This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 03-31-2022 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-2020 Worksheet S Peri od: From 07/01/2021 Parts I-III AND SETTLEMENT SUMMARY 06/30/2022 Date/Time Prepared: 11/15/2022 12:36 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 11/15/2022 Time: 12:36 pm] Manually prepared cost report use only Ilf this is an amended report enter the number of times the provider resubmitted this cost report [Medicare Utilization. Enter "F" for full or "L" for low. 4 [1] Cost Report Status
[1] As Submitted
[2] Settled without Audit
[3] Settled with Audit
[4] Date Received:
[5] To. NPR Date:
[6] 10. NPR Date:
[7] 11. Contractor's Vendor Code:
[7] 12. [8] Final Report for this Provider CCN
[9] [8] Final Report for this Provider CCN
[10] NPR Date:
[11] 12. Contractor's Vendor Code:
[12] [9] If line 5, column 1 is 4: Enter
[13] NPR Date:
[14] 12. Contractor's Vendor Code:
[15] 13. NPR Date:
[16] 13. NPR Date:
[17] 14. Contractor's Vendor Code:
[18] 15. Contractor's Vendor Code:
[18] 16. NPR Date:
[18] 17. Contractor's Vendor Code:
[18] 17. Contractor's Vendor Code:
[18] 18. Contractor's Vendor Code:
[18] 19. NPR Date:
[18] 19. NPR Date:
[18] 19. NPR Date:
[18] 19. NPR Date:
[19] 19. NPR Date: Contractor use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened (5) Amended

PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ASCENSION ST VINCENT SETON SPECIALTY (15-2020) for the cost reporting period beginning 07/01/2021 and ending 06/30/2022 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR			ELECTRONI C			
	1			SI GNATURE STATEMENT			
1	Betha	any Morrow	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	Bethany Morrow			2		
3	Signatory Title	VP-FI NANCE			3		
4	Date	11/15/2022 12: 36: 04 PM			4		

		Title XVIII				
Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
	1.00	2.00	3. 00	4. 00	5. 00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospi tal	0	-76, 001	-3	0	0	1. 00
2.00 Subprovi der - IPF	0	0	0		0	2. 00
3.00 Subprovider - IRF	0	0	0		0	3. 00
5.00 Swing Bed - SNF	0	0	0		0	5. 00
6.00 Swing Bed - NF	0				0	6. 00
200. 00 Total	0	-76, 001	-3	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-2020 Peri od: Worksheet S-2 From 07/01/2021 Part I Date/Time Prepared: 06/30/2022 11/15/2022 12:36 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 8050 TOWNSHIP LINE ROAD 1.00 PO Box: 1.00 State: IN 2.00 City: INDIANAPOLIS Zip Code: 46260 County: MARION 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, O, or N)
V XVIII XIX Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 ASCENSION ST VINCENT 152020 26900 02/08/2003 N 0 3.00 SETON SPECIALTY Subprovi der - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 Subprovi der - (Other) 6.00 6.00 Swing Beds - SNF 7 00 7 00 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 10.00 Hospi tal -Based NF 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 14.00 14.00 Hospital-Based Health Clinic - RHC 15.00 15 00 16.00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital-Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: 2.00 1.00 20.00 Cost Reporting Period (mm/dd/yyyy) 07/01/2021 06/30/2022 20.00 21.00 Type of Control (see instructions) 21.00 1 1. 00 2. 00 3.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for N N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this 22.01 Ν Ν 22.01 cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1.

Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)

Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) 22.02 22.02 N N Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to 22.03 N Ν Ν rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 22.04 Did this hospital receive a geographic reclassification from urban to 22.04 Ν Ν Ν rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, yes or "N" for no. 23 00 Which method is used to determine Medicaid days on lines 24 and/or 25 23 00 2 N below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-2020 Peri od: Worksheet S-2 From 07/01/2021 Part I Date/Time Prepared: 06/30/2022 11/15/2022 12:36 pm In-State In-State Out-of Out-of Medi cai d Medi cai d Medi cai d State State HMO days Medi cai d paid days el i gi bl e Medi cai d Medi cai d days paid days unpai d eligible days unpai d 1.00 2. 00 3. 00 4. 00 5. 00 6.00 24.00 If this provider is an IPPS hospital, enter the 0 24.00 \cap n in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state 0 0 0 0 0 25.00 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. Urban/Rural S Date of Geogr 1. 00 2.00 26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural. 26.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, 27.00 enter the effective date of the geographic reclassification in column 2. If this is a sole community hospital (SCH), enter the number of periods SCH status in 35.00 effect in the cost reporting period. Endi ng: Begi nni ng: 1.00 2.00 36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number 36, 00 of periods in excess of one and enter subsequent dates. If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status 37.00 0 is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see 37.01 37.01 instructions) If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is 38.00 greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates. Y/N Y/N 1.00 2.00 39. 00 39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or Ν Ν 40.00 "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions) XVIII XIX 1.00 2.00 3.00 Prospective Payment System (PPS)-Capital 45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance Ν 45.00 with 42 CFR Section §412.320? (see instructions) 46.00 | Is this facility eligible for additional payment exception for extraordinary circumstances Ν N Ν 46.00 pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through 47.00 | Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no. 47.00 Ν Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. Ν Ν Ν 48.00 Teaching Hospitals Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hospital Ν 56.00 was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2. 57.00 | If line 56 is yes, is this the first cost reporting period during which residents in approved 57 00 GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. 58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5. 58 00 59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I. 59.00

	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	umn 1.	If column 1				
	adjustement? Enter "Y" for yes or "N" for no in colu		I ME	Direct GME	IME	Direct GME	
		1. 00	2. 00	3. 00	4.00	5.00	
61. 00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N N	2.00	3.00	0.00		61.00
61. 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. 01
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. 02
61. 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. 03
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. 04
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. 05
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)						61.06
		Pro	ogram Name			Direct GME FTE Count	
61 10	Of the FTEs in line 61.05, specify each new program		1. 00	2. 00	3.00	4.00	61. 10
61. 20	specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0. 00	0. 00	61. 20
						1.00	
	ACA Provisions Affecting the Health Resources and Ser Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruc	trai ned ti ons)	in this cost	reporting peri		0.00	62.00
62. 01	Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog				your hospital	0.00	62. 01
63. 00	Teaching Hospitals that Claim Residents in Nonprovider Selection and Teaching Has your facility trained residents in nonprovider selection for yes or "N" for no in column 1. If yes, complete	ttings	during this co		ctions)	N	63. 00
				Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))	
	Section 5504 of the ACA Base Year FTE Residents in No			1.00 This base year	2.00 is your cost r	3.00 reporting	
64. 00	period that begins on or after July 1, 2009 and befor Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted non resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter in of (column 1 divided by (column 1 + column 2)). (see	y train -priman all non non-pr column	ned residents ry care nprovider rimary care n 3 the ratio	0.00	0.00	0. 000000	64. 00

In Lieu of Form CMS-2552-10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-2020 Peri od: Worksheet S-2 From 07/01/2021 Part I Date/Time Prepared: 06/30/2022 11/15/2022 12:36 pm Program Code Unwei ghted Unwei ghted Program Name Ratio (col. 3/ (col. 3 + col FTEs FTEs in Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 is yes, or your facility 0. 00 0. 00 0.000000 65.00 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) Unwei ghted Unwei ghted Ratio (col. 1/ FTEs FTEs in (col. 1 + col Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 0. 00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Unwei ghted Ratio (col. 3/ Program Code Unwei ahted FTES FTEs in (col. 3 + col Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3. 00 4.00 5.00 67.00 Enter in column 1, the program 0.000000 67.00 0.00 0.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)) (see instructions) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 Enter "Y" for yes or "N" for no. 71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most O 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF N 75.00 subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for 76.00 no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)

Health Financial Systems ASCENSION ST VINCENT SE	TON SDECLALTY	Inlio	u of Form CMS	2 2552 10
-	Provider CCN: 15-2020	Peri od: From 07/01/2021 To 06/30/2022	Worksheet S Part I Date/Time P 11/15/2022	-2 repared:
			1.00	12.00 p
Long Term Care Hospital PPS				
80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes an 81.00 Is this a LTCH co-located within another hospital for part or a "Y" for yes and "N" for no. TEFRA Providers		g period? Enter	Y N	80. 00 81. 00
85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TE 86.00 Did this facility establish a new Other subprovider (excluded under subprovider)			N	85. 00 86. 00
§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. 87.00 Is this hospital an extended neoplastic disease care hospital control 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	lassified under section		N	87. 00
		1. 00	XI X 2. 00	
Title V and XIX Services				
90.00 Does this facility have title V and/or XIX inpatient hospital s yes or "N" for no in the applicable column.	services? Enter "Y" for	N	Y	90.00
91.00 Is this hospital reimbursed for title V and/or XIX through the full or in part? Enter "Y" for yes or "N" for no in the applica		N	Υ	91.00
92.00 Are title XIX NF patients occupying title XVIII SNF beds (dual instructions) Enter "Y" for yes or "N" for no in the applicable	certification)? (see		N	92. 00
93.00 Does this facility operate an ICF/IID facility for purposes of "Y" for yes or "N" for no in the applicable column.		N	N	93. 00
94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and applicable column.	I"N" for no in the	N	N	94. 00
95.00 If line 94 is "Y", enter the reduction percentage in the applic		0. 00	0. 00	95. 00
96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or applicable column.	"N" for no in the	N	N	96. 00
97.00 If line 96 is "Y", enter the reduction percentage in the applic		0. 00	0. 00	97. 00
98.00 Does title V or XIX follow Medicare (title XVIII) for the interstepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for column 1 for title V, and in column 2 for title XIX.		N	N	98. 00
98.01 Does title V or XIX follow Medicare (title XVIII) for the report, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title title XIX.			N	98. 01
98.02 Does title V or XIX follow Medicare (title XVIII) for the calcubed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "		N	N	98. 02
for title V, and in column 2 for title XIX. 98.03 Does title V or XIX follow Medicare (title XVIII) for a critical reimbursed 101% of inpatient services cost? Enter "Y" for yes of		N 1	N	98. 03
for title V, and in column 2 for title XIX. 98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH rei outpatient services cost? Enter "Y" for yes or "N" for no in co		N	N	98. 04
in column 2 for title XIX. 98.05 Does title V or XIX follow Medicare (title XVIII) and add back Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in colu			N	98. 05
column 2 for title XIX. 98.06 Does title V or XIX follow Medicare (title XVIII) when cost rei Pts. I through IV? Enter "Y" for yes or "N" for no in column 1		N	N	98. 06
column 2 for title XIX. Rural Providers				
105.00 Does this hospital qualify as a CAH? 106.00 If this facility qualifies as a CAH, has it elected the all-inc	clusive method of pavmen	N t N		105. 00 106. 00
for outpatient services? (see instructions)	. 3			
107.00 Column 1: If line 105 is Y, is this facility eligible for cost training programs? Enter "Y" for yes or "N" for no in column 1. Column 2: If column 1 is Y and line 70 or line 75 is Y, do you approved medical education program in the CAH's excluded IPF a	(see instructions) I train I&Rs in an Ind/or IRF unit(s)?	N		107. 00
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 CRN		N		108. 00

Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&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 s this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 N				
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	e CRIVA TEE SCHE	uui e? 3ee 42	N		108. 00
	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					109. 00
therapy services provided by outside supplier? Enter "Y"					
for yes or "N" for no for each therapy.					
				1.00	
110.00 Did this hospital participate in the Rural Community Hospit	al Demonstratio	on project (§41	OA	N	110. 00
Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.					

		To 06/30/2022	Date/Time Pr 11/15/2022 1	
		1. 00	2. 00	_
111.00 If this facility qualifies as a CAH, did it participate in the Frontier Cor Health Integration Project (FCHIP) demonstration for this cost reporting por "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, expending the FCHIP demoin which this CAH is participating in a Enter all that apply: "A" for Ambulance services; "B" for additional beds; for tele-health services.	eriod? Enter nter the column 2.	N		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	2.50	5.00	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			0 115. 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.	Υ			117. 00
118.00 Is the mal practice insurance a claims-made or occurrence policy? Enter 1		2		118. 00
if the policy is claim-made. Enter 2 if the policy is occurrence.	Premi ums	Losses	Insurance	
	1. 00	2.00	3.00	_
118.01 List amounts of malpractice premiums and paid losses:		0 0		25 118. 01
		1.00	2.00	_
118.02 Are malpractice premiums and paid losses reported in a cost center other the Administrative and General? If yes, submit supporting schedule listing cost and amounts contained therein.		N N	2.00	118. 02
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provi §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 the Hold Harmless provision in ACA §3121 and applicable amendments? (see instru Enter in column 2, "Y" for yes or "N" for no.	for yes or e Outpatient	N	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.	charged to	N		121. 00
122.00 Does the cost report contain healthcare related taxes as defined in §1903(v Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the Worksheet A line number where these taxes are included.				122. 00
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes and "N" 1	for no. If	N		125. 00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, enter the certifi	ication date			126. 00
in column 1 and termination date, if applicable, in column 2. 127.00 If this is a Medicare certified heart transplant center, enter the certific				127. 00
in column 1 and termination date, if applicable, in column 2. 128.00 f this is a Medicare certified liver transplant center, enter the certified liver transplant center.				128. 00
in column 1 and termination date, if applicable, in column 2. 129.00 f this is a Medicare certified lung transplant center, enter the certification of the				129. 00
column 1 and termination date, if applicable, in column 2. 130.00 on this is a Medicare certified pancreas transplant center, enter the certified pancreas transplant center.				130. 00
date in column 1 and termination date, if applicable, in column 2. 131.00 of this is a Medicare certified intestinal transplant center, enter the certified intestinal transplant center.				131. 00
date in column 1 and termination date, if applicable, in column 2. 132.00 f this is a Medicare certified islet transplant center, enter the certific				132. 00
in column 1 and termination date, if applicable, in column 2. 133.00Removed and reserved	Sation date			133. 00
134.00 If this is an organ procurement organization (0P0), enter the 0P0 number in and termination date, if applicable, in column 2.	n column 1			134. 00
All Providers 140.00 Are there any related organization or home office costs as defined in CMS I chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home of are claimed, enter in column 2 the home office chain number. (see instructions)	office costs	Y	15H046	140. 00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-2020 Peri od: Worksheet S-2 From 07/01/2021 Part I 06/30/2022 Date/Time Prepared: To 11/15/2022 12:36 pm 3.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number
Name: ASCENSION ST VINCENT | Contractor's Name: WPS Contractor's Number: 08101 141 OO Name: ASCENSION ST VINCENT 141 00 142.00 Street: 250 WEST 96TH STREET PO Box: 142.00 143.00 City: INDIANAPOLIS 46290 143. 00 State: Zip Code: 1 00 144.00 Are provider based physicians' costs included in Worksheet A? 144. 00 N 1. 00 2.00 145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for 145 00 inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost allocation methodology changed from the previously filed cost report? 146.00 Ν Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. 1.00 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. 147. 00 Ν N 148 00 149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no Ν 149.00 Part A Part B Title V Title XIX 1.00 2.00 3.00 4.00 Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) 155.00 Hospi tal 155.00 Ν N 156.00 Subprovi der - IPF Ν Ν Ν Ν 156.00 157.00 Subprovi der - IRF 157 00 N Ν Ν N 158. 00 SUBPROVI DER 158. 00 159.00 SNF Ν Ν Ν 159. 00 Ν 160.00 HOME HEALTH AGENCY 160.00 Ν Ν Ν Ν 161.00 CMHC Ν Ν N 161. 00 1.00 Multicampus 165.00 s this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? N 165.00 Enter "Y" for yes or "N" for no. Name County State Zip Code CBSA FTE/Campus 0 1.00 2.00 3.00 4.00 5.00 166.00 If line 165 is yes, for each 0.00 166.00 campus enter the name in column O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) 1.00 Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act 167.00 s this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no. 167 00 168.00 of this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the 168.00 reasonable cost incurred for the HIT assets (see instructions) 168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions) 168.01 169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the 0.00169.00 transition factor. (see instructions) Begi nni ng Endi ng 1.00 2.00 170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting 170. 00 period respectively (mm/dd/yyyy) 1.00 2.00 171.00|If line 167 is "Y", does this provider have any days for individuals enrolled in 0171.00 N section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)

	Financial Systems ASCENSION ST VINCENT				eu of Form CMS-	
HUSPI	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-2020	Period: From 07/01/202 To 06/30/202		epared:
				Y/N	Date	2. 30 piii
				1. 00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N fmm/dd/yyyy format.	or all NO re	esponses. Ent	er all dates in	the	
	COMPLETED BY ALL HOSPITALS					4
1. 00	Provider Organization and Operation Has the provider changed ownership immediately prior to the b	ogi ppi pg. of	the cost	N	T	1.00
1.00	reporting period? If yes, enter the date of the change in col				V/I	1.00
			1.00	2. 00	3.00	
2. 00	Has the provider terminated participation in the Medicare Proyes, enter in column 2 the date of termination and in column		N N	2.00	3.00	2. 00
3. 00	voluntary or "I" for involuntary. Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home off or medical supply companies) that are related to the provider officers, medical staff, management personnel, or members of of directors through ownership, control, or family and other	ices, drug or its the board	N			3. 00
	relationships? (see instructions)		Y/N	Typo	Date	
			1.00	7ype 2. 00	3.00	
	Financial Data and Reports		1.00	2.00] 3.00	
4. 00	Column 1: Were the financial statements prepared by a Certif Accountant? Column 2: If yes, enter "A" for Audited, "C" for or "R" for Reviewed. Submit complete copy or enter date avail column 3. (see instructions) If no, see instructions.	Compiled,	Y	А		4. 00
5. 00	Are the cost report total expenses and total revenues differe those on the filed financial statements? If yes, submit recon		N			5. 00
				Y/N 1.00	Legal Oper. 2.00	
	Approved Educational Activities					
5. 00	Column 1: Are costs claimed for a nursing program? Column 2: is the legal operator of the program?	3	s the provide			6. 00
7. 00 8. 00	Are costs claimed for Allied Health Programs? If "Y" see inst Were nursing programs and/or allied health programs approved cost reporting period? If yes, see instructions.		wed during th	e N N		7. 00 8. 00
9. 00	Are costs claimed for Interns and Residents in an approved gr program in the current cost report? If yes, see instructions.	aduate medio	cal education	N		9. 00
10. 00	Was an approved Intern and Resident GME program initiated or cost reporting period? If yes, see instructions.	renewed in 1	the current	N		10.00
11. 00	Are GME cost directly assigned to cost centers other than I & Teaching Program on Worksheet A? If yes, see instructions.	R in an App	proved	N		11. 00
					Y/N 1.00	
	Bad Debts				1.00	
12. 00 13. 00	Is the provider seeking reimbursement for bad debts? If yes, If line 12 is yes, did the provider's bad debt collection pol			ost reporting	Y N	12. 00 13. 00
14. 00	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-payment Ped Complement	s waived? If	yes, see in	structions.	N	14. 00
15. 00	Bed Complement Did total beds available change from the prior cost reporting	period? If	yes, see ins		N	15. 00
			rt A		irt B	
		Y/N	Date	Y/N	Date	
	PS&R Data	1. 00	2.00	3. 00	4. 00	
4 / 00	Was the cost report proposed using the DSCD Deport only?	V	00/15/2022) V	00/15/2022	_

	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only?	Υ	09/15/2022	Υ	09/15/2022	16.00
	If either column 1 or 3 is yes, enter the paid-through					
	date of the PS&R Report used in columns 2 and 4 .(see					
	instructions)					
17. 00	Was the cost report prepared using the PS&R Report for	N		N		17. 00
	totals and the provider's records for allocation? If					
	either column 1 or 3 is yes, enter the paid-through date					
	in columns 2 and 4. (see instructions)					
18. 00	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		18. 00
	Report data for additional claims that have been billed					
	but are not included on the PS&R Report used to file this					
	cost report? If yes, see instructions.					
19. 00	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		19. 00
	Report data for corrections of other PS&R Report					
	information? If yes, see instructions.					

Heal th	Financial Systems ASCENSION ST VINCEN	NT SETON SPECIA	SETON SPECIALTY In Lie			eu of Form CMS-2552-10		
	TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-2020	Period: From 07/01/2021	Worksheet S			
				To 06/30/2022	Date/Time P			
		Descr	pti on	Y/N	11/15/2022 Y/N	12: 36 pm		
		(o .	1. 00	3. 00			
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20. 00		
		Y/N	Date	Y/N	Date			
21. 00	Was the cost report prepared only using the provider's	1. 00 N	2. 00	3. 00 N	4. 00	21. 00		
21.00	records? If yes, see instructions.	IV.		IN .		21.00		
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	EPT CHILDRENS H	OSPI TALS)					
22.00	Capital Related Cost	a i notrupti ono			N	22.00		
22. 00 23. 00	Have assets been relifed for Medicare purposes? If yes, see Have changes occurred in the Medicare depreciation expense		als made duri	ng the cost	N N	22. 00 23. 00		
24. 00	reporting period? If yes, see instructions. Were new leases and/or amendments to existing leases entered	ed into during	this cost rep	orting period?	N	24. 00		
25. 00	If yes, see instructions Have there been new capitalized leases entered into during	the cost repor	ting period?	If yes, see	N	25. 00		
26. 00	instructions. Were assets subject to Sec. 2314 of DEFRA acquired during the	he cost reporti	ng period? If	yes, see	N	26. 00		
27. 00	instructions. Has the provider's capitalization policy changed during the	e cost reportir	g period? If	yes, submit	N	27. 00		
	copy. Interest Expense	·						
28. 00	Were new loans, mortgage agreements or letters of credit en period? If yes, see instructions.	N	28. 00					
29. 00	Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see insti	N	29. 00					
30. 00	Has existing debt been replaced prior to its scheduled maturinstructions.	N	30. 00					
31. 00	Has debt been recalled before scheduled maturity without is	N	31. 00					
	instructions. Purchased Services							
32. 00	Have changes or new agreements occurred in patient care ser	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 app		g to competit	ive bidding? If	N	33. 00		
	no, see instructions. Provider-Based Physicians							
34. 00	Are services furnished at the provider facility under an allf yes, see instructions.	rrangement with	provi der-bas	ed physicians?	N	34. 00		
35. 00			its with the p	rovi der-based	N	35. 00		
	phrysicians during the cost reporting period? If yes, see if	iisti ucti olis.		Y/N	Date			
	lu ossi o i			1. 00	2. 00			
36. 00	Home Office Costs Were home office costs claimed on the cost report?			Υ		36.00		
37. 00	·	renared by the	home office?	Y		37. 00		
	If yes, see instructions.							
38. 00	If line 36 is yes, was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year end	d of the home o	ffi ce.	N		38.00		
39. 00	If line 36 is yes, did the provider render services to other see instructions.		,	N		39. 00		
40. 00	If line 36 is yes, did the provider render services to the instructions.	home office?	If yes, see	N		40. 00		
		00						
	Cost Report Preparer Contact Information							
41. 00		JI LL		HILL		41. 00		
42. 00	respectively. Enter the employer/company name of the cost report	ASCENSION ST V	I NCENT			42. 00		
43. 00	preparer.	N/A		JI LL. HI LL1@ASCI	ENSION ODG	43. 00		
43.00	report preparer in columns 1 and 2, respectively.	IV/ A		STEE. III EE I@ASCI	LINST UIN. UKU	43.00		

Heal th	Financial Systems ASCENSI	ON ST VINCEN	T SETON SPECIALT	Υ	In Lie	u of Form CMS-	2552-10
HOSPI 7	FAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTI	ONNAI RE	Provider CCN:	1		Worksheet S-2 Part II Date/Time Pre	pared:
						11/15/2022 12	36 pm
			3. 00				
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title/p	osition	MANAGER				41. 00
	held by the cost report preparer in columns 1,	2, and 3,					
	respecti vel y.						
42.00	Enter the employer/company name of the cost rep	ort					42. 00
	preparer.						
43.00	Enter the telephone number and email address of	the cost					43. 00
	report preparer in columns 1 and 2, respectivel	y.					

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provi der CCN: 15-2020

Peri od: Worksheet S-3 From 07/01/2021 Part I To 06/30/2022 Date/Time Prepared:

11/15/2022 12:36 pm I/P Days / O/P Visits / Trips Component Worksheet A No. of Beds Bed Days CAH Hours Title V Line Number Avai I abl e 5.00 1.00 2.00 3.00 4.00 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 30.00 26, 280 0.00 0 1.00 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2 00 HMO and other (see instructions) 2 00 3.00 HMO IPF Subprovider 3.00 HMO IRF Subprovider 4.00 4.00 5.00 Hospital Adults & Peds. Swing Bed SNF 5.00 0 Hospital Adults & Peds. Swing Bed NF 6.00 0 6.00 7.00 Total Adults and Peds. (exclude observation 72 26, 280 0.00 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8.00 8.00 CORONARY CARE UNIT 9.00 9.00 10.00 BURN INTENSIVE CARE UNIT 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 12.00 OTHER SPECIAL CARE (SPECIFY) 12.00 13.00 NURSERY 13.00 14.00 Total (see instructions) 72 26, 280 0.00 0 14.00 CAH visits 15.00 15.00 SUBPROVIDER - IPF 16.00 16.00 SUBPROVIDER - IRF 17.00 17.00 18.00 SUBPROVI DER 18.00 19.00 SKILLED NURSING FACILITY 19.00 20 00 NURSING FACILITY 20 00 21.00 OTHER LONG TERM CARE 21.00 22.00 HOME HEALTH AGENCY 22.00 23.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 HOSPI CE 24.00 24 00 24. 10 HOSPICE (non-distinct part) 30.00 24. 10 25. 00 CMHC - CMHC 25.00 26.00 RURAL HEALTH CLINIC 26, 00 26, 25 FEDERALLY QUALIFIED HEALTH CENTER 89 00 0 26.25 27.00 Total (sum of lines 14-26) 72 27.00 28.00 Observation Bed Days 28.00 29.00 Ambul ance Trips 29.00 30 00 Employee discount days (see instruction) 30.00 31.00 Employee discount days - IRF 31.00 Labor & delivery days (see instructions) Total ancillary labor & delivery room 0 32.00 32.00 32.01 32.01 outpatient days (see instructions) 33.00 LTCH non-covered days 33.00 33.01 LTCH site neutral days and discharges 33.01

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

20 00

21.00

22.00

23.00

24.00

24. 10

25.00 26, 00

26. 25

27.00

28.00

29.00

30.00

31.00

32.00

32.01

33.00

Total (see instructions)

SKILLED NURSING FACILITY

HOSPICE (non-distinct part)

Total (sum of lines 14-26)

Employee discount days - IRF

AMBULATORY SURGICAL CENTER (D. P.)

FEDERALLY QUALIFIED HEALTH CENTER

Employee discount days (see instruction)

Labor & delivery days (see instructions) Total ancillary labor & delivery room

outpatient days (see instructions)

33.01 LTCH site neutral days and discharges

CAH visits

SUBPROVI DER

HOSPI CE

CMHC - CMHC

SUBPROVIDER - IPF

SUBPROVIDER - IRF

NURSING FACILITY

OTHER LONG TERM CARE

HOME HEALTH AGENCY

RURAL HEALTH CLINIC

Observation Bed Days

LTCH non-covered days

Ambul ance Trips

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-2020

12

Ω

0

10, 291

0

0

0

41

0

0

0

Peri od: Worksheet S-3 From 07/01/2021 Part I

0.00

0.00

0.00

108.48

14.00

15.00

16.00

17.00

18.00

19.00

20 00

21.00

22.00

23.00

24 00

24. 10

25.00

26, 00

26.25

27.00

28.00

29.00

30.00

31.00

32.00

32.01

33.00

33.01

0.00

108.48

06/30/2022 Date/Time Prepared: 11/15/2022 12:36 pm Full Time Equivalents I/P Days / O/P Visits / Trips Title XVIII Component Title XIX Total All Total Interns Employees On Pati ents & Residents Payrol I 7.00 6.00 8.00 9.00 10.00 Hospital Adults & Peds. (columns 5, 6, 7 and 2, 811 12 10, 291 1.00 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) 1, 158 2 00 2.656 HMO IPF Subprovider 3.00 HMO IRF Subprovider 0 4.00 Hospital Adults & Peds. Swing Bed SNF 0 0 5.00 Hospital Adults & Peds. Swing Bed NF C 0 6.00 Total Adults and Peds. (exclude observation 2,811 12 10, 291 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8.00 CORONARY CARE UNIT 9.00 BURN INTENSIVE CARE UNIT 10.00 SURGICAL INTENSIVE CARE UNIT 11.00 OTHER SPECIAL CARE (SPECIFY) 12.00 NURSERY 13.00

2,811

Health Financial Systems ASCENSION ST VINCENT SETON SPECIALTY
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 1

Provi der CCN: 15-2020

					00/30/2022	11/15/2022 12:	
	·	Full Time		Di sch	arges		
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12. 00	13. 00	14. 00	15. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	66	1	263	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
2 00	for the portion of LDP room available beds)			54	40		2. 00
2. 00 3. 00	HMO and other (see instructions) HMO IPF Subprovider			54	40		2. 00 3. 00
4. 00	HMO IRF Subprovider	+			0		4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF				U		5. 00
6. 00	Hospital Adults & Peds. Swing Bed NF						6. 00
7. 00	Total Adults and Peds. (exclude observation						7. 00
7.00	beds) (see instructions)						7.00
8. 00	INTENSIVE CARE UNIT						8. 00
9. 00	CORONARY CARE UNIT						9. 00
10. 00	BURN INTENSIVE CARE UNIT						10. 00
11. 00	SURGI CAL INTENSI VE CARE UNI T						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13. 00	NURSERY						13. 00
14. 00	Total (see instructions)	0. 00	0	66	1	263	14.00
15.00	CAH visits						15.00
16.00	SUBPROVI DER - I PF						16.00
17.00	SUBPROVI DER - I RF						17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24. 00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC						25.00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0. 00					26. 25
27. 00	Total (sum of lines 14-26)	0. 00					27. 00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance Tri ps						29. 00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32. 00	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room						32. 01
33. 00	outpatient days (see instructions) LTCH non-covered days	}					33. 00
	LTCH non-covered days LTCH site neutral days and discharges	}		0			33. 00
33.01	LIGHT SI LE HEULT AT MAYS AND UT SCHALGES	1		١	ı		55. 01

11, 568, 046

14, 218, 298

25, 786, 344

0

ol

0 194. 01

25, 786, 344 200. 00

194. 01 07951 MARKETI NG

200.00

TOTAL (SUM OF LINES 118 through 199)

 Heal th Financial
 Systems
 ASCENSION ST VINCENT
 SETON SPECIALTY

 RECLASSIFICATION
 AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES
 Provider CCN: 1

Provider CCN: 15-2020

					11/15/2022 12	:36 pm
	Cost Center Description	Adjustments	Net Expenses			
	·	(See A-8)	For Allocation	n		
		6.00	7.00			
	GENERAL SERVICE COST CENTERS			•		
1.00	00100 CAP REL COSTS-BLDG & FLXT	-13, 812	739, 269			1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	0	241, 377	,		2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	80, 101		1		4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	-505, 364				5. 00
7. 00	00700 OPERATION OF PLANT	0		1		7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE		· ·	1		8.00
9. 00	00900 HOUSEKEEPI NG		419, 230			9. 00
10. 00		-61, 810				10.00
13. 00		-7, 130				13. 00
15. 00		-7, 130				15. 00
				1		
16.00		0		1		16.00
17. 00		0		1		17. 00
18. 00		0	0)		18. 00
	INPATIENT ROUTINE SERVICE COST CENTERS		1			
30. 00		-203	9, 542, 267	1		30. 00
	ANCILLARY SERVICE COST CENTERS					
50. 00		0				50. 00
54. 00		0	,			54. 00
54. 01		0	5, 485	<u> </u>		54. 01
57.00	05700 CT SCAN	0	1, 185	5		57. 00
60.00	06000 LABORATORY	0	286, 676			60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0			63. 00
65.00	06500 RESPIRATORY THERAPY	-166	2, 120, 613	3		65. 00
66.00	06600 PHYSI CAL THERAPY	0	257, 403	3		66. 00
67.00		0				67.00
68. 00	06800 SPEECH PATHOLOGY	0				68. 00
69. 00	· · · · · · · · · · · · · · · · · · ·	0		1		69. 00
	07000 ELECTROENCEPHALOGRAPHY	0	0			70.00
71. 00	1 I		79, 606			71.00
72. 00			77,000	1		72.00
73. 00	l l		_			73. 00
	07400 RENAL DIALYSIS		_	í		74.00
74.00	SPECIAL PURPOSE COST CENTERS		212, 374	1		74.00
112 0	0 11300 I NTEREST EXPENSE	0	0	N .		113. 00
118.0		-508, 384				118.00
110.0		-300, 304	25, 277, 900	<u>/</u>		1118.00
100 0	NONREI MBURSABLE COST CENTERS					100 00
	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		•		190.00
	0 19100 RESEARCH	0	0			191. 00
	0 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	2		192. 00
	0 19300 NONPALD WORKERS	0	0	2		193. 00
	0 07950 BI OTERRORI SM GRANT	0	0)		194. 00
	1 07951 MARKETI NG	0	0)		194. 01
200. 0	O TOTAL (SUM OF LINES 118 through 199)	-508, 384	25, 277, 960)		200. 00

ASCENSION ST VINCENT SETON SPECIALTY

In Lieu of Form CMS-2552-10

Health Financial Systems RECLASSIFICATIONS Peri od: WOFKSHEEL ...
From 07/01/2021
To 06/30/2022 Date/Ti me Prepared: 11/15/2022 12:36 pm Provider CCN: 15-2020

		Increases			
	Cost Center	Li ne #	Sal ary	0ther	
	2. 00	3. 00	4. 00	5. 00	
	B - FURLOUGH RECLASS				
1.00	NURSING ADMINISTRATION	13. 00	0	2, 165	1.00
2.00	PHARMACY	15. 00	0	1, 550	2.00
3.00	ADULTS & PEDIATRICS	30.00	0	3, 898	3.00
4.00	RESPIRATORY THERAPY	65. 00	0	2, 150	4.00
5.00	PHYSI CAL THERAPY	66.00	0	296	5.00
6.00	OCCUPATI ONAL THERAPY	67. 00	0	563	6.00
	0		0	10, 622	
	E - VACCINE TO WKRS COMP				1
1.00	RESPIRATORY THERAPY	65. 00	0	1, 799	1.00
	0			1, 799	
	F - SALARY PTO ACCRUAL				1
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	77, 820	0	1.00
	TOTALS		77, 820		
500.00	Grand Total: Increases		77, 820	12, 421	500.00

ASCENSION ST VINCENT SETON SPECIALTY

In Lieu of Form CMS-2552-10

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-2020

						11/15/2022 12:36 piii
		Decreases				
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.	
	6. 00	7. 00	8. 00	9. 00	10.00	
	B - FURLOUGH RECLASS					
1.00	NURSING ADMINISTRATION	13. 00	2, 165	C)	1.00
2.00	PHARMACY	15. 00	1, 550	C)	0 2.00
3.00	ADULTS & PEDIATRICS	30.00	3, 898	C)	0 3.00
4.00	RESPIRATORY THERAPY	65.00	2, 150	C)	0 4.00
5.00	PHYSI CAL THERAPY	66.00	296	C)	0 5.00
6.00	OCCUPATI ONAL THERAPY	67. 00	563	C)	0 6.00
	0		10, 622)	
	E - VACCINE TO WKRS COMP					
1.00	RESPIRATORY THERAPY	65. 00	1, 799	C)	1.00
	0		1, 799)	
	F - SALARY PTO ACCRUAL					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	77, 820)	1.00
	TOTALS		0	77, 820		
500.00	Grand Total: Decreases		12, 421	77, 820)	500.00

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-2020

				10	0 06/30/2022	11/15/2022 12	
				Acqui si ti ons			
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances 1, 00				Retirements	
			2. 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	847, 629	0	0	0	0	1. 00
2.00	Land Improvements	3, 157	239, 676	0	239, 676	l e	2. 00
3.00	Buildings and Fixtures	15, 901, 288	0	0	0	0	3. 00
4.00	Building Improvements	436, 760	0	0	0	0	4. 00
5.00	Fi xed Equipment	1, 086, 014	100, 247		100, 247		5. 00
6.00	Movable Equipment	5, 953, 035	8, 100	0	8, 100	l .	6. 00
7.00	HIT designated Assets	0	0	0	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	24, 227, 883	348, 023	0	348, 023	0	8. 00
9.00	Reconciling Items	0	0	0	0	0	9. 00
10. 00	Total (line 8 minus line 9)	24, 227, 883	348, 023	0	348, 023	0	10. 00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6.00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	847, 629	0				1. 00
2.00	Land Improvements	242, 833	0				2. 00
3.00	Buildings and Fixtures	15, 901, 288	0				3. 00
4.00	Building Improvements	436, 760	0				4. 00
5.00	Fi xed Equi pment	1, 186, 261	0				5. 00
6.00	Movable Equipment	5, 961, 135	0				6. 00
7.00	HIT designated Assets	0	0				7. 00
8.00	Subtotal (sum of lines 1-7)	24, 575, 906	0				8. 00
9.00	Reconciling Items	0	0				9. 00
10.00	Total (line 8 minus line 9)	24, 575, 906	0				10.00

CAP REL COSTS-BLDG & FIXT

CAP REL COSTS-MVBLE EQUIP

Total (sum of lines 1-2)

1.00

2.00

3.00

1.00

2.00

3.00

RECONCILIATION OF CAPITAL COSTS CENTERS Worksheet A-7 Provi der CCN: 15-2020 Peri od: From 07/01/2021 To 06/30/2022 Part II Date/Time Prepared: 11/15/2022 12:36 pm SUMMARY OF CAPITAL Insurance (see Cost Center Description Depreciation Interest Taxes (see Lease instructions) instructions) 10.00 11.00 9.00 12.00 13.00 PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2 CAP REL COSTS-BLDG & FLXT 739, 269 13, 812 1.00 CAP REL COSTS-MVBLE EQUIP 0 2.00 241, 377 0 0 2.00 3.00 Total (sum of lines 1-2) 980, 646 13, 812 0 Ω 3.00 SUMMARY OF CAPITAL Cost Center Description 0ther Total (1) (sum Capital-Relate of cols. 9 d Costs (see through 14) instructions) 14.00 15. 00 PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2

0

753, 081

241, 377

994, 458

Heal tl	n Financial Systems ASCE	NSION ST VINCEN	IT SETON SPECIA	LTY	In Lie	u of Form CMS-:	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der Co		Period: From 07/01/2021 Fo 06/30/2022		pared:
		COMI	PUTATION OF RAT	TI 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 CI		1	17 400 50	0.700474		
1.00	CAP REL COSTS-BLDG & FLXT	17, 428, 509	l e	17, 428, 50		0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	7, 147, 396	l e	7, 147, 39			2. 00
3.00	Total (sum of lines 1-2)	24, 575, 905		24, 575, 90	_		3. 00
		ALLOCA ⁻	TION OF OTHER (CAPI TAL	SUMMARY O	F CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Relate	col s. 5			
			d Costs	through 7)			
		6.00	7. 00	8. 00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CO	FNTERS					

Health Financial Systems
ADJUSTMENTS TO EXPENSES

| Peri od: | Worksheet A-8 | From 07/01/2021 | To 06/30/2022 | Date/Time Prepared:

				T.	06/30/2022	Date/Time Prep 11/15/2022 12:	
				Expense Classification on		117 137 2022 12.	30 pili
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basi s/Code (2) 1.00	Amount 2.00	Cost Center 3.00		Wkst. A-7 Ref.	
1. 00	Investment income - CAP REL	B B		CAP REL COSTS-BLDG & FLXT	4. 00 1. 00	5. 00 11	1. 00
2. 00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2. 00
	COSTS-MVBLE EQUIP (chapter 2)						
3. 00	Investment income - other (chapter 2)	В	-9, 101	ADMINISTRATIVE & GENERAL	5. 00	11	3. 00
4. 00	Trade, quantity, and time		0		0.00	0	4. 00
5. 00	discounts (chapter 8) Refunds and rebates of		0		0.00	0	5. 00
6. 00	expenses (chapter 8) Rental of provider space by		0		0.00	0	6. 00
	suppliers (chapter 8)		-				
7. 00	Telephone services (pay stations excluded) (chapter		0		0.00	0	7. 00
0.00	21)		0		0.00	0	0.00
8. 00	Television and radio service (chapter 21)		0		0.00	0	8. 00
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	0		0.00	0	9. 00 10. 00
	adj ustment	7 0 2	0				
11. 00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11. 00
12. 00	Related organization	A-8-1	-392, 659			0	12. 00
13. 00	transactions (chapter 10) Laundry and linen service		0		0.00	0	13. 00
14. 00 15. 00	Cafeteria-employees and guests Rental of quarters to employee		-60, 673	DI ETARY	10. 00 0. 00	0	14. 00 15. 00
	and others		-				
16. 00	Sale of medical and surgical supplies to other than		0		0.00	0	16. 00
17. 00	patients Sale of drugs to other than		0		0.00	0	17. 00
	pati ents		0				
18. 00	Sale of medical records and abstracts		0		0.00	0	18. 00
19. 00	Nursing and allied health education (tuition, fees,		0		0. 00	0	19. 00
	books, etc.)						
20. 00 21. 00	Vending machines Income from imposition of	В	-1, 137 0	DI ETARY	10. 00 0. 00	0	20. 00 21. 00
200	interest, finance or penalty		C		0.00		21.00
22. 00	charges (chapter 21) Interest expense on Medicare		0		0.00	0	22. 00
	overpayments and borrowings to repay Medicare overpayments	1					
23. 00	Adjustment for respiratory	A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00
	therapy costs in excess of limitation (chapter 14)						
24. 00	Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
	therapy costs in excess of limitation (chapter 14)						
25. 00	Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114. 00		25. 00
2/ 22	(chapter 21)		_	CAD DEL COCTO DI DO A FLYT	4.55	5	27 22
26. 00	Depreciation - CAP REL COSTS-BLDG & FLXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26. 00
27. 00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
28. 00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19. 00		28. 00
29. 00 30. 00	Physicians' assistant Adjustment for occupational	A-8-3	0	OCCUPATIONAL THERAPY	0. 00 67. 00	0	29. 00 30. 00
	therapy costs in excess of			<u>.</u> .			
30. 99	limitation (chapter 14) Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
31. 00	instructions) Adjustment for speech	A-8-3	<u> </u>	SPEECH PATHOLOGY	68. 00		31. 00
51.00	pathology costs in excess of	n-0-3	U	STEEDIT TATIOLOGI	08.00		51.00
32. 00	limitation (chapter 14) CAH HIT Adjustment for		0		0. 00	0	32. 00
	Depreciation and Interest IC SHARED SAV REV ACO	В	E 025	ADMINISTRATIVE & GENERAL	5. 00		33. 00
JS. 00	LIC SHAKED SAV KEV ACU	l D	-5, 825	אוואוטוואו אוואוראוו אב מ GENEKAL	5.00	Ч	JJ. UU

ADJUSTMENTS TO EXPENSES Provi der CCN: 15-2020 Peri od: Worksheet A-8 From 07/01/2021 06/30/2022 Date/Time Prepared: To 11/15/2022 12:36 pm Expense Classification on Worksheet A 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 33. 02 LOBBYING OFFSET -1, 774 ADMI NI STRATI VE & GENERAL 5. 00 33. 02 Α 33. 03 ENTERTALNMENT - RT 33. 04 ENTERTALNMENT - ROUTLNE -166 RESPIRATORY THERAPY 33. 03 0 Α 65.00 Α -203 ADULTS & PEDIATRICS 30.00 33.04 33.05 ENTERTAL NMENT - A&G Α -467 ADMINISTRATIVE & GENERAL 5.00 0 33.05 PATIENT INTEREST INCOME -428 ADMINISTRATIVE & GENERAL 5.00 ol 33. 06 33 06 В -406 ADMI NI STRATI VE & GENERAL UNCLAIMED PROPERTY EXEMP RECOV 33.07 В 5.00 33.07 33. 08 MI SCELLANEOUS REVENUE - A&G В -21, 889 ADMI NI STRATI VE & GENERAL 5.00 33.08 50.00 TOTAL (sum of lines 1 thru 49) -508. 384 50.00 (Transfer to Worksheet A,

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

column 6, line 200.)

- 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.

				10 06/30/2022	11/15/2022 12	
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OF					
1 00	HOME OFFICE COSTS:	ADMINICTDATIVE & CENEDAL	LIONE OFFI OF CARLEAU	242.7(/	0	1 00
1.00	1	l .	HOME OFFICE CAPITAL	342, 766	0	1.00
2.00	1		HOME OFFICE INTEREST-CAPITAL	8, 976	0	2.00
3. 00 3. 01	1		HOME OFFICE INTEREST -A&G	54	2 001 410	3. 00
3.01	1	ADMINISTRATIVE & GENERAL EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE OTHER	3, 186, 720	3, 891, 419	3. 01
3. 02	1	NURSING ADMINISTRATION	SVH CHARGEBACK SVH CHARGEBACK	36, 399	36, 399	
3. 03	1	PHARMACY	SVH CHARGEBACK	78, 415	78, 415	
	1			11, 500	11, 500	3. 04
3.06		RESPIRATORY THERAPY	SVH CHARGEBACK	13, 018	13, 018	
3. 07	1	RESPIRATORY THERAPY	SVH CHAGEBACK	14, 221	14, 221	3. 07
3. 08	1	OCCUPATIONAL THERAPY	SVH CHARGEBACK	14, 221	14, 221	3. 08
3. 10	1	SPEECH PATHOLOGY	SVH CHARGEBACK	14, 221	14, 221	3. 10
3. 11	1	CAP REL COSTS-BLDG & FIXT	INTEREST EXPENSE	13, 656	13, 812	3. 11
3. 13	1	ADMINISTRATIVE & GENERAL	I NTEREST EXPENSE	71	0	3. 13
3. 14	l .		HEALTH INSURANCE	1, 418, 709	1, 338, 608	3. 14
4.00	l e	ADMINISTRATIVE & GENERAL	TRG ADMIN FEES - SUPPLIES	-84, 987	0	4. 00
4. 01		NURSI NG ADMI NI STRATI ON	TRG ADMIN FEES - CONTRACTED	-7, 130	0	4. 01
4. 02		ADMINISTRATIVE & GENERAL	TRG ADMIN FEES - OTHER	-27, 655	0	4. 02
4. 03	0.00	l .		0	0	4. 03
4. 04	0.00	l e		0	0	4. 04
4. 05	0.00			0	0	4. 05
5.00	TOTALS (sum of lines 1-4).			5, 033, 175	5, 425, 834	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

 been position to meritarioes 71, con amine it and or 2, the amount arronage should be rival eated in containing the time part.							
			Related Organization(s) and/or Home Office				
Symbol (1)	Name	Percentage of	Name	Percentage of			
•		Ownershi p		Ownershi p			
1. 00	2. 00	3. 00	4. 00	5. 00			
B. INTERRELATIONSHIP TO RELAT	ED ORGANIZATION(S) AND/OR HO	ME 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	ST VINCENT HEAL	100.00	0. 00	6. 00
7.00	G	ASCENSI ON	100.00	0. 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 organi zati on.
- 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

011102					To 06/30/2022	Date/Time Prep 11/15/2022 12:	pared:
	Net	Wkst. A-7 Ref.					
	Adjustments						
	(col. 4 minus						
	col. 5)*						
	6. 00	7. 00					
			NTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED O	RGANIZATIONS OR	CLAI MED	
	HOME OFFICE CO						
1. 00	342, 766						1. 00
2.00	8, 976						2. 00
3.00	54						3. 00
3. 01	-704, 699	0					3. 01
3. 02	0	0					3. 02
3. 03	0	0					3. 03
3. 04	0	0					3. 04
3.06	0	0					3. 06
3.07	0	0					3. 07
3. 08	0	0					3. 08
3. 10	0	0					3. 10
3. 11	-156						3. 11
3. 13	71						3. 13
3. 14	80, 101						3. 14
4.00	-84, 987						4. 00
4. 01	-7, 130						4. 01
4. 02	-27, 655	0					4. 02
4.03	0	0					4. 03
4.04	0	0					4. 04
4. 05	0	0					4. 05
5.00	-392, 659						5. 00

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

Related Organization(s)						
and/or Home Office						
Type of Business						
Type of business						
6. 00						
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:						

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

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

6.00	6.00
7.00	7.00
8.00	8.00
9.00	9.00
10.00	10.00
7. 00 8. 00 9. 00 10. 00 100. 00	100.00

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

In Lieu of Form CMS-2552-10 COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-2020 Peri od: Worksheet B From 07/01/2021 Part I Date/Time Prepared: 06/30/2022 11/15/2022 12:36 pm CAPITAL RELATED COSTS Cost Center Description Net Expenses BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Subtotal for Cost **BENEFITS** DEPARTMENT Allocation (from Wkst A col. 7) 1.00 2.00 4. 00 4A GENERAL SERVICE COST CENTERS 1 00 1 00 00100 CAP REL COSTS-BLDG & FLXT 739, 269 739, 269 2.00 00200 CAP REL COSTS-MVBLE EQUIP 241, 377 241, 377 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 1, 736, 882 1, 736, 882 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 4, 733, 947 50 314 16 428 41, 726 4 842 415 5 00 7.00 00700 OPERATION OF PLANT 939, 431 37, 043 12,095 0 988, 569 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 74,633 6, 047 1, 974 0 82, 654 8.00 9.00 00900 HOUSEKEEPI NG 419, 230 8, 401 2,743 o 430, 374 9.00 01000 DI FTARY 29, 983 9, 790 715, 790 676, 017 10 00 10.00 0 13.00 01300 NURSING ADMINISTRATION 583, 580 37, 624 12, 285 74, 408 707, 897 13.00 01500 PHARMACY 1, 957, 530 17, 606 5, 748 123, 097 2, 103, 981 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 7, 998 2, 612 16.00 16, 00 10.610 0 01700 SOCIAL SERVICE 4, 394 5, 829 17.00 0 1, 435 0 17.00 18.00 01851 PASTORAL CARE 5, 422 1,770 7, 192 18.00 INPATIENT ROUTINE SERVICE COST CENTERS 161, 779 1, 107, 425 03000 ADULTS & PEDIATRICS 495, 487 30.00 9, 542, 267 11, 306, 958 30.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 194, 537 5, 303 1, 731 22, 071 223, 642 50.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 59, 984 9, 533 3, 112 8, 345 80, 974 54.00 03630 ULTRA SOUND 5, 485 54.01 779 6, 264 54.01 0 05700 CT SCAN 57.00 1, 185 2.532 827 178 4, 722 57.00 06000 LABORATORY 2,070 289, 422 60.00 286, 676 676 0 60.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 63.00 65.00 06500 RESPIRATORY THERAPY 2, 120, 613 2, 387, 103 65.00 3.753 1.226 261, 511 66.00 06600 PHYSI CAL THERAPY 257, 403 5, 258 1,717 35, 454 299, 832 66.00 38, 094 06700 OCCUPATI ONAL THERAPY 277, 398 5, 258 1,717 67.00 322, 467 67.00 164, 712 68.00 06800 SPEECH PATHOLOGY 138, 536 5, 243 1,712 19, 221 68.00 69.00 06900 ELECTROCARDI OLOGY 0 C 0 Ω 69.00 0 07000 ELECTROENCEPHALOGRAPHY 70.00 0 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 79, 606 0 0 4, 573 84, 179 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72 00 72 00 0 C Λ 73.00 07300 DRUGS CHARGED TO PATIENTS C 0 0 0 73.00 07400 RENAL DIALYSIS 74.00 212, 374 0 0 212, 374 74.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 I NTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 241, 377 118.00 25, 277, 960 739, 269 1, 736, 882 25, 277, 960 118. 00 NONREI MBURSABLE COST CENTERS 0 190, 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 0 191. 00 191. 00 19100 RESEARCH 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 0 192. 00 193. 00 19300 NONPALD WORKERS 0 0 0 0 0 193. 00 194. 00 07950 BI OTERRORI SM GRANT 0 0 194. 00 Ω 194. 01 07951 MARKETI NG 0 C 0 0 0 194. 01 200.00 Cross Foot Adjustments 0 200.00 201.00 Negative Cost Centers 0 0 201. 00 25, 277, 960 202. 00 202.00 TOTAL (sum lines 118 through 201) 25, 277, 960 739, 269 241, 377 1, 736, 882

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-2020

			''	0 00/30/2022	11/15/2022 12	
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 O0100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL	4, 842, 415					5. 00
7.00 00700 OPERATION OF PLANT	234, 251	1, 222, 820)			7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	19, 586	11, 343				8. 00
9. 00 00900 HOUSEKEEPI NG	101, 981	15, 757		548, 112		9. 00
10. 00 01000 DI ETARY	169, 614	56, 241	0	25, 780	967, 425	10.00
13.00 01300 NURSING ADMINISTRATION	167, 743	70, 573	0	32, 350	0	13. 00
15. 00 01500 PHARMACY	498, 559	33, 024		15, 138	0	15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY	2, 514	15, 003		6, 877	0	16. 00
17. 00 01700 SOCI AL SERVI CE	1, 381	8, 242		3, 778	0	17. 00
18. 00 01851 PASTORAL CARE	1, 704	10, 170		4, 662	0	18. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1,704	10, 170	<u> </u>	4, 002		10.00
30. 00 03000 ADULTS & PEDIATRICS	2, 679, 307	929, 408	113, 583	426, 038	967, 425	30. 00
ANCI LLARY SERVICE COST CENTERS	2,017,001	727, 100	110,000	120, 000	707, 120	00.00
50. 00 05000 OPERATI NG ROOM	52, 994	9, 946	0	4, 559	0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	19, 188	17, 881	0	8, 196	0	54. 00
54. 01 03630 ULTRA SOUND	1, 484	17,001	_	0, 170	0	54. 01
57. 00 05700 CT SCAN	1, 119	4, 750	1	2, 177	0	57. 00
60. 00 06000 LABORATORY	68, 581	3, 883		1, 780	0	60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	00, 301	0,000		1, 700	0	63. 00
65. 00 06500 RESPIRATORY THERAPY	565, 648	7, 041	l ő	3, 227	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	71, 048	9, 862		4, 521	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	76, 412	9, 862		4, 521	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	39, 030	9, 834		4, 508	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	37,030	7,034		4, 500	0	69. 00
70. 00 07000 ELECTROCARD OLOGT	0	0		0	0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	19, 947	0		0	0	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	17, 747	0		0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATTENTS	0	0		0	0	73. 00
74. 00 07400 RENAL DI ALYSI S	50, 324	0	0	0	0	74.00
SPECIAL PURPOSE COST CENTERS	30, 324	U	<u> </u>	U	0	74.00
113. 00 11300 NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	4, 842, 415	1, 222, 820	113, 583	548, 112	967, 425	
NONREI MBURSABLE COST CENTERS	4,042,413	1, 222, 020	113, 303	540, 112	707, 423	110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	O	0	190. 00
191. 00 19100 RESEARCH	0	0	0	0		191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0		191.00
193. 00 19300 NONPALD WORKERS	0	0		0		192.00
194. 00 07950 BI OTERRORI SM GRANT	0	0		0		193.00
194. 01 07950 BTOTERRORTSM GRANT 194. 01 07951 MARKETI NG	0	0		0		194. 00
200.00 Cross Foot Adjustments	U	0	1	۷	U	200. 00
201.00 Negative Cost Centers		_			0	200.00
202.00 TOTAL (sum lines 118 through 201)	4, 842, 415	1, 222, 820	113, 583	548, 112		
202. 00 TOTAL (Suil TITIES TTO THE OUGH 201)	4,042,413	1, 222, 020	113, 363	J40, 112	707, 425	1202.00

Health Financial Systems ASCENSION ST VINCENT SETON SPECIALTY In Lieu of Form CMS-2552-10 COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-2020 Peri od: Worksheet B From 07/01/2021 Part I Date/Time Prepared: 06/30/2022 11/15/2022 12:36 pm OTHER GENERAL SERVI CE SOCIAL SERVICE PASTORAL CARE Cost Center Description NURSI NG PHARMACY MEDI CAL ADMI NI STRATI ON RECORDS & LI BRARY 13.00 15.00 17.00 18.00 16.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 7.00 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 10.00 01000 DI ETARY 01300 NURSING ADMINISTRATION 978.563 13 00 01500 PHARMACY 15.00 2, 650, 702 01600 MEDICAL RECORDS & LIBRARY 16.00 0 35, 004 01700 SOCIAL SERVICE 17.00 0 C 19, 230 C 01851 PASTORAL CARE 23, 728 18.00 O 0 Ω INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 696, 084 0 15, 787 19, 230 23, 728 ANCILLARY SERVICE COST CENTERS 05000 OPERATI NG ROOM 50.00 19,673 614 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 241 0 0 03630 ULTRA SOUND 54.01 0 0 85 0

| Period: | Worksheet B | From 07/01/2021 | Part | To 06/30/2022 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS ASCENSION ST VINCENT SETON SPECIALTY Provider CCN: 15-2020

				To 06/30/2022	Date/Time Prepared: 11/15/2022 12:36 pm
Cost Center Description	Subtotal	Intern &	Total		117 137 2022 12. 30 piii
'		Residents Cost			
		& Post			
		Stepdown			
		Adjustments			
GENERAL SERVICE COST CENTERS	24. 00	25. 00	26. 00		
1. 00 O0100 CAP REL COSTS-BLDG & FLXT					1. 00
2. 00 00200 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 NURSING ADMINISTRATION					13. 00
15. 00 01500 PHARMACY					15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY					16.00
17. 00 01700 SOCIAL SERVICE					17. 00
18. 00 01851 PASTORAL CARE					18. 00
INPATIENT ROUTINE SERVICE COST CENTERS				_	
30. 00 03000 ADULTS & PEDIATRICS	17, 177, 548	0	17, 177, 54	8	30.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	311, 428	0	311, 42	8	50. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	126, 480	0	126, 48	0	54.00
54. 01 03630 ULTRA SOUND	7, 833	0	7, 83	3	54. 01
57. 00 05700 CT SCAN	12, 896	0	12, 89	6	57. 00
60. 00 06000 LABORATORY	367, 368	0	367, 36	8	60. 00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	63. 00
65. 00 06500 RESPI RATORY THERAPY	3, 147, 218	0	3, 147, 21	8	65. 00
66. 00 06600 PHYSI CAL THERAPY	422, 533	0	422, 53	3	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	446, 480	0	446, 48	0	67. 00
68.00 06800 SPEECH PATHOLOGY	236, 354	0	236, 35	4	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	104, 770	0	104, 77	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 653, 937	0	2, 653, 93		73. 00
74. 00 07400 RENAL DI ALYSI S	263, 115	0	263, 11	5	74. 00
SPECIAL PURPOSE COST CENTERS					
113. 00 11300 INTEREST EXPENSE	05 077 0/0		05 077 07		113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	25, 277, 960	0	25, 277, 96	0	118. 00
NONREI MBURSABLE COST CENTERS	٥	O			100.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	-		0	190.00
191. 00 19100 RESEARCH 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0	191. 00 192. 00
	U	U		0	
193. 00 19300 NONPALD WORKERS	0	o			193. 00
194. 00 07950 BI OTERRORI SM GRANT	0	o		0	194. 00
194. 01 07951 MARKETI NG	0	o			194. 01
200.00 Cross Foot Adjustments	0	o			200.00
201.00 Negative Cost Centers	25 277 040	0	25 277 04	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	25, 277, 960	Ų	25, 277, 96	U	202. 00

From 07/01/2021 Part II 06/30/2022 Date/Time Prepared: 11/15/2022 12:36 pm CAPITAL RELATED COSTS **EMPLOYEE** Cost Center Description Directly BLDG & FIXT MVBLE EQUIP Subtotal Assigned New **BENEFITS** Capi tal DEPARTMENT Related Costs 1.00 2.00 2A 4.00 0 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 0 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 342, 766 50, 314 16, 428 409, 508 0 5.00 00700 OPERATION OF PLANT 37, 043 12, 095 7 00 0 49 138 7 00 0 00800 LAUNDRY & LINEN SERVICE 8.00 0 6,047 1, 974 8,021 0 8.00 9.00 00900 HOUSEKEEPI NG 0 8, 401 2,743 11, 144 0 9.00 01000 DI ETARY 0 0 29, 983 9.790 39, 773 10.00 10 00 0 01300 NURSING ADMINISTRATION 49.909 13.00 37, 624 12, 285 0 13.00 15.00 01500 PHARMACY 17, 606 5, 748 23, 354 0 15.00 01600 MEDICAL RECORDS & LIBRARY 0 16.00 7, 998 2, 612 10, 610 0 16.00 01700 SOCIAL SERVICE 17.00 4 394 5 829 17 00 1.435 0 18.00 01851 PASTORAL CARE 5, 422 1, 770 7, 192 0 18.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 0 495, 487 161, 779 0 30.00 657, 266 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 5, 303 1, 731 7,034 0 50.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 9,533 3, 112 12, 645 54.00 54.01 03630 ULTRA SOUND 54. 01 0000000000000 0 0 05700 CT SCAN 2.532 827 3.359 57.00 57.00 0 2, 746 60.00 06000 LABORATORY 2,070 0 60.00 676 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 0 63.00 06500 RESPIRATORY THERAPY 4, 979 65.00 3, 753 1.226 0 65.00 06600 PHYSI CAL THERAPY 6, 975 66.00 5, 258 1, 717 0 66.00 6, 975 67.00 06700 OCCUPATIONAL THERAPY 5, 258 1,717 0 67.00 06800 SPEECH PATHOLOGY 68.00 5, 243 1,712 6, 955 68.00 06900 ELECTROCARDI OLOGY 69.00 69.00 0 0 0 C 0 70.00 07000 ELECTROENCEPHALOGRAPHY C 0 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 71.00 71.00 0 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 72.00 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 C Λ 73.00 07400 RENAL DIALYSIS 74.00 0 74.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 342, 766 739, 269 241, 377 1, 323, 412 0 118.00 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 0 0 0 0 191. 00 191. 00 19100 RESEARCH Ω 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 0 192. 00 193. 00 19300 NONPALD WORKERS 0 0 0 0 0 193.00 0 0 0 194. 00 07950 BI OTERRORI SM GRANT 0 0 194.00 194. 01 07951 MARKETI NG 0 194.01 0 0 0 C 200.00 Cross Foot Adjustments 0 200.00 Negative Cost Centers 201.00 0 201.00 202 00 TOTAL (sum lines 118 through 201) 342 766 739, 269 241 377 1 323 412 0 202. 00

Provider CCN: 15-2020

Peri od:

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-2020

			''	0 00/30/2022	11/15/2022 12	
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 CAP REL COSTS-BLDG & FLXT						1. 00
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00 00500 ADMINISTRATIVE & GENERAL	409, 508					5. 00
7.00 00700 OPERATION OF PLANT	19, 810	l .				7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	1, 656	l				8. 00
9. 00 00900 HOUSEKEEPI NG	8, 624	888		20, 656		9. 00
10. 00 01000 DI ETARY	14, 344	3, 171	0	972	58, 260	10.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	14, 186		0	1, 219	0	13. 00
15. 00 01500 PHARMACY	42, 162	1, 862		570	0	15. 00
16. 00 01600 MEDICAL RECORDS & LI BRARY	213	846		259	0	16. 00
17. 00 01700 SOCIAL SERVICE	117	465		142	0	17. 00
18. 00 01851 PASTORAL CARE	144	573			0	18. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	144	573	0	170	0	10.00
30. 00 03000 ADULTS & PEDI ATRI CS	226, 577	52, 404	10, 317	16, 056	58, 260	30.00
ANCI LLARY SERVI CE COST CENTERS	220, 377	52, 404	10, 317	10,030	30, 200	30.00
50. 00 05000 OPERATING ROOM	4, 482	561	0	172	0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 623	1, 008			0	54.00
54. 00 03400 RADI OLOGI - DI AGNOSTI C 54. 01 03630 ULTRA SOUND	1, 623	1,008	•	309	0	54. 00
57. 00 05700 CT SCAN	95	268		82	0	57.00
60. 00 06000 LABORATORY	5. 800	219	•		0	60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	5, 800	219		67	0	63.00
· · · · · · · · · · · · · · · · · · ·	_	-	0	ı "I	0	
65. 00 06500 RESPIRATORY THERAPY	47, 835	397	1	122		65. 00
66. 00 06600 PHYSI CAL THERAPY	6, 008	556		170	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	6, 462	556		170	0	67.00
68. 00 06800 SPEECH PATHOLOGY	3, 301	555	•	170	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0	0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 687	0	0	0	0	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
74. 00 07400 RENAL DI ALYSI S	4, 256	0	0	0	0	74. 00
SPECIAL PURPOSE COST CENTERS			1			
113. 00 11300 I NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	409, 508	68, 948	10, 317	20, 656	58, 260	118. 00
NONREI MBURSABLE COST CENTERS	1		1			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1	1			190. 00
191. 00 19100 RESEARCH	0	0	0	0		191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	0		193. 00
194.00 07950 BIOTERRORISM GRANT	0	0	0	0		194. 00
194. 01 07951 MARKETI NG	0	0	0	0	0	194. 01
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0	0	0		201. 00
202.00 TOTAL (sum lines 118 through 201)	409, 508	68, 948	10, 317	20, 656	58, 260	202. 00

| Peri od: | Worksheet B | From 07/01/2021 | Part II | To 06/30/2022 | Date/Time Prepared: | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/14/2020 | 12/ Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-2020

					0 06/30/2022	Date/IIme Pre 11/15/2022 12	
						OTHER GENERAL	. 30 piii
						SERVI CE	
	Cost Center Description	NURSI NG	PHARMACY	MEDI CAL	SOCIAL SERVICE	PASTORAL CARE	
	·	ADMI NI STRATI ON		RECORDS &			
				LI BRARY			
		13. 00	15. 00	16. 00	17. 00	18. 00	
	GENERAL SERVICE COST CENTERS				T T		
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200 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	(0.202					10.00
13.00	01300 NURSI NG ADMI NI STRATI ON	69, 293	47.040				13.00
15. 00	01500 PHARMACY	0	67, 948	11 000			15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0	11, 928			16.00
17. 00	01700 SOCIAL SERVICE	0	0	0		0.005	17. 00
18. 00	01851 PASTORAL CARE INPATIENT ROUTINE SERVICE COST CENTERS	J U	U _I	C	U	8, 085	18. 00
30. 00	03000 ADULTS & PEDIATRICS	49, 290	0	5, 389	6, 553	8, 085	30. 00
30.00	ANCI LLARY SERVICE COST CENTERS	49, 290	<u> </u>	3, 309	0, 333	6, 063	30.00
50. 00	05000 OPERATING ROOM	1, 393	o	209	0	0	50.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 343	0	82		0	54.00
54. 01	03630 ULTRA SOUND		o	29		0	•
57. 00	05700 CT SCAN		0	44		0	57.00
60.00	06000 LABORATORY		0	1, 259		0	60.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.		Ö	1, 20,	0	0	63. 00
65. 00	06500 RESPI RATORY THERAPY	12, 440	o	2, 899	0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	2, 598	o	200		0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	2, 302	ol	242		0	67. 00
68. 00	06800 SPEECH PATHOLOGY	1, 270	o	113		0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	o	C		0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	o	C	o	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	o	219	o	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	o	C	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	67, 948	1, 101	0	0	73. 00
74.00	07400 RENAL DIALYSIS	0	o	142	0	0	74.00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300 I NTEREST EXPENSE						113. 00
118.00	7	69, 293	67, 948	11, 928	6, 553	8, 085	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C			190. 00
	19100 RESEARCH	0	0	C	0		191. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	C	0	0	192. 00
	19300 NONPALD WORKERS	0	0	C	0		193. 00
	07950 BIOTERRORISM GRANT	0	0	C	0		194. 00
	07951 MARKETI NG	0	0	C	0	0	194. 01
200.00	, , , , , , , , , , , , , , , , , , ,						200. 00
201.00		0	0	C	0		201. 00
202.00	TOTAL (sum lines 118 through 201)	69, 293	67, 948	11, 928	6, 553	8, 085	202. 00

192. 00

193.00

194. 00

194. 01

200. 00

201.00

202.00

Health Financial Systems ASCENSION ST VINCENT SETON SPECIALTY In Lieu of Form CMS-2552-10 ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 15-2020 Peri od: Worksheet B From 07/01/2021 Part II 06/30/2022 Date/Time Prepared: 11/15/2022 12:36 pm Cost Center Description Subtotal Intern & Total Residents Cost & Post Stepdown Adj ustments 24.00 25.00 26.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 13.00 01300 NURSING ADMINISTRATION 13.00 01500 PHARMACY 15.00 15.00 16.00 |01600 | MEDI CAL RECORDS & LI BRARY 16.00 01700 SOCIAL SERVICE 17.00 17.00 01851 PASTORAL CARE 18.00 18.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 1, 090, 197 0 1, 090, 197 30.00 30.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 13.851 13.851 50.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 15, 667 0 15, 667 54.00 03630 ULTRA SOUND 54.01 155 0 155 54.01 57.00 05700 CT SCAN 0 3.848 57.00 3 848 06000 LABORATORY 0 60.00 10,091 10,091 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 63.00 06500 RESPIRATORY THERAPY 65.00 68, 672 0 68, 672 65.00 06600 PHYSI CAL THERAPY 16,507 16, 507 66.00 66.00 06700 OCCUPATIONAL THERAPY 16, 707 67.00 16, 707 67.00 06800 SPEECH PATHOLOGY 12, 364 12, 364 68.00 68.00 06900 ELECTROCARDI OLOGY 0 69.00 69.00 C 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 70.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 1, 906 0 1, 906 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 69.049 0 69.049 73.00 07400 RENAL DIALYSIS 74.00 4, 398 0 4, 398 74.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113. 00 SUBTOTALS (SUM OF LINES 1 through 117) 0 1, 323, 412 1, 323, 412 118.00 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190.00 0 191. 00 19100 RESEARCH 0 0 191.00

0

0

1, 323, 412

0

0

0

0

0

1, 323, 412

0

0

0

0

0

192. 00 19200 PHYSICIANS' PRIVATE OFFICES

Cross Foot Adjustments

Negative Cost Centers

TOTAL (sum lines 118 through 201)

193. 00 19300 NONPALD WORKERS

194. 01 07951 MARKETI NG

200.00

201.00

202.00

194. 00 07950 BI OTERRORI SM GRANT

Health Financial Systems ASCENSION ST VINCENT SETON SPECIALTY In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-2020 Peri od: Worksheet B-1 From 07/01/2021 06/30/2022 Date/Time Prepared: 11/15/2022 12:36 pm CAPITAL RELATED COSTS Reconciliation ADMINISTRATIVE Cost Center Description BLDG & FIXT MVBLE EQUIP **EMPLOYEE** (SQUARE FEET) (SQUARE FEET) BENEFITS & GENERAL (ACCUM. COST) DEPARTMENT (GROSS SALARI ES) 1.00 2.00 5A 5. 00 4.00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 1 00 49.633 2.00 00200 CAP REL COSTS-MVBLE EQUIP 49, 633 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 11, 557, 294 4.00 00500 ADMINISTRATIVE & GENERAL 3.378 3. 378 20, 435, 545 5 00 277, 647 -4, 842, 415 5 00 7.00 00700 OPERATION OF PLANT 2,487 2, 487 C 988, 569 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 406 406 82, 654 8.00 00900 HOUSEKEEPI NG 564 564 0 0 430, 374 9.00 9.00 01000 DI ETARY 0 715, 790 2.013 2.013 10 00 10 00 0 13.00 01300 NURSING ADMINISTRATION 2,526 2, 526 495, 114 0 707, 897 13.00 01500 PHARMACY 819, 098 0 2, 103, 981 15.00 1, 182 1, 182 15.00 0 01600 MEDICAL RECORDS & LIBRARY 16, 00 537 537 10.610 16, 00 0 01700 SOCIAL SERVICE O 5, 829 17.00 295 295 17.00 18.00 01851 PASTORAL CARE 364 0 7, 192 18.00 364 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 11, 306, 958 30.00 33, 266 33, 266 7, 368, 849 0 30.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 223, 642 50.00 356 356 146, 865 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 640 640 55, 526 0 80, 974 54.00 03630 ULTRA SOUND 0 54.01 5, 185 6, 264 54.01 0 C 05700 CT SCAN 57.00 170 170 1, 185 4, 722 57.00 06000 LABORATORY 139 289, 422 60.00 139 C 0 0 0 60.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 06500 RESPIRATORY THERAPY 1, 740, 109 2, 387, 103 65.00 252 252 65.00 66.00 06600 PHYSI CAL THERAPY 353 353 235, 912 299, 832 66.00 06700 OCCUPATI ONAL THERAPY 253, 480 67.00 353 353 0 322, 467 67.00 164, 712 68.00 06800 SPEECH PATHOLOGY 352 352 127, 898 68.00 69.00 06900 ELECTROCARDI OLOGY 0 C C Ω 69.00 07000 ELECTROENCEPHALOGRAPHY 0 0 70.00 70.00 0 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 30, 426 84, 179 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72 00 C 0 Λ 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 C 0 0 0 73.00 07400 RENAL DIALYSIS 74.00 0 212, 374 74.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 I NTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 11, 557, 294 118.00 49,633 49,633 -4, 842, 415 20, 435, 545 118. 00 NONREI MBURSABLE COST CENTERS 0 190, 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 0 191. 00 191. 00 19100 RESEARCH 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 192.00 193. 00 19300 NONPALD WORKERS 0 0 0 0 0 193. 00 194. 00 07950 BI OTERRORI SM GRANT 0 0 194 00 Ω 194. 01 07951 MARKETI NG 0 C 0 0 0 194. 01 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 241, 377 202.00 Cost to be allocated (per Wkst. B, 739, 269 1, 736, 882 4, 842, 415 202, 00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 14.894707 4.863236 0. 236960 203. 00 0.150284 204.00 Cost to be allocated (per Wkst. B, 409, 508 204. 00

0. 020039 205. 00

206.00

207.00

0.000000

Part II)

(per Wkst. B-2)

Parts III and IV)

II)

Unit cost multiplier (Wkst. B, Part

NAHE unit cost multiplier (Wkst. D,

NAHE adjustment amount to be allocated

205 00

206.00

207.00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-2020 | Period: | Worksheet B-1

207.00

From 07/01/2021 06/30/2022 Date/Time Prepared: 11/15/2022 12:36 pm Cost Center Description OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY NURSI NG LINEN SERVICE (SQUARE FEET) (TOTAL PATIENT ADMINISTRATION PLANT (SQUARE FEET) (POUNDS OF DAYS) (DIRECT NURS LAUNDRY) HRS.) 7.00 8.00 9.00 10.00 13.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 43, 768 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 406 100 9.00 00900 HOUSEKEEPI NG 564 C 42, 798 9.00 10.00 01000 DI ETARY 2,013 2,013 10, 291 10.00 01300 NURSING ADMINISTRATION 2.526 183, 845 13 00 2 526 Ω 13 00 01500 PHARMACY 15.00 1, 182 C 1, 182 0 0 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 537 537 0 0 16.00 01700 SOCIAL SERVICE 17.00 295 C 295 0 0 17.00 01851 PASTORAL CARE 18.00 364 18 00 Ω 364 0 INPATIENT ROUTINE SERVICE COST CENTERS 100 30.00 03000 ADULTS & PEDIATRICS 33, 266 33, 266 10, 291 130, 775 30.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 356 356 3, 696 50.00 05400 RADI OLOGY-DI AGNOSTI C 640 0 640 0 54.00 54.00 0 0 54.01 03630 ULTRA SOUND 0 0 54.01 0 C 05700 CT SCAN 0 57 00 170 0 170 57 00 0 06000 LABORATORY 0 60.00 139 0 139 0 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 63.00 0 63.00 65.00 06500 RESPIRATORY THERAPY 252 0 252 0 33,005 65.00 06600 PHYSI CAL THERAPY Ω 6, 892 66.00 353 353 66.00 06700 OCCUPATIONAL THERAPY 67.00 353 353 6, 107 67.00 352 06800 SPEECH PATHOLOGY 3, 370 68.00 352 0 68.00 06900 ELECTROCARDI OLOGY 0 69.00 69.00 0 C 07000 ELECTROENCEPHALOGRAPHY 0 70.00 0 0 70.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 0 72.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 73.00 0 07400 RENAL DIALYSIS 74.00 \mathcal{C} 0 Ω 74.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 100 42, 798 10, 291 183, 845 118. 00 43, 768 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 190. 00 0 191. 00 19100 RESEARCH 0 0 0 0 191.00 0 0 192.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 193. 00 19300 NONPALD WORKERS 0 0 0 0 0 193.00 194. 00 07950 BI OTERRORI SM GRANT 0 0 0 o 0 194.00 0 194, 01 194. 01 07951 MARKETI NG 0 C 0 0 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 Cost to be allocated (per Wkst. B, 202.00 1, 222, 820 113, 583 548, 112 967, 425 978, 563 202. 00 Part I) 1, 135. 830000 203 00 Unit cost multiplier (Wkst. B, Part I) 27 938677 12 806954 94 006899 5. 322761 203. 00 204.00 Cost to be allocated (per Wkst. B, 68, 948 10, 317 20, 656 58, 260 69, 293 204. 00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 1.575306 103. 170000 0.482639 5.661257 0. 376910 205. 00 II)206 00 NAHE adjustment amount to be allocated 206 00 (per Wkst. B-2)

207.00

NAHE unit cost multiplier (Wkst. D,

Parts III and IV)

Heal th	Financial Systems ASCE	NSION ST VINCENT	T SETON SPECIA	LTY	In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS			Provider C	CN: 15-2020 F	eri od:	Worksheet B-1	
					rom 07/01/2021 o 06/30/2022	Data/Time Dros	oorod.
				'	0 06/30/2022	Date/Time Prep 11/15/2022 12:	
					OTHER GENERAL	117 107 2022 12.	oo piii
					SERVI CE		
	Cost Center Description	PHARMACY	MEDI CAL	SOCIAL SERVICE	PASTORAL CARE		
	'	(COSTED	RECORDS &		(TOTAL PATIENT		
		REQUIS.)	LI BRARY	(TOTAL PATIENT	DAYS)		
		,	(GROSS	DAYS)	,		
			CHARGES)				
		15. 00	16. 00	17. 00	18. 00		
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	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 NURSING ADMINISTRATION						13.00
15.00	01500 PHARMACY	100					15.00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	79, 890, 662				16.00
17. 00	01700 SOCIAL SERVICE	0	, ,	10, 291			17. 00
	01851 PASTORAL CARE	0	Ċ		1		18. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>		,ı	10,271		.0.00
30.00	03000 ADULTS & PEDIATRICS	0	36, 013, 819	10, 291	10, 291		30.00
	ANCILLARY SERVICE COST CENTERS	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			,		
50.00	05000 OPERATING ROOM	0	1, 401, 357	' C	0		50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	551, 147	'l c	o		54.00
54. 01	03630 ULTRA SOUND	o	194, 004				54.01
57. 00	05700 CT SCAN	o	293, 160	1	0		57.00
60.00	06000 LABORATORY	o	8, 451, 395	1			60.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	C,, C		1		63. 00
65. 00	06500 RESPI RATORY THERAPY	0	19, 454, 527		1		65. 00
	06600 PHYSI CAL THERAPY	0	1, 339, 030		1		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	1, 625, 004	1	1		67. 00
68. 00	06800 SPEECH PATHOLOGY	0	758, 869		1		68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	700,007		1		69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY				1		70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		1, 469, 738				71.00
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS		1, 407, 730				71.00
	07300 DRUGS CHARGED TO PATIENTS	100	7, 386, 513	1			73. 00
	07400 RENAL DIALYSIS	0	952, 099	1	1		74. 00
74.00	SPECIAL PURPOSE COST CENTERS	U	732, 077	'	o _l		74.00
113 00	11300 INTEREST EXPENSE	1					113. 00
118. 00		100	79, 890, 662	10, 291	10, 291		118. 00
	NONREI MBURSABLE COST CENTERS		77,070,002	., .0,2,,	10,271		
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	C) C	0		190. 00
	19100 RESEARCH	o	C	1			191. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	C	1			192. 00
	19300 NONPALD WORKERS	0	Ċ		o		193. 00
	07950 BI OTERRORI SM GRANT	0	Č		o		194. 00
	07951 MARKETI NG	o o	Č				194. 01
200.00				1			200. 00
201.00							201.00
202.00		2, 650, 702	35, 004	19, 230	23, 728		202.00
202.00	Part I)	2,030,702	33, 004	17, 230	23, 720		202.00
203. 00		26, 507. 020000	0. 000438	1. 868623	2. 305704		203. 00
204. 00		67, 948	11, 928	1			204. 00
204.00	Part II)	07, 740	11, 720	, 0, 353	0,000		204.00
205. 00		679. 480000	0. 000149	0. 636770	0. 785638		205. 00
200.00	II)	3, 7, 400000	3. 000 147	3.030770	3. 703030		_00.00
206. 00							206. 00
	(per Wkst. B-2)						00
207.00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						

Health Financial Systems	ASCENSION ST VINCENT S	ETON SPECIALTY	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-2020	From 07/01/2021	Worksheet C Part I Date/Time Prepared:

				o 06/30/2022	Date/Time Pre 11/15/2022 12	
		Title	XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	17, 177, 548		17, 177, 548	0	17, 177, 548	30. 00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	311, 428		311, 428		311, 428	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	126, 480		126, 480		126, 480	
54. 01 03630 ULTRA SOUND	7, 833	l e	7, 833		7, 833	
57.00 05700 CT SCAN	12, 896	l e	12, 896		12, 896	
60. 00 06000 LABORATORY	367, 368		367, 368	0	367, 368	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0		[C	0	0	63. 00
65. 00 06500 RESPI RATORY THERAPY	3, 147, 218	ŀ	3, 147, 218		3, 147, 218	
66. 00 06600 PHYSI CAL THERAPY	422, 533	l e	422, 533		422, 533	
67. 00 06700 OCCUPATI ONAL THERAPY	446, 480	l e	446, 480		446, 480	
68. 00 06800 SPEECH PATHOLOGY	236, 354	0	236, 354	0	236, 354	
69. 00 06900 ELECTROCARDI OLOGY	0		C	0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0		C	0	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	104, 770		104, 770	0	104, 770	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0		C	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 653, 937		2, 653, 937	0	2, 653, 937	73. 00
74. 00 07400 RENAL DIALYSIS	263, 115		263, 115	0	263, 115	74. 00
SPECIAL PURPOSE COST CENTERS	,					
113.00 11300 INTEREST EXPENSE						113. 00
200.00 Subtotal (see instructions)	25, 277, 960	0	25, 277, 960	0	25, 277, 960	200. 00
201.00 Less Observation Beds	0		[C)	0	201. 00
202.00 Total (see instructions)	25, 277, 960	0	25, 277, 960	0	25, 277, 960	202. 00

201.00

202. 00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-2020 Peri od: Worksheet C From 07/01/2021 Part I 06/30/2022 Date/Time Prepared: 11/15/2022 12:36 pm Title XVIII Hospi tal PPS Charges TEFRA Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other + col . 7) Ratio I npati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 36, 013, 819 36, 013, 819 30.00 03000 ADULTS & PEDIATRICS 30.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 1, 384, 925 16, 432 1, 401, 357 0. 222233 0.000000 50.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 546, 556 4, 591 551, 147 0. 229485 0.000000 54.00 03630 ULTRA SOUND 191, 130 2,874 194,004 0.040375 0.000000 54.01 54.01 57.00 05700 CT SCAN 291, 460 1,700 293, 160 0.043990 0.000000 57.00 60.00 06000 LABORATORY 8, 451, 080 315 8, 451, 395 0.043468 0.000000 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 0.000000 63.00 63.00 06500 RESPIRATORY THERAPY 19, 438, 077 19, 454, 527 0.000000 65.00 16, 450 0. 161773 65.00 66.00 06600 PHYSI CAL THERAPY 1, 339, 030 1, 339, 030 0.315552 0.000000 66.00 67.00 06700 OCCUPATIONAL THERAPY 1, 625, 004 1, 625, 004 0. 274756 0.000000 67.00 06800 SPEECH PATHOLOGY 758, 869 758, 869 0.000000 68.00 0 0.311456 68.00 69.00 06900 ELECTROCARDI OLOGY 0 C 0 0.000000 0.000000 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0.000000 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 1, 456, 289 13, 449 1, 469, 738 0.071285 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 0.000000 72.00 72.00 \cap 73.00 07300 DRUGS CHARGED TO PATIENTS 7, 352, 625 33,888 7, 386, 513 0. 359295 0.00000073.00 07400 RENAL DIALYSIS 952, 099 952, 099 0. 276353 0.000000 74.00 74.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 I NTEREST EXPENSE 113.00 200.00 Subtotal (see instructions) 79, 800, 963 89, 699 79, 890, 662 200.00

79, 800, 963

89, 699

79 890 662

201.00

202.00

Less Observation Beds

Total (see instructions)

Health Financial Systems	ASCENSION ST VINCEN	T SETON SPECIALTY	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES			Peri od: From 07/01/2021 To 06/30/2022	Worksheet C Part I Date/Time Prepared: 11/15/2022 12:36 pm
		Title XVIII	Hospi tal	PPS

				11/15/2022 12	. 30 piii
		Title XVIII	Hospi tal	PPS	
Cost Center Description	PPS Inpatient				
	Rati o				
	11. 00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS					30. 00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0. 222233				50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 229485				54.00
54. 01 03630 ULTRA SOUND	0. 040375				54. 01
57. 00 05700 CT SCAN	0. 043990				57. 00
60. 00 06000 LABORATORY	0. 043468				60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000				63.00
65. 00 06500 RESPI RATORY THERAPY	0. 161773				65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 315552				66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 274756				67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 311456				68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000				69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000				70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 071285				71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000				72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 359295				73. 00
74. 00 07400 RENAL DIALYSIS	0. 276353				74. 00
SPECIAL PURPOSE COST CENTERS					
113. 00 11300 I NTEREST EXPENSE		·			113. 00
200.00 Subtotal (see instructions)					200. 00
201.00 Less Observation Beds					201. 00
202.00 Total (see instructions)					202. 00

Health Financial Systems	ASCENSION ST VINCENT SETON SPECIALTY			In Lieu of Form CMS-2552-10
COMPUTATION OF DATIO OF COSTS TO CHARCES		Providor CCN: 15 2020	Pori od:	Workshoot C

Health Finar	ncial Systems ASCE	NSION SI VINCEN	I SETON SPECIA	LIY	In Lie	u of Form CMS-2	2552-10
COMPUTATI ON	OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-2020			Period: From 07/01/2021 To 06/30/2022	11/15/2022 12	
			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)					
		1.00	2. 00	3. 00	4. 00	5. 00	
	IENT ROUTINE SERVICE COST CENTERS			,			
	ADULTS & PEDIATRICS	17, 177, 548		17, 177, 54	8 0	0	30.00
	LARY SERVICE COST CENTERS						
	OPERATING ROOM	311, 428		311, 42		0	50.00
	RADI OLOGY-DI AGNOSTI C	126, 480		126, 48		0	54. 00
	ULTRA SOUND	7, 833		7, 83		0	54. 01
	CT SCAN	12, 896		12, 89		0	57. 00
60.00 06000	LABORATORY	367, 368		367, 36	8 0	0	60.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0			0 0	0	63. 00
65.00 06500	RESPI RATORY THERAPY	3, 147, 218	0	3, 147, 21	8 0	0	65. 00
66.00 06600	PHYSI CAL THERAPY	422, 533	0	422, 53	3 0	0	66. 00
67.00 06700	OCCUPATIONAL THERAPY	446, 480	0	446, 48	0 0	0	67. 00
68.00 06800	SPEECH PATHOLOGY	236, 354	0	236, 35	4 0	0	68. 00
69.00 06900	ELECTROCARDI OLOGY	0			0 0	0	69. 00
70.00 07000	ELECTROENCEPHALOGRAPHY	0			0 0	0	70. 00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	104, 770		104, 77	0 0	0	71. 00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0			o ol	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	2, 653, 937		2, 653, 93	7 0	0	73. 00
74.00 07400	RENAL DIALYSIS	263, 115		263, 11	5 0	0	74.00
SPECI	AL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE						113. 00
200.00	Subtotal (see instructions)	25, 277, 960	0	25, 277, 96	ol ol	0	200. 00
201.00	Less Observation Beds	0			o	0	201. 00
202. 00	Total (see instructions)	25, 277, 960	0	25, 277, 96	ol ol	0	202. 00

Hearth Financial Systems ASCEN	ISTON ST VINCEN	I SETON SPECIA	LIY	In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CO	CN: 15-2020	Peri od:	Worksheet C	
				From 07/01/2021	Part I	
				To 06/30/2022	Date/Time Prep 11/15/2022 12	
		Ti tl	e XIX	Hospi tal	Cost	. 30 piii
		Charges	.=			
Cost Center Description	I npati ent	Outpati ent	Total (col.	Cost or Other	TEFRA	
· ·	'	•	+ col. 7)	Ratio	Inpati ent	
			Í		Rati o	
	6.00	7. 00	8. 00	9. 00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	36, 013, 819		36, 013, 81	9		30. 00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	1, 384, 925	16, 432	1, 401, 35	7 0. 222233	0.000000	50. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	436, 389	4, 591	440, 98	0. 286816	0.000000	54.00
54. 01 03630 ULTRA SOUND	191, 130	2, 874	194, 00	0. 040375	0.000000	54. 01
57. 00 05700 CT SCAN	291, 460	1, 700	293, 16	0. 043990	0.000000	57.00
60. 00 06000 LABORATORY	8, 451, 080	315	8, 451, 39	0. 043468	0.000000	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0. 000000	0.000000	63. 00
65. 00 06500 RESPIRATORY THERAPY	19, 424, 779	16, 450	19, 441, 22	9 0. 161884	0.000000	65. 00
66. 00 06600 PHYSI CAL THERAPY	1, 339, 030	0	1, 339, 03	0. 315552	0.000000	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	1, 625, 004	0	1, 625, 00	0. 274756	0.000000	67. 00
68.00 06800 SPEECH PATHOLOGY	758, 869	0	758, 8 <i>6</i>	9 0. 311456	0.000000	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0. 000000	0.000000	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0. 000000	0.000000	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 456, 289	13, 449	1, 469, 73			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0. 000000	0.000000	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	7, 352, 625	33, 888	7, 386, 51	3 0. 359295	0.000000	73. 00
74. 00 07400 RENAL DIALYSIS	952, 098	0	952, 09	0. 276353	0.000000	74. 00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 I NTEREST EXPENSE						113. 00
200.00 Subtotal (see instructions)	79, 677, 497	89, 699	79, 767, 19	6		200. 00
201.00 Less Observation Beds						201. 00
202.00 Total (see instructions)	79, 677, 497	89, 699	79, 767, 19	6		202. 00

	11.00		
INPATIENT ROUTINE SERVICE COST CENTERS			
30. 00 03000 ADULTS & PEDIATRICS			30. 00
ANCILLARY SERVICE COST CENTERS			
50.00 05000 OPERATING ROOM	0. 000000		50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000		54. 00
54. 01 03630 ULTRA SOUND	0. 000000		54. 01
57. 00 05700 CT SCAN	0. 000000		57. 00
60. 00 06000 LAB0RAT0RY	0. 000000		60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000		63. 00
65. 00 06500 RESPI RATORY THERAPY	0. 000000		65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000		66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000		67. 00
68.00 06800 SPEECH PATHOLOGY	0. 000000		68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000		69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000		70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000		71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	1	72. 00
73.00 O7300 DRUGS CHARGED TO PATIENTS	0. 000000	1	73. 00
74. 00 07400 RENAL DI ALYSI S	0. 000000		74. 00
SPECIAL PURPOSE COST CENTERS	•		
113. 00 11300 I NTEREST EXPENSE			113. 00
200.00 Subtotal (see instructions)			200. 00
201.00 Less Observation Beds			201. 00
202.00 Total (see instructions)			202. 00

Health Financial Systems ASCE	NSION ST VINCEN	T SETON SPECIA	LTY	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider Co		Period: From 07/01/2021 To 06/30/2022		pared: :36 pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col . 1 - col			
	26)	0.00	2)	4.00	F 00	
INDATIENT POLITINE CEDVICE COCT CENTEDS	1. 00	2.00	3. 00	4. 00	5. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1 000 107	0	1 000 10	10 201	105.04	20.00
30. 00 ADULTS & PEDIATRICS	1, 090, 197		1, 090, 19			1
200. 00 Total (lines 30 through 199)	1, 090, 197		1, 090, 19	7 10, 291		200. 00
Cost Center Description	Inpatient	Inpati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
	4.00	6)				
INDATIENT DOUTINE CERVICE COCT CENTERC	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS			1			
30. 00 ADULTS & PEDIATRICS	2, 811		•			30. 00
200.00 Total (lines 30 through 199)	2, 811	297, 797				200. 00

Health Financial Systems ASCENSION ST VINCENT SETON SPECIALTY In Lieu of Form CMS-2552-10							
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der Co	CN: 15-2020	Peri od: From 07/01/2021	Worksheet D		
				To 06/30/2022	Part II Date/Time Pre	pared:	
					11/15/2022 12		
			XVIII	Hospi tal	PPS		
Cost Center Description	Capi tal	Total Charges			Capital Costs		
		(from Wkst. C,		Program	(column 3 x		
	(from Wkst. B,			. Charges	column 4)		
	Part II, col.	8)	2)				
	26)						
	1.00	2. 00	3. 00	4. 00	5. 00		
ANCILLARY SERVICE COST CENTERS		T			T		
50.00 05000 OPERATING ROOM	13, 851						
54. 00 05400 RADI OLOGY-DI AGNOSTI C	15, 667						
54.01 03630 ULTRA SOUND	155		l .		l		
57.00 05700 CT SCAN	3, 848		l .			57. 00	
60. 00 06000 LABORATORY	10, 091	8, 451, 395	0. 00119	2, 488, 913	2, 972	60. 00	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.00000		0	63.00	
65. 00 06500 RESPI RATORY THERAPY	68, 672	19, 454, 527	0.00353	5, 322, 860	18, 790	65. 00	
66. 00 06600 PHYSI CAL THERAPY	16, 507	1, 339, 030	0. 01232	28 324, 896	4, 005	66. 00	
67. 00 06700 OCCUPATI ONAL THERAPY	16, 707	1, 625, 004	0. 01028	402, 345	4, 137	67. 00	
68.00 06800 SPEECH PATHOLOGY	12, 364	758, 869	0. 01629	191, 194	3, 115	68. 00	
69. 00 06900 ELECTROCARDI OLOGY	0	0	0.00000	00	0	69. 00	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0.00000	00	0	70. 00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 906	1, 469, 738	0. 00129	440, 405	571	71. 00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0. 00000	00	0	72. 00	
73.00 07300 DRUGS CHARGED TO PATIENTS	69, 049	7, 386, 513	0. 00934	18 2, 133, 892	19, 948	73. 00	
74.00 07400 RENAL DIALYSIS	4, 398	952, 099	0.0046	9 183, 775	849	74.00	
200.00 Total (lines 50 through 199)	233, 215			12, 228, 914	64, 393	200. 00	

Health Financial Systems ASCE	NSION ST VINCEN	T SETON SPECIA	LTY	In Li€	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COST	TS Provider CO		Period: From 07/01/2021 Fo 06/30/2022		pared: :36 pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng	Allied Health	Allied Health	All Other	
	Program	Program	Post-Stepdown	Cost	Medi cal	
	Post-Stepdown		Adjustments		Education Cost	
	Adjustments					
	1A	1.00	2A	2. 00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0	(0	0	30.00
200.00 Total (lines 30 through 199)	0	0	(0	0	200. 00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem (col.	Inpati ent	
	Adjustment	(sum of cols.	Days	5 ÷ col . 6)	Program Days	
	Amount (see	1 through 3,				
	instructions)	minus col. 4)				
	4. 00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0	10, 29°	0.00	2, 811	30.00
200.00 Total (lines 30 through 199)		0	10, 29 ⁻	1	2, 811	200. 00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8)					
	9. 00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0					30. 00
200.00 Total (lines 30 through 199)	0					200. 00

Health Financial Systems	ASCENSION ST VINCENT SETON SPECIALTY			In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-2020	Peri od:	Worksheet D

THROUG	H COSTS				From 07/01/2021 To 06/30/2022	Part IV Date/Time Pre 11/15/2022 12	
			Title	XVIII	Hospi tal	PPS	
	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 OPERATI NG ROOM	0	0		0	0	50. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	54. 00
54. 01	03630 ULTRA SOUND	0	0		0	0	54. 01
57.00	05700 CT SCAN	0	0		0	0	57. 00
60.00	06000 LABORATORY	0	0		0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0	63. 00
65.00	06500 RESPI RATORY THERAPY	0	0		0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0		0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	0	0		0 0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0		0 0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73. 00
74.00	07400 RENAL DIALYSIS	0	0		0 0	0	74.00
200.00	Total (lines 50 through 199)	0	0		0 0	0	200. 00

Health Financial Systems	al Systems ASCENSION ST VINCENT SETON SPECIALTY					2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILL/ THROUGH COSTS	ATIENT ANCILLARY SERVICE OTHER PASS		Provider CCN: 15-2020		Worksheet D Part IV Date/Time Prep 11/15/2022 12:	
		Title	: XVIII	Hospi tal	PPS	
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.	

					11/15/2022 12:	: 30 PIII
		Title	XVIII	Hospi tal	PPS	
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)	col s. 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	(1, 401, 357	0.000000	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	(551, 147	0.000000	54.00
54. 01 03630 ULTRA SOUND	0	0	(194, 004	0.000000	54. 01
57. 00 05700 CT SCAN	0	0	(293, 160	0.000000	57.00
60. 00 06000 LABORATORY	0	0	(8, 451, 395	0.000000	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	(0	0.000000	63.00
65. 00 06500 RESPIRATORY THERAPY	0	0		19, 454, 527	0.000000	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0		1, 339, 030	0.000000	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		1, 625, 004	0.000000	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0		758, 869		68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0	0.000000	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0	0. 000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(1, 469, 738		
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(0	0. 000000	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	(7, 386, 513		
74. 00 07400 RENAL DIALYSIS	0	0		952, 099		
200.00 Total (lines 50 through 199)		0	l	43, 876, 843		200.00
200.00 1.000. (1.1.00 00 till ough 177)	1		'	.5, 5, 5, 5, 5, 5	1	

		- 05-011 05-014			6.5. 010	
	NSION ST VINCENT				eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	Provi der CO		Period: From 07/01/2021	Worksheet D Part IV	
THROUGH COSTS				To 06/30/2022		nared:
				10 00/ 30/ 2022	11/15/2022 12	
		Title	XVIII	Hospi tal	PPS	
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	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0. 000000	423, 759		0 16, 432	0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	158, 673		0 4, 591	0	54.00
54.01 03630 ULTRA SOUND	0. 000000	62, 382		0 2, 874	0	54. 01
57.00 05700 CT SCAN	0. 000000	95, 820		0 1, 700	0	57. 00
60. 00 06000 LABORATORY	0. 000000	2, 488, 913		0 315	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0		0	0	63. 00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	5, 322, 860		0 16, 450	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	324, 896		0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	402, 345		0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	191, 194		0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	0		0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	440, 405		0 13, 449	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	2, 133, 892		0 33, 398	0	73. 00
74.00 07400 RENAL DIALYSIS	0. 000000	183, 775		0 0	0	74. 00
200.00 Total (lines 50 through 199)		12, 228, 914		89, 209	0	200. 00

In Lieu of Form CMS-2552-10

near tr	i i i i i alici ai Systellis ASCL	NOTON OF VINCEN	II SETON SPECIA	LII.	III LI C	u or rorm cws	2552-10
APP0R	APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCI		Provi der CO		Period: From 07/01/2021 To 06/30/2022	Worksheet D Part V Date/Time Pre	narod:
					10 00/30/2022	11/15/2022 12	
			Title	XVIII	Hospi tal	PPS	. 50 piii
			11 210	Charges	nospi tui	Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
	555 Conton Bood Ptron		Services (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Servi ces Not	(,	
		Part I, col. 9		Subject To	Subject To		
		·		Ded. & Coins.			
				(see inst.)	(see inst.)		
		1.00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0. 222233	16, 432		0 0	3, 652	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 229485	4, 591		0	1, 054	54.00
54.01	03630 ULTRA SOUND	0. 040375	2, 874		0	116	54. 01
57.00	05700 CT SCAN	0. 043990	1, 700		0	75	57.00
60.00	06000 LABORATORY	0. 043468	315		0	14	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0 0	0	63.00
65.00	06500 RESPI RATORY THERAPY	0. 161773	16, 450		0 0	2, 661	65. 00
66.00	06600 PHYSI CAL THERAPY	0. 315552	0		0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 274756	0		0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0. 311456	0		0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 000000	0		0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 071285	13, 449		0	959	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 359295	33, 398		0 490	12, 000	73. 00
74.00	07400 RENAL DIALYSIS	0. 276353	0		0	0	74. 00
200.00	Subtotal (see instructions)		89, 209		0 490	20, 531	200.00
201.00	Less PBP Clinic Lab. Services-Program				0 0		201. 00
	Only Charges						
202.00	Net Charges (line 200 - line 201)		89, 209		0 490	20, 531	202. 00

				10 06/30/2022	Date/lime Prepai 11/15/2022 12:30	
		Title	XVIII	Hospi tal	PPS	
	Cos	sts		<u> </u>		
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Servi ces Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
ANOLUL ARV OFRIGO COOT OFFITERS	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS	1					-0.00
50. 00 05000 OPERATING ROOM	0	0				50. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C		0				54. 00
54. 01 03630 ULTRA SOUND	0	0				54. 01
57. 00 05700 CT SCAN		0				57. 00
60. 00 06000 LABORATORY		0				50.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0				53.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY		0				55. 00 56. 00
		0				56. 00 57. 00
67. 00 06700 0CCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY		0				57. 00 58. 00
69. 00 06900 ELECTROCARDI OLOGY		0				58. 00 59. 00
70. 00 07000 ELECTROCARDI OLOGT						70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS						71. 00
72. 00 07700 MEDICAL SUPPLIES CHARGED TO PATTENTS						72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		176				73. 00
74. 00 07400 RENAL DI ALYSI S		170				74. 00
200.00 Subtotal (see instructions)		176				00.00
201.00 Less PBP Clinic Lab. Services-Program		170				01. 00
Only Charges					20	, , , 50
202.00 Net Charges (line 200 - line 201)		176			20	02. 00
3.2 (=)	-		1		1==	

Health Financial Systems ASCE	NSION ST VINCEN	T SETON SPECIA	LTY	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider Co		Period: From 07/01/2021 To 06/30/2022	Worksheet D Part I Date/Time Pre 11/15/2022 12	pared: :36 pm
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,	,	Related Cost	The state of the s		
	Part II, col.		(col . 1 - col			
	26)		2)			
	1. 00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS				<u>'</u>		
30. 00 ADULTS & PEDIATRICS	1, 090, 197	0	1, 090, 19	7 10, 291	105. 94	30.00
200.00 Total (lines 30 through 199)	1, 090, 197		1, 090, 19	7 10, 291		200.00
Cost Center Description	I npati ent	Inpatient				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	12	1, 271				30.00
200.00 Total (lines 30 through 199)	12					200.00
, , , , , , , , , , , , , , , , , , , ,	!	'	'			

In Lieu of Form CMS-2552-10 Health Financial Systems ASCENSION ST VINCENT SETON SPECIALTY APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS Provi der CCN: 15-2020 Peri od: Worksheet D From 07/01/2021 Part II Date/Time Prepared: 06/30/2022 11/15/2022 12:36 pm Title XIX Hospi tal Cost Total Charges Ratio of Cost Capital Costs Cost Center Description Capi tal Inpati ent (from Wkst. C, to Charges Related Cost Program (column 3 x (from Wkst. B, Part I, col. (col. 1 ÷ col column 4) Charges Part II, col. 8) 2) 26) 1.00 2.00 3.00 4.00 5.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 13, 851 1, 401, 357 0.009884 5,050 50 50.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 15, 667 440, 980 0.035528 5, 243 186 54.00 54.01 03630 ULTRA SOUND 155 194, 004 0.000799 7,668 54.01 6 57. 00 05700 CT SCAN 3,848 293, 160 0.013126 6, 031 79 57.00 06000 LABORATORY 8, 451, 395 0.001194 60.00 10, 091 53, 879 64 60.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 0 63.00 65.00 06500 RESPIRATORY THERAPY 68, 672 19, 441, 229 0.003532 209, 674 741 65.00 66.00 16, 507 06600 PHYSI CAL THERAPY 1, 339, 030 0.012328 99 66.00 8, 063 06700 OCCUPATI ONAL THERAPY 16, 707 1, 625, 004 67.00 0.010281 11,646 120 67.00 68.00 06800 SPEECH PATHOLOGY 12, 364 758, 869 0.016293 7, 169 117 68.00 06900 ELECTROCARDI OLOGY 0.000000 69.00 0 0 69.00 0 70. 00 07000 ELECTROENCEPHALOGRAPHY 0.000000 70.00 Ω 0 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 1,906 1, 469, 738 0.001297 9, 375 12 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 0 72.00 73. 00 07300 DRUGS CHARGED TO PATIENTS 69.049 0.009348 409 73.00 7, 386, 513 43.761 74.00 07400 RENAL DIALYSIS 4, 398 952, 098 0. 004619 0 74.00 200.00 Total (lines 50 through 199) 233, 215 43, 753, 377 367, 559 1, 883 200. 00

Heal th Financ	cial Systems	ASCENSION ST VINCENT	SETON SPECIA	LTY	In Lie	eu of Form CMS-	2552-10
APPORTI ONMEN	T OF INPATIENT ROUTINE SERVICE OTH	ER PASS THROUGH COST		!	Period: From 07/01/2021 To 06/30/2022	Worksheet D Part III Date/Time Pre 11/15/2022 12	
				e XIX	Hospi tal	Cost	
	Cost Center Description	Nursi ng Program Post-Stepdown Adj ustments	Nursi ng Program	Allied Health Post-Stepdowr Adjustments		All Other Medical Education Cost	
		1A	1. 00	2A	2. 00	3. 00	
INPATI	ENT ROUTINE SERVICE COST CENTERS						
1 1	ADULTS & PEDLATRICS Total (lines 30 through 199)	0	0		0	0	30. 00 200. 00
	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	200.00
		4.00	5. 00	6. 00	7. 00	8. 00	
I NPATI	ENT ROUTINE SERVICE COST CENTERS						
	ADULTS & PEDIATRICS Total (lines 30 through 199)	0	0	10, 29 10, 29			30. 00 200. 00
	Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00					
INPATI	ENT ROUTINE SERVICE COST CENTERS						
	ADULTS & PEDIATRICS Total (lines 30 through 199)	0					30. 00 200. 00

| Peri od: | Worksheet D | Part IV | To | 06/30/2022 | Date/Time Prepared: | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 12/4/2021 | 1 THROUGH COSTS

				00, 00, 2022	11/15/2022 12	
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Non Physician		Nursi ng		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	50. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	(0	0	54. 00
54. 01 03630 ULTRA SOUND	0	0	(0	0	54. 01
57. 00 05700 CT SCAN	0	0	(0	0	57. 00
60. 00 06000 LABORATORY	0	0	(0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	(0	0	63. 00
65. 00 06500 RESPI RATORY THERAPY	0	0	(0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0	(0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	(0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	(0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	(0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	(0	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	(0	0	73. 00
74.00 07400 RENAL DIALYSIS	0	0	(0	0	74. 00
200.00 Total (lines 50 through 199)	0	0	(0	0	200. 00

Health Financial Systems	ASCENSION ST VINCENT S	SETON SPECIALTY	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-2020	Peri od: From 07/01/2021	Worksheet D Part IV Date/Time Prepared:

			1	Го 06/30/2022	Date/Time Prep 11/15/2022 12:	
		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)	col s. 2, 3,	8)	7)	
			and 4)		(see	
					instructions)	
	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS				1		
50. 00 05000 OPERATI NG ROOM	0	0	(1, 401, 357		1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	(440, 980		1
54. 01 03630 ULTRA SOUND	0	0	(194, 004		1
57. 00 05700 CT SCAN	0	0	(293, 160	1	1
60. 00 06000 LABORATORY	0	0	(8, 451, 395	0. 000000	1
63.00 O6300 BLOOD STORING, PROCESSING & TRANS.	0	0	(0	0. 000000	63.00
65. 00 06500 RESPI RATORY THERAPY	0	0	(19, 441, 229	0.000000	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0	(1, 339, 030	0.000000	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	(1, 625, 004	0.000000	67. 00
68.00 06800 SPEECH PATHOLOGY	0	0	(758, 869	0.000000	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	(0	0.000000	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	(0	0.000000	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(1, 469, 738	0. 000000	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(0	0.000000	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	(7, 386, 513	0.000000	73. 00
74.00 07400 RENAL DIALYSIS	0	0	(952, 098	0.000000	74. 00
200.00 Total (lines 50 through 199)	0	0	(43, 753, 377		200. 00

Health Financial Systems ASCE	NSION ST VINCENT	SETON SPECIA	I TV	In lie	eu of Form CMS-2	2552_10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS			CN: 15-2020	Period: From 07/01/2021 To 06/30/2022	Worksheet D Part IV	pared:
		Ti tl	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	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	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 000000	5, 050		0	0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	5, 243		0	0	54.00
54. 01 03630 ULTRA SOUND	0. 000000	7, 668		0	0	54. 01
57. 00 05700 CT SCAN	0. 000000	6, 031		0	0	57.00
60. 00 06000 LABORATORY	0. 000000	53, 879		0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0	0	63.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	209, 674		0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	8, 063		0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	11, 646		0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	7, 169		0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	0		0 0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	9, 375		0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		o o	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	43, 761		ol o	0	73. 00
74.00 07400 RENAL DIALYSIS	0. 000000	0		ol o	0	74. 00
200 00 Total (Lines 50 through 199)		367 559		0	0	200 00

367, 559

0 72.00 0 73.00 0 74.00 0 200.00 0 0

200.00

Total (lines 50 through 199)

		VT 0570V 0050V VTV		5.5	
	Financial Systems ASCENSION ST VINCE			u of Form CMS-2	2552-10
COMPUI	TATION OF INPATIENT OPERATING COST	Provider CCN: 15-2020	Peri od:	Worksheet D-1	
			From 07/01/2021 To 06/30/2022	Date/Time Pre	narod:
			10 00/30/2022	11/15/2022 12	
		Title XVIII	Hospi tal	PPS	. 50 piii
	Cost Center Description	THE ANTI-	nospi tui	110	
	oost contor bescription			1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				1
1.00	Inpatient days (including private room days and swing-bed	days, excluding newborn)		10, 291	1.00
2.00	Inpatient days (including private room days, excluding swi			10, 291	2.00
3.00	Private room days (excluding swing-bed and observation bed		rivate room davs.	0	3.00
	do not complete this line.	3.1			
4.00	Semi-private room days (excluding swing-bed and observation	n bed days)		10, 291	4. 00
5.00	Total swing-bed SNF type inpatient days (including private		er 31 of the cost	0	5. 00
	reporting period	3 ,			
6.00	Total swing-bed SNF type inpatient days (including private	room days) after December	31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)				
7.00	Total swing-bed NF type inpatient days (including private	room days) through Decembe	r 31 of the cost	0	7. 00
	reporting period				
8.00	Total swing-bed NF type inpatient days (including private	room days) after December	31 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)				
9.00	Total inpatient days including private room days applicable	e to the Program (excluding	g swing-bed and	2, 811	9. 00
	newborn days) (see instructions)				
10. 00			room days)	0	10.00
	through December 31 of the cost reporting period (see inst				
11 00	Swing-bed SNE type inpatient days applicable to title XVII	L only (including private	room davs) after l	0	1 11 00

10, 291 a. (inpatient days (including private room days, excluding saling-bed and newborn days). 20 Private room days (excluding saling-bed and observation bed days). If you have only private room days. 30 ont complete this line. 31 on his variety read room days (excluding saling-bed and observation bed days). If you have only private room days. 32 on not complete this line. 33 on his variety read room days (excluding private room days) through December 31 of the cost reporting period (if calendary year, enter 0 on this line). 40 Total saling-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendary year, enter 0 on this line). 40 Total saling-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendary year, enter 0 on this line). 40 Total saling-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period of Total saling-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period of SNF type inpatient days applicable to the Program (excluding private room days) after December 31 of the cost reporting period (if calendary year, enter 0) on this line). 40 Saling-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (it is sy or XIX only (including private room days). 41 Saling-bed SNF type inpatient days applicable to titles XVIII only (including private room days). 42 Saling-bed SNF type inpatient days applicable to titles VIVII only (including private room days). 43 Saling-bed SNF type inpatient days applicable to titles VIVII only (including private room days). 44 Saling-bed SNF type inpatient days applicable to service setter December 31 of the cost reporting period (if calendary year, enter 0 on this line). 45 Saling-bed SNF type inpatient days applicable to service setter December 31 of the cost reporting period (includi		Source Book (ptron	1. 00	
10. Inpattient days (including private room days, excluding newborn) 10. 291 1. Dispatch that days (including private room days, excluding swing-bed and neaborn days) 10. 291 1. Dispatch that the private room days (excluding swing-bed and observation bed days). If you have only private room days, 10. 291 1. Dispatch that the private room days (excluding swing-bed and observation bed days). If you have only private room days, 10. 291 1. Dispatch that the private room days (excluding swing-bed and observation bed days). 10. 291 1. Dispatch that the private room days (excluding swing-bed and observation bed days). 10. 291 1. Dispatch that the private room days are provided that the cost reporting period (if call endar year, enter 0 on this line). 10. Dispatch that the private room days after December 31 of the cost reporting period (if call endar year, enter 0 on this line). 10. Dispatch that the private room days (including private room days) after December 31 of the cost reporting period (if call endar year, enter 0 on this line). 10. Dispatch that the private room days (including private room days) after December 31 of the cost reporting period (if call endar year, enter 0 on this line). 10. Dispatch that the private room days (including private room days) after December 31 of the cost reporting period (if call endar year, enter 0 on this line). 10. Dispatch days including private room days) after December 31 of the cost reporting period (if call endar year, enter 0 on this line). 10. Dispatch days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if call endar year, enter 0 on this line). 11. Dispatch days including private room days). 11. Dispatch days including private room days). 11. Dispatch days including private room days. 11. Dispatch days including private room				
10,291 10,291 2. 2.00 Private room days (secluding bring-bed and observation bad days) 15 you have only private room days (so nor complete this line. 2.01 Private room days (secluding seing-bed and observation bed days) 15 you have only private room days 10,291 4. 2.02 Soil private room days (secluding seing-bed and observation bed days) 10,291 4. 2.03 Soil private room days 10,291 4. 2.04 Soil private room days 10,291 4. 2.05 Soil private room days 10,291 4. 2.06 Soil private room days 10,291 4. 2.07 Soil private room days 10,291 4. 2.08 Soil private room days 10,291 4. 2.09 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7. 2.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7. 2.01 Soil private room days (see instructions) 7. 2.02 Soil private room days (see instructions) 7. 2.03 Soil private room days (see instructions) 7. 2.04 Soil private room days (see instructions) 7. 2.05 Soil private room days (see instructions) 7. 2.06 Soil private room days (see instructions) 7. 2. 2. 3. 3. 3. 3. 3. 3. 3. 3. 3. 3. 3. 3. 3.	1 00		40.004	1 4 04
A construction gravity (excluding saring-bed and observation bed days). If you have only private room days, do not complete this line. A construction of the private room days (excluding saring-bed and observation bed days). A construction of the private room days (excluding saring-bed and observation bed days). A construction of the private room days (including private room days) after December 31 of the cost reporting period (if call endary year, enter 0 on this line). A construction period (if call endary year, enter 0 on this line). A construction period (if call endary year, enter 0 on this line). A construction of the properties of the private room days) after December 31 of the cost reporting period (if call endary year, enter 0 on this line). A construction of the properties of t				1.00
do not complete this line. 10 Seni-private room days (excluding swing-bed and observation bed days) through December 31 of the cost 10,291 d. Seni-private room days (excluding private room days) after December 31 of the cost 10,291 d. Seni-private room days (and und private room days) after December 31 of the cost 10,291 d. Seni-private room days) after December 31 of the cost 10,291 d. Seni-private room days (and und private room days) after December 31 of the cost 10,291 d. Seni-private room days (and und grivate room days) after December 31 of the cost 10,291 d. Seni-private room days (and und grivate room days) after December 31 of the cost 10,291 d. Seni-private room days) after December 31 of the cost 10,291 d. Seni-private room days (and und grivate room days) after December 31 of the cost 10,291 d. Seni-private room days) after December 31 of the cost 10,291 d. Seni-private room days and private room days after 10,291 d. Seni-private room days applicable to the Program (excluding swing-bed and 11,291 d. Seni-private room days) after 10,291 d. Seni-private room days applicable to 11,291 d. Seni-private room days) after 10,291 d. Seni-private room days applicable to 11,291 d. Seni-private room days) after 10,291 d. Seni-private room days applicable to 11,291 d. Seni-private room days after 10,291 d. Seni-private room days applicable to 11,291 d. Seni-private room days applicable to 11,291 d. Seni-private room days) after 10,291 d. Seni-private room days applicable to 11,291 d. Seni-private room da				2.00
Semi_private room days (excluding saing-bed and observation bed days) 10,291 4,	3.00		0	3.00
10tal swing-bed SNF type inpattient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 0 0 0 0 0 0 0 0 0	4 00		10 201	1 4 0
reporting period (If calendar year, enter 0 on this line) 7.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (If calendar year, enter 0 on this line) 8.00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period (If calendar year, enter 0 on this line) 9.00 Total inpatient days the plant and days (including private room days) after December 31 of the cost reporting period (If calendar year, enter 0 on this line) 1.00 Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and new period days) (see instructions) 1.00 Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and through December 31 of the cost reporting period (see instructions) 1.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions) 1.00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (see instructions) 1.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 1.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 1.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 1.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 1.00 Swing-bed NF type inpatient days applicable to services through December 31 of the cost reporting period (line Swing-bed SWF services applicable to services through December 31 of the cost reporting period (line Swing-bed SWF services applicable to services after December 31 of the cost reporting period (line Swing-bed cost applicable to SWF type services through December 31 of the cost reporting period (line Swing-bed cost applicable to				1
10tal swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	5.00		Ü	5.0
reporting period (if calendar year, enter 0 on this line) 7. To lotal swing-bed MF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 8. To lotal inpatient days including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9. Swing-bed SM type inpatient days applicable to the Program (excluding swing-bed and 2, 811 on through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 10. Swing-bed SM type inpatient days applicable to title XVIII only (including private room days) after becomes 31 of the cost reporting period (if calendar year, enter 0 on this line) 11. Swing-bed SM 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) 12. Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) 13. Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) 14. Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) 15. Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) 16. Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) 17. Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days) 18. Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) 19. Swing-bed NF type inpatient days applicable to services through December 31 of the cost cost including the Aviant of the cost reporting period (including the Aviant of the Cost applicable to NF type services after December 31 of the cost reporting period (including the Avi	4 00		0	4 0
Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period of 10 total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if cal endar year, enter 0 on this line) fortal inpatient days including private room days applicable to the Program (excluding swing-bed and 7 total inpatient days including private room days applicable to the Program (excluding swing-bed and 7 total inpatient days applicable to the Program (excluding swing-bed and 7 total inpatient days applicable to the Program (excluding private room days) after December 31 of the cost reporting period (see instructions)	0.00		U	0.0
reporting period Total inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to the Program (excluding swing-bed and calendar year, enter 0 on this line) Total inpatient days including private room days applicable to the Program (excluding swing-bed and calendar year) Swing-bed SNF type Inpatient days applicable to title XVIII only (including private room days) Swing-bed SNF type Inpatient days applicable to title XVIII only (including private room days) after became 31 of the cost reporting period (if calendar year, enter 0 on this line) Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) after becames 31 of the cost reporting period (if calendar year, enter 0 on this line) Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) 0 13. Wedically necessary private room days applicable to titles V or XIX only (including private room days) 0 14. Wedically necessary private room days applicable to the Program (excluding swing-bed days) 0 14. Wedically necessary private room days applicable to the Program (excluding swing-bed days) 0 15. SWING BED ADJUSTINET Wedically necessary private room days applicable to services through becember 31 of the cost opporting period (including private room days) 0 15. Wedically necessary private room days applicable to services after becember 31 of the cost opporting period (including private room days) 0 15. Wedically necessary private room days applicable to services through becember 31 of the cost opporting period (including private room days) 0 15. Wedically necessary swing-bed SWF services applicable to services after becember 31 of the cost opporting period (including private room days (including private room days) 0 15. Wedically necessary swing-bed SWF services after becember 31 of the cost reporting period (line 5 x line 17) Swing-	7 00		0	7.0
Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions) No more of the cost reporting period (see instructions) Swing-bed SM type inpatient days applicable to title XVIII only (including private room days) after sold in the cost reporting period (see instructions) Swing-bed SM type inpatient days applicable to title XVIII only (including private room days) after sold including private room days) after sold in the cost reporting period (see instructions) 12.00 Swing-bed MF type inpatient days applicable to title XVIII only (including private room days) 13.00 Swing-bed MF type inpatient days applicable to title XVIII only (including private room days) 14.00 Swing-bed MF type inpatient days applicable to titles V or XIX only (including private room days) 15.00 Swing-bed MF type inpatient days applicable to titles V or XIX only (including private room days) 16.00 Misclaily necessary private room days applicable to the Program (excluding swing-bed days) 17.00 Misclaily necessary private room days applicable to the Program (excluding swing-bed days) 18.00 Misclaily necessary private room days applicable to services through December 31 of the cost 18.00 Misclaily necessary private room days applicable to services after December 31 of the cost 18.00 Misclaily necessary private room days applicable to services after December 31 of the cost 18.00 Misclail room swing-bed NF services applicable to services after December 31 of the cost 18.00 Misclail room swing-bed NF services applicable to services after December 31 of the cost 18.00 Medical rate for swing-bed NF services applicable to services after December 31 of the cost 18.00 Medical rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line 5 x line 17) 28.00 Swing-bed cos	7.00		O	/.0
reporting period (if calendar year, enter 0 on this line) 9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 10.00 Sing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after becember 31 of the cost reporting period (see instructions) through becember 31 of the cost reporting period (if calendar year, enter 0 on this line) SNIng-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) SNIng-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line) After 10 on this line) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line) Medically necessary private room days applicable to titles V or XIX only (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 10 on the sum of the cost reporting period (if calendar year, enter 0 on this line) 10 on the sum of the cost reporting period (if calendar year, enter 0 on this line) 10 on the sum of the cost reporting period (if calendar year, enter 0 on this line) 10 on the sum of the cost reporting period (in the cost period period period period period period (in the cost period period period period (in the cost period (in th	8 00		0	8.0
10 10 Total Inpatient days including private room days applicable to the Program (excluding swing-bed and length or days) (see instructions) 0 10			_	
newborn days) (see instructions) 10. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after become and through December 31 of the cost reporting period (see instructions) 11. 00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) after become 31 of the cost reporting period (if calendar year, enter 0 on this line) 13. 00 Swing-bed WF type inpatient days applicable to titles V or XIX only (including private room days) 14. 00 Swing-bed WF type inpatient days applicable to titles V or XIX only (including private room days) 15. 00 Swing-bed WF type inpatient days applicable to titles V or XIX only (including private room days) 16. 00 Swing-bed WF type inpatient days applicable to titles V or XIX only (including private room days) 17. 00 Swing-bed WF type inpatient days applicable to the Program (excluding swing-bed days) 18. 00 Swing-bed Swing-bed SWF services applicable to the Program (excluding swing-bed days) 19. 00 Swing-bed Swing-bed SWF services applicable to services after December 31 of the cost 19. 00 Swing-bed Swing-bed SWF services applicable to services after December 31 of the cost 19. 00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 19. 00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 19. 00 Swing-bed cost applicable to SWF type services after December 31 of the cost reporting period (line 2 cappling period Swing-bed Swing-Swing	9.00		2, 811	9.0
through December' 31 of the cost reporting period (see Instructions) 12. 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. 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14. 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 15. 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 16. 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 17. 00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 18. 00 Now Swing-y days (title V or XIX only) 19. 01 16. 19. 00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 19. 00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (including reporting period in rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (including reporting period in reporting period in reporting period (including reporting period in reporting period (including repor			, -	
11.00 Swing-bed SMF 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) 12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 15.00 Total nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only) 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (including private room days) 19.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (including private room days) 10.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (including private room days) 10.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (including private room days) 10.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (including private room days) 10.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (including private room period	10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.0
December 31 of the cost reporting period (if calendar year, enter 0 on this line) 1.2		through December 31 of the cost reporting period (see instructions)		
12.00 Swing-bed NF type inpatient days applicable to titles v or XIX only (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 0 14. 00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 0 15. 00 Nursery days (title V or XIX only) 0 16. 00 Nursery days (title V or XIX only) 0 16. 00 Nursery days (title V or XIX only) 0 16. 00 Nursery days (title V or XIX only) 0 16. 00 Nursery days (title V or XIX only) 0 16. 00 Nursery days (title V or XIX only) 0 16. 00 Nursery days (title V or XIX only) 0 16. 00 Nursery days (title V or XIX only) 0 16. 00 Nursery days (title V or XIX only) 0 16. 00 Nursery days (title V or XIX only) 0 16. 00 Nursery days (title V or XIX only) 0 16. 00 Nursery days (title V or XIX only) 0 16. 00 Nursery days (title V or XIX only) 0 16. 00 Nursery days (title V or XIX only) 0 16. 00 Nursery days (title V or XIX only) 0 16. 00 Nursery days (title V or XIX only) 0 16. 00	11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11.0
through December 31 of the cost reporting period 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 15.00 Nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only) 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period 19.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period 20.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period 20.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period 21.00 Total general inpatient routine service cost (see instructions) 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 6 x line 18) 23.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 19) 26.00 Central inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 27. Total swing-bed cost (see instructions) 28.00 Private room charges (excluding swing-bed cost (line 27 + line 28) 29.00 Private room charges (excluding swing-bed charges) 30.00 General inpatient routine service cost period (line 27 + line 28) 30.00 Average per dem private room cost differential (line 29 + line 3) 30.00 Average per dem private room cost differential (line 2				
13.00 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 (if calendar year, enter 0 on this line) 0 14. 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 0 15. 15.00 Nursery days (title V or XIX only) 0 16. SWING BED ADUSTNET 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (including a day) 17. 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (including a day) 18. 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (including a day) 18. 19.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (including a day) 19. 20.00 Medical d rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (including period) 19. 20.00 Medical d rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (including period) 19. 20.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 5 x line 17) 25. 20.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x x line 18) 25. 20.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x x line 20) 26. 20.00 Ceneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 17, 177, 548 period (line 20) 26. 20.00 Ceneral inpatient routine service cost net of swing-bed and observation bed charges) 0 26. 20.00 Ceneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 17, 177, 548 period (line 29 minus line 30) 10.00 (line 20 minus line 30) 10.00 (line 20 minus line 30) 10.00 (line 20 minus line 30) 10.00 (l	12.00		0	12.0
after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 0 14. 15.00 Total nursery days (title V or XIX only) 0 15. 16.00 Nursery days (title V or XIX only) 0 15. 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 0.00 17. 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 0.00 18. 19.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost 0.00 19. 19.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost 0.00 19. 19.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost 0.00 19. 19.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost 0.00 19. 19.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost 0.00 17. 19.00 Medical drate for swing-bed NF services after December 31 of the cost reporting period (line 0.00 17. 19.01 Nine 19. 17. 17. 17. 18. 17. 17. 18. 17. 17. 18. 17. 18. 18. 18. 19.				
14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 0 14.	13. 00		0	13.0
15.00 Total nursery days' (title V or XIX only) 0 16.	44.00		0	
16.00 Nursery days (title v or XIX only) 0 16.				
SWING BED ADJUSTMENT 17.00 Medicad rar rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period reporting period rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period rate for swing-bed NF services applicable to services through December 31 of the cost reporting period reporting peri			-	
17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (19.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost (19.00 Medicare rate for swing-bed NF services applicable to services through December 31 of the cost (19.00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost (19.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost (19.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost (19.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost (19.00 Medicaid rate for swing-bed SNF type services through December 31 of the cost reporting period (110 NE) (19.00 Medicaid rate for swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (110 NE) (19.00 Medicaid rate for swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (110 NE) (19.00 Medicaid rate for swing-bed cost applicable to NF type services after December 31 of the cost reporting period (110 NE) (19.00 Medicaid rate for swing-bed cost and private room cost differ	16.00		0	16.0
reporting period 18. 00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period reporting period Power of the cost reporting Power of Pow	17 00		0.00	17 0
Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19.00 Medicard rate for swing-bed NF services applicable to services through December 31 of the cost reporting period 19.00 Medicard rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 17,177,548 21.00 Total general inpatient routine service cost (see instructions) 17,177,548 21.00 17,177,548 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 20) 26.00 Compared to the cost services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Compared to the cost services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Compared to the cost service cost net of swing-bed cost (line 21 minus line 26) 27.00 Compared to the cost service cost net of swing-bed cost (line 21 minus line 26) 27.00 Compared to the cost reporting period (line 8 x line 20) 28.00 Compared to the cost service cost net of swing-bed and observation bed charges) 28.00 Compared to the cost reporting period (line 8 x line 21) 27.00 Compared to the cost service cost languages and period to the cost reporting period (line 8 x line 21) 28.00 Compared to the cost service cost languages and cost applicable to the languages and cost applicable to th	17.00		0.00	17.0
reporting period Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period 10.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 11.00 Total general inpatient routine service cost (see instructions) 12.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 12.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 12.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18) 12.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 12.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 12.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 12.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 12.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 12.00 Total swing-bed cost (see instructions) 12.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 12.00 Total swing-bed cost (see instructions) 12.00 Total swing-bed cost (see instructions) 12.00 Swing-bed cost applicable to NF type service cost (line 21 minus line 26) 12.00 Total swing-bed cost (see instructions) 12.00 Swing-bed cost applicable to NF type service cost (see line 21 minus line 26) 12.00 Total swing-bed cost (see instructions) 12.00 Swing-bed cost applicable to NF type service cost (see line 30 sine	10 00		0.00	10 0
Medicaid Tarte for swing-bed NF services applicable to services through December 31 of the cost reporting period (period general inpatient routine service cost (see instructions) 17, 177, 548 21.	10.00		0.00	10.0
reporting period Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 17, 177, 548 18, 21. 20. 00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23. 00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24. 00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 25. 00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 18) 26. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 27. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 28. 1 Ine 20) 29. 20. 00 Total swing-bed cost (see instructions) 20. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28. PRIVATE ROWN DIFFERENTIA ADJUSTMENT 28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29. 00 Semi-private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 30. 01 Semi-private room charges (excluding swing-bed charges) 30. 02 Semi-private room charges (excluding swing-bed charges) 30. 03 Average private room per diem charge (line 29 + line 3) 30. 04 Average private room cost differential (line 32 minus line 33) (see instructions) 30. 04 Overage per diem private room cost differential (line 34 x line 31) 30. 05 Overage per diem private room cost differential (line 34 x line 31) 30. 00 Average per diem private room cost differential (line 3 x line 35) 30. 00 Private room cost differential adjustment (line 3 x line 35) 30. 01 Average per diem private room cost differential (line 3 x line 35) 30. 01 Average per diem private room cost differential (line 3 x line 35) 30. 02 Ave	19 00		0.00	19 0
Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period 17, 177, 548 21.	. ,		0.00	
reporting period Total general inpatient routine service cost (see instructions) 22. 00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23. 00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24. 00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 18) 25. 00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 8 x line 20) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) Total swing-bed cost (see instructions) Swing-bed cost (see instructions) Total swing-bed	20.00		0.00	20.0
22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 General inpatient routine service cost net of swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 31.00 Semi-private room charges (excluding swing-bed charges) 31.00 Average private room per diem charge (line 29 + line 3) 32.00 Average perivate room per diem charge (line 29 + line 3) 33.00 Average per diem private room charge differential (line 30 + line 4) 34.00 Average per diem private room cost differential (line 3 x line 31) 35.00 Average per diem private room cost differential (line 3 x line 31) 37.00 Private room cost differential adjustment (line 3 x line 35) 38.00 Applicable to SNF type services after December 31 of the cost reporting period (line 8 2 24. 24.00 Average per diem private room cost differential (line 3 x line 35) 38.00 Average per diem private room cost differential (line 3 x line 35) 39.00 Average semi-private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (reporting period		
5 x line 17) Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) Deceral inpatient routine service charges (excluding swing-bed charges) Deceral inpatient routine service cost/charge ratio (line 27 + line 28) Average private room charges (excluding swing-bed charges) Average per diem private room per diem charge (line 29 + line 3) Average per diem private room charge differential (line 30 + line 4) Deceral inpatient routine service cost/charge ratio (line 27 + line 28) Average per diem private room charge differential (line 30 + line 4) Deceral inpatient routine service cost/charge ratio (line 30 + line 4) Deceral inpatient routine service cost/charge ratio (line 30 + line 31) Deceral inpatient routine service cost differential (line 30 + line 31) Deceral inpatient routine service cost net of swing-bed cost and private room cost differential (line 37 + line 38) Deceral inpatient routine service cost net of swing-bed cost and private room cost differential (line 37 + line 38) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) Aliance of the cost reporting period (line 14 x line 35) Aliance of the cost reporting period (line 14 x line 35) Aliance of the cost reporting period (line 14 x line 35) Aliance of the cost reporting period (line 14 x line 35) Aliance of the cost reporting period (line 14 x line 35) Aliance of the cost reporting	21.00	Total general inpatient routine service cost (see instructions)	17, 177, 548	21.0
23. 00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24. 00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26. 00 Total swing-bed cost (see instructions) 27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28. 00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29. 00 Private room charges (excluding swing-bed charges) 30. 00 Swing-bed cost (see instructions) 31. 00 General inpatient routine service cost/charge ratio (line 27 + line 28) 32. 00 Average private room per diem charge (line 29 + line 3) 33. 00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 34. 00 Average per diem private room cost differential (line 34 x line 31) 35. 00 Average per diem private room cost differential (line 34 x line 31) 36. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 17, 177, 548) 37. 07 of the cost reporting period (line 20 to the cost reporting period (line 8 to the cost reporting period (line 9 x line 31 of the cost reporting period (line 9 x line 20 to the cost reporting period (line 14 x line	22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	22. 0
x line 18) Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) Ceneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT Ceneral inpatient routine service charges (excluding swing-bed and observation bed charges) Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) Ceneral inpatient routine service cost/charge ratio (line 27 + line 28) Ceneral inpatient routine service cost/charge ratio (line 27 + line 28) Average private room per diem charge (line 30 + line 4) Average per diem private room charge differential (line 32 minus line 33)(see instructions) Average per diem private room cost differential (line 34 x line 31) Private room cost differential adjustment (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential		5 x line 17)		
24. 00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26. 00 Total swing-bed cost (see instructions) 26. 00 Total swing-bed cost (see instructions) 27. 00 Deneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28. 00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 29. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 30. 01 Ogeneral inpatient routine service cost/charge ratio (line 27 * line 28) 30. 01 Average private room per diem charge (line 29 * line 3) 30. 01 Average semi-private room per diem charge (line 30 * line 4) 30. 01 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 30. 01 Average per diem private room cost differential (line 34 x line 31) 30. 01 Average per diem private room cost differential (line 34 x line 31) 30. 01 Average per diem private room cost differential (line 3 x line 35) 30. 01 Average per diem private room cost differential (line 3 x line 35) 30. 01 Average per diem private room cost differential (line 3 x line 35) 30. 01 Average per diem private room cost differential (line 3 x line 35) 30. 01 Average per diem private room cost differential (line 3 x line 35) 30. 01 Average per diem private room cost differential (line 3 x line 35) 30. 01 Average per diem private room cost differential (line 3 x line 35) 31. 00 Average per diem private room cost differential (line 3 x line 35) 32. 00 Average per diem private room cost differential (line 3 x line 35) 33. 00 Average per diem private room cost differential (line 3 x line 35) 34. 00 Average per diem private room cost differential (line 3 x line 35) 35. 00 Average per diem private room cost differential (line 3 x line 35) 36.	23. 00		0	23.0
7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 25. v line 20) Total swing-bed cost (see instructions) Ceneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT Ceneral inpatient routine service charges (excluding swing-bed and observation bed charges) Ceneral inpatient routine service charges (excluding swing-bed and observation bed charges) Ceneral inpatient routine service charges (excluding swing-bed charges) Ceneral inpatient routine service cost/charge ratio (line 27 ÷ line 28) Ceneral inpatient routine service cost/charge ratio (line 27 ÷ line 28) Ceneral inpatient routine service cost/charge ratio (line 27 ÷ line 28) Ceneral inpatient routine service cost/charge ratio (line 27 ÷ line 28) Ceneral inpatient routine service cost/charge ratio (line 30 ÷ line 4) Ceneral inpatient routine service cost charge (line 30 ÷ line 4) Ceneral inpatient routine service cost differential (line 32 minus line 33)(see instructions) Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 17, 177, 548) Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 17, 177, 548) Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 17, 177, 548) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost (line 92 × line 38) Ceneral inpatient routine service cost (line 92 × line 38) Ceneral inpatient routine service cost (line 92 × line 38) Ceneral inpatient routine service cost (line 92 × line 38) Ceneral inpatient routine service cost (line 92 × line 38) Ceneral inpatient routine service cost (line 92 × line 38) Ceneral inpatient routine service cost (line 92 × line 38) Ceneral inpatient routine service cost (line 92 × line 38) Ceneral inpatient routine service cost (line 92 × line 38) Ceneral inpatient routin				
25. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26. 00 Total swing-bed cost (see instructions) 27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28. 00 Private ROOM DIFFERENTIAL ADJUSTMENT 29. 00 Private room charges (excluding swing-bed and observation bed charges) 29. 00 Private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 31. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32. 00 Average private room per diem charge (line 29 ÷ line 3) 33. 00 Average semi-private room per diem charge (line 30 ÷ line 4) 34. 00 Average per diem private room cost differential (line 34 x line 31) 35. 00 Average per diem private room cost differential (line 34 x line 31) 36. 00 Private room cost differential adjustment (line 3 x line 35) 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	24. 00		0	24. 0
x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) Private room charges (excluding swing-bed charges) General inpatient routine service charges (excluding swing-bed and observation bed charges) O Private room charges (excluding swing-bed charges) O Semi-private room per diem charge (line 27 ÷ line 28) O Average private room per diem charge (line 29 ÷ line 3) O Average semi-private room per diem charge (line 30 ÷ line 4) O Average per diem private room cost differential (line 32 minus line 33) (see instructions) O Average per diem private room cost differential (line 34 x line 31) O Private room cost differential adjustment (line 3 x line 35) O Private room cost differential adjustment (line 3 x line 35) O General inpatient routine service cost net of swing-bed cost and private room cost differential (line 17, 177, 548 and 17, 177, 548 and 18, 190) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38. 00 O Program general inpatient routine service cost (line 9 x line 38) O Program general inpatient routine service cost (line 9 x line 38) O Medically necessary private room cost applicable to the Program (line 14 x line 35)	05 00	, ,	0	05.0
26. 00 Total swing-bed cost (see instructions) 27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29. 00 Pri vate room charges (excluding swing-bed charges) 30. 00 Semi-pri vate room charges (excluding swing-bed charges) 30. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 30. 00 Average pri vate room per diem charge (line 29 ÷ line 3) 30. 00 Average semi-private room per diem charge (line 30 ÷ line 4) 30. 00 Average per diem private room cost differential (line 32 minus line 33)(see instructions) 30. 00 Average per diem private room cost differential (line 34 x line 31) 30. 00 Foreal inpatient routine service cost net of swing-bed cost and private room cost differential (line 37 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 26. 27 minus line 36) Program general inpatient routine service cost (line 9 x line 38) 4, 692, 065 39.	25.00		0	25.0
27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRI VATE ROOM DIFFERENTIAL ADJUSTMENT 28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 9. 00 Pri vate room charges (excluding swing-bed charges) 9. 00 Semi-pri vate room charges (excluding swing-bed charges) 9. 00 Semi-pri vate room charges (excluding swing-bed charges) 9. 00 30. 31. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 9. 00 Average pri vate room per diem charge (line 29 ÷ line 3) 9. 00 Average semi-pri vate room per diem charge (line 30 ÷ line 4) 9. 00 Average per diem pri vate room cost differential (line 32 minus line 33)(see instructions) 9. 00 34. 35. 00 Average per diem pri vate room cost differential (line 34 x line 31) 9. 00 Average per diem pri vate room cost differential (line 3 x line 35) 9. 00 General inpatient routine service cost net of swing-bed cost and pri vate room cost differential (line 27 minus line 36) PART II - HOSPI TAL AND SUBPROVI DERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38. 00 Adjusted general inpatient routine service cost per diem (see instructions) 9. 00 Average per diem private room cost diem (see instructions) 9. 00 Average per diem private room cost diem private room co	24 00	,	0	24 0
PRI VATE ROOM DIFFERENTIAL ADJUSTMENT 28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 0 Pri vate room charges (excluding swing-bed charges) 0 Semi-pri vate room charges (excluding swing-bed charges) 0 Semi-pri vate room charges (excluding swing-bed charges) 0 Semi-pri vate room charges (excluding swing-bed charges) 0 Oseneral inpatient routine service cost/charge ratio (line 27 ÷ line 28) 0 Average pri vate room per diem charge (line 29 + line 3) 0 Average semi-pri vate room per diem charge (line 30 ÷ line 4) 0 Average per diem pri vate room charge differential (line 32 minus line 33) (see instructions) 0 Average per diem pri vate room cost differential (line 34 x line 31) 0 Average per diem pri vate room cost differential (line 34 x line 31) 0 Pri vate room cost differential adjustment (line 3 x line 35) 0 General inpatient routine service cost net of swing-bed cost and pri vate room cost differential (line 17, 177, 548 27 minus line 36) 0 PART II - HOSPITAL AND SUBPROVIDERS ONLY 0 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 0 Adjusted general inpatient routine service cost per diem (see instructions) 0 Program general inpatient routine service cost (line 9 x line 38) 0 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.		, , ,	-	
28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29. 00 Private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 31. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32. 00 Average private room per diem charge (line 29 ÷ line 3) 33. 00 Average semi-private room per diem charge (line 30 ÷ line 4) 34. 00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35. 00 Average per diem private room cost differential (line 34 x line 31) 36. 00 Private room cost differential adjustment (line 3 x line 35) 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 17, 177, 548) 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38. 00 Adjusted general inpatient routine service cost (line 9 x line 38) 4, 692, 065 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 28. 29. 29. 30. 40. 50. 50. 50. 50. 50. 50. 5	27.00		17, 177, 346	27.0
29. 00 Private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 31. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32. 00 Average private room per diem charge (line 29 ÷ line 3) 33. 00 Average semi-private room per diem charge (line 30 ÷ line 4) 34. 00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35. 00 Average per diem private room cost differential (line 34 x line 31) 36. 00 Private room cost differential adjustment (line 3 x line 35) 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 17, 177, 548) Adjusted general inpatient routine service cost per diem (see instructions) 38. 00 Adjusted general inpatient routine service cost (line 9 x line 38) 4, 692, 065 39. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 John Land Subration (line 27 + line 28) 0 John Semi-private room charges (excluding swing-bed charges) 0 John Semi-private room charges (excluding swing-bed charges) 0 John Semi-private room charges (excluding swing-bed charges) 0 John Semi-private room charges (line 27 + line 28) 0 John Semi-private room charges (line 27 + line 28) 0 John Semi-private room charges (line 27 + line 28) 0 John Semi-private room charges (line 27 + line 28) 0 John Semi-private room charges (line 29 + line 38) 0 John Semi-private room charges (line 27 + line 28) 0 John Semi-private room charges (line 27 + line 28) 0 John Semi-private room charges (line 27 + line 28) 0 John Semi-private room charges (line 27 + line 28) 0 John Semi-private room charges (line 27 + line 28) 0 John Semi-private room charges (line 27 + line 28) 0 John Semi-private room charges (line 27 + line 28) 0 John Semi-private room charges (line 27 + line 28) 0 John Semi-private room charges (line 29 + line 38) 0 John Semi-private room charges (line 29 + line 38) 0 John Semi-private room charges (line 29 + line 38) 0 John Semi-priv	28 00		Ω	28. 0
30. 00 Semi-private room charges (excluding swing-bed charges) 31. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32. 00 Average private room per diem charge (line 29 ÷ line 3) 33. 00 Average semi-private room per diem charge (line 30 ÷ line 4) 34. 00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35. 00 Average per diem private room cost differential (line 34 x line 31) 36. 00 Private room cost differential adjustment (line 3 x line 35) 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38. 00 Adjusted general inpatient routine service cost per diem (see instructions) 39. 00 Program general inpatient routine service cost (line 9 x line 38) 4, 692, 065 940. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 10. 00. 00. 00. 00. 00. 00. 00. 00. 00			-	
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 ÷ line 34) 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) 38.00 Program general inpatient routine service cost (line 9 x line 38) 4,692,065 39. 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 0.00 32. 0.00 32. 17.177,548 18.00 Average per diem charge (line 29 ÷ line 38) 0.00 0.00 33. 19.00 Program general inpatient routine service cost (line 9 x line 38) 10.00 Average per vate room per diem charge (line 29 ÷ line 38) 10.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions) 10.00 32. 10.00 33. 10.00 35. 10.00 35. 10.00 36. 10.00 36. 10.00 37. 10.00 36. 10.00 36. 10.00 37. 10.00 36. 10.00 36. 10.00 36. 10.00 36. 10.00 37. 10.00 36. 10.00 3			-	
32.00 Average private room per diem charge (line 29 ÷ line 3) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 36.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 17, 177, 548 and 18, 18, 19, 19, 19, 19, 19, 19, 19, 19, 19, 19				
33. 00 Average semi-private room per diem charge (line 30 ÷ line 4) 34. 00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35. 00 Average per diem private room cost differential (line 34 x line 31) 36. 00 Private room cost differential adjustment (line 3 x line 35) 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 17, 177, 548) 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38. 00 Adjusted general inpatient routine service cost per diem (see instructions) 10. 00 J 32. 38. 00 Average per diem private room cost differential (line 17, 177, 548) 17, 177, 548 J 37. 18. 00 Average per diem private room cost differential (line 17, 177, 548) 19, 10 J 20 J		i , , , , , , , , , , , , , , , , , , ,		
34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 34.00 Average per diem private room cost differential (line 34 x line 31) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 36.01 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 17, 177, 548) 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 10.00 Program general inpatient routine service cost (line 9 x line 38) 4,692,065 39. 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)				•
35. 00 Average per diem private room cost differential (line 34 x line 31) 36. 00 Private room cost differential adjustment (line 3 x line 35) 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 17, 177, 548 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38. 00 Adjusted general inpatient routine service cost per diem (see instructions) 97. 00 Program general inpatient routine service cost (line 9 x line 38) 10. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 10. 00 Jac. 10. 00 Jac. 11. 669. 18 12. 00 Jac. 13. 00 Jac. 13. 00 Jac. 14. 692, 065 15. 00 Jac. 16. 00 Jac. 17. 177, 548 17. 177, 548 18. 00 Jac. 19. 00 Jac. 10. 00 Jac. 11. 00 Jac. 12. 00 Jac. 13. 00 Jac. 14. 00 Jac. 15. 00 Jac. 16. 00 Jac. 17. 177, 548 17. 177,				1
36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Program general inpatient routine service cost (line 9 x line 38) 4,692,065 39. 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)				1
37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38. 00 Adjusted general inpatient routine service cost per diem (see instructions) 39. 00 Program general inpatient routine service cost (line 9 x line 38) 4, 692, 065 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.				36.0
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,669.18 38. 97.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 27. minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST ADJUSTMENTS 38. 00 Adjusted general inpatient routine service cost per diem (see instructions) 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)			-	
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) 1,669.18 38. 97.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 1,669.18 1,669.18 1,692.065 1,692.		' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '		
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,669.18 38.00 Program general inpatient routine service cost (line 9 x line 38) 4,692,065 39. 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.				1
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,669.18 38. 39.00 Program general inpatient routine service cost (line 9 x line 38) 4,692,065 39. 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.				1
39.00 Program general inpatient routine service cost (line 9 x line 38) 4,692,065 39. 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.	38. 00		1, 669. 18	38.0
	39. 00	Program general inpatient routine service cost (line 9 x line 38)	4, 692, 065	39.0
41.00 Total Program general inpatient routine service cost (line 39 + line 40) 4,692,065 41.	40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		
	41.00	Total Program general inpatient routine service cost (line 39 + line 40)	4, 692, 065	41.0

	Financial Systems ASCEMATION OF INPATIENT OPERATING COST	NOTON OF VINCE!	NT SETON SPECIA Provider C	CN: 15-2020	Peri od:	worksheet D-1	
					From 07/01/2021 To 06/30/2022	Date/Time Pre	nared:
						11/15/2022 12	: 36 pm
	Cost Center Description	Total	Ti tl e	Average Per	Hospital Program Days	PPS Program Cost	
	cost center bescription		Inpatient Days			(col. 3 x col.	
		1.00	0.00	col . 2)	4.00	4)	
42 00	NURSERY (title V & XIX only)	1. 00	2. 00	3. 00	4. 00	5. 00	42. 00
42.00	Intensive Care Type Inpatient Hospital Units						42.00
43.00	INTENSIVE CARE UNIT						43. 00
44. 00	CORONARY CARE UNIT						44.00
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 00 46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description						
48. 00	Program inpatient ancillary service cost (Wk:	st D2 col '	2 line 200)			1. 00 2, 228, 099	48. 00
49. 00	Total Program inpatient costs (sum of lines			ons)		6, 920, 164	1
	PASS THROUGH COST ADJUSTMENTS					., .,	
50. 00	Pass through costs applicable to Program inpa	atient routine	services (from	n Wkst. D, sum	of Parts I and	297, 797	50.00
51. 00		atient ancilla	ry services (fr	om Wkst. D, s	um of Parts II	64, 393	51.00
	and IV)		,				
52.00	Total Program excludable cost (sum of lines					362, 190	1
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line !		erated, non-pny	/sician anestn	etist, and	6, 557, 974	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION	02)					
54. 00							54.00
55. 00 56. 00						0.00	1
57. 00							57.00
58. 00	Bonus payment (see instructions)	g	g (.			0	
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996, เ	updated and co	mpounded by the	0.00	59. 00
60. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost report w	odated by the m	narket basket		0.00	60.00
61. 00	If line 53/54 is less than the lower of line				the amount by	0	
	which operating costs (line 53) are less than		ts (lines 54 x	60), or 1% of	the target		
62. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)				0	62. 00
63. 00	Allowable Inpatient cost plus incentive payment	ent (see instru	uctions)			ő	
	PROGRAM INPATIENT ROUTINE SWING BED COST					_	
64. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts through Dece	ember 31 of the	e cost reporti	ng period (See	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	per 31 of the o	cost reporting	period (See	0	65. 00
	instructions)(title XVIII only)				=		
66. 00	Total Medicare swing-bed SNF inpatient routing CAH (see instructions)	ne costs (line	64 plus line 6	ob)(title XVII	I only). For	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routing	e costs through	n December 31 d	of the cost re	porting period	0	67. 00
	(line 12 x line 19)					_	
68. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	e costs after l	December 31 of	the cost repo	rting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient	routine costs	(line 67 + line	e 68)		0	69. 00
	PART III - SKILLED NURSING FACILITY, OTHER NU	JRSING FACILITY	, AND ICF/IID	ONLY			
70.00	Skilled nursing facility/other nursing facili						70.00
71. 00 72. 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		Title 70 - Title	2)			71. 00 72. 00
73. 00	Medically necessary private room cost applications	,	m (line 14 x li	ne 35)			73. 00
74. 00	Total Program general inpatient routine serv	•					74.00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	e costs (from V	Worksheet B, P	art II, column		75. 00
76. 00	20, 1110 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00	Program capital-related costs (line 9 x line	76)					77. 00
78. 00	Inpatient routine service cost (line 74 minus		anavi dan maa	46)			78. 00 79. 00
/ 7. UU	9.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.						

Health Financial Systems ASCE	NSION ST VINCEN	T SETON SPECIAL	_TY	In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 07/01/2021 To 06/30/2022	Date/Time Pre 11/15/2022 12	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(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	1, 090, 197	17, 177, 548	0.06346	6 0	0	90. 00
91.00 Nursing Program cost	0	17, 177, 548	0.00000	0 0	0	91.00
92.00 Allied health cost	0	17, 177, 548	0.00000	0 0	0	92. 00
93.00 All other Medical Education	0	17, 177, 548	0. 00000	0 0	0	93. 00

Health Financial Systems	ASCENSION ST VINCENT S	SETON SPECIALTY	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 15-2020	Peri od:	Worksheet D-1	
			From 07/01/2021 To 06/30/2022	Date/Time Prep 11/15/2022 12:	pared: :36 pm
		Title XIX	Hospi tal	Cost	
Cost Center Description					
				1. 00	
PART I - ALL PROVIDER COMPONENTS					
I NPATI ENT DAYS					
1.00 Inpatient days (including private room	m days and swing-bed days	s, excluding newborn)		10, 291	1.00
2.00 Inpatient days (including private room	m days, excluding swing-b	ped and newborn days)		10, 291	2.00
3.00 Private room days (excluding swing-be	d and observation bed day	ys). If you have only pr	ivate room days,	0	3. 00

	Cost Center Description		
	DADT I ALL DROW DED COMPONENTS	1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS		1
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	10, 291	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	10, 291	2. 00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	0	3. 00
4 00	do not complete this line.	10 201	4 00
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation bed days) Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	10, 291 0	4. 00 5. 00
5.00	reporting period	o	3.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)		1
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	١	
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	12	9. 00
10.00	newborn days) (see instructions)	0	10.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	U	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12. 00
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13. 00
13.00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	١	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14. 00
15. 00	Total nursery days (title V or XIX only)	0	15. 00
16. 00	Nursery days (title V or XIX only)	0	16. 00
17. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0.00	17. 00
17.00	reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0. 00	18. 00
40.00	reporting period	2.22	40.00
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0. 00	19. 00
20. 00	Medicald rate for swing-bed NF services applicable to services after December 31 of the cost	0. 00	20. 00
	reporting period		1
21. 00	Total general inpatient routine service cost (see instructions)	17, 177, 548	•
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6)	0	23. 00
	x line 18)		
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24. 00
25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
25.00	x line 20)	٥	25.00
26. 00	Total swing-bed cost (see instructions)	0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	17, 177, 548	27. 00
00.00	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT		00.00
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges) Private room charges (excluding swing-bed charges)	0	28. 00 29. 00
30. 00	Semi -pri vate room charges (excluding swing-bed charges)	0	30.00
31. 00	General inpatient routine service cost/charge ratio (line 27 + line 28)	0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)	0. 00	32. 00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	0. 00	1
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)	0.00	1
35. 00 36. 00	Average per diem private room cost differential (line 34 x line 31) Private room cost differential adjustment (line 3 x line 35)	0. 00 0	35. 00 36. 00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	17, 177, 548	37.00
	27 minus line 36)	, ,	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
20 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routing corpulations and the cost partial cost instructions.	1, 669. 18	20 00
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38)	20, 030	38. 00 39. 00
40. 00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	20, 030	40.00
41. 00	Total Program general inpatient routine service cost (line 39 + line 40)		

41.00 | Total Program general inpatient routine service cost (line 39 + line 40) 20, 030 | 41. 00

COMPUTA	ATION OF INPATIENT OPERATING COST		Provi der (CCN: 15-2020	Peri od: From 07/01/2021	Worksheet D-1	
					To 06/30/2022	Date/Time Pre 11/15/2022 12	
	Cost Center Description	Total	Ti t	le XIX Average Per	Hospital Program Days	Cost Program Cost	
	cost conter bescription	Inpatient Cost				(col. 3 x col. 4)	
		1.00	2. 00	3.00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units						42. 00
43. 00	INTENSIVE CARE UNIT						43. 00
44. 00	CORONARY CARE UNIT						44. 00
45. 00	BURN INTENSIVE CARE UNIT						45. 00
46. 00 47. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
47.00	Cost Center Description			1			47.00
						1. 00	
48. 00 49. 00	Program inpatient ancillary service cost (Wks			one)		63, 854	48. 00
49.00	Total Program inpatient costs (sum of lines A PASS THROUGH COST ADJUSTMENTS	41 through 48)(see mstructi	ons)		83, 884	49. 00
50. 00	Pass through costs applicable to Program inpa	atient routine	services (fro	m Wkst. D, su	n of Parts I and	0	50. 00
51. 00	III) Pass through costs applicable to Program inpa	atient ancillar	v services (f	rom Wkst. D. :	sum of Parts II	0	51. 00
	and IV)		, (.				
52.00	Total Program excludable cost (sum of lines!			: -:+		0	52.00
53. 00	Total Program inpatient operating cost exclude medical education costs (line 49 minus line !		rated, non-pn	ysician anesti	netist, and	0	53. 00
	TARGET AMOUNT AND LIMIT COMPUTATION	,					
	Program di scharges					0	54.00
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)					0. 00 0	55. 00 56. 00
57. 00	Difference between adjusted inpatient operati	ing cost and ta	rget amount (line 56 minus	line 53)	0	57. 00
58. 00	Bonus payment (see instructions)	3	3 • • • • • • • • •		,	0	58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost remarket basket	porting period	endi ng 1996,	updated and c	ompounded by the	0. 00	59. 00
60. 00	Lesser of lines 53/54 or 55 from prior year (cost report, up	dated by the	market basket		0.00	60.00
61. 00	If line 53/54 is less than the lower of lines					0	61. 00
	which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see i		s (lines 54 x	60), or 1% o	f the target		
62. 00	Relief payment (see instructions)	instructions)				0	62. 00
63. 00	Allowable Inpatient cost plus incentive payme	ent (see instru	ctions)			0	63. 00
(4.00	PROGRAM INPATIENT ROUTINE SWING BED COST	t- th D	21 -5 +1			0	
64. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts through Dece	mber 31 of th	e cost report	ng period (See	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the	cost reportin	g period (See	0	65. 00
// 00	instructions)(title XVIII only)	(1:	/	/F) /±: ±1 = \/\/!	LL-)		// 00
66. 00	Total Medicare swing-bed SNF inpatient routing CAH (see instructions)	ne costs (iine	64 prus rine	65)(title XVI	i only). For	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routing	e costs through	December 31	of the cost r	eporting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine	o costs often D	ocombor 21 of	the cost ron	arting pariod	0	68. 00
00.00	(line 13 x line 20)	e costs after D	ecember 31 or	the cost rep	of tring period		00.00
69. 00	Total title V or XIX swing-bed NF inpatient (0	69. 00
70.00	PART III - SKILLED NURSING FACILITY, OTHER NU						70.00
70. 00 71. 00	Skilled nursing facility/other nursing facili Adjusted general inpatient routine service co	-)		70. 00 71. 00
72. 00	Program routine service cost (line 9 x line		70				72. 00
	Medically necessary private room cost applica	able to Program					73. 00
74. 00	Total Program general inpatient routine servi	•		•	Domt II!		74.00
75. 00	Capital-related cost allocated to inpatient (26, line 45)	ioutine service	costs (Trom	worksneet B, I	≃art II, COIUMN		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00	Program capital-related costs (line 9 x line	,					77. 00
78. 00	Inpatient routine service cost (line 74 minus		royldor ros	de)			78. 00 79. 00
/ 7. UU	79.00 Aggregate charges to beneficiaries for excess costs (from provider records)						

79.00

80.00

81.00

82.00

83.00

84. 00 85. 00

86.00

0 87.00 0.00 88.00 0 89.00

79.00 Aggregate charges to beneficiaries for excess costs (from provider records)

Program inpatient ancillary services (see instructions)
Utilization review - physician compensation (see instructions)
Total Program inpatient operating costs (sum of lines 83 through 85)
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST

Inpatient routine service cost limitation (line 9 x line 81)

Reasonable inpatient routine service costs (see instructions)

87.00 Total observation bed days (see instructions)
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)

89.00 Observation bed cost (line 87 x line 88) (see instructions)

Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) Inpatient routine service cost per diem limitation

81.00

82.00

83.00

84.00

85. 00 86. 00

Health Financial Systems ASCE	NSION ST VINCEN	T SETON SPECIAL	_TY	In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 07/01/2021 To 06/30/2022		
		Ti tl	e XIX	Hospi tal	11/15/2022 12 Cost	: 36 PIII
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	1, 090, 197	17, 177, 548	0.06346	6 0	0	90. 00
91.00 Nursing Program cost	0	17, 177, 548	0.00000	0	0	91.00
92.00 Allied health cost	0	17, 177, 548	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	17, 177, 548	0. 00000	0 0	0	93. 00

Heal th Fi	nancial Systems ASCENSION ST VINCENT SE	ETON SPECIA	LTY	In Lie	eu of Form CMS-2	2552-10
		Provi der CO		Peri od:	Worksheet D-3	
				From 07/01/2021 To 06/30/2022	Date/Time Prep 11/15/2022 12	
		Title	XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos		Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
			1.00	2.00	2)	
LN	PATIENT ROUTINE SERVICE COST CENTERS		1. 00	2. 00	3. 00	
	000 ADULTS & PEDIATRICS			9, 656, 648		30.00
	CILLARY SERVICE COST CENTERS			7, 030, 040		30.00
	OOO OPERATING ROOM		0. 22223	3 423, 759	94, 173	50.00
54.00 05	400 RADI OLOGY-DI AGNOSTI C		0. 22948			1
54. 01 03	630 ULTRA SOUND		0. 04037			54. 01
57. 00 05	700 CT SCAN		0. 04399	95, 820	4, 215	57. 00
60.00 06	000 LABORATORY		0. 04346	2, 488, 913	108, 188	60.00
	300 BLOOD STORING, PROCESSING & TRANS.		0.00000	0 0	0	63. 00
	500 RESPI RATORY THERAPY		0. 16177			1
•	600 PHYSI CAL THERAPY		0. 31555			66. 00
	700 OCCUPATI ONAL THERAPY		0. 27475			67. 00
	800 SPEECH PATHOLOGY		0. 31145		1	1
	900 ELECTROCARDI OLOGY		0. 00000		0	69. 00
	000 ELECTROENCEPHALOGRAPHY		0.00000		0	70.00
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 07128		1	1
	200 NPL. DEV. CHARGED TO PATIENTS		0.00000		0	72.00
	300 DRUGS CHARGED TO PATIENTS 400 RENAL DIALYSIS		0. 35929 0. 27635			1
200.00	Total (sum of lines 50 through 94 and 96 through 98)		0. 27635	12, 228, 914		1
200.00	Less PBP Clinic Laboratory Services-Program only charges	(line 61)		12, 220, 914		200.00
201.00	Net charges (line 200 minus line 201)	(TITIE OI)		12, 228, 914		201.00
202.00	inet charges (Title 200 militius Title 201)		l	12, 220, 714	i	1202.00

111-45 F:	ACCENCION CT VINCENT	CETON CDECLA	1. T.V	1 1:-	£ F CMC :	2552 40
	INCI LLARY SERVICE COST APPORTIONMENT	Provider C		Period:	u of Form CMS-2 Worksheet D-3	
	MOLEPHAT SERVICE 6631 ATTORTIONNEW	Trovider of		From 07/01/2021 To 06/30/2022		pared:
		Ti tl	e XIX	Hospi tal	Cost	
	Cost Center Description		Ratio of Cos		I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
	THE DOUTLING OFFICE COOK OFFICE		1.00	2. 00	3. 00	
	TIENT ROUTINE SERVICE COST CENTERS			407.0//		00.00
	O ADULTS & PEDI ATRI CS			197, 966		30. 00
	LLARY SERVICE COST CENTERS O OPERATING ROOM		0. 22223	3 5, 050	1, 122	50.00
	O RADI OLOGY-DI AGNOSTI C		0. 22223			ł
	O ULTRA SOUND		0. 26061			1
	O CT SCAN		0.04399		265	57.00
	O LABORATORY		0.04346			
	O BLOOD STORING, PROCESSING & TRANS.		0.00000		2, 342	63.00
1	O RESPI RATORY THERAPY		0. 16188		-	
	O PHYSI CAL THERAPY		0. 31555		2, 544	
1	O OCCUPATI ONAL THERAPY		0. 27475			67. 00
	O SPEECH PATHOLOGY		0. 31145			
69.00 0690	O ELECTROCARDI OLOGY		0.00000	0	0	69. 00
	O ELECTROENCEPHALOGRAPHY		0.00000	0	0	70. 00
71.00 0710	O MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 07128	9, 375	668	71. 00
72.00 0720	O IMPL. DEV. CHARGED TO PATIENTS		0.00000	0 0	0	72.00
73.00 0730	O DRUGS CHARGED TO PATIENTS		0. 35929	43, 761	15, 723	73. 00
74.00 0740	O RENAL DIALYSIS		0. 27635	3 0	0	74. 00
200.00	Total (sum of lines 50 through 94 and 96 through 98)			367, 559	63, 854	200. 00
201.00	Less PBP Clinic Laboratory Services-Program only charges	s (line 61)		0		201. 00
202.00	Net charges (line 200 minus line 201)			367, 559		202. 00

Health Financial Systems	ASCENSION ST VINCENT S	ETON SPECIALTY	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-2020	Peri od: From 07/01/2021 To 06/30/2022	Worksheet E Part B Date/Time Prepared: 11/15/2022 12:36 pm

	Ti	tle XVIII	Hospi tal	11/15/2022 12: PPS	:36 pm
			nespi tai		
	DADT B MEDICAL AND OTHER HEALTH SERVICES			1.00	
1. 00	PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions)			176	1.00
2. 00	Medical and other services reimbursed under OPPS (see instructions)			20, 531	2.00
3.00	OPPS payments			9, 543	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 instructions)			0.000	5. 00
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		Ö	9. 00
10.00	Organ acqui si ti ons			0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			176	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
12. 00	Reasonable charges Ancillary service charges			490	12. 00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			490	14.00
	Customary charges				
15. 00	Aggregate amount actually collected from patients liable for payment f			0	15.00
16. 00	Amounts that would have been realized from patients liable for payment	for services of	n a chargebasis	0	16. 00
17. 00	had such payment been made in accordance with 42 CFR §413.13(e) Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17. 00
18. 00	Total customary charges (see instructions)			490	
19. 00	Excess of customary charges over reasonable cost (complete only if lir	ne 18 exceeds Li	ne 11) (see	314	19. 00
	instructions)				
20. 00	Excess of reasonable cost over customary charges (complete only if line instructions)	ne 11 exceeds li	ne 18) (see	0	20. 00
21. 00	instructions) Lesser of cost or charges (see instructions)			176	21. 00
22. 00	Interns and residents (see instructions)			0	22. 00
23. 00	Cost of physicians' services in a teaching hospital (see instructions))		0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			9, 543	24. 00
05.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT				05.00
25. 00 26. 00	Deductibles and coinsurance amounts (for CAH, see instructions) Deductibles and Coinsurance amounts relating to amount on line 24 (for	· CΔH see instr	uctions)	0 1, 861	25. 00 26. 00
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the			7, 858	
	instructions)		(,,,,,,,	
28. 00	Direct graduate medical education payments (from Wkst. E-4, line 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)			7, 858 0	30. 00 31. 00
32. 00	Primary payer payments Subtotal (line 30 minus line 31)			7, 858	ł
02.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)			1,7000	02.00
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0	33. 00
34. 00	Allowable bad debts (see instructions)			0	34. 00
35. 00	Adjusted reimbursable bad debts (see instructions)			0	35. 00 36. 00
36. 00 37. 00	Allowable bad debts for dual eligible beneficiaries (see instructions) Subtotal (see instructions)	,		7, 858	
38. 00				0	
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)				39. 50
39. 97	Demonstration payment adjustment amount before sequestration			0	39. 97
39. 98 39. 99	Partial or full credits received from manufacturers for replaced device	es (see instruc	tions)	0	39. 98 39. 99
40. 00	RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions)			7, 858	
40. 01	Sequestration adjustment (see instructions)			20	40. 01
40. 02	Demonstration payment adjustment amount after sequestration			0	40. 02
40. 03	Sequestration adjustment-PARHM pass-throughs				40. 03
41. 00	Interim payments			7, 841	•
41. 01 42. 00	Interim payments-PARHM			0	41. 01 42. 00
42. 00	Tentative settlement (for contractors use only) Tentative settlement-PARHM (for contractor use only)				42.00
43. 00	Balance due provider/program (see instructions)			-3	1
43. 01	Balance due provider/program-PARHM (see instructions)				43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordance with	CMS Pub. 15-2,	chapter 1,	0	44. 00
	§115. 2				
90. 00	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)			0	90.00
91. 00	Outlier reconciliation adjustment amount (see instructions)			0	91.00
92. 00	The rate used to calculate the Time Value of Money			0.00	
93. 00	Time Value of Money (see instructions)			0	93. 00
94. 00	Total (sum of lines 91 and 93)			0	94. 00

Health Financial Systems	ASCENSION ST VINCENT SETON SPECIALTY	In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-2020	From 07/01/2021	Worksheet E Part B Date/Time Pre 11/15/2022 12	
	Title XVIII	Hospi tal	PPS	
·				
			1. 00	
MEDICARE PART B ANCILLARY COSTS				
200.00 Part B Combined Billed Days			0	200. 00

Number

1 00

2 00

8.00

0

Provider CCN: 15-2020 Peri od: Worksheet E-1 From 07/01/2021 Part I 06/30/2022 Date/Time Prepared: 11/15/2022 12:36 pm Title XVIII Hospi tal PPS Part B Inpatient Part A mm/dd/yyyy mm/dd/yyyy Amount Amount 1.00 2.00 3.00 4.00 1.00 Total interim payments paid to provider 4, 726, 411 7, 841 1. 00 2.00 Interim payments payable on individual bills, either 2.00 submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 3.00 List separately each retroactive lump sum adjustment 3.00 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 3.01 ADJUSTMENTS TO PROVIDER 0 0 3.01 0 3.02 0 3.02 3.03 0 3.03 0 3.04 0 0 3.04 3.05 0 0 3.05 Provider to Program 3.50 ADJUSTMENTS TO PROGRAM 0 0 3.50 3.51 0 3.51 0 0 3.52 3.52 0 3.53 3.53 0 0 3.54 0 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 0 0 3.99 3.50-3.98) 7, 841 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 4, 726, 411 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropri ate) TO BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after 5.00 desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 TENTATIVE TO PROVIDER 0 0 5.01 5.02 0 0 5.02 0 5.03 0 5.03 Provider to Program 5.50 TENTATI VE TO PROGRAM 0 0 5.50 5.51 0 0 5. 51 0 5.52 0 5.52 5. 99 0 Subtotal (sum of lines 5.01-5.49 minus sum of lines 0 5. 99 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on 6.00 the cost report. (1) SETTLEMENT TO PROVIDER 6.01 0 6.01 76, 001 6 02 SETTLEMENT TO PROGRAM 3 6.02 7.00 Total Medicare program liability (see instructions) 4, 650, 410 7, 838 7.00 Contractor NPR Date (Mo/Day/Yr)

8.00 Name of Contractor

Health Financial Systems	ASCENSION ST VINCENT S	SETON SPECIALTY	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 15-2020	From 07/01/2021	Worksheet E-3 Part IV Date/Time Prepared: 11/15/2022 12:36 pm

			10 00/30/2022	11/15/2022 12	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART IV - MEDICARE PART A SERVICES - LTCH PPS				
	Net Federal PPS Payments (see instructions)			4, 379, 363	1. (
	Full standard payment amount			3, 579, 669	1. (
	Short stay outlier standard payment amount			799, 694	1. (
	Site neutral payment amount - Cost			0	1. (
	Site neutral payment amount - IPPS comparable			0	1.
	Outlier Payments			733, 343	2.
	Total PPS Payments (sum of lines 1 and 2)			5, 112, 706	
	Nursing and Allied Health Managed Care payments (see instructi	ons)		0	4.
	Organ acquisition (DO NOT USE THIS LINE)				5.
	Cost of physicians' services in a teaching hospital (see instr	ructions)		0	6. (
	Subtotal (see instructions)			5, 112, 706	7.
	Primary payer payments			4, 658	
00	Subtotal (line 7 less line 8).			5, 108, 048	9.
	Deducti bl es			0	10.
1.00	Subtotal (line 9 minus line 10)			5, 108, 048	11.
	Coi nsurance			595, 314	12.
	Subtotal (line 11 minus line 12)			4, 512, 734	13.
	Allowable bad debts (exclude bad debts for professional servic	ces) (see instructions)		229, 740	
5. 00	Adjusted reimbursable bad debts (see instructions)			149, 331	15.
. 00	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		209, 451	16.
7.00	Subtotal (sum of lines 13 and 15)			4, 662, 065	17.
3. 00 I	Direct graduate medical education payments (from Wkst. E-4, li	ne 49)		0	18.
9.00	Other pass through costs (see instructions)			0	19.
0.00	Outlier payments reconciliation			0	20.
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	21.
. 50 I	Pioneer ACO demonstration payment adjustment (see instructions	s)		0	21.
. 98 I	Recovery of accelerated depreciation.			0	21.
l. 99	Demonstration payment adjustment amount before sequestration			0	21.
2.00	Total amount payable to the provider (see instructions)			4, 662, 065	22.
2. 01	Sequestration adjustment (see instructions)			11, 655	22.
2. 02 I	Demonstration payment adjustment amount after sequestration			0	22.
3. 00	Interim payments			4, 726, 411	23.
1.00	Tentative settlement (for contractor use only)			0	24.
i. 00 I	Balance due provider/program (line 22 minus lines 22.01, 22.02	2, 23 and 24)		-76, 001	25.
	Protested amounts (nonallowable cost report items) in accordar §115.2	nce with CMS Pub. 15-2,	chapter 1,	0	26.
	TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount from Wkst. E-3, Pt IV, line 2 (see ins	structions)		733, 343	
	Outlier reconciliation adjustment amount (see instructions)			0	51.
	The rate used to calculate the Time Value of Money (see instru	ıcti ons)		0. 00	
3.00	Time Value of Money (see instructions)			0	53.

Health Financial Systems	ASCENSION ST VINCENT SETON SPECIALTY	In	Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-2020	Peri od:	Worksheet E-3

From 07/01/2021 | Part VII 06/30/2022 Date/Time Prepared: 11/15/2022 12:36 pm Hospi tal Title XIX Cost Inpati ent Outpati ent 1.00 2.00 PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES COMPUTATION OF NET COST OF COVERED SERVICES 1.00 Inpatient hospital/SNF/NF services 83, 884 1.00 Medical and other services 2.00 2.00 Λ 3.00 Organ acquisition (certified transplant centers only) 3.00 Subtotal (sum of lines 1, 2 and 3) 4.00 83, 884 4.00 5.00 Inpatient primary payer payments 5.00 Outpatient primary payer payments 6.00 Ω 6.00 7.00 Subtotal (line 4 less sum of lines 5 and 6) 83, 884 0 7.00 COMPUTATION OF LESSER OF COST OR CHARGES Reasonable Charges 8.00 Routine service charges 197, 966 8.00 9.00 Ancillary service charges 0 9.00 367, 559 10.00 Organ acquisition charges, net of revenue 10.00 0 11 00 Incentive from target amount computation 11 00 0 565, 525 12.00 Total reasonable charges (sum of lines 8 through 11) 0 12.00 CUSTOMARY CHARGES Amount actually collected from patients liable for payment for services on a charge 13.00 0 13.00 basi s 14.00 Amounts that would have been realized from patients liable for payment for services on 0 0 14.00 a charge basis had such payment been made in accordance with 42 CFR §413.13(e) 15.00 Ratio of line 13 to line 14 (not to exceed 1.000000) 0.000000 0.000000 15.00 16.00 Total customary charges (see instructions) 565, 525 16.00 17.00 17.00 Excess of customary charges over reasonable cost (complete only if line 16 exceeds 481, 641 0 line 4) (see instructions) 18.00 Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 0 18.00 (see instructions) 19.00 Interns and Residents (see instructions) 0 19.00 0 20.00 Cost of physicians' services in a teaching hospital (see instructions) 0 20.00 21.00 Cost of covered services (enter the lesser of line 4 or line 16) 83, 884 0 21.00 PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers 22.00 0 0 22.00 Other than outlier payments 0 23.00 23.00 Outlier payments Λ 24.00 Program capital payments 0 24.00 0 25.00 Capital exception payments (see instructions) 25.00 26 00 Routine and Ancillary service other pass through costs 0 26 00 0 27.00 Subtotal (sum of lines 22 through 26) 0 27.00 Customary charges (title V or XIX PPS covered services only) 0 28.00 28.00 29.00 Titles V or XIX (sum of lines 21 and 27) 83, 884 0 29.00 COMPUTATION OF REIMBURSEMENT SETTLEMENT 30.00 Excess of reasonable cost (from line 18) 0 30.00 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 83, 884 0 31.00 32.00 Deducti bl es 32.00 0 0 33 00 33 00 Coi nsurance 0 0 34.00 Allowable bad debts (see instructions) 0 Ω 34.00 35.00 Utilization review 35.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 36, 00 83.884 36, 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 37.00 0 37.00 38.00 Subtotal (line 36 ± line 37) 83, 884 38.00 0 Direct graduate medical education payments (from Wkst. E-4) 39.00 39.00 40.00 Total amount payable to the provider (sum of lines 38 and 39) 83.884 0 40.00 41.00 Interim payments 83, 884 0 41.00 Balance due provider/program (line 40 minus line 41) 42.00 0 42.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 43.00 43.00 0

chapter 1, §115.2

Health Financial Systems

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column onl y)

Provider CCN: 15-2020

Peri od: From 07/01/2021 To 06/30/2022 Date/Ti me Prepared: 11/15/2022 12:36 pm

OH y)					11/15/2022 12	:36 pm
		General Fund		Endowment Fund	Plant Fund	
		1.00	Purpose Fund 2.00	3. 00	4. 00	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
1.00	Cash on hand in banks	500	0	0	0	
2.00	Temporary investments	0	Ί	_		
3. 00	Notes receivable	0	0	0	0	
4.00	Accounts receivable	11, 716, 760		0	0	
5.00	Other receivable	4 ((0 (01	0	0	0	
6. 00 7. 00	Allowances for uncollectible notes and accounts receivable Inventory	-4, 668, 691 478, 776		0	0	
8. 00	Prepai d expenses	655		0	0	
9. 00	Other current assets	665, 450		0	0	
10.00	Due from other funds	0	Ō	Ō	0	
11. 00	Total current assets (sum of lines 1-10)	8, 193, 450	0	0	0	11. 00
	FIXED ASSETS					
12. 00	Land	847, 629		_	0	1
13. 00	Land improvements	242, 832		_	0	
14. 00	Accumulated depreciation	-30, 046		_	_	1
15. 00 16. 00	Buildings	15, 901, 288 -11, 124, 242	1	0	0	
17. 00	Accumulated depreciation Leasehold improvements	436, 760	1	0	0	
18. 00	Accumulated depreciation	-53, 700	1	_	0	
19. 00	Fi xed equipment	1, 186, 261	1	_	0	
20.00	Accumulated depreciation	-1, 069, 288	1	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21. 00
22. 00	Accumulated depreciation	0	0	0	0	
23. 00	Major movable equipment	5, 961, 135	1	0	0	
24. 00	Accumulated depreciation	-5, 160, 314	1	0	0	1
25. 00	Mi nor equipment depreciable	0	0	_	0	
26. 00 27. 00	Accumulated depreciation HIT designated Assets		0	0	0	
28. 00	Accumulated depreciation		0	0	0	
29. 00	Mi nor equi pment-nondepreci abl e			_	0	
30.00	Total fixed assets (sum of lines 12-29)	7, 138, 315	0	0	0	
	OTHER ASSETS					
31. 00	Investments	0	0	0		
32. 00	Deposits on Leases	0	0	_		
33. 00	Due from owners/officers	0	0	_	0	
34. 00	Other assets	30, 640			0	1
35. 00 36. 00	Total other assets (sum of lines 31-34) Total assets (sum of lines 11, 30, and 35)	30, 640 15, 362, 405		_	-	
30.00	CURRENT LIABILITIES	13, 302, 403	,		0	30.00
37. 00	Accounts payable	146, 905	0	0	0	37. 00
38.00	Salaries, wages, and fees payable	735, 720	1	0	0	38. 00
39. 00	Payroll taxes payable	0	0	0	0	39. 00
40.00	Notes and Loans payable (short term)	0	0	0	0	1
41. 00	Deferred income	0	0	0	0	
42. 00	Accel erated payments	0			_	42. 00
43. 00 44. 00	Due to other funds Other current liabilities	2, 911, 469	0	0	0	
45.00	Total current liabilities (sum of lines 37 thru 44)	3, 794, 094		_		1
43.00	LONG TERM LIABILITIES	3, 774, 074		0	0	43.00
46.00	Mortgage payable	0	0	0	0	46. 00
47.00	Notes payable	0	0	0		
48. 00	Unsecured Loans	0	0	0	0	48. 00
49. 00	Other long term liabilities	402, 434		0	0	
50.00	Total long term liabilities (sum of lines 46 thru 49)	402, 434				
51. 00	Total liabilities (sum of lines 45 and 50)	4, 196, 528	0	0	0	51.00
E2 00	CAPITAL ACCOUNTS General fund balance	11 1/5 077	,			F2 00
52. 00 53. 00	Specific purpose fund	11, 165, 877	0			52. 00 53. 00
54. 00	Donor created - endowment fund balance - restricted			0		54.00
55. 00	Donor created - endowment fund balance - unrestricted			Ö		55. 00
56. 00	Governing body created - endowment fund balance			0		56.00
57. 00	Plant fund balance - invested in plant		1		0	57. 00
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
	repl acement, and expansi on					
59. 00	Total fund balances (sum of lines 52 thru 58)	11, 165, 877		0	0	
60. 00	Total liabilities and fund balances (sum of lines 51 and 59)	15, 362, 405	0		0	60.00
	l∝,\	I	I	I	ı	1

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-2020

| Peri od: | From 07/01/2021 | To 06/30/2022 | Date/Ti me Prepared:

					To 06/30/2022	2 Date/Time Pre 11/15/2022 12	
		General	Fund	Special P	urpose Fund	Endowment Fund	. 30 piii
				'	<u>'</u>		
		1.00	2. 00	3. 00	4. 00	5. 00	
1. 00	Fund balances at beginning of period		10, 211, 317		1	O	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		954, 561				2. 00
3.00	Total (sum of line 1 and line 2)	_	11, 165, 878		-	0	3. 00
4.00	Additions (credit adjustments) (specify)	0			0	0	4. 00
5.00		0			0	0	5. 00
6.00		0			0	0	6. 00
7.00		0			0	0	7. 00
8.00		0			0	0	8. 00
9.00	T	0			0	0	9.00
10.00	Total additions (sum of line 4-9)		0		1	0	10.00
11.00	Subtotal (line 3 plus line 10)		11, 165, 878		(0	11.00
12.00	Deductions (debit adjustments) (specify)	0			0	0	12.00
13.00	ROUNDI NG				0	0	13.00
14.00		0			0	0	14.00
15.00		0			0	0	15.00
16.00		0			0	0	16.00
17.00	T-+-1 d-d+: (6 l: 12 17)	0	1		0	0	17. 00
18.00	Total deductions (sum of lines 12-17)		11 1/5 077				18.00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)		11, 165, 877		1	J	19. 00
	Islieet (Title II illitius Title 16)	Endowment Fund	PI ant	Fund			
		Endownierre Turia	TTGITE	T dila			
		6.00	7. 00	8. 00			
1. 00	Fund balances at beginning of period	0			0		1, 00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	O			О		3. 00
4.00	Additions (credit adjustments) (specify)		0				4. 00
5.00	, , , , , , , , , , , , , , , , , , ,		0				5. 00
6.00			0				6. 00
7. 00			0				7. 00
8.00			0				8. 00
9.00			o				9. 00
10.00	Total additions (sum of line 4-9)	o			o		10.00
11. 00	Subtotal (line 3 plus line 10)	O			O		11.00
12. 00	Deductions (debit adjustments) (specify)		0				12.00
13. 00	ROUNDI NG		0				13. 00
14. 00	The state of the s		0				14. 00
15. 00			0				15. 00
16. 00			0				16.00
17. 00			n				17. 00
18. 00	Total deductions (sum of lines 12-17)	o			o		18.00
19. 00	Fund balance at end of period per balance				0		19.00
17.00	sheet (line 11 minus line 18)	1			<u> </u>		17.00
	12	1		1	1	· ·	1

Health Financial Systems ASCENSION ST VINCENT SETON SPECIALTY In Lieu of Form CMS-2552-10 STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-2020 Peri od: Worksheet G-2 From 07/01/2021 Parts I & II Date/Time Prepared: 06/30/2022 11/15/2022 12:36 pm Cost Center Description Outpati ent Inpati ent Total 1.00 2. 00 3.00 PART I - PATIENT REVENUES General Inpatient Routine Services 1.00 Hospi tal 36, 187, 249 36, 187, 249 1.00 2.00 SUBPROVIDER - IPF 2.00 3.00 SUBPROVIDER - IRF 3.00 4.00 SUBPROVI DER 4.00 Swing bed - SNF Swing bed - NF 5.00 0 0 5.00 6.00 0 6.00 0 SKILLED NURSING FACILITY 7.00 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) 36, 187, 249 36, 187, 249 10 00 Intensive Care Type Inpatient Hospital Services 11.00 INTENSIVE CARE UNIT 11.00 12.00 CORONARY CARE UNIT 12.00 BURN INTENSIVE CARE UNIT 13 00 13 00 SURGICAL INTENSIVE CARE UNIT 14.00 14.00 15.00 OTHER SPECIAL CARE (SPECIFY) 15.00 Total intensive care type inpatient hospital services (sum of lines 16, 00 0 0 16, 00 11 - 15) 17.00 36, 187, 249 17.00 Total inpatient routine care services (sum of lines 10 and 16) 36, 187, 249 18.00 Ancillary services 42, 844, 925 92, 573 42, 937, 498 18.00 Outpatient services 19.00 0 19.00 RURAL HEALTH CLINIC 20.00 0 0 0 20.00 21.00 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 21.00 22. 00 HOME HEALTH AGENCY 22.00 AMBULANCE SERVICES 23.00 23.00 CMHC 24.00 24.00

Health Financial Systems	ASCENSION ST VINCENT SETON SPECIALTY		ASCENSION ST VINCENT SETON SPECIALTY			In Lieu of Form CMS-2552-10
STATEMENT OF DEVENUES AND EXPENSES		Providor CCN: 15 2020	Pari ad:	Workshoot C 2		

Heal th	Financial Systems ASCENSION ST VINCENT	Γ SETON SPECIALTY	In Lie	eu of Form CMS-2	2552-10
STATEM	ENT OF REVENUES AND EXPENSES	Provi der CCN: 15-2020	Peri od:	Worksheet G-3	
			From 07/01/2021		
			To 06/30/2022		
				11/15/2022 12	: 36 pm
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, li	ino 20)		79, 124, 747	1. 00
2.00	Less contractual allowances and discounts on patients' accounts			52, 674, 411	2.00
3.00	Net patient revenues (line 1 minus line 2)	uits		26, 450, 336	3.00
4. 00	Less total operating expenses (from Wkst. G-2, Part II, line	a 43)		25, 786, 344	ı
5.00	Net income from service to patients (line 3 minus line 4)	6 43)		663, 992	5. 00
3.00	OTHER I NCOME			003, 772	3.00
6.00	Contributions, donations, bequests, etc			0	6.00
7. 00	Income from investments			Ö	7. 00
8.00	Revenues from telephone and other miscellaneous communication	on services		0	8.00
9. 00	Revenue from television and radio service	o oo. v. ooo		0	9.00
10. 00	Purchase di scounts			0	10.00
11. 00	Rebates and refunds of expenses			0	11.00
12. 00	Parking lot receipts			0	12.00
	Revenue from Laundry and Linen service			o o	13.00
14. 00	Revenue from meals sold to employees and guests			60, 673	
	Revenue from rental of living quarters			0	ı
	Revenue from sale of medical and surgical supplies to other	than patients		Ö	16. 00
	Revenue from sale of drugs to other than patients	than patronto		Ö	17. 00
18. 00	Revenue from sale of medical records and abstracts			0	18. 00
	Tuition (fees, sale of textbooks, uniforms, etc.)			Ö	19. 00
	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
	Rental of vending machines			1, 137	1
22. 00	Rental of hospital space			0	22. 00
23. 00	Governmental appropriations			o o	23. 00
24. 00	MI SCELLANEOUS REVENUE			21, 889	
	NET ASSETS FROM RESTRICTED FUNDS			21,007	24. 01
24. 02	UNRESTRICTED DONATIONS			0	24. 02
24. 03	PATIENT INTERENST INCOME			428	
24. 04	HHS STIMULU OP REV 30B			5, 825	•
24. 05	FOUNDATION INTERCOMPANY TRANSFER			0,020	24. 05
24. 06	SEMINARS TUITION REVENUE			o o	24. 06
24. 07	MEDICAL AFFAIRS ADMIN - ADMINISTRATI			o o	24. 07
24. 08	GAIN ON SALE OF PPE			0	24. 08
24. 09	INTRA/INTERCOMPANY OPERATING REVENUE			8, 097	1
24. 10	AUXILIARY/GIFT SHOP INCOME			0,077	24. 10
	BILLING ARRANGEMENTS			o o	24. 11
24. 12	UNCLAI MED PROPERTY			406	24. 12
	COVI D-19 PHE Fundi ng			192, 114	1
	Total other income (sum of lines 6-24)			290, 569	1
	Total (line 5 plus line 25)			954, 561	
	OTHER EXPENSES (SPECIFY)			0	27. 00
	Total other expenses (sum of line 27 and subscripts)			0	28. 00
	Net income (or loss) for the period (line 26 minus line 28)			954, 561	•
27.30	1 (2. 1000) 101 the port of (1110 20 million 11110 20)			, , , , , , , ,	00