Health Financial Systems	ASCENSION ST. VI				u of Form CMS-25	552-10
This report is required by law (42 USC 1395g; 42 CF						
payments made since the beginning of the cost repor	ting period being	g deemed overpa	ayments (42	USC 1395g).	OMB NO. 0938-00 EXPIRES 03-31-2	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPO	RT CERTIFICATION	Provider CCN	: 15-1309	Peri od:	Worksheet S	
AND SETTLEMENT SUMMARY				From 07/01/2020 To 06/30/2021	Parts I-III	o road.
				To 06/30/2021	Date/Time Prepa 11/18/2021 4:43	
PART I - COST REPORT STATUS			l			
Provider 1. [X] Electronically prepared cost				Date: 11/18/2	021 Time: 4:	43 pm
use only 2. [ ] Manually prepared cost report						
3. [ 0 ] If this is an amended report 4. [ F ] Medicare Utilization. Enter "	enter the number F" for full or "	of times the L" for low.	provider re	submitted this c	ost report	
	Recei ved:			PR Date:		
use only (1) As Submitted 7. Contr (2) Settled without Audit 8. [N]	actor No. Initial Report f	or this Provid	er CCN 12 [	ontractor's Vendo	or Code: olumn 1 is 4. En	4 ter
(3) Settled with Audit 9. [N]	Final Report for	this Provider	CCN		nes reopened = 0	
(4) Reopened						
(5) Amended						
PART II - CERTIFICATION MISREPRESENTATION OF FALSIFICATION OF ANY INFORMATI	ON CONTAINED IN T	THIS COST REPOR		INI SHARLE BY CRU		
ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UND						
PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY O						1
ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MA	Y RESULT.					
CERTIFICATION BY CHIEF FINANCIAL OFFICER OF	ADMINISTRATOR 0	F PROVIDER(S)				
I HEREBY CERTIFY that I have read the above	e certification s	tatement and t	hat I have	examined the acc	ompanyi ng	
electronically filed or manually submitted						
Expenses prepared by ASCENSION ST. VINCENT						
and ending 06/30/2021 and to the best of my						
complete and prepared from the books and re except as noted. I further certify that I						
health care services, and that the services						
laws and regulations.		no ocor ropor	t nore prot			
[ X ]I have read and agree with the above of	pertification sta	tement   cert	ify that I	intend my electr	onic	
signature on this certification state						
3	(Si gned	0 9 0	•	5 5	5	
	(or gried	/		strator of Provid	ler(s)	
		VP OF FI	NANCE			
		Title	-			
			21 04: 42: 58	PM		
		Date				
		Title X	VIII			
Cost Center Description	Title V	Part A	Part B	НІТ	Title XIX	
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY		01 070	F0.44			1 00
1.00 Hospital	0	81, 379	50, 41	0 0	0	1.00

1.00	Hospi tal	0	81, 379	50, 410	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	252, 947	0		0 5.00
6.00	Swing Bed - NF	0				0 6.00
200.00	Total	0	334, 326	50, 410	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.

	THE AND HOST FIRE HEALTH CARE COMILER	IDENTIFICATION DATA	Provic	aer CCN:		Period: From 07/01/ To 06/30/		Workshe Part I Date/Ti 11/18/2	ime Pre	epared
	1.00	2.00		3.00		4	1.00			
	Hospital and Hospital Health Care Co									
00	Street: 1206 EAST NATIONAL AVENUE	PO Box:	Zin Cod	0. 17021	Count					1.0
00	City: BRAZIL	State: IN Component Name	CCN	e: 47834 CBSA	Provi der	y: CLAY Date	Payme	nt Syst	tem (P	Z. (
		component Name	Number	Number		Certi fi ed		0, or		
							V	XVIII		1
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Componer									
00	Hospi tal	ASCENSION ST. VINCENT	151309	45460	1	08/08/2001	N	0	0	3.
00	Subprovider - IPF	CLAY								4.
00	Subprovider - IRF									5.
00	Subprovider - (Other)									6.
00	Swing Beds - SNF	ASCENSION ST. VINCENT	15Z309	45460		08/08/2001	Ν	0	N	7.
	Swiring bedds Silvi	CLAY SWING	102007	10100		00/00/2001				''
00	Swing Beds - NF			1						8.
00	Hospital-Based SNF									9.
00	Hospital-Based NF									10.
00	Hospital-Based OLTC									11.
00										12.
00										13.
00										14
00 00	Hospital-Based Health Clinic - RHC Hospital-Based Health Clinic - FQHC									15
00	•									17
00	Renal Dialysis									18
	Other									19
		1				From:		Tc	):	
						1.00		2.	00	
	Cost Reporting Period (mm/dd/yyyy)					07/01/20	020	06/30	/2021	20.
00	Type of Control (see instructions)					1				21
				_	1.00			-	00	-
									()()	
	Innationt DDS Information				1.00	2.00		3.		
00	Inpatient PPS Information	currently receiving pa	ments for	~				3.		22
00	Does this facility qualify and is it				N	2.00		3.		22
00	Does this facility qualify and is it disproportionate share hospital adju	stment, in accordance w	th 42 CFF					3.1		22
00	Does this facility qualify and is it	stment, in accordance w or yes or "N" for no. Is	th 42 CFF this					3. '		22
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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 S 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 reporting in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital receive a geograph rural as a result of the cost reporting in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital receive a geograph rural as a result of the revised OMB adopted by CMS in FY 2015? Enter in co for the portion of the cost reporting in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Which method is used to determine Me	istment, in accordance w ryes or "N" for no. Is k412.106(c)(2)(Pickle am ryes or "N" for no. icompensated 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 inst "for no, for the porti- ter 1. Enter in column 2 te cost reporting period ic reclassification from ds for delineating stat tolumn 1, "Y" for yes or g period prior to Octob- no for the portion of the er October 1. (see inst 100 but not more than 4- 2.105)? Enter in column ic reclassification from delineations for statis column 1, "Y" for yes o g period prior to Octob- no for the portion of the er October 1. (see inst 100 but not more than 4- 2.105)? Enter in column dic reclassification from delineations for statis column 1, "Y" for yes o g period prior to Octob- no for the portion of the er October 1. (see inst 100 but not more than 4- 2.105)? Enter in column dicaid days on lines 24 of admission, 2 if cension of identifying the days	th 42 CFF this endment ts for thi 'for no 1 October 'n nof the con- sated can structions) nof the "Y" for on or afit murban to stical are "N" for r er 1. Enter to cost ructions) 29 beds (a 3, "Y" for murban to tical area "N" for er 1. Enter to cost ructions) 29 beds (a 1. States) 29 beds (a 2. States) 20 beds	s for 1. cost re ns) yes ter preas no er as no er as for 5 3	N	N N N				22 22 22 22 22

Health Financial Systems ASCENSI	ON ST. VINC	ENT CLAY			In Lieu	of Forr	n CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		Provider CC			1/2020 F D/2021 E 1	/orkshe Part I Date/Ti 1/18/20	me Pre 021 4:	pared:
	In-State Medicaid paid days	In-State Medi cai d el i gi bl e unpai d days 2.00	Out-of State Medicaid paid days 3.00	Out-of State Medi cai d el i gi bl e unpai d 4.00	Medicaio HMO days 5.00	s Medi da	her i cai d ays	
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				3.00	0	0	24.00
<pre>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.</pre>	0	0	0	0		0		25. 00
				Urban/R	ural S D 10	ate of 2.0		
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	the	1			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.	pplicable,		1			27.00
35.00 If this is a sole community hospital (SCH), enter th effect in the cost reporting period.		periods so			0			35.00
				Begi nr 1. C		Endi r 2. 0	<u> </u>	
36.00 Enter applicable beginning and ending dates of SCH s of periods in excess of one and enter subsequent dat		cript line	36 for numb	ber				36.00
<ul><li>37.00 If this is a Medicare dependent hospital (MDH), ente 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	ayment in	IS	0			37.00 37.01
<ul> <li>accordance with FY 2016 OPPS final rule? Enter "Y" finstructions)</li> <li>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.</li> </ul>	s of MDH st	atus. Ifli	ne 37 is					38. 00
				Y/		Y/N 2.0		
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	0	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
Teaching Hospitals 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	approved G e to column rograms in cable CRs)	ME programs 1 is "Y", the prior y	s? Enter "Y" or if this year or penu	' for yes or hospital ultimate				56.00
Enter "Y" for yes; otherwise, enter "N" for no in co 57.00 If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" fo is "Y" did residents start training in the first mon for yes or "N" for no in column 2. If column 2 is " "N", complete Wkst. D, Parts III & IV and D-2, Pt. I	period duri r yes or "N th of this Y", complet	" for no in cost report e Worksheet	n column 1. ing period?	If column 1 P Enter "Y"				57.00
58.00 If line 56 is yes, did this facility elect cost reim defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	bursement f	or physicia	ans' service	es as				58.00
59.00 Are costs claimed on line 100 of Worksheet A? If ye			Pt. I.		N			59.00

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Α	Provider C		eriod: rom 07/01/2020	Worksheet S-2 Part I	
				o 06/30/2021	Date/Time Pre	
			NAHE 413.85	Worksheet A	11/18/2021 4: Pass-Through	43 pr
			Y/N	Line #	Qualification Criterion Code	
			1.00	2.00	3.00	
.00 Are you claiming nursing and allied health education (			N			60.
any programs that meet the criteria under 42 CFR 413.8 instructions) Enter "Y" for yes or "N" for no in colu is "Y", are you impacted by CR 11642 (or subsequent CR adjustement? Enter "Y" for yes or "N" for no in colum	umn 1. R) NAHE	lf column 1				
	Y/N	IME	Direct GME	IME	Direct GME	
.00 Did your hospital receive FTE slots under ACA	1.00 N	2.00	3.00	4.00	5.00	61
section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	IN			0.00	0.00	
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.
instructions) 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.
<ul> <li>ACA). (see instructions)</li> <li>O3 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.
<pre>instructions) 04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the</pre>						61.
current cost reporting period. (see instructions). 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
<ul> <li>61.04 minus line 61.03). (see instructions)</li> <li>66 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)</li> </ul>						61
	Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
<ul> <li>.10 Of the FTEs in line 61.05, specify each new program special ty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.</li> <li>.20 Of the FTEs in line 61.05, specify each expanded</li> </ul>				0.00		
program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	
					1.00	
ACA Provisions Affecting the Health Resources and Serv	/i ces A	Administration	(HRSA)		1.00	
00 Enter the number of FTE residents that your hospital t	rai ned			od for which	0.00	62
your hospital received HRSA PCRE funding (see instruct OI Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC progr	Teachi			your hospital	0.00	62
Teaching Hospitals that Claim Residents in Nonprovider	^ Setti	ngs		oni od? Enter	NI	10
00 Has your facility trained residents in nonprovider set "Y" for yes or "N" for no in column 1. If yes, complet					N	63
			Unweighted FTEs	Unweighted FTEs in	Ratio (col. 1/ (col. 1 + col.	
			Nonprovi der	Hospi tal	2))	
			Site			
			Si te 1.00	2.00	3.00	
Section 5504 of the ACA Base Year FTE Residents in Nor			Si te 1.00			
Section 5504 of the ACA Base Year FTE Residents in Nor period that begins on or after July 1, 2009 and before .00 Enter in column 1, if line 63 is yes, or your facility	June	30, 2010.	Si te 1.00	is your cost r	eporti ng	64
period that begins on or after July 1, 2009 and before	<u>e June</u> / train ·primar all non	30, 2010. Ted residents by care provider	Si te 1.00 This base year	is your cost r	eporti ng	64
period that begins on or after July 1, 2009 and before 00 Enter in column 1, if line 63 is yes, or your facility in the base year period, the number of unweighted non- resident FTEs attributable to rotations occurring in a	e June / train primar all non non-pr column	30, 2010. ed residents y care provider imary care 3 the ratio	Si te 1.00 This base year	is your cost r	eporti ng	64

	EX IDENTIFICATION D	AIA Provider (		eriod: .om 07/01/2020	Worksheet S-2 0 Part I	2
			To			
	Program Name	Program Code	Unweighted	Unweighted	Ratio (col. 3,	/
			FTEs Nonprovider	FTEs in Hospital	(col. 3 + col. 4))	•
_	1.00		Site			4
00 Enter in column 1, if line 63	1.00	2.00	3.00	4.00	5.00 0.00000	0 65.0
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column						
5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)						
			Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1, (col. 1 + col. 2))	
			1.00	2.00	3.00	
Section 5504 of the ACA Current Y beginning on or after July 1, 201		n Nonprovider Settin	gsEffective fo	r cost report	ting periods	
Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 +	nl. Enter in column <u>column 2)). (see ir</u>	3 the ratio of				
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3, (col. 3 + col. 4))	
00 Enter in column 1, the program	Program Name		FTĔs Nonprovider Site 3.00	FTES in Hospital	(col. 3 + col. 4)) 5.00	
00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	-	Program Code	FTĔs Nonprovider Site	FTEs in Hospital	(col. 3 + col. 4)) 5.00	
name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column	-	Program Code	FTĔs Nonprovider Site 3.00	FTES in Hospi tal 4.00 0.0	(col . 3 + col . 4)) 5.00 00 0.000000	
name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	1.00 25	Program Code 2.00	FTĔs Nonprovi der Si te 3.00 0.00	FTES in Hospi tal 4.00 0.0	(col. 3 + col. 4)) 5.00	
name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	1.00 25 rchiatric Facility (	Program Code 2.00	FTĔs Nonprovi der Si te 3.00 0.00	FTES in Hospi tal 4.00 0.0	(col. 3 + col. 4)) 5.00 00 0.000000	
<pre>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)</pre>	1.00 1.00 2S rchiatric Facility ( the facility have a fore November 15, 2 umn 2: Did this fac 2 412.424 (d)(1)(iii ate which program y	Program Code 2.00 (IPF), or does it contain approved GME teaching 2004? Enter "Y" for your of the second 2004? Enter "Y" for your of the second	FTEs Nonprovi der Si te 3.00 0.00 tain an IPF subplication tain an IPF subplication types or "N" for mean the sin a new teach yes or "N" for mean the sin a new teach	FTES in Hospital 4.00 0.0 0.0 1.0 1.0 1.0 N he most o. (see ing o.	(col. 3 + col. 4)) 5.00 00 0.000000	70. (
<pre>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)</pre>	1.00 1.00 2S Achiatric Facility ( the facility have a fore November 15, 2 umn 2: Did this fac 2 412.424 (d)(1)(iii ate which program y / PPS nabilitation Facilit	Program Code 2.00 (IPF), or does it contained an approved GME teaching 2004? Enter "Y" for your fo	FTEs Nonprovi der Si te 3.00 0.00 tain an IPF subplication tain an IPF subplication ing program in the yes or "N" for me s in a new teach yes or "N" for me s cost reporting	FTES in Hospital 4.00 0.0 0.0 1.0 1.0 1.0 N he most o. (see ing o.	(col . 3 + col . 4)) 5.00 00 0.000000 00 2.00 3.00 00 2.00 3.00	

Health Financial Syste	ems ASCENSION ST. V	INCENT CLAY		In Lie	u of Form CMS	-2552-10
HOSPI TAL AND HOSPI TAL	HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C		Period: From 07/01/2020 To 06/30/2021	Worksheet S- Part I Date/Time Pro 11/18/2021 4	epared:
					1.00	-
81.00 Is this a LTCH "Y" for yes and	term care hospital (LTCH)? Enter "Y" for yes co-located within another hospital for part o l "N" for no.			g period? Enter	N N	80. 00 81. 00
86.00 Did this facili	ospital under 42 CFR Section §413.40(f)(1)(i) ty establish a new Other subprovider (exclude		2		N	85.00 86.00
87.00 Is this hospita	i)? Enter "Y" for yes and "N" for no. I an extended neoplastic disease care hospita i)? Enter "Y" for yes or "N" for no.	l classi fied	under section		N	87.00
				V 1.00	XI X 2.00	_
90.00 Does this facil	Services ity have title V and/or XIX inpatient hospita	I services? E	nter "Y" for	N	Y	90.00
91.00 Ís this hospita	no in the applicable column. I reimbursed for title V and/or XIX through t			Ν	N	91.00
92.00 Are title XIX N	? Enter "Y" for yes or "N" for no in the appl IF patients occupying title XVIII SNF beds (du inter "Y" for yes or "N" for no in the applica	al certificat			Y	92.00
93.00 Does this facil	"N" for no in the applicable column.		d XIX? Enter	Ν	N	93.00
94.00 Does title V or applicable colu	XIX reduce capital cost? Enter "Y" for yes,	and "N" for n	o in the	Ν	N	94.00
95.00 If line 94 is " 96.00 Does title V or	Y", enter the reduction percentage in the app $^{\circ}$ XIX reduce operating cost? Enter "Y" for yes			0. 00 N	0. 00 N	95.00 96.00
98.00 Does title V or stepdown adjust	Y", enter the reduction percentage in the app XIX follow Medicare (title XVIII) for the in ments on Wkst. B, Pt. I, col. 25? Enter "Y" f	terns and res	idents post	0. 00 N	0. 00 Y	97.00 98.00
98.01 Does title V or C, Pt. I? Enter	tle V, and in column 2 for title XIX. • XIX follow Medicare (title XVIII) for the re • "Y" for yes or "N" for no in column 1 for ti			Ν	Y	98. 01
	·XIX follow Medicare (title XVIII) for the ca st. D-1, Pt. IV, line 89? Enter "Y" for yes o			Ν	Y	98. 02
98.03 Does title V or reimbursed 101%	d in column 2 for title XIX. * XIX follow Medicare (title XVIII) for a crit 5 of inpatient services cost? Enter "Y" for ye d in column 2 for title XIX.			N	Ν	98.03
98.04 Does title V or outpatient serv	·XIX follow Medicare (title XVIII) for a CAH rices cost? Enter "Y" for yes or "N" for no in			Ν	Ν	98.04
	<ul> <li>TITLE XIX.</li> <li>XIX follow Medicare (title XVIII) and add ba col. 4? Enter "Y" for yes or "N" for no in c</li> </ul>			N N	Y	98.05
Pts. I through column 2 for ti	XIX follow Medicare (title XVIII) when cost IV? Enter "Y" for yes or "N" for no in column tle XIX.	reimbursed fo 1 for title	r Wkst. D, V, and in	N	Y	98.06
Rural Providers	; tal qualify as a CAH?			Y		105.00
106.00 If this facilit	y qualifies as a CAH, has it elected the all- services? (see instructions)	inclusive met	hod of paymen			106. 00
training progra Column 2: If c approved medica	ne 105 is Y, is this facility eligible for co ms? Enter "Y" for yes or "N" for no in column column 1 is Y and line 70 or line 75 is Y, do I education program in the CAH's excluded IP res or "N" for no in column 2. (see instructi	1. (see ins you train I&R F and/or IRF	tructions) s in an	N		107.00
108.00 Is this a rural	hospital qualifying for an exception to the 2.113(c). Enter "Y" for yes or "N" for no.		dul e? See 42	Ν		108.00
	-	Physi cal 1.00	Occupational 2.00	Speech 3.00	Respi ratory 4.00	-
therapy service	I qualifies as a CAH or a cost provider, are s provided by outside supplier? Enter "Y" for no for each therapy.	Y	Y	Y	N	109.00
					1.00	-
Demonstration)f	al participate in the Rural Community Hospita for the current cost reporting period? Enter " weet E, Part A, lines 200 through 218, and Wor	Y" for yes or	"N" for no.	f yes,	N	110.00

		ri od:	Worksheet S-	2
	Fr	om 07/01/2020 06/30/2021		
11.00 If this facility qualifies as a CAH, did it participate in the Frontier Co Health Integration Project (FCHIP) demonstration for this cost reporting p "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, e integration prong of the FCHIP demo in which this CAH is participating in Enter all that apply: "A" for Ambulance services; "B" for additional beds; for tele-health services.	period? Enter enter the column 2.	<u>1.00</u> N	2.00	111.
	1.00	2.00	3.00	-
2.00 Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information	N			112.
15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-1, chapter 22, §2208.1.	N			0115.
16.00 Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.
17.00 Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.
8.00 Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2			118.
	Premi ums	Losses	Insurance	
8.01 List amounts of malpractice premiums and paid losses:	1. 00 114, 685	2.00	3.00	0118.
		1.00	0.00	_
8.02 Are malpractice premiums and paid losses reported in a cost center other t Administrative and General? If yes, submit supporting schedule listing co and amounts contained therein.		<u> </u>	2.00	118.
				119.
9.00 DO NOT USE THIS LINE D.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless prov §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" "N" for no. Is this a rural hospital with < 100 beds that qualifies for th Hold Harmless provision in ACA §3121 and applicable amendments? (see instr	for yes or ne Outpatient	Ν	N	120.
<ul> <li>9.00 D0 NOT USE THIS LINE</li> <li>0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless prov §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" "N" for no. Is this a rural hospital with &lt; 100 beds that qualifies for th Hold Harmless provision in ACA §3121 and applicable amendments? (see instr Enter in column 2, "Y" for yes or "N" for no.</li> <li>1.00 Did this facility incur and report costs for high cost implantable devices</li> </ul>	for yes or ne Outpatient ructions)	N	N	
<ul> <li>9.00 D0 NOT USE THIS LINE</li> <li>0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless prov §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" "N" for no. Is this a rural hospital with &lt; 100 beds that qualifies for th Hold Harmless provision in ACA §3121 and applicable amendments? (see instr Enter in column 2, "Y" for yes or "N" for no.</li> <li>1.00 Did this facility incur and report costs for high cost implantable devices patients? Enter "Y" for yes or "N" for no.</li> <li>2.00 Does the cost report contain healthcare related taxes as defined in §1903( Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the Worksheet A line number where these taxes are included.</li> </ul>	for yes or ne Outpatient ructions) c charged to (w)(3) of the		N 5. 00	120. 121. 122.
<ul> <li>0.00 D0 NOT USE THIS LINE</li> <li>0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless prov \$3121 and applicable amendments? (see instructions) Enter in column 1, "Y" "N" for no. Is this a rural hospital with &lt; 100 beds that qualifies for th Hold Harmless provision in ACA \$3121 and applicable amendments? (see instr Enter in column 2, "Y" for yes or "N" for no.</li> <li>0.00 Did this facility incur and report costs for high cost implantable devices patients? Enter "Y" for yes or "N" for no.</li> <li>0.00 Does the cost report contain heal thcare related taxes as defined in \$1903( Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the Worksheet A line number where these taxes are included. Transplant Center Information</li> <li>0.00 Does this facility operate a transplant center? Enter "Y" for yes and "N"</li> </ul>	for yes or ne Outpatient ructions) s charged to (w)(3) of the r in column 2	Y		121.
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<ul> <li>0.00 D0 NOT USE THIS LINE</li> <li>0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless prov §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" "N" for no. Is this a rural hospital with &lt; 100 beds that qualifies for th Hold Harmless provision in ACA §3121 and applicable amendments? (see instr Enter in column 2, "Y" for yes or "N" for no.</li> <li>0.00 Did this facility incur and report costs for high cost implantable devices patients? Enter "Y" for yes or "N" for no.</li> <li>0.00 Does the cost report contain heal thcare related taxes as defined in §1903( Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the Worksheet A line number where these taxes are included. Transplant Center Information</li> <li>0.00 Does this facility operate a transplant center? Enter "Y" for yes and "N" yes, enter certification date(s) (mm/dd/yyyy) below.</li> <li>0.00 If this is a Medicare certified kidney transplant center, enter the certif in column 1 and termination date, if applicable, in column 2.</li> </ul>	for yes or ne Outpatient ructions) charged to (w)(3) of the r in column 2 for no. If fication date	Y Y		121. 122. 125. 126.
<ul> <li>0.00 D0 NOT USE THIS LINE</li> <li>0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless prov \$3121 and applicable amendments? (see instructions) Enter in column 1, "Y" "N" for no. Is this a rural hospital with &lt; 100 beds that qualifies for th Hold Harmless provision in ACA \$3121 and applicable amendments? (see instru- Enter in column 2, "Y" for yes or "N" for no.</li> <li>1.00 Did this facility incur and report costs for high cost implantable devices patients? Enter "Y" for yes or "N" for no.</li> <li>2.00 Does the cost report contain heal thcare related taxes as defined in \$1903( Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the Worksheet A line number where these taxes are included. Transplant Center Information</li> <li>5.00 Does this facility operate a transplant center? Enter "Y" for yes and "N" yes, enter certification date(s) (mm/dd/yyyy) below.</li> <li>5.00 If this is a Medicare certified kidney transplant center, enter the certifi 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 the certifi</li> </ul>	for yes or ne Outpatient ructions) charged to (w)(3) of the in column 2 for no. If fication date cation date	Y Y		121.
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OSPITAL AND HOSPITAL HEALTH CARE COMPLEX	K I DENTIFICATION	DATA	I NCENT CLAY Provider C	CN: 15-1309		d: 07/01/2020 06/30/2021	Worksheet S-2 Part I Date/Time Pre 11/18/2021 4:	epared:
1.00		2.00				3.00		-
If this facility is part of a chai					e name ar	nd address	of the	
home office and enter the home off 41.00Name: ST. VINCENT HEALTH	Contractor'				ctor's N	umber: 0800	1	141.00
42.00 Street: 250 WEST 96TH STREET SUITE		3 Nullie. W 3		Contra				142.00
43. 00 City: INDIANAPOLIS	State:	IN		Zip Co	de:	4626	0	143.00
	· · ·							
							1.00	
44.00 Are provider based physicians' cos	ts included in W	orksheet A	?				Y	144.00
						1.00		_
45.00 If costs for renal services are cl	aimed an Wkat A	line 74	and the east	o for		1.00	2.00	145.0
<ul> <li>inpatient services only? Enter "Y" no, does the dialysis facility inc period? Enter "Y" for yes or "N"</li> <li>46.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/d)</li> </ul>	for yes or "N" Lude Medicare ut for no in column y changed from th column 1. (See )	for no in o ilization 2. he previous CMS Pub. 19	column 1. If for this cost sly filed cos	column 1 is reporting t report?		Ν		145.0
Jos, enter the approval date (min/a								
							1.00	
47.00 Was there a change in the statisti							N	147.0
48.00 Was there a change in the order of							N	148.0
49.00 Was there a change to the simplifi	ed cost finding i	method? En		1		T' 11	N	149.0
		_	Part A	Part B		Title V	Title XIX	-
Does this facility contain a provi	dor that qualifi	oc for on	1.00	2.00	coti on c	3.00	4.00	
or charges? Enter "Y" for yes or "								
55. 00 Hospi tal			N	N N	. (300 -	N	N	155. C
56.00 Subprovider - IPF			N	N		N	N	156. C
57.00 Subprovi der – IRF			N	N		Ν	N	157.0
58. 00 SUBPROVI DER								158.0
59. 00 SNF			N	N		Ν	N	159. 0
60. 00 HOME HEALTH AGENCY			N	N		N	N	160. 0
61.00 CMHC				N		N	N	161.0
							1.00	-
Multicampus							1.00	
65.00 s this hospital part of a Multica	mpus hospital th	at has one	or more camp	uses in dif	ferent C	BSAs?	N	165. 0
Enter "Y" for yes or "N" for no.	· ·		•					
_	Name		County		Zip Code		FTE/Campus	_
	0		1.00	2.00	3.00	4.00	5.00	
66.00 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)							0.00	0 166. C
							1.00	1
Health Information Technology (HIT	) incentive in t	he America	n Recovery an	d Reinvestm	ent Act			
57.00 s this provider a meaningful user 58.00 of this provider is a CAH (line 10 reasonable cost incurred for the H	5 is "Y") and is	a meaning	ful user (lin		"), ente	r the	Y	167. C 168. C
58.01 If this provider is a CAH and is n				r qualify f	or a har	dshi p	N	168. C
exception under §413.70(a)(6)(ii)?	Enter "Y" for y	es or "N"	for no. (see	instruction	s)			
59.00  f this provider is a meaningful u transition factor. (see instructio		"Y") and	s not a CAH	(line 105 i	s "N"),	enter the	0.0	0169. C
					B	egi nni ng	Endi ng	
						1.00	2.00	
70.00 Enter in columns 1 and 2 the EHR b period respectively (mm/dd/yyyy)	eginning date an	d ending d	ate for the r	eporti ng				170. 0
						1 00	2.00	-
71 00 lf line 147 is "V" doos this	idor have any de	ve for int	vi dual a anco	Llod in		1.00	2.00	0171 0
71.00 If line 167 is "Y", does this prov section 1876 Medicare cost plans r						N		0171.0

	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-1309	Period: From 07/01/2020 To 06/30/2021	Worksheet S- Part II Date/Time Pr 11/18/2021 4	epared:
				Y/N 1.00	Date 2.00	
	General Instruction: Enter Y for all YES responses. Enter N for	r all NO re	sponses. Ente			
	mm/dd/yyyy format.					_
	COMPLETED BY ALL HOSPITALS Provider Organization and Operation					_
. 00	Has the provider changed ownership immediately prior to the be	ginning of	the cost	N		1.00
	reporting period? If yes, enter the date of the change in colu		instructions)			
			Y/N 1.00	Date 2.00	V/I 3.00	
. 00	Has the provider terminated participation in the Medicare Prog yes, enter in column 2 the date of termination and in column 3 voluntary or "I" for involuntary.		N	2.00	3.00	2.00
. 00	Is the provider involved in business transactions, including macontracts, with individuals or entities (e.g., chain home offic or medical supply companies) that are related to the provider of officers, medical staff, management personnel, or members of the of directors through ownership, control, or family and other si- relationships? (see instructions)	ces, drug or its he board	Y			3.00
			Y/N	Туре	Date	
	Financial Data and Reports		1.00	2.00	3.00	
. 00	Column 1: Were the financial statements prepared by a Certific Accountant? Column 2: If yes, enter "A" for Audited, "C" for or "R" for Reviewed. Submit complete copy or enter date availab column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues differen	Compiled, ble in	Y	A		4.00
. 00	those on the filed financial statements? If yes, submit reconci					0.00
				Y/N	Legal Oper.	
	Approved Educational Activities			1.00	2.00	
. 00	Column 1: Are costs claimed for nursing school? Column 2: If the legal operator of the program?	yes, is th	ne provider is	5 N		6.00
. 00 . 00	Are costs claimed for Allied Health Programs? If "Y" see instru- Were nursing school and/or allied health programs approved and cost reporting period? If yes, see instructions.		l during the	N N		7.00 8.00
. 00	Are costs claimed for Interns and Residents in an approved grad	duate medic	al education	Ν		9.00
0. 00	program in the current cost report? If yes, see instructions. Was an approved Intern and Resident GME program initiated or re-	enewed in t	he current	Ν		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	V /N	11.0
					Y/N 1.00	_
	Bad Debts					
2.00 3.00	If line 12 is yes, did the provider's bad debt collection polic			ost reporting	Y N	12.00 13.00
4. 00	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-payments Bed Complement	waived? If	yes, see in:	structions.	Ν	14.00
5.00	Did total beds available change from the prior cost reporting		<b>2</b> ·		N	15.00
		Par Y/N	t A Date	Par Y/N	t <u>B</u> Date	
		1.00	2.00	3.00	4.00	
5. 00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through	Y	10/08/2021	Y	10/08/2021	16. 0
7.00	date of the PS&R Report used in columns 2 and 4. (see instructions) Was the cost report prepared using the PS&R Report for	N		N		17.0
7.00	totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	i v		IN IN		17.0
8. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report2 if yes, see instructions	Ν		Ν		18.0
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		Ν		19.0

HOSPI T	Financial Systems ASCENSION ST. AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNALRE	Provider (	CCN: 15-1309	Period: From 07/01/2020 To 06/30/2021	Date/Time P 11/18/2021	-2 repared:
			<u>iption</u> 0	<u>Y/N</u> 1.00	Y/N 3.00	_
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		0	N	N	20.0
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		Ν		21.0
	CONDUCTED DV COST DELUDURCED AND TEEDA HOCDUTALS ONLY (EVO				1.00	_
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE Capital Related Cost	EPT CHILDRENS I	HUSPITALS)			-
2.00	Have assets been relifed for Medicare purposes? If yes, see	e instructions			N	22.0
	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.			ring the cost	N	23.0
	Were new leases and/or amendments to existing leases entere If yes, see instructions		N	24.0		
	Have there been new capitalized leases entered into during instructions.	5	N	25.0		
	Were assets subject to Sec. 2314 of DEFRA acquired during the instructions.		N	26.0		
27.00	Has the provider's capitalization policy changed during the copy. Interest Expense	yes, subiii t	N	27.0		
8. 00	Were new loans, mortgage agreements or letters of credit er period? If yes, see instructions.	ntered into du	ring the cost	t reporting	N	28.0
9. 00	Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see inst		ebt Service I	Reserve Fund)	N	29. (
0. 00	Has existing debt been replaced prior to its scheduled mate instructions.	5	5		N	30.0
	Has debt been recalled before scheduled maturity without is instructions. Purchased Services	ssuance of new	debt? If yes	s, see	N	31.0
	Have changes or new agreements occurred in patient care set arrangements with suppliers of services? If yes, see instru		ed through co	ontractual	N	32.0
3. 00	If line 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions.		ng to competi	tive bidding? If	Ν	33. (
	Provi der-Based Physi ci ans				1	
	Are services furnished at the provider facility under an an If yes, see instructions.	0	·		Y	34. (
5.00	If line 34 is yes, were there new agreements or amended exi physicians during the cost reporting period? If yes, see in		nts with the	provider-based Y/N	N Date	35. (
				1,00	2.00	
	Home Office Costs					
	Were home office costs claimed on the cost report?			Y		36.0
	If line 36 is yes, has a home office cost statement been pulf yes, see instructions.					37. (
	If line 36 is yes, was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year end of line 26 is year did the provider render services to atte	d of the home	offi ce.			38.0
	If line 36 is yes, did the provider render services to othe see instructions. If line 36 is yes, did the provider render services to the		5	s, N N		40. (
2.00	instructions.					+0.0
		1	. 00	2.	00	
	Cost Report Preparer Contact Information Enter the first name, last name and the title/position	JILL		HILL		41. (
2. 00	held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report	ASCENSI ON				42. (
2.00	preparer.					1 72. (
	Enter the telephone number and email address of the cost	317-583-3519		JI LL. HI LL1@ASC		43.0

Health Financial Systems	ASCENSI ON ST.	VINCENT CLAY	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT	QUESTI ONNAI RE	Provider CCN: 15-1309		Worksheet S-2	
			From 07/01/2020 To 06/30/2021		pared: 43 pm
		3.00			
Cost Report Preparer Contact Information					
41.00 Enter the first name, last name and the ti	tle/position	REIMBURSEMENT MANAGER			41.00
held by the cost report preparer in columr	ns 1, 2, and 3,				
respecti vel y.					
42.00 Enter the employer/company name of the cos	st report				42.00
preparer.					
43.00 Enter the telephone number and email addre	ess of the cost				43.00
report preparer in columns 1 and 2, respec	cti vel y.				

		ASCENSION ST. \		01 45 4000		eu of Form CMS-	
HOSPII	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	al data	Provi der C	CN: 15-1309	Period: From 07/01/202 To 06/30/202		epared:
						I/P Days / O/P Visits / Trips	
	Component	Worksheet A Line Number	No. of Beds	Bed Days Avai I abl e	CAH Hours	Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00 2.00 3.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider	30. 00	25	5 9, 1	25 5, 736. 0	0 0	1.00 2.00 3.00
4.00 5.00 6.00 7.00	HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation		25	5 9.1	25 5, 736. 0	0	4.00 5.00 6.00
8.00 9.00 10.00 11.00 12.00	beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)		23	9, 1	25 5,736.0		8.00 9.00 10.00 11.00 12.00
13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00 22.00 23.00 24.00 24.10	NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part)	30. 00	25	5 9, 1	25 5, 736. 0	o o o	15.00 16.00 17.00 18.00 20.00 21.00 22.00 23.00 24.00 24.10
25. 00 26. 00 26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 01	CMHC - CMHC RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions)	89.00	25		0	0	25.00 26.00 26.25 27.00
33. 00 33. 01	LTCH non-covered days LTCH site neutral days and discharges						33. 00 33. 01

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CO	CN: 15-1309		eriod: rom 07/01/2020 o 06/30/2021	Worksheet S-3 Part I Date/Time Pre 11/18/2021 4:	pared:
		I/P Days	/ O/P Visits	/ Trips		Full Time E		
	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 2.00 3.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider	130 12 0	0 33 0		39			1.00 2.00 3.00
3.00 4.00	HMO IRF Subprovider	0	0					4.00
4.00 5.00	Hospital Adults & Peds. Swing Bed SNF	342	0		81			5.00
6.00	Hospital Adults & Peds. Swing Bed NF	012	0	0	0			6.00
7.00	Total Adults and Peds. (exclude observation	472	0	6	20			7.00
8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 17.00 18.00 19.00 20.00 21.00 22.00 23.00 24.00 24.10 25.00	beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P. ) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC	472 8, 518	0 544		20 40 0	0.00	51.56	$\begin{array}{c} 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 20.\ 00\\ 21.\ 00\\ 22.\ 00\\ 23.\ 00\\ 24.\ 00\\ 24.\ 10\\ 25.\ 00\\ \end{array}$
26.00 26.25 27.00 28.00 29.00 30.00 31.00 32.00 32.01	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions)	0 0 0	0 0 0	3	0 36 3 0 0 0	0. 00 0. 00	0.00 51.56	
33. 00 33. 01	LTCH non-covered days LTCH si te neutral days and discharges	0 0						33. 00 33. 01

	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC,	ASCENSION ST. VI AL DATA	Provider C	CN: 15-1309	Period: From 07/01/2020 To 06/30/2021	u of Form CMS-2 Worksheet S-3 Part I Date/Time Pre 11/18/2021 4:4	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	
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SUBCLOL INTENSIVE CARE UNIT		0		5 12 0 0	59	1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00
11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 23. 00 24. 00 24. 10 25. 00 26. 00 26. 25 27. 00 28. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P. ) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days	0. 00 0. 00 0. 00	0		26 0	59	11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00 23. 00 24. 00 24. 10 25. 00 26. 00 26. 02 27. 00 28. 00
29.00 30.00 31.00 32.00 32.01 33.00	Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days LTCH site neutral days and discharges				0		29.00 30.00 31.00 32.00 32.01 33.00 33.01

Heal th	Financial Systems ASCENSION ST. VINC	ENT CLAY		ln Li€	u of Form CMS-2	2552-10			
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CC		Period:	Worksheet S-1	0			
				From 07/01/2020 To 06/30/2021	Date/Time Pre 11/18/2021 4:				
					1.00				
	Uncompensated and indigent care cost computation				1.00				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 div	ided by li	ne 202 column	8)	0. 306153	1.00			
	Medicaid (see instructions for each line)								
2.00	Net revenue from Medicaid				1, 393, 690	2.00			
3.00	Did you receive DSH or supplemental payments from Medicaid?				N	3.00			
4.00	If line 3 is yes, does line 2 include all DSH and/or supplement			i d?		4.00			
5.00 6.00	If line 4 is no, then enter DSH and/or supplemental payments fr Medicaid charges	om Medical	a		0 15, 163, 784	5.00 6.00			
7.00	Medicaid cost (line 1 times line 6)				4, 642, 438	7.00			
8.00	Difference between net revenue and costs for Medicaid program (	line 7 min	us sum of lin	es 2 and 5 <sup>.</sup> if	3, 248, 748				
0.00	< zero then enter zero)				0,210,710	0.00			
	Children's Health Insurance Program (CHIP) (see instructions fo	r each line	e)						
9.00	Net revenue from stand-alone CHIP				0	9.00			
10.00	Stand-alone CHIP charges				0				
11.00	Stand-alone CHIP cost (line 1 times line 10)				0	11.00			
12.00	Difference between net revenue and costs for stand-alone CHIP (	line 11 mi	nus line 9; i	f < zero then	0	12.00			
	enter zero) Other state or local government indigent care program (see inst	ructions fo	or each line)						
13.00	Net revenue from state or local indigent care program (Net incl			)	0	13.00			
14.00	Charges for patients covered under state or local indigent care				0 0	14.00			
	10)	1 3 (							
15.00	State or local indigent care program cost (line 1 times line 14				0	15.00			
16.00	Difference between net revenue and costs for state or local ind	igent care	program (lin	e 15 minus line	0	16.00			
	13; if < zero then enter zero)								
	Grants, donations and total unreimbursed cost for Medicaid, CHI instructions for each line)	P and State	errocar rhurg	ent care prograi	iis (see				
17.00	Private grants, donations, or endowment income restricted to fu	ndi ng char	itv care		0	17.00			
18.00	Government grants, appropriations or transfers for support of h				0	18.00			
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local	indigent	care programs	(sum of lines	3, 248, 748	19.00			
	8, 12 and 16)		Lint in a constant	Luca una al	Tatal (asl 1				
			Uni nsured pati ents	Insured patients	Total (col. 1 + 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 fac	ility	1, 053, 92	9 345, 165	1, 399, 094	20.00			
21.00	(see instructions) Cost of patients approved for charity care and uninsured discou	nts (see	322, 66	4 345, 165	667, 829	21.00			
21.00	instructions)	1113 (300	522, 00	- 545, 105	007,027	21.00			
22.00	Payments received from patients for amounts previously written	off as	93, 66	0 12, 540	106, 200	22.00			
23.00	charity care Cost of charity care (line 21 minus line 22)		229, 00	4 332, 625	561, 629	23.00			
24.00	Deve the ensure on Line 20 column 2, include channess for notion			- <del>C</del> - + - · · · · · · +	1.00	24.00			
24.00	Does the amount on line 20 column 2, include charges for patien imposed on patients covered by Medicaid or other indigent care		ond a rength	or stay limit	N	24.00			
25.00	If line 24 is yes, enter the charges for patient days beyond th		care program	's length of	0	25.00			
	stay limit								
26.00									
27.00 27.01	Medicare reimbursable bad debts for the entire hospital complex Medicare allowable bad debts for the entire hospital complex (s				209, 030				
27.01 28.00	Non-Medicare bad debt expense (see instructions)		(10115)		2, 450, 284				
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt exp	ense (see	instructions)		862, 717				
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	(			1, 424, 346				
	Total unreimbursed and uncompensated care cost (line 19 plus li	ne 30)			4, 673, 094				

		ASCENSION ST. VI				u of Form CMS-	2552-10
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	F EXPENSES	Provider CO		Period:	Worksheet A	
					From 07/01/2020 To 06/30/2021	Date/Time Pre	nared
					10 00/ 30/ 2021	11/18/2021 4:	43 pm
	Cost Center Description	Sal ari es	Other	Total (col.	Reclassificati		
	·			+ col. 2)	ons (See A-6)	Trial Balance	
						(col. 3 +-	
						col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT		405, 627	405, 62			
2.00	00200 CAP REL COSTS-MVBLE EQUIP		529, 823				
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	135, 606	1, 026, 366			.,	
5.00	00500 ADMINI STRATI VE & GENERAL	407, 391	5, 805, 518	6, 212, 90	9 -43, 220	6, 169, 689	5.00
7.00	00700 OPERATION OF PLANT	0	963, 443	963, 44	3 10, 408	973, 851	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	51, 103	51, 10	3 0	51, 103	8.00
9.00	00900 HOUSEKEEPI NG	0	409, 919	409, 91	9 11, 202	421, 121	9.00
10.00	01000 DI ETARY	О	388, 220	388, 22	0 -337, 155	51,065	10.00
11.00	01100 CAFETERI A	0	0		0 343, 810	343, 810	11.00
13.00	01300 NURSING ADMINISTRATION	155, 279	7, 777	163, 05	6 1, 339	164, 395	13.00
	01400 CENTRAL SERVICES & SUPPLY	8, 668	13, 952	22, 62	0 7,747	30, 367	14.00
15.00	01500 PHARMACY	233, 665	307, 341	541,00			
	01600 MEDI CAL RECORDS & LI BRARY	0	0		0 0		1
	INPATIENT ROUTINE SERVICE COST CENTERS	-				-	1
30, 00	03000 ADULTS & PEDIATRICS	756, 969	46, 475	803, 44	4 -274	803, 170	30.00
	ANCILLARY SERVICE COST CENTERS		,				1
50.00	05000 OPERATING ROOM	318, 305	253, 206	571, 51	1 -115, 539	455, 972	50.00
	05300 ANESTHESI OLOGY	0	0		0 0		
	05400 RADI OLOGY-DI AGNOSTI C	650, 830	214, 915	865, 74	5 0	865, 745	
	06000 LABORATORY	35, 517	1, 588, 236				
65.00	06500 RESPIRATORY THERAPY	129, 417	29,030			158, 784	
66.00	06600 PHYSI CAL THERAPY	0	821, 952				
67.00	06700 OCCUPATI ONAL THERAPY	0	021, 702		0 189, 691	189, 691	
	06800 SPEECH PATHOLOGY	0	72, 672				
	06900 ELECTROCARDI OLOGY	75, 478	11, 815				
	07000 ELECTROENCEPHALOGRAPHY	, 3, 470	0		0 0		
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	666		-		
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	123, 394	123, 39			
	07300 DRUGS CHARGED TO PATIENTS	0	123, 394		0 0		
73.00	OUTPATIENT SERVICE COST CENTERS	U	0		0 0	0	/ /3.00
91.00	09100 EMERGENCY	744, 867	1, 371, 536	2, 116, 40	3 -3, 100	2, 113, 303	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	744,007	1, 371, 330	2, 110, 40	-3,100	2, 113, 303	92.00
92.00	SPECIAL PURPOSE COST CENTERS						92.00
118.00		3, 651, 992	14, 442, 986	18, 094, 97	8 0	18, 094, 978	110 00
116.00	NONREI MBURSABLE COST CENTERS	3,001,992	14, 442, 900	10, 094, 97	0 0	10, 094, 970	
100 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190.00
	19000 GFFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CLANS' PRI VATE OFFI CES	0	-				
	19200 PHYSICIANS PRIVATE OFFICES	0	27, 334				192.00
		0	0		-		193.00
	19301 MISSION SERVICES	2 (51 000	30		0 0		
200.00	TOTAL (SUM OF LINES 118 through 199)	3, 651, 992	14, 470, 350	18, 122, 34	2 0	18, 122, 342	1200.00

CLAS	Financial Systems SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider C	CN: 15-1309	Peri od:	Worksheet A
					From 07/01/2020 To 06/30/2021	Date/Time Prepare 11/18/2021 4:43 p
	Cost Center Description	Adjustments	Net Expenses			
			or Allocation			
		6.00	7.00			
~~	GENERAL SERVICE COST CENTERS		405 (07			
00	00100 CAP REL COSTS-BLDG & FIXT	0	405, 627			1.
00	00200 CAP REL COSTS-MVBLE EQUI P	0	529, 823			2.
00	00400 EMPLOYEE BENEFI TS DEPARTMENT	6, 448	1, 168, 420			4.
00	00500 ADMINISTRATIVE & GENERAL	-694, 306	5, 475, 383			5.
00	00700 OPERATION OF PLANT	0	973, 851			7.
00	00800 LAUNDRY & LINEN SERVICE	0	51, 103			8.
00	00900 HOUSEKEEPING	0	421, 121			9.
0.00	01000 DI ETARY	0	51, 065			10.
. 00		-28, 573	315, 237			11.
	01300 NURSI NG ADMI NI STRATI ON	0	164, 395			13.
. 00	01400 CENTRAL SERVICES & SUPPLY	0	30, 367			14.
5.00	01500 PHARMACY	-841	540, 165			15.
. 00	01600 MEDI CAL RECORDS & LI BRARY	0	0			16.
	INPATIENT ROUTINE SERVICE COST CENTERS		000.470			
0. 00	03000 ADULTS & PEDIATRICS	0	803, 170			30.
	ANCI LLARY SERVICE COST CENTERS	10.150	442.022	1		
0.00	05000 OPERATI NG ROOM 05300 ANESTHESI OLOGY	-12, 150	443, 822			50.
8.00		0	0			53.
. 00	05400 RADI OLOGY-DI AGNOSTI C	-8, 546	857, 199			54.
0.00		0	1, 623, 753			60.
5.00		0	158, 784			65.
b. 00	06600 PHYSI CAL THERAPY	0	627, 924			66.
. 00	06700 OCCUPATIONAL THERAPY	Ű	189, 691			67.
3.00		0	72, 672			68.
9.00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	Ű	87, 293 0			69. 70.
. 00		0				70.
2.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS		129, 448			71.
	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	123, 394			
8.00	OUTPATIENT SERVICE COST CENTERS	0	0			73.
. 00	09100 EMERGENCY	0	2, 113, 303			91.
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	2, 113, 303			92.
00	SPECIAL PURPOSE COST CENTERS			I		92.
8.00		-737, 968	17, 357, 010			118.
0.00	NONREI MBURSABLE COST CENTERS	-737,900	17, 337, 010	I		
0 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0			190.
	19000 GFFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CLANS' PRI VATE OFFI CES	0	27, 334			190.
	19200 PHYSICIANS PRIVATE OFFICES	0	27, 334			192.
	19300 NONPALD WORKERS 19301 MI SSI ON SERVI CES	0	30			193.
	17301 WI JJI UN JERVI LEJ	0	30	1		193

	Financial Systems		ASCENSION ST. V	INCENT CLAY		In Lie	u of Form CMS-2	2552-10
RECLAS	SSI FI CATI ONS			Provider C	CN: 15-1309	Period: From 07/01/2020 To 06/30/2021	Worksheet A-6 Date/Time Prep 11/18/2021 4:4	pared:
		Increases						
	Cost Center	Line #	Salary	Other				
	2.00	3.00	4.00	5.00				
	A - PANDEMIC WORKERS COMP							
1.00	EMERGENCY	91.00	0	2, 485				1.00
	TOTALS		0	2, 485				
	B - CAFETERIA							
1.00	CAFETERI A			<u>343, 8</u> 10				1.00
			0	343, 810				
	C - MEDICAL SUPPLIES							
1.00	MEDICAL SUPPLIES CHARGED TO	71.00		128, 782				1.00
	PATI ENTS							
2.00								2.00
3.00								3.00
4.00	<u> </u>							4.00
			0	128, 782				
	D – OT RECLASS							
1.00	OCCUPATI ONAL THERAPY	<u> </u>	0	18 <u>9, 6</u> 91				1.00
	TOTALS		0	189, 691				
	F - Pandemic Other Expenses							
1.00	CENTRAL SERVICES & SUPPLY	14.00		7, 747				1.00
2.00	DI ETARY	10.00		6, 655				2.00
3.00	HOUSEKEEPING	9.00		11, 202				3.00
4.00	OPERATION OF PLANT			10, 408				4.00
			0	36, 012				
	G - Pandemic Salaries & Benef							
1.00	NURSING ADMINISTRATION	13.00	1, 140	199				1.00
2.00	ADULTS & PEDIATRICS	30.00	340	59				2.00
3.00	OPERATING ROOM	50.00	2, 494	435				3.00
4.00	RESPIRATORY THERAPY	65.00	287	50				4.00
5.00	EMERGENCY	91.00	<u> </u>	$- \frac{327}{1070}$				5.00
F00 01			6, 138	1,070				F00 00
500.00	) Grand Total: Increases		6, 138	701, 850				500.00

RECLAS	SSIFICATIONS			Provi der	CCN: 15-1309	Peri od:	Worksheet A-6	
						From 07/01/2020 To 06/30/2021	Date/Time Prepar	rod
						10 00/ 30/ 2021	11/18/2021 4:43	
		Decreases						
	Cost Center	Line #	Sal ary	0ther	Wkst. A-7 Re	f.		
	6. 00	7.00	8.00	9.00	10.00			
	A - PANDEMIC WORKERS COMP	· · ·			1			
1.00	EMERGENCY	91.00	<u>2, 4</u> 85	(	D	Q	1	1.00
	TOTALS		2, 485	(	0			
	B – CAFETERIA	I I	I		1	1		
1.00	DI ETARY	10.00	+	<u>343, 8</u> 10		_	1	1.00
			0	343, 810	0			
	C - MEDICAL SUPPLIES				-1			
1.00	ADULTS & PEDIATRICS	30.00		673				1.00
2.00	OPERATING ROOM	50.00		118, 468				2.00
3.00	PHYSI CAL THERAPY	66.00		4, 33				3.00
4.00	EMERGENCY	91.00		5, 304		_	Z	4.00
			0	128, 782	2			
1 00	D - OT RECLASS	(4.00	0	100 (0)	1	0		1 00
1.00	PHYSICAL THERAPY	<u>66.</u> 00	¥_	<u>189, 69</u> 		Q		1.00
	F - Pandemic Other Expenses		U	109,09	1			
1.00	ADMI NI STRATI VE & GENERAL	5,00		36, 012	2			1.00
2.00	ADMINI STRATIVE & GENERAL	5.00		30, 012	2			2.00
3.00								3.00
4.00								4.00
4.00		+	— — — <del> </del>	36,012		-		4.00
	G - Pandemic Salaries & Bene	fits	V	00,012	-			
1.00	ADMI NI STRATI VE & GENERAL	5.00	6, 138	1, 070	1			1.00
2.00		0.00	0, 100	1,070				2.00
3.00								3.00
4.00								4.00
5.00								5.00
	F	$\vdash +$	6, 138	1,070		1		
500 00	) Grand Total: Decreases		8, 623	699, 365			500	0. 00

Provider         Provider         CN: 15-1309         Period: From 07/01/2020 To 06/30/2021         Worksheet A-7 Date/Time Prepared: Date/Time Prepared: 11/18/2021 4: 43 pm           PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES         0         0         4.00         5.00           1.00         2.00         3.00         4.00         5.00         1.00           2.00         Beginning Balances         2.500         0 <th>Heal th</th> <th>Financial Systems</th> <th>ASCENSION ST.</th> <th>VINCENT CLAY</th> <th></th> <th></th> <th>In Lie</th> <th>u of Form CMS-2</th> <th>2552-10</th>	Heal th	Financial Systems	ASCENSION ST.	VINCENT CLAY			In Lie	u of Form CMS-2	2552-10
Beginning Balances         Purchases         Donation         Total         Disposal s and Retirements           1.00         2.00         3.00         4.00         5.00           Land         2,500         0         0         0         0         2.00           1.00         Land Improvements         284,755         173,476         0         173,476         0         2.00           3.00         Building more vements         284,755         173,476         0         0         0         2.00         2.00         2.04,487         3.00           4.00         Building improvements         995,040         0         0         0         0         4.00         5.00           5.00         Fixed Equipment         3,117,832         13,504         0         13,504         0         5.00           6.00         Movable Equipment         7,752,368         218,680         0	RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provider CC	CN: 15-1309	Fr	om 07/01/2020	Part I Date/Time Pre	pared:
Balances         Retirements           1.00         2.00         3.00         4.00         5.00           PART 1 - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES         0         0         0         0         1.00           2.00         Land         10.940,946         0         0         0         0         1.00           2.00         Land Improvements         284,755         173,476         0         173,476         0         226,487         3.00           4.00         Building Improvements         995,040         0         0         0         0         0         4.00           5.00         HiT designated Assets         7,752,368         218,680         0         218,680         0         6.00         7.00           9.00         Reconciling Items         0 <td></td> <td></td> <td></td> <td></td> <td>Acqui si ti on</td> <td>s</td> <td></td> <td></td> <td></td>					Acqui si ti on	s			
PART I         - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES           1.00         Land         2,500         0         0         0         0         1.00           2.00         Land Improvements         2,500         0         0         0         0         2.00           3.00         Buildings and Fixtures         10,940,946         0         0         0         2.26,487           3.00         Hard Equipment         3,117,832         13,504         0         13,504         0         5.00           6.00         Movable Equipment         7,752,368         218,680         0         226,487         8.00           9.00         Subtotal (sum of lines 1-7)         23,093,441         405,660         0         405,660         226,487         8.00           9.00         Total (line 8 minus line 9)         23,093,441         405,660         0         405,660         226,487         10.00           10.00         Total (line 8 minus line 9)         23,093,441         405,660         0         405,660         226,487         10.00           10.00         Total (line 8 minus line 9)         23,093,441         405,660         0         405,660         226,487         10.00           2.00			Begi nni ng	Purchases	Donati on		Total		
PART I         - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES         0         0         0         0         0         0         0         1.00           Land         Land Improvements         284,755         173,476         0         173,476         0         2.00 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>									
1.00       Land       2,500       0       0       0       0       0       1.00         2.00       Land Improvements       284,755       173,476       0       173,476       0       2.00         3.00       Buil dings and Fixtures       10,940,946       0       0       0       226,487       3.00         4.00       Buil ding Improvements       995,040       0       0       0       0       4.00         5.00       Fixed Equipment       3,117,832       13,504       0       13,504       0       6.00         6.00       Movable Equipment       7,752,368       218,680       0       218,680       0       6.00         7.00       HIT designated Assets       0 </td <td></td> <td></td> <td></td> <td>2.00</td> <td>3.00</td> <td></td> <td>4.00</td> <td>5.00</td> <td></td>				2.00	3.00		4.00	5.00	
2.00       Land Improvements       284,755       173,476       0       173,476       0       2.00         3.00       Buildings and Fixtures       10,940,946       0       0       0       226,487       3.00         4.00       Building Improvements       995,040       0       0       0       0       4.00         5.00       Fixed Equipment       3,117,832       13,504       0       13,504       0       5.00         6.00       Movable Equipment       7,752,368       218,680       0       226,487       8.00         6.00       HT designated Assets       0       0       0       0       7.00         8.00       Subtotal (sum of lines 1-7)       23,093,441       405,660       0       405,660       226,487       10.00         9.00       Reconciling Items       0       0       0       0       0       0       0       9.00         10.00       Total (line 8 minus line 9)       23,093,441       405,660       0       405,660       226,487       10.00         1.00       Land       PART 1 - ANALYSI S OF CHANGES IN CAPITAL ASSET BALANCES       10,001       405,660       2.00       3.00         1.00       Land       NG									
3.00       Buildings and Fixtures       10,940,946       0       0       0       226,487       3.00         4.00       Building Improvements       995,040       0       0       0       0       0       4.00         5.00       Fixed Equipment       3,117,832       13,504       0       13,504       0       5.00         6.00       Movable Equipment       7,752,368       218,680       0       218,680       0       6.00         7.00       HIT designated Assets       0       0       0       0       0       7.00         8.00       Subtotal (sum of lines 1-7)       23,093,441       405,660       0       405,660       226,487       8.00         9.00       Reconciling Items       0       0       0       0       0       9.00         10.00       Total (line 8 minus line 9)       23,093,441       405,660       0       405,660       226,487       10.00         10.00       Land       Ending Balance       Full y       Depreciated       Assets       6.00       7.00       2.00       3.00       4.00       2.00       3.00         9.00       Land       Inprovements       458,231       0       2.00       3.00 <td>1.00</td> <td>Land</td> <td>2, 500</td> <td>0</td> <td></td> <td>0</td> <td>0</td> <td>0</td> <td>1.00</td>	1.00	Land	2, 500	0		0	0	0	1.00
4.00       Building Improvements       995,040       0       0       0       0       0       4.00         5.00       Fixed Equipment       3,117,832       13,504       0       13,504       0       5.00         6.00       Movable Equipment       7,752,368       218,680       0 <td>2.00</td> <td>Land Improvements</td> <td>284, 755</td> <td>173, 476</td> <td></td> <td>0</td> <td>173, 476</td> <td></td> <td>2.00</td>	2.00	Land Improvements	284, 755	173, 476		0	173, 476		2.00
5.00       Fixed Equipment       3, 117, 832       13, 504       0       13, 504       0       5.00         6.00       Movable Equipment       7, 752, 368       218, 680       0       228, 680       0       6.00         7.00       HIT designated Assets       0	3.00		10, 940, 946	0		0	0	226, 487	3.00
6.00       Movable Equipment       7,752,368       218,680       0       218,680       0       6.00         7.00       HIT designated Assets       0	4.00			0		0	0	0	4.00
7.00       HIT designated Assets       0       0       0       0       0       0       0       7.00         8.00       Subtotal (sum of lines 1-7)       23,093,441       405,660       0       405,660       226,487       8.00         9.00       Reconciling items       0 </td <td>5.00</td> <td>Fixed Equipment</td> <td>3, 117, 832</td> <td>13, 504</td> <td></td> <td>0</td> <td>13, 504</td> <td>0</td> <td>5.00</td>	5.00	Fixed Equipment	3, 117, 832	13, 504		0	13, 504	0	5.00
8.00       Subtotal (sum of lines 1-7)       23,093,441       405,660       0       405,660       226,487       8.00         9.00       Reconciling Items       0       <	6.00	Movable Equipment	7, 752, 368	218, 680		0	218, 680	0	6.00
9.00         Reconciling Items         0         0         0         0         0         0         9.00           10.00         Total (line 8 minus line 9)         23,093,441         405,660         0         405,660         226,487         10.00           Image: Construct of the state of	7.00		0	0		0	0	0	7.00
10.00         Total (line 8 minus line 9)         23,093,441         405,660         0         405,660         226,487         10.00           Ending Balance         Fully         Depreciated         Assets         6.00         7.00         7.00         7.00         7.00         7.00         1.00         1.00         2.00         1.00         2.00         1.00         1.00         2.00         1.00         2.00         1.00         2.00         1.00         2.00         1.00         2.00         1.00         2.00         3.00         413 mprovements         2.00         3.00         4.00         5.00         7.10         458,231         0         3.00         4.00         5.00         4.00         5.00         4.00         5.00         4.00         5.00	8.00	Subtotal (sum of lines 1-7)	23, 093, 441	405, 660		0	405, 660	226, 487	8.00
PART I         - ANALYSIS OF CHANGES IN CAPITAL ASSET         Fully Depreciated Assets         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         2.00         0         7.00         1.00         1.00         2.00         1.00         2.00         0         1.00         2.00         0         1.00         2.00         3.00         Buildings and Fixtures         10,714,459         0         3.00         4.00         5.00         5.00         6.00         7.00         4.00         5.00         5.00         6.00         7.00         4.00         5.00         7.00         4.00         5.00         7.00         4.00         5.00         7.00         4.00         5.00         7.00         4.00         5.00         7.00         4.00         5.00         7.00         4.00         5.00         7.00         4.00         5.00         7.00         8.00         7.00         8.00         7.00         8.00         7.00         8.00         7.00         7.00         7.00         7.00         8.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         <	9.00	Reconciling Items	0	0		0	0	0	9.00
PART I         - ANALYSIS OF CHANGES IN CAPITAL ASSET         BLANCES         6.00         7.00           1.00         Land         2,500         0         1.00         2.00         1.00         2.00         1.00         2.00         3.00         Buildings and Fixtures         10,714,459         0         3.00         4.00         5.00         Fixed Equipment         3.131,336         0         4.00         5.00         5.00         6.00         7.00         4.00         5.00         6.00         995,040         0         4.00         5.00         4.00         5.00         6.00         7.00         4.00         5.00         6.00         7.00         4.00         5.00         6.00         7.00         4.00         5.00         6.00         7.00         4.00         5.00         6.00         7.00         8.00         5.00         6.00         7.00         8.00         5.00         6.00         7.00         8.00         7.00         8.00         7.00         8.00         7.00         8.00         7.00         8.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         <	10.00	Total (line 8 minus line 9)	23, 093, 441	405, 660		0	405, 660	226, 487	10.00
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES         6.00         7.00           1.00         Land         2,500         0         1.00           2.00         Land Improvements         458,231         0         2.00           3.00         Building Improvements         10,714,459         0         3.00           4.00         Building Improvements         995,040         0         4.00           5.00         Fixed Equipment         3,131,336         0         5.00           6.00         Movable Equipment         7,971,048         0         6.00           Subtotal (sum of lines 1-7)         23,272,614         0         8.00         8.00         8.00           9.00         Reconciling Items         0         0         0         9.00         9.00			Endi ng Bal ance	Fully					
BART I         - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES           1.00         Land         2,500         0         1.00           2.00         Land Improvements         458,231         0         2.00           3.00         Buildings and Fixtures         10,714,459         0         3.00           4.00         Building Improvements         995,040         0         4.00           5.00         Fixed Equipment         3,131,336         0         5.00           6.00         Movable Equipment         7,971,048         0         6.00           9.00         Reconciling Items         0         0         9.00			-	Depreciated					
PART I         - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES           1.00         Land         2,500         0         1.00           2.00         Land Improvements         458,231         0         2.00           3.00         Buildings and Fixtures         10,714,459         0         3.00           4.00         Building Improvements         995,040         0         4.00           5.00         Fixed Equipment         3,131,336         0         5.00           6.00         Movable Equipment         7,971,048         0         6.00           7.00         HIT designated Assets         0         0         7.00         8.00           9.00         Reconciling Items         0         0         9.00         9.00				Assets					
1.00       Land       2,500       0       1.00         2.00       Land Improvements       458,231       0       2.00         3.00       Buildings and Fixtures       10,714,459       0       3.00         4.00       Building Improvements       995,040       0       4.00         5.00       Fixed Equipment       3,131,336       0       5.00         6.00       Movable Equipment       7,971,048       0       6.00         7.00       HIT designated Assets       0       0       7.00         8.00       Subtotal (sum of lines 1-7)       23,272,614       0       8.00         9.00       Reconciling Items       0       0       9.00				7.00					
2.00       Land Improvements       458,231       0       2.00         3.00       Buildings and Fixtures       10,714,459       0       3.00         4.00       Building Improvements       995,040       0       4.00         5.00       Fixed Equipment       3,131,336       0       5.00         6.00       Movable Equipment       7,971,048       0       6.00         7.00       HIT designated Assets       0       0       7.00         8.00       Subtotal (sum of lines 1-7)       23,272,614       0       8.00         9.00       Reconciling Items       0       0       9.00		PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	BALANCES						
3.00       Buildings and Fixtures       10,714,459       0       3.00         4.00       Building Improvements       995,040       0       4.00         5.00       Fixed Equipment       3,131,336       0       5.00         6.00       Movable Equipment       7,971,048       0       6.00         7.00       HIT designated Assets       0       0       7.00         8.00       Subtotal (sum of lines 1-7)       23,272,614       0       8.00         9.00       Reconciling Items       0       0       9.00	1.00	Land	2, 500	0					1.00
4.00       Building Improvements       995,040       0       4.00         5.00       Fixed Equipment       3,131,336       0       5.00         6.00       Movable Equipment       7,971,048       0       6.00         7.00       HIT designated Assets       0       0       7.00         8.00       Subtotal (sum of lines 1-7)       23,272,614       0       8.00         9.00       Reconciling Items       0       0       9.00	2.00	Land Improvements	458, 231	0					2.00
5.00       Fixed Equipment       3, 131, 336       0       5.00         6.00       Movable Equipment       7, 971, 048       0       6.00         7.00       HIT designated Assets       0       0       7.00         8.00       Subtotal (sum of lines 1-7)       23, 272, 614       0       8.00         9.00       Reconciling Items       0       0       9.00	3.00	Buildings and Fixtures	10, 714, 459	0					3.00
6.00       Movable Equipment       7,971,048       0       6.00         7.00       HIT designated Assets       0       0       7.00         8.00       Subtotal (sum of lines 1-7)       23,272,614       0       8.00         9.00       Reconciling Items       0       0       9.00	4.00	Building Improvements	995, 040	0					4.00
7.00       HIT designated Assets       0       0       7.00         8.00       Subtotal (sum of lines 1-7)       23,272,614       0       8.00         9.00       Reconciling Items       0       0       9.00	5.00		3, 131, 336	0					5.00
7.00       HIT designated Assets       0       0       7.00         8.00       Subtotal (sum of lines 1-7)       23,272,614       0       8.00         9.00       Reconciling Items       0       0       9.00	6.00	Movable Equipment	7, 971, 048	0					6.00
9.00 Reconciling Items 0 0 9.00	7.00		0	0					7.00
	8.00	Subtotal (sum of lines 1-7)	23, 272, 614	0					8.00
10.00 Total (line 8 minus line 9) 23.272.614 0 10.00	9.00	Reconciling Items	0	0					9.00
	10.00	Total (line 8 minus line 9)	23, 272, 614	0					10.00

Heal th	Financial Systems	ASCENSI ON ST.	VINCENT CLAY		In Lie	u of Form CMS-2	2552-10
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provider CO	CN: 15-1309	Peri od:	Worksheet A-7	
					From 07/01/2020 To 06/30/2021		narod
					10 00/30/2021	11/18/2021 4:4	
			SL	JMMARY OF CAP	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 WORK			nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	405, 627	0		0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	496, 405	33, 418		0 0	0	2.00
3.00	Total (sum of lines 1-2)	902, 032	33, 418		0 0	0	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	405, 627				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	529, 823				2.00
3.00	Total (sum of lines 1-2)	0	935, 450				3.00

Health Financial Systems	ASCENSI ON ST.	VINCENT CLAY		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider CO		Period: From 07/01/2020 To 06/30/2021		
	COM	PUTATION OF RAT	FI 0S	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capitalized	Gross Assets	Ratio (see	Insurance	
		Leases	for Ratio (col. 1 - col. 2)	instructions)		
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE		1				
1.00 CAP REL COSTS-BLDG & FIXT	12, 170, 230				0	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	11, 102, 384					2.00
3.00 Total (sum of lines 1-2)	23, 272, 614		23, 272, 614			3.00
	ALLUCA	TION OF OTHER (	APITAL	SUMMARY O	F CAPITAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Rel ate				
		d Costs	through 7)			
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE				405 (07	0	4 00
1.00 CAP REL COSTS-BLDG & FIXT 2.00 CAP REL COSTS-MVBLE EQUIP	0	0		405, 627	0	1.00
	0	0		496, 405		2.00
3.00 Total (sum of lines 1-2)	0	0	I JMMARY OF CAPI	902, 032	33, 418	3.00
		50	JWWARY OF CAPT			
Cost Center Description	Interest	Insurance (see			Total (2) (sum	
		instructions)	instructions)			
				d Costs (see	through 14)	
	11.00	10.00	10.00	instructions)	45.00	
PART III - RECONCILIATION OF CAPITAL COSTS C	11.00	12.00	13.00	14.00	15.00	
1.00 CAP REL COSTS-BLDG & FIXT	0	0	(	0 0	405, 627	1.00
2.00 CAP REL COSTS-BEDG & TTXT	0	-			529, 823	2.00
3.00 Total (sum of lines 1-2)	0	-		0	935, 450	3.00
			I	- U	,,	0.00

				From 07/01/2020 To 06/30/2021	Date/Time Prep 11/18/2021 4:4	parec 43 pm
		-	Expense Classification c To/From Which the Amount is		11/10/2021 1.	
			TO/TTOM WITCH THE AMOUNT T.			
Cost Center Description		Amount	Cost Center			
Investment income - CAP RFL						1.
COSTS-BLDG & FIXT (chapter 2)						
COSTS-MVBLE EQUIP (chapter 2)						
	В	-8, 234 A	ADMINISTRATIVE & GENERAL	5.00	0	3.
Trade, quantity, and time		О		0.00	0	4.
Refunds and rebates of		o		0.00	0	5.
expenses (chapter 8) Pental of provider space by		0		0.00	0	6.
suppliers (chapter 8)		0				
stations excluded) (chapter		0		0.00	0	7.
Television and radio service		0		0.00	0	8
Parking lot (chapter 21) Provider-based physician	A-8-2	0 -20, 696		0.00	0 0	
Sale of scrap, waste, etc.		О		0.00	0	11
Related organization transactions (chapter 10)	A-8-1	1, 909, 617			0	
	В	0 -28, 5730	CAFETERI A		0	
Rental of quarters to employee		0		0.00	0	
Sale of medical and surgical supplies to other than		Ο		0.00	0	16
Sale of drugs to other than	В	-841 F	PHARMACY	15.00	0	17
Sale of medical records and		О		0.00	0	18
Nursing and allied health education (tuition, fees,		О		0.00	0	19
		0		0.00	0	20
Income from imposition of		0		0.00	0	
charges (chapter 21)						
		0		0.00	0	22
repay Medicare overpayments			DESDI DATADY THEDADY	(E. 00)		23
therapy costs in excess of	A-0-3	UF	LUITATUNT INEKAMT	65.00		23
limitation (chapter 14) Adjustment for physical	A-8-3	OF	PHYSICAL THERAPY	66.00		24
therapy costs in excess of						
Utilization review - physicians' compensation		0*	*** Cost Center Deleted ***	* 114.00		25
(chapter 21) Depreciation - CAP REL		00	CAP REL COSTS-BLDG & FIXT	1.00	0	26
COSTS-BLDG & FIXT					0	
COSTS-MVBLE EQUIP					0	
		0	*** Cost Center Deleted ***	* 19.00 0.00	0	28 29
Adjustment for occupational therapy costs in excess of	A-8-3	oc	OCCUPATI ONAL THERAPY	67.00		30
Hospice (non-distinct) (see		OA	ADULTS & PEDIATRICS	30.00		30
instructions) Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	00 83		31
pathology costs in excess of limitation (chapter 14)	h-0-3				_1	
CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.
	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL COSTS-WWBLE EQUIP (chapter 2) Investment income - other (chapter 2) Trade, quantity, and time discounts (chapter 8) Refunds and rebates of expenses (chapter 8) Refunds esrvices (pay stations excluded) (chapter 21) Tel evision and radio service (chapter 21) Parking lot (chapter 21) Provider-based physician adjustment Sale of scrap, waste, etc. (chapter 23) Related organization transactions (chapter 10) Laundry and Linen service Cafeteria-employees and guests Rental of quarters to employee and others Sale of medical and surgical supplies to other than patients Sale of medical records and abstracts Nursing and allied heal th education (tuition, fees, books, etc.) Vending machines Income from imposition of interest, finance or penal ty charges (chapter 21) Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments Adjustment for respiratory therapy costs in excess of Limitation (chapter 14) Adjustment for physical therapy costs in excess of Limitation (chapter 14) Adjustment for physical therapy costs in excess of Limitation (chapter 14) Adjustment for physical therapy costs in excess of Limitation (chapter 14) Adjustment for occupational therapy costs in excess of Limitation (chapter 14) Hospice (non-distinct) (see instructions) Adjustment for speech pathology costs in excess of Limitation (chapter 14) Hospice (non-distinct) (see instructions) Adjustment for speech pathology costs in excess of Limitation (chapter 14) Hospice (non-distinct) (see instructions) Adjustment for speech pathology costs in excess of Limitation (chapter 14) Hospice (non-distinct) (see instructions) Adjustment for speech pathology costs in excess of Limitation (chapter 14) CAH HIT Adjustment for	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL COSTS-WBLE EQUIP (chapter 2) Investment income - other (chapter 2) Trade, quantity, and time discounts (chapter 8) Refunds and rebates of expenses (chapter 8) Retail of provider space by suppliers (chapter 8) Telephone services (pay stations excluded) (chapter 21) Television and radio service (chapter 21) Parking lot (chapter 21) Provider-based physician A-8-2 adjustment Sale of Scrap, waste, etc. (chapter 23) Related organization A-8-1 transactions (chapter 10) Laundry and linen service Cafeteria - employees and guests Rental of quarters to employee and others Sale of medical and surgical supplies to other than patients Sale of medical records and abstracts Nursing and allied heal th education (tuition, fees, books, etc.) Vending machines Income from imposition of interest. Finance or penal ty charges (chapter 10) Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments Adjustment for respiratory A-8-3 therapy costs in excess of limitation (chapter 14) Adjustment for physical A-8-3 therapy costs in excess of limitation (chapter 14) Adjustment for cospensition (chapter 21) Depreciation - CAP REL COSTS-MURE EQUIP Non-physician Anesthetist Physicians' assistant Adjustment for occupational A-8-3 therapy costs in excess of limitation (chapter 14) Adjustment for ospech A-8-3 therapy costs in excess of limitation (chapter 14) Adjustment for spech A-8-3 therapy costs in excess of limitation (chapter 14) Adjustment for physical A-8-3 therapy costs in excess of limitation (chapter 14) Adjustment for ospech A-8-3 therapy costs in excess of limitation (chapter 14) Adjustment for copentional A-8-3 therapy costs in excess of limitation (chapter 14) Adjustment for bysech A-8-3	Investment income - CAP RELB-235, 598COSTS-BLDG & FIXT (chapter 2)0Investment income - CAP REL0COSTS-WBLE EQUIP (chapter 2)0Investment income - otherBChapter 2)Trade, quantity, and timediscounts (chapter 8)0Refunds and rebates of0expenses (chapter 8)0Rental of provider space by0suppliers (chapter 8)0Rental of provider space by0suppliers (chapter 8)0rade, guantity, and time0chapter 21)0Telephone services (pay0stations excluded) (chapter0chapter 21)0Provider-based physicianA-8-2adjustment0Sale of scrap, waste, etc.0(chapter 23)0Related organizationA-8-1Related organizationA-8-1transactions (chapter 10)Laundry and linen service0Cafeteria-employees and guests8Sale of medical and surgical0sale of drugs to other than8patients0Sale of medical records and abstrats0Nursing and allied heal th education (tuition, fees, books, etc.)0Vending machines0Income from inposition of Interest, finance or penalty charges (chapter 21)0Interest, finance or penalty charges chapter 21)0Interest, finance or penalty charges chapter 21)0Intere	1.002.003.00Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)B-235,596 (CAP REL COSTS-BLDG & FIXT (CAP REL COSTS-BLDG & FIXT (CAP REL COSTS-BLDG & FIXT (Chapter 2)Investment income - other (chapter 2)B-8.234 ADMINISTRATIVE & GENERAL (Capter 2)Investment income - other (chapter 2)B-8.234 ADMINISTRATIVE & GENERALCosts-MVBLE FOULP (chapter 2)B-8.234 ADMINISTRATIVE & GENERALCosts-MVBLE FOULP (chapter 2)C0Stations excluded) (chapter 21)00Provider-based physician adjustmentA-8-2-20,696Sale of scrap, waste, etc. (chapter 3)A-8-11,909,617Rentat of guarters to employee and others Sale of medical records and abstration sale of medical records and abstrationA-8-11,909,617Charter 1Cafteria-employees and guests Rental of quarters to employee and othersB-28,573Sale of medical records and abstration therapy costs in excess of limitation (chapter 14) Adjustment for physicial (chapter 21)A-8-3OInterest, Fallo A Capter 14) Adjustment for physicial (chapter 21)A-8-3OPressing Computer 14) Adjustment for physicial (chapter 21)A-8-3OCost Center Deleted *** (Capter 21)O-*** Cost Center Deleted ***Optrovider science of (chapter 21)A-8-3OCost Center Deleted *** (Chapter 21)A-8-3OCost Center Deleter 14) Adjustment for physicial (chapter 21)A-8-3O </td <td>Investment Income - CAP RLL         B         -235, 598 GAP REL COSTS-BLDG &amp; FLXT         4.0           COSTS-BLDG &amp; FLXT         Chapter 2)         Investment Income - CAP RLL         0         CAP REL COSTS-BLDG &amp; FLXT         1.0           Investment Income - CAP RLL         0         CAP REL COSTS-BLDG &amp; FLXT         1.0         2.00           Investment Income - CAP RLL         0         CAP REL COSTS-HVBLE EDUIP         2.00           Investment Income - CAP RLL         0         0         0.00           discounts (Chapter 8)         0         0         0.00           Refunds and relates of expenses (Chapter 2)         0         0.00         0.00           Rental of provider space by         0         0         0.00         0.00           Stations excluded) (Chapter 2)         0         0         0.00         0.00           Provider space bysician         A-8-2         -20.696         0         0.00           Stations excluded) (Chapter 2)         0         0         0.00         0.00           Chapter 23)         A-8-1         1,909,617         0         0.00         0.00           Carteria - employees and guests         B         -28,573/CAFETERIA         11.00         0.00         0.00           Sale of med</td> <td>Increatment increase         1.00         2.00         3.00         4.00         5.00           COSTS-HUBLE AS FAX (chapter 2) (chapter 2)         0         0.00         0         0         0         0           COSTS-HUBLE BLIG &amp; FAX (chapter 2) (rowstment income - dubter)         B         -235,590(AP REL COSTS-HWBLE EQUIP         2.00         0           Investment income - dubter)         B         -8,234 ADMINISTRATIVE &amp; CENERAL         5.00         0           Investment income - dubter 2)         B         -8,234 ADMINISTRATIVE &amp; CENERAL         5.00         0           Investment income - dubter 2)         0         0.00         0         0.00         0           Supplicities (chapter 8)         0         0         0.00         &lt;</td>	Investment Income - CAP RLL         B         -235, 598 GAP REL COSTS-BLDG & FLXT         4.0           COSTS-BLDG & FLXT         Chapter 2)         Investment Income - CAP RLL         0         CAP REL COSTS-BLDG & FLXT         1.0           Investment Income - CAP RLL         0         CAP REL COSTS-BLDG & FLXT         1.0         2.00           Investment Income - CAP RLL         0         CAP REL COSTS-HVBLE EDUIP         2.00           Investment Income - CAP RLL         0         0         0.00           discounts (Chapter 8)         0         0         0.00           Refunds and relates of expenses (Chapter 2)         0         0.00         0.00           Rental of provider space by         0         0         0.00         0.00           Stations excluded) (Chapter 2)         0         0         0.00         0.00           Provider space bysician         A-8-2         -20.696         0         0.00           Stations excluded) (Chapter 2)         0         0         0.00         0.00           Chapter 23)         A-8-1         1,909,617         0         0.00         0.00           Carteria - employees and guests         B         -28,573/CAFETERIA         11.00         0.00         0.00           Sale of med	Increatment increase         1.00         2.00         3.00         4.00         5.00           COSTS-HUBLE AS FAX (chapter 2) (chapter 2)         0         0.00         0         0         0         0           COSTS-HUBLE BLIG & FAX (chapter 2) (rowstment income - dubter)         B         -235,590(AP REL COSTS-HWBLE EQUIP         2.00         0           Investment income - dubter)         B         -8,234 ADMINISTRATIVE & CENERAL         5.00         0           Investment income - dubter 2)         B         -8,234 ADMINISTRATIVE & CENERAL         5.00         0           Investment income - dubter 2)         0         0.00         0         0.00         0           Supplicities (chapter 8)         0         0         0.00         <

 33. 00
 Admin Revenue
 B
 -1, 208
 ADMI NI STRATI VE & GENERAL
 5. 00

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 St. Vincent Clay\300
 - Medicare Cost Report\20210630\HFS\20210630 Clay.mcrx

Heal th	Financial Systems		ASCENSION ST.	VINCENT CLAY	In Lie	eu of Form CMS-2	2552-10
ADJUST	MENTS TO EXPENSES			Provider CCN: 15-1309	Period: From 07/01/2020	Worksheet A-8	
					To 06/30/2021		pared: 43 pm
				Expense Classification	on Worksheet A		
				To/From Which the Amount	is to be Adjusted		
	Cost Center Description	· · · · ·		Cost Center		Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.03	LOBBYING	A	-474	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	DONATI ONS	A	-3, 672	ADMI NI STRATI VE & GENERAL	5.00	0	33.04
33.06	PROVIDER TAX	A	-1,005,079	ADMI NI STRATI VE & GENERAL	5.00	0	33.06
33.08	Physician Fund Expense	A	-1, 343, 210	ADMI NI STRATI VE & GENERAL	5.00	0	33.08
50.00	TOTAL (sum of lines 1 thru 49)		-737, 968	3			50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

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

A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

Heal th	Financial Systems	ASCENSION ST.	VINCENT CLAY	In Lie	eu of Form CMS-	2552-10
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOM		Period:	Worksheet A-8	8-1
OFFICE	COSTS			From 07/01/2020 To 06/30/2021		narod
				10 00/30/2021	11/18/2021 4:	
	Line No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1.00	2.00	3.00	4.00	5.00	
		MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OF	RGANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:				-	
1.00			HOME OFFICE - CAPITAL	290, 981		1.00
2.00		ADMINISTRATIVE & GENERAL	HOME OFFICE - INTEREST - Cap			2.00
3.00			HOME OFFICE - INTEREST - A&G			3.00
3.01			HOME OFFICE - OTHER	4, 623, 491		3.01
3.02			SVH CHARGEBACKS	1, 416	1, 416	3. 02
3.03	54.00	RADI OLOGY-DI AGNOSTI C	SVH CHARGEBACKS	45, 784	45, 784	3.03
3.04	69.00	ELECTROCARDI OLOGY	SVH CHARGEBACKS	10, 096	10, 096	3.04
3.05	91.00	EMERGENCY	SVH CHARGEBACKS	-500	-500	3.05
3.07	4.00	EMPLOYEE BENEFITS DEPARTMENT	HEALTH INSURANCE	672, 696	666, 248	3.07
3.08	1.00	CAP REL COSTS-BLDG & FIXT	INTEREST EXPENSE	235, 598	0	3.08
3.09	5.00	ADMINISTRATIVE & GENERAL	INTEREST EXPENSE	2, 981	238, 579	3.09
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4).			5, 887, 796	3, 978, 179	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

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

has	not	been posted to Worksheet A,	columns 1 and/or 2, the amou	nt allowable sh	ould be indicated in column 4	of this part.	
					Related Organization(s) and/	or Home Office	
					<b>o i i</b>		
		Symbol (1)	Name	Percentage of	Name	Percentage of	
			Name	U U	Name	Ŭ,	
				Ownershi p		Ownership	
		1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:						

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

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

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

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

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

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

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

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

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

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

Health Financial Systems ASCENSION ST. VINCENT	CLAY In Lieu	of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME Prov OFFICE COSTS	From 07/01/2020	Worksheet A-8-1 Date/Time Prepared:

	-					11/18/2021 4:4	43 pm
	Net	Wkst. A-7 Ref.					
	Adjustments						
	(col. 4 minus						
	col. 5)*						
	6.00	7.00					
	A. COSTS INCUR	RED AND ADJUSTN	MENTS REQUIRED AS A RESULT OF TRA	NSACTIONS WITH RELATED O	RGANIZATIONS OR (	CLAIMED	
	HOME OFFICE CO	STS:					
1.00	290, 981	0					1.00
2.00	5, 157	0					2.00
3.00	96	0					3.00
3.01	1, 606, 935	0					3.01
3.02	0	0					3.02
3.03	0	0					3.03
3.04	0	0					3.04
3.05	0	0					3.05
3.07	6, 448	0					3.07
3.08	235, 598						3.08
3.09	-235, 598						3.09
4.00	0	0					4.00
5.00	1, 909, 617						5.00
				C		/ I.	

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.

Rel ated Organi zati on(s)		
and/or Home Office		
Type of Business		
6.00	1	
 B. INTERRELATIONSHIP TO RELA	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 reimbursement under title XVIII

i ci ilibui							
6.00	Admi ni strati on	6.00					
7.00	Admi ni strati on	7.00					
8.00		8.00					
9.00		9.00					
9. 00 10. 00		10.00					
100.00		100.00					

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

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

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

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

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

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

				VUNCENT CLAY				2552 10
	Financial Syste R BASED PHYSIC		ASCENSION SI.	VINCENT CLAY	CN: 15-1309	Period:	eu of Form CMS- Worksheet A-8	
FROVIDE	IN DAGLU FIIIGIG			FIOVICEIC		rom 07/01/2020		-2
						Fo 06/30/2021	Date/Time Pre	
			<b>- - - -</b>				11/18/2021 4:	<u>43 pm</u>
	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professi onal	Provider Component		Physician/Prov ider Component	
		rdentifier	Remuneration	Component	component		Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00		OPERATI NG ROOM	12, 150	12, 150	3.00	0.00	0	1.00
2.00		RADI OLOGY-DI AGNOSTI C	8, 546	8, 546	0	0	0	2.00
3.00		EMERGENCY	1, 294, 177	0	1, 294, 177	0	0	3.00
4.00	0.00		0	0	0	0	0	4,00
5.00	0.00		0	0	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	8,00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1, 314, 873	20, 696	1, 294, 177		0	
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		I denti fi er	Limit	Unadjusted RCE	Memberships &		of Mal practi ce	
				Limit	Conti nui ng	Share of col.	Insurance	
					Education	12		
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00		OPERATING ROOM	0	0	0	0	0	1.00
2.00		RADI OLOGY-DI AGNOSTI C	0	0	0		0	2.00
3.00		EMERGENCY	0	0	0	-	0	3.00
4.00	0.00		0	0			0	4.00
5.00	0.00		0	0	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	8.00
9.00	0.00		0	0	0	-	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	ő	0	200.00
	WKSL A LINE #	I denti fi er	Component	Limit	Di sal l owance	Adjustment		
		rdentifier	Share of col.		DI Sal i Owance			
			14					
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00		OPERATI NG ROOM	0					1.00
2.00		RADI OLOGY-DI AGNOSTI C	0	0				2,00
3.00		EMERGENCY	0	0	0			3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5,00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	20, 696		200.00
		•	-					

OUTSIC	IABLE COST DETERMINATION FOR THERAPY SERVICES I DE SUPPLIERS	-URNI SHED BY	Provider CC	N: 15-1309	Peri od: From 07/01/2020 To 06/30/2021	Worksheet A-8 Parts I-VI Date/Time Pre 11/18/2021 4:4	pared:
					Physical Therapy		10 pm
						1.00	
	PART I - GENERAL INFORMATION						
1.00 2.00	Total number of weeks worked (excluding aides	s) (see instruc	ctions)			52 780	1.00 2.00
3.00	Line 1 multiplied by 15 hours per week Number of unduplicated days in which supervis	or or therapis	st was on provi	der site (se	e instructions)	304	3.00
4.00	Number of unduplicated days in which therapy					5	4.00
5.00	nor therapist was on provider site (see instr		anists (saa in	ctructionc)		0	5.00
6.00	Number of unduplicated offsite visits - super Number of unduplicated offsite visits - thera	apy assistants	(include only	visits made	by therapy	0	6.00
	assistant and on which supervisor and/or ther						
7.00	instructions) Standard travel expense rate					9. 57	7.00
8.00	Optional travel expense rate per mile					0.00	
		Supervi sors	Therapi sts	Assi stants		Trai nees	
9.00	Total hours worked	1.00 2,023.00	2.00 2,037.00	3.00	4.00 00 0.00	5.00	9.00
10.00	AHSEA (see instructions)	98.87			88 0.00	0.00	
11.00	Standard travel allowance (columns 1 and 2,	42.99	42.99	27.	94		11.00
	one-half of column 2, line 10; column 3, one-half of column 3, line 10)						
12.00	Number of travel hours (provider site)	0	0		0		12.00
12.01	Number of travel hours (offsite)	0	0		0		12.01
13.00 13.01	Number of miles driven (provider site) Number of miles driven (offsite)	0	0		0		13.00 13.01
10101							10101
	Part II - SALARY EQUIVALENCY COMPUTATION					1.00	
14.00	Supervisors (column 1, line 9 times column 1,	line 10)				200, 014	14.00
15.00	Therapists (column 2, line 9 times column 2,	line 10)				175, 121	15.00
16.00 17.00	Assistants (column 3, line 9 times column 3,		ratory thorany	or Lines 1	1 14 for all	337,068	
17.00	Subtotal allowance amount (sum of lines 14 ar others)	ia is ior respi	ratory therapy	or times 14		712, 203	17.00
18.00	Aides (column 4, line 9 times column 4, line					0	
19.00 20.00	Trainees (column 5, line 9 times column 5, li		thorapy or lin	oc 17 and 10	) for all others)	0 712, 203	19.00 20.00
20.00	Total allowance amount (sum of lines 17-19 for If the sum of columns 1 and 2 for respiratory						20.00
	occupational therapy, line 9, is greater than	line 2, make					
21.00	the amount from line 20. Otherwise complete Weighted average rate excluding aides and tra		divided by su	m of columns	and 2 line 9	0.00	21.00
21.00	for respiratory therapy or columns 1 thru 3,					0.00	21.00
22.00	Weighted allowance excluding aides and traine	es (line 2 tim	nes line 21)			0	
23.00	Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW	ANCE AND TRAVE	I EXPENSE COMP	LITATION - PE	20VIDER SITE	712, 203	23.00
	Standard Travel Allowance	ANGE AND TRAVE					
	Therapists (line 3 times column 2, line 11)					13, 069	
25.00 26.00	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or	sum of lines ?	A and 25 for a	II others)		140 13, 209	
27.00	Standard travel expense (line 7 times line 3				3 and 4 for all	2, 957	27.00
~~ ~~	others)						
28.00	Total standard travel allowance and standard 27)	travel expense	e at the provid	er site (sur	n of lines 26 and	16, 166	28.00
	Optional Travel Allowance and Optional Travel						
29.00	Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3,		nd 2, line 12)			0	29.00 30.00
30.00 31.00	Subtotal (line 29 for respiratory therapy or	· ·	9 and 30 for a	ll others)		0	30.00
32.00	Optional travel expense (line 8 times columns				oy or sum of	0	32.00
22.00	columns 1-3, line 13 for all others)		20)			1/ 1//	22.00
33.00 34.00	Standard travel allowance and standard travel Optional travel allowance and standard travel			d 31)		16, 166 0	
35.00	Optional travel allowance and optional travel	expense (sum	of lines 31 an	d 32)		0	
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA	NCE AND TRAVEL	EXPENSE COMPU	TATION - SEF	RVICES OUTSIDE PRO	OVIDER SITE	-
36.00	Standard Travel Expense Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	
38.00	Subtotal (sum of lines 36 and 37)	<u> </u>				0	
39. 00	Standard travel expense (line 7 times the sum Optional Travel Allowance and Optional Travel		10 6)			0	39.00
40.00	Therapists (sum of columns 1 and 2, line 12.0		n 2, line 10)			0	40.00
41.00	Assistants (column 3, line 12.01 times column		,			0	41.00
42.00	Subtotal (sum of lines 40 and 41)	of columns 1	2 Line 12 01			0	
43.00	Optional travel expense (line 8 times the sum Total Travel Allowance and Travel Expense - C			e of the fol	lowing three line	0 es 44, 45,	43.00
	or 46, as appropriate.		•				
44.00	Standard travel allowance and standard travel Optional travel allowance and standard travel					0	44.00 45.00
45 00	THOT ODAL TRAVEL ALLOWANCE AND STANDARD TRAVEL	HYDENSE (SUM	OF LENES KY an	0 47 - SAA I	INSTRUCTIONS)	0	1 45 00

Health Financial Systems	ASCENSION ST. V	NCENT CLAY		Inlie	eu of Form CMS-2	2552-10
REASONABLE COST DETERMINATION FOR THERAPY SERVICES OUTSIDE SUPPLIERS		Provider CO	CN: 15-1309	Period: From 07/01/2020 To 06/30/2021	Worksheet A-8 Parts I-VI	-3 pared:
				Physical Therapy		
		6 1	- 42		1.00	4( 00
46.00 Optional travel allowance and optional trave	I expense (sum o Therapists		Aides	Trai nees	Total	46.00
	1.00	Assi stants 2.00	3.00	4.00	5.00	
PART V - OVERTIME COMPUTATION	1.00	2.00	5.00	4.00	5.00	
47.00 Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.0	0.00	0.00	47.00
48.00 Overtime rate (see instructions)	0.00	0.00	0.0	0.00		48.00
49.00 Total overtime (including base and overtime allowance) (multiply line 47 times line 48) CALCULATION OF LIMIT	0.00	0.00				49.00
50.00 Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0. (	0.00	0.00	50.00
51.00 Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions) DETERMINATION OF OVERTIME ALLOWANCE	0.00	0.00	0. (	0.00	0. 00	51.00
52.00 Adjusted hourly salary equivalency amount (see instructions)	85. 97	55.88	0. (	0.00		52.00
53.00 Overtime cost limitation (line 51 times line 52)	0	0		0 0		53.00
54.00 Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0		0 0		54.00
55.00 Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	O	0		0 0		55.00
56.00 Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0		0 0	0	56.00
					1.00	
Part VI - COMPUTATION OF THERAPY LIMITATION	AND EXCESS COST /	ADJUSTMENT				
57.00 Salary equivalency amount (from line 23)	(6 11 66				712, 203	
58.00 Travel allowance and expense - provider site			`		16, 166	
59.00 Travel allowance and expense - Offsite servi 60.00 Overtime allowance (from column 5, line 56)	ces (from fines	44, 45, 01 46	)		0	
61.00 Equipment cost (see instructions)					0	
						1
62.00 Supplies (see instructions) 63.00 Total allowance (sum of lines 57-62)					728, 369	1
64.00 Total cost of outside supplier services (fro	m vour records)				629, 696	
65.00 Excess over limitation (line 64 minus line 6 LINE 33 CALCULATION	J .	enter zero)				65.00
100.00 Line 26 = line 24 for respiratory therapy or	cum of lines 24	and 25 for a	LL others		13, 209	100 00
100.01 Line 27 = line 7 times line 3 for respirator				othors		100.00
100.02 Line 33 = line 28 = sum of lines 26 and 27	y therapy of sum			0 the 3	16, 166	
LINE 34 CALCULATION 101.00 Line 27 = line 7 times line 3 for respirator				others		101.00
101.01 Line 31 = line 29 for respiratory therapy or 101.02 Line 34 = sum of lines 27 and 31	sum of lines 29	and 30 Tor a	ii otners			101. 01 101. 02
LINE 35 CALCULATION 102.00 Line 31 = line 29 for respiratory therapy or 102.01 Line 32 = line 8 times columns 1 and 2, line				umns 1-3. line		102. 00 102. 01
13 for all others		J		,	0	

REASON	Financial Systems IABLE COST DETERMINATION FOR THERAPY SERVICES IE SUPPLIERS	ASCENSION ST. FURNI SHED BY	VINCENT CLAY Provider CC		eriod: rom 07/01/2020	u of Form CMS-2 Worksheet A-8 Parts I-VI Date/Time Pre 11/18/2021 4: Cost	-3 pared:
					-	1.00	
	PART I - GENERAL INFORMATION				1		
1.00 2.00	Total number of weeks worked (excluding aides Line 1 multiplied by 15 hours per week	s) (see instruc	tions)			52 780	1
3.00	Number of unduplicated days in which supervis	sor or therapis	t was on provid	der site (see i	instructions)	250	
4.00	Number of unduplicated days in which therapy					0	1
F 00	nor therapist was on provider site (see inst	ructions)				0	F 00
5.00 6.00	Number of unduplicated offsite visits - super Number of unduplicated offsite visits - there				therapy	0	5.00 6.00
	assistant and on which supervisor and/or the					-	
7 00	instructions)					0.57	7 00
7.00 8.00	Standard travel expense rate Optional travel expense rate per mile					9.57 0.00	
		Supervi sors	Therapi sts	Assi stants	Ai des	Trai nees	
9.00	Total hours worked	1.00 0.00	2.00	3.00	4.00	5.00	9.00
10.00	AHSEA (see instructions)	0.00	81.50	0.00			10.00
11.00	Standard travel allowance (columns 1 and 2,	40. 75	40. 75	0.00			11.00
	one-half of column 2, line 10; column 3, one-half of column 3, line 10)						
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13. 00 13. 01	Number of miles driven (provider site) Number of miles driven (offsite)	0	0	0			13.00 13.01
			-1				
	Part II - SALARY EQUIVALENCY COMPUTATION					1.00	
14.00	Supervisors (column 1, line 9 times column 1,	line 10)				0	14.00
15.00	Therapists (column 2, line 9 times column 2,					197, 312	1
16.00 17.00	Assistants (column 3, line 9 times column 3, Subtotal allowance amount (sum of lines 14 an		ratory therapy	or lines 14-1	6 for all	0 197, 312	
17.00	others)		ratory therapy	01 111163 14-10		177, 512	17.00
18.00	Aides (column 4, line 9 times column 4, line					0	
19.00 20.00	Trainees (column 5, line 9 times column 5, li Total allowance amount (sum of lines 17–19 fo		therapy or line	es 17 and 18 f	or all others)	0 197, 312	19.00
20.00	If the sum of columns 1 and 2 for respiratory						20.00
	occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete		no entries on l	ines 21 and 22	2 and enter on	line 23	
21.00	Weighted average rate excluding aides and tra		divided by sur	m of columns 1	and 2, line 9	0.00	21.00
22.00	for respiratory therapy or columns 1 thru 3,					0	22.00
22. 00 23. 00	Weighted allowance excluding aides and traine Total salary equivalency (see instructions)	ees (inne z tim	es line 21)			0 197, 312	
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW	ANCE AND TRAVE	L EXPENSE COMPU	JTATION - PROV	DER SITE	· · · · · · · · · · · · · · · · · · ·	1
24.00	Standard Travel Allowance Therapists (line 3 times column 2, line 11)					10, 188	1 24 00
24.00	Assistants (line 4 times column 3, line 11)					10, 188	
26.00	Subtotal (line 24 for respiratory therapy or					10, 188	
27.00	Standard travel expense (line 7 times line 3 others)	for respirator	y therapy or si	um of lines 3 a	and 4 for all	2, 393	27.00
28.00	Total standard travel allowance and standard	travel expense	at the provide	er site (sum o	flines 26 and	12, 581	28.00
	27)	<b>F</b>	-				
29.00	Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of		d 2. line 12 )			0	29.00
30.00	Assistants (column 3, line 10 times column 3,	line 12)				0	30.00
31.00	Subtotal (line 29 for respiratory therapy or			,		0	31.00
32.00	Optional travel expense (line 8 times columns columns 1-3, line 13 for all others)	s i and 2, i i ne	13 For respira	atory therapy (	or sum or	0	32.00
33.00	Standard travel allowance and standard travel	•	,			12, 581	
34.00 35.00	Optional travel allowance and standard travel Optional travel allowance and optional travel					0	34.00 35.00
35.00	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA				LES OUTSI DE PRO		35.00
	Standard Travel Expense						
36.00 37.00	Therapists (line 5 times column 2, line 11)					0	
38.00	Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37)					0	1
39.00	Standard travel expense (line 7 times the sur		d 6)			0	39.00
40.00	Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.0		2 line 10)			0	40.00
40.00	Assistants (column 3, line 12.01 times column		2, 1110 10)			0	
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sur Total Travel Allowance and Travel Expense - (			of the follow	wing three line	0	43.00
	or 46, as appropriate.					.5 44, 40,	
44.00	Standard travel allowance and standard travel	expense (sum	of lines 38 and	d 39 - see ins	tructions)	0	44.00
11/18/	2021 4.43 pm Y.\28250 - St Vincent Clav\300	Medicare Cost	Penart\ 202106	30\ HES\ 20210630			

	ABLE COST DETERMINATION FOR THERAPY SERVICES I E SUPPLIERS	FURNI SHED BY	Provider C(		Period: From 07/01/2020 To 06/30/2021 Occupational	Worksheet A-8 Parts I-VI Date/Time Pre 11/18/2021 4:-	pared:
					Therapy	Cost	
						1.00	
	Optional travel allowance and standard travel					0	
46.00	Optional travel allowance and optional travel	expense (sum Therapists	of lines 42 an Assistants	id 43 - see in Aides	structions) Trainees	0 Total	46.00
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
17.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.0	0 0.00	0.00	47.00
8.00	Overtime rate (see instructions)	0. 00	0.00				48.00
19.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.0	0 0.00		49.00
	CALCULATION OF LIMIT						
0. 00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0. 00	0.00	0.0	0 0.00	0.00	50. OC
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0. 00	0.00	0.0	0 0.00	0.00	51.00
2.00	DETERMINATION OF OVERTIME ALLOWANCE Adjusted hourly salary equivalency amount	81. 50	0.00	0.0	0 0.00		52.00
	(see instructions) Overtime cost limitation (line 51 times line	0	0.00		0 0		53.00
4. 00	52) Maximum overtime cost (enter the lesser of	0	0		0 0		54.00
5. 00	line 49 or line 53) Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0		0 0		55.00
6. 00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0		o o	0	56.00
				I			
	Part VI - COMPUTATION OF THERAPY LIMITATION A	ND EVCESS COST				1.00	
	Salary equivalency amount (from line 23)	IND EACESS COST	ADJUSTMENT			197, 312	57.00
8.00 9.00 0.00 1.00 2.00	Travel allowance and expense - provider site Travel allowance and expense - Offsite servic Overtime allowance (from column 5, line 56) Equipment cost (see instructions) Supplies (see instructions) Total allowance (sum of lines 57-62)	•		)		12, 581 0 0 0 0 209, 893	58.00 59.00 60.00 61.00 62.00
4. 00 5. 00	Total cost of outside supplier services (from Excess over limitation (line 64 minus line 63 LINE 33 CALCULATION	- if negative	e, enter zero)			173, 742 0	64.00 65.00
00. 01	Line 26 = line 24 for respiratory therapy or Line 27 = line 7 times line 3 for respiratory Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION				others	10, 188 2, 393 12, 581	100. 01
01. 01	Line $27 =$ line 7 times line 3 for respiratory Line $31 =$ line 29 for respiratory therapy or				others	0	101. 00 101. 01
	Line 34 = sum of lines 27 and 31					2, 393	J101. 02
	LINE 35 CALCULATION Line 31 = line 29 for respiratory therapy or		0	11		-	102.00

OUTSIE	IABLE COST DETERMINATION FOR THERAPY SERVICES DE SUPPLIERS	FURNI SHED BY	Provider CC	CN: 15-1309	Peri od: From 07/01/2020 To 06/30/2021	Worksheet A-8- Parts I-VI Date/Time Prep 11/18/2021 4:4	pared:
					Speech Pathology		
						1.00	
	PART I - GENERAL INFORMATION						
1.00 2.00	Total number of weeks worked (excluding aides Line 1 multiplied by 15 hours per week	s) (see instruc	tions)			52 780	•
3.00	Number of unduplicated days in which supervis	sor or therapis	t was on provi	der site (se	e instructions)	183	
4.00	Number of unduplicated days in which therapy	assistant was				0	4.00
5.00	nor therapist was on provider site (see instr Number of unduplicated offsite visits - super		anists (see in	structions)		0	5.00
6.00	Number of unduplicated offsite visits - thera	apy assi stants	(include only	visits made	by therapy	0	
	assistant and on which supervisor and/or the						
7.00	instructions) Standard travel expense rate					9.57	7.00
8.00	Optional travel expense rate per mile					0.00	
		Supervi sors	Therapi sts	Assi stants		Trai nees 5.00	
9.00	Total hours worked	1.00 0.00	2.00	3.00	4.00 00 0.00	0.00	9.00
10. 00	AHSEA (see instructions)	0. 00	78.34		00 0.00	0.00	•
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3,	39. 17	39.17	0.	00		11.00
	one-half of column 3, line 10)						
12.00	Number of travel hours (provider site)	0	0		0		12.00
12.01 13.00	Number of travel hours (offsite) Number of miles driven (provider site)	0	0		0		12.01 13.00
13.01	Number of miles driven (offsite)	0	0		0		13.00
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION					1.00	
14.00	Supervisors (column 1, line 9 times column 1,						14.00
15.00 16.00	Therapists (column 2, line 9 times column 2, Assistants (column 3, line 9 times column 3,					92, 363 0	15.00 16.00
17.00	Subtotal allowance amount (sum of lines 14 ar		ratory therapy	or lines 14	-16 for all	92, 363	
	others)						
18.00 19.00	Aides (column 4, line 9 times column 4, line Trainees (column 5, line 9 times column 5, li					0	18.00
20.00	Total allowance amount (sum of lines 17-19 for		therapy or line	es 17 and 18	3 for all others)	92, 363	
	If the sum of columns 1 and 2 for respiratory	therapy or co	lumns 1-3 for	physical the	erapy, speech path		1
	occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete		no entries on l	lines 21 and	1 22 and enter on	line 23	
21.00	Weighted average rate excluding aides and tra	ainees (line 17		m of columns	and 2, line 9	0.00	21.00
22.00	for respiratory therapy or columns 1 thru 3,						
22.00 23.00	Weighted allowance excluding aides and traine Total salary equivalency (see instructions)	ees (line 2 tim	ies line 21)			0 92, 363	
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW	ANCE AND TRAVE	L EXPENSE COMPL	UTATION - PF	ROVI DER SITE		1
24 00	Standard Travel Allowance Therapists (line 3 times column 2, line 11)					7 149	24.00
24.00	Assistants (line 4 times column 3, line 11)					, 100	
26.00	Subtotal (line 24 for respiratory therapy or					7, 168	26.00
27.00	Standard travel expense (line 7 times line 3 others)	for respirator	y therapy or s	um of lines	3 and 4 for all	1, 751	27.00
28.00	Total standard travel allowance and standard	travel expense	at the provid	er site (sur	n of lines 26 and	8, 919	28.00
	27)	<b>F</b>					1
29.00	Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of		d 2, line 12 )			0	29.00
30.00	Assistants (column 3, line 10 times column 3,		, ,			0	•
31.00	Subtotal (line 29 for respiratory therapy or				w or own of	0	•
32.00	Optional travel expense (line 8 times columns columns 1-3, line 13 for all others)	s i anu z, iine	is for respire	atory therap	by or sum or	0	32.00
33.00	Standard travel allowance and standard travel					8, 919	
34.00	Optional travel allowance and standard travel Optional travel allowance and optional travel					0	•
35.00	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA			/	VICES OUTSIDE PRO		35.00
	Standard Travel Expense						1
36.00 37.00	Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11)					0	•
38.00	Subtotal (sum of lines 36 and 37)					0	
39.00	Standard travel expense (line 7 times the sur		d 6)			0	
10 00	Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2 line 12 (		2 line 10)			0	40.00
40.00	Therapists (sum of columns 1 and 2, line 12.0 Assistants (column 3, line 12.01 times column		∠, rrne IU)			0	
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sur				Louing three Li	0	43.00
	Total Travel Allowance and Travel Expense - C	misite service	s, complete one	e or the tol	Towing three line	:5 44, 45,	
	•						
44.00	or 46, as appropriate. Standard travel allowance and standard travel Optional travel allowance and standard travel					0	44.00 45.00

alth Financial Systems ASONABLE COST DETERMINATION FOR THERAPY SERVICES	FURNISHED BY Provider CCN: 15-1309 Period:		Period:	u of Form CMS-2 Worksheet A-8		
ITSI DE SUPPLI ERS				From 07/01/2020 To 06/30/2021	Parts I-VI Date/Time Pre 11/18/2021 4:4	pared
			9	Speech Pathology		
				-	1.00	
0.00 Optional travel allowance and optional travel	expense (sum o	flines 42 an	d 43 - see in:	structions)		46. (
	Therapi sts	Assistants	Aides	Trai nees	Total	
	1.00	2.00	3.00	4.00	5.00	
PART V - OVERTIME COMPUTATION	0.00	0.00	0.0	0.00	0.00	47.
00 Overtime hours worked during reporting period (if column 5, line 47, is zero or	0.00	0.00	0.0	0.00	0.00	47.
equal to or greater than 2,080, do not						
complete lines 48-55 and enter zero in each						
column of line 56)						
00 Overtime rate (see instructions)	0.00	0.00	0.0	0.00		48.
0.00 Total overtime (including base and overtime	0.00	0.00	0.0	0.00		49.
allowance) (multiply line 47 times line 48)						
CALCULATION OF LIMIT	· · · · · · · · · · · · · · · · · · ·			-		
0.00 Percentage of overtime hours by category	0.00	0.00	0.0	0.00	0.00	50.
(divide the hours in each column on line 47						
by the total overtime worked - column 5,						
.00 Allocation of provider's standard work year	0.00	0.00	0.0	0.00	0.00	51
for one full-time employee times the	0.00	0.00	0.0	0.00	0.00	51.
percentages on line 50) (see instructions)						
DETERMINATION OF OVERTIME ALLOWANCE						
. 00 Adjusted hourly salary equivalency amount	78.34	0.00	0.0	0.00		52.
(see instructions)						
8.00 Overtime cost limitation (line 51 times line	0	0		0 0		53.
52)						
. 00 Maximum overtime cost (enter the lesser of	0	0		0 0		54.
line 49 or line 53) 0.00 Portion of overtime already included in	0	0		0		55.
hourly computation at the AHSEA (multiply	0	0		0		55.
line 47 times line 52)						
0.00 Overtime allowance (line 54 minus line 55 -	0	0		0 0	0	56.
if negative enter zero) ( Enter in column 5						
the sum of columns 1, 3, and 4 for						
respiratory therapy and columns 1 through 3						
for all others.)						
				-	1.00	
Part VI - COMPUTATION OF THERAPY LIMITATION A	ND EXCESS COST /	ADJUSTMENT				
.00 Salary equivalency amount (from line 23)					92, 363	
8.00 Travel allowance and expense - provider site					8, 919	
0.00 Travel allowance and expense - Offsite service	ces (from lines /	44, 45, or 46	)		0	59.
0.00 Overtime allowance (from column 5, line 56)					0	60.
. 00 Equipment cost (see instructions)					0	61.
2.00 Supplies (see instructions)					0	62.
					101, 282 72, 672	
00 Total allowance (sum of lines 57-62)	Nour records)					65.
.00 Total cost of outside supplier services (from	J .	enter zero)				05.
. 00 Total cost of outside supplier services (from 5. 00 Excess over limitation (line 64 minus line 64	J .	enter zero)			0	
<ul> <li>.00 Total cost of outside supplier services (from Excess over limitation (line 64 minus line 65 LINE 33 CALCULATION</li> </ul>	3 - if negative,		Il others			100.
00Total cost of outside supplier services (from Excess over limitation (line 64 minus line 63 LINE 33 CALCULATION00.00Line 26 = line 24 for respiratory therapy or	3 - if negative, sum of lines 24	and 25 for a		others	7, 168	
00Total cost of outside supplier services (from Excess over limitation (line 64 minus line 63 LINE 33 CALCULATION00.00Line 26 = line 24 for respiratory therapy or Line 27 = line 7 times line 3 for respiratory	3 - if negative, sum of lines 24	and 25 for a		others	7, 168 1, 751	100.
00Total cost of outside supplier services (from Excess over limitation (line 64 minus line 63 LINE 33 CALCULATION00.00Line 26 = line 24 for respiratory therapy or	3 - if negative, sum of lines 24	and 25 for a		others	7, 168	100.
.00Total cost of outside supplier services (from Excess over limitation (line 64 minus line 63 LINE 33 CALCULATION00.00Line 26 = line 24 for respiratory therapy or Line 27 = line 7 times line 3 for respiratory Line 33 = line 28 = sum of lines 26 and 27	3 - if negative, sum of lines 24 y therapy or sum	and 25 for a of lines 3 a	nd 4 for all		7, 168 1, 751	100. 100.
.00Total cost of outside supplier services (from Excess over limitation (line 64 minus line 64 LINE 33 CALCULATION00.00Line 26 = line 24 for respiratory therapy or Line 27 = line 7 times line 3 for respiratory0.01Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION01.00Line 27 = line 7 times line 3 for respiratory01.00Line 27 = line 7 times line 3 for respiratory01.00Line 27 = line 7 times line 3 for respiratory01.00Line 27 = line 7 times line 3 for respiratory01.00Line 31 = line 29 for respiratory therapy or	<pre>3 - if negative, sum of lines 24 y therapy or sum y therapy or sum</pre>	and 25 for a of lines 3 a of lines 3 a	nd 4 for all on the second sec		7, 168 1, 751 8, 919 1, 751 0	100. 100. 101. 101.
.00Total cost of outside supplier services (from Excess over limitation (line 64 minus line 64 LINE 33 CALCULATION00.00Line 26 = line 24 for respiratory therapy or Line 27 = line 7 times line 3 for respiratory Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION11.00Line 27 = line 7 times line 3 for respiratory Line 31 = line 29 for respiratory therapy or Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31	<pre>3 - if negative, sum of lines 24 y therapy or sum y therapy or sum</pre>	and 25 for a of lines 3 a of lines 3 a	nd 4 for all on the second sec		7, 168 1, 751 8, 919 1, 751	100. 100. 101. 101.
.00Total cost of outside supplier services (from Excess over limitation (line 64 minus line 64 LINE 33 CALCULATION00.00Line 26 = line 24 for respiratory therapy or Line 27 = line 7 times line 3 for respiratory Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION10.00Line 27 = line 7 times line 3 for respiratory Line 27 = line 7 times line 3 for respiratory Line 31 = line 29 for respiratory therapy or Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION	3 - if negative, sum of lines 24 y therapy or sum y therapy or sum sum of lines 29	and 25 for a of lines 3 an of lines 3 an and 30 for a	nd 4 for all o nd 4 for all o Il others		7, 168 1, 751 8, 919 1, 751 0 1, 751	100. 100. 101. 101. 101.
0.00Total cost of outside supplier services (from Excess over limitation (line 64 minus line 64 LINE 33 CALCULATION $00.00$ Line 26 = line 24 for respiratory therapy or Line 27 = line 7 times line 3 for respiratory Line 33 = line 28 = sum of lines 26 and 27 $10.00$ Line 37 = line 7 times line 3 for respiratory Line 34 CALCULATION $11.00$ Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31 $11.02$ Line 34 = sum of lines 27 and 31 $11.02$ Line 31 = line 29 for respiratory therapy or $12.00$ Line 31 = line 29 for respiratory therapy or	3 - if negative, sum of lines 24 y therapy or sum y therapy or sum sum of lines 29 sum of lines 29	and 25 for a of lines 3 an of lines 3 an and 30 for a and 30 for a	nd 4 for all on a for all on a for all others	others	7, 168 1, 751 8, 919 1, 751 0 1, 751 0 1, 751	100. 100. 101. 101. 101.
.00Total cost of outside supplier services (from Excess over limitation (line 64 minus line 64 LINE 33 CALCULATION00.00Line 26 = line 24 for respiratory therapy or Line 27 = line 7 times line 3 for respiratory Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION10.00Line 27 = line 7 times line 3 for respiratory Line 27 = line 7 times line 3 for respiratory Line 31 = line 29 for respiratory therapy or Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION	3 - if negative, sum of lines 24 y therapy or sum y therapy or sum sum of lines 29 sum of lines 29	and 25 for a of lines 3 an of lines 3 an and 30 for a and 30 for a	nd 4 for all on a for all on a for all others	others	7, 168 1, 751 8, 919 1, 751 0 1, 751 0 1, 751	100. 100. 101. 101. 101.

COST A	Financial Systems LLOCATION - GENERAL SERVICE COSTS	ASCENSION ST.	VINCENT CLAY Provider CO	N. 15 1200	Period:	u of Form CMS Worksheet B	2552-10
CUST P	LEUCATION - GENERAL SERVICE CUSTS		Provider co		From 07/01/2020	Part I	
					To 06/30/2021	Date/Time Pre	
			CAPI TAL REL			11/18/2021 4:	<u>43 pm</u>
			CALLIAL KEL	AILD COSIS			
	Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
		for Cost			BENEFI TS		
		Allocation			DEPARTMENT		
		(from Wkst A					
		col. 7) 0	1.00	2.00	4.00	4A	
	GENERAL SERVICE COST CENTERS	0	1.00	2.00	4.00	47	
1.00	00100 CAP REL COSTS-BLDG & FIXT	405, 627	405, 627				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	529, 823		529, 823	3		2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 168, 420	0	(	0 1, 168, 420		4.00
5.00	00500 ADMINISTRATIVE & GENERAL	5, 475, 383	151, 465	197, 84	1 133, 422	5, 958, 111	5.00
7.00	00700 OPERATION OF PLANT	973, 851	83, 242	108, 73	0 0	1, 165, 823	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	51, 103	8, 700	11, 36	4 0	71, 167	8.00
9.00	00900 HOUSEKEEPI NG	421, 121	4, 825	6, 30	2 0	432, 248	9.00
10.00	01000 DI ETARY	51, 065	10, 717	13, 99	8 0	75, 780	10.00
11.00	01100 CAFETERI A	315, 237	6, 079	7, 94	0 0	329, 256	
13.00	01300 NURSI NG ADMI NI STRATI ON	164, 395	9, 497	12, 40		238, 309	
14.00	01400 CENTRAL SERVICES & SUPPLY	30, 367	0		0 2, 882	33, 249	
15.00	01500 PHARMACY	540, 165	4, 761	6, 21		628, 842	
16.00	01600 MEDICAL RECORDS & LIBRARY	0	42, 209	55, 13	2 0	97, 341	16.00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	002 170	27 400	25 70		1 110 174	
30.00	03000 ADULTS & PEDIATRICS ANCILLARY SERVICE COST CENTERS	803, 170	27, 400	35, 78	9 251, 815	1, 118, 174	30.00
50.00	05000 OPERATING ROOM	443, 822	11, 248	14, 69	2 106, 670	576, 432	50.00
53.00	05300 ANESTHESI OLOGY	443, 022	11, 240		0 0	0,432	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	857, 199	7, 800	10, 18		1, 091, 598	
60.00	06000 LABORATORY	1, 623, 753	6, 379	8, 33		1, 650, 274	
65.00	06500 RESPIRATORY THERAPY	158, 784	7, 692	10, 04		219, 651	
66.00	06600 PHYSI CAL THERAPY	627, 924	0		0 0	627, 924	
67.00	06700 OCCUPATI ONAL THERAPY	189, 691	0	(	0 0	189, 691	
68.00	06800 SPEECH PATHOLOGY	72, 672	0	(	0 0	72, 672	
69.00	06900 ELECTROCARDI OLOGY	87, 293	0	(	0 25, 097	112, 390	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	(	0 0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	129, 448	0	(	0 0	129, 448	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	123, 394	0		0 0	123, 394	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	(	0 0	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	2, 113, 303	22, 570	29, 48	1 247, 477	2, 412, 831	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
118.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	17, 357, 010	404, 584	528, 46	1 1, 168, 420	17, 354, 605	1110 00
110.00	NONREI MBURSABLE COST CENTERS	17, 357, 010	404, 364	526, 40	1, 100, 420	17, 354, 005	1118.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		1,043	1, 36	2 0	2 /05	190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	27, 334	1, 043		0 0	27, 334	
	19300 NONPAI D WORKERS	27, 334	0		0 0		193.00
	19301 MI SSI ON SERVI CES	30	0		0 0		193.00
200.00		50	0	·			200. 00
	,	1					201.00
201.00	Negative Cost Centers		0	(	0 0	0	1201. UL

Heal th	Financial Systems	ASCENSION ST.	VINCENT CLAY		In Lie	u of Form CMS-:	2552-10
COST A	ALLOCATION - GENERAL SERVICE COSTS		Provider C	CN: 15-1309	Period: From 07/01/2020 To 06/30/2021	Worksheet B Part I Date/Time Pre 11/18/2021 4:	
	Cost Center Description	ADMI NI STRATI VE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVIC	HOUSEKEEPI NG	DI ETARY	
		5.00	7.00	8.00	9.00	10.00	
	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 ADMINI STRATI VE & GENERAL	5, 958, 111					5.00
7.00	00700 OPERATION OF PLANT	607, 907	1, 773, 730				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	37, 109	78, 717	186, 99	3		8.00
9.00	00900 HOUSEKEEPI NG	225, 391	43, 652	58	1 701, 872		9.00
10.00	01000 DI ETARY	39, 515	96, 961		0 0	212, 256	10.00
11.00	01100 CAFETERI A	171, 687	54, 999		0 0	0	11.00
13.00	01300 NURSING ADMINISTRATION	124, 264	85, 925		0 0	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	17, 337	0		0 0	0	14.00
15.00	01500 PHARMACY	327, 903	43, 074		0 0	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	50, 757	381, 880		0 0	0	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS					· · ·	
30.00	03000 ADULTS & PEDIATRICS	583, 061	247, 898	32, 77	6 177, 106	212, 256	30.00
	ANCI LLARY SERVICE COST CENTERS	· · · ·					1
50.00	05000 OPERATI NG ROOM	300, 575	101, 767	23, 87	6 112, 582	0	50.00
53.00	05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	569, 203	148, 667	33, 75	7 109, 394	0	54.00
60.00	06000 LABORATORY	860, 519	57, 714		0 29, 508	0	60.00
65.00	06500 RESPI RATORY THERAPY	114, 535	69, 595		0 0	0	65.00
66.00	06600 PHYSI CAL THERAPY	327, 425	149, 246	8, 37	3 0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	98, 912	0			0	67.00
68.00	06800 SPEECH PATHOLOGY	37, 894	0		0 0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	58, 605	0	7, 08	1 0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	67, 499	0		0 0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	64, 343	0		0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
	OUTPATIENT SERVICE COST CENTERS	· · · · · ·					
91.00	09100 EMERGENCY	1, 258, 147	204, 201	67,66	9 164, 062	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS						1
118.00		5, 942, 588	1, 764, 296	176, 20	7 592, 652	212, 256	118.00
	NONREI MBURSABLE COST CENTERS	1 . 1					
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 254	9, 434		0 0		190.00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	14, 253	0				192.00
	19300 NONPAID WORKERS	0	0		0 0		193.00
	19301 MI SSI ON SERVI CES	16	0		0 0	0	193.01
200.00							200.00
201.00		0	0		0 0		201.00
202.00	TOTAL (sum lines 118 through 201)	5, 958, 111	1, 773, 730	186, 99	3 701, 872	212, 256	202.00

Heal th	Financial Systems	ASCENSION ST.	VINCENT CLAY		In Lie	u of Form CMS-	2552-10
	LLOCATION - GENERAL SERVICE COSTS		Provider CC	CN: 15-1309	Peri od:	Worksheet B	
					From 07/01/2020	Part I	
					To 06/30/2021	Date/Time Pre	
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	11/18/2021 4: MEDI CAL	43 pm
	cost center bescription		ADMI NI STRATI ON	SERVICES &	FHARWACT	RECORDS &	
				SUPPLY		LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
	GENERAL SERVICE COST CENTERS	11.00	10.00	11.00	10.00	10.00	
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 ADMINI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9,00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERIA	555, 942					11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	19, 212	467, 710				13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	2, 782	0	53, 30	58		14.00
15.00	01500 PHARMACY	29,414	0	55, 50	0 1, 029, 233		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	27, 414	0		0 1,027,233	529, 978	
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	U 0	0		0 0	527,770	10.00
30, 00	03000 ADULTS & PEDI ATRI CS	139, 780	199, 919		0 0	16, 156	30.00
00.00	ANCI LLARY SERVICE COST CENTERS	107,700	177,717			10, 100	00.00
50.00	05000 OPERATI NG ROOM	60, 019	69, 494		0 0	61, 907	50.00
53.00	05300 ANESTHESI OLOGY	00,017	0,,,,,,		0 0	01, 707	
54.00	05400 RADI OLOGY-DI AGNOSTI C	128, 254	0		0 0	149, 738	
60,00	06000 LABORATORY	12, 852	3, 933		0 0	108, 046	
65.00	06500 RESPI RATORY THERAPY	24, 644	0, 700		0 0	6, 185	
66,00	06600 PHYSI CAL THERAPY	21,011	0		0 0	26, 331	
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0 0	6, 587	
68.00	06800 SPEECH PATHOLOGY	0	0		0 0	2, 495	
69.00	06900 ELECTROCARDI OLOGY	15, 369	2.795		0 0	22, 548	
70.00	07000 ELECTROENCEPHALOGRAPHY	0	2, 7,0		0 0	0 10	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	53, 30		0	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	00, 00	0 0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 1,029,233	0	
75.00	OUTPATIENT SERVICE COST CENTERS	V	0		1,027,235	0	/ 5. 00
91,00	09100 EMERGENCY	123, 616	191, 569		0 0	129, 985	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	125,010	171, 307		0	127,700	92.00
72.00	SPECIAL PURPOSE COST CENTERS						/2.00
118.00		555, 942	467, 710	53, 30	1, 029, 233	529, 978	1118 00
110.00	NONREI MBURSABLE COST CENTERS	333, 742	407,710	55, 50	1, 027, 233	527,770	1110.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190.00
	19200 PHYSI CLANS' PRI VATE OFFICES	0	0		0 0		192.00
	19300 NONPALD WORKERS	0	0		0 0		193.00
	19301 MI SSI ON SERVI CES	0	0		0 0		193.00
200.00		0	0			0	200.00
200.00		0	0		0 0	Ω	201.00
201.00	5	555, 942	467, 710	53, 30	-		•
202.00		000, 742	107,710	55, 50	1, 02 7, 200	027,770	202.00

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	ASCENSION ST. V	Provider CC	N: 15-1309	Peri od:	u of Form CMS-2552 Worksheet B
					From 07/01/2020 To 06/30/2021	Part I Date/Time Prepare 11/18/2021 4:43 p
	Cost Center Description	Subtotal	Intern &	Total		
		R	esidents Cost			
			& Post			
			Stepdown			
		04.00	Adjustments			
		24.00	25.00	26.00		
. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT		I			1.
. 00	00200 CAP REL COSTS-BEDG & TTXT					2
. 00	00400 EMPLOYEE BENEFITS DEPARTMENT					4.
. 00	00500 ADMI NI STRATI VE & GENERAL					5.
. 00	00700 OPERATION OF PLANT					7.
3.00	00800 LAUNDRY & LINEN SERVICE					8
. 00	00900 HOUSEKEEPI NG					9.
0.00	01000 DI ETARY					10.
1.00	01100 CAFETERI A					11.
3.00	01300 NURSI NG ADMI NI STRATI ON					13.
4.00	01400 CENTRAL SERVICES & SUPPLY					14.
5.00	01500 PHARMACY					15.
6.00	01600 MEDICAL RECORDS & LIBRARY					16.
	INPATIENT ROUTINE SERVICE COST CENTERS					
0. 00	03000 ADULTS & PEDIATRICS	2, 727, 126	0	2, 727, 1	26	30.
	ANCILLARY SERVICE COST CENTERS					
0. 00	05000 OPERATING ROOM	1, 306, 652	0	1, 306, 6	52	50.
3.00	05300 ANESTHESI OLOGY	0	0		0	53.
4.00	05400 RADI OLOGY-DI AGNOSTI C	2, 230, 611	0	2, 230, 6	11	54.
0.00	06000 LABORATORY	2, 722, 846	0	2, 722, 8		60.
5.00	06500 RESPI RATORY THERAPY	434, 610	0	434,6		65.
6.00	06600 PHYSI CAL THERAPY	1, 139, 299	0	1, 139, 2		66.
7.00	06700 OCCUPATI ONAL THERAPY	297, 284	0	297, 2		67.
	06800 SPEECH PATHOLOGY	113,061	0	113, 0		68.
	06900 ELECTROCARDI OLOGY	218, 788	0	218, 7		69.
0.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0	70.
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	250, 315	0	250, 3		71.
	07200 I MPL. DEV. CHARGED TO PATIENTS	187,737	0	187, 7		72.
3.00	07300 DRUGS CHARGED TO PATIENTS	1, 029, 233	0	1, 029, 2	33	73.
1.00	OUTPATIENT SERVICE COST CENTERS	4, 552, 080	0	4, 552, 0	200	91.
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	4, 552, 080	0	4, 552, 0	180	91.
2.00	SPECIAL PURPOSE COST CENTERS		0			92.
18. OC		17, 209, 642	0	17, 209, 6	42	118.
10.00	NONREIMBURSABLE COST CENTERS	17,207,042	0	17,207,0		
90 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	13,093	0	13, 0	03	190.
	19200 PHYSI CLANS' PRI VATE OFFICES	161, 593	0	161, 5		190.
	19300 NONPALD WORKERS	101, 375	0	101, 5	0	192.
	19301 MI SSI ON SERVI CES	46	0		46	193.
00. OC		0	0		0	200
00.0C 01.0C	5	0	0		0	200.
202.00	5	17, 384, 374	0	17, 384, 3	-	201.

ALLOCATION OF CAPITAL BELATED COSTS         Provider COX: 15-1309         Provider COX: 15-1309         Provider COX: 15-1309         Worksheet B From 07/01/2001         Worksheet B From 07/01/2001                EVENCE Cost Center Description               Directly Assigned Mere Bel and 0.000              CAPITAL RELATED COSTS               EVENCE BOUNCE		nancial Systems	ASCENSION ST.				u of Form CMS-	2552-10
Cost Center Description         Directly Assigned New Capital         BLDG & FIXT         NVBLE EQUIP         Subtotal         EMPLOYEE BENERAL SERVICE COST CENTERS           1.00         CONDOL CAP REL 000000 CAP REL 2.00         COST CENTERS         1.00         2.00         2A         4.00           1.00         CONDOL CAP REL 2.00         COST CENTERS         0         <	ALLOCATIO	ON OF CAPITAL RELATED COSTS				From 07/01/2020	Part II Date/Time Pre	epared: 43 pm
EXEMPTION         Assigned New Capital Related Costs         Service 0         DEMENTIS DEPARTMENT           0         0.000         2.00         2A         4.00           0         0.0000         CAP REL COSTS-FURGE         1.00         2.00         2.00         2.00           0.00000         CAP REL COSTS-WARE FOULP         0         1.00         2.00         2.00         2.00         2.00           0.00000         CAP REL COSTS-WARE FOULP         0         0.0000         0.000000         0.000000000				CAPI TAL REL	ATED COSTS			
O         1.00         2.00         2A         4.00           ION OCAP REL COST CENTERS         1.00         2.00         0.00 <td></td> <td>Cost Center Description</td> <td>Assigned New Capital</td> <td>BLDG &amp; FIXT</td> <td>MVBLE EQUIP</td> <td>Subtotal</td> <td><b>BENEFITS</b></td> <td></td>		Cost Center Description	Assigned New Capital	BLDG & FIXT	MVBLE EQUIP	Subtotal	<b>BENEFITS</b>	
1.00       00100 CAP REL COSTS-MUGE & FIXT       0				1.00	2.00	2A	4.00	
2.00         00200 CAP REL COSTS-MUBLE EQUIP         2.00           0.00         00500 ADM IN STRATI VE & CENERAL         545, 130         151, 465         197, 841         894, 436         0         5.00           0.00         00500 ADM IN STRATI VE & CENERAL         545, 130         151, 465         197, 841         894, 436         0         7.00           0.00         00500 ADM IN STRATI VE & CENERAL         0         8, 700         11.3.64         20, 064         0         8.00           0.00         00900 HUSE KEEPI NG         0         4, 825         6, 302         11, 127         0         9.00           0.1000 DIETARY         0.1000 KISI NS ADM IN STRATI ON         0         6, 079         7, 940         14, 019         11.00         11.00           0.1100 OLETERI A         SERVI CES & SUPPLY         0         0         0         0         14.00         14.00         15.00 <t< td=""><td>GEI</td><td>NERAL SERVICE COST CENTERS</td><td></td><td></td><td></td><td></td><td></td><td></td></t<>	GEI	NERAL SERVICE COST CENTERS						
4.00         00400         EMPLIPTIS DEPARTMENT         0	1.00 00	100 CAP REL COSTS-BLDG & FIXT						1.00
5.00         005500         ADMI IN STRATI VE & GENERAL         545, 130         151, 445         197, 841         894, 436         0         5.00           00         00700         OPERATI ON OF PLANT         0         83, 242         108, 730         191, 972         0         7.00           0.00         00000         HUINDRY & LINEN SERVICE         0         8, 700         11, 364         20, 064         0         8.00           0.00         00000         HEINEN SERVICE         0         0, 7, 940         11, 019         11.00           0.10         01000         CAFERIA         0         0, 79, 940         14, 019         11.00           0.10         01000         CAFERIAL SERVICES & SUPLY         0         0         0         0         13.00           0.10         01400         CALARY SERVICE COST CENTERS         0         27,400         35,789         63,189         0         0.00         <	2.00 00	200 CAP REL COSTS-MVBLE EQUIP						2.00
7.00         00700         0PERATION OF PLANT         00         83,220         108,730         191,972         0         7.00           00         00900         HUNENS & LINENS SERVICE         0         8.700         11,364         20.064         0         8.00         9.00         00900         HUNESKEEPING         0         4.825         6.302         11,127         0         9.00           10.00         01000         DIETARY         0         16.017         7.398         24,715         0         10.00           11.00         01100         CAFETERIA         0         6.079         7.40         14.1019         0         11.00           13.00         01300         VENTCE SUPLY         0         0         0         0         14.00         13.00           14.00         01400         CENTRAL SECORDS & LIBRARY         0         4,71         6,219         10,980         15.0	4.00 00	400 EMPLOYEE BENEFITS DEPARTMENT	0	0		0 0	0	4.00
8.00       000800       LAUNDRY & LINEN SERVICE       0       8.700       11.364       20.064       0       8.00         9.00       00900       HUSEKEEPING       0       4.825       6.302       11.127       0       9.00         10.00       01100       CAFETERIA       0       6.079       7.940       14.019       0       11.00         11.00       01100       CAFETERIA       0       9.07       0       0       0       11.00         11.00       01400       CENTRAL SERVICES & SUPPLY       0       0       0       0       14.00       0       15.00       16.00       16.00       16.00       16.00       16.00       16.00       16.00       16.00       16.00       16.00       16.00       16.00       16.00	5.00 00	500 ADMI NI STRATI VE & GENERAL	545, 130	151, 465	197, 84	894, 436	0	5.00
8.00       000800       LAUNDRY & LINEN SERVICE       0       8.700       11.364       20.064       0       8.00         9.00       00900       HUSEKEEPING       0       4.825       6.302       11.127       0       9.00         10.00       01100       CAFETERIA       0       6.079       7.940       14.019       0       11.00         11.00       01100       CAFETERIA       0       9.07       0       0       0       11.00         11.00       01400       CENTRAL SERVICES & SUPPLY       0       0       0       0       14.00       0       15.00       16.00       16.00       16.00       16.00       16.00       16.00       16.00       16.00       16.00       16.00       16.00       16.00       16.00	7.00 00	700 OPERATION OF PLANT	0	83, 242	108.73	191, 972	0	7.00
9.00         00900         HOUSEKEEPING         0         4.825         6.302         11.127         0         9.00           10.00         01000         DIETARY         0         10.717         13.998         24,715         0         10.00           11.00         01100         CAFETERIA         0         6.079         7,940         14,019         0         11.00           13.00         01300         NURSING ADMINISTRATION         0         9.00         0         0         0         13.00           14.00         14000         CENTRAL SERVICES & SUPPLY         0         0         0         0         0         15.00         15.00         0         0         15.00         15.00         15.00         15.00         15.00         14.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         50.00 <td></td> <td></td> <td>0</td> <td></td> <td></td> <td></td> <td></td> <td></td>			0					
10.00       01000       DETARY       0       10.717       13.998       24,715       0       10.00       011.00       011.00       011.00       011.00       011.00       011.00       011.00       011.00       011.00       011.00       011.00       011.00       011.00       014.00       0       0.997       12.405       21.902       0       13.00       13.00       13.00       014.00       0       0       0       0       0       0       14.00       0       0       0       0       0       14.00       0       0       0       0       0       13.00       014.00       0       0       0       0       0       0       0       14.00       0       0       0       0       0       14.00       0       14.00       0       14.00       0       14.00       0       14.00       0       14.00       0       14.00       0       14.00       0       14.00       0       14.01       14.092       25.940       0       5.00       5.00       5.00       54.00       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0			0					
11.00       01100       CAFETERIA       0       6,079       7,940       14,019       0       11.00         13.00       01300       NURSI NG ADMINI STRATION       0       9,497       12,405       21,902       0       13.00         14.00       1400       CENTRAL SERVICES & SUPPLY       0       4,761       6,219       10,980       0       15.00         15.00       01500       MARIANCY       0       42,209       55,132       97,341       0       16.00         10.00       0000 ADULTS & SERVICE COST CENTERS       0       27,400       35,789       63,189       0       30.00         00       00000 ADULTS & SERVICE COST CENTERS       0       11,248       14,692       25,940       0       53.00       53.00       53.00       53.00       53.00       63.189       0       54.00       60.00       6000       6000       6000       6000       66.00       67.00       0       0 <td< td=""><td></td><td></td><td>0</td><td>-</td><td></td><td></td><td></td><td></td></td<>			0	-				
13.00         OISSIO RESING ADMINISTRATION         0         9,497         12,405         21,902         0         13.00           14.00         01400 CENTRAL SERVICES & SUPPLY         0         0         0         0         0         0         0         0         0         0         0         14.00         13.00         0			0					
14.00       OINTAL SERVICES & SUPPLY       0       0       0       0       0       0       0       0       0       14.00         15.00       01500       PHARMACY       0       4,761       6,219       10,980       0       15.00         16.00       01600       MEDICAL RECORDS & LIBRARY       0       42,209       55,132       97,341       0       16.00         00       0000       ADULTS & PEDIATRICS       0       27,400       35,769       63,189       0       30.00         ANCILLARY SERVICE COST CENTERS       0       0       0       0       0       0       0       53.00       0       50.00       54.00       0       0       0       0       54.00       0       54.00       65.00       65.00       65.00       65.00       65.00       65.00       65.00       65.00       65.00       65.00       65.00       66.00       67.00       0       0       0       65.00       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       67.00       67.00       67.00       67.00       67.00       67.00       67.00			0					
15.00         O1500         PHARMACY         0         4,761         6,219         10,980         0         15.00           16.00         O1600         MEDICAL         RECORDS & LIBRARY         0         42,209         55,132         97,341         0         16.00           10.01         O3000         ADULTS & PEDIATRICS         0         27,400         35,789         63,189         0         16.00           ANCILLARY SERVICE COST CENTERS         0         11,248         14,692         25,940         0         53.00         53.00         05300         ANCILLARY SERVICE COST CENTERS         0         0         0         0         53.00         0         54.00         53.00         0         0         0         0         53.00         54.00         54.00         55.00         56.00         66.00         66.00         66.00         66.00         66.00			0		12,40		-	
16.00       01600 MEDI CAL RECORDS & LI BRARY       0       42, 209       55, 132       97, 341       0         1NPAT LENT ROUTINE SERVICE COST CENTERS       0       27, 400       35, 789       63, 189       0       0       00       00       0000 OPERATING ROUTINE SERVICE COST CENTERS       0       27, 400       35, 789       63, 189       0 <td></td> <td></td> <td>0</td> <td>-</td> <td></td> <td></td> <td></td> <td></td>			0	-				
INPATIENT ROUTINE SERVICE COST CENTERS         0         27,400         35,789         63,189         0         0         00 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>								
30.00         3000         ADULTS & PEDIATRICS         0         27,400         35,789         63,189         0         30.00           ANCILLARY SERVICE COST CENTERS         0         11,248         14,692         25,940         50.00         50.00         50.00         0         0         0         50.00         50.00         0         0         0         50.00         0         0         0         50.00         50.00         0         0         0         50.00         50.00         0         0         0         0         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         53.00         63.3189         0         50.00         53.00         50.00			0	42, 209	55, 13	32 97, 341	0	16.00
ANCI LLARY SERVICE COST CENTERS           50.00         OSG00         OPERATING ROOM         0         11,248         14,692         25,940         0         50.00           53.00         05300         ANESTHESI OLOGY         0         0         0         0         0         53.00           54.00         05400         RADI OLOGY-DI AGNOSTI C         0         7,800         10,189         17,989         54.00           60.00         06000         LABORATORY         0         6,379         8,332         14,711         0         65.00           66.00         06500         RESPI RATORY THERAPY         0         7,692         10,047         17,739         66.50           66.00         06600         PHYSI CAL THERAPY         0         0         0         0         66.00           66.00         06600         SPECH PATHOLOGY         0         0         0         66.00         68.00           69.00         06600         SPECH PATHOLOGY         0         0         0         0         0         69.00           0         0         0         0         0         0         0         0         71.00           71.00         07100			i					
50.00       05000       0PERATI NG ROOM       0       11, 248       14, 692       25, 940       0       50.00         53.00       05300       ANESTHESI OLOGY       0       0       0       0       53.00         54.00       05400       RAD IOGY-DI ARNOSTI C       0       7, 800       10, 189       17, 989       0       54.00         60.00       06000       LABORATORY       0       6, 379       8, 332       14, 711       0       60.00         65.00       06500       RESPI RATORY THERAPY       0       7, 692       10, 047       17, 739       0       65.00         66.00       06000       OCCUPATI ONAL THERAPY       0       0       0       0       0       66.00         67.00       06700       0CCUPATI ONAL THERAPY       0       0       0       0       67.00       68.00       0       0       0       0       68.00       0       68.00       0       69.00       69.00       69.00       69.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       0       0       0       71.00       70.00       71.00       0       0       0       0       <	30.00 03	000 ADULTS & PEDIATRICS	0	27, 400	35, 78	39 63, 189	0	30.00
53.00       05300       ANESTHESI OLOGY       0       0       0       0       53.00         54.00       05400       RADI OLOGY-DI AGNOSTI C       0       7,800       10,189       17,989       0       54.00         60.00       06000       LABORATORY       0       63.37       8,332       14,711       0       60.00         65.00       06500       RESPI RATORY THERAPY       0       7,692       10,047       17,739       6       65.00         66.00       06600       PHYSI CAL THERAPY       0       0       0       0       66.00       67.00       60.00       67.00       60.00       67.00       60.00       67.00       60.00       67.00       60.00       67.00       60.00       67.00       60.00       67.00       60.00       60.00 <t< td=""><td>ANG</td><td>CILLARY SERVICE COST CENTERS</td><td></td><td></td><td></td><td></td><td></td><td></td></t<>	ANG	CILLARY SERVICE COST CENTERS						
54.00       05400       RADI OLOGY-DI AGNOSTI C       0       7,800       10,189       17,989       0       54.00         60.00       06000       LABORATORY       0       6,379       8,332       14,711       0       60.00         65.00       05500       RESPI RATORY THERAPY       0       7,692       10,047       17,739       0       65.00         66.00       06600       PHYSI CAL THERAPY       0       0       0       0       0       66.00         67.00       06600       SPEECH PATHOLOGY       0       0       0       0       68.00       06800       SPEECH PATHOLOGY       0       0       0       0       68.00       06900       10,047       17,739       0       68.00       06900       0       0       0       0       68.00       06900       10,047       10,047       0       0       0       69.00       0	50.00 05	000 OPERATING ROOM	0	11, 248	14, 69	25, 940	0	50.00
60.00         06000         LABORATORY         0         6, 379         8, 332         14, 711         0         60.00           65.00         06500         RESPI RATORY THERAPY         0         7, 692         10, 047         17, 739         0         65.00           67.00         06700         0CUPATI ONAL THERAPY         0         0         0         0         65.00           68.00         06800         SPEECH PATHOLOGY         0         0         0         0         68.00           69.00         06900         ELECTROCARDIOLOGY         0         0         0         0         69.00           0.00         07000         ELECTROENCEPHALOGRAPHY         0         0         0         0         70.00         71.00         71.00         70.00         0         0         71.00         72.00         72.00         0         0         0         0         72.00         72.00         72.00         72.00         0         0         0         0         73.00         0         0         0         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< td=""><td>53.00 05</td><td>300 ANESTHESI OLOGY</td><td>0</td><td>0</td><td></td><td>0 0</td><td>0</td><td>53.00</td></td<>	53.00 05	300 ANESTHESI OLOGY	0	0		0 0	0	53.00
65.00         06500         RESPI RATORY THERAPY         0         7,692         10,047         17,739         0         65.00           66.00         06600         PHYSI CAL THERAPY         0         0         0         0         66.00         0         0         0         0         66.00         0         0         0         0         0         66.00         0         0         0         0         0         0         0         66.00         0         0         0         0         0         0         0         0         0         66.00         0	54.00 05	400 RADI OLOGY-DI AGNOSTI C	0	7, 800	10, 18	39 17, 989	0	54.00
65.00         06500         RESPI RATORY THERAPY         0         7,692         10,047         17,739         0         65.00           66.00         06600         PHYSI CAL THERAPY         0         0         0         0         66.00         0         0         0         0         66.00         0         0         0         0         0         66.00         0         0         0         0         0         0         0         66.00         0         0         0         0         0         0         0         0         0         66.00         0	60.00 06	000 LABORATORY	o	6, 379	8, 33	32 14, 711	0	60,00
66.00         06600         PHYSI CAL THERAPY         0         0         0         0         66.00           67.00         0CCUPATI ONAL THERAPY         0         0         0         0         66.00           68.00         0SE0C         PATHOLOGY         0         0         0         67.00         0         0         67.00         0         0         0         67.00         0         0         0         67.00         0         0         0         0         0         0         67.00         0         0         0         0         66.00         67.00         0         0         0         0         67.00         0         0         0         0         67.00         0         0         0         67.00         67.00         0			0				0	65.00
67.00         06700         OCUPATIONAL THERAPY         0         0         0         0         67.00         68.00         70.00         70.00         70.00         70.00         70.00         70.00         71.00         0         72.00         72.00         72.00         72.00         72.00         72.00         72.00         72.00         72.00         72.00         72.00         72.00         72.00         72.00         72.00			0	0				•
68.00         06800         SPECH         PATHOLOGY         0         0         0         0         68.00         68.00         69.00         06900         ELECTROCARDIOLOGY         0         0         0         0         0         0         69.00         0			0	0		0	-	
69.00         06900         ELECTROCARDIOLOGY         0 <td></td> <td></td> <td>0</td> <td>0</td> <td></td> <td>s</td> <td>-</td> <td></td>			0	0		s	-	
70.00         07000         ELECTROENCEPHALOGRAPHY         0         0         0         0         70.00         70.00           71.00         07100         MEDI CAL SUPPLIES CHARGED TO PATIENTS         0 <td></td> <td></td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td></td> <td></td>			0	0		0 0		
71.00         07100         MEDI CAL SUPPLIES CHARGED TO PATIENTS         0         0         0         0         71.00           72.00         07200         IMPL. DEV. CHARGED TO PATIENTS         0         0         0         0         0         72.00           73.00         07300         DRUGS CHARGED TO PATIENTS         0         0         0         0         0         72.00           0100         DUTPATIENT SERVICE COST CENTERS         0 </td <td></td> <td></td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td>-</td> <td></td>			0	0		0 0	-	
72.00         07200         IMPL.         DEV.         CHARGED TO PATIENTS         0         0         0         0         72.00           73.00         07300         DRUGS CHARGED TO PATIENTS         0         0         0         0         0         73.00           0UTPATIENT SERVICE COST CENTERS         0         0         0         0         0         0         0         0         0         91.00         91.00         90100         EMERGENCY         0         91.00         92.00         09200         0BSERVATION BEDS (NON-DISTINCT PART)         0         92.00         92200         085EVATION BEDS (NON-DISTINCT PART)         0         92.00         92.00         92000         GIFT, FLOWER, COST CENTERS         0         0         92.00         92000         GIFT, FLOWER, COFFEE SHOP & CANTEEN         0         1,043         1,362         2,405         0         190.00         192.00         192.00         192.00         192.00         192.00         192.00         0         0         0         192.00         0         0         192.00         192.00         192.00         193.00         193.00         193.00         193.00         193.00         0         0         0         192.00         193.00         0			0	0		0 0	-	
73.00         07300         DRUGS CHARGED TO PATIENTS         0         0         0         0         73.00           OUTPATIENT SERVICE COST CENTERS         91.00         09100         EMERGENCY         0         22,570         29,481         52,051         0         91.00         92.00         09200         OBSERVATION BEDS (NON-DISTINCT PART)         0         0         92.00         92.00         0000 (DISTINCT PART)         0         0         92.00         92.00         0000 (DISTINCT PART)         0         92.01         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         92.00         92.00         92.00         92			0	0				
OUTPATIENT SERVICE COST CENTERS           91.00         09100         EMERGENCY         0         22,570         29,481         52,051         0         91.00         92.00         92.00         09200         OBSERVATION BEDS (NON-DISTINCT PART)         0         22,570         29,481         52,051         0         92.00         92.00         92.00         92.00         92.00         SPECIAL PURPOSE COST CENTERS         0         10.00         92			Ŭ	0				
91.00         09100         EMERGENCY         0         22,570         29,481         52,051         0         91.00         92.00           92.00         09200         0BSERVATI ON BEDS (NON-DI STI NCT PART)         0         0         92.00         92.00         0BSERVATI ON BEDS (NON-DI STI NCT PART)         0         92.00			0	0		0 0	0	73.00
92.00         09200         0BSERVATI ON BEDS (NON-DI STI NCT PART)         0         92.00           SPECIAL PURPOSE COST CENTERS           118.00         SUBTOTALS (SUM OF LINES 1 through 117)         545,130         404,584         528,461         1,478,175         0         118.00           NONREL MBURSABLE COST CENTERS           190.00         19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN         0         1,043         1,362         2,405         0         190.00         192.00           192.00         19300         NONPAI D WORKERS         0         0         0         0         192.00         19301         NISSION SERVICES         0         0         0         193.00         19301         NISSION SERVICES         0         0         0         193.01         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         201.00         0         0         0         201.00								
SPECIAL PURPOSE COST CENTERS           SPECIAL PURPOSE COST CENTERS         SUBTOTALS (SUM OF LINES 1 through 117)         545, 130         404, 584         528, 461         1, 478, 175         0         118. 00           118.00         SUBTOTALS (SUM OF LINES 1 through 117)         545, 130         404, 584         528, 461         1, 478, 175         0         118. 00           190.00         190000         GIFT, FLOWER, COFFEE SHOP & CANTEEN         0         1, 043         1, 362         2, 405         0         190. 00           192.00         19200         PHYSI CI ANS' PRI VATE OFFI CES         0         0         0         192. 00         193.00         19300         19300         19300         19300         19301         NI SSI ON SERVI CES         0         0         0         0         193.00           200.00         Cross Foot Adjustments         0         0         0         200. 00         200. 00         200. 00         200. 00         0         0         200. 00			0	22, 570	29, 48		0	
SUBTOTALS         SUBTOTALS <t< td=""><td>92.00 09</td><td>200 OBSERVATION BEDS (NON-DISTINCT PART)</td><td></td><td></td><td></td><td>0</td><td></td><td>92.00</td></t<>	92.00 09	200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
NONRE         IMBURSABLE         COST         CENTERS           190.00         19000         GI FT,         FLOWER,         COFFEE         SHOP & CANTEEN         0         1,043         1,362         2,405         0         190.00           192.00         19200         PHYSI CI ANS'         PRI VATE         OFFICES         0         0         0         0         192.00           193.00         19300         NONPAI D         WORKERS         0         0         0         193.00         19301         MI SSI ON SERVI CES         0         0         0         193.01         200.00         Cross Foot Adjustments         0         200.00         200.00         200.00         201.00         0         0         0         201.00	SPI	ECIAL PURPOSE COST CENTERS				-		
190.00         190.00         GI FT, FLOWER, COFFEE SHOP & CANTEEN         0         1,043         1,362         2,405         0         190.00           192.00         19200         PHYSI CI ANS' PRI VATE OFFICES         0         0         0         0         192.00           193.00         19300         NONPAI D WORKERS         0         0         0         0         193.00           193.01         19301         MI SSI ON SERVI CES         0         0         0         0         193.01           200.00         Cross Foot Adj ustments         0         0         0         200.00         200.00         201.00         0         0         0         201.00	118.00	SUBTOTALS (SUM OF LINES 1 through 117)	545, 130	404, 584	528, 46	51 1, 478, 175	0	118.00
192.00       19200       PHYSI CI ANS' PRI VATE OFFICES       0       0       0       192.00         193.00       19300       NONPAI D WORKERS       0       0       0       0       193.00         193.01       19301       MISSI ON SERVICES       0       0       0       0       193.01         200.00       Cross Foot Adjustments       0       0       0       200.00         201.00       Negative Cost Centers       0       0       0       0       201.00	NO	NREIMBURSABLE COST CENTERS						
192.00       19200       PHYSI CI ANS' PRI VATE OFFICES       0       0       0       192.00         193.00       19300       NONPAI D WORKERS       0       0       0       0       193.00         193.01       19301       MISSI ON SERVICES       0       0       0       0       193.01         200.00       Cross Foot Adjustments       0       0       0       200.00         201.00       Negative Cost Centers       0       0       0       0       201.00			0	1,043	1, 36	2, 405	0	190.00
193.00         19300         NONPAID         WORKERS         0         0         0         193.00         193.00         193.01         193.01         193.01         193.01         NISSION SERVICES         0         0         0         0         193.01         193.01         193.01         Number of the second sec			-	-				
193.01       19301       MISSION SERVICES       0       0       0       193.01         200.00       Cross Foot Adjustments       0       0       200.00       200.00         201.00       Negative Cost Centers       0       0       0       0       201.00			0	0		0 0		
200.00         Cross Foot Adjustments         0         200.00           201.00         Negative Cost Centers         0         0         0         0         201.00			0	0				
201.00 Negative Cost Centers 0 0 0 0 201.00			0	0			0	
				~			~	
202. 00    101AE (Sulli 111165 116 tili 00gli 201)   545, 130  405, 627  529, 823  1, 480, 580  0 202. 00		5	E / E 100		E00.07			
	202.00	TOTAL (Sum TIMES TTO LITTOUGH 201)	545, 130	405, 627	J 529, 82	1, 480, 580	0	1202.00

Heal th	Financial Systems	ASCENSION ST. \	/INCENT CLAY		In Lie	u of Form CMS-:	2552-10
ALLOCA	ATION OF CAPITAL RELATED COSTS		Provider C	CN: 15-1309	Period: From 07/01/2020 To 06/30/2021	Worksheet B Part II Date/Time Pre 11/18/2021 4:	
	Cost Center Description	ADMI NI STRATI VE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVIC	HOUSEKEEPI NG E	DI ETARY	
		5.00	7.00	8.00	9.00	10.00	
	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 ADMI NI STRATI VE & GENERAL	894, 436					5.00
7.00	00700 OPERATION OF PLANT	91, 259	283, 231				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	5, 571	12, 570	38, 20	)5		8.00
9.00	00900 HOUSEKEEPI NG	33, 836	6, 970	11	9 52, 052		9.00
10.00	01000 DI ETARY	5, 932	15, 483		0 0	46, 130	10.00
11.00	01100 CAFETERI A	25, 774	8, 782		0 0	0	11.00
13.00	01300 NURSING ADMINISTRATION	18, 655	13, 721		0 0	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	2,603	0		0 0	0	14.00
15.00	01500 PHARMACY	49, 225	6, 878		0 0	0	15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	7,620	60, 979		0 0	0	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS	· · · ·					1
30.00	03000 ADULTS & PEDIATRICS	87, 530	39, 585	6, 69	7 13, 135	46, 130	30.00
	ANCI LLARY SERVICE COST CENTERS	· · · ·					1
50.00	05000 OPERATI NG ROOM	45, 123	16, 250	4, 87	8, 349	0	50.00
53.00	05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	85, 449	23, 739	6, 89	8, 113	0	54.00
60.00	06000 LABORATORY	129, 182	9, 216	1	0 2, 188	0	60.00
65.00	06500 RESPI RATORY THERAPY	17, 194	11, 113	1	0 0	0	65.00
66.00	06600 PHYSI CAL THERAPY	49, 153	23, 832	1, 71	1 0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	14, 849	0			0	67.00
68.00	06800 SPEECH PATHOLOGY	5, 689	0		0 0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	8, 798	0	1, 44	7 0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	10, 133	0		0 0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	9,659	0		0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
	OUTPATIENT SERVICE COST CENTERS						1
91.00	09100 EMERGENCY	188, 872	32, 607	13, 82	4 12, 167	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS						1
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	892, 106	281, 725	36, 00	43, 952	46, 130	118.00
100.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	188	1, 506		0 0	0	190.00
	19000 GIFT, PLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CLANS' PRI VATE OFFI CES	2, 140	1, 508				190.00
	19200 PHYSICIANS PRIVATE OFFICES	2, 140	0	_,			192.00
	1 19300 NONPALD WORKERS	0	0		0 0		
		2	0		0	0	193.01
200.00	5		0		0	0	200.00
201.00	5	004 404	0	20.00			201.00
202.00	)   TOTAL (sum lines 118 through 201)	894, 436	283, 231	38, 20	52, 052	46, 130	∠UZ. UU

Heal th	Financial Systems	ASCENSI ON ST.	VINCENT CLAY		In Lie	u of Form CMS-	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider CC	CN: 15-1309	Peri od:	Worksheet B	
					From 07/01/2020 To 06/30/2021	Part II Date/Time Pre	nored
					10 00/30/2021	11/18/2021 4:	
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
			ADMI NI STRATI ON	SERVICES &		RECORDS &	
				SUPPLY		LI BRARY	
		11.00	13.00	14.00	15.00	16.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERI A	48, 575					11.00
13.00	01300 NURSING ADMINISTRATION	1, 679	55, 957				13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	243	0	2, 84	46		14.00
15.00	01500 PHARMACY	2, 570	0		0 69, 653		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0		0 0	165, 940	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	12, 213	23, 920		0 0	5, 059	30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	5, 244	8, 314		0 0	19, 384	50.00
53.00	05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	11, 206	0		0 0	46, 879	54.00
60.00	06000 LABORATORY	1, 123	470		0 0	33, 831	60.00
65.00	06500 RESPI RATORY THERAPY	2, 153	0		0 0	1, 937	65.00
66.00	06600 PHYSI CAL THERAPY	0	0		0 0	8, 245	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0		0 0	2, 063	67.00
68.00	06800 SPEECH PATHOLOGY	0	0		0 0	781	68.00
69.00	06900 ELECTROCARDI OLOGY	1, 343	334		0 0	7, 060	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	2, 84	46 0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 69, 653	0	73.00
	OUTPATIENT SERVICE COST CENTERS						1
91.00	09100 EMERGENCY	10, 801	22, 919		0 0	40, 701	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	48, 575	55, 957	2, 84	46 69, 653	165, 940	118.00
	NONREI MBURSABLE COST CENTERS						
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190.00
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0	0	192.00
193.00	19300 NONPAI D WORKERS	0	0		0 0	0	193.00
193.01	19301 MISSION SERVICES	0	0		0 0	0	193. 01
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0		0 0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	48, 575	55, 957	2, 84	46 69, 653	165, 940	202.00
			-				

	Financial Systems TION OF CAPITAL RELATED COSTS	ASCENSION ST.	Provi der C	N. 15-1309	Peri od:	u of Form CMS-2552 Worksheet B
LLOON					From 07/01/2020 To 06/30/2021	Part II Date/Time Prepare 11/18/2021 4:43
	Cost Center Description	Subtotal	Intern &	Total		
			Residents Cost			
			& Post			
			Stepdown			
		24.00	Adjustments	24.00		
	GENERAL SERVICE COST CENTERS	24.00	25.00	26.00		
1.00	00100 CAP REL COSTS-BLDG & FIXT			[		1
2.00	00200 CAP REL COSTS-BEDG & TTXT					2
1.00	00400 EMPLOYEE BENEFITS DEPARTMENT					4
5.00	00500 ADMINI STRATI VE & GENERAL					5
7.00	00700 OPERATION OF PLANT					7
3.00	00800 LAUNDRY & LINEN SERVICE					8
9.00	00900 HOUSEKEEPING					9
	01000 DI ETARY					10
						11
	01300 NURSI NG ADMI NI STRATI ON					13
	01400 CENTRAL SERVICES & SUPPLY					14
	01500 PHARMACY					15
6.00	01600 MEDI CAL RECORDS & LI BRARY					16
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS	297, 458	0	297, 4	58	30
	ANCI LLARY SERVI CE COST CENTERS			1		
50.00	05000 OPERATI NG ROOM	133, 482	0			50
	05300 ANESTHESI OLOGY	0	0		0	53
	05400 RADI OLOGY-DI AGNOSTI C	200, 272	0	200, 2		54
0. 00	06000 LABORATORY	190, 721	0	190, 7		60
	06500 RESPI RATORY THERAPY	50, 136	0	50, 1	36	65
6. 00	06600 PHYSI CAL THERAPY	82, 941	0	82, 9	941	66
7.00	06700 OCCUPATI ONAL THERAPY	17, 340	0	17, 3	40	67
8.00	06800 SPEECH PATHOLOGY	6, 470	0	6, 4	70	68
9.00	06900 ELECTROCARDI OLOGY	18, 982	0	18, 9	82	69
0.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0	70
1.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	12, 979	0	12, 9	79	71
2.00	07200 IMPL. DEV. CHARGED TO PATIENTS	9, 659	0	9,6	59	72
3.00	07300 DRUGS CHARGED TO PATIENTS	69, 653	0	69,6	53	73
	OUTPATIENT SERVICE COST CENTERS					
1.00	09100 EMERGENCY	373, 942	0	373, 9	42	91
2.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0			92
	SPECIAL PURPOSE COST CENTERS					
18.00	SUBTOTALS (SUM OF LINES 1 through 117)	1, 464, 035	0	1, 464, 0	35	118
	NONREI MBURSABLE COST CENTERS					
90.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,099	0	4,0	199	190
	19200 PHYSI CLANS' PRI VATE OFFI CES	12, 444	0			192
	19300 NONPAI D WORKERS	0	0		0	193
	19301 MI SSI ON SERVI CES	2	0		2	193
00.00		0	0		0	200
201.00	5	0	0		0	200
	program vo oust outlets	0	0	1, 480, 5	80	201

ST AI	LOCAT	cial Systems ION - STATISTICAL BASIS	ASCENSION ST.	Provider CC		Period: From 07/01/2020	Worksheet B-1	
						To 06/30/2021	Date/Time Pre 11/18/2021 4:	pare
			CAPI TAL REI	LATED COSTS			117 107 2021 11	
		Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconci l i ati on	ADMI NI STRATI VE	
			(SQUARE FEET)		BENEFITS		& GENERAL	
					DEPARTMENT		(ACCUM. COST)	
					(GROSS SALARI ES)			
			1.00	2.00	4. 00	5A	5.00	+
	GENER	AL SERVICE COST CENTERS						
		CAP REL COSTS-BLDG & FIXT	82, 473					1
		CAP REL COSTS-MVBLE EQUIP		82, 473				2
		EMPLOYEE BENEFITS DEPARTMENT	0	0 0	3, 513, 90			4
		ADMINISTRATIVE & GENERAL	30, 796		401, 25	_	11, 426, 263	
		OPERATION OF PLANT	16, 925			0 0	1, 165, 823	
		LAUNDRY & LINEN SERVICE	1, 769			0 0	71, 167	
		HOUSEKEEPI NG DI ETARY	981 2, 179				432, 248 75, 780	
		CAFETERIA	1, 236				329, 256	
		NURSI NG ADMI NI STRATI ON	1, 230		156, 41		238, 309	
		CENTRAL SERVICES & SUPPLY	1, 31		8, 66		33, 249	
		PHARMACY	968		233, 66		628, 842	
		MEDICAL RECORDS & LIBRARY	8, 582			0 0	97, 341	
		ENT ROUTINE SERVICE COST CENTERS	.,			-1 -1	,	1
		ADULTS & PEDIATRICS	5, 571	5, 571	757, 30	9 0	1, 118, 174	30
		ARY SERVICE COST CENTERS						
		OPERATING ROOM	2, 287	2, 287	320, 79	9 0	576, 432	
		ANESTHESI OLOGY	0	0 0		0 0	0	
		RADI OLOGY-DI AGNOSTI C	1, 586		650, 83		1, 091, 598	
		LABORATORY	1, 297		35, 51		1, 650, 274	
		RESPI RATORY THERAPY	1, 564		129, 70		219, 651	
		PHYSI CAL THERAPY	0	0		0 0	627, 924	
		OCCUPATIONAL THERAPY	0	0		0 0	189, 691	
		SPEECH PATHOLOGY	0	0	75 47	0 0	72, 672	
		ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY	0	0	75, 47	8 0	112, 390	
		MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			0 129, 448	
		IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	129, 448	
		DRUGS CHARGED TO PATIENTS	0	0		0 0	123, 394	
		TIENT SERVICE COST CENTERS	0	0		<u>v</u>	0	- ^`
		EMERGENCY	4, 589	4, 589	744, 25	9 0	2, 412, 831	9
		OBSERVATION BEDS (NON-DISTINCT PART)	.,	.,	,		_,,	92
	SPECI	AL PURPOSE COST CENTERS						
8.00		SUBTOTALS (SUM OF LINES 1 through 117)	82, 261	82, 261	3, 513, 90	1 -5, 958, 111	11, 396, 494	118
		MBURSABLE COST CENTERS	1	1				
		GIFT, FLOWER, COFFEE SHOP & CANTEEN	212			0 0	2, 405	
		PHYSICIANS' PRIVATE OFFICES	0			0 0	27, 334	
		NONPAID WORKERS	0	-		0 0		193
		MISSION SERVICES	0	0		0 0	30	193
0.00		Cross Foot Adjustments						200
1.00		Negative Cost Centers	ADE ( )7	E20 022	1 1/0 40		E 0E0 111	201
2.00		Cost to be allocated (per Wkst. B, Part I)	405, 627	529, 823	1, 168, 42	U I	5, 958, 111	202
3. 00		Unit cost multiplier (Wkst. B, Part I)	4. 918301	6. 424199	0. 33251	4	0. 521440	1203
3.00 4.00		Cost to be allocated (per Wkst. B,	4. 710301	0. 424199	0. 33201		894, 436	
ч. UU		Part II)				Ŭ	074, 430	202
5.00		Unit cost multiplier (Wkst. B, Part			0.00000	o	0. 078279	205
						-	1.0.02//	<b>_</b>
6. 00		NAHE adjustment amount to be allocated						206
		(per Wkst. B-2)						

	Financial Systems	ASCENSI ON ST.				u of Form CMS-	
COST A	ALLOCATION - STATISTICAL BASIS		Provider C		Period: From 07/01/2020	Worksheet B-1	
					To 06/30/2021	Date/Time Pre	pared:
						11/18/2021 4:	43 pm
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG		CAFETERI A	
		PLANT	LINEN SERVICE	(HOURS OF	(MEALS SERVED)	(HOURS)	
		(SQUARE FEET)	(POUNDS OF LAUNDRY)	SERVI CE)			
		7.00	8.00	9.00	10.00	11.00	
	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 ADMINI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT	39, 861					7.00
8.00	00800 LAUNDRY & LINEN SERVICE	1, 769	70, 196				8.00
9.00	00900 HOUSEKEEPI NG	981	218	12, 10	7		9.00
10.00	01000 DI ETARY	2, 179	0		0 100		10.00
11.00	01100 CAFETERI A	1, 236	0		0 0	4, 196	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	1, 931	0		0 0	145	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	-		0 0	21	
15.00	01500 PHARMACY	968			0 0	222	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	8, 582	0		0 0	0	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS	1					
30.00	03000 ADULTS & PEDI ATRI CS	5, 571	12, 304	3, 05	5 100	1, 055	30.00
	ANCI LLARY SERVI CE COST CENTERS						-
50.00	05000 OPERATI NG ROOM	2, 287	8, 963			453	
53.00	05300 ANESTHESI OLOGY	0	-		0 0	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 341	12, 672			968	
60.00	06000 LABORATORY	1, 297	0	50		97	
65.00	06500 RESPI RATORY THERAPY	1, 564			0 0	186	
66.00	06600 PHYSI CAL THERAPY	3, 354			0 0	0	
67.00	06700 OCCUPATIONAL THERAPY	0	786		0 0	0	
68.00	06800 SPEECH PATHOLOGY	0	0		0 0	0	
69.00		0	2, 658		0 0	116	
70.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			0	
71.00 72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	0			0 0	0	
73.00	OUTPATIENT SERVICE COST CENTERS	0	0		0 0	0	/3.00
91.00	09100 EMERGENCY	4, 589	25, 403	2, 83	0 0	933	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	4, 307	20,403	2,03	0 0	733	92.00
92.00	SPECIAL PURPOSE COST CENTERS						92.00
118.00		39, 649	66, 147	10, 22	3 100	4 196	118.00
110.00	NONREI MBURSABLE COST CENTERS	37,047	00, 147	10,22	5 100	4,170	110.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	212	0		0 0	0	190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0					192.00
	19300 NONPALD WORKERS		-, 047 Λ		0 0		192.00
	19301 MI SSI ON SERVICES		n				193.00
200.00						0	200.00
200.00							200.00
202.00	5	1, 773, 730	186, 993	701, 87	2 212, 256	555, 942	
_0_0	Part I)	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		,,,,,,,		000, 742	
203.00		44. 497880	2. 663870	57.97241	3 2, 122. 560000	132. 493327	203.00
204.00		283, 231					204.00
	Part II)	200,201		02,00	, 100	.5, 576	
205.00		7. 105466	0. 544262	4. 29933	1 461. 300000	11. 576501	205.00
206.00							206.00
	(per Wkst. B-2)						
207.00	NAHE unit cost multiplier (Wkst. D,						207.00
	Parts III and IV)	1		1			1

COST ALI	LOCATION - STATISTICAL BASIS		Provider CC	N· 15_1309	Peri od:	Worksheet B-1	
			i i otraor oo	10 1007	From 07/01/2020	WULKSHEEL D-I	
					To 06/30/2021	Date/Time Prepa	ared:
				DUADINA		11/18/2021 4:43	\$ pm
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES &	PHARMACY (COSTED	MEDI CAL RECORDS &		
		ADMINI SIKATI ON	SUPPLY	REQUIS.)	LIBRARY		
		(DI RECT NURS.	(COSTED	REGUIS. )	(GROSS		
		HRS. )	REQUIS.)		CHARGES)		
		13.00	14.00	15.00	16.00		
	SENERAL SERVICE COST CENTERS	1 1					
	00100 CAP REL COSTS-BLDG & FIXT						1.00
	00200 CAP REL COSTS-MVBLE EQUIP						2.00
	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
	00500 ADMI NI STRATI VE & GENERAL						5.00
	00700 OPERATION OF PLANT						7.00
	00800 LAUNDRY & LINEN SERVICE						8.00
	00900 HOUSEKEEPING						9.00
	D1000 DI ETARY						10.00
		42.240					11.00
	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	42, 340	100				13.00 14.00
	01500 PHARMACY	0	0	1 0	00		14. 00 15. 00
	01600 MEDICAL RECORDS & LIBRARY	0	0	1, 0	0 52, 263, 690		16. 00
	NPATIENT ROUTINE SERVICE COST CENTERS	U	UU		0 52,205,090	I	10.00
	33000 ADULTS & PEDIATRICS	18, 098	0		0 1, 593, 271	3	30. 00
	NCILLARY SERVICE COST CENTERS	10,070	0		1, 373, 271	3	50. 00
	D5000 OPERATING ROOM	6, 291	0		0 6, 105, 226	5	50.00
	05300 ANESTHESI OLOGY	0,2,1	0		0 0	-	53. OC
	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 14, 764, 468		54. OC
	06000 LABORATORY	356	0		0 10, 655, 452		60.00
	06500 RESPI RATORY THERAPY	0	0		0 610,001		65.00
	06600 PHYSI CAL THERAPY	0	0		0 2, 596, 770		66.00
67.00 0	06700 OCCUPATI ONAL THERAPY	0	0		0 649, 653	6	67.00
68.00 0	06800 SPEECH PATHOLOGY	0	0		0 246, 072	6	68.00
69.00 0	06900 ELECTROCARDI OLOGY	253	0		0 2, 223, 716	6	69.00
70.00 0	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	7	70.00
71.00 0	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	100		0 0	7	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	7	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0	1, 0	00 0	7	73.00
	DUTPATIENT SERVICE COST CENTERS	,					
	09100 EMERGENCY	17, 342	0		0 12, 819, 061		91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)					9	92.00
	SPECIAL PURPOSE COST CENTERS		100				
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	42, 340	100	1, 0	00 52, 263, 690	11	18.00
	IONREI MBURSABLE COST CENTERS	0	ol		0	10	00 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		90.00 92.00
	19200 PHYSICIANS PRIVATE OFFICES	0	0				92.00 93.00
	19300 NONPAT D WORKERS 19301 MI SSI ON SERVI CES	0	0		0 0		93. 00 93. 01
200.00	Cross Foot Adjustments	0	0				93.0 00.00
200.00	Negative Cost Centers						00. 00 01. 00
201.00	Cost to be allocated (per Wkst. B,	467, 710	53, 368	1, 029, 2	33 529, 978		01.00
-32.00	Part I)	407,710	55, 500	1,027,2	527,770	20	- <u>-</u> . 00
203.00	Unit cost multiplier (Wkst. B, Part I)	11. 046528	533. 680000	1, 029. 2330	00 0. 010140	20	03.00
204.00	Cost to be allocated (per Wkst. B,	55, 957	2, 846	69, 6			04.00
	Part II)		_, = 10		, , , , , , , , , , , , , , , , , ,	20	
205.00	Unit cost multiplier (Wkst. B, Part	1. 321611	28. 460000	69.6530	0. 003175	20	05.00
	11)						
206.00	NAHE adjustment amount to be allocated					20	06.00
007 00	(per Wkst. B-2)						
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)					20	07.00

Health Financial Systems	ASCENSI ON ST.	VINCENT CLAY		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 07/01/2020 To 06/30/2021	Worksheet C Part I Date/Time Pre 11/18/2021 4:	
		Title	XVIII	Hospi tal	Cost	
				Costs		
Cost Center Description	(from Wkst. B, Part I, col.	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	26)					
	1.00	2.00	3.00	4.00	5.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS				-		
30. 00 03000 ADULTS & PEDI ATRI CS	2, 727, 126		2, 727, 12	6 0	0	30.00
ANCI LLARY SERVI CE COST CENTERS	1 00/ (50		4 00/ /5	0		50.00
50. 00 05000 OPERATING ROOM	1, 306, 652		1, 306, 65	2 0	0	
53. 00 05300 ANESTHESI OLOGY	0 2 2 2 2 ( 1 1		0 000 (1	0 0	0	00.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY	2, 230, 611		2, 230, 61		0	0 11 00
65. 00 06500 RESPIRATORY THERAPY	2, 722, 846 434, 610		2, 722, 84 434, 61			
66. 00 06600 PHYSI CAL THERAPY	1, 139, 299					
67. 00 06700 OCCUPATIONAL THERAPY	297, 284		1, 139, 29 297, 28			
68. 00 06800 SPEECH PATHOLOGY	113, 061	0	113, 06			
69. 00 06900 ELECTROCARDI OLOGY	218, 788	0	218, 78		0	
70. 00 07000 ELECTROENCEPHALOGRAPHY	210,700		210,70		0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	250, 315		250, 31	5 0	0	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	187, 737		187, 73		0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	1, 029, 233		1, 029, 23		0	
OUTPATIENT SERVICE COST CENTERS	110271200		1,02,720	<u> </u>		10100
91. 00 09100 EMERGENCY	4, 552, 080		4, 552, 08	0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	958, 487		958, 48		0	
200.00 Subtotal (see instructions)	18, 168, 129	0	18, 168, 12	9 0	0	200.00
201.00 Less Observation Beds	958, 487		958, 48		0	201.00
202.00 Total (see instructions)	17, 209, 642	0	17, 209, 64	2 0	0	202.00

ANCI LLARY SERVICE COST CENTERS           50.00         05000         OPERATI NG ROOM         142,009         5,963,217         6,105,226         0.214022         0.000000         5           53.00         05300         ANESTHESI OLOGY         0         0         0.000000         0.000000         5           54.00         05400         RADI OLOGY-DI AGNOSTI C         172,511         14,591,957         14,764,468         0.151080         0.000000         6           60.00         06000         LABORATORY         268,266         10,387,186         10,655,452         0.25535         0.000000         6           65.00         06600         RESPI RATORY THERAPY         297,153         312,848         610,001         0.712474         0.000000         6           66.00         06600         PHYSI CAL THERAPY         194,635         2,402,135         2,596,770         0.438737         0.000000         6           67.00         06700         OCCUPATI ONAL THERAPY         117,456         532,197         649,653         0.457604         0.000000         6           69.00         06900         ELECTROCARDI OLOGY         41,716         2,182,000         2,223,716         0.98388         0.000000         0         0.000000	Health Financial Systems	ASCENSION ST.	VINCENT CLAY		In Lie	u of Form CMS-	2552-10
Image: construction         To         06/30/2021 Tit/18/2021 4:43         Date/Time Preparent (11/18/2021 4:43)           Cost Center Description         Inpatient         Outpatient         Total (col. 6 + col. 7)         Cost or Other Ratio         TEFRA Inpatient Ratio           0.000         03000 ADULTS & PEDIATRICS         832,120         0.00         0.00         0.00           30.00         05000 ADULTS & PEDIATRICS         832,120         832,120         0.00         0.00000           ANCILLARY SERVICE COST CENTERS         0.00         0.00         0.00000         0.000000         0.000000         0.000000           50.00         05000 APERATING ROOM         142,009         5,963,217         6,105,226         0.214022         0.000000           51.00         05000 ADULTS & PEDIATRICS         0         0         0         0         0.000000         0.000000           52.00         05000 ANESTHESI 0LOGY         0         0         0         0.000000         0.000000         0.000000           60.00         06400 LABORATORY         268,266         10,387,186         10,655,452         0.255535         0.000000         0           61.00         06400 CLABORATORY         268,266         10,387,186         10,656,452         0.457604         0.000000 </td <td>COMPUTATION OF RATIO OF COSTS TO CHARGES</td> <td></td> <td>Provider CO</td> <td></td> <td></td> <td></td> <td></td>	COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CO				
Cost Center Description         Inpatient         Outpatient         Total (col. 6 + col. 7)         Cost or 0ther Ratio         TEFRA Inpatient Ratio           30.00         0000 ADULTS & PEDIATRICS         6.00         7.00         8.00         9.00         10.00           30.00         03000 ADULTS & PEDIATRICS         832,120         832,120         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00000         0.000000							nored.
Title XVIII         Hospital         Cost           Cost Center Description         Title XVIII         Hospital         Cost           Cost Center Description         Title XVIII         Hospital         Cost           Inpatient         Total (col. 6 + col. 7)         Cost of Other Ratio         TEFRA Inpatient Ratio           Inpatient         Total (col. 6 + col. 7)         Cost of Other Ratio         TEFRA Inpatient Ratio           0.00         Other Service Cost Centers           0.00         Source Cost Centers           50.00         Source Cost Centers           0         0         0         Condoto 0         Condoto 0           50.00         Source Cost Centers           50.00         Sourcenters <t< td=""><td></td><td></td><td></td><td></td><td>10 06/30/2021</td><td></td><td></td></t<>					10 06/30/2021		
Cost Center Description         Inpatient         Outpatient         Total (col. 6 + col. 7)         Cost or Other Ratio         TEFRA Inpatient Ratio           30.00         03000 ADULTS & PEDIATRICS         6.00         7.00         8.00         9.00         10.00           30.00         03000 ADULTS & PEDIATRICS         832,120         832,120         0.00         0.00         0.00         0.00000         0.000000         0.000000         0.000000         0.000000         0.000000         0.000000         0.000000         0.000000         0.000000         0.0000000         0.000000         0.000000         0.000000         0.000000         0.000000         0.000000         0.000000         0.000000         0.000000         0.			Title	XVIII	Hospi tal		
Cost Center Description         Inpatient         Outpatient         Total (col. 6 + col. 7)         Cost or 0ther Ratio         TEFRA Inpatient Ratio           30.00         INPATIENT ROUTINE SERVICE COST CENTERS         6.00         7.00         8.00         9.00         10.00           30.00         O3000(ADULTS & PEDIATRICS         832,120         832,120         333,120         333,120         333,120         333,120         333,120         333,120         333,120         333,12,84         610,001         0,712474         0,000000         333,12,844         610,001         0,712474         0,000000         333,12,844         610,001         0,712474         0,000000         345,55         332							
Image: Next Next Next Next Next Next Next Next	Cost Center Description	Inpatient		Total (col. 6	Cost or Other	TEFRA	
6.00         7.00         8.00         9.00         10.00           30.00         ADULTS & PEDIATRICS         832, 120         832, 120         333, 120         333, 120			·	+ col. 7)	Rati o	I npati ent	
INPATI ENT ROUTI NE SERVI CE COST CENTERS           30. 00         03000 ADULTS & PEDI ATRI CS         832, 120         832, 150         832, 150         832,						Ratio	
30. 00       03000 ADULTS & PEDIATRICS       832, 120       832, 120       532, 535       533, 532, 533       533, 532, 533       532, 120       532, 127       533, 542, 542       532, 535, 50, 000000       65, 652       532, 127       533, 544, 542       532, 127       533, 544, 542       532, 127       533, 544, 542       532, 127       533, 544, 542       532, 127       533, 544, 542       533, 544, 542       533, 544, 542       533, 544, 542       533, 544, 542       533, 544, 542       533, 544, 542       533, 544, 542       533, 544, 542       533, 542, 542       533, 542, 542       533, 542, 542       533, 542, 542       533, 542, 542       533, 542, 55		6.00	7.00	8.00	9.00	10.00	
ANCI LLARY SERVICE COST CENTERS           50.00         05000         OPERATI NG ROOM         142,009         5,963,217         6,105,226         0.214022         0.000000         5           53.00         05300         ANESTHESI OLOGY         0         0         0.000000         0.000000         5           54.00         05400         RADI OLOGY-DI AGNOSTI C         172,511         14,591,957         14,764,468         0.151080         0.000000         6           60.00         06000         LABORATORY         268,266         10,387,186         10,655,452         0.255535         0.000000         6           65.00         06600         RESPI RATORY THERAPY         297,153         312,848         610,001         0.712474         0.000000         6           66.00         06600         PHYSI CAL THERAPY         194,635         2,402,135         2,596,770         0.438737         0.000000         6           67.00         06700         OCCUPATI ONAL THERAPY         117,456         532,197         649,653         0.457604         0.000000         6           69.00         06900         ELECTROCARDI OLOGY         41,716         2,182,000         2,223,716         0.098388         0.0000000         0         0.000000							
50.00       05000       0PERATI NG ROOM       142,009       5,963,217       6,105,226       0.214022       0.000000       5         53.00       05300       ANESTHESI OLOGY       0       0       0       0.000000       0.000000       5         54.00       05400       RADI OLOGY-DI AGNOSTI C       172,511       14,591,957       14,764,468       0.151080       0.000000       5         60.00       06500       LABORATORY       268,266       10,387,186       10,655,452       0.25553       0.000000       6         65.00       06500       RESPI RATORY THERAPY       297,153       312,848       610,001       0.712474       0.000000       6         66.00       06600       PHYSI CAL THERAPY       194,635       2,402,135       2,596,770       0.438737       0.000000       6         67.00       06700       OCCUPATI ONAL THERAPY       117,456       532,197       649,653       0.457604       0.000000       6         68.00       06800       SPEECH PATHOGRAPHY       0       0       0.000000       0       0.000000       6         70.00       07000       ELECTROCARDI OLOGY       41,716       2,182,000       2,223,716       0.098388       0.0000000       0		832, 120		832, 120	0		30.00
53.00       05300       ANESTHESI OLOGY       0       0       0       0       0.000000       0.000000       5         54.00       05400       RADI OLOGY-DI AGNOSTI C       172, 511       14, 591, 957       14, 764, 468       0.151080       0.000000       5         60.00       06000       LABORATORY       268, 266       10, 387, 186       10, 655, 452       0.255535       0.000000       6         65.00       06500       RESPI RATORY THERAPY       297, 153       312, 848       610, 001       0.712474       0.000000       6         66.00       06600       PHYSI CAL THERAPY       194, 655       2, 402, 135       2, 596, 770       0.438737       0.000000       6         67.00       06700       OCCUPATI ONAL THERAPY       117, 456       532, 197       649, 653       0.457604       0.000000       6         68.00       06800       SPEECH PATHOLOGY       5,955       240, 117       246, 072       0.459463       0.000000       6         69.00       06900       ELECTROCARDI OLOGY       41, 716       2, 182, 000       2, 223, 716       0.098388       0.000000       7         70.00       07000       ELECTROENCPHALOGRAPHY       0       0       0.0000000       0.000							
54.00       05400       RADI OLOGY - DI AGNOSTI C       172, 511       14, 591, 957       14, 764, 468       0. 151080       0.000000       56         60.00       06000       LABORATORY       268, 266       10, 387, 186       10, 655, 452       0. 255535       0.000000       66         65.00       06500       RESPI RATORY THERAPY       297, 153       312, 848       610, 001       0. 712474       0.000000       66         66.00       06600       PHYSI CAL THERAPY       194, 635       2, 402, 135       2, 596, 770       0. 438737       0.000000       6         67.00       06700       OCCUPATI ONAL THERAPY       117, 456       532, 197       649, 653       0. 457604       0.000000       6         68.00       068000       SPEECH PATHOLOGY       5, 955       240, 117       246, 072       0. 459463       0.000000       6         69.00       06900       ELECTROCARDI OLOGY       41, 716       2, 182, 000       2, 223, 716       0.098388       0.000000       7         70.00       07000       ELECTROENCEPHALOGRAPHY       0       0       0.000000       7       0.000000       7       0.000000       7       0.000000       7       0.000000       7       0.000000       7		142,009	5, 963, 217	6, 105, 220			
60.00       06000       LABORATORY       268, 266       10, 387, 186       10, 655, 452       0. 255535       0. 000000       6         65.00       06500       RESPI RATORY THERAPY       297, 153       312, 848       610, 001       0. 712474       0. 000000       6         66.00       06600       PHYSI CAL THERAPY       194, 635       2, 402, 135       2, 596, 770       0. 438737       0. 000000       6         67.00       0C000       OCUPATI ONAL THERAPY       117, 456       532, 197       649, 653       0. 457604       0. 000000       6         68.00       06800       SPEECH PATHOLOGY       5, 955       240, 117       246, 072       0. 459463       0. 000000       6         69.00       06900       ELCTROCARDI OLOGY       41, 716       2, 182, 000       2, 223, 716       0. 998388       0. 000000       7         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       108, 353       785, 215       893, 568       0. 280130       0. 000000       7         72.00       07200       IMPL.       DEV. CHARGED TO PATI ENTS       258, 924       2, 561, 457       2, 820, 381       0. 364927       0. 000000       7         73.00       07300       DRUGS CHARGED TO PATI ENTS		-	0	(			
65.00       06500       RESPI RATORY THERAPY       297, 153       312, 848       610, 001       0.712474       0.000000       6         66.00       06600       PHYSI CAL THERAPY       194, 635       2, 402, 135       2, 596, 770       0.438737       0.000000       6         67.00       06700       OCCUPATI ONAL THERAPY       117, 456       532, 197       649, 653       0.457604       0.000000       6         68.00       06800       SPEECH PATHOLOGY       5, 955       240, 117       246, 072       0.459463       0.000000       6         69.00       06900       ELECTROCARDI OLOGY       41, 716       2, 182, 000       2, 223, 716       0.098388       0.000000       0       0       0.000000       0<							
66.00       06600       PHYSI CAL THERAPY       194, 635       2, 402, 135       2, 596, 770       0.438737       0.000000       6         67.00       06700       OCCUPATI ONAL THERAPY       117, 456       532, 197       649, 653       0.457604       0.000000       6         68.00       06800       SPECH PATHOLOGY       5, 955       240, 117       246, 072       0.459463       0.000000       6         69.00       06900       ELECTROCARDI OLOGY       41, 716       2, 182, 000       2, 223, 716       0.098388       0.000000       6         70.00       07000       ELECTROCARDI OLOGY       41, 716       2, 182, 000       2, 223, 716       0.098388       0.000000       6         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       108, 353       785, 215       893, 568       0.280130       0.000000       7         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       108, 353       785, 215       893, 568       0.280130       0.000000       7         73.00       07000       DRUGS CHARGED TO PATI ENTS       258, 924       2, 561, 457       2, 820, 381       0.364927       0.000000       7         70.00       DTOPATI ENT SERVICE COST CENTERS       9100       EMERGENCY							
67.00       06700       OCCUPATI ONAL THERAPY       117, 456       532, 197       649, 653       0. 457604       0. 000000       6         68.00       06800       SPEECH PATHOLOGY       5, 955       240, 117       246, 072       0. 459463       0. 000000       6         69.00       06900       ELECTROCARDI OLOGY       41, 716       2, 182, 000       2, 223, 716       0. 098388       0. 000000       6         70.00       07000       ELECTROENCEPHALOGRAPHY       0       0       0       0. 000000       0. 000000       7         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       108, 353       785, 215       893, 568       0. 280130       0. 000000       7         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       41, 330       193, 551       234, 881       0. 799286       0. 000000       7         73.00       07300       DRUGS CHARGED TO PATI ENTS       258, 924       2, 561, 457       2, 820, 381       0. 364927       0. 000000       7         0UTPATI ENT SERVICE COST CENTERS       9100       EMERGENCY       9100       EMERGENCY       0. 000000       9200       0BSERVATI ON BEDS (NON-DI STI NCT PART)       39, 444       721, 707       761, 151       1. 259260       0. 000000							
68.00       06800       SPECH PATHOLOGY       5,955       240,117       246,072       0.459463       0.000000       6         69.00       06900       ELECTROCARDI OLOGY       41,716       2,182,000       2,223,716       0.098388       0.000000       6         70.00       07000       ELECTROENCEPHALOGRAPHY       0       0       0       0.000000       0.000000       7         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       108,353       785,215       893,568       0.280130       0.000000       7         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       41,330       193,551       234,881       0.799286       0.000000       7         001704T ENT SERVICE COST CENTERS       00100TPATI ENT SERVICE COST CENTERS       00100TPATI ENT SERVICE COST CENTERS       0       0.355102       0.000000       0.000000       0         91.00       09200       0BSERVATI ON BEDS (NON-DI STINCT PART)       39,444       721,707       761,151       1.259260       0.000000       9         200.00       Subtotal (see instructions)       2,579,362       53,633,158       56,212,520       0.000000       9							
69.00       06900       ELECTROCARDI OLOGY       41, 716       2, 182, 000       2, 223, 716       0.098388       0.000000       6         70.00       07000       ELECTROENCEPHALOGRAPHY       0       0       0       0.000000       0.000000       0.000000       7         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       108, 353       785, 215       893, 568       0.280130       0.000000       7         72.00       07200       IMPL.       DEV.       CHARGED TO PATI ENTS       41, 330       193, 551       234, 881       0.799286       0.000000       7         73.00       07300       DRUGS CHARGED TO PATI ENTS       258, 924       2, 561, 457       2, 820, 381       0.364927       0.000000       7         00TPATI ENT SERVI CE COST CENTERS       91.00       09100       EMERGENCY       09100       EMERGENCY       0.000000       92.00       09200       OBSERVATI ON BEDS (NON-DI STINCT PART)       39, 444       721, 707       761, 151       1.259260       0.000000       92.00         92.00       09200       Subtotal (see instructions)       2, 579, 362       53, 633, 158       56, 212, 520       0.000000       92.00							
70.00         07000         ELECTROENCEPHALOGRAPHY         0         0         0         0.000000         0.000000         7.000         0.000000         0.000000         7.000         0.000000         0.000000         7.000         0.000000         0.000000         7.000         0.000000         7.000         0.000000         0.000000         7.000         0.000000         0.000000<							
71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       108, 353       785, 215       893, 568       0. 280130       0. 000000       7         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       41, 330       193, 551       234, 881       0. 799286       0. 000000       7         73.00       07300       DRUGS CHARGED TO PATI ENTS       258, 924       2, 561, 457       2, 820, 381       0. 364927       0. 000000       7         0UTPATI ENT SERVI CE COST CENTERS       91.00       09100       EMERGENCY       59, 490       12, 759, 571       12, 819, 061       0. 355102       0. 000000       9         92.00       092000       OSERVATI ON BEDS (NON-DI STI NCT PART)       39, 444       721, 707       761, 151       1. 259260       0. 000000       9         200.00       Subtotal (see i instructions)       2, 579, 362       53, 633, 158       56, 212, 520       20       20		41, 716	2, 182, 000	2, 223, 710	6 0. 098388		
72. 00       07200       IMPL. DEV. CHARGED TO PATIENTS       41, 330       193, 551       234, 881       0. 799286       0. 000000       7         73. 00       07300       DRUGS CHARGED TO PATIENTS       258, 924       2, 561, 457       2, 820, 381       0. 364927       0. 000000       7         0UTPATIENT SERVICE COST CENTERS       91. 00       09100       EMERGENCY       59, 490       12, 759, 571       12, 819, 061       0. 355102       0. 000000       0         92. 00       09200       OBSERVATI ON BEDS (NON-DI STINCT PART)       39, 444       721, 707       761, 151       1. 259260       0. 000000       9         200. 00       Subtotal (see instructions)       2, 579, 362       53, 633, 158       56, 212, 520       0. 000000       9	70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	(	0. 000000	0.000000	70.00
73. 00       07300       DRUGS CHARGED TO PATIENTS       258,924       2,561,457       2,820,381       0.364927       0.000000       7         0UTPATIENT SERVICE COST CENTERS       0       09100       EMERGENCY       59,490       12,759,571       12,819,061       0.355102       0.000000       0         92. 00       09200       OBSERVATION BEDS (NON-DI STINCT PART)       39,444       721,707       761,151       1.259260       0.000000       9         200. 00       Subtotal (see instructions)       2,579,362       53,633,158       56,212,520       0       20		108, 353	785, 215	893, 568	0. 280130		
OUTPATI ENT SERVICE COST CENTERS           91. 00         09100         EMERGENCY         59, 490         12, 759, 571         12, 819, 061         0. 355102         0. 000000         9200           92. 00         09200         OBSERVATI ON BEDS (NON-DI STINCT PART)         39, 444         721, 707         761, 151         1. 259260         0. 000000         9200           200. 00         Subtotal (see instructions)         2, 579, 362         53, 633, 158         56, 212, 520         200	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	41, 330	193, 551	234, 881	0. 799286	0.00000	72.00
91. 00         09100         EMERGENCY         59, 490         12, 759, 571         12, 819, 061         0. 355102         0. 000000         92           92. 00         09200         OBSERVATI ON BEDS (NON-DI STINCT PART)         39, 444         721, 707         761, 151         1. 259260         0. 000000         92           200. 00         Subtotal (see instructions)         2, 579, 362         53, 633, 158         56, 212, 520         20		258, 924	2, 561, 457	2, 820, 38	0. 364927	0.00000	73.00
92.00         09200         OBSERVATI ON BEDS (NON-DI STINCT PART)         39,444         721,707         761,151         1.259260         0.000000         9           200.00         Subtotal (see instructions)         2,579,362         53,633,158         56,212,520         20         20							
200.00         Subtotal (see instructions)         2, 579, 362         53, 633, 158         56, 212, 520         20	91. 00 09100 EMERGENCY	59, 490	12, 759, 571	12, 819, 06	0. 355102	0.00000	91.00
		39, 444	721, 707	761, 15	1 1. 259260	0.00000	92.00
		2, 579, 362	53, 633, 158	56, 212, 520	C		200.00
201.00 Less observation Beds 20	201.00 Less Observation Beds						201.00
202.00         Total (see instructions)         2, 579, 362         53, 633, 158         56, 212, 520         20	202.00   Total (see instructions)	2, 579, 362	53, 633, 158	56, 212, 520	C		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES         Provider CCN: 15-1309         Period: From 07/01/2020 To 06/30/2021         Worksheet C Part 1 Date/Time Prepared: 11/18/2021 4:43 pm           Impatient         Ratio         11:00         11:00         00000         00000         00000         00000         00000         00000         00000         000000         000000         000000         000000         000000         000000         000000         000000         000000         000000         000000         0000000         0000000         0000000         0000000         0000000         0000000         0000000         0000000         0000000         0000000         0000000         0000000         0000000         0000000         0000000         0000000         000000         0000000         0000000         000000         000000         000000         000000         000000         000000         0000000         0000000         0000000         0000000         0000000         0000000         0000000         0000000         000000         000000         0000000         000000         000000         000000         000000         000000         000000         000000         000000         000000         000000         000000         000000         000000         0000000         000000         0000	Health Financial Systems	ASCENSION ST. VI	NCENT CLAY	In Lie	u of Form CMS-	2552-10
Cost Center Description         PPS Inpatient Ratio         1           30.00         03000 ADULTS & PEDIATRICS         30.00           ANCILLARY SERVICE COST CENTERS         30.00           50.00         05000 OPERATING ROOM         0.000000           53.00         05300 ANESTHESI OLOGY         0.000000           54.00         05400 RADIORY         0.000000           54.00         06500 ILABORATORY         0.000000           64.00         06500 RESPI RATORY THERAPY         0.000000           65.00         06500 RESPI RATORY THERAPY         0.000000           66.00         06600 PHYSI CAL THERAPY         0.000000           67.00         06700 OCCUPATI ONAL THERAPY         0.000000           68.00         06800 SPEECH PATHOLOGY         0.000000           68.00         06900 ELECTROCARDI OLOGY         0.000000           71.00         70.00         68.00           69.00         07000 ELECTROCARDI OLOGY         0.000000           71.00         71.00         71.00           72.00         07200 IMPL. DEV. CHARGED TO PATI ENTS         0.000000           73.00         000000         72.00           73.00         000000         72.00           73.00         000000	COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1309	From 07/01/2020	Part I Date/Time Pre	
Ratio         Ratio           30.00         O3000 ADULTS & PEDIATRICS         30.00           ANCILLARY SERVICE COST CENTERS         30.00           50.00         OPERATING ROM         0.000000           53.00         05300 APESTHESI OLOGY         0.000000           54.00         05400 RADIOLOGY -DI AGNOSTI C         0.000000           54.00         05400 RADIOLOGY -DI AGNOSTI C         0.000000           66.00         06500 RESPI RATORY         0.000000           65.00         06500 RESPI RATORY THERAPY         0.000000           66.00         06000 PHYSI CAL THERAPY         0.000000           67.00         06700 OCUPATI ONAL THERAPY         0.000000           68.00         SEECH PATHOLOGY         0.000000           69.00         06900 ELECTROCARDIOLOGY         0.000000           70.00         07100 MEDICAL SUPPLIES CHARGED TO PATIENTS         0.000000           71.00         07100 IMPL. DEV. CHARGED TO PATIENTS         0.000000           72.00         07300 DRUGS CHARGED TO PATIENTS         0.000000           72.00         07300 DRUGS CHARGED TO PATIENTS         0.000000           71.00         07300 DRUGS CHARGED TO PATIENTS         0.000000           72.00         07300 DRUGS CHARGED TO PATIENTS         0.00			Title XVIII	Hospi tal	Cost	
11.00         11.00           0.00         INPATI ENT ROUTI NE SERVICE COST CENTERS         30.00           ANCI LLARY SERVICE COST CENTERS         30.00           50.00         05000   OPERATI NG ROOM         0.000000           53.00         05300   ANESTHESI OLOGY         0.000000           54.00         05400 RADI LOGY - DI AGNOSTI C         0.000000           60.00         66000   LABORATORY         0.000000         54.00           60.00         66000 RESPI RATORY THERAPY         0.000000         66.00           65.00         06500 RESPI RATORY THERAPY         0.000000         66.00           66.00         06000 PEECH PATHOLOGY         0.000000         66.00           67.00         06700 OCCUPATI ONAL THERAPY         0.000000         68.00           68.00         06800 SPEECH PATHOLOGY         0.000000         68.00           69.00         GEPOOLELECTROCARDI OLOGY         0.000000         68.00           69.00         GEPOOLELECTROCARDI OLOGY         0.000000         71.00           71.00         07100         MEDI CAL SUPPLIES CHARGED TO PATI ENTS         0.000000         72.00           72.00         07200 I MPL. DEV. CHARGED TO PATI ENTS         0.000000         72.00         72.00         72.00         72.00 </td <td>Cost Center Description</td> <td>PPS Inpatient</td> <td></td> <td></td> <td></td> <td></td>	Cost Center Description	PPS Inpatient				
INPATIENT ROUTINE SERVICE COST CENTERS         30.00           30.00         ADULTS & PEDIATRICS         30.00           ANCILLARY SERVICE COST CENTERS         50.00           50.00         OSOOO OPERATING ROOM         0.000000           53.00         05300 ANESTHESI OLOGY         0.000000           54.00         05400 RADIOLOGY-DI AGNOSTI C         0.000000           60.00         06500 RESPI RATORY         0.000000           65.00         06500 RESPI RATORY THERAPY         0.000000           65.00         06500 RESPI RATORY THERAPY         0.000000           66.00         06600 PHYSI CAL THERAPY         0.000000           67.00         06700 OCUPATI ONAL THERAPY         0.000000           68.00         OB600 SPEECH PATHOLOGY         0.000000           69.00         06900 ELECTROCARDI OLOGY         0.000000           70.00         07100 REDICAL SUPPLIES CHARGED TO PATIENTS         0.000000           71.00         07100 MEDICAL SUPPLIES CHARGED TO PATIENTS         0.000000           72.00         73.00         73.00         73.00           71.00         07100 EMERGENCY         0.000000         73.00           71.00         09100 EMERGENCY         0.000000         91.00           72.00         0						
30. 00         O3000         ADULTS & PEDIATRICS         30. 00           ANCILLARY SERVICE COST CENTERS         50. 00         05000         OPERATING ROOM         0. 000000         53. 00           53. 00         05300         ANESTHESI OLOGY         0. 000000         53. 00         50. 00           54. 00         05400         RADI OLOGY - DI AGNOSTI C         0. 000000         54. 00           60. 00         06000         LABORATORY         0. 000000         60. 00           65. 00         06500         RESPI RATORY THERAPY         0. 000000         65. 00           66. 00         06600         PHYSI CAL THERAPY         0. 000000         67. 00           66. 00         06500         SPEECH PATHOLOGY         0. 000000         67. 00           68. 00         06800         SPEECH PATHOLOGY         0. 000000         68. 00           69. 00         06900         ELECTROCARDI OLOGY         0. 000000         69. 00           71. 00         07100         MEDI CAL SUPPLIES CHARGED TO PATIENTS         0. 000000         71. 00           71. 00         07100         MEDI CAL SUPPLIES CHARGED TO PATIENTS         0. 000000         72. 00           73. 00         07100         MEDI CAL SUPPLIES COST CENTERS         72. 00		11.00				
ANCI LLARY SERVICE COST CENTERS         50.00         05000         0PERATING ROM         0.000000         53.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         53.00         50.00         53.00         63.00         63.00         60.00         60.00         60.00         60.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         68.00         69.00         69.00         69.00         69.00         69.00         69.00         69.00         69.00         70.00         70.00         71.00         71.00         71.00         71.00         71.00         71.00         71.00         73.00         73.00         73.00         73.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>						
50.00         05000         0PERATING ROOM         0.000000         50.00           53.00         05300         ANESTHESI OLOGY         0.000000         53.00           54.00         05400         RADI OLOGY-DI AGNOSTI C         0.000000         54.00           60.00         06000         LABORATORY         0.000000         60.00           65.00         06500         RESPI RATORY THERAPY         0.000000         60.00           66.00         06600         PHYSI CAL THERAPY         0.000000         66.00           67.00         06700         OCCUPATI ONAL THERAPY         0.000000         67.00           68.00         06800         SPEECH PATHOLOGY         0.000000         68.00           69.00         06900         ELECTROCARDI OLOGY         0.000000         68.00           71.00         07100         MEDI CAL SUPPLIES CHARGED TO PATIENTS         0.000000         71.00           71.00         07200         IMPL. DEV. CHARGED TO PATIENTS         0.000000         72.00           73.00         07300         DRUGS CHARGED TO PATIENTS         0.000000         73.00           71.00         07100         EMERGENCY         0.000000         73.00           71.00         09100         EMERGE						30.00
53.00       05300       ANESTHESI OLOGY       0.000000       53.00         54.00       05400       RADI OLOGY-DI AGNOSTI C       0.000000       60.00         60.00       06000       LABORATORY       0.000000       60.00         65.00       06500       RESPI RATORY THERAPY       0.000000       65.00         66.00       06600       PHYSI CAL THERAPY       0.000000       66.00         67.00       06700       CCUPATI ONAL THERAPY       0.000000       67.00         68.00       06800       SPEECH PATHOLOGY       0.000000       68.00         69.00       06900       ELECTROCARDI OLOGY       0.000000       69.00         70.00       7000       ELECTROCARDI OLOGY       0.000000       70.00         71.00       0700       ELECTROCARDI OLOGY       0.000000       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0.000000       72.00         73.00       OTUDATI ENT SERVICE COST CENTERS       0.000000       72.00         91.00       09100       EMERGENCY       0.000000       92.00         92.00       09200       OBSERVATI ON BEDS (NON-DI STI NCT PART)       0.000000       92.00         200.00       Subtotal (see i instru						
54.00       05400       RADI 0L0GY-DI AGNOSTI C       0.00000       54.00         60.00       06000       LABORATORY       0.000000       60.00         65.00       06500       RESPI RATORY THERAPY       0.000000       65.00         66.00       06600       PHYSI CAL THERAPY       0.000000       66.00         67.00       06700       OCCUPATI ONAL THERAPY       0.000000       67.00         68.00       06800       SPEECH PATHOLOGY       0.000000       68.00         69.00       06900       ELECTROCARDI OLOGY       0.000000       69.00         70.00       07000       ELECTROENCEPHALOGRAPHY       0.000000       70.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0.000000       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0.000000       72.00         72.00       07200       DAUGS CHARGED TO PATI ENTS       0.000000       72.00         71.00       07100       MERGENCY       0.000000       72.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0.000000       72.00         72.00       07200       OBSERVATI ON BEDS (NON-DI STI NCT PART)       0.000000       91.00 <tr< td=""><td>50.00 05000 OPERATI NG ROOM</td><td>0. 000000</td><td></td><td></td><td></td><td>50.00</td></tr<>	50.00 05000 OPERATI NG ROOM	0. 000000				50.00
60.00       06000       LABORATORY       0.000000       60.00         65.00       06500       RESPI RATORY THERAPY       0.000000       65.00         66.00       06600       PHYSI CAL THERAPY       0.000000       66.00         67.00       06700       OCCUPATI ONAL THERAPY       0.000000       67.00         68.00       06800       SPEECH PATHOLOGY       0.000000       67.00         69.00       06900       ELECTROCARDI OLOGY       0.000000       68.00         69.00       07000       ELECTROENCEPHALOGRAPHY       0.000000       70.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0.000000       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0.000000       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0.000000       72.00         73.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0.000000       73.00         017000       EMERGENCY       0.000000       73.00       91.00         92.00       09200       OBSERVATI ON BEDS (NON-DI STI NCT PART)       0.000000       92.00         200.00       Subtotal (see i nstructions)       0.000000       92.00       200.00 <td>53. 00 05300 ANESTHESI OLOGY</td> <td>0. 000000</td> <td></td> <td></td> <td></td> <td>53.00</td>	53. 00 05300 ANESTHESI OLOGY	0. 000000				53.00
65.00       06500       RESPI RATORY THERAPY       0.000000       65.00         66.00       06600       PHYSI CAL THERAPY       0.000000       66.00         67.00       06700       0CCUPATI ONAL THERAPY       0.000000       67.00         68.00       06800       SPEECH PATHOLOGY       0.000000       68.00         69.00       06900       ELECTROCARDI OLOGY       0.000000       69.00         70.00       07000       ELECTROENCEPHALOGRAPHY       0.000000       70.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0.000000       71.00         71.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0.000000       72.00         73.00       OT2000       RURGED TO PATI ENTS       0.000000       72.00         73.00       OT2000       RURGENCY       0.000000       73.00         91.00       O9100       EMERGENCY       0.000000       91.00         92.00       09200       OBSERVATI ON BEDS (NON-DI STI NCT PART)       0.000000       92.00         200.00       Subtotal (see i nstructions)       0.000000       92.00       92.00	54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
66.00       06600       PHYSI CAL THERAPY       0.000000       67.00         67.00       06700       0CCUPATI ONAL THERAPY       0.000000       67.00         68.00       06800       SPECH PATHOLOGY       0.000000       68.00         69.00       06900       ELECTROCARDI OLOGY       0.000000       69.00         70.00       07000       ELECTROENCEPHALOGRAPHY       0.000000       70.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0.000000       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0.000000       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0.000000       73.00         00TPATI ENT SERVICE COST CENTERS       0.000000       73.00       73.00         91.00       09100       EMERGENCY       0.000000       91.00         92.00       09200       OBSERVATI ON BEDS (NON-DI ST INCT PART)       0.000000       92.00         200.00       Subtotal (see instructions)       0.000000       92.00       200.00	60. 00 06000 LABORATORY	0. 000000				60.00
67.00       06700       0CCUPATIONAL THERAPY       0.000000       67.00         68.00       06800       SPEECH PATHOLOGY       0.000000       68.00         69.00       06900       ELECTROCARDIOLOGY       0.000000       69.00         70.00       07000       ELECTROENCEPHALOGRAPHY       0.000000       70.00         71.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENTS       0.000000       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0.000000       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0.000000       72.00         73.00       0017041       ENT SERVICE COST CENTERS       0.000000       72.00         91.00       09100       EMERGENCY       0.000000       91.00         92.00       09200       OBSERVATION BEDS (NON-DISTINCT PART)       0.000000       92.00         200.00       Subtotal (see instructions)       0.000000       92.00       200.00	65. 00 06500 RESPI RATORY THERAPY	0. 000000				65.00
68.00         06800         SPEECH PATHOLOGY         0.000000         68.00           69.00         06900         ELECTROCARDIOLOGY         0.000000         69.00           70.00         07000         ELECTROENCEPHALOGRAPHY         0.000000         70.00           71.00         07100         MEDICAL SUPPLIES CHARGED TO PATIENTS         0.000000         71.00           72.00         07300         DRUGS CHARGED TO PATIENTS         0.000000         72.00           73.00         07300         DRUGS CHARGED TO PATIENTS         0.000000         72.00           91.00         09100         EMERGENCY         0.000000         91.00           92.00         09200         OBSERVATION BEDS (NON-DISTINCT PART)         0.000000         92.00           200.00         Subtotal (see instructions)         0.000000         200.00         92.00	66. 00 06600 PHYSI CAL THERAPY	0. 000000				66.00
69.00         06900         ELECTROCARDIOLOGY         0.000000         69.00           70.00         07000         ELECTROENCEPHALOGRAPHY         0.000000         70.00           71.00         07100         MEDICAL SUPPLIES CHARGED TO PATIENTS         0.000000         71.00           72.00         07200         IMPL. DEV. CHARGED TO PATIENTS         0.000000         72.00           73.00         07000         DRUGS CHARGED TO PATIENTS         0.000000         72.00           017971         DEV. CHARGED TO PATIENTS         0.000000         72.00           91.00         09100         EMERGENCY         0.000000         91.00           92.00         09200         OBSERVATION BEDS (NON-DISTINCT PART)         0.000000         92.00           200.00         Subtotal (see instructions)         200.00         200.00         200.00	67.00 06700 OCCUPATI ONAL THERAPY	0. 000000				67.00
70. 00         07000         ELECTROENCEPHALOGRAPHY         0.000000         70.00           71. 00         07100         MEDI CAL SUPPLIES CHARGED TO PATI ENTS         0.000000         71.00           72. 00         07200         IMPL. DEV. CHARGED TO PATI ENTS         0.000000         72.00           73. 00         07000         DRUGS CHARGED TO PATI ENTS         0.000000         72.00           73. 00         00TPATI ENT SERVICE COST CENTERS         0.000000         73.00           91. 00         9100         EMERGENCY         0.000000         91.00           92. 00         09200         0BSERVATI ON BEDS (NON-DI STI NCT PART)         0.000000         92.00           200. 00         Subtotal (see i nstructions)         0.000000         200.00         200.00	68.00 06800 SPEECH PATHOLOGY	0. 000000				68.00
71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENTS       0.000000       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0.000000       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0.000000       73.00         0UTPATIENT SERVICE COST CENTERS       0.000000       73.00         91.00       09100       MERGENCY       0.000000         92.00       09200       0BSERVATION BEDS (NON-DISTINCT PART)       0.000000       92.00         200.00       Subtotal (see instructions)       200.00       200.00       200.00	69.00 06900 ELECTROCARDI OLOGY	0. 000000				69.00
72.00         07200         IMPL. DEV. CHARGED TO PATIENTS         0.000000         72.00           73.00         07300         DRUGS CHARGED TO PATIENTS         0.000000         73.00           0UTPATIENT SERVICE COST CENTERS         0.000000         91.00         91.00           92.00         09200         0BSERVATION BEDS (NON-DISTINCT PART)         0.000000         92.00           200.00         Subtotal (see instructions)         0.000000         200.00         200.00	70.00 07000 ELECTROENCEPHALOGRAPHY	0. 000000				70.00
73. 00         07300         DRUGS CHARGED TO PATIENTS         0.000000         73.00           0UTPATIENT SERVICE COST CENTERS         0.000000         91.00         91.00         91.00         92.00         9200         0BSERVATION BEDS (NON-DISTINCT PART)         0.000000         92.00         92.00         92.00         9200.00         9200.00         92.00	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71.00
OUTPATI ENT SERVICE COST CENTERS         0.000000         91.00           91.00         09100         EMERGENCY         0.000000         92.00           92.00         09200         OBSERVATION BEDS (NON-DISTINCT PART)         0.000000         92.00           200.00         Subtotal (see instructions)         0.000000         200.00	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000				72.00
91. 00         09100         EMERGENCY         0.000000         91. 00           92. 00         09200         0BSERVATI ON BEDS (NON-DI STI NCT PART)         0.000000         92. 00           200. 00         Subtotal (see instructions)         0.000000         200. 00         200. 00	73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
92. 00         09200         0BSERVATION BEDS (NON-DISTINCT PART)         0.000000         92.00	OUTPATIENT SERVICE COST CENTERS	· · ·				1
200.00 Subtotal (see instructions) 200.00	91.00 09100 EMERGENCY	0.000000				91.00
	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000				92.00
201.00 Less Observation Bods 201.00	200.00 Subtotal (see instructions)					200.00
	201.00 Less Observation Beds					201.00
202.00 Total (see instructions) 202.00	202.00 Total (see instructions)					202.00

Health Financial Systems	ASCENSION ST.	VINCENT CLAY		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CO		Period: From 07/01/2020 To 06/30/2021	Worksheet C Part I Date/Time Pre 11/18/2021 4:	
		Ti tl	e XIX	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS			_			
30. 00 03000 ADULTS & PEDIATRICS	2, 727, 126		2, 727, 12	6 0	2, 727, 126	30.00
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATI NG ROOM	1, 306, 652		1, 306, 65	2 0	1, 306, 652	50.00
53. 00 05300 ANESTHESI OLOGY	0			0 0	0	
54.00 05400 RADI OLOGY-DI AGNOSTI C	2, 230, 611		2, 230, 61		2, 230, 611	•
60. 00 06000 LABORATORY	2, 722, 846		2, 722, 84		2, 722, 846	
65. 00 06500 RESPI RATORY THERAPY	434, 610	0	434, 61		434, 610	•
66. 00 06600 PHYSI CAL THERAPY	1, 139, 299	0	1, 139, 29	9 0	1, 139, 299	•
67.00 06700 OCCUPATI ONAL THERAPY	297, 284	0	297, 28		297, 284	•
68.00 06800 SPEECH PATHOLOGY	113, 061	0	113, 06	1 0	113, 061	
69. 00 06900 ELECTROCARDI OLOGY	218, 788		218, 78	8 0	218, 788	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0			0 0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	250, 315		250, 31	5 0	250, 315	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	187, 737		187, 73	7 0	187, 737	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 029, 233		1, 029, 23	3 0	1, 029, 233	73.00
OUTPATIENT SERVICE COST CENTERS			_			
91.00 09100 EMERGENCY	4, 552, 080		4, 552, 08	0 0	4, 552, 080	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	958, 487		958, 48	7	958, 487	92.00
200.00 Subtotal (see instructions)	18, 168, 129	0	18, 168, 12	9 0	18, 168, 129	200.00
201.00 Less Observation Beds	958, 487		958, 48	7	958, 487	201.00
202.00 Total (see instructions)	17, 209, 642	0	17, 209, 64	2 0	17, 209, 642	202.00

Health Financial Systems	ASCENSION ST.	VINCENT CLAY		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CO		Period:	Worksheet C	
				From 07/01/2020 To 06/30/2021	Part I Date/Time Pre	narod
				10 00/ 30/ 2021	11/18/2021 4:	
		Titl	e XIX	Hospi tal	Cost	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
			+ col. 7)	Rati o	Inpati ent	
					Ratio	
	6.00	7.00	8.00	9.00	10.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS				-1		
30. 00 03000 ADULTS & PEDI ATRI CS	832, 120		832, 120			30.00
ANCI LLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	142,009	5, 963, 217	6, 105, 220			
53. 00 05300 ANESTHESI OLOGY	0	0	(	0. 000000		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	172, 511	14, 591, 957				
60. 00 06000 LABORATORY	268, 266	10, 387, 186				
65. 00 06500 RESPI RATORY THERAPY	297, 153	312, 848				
66.00 06600 PHYSI CAL THERAPY	194, 635	2, 402, 135				
67.00 06700 OCCUPATI ONAL THERAPY	117, 456	532, 197				
68. 00 06800 SPEECH PATHOLOGY	5, 955	240, 117				
69. 00 06900 ELECTROCARDI OLOGY	41, 716	2, 182, 000				
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0. 000000		
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	108, 353	785, 215				
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	41, 330	193, 551	234, 88			
73. 00 07300 DRUGS CHARGED TO PATIENTS	258, 924	2, 561, 457	2, 820, 38	0. 364927	0.00000	73.00
91.00 09100 EMERGENCY	E0 400	10 750 571	10.010.04	1 0.255102	0, 000000	01 00
	59, 490	12, 759, 571				
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 200.00 Subtotal (see instructions)	39,444	721, 707			0.00000	200.00
201.00 Less Observation Beds	2, 579, 362	53, 633, 158	56, 212, 520			200.00
201.00 Total (see instructions)	2, 579, 362	53, 633, 158	56, 212, 520			201.00
	2, 377, 302	JS, USS, 158	00, 212, 520		I	202.00

Health Financial Systems	ASCENSION ST. VI	NCENT CLAY	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1309	Period: From 07/01/2020 To 06/30/2021	Worksheet C Part I Date/Time Prep 11/18/2021 4:4	
		Title XIX	Hospi tal	Cost	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS					30.00
ANCI LLARY SERVI CE COST CENTERS					
50.00 05000 OPERATING ROOM	0. 000000				50.00
53. 00 05300 ANESTHESI OLOGY	0. 000000				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
60. 00 06000 LABORATORY	0. 000000				60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000				66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000				67.00
68.00 06800 SPEECH PATHOLOGY	0.000000				68.00
69. 00 06900 ELECTROCARDI OLOGY	0.000000				69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0.000000				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.000000				73.00
OUTPATIENT SERVICE COST CENTERS					
91. 00 09100 EMERGENCY	0. 000000				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000				92.00
200.00 Subtotal (see instructions)					200. 00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)					202.00

Health Financial Systems	ASCENSI ON ST.	VINCENT CLAY		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provider C		Period:	Worksheet D	
				From 07/01/2020 To 06/30/2021	Part II Date/Time Pre	narodi
				10 00/30/2021	11/18/2021 4:	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	100.100	( 105 00/		10.00/	(00	
50. 00 05000 OPERATING ROOM	133, 482	6, 105, 226				
53. 00 05300 ANESTHESI OLOGY	0	0	0.0000		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	200, 272					54.00
60. 00 06000 LABORATORY	190, 721					
65. 00 06500 RESPIRATORY THERAPY	50, 136					65.00
66.00 06600 PHYSI CAL THERAPY	82, 941					66.00
67. 00 06700 OCCUPATI ONAL THERAPY	17, 340					67.00
68. 00 06800 SPEECH PATHOLOGY	6, 470					68.00
69. 00 06900 ELECTROCARDI OLOGY	18, 982	2, 223, 716				69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	000 5 ( 0	0.00000		0	70.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	12, 979					71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	9,659				0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	69, 653	2, 820, 381	0. 02469	6 77, 243	1, 908	73.00
	272.042	12 010 0/1	0.0001	1 4 0/1	104	01 00
91.00 09100 EMERGENCY	373, 942				124	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	104, 546					
200.00  Total (lines 50 through 199)	1, 271, 123	55, 380, 400	1	418, 690	13, 562	200.00

Health Financial Systems	ASCENSI ON ST.	VINCENT CLAY		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PAS	S Provider C	CN: 15-1309	Period:	Worksheet D	
THROUGH COSTS				From 07/01/2020		
				To 06/30/2021	Date/Time Pre	
					11/18/2021 4:4	43 pm
			XVIII	Hospi tal	Cost	
Cost Center Description				Allied Health	Allied Health	
		Post-Stepdown		Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS	1		-			
50.00 05000 OPERATING ROOM	0	C		0 0	0	50.00
53. 00 05300 ANESTHESI OLOGY	0	C		0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	C	)	0 0	0	54.00
60. 00 06000 LABORATORY	0	C		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	C		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	C		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	c c	)	0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	l c		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	l c		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	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0			0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS		-	1		-	
91. 00 09100 EMERGENCY	0	0		0 0	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
200.00 Total (lines 50 through 199)	0			0 0	0	200.00
			1	- I		

Health Financial Systems	ASCENSI ON ST.	VINCENT CLAY		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	S Provider C		Period:	Worksheet D	
THROUGH COSTS				From 07/01/2020 To 06/30/2021		narod
				To 06/30/2021	11/18/2021 4:	43 pm
		Title	e XVIII	Hospi tal	Cost	10 pm
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
	Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 O5000 OPERATI NG ROOM	0	0		0 6, 105, 226		50.00
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0. 000000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 14, 764, 468		
60. 00 06000 LABORATORY	0	0		0 10, 655, 452		60.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 610, 001		
66. 00 06600 PHYSI CAL THERAPY	0	0		0 2, 596, 770	0. 000000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 649, 653	0.00000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 246, 072	0.00000	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 2, 223, 716	0.00000	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0.00000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 893, 568	0.00000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 234, 881	0.00000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 2, 820, 381	0.00000	73.00
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	0	0		0 12, 819, 061	0. 000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 761, 151	0.00000	92.00
200.00   Total (lines 50 through 199)	0	0		0 55, 380, 400		200. 00

Health Financial Systems	ASCENSION ST. \	/INCENT CLAY		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	Provider CO	CN: 15-1309	Peri od:	Worksheet D	
THROUGH COSTS				From 07/01/2020 To 06/30/2021	Part IV Date/Time Pre	nared
				10 00/ 30/ 2021	11/18/2021 4:	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS	1 1		1		1	
50.00 05000 OPERATI NG ROOM	0. 000000	19, 226		0 0	0	50.00
53.00 05300 ANESTHESI OLOGY	0. 000000	0		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	58, 980		0 0	0	54.00
60. 00 06000 LABORATORY	0. 000000	97, 533		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	82, 060		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0.000000	22, 229		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0.000000	11, 697		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	2, 811		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	3, 506		0 0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	38, 133		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.000000	77, 243		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS			_			
91.00 09100 EMERGENCY	0. 000000	4, 261		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	1, 011		0 0	0	92.00
200.00 Total (lines 50 through 199)		418, 690		0 0	0	200. 00

Health Financial Systems	ASCENSI ON ST.	VINCENT CLAY		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CO		Period: From 07/01/2020 To 06/30/2021		
		Title	XVIII	Hospi tal	Cost	
			Charges		Costs	
Cost Center Description		PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 214022		1, 686, 89	1 0	0	
53. 00 05300 ANESTHESI OLOGY	0. 000000			0 0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 151080		3, 953, 41		0	54.00
60. 00 06000 LABORATORY	0. 255535	0	2, 866, 20	9 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 712474	0	89, 45	4 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 438737	0	673, 88	4 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 457604	0	74, 71	8 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 459463	0	17,05	2 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 098388	0	272, 94	1 0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 280130	0	193, 68	2 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 799286	0	66, 52	5 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 364927	0	1, 308, 11	0 2, 683	0	73.00
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	0. 355102	0	2, 126, 76	6 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 259260	0	217, 91	5 0	0	92.00
200.00 Subtotal (see instructions)		0	13, 547, 56	2 2, 683	0	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		0	13, 547, 56	2 2, 683	0	202.00

Health Financial Systems	ASCENSI ON ST.	VINCENT CLAY		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CC	CN: 15-1309	Period: From 07/01/2020 To 06/30/2021	Worksheet D Part V Date/Time Pre 11/18/2021 4:	
		Title	XVIII	Hospi tal	Cost	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATING ROOM	361, 032					50.00
53. 00 05300 ANESTHESI OLOGY	0	-				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	597, 282					54.00
60. 00 06000 LABORATORY	732, 417					60.00
65. 00 06500 RESPI RATORY THERAPY	63, 734					65.00
66. 00 06600 PHYSI CAL THERAPY	295, 658					66.00
67. 00 06700 OCCUPATI ONAL THERAPY	34, 191					67.00
68.00 06800 SPEECH PATHOLOGY	7,835					68.00
69. 00 06900 ELECTROCARDI OLOGY	26, 854					69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	54, 256					71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	53, 173					72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	477, 365	979				73.00
OUTPATIENT SERVICE COST CENTERS	755.040					
91.00 09100 EMERGENCY	755, 219					91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART)	274, 412					92.00
200.00 Subtotal (see instructions)	3, 733, 428	979				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges	2 7 2 2 4 2 0	070				202.00
202.00   Net Charges (line 200 - line 201)	3, 733, 428	979				202.00

Health Financial Systems	ASCENSION ST.	VINCENT CLAY		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CO		Period:	Worksheet D	
		Component (		From 07/01/2020 To 06/30/2021	Part V Date/Time Pre	nared
		component	50N. 15 2507	10 00/ 30/ 2021	11/18/2021 4:	
		Title	XVIII	Swing Beds - SNF		
			Charges		Costs	
Cost Center Description		PPS Reimbursed		Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.			
	1.00	0.00	(see inst.)	(see inst.)	F 00	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	0.014000	0		0	0	
50. 00 05000 0PERATI NG ROOM 53. 00 05300 ANESTHESI OLOGY	0. 214022 0. 000000			0 0	0	
	0. 000000			0 0	-	
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY	0. 151080			0 0	0	
65. 00 06500 RESPI RATORY THERAPY	0. 255535			0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY				0 0	Ű	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 438737 0. 457604			0 0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 457604			0 0	0	67.00
69. 00 06900 ELECTROCARDI OLOGY	0. 459463			0 0	0	
70. 00 07000 ELECTROEARD OLOGT	0. 098388			0 0	0	
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0. 280130			0 0	0	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 280130			0 0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 364927			0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS	0. 304927	0		0 0	0	73.00
91. 00 09100 EMERGENCY	0. 355102	0		0 0	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 259260			0 0	0	
200.00 Subtotal (see instructions)		0		0 0	, s	200.00
201.00 Less PBP Clinic Lab. Services-Program		l		0 0	Ű	201.00
Only Charges				-		
202.00 Net Charges (line 200 - line 201)		o		0 0	0	202.00

Health Financial Systems	ASCENSI ON ST.	VINCENT CLAY		In Lieu	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CC	CN: 15-1309	Peri od:	Worksheet D	
		Component (	CCN: 15-Z309	From 07/01/2020 To 06/30/2021	Part V Date/Time Pre	narod
		component (	JUN. 15-2309	10 00/30/2021	11/18/2021 4:	
		Title	XVIII	Swing Beds - SNF	Cost	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCI LLARY SERVI CE COST CENTERS						50.00
50. 00 05000 OPERATING ROOM	0	0				50.00
53. 00 05300 ANESTHESI OLOGY	0	0				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
	0	0				60.00
65. 00 06500 RESPI RATORY THERAPY	0	0				65.00
66. 00 06600 PHYSI CAL THERAPY	0	0				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0				67.00
68.00 06800 SPEECH PATHOLOGY	0	0				68.00
	0	0				69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS		0				
	0	0				73.00
0UTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY	0	0				91.00
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				91.00
200.00 Subtotal (see instructions)	0	0				200.00
201.00 Less PBP Clinic Lab. Services-Program	0	0				200.00
Only Charges	0					201.00
202.00 Net Charges (line 200 - line 201)	0	0				202.00
202.00   met charges (The 200 - The 201)	0	0	I			202.00

	Financial Systems ASCENSION ST. V ATION OF INPATIENT OPERATING COST	Provider CCN: 15-1309	Peri od:	u of Form CMS-2 Worksheet D-1	
			From 07/01/2020 To 06/30/2021	Date/Time Prep	
		Title XVIII	Hospi tal	11/18/2021 4:4 Cost	43
	Cost Center Description		- noopi tui	1.00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
00	INPATIENT DAYS Inpatient days (including private room days and swing-bed da	avs excluding newborn)		956	1 1
00	Inpatient days (including private room days, excluding swing			575	2
00	Private room days (excluding swing-bed and observation bed o		ivate room days,	0	3
00	do not complete this line. Semi-private room days (excluding swing-bed and observation	bed days)		239	4
00	Total swing-bed SNF type inpatient days (including private r		er 31 of the cost	185	
20	reporting period	noom dava) oftan Dacamban	21 of the east	10/	
00	Total swing-bed SNF type inpatient days (including private r reporting period (if calendar year, enter 0 on this line)	room days) arter becember	31 OF THE COST	196	6
0C	Total swing-bed NF type inpatient days (including private ro	oom days) through December	31 of the cost	0	7
00	reporting period Total swing-bed NF type inpatient days (including private ro	oom days) after December (	1 of the cost	0	8
50	reporting period (if calendar year, enter 0 on this line)		in on the cost	0	
00	Total inpatient days including private room days applicable	to the Program (excluding	swing-bed and	130	9
. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII	only (including private i	oom davs)	147	10
	through December 31 of the cost reporting period (see instru	uctions)	5		
00	Swing-bed SNF type inpatient days applicable to title XVIII December 31 of the cost reporting period (if calendar year,		room days) after	195	11
. 00	Swing-bed NF type inpatient days applicable to titles V or >		e room days)	0	12
~~	through December 31 of the cost reporting period				1.1
00	Swing-bed NF type inpatient days applicable to titles V or > after December 31 of the cost reporting period (if calendar			0	13
	Medically necessary private room days applicable to the Prog			0	14
00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	
. 00	SWING BED ADJUSTMENT			0	
. 00	Medicare rate for swing-bed SNF services applicable to servi	ices through December 31 o	of the cost		17
00	reporting period Medicare rate for swing-bed SNF services applicable to servi reporting period	ices after December 31 of	the cost		18
. 00	Medicaid rate for swing-bed NF services applicable to servic reporting period	ces through December 31 of	f the cost	216. 95	19
. 00	Medicaid rate for swing-bed NF services applicable to servic reporting period	ces after December 31 of	he cost	216. 95	20
. 00	Total general inpatient routine service cost (see instruction			2, 727, 126	21
. 00	Swing-bed cost applicable to SNF type services through Decem 5 x line 17)	mber 31 of the cost report	ing period (line	0	22
	Swing-bed cost applicable to SNF type services after December			-	24
00		er 31 of the cost reportin	ng period (line 6	0	
	x line 18) Swing-bed cost applicable to NF type services through Decemb			0	23
. 00	x line 18) Swing-bed cost applicable to NF type services through Decemb 7 x line 19)	ber 31 of the cost reporti	ng period (line	0	23 24
. 00	x line 18) Swing-bed cost applicable to NF type services through Decemb 7 x line 19) Swing-bed cost applicable to NF type services after December	ber 31 of the cost reporti	ng period (line		23 24
. 00 . 00 . 00	x line 18) Swing-bed cost applicable to NF type services through Decemb 7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions)	ber 31 of the cost reporting	ng period (line	0 0 1, 086, 856	23 24 25 26
. 00 . 00 . 00	x line 18) Swing-bed cost applicable to NF type services through Decemb 7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	ber 31 of the cost reporting	ng period (line	0	23 24 25 26
. 00 . 00 . 00 . 00	x line 18) Swing-bed cost applicable to NF type services through Decemb 7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions)	ber 31 of the cost reporting r 31 of the cost reporting t (line 21 minus line 26)	ng period (line period (line 8	0 0 1, 086, 856	23 24 25 26
00 00 00 00 00	x line 18) Swing-bed cost applicable to NF type services through Decemb 7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges)	ber 31 of the cost reporting r 31 of the cost reporting t (line 21 minus line 26)	ng period (line period (line 8	0 0 1, 086, 856 1, 640, 270 0 0	23 24 25 26 27 28 29
00 00 00 00 00 00	x line 18) Swing-bed cost applicable to NF type services through Decemb 7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)	ber 31 of the cost reporting r 31 of the cost reporting t (line 21 minus line 26) bed and observation bed ch	ng period (line period (line 8	0 1, 086, 856 1, 640, 270 0 0 0	23 24 25 26 27 28 29 30
00 00 00 00 00 00 00 00	x line 18) Swing-bed cost applicable to NF type services through Decemb 7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-te Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27)	ber 31 of the cost reporting r 31 of the cost reporting t (line 21 minus line 26) bed and observation bed ch	ng period (line period (line 8	0 1, 086, 856 1, 640, 270 0 0 0 0 0. 000000	23 24 25 26 27 28 29 30 31
00 00 00 00 00 00 00 00 00	x line 18) Swing-bed cost applicable to NF type services through Decemb 7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-b Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3)	ber 31 of the cost reporting r 31 of the cost reporting t (line 21 minus line 26) bed and observation bed cf 7 + line 28)	ng period (line period (line 8	0 1, 086, 856 1, 640, 270 0 0 0 0 0. 000000 0. 00	23 24 25 26 27 28 29 30 31 32
	x line 18) Swing-bed cost applicable to NF type services through Decemb 7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-b Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)	ber 31 of the cost reporting r 31 of the cost reporting t (line 21 minus line 26) bed and observation bed ch 7 ÷ line 28)	ng period (line g period (line 8 narges)	0 1, 086, 856 1, 640, 270 0 0 0 0. 000000 0. 000000 0. 00	23 24 25 26 27 28 29 30 31 32 33
00 00 00 00 00 00 00 00 00 00	x line 18) Swing-bed cost applicable to NF type services through Decemb 7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DI FFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-b Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 m	ber 31 of the cost reporting r 31 of the cost reporting t (line 21 minus line 26) bed and observation bed ch 7 ÷ line 28) ) minus line 33)(see instruct	ng period (line g period (line 8 narges)	0 1, 086, 856 1, 640, 270 0 0 0. 000000 0. 000000 0. 00 0. 00 0. 00	23 24 25 26 27 30 31 32 33 34
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	x line 18) Swing-bed cost applicable to NF type services through Decemb 7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 30 ÷ line 4) Average per diem private room cost differential (line 34 x l	ber 31 of the cost reporting r 31 of the cost reporting <u>t (line 21 minus line 26)</u> bed and observation bed ch 7 ÷ line 28) ) minus line 33)(see instruct line 31)	ng period (line g period (line 8 narges)	0 1, 086, 856 1, 640, 270 0 0 0 0. 000000 0. 000000 0. 00	23 24 25 26 27 28 29 30 31 32 33 34 35
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	x line 18) Swing-bed cost applicable to NF type services through Decemb 7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room cost differential (line 34 × l Private room cost differential adjustment (line 3 × line 35) General inpatient routine service cost net of swing-bed cost	ber 31 of the cost reporting r 31 of the cost reporting <u>t (line 21 minus line 26)</u> bed and observation bed ch 7 ÷ line 28) ) minus line 33)(see instruct line 31)	ng period (line g period (line 8 harges)	0 1, 086, 856 1, 640, 270 0 0 0. 000000 0. 000000 0. 00 0. 00 0. 00 0. 00	23 24 25 26 27 28 29 30 31 32 33 34 35 36
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	x line 18) Swing-bed cost applicable to NF type services through Decemb 7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-the Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 30 ÷ line 4) Average per diem private room cost differential (line 34 x 1 Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost 27 minus line 36)	ber 31 of the cost reporting r 31 of the cost reporting <u>t (line 21 minus line 26)</u> bed and observation bed ch 7 ÷ line 28) ) minus line 33)(see instruct line 31)	ng period (line g period (line 8 harges)	0 1, 086, 856 1, 640, 270 0 0 0 0. 000000 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00	23 24 25 26 27 28 29 30 31 32 33 34 35 36
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	x line 18) Swing-bed cost applicable to NF type services through Decemb 7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room cost differential (line 34 × l Private room cost differential adjustment (line 3 × line 35) General inpatient routine service cost net of swing-bed cost	ber 31 of the cost reporting r 31 of the cost reporting t (line 21 minus line 26) bed and observation bed ch 7 ÷ line 28) ) minus line 33)(see instruct line 31) ) t and private room cost di	ng period (line g period (line 8 harges)	0 1, 086, 856 1, 640, 270 0 0 0 0. 000000 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00	23 24 25 26 27 28 29 30 31 32 33 34 35 36
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	x line 18) Swing-bed cost applicable to NF type services through Decemb 7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-b Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 30 ÷ line 4) Average semi-private room per diem charge differential (line 32 m Average per diem private room cost differential (line 34 x l Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost 27 minus line 36) PART 11 - HOSPITAL AND SUBPROVIDERS ONLY	ber 31 of the cost reporting r 31 of the cost reporting t (line 21 minus line 26) bed and observation bed ch 7 ÷ line 28) ) minus line 33)(see instruct line 31) ) t and private room cost di DJUSTMENTS	ng period (line g period (line 8 harges)	0 1, 086, 856 1, 640, 270 0 0 0 0. 000000 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00	23 24 25 26 27 30 31 32 33 34 35 36 37
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	x line 18) Swing-bed cost applicable to NF type services through Decemb 7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-b Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room cost differential (line 34 × 1 Private room cost differential adjustment (line 3 × line 35) General inpatient routine service cost net of swing-bed cost 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AE	ber 31 of the cost reporting r 31 of the cost reporting t (line 21 minus line 26) bed and observation bed cf 7 ÷ line 28) ) minus line 33)(see instruct line 31) ) t and private room cost di DJUSTMENTS ee instructions) ne 38)	ng period (line g period (line 8 harges)	0 1, 086, 856 1, 640, 270 0 0 0. 000000 0. 00 0. 00 0.00000000	23 24 25 26 27 30 31 32 33 34 35 36 37 38 37

OMPUTATION OF INPATIEN	T OPERATING COST		Provider C		Period:	Worksheet D-1	
					From 07/01/2020 To 06/30/2021	Date/Time Pre 11/18/2021 4:	
Cost Contor	Decerintian	Tatal		XVIII	Hospital	Cost	
Cost Center	Description	Total Inpatient Costl	Total npatient Days	Average Per Diem (col. 1 col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
2.00 NURSERY (title V	& XIX only)						42.
3.00 INTENSIVE CARE U	pe Inpatient Hospital Units	1		1			43.
4.00 CORONARY CARE UN							43.
5.00 BURN INTENSIVE C							45.
6.00 SURGI CAL INTENSI							46.
7.00 OTHER SPECIAL CA						-	47.
Cost Center	Description					1 00	
8.00 Program inpatien	t ancillary service cost (Wk	st D_3 col 3	line 200)			1.00 154,814	48.
	patient costs (sum of lines			ns)		525, 657	
PASS THROUGH COST							
	ts applicable to Program inp	atient routine s	ervices (from	wkst. D, sum	of Parts I and	0	50.
1 00 Data through and					m of Doubo II	0	
1.00 Pass through cos and IV)	ts applicable to Program inp	atrent and trary	services (II	UNI WKSL. D, SU	IN OF PARTS IT	0	51.
,	cludable cost (sum of lines	50 and 51)				0	52.
5	patient operating cost exclu		ated, non-phy	sician anesthe	etist, and	0	
	n costs (line 49 minus line	52)					
	LIMIT COMPUTATION					0	
4.00 Program discharg 5.00 Target amount pe						0 0.00	
5.00 Target amount (1						0.00	
5	en adjusted inpatient operat	ing cost and tar	get amount (I	ine 56 minus l	ine 53)	0	57.
3.00 Bonus payment (se						0	
	53/54 or 55 from the cost re	porting period e	nding 1996, ι	pdated and cor	npounded by the	0.00	59.
market basket 0.00 Lesser of lines !	53/54 or 55 from prior year	cost report und	ated by the m	arket hasket		0.00	60.
	less than the lower of line				the amount by	0.00	
	costs (line 53) are less tha					-	
	otherwise enter zero (see	instructions)					
2.00 Relief payment (		ant (and instruc	ti ana)			0	
	ent cost plus incentive paym ROUTINE SWING BED COST	ient (see instruc	tions)			0	63.
	ed SNF inpatient routine cos	ts through Decem	ber 31 of the	cost reportin	ng period (See	419, 338	64.
instructions)(ti							
	ed SNF inpatient routine cos	sts after Decembe	r 31 of the c	ost reporting	period (See	556, 265	65.
instructions)(ti 6.00 Total Medicare s	ving-bed SNF inpatient routi	ne costs (line 6	4 nlus line A	5)(title XVIII	only) For	975, 603	66
CAH (see instruct					onity). Tor	773,003	00.
	ving-bed NF inpatient routin	e costs through	December 31 c	of the cost rep	porting period	0	67.
(line 12 x line							
	ving-bed NF inpatient routin	e costs after De	cember 31 of	the cost repoi	rting period	0	68.
line 13 x line 19.00 Total title V or	XIX swing-bed NF inpatient	routine costs (1	ine 67 + line	68)		0	69.
	D NURSING FACILITY, OTHER N			,			
0.00 Skilled nursing	facility/other nursing facil	ity/ICF/IID rout	ine service c	ost (line 37)			70.
	inpatient routine service c		ne 70 ÷ line	2)			71.
5	service cost (line 9 x line ary private room cost applic	,	(line 14 v !:	no 35)			72.
	neral inpatient routine serv						74.
5 5	cost allocated to inpatient	•			art II, column		75.
26, line 45)	•						
	related costs (line 75 ÷ li						76.
U 1	related costs (line 9 x line service cost (line 74 minu						77.
	e service cost (line 74 minu s to beneficiaries for exces		ovider record	ls)			79.
55 5 5	itine service costs for comp	• •		· · ·	us line 79)		80.
.00 Inpatient routine	e service cost per diem limi			-			81.
	e service cost limitation (I	,					82.
	ent routine service costs (		)				83.
	t ancillary services (see in ew - physician compensation		s)				84.
	patient operating costs (sum						85.
<u>v</u>	TION OF OBSERVATION BED PAS						1 30.
7.00 Total observation	n bed days (see instructions	5)				336	
8.00 Adjusted general	inpatient routine cost per	•	line 2)			2, 852. 64	
3	cost (line 87 x line 88) (se					958, 487	

Health Financial Systems	ASCENSION ST.	VINCENT CLAY		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Peri od:	Worksheet D-1	
				From 07/01/2020 To 06/30/2021	Date/Time Pre 11/18/2021 4:	
		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	297, 458	2, 727, 126	0. 10907	4 958, 487	104, 546	90.00
91.00 Nursing School cost	0	2, 727, 126	0.00000	958, 487	0	91.00
92.00 Allied health cost	0	2, 727, 126	0. 00000	958, 487	0	92.00
93.00 All other Medical Education	0	2, 727, 126	0.00000	958, 487	0	93.00

MPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-1309	Period:	Worksheet D-1	
			To 06/30/2021		
		Title XIX	Hospi tal		43
	Cost Center Description	From B7/01/2020 Title XIX         From B7/01/2020 Title XIX         Date / Time Propertion (11/18/2011 4/43           cmip rivate         Title XIX         Hospital         Cost           cmip rivate         Total XIX         Hospital         Cost           cmip rivate         Cost         Total XIX         From SIX           cmip rivate         Cost         Cost         Cost           cmip rivate         Cost         Cost         Cost           cmip rivate         Cost         Cost         Cost         Cost           cmip rivate         Cost         Cost         Cost         Cost         Cost           cmip rivate         Cost         Cost			
	PART I - ALL PROVIDER COMPONENTS			1.00	
~~	INPATIENT DAYS			05/	
00 00					
00	Private room days (excluding swing-bed and observation bed da		rivate room days,		
0	do not complete this line.	and dave)		220	
00			er 31 of the cost		
	reporting period	5			
00	Total swing-bed SNF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line)	oom days) after December	31 of the cost	196	6
00		om days) through December	<sup>-</sup> 31 of the cost	0	7
~~	reporting period		1 - <del>C</del> + b +		
00	reporting period (if calendar year, enter 0 on this line)	om days) arter December .	or the cost	0	8
00	Total inpatient days including private room days applicable t	to the Program (excluding	g swing-bed and	0	9
00	newborn days) (see instructions) Swing-bed SNE type inpatient days applicable to title XVIII o	only (including private u	coom dave)	0	10
00	through December 31 of the cost reporting period (see instruc		oom days)	0	
00			room days) after	0	1
00			te room davs)	0	12
	through December 31 of the cost reporting period	<u> </u>	5 -		
00				0	13
00				0	14
	Total nursery days (title V or XIX only)		-	-	
00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16
00		ces through December 31 (	of the cost		11
00	reporting period	an often December 21 of	the east		1
00	reporting period	ces after December 31 of	the cost		18
00		es through December 31 of	f the cost	216. 95	19
. 00	reporting period Medicaid rate for swing-bed NE services applicable to service	es after December 31 of i	the cost	216 95	20
00	reporting period				
	Total general inpatient routine service cost (see instruction				
00	5 x line 17)	per 31 of the cost report	ting period (line	0	22
. 00	Swing-bed cost applicable to SNF type services after December	- 31 of the cost reportin	ng period (line 6	0	23
00	x line 18) Swing-bed cost applicable to NE type services through Decembe	or 31 of the cost reporti	na period (line	0	24
00	7 x line 19)		ng period (rine	0	2
. 00		31 of the cost reporting	g period (line 8	0	25
. 00	x line 20) Total swing-bed cost (see instructions)			1, 086, 856	26
	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)			
00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	ed and observation bed of	arges)	0	28
	Private room charges (excluding swing-bed charges)		u 903)		
00	Semi-private room charges (excluding swing-bed charges)			0	30
00 00	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 = line 3)	÷line 28)			
	Average semi-private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)				
		nus line 33)(see instruc	ctions)		
	Average per diem private room cost differential (line 34 x li	ne 31)			
	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost pet of swing-bed cost	and private room cost di	fforential (line	-	
	27 minus line 36)	and private room cost di	inerentiar (ITNe	1, 040, 270	3
. 00	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
. 00					1. C.
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ			2 852 64	20
. 00		e instructions)		2, 852. 64 0	

OMPUTATION OF INPATIENT OPERATING COST		Provider C		Period:	Worksheet D-	1
				From 07/01/2020 To 06/30/2021	Date/Time Pre 11/18/2021 4:	
Cost Center Description	Total	Ti tl Total	e XIX Average Per	Hospital Program Days	Cost Program Cost	
cost center bescription	Inpatient Cost				(col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
2.00 NURSERY (title V & XIX only)						42.
Intensive Care Type Inpatient Hospital Ur 3.00 INTENSIVE CARE UNIT						43.
4. 00 CORONARY CARE UNIT						43.
5. 00 BURN INTENSIVE CARE UNIT						45.
5. 00 SURGI CAL I NTENSI VE CARE UNI T						46.
7. 00 OTHER SPECIAL CARE (SPECIFY)						47.
Cost Center Description					1.00	
3.00 Program inpatient ancillary service cost	(Wkst. D-3, col. 3,	line 200)			1.00	48.
9.00 Total Program inpatient costs (sum of lir			ons)		(	) 49.
PASS THROUGH COST ADJUSTMENTS						
0.00 Pass through costs applicable to Program	inpatient routine s	services (from	n Wkst. D, sum	of Parts I and	C	50.
1.00 Pass through costs applicable to Program	inpatient ancillary	/ services (fr	om Wkst D s	m of Parts II	C	51.
and IV)		,				
2.00 Total Program excludable cost (sum of lir					C	
3.00 Total Program inpatient operating cost ex		ated, non-phy	sician anesth	etist, and	C	53.
medical education costs (line 49 minus li TARGET AMOUNT AND LIMIT COMPUTATION	ne 52)					-
4. 00 Program di scharges					(	54.
5.00 Target amount per discharge					0.00	55.
5.00 Target amount (line 54 x line 55)					(	
7.00 Difference between adjusted inpatient ope	erating cost and tar	rget amount (I	ine 56 minus	ine 53)	(	
3.00  Bonus payment (see instructions) 9.00  Lesser of lines 53/54 or 55 from the cost	t reporting period e	nding 1996 i	indated and co	mounded by the	0.00	
market basket	r reporting period e	shuring 1770, c		ipounded by the	0.00	J 37.
0.00 Lesser of lines 53/54 or 55 from prior ye					0.00	60.
1.00 If line 53/54 is less than the lower of I				2	(	) 61.
which operating costs (line 53) are less amount (line 56), otherwise enter zero (s		s (TThes 54 x	60), or 1% or	the target		
2.00 Relief payment (see instructions)					C	62.
3.00 Allowable Inpatient cost plus incentive p	payment (see instruc	ctions)			(	63.
PROGRAM INPATIENT ROUTINE SWING BED COST	anota through Dagan	box 21 of the	ant report	an portiod (Soo		
4.00 Medicare swing-bed SNF inpatient routine instructions)(title XVIII only)	costs through Decen	nder 31 of the	e cost reporti	ng period (See	C	64.
5.00 Medicare swing-bed SNF inpatient routine	costs after Decembe	er 31 of the c	cost reporting	period (See	C	65.
instructions)(title XVIII only)						
5.00 Total Medicare swing-bed SNF inpatient ro	outine costs (line é	64 plus line 6	5)(title XVII	only). For	(	66.
CAH (see instructions) 7.00 Title V or XIX swing-bed NF inpatient rou	utine costs through	December 31 c	of the cost re	porting period	C	67.
(line 12 x line 19)				sorting period		
3.00 Title V or XIX swing-bed NF inpatient rou	utine costs after De	ecember 31 of	the cost repo	rting period	C	68.
(line 13 x line 20)	ant noutine costs (1	ing (7 . ling	(0)			
P. 00 Total title V or XIX swing-bed NF inpatie PART III - SKILLED NURSING FACILITY, OTHE	· · · ·		/		(	) 69.
0.00 Skilled nursing facility/other nursing facility						70.
1.00 Adjusted general inpatient routine servic		ne 70 ÷ line	2)			71.
2.00 Program routine service cost (line 9 x li	,	(1. 44 1.	25)			72.
3.00 Medically necessary private room cost app 4.00 Total Program general inpatient routine s						73.
5.00 Capital related cost allocated to inpatie	•			art II, column		75.
26, line 45)						
5.00 Per diem capital-related costs (line 75						76.
7.00  Program capital-related costs (line 9 x   3.00  Inpatient routine service cost (line 74 m						77.
B.00  Inpatient routine service cost (line 74 m D.00  Aggregate charges to beneficiaries for ex	· ·	rovi der record	ls)			78.
.00 Total Program routine service costs for o			· · ·	us line 79)		80.
.00 Inpatient routine service cost per diem I	•		-	,		81.
. 00 Inpatient routine service cost limitation	• • • •					82.
3.00 Reasonable inpatient routine service cost	•	5)				83.
4.00  Program inpatient ancillary services (see 5.00  Utilization review - physician compensati		ns)				84.
5.00 Total Program inpatient operating costs (						86.
PART IV - COMPUTATION OF OBSERVATION BED	•	~ ,				
7.00 Total observation bed days (see instructi					336	
3.00 Adjusted general inpatient routine cost p 9.00 Observation bed cost (line 87 x line 88)		line 2)			2, 852. 64 958, 487	
						1 07

Health Financial Systems	ASCENSION ST.	VINCENT CLAY		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Peri od:	Worksheet D-1	
				From 07/01/2020 To 06/30/2021	Date/Time Pre 11/18/2021 4:	
		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	297, 458	2, 727, 126	0. 10907	4 958, 487	104, 546	90.00
91.00 Nursing School cost	0	2, 727, 126	0.00000	958, 487	0	91.00
92.00 Allied health cost	0	2, 727, 126	0.00000	958, 487	0	92.00
93.00 All other Medical Education	0	2, 727, 126	0.00000	958, 487	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT         Provider CN: 15-1309         Period: From 07/01/200 To         Worksheet D-3           INPATIENT ANCILLARY SERVICE COST APPORTIONMENT         Inpatient         Hord / 11/18/2021         Date/Time Prepared: 11/18/2021         Date/Time Prepared: 11	Health Financial Systems	ASCENSION ST. VINCENT CLAY		In Lie	u of Form CMS-:	2552-10
To         06/30/2021         Date/Time Prepared: 11/18/2021 4:43 pm           Title XVIII         Hospital         Cost           Cost Center Description         Title XVIII         Hospital         Cost           Cost Center Description         Inpatient Program Costs Col. 1 x col. 2)         Inpatient Program Costs Col. 1 x col. 2)           1.00         2.00         3.00           Ancite XVICE COST CENTERS           50.00         05300 [APULTS & PEDIATRI CS ANCILLARY SERVICE COST CENTERS         30.00           50.00         05300 [AVESTHESI OLOGY         0.000000         0         0         53.00           50.00         05300 [AVESTHESI OLOGY         0.151080         58.980         8.911         53.00           50.00         05300 [AVESTHESI OLOGY         0.151080         58.980         8.911         54.00           60.00         06500 [RESPI RATORY THERAPY         0.214022         19.226         4.115         50.00           60.00         06500 [RESPI RATORY THERAPY         0.214022         9.753         60.00           60.00         06500 [RESPI RATORY THERAPY         0.438737         22.22         9.753         66.00						

Health Financial Systems	ASCENSION ST. VINCENT CLAY		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C		Period:	Worksheet D-3	
	Component		From 07/01/2020 To 06/30/2021	Date/Time Pre	pared <sup>.</sup>
	competition e			11/18/2021 4:	
	Title		Swing Beds - SNF		
Cost Center Description		Ratio of Cost		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	2.00	2)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS		1			30.00
ANCI LLARY SERVICE COST CENTERS		1			30.00
50. 00 05000 OPERATING ROOM		0. 21402	2 13, 676	2, 927	50.00
53. 00 05300 ANESTHESI OLOGY		0.00000		0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C		0. 15108		2, 594	54.00
60. 00 06000 LABORATORY		0. 25553	5 59, 936	15, 316	60.00
65. 00 06500 RESPI RATORY THERAPY		0. 71247	4 137, 791	98, 173	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 43873	7 140, 044	61, 442	66.00
67.00 06700 OCCUPATI ONAL THERAPY		0. 45760	4 86, 844	39, 740	67.00
68.00 06800 SPEECH PATHOLOGY		0. 45946			
69. 00 06900 ELECTROCARDI OLOGY		0. 09838		79	
70. 00 07000 ELECTROENCEPHALOGRAPHY		0.00000		0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 28013			71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 79928		0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0.36492	7 74, 123	27, 049	73.00
91.00 OUTPATIENT SERVICE COST CENTERS		0. 35510	2 0	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 25926			
200.00 Total (sum of lines 50 through 94 and	96 through 98)	1.23720	565, 490		
201.00 Less PBP Clinic Laboratory Services-Pr			505, 490 N		200.00
202.00 Net charges (line 200 minus line 201)	ogram only charges (inne of)		565, 490		201.00
		1	505,470	I	202.00

Health Financial Systems	ASCENSION ST. VINCENT CLAY		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CC	CN: 15-1309	Peri od:	Worksheet D-3	
			From 07/01/2020 To 06/30/2021	Date/Time Pre	nared
			10 00/ 50/ 2021	11/18/2021 4:	43 pm
	Titl	e XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges		Program Costs	
			Charges	(col. 1 x col.	
		1.00	0.00	2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS           30. 00         03000 ADULTS & PEDI ATRI CS			0		30, 00
ANCI LLARY SERVICE COST CENTERS			0		30.00
50. 00 05000 OPERATI NG ROOM		0, 21402	0	0	50, 00
53. 00 05300 ANESTHESI OLOGY		0. 00000	-	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 15108		0	54.00
60. 00 06000 LABORATORY		0. 25553		0	60.00
65. 00 06500 RESPI RATORY THERAPY		0.71247	74 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY		0.43873	37 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY		0.45760	04 0	0	67.00
68.00 06800 SPEECH PATHOLOGY		0.45946	53 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY		0. 09838	38 0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0.0000		0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 28013		0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 79928		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 36492	27 0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
91.00 09100 EMERGENCY		0.35510		0	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)		1. 25926	0 0	0	92.00
200.00 Total (sum of lines 50 through 94 and 9			0		200. 00 201. 00
201.00 Less PBP Clinic Laboratory Services-Pro	ogram only charges (line 61)		0		
202.00 Net charges (line 200 minus line 201)	I		I U		202.00

	Financial Systems     ASCENSION ST. VINCENT CLAY     In Li       ATION OF REIMBURSEMENT SETTLEMENT     Provider CCN: 15-1309     Period:	eu of Form CMS-2 Worksheet E	2552-10
CALCUL	From 07/01/2020 To 06/30/2021	) Part B I Date/Time Pre	
	Title XVIII Hospital	11/18/2021 4: 4 Cost	43 pm_
	PART B - MEDICAL AND OTHER HEALTH SERVICES	1.00	
1.00	Medical and other services (see instructions)	3, 734, 407	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments	0	3.00
4.00 4.01	Outlier payment (see instructions) Outlier reconciliation amount (see instructions)	0	4.00 4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00 8.00	Sum of lines 3, 4, and 4.01, divided by line 6 Transitional corridor payment (see instructions)	0.00	7.00 8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acqui si ti ons	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES	3, 734, 407	11.00
	Reasonable charges		
12.00	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) Customary charges	0	14.00
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis	0	16.00
17.00	had such payment been made in accordance with 42 CFR §413.13(e) Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17 00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see	0	19.00
20.00	instructions) Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see	0	20.00
20.00	instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	3, 771, 751	
22.00 23.00	Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see instructions)	0	22.00 23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00 26.00	Deductibles and coinsurance amounts (for CAH, see instructions) Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	43, 779 2, 066, 664	25. 00 26. 00
20.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see	1, 661, 308	
	instructions)		
28.00 29.00	Direct graduate medical education payments (from Wkst. E-4, line 50) ESRD direct medical education costs (from Wkst. E-4, line 36)	0	28. 00 29. 00
30.00	Subtotal (sum of lines 27 through 29)	1, 661, 308	
31.00	Primary payer payments	1, 426	
32.00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	1, 659, 882	32.00
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	320, 177	
35.00 36.00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions)	208, 115 268, 971	35.00 36.00
37.00	Subtotal (see instructions)	1, 867, 997	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00 39.50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00 30.50
39.30 39.97	Pioneer ACO demonstration payment adjustment (see instructions) Demonstration payment adjustment amount before sequestration	0	39. 50 39. 97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40. 00 40. 01	Subtotal (see instructions) Sequestration adjustment (see instructions)	1, 867, 997	40. 00 40. 01
40. 02	Demonstration payment adjustment amount after sequestration	0	40. 02
40. 03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00 41.01	Interim payments Interim payments-PARHM	1, 817, 587	41.00 41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01
43. 00 43. 01	Balance due provider/program (see instructions) Balance due provider/program-PARHM (see instructions)	50, 410	43.00 43.01
43.01 44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	0	
	<u>\$115.2</u>		
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		1 0	74.00

NALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC	CN: 15-1309	Period: From 07/01/2020 To 06/30/2021	Worksheet E-1 Part I Date/Time Prep 11/18/2021 4:4	pared
		Title	XVIII	Hospi tal	Cost	
		I npati en	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		404, 33	37 0	1, 817, 587 0	1. 2.
. 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			0	0	3.
. 02				0	0	
. 03 . 04				0	0	3. 3.
. 04 . 05				0	0	
. 00	Provider to Program	1				
50	ADJUSTMENTS TO PROGRAM			0	0	
51				0	0	
52				0	0	
53 54				0	0	3
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	
00	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		404, 33	37	1, 817, 587	4.
00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after					5.
00	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					5
01	TENTATI VE TO PROVIDER			0	0	5
02				0	0	
03				0	0	5
FO	Provider to Program					-
50 51	TENTATI VE TO PROGRAM			0	0	
52				0	0	
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	5
00	Determined net settlement amount (balance due) based on the cost report. (1)					6
01	SETTLEMENT TO PROVIDER		81, 3		50, 410	
02	SETTLEMENT TO PROGRAM		40E 7	0	0 1 947 007	6
00	Total Medicare program liability (see instructions)		485, 7	Contractor	1,867,997 NPR Date	7
				Number	(Mo/Day/Yr)	
		C		1.00	2.00	

NALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider Concernent (	CN: 15-1309 CCN: 15-Z309	Peri From To	od: 07/01/2020 06/30/2021	Date/Time Pre	pared
		Title	XVIII	Swin	g Beds - SNF	11/18/2021 4: Cost	43 pr
			t Part A	JSWIT		T B	
			Amount	n	nm/dd/yyyy	Amount	
		1.00	2.00		3. 00	4.00	
. 00	Total interim payments paid to provider		985, 7	77		0	1. (
. 00	Interim payments payable on individual bills, either			0		0	2.0
	submitted or to be submitted to the contractor for						
	services rendered in the cost reporting period. If none,						
. 00	write "NONE" or enter a zero						1
. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate						3. (
	for the cost reporting period. Also show date of each						
	payment. If none, write "NONE" or enter a zero. (1)						
	Program to Provider						
. 01	ADJUSTMENTS TO PROVIDER			0		0	
. 02				0		0	
. 03				0		0	
. 04 . 05				0 0		0	
. 05	Provider to Program			0		0	· 3.
50	ADJUSTMENTS TO PROGRAM			0		0	3.
51				0		0	3.
52				0		0	3.
. 53				0		0	
. 54				0		0	
. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0		0	3.
. 00	Total interim payments (sum of lines 1, 2, and 3.99)		985, 7	77		0	4.
. 00	(transfer to Wkst. E or Wkst. E-3, line and column as		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			Ű	
	appropri ate)						
	TO BE COMPLETED BY CONTRACTOR	1					
. 00	List separately each tentative settlement payment after						5.
	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						
	Program to Provider					L	
. 01	TENTATI VE TO PROVI DER			0		0	5.
. 02				0		0	5.
03				0		0	5.
	Provider to Program						
50 51	TENTATI VE TO PROGRAM			0		0	
51				0		0	
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0		0	
,,	5. 50-5. 98)			Ŭ		l s	
00	Determined net settlement amount (balance due) based on					l	6.
_	the cost report. (1)					1	
01	SETTLEMENT TO PROVIDER		252, 9			0	
02	SETTLEMENT TO PROGRAM		1, 238, 7	0		0	
. 00	Total Medicare program liability (see instructions)		1,238,7		Contractor	NPR Date	7.
					Number	(Mo/Day/Yr)	
		(	)		1.00	2.00	
00	Name of Contractor						8.

Heal th	Financial Systems ASCENSION ST. VII	NCENT CLAY	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1309	Peri od:	Worksheet E-1	
			From 07/01/2020		
			To 06/30/2021	Date/Time Pre 11/18/2021 4:	
		Title XVIII	Hospi tal	Cost	43 pili
			10301 tui	0031	
				1,00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				1
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.	S-3, Pt. I col. 15 line	14		1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8	-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 l	ine 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of c	ertified HIT technology	Wkst. S-2, Pt. I		7.00
	line 168				
8.00	Calculation of the HIT incentive payment (see instructions)				8.00
9.00	Sequestration adjustment amount (see instructions)				9.00
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				-
	Initial/interim HIT payment adjustment (see instructions)				30.00
	Other Adjustment (specify)				31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and l	ine 31) (see instruction	s)		32.00

	inancial Systems ASCENSION ST. VINCEN FION OF REIMBURSEMENT SETTLEMENT - SWING BEDS Pro	vider CCN: 15-1309	Peri od:	u of Form CMS-2 Worksheet E-2	
		nponent CCN: 15-Z309	From 07/01/2020 To 06/30/2021	Date/Time Prep 11/18/2021 4:4	
		Title XVIII	Swing Beds - SNF		
			Part A	Part B	
			1.00	2.00	
	OMPUTATION OF NET COST OF COVERED SERVICES		005 250	0	1 1
	npatient routine services - swing bed-SNF (see instructions)		985, 359	0	
	npatient routine services - swing bed-NF (see instructions) ncillary services (from Wkst. D-3, col. 3, line 200, for Part A,	and cum of Wket D	260, 414	0	2
	art V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-b			0	3
	nstructions)	eu pass-tillough, see			
	lursing and allied health payment-PARHM (see instructions)				3
	er diem cost for interns and residents not in approved teaching	program (see		0.00	4
i	nstructions)				
	rogram days		342	0	
	nterns and residents not in approved teaching program (see instr			0	
	Itilization review - physician compensation - SNF optional method	onl y	0		7
	ubtotal (sum of lines 1 through 3 plus lines 6 and 7)		1, 245, 773	0	8
	rimary payer payments (see instructions) ubtotal (line 8 minus line 9)		1 245 772	0	9 10
	eductibles billed to program patients (exclude amounts applicabl	e to physician	1, 245, 773	0	11
	rofessional services)	e to physician	0	0	''
	ubtotal (line 10 minus line 11)		1, 245, 773	0	12
	oinsurance billed to program patients (from provider records) (e	xcl ude coi nsurance	7,049	0	13
f	or physician professional services)				
00 8	0% of Part B costs (line 12 x 80%)			0	14
	ubtotal (see instructions)		1, 238, 724	0	15
	THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16
	ioneer ACO demonstration payment adjustment (see instructions)	<b>`</b>			16
	ural community hospital demonstration project (§410A Demonstrati	on) payment	0		16
	djustment (see instructions) wemonstration payment adjustment amount before sequestration		0	0	16
	I lowable bad debts (see instructions)		0	0	
	djusted reimbursable bad debts (see instructions)		0	0	
	llowable bad debts for dual eligible beneficiaries (see instruct	ions)	0	0	
	otal (see instructions)		1, 238, 724	0	
01 S	equestration adjustment (see instructions)		0	0	19
02 D	emonstration payment adjustment amount after sequestration)		0	0	19
	equestration adjustment-PARHM pass-throughs				19
	equestration for non-claims based amounts (see instructions)		0	0	
	nterim payments		985, 777	0	
	nterim payments-PARHM			0	20
	entative settlement (for contractor use only) entative settlement-PARHM (for contractor use only)		0	0	21
	alance due provider/program (line 19 minus lines 19.01, 19.02, 1	0.25.20 and 21)	252, 947	0	
	al ance due provider/program-PARHM (see instructions)	7.20, 20, and 21)	232, 747	0	22
	Protested amounts (nonallowable cost report items) in accordance	with CMS Pub. 15-2.	0	0	
	hapter 1, §115.2				
R	ural Community Hospital Demonstration Project (§410A Demonstration	on) Adjustment			
	s this the first year of the current 5-year demonstration period	under the 21st			200
	entury Cures Act? Enter "Y" for yes or "N" for no.				
	ost Reimbursement				001
	ledicare swing-bed SNF inpatient routine service costs (from Wkst 6 (title XVIII hospital))	. D-I, Pt. II, IIne			201
	ledicare swing-bed SNF inpatient ancillary service costs (from Wk	st D-3 col 3 lin	۹		202
	00 (title XVIII swing-bed SNF))		0		202
	otal (sum of lines 201 and 202)				203
	ledicare swing-bed SNF discharges (see instructions)				204
	omputation of Demonstration Target Amount Limitation (N/A in fir	st year of the curre	nt 5-year demonst	ration	
	eriod)				
	ledicare swing-bed SNF target amount				205
	ledicare swing-bed SNF inpatient routine cost cap (line 205 times				206
	djustment to Medicare Part A Swing-Bed SNF Inpatient Reimburseme program reimbursement under the §410A Demonstration (see instruct				207
	ledicare swing-bed SNF inpatient service costs (from Wkst. E-2, c	-	1		207
	nd 3)		·		200
	djustment to Medicare swing-bed SNF PPS payments (see instructio	ns)			209
	leserved for future use				210
	omparision of PPS versus Cost Reimbursement				
	otal adjustment to Medicare swing-bed SNF PPS payment (line 209	plus line 210) (see			215

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1309	Period: From 07/01/2020		
			To 06/30/2021	Date/Time Pre 11/18/2021 4:	
		Title XVIII	Hospi tal	Cost	
				1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICA	ARE PART & SERVICES - COST		1.00	
00	Inpatient services	ARE FART A SERVICES COST	RETINDORSEMENT	525, 657	1 1.
. 00	Nursing and Allied Health Managed Care payment (see instruc	ctions)		0	
. 00	Organ acqui si ti on			0	3.
. 00	Subtotal (sum of lines 1 through 3)			525, 657	
. 00	Primary payer payments			18, 525	
. 00	Total cost (line 4 less line 5). For CAH (see instructions)	)		512, 389	6
	COMPUTATION OF LESSER OF COST OR CHARGES				-
00	Reasonable charges Routine service charges			0	
. 00 . 00	Ancillary service charges			0	
. 00	Organ acquisition charges, net of revenue			0	
D. 00	Total reasonable charges			0	
	Customary charges			-	1.1
1.00	Aggregate amount actually collected from patients liable for	or payment for services on	a charge basis	0	111
2.00	Amounts that would have been realized from patients liable	for payment for services of	n a charge basis	0	12
	had such payment been made in accordance with 42 CFR 413.13	3(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	
5.00	Excess of customary charges over reasonable cost (complete instructions)	only if line 14 exceeds li	ne 6) (see	0	15
6. 00	Excess of reasonable cost over customary charges (complete	only if line 6 exceeds lin	a 14) (see	0	16
0.00	instructions)		(300	0	'0
7.00	Cost of physicians' services in a teaching hospital (see in	nstructions)		0	17
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
3.00	Direct graduate medical education payments (from Worksheet	E-4, line 49)		0	
9.00	Cost of covered services (sum of lines 6, 17 and 18)			512, 389	
0.00	Deductibles (exclude professional component)			27, 588	
1.00 2.00	Excess reasonable cost (from line 16) Subtotal (line 19 minus line 20 and 21)			0	
2.00	Coi nsurance			484, 801 0	
I. 00	Subtotal (line 22 minus line 23)			484, 801	
5.00	Allowable bad debts (exclude bad debts for professional ser	rvices) (see instructions)		1, 408	
5.00	Adjusted reimbursable bad debts (see instructions)			915	
. 00	Allowable bad debts for dual eligible beneficiaries (see in	nstructions)		0	
3. 00	Subtotal (sum of lines 24 and 25, or line 26)			485, 716	28
9.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
9.50	Pioneer ACO demonstration payment adjustment (see instructi			0	
9.99	Demonstration payment adjustment amount before sequestration	on		0	1
0.00	Subtotal (see instructions)			485, 716	
). 01	Sequestration adjustment (see instructions)			0	
). 02 ). 03	Demonstration payment adjustment amount after sequestration	[]		0	30
. 03	Sequestration adjustment-PARHM Interim payments			404, 337	
1.00	Interim payments-PARHM			404, 337	31
2.00	Tentative settlement (for contractor use only)			0	
2. 01	Tentative settlement-PARHM (for contractor use only)			0	32
3.00	Balance due provider/program (line 30 minus lines 30.01, 30	0.02, 31, and 32)		81, 379	
0 04	Balance due provider/program-PARHM (lines 2, 3, 18, and 26,		and 32.01)		33
3. 01					

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1309	Peri od:	Worksheet E-3	2552-10
			From 07/01/2020		norod.
			To 06/30/2021	Date/Time Pre 11/18/2021 4:	43 pm
		Title XIX	Hospi tal	Cost	
			Inpati ent	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SI COMPUTATION OF NET COST OF COVERED SERVICES	ERVICES FOR TITLES V OR X	ATX SERVICES		-
1.00	Inpatient hospital/SNF/NF services		0		1.00
2.00	Medical and other services		0	0	
3.00	Organ acquisition (certified transplant centers only)		0	-	3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	
7.00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable Charges				-
8.00	Routi ne servi ce charges		0		8.00
9.00	Ancillary service charges		0	0	
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)		0	0	12.00
10.00	CUSTOMARY CHARGES	· · ·			1 4 9 9 9
13.00	Amount actually collected from patients liable for payment for basis	or services on a charge	0	0	13.00
14.00	Amounts that would have been realized from patients liable f	or navment for services o	on O	0	14.00
14.00	a charge basis had such payment been made in accordance with		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		0	0	
17.00	Excess of customary charges over reasonable cost (complete o	nly if line 16 exceeds	0	0	17.00
10 00	line 4) (see instructions)			0	10.00
18.00	Excess of reasonable cost over customary charges (complete or 16) (see instructions)	niy if line 4 exceeds if	1e 0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see ins	tructions)	0	0	1
21.00	Cost of covered services (enter the lesser of line 4 or line		0	0	
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	e completed for PPS provi	ders.		
22.00	Other than outlier payments		0	0	
23.00	Outlier payments		0	0	
24.00	Program capital payments		0		24.00
25.00 26.00	Capital exception payments (see instructions) Routine and Ancillary service other pass through costs		0	0	25.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	1
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	
29.00	Titles V or XIX (sum of lines 21 and 27)		0	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30. 00	Excess of reasonable cost (from line 18)		0	0	
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and	6)	0	0	
32.00	Deducti bl es Coi nsurance		0	0	1
33.00	Allowable bad debts (see instructions)		0	0	
35.00	Utilization review		0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 a	nd 33)	0	0	1
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	-	0	0	1
38.00	Subtotal (line 36 ± line 37)		0	0	
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	)	0	0	
41.00	Interim payments		0	0	
10 05	Balance due provider/program (line 40 minus line 41)		0	0	42.00
42.00 43.00	Protested amounts (nonallowable cost report items) in accord	anaa with CMC Dut 15 C	0	0	

	E SHEET (If you are nonproprietary and do not maintain	Provider CC		eriod: rom 07/01/2020	Worksheet G	
nia-i niy)	ype accounting records, complete the General Fund column		T		Date/Time Pre 11/18/2021 4:	
		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	226	0	0	0	1 1.
00	Temporary investments	0	0	0	0	2.
00	Notes receivable	0	0	0	0	3.
00	Accounts receivable	5, 249, 431	0	0	0	4.
00	Other receivable	803, 975	0	0	0	
00 00	Allowances for uncollectible notes and accounts receivable Inventory	-3, 202, 222 317, 621	0	0	0	
00	Prepai d expenses	0	0	0	0	
00	Other current assets	-3, 159	0	0	0	
. 00	Due from other funds	287, 318	0	0	0	10
. 00	Total current assets (sum of lines 1-10)	3, 453, 190	0	0	0	11
~ ~	FI XED_ASSETS	0.500				
. 00	Land	2, 500	0	0	0	12
. 00 . 00	Land improvements Accumulated depreciation	458, 231 -224, 856	0	0	0	13
. 00	Buildings	10, 714, 459	0	0	0	15
. 00	Accumulated depreciation	-5, 426, 872	0	0	0	16
. 00	Leasehold improvements	995, 040	0	0	0	17
. 00	Accumulated depreciation	-669, 124	0	0	0	18
. 00	Fixed equipment	3, 131, 335	0	0	0	19
. 00	Accumulated depreciation	-2, 645, 194	0	0	0	20
	Automobiles and trucks	0	0	0	0	21
. 00	Accumulated depreciation	0	0	0	0	22
	Major movable equipment	7, 971, 049	0	0	0	23
. 00 . 00	Accumulated depreciation Minor equipment depreciable	-6, 949, 759	0	0	0	24
. 00	Accumulated depreciation	0	0	0	0	26
. 00	HIT designated Assets	0	0	0	0	27
. 00	Accumulated depreciation	0	0	0	0	28
. 00	Minor equipment-nondepreciable	0	0	0	0	29
. 00	Total fixed assets (sum of lines 12-29)	7, 356, 809	0	0	0	30
	OTHER ASSETS					
. 00	Investments	0	0	0	0	31
. 00	Deposits on Leases	0	0	0	0	32
. 00	Due from owners/officers Other assets	0	0 00( 120	0	0	33
. 00	Total other assets (sum of lines 31-34)	0	2, 006, 130 2, 006, 130	0	0	35
. 00	Total assets (sum of lines 11, 30, and 35)	10, 809, 999	2,000,130	0	0	36
. 00	CURRENT LI ABI LI TI ES	10,007,777	2,000,100	0		
. 00	Accounts payable	347, 561	0	0	0	37
. 00	Salaries, wages, and fees payable	621, 263	0	0	0	38
. 00	Payroll taxes payable	0	0	0	0	
	Notes and Loans payable (short term)	114, 037	0	0	0	40
. 00	Deferred income	0	0	0	0	
. 00 . 00	Accelerated payments Due to other funds	0	0	0	0	42
. 00	Other current liabilities	4, 312, 304	0	0	0	
. 00	Total current liabilities (sum of lines 37 thru 44)	5, 395, 165	0	0	0	
	LONG TERM LI ABI LI TI ES	0,0,0,100				
. 00	Mortgage payable	0	0	0	0	46
. 00	Notes payable	6, 982, 771	0	0	0	47
. 00	Unsecured Loans	0	0	0	0	
. 00	Other long term liabilities	80, 595	0	0	0	49
. 00	Total long term liabilities (sum of lines 46 thru 49)	7,063,366	0	0	0	50
. 00	Total liabilities (sum of lines 45 and 50)	12, 458, 531	0	0	0	51
. 00	CAPITAL ACCOUNTS General fund balance	-1, 648, 532				52
. 00	Specific purpose fund	1,040,002	2, 006, 130			53
. 00	Donor created - endowment fund balance - restricted		_, 000, 100	О		54
. 00	Donor created - endowment fund balance - unrestricted			0		55
. 00	Governing body created - endowment fund balance			О		56
. 00	Plant fund balance - invested in plant				0	57
8. 00	Plant fund balance - reserve for plant improvement,				0	58
	replacement, and expansion		0 00/ 1	_	-	
. 00 . 00	Total fund balances (sum of lines 52 thru 58)	-1, 648, 532	2,006,130	0	0	
( )( )	Total liabilities and fund balances (sum of lines 51 and	10, 809, 999	2, 006, 130	0	0	60

STATEN	IENT OF CHANGES IN FUND BALANCES		Provider CC	CN: 15-1309	Period: From 07/01/2020 To 06/30/2021	Worksheet G-1 Date/Time Pre 11/18/2021 4:	pared: 43 pm
		General	Fund	Special F	Purpose Fund	Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		-1, 904, 870	0100	1, 694, 245	0.00	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,094,714				2.00
3.00	Total (sum of line 1 and line 2)		-810, 156		1, 694, 245		3.00
4.00	Additions (credit adjustments) (specify)	0			0	0	4.00
5.00	Contri buti ons	0		10, 14	16	0	5.00
6.00	Restricted Invest. Income - HSD	0		156, 54		0	6.00
7.00		0			0	0	7.00
8.00	Transfer from Affiliates	-838, 372			0	0	8.00
9.00	Rounding	- 4			0	0	9.00
10.00	Total additions (sum of line 4-9)		-838, 376		166, 693		10.00
11.00	Subtotal (line 3 plus line 10)		-1, 648, 532		1, 860, 938		11.00
12.00	Transfer from Affiliates	0		3, 67		0	12.00
13.00		0		140.00	0	0	13.00
14.00 15.00	Restricted Invest. Income - HSD	0		-148, 86	0	0	14.00 15.00
16.00		0			0	0	16.00
17.00		0			0	0	17.00
18.00	Total deductions (sum of lines 12-17)	0	0		-145, 192	0	18.00
19.00	Fund balance at end of period per balance		-1, 648, 532		2, 006, 130		19.00
17.00	sheet (line 11 minus line 18)		1,010,002		2,000,100		17.00
		Endowment Fund	PI ant	Fund			
		6.00	7.00	8.00	_		
1.00	Fund balances at beginning of period	0			0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0			0		3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00	Contri buti ons		0				5.00
6.00	Restricted Invest. Income - HSD		0				6.00
7.00			0				7.00
8.00	Transfer from Affiliates		0				8.00
9.00	Roundi ng		0		-		9.00
10.00 11.00	Total additions (sum of line 4-9)	0			0		10.00 11.00
12.00	Subtotal (line 3 plus line 10) Transfer from Affiliates	0	0		0		12.00
12.00			0				12.00
14.00	Restricted Invest. Income - HSD		0				14.00
15.00			0				14.00
16.00			0				16.00
17.00			0				17.00
	Total deductions (sum of lines 12-17)	0	Ŭ		0		18.00
18.00							
18.00 19.00	Fund balance at end of period per balance	0			0		19.00

STATEN	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider CCN				
				Period: From 07/01/2020 To 06/30/2021	Worksheet G-2 Parts I & II Date/Time Pre 11/18/2021 4:4	pared:
	Cost Center Description		Inpati ent	Outpati ent	Total	
			1.00	2.00	3.00	
	PART I - PATIENT REVENUES					
	General Inpatient Routine Services					1
1.00	Hospi tal		1, 952, 93	33	1, 952, 933	1.00
2.00	SUBPROVIDER - IPF					2.00
3.00	SUBPROVIDER - IRF					3.00
4.00	SUBPROVIDER					4.00
5.00	Swing bed - SNF			0	0	5.00
6.00	Swing bed - NF			0	0	6.00
7.00	SKILLED NURSING FACILITY					7.00
8.00	NURSING FACILITY					8.00
9.00	OTHER LONG TERM CARE					9.00
10.00	Total general inpatient care services (sum of lines 1-9)		1, 952, 93	33	1, 952, 933	10.00
	Intensive Care Type Inpatient Hospital Services			- <u>-</u>		
11.00	I NTENSI VE CARE UNI T					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	
10.00	11-15)	TTHES		0	0	10.00
17.00	Total inpatient routine care services (sum of lines 10 and 16		1, 952, 93	13	1, 952, 933	17.00
18.00	Ancillary services	,	1, 648, 41		40, 694, 607	
19.00	Outpati ent servi ces		98, 93		13, 565, 844	
20.00	RURAL HEALTH CLINIC		70, 70	0 0	13, 303, 044	
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0 0	0	
22.00	HOME HEALTH AGENCY			0	0	21.00
23.00	AMBULANCE SERVICES					23.00
24.00	CMHC					24.00
25.00	AMBULATORY SURGICAL CENTER (D. P. )					25.00
26.00	HOSPI CE					26.00
27.00	Other Patient Service Revenue			0 214	214	
27.00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst	3, 700, 27		56, 213, 598	
20.00	G-3, line 1)	to wkst.	5, 700, 27	52, 515, 521	50, 215, 570	20.00
	PART II - OPERATING EXPENSES					1
29.00	Operating expenses (per Wkst. A, column 3, line 200)			18, 122, 342		29.00
30.00	ADD (SPECIFY)			0		30.00
31.00				0		31.00
32.00				0		32.00
32.00				0		32.00
34.00				0		34.00
34.00				0		34.00
36.00	Total additions (sum of lines 20.25)			0		36.00
36.00	Total additions (sum of lines 30-35) DEDUCT (SPECIFY)			0		36.00
37.00				0		
38.00				-		38.00
				0		39.00
40.00				0		40.00
41.00	Tatal daduations (sum of lines 27 (1)			-		41.00
	Total deductions (sum of lines 37-41)			0		42.00
42.00 43.00	Total operating expenses (sum of lines 29 and 36 minus line 4	) (+ mon - f		18, 122, 342		43.00

STATEMENT OF REVENUES AND EXPENSES       Provider CON: 15-1309       Period: From 07/01/2021       Worksheet G-3         1.00       Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)       1.00       Intraction 07/01/2021         1.00       Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)       56, 213, 598       1.00         3.00       Net patient revenues (line 1 minus line 2)       1.00       18, 573, 966       3.00         3.00       Net patient revenues (line 3 minus line 4)       18, 573, 966       3.00         0.00       Contributions, donations, bequests, etc       18, 723, 966       3.00         0.00       Revenue from telephone and other miscel aneous communication services       0       9, 00         0.00       Revenue from television and radio service       0       9, 00         0.01       Revenue from television and radio service       0       9, 00         0.00       Revenue from television and radio service       0       10, 00         0.01       Revenue from television and radio service       0       10, 00         0.01       Revenue from as Is sold to employees and guests       0       11, 00         11.00       12.00       Revenue from as all sold to englowes and abstracts       0       15, 00         13.00       Revenue from s	Heal th	ealth Financial Systems ASCENSION ST. VINCENT CLAY In Lie				u of Form CMS-2	2552-10		
To         06/30/2021         Date/Time Prepared: 11/18/2021 4:43 pm           1.00         Total patient revenues (from Wkst. G-2, Part I, column 3, Line 28)         1.00         1.00           2.00         Less contractual all owances and discounts on patients' accounts         37, 639, 632 2.00           3.00         Net patient revenues (line 1 minus line 2)         18, 573, 966 3.00           0.01         Less total operating expenses (from Wkst. G-2, Part II, Line 43)         18, 573, 966 3.00           0.00         Net income from service to patients (line 3 minus line 4)         451, 622 4.00           0.01         Income from investments         13, 709 6.00           0.00         Revenues from telephone and other miscellaneous communication services         0           0.00         Revenue from telephone and other miscellaneous communication services         0           0.00         Revenue from rentel ophone service         0           0.00         Revenue from rental of living quarters         0           0.010         Revenue from rental of living quarters         0           0.01100         Revenue from rental of medical and surgical supplies to other than patients         0           0.01         Revenue from sele of mugs to other than patients         0           0.010         Revenue from meals sold to employses and canteen         0	STATE					Worksheet G-3			
100         Total patient revenues (from Wkst. 6-2, Part I, column 3, line 28)         1.00           1.00         Less contractual allowances and discounts on patients' accounts         37, 639, 632         2.00           3.00         Net patient revenues (line 1 minus line 2)         16, 573, 966         3.00           0.00         Less contractual allowances and discounts on patients' accounts         37, 639, 632         2.00           3.00         Net patient revenues (line 1 minus line 2)         18, 573, 966         3.00           0.00         Less total operating expenses (from Wkst. G-2, Part II, line 43)         18, 122, 342         4.00           5.00         Net income from investments         130         7.00         1.000           6.00         Contributions, donations, bequests, etc         31, 709         6.00           0.01         Revenues from telephone and radio service         0         9, 00           0.00         Purchase discounts         0         10.00           0.00         Revenue from television and radio service         0         12.00           0.01         Revenue from television and radio service         0         12.00           0.00         Revenue from television and radio service         0         12.00           0.00         Revenue from sale of meals sold to employe						Dato/Timo Prov	ared.		
1.00         Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)         56, 213, 598         1.00           2.00         Less contractual allowances and discounts on patients' accounts         37, 639, 632         2.00           3.00         Net patient revenues (line 1 minus line 2)         18, 573, 966         3.00           4.00         Less total operating expenses (from Wkst. G-2, Part II, line 43)         18, 122, 342         4.00           0.00         Less total operating expenses (from Wkst. G-2, Part II, line 43)         451, 624         5.00           0.00         Contributions, donations, bequests, etc         18, 122, 342         4.00           0.00         Revenues from telephone and other miscellaneous communication services         0         8.00           0.00         Revenue from television and radio service         0         9.00           0.01.00         Parchase discounts         0         10.00           0.01.00         Parking lot receipts         0         11.00           0.01.00         Revenue from meals sold to employees and guests         28, 573         14.00           11.00         Revenue from sale of drugs to other than patients         0         15.00           12.00         Revenue from sale of drugs to other than patients         0         16.00           13.00 </td <td></td> <td colspan="8">10 06/30/2021</td>		10 06/30/2021							
1.00         Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)         56, 213, 598         1.00           2.00         Less contractual allowances and discounts on patients' accounts         37, 639, 632         2.00           3.00         Net patient revenues (line 1 minus line 2)         18, 573, 966         3.00           4.00         Less total operating expenses (from Wkst. G-2, Part II, line 43)         18, 122, 342         4.00           0.00         Less total operating expenses (from Wkst. G-2, Part II, line 43)         451, 624         5.00           0.00         Contributions, donations, bequests, etc         18, 122, 342         4.00           0.00         Revenues from telephone and other miscellaneous communication services         0         8.00           0.00         Revenue from television and radio service         0         9.00           0.01.00         Parchase discounts         0         10.00           0.01.00         Parking lot receipts         0         11.00           0.01.00         Revenue from meals sold to employees and guests         28, 573         14.00           11.00         Revenue from sale of drugs to other than patients         0         15.00           12.00         Revenue from sale of drugs to other than patients         0         16.00           13.00 </td <td></td> <td></td> <td></td>									
2.00Less contractual al lowances and discourts on patients' accounts37, 639, 6322.00Net patient revenues (line 1 minus line 2)18, 573, 9663.001.00Less total operating expenses (from Wkst. 6-2, Part II, line 43)18, 573, 9663.000.01Net income from service to patients (line 3 minus line 4)451, 6245.000.01Contributions, donations, bequests, etc31, 7096.001.00Revenue from telephone and other miscellaneous communication services08.009.00Revenue from telephone and other miscellaneous communication services08.009.00Revenue from telephone and other miscellaneous communication services010.0010.00Parchase discounts010.0011.00Rebates and refunds of expenses011.0012.00Parchase discounts13.0012.0013.00Revenue from meals sold to employees and guests28, 57314.0014.00Revenue from sale of medical and surgical supplies to other than patients015.0015.00Revenue from sale of medical and surgical supplies to other than patients014.0017.00Revenue from sale of medical and surgical supplies to other than patients014.0018.00Revenue from sale of medical cords and abstracts14818.0019.00Revenue from sale of medical records and abstracts014.0010.00Revenue from sale of nomeli space021.0010.00Revenue from sale of nomeli space <td< td=""><td></td><td>1</td><td></td><td></td><td></td><td></td><td></td></td<>		1							
3.00         Net patient revenues (line 1 minus line 2)         18,573,966         3.00           4.00         Less total operating expenses (from Wkst. 6-2, Part II, line 43)         18,122,342         4.00           0         Income from service to patients (line 3 minus line 4)         451,624         5.00           0         Contributions, donations, bequests, etc         31,709         6.00           1         noome from investments         30         7.00           8.00         Revenues from television and radio service         0         9.00           9.00         Revenue from television and radio service         0         9.00           10.00         Purchase discounts         0         10.00           11.00         Rebates and refunds of expenses         0         10.00           12.00         Revenue from neals od to employees and guests         28,573         14.00           13.00         Revenue from sale of medical and surgical supplies to other than patients         0         15.00           16.00         Revenue from sale of medical records and abstracts         14.17.00         19.00           18.00         Revenue from sale of medical records and abstracts         0         19.00           10.00         Revenue from sale of medical records and abstracts         0 <t< td=""><td></td><td></td><td></td><td></td></t<>									
4.00       Less total operating expenses (from Wkst. G-2, Part II, line 43)       18,122,342       4.00         5.00       Net income from service to patients (line 3 minus line 4)       451,624       5.00         0.01       Contributions, donations, bequests, etc       31,709       6.00         7.00       Income from investments       130       7.00         8.00       Revenues from telephone and other miscellaneous communication services       0       9.00         9.00       Revenue from television and radio service       0       9.00         10.00       Parking lot receipts       0       11.00         11.00       Revenue from laundry and linen service       0       13.00         12.00       Parking lot receipts       0       13.00         13.00       Revenue from sela of medical and surgical supplies to other than patients       0       16.00         14.00       Revenue from sale of drugs to other than patients       0       16.00         15.00       Revenue from gits, flowers, coffee shops, and canteen       0       19.00         17.00       Revenue from gits, flowers, coffee shops, and canteen       0       20.00         17.00       Revenue from sale of medical necords and abstracts       148       18.00         10.00       Revenue from git			on patients' accoun <sup>.</sup>	ts					
5.00Net income from service to patients (line 3 minus line 4)451,6245.00OTHER INCOMEOTHER INCOME31,7096.000Contributions, donations, bequests, etc1307.000.00Revenues from telephone and other miscellaneous communication services08.009.00Revenues from telephone and other miscellaneous communication services09.0010.00Purchase discounts010.0011.00Rebates and refunds of expenses011.0012.00Parking lot receipts012.0013.00Revenue from meals sold to employees and guests28.57314.0015.00Revenue from meals sold to employees and guests015.0016.00Revenue from sale of medical and surgical supplies to other than patients016.0017.00Revenue from sale of fuedis other than patients1417.0018.00Revenue from gifts, flowers, coffee shops, and canteen020.0021.00Rental of hospital space170,68422.0022.00Rental of vending machines170,68422.0023.00Governmental appropriations12.0023.0024.00Misc. Income3,67224.0124.00Misc. Income3,67224.0125.00Total other income (sum of lines 6-24)643.09025.0026.00Total (line 5 plus line 25)1,094,71426.0027.00OTHER EXPENSES (SPECIFY)027.0028.00Total other i									
OTHER I NCOME6.00Contributions, donations, bequests, etc31,7097.00Income from investments31,7098.00Revenues from telephone and other miscel laneous communication services09.00Revenue from television and radio service010.00Purchase discounts011.00Rebates and refunds of expenses012.00Parking lot receipts013.00Revenue from neals sold to employees and guests28,57314.00Revenue from sale of medical and surgical supplies to other than patients015.00Revenue from sale of medical and surgical supplies to other than patients16.0010.00Tuition (fees, sale of textbooks, uniforms, etc.)010.00Revenue from gilts, flowers, coffee shops, and canteen011.00Revenue from gilts, flowers, coffee shops, and canteen012.00Revenue from for Restriction3,67213.00Governmental appropriations013.00Governenteria appropriations013.00Sc. 10397,83114.00Revenue from Restriction3,67214.00Revenue from sale of from Restriction3,67214.00Revenue from sale of textbooks, uniforms, etc.)015.00Revenue from flowers, coffee shops				43)					
6.00       Contributions, donations, bequests, etc       31,709       6.00         7.00       Income from investments       130       7.00         8.00       Revenues from telephone and other miscellaneous communication services       0       8.00         9.00       Revenue from television and radio service       0       9.00         10.00       Purchase discounts       0       10.00         11.00       Rebates and refunds of expenses       0       11.00         12.00       Parking lot receipts       0       12.00         13.00       Revenue from meal sold to employees and guests       0       13.00         14.00       Revenue from sale of medical and surgical supplies to other than patients       0       16.00         15.00       Revenue from sale of medical records and abstracts       148       18.00         19.00       Revenue from sale of medical records and abstracts       0       19.00         10.00       Revenue from sale of medical records and abstracts       0       19.00         10.00       Revenue from gifts, flowers, coffee shops, and canteen       0       19.00         10.00       Revenue from sale of medical necords and abstracts       0       10.00         10.00       Revanue from gifts, flowers, coffee shops, and canteen	5.00		3 minus line 4)			451, 624	5.00		
7.00Income from investments1307.008.00Revenues from tel ephone and other miscel laneous communication services08.009.00Revenue from tel epision and radio service09.0010.00Purchase discounts010.0011.00Rebates and refunds of expenses011.0012.00Parking lot receipts012.0013.00Revenue from laundry and linen service013.0014.00Revenue from rental of living quarters015.0015.00Revenue from sale of medical and surgical supplies to other than patients016.0016.00Revenue from sale of medical records and abstracts14818.0019.00Tuition (fees, sale of textbooks, uniforms, etc.)019.0021.0022.00Rental of hospital space021.0021.0023.00Governmental appropriations021.0024.0024.01Assets Released from Restriction3.67224.0125.00Total other income (sum of lines 6-24)643.09025.0026.00Total other income (sum of lines 6-24)01,004,71426.00Total other expenses (sum of line 27 and subscripts)028.00	( 00					01.700	( 00		
8.00Revenues from telephone and other miscel laneous communication services08.009.00Revenue from television and radio service09.0010.00Purchase discounts010.0011.00Rebates and refunds of expenses011.0012.00Parking lot receipts012.0013.00Revenue from laundry and linen service013.0014.00Revenue from meals sold to employees and guests28,57314.0015.00Revenue from sale of medical and surgical supplies to other than patients015.0016.00Revenue from sale of drugs to other than patients015.0018.00Revenue from sale of fextbooks, uniforms, etc.)014.0019.00Reval of hospital space020.0021.00Revenue and phopopriations023.0022.00Rental of hospital space023.0023.00Governmental appropriations023.0024.00Total other income (sum of lines 6-24)0397,83124.00Total (line 5 plus line 25)1,094,71426.0026.00Total (line sepneses (sum of line 27 and subscripts)028.00									
9.00       Revenue from television and radio service       0       9.00         10.00       Purchase discounts       0       10.00         11.00       Rebates and refunds of expenses       0       11.00         12.00       Parking lot receipts       0       12.00         13.00       Revenue from laundry and linen service       0       13.00         14.00       Revenue from reals sold to employees and guests       28,57       14.00         15.00       Revenue from rental of living quarters       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 medical records and abstracts       14       17.00         18.00       Revenue from gifts, flowers, coffee shops, and canteen       0       20.00         20.00       Rental of vending machines       0       21.00         22.00       Rental of hospital space       0       21.00         23.00       Governmental appropriations       0       21.00         24.00       Misc. Income       3.672       24.01         24.50       COVID-19 PHE Funding       397.831       24.50         25.00       Total other income (sum of lines 6-24) <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>									
10.00       Purchase discounts       0       10.00         11.00       Rebates and refunds of expenses       0       11.00         12.00       Parking lot receipts       0       12.00         13.00       Revenue from laundry and linen service       0       13.00         14.00       Revenue from meals sold to employees and guests       28,573       14.00         15.00       Revenue from sale of medical and surgical supplies to other than patients       0       16.00         16.00       Revenue from sale of medical records and abstracts       11.00       0       16.00         17.00       Revenue from gifts, flowers, coffee shops, and canteen       0       19.00       19.00         10.00       Reval of hospital space       0       23.00       23.00       23.00       23.00         24.00       Misc. Income       3.672       24.01       39.7831       24.50         25.00       Total other income (sum of lines 6-24)       643.090       25.00       643.090       25.00         26.00       Total (line 5 plus line 25)       10, 28.00       28.00       28.00       28.00       28.00       28.00       28.00       28.00       28.00       28.00       28.00       28.00       28.00       28.00       28.00 </td <td></td> <td></td> <td>neous communication</td> <td>servi ces</td> <td></td> <td>-</td> <td></td>			neous communication	servi ces		-			
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 service       0       13.00         14.00       Revenue from meals sold to employees and guests       28.573       14.00         15.00       Revenue from rental of living quarters       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 furgs to other than patients       0       16.00         18.00       Revenue from sale of fungs to other than patients       14       17.00         18.00       Revenue from gale of textbooks, uniforms, etc.)       0       19.00         20.00       Rental of vending machines       0       20.00         21.00       Rental of hospital space       0       21.00         22.00       Rental of hospital space       10, 302       24.00         23.00       Governmental appropriations       0       23.00         24.01       Assets Released from Restriction       3.672       24.01         25.00       Total other income (sum of lines 6-24)       643.090       25.00         25.00 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></td<>									
12.00       Parking lot receipts       0       12.00         13.00       Revenue from laundry and linen service       0       13.00         14.00       Revenue from meals sold to employees and guests       28,573       14.00         15.00       Revenue from rental of living quarters       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 medical records and abstracts       14.8       17.00         18.00       Revenue from sale of medical records and abstracts       14.8       18.00         19.00       Tuition (fees, sale of textbooks, uniforms, etc.)       0       19.00       20.00         20.00       Revenue from gatch nes       0       21.00         21.00       Rental of vending machines       0       21.00         22.00       Rental of hospital space       0       23.00         23.00       Governmental appropriations       0       23.00         24.00       Assets Rel eased from Restriction       3.672       24.01         24.50       COVID-19 PHE Funding       397,831       24.50         25.00       Total other income (sum of lines 6-24)       643,090       25.00         26						-			
13.00       Revenue from laundry and linen service       0       13.00         14.00       Revenue from meals sold to employees and guests       28,573       14.00         15.00       Revenue from rental of living quarters       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 medical records and abstracts       14.8       18.00         19.00       Tuit ion (fees, sale of textbooks, uniforms, etc.)       0       19.00         20.00       Rental of vending machines       0       17.00         22.00       Rental of hospital space       0       21.00         23.00       Governmental appropriations       0       21.00         24.00       Misc. Income       3,672       24.01         25.00       Total other income (sum of lines 6-24)       643,090       25.00         25.00       Total (line 5 plus line 25)       1,094,714       26.00         27.00       Total other expenses (sum of line 27 and subscripts)       0       27.00									
14.00       Revenue from meals sold to employees and guests       28,573       14.00         15.00       Revenue from rental of living quarters       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 medical records and abstracts       14.00       16.00         18.00       Revenue from sale of medical records and abstracts       148       18.00         19.00       Tuition (fees, sale of textbooks, uniforms, etc.)       0       19.00         20.00       Revenue from gifts, flowers, coffee shops, and canteen       0       20.00         21.00       Rental of vending machines       0       21.00         23.00       Governmental appropriations       0       23.00         24.01       Assets Released from Restriction       3, 672       24.00         24.50       Total other income (sum of lines 6-24)       643,090       25.00         25.00       Total (line 5 plus line 25)       1, 044, 714       26.00         27.00       28.00       Total other expenses (sum of line 27 and subscripts)       0       28.00									
15.00Revenue from rental of living quarters015.0016.00Revenue from sale of medical and surgical supplies to other than patients016.0017.00Revenue from sale of drugs to other than patients016.0018.00Revenue from sale of medical records and abstracts14817.0019.00Tuition (fees, sale of textbooks, uniforms, etc.)019.0020.00Revenue from gifts, flowers, coffee shops, and canteen020.0021.00Rental of vending machines021.0023.00Governmental appropriations023.0024.00Misc. Income024.0024.01Assets Released from Restriction3,67224.0124.50Total other income (sum of lines 6-24)643,09025.0025.00Total (line 5 plus line 25)1,094,71426.0027.0028.00Total other expenses (sum of line 27 and subscripts)028.00			locto						
16.00Revenue from sale of medical and surgical supplies to other than patients016.0017.00Revenue from sale of drugs to other than patients4117.0018.00Revenue from sale of medical records and abstracts14818.0019.00Tuition (fees, sale of textbooks, uniforms, etc.)019.0020.00Revenue from gifts, flowers, coffee shops, and canteen020.0021.00Rental of vending machines021.0022.00Rental of hospital space021.0023.00Governmental appropriations023.0024.01Assets Released from Restriction3,67224.0124.50COVID-19 PHE Funding397,83124.5025.00Total other income (sum of lines 6-24)1,094,71426.0026.00Total (line 5 plus line 25)1,094,71426.0027.00OTHER EXPENSES (SPECIFY)027.0028.00Total other expenses (sum of line 27 and subscripts)028.00			lests						
17.00       Revenue from sale of drugs to other than patients       41       17.00         18.00       Revenue from sale of medical records and abstracts       148       18.00         19.00       Tuition (fees, sale of textbooks, uniforms, etc.)       0       19.00         20.00       Revenue from gifts, flowers, coffee shops, and canteen       0       20.00         21.00       Rental of vending machines       0       21.00         22.00       Rental of hospital space       0       21.00         23.00       Governmental appropriations       0       23.00         24.01       Assets Released from Restriction       3,672       24.01         24.50       COVID-19 PHE Funding       397,831       24.50         25.00       Total other income (sum of lines 6-24)       1,094,714       26.00         26.00       Total (tine 5 plus line 25)       1,094,714       26.00         27.00       OTHER EXPENSES (SPECIFY)       0       27.00         28.00       Total other expenses (sum of line 27 and subscripts)       0       28.00			supplies to other the	aan nationts					
18.00       Revenue from sale of medical records and abstracts       148       18.00         19.00       Tuition (fees, sale of textbooks, uniforms, etc.)       0       19.00         20.00       Revenue from gifts, flowers, coffee shops, and canteen       0       20.00         21.00       Rental of vending machines       0       21.00         22.00       Rental of hospital space       170,684       22.00         23.00       Governmental appropriations       0       23.00         24.01       Assets Released from Restriction       3,672       24.01         24.50       COVI D-19 PHE Funding       397,831       24.50         25.00       Total other income (sum of lines 6-24)       643,090       25.00         26.00       Total (line 5 plus line 25)       1,094,714       26.00         27.00       OTHER EXPENSES (SPECIFY)       0       27.00         28.00       Total other expenses (sum of line 27 and subscripts)       0       28.00				lan patrents		-			
19.00       Tuition (fees, sale of textbooks, uniforms, etc.)       0       19.00         20.00       Revenue from gifts, flowers, coffee shops, and canteen       0       20.00         21.00       Rental of vending machines       0       21.00         22.00       Rental of hospital space       170,684       22.00         23.00       Governmental appropriations       0       23.00         24.00       Misc. Income       10,302       24.00         24.01       Assets Released from Restriction       3,672       24.01         25.00       Total other income (sum of lines 6-24)       643.090       25.00         26.00       Total (line 5 pl us line 25)       1,094,714       26.00         27.00       OTHER EXPENSES (SPECIFY)       0       27.00         28.00       Total other expenses (sum of line 27 and subscripts)       0       28.00									
20.00       Revenue from gifts, flowers, coffee shops, and canteen       0       20.00         21.00       Rental of vending machines       0       21.00         22.00       Rental of hospital space       170,684       22.00         23.00       Governmental appropriations       0       23.00         24.00       Misc. Income       10,302       24.00         24.01       Assets Released from Restriction       3,672       24.01         25.00       Total other income (sum of lines 6-24)       643,090       25.00         26.00       Total (line 5 plus line 25)       1,094,714       26.00         27.00       OTHER EXPENSES (SPECIFY)       0       27.00         28.00       Total other expenses (sum of line 27 and subscripts)       0       28.00									
21.00       Rental of vending machines       0       21.00         22.00       Rental of hospital space       170,684       22.00         23.00       Governmental appropriations       0       23.00         24.00       Misc. Income       10,302       24.00         24.01       Assets Released from Restriction       3,672       24.01         25.00       Total other income (sum of lines 6-24)       643,090       25.00         26.00       Total (line 5 plus line 25)       1,094,714       26.00         27.00       OTHER EXPENSES (SPECIFY)       0       27.00         28.00       Total other expenses (sum of line 27 and subscripts)       0       28.00			,						
22.00       Rental of hospital space       170,684       22.00         23.00       Governmental appropriations       0       23.00         24.00       Misc. Income       10,302       24.00         24.01       Assets Released from Restriction       3,672       24.01         25.00       COVID-19 PHE Funding       397,831       24.50         25.00       Total other income (sum of lines 6-24)       643,090       25.00         26.00       Total (line 5 plus line 25)       1,094,714       26.00         27.00       OTHER EXPENSES (SPECIFY)       0       27.00         28.00       Total other expenses (sum of line 27 and subscripts)       0       28.00		5							
23.00       Governmental appropriations       0       23.00         24.00       Misc. Income       10,302       24.00         24.01       Assets Released from Restriction       3,672       24.01         24.50       COVID-19 PHE Funding       397,831       24.50         25.00       Total other income (sum of lines 6-24)       643,090       25.00         26.00       Total (line 5 plus line 25)       1,094,714       26.00         27.00       OTHER EXPENSES (SPECIFY)       0       27.00         28.00       Total other expenses (sum of line 27 and subscripts)       0       28.00									
24.00       Misc. Income       10,302       24.00         24.01       Assets Released from Restriction       3,672       24.01         24.50       COVID-19 PHE Funding       397,831       24.50         25.00       Total other income (sum of lines 6-24)       643,090       25.00         26.00       Total (line 5 plus line 25)       1,094,714       26.00         27.00       OTHER EXPENSES (SPECIFY)       0       27.00         28.00       Total other expenses (sum of line 27 and subscripts)       0       28.00									
24.01       Assets Released from Restriction       3,672       24.01         24.50       COVID-19 PHE Funding       397,831       24.50         25.00       Total other income (sum of lines 6-24)       643,090       25.00         26.00       Total (line 5 plus line 25)       1,094,714       26.00         27.00       OTHER EXPENSES (SPECIFY)       0       27.00         28.00       Total other expenses (sum of line 27 and subscripts)       0       28.00									
24. 50       COVI D-19 PHE Funding       397, 831       24. 50         25. 00       Total other income (sum of lines 6-24)       643, 090       25. 00         26. 00       Total (line 5 plus line 25)       1, 094, 714       26. 00         27. 00       OTHER EXPENSES (SPECI FY)       0       27. 00         28. 00       Total other expenses (sum of line 27 and subscripts)       0       28. 00									
25.00       Total other income (sum of lines 6-24)       643,090       25.00         26.00       Total (line 5 plus line 25)       1,094,714       26.00         27.00       OTHER EXPENSES (SPECIFY)       0       27.00         28.00       Total other expenses (sum of line 27 and subscripts)       0       28.00	24.50						24.50		
26.00       Total (line 5 plus line 25)       1,094,714       26.00         27.00       OTHER EXPENSES (SPECIFY)       0       27.00         28.00       Total other expenses (sum of line 27 and subscripts)       0       28.00							25.00		
27.00         OTHER EXPENSES (SPECIFY)         0         27.00           28.00         Total other expenses (sum of line 27 and subscripts)         0         28.00	26.00						26.00		
							27.00		
29.00         Net income (or loss) for the period (line 26 minus line 28)         1,094,714         29.00						0	28.00		
	29.00	Net income (or loss) for the period (line 2	26 minus line 28)			1, 094, 714	29.00		