		SCENSION ST. VIN				u of Form CMS-2	
	eport is required by law (42 USC 1395g; 42 C ts made since the beginning of the cost repo					OMB NO. 0938-	0050
						EXPIRES 03-31	-2022
	AL AND HOSPITAL HEALTH CARE COMPLEX COST REP TTLEMENT SUMMARY	ORT CERTIFICATIO	N Provider CC	CN: 15-1303	Period: From 07/01/2020 To 06/30/2021	Worksheet S Parts I-III Date/Time Pre 11/29/2021 1:	
PART I	- COST REPORT STATUS					11/2//2021 1.	
Provi d	er 1. [X] Electronically prepared cost				Date: 11/29/2	2021 Time: 1	:17 pm
use on	<pre>Iy 2. []Manually prepared cost repor 3. [0]If this is an amended report 4. [F]Medicare Utilization. Enter</pre>	enter the number	r of times the	e provider re	submitted this c	ost report	
Contra		Recei ved:	E TOT TOW.	10 N	PR Date:		
use on	ly (1) Ås Submitted 7. Cont (2) Settled without Audit 8. [N	ractor No	for this Provi or this Provide	der CCN 12.[ontractor's Vende 0]Ifline 5, co	or Code: olumn 1 is 4: E mes reopened =	
PART I	I – CERTIFICATION						
ADMI NI PROVI D	RESENTATION OR FALSIFICATION OF ANY INFORMAT STRATIVE ACTION, FINE AND/OR IMPRISONMENT UN ED OR PROCURED THROUGH THE PAYMENT DIRECTLY STRATIVE ACTION, FINES AND/OR IMPRISONMENT M. CERTIFICATION BY CHIEF FINANCIAL OFFICER O I HEREBY CERTIFY that I have read the abov electronically filed or manually submitted	DER FEDERAL LAW. DR INDIRECTLY OF AY RESULT. R ADMINISTRATOR e certification	FURTHERMORE, A KICKBACK OR OF PROVIDER(S) statement and	IF SERVICES WERE OTHERW that I have	IDENTIFIED IN TH ISE ILLEGAL, CRIM examined the acc	HIS RÉPORT WERE MINAL, CIVIL AN ompanying	
	Expenses prepared by ASCENSION ST. VINCENT 07/01/2020 and ending 06/30/2021 and to th correct, complete and prepared from the bo instructions, except as noted. I further provision of health care services, and tha compliance with such laws and regulations.	JENNINGS (15-1 e best of my kno oks and records certify that I a	303) for the wledge and bel of the provide m familiar wit	cost reporti ief, this re er in accorda th the laws a	ng period beginn port and stateme nce with applica nd regulations r	ing nt are true, ble egarding the	
	[X]I have read and agree with the above	certification st	atement. I cer	rtifv that I	intend my electr	oni c	
	signature on this certification state						
		(Si gne	ed) CHRI ST	OPHER HONS			
			0ffi c	er or Adminis	strator of Provic	ler(s)	
				FINANCE			
			Title	FTNANCE			
				2021 01: 17: 44	1 PM		
			Date				
			Title				
	Cost Center Description	Title V	Part A	Part B	HIT 1.00	Title XIX	
	PART III - SETTLEMENT SUMMARY	1.00	2.00	3.00	4.00	5.00	
1.00	Hospi tal	0	221, 943	-428, 2	72 0	0	1.00
2.00	Subprovider - IPF	0	0		0	0	
3.00	Subprovider - IRF	0	0		0	0	3.00

200.00Total0341,247-428,272000200.00The 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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11/29/2021 1:17 pm Y: \28550 - St. Vincent Jennings\300 - Medicare Cost Report\20210630\HFS\20210630 St. Vincent Jennings.mcrx

5.00

6.00

Swing Bed - SNF

Swing Bed - NF

10.00 RURAL HEALTH CLINIC I

5.00

6.00

0

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0 10.00

	AL AND HOSPITAL HEALTH CARE COMPLEX	DENTIFICATION DATA	Provio	ler CCN: 1	15-1303	Period: From 07/01/ To 06/30/		Workshe Part I Date/Ti 11/29/2	ime Pre	epared
	1.00	2.00		3.00		4	1.00			
00	Hospital and Hospital Health Care Co Street: 301 HENRY STREET	PO Box:								1.
10	City: NORTH VERNON	State: IN	Zin Cod	e: 47265	Count	ty: JENNINGS				2.
		Component Name	CCN	CBSA	Provi der		Pavme	nt Syst	em (P.	2.
			Number	Number	Туре	Certified	2	0, or		
							V	XVIII	XI X	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
_	Hospital and Hospital-Based Componen		151000	00045		07 (04 (100 (-		
0	Hospi tal	ASCENSION ST. VINCENT JENNINGS	151303	99915	1	07/01/1996	Ν	0	0	3
0	Subprovider - IPF	JENNINGS								4
0	Subprovider - IRF									5
0	Subprovider - (Other)									6
0	Swing Beds - SNF	ASCENSION ST. VINCENT	15Z303	99915		07/05/1991	Ν	0	N	7
		JENNINGS SWING								
0	Swing Beds - NF									8
0	Hospital-Based SNF									9
00	Hospital-Based NF									10
00	Hospital-Based OLTC									11
00	Hospital-Based HHA								1	12
00	Separately Certified ASC Hospital-Based Hospice									13
00	Hospital-Based Health Clinic - RHC									15
	Hospital -Based Health Clinic - FQHC									16
	Hospital-Based (CMHC) I									17
00	Renal Dialysis									18
00	Other									19
						From:		Tc		4
						1.00	200	2.		00
	Cost Reporting Period (mm/dd/yyyy)					07/01/20	520	06/30	/2021	20
00	Type of Control (see instructions)					1				21
					1.00	2.00		3.	00	1
	Inpatient PPS Information				1.00	2.00				
00	Inpatient PPS Information Does this facility qualify and is it	currently receiving pay	/ments foi	-	N	N				22
00	Does this facility qualify and is it disproportionate share hospital adju	stment, in accordance wi	th 42 CFI	2						22
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alth Financia DSPITAL AND HO	OSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ST. VINCEN TA I	Provider CC	CN: 15-1303	Peri od:		Workshe		
					From 07/01 To 06/30	/2021	Part I Date/Ti <u>11/29/2</u>		
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days		Medicai HMO day	's Med	ther di cai d days	
		1.00	2.00	3.00	4.00	5.00		5.00	
in-state Medicaid out-of-s out-of-s 4, Medic column 5 5.00 If this Medicaid out-of-s Medicaid	provider is an IPPS hospital, enter the Medicaid paid days in column 1, in-state eligible unpaid days in column 2, tate Medicaid paid days in column 3, tate Medicaid eligible unpaid days in column aid HMO paid and eligible but unpaid days in , and other Medicaid days in column 6. provider is an IRF, enter the in-state paid days in column 1, the in-state eligible unpaid days in column 2, tate Medicaid days in column 3, out-of-state eligible unpaid days in column 4, Medicaid and eligible but unpaid days in column 5.	0	0		0		0	C	24. (
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5.00 Enter yo	ur standard geographic classification (not wa	ade) status	at the bec	ainnina of t	1.00	2	2.0	00	26.0
cost rep 7.00 Enter yo reportin	orting period. Enter "1" for urban or "2" for ur standard geographic classification (not wa g period. Enter in column 1, "1" for urban or e effective date of the geographic reclassifi	rural. age) status r "2" for ru	at the end ural. If ap	d of the cos		2			27. (
5.00 If this	is a sole community hospital (SCH), enter the n the cost reporting period.			CH status ir	I I	0			35.0
enecti	The cost reporting period.				Begi nni		Endi		
.00 Enter ap	plicable beginning and ending dates of SCH st	tatus. Subse	cript line	36 for numb	1.00		2. (00	36.
.00 If this	ds in excess of one and enter subsequent date is a Medicare dependent hospital (MDH), enter fect in the cost reporting period.		of period	ds MDH statu	IS	0			37.
accordan i nstruct	hospital a former MDH that is eligible for th ce with FY 2016 OPPS final rule? Enter "Y" fo ions) 37 is 1, enter the beginning and ending dates	or yes or "I	N" for no.	(see					37.
	than 1, subscript this line for the number of bsequent dates.	f periods i	n excess of	one and					
onton ou					Y/N		Y/		
hospi tal 1 "Y" fo accordan	s facility qualify for the inpatient hospital s in accordance with 42 CFR §412.101(b)(2)(i) r yes or "N" for no. Does the facility meet 1 ce with 42 CFR 412.101(b)(2)(i), (ii), or (ii or no. (see instructions)), (ii), or the mileage	(iii)? Ent requiremen	er in colum nts in	in		<u>2. (</u> N		39.
0.00 Is this "N" for	hospital subject to the HAC program reduction no in column 1, for discharges prior to Octob lumn 2, for discharges on or after October 1.	per 1. Ente	⁻"Y" for y				N	I	40.
						V 1.00	XVIII 2.00	XI X 3.00	-
5.00 Does thi	ive Payment System (PPS)-Capital s facility qualify and receive Capital paymer	nt for disp	roporti onat	e share in	accordance	N	N	N	45.
.00 Is this pursuant	CFR Section §412.320? (see instructions) facility eligible for additional payment exce to 42 CFR §412.348(f)? If yes, complete Wksi					N	N	N	46.
	a new hospital under 42 CFR §412.300(b) PPS o acility electing full federal capital payment	•		2		N	N N	N N	47.
.00 Is the f	Hospi tal s		NE programs	s? Enter "Y"	for yes or	N			56.
Teaching 00 Is this	a hospital involved in training residents in		I I S "Y"	or it this					
00 Is this. "N" for was invo year, an Enter "Y	no in column 1. For column 2, if the response lved in training residents in approved GME pr d are you are impacted by CR 11642 (or applic " for yes; otherwise, enter "N" for no in col	e to column rograms in cable CRs) 1 umn 2.	the prior y MA direct G	vear or penu GME payment	reduction?				
Teaching 1 S this "N" for was invo year, an Enter "Y 2.00 If line GME prog is "Y" d for yes	no in column 1. For column 2, if the response lved in training residents in approved GME pr d are you are impacted by CR 11642 (or applic " for yes; otherwise, enter "N" for no in col 56 is yes, is this the first cost reporting p rams trained at this facility? Enter "Y" for id residents start training in the first mont or "N" for no in column 2. If column 2 is "N	e to column rograms in cable CRs) I umn 2. period durin r yes or "N th of this of (", complete	the prior y MA direct G ng which re for no in cost report Worksheet	year or penu GME payment esidents in n column 1. ing period?	reduction? approved If column 1 Enter "Y"				57.
5.00 Teaching Was invo year, an Enter "Y T.00 If line GME prog is "Y" d for yes "N", com If line	no in column 1. For column 2, if the response lved in training residents in approved GME pr d are you are impacted by CR 11642 (or applic " for yes; otherwise, enter "N" for no in col 56 is yes, is this the first cost reporting p rams trained at this facility? Enter "Y" for id residents start training in the first monting	e to column rograms in f cable CRs) / umn 2. beriod durin r yes or "N" th of this of (", completed , if applic boursement for	the prior y MA direct G g which re for no in cost report e Worksheet cable. or physicia	year or penu GME payment esidents in n column 1. ting period? t E-4. If co	reduction? approved If column 1 Enter "Y" lumn 2 is	N			57.

J3PT I	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provider CO		Period: From 07/01/2020	u of Form CMS-2 Worksheet S-2 Part I	
					06/30/2021	Date/Time Pre 11/29/2021 1:	
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
				1.00	2.00	3.00	
). 00	Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in col is "Y", are you impacted by CR 11642 (or subsequent C adjustement? Enter "Y" for yes or "N" for no in colu	85? (s umn 1. R) NAHE	ee lf column 1	N			60.
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	-
I. 00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.
I. 01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.
I. 02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of						61.
I. 03	ACA). (see instructions) Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.
I. 04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the						61.
. 05	current cost reporting period. (see instructions). Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line						61.
I. 06	61.04 minus line 61.03). (see instructions) Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.
		Pro	ogram Name	Program Code	Unweighted IME FTE Count	Direct GME FTE Count	
. 10	Of the FTEs in line 61.05, specify each new program		1.00	2.00	3.00	4.00	
	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. Enter in column 4,				0.00		
	the direct GME FTE unweighted count.						
						1.00	1
2. 00	ACA Provisions Affecting the Health Resources and Ser Enter the number of FTE residents that your hospital				iod for which	0.00	62.
	your hospital received HRSA PCRE funding (see instruc Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog	ti ons) Teachi	ng Health Cen	ter (THC) into		0.00	
. 00	Teaching Hospitals that Claim Residents in Nonprovide Has your facility trained residents in nonprovider se	er Setti ettings	ngs during this co	ost reporting		N	63.
	"Y" for yes or "N" for no in column 1. If yes, comple		. <u>3 04 thi Ough (</u>	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in No period that begins on or after July 1, 2009 and befor			This base year	is your cost r	reporting	

		ATA Provider (eriod:	Worksheet S-2	-
			Fr Tc	om 07/01/2020 06/30/2021	Date/Time Pre	
	Program Name	Program Code	Unweighted	Unweighted	11/29/2021 1: Ratio (col. 3/	
			FTEs Nonprovi der	FTEs in Hospital	(col. 3 + col. 4))	
_			Si te	•		
.00 Enter in column 1, if line 63	1.00	2.00	3.00	4.00	5.00 0.000000	
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column						
5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			Unweighted	Unwei ghted	Ratio (col. 1/	
			FTEs Nonprovi der Si te	FTEs in Hospital	(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 Settin	gsEffective fo	r cost reporti	ing periods	
FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	unweighted non-prima al. Enter in column	ry care resident 3 the ratio of	Unwei ghted FTEs	Unweighted FTEs in	Ratio (col. 3/	
			Nonprovi der	Hospi tal	(col. 3 + col. 4))	
	1.00	2.00	Nonprovi der Si te 3.00	Hospi tal 4.00	4))	_
.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)	1.00	2.00	Nonprovi der Si te	Hospi tal	4))	_
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)		2.00	Nonprovi der Si te 3.00	Hospi tal 4.00	4)) 5.00 0.000000	_
name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	PS ychiatric Facility (Nonprovi der Si te 3. 00 0. 00	Hospi tal <u>4.00</u> 0.00 <u>1.0</u>	4)) 5.00 0.000000 0.0000000 0.0000000	67.0
<pre>name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)</pre>	PS ychiatric Facility (the facility have a efore November 15, 2 lumn 2: Did this fac R 412.424 (d)(1)(iii cate which program y	IPF), or does it con n approved GME teach 004? Enter "Y" for j ility train resident)(D)? Enter "Y" for j	Nonprovi der Si te 3.00 0.00 tain an IPF subp ing program in t yes or "N" for n s in a new teach yes or "N" for n	Hospi tal 4.00 0.00 1.0 1.0 rovi der? N he most o. (see i ng o.	4)) 5.00 0.000000 0.0000000 0.0000000	70. C
<pre>name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)</pre>	PS ychiatric Facility (the facility have a efore November 15, 2 lumn 2: Did this fac R 412.424 (d)(1)(iii cate which program y y PPS habilitation Facilit	IPF), or does it con n approved GME teach 004? Enter "Y" for ility train resident)(D)? Enter "Y" for ear began during this	Nonprovi der Si te 3.00 0.00 tain an IPF subp ing program in t yes or "N" for n s cost reporting	Hospi tal 4.00 0.00 1.0 1.0 rovi der? N he most o. (see i ng o.	4)) 5.00 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.00000000	_

Health Financial Systems	ASCENSION ST. VIN	CENT JENNINGS		In Lie	u of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFI	CATION DATA	Provider C	CN: 15-1303	Peri od: From 07/01/2020 To 06/30/2021	Worksheet S- Part I Date/Time Pr 11/29/2021 1	epared:
					1.00	
Long Term Care Hospital PPS 80.00 Is this a long term care hospital (LTCH)? E 81.00 Is this a LTCH co-located within another hose "Y" for yes and "N" for no.				g period? Enter	N N	80. 00 81. 00
TEFRA Providers85.00Is this a new hospital under 42 CFR Section86.00Did this facility establish a new Other subplication					N	85.00 86.00
\$413.40(f)(1)(ii)? Enter "Y" for yes and " 87.00 Is this hospital an extended neoplastic dise	l" for no. ease care hospita				N	87.00
1886(d)(1)(B)(vi)? Enter "Y" for yes or "N"	for no.			V	XI X	
Title V and XIX Services				1.00	2.00	
90.00 Does this facility have title V and/or XIX i	npatient hospita	I services? E	nter "Y" for	N	Y	90.00
yes or "N" for no in the applicable column. 91.00 Is this hospital reimbursed for title V and/ full or in part? Enter "Y" for yes or "N" for				N	Ν	91.00
92.00 Are title XIX NF patients occupying title XI instructions) Enter "Y" for yes or "N" for r	/III SNF beds (du	al certificat			Ν	92.00
93.00 Does this facility operate an ICF/IID facili "Y" for yes or "N" for no in the applicable	ty for purposes		d XIX? Enter	Ν	Ν	93.00
94.00 Does title V or XIX reduce capital cost? Ent applicable column.		and "N" for n	o in the	Ν	Ν	94.00
95.00 If line 94 is "Y", enter the reduction perce 96.00 Does title V or XIX reduce operating cost? E				0. 00 N	0. 00 N	95.00 96.00
applicable column. 97.00 fline 96 is "Y", enter the reduction perce	5 11			0.00	0.00	97.00
98.00 Does title V or XIX follow Medicare (title) stepdown adjustments on Wkst. B, Pt. I, col. column 1 for title V, and in column 2 for ti	25? Enter "Y" f			N	Y	98.00
98.01 Does title V or XIX follow Medicare (title) C, Pt. I? Enter "Y" for yes or "N" for no ir	(VIII) for the re				Y	98.01
 title XIX. 98.02 Does title V or XIX follow Medicare (title) bed costs on Wkst. D-1, Pt. IV, line 89? Ent 				N	Y	98. 02
 98.03 for title V, and in column 2 for title XIX. 98.03 Does title V or XIX follow Medicare (title XIX reimbursed 101% of inpatient services cost? 					Ν	98.03
<pre>for title V, and in column 2 for title XIX. 98.04 Does title V or XIX follow Medicare (title) outpatient services cost? Enter "Y" for yes</pre>				N	Ν	98. 04
in column 2 for title XIX. 98.05 Does title V or XIX follow Medicare (title) Wkst. C, Pt. I, col. 4? Enter "Y" for yes or					Y	98. 05
column 2 for title XIX. 98.06 Does title V or XIX follow Medicare (title) Pts. I through IV? Enter "Y" for yes or "N"	(VIII) when cost	reimbursed fo	r Wkst. D,	N	Y	98.06
column 2 for title XIX. Rural Providers						-
105.00 Does this hospital qualify as a CAH?				Y		105.00
106.00 If this facility qualifies as a CAH, has it for outpatient services? (see instructions)						106.00
107.00 Column 1: If line 105 is Y, is this facility training programs? Enter "Y" for yes or "N" Column 2: If column 1 is Y and line 70 or I	for no in column ine 75 is Y, do	1. (see ins you train I&R	tructions) s in an	N		107.00
approved medical education program in the C4 Enter "Y" for yes or "N" for no in column 2. 108.00 Is this a rural hospital qualifying for an e	(see instructi	ons)		N		108.00
CFR Section §412.113(c). Enter "Y" for yes o	or "N" for no.	Physi cal	Occupati ona	I Speech	Respi ratory	
		1.00	2.00	3.00	4.00	
109.00 If this hospital qualifies as a CAH or a cos therapy services provided by outside supplie for yes or "N" for no for each therapy.		N	N	N	N	109.00
					1.00	
110.00 Did this hospital participate in the Rural (Demonstration) for the current cost reporting complete Worksheet E, Part A, lines 200 thro applicable.	period? Enter "	Y" for yes or	"N" for no.	lf yes,	Ν	110.00

	CN: 15-1303	Peri od:	Worksheet S-	2
		From 07/01/2020 To 06/30/2021		
	I		11/2//2021	
11.00 If this facility qualifies as a CAH, did it participate in the Frontier Co Health Integration Project (FCHIP) demonstration for this cost reporting p "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, e integration prong of the FCHIP demo in which this CAH is participating in Enter all that apply: "A" for Ambulance services; "B" for additional beds; for tele-health services.	period? Enter enter the column 2.	1.00 N	2.00	111.
	1.00	2.00	3.00	_
12.00 Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable. Miscell aneous Cost Reporting Information	N			112.
15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-1, chapter 22, §2208.1.	N			0115.
16.00 Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.
 17.00 Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no. 	Y			117.
18.00 Is the malpractice insurance a claims-made or occurrence policy? Enter 1		2		118.
if the policy is claim-made. Enter 2 if the policy is occurrence.	Premiums	Losses	Insurance	
	1.00	2.00	3.00	_
8.01 List amounts of malpractice premiums and paid losses:	104, 9	10 ()	0118.
		1.00	2.00	_
 8. 02 Are malpractice premiums and paid losses reported in a cost center other t Administrative and General? If yes, submit supporting schedule listing cc and amounts contained therein. 9. 00 DO NOT USE THIS LINE 	ost centers	N	N	118. 119. 120.
0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless prov §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Hold Harmless provision in ACA §3121 and applicable amendments? (see instr	' for yes or ne Outpatient			120.
0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless prov §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" "N" for no. Is this a rural hospital with < 100 beds that qualifies for th Hold Harmless provision in ACA §3121 and applicable amendments? (see instr Enter in column 2, "Y" for yes or "N" for no.	for yes or ne Outpatient ructions)			120.
 0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless prov \$3121 and applicable amendments? (see instructions) Enter in column 1, "Y" "N" for no. Is this a rural hospital with < 100 beds that qualifies for th Hold Harmless provision in ACA \$3121 and applicable amendments? (see instr Enter in column 2, "Y" for yes or "N" for no. 1.00 Did this facility incur and report costs for high cost implantable devices patients? Enter "Y" for yes or "N" for no. 	for yes or ne Outpatient ructions) s charged to	Y		121.
 0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless prov \$3121 and applicable amendments? (see instructions) Enter in column 1, "Y" "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Hold Harmless provision in ACA \$3121 and applicable amendments? (see instructions) 1.00 Did this facility incur and report costs for high cost implantable devices patients? Enter "Y" for yes or "N" for no. 2.00 Does the cost report contain heal thcare related taxes as defined in \$1903(Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the Worksheet A line number where these taxes are included. 	for yes or ne Outpatient ructions) s charged to (w)(3) of the	Y Y	5.00	121.
 0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless prov §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" "N" for no. Is this a rural hospital with < 100 beds that qualifies for th Hold Harmless provision in ACA §3121 and applicable amendments? (see instr Enter in column 2, "Y" for yes or "N" for no. 1.00 Did this facility incur and report costs for high cost implantable devices patients? Enter "Y" for yes or "N" for no. 2.00 Does the cost report contain heal thcare related taxes as defined in §1903(Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the Worksheet A line number where these taxes are included. Transplant Center Information 5.00 Does this facility operate a transplant center? Enter "Y" for yes and "N" 	for yes or ne Outpatient ructions) s charged to (w)(3) of the in column 2	Y Y		121.
 0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless prov \$3121 and applicable amendments? (see instructions) Enter in column 1, "Y" "N" for no. Is this a rural hospital with < 100 beds that qualifies for th Hold Harmless provision in ACA \$3121 and applicable amendments? (see instr Enter in column 2, "Y" for yes or "N" for no. 1.00 Did this facility incur and report costs for high cost implantable devices patients? Enter "Y" for yes or "N" for no. 2.00 Does the cost report contain heal thcare related taxes as defined in \$1903(Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the Worksheet A line number where these taxes are included. Transplant Center Information 5.00 Does this facility operate a transplant center? Enter "Y" for yes and "N" yes, enter certification date(s) (mm/dd/yyyy) below. 	for yes or ne Outpatient ructions) s charged to (w)(3) of the in column 2 for no. If	Y Y		121. 122. 125.
 0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless prov \$3121 and applicable amendments? (see instructions) Enter in column 1, "Y" "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Hold Harmless provision in ACA \$3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no. 1.00 Did this facility incur and report costs for high cost implantable devices patients? Enter "Y" for yes or "N" for no. 2.00 Does the cost report contain healthcare related taxes as defined in \$1903(Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the Worksheet A line number where these taxes are included. Transplant Center Information 5.00 Does this facility operate a transplant center? Enter "Y" for yes and "N" yes, enter certification date(s) (mm/dd/yyyy) below. 5.00 If this is a Medicare certified kidney transplant center, enter the certifing in column 1 and termination date, if applicable, in column 2. 	for yes or ne Outpatient ructions) s charged to (w)(3) of the in column 2 for no. If fication date	Y Y		121. 122. 125. 126.
 0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless prov §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" "N" for no. Is this a rural hospital with < 100 beds that qualifies for th Hold Harmless provision in ACA §3121 and applicable amendments? (see instr Enter in column 2, "Y" for yes or "N" for no. 1.00 Did this facility incur and report costs for high cost implantable devices patients? Enter "Y" for yes or "N" for no. 2.00 Does the cost report contain heal thcare related taxes as defined in §1903(Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the Worksheet A line number where these taxes are included. Transplant Center Information 5.00 Does this facility operate a transplant center? Enter "Y" for yes and "N" yes, enter certification date(s) (mm/dd/yyyy) below. 5.00 If this is a Medicare certified kidney transplant center, enter the certifi in column 1 and termination date, if applicable, in column 2. 	for yes or ne Outpatient ructions) s charged to (w)(3) of the in column 2 for no. If fication date cation date	Y Y		121. 122. 125. 126. 127.
 0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless prov \$3121 and applicable amendments? (see instructions) Enter in column 1, "Y" "N" for no. Is this a rural hospital with < 100 beds that qualifies for th Hold Harmless provision in ACA \$3121 and applicable amendments? (see instr Enter in column 2, "Y" for yes or "N" for no. 1.00 Did this facility incur and report costs for high cost implantable devices patients? Enter "Y" for yes or "N" for no. 2.00 Does the cost report contain healthcare related taxes as defined in \$1903(Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the Worksheet A line number where these taxes are included. Transplant Center Information 5.00 Does this facility operate a transplant center? Enter "Y" for yes and "N" yes, enter certification date(s) (mm/dd/yyyy) below. 6.00 If this is a Medicare certified kidney transplant center, enter the certifi in column 1 and termination date, if applicable, in column 2. 8.00 If this is a Medicare certified liver transplant center, enter the certifi in column 1 and termination date, if applicable, in column 2. 8.00 If this is a Medicare certified liver transplant center, enter the certifi in column 1 and termination date, if applicable, in column 2. 	for yes or ne Outpatient ructions) s charged to (w)(3) of the in column 2 for no. If fication date cation date	Y Y N		121. 122. 125. 126. 127. 128.
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DAT		Provider CC	N: 15-13			7/01/2020 6/30/2021	Worksheet S- Part I Date/Time Pro 11/29/2021 1	epared:
1.00		2.00					3.00		
If this facility is part of a cha home office and enter the home of					the n	ame and	d address	of the	
141. 00Name: ASCENSI ON ST. VI NCENT	Contractor's Na				tracto	or's Nu	mber: 0800	1	141.00
142.00 Street: 250 WEST 96TH STREET, SUIT	E 215 PO Box:								142.00
143.00 City: INDIANAPOLIS	State:	I N		Zip	Code:		4626	0	143.00
								1.00	_
144.00 Are provider based physicians' cos	sts included in Works	sheet A?						Y	144.00
							1.00	2.00	
 45.00 If costs for renal services are clipatient services only? Enter "Y" no, does the dialysis facility in period? Enter "Y" for yes or "N" 46.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/d) 	' for yes or "N" for clude Medicare utiliz for no in column 2. gy changed from the p n column 1. (See CMS	no in co zation fo previousl Pub. 15:	olumn 1. lf c or this cost ly filed cost	olumn 1 reporti report	ng ?		Ν		145. 00 146. 00
								1.00	4.4=
147.00 Was there a change in the statisti 148.00 Was there a change in the order o								N N	147.00
148.00 Was there a change in the order of 149.00 Was there a change to the simplifi					l" for	no.		N	148.00
			Part A		rt B	-	itle V	Title XIX	
			1.00		00		3.00	4.00	
Does this facility contain a prov									
or charges? Enter "Y" for yes or 55.00 Hospi tal	<u>N° TOR NO TOR each (</u>	componen	t tor Part A N		<u>~тв.</u> N	<u>(See 4.</u>	<u>2 CFR 9413</u> N	. 13) N	155.0
56.00 Subprovi der – IPF			N		N		N	N	156.0
57.00 Subprovider - IRF			N		N		Ν	N	157.0
58. 00 SUBPROVI DER									158. 0
59.00 SNF 60.00 HOME HEALTH AGENCY			N		N		N	N	159.0
61. 00 CMHC			Ν		N N		N N	N N	160.0
								1.00	_
Multicampus 65.001s this hospital part of a Multica Enter "Y" for yes or "N" for no.	ampus hospital that h	has one o	or more campu	ises in	di ffei	rent CE	3SAs?	N	165. 0
	Name		County	Stat	e Zip	Code	CBSA	FTE/Campus	
	0		1.00	2.00) (3.00	4.00	5.00	
66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)								0.0	0166.0
								1.00	
Health Information Technology (HI						t Act			
67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the 1	05 is "Y") and is a r	meani ngfu	ul user (line			enter	the	Y	167. 0 168. 0
68.01 If this provider is a CAH and is i				qualif	y for	a harc	lshi p	N	168.0
exception under §413.70(a)(6)(ii) 69.00 If this provider is a meaningful	user (line 167 is "Y'					'N"), €	enter the	0.0	0169. 0
transition factor. (see instruction	ons)					Do	ai nni na	Ending	
						ве	<u>gi nni ng</u> 1. 00	Endi ng 2. 00	-
70.00 Enter in columns 1 and 2 the EHR I period respectively (mm/dd/yyyy)	beginning date and er	ndi ng dat	te for the re	eporting	J			2.00	170. 0
							1 00	0.07	_
71.00 fline 167 is "Y", does this prov	i den havo anv dovo d	for indi-	vi dual s oprol	Lod in			1.00 N	2.00	0171.0
section 1876 Medicare cost plans i "Y" for yes and "N" for no in colu	reported on Wkst. S-3	3, Pt. I,	line 2, col	. 6? Er			IN		

In Lieu of Form CMS-2552-10 Health Financial Systems ASCENSION ST. VINCENT JENNINGS HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 15-1303 Peri od. Worksheet S-2 From 07/01/2020 Part II 06/30/2021 Date/Time Prepared: То 11/29/2021 1:17 pm Y/N Date 1.00 2.00 General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Provider Organization and Operation 1.00 Has the provider changed ownership immediately prior to the beginning of the cost Ν 1.00 reporting period? If yes, enter the date of the change in column 2. (see instructions) V/I Y/N Date 1.00 2.00 3.00 Has the provider terminated participation in the Medicare Program? If 2.00 Ν 2 00 yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary. Is the provider involved in business transactions, including management 3.00 Ν 3.00 contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions) Y/N Date Туре 1.00 2.00 3.00 Financial Data and Reports Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, 4.00 Y А 4.00 or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions. 5.00 Are the cost report total expenses and total revenues different from Ν 5.00 those on the filed financial statements? If yes, submit reconciliation. Y/N Legal Oper 1.00 2.00 Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is Ν 6.00 6.00 the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see instructions. 7.00 Ν 7 00 8.00 Were nursing school and/or allied health programs approved and/or renewed during the Ν 8.00 cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved graduate medical education 9 00 Ν 9.00 program in the current cost report? If yes, see instructions. Was an approved Intern and Resident GME program initiated or renewed in the current 10.00 Ν 10.00 cost reporting period? If yes, see instructions. 11.00 Are GME cost directly assigned to cost centers other than I & R in an Approved Ν 11.00 Teaching Program on Worksheet A? If yes, see instructions Y/N 1.00 Bad Debts 12.00 Is the provider seeking reimbursement for bad debts? If yes, see instructions. 12.00 Y 13.00 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting Ν 13.00 period? If yes, submit copy. 14.00 If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions. Ν 14.00 Bed Complement 15.00 Did total beds available change from the prior cost reporting period? If yes, Υ 15.00 see instructions. Part B Part A Y/N Date Y/N Date 1.00 2.00 3.00 4.00 PS&R Data 10/04/2021 Was the cost report prepared using the PS&R Report only? 10/04/2021 16.00 Υ γ 16.00 If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see

instructions) 17.00 Was the cost report prepared using the PS&R Report for Ν Ν 17.00 totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) 18.00 If line 16 or 17 is yes, were adjustments made to PS&R Ν Ν 18.00 Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. 19.00 If line 16 or 17 is yes, were adjustments made to PS&R 19.00 Ν Ν Report data for corrections of other PS&R Report information? If yes, see instructions.

Health Financial Syste

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Liou of Form CMS_2552_10

Heal th	Financial Systems ASCENSION ST. V	VINCENT JENNINGS	;	In Lie	u of Form CMS-	-2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CN: 15-1303 P F	eriod: rom 07/01/2020 o 06/30/2021	Worksheet S-: Part II Date/Time Pro	2 epared:
		Descr	iption	Y/N	11/29/2021 1: Y/N	: 17 pm
			0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EX	CHILDRENS H			1.00	
	Capital Related Cost	SELL CHIEDRENS I	1001117(20)			
22 00	Have assets been relifed for Medicare purposes? If yes, s	ee instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expension reporting period? If yes, see instructions.		als made durin	g the cost	N	23.00
24.00	Were new leases and/or amendments to existing leases ente If yes, see instructions	red into during	this cost repo	rting period?	Y	24.00
25.00	Have there been new capitalized leases entered into during instructions.	g the cost repor	ting period? I	f yes, see	Ν	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during instructions.	the cost reporti	ng period? If	yes, see	Ν	26.00
27.00	Has the provider's capitalization policy changed during the copy.	he cost reportir	ng period? If y	es, submit	Ν	27.00
28.00	Interest Expense Were new Loans, mortgage agreements or letters of credit	entered into dur	ing the cost r	eporti ng	N	28.00
29. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/o		ebt Service Res	erve Fund)	Ν	29.00
30. 00	treated as a funded depreciation account? If yes, see ins Has existing debt been replaced prior to its scheduled ma		debt? If yes,	see	Ν	30.00
31.00	instructions. Has debt been recalled before scheduled maturity without	issuance of new	debt? If yes,	see	Ν	31.00
	instructions. Purchased Services					-
32.00	Have changes or new agreements occurred in patient care s	ervi ces furni she	ed through cont	ractual	Y	32.00
33.00	arrangements with suppliers of services? If yes, see inst If line 32 is yes, were the requirements of Sec. 2135.2 a		ng to competiti	ve bidding? If	Y	33.00
	no, see instructions.					
	Provi der-Based Physi ci ans			<u> </u>		-
	Are services furnished at the provider facility under an a If yes, see instructions.	0			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended exphysicians during the cost reporting period? If yes, see		its with the pr		N	35.00
				Y/N 1.00	Date	
	Home Office Costs			1.00	2.00	_
36 00	Were home office costs claimed on the cost report?			Y		36.00
	If line 36 is yes, has a home office cost statement been	prepared by the	home office?	Y		37.00
57.00	If yes, see instructions.	prepared by the	nome office:			57.00
38.00	If line 36 is yes, was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year end			N		38.00
39.00	If line 36 is yes, did the provider render services to ot see instructions.			N		39.00
40.00	If line 36 is yes, did the provider render services to the instructions.	e home office?	lf yes, see	N		40.00
		1.	00	2.	00	
	Cost Report Preparer Contact Information	1				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively:	JILL		HILL		41.00
42.00	respectively. Enter the employer/company name of the cost report	ASCENSI ON				42.00
43.00	preparer. Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(317) 583-3519	1	JI LL. HI LL1@ASC	ENSI ON. ORG	43.00

Heal th	Financial Systems ASCE	ENSION ST.	VI NC	ENT JENNINGS	In Lie	u of Form CMS-	2552-10
H0SPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUEST	I ONNAI RE		Provider CCN: 15-13	eriod:	Worksheet S-2	
					rom 07/01/2020 o 06/30/2021		pared: 17 pm
				3.00			
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title/p	oosition	RE	IMBURSEMENT MANAGER			41.00
	held by the cost report preparer in columns 1,	2, and 3,					
	respecti vel y.						
42.00	Enter the employer/company name of the cost rep	port					42.00
	preparer.						
43.00	Enter the telephone number and email address of	f the cost					43.00
	report preparer in columns 1 and 2, respectivel	у.					

^{11/29/2021 1:17} pm Y: \28550 - St. Vincent Jennings\300 - Medicare Cost Report\20210630\HFS\20210630 St. Vincent Jennings.mcrx

HOSPLT	Financial Systems AS AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC		NCENT JENNINGS Provider CO		Peri od:	Worksheet S-	
					From 07/01/2020 To 06/30/2021	Part I	epared:
						I/P Days / O/I	
						<u>Visits / Trip</u> s	3
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
		Line Number 1.00	2.00	Available	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00	2.00	3.00			1.00
1.00	8 exclude Swing Bed, Observation Bed and	30.00	20	7, 1	25 11, 100.00		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 Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation		25	9, 1	25 11, 160. 00	(7.00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNI T						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		25	0.1			13.00
14.00 15.00	Total (see instructions)		25	9, 1	25 11, 160. 00		0 14.00 0 15.00
16.00	CAH visits 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	88.00				(26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89.00					26.25
27.00	Total (sum of lines 14-26)		25				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
33.00	outpatient days (see instructions) LTCH non-covered days						33.00
JJ. UU	LIGH HOH-COVELEG Gays			1		1	33.00

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CO	CN: 15-1303		eriod: com 07/01/2020 o 06/30/2021	Worksheet S-3 Part I Date/Time Pre 11/29/2021 1:	pared:
		I/P Days / O/P Visits / Trips Full Time Equivalents						
	Component	Title XVIII	Title XIX	Total All Patients		Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00		9.00	10.00	
1.00 2.00 3.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO 1PF Subprovider	288 111 0	13 16 0		65			1.00 2.00 3.00
4.00	HMO I RF Subprovi der	o	0					4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	135	0		14			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	:	21			6.00
7.00	Total Adults and Peds. (exclude observation	423	13	70	00			7.00
8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00	beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF	423 6, 946	13 973		00 97	0. 00	49.61	15.00 16.00 17.00
18.00 19.00 20.00 21.00 22.00 23.00 24.00 24.10 25.00 26.00 26.25	SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER	0 0	0 0		0 0 0	0. 00 0. 00	0. 00 0. 00	26. 25
27.00 28.00 29.00 30.00 31.00 32.00 32.01	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	0	0		45 0 0 0 0	0. 00	49.61	27.00 28.00 29.00 30.00 31.00 32.00 32.01
33. 00 33. 01	outpatient days (see instructions) LTCH non-covered days LTCH site neutral days and discharges	0 0						33. 00 33. 01

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	CN: 15-1303	Period: From 07/01/2020 To 06/30/2021	Worksheet S-3 Part I Date/Time Pre 11/29/2021 1:	pared:
		Full Time Equivalents		Di s	charges		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers	12.00	12.00	14.00	Pati ents	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	11.00	12.00	13.00	14.00 86 5	<u>15.00</u> 142	1.00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00 23. 00 24. 10 25. 00 26. 25 27. 00 28. 00 30. 00 31. 00	8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider HMO IPF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSI VE CARE UNIT CORONARY CARE UNIT BURN INTENSI VE CARE UNIT SURGICAL INTENSI VE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IPF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF	0. 00 0. 00 0. 00 0. 00 0. 00	0		32 7 0 0 86 5	142	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 22.00 23.00 24.10 25.00 26.00 26.25 27.00 26.00 26.00 27.00 28.00 29.00 30.00 31.00 31.00
32. 00 32. 01	Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions)						32.00 32.01
33.00 33.01	LTCH non-covered days LTCH site neutral days and discharges				0		33.00 33.01

Heal th	Financial Systems	ASCENSION ST. VINCENT	JENNI NGS		In Lie	eu of Form CMS-2	2552-10	
	AL UNCOMPENSATED AND INDIGENT CARE DATA			N: 15-1303	Peri od:	Worksheet S-1		
					From 07/01/2020			
					To 06/30/2021			
	· · · · ·					11/29/2021 1:		
						1.00		
	Uncompensated and indigent care cost comp	utation						
1.00	Cost to charge ratio (Worksheet C, Part I	line 202 column 3 divic	led by lin	ie 202 columr	18)	0. 253489	1.00	
	Medicaid (see instructions for each line)							
2.00	Net revenue from Medicaid					2, 385, 276		
3.00	Did you receive DSH or supplemental payme					Y	3.00	
4.00	If line 3 is yes, does line 2 include all				ii d?	Y	4.00	
5.00	If line 4 is no, then enter DSH and/or su	pplemental payments from	n Medicaid			0	5.00	
6.00	Medi cai d charges					20, 487, 443	6.00	
7.00	Medicaid cost (line 1 times line 6)	6 N K 11 (1)	- ·	C 1 ·	0 1 5 1 6	5, 193, 341	7.00	
8.00	Difference between net revenue and costs	for Medicald program (II	ne / minu	IS SUM OT III	ies 2 and 5; IT	2, 808, 065	8.00	
	< zero then enter zero) Children's Health Insurance Program (CHIP	(see instructions for	oach ling)				
9.00	Net revenue from stand-al one CHIP					0	9.00	
10.00	Stand-al one CHIP charges					0		
11.00	Stand-alone CHIP cost (line 1 times line	10)				0		
12.00	Difference between net revenue and costs		ne 11 min	us line 9: i	f < zero then	0		
	enter zero)							
	Other state or local government indigent	care program (see instru	ctions fo	r each line)				
13.00	Net revenue from state or local indigent					0		
14.00	Charges for patients covered under state	or local indigent care p	orogram (N	lot included	in lines 6 or	0	14.00	
	10)					_		
15.00	State or local indigent care program cost			(1)	45 1	0		
16.00	Difference between net revenue and costs 13; if < zero then enter zero)	for state or local indig	jent care	program (III	ie 15 minus line	0	16.00	
	Grants, donations and total unreimbursed	cost for Medicaid CHLP	and state	/local indic	ent care progra	I NS (SPP		
	instructions for each line)	cost for medicald, chiri				13 (366		
17.00	Private grants, donations, or endowment i	ncome restricted to fund	ling chari	ty care		0	17.00	
18.00	Government grants, appropriations or tran					0	18.00	
19.00	Total unreimbursed cost for Medicaid, CH	IP and state and local i	ndigent c	are programs	(sum of lines	2, 808, 065	19.00	
	8, 12 and 16)					T b b b b b		
				Uni nsured pati ents	Insured patients	Total (col. 1 + col. 2)		
			F	1.00	2.00	3.00		
	Uncompensated Care (see instructions for	each line)		1.00	2.00	3.00		
20.00	Charity care charges and uninsured discou		ity	1, 862, 6	7 658, 218	2, 520, 895	20.00	
	(see instructions)		5					
21.00	Cost of patients approved for charity car	e and uninsured discount	s (see	472, 10	658, 218	1, 130, 386	21.00	
	instructions)							
22.00	Payments received from patients for amoun	ts previously written of	'f as	111, 35	53 11, 532	122, 885	22.00	
22.00	charity care	22)		360, 8 ⁻	E 414 404	1, 007, 501	22.00	
23.00	Cost of charity care (line 21 minus line	22)		300, 8	5 646, 686	1,007,301	23.00	
						1.00		
24.00	Does the amount on line 20 column 2, incl	ude charges for patient	davs bevo	nd a length	of stav limit	N N	24.00	
	imposed on patients covered by Medicaid o							
25.00	If line 24 is yes, enter the charges for			care program	's length of	0	25.00	
	stay limit							
26.00	Total bad debt expense for the entire hos					3, 986, 888 451, 968		
27.00								
27.01								
28.00	Non-Medicare bad debt expense (see instru		(3, 291, 553		
29.00	Cost of non-Medicare and non-reimbursable	•	ise (see i	nstructions)		1,077,739	1	
30.00	Cost of uncompensated care (line 23 colum	n 3 prus rine 29)				2, 085, 240	30.00	
31.00	Total unreimbursed and uncompensated care	cost (line 10 plus line	30)			4, 893, 305	31 00	

Heal th	Financial Systems AS	CENSION ST. VINC	ENT JENNINGS		In Lie	eu of Form CMS-:	2552-10
RECLASS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CO		Peri od:	Worksheet A	
					From 07/01/2020		norod.
					To 06/30/2021	Date/Time Pre 11/29/2021 1:	
	Cost Center Description	Sal ari es	Other	Total (col 1	Recl assi fi cati		
		our un roo	011101	+ col. 2)		Trial Balance	
						(col. 3 +-	
						col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS			_			
	00100 CAP REL COSTS-BLDG & FIXT		754, 040	754, 04			1.00
	00400 EMPLOYEE BENEFITS DEPARTMENT	64, 138	1, 066, 524	1, 130, 66		.,	4.00
	00500 ADMINISTRATIVE & GENERAL	249, 122	4, 541, 805	4, 790, 92			
	00700 OPERATION OF PLANT	0	712, 356	712, 35			
	00800 LAUNDRY & LINEN SERVICE	0	31, 424	31, 42			
	00900 HOUSEKEEPI NG	0	393, 092				9.00
	01000 DI ETARY	0	338, 305	338, 30			1
	01100 CAFETERI A	0	0		270, 039		1
	01300 NURSING ADMINISTRATION	212, 899	14, 814	227, 71			13.00
	01400 CENTRAL SERVICES & SUPPLY	0	3, 820	3, 82			14.00
	01500 PHARMACY	184, 570	553, 702	738, 27			15.00
	01600 MEDICAL RECORDS & LIBRARY	0	0		0 0	0	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	818, 408	503, 973	1, 322, 38	1 2, 628	1, 325, 009	30.00
	ANCI LLARY SERVI CE COST CENTERS	10/ 100	4/0 754	050.00	17 (07	0.11.00/	
	05000 OPERATING ROOM	196, 182	162, 751	358, 93			
	05400 RADI OLOGY - DI AGNOSTI C	642, 395	663, 176	1, 305, 57			54.00
	06000 LABORATORY	17, 702	1, 616, 600	1, 634, 30	2 0	1	60.00
	06500 RESPI RATORY THERAPY	0	10,000	242.22		0	65.00
	06600 PHYSI CAL THERAPY	231, 420	10, 903	242, 32			
	06700 OCCUPATIONAL THERAPY	0	0		31,100		1
	06800 SPEECH PATHOLOGY	0	0		0	-	68.00
	06900 ELECTROCARDI OLOGY	0	(201	(20)	J U 1 01 570	0	69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPLANTABLE DEVICES CHARGED TO	0	6, 201 11, 421	6, 20 ⁻ 11, 42 ⁻		27, 771 11, 421	
72.00	PATIENTS	0	11,421	11,42	0	11,421	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0			0	73.00
	03950 ADULT MENTAL HEALTH	0	421, 238	421, 23	3 0		•
	OUTPATIENT SERVICE COST CENTERS	0	121,200	121,20	<u> </u>	121,200	/0.00
	08800 RURAL HEALTH CLINIC	0	0		0 0	0	88.00
	09100 EMERGENCY	950, 282	1, 429, 643			-	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	,00,202	1, 12, 7, 0, 10	2/0///2	., .20	2,0,0,000	92.00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	3, 567, 118	13, 235, 788	16, 802, 90	5 0	16, 802, 906	118.00
-	NONREI MBURSABLE COST CENTERS					.,	
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	(0 0	0	190.00
	19100 RESEARCH	0	0		0 0		191.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	(0 0		192.00
	07950 OTHER NRCC	0	39, 107	39, 10	7 0	39, 107	194.00
	07951 SPN	0	0		0 0		194.01
	07952 OUTPATIENT CLINICS	0	0	(0 0		194.02
	07953 MARKETI NG	0	0	(0 0		194.03
200.00	TOTAL (SUM OF LINES 118 through 199)	3, 567, 118	13, 274, 895	16, 842, 01	3 0	16, 842, 013	200. 00
Į.	5 ,					•	

RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CCN:	15-1303		A Prepared: 1 1:17 pm
	Cost Center Description	Adjustments	Net Expenses		· · ·	
			For Allocation			
		6.00	7.00			
	GENERAL SERVICE COST CENTERS					
1.00	00100 CAP REL COSTS-BLDG & FIXT	-321, 211	432, 829			1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	6, 046	1, 136, 708			4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	866, 177	5, 632, 625			5.00
7.00	00700 OPERATION OF PLANT	0	718, 657			7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	31, 424			8.00
9.00	00900 HOUSEKEEPI NG	0	397, 653			9.00
10.00	01000 DI ETARY	0	68, 266			10.00
11.00	01100 CAFETERI A	-47, 742	222, 297			11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	227, 841			13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	-99	13, 648			14.00
15.00	01500 PHARMACY	-9, 027	729, 245			15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0			16.00
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS	-98, 316	1, 226, 693			30.00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	341, 326			50.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	-86, 127	1, 216, 944			54.00
60.00	06000 LABORATORY	-29, 972	1, 604, 330			60.00
65.00	06500 RESPI RATORY THERAPY	0	o			65.00
66.00	06600 PHYSI CAL THERAPY	-89	211, 730			66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	31, 100			67.00
68.00	06800 SPEECH PATHOLOGY	0	0			68.00
69.00	06900 ELECTROCARDI OLOGY	0	o			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	27, 771			71.00
72.00	07200 I MPLANTABLE DEVICES CHARGED TO PATIENTS	0	11, 421			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	o			73.00
76.00	03950 ADULT MENTAL HEALTH	0	421, 238			76.00
	OUTPATIENT SERVICE COST CENTERS		· · · · ·			
88.00	08800 RURAL HEALTH CLINIC	0	0			88.00
91.00	09100 EMERGENCY	0	2, 378, 800			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)					92.00
	SPECIAL PURPOSE COST CENTERS					
118.00		279, 640	17, 082, 546			118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0			190. 00
	19100 RESEARCH	0	0			191.00
	19200 PHYSICIANS' PRIVATE OFFICES	0	o			192.00
	07950 OTHER NRCC	0	39, 107			194.00
	07951 SPN	0	0			194.00
	07952 OUTPATI ENT CLINICS	0	0			194.01
	07953 MARKETI NG	0				194.02
		U U	U			1174.03

Heal th	Financial Systems	AS	CENSION ST. VIN	CENT JENNING	5	In Lie	u of Form CMS	-2552-10
RECLAS	SIFICATIONS			Provider (CCN: 15-1303	Peri od:	Worksheet A-	6
						From 07/01/2020		
						To 06/30/2021	Date/Time Pr	
		Increases					11/29/2021 1	: 17 pm
	Cost Center	Line #	Salary	Other				
	2.00	3.00	4,00	5.00				
	A - CAFETERIA	5.00	4.00	5.00				
1.00	CAFETERIA	11.00	0	270, 039				1.00
	TOTALS		— — — o	270, 039				
	B - MEDICAL SUPPLIES				1			1
1.00	MEDI CAL SUPPLI ES CHARGED TO	71.00		21, 570				1.00
	PATI ENTS							
2.00								2.00
3.00								3.00
4.00	L							4.00
			0	21, 570				
	C - OCCUPATIONAL THERAPY RECL							
1.00	OCCUPATI ONAL THERAPY	<u> </u>	29, 699	<u> </u>				1.00
	TOTALS		29, 699	1, 401				
	D - Pandemic Salaries & Benef							
1.00	NURSING ADMINISTRATION	13.00	120	8				1.00
2.00	ADULTS & PEDIATRICS	30.00	2, 758	179				2.00
3.00	PHYSICAL THERAPY	66.00	560	36				3.00
4.00	EMERGENCY	91.00	27	2				4.00
	TOTALS		3, 465	225				
	E - Pandemic Other Expenses							
1.00	CENTRAL SERVICES & SUPPLY	14.00		9, 927				1.00
2.00	HOUSEKEEPING	9.00		4, 561				2.00
3.00	OPERATION_OF_PLANT			<u>6, 301</u>				3.00
500.00			0	20, 789				500.00
500.00	Grand Total: Increases		33, 164	314, 024				500.00

Heal th	Financial Systems	AS	SCENSION ST. VI	CENT JENNING	S	In Lie	u of Form CMS	-2552-10
RECLAS	SIFICATIONS			Provider (CCN: 15-1303	Peri od:	Worksheet A-	6
						From 07/01/2020 To 06/30/2021	Date/Time Pr 11/29/2021 1	epared: :17_pm
		Decreases						
	Cost Center	Line #	Sal ary	Other	Wkst. A-7 Ref			
	6.00	7.00	8.00	9.00	10.00			
	A – CAFETERIA							
1.00	DI ETARY		0	27 <u>0, 0</u> 39		<u>o</u>		1.00
	TOTALS		0	270, 039)			
	B - MEDICAL SUPPLIES							
1.00	ADULTS & PEDIATRICS	30.00		309				1.00
2.00	OPERATING ROOM	50.00		17, 607	r			2.00
3.00	RADI OLOGY – DI AGNOSTI C	54.00		2, 500)			3.00
4.00	EMERGENCY	91.00		1, 154	ŀ			4.00
			0	21, 570)	7		
	C - OCCUPATIONAL THERAPY RECI	LASS						
1.00	PHYSICAL THERAPY	66.00	29, 699	1, 401		0		1.00
	TOTALS		29, 699	1, 401				
	D - Pandemic Salaries & Benet	fits 🛛						
1.00	ADMI NI STRATI VE & GENERAL	5.00	3, 465	225		0		1.00
2.00		0.00	0	C)	0		2.00
3.00		0.00	0	C)	0		3.00
4.00		0.00	0	C)	0		4.00
	TOTALS		3, 465	225)			
	E - Pandemic Other Expenses							
1.00	ADMI NI STRATI VE & GENERAL	5.00		20, 789				1.00
2.00								2.00
3.00								3.00
			0	20, 789				
500.00	Grand Total: Decreases		33, 164	314, 024	+			500.00

Heal th	Health Financial Systems ASCENSION ST. VINCENT JENNINGS In Lieu of Form CMS-2552									
	ILIATION OF CAPITAL COSTS CENTERS		Provider CC	CN: 15-1303		iod: m 07/01/2020				
					То	06/30/2021	Date/Time Pre 11/29/2021 1:	pared:		
				Acqui si ti on	s		11/2/2021 1.			
		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									
1.00	Land	127, 944	0		0	0	0	1.00		
2.00	Land Improvements	539, 256	275		0	275		2.00		
3.00	Buildings and Fixtures	15, 070, 133	0		0	0	-205, 791	3.00		
4.00	Building Improvements	0	0		0	0	0			
5.00	Fixed Equipment	1, 053, 641	0		0	0	-26, 160			
6.00	Movable Equipment	5, 355, 527	975, 013		0	975, 013	0	6.00		
7.00	HIT designated Assets	0	0		0	0	0	7.00		
8.00	Subtotal (sum of lines 1-7)	22, 146, 501	975, 288		0	975, 288	-231, 951	8.00		
9.00	Reconciling Items	0	0		0	0	0	9.00		
10.00	Total (line 8 minus line 9)	22, 146, 501	975, 288		0	975, 288	-231, 951	10.00		
		Endi ng Bal ance	Fully							
			Depreci ated							
			Assets							
		6.00	7.00							
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET									
1.00	Land	127, 944	0					1.00		
2.00	Land Improvements	539, 531	0					2.00		
3.00	Buildings and Fixtures	15, 275, 924	0					3.00		
4.00	Building Improvements	0	0					4.00		
5.00	Fixed Equipment	1, 079, 801	0					5.00		
6.00	Movable Equipment	6, 330, 540	0					6.00		
7.00	HIT designated Assets	0	0					7.00		
8.00	Subtotal (sum of lines 1-7)	23, 353, 740	0					8.00		
9.00	Reconciling Items	0	0					9.00		
10.00	Total (line 8 minus line 9)	23, 353, 740	0					10.00		

Heal th	Financial Systems AS	SCENSION ST. VI	NCENT JENNINGS		In Lieu of Form CMS-2552-			
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider CC		Period: From 07/01/2020 To 06/30/2021		pared:	
			SU	JMMARY OF CAPI	TAL			
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)		
		9.00	10.00	11.00	12.00	13.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2				
1.00	CAP REL COSTS-BLDG & FIXT	432, 829	0	321, 21	1 0	0	1.00	
3.00	Total (sum of lines 1-2)	432, 829	0	321, 21	1 0	0	3.00	
		SUMMARY O	F CAPITAL					
	Cost Center Description	Other	Total (1) (sum	1				
		Capi tal -Rel ate	of cols. 9					
		d Costs (see	through 14)					
		instructions)						
		14.00	15.00					
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	754, 040				1.00	
3.00	Total (sum of lines 1-2)	0	754, 040				3.00	

Health Financial Systems AS	SCENSION ST. VI	NCENT JENNINGS		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C	F	Period: From 07/01/2020 To 06/30/2021	Worksheet A-7 Part III Date/Time Prep 11/29/2021 1:	
	COMI	PUTATION OF RAT	FI OS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col.	Ratio (see instructions)	Insurance	
	1.00	2.00	2)	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE		2.00	3.00	4.00	5.00	
1.00 CAP REL COSTS-BLDG & FIXT	22, 889, 840	0	22, 889, 840	1.000000	0	1.00
3.00 Total (sum of lines 1-2)	22, 889, 840		22, 889, 840			3.00
	ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITA					
Cost Center Description	Taxes	Other Capital-Relate d Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
	6.00	7.00	8,00	9,00	10,00	
PART III - RECONCILIATION OF CAPITAL COSTS CE		7.00	0.00	7.00	10.00	
1.00 CAP REL COSTS-BLDG & FIXT	0	0	0	432, 829	0	1.00
3.00 Total (sum of lines 1-2)	0	0	0	432, 829	0	3.00
		SL	JMMARY OF CAPI	TAL .		
Cost Center Description	Interest	Insurance (see			Total (2) (sum	
		instructions)	instructions)	Capi tal -Rel ate		
				d Costs (see instructions)	through 14)	
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	-					
1.00 CAP REL COSTS-BLDG & FIXT	0				432, 829	1.00
3.00 Total (sum of lines 1-2)	0	0	(0 0	432, 829	3.00

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

ASCENSION ST VINCENT IENNINGS

Heal th	Financial Systems	AS	CENSION ST. VI	NCENT JENNINGS	In Lie	u of Form CMS-2	2552-10
	MENTS TO EXPENSES				Peri od:	Worksheet A-8	
					From 07/01/2020 To 06/30/2021	Date/Time Pre	
				Evenence Classification on	Waskeheet A	11/29/2021 1:	17 pm
				Expense Classification on To/From Which the Amount is			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
1.00		1.00	2.00	3.00	4.00	5.00	1 00
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	В	-317, 198	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL		0	*** Cost Center Deleted ***	2.00	0	2.00
2 00	COSTS-MVBLE EQUIP (chapter 2)	D.	0.010		F 00		2 00
3.00	Investment income - other (chapter 2)	В	-8, 818	ADMI NI STRATI VE & GENERAL	5.00	0	3.00
4.00	Trade, quantity, and time		0		0.00	0	4.00
F 00	discounts (chapter 8)		0		0.00	0	F 00
5.00	Refunds and rebates of expenses (chapter 8)		U		0.00	0	5.00
6.00	Rental of provider space by		0		0.00	0	6.00
7 00	suppliers (chapter 8)		0		0.00	0	7 00
7.00	Telephone services (pay stations excluded) (chapter		U		0.00	0	7.00
	21)						
8.00	Tel evi si on and radio servi ce		0		0.00	0	8.00
9.00	(chapter 21) Parking lot (chapter 21)		0		0.00	0	9,00
10.00	Provi der-based physi ci an	A-8-2	-217, 128		0.00	0	
44 00	adjustment				0.00		44 00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization	A-8-1	2, 191, 839			0	12.00
	transactions (chapter 10)						10.00
	Laundry and linen service Cafeteria-employees and guests	В	U _ 17 _ 71 _	CAFETERI A	0.00 11.00	0	
	Rental of quarters to employee		-47, 742	CALETERIA	0.00	0	
	and others						
16.00	Sale of medical and surgical supplies to other than		0		0.00	0	16.00
	patients						
17.00	Sale of drugs to other than		0		0.00	0	17.00
18.00	patients Sale of medical records and		0		0.00	0	18.00
10.00	abstracts		0		0.00	0	18.00
19.00	Nursing and allied health		0		0.00	0	19.00
	education (tuition, fees, books, etc.)						
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of		0		0.00	0	
	interest, finance or penal ty						
22.00	charges (chapter 21) Interest expense on Medicare		0		0.00	0	22.00
	overpayments and borrowings to		Ū		0.00	Ű	
22.00	repay Medicare overpayments	A 0 0	~		(5.00		22.00
∠3.UU	Adjustment for respiratory therapy costs in excess of	A-8-3	U	RESPI RATORY THERAPY	65.00		23.00
	limitation (chapter 14)						
24.00	Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66.00		24.00
	therapy costs in excess of limitation (chapter 14)						
25.00	Utilization review -		0	*** Cost Center Deleted ***	114.00		25.00
	physicians' compensation						
26.00	(chapter 21) Depreciation - CAP REL		Ω	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
	COSTS-BLDG & FLXT						
27.00	Depreciation - CAP REL		0	*** Cost Center Deleted ***	2.00	0	27.00
28.00	COSTS-MVBLE EQUIP Non-physician Anesthetist		Ω	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	67.00		30.00
	therapy costs in excess of limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
04	instructions)						04 07
31.00	Adjustment for speech pathology costs in excess of	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
	limitation (chapter 14)						
32.00	CAH HIT Adjustment for		0		0.00	0	32.00
33 00	Depreciation and Interest LATE PENALTY FEES	А	- 00	CENTRAL SERVICES & SUPPLY	14.00	0	33.00
55.00			- 7 7	BELLINE SERVICES & SUITER	14.00	U	

 33. 00
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Health Financial Systems	AS	CENSION ST. VI	NCENT JENNINGS	In Lie	u of Form CMS-2	2552-10
ADJUSTMENTS TO EXPENSES			Provider CCN: 15-1303	Peri od:	Worksheet A-8	
				From 07/01/2020 To 06/30/2021		
			Expense Classification of	n Worksheet A	11/29/2021 1.	
			To/From Which the Amount is			
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 CHARI TABLE EXPENSE	A	-33	ADMI NI STRATI VE & GENERAL	5.00	0	33.01
33. 02 ENTERTAI NMENT	A	-766	ADMI NI STRATI VE & GENERAL	5.00	0	33.02
33. 03 ENTERTAI NMENT	A	-89	PHYSI CAL THERAPY	66.00	0	33.03
33.04 PROMOTIONAL ITEMS	A	-622	ADULTS & PEDIATRICS	30.00	0	33.04
33. 05 PROVI DER TAX ADJUSTMENT	A	-957, 038	ADMI NI STRATI VE & GENERAL	5.00	0	33.05
33.06 LOBBYI NG	A		ADMI NI STRATI VE & GENERAL	5.00	0	33.06
33.07 MISC REVENUE	В	-869	ADMI NI STRATI VE & GENERAL	5.00	0	33.07
33.09 MISC REVENUE	В	-9, 027	PHARMACY	15.00	0	33.09
33.12 MISC REVENUE	В	2, 900	RADIOLOGY - DIAGNOSTIC	54.00	0	33.12
33.15 IC PHYSICIAN FUND	A	-353, 047	ADMI NI STRATI VE & GENERAL	5.00		33.15
33.16 PROMOTIONAL ITEMS	A	-2, 149	ADULTS & PEDIATRICS	30.00	0	33.16
50.00 TOTAL (sum of lines 1 thru 49)		279, 640				50.00
(Transfer to Worksheet A,						
column 6 line 200)						

 column 6, line 200.)

 (1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

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

Heal th	Financial Systems	ASCENSION ST. V	INCENT JENNINGS	In Lie	eu of Form CMS-	2552-10
STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME				Peri od:	Worksheet A-8	3-1
OFFICE COSTS				From 07/01/2020 To 06/30/2021		nared
					11/29/2021 1:	
	Line No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost		
					Wks. A, column	
					5	
	1.00	2.00	3.00	4.00	5.00	
		MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED O	RGANI ZATI ONS OR	CLAI MED	
	HOME OFFICE COSTS:		1			
1.00		ADMINISTRATIVE & GENERAL	HOME OFFICE - CAPITAL	266, 173	0	1.00
2.00		ADMINISTRATIVE & GENERAL	HOME OFFICE - INTEREST	4, 805	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE - OTHER	4, 909, 848	2, 995, 033	3.00
3.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	SVH CHARGEBACKS	2, 751	2, 751	3.01
3.02	5.00	ADMINISTRATIVE & GENERAL	SVH CHARGEBACKS	22, 500	22, 500	3.02
3.03	30.00	ADULTS & PEDIATRICS	SVH CHARGEBACKS	235, 037	235, 037	3.03
3.04	15.00	PHARMACY	SVH CHARGEBACKS	17, 500	17, 500	3.04
3.05	54.00	RADIOLOGY - DIAGNOSTIC	SVH CHARGEBACKS	36, 918	36, 918	3.05
3.06	4.00	EMPLOYEE BENEFITS DEPARTMENT	HEALTH INSURANCE	630, 750	624, 704	3.06
3.07	1.00	CAP REL COSTS-BLDG & FIXT	INTEREST EXPENSE	317, 198	321, 211	3.07
3.08	5.00	ADMINISTRATIVE & GENERAL	INTEREST EXPENSE	4, 013	0	3.08
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4).			6, 447, 493	4, 255, 654	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

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

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

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

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

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

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

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

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

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

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

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

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

Health Financial Systems	ASCENSION ST. VINCENT JENNINGS	In Lieu of Form CMS-2552-10		
STATEMENT OF COSTS OF SERVICES FROM RELA OFFICE COSTS	ATED ORGANIZATIONS AND HOME Provider CCN: 15-1303	From 07/01/2020		
		To 06/30/2021 Date/Time Prepared:		

			11/29/2021 1:	<u>17 pili</u>
	Net	Wkst. A-7 Ref.		
	Adjustments			
	(col. 4 minus			
	col. 5)*			
	6.00	7.00		
	A. COSTS INCUR	RED AND ADJUSTN	IENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED	
	HOME OFFICE CO	STS:		
1.00	266, 173	0		1.00
2.00	4,805	0		2.00
3.00	1, 914, 815	0		3.00
3.01	0	0		3.01
3.02	0	0		3. 02
3.03	0	0		3.03
3.04	0	0		3.04
3.05	0	0		3.05
3.06	6,046	0		3.06
3.07	-4,013			3.07
3.08	4,013	0		3.08
4.00	0	0		4.00
5.00	2, 191, 839			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.

Rel ated Organi zati on(s)		
and/or Home Office		
Type of Business		
6.00		
B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

rerinbui	Sement under title Aviii.	
6.00	ADMI NI STRATI ON	6.00
7.00	ADMI NI STRATI ON	7.00
8.00		8.00
9.00		9.00
10.00		10.00
100.00		100.00

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

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

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

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

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

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

Heal th	Fina	anci al	Systems	

ASCENSION ST. VINCENT JENNINGS

In Lieu of Form CMS-2552-10

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COST ALLOCATION - GENERAL SERVICE COSTS		Provi der CC	F	Period: From 07/01/2020 Fo 06/30/2021	Worksheet B Part I Date/Time Pre 11/29/2021 1:	
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPI TAL <u>RELATED COSTS</u> BLDG & FI XT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMI NI STRATI VE & GENERAL	
	0	1.00	4.00	4A	5.00	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FIXT	432, 829					1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	1, 136, 708		1, 136, 708			4.00
5.00 00500 ADMINI STRATI VE & GENERAL	5, 632, 625		79, 715			
7.00 00700 OPERATION OF PLANT	718, 657		(
8.00 00800 LAUNDRY & LINEN SERVICE	31, 424		(
9. 00 00900 HOUSEKEEPI NG	397, 653		(406, 537	205, 594	9.00
10. 00 01000 DI ETARY	68, 266		(,		
11. 00 01100 CAFETERI A	222, 297		(11.00
13.00 01300 NURSING ADMINISTRATION	227, 841	1, 027	69, 124	1 297, 992	150, 701	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	13, 648	7, 201	(20, 849	10, 544	14.00
15. 00 01500 PHARMACY	729, 245	4, 052	59, 892	2 793, 189	401, 132	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	34, 279	(34, 279	17, 336	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	1, 226, 693	40, 607	266, 466	5 1, 533, 766	775, 656	30.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	341, 326	32, 268	63, 660	437, 254	221, 128	50.00
54.00 05400 RADIOLOGY - DIAGNOSTIC	1, 216, 944	26, 150	208, 455	1, 451, 549	734, 077	54.00
60. 00 06000 LABORATORY	1,604,330		5, 744			
65. 00 06500 RESPI RATORY THERAPY	0	0	(0	1
66.00 06600 PHYSI CAL THERAPY	211, 730	15, 361	65, 640	292, 731	148, 040	1
67. 00 06700 OCCUPATI ONAL THERAPY	31, 100		9, 63			
68. 00 06800 SPEECH PATHOLOGY	0		,, 001			
69. 00 06900 ELECTROCARDI OLOGY	0	0	(-		1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	27, 771	0	(-		
72. 00 07200 I MPLANTABLE DEVICES CHARGED TO	11, 421		(
PATI ENTS	11,421		·			
	401 000	0	(0	
76.00 03950 ADULT MENTAL HEALTH	421, 238	0	(421, 238	213, 028	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0)			
91.00 09100 EMERGENCY	2, 378, 800	26, 119	308, 375			
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)				0	1	92.00
SPECIAL PURPOSE COST CENTERS	17 000 544	000 404	4 4 9 4 7 9	1	E (/0.050	110 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 17,082,546	298, 481	1, 136, 708	3 16, 948, 198	5, 662, 859	118.00
NONREI MBURSABLE COST CENTERS		0.000		0.000	1 400	100.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0		(190.00
191.00 19100 RESEARCH	0	-	(191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	(192.00
194.00079500THER NRCC	39, 107		(0,1,10,		
194. 01 07951 SPN	0	86, 082	(194. 01
194. 02 07952 OUTPATIENT CLINICS	0	46, 027	(46, 027		194. 02
194. 03 07953 MARKETI NG	0	0	(0 0	0	194.03
200.00 Cross Foot Adjustments				0		200.00
201.00 Negative Cost Centers		0	(0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	17, 121, 653	432, 829	1, 136, 708	3 17, 121, 653	5, 750, 578	202.00

		SCENSION ST. VI	NCENT JENNINGS		In Lie	u of Form CMS-	2552-10
COST A	ALLOCATION - GENERAL SERVICE COSTS		Provider C	CN: 15-1303	Period: From 07/01/2020 To 06/30/2021	Worksheet B Part I Date/Time Pre 11/29/2021 1:	
	Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPIN	G DI ETARY	CAFETERI A	
		7.00	8.00	9.00	10.00	11.00	
	GENERAL SERVICE COST CENTERS	,					
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT	1, 141, 590					7.00
8.00	00800 LAUNDRY & LINEN SERVICE	1, 512	49, 535				8.00
9.00	00900 HOUSEKEEPI NG	28, 561	31, 424	672, 1			9.00
10.00	01000 DI ETARY	14, 082	0	11, 4	78 134, 945		10.00
11.00	01100 CAFETERI A	29, 019	0		0 0	377, 327	11.00
13.00	01300 NURSING ADMINISTRATION	3, 302	0		0 0	17, 550	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	23, 151	0		0 0	0	14.00
15.00	01500 PHARMACY	13, 028	0	16, 0	15 0	17, 550	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	110, 207	0		0 0	0	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS	· · · · · ·					
30.00	03000 ADULTS & PEDI ATRI CS	130, 554	0	44, 8	43 134, 945	87, 750	30.00
	ANCI LLARY SERVI CE COST CENTERS						
50.00	05000 OPERATI NG ROOM	103, 743	18, 111	268, 5	27 0	35, 100	50.00
54.00	05400 RADI OLOGY - DI AGNOSTI C	84, 072	0			78, 975	
60.00	06000 LABORATORY	35, 065	0			0	
65.00	06500 RESPIRATORY THERAPY	0	0	, .	0 0	0	
66.00	06600 PHYSI CAL THERAPY	49, 385	0	15, 7	49 0	26, 325	
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	
68.00	06800 SPEECH PATHOLOGY	0	0		0 0	0	
69.00	06900 ELECTROCARDI OLOGY	0	0		0 0	0	
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	
72.00	07200 I MPLANTABLE DEVICES CHARGED TO	0	0		0 0	0	
72.00	PATIENTS	0	0		0	0	12.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
76.00	03950 ADULT MENTAL HEALTH	0	0		0 0	0	
70.00	OUTPATIENT SERVICE COST CENTERS	U U	0		0 0	0	70.00
88.00	08800 RURAL HEALTH CLINIC	o	0		0 0	0	88.00
91.00	09100 EMERGENCY	83, 973	0			114, 077	
91.00		83,973	0	218, 3	44 0	114, 077	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
110.00	SPECIAL PURPOSE COST CENTERS	700 (54	40 525	(27.0	104 045		110 00
118.00		709, 654	49, 535	627, 0	06 134, 945	377, 327	118.00
	NONREI MBURSABLE COST CENTERS	7 000			a a		1.00.00
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	7, 200	0		0 0		190.00
	19100 RESEARCH	0	0		0 0		191.00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0		0 0		192.00
	07950 OTHER NRCC	0	0	45, 1			194.00
	07951 SPN	276, 759	0		0 0		194.01
	207952 OUTPATIENT CLINICS	147, 977	0		0 0		194. 02
	3 07953 MARKETI NG	0	0		0 0	0	194. 03
200.00	5						200.00
201.00		0	0		0 0		201.00
202.00) TOTAL (sum lines 118 through 201)	1, 141, 590	49, 535	672, 1	16 134, 945	377, 327	202.00

		SCENSION ST. VII	VCENT JENNINGS			u of Form CMS-	2552-10
	LLOCATION - GENERAL SERVICE COSTS		Provider CC	N: 15-1303	Period: From 07/01/2020 To 06/30/2021	Worksheet B Part I Date/Time Pre 11/29/2021 1:	
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	Subtotal	
		13.00	14.00	15.00	16.00	24.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
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						11.00
13.00	01300 NURSING ADMINISTRATION	469, 545					13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	54, 544				14.00
15.00	01500 PHARMACY	0	0	1, 240, 9	14		15.00
	01600 MEDICAL RECORDS & LIBRARY	0	0		0 161, 822		16.00
	INPATIENT ROUTINE SERVICE COST CENTERS				- i - i - i		1
30.00	03000 ADULTS & PEDIATRICS	192, 148	4, 396		0 4,722	2, 908, 780	1 30. 00
	ANCILLARY SERVICE COST CENTERS	· · ·	· · ·		- · · · · ·	· · ·	
50.00	05000 OPERATI NG ROOM	40, 272	15, 372		0 9,954	1, 149, 461	1 50. OC
	05400 RADI OLOGY - DI AGNOSTI C	0	5, 326		0 45, 473	2, 432, 037	54.00
	06000 LABORATORY	0	0		0 48,047	2, 543, 341	60.00
	06500 RESPI RATORY THERAPY	0	0		0 154	154	1
	06600 PHYSI CAL THERAPY	0	0		0 2,610	534, 840	
	06700 OCCUPATI ONAL THERAPY	0	0		0 193	61, 532	
	06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
	06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	6, 608		0 0	48, 423	71.00
	07200 I MPLANTABLE DEVICES CHARGED TO	0	2, 224		0 0	19, 421	72.00
/ 21 00	PATIENTS				0		/ 2/ 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	o	1, 240, 9	14 0	1, 240, 914	73.00
	03950 ADULT MENTAL HEALTH	0	0	.,,	0 1,897	636, 163	
	OUTPATIENT SERVICE COST CENTERS	-1	-1		.,		
88.00	08800 RURAL HEALTH CLINIC	0	0		0 0	0	88. 00
	09100 EMERGENCY	237, 125	20, 618		0 48, 772	4, 808, 367	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS	· · · · · ·					
118.00		469, 545	54, 544	1, 240, 9	14 161, 822	16, 383, 433	1118.00
	NONREI MBURSABLE COST CENTERS	1					
190.00	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		0 0	10, 571	190. oc
	19100 RESEARCH	0	0		0 0		191.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0		192.00
	07950 OTHER NRCC	0	0		0 0	103, 994	
	07951 SPN	0	0 0		0 0	406, 374	
	07952 OUTPATIENT CLINICS	0	0 0		0 0	217, 281	
	07953 MARKETI NG	0	0		0 0		194.03
194 03	107 7 0 0 1 m m m m m m m m m m m m m m m m m		0		- U		
	Cross Foot Adjustments					0	1200 00
194.03 200.00 201.00	· · · · · · · · · · · · · · · · · · ·	0	0		0 0		200.00

Health Financial Systems	ASCENSION ST. VINC	CENT JENNINGS	In Lieu of Form CMS-	2552-10
COST ALLOCATI ON - GENERAL SERVI CE COSTS		Provider CCN: 15-1303	Period: Worksheet B From 07/01/2020 Part I To 06/30/2021 11/29/2021 1:	
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 & FLXT				1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT				4.00
5. 00 00500 ADMINI STRATI VE & GENERAL				5.00
7.00 00700 OPERATION OF PLANT				7.00
8.00 00800 LAUNDRY & LINEN SERVICE				8.00
9. 00 00900 HOUSEKEEPING				9.00
10. 00 01000 DI ETARY				10.00
11. 00 01100 CAFETERIA				11.00
13.00 01300 NURSING ADMINISTRATION				13.00
14.00 01400 CENTRAL SERVICES & SUPPLY				14.00
15.00 01500 PHARMACY				15.00
16.00 01600 MEDICAL RECORDS & LIBRARY				16.00
INPATIENT ROUTINE SERVICE COST CENTER	S			
30. 00 03000 ADULTS & PEDIATRICS	0	2, 908, 780		30.00
ANCI LLARY SERVI CE COST CENTERS				
50.00 05000 OPERATING ROOM	0	1, 149, 461		50.00
54.00 05400 RADIOLOGY - DIAGNOSTIC	0	2, 432, 037		54.00
60. 00 06000 LABORATORY	0	2, 543, 341		60.00
65. 00 06500 RESPI RATORY THERAPY	0	154		65.00
66.00 06600 PHYSI CAL THERAPY	0	534, 840		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	61, 532		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATI	ENIS O	48, 423		71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO	0	19, 421		72.00
PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	о	1, 240, 914		73.00
76. 00 03950 ADULT MENTAL HEALTH	0	636, 163		76.00
OUTPATIENT SERVICE COST CENTERS	0	030, 103		/0.00
88.00 08800 RURAL HEALTH CLINIC	0	0		88.00
91. 00 09100 EMERGENCY	Ő	4, 808, 367		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT F		.,,		92.00
SPECIAL PURPOSE COST CENTERS				
118.00 SUBTOTALS (SUM OF LINES 1 through	ih 117) 0	16, 383, 433		118.00
NONREI MBURSABLE COST CENTERS				
190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CAI	ITEEN O	10, 571		190.00
191. 00 19100 RESEARCH	0	0		191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		192.00
194.00079500THER NRCC	0	103, 994		194.00
194. 01 07951 SPN	0	406, 374		194.01
194. 02 07952 OUTPATIENT CLINICS	0	217, 281		194. 02
194. 03 07953 MARKETI NG	0	0		194.03
200.00 Cross Foot Adjustments	0	0		200.00
201.00 Negative Cost Centers	0	0		201.00
202.00 TOTAL (sum lines 118 through 20) 0	17, 121, 653		202.00

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		OF	C۸		DEL	ATED	CC

ASCENSION ST. VINCENT JENNINGS

In Lieu of Form CMS-2552-10

Heal th F	inancial Systems AS	SCENSION ST. VI	NCENT JENNINGS		In Lie	eu of Form CMS-:	2552-10
ALLOCATI	ON OF CAPITAL RELATED COSTS		Provider CC		Period: From 07/01/2020 To 06/30/2021	Date/Time Pre	pared:
			CAPI TAL			11/29/2021 1:	17 pm
			RELATED COSTS				
	Cost Center Description	Directly	BLDG & FIXT	Subtotal	EMPLOYEE	ADMI NI STRATI VE	
	cost center bescription	Assigned New	DEDG & TIXI	Subtotal	BENEFITS	& GENERAL	
		Capital			DEPARTMENT	& GENERAL	
		Related Costs			DEFACIMENT		
		0	1.00	2A	4.00	5.00	
GE	ENERAL SERVICE COST CENTERS	0	1.00	20	4.00	5.00	
	0100 CAP REL COSTS-BLDG & FIXT						1.00
	0400 EMPLOYEE BENEFITS DEPARTMENT	0	0		0 0		4.00
	0500 ADMI NI STRATI VE & GENERAL	2, 224	38, 238	40, 46	0	40, 462	5.00
	0700 OPERATION OF PLANT	-167		39, 34		2, 698	
	0800 LAUNDRY & LINEN SERVICE	0	470	47		113	8.00
	0900 HOUSEKEEPING	119		9,00		1, 446	
	1000 DI ETARY	567	4, 380	4, 94		258	
	1100 CAFETERIA	307	9, 026	9, 02		823	•
	1300 NURSI NG ADMI NI STRATI ON	3, 081		9, 02 4, 10		1, 060	
	1400 CENTRAL SERVICES & SUPPLY	3,001	7, 201			74	14.00
	1500 PHARMACY	27.00(7,20			
		27, 996		32, 04			
	1600 MEDICAL RECORDS & LIBRARY	0	34, 279	34, 27	9 0	122	16.00
	NPATIENT ROUTINE SERVICE COST CENTERS	20 (10	10 (07	00.00		E 457	20.00
	3000 ADULTS & PEDIATRICS	39, 618	40, 607	80, 22	5 0	5, 457	30.00
	NCI LLARY SERVI CE COST CENTERS	FF 020	22.240	00.10		1	50.00
	5000 OPERATING ROOM	55, 920		88, 18			
	5400 RADI OLOGY - DI AGNOSTI C	390, 618		416, 76			54.00
	6000 LABORATORY	2, 135	10, 907	13, 04	2 0		60.00
	6500 RESPI RATORY THERAPY	0	0	10.11	0 0	0	65.00
	6600 PHYSI CAL THERAPY	3, 252	15, 361	18, 61		1,042	•
	6700 OCCUPATIONAL THERAPY	0	0		0 0	145	•
	6800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
	6900 ELECTROCARDI OLOGY	0	0		0 0	0	
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2,860	0	2, 86	0 0	99	71.00
72.00 07	7200 IMPLANTABLE DEVICES CHARGED TO	0	0		0 0	41	72.00
70.00	PATIENTS						
	7300 DRUGS CHARGED TO PATIENTS	0			0 0		73.00
	3950 ADULT MENTAL HEALTH	726	0	72	6 0	1, 499	76.00
	UTPATIENT SERVICE COST CENTERS						
	8800 RURAL HEALTH CLINIC	0	0		0 0		
	9100 EMERGENCY	28, 498	26, 119	54, 61		9, 658	•
	9200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
	PECIAL PURPOSE COST CENTERS		000.101	055.00			
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	557, 447	298, 481	855, 92	8 0	39,845	118.00
	ONREI MBURSABLE COST CENTERS						1.00.00
	9000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	2, 239	2, 23			190.00
	9100 RESEARCH	0	0		0 0		191.00
	9200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0		192.00
	7950 OTHER NRCC	0	0		0 0		194.00
194.010		0	86, 082	86, 08			194.01
	7952 OUTPATIENT CLINICS	0	46, 027	46, 02			194. 02
	7953 MARKETI NG	0	0		0 0	0	194. 03
200.00	Cross Foot Adjustments				0		200.00
201.00	Negative Cost Centers		0		0 0		201.00
202.00	TOTAL (sum lines 118 through 201)	557, 447	432, 829	990, 27	6 0	40, 462	202.00

	Financial Systems A: TION OF CAPITAL RELATED COSTS	APITAL RELATED COSTS		Provider CCN: 15-1303		u of Form CMS- Worksheet B Part II Date/Time Pre 11/29/2021 1:	epared:
	Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI N	G DI ETARY	CAFETERI A	
	1	7.00	8.00	9.00	10.00	11.00	
1 00	GENERAL SERVICE COST CENTERS	1					1 4 00
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL	10.010					5.00
7.00	00700 OPERATION OF PLANT	42,043					7.00
8.00	00800 LAUNDRY & LINEN SERVICE	56	639				8.00
9.00	00900 HOUSEKEEPI NG	1,052	405				9.00
10.00	01000 DI ETARY	519	0		03 5, 927		10.00
11.00	01100 CAFETERI A	1,069			0 0	10, 918	
13.00	01300 NURSING ADMINISTRATION	122	0		0 0	508	
14.00	01400 CENTRAL SERVICES & SUPPLY	853	0		0 0	0	
15.00	01500 PHARMACY	480	0	2	84 0	508	
16.00	01600 MEDI CAL RECORDS & LI BRARY	4, 059	0		0 0	0	16.00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1					
30.00	03000 ADULTS & PEDI ATRI CS	4,808	0	79	94 5, 927	2, 539	30.00
	ANCILLARY SERVICE COST CENTERS	1		r			
50.00	05000 OPERATI NG ROOM	3, 821	234			1, 016	
54.00	05400 RADI OLOGY - DI AGNOSTI C	3, 096			77 0	2, 285	
60.00	06000 LABORATORY	1, 291	0	34	45 0	0	
65.00	06500 RESPI RATORY THERAPY	0	0		0 0	0	
66.00	06600 PHYSI CAL THERAPY	1, 819	0	2	79 0	762	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0		0 0	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	
72.00	07200 I MPLANTABLE DEVICES CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
76.00	03950 ADULT MENTAL HEALTH	0	0		0 0	0	76.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0			0 0	0	88.00
91.00	09100 EMERGENCY	3, 093	0	3, 8	68 0	3, 300	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS	1					
118.00		26, 138	639	11, 10	07 5, 927	10, 918	118.00
100.00	NONREI MBURSABLE COST CENTERS	0/5					100.00
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	265	0		0 0		190.00
		0	0		0 0		191.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0		192.00
	07950 OTHER NRCC	0	0		99 0		194.00
	07951 SPN	10, 190			0 0		194.01
194.02	07952 OUTPATIENT CLINICS	5, 450	0		0		194.02
101 00	07953 MARKETI NG	0	0		0 0	0	194.03
200.00	Cross Foot Adjustments	_	_			-	200.00
	Cross Foot Adjustments Negative Cost Centers	0 42,043	0	11, 90	0 0 06 5, 927		200.00 201.00 202.00

Heal th	Financial Systems A	SCENSION ST. VII	NCENT JENNINGS		In Lie	u 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 11/29/2021 1:	
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	Subtotal	
		13.00	14.00	15.00	16.00	24.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4,00
5.00	00500 ADMINI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERI A						11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	5, 798					13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0,770	8, 128				14.00
15.00	01500 PHARMACY	0	0, 120	36, 14	12		15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	0	00, 1	0 38, 460		16.00
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	0	0		00,100		10.00
30, 00	03000 ADULTS & PEDIATRICS	2, 373	655		0 1, 123	103, 901	30.00
00.00	ANCI LLARY SERVICE COST CENTERS	2,010			.,	100,701	
50.00	05000 OPERATI NG ROOM	497	2, 291		0 2,366	104, 726	50.00
54.00	05400 RADI OLOGY - DI AGNOSTI C	0	794		0 10, 810	439, 495	•
60.00	06000 LABORATORY	0	0		0 11, 422	31, 867	
65.00	06500 RESPI RATORY THERAPY	0	0		0 37	37	
66, 00	06600 PHYSI CAL THERAPY	0	0		0 620	23, 135	
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0 46	191	
68.00	06800 SPEECH PATHOLOGY	0	0		0 0	0	
69.00	06900 ELECTROCARDI OLOGY	0	0		0 0	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	985		0 0	3, 944	
72.00	07200 I MPLANTABLE DEVICES CHARGED TO	0	331		0 0	372	
72.00	PATIENTS		001		Ŭ Ŭ	072	12.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	36, 14	12 0	36, 142	73.00
	03950 ADULT MENTAL HEALTH	0	0	00, 1	0 451	2, 676	
	OUTPATIENT SERVICE COST CENTERS	-1	-			_,	
88.00	08800 RURAL HEALTH CLINIC	0	0		0 0	0	88.00
91.00	09100 EMERGENCY	2, 928	3, 072		0 11, 585	92, 121	•
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS						1
118.00		5, 798	8, 128	36, 14	42 38, 460	838, 607	118.00
	NONREI MBURSABLE COST CENTERS						1
190.00	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		0 0	2, 512	190.00
191.00	19100 RESEARCH	0	0		0 0	0	191.00
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0	0	192.00
194.00	07950 OTHER NRCC	0	0		0 0	938	194.00
194.01	07951 SPN	0	0		0 0	96, 578	194.01
194.02	07952 OUTPATIENT CLINICS	0	0		0 0	51, 641	194.02
	07953 MARKETI NG	0	0		0 0	0	194.03
200.00							200.00
201.00		0	0		0 0		201.00
202.00	TOTAL (sum lines 118 through 201)	5, 798	8, 128	36, 14	12 38, 460	990, 276	202.00

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Health Financial Systems	ASCENSION ST. VIN	CENT JENNINGS	In Lieu of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-1303	 Period: Worksheet B From 07/01/2020 Part II Date/Time Pro 11/29/2021 1: 	epared:
Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments 25.00	Total	2 2 2 1	
GENERAL SERVICE COST CENTERS	20100	20100		
1.00 00100 CAP REL COSTS-BLDG & FIXT 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT				1.00 4.00
5. 00 00500 ADMINI STRATI VE & GENERAL				5.00
7.00 00700 OPERATION OF PLANT				7.00
8.00 00800 LAUNDRY & LINEN SERVICE				8.00
9. 00 00900 HOUSEKEEPI NG				9.00
10. 00 01000 DI ETARY				10.00
11. 00 01100 CAFETERI A				11.00
13.00 01300 NURSING ADMINISTRATION				13.00
14.00 01400 CENTRAL SERVICES & SUPPLY				14.00
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	103, 901		30.00
ANCI LLARY SERVI CE COST CENTERS				_
50. 00 05000 OPERATI NG ROOM	0	104, 726		50.00
54.00 05400 RADIOLOGY - DIAGNOSTIC	0	439, 495		54.00
60. 00 06000 LABORATORY	0	31, 867		60.00
65. 00 06500 RESPI RATORY THERAPY	0	37		65.00
66. 00 06600 PHYSI CAL THERAPY	0	23, 135		66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	191		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3, 944		71.00
72.00 07200 I MPLANTABLE DEVICES CHARGED TO	0	372		72.00
PATIENTS				70.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	36, 142		73.00
76.00 03950 ADULT MENTAL HEALTH	0	2, 676		76.00
OUTPATI ENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC	0	0		88.00
91. 00 09100 EMERGENCY	0	92, 121		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	72, 121		92.00
SPECIAL PURPOSE COST CENTERS	<u>Ч</u>			72.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117	7) 0	838, 607		118.00
NONREI MBURSABLE COST CENTERS	<u> </u>	030,007		110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	2, 512		190.00
191. 00 19100 RESEARCH	0	0		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	õ		192.00
194. 00 07950 OTHER NRCC	0	938		194.00
194. 01 07951 SPN	0	96, 578		194.00
194. 02 07952 OUTPATIENT CLINICS	0	51, 641		194.02
194. 03 07953 MARKETI NG	0	0		194.02
200.00 Cross Foot Adjustments	0	0		200.00
201.00 Negative Cost Centers	0	0		201.00
202.00 TOTAL (sum lines 118 through 201)	0	990, 276		202.00
	, y			1

Health Financial Systems A	SCENSION ST. VIN	ICENT JENNINGS		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider C	F	eriod: rom 07/01/2020 o 06/30/2021	Worksheet B-1 Date/Time Pre	pared:
Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFI TS DEPARTMENT (GROSS SALARI ES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	DPERATI ON OF PLANT (SQUARE FEET)	<u>17 pm</u>
	1.00	4.00	5A	5.00	7.00	
GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT	69, 965					1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	09, 905	3, 502, 980				4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL	6, 181	245, 657		11, 371, 075		5.00
7.00 00700 OPERATION OF PLANT	6, 387	0		758, 169	57, 397	7.00
8.00 00800 LAUNDRY & LINEN SERVICE	76	0	C	,	76	
9. 00 00900 HOUSEKEEPING	1,436	0	0	406, 537	1, 436	1
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A	708 1, 459	0		72, 646 231, 323	708 1, 459	
13. 00 01300 NURSI NG ADMI NI STRATI ON	166	213, 019			166	1
14.00 01400 CENTRAL SERVICES & SUPPLY	1, 164	0	C	20, 849	1, 164	
15.00 01500 PHARMACY	655	184, 570			655	1
16. 00 01600 MEDI CAL RECORDS & LI BRARY	5, 541	0	C	34, 279	5, 541	16.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 O3000 ADULTS & PEDI ATRI CS	6, 564	821, 166	C	1, 533, 766	6, 564	30.00
ANCI LLARY SERVICE COST CENTERS	0,001	0217100		1,000,100	0,001	
50.00 05000 OPERATI NG ROOM	5, 216	196, 182			5, 216	
54. 00 05400 RADIOLOGY - DIAGNOSTIC	4,227	642, 395		.,	4, 227	
60. 00 06000 LABORATORY 65. 00 06500 RESPI RATORY THERAPY	1, 763	17, 702		1, 620, 981	1, 763 0	1
66. 00 06600 PHYSI CAL THERAPY	2, 483	202, 281		292, 731	2, 483	1
67. 00 06700 OCCUPATI ONAL THERAPY	0	29, 699	-		0	1
68.00 06800 SPEECH PATHOLOGY	0	0	C	0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0	C	-	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPLANTABLE DEVICES CHARGED TO	0	0		27, 771 11, 421	0	
PATIENTS	0	0		11,421	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	c	0	0	73.00
76.00 03950 ADULT MENTAL HEALTH	0	0	C	421, 238	0	76.00
					0	
88.00 08800 RURAL HEALTH CLINIC 91.00 09100 EMERGENCY	0 4, 222	0 950, 309			0 4, 222	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	4,222	730, 307		2,713,274	4,222	92.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	48, 248	3, 502, 980	-5, 750, 578	11, 197, 620	35, 680	118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP, & CANTEEN	2(2)			2 220	242	100.00
190.00 19000 GTFT, FLOWER, COFFEE SHOP, & CANTEEN 191.00 19100 RESEARCH	362	0				190. 00 191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		-		192.00
194.00 07950 OTHER NRCC	0	0	C	39, 107		194.00
194. 01 07951 SPN	13, 915	0	C	86, 082	13, 915	1
194. 02 07952 OUTPATIENT CLINICS	7,440	0	C	46, 027		194.02
194.03 07953 MARKETING 200.00 Cross Foot Adjustments	0	0		0	0	194. 03 200. 00
201.00 Negative Cost Centers						200.00
202.00 Cost to be allocated (per Wkst. B,	432, 829	1, 136, 708		5, 750, 578	1, 141, 590	
Part I)	4 494945			0.505700	40,0000/7	
203.00 Unit cost multiplier (Wkst. B, Part I)	6. 186365	0. 324497		0. 505720	19.889367	
204.00 Cost to be allocated (per Wkst. B, Part II)		0	1	40, 462	42, 043	204.00
205.00 Unit cost multiplier (Wkst. B, Part		0. 000000		0. 003558	0. 732495	205. 00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207.00 NAHE unit cost multiplier (Wkst. D,						207.00
Parts III and IV)						

)ST AI	LLOCAT	ION - STATISTICAL BASIS		Provider CC		Period: From 07/01/2020 To 06/30/2021	Worksheet B-1 Date/Time Pre	epar
		Cost Center Description	LAUNDRY & LI NEN SERVI CE (I TEMI ZED BI LLS)	HOUSEKEEPI NG (HOURS OF SERVI CE)	DI ETARY (BED DAYS AVAI LABLE)	CAFETERI A (FTES)	11/29/2021 1: NURSI NG ADMI NI STRATI ON (DI RECT NURS.	
			8.00	9.00	10.00	11.00	HRS.) 13.00	+
1	CENER	AL SERVICE COST CENTERS	0.00	9.00	10.00	11.00	13.00	-
00 00 00 00 00 00	00100 00400 00500 00700 00800 00900	CAP REL COSTS-BLDG & FIXT EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL OPERATION OF PLANT LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY	31, 424 19, 935 0		9, 12	25		1 4 5 7 8 9
1.00	01100	CAFETERIA	0	0		0 43		11
3.00	01300	NURSING ADMINISTRATION	0	0		0 2	40, 516	13
1.00	01400	CENTRAL SERVICES & SUPPLY	0	0		0 0	0	14
5.00	01500	PHARMACY	0	60		0 2	0	15
5.00	01600	MEDICAL RECORDS & LIBRARY	0	0		0 0	0	16
	I NPATI	ENT ROUTINE SERVICE COST CENTERS						1
		ADULTS & PEDIATRICS	0	168	9, 12	25 10	16, 580	0 30
		ARY SERVICE COST CENTERS			· · ·			1
		OPERATING ROOM	11, 489	1,006		0 4	3, 475	50
1.00	05400	RADIOLOGY - DIAGNOSTIC	0			0 9	0	
		LABORATORY	0	73		0 0	0	60
		RESPI RATORY THERAPY	0	0		0 0	0	
		PHYSI CAL THERAPY	0	59		0 3	0	
		OCCUPATIONAL THERAPY	0	0		0 0	0	
		SPEECH PATHOLOGY	0	0		0 0	0	
		ELECTROCARDI OLOGY	0	0		0 0	0	
		MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			0	
		IMPLANTABLE DEVICES CHARGED TO	0	0		0 0	0	
	07200	PATIENTS	0	Ŭ		0	0	1 1 2
3. 00	07300	DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73
		ADULT MENTAL HEALTH	0	0		0 0	0	
		FIENT SERVICE COST CENTERS	, <u> </u>			<u> </u>	Ŭ	
		RURAL HEALTH CLINIC	0	0		0 0	0	88
		EMERGENCY	0			0 13		
		OBSERVATION BEDS (NON-DISTINCT PART)	0	010		0 13	20, 401	92
		AL PURPOSE COST CENTERS					<u> </u>	- 74
8.00		SUBTOTALS (SUM OF LINES 1 through 117)	31, 424	2, 349	9, 12	25 43	40, 516	1110
0.00		MBURSABLE COST CENTERS	51,424	2, 347	7,12	-5 45	40, 510	
0 00		GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		0 0	0	190
		RESEARCH	0	0		0 0		190
		PHYSICIANS' PRIVATE OFFICES		0				192
		OTHER NRCC		169		0 0		192
	07951			0				194
		OUTPATIENT CLINICS	0	-		0 0		194
		MARKETING	0	0		0 0		194
0. 00		Cross Foot Adjustments					0	200
0.00		Negative Cost Centers						200
2.00		Cost to be allocated (per Wkst. B,	49, 535	672, 116	134, 94	377, 327	469, 545	
		Part I)						
)3.00)4.00		Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II)	1. 576343 639					
5. 00		Unit cost multiplier (Wkst. B, Part II)	0. 020335	4. 728356	0. 64953	253. 906977	0. 143104	205
06.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206
								1

COST A	Financial Systems AS LLOCATION - STATISTICAL BASIS	SCENSION ST. VI	Provi der CC	N. 1E 1202	In Lieu of Form C Period: Worksheet	
CUSTA	LLUCATION - STATISTICAL DASIS		Provider CC	N. 13-1303	From 07/01/2020 To 06/30/2021 Date/Time 11/29/2021	Prepared:
	Cost Center Description	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S.) 14.00	PHARMACY (COSTED REQUI S.) 15. 00	MEDI CAL RECORDS & LI BRARY (GROSS CHARGES) 16.00		
	GENERAL SERVICE COST CENTERS	1				
11. 00 13. 00	00100 CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	280, 046				1.00 4.00 5.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00
	01500 PHARMACY	200, 040	100			15.00
	01600 MEDICAL RECORDS & LIBRARY	0	0	60, 669, 84	17	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS	22, 570	0	1, 770, 64	17	30.00
50.00	ANCI LLARY SERVI CE COST CENTERS	78, 925	0	3, 732, 34	12	50.00
	05400 RADI OLOGY - DI AGNOSTI C	27, 343	0	17, 050, 39		54.00
	06000 LABORATORY	0	0	18, 015, 44		60.00
	06500 RESPI RATORY THERAPY	0	0	57, 73	36	65.00
	06600 PHYSI CAL THERAPY	0	0	978, 49	90	66.00
	06700 OCCUPATI ONAL THERAPY	0	0	72, 46		67.00
	06800 SPEECH PATHOLOGY	0	0		0	68.00
	06900 ELECTROCARDI OLOGY	0	0		0	69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	33, 930	0		0	71.00
72.00	07200 I MPLANTABLE DEVICES CHARGED TO PATIENTS	11, 421	0		0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	100		0	73.00
	03950 ADULT MENTAL HEALTH	0	0	711, 41	12	76.00
	OUTPATIENT SERVICE COST CENTERS		Letter and the second s	· · · ·		
88.00	08800 RURAL HEALTH CLINIC	0	0		0	88.00
91.00	09100 EMERGENCY	105, 857	0	18, 280, 91	16	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)					92.00
	SPECIAL PURPOSE COST CENTERS				-	
118.00		280, 046	100	60, 669, 84	17	118.00
100.00	NONREI MBURSABLE COST CENTERS		o			100.00
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 19100 RESEARCH	0	0		0	190.00 191.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0	191.00
	07950 OTHER NRCC	0	0		0	194.00
	07951 SPN	0	0		0	194.01
	07952 OUTPATIENT CLINICS	0	0		0	194. 02
	07953 MARKETI NG	0	0		0	194. 03
200.00						200.00
201.00						201.00
202.00	Part I)	54, 544		161, 82		202.00
203.00 204.00	Cost to be allocated (per Wkst. B,	0. 194768 8, 128		0. 00266 38, 46		203.00 204.00
205.00	Part II) Unit cost multiplier (Wkst. B, Part II)	0. 029024	361. 420000	0.00063	34	205.00
206.00						206.00
207.00						207.00

		SCENSION ST. VI	NCENT JENNINGS			u of Form CMS-	2552-10
COMPUTAT	FION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 07/01/2020 To 06/30/2021	Worksheet C Part I Date/Time Pre 11/29/2021 1:	
		_	Title	XVIII	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
11	NPATIENT ROUTINE SERVICE COST CENTERS	-					
30.00 0	3000 ADULTS & PEDIATRICS	2, 908, 780		2, 908, 78	0 0	0	30.00
IA	NCILLARY SERVICE COST CENTERS						
50.00 0	5000 OPERATING ROOM	1, 149, 461		1, 149, 46	1 0	0	50.00
54.00 0	5400 RADIOLOGY - DIAGNOSTIC	2, 432, 037		2, 432, 03	7 0	0	54.00
60.00 0	6000 LABORATORY	2, 543, 341		2, 543, 34	1 0	0	60.00
65.00 0	6500 RESPI RATORY THERAPY	154	0	15	4 0	0	65.00
66.00 0	6600 PHYSI CAL THERAPY	534, 840	0	534, 84	0 0	0	66.00
67.00 0	6700 OCCUPATIONAL THERAPY	61, 532	0	61, 53	2 0	0	67.00
68.00 0	6800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69.00 0	6900 ELECTROCARDI OLOGY	0			0 0	0	69.00
71.00 0	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	48, 423		48, 42	3 0	0	71.00
72.00 0	7200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	19, 421		19, 42	1 0	0	72.00
73.00 0	7300 DRUGS CHARGED TO PATIENTS	1, 240, 914		1, 240, 91	4 0	0	73.00
76.00 0	3950 ADULT MENTAL HEALTH	636, 163		636, 16	3 0	0	76.00
OL	UTPATIENT SERVICE COST CENTERS					_	
88.00 0	8800 RURAL HEALTH CLINIC	0			0 0	0	88.00
91.00 0	9100 EMERGENCY	4, 808, 367		4, 808, 36	7 0	0	91.00
92.00 0	9200 OBSERVATION BEDS (NON-DISTINCT PART)	978, 475		978, 47	5	0	92.00
200.00	Subtotal (see instructions)	17, 361, 908	0	17, 361, 90	8 0	0	200.00
201.00	Less Observation Beds	978, 475		978, 47	5	0	201.00
202.00	Total (see instructions)	16, 383, 433	0	16, 383, 43	3 0	0	202.00

Health Financial Systems A	SCENSION ST. VII	NCENT JENNINGS		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 07/01/2020	Worksheet C Part I	
			T	06/30/2021	Date/Time Pre 11/29/2021 1:	
		Title	XVIII	Hospi tal	Cost	
		Charges				
Cost Center Description	Inpati ent	Outpati ent		Cost or Other	TEFRA	
			+ col. 7)	Ratio	Inpati ent	
	(0.00	Ratio	
	6.00	7.00	8.00	9.00	10.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	4 044 007		4 044 00	-		00.00
30. 00 03000 ADULTS & PEDIATRICS	1, 214, 987		1, 214, 987			30.00
ANCI LLARY SERVI CE COST CENTERS	4 0.50	0 700 000	0.700.046			
50. 00 05000 OPERATING ROOM	4, 252	3, 728, 090			0.00000	50.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	146, 115	16, 904, 276			0.00000	54.00
	406, 333	17, 609, 116			0.000000	
65. 00 06500 RESPIRATORY THERAPY	30, 376	27, 360			0.000000	65.00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	132,037	846, 453			0.000000	66.00 67.00
	27, 924	44, 540	72, 464	0.849139 0.000000	0.000000	67.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	0	0			0.000000	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	99, 095	0 252 704	452.001	0. 000000	0.000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPLANTABLE DEVICES CHARGED TO	99,095	353, 786 54, 982			0.000000	
PATIENTS	0	54, 982	54, 982	0. 353225	0.00000	/2.00
73.00 07300 DRUGS CHARGED TO PATIENTS	309, 700	3, 144, 328	3, 454, 028	0. 359266	0.00000	73.00
76.00 03950 ADULT MENTAL HEALTH	0	711, 412	711, 412	0. 894226	0.00000	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0	0			88.00
91.00 09100 EMERGENCY	66, 171	18, 214, 745			0.00000	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	39, 373	516, 287	555, 660	1. 760924	0.00000	
200.00 Subtotal (see instructions)	2, 476, 363	62, 155, 375	64, 631, 738	3		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	2, 476, 363	62, 155, 375	64, 631, 738	3		202.00

In Lieu of Form CMS-2552-10

	ASCENSION ST. VINC			1 01 F0111 CM3-2552-
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1303	Peri od:	Worksheet C
			From 07/01/2020	Part I
			To 06/30/2021	Date/Time Prepared
		Title XVIII	Hospi tal	<u>11/29/2021 1:17 pr</u> Cost
Cost Center Description	PPS Inpatient			0031
	Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30.
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATI NG ROOM	0. 000000			50.
54.00 05400 RADIOLOGY - DIAGNOSTIC	0. 000000			54.
50. 00 06000 LABORATORY	0. 000000			60.
55. 00 06500 RESPI RATORY THERAPY	0. 000000			65.
56. 00 06600 PHYSI CAL THERAPY	0. 000000			66.
57.00 06700 OCCUPATI ONAL THERAPY	0. 000000			67.
68.00 06800 SPEECH PATHOLOGY	0. 000000			68.
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69.
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71.
72.00 07200 I MPLANTABLE DEVICES CHARGED TO PATIENTS	0. 000000			72.
3.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.
76.00 03950 ADULT MENTAL HEALTH	0. 000000			76.
OUTPATIENT SERVICE COST CENTERS				
38.00 08800 RURAL HEALTH CLINIC				88.
91.00 09100 EMERGENCY	0. 000000			91.
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92.
200.00 Subtotal (see instructions)				200.
201.00 Less Observation Beds				201.
202.00 Total (see instructions)				202.

Heal th Financial	Systems A	SCENSION ST. VI	NCENT JENNINGS		In Lie	u of Form CMS-:	2552-10
COMPUTATION OF I	RATIO OF COSTS TO CHARGES		Provider C		Period: From 07/01/2020 To 06/30/2021	Worksheet C Part I Date/Time Pre 11/29/2021 1:	
			Titl	e XIX	Hospi tal	Cost	
					Costs		
Cos	t Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
I NPATI ENT	ROUTINE SERVICE COST CENTERS						
30.00 03000 ADU	ILTS & PEDI ATRI CS	2, 908, 780		2, 908, 78	0 0	2, 908, 780	30.00
ANCI LLARY	SERVICE COST CENTERS						
50.00 05000 OPE	RATING ROOM	1, 149, 461		1, 149, 46	1 0	1, 149, 461	50.00
	IOLOGY – DIAGNOSTIC	2, 432, 037		2, 432, 03		2, 432, 037	
60.00 06000 LAB		2, 543, 341		2, 543, 34		2, 543, 341	•
	PI RATORY THERAPY	154		15	4 0	154	
	SI CAL THERAPY	534, 840		534, 84		534, 840	
	UPATIONAL THERAPY	61, 532	0	61, 53	2 0	61, 532	
	ECH PATHOLOGY	0	0		0 0	0	
	CTROCARDI OLOGY	0			0 0	0	07100
	ICAL SUPPLIES CHARGED TO PATIENTS	48, 423		48, 42		48, 423	
	PLANTABLE DEVICES CHARGED TO	19, 421		19, 42	1 0	19, 421	72.00
73.00 07300 DRU	IGS CHARGED TO PATIENTS	1, 240, 914		1, 240, 91	4 0	1, 240, 914	73.00
76.00 03950 ADU	ILT MENTAL HEALTH	636, 163		636, 16	3 0	636, 163	76.00
	IT SERVICE COST CENTERS						
	AL HEALTH CLINIC	0			0 0	0	
91.00 09100 EME		4, 808, 367		4, 808, 36	7 0	4, 808, 367	91.00
92.00 09200 OBS	ERVATION BEDS (NON-DISTINCT PART)	978, 475		978, 47	5	978, 475	
	ototal (see instructions)	17, 361, 908				17, 361, 908	
	s Observation Beds	978, 475		978, 47		978, 475	
202.00 Tot	al (see instructions)	16, 383, 433	0	16, 383, 43	3 0	16, 383, 433	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-1303 Period: Worksheet C From 07/01/2020 Part I	
To 06/30/2021 Date/Time F 11/29/2021	
Title XIX Hospital Cos	<u>. 17 pili</u>
Charges	
Cost Center Description Inpatient Outpatient Total (col. 6 Cost or Other TEFRA	
+ col. 7) Ratio Inpatient	
Ratio Ratio	
<u>6.00</u> 7.00 8.00 9.00 10.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	
30.00 O3000 ADULTS & PEDI ATRI CS 1, 214, 987 1, 214, 987	30.00
ANCI LLARY SERVICE COST CENTERS	
50.00 05000 OPERATI NG ROOM 4, 252 3, 728, 090 3, 732, 342 0. 307973 0. 0000	
54.00 05400 RADI OLOGY - DI AGNOSTI C 146, 115 16, 904, 276 17, 050, 391 0. 142638 0. 0000	
60.00 06000 LABORATORY 406, 333 17, 609, 116 18, 015, 449 0. 141176 0. 0000	
65.00 06500 RESPI RATORY THERAPY 30, 376 27, 360 57, 736 0.002667 0.0000	
66.00 06600 PHYSI CAL THERAPY 132, 037 846, 453 978, 490 0. 546597 0. 0000	
67.00 06700 OCCUPATI ONAL THERAPY 27,924 44,540 72,464 0.849139 0.0000	
68.00 06800 SPEECH PATHOLOGY 0 0 0.00000 0.0000	
69. 00 06900 ELECTROCARDI OLOGY 0 0 0. 00000 0. 0000	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 99, 095 353, 786 452, 881 0. 106922 0. 0000	
72. 00 07200 MPLANTABLE DEVICES CHARGED TO 0 54, 982 54, 982 0. 353225 0. 0000	0 72.00
PATI ENTS 73. 00 07300 DRUGS CHARGED TO PATI ENTS 309, 700 3, 144, 328 3, 454, 028 0. 359266 0. 0000	0 73.00
76.00 03950 ADULT MENTAL HEALTH 0 71.412 711.412 0.894226 0.0000	
	/0.00
88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0 0.00000 0.0000	0 88.00
91. 00 09100 EMERGENCY 66, 171 18, 214, 745 18, 280, 916 0. 263027 0. 0000	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 39, 373 516, 287 555, 660 1. 760924 0. 0000	92.00
200.00 Subtotal (see instructions) 2,476,363 62,155,375 64,631,738	200.00
201.00 Less Observation Beds	201.00
202.00 Total (see instructions) 2, 476, 363 62, 155, 375 64, 631, 738	202.00

Health Financial Systems	ASCENSION SI. VIN	CENT JENNINGS	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1303	Peri od: From 07/01/2020 To 06/30/2021	Worksheet C Part I Date/Time Prepared: 11/29/2021 1:17 pm
		Title XIX	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATI NG ROOM	0. 000000			50.00
54.00 05400 RADIOLOGY - DIAGNOSTIC	0. 000000			54.00
60. 00 06000 LABORATORY	0. 000000			60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000			65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000			67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000			68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0. 000000			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.00
76.00 03950 ADULT MENTAL HEALTH	0. 000000			76.00
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	0.000000			88.00
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
· · · · ·				•

Health Financial Systems	ASCENSION ST. VI	NCENT JENNINGS		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS	Provider C		Period: From 07/01/2020 To 06/30/2021	Worksheet D Part II Date/Time Pre 11/29/2021 1:	
		Title	e XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATI NG ROOM	104, 726	3, 732, 342	0. 02805	9 2, 126	60	50.00
54.00 05400 RADIOLOGY – DIAGNOSTIC	439, 495	17, 050, 391	0. 02577	6 34, 284	884	54.00
60. 00 06000 LABORATORY	31, 867	18, 015, 449	0. 00176	9 177, 767	314	60.00
65. 00 06500 RESPI RATORY THERAPY	37	57, 736	0. 00064	1 18, 808	12	65.00
66. 00 06600 PHYSI CAL THERAPY	23, 135	978, 490	0. 02364	4 27, 188	643	66.00
67.00 06700 OCCUPATI ONAL THERAPY	191	72, 464	0. 00263	6 5, 434	14	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0. 00000	0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0. 00000	0 0	0	69.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	3, 944	452, 881	0. 00870	9 46, 677	407	71.00
72.00 07200 I MPLANTABLE DEVICES CHARGED TO	372	54, 982	0. 00676	6 0	0	72.00
PATIENTS						
73.00 07300 DRUGS CHARGED TO PATIENTS	36, 142	3, 454, 028	0. 01046	4 234, 333	2, 452	73.00
76.00 03950 ADULT MENTAL HEALTH	2,676	711, 412	0. 00376	2 0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0	0.00000	0 0	0	88.00
91. 00 09100 EMERGENCY	92, 121	18, 280, 916	0. 00503	9 2, 782	14	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	34, 951	555, 660	0. 06290	0 8, 664	545	92.00
200.00 Total (lines 50 through 199)	769, 657	63, 416, 751		558, 063	5, 345	200. 00

Health Financial Systems AS	SCENSION ST. VI	NCENT JENNINGS		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	S Provider C		Period:	Worksheet D	
THROUGH COSTS				From 07/01/2020 To 06/30/2021		narod
				10 00/ 30/ 2021	11/29/2021 1:	
		Title	× XVIII	Hospi tal	Cost	
Cost Center Description	Non Physician	Nursing School	Nursing Schoo	I Allied Health	Allied Health	
	Anesthetist	Post-Stepdown	-	Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	0		0 0	0	50.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0	0		0 0	0	54.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO	0	0		0 0	0	72.00
PATIENTS	_	_		_	_	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
76.00 03950 ADULT MENTAL HEALTH	0	0		0 0	0	76.00
OUTPATIENT SERVICE COST CENTERS			1			
88. 00 08800 RURAL HEALTH CLINIC	0	0		0 0	0	88.00
91.00 09100 EMERGENCY	0	0		0 0	0	91.00
92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0	_		0	0	92.00
200.00 Total (lines 50 through 199)	0	0	1	0	0	200. 00

Health Financial Systems	ASCENSION ST. VI	NCENT JENNINGS		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	S Provider CO		Period:	Worksheet D	
THROUGH COSTS				From 07/01/2020 To 06/30/2021		narod
				10 00/30/2021	11/29/2021 1:	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	All Other	Total Cost	Total		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)	cols. 2, 3,	8)	7)	
			and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS				-		
50.00 05000 OPERATI NG ROOM	0	0		0 3, 732, 342		
54.00 05400 RADIOLOGY - DIAGNOSTIC	0	0		0 17, 050, 391		
60. 00 06000 LABORATORY	0	0		0 18, 015, 449		
65. 00 06500 RESPI RATORY THERAPY	0	0		0 57, 736		65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 978, 490		
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 72, 464		
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0. 000000	
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0. 000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 452, 881		
72.00 07200 IMPLANTABLE DEVICES CHARGED TO	0	0		0 54, 982	0. 000000	72.00
PATIENTS						
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 3, 454, 028		
76.00 03950 ADULT MENTAL HEALTH	0	0		0 711, 412	0.00000	76.00
OUTPATIENT SERVICE COST CENTERS				-		
88.00 08800 RURAL HEALTH CLINIC	0	0		0 0	0. 000000	
91.00 09100 EMERGENCY	0	0		0 18, 280, 916		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 555, 660		
200.00 Total (lines 50 through 199)	0	0		0 63, 416, 751		200. 00

Health Financial Systems A	SCENSION ST. VIN	ICENT JENNINGS		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SET THROUGH COSTS	RVICE OTHER PASS	Provider CO	CN: 15-1303	Period: From 07/01/2020 To 06/30/2021	Worksheet D Part IV Date/Time Pre	nared [.]
					11/29/2021 1:	
			XVIII	Hospi tal	Cost	
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 000000	2, 126		0 0	0	50.00
54.00 05400 RADIOLOGY – DIAGNOSTIC	0. 000000	34, 284		0 0	0	54.00
60. 00 06000 LABORATORY	0. 000000	177, 767		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	18, 808		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	27, 188		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	5, 434		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	46, 677		0 0	0	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO	0. 000000	0		0 0	0	72.00
PATIENTS						
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	234, 333		0 0	0	73.00
76.00 03950 ADULT MENTAL HEALTH	0. 000000	0		0 0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0. 000000	0		0 0	0	88.00
91.00 09100 EMERGENCY	0. 000000	2, 782		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	8, 664		0 0	0	92.00
200.00 Total (lines 50 through 199)		558, 063		0 0	0	200.00

Health Financial Systems AS	SCENSION ST. VI	NCENT JENNINGS		In Lie	u of Form CMS-2	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 11/29/2021 1:	
		Title	XVIII	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			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1					
50. 00 05000 OPERATI NG ROOM	0. 307973		768, 51		0	50.00
54.00 05400 RADIOLOGY - DIAGNOSTIC	0. 142638		3, 568, 62		0	54.00
60. 00 06000 LABORATORY	0. 141176	0	3, 969, 66		0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 002667	0	17, 12		0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 546597		123, 16		0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 849139		2, 99	7 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 106922	0	64, 86	7 0	0	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO	0. 353225	0	13, 86	8 0	0	72.00
PATIENTS						
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 359266		938, 82		0	
76.00 03950 ADULT MENTAL HEALTH	0. 894226	0	417, 48	2 0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC						88.00
91.00 09100 EMERGENCY	0. 263027	0	2, 963, 17	4 986	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 760924	0	218, 15	1 0	0	92.00
200.00 Subtotal (see instructions)		0	13, 066, 45	9 1, 764	0	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		0	13, 066, 45	9 1, 764	0	202.00

Health Financial Systems AS	SCENSION ST. VI	NCENT JENNINGS		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 11/29/2021 1:	
		Title	XVIII	Hospi tal	Cost	
	Cos					
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCI LLARY SERVI CE COST CENTERS			1			
50. 00 05000 OPERATI NG ROOM	236, 683					50.00
54.00 05400 RADI OLOGY - DI AGNOSTI C	509, 021					54.00
60. 00 06000 LABORATORY	560, 421					60.00
65. 00 06500 RESPI RATORY THERAPY	46					65.00
66. 00 06600 PHYSI CAL THERAPY	67, 322					66.00
67.00 06700 OCCUPATI ONAL THERAPY	2, 545	0				67.00
68.00 06800 SPEECH PATHOLOGY	0	0				68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	6, 936	0				71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO	4, 899	0				72.00
PATIENTS						
73.00 07300 DRUGS CHARGED TO PATIENTS	337, 286					73.00
76.00 03950 ADULT MENTAL HEALTH	373, 323	0				76.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC						88.00
91.00 09100 EMERGENCY	779, 395	259				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	384, 147					92.00
200.00 Subtotal (see instructions)	3, 262, 024	539				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)	3, 262, 024	539				202.00

Health Financial Systems A	SCENSION ST. VI	NCENT JENNINGS		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Period:	Worksheet D	
		Component		From 07/01/2020 To 06/30/2021		narod
		Component	JUN. 15-Z303	10 00/30/2021	11/29/2021 1:	
		Title	XVIII	Swing Beds - SNF		
			Charges		Costs	
Cost Center Description	Cost to Charge			Cost	PPS Services	
		Services (see		Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS		-		-1 -	-	
50. 00 05000 OPERATING ROOM	0. 307973			0 0	0	50.00
54.00 05400 RADI OLOGY - DI AGNOSTI C	0. 142638			0 0	0	54.00
60. 00 06000 LABORATORY	0. 141176			0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 002667			0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 546597			0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 849139			0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000			0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 106922			0 0	0	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO	0. 353225	0		0 0	0	72.00
PATI ENTS 73. 00 07300 DRUGS CHARGED TO PATI ENTS	0. 359266	0		0 0	0	73.00
76. 00 03950 ADULT MENTAL HEALTH	0. 359200			0 0	0	76.00
OUTPATIENT SERVICE COST CENTERS	0. 894220	0		0 0	0	78.00
88. 00 08800 RURAL HEALTH CLINIC						88.00
91. 00 09100 EMERGENCY	0. 263027	0		0 0	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 760924			0 0	0	92.00
200.00 Subtotal (see instructions)	1.700721	0		0 0	-	200.00
201.00 Less PBP Clinic Lab. Services-Program		l		0 0	Ū	200.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		о о		o o	0	202. 00

Health Financial Systems AS	SCENSION ST. VI	NCENT JENNINGS		In Lieu of Form CMS-2552-10			
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-1303	Period: From 07/01/2020	Worksheet D Part V		
		Component	CCN: 15-Z303	To 06/30/2021	Date/Time Pre 11/29/2021 1:		
		Title	e XVIII	Swing Beds - SNF			
	Cos	sts					
Cost Center Description	Cost	Cost	1				
	Reimbursed	Reimbursed					
	Servi ces	Services Not					
	Subject To	Subject To					
	Ded. & Coins.	Ded. & Coins.					
	(see inst.)	(see inst.)					
	6.00	7.00					
ANCI LLARY SERVI CE COST CENTERS							
50.00 05000 OPERATI NG ROOM	0	0				50.00	
54.00 05400 RADIOLOGY - DIAGNOSTIC	0	0				54.00	
60. 00 06000 LABORATORY	0	0				60.00	
65. 00 06500 RESPI RATORY THERAPY	0	0				65.00	
66. 00 06600 PHYSI CAL THERAPY	0	0				66.00	
67.00 06700 OCCUPATI ONAL THERAPY	0	0				67.00	
68.00 06800 SPEECH PATHOLOGY	0	0				68.00	
69. 00 06900 ELECTROCARDI OLOGY	0	0				69.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00	
72.00 07200 I MPLANTABLE DEVICES CHARGED TO	0	0				72.00	
PATIENTS							
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0				73.00	
76.00 03950 ADULT MENTAL HEALTH	0	0				76.00	
OUTPATIENT SERVICE COST CENTERS							
88.00 08800 RURAL HEALTH CLINIC						88.00	
91. 00 09100 EMERGENCY	0	0				91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00	
200.00 Subtotal (see instructions)	0	0				200.00	
201.00 Less PBP Clinic Lab. Services-Program	0					201.00	
Only Charges							
202.00 Net Charges (line 200 - line 201)	0	0				202.00	

Health Financial Systems A	SCENSION ST. VI	NCENT JENNINGS		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COS			Period: From 07/01/2020 To 06/30/2021	Date/Time Pre 11/29/2021 1:	
			e XIX	Hospi tal	Cost	
Cost Center Description	Nursing School Post-Stepdown		Allied Healt Post-Stepdow	Allied Health Cost	All Other Medical	
	Adjustments		Adjustments		Education Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	1	0 0	0	30.00
200.00 Total (lines 30 through 199)	0	0		0 0	0	200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patien	Per Diem (col.	Inpatient	
	Adj ustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,	-			
	instructions)	minus col. 4)				
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	81	0 0.00	13	30.00
200.00 Total (lines 30 through 199)		0	81	0	13	200.00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0					30.00
200.00 Total (lines 30 through 199)	0					200.00

Health Financial Systems AS	SCENSION ST. VI	NCENT JENNINGS		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PAS	S Provider C		Period:	Worksheet D	
THROUGH COSTS				From 07/01/2020		
				To 06/30/2021	Date/Time Pre 11/29/2021 1:	
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Non Physician			I Allied Health		
		Post-Stepdown		Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS		•				
50. 00 05000 OPERATI NG ROOM	0	C		0 0	0	50.00
54.00 05400 RADIOLOGY - DIAGNOSTIC	0	0		0 0	0	54.00
60. 00 06000 LABORATORY	0	0)	0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0)	0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0)	0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0)	0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO	0	0)	0 0	0	72.00
PATIENTS						
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
76.00 03950 ADULT MENTAL HEALTH	0	0		0 0	0	76.00
OUTPATIENT SERVICE COST CENTERS	1			1		
88.00 08800 RURAL HEALTH CLINIC	0	0		0 0	0	88.00
91.00 09100 EMERGENCY	0	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
200.00 Total (lines 50 through 199)	0	0	1	0 0	0	200. 00

Health Financial Systems A	SCENSION ST. VI	NCENT JENNINGS		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	S Provider CO		Period:	Worksheet D	
THROUGH COSTS				From 07/01/2020		norod.
				To 06/30/2021	Date/Time Pre 11/29/2021 1:	
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpatient	(from Wkst. C,		
	Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	cols. 2, 3,	8)	7)	
			and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATI NG ROOM	0	0		0 3, 732, 342		
54.00 05400 RADIOLOGY – DIAGNOSTIC	0	0		0 17, 050, 391		
60. 00 06000 LABORATORY	0	0		0 18, 015, 449		
65. 00 06500 RESPI RATORY THERAPY	0	0		0 57, 736		65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 978, 490		
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 72, 464	0. 000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0.000000	
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0.000000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 452, 881		71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO	0	0		0 54, 982	0.000000	72.00
PATIENTS						
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 3, 454, 028		
76.00 03950 ADULT MENTAL HEALTH	0	0		0 711, 412	0.00000	76.00
OUTPATIENT SERVICE COST CENTERS				-		
88.00 08800 RURAL HEALTH CLINIC	0	0		0 0	0. 000000	
91. 00 09100 EMERGENCY	0	0		0 18, 280, 916		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 555, 660		
200.00 Total (lines 50 through 199)	0	0		0 63, 416, 751		200. 00

Health Financial Systems ASCENSION ST. VINCENT JENNINGS In Lieu of Form CMS-2552-							
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	Provider CO	CN: 15-1303	Period: From 07/01/2020	Worksheet D		
THROUGH COSTS				To 06/30/2021	Part IV Date/Time Pre	nared	
				10 00/ 30/ 2021	11/29/2021 1:		
		Titl	e XIX	Hospi tal	Cost		
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent		
	Ratio of Cost	Program	Program	Program	Program		
	to Charges	Charges	Pass-Through		Pass-Through		
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9		
	7)		x col. 10)		x col. 12)		
	9.00	10.00	11.00	12.00	13.00		
ANCI LLARY SERVI CE COST CENTERS	1 1		r	-			
50.00 05000 OPERATING ROOM	0. 000000	0		0 0	0	50.00	
54.00 05400 RADI OLOGY - DI AGNOSTI C	0. 000000	8, 680		0 0	0	54.00	
60. 00 06000 LABORATORY	0. 000000	21, 130		0 0	0	60.00	
65. 00 06500 RESPI RATORY THERAPY	0. 000000	0		0 0	0	65.00	
66. 00 06600 PHYSI CAL THERAPY	0. 000000	1, 605		0 0	0	66.00	
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	0		0 0	0	67.00	
68.00 06800 SPEECH PATHOLOGY	0. 000000	0		0 0	0	68.00	
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	0		0 0	0	69.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	441		0 0	0	71.00	
72.00 07200 IMPLANTABLE DEVICES CHARGED TO	0. 000000	0		0 0	0	72.00	
PATIENTS							
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	6, 249		0 0	0	73.00	
76.00 03950 ADULT MENTAL HEALTH	0. 000000	0		0 0	0	76.00	
OUTPATIENT SERVICE COST CENTERS							
88.00 08800 RURAL HEALTH CLINIC	0. 000000	0		0 0	0	88.00	
91. 00 09100 EMERGENCY	0. 000000	13, 569		0 0	0	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	9, 407		0 0	0	92.00	
200.00 Total (lines 50 through 199)		61, 081		0 0	0	200. 00	

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In Lieu of Form CMS-2552-10

Heal th	Financial Systems ASCENSION ST. VINC	ENT JENNINGS	In Lie	u of Form CMS-2	2552-10	
COMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-1303	Peri od:	Worksheet D-1		
			From 07/01/2020 To 06/30/2021	Date/Time Pre	pared:	
				11/29/2021 1:		
	Cast Canton Description	Title XVIII	Hospital	Cost		
	Cost Center Description			1.00		
	PART I - ALL PROVIDER COMPONENTS			1.00		
	INPATIENT DAYS					
1.00	Inpatient days (including private room days and swing-bed day			1, 045	1.00	
2.00	Inpatient days (including private room days, excluding swing-			810	2.00	
3.00	Private room days (excluding swing-bed and observation bed da do not complete this line.	nys). If you have only p	rivate room days,	0	3.00	
4.00	Semi-private room days (excluding swing-bed and observation b	ed days)		465	4.00	
5.00	Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	105	5.00	
	reporting period					
6.00	Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	109	6.00	
7.00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roo	m dave) through Decombo	r 21 of the cost	21	7.00	
7.00	reporting period	in days) through becembe	ST OF the cost	21	7.00	
8.00	Total swing-bed NF type inpatient days (including private roo	om days) after December	31 of the cost	0	8.00	
	reporting period (if calendar year, enter 0 on this line)					
9.00	Total inpatient days including private room days applicable t	the Program (excluding	g swing-bed and	288	9.00	
10.00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private	coom dave)	105	10.00	
10.00	through December 31 of the cost reporting period (see instruc		toom days)	105	10.00	
11.00	Swing-bed SNF type inpatient days applicable to title XVIII of	only (including private	room days) after	30	11.00	
	December 31 of the cost reporting period (if calendar year, e					
12.00	Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period	X only (including priva	te room days)	0	12.00	
13.00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including priva	te room days)	0	13.00	
10.00	after December 31 of the cost reporting period (if calendar y			0	10.00	
14.00	Medically necessary private room days applicable to the Progr			0	14.00	
15.00	Total nursery days (title V or XIX only)			0	15.00	
16.00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16.00	
17 00	Medicare rate for swing-bed SNF services applicable to servic	es through December 31	of the cost		17.00	
17.00	reporting period	the organization of the			17.00	
18.00	Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost		18.00	
	reporting period		- · · · ·			
19.00	Medicaid rate for swing-bed NF services applicable to service reporting period	es through December 31 o	r the cost	216.95	19.00	
20.00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of	the cost	216.95	20.00	
	reporting period					
21.00	Total general inpatient routine service cost (see instruction			2, 908, 780		
22.00	Swing-bed cost applicable to SNF type services through Decemb 5×10^{-1} x line 17)	per 31 of the cost repor	ting period (line	0	22.00	
23.00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporti	na period (line 6	0	23.00	
20.00	x line 18)		ig period (inic o	0	20.00	
24.00	Swing-bed cost applicable to NF type services through December	er 31 of the cost report	ng period (line	4, 556	24.00	
05 00	7 x line 19)	04 6 44 4			05 00	
25.00	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reporting	g period (line 8	0	25.00	
26.00	Total swing-bed cost (see instructions)			611, 494	26.00	
27.00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		2, 297, 286		
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT					
28.00	General inpatient routine service charges (excluding swing-be	ed and observation bed c	narges)	0	•	
29.00 30.00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29.00 30.00	
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)	20)		0.00		
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)				33.00	
34.00	Average per diem private room charge differential (line 32 mi	, ,	ctions)		34.00	
35.00	Average per diem private room cost differential (line 34 x li	ne 31)		0. 00 0	35.00 36.00	
36.00 37.00						
57.00	27 minus line 36)	and private room cost u		2, 297, 286	37.00	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1	
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ					
38.00	Adjusted general inpatient routine service cost per diem (see	-		2, 836. 16		
39.00 40.00	Program general inpatient routine service cost (line 9 x line Medically peopsary private room cost applicable to the Progr			816, 814 0		
	Medically necessary private room cost applicable to the Progr Total Program general inpatient routine service cost (line 39			816, 814	•	
				510, 514		

	Financial Systems	ASCENSION ST. VII		CN: 15-1303	Peri od:	u of Form CMS- Worksheet D-1	
					From 07/01/2020 To 06/30/2021	Date/Time Pre	epare
			T: +1 /		llaanital	11/29/2021 1:	17
	Cost Center Description	Total	Total	e XVIII Average Per	Hospital Program Days	Cost Program Cost	
		Inpatient Cost				(col. 3 x col.	
				col. 2)		4)	
		1.00	2.00	3.00	4.00	5.00	1.0
00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Uni	+0					42
00	INTENSIVE CARE UNIT			1			43
00	CORONARY CARE UNIT						44
. 00	BURN INTENSIVE CARE UNIT						45
. 00	SURGICAL INTENSIVE CARE UNIT						46
00							47
	Cost Center Description						
						1.00	
00	Program inpatient ancillary service cost (200		155, 334	
00	Total Program inpatient costs (sum of line PASS THROUGH COST ADJUSTMENTS	es 41 through 48)(see Instructio	ons)		972, 148	3 49
00	Pass through costs applicable to Program i	nnatient routine	services (from	Wkst D su	m of Parts L and	C	50
00		inputriont routine					
. 00	Pass through costs applicable to Program i	npatient ancillar	y services (fr	om Wkst. D, s	sum of Parts II	C	51
	and IV)						
. 00	Total Program excludable cost (sum of line					0	
. 00	Total Program inpatient operating cost exc medical education costs (line 49 minus lin		lated, non-phy	sician anesti	netist, and	C) 53
	TARGET AMOUNT AND LIMIT COMPUTATION	IG JZJ					
. 00	Program di scharges					C	54
. 00	Target amount per discharge					0.00	
. 00	Target amount (line 54 x line 55)					0	56
. 00	Difference between adjusted inpatient oper	ating cost and ta	rget amount (I	ine 56 minus	line 53)	C	
. 00	Bonus payment (see instructions)					C	
. 00	Lesser of lines 53/54 or 55 from the cost	reporting period	ending 1996, ι	updated and co	ompounded by the	0.00	59
. 00	market basket Lesser of lines 53/54 or 55 from prior yea	ar cost report un	dated by the r	narkat haskat		0.00	60
. 00	If line 53/54 is less than the lower of li				the amount by	0.00	
	which operating costs (line 53) are less t					-	
	amount (line 56), otherwise enter zero (se				J		
. 00	Relief payment (see instructions)					C	
. 00	Allowable Inpatient cost plus incentive pa	iyment (see instru	ctions)			0	63
00	PROGRAM INPATIENT ROUTINE SWING BED COST	aata through Daga	mbor 21 of the	anot report	ng pariod (Caa	207 707	64
. 00	Medicare swing-bed SNF inpatient routine c instructions)(title XVIII only)	costs through bece		e cost reporti	ng period (see	297, 797	04
. 00	Medicare swing-bed SNF inpatient routine of	osts after Decemb	er 31 of the d	cost reportin	n period (See	85, 085	65
	instructions)(title XVIII only)			boot ropor tring	g poi i cu (coo	00,000	
. 00	Total Medicare swing-bed SNF inpatient rou	itine costs (line	64 plus line 6	55)(title XVI	ll only). For	382, 882	2 66
	CAH (see instructions)						
. 00	Title V or XIX swing-bed NF inpatient rout	ine costs through	December 31 d	of the cost re	eporting period	0	67
00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient rout	ing costs ofter D	ocombor 21 of	the cost rop	orting pariod	0	
. 00	(line 13 x line 20)	The costs after D	ecember 31 01	the cost rep	si ting period	C	68
. 00	Total title V or XIX swing-bed NF inpatier	nt routine costs (line 67 + line	e 68)		C	69
	PART III - SKILLED NURSING FACILITY, OTHER			,			
. 00	Skilled nursing facility/other nursing fac	cility/ICF/IID rou	tine service o	cost (line 37))		70
. 00	Adjusted general inpatient routine service		ine 70 ÷ line	2)			7
. 00	Program routine service cost (line 9 x lir	,		25			72
. 00	Medically necessary private room cost appl	U U	•	,			73
. 00	Total Program general inpatient routine se	•			Dart II column		74
. 00	Capital-related cost allocated to inpatier 26, line 45)	it routine service	CUSIS (FROM)	NULKSHEEL B, I	artir, column		75
. 00	Per diem capital-related costs (line 75 ÷	line 2)					76
. 00	Program capital -related costs (line 9 x li						7
. 00	Inpatient routine service cost (line 74 mi						78
00	Aggregate charges to beneficiaries for exc	cess costs (from p	rovider record	ls)			79
00	Total Program routine service costs for co	•	ost limitation	n (line 78 min	nus line 79)		80
. 00	Inpatient routine service cost per diem li		、 、				8
00	Inpatient routine service cost limitation	•					8
00	Reasonable inpatient routine service costs	•	5)				8
. 00 . 00	Program inpatient ancillary services (see Utilization review - physician compensation		ns)				8
. 00	Total Program inpatient operating costs (s						8
	PART IV - COMPUTATION OF OBSERVATION BED P						
. 00	Total observation bed days (see instruction					345	8
			Line 2)			2, 836. 16	
. 00	Adjusted general inpatient routine cost pe Observation bed cost (line 87 x line 88) (•	TTHE Z)			978, 475	

Health Financial Systems A	SCENSION ST.	VI NC	ENT JENNINGS		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 Prep 11/29/2021 1:	
			Title	XVIII	Hospi tal	Cost	
Cost Center Description	Cost	R	outine Cost	column 1 ÷	Total	Observati on	
		(f	rom 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	103, 90)1	2, 908, 780	0. 03572	0 978, 475	34, 951	90.00
91.00 Nursing School cost		0	2, 908, 780	0.00000	0 978, 475	0	91.00
92.00 Allied health cost		0	2, 908, 780	0.00000	0 978, 475	0	92.00
93.00 All other Medical Education		0	2, 908, 780	0.00000	0 978, 475	0	93.00

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Heal th	Financial Systems ASCENSION ST. VI	NCENT JENNINGS	In Lie	eu of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-1303	Peri od:	Worksheet D-1	
			From 07/01/2020 To 06/30/2021	Date/Time Pre	
		Title XIX	Hocpital	11/29/2021 1: *	17 pm
	Cost Center Description		Hospi tal	Cost	
				1.00	
	PART I - ALL PROVIDER COMPONENTS				
1 00	INPATIENT DAYS	ave eveluding newhorn)		1, 045	1 00
1.00 2.00	Inpatient days (including private room days and swing-bed d Inpatient days (including private room days, excluding swin			810	1.00 2.00
3.00	Private room days (excluding swing-bed and observation bed		rivate room davs.	0	3.00
	do not complete this line.				
4.00	Semi-private room days (excluding swing-bed and observation			465	4.00
5.00	Total swing-bed SNF type inpatient days (including private reporting period	room days) through Decembe	er 31 of the cost	118	5.00
6.00	Total swing-bed SNF type inpatient days (including private	room days) after December	31 of the cost	96	6.00
0.00	reporting period (if calendar year, enter 0 on this line)			,	0.00
7.00	Total swing-bed NF type inpatient days (including private r	oom days) through December	31 of the cost	21	7.00
0 00	reporting period				0.00
8.00	Total swing-bed NF type inpatient days (including private r reporting period (if calendar year, enter 0 on this line)	oom days) after December .	31 of the cost	0	8.00
9.00	Total inpatient days including private room days applicable	to the Program (excluding	swing-bed and	13	9.00
	newborn days) (see instructions)	0 1 0	, ₀		
10.00	Swing-bed SNF type inpatient days applicable to title XVIII		room days)	0	10.00
11.00	through December 31 of the cost reporting period (see instr Swing-bed SNF type inpatient days applicable to title XVIII		soom dave) after	0	11.00
11.00	December 31 of the cost reporting period (if calendar year,		oom uays) arter	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or		te room days)	0	12.00
	through December 31 of the cost reporting period				
13.00	Swing-bed NF type inpatient days applicable to titles V or			0	13.00
14.00	after December 31 of the cost reporting period (if calendar Medically necessary private room days applicable to the Pro			0	14.00
	Total nursery days (title V or XIX only)	gram (excluding swrng-bed	uays)	0	15.00
	Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to serv	ices through December 31 o	of the cost		17.00
18.00	reporting period Medicare rate for swing-bed SNF services applicable to serv	ices after December 31 of	the cost		18.00
10.00	reporting period		110 0031		10.00
19.00	Medicaid rate for swing-bed NF services applicable to servi	ces through December 31 of	ີ the cost	216. 95	19.00
~~ ~~	reporting period			01/ 05	
20.00	Medicaid rate for swing-bed NF services applicable to servi reporting period	ces after December 31 of 1	ine cost	216.95	20.00
21.00	Total general inpatient routine service cost (see instructi	ons)		2, 908, 780	21.00
22.00	Swing-bed cost applicable to SNF type services through Dece		ting period (line		22.00
	5 x line 17)				
23.00	Swing-bed cost applicable to SNF type services after Decemb x line 18)	er 31 of the cost reportin	ng period (line 6	0	23.00
24.00	Swing-bed cost applicable to NF type services through Decem	ber 31 of the cost reporti	ng period (line	4, 556	24.00
21.00	7 x line 19)		ng period (inne	1,000	21.00
25.00	Swing-bed cost applicable to NF type services after December	r 31 of the cost reporting	g period (line 8	0	25.00
24 00	x line 20) Total aving had anot (and instructions)			(11 404	24 00
26.00 27.00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	t (line 21 minus line 26)		611, 494 2, 297, 286	26.00 27.00
27.00	PRIVATE ROOM DI FFERENTI AL ADJUSTMENT			2,277,200	27.00
28.00	General inpatient routine service charges (excluding swing-	bed and observation bed ch	narges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)			0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	7 (1		0	30.00
31.00 32.00	General inpatient routine service cost/charge ratio (line 2 Average private room per diem charge (line 29 ÷ line 3)	7 ÷ 11he 28)		0. 000000 0. 00	31.00 32.00
33.00	Average semi-private room per diem charge (line 2) + line 3))		0.00	33.00
34.00	Average per diem private room charge differential (line 32	-	ctions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 \boldsymbol{x}			0.00	
36.00	Private room cost differential adjustment (line 3 x line 35		fforontial (1)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cos 27 minus line 36)	i and private room cost di	irerentiai (line	2, 297, 286	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST A	DJUSTMENTS			
38.00	Adjusted general inpatient routine service cost per diem (s	ee instructions)		2, 836. 16	
39.00	Program general inpatient routine service cost (line 9 x li	-		36, 870	
40.00	Medically necessary private room cost applicable to the Pro Total Program general inpatient routine service cost (line			0 36, 870	•
11.00	ista ingram general inpatrent routine service cost (IIIe			30, 070	1 -1.00

	Financial Systems TATION OF INPATIENT OPERATING COST	ASCENSION ST. VI		CN: 15-1303	Peri od:	u of Form CMS- Worksheet D-1	
					From 07/01/2020 To 06/30/2021	Date/Time Pre	
						11/29/2021 1:	
	Cost Center Description	Total	Iit Total	le XIX Average Per	Hospital Program Days	Cost Program Cost	
		Inpati ent Cost		sDiem (col. 1		(col. 3 x col.	
		1.00	2.00	col. 2) 3.00	4.00	<u>4)</u> 5.00	+
00	NURSERY (title V & XIX only)						42
	Intensive Care Type Inpatient Hospital Uni	ts					_
00							43
00 00	CORONARY CARE UNI T BURN INTENSI VE CARE UNI T						44
00	SURGICAL INTENSIVE CARE UNIT						46
	OTHER SPECIAL CARE (SPECIFY)						47
	Cost Center Description						
00	Program inpatient ancillary service cost (What D 2 col 2	Line 200)			<u> </u>	1 48
00 00	Total Program inpatient costs (sum of line			nns)		64, 394	
00	PASS THROUGH COST ADJUSTMENTS		See Ther dett	51137		01,071	- · ·
00	Pass through costs applicable to Program i	npatient routine	services (fro	n Wkst. D, su	n of Parts I and	C	50
00	Pass through costs applicable to Program i and IV)	npatient ancillar	y services (f	rom Wkst. D,	sum of Parts II	C	51
00	Total Program excludable cost (sum of line:	s 50 and 51)				C	52
00	Total Program inpatient operating cost exc		lated, non-ph	ysician anest	netist, and	C	
	medical education costs (line 49 minus line	e 52)					
00	TARGET AMOUNT AND LIMIT COMPUTATION						
00 00	Program discharges Target amount per discharge					0. 00	
00	Target amount (line 54 x line 55)					0.00	
00	Difference between adjusted inpatient oper-	ating cost and ta	rget amount (line 56 minus	line 53)	C	5
00	Bonus payment (see instructions)					C	
00	Lesser of lines 53/54 or 55 from the cost market basket	reporting period	endi ng 1996,	updated and c	ompounded by the	0.00	5
00	Lesser of lines 53/54 or 55 from prior yea	r cost report. up	dated by the	market basket		0.00) 6
00	If line 53/54 is less than the lower of line				the amount by	C	
	which operating costs (line 53) are less t		s (lines 54 x	60), or 1% o	f the target		
~~	amount (line 56), otherwise enter zero (se	e instructions)					
00 00	Relief payment (see instructions)	mont (coo instru	ations)			C	
00	Allowable Inpatient cost plus incentive pa PROGRAM INPATIENT ROUTINE SWING BED COST					C.	10.
00	Medicare swing-bed SNF inpatient routine c	osts through Dece	mber 31 of th	e cost report	ng period (See	C	0 64
	instructions)(title XVIII only)						
00	Medicare swing-bed SNF inpatient routine co	osts after Decemb	er 31 of the	cost reportin	g period (See	C	65
00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient rou	tine costs (line	64 plus line	65)(title XVI	lonly) For	C	66
	CAH (see instructions)						
00	Title V or XIX swing-bed NF inpatient rout	ine costs through	December 31	of the cost r	eporting period	C	67
~~	(line 12 x line 19)			***			
00	Title V or XIX swing-bed NF inpatient rout (line 13 x line 20)	The costs after D	ecemper 31 or	the cost rep	orting period	Ĺ	68
00	Total title V or XIX swing-bed NF inpatien	t routine costs (line 67 + lin	e 68)		C) 69
	PART III - SKILLED NURSING FACILITY, OTHER	NURSING FACILITY	, AND ICF/IID	ONLY			
00	Skilled nursing facility/other nursing fac	5)		70
00 00	Adjusted general inpatient routine service Program routine service cost (line 9 x line		ine /U ÷ line	∠)			7
00	Medically necessary private room cost appl	· ·	(line 14 x l	ine 35)			73
00	Total Program general inpatient routine se	U U	•	,			74
00	Capital-related cost allocated to inpatien	t routine service	costs (from	Worksheet B,	Part II, column		7!
00	26, line 45)	line 2)					_
00 00	Per diem capital-related costs (line 75 ÷ Program capital-related costs (line 9 x li						70
00	Inpatient routine service cost (line 74 mi						78
00	Aggregate charges to beneficiaries for exc		rovi der recor	ds)			79
00	Total Program routine service costs for co	•	ost limitatio	n (line 78 mi	nus line 79)		80
00	Inpatient routine service cost per diem lin		`				8
00 00	Inpatient routine service cost limitation Reasonable inpatient routine service costs	•	· .				8
00	Program inpatient ancillary services (see	•	-,				84
00	Utilization review - physician compensation		ns)				85
00	Total Program inpatient operating costs (s		rough 85)				86
00	PART IV - COMPUTATION OF OBSERVATION BED P					0.45	
00	Total observation bed days (see instruction		line 2)			345 2, 836. 16	
00	Adjusted general inpatient routine cost pe						

Health Financial Systems A	SCENSION ST.	VI NCE	ENT JENNINGS		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 Prep 11/29/2021 1:	
			Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Ro	outine Cost	column 1 ÷	Total	Observati on	
		(fr	rom 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	103, 90)1	2, 908, 780	0. 03572	0 978, 475	34, 951	90.00
91.00 Nursing School cost		0	2, 908, 780	0.00000	0 978, 475	0	91.00
92.00 Allied health cost		0	2, 908, 780	0.00000	0 978, 475	0	92.00
93.00 All other Medical Education		0	2, 908, 780	0.00000	0 978, 475	0	93.00

Health Financial Systems ASCENSION ST. VINCE	ENT JENNINGS		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CO		Period: From 07/01/2020 To 06/30/2021	Date/Time Pre	pared:
				11/29/2021 1:	17 pm
	Title	XVIII	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS			434, 370		30.00
ANCI LLARY SERVI CE COST CENTERS		<u> </u>	101,070		00.00
50, 00 05000 OPERATI NG ROOM		0, 30797	3 2, 126	655	50.00
54.00 05400 RADI OLOGY - DI AGNOSTI C		0. 14263			54.00
60. 00 06000 LABORATORY		0. 14117	6 177, 767	25, 096	60.00
65. 00 06500 RESPI RATORY THERAPY		0. 00266	7 18, 808	50	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 54659	7 27, 188	14, 861	66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0.84913	9 5, 434	4, 614	67.00
68.00 06800 SPEECH PATHOLOGY		0.00000	0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY		0.00000	0 0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 10692	2 46, 677	4, 991	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS		0. 35322	5 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 35926		84, 188	
76.00 03950 ADULT MENTAL HEALTH		0. 89422	6 0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC		0.00000		0	00.00
91. 00 09100 EMERGENCY		0. 26302			
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 76092			
200.00 Total (sum of lines 50 through 94 and 96 through 98)			558, 063		
201.00 Less PBP Clinic Laboratory Services-Program only charges	s (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)			558, 063		202.00

Health Financial Systems ASCENSION ST. VINCE				eu of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CO	CN: 15-1303	Peri od:	Worksheet D-3	3
	Component (CCN: 15-Z303	From 07/01/2020 To 06/30/2021		narod
	Component	30N. 13-2303	10 00/30/2021	11/29/2021 1:	17 pm
	Title	XVIII	Swing Beds - SNI		
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	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS				1	
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
ANCI LLARY SERVI CE COST CENTERS		0.0070	70 0.10/	/	50.00
50. 00 05000 OPERATI NG ROOM 54. 00 05400 RADI OLOGY - DI AGNOSTI C		0. 3079 0. 1426			
60. 00 06000 LABORATORY		0. 1426			
65. 00 06500 RESPIRATORY THERAPY		0. 1411			1
66. 00 06600 PHYSI CAL THERAPY		0. 5465			
67. 00 06700 OCCUPATI ONAL THERAPY		0. 8491			
68. 00 06800 SPEECH PATHOLOGY		0.0000		0	1
69. 00 06900 ELECTROCARDI OLOGY		0.0000		0	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0, 1069		-	71.00
72. 00 07200 I MPLANTABLE DEVICES CHARGED TO PATIENTS		0. 3532		0	
73.00 07300 DRUGS CHARGED TO PATIENTS		0.3592		14, 015	
76.00 03950 ADULT MENTAL HEALTH		0.8942		0	
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC		0.0000	00	0	88.00
91. 00 09100 EMERGENCY		0. 26302	27 672	177	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 76092	24 C	0	92.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)			160, 365	63, 909	200.00
201.00 Less PBP Clinic Laboratory Services-Program only charges	5 (line 61)		C		201.00
202.00 Net charges (line 200 minus line 201)			160, 365	j l	202.00

Health Financial Systems ASCENSION ST. VINC	ENT JENNINGS		In Lie	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CO		Period: From 07/01/2020		
			To 06/30/2021	Date/Time Pre 11/29/2021 1:	
	Titl	e XIX	Hospi tal	Cost	
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	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1	-		
30. 00 03000 ADULTS & PEDI ATRI CS			47, 957		30.00
ANCI LLARY SERVI CE COST CENTERS			-	-	
50. 00 05000 OPERATI NG ROOM		0. 30797			
54. 00 05400 RADI OLOGY - DI AGNOSTI C		0. 14263			•
60. 00 06000 LABORATORY		0. 14117			•
65. 00 06500 RESPI RATORY THERAPY		0. 00266		-	
66. 00 06600 PHYSI CAL THERAPY		0. 54659			66.00
67.00 06700 OCCUPATI ONAL THERAPY		0.84913		0	67.00
68.00 06800 SPEECH PATHOLOGY		0.00000		0	68.00
69.00 06900 ELECTROCARDI OLOGY		0.00000		0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 10692		47	
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS		0. 35322		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 35926			•
76.00 03950 ADULT MENTAL HEALTH		0. 89422	6 0	0	76.00
OUTPATIENT SERVICE COST CENTERS			-	-	
88.00 08800 RURAL HEALTH CLINIC		0.00000		-	
91.00 09100 EMERGENCY		0. 26302			
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 76092			
200.00 Total (sum of lines 50 through 94 and 96 through 98)			61, 081		
201.00 Less PBP Clinic Laboratory Services-Program only charges	s (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)		l	61, 081	I	202.00

3.00 OPFS payment Size instructions) 0		Financial Systems ASCENSION ST. VINCENT J	ENNINGS vider CCN: 15-1303	In Lie Period: From 07/01/2020 To 06/30/2021		pared:
Dest 6. UPTICAL AND OTHER HEAT LESENCES 3,725,553 1.0 Weld all and other services reinbursed under OPPS (see Instructions) 3,725,553 1.0 200 Weld all and other services reinbursed under OPPS (see Instructions) 0.0 2.0 201 Determine the object all generation services reinbursed under OPPS (see Instructions) 0.0 0.0 0.0 Differ the object all generation services reinbursed under OPPS (see Instructions) 0.0 0.0 0.0 Differ the object all generation services reinbursed under OPPS (see Instructions) 0.0 0.0 0.0 Differ the object all generation services reinbursed under OPPS (see Instructions) 0.0 0.0 0.0 Differ the object all generation services on a charged set one 0.0 0.0 0.0 Differ the object all generation charges 0.0 0.0 0.0 0.0 Differ the object all generation charges 0.0 0.0 0.0 0.0 0.0 Differ the object all generation charges 0.0			Title XVIII	Hospi tal	Cost	
1.00 Medical and other services (relearned under OPF) (see instructions) 3.262,583 1.0 3.00 OPFS payments 0.0 2.00 3.00 OPFS payments 0.0 2.00 3.00 OPFS payments 0.0 2.00 3.00 OPFS payments 0.00 2.00 3.00 OPFS payments 0.00 5.00 5.00 Finter the hospital specific payment to cost ratil (see instructions) 0.00 0.00 7.00 Sam of lines 1, 4, and 4.01, divided by line 8 0.00 0.00 7.00 Sam of lines 1, 4, and 4.01, divided by line 8 0.00 0.00 7.00 Anci liney sorvice other pass through costs from Nist. 0, Pt. IV, col. 13, line 200 0 0.00 7.00 Anci liney sorvice other pass through costs from Nist. 0, Pt. IV, col. 13, line 200 0 10.00 7.00 Cost (can of lines 1 and 150 Cost (can of lines 1 and 150 10.00 7.00 Roti or lines 1 and 10.00 0 12.00 7.00 Cost (can of lines 1 and 150 Cost (can of lines 1 and 150 0 7.00 Roti or line 50 (cost instructions) 0 14.00 7.00 Roti or line 50 (cost instructions) 0 14.00 7.00 Roti or line 50 (cost instructions) </td <td></td> <td></td> <td></td> <td></td> <td>1.00</td> <td></td>					1.00	
2.00 Weak call and other services rel insurants under dive's (see instructions) 0 2.00 0.00 Open payments 0	1 00				3 262 563	1 00
4.00 Outlier payment (see instructions) 0)			2.00
4.0 Outlier reconsiliation amount (see instructions) 0						3.00
5.00 Enter the hospital specific payment to cost ratio (see instructions) 0.000 5.00 6.01 Line 2 times Line 3 4. and 4.01. divided by Line a 0.000 5.00 7.00 Sam of Lines 3. 4. and 4.01. divided by Line a 0.00 5.00 0.00 5.00 7.00 Sam of Lines 3. 4. and 4.01. divided by Line a 0.00 5.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td>4.00</td>						4.00
2.00 Sum of lines 3, 4, and 4.01, alivided by line 6 0.00 7.00 0.00			s)		-	
8.00 Transitional corridor payerits (see Instructions) 0						6.00
9.00 And Harry service other pass through casts from Wist. D. Pt. IV. col. 13. Hine 200 0 0 0 0 0 0.00 0 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td></td<>						
10.00 Organ acquisitions 0 10.00 10.00 Total cost (sum of lines 1 and 10) (see instructions) 2.222.63 11.0 10.00 Cost (sum of lines 1 and 10) (see instructions) 2.222.63 11.0 10.00 Cost (sum of lines 1 and 10) (see instructions) 0.10.0 12.00 11.00 Cost (sum of lines 1 and 10) (see instructions) 0.10.0 12.00 11.00 Cost (sum of lines 1 and 10) (see instructions) 0.10.0 12.00 11.00 Cost (sum of lines 1 and 10) (see instructions) 0.10.0 12.00 11.00 Cost (sum of lines 1 and 10) (see instructions) 0.00000 17.0 11.00 Cost (sum of lines 1 and 10) (see instructions) 0.00000 17.0 11.00 Cost (sum of lines 2, 4.0, 1.0, 8.000) 17.00 0.000000 17.0 11.01 Cost of physic (see instructions) 3.275.18 21.0 17.00 0.00000 17.0 11.01 Cost of physic (see instructions) 3.275.18 21.0 21.0 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00<			ol. 13, line 200			
COMPUTATION OF LESSER OF COST OR ChaRGES Name 12.00 Ancillary service charges 12.01 Organ acquisit in charges (sem of lines 12 and 13) 14.00 Total reasonable charges (sem of lines 12 and 13) 15.01 Argangle anconi, actually coll sector fore payment for services on a charge basis 16.02 Areants that would have been realized from patients liable for payment for services on a charge basis 16.02 Batio of line 15 to line 16 (not to exceed 1.000000) 16.03 Batio of line 15 to line 16 (not to exceed 1.000000) 10.01 Catactemery charges (see instructions) 10.01 Description (sem of control cattemery charges (see instructions) 10.01 Exercise of cost or charges (see instructions) 10.01 Exercise of cost or charges (see instructions) 10.01 Description (for dimers catter) of hospital (see instructions) 10.01 Description (for dimers catter) (for dimers catter) 10.01 Description (for dimers catter) 10.01 Description (for dimers catter) 10.02 Description (for dimers catter) 10.01 Description (for dimers catter) 10.02 Description (for dime						10.00
Reacting acquisition charges 12.0 12.00 Ancil lary service charges 11.00 13.00 Organ acquisition charges (from West. D-4, Pt. 111, col. 4, line 69) 0 13.00 15.00 Castcharry charges (sum of lines 12 and 13) 0 14.00 15.00 Castcharry charges (sum of lines 12 and 24 from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFE 431.31(e) 15.00 16.00 Total customary charges (sum of line 15 to the cased. 1000000) 0.000000 T.00 16.00 18.00 Total customary charges (sum of line 16, not exceed. 1000000) 0.000000 T.00 18.00 19.00 Excess of customary charges (sum of lines 3, 4.4, 4.0, 8 and 9) 0 20.0 20.01 Lesser of cost or charges (see Instructions) 3.295, 189 21.00 21.00 Lesser of cost or charges (see Instructions) 0 22.0 22.0 21.00 Lesser of cost or charges (see Instructions) 0 22.0 22.0 22.0 22.00 Dotatin (see Instructions) 0 24.0 22.4 22.0 22.0 22.0 22.0 22.0	11.00				3, 262, 563	11.00
12.00 Ancillary service charges 0 12.00 Total reasonable charges (can of lines 12 and 13) 0 14.00 0 14.00 13.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 15.00 15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 15.00 15.00 Restrict that would have been realized from patients liable for payment for services on a charge basis 0 15.00 16.00 Nation of line 15 to line 16 (not to exceed 1.00000) 0 16.00 0 16.00 17.00 Excess of customary charges (see instructions) 0 0 16.00 0 16.00 0 16.00 0 16.00 0 16.00 0 16.00 0 16.00 0 16.00 0 16.00 0 16.00 0 16.00 0 16.00 0 16.00 0 0 16.00 0 16.00 0 0 16.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						
14. 00 Iotal reasonable charges (sum of lines 12 and 13) 0 14. 00 05. 00 Aggregate amount actually collected from patients Liable for payment for services on a charge basis 0 15. 00 15. 00 Aggregate amount actually collected from patients Liable for payment for services on a charge basis 0 15. 00 16. 00 Amount Stat would have been realized from patients Liable for payment for services on a charge basis 0 15. 00 17. 00 Excess of customary charges (see instructions) 0 0.000000 17. 00 18. 00 Icationary charges (see instructions) 3. 295, 18 27. 00 18. 00 21. 00 Lesser of cost or charges (see instructions) 3. 295, 18 27. 00 27. 00 21. 00 Lesser of cost or charges (see instructions) 0 28. 00 28	12.00				0	12.00
Customary charges Control 15:00 Aggregate amount actually collected from patients liable for payment for services on a charge basis Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e) 0 15:00 16:00 Ratio of line 15 to line 16 (not to exceed 1.000000) 0 </td <td></td> <td></td> <td>9)</td> <td></td> <td>-</td> <td>13.00</td>			9)		-	13.00
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38.00MSP-LCC reconciliation amount from PS&R38.0039.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)039.50Pioneer ACO demonstration payment adjustment (see instructions)39.5039.97Demonstration payment adjustment amount before sequestration039.98Partial or full credits received from manufacturers for replaced devices (see instructions)039.99RECOVERY OF ACCELERATED DEPRECIATION039.99RECOVERY OF ACCELERATED DEPRECIATION1,931,36740.00Subtotal (see instructions)1,931,36740.01Sequestration adjustment (see instructions)040.02Demonstration payments2,359,63941.00Interim payments2,359,63941.00Interim payments-PARHM41.0142.00Tentative settlement (for contractors use only)42.0043.00Bal ance due provi der/program (see instructions)-428,27243.00Bal ance due provi der/program (see instructions)43.0044.00Protested amounts (nonaliowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.243.0090.00Original outlier amount (see instructions)090.0091.00Outlier reconciliation adjustment amount (see instructions)092.00The rate used to calculate the Time Value of Money0.0092.00Time Value of Money (see instructions)091.0092.00Time Value of Money (see instructions)092.0093.00Time Value of Money (see instructions)		5	ons)			
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39. 97Demonstration payment adjustment amount before sequestration039. 9739. 98Partial or full credits received from manufacturers for replaced devices (see instructions)039. 9739. 99RECOVERY OF ACCELERATED DEPRECIATION039. 9740. 00Subtotal (see instructions)1, 931, 36740. 0040. 01Sequestration adjustment (see instructions)040. 0040. 02Demonstration payment adjustment amount after sequestration040. 0040. 03Sequestration adjustment-PARHM pass-throughs040. 0041. 01Interim payments2, 359, 63941. 0041. 01Interim payments-PARHM2, 359, 63941. 0042. 01Tentative settlement (for contractor use only)42. 0143. 01Bal ance due provi der/program (see instructions)-428, 27243. 01Bal ance due provi der/program (see instructions)-428, 27243. 01Bal ance due provi der/program (see instructions)44. 0044. 00Protested amount (see instructions)-428, 27243. 01Demonal outlier amount (see instructions)044. 00Original outlier amount (see instructions)090. 00Original outlier amount (see instructions)091. 00Outlier reconciliation adjustment amount (see instructions)092. 00The rate used to calculate the Time Value of Money0. 0093. 00Time Value of Money (see instructions)093. 00						39.00
39.98Partial or full credits received from manufacturers for replaced devices (see instructions)039.9439.99RECOVERY OF ACCELERATED DEPRECIATION039.9440.00Subtotal (see instructions)1,931,36740.0040.01Sequestration adjustment (see instructions)040.0140.03Demonstration payment adjustment amount after sequestration040.0241.00Interim payments2,359,63941.0041.01Interim payments-PARHM20.01Tentative settlement (for contractors use only)042.0042.01Tentative settlement (for contractor use only)042.0042.0043.00Balance due provider/program (see instructions)-428,27243.0044.00Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.2090.0090.00Original outlier amount (see instructions)090.0091.00Outlier reconciliation adjustment amount (see instructions)090.0092.00The rate used to calculate the Time Value of Money0.0092.0093.00Time Value of Money (see instructions)093.00						39.50
39.99RECOVERY OF ACCELERATED DEPRECIATION039.9940.00Subtotal (see instructions)1,931,36740.0040.01Sequestration adjustment (see instructions)040.0040.02Demonstration payment adjustment amount after sequestration040.0040.03Sequestration adjustment-PARHM pass-throughs40.0041.00Interim payments2,359,63941.0041.01Interim payments-PARHM2,359,63941.0042.00Tentative settlement (for contractors use only)042.0043.00Balance due provider/program (see instructions)-428,27243.0043.01Balance due provider/program-PARHM (see instructions)-428,27243.0044.00Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, st15.2090.0090.00Original outlier amount (see instructions)090.0091.00Outlier reconciliation adjustment amount (see instructions)091.0092.00The rate used to calculate the Time Value of Money0.0092.0093.00Time Value of Money (see instructions)093.00			avicas (sea instruc	tions)		
40.01Sequestration adjustment (see instructions)40.0140.02Demonstration payment adjustment amount after sequestration40.0140.03Sequestration adjustment-PARHM pass-throughs40.0141.00Interim payments2,359,63941.01Interim payments-PARHM41.0142.00Tentative settlement (for contractors use only)42.0142.01Tentative settlement -PARHM (for contractor use only)42.0143.00Balance due provider/program (see instructions)-428,27243.01Balance due provider/program-PARHM (see instructions)-428,27243.01Balance due provider/program-PARHM (see instructions)43.0144.00Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,090.00Original outlier amount (see instructions)091.00Outlier reconciliation adjustment amount (see instructions)092.00The rate used to calculate the Time Value of Money0.0093.00Time Value of Money (see instructions)093.00		· · · · · · · · · · · · · · · · · · ·				39.99
40.02Demonstration payment adjustment amount after sequestration040.0340.03Sequestration adjustment-PARHM pass-throughs40.0341.00Interim payments2,359,63941.0041.01Interim payments-PARHM2,359,63941.0042.00Tentative settlement (for contractors use only)042.0042.01Tentative settlement (for contractor use only)042.0043.00Balance due provider/program (see instructions)-428,27243.0043.01Balance due provider/program -PARHM (see instructions)-428,27243.0044.00Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.2090.0090.00Original outlier amount (see instructions)090.0091.00Outlier reconciliation adjustment amount (see instructions)091.0092.00The rate used to calculate the Time Value of Money0.0092.0093.00Time Value of Money (see instructions)093.00						
40.03Sequestration adjustment-PARHM pass-throughs40.0341.00Interim payments2,359,63941.01Interim payments-PARHM41.0142.00Tentative settlement (for contractors use only)41.0142.01Tentative settlement (for contractor use only)42.0143.00Bal ance due provider/program (see instructions)-428,27243.01Bal ance due provider/program (see instructions)-428,27244.00Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.2090.00Original outlier amount (see instructions)091.00Outlier reconciliation adjustment amount (see instructions)092.00The rate used to calculate the Time Value of Money0.0093.00Time Value of Money (see instructions)093.00Time Value of Money (see instructions)093.00Time Value of Money (see instructions)0						
41.00Interim payments2,359,63941.0041.01Interim payments-PARHM41.0142.00Tentative settlement (for contractors use only)042.0042.01Tentative settlement-PARHM (for contractor use only)042.0043.00Balance due provider/program (see instructions)-428,27243.0143.01Balance due provider/program-PARHM (see instructions)-428,27243.0144.00Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2044.0090.00Original outlier amount (see instructions)090.0091.00Outlier reconciliation adjustment amount (see instructions)091.0092.00The rate used to calculate the Time Value of Money0.0092.0093.00Time Value of Money (see instructions)093.00					0	40.02
42.00 Tentative settlement (for contractors use only) 0 42.00 42.01 Tentative settlement-PARHM (for contractor use only) 42.01 43.00 Balance due provider/program (see instructions) -428,272 43.00 43.01 Balance due provider/program-PARHM (see instructions) -428,272 43.01 44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 §115.2 TO BE COMPLETED BY CONTRACTOR 0 90.00 90.00 90.00 Original outlier amount (see instructions) 0 90.00 91.00 91.00 Outlier reconciliation adjustment amount (see instructions) 0 91.00 91.00 92.00 The rate used to calculate the Time Value of Money 0.00 92.00 93.00 93.00					2, 359, 639	
42.01 Tentative settlement-PARHM (for contractor use only) 42.01 43.00 Balance due provider/program (see instructions) -428,272 43.01 Balance due provider/program-PARHM (see instructions) -428,272 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 90.00 Original outlier amount (see instructions) 0 91.00 Outlier reconciliation adjustment amount (see instructions) 0 92.00 The rate used to calculate the Time Value of Money 0.00 93.00 Time Value of Money (see instructions) 0		1 3				41.01
43.00 Balance due provider/program (see instructions) -428,272 43.00 43.01 Balance due provider/program-PARHM (see instructions) -428,272 43.00 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 90.00 Original outlier amount (see instructions) 0 90.00 91.00 Outlier reconciliation adjustment amount (see instructions) 0 91.00 92.00 The rate used to calculate the Time Value of Money 0.00 92.00 93.00 Time Value of Money (see instructions) 0 93.00					0	42.00
44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.2 0 44.00 90.00 Original outlier amount (see instructions) 0 90.00 90.00 91.00 Outlier reconciliation adjustment amount (see instructions) 0 91.00 91.00 92.00 The rate used to calculate the Time Value of Money 0.00 92.00 93.00 93.00					-428, 272	
§115. 2 TO BE COMPLETED BY CONTRACTOR 90. 00 Original outlier amount (see instructions) 0 90. 00 91. 00 Outlier reconciliation adjustment amount (see instructions) 0 91. 00 92. 00 The rate used to calculate the Time Value of Money 0.00 92. 00 93. 00 Time Value of Money (see instructions) 0 93. 00					-	43.01
TO BE COMPLETED BY CONTRACTOR90.00Original outlier amount (see instructions)090.0091.00Outlier reconciliation adjustment amount (see instructions)091.0092.00The rate used to calculate the Time Value of Money0.0092.0093.00Time Value of Money (see instructions)093.00	44.00		ιτη CMS Pub. 15-2,	cnapter 1,	0	44.00
90.00Original outlier amount (see instructions)090.0091.00Outlier reconciliation adjustment amount (see instructions)091.0092.00The rate used to calculate the Time Value of Money0.0092.0093.00Time Value of Money (see instructions)093.00					I	
92.00The rate used to calculate the Time Value of Money0.0092.0093.00Time Value of Money (see instructions)093.00		Original outlier amount (see instructions)				
93.00 Time Value of Money (see instructions) 0 93.00						
		5				
	94.00	Total (sum of lines 91 and 93)			0	94.00

ANALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC	CN: 15-1303	Period: From 07/01/2020 To 06/30/2021		pared: 17 pm
		Title	XVIII	Hospi tal	Cost	
		I npati en	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		657, 30	04	2, 287, 839	1.00
2.00	Interim payments payable on individual bills, either			0	0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER			0 01/21/2021	71,800	3. 01
3.02				0	0	3. 02
3.03				0	0	3.03
3.04				0	0	3.04
3.05				0	0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM			0	0	3.50
3.51				0	0	3.51
3.52				0	0	3. 52
3.53				0	0	3.53
3.54				0	0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	71, 800	3.99
4 00	3. 50-3. 98)				2 250 (20	1.00
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as		657, 30)4	2, 359, 639	4.00
	appropriate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider				-	
5.01	TENTATI VE TO PROVI DER			0	0	5.01
5.02				0	0	5.02
5.03				0	0	5.03
	Provider to Program			0	0	
5.50 5.51	TENTATI VE TO PROGRAM			0	0	5.50 5.51
5.51 5.52				0	0	5.52
5.92 5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5.99
J. 77	5. 50-5. 98)			0	0	J. 71
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					2. 50
6. 01	SETTLEMENT TO PROVIDER		221, 9	43	0	6. 01
6. 02	SETTLEMENT TO PROGRAM			0	428, 272	6. 02
7.00	Total Medicare program liability (see instructions)		879, 24	47	1, 931, 367	7. OC
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
				1.00	2.00	

VALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC Component C	1	Period: From 07/01/2020 Fo 06/30/2021	Date/Time Pre	pared
			NA (1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		11/29/2021 1:	17 pm
		Inpati en		wing Beds - SNF	Cost	
		Inpatren	LPARLA	Par	ιв	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00	Total interim payments paid to provider		331, 95	5	0	1. (
00	Interim payments payable on individual bills, either		(D	0	2.0
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment					3.0
00	amount based on subsequent revision of the interim rate					0.
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
~ ~	Program to Provider					
01 02	ADJUSTMENTS TO PROVIDER				0	
02					0	
03					0	
05				5	0	
	Provider to Program	I		-		
50	ADJUSTMENTS TO PROGRAM			C	0	
51				C	0	
52				D	0	
53					0	
54 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines				0	
77	3. 50-3. 98)				0	J.
00	Total interim payments (sum of lines 1, 2, and 3.99)		331, 95	5	0	4.
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after					1 -
00	desk review. Also show date of each payment. If none,					5.
	write "NONE" or enter a zero. (1)					
	Program to Provider					
01	TENTATI VE TO PROVI DER			D	0	
02				D	0	
03			(0	0	5.
50	Provider to Program TENTATIVE TO PROGRAM				0	5.
50 51					0	
52					0	
99	Subtotal (sum of lines 5.01–5.49 minus sum of lines				0	
	5. 50-5. 98)					
00	Determined net settlement amount (balance due) based on					6.
01	the cost report. (1)		110 20			
01 02	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM		119, 304	4	0	6. 6.
02 00	Total Medicare program liability (see instructions)		451, 259	5	0	
50			451,25	Contractor	NPR Date	/.
				Number	(Mo/Day/Yr)	
)	1,00	2.00	

Heal th	Financial Systems ASCENSION ST. VINC	ENT JENNINGS	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1303	Peri od:	Worksheet E-1	
			From 07/01/2020 To 06/30/2021		narad
			10 00/30/2021	11/29/2021 1:	17 pm
		Title XVIII	Hospi tal	Cost	<u>··· p···</u>
				1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				4
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				4
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.		14		1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8	-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3	ine 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of c	ertified HIT technology	Wkst. S-2, Pt. I		7.00
	line 168				
8.00	Calculation of the HIT incentive payment (see instructions)				8.00
9.00	Sequestration adjustment amount (see instructions)				9.00
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
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 l	ine 31) (see instruction	s)		32.00

ALCULAT	inancial Systems ASCENSION ST. VINCENT JENNINGS ION OF REIMBURSEMENT SETTLEMENT - SWING BEDS Provider CO	CN: 15-1303	Peri od:	u of Form CMS-2 Worksheet E-2	
	Component	CCN: 15-Z303	From 07/01/2020 To 06/30/2021	Date/Time Prep 11/29/2021 1:	
	Ti tl e	XVIII	Swing Beds - SNF		
			Part A	Part B	
00			1.00	2.00	
	OMPUTATION OF NET COST OF COVERED SERVICES npatient routine services - swing bed-SNF (see instructions)		386, 711	0	1.
	npatient routine services - swing bed-SM (see instructions)		500, 711	0	2.
. 00 A	ncillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum art V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-		64, 548	0	3.
	nstructions) lursing and allied health payment-PARHM (see instructions)				3.
	Per diem cost for interns and residents not in approved teaching program	(see		0.00	4.
	nstructions)				
	rogram days		135	0	5.
	nterns and residents not in approved teaching program (see instructions)		0	0	
	Itilization review - physician compensation - SNF optional method only ubtotal (sum of lines 1 through 3 plus lines 6 and 7)		451, 259	0	7. 8.
	rimary payer payments (see instructions)		451, 259	0	9.
	ubtotal (line 8 minus line 9)		451, 259	0	10.
	eductibles billed to program patients (exclude amounts applicable to phy	si ci an	0	0	11.
р	rofessional services)				
2.00 S	ubtotal (line 10 minus line 11)		451, 259	0	12.
	oinsurance billed to program patients (from provider records) (exclude c	oi nsurance	0	0	13.
	for physician professional services)				
	0% of Part B costs (line 12 x 80%)		451 250	0	14.
	ubtotal (see instructions) THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		451, 259	0	15. 16.
	ioneer ACO demonstration payment adjustment (see instructions)		0	0	16.
	ural community hospital demonstration project (§410A Demonstration) paym	ent	0		16.
	djustment (see instructions)		-		
5. 99 D	emonstration payment adjustment amount before sequestration		0	0	16.
7.00 A	llowable bad debts (see instructions)		0	0	17.
	djusted reimbursable bad debts (see instructions)		0	0	
	llowable bad debts for dual eligible beneficiaries (see instructions)		0	0	18.
	otal (see instructions)		451, 259	0	19.
	equestration adjustment (see instructions) emonstration payment adjustment amount after sequestration)		0	0	19. 19.
	equestration adjustment-PARHM pass-throughs		0	0	19.
	equestration for non-claims based amounts (see instructions)		0	0	19.
	nterim payments		331, 955	0	20.
	nterim payments-PARHM			-	20.
	entative settlement (for contractor use only)		0	0	
. 01 T	entative settlement-PARHM (for contractor use only)				21.
2. 00 B	alance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20	, and 21)	119, 304	0	22.
	alance due provider/program-PARHM (see instructions)				22.
	rotested amounts (nonallowable cost report items) in accordance with CMS	Pub. 15-2,	0	0	23.
	hapter 1, §115.2 ural Community Haspital Demonstration Draiget (\$4104 Demonstration) Adju	ctmont			
	ural Community Hospital Demonstration Project (§410A Demonstration) Adju s this the first year of the current 5-year demonstration period under t				200.
	entury Cures Act? Enter "Y" for yes or "N" for no.	10 2131			200.
	ost Reimbursement				
1. 00 M	ledicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, P	t. II, line			201.
	6 (title XVIII hospital))				
	ledicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3,	col. 3, lin	e		202.
	00 (title XVIII swing-bed SNF)) otal (sum of lines 201 and 202)				203.
	ledicare swing-bed SNF discharges (see instructions)				203.
	omputation of Demonstration Target Amount Limitation (N/A in first year	of the curre	nt 5-vear demonst	ration	201.
pe	eri od)				
5.00 M	ledicare swing-bed SNF target amount				205.
	ledicare swing-bed SNF inpatient routine cost cap (line 205 times line 20	4)			206.
	djustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement				
	rogram reimbursement under the §410A Demonstration (see instructions)				207.
	ledicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, s	um of lines	1		208.
	nd 3) diustmont to Modicaro swing bod SNE RPS payments (soo instructions)				209.
	djustment to Medicare swing-bed SNF PPS payments (see instructions) eserved for future use				209. 210.
	omparision of PPS versus Cost Reimbursement				- 10.
	otal adjustment to Medicare swing-bed SNF PPS payment (line 209 plus lin	e 210) (see			215.

Health Financial Systems ASCENSION ST. VIN CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-1303	Period: From 07/01/2020 To 06/30/2021	Worksheet E-3 Part V Date/Time Pre 11/29/2021 1:	pare
		Title XVIII	Hospi tal	Cost	
				1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICAR	E DART A SERVICES - COST		1.00	
. 00	Inpatient services	ETAKTA SERVICES - COS	KETWDORSEWENT	972, 148	1 1
. 00	Nursing and Allied Health Managed Care payment (see instruct	ions)		0	
. 00	Organ acquisition			0	
00	Subtotal (sum of lines 1 through 3)			972, 148	
. 00	Primary payer payments			0	5
. 00	Total cost (line 4 less line 5). For CAH (see instructions)			981, 869	6
	COMPUTATION OF LESSER OF COST OR CHARGES				1
	Reasonabl e charges				
. 00	Routine service charges			0	
00	Ancillary service charges			0	
00	Organ acquisition charges, net of revenue			0	
0.00	Total reasonable charges			0	10
1 00	Customary charges		1		1
1.00	Aggregate amount actually collected from patients liable for			0	
2.00	Amounts that would have been realized from patients liable f had such payment been made in accordance with 42 CFR 413.13(on a charge basis	0	12
3. 00	Ratio of line 11 to line 12 (not to exceed 1.000000)	.e)		0.000000	12
1. 00	Total customary charges (see instructions)			0.000000	
5.00	Excess of customary charges over reasonable cost (complete c	nlvifline 14 exceeds li	ne 6) (see	0	
5.00	instructions)			0	'`
6.00	Excess of reasonable cost over customary charges (complete c	only if line 6 exceeds lin	ne 14) (see	0	16
	instructions)	5	, ,		
7.00	Cost of physicians' services in a teaching hospital (see ins	structions)		0	17
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
3.00	Direct graduate medical education payments (from Worksheet E	-4, line 49)		0	
9.00 0.00	Cost of covered services (sum of lines 6, 17 and 18) Deductibles (exclude professional component)			981, 869 104, 912	
1.00	Excess reasonable cost (from line 16)			104, 912	
2.00	Subtotal (line 19 minus line 20 and 21)			876, 957	
3.00	Coi nsurance			0/0, /3/	
4.00	Subtotal (line 22 minus line 23)			876, 957	
5.00	Allowable bad debts (exclude bad debts for professional serv	vices) (see instructions)		3, 523	
6.00	Adjusted reimbursable bad debts (see instructions)			2, 290	
7.00	Allowable bad debts for dual eligible beneficiaries (see ins	structions)		0	27
B. 00	Subtotal (sum of lines 24 and 25, or line 26)			879, 247	28
9.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	29
9.50	Pioneer ACO demonstration payment adjustment (see instruction	ons)		0	29
9.99	Demonstration payment adjustment amount before sequestration	1		0	1
0. 00	Subtotal (see instructions)			879, 247	
0.01	Sequestration adjustment (see instructions)			0	
0. 02	Demonstration payment adjustment amount after sequestration			0	
0.03	Sequestration adjustment-PARHM			157 004	30
1.00	Interim payments			657, 304	31
1.01 2.00	Interim payments-PARHM Tentative settlement (for contractor use only)			0	
2.00	Tentative settlement (for contractor use only) Tentative settlement-PARHM (for contractor use only)			0	32
2.01	Balance due provider/program (line 30 minus lines 30.01, 30.	02 31 and 32)		221, 943	
3.00	Balance due provider/program-PARHM (lines 2, 3, 18, and 26,		and 32 01)	221, 743	33
4.00	Protested amounts (nonallowable cost report items) in accord			0	34
	§115. 2			0	~

	Financial Systems ASCENSION ST. VII E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column	Provider C	CN: 15-1303 F F	eriod: rom 07/01/2020 o 06/30/2021	u of Form CMS-: Worksheet G Date/Time Pre 11/29/2021 1:	pare
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
00	Cash on hand in banks	329, 624	(0	0	1 1
00	Temporary investments	0	(C	0	0	2
00	Notes receivable	0	C	0	0	3
00	Accounts receivable	5, 616, 396		0	0	
00	Other receivable	339, 053		-	0	
00 00	Allowances for uncollectible notes and accounts receivable	-3, 792, 259			0	
00	Inventory Prepaid expenses	188, 192		0	0	
00	Other current assets	291, 366		0	0	
00	Due from other funds	0		0	0	10
00	Total current assets (sum of lines 1-10)	2, 972, 372	C	0	0	11
	FI XED ASSETS					
00	Land	127, 944	C	0	0	12
00	Land improvements	539, 531	C	-	0	13
00	Accumulated depreciation	-439, 323	0	-	0	14
00	Buildings	14, 864, 342		0	0	15
00	Accumulated depreciation Leasehold improvements	-8, 032, 806		0	0	16
00	Accumulated depreciation	0		, i i i i i i i i i i i i i i i i i i i	0	18
	Fixed equipment	1, 027, 481		-	0	19
00	Accumulated depreciation	-955, 735		0	0	20
00	Automobiles and trucks	17, 900	0	0	0	21
00	Accumulated depreciation	-17, 900	(C	0	0	22
	Major movable equipment	6, 069, 776	0	, i i i i i i i i i i i i i i i i i i i	0	23
00	Accumulated depreciation	-4, 586, 793	0	U U	0	24
00	Minor equipment depreciable	242, 864	0		0	25
00	Accumulated depreciation	-200, 035			0	26
00	HIT designated Assets Accumulated depreciation	0		-	0	27
00	Mi nor equi pment-nondepreci abl e	0		U U	0	29
00	Total fixed assets (sum of lines 12-29)	8, 657, 246		-	0	30
	OTHER ASSETS					
00	Investments	0	0	0	0	31
00	Deposits on Leases	0	C		0	32
00	Due from owners/officers	0	C	-	0	33
00	Other assets	530	0	-	0	34
00	Total other assets (sum of lines 31-34)	530			0	35
00	Total assets (sum of lines 11, 30, and 35)	11, 630, 148		0	0	36
00	CURRENT LI ABI LI TI ES Accounts payabl e	660, 873	C	0	0	37
00	Salaries, wages, and fees payable	151, 156			0	38
00	Payrol I taxes payable	11, 775			0	
	Notes and Loans payable (short term)	153, 534	C	0	0	
00	Deferred income	63, 680	c	0	0	41
00	Accelerated payments	0				42
00	Due to other funds	0	C	-	0	
00	Other current liabilities	2,947,230			0	
00	Total current liabilities (sum of lines 37 thru 44)	3, 988, 248		0	0	45
00	LONG TERM LIABILITIES Mortgage payable	0	0	0	0	46
00	Notes payable	0		0	0	40
00	Unsecured Loans	0		0	0	
00	Other long term liabilities	9, 464, 934		o o	0	
00	Total long term liabilities (sum of lines 46 thru 49)	9, 464, 934		0	0	
00	Total liabilities (sum of lines 45 and 50)	13, 453, 182	0	0	0	51
	CAPI TAL ACCOUNTS					
00	General fund balance	-1, 823, 034				52
00	Specific purpose fund		C	_		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 Plant fund balance - invested in plant			0	0	
00	Plant fund balance - reserve for plant improvement,				0	
50	replacement, and expansion				0	"
		1 0 2 0 2 1		0	0	59
00	Total fund balances (sum of lines 52 thru 58)	-1, 823, 034		' UI	0	1 .

		SCENSION ST. VIN				In Lie	u of Form CMS-	
STATEMENT OF CHANGES IN FUND BALANCES		From (om 07/01/2020		Prepared:		
		General	Fund	Speci al	Pur	pose Fund	Endowment Fund	
		1.00	2.00	3,00		4.00	5, 00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 15.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Grant/Donation Intercompany Transfers Rounding Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	-59, 562 -2, 415, 271 0 0 1 1 0 0 0 0 0 0 0 0 0 0	2,00 -4,427,211 5,079,009 651,798 -2,474,832 -1,823,034 0 -1,823,034	3.00		4.00 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00
		Endowment Fund	PI ant					
1.00	Fund balances at beginning of period	6.00	7.00	8.00	0			1.00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Grant/Donation Intercompany Transfers Rounding	0	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 18.00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17)	000	0 0 0 0 0 0		0 0			10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0			0			19.00

	Financial Systems ASCENSION ST. VIN			u of Form CMS-2552-1		
STATEN	MENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider C	CN: 15-1303	Period: From 07/01/2020 To 06/30/2021		pared:
	Cost Center Description	•	I npati ent	Outpati ent	Total	
			1.00	2.00	3.00	
	PART I - PATIENT REVENUES					-
1.00	General Inpatient Routine Services Hospital		2, 428, 2	24	2, 428, 224	1.00
2.00	SUBPROVIDER - IPF		2, 420, 2	24	2, 420, 224	2.00
3.00	SUBPROVIDER - IRF					3.00
4.00	SUBPROVIDER					4.00
5.00	Swing bed - SNF			0	0	5.00
6.00	Swing bed - NF			0	0	6.00
7.00	SKILLED NURSING FACILITY					7.00
8.00	NURSING FACILITY					8.00
9.00	OTHER LONG TERM CARE					9.00
10.00	Total general inpatient care services (sum of lines 1-9)		2, 428, 2	24	2, 428, 224	10.00
11.00	Intensive Care Type Inpatient Hospital Services		1			11.00
12.00	CORONARY CARE UNIT					12.00
13.00	BURN INTENSIVE CARE UNIT					13.00
14.00	SURGI CAL I NTENSI VE CARE UNI T					14.00
15.00	OTHER SPECIAL CARE (SPECIFY)					15.00
16.00	Total intensive care type inpatient hospital services (sum o	flines		0	0	16.00
	11-15)					
17.00	Total inpatient routine care services (sum of lines 10 and 1	5)	2, 428, 2		2, 428, 224	
18.00	Ancillary services		1, 121, 2			
19.00 20.00	Outpatient services RURAL HEALTH CLINIC		105, 5	44 18, 712, 994 0 0		19.00 20.00
20.00	FEDERALLY QUALIFIED HEALTH CENTER			0 0		
21.00	HOME HEALTH AGENCY			0	0	21.00
23.00	AMBULANCE SERVICES					23.00
24.00	СМНС					24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)					25.00
26.00	HOSPI CE					26.00
27.00	Other Patient Service Revenue			0 2	2	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column	3 to Wkst.	3, 654, 9	73 60, 976, 769	64, 631, 742	28.00
	G-3, line 1) PART II - OPERATING EXPENSES					-
29.00	Operating expenses (per Wkst. A, column 3, line 200)		1	16, 842, 013		29.00
30.00	ADD (SPECIFY)			0		30.00
31.00				0		31.00
32.00				0		32.00
33.00				0		33.00
34.00				0		34.00
35.00				0		35.00
36.00	Total additions (sum of lines 30-35)			0		36.00
37.00	DEDUCT (SPECI FY)			0		37.00
38.00				0		38.00
39.00 40.00				0		39.00 40.00
40.00				0		40.00
41.00	Total deductions (sum of lines 37-41)			n		41.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line	42)(transfer		16, 842, 013		43.00
43.00						

Heal th	u of Form CMS-2	2552-10				
STATE	STATEMENT OF REVENUES AND EXPENSES Provider CCN: 15-1303 Period:					
	From 07/01/2020				bared:	
	To 06/30/2021					
	11/29/2021 1:					
				1.00		
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, lin			64, 631, 742	1.00	
2.00	Less contractual allowances and discounts on patients' account	its		45, 445, 845	2.00	
3.00	Net patient revenues (line 1 minus line 2)	19, 185, 897 16, 842, 013	3.00			
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)				4.00	
5.00	Net income from service to patients (line 3 minus line 4)			2, 343, 884	5.00	
	OTHER I NCOME					
6.00	Contributions, donations, bequests, etc			-5, 000	6.00	
7.00	Income from investments			0	7.00	
8.00	Revenues from telephone and other miscellaneous communication	Services		0	8.00	
9.00	Revenue from television and radio service			0	9.00	
10.00	Purchase di scounts			0	10.00	
11.00	Rebates and refunds of expenses			0	11.00 12.00	
12.00 13.00	Parking lot receipts Revenue from laundry and linen service			0	12.00	
13.00	Revenue from meals sold to employees and guests			47, 374	13.00	
14.00				47, 374	14.00	
16.00		han nationts		0	16.00	
	Revenue from sale of drugs to other than patients			9,027	17.00	
	Revenue from sale of medical records and abstracts			384	18.00	
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00	
	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00	
	Rental of vending machines			0	21.00	
22.00				176, 248		
23.00				0	23.00	
24.00				87, 198		
	COVID-19 PHE Funding			2, 419, 894		
	Total other income (sum of lines 6-24)			2, 735, 125		
	Total (line 5 plus line 25)			5, 079, 009		
	OTHER EXPENSES (SPECI FY)			0	27.00	
	Total other expenses (sum of line 27 and subscripts)			0	28.00	
29.00	Net income (or loss) for the period (line 26 minus line 28)			5, 079, 009	29.00	