Health Financial Systems ASCENSION ST. \				u of Form CMS-2	552-10
This report is required by law (42 USC 1395g; 42 CFR 413.20(b)					
payments made since the beginning of the cost reporting period	being dee	med overpayments (	42 USC 1395g).	OMB NO. 0938-0	
				EXPI RES 03-31-	2022
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFIC.	ATION Pro	ovider CCN: 15-1307	Peri od:	Worksheet S	
AND SETTLEMENT SUMMARY			From 07/01/2021 To 06/30/2022	Parts I-III Date/Time Prep	arod
			10 00/ 30/ 2022	11/28/2022 9:5	
PART I - COST REPORT STATUS					
Provider 1. [X] Electronically prepared cost report			Date: 11/28/20	022 Time: 9:	58 am
use only 2. [ ] Manually prepared cost report					
3. [ 0 ] If this is an amended report enter the n	umber of t	imes the provider	resubmitted this co	ost report	
4. [ F ] Medicare Utilization. Enter "F" for full	or "L" fo				
Contractor 5. [1] Cost Report Status 6. Date Received:			NPR Date:	0	
use only (1) As Submitted 7. Contractor No. (2) Settled without Audit 8. [N] Initial Rep	ort for th	is Provider CCN 12	. Contractor's Vendo	)r COOLE: Jump 1 is 1. Fr	4 tor
(3) Settled with Audit 9. [N] Final Report	t for this	s Provider CCN		ies reopened = 0	
(4) Reopened					, ,.
(5) Amended					
PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINI					
MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINE					)
ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL					
PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY	Y OF A KIC	KBACK OR WERE OTHE	RWISE ILLEGAL, CRIM	INAL, CIVIL AND	)
ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.					
CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRA	TOR OF PRO	VIDER(S)			
I HEREBY CERTIFY that I have read the above certificat	ion stater	ent and that I hav	ve examined the acco	ompanyi ng	
electronically filed or manually submitted cost report					
Statement of Revenue and Expenses prepared by ASCENSIO					
reporting period beginning 07/01/2021 and ending 06/30					
report and statement are true, correct, complete and p	repared fr	om the books and r	records of the provi	der in	
accordance with applicable instructions, except as not	ed. I furt	her certify that I	am familiar with t	the laws and	
regulations regarding the provision of health care ser			s identified in this	s cost	
report were provided in compliance with such laws and	regul ati or	IS.			
SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	CHECKBOX		ELECTRONI C		
	2	SI	GNATURE STATEMENT		

SIGNATURE OF CHIEF FINA	INCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONIC	
	1	2	SI GNATURE STATEMENT	
Christ	topher Hons	Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2 Signatory Printed Name	Christopher Hons			2
3 Signatory Title	VP OF FINANCE			3
4 Date	11/28/2022 09: 58: 00 AM			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	334, 319	209, 058	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	112, 225	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		57, 557		0	10.00
10.01	RURAL HEALTH CLINIC II	0		55, 046		0	10.01
200.00	Total	0	446, 544	321, 661	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-MEDI CARE.

	AL AND HOSPITAL HEALTH CARE COMPLEX I	DENTIFICATION DATA	Provio	ler CCN		Period: From 07/01/ To 06/30/	2021	Workshe Part I Date/Ti 11/28/2	me Pre	pared:
	1.00	2.00		3.00		2	1.00	11/20/2	.022 9.	
00	Hospital and Hospital Health Care Co		1							1 00
. 00 . 00	Street: 412 NORTH MONROE City: WILLIAMSPORT	PO Box: State: IN	Zip Cod	e: 4799	23 Count	y: WARREN				1.00
		Component Name	CCN	CBS	A Provider	Date		nt Syst		
			Number	Numb	er Type	Certified	I, V	0, or XVIII		-
		1.00	2.00	3.0	0 4.00	5.00	6.00	-		1
0.0	Hospital and Hospital-Based Componen		454007	0000		07/04/40//	. NI			
. 00	Hospi tal	ASCENSION ST. VINCENT WILLIAMSPORT	151307	2920	0 1	07/01/1966	N	0	0	3.00
. 00	Subprovider - IPF								1	4.00
. 00 . 00	Subprovider - IRF Subprovider - (Other)									5. 00 6. 00
00	Swing Beds - SNF	ST. VINCENT	15Z307	9991	5	02/01/1988	Ν	0	N	7.00
~~		WILLIAMSPORT SWING BEDS								
00 00	Swing Beds - NF Hospital-Based SNF									8.00
0.00	Hospi tal -Based NF								1	10.00
1.00	Hospi tal -Based OLTC									11.00
2.00 3.00	Hospital-Based HHA Separately Certified ASC									12.00 13.00
. 00	Hospi tal -Based Hospi ce								1	14.00
5.00	Hospital-Based Health Clinic - RHC	NORTH CLINIC	153993	2920		05/06/2001	Ν	0	N	15.00
5. 01	Hospital-Based Health Clinic - RHC	SOUTH CLINIC	153994	9991	5	08/01/2001	N	0	N	15.01
5. 00	Hospital-Based Health Clinic - FQHC								1	16.00
7.00	Hospital-Based (CMHC) I									17.00
3.00 9.00	Renal Dialysis Other									18.00
		I			I	From:		То		
). 00	Cost Reporting Period (mm/dd/yyyy)					1.00	121	2.0 06/30/		20.00
	Type of Control (see instructions)					1	JZ 1	00/ 30/	2022	20.00
				_	1.00	0.00				_
	Inpatient PPS Information				1.00	2.00		3.0	0	
. 00	Does this facility qualify and is it				Ν	N				22.00
	disproportionate share hospital adju §412.106? In column 1, enter "Y" fo			2						
	facility subject to 42 CFR Section §									
01	hospital?) In column 2, enter "Y" fo		- 6 +:	_	N					22.01
. 01	Did this hospital receive interim un cost reporting period? Enter in colu				N	N				22.01
		riod occurring prior to	October ?	I.						
	Enter in column 2, "Y" for yes or "N	riod occurring prior to " for no for the portion	October of the d	I.						
02		riod occurring prior to " for no for the portion er October 1. (see instr	October 7 of the c uctions)	l. cost	Ν	N				22. 02
. 02	Enter in column 2, "Y" for yes or "N reporting period occurring on or aft Is this a newly merged hospital that payments to be determined at cost re	riod occurring prior to " for no for the portion er October 1. (see instr requires final uncompen port settlement? (see in	October of the o uctions) sated car structior	re	Ν	N				22. 02
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2. 03	Enter in column 2, "Y" for yes or "N reporting period occurring on or aft Is this a newly merged hospital that payments to be determined at cost re Enter in column 1, "Y" for yes or "N cost reporting period prior to Octob or "N" for no, for the portion of th October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in c for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital receive a geograph rural as a result of the cost reportin in accordance with 42 CFR 41 yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OMB adopted by CMS in FY 2021? Enter in for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no.	riod occurring prior to " for no for the portion er October 1. (see instr requires final uncompen port settlement? (see in " for no, for the portio er 1. Enter in column 2, e cost reporting period ic reclassification from ds for delineating stati olumn 1, "Y" for yes or g period prior to Octobe no for the portion of th er October 1. (see instr 100 but not more than 49 2.105)? Enter in column ic reclassification from delineations for statis column 1, "Y" for yes or g period prior to Octobe no for the portion of th er October 1. (see instr 100 but not more than 49 2.105)? Enter in column	October of the outions) sated can struction n of the "Y" for on or aff urban to stical an "N" for r 1. Ente e cost uctions) 9 beds (a "N" for r 1. Ente e cost uctions) 9 beds (a 3, "Y" 1	L. cost re is) yes cer or eas or eas or o eas no er	Ν	N				22. 03 22. 04
2. 03	Enter in column 2, "Y" for yes or "N reporting period occurring on or aft Is this a newly merged hospital that payments to be determined at cost re Enter in column 1, "Y" for yes or "N cost reporting period prior to Octob or "N" for no, for the portion of th October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in c for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital receive a geograph rural as a result of the revised OMB adopted by CMS in FY 2021? Enter in for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital receive a geograph rural as a result of the revised OMB adopted by CMS in FY 2021? Enter in for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Which method is used to determine Me	riod occurring prior to " for no for the portion er October 1. (see instr requires final uncompen port settlement? (see in " for no, for the portio er 1. Enter in column 2, e cost reporting period ic reclassification from ds for delineating stati olumn 1, "Y" for yes or g period prior to Octobe no for the portion of th er October 1. (see instr 100 but not more than 49 2.105)? Enter in column ic reclassification from delineations for statis column 1, "Y" for yes or g period prior to Octobe no for the portion of th er October 1. (see instr 100 but not more than 49 2.105)? Enter in column delineations for statis column 1, "Y" for yes or g period prior to Octobe no for the portion of th er October 1. (see instr 100 but not more than 49 2.105)? Enter in column	October 2 of the outions) sated can struction n of the "Y" for on or aff urban to stical an "N" for r 1. Ente e cost uctions) 9 beds (a 3, "Y" for r 1. Ente e cost uctions) 9 beds (a 3, "Y" 1 and/or 25	L. cost re is) yes cer o reas no er as ro as ro as ro as ro as ro as o con as o con as b as con as b as b as as b as b as as b as as as as as as as as as as	Ν	Ν				22. 02 22. 03 22. 04 23. 00
2. 02 2. 03 2. 04 3. 00	Enter in column 2, "Y" for yes or "N reporting period occurring on or aft Is this a newly merged hospital that payments to be determined at cost re Enter in column 1, "Y" for yes or "N cost reporting period prior to Octob or "N" for no, for the portion of th October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in c for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital receive a geograph rural as a result of the cost reportin in accordance with 42 CFR 41 yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OMB adopted by CMS in FY 2021? Enter in for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no.	riod occurring prior to "for no for the portion er October 1. (see instr requires final uncompen port settlement? (see in "for no, for the portio er 1. Enter in column 2, e cost reporting period ic reclassification from ds for delineating stati olumn 1, "Y" for yes or g period prior to Octobe no for the portion of th er October 1. (see instr 100 but not more than 49 2. 105)? Enter in column ic reclassification from delineations for statis column 1, "Y" for yes or g period prior to Octobe no for the portion of th er October 1. (see instr 100 but not more than 49 2. 105)? Enter in column dic reclassification from delineations for statis column 1, "Y" for yes or g period prior to Octobe no for the portion of th er October 1. (see instr 100 but not more than 49 2.105)? Enter in column dicaid days on lines 24 of admission, 2 if censu of identifying the days	October 2 of the o uctions) sated can struction n of the "Y" for on or aff urban to stical ar "N" for r 1. Ente e cost uctions) 9 beds (a 3, "Y" for urban to tical are "N" for r 1. Ente e cost uctions) 9 beds (a 3, "Y" 1 and/or 25 s days, o in this o	L. cost re s) yes cer reas reas ro eas eas eas eas eas eas eas eas	Ν	N				22. 03

Health Financial Systems ASCENSION S	T. VINCENT	WI LLI AMSPOF	RT.		In Lieu	of Form	n CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION D	ATA	Provider CC	N: 15-1307	Period: From 07/0 To 06/30	1/2021 P 0/2022 D	lorkshee art l ate/Tir 1/28/20	ne Pre	pared:
	In-State Medicaid paid days	In-State Medicaid eligible unpaid days 2.00	Out-of State Medicaid paid days 3.00	Out-of State Medicaid eligible unpaid 4.00	Medicaio HMO days	s Medi da	her caid ays 00	
24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in	0			0	3.00	0	0	24.00
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		0		25. 00
				Urban/Ri	ural S D. DO	ate of 2.00		
26.00 Enter your standard geographic classification (not w cost reporting period. Enter "1" for urban or "2" fo		at the beg	jinning of t		2		-	26.00
27.00 Enter your standard geographic classification (not w reporting period. Enter in column 1, "1" for urban o enter the effective date of the geographic reclassif	age) status r "2" for r ication in	ural. If ap column 2.	plicable,		2			27.00
35.00 If this is a sole community hospital (SCH), enter th effect in the cost reporting period.		perious su			0			35.00
				Beginn 1. C		Endi n 2. 00		
36.00 Enter applicable beginning and ending dates of SCH s of periods in excess of one and enter subsequent dat		cript line	36 for numb	ber				36.00
<ul> <li>37.00 If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period.</li> <li>37.01 Is this hospital a former MDH that is eligible for t</li> </ul>	r the numbe he MDH tran	sitional pa	yment in	IS	0			37. 00 37. 01
accordance with FY 2016 OPPS final rule? Enter "Y" f instructions) 38.00 If line 37 is 1, enter the beginning and ending date greater than 1, subscript this line for the number o enter subsequent dates.	s of MDH st	atus. Ifli	ne 37 is					38.00
				Y/I 1. C		Y/N 2.00		
39.00 Does this facility qualify for the inpatient hospita hospitals in accordance with 42 CFR §412.101(b)(2)(i 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions)	), (ii), or the mileage	(iii)? Ent requiremen	er in colum nts in	ime N in		<u> </u>	5	39.00
40.00 Is this hospital subject to the HAC program reductio "N" for no in column 1, for discharges prior to Octo no in column 2, for discharges on or after October 1	ber 1. Ente	r "Y" for y				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 payme with 42 CFR Section §412.320? (see instructions)	nt for disp	roporti onat	e share in	accordance	N	N	N	45.00
46.00 Is this facility eligible for additional payment exc pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III.					N	N	Ν	46.00
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS 48.00 Is the facility electing full federal capital paymen					N N	N N	N N	47.00 48.00
<ul> <li>56.00 Is this a hospital involved in training residents in "N" for no in column 1. For column 2, if the respons was involved in training residents in approved GME p</li> </ul>	approved G e to column	ME programs 1 is "Y",	? Enter "Y" or if this	for yes or hospital				56.00
year, and are you are impacted by CR 11642 (or appli Enter "Y" for yes; otherwise, enter "N" for no in co 57.00 If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" fo is "Y" did residents start training in the first mon for yes or "N" for no in column 2. If column 2 is " "N", complete Wkst. D, Parts III & IV and D-2, Pt. I	lumn 2. period duri r yes or "N th of this Y", complet	ng which re " for no in cost report e Worksheet	esidents in 1 column 1. 1 ing period?	approved If column 1 ' Enter "Y"				57.00
58.00 If line 56 is yes, did this facility elect cost reim defined in CMS Pub. 15–1, chapter 21, §2148? If yes,	bursement f	or physicia	ins' service	es as	N			58.00
59.00 Are costs claimed on line 100 of Worksheet A? If ye			Pt. I.		N			59.00

OSPI I	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provider CO	F	eriod: rom 07/01/2021 o 06/30/2022	Date/Time Pre	parec
				NAHE 413.85 Y/N	Worksheet A Line #	11/28/2022 9: Pass-Through Qual i fi cati on Cri teri on Code	
				1.00	2.00	3.00	
D. 00	Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in col is "Y", are you impacted by CR 11642 (or subsequent C adjustement? Enter "Y" for yes or "N" for no in colu	85? (s umn 1. R) NAHE	ee lf column 1	N			60.
	adjustement; cirter i for yes of in for no fir cord	Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	1
I. 00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				0.00	0.00	61.
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)						61.
. 02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.
I. 03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.
. 04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61.
. 05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.
. 06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.
		Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1.00	2.00	3.00	4.00	1
	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE				0. 00		
	residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.						
						1.00	
00	ACA Provisions Affecting the Health Resources and Ser Enter the number of FTE residents that your hospital				iod for which	0.00	62
	your hospital received HRSA PCRE funding (see instruc Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog	tions) Teachi Iram. (s	ng Health Cen ee instruction	ter (THC) into		0.00	
. 00	Teaching Hospitals that Claim Residents in Nonprovide Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple	ettings	during this co			N	63
				Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
	Contion EEOA of the ACA Base Very FTE Desident ' "	ppport	lon Satting	1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in No period that begins on or after July 1, 2009 and befor			mis base year	is your cost r	eporting	
. 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	y train -primar	ed residents y care	0.00	0.00	0. 000000	64
	settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter in						

 of (column 1 divided by (column 1 + column 2)). (see instructions)
 Image: second second

	EX IDENTIFICATION DA	ATA Provider (		eriod: com 07/01/2021	Worksheet S-2 Part I	2
			Tc			
	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col. 3/	1
			FTEs Nonprovider	FTEs in Hospital	(col. 3 + col. 4))	
-			Site			4
.00 Enter in column 1, if line 63	1.00	2.00	3.00	4.00	5.00 0.000000	) 65 (
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 Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
Section 5504 of the ACA Current N beginning on or after July 1, 201		n Nonprovider Settin	gsEffective fo	r cost reporti	ng periods	
FTEs attributable to rotations oc Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 +	unweighted non-prima al. Enter in column	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	1
.00 Enter in column 1, the program name associated with each of your primary care programs in			0.00	0. 00	0. 000000	07.0
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)						
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				1.0	0 2.00 3.00	-
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)		IPF), or does it con	tain an IPF subp			70.
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) Inpatient Psychiatric Facility Pf .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 CFF Column 3: If column 2 is Y, indic (see instructions)	ychiatric Facility ( the facility have a efore November 15, 2 umn 2: Did this fac R 412.424 (d)(1)(iii cate which program y	n approved GME teach 2004? Enter "Y" for Sility train resident )(D)? Enter "Y" for	ing program in t yes or "N" for n s in a new teach yes or "N" for n	rovider? N he most o. (see ing o.		
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) Inpatient Psychiatric Facility PF Not Is this facility an Inpatient Psy Enter "Y" for yes or "N" for no. 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 CFF Column 3: If column 2 is Y, indic	ychiatric Facility ( the facility have a efore November 15, 2 umn 2: Did this fac R 412.424 (d)(1)(iii cate which program y y PPS nabilitation Facilit	n approved GME teach 2004? Enter "Y" for 2011 ty train resident 2012)? Enter "Y" for 2012 rear began during this	ing program in t yes or "N" for n s in a new teach yes or "N" for n s cost reporting	rovider? N he most o. (see ing o.	0	70.0

Health Financial Systems ASCENSION ST. VINCENT WILLIAMSPORT In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1307 Peri od: Worksheet S-2 From 07/01/2021 Part I 06/30/2022 Date/Time Prepared: То 11/28/2022 9:58 am 1.00 Long Term Care Hospital PPS 80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. 80 00 Ν 81.00 Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter Ν 81.00 for yes and "N" for no. TEFRA Providers 85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. Ν 85 00 86.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section 86.00 §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital classified under section 87 00 Ν 87.00 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. V XIX 1.00 2.00 Title V and XIX Services 90.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for Y Ν 90 00 ves or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column. 91 00 Ν Ν 91 00 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column. Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column. 92.00 Υ 92.00 93.00 Ν Ν 93.00 94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the 94 00 Ν Ν applicable column. 95.00 If line 94 is "Y", enter the reduction percentage in the applicable column. 0 00 0 00 95 00 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the Ν Ν 96.00 applicable column 97.00 If line 96 is "Y", enter the reduction percentage in the applicable column. 97 00 0 00 0.00 98.00 Does title V or XIX follow Medicare (title XVIII) for the interns and residents post Ν 98.00 Υ 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. Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. Υ 98.01 98.01 Ν C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.02 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation Ν γ 98.02 bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.03 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) Ν 98.03 Ν reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and Ν Ν 98.04 in column 2 for title XIX. 98.05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in γ 98.05 Ν column 2 for title XIX. 98.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Ν Υ 98.06 Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Rural Providers 105.00 Does this hospital qualify as a CAH? Y 105 00 106.00 If this facility qualifies as a CAH, has it elected the all-inclusive method of payment 106.00 Ν for outpatient services? (see instructions) 107.00 Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Ν 107.00 Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train L&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions) 108.00 Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no. 108.00 Ν Physi cal Occupati onal Speech Respi ratory 1.00 2 00 3 00 4 00 109.00 If this hospital qualifies as a CAH or a cost provider, are Ν 109.00 Ν Ν Ν therapy services provided by outside supplier? Enter " for yes or "N" for no for each therapy. 1.00 110.00 Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, 110.00 Ν complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as appi i cabl e.

Health Financial Systems ASCENSION ST. VINCENT WILLIAMSPOR HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CC		In Lie eriod:	worksheet S-	
		om 07/01/2021	Part I	epared:
		1.00		
111.00 If this facility qualifies as a CAH, did it participate in the Frontier Co Health Integration Project (FCHIP) demonstration for this cost reporting p "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, e integration prong of the FCHIP demo in which this CAH is participating in Enter all that apply: "A" for Ambulance services; "B" for additional beds; for tele-health services.	period? Enter enter the column 2.	1.00 N	2.00	111.00
	1.00	2.00	3.00	_
112.00 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", enter 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			112.00
115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N			0115.00
116.00 Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00 Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00 Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00
118.01 List amounts of malpractice premiums and paid losses:	Premi ums <u>1.00</u> 114,561	2.00	I nsurance	0 118. 01
		1 00	2.00	_
118.02 Are malpractice premiums and paid losses reported in a cost center other t Administrative and General? If yes, submit supporting schedule listing cc and amounts contained therein.		<u> </u>	2.00	118. 02
19.00 D0 NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless prov §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" "N" for no. Is this a rural hospital with < 100 beds that qualifies for th Hold Harmless provision in ACA §3121 and applicable amendments? (see instr Enter in column 2, "Y" for yes or "N" for no.	' for yes or ne Outpatient	Ν	N	119.00 120.00
121.00 Did this facility incur and report costs for high cost implantable devices patients? Enter "Y" for yes or "N" for no.	s charged to	Y		121.00
122.00 Does the cost report contain healthcare related taxes as defined in §1903( Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter		Y	5.00	122.00
the Worksheet A line number where these taxes are included.	for no lf	N		125.00
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes and "N"				126. 00
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes and "N" yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, enter the certif				
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes and "N" yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, enter the certifing in column 1 and termination date, if applicable, in column 2. 127.00 If this is a Medicare certified heart transplant center, enter the certification of the certification of the center of the cent	fication date			127.00
<ul> <li>Transplant Center Information</li> <li>25.00 Does this facility operate a transplant center? Enter "Y" for yes and "N" yes, enter certification date(s) (mm/dd/yyyy) below.</li> <li>26.00 If this is a Medicare certified kidney transplant center, enter the certific in column 1 and termination date, if applicable, in column 2.</li> <li>27.00 If this is a Medicare certified heart transplant center, enter the certific in column 1 and termination date, if applicable, in column 2.</li> </ul>	fication date cation date			
Transplant Center Information125.00Does this facility operate a transplant center? Enter "Y" for yes and "N" yes, enter certification date(s) (mm/dd/yyyy) below.126.00If this is a Medicare certified kidney transplant center, enter the certifi in column 1 and termination date, if applicable, in column 2.127.00If this is a Medicare certified heart transplant center, enter the certifi in column 1 and termination date, if applicable, in column 2.128.00If this is a Medicare certified liver transplant center, enter the certifi in column 1 and termination date, if applicable, in column 2.129.00If this is a Medicare certified lung transplant center, enter the certific column 1 and termination date, if applicable, in column 2.	Fication date cation date cation date cation date in			128. 00 129. 00
<ul> <li>Transplant Center Information</li> <li>25.00 Does this facility operate a transplant center? Enter "Y" for yes and "N" yes, enter certification date(s) (mm/dd/yyyy) below.</li> <li>26.00 If this is a Medicare certified kidney transplant center, enter the certific in column 1 and termination date, if applicable, in column 2.</li> <li>27.00 If this is a Medicare certified heart transplant center, enter the certific in column 1 and termination date, if applicable, in column 2.</li> <li>28.00 If this is a Medicare certified liver transplant center, enter the certific in column 1 and termination date, if applicable, in column 2.</li> <li>28.00 If this is a Medicare certified liver transplant center, enter the certific in column 1 and termination date, if applicable, in column 2.</li> <li>29.00 If this is a Medicare certified lung transplant center, enter the certific column 1 and termination date, if applicable, in column 2.</li> <li>30.00 If this is a Medicare certified pancreas transplant center, enter the certific date in column 1 and termination date, if applicable, in column 2.</li> </ul>	fication date cation date cation date cation date in tification			128. 00 129. 00 130. 00
<ul> <li>Transplant Center Information</li> <li>25.00 Does this facility operate a transplant center? Enter "Y" for yes and "N" yes, enter certification date(s) (mm/dd/yyyy) below.</li> <li>26.00 If this is a Medicare certified kidney transplant center, enter the certifin column 1 and termination date, if applicable, in column 2.</li> <li>27.00 If this is a Medicare certified heart transplant center, enter the certifin column 1 and termination date, if applicable, in column 2.</li> <li>28.00 If this is a Medicare certified liver transplant center, enter the certifin column 1 and termination date, if applicable, in column 2.</li> <li>28.00 If this is a Medicare certified liver transplant center, enter the certific in column 1 and termination date, if applicable, in column 2.</li> <li>29.00 If this is a Medicare certified lung transplant center, enter the certific column 1 and termination date, if applicable, in column 2.</li> <li>30.00 If this is a Medicare certified pancreas transplant center, enter the certific date in column 1 and termination date, if applicable, in column 2.</li> <li>31.00 If this is a Medicare certified intestinal transplant center, enter the certified intestinal transplant center, enter the certified to the in column 1 and termination date, if applicable, in column 2.</li> </ul>	Fication date cation date cation date cation date in tification ertification			128.00 129.00 130.00 131.00
<ul> <li>Transplant Center Information</li> <li>125.00 Does this facility operate a transplant center? Enter "Y" for yes and "N" yes, enter certification date(s) (mm/dd/yyyy) below.</li> <li>126.00 If this is a Medicare certified kidney transplant center, enter the certific in column 1 and termination date, if applicable, in column 2.</li> <li>127.00 If this is a Medicare certified heart transplant center, enter the certific in column 1 and termination date, if applicable, in column 2.</li> <li>128.00 If this is a Medicare certified liver transplant center, enter the certific in column 1 and termination date, if applicable, in column 2.</li> <li>128.00 If this is a Medicare certified luver transplant center, enter the certific in column 1 and termination date, if applicable, in column 2.</li> <li>129.00 If this is a Medicare certified lung transplant center, enter the certific column 1 and termination date, if applicable, in column 2.</li> <li>130.00 If this is a Medicare certified pancreas transplant center, enter the certific date in column 1 and termination date, if applicable, in column 2.</li> <li>131.00 If this is a Medicare certified intestinal transplant center, enter the certific date in column 1 and termination date, if applicable, in column 2.</li> <li>132.00 If this is a Medicare certified intestinal transplant center, enter the certific date in column 1 and termination date, if applicable, in column 2.</li> <li>132.00 If this is a Medicare certified islet transplant center, enter the certific in column 1 and termination date, if applicable, in column 2.</li> <li>133.00 Removed and reserved</li> </ul>	fication date cation date cation date cation date in tification ertification cation date			128.00 129.00 130.00 131.00 132.00
Transplant Center Information125.00Does this facility operate a transplant center? Enter "Y" for yes and "N" yes, enter certification date(s) (mm/dd/yyyy) below.126.00If this is a Medicare certified kidney transplant center, enter the certifi in column 1 and termination date, if applicable, in column 2.127.00If this is a Medicare certified heart transplant center, enter the certifi in column 1 and termination date, if applicable, in column 2.128.00If this is a Medicare certified liver transplant center, enter the certifi in column 1 and termination date, if applicable, in column 2.129.00If this is a Medicare certified lung transplant center, enter the certific column 1 and termination date, if applicable, in column 2.130.00If this is a Medicare certified pancreas transplant center, enter the certific date in column 1 and termination date, if applicable, in column 2.131.00If this is a Medicare certified pancreas transplant center, enter the certific date in column 1 and termination date, if applicable, in column 2.131.00If this is a Medicare certified intestinal transplant center, enter the certified in column 1 and termination date, if applicable, in column 2.131.00If this is a Medicare certified intestinal transplant center, enter the certified in column 1 and termination date, if applicable, in column 2.132.00If this is a Medicare certified intestinal transplant center, enter the certified in column 1 and termination date, if applicable, in column 2.132.00If this is a Medicare certified intestinal transplant center, enter the certified is enter, in column 2.	fication date cation date cation date cation date in tification ertification cation date			127. 00 128. 00 129. 00 130. 00 131. 00 132. 00 133. 00 134. 00

ealth Financial Systems OSPITAL AND HOSPITAL HEALTH CARE COMPLE			T WILLIAMSPO Provider CO			i od:	u of Form CMS Worksheet S-	
					To	m 07/01/2021 06/30/2022	Part I Date/Time Pr 11/28/2022 9	
1.00		2.00				3.00	1172072022 9	<u>, 50 am</u>
If this facility is part of a chai home office and enter the home off					e name	and address	of the	
1.00 Name: ASCENSION ST. VINCENT	Contractor's				actor's	Number: 0800	)1	141.0
2.00 Street: 250 W. 96TH ST. SUITE 215	PO Box:							142.0
43.00 City: INDIANAPOLIS	State:	IN		Zip Co	ode:	4629		143.0
							1.00	-
44.00 Are provider based physicians' cos	sts included in Wor	ksheet A?					Y	144. (
						1.00	2.00	-
<ul> <li>15.00 If costs for renal services are clip inpatient services only? Enter "Y" no, does the dialysis facility inceperiod? Enter "Y" for yes or "N"</li> <li>6.00 Has the cost allocation methodology</li> </ul>	' for yes or "N" fo clude Medicare util for no in column 2 gy changed from the	r no in co ization fo previous	olumn 1. lf o or this cost ly filed cos <sup>.</sup>	column 1 is reporting t report?		N		145. (
Enter "Y" for yes or "N" for no ir yes, enter the approval date (mm/o			-2, chapter 4	40, §4020)	It			
							1.00	-
47.00Was there a change in the statisti	cal basis? Enter "	Y" for ye	s or "N" for	no.			N 1.00	147. (
18.00Was there a change in the order of	f allocation? Enter	"Y" for	yes or "N" fo	or no.	_		N	148.
19.00 Was there a change to the simplifi	ed cost finding me	thod? Ente	er "Y" for ye Part A	es or "N" 1 Part E		Title V	N Title XIX	149. (
			1.00	2.00		3.00	4.00	-
Does this facility contain a provi								
or charges? Enter "Y" for yes or ' 5.00 Hospi tal	'N" for no for each	componen	<u>it for Part A</u> N	and Part N	B. (See	<u>e 42 CFR §413</u> N	8. 13) N	155.
6. 00 Subprovi der – TPF			N	N N		N	N	155.
7.00 Subprovider - IRF			Ν	N		Ν	N	157.
8. 00 SUBPROVI DER			N			N	N	158.
59.00 SNF 50.00 HOME_HEALTH_AGENCY			N N	N N		N N	N N	159. 160.
01. 00 CMHC				N		N	N	161.
							1.00	-
Multicampus						0004-0	N	1/5
55.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	ampus hospital that	has one o	or more camp	uses in dif	rferent	CBSAS?	N	165.0
	Name		County	State	Zip Co		FTE/Campus	
	0		1.00	2.00	3.00	9 4.00	5.00	00 166.
56.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)							0.0	
							1.00	
Health Information Technology (HI 7.00 Is this provider a meaningful user 8.00 If this provider is a CAH (line 10	under §1886(n)?	Enter "Y"	for yes or '	"N" for no.			Y	167. 168.
reasonable cost incurred for the H 8.01 If this provider is a CAH and is r	IT assets (see ins	tructions)	)				N	168.
exception under §413.70(a)(6)(ii)? 9.00lf this provider is a meaningful u	? Enter "Y" for yes user (line 167 is "'	or "N" fo	or no. (see i	instructior	ıs)	•		00169.
transition factor. (see instruction	ons)					Begi nni ng	Endi ng	
0.00 Enter in columns 1 and 2 the EHR k	beginning date and	ending da	te for the re	eporting		1.00	2.00	170.
period respectively (mm/dd/yyyy)		3						
					-			
/1.00 If line 167 is "Y", does this prov						1.00	2.00	0171.

IUSPI I	Financial Systems ASCENSION ST. VINC AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNALRE			Period:	u of Form CMS- Worksheet S-2	
			F	From 07/01/2021 To 06/30/2022	Part II	
					11/28/2022 9:	
				Y/N	Date	
	General Instruction: Enter Y for all YES responses. Enter M	for all NO re	sponses Enter	<u> </u>	2.00 the	
	mm/dd/yyyy format.		Sponses. Enter			
	COMPLETED BY ALL HOSPITALS					
00	Provider Organization and Operation	. hanimine of	4b+	N		1 1 0
. 00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in o			N		1.0
	reporting period. In yes, enter the date of the change in t	501 dilli1 2. (300	Y/N	Date	V/I	
			1.00	2.00	3.00	
. 00	Has the provider terminated participation in the Medicare F	5	N			2.0
	yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.	III 3, V TOP				
. 00	Is the provider involved in business transactions, includir	ng management	N			3.0
	contracts, with individuals or entities (e.g., chain home of					
	or medical supply companies) that are related to the provid					
	officers, medical staff, management personnel, or members of directors through ownership, control, or family and other					
	relationships? (see instructions)	a similar				
			Y/N	Туре	Date	
			1.00	2.00	3.00	
. 00	Financial Data and Reports Column 1: Were the financial statements prepared by a Cert	ified Public	N			4.0
. 00	Accountant? Column 2: If yes, enter "A" for Audited, "C" f					4.0
	or "R" for Reviewed. Submit complete copy or enter date ava					
- 00	column 3. (see instructions) If no, see instructions.		N			
5.00	Are the cost report total expenses and total revenues different those on the filed financial statements? If yes, submit reconcisional statements of the statement of the stateme		N			5.0
				Y/N	Legal Oper.	
				1.00	2.00	
0.0	Approved Educational Activities	0.16				
b. 00	Column 1: Are costs claimed for a nursing program? Column is the legal operator of the program?	2: IT yes, Is	s the provider	N		6.0
. 00	Are costs claimed for Allied Health Programs? If "Y" see in	nstructions.		N		7.0
3.00	Were nursing programs and/or allied health programs approve		wed during the	N		8.0
	cost reporting period? If yes, see instructions.					
9.00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction	0	cal education	N		9.0
0.00	Was an approved Intern and Resident GME program initiated of		the current	Ν		10.0
	cost reporting period? If yes, see instructions.					
1.00	Are GME cost directly assigned to cost centers other than I	& R in an App	proved	N		11.0
	Teaching Program on Worksheet A? If yes, see instructions.				Y/N	
					1.00	
	Bad Debts				1	
	Is the provider seeking reimbursement for bad debts? If yes				Y	12.0
3.00	If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.	olicy change o	during this cos	st reporting	N	13.0
	If line 12 is yes, were patient deductibles and/or co-payme	ents waived? If	°ves, see inst	tructions.	N	14.0
4.00	Bed Complement					
4.00		ng period? If			N	15.0
	Did total beds available change from the prior cost reporti			Par	T B	
	Did total beds available change from the prior cost reporti	Par	1			
	Und total beds available change from the prior cost reportion	Y/N	Date	Y/N	Date 4 00	
	PS&R Data		1		4. 00	
5.00	PS&R Data Was the cost report prepared using the PS&R Report only?	Y/N	Date	Y/N		16.0
5.00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through	Y/N 1.00	Date 2.00	Y/N 3.00	4.00	16. 0
5.00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see	Y/N 1.00	Date 2.00	Y/N 3.00	4.00	16.0
5.00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y/N 1.00	Date 2.00	Y/N 3.00	4.00	
5.00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If	Y/N 1.00 Y	Date 2.00	Y/N 3.00 Y	4.00	
5.00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Y/N 1.00 Y	Date 2.00	Y/N 3.00 Y	4.00	
5. 00 6. 00 7. 00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y/N 1.00 Y N	Date 2.00	Y/N 3.00 Y N	4.00	17. C
5. 00 6. 00 7. 00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R	Y/N 1.00 Y	Date 2.00	Y/N 3.00 Y	4.00	17. 0
6. 00 7. 00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y/N 1.00 Y N	Date 2.00	Y/N 3.00 Y N	4.00	17. 0
15.00 16.00 17.00 18.00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	Y/N 1.00 Y N N	Date 2.00	Y/N 3.00 Y N N	4.00	16. 0 17. 0 18. 0
15. 00 16. 00 17. 00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	Y/N 1.00 Y N	Date 2.00	Y/N 3.00 Y N	4.00	17. 0

ASCENSI ON	ST.	VI NCENT	WI LLI AMSPORT

Heal th	Financial Systems ASCENSION ST. VINC	CENT WILLIAMSPO	JR I	In Lie	u of Form CMS	5-2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	1	Period: From 07/01/2021 Fo 06/30/2022	Worksheet S Part II Date/Time P 11/28/2022	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:			N	Ν	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
				-	1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	EPT CHILDRENS H	HOSPI TALS)			
	Capital Related Cost					
	Have assets been relifed for Medicare purposes? If yes, see				Ν	22.00
23.00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	due to apprais	sals made durir	ng the cost	N	23.00
24.00	Were new leases and/or amendments to existing leases enterous If yes, see instructions	orting period?	Ν	24.00		
25.00	Have there been new capitalized leases entered into during instructions.	the cost repo	rting period? I	f yes, see	Ν	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the instructions.	yes, see	Ν	26.00		
27.00	Has the provider's capitalization policy changed during the copy.	yes, submit	Ν	27.00		
	Interest Expense			l		
28.00	Were new loans, mortgage agreements or letters of credit en period? If yes, see instructions.	ntered into du	ring the cost r	reporting	N	28.00
29.00	Did the provider have a funded depreciation account and/or		ebt Service Res	serve Fund)	Ν	29.00
30.00	treated as a funded depreciation account? If yes, see inst Has existing debt been replaced prior to its scheduled mate		debt? If yes,	see	Ν	30.00
31.00	instructions. Has debt been recalled before scheduled maturity without is	ssuance of new	debt? If yes,	see	Ν	31.00
	i nstructi ons. Purchased Servi ces					_
32.00	Have changes or new agreements occurred in patient care se	rvi ces furni she	ed through cont	tractual	N	32.00
33, 00	arrangements with suppliers of services? If yes, see instru If line 32 is yes, were the requirements of Sec. 2135.2 ap		na to competiti	ve biddina? If	Ν	33.00
	no, see instructions.		5	Jan 199		_
24 00	Provider-Based Physicians Are services furnished at the provider facility under an a	rrangement with	h providor base	od physicians?	Y	34.00
34.00	If yes, see instructions.	rrangement with		eu physicians?	T	34.00
35.00	If line 34 is yes, were there new agreements or amended exi physicians during the cost reporting period? If yes, see in		nts with the pr	rovi der-based	Y	35.00
	physicians during the cost reporting period: in yes, see in	instructions.		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	repared by the	home office?	Y		37.00
38. 00	If yes, see instructions. If line 36 is yes , was the fiscal year end of the home of	fice different	from that of	N		38.00
	the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe	d of the home o	offi ce.	N		39.00
40.00	see instructions. If line 36 is yes, did the provider render services to the	home office?	lf ves. see	N		40.00
	instructions.	1				
		1.	. 00	2.	00	
	Cost Report Preparer Contact Information					_
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	JILL		HILL		41.00
42.00	respectively. Enter the employer/company name of the cost report	ASCENSI ON				42.00
	preparer.					
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	NA		JI LL. HI LL1@ASCE	ENSI ON. ORG	43.00

Heal th	Financial Systems	VI NCEN	WILLI AMSPOI	RT	In Lieu of Form CMS-2552-			
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE			Provider CC		Period: From 07/01/2021	Worksheet S-2 Part II		
						To 06/30/2022	Date/Time Pre 11/28/2022 9:	58 am
				3.	00			
	Cost Report Preparer Contact Informatior	1						
41.00	Enter the first name, last name and the	title/position	REI	MBURSEMENT !	MANAGER			41.00
	held by the cost report preparer in colu	umns 1, 2, and	3,					
	respecti vel y.							
42.00	Enter the employer/company name of the c	cost report						42.00
	preparer.							
43.00	Enter the telephone number and email add	ress of the co	st					43.00
	report preparer in columns 1 and 2, resp	oecti vel y.						

<sup>11/28/2022 9:58</sup> am Y: \28950 - St. Vincent Williamsport Hospital \300 - Medicare Cost Report \20220630 \HFS \20220630 Williamsport.mcr

		ENSION ST. VINCE				eu of Form CMS-2	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	AL DATA	Provider CC	CN: 15-1307	Period: From 07/01/2021 To 06/30/2022	Worksheet S-3 Part I Date/Time Prep 11/28/2022 9:5	
	Company	Waskabaat A	No. of Dodo	Ded Davia		I/P Days / O/P Visits / Trips Title V	
	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAR HOULS	nite v	
		1.00	2.00	3.00	4.00	5.00	
1.00 2.00 3.00 4.00	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 HMO IRF Subprovider	30. 00	16	5, 84	40 34, 368. 00		1.00 2.00 3.00 4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 7.00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions)		16	5, 84	40 34, 368. 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	INTENSIVE 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 - IRF SUBPROVIDER	43. 00	16	5, 84	40 34, 368. 00	0 0 0	8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00
$\begin{array}{c} 19.\ 00\\ 20.\ 00\\ 21.\ 00\\ 22.\ 00\\ 23.\ 00\\ 24.\ 10\\ 25.\ 00\\ 26.\ 01\\ 26.\ 01\\ 26.\ 25\\ 27.\ 00\\ 28.\ 00\\ 29.\ 00\\ 30.\ 00\\ 31.\ 00\\ 32.\ 01\\ \end{array}$	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 RURAL HEALTH CLINIC II 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 88. 01 89. 00	16 0		0	0 0 0	$\begin{array}{c} 19.\ 00\\ 20.\ 00\\ 21.\ 00\\ 22.\ 00\\ 23.\ 00\\ 24.\ 00\\ 24.\ 10\\ 25.\ 00\\ 26.\ 01\\ 26.\ 25\\ 27.\ 00\\ 28.\ 00\\ 29.\ 00\\ 30.\ 00\\ 31.\ 00\\ 32.\ 01\\ \end{array}$
33. 00 33. 01	LTCH non-covered days LTCH site neutral days and discharges						33. 00 33. 01

11/28/2022 9:58 am Y: \28950 - St. Vincent Williamsport Hospital \300 - Medicare Cost Report \20220630 \HFS \20220630 Williamsport.mcr

103F1	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	STI CAL DATA Provi der CCN: 15-1307		CN: 15-1307		eriod: fom 07/01/2021 0 06/30/2022	Worksheet S-3 Part I Date/Time Pre 11/28/2022 9:	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)	805	19	1, 43	32			1.00
2.00	HMO and other (see instructions)	337	67					2.00
3.00	HMO IPF Subprovider	0	0					3.00
4.00	HMO I RF Subprovider	0	0					4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	410	0	47				5.00
5.00	Hospital Adults & Peds. Swing Bed NF	1 015	0	1 00	0			6.00
7.00 3.00	Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT	1, 215	19	1, 90	5			7.00 8.00
9.00 9.00	CORONARY CARE UNIT							9.00
10.00	BURN INTENSIVE CARE UNIT							10.00
11.00	SURGI CAL I NTENSI VE CARE UNI T							11.00
12.00	OTHER SPECIAL CARE (SPECIFY)							12.00
13.00	NURSERY		0		0			13.00
14.00	Total (see instructions)	1, 215	19	1, 90	03	0.00	69.70	14.00
15.00	CAH visits	7, 533	476	25, 33	31			15.00
16.00	SUBPROVIDER - IPF							16.00
17.00	SUBPROVIDER - IRF							17.00
18.00	SUBPROVIDER							18.00
19.00	SKILLED NURSING FACILITY							19.00
20.00	NURSING FACILITY							20.00
21.00	OTHER LONG TERM CARE							21.00 22.00
22.00 23.00	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P. )							22.00
24.00	HOSPICE							23.00
24.10	HOSPICE (non-distinct part)				0			24.00
25.00	CMHC - CMHC				Ŭ			25.00
26.00	RURAL HEALTH CLINIC	1, 294	117	7,49	71	0.00	11.56	
26. 01	RURAL HEALTH CLINIC II	3, 490	186	15, 38		0.00	18.57	26.01
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)					0.00	99.83	27.00
28.00	Observation Bed Days		0	84	43			28.00
29.00	Ambul ance Trips	505						29.00
30.00	Employee discount days (see instruction)				6			30.00
31.00	Employee discount days - IRF				0			31.00
32.00	Labor & delivery days (see instructions)	0	0		0			32.00
32.01	Total ancillary labor & delivery room				0			32.01
	outpatient days (see instructions)							
33.00	LTCH non-covered days	0						33.00

	Financial Systems ASCE ASCE ASCE ASCE ASCE ASCE ASCE ASCE	INSION ST. VINCEN AL DATA	Provider CO		Period: From 07/01/2021 To 06/30/2022	u of Form CMS-2 Worksheet S-3 Part I Date/Time Pre 11/28/2022 9:	pared:
		Full Time Equivalents		Di s	charges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 23.\ 00\\ 24.\ 00\\ 23.\ 00\\ 24.\$	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 SNF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE 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 - IRF SUBPROVIDER - IRF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P. ) HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC II FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction)	0.00	<u>    12.00      0</u> 0	1	97 10 65 16 0 97 10	<u>15.00</u> 337 337	$\begin{array}{c} 1.\ 00\\ \hline \\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ \hline \\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 20.\ 00\\ 21.\ 00\\ 22.\ 00\\ 23.\ 00\\ 24.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 27.\ 00\\ 28.\ 00\\ 29.\ 00\\ 30.\ 00\\ \end{array}$
31.00 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. 00 32. 00 32. 01 33. 00 33. 01

Heal th	Financial Systems ASCE	NSION ST. VINC	ENT WILLIAMSPO	RT	In Lie	eu of Form CMS-2	2552-10
	AL-BASED RHC/FQHC STATISTICAL DATA		Provider C		Period:	Worksheet S-8	
			Component (	CCN: 15-3993	From 07/01/2021 To 06/30/2022	Date/Time Pre 11/28/2022 9:	
					RHC I	Cost	
					1	00	-
	Clinic Address and Identification					00	
1.00	Street				1731 RINGER LA	NE	1.00
				ty	State	ZIP Code	
				00	2.00	3.00	
2.00	City, State, ZIP Code, County		WI LLI AMSPORT	-	I N	47993	2.00
						1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Ente	er "R" for rura	l or "U" for u	irban		0	3.00
					nt Award	Date	
	Source of Federal Funds				1.00	2.00	
4.00	Community Health Center (Section 330(d), PHS	Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Ac						5.00
6.00	Health Services for the Homeless (Section 340	(d), PHS Act)					6.00
7.00	Appalachian Regional Commission						7.00
8.00 9.00							8.00 9.00
9.00 9.01	OTHER (SPECI FY)						9.00
9.02							9.02
9.03							9.03
9.04							9.04
9.05							9.05
9.06							9.06
9.07 9.08							9. 07 9. 08
9.00							9.00
9.10							9.10
10.00	Does this facility operate as other than a ho	cnital bacod P	UC or EOUC2 En	tor "V" for	1.00 N	2.00	10.00
10.00	yes or "N" for no in column 1. If yes, indica 2. (Enter in subscripts of line 11 the type of hours.)	ite number of o	ther operation	s in column	N		10.00
		Sun	day	N	londay	Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
11 00	Facility hours of operations (1) CLINIC			07:00	19:00	07:00	11.00
11.00				07.00	19.00	07.00	11.00
					1.00	2.00	
	Have you received an approval for an exception		2		Y	_	12.00
13.00	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colu number of providers included in this report. numbers below.	ımn 1. lfyes,	enter in colum	in 2 the	N	0	13.00
					ider name	CCN number	
14.00					1.00	2.00	14.00
14.00	RHC/FQHC name, CCN number	Y/N	V	XVIII	XIX	Total Visits	14.00
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all						15.00
	GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						
		I			1	1	

Health Financial Systems AS	CENSION ST. VIN	CENT WILLIAMSPO	DRT	In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider C	CN: 15-1307	Peri od:	Worksheet S-8	3
		Component	CCN: 15-3993	From 07/01/2021 To 06/30/2022	Date/Time Pre 11/28/2022 9:	epared: 58 am
				RHC I	Cost	
		Cou	unty			
		4.	.00			
2.00 City, State, ZIP Code, County		WARREN				2.00
	Tuesday	Wedn	esday	Thur	sday	
	to	from	to	from	to	
	6.00	7.00	8.00	9.00	10.00	
Facility hours of operations (1)						
11.00 CLINIC	19: 00	07:00	19:00	07:00	19: 00	11.00
	Fri	i day	Sa	turday		
	from	to	from	to		
	11.00	12.00	13.00	14.00		
Facility hours of operations (1)						
11.00 CLINIC	07:00	19:00				11.00

<sup>11/28/2022 9:58</sup> am Y: \28950 - St. Vincent Williamsport Hospital \300 - Medicare Cost Report \20220630 \HFS \20220630 Williamsport.mcr

Heal th	Financial Systems ASCE	NSION ST. VIN	CENT WILLIAMSPO	RT	In Lie	eu of Form CMS-2	2552-10
	AL-BASED RHC/FQHC STATISTICAL DATA		Provi der C		Period:	Worksheet S-8	
			Component	CCN: 15-3994	From 07/01/2021 To 06/30/2022	Date/Time Pre 11/28/2022 9:	
					RHC II	Cost	
					1.	00	
	Clinic Address and Identification						
1.00	Street		Ci	ty	440 W. SONGER State	LANE ZIP Code	1.00
				00	2.00	3.00	
2.00	City, State, ZIP Code, County		VEEDERSBURG			47987	2.00
						1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Ente	er "R" for rur	al or "U" for u	ırban		0	3.00
	· · · · · · · · · · · · · · · · · · ·			Gra	nt Award	Date	
	Source of Federal Funds				1.00	2.00	
4.00	Community Health Center (Section 330(d), PHS	Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Ac						5.00
6.00	Health Services for the Homeless (Section 340	(d), PHS Act)					6.00
7.00	Appal achi an Regional Commission						7.00
8.00 9.00	Look-Alikes OTHER (SPECIFY)						8.00 9.00
9.01							9.01
9.02							9.02
9.03							9.03
9.04							9.04
9.05 9.06							9.05 9.06
9.00							9.00
9.08							9.08
9.09							9.09
9.10							9.10
					1.00	2.00	
10. 00	Does this facility operate as other than a horyes or "N" for no in column 1. If yes, indica 2. (Enter in subscripts of line 11 the type of hours.)	ite number of	other operation	ns in column	N	0	10.00
		Sur	nday	N	londay	Tuesday	
		from	to	from	to	from	
	Facility hours of operations (1)	1.00	2.00	3.00	4.00	5.00	
11.00	CLINIC			07:00	17: 50	07:00	11.00
	•			•			
12.00	Have you reactived on entroyed for an eventia	n to the prod	uativity atonda	and 2	1.00	2.00	12.00
12.00 13.00	Have you received an approval for an exception is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colu number of providers included in this report. numbers below.	in CMS Pub. umn 1. If yes,	100-04, chapter enter in colum	9, section n 2 the	Y N	0	12.00 13.00
					ider name	CCN number	
14.00	RHC/FQHC name, CCN number				1.00	2.00	14.00
14.00	מתלרעתל המווופ, כנוא העוווספר	Y/N	V	XVIII	XIX	Total Visits	14.00
		1.00	2.00	3.00	4.00	5. 00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00
	'					·	

Health Financial Systems AS	CENSION ST. VINC	CENT WILLIAMSP	ORT	In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der	CCN: 15-1307	Peri od:	Worksheet S-8	3
		Component	CCN: 15-3994	From 07/01/2021 To 06/30/2022	Date/Time Pre 11/28/2022 9:	epared: 58 am
		_		RHC II	Cost	
		Co	unty			
		4	. 00			
2.00 City, State, ZIP Code, County		FOUNTAI N				2.00
	Tuesday	Wed	nesday	Thur	sday	
	to	from	to	from	to	
	6.00	7.00	8.00	9.00	10.00	
Facility hours of operations (1)						
11.00 CLINIC	17:50	07:00	17:50	07:00	17: 50	11.00
	Fri	day	Sa	iturday		
	from	to	from	to		
	11.00	12.00	13.00	14.00		
Facility hours of operations (1)						
11.00 CLINIC	07:00	17: 50				11.00

<sup>11/28/2022 9:58</sup> am Y: \28950 - St. Vincent Williamsport Hospital \300 - Medicare Cost Report \20220630 \HFS \20220630 Williamsport.mcr

Medicaid (see instructions for each line)         1.00337         2.00           Note revenue from Medicaid         1.00337         2.00         3.00         1.00337         2.00         3.00         1.00337         2.00         3.00         1.00337         3.00         1.00337         3.00         3.00         1.00337         3.00         3.00         1.00337         3.00         3.00         0.00         1.00337         3.00         3.00         0.00         1.00337         3.00         0.00         1.00337         3.00         0.00         1.00337         3.00         1.00337         3.00         1.00337         3.00         1.00337         3.00         1.00337         3.00         0.00         1.00337         3.00         0.00         1.00337         1.00337         0.00         1.00337         1.00337         0.00         1.00337         1.00337         0.00         1.00337         1.00337         0.00         1.00337         1.00337         1.000         1.00337         1.00337         1.00337         1.00337         1.000         1.000         1.000         1.000         1.000         1.000         1.000         1.000         1.000         1.000         1.000         1.000         1.000         1.000         1.000         1.000	Heal th	Financial Systems ASCENSION ST. VINCENT V			In Lie	eu of Form CMS-	2552-10				
To         06/30/2022         Date/Time Properated 11/28/2022 v 5:8 and 1.00           0         Cost to charge ratio (Merksheet C, Part I line 202 column 3 divided by line 202 column 8)         0.295628           1.00         State Charge ratio (Merksheet C, Part I line 202 column 3 divided by line 202 column 8)         0.295628           2.00         Not revenue from Medicaid         1.00         3.00           3.00         Did you receive DSH or supplemental payments from Medicaid         1.00, 3.37         2.00           4.00         If line 3 is yes, does line 2 include all DSH and/or supplements from Medicaid         1.00, 4.00         5.00           6.00         Medicaid charges         1.00         5.00         6.00         4.00           6.00         Difference between netter DSH and/or supplements from Medicaid         1.00         5.00         9.00           0.01         Difference between netter zero)         0.00         5.00         9.00         0.00           0.01         Stand-alone CHP Corgram (CHIP) (see Instructions for each line)         0.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00	HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	rovider CCN	l: 15-1307		Worksheet S-1	0				
Uncompensated and indigent care cost computation         Incompensated and indigent care cost computation           10         Cost to charge ratio (Worksheet C, Part I line 202 colum 3 divided by line 202 colum 8)         0.295628         1.00           10         Cost to charge ratio (Worksheet C, Part I line 202 colum 3 divided by line 202 colum 8)         0.295628         1.00           10         Vour receive DSM or supplemental payments from Medicaid?         N         3.00         0.00           10         If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?         N         4.00           5.00         If line 4 is no, then enter DSH and/or supplemental payments from Medicaid?         N         4.04           6.00         Modicai charges         1.00         5.00         5.70         1.60           7.00         Difference bateen net revenue and costs for Medicaid program (Line 7 minus sum of lines 2 and 5; if 3.641,242         8.00           6.2         Core Uhen enter zero)         0         0         0.00           10.00         Stand-alone CHP coreuse trans attand-alone CHP core cost (line 11 mes line 10)         0         11.00           12.00         Difference bateen net revenue and costs for state or local indigent care program (Not include in lines 6 or 10)         0         13.00           10.00         Stand-alone CHP core or cost (line 1 time 1											
1.00       Cost to charge ratio (Morksheet C, Part 1 line 202 colum 3 divided by line 202 colum 8)       0.025628       1.00         2.00       Net revenue from Medicaid       1,003,37       2.00         3.00       Did you receive DSK       1,003,37       2.00         4.00       If i line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid       1,003,37       2.00         6.00       Modicaid cost (line 1 times line 6)       1,003,37       2.00       1,003,37       2.00         6.00       Modicaid cost (line 1 times line 6)       1,001,37       2.00       1,001,37       2.00         6.00       Modicaid cost (line 1 times line 6)       1,001,37       2.00       1,001,37       2.00         6.00       Difference between net revenue and costs for Medicaid Program (line 7 minus sum of lines 2 and 5: if 3,041,242       8.00       1.00         7.00       Stand-alone CHP cost (line 1 times line 10)       0       0.00       1.00       0.00       1.0						1.00					
Medical (see instructions for each line)         1,003,33         2.00           Note revenue from Medicald         1,003,03         0.00         1,103,33         2.00         3.00           10 If Jine 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicald?         N         3.00         0.00		Uncompensated and indigent care cost computation				1					
2.00       Net revenue from Medicaid       1,003,337       2.00         3.00       Did you receive DSH or supplements prom Medicaid?       1,003,337       2.00         4.00       If line 3 is sy, does line 2 include all DSH and/or supplemental payments from Medicaid?       1,003,337       2.00         6.00       Medicaid cost (line 1 times line 6)       5.00       16 line 4 is no, then enter DSH and/or supplemental payments from Medicaid       0,00       4.644,577       7.00         6.00       Medicaid cost (line 1 times line 6)       5.00       16 line 4 is no, then enter DSH and/or supplemental payments from Medicaid?       3.641,242       8.00         9.00       Medicaid cost (line 1 times line 10)       3.641,242       8.00       9.00       1.005       3.641,242       8.00       9.00         9.00       Stand-alone CHP cost (line 1 times line 10)       0.00       1.000       9.00       9.00       9.00       9.00       1.000	1.00		ded by line	e 202 column	8)	0. 295628	1.00				
3.00       Did you receive DSH or supplemental payments from Medical d?       N       3.00         0.01       Filine 3 is yes, des line 2 include all DSH and/or supplemental payments from Medicaid       N       4.00         5.00       If line 4 is no, then enter DSH and/or supplemental payments from Medicaid       N       4.00         5.00       Medicaid charges       If line 4 is no, then enter DSH and/or supplemental payments from Medicaid       0       5.00         0.00       Medicaid charges       If line 4 is no, then enter DSH and/or supplemental payments from Medicaid       15.710.886 4.00         0.00       Bit frame battween ent revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if       0       0,00         0.01       Net revenue from stand-al one CHP       0       9,00         0.00       Stand-al one CHP cost (line 1 times line 10)       0       12.00         0.01       Difference battween ent revenue and costs for stand-al one CHP (line 11 minus line 9; if < zero then						1 000 007					
4.00       If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?       4.00         5.00       If line 4 is no, then enter DSH and/or supplemental payments from Medicaid       5.00         6.00       Medicaid cost (line 1 times line 6)       5.00         8.00       Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if 3, 641, 242       8.00         9.00       Net revenue from stand-alone CHP       0       9.00         10.00       Stand-alone CHP cost (line 1 times line 10)       0       10.00       0       0         12.00       Difference between net revenue and costs for stand-alone CHP cost (line 1 times line 10)       0       11.00       0       11.00         12.00       Difference between the revenue and costs for stand-alone CHP cost (line 1 times line 10)       0       13.00         13.00       Net revenue from state or local indigent care program (ket included on lines 2, 5 or 9)       0       13.00         14.00       Charges for patients covered under state or local indigent care program (ket included in lines 3.00       14.00       15.00         15.00       Difference between net revenue and costs for state or local indigent care programs (sum of lines 3.00       0       16.00         16.00       Difference between net revenue and costs for state or local indigent care programs (sum of lines 3.00       <											
5.00       If line 4 is no, then enter DSH and/or supplemental payments from Medical d       0       5.00         6.00       Medicaid cost (line 1 times line 6)       5.00         7.00       Medicaid cost (line 1 times line 6)       3.641,242         8.00       Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5: if 3.641,242       8.00         9.00       Net revenue from stand-alone CHP (line 11 times line 10)       0       9.00         10.00       Stand-alone CHP cost (line 1 times line 10)       0       11.00         11.00       Stand-alone CHP cost (line 1 times line 10)       0       12.00         0.00       Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)       0       13.00         13.00       Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)       0       14.00         16.00       Difference between net revenue and costs for state or local indigent care program (line 15 minus line 0       0       16.00         10.01       State or local indigent care program cost (line 1 times line 14)       0       15.00       16.00         10.02       Difference between net revenue and costs for Medicaid, CHP and state/local indigent care programs (sum of lines 0       16.00         10.03       State or local indigent care program for abital unreimbursed cost fo											
6.00       Medicaid charges       15,710,889       6.00         7.00       Medicaid cost (line 1 times line 6)       4.644,579       7.00         8.00       Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5: 1f       3.641,242         8.00       Stand-alone CHIP charges       0       0         10.00       Stand-alone CHIP cost (line 1 times line 10)       0       10.00         12.00       Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)				IT OIL WELLCE	in u :	0	•				
7.00       Wedicald cost f(ine 1 times line 6)       4.644,579       7.00         8.00       Difference between net revenue and costs for Medical program (line 7 minus sum of lines 2 and 5; if       3.641,242       8.00         9.00       Net revenue from stand-al one CHIP       0       9.00       0       9.00         10.00       Stand-alone CHIP Cost (line 1 times line 10)       0       1.00       9.00       0 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td>-</td> <td>•</td>						-	•				
< zero them enter zero)		5					•				
Children's Health Insurance Program (CHIP) (see instructions for each Line) <ul> <li>Children's Health Insurance Program (CHIP) (see instructions for each Line)</li> <li>Stand-alone CHIP cost (Line 1 times Line 10)</li> <li>Stand-alone CHIP cost (Line 1 times Line 10)</li> <li>Other state or local indigent care program (see instructions for each Line)</li> <li>Other state or local indigent care program (Not included on Lines 2, 5 or 9)</li> <li>Other state or local indigent care program (Not included on Lines 2, 5 or 9)</li> <li>Other state or local indigent care program (Not included on Lines 2, 5 or 9)</li> <li>Other state or local indigent care program (Not included in Lines 6 or 10)</li> <li>Other state or local indigent care program (Not included in Lines 6 or 10)</li> <li>Other state or local indigent care program (Not included in Lines 6 or 10)</li> <li>Other care the enter zero)</li> <li>Corrants, donations, or endownent income restricted to funding charity care</li> <li>Other grants, appropriations or transfers for support of hospital operations</li> <li>Other year ents, donations, or endownent income restricted to funding charity care</li> <li>Otal (col 1, 20)</li> <li>Otal (col 1, 20)</li> <li>Otal (col 1, 20)</li> <li>Otal (col 2, 21)</li> <li>Otal (col 2, 21)</li> <li>Otal (col 2, 30)</li> <li>Otal (col 2, 30)</li> <li>Otal (col 2, 30)</li></ul>	8.00	Difference between net revenue and costs for Medicaid program (	ine 7 minus	s sum of lir	es 2 and 5; if	3, 641, 242	8.00				
9.00       Net revenue from stand-al one CHIP (charges       0       9.00       0		< zero then enter zero)									
10. 00       Stand-allone CHIP charges       0       10. 00         10. 00       Difference between net revenue and costs for stand-allone CHIP (line 11 minus line 9; if < zero then included on lines 2, 5 or 9)			each line)	)		-					
11.00       Stand-atone CHIP cost (line 1 times line 10)       0       11.00       0         12.00       Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)											
12.00       Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then of the state or local indigent care program (see instructions for each line)		8				-					
enter zero)       0         01.00       Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)       0         13.00       Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)       0       13.00         14.00       Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)       0       14.00         15.00       State or local indigent care program cost (line 1 times line 14)       0       0       0         16.00       Difference between net revenue and costs for state or local indigent care program (line 15 minus line 0       0       16.00         01       Gorants, donations, and total unreinbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)       0       17.00         17.00       Private grants, appropriations or transfers for support of hospital operations       0       18.00         19.00       Total unreinbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 3, 641, 242       19.00         19.00       Cost of patients appropriations or transfers for support of hospital operations       0       0       16.00         10.00       Cost of patients approved for charity care and uninsured discounts (see 11/2, 973, 566       387, 230       1, 120, 795       20.00         21.00       Cost of patients approved for c			ine 11 min	ıs line Q∙i	f < zero then	-	•				
Other state or local government indigent care program (see instructions for each line)         13.00           13.00         Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)         0         13.00           14.00         Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)         0         14.00           15.00         State or local indigent care program cost (line 1 times line 14)         0         15.00           16.00         Difference between net revenue and costs for state or local indigent care program (line 15 minus line)         0           17.00         Private grants, donations, or endowment income restricted to funding charity care         0         17.00           18.00         Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (see instructions for each line)         0         18.00           19.00         Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 3, 641, 242         19.00           19.00         Total unreimbursed care (see instructions for each line)         1.00         2.00         3.00           10.00         Covernment grants appropriet discounts for the entire facility (see instructions)         1.10,2,795         20.00           21.00         Cost of patients approved for charity care and uninsured discounts (see instructions)         1.00         20,00	12.00					0	12.00				
14.00       Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)       0       14.00         15.00       State or local indigent care program cost (line 1 times line 14)       0       15.00         16.00       Difference between net revenue and costs for state or local indigent care program (line 15 minus line 10)       0       15.00         17.00       Private grants, donations, or endowment income restricted to funding charity care       0       0         18.00       Forwards, approximations or transfers for support of hospital operations       0       18.00         19.00       Total unrelmbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 3, 641, 242       19.00         19.00       Total unrelmbursed care (see instructions for each line)       1.00       2.00       3.00         20.00       Charity care charges and uninsured discounts for the entire facility (see instructions)       1.00       2.00       3.00         21.00       Cost of patients approved for charity care and uninsured discounts (see instructions)       1.00       2.00 <td< td=""><td></td><td></td><td>ructions for</td><td><sup>-</sup> each line)</td><td></td><td></td><td></td></td<>			ructions for	<sup>-</sup> each line)							
10)       10.0       15.00       State or local indigent care program cost (line 1 times line 14)       0       15.00       15.00         16.00       Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13, if < zero then enter zero)	13.00					0	13.00				
15.00       State or local indigent care program cost (line 1 times line 14)       0       15.00         16.00       Difference between net revenue and costs for state or local indigent care program (line 15 minus line       0         13. if < zero then enter zero)	14.00		program (No	ot included	in lines 6 or	0	14.00				
16.00       Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	45 00						45.00				
13: If < zero then enter zero)				arogram (lir	o 15 minus lino						
Instructions and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)       0       17.00       Private grants, donations, or endowment income restricted to funding charity care       0       17.00         18.00       Government grants, appropriations or transfers for support of hospital operations       0       18.00       3, 641, 242       19.00         19.00       Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines       3, 641, 242       19.00         19.00       Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines       3, 641, 242       19.00         20.01       Uncompensated Care (see instructions for each line)       0       1.00       2.00       3.00         20.02       Charity care charges and uninsured discounts for the entire facility (see instructions)       733, 565       387, 230       604, 092       21.00         21.00       Cost of patients approved for charity care and uninsured discounts (see instructions)       216, 862       387, 230       604, 092       21.00         22.00       Payments received from patients for amounts previously written off as 0       0       0       22.00       22.00         23.00       Cost of charity care (line 21 minus line 22)       216, 862       387, 230       604, 092       23.00	10.00		yent care p	Jiogram (TT		0	10.00				
17.00       Private grants, donations, or endowment income restricted to funding charity care       0       17.00         18.00       Government grants, appropriations or transfers for support of hospital operations       0       0       18.00         19.00       Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines       3, 641, 242       19.00         19.00       Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines       Total (col 1       + col 2)         10.00       2.00       3, 00       Total (col 1       + col 2)       1.00       2.00       3, 00         20.00       Charity care charges and uninsured discounts for the entire facility (see instructions)       Total (col 1       + col 2)       1.10       2.00 <td></td> <td></td> <td>o and state</td> <td>/local indic</td> <td>ent care progra</td> <td>ms (see</td> <td></td>			o and state	/local indic	ent care progra	ms (see					
18.00       Government grants, appropriations or transfers for support of hospital operations       0       18.00         19.00       Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines)       3,641,242       19.00         10.00       10.00       2.00       3.00       3.00         10.00       Charity care charges and uninsured discounts for the entire facility (see instructions)       733,565       387,230       1,120,795       20.00         21.00       Cost of patients approved for charity care and uninsured discounts (see instructions)       216,862       387,230       0       22.00         22.00       Payments received from patients for amounts previously written off as charity care       0       0       22.00       23.00         24.00       Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit inposed on patients covered by Medicaid or other indigent care program?       1.00       23.00       25.00         25.00       Total acet reimbursable bad debts for the entire hospital complex (see instructions)       1.597,543       26.00         27.00       Medicare reimbursable bad debts for the entire hospital complex (see instructions)       1.597,543       26.00         26.00       Total acet bad debt expense (see instructions)       1.597,543       26.00       23.00       25.00											
19.00       Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 641, 242       19.00         8, 12 and 16)       Uninsured patients       Insured patients       Total (col. 1)         20.00       2.00       3.00		0	0	2							
8, 12 and 16)       Uninsured patients       Insured patients       Total (col. 1 et al. 0         20.00       Charity care charges and uninsured discounts for the entire facility (see instructions)       733,565       387,230       1,120,795       20.00         21.00       Cost of patients approved for charity care and uninsured discounts (see instructions)       216,862       387,230       604,092       21.00         22.00       Payments received from patients for amounts previously written off as charity care       0       0       0       22.00         23.00       Cost of charity care (line 21 minus line 22)       216,862       387,230       604,092       23.00         24.00       Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?       1.00       24.00         25.00       If line 24 is yes, enter the charges for patient days beyond the indigent care program?       1,597,543       26.00         27.01       Medicare reimbursable bad debts for the entire hospital complex (see instructions)       1,597,543       26.00         27.01       Medicare allowable bad debts for the entire hospital complex (see instructions)       339,863       27.00         28.00       Non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)       1,237,690       28.00         <					(cum of lines	-	•				
Uncompensated Care (see instructions for each line)Uninsured patientsInsured patientsTotal (col. 1 + col. 2)20.00Charity care charges and uninsured discounts for the entire facility (see instructions)733,565387,2301,120,79520.0021.00Cost of patients approved for charity care and uninsured discounts (see instructions)216,862387,230604,09221.0022.00Payments received from patients for amounts previously written off as charity care00022.0023.00Cost of charity care (line 21 minus line 22)216,862387,230604,09223.0024.00Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?1.0025.0025.00If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit1,597,54326.0027.00Medicare enibursable bad debts for the entire hospital complex (see instructions)359,85327.0127.01Medicare and non-reimbursable Medicare bad debt expense (see instructions)359,85327.0128.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)359,85327.0128.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)1,237,69028.0029.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)491,84529.0029.00Cost of non-Medicare and non-reimbursable Med	19.00		Thurgent ca	are programs	(Sull OF THES	3, 041, 242	19.00				
Uncompensated Care (see instructions for each line)1.002.003.0020.00Charity care charges and unisured discounts for the entire facility (see instructions)733,565387,2301,120,79520.0021.00Cost of patients approved for charity care and uninsured discounts (see instructions)216,862387,230604,09221.0022.00Payments received from patients for amounts previously written off as charity care0022.0023.00Cost of charity care (line 21 minus line 22)216,862387,230604,09223.0024.00Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit 				Uni nsured	Insured	Total (col. 1					
Uncompensated Care (see instructions for each line)20.00Charity care charges and uninsured discounts for the entire facility (see instructions)733,565387,2301,120,79520.0021.00Cost of patients approved for charity care and uninsured discounts (see instructions)216,862387,230604,09221.0022.00Payments received from patients for amounts previously written off as charity care00022.0023.00Cost of charity care (line 21 minus line 22)216,862387,230604,09223.0024.00Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?1.0025.0025.00If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit025.0027.01Medicare reimbursable bad debts for the entire hospital complex (see instructions)1,597,54326.0027.01Medicare allowable bad debts for the entire hospital complex (see instructions)359,85327.0128.00Non-Medicare allowable bad debts for the entire hospital complex (see instructions)1,237,69028.0029.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)1,237,69028.0029.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)1,095,93730.0030.00Cost of nucompensated care (line 23 column 3 plus line 29)1,095,93730.00			_								
20. 00Charity care charges and uninsured discounts for the entire facility (see instructions)733,565387,2301,120,79520.0021. 00Cost of patients approved for charity care and uninsured discounts (see instructions)216,862387,230604,09221.0022. 00Payments received from patients for amounts previously written off as charity care00022.0023. 00Cost of charity care (line 21 minus line 22)216,862387,230604,09223.0024. 00Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?N24.0025. 00If line 24 is yes, enter the charges for patient days beyond the indigent care program?23.9025.0026. 00Total bad debt expense for the entire hospital complex (see instructions)1,597,54326.0027. 00Medicare reimbursable bad debts for the entire hospital complex (see instructions)1,597,54326.0027. 01Medicare allowable bad debts for the entire hospital complex (see instructions)359,85327.0028. 00Non-Medicare bad debt spructions)1,237,69028.0029. 00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)491,84529.0030. 00Cost of nucompensated care (line 23 column 3 plus line 29)1,095,93730.00				1.00	2.00	3.00					
(see instructions)21.00Cost of patients approved for charity care and uninsured discounts (see instructions)22.00Payments received from patients for amounts previously written off as charity care23.00Cost of charity care (line 21 minus line 22)24.00Des the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?25.001f line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit26.0027.00Medicare reimbursable bad debts for the entire hospital complex (see instructions)27.0027.01Medicare allowable bad debts for the entire hospital complex (see instructions)27.0128.0029.0020.0120.0221.0322.0323.0424.0025.001626.0027.0128.0029.0029.0020.0120.0220.0320.0320.0421.0421.0522.0523.0524.0625.0026.0027.0128.0029.0029.0020.0129.0020.0229.0020.0320.0320.0421.0522.0523.0624.0725.08 <td>20 00</td> <td></td> <td></td> <td>733 54</td> <td>5 387 230</td> <td>1 120 705</td> <td>20.00</td>	20 00			733 54	5 387 230	1 120 705	20.00				
21.00Cost of patients approved for charity care and uninsured discounts (see instructions)216,862387,230604,09221.0022.00Payments received from patients for amounts previously written off as charity care00022.0023.00Cost of charity care (line 21 minus line 22)216,862387,230604,09223.001.0024.00Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?25.00If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit025.0026.00Total bad debt expense for the entire hospital complex (see instructions)1,597,54326.0027.01Medicare allowable bad debts for the entire hospital complex (see instructions)3359,85327.0028.00Non-Medicare bad debt expense (see instructions)1,237,69028.0029.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)1,237,69028.0030.00Cost of uncompensated care (line 23 column 3 plus line 29)1,095,93730.00	20.00		ii ty	755, 50	5 507,250	1, 120, 793	20.00				
22.00       Payments received from patients for amounts previously written off as charity care       0       0       22.00         23.00       Cost of charity care (line 21 minus line 22)       216,862       387,230       604,092       23.00         24.00       Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?       N       24.00         25.00       If line 24 is yes, enter the charges for patient days beyond the indigent care program?       1,597,543       26.00         26.00       Total bad debt expense for the entire hospital complex (see instructions)       1,597,543       26.00         27.00       Medicare reimbursable bad debts for the entire hospital complex (see instructions)       359,853       27.01         28.00       Non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)       1,237,690       28.00         29.00       Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)       491,845       29.00         30.00       Cost of uncompensated care (line 23 column 3 plus line 29)       1,095,937       30.00	21.00		nts (see	216, 86	387, 230	604, 092	21.00				
charity care       23.00       Cost of charity care (line 21 minus line 22)       216,862       387,230       604,092       23.00         24.00       Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?       1.00       24.00         25.00       If line 24 is yes, enter the charges for patient days beyond the indigent care program?       0       25.00       25.00         26.00       Total bad debt expense for the entire hospital complex (see instructions)       1,597,543       26.00         27.00       Medicare reimbursable bad debts for the entire hospital complex (see instructions)       23.3,904       27.00         27.01       Medicare allowable bad debts for the entire hospital complex (see instructions)       359,853       27.01         28.00       Non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)       1,237,690       28.00         29.00       Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)       491,845       29.00         30.00       Cost of uncompensated care (line 23 column 3 plus line 29)       1,095,937       30.00		instructions)									
23.00       Cost of charity care (line 21 minus line 22)       216,862       387,230       604,092       23.00         24.00       Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit       N       24.00         25.00       If line 24 is yes, enter the charges for patient days beyond the indigent care program?       N       24.00         26.00       Total bad debt expense for the entire hospital complex (see instructions)       1,597,543       26.00         27.01       Medicare reimbursable bad debts for the entire hospital complex (see instructions)       1,597,543       26.00         28.00       Non-Medicare allowable bad debts for the entire hospital complex (see instructions)       359,853       27.01         28.00       Non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)       1,237,690       28.00         29.00       Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)       491,845       29.00         30.00       Cost of uncompensated care (line 23 column 3 plus line 29)       1,095,937       30.00	22.00		off as		0 0	0	22.00				
24.00       Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit       N       24.00         25.00       If line 24 is yes, enter the charges for patient days beyond the indigent care program?       N       24.00         25.00       If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit       N       24.00         26.00       Total bad debt expense for the entire hospital complex (see instructions)       1,597,543       26.00         27.00       Medicare reimbursable bad debts for the entire hospital complex (see instructions)       233,904       27.00         27.01       Medicare allowable bad debts for the entire hospital complex (see instructions)       359,853       27.01         28.00       Non-Medicare bad debt expense (see instructions)       1,237,690       28.00         29.00       Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)       491,845       29.00         30.00       Cost of uncompensated care (line 23 column 3 plus line 29)       1,095,937       30.00	22.00			21/ 0/	207.220	(04.000					
24.00Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limitN24.0025.00If line 24 is yes, enter the charges for patient days beyond the indigent care program?025.0025.00If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit025.0026.00Total bad debt expense for the entire hospital complex (see instructions)1,597,54326.0027.00Medicare reimbursable bad debts for the entire hospital complex (see instructions)233,90427.0027.01Medicare allowable bad debts for the entire hospital complex (see instructions)359,85327.0128.00Non-Medicare bad debt expense (see instructions)1,237,69028.0029.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)1,237,69028.0030.00Cost of uncompensated care (line 23 column 3 plus line 29)1,095,93730.00	23.00	Cost of charity care (The 21 minus The 22)		216,80	387,230	604, 092	23.00				
24.00Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limitN24.0025.00If line 24 is yes, enter the charges for patient days beyond the indigent care program?025.0025.00If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit025.0026.00Total bad debt expense for the entire hospital complex (see instructions)1,597,54326.0027.00Medicare reimbursable bad debts for the entire hospital complex (see instructions)233,90427.0027.01Medicare allowable bad debts for the entire hospital complex (see instructions)359,85327.0128.00Non-Medicare bad debt expense (see instructions)1,237,69028.0029.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)1,237,69028.0030.00Cost of uncompensated care (line 23 column 3 plus line 29)1,095,93730.00						1.00					
25.00If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit025.0026.00Total bad debt expense for the entire hospital complex (see instructions)1,597,54326.0027.00Medicare reimbursable bad debts for the entire hospital complex (see instructions)23,90427.0027.01Medicare allowable bad debts for the entire hospital complex (see instructions)359,85327.0128.00Non-Medicare bad debt expense (see instructions)1,237,69028.0029.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)1,237,69028.0030.00Cost of uncompensated care (line 23 column 3 plus line 29)1,095,93730.00	24.00	Does the amount on line 20 column 2, include charges for patien	t days beyor	nd a length	of stay limit		24.00				
stay limit26.00Total bad debt expense for the entire hospital complex (see instructions)1,597,54326.0027.00Medicare reimbursable bad debts for the entire hospital complex (see instructions)233,90427.0027.01Medicare allowable bad debts for the entire hospital complex (see instructions)359,85327.0128.00Non-Medicare bad debt expense (see instructions)1,237,69028.0029.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)491,84529.0030.00Cost of uncompensated care (line 23 column 3 plus line 29)1,095,93730.00				-	•						
26.00Total bad debt expense for the entire hospital complex (see instructions)1,597,54326.0027.00Medicare reimbursable bad debts for the entire hospital complex (see instructions)233,90427.0027.01Medicare allowable bad debts for the entire hospital complex (see instructions)359,85327.0128.00Non-Medicare bad debt expense (see instructions)1,237,69028.0029.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)491,84529.0030.00Cost of uncompensated care (line 23 column 3 plus line 29)1,095,93730.00	25.00		e indigent o	care program	's length of	0	25.00				
27.00Medicare reimbursable bad debts for the entire hospital complex (see instructions)233,90427.0027.01Medicare allowable bad debts for the entire hospital complex (see instructions)359,85327.0128.00Non-Medicare bad debt expense (see instructions)1,237,69028.0029.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)491,84529.0030.00Cost of uncompensated care (line 23 column 3 plus line 29)1,095,93730.00	24 00		tructions)			1 507 542	24 00				
27. 01Medicare allowable bad debts for the entire hospital complex (see instructions)359,85327. 0128. 00Non-Medicare bad debt expense (see instructions)1,237,69028. 0029. 00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)491,84529. 0030. 00Cost of uncompensated care (line 23 column 3 plus line 29)1,095,93730. 00				(ctions)							
28.00Non-Medicare bad debt expense (see instructions)1, 237, 69028.0029.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)491, 84529.0030.00Cost of uncompensated care (line 23 column 3 plus line 29)1, 095, 93730.00			•	,							
29.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)491,84529.0030.00Cost of uncompensated care (line 23 column 3 plus line 29)1,095,93730.00				013)							
30. 00         Cost of uncompensated care (line 23 column 3 plus line 29)         1,095,937         30.00			ense (see in	nstructions)							
31.00 Total unreimbursed and uncompensated care cost (line 19 plus line 30) 4,737,179 31.00											
	31.00	Total unreimbursed and uncompensated care cost (line 19 plus lin	ne 30)			4, 737, 179	31.00				

Heal th	Financial Systems ASCE	ENSION ST. VINCEN	IT WILLIAMSPO	RT	In Lie	eu of Form CMS-	2552-10
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CO		Peri od:	Worksheet A	
					From 07/01/2021	Data /Tima Dra	nored.
					To 06/30/2022	Date/Time Pre 11/28/2022 9:	58 am
	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati		
	'			+ col. 2)	ons (See A-6)	Trial Balance	
						(col. 3 +-	
						col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS				-		1
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT		115, 101				
2.00	00200 NEW CAP REL COSTS-MVBLE EQUI P		847, 741				
3.00	00300 OTHER CAPITAL RELATED COSTS	407 500	0		0 0	-	
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	137, 580	2,074,891			_,	
5.00	00500 ADMI NI STRATI VE & GENERAL	517, 429	5, 933, 015			-,,	
7.00	00700 OPERATION OF PLANT	0	598, 632				
8.00	00800 LAUNDRY & LINEN SERVICE	0	0		0 0	-	
9.00	00900 HOUSEKEEPING	0	419, 351			,	
10.00		0	0		0 0	0	
13.00	01300 NURSI NG ADMI NI STRATI ON	8, 491	3, 450			11, 941	
14.00	01400 CENTRAL SERVICES & SUPPLY	256	18, 011				
15.00	01500 PHARMACY	161, 639	492, 808				
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0		0 0	0	16.00
30, 00	03000 ADULTS & PEDIATRICS	1, 526, 757	369, 910	1, 896, 66	7 -24, 337	1, 872, 330	30,00
43.00	03000 ADULTS & PEDIATRICS 04300 NURSERY	1, 526, 757	369, 910		7 -24, 337 0 0		
43.00	ANCI LLARY SERVI CE COST CENTERS	U	0		0 0	0	43.00
50.00	05000 OPERATI NG ROOM	444, 951	293, 392	738, 34	3 -11, 302	727, 041	50.00
53.00	05300 ANESTHESI OLOGY	444, 931	293, 392		0 0		
54.00	05400 RADI OLOGY-DI AGNOSTI C	785, 964	161, 050				
60.00	06000 LABORATORY	249	1, 620, 599				
65.00	06500 RESPIRATORY THERAPY	25, 304	14, 125			39, 429	
66, 00	06600 PHYSI CAL THERAPY	284, 159	35, 977			320, 136	
68.00	06800 SPEECH PATHOLOGY	201,107	00, 777		0 0	020,100	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	19, 595			41, 052	
72.00	07200 I MPL. DEV. CHARGED TO PATI ENT	0	5, 541	5, 54			
	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0		
	OUTPATIENT SERVICE COST CENTERS				-1	-	
88.00	08800 RURAL HEALTH CLINIC	858, 738	235, 679	1, 094, 41	7 22,000	1, 116, 417	88.00
88. 01	08801 RURAL HEALTH CLINIC II	1, 563, 704	433, 456	1, 997, 16	0 0		
90.00	09000 CLI NI C	0	0		0 0		
90.01	09001 COVID-19 VACCINE CLINIC	o	0		0 0	0	90.01
91.00	09100 EMERGENCY	1, 053, 817	2,073,709	3, 127, 52	6 -7, 818	3, 119, 708	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS			•		•	
95.00	09500 AMBULANCE SERVICES	787, 816	91, 210	879, 02	6 0	879, 026	95.00
	SPECIAL PURPOSE COST CENTERS	_		_		_	
118.00		8, 156, 854	15, 857, 243	24, 014, 09	7 0	24, 014, 097	118.00
	NONREI MBURSABLE COST CENTERS						
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0		192.00
	19300 NONPAI D WORKERS	0	0		0 0		193.00
	19301 ORTHO CLINIC	0	2, 987				193. 01
	19303 ENT CLINIC	191, 551	32, 717				
	07950 MARKETI NG	0	0		0 0		194.00
200.00	TOTAL (SUM OF LINES 118 through 199)	8, 348, 405	15, 892, 947	24, 241, 35	2 0	24, 241, 352	200. 00

	Financial Systems ASCE SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	NSION ST. VINCE	Provider CCI		Peri od:	u of Form CMS Worksheet A	-2552-1
RECLAS	STFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	F EXPENSES	Provider CCI	N: 15-1307	From 07/01/2021	worksneet A	
					To 06/30/2022	Date/Time Pr 11/28/2022 9	epared:
	Cost Center Description	Adjustments	Net Expenses			1172072022 7	. 50 am
		(See A-8) F	or Allocation				
		6.00	7.00				
1.00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT	0	115, 101				1.00
2.00	00200 NEW CAP REL COSTS-BLDG & FIXT	0	847, 741				2.00
3.00	00300 OTHER CAPITAL RELATED COSTS	0	047,741				3.00
3.00 4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	26, 322	2, 238, 793				4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	77, 936	6, 528, 380				5.00
7.00	00700 OPERATION OF PLANT	0	598, 632				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	0 0				8.00
9.00	00900 HOUSEKEEPING	0	419, 351				9.00
10.00	01000 DI ETARY	0	0				10.00
13.00	01300 NURSI NG ADMI NI STRATI ON	Ő	11, 941				13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	18, 267				14.00
15.00	01500 PHARMACY	-61	654, 386				15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0				16.00
101.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	-16, 571	1, 855, 759				30. 00
43.00	04300 NURSERY	0	0				43.00
	ANCI LLARY SERVICE COST CENTERS		I				
50.00	05000 OPERATING ROOM	-113, 120	613, 921				50.00
53.00	05300 ANESTHESI OLOGY	0	O				53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	-72, 565	874, 449				54.00
60.00	06000 LABORATORY	0	1, 620, 848				60.00
65.00	06500 RESPI RATORY THERAPY	0	39, 429				65.00
66.00	06600 PHYSI CAL THERAPY	0	320, 136				66.00
68.00	06800 SPEECH PATHOLOGY	0	0				68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	-26, 817	14, 235				71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	5, 541				72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0				73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	-34, 995	1, 081, 422				88.00
88. 01	08801 RURAL HEALTH CLINIC II	-60, 416	1, 936, 744				88. 01
90.00	09000 CLI NI C	0	0				90.00
90. 01	09001 COVID-19 VACCINE CLINIC	0	0				90.01
91.00	09100 EMERGENCY	0	3, 119, 708				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0	879, 026				95.00
	SPECIAL PURPOSE COST CENTERS	000 5	20.700.61-				
118.00		-220, 287	23, 793, 810				118.00
102.04	NONREI MBURSABLE COST CENTERS		0				100.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0				192.00
	19300 NONPALD WORKERS	0	0				193.00
	19301 ORTHO CLINIC	0	2, 987				193.01
		0	224, 268				193.02
	07950 MARKETING		0				194.00
200.00	TOTAL (SUM OF LINES 118 through 199)	-220, 287	24, 021, 065				200. 0

Heal th	Financial Systems	ASC	ENSION ST. VIN	CENT WILLIAMSP	ORT	In Lie	u of Form CMS	-2552-10
RECLAS	SIFICATIONS			Provider (	CCN: 15-1307	Period:	Worksheet A-	6
						From 07/01/2021 To 06/30/2022	Date/Time Pr 11/28/2022 9	epared: 58 am
		Increases						
	Cost Center	Line #	Sal ary	0ther				
	2.00	3.00	4.00	5.00				
	A - MEDICAL SUPPLIES							
1.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	21, 457				1.00
	PATI ENTS							
2.00		0.00	0	0				2.00
3.00		0.00	0	0				3.00
	TOTALS		ō	21, 457	1			1
	I - RHC WAGES - DR. SHARMA							1
1.00	RURAL HEALTH CLINIC	88.00	22, 000	0				1.00
	TOTALS		22,000	ō	1			1
500.00	Grand Total: Increases		22, 000	21, 457	1			500.00

<sup>11/28/2022 9:58</sup> am Y: \28950 - St. Vincent Williamsport Hospital \300 - Medicare Cost Report \20220630 \HFS \20220630 Williamsport.mcr

Heal th	Financial Systems	ASC	ENSION ST. VINC	CENT WILLIAMSPO	ORT	In Lie	u of Form CMS	-2552-10
RECLASS	SEFECATIONS			Provider (		Period: From 07/01/2021	Worksheet A-	6
						To 06/30/2022	Date/Time Pr 11/28/2022 9	epared: : <u>58 am</u>
		Decreases						
	Cost Center	Line #	Sal ary	0ther	Wkst. A-7 Ref			
	6.00	7.00	8.00	9.00	10.00			
	A - MEDICAL SUPPLIES							
1.00	ADULTS & PEDIATRICS	30.00	0	2, 337		0		1.00
2.00	OPERATING ROOM	50.00	0	11, 302		0		2.00
3.00	EMERGENCY	91.00	0	7, 818		0		3.00
	TOTALS		0	21, 457				
	I - RHC WAGES - DR. SHARMA							
1.00	ADULTS & PEDIATRICS	30.00	22, 000	0		0		1.00
	TOTALS		22, 000	0		7		
500.00	Grand Total: Decreases		22, 000	21, 457				500.00

<sup>11/28/2022 9:58</sup> am Y: \28950 - St. Vincent Williamsport Hospital \300 - Medicare Cost Report \20220630 \HFS \20220630 Williamsport.mcr

In Lieu of Form CMS-2552-10 Worksheet A-7

RECONC	TELATION OF CALIFICE COSTS CENTERS			SN. 13-1307		m 07/01/2021 06/30/2022	Part I Date/Time Prep 11/28/2022 9:5	
	A			Acqui si ti on	Acqui si ti ons			
		Begi nni ng	Purchases	Donati on		Total	Disposals and	
		Bal ances					Retirements	
		1.00	2.00	3.00		4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE			-				
1.00	Land	128, 894	251, 935		0	251, 935	0	1.00
2.00	Land Improvements	348, 497	131, 082		0	131, 082	0	2.00
3.00	Buildings and Fixtures	9,045,644	18, 684		0	18, 684	0	3.00
4.00	Building Improvements	0	0		0	0	0	4.00
5.00	Fixed Equipment	1, 772, 753	19, 017		0	19, 017	0	5.00
6.00	Movable Equipment	5, 715, 953	173, 050		0	173, 050	0	6.00
7.00	HIT designated Assets	0	0		0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	17,011,741	593, 768		0	593, 768	0	8.00
9.00	Reconciling Items	0	0		0	0	0	9.00
10.00	10.00 Total (line 8 minus line 9)		593, 768		0	593, 768	0	10.00
		Endi ng Bal ance						
			Depreci ated					
			Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE			1				
1.00	Land	380, 829	0					1.00
2.00	Land Improvements	479, 579	0					2.00
3.00	Buildings and Fixtures	9, 064, 328	0					3.00
4.00	Building Improvements	0	0					4.00
5.00	Fixed Equipment	1, 791, 770	0					5.00
6.00	Movable Equipment	5, 889, 003	0					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	17, 605, 509	0					8.00
9.00	Reconciling Items	0	0					9.00
10.00	Total (line 8 minus line 9)	17, 605, 509	0				l	10.00

Heal th	Fi nanci al	Systems	
DECONIC			COSTS

near th	Real LITE FINANCIAL SYSTEMS ASCENSION ST. VINCENT WILLIAMSPORT THE LIEU OF FORM CM3-2332-10						
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provider (	CCN: 15-1307	Period: From 07/01/2021 To 06/30/2022	Worksheet A-7 Part II Date/Time Pre 11/28/2022 9:	pared:
SUMMARY OF CAPITAL							
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)		
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	61, 558	(	C	0 39,025	14, 518	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	797, 296	50, 445	5	0 0	0	2.00
3.00	Total (sum of lines 1-2)	858, 854	50, 445	5	0 39, 025	14, 518	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sur	n			
		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	N 2, LINES 1 a	and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	115, 10 <sup>-</sup>	1			1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	847, 74 <sup>-</sup>	1			2.00
3.00	Total (sum of lines 1-2)	0	962, 842	2			3.00

lealth Finan	cial Systems A	SCENSION ST. VINC	CENT_WILLIAMSPO	RT	In Lie	eu of Form CMS-2	2552-10
RECONCI LI ATI	ON OF CAPITAL COSTS CENTERS		Provider C		Period: From 07/01/2021 To 06/30/2022	Worksheet A-7 Part III Date/Time Prep 11/28/2022 9:5	
		COM	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. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
	AP REL COSTS-BLDG & FIXT	11, 716, 505		11, 716, 505		0	1.00
	AP REL COSTS-MVBLE EQUIP	5, 889, 004		5, 889, 004			2.00
3.00 Total	(sum of lines 1-2)	17, 605, 509		17, 605, 509			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 I	III - RECONCILIATION OF CAPITAL COSTS	CENTERS					
1.00 NEW C	AP REL COSTS-BLDG & FIXT	C	0 0	C	61, 558	0	1.00
2.00 NEW C	AP REL COSTS-MVBLE EQUIP	C	0 0	C	797, 296	50, 445	2.00
3.00 Total	(sum of lines 1-2)	C	0 0	C	858, 854	50, 445	3.00
			SI	JMMARY OF CAPIT	ΓAL		
	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 I	III - RECONCILIATION OF CAPITAL COSTS		12100	10100	11100	10100	
	AP REL COSTS-BLDG & FIXT	C	39, 025	14, 518	3 0	115, 101	1.00
	AP REL COSTS-MVBLE EQUIP			0		847, 741	2.00
	(sum of lines 1-2)		-	14, 518	3 0		
	( · · · · · · · · · · · · · · · · · · ·	1		,			

Heal th	Fi nan	ci al	Systems
AD JUST	MENTS	TO F	XPENSES

## ASCENSION ST. VINCENT WILLIAMSPORT

	Financial Systems	ASCEN	SION ST. VINC	CENT_WILLIAMSPORT		eu of Form CMS-2	2552-10
ADJUSTI	MENTS TO EXPENSES			Provider CCN: 15-1307	Period: From 07/01/2021 To 06/30/2022	Worksheet A-8 Date/Time Prep	pared:
				Expense Classification on To/From Which the Amount is		11/28/2022 9:	58 am
	Cost Center Description		Amount	Cost Center		Wkst. A-7 Ref.	
1.00	Investment income - NEW CAP	1.00 B	2.00	3.00 NEW CAP REL COSTS-BLDG &	4.00	5.00	1.00
	REL COSTS-BLDG & FIXT (chapter	5	101,100	FLXT			
2.00	2) Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2. 00
. 00	2) Investment income - other (chapter 2)	В	-9, 219	ADMI NI STRATI VE & GENERAL	5.00	0	3. 00
. 00	Trade, quantity, and time		0		0.00	0	4.00
. 00	discounts (chapter 8) Refunds and rebates of		0		0.00	0	5.00
	expenses (chapter 8)		Ū				
5.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6. 00
7.00	Telephone services (pay stations excluded) (chapter 21)		C	)	0.00	0	7.00
3. 00	Tel evi si on and radio service (chapter 21)		C		0.00	0	8.00
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician adjustment	A-8-2	0 -78, 120		0.00	0 0	9. 00 10. 00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11. 00
12.00	Related organization transactions (chapter 10)	A-8-1	1, 959, 264			0	12.00
13.00	Laundry and linen service		0		0.00		13.00
4.00 5.00	Cafeteria-employees and guests Rental of quarters to employee		0 0		0.00 0.00		14. 00 15. 00
6.00	and others Sale of medical and surgical supplies to other than		C		0.00	0	16. 00
7.00	patients Sale of drugs to other than		0		0.00	0	17.00
18.00	patients Sale of medical records and		0		0.00	0	18.00
19. 00	abstracts Nursing and allied health education (tuition, fees,		0		0.00	0	19. 00
20. 00	books, etc.) Vending machines		O		0.00	0	20. 00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		C		0.00	0	22. 00
23.00	Adjustment for respiratory therapy costs in excess of	A-8-3	C	RESPI RATORY THERAPY	65.00		23. 00
24.00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	C	PHYSI CAL THERAPY	66.00		24. 00
25.00	limitation (chapter 14) Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114.00		25. 00
26. 00	(chapter 21) Depreciation - NEW CAP REL		C	NEW CAP REL COSTS-BLDG &	1.00	0	26. 00
27.00	COSTS-BLDG & FIXT Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	FLXT NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
	Non-physician Anesthetist		0	*** Cost Center Deleted ***			28. 00
	Physicians' assistant Adjustment for occupational	A-8-3	0	*** Cost Center Deleted ***	0.00 67.00		29. 00 30. 00
30.00	therapy costs in excess of limitation (chapter 14)	A-0-3	0		07.00		30.00
30. 99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30. 99
	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	O	SPEECH PATHOLOGY	68.00		31.00

ADJUST	MENTS TO EXPENSES			Provider CCN: 15-1307 Period: From 07/01/2021		Worksheet A-8	
					To 06/30/2022		
						11/28/2022 9:	58 am
				Expense Classification or			
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
32.00	CAH HIT Adjustment for		0		0.00	0	32.00
	Depreciation and Interest						
	Corporate Sponsorship	A		ADMI NI STRATI VE & GENERAL	5.00		33.00
	Promotional Items	A		ADMI NI STRATI VE & GENERAL	5.00		33.01
33.02	Promotional Items	A	-2861	RADI OLOGY-DI AGNOSTI C	54.00	0	33.02
33.03	Provider Tax	A	-1, 495, 411/	ADMI NI STRATI VE & GENERAL	5.00	0	33.03
33.04	Lobbyi ng	A	-493/	ADMI NI STRATI VE & GENERAL	5.00	0	33.04
33.05	Physician Fund	A	-184, 109/	ADMI NI STRATI VE & GENERAL	5.00	0	33.05
33.06	Mid Level Providers - A&P	A	-16, 571/	ADULTS & PEDIATRICS	30.00	0	33.06
33.07	Mid Level Providers -	A	-113, 120(	OPERATING ROOM	50.00	0	33.07
	Anesthesi ol ogi st						
	Mission Point Savings	В	-47, 733 I	EMPLOYEE BENEFITS DEPARTMEN	T 4.00	0	33.08
33.09	Misc Income - Admin	В	-171	ADMI NI STRATI VE & GENERAL	5.00	0	33.09
33.10	Misc Income - Drugs	В	-61	PHARMACY	15.00	0	33.10
33. 11	Non-RHC Physician Costs	A	-34, 995 I	RURAL HEALTH CLINIC	88.00	0	33. 11
33. 12	Non-RHC Physician Costs	A	-60, 416	RURAL HEALTH CLINIC II	88.01	0	33. 12
33.13	Bad Debt Expense	A	8/	ADMI NI STRATI VE & GENERAL	5.00	0	33.13
50.00	TOTAL (sum of lines 1 thru 49)		-220, 287				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. VIN	CENT WILLI AMSPORT	In Lie	eu of Form CMS-	2552-10
STATEM	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOM		Peri od:	Worksheet A-8	3-1
OFFICE	OFFICE COSTS			From 07/01/2021 To 06/30/2022		
	Line No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost		
					Wks. A, column	
			0.00		5	
			3.00	4.00	5.00	
	HOME OFFICE COSTS:	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OF	GANIZATIONS OR	CLAIMED	
1.00	5.00	ADMINISTRATIVE & GENERAL	Home Office - Capital	279, 257	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	Home Office - Interest	8, 541	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	Home Office - Other	5, 635, 122	3, 964, 525	3.00
3.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	ASVH Chargebacks	2, 751	2, 751	3.01
3.02	15.00	PHARMACY	ASVH CHARGEBACKS	4,000	4,000	3. 02
3.03	30.00	ADULTS & PEDIATRICS	ASVH CHARGEBACKS	5, 715	5, 715	3.03
3.04	54.00	RADI OLOGY-DI AGNOSTI C	ASVH CHARGEBACKS	11,004	11, 004	3.04
3.05	91.00	EMERGENCY	ASVH Chargebacks	300	300	3.05
3.06	4.00	EMPLOYEE BENEFITS DEPARTMENT	Health Insurance	1, 311, 611	1, 237, 556	3.06
3.07	1.00	NEW CAP REL COSTS-BLDG & FIX	Interest Expense	131, 160	0	3.07
3.08	5.00	ADMINISTRATIVE & GENERAL	Interest Expense	678	132, 665	3.08
3.09	71.00	MEDICAL SUPPLIES CHARGED TO	TRG ADMIN FEES - SUPPLIES	-26, 817	0	3.09
3.10	5.00	ADMINISTRATIVE & GENERAL	TRG ADMIN FEES - CONTRACTED	-16, 624	0	3.10
4.00	5.00	ADMINISTRATIVE & GENERAL	TRG ADMING FEES - OTHER	-28, 918	0	4.00
4.01	0.00			0	0	4.01
5.00	TOTALS (sum of lines 1-4).			7, 317, 780	5, 358, 516	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.

has not been posted to not sheet A, conditions 1 and/or 2, the amount allowable should be that cated the condition 4 of this part.								
				Related Organization(s) and/	or Home Office			
				3 ()				
	Symbol (1)	Name	Percentage of	Name	Percentage of			
	Symbol (1)	Name		Name				
			Ownership		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.

6.00	G	ASCENSION SVH	100.00	ASCENSION SVH	100. 00	6.00			
7.00	G	ASCENSI ON	100.00	ASCENSI ON	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.

MCRI F32 - 17. 12. 175. 4

## Health Financial Systems ASCENSION ST. VINCENT WILLIAMSPORT In Lieu of Form CMS-2552-10 STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME Provider CCN: 15-1307 Peri od: Worksheet A-8-1 From 07/01/2021 To 06/30/2022 Date/Time Prepared: OFFICE COSTS

				/28/2022 9:58 am
	Net	Wkst. A-7 Ref.		72072022 7:00 um
	Adjustments			
	(col. 4 minus			
	col. 5)*			
	6.00	7.00		
	A. COSTS INCUR	RED AND ADJUSTN	MENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAI	MED
	HOME OFFICE CO			
1.00	279, 257	0		1.00
2.00	8, 541	0		2.00
3.00	1, 670, 597	0		3.00
3.01	0	0		3.01
3.02	0	0		3.02
3.03	0	0		3.03
3.04	0	0		3.04
3.05	0	0		3.05
3.06	74,055	0		3.06
3.07	131, 160	11		3.07
3.08	-131, 987	0		3.08
3.09	-26, 817	0		3.09
3.10	-16, 624	0		3.10
4.00	-28, 918	0		4.00
4.01	0	0		4.01
5.00	1, 959, 264			5.00
* The	amounts on Line	s 1_4 (and sub	oscripts as appropriate) are transferred in detail to Worksheet A. column 6	lines as

The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which

has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.	
Related Organization(s)	
and/or Home Office	
Type of Busi ness	
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

rerinbur	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 10. 00		9.00
10.00		10.00
100.00		100.00

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

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

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

 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.

Health Financial Systems

## ASCENSION ST. VINCENT WILLIAMSPORT

In Lieu of Form CMS-2552-10

PROVI DE	R BASED PHYSIC	I AN ADJUSTMENT	Provi der CCN: 15-1307 Peri od:			Worksheet A-8-2		
						From 07/01/2021 To 06/30/2022	Date/Time Pre	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		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	5, 841	5, 841	C	0	0	1.00
2.00	54.00	RADI OLOGY-DI AGNOSTI C	72, 279	72, 279	C	0	0	2.00
3.00	91.00	EMERGENCY	1, 612, 172		1, 612, 172	0	0	3.00
4.00	0.00		0	0	C	0	0	4.00
5.00	0.00		0	0	C	0	0	5.00
6.00	0.00		0	0	C	0	0	6.00
7.00	0.00		0	0	C	0	0	7.00
8.00	0.00		0	0	C	0	0	8.00
9.00	0.00		0	0	C	0	0	9.00
10.00	0.00		0	0	C	0	0	10.00
200.00			1, 690, 292	78, 120	1, 612, 172		0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		I denti fi er	Limit	Unadjusted RCE	Memberships &		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	-	C		0	
2.00		RADI OLOGY-DI AGNOSTI C	0	0	C		0	2.00
3.00		EMERGENCY	0	0	C	0	0	3.00
4.00	0.00		0	0	C	0	0	4.00
5.00	0.00		0	0	C	0	0	5.00
6.00	0.00		0	0	C	0	0	6.00
7.00	0.00		0	0	C	0	0	7.00
8.00	0.00		0	0	C	0	0	8.00
9.00	0.00		0	0	C	0	0	9.00
10.00	0.00		0	0	C	0	0	
200.00			0	0	C		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.					
	1.00	2.00	14 15. 00	16.00	17.00	18.00		
1.00		ADMI NI STRATI VE & GENERAL	15.00		17.00			1.00
2.00		RADI OLOGY-DI AGNOSTI C		0				2.00
3.00		EMERGENCY		0				3.00
4.00	0.00			0		0		4.00
4.00 5.00	0.00			0				4.00 5.00
6.00	0.00					-		6.00
7.00	0.00			0		, i i i i i i i i i i i i i i i i i i i		8.00 7.00
8.00	0.00			0				7.00 8.00
9.00	0.00		0	-				8.00 9.00
	0.00			0				9.00 10.00
10.00 200.00	0.00		0	-	-			200.00
200.00	l l		1 0	I 0		1 70,120		200.00

COST ALLOCATION - GENERAL SERVICE COSTS						Worksheet B Part I Date/Time Prepared 11/28/2022 9:58 an	
			CAPI TAL REL	ATED COSTS			
	Cost Center Description	Net Expenses for Cost Allocation	NEW BLDG & FIXT	NEW MVBLE EQUI P	EMPLOYEE BENEFI TS DEPARTMENT	Subtotal	
		(from Wkst A					
		col. 7)					
		0	1.00	2.00	4.00	4A	
1 00	GENERAL SERVICE COST CENTERS	115 101	115 101				1 1 00
1.00 2.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP	115, 101 847, 741	115, 101	017 71	1		1.00 2.00
2.00 4.00	00200 New CAP REL COSTS-MVBLE EQUIP	2, 238, 793	0	847, 74	0 2, 238, 793		4.00
4.00 5.00	00500 ADMINI STRATI VE & GENERAL	6, 528, 380	8, 544	62, 93		6, 740, 938	4.00 5.00
7.00	00700 OPERATION OF PLANT	598, 632	14, 074	103, 65		716, 361	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	646	4, 75		5, 402	
9.00	00900 HOUSEKEEPING	419, 351	111	4, 73		420, 281	9.00
10.00	01000 DI ETARY	0	0		0 0	0	
13.00	01300 NURSI NG ADMI NI STRATI ON	11, 941	2, 115	15, 57	0 0	31, 946	
14.00	01400 CENTRAL SERVICES & SUPPLY	18, 267	2, 110	10/07	0 70	18, 337	14.00
15.00	01500 PHARMACY	654, 386	0		0 44,073	698, 459	15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	4, 336	31, 93		36, 273	
	INPATIENT ROUTINE SERVICE COST CENTERS						1
30.00	03000 ADULTS & PEDIATRICS	1, 855, 759	15, 600	114, 89	9 410, 293	2, 396, 551	30.00
43.00	04300 NURSERY	0	0		0 0	0	43.00
	ANCILLARY SERVICE COST CENTERS	r					
50.00	05000 OPERATING ROOM	613, 921	9, 425	69, 41	8 121, 322	814, 086	
53.00	05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	874, 449	7, 518	55, 37		1, 151, 642	
60.00	06000 LABORATORY	1, 620, 848	3, 019	22, 23		1, 646, 171	60.00
65.00	06500 RESPI RATORY THERAPY	39, 429	1, 933	14, 23		62, 497	65.00
66.00	06600 PHYSI CAL THERAPY	320, 136	4, 221	31, 08		432, 924	66.00
68.00	06800 SPEECH PATHOLOGY	0	1 105	0.00	0 0	0	68.00
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	14, 235	1, 125	8, 28	4 0	23, 644	
72.00 73.00	07200 I MPL. DEV. CHARGED TO PATI ENT 07300 DRUGS CHARGED TO PATI ENTS	5, 541 0	1 014	7, 48	0	5, 541	72.00 73.00
73.00	OUTPATIENT SERVICE COST CENTERS	0	1, 016	7,40	0 0	8, 496	/3.00
88.00	08800 RURAL HEALTH CLINIC	1,081,422	9, 776	72, 00	1 240, 146	1, 403, 345	88.00
88.01	08801 RURAL HEALTH CLINIC II	1, 936, 744	13, 881	102, 23		2, 479, 225	
90.00	09000 CLINIC	1, 730, 744	13, 001	102, 20	0 0	2, 477, 223	90.00
90.01	09001 COVID-19 VACCINE CLINIC	0	0		0 0	0	90.01
91.00	09100 EMERGENCY	3, 119, 708	8, 155	60, 06	4 287, 338	3, 475, 265	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	-,,	-,			0,,0	1
	OTHER REIMBURSABLE COST CENTERS	I					
95.00	09500 AMBULANCE SERVICES	879, 026	5, 345	39, 37	0 214, 809	1, 138, 550	95.00
	SPECIAL PURPOSE COST CENTERS						1
118.00		23, 793, 810	110, 840	816, 35	5 2, 186, 564	23, 705, 934	118.00
	NONREI MBURSABLE COST CENTERS						
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0		0 0		192.00
	19300 NONPAID WORKERS	0	0		0 0		193.00
	19301 ORTHO CLINIC	2, 987	1, 210	8, 91		13, 110	
	19303 ENT CLINIC	224, 268	3, 051	22, 47	3 52, 229	302, 021	
	07950 MARKETI NG	0	0		0 0		194.00
200.00							200.00
201.00	5	24 021 0/5	115 101	047 74			201.00
202.00	TOTAL (sum lines 118 through 201)	24, 021, 065	115, 101	847, 74	1 2, 238, 793	24, 021, 065	202.00

		LINGTON ST. VINC					2332-10
COST	ALLOCATION - GENERAL SERVICE COSTS		Provider C	CN: 15-1307 P	eriod: rom 07/01/2021	Worksheet B Part I	
					o 06/30/2022	Date/Time Pre	narod
					0 00/30/2022	11/28/2022 9:	
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	cost center bescription	& GENERAL	PLANT	LINEN SERVICE	HOUSEREEFTING	DILIANI	
		5.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS	5.00	7.00	0.00	9.00	10.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT			1			1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL	6, 740, 938					5.00
7.00	00700 OPERATION OF PLANT	279, 451					7.00
8.00	00800 LAUNDRY & LINEN SERVICE	2, 107					8.00
9.00	00900 HOUSEKEEPI NG	163, 951	1, 609	0	585, 841		9.00
10.00	01000 DI ETARY	0	0	0	0	0	10.00
13.00	01300 NURSING ADMINISTRATION	12, 462	30, 596	0	13, 506	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	7, 153	0	0	0	0	14.00
15.00	01500 PHARMACY	272, 467	0	0	0	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	14, 150		0	27, 695	0	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	934, 890	225, 712	11, 798	99, 634	0	30.00
43.00	04300 NURSERY	0				0	
45.00	ANCI LLARY SERVI CE COST CENTERS	0	0	0	0	0	45.00
50.00	05000 OPERATI NG ROOM	317, 573	136, 368	842	60, 197	0	50.00
53.00	05300 ANESTHESI OLOGY	0	130, 300	042		0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	449, 253	108, 772	-	-	0	
60.00	06000 LABORATORY	642, 168				0	
65.00	06500 RESPIRATORY THERAPY					0	
66.00	06600 PHYSI CAL THERAPY	24, 380 168, 883			,	0	66.00
						•	
68.00	06800 SPEECH PATHOLOGY	0	,	0	-	0	
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	9, 223			7, 183	0	
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	2, 162		0	0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	3, 314	14, 695	0	6, 487	0	73.00
	OUTPATIENT SERVICE COST CENTERS	1					
88.00	08800 RURAL HEALTH CLINIC	547, 442	0			0	
88. 01	08801 RURAL HEALTH CLINIC II	967, 141	0	38	88, 657	0	
90.00	09000 CLI NI C	0	0	0	0	0	
90.01	09001 COVID-19 VACCINE CLINIC	0	0	0	0	0	
91.00	09100 EMERGENCY	1, 355, 690	117, 991	3, 370	52, 085	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVI CES	444, 146	77, 341	84	34, 141	0	95.00
	SPECIAL PURPOSE COST CENTERS						
118.00		6, 618, 006	934, 156	16, 852	558, 624	0	1118.00
	NONREI MBURSABLE COST CENTERS						
192 00	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0	0	192.00
	19300 NONPAID WORKERS	0	0	0	-		193.00
	1 19301 ORTHO CLINIC	5, 114	17, 510	-	7, 729		193.01
	2 19303 ENT CLINIC	117, 818			19, 488		193.02
	DO7950 MARKETI NG		, 140 ^	0	17,400		194.00
200.00		0			0	0	200.00
200.00		0	_		_	0	200.00
201.00		6, 740, 938	995, 812	16, 852	585, 841		201.00
202.00	J INAL (Sum THES TIO (IN OUGH 201)	0, 740, 938	1 770,012	1 10, 652	JOJ, 641	0	1202. UU

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COST A		CENEDAL	SED/

		LINSTON ST. VINCI			III LIE		2552-10
COST /	ALLOCATION - GENERAL SERVICE COSTS		Provider CC		eriod: rom 07/01/2021	Worksheet B Part I	
				T	o 06/30/2022	Date/Time Pre	
	Cost Contor Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	<u>11/28/2022 9:</u> Subtotal	58 am
	Cost Center Description	ADMI NI STRATI ON	SERVICES &	PRAKINACT	RECORDS &	Subtotal	
			SUPPLY		LI BRARY		
		13.00	14.00	15.00	16.00	24.00	
	GENERAL SERVICE COST CENTERS	1 1			1 1		
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
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
13.00	01300 NURSI NG ADMI NI STRATI ON	88, 510					13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	8	25, 498				14.00
15.00	01500 PHARMACY	0	20, 170	970, 926			15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	0	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			16.00
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	9	0	140,007		10.00
30.00	03000 ADULTS & PEDIATRICS	32,003	0	C	13, 168	3, 713, 756	30.00
43.00	04300 NURSERY	02,000	o	C		0	•
101.00	ANCI LLARY SERVICE COST CENTERS				۰ ۱		
50.00	05000 OPERATI NG ROOM	8, 930	0	C	11, 721	1, 349, 717	50.00
53.00	05300 ANESTHESI OLOGY	0	o	C		0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	0	27, 012	1, 784, 863	•
60.00	06000 LABORATORY	0	0	0	29, 826	2, 381, 130	
65.00	06500 RESPIRATORY THERAPY	0	0	0	3, 192	130, 381	•
66.00	06600 PHYSI CAL THERAPY	9	0	0	5, 211	695, 559	
68.00	06800 SPEECH PATHOLOGY	0	0	0	0,2.1	0,00,007	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	22, 466	0	0	78, 789	•
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0	3, 032	C	0	10, 735	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0,002	970, 926		1,003,918	•
70.00	OUTPATIENT SERVICE COST CENTERS	۹ ۱		710,720	۰ <u>۱</u>	1,000,710	/0.00
88.00	08800 RURAL HEALTH CLINIC	6, 287	0	C	3, 006	2, 022, 563	88.00
88.01	08801 RURAL HEALTH CLINIC II	19, 718	0	0	6, 485	3, 561, 264	•
90.00	09000 CLINIC	0	0		0,400	0, 301, 204	90.00
90.01	09001 COVID-19 VACCINE CLINIC	0	0	0	0	0	90.01
91.00	09100 EMERGENCY	17, 575	0		33, 358	5, 055, 334	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	17, 575	0	C C	55, 550	5,055,554	92.00
72.00	OTHER REIMBURSABLE COST CENTERS	II			II		/2.00
95.00	09500 AMBULANCE SERVICES	0	0	C	7, 878	1, 702, 140	95.00
/5.00	SPECIAL PURPOSE COST CENTERS	0	<u> </u>		7,070	1,702,140	/0.00
118.00		84, 530	25, 498	970, 926	140, 857	23, 490, 149	118 00
110.00	NONREI MBURSABLE COST CENTERS	01,000	20, 170	710,720	110,007	20, 170, 117	1110.00
192 00	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	C	0	0	192.00
	19300 NONPAID WORKERS	0	0		0		193.00
	19301 ORTHO CLINIC	0	0			43, 463	
	219303 ENT CLINIC	3, 980	0		0	487, 453	
	07950 MARKETI NG	3, 700	0		0		194.00
200.00		0	Ŭ		0		200.00
200.00	5	0	0	n	0		200.00
201.00	5	88, 510	25, 498	970, 926	140, 857		
202.00		00,010	20, 790	710, 720	1,00,001	21,021,000	1-02.00

Heal th	Financial Systems ASC	ENSION ST. VINCE	ENT WILLIAMSPOR	T	In Lieu of Form CN	IS-2552-10
COST AL	LOCATION - GENERAL SERVICE COSTS		Provider CC	N: 15-1307	Period: Worksheet E	3
					From 07/01/2021 Part I	
					To 06/30/2022 Date/Time F	Prepared:
					11/28/2022	9:58 am
	Cost Center Description	Intern &	Total			
		Residents Cost				
		& Post				
		Stepdown				
		Adjustments				
		25.00	26.00			
	GENERAL SERVICE COST CENTERS					
	00100 NEW CAP REL COSTS-BLDG & FIXT					1.00
	00200 NEW CAP REL COSTS-MVBLE EQUIP					2,00
	00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
	00500 ADMINI STRATI VE & GENERAL					5.00
						7.00
	00700 OPERATION OF PLANT					
	00800 LAUNDRY & LINEN SERVICE					8.00
	00900 HOUSEKEEPI NG					9.00
	01000 DI ETARY					10.00
13.00	01300 NURSING ADMINISTRATION					13.00
14.00	01400 CENTRAL SERVICES & SUPPLY					14.00
15.00	01500 PHARMACY					15.00
	01600 MEDICAL RECORDS & LIBRARY					16.00
	INPATIENT ROUTINE SERVICE COST CENTERS	1				
	03000 ADULTS & PEDI ATRI CS	0	3, 713, 756			30.00
	04300 NURSERY	0	0			43.00
		0	0			43.00
	ANCI LLARY SERVICE COST CENTERS		1 0 10 7 17			- 50.00
	05000 OPERATING ROOM	0	1, 349, 717			50.00
	05300 ANESTHESI OLOGY	0	0			53.00
	05400 RADI OLOGY-DI AGNOSTI C	0	1, 784, 863			54.00
	06000 LABORATORY	0	2, 381, 130			60.00
65.00	06500 RESPI RATORY THERAPY	0	130, 381			65.00
66.00	06600 PHYSI CAL THERAPY	0	695, 559			66.00
68.00	06800 SPEECH PATHOLOGY	0	0			68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	78, 789			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	10, 735			72.00
	07300 DRUGS CHARGED TO PATIENTS	0	1,003,918			73.00
	OUTPATIENT SERVICE COST CENTERS		.,			
88.00	08800 RURAL HEALTH CLINIC	0	2, 022, 563			88.00
	08801 RURAL HEALTH CLINIC II	0	3, 561, 264			88.01
	09000 CLINIC	0	3, 301, 204			90.00
		-	0			
	09001 COVID-19 VACCINE CLINIC	0				90.01
	09100 EMERGENCY	0	5, 055, 334			91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0				92.00
	OTHER REIMBURSABLE COST CENTERS					
	09500 AMBULANCE SERVI CES	0	1, 702, 140			95.00
	SPECIAL PURPOSE COST CENTERS					
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	23, 490, 149			118.00
	NONREIMBURSABLE COST CENTERS					
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0			192.00
	19300 NONPALD WORKERS	0	0			193.00
	19301 ORTHO CLINIC	0	43, 463			193.01
	19303 ENT CLINIC	0	487, 453			193.02
	07950 MARKETI NG	0	487, 455			193.02
		0				
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	24, 021, 065			202.00

In Lieu of Form CMS-2552-10

		NSION SI. VINC				u of Form CMS-2	2552-10
ALLOCAT	ION OF CAPITAL RELATED COSTS		Provider C		eriod: com 07/01/2021 p 06/30/2022	Worksheet B Part II Date/Time Pre 11/28/2022 9:	
			CAPI TAL REL	ATED COSTS		1172072022 9.	
	Cost Center Description	Di rectl y	NEW BLDG &	NEW MVBLE	Subtotal	EMPLOYEE	
		Assigned New	FLXT	EQUI P		BENEFI TS	
		Capi tal				DEPARTMENT	
		Related Costs					
		0	1.00	2.00	2A	4.00	
	GENERAL SERVICE COST CENTERS	1		ГГ			
	DO100 NEW CAP REL COSTS-BLDG & FIXT						1.00
	DO200 NEW CAP REL COSTS-MVBLE EQUIP					_	2.00
	DO400 EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
	DO500 ADMINISTRATIVE & GENERAL	426, 039	8, 544	62, 930	497, 513	0	5.00
	DO700 OPERATION OF PLANT	0	14, 074	103, 655	117, 729	0	
	DO800 LAUNDRY & LINEN SERVICE	0	646	4, 756	5, 402	0	
	DO900 HOUSEKEEPI NG	0	111	819	930	0	9.00
	D1000 DI ETARY	0	0	0	0	0	10.00
	D1300 NURSI NG ADMI NI STRATI ON	0	2, 115	15, 575	17, 690	0	13.00
	01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
	D1500 PHARMACY	0	0	0	0	0	15.00
	D1600 MEDICAL RECORDS & LIBRARY	0	4, 336	31, 937	36, 273	0	16.00
	NPATIENT ROUTINE SERVICE COST CENTERS	i					
	D3000 ADULTS & PEDIATRICS	0	15, 600	114, 899	130, 499	0	
	D4300 NURSERY	0	0	0	0	0	43.00
	ANCI LLARY SERVI CE COST CENTERS	i .	i				
	D5000 OPERATI NG ROOM	0	9, 425	69, 418	78, 843	0	
	D5300 ANESTHESI OLOGY	0	0	0	0	0	
	D5400 RADI OLOGY-DI AGNOSTI C	0	7, 518	55, 371	62, 889	0	54.00
	D6000 LABORATORY	0	3, 019	22, 236	25, 255	0	60.00
	D6500 RESPI RATORY THERAPY	0	1, 933	14, 236	16, 169	0	65.00
	D6600 PHYSI CAL THERAPY	0	4, 221	31, 087	35, 308	0	66.00
	D6800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
	D7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1, 125	8, 284	9, 409	0	71.00
	D7200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	1, 016	7, 480	8, 496	0	73.00
	DUTPATIENT SERVICE COST CENTERS						
	D8800 RURAL HEALTH CLINIC	0	9, 776	72, 001	81, 777	0	
	D8801 RURAL HEALTH CLINIC II	0	13, 881	102, 237	116, 118	0	
	09000 CLI NI C	0	0	0	0	0	
	D9001 COVID-19 VACCINE CLINIC	0	0	0	0	0	90.01
	D9100 EMERGENCY	0	8, 155	60, 064	68, 219	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
	OTHER REIMBURSABLE COST CENTERS	1					
	09500 AMBULANCE SERVI CES	0	5, 345	39, 370	44, 715	0	95.00
	SPECIAL PURPOSE COST CENTERS	1		[]			
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	426, 039	110, 840	816, 355	1, 353, 234	0	118.00
	NONREI MBURSABLE COST CENTERS	1	l	[]			
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		192.00
	19300 NONPAI D WORKERS	0	0	0	0		193.00
	19301 ORTHO CLINIC	0	1, 210	8, 913	10, 123		193.01
	19303 ENT CLINIC	0	3, 051	22, 473	25, 524		193.02
	D7950 MARKETING	0	0	0	0	0	194.00
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)	426, 039	115, 101	847, 741	1, 388, 881	0	202.00

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	TI ON OF CAPITAL RELATED COSTS		Provider C	CN: 15-1307 P	eriod: rom 07/01/2021 o 06/30/2022	Worksheet B Part II Date/Time Pre 11/28/2022 9:	epared:
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	·	& GENERAL	PLANT	LINEN SERVICE			
		5.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS		-				
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	497, 513					5.00
7.00	00700 OPERATION OF PLANT	20, 625	138, 354				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	156		6, 856			8.00
9.00	00900 HOUSEKEEPI NG	12, 100	224	0	13, 254		9.00
10.00	01000 DI ETARY	0	0	0	0	0	10.00
13.00	01300 NURSI NG ADMI NI STRATI ON	920	4, 251	0	306	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	528	0	0	0	0	14.00
15.00	01500 PHARMACY	20, 109	0	0	0	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	1,044	8, 717	0	627	0	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	68, 999	31, 359	4, 798	2, 253	0	30.00
43.00	04300 NURSERY	0	0	0	0	0	43.00
	ANCI LLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	23, 438	18, 946	343	1, 362	0	
53.00	05300 ANESTHESI OLOGY	0	0	, s		0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	33, 157					
60.00	06000 LABORATORY	47, 395				0	
65.00	06500 RESPI RATORY THERAPY	1, 799				0	65.00
66.00	06600 PHYSI CAL THERAPY	12, 464	8, 485	206	610	0	
68.00	06800 SPEECH PATHOLOGY	0	0	-	-	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	681	2, 261	0	163	0	
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	160	-	0	0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	245	2, 042	0	147	0	73.00
	OUTPATIENT SERVICE COST CENTERS		-			-	
88.00	08800 RURAL HEALTH CLINIC	40, 404				0	
88.01	08801 RURAL HEALTH CLINIC II	71, 379	0	16		0	
90.00	09000 CLINIC	0	0	0	-	0	
90.01	09001 COVID-19 VACCINE CLINIC	0	0	0	-	0	
91.00	09100 EMERGENCY	100, 058	16, 393	1, 371	1, 178	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
05 00	OTHER REIMBURSABLE COST CENTERS	22,700	10 745	24	770	0	05 00
95.00	09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	32, 780	10, 745	34	772	0	95.00
118.00		488, 441	129, 788	6, 856	12, 638	0	118.00
110.00	NONREIMBURSABLE COST CENTERS	400, 441	129,700	0, 830	12,030	0	110.00
192 00	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0	0	192.00
	19300 NONPALD WORKERS	0	-				193.00
	19301 ORTHO CLINIC	377	-	-			193.01
	19303 ENT CLINIC	8, 695			441		193.02
	07950 MARKETI NG	0,079	0,100		0		194.00
200.00			Ĭ	Ĭ	0		200.00
200.00	5	0	0	0	0	n	201.00
202.00		497, 513	138, 354	6, 856	13, 254		202.00
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In Lieu of Form CMS-2552-10

ALLOCA	ATION OF CAPITAL RELATED COSTS		Disas data C(	N. 1E 1007			
	THOR OF CATTINE RELATED COSTS		Provider CO	F	veriod: rom 07/01/2021 o 06/30/2022	Worksheet B Part II Date/Time Pre 11/28/2022 9:	pared: 58 am
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	Subtotal	
		13.00	14.00	15.00	16.00	24.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
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
13.00	01300 NURSI NG ADMI NI STRATI ON	23, 167					13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	20,107	530				14.00
15.00	01500 PHARMACY	2	0	20, 109	)		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0	20, 109			16.00
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	U U	0		40,001		10.00
30, 00	03000 ADULTS & PEDIATRICS	8, 377	0	C	4, 362	250, 647	30, 00
43.00	04300 NURSERY	0, 377	0			250, 047	
43.00	ANCI LLARY SERVICE COST CENTERS	U	0		u U	0	43.00
50.00	05000 OPERATING ROOM	2, 337	0	C	3, 882	129, 151	50.00
53.00	05300 ANESTHESI OLOGY	2, 337	0			129, 131	
53.00	05400 RADI OLOGY -DI AGNOSTI C	0	0		-	-	
60.00	06000 LABORATORY	0	0		9, 879	121, 260 89, 034	
65.00	06500 RESPI RATORY THERAPY	0	0		1,057	23, 190	
		0	0				
66.00	06600 PHYSI CAL THERAPY 06800 SPEECH PATHOLOGY	2	0		1, 726	58, 801	
68.00		0	0		0	0	68.00
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	467		0	12, 981	
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0	63	0	-	223	
73.00	07300 DRUGS CHARGED TO PATIENTS	U	0	20, 109	0	31, 039	73.00
00.00	OUTPATIENT SERVICE COST CENTERS	1 ( 4 (	0		00/	10/ 055	00.00
88.00	08800 RURAL HEALTH CLINIC	1,646	0	0		126, 255	
88.01	08801 RURAL HEALTH CLINIC II	5, 161	0	C		196, 828	
90.00	09000 CLINIC	0	0	C	-	0	90.00
90.01	09001 COVID-19 VACCINE CLINIC	0	0	C	-	0	90.01
91.00	09100 EMERGENCY	4, 600	0	C	11, 054	202, 873	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS					04.454	
95.00	09500 AMBULANCE SERVICES	0	0	C	2, 610	91, 656	95.00
	SPECIAL PURPOSE COST CENTERS				· · · · · · · · · · · · · · · · · · ·		
118.00		22, 125	530	20, 109	46, 661	1, 333, 938	118.00
	NONREI MBURSABLE COST CENTERS	-1		-			
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	C	1		192.00
	19300 NONPAI D WORKERS	0	0	C	-		193.00
	19301 ORTHO CLINIC	0	0	C	0	13, 108	
	2 19303 ENT CLINIC	1, 042	0		0		193.02
	07950 MARKETI NG	0	0	C	0		194.00
200.00							200.00
201.00		0	0	0	0		201.00
202.00	)   TOTAL (sum lines 118 through 201)	23, 167	530	20, 109	46, 661	1, 388, 881	202.00

Health Financial Systems	ASCENSION ST. VINCE	NT WILLIAMSPORT	Γ	In_Lieu	of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN	l: 15-1307		Worksheet B
				From 07/01/2021	Part II
					Date/Time Prepared:
Cost Conton Deporintion	Intern 9	Tatal			11/28/2022 9:58 am
Cost Center Description	Intern &	Total			
	Residents Cost				
	& Post				
	Stepdown				
	Adjustments				
	25.00	26.00			
GENERAL SERVICE COST CENTERS					
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5. 00 00500 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
13. 00 01300 NURSI NG ADMI NI STRATI ON					13.00
					14.00
15.00 01500 PHARMACY					15.00
16.00 01600 MEDI CAL RECORDS & LI BRARY					16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS	0	250, 647			30.00
43. 00 04300 NURSERY	0	0			43.00
ANCI LLARY SERVI CE COST CENTERS					
50.00 05000 OPERATING ROOM	0	129, 151			50.00
53. 00 05300 ANESTHESI OLOGY	0	0			53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	121, 260			54.00
60. 00 06000 LABORATORY	0	89, 034			60.00
65. 00 06500 RESPIRATORY THERAPY	0	23, 190			65.00
66. 00 06600 PHYSI CAL THERAPY	0	58, 801			66.00
68. 00 06800 SPEECH PATHOLOGY	0	50, 001			68.00
	-	12, 981			71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	0	223			72.00
73.00 O7300 DRUGS CHARGED TO PATIENTS	0	31, 039			73.00
OUTPATIENT SERVICE COST CENTERS	I				
88.00 08800 RURAL HEALTH CLINIC	0	126, 255			88.00
88.01 08801 RURAL HEALTH CLINIC II	0	196, 828			88. 01
90. 00 09000 CLINIC	0	0			90.00
90.01 09001 COVID-19 VACCINE CLINIC	0	0			90.01
91.00 09100 EMERGENCY	0	202, 873			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PA	RT) O				92.00
OTHER REIMBURSABLE COST CENTERS					
95. 00 09500 AMBULANCE SERVICES	0	91, 656			95.00
SPECIAL PURPOSE COST CENTERS	0	71,000			/3.00
118.00 SUBTOTALS (SUM OF LINES 1 through	117) 0	1, 333, 938			118.00
	0	1, 333, 738			
NONREI MBURSABLE COST CENTERS		0			102.02
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0			192.00
193. 00 19300 NONPALD WORKERS	0	0			193.00
193. 01 19301 ORTHO CLINIC	0	13, 108			193.01
		41, 835			193.02
193. 02 19303 ENT CLINIC	0	41,000			
193. 02 19303 ENT_CLINIC 194. 00 07950 MARKETING	0	41,033			194.00
194. 00 07950 MARKETI NG	0				194.00
194.0007950MARKETING200.00Cross Foot Adjustments	0	0			194.00 200.00
194. 00 07950 MARKETI NG	0	0 0			194.00

## ASCENSION ST. VINCENT WILLIAMSPORT

In Lieu of Form CMS-2552-10

Heal th	Financial Systems ASCE	ENSION ST. VINC	ENT WILLIAMSPO	RT	In Lie	u of Form CMS-2	2552-10
	LLOCATION - STATISTICAL BASIS		Provider CC		eri od:	Worksheet B-1	
					rom 07/01/2021		
					06/30/2022	Date/Time Pre	
			ATED COCTC			11/28/2022 9:	58 am
		CAPI TAL REL	ATED CUSTS				
					D		
	Cost Center Description	NEW BLDG &	NEW MVBLE	EMPLOYEE	Reconciliation		
		FLXT	EQUI P	BENEFITS		& GENERAL	
		(SQUARE	(SQUARE	DEPARTMENT		(ACCUM.	
		FEET)	FEET)	(GROSS		COST)	
				SALARI ES)			
		1.00	2.00	4.00	5A	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	53, 831					1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP		53, 831				2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0	8, 210, 825			4.00
5.00	00500 ADMINISTRATIVE & GENERAL	3, 996	3, 996	517, 429		17, 280, 127	5.00
7.00	00700 OPERATION OF PLANT	6, 582	6, 582	0	0	716, 361	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	302	302	0	0	5, 402	8.00
9.00	00900 HOUSEKEEPING	52	52	0	0	420, 281	9.00
7.00 10.00	01000 DI ETARY	0	0	0	0	420, 281	1
		-	-	0 401	0	-	10.00
13.00	01300 NURSI NG ADMI NI STRATI ON	989	989	8, 491		31, 946	
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	256		18, 337	14.00
15.00	01500 PHARMACY	0	0	161, 639	0	698, 459	
16.00	01600 MEDICAL RECORDS & LIBRARY	2, 028	2, 028	0	0	36, 273	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	7, 296	7, 296	1, 504, 757	0	2, 396, 551	30.00
43.00	04300 NURSERY	0	0	0	0	0	43.00
	ANCI LLARY SERVICE COST CENTERS						1
50.00	05000 OPERATING ROOM	4, 408	4, 408	444, 951	0	814, 086	50.00
53.00	05300 ANESTHESI OLOGY	0	0	0	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 516	3, 516	785, 964	-	1, 151, 642	54.00
60.00	06000 LABORATORY	1, 412		249		1, 646, 171	60.00
			1, 412				
65.00	06500 RESPI RATORY THERAPY	904	904	25, 304		62, 497	65.00
66.00	06600 PHYSI CAL THERAPY	1, 974	1, 974	284, 159	0	432, 924	66.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	526	526	0	0	23, 644	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	5, 541	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	475	475	0	0	8, 496	73.00
	OUTPATIENT SERVICE COST CENTERS						1
88.00	08800 RURAL HEALTH CLINIC	4, 572	4, 572	880, 738	0	1, 403, 345	88.00
88.01	08801 RURAL HEALTH CLINIC II	6, 492	6, 492	1, 563, 704	0	2, 479, 225	88.01
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.01	09001 COVID-19 VACCINE CLINIC	0	0	0	0	0	90.01
91.00	09100 EMERGENCY	3, 814	3, 814	1, 053, 817	0	3, 475, 265	91.00
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	3,014	3, 014	1,055,017	0	3, 475, 205	
92.00							92.00
	OTHER REIMBURSABLE COST CENTERS	0.500	0.500	707.04/		1 100 550	
95.00	09500 AMBULANCE SERVICES	2, 500	2, 500	787, 816	0	1, 138, 550	95.00
	SPECIAL PURPOSE COST CENTERS						
118.00		51, 838	51, 838	8, 019, 274	-6, 740, 938	16, 964, 996	118.00
	NONREI MBURSABLE COST CENTERS						
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0	0	192.00
	19300 NONPALD WORKERS	0	0	0	0	0	193.00
193.01	19301 ORTHO CLINIC	566	566	0	0	13, 110	193.01
	19303 ENT CLINIC	1, 427	1, 427	191, 551	0	302, 021	193.02
	07950 MARKETI NG	0	0	0	0		194.00
200.00		J	, in the second s	0	Ū		200.00
200.00							201.00
		115, 101	047 741	2 220 702		( 740 020	
			847, 741	2, 238, 793		6, 740, 938	202.00
202.00							
	Part I)		45 340400				
203.00	Part I) Unit cost multiplier (Wkst. B, Part I)	2. 138192	15. 748193	0. 272664		0.390098	
	Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,		15. 748193	0. 272664 0		0. 390098 497, 513	
203.00 204.00	Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II)		15. 748193	0		497, 513	204.00
203.00	Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II)		15. 748193	0. 272664 0 0. 000000			204.00
203.00 204.00	Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II)		15. 748193	0		497, 513	204.00
203.00 204.00	Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II)		15. 748193	0		497, 513	204.00
203.00 204.00 205.00	Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II)		15. 748193	0		497, 513	204. 00 205. 00
203.00 204.00 205.00	Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II) NAHE adjustment amount to be allocated (per Wkst. B-2)		15. 748193	0		497, 513 0. 028791	204. 00 205. 00
203.00 204.00 205.00 206.00	Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II) NAHE adjustment amount to be allocated (per Wkst. B-2)		15. 748193	0		497, 513 0. 028791	204.00 205.00 206.00

Heal th Financial	Systems
COST ALLOCATION	

## ASCENSION ST. VINCENT WILLIAMSPORT

In Lieu of Form CMS-2552-10

Health Financial Systems ASCE	ENSION ST. VINC	ENT WILLIAMSPO	RT	In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS				eri od:	Worksheet B-1	
				rom 07/01/2021	Data (Time Dres	
			T	06/30/2022	Date/Time Pre 11/28/2022 9:	pared: 58 am
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	
	PLANT	LINEN SERVICE	(SQUARE		ADMI NI STRATI ON	
	(SQUARE FEET)	(POUNDS OF	FEET)	SERVED)		
	,	LAUNDRY)	, í		(DI RECT	
		, í			NRSING HRS)	
	7.00	8.00	9.00	10.00	13.00	
GENERAL SERVICE COST CENTERS						
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL						5.00
7.00 00700 OPERATION OF PLANT	32, 189					7.00
8.00 00800 LAUNDRY & LINEN SERVICE	302	86, 833				8.00
9. 00 00900 HOUSEKEEPI NG	52	0	42, 899			9.00
10. 00 01000 DI ETARY	0	0	0	0		10.00
13.00 01300 NURSING ADMINISTRATION	989	0	989	0	84, 240	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	8	14.00
15.00 01500 PHARMACY	0	0	0	0	0	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	2, 028	0	2, 028	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	7, 296	60, 784	7, 296	0	30, 458	30.00
43.00 04300 NURSERY	0	0	0	0	0	43.00
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATI NG ROOM	4, 408	4, 341	4, 408	0	8, 499	50.00
53. 00 05300 ANESTHESI OLOGY	0	0	0	0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	3, 516	868	3, 516	0	0	54.00
60. 00 06000 LABORATORY	1, 412	0	1, 412	0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	904	0	904	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	1, 974	2, 605	1, 974	0	9	66.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	526	0	526	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	475	0	475	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	237	4, 572	0	5, 984	88.00
88.01 08801 RURAL HEALTH CLINIC II	0	197	6, 492	0	18, 767	88. 01
90. 00 09000 CLINIC	0	0	0	0	0	90.00
90.01 09001 COVID-19 VACCINE CLINIC	0	0	0	0	0	90.01
91.00 09100 EMERGENCY	3, 814	17, 367	3, 814	0	16, 727	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES	2, 500	434	2, 500	0	0	95.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	30, 196	86, 833	40, 906	0	80, 452	118.00
NONREI MBURSABLE COST CENTERS						
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0	0	192.00
193.00 19300 NONPALD WORKERS	0	0	0	0	0	193.00
193. 01 19301 ORTHO CLI NI C	566	0	566	0	0	193.01
193. 02 19303 ENT CLINIC	1, 427	0	1, 427	0		193. 02
194. 00 07950 MARKETI NG	0	0	0	0	0	194.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B,	995, 812	16, 852	585, 841	0	88, 510	202.00
Part I)						
203.00 Unit cost multiplier (Wkst. B, Part I)	30. 936407	0. 194074	13. 656286	0.000000	1.050689	203.00
204.00 Cost to be allocated (per Wkst. B,	138, 354	6, 856	13, 254	0	23, 167	204.00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part	4. 298176	0. 078956	0. 308958	0.000000	0. 275012	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)						

Health Financial	Systems
MOLTADOLIA T200	

Health Financial Systems	ASCENSION ST. VINCE	NT WILLIAMSPORT	Г	In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CCN		Period:	Worksheet B-1	
				rom 07/01/2021		
			1	o 06/30/2022	Date/Time Pre 11/28/2022 9:	
Cost Center Description	CENTRAL	PHARMACY	MEDI CAL		1172072022 7.3	
	SERVICES &	(COSTED	RECORDS &			
	SUPPLY	REQUIS.)	LIBRARY			
	(DI RECT COSTS)		(GROSS			
			CHARGES)			
	14.00	15.00	16.00			
GENERAL SERVICE COST CENTERS						
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 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
13.00 01300 NURSING ADMINISTRATION						13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	46, 593					14.00
15.00 01500 PHARMACY	0	100				15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	0	74, 302, 499			16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0	6, 945, 324			30.00
43.00 04300 NURSERY	0	0	C	)		43.00
ANCI LLARY SERVI CE COST CENTERS		· · · · · ·				
50.00 05000 OPERATI NG ROOM	0	0	6, 182, 030	)		50.00
53. 00 05300 ANESTHESI OLOGY	0	0	C	)		53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0	14, 246, 591			54.00
60. 00 06000 LABORATORY	0	0	15, 731, 064			60.00
65. 00 06500 RESPI RATORY THERAPY	0	0	1, 683, 400	)		65.00
66. 00 06600 PHYSI CAL THERAPY	0	0	2, 748, 433	B		66.00
68.00 06800 SPEECH PATHOLOGY	0	0	C	)		68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	rs 41, 052	0	C	)		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	5, 541	0	C	)		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	100	C	)		73.00
OUTPATIENT SERVICE COST CENTERS		· · · · ·				
88.00 08800 RURAL HEALTH CLINIC	0	0	1, 585, 438	8		88.00
88.01 08801 RURAL HEALTH CLINIC II	0	0	3, 420, 474	ŀ		88. 01
90. 00 09000 CLINIC	0	0	C	)		90.00
90.01 09001 COVID-19 VACCINE CLINIC	0	0	C	)		90.01
91.00 09100 EMERGENCY	0	0	17, 604, 442			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	Г)					92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES	0	0	4, 155, 303	8		95.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1 through 1	117) 46, 593	100	74, 302, 499	)		118.00
NONREI MBURSABLE COST CENTERS						
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	C	)		192.00
193.00 19300 NONPALD WORKERS	0	0	C	)		193.00
193.01 19301 ORTHO CLINIC	0	0	C	)		193.01
193.02 19303 ENT CLINIC	0	0	C	)		193. 02
194.00 07950 MARKETI NG	0	0	C	)		194.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B,	25, 498	970, 926	140, 857	1		202.00
Part I)						
203.00 Unit cost multiplier (Wkst. B, Part	t I) 0.547250	9, 709. 260000	0. 001896			203.00
204.00 Cost to be allocated (per Wkst. B,	530	20, 109	46, 661			204.00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part	t 0. 011375	201.090000	0.000628	8		205.00
11)						
206.00 NAHE adjustment amount to be alloca	ated					206. 00
(per Wkst. B-2)						
207.00 NAHE unit cost multiplier (Wkst. D,						207.00
Parts III and IV)		ļ		I		I

	ATLON OF RATIO OF COSTS TO CHARGES		Provider C	F	Period: From 07/01/2021 To 06/30/2022	Worksheet C Part I Date/Time Pre 11/28/2022 9:	pared.
			Title	XVIII	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj.		Di sal I owance		
		Part I, col.					
		26)	2.00	2.00	1.00	F 00	
	INDATIENT DOUTINE SEDVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
30, 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	3, 713, 756	1	3, 713, 756	0	0	30.00
	04300 NURSERY	3, /13, /50		3, /13, /50		0	
43.00	ANCI LLARY SERVICE COST CENTERS	0				0	43.00
50, 00	05000 OPERATING ROOM	1, 349, 717		1, 349, 717	0	0	50.00
53.00	05300 ANESTHESI OLOGY	1, 347, 717		1, 347, 717		0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 784, 863		1, 784, 863	3 O	0	54.00
60.00	06000 LABORATORY	2, 381, 130		2, 381, 130		0	60.00
65.00	06500 RESPIRATORY THERAPY	130, 381		130, 381		0	65.00
66.00	06600 PHYSI CAL THERAPY	695, 559		695, 559		0	66.00
68.00	06800 SPEECH PATHOLOGY	0	c	, c	0 0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	78, 789		78, 789	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	10, 735		10, 735	ō 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,003,918		1, 003, 918	3 0	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	2, 022, 563		2, 022, 563	3 0	0	00.00
88. 01	08801 RURAL HEALTH CLINIC II	3, 561, 264		3, 561, 264	l 0	0	00.01
90.00	09000 CLI NI C	0		C	0 0	0	90.00
90. 01	09001 COVID-19 VACCINE CLINIC	0		C	0 0	0	90.01
91.00	09100 EMERGENCY	5, 055, 334		5, 055, 334		0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 140, 090		1, 140, 090	)	0	92.00
	OTHER REIMBURSABLE COST CENTERS	1	1	1	1		
	09500 AMBULANCE SERVICES	1, 702, 140		1, 702, 140			95.00
200.00		24, 630, 239		24, 630, 239			200.00
201.00		1, 140, 090		1, 140, 090			201.00
202.00	Total (see instructions)	23, 490, 149	0	23, 490, 149	0	0	202.00

	LINSTON ST. VINCE					2332-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Peri od:	Worksheet C	
				From 07/01/2021	Part I	
				To 06/30/2022	Date/Time Pre 11/28/2022 9:	
		Title	e XVIII	Hospi tal	Cost	<u>50 ani</u>
		Charges			0031	
Cost Center Description	I npati ent	Outpati ent	Total (col	6 Cost or Other	TEFRA	
	inputront	outputtont	+ col. 7	Ratio	Inpati ent	
				hatro	Ratio	
	6.00	7.00	8,00	9,00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	5, 110, 638		5, 110, 63	8		30.00
43. 00 04300 NURSERY	0			0		43.00
ANCI LLARY SERVI CE COST CENTERS						1
50.00 05000 OPERATING ROOM	191, 817	5, 990, 213	6, 182, 03	0. 218329	0.000000	50.00
53. 00 05300 ANESTHESI OLOGY	0	0		0 0.000000	0. 000000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	739, 507	13, 507, 084	14, 246, 59	0. 125284	0. 000000	54.00
60. 00 06000 LABORATORY	1, 414, 420	14, 316, 644	15, 731, 06	0. 151365	0. 000000	60.00
65. 00 06500 RESPI RATORY THERAPY	88, 713	1, 594, 687	1, 683, 40	0. 077451	0. 000000	65.00
66. 00 06600 PHYSI CAL THERAPY	265, 966	2, 482, 467	2, 748, 43	0. 253075	0. 000000	66.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0.000000	0. 000000	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	717, 865	910, 866	1, 628, 73	0. 048374	0. 000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	6, 683	57, 924	64, 60	0. 166158	0. 000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 387, 929	2,074,725	3, 462, 65	0. 289927	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	1, 585, 438	1, 585, 43	8		88.00
88.01 08801 RURAL HEALTH CLINIC II	0	3, 420, 474	3, 420, 47	4		88.01
90. 00 09000 CLINIC	0	C		0 0.000000		
90.01 09001 COVID-19 VACCINE CLINIC	0	C		0 0.000000	0. 000000	
91. 00 09100 EMERGENCY	344, 776	17, 259, 666	17, 604, 44	2 0. 287162	0. 000000	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	24, 785	1, 809, 901	1, 834, 68	0. 621409	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	98	4, 155, 205	4, 155, 30	0. 409631	0. 000000	
200.00 Subtotal (see instructions)	10, 293, 197	69, 165, 294	79, 458, 49	1		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	10, 293, 197	69, 165, 294	79, 458, 49	1		202.00

Health Financial Systems AS	CENSION ST. VINCEN	NT WILLIAMSPORT	In Lieu of Form CMS-2552-1		
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1307	Peri od: From 07/01/2021 To 06/30/2022	Worksheet C Part I Date/Time Pre 11/28/2022 9:	
		Title XVIII	Hospi tal	Cost	
Cost Center Description	PPS Inpatient Ratio 11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS					30.00
43.00 04300 NURSERY					43.00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATI NG ROOM	0. 000000				50.00
53. 00 05300 ANESTHESI OLOGY	0. 000000				53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
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
68.00 06800 SPEECH PATHOLOGY	0, 000000				68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0.000000				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
OUTPATIENT SERVICE COST CENTERS					1
88.00 08800 RURAL HEALTH CLINIC					88.00
88.01 08801 RURAL HEALTH CLINIC II					88.01
90. 00 09000 CLINIC	0. 000000				90.00
90.01 09001 COVID-19 VACCINE CLINIC	0. 000000				90.01
91. 00 09100 EMERGENCY	0. 000000				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000				92.00
OTHER REIMBURSABLE COST CENTERS	· ·				
95. 00 09500 AMBULANCE SERVICES	0. 000000				95.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)					202.00
	1 I				

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 9:	pared: 58 am
		Titl	e XIX	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj.		Di sal I owance		
	Part I, col.					
	26)	0.00		6.00		
	1.00	2.00	3.00	4.00	5.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0.740.754		0.740.75	را م	0.740.75/	
30. 00 03000 ADULTS & PEDI ATRI CS	3, 713, 756		3, 713, 75		3, 713, 756	
43. 00 04300 NURSERY	0			0 0	0	43.00
ANCI LLARY SERVI CE COST CENTERS	1 040 717	1	1 240 71	7	1 240 717	
50. 00 05000 OPERATI NG ROOM	1, 349, 717		1, 349, 71	/ 0	1, 349, 717	
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	1 704 0(2		1 704 04		1 704 0(2	
60. 00 06000 LABORATORY	1, 784, 863		1, 784, 86		1, 784, 863	
65. 00 06500 RESPIRATORY THERAPY	2, 381, 130		2, 381, 13		2, 381, 130	•
66. 00 06600 PHYSI CAL THERAPY	130, 381		130, 38		130, 381 695, 559	•
68. 00 06800 SPEECH PATHOLOGY	695, 559		695, 55	0 0	095, 559	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	78, 789	0	78, 78	°	78, 789	•
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	10, 735		10, 73		10, 735	
73.00 07300 DRUGS CHARGED TO PATIENTS	1,003,918		1, 003, 91		1, 003, 918	
OUTPATIENT SERVICE COST CENTERS	1,003,910		1,003,91	0 0	1,003,910	/3.00
88.00 08800 RURAL HEALTH CLINIC	2,022,563		2, 022, 56	3 0	2, 022, 563	88 00
88. 01 08801 RURAL HEALTH CLINIC II	3, 561, 264		3, 561, 26		3, 561, 264	
90. 00 09000 CLINIC	0,001,201		0,001,20	0 0	0,001,201	
90. 01 09001 COVID-19 VACCINE CLINIC	0			0 0	0	90.01
91. 00 09100 EMERGENCY	5,055,334		5, 055, 33	4 0	5,055,334	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 140, 090		1, 140, 09		1, 140, 090	•
OTHER REIMBURSABLE COST CENTERS	1,110,070		1, 110, 07		111101070	12.00
95. 00 09500 AMBULANCE SERVICES	1, 702, 140		1, 702, 14	0 0	1, 702, 140	95.00
200.00 Subtotal (see instructions)	24, 630, 239				24, 630, 239	
201.00 Less Observation Beds	1, 140, 090		1, 140, 09		1, 140, 090	
202.00 Total (see instructions)	23, 490, 149					

<sup>11/28/2022 9:58</sup> am Y: \28950 - St. Vincent Williamsport Hospital \300 - Medicare Cost Report \20220630 \HFS \20220630 Williamsport.mcr

Hearth Frhancial Systems ASC	ENSION ST. VINCE	NI WILLIAMSPU	RI .	In Lie	U OT FORM CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Peri od:	Worksheet C	
				From 07/01/2021	Part I	
				To 06/30/2022	Date/Time Pre 11/28/2022 9:	
		Ti +1	e XIX	Hospi tal	Cost	JO dili
		Charges	e viv		COST	
Cost Center Description	Inpatient	Outpatient	Total (col	6 Cost or Other	TEFRA	
	inpatrent	outputient	+ col. 7	Ratio	Inpatient	
				hatro	Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	5, 110, 638		5, 110, 63	8		30.00
43. 00 04300 NURSERY	0			0		43.00
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	191, 817	5, 990, 213	6, 182, 03	0 0. 218329	0.000000	50.00
53. 00 05300 ANESTHESI OLOGY	0	0		0 0.000000	0.000000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	739, 507	13, 507, 084	14, 246, 59	0. 125284	0.000000	54.00
60. 00 06000 LABORATORY	1, 414, 420	14, 316, 644	15, 731, 06	0. 151365	0.000000	60.00
65. 00 06500 RESPI RATORY THERAPY	88, 713	1, 594, 687	1, 683, 40	0.077451	0.000000	65.00
66. 00 06600 PHYSI CAL THERAPY	265, 966	2, 482, 467	2, 748, 43	3 0. 253075	0.000000	66.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0.000000	0. 000000	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	717, 865	910, 866	1, 628, 73	0. 048374	0. 000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	6, 683	57, 924	64,60	0. 166158	0. 000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 387, 929	2,074,725	3, 462, 65	4 0. 289927	0. 000000	73.00
OUTPATIENT SERVICE COST CENTERS			•			1
88.00 08800 RURAL HEALTH CLINIC	0	1, 585, 438	1, 585, 43	8 1. 275712	0. 000000	88.00
88.01 08801 RURAL HEALTH CLINIC II	0	3, 420, 474	3, 420, 47	4 1.041161	0. 000000	88.01
90. 00 09000 CLINIC	0	0		0 0.000000	0. 000000	90.00
90.01 09001 COVID-19 VACCINE CLINIC	0	0		0 0.000000	0.000000	90.01
91. 00 09100 EMERGENCY	344, 776	17, 259, 666	17, 604, 44	2 0. 287162	0. 000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	24, 785	1, 809, 901	1, 834, 68	6 0. 621409	0.00000	92.00
OTHER REIMBURSABLE COST CENTERS						]
95. 00 09500 AMBULANCE SERVI CES	98	4, 155, 205	4, 155, 30	0. 409631	0.00000	95.00
200.00 Subtotal (see instructions)	10, 293, 197	69, 165, 294	79, 458, 49	1	1	200.00
201.00 Less Observation Beds					1	201.00
202.00 Total (see instructions)	10, 293, 197	69, 165, 294	79, 458, 49	1	1	202.00

<sup>11/28/2022 9:58</sup> am Y: \28950 - St. Vincent Williamsport Hospital \300 - Medicare Cost Report \20220630 \HFS \20220630 Williamsport.mcr

Health Financial Systems ASC	ENSION ST. VINCEN	IT WI LLI AMSPORT	In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1307	Peri od: From 07/01/2021 To 06/30/2022	Worksheet C Part I Date/Time Pre 11/28/2022 9:	
		Title XIX	Hospi tal	Cost	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
43. 00 04300 NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS					
50.00 O5000 OPERATING ROOM	0. 000000				50.00
53. 00 05300 ANESTHESI OLOGY	0. 000000				53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
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
68.00 06800 SPEECH PATHOLOGY	0. 000000				68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.000000				73.00
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC	0, 000000				88.00
88.01 08801 RURAL HEALTH CLINIC II	0.000000				88.01
90. 00 09000 CLINIC	0.000000				90.00
90.01 09001 COVID-19 VACCINE CLINIC	0.000000				90.01
91. 00 09100 EMERGENCY	0. 000000				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000				92.00
OTHER REIMBURSABLE COST CENTERS					
95. 00 09500 AMBULANCE SERVICES	0. 000000				95.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)					202.00
	1				

Health Financial Systems ASC	ENSION ST. VINC	ENT WILLIAMSPO	RT	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provider CO		Period: From 07/01/2021 To 06/30/2022	Worksheet D Part II Date/Time Pre 11/28/2022 9:	
			XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,			. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1	r	1			
50.00 05000 OPERATING ROOM	129, 151	6, 182, 030			2, 251	
53. 00 05300 ANESTHESI OLOGY	0	e e e e e e e e e e e e e e e e e e e	0.00000		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	121, 260	14, 246, 591	0. 00851	2 261, 139	2, 223	54.00
60. 00 06000 LABORATORY	89, 034	15, 731, 064	0. 00566	0 576, 210	3, 261	60.00
65. 00 06500 RESPI RATORY THERAPY	23, 190	1, 683, 400	0. 01377	6 18, 504	255	65.00
66. 00 06600 PHYSI CAL THERAPY	58, 801	2, 748, 433	0. 02139	80, 784	1, 728	66.00
68.00 06800 SPEECH PATHOLOGY	0	0	0.00000	0 0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	12, 981	1, 628, 731	0. 00797	281, 632	2, 245	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	223	64, 607	0. 00345	3, 341	12	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	31, 039	3, 462, 654	0. 00896	527, 986	4, 733	73.00
OUTPATIENT SERVICE COST CENTERS						1
88.00 08800 RURAL HEALTH CLINIC	126, 255	1, 585, 438	0. 07963	4 0	0	88.00
88.01 08801 RURAL HEALTH CLINIC II	196, 828	3, 420, 474	0. 05754	4 0	0	88. 01
90. 00 09000 CLINIC	0	0	0.00000	0 0	0	90.00
90.01 09001 COVID-19 VACCINE CLINIC	0	0	0.00000	0 0	0	90.01
91. 00 09100 EMERGENCY	202, 873	17, 604, 442	0. 01152	4,825	56	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	76, 947	1, 834, 686	0. 04194	0 15, 102	633	92.00
OTHER REIMBURSABLE COST CENTERS			•			1
95. 00 09500 AMBULANCE SERVI CES						95.00
200.00 Total (lines 50 through 199)	1, 068, 582	70, 192, 550		1, 877, 280	17, 397	200. 00

Health Financial Systems ASC	ENSION ST. VINC	ENT WILLIAMSPO	RT	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PASS	S Provider C	CN: 15-1307	Period: From 07/01/2021	Worksheet D Part IV	
THROUGH COSTS				To 06/30/2022		pared:
					11/28/2022 9:	
			XVIII	Hospi tal	Cost	
Cost Center Description	Non Physician		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		0	1	0 0		
50. 00 05000 OPERATI NG ROOM 53. 00 05300 ANESTHESI OLOGY	0			0 0	0	50.00 53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0			0 0		53.00
60. 00 06000 LABORATORY	0			0 0		60.00
65. 00 06500 RESPIRATORY THERAPY	0			0 0		65.00
66. 00 06600 PHYSI CAL THERAPY	0			0 0		66.00
68. 00 06800 SPEECH PATHOLOGY	0					68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0				0	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	0			0 0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0			0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS			1	0	<u> </u>	70.00
88.00 08800 RURAL HEALTH CLINIC	0	0		0 0	0	88.00
88.01 08801 RURAL HEALTH CLINIC II	0	0		0 0	0	88.01
90. 00 09000 CLINIC	0	0		0 0	0	90.00
90.01 09001 COVID-19 VACCINE CLINIC	0	0		0 0	0	90.01
91.00 09100 EMERGENCY	0	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
OTHER REIMBURSABLE COST CENTERS						1
95. 00 09500 AMBULANCE SERVI CES						95.00
200.00 Total (lines 50 through 199)	0	0	1	0 0	0	200. 00

11/28/2022 9:58 am Y: \28950 - St. Vincent Williamsport Hospital \300 - Medicare Cost Report \20220630 \HFS \20220630 Williamsport.mcr

Health Financial Systems ASC	ENSION ST. VINC	ENT WILLIAMSPO	RT	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	S Provider C		Period:	Worksheet D	
THROUGH COSTS				From 07/01/2021	Part IV	
				To 06/30/2022	Date/Time Pre 11/28/2022 9:	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
	Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	cols. 2, 3,	8)	7)	
			and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVICE COST CENTERS						
50.00 05000 OPERATI NG ROOM	0	0		0 6, 182, 030	0.000000	50.00
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0.000000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 14, 246, 591	0.000000	54.00
60. 00 06000 LABORATORY	0	0		0 15, 731, 064	0.000000	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 1, 683, 400	0. 000000	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		2, 748, 433	0. 000000	66.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0. 000000	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		1, 628, 731	0. 000000	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	0	0		64,607	0. 000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		3, 462, 654	0. 000000	73.00
OUTPATIENT SERVICE COST CENTERS	-					1
88.00 08800 RURAL HEALTH CLINIC	0	0		0 1, 585, 438	0.000000	88.00
88.01 08801 RURAL HEALTH CLINIC II	0	0		3, 420, 474	0. 000000	88.01
90. 00 09000 CLINIC	0	0		0 0	0. 000000	90.00
90.01 09001 COVID-19 VACCINE CLINIC	0	0		0 0	0. 000000	90.01
91.00 09100 EMERGENCY	0	0		17, 604, 442	0. 000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		1, 834, 686	0. 000000	92.00
OTHER REI MBURSABLE COST CENTERS			•			1
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	0	0		70, 192, 550		200.00
· · · · · · · · · · · · · · · · · · ·			•		•	•

Health Financial Systems ASC	ENSION ST. VINCE	NT WILLIAMSPO	RT	In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PASS	Provider CO		Period:	Worksheet D	
THROUGH COSTS				From 07/01/2021 To 06/30/2022	Part IV Date/Time Pre	narod
				10 00/ 30/ 2022	11/28/2022 9:	58 am
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷ col.		Costs (col. 8	3	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS	1 1			T	1	
50. 00 05000 OPERATI NG ROOM	0. 000000	107, 757		0 0	0	50.00
53.00 05300 ANESTHESI OLOGY	0. 000000	0		0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	261, 139		0 0	0	54.00
60. 00 06000 LABORATORY	0. 000000	576, 210		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	18, 504		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	80, 784		0 0	0	66.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	0		0 0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	281, 632		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000	3, 341		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	527, 986		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0. 000000	0		0 0	0	88.00
88.01 08801 RURAL HEALTH CLINIC II	0. 000000	0		0 0	0	88. 01
90. 00 09000 CLI NI C	0. 000000	0		0 0	0	90.00
90.01 09001 COVID-19 VACCINE CLINIC	0. 000000	0		0 0	0	90.01
91.00 09100 EMERGENCY	0. 000000	4, 825		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	15, 102		0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVI CES						95.00
200.00   Total (lines 50 through 199)		1, 877, 280		0 0	0	200. 00

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Health Financial Systems ASCE	ENSION ST. VINC	ENT WILLIAMSPO	RT	In Lie	u of Form CMS-	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 9:	
		Title	XVIII	Hospi tal	Cost	<u>50 ann</u>
			Charges	nospi tui	Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
oust conter beschiption	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C.	inst.)	Servi ces	Servi ces Not	(000 1101)	
	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 OPERATI NG ROOM	0. 218329	0	1, 499, 42	8 0	0	50.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	0		0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 125284	0	3, 764, 95	8 0	0	54.00
60. 00 06000 LABORATORY	0. 151365	0	4, 907, 19	3 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 077451	0	536, 30	07 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 253075	0	830, 06	5 0	0	66.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	0		0 0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 048374	0	308, 68	6 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 166158	0	14, 96	7 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 289927	0	516, 25	3 1, 684	0	73.00
OUTPATIENT SERVICE COST CENTERS			•			
88.00 08800 RURAL HEALTH CLINIC						88.00
88.01 08801 RURAL HEALTH CLINIC II						88.01
90. 00 09000 CLINIC	0. 000000	0		0 0	0	90.00
90.01 09001 COVID-19 VACCINE CLINIC	0. 000000	0		0 0	0	90.01
91.00 09100 EMERGENCY	0. 287162	0	3, 726, 77	7 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 621409	0	661, 72	1 0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVI CES	0. 409631			0		95.00
200.00 Subtotal (see instructions)		0	16, 766, 35	5 1, 684	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	16, 766, 35	5 1, 684	0	202.00

Heal th	Financial Systems ASCI	ENSION ST. VINC	ENT WILLIAMSPO	RT	In Lie	u of Form CMS	-2552-10
APPORT	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Period: From 07/01/2021 To 06/30/2022	11/28/2022 9	
			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	0.07.0/0					
	05000 OPERATING ROOM	327, 369					50.00
	05300 ANESTHESI OLOGY	0					53.00
	05400 RADI OLOGY-DI AGNOSTI C	471, 689					54.00
	06000 LABORATORY	742, 777					60.00
	06500 RESPI RATORY THERAPY	41, 538					65.00
	06600 PHYSI CAL THERAPY	210, 069	0				66.00
	06800 SPEECH PATHOLOGY	0	-				68.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	14, 932					71.00
	07200 IMPL. DEV. CHARGED TO PATIENT	2, 487					72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	149, 676	488				73.00
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC						88.00
88.01	08801 RURAL HEALTH CLINIC II						88.01
	09000 CLI NI C	0	0				90.00
90.01	09001 COVID-19 VACCINE CLINIC	0	0				90.01
91.00	09100 EMERGENCY	1, 070, 189	0				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	411, 199	0				92.00
	OTHER REIMBURSABLE COST CENTERS		•				
95.00	09500 AMBULANCE SERVICES	0					95.00
200.00	Subtotal (see instructions)	3, 441, 925	488				200.00
201.00	Less PBP Clinic Lab. Services-Program	0					201.00
	Only Charges						
202.00	Net Charges (line 200 - line 201)	3, 441, 925	488				202.00

Health Financial Systems ASCI	ENSION ST. VINC	ENT WILLIAMSPO	RT	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Peri od:	Worksheet D	
		Company		From 07/01/2021	Part V	
		Component	CCN: 15-Z307	To 06/30/2022	Date/Time Pre 11/28/2022 9:	s8 am
		Title	XVIII	Swing Beds - SNF		
			Charges	oning bodd oni	Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.	Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATI NG ROOM	0. 218329			0 0	0	
53. 00 05300 ANESTHESI OLOGY	0. 000000			0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 125284	0		0 0	0	54.00
60. 00 06000 LABORATORY	0. 151365	0		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 077451	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 253075	0		0 0	0	66.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	0		0 0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 048374	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 166158	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 289927	0		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC						88.00
88.01 08801 RURAL HEALTH CLINIC II						88.01
90. 00 09000 CLINIC	0. 000000	0		0 0	0	90.00
90.01 09001 COVID-19 VACCINE CLINIC	0. 000000	0		0 0	0	90.01
91.00 09100 EMERGENCY	0. 287162	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 621409	0		0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS		•	•			
95. 00 09500 AMBULANCE SERVI CES	0. 409631			0		95.00
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 ASC	ENSION ST. VINC	ENT WILLIAMSPO	RT	In Lie	u of Form CMS-	-2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-1307	Peri od:	Worksheet D	
		Component	CON. 15 7207	From 07/01/2021 To 06/30/2022	Part V Date/Time Pre	onorod.
		component	CCN: 15-Z307	To 06/30/2022	11/28/2022 9:	
		Title	XVIII	Swing Beds - SNF		
	Co	sts				
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 05000 OPERATING ROOM	0	0				50.00
53. 00 05300 ANESTHESI OLOGY	0	0				53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
60. 00 06000 LABORATORY	0	0				60.00
65. 00 06500 RESPI RATORY THERAPY	0	0				65.00
66. 00 06600 PHYSI CAL THERAPY	0	0				66.00
68.00 06800 SPEECH PATHOLOGY	0	0				68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0				73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC						88.00
88.01 08801 RURAL HEALTH CLINIC II						88. 01
90. 00 09000 CLINIC	0	0				90.00
90.01 09001 COVID-19 VACCINE CLINIC	0	0				90.01
91.00 09100 EMERGENCY	0	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0					95.00
200.00 Subtotal (see instructions)	0	0				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)	0	0				202.00

Health Financial Systems	ASCENSION ST. VINC	ENT WILLIAMSPO	RT	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHE	R PASS THROUGH COST	rs Provider C		Period: From 07/01/2021 To 06/30/2022		epared: 58 am
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Nursi ng Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
	1A	1.00	2A	2.00	3, 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS 43.00 04300 NURSERY 200.00 Total (lines 30 through 199)	000000000000000000000000000000000000000	0 0 0	(		0 0 0	
Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	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 & PEDIATRICS           43.00         04300         NURSERY           200.00         Total (lines 30 through 199)	0	0	2, 275 ( 2, 275	0.00	0	
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00			1		
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS 43. 00 04300 NURSERY 200. 00 Total (lines 30 through 199)	0 0 0					30. 00 43. 00 200. 00

Health Financial Systems ASC	ENSION ST. VINC	ENT WILLIAMSPO	RT	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVICE OTHER PASS	S Provider C	CN: 15-1307	Period: From 07/01/2021 To 06/30/2022		
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	Anesthetist	Program	Program	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
	1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS	-					
50.00 05000 OPERATING ROOM	0	0		0 0	0	50.00
53. 00 05300 ANESTHESI OLOGY	0	0	)	0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	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
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS	- -	•			•	1
88.00 08800 RURAL HEALTH CLINIC	0	0	)	0 0	0	88.00
88.01 08801 RURAL HEALTH CLINIC II	0	0		0 0	0	88.01
90. 00 09000 CLINIC	0	0		0 0	0	90.00
90.01 09001 COVID-19 VACCINE CLINIC	0	0		0 0	0	90.01
91.00 09100 EMERGENCY	0	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
OTHER REIMBURSABLE COST CENTERS		•			•	1
95.00 09500 AMBULANCE SERVICES						95.00
200.00   Total (lines 50 through 199)	0	c		0 0	0	200. 00

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Health Financial Systems ASC	ENSION ST. VINC	ENT WILLIAMSPO	RT	In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	S Provider CO		Period:	Worksheet D	
THROUGH COSTS				From 07/01/2021	Part IV	
				To 06/30/2022	Date/Time Pre 11/28/2022 9:	
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
	Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	cols. 2, 3,	8)	7)	
			and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	0		0 6, 182, 030		
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0. 000000	•
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 14, 246, 591	0.00000	
60. 00 06000 LABORATORY	0	0		0 15, 731, 064		
65. 00 06500 RESPI RATORY THERAPY	0	0		0 1, 683, 400	0.00000	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0	(	2, 748, 433	0.000000	66.00
68.00 06800 SPEECH PATHOLOGY	0	0	(	0 0	0.000000	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(	0 1, 628, 731	0.00000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	(	0 64, 607	0.00000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	(	3, 462, 654	0. 000000	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0	(	D 1, 585, 438	0. 000000	88.00
88.01 08801 RURAL HEALTH CLINIC II	0	0	(	3, 420, 474	0. 000000	88.01
90. 00 09000 CLI NI C	0	0	(	0 0	0.000000	90.00
90.01 09001 COVID-19 VACCINE CLINIC	0	0	(	0 0	0. 000000	90.01
91.00 09100 EMERGENCY	0	0	(	0 17, 604, 442	0.00000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	(	1, 834, 686	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS			•			1
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	0	0	(	70, 192, 550		200. 00

Health Financial Systems ASC	ENSION ST. VINCE	ENT WILLIAMSPO	RT	In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PASS	Provider C		Period:	Worksheet D	
THROUGH COSTS				From 07/01/2021 To 06/30/2022		narod
				10 00/ 30/ 2022	11/28/2022 9:	
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.		Costs (col. 8	3	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS	1		1			
50. 00 05000 OPERATI NG ROOM	0. 000000	7, 223		0 0	0	50.00
53.00 05300 ANESTHESI OLOGY	0. 000000	0		0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	29, 815		0 0	0	54.00
60. 00 06000 LABORATORY	0. 000000	43, 311		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	5, 976		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	2, 737		0 0	0	66.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	0		0 0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	19, 948		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	15, 155		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS	1			1		
88.00 08800 RURAL HEALTH CLINIC	0. 000000	0		0 0	0	88.00
88.01 08801 RURAL HEALTH CLINIC II	0. 000000	0		0 0	0	88.01
90. 00 09000 CLINIC	0. 000000	0		0 0	0	90.00
90.01 09001 COVID-19 VACCINE CLINIC	0. 000000	0		0 0	0	90.01
91. 00 09100 EMERGENCY	0. 000000	62, 772		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS	· · · · · · · · · · · · · · · · · · ·		1	1		
95. 00 09500 AMBULANCE SERVICES					1	95.00
200.00   Total (lines 50 through 199)		186, 937		0 0	0	200.00

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ASCENSI ON	ST.	VI NCENT	WI LLI AMSPORT

3.00       Private room days, (accluding swing-bed and observation bed days). If you have only private room days, do do not complete this line.       0       3.00       Private room days (accluding swing-bed and observation bod days).       0       3.00       1, 432       4.00         4.00       Somi-private room days (accluding swing-bed and observation bod days).       10		Financial Systems ASCENSION ST. VINCEN ATION OF INPATIENT OPERATING COST	IT WILLIAMSPORT Provider CCN: 15-1307	Peri od:	u of Form CMS-2 Worksheet D-1	
Dot Classes         Cost Center Description         1.00           IMPAIL EXIL DROWNERS         1.00           Impair Leff DROWNERS         0.00           Cost Center Dasys (Including perivate room days, excluding sening-bed and neekorm)         2,275         2.00           Cost Center Dasys (Including perivate room days, excluding sening-bed and neekorm)         2,745         2.00           Cost Center Dasys (Including perivate room days, excluding sening-bed and neekorm)         2,755         2.00           Cost Center Dasys (Including perivate room days) (Including perivate room days) through December 31 of the cost         1,432         4.00           Cost Center Dasys (Including perivate room days) (Including private room days)						
PART 1 - ALL PROVIDER COMPONENTS         1.00           100 Input Inter JANS         Initial particle Components         1.00           100 Input Inter JANS         Initial particle Components         2.7.64         1           100 Input Inter JANS         Initial particle Composition (asy, excluding saving-bed and newborn days)         2.7.75         2.00           200 Private room days (excluding saving-bed and observation bed days)         15 you have only private room days)         2.7.64         1           4.00 Somi_private room days (excluding saving-bed and observation bed days)         15 you have only private room days)         1.422         4           6.00 Total saving-bed SF type input ind tays (Including private room days) after December 31 of the cost         0         7.00         1         1.00         6         0           7.00 Total saving-bed SF type input ind tays (Including private room days) after December 31 of the cost         0         7.00         1         0         5.00         1         0.00         5.00         1         0.00         5.00         1         0.00         5.00         1         0.00         5.00         1         0.00         5.00         1         0.00         5.00         1         0.00         5.00         1         0.00         5.00         1         0.00         5.00         1		Cost Contor Description	Title XVIII	Hospi tal	Cost	
INPARTENT DAYS         Institut days (including private room days, ackluding swing-bed day, excluding newborn)         2.74         2.00           10         Inpatient days (including private room days, ackluding swing-bed and newborn days)         2.78         2.00           10         Sami-private room days (excluding swing-bed and observation bed days)         1.01         3.00           0.01         Sami-private room days (excluding swing-bed and observation bed days)         1.14.22         0.00           0.01         Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost         0.01           0.01         Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost         0.01           0.01         Total swing-bed NF type inpatient days applicable to the Norgam (excluding private room days)         1.02           0.01         Total inpatient days inpatient days applicable to till & XIII only (including private room days)         2.27           0.01         Total inpatient days applicable to till & XIII only (including private room days)         2.27           0.02         Sing-bed NF type inpatient days applicable to till & XIII only (including private room days)         2.27           1.00         Sing-bed NF type inpatient days applicable to till & XIII only (including private room days)         2.27           1.01         Sing-bed NF type inpatient days applicable to till as V		cost center bescription			1.00	
1.00       Impattent days (including private room days, and saing-bed days dawn dawn days)       2,746       1.00         2.01       Impattent days (including private room days, excluding swing-bed and observation bed days).       2,746       1.00         3.00       Private room days (xecluding swing-bed and observation bed days).       1,437       4.00         5.00       Total swing-bed SNF type inpattent days (including private room days). through December 31 of the cost       1.60       6.00         6.00       Total swing-bed SNF type inpattent days (including private room days). through December 31 of the cost       0.00       7.00         7.00       reporting period (including yinvate room days). after December 31 of the cost       0.00       0.00         8.00       Total swing-bed SNF type inpattent days (including private room days). after December 31 of the cost       0.00         9.00       Total inpattent days including private room days). after December 31 of the cost       0.00         9.01       Total swing-bed SNF type inpattent days applicable to title XVIII only (including private room days)       10.00         9.02       String-bed SNF type inpattent days applicable to title XVIII only (including private room days)       10.00         9.03       String-bed SNF type inpattent days applicable to intres V or XX only (including private room days)       10.00         9.03       String-bed SNF type inpattent days applicable to servic						
2.00       Impaintent days (including private room days, excluding swing-bed and networm days).       2,275       2,00         00       Derivate room days (excluding swing-bed and observation bed days).       17 you have only private room days, of the cost       3,00         00       Not start, bed SM: Type Inpatient days (including private room days) after Becember 31 of the cost       16,00         01       Total swing-bed SM: type Inpatient days (including private room days) after Becember 31 of the cost       0,00         01       Total swing-bed SM: type Inpatient days (including private room days) after Becember 31 of the cost       0,00         0.00       Total swing-bed SM: type Inpatient days (including private room days) after Becember 31 of the cost       0,00         0.00       Total Inpatient days including private room days and the Program (accluding wire room days)       0,00         0.00       Total Inpatient days applicable to the Program (accluding wire room days)       0,00         0.01       Swing bed SM: type Inpatient days applicable to the Program (accluding wire room days)       0,00         0.01       Swing bed SM: type Inpatient days applicable to the SW (including private room days)       0,00         0.01       Swing bed SM: type Inpatient days applicable to the SW (including private room days)       0,00         0.01       Swing bed SM: type Inpatient days applicable to the SW (including private room days)       0,00	1 00		(s excluding newborn)		2 746	1 00
4.00       Seel. private room days (excluding soling-bed and observation bed days) reporting period       1,422       4.00         5.00       Total swing-bed SN type inpatient days (including private room days) after becember 31 of the cost reporting period       1,632       5.00         7.00       Total swing-bed SN type inpatient days (including private room days) through December 31 of the cost reporting period       0       7.00         7.00       Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period (including private room days) program (excluding sning-bed and 0.00       0	2.00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed da	-bed and newborn days)	ivate room days,	2, 275	2.00
6.00       Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period       6.00         7.00       Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost       0.7         8.00       Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost       0.8         0.00       Total inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost       0.8         0.00       Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)       13.0         10.00       Swing-bed NF type inpatient days applicable to title XVI only (including private room days)       12.00         13.00       Swing-bed NF type inpatient days applicable to title XVI only (including private room days)       13.00         13.00       Swing-bed NF type inpatient days applicable to ittle XVI only (including private room days)       14.00         14.00       Ned Cally necessary private room days applicable to the Program (excluding swing-bed days)       14.00         14.00       Ned ADJUSTNNI       0       15.00         14.00       Ned ADJUSTNNI       0       15.00         14.00       Ned ADJUSTNNI       0       16.00         14.00       Ned ADJUSTNNI		Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost		4.00 5.00
7.00       Initial swing-bed NF type inpatient days (including private room days) through Becember 31 of the cost reporting period (if calendar year, enter 0 on this line)       0       7.00         8.00       Total swing-bed NF type inpatient days (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line)       0       0         9.00       Iotal Inpatient days applicable to the Program (excluding private room days) through Becember 31 of the cost reporting period (ise instructions)       0       0         10.00       Swing-bed NF type inpatient days applicable to the Program (excluding private room days) through Becember 31 of the cost reporting period       13.8       1.00         10.00       Swing-bed NF type inpatient days applicable to the VIX only (including private room days)       0       12.00         11.00       Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days)       0       13.00         12.00       Swing-bed NF type inpatient days applicable to services through December 31 of the cost reporting period       13.00         13.00       Numsery days (title V or XIX only)       0       15.00         14.00       Medicare rate for swing-bed SNF specices applicable to services after December 31 of the cost reporting period       13.00         13.00       Swing-bed SNF specices applicable to Services after December 31 of the cost reporting period       3.713,756       10.00	6.00	Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	160	6.00
reporting period (if calendar year, enter 0 on this line)         9.0           0.0         Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)         9.0           10.0         Swing-bed SWT type inpatient days applicable to title XVIII only (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line)         12.00           10.0         Swing-bed WT type inpatient days applicable to title XV or XIX only (including private room days) after through becember 31 of the cost reporting period (if calendar year, enter 0 on this line)         12.00           13.00         Numsery days (title V or XIX only)         0         13.00           14.00         Medically necessary private room days applicable to the Program (excluding swing-bed days)         0         13.00           14.00         Medical are rate for swing-bed SWF services applicable to services through becember 31 of the cost reporting period         18.00           15.00         Numsery days (title V or XIX only)         0         16.00           16.00         Medical are rate for swing-bed SWF services applicable to services after December 31 of the cost reporting period (line 6 and service cost septicable to services after December 31 of the cost reporting period (line 6 and service cost septicable to services after December 31 of the cost reporting period (line 6 x 10 apprivate room days applicable to SWF type services after December 31 of the cost reporting period (line 6 x 10 apprivate room charges (excluding swing-bed	7.00	Total swing-bed NF type inpatient days (including private roo	om days) through December	31 of the cost	0	7.00
newborn days) (see instructions)       272       10.00         0.00       Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line)       272       10.00         10.00       Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) after 138       11.00         10.00       Swing-bed NF type inpatient days applicable to title XV or XIX only (including private room days)       01.200         11.00       Swing-bed NF type inpatient days applicable to title SV or XIX only (including private room days)       01.200         11.00       Swing-bed NF type inpatient days applicable to title SV or XIX only (including private room days)       01.300         12.00       Numped NF type inpatient days applicable to title SV or XIX only (including private room days)       01.300         13.00       Numped NF type inpatient days applicable to title SV or XIX only (including private room days)       01.500         14.00       Numsery days (title V or XIX only)       01.500         15.00       Numsery days (title V or XIX only)       01.500         17.00       Medicaid rate for swing-bed SF services applicable to services through December 31 of the cost reporting period (inc reporting period (inc days days) include to services after December 31 of the cost reporting period (inc day 11.000)       21.00         10.00       Medicaid rate for swing-bed	8.00	Total swing-bed NF type inpatient days (including private roo	om days) after December 3	1 of the cost	0	8.00
through December 31 of the cost reporting period (see instructions)       11.00         10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after becember 31 of the cost reporting period (1f calendar year, enter 0 on this line)       12.01         10.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (1f calendar year, enter 0 on this line)       01.2.01         11.00 Owing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (1f calendar year, enter 0 on this line)       01.2.01         11.00 Owing-tota nursery days (title V or XIX only)       01.5.00       01.6.00         11.00 Owing-tota nursery days (title V or XIX only)       01.6.00         01.00 Wedicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period       18.00         11.00 Owing-tota day rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period       19.00         12.00 Nedical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period       19.00         12.00 Nedical drate for swing-bed NF services through December 31 of the cost reporting period       10.00         12.00 Nedical drate for swing-bed NF services after December 31 of the cost reporting period       10.00         12.00 Nedical drate for swing-bed NF services after December 31 of the cost reporting pe		newborn days) (see instructions)	0			9.00
December 31 of the cost reporting period (if calendar year, enter 0 on this line)         1.00           10.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)         0         1.00           10.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)         0         1.00           10.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)         0         1.00           11.00 Medically necessary private room days applicable to the Program (excluding swing-bed days)         0         1.00           12.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost         1.00         1.00           12.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost         1.00         1.00           12.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost         2.10         1.00           12.00 Medical rate for swing-bed NF services applicable to services after December 31 of the cost         2.11         1.00           12.00 Medical rate for swing-bed NF services applicable to services after December 31 of the cost         2.21         1.00           12.00 Medical rate for swing-bed NF services applicable to services after December 31 of the cost         2.11         10           12.00 Medical rate for swing-bed NF services after December 31 of the cost reporting period (		through December 31 of the cost reporting period (see instruc	ctions)	5		
through December 31 of the cost reporting period       13.00         10.00       Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) of 14.00       014.00         11.00       Wing Cally 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       0       0         15.00       Wing EED ADJUSTNEHT       0       0       16.00       0         16.00       Winsery days (title V or XIX only)       0       16.00         17.00       Wed Care rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period       17.00         18.00       Medicaid rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period       18.00         20.00       Swing-bed Cost applicable to SNF type services after December 31 of the cost reporting period (line 5 wing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 wing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 wing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 wing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 wing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 wing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 wing-bed cost sep i		December 31 of the cost reporting period (if calendar year, e	enter 0 on this line)			
after December'31 of the cost reporting period (if calendar year, enter 0 on this line)       14.00         41.00       Medically necessary private room days applicable to the Program (excluding swing-bed days)       0         15.00       Total nursery days (title V or XIX only)       0         16.00       Nursery days (title V or XIX only)       0         17.00       Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period       17.00         18.00       Molicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period       18.00         19.00       Modical d rate for swing-bed NF services applicable to services after December 31 of the cost 231.10       19.00         20.00       Medical d rate for swing-bed NF service cost (see instructions)       3.713,766       21.00         21.00       Total general inpatient routine service cost (see instructions)       3.713,766       21.00         22.00       Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6       0       23.00         24.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8       0       25.00         25.00       Swing-bed cost (see instructions)       6.36,990       26.00       26.00       16.26       28.00         26.00 <td< td=""><td></td><td>through December 31 of the cost reporting period</td><td></td><td>5</td><td>-</td><td></td></td<>		through December 31 of the cost reporting period		5	-	
15.00       Total nursery days (title V or XIX only)       0       15.00         16.00       Nursery days (title V or XIX only)       0       16.00         17.00       Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period       17.00         18.00       Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period       18.00         19.00       Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 231.00       231.10         20.00       Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 231.00       20.00         21.00       Total general inpatient routine service cost (see instructions)       3.713.756       21.00         22.00       Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)       3.713.756       21.00         23.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 20)       3.707.766       20.00         24.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)       636.990       26.00         25.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)       27.00       27.00       27.00       28.00		after December 31 of the cost reporting period (if calendar y	year, enter 0 on this lir	ne)	-	14.00
SWING BED ADJUSTMENT           17.00         Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period         17.00           18.00         Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period         18.00           19.00         Medicaid rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period         231.10           20.00         Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period         231.10           21.00         Total general inpatient routine service cost (see instructions)         3,713,756         21.00           21.00         Total general inpatient routine services after December 31 of the cost reporting period (line 5 x line 17)         3,713,756         21.00           21.00         Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 7 x line 19)         0,21.00         24.00           25.00         Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)         0,26.00         24.00           26.00         Total swing-bed cost (see instructions)         636,990         26.00         27.00           27.00         General inpatient routine service cost net of swing-bed and observation bed charges)         0,00.00         27.00         28.00         <		Total nursery days (title V or XIX only)	, <u> </u>	5,7		15.00
17.00       Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period       17.00         18.00       Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period       18.00         19.00       Medicare rors wing-bed NF services applicable to services after December 31 of the cost reporting period       231.10         20.00       Medicare for swing-bed NF services applicable to services after December 31 of the cost reporting period       231.10         21.00       Total general inpatient routine service cost (see instructions)       3,713,756         22.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 5 x line 17)       0         23.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 18)       0         24.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 19)       0         25.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)       0         26.00       Total swing-bed cost (see instructions)       3,076,766         27.00       General inpatient routine service cost net of swing-bed and observation bed charges)       0         28.00       General inpatient routine service cost net of swing-bed cost (line 27 + line 28)       0	16.00				0	16.00
reporting period18.00Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period18.0019.00Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period231.1020.00Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period231.1020.00Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost s x line 17)23.11.1020.00Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 18)3,713,75621.00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line f x line 18)023.00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line f x line 18)024.00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line f x line 20)025.00Swing-bed cost (see instructions) x line 20)636,99026.00Total swing-bed cost (see instructions) x line 20)027.00General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 03,076,76627.00General inpatient routine service cost charges (excluding swing-bed charges) 0020.00Semi-private room charge (line 29 + line 3) 0020.00Average per viate room per diem charge (line 29 + line 3) 0020.00Average per diem private room cost diff	17.00		ces through December 31 c	of the cost		17.00
19.00       Medicaid "ate for swing-bed NF services applicable to services through December 31 of the cost reporting period       231.10       19.00         20.00       Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period       231.10       20.00         21.00       Total general inpatient routine service cost (see instructions)       3,713,756       21.00         22.00       Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)       3,713,756       21.00         23.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 19)       23.00         24.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)       636,990       26.00         25.00       Swing-bed cost (see instructions)       636,990       26.00       27.00         26.00       Total swing-bed cost (see instructions)       636,990       26.00       27.00         27.00       General inpatient routine service cost net of swing-bed and observation bed charges)       0       0       0         29.00       Virtal swing-bed charges (excluding swing-bed charges)       0       0       0       0         30.00       Semi-private room charges (excluding swing-bed charges)       0       0       0		reporting period	C C			18.00
20.00Nedicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period231.1020.0021.00Total general inpatient routine service cost (see instructions)3,713,75621.0022.00Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 5 x line 17)022.0023.00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 19)023.0024.00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 19)024.0025.00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)025.0026.00Total swing-bed cost (see instructions)636.99026.0027.00General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)3,076,76627.0029.00Private room charges (excluding swing-bed charges)00020.00Average peri inpatient routine service cost/charge ratio (line 27 + line 28)0.00000031.0030.00Average per diem private room charge differential (line 34 x line 31)0.0033.0031.00Average per diem private room charge differential (line 34 x line 31)0.0034.0031.00Average per diem private room charge differential (line 34 x line 31)0.0034.0031.00Average per diem private room charge differential (line 34 x line 31)0.0035.0032.00Private room cost	19. 00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 of	the cost	231.10	19.00
21.00Total general inpatient routine service cost (see instructions)3, 713, 75621.0022.00Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 6 x line 18)022.0023.00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 19)023.0025.00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)024.0026.00Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)025.0026.00Total swing-bed cost see instructions)636,990 3,076,76626.0026.00Total swing-bed cost (see instructions)636,990 3,076,76627.0028.00General inpatient routine service cost net of swing-bed charges)028.0029.00Private room charges (excluding swing-bed charges)028.0020.00Semi-private room charges (excluding swing-bed charges)028.0020.00Semi-private room charges (excluding swing-bed charges)0020.00Average per ivate room charge (line 29 + line 3)00.0031.00Average per diem private room cost differential (line 32 + line 3)0032.00Average per diem private room cost differential (line 34 x line 31)0033.00Average per diem private room cost differential (line 34 x line 31)0037.00General inpatient routine service cost reprive cost and privat	20.00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of t	he cost	231.10	20.00
23.00Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)23.0024.00Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 8 r x line 19)24.0025.00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 tine 20)25.0026.00Total swing-bed cost (see instructions)636,99027.00General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 		Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decemb		ing period (line		21. 00 22. 00
24.00       Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)       0       24.00         25.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)       0       0       25.00       0         26.00       Total swing-bed cost (see instructions)       636,990       26.00         27.00       General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)       3,076,766       27.00         29.00       Private room charges (excluding swing-bed charges)       0       28.00         29.00       Semi-private room charges (excluding swing-bed charges)       0       0       28.00         30.00       Semi-private room charges (excluding swing-bed charges)       0	23.00	Swing-bed cost applicable to SNF type services after December	- 31 of the cost reportin	ng period (line 6	0	23.00
x line 20)x line 30x line 31x line 31x line 31x line 31x line 3226.00Total swing-bed cost (see instructions)636,99026.0027.00General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)3,076,76627.0028.00General inpatient routine service charges (excluding swing-bed and observation bed charges)028.0029.00Private room charges (excluding swing-bed charges)029.0030.00Semi-private room charges (excluding swing-bed charges)0031.00General inpatient routine service cost/charge ratio (line 27 + line 28)0.00000031.0032.00Average private room per diem charge (line 29 + line 3)0.00032.0034.00Average per diem private room cost differential (line 34 × line 31)0.0035.0035.00Average per diem private room cost differential (line 34 × line 31)0.0035.0036.00Private room cost differential adjustment (line 3 × line 35)036.0037.00General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 076, 76637.0038.00Adjusted general inpatient routine service cost per diem (see instructions)1, 352.4238.0038.00Adjusted general inpatient routine service cost (line 9 × line 38)1, 088, 69839.0040.00Medi cally necessary private room cost applicable to the Program (line 14 × line 35)040.00	24.00	Swing-bed cost applicable to NF type services through Decembe	er 31 of the cost reporti	ng period (line	0	24.00
27. 00General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)3,076,76627. 00PRIVATE ROOM DIFFERENTIAL ADJUSTMENT28. 00General inpatient routine service charges (excluding swing-bed and observation bed charges)028. 0029. 00Private room charges (excluding swing-bed charges)029. 0030. 00Semi-private room charges (excluding swing-bed charges)000. 0031. 00General inpatient routine service cost/charge ratio (line 27 ÷ line 28)0. 000000031. 0032. 00Average private room per diem charge (line 30 + line 4)0. 0032. 0033. 00Average per diem private room charge differential (line 32 minus line 33) (see instructions)0. 0034. 0034. 00Average per diem private room cost differential (line 3 × line 35)0. 0035. 0037. 00General inpatient routine service cost net of swing-bed cost and private room cost differential (line 36)3,076,76677. minus line 36)PART 11 - HOSPITAL AND SUBPROVIDERS ONLY1,352. 4238. 0038. 00Adjusted general inpatient routine service cost per diem (see instructions)1,352. 4238. 0039. 00Medically necessary private room cost applicable to the Program (line 14 × line 35)040. 00	25.00		31 of the cost reporting	period (line 8	0	25.00
29.00Private room charges (excluding swing-bed charges)029.0030.00Semi-private room charges (excluding swing-bed charges)030.0031.00General inpatient routine service cost/charge ratio (line 27 ÷ line 28)0.00000031.0032.00Average private room per diem charge (line 29 ÷ line 3)0.0032.0033.00Average semi-private room per diem charge differential (line 30 ÷ line 4)0.0032.0034.00Average per diem private room cost differential (line 34 x line 31)0.0034.0035.00Average per diem private room cost differential (line 3 x line 35)0.0035.0036.00Private room cost differential adjustment (line 3 x line 35)036.0037.00General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 076, 766)37.0027.minus line 36)PART II - HOSPITAL AND SUBPROVIDERS ONLY0PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS1, 352.4238.0038.00Adjusted general inpatient routine service cost (line 9 x line 38)1, 088, 69839.0040.00Medically necessary private room cost applicable to the Program (line 14 x line 35)040.00		General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)			1
30.00Semi-private room charges (excluding swing-bed charges)030.0031.00General inpatient routine service cost/charge ratio (line 27 ÷ line 28)0.00000031.0032.00Average private room per diem charge (line 29 ÷ line 3)0.0032.0033.00Average semi-private room per diem charge (line 30 ÷ line 4)0.0032.0034.00Average per diem private room cost differential (line 32 minus line 33) (see instructions)0.0033.0035.00Average per diem private room cost differential (line 3 x line 31)0.0035.0036.00Private room cost differential adjustment (line 3 x line 35)0.36.0036.0037.00General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 076, 766)37.0027 minus line 36)PART II - HOSPITAL AND SUBPROVIDERS ONLY38.00Adjusted general inpatient routine service cost per diem (see instructions)1, 352.4238.00Adjusted general inpatient routine service cost (line 9 x line 38)1, 088, 69839.0040.00Medically necessary private room cost applicable to the Program (line 14 x line 35)040.00		General inpatient routine service charges (excluding swing-be	ed and observation bed ch	narges)		28.00
31.00General inpatient routine service cost/charge ratio (line 27 ÷ line 28)0.00000031.0032.00Average private room per diem charge (line 29 ÷ line 3)0.000.0032.0033.00Average semi-private room per diem charge (line 30 ÷ line 4)0.0033.0034.00Average per diem private room charge differential (line 32 minus line 33) (see instructions)0.0034.0035.00Average per diem private room cost differential (line 34 x line 31)0.0034.0036.00Private room cost differential adjustment (line 3 x line 35)036.0037.00General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 076, 766)37.0027 minus line 36)PART 11 - HOSPITAL AND SUBPROVIDERS ONLY0PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS1, 352.4238.0038.00Adjusted general inpatient routine service cost (line 9 x line 38)1, 088, 69839.0040.00Medically necessary private room cost applicable to the Program (line 14 x line 35)040.00					-	29.00
32.00Average private room per diem charge (line 29 ÷ line 3)0.0032.0033.00Average semi-private room per diem charge (line 30 ÷ line 4)0.0033.0034.00Average per diem private room charge differential (line 32 minus line 33) (see instructions)0.0034.0035.00Average per diem private room cost differential (line 34 x line 31)0.0034.0036.00Private room cost differential adjustment (line 3 x line 35)0.0035.0037.00General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 076, 766)027 minus line 36)PART 11 - HOSPITAL AND SUBPROVIDERS ONLY37.00PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS1, 352.4238.00Adjusted general inpatient routine service cost per diem (see instructions)1, 352.4239.00Program general inpatient routine service cost (line 9 x line 38)1, 088, 69840.00Medically necessary private room cost applicable to the Program (line 14 x line 35)0			÷line 28)		-	
33.00       Average semi-private room per diem charge (line 30 ÷ line 4)       0.00       33.00         34.00       Average per diem private room charge differential (line 32 minus line 33) (see instructions)       0.00       34.00         35.00       Average per diem private room cost differential (line 34 x line 31)       0.00       35.00         36.00       Private room cost differential adjustment (line 3 x line 35)       0       36.00         37.00       General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 076, 766       37.00         27 minus line 36)       PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS       38.00         38.00       Adjusted general inpatient routine service cost per diem (see instructions)       1, 352.42       38.00         39.00       Program general inpatient routine service cost (line 9 x line 38)       1, 088, 698       39.00         40.00       Medically necessary private room cost applicable to the Program (line 14 x line 35)       0       40.00						
35.00       Average per diem private room cost differential (line 34 x line 31)       0.00       35.00         36.00       Private room cost differential adjustment (line 3 x line 35)       0       36.00       0       36.00         37.00       General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)       0       37.00       37.00         PART 11 - HOSPITAL AND SUBPROVIDERS ONLY       PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS       0       37.00         38.00       Adjusted general inpatient routine service cost (line 9 x line 38)       1, 352.42       38.00         90.00       Program general inpatient root cost applicable to the Program (line 14 x line 35)       0       40.00						33.00
36.00       Private room cost differential adjustment (line 3 x line 35)       0       36.00       36.00         37.00       General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)       0       3,076,766       37.00         PART 11 - HOSPITAL AND SUBPROVIDERS ONLY       PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS       1,352.42       38.00         38.00       Adjusted general inpatient routine service cost (line 9 x line 38)       1,088,698       39.00         40.00       Medically necessary private room cost applicable to the Program (line 14 x line 35)       0       40.00				tions)		
37.00       General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2.7 minus line 36)       3,076,766       37.00         PART II - HOSPITAL AND SUBPROVIDERS ONLY       PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS       38.00       Adjusted general inpatient routine service cost per diem (see instructions)       1,352.42       38.00         39.00       Program general inpatient routine service cost (line 9 x line 38)       1,088,698       39.00         40.00       Medically necessary private room cost applicable to the Program (line 14 x line 35)       0       40.00			ne 31)			
PART II - HOSPITAL AND SUBPROVIDERS ONLY         PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS         38.00       Adjusted general inpatient routine service cost per diem (see instructions)       1,352.42       38.00         39.00       Program general inpatient routine service cost (line 9 x line 38)       1,088,698       39.00         40.00       Medically necessary private room cost applicable to the Program (line 14 x line 35)       0       40.00		General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line		
38.00Adjusted general inpatient routine service cost per diem (see instructions)1,352.4238.0039.00Program general inpatient routine service cost (line 9 x line 38)1,088,69839.0040.00Medically necessary private room cost applicable to the Program (line 14 x line 35)040.00		PART II - HOSPITAL AND SUBPROVIDERS ONLY				
39.00Program general inpatient routine service cost (line 9 x line 38)1,088,69839.0040.00Medically necessary private room cost applicable to the Program (line 14 x line 35)040.00	00 55				1 0=5	00.00
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00			-			38.00
						1
T, ou potar program general inpatrent routine service cost (intels7 † 1116 40) I 1,000,0701 41,00	40.00		, , ,			

Heal th	Fi nanci al	Systems	

ASCENSI ON	ST.	VI NCENT	WI LLI AMSPORT	

In Lieu of Form CMS-2552-10

	Financial Systems A	SCENSION ST. VINC	ENT WILLIAMSPO	JRT	In Lie	eu of Form CMS-	2552-1
OMPUT	TATION OF INPATIENT OPERATING COST		Provider (		Peri od: From 07/01/2021 To 06/30/2022		pared:
			Ti +1	e XVIII	Hospi tal	11/28/2022 9: Cost	1116 80
	Cost Center Description	Total	Total	Average Per		Program Cost	
	cost center bescription			s Diem (col. 1	⊥ 110graiii Days	$(col \cdot 3 \times col \cdot$	
		inputront obst		col . 2)		4)	
		1.00	2.00	3.00	4.00	5.00	
2.00	NURSERY (title V & XIX only)	0	(	0 O. C	0 00	0	42.0
	Intensive Care Type Inpatient Hospital Uni	ts					
3.00	INTENSIVE CARE UNIT						43.0
4.00	CORONARY CARE UNIT						44.0
5.00	BURN INTENSIVE CARE UNIT						45.0
6.00	SURGI CAL INTENSI VE CARE UNI T						46.0
7.00	OTHER SPECIAL CARE (SPECIFY)						47.0
	Cost Center Description					1.00	
8.00	Program inpatient ancillary service cost (	Wkst D-3 col 3	line 200)			343, 365	48.0
9.00	Total Program inpatient costs (sum of line			ons)		1, 432, 063	
	PASS THROUGH COST ADJUSTMENTS			51107		1, 102, 000	1
0.00	Pass through costs applicable to Program i	npatient routine	services (fro	m Wkst. D, sum	of Parts I and	0	50.0
1.00	Pass through costs applicable to Program i	npatient ancillar	ry services (f	rom Wkst. D, s	um of Parts II	0	51.0
	and IV)						
2.00	Total Program excludable cost (sum of line					0	
3.00	Total Program inpatient operating cost exc		elated, non-ph	ysician anesth	ietist, and	0	53.0
	medical education costs (line 49 minus lin TARGET AMOUNT AND LIMIT COMPUTATION	e 52)					-
1 00	Program discharges					0	54.0
5.00	Target amount per discharge					0.00	
6.00	Target amount (line 54 x line 55)					0.00	
7.00	Difference between adjusted inpatient oper	ating cost and ta	arget amount (	line 56 minus	line 53)	0	
8.00	Bonus payment (see instructions)		inget anount (	1110 30 1111103	11110 33)	0	
9.00	Lesser of lines 53/54 or 55 from the cost	reporting period	endi na 1996.	updated and cc	mpounded by the	-	
	market basket	· · · · · · · · · · · · · · · · · · ·					
0.00	Lesser of lines 53/54 or 55 from prior yea	r cost report, up	dated by the	market basket		0.00	60. C
1.00	If line 53/54 is less than the lower of li	nes 55, 59 or 60	enter the less	ser of 50% of	the amount by	0	61.0
	which operating costs (line 53) are less t		s (lines 54 x	60), or 1% of	the target		
	amount (line 56), otherwise enter zero (se	e instructions)					
2.00	Relief payment (see instructions)					0	
3.00	Allowable Inpatient cost plus incentive pa PROGRAM INPATIENT ROUTINE SWING BED COST	yment (see instru	ictions)			0	63.0
4.00	Medicare swing-bed SNF inpatient routine c	osts through Dece	mber 31 of th	e cost reporti	na period (See	367, 858	64.0
4.00	instructions) (title XVIII only)	USIS through beec			ng period (see	307,030	04.0
5.00	Medicare swing-bed SNF inpatient routine c	osts after Decemb	er 31 of the	cost reporting	period (See	186, 634	65.0
	instructions)(title XVIII only)				•		
6.00	5 1	tine costs (line	64 plus line	65)(title XVII	l only). For	554, 492	66.0
	CAH (see instructions)			<b>C</b> 11			
7.00	Title V or XIX swing-bed NF inpatient rout (line 12 x line 19)	ine costs through	December 31	or the cost re	porting period	0	67.0
8 00	Title V or XIX swing-bed NF inpatient rout	ine costs after [	ecember 31 of	the cost rend	orting period	0	68.0
0.00	(line 13 x line 20)			the cost repo	i tring period	0	00.0
9.00	· · · · · · · · · · · · · · · · · · ·	t routine costs (	line 67 + lin	e 68)		0	69.0
	PART III - SKILLED NURSING FACILITY, OTHER						
0.00	Skilled nursing facility/other nursing fac						70. C
1.00	Adjusted general inpatient routine service		ine 70 ÷ line	2)			71.0
2.00	Program routine service cost (line 9 x lin						72.0
3.00	Medically necessary private room cost appl	U	•				73.0
4.00	Total Program general inpatient routine se	•			ont II!		74.0
5.00	Capital-related cost allocated to inpatien	i routine service	e costs (from	worksneet B, P	art II, column		75. C
6.00	26, line 45) Per diem capital-related costs (line 75 ÷	line 2)					76.0
7.00	Program capital -related costs (line 9 x li						77.0
8.00	Inpatient routine service cost (line 74 mi	· ·					78.0
9.00			provi der recor	ds)			79.0
0.00	Total Program routine service costs for co			· .	us line 79)		80.
1.00	Inpatient routine service cost per diem li	•			,		81.
2.00	Inpatient routine service cost limitation		)				82.
3.00	Reasonable inpatient routine service costs	•					83. (
4.00	Program inpatient ancillary services (see	instructions)					84. (
5.00	Utilization review - physician compensatio						85.0
	Total Program inpatient operating costs (s		nrough 85)			l	86. (
	PART IV - COMPUTATION OF OBSERVATION BED PART	ASS THROUGH COST				1	
6. 00		``					
6. 00 7. 00	Total observation bed days (see instructio		Line 2			843	
6.00 7.00 8.00		r diem (line 27 ÷				843 1, 352. 42 1, 140, 090	88. 0

Health Financial Systems ASCI	ENSION ST. VINC	CENT WILLIAMSPO	RT	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 07/01/2021	Worksheet D-1	
				To 06/30/2022	Date/Time Pre 11/28/2022 9:	pared: 58 am
		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	250, 647	3, 713, 756	0.067492	2 1, 140, 090	76, 947	90.00
91.00 Nursing Program cost	0	3, 713, 756	0.00000	0 1, 140, 090	0	91.00
92.00 Allied health cost	C	3, 713, 756	0.00000	0 1, 140, 090	0	92.00
93.00 All other Medical Education	C	3, 713, 756	0.00000	1, 140, 090	0	93.00

<sup>11/28/2022 9:58</sup> am Y: \28950 - St. Vincent Williamsport Hospital \300 - Medicare Cost Report \20220630 \HFS \20220630 Williamsport.mcr

## ASCENSION ST VINCENT WILLIAMSDODT

	Financial Systems ASCENSION ST. VINCEN ATION OF INPATIENT OPERATING COST	T WILLIAMSPORT Provider CCN: 15-1307	In Lie Period:	u of Form CMS-2 Worksheet D-1	
COMI DI			From 07/01/2021 To 06/30/2022	Date/Time Pre	pared:
		Title XIX	Hospi tal	11/28/2022 9: Cost	
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				-
1.00	Inpatient days (including private room days and swing-bed day	s, excluding newborn)		2, 746	1.0
2.00 3.00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed da do not complete this line.		rivate room days,	2, 275 0	
. 00 . 00	Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	1, 432 311	4.0 5.0
. 00	reporting period Total swing-bed SNF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line)	om days) after December	31 of the cost	160	6.0
. 00	Total swing-bed NF type inpatient days (including private roo reporting period	m days) through December	- 31 of the cost	0	7.0
3.00	Total swing-bed NF type inpatient days (including private roo reporting period (if calendar year, enter 0 on this line)	m days) after December 3	31 of the cost	0	8.0
9.00	Total inpatient days including private room days applicable to newborn days) (see instructions)	0 1 0	, ,	19	9.0
0. 00	Swing-bed SNF type inpatient days applicable to title XVIII o through December 31 of the cost reporting period (see instruc		room days)	0	10. 0
1. 00	Swing-bed SNF type inpatient days applicable to title XVIII o December 31 of the cost reporting period (if calendar year, e		room days) after	0	11.0
2.00	Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period		•	0	12.0
3.00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar y	ear, enter O on this lir	ne)	0	13.0
	Medically necessary private room days applicable to the Progr	am (excluding swing-bed	days)	0	
5.00 6.00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to servic	os through Docombor 21 (	of the east		17.0
8.00	reporting period Medicare rate for swing-bed SNF services applicable to servic	5			17.0
	reporting period Medicaid rate for swing-bed NF services applicable to service			231.10	
	reporting period Medicaid rate for swing-bed NF services applicable to service	-		231.10	
1. 00	reporting period Total general inpatient routine service cost (see instruction			3, 713, 756	
2.00	Swing-bed cost applicable to SNF type services through Decemb $5 \times 1$ ine 17)		ting period (line	0	1
3. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reportin	ng period (line 6	0	23.0
4. 00	Swing-bed cost applicable to NF type services through Decembe 7 x line 19)	r 31 of the cost reporti	ng period (line	0	24.0
5. 00	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reporting	g period (line 8	0	25.0
26.00 27.00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		636, 990 3, 076, 766	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	d and abcomuction had a		0	
8.00	General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges)		lar ges)	0	
0. 00	Semi-private room charges (excluding swing-bed charges)			0	30. C
1.00 2.00	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3)	÷ line 28)		0.000000	
2.00 3.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
4.00	Average per diem private room charge differential (line 32 mi	nus line 33)(see instruc	ctions)	0.00	
5.00	Average per diem private room cost differential (line 34 x li			0.00	35. C
6.00 7.00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	0 3, 076, 766	36. C 37. C
	27 minus Line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY			5, 5, 6, 700	
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ				
38.00	Adjusted general inpatient routine service cost per diem (see			1, 352. 42	
39.00	Program general inpatient routine service cost (line 9 x line			25, 696	
40.00	Medically necessary private room cost applicable to the Progr Total Program general inpatient routine service cost (line 39			0 25, 696	40.00

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In Lieu of Form CMS-2552-10

Jui th	Financial Systems AS	CENSION ST. VIN	CENT WILLIA	VISPUI	<b>Π</b>	In Lie	u of Form CMS-	2552-
OMPUT	FATION OF INPATIENT OPERATING COST		Provi de	er CC		Period: From 07/01/2021 To 06/30/2022		pared
							11/28/2022 9:	58 am
	Cost Conton Deceription	Tatal	-	11 τι	e XIX	Hospi tal	Cost	
	Cost Center Description	Total	Total	Davs	Average Per Diem (col. 1	Program Days	Program Cost (col. 3 x col.	
				Juys	col . 2)		4)	
		1.00	2.00		3.00	4.00	5.00	
2.00	NURSERY (title V & XIX only)		ס	0	0.0	0 0	0	42. (
	Intensive Care Type Inpatient Hospital Unit	S	-					
3.00	INTENSIVE CARE UNIT							43.
1.00	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							17.
	·						1.00	
B. 00	5 1 5						36, 409	
9.00		s 41 through 48)	<u>(see instru</u>	ctio	ns)		62, 105	49.0
0. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program in	nationt routing	conviloos (	from	Wkst D sum	of Dorte L and	0	50.0
J. UU	)		Services (		WKSL. D, SUII	OF PALLS F ANU	0	50.
1.00	Pass through costs applicable to Program ir	npatient ancilla	rv services	(fr	om Wkst. D. si	um of Parts II	0	51.0
	and IV)		· ) · · · · · · · · · · · · · · · · · ·	(				
2.00	Total Program excludable cost (sum of lines						0	
3.00	Total Program inpatient operating cost excl		elated, non	-phy	sician anesth	etist, and	0	53.
	medical education costs (line 49 minus line	9 52)						-
1 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges						0	54.
5.00	Target amount per discharge						0.00	
b. 00	Target amount (line 54 x line 55)						0	
. 00	Difference between adjusted inpatient opera	ating cost and t	arget amoun	t (I	ine 56 minus	ine 53)	0	
8.00	Bonus payment (see instructions)	-	-				0	58.
0. 00	Lesser of lines 53/54 or 55 from the cost r	reporting period	endi ng 199	6, u	pdated and co	mpounded by the	0.00	59.
	market basket						0.00	1 10
). 00 I. 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 0	
1.00	which operating costs (line 53) are less th						0	01.
	amount (line 56), otherwise enter zero (see			1 /		the turget		
2.00	Relief payment (see instructions)						0	62.
3.00	Allowable Inpatient cost plus incentive pay	/ment (see instr	uctions)				0	63.
	PROGRAM INPATIENT ROUTINE SWING BED COST						-	
4.00	Medicare swing-bed SNF inpatient routine co	osts through Dec	ember 31 of	the	cost reporti	ng period (See	0	64.
5. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine co	osts after Decem	her 31 of t	he c	ost reporting	neriod (See	0	65.
5.00	instructions)(title XVIII only)			110 0	ost reporting	perrou (bee	0	00.
6.00	Total Medicare swing-bed SNF inpatient rout	tine costs (line	64 plus li	ne 6	5)(title XVII	only). For	0	66.
	CAH (see instructions)							
7.00	Title V or XIX swing-bed NF inpatient routi	ne costs throug	h December	31 o	f the cost re	porting period	0	67.
0 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routi	no coste after	Docombor 21	of	the cost rope	sting poriod	0	68.
5.00	(line 13 x line 20)	ne costs arter	December 31	01	the cost repu	ting periou	0	00.
9.00	1 · ·	t routine costs	(line 67 +	line	68)		0	69.
	PART III - SKILLED NURSING FACILITY, OTHER							
0.00	Skilled nursing facility/other nursing faci	2						70.
1.00	Adjusted general inpatient routine service		ııne 70 ÷ l	ı ne	2)			71.
2.00	Program routine service cost (line 9 x line Medically necessary private room cost appli		m (line 14	v Li	ne 35)			72.
1. 00	Total Program general inpatient routine ser				ne 33)			74.
5.00	Capital -related cost allocated to inpatient	•			orksheet B. Pa	art II. column		75.
	26, line 45)					,		
6.00	Per diem capital-related costs (line 75 ÷ l	ine 2)						76.
. 00	Program capital-related costs (line 9 x lir							77.
. 00	Inpatient routine service cost (line 74 mir				- >			78.
. 00	Aggregate charges to beneficiaries for exce	•	•		· · ·	ic line 70)		79.
. 00 . 00	Total Program routine service costs for com Inpatient routine service cost per diem lim	•	cost inmita	u un		us IIIIe /9)		80. 81.
. 00	Inpatient routine service cost per drem fin		1)					82.
. 00	Reasonable inpatient routine service cost	•	· .					83.
1. 00	Program inpatient ancillary services (see i							84.
5.00	Utilization review - physician compensation		ons)					85.
5.00	1 3	•						86.
_	PART IV - COMPUTATION OF OBSERVATION BED PA							
7.00	Total observation bed days (see instruction						843	
	Adjusted general inpatient routine cost per	urem (Trne 27	- IINE Z)				1, 352. 42	Ι ὄὄ.
B. 00	Observation bed cost (line 87 x line 88) (s	an instructions					1, 140, 090	00

Health Financial Systems ASC	ENSION ST. VI	INCENT	WI LLI AMSPOR	RT	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 9:	pared: 58 am
			Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Ro	outine Cost	column 1 ÷	Total	Observati on	
		(fr	om 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	250, 6	547	3, 713, 756	0.06749	2 1, 140, 090	76, 947	90.00
91.00 Nursing Program cost		0	3, 713, 756	0.00000	0 1, 140, 090	0	91.00
92.00 Allied health cost		0	3, 713, 756	0.00000	0 1, 140, 090	0	92.00
93.00 All other Medical Education	1	0	3, 713, 756	0.00000	0 1, 140, 090	0	93.00

<sup>11/28/2022 9:58</sup> am Y: \28950 - St. Vincent Williamsport Hospital \300 - Medicare Cost Report \20220630 \HFS \20220630 Williamsport.mcr

Health Financial Systems ASCENSION ST. VINCENT WILLIAMS	PORT	In Lie	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT Provider		Peri od:	Worksheet D-3	
		From 07/01/2021 To 06/30/2022	Date/Time Pre	narod.
		10 00/30/2022	11/28/2022 9:	
Tit	le XVIII	Hospi tal	Cost	
Cost Center Description	Ratio of Cos		Inpati ent	
	To Charges	Program	Program Costs	
		Charges	(col. 1 x col.	
	1.00	0.00	2)	
INDATIENT DOUTINE CEDULCE COST CENTERS	1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS           30. 00         03000 ADULTS & PEDI ATRI CS		2 275 570		30, 00
43. 00 04300 NURSERY		2, 275, 579		43.00
ANCI LLARY SERVICE COST CENTERS				43.00
50. 00 05000 OPERATI NG ROOM	0. 21832	9 107, 757	23, 526	50.00
53. 00 05300 ANESTHESI OLOGY	0.00000		23, 320	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 12528		-	54.00
60. 00 06000 LABORATORY	0. 15136			
65. 00 06500 RESPI RATORY THERAPY	0.07745			
66. 00 06600 PHYSI CAL THERAPY	0. 25307			66.00
68.00 06800 SPEECH PATHOLOGY	0.00000		0	68,00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 04837		13, 624	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 16615		555	
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 28992		153, 077	73.00
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	0.00000	0	0	88.00
88.01 08801 RURAL HEALTH CLINIC II	0.00000	0	0	88. 01
90. 00 09000 CLINIC	0.00000	0 0	0	90.00
90. 01 09001 COVID-19 VACCINE CLINIC	0.00000	0 0	0	90. 01
91. 00 09100 EMERGENCY	0. 28716	2 4, 825	1, 386	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 62140	9 15, 102	9, 385	92.00
OTHER REIMBURSABLE COST CENTERS				
95. 00 09500 AMBULANCE SERVI CES				95.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)		1, 877, 280		
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61		0		201.00
202.00 Net charges (line 200 minus line 201)		1, 877, 280		202.00

Health Financial Systems ASCENSION ST. VINCENT WILLIAM	SPORT	In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT Provider		eriod:	Worksheet D-3	
0		rom 07/01/2021		
Componer	nt CCN: 15-Z307	o 06/30/2022	Date/Time Pre 11/28/2022 9:	
Ti		wing Beds - SNF	Cost	
Cost Center Description	Ratio of Cost		Inpati ent	
	To Charges		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				30.00
43. 00 04300 NURSERY				43.00
ANCI LLARY SERVI CE COST CENTERS				
50. 00 O5000 OPERATING ROOM	0. 218329			
53. 00 05300 ANESTHESI OLOGY	0.00000		-	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 125284			
60. 00 06000 LABORATORY	0. 151365			
65. 00 06500 RESPI RATORY THERAPY	0.077451			
66. 00 06600 PHYSI CAL THERAPY	0. 253075			
68.00 06800 SPEECH PATHOLOGY	0.00000		0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.048374		6, 000	
72.00 07200 I MPL. DEV. CHARGED TO PATI ENT	0. 166158		0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 28992	90, 032	26, 103	73.00
OUTPATIENT SERVICE COST CENTERS			-	
88. 00 08800 RURAL HEALTH CLINIC	0.00000		0	
88.01 08801 RURAL HEALTH CLINIC II	0.00000		0	88.01
90. 00 09000 CLINIC	0.00000	-	0	90.00
90. 01 09001 COVID-19 VACCINE CLINIC	0.00000		0	90.01
91.00 09100 EMERGENCY	0. 287162		0	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0. 621409	4, 351	2, 704	92.00
OTHER REIMBURSABLE COST CENTERS				
95. 00 09500 AMBULANCE SERVICES			404	95.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)		751, 724		
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 6'		0		201.00
202.00 Net charges (line 200 minus line 201)	I	751, 724		202.00

Health Financial Systems ASCENSION ST. VINCENT WILL	I AMSPORT	In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT Prov		Peri od:	Worksheet D-3	
		From 07/01/2021 To 06/30/2022	Date/Time Pre	narod.
		10 00/30/2022	11/28/2022 9:	
	Title XIX	Hospi tal	Cost	
Cost Center Description	Ratio of Cos		Inpati ent	
	To Charges		Program Costs	
		Charges	(col. 1 x col.	
	1.00	0.00	2)	
	1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS           30. 00         03000         ADULTS & PEDI ATRI CS		116, 903		30.00
43. 00 04300 NURSERY		110, 903		43.00
ANCI LLARY SERVICE COST CENTERS		0		43.00
50. 00 OS000 OPERATI NG ROOM	0. 21832	9 7, 223	1, 577	50.00
53. 00 05300 ANESTHESI OLOGY	0.00000		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 12528		3, 735	54.00
60. 00 06000 LABORATORY	0. 15136		6, 556	
65. 00 06500 RESPI RATORY THERAPY	0.07745		463	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 25307		693	66.00
68.00 06800 SPEECH PATHOLOGY	0.00000	0 0	0	68.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0. 04837	4 19, 948	965	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 16615	8 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 28992	7 15, 155	4, 394	73.00
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	1. 27571		0	88.00
88.01 08801 RURAL HEALTH CLINIC II	1.04116		0	88. 01
90. 00 09000 CLINIC	0.00000		0	90.00
90. 01 09001 COVI D-19 VACCI NE CLI NI C	0.00000		0	90.01
91. 00 09100 EMERGENCY	0. 28716		18, 026	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0. 62140	9 0	0	92.00
OTHER REI MBURSABLE COST CENTERS		-		
95. 00 09500 AMBULANCE SERVICES		404 007	a. 100	95.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)	- (1)	186, 937	36, 409	
201.00 Less PBP Clinic Laboratory Services-Program only charges (lin	e oi)	104 007		201.00
202.00 Net charges (line 200 minus line 201)	ļ	186, 937		202.00

	Financial Systems ASCENSION ST. VINCEN ATION OF REIMBURSEMENT SETTLEMENT	T WILLIAMSPORT Provider CCN: 15-1307	In Lie Period: From 07/01/2021 To 06/30/2022	Worksheet E Part B Date/Time Pre 11/28/2022 9:	pared:
		Title XVIII	Hospi tal	Cost	
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)			3, 442, 413	1.00
2.00 3.00	Medical and other services reimbursed under OPPS (see instruc OPPS payments	tions)		0	2.00 3.00
4.00	Outlier payment (see instructions)			0	4.00
4.01	Outlier reconciliation amount (see instructions)			0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instru	ctions)		0.000	
6.00 7.00	Line 2 times line 5 Sum of lines 3, 4, and 4.01, divided by line 6			0.00	6.00 7.00
8.00	Transitional corridor payment (see instructions)			0.00	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 13, line 200		0	9.00
10.00	Organ acqui si ti ons			0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES			3, 442, 413	11.00
	Reasonable charges				
12.00	Ancillary service charges				12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	ine 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13) Customary charges			0	14.00
15.00	Aggregate amount actually collected from patients liable for	payment for services on	a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable fo		on a chargebasis	0	16.00
17.00	had such payment been made in accordance with 42 CFR §413.13( Ratio of line 15 to line 16 (not to exceed 1.000000)	e)		0. 000000	17.00
18.00	Total customary charges (see instructions)			0.000000	18.00
19.00	Excess of customary charges over reasonable cost (complete on	ly if line 18 exceeds l	ine 11) (see	0	19.00
20.00	instructions)	ly if line 11 exceeds 1	ing 19) (coo	0	20.00
20. 00	Excess of reasonable cost over customary charges (complete on instructions)	ity if the firexceeds i	The T8) (See	0	20.00
21.00	Lesser of cost or charges (see instructions)			3, 476, 837	21.00
22.00	Interns and residents (see instructions)			0	
23.00 24.00	Cost of physicians' services in a teaching hospital (see inst Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	ructions)		0	23.00 24.00
24.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	24.00
25.00	Deductibles and coinsurance amounts (for CAH, see instruction	-		37, 632	
26.00	Deductibles and Coinsurance amounts relating to amount on lin	-	· ·	2, 136, 033	
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) instructions)	prus the sum of filles 2	z and z3] (see	1, 303, 172	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, I	ine 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29.00
30.00 31.00	Subtotal (sum of lines 27 through 29) Primary payer payments			1, 303, 172 108	
32.00	Subtotal (line 30 minus line 31)			1, 303, 064	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI	CES)		,	
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0	
34.00 35.00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			305, 842 198, 797	
36.00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		120, 849	
37.00	Subtotal (see instructions)			1, 501, 861	
38.00	MSP-LCC reconciliation amount from PS&R			0	
39.00 39.50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction	c)		0	39.00 39.50
39.97	Demonstration payment adjustment amount before sequestration	3)		0	39.97
39. 98	Partial or full credits received from manufacturers for repla	ced devices (see instru	ctions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0	39.99
40. 00 40. 01	Subtotal (see instructions) Sequestration adjustment (see instructions)			1, 501, 861 3, 755	
40.01	Demonstration payment adjustment amount after sequestration			3,755	40.01
40.03	Sequestration adjustment-PARHM pass-throughs				40. 03
41.00	Interim payments			1, 289, 048	
41.01 42.00	Interim payments-PARHM Tentative settlement (for contractors use only)			0	41.01 42.00
42.00	Tentative settlement-PARHM (for contractor use only)			0	42.00
43.00	Balance due provider/program (see instructions)			209, 058	43.00
43.01	Balance due provider/program-PARHM (see instructions)	non with ONC D. 1 45 C	obortor 1	25 000	43.01
44.00	Protested amounts (nonallowable cost report items) in accorda §115.2	nce with CMS Pub. 15-2,	cnapter 1,	25, 000	44.00
	TO BE COMPLETED BY CONTRACTOR				1
90.00	Original outlier amount (see instructions)			0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0	
92.00	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)			0.00	92.00 93.00
93.00					

Health Financial Systems	ASCENSION ST.	VI NCENT	WILLI AMSPORT		In Lieu	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT			Provider CCN: 15		Period: From 07/01/2021	Worksheet E	
						Date/Time Pre	
						11/28/2022 9:	<u>58 am</u>
			Title XVII	11	Hospi tal	Cost	
						1.00	
MEDICARE PART B ANCILLARY COSTS							
200.00 Part B Combined Billed Days						0	200. 00

<sup>11/28/2022 9:58</sup> am Y: \28950 - St. Vincent Williamsport Hospital \300 - Medicare Cost Report \20220630 \HFS \20220630 Williamsport.mcr

ANALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC		Period: From 07/01/2021 To 06/30/2022	Worksheet E-1 Part I Date/Time Prep 11/28/2022 9:5	pared: 58 am
		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		819, 39	0	1, 289, 048 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	03/10/2022	86, 30	00	0	3. 01
3.02 3.03 3.04 3.05				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)		86, 30		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		905, 69	20	1, 289, 048	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
5.50	Provider to Program TENTATIVE TO PROGRAM			0	0	5.50
5.50	TENTATIVE TO PROGRAM			0	0	5.50
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		334, 31		209, 058	6.01
6.02	SETTLEMENT TO PROGRAM		1, 240, 00	0	0 1, 498, 106	6.02
7.00	Total Medicare program liability (see instructions)		1, 240, 00	Contractor Number	NPR Date (Mo/Day/Yr)	7.00
		0	)	1.00	2.00	

IALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC Component C			iod: m 07/01/2021 06/30/2022		pare
						11/28/2022 9:	58 ar
		Inpatien <sup>-</sup>	XVIII	Swin	ng Beds - SNF	Cost t B	
		Inpatren	LPAILA		Par	ιв	
		mm/dd/yyyy	Amount		mm/dd/yyyy	Amount	
		1.00	2.00		3.00	4.00	
00	Total interim payments paid to provider		473, 6	96		0	1.
00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for			0		0	2.
	services rendered in the cost reporting period. If none, write "NONE" or enter a zero						
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate						3.
	for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						
	Program to Provider						
01	ADJUSTMENTS TO PROVIDER	03/11/2022	95, 0			0	
)2				0		0	
)3 )4				0 0		0	
)4 )5				0		0	
,5	Provider to Program	II		0		0	1 3
0	ADJUSTMENTS TO PROGRAM			0		0	3
1				0		0	3
52				0		0	
53				0		0	
54 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		95, 0	0		0	
9	3. 50-3. 98)		95, 0	00		0	3
00	Total interim payments (sum of lines 1, 2, and 3.99)		568, 6	96		0	4
	(transfer to Wkst. E or Wkst. E-3, line and column as						
	appropri ate)						
~	TO BE COMPLETED BY CONTRACTOR	1 1					1 .
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none,						5
	write "NONE" or enter a zero. (1)						
	Program to Provider						
)1	TENTATI VE TO PROVIDER			0		0	
)2				0		0	
13	Provider to Program			0		0	5
0	TENTATI VE TO PROGRAM			0		0	5
51				0		0	
52				0		0	
9	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0		0	5
0	Determined net settlement amount (balance due) based on the cost report. (1)						6
01	SETTLEMENT TO PROVIDER		112, 2	25		0	
)2	SETTLEMENT TO PROGRAM			0		0	
00	Total Medicare program liability (see instructions)		680, 9			0	7
					Contractor Number	NPR Date (Mo/Day/Yr)	
		0	)		1.00	2.00	8

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-1307 Period: Worksheet E-1 From 07/01/2021 Part II	od.
	nd.
To 06/30/2022 Date/Time Prepare	
Title XVIII Hospital Cost	
1.00	
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS	
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION	~~
	. 00
	. 00
reporting periods beginning on or after 10/01/2013, line 32) 3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 3.	. 00
	. 00
reporting periods beginning on or after 10/01/2013, line 32)	. 00
	. 00
	. 00
	. 00
Line 168	. 00
	. 00
	. 00
	. 00
I NPATI ENT HOSPI TAL SERVICES UNDER THE I PPS & CAH	
30.00 Initial/interim HIT payment adjustment (see instructions) 30.	. 00
31.00 Other Adjustment (specify) 31.	. 00
32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions) 32.	. 00

CULATION OF REIMBURSEMENT		VINCENT WILLIAMSPORT Provider CCN: 15-1307	Peri od:	u of Form CMS-2 Worksheet E-2	
		Component CCN: 15-Z307	From 07/01/2021 To 06/30/2022	Date/Time Pre	pare
		Title XVIII	Swing Beds - SNF	11/28/2022 9: Cost	58 80
			Part A	Part B	
			1.00	2.00	
COMPUTATION OF NET COS					
· ·	/ices - swing bed-SNF (see instruc		560, 037	0	
· ·	/ices - swing bed-NF (see instruct		107 (00		2
Part V, cols. 6 and 7	rom Wkst. D-3, col. 3, line 200, f line 202, for Part B) (For CAH a		127, 603	0	3.
instructions)	ath normant DADUM (coo instructio	nc)			3
	alth payment-PARHM (see instructio erns and residents not in approved			0.00	
instructions)	and residents not in approved	teaching program (see		0.00	4
00 Program days			410	0	5
00 Interns and residents	not in approved teaching program	(see instructions)		0	6
00 Utilization review -	ohysician compensation - SNF optio	nal method only	0		7
	s 1 through 3 plus lines 6 and 7)		687, 640	0	8
00 Primary payer payment			0	0	
00 Subtotal (line 8 minu			687, 640	0	10
00 Deductibles billed to professional services	program patients (exclude amounts	applicable to physician	0	0	11
00 Subtotal (line 10 min			687, 640	0	12
	program patients (from provider r	ecords) (exclude coinsurance	7, 379	0	
for physician profess			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Ū	
00 80% of Part B costs (				0	14
00 Subtotal (see instruc	tions)		680, 261	0	15
	E INSTRUCTIONS) (SPECIFY)		0	0	16
	tion payment adjustment (see instr				16
5 1	tal demonstration project (§410A D	emonstration) payment	0		16
adjustment (see instr		- + '			11
	adjustment amount before sequestr	ation	3, 642	0	
	bad debts (see instructions)		2, 367	0	
	or dual eligible beneficiaries (se	e instructions)	2, 307	0	
00 Total (see instructio	0		682, 628	0	
01 Sequestration adjustm			1, 707	0	
	adjustment amount after sequestra	tion)	0	0	19
03 Sequestration adjustm	ent-PARHM pass-throughs				19
25 Sequestration for non	-claims based amounts (see instruc	tions)	0	0	19
00 Interim payments			568, 696	0	20
01 Interim payments-PARH					20
1	(for contractor use only)		0	0	
	PARHM (for contractor use only)	10 00 10 05 00 1 01	110.005		21
	program (line 19 minus lines 19.01	, 19.02, 19.25, 20, and 21)	112, 225	0	
	program-PARHM (see instructions) nallowable cost report items) in a	coordance with CMS Rub 15 2	0	0	22
chapter 1, §115.2	la rowable cost report rtellis) rn a	ccordance writh cm3 Fdb. 13-2,	0	0	23
	al Demonstration Project (§410A D	emonstration) Adjustment			1
0.00 Is this the first yea	of the current 5-year demonstrat	ion period under the 21st			200
	ter "Y" for yes or "N" for no.				
Cost Reimbursement					
	F inpatient routine service costs	(Trom WKST. D-I, PT. II, IIne			201
66 (title XVIII hospi	Finpatient ancillary service cost	s (from Wkst D 2 col 2 lin			202
200 (title XVIII swin			, 		202
. 00 Total (sum of lines 2					203
.00 Medicare swing-bed SN	discharges (see instructions)				204
	ration Target Amount Limitation (	N/A in first year of the curren	nt 5-year demonst	tration	
period)					1
0.00 Medicare swing-bed SN	5	205 times line 204)			205
	<u>F inpatient routine cost cap (line</u> Part A Swing-Bed SNF Inpatient Re			l	206
	under the §410A Demonstration (se				207
ů, na stalo	inpatient service costs (from Wk	•			208
and 3)					
,	e swing-bed SNF PPS payments (see	instructions)			209
).00 Reserved for future u					210
	sus Cost Reimbursement				
.00 Total adjustment to M	edicare swing-bed SNF PPS payment	(line 209 plus line 210) (see			215

Title XVIII PART A SERVICES - COST ns) ayment for services on payment for services on payment for services of	a charge basi s on a charge basi s	Cost 1.00 1,432,063 0 1,432,063 0 1,432,063 0 1,446,384 0 0 0 0 0 0 0 0 0 0 0 0 0
ns) ayment for services on payment for services c	a charge basi s on a charge basi s	1, 432, 063 0 0 1, 432, 063 0 1, 432, 063 0 1, 446, 384 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
ns) ayment for services on payment for services c	a charge basi s on a charge basi s	1, 432, 063 0 0 1, 432, 063 0 1, 432, 063 0 1, 446, 384 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
ns) ayment for services on payment for services c	a charge basi s on a charge basi s	0 0 1, 432, 063 0 1, 446, 384 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
ayment for services on payment for services c	on a charge basis	0 0 1, 432, 063 0 1, 446, 384 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
ayment for services on payment for services c	on a charge basis	0 1, 432, 063 0 1, 446, 384 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
payment for services o	on a charge basis	1, 432, 063 0 1, 446, 384 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
payment for services o	on a charge basis	0 1, 446, 384 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
payment for services o	on a charge basis	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
payment for services o	on a charge basis	0 0 0 0 0 0 0 0 0 0 0 0
payment for services o	on a charge basis	0 0 0 0 0 0 0 0 0 0 0 0
payment for services o	on a charge basis	0 0 0 0 0 0 0 0 0 0 0 0
payment for services o	on a charge basis	0 0 0 0 0.000000 0
payment for services o	on a charge basis	0 0 0 0.000000 0
payment for services o	on a charge basis	0 0 0. 000000 0
payment for services o	on a charge basis	0 0. 000000 0
payment for services o	on a charge basis	0 0. 000000 0
		0. 000000 0
	ne 6) (see	0
v if line 14	ne 6) (see	0
vieling 14	ne 6) (see	0
y if line 14 exceeds li	, .	
-		
y if line 6 exceeds lin	ne 14) (see	0
uctions)		0
, line 49)		0
		1, 446, 384
		227, 092
		0
		1, 219, 292
		0
		1, 219, 292
es) (see instructions)		36, 654
uctions)		23, 825 16, 695
		1, 243, 117
		1, 243, 117
)		0
,		0
		0
		1, 243, 117
		3, 108
		0
		905, 690
		_
		0
		224 210
21 and 20)		334, 319
, 31, and 32) nus lines 30.03, 31.01,	and 32 01)	1
		, 31, and 32)

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1307	Peri od:	Worksheet E-3	2552
			From 07/01/2021 To 06/30/2022	Part VII Date/Time Pre	
				11/28/2022 9:	
		Title XIX	Hospi tal	Cost	
			Inpatient	Outpatient	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SE	EDVICES FOR TITLES V OR Y		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES	ERVICES FOR TITLES V OR A	ITA SERVICES		1
00	Inpatient hospital/SNF/NF services		62, 105		1 1.
00	Medical and other services			0	
00	Organ acquisition (certified transplant centers only)		0		3.
00	Subtotal (sum of lines 1, 2 and 3)		62, 105	0	4
00	Inpatient primary payer payments		0		5
00	Outpatient primary payer payments			0	6
00	Subtotal (line 4 less sum of lines 5 and 6)		62, 105	0	7
	COMPUTATION OF LESSER OF COST OR CHARGES				-
00	Reasonable Charges Routine service charges		116, 903		8
00	Ancillary service charges		186, 937	0	
. 00	Organ acquisition charges, net of revenue		0	0	10
. 00	Incentive from target amount computation		0		11
. 00	Total reasonable charges (sum of lines 8 through 11)		303, 840	0	
	CUSTOMARY CHARGES				1
3.00	Amount actually collected from patients liable for payment for	or services on a charge	0	0	13
. 00	basis Amounts that would have been realized from patients liable for	or payment for services o	on O	0	14
	a charge basis had such payment been made in accordance with				
5.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15
. 00	Total customary charges (see instructions)		303, 840	0	16
. 00	Excess of customary charges over reasonable cost (complete or	nly if line 16 exceeds	241, 735	0	17
	line 4) (see instructions)				10
3. 00	Excess of reasonable cost over customary charges (complete or 16) (see instructions)	niy if line 4 exceeds if	ie U	0	18
9.00	Interns and Residents (see instructions)		0	0	19
). 00	Cost of physicians' services in a teaching hospital (see inst	tructions)	0	0	20
1.00	Cost of covered services (enter the lesser of line 4 or line		62, 105	0	
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be				
2.00	Other than outlier payments		0	0	22
3.00	Outlier payments		0	0	23
1.00	Program capital payments		0		24
6.00	Capital exception payments (see instructions)		0	_	25
5.00	Routine and Ancillary service other pass through costs		0	0	26
7.00	Subtotal (sum of lines 22 through 26)		0	0	27
3.00 9.00	Customary charges (title V or XIX PPS covered services only)		42 105	0	28
7.00	Titles V or XIX (sum of lines 21 and 27) COMPUTATION OF REIMBURSEMENT SETTLEMENT		62, 105	0	29
0. 00	Excess of reasonable cost (from line 18)		0	0	30
. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 0	6)	62, 105	0	
2.00	Deducti bl es	- /	0	0	
8. 00	Coinsurance		0	0	33
. 00	Allowable bad debts (see instructions)		0	0	
. 00	Utilization review		0		35
. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	nd 33)	62, 105	0	
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
3.00	Subtotal (line 36 ± line 37)		62, 105	0	
9.00	Direct graduate medical education payments (from Wkst. E-4)	\ \		_	39
0.00	Total amount payable to the provider (sum of lines 38 and 39)	)	62, 105	0	
1.00 2.00	Interim payments Balance due provider/program (line 40 minus line 41)		62, 105	0	41
2.00	Protested amounts (nonallowable cost report items) in accorda	ance with CMS Pub 15-2	0	0	42
	chapter 1, §115.2		0	0	-3

	inancial Systems ASCENSION ST. VINC SHEET (If you are nonproprietary and do not maintain	Provi der C	CN: 15-1307	Period:	u of Form CMS- Worksheet G	
und-typ nly)	be accounting records, complete the General Fund column			From 07/01/2021 To 06/30/2022		
		General Fund	Specific Purpose Fund	Endowment Fund	11/28/2022 9: Plant Fund	<u>58 a</u>
		1.00	2.00	3.00	4.00	
	URRENT ASSETS			-		l .
	ash on hand in banks	263, 064	(		0	1.
	emporary investments lotes receivable	0			0	
	ccounts receivable	6, 527, 502		-	0	
	ither receivable	55, 011		0	0	
	I lowances for uncollectible notes and accounts receivable	-4, 271, 475			0	6
	nventory	340, 186		0	0	7
00 P	repai d'expenses	0		0 0	0	8
	ther current assets	490, 265		-	0	9
	ue from other funds	692, 940	(		0	10
	otal current assets (sum of lines 1-10)	4, 097, 493	(	0 0	0	11
	I XED_ASSETS					1
	and	380, 829			0	
	and improvements ccumulated depreciation	479, 579 -209, 009			0	13
	uildings	9, 064, 328		-	0	15
	ccumulated depreciation	-5, 965, 259		-	0	16
	easehold improvements	0		0 0	0	17
	ccumul ated depreciation	0	(	0 0	0	18
9.00 F	ixed equipment	1, 791, 770		0 0	0	19
0. 00 A	ccumulated depreciation	-1, 191, 327	(	0 0	0	20
	utomobiles and trucks	51, 450		-	0	21
	ccumul ated depreciation	-51, 450	(	-	0	22
	lajor movable equipment	5, 837, 554		- -	0	23
	ccumulated depreciation	-4, 465, 125		-	0	24
	linor equipment depreciable ccumulated depreciation	0		-	0	25
	IT designated Assets	0		- -	0	27
	ccumulated depreciation	0		-	0	28
	li nor equi pment-nondepreci abl e	0		0 0	0	29
	otal fixed assets (sum of lines 12-29)	5, 723, 340	(	0 0	0	30
OT	THER ASSETS					
	nvestments	0	(		0	31
	eposits on leases	0	(	-	0	32
	ue from owners/officers	0		0	0	
	other assets otal other assets (sum of lines 31-34)	43, 739 43, 739			0	
	otal assets (sum of lines 11, 30, and 35)	9, 864, 572			0	
	URRENT LIABILITIES	9,004,372	234,07		0	1 30
	ccounts payable	766, 334		0 0	0	37
	al aries, wages, and fees payable	732, 197			0	38
	ayroll taxes payable	0		0 0	0	39
0. 00 N	otes and loans payable (short term)	57, 759	(	0 0	0	40
	eferred income	556, 376	(	0 0	0	
	ccelerated payments	0				42
	ue to other funds	2, 250, 996		0 0	0	
	ither current liabilities	986, 517	(		0	
	otal current liabilities (sum of lines 37 thru 44)	5, 350, 179		0 0	0	45
	ONG TERM LIABILITIES	0	(	0	0	46
	otes payable	0		-	0	47
	Insecured Loans	3, 571, 004		-	0	
	ther long term liabilities	41, 504		-	0	
D. 00 T	otal long term liabilities (sum of lines 46 thru 49)	3, 612, 508		0 0	0	50
	otal liabilities (sum of lines 45 and 50)	8, 962, 687	(	0 0	0	51
	API TAL ACCOUNTS					
	eneral fund balance	901, 885		.		52
	pecific purpose fund		234, 89			53
	onor created - endowment fund balance - restricted			0		54
	onor created - endowment fund balance - unrestricted			0		55
	overning body created - endowment fund balance lant fund balance - invested in plant			0	0	
	lant fund balance - reserve for plant improvement,				0	
	eplacement, and expansion				0	"
	otal fund balances (sum of lines 52 thru 58)	901, 885	234, 89	1 0	0	59
	otal liabilities and fund balances (sum of lines 51 and	9, 864, 572			0	

		ENSION ST. VINCE				u of Form CMS-2	2552-10
STATEN	ENT OF CHANGES IN FUND BALANCES		Provider CC	N: 15-1307	Period: From 07/01/2021 To 06/30/2022	Worksheet G-1 Date/Time Pre 11/28/2022 9:	
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) NET ASSET TRANSFERS Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Transfer to/from affiliates	2, 847, 340 0 0 0 0 0 112 0 0 0 0 0 0 0 0 0	-1, 567, 433 -377, 910 -1, 945, 343 2, 847, 340 901, 997		234, 891 234, 891 0 0 0 0 0 0 234, 891 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1.00 2.00 3.00 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 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)		112 901, 885		0 234, 891		18. 00 19. 00
		Endowment Fund	PI ant	Fund			
		6.00	7.00	8.00			
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) NET ASSET TRANSFERS	0	000000000000000000000000000000000000000	0.00	0		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         19.00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Transfer to/from affiliates Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0 0 0	0 0 0 0 0 0		0 0 0 0		9.00         10.00         11.00         12.00         13.00         14.00         15.00         16.00         17.00         18.00         19.00

	Financial Systems ASCENSION ST. VINCENT IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider C		Period:	u of Form CMS-2 Worksheet G-2	
		TTOVIDET C		From 07/01/2021	Parts I & II Date/Time Pre 11/28/2022 9:	pared:
	Cost Center Description		Inpati ent		Total	
			1.00	2.00	3.00	
	PART I - PATIENT REVENUES					-
1 00	General Inpatient Routine Services		E 610 0	01	E 410 001	1 1 00
1.00 2.00	Hospital SUBPROVIDER - IPF		5, 619, 0	51	5, 619, 081	1.00
2.00	SUBPROVIDER - IRF					3.00
4.00	SUBPROVI DER					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					9.00
10.00	Total general inpatient care services (sum of lines 1-9)		5, 619, 0	81	5, 619, 081	10.00
	Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT					11.00
12.00	CORONARY CARE UNIT					12.00
13.00	BURN INTENSIVE CARE UNIT					13.00
14.00	SURGICAL INTENSIVE CARE UNIT					14.00 15.00
15.00 16.00	OTHER SPECIAL CARE (SPECIFY) Total intensive care type inpatient hospital services (sum of	lines		0	0	•
10.00	11-15)	TTHES		0	0	10.00
17.00	Total inpatient routine care services (sum of lines 10 and 16	)	5, 619, 0	81	5, 619, 081	17.00
18.00	Ancillary services		4, 813, 0			•
19.00	Outpatient services		369, 5			•
20.00	RURAL HEALTH CLINIC			0 1, 585, 438	1, 585, 438	20.00
20. 01	RURAL HEALTH CLINIC II			0 3, 420, 474	3, 420, 474	20.01
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0 0	0	•
22.00	HOME HEALTH AGENCY					22.00
23.00	AMBULANCE SERVICES			98 4, 155, 205	4, 155, 303	•
24.00						24.00
25.00 26.00	AMBULATORY SURGICAL CENTER (D. P. ) HOSPICE					25.00 26.00
28.00	Other Patient Service Revenue			0 0	0	•
27.00	Other Patient Service Revenue - NRCCs			0 865, 965		•
27.01	OTHER (SPECIFY)			0 000, 700	000,700	•
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst.	10, 801, 7	94 69, 858, 441	80, 660, 235	
	G-3, line 1)					
	PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)			24, 241, 352		29.00
30.00	ADD (SPECIFY)			0		30.00
31.00				0		31.00
32.00				0		32.00
33.00 34.00				0		33.00 34.00
34.00 35.00				0		34.00
35.00	Total additions (sum of lines 30–35)			<u>∩</u>		35.00
37.00	DEDUCT (SPECIFY)			0		37.00
38.00				0		38.00
39.00				0		39.00
40.00				0		40.00
41.00				0		41.00
42.00	Total deductions (sum of lines 37-41)			0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 4	2)(transfer		24, 241, 352		43.00
	to Wkst. G-3, line 4)					1

Health Financial Systems

## ASCENSI ON ST. VINCENT WILLIAMSPORT

In Lieu of Form CMS-2552-10

Health	Financial Systems ASCENSION ST. VINCEN	I WILLIAMSPORT	In Lie	u of Form CMS-2	2552-10
STATE	ENT OF REVENUES AND EXPENSES	Provider CCN: 15-1307	Peri od:	Worksheet G-3	
			From 07/01/2021 To 06/30/2022	Date/Time Pre	narod
			10 00/30/2022	11/28/2022 9:	58 am
				1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line	e 28)		80, 660, 235	1.00
2.00	Less contractual allowances and discounts on patients' account	ts		58, 691, 780	2.00
3.00	Net patient revenues (line 1 minus line 2)			21, 968, 455	
4.00	Less total operating expenses (from Wkst. G-2, Part II, line -	43)		24, 241, 352	
5.00	Net income from service to patients (line 3 minus line 4)			-2, 272, 897	5.00
	OTHER I NCOME				-
6.00	Contributions, donations, bequests, etc			-5, 136	
7.00	Income from investments			242	1
8.00	Revenues from telephone and other miscellaneous communication	services		0	
9.00	Revenue from television and radio service			0	
10.00	Purchase di scounts			0	
11.00	Rebates and refunds of expenses			0	
12.00	Parking lot receipts			0	
13.00	Revenue from laundry and linen service			0	
14.00	Revenue from meals sold to employees and guests Revenue from rental of living quarters			452 0	1
16.00	Revenue from sale of medical and surgical supplies to other th	han nationts		0	1
17.00		han patrents		0	17.00
18.00	Revenue from sale of medical records and abstracts			171	
19.00				0	
20.00	Revenue from gifts, flowers, coffee shops, and canteen			56	
21.00	Rental of vending machines			0	
22.00	Rental of hospital space			0	
23.00	Governmental appropriations			0	23.00
24.00	OTHER (SPECIFY)			0	1
24.01	Other - Credentialing			54,809	1
	Other - Pharmacy Services			61	1
24.04	Rental Income - ENT Clinic			141, 446	24.04
24.06	Other			119, 214	24.06
24.14	Other - Food Services			5, 085	24.14
24. 15	Other - State Program Revenue			8, 500	24.15
24. 17	Other - On-Site Clinics			1, 872	24.17
24.19	Other - South Clinic			2, 147	24.19
24.23	Other - Phys Fund Rev IC			184, 109	1
24. 24	Other - Unclaimed Property Exemptions			29, 486	1
24. 25	Other - Contract Services Revenue			350, 000	
24.26	5			350	1
24.28	Other - Shared Savings Payments			47, 733	
24.50	COVI D-19 PHE Funding			954, 390	1
25.00				1, 894, 987	
26.00	Total (line 5 plus line 25)			-377, 910	1
	OTHER EXPENSES (SPECIFY)			0	
28.00	Total other expenses (sum of line 27 and subscripts)			0 277 010	
29.00	Net income (or loss) for the period (line 26 minus line 28)		I	-377, 910	29.00

In Lieu of Form CMS-2552-10

Heal th	Financial Systems ASCE	ENSION ST. VINC	ENT WILLIAMSPO	RT	In Lie	eu of Form CMS-2	2552-10
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C	CN: 15-1307	Peri od:	Worksheet M-1	
			Component	CCN: 15-3993	From 07/01/2021 To 06/30/2022	Date/Time Pre 11/28/2022 9:	
					RHC I	Cost	
		Compensation	Other Costs	Total (col.	1 Recl assi fi cati		
				+ col. 2)	ons	Trial Balance	
				,		(col. 3 + col.	
						4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS			•			
1.00	Physi ci an	327, 876	0	327, 87	21,960	349, 836	1.00
2.00	Physician Assistant	0	0		0 0		2.00
3.00	Nurse Practitioner	165, 835	0	165, 83	-20	165, 815	3.00
4.00	Visiting Nurse	0	0		0 0	0	4.00
5.00	Other Nurse	248, 382	0	248, 38	32 0	248, 382	5.00
6.00	Clinical Psychologist	0	0		0 0	0	6.00
7.00	Clinical Social Worker	0	0		0 0	0	7.00
8.00	Laboratory Techni ci an	0	0		0 0	0	8.00
9.00	Other Facility Health Care Staff Costs	116, 645	0	116, 64	5 0	116, 645	9,00
10.00	Subtotal (sum of lines 1 through 9)	858, 738	0	858, 73			10.00
11.00	Physician Services Under Agreement	0	0	,	0 0	0	11.00
12.00	Physician Supervision Under Agreement	0	0		0 0	0	12.00
13.00	Other Costs Under Agreement	0	0		0 0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		0 0	0	14.00
15.00	Medical Supplies	0	4, 298	4, 29	0	4, 298	
16.00	Transportation (Health Care Staff)	0	., _, 0	.,	0 0	0	16.00
17.00	Depreciation-Medical Equipment	0	0		0 0	0	17.00
18.00	Professional Liability Insurance	0	0		0 0	0	18.00
19.00	Other Health Care Costs	0	231, 381	231, 38	31 0	231, 381	19.00
20.00	Allowable GME Costs	Ĵ	2017 001	201,00		2017001	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	235, 679	235, 67	79 0	235, 679	21.00
22.00	Total Cost of Health Care Services (sum of	858, 738	235, 679				22.00
22.00	lines 10, 14, and 21)	000,700	200, 077	1,0,1,1	21, 710	1, 110, 007	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES	I			1	1	
23.00	Pharmacy	0	0		0 0	0	23.00
24.00	Dental	0	0		0 0		24.00
25.00	Optometry	0	0		0 0	0	25.00
25.01	Tel eheal th	0	0		0 60	60	25.01
25.02	Chronic Care Management	0	0		0 0		25.02
26.00	All other nonreimbursable costs	0	0		0 0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	0		0 60	60	
	through 27)	-	-		-		
	FACILITY OVERHEAD	II		1	1	1	
29.00	Facility Costs	0	0		0 0	0	29.00
30.00	Administrative Costs	0	0		0 0	0	30,00
31.00	Total Facility Overhead (sum of lines 29 and	0	0		0 0	0	31.00
	30)	Ĵ	Ū.			ĺ	
32.00	Total facility costs (sum of lines 22, 28	858, 738	235, 679	1, 094, 41	7 22,000	1, 116, 417	32.00
	and 31)						

Heal th	Financial Systems ASCE	NSION ST. VINC	ENT WILLIAMSPO	RT	In Lie	u of Form CMS-	2552-10
	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C	CN: 15-1307	Peri od:	Worksheet M-	
			Component	CON. 15 2002	From 07/01/2021	Data (Tima Dra	anorod.
			component	CCN: 15-3993	To 06/30/2022	Date/Time Pre 11/28/2022 9:	
					RHC I	Cost	
		Adjustments	Net Expenses				
			for Allocation	1			
			(col. 5 + col.				
			6)	-			
		6.00	7.00				
1 00	FACILITY HEALTH CARE STAFF COSTS	04.005	014.044	1			1
1.00	Physician	-34, 995		1			1.00
2.00	Physician Assistant	0					2.00
3.00	Nurse Practitioner	0	165, 815				3.00
4.00 5.00	Visiting Nurse	0	240 202				4.00 5.00
5.00 6.00	Other Nurse	0	248, 382				6.00
7.00	Clinical Psychologist Clinical Social Worker	0					7.00
7.00 8.00	Laboratory Techni ci an	0					8.00
9.00	Other Facility Health Care Staff Costs	0	116, 645				9.00
10.00	Subtotal (sum of lines 1 through 9)	-34, 995		•			10.00
11.00	Physician Services Under Agreement	-34, 773	043,003	1			11.00
12.00	Physician Supervision Under Agreement	0	-				12.00
13.00	Other Costs Under Agreement	0		1			13.00
14.00	Subtotal (sum of lines 11 through 13)	0					14.00
15.00	Medi cal Supplies	0	4, 298				15.00
16.00	Transportation (Health Care Staff)	0	0 1, 2,0	1			16.00
17.00	Depreciation-Medical Equipment	0					17.00
18.00	Professional Liability Insurance	0					18.00
19.00	Other Health Care Costs	0	231, 381				19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	235, 679				21.00
22.00	Total Cost of Health Care Services (sum of	-34, 995		•			22.00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES		-				
23.00	Pharmacy	0	-	•			23.00
24.00	Dental	0	-	•			24.00
25.00	Optometry	0	0				25.00
25.01	Tel eheal th	0	60	•			25.01
25.02	Chronic Care Management	0	0				25.02
26.00	All other nonreimbursable costs	0	0				26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	60				28.00
	through 27)						_
20.00	FACILITY OVERHEAD			1			
29.00	Facility Costs	0	0	•			29.00
30.00	Administrative Costs	0	0				30.00
31.00	Total Facility Overhead (sum of lines 29 and	0	0				31.00
32, 00	30) Total facility costs (sum of lines 22, 28	-34, 995	1, 081, 422				32,00
JZ. 00	and 31)	- 34, 993	1,001,422				32.00
			I	1			1

In Lieu of Form CMS-2552-10

пеат сп	Fillancial Systems ASCE	INSTUN ST. VINCI	ENT WILLIAMSPU	RI		U UI FUIII CM3	2552-10
ANALYS	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C	CN: 15-1307	Peri od:	Worksheet M-1	
			Component	CCN: 15-3994	From 07/01/2021 To 06/30/2022	Date/Time Pre	pared <sup>.</sup>
			oomponone		10 00/00/2022	11/28/2022 9:	
					RHCII	Cost	
		Compensation	Other Costs	Total (col.	1 Reclassi fi cati		
				+ col. 2)	ons	Trial Balance	
						(col . 3 + col .	
						4)	
		1.00	2.00	3.00	4.00	5.00	
1 00	FACILITY HEALTH CARE STAFF COSTS	(10 542)	0	(10 5	10 7 000	(11.240	1 00
1.00	Physician	618, 542	0				1.00
2.00	Physician Assistant	0	0		0 0		2.00
3.00	Nurse Practitioner	334, 444	0	334, 4	44 -1,000		3.00
4.00	Visiting Nurse	405 725	0	405 7		0	4.00
5.00	Other Nurse	485, 725	0	485, 72	25 0	485, 725	5.00
6.00	Clinical Psychologist	0	0		0 0	0	6.00
7.00	Clinical Social Worker	0	0		0 0	0	7.00
8.00	Laboratory Technician	124 002	0	124.00	- U U 93 0		8.00
9.00	Other Facility Health Care Staff Costs	124, 993	0	124, 9			9.00
10.00	Subtotal (sum of lines 1 through 9)	1, 563, 704	0	1, 563, 70	-8, 302		
11.00	Physician Services Under Agreement	0	0		0 0	0	11.00
12.00	Physician Supervision Under Agreement	0	0		0 0	0	12.00
13.00	Other Costs Under Agreement	0	0		0 0	0	13.00
14.00	Subtotal (sum of lines 11 through 13) Medical Supplies	0	U 1 1 2		0 0	0	14.00
15.00		0	7, 713	7,7	0 0	7, 713	
16.00 17.00	Transportation (Health Care Staff)	0	0		0 0	0	16.00
17.00	Depreciation-Medical Equipment Professional Liability Insurance	0	0		0 0	0	17.00
18.00	Other Health Care Costs	0	425, 743	425, 7	12 0	425, 743	
20.00	Allowable GME Costs	0	423, 743	425, 74	+5 0	420, 743	20.00
20.00	Subtotal (sum of lines 15 through 20)	0	433, 456	433, 4	56 0	433, 456	
21.00	Total Cost of Health Care Services (sum of	1, 563, 704	433, 456				
22.00	lines 10, 14, and 21)	1, 303, 704	433, 430	1, 997, 10	-0, 302	1, 900, 000	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0		0 0	0	23.00
24.00	Dental	0	0		0 0	0	24.00
25.00	Optometry	0	0		0 0	0	25.00
25.01	Tel eheal th	0	0		0 8, 302		
25.02	Chronic Care Management	0	0		0 0		25.02
26.00	All other nonreimbursable costs	0	0		0 0	0	26.00
27.00	Nonallowable GME costs		0		0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	0		0 8, 302	8, 302	28.00
201 00	through 27)		0		0,002	0,002	20100
	FACILITY OVERHEAD	I I				1	
29.00	Facility Costs	0	0		0 0	0	29.00
30.00	Administrative Costs	o	0		0 0	-	30.00
31.00	Total Facility Overhead (sum of lines 29 and	o	0		0 0	0	31.00
	30)		-				
32.00	Total facility costs (sum of lines 22, 28	1, 563, 704	433, 456	1, 997, 10	50 0	1, 997, 160	32.00
	and 31)						

Heal th	Financial Systems ASCE	NSION ST. VINC	CENT WILLIAMSPO	RT	In Lie	u of Form CMS-	2552-10
	SIS OF HOSPITAL-BASED RHC/FQHC COSTS			CN: 15-1307	Peri od:	Worksheet M-1	
			Company	CON 15 2004	From 07/01/2021		
			Component	CCN: 15-3994	To 06/30/2022	Date/Time Pre 11/28/2022 9:	
					RHC II	Cost	00 411
		Adjustments	Net Expenses				
		,	for Allocation	n			
			(col. 5 + col.				
			6)				
		6.00	7.00				
	FACILITY HEALTH CARE STAFF COSTS		1	1			
1.00	Physi ci an	-60, 416					1.00
2.00	Physician Assistant	0	C				2.00
3.00	Nurse Practitioner	0	333, 444	ł.			3.00
4.00	Visiting Nurse	0	C	D			4.00
5.00	Other Nurse	0	485, 725				5.00
6.00	Clinical Psychologist	0	C C	D			6.00
7.00	Clinical Social Worker	0	C	D			7.00
8.00	Laboratory Techni ci an	0	C	D			8.00
9.00	Other Facility Health Care Staff Costs	0	124, 993	1			9.00
10.00	Subtotal (sum of lines 1 through 9)	-60, 416					10.00
11.00	Physician Services Under Agreement	0	C				11.00
12.00	Physician Supervision Under Agreement	0	C				12.00
13.00	Other Costs Under Agreement	0	C				13.00
14.00	Subtotal (sum of lines 11 through 13)	0	C	· ]			14.00
15.00	Medical Supplies	0	7, 713				15.00
	Transportation (Health Care Staff)	0	C				16.00
17.00	Depreciation-Medical Equipment	0	C	D			17.00
	Professional Liability Insurance	0	C	D			18.00
19.00	Other Health Care Costs	0	425, 743	8			19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	433, 456	1			21.00
22.00	Total Cost of Health Care Services (sum of	-60, 416	1, 928, 442	2			22.00
	lines 10, 14, and 21)						-
22.00	COSTS OTHER THAN RHC/FQHC SERVICES	0					1 22 20
23.00	Pharmacy	0					23.00
24.00	Dental	0	C	•			24.00
25.00	Optometry	0	C 0.000				25.00
25.01	Telehealth Chronic Care Management	0	8, 302				25.01
25.02	Chronic Care Management	0					25.02
26.00	All other nonreimbursable costs	0					26.00
27.00	Nonallowable GME costs	0	0.000				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	8, 302	<u> </u>			28.00
	through 27) FACILITY OVERHEAD						-
29.00	Facility Costs	0					29.00
29.00	Admi ni strati ve Costs	0					30,00
30.00	Total Facility Overhead (sum of lines 29 and	0					31.00
51.00	30)	0		í			31.00
32.00	Total facility costs (sum of lines 22, 28	-60, 416	1, 936, 744				32.00
52.00	and 31)	00,410	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				52.00
		1	1	1			1

Heal th	Financial Systems ASCE	ENSION ST. VINC	ENT WILLIAMSPO	RT	In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	ERVI CES	Provider C	CN: 15-1307	Peri od:	Worksheet M-2	
			Component	CCN: 15-3993	From 07/01/2021 To 06/30/2022	Date/Time Pre	aarad
			component	JUN. 10-3773	10 00/ 30/ 2022	11/28/2022 9:	
					RHC I	Cost	
		Number of FTE	Total Visits	Productivit	y Minimum Visits	Greater of	
		Personnel		Standard (1	) (col. 1 x col.	col. 2 or col.	
					3)	4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons						
1.00	Physi ci an	1.08			1 1		1.00
2.00	Physician Assistant	0.00			1 0		2.00
3.00	Nurse Practitioner	1.55			1 2		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.63			3	7, 491	4.00
5.00	Visiting Nurse	0.00				0	5.00
6.00	Clinical Psychologist	0.00				0	6.00
7.00	Clinical Social Worker	0.00				0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00				0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7. 02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.63	7, 491			7, 491	8.00
9.00	Physician Services Under Agreements		0			0	9.00
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,							7100
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO	) HOSPI TAL-BASE	D RHC/FQHC SER	VICES			
10.00	Total costs of health care services (from Wks	st. M-1, col. 7	7, line 22)			1, 081, 362	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1,	col. 7, line 2	28)			60	11.00
12.00	2.00 Cost of all services (excluding overhead) (sum of lines 10 and 11)						12.00
13.00	3.00 Ratio of hospital-based RHC/FOHC services (line 10 divided by line 12)						13.00
14.00	4.00 Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)						
15.00	5.00 Parent provider overhead allocated to facility (see instructions)						15.00
16.00	Total overhead (sum of lines 14 and 15)					941, 141	
17.00	Allowable GME overhead (see instructions)					0	17.00
	Enter the amount from line 16					941, 141	
	Overhead applicable to hospital-based RHC/FQ					941, 089	
20.00	Total allowable cost of hospital-based RHC/F	2HC services (s	sum of lines 10	and 19)		2, 022, 451	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FOHC SERVICES         Provider CCN: 15-1307 Component CCN: 15-3994         Period: For 007/01/2022         Worksheet M-2 Det FTIME Prepared: 11/28/2022 9:58 and Contained (1)           VISITS AND PRODUCTIVITY         Number of FTE Personnel         Total VIsits         Productivity Minimu Visits Standard (1)         RHC II         Cost           VISITS AND PRODUCTIVITY         1.00         2.00         3.00         4.00         5.00           VISITS AND PRODUCTIVITY         0.00         0         1         0         2.00         3.00         4.00         5.00           0.00         Physician         1.60         8.005         1         2         0.00         2.00         3.00         4.00         5.00           0.00         Physician Assistant         0.00         0         1         0         2.00         3.00         4.00         5.00           0.00         Visiting Nurse         0.00         0         15.380         5         15.380         4.00           0.00         0 <t< th=""><th>Heal th</th><th>Financial Systems ASCI</th><th>ENSION ST. VINC</th><th>ENT WILLIAMSPO</th><th>RT</th><th>In Lie</th><th>eu of Form CMS-:</th><th>2552-10</th></t<>	Heal th	Financial Systems ASCI	ENSION ST. VINC	ENT WILLIAMSPO	RT	In Lie	eu of Form CMS-:	2552-10
Component CCN: 15-3994         To         0/6/30/202         Date/Time Prepared: Date/Time Prepared: RHC 11           Number of FTE Personnel         Total Visits         Productivity Minimum Visits Standard (1)         Cost           VISITS AND PRODUCTIVITY Positions         1.00         2.00         3.00         4.00         5.00           1.00         Productivity Minimum Visits         Greater of Col. 1 x col. 2 or col. 3 4         1.00         2.00         3.00         4.00         5.00           1.00         Pasitions         0.00         0         1.00         2.00         3.00         4.00         5.00           0.00         Physician Assistant         0.00         0         1.00         2.00         1.00         2.00         3.00         4.00         2.00           0.00         Nurse Practitioner         2.90         7.375         1         3         3.00         0         0         0         0         0         0.00         0 </td <td>ALLOCA</td> <td>TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S</td> <td>ERVI CES</td> <td>Provider C</td> <td>CN: 15-1307</td> <td></td> <td>Worksheet M-2</td> <td></td>	ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	ERVI CES	Provider C	CN: 15-1307		Worksheet M-2	
Image: Number of FTE         Number of FTE         Total Visits         Productivity         Num wisits         Greater of creater of standard (1)           VISITS AND PRODUCTIVITY         1.00         2.00         3.00         4.00         5.00           00         Physician         5.00         1         2         2.00         3.00         4.00         5.00           0.00         Physician Assistant         0.00         0         1         0         2.00         3.00         4.00         5.00				Component	CN: 15-300/		Dato/Timo Pro	narod
Number of FTE Personnel         Total Visits         Productivity         Minimum Visits         Greater of (col. 1 x col. col. 2 or col. 3)         4           1.00         2.00         3.00         4.00         5.00           VISITS AND PRODUCTIVITY Positions         1.00         2.00         3.00         4.00         5.00           1.00         Physician         1.60         8.005         1         2         1.00           2.00         3.00         4.00         5.00         1         0         2.00           3.00         Nurse Practitioner         2.90         7.375         1         3         3.00           4.00         Subtotal (sum of Lines 1 through 3)         4.50         15,380         5         15,380         4.00           5.00         Visiting Nurse         0.00         0         0         0         6.00         0         6.00         0				component	JON. 13-3774	10 00/30/2022		
Personnel         Standard (1)         Col. 1 x col.         Col. 2 or col.           1.00         2.00         3.00         4.00         5.00           VISITS AND PRODUCTIVITY				_		RHC II		
Image: Note of the second se				Total Visits				
VISITS AND PRODUCTIVITY           Positions           1.00         2.00         3.00         4.00         5.00           VISITS AND PRODUCTIVITY           Positions         1.00         8.005         1         2         1.00           2.00         Physician Assistant         0.00         0         1         0         2.00           3.00         Visiting Nurse         2.90         7,375         1         3         3.00           4.00         Subtotal (sum of lines 1 through 3)         4.50         15,380         5         15,380         4.00         0			Personnel		Standard (1)			
VISITS AND PRODUCTIVITY           Positions           1.00         Physician Assistant         0.00         0         1         0         2.00           2.00         Physician Assistant         0.00         0         1         0         2.00           3.00         Nurse Practitioner         2.90         7,375         1         3         3.00           4.00         Subtotal (sum of lines 1 through 3)         4.50         15,380         5         15,380         0         5.00         0         5.00         0         5.00         0         5.00         0         5.00         0         5.00         0         5.00         0         5.00         0         5.00         0         5.00         0         5.00         0         5.00         0         5.00         0         5.00         0         5.00         0         5.00         0         5.00         0         5.00         0         5.00         0         7.00         0         7.00         0         7.00         0         7.00         0         7.00         0         7.00         0         7.00         0         7.00         0         7.00         0         7.00         0         7.00<			1.00	0.00	0.00			
Positions           1.00         Physician Assistant         1.60         8.005         1         2         1.00           3.00         Nurse Practitioner         2.90         7.375         1         3         3.00           4.00         Subtotal (sum of lines 1 through 3)         4.50         15,380         5         15,380         4.00           5.00         Visiting Nurse         0.00         0         0         0         5         0         5         15,380         4.00           6.00         Clinical Social Worker         0.00         0         0         6.00         7.01         0         0         7.01         0         0         7.01         0         0         7.01         0         0         7.02         0         0         7.02         0         0         7.02         0         7.02         0         0         7.02         0         0         7.02         0         7.02         0         0         7.02         0         0         7.02         0         9.00         9.00         9.00         9.00         9.00         9.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00 <td< td=""><td></td><td></td><td>1.00</td><td>2.00</td><td>3.00</td><td>4.00</td><td>5.00</td><td></td></td<>			1.00	2.00	3.00	4.00	5.00	
1.00       Physician       1.60       8,005       1       2       1.00         2.00       Physician Assistant       0.00       0       1       0       2.00         3.00       Nurse Practitioner       2.90       7,375       1       3       3.00         4.00       Subtotal (sum of lines 1 through 3)       4.50       15,380       5       15,380       3.00         6.00       Clinical Psychologist       0.00       0       0       0       6.00       6.00       6.00       0       6.00       7.00       7.00       7.00       7.00       7.00       7.00       7.00       7.00       7.02       10 abetes Self Management Training (FOHC       0.00       0       7.02       0       7.02       0       7.02       0       7.02       0       7.02       0       7.02       0       7.02       0       7.02       0       7.02       0       7.02       0       7.02       0       9.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
2.00       Physician Assistant       0.00       0       1       0       2.00         3.00       Nurse Practitioner       2.90       7.375       1       3       3.00         4.00       Subtotal (sum of lines 1 through 3)       4.50       15,380       5       15,380       3.00         5.00       Visiting Nurse       0.00       0	1 00		1.60	8 005		1 2		1 00
3.00       Nurse Practitioner       2.90       7,375       1       3       3.00         4.00       Subtotal (sum of lines 1 through 3)       4.50       15,380       5       15,380       4.00         5.00       Visiting Nurse       0.00       0       0       0       0       5       15,380       4.00         5.00       Visiting Nurse       0.00       0       0       0       0       5       0		5				1 0		
4.00       Subtotal (sum of lines 1 through 3)       4.50       15,380       5       15,380       4.00         5.00       Visiting Nurse       0.00       0 </td <td></td> <td>5</td> <td></td> <td></td> <td></td> <td>1 3</td> <td></td> <td></td>		5				1 3		
5.00       Visiting Nurse       0.00       0       0       5.00       5.00         6.00       Clinical Psychologist       0.00       0       0       6.00       0       6.00       0       6.00       0       6.00       0       6.00       0       6.00       0       6.00       0       6.00       0       7.00       0       7.00       0       7.00       0       7.00       0       7.00       0       7.00       0       7.01       Medical Nutrition Therapist (FQHC only)       0.00       0       0       7.02       0       7.01       0       7.01       0       7.01       0       7.02       0       7.02       0       0       15.380       15.380       15.380       0       7.02       0       7.02       0       7.02       0       9.00       9						5	15 380	
6.00       Clinical Psychologist       0.00       0       0       0       0       0       0       0       0       0       0       0       0       0       7.00       0       0       0       0       0       0       7.00       0       0       0       0       0       0       7.00       0						0		
7.00       Clinical Social Worker       0.00       0       0       7.00         7.01       Medical Nutrition Therapist (FOHC only)       0.00       0       0       7.01         7.02       Diabetes Self Management Training (FOHC only)       0.00       0       0       7.02         8.00       Total FTEs and Visits (sum of lines 4       4.50       15,380       15,380       15,380         9.00       Physician Services Under Agreements       0       0       0       9.00         9.00       Total costs of healt th care services (from Wkst. M-1, col. 7, line 22)       1,928,442       10.00         10.00       Total costs of healt th care services (from Wkst. M-1, col. 7, line 28)       8,302       11.00         12.00       Cost of all services (excluding overhead) (sum of lines 10 and 11)       1,936,744       12.00         13.00       Ratio of hospital-based RHC/FOHC services (line 10 divided by line 12)       0.95713       13.00         15.00       Parent provider overhead allocated to facility (see instructions)       1,624,520       15.00         16.00       Total overhead (see instructions)       0       1,624,520       16.00         16.00       Total overhead (see instructions)       0       1,624,520       16.00         17.00       Allowable GM							-	
7.01Medical Nutrition Therapist (FQHC only)0.000007.017.02Diabetes Self Management Training (FQHC0.000007.028.00Total FTEs and Visits (sum of lines 44.5015,38015,38015,3808.009.00Physician Services Under Agreements0009.00Intrough 7)9.00Physician Services Under Agreements009.00Intrough 7)9.00Total costs of health care services (from Wkst. M-1, col. 7, line 22)1,928,44210.0011.00Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)8,30211.0012.00Cost of all services (excluding overhead) (sum of lines 10 and 11)1,938,74412.0013.00Ratio of hospital -based RHC/FQHC services (line 10 divided by line 12)0.99571313.0014.00Total overhead allocated to facility (see instructions)1,624,52015.0015.00Parent provider overhead (sum of lines 14 and 15)1,624,52016.0017.00Allowable GME overhead (see instructions)01,624,52018.0018.00Enter the amount from line 161,624,52018.0017.0019.00Overhead applicable to hospital -based RHC/FOHC services (line 13 x line 18)1,617,55619.00							-	
onl y) Total FTEs and Visits (sum of lines 4 through 7)4.5015,38015,3809.00Physician Services Under Agreements009.00DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES10.00Total costs of health care services (from Wkst. M-1, col. 7, line 22)1,928,44210.0011.00Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)8,30211.0012.00Cost of all services (excluding overhead) (sum of lines 10 and 11)1,936,74412.0013.00Ratio of hospital-based RHC/FOHC services (line 10 divided by line 12)0.99571313.0014.00Total noverhead allocated to facility (see instructions)1,624,52015.0015.00Parent provider overhead allocated to facility (see instructions)1,624,52016.0017.00Allowable GME overhead (see instructions)017.0018.00Enter the amount from line 161,624,52018.0019.00Overhead applicable to hospital-based RHC/FOHC services (line 13 x line 18)1,617,556							0	
8.00       Total FTEs and Visits (sum of lines 4 through 7)       4.50       15,380       15,380       15,380       0       9.00         9.00       Physician Services Under Agreements       0       0       0       9.00       9.00         DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES         10.00       Total costs of health care services (from Wkst. M-1, col. 7, line 22)       1,928,442       10.00         11.00       Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)       8,302       11.00         12.00       Cost of all services (excluding overhead) (sum of lines 10 and 11)       1,936,744       12.00         13.00       Ratio of hospital-based RHC/FOHC overhead - (from Worksheet. M-1, col. 7, line 31)       0       14.00         15.00       Parent provider overhead allocated to facility (see instructions)       1,624,520       15.00         16.00       Total overhead (sum of lines 14 and 15)       1,624,520       15.00         17.00       Allowable GME overhead (see instructions)       0       17.00         18.00       Enter the amount from line 16       1,624,520       18.00         19.00       Overhead applicable to hospital-based RHC/FOHC services (line 13 x line 18)       1,617,556       19.00	7.02	Diabetes Self Management Training (FQHC	0.00	0			0	7.02
9.00through 7) Physician Services Under Agreements009.00In the service of the service								
9.00         Physician Services Under Agreements         0         0         9.00           DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES           1.00           DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES           1.00           DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES           1.00           Total nonreimbursable costs (from Wkst. M-1, col. 7, line 22)           1, 928, 442           0.00           Cost of all services (from Wkst. M-1, col. 7, line 28)           1, 928, 442           1, 928, 442           1, 928, 442           1, 928, 442           1, 928, 442           1, 928, 442           1, 928, 442           1, 936, 744           1, 936, 744           1, 936, 744           1, 936, 744           1, 936, 744           1, 936, 744           1, 936, 744           1, 936, 744           1, 936, 744           1, 936, 744	8.00		4.50	15, 380			15, 380	8.00
1.001.00DETERMI NATION OF ALLOWABLE COST APPLI CABLE TO HOSPI TAL-BASED RHC/FOHC SERVI CES10.00Total costs of health care services (from Wkst. M-1, col. 7, line 22)1,928,44211.00Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)8,30212.00Cost of all services (excluding overhead) (sum of lines 10 and 11)1,936,74413.00Ratio of hospital -based RHC/FQHC services (line 10 divided by line 12)0.99571314.00Total hospital -based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)015.00Parent provider overhead allocated to facility (see instructions)1,624,52016.00Total overhead (sum of lines 14 and 15)1,624,52017.00Allowable GME overhead (see instructions)018.00Enter the amount from line 161,624,52019.00Overhead applicable to hospital -based RHC/FQHC services (line 13 x line 18)1,617,556								
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES10.00Total costs of health care services (from Wkst. M-1, col. 7, line 22)1,928,44210.0011.00Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)8,30211.0012.00Cost of all services (excluding overhead) (sum of lines 10 and 11)1,936,74412.0013.00Ratio of hospital -based RHC/FOHC services (line 10 divided by line 12)0.99571313.0014.00Total overhead allocated to facility (see instructions)014.0015.00Parent provider overhead allocated to facility (see instructions)1,624,52016.0017.00Allowable GME overhead (see instructions)017.0018.00Enter the amount from line 161,624,52018.0019.00Overhead applicable to hospital -based RHC/FOHC services (line 13 x line 18)1,617,556	9.00	Physician Services Under Agreements		0			0	9.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES10.00Total costs of health care services (from Wkst. M-1, col. 7, line 22)1,928,44210.0011.00Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)8,30211.0012.00Cost of all services (excluding overhead) (sum of lines 10 and 11)1,936,74412.0013.00Ratio of hospital -based RHC/FOHC services (line 10 divided by line 12)0.99571313.0014.00Total overhead allocated to facility (see instructions)014.0015.00Parent provider overhead allocated to facility (see instructions)1,624,52016.0017.00Allowable GME overhead (see instructions)017.0018.00Enter the amount from line 161,624,52018.0019.00Overhead applicable to hospital -based RHC/FOHC services (line 13 x line 18)1,617,556							4.00	
10.00       Total costs of health care services (from Wkst. M-1, col. 7, line 22)       1,928,442       10.00         11.00       Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)       8,302       11.00         12.00       Cost of all services (excluding overhead) (sum of lines 10 and 11)       1,936,744       12.00         13.00       Ratio of hospital -based RHC/FQHC services (line 10 divided by line 12)       0.995713       13.00         14.00       Total noverhead allocated to facility (see instructions)       0       14.00         15.00       Parent provider overhead allocated to facility (see instructions)       1, 624, 520       15.00         17.00       Allowable GME overhead (see instructions)       0       17.00       17.00         18.00       Enter the amount from line 16       1, 624, 520       18.00         19.00       Overhead applicable to hospital -based RHC/FOHC services (line 13 x line 18)       1, 617, 556       19.00		DETERMINATION OF ALLOWARD F OOCT ADDITION F TO			14.050		1.00	
11.00       Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)       8,302       11.00         12.00       Cost of all services (excluding overhead) (sum of lines 10 and 11)       1,936,744       12.00         13.00       Ratio of hospital -based RHC/FQHC services (line 10 divided by line 12)       0.995713       13.00         14.00       Total hospital -based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)       0       14.00         15.00       Parent provider overhead allocated to facility (see instructions)       1,624,520       15.00         16.00       Total overhead (sum of lines 14 and 15)       0       17.00       17.00         18.00       Enter the amount from line 16       0       1,624,520       18.00         19.00       Overhead applicable to hospital -based RHC/FOHC services (line 13 x line 18)       1,617,556       19.00	10.00				VICES		1 000 440	10.00
12.00       Cost of all services (excluding overhead) (sum of lines 10 and 11)       1,936,744       12.00         13.00       Ratio of hospital -based RHC/FQHC services (line 10 divided by line 12)       0.995713       13.00         14.00       Total hospital -based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)       0       14.00         15.00       Parent provider overhead allocated to facility (see instructions)       1,624,520       15.00         16.00       Total overhead (sum of lines 14 and 15)       1,624,520       16.00         17.00       Allowable GME overhead (see instructions)       0       17.00         18.00       Enter the amount from line 16       1,624,520       18.00         19.00       Overhead applicable to hospital -based RHC/FOHC services (line 13 x line 18)       1,617,556       19.00								•
13.00       Ratio of hospital -based RHC/FQHC services (line 10 divided by line 12)       0.995713       13.00         14.00       Total hospital -based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)       0       14.00         15.00       Parent provider overhead allocated to facility (see instructions)       1,624,520       15.00         16.00       Total overhead (sum of lines 14 and 15)       1,624,520       16.00         17.00       Allowable GME overhead (see instructions)       0       17.00         18.00       Overhead applicable to hospital -based RHC/FQHC services (line 13 x line 18)       1,617,556       19.00								•
14.00       Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)       0       14.00         15.00       Parent provider overhead allocated to facility (see instructions)       1, 624, 520       15.00         16.00       Total overhead (sum of lines 14 and 15)       1, 624, 520       16.00         17.00       Allowable GME overhead (see instructions)       0       17.00         18.00       Enter the amount from line 16       1, 624, 520       18.00         19.00       Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)       1, 617, 556       19.00								
15.00       Parent provider overhead allocated to facility (see instructions)       1, 624, 520       15.00         16.00       Total overhead (sum of lines 14 and 15)       1, 624, 520       16.00         17.00       Allowable GME overhead (see instructions)       0       17.00         18.00       Enter the amount from line 16       1, 624, 520       18.00         19.00       Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)       1, 617, 556       19.00								
16.00       Total overhead (sum of lines 14 and 15)       1, 624, 520       16.00         17.00       Allowable GME overhead (see instructions)       0       17.00         18.00       Enter the amount from line 16       1, 624, 520       18.00         19.00       Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)       1, 617, 556       19.00								
17.00       Allowable GME overhead (see instructions)       0       17.00         18.00       Enter the amount from line 16       1,624,520       18.00         19.00       Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)       1,617,556       19.00								
19.00Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)1, 617, 55619.00								
19.00Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)1,617,55619.00							1, 624, 520	
20.00 Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19) 3,545,998 20.00	19.00	Overhead applicable to hospital-based RHC/FQ	HC services (li	ne 13 x line 1	8)			
	20.00	Total allowable cost of hospital-based RHC/F	DHC services (s	sum of lines 10	and 19)		3, 545, 998	20.00

	Financial Systems ASCENSION ST. VINCENT ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 15-1307	Peri od:	u of Form CMS-2 Worksheet M-3	
SERVI (	ES	Component CCN: 15-3993	From 07/01/2021 To 06/30/2022	Date/Time Pre 11/28/2022 9:	
		Title XVIII	RHC I	Cost	oo uiii
				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from	m Wkst. M-2, line 20)		2, 022, 451	1.0
2.00	Cost of injections/infusions and their administration (from Wi			39, 986	2.0
3.00	Total allowable cost excluding injections/infusions (line 1 mi	nus line 2)		1, 982, 465	3.0
4.00 5.00	Total Visits (from Wkst. M-2, column 5, line 8)	ing ()		7, 491 0	4.0 5.0
6.00	Physicians visits under agreement (from Wkst. M-2, column 5, I Total adjusted visits (line 4 plus line 5)	The 9)		7, 491	6.0
7.00	Adjusted cost per visit (line 3 divided by line 6)			264.65	
7.00			Cal cul ati on		7.0
			Data Daried 1	Data Daried 2	
			Rate Period 1 (07/01/2021	(01/01/2022	
			through	through	
			12/31/2021)	06/30/2022)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.	6 or your contractor)	257.93	263.35	
9.00	Rate for Program covered visits (see instructions)		257.93	263.35	9.0
10 00	CALCULATION OF SETTLEMENT	contractor records)	( 25	(50	1 10 0
0.00	Program covered visits excluding mental health services (from Program cost excluding costs for mental health services (line	-	635 163, 786	659 173, 548	
2.00	Program covered visits for mental health services (from contra		03,700	0	
3.00	Program covered cost from mental health services (line 9 x lin		0	0	
14.00	Limit adjustment for mental health services (see instructions)		0	0	
15.00	Graduate Medical Education Pass Through Cost (see instruction	5)			15.0
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2		0	337, 334	
16.01	Total program charges (see instructions) (from contractor's red	-		283, 176	
16.02	Total program preventive charges (see instructions) (from provi	-		19, 137	
16. 03 16. 04	Total program preventive costs ((line 16.02/line 16.01) times Total Program non-preventive costs ((line 16 minus lines 16.03)			22, 797 221, 873	
10. 04	(Titles V and XIX see instructions.)	and to) trilles . 00)		221,075	10.0
16. 05	Total program cost (see instructions)		0	244, 670	16.0
17.00	Primary payer amounts			0	17.0
18. 00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		37, 196	18.0
19. 00	records) Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		45, 369	19.0
	records)			044 /70	00.5
20.00 21.00	Net Medicare cost excluding vaccines (see instructions) Program cost of vaccines and their administration (from Wkst.	M 4 Lipo 14)		244,670	
22.00	Total reimbursable Program cost (line 20 plus line 21)	M-4, TTHE 18)		12, 421 257, 091	
23.00	Allowable bad debts (see instructions)			4, 552	
23.01	Adjusted reimbursable bad debts (see instructions)			2, 959	
24.00	Allowable bad debts for dual eligible beneficiaries (see insti	ructions)		766	24.0
5.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
5.50	Pioneer ACO demonstration payment adjustment (see instructions	5)		0	
25.99	Demonstration payment adjustment amount before sequestration			0	
26.00 26.01	Net reimbursable amount (see instructions) Sequestration adjustment (see instructions)			260, 050	
26.01	Demonstration payment adjustment amount after sequestration			650 0	
27.02	Interim payments			201, 843	
28.00	Tentative settlement (for contractor use only)			201,010	28.0
29.00	Balance due component/program (line 26 minus lines 26.01, 26.0	02, 27, and 28)		57, 557	
30. 00	Protested amounts (nonallowable cost report items) in accordanchapter I, §115.2	nce with CMS Pub. 15-II,		0	30.0

ALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 15-1307	Peri od:	Worksheet M-3	
ERVI CES	Component CCN: 15-3994	From 07/01/2021 To 06/30/2022	Date/Time Prep 11/28/2022 9:5	
	Title XVIII	RHC II	Cost	<u></u>
			1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FOHC SERVICES				
00 Total Allowable Cost of hospital-based RHC/FQHC Services (from	Wkst. M-2, line 20)		3, 545, 998	1.
00 Cost of injections/infusions and their administration (from Wk	st. M-4, line 15)		105, 994	2.
00 Total allowable cost excluding injections/infusions (line 1 mi	nus line 2)		3, 440, 004	3.
00 Total Visits (from Wkst. M-2, column 5, line 8)			15, 380	4.
00 Physicians visits under agreement (from Wkst. M-2, column 5, I	ine 9)		0	5.
00 Total adjusted visits (line 4 plus line 5)			15, 380	6.
00 Adjusted cost per visit (line 3 divided by line 6)			223.67	7.
		Cal cul ati on	OF LIMIT (I)	
		Rate Period 1		
		(07/01/2021	(01/01/2022	
		through	through	
		12/31/2021)	06/30/2022) 2.00	
00 Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.	6 or your contractor)	249.16	2.00	8.
00 Rate for Program covered visits (see instructions)		223.67	2234.37	9.
CALCULATION OF SETTLEMENT		223.07	223.07	· ·
0.00 Program covered visits excluding mental health services (from	contractor records)	1, 821	1, 669	10.
1.00 Program cost excluding costs for mental health services (line		407, 303	373, 305	
2.00 Program covered visits for mental health services (from contra		0	0	12.
3.00 Program covered cost from mental health services (line 9 x lin	e 12)	0	0	13.
4.00 Limit adjustment for mental health services (see instructions)		0	0	14.
5.00 Graduate Medical Education Pass Through Cost (see instructions	)			15.
5.00 Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	-	0	780, 608	
6.01  Total program charges (see instructions)(from contractor's rec			713, 181	
5.02 Total program preventive charges (see instructions)(from provi	-		42, 985	
6.03 Total program preventive costs ((line 16.02/line 16.01) times	-		47,049	
6.04 Total Program non-preventive costs ((line 16 minus lines 16.03	and 18) times .80)		517, 681	16.
(Titles V and XIX see instructions.)		0	E44 720	14
6.05  Total program cost (see instructions) 7.00  Primary payer amounts		0	564, 730 0	16. 17.
3.00 Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		86, 458	
records)			00, 400	10.
<ol> <li>OO Beneficiary coinsurance for RHC/FQHC services (see instruction records)</li> </ol>	s) (from contractor		116, 748	19.
0.00 Net Medicare cost excluding vaccines (see instructions)			564, 730	20.
1.00 Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		53, 372	
2.00 Total reimbursable Program cost (line 20 plus line 21)			618, 102	
3.00 Allowable bad debts (see instructions)			9, 163	
3.01 Adjusted reimbursable bad debts (see instructions)			5, 956	23.
4.00 Allowable bad debts for dual eligible beneficiaries (see instr	uctions)		2, 286	24.
5.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS)			0	25.
5.50 Pioneer ACO demonstration payment adjustment (see instructions	)		0	
5.99 Demonstration payment adjustment amount before sequestration			0	
6.00 Net reimbursable amount (see instructions)			624, 058	
6.01 Sequestration adjustment (see instructions)			1, 560	
6.02 Demonstration payment adjustment amount after sequestration			0	26.
7.00 Interim payments			567, 452	
3.00  Tentative settlement (for contractor use only) 7.00  Balance due component/program (line 26 minus lines 26.01, 26.0	2 27 and 28)		0 55 046	28.
9.00  Balance due component/program (line 26 minus lines 26.01, 26.0 D.00  Protested amounts (nonallowable cost report items) in accordan			55, 046 0	29. 30.
	CO WILLI OWD FUD. 10-11,		0	1 30.

Heal th	Financial Systems ASCENSION ST. VINC	ENT WILLIAMSPO	RT	In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provider CC		Period:	Worksheet M-4	
		Component (		From 07/01/2021 To 06/30/2022	Date/Time Pre 11/28/2022 9:	
		Title	XVIII	RHC I	Cost	
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1.00	2.00	2. 01	2.02	
1.00 2.00	Health care staff cost (from Wkst. M-1, col. 7, line 10) Ratio of injection/infusion staff time to total health care staff time	845, 683 0. 000143				1.00 2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	121	47	6 136	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	11, 346			0	4.00
5.00 6.00	Direct cost of injections/infusions (line 3 plus line 4)	11, 467				5.00 6.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1, 081, 362	1, 081, 36	2 1, 081, 362	1, 081, 362	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	941, 089				7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 010604				8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	9, 979				9.00
10. 00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	21, 446				10. 00
11.00	Total number of injections/infusions (from your records)	70		-		
12.00	Cost per injection/infusion (line 10/line 11)	306.37				
13.00	Number of injection/infusion administered to Program beneficiaries	13	12			
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	3, 983	8, 34	8 90	0	14.00
15. 00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		39, 98	6		15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		12, 42	1		16. 00

Heal th	Financial Systems ASCENSION ST. VINC	ENT WILLIAMSPO	RT	In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provider CC		Period:	Worksheet M-4	
		Component (		From 07/01/2021 To 06/30/2022	Date/Time Pre 11/28/2022 9:	
			XVIII	RHC II	Cost	
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1.00	2.00	2. 01	2.02	
1.00 2.00	Health care staff cost (from Wkst. M-1, col. 7, line 10) Ratio of injection/infusion staff time to total health care staff time	1, 494, 986 0. 000278				1.00 2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	416	1, 01	5 296	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	34, 378	21, 53	9 0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	34, 794			0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1, 928, 442	1, 928, 44	2 1, 928, 442	1, 928, 442	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1, 617, 556				7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 018043			0. 000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	29, 186			0	9.00
10. 00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	63, 980			0	10.00
11.00	Total number of injections/infusions (from your records)	228			0	
12.00	Cost per injection/infusion (line 10/line 11)	280. 61				
13.00	Number of injection/infusion administered to Program beneficiaries	103	32		0	
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	28, 903	24, 27	1 198	0	14.00
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		105, 99	4		15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		53, 37	2		16.00

Health Financial Systems	ASCENSION ST. VINC	ENT WILLIAMSPORT	In Lie	eu of Form CMS-2	2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQ		Provi der CCN: 15-1307	Peri od:	Worksheet M-5	
SERVICES RENDERED TO PROGRAM BENEFICIARIES			From 07/01/2021		
		Component CCN: 15-3993	To 06/30/2022		
			DUO I	11/28/2022 9:5	58 am
			RHC I	Cost	
				t B Amount	
				2.00	
1.00 Total interim payments paid to hospital	based BHC/EOHC		1.00	2.00	1.00
2.00 Interim payments payable on individual		tod or to be submitted to		201, 843	2.00
the contractor for services rendered in				0	2.00
"NONE" or enter a zero	The cost reporting	period. Il none, write			
	List separately each retroactive lump sum adjustment amount based on subsequent				3.00
revision of the interim rate for the co					5.00
payment. If none, write "NONE" or enter		A so show date of each			
Program to Provider	u 2010. (1)				
3. 01				0	3. 01
3. 02				0	3.02
3. 03				0	3.03
3.04				0	3.04
3. 05				0	3.05
Provider to Program					0.00
3. 50				0	3.50
3. 51				0	3.51
3. 52				0	3.52
3. 53				0	3.53
3. 54				0	3.54
3.99 Subtotal (sum of lines 3.01-3.49 minus	sum of lines 3.50-3.	98)		0	3.99
4.00 Total interim payments (sum of lines 1,	2, and 3.99) (trans	fer to Worksheet M-3, line		201, 843	4.00
27)					
TO BE COMPLETED BY CONTRACTOR					
5.00 List separately each tentative settleme		k review. Also show date of	F		5.00
each payment. If none, write "NONE" or	enter a zero. (1)				
Program to Provider					
5. 01				0	5.01
5. 02				0	5.02
5. 03				0	5.03
Provider to Program					
5. 50				0	5.50
5. 51				0	5.51
5. 52		00)		0	5.52
5.99 Subtotal (sum of lines 5.01-5.49 minus		<i>.</i>		0	5.99
6.00 Determined net settlement amount (balar	nce due) based on the	e cost report. (1)			6.00
6.01 SETTLEMENT TO PROVIDER				57, 557	6.01
6.02 SETTLEMENT TO PROGRAM				0	6.02
7.00 Total Medicare program liability (see i	nstructions)		0.1.1	259, 400	7.00
			Contractor	NPR Date	
		0	Number 1.00	(Mo/Day/Yr) 2.00	
8.00 Name of Contractor		0	1.00	2.00	8.00
0.00 maile of contractor	I		I.	ı	0.00

Health Financial Systems	ASCENSI ON ST. VI NCI	ENT WILLIAMSPORT	Inlie	eu of Form CMS-2	2552-10
	HOSPITAL-BASED RHC/FQHC PROVIDER FOR	Provi der CCN: 15-1307	Peri od:	Worksheet M-5	
SERVICES RENDERED TO PROC		Component CCN: 15-3994	From 07/01/2021 To 06/30/2022	Date/Time Prep	
			RHC II	11/28/2022 9:5 Cost	58 am
				T B	
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00 Total interim paym	ents paid to hospital-based RHC/FQHC		1.00	567, 452	1.00
2.00 Interim payments p	ayable on individual bills, either submit services rendered in the cost reporting			0	2.00
3.00 List separately ea revision of the in					3. 00
Program to Provide	r				
3.01				0	3. 01
3. 02				0	3.02
3.03				0	3.03
3.04				0	3.04
3. 05				0	3.05
Provider to Progra	m			-	
3.50				0	3.50
3. 51				0	3.51
3. 52				0	3.52
3. 53 3. 54				0	3. 53 3. 54
4	ines 3.01-3.49 minus sum of lines 3.50-3.	08)		0	3. 99
4.00 Total interim paym 27)	nents (sum of lines 1, 2, and 3.99) (trans			567, 452	4.00
TO BE COMPLETED BY					
	ch tentative settlement payment after des	k review. Also show date of	F		5.00
	oone, write "NONE" or enter a zero. (1)				
Program to Provide	F			0	5.01
5. 01 5. 02				0	5.01
5.02				0	5.02
Provider to Progra	m			0	5.05
5.50				0	5.50
5.51				0	5.50
5. 52				0	5.52
	ines 5.01-5.49 minus sum of lines 5.50-5.	98)		0	5.99
	tlement amount (balance due) based on the				6.00
6.01 SETTLEMENT TO PROV	I DER			55, 046	6. 01
6.02 SETTLEMENT TO PROG	RAM			0	6. 02
7.00 Total Medicare pro	gram liability (see instructions)			622, 498	7.00
			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00 Name of Contractor					8.00