Health Financial Systems ASCENSION ST VI				of Form CMS-25	52-10
This report is required by law (42 USC 1395g; 42 CFR 413.20(b)	). Failur∉	e to report can resul	t in all interim	FORM APPROVED	
payments made since the beginning of the cost reporting period	being dee	med overpayments (42	2 USC 1395g).	OMB NO. 0938-00 EXPIRES 03-31-2	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFIC. AND SETTLEMENT SUMMARY	ATI ON Pro	ovider CCN: 15-1314	Period: From 07/01/2021 To 06/30/2022	Worksheet S Parts I-III Date/Time Prepa 11/29/2022 10:4	
PART I - COST REPORT STATUS					
Provider 1. [X] Electronically prepared cost report			Date: 11/29/20	022 Time: 10:	42 am
use only 2.[ ]Manually prepared cost report					
3.[ 0 ]If this is an amended report enter the n 4.[ F ]Medicare Utilization. Enter "F" for full	or "L" f	times the provider re or low.	esubmitted this co	st report	
Contractor use only5. [1] Cost Report Status (1) As Submitted6. Date Received: 7. Contractor No. (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended6. Date Received: 7. Contractor No. (7. Contractor No. 	oort for t t for thi	11.0 nis Provider CCN 12.		r Code: lumn 1 is 4: En es reopened = 0:	
PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINI	STRATOR O	PROVIDER(S)			
MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINE ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTL' ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.	D IN THIS LAW. FURT	COST REPORT MAY BE F HERMORE, IF SERVICES	G IDENTIFIED IN TH	IS REPORT WERE	
CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRA	TOR OF PR	OVI DER(S)			
I HEREBY CERTIFY that I have read the above certificat electronically filed or manually submitted cost report Statement of Revenue and Expenses prepared by ASCENSIO reporting period beginning 07/01/2021 and ending 06/30 report and statement are true, correct, complete and p accordance with applicable instructions, except as not regulations regarding the provision of health care ser report were provided in compliance with such laws and	and submi N ST VINC /2022 and repared fi ed. I fur vices, and regulatio	tted cost report and ENT SALEM HOSPITAL ( to the best of my kr rom the books and rec ther certify that I is that the services i	d the Balance Shee 15-1314 ) for the nowledge and belie cords of the provi am familiar with t identified in this	t and cost f, this der in he laws and	
SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	CHECKBOX		ELECTRONI C		
1	2		NATURE STATEMENT		
	v	I have read and agrest statement. I certify			1

	Chris	
2	2 Signatory Printed Name Chri	2 Si
3	3 Signatory Title VP 0	3 Si
4	4 Date 11/2	4 Da
_	3 Signatory Title VP 0	3 Si

			Title XVIII				
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	157, 509	417, 377	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	61, 616	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200.00	Total	0	219, 125	417, 377	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.

	AL AND HOST THE HEALTH GAILE COMPLEX	IDENTIFICATION DATA	Provid	ler CCN: 1		Period: From 07/01/ To 06/30/		Part I Date/T		epared:
	1.00	2.00		3.00		,	1.00	11/29/	2022 10	): 42 ar
	Hospital and Hospital Health Care Co			3.00			+. 00			
00	Street: 911 N. SHELBY STREET	P0 Box:								1.0
00	City: SALEM	State: IN	Zip Cod	e: 47167	Count	y: WASHINGT	NC			2.0
	· · · · · · ·	Component Name	CCN	CBSA	Provi der	Date	Payme	ent Syst	tem (P,	
			Number	Number	Туре	Certified		, 0, or		
							V	XVIII	_	_
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
~~	Hospital and Hospital-Based Componen		454044	01110		40 (04 (0000	N	0		
00	Hospi tal	ASCENSION ST VINCENT	151314	31140	1	12/01/2002	Ν	0	0	3.0
00	Subprovider - IPF	SALEM HOSPITAL								4.0
00	Subprovider - IRF									5.0
00	Subprovider - (Other)									6.0
00	Swing Beds - SNF	ASCENSION ST VINCENT	15Z314	31140		12/01/2002	N	0	N	7.0
00	Swing beds - Shi	SALEM SWING	152514	51140		12/01/2002	IN IN			/.0
00	Swing Beds - NF	SALEM SWING								8.0
00	Hospital-Based SNF									9.0
. 00	Hospital -Based NF									10.0
. 00	Hospi tal -Based OLTC									11. (
. 00	Hospi tal -Based HHA		1							12. (
. 00	Separately Certified ASC		1							13. (
. 00	Hospi tal -Based Hospi ce									14.0
. 00	Hospital-Based Health Clinic - RHC				1					15.0
. 00	Hospital-Based Health Clinic - FQHC									16.
00	Hospital-Based (CMHC) I									17.
00	Renal Dialysis									18.
00	Other									19.
						From:		To		4
						1.00		2.		
	Cost Reporting Period (mm/dd/yyyy)					07/01/20	021	06/30	/2022	20.
. 00	Type of Control (see instructions)					1				21.
					1 00				~ ~	-
					1.00	2.00		3.	00	
	Inpatient PPS Information		manta fa					3.	00	
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. 00	Does this facility qualify and is it disproportionate share hospital adju	stment, in accordance w	íth 42 CFI					3.	00	22.0
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01 02 03	Does this facility qualify and is it disproportionate share hospital adju §412.106? In column 1, enter "Y" fo facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fo Did this hospital receive interim un cost reporting period? Enter in colu the portion of the cost reporting pe Enter in column 2, "Y" for yes or "N reporting period occurring on or aft Is this a newly merged hospital that payments to be determined at cost re Enter in column 1, "Y" for yes or "N cost reporting period prior to Octob or "N" for no, for the portion of th October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in co for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft boes this hospital receive a geograph rural as a result of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft boes this hospital receive a geograph rural as a result of the revised OMB adopted by CMS in FY 2021? Enter in c for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft boes this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Which method is used to determine Me	stment, in accordance w r yes or "N" for no. Is 412.106(c)(2)(Pickle am r yes or "N" for no. compensated care paymen mn 1, "Y" for yes or "N riod occurring prior to "for no for the portio er October 1. (see inst requires final uncompe port settlement? (see i "for no, for the porti er 1. Enter in column 2 e cost reporting period ic reclassification fro ds for delineating stat olumn 1, "Y" for yes or g period prior to Octob no for the portion of t er October 1. (see inst 100 but not more than 4 2.105)? Enter in column ic reclassification fro delineations for stati column 1, "Y" for yes o g period prior to Octob no for the portion of t er October 1. (see inst 100 but not more than 4 2.105)? Enter in column dic reclassification fro delineations for stati column 1, "Y" for yes o g period prior to Octob no for the portion of t en October 1. (see inst 100 but not more than 4 2.105)? Enter in column dicaid days on lines 24 of admission, 2 if cens of identifying the days	th 42 CFI this endment ts for thi "for no f October of n of the of structions) nsated can nstruction on of the struction on of the struction on or aff m urban to istical au "N" for rer 1. Enton he cost ructions) 99 beds (a 3, "Y" for m urban to stical are r "N" for er 1. Enton he cost ructions) 99 beds (a n 3, "Y" for he cost ructions) 99 beds (a h 3, "Y" for he cost stical are ructions) 99 beds (a h 3, "Y" for he cost stical are ructions)	s For L. cost re ns) yes ter preas no er as pr as for as for as for 3 5 7 8	N N N	N N N N		ľ	J	22. 22. 22. 22.

Health Financial Systems ASCENSION S	T VINCENT SA	ALEM HOSPIT.	AL		In Lieu	of Form	CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION D	ATA	Provider CC	N: 15-1314	Period: From 07/0 To 06/30	1/2021 F 0/2022 D	orkshee art l ate/Tin 1/29/20	ne Prep	pared:
	In-State Medicaid paid days	In-State Medicaid eligible unpaid days 2.00	Out-of State Medicaid paid days 3.00	Out-of State Medicaid eligible unpaid 4.00	Medicaio HMO days	s Medi da	her caid lys 00	
24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in	0			0		0	0	24.00
column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0		0		25. 00
				Urban/Ri	ural S D 00	ate of 2.00		
26.00 Enter your standard geographic classification (not w cost reporting period. Enter "1" for urban or "2" fo		at the beg	jinning of t		2			26.00
27.00 Enter your standard geographic classification (not w reporting period. Enter in column 1, "1" for urban o enter the effective date of the geographic reclassif	age) status r "2" for r ication in	ural. If ap column 2.	plicable,		2			27.00
35.00 If this is a sole community hospital (SCH), enter th effect in the cost reporting period.	e number or	periods su	H Status Ir		0			35.00
				Beginn 1. C		Endi n 2. 00		
36.00 Enter applicable beginning and ending dates of SCH s of periods in excess of one and enter subsequent dat		cript line	36 for numb	er				36.00
<ul><li>37.00 If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period.</li><li>37.01 Is this hospital a former MDH that is eligible for t</li></ul>	r the numbe he MDH tran	sitional pa	yment in	IS	0			37. 00 37. 01
accordance with FY 2016 OPPS final rule? Enter "Y" f instructions) 38.00 If line 37 is 1, enter the beginning and ending date greater than 1, subscript this line for the number o enter subsequent dates.	s of MDH st	atus. Ifli	ne 37 is					38. 00
				Y/I 1. C		Y/N 2.00		
39.00 Does this facility qualify for the inpatient hospita hospitals in accordance with 42 CFR §412.101(b)(2)(i 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions)	), (ii), or the mileage	(iii)? Ent requiremen	er in colum nts in	ime N in		N	)	39.00
40.00 Is this hospital subject to the HAC program reductio "N" for no in column 1, for discharges prior to Octo no in column 2, for discharges on or after October 1	ber 1. Ente	r"Y" for y				N		40. 00
					V 1.00	XVIII 2.00	XI X 3.00	
Prospective Payment System (PPS)-Capital 45.00 Does this facility qualify and receive Capital payme with 42 CFR Section §412.320? (see instructions)	nt for disp	roporti onat	e share in	accordance	N	N	N	45.00
46.00 Is this facility eligible for additional payment exc pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III.					N	N	N	46.00
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS 48.00 Is the facility electing full federal capital paymen					N N	N N	N N	47.00 48.00
Teachi ng Hospi tal s							IN	
56.00 Is this a hospital involved in training residents in "N" for no in column 1. For column 2, if the respons was involved in training residents in approved GME p year, and are you are impacted by CR 11642 (or appli Enter "Y" for yes; otherwise, enter "N" for no in co	e to column rograms in cable CRs)∣	1 is "Y", the prior y	or if this vear or penu	hospital Itimate	N			56.00
57.00 If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" fo is "Y" did residents start training in the first mon for yes or "N" for no in column 2. If column 2 is " "N", complete Wkst. D, Parts III & IV and D-2, Pt. I	period duri r yes or "N th of this Y", complet	" for no in cost report e Worksheet	n column 1. ing period?	lf column 1 P Enter "Y"				57.00
58.00 If line 56 is yes, did this facility elect cost reim defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	bursement f	or physicia	ins' service	es as				58.00
59.00 Are costs claimed on line 100 of Worksheet A? If yes,			Pt. I.		N			59.00

alth Financial Systems ASCENSION ST		T SALEM HOSPIT	CN: 15-1314 P	eriod:	Worksheet S-2	
			F T	rom 07/01/2021 o 06/30/2022		
			NAHE 413.85	Worksheet A	11/29/2022 10 Pass-Through	:42 an
			Y/N	Line #	Qualification Criterion Code	
			1.00	2.00	3.00	1
D.00 Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in col is "Y", are you impacted by CR 11642 (or subsequent C adjustement? Enter "Y" for yes or "N" for no in colu	85? (s umn 1. R) NAHE	see If column 1	N			60.0
	Y/N	IME	Direct GME	IME	Direct GME	
1.00 Did your baselitely seesing FTE state under ACA	1.00	2.00	3.00	4.00	5.00	
1.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	. 0. 00	61.0
1.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see						61.0
instructions) 1.02 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						61.0
<ul> <li>ACA). (see instructions)</li> <li>1.03 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</li> </ul>						61.0
instructions) 1.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the						61.0
current cost reporting period. (see instructions). 1.05 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. C
61.04 minus line 61.03). (see instructions) 1.06 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)						61.0
	Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	1
<ul> <li>1.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.</li> <li>1.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name.</li> </ul>				0.00		61. 1
Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.						
					1.00	
ACA Provisions Affecting the Health Resources and Ser	rvi ces A	Administration	(HRSA)		1.00	
2.00 Enter the number of FTE residents that your hospital	trai nec			od for which	0.00	62.0
your hospital received HRSA PCRE funding (see instruc 2.01 Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC proc	Teachi			your hospital	0.00	62.
Teaching Hospitals that Claim Residents in Nonprovide 3.00 Has your facility trained residents in nonprovider se	er Setti ettings	ngs during this co	ost reporting p		N	63.
"Y" for yes or "N" for no in column 1. If yes, comple	ete line	es 64 through (	67. (see instru Unweighted	uctions) Unweighted	Ratio (col. 1/	,
			FTĔs Nonprovider	FTEs in Hospital	(col . 1 + col . 2))	
			Si te 1.00	2.00	3.00	-
	onprovid	der Settings				
Section 5504 of the ACA Base Year FTE Residents in No						
period that begins on or after July 1, 2009 and befor			0.00	0.00	0.000000	1 1 4
	y trair -primar all nor lnon-pr	ed residents y care provider imary care	0.00	0.00	0. 000000	64.

SPITAL AND HOSPITAL HEALTH CARE COMPI	LEX IDENTIFICATION DA	ATA Provider		eri od:	Worksheet S-2	2
			F To	rom 07/01/2021 o 06/30/2022	Date/Time Pre	pared:
	Program Name	Program Code	Unweighted	Unweighted	11/29/2022 10 Ratio (col. 3/	
			FTEs	FTEs in	(col . 3 + col .	
			Nonprovi der	Hospi tal	4))	
			Si te			
	1.00	2.00	3.00	4.00	5.00	
.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3			0. 00	) O. OC	0. 00000C	05.0
divided by (column 3 + column 4)). (see instructions)			Unweighted FTEs Nonprovider	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			Si te	noopi tui		
			1.00	2.00	3.00	
Section 5504 of the ACA Current	Year FTE Residents i	n Nonprovider Settir	ngsEffective fo	or cost reporti	ing periods	
		rovider settings.				
Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	unweighted non-prima al. Enter in column	ry care resident 3 the ratio of	Unweighted FTEs Nonprovider	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
FTEs that trained in your hospit (column 1 divided by (column 1 +	unweighted non-prima al. Enter in column column 2)). (see in	ry care resident 3 the ratio of structions)	FTĔs Nonprovider Site 3.00	FTES in Hospital	(col. 3 + col. 4)) 5.00	_
FTEs that trained in your hospit	unweighted non-prima al. Enter in column <u>column 2)). (see in</u> Program Name	ry care resident 3 the ratio of structions) Program Code	FTĔs Nonprovider Site	FTES in Hospital	(col. 3 + col. 4)) 5.00	_
FTEs that trained in your hospit (column 1 divided by (column 1 + column 1 divided by (column 1 + experience) .00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	unweighted non-prima al. Enter in column column 2)). (see in Program Name 1.00	ry care resident 3 the ratio of structions) Program Code	FTĔs Nonprovider Site 3.00	FTES in Hospital	(col . 3 + col . 4)) 5.00 0.000000	_
FTEs that trained in your hospit (column 1 divided by (column 1 + (column 1 divided by (column 1 + ) 00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	unweighted non-prima al. Enter in column column 2)). (see in Program Name 1.00 1.00	ry care resident 3 the ratio of structions) Program Code 2.00	FTEs Nonprovi der Si te 3.00 0.00	FTES in Hospi tal 4.00 0.00 1.0	(col . 3 + col . 4)) 5.00 0.0000000	67.0
FTEs that trained in your hospit (column 1 divided by (column 1 + (column 1 divided by (column 1 + 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) Inpatient Psychiatric Facility P 00 Is this facility an Inpatient Ps Enter "Y" for yes or "N" for no 10 If line 70 is yes: Column 1: Did recent cost report filed on or b 42 CFR 412.424(d)(1)(iii)(c)) Co program in accordance with 42 CF Column 3: If column 2 is Y, indi (see instructions)	unweighted non-prima al. Enter in column column 2)). (see in Program Name 1.00 1.00 1.00 PS ychiatric Facility ( the facility have a efore November 15, 2 lumn 2: Did this fac R 412.424 (d)(1)(iii cate which program y	ry care resident 3 the ratio of structions) Program Code 2.00 IPF), or does it cor n approved GME teach 004? Enter "Y" for ility train resident )(D)? Enter "Y" for	FTEs Nonprovi der Si te 3.00 0.00 ntain an IPF subp ning program in t yes or "N" for r ts in a new teach yes or "N" for r	FTES in Hospital 4.00 0.00 1.0 provider? N the most no. (see ing no.	(col . 3 + col . 4)) 5.00 0.0000000	70. (
FTEs that trained in your hospit (column 1 divided by (column 1 + (column 1 divided by (column 1 + )         .00       Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)         .00       Inpatient Psychiatric Facility P is this facility an Inpatient Ps Enter "Y" for yes or "N" for no .00         .00       If line 70 is yes: Column 1: Did recent cost report filed on or b 42 CFR 412. 424(d)(1)(iii)(c)) Co program in accordance with 42 CF Column 3: If column 2 is Y, indi	unweighted non-prima al. Enter in column column 2)). (see in Program Name 1.00 1.00 1.00 PS ychiatric Facility ( the facility have a efore November 15, 2 lumn 2: Did this fac R 412.424 (d)(1)(iii) cate which program y y PPS habilitation Facility	ry care resident 3 the ratio of structions) Program Code 2.00 2.00 IPF), or does it cor n approved GME teach 004? Enter "Y" for ility train resident )(D)? Enter "Y" for ear began during thi	TTES Nonprovider Site 3.00 0.00 ntain an IPF subp ning program in t yes or "N" for r ts in a new teach yes or "N" for r s cost reporting	FTES in Hospital 4.00 0.00 1.0 provider? N the most no. (see ing no.	(col . 3 + col . 4)) 5.00 0.0000000 0.00000000000000000000	_

Health Financial Systems	ASCENSION ST VINCENT	SALEM HOSPI	TAL	In Lie	u of Form CMS-	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DATA	Provider C	CN: 15-1314	Period: From 07/01/2021 To 06/30/2022	Worksheet S-2 Part I Date/Time Pro 11/29/2022 10	epared:
					1.00	
Long Term Care Hospital PPS 80.00 Is this a long term care hospital ( 81.00 Is this a LTCH co-located within an "Y" for yes and "N" for no.				g period? Enter	N N	80.00 81.00
TEFRA Providers 85.00 Is this a new hospital under 42 CFR 86.00 Did this facility establish a new O 6422 (06) (1) (1) (2) Frank Weight (1) (2) (2) (2) (2) (2) (2) (2) (2) (2) (2	ther subprovider (exclude				N	85. 00 86. 00
\$413. 40(f)(1)(ii)? Enter "Y" for y 87.00 Is this hospital an extended neopla 199((4)(1)(D)(vi)? Enter "Y" for y	stic disease care hospita	l classi fied	under sectior	I	N	87.00
1886(d)(1)(B)(vi)? Enter "Y" for ye	S 01 N 101 110.			V 1.00	XI X 2.00	-
Title V and XIX Services90.00Does this facility have title V and	l/or XLX inpatient hospita	services? F	nter "Y" for	N	Y	90.00
yes or "N" for no in the applicable 91.00 Is this hospital reimbursed for tit	column.			N	N	91.00
full or in part? Enter "Y" for yes 92.00 Are title XIX NF patients occupying	or "N" for no in the appl	icable column	l.	N.	Y	92.00
instructions) Enter "Y" for yes or	"N" for no in the applical	ble column.	, .	N	N	93.00
93.00 Does this facility operate an ICF/I "Y" for yes or "N" for no in the ap	plicable column.					
94.00 Does title V or XIX reduce capital applicable column.				N	N	94.00
95.00 If line 94 is "Y", enter the reduct 96.00 Does title V or XIX reduce operation				0. 00 N	0.00 N	95.00 96.00
applicable column. 97.00  fline 96 is "Y", enter the reduct	ion percentage in the app	licable colum	ın.	0.00	0.00	97.00
98.00 Does title V or XIX follow Medicare stepdown adjustments on Wkst. B, Pt	. I, col. 25? Enter "Y" f			N	Y	98.00
<pre>column 1 for title V, and in column 98.01 Does title V or XIX follow Medicare C, Pt. 1? Enter "Y" for yes or "N" title VIX</pre>	e (title XVIII) for the re				Y	98. 01
98.02 Does title V or XIX follow Medicare bed costs on Wkst. D-1, Pt. IV, III	e 89? Enter "Y" for yes o			Ν	Y	98. 02
98.03 for title V, and in column 2 for ti 98.03 Does title V or XIX follow Medicare reimbursed 101% of inpatient service	e (title XVIII) for a crit ees cost? Enter "Y" for ye				Ν	98. 03
98.04 for title V, and in column 2 for ti 98.04 Does title V or XIX follow Medicare outpatient services cost? Enter "Y"	e (title XVIII) for a CAH			N	Ν	98. 04
98.05   in column 2 for title XIX. 98.05   Does title V or XIX follow Medicare Wkst. C, Pt. I, col. 4? Enter "Y" f					Y	98.05
<ul> <li>column 2 for title XIX.</li> <li>98.06 Does title V or XIX follow Medicare Pts. I through IV? Enter "Y" for ye column 2 for title XIX.</li> </ul>				N	Ν	98.06
Rural Providers 105.00Does this hospital gualify as a CAH	12			Y		105.00
106.00 If this facility qualifies as a CAH	l, has it elected the all-	inclusive met	hod of paymer			105.00
for outpatient services? (see instr 107.00 Column 1: If line 105 is Y, is this training programs? Enter "Y" for ye Column 2: If column 1 is Y and lin approved medical education program	s facility eligible for co es or "N" for no in column ne 70 or line 75 is Y, do	1. (see ins you train I&R	structions) As in an	N		107.00
Enter "Y" for yes or "N" for no in	column 2. (see instruction	ons)				100.00
108.00 Is this a rural hospital qualifying CFR Section §412.113(c). Enter "Y"						108.00
		Physi cal 1.00	Occupationa 2.00	3.00	Respiratory 4.00	
109.00 If this hospital qualifies as a CAH therapy services provided by outsic for yes or "N" for no for each ther	le supplier? Enter "Y"	Ν	N	N	N	109.00
					1.00	-
110.00 Did this hospital participate in th Demonstration) for the current cost complete Worksheet E, Part A, lines	reporting period? Enter "	Y" for yes or	"N" for no.	lf yes,	N	110.00
applicable.			200 thit			

ealth Financial Systems ASCENSION ST VINCENT	Provider CC	CN: 15-1314	Period:	eu of Form CMS Worksheet S-	
			From 07/01/202 To 06/30/202	1 Part I	epared
		I		1172772022 1	0.42 0
11.00 If this facility qualifies as a CAH, did it participate in th Health Integration Project (FCHIP) demonstration for this cos "Y" for yes or "N" for no in column 1. If the response to col integration prong of the FCHIP demo in which this CAH is part Enter all that apply: "A" for Ambulance services; "B" for add for tele-health services.	st reporting p lumn 1 is Y, e ticipating in	period? Enter enter the column 2.	1.00 N	2.00	111. (
		1.00	2.00	3.00	-
12.00 Did this hospital participate in the Pennsylvania Rural Heal demonstration for any portion of the current cost reporting parter "Y" for yes or "N" for no in column 1. If column 1 is in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceas participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information	period? "Y", enter e	N			112. (
15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or in column 1. If column 1 is yes, enter the method used (A, B, in column 2. If column 2 is "E", enter in column 3 either "93 for short term hospital or "98" percent for long term care (i psychiatric, rehabilitation and long term hospitals providers the definition in CMS Pub. 15-1, chapter 22, §2208.1.	, or E only) 3" percent includes s) based on	N			0115.0
16.00 Is this facility classified as a referral center? Enter "Y" 1 "N" for no.	for yes or	N			116. (
17.00 Is this facility legally-required to carry malpractice insura "Y" for yes or "N" for no.	ance? Enter	Y			117. (
18.00 Is the malpractice insurance a claims-made or occurrence poli if the policy is claim-made. Enter 2 if the policy is occurre			2		118. (
8.01 List amounts of malpractice premiums and paid losses:		Premi ums 1.00 104,20	Losses	3.00	0118.
8.02 Are malpractice premiums and paid losses reported in a cost of Administrative and General? If yes, submit supporting schedu and amounts contained therein.			1.00 N	2.00	118.
9.00 DO NOT USE THIS LINE 0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qua Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.	column 1, "Y alifies for th	' for yes or ne Outpatient		Ν	119. 120.
1.00 Did this facility incur and report costs for high cost implan patients? Enter "Y" for yes or "N" for no.	ntable devices	s charged to	Y		121.
2.00 Does the cost report contain healthcare related taxes as defi Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information				5.00	122.
5.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 6.00   f this is a Medicare certified kidney transplant center, en	ter the certif		N		125. 126.
in column 1 and termination date if applicable in column 2		aati an data			127.
in column 1 and termination date, if applicable, in column 2. 7.00 If this is a Medicare certified heart transplant center, enter in column 1 and termination date, if applicable, in column 2.	er the certifi	cation date			
7.00 If this is a Medicare certified heart transplant center, enter in column 1 and termination date, if applicable, in column 2. 8.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2.	er the certifi er the certifi	cation date			
<ul> <li>7.00 If this is a Medicare certified heart transplant center, enter in column 1 and termination date, if applicable, in column 2.</li> <li>8.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2.</li> <li>9.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2.</li> </ul>	er the certifi er the certifi r the certific	cation date	n		128. 129.
<ul> <li>7.00 If this is a Medicare certified heart transplant center, enter in column 1 and termination date, if applicable, in column 2.</li> <li>8.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2.</li> <li>9.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2.</li> <li>9.00 If this is a Medicare certified pancreas transplant center, enter column 1 and termination date, if applicable, in column 2.</li> <li>9.00 If this is a Medicare certified pancreas transplant center, enter column 1 and termination date, if applicable, in column 2.</li> </ul>	er the certifi er the certifi r the certific enter the cert umn 2.	cation date cation date i tification	n		129. 130.
<ul> <li>7.00 If this is a Medicare certified heart transplant center, enter in column 1 and termination date, if applicable, in column 2.</li> <li>8.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2.</li> <li>9.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2.</li> <li>9.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2.</li> <li>9.00 If this is a Medicare certified pancreas transplant center, enter date in column 1 and termination date, if applicable, in colum 4.</li> <li>9.00 If this is a Medicare certified intestinal transplant center, enter date in column 1 and termination date, if applicable, in colum 4.</li> </ul>	er the certifi er the certifi r the certific enter the cert umn 2. , enter the ce umn 2.	cation date cation date in tification ertification	n		129. 130. 131.
<ul> <li>7.00 If this is a Medicare certified heart transplant center, enter in column 1 and termination date, if applicable, in column 2.</li> <li>8.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2.</li> <li>9.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2.</li> <li>9.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2.</li> <li>9.00 If this is a Medicare certified panceas transplant center, enter date in column 1 and termination date, if applicable, in colum 1.</li> </ul>	er the certifi er the certifi r the certific enter the cert umn 2. , enter the ce umn 2. er the certifi	cation date cation date in tification ertification cation date	n		129. 130.

alth Financial Systems )SPITAL AND HOSPITAL HEALTH CARE COMPLE			SALEM HOSPIT		Peri od		u of Form CMS- Worksheet S-:	
SPITAL AND NUSPITAL MEALIN CARE COMPLE	X IDENTIFICATION	DATA	Provider co	N. 15-1514	From C	)7/01/2021 )6/30/2022	Part I Date/Time Pr	epared
1.00		2.00				3.00	11/29/2022 1	0.42 0
If this facility is part of a chai		enter on li			e name an		of the	
home office and enter the home off 1.00Name: ASCENSION ST. VINCENT	Contractor r		itractor numb		ictor's Ni	umber: 0800	)1	141.
2. 00 Street: 250 WEST 96TH STREET SUITE		3 Maile. W 3		Contra				142.
3.00 City: NDIANAPOLIS	State:	IN		Zip Co	de:	4629	0	143.
							1.00	_
4.00 Are provider based physicians' cos	ts included in W	lorksheet A?	•				1.00 Y	144.
						1.00	2.00	4.45
<ul> <li>5.00 If costs for renal services are cl inpatient services only? Enter "Y" no, does the dialysis facility inc period? Enter "Y" for yes or "N"</li> <li>6.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in</li> </ul>	for yes or "N" lude Medicare ut for no in column y changed from t	for no in c ilization f 12. the previous	olumn 1. If o for this cost ly filed cos	column 1 is reporting t report?		Ν		145. 146.
yes, enter the approval date (mm/d			,					
							1.00	_
7.00Was there a change in the statisti	cal basis? Enter	"Y" for ve	s or "N" for	no.			1.00 N	147.
8.00Was there a change in the order of	allocation? Ent	er "Y" for	yes or "N" fo	or no.			N	148.
9.00 Was there a change to the simplifi	ed cost finding	method? Ent	2			T' 11 \/	N N	149.
		-	<u>Part A</u> 1.00	Part E 2.00	5	<u>Title V</u> 3.00	Title XIX 4.00	-
Does this facility contain a provi			exemption fro	n the appli		of the lowe	er of costs	
or charges? Enter "Y" for yes or "	N" for no for ea	ach componer			3. (See 4			-
5.00Hospital 5.00Subprovider - IPF			N N	N N		N N	N	155.
7. 00 Subprovider - TRF			N	N		N	N	157.
8. 00 SUBPROVI DER								158.
9.00 SNF			N	N		N	N	159.
0.00HOME HEALTH AGENCY 1.00CMHC			N	N N		N N	N N	160. 161.
								1011
							1.00	_
Multicampus 5.00Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	mpus hospital th	nat has one	or more camp	uses in dif	ferent C	BSAs?	N	165.
	Name		County	State	Zip Code	CBSA	FTE/Campus	
	0		1.00	2.00	3.00	4.00	5.00	
5.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)							0.0	0166.
							1.00	-
Health Information Technology (HIT							1	
7.00 Is this provider a meaningful user 3.00 If this provider is a CAH (line 10 reasonable cost incurred for the H	5 is "Y") and is	a meaningf	ul user (line			r the	Y	167 168
3.01 If this provider is a CAH and is n exception under §413.70(a)(6)(ii)?	ot a meaningful 'Enter "Y" for y	user, does ves or "N" f	this providen for no. (see i	nstruction	ıs)	•	N	168
9.00 If this provider is a meaningful u transition factor. (see instruction		s "Y") and i	s not a CAH	(line 105 i				0169
					Be	egi nni ng	Endi ng 2.00	_
D.00 Enter in columns 1 and 2 the EHR b period respectively (mm/dd/yyyy)	eginning date ar	nd ending da	te for the re	eporting		1.00	2.00	170.
								_
1.00  fline 167 is "Y", does this prov	i den have anv da	ws for indi	viduals opro	ledin		1.00 N	2.00	0171.
	THEFT HAVE ANY DA		viuuais enrol	ieu ill		IN		01/1.

leal th	Financial Systems ASCENSION ST VINCE	NT SALEM HOSPI	TAL	In Lie	eu of Form CMS-	2552-10
IOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C		Period: From 07/01/2021 Fo 06/30/2022	Worksheet S-2 Part II Date/Time Pre 11/29/2022 10	epared:
				Y/N	Date	). 42 ali
	General Instruction: Enter Y for all YES responses. Enter N	for all NO ra	ononcoo Entor	1.00	2.00	
	mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	I TOF ALL NU FE	esponses. Enter	all dates in i	the	
00	Provider Organization and Operation	. hanimi an af	++	N		1 1 00
. 00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in c	column 2. (see	instructions)	N		1.00
			Y/N	Date	V/I	
. 00	Has the provider terminated participation in the Medicare F	)rogram2 lf	1.00 N	2.00	3.00	2.00
00	yes, enter in column 2 the date of termination and in colum voluntary or "1" for involuntary.		N IN			2.00
. 00	Is the provider involved in business transactions, includin contracts, with individuals or entities (e.g., chain home or or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members of of directors through ownership, control, or family and other	offices, drug der or its of the board	Y			3. 00
	relationships? (see instructions)		N/ /N	Turne	Data	
			Y/N 1.00	Type 2.00	Date 3.00	
	Financial Data and Reports		1.00	2.00	0.00	<u> </u>
. 00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" f or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	for Compiled,	Y	A		4.00
. 00	Are the cost report total expenses and total revenues diffe	erent from	N			5.00
	those on the filed financial statements? If yes, submit rec	conciliation.		Y/N	Legal Oper.	
				1.00	2.00	
	Approved Educational Activities					
00	Column 1: Are costs claimed for a nursing program? Column is the legal operator of the program?	2: If yes, is	s the provider	N		6.00
. 00 . 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing programs and/or allied health programs approve cost reporting period? If yes, see instructions.		ved during the	N N		7.00 8.00
. 00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction	is.		Ν		9.00
0. 00	Was an approved Intern and Resident GME program initiated c	or renewed in t	the current	N		10.00
1.00	cost reporting period? If yes, see instructions. 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	
	Bad Debts				1.00	
	Is the provider seeking reimbursement for bad debts? If yes	s, see instruct	tions.		Y	12.00
	If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.		-		N	13.00
	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	ents waived? It	yes, see inst	Tructions.	N	14.00
	Did total beds available change from the prior cost reporti		yes, see instr rt A	Par	N N	15.00
		Y/N	Date	Y/N	Date 4.00	
	PS&R Data	1.00	2.00	3.00	4.00	
	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	10/07/2022	Y	10/07/2022	16.00
. 00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Ν		Ν		17.00
3. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	Ν		Ν		18.00
9. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report	Ν		N		19.00

Health Financial Systems

In Lieu of Form CMS-2552-10

	ASCENSION ST VINC					
HOSPI T	HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CN: 15-1314	Period: From 07/01/2021 To 06/30/2022	Worksheet S Part II Date/Time P	repared:
					11/29/2022	10:42 am
			iption	Y/N	Y/N	
20,00	LE Line 1/ en 17 is une adjustments made to DCOD		0	1.00	3.00	20.00
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		1.00	2.00	3.00	4.00	21.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	CEPT CHILDRENS H	IOSPI TALS)			
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, so	ee instructions			Ν	22.00
23.00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	ing the cost	Ν	23.00		
24.00	Were new leases and/or amendments to existing leases enter If yes, see instructions	porting period?	Ν	24.00		
25.00	Have there been new capitalized leases entered into during instructions.	lf yes, see	Ν	25.00		
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during	the cost reporti	ng period? I	f yes, see	Ν	26.00
27.00	instructions. Has the provider's capitalization policy changed during th	yes, submit	Ν	27.00		
	copy.					
28.00	Interest Expense Were new Loans, mortgage agreements or Letters of credit of	entered into dur	ing the cost	reporting	N	28.00
29.00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or	r bond funds (De	ebt Service R	eserve Fund)	Y	29.00
30. 00	treated as a funded depreciation account? If yes, see ins Has existing debt been replaced prior to its scheduled ma		debt? If ves	See	N	30.00
	instructions.	5	5			
31.00	Has debt been recalled before scheduled maturity without i instructions.	issuance of new	debt? If yes	, see	Ν	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care so		ed through co	ntractual	N	32.00
33.00	arrangements with suppliers of services? If yes, see inst If line 32 is yes, were the requirements of Sec. 2135.2 a		ng to competi	tive bidding? If	Ν	33.00
	no, see instructions. Provider-Based Physicians					-
24 00	Are services furnished at the provider facility under an a	arrangement with	nrovidor ba	cod physicians?	Y	34.00
34.00	If yes, see instructions.	arrangement wrti	i provider-ba	seu priysi ci ans?	T	34.00
35.00	If line 34 is yes, were there new agreements or amended ex physicians during the cost reporting period? If yes, see		nts with the	provi der-based	Y	35.00
				Y/N	Date	
				1.00	2.00	
_	Home Office Costs					
	Were home office costs claimed on the cost report?			Y		36.00
37.00	If line 36 is yes, has a home office cost statement been	prepared by the	home office?	Y		37.00
38.00	If yes, see instructions. If line 36 is yes , was the fiscal year end of the home o	ffice different	from that of	N		38.00
39.00	the provider? If yes, enter in column 2 the fiscal year en If line 36 is yes, did the provider render services to oth			, N		39.00
40.00	see instructions.		16	N		40.00
40.00	If line 36 is yes, did the provider render services to the instructions.	e nome office?	TT yes, see	N		40.00
		1	00	2	00	_
	Cost Report Preparer Contact Information			2.		
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	JILL		HILL		41.00
	respectively.					
42.00	Enter the employer/company name of the cost report	ASCENSI ON				42.00
43.00	preparer. Enter the telephone number and email address of the cost	N/A		JI LL. HI LL1@ASCI	ENSI ON. ORG	43.00
	report preparer in columns 1 and 2, respectively.	1				11

Heal th	Financial Systems ASCENSION ST V	/I NCEI	NT SALEM HOSPITAL	_	In Lieu	u of Form CMS-	2552-10
H0SPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	-	Provider CCN: 15-1314			Worksheet S-2	
				To	om 07/01/2021 06/30/2022	Part II Date/Time Pre 11/29/2022 10	pared: :42 am
			3.00				
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title/position		MANAGER, REIMBURSEMENT				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 report						42.00
	preparer.						
43.00	Enter the telephone number and email address of the co	st					43.00
	report preparer in columns 1 and 2, respectively.						

	Financial Systems ASCE AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	NSION ST VINCEN AI DATA	Provider C		Peri od:	u of Form CMS- Worksheet S-3	
					From 07/01/2021 To 06/30/2022	Part I Date/Time Pre 11/29/2022 10	epared: ):42 am
						I/P Days / O/P Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
		Line Number	0.00	Avai I abl e	4.00	5.00	
1 00	Upperital Adulta & Dada (palumpa E ( 7 and	1.00	2.00	3.00	4.00	5.00	1.00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30. 00	25	9, 1	25 3, 144. 00		1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00 5.00	HMO I RF Subprovider					0	4.00
5.00 6.00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF					0	
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	9, 1	25 3, 144. 00		
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.0
10.00 11.00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						10.0
12.00	OTHER SPECIAL CARE (SPECIFY)						12.0
13.00	NURSERY						12.0
14.00	Total (see instructions)		25	9, 1	25 3, 144. 00	0	
15.00	CAH visits					0	
16.00	SUBPROVIDER - IPF						16.0
17.00	SUBPROVIDER - IRF						17.0
18.00	SUBPROVI DER						18.0
19.00	SKILLED NURSING FACILITY						19. C
20.00	NURSING FACILITY						20.0
21.00	OTHER LONG TERM CARE						21.0
22.00	HOME HEALTH AGENCY						22.0
23.00	AMBULATORY SURGICAL CENTER (D. P. )						23.0
4.00 4.10	HOSPICE HOSPICE (non-distinct part)	30, 00					24.0
25.00	CMHC - CMHC	30.00					24.
6.00	RURAL HEALTH CLINIC	88.00				0	
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	
7.00	Total (sum of lines 14-26)	07100	25				27.0
8.00	Observation Bed Days		20			0	
9.00	Ambul ance Trips						29.0
30.00	Employee discount days (see instruction)						30.0
1. 00	Employee discount days - IRF						31.0
32.00	Labor & delivery days (see instructions)		0		0		32.0
32.01	Total ancillary labor & delivery room						32.0
	outpatient days (see instructions)						
33.00	LTCH non-covered days						33. 0 33. 0
33. UI	LTCH site neutral days and discharges					1	1 33

10SPI 1	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider C	CN: 15-1314		eriod: com 07/01/2021 0 06/30/2022	Worksheet S-3 Part I Date/Time Pre 11/29/2022 10	pared:
		I/P Days	/ O/P Visits	/ Trips		Full Time E	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients		Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00		9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	71	1	1.	31			1.00
2.00	HMO and other (see instructions)	14	16					2.00
3.00	HMO IPF Subprovider	0	0					3.00
1.00	HMO IRF Subprovider	0	0					4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	32	0		48			5.00
5.00	Hospital Adults & Peds. Swing Bed NF	100	0		3			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	103	1	1:	82			7.00
3.00	INTEŃSIVE CARE UNIT							8.00
9.00	CORONARY CARE UNIT							9.0
0.00	BURN INTENSIVE CARE UNIT							10.0
1.00	SURGICAL INTENSIVE CARE UNIT							11.0
2.00	OTHER SPECIAL CARE (SPECIFY)							12.0
3.00	NURSERY							13.0
4.00	Total (see instructions)	103	1		82	0.00	60.36	
5.00	CAH visits	7,344	764	31, 7	62			15.0
6.00	SUBPROVIDER - IPF							16.0
7.00 8.00	SUBPROVI DER – I RF SUBPROVI DER							17. C
9.00	SKILLED NURSING FACILITY							19.0
0.00	NURSING FACILITY							20.0
1.00	OTHER LONG TERM CARE							21.0
2.00	HOME HEALTH AGENCY							22.0
3.00	AMBULATORY SURGICAL CENTER (D. P.)							23.0
4.00	HOSPI CE							24.0
4. 10	HOSPICE (non-distinct part)				0			24.1
5.00	CMHC - CMHC							25.0
6.00	RURAL HEALTH CLINIC	0	0		0	0.00	0.00	
6.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0.00	0.00	
7.00	Total (sum of lines 14-26)		0		~ 7	0.00	60.36	
8.00	Observation Bed Days	0	0	2	97			28.0
9.00	Ambulance Trips Employee discount days (see instruction)	0			0			29.0 30.0
1.00	Employee discount days (see fistraction)				0			31.0
2.00	Labor & delivery days (see instructions)	0	0		0			32.0
2.00	Total ancillary labor & delivery room	0	0		0			32.0
2.01	outpatient days (see instructions)				Ŭ			32.0
33.00	LTCH non-covered days	О						33.0
	LTCH site neutral days and discharges	0						33.0

HOSPI T	HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA			Provider CCN: 15-1314		Worksheet S-3 Part I Date/Time Pre 11/29/2022 10	pared:
		Full Time Equivalents		Di s	charges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 22.\ 00\\ 23.\ 00\\ 24.\ 00\\ 24.\ 00\\ 24.\ 00\\ 24.\ 00\\ 24.\ 00\\ 25.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 29.\ 00\\ 30.\ 00\\ 31.\ 00\\ 32.\ 00\\ \end{array}$	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSI VE CARE UNIT CORONARY CARE UNIT SURGICAL INTENSI VE CARE UNIT SURGICAL INTENSI VE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits SUBPROVI DER - IPF SUBPROVI DER - IPF SUBPROVI DER - IRF SUBPROVI SURGI SCAL CENTER (D. P. ) HOSPI CE (NON-dI STINCT PROVI SURGI SCAL CENTER (D. P. ) HOSPI CE (NON-DI STINCT SCAL SCAL SCAL SCAL SCAL SCAL SCAL SCAL	0. 00 0. 00 0. 00 0. 00 0. 00	0		23 1 6 7 0 0 23 1	50	$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 12.\ 00\\ 13.\ 00\\ 15.\ 00\\ 15.\ 00\\ 15.\ 00\\ 22.\ 00\\ 23.\ 00\\ 24.\ 00\\ 22.\ 00\\ 23.\ 00\\ 24.\ 00\\ 25.\ 00\\ 26.\ 25\\ 27.\ 00\\ 28.\ 00\\ 26.\ 00\\ 30.\ 00\\ 31.\ 00\\ 31.\ 00\\ 32.\ 00\\ 31.\ 00\\ 32.\ 00\\ 31.\ 00\\ 32.\ 00\\ 31.\ 00\\ 32.\ 00\\ 32.\ 00\\ 32.\ 00\\ 32.\ 00\\ 32.\ 00\\ 32.\ 00\\ 33.\ $
32. 01 33. 00	Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days LTCH site neutral days and discharges				0		32. 0 32. 0 33. 0 33. 0

Heal th	Financial Systems ASCENSION ST VINCENT S	ALEM HOSPIT	TAL	In Lie	u of Form CMS-2	2552-10	
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CO		Peri od:	Worksheet S-1	0	
				From 07/01/2021 To 06/30/2022	Date/Time Pre	narod	
				10 06/30/2022	11/29/2022 10		
					1.00		
	Uncompensated and indigent care cost computation						
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 di	vided by li	ne 202 column	8)	0. 290318	1.00	
	Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid				2, 318, 188	2.00	
3.00 4.00	Did you receive DSH or supplemental payments from Medicaid?	tal novement	a from Madiaa	: 40	N	3.00	
4.00 5.00	If line 3 is yes, does line 2 include all DSH and/or supplemen If line 4 is no, then enter DSH and/or supplemental payments f			10?	0	4.00 5.00	
6.00	Medicaid charges	I OIII Meur Car	u		16, 756, 493	6.00	
7.00	Medicaid cost (line 1 times line 6)				4, 864, 712	7.00	
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if 2,546,524						
	< zero then enter zero)	(			_, _ , _ ,	8.00	
	Children's Health Insurance Program (CHIP) (see instructions for	or each lin	e)				
9.00	Net revenue from stand-alone CHIP				0		
10.00	Stand-alone CHIP charges				0		
11.00	Stand-alone CHIP cost (line 1 times line 10)				0		
12.00	Difference between net revenue and costs for stand-alone CHIP	(line 11 mi	nus line 9; i	f < zero then	0	12.00	
	enter zero)	tructions f	on each line)				
13.00	Other state or local government indigent care program (see ins Net revenue from state or local indigent care program (Not inc			<u>\</u>	0	13.00	
13.00	Charges for patients covered under state or local indigent care				0		
14.00	10)		Not The udeu	In Thes 0 of	0	14.00	
15.00	State or local indigent care program cost (line 1 times line 1	4)			0	15.00	
16.00							
	13; if < zero then enter zero)	0					
	Grants, donations and total unreimbursed cost for Medicaid, CH	IP and stat	e∕local indig	ent care program	ns (see		
47 00	instructions for each line)					1 7	
17.00	Private grants, donations, or endowment income restricted to f				0		
18. 00 19. 00	Government grants, appropriations or transfers for support of Total unreimbursed cost for Medicaid , CHIP and state and Loca			(cum of lines	0 2, 546, 524		
19.00	8, 12 and 16)	i inui gent		(Sull OF TITIES	2, 540, 524	19.00	
	0, 12 and 10)		Uni nsured	Insured	Total (col. 1		
			patients	patients	+ col. 2)		
			1.00	2.00	3.00		
	Uncompensated Care (see instructions for each line)			-			
20.00	Charity care charges and uninsured discounts for the entire fa	cility	634, 42	6 436, 771	1, 071, 197	20.00	
	(see instructions)				(00.05)		
21.00	Cost of patients approved for charity care and uninsured disco	unts (see	184, 18	5 436, 771	620, 956	21.00	
22.00	instructions) Payments received from patients for amounts previously written	off as		o o	0	22.00	
22.00	chari ty care	011 43		0	0	22.00	
23.00	Cost of charity care (line 21 minus line 22)		184, 18	5 436, 771	620, 956	23.00	
					1.00		
24.00	Does the amount on line 20 column 2, include charges for patie	nt days bey	ond a length	of stay limit	N	24.00	
	imposed on patients covered by Medicaid or other indigent care						
25.00	If line 24 is yes, enter the charges for patient days beyond t	he indigent	care program	's length of	0	25.00	
0/ 00	stay limit				0.045.045	04 00	
26.00	Total bad debt expense for the entire hospital complex (see in				2, 015, 045		
27. 00 27. 01	Medicare reimbursable bad debts for the entire hospital comple Medicare allowable bad debts for the entire hospital complex (				236, 925 364, 500		
27.01	Non-Medicare bad debt expense (see instructions)	SEE INSTIUC	1101157		364, 500 1, 650, 545		
28.00 29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt ex	nense (see	instructions)		606, 758		
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	ponse (see			1, 227, 714		
	Total unreimbursed and uncompensated care cost (line 19 plus l	ine 30)			3, 774, 238		
		/					

RECLAS	Financial Systems ASCEN SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	ISI ON ST VI NCENT E EXPENSES	Provider CO		Peri od:	u of Form CMS-: Worksheet A	
					From 07/01/2021 To 06/30/2022	Date/Time Pre 11/29/2022 10	
	Cost Center Description	Sal ari es	Other	Total (col. + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS				1		-
1.00	00100 CAP REL COSTS-BLDG & FIXT		276, 584			276, 584	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		362, 790			362, 790	2.00
3.00	00300 OTHER CAP RELATED COST	4.4. 0.00	0		0 0	0	3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	146, 822	1, 223, 894			1, 370, 716	
5.00	00500 ADMINISTRATIVE & GENERAL	471, 147	4, 286, 096			4, 757, 243	5.00
6.00	00600 MAINTENANCE & REPAIRS	0	-2, 268			0	6.00
7.00	00700 OPERATION OF PLANT	0	1, 152, 856			1, 150, 588	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	70, 143			70, 143	
9.00	00900 HOUSEKEEPI NG	0	379, 738			379, 738	
	01000 DI ETARY	0	375, 901 0	375, 90		45, 227	10.00
	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON	U	-			330, 674	
	01400 CENTRAL SERVICES & SUPPLY	172, 232	7, 116 6, 398			179, 348 6, 398	
	01500 PHARMACY	207,637				0, 398	14.00
	01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY	207, 837	-223, 882 0		5 16, 245 0 0	0	•
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	0	0		0 0	0	16.00
30, 00	03000 ADULTS & PEDIATRICS	880, 152	114, 253	994, 40	5 -94	994, 311	30.00
30.00	ANCI LLARY SERVICE COST CENTERS	000, 152	114, 200	774, 40	- 74	774, 311	30.00
50.00	05000 OPERATING ROOM	506, 448	222, 802	729, 25	0 -82, 642	646, 608	50.00
	05400 RADI OLOGY - DI AGNOSTI C	756, 560	187, 725			942, 760	
	05800 MAGNETIC RESONANCE I MAGING (MRI)	, 30, 300	107, 725	744,20	0 1, 325	742,700	54.00
	06000 LABORATORY	0	1, 352, 721	1, 352, 72	1 0	1, 352, 721	60.00
	06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	1, 332, 721		0 0	1, 332, 721	61.00
	06500 RESPIRATORY THERAPY	63, 866	8, 589		s	72, 455	
	06600 PHYSI CAL THERAPY	493, 730	5, 494			439, 110	
	06700 OCCUPATI ONAL THERAPY	0	0, 171		0 60, 114	60, 114	
	06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
	06900 ELECTROCARDI OLOGY	183, 811	4, 130	187, 94	-	187, 941	69.00
	07000 ELECTROENCEPHALOGRAPHY	0	0	10,7,71	0 0	0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	23, 115	23, 11	5 92, 181	115, 296	
	07200 IMPLANTABLE DEVICES CHARGED TO	0	57, 391	57, 39		57, 391	72.00
73.00	PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	770, 771	770, 77	1 -16, 245	754, 526	73.00
	07400 RENAL DIALYSIS	0	0		0 -10, 243	754, 520	74.00
	07500 ASC (NON-DI STINCT PART)	0	0		0 0	0	75.00
	03950 SLEEP DI SORDER	68, 227	64, 021	132, 24	5	132, 248	
	07501 ADULT MENTAL HEALTH	00, 227	392, 397			392, 397	
	07697 CARDI AC REHABI LI TATI ON	126, 389	2, 801			129, 190	
/0. //	OUTPATIENT SERVICE COST CENTERS	120, 307	2,001	127,17	0	127,170	/0. //
88.00	08800 RURAL HEALTH CLINIC	0	0		0 0	0	88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0	
	09000 CLINIC	0	0			0	
	09100 EMERGENCY	944, 682	1, 148, 848	2, 093, 53	0 -7, 920	2, 085, 610	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	744,002	1, 140, 040	2,073,33	1, 120	2,000,010	92.00
	OTHER REIMBURSABLE COST CENTERS						/2.00
	09500 AMBULANCE SERVICES	0	35, 160	35, 16	0 0	35, 160	95.00
70.00	SPECIAL PURPOSE COST CENTERS		00,100	00,10	0	00,100	/0.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	5, 021, 703	12, 305, 584	17, 327, 28	7 0	17, 327, 287	118.00
100 00	NONREI MBURSABLE COST CENTERS		^				100 00
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		0 0		190.00
	19100 RESEARCH	0	0		0 0		191.00
	19200 PHYSICIANS' PRIVATE OFFICES 19300 NONPAID WORKERS	167, 397	932	168, 32		168, 329	192.00
	19300 NUNPALD WORKERS 19301 OTHER NONRELMBURSABLE COSTS	0	0				193.00
	19302 NEW HORIZON OP	0	0		0 0		193.01
200.00		5, 189, 100	0 12, 306, 516	17, 495, 61		0 17, 495, 616	
			12.300.310	ı ı/,475,0l	0 0	17.470.00	12001 00

Health Financial Systems	ASCENSION ST VINCENT S	SALEM HOSPI TAL	In Lie	u of Form CMS-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL	BALANCE OF EXPENSES	Provider CCN: 15-1314	Peri od: Erom 07/01/2021	Worksheet A

NEGEAS	STITCATION AND ADJUSTMENTS OF TREAD BREANCE OF	I EXI ENGES		From 07/01/2021 To 06/30/2022 Da	ate/Time Prepared:
	Cast Contor Description	Adjustmonts	Net Expenses	11	/29/2022 10:42 am
	Cost Center Description	Adjustments (See A-8)	For Allocation		
		6.00	7.00		
	GENERAL SERVICE COST CENTERS				
1.00	00100 CAP REL COSTS-BLDG & FIXT	0	276, 584		1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	0	362, 790		2.00
3.00	00300 OTHER CAP RELATED COST	0	0		3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	46, 403	3 1, 417, 119		4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	1, 029, 242	2 5, 786, 485		5.00
6.00	00600 MAINTENANCE & REPAIRS	0	0		6.00
7.00	00700 OPERATION OF PLANT	0	.,		7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	70, 143		8.00
9.00	00900 HOUSEKEEPI NG	0	379, 738		9.00
10.00	01000 DI ETARY	44.012	45, 227		10.00
11.00		-44,013			11.00
13.00 14.00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	-1, 878 0			13.00 14.00
14.00	01500 PHARMACY	0	-/		14.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	-		16.00
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0			10.00
30.00	03000 ADULTS & PEDI ATRI CS	-140, 400	853, 911		30.00
	ANCI LLARY SERVICE COST CENTERS	,			
50.00	05000 OPERATI NG ROOM	-25,000	621, 608		50.00
54.00	05400 RADI OLOGY - DI AGNOSTI C	-99, 035			54.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		58.00
60.00	06000 LABORATORY	0	1, 352, 721		60.00
61.00	06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0		61.00
65.00	06500 RESPI RATORY THERAPY	0	72, 455		65.00
66.00	06600 PHYSI CAL THERAPY	0	439, 110		66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	60, 114		67.00
68.00	06800 SPEECH PATHOLOGY	0			68.00
69.00	06900 ELECTROCARDI OLOGY	-61, 692	126, 249		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	21 004			70.00
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPLANTABLE DEVICES CHARGED TO	-31, 806 0			71.00 72.00
72.00	PATIENTS	U	57, 391		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	-72, 245	682, 281		73.00
74.00	07400 RENAL DI ALYSI S	, 2, 2.10			74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	o o		75.00
75.01	03950 SLEEP DI SORDER	0	132, 248		75.01
75.03	07501 ADULT MENTAL HEALTH	0			75.03
76.97	07697 CARDI AC REHABI LI TATI ON	O	129, 190		76. 97
	OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	0	-		88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000 CLINIC	0	0		90.00
91.00	09100 EMERGENCY	0	2, 085, 610		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				92.00
95 00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	0	35, 160		95.00
<i>9</i> 5.00	SPECIAL PURPOSE COST CENTERS	0	55,100		93.00
118.00		599, 576	17, 926, 863		118.00
	NONREI MBURSABLE COST CENTERS				
190.00	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		190.00
191.00	19100 RESEARCH	0	0		191.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	168, 329		192.00
193.00	19300 NONPALD WORKERS	0	0 0		193.00
	19301 OTHER NONREI MBURSABLE COSTS	0	0 0		193. 01
	19302 NEW HORIZON OP	0	0		193. 02
200.00	TOTAL (SUM OF LINES 118 through 199)	599, 576	18, 095, 192		200.00

Heal th	Financial Systems	ASCE	NSION ST VINCE	NT SALEM HOSPI	TAL	In Lie	u of Form CMS	-2552-10
RECLAS	SIFICATIONS			Provider (	CCN: 15-1314	Peri od:	Worksheet A-	6
						From 07/01/2021 To 06/30/2022	Date/Time Pr 11/29/2022 1	epared: 0:42 am_
		Increases						
	Cost Center	Line #	Salary	Other				
	2.00	3.00	4.00	5.00				
	A – CAFETERIA							_
1.00	CAFETERI A	<u>11.00</u>	0	<u> </u>				1.00
	B - BILLABLE MEDICAL SUPPLIES	;			1			1
1.00	MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	71.00		92, 181				1.00
2.00								2.00
3.00								3.00
4.00								4.00
				92, 181				
	C - PT/OT							
1.00	OCCUPATI ONAL THERAPY	67.00	59, 452	662				1.00
			59, 452	662				
	D - Pharmacy							
1.00	PHARMACY			1 <u>6, 2</u> 45				1.00
			0	16, 245				
	E - Maintenance		r		1			-
1.00	MAINTENANCE & REPAIRS	<u>    6.</u> 00	+	<u>2, 2</u> 68				1.00
			0	2, 268				
500.00	Grand Total: Increases	I	59, 452	442, 030				500.00

Heal th	Financial Systems	ASCE	NSION ST VINCEN	IT SALEM HOSPI	TAL	In Lie	u of Form CMS-	-2552-10
RECLAS	SI FI CATI ONS			Provider (	CCN: 15-1314	Peri od:	Worksheet A-	5
						From 07/01/2021 To 06/30/2022	Date/Time Pre	anarad
						10 00/30/2022	11/29/2022 10	2):42 am
	Cost Center	Line #	Salary	0ther	Wkst. A-7 Ref	,		
	6. 00	7.00	8.00	9.00	10.00			
	A – CAFETERIA				1			
1.00	DI ETARY		0	33 <u>0, 6</u> 74		Q		1.00
	TOTALS		0	330, 674				
	B - BILLABLE MEDICAL SUPPLIES				1	-		-
1.00	ADULTS & PEDIATRICS	30.00		94				1.00
2.00	OPERATING ROOM	50.00		82, 642				2.00
3.00	RADIOLOGY - DIAGNOSTIC	54.00		1, 525				3.00
4.00	EMERGENCY	91.00	↓	7,920				4.00
			0	92, 181				
	C - PT/OT	r			T	1		_
1.00	PHYSICAL THERAPY		5 <u>9, 4</u> 52					1.00
			59, 452	662				
	D - Pharmacy	I			1			-
1.00	DRUGS_CHARGED_TO_PATIENTS			1 <u>6, 2</u> 45				1.00
			0	16, 245				]
	E - Maintenance				-			
1.00	OPERATION OF PLANT		+	2,268		_		1.00
			0	2, 268				
500.00	Grand Total: Decreases		59, 452	442, 030				500.00

Heal th Financia	1 5	Systems		
RECONCI LI ATI ON	0F	CAPI TAL	COSTS	CENTERS

# ASCENSION ST VINCENT SALEM HOSPITAL Provider CCN: 15-1314 Period:

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

To 06/30/2022 Date/Ti 11/29/2	)22 10:42 am
Acqui si ti ons	
Beginning Purchases Donation Total Disposal	s and
Bal ances Retirem	
<u>1.00</u> <u>2.00</u> <u>3.00</u> <u>4.00</u> <u>5.00</u>	)
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES	
1.00 Land 180,000 0 0	0 1.00
2.00 Land Improvements 0 0 0 0	0 2.00
3.00         Buildings and Fixtures         2,704,720         337,002         0         337,002	0 3.00
4.00 Building Improvements 859,079 0 0 0	0 4.00
5.00 Fixed Equipment 1,878,154 0 0 0	0 5.00
6.00 Movable Equipment 2, 787, 121 458, 980 0 458, 980	0 6.00
7.00 HIT designated Assets 0 0 0 0	0 7.00
8.00 Subtotal (sum of Lines 1-7) 8,409,074 795,982 0 795,982	0 8.00
9.00 Reconciling Items 0 0 0 0	0 9.00
10.00 Total (line 8 minus line 9) 8,409,074 795,982 0 795,982	0 10.00
Ending Balance Fully	
Depreciated	
Assets	
6.00 7.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES	
1.00 Land 180,000 0	1.00
2.00 Land Improvements 0 0	2.00
3.00 Buildings and Fixtures 3,041,722 0	3.00
4.00 Building Improvements 859,079 0	4.00
5.00 Fixed Equipment 1,878,154 0	5.00
6.00 Movable Equipment 3, 246, 101 0	6.00
7.00 HIT designated Assets 0 0	7.00
8.00 Subtotal (sum of lines 1-7) 9,205,056 0	8.00
9.00 Reconciling Items 0 0	9.00
10.00 Total (line 8 minus line 9) 9,205,056 0	10.00

Heal th	n Financial Systems ASCE	NSION ST VINCEN	T SALEM HOSPIT	ΓAL	ln Li€	eu of Form CMS-	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider CO		Period: From 07/01/2021 To 06/30/2022	Worksheet A-7 Part II Date/Time Pre 11/29/2022 10	pared:
			SL	JMMARY OF CAPI	TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)		
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	276, 584	0		0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	349, 199	13, 591		0 0	0	2.00
3.00	Total (sum of lines 1-2)	625, 783	13, 591		0 0	0	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description	0ther	Total (1) (sum				
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15.00			-	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	276, 584				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	362, 790				2.00
3.00	Total (sum of lines 1-2)	0	639, 374				3.00

Health Financial Systems AS	CENSION ST VINCE	NT SALEM HOSPIT	AL	In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 07/01/2021 To 06/30/2022	Worksheet A-7 Part III Date/Time Prep 11/29/2022 103	pared:
	COM	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)	instructions)	Insurance	
PART III - RECONCILIATION OF CAPITAL COSTS	1.00	2.00	3.00	4.00	5.00	
1.00 CAP REL COSTS-BLDG & FIXT 2.00 CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)	5, 958, 956 3, 246, 101 9, 205, 057	0	5, 958, 95 3, 246, 10 9, 205, 05 CAPI TAL	1 0. 352643 7 1. 000000		1.00 2.00 3.00
Cost Center Description	Taxes	Other Capi tal -Rel ate d Costs	Total (sum of cols. 5 through 7)	F Depreciation	Lease	
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS 1.00 CAP REL COSTS-BLDG & FIXT	CENTERS			0 276, 584	0	1.00
2.00 CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)	0			0 270, 384 0 349, 199 0 625, 783	13, 591	2.00 3.00
		SL	JMMARY OF CAPI		.,	
Cost Center Description	Interest	Insurance (see instructions)			Total (2) (sum of cols. 9 through 14)	
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS1.00CAP REL COSTS-BLDG & FIXT2.00CAP REL COSTS-MVBLE EQUIP3.00Total (sum of lines 1-2)	CENTERS 0 0 0 0	0		0 0 0 0 0 0	276, 584 362, 790 639, 374	1.00 2.00 3.00

Heal th	Fi nanc	i al	Systems
AD JUST	MENTS 1	0 F	XPENSES

### ASCENSION ST VINCENT SALEM HOSPITAL

	Financial Systems	ASCEN	ISION ST VINCE	NT SALEM HOSPITAL	In Lie	u of Form CMS-2	2552-10
ADJUST	MENTS TO EXPENSES				Period: From 07/01/2021 To 06/30/2022	Worksheet A-8 Date/Time Prep 11/29/2022 103	pared:
				Expense Classification of To/From Which the Amount is			42 am
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
1.00	Investment income - CAP REL	1.00	2.00	3.00 CAP REL COSTS-BLDG & FIXT	4.00	5.00	1.00
1.00	COSTS-BLDG & FIXT (chapter 2)		C		1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		C	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other	В	-6, 169	ADMI NI STRATI VE & GENERAL	5.00	0	3.00
4.00	(chapter 2) Trade, quantity, and time		C		0.00	0	4.00
	discounts (chapter 8)		-				
5.00	Refunds and rebates of expenses (chapter 8)		C		0.00	0	5.00
6.00	Rental of provider space by		C		0.00	0	6.00
7.00	suppliers (chapter 8) Telephone services (pay		C		0.00	0	7.00
	stations excluded) (chapter						
8.00	21) Television and radio service		C		0.00	0	8.00
0.00	(chapter 21)						0.00
9.00 10.00	Parking lot (chapter 21) Provider-based physician	A-8-2	-270, 553		0.00	0	
	adjustment						
	Sale of scrap, waste, etc. (chapter 23)		C		0.00	0	11.00
12.00	Related organization	A-8-1	2, 148, 326			0	12.00
13.00	transactions (chapter 10) Laundry and linen service		C		0.00	0	13.00
	Cafeteria-employees and guests		-44,013	CAFETERI A	11.00		
15.00	Rental of quarters to employee and others		C		0.00	0	15.00
16.00	Sale of medical and surgical		C		0.00	0	16.00
	supplies to other than patients						
17.00	Sale of drugs to other than patients		C		0.00	0	17.00
18.00	Sale of medical records and		C		0.00	0	18.00
10 00	abstracts Nursing and allied health		C		0.00	0	19.00
19.00	education (tuition, fees,		C		0.00	0	19.00
20 00	books, etc.) Vending machines		C		0.00	0	20.00
	Income from imposition of		C		0.00		
	interest, finance or penalty charges (chapter 21)						
22.00	Interest expense on Medicare		C		0.00	0	22.00
	overpayments and borrowings to repay Medicare overpayments						
23.00	Adjustment for respiratory	A-8-3	C	RESPI RATORY THERAPY	65.00		23. 00
	therapy costs in excess of limitation (chapter 14)						
24.00	Adjustment for physical	A-8-3	C	PHYSICAL THERAPY	66.00		24.00
	therapy costs in excess of limitation (chapter 14)						
25.00	Utilization review -		C	*** Cost Center Deleted ***	114.00		25.00
	physicians' compensation (chapter 21)						
26.00	Depreciation - CAP REL		C	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	COSTS-BLDG & FIXT Depreciation - CAP REL		C	CAP REL COSTS-MVBLE EQUIP	2.00	о	27.00
28 00	COSTS-MVBLE EQUIP Non-physician Anesthetist		c	*** Cost Center Deleted ***	19.00		28.00
	Physicians' assistant		C		0.00		29.00
30.00	Adjustment for occupational therapy costs in excess of	A-8-3	C	OCCUPATI ONAL THERAPY	67.00		30.00
	limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see instructions)		C	ADULTS & PEDIATRICS	30.00		30. 99
31.00	Adjustment for speech	A-8-3	C	SPEECH PATHOLOGY	68.00		31.00
	pathology costs in excess of limitation (chapter 14)						
32.00	CAH HIT Adjustment for		C		0.00	0	32.00
33, 00	Depreciation and Interest OTHER REVENUE - ADMINISTRATION	В	-72.245	DRUGS CHARGED TO PATIENTS	73.00	0	33.00
					, 0. 00	، ۹	0. 00

Heal th	Financial Systems	ASCE	SION ST VINCE	NT SALEM HOSPI TAL	In Lie	eu of Form CMS-2	2552-10
ADJUST	MENTS TO EXPENSES				Period: From 07/01/2021	Worksheet A-8	
					To 06/30/2022	Date/Time Pre 11/29/2022 10	
				Expense Classification or			
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Pasis (Codo (2))	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	cost center bescription	1.00	2.00	3,00	4, 00	5, 00	
33.01	BUILDING RENTAL INCOME	В		ELECTROCARDI OLOGY	69.00		33.01
33.06	BAD DEBT	A		ADMI NI STRATI VE & GENERAL	5.00		33.06
33.07	CHARI TABLE EXPENSE	A		ADMI NI STRATI VE & GENERAL	5.00		33.07
33.08	PROVIDER TAX ADJUSTMENT	A		ADMI NI STRATI VE & GENERAL	5.00		33.08
33.09	MEDICAL RECORDS FOR SPN	A		ADMI NI STRATI VE & GENERAL	5.00		33.09
33.10	LOBBYING	A		ADMI NI STRATI VE & GENERAL	5.00		33.10
33.12	IC PHYSICIAN FUND	A		ADMI NI STRATI VE & GENERAL	5.00		33.12
50.00	TOTAL (sum of lines 1 thru 49)		599, 576			-	50.00
	(Transfer to Worksheet A,		2, 0, 0				
	column 6, line 200.)						

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

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

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

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

Heal th	Health Financial Systems ASCENSION ST VINCENT SALEM HOSPITAL In Lieu of Form CMS-25					2552-10
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOM		Period: From 07/01/2021	Worksheet A-8	-1
OFFICE				To 06/30/2022	Date/Time Pre	
	Line No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost		
					Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
		MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED O	RGANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:					
1.00	5.00		Home Office - Capital	234, 167	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	Home Office - Interest	6, 169	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	Home Office - Other	4, 913, 051	2, 983, 990	3.00
3.01	15.00	PHARMACY	SVH CHARGEBACKS	4,000	4,000	3. 01
3.02	4.00	EMPLOYEE BENEFITS DEPARTMENT	HEALTH INSURANCE	821, 855	775, 452	3.02
3.03	71.00	MEDICAL SUPPLIES CHARGED TO	TRG ADMIN FEES - SUPPLIES	-31,806	0	3.03
3.04	13.00	NURSING ADMINISTRATION	TRG ADMIN FEES - CONTRACTED	-1, 878	0	3.04
4.00	5.00	ADMINISTRATIVE & GENERAL	TRG ADMIN FEES - OTHER	-33, 790	0	4.00
5.00	TOTALS (sum of lines 1-4).			5, 911, 768	3, 763, 442	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.

1103 1101	been posted to norkaneet A,				or this part.	
				Related Organization(s) and/	or Home Office	1
						1
						1
						1
		<b>.</b> .				l
	Symbol (1)	Name	Percentage of	Name	Percentage of	1
			Ownership		Ownership	1
	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.

1 CT IIIDUI						
6.00	G	ASCENSI ON SVH	100.00	ASCENSION SVH	100.00	6.00
7.00	G	ASCENSI ON	100.00	ASCENSION	100.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or	HOME OFFICE				100.00
	non-financial) specify:					

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

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

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

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

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

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

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

Health Financial Systems	ASCENSION ST VINCENT	SALEM HOSPI TAL	In Lie	u of Form CMS-2552-10
STATEMENT OF COSTS OF SERVIC	FROM RELATED ORGANIZATIONS AND HOME	Provider CCN: 15-1314	Peri od:	Worksheet A-8-1
OFFICE COSTS			From 07/01/2021	
			To 06/30/2022	Date/Time Prepared:
				11/29/2022 10:42 am
Net Wkst. A	7 Ref.			

	Net	Wkst. A-7 Ref.		
	Adjustments			
	(col. 4 minus			
	col. 5)*			
	6.00	7.00		
	A. COSTS INCUR	RED AND ADJUSTN	IENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED	
	HOME OFFICE CO	STS:		
1.00	234, 167	0		1.00
2.00	6, 169	0		2.00
3.00	1, 929, 061	0		3.00
3.01	0	0		3.01
3.02	46, 403	0		3. 02
3.03	-31, 806	0		3.03
3.04	-1,878	0		3.04
4.00	-33, 790	0		4.00
5.00	2, 148, 326			5.00

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

nas not	been posted to worksheet A,	cordinins randyor z, the amount arrowable should be find cated fin cordinin 4 of this part.	
	Related Organization(s)		
	and/or Home Office		
	Type of Business	1	
	6, 00		
	0.00		
	B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HOME OFFICE:	
-			

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

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

reimbur	rsement under title XVIII.	
6.00	ADMI NI STRATI ON	6.00
7.00	ADMI NI STRATI ON	7.00
8.00		8.00
9.00		9.00
10.00		10.00
100.00		100.00

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

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

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

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

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

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

Heal th	Fi nanci a	I Systems	

#### ASCENSION ST VINCENT SALEM HOSPITAL IN Lieu of Form CMS-2552-10

neur tri	Tinunciui Syste	JIII3 750	Endlon of vinto	INT SALEM HOST	17.6			2002 10
PROVI DE	ER BASED PHYSIC	I AN ADJUSTMENT		Provider (		Period: From 07/01/2021 To 06/30/2022	2 Date/Time Pre	epared:
							11/29/2022 10	):42 am
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
					•		Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00		ADMI NI STRATI VE & GENERAL	6, 118				0	1.00
2.00		ADULTS & PEDIATRICS	140, 400				0	
3.00		OPERATI NG ROOM	25, 000				0	
							-	
4.00		RADIOLOGY - DIAGNOSTIC	99, 035			0	0	
5.00		EMERGENCY	959, 990	0	959, 990	0 0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	(	0	0	8.00
9.00	0.00		0				0	
10.00	0.00		0	0			0	
	0.00		0	0	050.000	0	-	
200.00			1, 230, 543				0	200.00
	Wkst. A Line #		Unadjusted RCE		Cost of	Provi der	Physician Cost	
		I denti fi er	Limit	Unadjusted RCE		Component	of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00		ADMINISTRATIVE & GENERAL	0					1.00
2.00		ADULTS & PEDIATRICS	0	0			0	
3.00		OPERATING ROOM	0	0		-	0	
			0	0		0	-	
4.00		RADI OLOGY – DI AGNOSTI C	0	0	(	0	0	
5.00		EMERGENCY	0	0	C	0 0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0 0	0	8.00
9.00	0.00		0	0	(		0	
10.00	0.00		0				0	
	0.00		0	0				
200.00			0	0			0	200.00
	Wkst. A Line #		Provi der	Adjusted RCE	RCE	Adjustment		
		Identi fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00		ADMINISTRATIVE & GENERAL	0	0	0			1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	C	140, 400		2.00
3.00	50.00	OPERATING ROOM	0	0	0	25,000		3.00
4.00	54.00	RADIOLOGY - DIAGNOSTIC	0	0	0	99, 035		4.00
5.00		EMERGENCY	0	0	(			5.00
6.00	0.00							6,00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0 0		8.00
9.00	0.00		0	0	0	0 0		9.00
10.00	0.00		0	0	C	0		10.00
200.00			0	0	0	270, 553		200.00
		1			1			

	Financial         Systems         ASCE           LLOCATION         -         GENERAL         SERVICE         COSTS	NSION ST VINCE	Provider C	CN: 15-1314 P	eriod:	u of Form CMS- Worksheet B	2552-10
					rom 07/01/2021 o 06/30/2022	Part I Date/Time Pre 11/29/2022 10	
			CAPI TAL REI	ATED COSTS		11/27/2022 10	1. 42 am
	Cost Center Description	Net Expenses for Cost	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFI TS	Subtotal	
		Allocation (from Wkst A			DEPARTMENT		
		<u>col.7)</u>	1.00	2.00	4.00	4A	
	GENERAL SERVICE COST CENTERS			2.00			
1.00	00100 CAP REL COSTS-BLDG & FIXT	276, 584	276, 584				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	362, 790		362, 790			2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 417, 119	3, 236		., .==,	E 074 0E1	4.00
5.00 6.00	00500 ADMI NI STRATI VE & GENERAL 00600 MAI NTENANCE & REPAI RS	5, 786, 485	31, 153	25, 896	132, 717	5, 976, 251 0	5.00
7.00	00700 OPERATION OF PLANT	1, 150, 588	45, 218	6, 026	0	1, 201, 832	
8.00	00800 LAUNDRY & LINEN SERVICE	70, 143	0	0,020	0	70, 143	
9.00	00900 HOUSEKEEPI NG	379, 738	8, 488	451	0	388, 677	
10.00	01000 DI ETARY	45, 227	26, 713	2, 422	0	74, 362	10.00
11.00	01100 CAFETERI A	286, 661	0	0	0	286, 661	
13.00	01300 NURSING ADMINISTRATION	177, 470	1, 055	4, 234	48, 516	231, 275	
14.00	01400 CENTRAL SERVICES & SUPPLY	6, 398	0	0	0	6, 398	
15.00 16.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	0	2, 722 12, 925	41, 953	58, 489 0	103, 164	
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	0	12, 923	0	0	12, 925	10.00
30.00	03000 ADULTS & PEDI ATRI CS	853, 911	30, 754	24, 125	247, 929	1, 156, 719	30. 00
	ANCILLARY SERVICE COST CENTERS					.,	
50.00	05000 OPERATI NG ROOM	621, 608	29, 605	104, 919	142, 661	898, 793	50.00
54.00	05400 RADI OLOGY - DI AGNOSTI C	843, 725	17, 959	92, 069	213, 115	1, 166, 868	54.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	
60.00	06000 LABORATORY	1, 352, 721	5, 185	0	0	1, 357, 906	
61.00	06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0.000	E 447	47.000	0	61.00
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	72, 455 439, 110	2, 999 6, 286			98, 591 569, 107	
67.00	06700 OCCUPATI ONAL THERAPY	60, 114	1, 198			78, 059	
68.00	06800 SPEECH PATHOLOGY	00,111	0	0	0	0,007	
69.00	06900 ELECTROCARDI OLOGY	126, 249	7, 715	41, 334	51, 778	227,076	
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	83, 490	0	0	0	83, 490	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	57, 391	0	0	0	57, 391	
73.00	07300 DRUGS CHARGED TO PATIENTS	682, 281	0	0	0	682, 281	
74.00	07400 RENAL DI ALYSI S	0	0	0	0	0	
75.00 75.01	07500 ASC (NON-DI STI NCT PART) 03950 SLEEP DI SORDER	122 249	0 000 7 000	679	10 210	0 150 044	
75.01	07501 ADULT MENTAL HEALTH	132, 248 392, 397	7, 820 6, 431	0/9	19, 219	159, 966 398, 828	
	07697 CARDI AC REHABI LI TATI ON	129, 190		1, 541	35, 602	167, 652	
	OUTPATIENT SERVICE COST CENTERS	,	.,	.,		,	
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	
90.00	09000 CLI NI C	0	0	0	0	0	
91.00	09100 EMERGENCY	2, 085, 610	12, 402	10, 614	266, 107	2, 374, 733	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
95.00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	35, 160	0	0	0	35, 160	95.00
	SPECIAL PURPOSE COST CENTERS			-	-		
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	17, 926, 863	261, 183	362, 790	1, 373, 201	17, 864, 308	118.00
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0		190. 00
	19100 RESEARCH	0	0	0	-		191.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	168, 329	13, 603	0	47, 154	229, 086	
	19300 NONPAI D WORKERS	0	0	0	0		193.00
	19301 OTHER NONREI MBURSABLE COSTS	0	0	0	0		193.01
	19302 NEW HORIZON OP	0	1, 798	0	0		193.02
200.00 201.00			_	_	_		200.00
		18, 095, 192	276, 584	362, 790	0 1, 420, 355		
202.00		1 18 095 192	1 276 584	i 362,790	I. 420. 355	18.095.192	1202.0

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In Lieu of Form CMS-2552-10

-	*	ENSION ST VINCEN				eu of Form CMS-	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provider C		eriod: rom 07/01/2021	Worksheet B Part I	
				T		Date/Time Pre	epared:
					00,00,2022	11/29/2022 10	): 42 am
	Cost Center Description	ADMI NI STRATI VE	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
		& GENERAL	REPAI RS	PLANT	LINEN SERVICE		
		5.00	6.00	7.00	8.00	9.00	
	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, 976, 251					5.00
6.00	00600 MAINTENANCE & REPAIRS	0	C				6.00
7.00	00700 OPERATION OF PLANT	592, 663	C	1, 794, 495			7.00
8.00	00800 LAUNDRY & LINEN SERVICE	34, 590	C	0	104, 733		8.00
9.00	00900 HOUSEKEEPI NG	191, 669	C	77, 327	0	657, 673	9.00
10.00	01000 DI ETARY	36, 670	0	243, 362	0	0	10.00
11.00	01100 CAFETERI A	141, 362	C	0	0	0	11.00
13.00	01300 NURSING ADMINISTRATION	114,049	C	9, 614	0	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	3, 155	C	0	0	0	14.00
15.00	01500 PHARMACY	50, 874	C	24, 795	0	15, 346	15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	6, 374	C		0	0	1
	INPATIENT ROUTINE SERVICE COST CENTERS	· · · · · ·					1
30.00	03000 ADULTS & PEDIATRICS	570, 416	C	280, 172	13, 306	90, 744	30.00
	ANCILLARY SERVICE COST CENTERS	· · · · ·					1
50.00	05000 OPERATI NG ROOM	443, 224	C	269, 702	11, 748	99, 418	50.00
54.00	05400 RADI OLOGY - DI AGNOSTI C	575, 421	C		12, 821	80, 736	
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	C		0		1
60.00	06000 LABORATORY	669, 628	C	47, 235	0	36, 920	
61.00	06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY				-		61.00
65.00	06500 RESPI RATORY THERAPY	48, 618	0	27, 321	0	0	
66.00	06600 PHYSI CAL THERAPY	280, 645	0		11, 479		
67.00	06700 OCCUPATI ONAL THERAPY	38, 493	0		0	0	1
68.00	06800 SPEECH PATHOLOGY	0	Ő		0	0	
69.00	06900 ELECTROCARDI OLOGY	111, 979	0		0	79, 179	
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	41, 172	0	0	0	0	
72.00	07200 I MPLANTABLE DEVICES CHARGED TO	28, 301	0		0	0	
72.00	PATIENTS	20, 301	0	0	0	l	/2.00
73.00	07300 DRUGS CHARGED TO PATIENTS	336, 455	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	000, 100	0	0	0	0	
75.00	07500 ASC (NON-DI STINCT PART)	0	0	0	0		1
75.01	03950 SLEEP DI SORDER	78, 885	C	-	3, 720	-	
75.03	07501 ADULT MENTAL HEALTH	196, 675	C		3, 720		
76.97	07697 CARDI AC REHABI LI TATI ON	82,675	C		14, 085		
70. 77	OUTPATIENT SERVICE COST CENTERS	02,075	0	12,017	14,005	12,700	/0. //
88.00	08800 RURAL HEALTH CLINIC	0	C	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C		0		89.00
90.00	09000 CLINIC	0	0	0	0	0	
90.00 91.00	09100 EMERGENCY	1, 171, 062	0	112, 987	32, 044		
91.00 92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 171, 002	U	112, 707	32, 044	100, 900	92.00
92.00	OTHER REIMBURSABLE COST CENTERS					l	92.00
05 00		17 220	0	0	0	0	95.00
95.00	09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	17, 339	C	0	0	0	95.00
118.00		5, 862, 394	C	1, 654, 187	99, 203	639, 880	1110 00
116.00	NONREI MBURSABLE COST CENTERS	5, 602, 594	0	1,034,167	99, 203	039,000	110.00
100.00			0	0	0		100.00
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		0		190.00
		0	0		0		191.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	112, 970	0		5, 530		192.00
	19300 NONPALD WORKERS	0	0	-	0		193.00
	19301 OTHER NONREI MBURSABLE COSTS	0	0		0		193.01
	19302 NEW HORI ZON OP	887	C	16, 383	0	0	193.02
200.00			-		_	-	200.00
201.00		0	0		0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	5, 976, 251	0	1, 794, 495	104, 733	657, 673	202.00

	LLOCATION - GENERAL SERVICE COSTS		Provider C	F	eriod: rom 07/01/2021	Worksheet B Part I	
				T	0 06/30/2022	Date/Time Pre 11/29/2022 10	
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON		PHARMACY	
	-	10.00	11.00	13.00	SUPPLY 14.00	15.00	
	GENERAL SERVICE COST CENTERS	10.00	11.00	13.00	14.00	15.00	
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
6.00	00600 MAINTENANCE & REPAIRS						6.00
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	354, 394					10.00
11.00	01100 CAFETERI A	0	428, 023				11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	15, 233				13.00
	01400 CENTRAL SERVICES & SUPPLY	0	0	0	9, 553		14.00
15.00	01500 PHARMACY	0	15, 145			209, 349	
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	C	0	0	0	16.00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	054.004		10/ 750			
30.00	03000 ADULTS & PEDI ATRI CS	354, 394	68, 481	126, 752	420	0	30.00
	ANCI LLARY SERVICE COST CENTERS	0	F2 010	00.400	2.4/0		50.00
50.00	05000 OPERATING ROOM	0	53, 312	80, 428		0	
54.00	05400 RADIOLOGY - DIAGNOSTIC	0	69, 440 0			0	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI) 06000 LABORATORY	0	0	0		0	
60.00		0	U	0	0	0	
61.00 65.00	06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY 06500 RESPIRATORY THERAPY	0	5, 705	0	156	0	61.00 65.00
66.00	06600 PHYSI CAL THERAPY	0	49, 569			0	
67.00	06700 OCCUPATI ONAL THERAPY	0	6, 787			0	
68.00	06800 SPEECH PATHOLOGY	0	0, 707	0		0	
69.00	06900 ELECTROCARDI OLOGY	0	21, 912	1, 337	-	0	
	07000 ELECTROENCEPHALOGRAPHY	0	21, 712	0		0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		0	
72.00	07200 I MPLANTABLE DEVICES CHARGED TO	0	0	0		0	
/ 2. 00	PATIENTS	0	Ū.		1,20,	Ū.	12100
73.00	07300 DRUGS CHARGED TO PATIENTS	0	C	0	0	209, 349	73.00
74.00	07400 RENAL DIALYSIS	0	C	0	0	0	1
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	03950 SLEEP DI SORDER	0	9, 708	80	23	0	75.01
75.03	07501 ADULT MENTAL HEALTH	0	C	0	3	0	75.03
76. 97	07697 CARDI AC REHABI LI TATI ON	0	13, 858	24, 817	23	0	76.97
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	C	0	0	0	
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C			0	
	09000 CLI NI C	0	C	0	-	0	
	09100 EMERGENCY	0	77, 828	136, 757	1, 498	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REI MBURSABLE COST CENTERS			1			
95.00	09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
	SPECIAL PURPOSE COST CENTERS						
118.00		354, 394	406, 978	370, 171	9, 535	209, 349	118.00
100.00	NONREI MBURSABLE COST CENTERS	~	~			^	100.00
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0				190.00
	19100 RESEARCH 19200 PHYSI CLANS' PRI VATE OFFI CES	0		0	0		191.00 192.00
	19200 PHYSICIANS' PRIVATE OFFICES	0	21, 045		0		192.00
	19300 NONPALD WORKERS	0	0		-		193.00
	19302 NEW HORIZON OP	0			18		193.01
		0	U		18	0	
	Cross Foot Adjustments	1					
200. 00 201. 00		0	0	0	0	0	200.00

OST ALLOCA	ancial Systems ASCEM ATLON - GENERAL SERVICE COSTS		F SALEM HOSPI	CN: 15-1314	Period:	Worksheet B
					From 07/01/2021 To 06/30/2022	Part I Date/Time Prepare 11/29/2022 10:42
	Cost Center Description	MEDI CAL RECORDS & LI BRARY	Subtotal	Intern & Residents Cos & Post Stepdown Adjustments		
		16.00	24.00	25.00	26.00	
	RAL SERVICE COST CENTERS			Т	- T - T	
	O CAP REL COSTS-BLDG & FIXT					1
	O CAP REL COSTS-MVBLE EQUIP					2
	O EMPLOYEE BENEFITS DEPARTMENT					4
	0 ADMINISTRATIVE & GENERAL					5
	0 MAINTENANCE & REPAIRS					6
	O OPERATION OF PLANT					7
	O LAUNDRY & LINEN SERVICE					8
	0 HOUSEKEEPI NG					9
						10
						11
	0 NURSI NG ADMI NI STRATI ON					13
	0 CENTRAL SERVICES & SUPPLY					14
	O PHARMACY	407.044				15
	0 MEDI CAL RECORDS & LI BRARY	137, 044				16
	TIENT ROUTINE SERVICE COST CENTERS					
	0 ADULTS & PEDIATRICS	23, 601	2, 685, 005		0 2, 685, 005	30
	LLARY SERVICE COST CENTERS	10.070		1		
	O OPERATING ROOM	18, 373	1, 877, 466	1	0 1, 877, 466	50
	0 RADI OLOGY - DI AGNOSTI C	23, 932	2, 093, 788	3	0 2, 093, 788	54
	0 MAGNETIC RESONANCE IMAGING (MRI)	0	)		0 0	58
	O LABORATORY	0	2, 111, 689		0 2, 111, 689	60
	0 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	1.0//	(		0	61
	0 RESPI RATORY THERAPY	1, 966	182, 357	1	0 182, 357	65
	0 PHYSI CAL THERAPY	19, 423	1, 033, 828		0 1,033,828	66
	0 OCCUPATIONAL THERAPY	0	134, 253		0 134, 253	67
	0 SPEECH PATHOLOGY	0	[ []		0 0	68
		7, 552	519, 388	5	0 519, 388	69
	O ELECTROENCEPHALOGRAPHY	0	107 200		0	70
	0 MEDICAL SUPPLIES CHARGED TO PATIENTS 00 IMPLANTABLE DEVICES CHARGED TO	0	127, 209 86, 959	1	0 127, 209 0 86, 959	72
. 00  0720	PATIENTS	0	00, 939	<b>^</b>	0 00, 939	12
. 00 0730	DO DRUGS CHARGED TO PATIENTS	0	1, 228, 085		0 1, 228, 085	73
	O RENAL DI ALYSI S	0	1, 220, 000		0 1, 220, 000	74
	O ASC (NON-DI STINCT PART)	0	(		0 0	75
	O SLEEP DI SORDER	3, 346	352, 106		0 352, 106	75
	1 ADULT MENTAL HEALTH	0	700, 358		0 700, 358	75
	7 CARDI AC REHABI LI TATI ON	4, 776	332, 803		0 332, 803	76
	ATIENT SERVICE COST CENTERS			1		
	O RURAL HEALTH CLINIC	0	C	)	0 0	88
. 00 0890	0 FEDERALLY QUALIFIED HEALTH CENTER	0	C		0 0	89
	O CLINIC	0	C	þ	0 0	90
	O EMERGENCY	26, 822	4, 040, 711		0 4, 040, 711	91
. 00 0920	O OBSERVATION BEDS (NON-DISTINCT PART)				0	92
OTHE	R REIMBURSABLE COST CENTERS					
. 00 0950	O AMBULANCE SERVICES	0	52, 499		0 52, 499	95
SPEC	I AL PURPOSE COST CENTERS					
8.00	SUBTOTALS (SUM OF LINES 1 through 117)	129, 791	17, 558, 504	ŀ	0 17, 558, 504	118
NONR	EIMBURSABLE COST CENTERS					
	O GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	C		0 0	190
1.001910	0 RESEARCH	0	C		0 0	191
2.00 1920	0 PHYSI CLANS' PRI VATE OFFI CES	7, 253	517, 602	2	0 517, 602	192
3. 00 1930	O NONPAID WORKERS	0	C		0 0	193
3. 01 1930	1 OTHER NONREI MBURSABLE COSTS	0	C	D	0 0	193
3. 02 1930	2 NEW HORIZON OP	0	19, 086		0 19, 086	193
0. 00	Cross Foot Adjustments		C		0 0	200
1.00	Negative Cost Centers	О	C	D	0 0	201

Heal th	Fina	nci	al S	Syste	ems	
		OF	CAP	ΙΤΔΙ	RELATED	C

Heal th	Financial Systems ASCE	NSION ST VINCEN	NT SALEM HOSPIT	ΓAL	In Lie	u of Form CMS-2	2552-10
	TION OF CAPITAL RELATED COSTS		Provider C	CN: 15-1314 Pe	eri od:	Worksheet B	
					rom 07/01/2021 0 06/30/2022	Part II Date/Time Pre	pared:
						11/29/2022 10	
			CAPITAL REI	LATED COSTS			
	Cost Center Description	Directly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
	cost center bescription	Assigned New		WVDEL EQUIT	50510101	BENEFITS	
		Capi tal				DEPARTMENT	
		Related Costs					
		0	1.00	2.00	2A	4.00	
1 00	GENERAL SERVICE COST CENTERS						1 1 00
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00 2.00
2.00 4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	3, 236	0	3, 236	3, 236	4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	234, 167	31, 153		291, 216	302	5.00
6.00	00600 MAINTENANCE & REPAIRS	0	0	20,070	0	0	6.00
7.00	00700 OPERATION OF PLANT	0	45, 218	6, 026	51, 244	0	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900 HOUSEKEEPI NG	0	8, 488		8, 939	0	9.00
10.00	01000 DI ETARY	0	26, 713	2, 422	29, 135	0	10.00
11.00		0	0	0	0	0	11.00
13.00 14.00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	0	1, 055	4, 234	5, 289	111 0	13.00 14.00
14.00	01500 PHARMACY	0	2.722	41, 953	44, 675	133	
16.00	01600 MEDI CAL RECORDS & LI BRARY	0			12, 925	0	
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		12,720		12, 720		10.00
30.00	03000 ADULTS & PEDIATRICS	0	30, 754	24, 125	54, 879	565	30.00
	ANCI LLARY SERVI CE COST CENTERS						
50.00	05000 OPERATING ROOM	0			134, 524	325	50.00
54.00	05400 RADI OLOGY - DI AGNOSTI C	0	17, 959		110, 028	486	
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	0	0	0	58.00
60.00	06000 LABORATORY	0	5, 185	0	5, 185	0	60.00
61.00 65.00	06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY 06500 RESPIRATORY THERAPY	0	2, 999	5, 147	8, 146	41	61.00 65.00
66.00	06600 PHYSI CAL THERAPY	0	6, 286		7, 666	279	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	1, 198		1, 198	38	
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0	7, 715	41, 334	49, 049	118	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO	0	0	0	0	0	72.00
73.00	PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
	07500 ASC (NON-DI STINCT PART)	0	0	0	0	0	75.00
75.01	03950 SLEEP DI SORDER	0	7, 820	679	8, 499	44	75.01
75.03	07501 ADULT MENTAL HEALTH	0	6, 431	0	6, 431	0	75.03
76.97	07697 CARDI AC REHABI LI TATI ON	0	1, 319	1, 541	2, 860	81	76.97
	OUTPATIENT SERVICE COST CENTERS		-				
	08800 RURAL HEALTH CLINIC	0		0	0	0	
	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	0	-	0	0	0	
90.00 91.00	09100 EMERGENCY	0		10, 614	23, 016	0 606	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	12,402	10, 014	23, 010	000	92.00
72.00	OTHER REIMBURSABLE COST CENTERS		<u> </u>	11	0		72.00
95.00	09500 AMBULANCE SERVI CES	0	0	0	0	0	95.00
	SPECIAL PURPOSE COST CENTERS						1
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	234, 167	261, 183	362, 790	858, 140	3, 129	118.00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0			0		190.00
	19100 RESEARCH	0		0	0		191.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	13, 603	0	13, 603		192.00
	19300 NONPAID WORKERS 19301 OTHER NONREIMBURSABLE COSTS	0		0	0		193. 00 193. 01
	219301 OTHER NUNREIMBURSABLE CUSTS		1, 798	0	0 1, 798		193.01
200.00		0	1, 790		1, 730	0	200.00
200.00			о о	0	0		201.00
202.00		234, 167	276, 584	362, 790	873, 541		202.00
	- · · · · · · · · · · · · · · · · · · ·		-	· ·			·

Heal th	Fi na	nci a	al S	yste	ms		
		OF	CADI	TAI	DEL	ATED	1

ASCENSI ON	ST	VI NCENT	SALEM	HOSPI TAL

In Lieu of Form CMS-2552-10

	TI ON OF CAPITAL RELATED COSTS	INSTON ST VINCE	Provider C	CN: 15-1314 P	eriod: rom 07/01/2021	Worksheet B Part II	2552-10
				Т		Date/Time Pre 11/29/2022 10	pared:
	Cost Center Description	ADMI NI STRATI VE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	. 42 dili
		5.00	6.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS	1			1		
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINI STRATI VE & GENERAL	291, 518					5.00
6.00	00600 MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700 OPERATION OF PLANT	28, 910	0	80, 154			7.00
8.00	00800 LAUNDRY & LINEN SERVICE	1, 687	0	0	1, 687		8.00
9.00	00900 HOUSEKEEPI NG	9, 350	0	3, 454	0	21, 743	
10.00	01000 DI ETARY	1, 789	0	10, 870	0	0	
11.00	01100 CAFETERIA	6, 896	0	0	0	0	
13.00	01300 NURSI NG ADMI NI STRATI ON	5, 563	0	429	0	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	154	0	0	0	0	
15.00	01500 PHARMACY	2,482	0	1, 107	0	507	15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	311	0	5, 259	0	0	16.00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	27.025	0	10 515	214	2,000	20.00
30.00	03000 ADULTS & PEDI ATRI CS ANCI LLARY SERVI CE COST CENTERS	27, 825	0	12, 515	214	3,000	30.00
50.00	05000 OPERATING ROOM	21, 620	0	12, 047	189	3, 287	50.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	28,069	0	7, 308	207	2,669	1
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	20,009	0	, 300 0	207	2,009	58.00
60.00	06000 LABORATORY	32,664	0	2, 110	0	1, 221	1
61.00	06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	52,004		2,110	0	1,221	61.00
65.00	06500 RESPI RATORY THERAPY	2, 372	0	1, 220	0	0	
66.00	06600 PHYSI CAL THERAPY	13, 690	0	2, 558	185	1, 529	1
67.00	06700 OCCUPATI ONAL THERAPY	1, 878	0	487	0	0	1
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	
69.00	06900 ELECTROCARDI OLOGY	5, 462	0	3, 140	0		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	o	_, 0	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2,008	0	0	0	0	
72.00	07200 I MPLANTABLE DEVICES CHARGED TO	1, 381	0	0	0	0	1
	PATIENTS						
73.00	07300 DRUGS CHARGED TO PATIENTS	16, 412	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	03950 SLEEP DI SORDER	3, 848	0	3, 182	60	831	75.01
75.03	07501 ADULT MENTAL HEALTH	9, 594	0	2, 617	0	1, 529	75.03
76.97	07697 CARDI AC REHABI LI TATI ON	4, 033	0	537	227	426	76.97
	OUTPATIENT SERVICE COST CENTERS	1			1		
	08800 RURAL HEALTH CLINIC	0	0	0	0	0	
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000 CLI NI C	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	57, 120	0	5, 047	516	3, 538	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
05 00	OTHER REIMBURSABLE COST CENTERS	0.1/	0			0	
95.00	09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	846	0	0	0	0	95.00
118.00		285, 964	0	73, 887	1, 598	21 155	118.00
110.00	NONREIMBURSABLE COST CENTERS	205, 904	0	73,007	1, 370	21, 155	110.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
	19100 RESEARCH	0	0	0	o		191.00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	5, 511	0	5, 535	89		192.00
	19300 NONPAI D WORKERS	0,011	0	0	0		193.00
	19301 OTHER NONREL MBURSABLE COSTS	0	0	0	o o		193.01
	19302 NEW HORIZON OP	43	0	732	Ő		193.02
200.00			-				200.00
201.00		0	0	0	0		201.00
202.00		291, 518	0	80, 154	1, 687	21, 743	202.00
					•		

	Cost Center Description				rom 07/01/2021	Part II	
	Cost Center Description				06/30/2022	Date/Time Pre 11/29/2022 10	
	cost center bescription	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
1.00 00100	AL SERVICE COST CENTERS			1	11		
	CAP REL COSTS-BLDG & FIXT						1.00
	CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT						2.00
	ADMINISTRATIVE & GENERAL						5.00
	MAINTENANCE & REPAIRS						6.00
	OPERATION OF PLANT						7.00
	LAUNDRY & LINEN SERVICE						8.00
	HOUSEKEEPING						9.00
10.00 01000	DI ETARY	41, 794					10.00
11.00 01100	CAFETERIA	0	6, 896	þ			11.00
13.00 01300	NURSING ADMINISTRATION	0	245	5 11, 637	7		13.00
	CENTRAL SERVICES & SUPPLY	0	C	-			14.00
	PHARMACY	0	244			49, 148	
	MEDICAL RECORDS & LIBRARY	0	C	) C	0 0	0	16.00
	I ENT ROUTI NE SERVI CE COST CENTERS	41 704	1 102	2 005		0	1 20 00
	ADULTS & PEDIATRICS	41, 794	1, 103	3, 985	5 7	0	30.00
	OPERATING ROOM	0	859	2, 528	3 40	0	50.00
	RADIOLOGY - DIAGNOSTIC	0	1, 119			0	
	MAGNETIC RESONANCE I MAGING (MRI)	0	(, 11) C			0	
	LABORATORY	0	C			0	
	PBP_CLINICAL_LAB. SERVICE-PRGM. ONLY	-					61.00
5.00 06500	RESPI RATORY THERAPY	0	92	2 0	3	0	65.00
66.00 06600	PHYSI CAL THERAPY	0	799		) 1	0	66.00
57.00 06700	OCCUPATI ONAL THERAPY	0	109	) C	0 0	0	67.00
	SPEECH PATHOLOGY	0	C			0	
	ELECTROCARDI OLOGY	0	353			0	
	ELECTROENCEPHALOGRAPHY	0	C			0	
	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C			0	
72.00 07200	IMPLANTABLE DEVICES CHARGED TO	0	C	C	20	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	C		0	49, 148	73.00
	RENAL DIALYSIS	0	C			0	
	ASC (NON-DI STINCT PART)	0	C	-	-	0	
	SLEEP DI SORDER	0	156	3	3 0	0	
	ADULT MENTAL HEALTH	0	C		0	0	75.03
76.97 07697	CARDI AC REHABI LI TATI ON	0	223	780	0 0	0	76.97
	TI ENT SERVICE COST CENTERS			1	1		
	RURAL HEALTH CLINIC	0	C			0	
	FEDERALLY QUALIFIED HEALTH CENTER	0	C	C	-	0	
	CLINIC	0	C			0	
91.00 09100		0	1, 255	4, 299	24	0	71.00
	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	AMBULANCE SERVICES	0	C		0	0	95.00
	AMBOLANCE SERVICES	U		<u> </u>		0	95.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	41, 794	6, 557	11, 637	/ 154	49 148	118.00
	IMBURSABLE COST CENTERS		0,007	1 11,007	101	17,110	1110.00
	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	C		0	0	190.00
91.0019100		0	C		0	0	191.00
92.00 19200	PHYSI CLANS' PRI VATE OFFI CES	0	339	c c	0	0	192.00
	NONPAID WORKERS	0	C		0		193.00
	OTHER NONREIMBURSABLE COSTS	0	C	C	0 0		193. 01
	NEW HORIZON OP	0	C	C	0 0		193. 02
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	C		0		201.00
202.00	TOTAL (sum lines 118 through 201)	41, 794	6, 896	11, 637	154	49, 148	202.00

Health Financial				Systems					
		OE	CAD		DEI	ATED	6		

	ATLON OF CAPITAL RELATED COSTS	NSION ST VINCENT	Provider C		Peri od: From 07/01/2021 To 06/30/2022	Worksheet B Part II Date/Time Prepared: 11/29/2022 10:42 am
	Cost Center Description	MEDI CAL RECORDS & LI BRARY	Subtotal	Intern & Residents Cos & Post Stepdown Adjustments		
		16.00	24.00	25.00	26.00	
1 00	GENERAL SERVICE COST CENTERS			1		
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 ADMI NI STRATI VE & GENERAL					5.00
6.00	00600 MAINTENANCE & REPAIRS					6.00
7.00	00700 OPERATION OF PLANT					7.00
8.00	00800 LAUNDRY & LINEN SERVICE					8.00
9.00	00900 HOUSEKEEPI NG					9.00
10.00	01000 DI ETARY					10.00
11.00	01100 CAFETERI A					11.00
13.00	01300 NURSI NG ADMI NI STRATI ON					13.00
14.00	01400 CENTRAL SERVICES & SUPPLY					14.00
15.00	01500 PHARMACY					15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	18, 495				16.00
10.00		16, 493				18.00
~~ ~~	INPATIENT ROUTINE SERVICE COST CENTERS	0.405	4.40, 070		0 440.070	
30.00	03000 ADULTS & PEDIATRICS	3, 185	149, 072		0 149, 072	30.00
	ANCI LLARY SERVI CE COST CENTERS			1		
50.00	05000 OPERATING ROOM	2, 480	177, 899		0 177, 899	50.00
54.00	05400 RADI OLOGY - DI AGNOSTI C	3, 230	153, 132		0 153, 132	54.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0 0	58.00
60.00	06000 LABORATORY	0	41, 180	)	0 41, 180	60.00
61.00	06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY					61.00
65.00	06500 RESPI RATORY THERAPY	265	12, 139		0 12, 139	65.00
66.00	06600 PHYSI CAL THERAPY	2, 621	29, 328		0 29, 328	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	3, 710		0 3, 710	67.00
68.00	06800 SPEECH PATHOLOGY	0	0, 7.10	1	0 0	68.00
69.00	06900 ELECTROCARDI OLOGY	1,019	61, 802		0 61,802	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	1,019	01, 002		0 01,802	70.00
		0	2 050			
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,050		0 2,050	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO	0	1, 401		0 1, 401	72.00
	PATIENTS					
73.00	07300 DRUGS CHARGED TO PATIENTS	0	65, 560		0 65, 560	73.00
74.00	07400 RENAL DI ALYSI S	0	0		0 0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0		0 0	75.00
75.01	03950 SLEEP DI SORDER	452	17, 075		0 17,075	75.01
75.03	07501 ADULT MENTAL HEALTH	0	20, 171		0 20, 171	75.03
76.97	07697 CARDI AC REHABI LI TATI ON	645	9, 812		0 9,812	76.97
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0	0		0 0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0		0 0	89.00
90.00	09000 CLINIC	Ő	0		0 0	90.00
		3, 619	99, 040	1		
92.00					0	92.00
	OTHER REIMBURSABLE COST CENTERS			1		
95.00	09500 AMBULANCE SERVICES	0	846		0 846	95.00
	SPECIAL PURPOSE COST CENTERS			-		
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	17, 516	844, 217		0 844, 217	118.00
	NONREI MBURSABLE COST CENTERS					
190.00	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		0 0	190.00
191.00	19100 RESEARCH	0	0		0 0	191.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	979	26, 751		0 26, 751	192.00
	19300 NONPALD WORKERS	0	0		0 0	193.00
	19301 OTHER NONREI MBURSABLE COSTS	0	0		0 0	193.01
	19302 NEW HORIZON OP		2, 573		0 2,573	193.02
200.00	Cross Foot Adjustmonts	0	2, 373		0 2, 573	200.00
200100			0	1	0	
	Negetive Cect Corteres					1 1001 00
201.00		0 18, 495	0 873, 541		0 0 0 873, 541	201.00 202.00

## ASCENSION ST VINCENT SALEM HOSPITAL

In Lieu of Form CMS-2552-10 Worksheet B-1

	· · · · · · · · · · · · · · · · · · ·	NSION ST VINCEN				u of Form CMS-	
OST ALI	LOCATION - STATISTICAL BASIS		Provider C		Period: From 07/01/2021	Worksheet B-1	
					o 06/30/2022		
						11/29/2022 10	): 42 a
		CAPITAL REL	LATED COSTS				
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconci I i ati on	ADMI NI STRATI VE	
	bost benter beschiption	(SQUARE FEET)	(COSTED	BENEFITS		& GENERAL	
			REQUIS.)	DEPARTMENT		(ACCUM. COST)	
			,	(GROSS		. ,	
				SALARI ES)			
		1.00	2.00	4.00	5A	5.00	
	GENERAL SERVICE COST CENTERS	100 740					
	DO100 CAP REL COSTS-BLDG & FIXT	102, 740					1.
	00200 CAP REL COSTS-MVBLE EQUIP	1 202	362, 535				2.
	DO400 EMPLOYEE BENEFITS DEPARTMENT DO500 ADMINISTRATIVE & GENERAL	1, 202 11, 572	0 25, 878			12, 118, 941	4.
	DOGOO MAINTENANCE & REPAIRS	11, 372	23, 070	4/1, 14/		12, 110, 941	
	DO700 OPERATION OF PLANT	16, 796	6, 022		-	1, 201, 832	
	DO800 LAUNDRY & LINEN SERVICE	0	0		0 0	70, 143	
	DO900 HOUSEKEEPI NG	3, 153	451	C	0	388, 677	
0.00	D1000 DI ETARY	9, 923	2, 420	c	0 0	74, 362	10.
	D1100 CAFETERI A	0	0	C	0 0	286, 661	11.
-	01300 NURSING ADMINISTRATION	392	4, 231	172, 232	0	231, 275	
	01400 CENTRAL SERVICES & SUPPLY	0	0	C		6, 398	
	D1500 PHARMACY	1,011	41, 924				
	01600 MEDI CAL RECORDS & LI BRARY	4, 801	0	C	0 0	12, 925	16.
	NPATIENT ROUTINE SERVICE COST CENTERS	11 404	24.100	000 152		1 15/ 710	1 20
	03000 ADULTS & PEDIATRICS ANCILLARY SERVICE COST CENTERS	11, 424	24, 108	880, 152	0	1, 156, 719	30.
	D5000 OPERATING ROOM	10, 997	104, 844	506, 448	0	898, 793	50.
	D5400 RADIOLOGY - DIAGNOSTIC	6, 671	92, 004			1, 166, 868	
	D5800 MAGNETIC RESONANCE I MAGING (MRI)	0,0/1	0			0	
	D6000 LABORATORY	1, 926	0		-	1, 357, 906	
	06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	.,	-	-	0	.,	61
	06500 RESPI RATORY THERAPY	1, 114	5, 143	63, 866	0	98, 591	65
. 00 0	06600 PHYSI CAL THERAPY	2, 335	1, 379	434, 278	0	569, 107	66
. 00 0	06700 OCCUPATI ONAL THERAPY	445	0	59, 452	0	78, 059	67
. 00 0	D6800 SPEECH PATHOLOGY	0	0	C	0 0	0	68
	06900 ELECTROCARDI OLOGY	2, 866	41, 305	183, 811	0	227, 076	69
	07000 ELECTROENCEPHALOGRAPHY	0	0	C	0 0	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	C	-	83, 490	
2.00 0	07200 IMPLANTABLE DEVICES CHARGED TO	0	0	C	0 0	57, 391	72
s. oo o	PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	682, 281	73
	07400 RENAL DIALYSIS	0	0		-	002, 201	
	07500 ASC (NON-DI STINCT PART)	0	0		-	0	
	03950 SLEEP DI SORDER	2,905	679		-	159, 966	
	07501 ADULT MENTAL HEALTH	2, 389	0	00,22,		398, 828	
	07697 CARDI AC REHABI LI TATI ON	490	1, 540	126, 389			
	DUTPATIENT SERVICE COST CENTERS						
3.00 0	08800 RURAL HEALTH CLINIC	0	0	C	0 0	0	88.
9.00 0	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	C	0 0	0	89
	09000 CLI NI C	0	0	C	0 0	0	
	09100 EMERGENCY	4, 607	10, 607	944, 682	0	2, 374, 733	
. 00 0	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS					05.4/0	
	09500 AMBULANCE SERVICES	0	0	C	0 0	35, 160	95
8.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	97, 019	362, 535	4, 874, 881	-5, 976, 251	11 000 057	1110
	IONREI MBURSABLE COST CENTERS	97,019	302, 333	4, 0/4, 001	-5, 970, 251	11, 888, 057	1110
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	C	0	0	190
	19100 RESEARCH	0	0				191
	19200 PHYSI CLANS' PRI VATE OFFI CES	5,053	0	167, 397		229, 086	
	19300 NONPAID WORKERS	0	0	C			193
	19301 OTHER NONREIMBURSABLE COSTS	0	0	C	0		193
3. 02 1	19302 NEW HORIZON OP	668	0	C	0	1, 798	
0. 00	Cross Foot Adjustments						200
1.00	Negative Cost Centers						201
2.00	Cost to be allocated (per Wkst. B,	276, 584	362, 790	1, 420, 355	5	5, 976, 251	202
	Part I)						
3.00	Unit cost multiplier (Wkst. B, Part I)	2. 692077	1. 000703			0. 493133	
4.00	Cost to be allocated (per Wkst. B,			3, 236		291, 518	204
	Part II)			0.000/10		0 004055	005
5.00	Unit cost multiplier (Wkst. B, Part			0.000642		0. 024055	205
6.00	)  NAHE adjustment amount to be allocated						204
0.00	(per Wkst. B-2)						206.
				1	1		0.07
07.00	NAHE unit cost multiplier (Wkst. D,						207.

Heal th Financi al			Systems				
	COST A			[			

## ASCENSION ST VINCENT SALEM HOSPITAL

In Lieu of Form CMS-2552-10

Cost Center Description     MAINTENANCE & OPERATION OF LAUNDRY & HOU REPAIRS     PLANT     LINEN SERVICE     ()	od:	eu of Form CMS-2 Worksheet B-1	
Cost Center Description         MAINTENANCE & COPERATION OF PLANT (SQUARE FEET)         LAUNDRY & LINEN SERVICE         LAUNDRY & COUPLANT (SQUARE FEET)         LAUNDRY & COUPLANT (SQUARE FEET)         LAUNDRY & COUPLANT (SQUARE FEET)         LAUNDRY & COUPLANT (SQUARE FEET)         LAUNDRY         EVENTSERVICE COST CENTERS           1.000         OOTOO CAP REL COSTS-MELE EQUIP         6.00         7.00         8.00           4.000         OOTOO CAP REL COSTS-MELE EQUIP         0         0         0           4.000         OOGOO CAP REL COSTS-MELE EQUIP         0         7.01         0           0.0000 (ADMIN ISTRATI VE & CENERAL         0         7.01         7.02         7.02           0.0000 (ADMIN ISTRATI VE & CENERAL         0         7.01         7.02         7.02         7.02           0.00000 (ADMIN ISTRATI VE & CENERAL         0         0         7.02         0         17.482           0.00000 (ADMIN ISTRATI VE & CENERAL         0         0         3.153         0         0           1.000 (1000 CETERI A         SERVICE         0         0         1.011         0         0           1.000 (1000 CALLARY SERVICE COST CENTERS         0         1.011         0         0         0           1.000 (1000 ADDILAL RECORDS & LIBRARY         0         1.0497         1			
Cost Center Description         MAINTENANCE & REPAIRS (SQUARE FEET)         OPERATION OF PLANT (SQUARE FEET)         LAUNDRY & LINEN SERVICE (SQUARE FEET)         Hold LAUNDRY)           1.00         00100 CAP REL COST CENTERS         6.00         7.00         8.00           1.00         00100 CAP REL COST-SHUEL EQUIP         0         0         0           1.00         00200 CAP REL COSTS-MUBLE EQUIP         0         0         0           1.00         00400 EMPLOYEE BENEFITS DEPARTMENT         0         7.3, 170         0           0.00         00000 OPERATION OF PLANT         0         7.3, 170         0           0.00         00000 INUINEY & LINEN SERVICE         0         3, 153         0           0.00         00000 INUISENERAL         0         0         0         0           1.00         01000 OPERATION OF PLANT         0         9, 923         0           1.00         01000 OPERATION OF PLANT         0         0         0         0           1.00         01000 OPERATION OF PLANT         0         0         0         0         0           1.00         01000 OPERATION OF PLANT         0         0         0         0         0           1.00         01000 AUBLING TRANCE         0 <td>07/01/2021 06/30/2022</td> <td>Date/Time Pre</td> <td>hared</td>	07/01/2021 06/30/2022	Date/Time Pre	hared
REPAIRS (SQUARE FEET)         REPAIRS (SQUARE FEET)         LI NEN SERVICE (POUNDS)         LI NEN SERVICE (POUNDS)         CO           00100         CAP REL COSTS - BLIDG & FLXT (SQUARE FEET)         6.00         7.00         8.00           1.00         00100         CAP REL COSTS - BLIDG & FLXT (SQUARE TEXT)         0         8.00           1.00         00400         CAP REL COSTS - MUBLE EQUIP 4.00         00400         EMPLAYEE BENEFITS DEPARTMENT 0         0           5.00         00500         ADMINTENANCE & REPAIRS 0         0         73, 170           8.00         00800         LAUNDRY & LI NEN SERVICE 0         0         0         73, 170           8.00         00800         DEVERTERIA 0         0         3, 153         0           10.00         10100         CAFETERIA 0         0         9, 22         0           11.00         01400         EXTRAL SERVICE S& SUPPLY 0         0         0         0           15.00         01500         MACIDARCY 0         0         1, 011         0           10.00         CASON PHARMACY 0         0         1, 1424         2, 221           MACILLARY SERVICE COST CENTERS         0         1, 1424         2, 221           MACILLARY SERVICE COST CENTERS         0	00/ 30/ 2022	11/29/2022 10:	
GENERAL SERVICE COST CENTERS         (COUNDS OF LAUNDRY)         3           1.00         00100[CAP REL COSTS-BLDG & F1XT         0	DUSEKEEPI NG	DI ETARY	
GENERAL SERVICE COST CENTERS         6.00         7.00         8.00           1.00         OD100 CAP REL COSTS -ENDLG & FIXT         6.00         7.00         8.00           2.00         D0200 CAP REL COSTS -MUBLE EQUIP         6.00         7.00         8.00           4.00         D0400 EMPLOYEE BENEFITS DEPARTIMENT         0         7.170         8.00           5.00         D0500 OPERATION OF PLANT         0         7.170         8.00           6.00         D0400 DETARY         0         7.170         8.00           0.00         D0500 DEVERTION OF PLANT         0         7.170         8.00           0.00         D0500 DEVERTION OF PLANT         0         9.923         0         0           1.00         D100 CAFETERI A         0         0         9.923         0           1.00         D100 CAFETERI A         0         0         0         0           1.00         D100 CARTRAL SERVICES & SUPPLY         0         0         0         0           1.00         D100 OPHARMACY         0         1.011         0         0           1.00         D10AULTS & PEDI ATRICS         0         1.1,424         2,221           ANCI LLARY SERVICE COST CENTERS         0	(HOURS OF	(MEALS SERVED)	
6.00         7.00         8.00           1.00         00100         CAP         REL COSTS-BLDG & FIXT         0           2.00         00200         CAP         REL COSTS-MVBLE EQUIP         0           4.00         00400         EMPERTS         0         7           0.00         00500         AMIN IN STRATI VE & GENERAL         0         7           0.00         00700         OPERATI ON OF PLANT         0         7         7           8.00         00800         LAUNDRY & LI NEN SERVI CE         0         0         3         153         0           10.00         01000         CAPETERIA         0         0         0         0         0         0           11.00         01100         CAPETERIA         0         0         0         0         0         0           11.00         01000         CHARY         0         3/11         0         0         0         0         0           11.00         1100         CAPETERIA         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0 <td>SERVICE)</td> <td></td> <td></td>	SERVICE)		
GENERAL SERVICE COST CENTERS           1.00         00100 CAP REL COSTS -BLDG & FLXT           0.00         00200 CAP REL COSTS - MVBLE EQUI P           4.00         00400 EMPLOYEE BENEFI TS DEPARTMENT           5.00         00500 ADMI NI STRATI VE & GENERAL           6.00         00600 LAUNDRY & LINEN SERVICE         0           0.00         00700 OPERATION OF FLANT         0           7.00         00700 OPERATION OF FLANT         0           9.00         00900 LAUNDRY & LINEN SERVICE         0         0           9.00         00900 LAUNDRY & LINEN SERVICE         0         9, 923         0           11.00         01100 CAEFTERI A         0         9, 923         0           13.00         01300 NURSING ADMIN ISTRATION         0         392         0           14.00         01400 CENTRAL SERVICES & SUPPLY         0         0         0           15.00         01300 MESING ROMINISTRATICS         0         1, 424         2, 221           ANCI LLARY SERVI CE COST CENTERS         0         1, 424         2, 221           ANCI LLARY SERVI CE COST CENTERS         0         1, 424         2, 221           ANCI LLARY SERVI CE COST CENTERS         0         0         0         0			
1.00         00100         CAP         PEL         COSTS-BLDG & FIXT           2.00         00200         CAP         REL         COSTS-MUBLE         EQUIP           4.00         00400         EMPLOYEE         BENEFITS         DEPARTMENT           5.00         00500         ADMINISTRATIVE & GENERAL         0           6.00         00600         MINNORCE & REPARS         0           7.00         00700         DEPRATION OF PLANT         0         73, 170           8.00         00800         LAUNORY & LINEN SERVICE         0         0         17, 482           9.00         00900         HOUSEKEEPING         0         9, 923         0         0           11.00         1100         CAPETERIA         0         0         0         0         0           11.00         10100         CERVEY         0         0         0         0         0         0           13.00         01800         CERVICE COST CENTERS         0         1, 424         2, 221         AKCULARY SERVICE COST CENTERS         0         1, 424         2, 221           AKCULARY SERVICE COST CENTERS         0         0         0         0         0         0         0         <	9.00	10.00	
2.00         0200         CAP_REL_COSTS-MVBLE_EQUIP           4.00         00400         EMPLOYEE BENEFITS DEPARTMENT           5.00         00500         ADMI NI STRATI VE & GENERAL           6.00         00600         ADMI NI STRATI VE & GENERAL           6.00         00600         ADMI NI STRATI VE & GENERAL           6.00         00600         AUMDEY & LINEN SERVICE         0           7.00         0700         OPERATION OF PLANT         0           8.00         00900         HUNDEX KEEPI NG         0         3, 153         0           10.00         01000         DI ETARY         0         9, 923         0           11.00         01100         CAPETERI A         0         0         0           13.00         01300         NURSI NG DMI NI STRATI ON         0         392         0           14.00         OHADE NG DMI NI STRATI ON         0         392         0         0           15.00         01600         PHARMACY         0         1,011         0           16.00         1600         HADAMACY         0         1,011         0           16.00         01600         PEDI ATRI CS         0         1,1,424         2,221			4 00
4.00         Oddol         EMPLOYEE BENEFITS DEPARTMENT			1.00
5.00         OSGO         ADMI NI STRATI VE & GENERAL         0           6.00         00600         MAI NTENANCE & REPAIRS         0           7.00         O7700         OPERATI ON OF PLANT         0         73, 170           8.00         00900         HOUSEKEEPI NG         0         3, 153         0           0.00         01000         DI TARY         0         9, 923         0           11.00         01100         CAFETERI A         0         0         0           13.00         01300         NURSI NG DMI NI STRATI ON         0         3922         0           14.00         OH400         CENTRAL SERVI CES & SUPPLY         0         0         0         0           15.00         01500         PHAMACY         0         1,011         0         0           16.00         O1600         PHAMACY         0         1,011         0         0           17.02         AUCILLARY SERVI CE COST CENTERS         0         11,424         2,221         1           AUCILLARY SERVI CE COST CENTERS         0         1,424         2,221         1         1           40         0         6000         RADI LOKOM         1,400         6,671			2.00
6.00         00600         MAI NTENANCE & REPAIRS         0           7.00         00700         0PERATI ON OF PLANT         0         73, 170           7.00         00800         LAUNDRY & LINEN SERVICE         0         0         17, 482           9.00         00900         HOUSEKEEPI NG         0         3, 153         0           10.00         10100         CAFETERIA         0         9, 00         0         0           11.00         01100         CAFETERIA         0         0         0         0           11.00         01300         DURSING ADMINI STRATI ON         0         392         0           11.00         01400         DURSING ADMINI STRATI ON         0         392         0           15.00         01500         PHARMACY         0         1,011         0           16.00         DIGO MEDI CAL RECORDS & LI BRARY         0         4,801         0           16.00         05000         PERATI NG ROOM         0         11,424         2,221           ANOLLARY SERVICE COST CENTERS			4.00 5.00
7.00       00700       DPERATION OF PLANT       0       73, 170         8.00       00800       LAUNDRY & LINEN SERVICE       0       0       17, 482         9.00       00900       HOUSEKEEPING       0       3, 153       0         10.00       01100       CAFETERIA       0       9, 923       0         11.00       01100       CAFETERIA       0       0       0         13.00       01300       NURSI NG ADMI NI STRATION       0       392       0         14.00       01400       CENTRAL SERVICES & SUPPLY       0       0       0       0         15.00       01500       PHARMACY       0       1,011       0       0       0         16.00       01600       MEDI CAL RECORDS & LI BRARY       0       1,011       0       0         00       03000       ADUOTS & PEDI ATRI CS       0       1,1424       2,221       ANCILLARY SERVICE COST CENTERS         50.00       05400       RADI OLOGY - DI AGNOSTI C       0       6,671       2,140       0       0         60.00       06000       LABORATORY       0       1,926       0       0       0       0         61.00       06000			6.00
8.00         00800         LAUNDRY & LINEN SERVICE         0         0         17,482           9.00         00900         HOUSEKEEPING         0         3,153         0           10.00         01000         DIETARY         0         9,923         0           11.00         CAFETERIA         0         0         0         0           13.00         01300         NURSING ADMINISTRATION         0         392         0           14.00         01400         CENTRAL SERVICES & SUPPLY         0         0         0           15.00         01500         PHARMACY         0         1,011         0         0           16.00         01600         MEDICAL RECORDS & LIBRARY         0         1,011         0         0           16.00         03000         ADULTS & PEDIATRICE         0         1,424         2,221         ANCILLARY SERVICE COST CENTERS           50.00         05000         OPERATING ROOM         0         10,997         1,961         2,140         0           54.00         05400         ADIOLOGY - DIAGNOSTIC         0         6,671         2,140         0           65.00         06500         RESPIRATORY THERAPY         0         1,926 </td <td></td> <td></td> <td>7.00</td>			7.00
9.00         00900         HOUSEKEEPING         0         3, 153         0           10.00         01000         DETARY         0         9, 923         0           11.00         01300         NURSING ADMINISTRATION         0         392         0           13.00         01400         CENTRAL SERVICES & SUPLY         0         0         0           14.00         01400         CENTRAL SERVICES & SUPLY         0         0         0           16.00         01500         PHARMACY         0         1,011         0           16.00         01600         ABARY         0         4,801         0           17.00         01600         ABARY         0         4,801         0           10.00         0000         ADUTS & PEDIATRICS         0         11,424         2,221           ANCILLARY SERVICE COST CENTERS         0         0         0         0         0           0.00         05400         RADIOLOGY - DIAGNOSTIC         0         6,671         2,140           58.00         05400         RADIORTY         0         1,114         0           64.00         06000         LIBARTORY THERAPY         0         1,114         0<			8.00
10.00         01000         DI ETARY         0         9,923         0           11.00         01100         CAFETERIA         0         0         0           13.00         10300         NURSING ADMINISTRATION         0         392         0           14.00         01400         CENTRAL SERVICES & SUPPLY         0         0         0           14.00         01500         PHARMACY         0         1,011         0           0         01600         PHARMACY         0         1,011         0           0         01600         MARCI LAR ECORDS & LI BRARY         0         4,801         0           0         11.424         2,221          0         11.424         2,221           0         03000         ADUTS & PEDI ATRICS         0         11.424         2,221           50.00         05000         OPERATING ROOM         0         10,997         1,961           54.00         0400         ADIOLOGY - DI AGIOSTIC         0         6,671         2,140           58.00         05000         LABRATORY THERAPY         0         1,114         0           61.00         06000         LINICAL LAB. SERVICE-PRGM. ONLY         0 <td>2, 957</td> <td></td> <td>9.00</td>	2, 957		9.00
11.00         01100         CAFETERIA         0         0         0           13.00         01300         NURSI NG ADMINI STRATI ON         0         392         0           14.00         1400         CENTRAL SERVI CES & SUPPLY         0         0         0           15.00         01500         PHARMACY         0         1,011         0           16.00         0EDI CAL RECORDS & LI BRARY         0         4,801         0           10.00         03000         ADULTS & PEDI ATRI CS         0         11,424         2,221           ANCILLARY SERVICE COST CENTERS         0         11,424         2,221         1,961           50.00         05400         PRENTING ROOM         0         10,997         1,961           54.00         05400         RAGNEY         0         1,926         0           61.00         06100         PBP CLINICAL LAB. SERVICE-PRGM. ONLY         0         1,926         0           65.00         06500         RESPI RATORY         0         1,114         0         0           66.00         06500         PHY I ONLI THERAPY         0         2,335         1,916         0           67.00         06700         0CLUPTI ONAL THERA	2, 737	2, 361	10.00
13.00         01300         NURSING ADMINISTRATION         0         392         0           14.00         01400         CENTRAL SERVICES & SUPPLY         0         0         0         0           15.00         01500         PHARMACY         0         1,011         0           16.00         01600         MEDICAL RECORDS & LIBRARY         0         4,801         0           17.011         0         0         4,801         0         1,011         0           16.00         01600         MEDICAL RECORDS & LIBRARY         0         4,801         0           17.0217         8         PEDIATRICS         0         11,424         2,221           ANCILLARY SERVICE COST CENTERS         0         0         0,997         1,961           50.00         05000         MAGNETIC RESONANCE I MAGING (MRI)         0         0         0           50.00         065000         RAGRATORY         0         1,226         0         0           61.00         06500         RESPI RATORY THERAPY         0         2,335         1,916         0           67.00         0600PPT LINI CAL LAB. SERVICE-PRGM. ONLY         0         0         0         0           66.	0	0	11.00
14.00       01400       CENTRAL SERVICES & SUPPLY       0       0       0         15.00       01500       PHARMACY       0       1,011       0         16.00       01600       MEDICAL RECORDS & LIBRARY       0       4,801       0         1000       11021       Service COST CENTERS       0       11,424       2,221         ANCI LLARY SERVICE COST CENTERS       0       0       6,671       2,140         50.00       05000       OPERATING ROOM       0       0       0       0         54.00       05400       RADIOLOGY - DIAGNOSTIC       0       6,671       2,140       0         58.00       05600       MASNETI C RESONANCE I MAGING (MRI)       0       0       0       0         61.00       06100       PBP CLINICAL LAB. SERVICE-PRGM. ONLY       0       1,914       0         65.00       06500       RESPI RATORY THERAPY       0       1,114       0       0         66.00       06600       PHSY ICAL THERAPY       0       2,335       1,916       0         67.00       06700       0CUPATIONAL THERAPY       0       2,866       0       0       0         70.00       07000       ELCTROCARDIOLOGY <td>0</td> <td>0</td> <td>13.00</td>	0	0	13.00
15.00         01500         PHARMACY         0         1,011         0           16.00         01600         MEDICAL         RECORDS & LIBRARY         0         4,801         0           10.00         10300         ADUTINE         SERVICE COST CENTERS         0         11,424         2,221           ANCILLARY SERVICE         COST CENTERS         0         11,424         2,221           ANCILLARY SERVICE         COST CENTERS         0         10,997         1,961           50.00         05400         RADIOLOGY - DIAGNOSTIC         0         6,671         2,140           58.00         06500         LABORATORY         0         1,926         0           61.00         06500         RESPI RATORY         0         1,114         0           65.00         06500         RESPI RATORY         0         1,114         0           66.00         06400         PHYSI CAL THERAPY         0         445         0           67.00         06700         0CUPATI ONAL THERAPY         0         2,335         1,916           67.00         06700         ELECTROCARDI OLOGY         0         0         0           68.00         06800         SPEECH PATHOLOGY	0	0	14.00
16.00         D1600         MEDI CAL         RECORDS & LI BRARY         0         4,801         0           INPATI <ent routine<="" td="">         SERVICE COST CENTERS         0         11,424         2,221           ANCI         LLARY SERVICE COST CENTERS         0         11,424         2,221           ANCI         LLARY SERVICE COST CENTERS         0         10,997         1,961           54.00         05800         MAGNETIC RESONANCE I MAGING (MRI)         0         0         0           56.00         05800         MAGNETIC RESONANCE I MAGING (MRI)         0         0         0           65.00         06000         LABORATORY         0         1,114         0           65.00         06500         RESPI RATORY THERAPY         0         2,335         1,916           67.00         06700         OCUPATI ONAL         THERAPY         0         2,335         1,916           67.00         06700         DCUPATI ONAL         THERAPY         0         2,335         1,916           67.00         06700         OCUPATI ONAL         THERAPY         0         2,866         0           70.00         06900         ELECTROCARDI OLOGY         0         0         0         0</ent>	69	o	15.00
INPATI ENT ROUTI NE SERVI CE COST CENTERS         0         11, 424         2, 221           30.00         03000 ADULTS & PEDI ATRI CS         0         11, 424         2, 221           ANCI LLARY SERVI CE COST CENTERS         0         11, 424         2, 221           50.00         05000 OPERATI NG ROM         0         10, 997         1, 961           54.00         05400         RADI OLOGY - DI AGNOSTI C         0         6, 671         2, 140           58.00         05800         MACNETI C RESONANCE I MAGI NG (MRI )         0         0         0         0           64.00         06000         LABORATORY         0         1, 926         0         0         1, 926         0           65.00         06500         RESPI RATORY THERAPY         0         1, 114         0         66.00         06600         PHYSI CAL THERAPY         0         2, 335         1, 916           67.00         0COUPATI ONAL THERAPY         0         2, 335         1, 916         0         0         0         0           68.00         06600         SPEECH PATHOLOGY         0         0         0         0         0         0         0         0         0         0         0         0         0 <td>0</td> <td>1</td> <td>16.00</td>	0	1	16.00
30.00       O3000       ADULTS & PEDIATRICS       0       11,424       2,221         ANCILLARY SERVICE COST CENTERS         50.00       OPERATING ROM       0       10,997       1,961         54.00       05400       RADIOLOGY - DIAGNOSTIC       0       6,671       2,140         58.00       05800       MAGNETIC RESONANCE IMAGING (MRI)       0       0       0       0         60.00       06000       LABORATORY       0       1,926       0       0       0         61.00       DBP CLINICAL LAB. SERVICE-PRGM. ONLY       0       1,114       0		·	
ANCILLARY SERVICE COST CENTERS           50:00         05000         OPERATING ROOM         0         10,997         1,961           54:00         05400         RADIOLOGY - DIAGNOSTIC         0         6,671         2,140           58:00         05800         MAGNETIC RESONANCE I MAGING (MRI)         0         0         0           60:00         06000         LABORATORY         0         1,926         0           61:00         06100         PBP CLINICAL LAB. SERVICE-PRGM. ONLY         0         1,114         0           65:00         06500         RESPIRATORY THERAPY         0         1,114         0           66:00         0600         PUSICAL THERAPY         0         2,335         1,916           67:00         06700         0CUPATIONAL THERAPY         0         445         0           68:00         06800         SPEECH PATHOLOGY         0         0         0         0           69:00         06900 ELECTROCARDIOLOGY         0         0         0         0         0           71:00         00         0         0         0         0         0         0           71:00         00         0         0         0         0	408	2, 361	30.00
50.00         05000         0PERATING ROM         0         10,997         1,961           54.00         05400         RADI OLOGY         - DI AGNOSTI C         0         6,671         2,140           58.00         05800         MAGNETI C RESONANCE I MAGI NG (MRI )         0         0         0           60.00         06000         LABORATORY         0         1,926         0           61.00         06100         PBP CLINICAL LAB. SERVICE-PRGM. ONLY         -         -         -           65.00         06500         RESPI RATORY THERAPY         0         1,114         0         -           67.00         06700         OCUPATI ONAL THERAPY         0         2,335         1,916           67.00         06700         CCUPATI ONAL THERAPY         0         0         0         0           68.00         06600         SPECH PATHOLOGY         0         0         0         0         0         0           70.00         67000         ELECTROCARDI OLOGY         0         0         0         0         0         0           71.00         07000         ELECTROENCEPHALOGRAPHY         0         0         0         0         0         0         0			
58.00         05800         MAGNETIC RESONANCE IMAGING (MRI)         0	447	0	50.00
60.00       06000       LABORATORY       0       1,926       0         61.00       06100       PBP       CLINICAL LAB. SERVICE-PRGM. ONLY       0       1,114       0         65.00       06500       RESPIRATORY THERAPY       0       1,114       0         66.00       06600       PHYSICAL THERAPY       0       2,335       1,916         67.00       06700       0CUPATIONAL THERAPY       0       445       0         68.00       06800       SPEECH PATHOLOGY       0       0       0         69.00       06900       ELECTROCARDIOLOGY       0       0       0         70.00       07000       ELECTROENCEPHALOGRAPHY       0       0       0         71.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENTS       0       0       0         73.00       07300       DRUGS CHARGED TO PATIENTS       0       0       0         73.00       07300       DRUGS CHARGED TO PATIENTS       0       0       0         75.00       07500       ASC (NON-DI STINCT PART)       0       0       0         75.01       03950       SLEEP DI SORDER       0       2,389       0         76.97       07697 <td>363</td> <td>0</td> <td>54.00</td>	363	0	54.00
61.00       06100       PBP CLINICAL LAB. SERVICE-PRGM. ONLY       0       1, 114       0         65.00       06500       RESPI RATORY THERAPY       0       1, 114       0         66.00       06600       PHYSICAL THERAPY       0       2, 335       1, 916         67.00       06700       OCCUPATIONAL THERAPY       0       445       0         68.00       06800       SPEECH PATHOLOGY       0       0       0         69.00       06900       ELECTROCARDIOLOGY       0       0       0         69.00       07000       ELECTROCARDIOLOGY       0       0       0         70.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0       0       0         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0       0       0         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       0       0         73.00       07500       ASC (NON-DI STI NCT PART)       0       0       0         75.01       03950       SLEEP DI SORDER       0       2, 389       0         75.03       07501       ADULT MENTAL HEALTH       0       2, 389       0         76.97	0	0	58.00
65.00       06500       RESPI RATORY THERAPY       0       1, 114       0         66.00       06600       PHYSI CAL THERAPY       0       2, 335       1, 916         67.00       0CCUPATI ONAL THERAPY       0       445       0         68.00       06800       SPEECH PATHOLOGY       0       0       0         69.00       06900       ELECTROCARDI OLOGY       0       2, 866       0         70.00       07000       ELECTROCARDI OLOGY       0       0       0         70.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0       0       0         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0       0       0         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       0       0         73.00       07300       RUGS CHARGED TO PATI ENTS       0       0       0         75.00       07500       ASC (NON-DI STI NCT PART)       0       0       0         75.01       03950       SLEEP DI SORDER       0       2, 389       0         76.97       07697 CARDI AC REHABI LI TATI ON       0       490       2, 351         0UTPATI ENT SERVI CE COST CENTERS <td< td=""><td>166</td><td>0</td><td>60.00</td></td<>	166	0	60.00
66.00       06600       PHYSI CAL THERAPY       0       2,335       1,916         67.00       06700       0CCUPATI ONAL THERAPY       0       445       0         68.00       06800       SPECH PATHOLOGY       0       0       0         69.00       06900       ELECTROCARDI OLOGY       0       0       0         70.00       07000       ELECTROCARDI OLOGY       0       0       0         70.00       07000       ELECTROCARDI OLOGY       0       0       0         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0       0       0         72.00       07200       IMPLANTABLE DEVI CES CHARGED TO PATI ENTS       0       0       0         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       0       0         74.00       07400       RENAL DI ALYSI S       0       0       0         75.00       07500       ASC (NON-DI STI NCT PART)       0       0       0         75.01       03950       SLEEP DI SORDER       0       2, 389       0         75.03       07501       ADULT MENTAL HEALTH       0       2, 389       0         00TPATI ENT SERVI CE COST CENTERS			61.00
67.00       06700       0CCUPATIONAL THERAPY       0       445       0         68.00       06800       SPEECH PATHOLOGY       0       0       0         69.00       06900       ELECTROCARDIOLOGY       0       2,866       0         70.00       O7000       ELECTROCARDIOLOGY       0       0       0         71.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENTS       0       0       0         72.00       07200       IMPLANTABLE DEVICES CHARGED TO PATIENTS       0       0       0         73.00       07300       DRUGS CHARGED TO PATIENTS       0       0       0         73.00       07400       RENAL DI ALYSI S       0       0       0         75.00       07500       ASC (NON-DI STINCT PART)       0       0       0         75.01       03950       SLEEP DI SORDER       0       2,389       0         75.03       07501       ADULT MENTAL HEALTH       0       2,389       0         76.97       CARDIAC REHABILITATION       0       490       2,351         0UTPATI ENT SERVICE COST CENTERS       0       0       0       0         88.00       08800       RURAL HEALTH CLINIC       0<	0	0	65.00
68.00       06800       SPEECH PATHOLOGY       0       0       0         69.00       06900       ELECTROCARDI OLOGY       0       2,866       0         70.00       07000       ELECTROENCEPHALOGRAPHY       0       0       0         71.00       OT100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0       0       0         72.00       07200       IMPLANTABLE DEVI CES CHARGED TO       0       0       0         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       0       0         73.00       07400       RENAL DI ALYSI S       0       0       0         75.00       07500       ASC (NON-DI STI NCT PART)       0       0       0         75.01       03950       SLEEP DI SORDER       0       2, 389       0         75.03       07501       ADULT MENTAL HEALTH       0       2, 389       0         75.03       07501       ADULT MENTAL HEALTH       0       490       2, 351         OUTPATI ENT SERVICE COST CENTERS         O       0       0         0       08800       RURAL HEALTH CLINIC       0       0       0         0       09000 <td< td=""><td>208</td><td>0</td><td>66.00</td></td<>	208	0	66.00
69.00       06900       ELECTROCARDIOLOGY       0       2,866       0         70.00       07000       ELECTROENCEPHALOGRAPHY       0       0       0         71.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENTS       0       0       0         72.00       07200       IMPLANTABLE DEVICES CHARGED TO       0       0       0         73.00       07300       DRUGS CHARGED TO PATIENTS       0       0       0         73.00       07400       RENAL DI ALYSIS       0       0       0         75.00       07500       ASC (NON-DI STINCT PART)       0       0       0         75.01       03950       SLEEP DI SORDER       0       2, 389       0         75.03       07501       ADULT MENTAL HEALTH       0       2, 389       0         76.97       07697       CARDIA C REHABILITATION       0       490       2, 351         OUTPATI ENT SERVICE COST CENTERS         88.00       08800       RURAL HEALTH CLINIC       0       0       0         89.00       08800       RURAL HEALTH CLINIC       0       0       0       0         90.00       09000       CLINIC       0       0 <td>0</td> <td>0</td> <td>67.00</td>	0	0	67.00
70.00         07000         ELECTROENCEPHALOGRAPHY         0         0         0           71.00         07100         MEDI CAL SUPPLI ES CHARGED TO PATI ENTS         0         0         0           72.00         07200         IMPLANTABLE DEVICES CHARGED TO         0         0         0           73.00         07300         DRUGS CHARGED TO PATI ENTS         0         0         0           74.00         07400         RENAL DI ALYSI S         0         0         0           75.00         07500         ASC (NON-DI STI NCT PART)         0         0         0           75.01         03950         SLEEP DI SORDER         0         2, 905         621           75.03         07501         ADULT MENTAL HEALTH         0         2, 389         0           76.97         07697 CARDI AC REHABI LI TATI ON         0         490         2, 351           OUTPATI ENT SERVI CE COST CENTERS           UMAL DI ALYSI S           O           0         0         490         2, 351           0         0         490         2, 351         0           0         0         0         0         0         0	0	0	68.00
71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0       0       0         72.00       07200       I MPLANTABLE DEVICES CHARGED TO       0       0       0         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       0       0         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       0       0         74.00       07400       RENAL DI ALYSI S       0       0       0         75.00       07500       ASC (NON-DI STI NCT PART)       0       0       0         75.01       03950       SLEEP DI SORDER       0       2, 905       621         75.03       07501       ADULT MENTAL HEALTH       0       2, 389       0         76.97       07697       CARDI AC REHABI LI TATI ON       0       490       2, 351         OUTPATI ENT SERVICE COST CENTERS         88.00       08800       RURAL HEALTH CLINIC       0       0       0         89.00       08800       RURALLY QUALI FIED HEALTH CENTER       0       0       0       0         90.00       09000       CLINIC       0       0       0       0       0 <td>356</td> <td>0</td> <td>69.00</td>	356	0	69.00
72. 00         07200         IMPLANTABLE DEVICES CHARGED TO PATIENTS         0         0         0           73. 00         07300         DRUGS CHARGED TO PATIENTS         0         0         0           74. 00         07400         RENAL DI ALYSIS         0         0         0           75. 00         07500         ASC (NON-DI STINCT PART)         0         0         0           75. 01         03950         SLEEP DI SORDER         0         2, 905         621           75. 03         07501         ADULT MENTAL HEALTH         0         2, 389         0           76. 97         07697         CARDI AC REHABILI TATION         0         490         2, 351           OUTPATI ENT SERVICE COST CENTERS           88. 00         08800         RURAL HEALTH CLINIC         0         0         0           89. 00         08900         FEDERALLY QUALIFIED HEALTH CENTER         0         0         0         0           90. 00         09000         CLINIC         0         0         0         0         0	0	0	70.00
PATIENTS         O         O           73.00         07300         DRUGS CHARGED TO PATIENTS         O         O         O           74.00         07400         RENAL DIALYSIS         O         O         O         O           75.00         07500         ASC (NON-DI STINCT PART)         O         O         O         O           75.01         03950         SLEEP DI SORDER         O         2,905         621           75.03         07501         ADULT MENTAL HEALTH         O         2,389         O           75.03         07697         CARDI AC REHABI LI TATI ON         0         490         2,351           OUTPATI ENT SERVI CE COST CENTERS         0         0         0         0           88.00         08800         RURAL HEALTH CLINIC         O         0         0           89.00         08900         FEDERALLY QUALIFIED HEALTH CENTER         O         0         0           90.00         09000         CLINIC         0         0         0         0	0	0	71.00
73.00       07300       DRUGS CHARGED TO PATIENTS       0       0       0         74.00       07400       RENAL DI ALYSI S       0       0       0         75.01       037500       ASC (NON-DI STINCT PART)       0       0       0         75.01       03950       SLEEP DI SORDER       0       2,905       621         75.03       07501       ADULT MENTAL HEALTH       0       2,389       0         76.97       CARDI AC REHABILI TATI ON       0       490       2,351         OUTPATIENT SERVICE COST CENTERS         88.00       08800       RURAL HEALTH CLINIC       0       0         89.00       08900       FEDERALLY QUALIFIED HEALTH CENTER       0       0       0         90.00       09000       CLINIC       0       0       0	0	0	72.00
74.00       07400       RENAL DI ALYSI S       0       0       0         75.00       07500       ASC (NON-DI STINCT PART)       0       0       0         75.01       03950       SLEEP DI SORDER       0       2,905       621         75.03       07501       ADULT MENTAL HEALTH       0       2,389       0         76.97       CARDI AC REHABILI TATI ON       0       490       2,351         UUTPATI ENT SERVICE COST CENTERS         88.00       08800       RURAL HEALTH CLINIC       0       0         89.00       08900       FEDERALLY QUALIFIED HEALTH CENTER       0       0       0         90.00       09000       CLINIC       0       0       0       0			
75.00         07500         ASC (NON-DI STINCT PART)         0         0         0           75.01         03950         SLEEP DI SORDER         0         2,905         621           75.03         07501         ADULT MENTAL HEALTH         0         2,389         0           76.97         07697         CARDIA C REHABILITATION         0         490         2,351           OUTPATI ENT SERVICE COST CENTERS           88.00         08800         RURAL HEALTH CLINIC         0         0         0           89.00         08900         FEDERALLY QUALIFIED HEALTH CENTER         0         0         0         0           90.00         09000         CLINIC         0         0         0         0         0	0	0	73.00
75. 01       03950       SLEEP       DI SORDER       0       2, 905       621         75. 03       07501       ADULT       MENTAL       HEALTH       0       2, 389       0         76. 97       07697       CARDIAC       REHABILITATION       0       490       2, 351         OUTPATIENT SERVICE COST CENTERS         88. 00       08800       RURAL HEALTH CLINIC       0       0       0         89. 00       08900       FEDERALLY QUALIFIED       HEALTH CENTER       0       0       0         90. 00       09000       CLINIC       0       0       0       0       0	0	0	74.00
75.03       07501       ADULT MENTAL HEALTH       0       2,389       0         76.97       07697       CARDI AC REHABILI TATI ON       0       490       2,351         OUTPATI ENT SERVICE COST CENTERS         88.00       08800       RURAL HEALTH CLINIC       0       0       0         89.00       08900       FEDERALLY QUALIFIED HEALTH CENTER       0       0       0         90.00       09000       CLINIC       0       0       0	112	0	75.00
76.97         07697         CARDI AC         REHABILITATION         0         490         2,351           OUTPATI ENT         SERVICE         COST         CENTERS         0         0         0         0           88.00         08800         RURAL         HEALTH         CLINIC         0         0         0         0           99.00         08900         FEDERALLY         QUALI FIED         HEALTH         CENTER         0         0         0           90.00         09000         CLINIC         0         0         0         0	113		75.01
OUTPATI ENT SERVICE COST CENTERS           88.00         08800         RURAL HEALTH CLINIC         0         0         0           89.00         08900         FEDERALLY QUALIFIED HEALTH CENTER         0         0         0           90.00         09000         CLINIC         0         0         0	208		75.03
88.00         08800         RURAL HEALTH CLINIC         0         0         0           89.00         08900         FEDERALLY QUALIFIED HEALTH CENTER         0         0         0         0           90.00         09000         CLINIC         0         0         0         0	58	0	76.97
89.00         08900         FEDERALLY QUALIFIED HEALTH CENTER         0         0         0           90.00         09000         CLINIC         0         0         0	0	0	88.00
90.00 09000 CLINIC 0 0 0	0	0	89.00
	0	0	90.00
	481	0	91.00
92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART)	101	Ű	92.00
OTHER REIMBURSABLE COST CENTERS			72.00
95.00 09500 AMBULANCE SERVICES 0 0 0 0	0	0	95.00
SPECIAL PURPOSE COST CENTERS			
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 0 67, 449 16, 559	2, 877	2, 361	118.00
NONREI MBURSABLE COST CENTERS			
190. 00 19000 GI FT, FLOWER, COFFEE SHOP, & CANTEEN 0 0 0	0	0	190.00
191.00 19100 RESEARCH 0 0 0	0		191.00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 5, 053 923	80	0	192.00
193. 00 19300 NONPAI D WORKERS 0 0 0	0	0	193.00
193.01 19301 OTHER NONREI MBURSABLE COSTS 0 0 0	o	0	193. 01
193.02 19302 NEW HORI ZON OP 0 668 0	0		193. 02
200.00 Cross Foot Adjustments			200.00
201.00 Negative Cost Centers			201.00
202.00         Cost to be allocated (per Wkst. B,         0         1,794,495         104,733	657, 673	354, 394	202.00
Part I)			
203.00         Unit cost multiplier (Wkst. B, Part I)         0.000000         24.525010         5.990905	222. 412242		
204.00         Cost to be allocated (per Wkst. B,         0         80, 154         1, 687	21, 743	41, 794	204.00
Part II)	7 0500/	47 70400	205 25
205.00         Unit cost multiplier (Wkst. B, Part         0.000000         1.095449         0.096499	7. 353061	17. 701821	205.00
11)			204 00
206.00 NAHE adjustment amount to be allocated			206.00
(per Wkst. B-2)			207 00
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)			207.00
	I	ı I	

SI ALL	LOCATION - STATISTICAL BASIS		Provider CC		Period: From 07/01/2021	Worksheet B-1	
					To 06/30/2022		
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	11/29/2022 10 MEDI CAL	1:42
	· · · · · · · · · · · · · · · · · · ·	(HOURS)	ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &	
			(DI RECT NURS.	SUPPLY (COSTED	REQUIS.)	LIBRARY (TIME SPENT)	
			HRS. )	REQUIS.)		(TIME SPENT)	
		11.00	13.00	14.00	15.00	16.00	
	ENERAL SERVICE COST CENTERS						
	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.
	0400 EMPLOYEE BENEFITS DEPARTMENT						4.
	00500 ADMI NI STRATI VE & GENERAL						5.
0 00	0600 MAINTENANCE & REPAIRS						6.
	00700 OPERATION OF PLANT						7.
	0800 LAUNDRY & LINEN SERVICE						8.
	0900 HOUSEKEEPI NG 01000 DI ETARY						9. 10.
	11000 DFETART 11000 CAFETERIA	107, 142	,				111.
	1300 NURSI NG ADMI NI STRATI ON	3, 813					13.
	1400 CENTRAL SERVICES & SUPPLY	C		432, 58	C		14.
	1500 PHARMACY	3, 791		1, 13			15.
	1600 MEDICAL RECORDS & LIBRARY	C	0		0 0	99, 538	16.
	NPATIENT ROUTINE SERVICE COST CENTERS	47 440	17.045	10.00	4	17 140	20
	03000 ADULTS & PEDIATRICS NCILLARY SERVICE COST CENTERS	17, 142	17, 345	19, 00	4 0	17, 142	30.
	D5000 OPERATING ROOM	13, 345	11, 006	111, 75	0 0	13, 345	50.
	05400 RADIOLOGY - DIAGNOSTIC	17, 382		43, 65		17, 382	
	5800 MAGNETIC RESONANCE IMAGING (MRI)	C	0		o o	0	
	06000 LABORATORY	C	0		0 0	0	
	06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY						61.
		1, 428		7,06		1, 428	
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	12, 408 1, 699		3, 50	2 0 D 0	14, 107 0	
	6800 SPEECH PATHOLOGY	1,095	0		0 0	0	
	06900 ELECTROCARDI OLOGY	5, 485	-	2, 91	-	5, 485	
	7000 ELECTROENCEPHALOGRAPHY	C	0		o o	0	
00 0	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	C	0	115, 27	5 0	0	71.
00 0	7200 IMPLANTABLE DEVICES CHARGED TO	C	0	57, 39	1 0	0	72.
00 0	PATIENTS 07300 DRUGS CHARGED TO PATIENTS				0 100	o	73.
	7400 RENAL DIALYSIS		0			0	
	07500 ASC (NON-DI STINCT PART)		0		0 0	0	
	3950 SLEEP DI SORDER	2, 430	11	1, 04	3 0	2, 430	75.
	7501 ADULT MENTAL HEALTH	C	0	14		0	
	07697 CARDI AC REHABI LI TATI ON	3, 469	3, 396	1, 02	9 0	3, 469	76.
	UTPATIENT SERVICE COST CENTERS					0	
	8800 RURAL HEALTH CLINIC 8900 FEDERALLY QUALIFIED HEALTH CENTER					0	
	9000 CLINIC		0		0 0	0	
	09100 EMERGENCY	19, 482	18, 714	67, 84		19, 482	
00 0	9200 OBSERVATION BEDS (NON-DISTINCT PART)						92.
	THER REIMBURSABLE COST CENTERS	[	-		1		
	09500 AMBULANCE SERVICES	C	0 0		0 0	0	95.
3. 00	PECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	101, 874	50, 655	431, 74	8 100	94, 270	1118
	ONREI MBURSABLE COST CENTERS	101,874	1 50, 055	431,74	100	74, 270	1 10.
	9000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	C	0		0 0	0	190.
I. 00 1	9100 RESEARCH	C	0		0 0	0	191.
	9200 PHYSI CLANS' PRI VATE OFFI CES	5, 268	0		o o	5, 268	
	9300 NONPALD WORKERS	C	0		0 0		193.
	9301 OTHER NONRELMBURSABLE COSTS		0	0.0	0		193.
3. 02 1 ). 00	9302 NEW HORIZON OP Cross Foot Adjustments		0	83	∠ 0	0	193. 200.
1.00	Negative Cost Centers						200.
2.00	Cost to be allocated (per Wkst. B, Part I)	428, 023	370, 171	9, 55	3 209, 349	137, 044	
3.00 4.00	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	3. 994913 6, 896		0. 02208 15		1. 376801 18, 495	
5. 00	Part II) Unit cost multiplier (Wkst. B, Part II)	0. 064363	0. 229731	0.00035	6 491. 480000	0. 185808	205
5. 00	NAHE adjustment amount to be allocated						206.
	(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,						207.
7.00							

	Heal th Financial		I Syst	Systems			
COMPUTATION OF			RATIO	0F	COSTS	TO	С

COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CO		Period: From 07/01/2021 To 06/30/2022	Worksheet C Part I Date/Time Pre 11/29/2022 10		
		Title	XVIII	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost 1 (from Wkst. B, Part I, col. 26)	Гherapy 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 & PEDIATRICS	2, 685, 005		2, 685, 00	05 0	0	30.00
ANCI LLARY SERVICE COST CENTERS						
50.00 05000 OPERATI NG ROOM	1, 877, 466		1, 877, 46		0	50.00
54.00 05400 RADIOLOGY – DIAGNOSTIC	2, 093, 788		2, 093, 78	38 0	0	54.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0			0 0	0	58.00
60. 00 06000 LABORATORY	2, 111, 689		2, 111, 68	39 0	0	60.00
61.00 06100 PBP CLINICAL LAB. SERVICE-PRGM. (				0 0	0	61.00
65. 00 06500 RESPI RATORY THERAPY	182, 357	0	182, 35		0	65.00
66. 00 06600 PHYSI CAL THERAPY	1, 033, 828	0	1, 033, 82	28 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	134, 253	0	134, 25	53 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	519, 388		519, 38	38 0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0			0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIE	ENTS 127, 209		127, 20	09 0	0	71.00
72.00 07200 I MPLANTABLE DEVICES CHARGED TO PATI ENTS	86, 959		86, 95	59 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 228, 085		1, 228, 08	35 0	0	73.00
74.00 07400 RENAL DIALYSIS	0			0 0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0			0 0	0	75.00
75. 01 03950 SLEEP DI SORDER	352, 106		352, 10	06 0	0	75.01
75.03 07501 ADULT MENTAL HEALTH	700, 358		700, 35	58 0	0	75.03
76. 97 07697 CARDI AC REHABI LI TATI ON	332, 803		332, 80	03 0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0			0 0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	R 0			0 0	0	89.00
90. 00 09000 CLI NI C	0			0 0	0	90.00
91.00 09100 EMERGENCY	4, 040, 711		4, 040, 71		0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT P/	ART) 1, 674, 875		1, 674, 87	75	0	92.00
OTHER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVI CES	52, 499		52, 49			95.00
200.00 Subtotal (see instructions)		0				95.00 200.00
	19, 233, 379	0		,		200.00
	1, 674, 875	~	1, 674, 87			201.00
202.00  Total (see instructions)	17, 558, 504	0	17, 558, 50	04 0	0	JZUZ. UU

Heal th	Financial Systems ASCE	NSION ST VINCEN	IT SALEM HOSPIT	AL	In Lie	u of Form CMS-:	2552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider CC		Period: From 07/01/2021 To 06/30/2022	Worksheet C Part I Date/Time Pre 11/29/2022 10	
			Title	XVIII	Hospi tal	Cost	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
		6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS				_		
30.00	03000 ADULTS & PEDIATRICS	466, 502		466, 50	2		30.00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	108, 414	8, 476, 798			0. 000000	
	05400 RADI OLOGY - DI AGNOSTI C	51, 336	14, 041, 379	14, 092, 71		0. 000000	
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0.000000	0. 000000	
	06000 LABORATORY	114, 176	10, 378, 053	10, 492, 22		0. 000000	
	06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0		0 0.000000	0. 000000	
	06500 RESPI RATORY THERAPY	9, 021	945, 778	954, 79		0. 000000	
	06600 PHYSI CAL THERAPY	30, 196	2, 329, 756	2, 359, 95		0. 000000	
	06700 OCCUPATI ONAL THERAPY	6, 592	316, 484	323, 07		0. 000000	
	06800 SPEECH PATHOLOGY	0	0		0 0.000000	0. 000000	
	06900 ELECTROCARDI OLOGY	16, 593	2,033,037	2, 049, 63		0. 000000	
	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0. 000000	0. 000000	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	63, 034	1, 158, 041	1, 221, 07		0. 000000	
	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	2, 679	237, 032	239, 71	1 0. 362766	0. 000000	72.00
	07300 DRUGS CHARGED TO PATIENTS	135, 556	3, 580, 605	3, 716, 16		0.000000	73.00
	07400 RENAL DIALYSIS	0	0		0.000000	0.000000	74.00
	07500 ASC (NON-DISTINCT PART)	0	0		0.000000	0.00000	
	03950 SLEEP DI SORDER	0	940, 453	940, 45		0.00000	75.01
	07501 ADULT MENTAL HEALTH	0	1, 146, 431	1, 146, 43		0. 000000	
76.97	07697 CARDI AC REHABI LI TATI ON	0	334, 968	334, 96	8 0. 993537	0.00000	76.97
	OUTPATIENT SERVICE COST CENTERS			-	1		_
	08800 RURAL HEALTH CLINIC	0	0		0		88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0		89.00
	09000 CLI NI C	0	0		0 0. 000000	0. 000000	
	09100 EMERGENCY	49, 430	13, 090, 435			0. 000000	1
92.00	09200 OBSERVATI ON BEDS (NON-DI STINCT PART) OTHER REIMBURSABLE COST CENTERS	24, 597	392, 915	417, 51	2 4. 011561	0. 000000	92.00
95.00	09500 AMBULANCE SERVICES	0	0		0.00000	0. 000000	95.00
200.00		1, 078, 126	59, 402, 165			0.00000	200.00
200.00		1,070,120	57,402,105	00,400,29	1		200.00
201.00		1, 078, 126	59, 402, 165	60, 480, 29	1		201.00
202.00		1, 070, 120	57, 402, 105	00,400,27	.1	I	1202.00

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COMPUT	ATLON		DATIO		COCTC	TO

In Lieu of Form CMS-2552-10

	LINSTON ST VINCENT			
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1314	Peri od: From 07/01/2021 To 06/30/2022	Worksheet C Part I Date/Time Prepared: 11/29/2022 10:42 a
		Title XVIII	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30.0
ANCILLARY SERVICE COST CENTERS	· · ·			
50. 00 05000 OPERATI NG ROOM	0.000000			50.0
54.00 05400 RADIOLOGY - DIAGNOSTIC	0. 000000			54.0
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000			58.0
60. 00 06000 LABORATORY	0. 000000			60.0
61.00 06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0.000000			61.0
65. 00 06500 RESPI RATORY THERAPY	0.000000			65.0
66. 00 06600 PHYSI CAL THERAPY	0.000000			66.0
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67.0
68.00 06800 SPEECH PATHOLOGY	0. 000000			68.0
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69.0
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			70.0
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71.0
72. 00 07200 I MPLANTABLE DEVICES CHARGED TO	0. 000000			72.0
PATIENTS				
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.0
74.00 07400 RENAL DIALYSIS	0. 000000			74.0
75.00 07500 ASC (NON-DISTINCT PART)	0. 000000			75.0
75. 01 03950 SLEEP DI SORDER	0.000000			75.0
75.03 07501 ADULT MENTAL HEALTH	0.000000			75.0
76. 97 07697 CARDI AC REHABI LI TATI ON	0, 000000			76.9
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC				88.0
89.00 08900 FEDERALLY QUALI FIED HEALTH CENTER				89.0
90. 00 09000 CLINIC	0, 000000			90.0
91. 00 09100 EMERGENCY	0.000000			91.0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.0
OTHER REIMBURSABLE COST CENTERS				
95. 00 09500 AMBULANCE SERVICES	0.000000			95.0
200.00 Subtotal (see instructions)				200. 0
201.00 Less Observation Beds				201.0
202.00 Total (see instructions)				202. 0
	1			1202.0

Heal th	ıl Syst	Systems					
COMPLIT	ATLON	0F	RATIO	0F	COSTS	TO	С

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-1314	Period: From 07/01/2021 To 06/30/2022		pared:
	-	Titl	e XIX	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.		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 & PEDIATRICS	2, 685, 005		2, 685, 00	5 0	2, 685, 005	30.00
ANCI LLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	1, 877, 466		1, 877, 46		1, 877, 466	
54.00 05400 RADIOLOGY - DIAGNOSTIC	2, 093, 788		2, 093, 78	8 0	2, 093, 788	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0			0 0	0	
60. 00 06000 LABORATORY	2, 111, 689		2, 111, 68	9 0	2, 111, 689	
61.00 06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0			0 0	0	
65. 00 06500 RESPI RATORY THERAPY	182, 357	0	182, 35	7 0	182, 357	65.00
66. 00 06600 PHYSI CAL THERAPY	1, 033, 828	0	1, 033, 82	8 0	1, 033, 828	66.00
67.00 06700 OCCUPATI ONAL THERAPY	134, 253	0	134, 25	3 0	134, 253	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	519, 388		519, 38	8 0	519, 388	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0			0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	127, 209		127, 20	9 0	127, 209	71.00
72. 00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	86, 959		86, 95	9 0	86, 959	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 228, 085		1, 228, 08	5 0	1, 228, 085	73.00
74.00 07400 RENAL DI ALYSI S	0			0 0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0			0 0	0	75.00
75. 01 03950 SLEEP DI SORDER	352, 106		352, 10	6 0	352, 106	75.01
75.03 07501 ADULT MENTAL HEALTH	700, 358		700, 35	8 0	700, 358	75.03
76. 97 07697 CARDI AC REHABI LI TATI ON	332, 803		332, 80	3 0	332, 803	76.97
OUTPATIENT SERVICE COST CENTERS			_			
88.00 08800 RURAL HEALTH CLINIC	0			0 0	0	00.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0			0 0	0	00000
90. 00 09000 CLINIC	0			0 0	0	
91. 00 09100 EMERGENCY	4, 040, 711		4, 040, 71	1 0	4, 040, 711	91.00
92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	1, 674, 875		1, 674, 87	5	1, 674, 875	92.00
OTHER REI MBURSABLE COST CENTERS	50.155			-	50.155	0.5 0.5
95.00 09500 AMBULANCE SERVICES	52, 499		52, 49			
200.00 Subtotal (see instructions)	19, 233, 379				19, 233, 379	
201.00 Less Observation Beds	1, 674, 875		1, 674, 87		1, 674, 875	
202.00  Total (see instructions)	17, 558, 504	0	17, 558, 50	4 0	17, 558, 504	202.00

Heal th	Financial Systems ASCE	NSION ST VINCEN	IT SALEM HOSPIT	- AL	In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider CO		Period: From 07/01/2021 To 06/30/2022	Worksheet C Part I Date/Time Pre 11/29/2022 10	pared: :42 am
			Ti tl	e XIX	Hospi tal	Cost	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
		6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			•			
30.00	03000 ADULTS & PEDIATRICS	466, 502		466, 50	2		30.00
	ANCILLARY SERVICE COST CENTERS						1
50.00	05000 OPERATI NG ROOM	108, 414	8, 476, 798	8, 585, 21	2 0. 218686	0.00000	50.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	51, 336	14, 041, 379	14, 092, 71	5 0. 148572	0.000000	54.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0.000000	0.000000	58.00
60.00	06000 LABORATORY	114, 176	10, 378, 053	10, 492, 22	9 0. 201262	0.000000	60.00
61.00	06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0		0.000000	0. 000000	61.00
65.00	06500 RESPI RATORY THERAPY	9, 021	945, 778	954, 79	9 0. 190990	0. 000000	65.00
66.00	06600 PHYSI CAL THERAPY	30, 196	2, 329, 756	2, 359, 95	2 0. 438072	0. 000000	66.00
67.00	06700 OCCUPATI ONAL THERAPY	6, 592	316, 484	323, 07	6 0. 415546	0. 000000	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	1	0.000000	0. 000000	68.00
69.00	06900 ELECTROCARDI OLOGY	16, 593	2,033,037	2, 049, 63	0 0. 253406	0. 000000	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0.000000	0.00000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	63, 034	1, 158, 041	1, 221, 07	5 0. 104178	0.00000	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	2, 679	237, 032	239, 71	1 0. 362766	0. 000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	135, 556	3, 580, 605	3, 716, 16	1 0. 330471	0.00000	73.00
74.00	07400 RENAL DIALYSIS	0	0		0.000000	0.00000	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0		0.000000	0. 000000	75.00
75.01	03950 SLEEP DI SORDER	0	940, 453	940, 45	3 0. 374400	0.00000	75.01
	07501 ADULT MENTAL HEALTH	0	1, 146, 431	1, 146, 43	1 0. 610903	0.00000	75.03
76.97	07697 CARDI AC REHABI LI TATI ON	0	334, 968	334, 96	8 0. 993537	0.00000	76.97
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	0	0		0 0. 000000	0.00000	
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0. 000000	0. 000000	
	09000 CLI NI C	0	0		0 0. 000000	0.00000	
	09100 EMERGENCY	49, 430	13, 090, 435			0.00000	
	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) OTHER REI MBURSABLE COST CENTERS	24, 597	392, 915	417, 51	2 4. 011561	0.000000	92.00
	09500 AMBULANCE SERVICES	0	0		0 0.000000	0.00000	95.00
200.00		1, 078, 126	59, 402, 165				200.00
201.00							201.00
202.00		1, 078, 126	59, 402, 165	60, 480, 29	1		202.00

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In Lieu of Form CMS-2552-10

COMPUTA	TION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1314	Period: From 07/01/2021 To 06/30/2022	Worksheet C Part I Date/Time Prepared 11/29/2022 10:42 a
			Title XIX	Hospi tal	Cost
	Cost Center Description	PPS Inpatient			
		Ratio			
		11.00			
	NPATIENT ROUTINE SERVICE COST CENTERS				
	D3000 ADULTS & PEDIATRICS				30. 0
	ANCILLARY SERVICE COST CENTERS				
	D5000 OPERATING ROOM	0. 000000			50.0
	05400 RADI OLOGY - DI AGNOSTI C	0. 000000			54.0
58.00 0	D5800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000			58.0
60.00 0	06000 LABORATORY	0. 000000			60.0
61.00 0	06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0. 000000			61.0
65.00 0	06500 RESPI RATORY THERAPY	0. 000000			65.0
66.00 0	D6600 PHYSI CAL THERAPY	0. 000000			66. (
67.00 0	06700 OCCUPATI ONAL THERAPY	0. 000000			67.0
68.00 C	06800 SPEECH PATHOLOGY	0. 000000			68.0
69.00 0	06900 ELECTROCARDI OLOGY	0. 000000			69.0
70.00 0	07000 ELECTROENCEPHALOGRAPHY	0. 000000			70.0
71.00 0	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71.0
72.00 0	07200 IMPLANTABLE DEVICES CHARGED TO	0. 000000			72.0
	PATIENTS				
73.00 0	07300 DRUGS CHARGED TO PATIENTS	0. 000000			73. (
74.00 0	07400 RENAL DIALYSIS	0. 000000			74.0
75.00 0	D7500 ASC (NON-DISTINCT PART)	0. 000000			75. (
75.01 0	03950 SLEEP DI SORDER	0. 000000			75. (
75.03 0	07501 ADULT MENTAL HEALTH	0. 000000			75. (
76.97 0	07697 CARDI AC REHABI LI TATI ON	0. 000000			76.0
0	DUTPATIENT SERVICE COST CENTERS	·			
88.00 0	08800 RURAL HEALTH CLINIC	0. 000000			88. (
89.00 0	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000			89.0
90.00 0	09000 CLINIC	0. 000000			90.0
91.00 0	D9100 EMERGENCY	0. 000000			91. (
92.00 0	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92.0
0	THER REIMBURSABLE COST CENTERS				
95.00 0	09500 AMBULANCE SERVICES	0. 000000			95.0
200.00	Subtotal (see instructions)				200. (
201.00	Less Observation Beds				201. (
202.00	Total (see instructions)				202.0

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS         Provider CCN: 15-1314         Period: From 06/30/2022         Worksheet D From 06/30/2022           Cost Center Description         Capital Related Cost (from Wkst. 6) Part II. col. 20         Total Charges (stio of Cost (stim 0 kst. 6) Part II. col. 20         Hospital Cost         Capital Cost         Cost Cost Cost (col mn 4)         Capital Cost Cost           ANCILLARY SERVICE COST CENTERS         1.00         2.00         3.00         4.00         5.00           50.00         05000 (PEDRATING ROM CRUD RADIOLARD KLINKS, B) Part II. col. 20         1.00         2.00         3.00         4.00         5.00           60.00         05000 (PEDRATING ROM COST CENTERS         1.00         2.00         3.00         4.00         5.00           50.00         05000 (PEDRATING ROM COST CENTERS         1.00         2.00         3.00         4.00         5.00           60.00         06000 (PADIOLOCY - DI AGNOSTIC         15.132         0.020022         0.010325         38.151         150.00         6.00           60.00         06000 PHSTICAL LAB. SERVICE-PRGM. ONLY         11.402.22         33.010         6.64         58.00         72.02           66.00         06500 DESST RATORY THERAPY         29.328         2.359.952         0.012714         5.640         72.02	Health Financial Systems AS	CENSION ST VINCE	NT SALEM HOSPI	ΓAL	In Lie	eu of Form CMS-:	2552-10
Cost Center Description         Capital Related Cost (from Wkst. 6, Part II, col)         Title XVIII         Hospital         Capital Inpatient         Cost Cost           MACILLARY SERVICE COST CENTERS         Cost Center Description         Capital Rel ated Cost (from Wkst. 6, Part II, col)         Part I, col, 20         0.0000         4.00         5.00           MACILLARY SERVICE COST CENTERS         1.00         2.00         3.00         4.00         5.00           50.00         05000 (Rept Cost)         Display         16,95,212         0.020722         33,010         684           50.00         05000 (RabDicOcy - DIAGNOSTIC         153,132         14,092,715         0.000000         684         50.00           66.00         06000 (ABORDICOCY - DIAGNOSTIC         153,132         14,092,715         0.000229         38,151         150         60.00           66.00         06000 (ABORDICOCY         0         0.000229         38,151         150         60.00           66.00         06000 (PPS CLINICAL LAB SERVICE-PRGM. ONLY         12,139         954,799         0.012714         5,640         72         65.00           67.00         06700 OCUPATIONAL THERAPY         3,710         323,076         0.011483         1,122         13         67.00           68.00	APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPI	TAL COSTS	Provider C	CN: 15-1314			
ANCLILARY SERVICE COST CENTERS         Title XVIII         Hospital         Cost Cost         Capital Related Cost (from Wkst. 6, Part II, col. 20)         Total Charges (rom Wkst. 6, Part I, col. 20)         Ratio of Cost Cost (col. 1 + col. 8)         Total Charges (col. 1 + col. 8)         Ratio of Cost Cost (col. 1 + col. 8)         Capital Cost Column 4)         Cost Capital Cost Column 4)           50.00         05000 (DEERATI NG ROM RADOL RADIOLTORY         177, 899 1.000         8, 585, 212 0.020722         0.020722 33, 010         33, 010         684 50.00         50.00           50.00         05000 (ABOR TIC C RESONANCE IMAGI NG (MR1) 0.000000 (LABORATORY 61.00         177, 899 0.02724         8, 585, 212 0.020722         0.020722 0.000000 0         33, 010         684 50.00         56.00           66.00         06000 RESPIRATORY 61.00         14, 180 0.04100 PE CLINICAL LAB. SERVICE-PRGM. ONLY 61.00         14, 180 0.0422, 229 0.0032925         0.012714 38, 151         5, 640 58, 00         72, 65, 00 58, 00         56.00 0.000000 0         58, 00 0.012714 5, 640         72, 00 0.020721         5, 640 0.022, 0.012427         6, 694 83, 67.00 0.000000 0         68, 00 0.000000 0         72, 00 0.000000 0         72, 00 0.000000 0         72, 00 0.000000 0         72, 00 0.000000 0         72, 00 0.000000 0         72, 00 0.00							narod
Cost Center Description         Capital Related Cost (from Wkst. B, 26)         Total Charges (from Wkst. B, 26)         Ratio of Cost (solumn 4)         Inpatial Cost Cost (column 3)         Cost (column 4)           ANCILLARY SERVICE COST CENTERS         1.00         2.00         3.00         4.00         5.00           50.00         05000 (DPERATING ROOM 54.00         177, 899         8, 585, 212         0.020722         33, 010         684         50.00           56.00         05000 (March TL C RESONANCE LMGING (MRI )         0         0.0000000         0         0.88.00           56.00         05600 (PERATING ROOM 56.00         177, 899         8, 585, 212         0.020722         33, 010         684         50.00           56.00         05600 MAGNETI C RESONANCE IMGING (MRI )         0         0.000000         0         0.58.00           66.00         06600 PHYSICAL LAL SERVICE-PRGM. ONLY         11, 180         10, 492, 229         0.003925         38, 151         150         60.00           66.00         06600 PHYSICAL THERAPY         2, 328         2, 359, 952         0.011483         1, 122         13, 67.00           67.00         0200 OCUPATIONAL THERAPY         3, 710         323, 076         0.000000         0         0         0         0         0         0					10 00/ 30/ 2022		
Rel ated Cost (From Wist. E. 26)         (From Wist. E. 8)         (Col. 1 + col. 8)         Program (Col. 1 + col. 2)         (Col. umn 4)         (col. umn 4)           400         50.00         05000         0PFRATI NG ROOM         177, 899         8, 585, 212         0.020722         33, 010         684         50.00           50.00         05000         0PFRATI NG ROOM         177, 899         8, 585, 212         0.020722         33, 010         684         50.00           50.00         05000         ANCILLARY SERVICE COST CENTERS         0         0.000000         0         0.58.00           60.00         06000         MAGNATING ROOM         177, 899         8, 585, 212         0.020722         33, 010         684         50.00           61.00         06100 PBP CLIN CAL LAB SERVICE-PRGM. ONLY         12, 139         954, 799         0.01214         5, 640         72         65.00           67.00         06700         0CCUPATI ONAL THERAPY         29, 328         2, 359, 952         0.012427         6, 640         73         66.00         66000         66000         66000         66000         0         0         0.000000         0         0         66.00         6600         66.00         6600         0         65.00         0			Title	XVIII	Hospi tal		
Rel ated Cost (From Wist. E. 26)         (From Wist. E. Part II. col. 26)         (From Wist. E. 8)         (Col. 1 + col. 8)         Program (Col. 1 + col. 2)         (Col. umn 4)           50.00         05000         OPERATI NG ROOM         177, 899         8, 585, 212         0.020722         33, 010         684           50.00         05000         OPERATI NG ROOM         177, 899         8, 585, 212         0.020722         33, 010         684         50.00           50.00         05000         ANCILLARY SERVICE COST CENTERS         0         0.000000         0         0.58.00           60.00         06000         MACRETICAL MACING (MRI)         0         0         0.000000         0         0.58.00           60.00         06000         DABORATORY         41, 180         10.492, 229         0.03925         38, 151         150         60.00           60.00         06000         PHCARPY         29, 328         2, 359, 952         0.012427         6, 640         72         65.00           67.00         06700         0.00000         0         0         0.000000         0         0         66.00           68.00         06600 SPECH PATHORAT HERAPY         29, 371         323, 076         0.011483         1, 122         13	Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
Part II, col 26)         8)         2)         3         4           26)         1.00         2.00         3.00         4.00         5.00           ANCILLARY SERVICE COST CENTERS         1.00         2.00         3.00         4.00         5.00           54.00         05000 (DPERATI NG ROM         177, 899         8.585, 212         0.020722         33, 010         684         50.00           56.00         05000 (DPERATI NG ROM         177, 899         8.585, 212         0.020722         33, 010         684         50.00           56.00         05000 (DESPI RACI RESINANCE I MAGI NG (MRI )         0         0.000000         0         58.00         5600         66.00         69.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00		Related Cost	(from Wkst. C,	to Charges		(column 3 x	
26)         200         3.00         4.00         5.00           ANCILLARY SERVICE COST CENTERS         1.00         2.00         3.00         4.00         5.00           50.00         05000         OPERATI NG ROOM         177,899         8.585,212         0.020722         33,010         664         50.00           54.00         05400         RADIOLOGY - DI AGNOSTI C         153,132         14,092,715         0.003020         0         0         58.00           60.00         06000         LABORATORY         41,180         10,492,229         0.003925         38,151         150         60.00           61.00         06100         PBP CLINI CAL LAB. SERVI CE-PRGM. ONLY         41,180         0,492,229         0.003925         38,151         150         61.00           66.00         06500         PESPI RATORY THERAPY         29,328         2,359,952         0.012427         6,694         83         66.00           66.00         06000 CUPATI ONAL THERAPY         3,710         323,076         0.011483         1,122         13         67.00           67.00         0000 CUPATI ONAL THERAPY         3,710         323,076         0.01483         1,511         456         69.00           69.00         06000					. Charges	column 4)	
Image: Note that the service cost centers         Image: Note cost centerse         Image: Note that centers		Part II, col.	8)	2)			
ANCILLARY SERVICE COST CENTERS           50.00         05000         OPERATING ROOM         177, 899         8, 585, 212         0. 202722         33, 010         684         50.00           54.00         05400         RADIOLOGY - DI AGNOSTI C         153, 132         14, 092, 715         0. 010666         9, 427         102         54.00         0.000000         0         0         58.00         0.000000         0         0         58.00         0.000000         0         0         58.00         0.000000         0         0         58.00         0.000000         0         0         58.00         0.000000         0         0         58.00         0.00000         0         0         58.00         0         0.00000         0         0         58.00         0.00000         0         0         58.00         0         0         0.003925         38.151         150         60.00         66.00         6600         PHST LAT HERAPY         12, 139         954.799         0.012714         5, 640         72         65.00         66.00         66.00         60.00         0.000000         0         0         60.00         68.00         69.00         69.00         60.00         68.00         66.00         69.00							
50.00       DFERATI NG ROOM       177, 899       8, 585, 212       0.020722       33, 010       664       50, 00         54.00       D5400       RADI OLOGY - DI AGNOSTI C       153, 132       14, 092, 715       0.010866       9, 427       102       54, 00         56.00       D5800       MAGNETI C       RESONANCE I MAGI NG (MRI )       0       0.0000000       0       058.00         60.00       D6100       PBP CLI NI CAL LAB. SERVI CE-PRGM. ONLY       41, 180       10, 492, 229       0.003925       38, 151       150       60.00         65.00       D6500       RESPI RATORY THERAPY       29, 232       2, 359, 952       0.012427       6, 694       83       66.00         66.00       D6600       PHYSI CAL THERAPY       3, 710       323, 076       0.011443       1, 122       13       67.00         60       06600       SPEECH PATHOLOGY       0       0       0.000000       0       68.00         69.00       06600       BECT ROCARDI OLOGY       61, 802       2, 049, 630       0.030153       15, 111       456       69.00         00       0       0       0       0.000000       0       0       0       0.000000       0       70.00         0		1.00	2.00	3.00	4.00	5.00	
54.00       05400       RADI OLOGY - DI AGNOSTI C       153, 132       14, 092, 715       0.000866       9, 427       102       54, 00         58.00       05800       MAGNETI C RESONANCE I MAGI NG (MRI )       0       0       0.000000       0       0       58.00         60.00       06000       LABORATORY       41, 180       10, 492, 229       0.003925       38, 151       150       60.00         65.00       06500       RESPIRATORY THERAPY       12, 139       954, 799       0.012714       5, 640       72       65, 00         66.00       06600       PHYSI CAL THERAPY       29, 328       2, 359, 952       0.012427       6, 694       83       66, 00         67.00       06700       0CCUPATI ONAL THERAPY       3, 710       323, 076       0.014483       1, 122       13       67.00         68.00       06600       SPECH PATHOLOGY       0       0       0.000000       0       68.00       0       69.00       0       0.000000       0       69.00       69.00       0.000000       0       70.00       71.00       0.01679       25, 458       43       71.00       70.00         71.00       07300       DRUGS CHARGED TO PATI ENTS       2,050       1,221,075			1	1	1	r	
58.00       05800       MAGNETIC RESONANCE IMAGING (MRI)       0       0       0.000000       0       0       58.00         60.00       06000       LABORATORY       41, 180       10, 492, 229       0.003925       38, 151       150       60.00         61.00       06500       RESPI RATORY THERAPY       12, 139       954, 799       0.012714       5, 640       72       65.00         66.00       06500       06500       RESPI RATORY THERAPY       29, 328       2, 359, 952       0.012214       5, 640       72       65.00         66.00       066000       000000       0       0       0.000000       0       68.00         67.00       06700       0CUPATI ONAL THERAPY       3, 710       323, 076       0.011483       1,122       13       67.00         68.00       6800       SPEECH PATHOLOGY       0       0       0.000000       0       0       68.00         69.00       045000       ELCTROCARDIOLOGY       61, 802       2, 049, 630       0.03153       15, 111       456       69.00         70.00       07100       MELATRABLE DEVI CES CHARGED TO PATI ENTS       2, 050       1, 221, 075       0.001679       25, 458       43       71.00							
60.00       06000       LABORATORY       41, 180       10, 492, 229       0.003925       38, 151       150       60.00         61.00       06100       PPP CLINICAL LAB. SERVICE-PRGM. ONLY       12, 139       954, 799       0.012714       5, 640       72       65.00         65.00       05600       RESPIRATORY THERAPY       29, 328       2, 359, 952       0.012427       6, 694       83       66.00         67.00       06000       CCUPATI ONAL THERAPY       3, 710       323, 076       0.011483       1, 122       13       67.00         68.00       06800       PEECER PATHOLOGY       0       0.000000       0       68.00         69.00       06900       ELECTROCARDIOLOGY       61, 802       2, 049, 630       0.030153       15, 111       456       69.00         70.00       07000       ELECTROENCEPHALOGRAPHY       0       0       0.000000       0       70.00         71.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENTS       2, 050       1, 221, 75       0.001679       25, 458       43       71.00         72.00       PATIENTS       0       0       0.0000000       0       0       72.00         73.00       07300       RUGS CHARGED TO PATIE							
61.00       06100       PBP CLINICAL LAB. SERVICE-PRGM. ONLY       61.00         65.00       06500       RESPIRATORY THERAPY       12,139       954,799       0.012714       5,640       72       65.00         64.00       06500       PHSYLICAL THERAPY       29,328       2,359,952       0.012714       5,640       73       66.00         67.00       0C00       0CUPATIONAL THERAPY       3,710       323,076       0.011483       1,122       13       67.00         68.00       0S600       SPEECH PATHOLOGY       0       0       0.000000       0       68.00         69.00       0S000       ELECTROCARDIOLOGY       61,802       2.049,630       0.030153       15,111       456       69.00       69.00       0       0.000000       0       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       72.00       PATHATABLE DEVICES CHARGED TO PATIENTS       2,050       1,221,075       0.001679       25,458       43       71.00         72.00       07200       IMPLANTABLE DEVICES CHARGED TO PATIENTS       65,560       3,716,161       0.017642       74,456       1,314       73.00         73.00       07400       RENAL DI ALYSIS		-	-				
65.00       06500       RESPI RATORY THERAPY       12, 139       954, 799       0.012714       5, 640       72       65.00         66.00       06600       PHYSI CAL THERAPY       29, 328       2, 359, 952       0.012427       6, 694       83       66.00         67.00       0500       OCUPATI (NAL THERAPY       3, 710       323, 076       0.011443       1, 122       13       67.00         68.00       06800       SPECH PATHOLOGY       0       0.000000       0       0       68.00         69.00       06900       ELECTROCARDI OLOGY       61, 802       2,049, 630       0.30153       15, 111       456       69.00         70.00       0700       ELECTROCARDI OLOGY       61, 802       2,049, 630       0.000000       0       70.00       0.000000       0       70.00       0.000000       0       70.00       0.000000       0       70.00       0.000000       0       72.00       72.00       72.00       PATI ENTS       55.60       3, 716, 161       0.017642       74, 456       1, 314       73.00       73.00       0.030000       0       0       75.00       75.00       75.00       75.00       75.00       75.00       75.00       75.00       75.00       75.00		41, 180	10, 492, 229	0. 00392	38, 151	150	
66.00       06600       PHYSI CAL THERAPY       29, 328       2, 359, 952       0.012427       6, 694       83       66.00         67.00       06700       0CCUPATI ONAL THERAPY       3, 710       323, 076       0.011483       1, 122       13       67.00         68.00       0SECE PATHOLOGY       0       0.000000       0       0       68.00         69.00       06900       ELECTROCARDI OLOGY       61, 802       2, 049, 630       0.030153       15, 111       456       69.00         70.00       07000       ELECTROENCEPHALOGRAPHY       0       0.000000       0       70.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       2, 050       1, 221, 075       0.001679       25, 458       43       71.00         72.00       07200       IMPLANTABLE DEVICES CHARGED TO PATI ENTS       2, 050       3, 716, 161       0.017642       74, 456       1, 314       73.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       65, 560       3, 716, 161       0.017642       74, 456       1, 314       73.00         74.00       07500       ASC (NON-DI STI NCT PART)       0       0.000000       0       75.01         75.01       03950       SLEEP DI							
67.00       06700       0CUPATIONAL THERAPY       3,710       323,076       0.011483       1,122       13       67.00         68.00       06800       SPEECH PATHOLOGY       0       0       0.000000       0       0       68.00         69.00       00000       EECTROCARDIOLOGY       61,802       2,049,630       0.030153       15,111       456       69.00         70.00       07000       EECTROENCEPHALOGRAPHY       0       0.000000       0       07.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENTS       2,050       1,221,075       0.001679       25,458       43       71.00         73.00       07300       DRUGS CHARGED TO PATIENTS       65,560       3,716,161       0.017642       74,456       1,314       73.00         74.00       07400       REANAL DI ALYSIS       0       0       0.000000       0       74.00         75.00       07500       ASC (NON-DI STINCT PART)       0       0       0.000000       0       75.00         75.01       03950       SLEEP DI SORDER       17,075       940,453       0.018156       0       75.01         76.97       CARDI AC REHABILITATION       9,812       334,968       0.029292 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
68.00       06800       SPECH PATHOLOGY       0       0       0.00000       0       0       68.00         69.00       06900       ELECTROCARDI OLOGY       61.802       2,049,630       0.030153       15,111       456       69.00         70.00       FLECTROCARDI OLOGY       61.802       2,049,630       0.030153       15,111       456       69.00         70.00       FLECTROCARDI OLOGY       61.802       2,049,630       0.030153       15,111       456       69.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       2,050       1,221,075       0.001579       25,458       43       71.00         72.00       D7200       IMPLANTABLE DEVI CES CHARGED TO       1,401       239,711       0.005845       836       5       72.00         PATI ENTS       07300       DRUGS CHARGED TO PATI ENTS       65,560       3,716,161       0.017642       74,456       1,314       73.00         75.00       07500       ASC (NON-DI STI NCT PART)       0       0       0.000000       0       75.00         75.01       03950       SLEEP DI SORDER       17,075       940,453       0.018156       0       75.03         76.97       ORADI AC REHABI LI TATI ON <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
69.00       06900       ELECTROCARDI OLOGY       61,802       2,049,630       0.030153       15,111       456       69.00         70.00       07000       ELECTROENCEPHALOGRAPHY       0       0       0.000000       0       70.00         71.00       MEDI CAL SUPPLIES CHARGED TO PATIENTS       2,050       1,221,075       0.001679       25,458       43       71.00         72.00       MPLANTABLE DEVICES CHARGED TO       1,401       239,711       0.005845       836       5       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       65,560       3,716,161       0.017642       74,456       1,314       73.00         74.00       07400       RENAL DI ALYSI S       0       0       0.000000       0       75.00         75.01       03950       SLEEP DI SORDER       17,075       940,453       0.018156       0       0       75.01         75.03       07501       ADULT MENTAL HEALTH       20,171       1,146,431       0.017595       0       0       76.97         017407       CARDI AC REHABI LITATI ON       9,812       334,968       0.029292       0       0       76.97         017500       08800       RIRAL HEALTH CLINIC       0							
70. 00         07000         ELECTROENCEPHALOGRAPHY         0         0         0.000000         0         0         70. 00           71. 00         07100         MEDI CAL SUPPLIES CHARGED TO PATIENTS         2,050         1,221,075         0.001679         25,458         43         71.00           72. 00         07200         IMPLANTABLE DEVICES CHARGED TO         1,401         239,711         0.005845         836         5         72.00           73. 00         07300         DRUGS CHARGED TO PATIENTS         65,560         3,716,161         0.017642         74,456         1,314         73.00           74. 00         07400         RENAL DI ALYSI S         0         0         0.000000         0         74.00           75. 01         03950         SLEEP DI SORDER         17,075         940,453         0.018156         0         0         75.01           76. 97         07697         CARDIAC REHABILITATION         9,812         334,968         0.029292         0         0         76.97           76. 97         07697         CARDIAC REHABILITATION         9,812         334,968         0.029292         0         0         88.00           88.00         08800         RURAL HEALTH         CENTERS		0	, i i i i i i i i i i i i i i i i i i i			-	
71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENTS       2,050       1,221,075       0.001679       25,458       43       71.00         72.00       07200       IMPLANTABLE DEVICES CHARGED TO       1,401       239,711       0.005845       836       5       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       65,560       3,716,161       0.017642       74,456       1,314       73.00         74.00       07400       RENAL DI ALYSI S       0       0.000000       0       74.00         75.00       07500       ASC (NON-DI STINCT PART)       0       0.000000       0       75.00         75.01       03950       SLEEP DI SORDER       17,075       940,453       0.018156       0       0       75.01         76.97       07697       CARDI AC REHABILITATION       9,812       334,968       0.029292       0       0       75.03         76.97       07697       CARDI AC REHABILITATION       9,812       334,968       0.029292       0       0       75.03         76.97       07697       CARDI AC REHABILITATION       9,812       334,968       0.029292       0       0       75.03         76.90       08000       RURAL HEALTH							
72.00       07200       IMPLANTABLE DEVICES CHARGED TO       1,401       239,711       0.005845       836       5       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       65,560       3,716,161       0.017642       74,456       1,314       73.00         74.00       07400       RENAL DI ALYSI S       0       0       0.000000       0       74.00         75.01       03950       SLEEP DI SORDER       17,075       940,453       0.018156       0       0       75.01         75.03       07501       ADULT MENTAL HEALTH       20,171       1,146,431       0.017595       0       0       75.03         76.97       07697       CARDI AC REHABILITATION       9,812       334,968       0.029292       0       0       76.97         00TPATI ENT SERVICE COST CENTERS       0       0       0.000000       0       0       88.00         88.00       08800       RURAL HEALTH CLINIC       0       0       0.000000       0       89.00         90.00       09000       CLINIC       0       0       0.000000       0       90.00         91.00       09000       CLINIC       0       0       0.000000       0       90.00<		0	, i i i i i i i i i i i i i i i i i i i				
PATI ENTS         PATI ENTS <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>							
73.00       07300       DRUGS CHARGED TO PATIENTS       65,560       3,716,161       0.017642       74,456       1,314       73.00         74.00       07400       RENAL DI ALYSI S       0       0       0.000000       0       74.00         75.00       07500       ASC (NON-DI STINCT PART)       0       0       0.000000       0       75.00         75.01       03950       SLEEP DI SORDER       17,075       940,453       0.018156       0       0       75.01         75.03       07501       ADULT MENTAL HEALTH       20,171       1,146,431       0.017595       0       0       76.97         07697       CARDI AC REHABI LI TATI ON       9,812       334,968       0.029292       0       0       76.97         0UTPATI ENT SERVICE COST CENTERS       0       0       0.000000       0       88.00       89.00       08900       FEDERALLY QUALIFIED HEALTH CENTER       0       0       0.000000       0       89.00       89.00       99.040       13,139,865       0.007537       0       91.00       91.00       92.00       09200       DSERVATI ON BEDS (NON-DI STINCT PART)       92,989       417,512       0.222722       5,805       1,293       92.00         95.00 <td< td=""><td></td><td>1, 401</td><td>239, 711</td><td>0. 00584</td><td>15 836</td><td>5</td><td>72.00</td></td<>		1, 401	239, 711	0. 00584	15 836	5	72.00
75.00         07500         ASC (NON-DI STINCT PART)         0         0         0.000000         0         75.00           75.01         03950         SLEEP DI SORDER         17,075         940,453         0.018156         0         0         75.01           75.03         07501         ADULT MENTAL HEALTH         20,171         1,146,431         0.017595         0         0         75.03           76.97         07697         CARDI AC REHABILI TATION         9,812         334,968         0.029292         0         0         76.97           0UTPATI ENT SERVICE COST CENTERS         0         0         0.000000         0         0         88.00           88.00         08900         FEDERALLY QUALI FI ED HEALTH CENTER         0         0         0.000000         0         89.00           90.00         09000 CLI NI C         0         0         0.000000         0         90.00         990.00         990.00         990.00         990.00         990.00         990.00         990.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90	73.00 07300 DRUGS CHARGED TO PATIENTS	65, 560	3, 716, 161	0. 01764	2 74, 456	1, 314	73.00
75. 01       03950       SLEEP DI SORDER       17,075       940,453       0.018156       0       0       75.01         75. 03       07501       ADULT MENTAL HEALTH       20,171       1,146,431       0.017595       0       0       75.03         76. 97       07697       CARDI AC REHABILI TATI ON       9,812       334,968       0.029292       0       0       76.97         0UTPATI ENT SERVICE COST CENTERS       0       0       0.000000       0       0       88.00         88.00       08900       FEDERALLY QUALI FI ED HEALTH CENTER       0       0       0.000000       0       89.00         90.00       09000       CLI NI C       0       0       0.000000       0       90.00         91.00       09100       EMERGENCY       99,040       13,139,865       0.007537       0       91.00         92.00       09200       OBSERVATI ON BEDS (NON-DI STI NCT PART)       92,989       417,512       0.222722       5,805       1,293       92.00         0THER REI MBURSABLE COST CENTERS       95.00       09500       AMBULANCE SERVICES       95.00	74.00 07400 RENAL DIALYSIS	0	0	0.0000	0 0	0	74.00
75.03       07501       ADULT MENTAL HEALTH       20,171       1,146,431       0.017595       0       0       75.03         76.97       07697       CARDI AC REHABI LI TATI ON       9,812       334,968       0.029292       0       0       76.97         0UTPATI ENT SERVICE COST CENTERS       0       0       0.000000       0       0       88.00         88.00       08800       RURAL HEALTH CLINIC       0       0       0.000000       0       88.00         90.00       09000       FEDERALLY QUALI FIED HEALTH CENTER       0       0       0.000000       0       89.00         90.00       09000       CLINIC       0       0       0.000000       0       99.00         91.00       09100       EMERGENCY       99,040       13,139,865       0.007537       0       91.00         92.00       09200       OBSERVATI ON BEDS (NON-DI STINCT PART)       92,989       417,512       0.222722       5,805       1,293       92.00         0       0       0       0       0.022722       5,805       1,293       92.00         0       0       0       0.222722       5,805       1,293       92.00       00         0	75.00 07500 ASC (NON-DISTINCT PART)	0	C	0.0000	0 0	0	75.00
76. 97         07697         CARDIAC REHABILITATION         9, 812         334, 968         0.029292         0         0         76. 97           OUTPATIENT SERVICE COST CENTERS         0         0         0.00000         0         0         88.00           88.00         08800         RURAL HEALTH CLINIC         0         0         0.00000         0         88.00           90.00         08900         FEDERALLY QUALIFIED HEALTH CENTER         0         0         0.00000         0         89.00           90.00         09000         CLINIC         0         0         0.000000         0         90.00           91.00         09100         EMERGENCY         99,040         13, 139,865         0.007537         0         91.00           92.00         09200         OBSERVATION BEDS (NON-DI STINCT PART)         92,989         417,512         0.222722         5,805         1,293         92.00           OTHER REI MBURSABLE COST CENTERS         0         0         95.00         95.00         955.00         95.00	75. 01 03950 SLEEP DI SORDER	17,075	940, 453	0. 01815	6 0	0	75.01
OUTPATI ENT SERVICE COST CENTERS           88.00         08800         RURAL HEALTH CLINIC         0         0         0.000000         0         88.00           89.00         08900         FEDERALLY QUALIFIED HEALTH CENTER         0         0         0.000000         0         89.00           90.00         09000         CLINIC         0         0         0.000000         0         99.00           91.00         09100         EMERGENCY         99,040         13,139,865         0.007537         0         0         91.00           92.00         OBSERVATI ON BEDS (NON-DI STINCT PART)         92,989         417,512         0.222722         5,805         1,293         92.00           OTHER REIMBURSABLE COST CENTERS         95.00         09500         AMBULANCE SERVICES         95.00	75.03 07501 ADULT MENTAL HEALTH	20, 171	1, 146, 431	0.01759	05 0	0	75.03
88.00         08800         RURAL         HEALTH         CLINIC         0         0         0.00000         0         0         88.00           89.00         08900         FEDERALLY         QUALIFIED         HEALTH         CENTER         0         0         0.000000         0         0         89.00           90.00         09000         CLINIC         0         0         0.000000         0         0         90.00           91.00         09100         EMERGENCY         99,040         13,139,865         0.007537         0         0         91.00           92.00         09200         OBSERVATION         BEDS         (NON-DI STINCT PART)         92,989         417,512         0.222722         5,805         1,293         92.00           OTHER         REI MBURSABLE COST CENTERS         95.00         09500         AMBULANCE SERVICES         95.00         95.00	76. 97 07697 CARDI AC REHABI LI TATI ON	9, 812	334, 968	0. 02929	02 0	0	76.97
89.00         08900         FEDERALLY QUALIFIED HEALTH CENTER         0         0.000000         0.000000         0         89.00         90.00         91.00         91.00         92.00	OUTPATIENT SERVICE COST CENTERS					•	
90.00         09000         CLINIC         0         0         0.00000         0         0         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         91.00         91.00         92.00         09200         0BSERVATION BEDS (NON-DISTINCT PART)         92.989         417,512         0.222722         5,805         1,293         92.00           0THER REI MBURSABLE COST CENTERS         95.00         09500         AMBULANCE SERVICES         95.00         95.00         9500	88.00 08800 RURAL HEALTH CLINIC	0	C	0.0000	0 0	0	88.00
91.00         09100         EMERGENCY         99,040         13,139,865         0.007537         0         91.00         91.00           92.00         09200         0BSERVATION BEDS (NON-DISTINCT PART)         92,989         417,512         0.222722         5,805         1,293         92.00           0THER REI MBURSABLE COST CENTERS         95.00         09500         AMBULANCE SERVICES         95.00         95.00	89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.0000	0 0	0	89.00
92. 00         09200         0BSERVATI ON BEDS (NON-DI STINCT PART)         92,989         417,512         0.222722         5,805         1,293         92.00           0THER REI MBURSABLE COST CENTERS         95.00         09500         AMBULANCE SERVICES         95.00         95.00	90. 00 09000 CLINIC	0	0	0.0000	0 0	0	90.00
OTHER REI MBURSABLE COST CENTERS         95.00       09500       AMBULANCE SERVICES       95.00	91.00 09100 EMERGENCY	99, 040	13, 139, 865	0.00753	37 0	0	91.00
95.00 09500 AMBULANCE SERVICES 95.00		92, 989	417, 512	0. 22272	2 5, 805	1, 293	92.00
	OTHER REIMBURSABLE COST CENTERS						
200.00 Total (Lines 50 through 199) 787,288 60.013,789 215,710 4.215 200.00	95. 00 09500 AMBULANCE SERVICES						95.00
	200.00 Total (lines 50 through 199)	787, 288	60, 013, 789		215, 710	4, 215	200.00

Health Financial Systems ASCE	ENSION ST VINCE	NT SALEM HOSPIT	TAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS	RVICE OTHER PASS					11/29/2022 10	pared: :42 am
			XVIII		Hospi tal	Cost	
Cost Center Description	Non Physician	Nursi ng	Nursi ng		Allied Health	Allied Health	
	Anesthetist	Program	Program		Post-Stepdown		
	Cost	Post-Stepdown			Adjustments		
		Adjustments					
	1.00	2A	2.00		3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	0	0		0	0	0	50.00
54.00 05400 RADIOLOGY - DIAGNOSTIC	0	0		0	0	0	54.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0	0	0	58.00
60. 00 06000 LABORATORY	0	0		0	0	0	60.00
61.00 06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY			1				61.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0	0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0	0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0	0	0	69.00
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 IMPLANTABLE DEVICES CHARGED TO	0	0		0	0	0	72.00
PATIENTS		-		-	-	-	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	l o		0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0		0	0	0	74.00
75.00 07500 ASC (NON-DI STINCT PART)	0	0		0	0	0	75.00
75. 01 03950 SLEEP DI SORDER	0	0		0	0	0	75.01
75.03 07501 ADULT MENTAL HEALTH	0	0		0	0	0	75.03
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00 08800 RURAL HEALTH CLINIC	0	0		0	0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0	0	89.00
90. 00 09000 CLINIC	0	0		0	0	0	90.00
91. 00 09100 EMERGENCY	0	0		0	0	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS				-			
95. 00 09500 AMBULANCE SERVICES							95.00
200.00 Total (lines 50 through 199)	0	o		0	0	0	200.00
	-	-		-	-	-	

Health Financial Systems ASC	ENSION ST VINCE	NT SALEM HOSPIT	AL	In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PAS	S Provider C	CN: 15-1314	Peri od:	Worksheet D	
THROUGH COSTS				From 07/01/2021	Part IV	
				To 06/30/2022	Date/Time Pre 11/29/2022 10	
		Title	XVIII	Hospi tal	Cost	. 42 am
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpatient	(from Wkst. C,	to Charges	
	Education Cost		Cost (sum of		(col. 5 ÷ col.	
		4)	cols. 2, 3,	8)	7)	
			and 4)		(see	
			,		instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS			-			
50. 00 05000 OPERATI NG ROOM	0	0		0 8, 585, 212		
54.00 05400 RADIOLOGY - DIAGNOSTIC	0	0		0 14, 092, 715		
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0.000000	58.00
60. 00 06000 LABORATORY	0	0		0 10, 492, 229	0.000000	
61.00 06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY						61.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 954, 799	0.000000	
66. 00 06600 PHYSI CAL THERAPY	0	0		0 2, 359, 952	0.000000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 323, 076	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0.000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 2, 049, 630	0.000000	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0.000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 1, 221, 075	0.000000	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO	0	0		0 239, 711	0. 000000	72.00
PATIENTS						
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 3, 716, 161	0.000000	
74.00 07400 RENAL DIALYSIS	0	0		0 0	0.000000	
75.00 07500 ASC (NON-DI STI NCT PART)	0	0		0 0	0.000000	
75. 01 03950 SLEEP DI SORDER	0	0		0 940, 453		
75.03 07501 ADULT MENTAL HEALTH	0	0		0 1, 146, 431		
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 334, 968	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS	-	-		-		
88.00 08800 RURAL HEALTH CLINIC	0	0		0 0	0.000000	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0.000000	
90.00 09000 CLINIC	0	0		0 10 100 0	0.000000	•
91.00 09100 EMERGENCY	0	0		0 13, 139, 865		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	l	0 417, 512	0.000000	92.00
		1	1			05 00
95.00 09500 AMBULANCE SERVICES				0 (0.012.700		95.00
200.00  Total (lines 50 through 199)	0	0	I	0 60, 013, 789	I	200.00

74.00       07400       RENAL DI ALYSI S       0.000000       0       0       0       74.0         75.00       07500       ASC (NON-DI STI NCT PART)       0.000000       0       0       0       75.0         75.01       03950       SLEEP DI SORDER       0.000000       0       0       0       0       75.0         75.03       07501       ADULT MENTAL HEALTH       0.000000       0       0       0       75.0         76.97       07697       CARDI AC REHABILI TATI ON       0.000000       0       0       0       75.0         76.97       07697       CARDI AC REHABILI TATI ON       0.000000       0       0       0       75.0         00000       08800       RURAL HEALTH CLINIC       0.000000       0       0       0       88.0         88.00       08900       FEDERALLY QUALIFIED HEALTH CENTER       0.000000       0       0       0       89.0         99.00       09000       CLINIC       0.000000       0	Health Financial Systems ASC	ENSION ST VINCENT	SALEM HOSPIT	TAL	In Li	eu of Form CMS-	2552-10
Ancount obsits         To         06/30/2022         Date/Time Program 11/29/2022         To         06/30/2022         Date/Time Program Program Charges (col. 6 + col.           Cost Center Description         Outpatient Notice Charges (col. 6 + col.         Inpatient Program Charges (col. 6 + col.         Inpatient Program Charges         Inpatient Program Charges         Outpatient Program Charges         Outpatient Program Charges         Outpatient Program Charges           50:00         05000         05000         0		RVICE OTHER PASS	Provider C	CN: 15-1314			
Cost Center Description         Outpatient Ratio of Cost to Charges (col. 6 + col.)         Inpatient Program Charges (col. 6 + col.)         Inpatient Program Charges         Uppatient Program Pass-Through Cost (col. 9 x col. 10)         Outpatient Program Pass-Through Cost (col. 9 x col. 10)           ANCILLARY SERVICE COST CENTERS         0.000000         33,010         0         0         0.000000           50:00         05000 (PEPRATING ROUM         0.000000         9,00         11.00         12.00         13.00           50:00         05000 (PEPRATING ROUM         0.000000         9,427         0         0         0.58.00           50:00         05000 (LABORATORY         0.000000         9,427         0         0         0.58.00           61:00         05000 (RSPIRATORY         0.000000         9,427         0         0         65.0           65:00         05000 RESPIRATORY         0.0000000         0         0         0.58.0           61:00         06000 RESPIRATORY         0.0000000         38,151         0         0         66.0           62:00         0600 RESPIRATORY         0.0000000         1.122         0         0         66.0           70:00         0         0.000000         1.122         0         0         67.0	THROUGH COSTS						nared
Cost Center Description         Outpatient Ratio of Cost to Charges (col. 6 + col. 7)         Inpatient Program Charges         Inpatient Program Charges         Outpatient Program Charges         Cost Costs (col. 8         Cost Program Charges         Outpatient Program Charges         Outpatient Program Charges         Outpatient Program Charges         Outpatient Program Charges         Outpatient Program Charges         Outpatient Program Charges         Outpatient Program Charges           ANCILLARY SERVICE COST CENTERS         0.00         0.00         0.00         10.00         12.00         13.00           50.00         OSGOO MAGNETIC CRESONAUCE IMAGING (MRI )         0.0000000         0					10 00/ 30/ 2022		
Ratio of Cost (col. 6 + col. 7)         Program (Charges (col. 6 + col. 7)         Program (Charges (col. 8)         Program (Charges (col. 8)         Program (Charges (col. 6)         Program (Charges (col. 6)         Program (Charges)         Program (Charges) <tht< td=""><td></td><td></td><td>Title</td><td>XVIII</td><td>Hospi tal</td><td></td><td></td></tht<>			Title	XVIII	Hospi tal		
Image: Col.         to         Charges (col.         Charges (col.         Pass-Through (costs (col.         Pass-Through (col.	Cost Center Description						
$ \begin{array}{ c c c c c c c c c c c c c c c c c c c$							
T)         x col. 10)         x col. 12)           9.00         10.00         11.00         12.00         13.00           ANCILLARY SERVICE COST CENTERS         0         000000         33.010         0         0         0         50.00           50.00         05000         0PERATING ROOM         0.000000         9.427         0         0         0         58.0           50.00         06000         PBP CLINICAL LAB. SERVICE-PRGM. ONLY         0.000000         9.427         0         0         0         66.0         66.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         6			Charges				
ANCILLARY SERVICE COST CENTERS         9.00         10.00         11.00         12.00         13.00           50.00         05000 [PERATING ROM         0.000000         33,010         0         0         0         50.00           54.00         05000 [PERATING ROM         0.000000         9,427         0         0         0         55.0           56.00         05000 [ABGNETIC RESONANCE I MAGING (MRI )         0.000000         0					8		
ANCILLARY SERVICE COST CENTERS           50.00         05000         OPERATING ROOM         0.000000         33,010         0         0         50.00           50.00         05000         ANCILLARY SERVICE COST CENTERS         0.000000         33,010         0         0         54.00           54.00         05400         RADICUCGY - DI AGNOSTIC         0.000000         9,427         0         0         0         54.00         56.00         0         54.00         56.00         0         54.00         56.00         0         0         0         0         0         54.00         56.00         0         0         0         0         0         54.00         56.00         0         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         67.00         67.00         67.00         66.00         67.00         67.00         67.00         67.00         66.00         67.00         66.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         68.00         68.							
50.00         OFERATI NG ROOM         0.000000         33,010         0         0         0         54.00           54.00         05400         RADIOLOGY - DI AGNOSTI C         0.000000         9,427         0         0         0         0         58.00         05800         MAGNETI C RESONANCE I MAGI NG (MRI )         0.000000         <		9.00	10.00	11.00	12.00	13.00	
54.00       05400       RADI OLOGY - DI AGNOSTI C       0.000000       9, 427       0       0       0       58.0         58.00       05800       MAGNETI C RESONANCE I MAGI NG (MR1)       0.000000       0				1	-1	-1 -	
58.00         05800         MAGNETIC RESONANCE I MAGING (MRI)         0.000000         0					-	-	•
60.00         06000         LABORATORY         0.000000         38, 151         0         0         60.0         61.00         061.00         PBP CLINICAL LAB. SERVICE-PRGM. ONLY         61.0         65.00         06500         RESPIRATORY THERAPY         0.000000         5, 640         0         0         65.00         06500         0         06500         0         0         65.00         06500         0         0         66.0         0         66.0         66.00         0         66.00         0         66.00         0         66.00         0         66.00         67.00         67.00         67.00         68.00         92.01         71.00         71.00         70.00         70.00         71.00         71.00         71.00         71.00         71.00         71.00         71.00         71.00         71.00         71.00         71.00         71.00         71.00 <th< td=""><td></td><td></td><td></td><td></td><td>0 0</td><td>-</td><td></td></th<>					0 0	-	
61.00       06100       PBP CLINICAL LAB. SERVICE-PRGM. ONLY       61.0         65.00       06500       RESPIRATORY THERAPY       0.000000       5,640       0       0       65.0         66.00       06500       RESPIRATORY THERAPY       0.000000       6,694       0       0       66.0         67.00       06700       0CCUPATIONAL THERAPY       0.000000       1,122       0       0       67.0         68.00       06800       SPEECH PATHOLOGY       0.000000       0       0       0       68.0       0         69.00       06900       ELECTROENCEPHALOGRAPHY       0.000000       0       0       0       69.0         70.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENTS       0.000000       25,458       0       0       71.0         73.00       07300       RENAL DI ALYSI S       0.000000       74.456       0       0       73.0         74.00       07400       RENAL DI ALYSI S       0.000000       0       0       75.0       75.0       75.0       75.0       75.0       75.0       75.0       75.0       75.0       75.0       75.0       75.0       75.0       75.0       75.0       75.0       75.0       75.0 <td< td=""><td></td><td></td><td>0</td><td></td><td>0 0</td><td></td><td></td></td<>			0		0 0		
65.00       06500       RESPI RATORY THERAPY       0.000000       5,640       0       0       65.00         66.00       06600       PHYSI CAL THERAPY       0.000000       6,694       0       0       66.00         67.00       0500       COUPATI ONAL THERAPY       0.000000       1,122       0       0       66.00         68.00       06800       SPEECH PATHOLOGY       0.000000       0       0       0       68.00         69.00       06900       ELECTROCARDI OLOGY       0.000000       15,111       0       0       69.00         70.00       07000       ELECTROCARDI OLOGY       0.000000       0       0       0       0       0       0         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0.000000       25,458       0       0       71.00       72.00       72.00       PATI ENTS       0.000000       74.456       0       0       73.00       73.00       000000       74.456       0       0       75.00       75.00       75.00       75.00       75.00       75.00       75.00       75.00       75.00       75.00       75.00       75.00       75.00       75.00       75.00       75.00       000000		0. 000000	38, 151		0 0	0	
66.00       06600       PHYSI CAL THERAPY       0.000000       6, 694       0       0       66.0         67.00       06700       0CCUPATI ONAL THERAPY       0.000000       1, 122       0       0       67.0         68.00       0800       SPEECH PATHOLOGY       0.000000       0       0       0       68.0       0       0       0       67.0         69.00       06900       ELECTROCARDI OLOGY       0.000000       0       0       0       68.0       0       0       69.0       0       0       0       68.0       0       0       68.0       0       0       0       68.0       0       0       0       68.0       0       0       0       68.0       0       0       0       68.0       0       0       0       69.0       <					-		
67.00       06700       0CUPATI 0NAL THERAPY       0.000000       1,122       0       0       67.00         68.00       06800       SPEECH PATHOLOGY       0.000000       0       0       0       68.00         69.00       06900       ELECTROCARDI OLOGY       0.000000       15,111       0       0       69.00         70.00       07000       ELECTROENCEPHALOGRAPHY       0.000000       0       0       0       70.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0.000000       25,458       0       0       71.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0.000000       836       0       0       73.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0.000000       74.456       0       0       73.00         75.00       07500       ASC (NON-DI STINCT PART)       0.000000       0       0       0       75.00         75.01       03950       SLEEP DI SORDER       0.000000       0       0       0       75.00         76.97       CARDI AL CHALTH HEALTH       0.000000       0       0       0       0       75.00         76.97       CARDI AC REHABI LITA					0 0		
68.00       06800       SPECH PATHOLOGY       0.00000       0       0       0       68.0         69.00       06900       ELECTROCARDI 0LOGY       0.000000       15, 111       0       0       0       69.0         70.00       DELECTROCARDI 0LOGY       0.000000       0					0 0		
69.00       06900       ELECTROCARDIOLOGY       0.000000       15,111       0					0 0	-	
70.00         07000         ELECTROENCEPHALOGRAPHY         0.000000         0         0         0         0         0         70.00         70.00         70.00         70.00         MEDI CAL SUPPLI ES CHARGED TO PATI ENTS         0.000000         25,458         0         0         0         71.00           72.00         07200         IMPLANTABLE DEVICES CHARGED TO         0.000000         25,458         0         0         0         72.00           73.00         07300         DRUGS CHARGED TO PATI ENTS         0.000000         74,456         0         0         0         73.00           74.00         07400         RENAL DI ALYSI S         0.000000         0         0         0         74.00           75.01         03950         SLEEP DI SORDER         0.000000         0         0         0         75.00           76.01         03950         SLEEP DI SORDER         0.000000         0         0         0         75.00           76.97         07697         CARDI AC REHABI LI TATI ON         0.000000         0         0         0         75.03           76.97         07697         CARDI AC REHABI LI TATI ON         0.000000         0         0         0         88.0			-		0 0	-	
71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENTS       0.00000       25,458       0       0       0       71.00         72.00       07200       IMPLANTABLE DEVICES CHARGED TO       0.000000       836       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0.000000       74,456       0       0       73.00         74.00       07400       RENAL DIALYSI S       0.000000       0       0       0       74.00         75.00       07500       ASC (NON-DISTINCT PART)       0.000000       0       0       0       75.00         75.01       03950       SLEEP DI SORDER       0.000000       0       0       0       75.00         76.97       07697       CARDI AC REHABILI TATI ON       0.000000       0       0       0       75.00         76.97       07697       CARDI AC REHABILI TATI ON       0.000000       0       0       0       0       88.0         88.00       08300       RURAL HEALTH       0.000000       0       0       0       88.0         99.00       08900       FEDERALLY QUALIFIED       0.000000       0       0       0       89.0         90.00					0 0		
72. 00       07200       IMPLANTABLE DEVICES CHARGED TO       0.000000       836       0       0       72.0         73. 00       07300       DRUGS CHARGED TO PATIENTS       0.000000       74.456       0       0       73.0         74. 00       07400       RENAL DI ALYSI S       0.000000       0       0       0       74.0         75. 00       07500       ASC (NON-DI STINCT PART)       0.000000       0       0       0       75.0         75. 01       03950       SLEEP DI SORDER       0.000000       0       0       0       75.0         75. 03       07501       ADULT MENTAL HEALTH       0.000000       0       0       0       75.0         76. 97       07697       CARDI AC REHABILITATION       0.000000       0       0       0       76.9         04900       FEDERALLY QUALIFIED HEALTH CENTER       0.000000       0       0       0       88.0         88. 00       08000       RURAL HEALTH CLINIC       0.000000       0       0       0       89.0         90. 00       090000       CLINIC       0.000000       0       0       0       90.0       90.0       90.0       90.00       90.00       90.00       90.00			0		0 0		
PATI ENTS         PATI ENTS         PATI ENTS         PATI ENTS         PATI ENTS           73.00         07300         DRUGS CHARGED TO PATI ENTS         0.000000         74.456         0         0         0         73.0           74.00         07400         RENAL DI ALYSI S         0.000000         0         0         0         0         74.0           75.00         07500         ASC (NON-DI STINCT PART)         0.000000         0         0         0         0         75.0           75.01         03950         SLEEP DI SORDER         0.000000         0         0         0         75.0           75.03         07501         ADULT MENTAL HEALTH         0.000000         0         0         0         75.0           76.97         CARDI AC REHABI LI TATI ON         0.000000         0         0         0         76.9           00000         08800         RURAL HEALTH CLINIC         0.000000         0         0         0         88.0           88.00         08800         RURAL HEALTH CLINIC         0.000000         0         0         0         89.0           90.00         09000         CLINI C         0.000000         0         0         0         0					0 0	-	
74.00       07400       RENAL DI ALYSI S       0.000000       0       0       0       74.0         75.00       07500       ASC (NON-DI STINCT PART)       0.000000       0       0       0       75.0         75.01       03950       SLEEP DI SORDER       0.000000       0       0       0       0       75.0         75.03       07501       ADULT MENTAL HEALTH       0.000000       0       0       0       75.0         76.97       07697       CARDI AC REHABI LI TATI ON       0.000000       0       0       0       75.0         76.97       07697       CARDI AC REHABI LI TATI ON       0.000000       0       0       0       0       75.0         76.97       07697       CARDI AC REHABI LI TATI ON       0.000000       0       0       0       0       75.0         90.00       08800       RURAL HEALTH CLINIC       0.000000       0       0       0       88.0         88.00       08800       RURAL HEALTH CLINIC       0.000000       0       0       0       89.0         90.00       09000       CLINIC       0.000000       0       0       0       90.0         91.00       09100       EMERGE		0.000000	836		0 0	0	/2.00
75.00       07500       ASC (NON-DI STINCT PART)       0.000000       0       0       0       75.0         75.01       03950       SLEEP DI SORDER       0.000000       0       0       0       75.0         75.03       07501       ADULT MENTAL HEALTH       0.000000       0       0       0       75.0         76.97       07697       CARDI AC REHABILITATION       0.000000       0       0       0       76.9         0UTPATIENT SERVICE COST CENTERS       0       000000       0       0       0       0       88.0         88.00       08900       FURAL HEALTH CLINIC       0.000000       0       0       0       88.0         90.00       09000       CLINIC       0.000000       0       0       0       88.0         90.00       09000       CLINIC       0.000000       0       0       0       90.0         90.00       09000       CLINIC       0.000000       0       0       0       90.0         91.00       09100       EMERGENCY       0.000000       0       0       0       92.0         01100       09200       OBSERVATION BEDS (NON-DI STINCT PART)       0.000000       0       0	73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	74, 456		0 0	0 0	73.00
75. 01       03950       SLEEP DI SORDER       0.000000       0       0       0       75. 0         75. 03       07501       ADULT MENTAL HEALTH       0.000000       0       0       0       75. 0         76. 97       07697       CARDI AC REHABILITATION       0.000000       0       0       0       0       76. 9         000000       0       0       0       0       0       0       0       76. 9         000000       0       0       0       0       0       0       0       76. 9         000000       0       0       0       0       0       0       0       76. 9         000000       0       0       0       0       0       0       0       76. 9         000000       0       0       0       0       0       0       76. 9         000000       0       0       0       0       0       0       88. 0         88. 00       08900       FEDERALLY QUALI FI ED HEALTH CENTER       0.000000       0       0       90. 0         90. 00       09100       EMERGENCY       0.000000       0       0       0       90. 0	74.00 07400 RENAL DIALYSIS	0. 000000	0		0 0	0 0	74.00
75.03       07501       ADULT MENTAL HEALTH       0.000000       0       0       0       75.0         76.97       07697       CARDI AC REHABILITATION       0.000000       0       0       0       0       76.9         0UTPATI ENT SERVICE COST CENTERS       0.000000       0       0       0       0       0       88.0         88.00       08800       RURAL HEALTH CLINIC       0.000000       0       0       0       88.0         90.00       09000       CLINIC       0.000000       0       0       0       89.0         90.00       09000       CLINIC       0.000000       0       0       0       90.0         91.00       09100       EMERGENCY       0.000000       0       0       0       91.0         92.00       09200       OBSERVATI ON BEDS (NON-DI STINCT PART)       0.000000       0       0       92.0         0THER REI MBURSABLE COST CENTERS       0       0       0       95.0       95.0	75.00 07500 ASC (NON-DISTINCT PART)	0. 000000	0		0 0	0 0	75.00
76.97         07697         CARDI AC         REHABILITATION         0.00000         0         0         0         0         76.97           0UTPATI ENT         SERVICE         COST         CENTERS         0         0         0         0         0         0         0         88.0         88.0         08000         RURAL HEALTH         CLINIC         0.000000         0         0         0         0         89.0         89.00         09000         CLINIC         0.000000         0         0         0         89.0         99.00         90.00         0         0         0         99.0         99.00         90.00         0         0         0         0         99.0         99.0         90.00         0         0         0         99.0         99.0         99.0         90.00         0         0         0         90.00         99.0         99.0         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         91.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00 <td>75. 01 03950 SLEEP DI SORDER</td> <td>0. 000000</td> <td>0</td> <td></td> <td>0 0</td> <td>0 0</td> <td>75.01</td>	75. 01 03950 SLEEP DI SORDER	0. 000000	0		0 0	0 0	75.01
OUTPATI ENT SERVICE COST CENTERS           88.00         08800         RURAL HEALTH CLINIC         0.000000         0         0         0         88.0           89.00         08900         FEDERALLY QUALIFIED HEALTH CENTER         0.000000         0         0         0         89.0           90.00         09000         CLINIC         0.000000         0         0         0         90.0           91.00         09100         EMERGENCY         0.000000         0         0         0         91.0           92.00         09200         OBSERVATI ON BEDS (NON-DI STINCT PART)         0.000000         5,805         0         0         92.0           0THER REI MBURSABLE COST CENTERS         95.00         09500         AMBULANCE SERVICES         95.0	75.03 07501 ADULT MENTAL HEALTH	0. 000000	0		0 0	0 0	75.03
88.00         08800         RURAL         HEALTH         CLINIC         0.000000         0         0         0         88.0         88.0           89.00         08900         FEDERALLY QUALIFIED         HEALTH         CENTER         0.000000         0         0         0         89.0         89.0         90.00         0         0         0         0         89.0         89.0         90.00         90.00         0         0         0         0         89.0         90.00         90.00         90.00         0         0         0         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         91.00         92.00         005ERVATION BEDS (NON-DISTINCT PART)         0.000000         0         0         0         91.00         92.00         000000         0         0         0         92.00         000000         0		0.000000	0		0 (	0 0	76.97
89.00         08900         FEDERALLY QUALIFIED HEALTH CENTER         0.000000         0         0         0         89.0           90.00         09000         CLINIC         0.000000         0         0         0         90.0           91.00         09100         EMERGENCY         0.000000         0         0         0         91.0           92.00         09200         OBSERVATION BEDS (NON-DISTINCT PART)         0.000000         5,805         0         0         92.0           0THER         REI MBURSABLE COST CENTERS           95.0         95.0         9500         AMBULANCE SERVICES         95.0         95.0				-		_	
90.00         09000         CLINIC         0.00000         0         0         0         90.0         91.0         91.0         91.0         91.0         91.0         91.0         92.0         92.0         00         00         00         92.0 <td></td> <td></td> <td>0</td> <td></td> <td>0 (</td> <td>0 0</td> <td></td>			0		0 (	0 0	
91.00         09100         EMERGENCY         0.000000         0         0         0         91.00         91.00           92.00         09200         0BSERVATI ON BEDS (NON-DI STI NCT PART)         0.000000         5,805         0         0         0         92.0           0THER         REI MBURSABLE COST CENTERS         95.00         09500         AMBULANCE SERVICES         95.0         95.0			0		0 (	0 0	
92. 00         09200         0BSERVATI ON BEDS (NON-DI STINCT PART)         0.000000         5,805         0         0         92. 0           0THER         REI MBURSABLE COST CENTERS         95. 00         09500         AMBULANCE SERVICES         95. 0 <td></td> <td></td> <td>0</td> <td></td> <td>0</td> <td>0 0</td> <td></td>			0		0	0 0	
OTHER REI MBURSABLE COST CENTERS       95. 00       09500       AMBULANCE SERVI CES       95. 00			0		-	-	
95. 00 09500 AMBULANCE SERVICES 95. 0		0. 000000	5, 805		0 (	0 0	92.00
						1	
							95.00
200.00           Total (lines 50 through 199)           215,710         0 <td>200.00  Total (lines 50 through 199)</td> <td></td> <td>215, 710</td> <td> </td> <td>0</td> <td>0 0</td> <td>200.00</td>	200.00  Total (lines 50 through 199)		215, 710		0	0 0	200.00

	ENSION ST VINCE				u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Period: From 07/01/2021 To 06/30/2022	Worksheet D Part V Date/Time Pre 11/29/2022 10	pared: ·42 am
		Title	e XVIII	Hospi tal	Cost	<u> </u>
			Charges	•	Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1					
50.00 05000 OPERATING ROOM	0. 218686				0	
54.00 05400 RADIOLOGY - DIAGNOSTIC	0. 148572			03 0	0	54.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000			0 0	0	58.00
60. 00 06000 LABORATORY	0. 201262		2, 238, 75	53 0	0	
61.00 06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0. 000000			0 0		61.00
65. 00 06500 RESPI RATORY THERAPY	0. 190990		22, 96	02 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 438072		557, 71		0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 415546		58, 65	50 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000			0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 253406		821, 05	59 0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 104178	0	266, 01	7 0	0	71.00
72. 00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0. 362766	C	72, 83	36 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 330471	0	912, 93	30 O	0	73.00
74.00 07400 RENAL DIALYSIS	0. 000000	0		0 0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0. 000000	0		0 0	0	75.00
75. 01 03950 SLEEP DI SORDER	0. 374400	0	2, 45	50 O	0	75.01
75.03 07501 ADULT MENTAL HEALTH	0. 610903	0	852, 86	6 0	0	75.03
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 993537	c c	129, 04	0 0	0	76.97
OUTPATIENT SERVICE COST CENTERS						1
88.00 08800 RURAL HEALTH CLINIC						88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER						89.00
90. 00 09000 CLINIC	0. 000000	0		0 0	0	90.00
91. 00 09100 EMERGENCY	0. 307515	0	1, 991, 20	01 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	4. 011561	0	133, 09	04 0	0	92.00
OTHER REIMBURSABLE COST CENTERS						1
95. 00 09500 AMBULANCE SERVICES	0. 000000			0		95.00
200.00 Subtotal (see instructions)		C	12, 897, 99	01 0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges				0 0		201.00
202.00 Net Charges (line 200 - line 201)		0	12, 897, 99	01 0	0	202. 00

PPORTIONMENT OF MEDICAL, OTH	ER HEALTH SERVICES AND	) VACCINE COST	Dreavilder C	ON 1E 1014			
				CN: 15-1314	Period: From 07/01/2021 To 06/30/2022	Worksheet D Part V Date/Time Pr 11/29/2022 1	epared: <u>0:42 am</u>
		1	Title	XVIII	Hospi tal	Cost	_
		Cos	sts				
Cost Center Descr	iption	Cost	Cost				
		Reimbursed	Reimbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
		6.00	7.00				
ANCILLARY SERVICE COST	CENTERS						
D. 00 05000 OPERATING ROOM		372, 360					50.00
4. 00  05400  RADI OLOGY – DI AGN		465, 878					54.00
3. 00 05800 MAGNETIC RESONANC	E IMAGING (MRI)	0	0				58.00
D. 00 06000 LABORATORY		450, 576	0				60.00
1.00 06100 PBP CLINICAL LAB.	SERVICE-PRGM. ONLY	0					61.00
5. 00 06500 RESPI RATORY THERA	РҮ	4, 386	0				65.0
5. 00 06600 PHYSI CAL THERAPY		244, 319	0				66.0
7.00 06700 OCCUPATIONAL THER	APY	24, 372	0				67.0
3. 00 06800 SPEECH PATHOLOGY		0	0				68.00
9. 00 06900 ELECTROCARDI OLOGY		208, 061	l o				69.00
0.00 07000 ELECTROENCEPHALOG	RAPHY	0	0				70.00
1.00 07100 MEDICAL SUPPLIES		27, 713	0				71.0
2.00 07200 IMPLANTABLE DEVIC		26, 422					72.0
PATIENTS			-				
3. 00 07300 DRUGS CHARGED TO	PATI ENTS	301, 697	0				73.0
4. 00 07400 RENAL DIALYSIS		0	0				74.0
5. 00 07500 ASC (NON-DISTINCT	PART)	0	0				75.0
5. 01 03950 SLEEP DI SORDER	,	917	0				75.0
5. 03 07501 ADULT MENTAL HEAL	ТН	521,018					75.0
5. 97 07697 CARDI AC REHABI LI T		128, 206	0				76.9
OUTPATIENT SERVICE COST		1207200					
3. 00 08800 RURAL HEALTH CLIN							88. 0
9. 00 08900 FEDERALLY QUALIFI							89.00
0. 00 09000 CLINIC		0	l o				90.0
1. 00 09100 EMERGENCY		612, 324					91.0
2. 00 09200 OBSERVATION BEDS	(NON_DISTINCT PART)	533, 915		•			92.00
OTHER REIMBURSABLE COST		555, 715	0	1			- 12.00
5. 00 09500 AMBULANCE SERVICE		0		1			95.00
0.00 Subtotal (see ins		3, 922, 164					200.00
	ab. Services-Program	3, 922, 104					200.00
Only Charges	ab. Services-riogralli						201.00
011 y charges 02.00 Net Charges (line	200 - Line 201)	3, 922, 164	0				202.00
net charges (TTHe	200 - 1116 201)	3,722,104	0	1			1202.0

Heal th Financi		NSION ST VINCE				u of Form CMS-	2552-10
APPORTI ONMENT	OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-1314   F	Period: From 07/01/2021	Worksheet D	
			Component		o 06/30/2022	Part V Date/Time Pre	nared
			oomponone		0 00,00,2022	11/29/2022 10	:42 am
			Title	XVIII S	wing Beds - SNF	Cost	
				Charges		Costs	
Co	ost Center Description	Cost to Charge			Cost	PPS Services	
			Services (see	Reimbursed	Reimbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins.	Ded. & Coins.		
				(see inst.)	(see inst.)	5.00	
		1.00	2.00	3.00	4.00	5.00	
	RY SERVICE COST CENTERS	0.010(0)					50.00
	PERATING ROOM	0. 218686	0	-	0	°	
	ADIOLOGY - DIAGNOSTIC	0. 148572	0		0	0	
	AGNETIC RESONANCE IMAGING (MRI)	0. 000000	0		0	0	
	ABORATORY	0. 201262	0	C	0	0	
	BP CLINICAL LAB. SERVICE-PRGM. ONLY	0. 000000		C	0		61.00
	ESPI RATORY THERAPY	0. 190990	0	C	0 0	0	
	HYSI CAL THERAPY	0. 438072	0	C	0 0	0	
	CCUPATI ONAL THERAPY	0. 415546	0	C	0 0	0	
	PEECH PATHOLOGY	0. 000000	0	C	0 0	0	68.00
69.00 06900 EI	LECTROCARDI OLOGY	0. 253406	0	C	0 0	0	69.00
70.00 07000 EI	LECTROENCEPHALOGRAPHY	0. 000000	0	C	0 0	0	70.00
71.00 07100 ME	EDICAL SUPPLIES CHARGED TO PATIENTS	0. 104178	0	C	0 0	0	71.00
72.00 07200 11	MPLANTABLE DEVICES CHARGED TO	0. 362766	0	C	0 0	0	72.00
	ATIENTS						
	RUGS CHARGED TO PATIENTS	0. 330471	0	C	0 0	0	
	ENAL DIALYSIS	0. 000000	0	C	0 0	0	74.00
	SC (NON-DISTINCT PART)	0. 000000	0	C	0 0	0	75.00
75.01 03950 SI	LEEP DI SORDER	0. 374400	0	C	0 0	0	75.01
75.03 07501 AI	DULT MENTAL HEALTH	0. 610903	0	C	0 0	0	75.03
76.97 07697 C/	ARDIAC REHABILITATION	0. 993537	0	C	0 0	0	76.97
OUTPATI	ENT SERVICE COST CENTERS	_		_			
88.00 08800 RI	URAL HEALTH CLINIC						88.00
89.00 08900 FE	EDERALLY QUALIFIED HEALTH CENTER						89.00
90.00 09000 CI	LINIC	0. 000000	0	C	0 0	0	90.00
91.00 09100 EM	MERGENCY	0. 307515	0	C	0 0	0	91.00
92.00 09200 08	BSERVATION BEDS (NON-DISTINCT PART)	4. 011561	0	c	0 0	0	92.00
OTHER R	EIMBURSABLE COST CENTERS						
95.00 09500 AM	MBULANCE SERVICES	0. 000000		C	)		95.00
200. 00 Si	ubtotal (see instructions)		0	C	0 0	0	200.00
201.00 Le	ess PBP Clinic Lab. Services-Program			c c	0		201.00
Or	nly Charges et Charges (line 200 – line 201)						202.00

Title XVIII     Swing Beds - SNF     Cc       Cost Center Description     Costs     Cost       Reimbursed     Reimbursed     Reimbursed       Services     Services Not     Subject To       Subject To     Subject To     Subject To       Ded. & Coins.     (see inst.)     (see inst.)       6.00     7.00	Prepared: 2 10:42 am
Component CCN: 15-Z314     To     06/30/2022     Date/Time 11/29/202       Title XVIII     Swing Beds - SNF     Cc       Costs       Cost Center Description       Costs       Costs       Cost       South       Cost       Cost<	2 10: 42 am st
Title XVIII       Swing Beds - SNF       Cc         Cost Center Description       Costs       Cost         Reimbursed       Reimbursed       Services Services Not       Subject To         Subject To       Subject To       Subject To       Subject To         Ded. & Coins.       (see inst.)       (see inst.)       6.00         6.00       7.00       0       0	st
Cost Center Description         Cost       Cost         Cost       Cost         Reimbursed       Reimbursed         Services       Services Not         Subject To       Subject To         Ded. & Coins.       (see inst.)         (see inst.)       (see inst.)         6.00       7.00	
Cost Center Description       Cost Reimbursed Services       Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)         ANCI LLARY SERVICE COST CENTERS         50.00       05000 OPERATING ROOM       0	50,00
Reimbursed Services     Reimbursed Services       Subject To Ded. & Coins. (see inst.)     Subject To Ded. & Coins. (see inst.)       ANCILLARY SERVICE COST CENTERS       50.00     05000 OPERATING ROOM	50.00
Subject To Ded. & Coins. (see inst.)     Subject To Ded. & Coins. (see inst.)       ANCI LLARY SERVICE COST CENTERS       50.00     05000       0     0	50.00
Ded. & Coins. (see inst.)         Ded. & Coins. (see inst.)           ANCI LLARY SERVI CE COST CENTERS           50.00         05000         OPERATI NG ROOM         0         0	50.00
(see inst.)         (see inst.)           ANCI LLARY SERVICE COST CENTERS         6.00         7.00           50.00         05000         OPERATING ROOM         0         0	50.00
ANCI LLARY SERVICE COST CENTERS         6.00         7.00           50.00         05000         OPERATING ROOM         0         0	50.00
ANCI LLARY SERVICE COST CENTERS         6.00         7.00           50.00         05000         OPERATING ROOM         0         0	50.00
50. 00 05000 OPERATING ROOM 0 0	50.00
	50.00
54. 00 05400 RADIOLOGY - DIAGNOSTIC 0 0	54.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 0	58.00
60. 00 06000 LABORATORY 0 0	60.00
61.00 OG100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY 0	61.00
65. 00 06500 RESPI RATORY THERAPY 0 0	65.00
66. 00 06600 PHYSI CAL THERAPY 0 0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY 0 0	67.00
68. 00 06800 SPEECH PATHOLOGY 0 0	68.00
69. 00 06900 ELECTROCARDI OLOGY 0 0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0	71.00
72. 00 07200 I MPLANTABLE DEVICES CHARGED TO 0 0	72.00
PATIENTS	
73.00 07300 DRUGS CHARGED TO PATIENTS 0 0	73.00
74. 00 07400 RENAL DIALYSIS 0 0 0	74.00
75. 00 07500 ASC (NON-DISTINCT PART) 0 0	75.00
75. 01 03950 SLEEP DI SORDER 0 0	75.01
75. 03 07501 ADULT MENTAL HEALTH 0 0 0	75.03
76. 97 07697 CARDI AC REHABI LI TATI ON 0 0	76.97
OUTPATIENT SERVICE COST CENTERS	
88.00 08800 RURAL HEALTH CLINIC	88.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	89.00
90. 00 09000 CLINIC 0 0	90.00
91. 00 09100 EMERGENCY 0 0	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0	92.00
OTHER REIMBURSABLE COST CENTERS	
95. 00 09500 AMBULANCE SERVICES 0	95.00
200.00 Subtotal (see instructions) 0 0	200.00
201.00 Less PBP Clinic Lab. Services-Program 0	201.00
Only Charges	
202.00 Net Charges (line 200 - line 201) 0 0	202.00

Health Financial Systems ASC	ENSION ST VINCE	NT SALEM HOSPI	TAL	ln Li€	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS			Period: From 07/01/2021 To 06/30/2022		
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Capital Related Cost	Swing Bed Adjustment	Reduced Capital	Total Patient Days	Per Diem (col. 3 / col. 4)	
	(from Wkst. B,		Related Cost		, , , , , , , , , , , , , , , , , , ,	
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS				÷		
30. 00 ADULTS & PEDIATRICS	149, 072	15, 067	134, 00	5 428	313.10	30.00
200.00 Total (lines 30 through 199)	149, 072		134, 00	5 428	6	200.00
Cost Center Description	Inpati ent	Inpati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7.00	1			
INPATIENT ROUTINE SERVICE COST CENTERS	-					
30. 00 ADULTS & PEDI ATRI CS	1	313				30.00
200.00 Total (lines 30 through 199)	1	313				200.00

Health Financial Systems		VI NCEN	IT SALEM HOSPI			eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ANCILLA	RY SERVICE CAPITAL COSTS		Provider C	CN: 15-1314	Peri od:	Worksheet D	
					From 07/01/2021 To 06/30/2022		narod
					10 00/ 30/ 2022	11/29/2022 10	
			Titl	e XIX	Hospi tal	Cost	<u> </u>
Cost Center Descriptio	n Capit	al	Total Charges			Capital Costs	
	Related	Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wks	st. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II,	col.	8)	2)	Ŭ		
	26)						
	1.0	0	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTE	RS						
50.00 05000 OPERATING ROOM	1	77, 899	8, 585, 212	0. 02072	32, 105	665	50.00
54.00 05400 RADIOLOGY - DIAGNOSTIC	1	53, 132	14, 092, 715	0. 01086	6 860	9	54.00
58.00 05800 MAGNETIC RESONANCE I MA	GING (MRI)	0	0	0.0000	00 0	0	58.00
60. 00 06000 LABORATORY		41, 180	10, 492, 229	0.00392	25 919	4	60.00
61.00 06100 PBP CLINICAL LAB. SERV	ICE-PRGM. ONLY			1			61.00
65. 00 06500 RESPI RATORY THERAPY		12, 139	954, 799	0. 01271	14 C	0	65.00
66.00 06600 PHYSI CAL THERAPY		29, 328	2, 359, 952	0. 01242	27 C	0	66.00
67.00 06700 OCCUPATIONAL THERAPY		3, 710	323, 076	0. 01148	33 C	0	67.00
68.00 06800 SPEECH PATHOLOGY		0	0	0.0000	00 0	0 0	68.00
69.00 06900 ELECTROCARDI OLOGY		61, 802	2,049,630	0. 03015	53 C	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY		0	0	0.0000	00 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARG	ED TO PATIENTS	2,050	1, 221, 075	0.00167	3, 826	6	71.00
72.00 07200 IMPLANTABLE DEVICES CH	ARGED TO	1,401	239, 711	0.00584	15 C	0	72.00
PATI ENTS							
73.00 07300 DRUGS CHARGED TO PATIE	NTS	65, 560	3, 716, 161	0. 01764	12 3, 038	54	73.00
74.00 07400 RENAL DIALYSIS		0	0	0.0000	00 0	0 0	74.00
75.00 07500 ASC (NON-DISTINCT PART	)	0	0	0.0000	00 0	0 0	75.00
75. 01 03950 SLEEP DI SORDER		17,075	940, 453	0. 01815	56 C	0	75.01
75.03 07501 ADULT MENTAL HEALTH		20, 171	1, 146, 431	0.01759	95 C	0	75.03
76. 97 07697 CARDIAC REHABILITATION		9,812	334, 968	0. 02929	92 C	0	76.97
OUTPATIENT SERVICE COST CENT	ERS						1
88.00 08800 RURAL HEALTH CLINIC		0	0	0.0000	)0 C	0	88.00
89.00 08900 FEDERALLY QUALIFIED HE	ALTH CENTER	0	0	0.0000	00 0	0	89.00
90. 00 09000 CLINIC		0	0	0.0000	00 0	0	90.00
91.00 09100 EMERGENCY		99, 040	13, 139, 865	0.00753	37 C	0	91.00
92.00 09200 OBSERVATION BEDS (NON-	DISTINCT PART)	92, 989	417, 512		990	220	92.00
OTHER REIMBURSABLE COST CENT	ERS						1
95.00 09500 AMBULANCE SERVICES							95.00
200.00 Total (lines 50 throug	h 199) 7	87, 288	60,013,789		41, 738	958	200.00

Health Financial Systems	ASCENSION ST VINCEN	T SALEM HOSPI	ΓAL	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTH	ER PASS THROUGH COST		F	Period: From 07/01/2021 To 06/30/2022	Worksheet D Part III Date/Time Pre 11/29/2022 10	
			e XIX	Hospi tal	Cost	
Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments		All Other Medical Education Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS 200.00 Total (lines 30 through 199)	0	0 0		0 0 0 0	0	30.00 200.00
Cost Center Description	Amount (see	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00         03000         ADULTS & PEDIATRICS           200.00         Total (lines 30 through 199)	0	0 0	428			30.00 200.00
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 & PEDLATRICS 200.00 Total (Lines 30 through 199)	0 0					30. 00 200. 00

Health Financial Systems ASCE	NSION ST VINCEN	NT SALEM HOSPIT	AL	In Li	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	VICE OTHER PASS			Period: From 07/01/2021 To 06/30/2022		
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Non Physician	Nursi ng	Nursi ng		Allied Health	
	Anesthetist	Program	Program	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS				1		
50.00 O5000 OPERATING ROOM	0	0		0 0		
54.00 05400 RADI OLOGY - DI AGNOSTI C	0	0		0 (	0 0	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0 0	
60. 00 06000 LABORATORY	0	0		0 0	0 0	
61.00 06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY						61.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 (	0 0	
66.00 06600 PHYSI CAL THERAPY	0	0		0 (	0 0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0 0	
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0 0	1
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 (	0 0	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0 0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0 0	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 (	0 0	73.00
74.00 07400 RENAL DIALYSIS	0	0		0 (	0 0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0		0 (	0 0	75.00
75. 01 03950 SLEEP DI SORDER	0	0		0 (	0 0	75.01
75.03 07501 ADULT MENTAL HEALTH	0	0		0 (	0 0	75.03
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 (	0 0	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0		0 (	0 0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	o o	89.00
90. 00 09000 CLINIC	0	0		0 0	o o	90.00
91.00 09100 EMERGENCY	0	0		0 (	0 0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVI CES						95.00
200.00   Total (lines 50 through 199)	0	0		0 0	o  0	200. 00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS         Provider CCN: 15-1314         Period: From 06/30/2020         Worksheet D Part IV Date/Time Prepared: To 12/2022 10(0.5 % - C01. S)           Cost Center Description         All Other Education Cost         Total Cost (sum of cols. 2, 3, and 4)         Total Cost (sum of cols. 2, 3, and 4)         Total Cost (sum of cols. 2, 3, and 4)         Ratio Of Cost (som of cols. 2, 3, and 4)         Hospital           50.00         05000 (PERATING ROM BADD (LLARY SERVICE COST CENTERS         0         0         0         0.000000         50.00         50.00         50.00         50.00         50.00         0         0.000000         50.00         50.00         50.00         60.00         14.092,715         0.000000         50.00         50.00         50.00         61.00         61.00         66.00         61.00         66.00         61.00         61.00         61.00         61.00         60.00         61.00         61.00         61.00         61.00         61.00         60.00         62.00         62.00         62.00         60.00         60.00         60.00         60.00         60.00         6	Heal th Fi	nancial Systems ASCE	ENSION ST VINCE	NT SALEM HOSPIT	AL	In Lie	u of Form CMS-2	2552-10
Integration         To         06/30/2022         Date/Time Prepared: 11/29/2022 10: 42 am           Cost Center Description         All Other Medical Education Cost         Total Cost (sum of cols, 2, 3, and 4)         Hospital         Cost           ANCILLARY SERVICE COST CENTERS         5.00         6.00         7.00         8.00           50.00         05000 DPERATING ROOM         0         0         0         0.000000 54.00           650.00         DESD/MARKET IMAGING (MRI)         0         0         0         0         0         0.000000 54.00           65.00         DESD/MARKET IMAGING (MRI)         0			RVICE OTHER PASS	S Provider C				
Cost Center Description         All Other Helical Education Cost         Title XIX         Hospital Total Cost         Total Cost Total Cost           ANCILLARY SERVICE COST CENTERS         All Other Education Cost         Total Cost (1, 2, 3, and 4)         Total Cost (1, 2, 2, 2, 3, 3, 2, 3, 2, 3, 2, 3, 3, 3, 3, 3, 3, 3, 3, 3, 3, 3, 3, 3,	THROUGH (	COSTS				From 07/01/2021	Part IV	narod
Cost Center Description         All Other Medical Education Cost         Total Cost (sum of Cols. 4)         Total Cost (sum of Cols. cols. 4)         Total Cost (sum of Cols. cols. 4)         Total Cost (sum of Cols. cols. 4)         Total Cost (sum of Cols. cols. 4)         Total Cost (sum of Cols. 4)         Total Cost (see (see (see (see (see (see (see (s						10 00/30/2022		:42 am
Cost Center Description         All Other Redical Education Cost         Total (sum of cols. 1, 2, 3, and 4)         Total Cost (sum of cols. 1, 2, 3, and 4)         Total Cost (sum of cols. 2, 3, and 4)         Total (cost (sum of cols. 2, 3, and 4)           50.00         00         0				Titl	e XIX	Hospi tal		
Medical Education Cost         (sum of cols. 4.00         Outpatient Cost (sum of a)         (From West, C, and 4)         (cols. Part I, col. 3)         (cols. b)		Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
ANCI LLARY SERVICE COST CENTERS         4.00         5.00         6.00         7.00         8.00           ANCI LLARY SERVICE COST CENTERS         0         0         0         0         0         0.000         8.00           ANCI LLARY SERVICE COST CENTERS         0         0         0         8.00         8.00           50.00         05000 RADIOLOGY - DI AGNOSTIC         0         0         0         8.585,212         0.000000           60.00         0.000 LABORATORY         0         0         0         10,492,715         0.000000           61.00         06100 PBP CLINICAL LAB, SERVICE-PRGM, ONLY         0         0         0         0.000000         66.00           66.00         06000 PHYSICAL THERAPY         0         0         0         0         0.000000         66.00           66.00         06000 PHYSICAL THERAPY         0         0         0         2.359,952         0.000000         68.00			Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
Image: Product of the service cost centers         Image: Product of the service cost centers         Image: Product of the service cost centers           ANCI LLARY SERVICE COST CENTERS         0         6.00         7.00         8.00           ANCI LLARY SERVICE COST CENTERS         0         0         0.00         0.00         8.585,212         0.000000         50.00           54.00         05400 RADI OLOGY - DI AGNOSTI C         0         0         0         14,092,715         0.000000         54.00           58.00         05600 MAORETI C ESSONANCE I MAGI NG (MRI )         0         0         0         0.000000         56.00           60.00         0000 CEBSPI RATORY THERAPY         0         0         0         0.000000         66.00           66.00         06500 RESPI RATORY THERAPY         0         0         0         2.359,952         0.000000         66.00           67.00         67.00 CCUPATI INAL THERAPY         0         0         0         0.000000         68.00           69.00         05400 ELECTROCARDI LOLGY         0         0         0         0.000000         68.00           71.00         0000 ELECTROCARDI LOLGY         0         0         0         0.000000         71.00           72.00         07200 I			Education Cost	1, 2, 3, and	Cost (sum of			
ANCILLARY SERVICE COST CENTERS         4.00         5.00         6.00         7.00         8.00           ANCILLARY SERVICE COST CENTERS         0         0         0         8.00         50.00         0         8.00         50.00         0         8.00         50.00         0         8.00         50.00         0         14.092.715         0.000000         54.00         50.00         0         0         14.092.715         0.000000         58.00         60.00         0         0.014.092.715         0.000000         58.00         60.00         0         0.014.092.715         0.000000         58.00         60.00.00000         60.00 <td></td> <td></td> <td></td> <td>4)</td> <td></td> <td>8)</td> <td></td> <td></td>				4)		8)		
ANCILLARY SERVICE COST CENTERS         4.00         5.00         6.00         7.00         8.00           50.00         05000 OPERATI NG ROM         0         0         8,585,212         0.000000         50.00           50.00         05000 OPERATI NG ROM         0         0         0         14,092,715         0.000000         54.00           50.00         06000         LABORATORY         0         0         0         0.000000         66.00           61.00         06100         PESP LINI CAL LAB. SERVICE-PRGM. ONLY         0         0         0         0.000000         66.00           65.00         06500 RESPI RATORY THERAPY         0         0         0         235,952         0.000000         66.00           66.00         06600 PHYSI CAL THERAPY         0         0         233,76         0.000000         68.00           69.00         06600 SEPECH PATHOLOGY         0         0         2,049,630         0.000000         69.00           69.00         06000 ELECTRORADI OLOGY         0         0         2,049,630         0.000000         71.00           71.00         07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS         0         0         1,221,075         0.0000000         73.00         73.00 <td></td> <td></td> <td></td> <td></td> <td>and 4)</td> <td></td> <td></td> <td></td>					and 4)			
ANCI LLARY SERVICE COST CENTERS           50.00         05000 (DPERATI NG R00M         0         0         8,585,212         0.000000         50.00           54.00         05400 (RADI OLGY - DI AGNOSTI C         0         0         0         14,092,715         0.000000         58.00           58.00         05800 (MAQNETI C RESONANCE I MAGI NG (MRI )         0         0         0         0.0000000         58.00         0.0000000         60.00         66.00         67.00         0.000000         67.00         0.000000         67.00         0.000000         70.00         70.00								
50.00       OPERATING ROOM       0       0       8,585,212       0.000000       50.00         54.00       OS400 RADIOLOGY - DIAGNOSTIC       0       0       14,092,715       0.000000       54.00         58.00       OS600 MAGNETIC RESONANCE I MAGING (MRI)       0       0       0       0.000000       58.00         60.00       O6000       LABORATORY       0       0       0       0.000000       60.00         61.00       O6500 RESPI RATORY THERAPY       0       0       0       954,799       0.000000       66.00         66.00       O6600 PHYSI CAL THERAPY       0       0       0       2,359,952       0.000000       66.00         67.00       O6000 COUPATI ONAL THERAPY       0       0       0       2,359,952       0.000000       66.00         68.00       O6600 SPEECH PATHOLOGY       0       0       0       0.000000       68.00       0       0.000000       68.00       0       0.000000       68.00       0       0.000000       68.00       0       0.000000       68.00       0       0.000000       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00 <td< td=""><td></td><td></td><td>4.00</td><td>5.00</td><td>6.00</td><td>7.00</td><td>8.00</td><td></td></td<>			4.00	5.00	6.00	7.00	8.00	
54:00       05400       RADI OLGGY - DI AGNOSTI C       0       0       14, 092, 715       0.000000       58.00         58:00       05800       MAGNETI C RESONANCE I MAGI NG (MRI )       0       0       0       0.000000       58.00         60:00       06000       LABORATORY       0       0       0       0.000000       58.00         61:00       06000       LABORATORY       0       0       0       0.000000       66.00         65:00       06500       RSPI RATORY THERAPY       0       0       0       954,799       0.000000       66.00         66:00       06600       PHYSI CAL THERAPY       0       0       0       0.000000       67.00         68:00       06600       SPECEH PATHOLOCY       0       0       0       0.000000       67.00         69:00       06900       ELECTROCABDI OLOGY       0       0       0       0.000000       69.00         71:00       07100       MELATTABLE DEVICES CHARGED TO PATI ENTS       0       0       1.21,075       0.000000       71.00         73:00       07300       DRUGS CHARGED TO PATI ENTS       0       0       0       0.000000       72.00         74:00       7300 <td></td> <td></td> <td></td> <td></td> <td>1</td> <td></td> <td></td> <td></td>					1			
58.00       05800       MAGNETIC RESONANCE I MAGI NG (MRI)       0       0       0       0.00000       58.00         60.00       06000       LABORATORY       0       0       0       10, 492, 229       0.000000       60.00         65.00       06500       RESPI RATORY THERAPY       0       0       0       2, 359, 952       0.000000       65.00         66.00       06700       0CUPATI ONAL THERAPY       0       0       0       2323, 976       0.000000       67.00         67.00       06700       0CUPATI ONAL THERAPY       0       0       0       0.000000       67.00         68.00       06600       SPECH PATHOLOGY       0       0       0       0.000000       68.00         69.00       06900       ELECTROCARDI OLOGY       0       0       0       0.000000       70.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0       0       1, 221, 075       0.000000       71.00         72.00       IMPLANTABLE DEVICES CHARGED TO       0       0       0.000000       72.00       0       0.000000       72.00         73.00       DRUGS CHARGED TO PATI ENTS       0       0       0       0.000000       72								
60.00       06000       LABORATORY       0       0       10, 492, 229       0.000000       60.00         61.00       06100       PBP CLINICAL LAB. SERVICE-PRGM. ONLY       0       0       0, 954, 799       0.000000       66.00         65.00       06500       RESPIRATORY THERAPY       0       0       0       9, 000000       66.00         66.00       06600       PHYSI CAL THERAPY       0       0       0       2, 359, 952       0.000000       66.00         67.00       06700       0CCUPATI ONAL THERAPY       0       0       0       0.000000       66.00         68.00       06800       SPEECH PATHOLOGY       0       0       0       0.000000       69.00         69.00       06900       ELCTROCARCIPHALOGRAPHY       0       0       0       0.000000       69.00         71.00       07100       ELCTROEACEPHALOGRAPHY       0       0       0       1, 221, 075       0.000000       71.00         72.00       07200       IMPLANTABLE DEVI CES CHARGED TO PATI ENTS       0       0       0       239, 711       0.000000       73.00         73.00       07300       DUSC HARGED TO PATI ENTS       0       0       0       0.000000 <t< td=""><td></td><td></td><td>0</td><td>0</td><td></td><td></td><td></td><td></td></t<>			0	0				
61.00       06100       PBP CLINICAL LAB. SERVICE-PRGM. ONLY       61.00         65.00       06500       RESPI RATORY THERAPY       0       0       954,799       0.000000       65.00         66.00       06500       RESPI RATORY THERAPY       0       0       0       2,359,952       0.000000       66.00         67.00       06700       0CCUPATI ONAL THERAPY       0       0       0       323,076       0.000000       67.00         68.00       06800       SPEECH PATHOLOGY       0       0       0       0.000000       67.00         69.00       06000       ELECTROCARDI LOGY       0       0       0       0.000000       67.00         70.00       07000       ELECTROENCEPHALOGRAPHY       0       0       0       0.000000       70.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0       0       0       239,711       0.000000       71.00         72.00       7020       IPVLANTABLE DEVI CES CHARGED TO       0       0       0       0.000000       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       0       0       0.000000       74.00         75.01       03505			0	0				
65.00       06500       RESPIRATORY THERAPY       0       0       954, 799       0.000000       65.00         66.00       06600       PHYSI CAL THERAPY       0       0       0       2, 359, 952       0.000000       66.00         67.00       05000       COUPATIONAL THERAPY       0       0       0       323, 076       0.000000       67.00         68.00       06800       SPEECH PATHOLOGY       0       0       0       0.000000       68.00         69.00       05900       ELECTROCARDIOLOGY       0       0       0       0.000000       70.00         71.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENTS       0       0       1, 221, 075       0.000000       71.00         72.00       07200       IMPLANTABLE DEVICES CHARGED TO PATIENTS       0       0       0       239, 711       0.000000       72.00         73.00       07300       RENAL DI ALYSIS       0       0       0       0.000000       74.00         74.00       O7400       RENAL DI ALYSIS       0       0       0       0.000000       75.01         75.01       03950       SLEEP DI SORDER       0       0       0       0.000000       75.03			0	0		0 10, 492, 229	0.000000	
66.00       06600       PHYSI CAL THERAPY       0       0       2,359,952       0.000000       66.00         67.00       06700       0CCUPATI ONAL THERAPY       0       0       0       323,076       0.000000       67.00         68.00       06800       SPEECH PATHOLOGY       0       0       0       0.000000       68.00         69.00       06900       ELECTROCARDI OLOGY       0       0       0       0.000000       68.00         70.00       07000       ELECTROCARDI OLOGY       0       0       0       0.000000       70.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0       0       0       239,711       0.000000       72.00         72.00       07300       DRUGS CHARGED TO PATI ENTS       0       0       0       0.000000       73.00         74.00       07300       DRUGS CHARGED TO PATI ENTS       0       0       0       0.000000       74.00         75.00       07500       ASC (NON-DI STI NCT PART)       0       0       0       0.000000       75.01         75.01       0350       SLEEP DI SORDER       0       0       0       0       0.000000       75.03								
67.00       06700       OCCUPATIONAL THERAPY       0       0       323,076       0.000000       67.00         68.00       06800       SPEECH PATHOLOGY       0       0       0       0.000000       68.00         69.00       06900       ELECTROCARDIOLOGY       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       1,221,075       0.000000       71.00         72.00       07200       IMPLANTABLE DEVICES CHARGED TO       0       0       0       239,711       0.000000       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0       0       0       0.000000       73.00         74.00       07400       RENAL DI ALYSIS       0       0       0       0.000000       75.00         75.00       07500       ASC (NON-DI STI NCT PART)       0       0       0       0.000000       75.01         75.01       03950       SLEEP DI SORDER       0       0       0       0.000000       75.03         76.97       CARDI			0	0				
68.00       06800       SPEECH PATHOLOGY       0       0       0       0.000000       68.00         69.00       06900       ELECTROCARDI 0LOGY       0       0       0       2,049,630       0.000000       69.00         70.00       OTOO       ELECTROCARDI 0LOGY       0       0       0       0       0.000000       69.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0       0       1,221,075       0.000000       71.00         72.00       07200       IMPLANTABLE DEVI CES CHARGED TO       0       0       239,711       0.000000       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       0       0       0.000000       73.00         74.00       07400       RENAL DI ALYSI S       0       0       0       0.000000       75.00         75.00       07501       ASC (NON-DI STI NCT PART)       0       0       0       0.000000       75.01         75.03       07501       ASL (ANDAL KEALTH       0       0       0       146,431       0.000000       75.03         76.97       ORADI AC REHABILI TATI ON       0       0       0       0       0.000000       76.97			0	0				
69.00       06900       ELECTROCARDIOLOGY       0       0       2,049,630       0.000000       69.00         70.00       07000       ELECTROENCEPHALOGRAPHY       0       0       0       0.000000       70.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0       0       1,221,075       0.000000       71.00         72.00       IMPLANTABLE DEVICES CHARGED TO       0       0       0       239,711       0.000000       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       0       0       0.000000       73.00         74.00       07400       RENAL DI ALYSI S       0       0       0       0.000000       74.00         75.01       03950       SLEEP DI SORDER       0       0       0       0.000000       75.01         75.01       03950       SLEEP DI SORDER       0       0       0       0.000000       75.03         76.97       ORADI AC REHABILITATI ON       0       0       0       0.000000       75.03         76.97       ORADI AC REHABILITATI ON       0       0       0       0.000000       88.00         89.00       08800       RURAL HEALTH CLINIC       0 <td></td> <td></td> <td>0</td> <td>0</td> <td></td> <td>0 323, 076</td> <td></td> <td></td>			0	0		0 323, 076		
70.00         07000         ELECTROENCEPHALOGRAPHY         0         0         0         0         0.000000         70.00           71.00         MEDI CAL SUPPLIES CHARGED TO PATIENTS         0         0         1,221,075         0.000000         71.00           72.00         O7200         IMPLANTABLE DEVICES CHARGED TO         0         0         0         239,711         0.000000         72.00           73.00         O7300         DRUGS CHARGED TO PATIENTS         0         0         0         3,716,161         0.000000         73.00           74.00         O7400         RENAL DI ALYSIS         0         0         0         0.000000         74.00           75.01         03950         SLEEP DI SORDER         0         0         0         0.000000         75.01           75.03         07501         ADULT MENTAL HEALTH         0         0         0         1,146,431         0.000000         76.97           76.97         OR697         CARDIAC REHABILITATION         0         0         0         0.000000         76.97           76.97         OT697         CARDIAC REHABILI TATION         0         0         0.000000         76.97           0UTPATIENT SERVICE COST CENTERS         0			0	0		0		
71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENTS       0       0       1, 221, 075       0.000000       71.00         72.00       07200       IMPLANTABLE DEVICES CHARGED TO       0       0       239, 711       0.000000       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0       0       0       3.716, 161       0.000000       73.00         74.00       07400       RENAL DI ALYSI S       0       0       0       0.000000       74.00         75.00       07500       ASC (NON-DI STINCT PART)       0       0       0       0.000000       75.00         75.01       03950       SLEEP DI SORDER       0       0       0       0       0.000000       75.01         76.97       07697       CARDI AC REHABILITATI ON       0       0       0       1.146, 431       0.000000       75.03         76.97       OR407 CARDI AC REHABILITATI ON       0       0       0       0.000000       76.97         0417041       MENTAL HEALTH       0       0       0       0       0.000000       75.03         76.97       OR407 CARDI AC REHABILITATI ON       0       0       0       0.000000       88.00 <td< td=""><td></td><td></td><td>0</td><td>0</td><td></td><td></td><td></td><td></td></td<>			0	0				
72. 00       07200       IMPLANTABLE DEVICES CHARGED TO PATIENTS       0       0       239,711       0.000000       72.00         73. 00       07300       DRUGS CHARGED TO PATIENTS       0       0       0       3,716,161       0.000000       73.00         74. 00       07400       RENAL DI ALYSI S       0       0       0       0       0.000000       74.00         75. 00       07500       ASC (NON-DI STINCT PART)       0       0       0       0.000000       75.00         75. 01       03950       SLEEP DI SORDER       0       0       0       0.000000       75.00         75. 03       07501       ADULT MENTAL HEALTH       0       0       0       0       0.000000       75.03         76. 97       ORADI AC REHABILITATION       0       0       0       0       0.000000       75.03         76. 97       ORADI AC REHABILITATI CON       0       0       0       0.000000       88.00         88.00       08800       RURAL HEALTH CLINIC       0       0       0       0.000000       89.00         90.00       09000       CLINIC       0       0       0       0.000000       90.00         91.00       09000			0	0				
PATI ENTS         PATI ENTS         O			0	0				•
74.00       07400       RENAL DIALYSIS       0       0       0       0.000000       74.00         75.00       07500       ASC (NON-DI STINCT PART)       0       0       0       0.000000       75.00         75.01       03950       SLEEP DI SORDER       0       0       0       940,453       0.000000       75.01         75.03       07501       ADULT MENTAL HEALTH       0       0       1,146,431       0.000000       75.03         76.97       7697       CARDI AC REHABILITATION       0       0       0       334,968       0.000000       76.97         0UTPATI ENT SERVICE COST CENTERS       0       0       0       0       0.000000       88.00         88.00       08800       RURAL HEALTH CLINIC       0       0       0       0.000000       89.00         90.00       09000       CLINIC       0       0       0       0.000000       89.00         90.00       09100       EMERGENCY       0       0       0       0.000000       91.00         92.00       09200       OBSERVATION BEDS (NON-DISTINCT PART)       0       0       13,139,865       0.000000       91.00         92.00       09200       MBULANCE	72.00 07		0	0		0 239, 711	0.00000	72.00
75.00       07500       ASC (NON-DI STINCT PART)       0       0       0       0.000000       75.00         75.01       03950       SLEEP DI SORDER       0       0       0       940,453       0.000000       75.01         75.03       07501       ADULT MENTAL HEALTH       0       0       0       1,146,431       0.000000       75.03         76.97       07697       CARDI AC REHABILITATION       0       0       0       334,968       0.000000       76.97         0UTPATIENT SERVICE COST CENTERS       0       0       0       0       0.000000       88.00         89.00       08900       FURALLY QUALIFIED HEALTH CENTER       0       0       0       0.000000       89.00         90.00       09000       CLINIC       0       0       0       0.000000       89.00         91.00       09100       EMERGENCY       0       0       0       0.000000       91.00         92.00       09200       OBSERVATION BEDS (NON-DI STINCT PART)       0       0       13,139,865       0.000000       92.00         00       09200       OBSERVATION BEDS (NON-DI STINCT PART)       0       0       417,512       0.000000       92.00	73.00 07	300 DRUGS CHARGED TO PATIENTS	0	0		0 3, 716, 161	0.00000	73.00
75. 01       03950       SLEEP DI SORDER       0       0       940, 453       0.00000       75. 01         75. 03       07501       ADULT MENTAL HEALTH       0       0       0       1, 146, 431       0.000000       75. 03         76. 97       07697       CARDI AC REHABI LI TATI ON       0       0       0       334, 968       0.000000       76. 97         0UTPATI ENT SERVICE COST CENTERS       0       0       0       0       0.000000       88. 00         88. 00       08800       RURAL HEALTH CLINIC       0       0       0       0.000000       89. 00         90. 00       09000       CLINIC       0       0       0       0.000000       89. 00         91. 00       09100       EMERGENCY       0       0       0       0.000000       91. 00         92. 00       09200       OBSERVATI ON BEDS (NON-DI STI NCT PART)       0       0       0       13, 139, 865       0.000000       91. 00         95. 00       09500       AMBULANCE SERVI CES       95. 00       95. 00       95. 00       95. 00	74.00 07	400 RENAL DIALYSIS	0	0		0 0	0.00000	74.00
75.03       07501       ADULT MENTAL HEALTH       0       0       1,146,431       0.000000       75.03         76.97       07697       CARDI AC REHABILI TATI ON       0       0       0       334,968       0.000000       76.97         OUTPATI ENT SERVICE COST CENTERS       0       0       0       0       0.000000       88.00         88.00       08800       RURAL HEALTH CLINIC       0       0       0       0.000000       89.00         90.00       09000       CLINIC       0       0       0       0.000000       89.00         91.00       09100       EMERGENCY       0       0       0       0.000000       90.00         92.00       09200       OBSERVATI ON BEDS (NON-DI STI NCT PART)       0       0       0       417,512       0.000000       92.00         95.00       09500       AMBULANCE SERVICES       95.00       95.00       95.00       95.00	75.00 07	500 ASC (NON-DISTINCT PART)	0	0		0 0	0.00000	75.00
76.97         07697         CARDI AC REHABILITATION         0         0         334,968         0.000000         76.97           OUTPATI ENT SERVICE COST CENTERS         OUTPATI ENT SERVICE COST CENTERS         0         0         0         0         0.000000         88.00           88.00         08800         RURAL HEALTH CLINIC         0         0         0         0.000000         88.00           89.00         08900         FEDERALLY QUALIFIED HEALTH CENTER         0         0         0         0.000000         89.00           90.00         09000         CLINIC         0         0         0         0.000000         89.00           91.00         09100         EMERGENCY         0         0         0         0.000000         91.00           92.00         09200         DESERVATION BEDS (NON-DI STINCT PART)         0         0         417,512         0.000000         92.00           07HER REI MBURSABLE COST CENTERS         UTHER REI MBURSABLE COST CENTERS         95.00         95.00	75.01 03	950 SLEEP DI SORDER	0	0		0 940, 453	0.00000	75.01
OUTPATI ENT SERVICE COST CENTERS           88.00         08800         RURAL HEALTH CLINIC         0         0         0         0.000000         88.00           89.00         08900         FEDERALLY QUALIFIED HEALTH CENTER         0         0         0         0.000000         89.00           90.00         09000         CLINIC         0         0         0         0.000000         89.00           91.00         09100         EMERGENCY         0         0         0         0.000000         91.00           92.00         09200         OBSERVATION BEDS (NON-DISTINCT PART)         0         0         417,512         0.000000         92.00           0THER REI MBURSABLE COST CENTERS         95.00         09500         AMBULANCE SERVICES         95.00	75.03 07	501 ADULT MENTAL HEALTH	0	0		0 1, 146, 431	0.00000	75.03
88.00       08800       RURAL HEALTH CLINIC       0       0       0       0.000000       88.00         89.00       08900       FEDERALLY QUALIFIED HEALTH CENTER       0       0       0       0.000000       89.00         90.00       09000       CLINIC       0       0       0       0.000000       90.00         91.00       09100       EMERGENCY       0       0       0       0.000000       91.00         92.00       09200       OBSERVATION BEDS (NON-DISTINCT PART)       0       0       417,512       0.000000       92.00         OTHER REI MBURSABLE COST CENTERS       95.00       09500       AMBULANCE SERVICES       95.00	76.97 07	697 CARDI AC REHABI LI TATI ON	0	0		0 334, 968	0.00000	76.97
89.00         08900         FEDERALLY QUALIFIED HEALTH CENTER         0         0         0         0.00000         89.00           90.00         09000         CLINIC         0         0         0         0         0.00000         90.00           91.00         09100         EMERGENCY         0         0         0         13,139,865         0.000000         91.00           92.00         09200         0BSERVATION BEDS (NON-DISTINCT PART)         0         0         0         417,512         0.000000         92.00           0THER         REIMBURSABLE COST CENTERS         95.00         9500         AMBULANCE SERVICES         95.00         95.00	OU.	TPATIENT SERVICE COST CENTERS						
90.00         09000         CLINIC         0         0         0         0.0000         90.00           91.00         09100         EMERGENCY         0         0         0         13,139,865         0.000000         91.00           92.00         09200         OBSERVATION BEDS (NON-DISTINCT PART)         0         0         0         417,512         0.000000         92.00           0THER         REIMBURSABLE COST CENTERS         95.00         9500         AMBULANCE SERVICES         95.00         95.00	88.00 08	800 RURAL HEALTH CLINIC	0	0		0 0	0. 000000	88.00
91.00         09100         EMERGENCY         0         0         13, 139, 865         0.00000         91.00           92.00         09200         0BSERVATI ON BEDS (NON-DI STI NCT PART)         0         0         0         417, 512         0.000000         92.00           0THER         REI MBURSABLE COST CENTERS         95.00         09500         AMBULANCE SERVICES         95.00         95.00			0	0		0 0	0.00000	89.00
92. 00         09200         0BSERVATI ON BEDS (NON-DI STINCT PART)         0         0         417, 512         0.000000         92. 00           OTHER REIMBURSABLE COST CENTERS         95. 00         09500         AMBULANCE SERVICES         95. 00         950. 0	90.00 09	000 CLINIC	0	0		0 0	0.00000	90.00
OTHER REIMBURSABLE COST CENTERS         95.00       09500         AMBULANCE SERVICES       95.00			0	0		0 13, 139, 865	0.00000	91.00
95.00 09500 AMBULANCE SERVICES 95.00	92.00 09	200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 417, 512	0.00000	92.00
200.00   Total (lines 50 through 199) 0 0 0 0 60,013,789 200.00								
	200.00	Total (lines 50 through 199)	0	0		0 60, 013, 789		200.00

Health Financial Systems ASC	ENSION ST VINCENT	T SALEM HOSPIT	TAL .	In Li	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	Provider C	CN: 15-1314	Period: From 07/01/202	Worksheet D 1 Part IV	
THROUGH COSTS				To 06/30/202	2 Date/Time Pre	
					11/29/2022 10	:42 am
			e XIX	Hospi tal	Cost	
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Throug		Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)	10.00	x col. 10)	10.00	x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVICE COST CENTERS	0, 000000	22.105	1	0	0 0	50.00
		32, 105		0		
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0. 000000	860		-	-	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000	0		0	0 0	
60. 00 06000 LABORATORY	0. 000000	919		0	0 0	
61.00 06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0.000000					61.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	0		0	0 0	
66. 00 06600 PHYSI CAL THERAPY	0. 000000	0		0	0 0	
67.00 06700 OCCUPATIONAL THERAPY	0. 000000	0		0	0 0	
68.00 06800 SPEECH PATHOLOGY	0. 000000	0		0	0 0	
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	0		0	0 0	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0	0 0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	3, 826		0	0 0	
72. 00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0. 000000	0		0	0 0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	3, 038		0	0 0	73.00
74.00 07400 RENAL DIALYSIS	0. 000000	0		0	0 0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0. 000000	0		0	0 0	75.00
75. 01 03950 SLEEP DI SORDER	0. 000000	0		0	0 0	75.01
75.03 07501 ADULT MENTAL HEALTH	0. 000000	0		0	0 0	75.03
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	0		0	0 0	76.97
OUTPATIENT SERVICE COST CENTERS			_			
88.00 08800 RURAL HEALTH CLINIC	0. 000000	0		0	0 0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0		0	0 0	89.00
90. 00 09000 CLINIC	0. 000000	0		0	0 0	90.00
91. 00 09100 EMERGENCY	0. 000000	0		0	0 0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	990		0	0 0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)		41, 738		0	o  0	200. 00

ASCENSI ON	ST	VI NCENT	SALEM	HOSP	I TAL	

	Financial Systems ASCENSION ST VINCENT ATION OF INPATIENT OPERATING COST	SALEM HOSPITAL Provider CCN: 15-1314	In Lie Period:	u of Form CMS-2 Worksheet D-1	
			From 07/01/2021 To 06/30/2022	Date/Time Pre 11/29/2022 10	
	Cost Center Description	Title XVIII	Hospi tal	Cost	
				1.00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				-
1.00	Inpatient days (including private room days and swing-bed days	s. excluding newborn)		479	1.00
2.00 3.00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed day do not complete this line.	bed and newborn days)	ivate room days,	428 0	2.00 3.00
4.00 5.00	Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private roo		er 31 of the cost	131 32	4.00 5.00
6.00	reporting period Total swing-bed SNF type inpatient days (including private roo reporting period (if calendar year, enter 0 on this line)	om days) after December	31 of the cost	16	6.00
7.00	Total swing-bed NF type inpatient days (including private room reporting period	m days) through December	31 of the cost	2	7.00
8.00	Total swing-bed NF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line)	-		1	8.00
9.00 10.00	Total inpatient days including private room days applicable to newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII on	0 1 0		71 32	9.00 10.00
11.00	through December 31 of the cost reporting period (see instruct Swing-bed SNF type inpatient days applicable to title XVIII of	tions) nly (including private r	5	0	
12.00	December 31 of the cost reporting period (if calendar year, en Swing-bed NF type inpatient days applicable to titles V or XI) through December 31 of the cost reporting period		e room days)	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XL fafter December 31 of the cost reporting period (if calendar y			0	13.00
14.00 15.00	Medically necessary private room days applicable to the Progra Total nursery days (title V or XIX only)	am (excluding swing-bed	days)	0	15.00
	Nursery days (title V or XIX only) SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service	es through December 31 c	of the cost	0	16. 00
18.00	reporting period Medicare rate for swing-bed SNF services applicable to service	C			18.00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	231.10	19.00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services reporting period	s after December 31 of t	he cost	231.10	20.00
21. 00 22. 00	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through December 5 x line 17)		ing period (line	2, 685, 005 0	
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reportin	ng period (line 6	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 7 x line 19)		0 1 1		24.00
25.00 26.00	Swing-bed cost applicable to NF type services after December 3 x line 20) Total swing-bed cost (see instructions)	si of the cost reporting	j period (IINe 8	231 271, 380	25. 00 26. 00
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		2, 413, 625	
28.00	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	narges)	0	
29.00 30.00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	
30.00	General inpatient routine service cost/charge ratio (line 27 -	÷line 28)		0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)	/		0.00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34.00	Average per diem private room charge differential (line 32 min	nus line 33)(see instruc	tions)		34.00
35.00	Average per diem private room cost differential (line 34 x lin	ne 31)		0.00	35.00
36. 00 37. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	0 2, 413, 625	36. 00 37. 00
	27 minus Line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				-
20.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU			F (00.01	
38.00 39.00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line	-		5, 639. 31 400, 391	
40.00	Medically necessary private room cost applicable to the Progra Total Program general inpatient routine service cost (line 39	am (line 14 x line 35)		0 400, 391	40.00

OMPUT	Financial Systems         ASC           ATION OF INPATIENT OPERATING COST         ASC	ENSION ST VINCEN		CN: 15-1314	Period:	u of Form CMS- Worksheet D-1	
					From 07/01/2021 To 06/30/2022		
					10 06/30/2022	11/29/2022 10	
				e XVIII	Hospi tal	Cost	
	Cost Center Description	Total	Total	Average Per		Program Cost	
		Inpatient Cost	inpatient bays		÷	(col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
00	NURSERY (title V & XIX only)						42
	Intensive Care Type Inpatient Hospital Units	S					
00	INTENSIVE CARE UNIT						4:
00	CORONARY CARE UNIT						44
00 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						43
	OTHER SPECIAL CARE (SPECIFY)						4
	Cost Center Description						
						1.00	
00	Program inpatient ancillary service cost (W					75, 450	
00	Total Program inpatient costs (sum of lines	41 through 48)(	see instructio	ons)		475, 841	4
00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program in	natient routine	services (from	n Wkst D sur	of Parts L and	C	5
00			301 11 003 (11 01	ii wixst. D, Su		C	1 .
00	Pass through costs applicable to Program in	patient ancillar	y services (fr	rom Wkst. D, s	sum of Parts II	C	) 5 <sup>.</sup>
<u>.</u>	and IV)						
. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		lated non nh	ici ci ca cascati	atiot and	C	
. 00	medical education costs (line 49 minus line		alated, non-phy	ysi ci an anestr	ietist, and	C	5
	TARGET AMOUNT AND LIMIT COMPUTATION	~~)					
. 00	Program di scharges					C	5
. 00	Target amount per discharge					0.00	) 5!
00	Target amount (line 54 x line 55)					C	
00	Difference between adjusted inpatient opera	ting cost and ta	rget amount (I	ine 56 minus	line 53)	C	
00	Bonus payment (see instructions)					0	
. 00	Lesser of lines 53/54 or 55 from the cost remarket basket	eporting period	ending 1996, i	updated and co	ompounded by the	0.00	5
. 00	Lesser of lines 53/54 or 55 from prior year	cost report, up	dated by the r	market basket		0.00	6
. 00	If line 53/54 is less than the lower of line				the amount by	C	6
	which operating costs (line 53) are less that		s (lines 54 x	60), or 1% of	f the target		
~ ~	amount (line 56), otherwise enter zero (see	instructions)					
. 00	Relief payment (see instructions)					C	
. 00	Allowable Inpatient cost plus incentive payr PROGRAM INPATIENT ROUTINE SWING BED COST	ment (see Instru	ictions)			C	) 63
. 00	Medicare swing-bed SNF inpatient routine cos	sts through Dece	mber 31 of the	e cost reporti	ng period (See	180, 458	3 64
	instructions)(title XVIII only)	0			0 1 1		
. 00	Medicare swing-bed SNF inpatient routine cos	sts after Decemb	er 31 of the o	cost reportino	g period (See	C	) 6!
00	instructions) (title XVIII only)	ina anata (lina	(1 plug lips )	(E) (+; +  ~ V)/		100 450	
. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	The costs (The	64 plus line d	bb)(title xvii	i oniy). For	180, 458	
. 00	Title V or XIX swing-bed NF inpatient routin	ne costs through	December 31 d	of the cost re	eporting period	C	6
	(line 12 x line 19)				511		
. 00	Title V or XIX swing-bed NF inpatient routin	ne costs after D	ecember 31 of	the cost repo	orting period	C	68
	(line 13 x line 20)			(0)			
. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N	,		/		C	0 69
. 00	Skilled nursing facility/other nursing facil				)		70
. 00	Adjusted general inpatient routine service of	2		• •			7
. 00	Program routine service cost (line 9 x line						7
. 00	Medically necessary private room cost applic						7:
. 00	Total Program general inpatient routine serv	•					7
. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	COSTS (From V	worksneet B, F	arτιι, column		7
. 00	Per diem capital-related costs (line 75 ÷ li	ine 2)					7
00	Program capital -related costs (line 9 x line						7
00	Inpatient routine service cost (line 74 min						7
00	Aggregate charges to beneficiaries for exces	ss costs (from p					7
00	Total Program routine service costs for com		ost limitation	n (line 78 mir	nus line 79)		8
00	Inpatient routine service cost per diem limi		`				8
00	Inpatient routine service cost limitation (I						8
00	Reasonable inpatient routine service costs	•	s)				8
. 00	Program inpatient ancillary services (see in Utilization review - physician compensation		ns)				8
. 00	Total Program inpatient operating costs (sur						8
	PART IV - COMPUTATION OF OBSERVATION BED PAS						
. 00	Total observation bed days (see instructions					297	8
~ ~	Adjusted general inpatient routine cost per	diem (line 27 ÷	line 2)			5, 639. 31	8
00	Observation bed cost (line 87 x line 88) (se					1, 674, 875	

Health Financial Systems ASCE	NSION ST VINCE	NT SALEM HOSPIT	AL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 07/01/2021	Worksheet D-1	
				To 06/30/2022	Date/Time Pre 11/29/2022 10	pared: :42 am_
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST					
90.00 Capital-related cost	149, 072	2, 685, 005	0. 05552	0 1, 674, 875	92, 989	90.00
91.00 Nursing Program cost	0	2, 685, 005	0.00000	0 1, 674, 875	0	91.00
92.00 Allied health cost	0	2, 685, 005	0.00000	0 1, 674, 875	0	92.00
93.00 All other Medical Education	0	2, 685, 005	0.00000	1, 674, 875	0	93.00

ASCENSI ON	ST	VI NCENT	SALEM	HOSPI TAL	
					-

1.00 Ir 2.00 Ir 3.00 Pr dd 4.00 Se 5.00 Tc 6.00 Tc	Cost Center Description ART I - ALL PROVIDER COMPONENTS IPATIENT DAYS npatient days (including private room days and swing-bed days npatient days (including private room days, excluding swing-bed rivate room days (excluding swing-bed and observation bed days o not complete this line. emi-private room days (excluding swing-bed and observation bed to not complete this line. emi-private room days (excluding swing-bed and observation bed to not complete this line. emi-private room days (excluding swing-bed and observation bed to not complete this line. emi-private room days (excluding swing-bed and observation bed to not complete this line. emi-private room days (including private room eporting period (if calendar year, enter 0 on this line) otal swing-bed NF type inpatient days (including private room eporting period	bed and newborn days) ys). If you have only pri ed days) om days) through December om days) after December 3	31 of the cost	Date/Time Pret 11/29/2022 10: Cost 1.00 479 428 0 131 32	
1.00 Ir 2.00 Ir 3.00 Pr dd 4.00 Se 5.00 Tc 6.00 Tc	ART I - ALL PROVIDER COMPONENTS IPATIENT DAYS npatient days (including private room days and swing-bed days npatient days (including private room days, excluding swing-bed rivate room days (excluding swing-bed and observation bed day o not complete this line. emi-private room days (excluding swing-bed and observation bed to any complete this line. emi-private room days (excluding swing-bed and observation bed to any complete this line. emi-private room days (excluding swing-bed and observation bed to any complete this line. emi-private room days (excluding swing-bed and observation bed to any complete this line) to any complete the sum of	s, excluding newborn) bed and newborn days) ys). If you have only pri ed days) m days) through December om days) after December 3	vate room days, - 31 of the cost	1.00 479 428 0 131	2.00 3.00
1.00 Ir 2.00 Ir 3.00 Pr dd 4.00 Se 5.00 Tc 6.00 Tc	ART I - ALL PROVIDER COMPONENTS IPATIENT DAYS npatient days (including private room days and swing-bed days npatient days (including private room days, excluding swing-bed rivate room days (excluding swing-bed and observation bed day o not complete this line. emi-private room days (excluding swing-bed and observation bed to any complete this line. emi-private room days (excluding swing-bed and observation bed to any complete this line. emi-private room days (excluding swing-bed and observation bed to any complete this line. emi-private room days (excluding swing-bed and observation bed to any complete this line) to any complete the sum of	bed and newborn days) ys). If you have only pri ed days) om days) through December om days) after December 3	31 of the cost	479 428 0 131	2.00 3.00
1.00 Ir 2.00 Ir 3.00 Pr dd 4.00 Se 5.00 Tc 6.00 Tc	IPATIENT DAYS hpatient days (including private room days and swing-bed days hpatient days (including private room days, excluding swing-bed rivate room days (excluding swing-bed and observation bed day o not complete this line. emi-private room days (excluding swing-bed and observation bed betal swing-bed SNF type inpatient days (including private room eporting period otal swing-bed SNF type inpatient days (including private room eporting period (if calendar year, enter 0 on this line) otal swing-bed NF type inpatient days (including private room eporting period (if calendar year, enter 0 on this line) otal swing-bed NF type inpatient days (including private room eporting period	bed and newborn days) ys). If you have only pri ed days) om days) through December om days) after December 3	31 of the cost	428 0 131	2.00 3.00
1.00 Ir 2.00 Ir 3.00 Pr da 4.00 Se 5.00 To 6.00 To re	npatient days (including private room days and swing-bed days npatient days (including private room days, excluding swing-be rivate room days (excluding swing-bed and observation bed day o not complete this line. emi-private room days (excluding swing-bed and observation be otal swing-bed SNF type inpatient days (including private roo eporting period otal swing-bed SNF type inpatient days (including private roo eporting period (if calendar year, enter 0 on this line) otal swing-bed NF type inpatient days (including private room eporting period (if calendar year, enter 0 on this line)	bed and newborn days) ys). If you have only pri ed days) om days) through December om days) after December 3	31 of the cost	428 0 131	2.00 3.00
2.00 Ir 3.00 Pr dd 4.00 Se 5.00 Tc 6.00 Tc	npatient days (including private room days, excluding swing-b rivate room days (excluding swing-bed and observation bed day o not complete this line. emi-private room days (excluding swing-bed and observation be otal swing-bed SNF type inpatient days (including private roo eporting period otal swing-bed SNF type inpatient days (including private roo eporting period (if calendar year, enter 0 on this line) otal swing-bed NF type inpatient days (including private room eporting period)	bed and newborn days) ys). If you have only pri ed days) om days) through December om days) after December 3	31 of the cost	428 0 131	2.00 3.00
4.00 Se 5.00 To 6.00 To re	emi-private room days (excluding swing-bed and observation be otal swing-bed SNF type inpatient days (including private roo eporting period otal swing-bed SNF type inpatient days (including private roo eporting period (if calendar year, enter 0 on this line) otal swing-bed NF type inpatient days (including private room eporting period	om days) through December om days) after December 3			4.00
6.00 To	otal swing-bed SNF type inpatient days (including private roc eporting period (if calendar year, enter 0 on this line) otal swing-bed NF type inpatient days (including private room eporting period		31 of the cost	' I	5.00
	otal swing-bed NF type inpatient days (including private room eporting period			16	6.00
	1 51	n days) through December	31 of the cost	2	7.00
8.00 To	otal swing-bed NF type inpatient days (including private room eporting period (if calendar year, enter 0 on this line)	5		1	8.00
ne	otal inpatient days including private room days applicable to ewborn days) (see instructions)	5 . 5	5	1	9.00
tł	wing-bed SNF type inpatient days applicable to title XVIII or nrough December 31 of the cost reporting period (see instruct wing-bed SNF type inpatient days applicable to title XVIII or	tions)	5	0	10.00
De	ecember 31 of the cost reporting period (if calendar year, er wing-bed NF type inpatient days applicable to titles V or XIX	nter 0 on this line)	5	0	12.00
th 13.00 Sv	nrough December 31 of the cost reporting period wing-bed NF type inpatient days applicable to titles V or XIX	only (including private	e room days)	0	13.00
14.00 Me	fter December 31 of the cost reporting period (if calendar ye edically necessary private room days applicable to the Progra otal nursery days (title V or XIX only)	ear, enter 0 on this line am (excluding swing-bed o	e) lays)	0	14.00 15.00
16.00 Nu	ursery days (title V or XIX only) // ING BED ADJUSTMENT			0	16.00
17.00 Me	edicare rate for swing-bed SNF services applicable to service eporting period	es through December 31 of	the cost		17.00
re	edicare rate for swing-bed SNF services applicable to service eporting period				18.00
re	edicaid rate for swing-bed NF services applicable to services eporting period	0			
re	edicaid rate for swing-bed NF services applicable to services eporting period otal general inpatient routine service cost (see instructions		le cost	231. 10 2, 685, 005	
22.00 Sv	wing-bed cost applicable to SNF type services through December x line 17)		ng period (line	0	22.00
x	wing-bed cost applicable to SNF type services after December line 18)			0	23.00
7	wing-bed cost applicable to NF type services through December x line 19) wing-bed cost applicable to NF type services after December 3				24.00 25.00
x	line 20) tal swing-bed cost (see instructions)	si si the cost reporting	porrou (rine o	231	
27.00 Ge	eneral inpatient routine service cost net of swing-bed cost ( RIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		2, 413, 625	27.00
1	eneral inpatient routine service charges (excluding swing-bed	d and observation bed cha	arges)	0	28.00
	rivate room charges (excluding swing-bed charges)			0	29.00 30.00
	emi-private room charges (excluding swing-bed charges) eneral inpatient routine service cost/charge ratio (line 27 ÷	Line 28)		0.000000	30.00
	verage private room per diem charge (line 29 ÷ line 3)			0.00	1
	verage semi-private room per diem charge (line 30 ÷ line 4)			0.00	1
	verage per diem private room charge differential (line 32 mir	nus line 33)(see instruct	i ons)	0.00	
	verage per diem private room cost differential (line 34 x lir			0.00	35.00
37.00 Ge	rivate room cost differential adjustment (line 3 x line 35) eneral inpatient routine service cost net of swing-bed cost a	and private room cost dif	ferential (line	0 2, 413, 625	36.00 37.00
PA	7 minus line 36) NRT II - HOSPITAL AND SUBPROVIDERS ONLY ROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS			
	djusted general inpatient routine service cost per diem (see			5, 639. 31	38.00
1	rogram general inpatient routine service cost (line 9 x line	-		5, 639, 31	
	edically necessary private room cost applicable to the Progra	-		5, 039	40.00
	otal Program general inpatient routine service cost (line 39	•			41.00

MPUT	TATION OF INPATIENT OPERATING COST		Provider C	CN: 15-1314	Peri od:	Worksheet D-1	
					From 07/01/2021 To 06/30/2022	Date/Time Pre	epare
				e XIX	Hospi tal	11/29/2022 10 Cost	): 42
	Cost Center Description	Total	Total	Average Per		Program Cost	
	•	Inpatient Cost	Inpatient Days			(col. 3 x col.	
				col. 2)		4)	-
00		1.00	2.00	3.00	4.00	5.00	10
00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Un	i to					42
00	INTENSIVE CARE UNIT						43
00	CORONARY CARE UNIT						44
00	BURN INTENSIVE CARE UNIT						45
00							46
00	OTHER SPECIAL CARE (SPECIFY)						47
	Cost Center Description						-
00						1.00	
00	Program inpatient ancillary service cost Total Program inpatient costs (sum of lin	•				12, 708 18, 347	
00	PASS THROUGH COST ADJUSTMENTS			5115)		10, 347	47
00	Pass through costs applicable to Program	inpatient routine	services (from	n Wkst. D. su	m of Parts I and	0	50
	)						
. 00	Pass through costs applicable to Program	inpatient ancillar	y services (fr	rom Wkst. D,	sum of Parts II	0	51
0.2	and IV)	50 1 51				-	
. 00	Total Program excludable cost (sum of lin		lated non nh	al al an anaat	actict and	0	
00	Total Program inpatient operating cost ex medical education costs (line 49 minus li		nated, non-phy	ysi ci an anest	netist, and	0	1 53
	TARGET AMOUNT AND LIMIT COMPUTATION						
00						0	54
00						0.00	55
00	Target amount (line 54 x line 55)					0	
00		rating cost and ta	rget amount (I	ine 56 minus	line 53)	0	
00	Bonus payment (see instructions)	reporting pariod	anding 100/	undeted and a	ampounded by the	0	
00	Lesser of lines 53/54 or 55 from the cost market basket	reporting period	ending 1996, t	updated and c	Silipounded by the	0.00	59
00	Lesser of lines 53/54 or 55 from prior ye	ar cost report, up	dated by the m	narket basket		0.00	60
00	If line 53/54 is less than the lower of I				the amount by	0	61
	which operating costs (line 53) are less		s (lines 54 x	60), or 1% o	f the target		
~~	amount (line 56), otherwise enter zero (s	ee instructions)				0	
. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive p	avmont (soo instru	(ctions)			0	
. 00	PROGRAM INPATIENT ROUTINE SWING BED COST					0	1 03
00	Medicare swing-bed SNF inpatient routine	costs through Dece	mber 31 of the	e cost report	ng period (See	0	64
	instructions)(title XVIII only)	-					
. 00	Medicare swing-bed SNF inpatient routine	costs after Decemb	er 31 of the c	cost reportin	g period (See	0	65
~~	instructions)(title XVIII only)		(4				
. 00	Total Medicare swing-bed SNF inpatient ro CAH (see instructions)	utine costs (line	64 prus rine e	5)(title XVI	TI ONLY). FOR	0	66
. 00	Title V or XIX swing-bed NF inpatient rou	tine costs through	December 31 d	of the cost r	eporting period	0	67
	(line 12 x line 19)	tino ocoro tinougi			opor tring por roa	Ū	
. 00	Title V or XIX swing-bed NF inpatient rou	tine costs after D	ecember 31 of	the cost rep	orting period	0	68
	(line 13 x line 20)					_	
. 00	y					0	69
. 00	PART III - SKILLED NURSING FACILITY, OTHE Skilled nursing facility/other nursing fa		•		)		70
. 00	Adjusted general inpatient routine servic	5			,		71
00	Program routine service cost (line 9 x li			,			72
00	Medically necessary private room cost app	licable to Program					73
00	Total Program general inpatient routine s	•					74
00	Capital-related cost allocated to inpatie	nt routine service	costs (from V	Vorksheet B,	Part II, column		75
00	26, line 45) Per diem capital-related costs (line 75 ÷	line 2)					76
00	Program capital -related costs (line 9 x l	· ·					77
00	Inpatient routine service cost (line 74 m	,					78
00	Aggregate charges to beneficiaries for ex	,	rovi der record	ds)			79
00	Total Program routine service costs for c	omparison to the c	ost limitation	n (line 78 mi	nus line 79)		80
00	Inpatient routine service cost per diem I						81
00	Inpatient routine service cost limitation	•					82
00	Reasonable inpatient routine service cost	•	is)				83
00	Program inpatient ancillary services (see Utilization review - physician compensati		ns)				84
. 00	Total Program inpatient operating costs (						86
	PART I V - COMPUTATION OF OBSERVATION BED						
. 00	Total observation bed days (see instructi					297	87
00	Adjusted general inpatient routine cost p	•				5, 639. 31	
00 00	Observation bed cost (line 87 x line 88)					1, 674, 875	

Health Financial Systems ASCE	NSION ST VINCE	NT SALEM HOSPIT	AL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 07/01/2021	Worksheet D-1	
				To 06/30/2022	Date/Time Prep 11/29/2022 10	pared: :42 am
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST					
90.00 Capital-related cost	149, 072	2, 685, 005	0. 055520	1, 674, 875	92, 989	90.00
91.00 Nursing Program cost	0	2, 685, 005	0.00000	1, 674, 875	0	91.00
92.00 Allied health cost	0	2, 685, 005	0.00000	1, 674, 875	0	92.00
93.00 All other Medical Education	0	2, 685, 005	0.00000	1, 674, 875	0	93.00

	CENT SALEM HOSPI			u of Form CMS-2	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1314	Period: From 07/01/2021	Worksheet D-3	
			To 06/30/2022	Date/Time Pre	pared:
				11/29/2022 10	
	Ti tl e	e XVIII	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	5.00	
30. 00 03000 ADULTS & PEDI ATRI CS			91, 080		30. 00
ANCI LLARY SERVI CE COST CENTERS					
50. 00 05000 OPERATI NG ROOM		0. 2186	36 33, 010	7, 219	50.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C		0. 1485		1, 401	54.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0.0000		0	
60. 00 06000 LABORATORY		0. 2012		7, 678	
61. 00 06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY		0.0000		0	
65. 00 06500 RESPI RATORY THERAPY		0. 1909			
66. 00 06600 PHYSI CAL THERAPY		0.4380			
67. 00 06700 OCCUPATI ONAL THERAPY		0. 4155		466	
68. 00 06800 SPEECH PATHOLOGY		0.0000		0	
69. 00 06900 ELECTROCARDI OLOGY		0.25340		3, 829	
70. 00 07000 ELECTROENCEPHALOGRAPHY		0.0000		0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS		0. 1041			
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 3827			
74. 00 07400 RENAL DIALYSIS		0.0000		24,000	
75. 00 07500 ASC (NON-DI STINCT PART)		0.0000		0	
75. 01 03950 SLEEP DI SORDER		0. 37440		0	1 / 0/ 00
75. 03 07501 ADULT MENTAL HEALTH		0. 61090		0	
76. 97 07697 CARDI AC REHABI LI TATI ON		0. 9935		0	•
OUTPATIENT SERVICE COST CENTERS		• • • • • • • • • • • • • • • • • • • •			
88. 00 08800 RURAL HEALTH CLINIC		0.0000	00	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.0000	00	0	89.00
90. 00 09000 CLINIC		0.0000		0	90.00
91. 00 09100 EMERGENCY		0. 3075		0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		4.0115	5, 805	23, 287	92.00
OTHER REIMBURSABLE COST CENTERS		1		1	
95.00 09500 AMBULANCE SERVICES	1)		01E 740	75 450	95.00
200.00Total (sum of lines 50 through 94 and 96 through 98201.00Less PBP Clinic Laboratory Services-Program only ch			215, 710	75, 450	200.00
201.00 [Less PBP clinic Laboratory Services-Program only cr 202.00] [Net charges (line 200 minus line 201)	arges (inne 61)		215, 710		201.00
202. OU INEL CIALYES (TITLE 200 INTING TITLE 201)		I	215,710	I	1202.00

Health Financial Systems ASCENSION ST VINCENT S	SALEM HOSPI	TAL	In Lie	eu of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1314	Peri od:	Worksheet D-3	
	0	001 45 3044	From 07/01/2021		
	Component	CCN: 15-Z314	To 06/30/2022	Date/Time Pre 11/29/2022 10	
	Title	e XVIII	Swing Beds - SNI		
Cost Center Description		Ratio of Cos	t Inpatient	Inpatient	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS			-	1	
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
ANCI LLARY SERVI CE COST CENTERS		0.010(			
50. 00 05000 OPERATING ROOM		0.2186			
54.00 05400 RADI OLOGY - DI AGNOSTI C		0.1485		-	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 60.00 06000 LABORATORY		0.0000		0	
61. 00 06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY		0.2012			1
65. 00 06500 RESPIRATORY THERAPY		0. 1909			
66. 00 06600 PHYSI CAL THERAPY		0. 1909			
67. 00 06700 OCCUPATI ONAL THERAPY		0. 4380			
68. 00 06800 SPEECH PATHOLOGY		0.0000			1
69. 00 06900 ELECTROCARDI OLOGY		0. 2534			
70. 00 07000 ELECTROENCEPHALOGRAPHY		0.0000			1
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 1041			1
72. 00 07200 I MPLANTABLE DEVICES CHARGED TO PATIENTS		0. 3627			
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 3304		-	
74.00 07400 RENAL DI ALYSI S		0.0000			1
75.00 07500 ASC (NON-DISTINCT PART)		0.0000		0	75.00
75. 01 03950 SLEEP DI SORDER		0. 3744		0	
75.03 07501 ADULT MENTAL HEALTH		0. 6109	D3 C	0 0	75.03
76. 97 07697 CARDI AC REHABI LI TATI ON		0. 9935	37 C	0 0	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC		0.0000	00	0	88.00
89. 00 08900 FEDERALLY QUALI FI ED HEALTH CENTER		0.0000	00	0	89.00
90. 00 09000 CLINIC		0.0000	00 00	0	90.00
91. 00 09100 EMERGENCY		0. 3075	15 C	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		4.0115	61 C	0 0	92.00
OTHER REIMBURSABLE COST CENTERS		1	1	T	
95.00 09500 AMBULANCE SERVICES					95.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)			36, 375	11, 217	200.00
201.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)			)	201.00
202.00 Net charges (line 200 minus line 201)		I	36, 375		202.00

	VINCENT SALEM HOSPI		In Lie	u of Form CMS-2	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1314	Period: From 07/01/2021	Worksheet D-3	
			To 06/30/2022	Date/Time Pre	pared:
				11/29/2022 10	
	Titl	e XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	5.00	
30. 00 03000 ADULTS & PEDI ATRI CS			8, 209		30.00
ANCI LLARY SERVICE COST CENTERS		1			1
50. 00 05000 OPERATI NG ROOM		0. 21868	36 32, 105	7, 021	50.00
54. 00 05400 RADI OLOGY – DI AGNOSTI C		0. 1485	72 860	128	54.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0.0000		0	
60. 00 06000 LABORATORY		0. 20120		185	60.00
61.00 06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY		0.0000		0	61.00
65. 00 06500 RESPI RATORY THERAPY		0. 1909		0	
66. 00 06600 PHYSI CAL THERAPY		0. 4380		0	
67. 00 06700 OCCUPATI ONAL THERAPY		0. 41554		0	07100
68. 00 06800 SPEECH PATHOLOGY		0.0000		0	
69. 00 06900 ELECTROCARDI OLOGY		0.25340		0	
70. 00 07000 ELECTROENCEPHALOGRAPHY 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.0000		0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS		0. 1041		399 0	
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 3304		1,004	•
74. 00 07400 RENAL DIALYSIS		0. 00000		0	
75. 00 07500 ASC (NON-DI STINCT PART)		0.00000		0	
75. 01 03950 SLEEP DI SORDER		0. 37440		0	
75.03 07501 ADULT MENTAL HEALTH		0. 61090		0	
76. 97 07697 CARDI AC REHABI LI TATI ON		0. 99353	37 0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC		0.0000	0 0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.0000		0	
90. 00 09000 CLINIC		0.0000		0	
91.00 09100 EMERGENCY		0. 3075		0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		4.01150	990	3, 971	92.00
		1			
95.00 09500 AMBULANCE SERVICES 200.00 Total (sum of lines 50 through 94 and 96 through	2 09)		41 700	10 700	95.00
201.00 Less PBP Clinic Laboratory Services-Program only			41, 738	12, 708	200.00
202.00 Net charges (line 200 minus line 201)	y charges (Time OT)		41, 738		201.00
		1	41,730		1202.00

	Financial Systems     ASCENSION ST VINCENT SALEM HOST       ATION OF REIMBURSEMENT SETTLEMENT     Provide	SPI TAL r CCN: 15-1314	In Lie Period:	u of Form CMS-2 Worksheet E	2552-10
UNECOL		0011. 10 1014	From 07/01/2021 To 06/30/2022	Part B Date/Time Pre	
	Ti	tle XVIII	Hospi tal	11/29/2022 10: Cost	:42 am_
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00 2.00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instructions)			3, 922, 164 0	1.00 2.00
3.00	OPPS payments			0	3.00
4.00	Outlier payment (see instructions)			0	4.00
4.01 5.00	Outlier reconciliation amount (see instructions)			0 0. 000	4.01 5.00
6.00	Enter the hospital specific payment to cost ratio (see instructions) Line 2 times line 5			0.000	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
8.00	Transitional corridor payment (see instructions)	40.11.000		0	8.00
9.00 10.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. Organ acquisitions	13, 11ne 200		0	9.00 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			3, 922, 164	
	COMPUTATION OF LESSER OF COST OR CHARGES				
12.00	Reasonable charges Ancillary service charges			0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0	14.00
15.00	Customary charges Aggregate amount actually collected from patients liable for payment f	or services on	a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment			0	16.00
	had such payment been made in accordance with 42 CFR §413.13(e)		5		
17.00 18.00	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions)			0. 000000 0	17.00 18.00
19.00	Excess of customary charges over reasonable cost (complete only if lin	e 18 exceeds li	ne 11) (see	0	
	instructions)				
20.00	Excess of reasonable cost over customary charges (complete only if lin instructions)	e 11 exceeds li	ne 18) (see	0	20.00
21.00	Lesser of cost or charges (see instructions)			3, 961, 386	21.00
22.00	Interns and residents (see instructions)			0	22.00
23.00 24.00	Cost of physicians' services in a teaching hospital (see instructions)			0	23.00 24.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	24.00
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)			49, 336	
26.00 27.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for			2,024,505	
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the instructions)	Sull Of Thes 22	anu 23] (See	1, 887, 545	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)			0	28.00
29.00 30.00	ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29)			0 1, 887, 545	29.00 30.00
30.00	Primary payer payments			1, 887, 545	
32.00	Subtotal (line 30 minus line 31)			1, 886, 745	32.00
22 00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) Composite rate ESRD (from Wkst. I-5, line 11)			0	33.00
34.00	Allowable bad debts (see instructions)			357, 128	
35.00	Adjusted reimbursable bad debts (see instructions)			232, 133	35.00
36.00 37.00	Allowable bad debts for dual eligible beneficiaries (see instructions) Subtotal (see instructions)			234, 254 2, 118, 878	
37.00	MSP-LCC reconciliation amount from PS&R			2, 110, 070	37.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39.00
39.01	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39.01
39. 50 39. 97	Pioneer ACO demonstration payment adjustment (see instructions) Demonstration payment adjustment amount before sequestration			0	39.50 39.97
39.98				0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0	39.99
40. 00 40. 01	Subtotal (see instructions) Sequestration adjustment (see instructions)			2, 118, 878 5, 297	40. 00 40. 01
40. 02	Demonstration payment adjustment amount after sequestration			0, 2, 1	40. 02
40.03	Sequestration adjustment-PARHM pass-throughs				40.03
41.00 41.01	Interim payments Interim payments-PARHM			1, 696, 204	41.00 41.01
41.01	Tentative settlement (for contractors use only)			0	
42.01	Tentative settlement-PARHM (for contractor use only)			447 07-	42.01
43. 00 43. 01	Balance due provider/program (see instructions) Balance due provider/program-PARHM (see instructions)			417, 377	43.00 43.01
43.01	Protested amounts (nonallowable cost report items) in accordance with	CMS Pub. 15-2,	chapter 1,	25, 000	
	§115. 2				
90.00	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)			0	90.00
90.00 91.00	Outlier reconciliation adjustment amount (see instructions)			0	90.00 91.00
92.00	The rate used to calculate the Time Value of Money				92.00
93.00 94.00	Time Value of Money (see instructions) Total (sum of lines 91 and 93)			0	93.00 94.00
74.00	Trotal Count of Trinos /T and /0/		I	0	1 / 7.00

Health Financial Systems	ASCENSION ST VINCENT	SALEM HOSPI TAL	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-1314	Period: From 07/01/2021	Worksheet E	
				Date/Time Pre	pared:
				11/29/2022 10	:42 am
		Title XVIII	Hospi tal	Cost	
				1.00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days				0	200.00

NALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC	N: 15-1314	Period: From 07/01/2021 To 06/30/2022		pared: :42 am
		Title	XVIII	Hospi tal	Cost	
		I npati ent	t Part A	Pa	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
. 00 . 00 . 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each		261, 0	73 0	1, 696, 204 0	1.00 2.00 3.00
	payment. If none, write "NONE" or enter a zero. (1) Program to Provider					
. 01 . 02 . 03 . 04 . 05 . 49	ADJUSTMENTS TO PROVIDER	03/14/2022	35, 2		0 0 0 0 0 0 0	3. 0 <sup>°</sup> 3. 0 <sup>°</sup> 3. 0 <sup>°</sup> 3. 0 <sup>°</sup> 3. 0 <sup>°</sup> 3. 4 <sup>°</sup>
	Provider to Program	Г				
50 51 52 53 54 99	ADJUSTMENTS TO PROGRAM Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		35, 2	0 0 0 0 0 00	0 0 0 0 0 0	3.5 3.5 3.5 3.5 3.5 3.5 3.9
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR		296, 2	73	1, 696, 204	4. C
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					5.0
01 02 03	TENTATIVE TO PROVIDER Provider to Program			0 0 0	0 0 0	5. C 5. C 5. C
50 51 52 99	TENTATIVE TO PROGRAM Subtotal (sum of lines 5.01-5.49 minus sum of lines			0 0 0 0	0 0 0 0	5.5 5.5 5.5 5.9
00	5.50-5.98) Determined net settlement amount (balance due) based on the cost report. (1)					6.0
01 02 00	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions)		157, 5 453, 7	0 82	417, 377 0 2, 113, 581	6.0 6.0 7.0
		0		Contractor Number 1.00	NPR Date (Mo/Day/Yr) 2.00	

NALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider Concernent (	CN: 15-1314 CCN: 15-Z314		riod: om 07/01/2021 06/30/2022	Worksheet E-1 Part I Date/Time Prep 11/29/2022 103	pared
		Title	e XVIII	Swi	ng Beds - SNF		
		Inpatien	t Part A		Par	tВ	
		mm/dd/yyyy	Amount		mm/dd/yyyy	Amount	
		1.00	2.00		3.00	4.00	
. 00 . 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		103, 3	0 0		0 0	
. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider						3. (
01	ADJUSTMENTS TO PROVIDER	03/14/2022	28, 1	00		0	3.0
02				0		0	3. (
. 03				0		0	3. (
04 05				0 0		0	3. 3.
49				o		0	3.
	Provider to Program		1				
50	ADJUSTMENTS TO PROGRAM			0		0	3.
51 52				0 0		0	3. 3.
52 53				0		0	3.
54				0		0	3.
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		28, 1	00		0	3.
~~	3.50-3.98)		101.4	00			
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		131, 4	92		0	4.
	TO BE COMPLETED BY CONTRACTOR						
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5.
	Program to Provider		1				
01	TENTATI VE TO PROVI DER			0		0	5.
02 03				0 0		0	5. 5.
03	Provider to Program			0		0	5.
50	TENTATI VE TO PROGRAM			0		0	5.
51				0		0	
52	Subtatal (sum of lines E 01 E 40 minut sum of lin			0		0	5.
99 00	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Determined net settlement amount (balance due) based on			0		0	5. 6.
00	the cost report. (1)						0.
01	SETTLEMENT TO PROVIDER		61, 6	16		0	6.
02	SETTLEMENT TO PROGRAM			0		0	6.
00	Total Medicare program liability (see instructions)		193, 1	08	Contractor	0 NPR Date	7.
					Number	(Mo/Day/Yr)	
	Name of Contractor	(	2		1.00	2.00	8.

		INCENT SALEM HOSPITAL	In Lie	u of Form CMS-	2552-10
CALCUL	From 07/01/2021 P To 06/30/2022 D 1			Worksheet E- Part II Date/Time Pro 11/29/2022 10	epared:
		Title XVIII	Hospi tal	Cost	
				1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPO	-			_
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCU				
1.00	Total hospital discharges as defined in AARA §4102 from				1.00
2.00	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines		for cost		2.00
0.00	reporting periods beginning on or after 10/01/2013, line 32)				
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4.00	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of		d plus for cost		4.00
F 00	reporting periods beginning on or after 10/01/2013, lir				F 00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line				5.00
6.00	Total hospital charity care charges from Wkst. S-10, co				6.00
7.00	CAH only - The reasonable cost incurred for the purchas line 168	se of certified HII technology	WKST. S-2, Pt. I		7.00
8.00	Calculation of the HIT incentive payment (see instructi	ons)			8.00
9.00	Sequestration adjustment amount (see instructions)	,			9.00
10.00	Calculation of the HIT incentive payment after sequest	ration (see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH	· · · ·			
30.00	Initial/interim HIT payment adjustment (see instruction	าร)			30.00
31.00	Other Adjustment (specify)	•			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30	) and line 31) (see instruction	ns)		32.00

	i nanci al Systems ASCENSI ON ST VI NCENT TON OF REI MBURSEMENT SETTLEMENT - SWI NG BEDS	Provi der CCN: 15-1314	Peri od:	u of Form CMS-2 Worksheet E-2	
		Component CCN: 15-Z314	From 07/01/2021 To 06/30/2022	Date/Time Pre	pared
		Title XVIII	Swing Beds - SNF	11/29/2022 10: Cost	:42 a
			Part A	Part B	
			1.00	2.00	
	OMPUTATION OF NET COST OF COVERED SERVICES		102.2/2	0	1 1 0
	<pre>npatient routine services - swing bed-SNF (see instructions) npatient routine services - swing bed-NF (see instructions)</pre>		182, 263	0	1.C
	ncillary services (from Wkst. D-3, col. 3, line 200, for Par	t A and sum of Wkst D	11, 329	0	3.0
	art V, cols. 6 and 7, line 202, for Part B) (For CAH and swi			0	0.0
	nstructions)				
1	ursing and allied health payment-PARHM (see instructions)				3. (
	er diem cost for interns and residents not in approved teach nstructions)	ing program (see		0.00	4.0
	rogram days		32	0	5.0
	nterns and residents not in approved teaching program (see i	nstructions)		0	6. (
	tilization review - physician compensation - SNF optional me	thod only	0		7.0
	ubtotal (sum of lines 1 through 3 plus lines 6 and 7)		193, 592	0	8.0
	rimary payer payments (see instructions) ubtotal (line 8 minus line 9)		193, 592	0	9. C
	eductibles billed to program patients (exclude amounts appli-	cable to physician	193, 392	0	11.0
	rofessional services)			-	
	ubtotal (line 10 minus line 11)		193, 592	0	12.0
	oinsurance billed to program patients (from provider records	) (exclude coinsurance	0	0	13.0
	or physician professional services)			0	14. C
	0% of Part B costs (line 12 x 80%) ubtotal (see instructions)		193, 592	0	14.0
	THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.0
	ioneer ACO demonstration payment adjustment (see instruction	s)			16.5
6.55 R	ural community hospital demonstration project (§410A Demonst		0		16.5
	djustment (see instructions)		0	0	11.0
	emonstration payment adjustment amount before sequestration Ilowable bad debts (see instructions)		0	0	16.9 17.0
	djusted reimbursable bad debts (see instructions)		0	0	17.0
	llowable bad debts for dual eligible beneficiaries (see inst	ructions)	0	0	18.0
	otal (see instructions)		193, 592	0	19.0
	equestration adjustment (see instructions)		484	0	19.0
	emonstration payment adjustment amount after sequestration)		0	0	
	equestration adjustment-PARHM pass-throughs equestration for non-claims based amounts (see instructions)		0	0	19.0 19.2
	nterim payments		131, 492	0	
	nterim payments-PARHM				20.0
	entative settlement (for contractor use only)		0	0	21.0
1	entative settlement-PARHM (for contractor use only)		10.101		21.0
	alance due provider/program (line 19 minus lines 19.01, 19.0 alance due provider/program-PARHM (see instructions)	2, 19.25, 20, and 21)	61, 616	0	22. C 22. C
	rotested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-2.	0	0	
cl	hapter 1, §115.2			_	
	ural Community Hospital Demonstration Project (§410A Demonst				
	s this the first year of the current 5-year demonstration pe	riod under the 21st			200. 0
	entury Cures Act? Enter "Y" for yes or "N" for no.				
	edicare swing-bed SNF inpatient routine service costs (from )	Wkst. D-1, Pt. II, line			201.0
	6 (title XVIII hospital))				
	edicare swing-bed SNF inpatient ancillary service costs (fro	m Wkst. D-3, col. 3, lin	ie		202. 0
	00 (title XVIII swing-bed SNF)) otal (sum of lines 201 and 202)				203. 0
	edicare swing-bed SNF discharges (see instructions)				203. C
	omputation of Demonstration Target Amount Limitation (N/A in	first year of the curre	nt 5-year demonst		201.0
pe	eriod)	5			
	edicare swing-bed SNF target amount				205. C
	edicare swing-bed SNF inpatient routine cost cap (line 205 t				206. C
	djustment to Medicare Part A Swing-Bed SNF Inpatient Reimburs rogram reimbursement under the §410A Demonstration (see inst				207. 0
1	edicare swing-bed SNF inpatient service costs (from Wkst. E-	-	1		207.0
	nd 3)	2, 301. 1, 30m 01 11163	·		
09. 00 A	djustment to Medicare swing-bed SNF PPS payments (see instru	ctions)			209. 0
	eserved for future use				210. 0
	omparision of PPS versus Cost Reimbursement	200 plup line 210) (			1015 0
	otal adjustment to Medicare swing-bed SNF PPS payment (line . nstructions)	zua hina illie ziu) (see			215.0

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1314	Peri od: From 07/01/2021 To 06/30/2022	Worksheet E-3 Part V Date/Time Prep 11/29/2022 10:	pare
		Title XVIII	Hospi tal	Cost	
				1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE	PART A SERVICES - COST		1.00	
. 00	Inpatient services	TARTA SERVICES - COST	ILT WDOILSEWENT	475, 841	1
. 00	Nursing and Allied Health Managed Care payment (see instruction	ons)		473,041	2
00	Organ acqui si ti on	013)		0	3
00	Subtotal (sum of lines 1 through 3)			475, 841	4
00	Primary payer payments			0	5
00	Total cost (line 4 less line 5). For CAH (see instructions)			480, 599	6
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e charges				1
00	Routi ne servi ce charges			0	7
00	Ancillary service charges			0	8
00	Organ acquisition charges, net of revenue			0	9
0. 00	Total reasonable charges			0	10
	Customary charges				
. 00	Aggregate amount actually collected from patients liable for		U U	0	
2.00	Amounts that would have been realized from patients liable fo		on a charge basis	0	12
	had such payment been made in accordance with 42 CFR 413.13(e	)			
3. 00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.00000	
1.00	Total customary charges (see instructions)			0	14
5.00	Excess of customary charges over reasonable cost (complete on	ly if line 14 exceeds li	ne 6) (see	0	15
00	instructions)	ly if line ( avecade lin	14) (222	0	1/
5.00	Excess of reasonable cost over customary charges (complete on instructions)	Ty IT THE 8 exceeds IT	le 14) (See	0	16
7.00	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	17
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				1
3. 00	Direct graduate medical education payments (from Worksheet E-	4, line 49)		0	18
9.00	Cost of covered services (sum of lines 6, 17 and 18)			480, 599	
0. 00	Deductibles (exclude professional component)			30, 472	20
. 00	Excess reasonable cost (from line 16)			0	21
2.00	Subtotal (line 19 minus line 20 and 21)			450, 127	22
3.00	Coinsurance			0	23
1.00	Subtotal (line 22 minus line 23)			450, 127	24
6. 00	Allowable bad debts (exclude bad debts for professional servi-	ces) (see instructions)		7, 372	25
6. 00	Adjusted reimbursable bad debts (see instructions)			4, 792	26
	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		4, 524	
3. 00	Subtotal (sum of lines 24 and 25, or line 26)			454, 919	
0. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	29
9.50	Pioneer ACO demonstration payment adjustment (see instruction	s)		0	29
9. 98	Recovery of accelerated depreciation.			0	29
9.99	Demonstration payment adjustment amount before sequestration			0	29
). 00	Subtotal (see instructions)			454, 919	
0.01	Sequestration adjustment (see instructions)			1, 137	30
). 02	Demonstration payment adjustment amount after sequestration			0	30
0.03	Sequestration adjustment-PARHM			204 272	30
	Interim payments			296, 273	
1.01	Interim payments-PARHM			~	31
2.00	Tentative settlement (for contractor use only) Tentative settlement-PARHM (for contractor use only)			0	
2.01	Balance due provider/program (line 30 minus lines 30.01, 30.0	2  21  and  22		157 500	32
3.00	Balance due provider/program (line 30 minus lines 30.01, 30.0 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, m	· · · ·	and 32 01)	157, 509	33
1 01					1 33
3. 01 4. 00	Protested amounts (nonallowable cost report items) in accorda			25, 000	34

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1314	Period: From 07/01/2021 To 06/30/2022	Worksheet E-3 Part VII Date/Time Pre 11/29/2022 10	pared:
		Title XIX	Hospi tal	Cost	
			Inpati ent	Outpatient	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES	ICES FOR TITLES V OR A	IN SERVICES		-
1.00	Inpatient hospital/SNF/NF services		18, 347		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		18, 347	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments		10 247	0	
7.00	Subtotal (line 4 less sum of lines 5 and 6) COMPUTATION OF LESSER OF COST OR CHARGES		18, 347	0	7.00
	Reasonable Charges				-
8.00	Routi ne servi ce charges		8, 209		8.00
9.00	Ancillary service charges		41, 738	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		49, 947	0	12.00
12 00	CUSTOMARY CHARGES			0	1 1 2 . 00
13.00	Amount actually collected from patients liable for payment for basis	services on a charge	0	0	13.00
14.00	Amounts that would have been realized from patients liable for a charge basis had such payment been made in accordance with 42		n 0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	CFR 9413.13(e)	0. 000000	0,000000	15 00
	Total customary charges (see instructions)		49, 947	0.000000	16.00
17.00	Excess of customary charges over reasonable cost (complete only	ifline 16 exceeds	31, 600	0	
	line 4) (see instructions)				
18.00	Excess of reasonable cost over customary charges (complete only 16) (see instructions)	ifline 4 exceeds lin	e 0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
	Cost of physicians' services in a teaching hospital (see instru		0	0	
21.00	Cost of covered services (enter the lesser of line 4 or line 16		18, 347	0	21.00
~~ ~~	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be co	ompleted for PPS provi			
	Other than outlier payments Outlier payments		0	0	22.00 23.00
	Program capital payments		0	0	23.00
	Capital exception payments (see instructions)		0		25.00
	Routine and Ancillary service other pass through costs		0	0	
	Subtotal (sum of lines 22 through 26)		0	0	27.00
	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		18, 347	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00 32.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) Deductibles		18, 347 0	0	
	Coi nsurance		0	0	•
	Allowable bad debts (see instructions)		0	0	
35.00	Utilization review		0	Ũ	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	18, 347	0	•
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		18, 347	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		18, 347	0	
41.00	Interim payments		18, 347	0	
42.00	Balance due provider/program (line 40 minus line 41)	o with CMS Dub 15 0	0	0	
43.00	Protested amounts (nonallowable cost report items) in accordanc chapter 1, §115.2	e with two Pub 15-2,	0	0	43.00

ALANC	Financial Systems ASCENSION ST VINCEN E SHEET (If you are nonproprietary and do not maintain	Provi der C	CN: 15-1314 P	eriod: rom 07/01/2021	u of Form CMS-: Worksheet G	2002
una-t nly)	ype accounting records, complete the General Fund column			o 06/30/2022	Date/Time Pre 11/29/2022 10	pare : 42
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
00	Cash on hand in banks	-6, 907	C	0	0	1 1
00	Temporary investments	0	C	0	0	2
00	Notes receivable	0	C	0	0	3
00	Accounts receivable	5, 171, 580	C	0	0	
00	Other receivable	938, 797	C	-	0	
00	Allowances for uncollectible notes and accounts receivable	-3, 319, 522	C	Ŭ	0	6
00 00	Inventory Prepaid expenses	321, 302		0	0	
00	Other current assets	705, 331		0	0	9
0.00	Due from other funds	,00,001		Ŭ	0	10
. 00	Total current assets (sum of lines 1-10)	3, 810, 581		-	0	11
	FI XED ASSETS					1
. 00	Land	180, 000	C	0	0	12
8.00	Land improvements	0	C	0	0	13
1.00	Accumulated depreciation	0	C	-	0	14
6.00	Buildings	3, 041, 723		-	0	15
b. 00	Accumulated depreciation	-1, 069, 676	0	Ű	0	16
7.00	Leasehold improvements	859, 079	0	Ű	0	17
3.00 9.00	Accumulated depreciation Fixed equipment	-858, 993 1, 878, 154		-	0	18
). 00	Accumulated depreciation	-867, 685		Ŭ	0	20
	Automobiles and trucks	-007,003		-	0	21
2.00	Accumulated depreciation	0		0	0	22
	Major movable equipment	3, 246, 101	C C	0	0	23
I. 00	Accumulated depreciation	-2, 177, 895	c	0	0	24
5.00	Minor equipment depreciable	0	C	0	0	25
5.00	Accumul ated depreciation	0	C	0	0	26
7.00	HIT designated Assets	0	C	0	0	27
	Accumulated depreciation	0	C	0	0	28
9.00	Minor equipment-nondepreciable	0	C		0	29
0. 00	Total fixed assets (sum of lines 12-29) OTHER ASSETS	4, 230, 808	C	0	0	30
. 00	Investments	0	C	0	0	31
2.00	Deposits on Leases	0			0	32
3.00	Due from owners/officers	0		Ŭ	0	33
1.00	Other assets	96, 176		0	0	34
5.00	Total other assets (sum of lines 31-34)	96, 176		0	0	35
5.00	Total assets (sum of lines 11, 30, and 35)	8, 137, 565	C	0	0	36
	CURRENT LI ABI LI TI ES					
7.00	Accounts payable	564, 539	C		0	37
3. 00	Salaries, wages, and fees payable	307, 660	C		0	38
9.00	Payroll taxes payable	0	0	0	0	
	Notes and Loans payable (short term)	0		0	0	
1.00 2.00	Deferred income Accelerated payments	327, 914	C	0	0	41
2.00 3.00	Due to other funds	1, 715, 259	, c	0	0	
1. 00	Other current liabilities	985, 489		-	0	
5.00	Total current liabilities (sum of lines 37 thru 44)	3, 900, 861			0	
	LONG TERM LIABILITIES		-		-	
5.00	Mortgage payable	0	C	0	0	46
. 00	Notes payable	0	c	0	0	47
3. 00	Unsecured Loans	0	C	0	0	48
9.00	Other long term liabilities	92, 406		-	0	
0.00	Total long term liabilities (sum of lines 46 thru 49)	92, 406			0	
. 00	Total liabilities (sum of lines 45 and 50)	3, 993, 267	C	0	0	51
00	CAPITAL ACCOUNTS	4 144 200				-
2.00 3.00	General fund balance Specific purpose fund	4, 144, 298	0			52
1. 00	Donor created - endowment fund balance - restricted					54
5.00	Donor created - endowment fund balance - restricted			0		55
5.00	Governing body created - endowment fund balance			0		56
7.00	Plant fund balance - invested in plant			Ĭ	0	
3.00	Plant fund balance - reserve for plant improvement,				0	
-	replacement, and expansion				-	
9.00	Total fund balances (sum of lines 52 thru 58)	4, 144, 298	C	0	0	59
0. 00	Total liabilities and fund balances (sum of lines 51 and	8, 137, 565			0	60

	Financial Systems ASCE ENT OF CHANGES IN FUND BALANCES	NSION ST VINCEN	Provi der CC				Worksheet G-1 Date/Time Pre 11/29/2022 10	pared:
		General	Fund	Speci al	Purpose	Fund	Endowment Fund	
		1.00	2.00	3.00		4. 00	5.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Contributions/Donations/Grant Revenue Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Transfer from Affiliates Released Capital Rounding Total deductions (sum of lines 12-17) Fund balance at end of period per balance	0 0 54, 031 0 0 0 -841, 067 0 0 27, 015 0	1, 048, 966 2, 227, 249 3, 276, 215 54, 031 3, 330, 246 -814, 052 4, 144, 298			0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$
	sheet (line 11 minus line 18)	Endowment Fund	PI ant	Fund				
	-	6.00	7.00	8.00				
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Contributions/Donations/Grant Revenue	0	0 0 0 0 0		0			1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Transfer from Affiliates Released Capital Rounding	00	0 0 0 0 0 0		0			10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00
18.00 19.00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0			0 0			18.00 19.00

Health Financial Systems         ASCENSION ST VINCENT SALEM HOSPI           STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES         Provider C				Period:	u of Form CMS-2552-10 Worksheet G-2			
STATEN	IENT OF PATTENT REVENUES AND OPERATING EXPENSES	Provider C	CN. 15-1314	From 07/01/2021 To 06/30/2022	Parts I & II	pared:		
	Cost Center Description		I npati ent	Outpati ent	Total			
			1.00	2.00	3.00			
	PART I – PATIENT REVENUES							
	General Inpatient Routine Services							
1.00	Hospi tal		1, 962, 8	10	1, 962, 810			
2.00	SUBPROVIDER - I PF					2.00		
3.00	SUBPROVIDER - IRF					3.00		
4.00	SUBPROVIDER			0		4.00		
5.00	Swing bed - SNF			0	0			
6.00 7.00	Swing bed - NF SKILLED NURSING FACILITY			0	0	6.00 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)		1, 962, 8	10	1, 962, 810			
10.00	Intensive Care Type Inpatient Hospital Services		1,702,0		1, 702, 010	10.00		
11.00	INTENSIVE CARE UNIT					1 11. 00		
12.00	CORONARY CARE UNIT					12.00		
13.00	BURN INTENSIVE CARE UNIT					13.00		
14.00	SURGI CAL I NTENSI VE CARE UNI T					14.00		
15.00	OTHER SPECIAL CARE (SPECIFY)					15.00		
16.00	Total intensive care type inpatient hospital services (sum	of lines		0	0	16.00		
	11-15)							
17.00	Fotal inpatient routine care services (sum of lines 10 and 16)		1, 962, 8	10	1, 962, 810	17.00		
18.00	Ancillary services		525, 95	51 44, 465, 956	44, 991, 907	18.00		
19.00	Outpatient services		74, 02	27 13, 451, 548	13, 525, 575	19.00		
20.00	RURAL HEALTH CLINIC			0 0	0			
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0 0	0			
22.00	HOME HEALTH AGENCY					22.00		
23.00	AMBULANCE SERVICES			0 0	0			
24.00						24.00		
25.00	AMBULATORY SURGICAL CENTER (D. P. )					25.00		
26.00	HOSPI CE					26.00		
27.00 28.00	Other Patient Service Revenue Total patient revenues (sum of lines 17-27)(transfer colum	n 2 ta Wkat	2, 562, 78	0 38 57, 917, 504	0 60, 480, 292			
28.00	G-3, line 1)	N 3 LO WKSL.	2, 502, 78	58 57, 917, 504	00, 480, 292	28.00		
	PART II - OPERATING EXPENSES							
29.00	Operating expenses (per Wkst. A, column 3, line 200)		1	17, 495, 616		29.00		
30.00	ADD (SPECIFY)			0		30.00		
31.00				0		31.00		
32.00				0		32.00		
33.00				0		33.00		
34.00				0		34.00		
35.00				0		35.00		
36.00	Total additions (sum of lines 30-35)			0		36.00		
37.00	DEDUCT (SPECIFY)			0		37.00		
38.00				0		38.00		
39.00				0		39.00		
40.00				0		40.00		
41.00				0		41.00		
42.00	Total deductions (sum of lines 37-41)			0		42.00		
43.00	Total operating expenses (sum of lines 29 and 36 minus lin			17, 495, 616		43.00		

	Financial Systems	ASCENSION ST VINCEN			u of Form CMS-2	
STATEMENT OF REVENUES AND EXPENSES			Provider CCN: 15-1314	Peri od: From 07/01/2021 To 06/30/2022	Worksheet G-3 Date/Time Prepared: 11/29/2022 10:42 am	
					1.00	
1.00	Total patient revenues (from Wks	60, 480, 292	1.00			
2.00	Less contractual allowances and o	42, 076, 933	2.00			
3.00	Net patient revenues (line 1 minu	is line 2)			18, 403, 359	3.00
4.00	Less total operating expenses (fi	rom Wkst. G-2, Part II, lin	e 43)		17, 495, 616	4.00
5.00	Net income from service to patien	nts (line 3 minus line 4)			907, 743	5.00
	OTHER INCOME					
6.00	Contributions, donations, beques	s, etc			-13, 793	6.00
7.00	Income from investments				28	7.00
8.00	Revenues from telephone and other	miscellaneous communicati	on services		0	8.00
9.00	Revenue from television and radio	servi ce			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
13.00	Revenue from Laundry and Linen se	ervi ce			0	13.00
14.00	Revenue from meals sold to employ	ees and guests			44, 013	14.00
15.00	Revenue from rental of living qua	irters			0	15.00
16.00	Revenue from sale of medical and	surgical supplies to other	than patients		0	16.00
17.00	Revenue from sale of drugs to oth				72, 245	17.00
18.00	Revenue from sale of medical reco	ords and abstracts			0	18.00
	Tuition (fees, sale of textbooks,				0	19.00
	Revenue from gifts, flowers, coft	ee shops, and canteen			0	20.00
21.00	Rental of vending machines				0	21.00
22.00	Rental of hospital space				239, 463	22.00
23.00	Governmental appropriations				0	23.00
24.00	OTHER (SPECI FY)				0	24.00
24.01	Other Operating Income				59, 936	
24.06	Unclaimed Property Exemptions					24.06
24.50	COVID-19 PHE Funding				911, 112	
	Total other income (sum of lines	6-24)			1, 319, 506	
	Total (line 5 plus line 25)				2, 227, 249	
	OTHER EXPENSES (SPECIFY)				0	27.00
28.00	Total other expenses (sum of line	1 2			0	28.00
29.00	Net income (or loss) for the peri	od (line 26 minus line 28)			2, 227, 249	29.00