 | 55 | 190.00 |
| | 19100 RESEARCH | 0 | | 2, 337 | 0 | | 191.00 |
| | 19200 PHYSI CLANS' PRI VATE OFFI CES | 0 | | 0 | 0 | | 192.00 |
| | 07950 OTHER NRCC | | 0 | | 0 | | 192.00 |
| | 07951 SPN | 0 | 90, 680 | 90, 680 | 0 | | 194.00 |
| | 07951 SPN 07952 OUTPATIENT CLINICS | | 48, 485 | | 0 | | 194.01 |
| | 07952 001PATTENT CETNICS | | 40, 400 | 40, 403 | 0 | | 194.02 |
| 200.00 | | 0 | | | 0 | | 200.00 |
| 200.00 | 5 | | _ | | 0 | | 200.00 |
| 201.00 | | 853, 844 | 455, 948 | 1, 309, 792 | 0 | | |
| 202.00 | | 055, 044 | 1 455, 940 | 1, 307, 792 | 0 | 272,200 | 202.00 |

| Health Financial Systems AS | SCENSION ST. VI | NCENT JENNINGS | | Inlie | u of Form CMS-: | 2552-10 |
|---|-----------------|----------------|---------------|----------------|-----------------|---------|
| ALLOCATION OF CAPITAL RELATED COSTS | | Provi der C | CN· 15-1303 ₽ | eri od: | Worksheet B | 2002 10 |
| RECORTION OF GRITINE RELITED COOLS | | in ovraci o | | rom 07/01/2021 | Part II | |
| | | | T | o 06/30/2022 | Date/Time Pre | pared: |
| | | | | | 11/28/2022 12 | :17 pm |
| Cost Center Description | OPERATION OF | LAUNDRY & | HOUSEKEEPI NG | DI ETARY | CAFETERI A | |
| | PLANT | LINEN SERVICE | | | | |
| | 7.00 | 8.00 | 9.00 | 10.00 | 11.00 | |
| GENERAL SERVICE COST CENTERS | | | | 1 | | 1 |
| 1.00 00100 CAP REL COSTS-BLDG & FIXT | | | | | | 1.00 |
| 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT | | | | | | 4.00 |
| 5.00 00500 ADMI NI STRATI VE & GENERAL | 4. 700 | | | | | 5.00 |
| 7.00 00700 OPERATION OF PLANT | 61, 722 | | | | | 7.00 |
| 8.00 00800 LAUNDRY & LINEN SERVICE | 82 | 1, 664 | | | | 8.00 |
| 9.00 00900 HOUSEKEEPI NG | 1, 544 | 1, 653 | 24, 057 | | | 9.00 |
| 10. 00 01000 DI ETARY | 761 | 0 | 267 | | | 10.00 |
| | 1, 569 | 0 | C | - | 15, 666 | |
| 13. 00 01300 NURSI NG ADMI NI STRATI ON | 179 | 0 | C | | 1, 022 | |
| 14.00 01400 CENTRAL SERVICES & SUPPLY | 1, 252 | 0 | C | - | 0 | |
| 15.00 01500 PHARMACY | 704 | 0 | 573 | | 681 | |
| 16.00 01600 MEDICAL RECORDS & LIBRARY | 5, 959 | 0 | C | 0 | 0 | 16.00 |
| INPATIENT ROUTINE SERVICE COST CENTERS | i | 1 | | 1 | | |
| 30. 00 03000 ADULTS & PEDI ATRI CS | 7,059 | 0 | 1, 613 | 7, 786 | 3, 406 | 30.00 |
| ANCI LLARY SERVI CE COST CENTERS | 1 | I | | 1 1 | | - |
| 50. 00 05000 OPERATI NG ROOM | 5, 609 | 11 | 8, 860 | | 1, 362 | |
| 54. 00 05400 RADIOLOGY – DIAGNOSTIC | 4, 546 | 0 | 1, 260 | | 3, 065 | • |
| 60. 00 06000 LABORATORY | 1, 896 | 0 | 687 | | 341 | |
| 65. 00 06500 RESPI RATORY THERAPY | 0 | 0 | C | - | 0 | |
| 66. 00 06600 PHYSI CAL THERAPY | 2, 670 | 0 | 573 | | 1, 022 | |
| 67.00 06700 OCCUPATI ONAL THERAPY | 0 | 0 | C | - | 0 | |
| 68.00 06800 SPEECH PATHOLOGY | 0 | 0 | C | | 0 | |
| 69. 00 06900 ELECTROCARDI OLOGY | 0 | 0 | C | 0 | 0 | |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 0 | C | 0 | 0 | |
| 72.00 07200 I MPLANTABLE DEVICES CHARGED TO PATIENTS | 0 | 0 | C | 0 | 0 | 72.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 0 | 0 | C | 0 | 0 | 73.00 |
| 76.00 03950 ADULT MENTAL HEALTH | 0 | 0 | c c | 0 | 0 | 76.00 |
| OUTPATIENT SERVICE COST CENTERS | | | • | | | 1 |
| 88.00 08800 RURAL HEALTH CLINIC | 0 | 0 | C | 0 | 0 | 88.00 |
| 91.00 09100 EMERGENCY | 4, 540 | 0 | 8, 668 | 0 | 4, 767 | 91.00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | | | | | | 92.00 |
| SPECIAL PURPOSE COST CENTERS | • | • | • | · · · | | 1 |
| 118.00 SUBTOTALS (SUM OF LINES 1 through 117) | 38, 370 | 1, 664 | 22, 501 | 7, 786 | 15, 666 | 118.00 |
| NONREI MBURSABLE COST CENTERS | | | | | | |
| 190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN | 389 | 0 | C | 0 | 0 | 190.00 |
| 191. 00 19100 RESEARCH | 0 | 0 | C | 0 | 0 | 191.00 |
| 192.00 19200 PHYSICIANS' PRIVATE OFFICES | 0 | 0 | C | 0 | 0 | 192.00 |
| 194.0007950 OTHER NRCC | 0 | 0 | 1, 556 | 0 | 0 | 194.00 |
| 194. 01 07951 SPN | 14, 962 | 0 | C | 0 | 0 | 194.01 |
| 194. 02 07952 OUTPATIENT CLINICS | 8, 001 | 0 | C | 0 | 0 | 194.02 |
| 194. 03 07953 MARKETI NG | 0 | 0 | C | 0 | 0 | 194.03 |
| 200.00 Cross Foot Adjustments | | | | | | 200. 00 |
| 201.00 Negative Cost Centers | 0 | 0 | C | 0 | 0 | 201.00 |
| 202.00 TOTAL (sum lines 118 through 201) | 61, 722 | 1, 664 | 24, 057 | 7, 786 | 15, 666 | 202.00 |
| | | | | | | |

| Heal th | Financial Systems A | SCENSION ST. VII | NCENT JENNINGS | | In Lie | u of Form CMS- | 2552-10 |
|------------------|--|-------------------------------|------------------------|-------------|---|--|---------|
| | TION OF CAPITAL RELATED COSTS | | Provider CC | CN: 15-1303 | Period: From 07/01/2021 To 06/30/2022 | Worksheet B Part II Date/Time Pre 11/28/2022 12 | |
| | Cost Center Description | NURSI NG ADMI NI STRATI ON | CENTRAL SERVI CES & | PHARMACY | MEDI CAL RECORDS & | Subtotal | |
| | | ADMINI STRATION | SUPPLY | | LIBRARY | | |
| | L | 13.00 | 14.00 | 15.00 | 16.00 | 24.00 | |
| | GENERAL SERVICE COST CENTERS | 11 | | | | | |
| 1.00 | 00100 CAP REL COSTS-BLDG & FIXT | | | | | | 1.00 |
| 4.00 | 00400 EMPLOYEE BENEFITS DEPARTMENT | | | | | | 4.00 |
| 5.00 | 00500 ADMINI STRATI VE & GENERAL | | | | | | 5.00 |
| 7.00 | 00700 OPERATION OF PLANT | | | | | | 7.00 |
| 8.00 | 00800 LAUNDRY & LINEN SERVICE | | | | | | 8.00 |
| 9.00 | 00900 HOUSEKEEPI NG | | | | | | 9.00 |
| 10.00 | 01000 DI ETARY | | | | | | 10.00 |
| 11.00 | 01100 CAFETERIA | | | | | | 11.00 |
| 13.00 | 01300 NURSING ADMINISTRATION | 14, 202 | | | | | 13.00 |
| 14.00 | 01400 CENTRAL SERVICES & SUPPLY | 0 | 9, 490 | | | | 14.00 |
| 15.00 | 01500 PHARMACY | 0 | 3 | 52, 98 | | | 15.00 |
| 16.00 | 01600 MEDI CAL RECORDS & LI BRARY | 0 | 0 | | 0 42, 918 | | 16.00 |
| | INPATIENT ROUTINE SERVICE COST CENTERS | T T | | | | | - |
| 30.00 | 03000 ADULTS & PEDIATRICS | 4, 870 | 857 | | 0 1, 404 | 130, 322 | 30.00 |
| | ANCI LLARY SERVICE COST CENTERS | ·[| | | | | |
| 50.00 | 05000 OPERATING ROOM | 1, 703 | 2, 339 | | 0 2, 587 | 121, 760 | |
| 54.00 | 05400 RADI OLOGY - DI AGNOSTI C | 0 | 671 | | 0 11, 342 | 538, 940 | 1 |
| 60.00 | 06000 LABORATORY | 0 | 14 | | 0 13, 234 | 78, 292 | 1 |
| 65.00 | 06500 RESPI RATORY THERAPY | 0 | 0 | | 0 83 | 3, 335 | |
| 66.00 | 06600 PHYSI CAL THERAPY | 0 | 73 | | 0 708 | 26, 974 | 1 |
| 67.00 | 06700 OCCUPATIONAL THERAPY | 0 | 0 | | 0 69 | 1, 196 | 1 |
| 68.00 | 06800 SPEECH PATHOLOGY | 0 | 0 | | 0 0 | 0 | 1 |
| 69.00 | 06900 ELECTROCARDI OLOGY | 0 | 0 | | 0 0 | 0 | |
| 71.00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 1, 310 | | 0 0 | 9, 512 | 1 |
| 72.00 | 07200 IMPLANTABLE DEVICES CHARGED TO | 0 | 360 | | 0 0 | 600 | 72.00 |
| | PATIENTS | | | 50.00 | | | |
| 73.00 | 07300 DRUGS CHARGED TO PATIENTS | 0 | 0 | 52, 98 | | 52, 982 | 1 |
| 76.00 | 03950 ADULT MENTAL HEALTH | 0 | 0 | | 0 410 | 10, 764 | 76.00 |
| 00.00 | OUTPATIENT SERVICE COST CENTERS | 0 | 0 | | | 0 | |
| 88.00 | 08800 RURAL HEALTH CLINIC | Ŭ Ŭ | 0 | | 0 0 | 0 | |
| 91.00 | 09100 EMERGENCY | 7, 629 | 3, 863 | | 0 13, 081 | 164, 998 | |
| 92.00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | | | | | | 92.00 |
| 118.00 | SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) | 14, 202 | 9, 490 | E2 00 | 42 010 | 1 120 475 | 110 00 |
| 118.00 | NONREIMBURSABLE COST CENTERS | 14, 202 | 9, 490 | 52, 98 | 32 42, 918 | 1, 139, 675 | 118.00 |
| 100.00 | 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN | 0 | 0 | | 0 0 | 2 002 | 190.00 |
| | 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN | 0 | 0 | | 0 0 | | 190.00 |
| | 19200 PHYSI CLANS' PRI VATE OFFI CES | 0 | 0 | | | | 191.00 |
| | | 0 | 0 | | | | 1 |
| | 07950 OTHER NRCC 07951 SPN | 0 | 0 | | | | 194.00 |
| | | 0 | 0 | | 0 0 | 107, 775 | |
| | 07952 OUTPATIENT CLINICS | 0 | 0 | | | | 194.02 |
| | 07953 MARKETING | 0 | 0 | | 0 | | 194.03 |
| 200.00 201.00 | | | _ | | | | 200.00 |
| | - 3 | 14, 202 | 0 9, 490 | 52, 98 | 0 0 32 42, 918 | 0 1, 309, 792 | 201.00 |
| 202.00 | TOTAL (sum lines 118 through 201) | 14, 202 | 9, 490 | 52, 90 | 42, 918 | 1, 309, 792 | 1202.00 |

| Heal th | Fi nanci | al Syste | ems |
|---------|----------|----------|-----|
| 411004 | | | |

| Health Fina | ncial Systems | ASCENSION SI. VI | NCENT JENNINGS | | In Lieu | i of Form CMS-2 | 552-10 |
|-------------|--|------------------|---|-------------|-----------------|----------------------------------|----------------|
| ALLOCATI ON | OF CAPITAL RELATED COSTS | | Provider CC | CN: 15-1303 | Peri od: | Worksheet B | |
| | | | | | From 07/01/2021 | Part II | |
| | | | | | To 06/30/2022 | Date/Time Prep 11/28/2022 12: | ared: |
| | Cost Center Description | Intern & | Total | | | 11/20/2022 12. | <u>17 piii</u> |
| | besch prion | Residents Cost | | | | | |
| | | & Post | | | | | |
| | | Stepdown | | | | | |
| | | Adjustments | | | | | |
| | | 25.00 | 26.00 | | | | |
| GENE | RAL SERVICE COST CENTERS | 23.00 | 20.00 | | | | |
| | O CAP REL COSTS-BLDG & FIXT | | | | | | 1.00 |
| | O EMPLOYEE BENEFITS DEPARTMENT | | | | | | 4.00 |
| | 0 ADMINISTRATIVE & GENERAL | | | | | | 5.00 |
| | O OPERATION OF PLANT | | | | | | 7.00 |
| | O LAUNDRY & LINEN SERVICE | | | | | | 8.00 |
| | O HOUSEKEEPING | | | | | | 9.00 |
| | O DI ETARY | | | | | | 9.00 10.00 |
| | | | | | | | |
| | | | | | | | 11.00 |
| | O NURSI NG ADMI NI STRATI ON | | | | | | 13.00 |
| | O CENTRAL SERVICES & SUPPLY | | | | | | 14.00 |
| | 0 PHARMACY | | | | | | 15.00 |
| | 0 MEDICAL RECORDS & LIBRARY | | | | | | 16.00 |
| | TIENT ROUTINE SERVICE COST CENTERS | | 100.000 | | | | |
| | 0 ADULTS & PEDIATRICS | 0 | 130, 322 | | | | 30.00 |
| | LLARY SERVICE COST CENTERS | 1 | 101 7(0 | | | | |
| | O OPERATING ROOM | 0 | | | | | 50.00 |
| | 0 RADIOLOGY - DIAGNOSTIC | 0 | | | | | 54.00 |
| | OLABORATORY | 0 | | | | | 60.00 |
| | 0 RESPI RATORY THERAPY | 0 | -, | | | | 65.00 |
| | 0 PHYSI CAL THERAPY | 0 | | | | | 66.00 |
| | O OCCUPATIONAL THERAPY | 0 | .,.,, | | | | 67.00 |
| | OSPEECH PATHOLOGY | 0 | - | | | | 68.00 |
| | 0 ELECTROCARDI OLOGY | 0 | - | | | | 69.00 |
| | MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | , | | | | 71.00 |
| 72.00 0720 | O IMPLANTABLE DEVICES CHARGED TO | 0 | 600 | | | | 72.00 |
| | PATIENTS | | | | | | |
| | O DRUGS CHARGED TO PATIENTS | 0 | | | | | 73.00 |
| | OADULT MENTAL HEALTH | 0 | 10, 764 | | | | 76.00 |
| | ATIENT SERVICE COST CENTERS | | | | | | |
| | ORURAL HEALTH CLINIC | 0 | | | | | 88.00 |
| | | 0 | | | | | 91.00 |
| | O OBSERVATION BEDS (NON-DISTINCT PART) | 0 | | | | | 92.00 |
| | AL PURPOSE COST CENTERS | - 1 | | | | | |
| 118.00 | SUBTOTALS (SUM OF LINES 1 through 117) | 0 | 1, 139, 675 | | | | 118.00 |
| | EI MBURSABLE COST CENTERS | | | | | | |
| | OGIFT, FLOWER, COFFEE SHOP, & CANTEEN | 0 | | | | | 190. 00 |
| 191.00 1910 | | 0 | | | | | 191.00 |
| | O PHYSI CI ANS' PRI VATE OFFI CES | 0 | | | | | 192.00 |
| | OOTHER NRCC | 0 | 1, 913 | | | | 194.00 |
| 194.010795 | 1 SPN | 0 | 107, 775 | | | ľ | 194. 01 |
| 194.020795 | 2 OUTPATIENT CLINICS | 0 | 57, 626 | | | · | 194. 02 |
| 194.030795 | 3 MARKETI NG | 0 | 0 | | | · | 194. 03 |
| 200.00 | Cross Foot Adjustments | 0 | 0 | | | | 200. 00 |
| 201.00 | Negative Cost Centers | 0 | 0 | | | | 201.00 |
| 202.00 | TOTAL (sum lines 118 through 201) | 0 | 1, 309, 792 | | | | 202.00 |
| - 1 | | | | | | 1- | |

| Health Financial Systems A: | SCENSION ST. VIN | NCENT JENNINGS | | In Lie | u of Form CMS-2 | 2552-10 |
|---|--|---|----------------|---|--|--------------------|
| COST ALLOCATION - STATISTICAL BASIS | | Provider C | F | Period: From 07/01/2021 O 06/30/2022 | Worksheet B-1 Date/Time Pre | pared: |
| Cost Center Description | CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET) | EMPLOYEE BENEFI TS DEPARTMENT (GROSS SALARI ES) | Reconciliatior | ADMI NI STRATI VE & GENERAL (ACCUM. COST) | 0PERATION OF PLANT (SQUARE FEET) | : <u>17 pm</u> |
| | 1.00 | 4.00 | 5A | 5.00 | 7.00 | |
| GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT | 69, 965 | | 1 | | | 1.00 |
| 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT | 09,905 | 4, 495, 922 | | | | 4.00 |
| 5.00 00500 ADMI NI STRATI VE & GENERAL | 6, 181 | 297, 066 | | 12, 425, 259 | | 5.00 |
| 7.00 00700 OPERATION OF PLANT | 6, 387 | 0 | C | | 57, 397 | 7.00 |
| 8.00 00800 LAUNDRY & LINEN SERVICE | 76 | 0 | C | | 76 | |
| 9. 00 00900 HOUSEKEEPI NG | 1,436 | 0 | C | 483, 956 | 1, 436 | 1 |
| 10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A | 708 1, 459 | 0 | | | 708 1, 459 | |
| 13. 00 01300 NURSI NG ADMI NI STRATI ON | 166 | 286, 741 | | | 1,437 | 1 |
| 14.00 01400 CENTRAL SERVICES & SUPPLY | 1, 164 | 0 | C | | 1, 164 | |
| 15. 00 01500 PHARMACY | 655 | 216, 045 | C | 762, 142 | 655 | 15.00 |
| 16.00 01600 MEDI CAL RECORDS & LI BRARY | 5, 541 | 0 | C | 36, 110 | 5, 541 | 16.00 |
| 30. 00 03000 ADULTS & PEDI ATRI CS | 6, 564 | 977, 919 | C | 1, 597, 830 | 6, 564 | 30.00 |
| ANCI LLARY SERVICE COST CENTERS | 0, 304 | 977, 919 | | 1, 397, 630 | 0, 304 | 30.00 |
| 50. 00 05000 OPERATI NG ROOM | 5, 216 | 253, 053 | C | 483, 243 | 5, 216 | 50.00 |
| 54.00 05400 RADI OLOGY – DI AGNOSTI C | 4, 227 | 752, 095 | C | 1, 510, 356 | 4, 227 | 54.00 |
| 60. 00 06000 LABORATORY | 1, 763 | 75, 307 | | | 1, 763 | |
| 65. 00 06500 RESPIRATORY THERAPY | 0 | 0 | C | | 0 | 1 |
| 66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 0CCUPATI ONAL THERAPY | 2, 483 | 167, 788 35, 222 | | | 2, 483 0 | 1 |
| 68. 00 06800 SPEECH PATHOLOGY | 0 | 33, 222 | | | 0 | |
| 69. 00 06900 ELECTROCARDI OLOGY | 0 | 0 | | 0 | 0 | |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 0 | C | 25, 752 | 0 | |
| 72.00 07200 I MPLANTABLE DEVICES CHARGED TO PATIENTS | 0 | 0 | | 10, 209 | 0 | |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 0 | 0 | | - | 0 | |
| 76.00 03950 ADULT MENTAL HEALTH OUTPATIENT SERVICE COST CENTERS | 0 | 0 | C | 410, 416 | 0 | 76.00 |
| 88.00 08800 RURAL HEALTH CLINIC | 0 | 0 | C | 0 | 0 | 88.00 |
| 91. 00 09100 EMERGENCY | 4, 222 | 1, 434, 686 | | | 4, 222 | |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | | | | | | 92.00 |
| SPECIAL PURPOSE COST CENTERS | | | | | | |
| 118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS | 48, 248 | 4, 495, 922 | -6, 382, 124 | 12, 268, 552 | 35, 680 | 118.00 |
| 190. 00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN | 362 | 0 | C | 2, 359 | 362 | 190.00 |
| 191. 00 19100 RESEARCH | 002 | 0 | | | | 191.00 |
| 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES | 0 | 0 | C | 0 | 0 | 192.00 |
| 194.0007950 OTHER NRCC | 0 | 0 | C | | | 194.00 |
| 194. 01 07951 SPN | 13, 915 | 0 | C | 90, 680 | 13, 915 | 1 |
| 194. 02 07952 0UTPATI ENT CLINICS 194. 03 07953 MARKETING | 7,440 | 0 | | 48, 485 | | 194. 02 194. 03 |
| 200.00 Cross Foot Adjustments | 0 | 0 | | 0 | 0 | 200.00 |
| 201.00 Negative Cost Centers | | | | | | 201.00 |
| 202.00 Cost to be allocated (per Wkst. B, Part I) | 455, 948 | 1, 292, 294 | | 6, 382, 124 | 1, 190, 545 | |
| 203.00Unit cost multiplier (Wkst. B, Part I)204.00Cost to be allocated (per Wkst. B, | 6. 516801 | 0. 287437 0 | | 0. 513641 292, 255 | 20. 742286 61, 722 | |
| Part II) 205.00 Unit cost multiplier (Wkst. B, Part | | 0. 000000 | | 0. 023521 | 1.075352 | 205. 00 |
| 206.00 NAHE adjustment amount to be allocated | | | | | | 206. 00 |
| (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, | | | | | | 207.00 |
| Parts III and IV) | | | | | | 207.00 |

| OST A | n Financial Systems A: ALLOCATION - STATISTICAL BASIS | SCENSION ST. VI | Provider CC | | Period: | u of Form CMS-: Worksheet B-1 | |
|----------------|---|------------------------|--------------|-------------|----------------------------------|----------------------------------|-------|
| | | | | | From 07/01/2021 To 06/30/2022 | Date/Time Pre 11/28/2022 12 | epare |
| | Cost Center Description | LAUNDRY & | HOUSEKEEPING | DI ETARY | CAFETERI A | NURSI NG | |
| | | LINEN SERVICE | (HOURS OF | (BED DAYS | (FTES) | ADMI NI STRATI ON | |
| | | (I TEMI ZED BI LLS) | SERVI CE) | AVAI LABLE) | | (DIRECT NURS. | |
| | | DI LL3) | | | | HRS.) | |
| | | 8.00 | 9.00 | 10.00 | 11.00 | 13.00 | |
| | GENERAL SERVICE COST CENTERS | - | | | | | |
| . 00 | 00100 CAP REL COSTS-BLDG & FIXT | | | | | | 1 |
| . 00 | 00400 EMPLOYEE BENEFITS DEPARTMENT | | | | | | 4 |
| . 00 | 00500 ADMINISTRATIVE & GENERAL | | | | | | 5 |
| . 00 | 00700 OPERATION OF PLANT | 15 30 4 | | | | | 7 |
| . 00 | 00800 LAUNDRY & LINEN SERVICE | 45, 724 | 0 500 | | | | 8 |
| . 00 | 00900 HOUSEKEEPING | 45, 423 | 2, 520 | 0.10 | - | | 9 |
| 0.00 | 01000 DI ETARY | 0 | 28 | 9, 12 | | | 10 |
| 1.00 3.00 | 01100 CAFETERIA 01300 NURSING ADMINISTRATION | 0 | 0 | | 0 46 0 3 | 53, 460 | 11 |
| 4.00 | | 0 | 0 | | | 0 | |
| | | 0 | 60 | | 0 2 | 0 | |
| | | 0 | 0 | | 0 0 | 0 | |
| 0.00 | INPATIENT ROUTINE SERVICE COST CENTERS | | 0 | | 0 0 | Ŭ | |
| D. 00 | | 0 | 169 | 9, 12 | 5 10 | 18, 332 | 30 |
| | ANCI LLARY SERVICE COST CENTERS | | | | | | |
| 0. 00 | 05000 OPERATING ROOM | 301 | 928 | | 0 4 | 6, 410 | 50 |
| 4.00 | 05400 RADIOLOGY - DIAGNOSTIC | 0 | 132 | | 0 9 | 0 | 54 |
| 0. 00 | 06000 LABORATORY | 0 | 72 | | 0 1 | 0 | 60 |
| 5.00 | 06500 RESPI RATORY THERAPY | 0 | 0 | | 0 0 | 0 | 65 |
| 5.00 | | 0 | 60 | | 0 3 | 0 | 66 |
| 7.00 | 06700 OCCUPATI ONAL THERAPY | 0 | 0 | | 0 0 | 0 | 67 |
| 3.00 | 06800 SPEECH PATHOLOGY | 0 | 0 | | 0 0 | 0 | 68 |
| 9.00 | 06900 ELECTROCARDI OLOGY | 0 | 0 | | 0 0 | 0 | 69 |
| 1.00 | | 0 | 0 | | 0 0 | 0 | |
| 2.00 | | 0 | 0 | | 0 0 | 0 | 72 |
| | PATIENTS | | | | | | 1 70 |
| | | 0 | 0 | | 0 0 0 0 | 0 | |
| 5.00 | | 0 | 0 | | 0 0 | 0 | 76 |
| 3. 00 | OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC | 0 | 0 | | 0 0 | 0 | 88 |
| | | 0 | 908 | | 0 14 | 28, 718 | |
| 2.00 | | 0 | 200 | | 14 | 20,710 | 92 |
| . 00 | SPECIAL PURPOSE COST CENTERS | | | | | | 1 12 |
| 8.00 | | 45, 724 | 2, 357 | 9, 12 | 5 46 | 53, 460 | 1118 |
| | NONREI MBURSABLE COST CENTERS | | | | | | |
| 90.00 | D 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN | 0 | 0 | | 0 0 | 0 | 190 |
| 91.00 | D 19100 RESEARCH | 0 | 0 | | 0 0 | 0 | 191 |
| 2.00 | D 19200 PHYSICIANS' PRIVATE OFFICES | 0 | 0 | | 0 0 | 0 | 192 |
| | DO7950OTHER NRCC | 0 | 163 | | 0 0 | | 194 |
| 94.01 | 1 07951 SPN | 0 | 0 | | 0 0 | | 194 |
| | 2 07952 OUTPATI ENT CLINICS | 0 | 0 | | 0 0 | | 194 |
| | 3 07953 MARKETI NG | 0 | 0 | | 0 0 | 0 | 194 |
| 0.00 | | | | | | | 200 |
| 01.00 | 0 | | | | | | 201 |
| 2.00 | Cost to be allocated (per Wkst. B, Part I) | 71, 533 | 833, 384 | 125, 41 | 3 325, 546 | 609, 878 | 202 |
| 03.00 | | 1. 564452 | 330. 707937 | 13. 74389 | 0 7, 077. 086957 | 11. 408118 | 203 |
| 04.00 | | 1, 664 | 24, 057 | 7, 78 | 6 15, 666 | 14, 202 | 204 |
| 05.00 | Part II) D Unit cost multiplier (Wkst. B, Part | 0. 036392 | 9. 546429 | 0. 85326 | 0 340. 565217 | 0. 265657 | 205 |
| | II) | | | | | | 206 |
| 06. 00 | J INALE ADJUSTMENT AMOUNT TO DE ALLOCATED | | | | | | |
| 06.00 07.00 | (per Wkst. B-2) | | | | | | 207 |

| 4.00 00400 PMATORE BERFITS DEPARTMENT | Heal th | Financial Systems AS | SCENSION ST. VI | NCENT JENNINGS | | In Lieu of Form C | MS-2552-10 |
|--|--|--|---|-----------------------|---|--|---|
| Cost Center Description CRTGAL SUPPLY SUPPLY PHAMAK/Y RECUIS.3 WFDICAL RECUIS.3 0 | COST A | LLOCATION - STATISTICAL BASIS | | Provider CC | CN: 15-1303 | From 07/01/2021 To 06/30/2022 Date/Time | Prepared: |
| CHARAL SERVICE COST CENTERS 1.00 COTO CAP REL COSTS.BUG & FIXT 4.00 DOUDQ EMPLOYEE BENEFITS DEPARTMENT 5.00 DOUDQ MINISTRATION OF PLANT 8.00 DOUDQ OFERATION OF PLANT 8.00 DOUDQ OFERATION OF PLANT 11.00 DITOD OFERATION OF PLANT 12.00 DOUDQ OFERATION OF PLANT 13.00 DITOD OFERATION OF PLANT 14.00 DITOD OFERATION OF PLANT 15.00 DITOD OFERATION OF PLANT 16.00 DITOD OFERATION SERVICE SA SUPPLY 260,369 16.00 DITOD OFERATION OF PLANT 16.00 DITOD OFERATION COST CONTRES 24,334 00 DOUDOFERATINE RECORDS & LIBRARY 0 00 DOUDOFERATINE RECORDS TO COST CONTRES 11,145,104 00 DOCODOFERATINE RECORD SA LIBRARY 2,078 00 DOCODOFERATINE RECORD SA LIBRARY 2,078 00 DIANTERSERVICE COST CONTRES 24,334 00 DOCODOFERATINE RECORD SA LIBRARY 2,078 00 DOUDOFERATINE RECORD SA LIBRARY 1,145,104 00 </td <td></td> <td>Cost Center Description</td> <td>SERVI CES & SUPPLY (COSTED REQUI S.)</td> <td>(COSTED REQUI S.)</td> <td>RECORDS & LI BRARY (GROSS CHARGES)</td> <td></td> <td>pm_</td> | | Cost Center Description | SERVI CES & SUPPLY (COSTED REQUI S.) | (COSTED REQUI S.) | RECORDS & LI BRARY (GROSS CHARGES) | | pm_ |
| 1. 00 00100 CAP ERL COST S-BLOE & FLYT 4. 00 00500 ADMINISTRATIVE & GENERAL 5. 00 00500 ADMINISTRATIVE & GENERAL 8. 00 00600 LAURENY & LINEN SERVICE 9. 00 00600 LAURENY & LINEN SERVICE 9. 00 00600 ADMINISTRATIVE & GENERAL 1. 10 11. 00 11. 0 | | | 14.00 | 15.00 | 16.00 | | |
| 16. 00 00 05. 449, 716 1 10 INPAT ENT ROUTINE SERVICE COST CENTERS 24.334 0 2, 272, 074 33 30. 00 03000 ADULTS & PEDIATING SERVICE COST CENTERS 50. 00 50.00 54.00 54.00 54.00 54.00 55.00 66.305 41.86, 732 55 50. 00 06000 CABDIDLOP, - DIAGNOSTIC 19.044 0 13, 680 66 60. 00 06000 CESPI RATORY THERAPY 0 0 112, 030 66 60. 00 06000 SPECH PATORY THERAPY 0 0 112, 030 66 61.00 06000 SPECH PATORUAL THERAPY 0 0 0 0 77 71.00 0 0 0 0 0 77 73.00 0 77 72.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 100 0 77 73.00 07300 RURAL HEALTH CLINIC 0 0 77 73 0 70 73 74.00 00 0 | 4.00 5.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00 | 00100 CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY | | 100 | | | 1.00 4.00 5.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00 |
| 30. 00 03000(ADULTS & PEDIATING COST CENTERS 24.334 0 2.772,074 33 50. 00 05000(PERATING COST CENTERS) 55.00 66.385 0 4.186,732 55.00 50. 00 05000(RESPIRATORY - DIAGNOSTIC 19.044 0 18.353.105 55.00 60. 00 06000(LBORATORY - DIAGNOSTIC 19.044 0 13.3680 66.00 60. 00 0000(RESPIRATORY THERAPY 0 0 133.680 66.00 60. 00 0000 CEUPETIONAL THERAPY 2.078 0 112,030 66.00 60. 00 0000 CELECTROARD 0.10GY 0 0 0 0 0 71. 00 000 0 0 0 0 77.71 0 0 77.72 73. 00 7300 <td></td> <td></td> <td></td> <td></td> <td></td> <td>16</td> <td>16.00</td> | | | | | | 16 | 16.00 |
| ANCLLARY SERVICE COST CENTERS Image: Control of the cont | | | | | | | |
| 50. 00 00 00 00 4, 166, 732 55 54. 00 05400 14, 166, 732 55 60. 00 06000 LARONSTI C 19, 044 0 18, 353, 105 55 60. 00 06500 RESPI RATORY THERAPY 0 0 133, 680 66 61. 00 065000 PHYSI CAL THERAPY 0 0 133, 680 66 61. 00 065000 SPECI PATHOLOGY 0 0 0 133, 680 66 61. 00 065000 SPECI PATHOLOGY 0 0 0 112, 030 66 64. 00 066000 SPECI PATHOLOGY 0 0 0 0 77 72. 00 07200 IMPLATABLE DEVICES CHARGED TO PATIENTS 37, 171 0 0 0 77 73. 00 07300 DRUSS CHARGED TO PATIENTS 0 100 0 77 74. 00 0300 DRUSS CHARGED TO PATIENTS 0 0 0 0 77 74. 00 0300 RUSS CHARGED TO PATIENTS 0 0 0 | 30.00 | | 24, 334 | 0 | 2, 272, 07 | 74 | 30.00 |
| 54.00 D600 RADIOLOCY - DLAGNOSTIC 19,044 0 18,353,105 55 60.00 GOROOLABORATORY 399 0 21,417,102 66 60.00 D66000 RESPIRATORY THERAPY 0 0 133,680 66 66.00 D66000 DCUPATIONAL THERAPY 0 0 112,030 66 67.00 D6000 ELCETROCARDIOLOGY 0 0 0 0 66 68.00 D66000 ELCETROCARDIOLOGY 0 0 0 0 66 69.00 G6000 ELCETROCARDIOLOGY 0 0 0 0 0 66 70.00 D000 ELCETROCARDIOLOGY 0 0 0 0 77 70.00 OTOOL IMPLATIABLE DEVICES CHARGED TO PATIENTS 0 100 0 0 77 70 00 0 0 77 70 00 0 0 0 74 00 0 0 0 0 0 0 0 0 111 111 111 111 111 | 50 00 | | 66 385 | 0 | 1 186 73 | 22 | 50.00 |
| 60.00 00000 LABORATORY 399 0 21,417,102 66 65.00 06500 PESP RATORY THERAPY 0 0 133,680 66 66.00 06500 PESP RATORY THERAPY 2,078 0 1,145,104 66 67.00 06600 SPEECH PATHOLOCY 0 0 0 66 68.00 06600 SPEECH PATHOLOCY 0 0 0 0 66 67.00 06000 ELECTROCARDIOLOCY 0 0 0 0 77 70.00 07200 IMPLANTABLE DEVICES CHARGED T0 10.209 0 0 77 73.00 07300 ROKIGS CHARGED TO PATIENTS 0 100 0 0 663,723 77 74.00 0000 0 0 0 0 0 663,723 77 75.00 03950 ADULT MENTAL HEALTH 0 0 0 0 0 10 99 92.00 92000 9200 | | | | | | | 54.00 |
| 66.00 06600 PHYSI CAL THERAPY 2,078 0 1,145,104 66 67.00 06700 000 112,030 66 68.00 06800 SPEECH PATHOLOGY 0 0 0 66 69.00 06800 SPEECH PATHOLOGY 0 0 0 0 66 67.00 0700 MUPLANTABLE DEVICES CHARGED TO 10,209 0 0 0 77 70.00 07300 DRUGS CHARGED TO PATIENTS 0 1000 0 663,723 77 00 7300 DRUGS CHARGED TO PATIENTS 0 1000 0 663,723 77 01700 MURCA CHARGED TO PATIENTS 0 0 0 663,723 77 01700 DUREAS CHARGED TO PATIENTS 0 0 0 0 11,166,166 9 92.00 092800 DSERVATION BEDS (NON-DISTINCT PART) 109,659 0 21,166,166 9 19 19 100 69,449,716 111 | 60.00 | | | 0 | | | 60.00 |
| 67.00 06700 0CCUPATIONAL THERAPY 0 0 112,030 66 68.00 06800 SPECH PATHOLOGY 0 0 0 66 71.00 06900 ELECTROCARDIOLOGY 0 0 0 77 72.00 7001 MEDICAL SUPPLIES CHARGED TO PATIENTS 37,171 0 0 77 73.00 70300 RUGS CHARGED TO PATIENTS 0 100 0 77 74.00 03950 ADULT MENTABLE DEVICES CHARGED TO PATIENTS 0 100 0 77 75.00 70300 RUGS CHARGED TO PATIENTS 0 100 0 77 76.00 8800 RUBAL HEALTH 0 0 0 0 88 71.00 0100 ERGENCY 109,659 0 21,166,166 99 71.00 SUBTOTALS (SUM OF LINES 1 through 117) 269,369 100 69,449,716 111 710.00 SUBTOTALS (SUM OF LINES 1 through 117) 269,369 0 0 19 | 65.00 | | 0 | 0 | | | 65.00 |
| 68.00 06800 SPEECH PATIENDACY 0 0 0 0 0 66 69.00 06900 ELECTROCARDIOLOGY 0 | | | | Ű | | | 66.00 |
| 69.00 06900 0 0 0 0 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 37,171 0 0 7 72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS 37,171 0 0 7 73.00 07300 DRUGS CHARGED TO PATIENTS 0 100 0 7 76.00 03950 ADULT MENTAL HEALTH 0 0 663,723 7 88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 8 92.00 09200 DERREENCY 109,659 0 21,166,166 9 92.00 09200 DERREVATION BEDS (NON-DISTINCT PART) 109,659 0 21,166,166 9 92.00 92000 BERCIAL FULS (SUM OF LINES 1 through 117) 269,369 100 69,449,716 111 109.00 19700 10100 ESEARCH 0 0 0 19 191.00 10100 ESEARCH 0 0 0 | | | - | - | 112, 03 | | 67.00 |
| 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 37,171 0 0 77 72.00 07200 IMPLANTABLE DEVICES CHARGED TO 10,209 0 0 77 73.00 07300 DRUGS CHARGED TO PATIENTS 0 100 0 77 76.00 0390 DRUGS CHARGED TO PATIENTS 0 100 0 77 00 0 0 0 663,723 77 00 000 0 0 0 663,723 70.00 0000 BEDS (NON-DISTINCT PART) 109,659 0 21,166,166 97 92.00 09200 000 GETER, TLOWER, COST CENTERS 97 97 90.00 <t< td=""><td></td><td></td><td>0</td><td>-</td><td></td><td>•</td><td>68.00</td></t<> | | | 0 | - | | • | 68.00 |
| 72.00 O7200 IMPLANTABLE DEVICES CHARGED TO 10, 209 0 0 73.00 O7300 DRUGS CHARGED TO PATIENTS 0 100 0 77 73.00 O3300 ADULT MENTAL HEALTH 0 0 663, 723 77 76.00 O3300 RURAL HEALTH CLINIC 0 0 663, 723 77 88.00 OBS00 RURAL HEALTH CLINIC 0 0 0 0 109, 659 0 21, 166, 166 99 91.00 OY200 OBSERVATION BEDS (NON-DISTINCT PART) 109, 659 0 21, 166, 166 99 91 | | | 27 171 | | | | 69.00 71.00 |
| 73.00 D7300 DRUGS CHARGED TO PATIENTS 0 100 0 76.00 03950 ADULT MENTAL HEALTH 0 0 663,723 77 00 07100 DRUGS CHARGED TO PATIENT SERVICE COST CENTERS 0 0 0 663,723 77 88.00 08800 RURAL HEALTH CLINIC 0 | | 07200 IMPLANTABLE DEVICES CHARGED TO | | - | | | 72.00 |
| OUTPATIENT SERVICE COST CENTERS 0 <t< td=""><td>73.00</td><td></td><td>0</td><td>100</td><td></td><td>0</td><td>73.00</td></t<> | 73.00 | | 0 | 100 | | 0 | 73.00 |
| 88.00 08800 RURAL HEALTH CLINIC 0 | 76.00 | 03950 ADULT MENTAL HEALTH | 0 | 0 | 663, 72 | 23 | 76.00 |
| 91.00 09100 EMERGENCY 109,659 0 21,166,166 9 92.00 09200(0BSERVATION BEDS (NON-DISTINCT PART)) 100,659 0 0 9 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 269,369 100 69,449,716 114 NONRE MBURSABLE COST CENTERS 118.00 0 0 0 0 19000 61FT, FLOWER, COFFEE SHOP, & CANTEEN 0 0 19900 0 19900 0 19900 0 19900 0 19900 0 0 19900 0 19900 0 0 19900 0 19900 0 19900 0 19900 0 0 19900 0 19900 19900 0 0 0 19900 19900 0 0 0 0 19900 | | | | | | | |
| 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 92.00 SPECIAL PURPOSE COST CENTERS 5PECIAL PURPOSE COST CENTERS 111.00 NONREI MBURSABLE COST CENTERS 111.00 69.449,716 111.11 NONREI MBURSABLE COST CENTERS 0 0 0 191.00 191.00 19100 RESEARCH 0 0 0 192.00 19200 PHYSI CLANS' PRI VATE OFFICES 0 0 0 192 194.00 07950 OTHER NRCC 0 0 192 0 0 192 194.00 07950 OTHER NRCC 0 0 0 192 194.00 197951 SPN 0 0 194 197951 194 0 0 194 197951 194 0 0 0 194 197951 194 0 194 197951 194 194 197 194 194 194 194 194 194 194 194 194 194 194 | | | - | | | | 88.00 |
| SPECIAL PURPOSE COST CENTERS 111 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 269,369 100 69,449,716 111 NORREI MBURSABLE COST CENTERS 0 0 0 191.00 69,449,716 111 190.00 191.00 RESEARCH 0 0 0 197 192.00 192000 GITT, FLOWER, COFFEE SHOP, & CANTEEN 0 0 0 197 194.00 07950 OTHER NRCC 0 0 0 197 194.00 07951 SPN 0 0 0 197 194.02 07952 OUTPATIENT CLINICS 0 0 0 197 194.02 07952 OUTPATIENT CLINICS 0 0 0 197 194.03 07953 MARKETING 0 0 0 0 197 2020.00 Cost to be allocated (per Wkst. B, Part 1) 0.245340 1,201,213 169,591 207 203.00 Unit cost multiplier (Wkst. B, Part 1) 0.24534 | | | 109, 659 | 0 | 21, 166, 16 | 56 | 91.00 |
| 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 269,369 100 69,449,716 114 NONREL MBURSABLE COST CENTERS 1900.00 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 0 0 191 190.00 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 0 0 0 199 191.00 GESEARCH 0 0 0 199 192.00 19200 PHYSICLANS' PRIVATE OFFICES 0 0 0 199 194.01 07951 SPN 0 0 0 199 194.02 07952 OUTPATIENT CLINICS 0 0 0 199 194.03 07953 MARKETING 0 0 0 199 200.00 Cross Foot Adjustments 0 0 0 199 2020.00 Cost to be allocated (per Wkst. B, Part I) 0.245340 12,012,130000 0.002442 200 203.00 Unit cost multiplier (Wkst. B, Part I) 0.245340 12,012.130000 0.002442 200 204.00 Cost to be allocated (per Wkst. B, Part I) 0.035230 529.820000 0.000618 200< | 92.00 | | | | | | 92.00 |
| NORE Impursable COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 0 0 0 0 190 191.00 RESEARCH 0 0 0 0 0 197 192.00 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 197 194.00 07950 OTHER NRCC 0 0 0 197 194.01 07951 SPN 0 0 0 197 194.02 07952 OUTPATIENT CLINICS 0 0 0 197 194.03 07953 MARKETING 0 0 0 197 200.00 Cross Foot Adjustments 0 0 0 197 201.00 Negative Cost Centers 200 200 200 200 200 12,012,133 169,591 200 203.00 Unit cost multiplier (Wkst. B, Part I) 0.245340 12,012,130000 0.002442 200 204.00 | 110 00 | | 260 260 | 100 | 60 110 71 | 16 | 118.00 |
| 190.00 IFT, FLOWER, COFFEE SHOP, & CANTEEN 0 0 0 194 191.00 RESEARCH 0 0 0 197 192.00 19200 PHYSI CLANS' PRI VATE OFFICES 0 0 0 197 194.00 07950 OTHER NRCC 0 0 0 197 194.00 07950 OTHER NRCC 0 0 0 197 194.01 07951 SPN 0 0 0 197 194.02 07952 OUTPATI ENT CLINICS 0 0 0 197 194.03 07953 MARKETING 0 0 0 197 200.00 Cross Foot Adjustments 0 0 0 197 202.00 Cost to be allocated (per Wkst. B, Part I) 0.245340 12,012.130000 0.002442 200 203.00 Unit cost multiplier (Wkst. B, Part I) 0.245340 12,012.130000 0.002442 200 204.00 Cost to be allocated (per Wkst. B, Part I) 0.035230 529.820000 0.000618 204 205.00 U | 110.00 | | 207, 307 | 100 | 07, 447, 71 | | |
| 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 192 194.00 07950 OTHER NRCC 0 0 194 194.01 07951 SPN 0 0 0 194 194.01 07951 SPN 0 0 0 194 194.02 07952 OUTPATIENT CLINICS 0 0 0 194 194.03 07953 MARKETING 0 0 0 0 194 200.00 Cross Foot Adjustments 0 0 0 0 194 201.00 Negative Cost Centers 200 201 0 0.002442 202 202.00 Cost to be allocated (per Wkst. B, Part I) 0.245340 12,012.130000 0.002442 203 203.00 Unit cost multiplier (Wkst. B, Part I) 0.245340 12,012.130000 0.002442 204 204.00 Cost to be allocated (per Wkst. B, Part I) 0.035230 529.820000 0.000618 204 205.00 Unit cost multiplier (Wkst. B, Part I) 0.035230 529.820000 0.000618 204< | 190.00 | | 0 | 0 | | 0 | 190.00 |
| 194.00 07950 OTHER NRCC 0 0 194.01 194.01 07951 SPN 0 0 0 194.02 194.02 07952 OUTPATIENT CLINICS 0 0 0 194.03 194.03 07953 MARKETING 0 0 0 194.03 200.00 Cross Foot Adjustments 0 0 0 0 194.02 201.00 Negative Cost Centers 0 0 0 0 200.02 0 Cost to be allocated (per Wkst. B, Part I) 0.245340 12,012.130000 0.002442 200.02 204.00 Cost to be allocated (per Wkst. B, Part I) 0.245340 12,012.130000 0.002442 204.02 204.00 205.00 Unit cost multiplier (Wkst. B, Part I) 0.035230 529.820000 0.000618 204.00 204.00 204.00 204.00 204.00 205.00 Unit cost multiplier (Wkst. B, Part I) 0.035230 529.820000 0.000618 204.00 204.00 204.00 204.00 204.00 204.00 204.00 204.00 204.00 204.00 204.00 204.00 204.00 <td< td=""><td>191.00</td><td>19100 RESEARCH</td><td>0</td><td>0</td><td></td><td>0</td><td>191.00</td></td<> | 191.00 | 19100 RESEARCH | 0 | 0 | | 0 | 191.00 |
| 194.01 07951 SPN 0 0 194.02 194.02 07952 OUTPATIENT CLINICS 0 0 0 194.03 194.03 07953 MARKETING 0 0 0 194.03 194.03 200.00 Cross Foot Adjustments 0 0 0 0 194.03 200.00 0 194.03 | 192.00 | 19200 PHYSICIANS' PRIVATE OFFICES | 0 | 0 | | 0 | 192.00 |
| 194.02 07952 OUTPATIENT CLINICS 0 0 194.03 194.03 07953 MARKETING 0 0 0 194.03 200.00 Cross Foot Adjustments 0 0 0 0 200 201.00 Negative Cost Centers 200 201 202 202 202 203.00 Cost to be allocated (per Wkst. B, Part I) 0.245340 12,012.130000 0.002442 203 203.00 Unit cost multiplier (Wkst. B, Part I) 0.245340 12,012.130000 0.002442 203 204.00 Cost to be allocated (per Wkst. B, Part I) 0.245340 12,012.130000 0.002442 203 205.00 Unit cost multiplier (Wkst. B, Part I) 0.035230 529.820000 0.000618 204 205.00 Unit cost multiplier (Wkst. B, Part I) 0.035230 529.820000 0.000618 204 206.00 NAHE adjustment amount to be allocated (per Wkst. D, 0.035230 529.820000 0.000618 204 207.00 NAHE unit cost multiplier (Wkst. D, 0.035230 529.820000 0.000618 204 | | | - | | | | 194.00 |
| 194.03 07953 MARKETING 0 0 194 200.00 Cross Foot Adjustments 200 200 201 0 Negative Cost Centers 200 201.00 Negative Cost Centers 200 | | | 0 | Ŭ | | | 194.01 |
| 200.00 Cross Foot Adjustments 200 201.00 Negative Cost Centers 200 202.00 Cost to be allocated (per Wkst. B, Part I) 66,087 1,201,213 169,591 200 203.00 Unit cost multiplier (Wkst. B, Part I) 0.245340 12,012.130000 0.002442 200 204.00 Cost to be allocated (per Wkst. B, Part I) 0.245340 12,012.130000 0.002442 200 205.00 Unit cost multiplier (Wkst. B, Part I) 0.035230 529.820000 0.000618 200 206.00 NAHE adjustment amount to be allocated (per Wkst. D, 0.035230 529.820000 0.000618 200 207.00 NAHE unit cost multiplier (Wkst. D, 0.035230 529.820000 0.000618 200 | | | | 0 | | | 194.02 |
| 201.00 Negative Cost Centers 201 202.00 Cost to be allocated (per Wkst. B, Part I) 66,087 1,201,213 169,591 202 203.00 Unit cost multiplier (Wkst. B, Part I) 0.245340 12,012.130000 0.002442 203 204.00 Cost to be allocated (per Wkst. B, Part I) 0.245340 12,012.130000 0.002442 203 205.00 Unit cost multiplier (Wkst. B, Part II) 0.035230 529.820000 0.000618 203 206.00 NAHE adjustment amount to be allocated (per Wkst. D, 0.035230 529.820000 0.000618 204 207.00 NAHE unit cost multiplier (Wkst. D, 0.035230 529.820000 0.000618 204 | | | 0 | 0 | | 0 | 194. 03 200. 00 |
| 202.00 Cost to be allocated (per Wkst. B, Part I) 66,087 1,201,213 169,591 203 203.00 Unit cost multiplier (Wkst. B, Part I) 0.245340 12,012.130000 0.002442 203 204.00 Cost to be allocated (per Wkst. B, Part I) 0.245340 12,012.130000 0.002442 203 204.00 Cost to be allocated (per Wkst. B, Part II) 9,490 52,982 42,918 204 205.00 Unit cost multiplier (Wkst. B, Part II) 0.035230 529.820000 0.000618 204 206.00 NAHE adjustment amount to be allocated (per Wkst. B, Part II) 0.035230 529.820000 0.000618 204 207.00 NAHE unit cost multiplier (Wkst. D, 0.035230 529.820000 0.000618 204 | | | | | | | 200.00 |
| 203.00 Unit cost multiplier (Wkst. B, Part I) 0.245340 12,012.130000 0.002442 203 204.00 Cost to be allocated (per Wkst. B, Part II) 9,490 52,982 42,918 204 205.00 Unit cost multiplier (Wkst. B, Part II) 0.035230 529.820000 0.000618 204 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 0.035230 529.820000 0.000618 204 207.00 NAHE unit cost multiplier (Wkst. D, 0.035230 529.820000 0.000618 204 | | Cost to be allocated (per Wkst. B, | 66, 087 | 1, 201, 213 | 169, 59 | 91 | 201.00 |
| 204.00 Cost to be allocated (per Wkst. B, Part II) 9,490 52,982 42,918 204 205.00 Unit cost multiplier (Wkst. B, Part II) 0.035230 529.820000 0.000618 204 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 0.035230 529.820000 0.000618 204 207.00 NAHE unit cost multiplier (Wkst. D, 201 0.000000 0.000000 0.000000 204 | 203.00 | | 0. 245340 | 12, 012. 130000 | 0.00244 | 12 | 203.00 |
| 206.00II) NAHE adjustment amount to be allocated (per Wkst. B-2)200207.00NAHE unit cost multiplier (Wkst. D,200 | | Cost to be allocated (per Wkst. B, | | | | | 204.00 |
| 206.00NAHE adjustment amount to be allocated (per Wkst. B-2)200207.00NAHE unit cost multiplier (Wkst. D,200 | 205.00 | Unit cost multiplier (Wkst. B, Part | 0. 035230 | 529. 820000 | 0. 00061 | 18 | 205.00 |
| | | NAHE adjustment amount to be allocated (per Wkst. B-2) | | | | | 206.00 |
| | 207.00 | | | | | | 207.00 |

| | ASCENSION ST. VI | NCENT JENNINGS | | | u of Form CMS- | 2552-10 |
|---|---|-----------------------|-------------|---|---|---------------------|
| COMPUTATION OF RATIO OF COSTS TO CHARGES | | Provider C | | Period: From 07/01/2021 To 06/30/2022 | Worksheet C Part I Date/Time Pre 11/28/2022 12 | epared: 2:17 pm_ |
| | | Title | XVIII | Hospi tal | Cost | |
| | | | | Costs | | |
| Cost Center Description | Total Cost (from Wkst. B, Part I, col. 26) | Therapy Limit Adj. | Total Costs | RCE Di sal I owance | Total Costs | |
| | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30. 00 03000 ADULTS & PEDI ATRI CS | 3, 027, 419 | | 3, 027, 41 | 9 0 | 0 | 30.00 |
| ANCILLARY SERVICE COST CENTERS | | | | | | |
| 50. 00 05000 OPERATI NG ROOM | 1, 274, 962 | | 1, 274, 96 | 2 0 | 0 | 50.00 |
| 54.00 05400 RADIOLOGY - DIAGNOSTIC | 2, 530, 652 | | 2, 530, 65 | 2 0 | 0 | 54.00 |
| 60. 00 06000 LABORATORY | 3, 240, 668 | | 3, 240, 66 | В О | 0 | 60.00 |
| 65. 00 06500 RESPI RATORY THERAPY | 326 | 0 | 32 | 6 0 | 0 | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 465, 693 | C | 465, 69 | 3 0 | 0 | 66.00 |
| 67.00 06700 OCCUPATIONAL THERAPY | 72, 802 | 0 | 72, 80 | 2 0 | 0 | 67.00 |
| 68.00 06800 SPEECH PATHOLOGY | 0 | 0 0 | | 0 0 | 0 | 00.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 0 | | | 0 0 | 0 | 07100 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 48, 099 | | 48, 09 | | 0 | |
| 72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS | 17, 958 | | 17, 95 | во | 0 | 72.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 1, 201, 213 | | 1, 201, 21 | 3 0 | 0 | 73.00 |
| 76.00 03950 ADULT MENTAL HEALTH | 622, 843 | | 622, 84 | 3 0 | 0 | 76.00 |
| OUTPATIENT SERVICE COST CENTERS | | • | | | | |
| 88.00 08800 RURAL HEALTH CLINIC | 0 | | | 0 0 | 0 | 00.00 |
| 91. 00 09100 EMERGENCY | 5, 563, 184 | | 5, 563, 18 | | 0 | , |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 1, 255, 333 | | 1, 255, 33 | | 0 | 1 12:00 |
| 200.00 Subtotal (see instructions) | 19, 321, 152 | | 1 17/021/10 | | | 200.00 |
| 201.00 Less Observation Beds | 1, 255, 333 | | 1, 255, 33 | | | 201.00 |
| 202.00 Total (see instructions) | 18, 065, 819 | ין C | 18, 065, 81 | 9 0 | 0 | 202.00 |

| Health Financial Systems AS | SCENSION ST. VI | NCENT JENNINGS | | In Lie | u of Form CMS-2 | 2552-10 |
|--|-----------------|---------------------|---------------|----------------------------|--------------------------------|------------------|
| COMPUTATION OF RATIO OF COSTS TO CHARGES | | Provider C | | Period: From 07/01/2021 | Worksheet C Part I | |
| | | | | To 06/30/2022 | Date/Time Pre 11/28/2022 12 | |
| | | Title | xviii | Hospi tal | Cost | <u>. 17 piii</u> |
| | | Charges | | | | |
| Cost Center Description | I npati ent | Outpati ent | Total (col. 6 | Cost or Other | TEFRA | |
| | | | + col. 7) | Rati o | Inpati ent | |
| | | | | | Ratio | |
| | 6.00 | 7.00 | 8.00 | 9.00 | 10.00 | |
| I NPATI ENT ROUTI NE SERVI CE COST CENTERS | | | | - | | |
| 30. 00 03000 ADULTS & PEDI ATRI CS | 1, 515, 134 | | 1, 515, 13 | 4 | | 30.00 |
| ANCI LLARY SERVICE COST CENTERS | | | | | | |
| 50. 00 05000 OPERATING ROOM | 0 | 4, 186, 732 | | | 0.00000 | |
| 54. 00 05400 RADI OLOGY - DI AGNOSTI C | 180, 549 | 18, 172, 556 | | | 0.00000 | 54.00 |
| | 581, 291 | 20, 835, 811 | | | 0.000000 | |
| 65. 00 06500 RESPIRATORY THERAPY | 54, 112 | 79, 568 | | | 0.000000 | |
| 66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY | 72, 433 | 1, 072, 671 | | | 0.000000 | 66.00 67.00 |
| 67.00 06700 OCCUPATI ONAL THERAPY 68.00 06800 SPEECH PATHOLOGY | 15, 261 | 96, 769 | 112, 03 | 0. 649844 | 0.000000 | |
| 69. 00 106800 SPEECH PATHOLOGY 69. 00 106900 ELECTROCARDI OLOGY | 0 | 0 | | 0.000000 | 0.000000 | |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 132,049 | 425, 658 | 557, 70 | | 0.000000 | |
| 72. 00 07200 IMPLANTABLE DEVICES CHARGED TO PATTENTS | 132,049 | 425, 658 55, 579 | | | 0.000000 | |
| PATIENTS | 0 | 55, 579 | 55, 57 | 9 0. 323106 | 0.000000 | 72.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 588, 389 | 3, 399, 412 | 3, 987, 80 | 0. 301222 | 0.00000 | 73.00 |
| 76.00 03950 ADULT MENTAL HEALTH | 0 | 663, 723 | 663, 72 | 0. 938408 | 0.00000 | 76.00 |
| OUTPATIENT SERVICE COST CENTERS | | | | _ | | |
| 88.00 08800 RURAL HEALTH CLINIC | 0 | 0 | | C | | 88.00 |
| 91. 00 09100 EMERGENCY | 148, 892 | 21, 017, 274 | | | 0.00000 | |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 83, 111 | 673, 829 | | | 0.00000 | |
| 200.00 Subtotal (see instructions) | 3, 371, 221 | 70, 679, 582 | 74, 050, 80 | 3 | | 200. 00 |
| 201.00 Less Observation Beds | | | | | | 201.00 |
| 202.00 Total (see instructions) | 3, 371, 221 | 70, 679, 582 | 74, 050, 80 | 3 | | 202.00 |

| COMPUTATION OF RATIO OF COSTS TO CHARGES | | Provider CCN: 15-1303 | Peri od: From 07/01/2021 To 06/30/2022 | Worksheet C Part I Date/Time Prep 11/28/2022 12: | |
|--|---------------|-----------------------|--|---|--------|
| | | Title XVIII | Hospi tal | Cost | |
| Cost Center Description | PPS Inpatient | | | | |
| | Ratio | | | | 1 |
| | 11.00 | | | | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | | |
| 30. 00 03000 ADULTS & PEDI ATRI CS | | | | | 30.00 |
| ANCI LLARY SERVI CE COST CENTERS | | | | | |
| 50. 00 05000 OPERATI NG ROOM | 0. 000000 | | | | 50.00 |
| 54.00 05400 RADIOLOGY - DIAGNOSTIC | 0. 000000 | | | | 54.OC |
| 60. 00 06000 LABORATORY | 0. 000000 | | | | 60.00 |
| 65. 00 06500 RESPI RATORY THERAPY | 0. 000000 | | | | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 0. 000000 | | | | 66.00 |
| 67.00 06700 OCCUPATI ONAL THERAPY | 0. 000000 | | | | 67.00 |
| 58.00 06800 SPEECH PATHOLOGY | 0. 000000 | | | | 68.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 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 | | | | | 1 |
| 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 | | | | | 1 |
| 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 |

| Heal th Finan | | SCENSION ST. VI | NCENT JENNINGS | | | u of Form CMS-: | 2552-10 |
|---------------|--|---|-----------------------|-------------|---|---|---------|
| COMPUTATI ON | OF RATIO OF COSTS TO CHARGES | | Provider C | | Period: From 07/01/2021 To 06/30/2022 | Worksheet C Part I Date/Time Pre 11/28/2022 12 | |
| | | | Titl | e XIX | Hospi tal | Cost | |
| | | | | | Costs | | |
| | Cost Center Description | Total Cost (from Wkst. B, Part I, col. 26) | Therapy Limit Adj. | Total Costs | RCE Di sal I owance | Total Costs | |
| | | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| | ENT ROUTINE SERVICE COST CENTERS | | | | | | |
| | ADULTS & PEDIATRICS | 3, 027, 419 | | 3, 027, 41 | 9 0 | 3, 027, 419 | 30.00 |
| | _ARY SERVICE COST CENTERS | | | | | | |
| | OPERATING ROOM | 1, 274, 962 | | 1, 274, 96 | 2 0 | 1, 274, 962 | |
| | RADIOLOGY - DIAGNOSTIC | 2, 530, 652 | | 2, 530, 65 | | 2, 530, 652 | |
| | LABORATORY | 3, 240, 668 | | 3, 240, 66 | | 3, 240, 668 | |
| | RESPI RATORY THERAPY | 326 | | 32 | | 326 | |
| | PHYSI CAL THERAPY | 465, 693 | | 465, 69 | | 465, 693 | |
| | OCCUPATIONAL THERAPY | 72, 802 | 0 | 72, 80 | 2 0 | 72, 802 | |
| | SPEECH PATHOLOGY | 0 | 0 | | 0 0 | 0 | 00.00 |
| | ELECTROCARDI OLOGY | 0 | | | 0 0 | 0 | 07100 |
| | MEDICAL SUPPLIES CHARGED TO PATIENTS | 48, 099 | | 48, 09 | | 48, 099 | |
| | IMPLANTABLE DEVICES CHARGED TO PATIENTS | 17, 958 | | 17, 95 | 8 0 | 17, 958 | 72.00 |
| 73.00 07300 | DRUGS CHARGED TO PATIENTS | 1, 201, 213 | | 1, 201, 21 | 3 0 | 1, 201, 213 | 73.00 |
| 76.00 03950 | ADULT MENTAL HEALTH | 622, 843 | | 622, 84 | 3 0 | 622, 843 | 76.00 |
| | TIENT SERVICE COST CENTERS | | · | | | | |
| | RURAL HEALTH CLINIC | 0 | | | 0 0 | 0 | 00.00 |
| | EMERGENCY | 5, 563, 184 | | 5, 563, 18 | | 5, 563, 184 | |
| | OBSERVATION BEDS (NON-DISTINCT PART) | 1, 255, 333 | | 1, 255, 33 | | 1, 255, 333 | |
| | Subtotal (see instructions) | 19, 321, 152 | | 17/021/10 | | 19, 321, 152 | |
| | Less Observation Beds | 1, 255, 333 | | 1, 255, 33 | | 1, 255, 333 | |
| 202.00 | Total (see instructions) | 18, 065, 819 | 0 | 18, 065, 81 | 9 0 | 18, 065, 819 | 202.00 |

| Health Financial Systems AS | SCENSION ST. VI | NCENT JENNINGS | | In Lie | u of Form CMS-2 | 2552-10 |
|--|-----------------|----------------|--------------|----------------------------|-----------------------|---------|
| COMPUTATION OF RATIO OF COSTS TO CHARGES | | Provider C | | Period: From 07/01/2021 | Worksheet C Part I | |
| | | | | o 06/30/2022 | Date/Time Pre | |
| | | | | | 11/28/2022 12 | :17 pm |
| | | | e XIX | Hospi tal | Cost | |
| | | Charges | | | | |
| Cost Center Description | Inpati ent | Outpati ent | | Cost or Other | TEFRA | |
| | | | + col. 7) | Rati o | Inpatient Ratio | |
| | 6.00 | 7.00 | 8,00 | 9,00 | 10.00 | |
| INPATIENT ROUTINE SERVICE COST CENTERS | 0.00 | 7.00 | 0.00 | 7.00 | 10.00 | |
| 30. 00 03000 ADULTS & PEDI ATRI CS | 1, 515, 134 | | 1, 515, 134 | l I | | 30.00 |
| ANCI LLARY SERVI CE COST CENTERS | | | | | | |
| 50.00 05000 OPERATI NG ROOM | 0 | 4, 186, 732 | 4, 186, 732 | 0. 304524 | 0.00000 | 50.00 |
| 54.00 05400 RADIOLOGY - DIAGNOSTIC | 180, 549 | 18, 172, 556 | 18, 353, 105 | 0. 137887 | 0. 000000 | 54.00 |
| 60. 00 06000 LABORATORY | 581, 291 | 20, 835, 811 | 21, 417, 102 | 0. 151312 | 0.00000 | 60.00 |
| 65. 00 06500 RESPI RATORY THERAPY | 54, 112 | 79, 568 | 133, 680 | 0. 002439 | 0.00000 | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 72, 433 | 1, 072, 671 | 1, 145, 104 | | 0.00000 | |
| 67.00 06700 OCCUPATI ONAL THERAPY | 15, 261 | 96, 769 | 112, 030 | | 0. 000000 | 67.00 |
| 68.00 06800 SPEECH PATHOLOGY | 0 | 0 | C | 0. 000000 | 0. 000000 | |
| 69. 00 06900 ELECTROCARDI OLOGY | 0 | 0 | C | 0. 000000 | 0. 000000 | |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 132, 049 | 425, 658 | | | 0.00000 | |
| 72.00 07200 I MPLANTABLE DEVICES CHARGED TO | 0 | 55, 579 | 55, 579 | 0. 323108 | 0.00000 | 72.00 |
| | 500,000 | 2 200 412 | 2 007 001 | 0 001000 | 0,000000 | 72.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS 76.00 03950 ADULT MENTAL HEALTH | 588, 389 | 3, 399, 412 | | | 0.000000 | |
| OUTPATIENT SERVICE COST CENTERS | 0 | 663, 723 | 663, 723 | 0.938408 | 0.00000 | 76.00 |
| 88. 00 08800 RURAL HEALTH CLINIC | 0 | 0 | (| 0.000000 | 0.000000 | 88.00 |
| 91. 00 09100 EMERGENCY | 148, 892 | 21, 017, 274 | 21, 166, 166 | | 0.000000 | |
| 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 83, 111 | 673, 829 | | | 0, 000000 | |
| 200.00 Subtotal (see instructions) | 3, 371, 221 | 70, 679, 582 | | | 0.00000 | 200.00 |
| 201.00 Less Observation Beds | -, , | | ,,, | | | 201.00 |
| 202.00 Total (see instructions) | 3, 371, 221 | 70, 679, 582 | 74, 050, 803 | 3 | | 202.00 |
| | | | | | | |

| iearth Frhanciar Systems | ASCENSION SI. VINC | ENT JENNINGS | In Lieu | J OT FORM CMS-2552- |
|--|--------------------|-----------------------|---|---------------------------|
| COMPUTATION OF RATIO OF COSTS TO CHARGES | | Provider CCN: 15-1303 | Period: From 07/01/2021 To 06/30/2022 | <u>11/28/2022</u> 12:17 p |
| | | Title XIX | Hospi tal | Cost |
| Cost Center Description | PPS Inpatient | | | |
| | Ratio | | | |
| | 11.00 | | | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | |
| 0.00 03000 ADULTS & PEDIATRICS | | | | 30. (|
| ANCI LLARY SERVI CE COST CENTERS | | | | |
| 50.00 05000 OPERATING ROOM | 0. 000000 | | | 50.0 |
| 54.00 05400 RADIOLOGY - DIAGNOSTIC | 0. 000000 | | | 54.0 |
| 0. 00 06000 LABORATORY | 0. 000000 | | | 60.0 |
| 5. 00 06500 RESPI RATORY THERAPY | 0. 000000 | | | 65.0 |
| 6. 00 06600 PHYSI CAL THERAPY | 0. 000000 | | | 66.0 |
| 7.00 06700 OCCUPATIONAL THERAPY | 0. 000000 | | | 67.0 |
| 8.00 06800 SPEECH PATHOLOGY | 0. 000000 | | | 68.0 |
| 9. 00 06900 ELECTROCARDI OLOGY | 0. 000000 | | | 69.0 |
| 1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0. 000000 | | | 71. (|
| 2.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS | 0. 000000 | | | 72. (|
| 3.00 07300 DRUGS CHARGED TO PATIENTS | 0. 000000 | | | 73.0 |
| 6.00 03950 ADULT MENTAL HEALTH | 0. 000000 | | | 76.0 |
| OUTPATIENT SERVICE COST CENTERS | | | | |
| 8.00 08800 RURAL HEALTH CLINIC | 0. 000000 | | | 88.0 |
| 1.00 09100 EMERGENCY | 0. 000000 | | | 91. (|
| 2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0. 000000 | | | 92.0 |
| 00.00 Subtotal (see instructions) | | | | 200. (|
| 01.00 Less Observation Beds | | | | 201. (|
| 202.00 Total (see instructions) | | | | 202. (|

| Health Financial Systems A | SCENSION ST. VI | NCENT JENNINGS | | In Lie | u of Form CMS-2 | 2552-10 |
|---|-----------------|----------------|--------------|---|--|---------|
| APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA | L COSTS | Provider C | | Period: From 07/01/2021 To 06/30/2022 | Worksheet D Part II Date/Time Pre 11/28/2022 12 | |
| | | Title | e XVIII | Hospi tal | Cost | • |
| Cost Center Description | Capi tal | Total Charges | Ratio of Cos | t Inpatient | Capital Costs | |
| | | (from Wkst. C, | to Charges | 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 | |
| ANCI LLARY SERVI CE COST CENTERS | 1 | 1 | 1 | | | |
| 50.00 O5000 OPERATI NG ROOM | 121, 760 | | | | 0 | |
| 54.00 05400 RADIOLOGY – DIAGNOSTIC | 538, 940 | 18, 353, 105 | 0. 02936 | 5 47,010 | 1, 380 | 54.00 |
| 60. 00 06000 LABORATORY | 78, 292 | 21, 417, 102 | 0. 00365 | 6 235, 196 | 860 | 60.00 |
| 65. 00 06500 RESPI RATORY THERAPY | 3, 335 | | 0. 02494 | 8 18, 080 | 451 | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 26, 974 | 1, 145, 104 | 0. 02355 | 6 29, 323 | 691 | 66.00 |
| 67.00 06700 OCCUPATI ONAL THERAPY | 1, 196 | 112, 030 | 0. 01067 | 6 5, 945 | 63 | 67.00 |
| 68.00 06800 SPEECH PATHOLOGY | 0 | 0 | 0.00000 | 0 0 | 0 | 68.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 0 | 0 | 0.00000 | 0 0 | 0 | 69.00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 9, 512 | 557, 707 | 0. 01705 | 6 49, 803 | 849 | 71.00 |
| 72.00 07200 IMPLANTABLE DEVICES CHARGED TO | 600 | 55, 579 | 0. 01079 | 5 0 | 0 | 72.00 |
| PATIENTS | | | | | | |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 52, 982 | 3, 987, 801 | 0. 01328 | 6 326, 642 | 4, 340 | 73.00 |
| 76.00 03950 ADULT MENTAL HEALTH | 10, 764 | 663, 723 | 0. 01621 | 8 0 | 0 | 76.00 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 88.00 08800 RURAL HEALTH CLINIC | 0 | 0 | 0.00000 | 0 0 | 0 | 88.00 |
| 91. 00 09100 EMERGENCY | 164, 998 | | 0.00779 | 5 6, 602 | 51 | 91.00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 54, 038 | 756, 940 | 0. 07139 | 0 9, 014 | 644 | |
| 200.00 Total (lines 50 through 199) | 1, 063, 391 | 72, 535, 669 | | 727, 615 | 9, 329 | 200. 00 |

| Health Financial Systems A | SCENSION ST. VI | NCENT JENNINGS | | In Lie | u of Form CMS-2 | 2552-10 |
|---|-----------------|----------------|-------------|----------------------------------|-----------------|---------|
| APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF | RVICE OTHER PAS | S Provider C | CN: 15-1303 | Peri od: | Worksheet D | |
| THROUGH COSTS | | | | From 07/01/2021 To 06/30/2022 | | nared |
| | | | | 10 00/30/2022 | 11/28/2022 12 | |
| | _ | Title | XVIII | Hospi tal | Cost | |
| Cost Center Description | Non Physician | Nursi ng | Nursi ng | | Allied Health | |
| | Anestheti st | Program | Program | Post-Stepdown | | |
| | Cost | Post-Stepdown | | Adjustments | | |
| | | Adjustments | | | | |
| | 1.00 | 2A | 2.00 | 3A | 3.00 | |
| ANCI LLARY SERVI CE COST CENTERS | 1 | | 1 | | | |
| 50. 00 05000 OPERATING ROOM | 0 | 0 | | 0 0 | 0 | 50.00 |
| 54. 00 05400 RADIOLOGY - DIAGNOSTIC | 0 | 0 | | 0 0 | 0 | 54.00 |
| 60. 00 06000 LABORATORY | 0 | 0 | | 0 C | 0 | 60.00 |
| 65. 00 06500 RESPI RATORY THERAPY | 0 | 0 | | 0 0 | 0 | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 0 | 0 | | 0 0 | 0 | 66.00 |
| 67.00 06700 OCCUPATI ONAL THERAPY | 0 | 0 | | 0 0 | 0 | 67.00 |
| 68.00 06800 SPEECH PATHOLOGY | 0 | 0 | | 0 C | 0 | 68.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 0 | 0 | | 0 C | 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 |

11/28/2022 12:17 pm Y: \28550 - St. Vincent Jennings\300 - Medicare Cost Report\20220630\HFS\20220630 St. Vincent Jennings.mcrx

| Health Financial Systems A | SCENSION ST. VI | NCENT JENNINGS | | In Lie | u of Form CMS-2 | 2552-10 |
|---|------------------|----------------|--------------|-----------------|--------------------------------|------------------|
| APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF | RVICE OTHER PASS | S Provider CO | | Period: | Worksheet D | |
| THROUGH COSTS | | | | From 07/01/2021 | | norod. |
| | | | | To 06/30/2022 | Date/Time Pre 11/28/2022 12 | |
| | | Title | XVIII | Hospi tal | Cost | <u>. 17 piir</u> |
| Cost Center Description | All Other | Total Cost | Total | | Ratio of Cost | |
| | Medi cal | (sum of cols. | Outpati ent | (from Wkst. C, | | |
| | Education Cost | 1, 2, 3, and | Cost (sum of | | (col. 5 ÷ col. | |
| | | 4) | col s. 2, 3, | 8) | 7) | |
| | | | and 4) | | (see | |
| | | | | | instructions) | |
| | 4.00 | 5.00 | 6.00 | 7.00 | 8.00 | |
| ANCI LLARY SERVI CE COST CENTERS | | | | | | |
| 50.00 05000 OPERATI NG ROOM | 0 | 0 | | 0 4, 186, 732 | | |
| 54.00 05400 RADIOLOGY – DIAGNOSTIC | 0 | 0 | | 0 18, 353, 105 | | |
| 60. 00 06000 LABORATORY | 0 | 0 | | 0 21, 417, 102 | | |
| 65. 00 06500 RESPI RATORY THERAPY | 0 | 0 | | 0 133, 680 | | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 0 | 0 | | 0 1, 145, 104 | | |
| 67.00 06700 OCCUPATI ONAL THERAPY | 0 | 0 | | 0 112, 030 | 0. 000000 | 67.00 |
| 68.00 06800 SPEECH PATHOLOGY | 0 | 0 | | 0 0 | 0.000000 | |
| 69. 00 06900 ELECTROCARDI OLOGY | 0 | 0 | | 0 0 | 0.000000 | 69.00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 0 | | 0 557, 707 | 0.000000 | 71.00 |
| 72.00 07200 IMPLANTABLE DEVICES CHARGED TO | 0 | 0 | | 0 55, 579 | 0.000000 | 72.00 |
| PATIENTS | | | | | | |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 0 | 0 | | 0 3, 987, 801 | | |
| 76.00 03950 ADULT MENTAL HEALTH | 0 | 0 | | 0 663, 723 | 0.00000 | 76.00 |
| OUTPATIENT SERVICE COST CENTERS | - | | | | | |
| 88.00 08800 RURAL HEALTH CLINIC | 0 | 0 | | 0 0 | 0. 000000 | |
| 91. 00 09100 EMERGENCY | 0 | 0 | | 0 21, 166, 166 | | 91.00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0 | 0 | | 0 756, 940 | | |
| 200.00 Total (lines 50 through 199) | 0 | 0 | | 0 72, 535, 669 | | 200. 00 |

| Health Financial Systems A | SCENSION ST. VIN | CENT JENNINGS | | In Lie | u of Form CMS-2 | 2552-10 |
|--|------------------|---------------|--------------|---|--|---------|
| APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS | RVICE OTHER PASS | Provider CC | CN: 15-1303 | Period: From 07/01/2021 To 06/30/2022 | Worksheet D Part IV Date/Time Pre 11/28/2022 12 | |
| | | Title | XVIII | Hospi tal | Cost | |
| Cost Center Description | Outpati ent | Inpati ent | Inpati ent | Outpati ent | Outpati ent | |
| | Ratio of Cost | Program | Program | Program | Program | |
| | to Charges | Charges | Pass-Through | | Pass-Through | |
| | (col. 6 ÷ col. | | Costs (col. | 8 | Costs (col. 9 | |
| | 7) | | x col. 10) | | x col. 12) | |
| | 9.00 | 10.00 | 11.00 | 12.00 | 13.00 | |
| ANCI LLARY SERVI CE COST CENTERS | | | | | | |
| 50.00 05000 OPERATING ROOM | 0. 000000 | 0 | | 0 0 | 0 | 50.00 |
| 54.00 05400 RADIOLOGY – DIAGNOSTIC | 0. 000000 | 47, 010 | | 0 0 | 0 | 54.00 |
| 60. 00 06000 LABORATORY | 0. 000000 | 235, 196 | | 0 0 | 0 | 60.00 |
| 65. 00 06500 RESPI RATORY THERAPY | 0.000000 | 18, 080 | | 0 0 | 0 | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 0.000000 | 29, 323 | | 0 0 | 0 | 66.00 |
| 67.00 06700 OCCUPATI ONAL THERAPY | 0.000000 | 5, 945 | | 0 0 | 0 | 67.00 |
| 68.00 06800 SPEECH PATHOLOGY | 0.000000 | 0 | | 0 0 | 0 | 68.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 0.000000 | 0 | | 0 0 | 0 | 69.00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0.000000 | 49, 803 | | 0 0 | 0 | 71.00 |
| 72.00 07200 IMPLANTABLE DEVICES CHARGED TO | 0. 000000 | 0 | | 0 0 | 0 | 72.00 |
| PATIENTS | | | | | | |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 0.000000 | 326, 642 | | 0 0 | 0 | 73.00 |
| 76.00 03950 ADULT MENTAL HEALTH | 0.000000 | 0 | | 0 0 | 0 | 76.00 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 88.00 08800 RURAL HEALTH CLINIC | 0.000000 | 0 | | 0 0 | 0 | 88.00 |
| 91.00 09100 EMERGENCY | 0. 000000 | 6, 602 | | 0 0 | 0 | 91.00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0. 000000 | 9, 014 | | 0 0 | 0 | 92.00 |
| 200.00 Total (lines 50 through 199) | | 727, 615 | | 0 0 | 0 | 200. 00 |

| Health Financial Systems AS | SCENSION ST. VI | NCENT JENNINGS | | In Lie | u of Form CMS-2 | 2552-10 |
|---|-----------------|----------------|--------------|---|---|---------|
| APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND | VACCINE COST | Provider C | | Period: From 07/01/2021 To 06/30/2022 | Worksheet D Part V Date/Time Pre 11/28/2022 12 | |
| | | Title | XVIII | Hospi tal | Cost | • |
| | | | Charges | | Costs | |
| Cost Center Description | Cost to Charge | PPS Reimbursed | Cost | Cost | PPS Services | |
| | Ratio From | Services (see | Reimbursed | Reimbursed | (see inst.) | |
| | Worksheet C, | inst.) | Servi ces | 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 | |
| ANCI LLARY SERVI CE COST CENTERS | | | | | | |
| 50.00 05000 OPERATING ROOM | 0. 304524 | | 532, 27 | | 0 | 50.00 |
| 54.00 05400 RADIOLOGY - DIAGNOSTIC | 0. 137887 | | 3, 330, 75 | | 0 | 54.00 |
| 60. 00 06000 LABORATORY | 0. 151312 | | 4, 027, 05 | | 0 | 60.00 |
| 65. 00 06500 RESPI RATORY THERAPY | 0. 002439 | | 22, 20 | | 0 | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 0. 406682 | | 206, 70 | 4 0 | 0 | 66.00 |
| 67.00 06700 OCCUPATI ONAL THERAPY | 0. 649844 | | 18, 46 | 0 0 | 0 | 67.00 |
| 68.00 06800 SPEECH PATHOLOGY | 0. 000000 | 0 | | 0 0 | 0 | 68.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 0. 000000 | 0 | | 0 0 | 0 | 69.00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0. 086244 | 0 | 63, 81 | 6 0 | 0 | 71.00 |
| 72.00 07200 IMPLANTABLE DEVICES CHARGED TO | 0. 323108 | 0 | 4, 32 | 2 0 | 0 | 72.00 |
| PATIENTS | | | | | | |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 0. 301222 | | 696, 02 | | | 73.00 |
| 76.00 03950 ADULT MENTAL HEALTH | 0. 938408 | 0 | 424, 42 | 7 0 | 0 | 76.00 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 88.00 08800 RURAL HEALTH CLINIC | | | | | | 88.00 |
| 91. 00 09100 EMERGENCY | 0. 262834 | 0 | 2, 763, 28 | 9 928 | 0 | 91.00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 1. 658431 | 0 | 233, 82 | | 0 | 92.00 |
| 200.00 Subtotal (see instructions) | | 0 | 12, 323, 16 | 9 1, 500 | 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, 323, 16 | 9 1, 500 | 0 | 202.00 |

| Health Financial Systems AS | S ASCENSI ON ST. VI NCENT JENNI NGS | | | | In Lieu of Form CMS-2552-10 | | |
|---|-------------------------------------|---------------|-------------|---|---|--------|--|
| APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND | VACCINE COST | Provider CC | CN: 15-1303 | Period: From 07/01/2021 To 06/30/2022 | Worksheet D Part V Date/Time Pre 11/28/2022 12 | | |
| | | Title | XVIII | Hospi tal | Cost | | |
| | Cos | | | | | | |
| Cost Center Description | Cost | Cost | | | | | |
| | Reimbursed | Reimbursed | | | | | |
| | Servi ces | Services Not | | | | | |
| | Subject To | Subject To | | | | | |
| | | Ded. & Coins. | | | | | |
| | (see inst.) | (see inst.) | | | | | |
| | 6.00 | 7.00 | | | | | |
| ANCI LLARY SERVI CE COST CENTERS | | | 1 | | | | |
| 50.00 O5000 OPERATING ROOM | 162, 091 | 0 | | | | 50.00 | |
| 54.00 05400 RADI OLOGY - DI AGNOSTI C | 459, 268 | | | | | 54.00 | |
| 60. 00 06000 LABORATORY | 609, 342 | 0 | | | | 60.00 | |
| 65. 00 06500 RESPI RATORY THERAPY | 54 | 0 | | | | 65.00 | |
| 66. 00 06600 PHYSI CAL THERAPY | 84, 063 | 0 | | | | 66.00 | |
| 67.00 06700 OCCUPATI ONAL THERAPY | 11, 996 | 0 | | | | 67.00 | |
| 68.00 06800 SPEECH PATHOLOGY | 0 | 0 | | | | 68.00 | |
| 69. 00 06900 ELECTROCARDI OLOGY | 0 | 0 | | | | 69.00 | |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 5, 504 | 0 | | | | 71.00 | |
| 72.00 07200 IMPLANTABLE DEVICES CHARGED TO | 1, 396 | 0 | | | | 72.00 | |
| PATIENTS | | | | | | | |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 209, 659 | | | | | 73.00 | |
| 76.00 03950 ADULT MENTAL HEALTH | 398, 286 | 0 | | | | 76.00 | |
| OUTPATIENT SERVICE COST CENTERS | | | | | | _ | |
| 88.00 08800 RURAL HEALTH CLINIC | | | | | | 88.00 | |
| 91.00 09100 EMERGENCY | 726, 286 | | | | | 91.00 | |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 387, 778 | | | | | 92.00 | |
| 200.00 Subtotal (see instructions) | 3, 055, 723 | 416 | | | | 200.00 | |
| 201.00 Less PBP Clinic Lab. Services-Program | 0 | | | | | 201.00 | |
| Only Charges | | | | | | | |
| 202.00 Net Charges (line 200 - line 201) | 3, 055, 723 | 416 | | | | 202.00 | |

| Health Financial Systems AS | SCENSION ST. VI | NCENT JENNINGS | | In Lie | u of Form CMS-2 | 2552-10 |
|--|-----------------|----------------------------|---------------|---|---|---------|
| APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND | VACCINE COST | Provider CC Component C | | Period: From 07/01/2021 To 06/30/2022 | Worksheet D Part V Date/Time Pre 11/28/2022 12 | |
| | | Title | XVIII | Swing Beds - SNF | | |
| | | | Charges | | Costs | |
| Cost Center Description | Cost to Charge | PPS Reimbursed | | Cost | PPS Services | |
| | | Services (see | Reimbursed | Reimbursed | (see inst.) | |
| | Worksheet C, | inst.) | Servi ces | Services Not | | |
| | Part I, col. 9 | | Subject To | Subject To | | |
| | | | Ded. & Coins. | Ded. & Coins. | | |
| | | | (see inst.) | (see inst.) | | |
| | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| ANCI LLARY SERVI CE COST CENTERS | | | | | | |
| 50. 00 05000 OPERATI NG ROOM | 0. 304524 | | | 0 0 | 0 | 50.00 |
| 54.00 05400 RADI OLOGY – DI AGNOSTI C | 0. 137887 | | | 0 0 | 0 | 54.00 |
| 60. 00 06000 LABORATORY | 0. 151312 | | | 0 0 | 0 | 60.00 |
| 65. 00 06500 RESPI RATORY THERAPY | 0. 002439 | 0 | | 0 0 | 0 | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 0. 406682 | 0 | | 0 0 | 0 | 66.00 |
| 67.00 06700 OCCUPATI ONAL THERAPY | 0. 649844 | 0 | | 0 0 | 0 | 67.00 |
| 68.00 06800 SPEECH PATHOLOGY | 0. 000000 | | | 0 0 | 0 | 68.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 0. 000000 | | | 0 0 | 0 | 69.00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0. 086244 | | | 0 0 | 0 | 71.00 |
| 72. 00 07200 I MPLANTABLE DEVICES CHARGED TO PATIENTS | 0. 323108 | 0 | | 0 0 | 0 | 72.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 0. 301222 | 0 | | 0 0 | 0 | 73.00 |
| 76.00 03950 ADULT MENTAL HEALTH | 0. 938408 | 0 | | 0 0 | 0 | 76.00 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 88.00 08800 RURAL HEALTH CLINIC | | | | | | 88.00 |
| 91.00 09100 EMERGENCY | 0. 262834 | 0 | | 0 0 | 0 | 91.00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 1. 658431 | 0 | | 0 0 | 0 | 92.00 |
| 200.00 Subtotal (see instructions) | | 0 | | 0 0 | 0 | 200.00 |
| 201.00 Less PBP Clinic Lab. Services-Program | | | | 0 0 | | 201.00 |
| Only Charges | | | | | | |
| 202.00 Net Charges (line 200 - line 201) | | 0 | | 0 0 | 0 | 202.00 |

| Health Financial Systems A | SCENSION ST. VI | NCENT JENNINGS | | In Lieu of Form CMS-2552-10 | | | |
|--|-----------------|----------------|--------------|----------------------------------|-------------------------|-----------------|--|
| APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND | VACCINE COST | Provider C | CN: 15-1303 | Peri od: | Worksheet D | | |
| | | Component (| CCN: 15-Z303 | From 07/01/2021 To 06/30/2022 | Part V Date/Time Pre | narad | |
| | | component (| JUN. 15-2303 | 10 00/ 30/ 2022 | 11/28/2022 12 | | |
| | | Title | XVIII | Swing Beds - SNF | | | |
| | Cos | | | | | | |
| Cost Center Description | Cost | Cost | | | | | |
| | Reimbursed | Reimbursed | | | | | |
| | Servi ces | Services Not | | | | | |
| | Subject To | Subject To | | | | | |
| | | Ded. & Coins. | | | | | |
| | (see inst.) | (see inst.) | | | | | |
| | 6.00 | 7.00 | | | | | |
| ANCI LLARY SERVI CE COST CENTERS | | | | | | 50.00 | |
| 50. 00 05000 OPERATING ROOM | 0 | 0 | | | | 50.00 | |
| 54. 00 05400 RADI OLOGY - DI AGNOSTI C | 0 | 0 | | | | 54.00 | |
| | 0 | 0 | | | | 60.00 | |
| 65. 00 06500 RESPI RATORY THERAPY | 0 | 0 | | | | 65.00 | |
| 66. 00 06600 PHYSI CAL 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 ELECTROCARDI OLOGY | 0 | 0 | | | | 69.00 | |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 0 | | | | 71.00 | |
| 72.00 07200 IMPLANTABLE DEVICES CHARGED TO | 0 | 0 | | | | 72.00 | |
| | | | | | | 70.00 | |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 0 | 0 | | | | 73.00 | |
| 76.00 03950 ADULT MENTAL HEALTH | 0 | 0 | | | | 76.00 | |
| 0UTPATI ENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC | | | | | | 00.00 | |
| 91. 00 09100 EMERGENCY | 0 | | | | | 88.00 91.00 | |
| 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0 | 0 | | | | | |
| | 0 | 0 | | | | 92.00 200.00 | |
| | 0 | 0 | | | | 200.00 | |
| | 0 | | | | | 201.00 | |
| 0nl y Charges 202.00 Net Charges (line 200 - line 201) | 0 | 0 | | | | 202.00 | |
| 202.00 Ivet Glarges (The 200 - The 201) | 0 | 0 | 1 | | | 1202. UU | |

| Health Financial Systems A | SCENSION ST. VI | NCENT JENNII | NGS | In Lie | eu of Form CMS- | 2552-10 |
|--|---|--|--|---|--|-------------------|
| APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA | ASS THROUGH COST | | - CCN: 15-1303 | Period: From 07/01/2021 To 06/30/2022 | Date/Time Pre 11/28/2022 12 | |
| | | | itle XIX | Hospi tal | Cost | |
| Cost Center Description | Nursing Program Post-Stepdown Adjustments | Nursing Program | Allied Heal Post-Stepdo Adjustment | | All Other Medical Education Cost | |
| | 1A | 1.00 | 2A | 2.00 | 3.00 | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30.00 03000 ADULTS & PEDLATRICS 200.00 Total (lines 30 through 199) | 0 | | 0 0 | 0 0 | | 30.00 |
| Cost Center Description | Swing-Bed Adjustment Amount (see instructions) | Total Cost (sum of col 1 through 3 minus col. | s. Days 3, | nt Per Diem (col. 5 ÷ col. 6) | Inpatient Program Days | |
| | 4.00 | 5.00 | 6.00 | 7.00 | 8.00 | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30.00 03000 ADULTS & PEDLATRICS 200.00 Total (lines 30 through 199) | 0 | | | 121 0. 00 121 | | 30.00 200.00 |
| Cost Center Description | Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00 | | | | | |
| I NPATI ENT ROUTI NE SERVI CE COST CENTERS | | | | | | |
| 30. 00 03000 ADULTS & PEDI ATRI CS 200. 00 Total (Lines 30 through 199) | 0 | | | | | 30. 00 200. 00 |

| Health Financial Systems A | SCENSION ST. VI | NCENT JENNINGS | | In Lie | eu of Form CMS-2 | 2552-10 |
|---|------------------|----------------|-------------|----------------------------------|------------------|---------|
| APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF | RVICE OTHER PASS | S Provider C | CN: 15-1303 | Peri od: | Worksheet D | |
| THROUGH COSTS | | | | From 07/01/2021 To 06/30/2022 | | narod |
| | | | | 10 00/30/2022 | 11/28/2022 12 | :17 pm |
| | | Titl | e XIX | Hospi tal | Cost | |
| Cost Center Description | Non Physician | Nursi ng | Nursi ng | Allied Health | Allied Health | |
| | Anestheti st | Program | Program | Post-Stepdown | | |
| | Cost | Post-Stepdown | | Adjustments | | |
| | | Adjustments | | | | |
| | 1.00 | 2A | 2.00 | 3A | 3.00 | |
| ANCI LLARY SERVI CE COST CENTERS | 1 | | 1 | | | |
| 50.00 05000 OPERATI NG ROOM | 0 | 0 | | 0 0 | 0 | 50.00 |
| 54.00 05400 RADIOLOGY - DIAGNOSTIC | 0 | 0 | | 0 0 | 0 | 54.00 |
| 60. 00 06000 LABORATORY | 0 | 0 | | 0 0 | 0 | 60.00 |
| 65. 00 06500 RESPI RATORY THERAPY | 0 | 0 | | 0 0 | 0 | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 0 | 0 | | 0 0 | 0 | 66.00 |
| 67.00 06700 OCCUPATI ONAL THERAPY | 0 | 0 | | 0 0 | 0 | 67.00 |
| 68.00 06800 SPEECH PATHOLOGY | 0 | 0 | | 0 0 | 0 | 68.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 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 |

11/28/2022 12:17 pm Y: \28550 - St. Vincent Jennings\300 - Medicare Cost Report\20220630\HFS\20220630 St. Vincent Jennings.mcrx

| Health Financial Systems A | SCENSION ST. VI | NCENT JENNINGS | | In Lieu of Form CMS-2552-1 | | | |
|---|------------------|----------------|--------------|----------------------------------|----------------|--------|--|
| APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF | RVICE OTHER PASS | S Provider CO | | Period: | Worksheet D | | |
| THROUGH COSTS | | | | From 07/01/2021 To 06/30/2022 | | narod | |
| | | | | 10 00/30/2022 | 11/28/2022 12 | | |
| | | Titl | e XIX | Hospi tal | Cost | | |
| Cost Center Description | All Other | Total Cost | Total | | Ratio of Cost | | |
| | Medi cal | (sum of cols. | Outpati ent | (from Wkst. C, | | | |
| | Education Cost | 1, 2, 3, and | Cost (sum of | Part I, col. | (col. 5 ÷ col. | | |
| | | 4) | col s. 2, 3, | 8) | 7) | | |
| | | | and 4) | | (see | | |
| | | | | | instructions) | | |
| | 4.00 | 5.00 | 6.00 | 7.00 | 8.00 | | |
| ANCI LLARY SERVI CE COST CENTERS | | - | | | | | |
| 50. 00 05000 OPERATING ROOM | 0 | 0 | | 0 4, 186, 732 | | | |
| 54. 00 05400 RADI OLOGY - DI AGNOSTI C | 0 | 0 | | 0 18, 353, 105 | | | |
| 60. 00 06000 LABORATORY | 0 | 0 | | 0 21, 417, 102 | | | |
| 65. 00 06500 RESPIRATORY THERAPY | 0 | 0 | | 0 133, 680 | | 65.00 | |
| 66. 00 06600 PHYSI CAL THERAPY | 0 | 0 | | 0 1, 145, 104 | | | |
| 67. 00 06700 OCCUPATI ONAL THERAPY | 0 | 0 | | 0 112,030 | | | |
| 68. 00 06800 SPEECH PATHOLOGY | 0 | 0 | | 0 0 | 0.00000 | | |
| 69. 00 06900 ELECTROCARDI OLOGY | 0 | 0 | | 0 0 | 0.00000 | | |
| 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS | 0 | 0 | | 0 557, 707 | | | |
| 72. 00 07200 I MPLANTABLE DEVICES CHARGED TO | 0 | 0 | | 0 55, 579 | 0. 000000 | 72.00 | |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS | 0 | 0 | | 0 3, 987, 801 | 0. 000000 | 72 00 | |
| 75.00 03950 ADULT MENTAL HEALTH | 0 | 0 | | 0 3, 987, 801 | | | |
| OUTPATIENT SERVICE COST CENTERS | 0 | 0 | | 0 003,723 | 0.000000 | 70.00 | |
| 88.00 08800 RURAL HEALTH CLINIC | 0 | 0 | | 0 0 | 0. 000000 | 88.00 | |
| 91. 00 09100 EMERGENCY | 0 | 0 | | 0 21, 166, 166 | | 91.00 | |
| 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0 | 0 | | 0 21, 100, 100 | | | |
| 200.00 Total (lines 50 through 199) | 0 | 0 | | 0 72, 535, 669 | | 200.00 | |
| | | 0 | 1 | -1 .2, 333, 007 | I | | |

| Health Financial Systems ASCENSION ST. VINCENT JENNINGS In Lieu of Form CMS-255 | | | | | | | |
|---|-----------------|-------------|--------------|---|--|--------|--|
| APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS | VICE OTHER PASS | Provider CC | CN: 15-1303 | Period: From 07/01/2021 To 06/30/2022 | Worksheet D Part IV Date/Time Pre 11/28/2022 12 | | |
| | | Ti tl | e XIX | Hospi tal | Cost | | |
| Cost Center Description | Outpati ent | Inpati ent | I npati ent | Outpati ent | Outpati ent | | |
| | Ratio of Cost | Program | Program | Program | Program | | |
| | to Charges | Charges | Pass-Through | n Charges | 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 | | |
| ANCI LLARY SERVI CE COST CENTERS | 1 | | | - 1 | | | |
| 50.00 05000 OPERATING ROOM | 0. 000000 | 0 | | 0 0 | 0 | 50.00 | |
| 54.00 05400 RADIOLOGY - DIAGNOSTIC | 0. 000000 | 20, 708 | | 0 0 | 0 | 54.00 | |
| 60. 00 06000 LABORATORY | 0. 000000 | 47, 235 | | 0 0 | 0 | 60.00 | |
| 65. 00 06500 RESPI RATORY THERAPY | 0. 000000 | 0 | | 0 0 | 0 | 65.00 | |
| 66. 00 06600 PHYSI CAL THERAPY | 0. 000000 | 2, 200 | | 0 0 | 0 | 66.00 | |
| 67.00 06700 OCCUPATI ONAL THERAPY | 0. 000000 | 0 | | 0 0 | 0 | 67.00 | |
| 68.00 06800 SPEECH PATHOLOGY | 0. 000000 | 0 | | 0 0 | 0 | 68.00 | |
| 69. 00 06900 ELECTROCARDI OLOGY | 0. 000000 | 0 | | 0 0 | 0 | 69.00 | |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0. 000000 | 5, 001 | | 0 0 | 0 | 71.00 | |
| 72.00 07200 IMPLANTABLE DEVICES CHARGED TO | 0. 000000 | 0 | | 0 0 | 0 | 72.00 | |
| PATIENTS | | | | | | | |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 0. 000000 | 17, 455 | | 0 0 | 0 | 73.00 | |
| 76.00 03950 ADULT MENTAL HEALTH | 0. 000000 | 0 | | 0 0 | 0 | 76.00 | |
| OUTPATIENT SERVICE COST CENTERS | | | | | | | |
| 88.00 08800 RURAL HEALTH CLINIC | 0. 000000 | 0 | | 0 0 | 0 | 88.00 | |
| 91. 00 09100 EMERGENCY | 0. 000000 | 39, 218 | | 0 0 | 0 | 91.00 | |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0. 000000 | 20, 394 | | 0 0 | 0 | 92.00 | |
| 200.00 Total (lines 50 through 199) | | 152, 211 | | 0 0 | 0 | 200.00 | |

Heal th Financia COMPUTATION OF

| cial Systems | ASCENSION ST. VINCEN | IT JENNI NGS | In Lie | u of Form CMS-2552-10 | |
|-----------------------------|----------------------|--------------|---|---|--|
| OF INPATIENT OPERATING COST | | | Period: From 07/01/2021 To 06/30/2022 | Worksheet D-1 Date/Time Pre 11/28/2022 12 | |
| | | Title XVIII | Hospi tal | Cost | |
| Cost Center Description | | | | | |

| | | 1.00 | |
|--------|--|---------------|--------|
| | PART I - ALL PROVIDER COMPONENTS | | |
| | INPATIENT DAYS | | |
| 1.00 | Inpatient days (including private room days and swing-bed days, excluding newborn) | 1, 160 | 1.00 |
| 2.00 | Inpatient days (including private room days, excluding swing-bed and newborn days) | 1, 121 | 2.00 |
| 3.00 | Private room days (excluding swing-bed and observation bed days). If you have only private room days, | 0 | 3.00 |
| | do not complete this line. | | |
| 4.00 | Semi-private room days (excluding swing-bed and observation bed days) | 640 | 4.00 |
| 5.00 | Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost | 19 | 5.00 |
| (00 | reporting period | | / 00 |
| 6.00 | Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost | 20 | 6.00 |
| 7 00 | reporting period (if calendar year, enter 0 on this line) | 0 | 7 00 |
| 7.00 | Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost | 0 | 7.00 |
| 0 00 | reporting period | 0 | 0 00 |
| 8.00 | Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost | 0 | 8.00 |
| 9.00 | reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to the Program (excluding swing-bed and | 305 | 9.00 |
| 9.00 | newborn days) (see instructions) | 305 | 9.00 |
| 10.00 | Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) | 7 | 10.00 |
| 10.00 | through December 31 of the cost reporting period (see instructions) | ' | 10.00 |
| 11.00 | Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after | 0 | 11.00 |
| 11.00 | December 31 of the cost reporting period (if calendar year, enter 0 on this line) | Ŭ | 11.00 |
| 12.00 | Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) | 0 | 12.00 |
| 12.00 | through December 31 of the cost reporting period | Ű | 12.00 |
| 13.00 | Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) | 0 | 13.00 |
| 101.00 | after December 31 of the cost reporting period (if calendar year, enter 0 on this line) | Ű | 101.00 |
| 14.00 | Medically necessary private room days applicable to the Program (excluding swing-bed days) | 0 | 14.00 |
| 15.00 | Total nursery days (title V or XIX only) | 0 | 15.00 |
| 16.00 | Nursery days (title V or XIX only) | 0 | |
| | SWING BED ADJUSTMENT | | |
| 17.00 | Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost | | 17.00 |
| | reporting period | | |
| 18.00 | Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost | | 18.00 |
| | reporting period | | |
| 19.00 | Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost | 231.10 | 19.00 |
| | reporting period | | |
| 20.00 | Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost | 231.10 | 20.00 |
| | reporting period | | |
| 21.00 | Total general inpatient routine service cost (see instructions) | 3, 027, 419 | 21.00 |
| 22.00 | Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line | 0 | 22.00 |
| | 5 x line 17) | | |
| 23.00 | Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 | 0 | 23.00 |
| | x line 18) | | |
| 24.00 | Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line | 0 | 24.00 |
| | 7 x line 19) | | |
| 25.00 | Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 | 0 | 25.00 |
| | x line 20) | | |
| | Total swing-bed cost (see instructions) | 101, 784 | |
| 27.00 | General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) | 2, 925, 635 | 27.00 |
| | PRIVATE ROOM DIFFERENTIAL ADJUSTMENT | | |
| | General inpatient routine service charges (excluding swing-bed and observation bed charges) | 0 | |
| | Private room charges (excluding swing-bed charges) | 0 | 29.00 |
| 30.00 | Semi-private room charges (excluding swing-bed charges) | 0 | |
| 31.00 | General inpatient routine service cost/charge ratio (line 27 ÷ line 28) | 0. 000000 | |
| 32.00 | Average private room per diem charge (line 29 ÷ line 3) | | 32.00 |
| 33.00 | Average semi-private room per diem charge (line 30 ÷ line 4) | | 33.00 |
| 34.00 | Average per diem private room charge differential (line 32 minus line 33)(see instructions) | | 34.00 |
| 35.00 | Average per diem private room cost differential (line 34 x line 31) | 0.00 | |
| 36.00 | Private room cost differential adjustment (line 3 x line 35) | 0 | 36.00 |
| 37.00 | General inpatient routine service cost net of swing-bed cost and private room cost differential (line | 2, 925, 635 | 37.00 |
| | 27 minus line 36) | | |
| | PART II - HOSPITAL AND SUBPROVIDERS ONLY | | |
| | PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS | | |
| 38.00 | Adjusted general inpatient routine service cost per diem (see instructions) | 2, 609. 84 | |
| | Program general inpatient routine service cost (line 9 x line 38) | 796, 001 | 39.00 |
| | 5 5 1 | 770,001 | |
| 40.00 | Medically necessary private room cost applicable to the Program (line 14 x line 35) Total Program general inpatient routine service cost (line 39 + line 40) | 0 796, 001 | 40.00 |

| NPUT | Financial Systems ATION OF INPATIENT OPERATING COST | ASCENSION ST. VII | | CCN: 15-1303 | Peri od: | u of Form CMS- Worksheet D-1 | |
|-------------|--|--------------------------|------------------------|------------------------------|----------------------------------|---------------------------------|-------|
| | | | | | From 07/01/2021 To 06/30/2022 | Date/Time Pre 11/28/2022 12 | |
| | | | Titl | e XVIII | Hospi tal | Cost | 2.17 |
| | Cost Center Description | Total Inpatient Cost | Total Inpatient Day | Average Per sDiem (col. 1 | Program Days | Program Cost (col. 3 x col. | |
| | | | | col . 2) | | 4) | _ |
| 00 | NURSERY (title V & XIX only) | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | 42. |
| 00 | Intensive Care Type Inpatient Hospital Unit | s | | | | | 1 12. |
| 00 | INTENSIVE CARE UNIT | | | | | | 43 |
| 00 | CORONARY CARE UNIT | | | | | | 44 |
| | BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT | | | | | | 45 |
| | OTHER SPECIAL CARE (SPECIFY) | | | | | | 40 |
| 00 | Cost Center Description | | | | | | |
| | | | | | | 1.00 | |
| | Program inpatient ancillary service cost (W | | | > | | 177, 273 | |
| 00 | Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS | <u>5 41 through 48)(</u> | see Instructi | ons) | | 973, 274 | 49 |
| 00 | Pass through costs applicable to Program in | patient routine | services (fro | m Wkst. D. sur | of Parts I and | C | 50 |
| | 111) | | | | | | |
| 00 | Pass through costs applicable to Program in | patient ancillar | y services (f | rom Wkst. D, s | sum of Parts II | C | 51 |
| 00 | and IV) Total Program excludable cost (sum of lines | 50 and 51) | | | | C | 52 |
| 00 | Total Program inpatient operating cost excl | | lated. non-ph | vsician anesti | netist, and | | |
| 00 | medical education costs (line 49 minus line | | acou, non pr | jer er an anee er | lotrot, and | | |
| | TARGET AMOUNT AND LIMIT COMPUTATION | | | | | | |
| | Program di scharges | | | | | 0 | |
| 00 00 | Target amount per discharge Target amount (line 54 x line 55) | | | | | 0.00 | |
| | Difference between adjusted inpatient opera | nting cost and ta | rget amount (| line 56 minus | line 53) | 0 | |
| 00 | Bonus payment (see instructions) | | g | | | 0 | |
| 00 | Lesser of lines 53/54 or 55 from the cost r | eporting period | endi ng 1996, | updated and co | ompounded by the | 0.00 | 59 |
| ~~ | market basket | | | | | 0.00 | |
| 00 00 | Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of lin | | | | the amount by | 0.00 | |
| 00 | which operating costs (line 53) are less th | | | | | Ŭ | 10 |
| | amount (line 56), otherwise enter zero (see | | | <i>,</i> . | 5 | | |
| | Relief payment (see instructions) | | | | | 0 | |
| 00 | Allowable Inpatient cost plus incentive pay PROGRAM INPATIENT ROUTINE SWING BED COST | ment (see Instru | ctions) | | | 0 |) 63 |
| 00 | Medicare swing-bed SNF inpatient routine co | sts through Dece | mber 31 of th | e cost reporti | na period (See | 18, 269 | 64 |
| | instructions)(title XVIII only) | Ū. | | | 0 1 1 | | |
| 00 | Medicare swing-bed SNF inpatient routine co | sts after Decemb | er 31 of the | cost reportino | g period (See | C | 65 |
| 00 | instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient rout | ine costs (line | 64 nlus line | 65) (titlo XV/I) | Lonly) For | 18, 269 | 66 |
| 00 | CAH (see instructions) | The costs (The | o4 prus rine | 05)((11) 8 8 8 | i oniy). Toi | 10, 207 | |
| 00 | Title V or XIX swing-bed NF inpatient routi | ne costs through | December 31 | of the cost re | eporting period | C | 67 |
| ~ ~ | (line 12 x line 19) | | | | | | |
| 00 | Title V or XIX swing-bed NF inpatient routi (line 13 x line 20) | ne costs after D | ecember 31 of | the cost repo | orting period | 0 | 68 |
| 00 | Total title V or XIX swing-bed NF inpatient | routine costs (| line 67 + lin | e 68) | | C | 69 |
| | PART III - SKILLED NURSING FACILITY, OTHER | | | | | | |
| | Skilled nursing facility/other nursing faci | | | | | | 70 |
| 00 | Adjusted general inpatient routine service | | ıne 70 ÷ line | 2) | | | 71 |
| 00 00 | Program routine service cost (line 9 x line Medically necessary private room cost appli | · · | (line 14 x l | ine 35) | | | 72 |
| 00 | Total Program general inpatient routine ser | | | | | | 74 |
| 00 | Capital-related cost allocated to inpatient | | | | Part II, column | | 75 |
| 00 | 26, line 45) | | | | | | |
| 00 00 | Per diem capital-related costs (line 75 ÷ l Program capital-related costs (line 9 × lin | | | | | | 76 |
| 00 | Program capital-related costs (line 9 x lin Inpatient routine service cost (line 74 min | | | | | | 78 |
| 00 | Aggregate charges to beneficiaries for exce | | rovider recor | ds) | | | 79 |
| 00 | Total Program routine service costs for com | parison to the c | | · · · · | nus line 79) | | 80 |
| 00 | Inpatient routine service cost per diem lim | | ` | | | | 81 |
| | Inpatient routine service cost limitation (| | | | | | 82 |
| 00 00 | Reasonable inpatient routine service costs Program inpatient ancillary services (see i | • | 5) | | | | 83 |
| 00 | Utilization review - physician compensation | | ns) | | | | 85 |
| | Total Program inpatient operating costs (su | • | | | | | 86 |
| | PART IV - COMPUTATION OF OBSERVATION BED PA | | | | | | |
| _ | | (a) | | | | 481 | 87 |
| 00 00 | Total observation bed days (see instruction Adjusted general inpatient routine cost per | | line 2 | | | 2, 609. 84 | |

| Health Financial Systems A | SCENSION ST. VI | NCENT JENNINGS | | In Lie | u of Form CMS-2 | 2552-10 |
|---|-----------------|----------------|------------|----------------------------|--------------------------------|-------------------|
| COMPUTATION OF INPATIENT OPERATING COST | | Provider CC | | Period: From 07/01/2021 | Worksheet D-1 | |
| | | | | To 06/30/2022 | Date/Time Pre 11/28/2022 12 | pared: :17 pm_ |
| | | Title | XVIII | Hospi tal | Cost | |
| Cost Center Description | Cost | Routine Cost | column 1 ÷ | Total | Observati on | |
| | | (from line 21) | column 2 | Observati on | Bed Pass | |
| | | | | Bed Cost (from | Through Cost | |
| | | | | line 89) | (col. 3 x col. | |
| | | | | | 4) (see | |
| | | | | | instructions) | |
| | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| COMPUTATION OF OBSERVATION BED PASS THROUGH (| COST | | | | | |
| 90.00 Capital-related cost | 130, 322 | 3, 027, 419 | 0. 04304 | 7 1, 255, 333 | 54, 038 | 90.00 |
| 91.00 Nursing Program cost | 0 | 3, 027, 419 | 0.00000 | 0 1, 255, 333 | 0 | 91.00 |
| 92.00 Allied health cost | 0 | 3, 027, 419 | 0.00000 | 0 1, 255, 333 | 0 | 92.00 |
| 93.00 All other Medical Education | C | 3, 027, 419 | 0.00000 | 1, 255, 333 | 0 | 93.00 |

In Lieu of Form CMS-2552-10

| Heal th | Financial Systems ASCENSION ST. VINCE | ENT JENNINGS | In Lie | u of Form CMS-2 | 2552-10 |
|----------------|---|--------------------------|----------------------------------|-----------------|---------|
| | ATION OF INPATIENT OPERATING COST | Provider CCN: 15-1303 | Peri od: | Worksheet D-1 | |
| | | | From 07/01/2021 To 06/30/2022 | Date/Time Pre | narod |
| | | | 10 00/30/2022 | 11/28/2022 12 | |
| | | Title XIX | Hospi tal | Cost | |
| | Cost Center Description | | | | |
| | | | | 1.00 | |
| | PART I - ALL PROVIDER COMPONENTS | | | | |
| 1.00 | INPATIENT DAYS Inpatient days (including private room days and swing-bed days | e oveluding nowbern) | | 1, 160 | 1.00 |
| 2.00 | Inpatient days (including private room days and swing-bed days) Inpatient days (including private room days, excluding swing-b | | | 1, 100 | |
| 3.00 | Private room days (excluding swing-bed and observation bed day | | ivate room days, | 0 | 3.00 |
| | do not complete this line. | | 5 | | |
| 4.00 | Semi-private room days (excluding swing-bed and observation be | | | 640 | |
| 5.00 | Total swing-bed SNF type inpatient days (including private roo | om days) through Decembe | r 31 of the cost | 19 | 5.00 |
| 6.00 | reporting period Total swing-bed SNF type inpatient days (including private roo | am days) after Decomber | 21 of the cost | 20 | 6.00 |
| 0.00 | reporting period (if calendar year, enter 0 on this line) | bii days) arter becenber | ST OF THE COST | 20 | 0.00 |
| 7.00 | Total swing-bed NF type inpatient days (including private roor | m days) through December | 31 of the cost | 0 | 7.00 |
| | reporting period | | | | |
| 8.00 | Total swing-bed NF type inpatient days (including private roor | m days) after December 3 | 1 of the cost | 0 | 8.00 |
| 9.00 | reporting period (if calendar year, enter 0 on this line) | a the Dreaman (avaluding | owing had and | 11 | 9.00 |
| 9.00 | Total inpatient days including private room days applicable to newborn days) (see instructions) | S the Program (excluding | Swing-beu anu | ļ I | 9.00 |
| 10.00 | Swing-bed SNF type inpatient days applicable to title XVIII or | nly (including private r | oom days) | 0 | 10.00 |
| | through December 31 of the cost reporting period (see instruct | tions) | • | | |
| 11.00 | Swing-bed SNF type inpatient days applicable to title XVIII or | | oom days) after | 0 | 11.00 |
| 12 00 | December 31 of the cost reporting period (if calendar year, er Swing-bed NF type inpatient days applicable to titles V or XI) | | o room dovic) | 0 | 12.00 |
| 12.00 | through December 31 of the cost reporting period | v only (including privat | e room uays) | 0 | 12.00 |
| 13.00 | Swing-bed NF type inpatient days applicable to titles V or XI) | K only (including privat | e room days) | 0 | 13.00 |
| | after December 31 of the cost reporting period (if calendar ye | | | | |
| | Medically necessary private room days applicable to the Progra | am (excluding swing-bed | days) | 0 | |
| | Total nursery days (title V or XIX only) Nursery days (title V or XIX only) | | | 0 | |
| 10.00 | SWING BED ADJUSTMENT | | | 0 | 10.00 |
| 17.00 | Medicare rate for swing-bed SNF services applicable to service | es through December 31 c | f the cost | | 17.00 |
| | reporting period | 5 | | | |
| 18.00 | Medicare rate for swing-bed SNF services applicable to service | es after December 31 of | the cost | | 18.00 |
| 19.00 | reporting period | through December 21 of | the cost | 231.10 | 10 00 |
| 19.00 | Medicaid rate for swing-bed NF services applicable to services reporting period | s through becember 31 of | the cost | 231.10 | 19.00 |
| 20.00 | Medicaid rate for swing-bed NF services applicable to services | s after December 31 of t | he cost | 231.10 | 20.00 |
| | reporting period | | | | |
| 21.00 | Total general inpatient routine service cost (see instructions | | | 3, 027, 419 | |
| 22.00 | Swing-bed cost applicable to SNF type services through December 5×1 (ine 17) | er 31 of the cost report | ing period (iine | 0 | 22.00 |
| 23.00 | Swing-bed cost applicable to SNF type services after December | 31 of the cost reportin | g period (line 6 | 0 | 23.00 |
| | x line 18) | | | | |
| 24.00 | Swing-bed cost applicable to NF type services through December | r 31 of the cost reporti | ng period (line | 0 | 24.00 |
| 25 00 | 7 x line 19) Swing had cast applicable to NE type capyings offer December (| 21 of the cost concrtine | pariod (line 9 | 0 | 25.00 |
| 25.00 | Swing-bed cost applicable to NF type services after December 3 x line 20) | si oi the cost reporting | periou (iiie o | 0 | 25.00 |
| 26.00 | Total swing-bed cost (see instructions) | | | 101, 784 | 26.00 |
| 27.00 | General inpatient routine service cost net of swing-bed cost | (line 21 minus line 26) | | 2, 925, 635 | 27.00 |
| ~~ ~~ | PRIVATE ROOM DIFFERENTIAL ADJUSTMENT | | <u>````</u> | | |
| 28.00 29.00 | General inpatient routine service charges (excluding swing-bed | d and observation bed ch | arges) | 0 | |
| 30.00 | Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) | | | 0 | 30.00 |
| 31.00 | General inpatient routine service cost/charge ratio (line 27 - | + line 28) | | 0.000000 | |
| 32.00 | Average private room per diem charge (line 29 ÷ line 3) | , | | 0.00 | |
| 33.00 | Average semi-private room per diem charge (line 30 ÷ line 4) | | | 0.00 | |
| 34.00 | Average per diem private room charge differential (line 32 min | | tions) | | 34.00 |
| 35.00 36.00 | Average per diem private room cost differential (line 34 x lin Private room cost differential adjustment (line 3 x line 35) | ne 31) | | 0. 00 0 | |
| 36.00 | General inpatient routine service cost net of swing-bed cost a | and private room cost di | fferential (line | 2, 925, 635 | |
| 07.00 | 27 minus line 36) | | | 2, 720, 000 | |
| | PART II - HOSPITAL AND SUBPROVIDERS ONLY | | | | |
| | PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU | | | | |
| 38.00 | Adjusted general inpatient routine service cost per diem (see | | | 2,609.84 | |
| 39.00 40.00 | Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progra | | | 28, 708 0 | |
| | Total Program general inpatient routine service cost (line 39 | . , | | 28, 708 | |
| | | - | | | |

| MPHT | Financial Systems FATION OF INPATIENT OPERATING COST | | Provider (| S CN: 15-1303 | Peri od: | u of Form CMS- Worksheet D-' | |
|--------------|--|-------------------------|-------------------------|-------------------|----------------------------------|---------------------------------|----------------|
| | | | | | From 07/01/2021 To 06/30/2022 | | epare |
| | | | Tit | le XIX | Hospi tal | Cost | , |
| | Cost Center Description | Total Inpatient Cost | Total Inpatient Days | | | Program Cost (col. 3 x col. | |
| | | 1.00 | 2.00 | col. 2) 3.00 | 4.00 | 4) 5.00 | - |
| 2.00 | NURSERY (title V & XIX only) | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | 42. |
| | Intensive Care Type Inpatient Hospital Unit | s | | | | | |
| 3.00 | INTENSIVE CARE UNIT | | | | | | 43. |
| 4.00 | CORONARY CARE UNIT | | | | | | 44. |
| 5.00 5.00 | BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT | | | | | | 45. 46. |
| | OTHER SPECIAL CARE (SPECIFY) | | | | | | 40. |
| | Cost Center Description | | | | | | |
| | | | · · · · · | | | 1.00 | |
| 3.00 | Program inpatient ancillary service cost (W | | | > | | 60, 716 | |
| 0. 00 | Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS | 5 41 through 48)(| see instruction | ons) | | 89, 424 | 49. |
| . 00 | Pass through costs applicable to Program in | patient routine | services (fro | m Wkst. D. sur | m of Parts I and | 0 | 50. |
| | | | | | | | |
| . 00 | Pass through costs applicable to Program in | patient ancillar | y services (f | rom Wkst. D, s | sum of Parts II | 0 | 51. |
| 00 | and IV) Total Program excludable cost (sum of lines | 50 and 51) | | | | | 52. |
| . 00 | Total Program excludable cost (sum of lines Total Program inpatient operating cost excl | | lated non-ph | vsician anesti | netist, and | |) 52.) 53. |
| | medical education costs (line 49 minus line | | | | | | |
| | TARGET AMOUNT AND LIMIT COMPUTATION | | | | | | |
| . 00 | Program di scharges | | | | | (| |
| . 00 | Target amount per discharge Target amount (line 54 x line 55) | | | | | 0.00 | |
| . 00 | Difference between adjusted inpatient opera | ting cost and ta | rget amount (| line 56 minus | line 53) | | |
| . 00 | Bonus payment (see instructions) | and ta | i got amount (| | | | |
| . 00 | Lesser of lines 53/54 or 55 from the cost r | reporting period | endi ng 1996, i | updated and co | ompounded by the | 0.00 | 59 |
| ~~ | market basket | | | | | | |
| . 00 . 00 | Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of lin | | | | the amount by | 0.00 | |
| . 00 | which operating costs (line 53) are less th | | | | | | |
| | amount (line 56), otherwise enter zero (see | | | | i the target | | |
| . 00 | Relief payment (see instructions) | | | | | 0 | |
| 00 | Allowable Inpatient cost plus incentive pay | ment (see instru | ctions) | | | (| 0 63 |
| . 00 | PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine co | sts through Dece | mber 31 of th | e cost reporti | ing period (See | | 0 64 |
| | instructions) (title XVIII only) | ie te tin eugn beee | | o ocor i opoi i | | | |
| . 00 | Medicare swing-bed SNF inpatient routine co | sts after Decemb | er 31 of the o | cost reporting | g period (See | C |) 65 |
| 00 | instructions)(title XVIII only) | | (4 | | | | |
| . 00 | Total Medicare swing-bed SNF inpatient rout CAH (see instructions) | The costs (Tine | 64 prus rine (| b5)(title XVI | TI ONLY). FOR | |) 66 |
| . 00 | Title V or XIX swing-bed NF inpatient routi | ne costs through | December 31 | of the cost re | eporting period | 0 | 67 |
| | (line 12 x line 19) | 5 | | | 1 51 | | |
| . 00 | Title V or XIX swing-bed NF inpatient routi | ne costs after D | ecember 31 of | the cost rep | orting period | 0 | 68 |
| . 00 | (line 13 x line 20) Total title V or XIX swing-bed NF inpatient | routine costs (| line 67 + lin | a 68) | | | 69. |
| . 00 | PART III - SKILLED NURSING FACILITY, OTHER | | | | | | |
| . 00 | Skilled nursing facility/other nursing faci | | • | |) | | 70 |
| . 00 | Adjusted general inpatient routine service | | ine 70 ÷ line | 2) | | | 71 |
| . 00 | Program routine service cost (line 9 x line | | (1) - 14 - 13 | 25) | | | 72 |
| . 00 . 00 | Medically necessary private room cost appli Total Program general inpatient routine ser | | | | | | 73 |
| . 00 | Capital -related cost allocated to inpatient | | | | Part II. column | | 75 |
| | 26, line 45) | | | | | | |
| . 00 | Per diem capital-related costs (line 75 ÷ l | | | | | | 76 |
| . 00 | Program capital -related costs (line 9 x lin | | | | | | 77 |
| 00 | Inpatient routine service cost (line 74 min Aggregate charges to beneficiaries for exce | | rovi der recor | ds) | | | 78 |
| 00 | Total Program routine service costs for com | · · · | | | nus line 79) | | 80 |
| 00 | Inpatient routine service cost per diem lim | • | | 、 · · · · · · · · | , | | 81 |
| 00 | Inpatient routine service cost limitation (| • | · . | | | | 82 |
| 00 | Reasonable inpatient routine service costs | • | s) | | | | 83 |
| 00 | Program inpatient ancillary services (see i | | nc) | | | | 84 |
| . 00 . 00 | Utilization review - physician compensation Total Program inpatient operating costs (su | | | | | | 85 |
| | PART IV - COMPUTATION OF OBSERVATION BED PA | | | | | <u> </u> | 1 55 |
| . 00 | Total observation bed days (see instruction | is) | | | | 481 | |
| | Adjusted general inpatient routine cost per | diem (line 27 ÷ | line 2) | | | 2, 609. 84 | 4 88 |
| 00 00 | Observation bed cost (line 87 x line 88) (s | an the set of the set | | | | 1, 255, 333 | |

| Health Financial Systems AS | SCENSION ST. VI | NCENT JENNINGS | | In Lie | u of Form CMS-2 | 2552-10 |
|---|-----------------|----------------|------------|----------------------------------|--------------------------------|-------------------|
| COMPUTATION OF INPATIENT OPERATING COST | | Provider CC | | Period: | Worksheet D-1 | |
| | | | | From 07/01/2021 To 06/30/2022 | Date/Time Pre 11/28/2022 12 | pared: :17 pm_ |
| | | Titl | e XIX | Hospi tal | Cost | |
| Cost Center Description | Cost | Routine Cost | column 1 ÷ | Total | Observati on | |
| | | (from line 21) | column 2 | Observati on | Bed Pass | |
| | | | | Bed Cost (from | Through Cost | |
| | | | | line 89) | (col. 3 x col. | |
| | | | | | 4) (see | |
| | | | | | instructions) | |
| | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| COMPUTATION OF OBSERVATION BED PASS THROUGH (| COST | | | | | |
| 90.00 Capital-related cost | 130, 322 | 3, 027, 419 | 0.04304 | 7 1, 255, 333 | 54, 038 | 90.00 |
| 91.00 Nursing Program cost | 0 | 3, 027, 419 | 0.00000 | 0 1, 255, 333 | 0 | 91.00 |
| 92.00 Allied health cost | 0 | 3, 027, 419 | 0.00000 | 0 1, 255, 333 | 0 | 92.00 |
| 93.00 All other Medical Education | 0 | 3, 027, 419 | 0.00000 | 0 1, 255, 333 | 0 | 93.00 |

| Health Financial Systems ASCENSION ST. VINC | ENT JENNINGS | | In Lie | u of Form CMS-2 | 2552-10 |
|--|--------------|--------------|----------------------------------|-----------------|---------|
| INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider C | | Period: | Worksheet D-3 | |
| | | | From 07/01/2021 To 06/30/2022 | Date/Time Pre | nared |
| | | | 10 00/ 30/ 2022 | 11/28/2022 12 | |
| | Title | XVIII | Hospi tal | Cost | |
| Cost Center Description | | Ratio of Cos | t Inpatient | Inpati ent | |
| | | To Charges | Program | Program Costs | |
| | | | Charges | (col. 1 x col. | |
| | | | | 2) | |
| | | 1.00 | 2.00 | 3.00 | |
| I NPATI ENT ROUTI NE SERVI CE COST CENTERS | | | 404 7// | | 0.0.00 |
| 30. 00 03000 ADULTS & PEDI ATRI CS ANCI LLARY SERVI CE COST CENTERS | | | 494, 766 | | 30.00 |
| 50.00 OS000 OPERATING ROOM | | 0. 30452 | 4 | 0 | 50.00 |
| 54. 00 05400 RADI OLOGY - DI AGNOSTI C | | 0. 30452 | | | 54.00 |
| 60. 00 06000 LABORATORY | | 0. 13788 | | | |
| 65. 00 06500 RESPIRATORY THERAPY | | 0. 00243 | | | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | | 0. 40668 | | | 66.00 |
| 67. 00 06700 OCCUPATI ONAL THERAPY | | 0. 64984 | | | 67.00 |
| 68. 00 06800 SPEECH PATHOLOGY | | 0. 00000 | | 0,000 | 68.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | | 0.00000 | | 0 | 69.00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | | 0.08624 | | 4, 295 | 71.00 |
| 72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS | | 0. 32310 | | 0 | 72.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | | 0. 30122 | 2 326, 642 | 98, 392 | 73.00 |
| 76.00 03950 ADULT MENTAL HEALTH | | 0. 93840 | 8 0 | 0 | 76.00 |
| OUTPATIENT SERVICE COST CENTERS | | | | | |
| 88.00 08800 RURAL HEALTH CLINIC | | 0.00000 | 0 | 0 | 88.00 |
| 91. 00 09100 EMERGENCY | | 0. 26283 | 4 6, 602 | 1, 735 | 91.00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | | 1. 65843 | | | |
| 200.00 Total (sum of lines 50 through 94 and 96 through 98) | | | 727, 615 | 177, 273 | |
| 201.00 Less PBP Clinic Laboratory Services-Program only charges | s (line 61) | | 0 | | 201.00 |
| 202.00 Net charges (line 200 minus line 201) | | | 727, 615 | | 202.00 |

| | ST. VINCENT JENNINGS | | | u of Form CMS- | 2552-10 |
|---|----------------------|---------------|----------------------------------|----------------|-----------------|
| INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider C | | Peri od: | Worksheet D-3 | |
| | Component (| CCN: 15-Z303 | From 07/01/2021 To 06/30/2022 | Date/Time Pre | nared |
| | oomponent v | 0011. 10 2000 | 10 00/00/2022 | 11/28/2022 12 | :17 pm |
| | Title | | Swing Beds - SNF | Cost | |
| Cost Center Description | | Ratio of Cos | | Inpati ent | |
| | | To Charges | Program | Program Costs | |
| | | | Charges | (col. 1 x col. | |
| | | 1.00 | 0.00 | 2) | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | 1.00 | 2.00 | 3.00 | |
| 30. 00 03000 ADULTS & PEDIATRICS | | 1 | 1 | 1 | 30.00 |
| ANCI LLARY SERVICE COST CENTERS | | | | | 30.00 |
| 50. 00 05000 OPERATING ROOM | | 0. 30452 | 24 0 | 0 | 50.00 |
| 54. 00 05400 RADIOLOGY - DIAGNOSTIC | | 0. 13788 | | 0 | |
| 60. 00 06000 LABORATORY | | 0. 15131 | | | |
| 65. 00 06500 RESPI RATORY THERAPY | | 0.00243 | 39 0 | 0 | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | | 0. 40668 | 2, 736 | 1, 113 | 66.00 |
| 67. 00 06700 OCCUPATI ONAL THERAPY | | 0. 64984 | 4 0 | 0 | 67.00 |
| 68.00 06800 SPEECH PATHOLOGY | | 0.00000 | 0 0 | 0 | 68.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | | 0.00000 | - | 0 | |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | | 0. 08624 | | 0 | |
| 72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS | | 0. 32310 | | 0 | |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | | 0. 30122 | | | |
| 76.00 03950 ADULT MENTAL HEALTH | | 0. 93840 | 0 0 | 0 | 76.00 |
| OUTPATIENT SERVICE COST CENTERS | | 0.0000 | | | 00.00 |
| 88. 00 08800 RURAL HEALTH CLINIC | | 0.00000 | | 0 | |
| 91.00 09100 EMERGENCY | | 0. 26283 | | 0 | |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 200.00 Total (sum of lines 50 through 94 and 96 through | 00) | 1. 65843 | 5, 579 | 0 | 92.00 200.00 |
| 201.00 Less PBP Clinic Laboratory Services-Program only | | | 5, 579 | 1,011 | 200.00 |
| 202.00 Net charges (line 200 minus line 201) | charges (The OT) | | 5, 579 | | 201.00 |
| zoz. obj – met charges (The zoo minus The zor) | | 1 | 5, 574 | I | 202.00 |

| Health Financial Systems ASCENSION ST. VINCE | ENT JENNINGS | | In Lie | u of Form CMS-2 | 2552-10 |
|---|--------------|---------------|---|--------------------------------|---------|
| INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CO | | Period: From 07/01/2021 To 06/30/2022 | Worksheet D-3 Date/Time Pre | |
| | | | 10 00/30/2022 | 11/28/2022 12 | :17 pm |
| | Titl | e XIX | Hospi tal | Cost | |
| Cost Center Description | | Ratio of Cost | | Inpati ent | |
| | | To Charges | Program | Program Costs | |
| | | | Charges | (col. 1 x col. | |
| | | | | 2) | |
| | | 1.00 | 2.00 | 3.00 | |
| I NPATI ENT ROUTI NE SERVI CE COST CENTERS | | | | | |
| 30. 00 03000 ADULTS & PEDI ATRI CS | | | 72, 961 | | 30.00 |
| ANCI LLARY SERVI CE COST CENTERS | | | | - | |
| 50. 00 05000 OPERATING ROOM | | 0. 30452 | | 0 | |
| 54. 00 05400 RADI OLOGY - DI AGNOSTI C | | 0. 13788 | | | |
| 60. 00 06000 LABORATORY | | 0. 15131 | | | 60.00 |
| 65. 00 06500 RESPI RATORY THERAPY | | 0.00243 | | 0 | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | | 0. 40668 | | | |
| 67.00 06700 OCCUPATI ONAL THERAPY | | 0. 64984 | | 0 | 67.00 |
| 68.00 06800 SPEECH PATHOLOGY | | 0.00000 | · · · | 0 | 68.00 |
| 69.00 06900 ELECTROCARDI OLOGY | | 0.00000 | | 0 | 69.00 |
| 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS | | 0. 08624 | | 431 | 71.00 |
| 72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS | | 0. 32310 | | 0 | 72.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | | 0. 30122 | | | 1 |
| 76.00 03950 ADULT MENTAL HEALTH | | 0. 93840 | 8 0 | 0 | 76.00 |
| OUTPATIENT SERVICE COST CENTERS | | | | | |
| 88.00 08800 RURAL HEALTH CLINIC | | 0.00000 | | 0 | 00.00 |
| 91. 00 09100 EMERGENCY | | 0. 26283 | | | |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | | 1. 65843 | | | |
| 200.00 Total (sum of lines 50 through 94 and 96 through 98) | | | 152, 211 | | |
| 201.00 Less PBP Clinic Laboratory Services-Program only charges | 5 (line 61) | | 0 | | 201.00 |
| 202.00 Net charges (line 200 minus line 201) | | | 152, 211 | | 202.00 |

| | Financial Systems ASCENSION ST. VINCENT JEN ATION OF REIMBURSEMENT SETTLEMENT Provid | NINGS der CCN: 15-1303 | Peri od: | u of Form CMS-2 Worksheet E | 2552-10 |
|------------------|---|---------------------------|----------------------------------|--------------------------------|----------------|
| | | | From 07/01/2021 To 06/30/2022 | | |
| | | Title XVIII | Hospi tal | 11/28/2022 12 Cost | :17 pm |
| | | | | 1.00 | |
| | PART B - MEDICAL AND OTHER HEALTH SERVICES | | | 1.00 | |
| 1.00 | Medical and other services (see instructions) | | | 3, 056, 139 | |
| 2.00 3.00 | Medical and other services reimbursed under OPPS (see instructions) OPPS payments | | | 0 | |
| 4.00 | Outlier payment (see instructions) | | | 0 | 4.00 |
| 4.01 | Outlier reconciliation amount (see instructions) | | | 0 | 4.01 |
| 5.00 6.00 | Enter the hospital specific payment to cost ratio (see instructions) Line 2 times line 5 | | | 0.000 | |
| 7.00 | Sum of lines 3, 4, and 4.01, divided by line 6 | | | 0.00 | |
| 8.00 | Transitional corridor payment (see instructions) | | | 0 | |
| 9. 00 10. 00 | Ancillary service other pass through costs from Wkst. D, Pt. IV, col Organ acquisitions | . 13, line 200 | | 0 | 9.00 10.00 |
| 11.00 | Total cost (sum of lines 1 and 10) (see instructions) | | | 3, 056, 139 | • |
| | COMPUTATION OF LESSER OF COST OR CHARGES | | | | |
| 12.00 | Reasonable charges Ancillary service charges | | | 0 | 12.00 |
| 13.00 | Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69) | | | 0 | |
| 14.00 | Total reasonable charges (sum of lines 12 and 13) | | | 0 | 14.00 |
| 15.00 | Customary charges Aggregate amount actually collected from patients liable for payment | for services on | a charge basis | 0 | 15.00 |
| 16.00 | Amounts that would have been realized from patients liable for payme | | | 0 | 16.00 |
| 17.00 | had such payment been made in accordance with 42 CFR §413.13(e) Ratio of line 15 to line 16 (not to exceed 1.000000) | | | 0. 000000 | 17 00 |
| 17.00 | Total customary charges (see instructions) | | | 0.000000 | |
| 19.00 | Excess of customary charges over reasonable cost (complete only if I | ine 18 exceeds li | ne 11) (see | 0 | 19.00 |
| 20.00 | instructions) Excess of reasonable cost over customary charges (complete only if I | ino 11 ovcoode li | no 19) (coo | 0 | 20.00 |
| 20.00 | instructions) | The TT exceeds TT | ne 16) (see | 0 | 20.00 |
| 21.00 | Lesser of cost or charges (see instructions) | | | 3, 086, 700 | |
| 22.00 23.00 | Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see instruction | c) | | 0 | |
| 24.00 | Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) | 3) | | 0 | |
| 05 00 | COMPUTATION OF REIMBURSEMENT SETTLEMENT | | | 04.057 | 05.00 |
| 25.00 26.00 | Deductibles and coinsurance amounts (for CAH, see instructions) Deductibles and Coinsurance amounts relating to amount on line 24 (f | or CAH see inst | ructions) | 34, 957 1, 547, 565 | 25.00 26.00 |
| 27.00 | Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus th | | | 1, 504, 178 | |
| 20.00 | instructions) | | | 0 | 20.00 |
| 28.00 29.00 | Direct graduate medical education payments (from Wkst. E-4, line 50) ESRD direct medical education costs (from Wkst. E-4, line 36) | | | 0 | |
| 30.00 | Subtotal (sum of lines 27 through 29) | | | 1, 504, 178 | |
| 31.00 32.00 | Primary payer payments Subtotal (line 30 minus line 31) | | | 316 1, 503, 862 | • |
| 32.00 | ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) | | | 1, 303, 802 | 32.00 |
| 33.00 | Composite rate ESRD (from Wkst. 1-5, line 11) | | | | 33.00 |
| 34.00 35.00 | Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) | | | 444, 765 289, 097 | |
| 36.00 | Allowable bad debts for dual eligible beneficiaries (see instruction | s) | | 312, 490 | |
| 37.00 | Subtotal (see instructions) | | | 1, 792, 959 | |
| 38.00 39.00 | MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) | | | 0 | 38.00 39.00 |
| 39.50 | Pioneer ACO demonstration payment adjustment (see instructions) | | | 0 | 39.50 |
| 39.97 | Demonstration payment adjustment amount before sequestration | | | 0 | |
| 39. 98 39. 99 | Partial or full credits received from manufacturers for replaced dev RECOVERY OF ACCELERATED DEPRECIATION | ices (see instruc | ctions) | 0 | |
| 40. 00 | Subtotal (see instructions) | | | 1, 792, 959 | |
| 40.01 | Sequestration adjustment (see instructions) | | | 4, 482 | 40. 01 |
| 40.02 | Demonstration payment adjustment amount after sequestration | | | 0 | 40.02 |
| 40. 03 41. 00 | Sequestration adjustment-PARHM pass-throughs Interim payments | | | 2, 070, 740 | 40.03 |
| 41.01 | Interim payments-PARHM | | | | 41.01 |
| 42.00 | Tentative settlement (for contractors use only) | | | 0 | |
| 42. 01 43. 00 | Tentative settlement-PARHM (for contractor use only) Balance due provider/program (see instructions) | | | -282, 263 | 42.01 43.00 |
| 43.01 | Balance due provider/program-PARHM (see instructions) | | | | 43.01 |
| 44.00 | Protested amounts (nonallowable cost report items) in accordance wit | h CMS Pub. 15-2, | chapter 1, | 25, 000 | 44.00 |
| | §115.2 TO BE COMPLETED BY CONTRACTOR | | | | |
| 90.00 | Original outlier amount (see instructions) | | | 0 | |
| 91.00 92.00 | Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money | | | 0 0.00 | |
| 92.00 93.00 | Time Value of Money (see instructions) | | | 0.00 | |
| | Total (sum of lines 91 and 93) | | | | 94.00 |

| Health Financial Systems | ASCENSION ST. VINCE | ENT JENNINGS | In Lie | u of Form CMS-2 | 2552-10 |
|---|---------------------|-----------------------|----------------------------------|-----------------|---------|
| CALCULATION OF REIMBURSEMENT SETTLEMENT | | Provider CCN: 15-1303 | Period: | Worksheet E | |
| | | | From 07/01/2021 To 06/30/2022 | Date/Time Pre | pared: |
| | | | | 11/28/2022 12 | |
| | | Title XVIII | Hospi tal | Cost | |
| | | | | | |
| | | | | 1.00 | |
| MEDICARE PART B ANCILLARY COSTS | | | | | |
| 200.00 Part B Combined Billed Days | | | | 0 | 200. 00 |

| ANALY | SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CC | CN: 15-1303 | Period: From 07/01/2021 To 06/30/2022 | | pared: 17 pm |
|--------------------------------------|--|-------------|-------------|---|--------------------------------------|---|
| | | Title | XVIII | Hospi tal | Cost | |
| | | I npati en | t Part A | Par | t B | |
| | | mm/dd/yyyy | Amount | mm/dd/yyyy | Amount | |
| | | 1.00 | 2.00 | 3.00 | 4.00 | |
| 1.00 2.00 | Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero | | 706, 1 | 15 0 | 2, 070, 740 0 | 1.00 2.00 |
| 3.00 | List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider | | | | | 3.00 |
| 3.01 | ADJUSTMENTS TO PROVIDER | 03/02/2022 | 201, 70 | 00 | 0 | 3. 01 |
| 3. 02 3. 03 3. 04 3. 05 | | | 20177 | 0 0 0 0 | 0 0 0 0 | 3. 02 3. 03 3. 04 3. 05 |
| | Provider to Program | | | | | |
| 3.50 3.51 3.52 3.53 3.54 | ADJUSTMENTS TO PROGRAM | | | 0 0 0 0 | 0 0 0 0 | 3. 50 3. 51 3. 52 3. 53 3. 54 |
| 3.99 | Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) | | 201, 70 | | 0 | 3. 99 |
| 4.00 | Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR | | 907, 8 | 15 | 2, 070, 740 | 4.00 |
| 5.00 | List separately each tentative settlement payment after | | | | | 5.00 |
| 5.00 | desk review. Al so show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider | | | | | 5.00 |
| 5.01 | TENTATI VE TO PROVI DER | | | 0 | 0 | 5. 01 |
| 5.02 | | | | 0 | 0 | 5. 02 |
| 5.03 | | | | 0 | 0 | 5.03 |
| | Provider to Program | | | | 0 | F F0 |
| 5.50 5.51 | TENTATI VE TO PROGRAM | | | 0 | 0 | 5.50 5.51 |
| 5.52 | | | | 0 | 0 | 5. 52 |
| 5.99 | Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98) | | | 0 | 0 | 5.99 |
| 6.00 | Determined net settlement amount (balance due) based on the cost report. (1) | | | | | 6. 00 |
| 6. 01 | SETTLEMENT TO PROVIDER | | | 0 | 0 | 6. 01 |
| 6.02 | SETTLEMENT TO PROGRAM | | 25, 2 | | 282, 263 | 6.02 |
| 7.00 | Total Medicare program liability (see instructions) | | 882, 53 | 36 Contractor Number | 1,788,477 NPR Date (Mo/Day/Yr) | 7.00 |
| | | 0 |) | 1.00 | 2.00 | |
| 8.00 | Name of Contractor | | | | | 8.00 |

| ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | | Provider CO | | Period: From 07/01/2021 To 06/30/2022 | | pared |
|---|---|-------------|----------|---|-------------------------|-------|
| | | Title | XVIII S | Swing Beds - SNF | | |
| | | Inpatien | t Part A | Par | t B | |
| | | mm/dd/yyyy | Amount | mm/dd/yyyy | Amount | |
| | | 1.00 | 2.00 | 3.00 | 4,00 | |
| 00 | Total interim payments paid to provider | | 18, 25 | | 0 | 1. (|
| 00 | Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero | | | D | 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 | | | -1 | | |
| 01 | ADJUSTMENTS TO PROVIDER | | | 0 | 0 | |
| 02 03 | | | | | 0 | |
| 03 04 | | | | | 0 | |
| 05 05 | | | | 0 | 0 | |
| | Provider to Program | I | | - | | |
| 0 | ADJUSTMENTS TO PROGRAM | | | C | 0 | |
| 51 | | | | C | 0 | |
| 52 | | | | | 0 | |
| 53 54 | | | | | 0 | |
| 99 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 appropriate) | | 18, 25 | 6 | 0 | 4 |
| | TO BE COMPLETED BY CONTRACTOR | | | | | |
| 00 | List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) | | | | | 5 |
| | Program to Provider | 1 | L | | 1 | |
|)1)2 | TENTATI VE TO PROVIDER | | | | 0 | |
|)2)3 | | | | 5 | 0 | |
| | Provider to Program | 1 | | ~ <u> </u> | 0 | 1 |
| 0 | TENTATI VE TO PROGRAM | | | D | 0 | 5 |
| 51 | | | | С | 0 | |
| 52 | | | | D | 0 | |
| 9 | Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Determined net settlement amount (balance due) based on | | | | 0 | 5 |
| | the cost report. (1) | | 0.74 | = | 0 | |
|)1)2 | SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM | | 2, 61 | | 0 | |
|)2)0 | Total Medicare program liability (see instructions) | | 20, 87 | 0 | 0 | |
| | | | 20,07 | Contractor Number | NPR Date (Mo/Day/Yr) | |
| | | (|) | 1.00 | 2.00 | |

| Heal th | Financial Systems ASCENSION ST. VINC | ENT JENNINGS | In Lie | u of Form CMS- | 2552-10 |
|--------------|---|-----------------------------|---|--|--------------|
| CALCUL | ATION OF REIMBURSEMENT SETTLEMENT FOR HIT | Provider CCN: 15-1303 | Period: From 07/01/2021 To 06/30/2022 | Worksheet E-1 Part II Date/Time Pre 11/28/2022 12 | pared: |
| | | Title XVIII | Hospi tal | Cost | |
| | | | | | |
| | | | | 1.00 | |
| | TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS | | | | - |
| 1 00 | HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION | | 44 | | 1 1 00 |
| 1.00 | Total hospital discharges as defined in AARA §4102 from Wkst. | | | | 1.00 |
| 2.00 | 2.00 Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, and 8 through 12, and plus for cost | | | | 2.00 |
| 3.00 | reporting periods beginning on or after 10/01/2013, line 32) | | | | |
| 3.00 4.00 | Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 | 1 and 9 through 12 and | plue for cost | | 3.00 4.00 |
| 4.00 | Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines reporting periods beginning on or after 10/01/2013, line 32) | r, and 8 through 12, and | prus for cost | | 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 | ino 20 | | | 6.00 |
| 7.00 | CAH only - The reasonable cost incurred for the purchase of c | | What S 2 Dt 1 | | 7.00 |
| 7.00 | line 168 | er till fed fill technology | WKSL. 3-2, FL. I | | 7.00 |
| 8.00 | Calculation of the HIT incentive payment (see instructions) | | | | 8.00 |
| 9.00 | Sequestration adjustment amount (see instructions) | | | | 9.00 |
| 10.00 | Calculation of the HIT incentive payment after sequestration | (see instructions) | | | 10.00 |
| | INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH | | | | |
| 30.00 | Initial/interim HIT payment adjustment (see instructions) | | | | 30.00 |
| 31.00 | Other Adjustment (specify) | | | | 31.00 |
| 32.00 | Balance due provider (line 8 (or line 10) minus line 30 and l | ine 31) (see instruction | s) | | 32.00 |

| LCULA | Financial Systems ASCENSION ST. VINCENT JENNINGS ATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS Provider CCN: 15-1 | | Worksheet E-2 | | |
|-------|---|---------------------------------------|----------------|--------------|--|
| | Component CCN: 15- | Z303 From 07/01/2021 To 06/30/2022 | | 12:17 p | |
| | Title XVIII | Swing Beds - SNI | 1 | | |
| | | <u>Part A</u> 1.00 | Part B 2.00 | | |
| (| COMPUTATION OF NET COST OF COVERED SERVICES | 1.00 | 2.00 | | |
| | Inpatient routine services - swing bed-SNF (see instructions) | 18, 452 | 0 |] 1. | |
| 1 | Inpatient routine services - swing bed-NF (see instructions) | | | 2. | |
| | Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wks Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through instructions) | | 0 | 3. | |
| | instructions) Nursing and allied health payment-PARHM (see instructions) | | | 3. | |
| 00 | Per diem cost for interns and residents not in approved teaching program (see instructions) | | 0.00 | | |
| | Program days | 7 | 0 | 5 | |
| 00 | Interns and residents not in approved teaching program (see instructions) | | 0 | 6 | |
| | Utilization review - physician compensation - SNF optional method only | C | | 7. | |
| | Subtotal (sum of lines 1 through 3 plus lines 6 and 7) | 20, 079 | | 8. | |
| | Primary payer payments (see instructions) | 0 | 0 | 9. | |
| | Subtotal (line 8 minus line 9) Deductibles billed to program patients (exclude amounts applicable to physician | 20, 079 | | 10. 11. | |
| | professional services) | | | ''' | |
| | Subtotal (line 10 minus line 11) | 20, 079 | 0 | 12. | |
| | Coinsurance billed to program patients (from provider records) (exclude coinsura | | 0 | 13 | |
| | for physician professional services) | | | | |
| | 80% of Part B costs (line 12 x 80%) | | 0 | | |
| | Subtotal (see instructions) | 20, 079 | | 15 | |
| | OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions) | C | 0 | 16 16 | |
| | Rural community hospital demonstration project (§410A Demonstration) payment | | | 16 | |
| | adjustment (see instructions) | | | '0 | |
| | Demonstration payment adjustment amount before sequestration | C | 0 | 16 | |
| . 00 | Allowable bad debts (see instructions) | 1, 299 | 0 | 17 | |
| | Adjusted reimbursable bad debts (see instructions) | 844 | | 17 | |
| | Allowable bad debts for dual eligible beneficiaries (see instructions) | 1, 299 | | 18 | |
| | Total (see instructions) | 20, 923 | | 19 19 | |
| | Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration) | 52 | | 19 | |
| | Sequestration adjustment-PARHM pass-throughs | | | 19 | |
| | Sequestration for non-claims based amounts (see instructions) | c | 0 | 19 | |
| | Interim payments | 18, 256 | 0 | 20 | |
| 01 | Interim payments-PARHM | | | 20 | |
| | Tentative settlement (for contractor use only) | C | 0 | 21 | |
| | Tentative settlement-PARHM (for contractor use only) | | _ | 21 | |
| | Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 2 | 21) 2, 615 | 0 | 22 | |
| | Balance due provider/program-PARHM (see instructions) Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 1 | 15-2. | 0 | 22 | |
| | chapter 1, §115.2 | J-Z, C | | 23 | |
| | Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment | | | 1 | |
| | Is this the first year of the current 5-year demonstration period under the 21st | | | 200 | |
| | Century Cures Act? Enter "Y" for yes or "N" for no. | | | | |
| | Cost Reimbursement Madiagra awing bad SNE inpatient routing corrige costs (from What D.1. Dt. 11 | Line | 1 | 1201 | |
| | Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, 66 (title XVIII hospital)) | TThe | | 201 | |
| | Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3 | 3. line | | 202 | |
| | 200 (title XVIII swing-bed SNF)) | | | | |
| | Total (sum of lines 201 and 202) | | | 203 | |
| | Medicare swing-bed SNF discharges (see instructions) | | | 204 | |
| | Computation of Demonstration Target Amount Limitation (N/A in first year of the period) $\label{eq:computation}$ | current 5-year demons | tration | | |
| | Medicare swing-bed SNF target amount | | 1 | 205 | |
| | Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204) | | | 205 | |
| | Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement | | | 1 | |
| | Program reimbursement under the §410A Demonstration (see instructions) | | | 207 | |
| | Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of I | ines 1 | | 208 | |
| | and 3) | | | 000 | |
| | Adjustment to Medicare swing-bed SNF PPS payments (see instructions) Reserved for future use | | | 209 210 | |
| | Reserved for future use Comparision of PPS versus Cost Reimbursement | | | 210 | |
| | Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) | | T | 215 | |

| Health Financial Systems ASCENSION ST. VIN CALCULATION OF REIMBURSEMENT SETTLEMENT | | Provider CCN: 15-1303 | Period: From 07/01/2021 To 06/30/2022 | 11/28/2022 12 | pare |
|---|--|---------------------------------|---|---------------|------|
| | | Title XVIII | Hospi tal | Cost | |
| | | | | 1.00 | |
| | PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDIC. | ARE PART A SERVICES - COST | REI MBURSEMENT | 1.00 | |
| . 00 | Inpatient services | | | 973, 274 | 1 1 |
| . 00 | Nursing and Allied Health Managed Care payment (see instru | icti ons) | | 0 | 2 |
| . 00 | Organ acquisition | , | | 0 | 3 |
| 00 | Subtotal (sum of lines 1 through 3) | | | 973, 274 | 4 |
| . 00 | Primary payer payments | | | 0 | 5 |
| . 00 | Total cost (line 4 less line 5). For CAH (see instructions | 5) | | 983, 007 | 6 |
| | COMPUTATION OF LESSER OF COST OR CHARGES | | | | |
| | Reasonabl e charges | | | | |
| . 00 | Routine service charges | | | 0 | 7. |
| . 00 | Ancillary service charges | | | 0 | 8 |
| . 00 | Organ acquisition charges, net of revenue | | | 0 | |
| D. 00 | Total reasonable charges | | | 0 | 10 |
| | Customary charges | | | | |
| 1.00 | Aggregate amount actually collected from patients liable f | 1 3 | U U | 0 | |
| 2.00 | Amounts that would have been realized from patients liable | | on a charge basis | 0 | 12 |
| | had such payment been made in accordance with 42 CFR 413.1 | 3(e) | | 0,000000 | 110 |
| 3.00 | Ratio of line 11 to line 12 (not to exceed 1.000000) | | | 0.000000 | |
| 1.00 | Total customary charges (see instructions) | anly if line 14 evenede li | no () (coo | 0 | 14 |
| 6.00 | Excess of customary charges over reasonable cost (complete instructions) | e only if line 14 exceeds if | ne 6) (see | 0 | 15 |
| 5.00 | Excess of reasonable cost over customary charges (complete | only if line 6 exceeds lin | 0 14) (600 | 0 | 16 |
| 0.00 | instructions) | e only if if the o exceeds if i | ie 14) (see | 0 | |
| 7.00 | Cost of physicians' services in a teaching hospital (see i | nstructions) | | 0 | 17 |
| | COMPUTATION OF REIMBURSEMENT SETTLEMENT | | | | 1 |
| 3. 00 | Direct graduate medical education payments (from Worksheet | E-4, line 49) | | 0 | 1 18 |
| 9.00 | Cost of covered services (sum of lines 6, 17 and 18) | | | 983, 007 | 19 |
| 0. 00 | Deductibles (exclude professional component) | | | 124, 280 | 20 |
| 1.00 | Excess reasonable cost (from line 16) | | | 0 | 21 |
| 2.00 | Subtotal (line 19 minus line 20 and 21) | | | 858, 727 | 22 |
| 3.00 | Coinsurance | | | 0 | 23 |
| 4.00 | Subtotal (line 22 minus line 23) | | | 858, 727 | 24 |
| 5.00 | Allowable bad debts (exclude bad debts for professional se | ervices) (see instructions) | | 40, 032 | 25 |
| 5.00 | Adjusted reimbursable bad debts (see instructions) | | | 26, 021 | 26 |
| 7.00 | Allowable bad debts for dual eligible beneficiaries (see i | nstructions) | | 33, 080 | 27 |
| 3.00 | Subtotal (sum of lines 24 and 25, or line 26) | | | 884, 748 | |
| 9.00 | OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) | | | 0 | 29 |
| 9.50 | Pioneer ACO demonstration payment adjustment (see instruct | i ons) | | 0 | 29 |
| 9. 98 | Recovery of accelerated depreciation. | | | 0 | 29 |
| 9.99 | Demonstration payment adjustment amount before sequestrati | on | | 0 | 29 |
| 0.00 | Subtotal (see instructions) | | | 884, 748 | |
|). 01 | Sequestration adjustment (see instructions) | | | 2, 212 | |
| 0. 02 | Demonstration payment adjustment amount after sequestratio | n | | 0 | |
|). 03 | | | | | 30 |
| . 00 | Interim payments | | | 907, 815 | |
| 1.01 | Interim payments-PARHM | | | | 31 |
| 2.00 | Tentative settlement (for contractor use only) | | | 0 | |
| 2. 01 | Tentative settlement-PARHM (for contractor use only) | 0 02 21 and 22) | | 05 070 | 32 |
| 0.00 | Balance due provider/program (line 30 minus lines 30.01, 3 | iu. uz, 31, and 32) | | -25, 279 | |
| 3.00 | Polonos dus providor (program DADUM (1) 0, 0, 10, 10) | minus lines 20 02 24 04 | | | |
| 3.00 3.01 4.00 | Balance due provider/program-PARHM (lines 2, 3, 18, and 26 Protested amounts (nonallowable cost report items) in acco | | | 25, 000 | 33 |

| | E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column | Provider C | F | veriod: rom 07/01/2021 o 06/30/2022 | Worksheet G Date/Time Pre 11/28/2022 12 | par€ ∵17 |
|----------|---|----------------------|----------------------------|---|---|-------------|
| | | General Fund | Speci fi c Purpose Fund | Endowment Fund | Plant Fund | |
| | CURRENT ASSETS | 1.00 | 2.00 | 3.00 | 4.00 | |
| 00 | Cash on hand in banks | 294, 752 | 0 | 0 | 0 | 1 |
| 00 | Temporary investments | 0 | 0 | 0 | 0 | 2 |
| 00 | Notes receivable | 0 | C | 0 | 0 | 3 |
| 00 | Accounts receivable | 5, 793, 643 | | 0 | 0 | |
| 00 | Other receivable | 702, 001 | 0 | - | 0 | |
| 00 | Allowances for uncollectible notes and accounts receivable | -4, 144, 996 | 0 | | 0 | 6 |
| 00 00 | Inventory Prepaid expenses | 189, 548 | | 0 | 0 | 8 |
| 00 | Other current assets | 254, 984 | | 0 | 0 | |
| 00 | Due from other funds | 201, 701 | | , i i i i i i i i i i i i i i i i i i i | 0 | 10 |
| 00 | Total current assets (sum of lines 1-10) | 3, 089, 932 | | 0 | 0 | 11 |
| | FIXED ASSETS | | | | | |
| 00 | Land | 127, 944 | 0 | 0 | 0 | 12 |
| 00 | Land improvements | 702, 434 | | - | 0 | 13 |
| 00 | Accumulated depreciation | -473, 745 | 0 | - | 0 | 14 |
| 00 | Buildings | 14, 773, 991 | 0 | - | 0 | 15 |
| 00 | Accumulated depreciation Leasehold improvements | -8, 444, 379 | | | 0 | 16 |
| 00 00 | Accumulated depreciation | 0 | | , i i i i i i i i i i i i i i i i i i i | 0 | 18 |
| | Fixed equipment | 1, 071, 087 | | - | 0 | 19 |
| | Accumulated depreciation | -965, 687 | | , i i i i i i i i i i i i i i i i i i i | 0 | 20 |
| | Automobiles and trucks | 17,900 | | 0 | 0 | 2 |
| 00 | Accumulated depreciation | -17, 900 | 0 | 0 | 0 | 22 |
| 00 | Major movable equipment | 6, 512, 705 | (C | 0 | 0 | 23 |
| | Accumulated depreciation | -4, 776, 275 | C | U U | 0 | 24 |
| | Minor equipment depreciable | 244, 221 | 0 | | 0 | 25 |
| | Accumulated depreciation | -204, 540 | 0 | | 0 | 26 |
| | HIT designated Assets | 0 | | - | 0 | 27 |
| | Accumulated depreciation Minor equipment-nondepreciable | 0 | | U U | 0 | 28 |
| | Total fixed assets (sum of lines 12-29) | 8, 567, 756 | | - | 0 | 30 |
| 00 | OTHER ASSETS | 0,007,700 | | | | |
| 00 | Investments | 0 | 0 | 0 | 0 | 3 |
| 00 | Deposits on Leases | 0 | (C | 0 | 0 | 32 |
| 00 | Due from owners/officers | 0 | C | 0 | 0 | 33 |
| 00 | Other assets | 534 | C | - | 0 | 34 |
| 00 | Total other assets (sum of lines 31-34) | 534 | | | 0 | 35 |
| 00 | Total assets (sum of lines 11, 30, and 35) | 11, 658, 222 | | 0 | 0 | 36 |
| ~~ | CURRENT LI ABI LI TI ES | 744 000 | | | 0 | 1 |
| 00 00 | Accounts payable Salaries, wages, and fees payable | 746, 232 197, 479 | | | 0 | 31 |
| 00 | Payroll taxes payable | 15, 183 | | | 0 | |
| | Notes and Loans payable (short term) | 149, 770 | | 0 | 0 | |
| | Deferred income | 303, 296 | C | 0 | 0 | |
| 00 | Accelerated payments | 0 | | | 1 | 42 |
| 00 | Due to other funds | 0 | C | - | 0 | |
| | Other current liabilities | 4, 642, 875 | | | 0 | |
| 00 | Total current liabilities (sum of lines 37 thru 44) | 6, 054, 835 | 0 | 0 | 0 | 45 |
| 00 | LONG TERM LI ABI LI TI ES | 0 | | | 0 | 1. |
| 00 00 | Mortgage payable Notes payable | 0 | | 0 | 0 | 40 |
| 00 | Unsecured Loans | 0 | | 0 | 0 | |
| 00 | Other long term liabilities | 9, 259, 743 | | 0 | 0 | |
| 00 | Total long term liabilities (sum of lines 46 thru 49) | 9, 259, 743 | | 0 | 0 | |
| 00 | Total liabilities (sum of lines 45 and 50) | 15, 314, 578 | | 0 | 0 | 5 |
| | CAPI TAL ACCOUNTS | | | | | |
| 00 | General fund balance | -3, 656, 356 | | | | 52 |
| 00 | Specific purpose fund | | C | | | 53 |
| 00 | Donor created - endowment fund balance - restricted | | | 0 | | 54 |
| 00 | Donor created - endowment fund balance - unrestricted | | | 0 | 1 | 55 |
| 00 | Governing body created - endowment fund balance | | | 0 | _ | 56 |
| 00 00 | Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement, | | | | 0 | |
| 00 | replacement, and expansion | | | | 0 | 1 30 |
| | Total fund balances (sum of lines 52 thru 58) | -3, 656, 356 | (| 0 | 0 | 59 |
| 00 | | | | | | |

| пеан и | Financial Systems AS | SCENSION ST. VIN | NCENT JENNINGS | | | In Lie | u of Form CMS- | 2552-10 |
|---|--|------------------|---|-------------|-----|--------------------------------------|--|--|
| STATEM | ENT OF CHANGES IN FUND BALANCES | | Provider CC | CN: 15-1303 | | riod: om 07/01/2021 06/30/2022 | Worksheet G- Date/Time Pro 11/28/2022 12 | epared: |
| | | General | Fund | Speci al | Pur | pose Fund | Endowment Fund | I |
| | | 1.00 | 2.00 | 2.00 | | 4.00 | F 00 | |
| 1.00 | Fund balances at beginning of period | 1.00 | 2.00 | 3.00 | | 4.00 | 5.00 | 1.00 |
| 2.00 | Net income (loss) (from Wkst. G-3, line 29) | | 6, 589, 511 | | | Ű | | 2.00 |
| 3.00 | Total (sum of line 1 and line 2) | | 4, 766, 477 | | | 0 | | 3.00 |
| 4.00 | Additions (credit adjustments) (specify) | 0 | | | 0 | | (| |
| 5.00 | Intercompany Transfers | -9, 131, 358 | | | 0 | | (| |
| 6.00 | Contributions/Donations/Grant Revenue | 26, 601 | | | 0 | | (| |
| 7.00 | 0+h | 722 1/0 | | | 0 | | (| |
| 8.00 9.00 | Other | 732, 168 0 | | | 0 | | | |
| 9.00 10.00 | Total additions (sum of line 4-9) | 0 | -8, 372, 589 | | U | 0 | | 10.00 |
| 11.00 | Subtotal (line 3 plus line 10) | | -3, 606, 112 | | | 0 | | 11.00 |
| 12.00 | Transfer to/from Affiliates | 125 | -3,000,112 | | 0 | 0 | (| |
| 13.00 | | 0 | | | 0 | | (| |
| 14.00 | | 0 | | | 0 | | (| |
| 15.00 | | 0 | | | 0 | | (| 15.00 |
| 16.00 | Released Capital | 50, 119 | | | 0 | | (| |
| 17.00 | Roundi ng | 0 | | | 0 | | (| |
| 18.00 | Total deductions (sum of lines 12-17) | | 50, 244 | | | 0 | | 18.00 |
| 19.00 | Fund balance at end of period per balance | | -3, 656, 356 | | | 0 | | 19.00 |
| | sheet (line 11 minus line 18) | Endowment Fund | PI ant | Fund | | | | |
| | | | | | | | | |
| 1.00 | Fund balances at beginning of period | 6.00 | 7.00 | 8.00 | 0 | | | |
| 2.00 | Net income (loss) (from Wkst. G-3, line 29) | | | | | | | 1 1 00 |
| | | Ű | | | - | | | 1.00 |
| | | | | | | | | 2.00 |
| 2.00 3.00 4.00 | Total (sum of line 1 and line 2) | 0 | 0 | | 0 | | | |
| 3.00 | | | 0 | | | | | 2.00 3.00 |
| 3.00 4.00 | Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) | | 0 0 0 | | | | | 2.00 3.00 4.00 |
| 3.00 4.00 5.00 | Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Intercompany Transfers | | 0 0 0 0 | | | | | 2.00 3.00 4.00 5.00 |
| 3.00 4.00 5.00 6.00 7.00 8.00 | Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Intercompany Transfers | | 0 0 0 0 0 | | | | | 2.00 3.00 4.00 5.00 6.00 7.00 8.00 |
| 3.00 4.00 5.00 6.00 7.00 8.00 9.00 | Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Intercompany Transfers Contributions/Donations/Grant Revenue Other | 0 | 0 0 0 0 0 0 | | 0 | | | 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 |
| 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 | Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Intercompany Transfers Contributions/Donations/Grant Revenue Other Total additions (sum of line 4-9) | 0 | 0 0 0 0 0 0 0 | | 0 | | | $\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ \end{array}$ |
| 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 | Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Intercompany Transfers Contributions/Donations/Grant Revenue Other Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) | 0 | 0 0 0 0 0 | | 0 | | | $\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00 \end{array}$ |
| 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 | Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Intercompany Transfers Contributions/Donations/Grant Revenue Other Total additions (sum of line 4-9) | 0 | 0 0 0 0 0 0 | | 0 | | | $\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ \end{array}$ |
| 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 | Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Intercompany Transfers Contributions/Donations/Grant Revenue Other Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) | 0 | 0 0 0 0 0 | | 0 | | | $\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ \end{array}$ |
| $\begin{array}{c} 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ \end{array}$ | Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Intercompany Transfers Contributions/Donations/Grant Revenue Other Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) | 0 | 0 0 0 0 0 0 | | 0 | | | $\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ \end{array}$ |
| 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 | Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Intercompany Transfers Contributions/Donations/Grant Revenue Other Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Transfer to/from Affiliates | 0 | 0 0 0 0 0 0 0 0 0 0 0 | | 0 | | | $\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ \end{array}$ |
| $\begin{array}{c} 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$ | Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Intercompany Transfers Contributions/Donations/Grant Revenue Other Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) | 0 | 0 0 0 0 0 0 0 0 0 0 0 | | 0 | | | $\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ \end{array}$ |
| $\begin{array}{c} 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$ | Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Intercompany Transfers Contributions/Donations/Grant Revenue Other Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Transfer to/from Affiliates Released Capital | 0 | 0 0 0 0 0 0 0 0 0 0 0 | | 0 | | | $\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$ |
| $\begin{array}{c} 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ \end{array}$ | Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Intercompany Transfers Contributions/Donations/Grant Revenue Other Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Transfer to/from Affiliates Released Capital Rounding | 0 0 0 | 0 0 0 0 0 0 0 0 0 0 0 | | 0 | | | $\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ \end{array}$ |

| | Financial Systems ASCENSION ST. VIN IENT OF PATIENT REVENUES AND OPERATING EXPENSES | | , CN: 15-1303 | Period: | eu of Form CMS-2 Worksheet G-2 | |
|----------------|---|--------------|------------------|----------------------------------|-----------------------------------|----------|
| STATEN | IENT OF PATTENT REVENUES AND OPERATING EXPENSES | Provi der C | UN: 15-1303 | From 07/01/2021 To 06/30/2022 | Parts I & II | pared: |
| | Cost Center Description | | I npati ent | Outpati ent | Total | |
| | · | | 1.00 | 2.00 | 3.00 | |
| | PART I – PATIENT REVENUES | | | | | |
| | General Inpatient Routine Services | | 1 | - | 1 | |
| 1.00 | Hospi tal | | 2, 586, 7 | 32 | 2, 586, 732 | |
| 2.00 | SUBPROVIDER - IPF | | | | | 2.00 |
| 3.00 | SUBPROVIDER - IRF | | | | | 3.00 |
| 4.00 | SUBPROVIDER | | | | | 4.00 |
| 5.00 | Swing bed - SNF | | | 0 | 0 | |
| 6.00 | Swing bed - NF | | | 0 | 0 | |
| 7.00 | SKILLED NURSING FACILITY | | | | | 7.00 |
| 8.00 | NURSING FACILITY | | | | | 8.00 |
| 9.00 | OTHER LONG TERM CARE | | 2 504 7 | 2.2 | 2 504 722 | 9.00 |
| 10.00 | Total general inpatient care services (sum of lines 1-9) Intensive Care Type Inpatient Hospital Services | | 2, 586, 7 | 32 | 2, 586, 732 | 10.00 |
| 11.00 | INTENSIVE CARE UNIT | | T | | 1 | 1 11. 00 |
| 12.00 | CORONARY CARE UNIT | | | | | 12.00 |
| 12.00 | BURN INTENSIVE CARE UNIT | | | | | 12.00 |
| 14.00 | SURGI CAL I NTENSI VE CARE UNI T | | | | | 14.00 |
| 14.00 | OTHER SPECIAL CARE (SPECIFY) | | | | | 14.00 |
| 16.00 | Total intensive care type inpatient hospital services (sum of | oflines | | 0 | 0 | |
| 10.00 | 11-15) | 51 111105 | | 0 | 0 | 10.00 |
| 17.00 | Total inpatient routine care services (sum of lines 10 and | 16) | 2, 586, 7 | 32 | 2, 586, 732 | 17.00 |
| 18.00 | Ancillary services | , | 1, 569, 9 | | | |
| 19.00 | Outpatient services | | 233, 4 | | | |
| 20.00 | RURAL HEALTH CLINIC | | | 0 0 | | 1 |
| 21.00 | FEDERALLY QUALIFIED HEALTH CENTER | | | 0 0 | 0 | 21.00 |
| 22.00 | HOME HEALTH AGENCY | | | | | 22.00 |
| 23.00 | AMBULANCE SERVI CES | | | | | 23.00 |
| 24.00 | СМНС | | | | | 24.00 |
| 25.00 | AMBULATORY SURGICAL CENTER (D. P.) | | | | | 25.00 |
| 26.00 | HOSPI CE | | | | | 26.00 |
| 27.00 | OTHER (SPECIFY) | | | 0 0 | 0 | 27.00 |
| 28.00 | Total patient revenues (sum of lines 17-27)(transfer column | 3 to Wkst. | 4, 390, 1 | 95 69, 660, 607 | 74, 050, 802 | 28.00 |
| | G-3, line 1) | | | | | |
| | PART II - OPERATING EXPENSES | | 1 | | 1 | |
| 29.00 | Operating expenses (per Wkst. A, column 3, line 200) | | | 18, 172, 647 | | 29.00 |
| 30.00 | ADD (SPECI FY) | | | 0 | | 30.00 |
| 31.00 | | | | 0 | | 31.00 |
| 32.00 | | | | 0 | | 32.00 |
| 33.00 | | | | 0 | | 33.00 |
| 34.00 | | | | 0 | | 34.00 |
| 35.00 | Tatal additions (our of lines 20.25) | | | 0 | | 35.00 |
| 36.00 | Total additions (sum of lines 30-35) | | | C | 1 | 36.00 |
| 37.00 38.00 | DEDUCT (SPECI FY) | | | 0 | | 37.00 |
| 38.00 | | | | 0 | | 38.00 |
| 39.00 40.00 | | | | 0 | | 40.00 |
| 40.00 | | | | 0 | | 40.00 |
| 41.00 | Total deductions (sum of lines 37-41) | | | 0 | | 41.00 |
| 42.00 | Total operating expenses (sum of lines 29 and 36 minus line | 42)(transfer | | 18, 172, 647 | | 42.00 |
| | | | | | | 1 10.00 |

| Heal th | Financial Systems ASCENSION ST. VII | NCENT JENNINGS | In Lie | u of Form CMS-2 | 2552-10 | | |
|---------|---|-----------------------|----------------------------|-----------------|---------|--|--|
| STATE | IENT OF REVENUES AND EXPENSES | Provider CCN: 15-1303 | Period: From 07/01/2021 | Worksheet G-3 | | | |
| | | | To 06/30/2022 | Date/Time Pre | | | |
| | · · · · · · · · · · · · · · · · · · · | | | 11/28/2022 12: | 17 pm | | |
| | | | | 1.00 | | | |
| 1.00 | 1.00 Total patient revenues (from Wkst. G-2, Part I, column 3, line 28) | | | | | | |
| 2.00 | Less contractual allowances and discounts on patients' acco | 49, 862, 418 | 2.00 | | | | |
| 3.00 | Net patient revenues (line 1 minus line 2) | 24, 188, 384 | 3.00 | | | | |
| 4.00 | Less total operating expenses (from Wkst. G-2, Part II, lin | | 18, 172, 647 | 4.00 | | | |
| 5.00 | Net income from service to patients (line 3 minus line 4) | | | 6, 015, 737 | 5.00 | | |
| | OTHER INCOME | | | | | | |
| 6.00 | Contributions, donations, bequests, etc | | | 541 | 6.00 | | |
| 7.00 | Income from investments | | | -732, 168 | 7.00 | | |
| 8.00 | Revenues from telephone and other miscellaneous communicati | on services | | 0 | 8.00 | | |
| 9.00 | Revenue from television and radio service | | | 0 | 9.00 | | |
| 10.00 | Purchase di scounts | | | 0 | 10.00 | | |
| 11.00 | | | | 0 | 11.00 | | |
| 12.00 | 5 1 | | | 0 | 12.00 | | |
| 13.00 | | | | 0 | 13.00 | | |
| 14.00 | | | | 48, 210 | | | |
| 15.00 | | | | 0 | 15.00 | | |
| 16.00 | | than patients | | 0 | 16.00 | | |
| 17.00 | | | | 10, 485 | | | |
| 18.00 | Revenue from sale of medical records and abstracts | | | 0 | 18.00 | | |
| 19.00 | | | | 0 | 19.00 | | |
| 20.00 | Revenue from gifts, flowers, coffee shops, and canteen | | | 0 | 20.00 | | |
| 21.00 | 5 | | | 0 | 21.00 | | |
| 22.00 | | | | 147, 988 | | | |
| 23.00 | | | | 0 | 23.00 | | |
| 24.00 | 1 5 | | | 83, 280 | | | |
| 24.50 | | | | 1, 015, 438 | | | |
| | Total other income (sum of lines 6-24) | | | 573, 774 | | | |
| | Total (line 5 plus line 25) | | | 6, 589, 511 | | | |
| 27.00 | | | | 0 | 27.00 | | |
| | Total other expenses (sum of line 27 and subscripts) | | | 0 | 28.00 | | |
| 29.00 | Net income (or loss) for the period (line 26 minus line 28) | | I | 6, 589, 511 | 29.00 | | |