Health Financial Systems	ST. VINCENT HE	ART CENTER		In Lie	u of Form CMS-2	2552-10
This report is required by law (42 USC 1395g; 42 CFI						
payments made since the beginning of the cost repor-	ting period beir	ng deemed over	payments (42 U	SC 1395g).	OMB NO. 0938-0 EXPIRES 03-31	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT	RT CERTIFICATION	N Provider CC	CN: 15-0153 P	eriod:	Worksheet S	2022
AND SETTLEMENT SUMMARY			F	rom 07/01/2020	Parts I-III	l
			1	0 06/30/2021	Date/Time Pre 11/22/2021 3:	
PART I - COST REPORT STATUS			i.			
Provider 1. [X] Electronically prepared cost				Date: 11/22/2	2021 Time: 3	:37 pm
use only 2. [] Manually prepared cost report 3. [0] If this is an amended report		r of times the	e provider resi	ubmitted this c	ost report	
4. [F] Medicare Utilization. Enter "	F" for full or	"L" for low.			lost report	
	Recei ved:			Date:		
use only (1) As Submitted 7. Contra (2) Settled without Audit 8. [N]	actor No. Initial Report	for this Provi	der CCN 12. [C	tractor's Vend	or code: plumn 1 is 4: E	4 nter
(3) Settled with Audit 9. [N]	Final Report fo	r this Provide	er CCN		mes reopened =	
(4) Reopened						
(5) Amended						
PART II - CERTIFICATION						
MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION						
ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UND PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OF						
ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MA		A KICKDACK UK	WERE OTHERWIS	L TELEGAE, CRI	WINAL, CIVIL AN	D
CERTIFICATION BY CHIEF FINANCIAL OFFICER OR		OF PROVIDER(S))			
I HEREBY CERTIFY that I have read the above				amined the acc	ompanyi ng	
electronically filed or manually submitted						
Expenses prepared by ST. VINCENT HEART CENT						
ending 06/30/2021 and to the best of my kno 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.						
[X]I have read and agree with the above c						
signature on this certification statem		5 5	5 1	^e my original s	signature.	
	(Si gne					
		UTTIC	er or Administ	rator of Provid	der(s)	
		SENI OR	DIRECTOR, FIN	ANCE		
		Title				
		11 (00 /	0001 00 07 10			
		 Date	2021 03: 37: 18	² M		
		Date				
Cast Contar Description	Title V	Title Part A	XVIII Part B	ніт	Title VIV	
Cost Center Description	1.00	Part A 2.00	3.00	4, 00	Title XIX 5.00	
PART III - SETTLEMENT SUMMARY	1.00	2.00	0.00	1.00	0.00	
1.00 Hospi tal	0	45, 990	-29, 263	0	-	1.00
1.00 Hospital 2.00 Subprovider - IPF 3.00 Subprovider - IRF	0 0	45, 990 0 0	-29, 263 0 0		0 0	1.00 2.00 3.00

200.00 Total -29, 263 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.

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45, 990

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Swing Bed - NF

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	TAL AND HOSPITAL HEALTH CARE COMPLEX	I DENTI FI CATI ON DATA	Provic	ler CCN:		Period: From 07/01/ To 06/30/		Workshe Part I Date/Ti 11/22/2	me Pre	pared:
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~~	Hospital and Hospital Health Care Co									1.0
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. 00	CITY. INDIANAPOLIS	Component Name	CCN	CBSA		zy: HAMILTON Date	Davme	ent Syst	om (D	2.0
		component Name	Number	Numbe		Certified		, 0, or		
							V		XIX	1
		1.00	2.00	3.00	4.00	5.00	6.00		8.00	1
	Hospital and Hospital-Based Componer	nt Identification:	-							
. 00	Hospi tal	ST. VINCENT HEART	150153	26900	D 1	12/05/2002	N	P	0	3.0
~ ~		CENTER								
00	Subprovider - IPF									4.0
00	Subprovider - IRF									5.0
00	Subprovider - (Other)									6.0
00 00	Swing Beds - SNF Swing Beds - NF									7. 0 8. 0
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	Separately Certified ASC									13.
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5. 00	Hospital-Based Health Clinic - RHC									15.
. 00										16.
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. 00	Other					<u> </u>				19.
						From:		To 2. (-
00	Cost Reporting Period (mm/dd/yyyy)					1.00	120	06/30		20.
	Type of Control (see instructions)					4	020	00/ 00/	2021	21.
. 00										21.
					1.00	2.00		3. (00	1
	Inpatient PPS Information									
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	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ATA	Provider CC	N: 15-0153	Peri od:		Worksh	eet S-2	
						30/2021	11/22/2	ime Pre 2021 3:	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medi cai d el i gi bl e unpai d	Medicai HMO day	/s Med)ther di cai d days	
		1.00	2.00	3.00	4.00	5.00		6.00	1
5. 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 column 5, and other Medicaid days in column 6. 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	0	0		0	1, 1	0	С) 24. (
	Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.								
					Urban/F	Rural S I		F Geogr 00	-
5.00	Enter your standard geographic classification (not wa		at the beg	jinning of t		1	۷.	00	26. (
	cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifi	age) status ~ "2" for r cation in	ural. If ap column 2.	plicable,		1			27. (
5.00	If this is a sole community hospital (SCH), enter the effect in the cost reporting period.	e number of	periods SC	CH status ir	1	0			35.0
					Begi n		Endi		-
. 00	Enter applicable beginning and ending dates of SCH s	tatus. Subs	cript line	36 for numb	1. er	00	2.	00	36.
	of periods in excess of one and enter subsequent date If this is a Medicare dependent hospital (MDH), enter	es.	·			0			37.
. 01	is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for th accordance with FY 2016 OPPS final rule? Enter "Y" fo instructions)								37.
00	If line 37 is 1, enter the beginning and ending dates								
5. UU	greater than 1, subscript this line for the number of enter subsequent dates.								38.
. UU	greater than 1, subscript this line for the number of				Y,		Y/		38.
9. 00	greater than 1, subscript this line for the number of enter subsequent dates. Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions)	f periods i payment a), (ii), or the mileage i)? Enter	djustment f (iii)? Ent requiremen in column 2	for low volu for low volu er in colum its in ? "Y" for ye	1. ime N in 25			00	39.
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HOSPI	TAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provider CO		eriod: rom 07/01/2020	Worksheet S-2 Part I	
				T	06/30/2021	Date/Time Pre 11/22/2021 3:	
				NAHE 413.85	Worksheet A	Pass-Through	
				Y/N	Line #	Qualification Criterion Code	
60.00	Are you claiming nursing and allied health education	(NAHE)	costs for	1.00 N	2.00	3.00	60.00
00.00	any programs that meet the criteria under 42 CFR 413.	85? (s	see				00100
	instructions) Enter "Y" for yes or "N" for no in col is "Y", are you impacted by CR 11642 (or subsequent C						
	adjustement? Enter "Y" for yes or "N" for no in colu	imn 2.					
		Y/N	IME	Direct GME	IME	Direct GME	
(1.00		1.00	2.00	3.00	4.00	5.00	(1.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in	N			0.00	0.00	61.00
(4.04	column 1. (see instructions)						(1 01
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports						61.01
	ending and submitted before March 23, 2010. (see						
61. 02	instructions) Enter the current year total unweighted primary care						61.02
	FTE count (excluding OB/GYN, general surgery FTEs,						
	and primary care FTEs added under section 5503 of ACA). (see instructions)						
61.03	Enter the base line FTE count for primary care						61.03
	and/or general surgery residents, which is used for determining compliance with the 75% test. (see						
	instructions)						
61.04	Enter the number of unweighted primary care/or						61.04
	surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						
61.05	Enter the difference between the baseline primary						61.05
	and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line						
	61.04 minus line 61.03). (see instructions)						
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary						61.06
	care or general surgery. (see instructions)						
			Minute				
		Pro	ogram Name	Program Code		Unweighted	
		Pro	ogram Name	Program Code		Unweighted Direct GME FTE Count	
(1.10	Of the FIFe in line (1 OF enceify each new program	Pro	1.00	2.00	FTE Count 3.00	Direct GME FTE Count 4.00	
61. 10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents	Pro			FTE Count	Direct GME FTE Count 4.00	61. 10
61. 10	specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in				FTE Count 3.00	Direct GME FTE Count 4.00	
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	specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see	Pro			FTE Count 3.00 0.00	Direct GME FTE Count 4.00 0.00	61. 10
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61. 20 62. 00 62. 01	 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 	rvices / trainec tions) a Teachi gram. (s er Setti ttings	Administration d in this cost ng Health Censee instruction ings during this cost	(HRSA) reporting peri ter (THC) into ns)	FTE Count 3.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	Di rect GME FTE Count 4.00 0.00 0.00 0.00 1.00 0.00	61. 10 61. 20 62. 00 62. 01
61. 20 62. 00 62. 01	 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. ACA Provisions Affecting the Health Resources and Sere Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instructed from a during in this cost reporting period of HRSA THC proof thas your facility trained residents in nonprovider see 	rvices / trainec tions) a Teachi gram. (s er Setti ttings	Administration d in this cost ng Health Censee instruction ings during this cost	(HRSA) reporting peri ter (THC) into ns) ost reporting p 67. (see instru Unweighted FTEs	FTE Count 3.00 0.000 0.00	Direct GME FTE Count 4.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	61. 10 61. 20 62. 00 62. 01
61. 20 62. 00 62. 01	 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. ACA Provisions Affecting the Health Resources and Sere Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instructed from a during in this cost reporting period of HRSA THC proof thas your facility trained residents in nonprovider see 	rvices / trainec tions) a Teachi gram. (s er Setti ttings	Administration d in this cost ng Health Censee instruction ings during this cost	(HRSA) reporting peri ter (THC) into ns) post reporting p 67. (see instru Unweighted	FTE Count 3.00 0.00	Di rect GME FTE Count 4.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	61. 10 61. 20 62. 00 62. 01
61. 20 62. 00 62. 01	 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. ACA Provisions Affecting the Health Resources and Sere Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instructions aduring in this cost reporting period of HRSA THC progration aduring in this cost reporting period of HRSA THC progration of the spour facility trained residents in nonprovide thas your facility trained residents in nonprovide "Y" for yes or "N" for no in column 1. If yes, completed the program for the program	rvi ces // trai nec ti ons) a Teachi gram. (s er Setti tti ngs ete li ne	Administration d in this cost ng Health Censee instruction ings during this cost es 64 through o	(HRSA) reporting peri ter (THC) into ns) ost reporting p 67. (see instru- Unweighted FTEs Nonprovider Si te 1.00	FTE Count 3.00 0.000 0.00	Direct GME FTE Count 4.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	61. 10 61. 20 62. 00 62. 01
61. 20 62. 00 62. 01	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. Of the FTEs in line 61.05, specify each expanded program special ty, if any, and the number of FTE residents for each expanded program. (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. ACA Provisions Affecting the Heal th Resources and Ser Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruct Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prograte Teaching Hospitals that Claim Residents in Nonprovide Has your facility trained residents in nonprovides "Y" for yes or "N" for no in column 1. If yes, complete Section 5504 of the ACA Base Year FTE Residents in Norther Section Sec	rvi ces // trai nec ti ons) a Teachi gram. (s er Setti set li ne bonprovi o	Administration d in this cost ng Health Cens see instruction ings during this cost during this cost es 64 through of der Settings	(HRSA) reporting peri ter (THC) into ns) ost reporting p 67. (see instru- Unweighted FTEs Nonprovider Si te 1.00	FTE Count 3.00 0.000 0.00	Direct GME FTE Count 4.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	61. 10 61. 20 62. 00 62. 01
61. 20 62. 00 62. 01	 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. Of the FTEs in line 61.05, specify each expanded program special ty, if any, and the number of FTE residents for each expanded program. (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. The program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. ACA Provisions Affecting the Heal th Resources and Ser Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instructions in this cost reporting period of HRSA THC program caching Hospitals that Claim Residents in Nonprovide Has your facility trained residents in nonprovider see "Y" for yes or "N" for no in column 1. If yes, comple 	vices / trainec ttions) a Teachi gram. (s er Setti ettings ette line onprovid re June cy train	Administration 1.00 Administration d in this cost ing Health Cen- see instruction ings during this co es 64 through of der Settings 30, 2010. hed residents	(HRSA) reporting peri ter (THC) into ns) ost reporting p 67. (see instru- Unweighted FTEs Nonprovider Si te 1.00	FTE Count 3.00 0	Di rect GME FTE Count 4.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	61. 10 61. 20 62. 00 62. 01 63. 00
61. 20 62. 00 62. 01 63. 00	<pre>specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. ACA Provisions Affecting the Health Resources and Ser Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruc Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC progr Teaching Hospitals that Claim Residents in Nonprovide Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple Section 5504 of the ACA Base Year FTE Residents in No period that begins on or after July 1, 2009 and befor Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted nor </pre>	rvi ces / trai nec titions) a Teachi gram. (s er Setti stti ngs ete line onprovi o re June y trai n -pri mar	Administration 1.00 Administration d in this cost ing Health Cen- see instruction ings during this cost during t	2.00 (HRSA) reporting peri ter (THC) into ns) post reporting p 67. (see instru- Unweighted FTEs Nonprovider Site 1.00 This base year	FTE Count 3.00 0	Di rect GME FTE Count 4.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	61. 10 61. 20 62. 00 62. 01 63. 00
61. 20 62. 00 62. 01 63. 00	 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. Of the FTEs in line 61.05, specify each expanded program special ty, if any, and the number of FTE residents for each expanded program. (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. The program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. ACA Provisions Affecting the Heal th Resources and Ser Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instructions in this cost reporting period of HRSA THC program caching Hospitals that Claim Residents in Nonprovide Has your facility trained residents in nonprovider see "Y" for yes or "N" for no in column 1. If yes, comple 	rvi ces // trai nec tions) a Teachi gram. (se er Setti titings ete line conprovi o re June cy trai ri- p-pri mar all nor	Administration d in this cost ing Health Cens see instruction ings during this co es 64 through of der Settings 30, 2010. ned residents ry care aprovider	2.00 (HRSA) reporting peri ter (THC) into ns) post reporting p 67. (see instru- Unweighted FTEs Nonprovider Site 1.00 This base year	FTE Count 3.00 0	Di rect GME FTE Count 4.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	61. 10 61. 20 62. 00 62. 01 63. 00
61. 20 62. 00 62. 01 63. 00	<pre>specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. ACA Provisions Affecting the Health Resources and Ser Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruct Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC provide Has your facility trained residents in Nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple Section 5504 of the ACA Base Year FTE Residents in No period that begins on or after July 1, 2009 and befor Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted nor resident FTEs attributable to rotations occurring in </pre>	rvices / trainec tions) Teachi rram. (Ser Setti ettings te line set line se	Administration 1.00 1.00 Administration d in this cost ing Health Cen- see instruction ings during this cost during this cost ings during this cost during this cost ings during this cost ings ings during this cost ings ings during this cost ings in	2.00 (HRSA) reporting peri ter (THC) into ns) post reporting p 67. (see instru- Unweighted FTEs Nonprovider Site 1.00 This base year	FTE Count 3.00 0	Di rect GME FTE Count 4.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	61. 10 61. 20 62. 00 62. 01 63. 00

	EX IDENTIFICATION DA	ATA Provider C		riod: om 07/01/2020	Worksheet S-2 Part I	
			Tc			
	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col. 3/	
		-	FTEs	FTEs in	$(col \cdot 3 + col \cdot$	
			Nonprovider Site	Hospi tal	4))	
-	1.00	2.00	3.00	4.00	5.00	1
.00 Enter in column 1, if line 63			0.00	0.00		65.0
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column						
4)). (see instructions)						
			Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	1
Section 5504 of the ACA Current beginning on or after July 1, 20		n Nonprovider Setting	gsEffective fo	r cost reporti	ng periods	
FTEs attributable to rotations of Enter in column 2 the number of u FTEs that trained in your hospita	unweighted non-prima	ry care resident				
(column 1 divided by (column 1 +			Unweighted FTEs Nonprovider	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
(column 1 divided by (column 1 +	<u>column 2)). (see in</u> Program Name	structions) Program Code	FTĔs Nonprovider Site	FTES in Hospital	(col. 3 + col. 4))	
.00 Enter in column 1, the program	column 2)). (see in	structions)	FTĔs Nonprovi der	FTEsin	(col. 3 + col. 4)) 5.00	
	<u>column 2)). (see in</u> Program Name	structions) Program Code	FTĔs Nonprovi der Si te 3.00	FTES in Hospital	(col. 3 + col. 4)) 5.00	_
OO Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 3 divided by (column 3 + column	<u>column 2)). (see in</u> Program Name	structions) Program Code	FTĔs Nonprovi der Si te 3.00	FTES in Hospital 4.00 0.00	(col . 3 + col . 4)) 5.00 0.000000	
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)	<u>column 2)). (see in</u> Program Name	structions) Program Code	FTĔs Nonprovi der Si te 3.00	FTES in Hospital 4.00 0.00	(col. 3 + col. 4)) 5.00	
OO Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 3 divided by (column 3 + column	<u>column 2)). (see in</u> Program Name <u>1.00</u> PS	structions) Program Code 2.00	FTEs Nonprovi der Si te 3.00 0.00	FTES in Hospital 4.00 0.00	(col . 3 + col . 4)) 5.00 0.000000	-
 00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 3 divided by (column 3 + column 4)). (see instructions) Inpatient Psychiatric Facility Pf 00 Is this facility an Inpatient Psy Enter "Y" for yes or "N" for no. 100 If line 70 is yes: Column 1: Did recent cost report filed on or be 42 CFR 412. 424(d)(1)(iii)(C)) Col program in accordance with 42 CFF Column 2: If column 2 is Y, indic (see instructions) 	<u>column 2)). (see in</u> Program Name <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u>	Program Code 2.00 2.00 Program Code 2.00 Program Code Program Code	FTEs Nonprovi der Si te 3.00 0.00 cain an IPF subp ng program in ti yes or "N" for m s in a new teach	FTES in Hospital 4.00 0.00 0.00 1.00 rovider? N he most b. (see ing 0.	(col . 3 + col . 4)) 5.00 0.000000	
 00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 3, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Inpatient Psychiatric Facility Pf for yes or "N" for no. 100 If line 70 is yes: Column 1: Did recent cost report filed on or be 42 CFR 412.424(d)(1)(iii)(c)) Col program in accordance with 42 CFC column 3: If column 2 is Y, indice 	column 2)). (see in Program Name 1.00 1.00 PS ychiatric Facility (the facility have a efore November 15, 2 umn 2: Did this fac R 412.424 (d)(1)(iii cate which program y y PPS	structions) Program Code 2.00 2.00 IPF), or does it cont n approved GME teachi 004? Enter "Y" for y ility train residents)(D)? Enter "Y" for y rear began during this	FTEs Nonprovi der Si te 3.00 0.00 cain an IPF subp ng program in t yes or "N" for m s in a new teach yes or "N" for m s cost reporting	FTES in Hospital 4.00 0.00 0.00 1.00 rovider? N he most b. (see ing 0.	(col . 3 + col . 4)) 5.00 0.000000 0.0000000 0.0000000 0.000000	_

Health Financial Systems ST. VINCENT H	EART CENTER		In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA			Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Pre 11/22/2021 3:	pared:
				1.00	
Long Term Care Hospital PPS					
80.00 Is this a long term care hospital (LTCH)? Enter "Y" for ye 81.00 Is this a LTCH co-located within another hospital for part of "Y" for yes and "N" for no.	s and "N" for or all of the	no. cost reporting	g period? Enter	N N	80.00 81.00
TEFRA Providers 85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEERA? Ente	r "Y" for ves	or "N" for no	N	85.00
86.00 Did this facility establish a new Other subprovider (excludes \$413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		2			86.00
87.00 Is this hospital an extended neoplastic disease care hospit. 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	al classified	under section		N	87.00
			V 1.00	XI X 2.00	-
Title V and XIX Services			· ·		
90.00 Does this facility have title V and/or XIX inpatient hospit. yes or "N" for no in the applicable column.	al services? E	nter "Y" for	N	Y	90.00
91.00 Is this hospital reimbursed for title V and/or XIX through full or in part? Enter "Y" for yes or "N" for no in the app			N	Y	91.00
92.00 Are title XIX NF patients occupying title XVIII SNF beds (d instructions) Enter "Y" for yes or "N" for no in the applic		ion)? (see		Ν	92.00
93.00 Does this facility operate an ICF/IID facility for purposes "Y" for yes or "N" for no in the applicable column.		nd XIX? Enter	N	Ν	93.00
94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, applicable column.	and "N" for r	no in the	N	Ν	94.00
95.00 If line 94 is "Y", enter the reduction percentage in the ap			0.00	0.00	95.00
96.00 Does title V or XIX reduce operating cost? Enter "Y" for ye applicable column.	s or "N" for r	no in the	N	N	96.00
97.00 fline 96 is "Y", enter the reduction percentage in the ap 98.00 Does title V or XIX follow Medicare (title XVIII) for the i			0.00 N	0.00 Y	97.00
stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y"					
 column 1 for title V, and in column 2 for title XIX. 98.01 Does title V or XIX follow Medicare (title XVIII) for the received of the column 1 for the received of the receiv			Ν	Y	98. 01
 title XIX. 98.02 Does title V or XIX follow Medicare (title XVIII) for the construction bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes 			Ν	Y	98.02
 for title V, and in column 2 for title XIX. 98.03 Does title V or XIX follow Medicare (title XVIII) for a cri reimbursed 101% of inpatient services cost? Enter "Y" for y 			N	Ν	98. 03
for title V, and in column 2 for title XIX. 98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH outpatient services cost? Enter "Y" for yes or "N" for no i			Ν	Ν	98.04
in column 2 for title XIX. 98.05 Does title V or XIX follow Medicare (title XVIII) and add b	ack the RCE di	sallowance on	N	Y	98.05
Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 2 for title XIX.	column 1 for t	itle V, and ir	ו		
98.06 Does title V or XIX follow Medicare (title XVIII) when cost Pts. I through IV? Enter "Y" for yes or "N" for no in colum column 2 for title XIX.			Ν	Y	98.06
Rural Providers			1		
105.00 Does this hospital qualify as a CAH? 106.00 If this facility qualifies as a CAH, has it elected the all	-inclusive met	hod of payment	N		105.00
for outpatient services? (see instructions) 107.00 Column 1: If line 105 is Y, is this facility eligible for c	ost reimbursem	nent for I&R			107.00
training programs? Enter "Y" for yes or "N" for no in colum Column 2: If column 1 is Y and line 70 or line 75 is Y, do approved medical education program in the CAH's excluded I	you train I&R	Rs in an			
Enter "Y" for yes or "N" for no in column 2. (see instruct	i ons)	. ,			
108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N		108.00
	Physi cal 1.00	Occupational 2.00	Speech 3.00	Respi ratory 4.00	-
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					109.00
		1	1		
110.00 Did this hospital participate in the Rural Community Hospita	al Demonstrati	on project (§4	10A	1.00 N	110.00
Demonstration)for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable.	"Y" for yes or	"N" for no. I	f yes,		

^{11/22/2021 3:37} pm D: \Shared drives\Finance_Net Revenue_IN - Acute\Reimbursement\Cost Reports\FY2021\Heart Ctr\SVHC2021.mcrx

	Provider CO	CN: 15-0153	Peri od:	Worksheet S-2	2552 2
			From 07/01/2020 To 06/30/2021		anaro
			10 00/30/2021	11/22/2021 3:	
					-
1.00 f this facility qualifies as a CAH, did it participate in the	- Frontier Co	ommuni tv	1.00 N	2.00	111.
Health Integration Project (FCHIP) demonstration for this cost					
"Y" for yes or "N" for no in column 1. If the response to colu					
integration prong of the FCHIP demo in which this CAH is parti					
Enter all that apply: "A" for Ambulance services; "B" for addi for tele-health services.	tional beds;	and/or "C"			
		1.00	2.00	3.00	
2.00 Did this hospital participate in the Pennsylvania Rural Health		N			112.
demonstration for any portion of the current cost reporting per Enter "Y" for yes or "N" for no in column 1. If column 1 is "					
in column 2, the date the hospital began participating in the					
demonstration. In column 3, enter the date the hospital cease					
participation in the demonstration, if applicable.					
Miscellaneous Cost Reporting Information	'N" for no	N			115
5.00 Is this an all-inclusive rate provider? Enter "Y" for yes or " in column 1. If column 1 is yes, enter the method used (A, B,		IN IN			0115.
in column 2. If column 2 is "E", enter in column 3 either "93"					
for short term hospital or "98" percent for long term care (ir	ncl udes				
psychiatric, rehabilitation and long term hospitals providers)) based on				
the definition in CMS Pub.15-1, chapter 22, §2208.1. 6.00 s this facility classified as a referral center? Enter "Y" fo	or ves or	N			116.
"N" for no.	JC3 01				
7.00 Is this facility legally-required to carry malpractice insurar	nce? Enter	Y			117.
"Y" for yes or "N" for no. 8.00 s the malpractice insurance a claims-made or occurrence polic	av2 Entor 1		2		118.
if the policy is claim-made. Enter 2 if the policy is occurrer			Z		110.
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	-
8.01 List amounts of malpractice premiums and paid losses:				0 687, 870	0118.
8.02 Are malpractice premiums and paid losses reported in a cost ce	optor other t	than the	1.00 N	2.00	118.
5. UZIALE IIIALPLACTICE PLEIIILUIIS AND PALO LUSSES LEPULTEU IILA COST CE	enter other	Linari trie			1110
Administrative and General? If ves, submit supporting schedul	e listina co	ost centers	IN IN		
Administrative and General? If yes, submit supporting schedul and amounts contained therein.	e listing co	ost centers	N.		
and amounts contained therein. 9.00D0 NOT USE THIS LINE	0				119.
and amounts contained therein. 9.00D0 NOT USE THIS LINE 0.00Is this a SCH or EACH that qualifies for the Outpatient Hold H	Harmless prov	/ision in ACA		N	119.
and amounts contained therein. 9.00 DO NOT USE THIS LINE 0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold H §3121 and applicable amendments? (see instructions) Enter in c	Harmless prov column 1, "Y	vision in ACA ' for yes or	Ν	N	119
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lealth Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLE			RT CENTER Provider CC	CN: 15-015		-iod: om 07/01/2020	eu of Form CMS Worksheet S- Part I	
					To	06/30/2021		
1.00		2.00				3.00		
If this facility is part of a cha home office and enter the home of					he name	e and address	of the	
41.00Name: ST. VINCENT HEALTH	Contractor's N				actor'	s Number: 0810	01	141.0
42.00 Street: 250 W. 96TH STREET	PO Box:							142.0
43.00 City: INDIANAPOLIS	State:	IN		Zip (Code:	462	60	143.0
							1.00	-
44.00 Are provider based physicians' co	sts included in Work	sheet A?					Y	144. (
45.00 f costs for renal services are c	Laimad an Wkat A	ino 74 -	and the east	for		1.00	2.00	145. (
 45.0011 costs for renar services and costs for renar services only? Enter "Y" no, does the dialysis facility im period? Enter "Y" for yes or "N" 46.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in 	" for yes or "N" for clude Medicare utili: for no in column 2. gy changed from the	no in co zation fo previous	olumn 1. lf c or this cost y filed cost	column 1 i reporting t report?	9	Ν		145. 0
yes, enter the approval date (mm/				+0, 3+020,	,			_
							1.00	-
47.00 Was there a change in the statist	ical basis? Enter "Y	" for yes	s or "N" for	no.			N 1.00	147.0
48.00 Was there a change in the order o	f allocation? Enter	"Y" for	yes or "N" fo	or no.			N	148. (
49.00 Was there a change to the simplif	ied cost finding met	hod? Ente					N	149. (
			Part A 1.00	Part 2.00		<u>Title V</u> 3.00	Title XIX 4.00	-
Does this facility contain a prov	ider that qualifies	for an e						
or charges? Enter "Y" for yes or							<u>3. 13)</u>	
55.00 Hospi tal			N	N		N	N	155. (
56.00 Subprovi der – IPF 57.00 Subprovi der – IRF			N N	N N		N N	N	156. (157. (
57. 00 SUBPROVI DER			IN	N I		IN	IN	157.0
59. 00 SNF			Ν	N		Ν	N	159. 0
60.00 HOME HEALTH AGENCY			Ν	N		N	N	160. 0
61.00 CMHC				N		N	N	161.0
							1.00	_
Multicampus 65.00 Is this hospital part of a Multica	ampus hospital that	has one (or more campu	uses in di	fferen	t CBSAs?	N	165. 0
Enter "Y" for yes or "N" for no.							/ -	
	Name 0		County 1.00		Zip C 3.0		FTE/Campus 5.00	_
166.00 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)			1.00	2.00	3.0			00 166. 0
							1.00	
Health Information Technology (HI						Act		
	r under §1886(n)? E	meani ngfi	ul user (line			nter the	Y	167. (168. (
68.00 If this provider is a CAH (line 10					for -	hondoh! -		1/0
68.00 If this provider is a CAH (line 1) reasonable cost incurred for the l	HIT assets (see inst		this pre-		ror a	narosni p	1	168. 0
68.00 If this provider is a CAH (line 1) reasonable cost incurred for the 1 68.01 If this provider is a CAH and is	HIT assets (see inst not a meaningful use	r, does ⁻			nns)			
 68.00 If this provider is a CAH (line 10) reasonable cost incurred for the line 10 (line 10) reasonable cost incurred for the line 10 (line 10) reasonable cost incurred for the line 10 (line 10) reasonable cost incurred for the line 10 (line 10) (HIT assets (see inst not a meaningful use ? Enter "Y" for yes user (line 167 is "Y	r, does [:] or "N" fo	or no. (see i	nstructi), enter the	9.0	99169. (
 68.00 If this provider is a CAH (line 10) reasonable cost incurred for the line 10 for the line 1	HIT assets (see inst not a meaningful use ? Enter "Y" for yes user (line 167 is "Y	r, does [:] or "N" fo	or no. (see i	nstructi		Begi nni ng	Endi ng	99169. (
 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the l 68.01 If this provider is a CAH and is a exception under §413.70(a) (6) (ii) 69.00 If this provider is a meaningful transition factor. (see instruction) 	HIT assets (see inst not a meaningful use ? Enter "Y" for yes user (line 167 is "Y ons)	r, does or "N" fo ") and is	or no. (see i s not a CAH (nstructio (line 105				
 68.01 If this provider is a CAH and is exception under §413.70(a)(6)(ii) 69.00 If this provider is a meaningful to the second secon	HIT assets (see inst not a meaningful use ? Enter "Y" for yes user (line 167 is "Y ons)	r, does or "N" fo ") and is	or no. (see i s not a CAH (nstructio (line 105		Begi nni ng	Endi ng	_
 68.00 If this provider is a CAH (line 10) reasonable cost incurred for the line acception under §413.70(a) (6) (ii) (69.00) If this provider is a meaningful transition factor. (see instruction factor) 70.00 Enter in columns 1 and 2 the EHR 10 	HIT assets (see inst not a meaningful use ? Enter "Y" for yes user (line 167 is "Y ons)	r, does or "N" fo ") and is	or no. (see i s not a CAH (nstructio (line 105		Begi nni ng	Endi ng	99169. (

	Financial Systems ST. VINCENT H AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0153	Period:	eu of Form CMS- Worksheet S-2	
55111	AL AND HOST THE HEALTH OAKE KETMOOKSEMENT QUESTIONINALKE	Trovider c		From 07/01/2020 To 06/30/2021	Part II	epared
				Y/N	Date	
				1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	for all NO re	esponses. Ent	er all dates in t	the	_
	Provider Organization and Operation					-
00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in c			N		1.
			Y/N	Date	V/I	
00	Has the provider terminated participation in the Medicare P	rearen 2 lf	1.00 N	2.00	3.00	2.
00	yes, enter in column 2 the date of termination and in column voluntary or "I" for involuntary.		IN IN			2.
00	Is the provider involved in business transactions, includin contracts, with individuals or entities (e.g., chain home o or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members o of directors through ownership, control, or family and othe relationships? (see instructions)	ffices, drug er or its f the board	Y			3.
			Y/N	Туре	Date	
			1.00	2.00	3.00	
00	Financial Data and Reports Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" f or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	or Compiled,	Y	A		4.
00	Are the cost report total expenses and total revenues diffe those on the filed financial statements? If yes, submit rec		N			5.
				Y/N 1.00	Legal Oper. 2.00	
00	Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2:	lfves is th	ne provider i	s N		6.
	the legal operator of the program?	11 900, 10 0				
00 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved		d during the	N N		7. 8.
00	cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction		cal education	Ν		9.
. 00	Was an approved Intern and Resident GME program initiated o cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I			N		10.
. 00	Teaching Program on Worksheet A? If yes, see instructions.			N	Y/N	11.
					1.00	
2.00	Bad Debts Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p			ost reporting	Y N	12. 13.
1. 00	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-payme				N	14.
5. 00	Bed Complement Did total beds available change from the prior cost reporti	<u>v</u> 1	yes, see ins rt A	tructions. Par	N t B	15.
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
. 00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4.(see	Y	10/08/2021	Y	10/08/2021	16.
. 00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Ν		Ν		17.
. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	Ν		Ν		18
. 00	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

VINCENT HEADT CENTED

Heal th	Financial Systems ST. VINCENT H	HEART CENTER		In Lie	u of Form CM	S-2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C		Period: From 07/01/2020 To 06/30/2021	Worksheet S Part II Date/Time P	-2 repared:
		Decer	ntion	Y/N	11/22/2021	<u>3:37 pm</u>
			ption)	1.00	Y/N 3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R		5	N 1.00	3.00	20.00
20.00	Report data for Other? Describe the other adjustments:			IN	IN IN	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's	N		N		21.00
	records? If yes, see instructions.					
	ANNOUSTED DV AGAT DELUDURASE AND TEEDA MARDUTALO ANNA (EVA				1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCI	EPT CHILDRENS H	USPITALS)			
22.00	Capital Related Cost Have assets been relifed for Medicare purposes? If yes, se	oinstructions			N	22.00
22.00	Have changes occurred in the Medicare depreciation expense		als mado duriu	a the cost	N	22.00
23.00	reporting period? If yes, see instructions.	uue to apprais		ig the cost	IN	23.00
24.00	Were new leases and/or amendments to existing leases enter	ed into during	this cost ren	orting period?	N	24.00
21100	If yes, see instructions	ou meo uu mg	the boot rop	or tring porrour		2
25.00	Have there been new capitalized leases entered into during	the cost repor	ting period?	lfyes, see	N	25.00
	instructions.		0.1	5		
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during t	he cost reporti	ng period? If	yes, see	N	26.00
	instructions.			-		
27.00	Has the provider's capitalization policy changed during the	e cost reportin	g period? If	yes, submit	N	27.00
	copy.					
	Interest Expense				NI NI	
28.00	Were new loans, mortgage agreements or letters of credit en	ntered into dur	ing the cost	reporting	N	28.00
29.00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or	bond funds (Do	ht Sorvico Po	corvo Eund)	N	29,00
29.00	treated as a funded depreciation account? If yes, see inst		DI SEIVICE RE	serve runu)	IN	29.00
30.00	Has existing debt been replaced prior to its scheduled mat		debt? If ves	SPP	N	30.00
00.00	instructions.		uose: :: joo,	000		00100
31.00	Has debt been recalled before scheduled maturity without is	ssuance of new	debt? If yes,	see	N	31.00
	instructions.		-			
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care se		d through con	tractual	N	32.00
	arrangements with suppliers of services? If yes, see instru					
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 ap	plied pertainin	g to competit	ive bidding? If	N	33.00
	no, see instructions. Provider-Based Physicians					
34 00	Are services furnished at the provider facility under an a	rrangement with	nrovi der-bas	ad physicians?	Y	34.00
54.00	If yes, see instructions.	i angement with	provider-bas			54.00
35.00		isting agreemen	ts with the n	rovi der-based	N	35.00
	physicians during the cost reporting period? If yes, see in					
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00				Y		36.00
37.00		repared by the	home office?	Y		37.00
20.00	If yes, see instructions.					20.00
38.00	If line 36 is yes, was the fiscal year end of the home of			N		38.00
39.00	the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe			Ν		39.00
37.00	see instructions.		ents: 11 yes,	IN		39.00
40.00	If line 36 is yes, did the provider render services to the	home office?	lf ves see	Ν		40.00
	instructions.					
		1.	00	2.	00	
	Cost Report Preparer Contact Information	1				
41.00	Enter the first name, last name and the title/position	JILL		HILL		41.00
	held by the cost report preparer in columns 1, 2, and 3,					
40.00	respectively.		T 11			40.00
42.00		ASCENSION HEAL	іп			42.00
43 00	preparer. Enter the telephone number and email address of the cost	(317) 583-3519		JI LL. HI LL1@ASC	ENSLON OPC	43.00
45.00	report preparer in columns 1 and 2, respectively.	(317) 303-3319		STEL. III LETEASU	LING ON ONG	+3.00
	1.0 2.10 1.0	1		ļ		

Heal th	Financial Systems ST. VINCENT	HEART CENTER	In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0153	Peri od:	Worksheet S-2	
			From 07/01/2020 To 06/30/2021		pared: 37 pm
		3.00			
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position	MANAGER, NET REVENUE			41.00
	held by the cost report preparer in columns 1, 2, and 3,	MANAGEMENT			
	respecti vel y.				
42.00	Enter the employer/company name of the cost report				42.00
	preparer.				
43.00	Enter the telephone number and email address of the cost				43.00
	report preparer in columns 1 and 2, respectively.				

^{11/22/2021 3:37} pm D:\Shared drives\Finance_Net Revenue_IN - Acute\Reimbursement\Cost Reports\FY2021\Heart Ctr\SVHC2021.mcrx

	Financial Systems TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	ST. VINCENT HE	Provider CO	N. 15 0152	Peri od:	u of Form CMS- Worksheet S-3	
HUSPII	AL AND HUSPITAL HEALTH CARE CUMPLEX STATISTIC.	AL DATA	Provider CC	JN: 15-0153	From 07/01/2020	Part I)
					To 06/30/2021	Date/Time Pre	
						11/22/2021 3:	
						I/P Days / O/P	
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
		Line Number	2.00	Avai I abl e	4.00	F 00	
1.00	Hachital Adults & Dods (columns E 6 7 and	1.00	2.00	3.00 39,0	4.00 55 0.00	5.00	1.00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and	30.00	107	39, 0	55 0.00	0	1.00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2.00
3.00	HMO I PF Subprovi der						3.00
4.00	HMO I RF Subprovi der						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	
6.00	Hospital Adults & Peds. Swing Bed NF					0	
7.00	Total Adults and Peds. (exclude observation		107	39, 0	55 0.00	0	
7.00	beds) (see instructions)		107	07,0	0.00	0	1.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9,00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGI CAL I NTENSI VE CARE UNI T						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		107	39, 0	55 0.00	0	14.00
15.00	CAH visits					0	
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPI CE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		107				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambul ance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0		0		32.00
32.01	Total ancillary labor & delivery room						32.01
	outpatient days (see instructions)						
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPI TAL	AND HOSPITAL HEALTH CARE COMPLEX STATISTICA	AL DATA	Provider CC	:N: 15-0153	Period: From 07/01/2020 To 06/30/2021	Worksheet S-3 Part I Date/Time Pre 11/22/2021 3:	pared:
		I/P Days	/ O/P Visits	/ Trips	Full Time I	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
8 6 100 100 2.00 100 3.00 100 4.00 100 5.00 100 5.00 100 6.00 100 7.00 100 9.00 C01 10.00 BUI 11.00 SUI 12.00 OTI 15.00 CAI 16.00 SUI 17.00 SUI 18.00 SUI 19.00 CAI 20.00 HOI 21.00 OTI 22.00 HOI 22.00 HOI 22.00 HOI 22.00 HOI 22.00 HOI 24.00 HOI 25.00 CMI 26.25 FEI 27.00 To 28.00 OB	<pre>spital Adults & Peds. (columns 5, 6, 7 and exclude Swing Bed, Observation Bed and spice days)(see instructions for col. 2 r the portion of LDP room available beds) 10 and other (see instructions) 10 IPF Subprovider 10 IPF Subprovider 10 IPF Subprovider 13 Adults & Peds. Swing Bed SNF 14 Adults and Peds. (exclude observation 15 ds) (see instructions) 17 ENSIVE CARE UNIT 18 RONARY CARE UNIT 19 RONARY CARE (SPECIFY) 19 RESERY 10 IS is 19 BPROVIDER - IPF 19 BPROVIDER - IPF 19 BPROVIDER - IRF 19 BPROVIDER 11 LLED NURSING FACILITY 19 REALTH AGENCY 19 ULATORY SURGICAL CENTER (D. P.) 19 ICE 19 SPICE 19 CE (non-distinct part) 10 C - CMHC 19 ADATORY SURGICAL CENTER (D. P.) 19 SPICE 19 CE (non-distinct part) 10 C - CMHC 19 ADATORY SURGICAL CENTER 10 Servation Bed Days 10 Julance Trips</pre>	8, 094 3, 964 0 0 8, 094 8, 094 0 0 0	1, 157 0 0 0 0 188 188 0 188 0 0 0 0 0 0 0	19, 4 19, 4 19, 4 19, 4	53 0 53 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	351.09	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
30.00 Emp 31.00 Emp 32.00 Lab 32.01 Tooout	ployee discount days (see instruction) ployee discount days - IRF bor & delivery days (see instructions) tal ancillary labor & delivery room tpatient days (see instructions)	0	0	10	0 0 0 0		30. 0 31. 0 32. 0 32. 0
	CH non-covered days CH site neutral days and discharges	0 0					33. 0 33. 0

	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC/	<u>ST. VINCENT HE</u> AL DATA	Provider C	CN: 15-0153	Peri od: From 07/01/2020 To 06/30/2021	u of Form CMS-2 Worksheet S-3 Part I Date/Time Pre 11/22/2021 3:	pared:
		Full Time Equivalents		Di s	charges	11/22/2021 5.	<u>57 pm</u>
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11.00	12.00	13.00	14.00	15.00	
1.00 2.00	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)		0		54 56 27 190	3, 935	1.00 2.00
3.00 4.00 5.00 6.00	HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF				0		3.00 4.00 5.00 6.00
7.00 8.00 9.00 10.00 11.00 12.00	Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						7.00 8.00 9.00 10.00 11.00 12.00
13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00 22.00 23.00 24.00 24.10 25.00	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	0.00	0	1, 6	54 56	3, 935	13.00 14.00 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 32.00 32.01 33.00	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) LTCH non-covered days LTCH site neutral days and discharges	0. 00 0. 00			0		26.00 26.25 27.00 28.00 29.00 30.00 31.00 32.00 32.01 33.00 33.01

	Financial Systems AL WAGE INDEX INFORMATION		ST. VINCENT H	Provi der C		Period:	Worksheet S-3	
						rom 07/01/2020 o 06/30/2021	Date/Time Pre	pareo
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)		11/22/2021 3: Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA SALARIES							
00	Total salaries (see instructions)	200.00	27, 425, 203	-71, 652	27, 353, 551	729, 975. 36	37.47	1.
00	Non-physician anesthetist Part A		C	0	C	0.00	0.00	2.
00	Non-physician anesthetist Part R		C	0	C	0.00	0.00	3.
00	Physician-Part A - Administrative		C	0	C	0.00	0.00	4
01 00	Physicians - Part A - Teaching Physician and Non		C	-	C C			
00	Physician-Part B Non-physician-Part B for hospital-based RHC and FQHC services		110, 443	0	110, 443	2, 080. 00	53. 10	6
00	Interns & residents (in an approved program)	21.00	C	0	C	0.00	0.00	7
D1	Contracted interns and residents (in an approved programs)		C	0	С	0.00	0.00	7
00	Home office and/or related organization personnel		3, 199, 639					
00 00	SNF Excluded area salaries (see instructions)	44.00	311		0 311			
00	OTHER WAGES & RELATED COSTS Contract labor: Direct Patient Care		629, 994	0	629, 994	11, 701. 80	53.84	11
00	Contract Labor: Top Level management and other management and administrative		C	0	С	0.00	0. 00	12
00	services Contract Labor: Physician-Part A - Administrative		1, 115, 236	0	1, 115, 236	7, 752. 76	143. 85	13
00	Home office and/or related organization salaries and wage-related costs		C	0	с	0.00	0. 00	14
	Home office salaries		6, 751, 959		6, 751, 959			
02 00	Related organization salaries Home office: Physician Part A - Administrative		C	-		0.00 0.00		
00	Home office and Contract Physicians Part A - Teaching		C	0	C	0.00	0.00	16
01	Home office Physicians Part A - Teaching		C	0	С	0.00		
02	Home office contract Physicians Part A - Teaching WAGE-RELATED COSTS		C	0	C	0.00	0.00	16
00	Wage-related costs (core) (see instructions)		8, 018, 180	0	8, 018, 180			17
00	Wage-related costs (other) (see instructions)							18
00 00	Excluded areas Non-physician anesthetist Part A		91 (0	91 C			19 20
00	Non-physician anesthetist Part B		C	0	C			21
00	Physician Part A – Administrative Dhysisian Dart A – Tasshing		C	0	с С			22
01 00 00 00	Physician Part A - Teaching Physician Part B Wage-related costs (RHC/FQHC) Interns & residents (in an		C C 32, 421 C	0	C C 32, 421 C			22 23 24 25
50	approved program) Home office wage-related		2, 300, 192	0	2, 300, 192	2		25
51	(core) Related organization wage-related (core)		C	0	С			25
. 52	Home office: Physician Part A - Administrative - wage-related (core)		C	0	С			25

Heal th	Financial Systems		ST. VINCENT H	EART CENTER		In Lie	eu of Form CMS-:	2552-10
	AL WAGE INDEX INFORMATION			Provider C	1	Period: From 07/01/2020 To 06/30/2021		
		Wkst. A Line	Amount	Reclassi fi cati	Adj usted	Paid Hours	Average Hourly	
		Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col.	Salaries in	col. 5)	
				A-6)	3)	col. 4		
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A		0	0	(C		25.53
	- Teaching - wage-related							
	(core)							
	OVERHEAD COSTS - DIRECT SALARI					-		
26.00	Employee Benefits Department	4.00	298, 275					
27.00	Administrative & General	5.00	1, 260, 433					
28.00	Administrative & General under		586, 099	0	586, 099	9 4, 386. 49	133. 61	28.00
	contract (see inst.)							
29.00	Maintenance & Repairs	6.00	0	0	(0. 00		29.00
30.00	Operation of Plant	7.00	818, 607	7, 856				
31.00	Laundry & Linen Service	8.00	994	0	994			
32.00	Housekeepi ng	9.00	0	0		0. 00		
33.00	Housekeeping under contract		843, 911	0	843, 91	1 33, 670. 73	25.06	33.00
	(see instructions)							
34.00	Dietary	10.00	0	0		0.00		34.00
35.00	Dietary under contract (see		615, 621	0	615, 621	1 20, 981. 06	29.34	35.00
	instructions)							
36.00	Cafeteri a	11.00	0	0		0. 00		
37.00	Maintenance of Personnel	12.00	0	0		0. 00		
38.00	Nursing Administration	13.00	1, 633, 622	16, 206	1, 649, 828			
39.00	Central Services and Supply	14.00	0	0	(0.00		
40.00	Pharmacy	15.00	1, 682, 477	16, 148				
41.00	Medical Records & Medical Records Library	16.00	170, 669	0	170, 669	9 4, 665. 35	36. 58	41.00
42.00	Soci al Servi ce	17.00	0	0		0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	(0.00	0.00	43.00

Heal th	Financial Systems		ST. VINCENT H	IEART CENTER		In Lie	eu of Form CMS-2	2552-10
HOSPI	TAL WAGE INDEX INFORMATION			Provider CO		Period: From 07/01/2020 To 06/30/2021	Worksheet S-3 Part III Date/Time Prep 11/22/2021 3:3	
		Worksheet A		Recl assi fi cati			Average Hourly	
		Line Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from	(col.2 ± col.		col. 5)	
				Worksheet A-6)	3)	col. 4		
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		26, 160, 752	-71, 652	26, 089, 10	0 729, 992. 36	35.74	1.00
	instructions)							
2.00	Excluded area salaries (see instructions)		311	0	31	1 7.08	43. 93	2.00
3.00	Subtotal salaries (line 1 minus line 2)		26, 160, 441	-71, 652	26, 088, 78	9 729, 985. 28	35. 74	3.00
4.00	Subtotal other wages & related costs (see inst.)		8, 497, 189	0	8, 497, 18	9 151, 373. 15	56. 13	4.00
5.00	Subtotal wage-related costs (see inst.)		10, 318, 372	0	10, 318, 37	2 0.00	39. 55	5.00
6.00	Total (sum of lines 3 thru 5)		44, 976, 002	-71, 652	44, 904, 35	0 881, 358. 43	50. 95	6.00
7.00	Total overhead cost (see instructions)		7, 910, 708	-265, 377	7, 645, 33	1 219, 087. 95	34. 90	7.00

Heal th	Financial Systems	ST. VINCENT HEA	ART CENTER		In Lie	u of Form CMS-2	2552-10
HOSPIT	AL WAGE RELATED COSTS		Provi der	CCN: 15-0153	Period: From 07/01/2020 To 06/30/2021	Worksheet S-3 Part IV Date/Time Pre 11/22/2021 3:	pared:
						Amount	
						Reported	
						1.00	
	PART IV - WAGE RELATED COSTS						-
	Part A - Core List RETIREMENT COST						-
1.00	401K Employer Contributions					1, 248, 985	1.00
2,00	Tax Sheltered Annuity (TSA) Employer Contrik	oution				1, 240, 905	
3.00	Nongualified Defined Benefit Plan Cost (see					0	
4.00	Qualified Defined Benefit Plan Cost (see ins					0	
4.00	PLAN ADMINI STRATI VE COSTS (Paid to External					0	4.00
5.00	401K/TSA Plan Administration fees	organi zatron)				0	5.00
6.00	Legal /Accounting/Management Fees-Pensi on Pla	an				0	6.00
7.00	Employee Managed Care Program Administration					224, 739	
7.00	HEALTH AND INSURANCE COST	11005				221,707	7.00
8.00	Heal th Insurance (Purchased or Self Funded)					0	8.00
8.01	Heal th Insurance (Self Funded without a Thir	rd Party Administ	rator)			0	
8.02	Heal th Insurance (Self Funded with a Third F					2, 976, 966	
8.03	Heal th Insurance (Purchased)	a cy nam notrati	5.)			2, 7, 6, 7,60	
9,00	Prescription Drug Plan					1, 259, 779	
10.00	Dental, Hearing and Vision Plan					107, 090	
11.00	Life Insurance (If employee is owner or bene	eficiary)				21, 990	
12.00	Accident Insurance (If employee is owner or					0	
13.00	Disability Insurance (If employee is owner of					175, 163	13.00
14.00	Long-Term Care Insurance (If employee is own		V)			0	
15.00	'Workers' Compensation Insurance	· · · · · · · ·	, ,			16, 491	15.00
16.00		ear, not the extra	aordinary a	ccrual requir	ed by FASB 106.	0	16.00
	Non cumulative portion)		2		,		
	TAXES						
17.00	FICA-Employers Portion Only					1, 974, 685	17.00
18.00	Medicare Taxes - Employers Portion Only					0	18.00
19.00	Unemployment Insurance					0	19.00
20.00	State or Federal Unemployment Taxes					30, 027	20.00
	OTHER						
21.00	Executive Deferred Compensation (Other Than instructions))	Retirement Cost I	Reported or	lines 1 thro	ugh 4 above. (see	0	21.00
	Day Care Cost and Allowances					0	
	Tuition Reimbursement					14, 777	
24.00	Total Wage Related cost (Sum of lines 1 -23))				8, 050, 692	24.00
	Part B - Other than Core Related Cost						
25.00	OTHER WAGE RELATED COSTS (SPECIFY)						25.00

Heal th	Financial Systems	ST. VINCENT HEAF	RT CENTER	In Lie	u of Form CMS-2	2552-10
HOSPI T	AL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 15-0153	Peri od:	Worksheet S-3	
				From 07/01/2020		aarad.
				To 06/30/2021	Date/Time Pre 11/22/2021 3:	
	Cost Center Description			Contract Labor		or pill
	·			1.00	2.00	
	PART V - Contract Labor and Benefit Cost					
	Hospital and Hospital-Based Component Identi	fi cati on:				
1.00	Total facility's contract labor and benefit	cost		122, 210	8, 050, 692	1.00
2.00	Hospi tal			122, 210	8, 050, 692	2.00
3.00	Subprovider - IPF					3.00
4.00	Subprovider - IRF					4.00
5.00	Subprovider - (Other)			0	0	5.00
6.00	Swing Beds - SNF			0	0	6.00
7.00	Swing Beds - NF			0	0	7.00
8.00	Hospital-Based SNF					8.00
9.00	Hospital-Based NF					9.00
10.00	Hospital-Based OLTC					10.00
11.00	Hospital-Based HHA					11.00
12.00	Separately Certified ASC					12.00
13.00	Hospi tal -Based Hospi ce					13.00
14.00	Hospital-Based Health Clinic RHC					14.00
15.00	Hospital-Based Health Clinic FQHC					15.00
16.00	Hospi tal -Based-CMHC					16.00
17.00	Renal Dialysis					17.00
18.00	Other			0	0	18.00

Heal th	Financial Systems ST. VINCENT HEART	CENTER		In Lie	u of Form CMS-2	2552-10	
		Provider CC	CN: 15-0153	Peri od:	Worksheet S-1	C	
				From 07/01/2020 To 06/30/2021	Date/Time Pre	arad	
				10 06/30/2021	11/22/2021 3:		
					11/22/2021 01	or pin	
					1.00		
	Uncompensated and indigent care cost computation						
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 div	ided by li	ne 202 column	8)	0. 171489	1.00	
	Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid				4, 783, 324	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	If line 4 is no, then enter DSH and/or supplemental payments fr	om Medicai	d		0	5.00	
6.00	Medicaid charges				45, 222, 402	6.00	
7.00 8.00	Medicaid cost (line 1 times line 6) Difference between net revenue and costs for Medicaid program (line 7 min	us sum of lin	oc 2 and E. if	7, 755, 144	7.00 8.00	
8.00	<pre>< zero then enter zero)</pre>	inne / min	us sum of fin	es z and s; TT	2, 971, 820	8.00	
	Children's Health Insurance Program (CHIP) (see instructions fo	r each lin	e)				
9.00	Net revenue from stand-al one CHIP				0	9.00	
10.00	Stand-al one CHIP charges				0	10.00	
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 f	or each line)				
	Net revenue from state or local indigent care program (Not incl				0		
14.00	Charges for patients covered under state or local indigent care	e program (Not included	in lines 6 or	0	14.00	
45 00	10)					45 00	
15.00	State or local indigent care program cost (line 1 times line 14		(1)	45	0	15.00	
16.00	Difference between net revenue and costs for state or local ind 13; if < zero then enter zero)	ligent care	program (IIn	e 15 minus line	0	16.00	
	Grants, donations and total unreimbursed cost for Medicaid, CHI	P and state	e/local india	ent care program	ns (see		
	instructions for each line)		errocar rhurg	ent care program	13 (366		
17.00	Private grants, donations, or endowment income restricted to fu	indi 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	2, 971, 820	19.00	
	8, 12 and 16)						
			Uni nsured	Insured	Total (col. 1		
			patients	patients	+ col . 2)		
	Uncompensated Care (see instructions for each line)		1.00	2.00	3.00		
20.00	Charity care charges and uninsured discounts for the entire fac	ility	3, 987, 43	3 562, 324	4, 549, 757	20.00	
20.00	(see instructions)	, i i i cy	3, 707, 40	5 502, 524	4, 547, 757	20.00	
21.00	Cost of patients approved for charity care and uninsured discoulinstructions)	ints (see	683, 80	1 562, 324	1, 246, 125	21.00	
22.00	Payments received from patients for amounts previously written	off as	416, 66	1 51, 232	467, 893	22.00	
23.00	charity care Cost of charity care (line 21 minus line 22)		267, 14	0 511, 092	778, 232	23.00	
					1.00		
24.00	Does the amount on line 20 column 2, include charges for patient		ond a length	of stay limit	N	24.00	
25.00	imposed on patients covered by Medicaid or other indigent care If line 24 is yes, enter the charges for patient days beyond th		care program	's length of	0	25.00	
04 00	stay limit				4 (70 004	0/ 00	
	Total bad debt expense for the entire hospital complex (see ins		ruation-		4, 672, 324		
	Medicare reimbursable bad debts for the entire hospital complex				85, 592 131, 680	27. 00 27. 01	
27.01 28.00							
28.00 29.00		ansa (seo	instructions)		4, 540, 644 824, 758		
30.00							
	Total unreimbursed and uncompensated care cost (line 19 plus li	ne 30)			4, 574, 810		
2.1.00		/			, ., ., ., ., .,	200	

Heal th	Financial Systems	ST. VINCENT HE	ART CENTER		In Lie	u of Form CMS-	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	F EXPENSES	Provider CO	CN: 15-0153	Peri od:	Worksheet A	
					From 07/01/2020	Data (Time Dres	
					To 06/30/2021	Date/Time Pre 11/22/2021 3:	area: 37 nm
	Cost Center Description	Sal ari es	Other	Total (col	1 Recl assi fi cati	Reclassi fi ed	
	Cost center bescription	54141103	other	+ 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		1, 808, 771	1, 808, 77	/1 -195, 142	1, 613, 629	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		2, 871, 680	2, 871, 68	143, 728	3, 015, 408	2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	298, 275	6, 354, 660			6, 415, 540	4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	1, 260, 433	23, 589, 450	24, 849, 88	-46, 767	24, 803, 116	5.00
7.00	00700 OPERATION OF PLANT	818, 607	3, 665, 515	4, 484, 12	2 77, 463	4, 561, 585	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	994	255, 852	256, 84	6 0	256, 846	8.00
9.00	00900 HOUSEKEEPI NG	0	1, 003, 599	1, 003, 59	9 9, 048	1, 012, 647	9.00
10.00	01000 DI ETARY	0	1, 841, 959	1, 841, 95	-1, 006, 695	835, 264	10.00
11.00	01100 CAFETERI A	0	0		0 1, 015, 801	1, 015, 801	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	1, 633, 622	1, 563, 862	3, 197, 48	17, 166	3, 214, 650	13.00
15.00	01500 PHARMACY	1, 682, 477	85, 684	1, 768, 16		1, 784, 803	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	170, 669	21, 299	191, 96	0 8	191, 968	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	11, 624, 494	1, 742, 546	13, 367, 04	0 123, 828	13, 490, 868	30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	4, 368, 611	1, 845, 482				
54.00	05400 RADI OLOGY-DI AGNOSTI C	977, 857	1, 414, 794	2, 392, 65	13, 654	2, 406, 305	54.00
57.00	05700 CT SCAN	0	0		0 0	0	57.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0 0	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	1, 982, 670	1, 571, 527	3, 554, 19		3, 555, 461	
60.00	06000 LABORATORY	0	3, 229, 918			3, 229, 918	
65.00	06500 RESPI RATORY THERAPY	1, 060, 256	431, 003	1, 491, 25	i9 10, 176	1, 501, 435	
66.00	06600 PHYSI CAL THERAPY	408, 963	36, 383			449, 389	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4, 118, 740			4, 118, 740	1
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	28, 722, 456			28, 722, 456	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	3, 912, 353	3, 912, 35	0	3, 912, 353	73.00
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	1, 136, 964	1, 033, 448	2, 170, 41	2 10, 912	2, 181, 324	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS						
118.00		27, 424, 892	91, 120, 981	118, 545, 87	3 0	118, 545, 873	118.00
	NONREI MBURSABLE COST CENTERS	I					
	19300 NONPAID WORKERS	0	0		0 0		193.00
	19301 MARKETING	311	197, 391				
200.00	D TOTAL (SUM OF LINES 118 through 199)	27, 425, 203	91, 318, 372	118, 743, 57	0	118, 743, 575	200.00

Heal th	Financial Systems	ST. VINCENT H	EART CENTER		In Lie	u of Form CMS-2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CC	CN: 15-0153	Peri od:	Worksheet A
					From 07/01/2020	
					To 06/30/2021	Date/Time Prepared: 11/22/2021 3:37 pm
	Cost Center Description	Adjustments	Net Expenses		- I	11/22/2021 3. 37 pm
	bost bontor boschiption		For Allocation			
		6.00	7.00			
	GENERAL SERVICE COST CENTERS	!				
1.00	00100 CAP REL COSTS-BLDG & FIXT	41, 481	1, 655, 110			1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	0	3, 015, 408			2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	42, 244	6, 457, 784			4.00
5.00	00500 ADMINISTRATIVE & GENERAL	-2,017,755	22, 785, 361			5.00
7.00	00700 OPERATION OF PLANT	0	4, 561, 585			7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	256, 846			8.00
9.00	00900 HOUSEKEEPI NG	0	1, 012, 647			9.00
10.00	01000 DI ETARY	0	835, 264			10.00
11.00	01100 CAFETERI A	-243, 277	772, 524			11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	-249	3, 214, 401			13.00
15.00	01500 PHARMACY	0	1, 784, 803			15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	-3, 123	188, 845			16.00
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDI ATRI CS	0	13, 490, 868			30.00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	-22, 917	6, 233, 450			50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	-45, 701	2, 360, 604			54.00
57.00	05700 CT SCAN	0	0			57.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0			58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	-272	3, 555, 189			59.00
60.00	06000 LABORATORY	0	3, 229, 918			60.00
65.00	06500 RESPI RATORY THERAPY	-57	1, 501, 378			65.00
66.00	06600 PHYSI CAL THERAPY	0	449, 389			66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4, 118, 740			71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	28, 722, 456			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	3, 912, 353			73.00
	OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	-313, 416	1, 867, 908			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)					92.00
	SPECIAL PURPOSE COST CENTERS					
118.00		-2, 563, 042	115, 982, 831			118.00
	NONREI MBURSABLE COST CENTERS	_1	_1			
	19300 NONPALD WORKERS	0	0			193.00
	19301 MARKETING	0	197, 702			193.01
200.00	TOTAL (SUM OF LINES 118 through 199)	-2, 563, 042	116, 180, 533			200.00

ECLAS	Financial Systems SIFICATIONS			Provider CCN	15-0153	Peri od:	Worksheet A-6	
						From 07/01/20 To 06/30/20		
		Increases						<u>/ pii</u>
	Cost Center	Line #	Salary	Other				
	2.00	3.00	4.00	5.00				
	A - CAPITAL		· · · ·					
. 00	CAP REL COSTS-MVBLE EQUIP	2.00	0	75, 277				1. (
. 00	ADMI NI STRATI VE & GENERAL	5.00	o	51, 414				2. (
. 00	CAP REL COSTS-MVBLE EQUIP	2.00	o	68, 451				3. (
	0			195, 142				
	B – CAFETERIA							
. 00	CAFETERI A	11.00	0	1,015,801				1. (
	0		0	1,015,801				
	C – PANDEMIC							
. 00	NURSING ADMINISTRATION	13.00	1, 487	0				1. (
. 00	ADULTS & PEDIATRICS	30.00	11, 202	0				2. (
. 00	OPERATING ROOM	50.00	346	0				3. (
. 00	RADI OLOGY-DI AGNOSTI C	54.00	3, 284	0				4. (
. 00	CARDIAC CATHETERIZATION	59.00	1, 264	0				5.0
. 00	PHYSICAL THERAPY		118	<u>0</u>				6. (
	0		17, 701	0				
	D - SALARY PTO ACCRUAL RECLAS							
. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	56, 800				1. (
	0		0	56, 800				
	E - FURLOUGH PAY RECLASS							
. 00	ADMI NI STRATI VE & GENERAL	5.00	0	880				1. (
. 00	NURSING ADMINISTRATION	13.00	0	960				2. (
. 00	ADULTS & PEDIATRICS	30.00	0	6, 752				3. (
. 00	OPERATING ROOM	50.00	0	346				4. (
. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	3, 284				5.0
	TOTALS		0	12, 222				
	F - C19 VACCINE PAY RECLASS							
. 00	PHARMACY	15.00	494	0				1. (
. 00	ADULTS & PEDIATRICS	30.00	1, 059	0				2. (
. 00	RADI OLOGY-DI AGNOSTI C	54.00	<u> </u>	<u>0</u>				3. (
	TOTALS		2, 538	0				
	G - STARP RECLASS							
. 00	ADMI NI STRATI VE & GENERAL	5.00	9, 819	0				1. (
. 00	OPERATION OF PLANT	7.00	7, 856	0				2. (
. 00	NURSING ADMINISTRATION	13.00	15, 679	0				3. (
. 00	PHARMACY	15.00	16, 148	0				4. (
. 00	ADULTS & PEDIATRICS	30.00	111, 567	0				5.0
. 00	OPERATING ROOM	50.00	41, 928	0				6. (
. 00	RADI OLOGY-DI AGNOSTI C	54.00	9, 385	0				7. (
. 00	RESPI RATORY THERAPY	65.00	10, 176	0				8.
. 00	PHYSICAL THERAPY	66.00	3, 925	0				9.
0.00	EMERGENCY		1 <u>0, 9</u> 12	0				10. (
	TOTALS		237, 395	0				
	H - VACCINE TO WORK COMP RECL		. 1	1				
. 00	ADMI NI STRATI VE & GENERAL	5.00	0	92				1. (
00	PHARMACY	15.00	0	494				2.
00	ADULTS & PEDIATRICS	30.00	0	1, 059				3.
00	RADI OLOGY-DI AGNOSTI C	<u>54.</u> 00	º	<u> </u>				4.
	TOTALS		0	2, 630				
	I - PANDEMIC OTHER COSTS RECL							
00	OPERATION OF PLANT	7.00	0	69, 607				1.
. 00	HOUSEKEEPI NG	9.00	0	9, 048				2.
. 00	<u>DI ETARY</u>		0	<u>9, 1</u> 06				3.
	TOTALS		0	87, 761				
	Grand Total: Increases		257, 634	1, 370, 356				5

Heal th	Fi nanci al	Systems
RECLAS	SIFICATION	S

ST. VINCENT HEART CENTER Provider CCN: 15-0153

In Lieu of Form CMS-2552-10 Period: Worksheet A-6 From 07/01/2020

						To 06/30/2021	Date/Time Prepared:
		Decreases					<u>11/22/2021 3:37 pm</u>
	Cost Center	Li ne #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00	-	
	A - CAPITAL						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	75, 277	11		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	51, 414			2.00
3.00	CAP REL COSTS-BLDG & FIXT	1.00	0	68, 451	11		3.00
	0		0	195, 142		-	
	B – CAFETERIA						
1.00	DI ETARY	10.00	0	1,015,801	0		1.00
	0		0	1, 015, 801			
	C - PANDEMIC					1	
1.00	ADMI NI STRATI VE & GENERAL	5.00	17, 701	0	-		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00			0	0	<u>0</u>		6.00
	0		17, 701	0			
4 00	D - SALARY PTO ACCRUAL RECLASS		F (000			1	
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	56, 800	0			1.00
			56, 800	0			
1 00	E - FURLOUGH PAY RECLASS	5 00	000	0	0		1.00
1.00 2.00	ADMI NI STRATI VE & GENERAL NURSI NG ADMI NI STRATI ON	5.00 13.00	880 960	0			1.00
2.00	ADULTS & PEDIATRICS	30.00		0	0		3.00
3.00 4.00	OPERATING ROOM	30.00 50.00	6, 752 346	0	0		4.00
4.00 5.00	RADI OLOGY-DI AGNOSTI C	54.00	3, 284	0	0		4.00
5.00	TOTALS	<u>54.00</u>	<u>3, 204</u> 12, 222	0	└── ── [॒]		5.00
	F - C19 VACCINE PAY RECLASS		12,222	0			
1.00	ADMI NI STRATI VE & GENERAL	5.00	2, 538	0	0		1.00
2.00	A DIM NO SHOULD LE CENERALE	0.00	2,000	0	-		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		2, 538	0		-	
	G - STARP RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	237, 395	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00			0	0	0		10.00
	TOTALS		237, 395	0			
	H - VACCINE TO WORK COMP RECLA					1	
1.00	ADMI NI STRATI VE & GENERAL	5.00	92	0			1.00
2.00	PHARMACY	15.00	494 1, 059	0			2.00
3.00	ADULTS & PEDIATRICS	30.00		0	-		3.00
4.00	RADI OLOGY-DI AGNOSTIC	<u>54.</u> 00	985	0	<u> </u>		4.00
	TOTALS	100	2, 630	0	<u> </u>		
1 00	ADMINI STRATI VE & GENERAL			07 7/1	0		1 00
1.00 2.00	ADIVITINT STRATT VE & GENERAL	5.00 0.00	0	87, 761 0			1.00
2.00		0.00	0	0			3.00
3.00	TOTALS		0			1	3.00
500 00	Grand Total: Decreases		329, 286	1, 298, 704		-	500.00
550.00		I	027,200	1,270,704	I	I	1 300.00

Heal th	Financial Systems	ST. VINCENT H	ST. VINCENT HEART CENTER			In Lieu of Form CMS-2552-10			
RECONC	RECONCILIATION OF CAPITAL COSTS CENTERS		Provider CCN: 15-0153		Period: From 07/01/2020 To 06/30/2021			pared:	
				Acqui si ti on	s				
		Begi nni ng	Purchases	Donati on		Total	Di sposal s and		
		Bal ances					Retirements		
		1.00	2.00	3.00		4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	BALANCES		_			_		
1.00	Land	0	0		0	0	0	1.00	
2.00	Land Improvements	203, 753	0		0	0	0	2.00	
3.00	Buildings and Fixtures	46, 020, 056	186, 656		0	186, 656	900, 804	3.00	
4.00	Building Improvements	0	0		0	0	0	4.00	
5.00	Fixed Equipment	1, 486, 660	0		0	0	0	5.00	
6.00	Movable Equipment	24, 900, 761	2, 859, 339		0	2,859,339	1, 236, 507	6.00	
7.00	HIT designated Assets	0	0		0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	72, 611, 230	3, 045, 995		0	3,045,995	2, 137, 311	8.00	
9.00	Reconciling Items	0	0		0	0	0	9.00	
10.00	Total (line 8 minus line 9)	72, 611, 230	3, 045, 995		0	3,045,995	2, 137, 311	10.00	
		Endi ng Bal ance	Fully		-				
		J	Depreciated						
			Assets						
		6.00	7.00						
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	BALANCES		•					
1.00	Land	0	0					1.00	
2.00	Land Improvements	203, 753	0	1				2.00	
3.00	Buildings and Fixtures	45, 305, 908	0	1				3.00	
4.00	Building Improvements	0	0					4.00	
5.00	Fixed Equipment	1, 486, 660	0					5.00	
6.00	Movable Equipment	26, 523, 593	0					6.00	
7.00	HIT designated Assets	0	0					7.00	
8.00	Subtotal (sum of lines 1-7)	73, 519, 914	0					8.00	
9.00	Reconciling Items	0	0					9.00	
10.00	Total (line 8 minus line 9)	73, 519, 914	0					10.00	
			- 1						

Heal th	Financial Systems	ST. VINCENT H	EART CENTER		In Lieu of Form CMS-2552-10			
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provider CC		Period:	Worksheet A-7		
					From 07/01/2020 To 06/30/2021		narod	
					10 00/ 30/ 2021	11/22/2021 3:		
			SL	JMMARY OF CAPI	TAL			
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see			
		0.00	40.00	11.00		instructions)		
	DADT LL DEGONOLLIATION OF AMOUNTS FROM WORL	9.00	10.00	11.00	12.00	13.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORK				-			
1.00	CAP REL COSTS-BLDG & FIXT	1, 190, 036		429, 52	3 0	189, 212	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	2, 606, 417	192, 725		0 0	38, 385	2.00	
3.00	Total (sum of lines 1-2)	3, 796, 453	192, 725	429, 52	3 0	227, 597	3.00	
		SUMMARY OF 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	1				
	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	1, 808, 771				1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	34, 153	2, 871, 680				2.00	
3.00	Total (sum of lines 1-2)	34, 153	4, 680, 451				3.00	

Health Financial Systems	ST. VINCENT HEART CENTER			In Lieu of Form CMS-2552-10		
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider CO	F	Period: From 07/01/2020 To 06/30/2021		
	COM	PUTATION OF RAT	-1 0S	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)		Insurance	
PART III - RECONCILIATION OF CAPITAL COSTS CE	1.00	2.00	3.00	4.00	5.00	
1.00 CAP REL COSTS-BLDG & FIXT 2.00 CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)	46, 996, 321 26, 523, 593 73, 519, 914	0	46, 996, 321 26, 523, 593 73, 519, 914	0. 360767	0 0 0 E_CAPLTAL	1.00 2.00 3.00
Cost Center Description	Taxes	Other Capi tal -Rel ate d Costs	Total (sum of		Lease	
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE 1.00 CAP REL COSTS-BLDG & FIXT 2.00 CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)	<u>NTERS</u> 0 0 0	0 0 0	((() 1, 231, 517 2, 606, 417 3, 837, 934	192, 725	1.00 2.00 3.00
		SL	IMMARY OF CAPI	ΓAL		
Cost Center Description	Interest	Insurance (see instructions)		Other Capital-Relate d Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE 1.00 CAP REL COSTS-BLDG & FIXT 2.00 CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)	NTERS 234, 381 143, 728 378, 109	0	38, 385	5 34, 153		1.00 2.00 3.00

lealth Financial Systems ADJUSTMENTS TO EXPENSES		ST. VINCENT H	Provi der CCN: 15-0153	Period: From 07/01/2020	u of Form CMS-2 Worksheet A-8	
				To 06/30/2021	Date/Time Pre 11/22/2021 3:	
			Expense Classification of To/From Which the Amount is		1 1 1 22 202 1 0.	
Cost Center Description	Basi s/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Li ne # 4.00	Wkst. A-7 Ref. 5.00	
1.00 Investment income - CAP REL			CAP REL COSTS-BLDG & FIXT	1.00	0	1.0
2.00 COSTS-BLDG & FIXT (chapter 2) 2.00 Investment income - CAP REL		C	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.0
COSTS-MVBLE EQUIP (chapter 2) B.OO Investment income - other	В	-30, 930	ADMI NI STRATI VE & GENERAL	5.00	0	3.0
(chapter 2)	_					
4.00 Trade, quantity, and time discounts (chapter 8)		Ĺ		0.00	0	4.0
5.00 Refunds and rebates of expenses (chapter 8)		C		0.00	0	5.0
6.00 Rental of provider space by		C		0.00	0	6.0
suppliers (chapter 8) 7.00 Telephone services (pay stations excluded) (chapter		C		0.00	0	7.0
.00 [21] .00 Television and radio service		C		0.00	0	8. C
(chapter 21) 2.00 Parking Lot (chapter 21)		C		0.00	0	9.0
10.00 Provider-based physician	A-8-2	-381, 617			0	
adjustment 1.00 Sale of scrap, waste, etc.		C		0.00	0	11.0
(chapter 23) 2.00 Related organization transactions (chapter 10)	A-8-1	3, 874, 338	3		0	12. C
3.00 Laundry and Linen service		0		0.00	0	
 4.00 Cafeteria-employees and guest 5.00 Rental of quarters to employe and others 		-243,277 C	CAFETERI A	11.00 0.00	0	
6.00 Sale of medical and surgical supplies to other than patients		C		0.00	0	16.0
7.00 Sale of drugs to other than patients		C		0.00	0	17.0
8.00 Sale of medical records and abstracts	В	-3, 123	MEDICAL RECORDS & LIBRARY	16.00	0	18.0
9.00 Nursing and allied health education (tuition, fees,		C		0.00	0	19. (
books, etc.) 0.00 Vending machines		C		0.00	0	
1.00 Income from imposition of interest, finance or penalty charges (chapter 21)		C		0.00	0	21. (
2.00 Interest expense on Medicare overpayments and borrowings t	o	C		0.00	0	22. (
 repay Medicare overpayments Adjustment for respiratory therapy costs in excess of 	A-8-3	C	RESPI RATORY THERAPY	65.00		23. 0
4.00 I imitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	C	PHYSI CAL THERAPY	66.00		24. 0
5.00 Utilization review - physicians' compensation		C	*** Cost Center Deleted ***	* 114.00		25.0
(chapter 21) 6.00 Depreciation - CAP REL COSTS-BLDG & FIXT		C	CAP REL COSTS-BLDG & FIXT	1.00	0	26. (
7.00 Depreciation - CAP REL		C	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.0
COSTS-MVBLE EQUIP 8.00 Non-physician Anesthetist		C	*** Cost Center Deleted ***			28.0
 9.00 Physicians' assistant 0.00 Adjustment for occupational therapy costs in excess of 	A-8-3	C C) *** Cost Center Deleted ***	* 0. 00 67. 00	0	29. 0 30. 0
0.99 Hospice (non-distinct) (see instructions)		C	ADULTS & PEDIATRICS	30.00		30. 9
1.00 Adjustment for speech pathology costs in excess of	A-8-3	C	*** Cost Center Deleted ***	* 68.00		31. (
limitation (chapter 14) 2.00 CAH HIT Adjustment for		C		0.00	0	32. (
Depreciation and Interest 3.00 ENTERTAINMENT - A&G	А	-82	ADMI NI STRATI VE & GENERAL	5.00	0	33. 0

 33. 00
 ENTERTAI NMENT - A&G
 A
 -82
 ADMI NI STRATI VE & GENERAL
 5. 00
 0
 33. 00

 11/22/2021
 3: 37 pm D: \Shared drives\Finance_Net Revenue_IN - Acute\Reimbursement\Cost Reports\FY2021\Heart Ctr\SVHC2021.mcrx

Health Financial Systems			ST. VINCENT H	IEART CENTER	In Lieu of Form CMS-2552-10			
ADJUST	ADJUSTMENTS TO EXPENSES			Provider CCN: 15-0153	Peri od:	Worksheet A-8		
					From 07/01/2020 To 06/30/2021		pared [.]	
					10 00/00/2021	11/22/2021 3:		
				Expense Classification o	n Worksheet A			
				To/From Which the Amount is	s to be Adjusted			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.		
	···· · · · · · · · · · · · · · · · · ·	1.00	2.00	3.00	4.00	5.00		
33.01	MISC INCOME	В	-9, 539	ADMI NI STRATI VE & GENERAL	5.00	0	33.01	
33.02	ENTERTAINMENT - NURS ADMIN	A	-249	NURSING ADMINISTRATION	13.00	0	33.02	
33.03	ENTERTAI NMENT - RESP THERAPY	A	-57	RESPI RATORY THERAPY	65.00	0	33.03	
33.04	LOBBYING DUES	A	-1, 383	ADMI NI STRATI VE & GENERAL	5.00	0	33.04	
33.05	ENTERTAI NMENT - SURGERY	A	-417	OPERATING ROOM	50.00	0	33.05	
33.06	PROVIDER TAX ADJUSTMENT	A	-5, 781, 798	ADMI NI STRATI VE & GENERAL	5.00	0	33.06	
33.07	ENTERTAI NMENT - CARDI AC CATH	A	-272	CARDIAC CATHETERIZATION	59.00	0	33.07	
33.08	LATE PENALTY FEES	A	-18, 480	ADMINISTRATIVE & GENERAL	5.00	0	33.08	
33.09	UNREALIZED GAIN ON INVESTMENTS	В	136, 790	CAP REL COSTS-BLDG & FIXT	1.00	9	33.09	
33.10	REALIZED GAIN	В	-95, 309	CAP REL COSTS-BLDG & FIXT	1.00	9	33.10	
33.11	PATIENT INTEREST INCOME	В	-7, 537	ADMI NI STRATI VE & GENERAL	5.00	0	33. 11	
33. 12	ADMI NI STRATI VE FEE	В		ADMI NI STRATI VE & GENERAL	5.00	0	33. 12	
50.00	TOTAL (sum of lines 1 thru 49)		-2, 563, 042				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).

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

Heal th	Health Financial Systems ST. VINCENT HEART CENTER In Lieu of Form CMS-2552-1							
STATEME	NT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOM		Peri od:	Worksheet A-8	8-1		
OFFICE				From 07/01/2020 To 06/30/2021	Date/Time Pre 11/22/2021 3:			
	Line No. Cost Center		Expense Items	Amount of	Amount			
				Allowable Cost				
					Wks. A, column			
					5			
	1.00	2.00	3. 00	4.00	5.00			
	HOME OFFICE COSTS:	MENTS REQUIRED AS A RESULT OF		RGANIZATIONS OR	CLAI MED			
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT		4, 407, 112	4, 364, 868	1.00		
2.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE - CAPITAL	1, 745, 267	0	2.00		
3.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE - INTEREST	30, 930	0	3.00		
3.01	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE - OTHER	5, 003, 905	2, 948, 008	3.01		
4.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	ST. VINCENT HEALTH CHARGEBAC	1, 058, 116	1, 058, 116	4.00		
4.01	5.00	ADMINISTRATIVE & GENERAL	ST. VINCENT HEALTH CHARGEBAC	5, 361, 329	5, 361, 329	4.01		
4.02	7.00	OPERATION OF PLANT	ST. VINCENT HEALTH CHARGEBAC	215, 140	215, 140	4.02		
4.03	13.00	NURSING ADMINISTRATION	ST. VINCENT HEALTH CHARGEBAC	36, 755	36, 755	4.03		
4.04	15.00	PHARMACY	ST. VINCENT HEALTH CHARGEBAC	-15,000	-15,000	4.04		
4.05	16.00	MEDICAL RECORDS & LIBRARY	ST. VINCENT HEALTH CHARGEBAC	185, 634	185, 634	4.05		
4.06	50.00	OPERATING ROOM	ST. VINCENT HEALTH CHARGEBAC	3, 035, 882	3, 035, 882	4.06		
4.07	54.00	RADI OLOGY-DI AGNOSTI C	ST. VINCENT HEALTH CHARGEBAC	239, 613	239, 613	4.07		
4.08	59.00	CARDI AC CATHETERI ZATI ON	ST. VINCENT HEALTH CHARGEBAC	1, 560	1, 560	4.08		
4.09	65.00	RESPI RATORY THERAPY	ST. VINCENT HEALTH CHARGEBAC	50, 036	50, 036	4.09		
4.10	66.00	PHYSI CAL THERAPY	ST. VINCENT HEALTH CHARGEBAC	12, 091	12, 091	4.10		
4.11	193.01	MARKETING	ST. VINCENT HEALTH CHARGEBAC	197, 368	197, 368	4.11		
5.00	0		0	21, 565, 738	17, 691, 400	5.00		

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

				Related Organization(s) an	d/or Home Office		
	Symbol (1)	Name	Percentage of	Name	Percentage of		
			Ownership		Ownershi p		
	1.00	2.00	3.00	4.00	5.00		
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:							

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

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

6.00 B	0. 00 ASCENSI ON	100.00	6.00
7.00 B	0.00 ST. VINCENT HEA	74.08	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			100.00
non-fi nanci al) speci fy:			

(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.

011102							То	06/30/2021	Date/Time Pr 11/22/2021 3	repared: 8:37 pm
	Net	Wkst. A-7 Ref.								
	Adjustments									
	(col. 4 minus									
	col. 5)*									
	6.00	7.00								
	A. COSTS INCUR	RED AND ADJUST	MENTS REQUIRED AS A RES	ULT OF TRAN	SACTIONS WITH	RELATED OF	RGANI	ZATIONS OR (CLAI MED	
	HOME OFFICE CC	STS:								
1.00	42, 244									1.00
2.00	1, 745, 267	0								2.00
3.00	30, 930									3.00
3.01	2, 055, 897	0								3. 01
4.00	C	0								4.00
4.01	C	0								4.01
4.02	C	0								4.02
4.03	C	0								4.03
4.04	C	0								4.04
4.05	C	0								4.05
4.06	C	0								4.06
4.07	C	0								4.07
4.08	C	0								4.08
4.09	C	0								4.09
4.10	C	0								4.10
4.11	C	0								4.11
5.00	3, 874, 338	8								5.00
* The			coninto oo onnronrioto		بالأستان والمتحديد	- : i		+ 4	(

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 Organization(s)						
and/or Home Office						
Type of Business						
6.00						
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:						

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

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

6.00 HEALTH SVCS	6.00						
7.00 HEALTH MGMT	7.00						
8.00	8.00						
9.00	9.00						
10.00	10.00						
100.00	100.00						
(1) Use the following symbols to indicate interrelationship to related organizations:							

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

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

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

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

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

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

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

Heal th	Financial Syste	ms	ST. VINCENT	HEART CENTER		In Lie	eu of Form CMS-	2552-10
PROVI DE	R BASED PHYSI CI	AN ADJUSTMENT	-			Period: From 07/01/2020 To 06/30/2021	Worksheet A-8	3-2 epared:
	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component		Physician/Prov ider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00		OPERATING ROOM	206, 500		184,000			1.00
2.00		RADI OLOGY-DI AGNOSTI C	79, 166					
3.00		EMERGENCY	859, 757					
4.00	0.00		0		-		-	4.00
5.00	0.00		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	0	9.00
10.00	0.00		0	0	(0 0	0	10.00
200.00			1, 145, 423					200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of		Physician Cost	
		Identifier	Limit	Unadjusted RCE			of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
	1.00	2.00	8.00	9.00	Education 12.00	12 13.00	14.00	
1.00		OPERATING ROOM	246, 400					1.00
2.00		RADI OLOGY-DI AGNOSTI C	33, 465					
3.00		EMERGENCY	546, 341	27, 317	(-	3.00
4.00	0.00	EMERGENCI	0	0	-	-	0	4.00
4.00 5.00	0.00		0		-	-	0	5.00
6.00	0.00						0	6.00
7.00	0.00			0	(0	7.00
8.00	0.00						0	8.00
9.00	0.00		0	0	(0	9,00
10.00	0.00		0	0	(°	0	
200.00	0.00		826, 206	41, 310	-	-	-	
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment	_	
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00		OPERATING ROOM	0					1.00
2.00		RADI OLOGY-DI AGNOSTI C	0					2.00
3.00		EMERGENCY	0	,	313, 416			3.00
4.00	0.00		0	0	(4.00
5.00	0.00		0	0	-	-		5.00
6.00	0.00		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		9.00
10.00	0.00		0	0	(0		10.00
200.00			0	826, 206	344, 931	381, 617		200.00

Heal th	Financial Systems	ST. VINCENT H	EART CENTER		In Lie	u of Form CMS-2	2552-10
	ALLOCATION - GENERAL SERVICE COSTS		Provider C	CN: 15-0153	Peri od:	Worksheet B	
					From 07/01/2020	Part I	
					To 06/30/2021	Date/Time Pre 11/22/2021 3:	pared: 37 nm
			CAPI TAL REL	ATED COSTS		1172272021 3.	
	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	
1 00	GENERAL SERVICE COST CENTERS	4 (55 440)	4 (55 440		-		1 0 00
1.00	00100 CAP REL COSTS-BLDG & FIXT	1, 655, 110	1, 655, 110				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	3,015,408	5 704	3, 015, 40			2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	6, 457, 784	5, 794				4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	22, 785, 361	116, 207	211, 7		23, 408, 956	5.00
7.00	00700 OPERATION OF PLANT	4, 561, 585	292, 974	533, 76		5, 583, 962	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	256, 846	22, 030			319, 246	8.00
9.00	00900 HOUSEKEEPI NG 01000 DI ETARY	1, 012, 647	46, 795 31, 795			1, 144, 696	
10.00 11.00	01100 CAFETERIA	835, 264 772, 524	31, 795	57, 92 71, 21		924, 985 882, 828	
13.00	01300 NURSING ADMINISTRATION	3, 214, 401	39, 089 36, 883				13.00
15.00	01500 PHARMACY	1, 784, 803	30, 883			2, 292, 971	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	188,845	38, 368			337, 516	
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	100, 043	50, 500	07, 70	40,401	337, 310	10.00
30, 00	03000 ADULTS & PEDIATRICS	13, 490, 868	576, 786	1, 050, 83	35 2, 779, 196	17, 897, 685	30, 00
00.00	ANCI LLARY SERVICE COST CENTERS	10, 170, 000	070,700	1,000,00	2,117,170	11,077,000	00.00
50.00	05000 OPERATI NG ROOM	6, 233, 450	162, 179	295, 47	70 1, 044, 058	7, 735, 157	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 360, 604	32, 486			2, 685, 974	54.00
57.00	05700 CT SCAN	0	0		0 0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	3, 555, 189	92, 207	167, 99	469, 635	4, 285, 021	59.00
60.00	06000 LABORATORY	3, 229, 918	20, 941	38, 15	53 0	3, 289, 012	60.00
65.00	06500 RESPI RATORY THERAPY	1, 501, 378	53, 545	97, 55	52 253, 392	1, 905, 867	65.00
66.00	06600 PHYSI CAL THERAPY	449, 389	0		0 97, 766	547, 155	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4, 118, 740	0		0 0	4, 118, 740	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	28, 722, 456	0		0 0	28, 722, 456	72.00
73.00		3, 912, 353	0		0 0	3, 912, 353	73.00
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	1, 867, 908	49, 442	90, 07	271, 724		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
	SPECIAL PURPOSE COST CENTERS				.1		
118.00		115, 982, 831	1, 655, 110	3, 015, 40	6, 474, 060	115, 982, 757	118.00
	NONREI MBURSABLE COST CENTERS					-	
	19300 NONPAI D WORKERS	0	0		0 0		193.00
	1 19301 MARKETI NG	197, 702	0		0 74	197, 776	
200.00	5		~				200.00
201.00	5	114 100 500	1 (55 110	2 015 44			201.00
202.00) TOTAL (sum lines 118 through 201)	116, 180, 533	1, 655, 110	3, 015, 40	6, 474, 134	116, 180, 533	202.00

11/22/2021 3:37 pm D:\Shared drives\Finance_Net Revenue_IN - Acute\Reimbursement\Cost Reports\FY2021\Heart Ctr\SVHC2021.mcrx

Heal th	Financial Systems	ST. VINCENT H	IEART CENTER		In Lie	u of Form CMS-2	2552-10
	ALLOCATION - GENERAL SERVICE COSTS		Provider C		Period: From 07/01/2020 To 06/30/2021	Worksheet B Part I Date/Time Pre 11/22/2021 3:	pared:
	Cost Center Description	ADMI NI STRATI VE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	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 ADMI NI STRATI VE & GENERAL	23, 408, 956					5.00
7.00	00700 OPERATION OF PLANT	1, 408, 996	6, 992, 958				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	80, 555	124, 223	524, 02	4		8.00
9.00	00900 HOUSEKEEPI NG	288, 840			0 1, 697, 406		9.00
10.00	01000 DI ETARY	233, 401			0 46,075	1, 383, 746	
11.00	01100 CAFETERIA	222, 763			0 56,646	0	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	935, 895			0 53, 449	-	
15.00	01500 PHARMACY	578, 583			0 54, 472		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	85, 165			0 55, 601	0	16.00
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	05,105	210, 355	1	0 55,001	0	10.00
30.00	03000 ADULTS & PEDIATRICS	4, 516, 105	3, 252, 429	327, 51	7 835, 851	1, 372, 888	30.00
30.00		4, 510, 105	3, 252, 429	327,51	/ 835,851	1, 372, 888	30.00
F0 00	ANCI LLARY SERVICE COST CENTERS	1, 951, 804	914, 505	50, 38	7 235, 022	0	50.00
50.00							
54.00	05400 RADI OLOGY-DI AGNOSTI C 05700 CT SCAN	677, 749				0	54.00
57.00		0	0		0 0	0	57.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0 0	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	1,081,235				0	59.00
60.00	06000 LABORATORY	829, 913			0 30, 347	0	60.00
65.00	06500 RESPI RATORY THERAPY	480, 906				277	65.00
66.00	06600 PHYSI CAL THERAPY	138, 063			0 0	0	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 039, 278			0 0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	7, 247, 504		1	0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	987, 200	0		0 0	0	73.00
	OUTPATIENT SERVICE COST CENTERS	-		-	-		
91.00	09100 EMERGENCY	575, 096	278, 796	50, 38	7 71, 649	10, 581	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)	23, 359, 051	6, 992, 958	524, 02	4 1, 697, 406	1, 383, 746	118.00
	NONREI MBURSABLE COST CENTERS						
	19300 NONPALD WORKERS	0	0		0 0	0	193.00
	19301 MARKETI NG	49, 905	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)	23, 408, 956	6, 992, 958	524, 02	4 1, 697, 406	1, 383, 746	202.00

Heal th	Financial Systems	ST. VINCENT HE	ART CENTER		Inlie	u of Form CMS-	2552-10
	ALLOCATION - GENERAL SERVICE COSTS		Provider CC		Period: From 07/01/2020 To 06/30/2021	Worksheet B Part I Date/Time Pre 11/22/2021 3:	pared:
	Cost Center Description	CAFETERI A A	NURSI NG DMI NI STRATI ON	PHARMACY	MEDI CAL RECORDS & LI BRARY	Subtotal	
		11.00	13.00	15.00	16.00	24.00	
	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						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	1, 382, 653					11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	85, 723	4, 992, 071				13.00
15.00	01500 PHARMACY	74, 135	285, 356	3, 497, 47	75		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	9, 928	38, 213		0 742, 776		16.00
	INPATIENT ROUTINE SERVICE COST CENTERS		·				
30.00	03000 ADULTS & PEDI ATRI CS	738, 396	2, 842, 194		0 137, 468	31, 920, 533	30.00
	ANCI LLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	167, 423	644, 435		0 86, 930	11, 785, 663	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	58, 072	223, 527		0 17, 129	3, 927, 981	54.00
57.00	05700 CT SCAN	0	0		0 0	0	57.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0 0	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	98, 706	379, 934		0 222, 191	6, 755, 923	59.00
60.00	06000 LABORATORY	0	0		0 58, 220	4, 325, 578	60.00
65.00	06500 RESPI RATORY THERAPY	66, 359	255, 425		0 14, 652	3, 128, 206	65.00
66.00	06600 PHYSI CAL THERAPY	24, 524	94, 398		0 2, 595	806, 735	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 46, 809	5, 204, 827	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 104, 362	36, 074, 322	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	3, 497, 47	75 39, 748	8, 436, 776	73.00
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	59, 372	228, 532		0 12, 672	3, 566, 236	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS						
118.00		1, 382, 638	4, 992, 014	3, 497, 47	75 742, 776	115, 932, 780	1118.00
	NONREI MBURSABLE COST CENTERS	· · · · · · · · · · · · · · · · · · ·		· · ·			
193.00	19300 NONPALD WORKERS	0	0		0 0	0	193.00
	19301 MARKETI NG	15	57		0 0	247, 753	
200.00							200.00
201.00		0	0		0 0		201.00
202.00		1, 382, 653	4, 992, 071	3, 497, 47	75 742, 776		
		,		-, -, -, -,			

Hear th	Financial Systems	ST. VINCENT HEA	ART CENTER		In Lieu	u of Form CMS-2552-1
COST A	LLOCATION - GENERAL SERVICE COSTS		Provider CC	CN: 15-0153	Peri od: From 07/01/2020 To 06/30/2021	Worksheet B Part I Date/Time Prepared: 11/22/2021 3:37 pm
	Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total			
		25.00	26.00			
	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					11.00
13.00	01300 NURSING ADMINISTRATION					13.00
15.00	01500 PHARMACY					15.00
16.00	01600 MEDICAL RECORDS & LIBRARY					16.00
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS	0	31, 920, 533			30.00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	11, 785, 663			50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	3, 927, 981			54.00
57.00	05700 CT SCAN	0	0			57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0			58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	6, 755, 923			59.00
60.00	06000 LABORATORY	0	4, 325, 578			60.00
65.00	06500 RESPI RATORY THERAPY	0	3, 128, 206			65.00
66.00	06600 PHYSI CAL THERAPY	0	806, 735			66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5, 204, 827			71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	36, 074, 322			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	8, 436, 776			73.00
	OUTPATIENT SERVICE COST CENTERS	· · ·				
91.00	09100 EMERGENCY	0	3, 566, 236			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0				92.00
	SPECIAL PURPOSE COST CENTERS	· ·				
118.00		0	115, 932, 780			118.00
	NONREI MBURSABLE COST CENTERS					
193.00	19300 NONPAI D WORKERS	0	0			193.00
	19301 MARKETI NG	0	247, 753			193. 0
200.00	Cross Foot Adjustments	0	0			200.00
201.00		0	0			201.00
201.00						

Heal th	Financial Systems	ST. VINCENT H	EART CENTER		In Lie	u of Form CMS-	2552-10
	TION OF CAPITAL RELATED COSTS		Provider CO		Period: From 07/01/2020 To 06/30/2021	Worksheet B Part II Date/Time Pre 11/22/2021 3:	pared:
			CAPI TAL REL	LATED COSTS			
	Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		0	1.00	2.00	2A	4.00	
	GENERAL SERVICE COST CENTERS						
1.00 2.00 4.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	0	5, 794	10, 55	56 16, 350	16, 350	1.00 2.00 4.00
5.00	00500 ADMINI STRATI VE & GENERAL	1, 745, 267	116, 207	211, 71		747	5.00
7.00	00700 OPERATION OF PLANT	0	292, 974	533, 76	826, 738	494	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	22, 030	40, 13	62, 165	1	8.00
9.00	00900 HOUSEKEEPI NG	0	46, 795	85, 25	54 132, 049	0	9.00
10.00	01000 DI ETARY	0	31, 795	57, 92	89, 721	0	10.00
11.00	01100 CAFETERI A	0	39, 089	71, 21	110, 304	0	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	36, 883			987	13.00
15.00	01500 PHARMACY	0	37, 589			1, 016	
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	38, 368	69, 90	02 108, 270	102	16.00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		574 704	1 050 00		7.01/	
30.00	03000 ADULTS & PEDIATRICS	0	576, 786	1, 050, 83	1, 627, 621	7, 016	30.00
50.00	ANCI LLARY SERVI CE COST CENTERS	0	162, 179	295, 47	457,649	2, 638	50.00
50.00	05400 RADI OLOGY-DI AGNOSTI C	0	32, 486			2, 638	
57.00	05700 CT SCAN	0	32, 460	59, 10	0 0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	92, 207	167, 99		1, 186	1
60.00	06000 LABORATORY	0	20, 941	38, 15		0	60.00
65.00	06500 RESPIRATORY THERAPY	0	53, 545			640	
66, 00	06600 PHYSI CAL THERAPY	0	00,010	,,,	0 0	247	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	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	73.00
	OUTPATIENT SERVICE COST CENTERS						1
91.00	09100 EMERGENCY	0	49, 442	90, 07	77 139, 519	686	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
	SPECIAL PURPOSE COST CENTERS						
118.00		1, 745, 267	1, 655, 110	3, 015, 40	08 6, 415, 785	16, 350	118.00
	NONREI MBURSABLE COST CENTERS	-	-		-	-	
	19300 NONPALD WORKERS	0	0		0 0		193.00
	19301 MARKETI NG	0	0		0 0	0	193.01
200.00					0	_	200.00
201.00 202.00		1, 745, 267	0 1, 655, 110	3, 015, 40	0 0)8 6, 415, 785		201.00
202.00	I TOTAL (Sum TITIES TTO LITUUGH 201)	1, 740, 207	1,000,110	3, 015, 40	0, 410, 785	10, 350	1202. UU

ALLOCATION OF CAPITAL RELATED COSTS Dividing of the construction of the cost of the co	Heal th	Financial Systems	ST. VINCENT H	FART CENTER		Inlie	u of Form CMS-:	2552-10
& GENERAL PLANT LINEN SERVICE 5:00 7:00 8:00 9:00 10.00 00 00100 CAP REL COSTS-BLID & FIXT 1:00 1:00 4:00 00200 CAP REL COSTS-BLID & FIXT 1:00 1:00 4:00 00200 CAP REL COSTS-BLID & FIXT 1:00 1:00 4:00 00200 CAP REL COSTS-BLID & FIXT 1:24,829 9:52,061 1:00 5:00 00200 CAPREL ENERTIS DEPARTMENT 1:24,829 9:52,061 8:00 9:00 9:00 00200 LAUNDRY & LINEN SERVICE 7:137 1:6,912 8:6,215 8:00 8:00 1:						Period: From 07/01/2020	Worksheet B Part II Date/Time Pre	pared:
GENERAL SERVICE COST CENTERS 1		Cost Center Description						
1.00 OD100 CAP REL COSTS-BLDC & FLXT 1.00 2.00 02000 CAP REL COSTS-MUBLE EQUIP 1.00 4.00 04000 EMPERIZE COSTS-MUBLE EQUIP 1.24,829 9.00 0900 OPERATION OF PLANT 1.24,829 10.00 01000 DIUSEKEENIAG 2.073,937 10.00 01000 OPERATION OF PLANT 1.24,829 10.00 01000 AUDICAFETERIA 1.97,364 10.00 0100 CAFETERIA 19,736 10.00 01000 PLANTARCY 11.00 10.00 01000 PLANTARCY 11.00 10.00 01000 ADULTS & PEDIATRICS 400,103 442,803 53,884 95,315 138,963 30.00 0500 OPERATING ROOM 172,919 124,506 8,290 26,801 0 10.00 00 00 0 0 0 0 0 0 0 0 <td< td=""><td></td><td></td><td>5.00</td><td>7.00</td><td>8.00</td><td>9.00</td><td>10.00</td><td></td></td<>			5.00	7.00	8.00	9.00	10.00	
2.00 02200 CAP REL COSTS-MUBLE EQUIP 2.073, 937 4.00 00400 EMPEDYET BENEFIT IS DEPARTMENT 2.073, 937 5.00 00500 ADMI NI STRATI VE & GENERAL 2.073, 937 7.00 00700 OPERATI (N OF PLANT 124, 829 952, 061 8.00 00800 LINEN SERVICE 7, 137 16, 912 86, 215 9.00 00900 HOUSEKEEPI NG 25, 590 35, 925 0 193, 564 9.00 10.00 01100 CAFETERI A 19, 736 30, 009 6, 460 11.00 11.00 01500 PHARMACY 51, 259 28, 857 0 6, 212 0 15.00 15.00 01500 PHARMACY 7, 545 29, 456 0 6, 341 0 16.00 16.00 03000 ADULTS & PEDI ATRI CS 400, 103 442, 803 53, 884 95, 315 138, 963 55.00 50.00 05000 PERATINC ROOM 172, 919 124, 506 8, 290 26, 801 55.00 55.00 51.00 05000 OC CATRI LC								
4.00 00400 EMPLOYEE BENEFLITS DEPARTMENT 4.00 5.00 00500 ADMI IN STRATIVE & CENERAL 2.073,937 7.00 7.00 00700 OPERATION OF PLANT 124,829 952,061 8.00 8.00 00800 LAUDRY & LINEN SERVICE 7,137 16,912 86,215 7.00 9.00 00900 HOUSEKEPING 22,590 35,925 0 193,564 9.00 10.00 01000 CAFETERIA 19,736 30.009 0 6,460 0 11.00 10.00 01000 PHARMACY 51,259 28,315 0 6,095 0 13.00 10.00 01000 MUSIS ING ADMINISTRATION 82,915 28,857 0 6,341 0 16.00 10.00 1000 MUDI S & PEDI ATRI CS 400,103 442,803 53,884 95,315 138,963 30.00 0.00 0 0 0 0 0 0 0 0 57.00 5.00 050.00 0 0 0 0 0 </td <td>1.00</td> <td>00100 CAP REL COSTS-BLDG & FIXT</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>1.00</td>	1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
5.00 00500 ADMINI STRATIVE & GENERAL 2.073,937	2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
7.00 00700 OPERATION OF PLANT 124, 829 952, 061 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 7, 137 16, 912 86, 215 8.00 9.00 9.00 00900 HOUSEKEEPING 25, 590 35, 925 0 193, 564 9.00 9.00 10.00 01100 CATETERIA 19, 736 30, 009 0 6, 460 0 11.00 11.00 01100 APATATION 82, 915 28, 857 0 6, 095 0 13.00 15.00 01600 MEDICAL RECORDS & LI BRARY 7, 545 29, 456 0 6, 311 0 16.00 0.00 00000 ADULTS & PEDI ATIC 400, 103 442, 803 53, 884 95, 315 138, 963 30.00 50.00 05000 OPERATI NOR COM 172, 919 124, 506 8, 290 26, 801 54.00 54.00 57.00 50.00 54.00 57.00 50.00 59.00 59.00 59.00 59.00 65.00 65.00	4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
8. 00 00800 LAUNDRY & LINEN SERVICE 7, 137 16, 912 86, 215 80, 00 9. 00 00900 HOUSEKEEPING 25, 590 35, 925 0 193, 564 9, 00 10. 00 01000 DIETARY 20, 678 24, 409 0 5, 254 140, 062 10. 00 11. 00 01100 CAFETERIA 19, 736 30, 009 0 6, 460 0 11. 00 13. 00 1030 NRSIN KOMINI STRATI ON 82, 915 28, 857 0 6, 212 0 15. 00 16. 00 10500 PHARMACY 51, 259 29, 456 0 6, 341 16. 00 10. 00 0000 ADULTS & PEDI ATRICS 400, 103 442, 803 53, 884 95, 315 38, 963 30. 00 50. 00 05000 PERATI NG ROOM 172, 919 124, 506 8, 290 26, 801 0 50. 00 57. 00 57. 00 57. 00 57. 00 57. 00 57. 00 58. 00 59. 00 58. 00 59. 00 59. 00 <td>5.00</td> <td>00500 ADMI NI STRATI VE & GENERAL</td> <td>2,073,937</td> <td></td> <td></td> <td></td> <td></td> <td>5.00</td>	5.00	00500 ADMI NI STRATI VE & GENERAL	2,073,937					5.00
8. 00 00800 LAUNDRY & LINEN SERVICE 7, 137 16, 912 86, 215 80, 00 9, 00 9. 00 00900 HUSEKEPING 25, 590 35, 925 0 193, 564 9, 00 10. 00 01000 DI ETARY 20, 678 24, 409 0 5, 254 140, 062 10. 00 11. 00 01100 CAFETERIA 19, 736 30, 009 0 6, 460 0 11. 00 13. 00 1030 NRSIN KOMIN INSTRATION 82, 915 28, 857 0 6, 212 0 15. 00 16. 00 10500 PHARMACY 51, 259 29, 456 0 6, 341 0 16. 00 10. 00 000 AULTS & PEDI ATRICS 400, 103 442, 803 53, 884 95, 315 38, 963 30. 00 50. 00 05000 PERATING ROOM 172, 919 124, 506 8, 290 26, 801 0 50. 00 53. 00 53. 00 53. 00 53. 00 53. 00 53. 00 53. 00 53. 00 <td>7.00</td> <td>00700 OPERATION OF PLANT</td> <td>124, 829</td> <td>952, 061</td> <td></td> <td></td> <td></td> <td>7.00</td>	7.00	00700 OPERATION OF PLANT	124, 829	952, 061				7.00
9.00 00900 HOUSEKEEPING 25, 590 35, 925 0 193, 564 9, 00 10.00 01000 DI ETARY 20, 678 24, 409 0 5, 254 140, 062 10. 00 11.00 01100 CAFETERIA 19, 736 30, 009 0 6, 460 0 11. 00 13.00 01300 NURSI NS ADMINISTRATION 82, 915 28, 315 0 6, 095 0 13. 00 16.00 16500 HARAKCY 7, 545 29, 456 0 6, 341 0 16. 00 16.00 03000 ADULTES & PEDIATRICS 400, 103 442, 803 53, 884 95, 315 138, 963 30. 00 0.00 03000 ADULTS & PEDIATRICS 400, 103 442, 803 5, 803 5, 368 0 54. 00 0.00 03000 ADULOGY-DIAGNOSTIC 60, 045 24, 940 5, 803 5, 368 0 54. 00 50.00 05800 MARCHITC RESONANCE IMAGING (MRI) 0 0 0	8.00	00800 LAUNDRY & LINEN SERVICE	7,137			5		8.00
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SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 2,069,516 952,061 86,215 193,564 140,062 118.00 NONREI MBURSABLE COST CENTERS 193.00 19300 NONPAI D WORKERS 0 0 0 193.00 193.00 193.01 193.00 193.01 193.01 200.00 0 0 193.01 200.00 200.00 201.00 0 0 0 0 201.00			50, 950	37, 957	8, 29	0 8, 170	1, 071	•
SUBTOTALS (SUM OF LINES 1 through 117) 2,069,516 952,061 86,215 193,564 140,062 118.00 NONREI MBURSABLE COST CENTERS 0 0 0 0 193.00 19300 NONPAI D WORKERS 0 0 0 193.00 193.00 193.01 193.01 200.00 0 0 0 193.01 200.00 200.00 200.00 201.00 0 0 0 0 0 201.00 201.00 0 0 0 0 201.00	92.00							92.00
NONREI MBURSABLE COST CENTERS 193.00 19300 NONPAI D WORKERS 0 0 0 193.00 193.01 19301 MARKETI NG 4, 421 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								
193.00 19300 NONPAID WORKERS 0 0 0 0 193.00 193.01 19301 MARKETING 4,421 0 0 0 193.01 200.00 Cross Foot Adjustments 200.00 0 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0 0 201.00	118.00		2,069,516	952, 061	86, 21	5 193, 564	140, 062	118.00
193.01 19301 MARKETING 4,421 0 0 0 193.01 200.00 Cross Foot Adjustments 201.00 0 0 0 0 201.00								
200.00 Cross Foot Adjustments 200.00	193.00	19300 NONPAI D WORKERS	0	0		0 0	0	193.00
201.00 Negative Cost Centers 0 0 0 0 0 0 0 201.00			4, 421	0		0 0	0	
	200.00	Cross Foot Adjustments						200.00
202.00 TOTAL (sum lines 118 through 201) 2,073,937 952,061 86,215 193,564 140,062 202.00	201.00	Negative Cost Centers	0	0		0 0	0	201.00
	202.00) TOTAL (sum lines 118 through 201)	2, 073, 937	952, 061	86, 21	5 193, 564	140, 062	202.00

Hoal th	Financial Systems	ST. VINCENT H	EADT CENTED		In Lie	eu of Form CMS-	2552 10
	TION OF CAPITAL RELATED COSTS		Provider CC		Period: From 07/01/2020 To 06/30/2021	Worksheet B Part II Date/Time Pre 11/22/2021 3:	epared:
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	PHARMACY	MEDI CAL RECORDS & LI BRARY	Subtotal	
		11.00	13.00	15.00	16.00	24.00	
	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	166, 509					11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	10, 323	232, 714				13.00
15.00	01500 PHARMACY	8, 928	13, 302	215, 64	5		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	1, 196	1, 781		0 154, 691		16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	88, 924	132, 495		0 28, 644	3, 015, 768	30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	20, 162	30, 041		0 18, 114	861, 120	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	6, 993	10, 420		0 3, 569	209, 399	54.00
57.00	05700 CT SCAN	0	0		0 0	0	57.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0 0	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	11, 887	17, 711		0 46, 216	524, 818	59.00
60.00	06000 LABORATORY	0	0		0 12, 131	164, 289	60.00
65.00	06500 RESPI RATORY THERAPY	7, 991	11, 907		0 3, 053	271, 423	65.00
66.00	06600 PHYSI CAL THERAPY	2, 953	4, 401		0 541	20, 374	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 9,754	101, 828	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 21, 746	663, 865	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	215, 64	5 8, 282	311, 388	73.00
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	7, 150	10, 653		0 2,641	267, 087	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)	166, 507	232, 711	215, 64	5 154, 691	6, 411, 359	118.00
	NONREI MBURSABLE COST CENTERS						
193.00	19300 NONPALD WORKERS	0	0		0 0	0	193.00
193. Oʻ	19301 MARKETI NG	2	3		0 0	4, 426	193.01
200.00	Cross Foot Adjustments					0	200.00
201.00	Negative Cost Centers	0	0		0 0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	166, 509	232, 714	215, 64	5 154, 691	6, 415, 785	202.00

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Heal th	Financial Systems	ST. VINCENT HE	ART CENTER		In Lie	u of Form CMS-25	52-10
	TION OF CAPITAL RELATED COSTS		Provider CC	CN: 15-0153	Period: From 07/01/2020 To 06/30/2021	Worksheet B Part II Date/Time Prepa 11/22/2021 3:37	ared:
	Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total				
		25.00	26.00				
	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						11.00
13.00	01300 NURSING ADMINISTRATION						13.00
15.00	01500 PHARMACY						15.00
16.00	01600 MEDICAL RECORDS & LIBRARY						16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	0	3, 015, 768			:	30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	861, 120			į	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	209, 399			į	54.00
57.00	05700 CT SCAN	0	0			į	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0			!	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	524, 818			!	59.00
60.00	06000 LABORATORY	0	164, 289			(60.00
65.00	06500 RESPI RATORY THERAPY	0	271, 423			6	65.00
66.00	06600 PHYSI CAL THERAPY	0	20, 374				66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	101, 828				71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	663, 865				72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	311, 388				73.00
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	0	267, 087			(91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	6, 411, 359			1'	18.00
	NONREI MBURSABLE COST CENTERS						
193.00	19300 NONPAID WORKERS	0	0			11	93.00
193.01	19301 MARKETI NG	0	4, 426			11	93. 01
200.00	Cross Foot Adjustments	0	0			20	00.00
201.00		0	0			20	01.00
202.00	TOTAL (sum lines 118 through 201)	0	6, 415, 785			20	02.00
	· · · · · · · · · · · · · · · · · · ·		·				

COST A	Financial Systems LLOCATION - STATISTICAL BASIS	ST. VINCENT H	Provider C	CN: 15-0153	Period:	Worksheet B-1	2552-10
2001 A				1	rom 07/01/2020		
				-	To 06/30/2021	Date/Time Pre 11/22/2021 3:	
		CAPI TAL REI	ATED COSTS			1172272021 0.	
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFI TS	Reconciliation	& GENERAL	
		(SQUARE ILLI)	(SOUARE ILLI)	DEPARTMENT		(ACCUM. COST)	
				(GROSS		(ACCOM: COST)	
				SALARI ES)			
		1.00	2.00	4.00	5A	5.00	
	GENERAL SERVICE COST CENTERS	110 54					
1.00	00100 CAP REL COSTS-BLDG & FIXT	112, 546					1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	204	112, 546		1		2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	394 7, 902	394 7, 902			92, 771, 577	4.00
5.00 7.00	00700 OPERATION OF PLANT						
7.00 8.00	00800 LAUNDRY & LINEN SERVICE	19, 922 1, 498	19, 922 1, 498	826, 463 994		5, 583, 962 319, 246	
8.00 9.00	00900 HOUSEKEEPING	3, 182	3, 182			1, 144, 696	
	01000 DI ETARY	2, 162	2, 162		-	924, 985	
	01100 CAFETERI A	2, 102			-	882, 828	
	01300 NURSI NG ADMI NI STRATI ON	2, 508				3, 709, 026	
	01500 PHARMACY	2, 500				2, 292, 971	
	01600 MEDICAL RECORDS & LIBRARY	2,609				337, 516	
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	2,007	2,007	170,00	, 0	007,010	10.00
30.00	03000 ADULTS & PEDI ATRI CS	39, 221	39, 221	11, 740, 51	1 0	17, 897, 685	30.00
	ANCILLARY SERVICE COST CENTERS				.] -]		
50.00	05000 OPERATI NG ROOM	11, 028	11, 028	4, 410, 539	9 0	7, 735, 157	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2,209	2, 209	987, 242	2 0	2, 685, 974	54.00
	05700 CT SCAN	0	0			0	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	(0 0	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	6, 270	6, 270	1, 983, 934	4 0	4, 285, 021	59.00
60.00	06000 LABORATORY	1, 424	1, 424	(0 0	3, 289, 012	60.00
65.00	06500 RESPI RATORY THERAPY	3, 641	3, 641	1, 070, 432	2 0	1, 905, 867	65.00
	06600 PHYSI CAL THERAPY	0	0	413, 000	6 0	547, 155	66.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(0 0	4, 118, 740	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(28, 722, 456	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	(0 0	3, 912, 353	73.00
	OUTPATIENT SERVICE COST CENTERS	1					
	09100 EMERGENCY	3, 362	3, 362	1, 147, 876	6 0	2, 279, 151	
92.00	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS	110 544	110 54	07.040.44			
118.00		112, 546	112, 546	27, 349, 160	-23, 408, 956	92, 573, 801	118.00
	NONREI MBURSABLE COST CENTERS	0	0			0	1102 00
	19300 NONPALD WORKERS	0	0				193.00
	19301 MARKETING	0	0	31	1 0	197, 776	
200.00							200.00
201.00		1, 655, 110	3, 015, 408	6, 474, 134	4	23, 408, 956	
202.00	Part I)	1,000,110	3, 013, 408	0,4/4,134	*	23, 400, 930	202.00
203.00		14. 706076	26. 792671	0. 236719	9	0. 252329	203 00
200.00				16, 350		2,073,937	
207.00	Part II)			10, 330		2,010,101	
205.00				0. 000598	3	0. 022355	205.00
206.00							206.00
	(per Wkst. B-2)						
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

193.01 19301 MARKETING 0 0 0 7 200.00 Cross Foot Adjustments Negative Cost Centers 0 0 0 7 201.00 Negative Cost Centers Cost to be allocated (per Wkst. B, Part I) 82.925695 524,024 1,697,406 1,383,746 1,382,653 203.00 Unit cost multiplier (Wkst. B, Part I) 82.925695 1.329605 21.311345 19.777972 2.128114 204.00 Cost to be allocated (per Wkst. B, Part I) 82.925695 1.329605 21.311345 19.777972 2.128114 205.00 Unit cost multiplier (Wkst. B, Part I) 82.925695 0.218753 2.430243 2.001915 0.256283 205.00 Unit cost multiplier (Wkst. B, Part I). 11.289975 0.218753 2.430243 2.001915 0.256283 11) 206.00 NAHE adjustment amount to be allocated III IIII III III IIII	Heal th	Financial Systems	ST. VINCENT H	EART CENTER		In Lie	u of Form CMS-	2552-10
Image: construction of the image in the image i	COST A	LLOCATION - STATISTICAL BASIS		Provider C			Worksheet B-1	
Cost Center Description OPERATION OF PLANT (SUMAR FEET) LAUNDRY & LAUNDRY (COURSE FEET) HOUSEKEEPING (MEALS SERVICE) DIETARY (MEALS SERVICE (MUNRS) CAFETRAL (HOURS) 1 00 00100 (AP RL 00ST-BLD A FLXT (2000) 7.00 8.00 9.00 10.00 11.00 2.00 00200 (AP RL 00ST-BLD A FLXT (2000) 8.00 9.00 10.00 11.00 4.00 00400 (EMPLOYE BENEFITS DEPARTMENT (2000) 84,328 84,328 84,328 84,326 7.9,646 9.00 49,00 2,656 0 2,656 0 49,00 9.00 10.02 10.02 10.02 10.02 10.02 10.02 10.02 10.02 10.02 10.02 10.02 10.02 10.02 10.00							Data /Tima Dra	narod
Cost Center Description OPERATION OF PLANT (SOUARE FEET) CulMDRY & LINN SERVE OUTCATE Contract Contract <thcontract< th=""> Contract <t< td=""><td></td><td></td><td></td><td></td><td></td><td>10 00/30/2021</td><td>11/22/2021 3</td><td>37 pm</td></t<></thcontract<>						10 00/30/2021	11/22/2021 3	37 pm
PLANT (SUARE FEET) LINEN SERVICE (SUARE FEET) (SOUARE FEET) (WANDRY) (WALS SERVED) (HOURS) (HOURS) 0 00100 CAP REL COST - ENTERS		Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPING	DIFTARY		
Image: constraint of the								
ENERAL SERVICE COST CENTERS 7.00 8.00 9.00 10.00 11.00 1.00 OOTOO CAP REL COSTS -BUG & FIXT			(SQUARE FEET)		,			
EFEREAL SERVICE COST CENTRES 1.00 OCIO CAP REL COSTS -BUDG & FIXT 2.00 OCOOD CAP REL COSTS -BUDG & FIXT 3.00 OCOSOG AMMINTS RATI VE & GENERAL 7.00 OCOSOG AMMINTS RATI VE & GENERAL 8.00 OCOSOG AMMINTS RATI VE & GENERAL 9.00 OCOSOG AMMINTS RATI VE & GENERAL 10.00 OTODO DIETARY 9.00 OCOSOG HUSEKCEPING 11.00 DITODO DIETARY 9.00 OCOSOG HABUNAS & LINEN SERVICE 11.00 DITODO DIETARY 9.00 OCOSOG HABUNAS 10.00 DITODO DIETARY 9.01 OCOSOG HABUNAS 9.01 OCOSOG HABUNAS 9.01 CAPETRIA 9.00 DITODO DIETARY 9.00 DITODO HEADINAS 9.01 CAPETRIA				LAUNDRY)				
1.00 00100 CAP REL COSTS-BUDG & FIXT			7.00	8.00	9.00	10.00	11.00	
2.00 00200 CAP REL COSTS-MUBLE FOULP								
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 84. 328 5.00 00500 ADMI NI STRATI VE & GENERAL 84. 328 9.00 00900 HUNESKEEPI NG 3. 182 0 9.00 00900 HUNESKEEPI NG 3. 182 0 79. 648 10.00 01100 CAFETRI A 2. 658 0 2. 658 0 649. 708 11.00 01100 CAFETRI A 2. 658 0 2. 556 0 34. 836 15.00 TISOD PHARMACY 2. 556 0 2. 556 0 34. 836 16.00 01000 MURSI NG ADMI NI STRATI ON 2. 508 0 2. 556 0 34. 836 16.00 01000 ADMI ESTRATI ESTRATI CS 39. 221 246. 326 39. 221 69. 415 346. 972 ANCILLARY SERVICE COST CENTERS 30. 200 0 0 0 0 0 0 0 0 0 0 0 0 0 78. 672 40.00 05000 CROD READRATI NG ROM 11. 028 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>1.00</td>								1.00
5. 00 00500 ADMINISTRATIVE & GENERAL 4 228 9. 00 00900 DERATION OF PLANT 84,328 34,328 79,648 9. 00 00900 LAUNDRY & LINEN SERVICE 1,498 394,120 79,648 9. 00 00900 INUSIS MS ADMINISTRATION 2,668 0,2,658 0 13. 00 1300 OIXON URSI MS ADMINISTRATION 2,556 0,2,556 0 10. 00 01000 MEDICAL RECORDS & LIBRARY 2,609 0 2,609 0 10. 00 01000 ODERDITAR RECORDS & LIBRARY 2,209 0,2,556 0 3,4,836 00 0000 ODERDITAR RECORDS & LIBRARY 2,209 0 2,609 0 4,665 INPATIENT ROUTINE SERVICE COST CENTERS								2.00
7. 00 00700 (PERATION OF PLANT 84, 328	4.00							4.00
B. 00 OOBOOL LAUNRY & LINEN SERVICE 1.498 394, 120 9.00 OOPON HOUSEKEEN IG 3.182 0.79, 648 11.00 01100 CAFETERIA 2.658 0 2.658 0 13.00 01300 NURSI IKG ADMI NI STRATI ON 2.508 0 2.508 0 40, 281 15.00 01500 PHARMACY 2.556 0 2.556 0 34, 836 16.00 01600 MEDI CAL, RECORDS & LIBRARY 2.656 0 2.556 0 34, 836 10.00 ODI CALL RECORDS & LIBRARY 2.609 0 4.665 14, 665 10.00 ODI CALL RECORDS & LIBRARY 2.009 2.009 2.009 2.788 0.00 0.00 ODOR OPERATING ROOM 11, 028 37, 896 11, 028 0 78, 672 54.00 05400 CARDI AC CATHETERI ZATI ON 6.270 26, 527 2.209 0 2.64, 382 60.00 00 0 0 0 0 0 0 0 0 0 0 <	5.00							5.00
9. 00 00900 HOUSEKEEPING 3. 182 0 79, 648 10. 00 01000 DIETAY 2. 162 0 2. 658 0 69, 964 11. 00 01100 CAFETERIA 2. 658 0 2. 656 0 40, 281 15. 00 01500 PHARMACY 2. 506 0 2. 556 0 34, 836 15. 00 01500 PHARMACY 2. 556 0 2. 659 0 4. 665 INPATIENT ROUTINE SERVICE COST CENTERS	7.00	00700 OPERATION OF PLANT	84, 328					7.00
10:00 DITARY 2, 162 0 2, 162 69, 964 11:00 OTIOO CAFETERIA 2, 658 0 2, 568 0 649, 708 11:00 OTIOO NURSI NG ADMINI STRATION 2, 508 0 2, 508 0 40, 281 15:00 OTIOO MEDI CAL RECORDS & LIBRARY 2, 506 0 2, 556 0 34, 336 00 OTIOO ONEDI CAL RECORDS & LIBRARY 2, 609 0 2, 609 0 4, 665 1NPATI ENT ROUTINE SERVICE COST CENTERS	8.00	00800 LAUNDRY & LINEN SERVICE	1, 498	394, 120				8.00
11.00 CASETERIA 2,658 0 2,658 0 649,708 13.00 01500 PHARMACY 2,556 0 2,556 0 40,281 15.00 01500 PHARMACY 2,609 0 2,609 0 4,665 11.020 03000 ADUITS & PEDIATRICS 39,221 246,320 39,221 69,415 346,672 ANCILLARY SERVICE COST CENTERS 30,221 246,320 39,221 69,415 346,072 ANCILLARY SERVICE COST CENTERS 30,000 0 0 0 78,896 11,028 37,896 78,209 0 27,288 50.00 05000 ADRIANTIC RESONANCE I MACING (MRI) 0	9.00	00900 HOUSEKEEPI NG	3, 182	0	79, 648	3		9.00
13:00 UISSING ADMINISTRATION 2.508 0 2.508 0 40.281 15:00 01500 PHARMACY 2.556 0 2.556 0 34.836 16:00 01500 MEDI CAL RECORDS & LIBRARY 2.609 0 2.609 0 4.665 INPATIENT ROUTINE SERVICE COST CENTERS	10.00	01000 DI ETARY	2, 162	0	2, 162	2 69, 964		10.00
15.00 01500 PHARMACY 2,556 0 2,556 0 34,836 16.00 0000 (MEDI CAL RECORDS & LIBRARY 2,609 0 2,609 0 4,665 30.00 0000 (ADULTS & PEDI ATRICS 39,221 246,326 39,221 69,415 346,972 ANOTLLARY SERVICE COST CENTERS	11.00	01100 CAFETERI A	2, 658	0	2, 658	3 0	649, 708	11.00
16.00 01600 [MEDI CAL, RECORDS & LI BRARY 2, 609 0 2, 609 0 4, 665 1NPATI ENT ROUTI NE SERVICE COST CENTERS 39, 221 246, 326 39, 221 69, 415 346, 972 ANCI LLARY SERVICE COST CENTERS	13.00	01300 NURSING ADMINISTRATION	2, 508	0	2, 508	3 0	40, 281	13.00
INPATIENT ROUTINE SERVICE COST CENTERS 39, 221 246, 326 39, 221 69, 415 346, 972 ANCILLARY SERVICE COST CENTERS 39, 221 246, 326 39, 221 69, 415 346, 972 ANCILLARY SERVICE COST CENTERS 37, 896 11, 028 0 65, 00 0 0 0 72, 288 0 72, 288 0 74, 672 74, 288 0 74, 672 74, 288 0	15.00	01500 PHARMACY	2, 556	0	2, 556	6 0	34, 836	15.00
30.00 03000/ADULTS & PEDIATRICS 39,221 246,326 39,221 69,415 346,972 ANCILLARY SERVICE COST CENTERS	16.00	01600 MEDICAL RECORDS & LIBRARY	2, 609	0	2, 609	9 0	4, 665	16.00
ANCILLARY SERVICE COST CENTERS 50.00 05000 PERATING ROOM 11,028 37,896 11,028 0 78,672 54.00 05400 RADIOLOGY-DIAGNOSTIC 2,209 0,527 2,209 0 77,288 57.00 05700 CT SCAN 0		INPATIENT ROUTINE SERVICE COST CENTERS						
50.00 OSO00 OPERATING ROOM 11,028 37,896 11,028 0 78,672 54.00 OS400 RADIOLOCY-DIAGNOSTIC 2,209 26,527 2,209 0 27,288 57.00 OS500 CRESONANCE IMAGING (MRI) 0 0 0 0 0 58.00 OS600 ARDAC CATHETERIZATION 6,270 26,527 6,270 0 46,382 00.00 O6500 LABORATORY 1,424 0 1,424 0 0 0 0 66.00 O66000 LABORATORY 3,641 18,948 3,641 14 31,182 61.00 O66000 HASICAL THERAPY 3,641 18,948 3,641 14 31,182 71.00 O7100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 <td>30.00</td> <td>03000 ADULTS & PEDI ATRI CS</td> <td>39, 221</td> <td>246, 326</td> <td>39, 22</td> <td>69, 415</td> <td>346, 972</td> <td>30.00</td>	30.00	03000 ADULTS & PEDI ATRI CS	39, 221	246, 326	39, 22	69, 415	346, 972	30.00
54.00 06400 RADIOLOGY-DIAGNOSTIC 2,209 26,527 2,209 0 27,288 57.00 05700 CT SCAN 0 <td< td=""><td></td><td>ANCILLARY SERVICE COST CENTERS</td><td></td><td></td><td></td><td></td><td></td><td></td></td<>		ANCILLARY SERVICE COST CENTERS						
57.00 05700 CT SCAN 0 0 0 0 0 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 <td>50.00</td> <td>05000 OPERATING ROOM</td> <td>11, 028</td> <td>37, 896</td> <td>11, 028</td> <td>3 0</td> <td>78, 672</td> <td>50.00</td>	50.00	05000 OPERATING ROOM	11, 028	37, 896	11, 028	3 0	78, 672	50.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0	54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 209	26, 527	2, 209	9 0	27, 288	54.00
59.00 CARDI AC CATHETERI ZATION 6,270 26,527 6,270 0 46,382 60.00 LABORATORY 1,424 0 1,424 0 0 65.00 06500 RESPI RATORY THERAPY 3,641 18,948 3,641 14 31,182 66.00 06600 PHYSI CAL THERAPY 0<	57.00	05700 CT SCAN	0	0	(0 0	0	57.00
59.00 CARDI AC CATHETERI ZATION 6,270 26,527 6,270 0 46,382 60.00 LABORATORY 1,424 0 1,424 0 0 65.00 06500 RESPI RATORY THERAPY 3,641 18,948 3,641 14 31,182 66.00 06600 PHYSI CAL THERAPY 0<	58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	(0 0	C	58.00
60.00 06000 LABORATORY 1, 424 0 1, 424 0 0 65.00 06500 RESPIRATORY THERAPY 3, 641 18, 948 3, 641 14 31, 182 66.00 0 0 0 0 0 0 0 11, 524 66.00 0	59.00	05900 CARDI AC CATHETERI ZATI ON	6, 270	26, 527	6, 270	0 0	46, 382	59.00
66.00 06600 PHYSICAL THERAPY 0 0 0 0 11,524 71.00 O7100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 73.00 O7300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 001700 EMERGENCY 3, 362 37, 896 3, 362 535 27, 899 91.00 O9100 EMERGENCY 3, 362 37, 896 3, 362 535 27, 899 92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART) 84, 328 394, 120 79, 648 69, 964 649, 701 NOREL MBURSABLE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 84, 328 394, 120 79, 648 69, 964 649, 701 NONREL MBURSABLE COST CENTERS 0 0 0 0 0 0 0 203.00 Instructure Cross Foot Adj ustments 0 0 0 0	60.00	06000 LABORATORY	1, 424			4 0	C	60.00
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 <	65.00	06500 RESPI RATORY THERAPY	3, 641	18, 948	3, 64	1 14	31, 182	65.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0	66.00	06600 PHYSI CAL THERAPY	0	0	(0 0	11, 524	66.00
73.00 OT300 DRUGS CHARGED TO PATIENTS 0			0	0	(0 0		
73.00 OT300 DRUGS CHARGED TO PATIENTS 0	72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(0 0	C	72.00
OUTPATI ENT SERVICE COST CENTERS Image: Control of the service cost centers 91.00 09100 EMERGENCY 3, 362 37, 896 3, 362 535 27, 899 92.00 09SERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS SPECIAL PURPOSE COST CENTERS 18.00 SUBTOTALS (SUM OF LINES 1 through 117) 84, 328 394, 120 79, 648 69, 964 649, 701 NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 193.00 19300 NONPAI D WORKERS 0 0 0 0 0 200.00 Cross Foot Adj ustments 0 0 0 0 0 7 201.00 Negati ve Cost Centers 0 0 0 0 7 2 1, 383, 746 1, 382, 653 2 2 1, 383, 746 1, 382, 653 2 2 1 1 3 3 3 2 2 1 3 3 4 1, 382, 653 3 3 3 3 3 3								
91.00 09100 EMERGENCY 3, 362 37, 896 3, 362 535 27, 899 92.00 0BSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS 500 500 500 500 649, 701 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 84, 328 394, 120 79, 648 69, 964 649, 701 193.00 IP3000 NONREI MBURSABLE COST CENTERS 0 0 0 0 0 193.01 19300 NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 200.00 Cross Foot Adjustments 0 0 0 0 0 7 201.00 Negative Cost Centers 0 0 0 0 7 7 203.00 Unit cost multiplier (Wkst. B, Part I) 82.925695 1.329605 21.311345 19.777972 2.128114 204.00 Cost to be allocated (per Wkst. B, Part I) 82.925695 1.329605 21.311345 19.777972 2.128114 205.00 Unit cost multiplier (Wkst. B, Part I) 82.925695 0.218753 2.430243 2.001915					1			
SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 84,328 394,120 79,648 69,964 649,701 NONREL MBURSABLE COST CENTERS 193.00 19300 NONREL MBURSABLE COST CENTERS 00 0 0 0 193.00 19300 NONREL MBURSABLE COST CENTERS 193.00 19300 NONREL MBURSABLE COST CENTERS 0 0 0 0 193.00 NONREL MBURSABLE COST CENTERS 0 0 0 0 0 0 0 19300 NONREL MBURSABLE COST CENTERS 0 0 0 0 202.00 Cost to be allocated (per Wkst. B, Part I) 82.925695 1.329605 21.311345 19.7	91.00		3, 362	37, 896	3, 362	2 535	27, 899	91.00
SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 84,328 394,120 79,648 69,964 649,701 NONREL MBURSABLE COST CENTERS 193.00 19300 NONREL MBURSABLE COST CENTERS 193.00 19300 NONREL MBURSABLE COST CENTERS 0 0 0 0 193.00 NONREL MBURSABLE COST CENTERS 0 0 0 0 0 193.00 NONREL MBURSABLE COST CENTERS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 <th< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>92.00</td></th<>								92.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 84, 328 394, 120 79, 648 69, 964 649, 701 NONREI MBURSABLE COST CENTERS 0<				I	1			
NONREI MBURSABLE COST CENTERS 193.00 19300 NONPAID WORKERS 0 0 0 0 0 193.01 19300 NONPAID WORKERS 0 0 0 0 0 0 200.00 Cross Foot Adjustments 0 0 0 0 0 7 201.00 Negative Cost Centers 0 0 0 0 7 202.00 Cost to be allocated (per Wkst. B, ent I) 82.925695 1.329605 21.311345 19.777972 2.128114 203.00 Unit cost multiplier (Wkst. B, Part I) 82.925695 1.329605 21.311345 19.777972 2.128114 204.00 Cost to be allocated (per Wkst. B, 952,061 86,215 193,564 140,062 166,509 Part II) Unit cost multiplier (Wkst. B, Part 11.289975 0.218753 2.430243 2.001915 0.256283 205.00 Unit cost multiplier (wkst. B, Part 11.289975 0.218753 2.430243 2.001915 0.256283 206.00 NAHE adjustment amount to b	118.00	SUBTOTALS (SUM OF LINES 1 through 117)	84, 328	394, 120	79, 648	69, 964	649, 701	118.00
193.01 19301 MARKETING 0 0 0 7 200.00 Cross Foot Adjustments Negative Cost Centers 0 0 0 7 201.00 Negative Cost Centers Cost to be allocated (per Wkst. B, Part I) 82.925695 524,024 1,697,406 1,383,746 1,382,653 203.00 Unit cost multiplier (Wkst. B, Part I) 82.925695 1.329605 21.311345 19.777972 2.128114 204.00 Cost to be allocated (per Wkst. B, Part I) 82.925695 1.329605 21.311345 19.777972 2.128114 205.00 Unit cost multiplier (Wkst. B, Part I) 82.925695 0.218753 2.430243 2.001915 0.256283 205.00 Unit cost multiplier (Wkst. B, Part I). 11.289975 0.218753 2.430243 2.001915 0.256283 11) 206.00 NAHE adjustment amount to be allocated III IIII III III IIII		NONREI MBURSABLE COST CENTERS						
200.00 Cross Foot Adjustments Negative Cost Centers Image: Cost Centers 202.00 Cost to be allocated (per Wkst. B, Part I) 6,992,958 524,024 1,697,406 1,383,746 1,382,653 203.00 Unit cost multiplier (Wkst. B, Part I) 82.925695 1.329605 21.311345 19.777972 2.128114 204.00 Cost to be allocated (per Wkst. B, Part I) 82.925695 1.329605 21.311345 140,062 166,509 205.00 Unit cost multiplier (Wkst. B, Part I). 11.289975 0.218753 2.430243 2.001915 0.256283 205.00 NAHE adjustment amount to be allocated Image: Cost Cost Cost Cost Cost Cost Cost Cost	193.00	19300 NONPALD WORKERS	0	0	(0 0	C	193.00
200.00 201.00 Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B, Part I) 6,992,958 524,024 1,697,406 1,383,746 1,382,653 203.00 Unit cost multiplier (Wkst. B, Part I) 82.925695 1.329605 21.311345 19.777972 2.128114 204.00 Cost to be allocated (per Wkst. B, Part II) 952,061 86,215 193,564 140,062 166,509 205.00 Unit cost multiplier (Wkst. B, Part 11.289975 0.218753 2.430243 2.001915 0.256283 206.00 NAHE adjustment amount to be allocated 11.289975 0.218753 2.430243 2.001915 0.256283			0					193.01
201.00 Negative Cost Centers 6,992,958 524,024 1,697,406 1,383,746 1,382,653 202.00 Cost to be allocated (per Wkst. B, Part I) 82.925695 1.329605 21.311345 19.777972 2.128114 204.00 Cost to be allocated (per Wkst. B, Part I) 82.925695 1.329605 21.311345 19.777972 2.128114 205.00 Unit cost multiplier (Wkst. B, Part I) 952,061 86,215 193,564 140,062 166,509 205.00 Unit cost multiplier (Wkst. B, Part I) 11.289975 0.218753 2.430243 2.001915 0.256283 206.00 NAHE adjustment amount to be allocated Intervention Intervention Intervention Intervention Intervention Intervention								200.00
202.00 Cost to be allocated (per Wkst. B, Part I) 6,992,958 524,024 1,697,406 1,383,746 1,382,653 203.00 Unit cost multiplier (Wkst. B, Part I) 82.925695 1.329605 21.311345 19.777972 2.128114 204.00 Cost to be allocated (per Wkst. B, Part II) 952,061 86,215 193,564 140,062 166,509 205.00 Unit cost multiplier (Wkst. B, Part I) 11.289975 0.218753 2.430243 2.001915 0.256283 206.00 NAHE adjustment amount to be allocated 11.289975	201.00							201.00
Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 82.925695 1.329605 21.311345 19.777972 2.128114 204.00 Cost to be allocated (per Wkst. B, Part I) 952,061 86,215 193,564 140,062 166,509 205.00 Unit cost multiplier (Wkst. B, Part II) 11.289975 0.218753 2.430243 2.001915 0.256283 206.00 NAHE adjustment amount to be allocated Image: Cost Cost Cost Cost Cost Cost Cost Cost			6, 992, 958	524, 024	1, 697, 406	1, 383, 746	1, 382, 653	1
203.00 Unit cost multiplier (Wkst. B, Part I) 82.925695 1.329605 21.311345 19.777972 2.128114 204.00 Cost to be allocated (per Wkst. B, Part I) 952,061 86,215 193,564 140,062 166,509 205.00 Unit cost multiplier (Wkst. B, Part II) 11.289975 0.218753 2.430243 2.001915 0.256283 206.00 NAHE adjustment amount to be allocated 110								
204.00 Cost to be allocated (per Wkst. B, Part II) 952,061 86,215 193,564 140,062 166,509 205.00 Unit cost multiplier (Wkst. B, Part II) 11.289975 0.218753 2.430243 2.001915 0.256283 206.00 NAHE adjustment amount to be allocated 11.289975 <td< td=""><td>203.00</td><td></td><td>82. 925695</td><td>1. 329605</td><td>21. 311345</td><td>5 19. 777972</td><td>2. 128114</td><td>203.00</td></td<>	203.00		82. 925695	1. 329605	21. 311345	5 19. 777972	2. 128114	203.00
Part II) Part II) 205.00 Unit cost multiplier (Wkst. B, Part I1. 289975 0. 218753 2. 430243 2. 001915 0. 256283 11) 206.00 NAHE adjustment amount to be allocated 11. 289975 0. 218753 2. 430243 2. 001915 0. 256283								
205.00 Unit cost multiplier (Wkst. B, Part 11.289975 0.218753 2.430243 2.001915 0.256283 11) 206.00 NAHE adjustment amount to be allocated 11.289975								
206.00 NAHE adjustment amount to be allocated	205.00		11. 289975	0. 218753	2. 430243	2. 001915	0. 256283	205.00
206.00 NAHE adjustment amount to be allocated								
	206.00							206.00
(per Wkst. B-2)								
	207.00							207.00
Parts III and IV)								

ST ALL	nancial Systems OCATION - STATISTICAL BASIS		Provider CC	N: 15-0153	Peri od:	Worksheet B-1
					From 07/01/2020	
					To 06/30/2021	Date/Time Prepare 11/22/2021 3:37
	Cost Center Description	NURSI NG	PHARMACY	MEDI CAL		
		ADMI NI STRATI ON		RECORDS &		
			REQUIS.)	LIBRARY		
		(HOURS)		(GROSS CHARGES)		
		13.00	15.00	16.00	_	
GF	NERAL SERVICE COST CENTERS	13.00	13.00	10.00		
	0100 CAP REL COSTS-BLDG & FIXT					1
00 00	200 CAP REL COSTS-MVBLE EQUIP					2
00 00	0400 EMPLOYEE BENEFITS DEPARTMENT					4
00 00	0500 ADMINISTRATIVE & GENERAL					5
	0700 OPERATION OF PLANT					7
	0800 LAUNDRY & LINEN SERVICE					8
	0900 HOUSEKEEPI NG					9
	1000 DI ETARY					10
	100 CAFETERI A					11
	300 NURSING ADMINISTRATION	609, 427				13
	500 PHARMACY	34, 836	100			15
	600 MEDICAL RECORDS & LIBRARY	4, 665	0	676, 035, 12	24	16
	IPATI ENT ROUTI NE SERVI CE COST CENTERS 3000 ADULTS & PEDI ATRI CS	346, 972	0	125, 084, 48		30
	ICI LLARY SERVICE COST CENTERS	340, 972	UU	125, 084, 48	50	30
	000 OPERATING ROOM	78, 672	0	79, 098, 99	20	50
	5400 RADI OLOGY-DI AGNOSTI C	27, 288	0	15, 586, 25		54
	5700 CT SCAN	27,200	0	15, 500, 20	0	57
	5800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0	58
	5900 CARDI AC CATHETERI ZATI ON	46, 382	0	202, 345, 91	12	59
	5000 LABORATORY	0	0	52, 975, 37		60
	5500 RESPIRATORY THERAPY	31, 182	0	13, 332, 12		65
	600 PHYSI CAL THERAPY	11, 524	0	2, 361, 17		66
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	42, 592, 18		71
	200 IMPL. DEV. CHARGED TO PATIENTS	0	0	94, 960, 55		72
	7300 DRUGS CHARGED TO PATIENTS	0	100	36, 167, 27	78	73
OU	ITPATIENT SERVICE COST CENTERS					
	P100 EMERGENCY	27, 899	0	11, 530, 78	38	91
	2200 OBSERVATION BEDS (NON-DISTINCT PART)					92
	PECIAL PURPOSE COST CENTERS				1	
8.00	SUBTOTALS (SUM OF LINES 1 through 117)	609, 420	100	676, 035, 12	24	118
	NREIMBURSABLE COST CENTERS				0	100
	2300 NONPALD WORKERS 2301 MARKETING	0	0		0	193 193
0.00	Cross Foot Adjustments	/	0		U	200
1.00	Negative Cost Centers					200
2.00	Cost to be allocated (per Wkst. B,	4, 992, 071	3, 497, 475	742, 77	76	201
2.00	Part I)	7,772,071	5, 477, 475	142, 1		202
3.00	Unit cost multiplier (Wkst. B, Part I)	8, 191418	34, 974. 750000	0.00109	99	203
4.00	Cost to be allocated (per Wkst. B,	232, 714	215, 645	154, 69		204
	Part II)	202,	2.0,010			
5.00	Unit cost multiplier (Wkst. B, Part	0. 381857	2, 156. 450000	0.00022	29	205
6.00	NAHE adjustment amount to be allocated					206
	(per Wkst. B-2)					
07.00	NAHE unit cost multiplier (Wkst. D,					207

Health Financial Systems	ST. VINCENT H	EART CENTER		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CO	CN: 15-0153	Period: From 07/01/2020 To 06/30/2021	Worksheet C Part I Date/Time Pre 11/22/2021 3:	pared: 37 pm
		Title	XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	BERCE Di sal l owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	31, 920, 533		31, 920, 5	33 0	31, 920, 533	30.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	11, 785, 663		11, 785, 6	63 0	11, 785, 663	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 927, 981		3, 927, 9	81 31, 515	3, 959, 496	54.00
57.00 05700 CT SCAN	0			0 0	0	00000
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0			0 0	0	00.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	6, 755, 923		6, 755, 9		6, 755, 923	
60. 00 06000 LABORATORY	4, 325, 578		4, 325, 5	78 0	4, 325, 578	
65. 00 06500 RESPI RATORY THERAPY	3, 128, 206	0	3, 128, 2		3, 128, 206	
66. 00 06600 PHYSI CAL THERAPY	806, 735	0	806, 7		806, 735	1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	5, 204, 827		5, 204, 8		5, 204, 827	1
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	36, 074, 322		36, 074, 3		36, 074, 322	1
73.00 07300 DRUGS CHARGED TO PATIENTS	8, 436, 776		8, 436, 7	76 0	8, 436, 776	73.00
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	3, 566, 236		3, 566, 2			
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	3, 126, 182		3, 126, 1		3, 126, 182	1
200.00 Subtotal (see instructions)	119, 058, 962	0	119, 058, 9			
201.00 Less Observation Beds	3, 126, 182		3, 126, 1		3, 126, 182	
202.00 Total (see instructions)	115, 932, 780	0	115, 932, 7	344, 931	116, 277, 711	202.00

Health Financial Systems	ST. VINCENT HE	ART CENTER		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CC	CN: 15-0153	Peri od: From 07/01/2020 To 06/30/2021	Worksheet C Part I Date/Time Pre 11/22/2021 3:	epared: 37 pm
			XVIII	Hospi tal	PPS	
Cost Center Description	Inpati ent	Charges Outpatient	+ col. 7)	6 Cost or Other Ratio	TEFRA Inpatient Ratio	
	6.00	7.00	8.00	9.00	10.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS ANCI LLARY SERVI CE COST CENTERS	112, 249, 134		112, 249, 13	34		30.00
50. 00 05000 OPERATING ROOM	76, 714, 770	2, 384, 220	79, 098, 99	0, 148999	0, 000000	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	6, 047, 588	9, 538, 665				
57. 00 05700 CT SCAN	0,017,000), 000, 000 0	10, 000, 20	0 0.000000		
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0 0.000000		
59. 00 05900 CARDI AC CATHETERI ZATI ON	83, 939, 909	118, 406, 003	202, 345, 9 [.]	0. 033388	0.00000	59.00
60. 00 06000 LABORATORY	44, 790, 910	8, 184, 467	52, 975, 3	0. 081653	0. 000000	60.00
65. 00 06500 RESPI RATORY THERAPY	10, 816, 711	2, 515, 413	13, 332, 12	0. 234637	0.00000	65.00
66. 00 06600 PHYSI CAL THERAPY	2, 315, 232	45, 946	2, 361, 1	0. 341666	0.00000	66.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	37, 702, 008	4, 890, 174				
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	63, 097, 291	31, 863, 266				
73. 00 07300 DRUGS CHARGED TO PATIENTS	32, 031, 949	4, 135, 329	36, 167, 2	0. 233271	0.00000	73.00
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	2, 923, 729	8, 607, 059				
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	2, 888, 348	9, 947, 003			0. 000000	
200.00Subtotal (see instructions)201.00Less Observation Beds	475, 517, 579	200, 517, 545	676, 035, 12	24		200. 00 201. 00
201.00Less Observation Beds202.00Total (see instructions)	475, 517, 579	200, 517, 545	676, 035, 12	24		201.00

Health Financial Systems	ST. VINCENT HEA	ART CENTER	In Lieu of Form CMS-2552-10			
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0153	Period:	Worksheet C		
			From 07/01/2020 To 06/30/2021	Part I Date/Time Prepared:		
			10 00/ 30/ 2021	11/22/2021 3: 37 pm		
		Title XVIII	Hospi tal	PPS		
Cost Center Description	PPS Inpatient					
	Ratio					
	11.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS				30.00		
ANCI LLARY SERVI CE COST CENTERS	0.440000					
50. 00 05000 OPERATING ROOM	0. 148999			50.00		
54. 00 05400 RADI OLOGY-DI AGNOSTI C 57. 00 05700 CT SCAN	0. 254038			54.00 57.00		
	0. 000000			57.00		
58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 59.00 05900 CARDI AC CATHETERI ZATI ON	0. 033388			58.00		
60. 00 06000 LABORATORY	0. 081653			60,00		
65. 00 06500 RESPI RATORY THERAPY	0. 234637			65.00		
66. 00 06600 PHYSI CAL THERAPY	0. 341666			66.00		
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 122201			71.00		
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 379887			71.00		
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 233271			72.00		
OUTPATIENT SERVICE COST CENTERS	0.200271			/3.00		
91. 00 09100 EMERGENCY	0. 336460			91.00		
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 243560			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	ST. VINCENT H	EART CENTER		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CO	CN: 15-0153	Period: From 07/01/2020 To 06/30/2021	Worksheet C Part I Date/Time Pre 11/22/2021 3:	pared: 37 pm
		Ti tl	e XIX	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj.		Di sal I owance		
	Part I, col.					
	26)					
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	31, 920, 533		31, 920, 53	33 0	31, 920, 533	30.00
ANCI LLARY SERVI CE COST CENTERS				1		
50.00 05000 OPERATI NG ROOM	11, 785, 663		11, 785, 60		11, 785, 663	•
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 927, 981		3, 927, 98	31, 515	3, 959, 496	•
57.00 05700 CT SCAN	0			0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0			0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	6, 755, 923		6, 755, 92	23 0	6, 755, 923	59.00
60. 00 06000 LABORATORY	4, 325, 578		4, 325, 5	78 0	4, 325, 578	60.00
65. 00 06500 RESPI RATORY THERAPY	3, 128, 206	0	3, 128, 20	06 0	3, 128, 206	65.00
66. 00 06600 PHYSI CAL THERAPY	806, 735	0	806, 73	35 0	806, 735	66.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	5, 204, 827		5, 204, 82		5, 204, 827	•
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	36, 074, 322		36, 074, 32	22 0	36, 074, 322	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	8, 436, 776		8, 436, 7	76 0	8, 436, 776	73.00
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	3, 566, 236		3, 566, 23	313, 416	3, 879, 652	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	3, 126, 182		3, 126, 18		3, 126, 182	•
200.00 Subtotal (see instructions)	119, 058, 962	0	119, 058, 90	52 344, 931		
201.00 Less Observation Beds	3, 126, 182		3, 126, 18	32	3, 126, 182	201.00
202.00 Total (see instructions)	115, 932, 780	0	115, 932, 78	30 344, 931	116, 277, 711	202.00

Health Financial Systems	ST. VINCENT HE	EART CENTER		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CO	CN: 15-0153	Period: From 07/01/2020 To 06/30/2021	Worksheet C Part I Date/Time Pre 11/22/2021 3:	epared: 37 pm
	-		e XIX	Hospi tal	Cost	
Cost Center Description	Inpatient	Charges Outpatient	+ col. 7)	6 Cost or Other Ratio	TEFRA Inpatient Ratio	
INPATIENT ROUTINE SERVICE COST CENTERS	6.00	7.00	8.00	9.00	10.00	
30. 00 03000 ADULTS & PEDI ATRI CS ANCI LLARY SERVICE COST CENTERS	112, 249, 134		112, 249, 13	34		30.00
50. 00 05000 OPERATI NG ROOM	76, 714, 770	2, 384, 220	79, 098, 9	0. 148999	0. 000000	50,00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	6, 047, 588	9, 538, 665				
57. 00 05700 CT SCAN	0, 047, 300	7, 550, 609 0	13, 300, 23	0 0.000000		
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0.000000		
59. 00 05900 CARDI AC CATHETERI ZATI ON	83, 939, 909	118, 406, 003	202, 345, 9			
60. 00 06000 LABORATORY	44, 790, 910	8, 184, 467				1
65. 00 06500 RESPI RATORY THERAPY	10, 816, 711	2, 515, 413	13, 332, 12	0. 234637	0.00000	65.00
66. 00 06600 PHYSI CAL THERAPY	2, 315, 232	45, 946	2, 361, 1	0. 341666	0. 000000	66.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	37, 702, 008	4, 890, 174	42, 592, 18	0. 122201	0. 000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	63, 097, 291	31, 863, 266	94, 960, 5	57 0. 379887	0.00000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	32, 031, 949	4, 135, 329	36, 167, 2	0. 233271	0.00000	73.00
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	2, 923, 729	8, 607, 059				1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 888, 348	9, 947, 003			0.00000	1
200.00 Subtotal (see instructions)	475, 517, 579	200, 517, 545	676, 035, 12	24		200.00
201.00 Less Observation Beds	475 547 570	000 547 545	(7/ 005 1)			201.00
202.00 Total (see instructions)	475, 517, 579	200, 517, 545	676, 035, 12	24		202.00

Health Financial Systems	ST. VINCENT HEA	ART CENTER	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0153	Period: From 07/01/2020	Worksheet C Part I
			To 06/30/2021	Date/Time Prepared:
				11/22/2021 3:37 pm
		Title XIX	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11.00			
I NPATI ENT ROUTI NE SERVI CE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
ANCI LLARY SERVI CE COST CENTERS	0,000000			F0.00
50. 00 05000 OPERATI NG ROOM 54. 00 05400 RADI OLOGY-DI AGNOSTI C	0.000000			50.00 54.00
57.00 05700 CT SCAN	0.000000			54.00
57.00 05700 CT SCAN 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000			57.00
59. 00 05900 CARDIAC CATHETERIZATION	0.000000			58.00
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
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.00
OUTPATIENT SERVICE COST CENTERS	0.000000			/3.00
91. 00 09100 EMERGENCY	0. 000000			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92.00
200.00 Subtotal (see instructions)				200.00
201.00 Less Observation Beds				201.00
202.00 Total (see instructions)				202.00
				1

Health Financial Systems	ST. VINCENT H	IEART CENTER		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider C		Period: From 07/01/2020 To 06/30/2021		pared: 37 pm
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col.	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col	Days	Per Diem (col. 3 / col. 4)	
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	3, 015, 768	0	3, 015, 76	8 21, 565	139.85	30.00
200.00 Total (lines 30 through 199)	3, 015, 768		3, 015, 76	8 21, 565		200.00
Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col.				
		(COL 5 X COL 6)				
	6.00	7.00	1			
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	8, 094		1			30.00
200.00 Total (lines 30 through 199)	8, 094	1, 131, 946				200. 00

Health Financial Systems	ST. VINCENT H	EART CENTER		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provider C	CN: 15-0153	Peri od:	Worksheet D	
				From 07/01/2020 To 06/30/2021		narodi
				10 00/30/2021	Date/Time Pre 11/22/2021 3:	
		Title	× XVIII	Hospi tal	PPS	<u>o, bii</u>
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						
50.00 05000 OPERATI NG ROOM	861, 120	79, 098, 990	0. 0108	37 28, 909, 525	314, 738	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	209, 399	15, 586, 253	0. 01343	35 4, 428, 413	59, 496	54.00
57.00 05700 CT SCAN	0	0	0.0000	0 00	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.0000		0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	524, 818	202, 345, 912	0.0025	35, 246, 042	91, 428	59.00
60. 00 06000 LABORATORY	164, 289	52, 975, 377	0.00310	01 17, 988, 971	55, 784	60.00
65. 00 06500 RESPI RATORY THERAPY	271, 423	13, 332, 124	0. 0203	59 3, 568, 457	72, 650	65.00
66. 00 06600 PHYSI CAL THERAPY	20, 374	2, 361, 178	0. 00863	29 1, 797, 509	15, 511	66.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	101, 828	42, 592, 182	0.0023	91 12, 422, 224	29, 702	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	663, 865	94, 960, 557	0.0069	36, 879, 502	257, 825	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	311, 388	36, 167, 278	0.0086	10 11, 728, 394	100, 981	73.00
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	267, 087	11, 530, 788	0. 0231	53 1, 266, 948	29, 346	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	295, 352	12, 835, 351	0. 0230	11 9, 364	215	92.00
200.00 Total (lines 50 through 199)	3, 690, 943	563, 785, 990		154, 245, 349	1, 027, 676	200.00

Health Financial Systems	ST. VINCENT H	EART CENTER		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER P/	ASS THROUGH COS		-	Period: From 07/01/2020 Fo 06/30/2021	Date/Time Pre 11/22/2021 3:	
			XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School Post-Stepdown Adjustments		Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS	•			-	•	
30. 00 03000 ADULTS & PEDIATRICS 200. 00 Total (lines 30 through 199)	0	0	(0 0 0 0	0	30.00 200.00
Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS			•			
30.00 03000 ADULTS & PEDIATRICS 200.00 Total (lines 30 through 199)	0	0	21, 56 21, 56			30.00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00	_	· · · · · · · · · · · · · · · · · · ·			
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1				00.00
30.00 03000 ADULTS & PEDIATRICS 200.00 Total (lines 30 through 199)	0					30.00 200.00

leal th Financial Systems ST. VINCENT HEART CENTER					u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEE	RVICE OTHER PASS	S Provider C		Peri od:	Worksheet D	
THROUGH COSTS				From 07/01/2020		
				To 06/30/2021		
		T: +1 a	. W/I I I	llooni tol	11/22/2021 3: PPS	37 pm
Cret Creter Description	New Discretesters		XVIII	Hospital		
Cost Center Description		Nursing School			Allied Health	
		Post-Stepdown		Post-Stepdown		
	Cost	Adjustments 2A	2.00	Adjustments 3A	2.00	
	1.00	ZA	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS					0	50.00
50. 00 O5000 OPERATING ROOM	0	0		0 0	0	50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
57.00 05700 CT SCAN	0	0		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	l o		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	l o		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS			1			
91.00 09100 EMERGENCY	0	0	1	0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	-		0	0	92.00
200.00 Total (lines 50 through 199)	0	0		0 0	0	200.00

Health Financial Systems	ST. VINCENT H	IEART CENTER		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI	RVICE OTHER PASS	S Provider C		Period:	Worksheet D	
THROUGH COSTS				From 07/01/2020 To 06/30/2021	Part IV Date/Time Pre	narod
				10 00/ 30/ 2021	11/22/2021 3:	
		Title	e XVIII	Hospi tal	PPS	<u> </u>
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
	Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS		1				
50.00 05000 OPERATING ROOM	0	0		0 79, 098, 990		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 15, 586, 253	0.000000	54.00
57.00 05700 CT SCAN	0	0		0 0	0.00000	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0.00000	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 202, 345, 912	0.00000	59.00
60. 00 06000 LABORATORY	0	0		52, 975, 377	0.00000	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 13, 332, 124	0.000000	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		2, 361, 178	0.000000	66.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		42, 592, 182	0.00000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		94, 960, 557	0.00000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		36, 167, 278	0.00000	73.00
OUTPATIENT SERVICE COST CENTERS		•				
91. 00 09100 EMERGENCY	0	0		0 11, 530, 788	0. 000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 12, 835, 351	0.000000	92.00
200.00 Total (lines 50 through 199)	0	C		563, 785, 990		200.00
					-	

Health Financial Systems	ST. VINCENT H	EART CENTER		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	5 Provider C		Peri od:	Worksheet D	
THROUGH COSTS				From 07/01/2020	Part IV	
				To 06/30/2021	Date/Time Pre	
			XVIII	Hospi tal	11/22/2021 3: PPS	<u>37 pili</u>
Cost Center Description	Outpati ent	Inpatient	Inpatient	Outpati ent	Outpati ent	
Cost center bescription	Ratio of Cost		Program	Program	Program	
		Program				
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.		Costs (col. 8	5	Costs (col. 9	
	/)	10.00	x col. 10)	10.00	x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS					-	
50.00 05000 OPERATI NG ROOM	0. 000000			0 1, 196, 499		50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	4, 428, 413		0 3, 568, 493		54.00
57.00 05700 CT SCAN	0. 000000	0		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	35, 246, 042		0 47, 117, 442	0	59.00
60. 00 06000 LABORATORY	0. 000000	17, 988, 971		0 2, 817, 127	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	3, 568, 457		0 709, 657	0	65.00
66.00 06600 PHYSI CAL THERAPY	0. 000000	1, 797, 509		0 6, 894	0	66.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	12, 422, 224		0 3, 292, 057	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	36, 879, 502		0 12, 331, 170	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	11, 728, 394		0 1, 752, 731	0	73.00
OUTPATIENT SERVICE COST CENTERS	· · · · ·		ı			
91.00 09100 EMERGENCY	0. 000000	1, 266, 948		0 3, 135, 601	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	9, 364		0 2, 556, 303	0	92.00
200.00 Total (lines 50 through 199)		154, 245, 349		0 78, 483, 974		200. 00

Health Financial Systems	ST. VINCENT H	IEART CENTER		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND) VACCINE COST	Provider CO		Period: From 07/01/2020 Fo 06/30/2021	Worksheet D Part V Date/Time Pre 11/22/2021 3:	
	1	Title	XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charge			Cost	PPS Services	
		Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.	Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS			1	-		
50.00 05000 OPERATING ROOM	0. 148999			0 0	178, 277	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 252016			0 0	899, 317	
57.00 05700 CT SCAN	0. 000000			0 0	0	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000			0 0	0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 033388			0 0	1, 573, 157	
60. 00 06000 LABORATORY	0. 081653			4 0	230, 027	
65. 00 06500 RESPI RATORY THERAPY	0. 234637			0 0	166, 512	
66. 00 06600 PHYSI CAL THERAPY	0. 341666			0 0	2, 355	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 122201			0 0	402, 293	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 379887			0 0	4, 684, 451	
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 233271	1, 752, 731		4, 759	408, 861	73.00
OUTPATIENT SERVICE COST CENTERS		1		1		
91.00 09100 EMERGENCY	0. 309279			0 0	969, 776	1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 243560	2, 556, 303		0 0	622, 613	1
200.00 Subtotal (see instructions)		78, 483, 974	15	4 4, 759	10, 137, 639	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)	1	78, 483, 974	15	4 4, 759	10, 137, 639	202.00

Heal th	Financial Systems	ST. VINCENT H	EART CENTER		In Lie	u of Form CMS-	2552-10
APPORT	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CC	CN: 15-0153	Period: From 07/01/2020 To 06/30/2021	Worksheet D Part V Date/Time Pre 11/22/2021 3:	
			Title	XVIII	Hospi tal	PPS	
		Cos					
	Cost Center Description	Cost	Cost				
		Rei mbursed	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						
	05000 OPERATING ROOM	0	0				50.00
	05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
	05700 CT SCAN	0	0				57.00
	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0				58.00
	05900 CARDI AC CATHETERI ZATI ON	0	0				59.00
	06000 LABORATORY	13	0				60.00
	06500 RESPI RATORY THERAPY	0	0				65.00
	06600 PHYSI CAL THERAPY	0	0				66.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	1, 110				73.00
	OUTPATIENT SERVICE COST CENTERS						
	09100 EMERGENCY	0	0				91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
200.00		13	1, 110				200.00
201.00		0					201.00
	Only Charges						
202.00	Net Charges (line 200 - line 201)	13	1, 110				202.00

Health Financial Systems	ST. VINCENT H	EART CENTER		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	Worksheet D Part V Date/Time Pre 11/22/2021 3:	
		Titl	e XIX	Hospi tal	Cost	
			Charges		Costs	
Cost Center Description	Cost to Charge			Cost	PPS Services	
		Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.	Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS		-			-	
50. 00 05000 OPERATI NG ROOM	0. 148999		32, 63		0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 252016		30, 14	1 0	0	54.00
57. 00 05700 CT SCAN	0. 000000			0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000			0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 033388		599, 02		0	59.00
60. 00 06000 LABORATORY	0. 081653	0	25, 75		0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 234637	0	24, 17		0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 341666	0		0 0	0	66.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 122201	0	50, 64		0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 379887	0	232, 27		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 233271	0	19, 56	3 0	0	73.00
OUTPATIENT SERVICE COST CENTERS	1			-		
91.00 09100 EMERGENCY	0. 309279		37, 39		0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 243560	0	60, 59	7 0	0	1 2.00
200.00 Subtotal (see instructions)		0	1, 112, 19	6 0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		0	1, 112, 19	6 0	0	202.00

Health Financial Systems		ST. VINCENT H	EART CENTER		In Lieu	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH	SERVICES AND \	VACCINE COST	Provider CC	CN: 15-0153	Period: From 07/01/2020 To 06/30/2021	Worksheet D Part V Date/Time Pre	unarrad.
					To 06/30/2021	11/22/2021 3:	
			Ti tl	e XIX	Hospi tal	Cost	
		Cos	sts				
Cost Center Description		Cost	Cost				
		Reimbursed	Reimbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
	C	Ded. & Coins.	Ded. & Coins.				
	_	(see inst.)	(see inst.)				
		6.00	7.00				
ANCI LLARY SERVICE COST CENTERS			-				
50.00 05000 OPERATI NG ROOM		4, 863	0				50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C		7, 596	0				54.00
57.00 05700 CT SCAN		0	0				57.00
58.00 05800 MAGNETIC RESONANCE I MAGI N	G (MRI)	0	0				58.00
59.00 05900 CARDI AC CATHETERI ZATI ON		20, 000					59.00
60.00 06000 LABORATORY		2, 103	0				60.00
65. 00 06500 RESPI RATORY THERAPY		5, 671	0				65.00
66.00 06600 PHYSI CAL THERAPY		0	0				66.00
71.00 07100 MEDICAL SUPPLIES CHARGED		6, 189	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PAT	ENTS	88, 238					72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		4, 563	0				73.00
OUTPATIENT SERVICE COST CENTERS							-
91.00 09100 EMERGENCY		11, 564					91.00
92.00 09200 OBSERVATION BEDS (NON-DIS		14, 759	0				92.00
200.00 Subtotal (see instruction		165, 546	0				200.00
201.00 Less PBP Clinic Lab. Serv	ces-Program	0					201.00
Only Charges							
202.00 Net Charges (line 200 - 1	ne 201)	165, 546	0				202.00

Heal th	Financial Systems ST. VINCENT HEA	RT CENTER	In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0153	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Pre	pared:
		Title XVIII	Hospi tal	11/22/2021 3: PPS	37 pm
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
1.00	INPATIENT DAYS Inpatient days (including private room days and swing-bed day	rs, excluding newborn)		21, 565	1.00
2.00 3.00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed da	bed and newborn days)	rivate room days,	21, 565 0	2.00
4.00	do not complete this line. Semi-private room days (excluding swing-bed and observation b	hod dave)	-	19, 453	4.00
5.00	Total swing-bed SNF type inpatient days (including private ro reporting period	5 /	er 31 of the cost	19, 455	
6.00	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	0	6.00
7.00	Total swing-bed NF type inpatient days (including private roc reporting period	om days) through December	31 of the cost	0	7.00
8.00	Total swing-bed NF type inpatient days (including private roc reporting period (if calendar year, enter 0 on this line)	om days) after December (31 of the cost	0	8.00
9.00	Total inpatient days including private room days applicable t newborn days) (see instructions)	to the Program (excluding	g swing-bed and	8, 094	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII of through December 31 of the cost reporting period (see instruc		room days)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII o December 31 of the cost reporting period (if calendar year, e	only (including private m	room days) after	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period		te room days)	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar y			0	13.00
14.00 15.00	Medically necessary private room days applicable to the Progr Total nursery days (title V or XIX only)			0	
16.00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	
17.00	Medicare rate for swing-bed SNF services applicable to servic	ces through December 31 d	of the cost	0.00	17.00
18.00	reporting period Medicare rate for swing-bed SNF services applicable to servic reporting period	ces after December 31 of	the cost	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to service reporting period	es through December 31 of	f the cost	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to service reporting period	es after December 31 of t	the cost	0.00	20. 00
21. 00 22. 00	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decemb		ting period (line	31, 920, 533 0	
23.00	5 x line 17) Swing-bed cost applicable to SNF type services after December	· 31 of the cost reportin	ng period (line 6	0	23.00
24.00	x line 18) Swing-bed cost applicable to NF type services through Decembe	er 31 of the cost reporti	na period (line	0	24.00
25.00	7 x line 19) Swing-bed cost applicable to NF type services after December		51 (0	
26.00	x line 20) Total swing-bed cost (see instructions)	· · · ·		0	
27.00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		31, 920, 533	
28.00	General inpatient routine service charges (excluding swing-be	ed and observation bed ch	narges)	0	1
29.00 30.00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	
30.00	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33.00
34.00	Average per diem private room charge differential (line 32 mi	nus line 33)(see instruc	ctions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x li	ne 31)		0.00	
36.00	Private room cost differential adjustment (line 3 x line 35)			0	
37.00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost di	fferential (line	31, 920, 533	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ				-
38.00	Adjusted general inpatient routine service cost per diem (see			1, 480. 20	38.00
38.00	Program general inpatient routine service cost fer drem (see			11, 980, 739	
40.00	Medically necessary private room cost applicable to the Progr	-		0	
	Total Program general inpatient routine service cost (line 39	, , ,		11, 980, 739	1
				. 1, 700, 707	1 . 1. 00

	Financial Systems	ST. VINCENT H				eu of Form CMS-	
COMPUT	ATION OF INPATIENT OPERATING COST		Provider C	CN: 15-0153	Period: From 07/01/2020	Worksheet D-1	l
					To 06/30/2021	Date/Time Pre	
			Title	e XVIII	Hospi tal	11/22/2021 3: PPS	37 pili
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost	Inpatient Days		÷	(col. 3 x col.	
		1.00	2.00	col. 2) 3.00	4.00	4)	
42.00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	I NTENSI VE CARE UNI T						43.00
44.00	CORONARY CARE UNIT						44.00
45.00 46.00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45.00
	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description			•			
40,00		-+ D 2 2	11			1.00	40.00
48.00 49.00	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines			ans)		28, 222, 066 40, 202, 805	
47.00	PASS THROUGH COST ADJUSTMENTS		300 111311 0011	5113)		40, 202, 003	47.00
50.00	Pass through costs applicable to Program inp	atient routine	services (fro	n Wkst. D, sum	of Parts I and	1, 131, 946	50.00
F4 00							
51.00	51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts I and IV)						
52.00	Total Program excludable cost (sum of lines	50 and 51)				2, 159, 622	52.00
53.00	Total Program inpatient operating cost exclu		lated, non-phy	ysician anesth	etist, and	38, 043, 183	53.00
	medical education costs (line 49 minus line	52)					-
54.00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					C	54.00
55.00	Target amount per discharge					0.00	
56.00	Target amount (line 54 x line 55)					C	
57.00	Difference between adjusted inpatient operat	ing cost and ta	rget amount (line 56 minus	line 53)	C	
58.00	Bonus payment (see instructions)	nonting noniod	anding 100/	undated and as	mounded by the		
59.00	Lesser of lines 53/54 or 55 from the cost re market basket	porting period	ending 1996, i	updated and co	inpounded by the	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year	cost report, up	dated by the m	market basket		0.00	60.00
61.00	If line 53/54 is less than the lower of line					C	61.00
	which operating costs (line 53) are less tha amount (line 56), otherwise enter zero (see		s (lines 54 x	60), or 1% of	the target		
62.00	Relief payment (see instructions)					C	62.00
63.00	Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)			0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST					-	
64.00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through Dece	mber 31 of the	e cost reporti	ng period (See	C	64.00
65.00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the (cost reportino	period (See	c c	65.00
	instructions)(title XVIII only)						
66.00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line (65)(title XVII	l only). For	0	66.00
67.00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	e costs through	December 31	of the cost re	norting period	l c	67.00
07.00	(line 12 x line 19)		December 51		por tring period		07.00
68.00	Title V or XIX swing-bed NF inpatient routin	e costs after D	ecember 31 of	the cost repo	rting period	C	68.00
(0.00	(line 13 x line 20)	routino costo (line (7 . lin	a (0)			
69.00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N			,		0	69.00
70.00	Skilled nursing facility/other nursing facil						70.00
71.00	Adjusted general inpatient routine service c		ine 70 ÷ line	2)			71.00
72.00	Program routine service cost (line 9 x line		(lin- 14)	- 2E)			72.00
73.00 74.00	Medically necessary private room cost applic Total Program general inpatient routine serv						73.00
74.00	Capital -related cost allocated to inpatient				art II, column		75.00
	26, line 45)				,		
76.00	Per diem capital-related costs (line 75 ÷ li						76.00
77.00 78.00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77.00
78.00	Aggregate charges to beneficiaries for exces		rovi der record	ds)			79.00
80.00	Total Program routine service costs for comp	· ·			us line 79)		80.00
81.00	Inpatient routine service cost per diem limi						81.00
82.00	Inpatient routine service cost limitation (I		· .				82.00
83.00 84.00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in		5)				83.00 84.00
85.00	Utilization review - physician compensation		ns)				85.00
86.00	Total Program inpatient operating costs (sum						86.00
0-	PART IV - COMPUTATION OF OBSERVATION BED PAS						
87.00 88.00	Total observation bed days (see instructions		line 2)			2, 112	
	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se	•				1, 480. 20 3, 126, 182	
07.00	Topservation bed cost (THE 87 X THE 88) (Se	e matructrons)				J 3, 120, 182	I 07.

Health Financial Systems	ST. VINCENT H	IEART CENTER		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 07/01/2020	Worksheet D-1	
				To 06/30/2021	Date/Time Pre 11/22/2021 3:	
		Title	XVIII	Hospi tal	PPS	
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	3, 015, 768	31, 920, 533	0. 09447	7 3, 126, 182	295, 352	90.00
91.00 Nursing School cost	0	31, 920, 533	0.00000	0 3, 126, 182	0	91.00
92.00 Allied health cost	0	31, 920, 533	0.00000	0 3, 126, 182	0	92.00
93.00 All other Medical Education	0	31, 920, 533	0.00000	0 3, 126, 182	0	93.00

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	Financial Systems ST. VINCENT HEA	ART CENTER	In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0153	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Pre	pared:
		Title XIX	Hospi tal	11/22/2021 3: Cost	
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed day	ys, excluding newborn)		21, 565	1.00
2.00	Inpatient days (including private room days, excluding swing			21, 565	
3.00	Private room days (excluding swing-bed and observation bed da do not complete this line.	ays). It you nave only pr	rivate room days,	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation b			19, 453	
5.00	Total swing-bed SNF type inpatient days (including private ro reporting period	oom days) through Decembe	er 31 of the cost	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6.00
7.00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roo	om davs) through December	31 of the cost	0	7.00
	reporting period			-	
8.00	Total swing-bed NF type inpatient days (including private roo reporting period (if calendar year, enter 0 on this line)	31 of the cost	0	8.00	
9.00	Total inpatient days including private room days applicable t	swing-bed and	188	9.00	
10.00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII o	only (including privato r	com davc)	0	10.00
10.00	through December 31 of the cost reporting period (see instruc		oom days)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII of		room days) after	0	11.00
12.00	December 31 of the cost reporting period (if calendar year, of Swing-bed NF type inpatient days applicable to titles V or XI		e room days)	0	12.00
10.00	through December 31 of the cost reporting period			0	10.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar v			0	13.00
14.00	Medically necessary private room days applicable to the Prog			0	
15.00 16.00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to service reporting period	ces through December 31 c	of the cost	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to service	ces after December 31 of	the cost	0.00	18.00
19.00	reporting period Medicaid rate for swing-bed NF services applicable to service	es through December 31 of	the cost	0.00	19.00
20.00	reporting period Medicaid rate for swing-bed NF services applicable to service	es after December 31 of t	he cost	0.00	20.00
21 00	reporting period Total general inpatient routine service cost (see instruction			31, 920, 533	21.00
21.00 22.00	Swing-bed cost applicable to SNF type services through Decemb		ing period (line	31, 920, 555	
23.00	5 x line 17) Swing had east applicable to SNE type conviges often December	a 21 of the east reportin	a paried (line (0	22.00
23.00	Swing-bed cost applicable to SNF type services after December x line 18)	31 OF THE COST REPORTER	ig period (Tine 6	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 7 x line 19)	er 31 of the cost reporti	ng period (line	0	24.00
25.00	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reporting	period (line 8	0	25.00
26.00	Total swing-bed cost (see instructions)			0	
27.00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		31, 920, 533	27.00
28.00	General inpatient routine service charges (excluding swing-be	ed and observation bed ch	narges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)			0	
30. 00 31. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	÷line 28)		0 0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.00
33.00 34.00	Average semi-private room per diem charge (line 30 ÷ line 4)	nus lino 22)(soo instruc	stions)	0.00	
34.00 35.00	Average per diem private room charge differential (line 32 mi Average per diem private room cost differential (line 34 x li	, ,		0.00 0.00	
36.00	Private room cost differential adjustment (line 3 x line 35)			0	36.00
37.00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost di	fferential (line	31, 920, 533	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
38.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD. Adjusted general inpatient routine service cost per diem (see			1, 480. 20	38.00
38.00 39.00	Program general inpatient routine service cost (line 9 x line			278, 278	
40.00	Medically necessary private room cost applicable to the Progr	, , ,		0	
41.00	Total Program general inpatient routine service cost (line 34	7 + IINE 40)		278, 278	41.00

	Financial Systems	ST. VINCENT H				u of Form CMS-	
COMPUT	ATION OF INPATIENT OPERATING COST		Provider C	CN: 15-0153	Period: From 07/01/2020	Worksheet D-1	
					To 06/30/2021	Date/Time Pre 11/22/2021 3:	
	Cost Center Description	Total	Ti tl Total	e XIX Average Per	Hospital Program Days	Cost Program Cost	
		Inpatient Cost				(col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units						42.00
	INTENSIVE CARE UNIT						43.00
	CORONARY CARE UNI T						44.00
	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45.00
	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description					1.00	
48.00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	, line 200)			499, 502	48.00
	Total Program inpatient costs (sum of lines	41 through 48)(see instructio	ons)		777, 780	49.00
	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	atient routine	services (from	n Wkst D sum	of Parts L and	0	50.00
51.00	5 11 5 1						
52.00	and IV) Total Program excludable cost (sum of lines	50 and 51)				0	52.00
53.00	Total Program inpatient operating cost exclu		lated, non-phy	ysician anesth	etist, and	0	53.00
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					1
	Program di scharges					0	54.00
	Target amount per discharge					0.00	
	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and ta	raet amount (l	ine 56 minus	line 53)	0	
	Bonus payment (see instructions)	ing cost and ta	get anount (i			0	
59.00	Lesser of lines 53/54 or 55 from the cost re	porting period	ending 1996, ເ	updated and co	mpounded by the	0.00	59.00
60.00	market basket Lesser of lines 53/54 or 55 from prior year	cost report. up	dated by the r	market basket		0.00	60.00
	If line 53/54 is less than the lower of line	s 55, 59 or 60	enter the less	ser of 50% of		0	
	which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see		s (lines 54 x	60), or 1% of	the target		
62.00	Relief payment (see instructions)	riisti ucti olis)				0	62.00
	Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)			0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of the	e cost reporti	na period (See	0	64.00
	instructions)(title XVIII only)	Ū.				-	
65.00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decemb	er 31 of the d	cost reporting	period (See	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 6	5)(title XVII	l only). For	0	66.00
	CAH (see instructions)						
67.00	Title V or XIX swing-bed NF inpatient routir (line 12 x line 19)	e costs through	December 31 d	of the cost re	porting period	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routir	e costs after D	ecember 31 of	the cost repo	rting period	0	68.00
69.00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routino costs (lino 67 Lin	5 69)		o	69.00
	PART III - SKILLED NURSING FACILITY, OTHER N			,			09.00
	Skilled nursing facility/other nursing facil	2					70.00
	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		ine 70 ÷ line	2)			71.00
	Medically necessary private room cost applic		(line 14 x li	ne 35)			73.00
74.00	Total Program general inpatient routine serv	ice costs (line	72 + line 73))			74.00
75.00	Capital-related cost allocated to inpatient 26, line 45)	routine service	costs (from V	Vorksheet B, P	art II, column		75.00
76.00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76.00
	Program capital -related costs (line 9 x line						77.00
	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		rovider record	ds)			78.00
	Total Program routine service costs for comp	· · ·			us line 79)		80.00
	Inpatient routine service cost per diem limi		`				81.00
	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (•				82.00
	Program inpatient ancillary services (see in		-,				84.00
85.00	Utilization review - physician compensation	(see instructio					85.00
	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PAS		rougn 85)				86.00
87.00	Total observation bed days (see instructions					2, 112	87.00
	Adjusted general inpatient routine cost per	diem (line 27 ÷	line 2)			1, 480. 20	
	Observation bed cost (line 87 x line 88) (se	e instructions)				3, 126, 182	I 87.00

Health Financial Systems	ST. VINCENT H	IEART CENTER		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period:	Worksheet D-1	
				From 07/01/2020 To 06/30/2021	Date/Time Pre 11/22/2021 3:	pared: 37 pm
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital-related cost	3, 015, 768	31, 920, 533	0. 09447	7 3, 126, 182	295, 352	90.00
91.00 Nursing School cost	0	31, 920, 533	0.00000	0 3, 126, 182	0	91.00
92.00 Allied health cost	0	31, 920, 533	0.00000	0 3, 126, 182	0	92.00
93.00 All other Medical Education	0	31, 920, 533	0. 00000	0 3, 126, 182	0	93.00

Health Financial Systems	ST. VINCENT HEAR	T CENTER		In Lie	u of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CO	CN: 15-0153	Peri od:	Worksheet D-3	
				From 07/01/2020 To 06/30/2021	Date/Time Pre	narod
				10 00/30/2021	11/22/2021 3:	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description			Ratio of Cos	t Inpatient	I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS			1			
30. 00 03000 ADULTS & PEDI ATRI CS				43, 469, 416		30.00
ANCI LLARY SERVI CE COST CENTERS			0.1.000			
50.00 OFERATING ROOM			0. 14899			
54. 00 05400 RADI OLOGY-DI AGNOSTI C			0. 25403			
57.00 05700 CT SCAN			0.0000		0	07100
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)			0.0000		0	00.00
59. 00 05900 CARDI AC CATHETERI ZATI ON			0. 03338			
60. 00 06000 LABORATORY 65. 00 06500 RESPI RATORY THERAPY			0. 08165			
66. 00 06600 PHYSICAL THERAPY			0. 23463			•
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS			0. 34160			
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS			0. 12220			•
73. 00 07300 DRUGS CHARGED TO PATIENTS			0. 2332			•
OUTPATIENT SERVICE COST CENTERS			0.2332	1 11, 720, 394	2, 733, 094	/3.00
91. 00 09100 EMERGENCY			0. 33646	1, 266, 948	426, 277	91 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)			0. 24356			92.00
200.00 Total (sum of lines 50 through 94 and 96	through 98)		0.24000	154, 245, 349		
201.00 Less PBP Clinic Laboratory Services-Prog		(line 61)		0	20, 222, 000	201.00
202.00 Net charges (line 200 minus line 201)	i a only onal gos			154, 245, 349	1	202.00
			1		1	

Health Financial Systems	ST. VINCEN	T HEART CENTER		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider C		Peri od:	Worksheet D-3	
				From 07/01/2020 To 06/30/2021	Date/Time Pre	nared
				10 00/ 30/ 2021	11/22/2021 3:	
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description			Ratio of Cos		Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
			1.00	0.00	2)	
			1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS			1	979, 097		30,00
ANCI LLARY SERVI CE COST CENTERS				979,097		30.00
50. 00 05000 OPERATING ROOM			0, 14899	412,669	61, 487	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C			0. 25201		13, 076	
57. 00 05700 CT SCAN			0.00000		0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)			0.00000	0 0	0	58.00
59.00 05900 CARDI AC CATHETERI ZATI ON			0. 03338	2, 320, 213	77, 467	59.00
60. 00 06000 LABORATORY			0. 08165	53 472, 930	38, 616	60.00
65. 00 06500 RESPI RATORY THERAPY			0. 23463	87, 290	20, 481	65.00
66. 00 06600 PHYSI CAL THERAPY			0. 34166			•
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS			0. 12220			•
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS			0. 37988			•
73.00 07300 DRUGS CHARGED TO PATIENTS			0. 23327	343, 698	80, 175	73.00
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY			0.30927		12, 588	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		2)	0. 24356		0	
200.00 Total (sum of lines 50 through 94 and 96				4, 387, 273	499, 502	•
201.00 Less PBP Clinic Laboratory Services-Prog	gram onry c	narges (Trne 61)				201.00
202.00 Net charges (line 200 minus line 201)			I	4, 387, 273		202.00

	Financial Systems ST. VINCENT HEAF ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0153	Peri od: From 07/01/2020 To 06/30/2021	u of Form CMS-2 Worksheet E Part A Date/Time Pre 11/22/2021 3:	pared:
		Title XVIII	Hospi tal	PPS	p····
				1.00	
1 00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			0	1 1 00
1.00 1.01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurr	ing prior to October 1 (see	9, 748, 289	1.00 1.01
1.02	instructions) DRG amounts other than outlier payments for discharges occurr	ing on or after October	1 (see	27, 842, 709	1. 02
1.03	instructions) DRG for federal specific operating payment for Model 4 BPCI for 1 (see instructions)	or discharges occurring	prior to October	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for October 1 (see instructions)	or discharges occurring	on or after	0	1.04
2.00	Outlier payments for discharges. (see instructions)			_	2.00
2.01 2.02	Outlier reconciliation amount Outlier payment for discharges for Model 4 BPCI (see instruct	ions)		0	2.01 2.02
2.02	Outlier payments for discharges occurring prior to October 1		71, 632	2.02	
2.04	Outlier payments for discharges occurring on or after October			207, 881	2.04
3.00	Managed Care Simulated Payments			0	3.00
4.00	Bed days available divided by number of days in the cost repo Indirect Medical Education Adjustment	rting period (see instru	uctions)	101.21	4.00
5.00	FTE count for allopathic and osteopathic programs for the mos	t recent cost reporting	period ending on	0.00	5.00
4 00	or before 12/31/1996. (see instructions) FTE count for allopathic and osteopathic programs that meet th	he criteria for an odd (on to the can for	0.00	4 00
5.00	new programs in accordance with 42 CFR 413.79(e)	ne criteria for an add-d	on to the cap for	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified			0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under cost report straddles July 1, 2011 then see instructions.	42 CFR §412.105(f)(1)(i	v)(B)(2) If the	0.00	7.01
3.00	Adjustment (increase or decrease) to the FTE count for allopa	thic and osteopathic pro	ograms for	0.00	8.00
	affiliated programs in accordance with 42 CFR 413.75(b), 413.				
0.01	1998), and 67 FR 50069 (August 1, 2002).	ata undar 6 FEO2 of the	ACA If the east	0.00	0.01
3. 01	The amount of increase if the hospital was awarded FTE cap slo report straddles July 1, 2011, see instructions.	ots under § 5503 of the	ACA. IT the cost	0.00	8. 01
3. 02	The amount of increase if the hospital was awarded FTE cap slo	ots from a closed teachi	ng hospital	0.00	8. 02
9.00	under § 5506 of ACA. (see instructions) Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line	es (8, 8,01 and 8,02)	(see	0.00	9.00
10.00	instructions) FTE count for allopathic and osteopathic programs in the curre	ent vear from vour recor	ds	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	5 5		0.00	11.00
12.00	Current year allowable FTE (see instructions)			0.00	
13.00	Total allowable FTE count for the prior year.			0.00	
14.00	Total allowable FTE count for the penultimate year if that year otherwise enter zero.	ar ended on or atter Sep	otember 30, 1997,	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.			0.00	15.00
	Adjustment for residents in initial years of the program			0.00	
	Adjustment for residents displaced by program or hospital clos	sure			17.00
	Adjusted rolling average FTE count Current year resident to bed ratio (line 18 divided by line 4	`		0.00 0.000000	
	Prior year resident to bed ratio (rifle to divided by rifle 4)).		0.000000	
	Enter the lesser of lines 19 or 20 (see instructions)			0. 000000	
22.00	IME payment adjustment (see instructions)			0	22.00
22. 01	IME payment adjustment - Managed Care (see instructions)			0	22.01
23. 00	Indirect Medical Education Adjustment for the Add-on for § 42 Number of additional allopathic and osteopathic IME FTE reside		CFR 412.105	0.00	23.00
24.00	(f)(1)(iv)(C). IME FTE Resident Count Over Cap (see instructions)			0.00	24.00
	If the amount on line 24 is greater than -0-, then enter the instructions)	lower of line 23 or line	e 24 (see	0.00	
26.00	Resident to bed ratio (divide line 25 by line 4)			0. 000000	26.00
27.00	IME payments adjustment factor. (see instructions)			0.000000	
	IME add-on adjustment amount (see instructions)			0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01	
29. 00 29. 01	Total IME payment (sum of lines 22 and 28) Total IME payment - Managed Care (sum of lines 22.01 and 28.0		0	29.00 29.01	
	Disproportionate Share Adjustment				
	Percentage of SSI recipient patient days to Medicare Part A pa	atient days (see instruc	ctions)	1.40	
31.00 32.00	Percentage of Medicaid patient days (see instructions) Sum of lines 30 and 31			6.88 8.28	
	Allowable disproportionate share percentage (see instructions))			32.00
		/		0.00	

Heal th	Financial Systems ST. VINCENT HEAR	RT CENTER	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT		Period:	Worksheet E	
			From 07/01/2020 To 06/30/2021	Part A Date/Time Pre	pared:
		T:		11/22/2021 3:	
		Title XVIII	Hospital Prior to 10/1	PPS On/After 10/1	
			1. 00	2.00	
	Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)		0	0	
35. 01 35. 02	Factor 3 (see instructions) Hospital uncompensated care payment (If line 34 is zero, enter	zero on this line) (see	0.00000000	0.000000000	35. 01 35. 02
00.02	instructions)		0	0	00.02
35.03	Pro rata share of the hospital uncompensated care payment amou		0	0	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03 Additional payment for high percentage of ESRD beneficiary dis		0		36.00
40.00	Total Medicare discharges, excluding MS-DRGs 652, 682, 683, 68		0		40.00
	instructions)		_		
			Before 1/1	On/After 1/1	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 68	33 684 an 685 (see	1.00	1.01	41.00
41.00	instructions)		0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-E	DRGs 652, 682, 683, 684	0	0	41.01
42.00	an 685. (see instructions)	fu for adjustment)	0.00		42.00
42.00 43.00	Divide line 41 by line 40 (if less than 10%, you do not qualif Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682		0.00		42.00 43.00
101 00	instructions)		0		101 00
44.00	Ratio of average length of stay to one week (line 43 divided b	by line 41 divided by 7	0. 000000		44.00
45.00	days) Average weekly cost for dialysis treatments (see instructions)		0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.		0.00	0.00	45.00
47.00	Subtotal (see instructions)		37, 870, 511		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, sn	nall rural hospitals	0		48.00
	only. (see instructions)			Amount	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions)			37, 870, 511	
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and			3, 010, 939	
51.00 52.00	Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, lir			0	51.00 52.00
53.00	Nursing and Allied Health Managed Care payment			0	
54.00	Special add-on payments for new technologies			13, 516	
54.01	Islet isolation add-on payment	22		0	
55.00 56.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69 Cost of physicians' services in a teaching hospital (see intru			0	55.00 56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. II		rough 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. I	V, col. 11 line 200)		0	
59.00	Total (sum of amounts on lines 49 through 58)			40, 894, 966	
60.00 61.00	Primary payer payments Total amount payable for program beneficiaries (line 59 minus	line 60)		16, 066 40, 878, 900	
62.00	Deductibles billed to program beneficiaries			1, 894, 836	
63.00	Coinsurance billed to program beneficiaries			1, 484	63.00
	Allowable bad debts (see instructions)			63, 540	
65.00 66.00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instr	suctions)		41, 301 13, 104	
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	uctions)		39, 023, 881	
68.00	Credits received from manufacturers for replaced devices for a	applicable to MS-DRGs (see	e instructions)	0	
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).((For SCH see instructions)	0	
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	cation) adjustment (see i	actructions)	0	
70. 50 70. 87	Rural Community Hospital Demonstration Project (§410A Demonstr Demonstration payment adjustment amount before sequestration	ation, aujustment (see 1)		0	
70.88	SCH or MDH volume decrease adjustment (contractor use only)			0	
70.89	Pioneer ACO demonstration payment adjustment amount (see instr	ructions)			70. 89
70.90	HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions)			0	
70. 91 70. 92	Bundled Model 1 discount amount (see instructions)			0	
70.93	· · · · · ·			657, 464	
70.94	HRR adjustment amount (see instructions)			0	
70.95	Recovery of accelerated depreciation			0	70. 95

CALCULATION OF REIMBURSE	S ST. VINCENT HE	Provider C		Period: From 07/01/2020 To 06/30/2021	Date/Time Pre 11/22/2021 3:	
		Title	XVIII	Hospi tal	PPS	
			FFY FFY	((уууу)	Amount	
70.96 Low volume adjust	ment for federal fiscal year (yyyy) (Enter	in column 0		0	1.00	70.9
the corresponding	g federal year for the period prior to 10/1))		0	0	10. 7
	ment for federal fiscal year (yyyy) (Enter			0	0	70.9
	g federal year for the period ending on or a	after 10/1)				
0.98 Low Volume Paymen					0	
	nount (see instructions)				0	70.9
	der (line 67 minus lines 68 plus/minus lines	s 69 & 70)			39, 681, 345	
	ustment (see instructions) ment adjustment amount after sequestration				0	71. C
	ustment-PARHM pass-throughs				0	71.0
2.00 Interim payments					39, 635, 355	
2.01 Interim payments-	PARHM					72.0
73.00 Tentative settlem	nent (for contractor use only)				0	73.0
1	nent-PARHM (for contractor use only)					73.0
	der/program (line 71 minus lines 71.01, 71.	02, 72, and			45, 990	74.0
73)						74.0
	der/program-PARHM (see instructions) s (nonallowable cost report items) in accord	danco with			0	74.0
CMS Pub. 15-2, ch					0	/ 3.0
TO BE COMPLETED B	Y CONTRACTOR (lines 90 through 96)					
	amount from Wkst. E, Pt. A, line 2, or sum	n of 2.03			0	90.0
plus 2.04 (see in						
	rom Wkst. L, Pt. I, line 2				0	91.0
	reconciliation adjustment amount (see inst				0	
	reconciliation adjustment amount (see instruction calculate the time value of money (see inst				0.00	93.0 94.0
	ney for operating expenses (see instructions				0.00	95.0
	ney for capital related expenses (see instructions				0	
			•	Prior to 10/1	On/After 10/1	
L				1.00	2.00	
HSP Bonus Payment						1
100.00 HSP bonus amount	(see instructions) for HSP Bonus Payment			0	<u>)</u> 0	100. 0
	factor (see instructions)			0.000000000	0.000000000	1101 0
3	amount for HSP bonus payment (see instruction	ons)		0.0000000000000000000000000000000000000		102.0
	r HSP Bonus Payment					1 · · ·
03.00 HRR adjustment fa				0.0000	0.0000	103. 0
	nctor (see instructions)					404 0
	nount for HSP bonus payment (see instruction			0) 0	_104. C
Rural Community H	nount for HSP bonus payment (see instruction ospital Demonstration Project (§410A Demons	stration) Adju			0	
Rural Community H 200.00 Is this the first	nount for HSP bonus payment (see instruction ospital Demonstration Project (§410A Demons year of the current 5-year demonstration p	stration) Adju				
Rural Community H 00.00 Is this the first Century Cures Act	nount for HSP bonus payment (see instruction ospital Demonstration Project (§410A Demons year of the current 5-year demonstration p ? Enter "Y" for yes or "N" for no.	stration) Adju				
Rural Community H 00.00 Is this the first Century Cures Act Cost Reimbursemen	nount for HSP bonus payment (see instruction ospital Demonstration Project (§410A Demons year of the current 5-year demonstration p ? Enter "Y" for yes or "N" for no. t	stration) Adju period under t				200. 0
Rural Community H 00.00 Is this the first Century Cures Act Cost Reimbursemen 01.00 Medicare inpatien	nount for HSP bonus payment (see instruction ospital Demonstration Project (§410A Demons year of the current 5-year demonstration p ?? Enter "Y" for yes or "N" for no. t t service costs (from Wkst. D-1, Pt. II, Ii	stration) Adju period under t				200. 0 201. 0
Rural Community H 200.00 Is this the first Century Cures Act Cost Reimbursemen 201.00 Medicare inpatien 202.00 Medicare discharg	nount for HSP bonus payment (see instruction ospital Demonstration Project (§410A Demons year of the current 5-year demonstration p ?? Enter "Y" for yes or "N" for no. t t service costs (from Wkst. D-1, Pt. II, Ii	stration) Adju period under t				200. 0 201. 0 202. 0
Rural Community H 00.00 Is this the first Century Cures Act Cost Reimbursemen 01.00 Medicare inpatien 02.00 Medicare discharg 03.00 Case-mix adjustme	nount for HSP bonus payment (see instruction ospital Demonstration Project (§410A Demons year of the current 5-year demonstration p ?? Enter "Y" for yes or "N" for no. t t service costs (from Wkst. D-1, Pt. II, Ii ges (see instructions)	stration) Adju period under t ne 49)	he 21st			200. 0 201. 0 202. 0
Rural Community H 200.00 Is this the first Century Cures Act Cost Reimbursemen 201.00 Medicare inpatien 202.00 Medicare discharg 203.00 Case-mix adjustme Computation of De period)	nount for HSP bonus payment (see instruction ospital Demonstration Project (§410A Demons year of the current 5-year demonstration p ? Enter "Y" for yes or "N" for no. t tservice costs (from Wkst. D-1, Pt. II, li ges (see instructions) ent factor (see instructions) monstration Target Amount Limitation (N/A i	stration) Adju period under t ne 49)	he 21st		trati on	200. 0 201. 0 202. 0 203. 0
Rural Community H 00.00 Is this the first Century Cures Act Cost Reimbursemen 01.00 Medicare inpatier 02.00 Medicare discharg 03.00 Case-mix adjustme Computation of De period) 04.00 Medicare target a	nount for HSP bonus payment (see instruction ospital Demonstration Project (§410A Demons year of the current 5-year demonstration p ? Enter "Y" for yes or "N" for no. t tservice costs (from Wkst. D-1, Pt. II, Ii ges (see instructions) ent factor (see instructions) monstration Target Amount Limitation (N/A i amount	stration) Adju period under t ne 49)	he 21st		tration	104. 0 200. 0 201. 0 202. 0 203. 0 204. 0
Rural Community H 00.00 Is this the first Century Cures Act Cost Reimbursemen 01.00 Medicare inpatier 02.00 Medicare discharg 03.00 Case-mix adjustme Computation of De period) 04.00 Medicare target a 05.00 Case-mix adjusted	nount for HSP bonus payment (see instruction ospital Demonstration Project (§410A Demons year of the current 5-year demonstration p ?? Enter "Y" for yes or "N" for no. t t service costs (from Wkst. D-1, Pt. II, Ii ges (see instructions) ent factor (see instructions) monstration Target Amount Limitation (N/A i amount t target amount (line 203 times line 204)	stration) Adju beriod under t ne 49) n first year	he 21st		tration	200. 0 201. 0 202. 0 203. 0 203. 0 204. 0 205. 0
Rural Community H 00.00 Is this the first Century Cures Act Cost Reimbursemen 01.00 Medicare inpatier 02.00 Medicare discharg 03.00 Case-mix adjustme Computation of De period) 04.00 Medicare target a 05.00 Case-mix adjusted 06.00 Medicare inpatier	nount for HSP bonus payment (see instruction ospital Demonstration Project (§410A Demons cyear of the current 5-year demonstration p c? Enter "Y" for yes or "N" for no. t t service costs (from Wkst. D-1, Pt. II, Ii ges (see instructions) ent factor (see instructions) monstration Target Amount Limitation (N/A i amount d target amount (line 203 times line 204) nt routine cost cap (line 202 times line 205	stration) Adju beriod under t ne 49) n first year	he 21st		tration	200. 0 201. 0 202. 0 203. 0 203. 0 204. 0 205. 0
Rural Community H 00.00 Is this the first Century Cures Act Cost Reimbursemen 01.00 Medicare inpatien 02.00 Medicare discharg 03.00 Case-mix adjustme Computation of De period) 04.00 Medicare target a 05.00 Case-mix adjusted 06.00 Medicare inpatien Adjustment to Med	nount for HSP bonus payment (see instruction ospital Demonstration Project (§410A Demons year of the current 5-year demonstration p ?? Enter "Y" for yes or "N" for no. t t service costs (from Wkst. D-1, Pt. II, Ii ges (see instructions) ent factor (see instructions) monstration Target Amount Limitation (N/A i amount t target amount (line 203 times line 204)	stration) Adju period under t ne 49) n first year	he 21st		tration	200. 0 201. 0 202. 0 203. 0 204. 0 205. 0 206. 0
Rural Community H 00.00 Is this the first Century Cures Act Cost Reimbursemen 01.00 Medicare inpatier 02.00 Medicare discharg 03.00 Case-mix adjustme Computation of De period) 04.00 Medicare target a 05.00 Case-mix adjustme 06.00 Medicare inpatier Adjustment to Med 07.00	nount for HSP bonus payment (see instruction ospital Demonstration Project (§410A Demons : year of the current 5-year demonstration p :? Enter "Y" for yes or "N" for no. t t service costs (from Wkst. D-1, Pt. II, Ii ges (see instructions) ent factor (see instructions) monstration Target Amount Limitation (N/A i amount d target amount (line 203 times line 204) it routine cost cap (line 202 times line 205 icare Part A Inpatient Reimbursement	stration) Adju period under t ne 49) n first year 5) structions)	he 21st		trati on	200. C 201. C 202. C 203. C 204. C 205. C 206. C 206. C
Rural Community H 00.00 Is this the first Century Cures Act Cost Reimbursemen 01.00 Medicare inpatien 02.00 Medicare discharg 03.00 Case-mix adjustme Computation of De period) 04.00 Medicare target adjusted 05.00 Case-mix adjusted 06.00 Medicare inpatien Adjustment to Med 07.00 Program reimburse 08.00 Medicare Part A i 1	nount for HSP bonus payment (see instruction ospital Demonstration Project (§410A Demons year of the current 5-year demonstration p ? Enter "Y" for yes or "N" for no. t t service costs (from Wkst. D-1, Pt. II, Ii yes (see instructions) ent factor (see instructions) monstration Target Amount Limitation (N/A i amount d target amount (line 203 times line 204) t routine cost cap (line 202 times line 205 icare Part A Inpatient Reimbursement ement under the §410A Demonstration (see ins	stration) Adju period under t ne 49) n first year 5) structions)	he 21st		trati on	200. 0 201. 0 202. 0 203. 0 204. 0 205. 0 206. 0 207. 0 208. 0
Rural Community H 00.00 Is this the first Century Cures Act Cost Reimbursemen 01.00 Medicare inpatier 02.00 Medicare discharg 03.00 Case-mix adjustme Computation of De De period) Odicare target a 05.00 Case-mix adjusted 06.00 Medicare inpatier Adjustment to Med Or.00 Program reimburse OB 08.00 Medicare Part A i 09.00 Adjustment to Med 10.00 Reserved for future	nount for HSP bonus payment (see instruction ospital Demonstration Project (§410A Demons year of the current 5-year demonstration p ?? Enter "Y" for yes or "N" for no. t t service costs (from Wkst. D-1, Pt. II, Ii ges (see instructions) ent factor (see instructions) monstration Target Amount Limitation (N/A i amount d target amount (line 203 times line 204) nt routine cost cap (line 202 times line 204) nt routine the §410A Demonstration (see ins mpatient service costs (from Wkst. E, Pt. A licare IPPS payments (see instructions)	stration) Adju beriod under t ne 49) n first year 5) structions) A, line 59)	he 21st		tration	200. C 201. C 202. C 203. C 205. C 206. C 206. C 207. C 208. C 209. C 209. C 210. C
Rural Community H 00.00 Is this the first Century Cures Act Cost Reimbursemen 01.00 Medicare inpatier 02.00 Medicare discharg 03.00 Case-mix adjustme Computation of De period) De 04.00 Medicare target a 05.00 Case-mix adjusted 06.00 Medicare target a 05.00 Case-mix adjusted 06.00 Medicare target a 07.00 Program reimburse 08.00 Medicare Part A i 09.00 Adjustment to Med 10.00 Reserved for future 11.00 Total adjustment	nount for HSP bonus payment (see instruction ospital Demonstration Project (§410A Demons cyear of the current 5-year demonstration p c? Enter "Y" for yes or "N" for no. t t service costs (from Wkst. D-1, Pt. II, Ii ges (see instructions) ent factor (see instructions) monstration Target Amount Limitation (N/A i amount d target amount (line 203 times line 204) nt routine cost cap (line 202 times line 205 icare Part A Inpatient Reimbursement ment under the §410A Demonstration (see ins npatient service costs (from Wkst. E, Pt. A dicare IPPS payments (see instructions)	stration) Adju period under t ne 49) n first year 5) structions) A, line 59)	he 21st		tration	200. 0 201. 0 202. 0 203. 0
Rural Community H 00.00 Is this the first Century Cures Act Cost Reimbursemen 01.00 Medicare inpatier 02.00 Medicare discharg 03.00 Case-mix adjustme Computation of De period) Computation of De period) 04.00 Medicare target a 05.00 Case-mix adjusted 06.00 Medicare target a 07.00 Program reimburse 08.00 Medicare Part A i 09.00 Adjustment to Med 10.00 Reserved for futu 11.00 Total adjustment	nount for HSP bonus payment (see instruction ospital Demonstration Project (§410A Demons : year of the current 5-year demonstration p c? Enter "Y" for yes or "N" for no. t t service costs (from Wkst. D-1, Pt. II, Ii ges (see instructions) ent factor (see instructions) monstration Target Amount Limitation (N/A i amount d target amount (line 203 times line 204) it routine cost cap (line 202 times line 204) it routine cost cap (line 202 times line 205 icare Part A Inpatient Reimbursement ement under the §410A Demonstration (see ins npatient service costs (from Wkst. E, Pt. A dicare IPPS payments (see instructions) ure use to Medicare IPPS payments (see instructions S versus Cost Reimbursement	stration) Adju period under t ne 49) n first year 5) structions) A, line 59) 5)	he 21st		trati on	200. C 201. C 202. C 203. C 203. C 205. C 206. C 207. C 207. C 208. C 208. C 208. C 209. C 210. C
Rural Community H 00.00 Is this the first Century Cures Act Cost Reimbursemen 01.00 Medicare inpatier 02.00 Medicare discharg 03.00 Case-mix adjustme Computation of De period) 04.00 Medicare target a 05.00 Case-mix adjustme 06.00 Medicare target a 07.00 Program reimburse 08.00 Medicare Part A i 09.00 Adjustment to Med 10.00 Reserved for futu 11.00 Total adjustment	nount for HSP bonus payment (see instruction ospital Demonstration Project (§410A Demons : year of the current 5-year demonstration p ?? Enter "Y" for yes or "N" for no. t t t service costs (from Wkst. D-1, Pt. II, Ii yes (see instructions) ent factor (see instructions) monstration Target Amount Limitation (N/A i amount d target amount (line 203 times line 204) it routine cost cap (line 202 times line 204) it routine cost cap (line 202 times line 205 icare Part A Inpatient Reimbursement ement under the §410A Demonstration (see ins npatient service costs (from Wkst. E, Pt. A dicare IPPS payments (see instructions) ure use to Medicare IPPS payments (see instructions S versus Cost Reimbursement to Medicare Part A IPPS payments (from line	stration) Adju period under t ne 49) n first year 5) structions) A, line 59) 5)	he 21st		trati on	200. C 201. C 202. C 203. C 205. C 206. C 206. C 207. C 208. C 209. C 211. C 211. C
Rural Community H 00.00 Is this the first Century Cures Act Cost Reimbursemen 01.00 Medicare inpatier 02.00 Medicare discharg 03.00 Case-mix adjustme Computation of De period) De 04.00 Medicare target a 05.00 Case-mix adjustme 06.00 Medicare inpatier Adjustment to Med OProgram reimburse 08.00 Medicare Part A i 09.00 Adjustment to Med 10.00 Reserved for futu 11.00 Total adjustment Comparision of PP De 12.00 Total adjustment	nount for HSP bonus payment (see instruction ospital Demonstration Project (§410A Demons : year of the current 5-year demonstration p c? Enter "Y" for yes or "N" for no. t t service costs (from Wkst. D-1, Pt. II, Ii ges (see instructions) ent factor (see instructions) monstration Target Amount Limitation (N/A i amount d target amount (line 203 times line 204) it routine cost cap (line 202 times line 204) it routine cost cap (line 202 times line 205 icare Part A Inpatient Reimbursement ement under the §410A Demonstration (see ins npatient service costs (from Wkst. E, Pt. A dicare IPPS payments (see instructions) ure use to Medicare IPPS payments (see instructions S versus Cost Reimbursement	stration) Adju period under t ne 49) n first year 5) structions) A, line 59) 5) e 211)	he 21st		trati on	200. C 201. C 202. C 203. C 203. C 205. C 206. C 207. C 207. C 208. C 208. C 208. C 209. C 210. C

V0	LUME CALCULATION EXHIBIT 4			Provider C		Period: From 07/01/2020	Worksheet E Part A Exhibi	+ 1
						To 06/30/2021	Date/Time Pre	pare
				Title	• XVIII	Hospi tal	11/22/2021 3: PPS	37
		W/S E, Part A	Amounts (from	Pre/Post	Period Prior		Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	0n/After 10/01	through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
C	DRG amounts other than outlier payments	1.00	0	0		0 0	0	1
1	DRG amounts other than outlier payments for discharges	1.01	9, 748, 289	0	9, 748, 28	9	9, 748, 289	1
2	occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	27, 842, 709	0		27, 842, 709	27, 842, 709	1
3	1 DRG for Federal specific operating payment for Model 4 BPCI occurring prior to	1. 03	0	0		o	0	1
4	October 1 DRG for Federal specific operating payment for Model 4 BPCl occurring on or after	1.04	0	о		0	0	1
C	October 1 Outlier payments for	2.00						2
1	discharges (see instructions) Outlier payments for	2. 02	0	0		o o	0	2
2	discharges for Model 4 BPCI Outlier payments for	2. 03	71, 632	0	71, 63	2	71, 632	2
3	discharges occurring prior to October 1 (see instructions) Outlier payments for	2. 04	207, 881	0		207, 881	207, 881	2
	di scharges occurring on or after October 1 (see instructions)							
C	Operating outlier reconciliation	2.01	0	0		0 0	0	3
C	Managed care simulated payments Indirect Medical Education Adju	3.00	0	0		0 0	0	4
C	Amount from Worksheet E, Part	21.00	0. 000000	0. 000000	0.00000	0 0. 000000		5
C	A, line 21 (see instructions) IME payment adjustment (see instructions)	22.00	0	0		o o	0	6
1	IME payment adjustment for managed care (see instructions)	22.01	0	0		o o	0	6
	Indirect Medical Education Adju	ustment for the	e Add-on for Se	ction 422 of t	he MMA			1
C	IME payment adjustment factor	27.00	0. 000000			0 0. 000000		1 7
C	(see instructions) IME adjustment (see	28.00	0	0		o o	0	6
1	instructions) IME payment adjustment add on	28. 01	0	0		o o	0	8
D	for managed care (see instructions) Total IME payment (sum of	29.00	0	0		0 0	0	Ģ
1	lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and	29.01	0	0		o o	0	Ģ
	8.01)]
20	Disproportionate Share Adjustme							
00	Allowable disproportionate share percentage (see instructions)	33.00	0. 0000	0. 0000	0.000	0 0.0000		10
00	Disproportionate share adjustment (see instructions)	34.00	0	0		0 0	0	11
D1	Uncompensated care payments	36.00	0	0		0 0	0	11
00	Additional payment for high per Total ESRD additional payment	centage of ESF 46.00	RD beneficiary 0	di scharges 0		0 0	0	12
00	(see instructions) Subtotal (see instructions)	47.00	37, 870, 511	0	9, 819, 92	1 28, 050, 590		
00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	47.00 48.00	0	0	7, 017, 72	0 0	0	1
00	Total payment for inpatient operating costs (see instructions)	49.00	37, 870, 511	0	9, 819, 92	1 28, 050, 590	37, 870, 511	15
00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	3, 010, 939	0	793, 42	0 2, 217, 519	3, 010, 939	16

Heal th	Financial Systems		ST. VINCENT H	FART CENTER		Inlie	eu of Form CMS-2	2552-10
	LUME CALCULATION EXHIBIT 4			Provi der C		Period: From 07/01/2020 To 06/30/2021	Worksheet E Part A Exhibi	t 4 pared:
				Title	XVIII	Hospi tal	PPS	
		W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
17.00	Special add-on payments for new technologies	54.00	13, 516	0	10, 26	6 3, 250	13, 516	17.00
17.01	Net organ aquisition cost							17.01
17. 02	Credits received from manufacturers for replaced	68.00	0	0		0 0	0	17.02
18.00	devices for applicable MS-DRGs Capital outlier reconciliation adjustment amount (see		0	0		0 0	0	18.00
19.00	instructions) SUBTOTAL			0	10, 623, 60	7 30, 271, 359	40, 894, 966	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20. 00 20. 01	Capital DRG other than outlier Model 4 BPCI Capital DRG other than outlier	1. 00 1. 01	2, 953, 269 0	0 0	777, 36	1 2, 175, 908 0 0	2, 953, 269 0	
21. 00 21. 01	Capital DRG outlier payments Model 4 BPCI Capital DRG	2. 00 2. 01	7, 760 0	0	2, 92	2 4, 838 0 0	7, 760 0	21.00 21.01
22. 00	outlier payments Indirect medical education	5.00	0. 0000	0.0000	0.000	0 0.0000		22.00
23.00	percentage (see instructions) Indirect medical education adjustment (see instructions)	6. 00	0	0		0 0	0	23.00
24.00	Al lowable di sproporti onate share percentage (see i nstructi ons)	10.00	0. 0169	0. 0169	0. 016	9 0. 0169		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	49, 910	0	13, 13	7 36, 773	49, 910	25.00
26.00	Total prospective capital payments (see instructions)	12.00	3, 010, 939	0	793, 42	0 2, 217, 519	3, 010, 939	26.00
		W/S E, Part A line	Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27. 00 28. 00	Low volume adjustment factor Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 96			0.00000	0 0. 000000	0	27.00 28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 97				0	0	29. 00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100. 00

)SPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provider CC Title		Period: From 07/01/2020 To 06/30/2021 Hospital		t 5 pared:
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Peri od on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
00	DRG amounts other than outlier payments	1.00					1.0
01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	9, 748, 289	9, 748, 28	9	9, 748, 289	1.0
02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	27, 842, 709		27, 842, 709	27, 842, 709	1. (
03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	1.03	0		0	0	1. (
04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	О		0	0	1. (
00	Outlier payments for discharges (see instructions)	2.00					2.0
01	Outlier payments for discharges for Model 4 BPCI	2.02	0		0 0	0	2. (
02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	71, 632	71, 63	2	71, 632	2. (
03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	207, 881		207, 881	207, 881	2. (
00	Operating outlier reconciliation	2.01	0		0 0		3. (
00	Managed care simulated payments	3.00	0		0 0	0	4.
00	Indirect Medical Education Adjustment Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0. 000000	0.00000	0 0. 000000		5.
00 01	IME payment adjustment (see instructions) IME payment adjustment for managed care (see	22. 00 22. 01	0				6. 6.
	instructions)						
00	Indirect Medical Education Adjustment for the IME payment adjustment factor (see instructions)	27.00	0. 000000	0.00000	0 0. 000000		7.
00	IME adjustment (see instructions)	28.00	0		0 0	0	8.
)1	IME payment adjustment add on for managed care (see instructions)	28.01	0		0 0	0	8.
00	Total IME payment (sum of lines 6 and 8)	29.00	0		0 0	0	9.
01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0		0 0	0	9.
	Disproportionate Share Adjustment		11				
00	Allowable disproportionate share percentage (see instructions)	33.00	0.0000	0.000			10.
00	Disproportionate share adjustment (see instructions)	34.00	0		0 0	0	11.
01	Uncompensated care payments Additional payment for high percentage of ESF	36.00	di cobargas		0 0	0	11.
00	Total ESRD additional payment (see instructions)	46.00	0		0 0	0	12.
00	Subtotal (see instructions)	47.00	37, 870, 511	9, 819, 92	1 28, 050, 590	37, 870, 511	13.
00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see	48.00	0		0 0	0	14.
00	instructions) Total payment for inpatient operating costs (see instructions)	49.00	37, 870, 511	9, 819, 92	1 28, 050, 590	37, 870, 511	15.
00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	3, 010, 939	793, 42	0 2, 217, 519	3, 010, 939	16.
00 01	Special add-on payments for new technologies Net organ acquisition cost	54.00	13, 516	10, 26	6 3, 250	13, 516	17. 17.
02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0		0 0	0	
. 00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0		0 0	0	18.
00	SUBTOTAL			10, 623, 60	7 30, 271, 359	40, 894, 966	19.

Heal th	Financial Systems	ST. VINCENT H	IEART CENTER		In Lie	eu of Form CMS-:	2552-10
	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provider CO		Period: From 07/01/2020 To 06/30/2021		pared:
			Title	XVIII	Hospi tal	PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	2, 953, 269	777, 30	2, 175, 908	2, 953, 269	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0		0 0	0	
21.00	Capital DRG outlier payments	2.00	7, 760	2, 92	4, 838	7, 760	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0		0 0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0		0 0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0. 0169	0.010	0. 0169		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	49, 910	13, 13	37 36, 773	49, 910	25.00
26.00	Total prospective capital payments (see instructions)	12.00	3, 010, 939	793, 42	20 2, 217, 519	3, 010, 939	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0		0	0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		C	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	657, 464	94, 88	562, 575	657, 464	30.00
30. 01	HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0		0 0	0	30. 01
31.00	HRR adjustment (see instructions)	70.94	0		0 0	0	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70. 91	0		0 0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
	HAC Reduction Program adjustment (see instructions)	70. 99			0 0	0	
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100. 00

	Financial Systems ST. VINCENT HEART ATION OF REIMBURSEMENT SETTLEMENT PI	rovider CCN: 15-0153	Period:	Worksheet E	200Z-IL
			From 07/01/2020 To 06/30/2021	Date/Time Pre	
		Title XVIII	Hospi tal	11/22/2021 3: PPS	37 pm
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)	20)		1, 123	
2.00 3.00	Medical and other services reimbursed under OPPS (see instructio OPPS payments	ns)		10, 137, 639 13, 401, 832	
4.00	Outlier payment (see instructions)			13, 580	
4.01	Outlier reconciliation amount (see instructions)			0	
5.00 6.00	Enter the hospital specific payment to cost ratio (see instructi Line 2 times line 5	ons)		0.000	1
7.00	Sum of Lines 3, 4, and 4.01, divided by Line 6			0.00	
8.00	Transitional corridor payment (see instructions)			0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV,	col. 13, line 200		0	
10. 00 11. 00	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)			0 1, 123	10.00 11.00
11.00	COMPUTATION OF LESSER OF COST OR CHARGES			1,120	
	Reasonabl e charges				
12.00	Ancillary service charges	40)			12.00 13.00
13.00 14.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line Total reasonable charges (sum of lines 12 and 13)	69)		0 4, 913	
111.00	Customary charges			1, 110	
15.00	Aggregate amount actually collected from patients liable for pay			0	
16.00	Amounts that would have been realized from patients liable for p had such payment been made in accordance with 42 CFR §413.13(e)	ayment for services o	n a chargebasis	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17.00
	Total customary charges (see instructions)			4, 913	
19.00	Excess of customary charges over reasonable cost (complete only	if line 18 exceeds li	ne 11) (see	3, 790	19.00
20.00	instructions) Excess of reasonable cost over customary charges (complete only	ifline 11 exceeds li	ne 18) (see	0	20.00
20.00	instructions)		10) (300	0	20.00
21.00	Lesser of cost or charges (see instructions)			1, 123	
22.00	Interns and residents (see instructions)	ti ana)		0	
23.00	Cost of physicians' services in a teaching hospital (see instruc Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	tions)		13, 415, 412	
21100	COMPUTATION OF REIMBURSEMENT SETTLEMENT			10/110/112	2.11.00
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)			0	
26.00 27.00	Deductibles and Coinsurance amounts relating to amount on line 2 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plu	-		1, 932, 714 11, 483, 821	
27.00	instructions)	S the Sull OF THES 22	and 25] (366	11, 403, 021	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line	50)		0	
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
	Subtotal (sum of lines 27 through 29) Primary payer payments			11, 483, 821 205	
	Subtotal (line 30 minus line 31)			11, 483, 616	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)			
33.00 34.00	Composite rate ESRD (from Wkst. I-5, line 11)			69 140	
34.00 35.00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			68, 140 44, 291	
36.00	Allowable bad debts for dual eligible beneficiaries (see instruc	tions)		33, 425	
	Subtotal (see instructions)			11, 527, 907	
38. 00 39. 00	MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
39.00 39.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	39.00
39.97	Demonstration payment adjustment amount before sequestration			0	
39. 98	Partial or full credits received from manufacturers for replaced	devices (see instruc	tions)	3, 783	
39.99	RECOVERY OF ACCELERATED DEPRECIATION				
40. 00 40. 01	Subtotal (see instructions) Sequestration adjustment (see instructions)			11, 527, 907 0	
40. 02	Demonstration payment adjustment amount after sequestration			0	1
40.03	Sequestration adjustment-PARHM pass-throughs				40.03
	Interim payments Interim payments-PARHM			11, 557, 170	41.00 41.01
	Tentative settlement (for contractors use only)			0	1
42.01	Tentative settlement-PARHM (for contractor use only)				42.01
43.00	Balance due provider/program (see instructions)			-29, 263	
43. 01 44. 00	Balance due provider/program-PARHM (see instructions) Protested amounts (nonallowable cost report items) in accordance	with CMS Pub 15-2	chanter 1	0	43.01 44.00
44.00	§115. 2	with Gwis Pub. 19-2, 1	snapter I,		++. 00
	TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount (see instructions)			0	
	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0 00	91.00 92.00
	Time Value of Money (see instructions)			0.00	
	Total (sum of lines 91 and 93)				94.00

ANALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC	CN: 15-0153	Period: From 07/01/2020 To 06/30/2021		pared:
			XVIII	Hospi tal	PPS	
		I npati en	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00 2.00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,		39, 635, 3	55 0	11, 557, 170 0	1.00 2.00
3. 00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3. 00
	Program to Provider					
3. 01 3. 02 3. 03 3. 04 3. 05	ADJUSTMENTS TO PROVIDER			0 0 0 0	0 0 0 0	3. 01 3. 02 3. 03 3. 04 3. 05
	Provider to Program					
3.50 3.51 3.52 3.53 3.54 3.99	ADJUSTMENTS TO PROGRAM Subtotal (sum of lines 3.01-3.49 minus sum of lines			0 0 0 0 0		3.50 3.51 3.52 3.53 3.54 3.99
4.00	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)		39, 635, 3		11, 557, 170	4. 00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					5.00
5.01	TENTATI VE TO PROVIDER			0	0	5.01
5.02				0	0	5.02
5.03				0	0	5.03
	Provider to Program TENTATIVE TO PROGRAM			0	0	5.50
5.50 5.51	TENTATIVE TO PROGRAM			0	0	5.50
5.52				0	0	
5.99	Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98)			0	0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)		45.0			6.00
6. 01 6. 02	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM		45, 9	90	0 29. 263	6. 01 6. 02
6.02 7.00	Total Medicare program liability (see instructions)		39, 681, 3	-	29, 263 11, 527, 907	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	,
		C)	1.00	2.00	

Heal th	Financial Systems ST. VINCENT HE	ART CENTER	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0153	Period: From 07/01/2020	Worksheet E- Part II	1
			To 06/30/2021	Date/Time Pre	epared:
				11/22/2021 3:	37 pm
		Title XVIII	Hospi tal	PPS	
				1.00	_
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				-
4 00	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATIC		44		1 1 00
1.00	Total hospital discharges as defined in AARA §4102 from Wkst		2 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	0 10			3.00 4.00
4.00 5.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1,	8-12			4.00
5.00 6.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	Line 20			6,00
7.00	Total hospital charity care charges from Wkst. S-10, col. 3		Wkct S 2 Dt I		7.00
7.00	CAH only - The reasonable cost incurred for the purchase of line 168	certified Hit technology	WKSL. 3-2, PL. I		7.00
8.00	Calculation of the HIT incentive payment (see instructions)				8.00
9.00	Sequestration adjustment amount (see instructions)				9.00
10.00	Calculation of the HIT incentive payment after sequestration	n (see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
31.00	Other Adjustment (specify)				31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and	line 31) (see instruction	is)		32.00

ALCULA	Financial Systems ST. VINCENT HEA TION OF REIMBURSEMENT SETTLEMENT	ART CENTER Provider CCN: 15-0153	Peri od:	u of Form CMS-2 Worksheet E-3	
			From 07/01/2020 To 06/30/2021	Part VII Date/Time Pre 11/22/2021 3:3	
		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	IX SERVICES		
	Inpatient hospital/SNF/NF services		777, 780		1.0
	Medical and other services			165, 546	
. 00	Organ acquisition (certified transplant centers only)		0		3.0
	Subtotal (sum of lines 1, 2 and 3)		777, 780	165, 546	
	Inpatient primary payer payments		0		5.0
	Outpatient primary payer payments		005 555	0	6.0
	Subtotal (line 4 less sum of lines 5 and 6) COMPUTATION OF LESSER OF COST OR CHARGES		777, 780	165, 546	7.0
	Reasonabl e Charges				ĺ
	Routi ne servi ce charges		0		8.0
. 00	Ancillary service charges		4, 387, 273	1, 112, 196	9. (
0. 00	Organ acquisition charges, net of revenue		0		10.
	Incentive from target amount computation		0		11. (
+	Total reasonable charges (sum of lines 8 through 11)		4, 387, 273	1, 112, 196	12.0
	CUSTOMARY CHARGES Amount actually collected from patients liable for payment fi	ar corvines on a charge	0	0	12
3.00	basis	or services on a charge	0	0	13.0
4.00	Amounts that would have been realized from patients liable f	or payment for services o	n 0	0	14.
	a charge basis had such payment been made in accordance with			-	
	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0.00000	
	Total customary charges (see instructions)		4, 387, 273 3, 609, 493	1, 112, 196	
	5 5			946, 650	17.
	line 4) (see instructions) Excess of reasonable cost over customary charges (complete o	nly if line 4 exceeds lin	0	0	18.
8.00	16) (see instructions)	The 4 exceeds The	e 0	0	10.
9.00	Interns and Residents (see instructions)		0	0	19.
	Cost of physicians' services in a teaching hospital (see ins	tructions)	0	0	20.
	Cost of covered services (enter the lesser of line 4 or line		777, 780	165, 546	21.
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	e completed for PPS provi			
	Other than outlier payments		0	0	22.
	Outlier payments		0	0	23.
	Program capital payments Capital exception payments (see instructions)		0		24. 25.
	Routine and Ancillary service other pass through costs		0	0	
	Subtotal (sum of lines 22 through 26)		0	0	
	Customary charges (title V or XIX PPS covered services only)		0	0	28.
	Titles V or XIX (sum of lines 21 and 27)		777, 780	165, 546	29.
H	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
	Excess of reasonable cost (from line 18)		0	0	
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and - Deductibles	6)	777, 780	165, 546	
	Deducti bl es Coi nsurance		0	0	
	Allowable bad debts (see instructions)		0	0	
	Utilization review		0	0	35.
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 a	nd 33)	777, 780	165, 546	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	-	0	0	37.
	Subtotal (line 36 ± line 37)		777, 780	165, 546	
	Direct graduate medical education payments (from Wkst. E-4)		0		39.
	Total amount payable to the provider (sum of lines 38 and 39)	777, 780	165, 546	
	Interim payments		777, 780	165, 546	
	Balance due provider/program (line 40 minus line 41)	anag with CNC Dut 15 C	0	0	42.
3.00	Protested amounts (nonallowable cost report items) in accord	ance with CMS Pub 15-2,	0	0	43.

	Financial Systems ST. VINCENT HI SHEET (If you are nonproprietary and do not maintain	Provi der C		eriod:	u of Form CMS-2 Worksheet G	
ınd-t ıly)	ype accounting records, complete the General Fund column			rom 07/01/2020 06/30/2021	Date/Time Pre	
		General Fund		Endowment Fund	11/22/2021 3: Plant Fund	37 pi
		1.00	Purpose Fund 2.00	3.00	4.00	
	CURRENT ASSETS		-	-		
00	Cash on hand in banks	40, 076, 689		0	0	
00 00	Temporary investments Notes receivable	31, 671, 543	0	0	0	
00	Accounts receivable	53, 215, 013	0	0	0	
00	Other receivable	318, 124	0	0	0	
00	Allowances for uncollectible notes and accounts receivable	-19, 442, 055	0	0	0	6
00	Inventory	2, 328, 132	0	0	0	
00	Prepai d expenses	0	0	0	0	
00	Other current assets	1, 794	0	0	0	
00	Due from other funds Total current assets (sum of lines 1-10)	0 108, 169, 240	0	0	0	10 11
00	FIXED ASSETS	100, 109, 240	0	0	0	1 ' '
.00	Land	0	0	0	0	1 12
00	Land improvements	203, 753	0	0	0	13
00	Accumulated depreciation	-84, 897	0	0	0	14
	Bui I di ngs	42, 166, 403	0	0	0	
	Accumulated depreciation	-35, 216, 603	0	0	0	
	Leasehold improvements	0	0	0	0	
	Accumulated depreciation Fixed equipment	4, 626, 165	0	0	0	18 19
	Accumul ated depreciation	-2, 104, 407		0	0	20
	Automobiles and trucks	2,101,107	0	o	0	
	Accumulated depreciation	0	0	0	0	
00	Major movable equipment	26, 523, 593	0	0	0	23
	Accumulated depreciation	-18, 656, 931	0	0	0	
	Minor equipment depreciable	0	0	0	0	25
	Accumulated depreciation	0	0	0	0	26
	HIT designated Assets	0	0	0	0	27
	Accumulated depreciation Minor equipment-nondepreciable	0	0	0	0	
	Total fixed assets (sum of lines 12-29)	17, 457, 076		0	0	
	OTHER ASSETS	111 1011 010	°			
00	Investments	0	0	0	0	31
. 00	Deposits on Leases	0	0	0	0	32
. 00	Due from owners/officers	0	0	0	0	33
	Other assets	1, 660, 128		0	0	
	Total other assets (sum of lines 31-34)	1, 660, 128		0	0	35
00	Total assets (sum of lines 11, 30, and 35) CURRENT LIABILITIES	127, 286, 444	0	0	0	36
. 00	Accounts payable	12, 283, 693	0	0	0	37
00	Salaries, wages, and fees payable	1, 567	0	0	0	
	Payroll taxes payable	0	0	0	0	39
	Notes and loans payable (short term)	0	0	0	0	
	Deferred income	0	0	0	0	
. 00	Accelerated payments	24, 373, 677		0	0	42
	Due to other funds Other current liabilities	10, 828, 081	0	0	0	
	Total current liabilities (sum of lines 37 thru 44)	47, 487, 018		0	0	
. 00	LONG TERM LIABILITIES	47,407,010	0	9	0	1 70
00	Mortgage payable	0	0	0	0	46
. 00	Notes payable	3, 561, 154	0	0	0	47
00	Unsecured Loans	0	0	0	0	
00	Other long term liabilities	94, 894		0	0	
	Total long term liabilities (sum of lines 46 thru 49)	3, 656, 048		0	0	
00	Total liabilities (sum of lines 45 and 50) CAPITAL ACCOUNTS	51, 143, 066	0	0	0	51
00	General fund balance	76, 143, 378				52
00	Specific purpose fund	, 1 10, 070	0			53
00	Donor created - endowment fund balance - restricted			0		54
. 00	Donor created - endowment fund balance - unrestricted			0		55
00	Governing body created - endowment fund balance			0		56
. 00	Plant fund balance - invested in plant				0	
. 00	Plant fund balance - reserve for plant improvement,				0	58
00	replacement, and expansion Total fund balances (sum of Lines 52 thru 58)	76 140 070	_	~	~	E .
. 00 . 00	Total fund balances (sum of lines 52 thru 58) Total liabilities and fund balances (sum of lines 51 and	76, 143, 378 127, 286, 444		0	0	
	TOTAL TRANTICIES AND TUNU DALANCES (SUII OF TIMES ST AND	127,200,444	1 0	0	0	1 00

Heal th	Financial Systems	ST. VINCENT HE	ART CENTER		In Lie	eu of Form CMS-2	2552-10
	ENT OF CHANGES IN FUND BALANCES		Provider CC		Period: From 07/01/2020 To 06/30/2021	Worksheet G-1 Date/Time Prep 11/22/2021 3:	pared:
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) ROUNDING Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) TRANSFER TO AFFILIATES NONCONTROLLING INTEREST Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	1,00 0 0 0 1 44,284,563 19,215,437 0 0 0 0	61, 143, 745 78, 499, 632 139, 643, 377 139, 643, 378 139, 643, 378 63, 500, 000 76, 143, 378	3.00			$\begin{array}{c} 1. \ 00\\ 2. \ 00\\ 3. \ 00\\ 4. \ 00\\ 5. \ 00\\ 6. \ 00\\ 7. \ 00\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 11. \ 00\\ 12. \ 00\\ 13. \ 00\\ 14. \ 00\\ 15. \ 00\\ 15. \ 00\\ 16. \ 00\\ 17. \ 00\\ 18. \ 00\\ 19. \ 00\\ \end{array}$
		Endowment Fund	PI ant	Fund	_		
1.00		6.00	7.00	8.00			
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0 0 0 0 0		0		1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00
9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00	ROUNDING Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) TRANSFER TO AFFILIATES NONCONTROLLING INTEREST	0 0	0 0 0 0 0 0 0		0 0		9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00
18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0			0 0		18. 00 19. 00

Heal th Financial	Systems
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In Lieu of Form CMS-2552-10

	FINANCIAL SYSTEMS SI. VINCENT HEART CENTER				2552-10
STATEN	ENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider (riod: om 07/01/2020 06/30/2021	Worksheet G-2 Parts I & II Date/Time Pre 11/22/2021 3:	
	Cost Center Description	Inpati ent	Outpati ent	Total	57 piii
	cost center bescription	1.00	2.00	3.00	
	PART I – PATIENT REVENUES	1.00	2.00	0.00	
	General Inpatient Routine Services				
1.00	Hospi tal	112, 247, 562		112, 247, 562	1.00
2.00	SUBPROVIDER - IPF	112, 217, 002		112, 217, 002	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVI DER				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	Ŭ		0	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)	112, 247, 562		112, 247, 562	10.00
10.00	Intensive Care Type Inpatient Hospital Services	112, 247, 302		112, 247, 302	10.00
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines	0		0	16.00
10.00	11-15)	0		0	10.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	112, 247, 562		112, 247, 562	17.00
18.00	Ancillary services	357, 456, 368	181, 963, 483	539, 419, 851	
19.00	Outpatient services	5, 813, 649	18, 554, 062	24, 367, 711	19.00
20.00	RURAL HEALTH CLINIC	5, 813, 049	18, 554, 002	24, 307, 711	20.00
20.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	20.00
21.00	HOME HEALTH AGENCY	0	0	0	21.00
22.00	AMBULANCE SERVICES				22.00
23.00	CMHC				23.00
24.00	AMBULATORY SURGICAL CENTER (D. P.)				25.00
26.00	HOSPICE				26.00
20.00	OTHER (SPECIFY)	0	0	0	20.00
27.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	475, 517, 579	200, 517, 545	676, 035, 124	
20.00	G-3, line 1)	475, 517, 517	200, 317, 343	070,033,124	20.00
	PART II - OPERATING EXPENSES		I		
29.00	Operating expenses (per Wkst. A, column 3, line 200)		118, 743, 575		29.00
30.00	ADD (SPECIFY)	0	110, 110, 010		30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)	Ŭ	0		36.00
37.00	DEDUCT (SPECIFY)	0	Ŭ		37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
40.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer		118, 743, 575		43.00
13.00	to Wkst. G-3, line 4)		110, 740, 070		10.00
	······································	1 1	I		I

Health Finand	cial Systems	ST. VINCENT HEAR	RT CENTER	In Lie	u of Form CMS-2	2552-10
	REVENUES AND EXPENSES		Provider CCN: 15-0153	Peri od:	Worksheet G-3	
				From 07/01/2020		
				To 06/30/2021	Date/Time Prep 11/22/2021 3:3	
					11/22/2021 3: 3	<u>57 piii</u>
					1.00	
1.00 Total	patient revenues (from Wkst. G-2, Part	L. column 3. line	28)		676, 035, 124	1.00
	contractual allowances and discounts on				482, 179, 767	2.00
	atient revenues (line 1 minus line 2)				193, 855, 357	3.00
	total operating expenses (from Wkst. G-	2. Part II. line 4	13)		118, 743, 575	4.00
	ncome from service to patients (line 3				75, 111, 782	5.00
	INCOME	, , , , , , , , , , , , , , , , , , , ,				
6.00 Contri	ibutions, donations, bequests, etc				0	6.00
7.00 Incom	e from investments				825, 545	7.00
8.00 Reven	ues from telephone and other miscellane	ous communication	servi ces		0	8.00
9.00 Reven	ue from television and radio service				0	9.00
10.00 Purcha	ase di scounts				0	10.00
11.00 Rebate	es and refunds of expenses				100	11.00
12.00 Parkiı	ng lot receipts				0	12.00
	ue from laundry and linen service				0	13.00
	ue from meals sold to employees and gue	ests			243, 277	14.00
	ue from rental of living quarters				0	
	ue from sale of medical and surgical su		nan patients		0	16.00
	ue from sale of drugs to other than pat				0	17.00
	ue from sale of medical records and abs				3, 123	
	on (fees, sale of textbooks, uniforms,				0	19.00
	ue from gifts, flowers, coffee shops, a	ind canteen			0	20.00
	l of vending machines				0	21.00
	l of hospital space				0	22.00
	nmental appropriations				0	23.00
	REVENUE				9, 539	
	ACT SERVICES REVENUE				0	24.01
	MI SC REVENUE				24, 027	24.02
	ARS TUITION REVENUE				0	24.03
	E FROM UNCONS ENTITIES				0	24.04
	NONOPERATING				0	24.05
					7, 537	
					7, 585	
	PROGRAM REVENUE				65, 533	
	-19 PHE Funding other income (sum of lines 6-24)				2, 201, 584 3, 387, 850	24. 50 25. 00
	(line 5 plus line 25)				3, 387, 850 78, 499, 632	
	EXPENSES (SPECIFY)				78, 499, 032	27.00
	other expenses (sum of line 27 and sub	scrints)			0	27.00
	ncome (or loss) for the period (line 26				78, 499, 632	
27.00 met 11	to the period (The 20	, minus inno 20)		I	/0, 4/7, 052	27.00

LCULATION OF CAPITAL PAYMENT	Provi der CCN: 15-0153	Period: From 07/01/2020 To 06/30/2021	Worksheet L Parts I-III Date/Time Pre 11/22/2021 3:	
	Title XVIII	Hospi tal	PPS	57 pi
			1.00	
PART I - FULLY PROSPECTIVE METHOD				-
CAPITAL FEDERAL AMOUNT			0.050.0/0	
00 Capital DRG other than outlier 01 Model 4 BPCI Capital DRG other than outlier			2, 953, 269 0	
00 Capital DRG outlier payments			7, 760	
01 Model 4 BPCI Capital DRG outlier payments			0	
00 Total inpatient days divided by number of days in the co	st reporting period (see inst	tructions)	53.57	
00 Number of interns & residents (see instructions)	····· ································		0.00	
00 Indirect medical education percentage (see instructions)			0.00	5.
00 Indirect medical education adjustment (multiply line 5 b	by the sum of lines 1 and 1.01	I, columns 1 and	0	6.
1.01) (see instructions)				
00 Percentage of SSI recipient patient days to Medicare Par	rt A patient days (Worksheet E	E, part A line	1.40	7.
30) (see instructions) 00 Percentage of Medicaid patient days to total days (see i	notructione)		6.88	8.
00 Sum of lines 7 and 8	listi ucti olis)		8.28	
.00 Allowable disproportionate share percentage (see instruc	tions)		1.69	
. 00 Di sproporti onate share adjustment (see instructions)			49, 910	
.00 Total prospective capital payments (see instructions)			3, 010, 939	
			1.00	
PART II - PAYMENT UNDER REASONABLE COST				
00 Program inpatient routine capital cost (see instructions			0	
00 Program inpatient ancillary capital cost (see instructio			0	
00 Total inpatient program capital cost (line 1 plus line 2 00 Capital cost payment factor (see instructions)	2)		0	
00 Capital cost payment factor (see instructions) 00 Total inpatient program capital cost (line 3 x line 4)			0	
00 [10tal_filpatrent program capital cost (fille 3_x fille 4)			0	5.
			1.00	
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
00 Program inpatient capital costs (see instructions)			0	1.
00 Program inpatient capital costs for extraordinary circum			0	
Net program inpatient capital costs (line 1 minus line 2	2)		0	
00 Applicable exception percentage (see instructions)			0.00	
00 Capital cost for comparison to payments (line 3 x line 4			0	
00 Percentage adjustment for extraordinary circumstances (s 00 Adjustment to capital minimum payment level for extraord		(ling ()	0.00	
00 Adjustment to capital minimum payment level for extraord 00 Capital minimum payment level (line 5 plus line 7)	a nary criculistances (TITIE 2)		0	
00 Current year capital payments (from Part I, line 12, as	applicable)		0	
.00 Current year comparison of capital minimum payment level		less line 9)	0	
.00 Carryover of accumulated capital minimum payment level o Worksheet L, Part III, line 14)			0	11.
.00 Net comparison of capital minimum payment level to capit			0	12.
.00 Current year exception payment (if line 12 is positive,			0	
.00 Carryover of accumulated capital minimum payment level o	over capital payment for the f	following period	0	14.
				1
(if line 12 is negative, enter the amount on this line)			~	45
. 00 Current year allowable operating and capital payment (se . 00 Current year operating and capital costs (see instruction)			0	