Heal th	Financial Systems	ASCENSION ST. \	/INCENT MERCY		In Lie	u of Form CMS-	2552-10
This r	eport is required by law (42 USC 1395g; 42 CF	R 413.20(b)). F	ailure to repo	ort can result	in all interim	FORM APPROVED	
paymen	ts made since the beginning of the cost repor	ting period bei	ng deemed over	payments (42	USC 1395g).	OMB NO. 0938- EXPIRES 03-31	
	AL AND HOSPITAL HEALTH CARE COMPLEX COST REPO	ORT CERTIFICATIO	ON Provider CO	CN: 15-1308	Period:	Worksheet S	
AND SE	TTLEMENT SUMMARY				From 07/01/2020 To 06/30/2021	Parts I-III Date/Time Pre	pared:
						11/23/2021 3:	
	- COST REPORT STATUS				D 1 11 (00 (0		
Provid use on					Date: 11/23/2	2021 Time: 3	3:53 pm
use on	3. [0] If this is an amended report		er of times the	e provider res	submitted this c	ost report	
	4. [F] Medicare Utilization. Enter '	F" for full or	"L" for low.				
Contra		Recei ved:			PR Date:		
use on	Iy (1) As Submitted 7. Contr (2) Settled without Audit 8. [N]	actor No. Initial Report	for this Provi	11.Cc ider CCN 12 [ntractor's Vendo	or Code: Slump 1 is 4, F	4 Inter
	(3) Settled with Audit 9. [N]	Final Report f	or this Provide	er CCN		mes reopened =	
	(4) Reopened						
	(5) Amended						
DADT I	I - CERTIFICATION						
	RESENTATION OR FALSIFICATION OF ANY INFORMATI	ON CONTAINED IN	N THIS COST REP	PORT MAY BE PL	INLSHABLE BY CRU	MINAL CLVLL AN	ID
	STRATIVE ACTION, FINE AND/OR IMPRISONMENT UND						
PROVI D	ED OR PROCURED THROUGH THE PAYMENT DIRECTLY O	R INDIRECTLY OF	A KICKBACK OF	R WERE OTHERWI	SE ILLEGAL, CRI	WINAL, CIVIL AM	١D
ADMI NI	STRATIVE ACTION, FINES AND/OR IMPRISONMENT MA	Y RESULT.					
	CERTIFICATION BY CHIEF FINANCIAL OFFICER OF	R ADMI NI STRATOR	OF PROVIDER(S))			
	I HEREBY CERTIFY that I have read the above						
	electronically filed or manually submitted						
	Expenses prepared by ASCENSION ST. VINCENT						
	and ending 06/30/2021 and to the best of my complete and prepared from the books and re						
	except as noted. I further certify that I						
	heal th care services, and that the services						
	laws and regulations.						
	[X]I have read and agree with the above o	certification s	tatement. I ce	rtify that I i	ntend my electr	oni c	
	signature on this certification stater	ment to be the	legally binding	g equivalent o	of my original s	i gnature.	
		(Si gn		OPHER HONS			
			Offi c	er or Adminis	trator of Provic	ler(s)	
			Title	FINANCE			
			nue				
			11/23/	2021 03: 53: 37	PM		
			Date				
			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	НІТ	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
1 00	PART III - SETTLEMENT SUMMARY		40.100				1 1 00
1.00	Hospi tal	0	19, 100	-93, 88		0	
2.00 3.00	Subprovider - IPF Subprovider - IRF	0	0		0	0	
5.00	Swing Bed - SNF	0	-29, 462		0	0	
6.00	Swing Bed - NF	0	27, 102		-	0	

200.00 Total 0 -10, 362 The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents , please contact 1-800-MEDICARE.

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11/23/2021 3:53 pm Y: \28650 - St. Vincent Mercy\300 - Medicare Cost Report\20210630\HFS\28650-21.mcrx

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ISPI	TAL AND HOSPITAL HEALTH CARE COMPLEX			der CCN:		Period: From 07/01/ To 06/30/	2021	Workshe Part I Date/Ti 11/23/2		epare
	1.00	2.00		3.00		L	1.00			
00	Hospital and Hospital Health Care Co Street: 1331 SOUTH A ST.	PO Box:	-							1.
00	City: ELWOOD	State: IN	Zin Cod	e: 46036-	- Count	y: MADI SON				2.
00		Component Name	CCN	CBSA	Provi der		Payme	nt Syst	em (P,	
			Number	Number	Туре	Certified		0, or	N)	
					-	5.00	V	XVIII	XIX	_
	Hospital and Hospital-Based Componer	1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
00	Hospi tal	ASCENSION ST. VINCENT MERCY	151308	26900	1	07/01/2001	N	0	0	3.
00	Subprovider - IPF									4.
00	Subprovider - IRF									5.
00	Subprovider - (Other)	ASCENSION ST VINCENT	157200	24000		07/01/2001	N			6.
00	Swing Beds - SNF	ASCENSION ST. VINCENT MERCY SWING	15Z308	26900		07/01/2001	N	0	N	7.
00	Swing Beds - NF									8.
00	Hospital-Based SNF								1	9.
. 00	Hospital-Based NF									10.
. 00	Hospital-Based OLTC									11.
00										12
00										13
00										15
00	Hospital -Based Health Clinic - FQHC									16
00										17
00	Renal Dialysis									18
00	Other		L			From:		Tc		19
						1.00		2.0		
00	Cost Reporting Period (mm/dd/yyyy)					07/01/20	020	06/30		20
00	Type of Control (see instructions)					1				21
						-				
					1 00			2	20	
					1.00	2.00		3. (00	_
.00	Inpatient PPS Information	currently receiving pa	ments for		1.00 N			3. (00	
00	Inpatient PPS Information					2.00		3. (00	
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	HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ATA	ENT MERCY Provider CC	CN: 15-1308	Peri	od:		Workshe		
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1 00 LE +bi	provider is an LDDS bespital opter the	1.00	2.00	3.00	4.0	00	5.00	0	5.00) 24. (
in-stat Medicai out-of- out-of- 4, Medi column 5.00 If this Medicai out-of- Medicai	s provider is an IPPS hospital, enter the te Medicaid paid days in column 1, in-state d eligible unpaid days in column 2, -state Medicaid paid days in column 3, -state Medicaid eligible unpaid days in column caid HMO paid and eligible but unpaid days in 5, and other Medicaid days in column 6. s provider is an IRF, enter the in-state d paid days in column 1, the in-state d eligible unpaid days in column 2, -state Medicaid days in column 3, out-of-state d eligible unpaid days in column 4, Medicaid d and eligible but unpaid days in column 5.		c			0		0	U	24. (
					Ur		ural S I	Date of 2.0		-
5.00 Enter y	your standard geographic classification (not w	age) status	at the bec	ginning of t	the	1.0	1	2.0	JU	26. (
7.00 Enter y reporti enter t	eporting period. Enter "1" for urban or "2" fo your standard geographic classification (not w ng period. Enter in column 1, "1" for urban o the effective date of the geographic reclassif	age) status r "2" for r ication in	ural. If ap column 2.	opl i cabl e,			1			27.0
	s is a sole community hospital (SCH), enter th in the cost reporting period.	e number of	periods SC	CH status in	n		0			35.0
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00 Enter :	applicable beginning and ending dates of SCH s	tatus Subs	crint line	36 for num	her	1.0	00	2. (00	36.
of peri	ods in excess of one and enter subsequent dat s is a Medicare dependent hospital (MDH), ente	es.	·				0			37.
.01 Is this	effect in the cost reporting period. s hospital a former MDH that is eligible for t ance with FY 2016 OPPS final rule? Enter "Y" f									37.
		01 yc3 01	N TOF NO.	(see						
3.00 If line greater	ctions) e 37 is 1, enter the beginning and ending date r than 1, subscript this line for the number o subsequent dates.	s of MDH st	atus. Ifli	ne 37 is						38.
3.00 If line greater	e 37 is 1, enter the beginning and ending date than 1, subscript this line for the number o	s of MDH st	atus. Ifli	ne 37 is		Y/1		Y/		38.
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3.00 If line greater enter s 2.00 Does th hospita 1 "Y" f accords or "N" 2.00 Is this "N" for	e 37 is 1, enter the beginning and ending date than 1, subscript this line for the number of subsequent dates. nis facility qualify for the inpatient hospita als in accordance with 42 CFR §412.101(b)(2)(i for yes or "N" for no. Does the facility meet ance with 42 CFR 412.101(b)(2)(i), (ii), or (i	s of MDH st f periods i l payment a), (ii), or the mileage ii)? Enter n adjustmen ber 1. Ente	atus. If li n excess of djustment f (iii)? Ent requiremer in column 2 t? Enter "\ r "Y" for \	ne 37 is fone and for low volu ter in colur nts in 2 "Y" for yes (" for yes o	mn es or	1.0	00	2. (N	00	_
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8.00 If line greater enter s 9.00 Does th hospita 1 "Y" for no in c 9.00 Is this "N" for no in c 9.00 Is this "N" for no in c 9.00 Is this pursuar Pt. III 9.00 Is this 3.00 Is this "N" for was inv year, a Enter " '.00 If line GME progent Substance "Y" for yes "N", co	a 37 is 1, enter the beginning and ending date than 1, subscript this line for the number of subsequent dates. his facility qualify for the inpatient hospital als in accordance with 42 CFR §412.101(b)(2)(i for yes or "N" for no. Does the facility meet ance with 42 CFR 412.101(b)(2)(i), (ii), or (i for no. (see instructions) is hospital subject to the HAC program reduction r no in column 1, for discharges prior to Octo column 2, for discharges on or after October 1 ctive Payment System (PPS)-Capital his facility qualify and receive Capital paymeet 2 CFR Section §412.320? (see instructions) is facility eligible for additional payment exc to 42 CFR §412.348(f)? If yes, complete Wks a new hospital under 42 CFR §412.300(b) PPS facility electing full federal capital paymen mg Hospitals s a hospital involved in training residents in r no in column 1. For column 2, if the respons yolved in training residents in approved GME p and are you are impacted by CR 11642 (or appli 'Y" for yes; otherwise, enter "N" for no in co params trained at this facility? Enter "Y" for did residents start training in the first mon	s of MDH st f periods i I payment a), (ii), or the mileage ii)? Enter n adjustmen ber 1. Ente . (see inst ut for disp eption for t. L, Pt. I capital? E t? Enter " approved G e to column rograms in cable CRs) I umn 2. period duri r yes or "N th of this Y", complet I, if appli	atus. If Ii n excess of djustment f (iii)? Ent requiremer in column 2 t? Enter "Y r"Y" for y ructions) roportionat extraordina II and Wkst nter "Y for Y" for yes 1 is "Y", the prior y MA direct C ng which re "for no ir cost report e Worksheet cable.	ne 37 is for low volu for low volu ter in colur ter in colur ter in colur 2 "Y" for yes (" for yes or yes or "N" for te share in ary circumst t. L-1, Pt. r yes or "N" for s? Enter "Y" or if this year or pend SME payment tesidents in n column 1. ting period' t E-4. If co	nn es or for accord tances 1 thro " for r no. " for y hospi 1 ul ti mat reduct approv 1 f col ? Ente ol umn 2	1.0 N N dance bugh no. yes or tal te ti on? yed umn 1 er "Y"	00 V 1.00 N N N N N	2.0 N XVIII 2.00 N N N	00 XIX 3.00 N N	40. 40. 45. 46.

alth Financial Systems ASCENSIO DSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		NCENT MERCY Provider CO		eri od:	u of Form CMS-2 Worksheet S-2	
			F T	rom 07/01/2020 o 06/30/2021	Part I Date/Time Pre	
			NAHE 413.85	Worksheet A	11/23/2021 3: Pass-Through	53 pm
			Y/N	Line #	Qualification Criterion Code	
			1.00	2.00	3.00	
D. 00 Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in col is "Y", are you impacted by CR 11642 (or subsequent C	85? (s umn 1. CR) NAHE	ee lf column 1	N			60. (
adjustement? Enter "Y" for yes or "N" for no in colu	Y/N	IME	Direct GME	I ME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in	N			0.00	0.00	61.
 column 1. (see instructions) 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 						61.
instructions) 1.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of						61.
 ACA). (see instructions) 1.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see linetructions) 						61.
instructions) 1.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the						61.
current cost reporting period. (see instructions). .05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line						61.
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	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
 1.10 Of the FTEs in line 61.05, specify each new program special ty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 1.20 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 1, the program name. And the IME FTE unweighted count. 				0.00		
					1.00	
ACA Provisions Affecting the Health Resources and Ser					1.00	
.00 Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruc	ctions)				0.00	
		nu mearth Cen	LEI (IHC) INTO	your nospital	0.00	02.
.01 Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC proc	gram. (s	<u>ee instructio</u>	ns)	-		
.01 Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog Teaching Hospitals that Claim Residents in Nonprovide	<u>gram. (s</u> er Setti ettings	<u>ee instruction</u> ngs during this co	ost reporting p 67. (see instru	ictions)	N	63.
 .01 Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC proc Teaching Hospitals that Claim Residents in Nonprovide .00 Has your facility trained residents in nonprovider set 	<u>gram. (s</u> er Setti ettings	<u>ee instruction</u> ngs during this co	ost reporting p	ictions)	N Ratio (col. 1/ (col. 1 + col. 2))	63.
 Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prograching Hospitals that Claim Residents in Nonprovide Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple Section 5504 of the ACA Base Year FTE Residents in No 	gram. (s er Setti ettings ete line	ee instruction ngs during this co s 64 through o ler Settings	ost reporting p 67. (see instru Unweighted FTEs Nonprovider Site 1.00	Unweighted FTEs in Hospital 2.00	Ratio (col. 1/ (col. 1 + col. 2)) 3.00	63.
2. 01 Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC progression to the term of term of the term of ter	gram. (s er Setti ettings ete line onprovid re June	ee instruction ngs during this co s 64 through o ler Settings 30, 2010.	ost reporting p 67. (see instru FTEs Nonprovider Site 1.00 This base year	Interiors)	Ratio (col. 1/ (col. 1 + col. 2)) <u>3.00</u> eporting	-
 .01 Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC progression to the term of the term of term of the term of term of the term of ter	gram. (s er Setti ettings ete line onprovid re June cy train n-primar all non-pr	ee instruction ngs during this co s 64 through of s 64 through of ed residents y care provider imary care	ost reporting p 67. (see instru Unweighted FTEs Nonprovider Site 1.00	Interiors)	Ratio (col. 1/ (col. 1 + col. 2)) <u>3.00</u> eporting	-
 O1 Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prograching Hospitals that Claim Residents in Nonprovide Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple Section 5504 of the ACA Base Year FTE Residents in No period that begins on or after July 1, 2009 and befor Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted nor resident FTEs attributable to rotations occurring in 	pram. (s er Setti ettings ete line onprovid e June cy train h-primar all non d non-pr h column instruc	ee instruction ngs during this co s 64 through of s 64 through of a 64 through of s 64 through of a 0, 2010. ed residents y care provider imary care 3 the ratio tions)	ost reporting p 67. (see instru FTEs Nonprovider Site 1.00 This base year	Interiors)	Ratio (col. 1/ (col. 1 + col. 2)) <u>3.00</u> eporting	-

	PLEX IDENTIFICATION D	ATA Provider (eriod:	Worksheet S-2	
			Fr Tc	com 07/01/2020 06/30/2021	Date/Time Pre	
	Program Name	Program Code	Unwei ghted	Unweighted	11/23/2021 3: Ratio (col. 3/	
			FTĔs Nonprovi der	FTEs in Hospital	(col. 3 + col. 4))	
	1.00	2.00	Si te 3. 00	4.00	5.00	-
.00 Enter in column 1, if line 63	1.00	2.00	3.00	4.00		65 0
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column						
divided by (column 3 + column 4)). (see instructions)						
			Unweighted	Unwei ghted	Ratio (col. 1/	/
			FTEs Nonprovider	FTEs in Hospital	(col. 1 + col. 2))	
			Si te	nospi tai	2))	
			1.00	2.00	3.00	
Section 5504 of the ACA Current beginning on or after July 1, 2		n Nonprovider Settin	gsEffective fo	or cost reporti	ing periods	
FTEs attributable to rotations Enter in column 2 the number of FTEs that trained in your hospi (column 1 divided by (column 1	unweighted non-prima tal. Enter in column	ary care resident 3 the ratio of	Unweighted	Unweighted	Ratio (col. 3/ (col. 3 + col.	
			FTEs Nonprovider Site	FTEs in Hospital	(01. 3 + 01. 4))	
7 00 Enter in column 1, the program	1.00	2.00	Nonprovi der Si te 3.00	Hospi tal 4.00	4))	_
7.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 3 divided by (column 3 + column 4)). (see instructions)		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		2.00	Nonprovi der Si te 3.00	Hospi tal 4.00 0.00	4)) 5.00 0.000000	_
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<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>	PPS sychiatric Facility (o. d the facility have a before November 15, 2 olumn 2: Did this fac FR 412.424 (d)(1)(iii i cate which program y	[IPF), or does it con an approved GME teach 2004? Enter "Y" for cility train resident)(D)? Enter "Y" for	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	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>	PPS sychiatric Facility (o. d the facility have a before November 15, 2 olumn 2: Did this fac FR 412.424 (d)(1)(iii i cate which program y ty PPS	(IPF), or does it con an approved GME teach 2004? Enter "Y" for cility train resident)(D)? Enter "Y" for gear began during thi	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 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 0.0000000	70. 0

Health Financial Systems ASCENSION ST. VINCENT MERCY In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1308 Peri od. Worksheet S-2 From 07/01/2020 Part I 06/30/2021 Date/Time Prepared: То 11/23/2021 3:53 pm 1.00 Long Term Care Hospital PPS 80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. 80 00 Ν 81.00 Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter Ν 81.00 for yes and "N" for no. TEFRA Providers 85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. Ν 85 00 86.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section 86.00 §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital classified under section 87 00 Ν 87.00 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. V XIX 1.00 2.00 Title V and XIX Services 90.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for Y 90.00 Ν ves or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column. 91 00 Ν γ 91 00 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column. Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter 92.00 Υ 92.00 93.00 Ν Ν 93.00 Y" for yes or "N" for no in the applicable column. 94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the 94 00 Ν Ν applicable column. 95.00 If line 94 is "Y", enter the reduction percentage in the applicable column. 0 00 0 00 95 00 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the Ν Ν 96.00 applicable column 97.00 If line 96 is "Y", enter the reduction percentage in the applicable column. 97 00 0 00 0.00 98.00 Does title V or XIX follow Medicare (title XVIII) for the interns and residents post Ν 98.00 Υ stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. Υ 98.01 98.01 Ν C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.02 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation Ν γ 98.02 bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.03 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) Ν 98.03 Ν reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and Ν Ν 98.04 in column 2 for title XIX. 98.05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on γ 98.05 Ν Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, 98.06 Ν Υ 98.06 Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in 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 elected the all-inclusive method of payment 106.00 Ν for outpatient services? (see instructions) 107.00 Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Ν 107.00 Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train L&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions) 108.00 Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no. Ν 108.00 Physi cal Occupati onal Speech Respi ratory 1.00 2 00 3 00 4 00 109.00 If this hospital qualifies as a CAH or a cost provider, are Ν 109.00 Ν Ν Ν therapy services provided by outside supplier? Enter " for yes or "N" for no for each therapy. 1.00 110.00 Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, 110.00 Ν complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as appi i cabl e.

alth Financial Systems ASCENSION ST. VI DSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der CC	CN: 15-1308	Peri od:	ieu of Form CMS Worksheet S-	
			From 07/01/20 To 06/30/20		
11.00 If this facility qualifies as a CAH, did it participate in th Health Integration Project (FCHIP) demonstration for this cos "Y" for yes or "N" for no in column 1. If the response to col integration prong of the FCHIP demo in which this CAH is part Enter all that apply: "A" for Ambulance services; "B" for add for tele-health services.	st reporting p umn 1 is Y, e ticipating in	period? Enter enter the column 2.	1.00 N	2.00	111. (
		1.00	2.00	3.00	-
12.00 Did this hospital participate in the Pennsylvania Rural Healt demonstration for any portion of the current cost reporting p Enter "Y" for yes or "N" for no in column 1. If column 1 is in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceas participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information	oeriod? "Y", enter e	N			112. (
15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or in column 1. If column 1 is yes, enter the method used (A, B, in column 2. If column 2 is "E", enter in column 3 either "93 for short term hospital or "98" percent for long term care (i psychiatric, rehabilitation and long term hospitals providers the definition in CMS Pub. 15-1, chapter 22, §2208.1.	or E only) 3" percent ncludes 5) based on	N			0115. (
16.00 Is this facility classified as a referral center? Enter "Y" f "N" for no.	for yes or	N			116. (
7.00 Is this facility legally-required to carry malpractice insura "Y" for yes or "N" for no.	ance? Enter	Y			117.
8.00 Is the malpractice insurance a claims-made or occurrence poli if the policy is claim-made. Enter 2 if the policy is occurre			2		118.
8.01 List amounts of malpractice premiums and paid losses:		1.00 138,4	2.00	3.00	0118.
			1.00		_
8.02 Are malpractice premiums and paid losses reported in a cost c Administrative and General? If yes, submit supporting schedu and amounts contained therein.			<u> </u>	2.00	118.
9. 00 DO NOT USE THIS LINE 0. 00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qua Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.	column 1, "Y alifies for th	' for yes or ne Outpatient		Ν	119. 120.
1.00Did this facility incur and report costs for high cost implan patients? Enter "Y" for yes or "N" for no.	ntable devices	s charged to	Y		121.
2.00 Does the cost report contain healthcare related taxes as defi Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information				5.00	122.
 00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 00 If this is a Medicare certified kidney transplant center, ent 	ter the certif		N		125. 126.
in column 1 and termination date, if applicable, in column 2. 7.00 If this is a Medicare certified heart transplant center, enter in column 1 and termination date, if applicable, in column 2.	er the certifi	cation date			127.
3.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2.	er the certifi				128.
0.00 If this is a Medicare certified lung transplant center, enter			n		129.
column 1 and termination date, if applicable, in column 2.	enter the cert	LITICATION			130.
column 1 and termination date, if applicable, in column 2. 0.00 If this is a Medicare certified pancreas transplant center, e date in column 1 and termination date, if applicable, in colu		ertification	1		1.21.
column 1 and termination date, if applicable, in column 2. 0.00 If this is a Medicare certified pancreas transplant center, e date in column 1 and termination date, if applicable, in colu 1.00 If this is a Medicare certified intestinal transplant center, date in column 1 and termination date, if applicable, in colu	enter the ce umn 2.				132.
column 1 and termination date, if applicable, in column 2. 0.00 If this is a Medicare certified pancreas transplant center, e date in column 1 and termination date, if applicable, in colu 1.00 If this is a Medicare certified intestinal transplant center,	enter the ce umn 2. er the certifi	cation date			132. 133. 134.

ealth Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLE?		ΑΤΑ	NCENT MERCY Provider C	CN: 15-1308		d: 07/01/2020 06/30/2021	u of Form CMS- Worksheet S-2 Part I Date/Time Pre 11/23/2021 3:	2 epared:
1.00		2.00				3.00		
If this facility is part of a chai home office and enter the home off					e name ar	nd address	of the	
41. 00 Name: ASCENSION ST. VINCENT	Contractor's				ctor's N	lumber: 0800)1	141.00
42.00 Street: 250 WEST 96TH STREET SUITE		Nume: In o						142.00
43.00 City: INDIANAPOLIS	State:	IN		Zip Co	de:	4626	0	143.00
							1.00	111.00
44.00 Are provider based physicians' cos	ts included in Wol	rksneet A:	, 				Y	144.00
						1.00	2.00	-
 45.00 If costs for renal services are cl inpatient services only? Enter "Y" no, does the dialysis facility inc period? Enter "Y" for yes or "N" 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 lude Medicare util for no in column 2 y changed from the column 1. (See Cl	or no in c lization f 2. e previous MS Pub. 15	column 1. If For this cost	column 1 is reporting t report?		N		145.00
		Ζ.						
							1.00	1
47.00 Was there a change in the statisti							N	147.00
48.00 Was there a change in the order of							N	148.00
49.00 Was there a change to the simplifi	eu cost finding me	ernoa? Ent	er "Y" for y Part A	1		TitloV	N Title XIX	149.00
			<u>Part A</u> 1.00	Part E 2.00		<u>Title V</u> 3.00	4.00	-
Does this facility contain a provi	der that qualifie	s for an e			cation o			
or charges? Enter "Y" for yes or "								
55.00Hospi tal			Ν	N		N	N	155.00
56.00 Subprovi der – IPF 57.00 Subprovi der – IRF			N	N		N	N	156.00
57. 00 Subprovider – TRF 58. 00 SUBPROVIDER			Ν	N		Ν	N	157.00
59. 00 SNF			Ν	N		N	N	159.00
60.00 HOME HEALTH AGENCY			Ν	N		N	N	160.00
61.00 CMHC				N		N	N	161.00
							1.00	-
Multicampus							1.00	
65.00 Is this hospital part of a Multica	mpus hospital tha	t has one	or more camp	uses in dif	ferent C	BSAs?	N	165.00
Enter "Y" for yes or "N" for no.	•				71 0 1	0004	ETE (0	
-	Name 0		County 1.00		Zip Code 3.00	e CBSA 4.00	FTE/Campus 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)				2.00	0.00			0 166. 00
							1.00	
Health Information Technology (HIT) incentive in th	e American	n Recovery an	d Reinvestr	ment Act			
67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the H	5 is "Y") and is a IT assets (see ins	a meaningf structions	ful user (lin s)	e 167 is "Y	"), ente		Y	167.00 168.00
68.01 If this provider is a CAH and is n						dshi p		168. 0 ⁻
exception under §413.70(a)(6)(ii)? 69.00 f this provider is a meaningful u transition factor. (see instructio	ser (line 167 is '					enter the	0.0	0169. 00
	,				В	egi nni ng	Endi ng	
						1.00	2.00	
70.00 Enter in columns 1 and 2 the EHR b period respectively (mm/dd/yyyy)	eginning date and	endi ng da	ate for the r	eporting				170.00
						1.00	2.00	-
71.00 If line 167 is "Y", does this prov section 1876 Medicare cost plans r						N		0171.00

OSPI T	Financial Systems ASCENSION ST. V AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-1308	Period:	u of Form CMS Worksheet S-	
				From 07/01/2020 To 06/30/2021	Part II	epared
				Y/N	Date	. 55 pi
	Constal Instruction: Enton V for all VES responses. Enton N	for all NO ro	onences Ent	1.00	2.00	-
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	TOP ALL NU PE	sponses. Ent	er all dates in i	Ine	_
	Provider Organization and Operation					-
. 00	Has the provider changed ownership immediately prior to the			N		1.
	reporting period? If yes, enter the date of the change in co	olumn 2. (see	instructions Y/N	Date	V/I	
			1.00	2.00	3.00	-
. 00	Has the provider terminated participation in the Medicare Pr yes, enter in column 2 the date of termination and in column voluntary or "I" for involuntary.		N			2.
. 00	Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home of or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members of of directors through ownership, control, or family and other relationships? (see instructions)	ffices, drug er or its f the board	N			3.
			Y/N	Туре	Date	
	Einancial Data and Danasta		1.00	2.00	3.00	
. 00	Financial Data and Reports Column 1: Were the financial statements prepared by a Certi Accountant? Column 2: If yes, enter "A" for Audited, "C" fo or "R" for Reviewed. Submit complete copy or enter date avai column 3. (see instructions) If no, see instructions.	or Compiled, lable in	Y	A		4.
. 00	Are the cost report total expenses and total revenues differ those on the filed financial statements? If yes, submit reco		N			5.
				Y/N 1.00	Legal Oper. 2.00	
	Approved Educational Activities			1.00	2.00	
. 00	Column 1: Are costs claimed for nursing school? Column 2:	lfyes, is th	ne provider i	s N		6.
. 00	the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see ins			Ν		7.
. 00	Were nursing school and/or allied health programs approved a cost reporting period? If yes, see instructions.		0	N		8.
. 00	Are costs claimed for Interns and Residents in an approved g program in the current cost report? If yes, see instructions	5.				9.
0. 00	Was an approved Intern and Resident GME program initiated or cost reporting period? If yes, see instructions.			N		10.
1.00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	N	Y/N	11.
					1.00	
	Bad Debts Is the provider seeking reimbursement for bad debts? If yes, If line 12 is yes, did the provider's bad debt collection po			ost reporting	Y N	12. 13.
4.00		nts waived? If	[°] yes, see in	structions.	Ν	14.
5.00	Bed Complement Did total beds available change from the prior cost reportin		<u>yes, see ins</u> t A		Y T B	15.
	-	Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
6. 00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through	Y	10/08/2021	Y	10/08/2021	16.
7.00	date of the PS&R Report used in columns 2 and 4 .(see instructions) Was the cost report prepared using the PS&R Report for	N		N		17.
,	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)	IV		IN IN		17.
8. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	Ν		Ν		18.
	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R	N		N		19.

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

CMS-2552-10
S-2 Prepared: 1 3:53 pm
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Heal th	Financial Systems ASCENSION ST	VINCENT MERCY		In Lie	u of Form CMS-	2552-10
H0SPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1308		eriod:	Worksheet S-2	
			T	rom 07/01/2020 o 06/30/2021		pared: 53 pm
		3.00				
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position	MANAGER OF REIMBURSEMENT				41.00
	held by the cost report preparer in columns 1, 2, and 3,					
	respectively.					
42.00	Enter the employer/company name of the cost report					42.00
	preparer.					
43.00	Enter the telephone number and email address of the cost					43.00
	report preparer in columns 1 and 2, respectively.					

^{11/23/2021 3:53} pm Y: \28650 - St. Vincent Mercy\300 - Medicare Cost Report\20210630\HFS\28650-21.mcrx

	Financial Systems TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	ASCENSION ST. V AL DATA	Provi der CC	CN: 15-1308	Peri od:	eu of Form CMS- Worksheet S-3	
					From 07/01/2020		norod.
					To 06/30/2021	Date/Time Pre 11/23/2021 3:	
						I/P Days / 0/P	
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
		Line Number		Avai I abl e			
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00	18	6, 5	70 16, 824. 00	0 0	1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	
6.00	Hospital Adults & Peds. Swing Bed NF					0	
7.00	Total Adults and Peds. (exclude observation		18	6, 5	70 16, 824. 00	0 0	7.00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	31.00	0		0 0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGI CAL I NTENSI VE CARE UNI T						11.00
12.00	DETOXIFICATION INTENSIVE CARE UNIT	35.00	0		0 0.00	0	
13.00	NURSERY						13.00
14.00	Total (see instructions)		18	6, 5	70 16, 824. 00		
15.00	CAH visits					0	
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPICE						24.0
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	
27.00	Total (sum of lines 14-26)		18			_	27.00
28.00	Observation Bed Days					0	
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
22.02	outpatient days (see instructions)						
33.00	LTCH non-covered days						33.00
33. UI	LTCH site neutral days and discharges					1	33.0

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider C	CN: 15-1308	Period: From 07/01/2020 To 06/30/2021		pared:
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00 2.00 3.00 4.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider	238 280 0 0	9 72 0 0				1.00 2.00 3.00 4.00
5.00 6.00 7.00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions)	99 337	0 0 9	2	23		5.00 6.00 7.00
8.00 9.00 10.00 11.00	INTEŃSÌVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT	O	0		0		8.00 9.00 10.00 11.00
12.00 13.00 14.00 15.00 16.00	DETOXIFICATION INTENSIVE CARE UNIT NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF	0 337 7, 231	0 9 672	86		66. 19	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	SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC				0		17.00 18.00 19.00 20.00 21.00 23.00 24.00 24.10 25.00 26.00
26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 01	FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room	0 0 0	0 0 0	43	0 0.00 0.00 30 3 0 0 0		26. 25
33. 00 33. 01	outpatient days (see instructions) LTCH non-covered days LTCH site neutral days and discharges	0					33. 00 33. 01

	Financial Systems // AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC/	ASCENSION ST. VI AL DATA	Provider CO	CN: 15-1308	Period: From 07/01/2020 To 06/30/2021	u of Form CMS-2 Worksheet S-3 Part I Date/Time Pre 11/23/2021 3:	pared:
		Full Time Equivalents	- i	Di s	charges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	11.00	0		73 25 0 0	205	1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00
11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 23. 00 24. 00 24. 10 25. 00 26. 25	SURGICAL INTENSIVE CARE UNIT DETOXIFICATION INTENSIVE CARE UNIT NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER	0.00	0		57 3	205	11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 23. 00 24. 00 24. 00 24. 10 25. 00 26. 20
27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 01 33. 00	Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days LTCH site neutral days and discharges	0.00			0 0		20. 23 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 01 33. 00 33. 01

Heal th	Financial Systems ASCENSION ST. VINCE	ENT MERCY		In Lie	u of Form CMS-2	2552-10	
H0SPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CC	CN: 15-1308	Period:	Worksheet S-1	C	
				From 07/01/2020 To 06/30/2021	Date/Time Pre 11/23/2021 3:		
					1.00		
	Uncompensated and indigent care cost computation				1.00		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 div	ided by lir	ne 202 columr	8)	0. 286060	1.00	
	Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid				912, 366	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?		с н. н	. 10	N	3.00	
4.00 5.00	If line 3 is yes, does line 2 include all DSH and/or supplement If line 4 is no, then enter DSH and/or supplemental payments fr			10?	0	4.00 5.00	
6.00	Medicaid charges	on medical	u		15, 781, 839	5.00 6.00	
7.00	Medicaid cost (line 1 times line 6)				4, 514, 553	7.00	
8.00	Difference between net revenue and costs for Medicaid program (line 7 minu	us sum of lir	es 2 and 5; if	3, 602, 187	8.00	
	< zero then enter zero)						
	Children's Health Insurance Program (CHIP) (see instructions fo	r each line	e)				
9.00	Net revenue from stand-al one CHIP				0		
10.00	Stand-alone CHIP charges				0	10. 00 11. 00	
11. 00 12. 00	Stand-alone CHIP cost (line 1 times line 10) Difference between net revenue and costs for stand-alone CHIP (ling 11 mir	nus line 0, i	f < zero then			
12.00	enter zero)					12.00	
	Other state or local government indigent care program (see inst	ructions fo	or each line)				
13.00	Net revenue from state or local indigent care program (Not incl				0		
14.00	Charges for patients covered under state or local indigent care	e program (N	Not included	in lines 6 or	0	14.00	
15.00	10) State or local indigent care program cost (line 1 times line 14	>			0	15.00	
15.00	Difference between net revenue and costs for state or local ind		program (lir	o 15 minus lino			
10.00	13; if < zero then enter zero)	ingent care		e is minus inne	0	10.00	
	Grants, donations and total unreimbursed cost for Medicaid, CHI	P and state	e/local indig	ent care program	ns (see		
	instructions for each line)				1		
17.00	Private grants, donations, or endowment income restricted to fu				0		
18. 00 19. 00	Government grants, appropriations or transfers for support of h Total unreimbursed cost for Medicaid, CHIP and state and local			(cum of lines	0 3, 602, 187	18. 00 19. 00	
19.00	8, 12 and 16)	Thur gent	care programs	(sum of fittes	3,002,107	19.00	
			Uni nsured	Insured	Total (col. 1		
		-	patients	patients	+ col . 2)		
	Uncompensated Care (see instructions for each line)		1.00	2.00	3.00		
20.00	Charity care charges and uninsured discounts for the entire fac	ility	1, 477, 96	7 746, 257	2, 224, 224	20.00	
20.00	(see instructions)		., ., ,, ,,	, 10, 20,		201 00	
21.00	Cost of patients approved for charity care and uninsured discou instructions)	ints (see	422, 78	746, 257	1, 169, 044	21.00	
22.00	Payments received from patients for amounts previously written charity care	off as	120, 71	3 20, 904	141, 617	22.00	
23.00	Cost of charity care (line 21 minus line 22)		302, 07	725, 353	1, 027, 427	23.00	
					1.00		
24.00	Does the amount on line 20 column 2, include charges for patien	it days beyo	ond a length	of stay limit	N	24.00	
25.00	imposed on patients covered by Medicaid or other indigent care If line 24 is yes, enter the charges for patient days beyond th	program?	0	5	0	25.00	
20.00	stay limit	ie margent		s rength of		20.00	
26.00	Total bad debt expense for the entire hospital complex (see ins				2, 600, 157		
27.00	Medicare reimbursable bad debts for the entire hospital complex				641, 284 986, 590		
27.01							
28.00	Non-Medicare bad debt expense (see instructions)				1, 613, 567		
29.00 30.00	Cost of non-Medicare and non-reimbursable Medicare bad debt exp Cost of uncompensated care (line 23 column 3 plus line 29)	ense (see i	instructions)		806, 883 1, 834, 310		
	Total unreimbursed and uncompensated care cost (line 19 plus li	ne 30)			5, 436, 497		
01.00					0,100,477	51.00	

	nancial Systems / FICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	ASCENSION ST. VI	Provider C	^N· 15_1308	Peri od:	wof Form CMS- Worksheet A	2002-1
RECERSSII	TCATTON AND ADJUSTMENTS OF TRIAL BALANCE OF	LAFLINGLO	FIOVIDELCO	SN. 15-1506	From 07/01/2020	WULKSHEEL A	
					To 06/30/2021	Date/Time Pre	
	Cost Center Description	Sal ari es	Other	Total (col	1 Reclassi fi cati	11/23/2021 3: Recl assi fi ed	53 pm
	cost center bescription	Salaries	other	+ col. 2)	ons (See A-6)	Trial Balance	
				,		(col . 3 +-	
						col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	NERAL SERVICE COST CENTERS						
	100 NEW CAP REL COSTS-BLDG & FIXT		1, 105, 260				
	200 NEW CAP REL COSTS-MVBLE EQUIP		549, 458			549, 458	
	300 OTHER CAPITAL RELATED COSTS		0		0 0	0	
	400 EMPLOYEE BENEFITS DEPARTMENT	65, 367	1, 316, 238			1, 381, 605	
	500 ADMI NI STRATI VE & GENERAL	335, 590	5, 713, 449				
	700 OPERATION OF PLANT	0	1, 171, 587	1, 171, 58			
	800 LAUNDRY & LINEN SERVICE	0	0		0 47, 818		
	900 HOUSEKEEPI NG	0	480, 754				
	000 DI ETARY	0	440, 080	440, 08			
	100 CAFETERI A	0	0		0 393, 941	393, 941	
	300 NURSI NG ADMI NI STRATI ON	10, 280	20, 510			30, 790	
	500 PHARMACY	215, 410	2, 986, 204			3, 201, 373	
	600 MEDICAL RECORDS & LIBRARY	0	79		9 0	79	
	700 SOCIAL SERVICE	85, 202	4, 675	89, 87	7 0	89, 877	17.00
	PATIENT ROUTINE SERVICE COST CENTERS						
	000 ADULTS & PEDIATRICS	577, 876	317, 791	895, 66			
	100 I NTENSI VE CARE UNI T	0	0		0 0		
	040 DETOXIFICATION INTENSIVE CARE UNIT	0	0		0 0	0	35.00
	CILLARY SERVICE COST CENTERS						
	000 OPERATING ROOM	366, 555	236, 959				
	400 RADI OLOGY-DI AGNOSTI C	694, 127	93, 905	788, 03			
	600 RADI OI SOTOPE	0	0		0 0	0	
	700 CT SCAN	0	0		0 0	0	
	800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0 0	0	
	000 LABORATORY	0	1, 202, 718			1, 202, 718	
	500 RESPI RATORY THERAPY	472, 096	19, 901	491, 99			
	600 PHYSI CAL THERAPY	345, 449	18, 088				
	700 OCCUPATI ONAL THERAPY	18, 409	0				
	800 SPEECH PATHOLOGY	26, 856	1, 071	27, 92		27, 927	
	900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
	000 ELECTROENCEPHALOGRAPHY	0	0	44.74	0 0	0	
	100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	41, 719				
72.00 072	200 IMPLANTABLE DEVICES CHARGED TO	0	201, 632	201, 63	0	201, 632	72.00
72 00 07	PATIENTS	0	2 70/	2.70		2 704	72 0
	300 DRUGS CHARGED TO PATIENTS 610 SLEEP LAB		2, 786			2, 786	
		23, 024	171			23, 766	
	480 ONCOLOGY	190, 909	29, 444	220, 35	0	220, 353	76.0
	TPATIENT SERVICE COST CENTERS	201 (72	22.270	224.04	10 221	222 712	
	000 CLINIC 100 EMERGENCY	201, 673 873, 308	32, 370			223, 712	
		873, 308	1, 370, 872	2, 244, 18	-1, 471	2, 242, 709	91.00
	200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	ECIAL PURPOSE COST CENTERS	4 502 121	17 257 701	21 050 05	2 0	21 050 052	1110 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NREIMBURSABLE COST CENTERS	4, 502, 131	17, 357, 721	21, 859, 85	0	21, 859, 852	1118.00
	000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190. 00
	200 PHYSICIANS' PRIVATE OFFICES	0	0		-		
	950 MARKETING	0	0		0 0		192.0
	950 MARKETTING 951 FOUNDATION	0	0		-		194. 0 194. 0
		0	0		-		194.02
	952 CLINIC	0	0		0 0		194. 0
200.00	953 VACANT TOTAL (SUM OF LINES 118 through 199)	0 4, 502, 131	0 17, 357, 721		0		
			17 357 771		()		1 21 11 1 1 1

RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CC	N: 15-1308	Period: From 07/01/2020	Worksheet A	
					To 06/30/2021	Date/Time Pro 11/23/2021 3	
	Cost Center Description		Net Expenses				
			or Allocation				
		6.00	7.00				_
	GENERAL SERVICE COST CENTERS		75 (04 (
	00100 NEW CAP REL COSTS-BLDG & FIXT	-348, 444	756, 816				1.0
	00200 NEW CAP REL COSTS-MVBLE EQUIP	0	549, 458				2.0
	00300 OTHER CAPITAL RELATED COSTS	0	0				3.0
	00400 EMPLOYEE BENEFITS DEPARTMENT	8, 092	1, 389, 697				4. C
	00500 ADMINI STRATI VE & GENERAL	-166, 886	5, 843, 985				5. C
	00700 OPERATION OF PLANT	0	1, 177, 883				7.0
	00800 LAUNDRY & LINEN SERVICE	0	47, 818				8.0
	00900 HOUSEKEEPI NG	0	441, 275				9.0
	01000 DI ETARY	0	51, 296				10.0
	01100 CAFETERI A	-44, 997	348, 944				11.0
3.00	01300 NURSING ADMINISTRATION	-489	30, 301				13.0
5.00	01500 PHARMACY	-3, 860	3, 197, 513				15.0
5.00	01600 MEDICAL RECORDS & LIBRARY	0	79				16. 0
7.00	01700 SOCIAL SERVICE	-1, 907	87, 970				17.0
	INPATIENT ROUTINE SERVICE COST CENTERS						
0. 00	03000 ADULTS & PEDIATRICS	-244, 218	653, 451				30. (
1.00	03100 I NTENSI VE CARE UNI T	0	0				31. (
5.00	02040 DETOXIFICATION INTENSIVE CARE UNIT	0	o				35. (
	ANCI LLARY SERVI CE COST CENTERS		1				
	05000 OPERATING ROOM	-38, 736	377, 559				50.0
	05400 RADI OLOGY-DI AGNOSTI C	-3, 527	791, 160				54. (
5.00	05600 RADI OI SOTOPE	0	0				56.0
	05700 CT SCAN	0	0				57.0
	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0				58.0
	06000 LABORATORY	0	1, 202, 718				60.0
	06500 RESPI RATORY THERAPY	0	492, 201				65.0
	06600 PHYSI CAL THERAPY	0	354, 329				66. (
	06700 OCCUPATI ONAL THERAPY	0	28, 598				67.
	06800 SPEECH PATHOLOGY	0	27, 927				68.
	06900 ELECTROCARDI OLOGY	0	0				69.
	07000 ELECTROENCEPHALOGRAPHY	0	0				70.
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	248, 944				71.0
	07200 IMPLANTABLE DEVICES CHARGED TO	0	201, 632				72.
. 00	PATIENTS	0	201, 032				/2.
00	07300 DRUGS CHARGED TO PATIENTS	0	2, 786				73.
	03610 SLEEP LAB	0	23, 766				76.0
	03480 ONCOLOGY	0	220, 353				76.
	OUTPATIENT SERVICE COST CENTERS	0	220, 333				- 70.
	09000 CLINIC	0	223, 712				90. (
	09100 EMERGENCY						
		-1, 275	2, 241, 434				91.0
	09200 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS						92.1
		046 247	21 012 (05				118.0
8.00		-846, 247	21, 013, 605				$-1^{118.1}$
	NONREIMBURSABLE COST CENTERS		0				-
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190.
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0				192.
	07950 MARKETI NG	0	0				194.
	07951 FOUNDATI ON	0	0				194.
	07952 CLI NI C	0	0				194.
	07953 VACANT	0	0				194. (
0.00	TOTAL (SUM OF LINES 118 through 199)	-846, 247	21,013,605				200.

Low Line # Salary Other 2.00 3.00 4.00 5.00 A - CAFETRIA 11.00 0 393,941 TOTALS 11.00 0 393,941 1.00 CAFETRIA 11.00 0 393,941 TOTALS 11.00 0 393,941 1. B - Laundry 1 1.00 0 393,941 1. 1.00 LAUNDRY & LINEN SERVICE 8.00 47,818 1. 0 D - BITI Bable Med Suppli es 0 47,818 1. 1.00 PARI ENTS 207,225 1. 1. 2.00 3.00 - - - 7. 3.00 - - 0 207,225 1. 1.00 DecuPATI ONAL THEAPY PELLESS 10,189 - - 1.00 Adult Tis & PEDI ATRICS 30.00 752 1.182 1. 2.00 RADIOLOC FUNITIC SA LINERAPY 60.00 14 2.49	Heal th	Financial Systems		ASCENSION ST. VI	NCENT MERCY	In Lie	u of Form CMS-2552-10
$ \begin{array}{ c c c c c c c c c c c c c c c c c c c$					Provi der CCN: 15-1308	Period: From 07/01/2020	
2.00 3.00 4.00 5.00 A - CAFETERIA 11.00 0 393, 941 1 1.00 CAFETERIA 0 393, 941 1 1.00 LAUNDRY & LINEN SERVICE 0 393, 941 1 1.00 LAUNDRY & LINEN SERVICE 0 47, 818 1 1.00 EAUNORY & LINEN SERVICE 0 47, 818 1 1.00 FBI 1 able Med Supplies 0 47, 818 1 1.00 PADICAL SUPPLIES CHARGED TO 71.00 207, 225 1 2.00			Increases				
A CAFETERIA 11.00 0 393.941 1. 1.00 TOTALS 0 393.941 1. 1.00 LAUNDRY & LINEN SERVICE 0 393.941 1. 1.00 LAUNDRY & LINEN SERVICE 8.00 47.818 1. 0 - 8111able Med Supplies 0 47.818 1. 1.00 - 8111able Med Supplies 0 207.225 1. 2.00 - 0 - 0 207.225 1. 2.00 - 0 - 0 207.225 5. 1.00 OCCUPATIONAL THERAPY RECLASS 0 - 0 207.225 1.00 OCCUPATIONAL THERAPY RECLASS 0 - 0 207.225 1.00 OCCUPATIONAL THERAPY 67.00 10.189 - 1 1.00 OCCUPATIONAL THERAPY 67.00 10.189 - 1 1.00 OCCUPATIONAL THERAPY 67.00 14.23 3. 1.00 ADULTS & PEDIATRICS 30.00 752 1.182 1. 2.00 RADIOLOCY-DLARONSTIC 54.00 3.411 5.412 3. <tr< td=""><td></td><td>Cost Center</td><td>Line #</td><td>Salary</td><td>Other</td><td></td><td></td></tr<>		Cost Center	Line #	Salary	Other		
1.00 CAFFTERIA 11.00 0 393,941 1. 10 0 393,941 1. 1. 1. 100 LAUNDRY & LINEN SERVICE 8.00 - 47,818 1. 1.00 Billable Med Supplies 0 47,818 1. 1.00 MEDICAL SUPPLIES CHARGED TO 71.00 207,225 1. 2.00 3.00 4.00 4.00 4.00 5.00 3.00 - 0 207,225 7. 1. 7.00 - 0 207,225 7. 7. 6.00 - - 0 207,225 7. 7. 7.00 - - 0 207,225 7. 7. 6.00 - - 0 207,225 7. 7. 7.00 - - 0 207,225 7. 7. 7.00 - - 0 207,225 7. 7. 8.00 10.0189 - - 1. 7. 7. 7. 7.		2.00	3.00	4.00	5.00		
TOTALS		A - CAFETERIA		· · · · · ·	÷		
TOTALS	1.00	CAFETERI A	11.00	0	393, 941		1.00
B Laundry A. O A. 7, 818 1. 1.00 LAUNDRY & LINEN SERVICE 8.00 47, 818 1. 0 BIH table Med Supplies 0 47, 818 1. 1.00 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 207, 225 1. 2.00 3.00 4.00 4.00 4.00 4.00 4.00							
1.00 LAUNDRY & LINEN SERVICE 8.00 47.818 1. 0 - 8111 abl e Med Supplies 0 47.818 1. 1.00 MEDICAL SUPPLIES CHARGED TO 71.00 207.225 2.00 2.00 - - 0 207.225 2.00 3.00 - - 0 207.225 2.00 4.00 - - 0 207.225 7. 5.00 - - 0 207.225 7. 6.00 - - 0 207.225 7. 1.00 COUPATI ONAL THERAPY RECLASS - - 0 207.225 1.00 COUPATI ONAL THERAPY RECLASS - - 0 207.225 7. 1.00 RADUIS & PEDIATRICS 30.00 752 1.182 3. 3. 1.00 RADUIS & PEDIATRICS 30.00 752 1.182 3. 2.00 RADUIS & PEDIATRICS 30.00 222.349 4. 4. 5.00 EMERGENCY 9.00 6.347 9.983 5. 5.<			I	· · ·			
D Billable Med Supplies 1.00 MEDICAL SUPPLIES CHARGED TO 71.00 207, 225 1. 2.00 3.00 47, 618 2. 3. 3.00 400 5.00 47, 618 2. 6.00 - - - 2.07, 225 2. 7.00 - - - 0 207, 225 7. 6.00 - - - 0 207, 225 7. 6.00 - - 0 207, 225 7. 7. 7.00 - - 0 207, 225 7. 7. 7.00 - - 0 207, 225 7. 7. 8.00 CCUPATI ONAL THERAPY RECLASS - - 0 7. 1. 9.00 CCUPATI ONAL THERAPY RECLASS - 1. 1. 1. 9.00 AULTS & PEDIATRICS 30.00 7.52 1.182 1. 1. 1.00 DUETRY	1.00		8,00		47, 818		1.00
D Billable Med Supplies 1.00 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 207,225 1. 2.00 2. 3.00 3.00 3.00 3.00 4.00							
1.00 MEDICAL SUPPLIES CHARGED TO 71.00 207,225 1. 2.00 3.00 4.00 3. 4.00 3. 5.00		D - Billable Med Supplies		-1	,		
2.00 A.00 2.00 3.00 4.00 3.00 4.00 5.00 6.00 7.00 4.00 5.00 6.00 7.00 6.00 7.00	1 00		71 00		207 225		1.00
2.00 3.00 4.00 3. 5.00 6.00 - - 0 207, 225 E - OCCUPATI ONAL THERAPY RECLASS - 0 207, 225 - 1.00 OCCUPATI ONAL THERAPY RECLASS - 0 - 0 F - Pandemic Sal ary Expenses - 0 - 0 1 1.00 ADULTS & PEDI ATRICS 30.00 752 1, 182 1 2.00 RADI OLOCY-DI AGNOSTI C 54.00 3, 411 5, 412 2 3.00 PHYSICAL THERAPY 66.00 14 23 3 4.00 SLEEP LAB 76.00 222 349 4 5.00 EMERGENCY 91.00 1, 918 3, 017 5 6 - Pandemic Other Expenses - - 0 19, 792 1 1.00 DIETARY 10.00 5, 157 . . 2 3.00 OPERATION OF PLANT 7.00 6, 240 . 2 . 1.00 AUSEKEPING 9.00 3, 339 . . <t< td=""><td></td><td></td><td>, 00</td><td></td><td>2077220</td><td></td><td></td></t<>			, 00		2077220		
3.00 4.00 3. 4.00 5.00 6.00	2.00						2.00
4.00 5.00 4. 5.00 - - - 6. 7.00 - 0 207, 225 7. E - OCCUPATI ONAL THERAPY RECLASS - 0 207, 225 7. 1.00 OCCUPATI ONAL THERAPY 67.00 10, 189 - - F - Pandemic Sal ary Expenses - 10, 189 - - 1. CCUPATI ONAL THERAPY 66.00 752 1, 182 1. 1. 2.00 RADI OLOGY-DI AGNOSTI C 54.00 3, 441 5, 412 2. 3.00 PHYSI CAL THERAPY 66.00 14 23 3. 4.00 SLEEP LAB 76.00 222 349 4. 5.00 EMERGENCY 91.00 1, 918 3, 017 5. G - Pandemic Other Expenses - - 0 19, 792 1. 1.00 DI ETARY 10.00 5, 157 1. 2. 2.00 HOUSEKEEPI NG 9.00 8, 339 2. 3. 3.00 OPERATI ON OF PLANT - <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td>3.00</td></t<>							3.00
5.00 6.00							4.00
6.00							5.00
7.00							6.00
E OCCUPATI ONAL THERAPY RECLASS 1.00 OCCUPATI ONAL THERAPY 67.00 10,189 0 F Pandemi c Sal ary Expenses 10,189 0 1. ADULTS & PEDI ATRI CS 30.00 752 1,182 1. 3.00 PHYSI CAL THERAPY 66.00 14 23 3. 4.00 SLEEP LAB 76.00 2222 349 4. 5.00 EMERGENCY							7.00
E OCCUPATI ONAL THERAPY 67.00 10,189 1.01 F Pandemic Sal ary Expenses 1.01,189 0 1.01 ADULTS & PEDI ATRICS 30.00 752 1,182 1.00 1.02 ADULTS & PEDI ATRICS 30.00 752 1,182 1.00 1.02 ADULTS & PEDI ATRICS 30.00 752 1,182 2.00 1.02 1.02 2.00 1.02 2.00 RADIOLOGY-DI AGNOSTIC 54.00 3,441 5,412 2.00 2.00 1.02 2.00 2.00 1.02 2.00 3.017 3.00 3.017 3.017 3.017 5.00 2.00 1.000 1.918 3.017 5.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 1.00 1.00 5.157 3.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00	7.00		+				7.00
1.00 OCCUPATI ONAL THERAPY 67.00 10,189 1 1.00 ADULTS & PEDI ATRI CS 30.00 752 1,182 1 2.00 RADI OLOGY-DI AGNOSTI C 54.00 3,441 5,412 2 3.00 PHYSI CAL THERAPY 66.00 14 23 3 4.00 SLEEP LAB 76.00 222 349 4 5.00 EMERGENCY 91.00 1,918 3,017 5 6 - Pandemi c Other Expenses 7 1 1 1 1.00 DI ETARY 10.00 5,157 1 1 1 1.00 DI ETARY 10.00 5,157 3 1 1 1 1.00 DI ETARY 10.00 5,157 3 1 1 1 1.00 DI ETARY 10.00 5,157 3 3 1 1 1.00 ADULTS & PEDI ATRI CS 30.00 356 1 1 1 1.00 ADULTS & PEDI ATRI CS 30.00 356 2 2 3			224	U	207, 225		
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F - Pandemic Sal ary Expenses 1.00 ADULTS & PEDI ATRI CS 30.00 752 1,182 1. 2.00 RADI OLOGY-DI AGNOSTI C 54.00 3,441 5,412 2. 3.00 PHYSI CAL THERAPY 66.00 14 23 3. 4.00 SLEEP LAB 76.00 222 349 4. 5.00 EMERGENCY 91.00 1,918 3,017 5. 6 - Pandemic Other Expenses 6.347 9,983 5. 6 - Pandemic Other Expenses 1. 1. 1. 2.00 HOUSEKEEPI NG 9.00 8,339 2. 3.00 OPERATION OF PLANT 7.00 6,296 3. H - C19 Vacci ne Adverse Reacti on 0 19,792 1. 1.00 ADULTS & PEDI ATRI CS 30.00 356 1. 2.00 RESPI RATORY THERAPY 65.00 240 2. 3.00 PHYSI CAL THERAPY 66.00 944 3. 4.00 EMERGENCY 91.00 506 4.	1.00	UCCUPATIONAL THERAPT					1.00
1.00 ADULTS & PEDIATRICS 30.00 752 1, 182 1. 2.00 RADIOLOGY-DIAGNOSTIC 54.00 3, 441 5, 412 2. 3.00 PHYSICAL THERAPY 66.00 14 23 3. 4.00 SLEEP LAB 76.00 222 349 3. 5.00 EMERGENCY 91.00 1,918 3,017 5. 6 Pandemic Other Expenses 6,347 9,983 5. 6 Pandemic Other Expenses 1. 1. 1. 1.00 DI ETARY 10.00 5,157 1. 2.00 HOUSEKEEPI NG 9.00 8,339 2. 3.00 OPERATION OF PLANT 7.00 6,296 3. 4.00 ADULTS & PEDIATRICS 30.00 356 1. 2.00 RESPI RATORY THERAPY 65.00 240 2. 3.00 PHYSI CAL THERAPY 66.00 944 3. 4.00 EMERGENCY 91.00 506 3. 4.00 EMERGENCY 91.00 506 3. <td></td> <td>E Dandomi o Sal arxy Exponence</td> <td></td> <td>10, 109</td> <td>0</td> <td></td> <td></td>		E Dandomi o Sal arxy Exponence		10, 109	0		
2.00 RADI OLOGY-DI AGNOSTI C 54.00 3,441 5,412 2. 3.00 PHYSI CAL THERAPY 66.00 14 23 3. 4.00 SLEEP LAB 76.00 222 349 4. 5.00 EMERGENCY 91.00 1,918 3,017 5. 6 - Pandemic Other Expenses 5. 5. 6 - Pandemic Other Expenses 7.00 1. 2.00 HOUSEKEEPI NG 9.00 8,339 2. 3.00 OPERATI ON OF PLANT 7.00 6,296 3. 4 C 19 Vacci ne Adverse Reacti on - 0 19,792 H - C 19 Vacci ne Adverse Reacti on 30.00 356 1. 2.00 RESPI RATORY THERAPY 65.00 240 2. 3.00 9HYSI CAL THERAPY 66.00 944 3. 4.00 EMERGENCY 91.00 506 3. 4.00 EMERGENCY 91.00 506 3.	1 00		20.00	750	1 100		1.00
3.00 PHYSI CAL THERAPY 66.00 14 23 3. 4.00 SLEEP LAB 76.00 222 349 4. 5.00 EMERGENCY 91.00 1,918 3,017 5. G - Pandemic Other Expenses 6,347 9,983 5. 5. G - Pandemic Other Expenses 10.00 5,157 1. 2.00 HOUSEKEEPI NG 9.00 8,339 2. 3.00 OPERATI ON OF PLANT 7.00 6,296 3. H - C19 Vacci ne Adverse Reacti on 0 19,792 1. H - C19 Vacci ne Adverse Reacti on 240 2. 3.00 0 PHYSI CAL THERAPY 65.00 240 2. 3.00 PHYSI CAL THERAPY 66.00 9.44 3. 4.00 EMERGENCY 91.00 506 3. Image: Construct of the Consthe Construct of the Construct of the Const							2.00
4.00 SLEEP LAB 76.00 222 349 4. 5.00 EMERGENCY 91.00 1,918 3,017 5. G - Pandemic Other Expenses 6,347 9,983 5. 1.00 DI ETARY 10.00 5,157 1. 2.00 HOUSEKEEPI NG 9.00 8,339 3. 3.00 OPERATI ON OF PLANT 7.00 6,296 3. H - C19 Vacci ne Adverse Reacti on 0 19,792 3. H - C19 Vacci ne Adverse Reacti on 30.00 356 1. 2.00 RESPI RATORY THERAPY 65.00 240 2. 3.00 PHYSI CAL THERAPY 66.00 944 3. 4.00 EMERGENCY 91.00 506 3. 4.00 EMERGENCY 91.00 506 4.							
5.00 EMERGENCY							3.00
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G - Pandemic Other Expenses 1.00 DI ETARY 10.00 5,157 1. 2.00 HOUSEKEEPING 9.00 8,339 2. 3.00 OPERATION OF PLANT 7.00 6,296 3. H - C19 Vacci ne Adverse Reaction 0 19,792 1. 1.00 ADULTS & PEDI ATRICS 30.00 356 1. 2.00 RESPI RATORY THERAPY 65.00 240 2. 3.00 PHYSI CAL THERAPY 66.00 944 3. 4.00 EMERGENCY 91.00 506 4.	5.00	EMERGENCY					5.00
1.00 DI ETARY 10.00 5,157 1. 2.00 HOUSEKEEPING 9.00 8,339 2. 3.00 OPERATION OF PLANT 7.00 6,296 3. H - C19 Vacci ne Adverse Reaction 0 19,792 1. 1.00 ADULTS & PEDI ATRICS 30.00 356 1. 2.00 RESPI RATORY THERAPY 65.00 240 2. 3.00 PHYSI CAL THERAPY 66.00 944 3. 4.00 EMERGENCY 91.00 506 3. 0 2,046 0 2,046 4.		C Dandania Othan Fu		6, 347	9, 983		
2.00 HOUSEKEEPING 9.00 8,339 2. 3.00 OPERATION_OF_PLANT	4 00		40.00		E 457		
3.00 OPERATION OF PLANT 7.00 6,296 3. H - C19 Vaccine Adverse Reaction 0 19,792 1.00 ADULTS & PEDIATRICS 30.00 356 1. 2.00 RESPIRATORY THERAPY 65.00 240 2. 3.00 PHYSI CAL THERAPY 66.00 944 3. 4.00 EMERGENCY 91.00 506 4.							1.00
H - C19 Vacci ne Adverse Reacti on 1.00 ADULTS & PEDIATRICS 30.00 356 2.00 RESPIRATORY THERAPY 65.00 240 3.00 944 4.00 EMERGENCY 91.00 506 0 2.046							2.00
H - C19 Vaccine Adverse Reaction 1.00 ADULTS & PEDIATRICS 30.00 356 1. 2.00 RESPIRATORY THERAPY 65.00 240 2. 3.00 PHYSI CAL THERAPY 66.00 944 3. 4.00 EMERGENCY 91.00 506 4.	3.00	OPERATION OF PLANT		+			3.00
1.00 ADULTS & PEDIATRICS 30.00 356 1. 2.00 RESPIRATORY THERAPY 65.00 240 2. 3.00 PHYSI CAL THERAPY 66.00 944 3. 4.00 EMERGENCY 91.00 506 4.				0	19, 792		
2.00 RESPIRATORY THERAPY 65.00 240 2. 3.00 PHYSI CAL THERAPY 66.00 944 3. 4.00 EMERGENCY 91.00 506 4.							
3. 00 PHYSI CAL THERAPY 66. 00 944 3. 4. 00 EMERGENCY 91. 00 506 4. 0 2, 046 4.							1.00
4.00 <u>EMERGENCY</u> 91.00 506 0 2,046							2.00
							3.00
	4.00	EMERGENCY	91.00				4.00
F00 00 (mand Tatal), Increases				0			
500, 00 juranu 10 tali increases 16, 536 680, 805 500.	500.00	Grand Total: Increases		16, 536	680, 805		500.00

Heal th	Financial Systems	ļ	ASCENSION ST. VI	NCENT MERCY		In Lie	u of Form CMS-2552-10
	SIFICATIONS			Provider (CCN: 15-1308	Period: From 07/01/2020 To 06/30/2021	Worksheet A-6 Date/Time Prepared: 11/23/2021 3:53 pm
		Decreases				I	1172372021 3. 33 pm
	Cost Center	Li ne #	Salary	Other	Wkst. A-7 Rei	F	
	6,00	7.00	8.00	9,00	10,00		
	A – CAFETERIA	7.00	0.00	7.00	10.00		
1.00	DI ETARY	10.00	0	393, 941		0	1.00
1.00	TOTALS		0			0	1.00
	B - Laundry		<u>ч</u>	373, 741			
1.00	HOUSEKEEPING	9.00		47, 818			1.00
1.00				47, 818		-	1.00
	D - Billable Med Supplies		9	17,010			
1.00	PHARMACY	15.00		241			1.00
2.00	ADULTS & PEDIATRICS	30,00		288			2.00
3.00	OPERATING ROOM	50.00		187, 219			3.00
4.00	RADI OLOGY-DI AGNOSTI C	54.00		2, 198			4.00
5.00	RESPI RATORY THERAPY	65.00		36			5.00
6.00	EMERGENCY	91.00		6, 912			6.00
7.00	CLINIC	90.00		10, 331			7.00
7.00				207, 225		-	7.00
	E - OCCUPATIONAL THERAPY RECL	ASS	9	207,220			
1.00	PHYSICAL THERAPY	66.00	10, 189				1.00
			10, 189	a	,	-	
	F - Pandemic Salary Expenses		10/10/				
1.00	ADMI NI STRATI VE & GENERAL	5.00	6, 347	9, 983			1.00
2.00		0.00	0,011	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			2.00
3.00							3.00
4.00							4.00
5.00							5.00
0.00		+	6, 347	9, 983		-	0.00
	G - Pandemic Other Expenses		0,017	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
1.00	ADMI NI STRATI VE & GENERAL	5.00		19, 792			1.00
2.00		0.00		.,,,,			2.00
3.00							3.00
0.00		+		19, 792		-	
	H - C19 Vaccine Adverse React	ion	V		•		
1.00	ADMI NI STRATI VE & GENERAL	5.00	2,046				1.00
2.00		0.00	2,010				2.00
3.00							3.00
4.00							4.00
	<u> </u>	+	2,046	0	<u> </u>	-	1.00
500,00	Grand Total: Decreases		18, 582	678, 759		-	500.00
00		I		,,,,,,,	1	I	1

Heal th	Financial Systems	ASCENSION ST. V	/INCENT MERCY			In Lie	u of Form CMS-2	2552-10
RECONC	LIATION OF CAPITAL COSTS CENTERS		Provider CO	CN: 15-1308		iod: m 07/01/2020 06/30/2021		pared:
				Acquisition:	s			
		Begi nni ng	Purchases	Donati on		Total	Di sposal s and	
		Bal ances					Retirements	
		1.00	2.00	3.00		4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE							
1.00	Land	465, 381	0		0	0	0	1.00
2.00	Land Improvements	589, 750	0		0	0	0	2.00
3.00	Buildings and Fixtures	13, 353, 069	0		0	0	0	3.00
4.00	Building Improvements	9, 711, 900	214, 351		0	214, 351	0	4.00
5.00	Fixed Equipment	3, 762, 547	70, 331		0	70, 331	0	5.00
6.00	Movable Equipment	7, 392, 851	764, 298		0	764, 298	0	6.00
7.00	HIT designated Assets	0	0		0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	35, 275, 498	1, 048, 980		0	1, 048, 980	0	8.00
9.00	Reconciling Items	0	0		0	0	0	9.00
10.00	Total (line 8 minus line 9)	35, 275, 498	1, 048, 980		0	1, 048, 980	0	10.00
		Ending Balance	Fully					
		Ũ	Depreci ated					
			Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	F BALANCES						
1.00	Land	465, 381	0					1.00
2.00	Land Improvements	589, 750	0					2.00
3.00	Buildings and Fixtures	13, 353, 069	0					3.00
4.00	Building Improvements	9, 926, 251	0					4.00
5.00	Fixed Equipment	3, 832, 878	0					5.00
6.00	Movable Equipment	8, 157, 149	0					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	36, 324, 478	0					8.00
9.00	Reconciling Items	0	0					9.00
10.00	Total (line 8 minus line 9)	36, 324, 478	0					10.00
	•							•

Heal th	Financial Systems	ASCENSION ST. \	/INCENT MERCY		In Lieu of Form CMS-2552-10		
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provider CC		Period:	Worksheet A-7	
					From 07/01/2020 To 06/30/2021		narod
					10 00/ 30/ 2021	11/23/2021 3:	53 pm
			SL	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 WOR				12.00	13.00	
1.00	NEW CAP REL COSTS-BLDG & FIXT	756, 705		348, 44	4 0	111	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	492, 746	56, 712		0 0	0	2.00
3.00	Total (sum of lines 1-2)	1, 249, 451		348, 44	4 0	111	3.00
		SUMMARY 0	F CAPITAL				
		0.11	T L L (4) (
	Cost Center Description		Total (1) (sum of cols. 9				
		Capital-Relate d Costs (see	through 14)				
		instructions)	thi ough 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1, 105, 260				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	549, 458				2.00
3.00	Total (sum of lines 1-2)	0	1, 654, 718				3.00

Health Financial Systems	ASCENSION ST.	VINCENT MERCY		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 07/01/2020 Fo 06/30/2021		
	COM	PUTATION OF RAT	FI 0S	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capitalized	Gross Assets	Ratio (see	Insurance	
		Leases	for Ratio (col. 1 - col. 2)	instructions)		
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE		1		1		
1.00 NEW CAP REL COSTS-BLDG & FIXT	14, 408, 201		14, 408, 201		0	1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	21, 916, 279		21, 916, 279		0	2.00
3.00 Total (sum of lines 1-2)	36, 324, 480		36, 324, 480		0	3.00
	ALLOCA	TION OF OTHER (CAPITAL	SUMMARY C	F CAPITAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Rel ate				
		d Costs	through 7)			
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE				75 (705		
1.00 NEW CAP REL COSTS-BLDG & FLXT	0	0		756, 705		1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	0	0		492, 746		2.00
3.00 Total (sum of lines 1-2)	0	0		1, 249, 451	56, 712	3.00
		SL	JMMARY OF CAPI			
Cost Center Description	Interest	Insurance (see			Total (2) (sum	
		instructions)	instructions)			
				d Costs (see	through 14)	
	44.00	10.00	10.00	instructions)	45.00	
PART III - RECONCILIATION OF CAPITAL COSTS C	11.00	12.00	13.00	14.00	15.00	
1.00 NEW CAP REL COSTS-BLDG & FIXT	INTERS 0	0	11.	1	756, 816	1.00
2.00 NEW CAP REL COSTS-BLDG & FIXT	0	-		-	549, 458	2.00
3.00 Total (sum of lines 1-2)	0	-		-	1, 306, 274	3.00
3.00 ± 0.00 (Sum of Thes $1-2$)	0	1 0		'I 0	1, 300, 274	5.00

	Financial Systems MENTS TO EXPENSES		ASCENSI ON ST.	Provider CCN: 15-1308 F	Period:	u of Form CMS-2 Worksheet A-8	
1.000001				F	rom 07/01/2020 o 06/30/2021		
	· · · · · · · · · · · · · · · · · · ·	1	1			11/23/2021 3:	
				Expense Classification on To/From Which the Amount is			
				To The Anount TS	to be Aujusted		
	Cost Center Description	Basi s/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Line # 4.00	Wkst. A-7 Ref. 5.00	
1.00	Investment income - NEW CAP	B		NEW CAP REL COSTS-BLDG &	4.00		1.00
	REL COSTS-BLDG & FIXT (chapter			FIXT			
2.00	2) Investment income - NEW CAP		0	NEW CAP REL COSTS-MVBLE	2.00	0	2.00
	REL COSTS-MVBLE EQUIP (chapter			EQUI P			
3.00	2) Investment income - other	В	-10, 695	ADMI NI STRATI VE & GENERAL	5.00	0	3.00
	(chapter 2)						1 00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of		0		0.00	0	5.00
6.00	expenses (chapter 8) Rental of provider space by		0		0.00	0	6.00
	suppliers (chapter 8)						
7.00	Telephone services (pay stations excluded) (chapter	A	-7, 446	ADMI NI STRATI VE & GENERAL	5.00	0	7.00
	21)						
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-247, 727			0	10.00
11.00	Sale of scrap, waste, etc.		0		0.00	0	11.00
12 00	(chapter 23) Related organization	A-8-1	1, 374, 280			0	12.00
12.00	transactions (chapter 10)	A-0-1	1, 374, 200			0	12.00
	Laundry and linen service	В	0		0.00 11.00		
	Cafeteria-employees and guests Rental of quarters to employee		-44, 997	CAFETERI A	0.00		
1 / 00	and others				0.00		1/ 00
16.00	Sale of medical and surgical supplies to other than		0		0.00	0	16.00
17 00	patients		2.040	DUADMACY	15.00		17 00
17.00	Sale of drugs to other than patients	В	-3,860	PHARMACY	15.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health		0		0.00	0	19.00
	education (tuition, fees,						
20. 00	books, etc.) Vending machines		0		0.00	0	20.00
21. 00	Income from imposition of		0		0.00	0	21.00
	interest, finance or penalty charges (chapter 21)						
22. 00	Interest expense on Medicare		0		0.00	0	22.00
	overpayments and borrowings to repay Medicare overpayments						
23.00	Adjustment for respiratory	A-8-3	0	RESPI RATORY THERAPY	65.00		23.00
	therapy costs in excess of limitation (chapter 14)						
24.00	Adjustment for physical	A-8-3	0	PHYSICAL 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 (chapter 21)						
26.00	Depreciation - NEW CAP REL		0	NEW CAP REL COSTS-BLDG &	1.00	0	26.00
27 00	COSTS-BLDG & FIXT Depreciation - NEW CAP REL		0	FIXT NEW CAP REL COSTS-MVBLE	2.00	0	27.00
	COSTS-MVBLE EQUIP			EQUI P			
	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00 0.00		28.00 29.00
	Physicians' assistant Adjustment for occupational	A-8-3		OCCUPATI ONAL THERAPY	67.00		30.00
	therapy costs in excess of						
30. 99	limitation (chapter 14) Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30.99
	instructions)						
31.00	Adjustment for speech pathology costs in excess of	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00

pathology costs in excess of limitation (chapter 14)

Health Financial Systems		ASCENSION ST.	VINCENT MERCY	In Lie	u of Form CMS-2	2552-10
ADJUSTMENTS TO EXPENSES				Period:	Worksheet A-8	
				From 07/01/2020 To 06/30/2021	Date/Time Pre	narod
				10 00/ 30/ 2021	11/23/2021 3:	
			Expense Classification or	Worksheet A		
			To/From Which the Amount is	to be Adjusted		
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	
32.00 CAH HIT Adjustment for		0		0.00	0	32.00
Depreciation and Interest						
33.00 Admin Revenue	В		ADMI NI STRATI VE & GENERAL	5.00		00.00
33.02 Social Service	В		SOCIAL SERVICE	17.00		00.02
33.03 Adults & Pediatrics	В	-18	ADULTS & PEDIATRICS	30.00	0	33.03
33.04 Operating Room	В	-38, 736	OPERATING ROOM	50.00	0	33.04
33.05 Emergency	В	-1, 275	EMERGENCY	91.00	0	33.05
33. 06 Lobbyi ng	A	-474	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.08 Community Relations	A	-1, 700	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.10 Med Affairs Admin	A	-39	EMPLOYEE BENEFITS DEPARTMEN	Г 4.00	0	33.10
33.11 Med Affairs Admin	A	-22, 743	ADMINISTRATIVE & GENERAL	5.00	0	33. 11
33.12 Provider Tax	A	-1, 278, 414	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13 Advertising	A	-600	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14 Marketing	A	-950	ADMINISTRATIVE & GENERAL	5.00	0	33.14
33.15 Promotional Items	A	-489	NURSING ADMINISTRATION	13.00	0	33.15
33.16 Physician Fund Expense	A	-172, 676	ADMI NI STRATI VE & GENERAL	5.00	0	33.16
50.00 TOTAL (sum of lines 1 thru 49)		-846, 247	,			50.00
(Transfer to Worksheet A,						
column 6, line 200.)						

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

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

Heal th	Financial Systems	ASCENSI ON ST.	VINCENT MERCY	In Lie	eu of Form CMS-	2552-10
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOM	ME Provider CCN: 15-1308	Peri od:	Worksheet A-8	8-1
OFFICE	COSTS			From 07/01/2020 To 06/30/2021		
	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	
	A. COSTS INCURRED AND ADJUST HOME OFFICE COSTS:	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED O	RGANIZATIONS OR	CLAI MED	
1.00	5.00	ADMINISTRATIVE & GENERAL	Home Office - Capital	351, 246	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	Home Office - Interest	6, 341	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	Home Office - Other	5, 055, 265	4, 046, 704	3.00
3.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	ASV CHARGEBACKS	2, 751	2, 751	3.01
3.02	15.00	PHARMACY	ASV CHARGEBACKS	4,000	4,000	3. 02
3.03	54.00	RADI OLOGY-DI AGNOSTI C	ASV CHARGEBACKS	44, 354	44, 354	3.03
3.04	65.00	RESPI RATORY THERAPY	ASV CHARGEBACKS	3, 744	3, 744	3.04
3.05	91.00	EMERGENCY	ASV CHARGEBACKS	-2, 400	-2,400	3.05
3.06	4.00	EMPLOYEE BENEFITS DEPARTMENT	Health Insurance	848, 235	840, 104	3.06
3.07	1.00	NEW CAP REL COSTS-BLDG & FIX	Interest Expense	344, 091	348, 444	3.07
3.08	5.00	ADMINISTRATIVE & GENERAL	Interest Expense	4, 354	0	3.08
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4).			6, 661, 981	5, 287, 701	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		Name	Ŭ,	
				Ownershi p		Ownership	
		1.00	2.00	3.00	4.00	5.00	
		B. INTERRELATIONSHIP TO RELA	TED ORGANIZATION(S) AND/OR HC	ME OFFICE:			

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

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

1 CT IIIDUI					
6.00	G	ASCENSI ON SVH	1.00 ASCENSION SVH	1.00	6.00
7.00	G	ASCENSI ON	1. 00 ASCENSI ON	1.00	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. VIN	CENT MERCY	u of Form CMS-2552-10	
STATEMENT OF COSTS OF SERVICES I OFFICE COSTS	FROM RELATED ORGANIZATIONS AND HOME	Provider CCN: 15-1308	Period: From 07/01/2020 To 06/30/2021	Worksheet A-8-1 Date/Time Prepared:

						11/23/2021 3:53	pm
	Net	Wkst. A-7 Ref.					
	Adjustments						
	(col. 4 minus						
	col. 5)*						
	6.00	7.00					
	A. COSTS INCUR	RED AND ADJUSTN	MENTS REQUIRED AS A RESULT OF TRAM	SACTIONS WITH RELATED O	RGANIZATIONS OR C	LAIMED	
	HOME OFFICE CO						
1.00	351, 246	0				1	1. 00
2.00	6, 341	0				2	2.00
3.00	1,008,561	0				3	3.00
3.01	0	0				3	3. 01
3.02	0	0				3	3. 02
3.03	0	0				3	3. 03
3.04	0	0				3	3. 04
3.05	0	0				3	3.05
3.06	8, 131	0				3	3.06
3.07	-4, 353	11				3	3.07
3.08	4, 354	0				3	3. 08
4.00	0	0				4	4.00
5.00	1, 374, 280					5	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

rerinbur	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.

Health Financial Systems ASCENSION ST. VINCENT MERCY PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 15-1308 Period	In Lieu of Form CMS-2552-10 d: Worksheet A-8-2
To C	07/01/2020 06/30/2021 Date/Time Prepared: 11/23/2021 3:53 pm
Wkst. A Line #Cost Center/Physician IdentifierTotal RemunerationProfessional ComponentProvider ComponentRCE	E Amount Physician/Prov ider Component Hours
1.00 2.00 3.00 4.00 5.00	6.00 7.00
1.00 30.00 ADULTS & PEDIATRICS 244,200 244,200 0 2.00 54.00 RADI OLOGY-DI AGNOSTIC 3,527 3,527 0 3.00 91.00 EMERGENCY 1,246,823 0 1,246,823	0 0 1.00 0 0 2.00 0 0 3.00
4.00 0.00 0 0 0 5.00 0.00 0 0 0 0 6.00 0.00 0 0 0 0	0 0 4.00 0 0 5.00 0 0 6.00
7.00 0.00 0 </td <td>0 0 7.00 0 0 8.00 0 0 9.00</td>	0 0 7.00 0 0 8.00 0 0 9.00
10.00 0.00 0<	0 0 10.00 0 200.00
Wkst. A Line # Cost Center/Physician Unadjusted RCE 5 Percent of Cost of Pr Identifier Limit Unadjusted RCE 5 Memberships & Cor	rovider Physician Cost mponent of Malpractice e of col. Insurance
1.00 2.00 8.00 9.00 12.00	13.00 14.00
1.00 30.00 ADULTS & PEDIATRICS 0 0 0	0 0 1.00
2.00 54.00 RADI OLOGY-DI AGNOSTI C 0 0 0	0 0 2.00
3.00 91.00 EMERGENCY 0 0 0	0 0 3.00
4.00 0.00 0 0	0 0 4.00
5.00 0.00 0 0	0 5.00
6.00 0.00 0 0	0 0 6.00
7.00 0.00 0 0	0 7.00
8.00 0.00 0 0	0 0 8.00
9.00 0.00 0 0	0 9.00
10.00 0.00 0 0	0 0 10.00
	0 0 200.00
Wkst. A Line # Cost Center/Physician Provider Adjusted RCE RCE Adj Identifier Component Limit Disallowance Adjusted RCE Adj	justment
	18.00
1.00 30.00 ADULTS & PEDI ATRI CS 0 0 0	244, 200 1. 00
2. 00 54. 00 RADI OLOGY-DI AGNOSTI C 0 0 0	3, 527 2. 00
3.00 91.00 EMERGENCY 0 0 0	0 3.00
4.00 0.00 0 0	0 4.00
5.00 0.00 0 0	0 5.00
6.00 0.00 0 0	0 6.00
7.00 0.00 0 0	0 7.00
8.00 0.00 0 0	0 8.00
9,00 0.00 0 0	0 9.00
10.00 0.00 0 0 0 200.00 0 0 0 0 0	0 10.00 247,727 200.00

Health F	inancial Systems	ASCENSION ST. V	INCENT MERCY		In Lie	u of Form CMS-:	2552-10
COST ALI	LOCATI ON – GENERAL SERVI CE COSTS		Provider CC		Period: From 07/01/2020 To 06/30/2021	Worksheet B Part I Date/Time Pre 11/23/2021 3:	pared: 53 pm
			CAPI TAL REL	ATED COSTS			
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	NEW BLDG & FIXT	NEW MVBLE EQUI P	EMPLOYEE BENEFI TS DEPARTMENT	Subtotal	
		0	1.00	2.00	4.00	4A	
	ENERAL SERVICE COST CENTERS	756, 816	756, 816		1		1.00
2.00 0 4.00 0	00400 NEW CAP REL COSTS-DUDG & TTAT 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	549, 458 1, 389, 697 5, 843, 985	0 233, 716	549, 45 10, 95	0 1, 389, 697	6, 191, 184	2.00 4.00
7.000 8.000	0700 OPERATI ON OF PLANT 10800 LAUNDRY & LI NEN SERVI CE 10900 HOUSEKEEPI NG	1, 177, 883 47, 818 441, 275	146, 596 9, 014 5, 494	8, 41		1, 332, 898 56, 832 446, 769	7.00 8.00 9.00
11.00 0	11000 DI ETARY 11100 CAFETERI A 11300 NURSI NG ADMI NI STRATI ON	51, 296 348, 944 30, 301	14, 948 9, 480 9, 305	22, 49	0 0 0 0 3 3, 221	66, 244 358, 424 65, 320	
16.000 17.000	11500 PHARMACY 11600 MEDICAL RECORDS & LIBRARY 11700 SOCIAL SERVICE	3, 197, 513 79 87, 970	8, 406 12, 780 2, 304		9 67, 503 0 0 0 26, 700	3, 339, 751 12, 859 116, 974	15. 00 16. 00 17. 00
30.00 0 31.00 0	NPATIENT ROUTINE SERVICE COST CENTERS 3000 ADULTS & PEDIATRICS 3100 INTENSIVE CARE UNIT	653, 451 0	37, 679 0		0 0	945, 408 0	30.00 31.00
	2040 DETOXIFICATION INTENSIVE CARE UNIT NCILLARY SERVICE COST CENTERS	0	0		0 0	0	35.00
50.00 0 54.00 0 56.00 0	5000 OPERATI NG ROOM 15400 RADI OLOGY-DI AGNOSTI C 15600 RADI OI SOTOPE 15700 CT SCAN	377, 559 791, 160 0 0	50, 569 32, 464 0 0	92, 79 222, 82		635, 794 1, 265, 044 0 0	50.00 54.00 56.00 57.00
58.00 0 60.00 0 65.00 0	95800 MAGNETI C RESONANCE I MAGI NG (MRI) 16000 LABORATORY 16500 RESPI RATORY THERAPY	0 1, 202, 718 492, 201	0 14, 216 11, 097	22, 29 17		0 1, 216, 934 673, 532	58. 00 60. 00
67.000 68.000	16600 PHYSI CAL THERAPY 16700 OCCUPATI ONAL THERAPY 16800 SPEECH PATHOLOGY 16900 ELECTROCARDI OLOGY	354, 329 28, 598 27, 927 0	33, 350 1, 178 0 0		9 105, 064 0 8, 962 0 8, 416 0 0	492, 922 38, 738 36, 343 0	67.00
71.00 0	17000 ELECTROENCEPHALOGRAPHY 17100 MEDICAL SUPPLIES CHARGED TO PATIENTS 17200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0 248, 944 201, 632	0 0 0		0 0 0 0 0 0	0 248, 944 201, 632	70.00 71.00 72.00
76.000 76.010	7300 DRUGS CHARGED TO PATLENTS 93610 SLEEP LAB 93480 ONCOLOGY	2, 786 23, 766 220, 353	0 4, 724 2, 239	4	0 0 9 7, 285 0 59, 825	2, 786 35, 824 282, 417	76.00
90.00 0 91.00 0	UTPATIENT SERVICE COST CENTERS 19000 CLINIC 19100 EMERGENCY 19200 OBSERVATION BEDS (NON-DISTINCT PART)	223, 712 2, 241, 434	9, 363 46, 700	30, 16	0 63, 198 6 274, 265	296, 273 2, 592, 565 0	91.00
S 118.00	PECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) ONREIMBURSABLE COST CENTERS	21, 013, 605	695, 622	549, 45	8 1, 389, 697	20, 952, 411	118.00
190.001 192.001 194.000	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 9200 PHYSICIANS' PRIVATE OFFICES 17950 MARKETING	0 0 0	2, 194 52, 232 4, 756		0 0 0 0 0 0	52, 232 4, 756	190. 00 192. 00 194. 00
194. 02 0 194. 03 0	17951 FOUNDATI ON 17952 CLI NI C 17953 VACANT	0 0 0	2, 012 0 0		0 0 0 0 0 0	0 0	194. 01 194. 02 194. 03
200.00 201.00 202.00	Cross Foot Adjustments Negative Cost Centers TOTAL (sum lines 118 through 201)	21, 013, 605	0 756, 816	549, 45	0 0 8 1, 389, 697		200. 00 201. 00 202. 00

Health Financial Systems	ASCENSION ST.	VINCENT MERCY		In Lie	eu of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C		Peri od:	Worksheet B	
				From 07/01/2020 To 06/30/2021	Part I Date/Time Pre	nared
				10 00/30/2021	11/23/2021 3:	
Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	& GENERAL	PLANT	LINEN SERVICE			
	5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS		[1			1 00
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00 2.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00
5. 00 00500 ADMINISTRATIVE & GENERAL	6, 191, 184					4.00 5.00
7. 00 00700 OPERATI ON OF PLANT	556, 738					7.00
8. 00 00800 LAUNDRY & LINEN SERVICE	23, 738			h		8.00
9. 00 00900 HOUSEKEEPI NG	186, 611	27, 572				9.00
10. 00 01000 DI ETARY	27,669			0 0		10.00
11. 00 01100 CAFETERIA	149, 710			0 0		11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	27, 284			1,092	0	13.00
15. 00 01500 PHARMACY	1, 394, 989	42, 187		0 0	0	15.00
16.00 01600 MEDI CAL RECORDS & LI BRARY	5, 371	64, 141		2, 233	0	16.00
17.00 01700 SOCIAL SERVICE	48, 859	11, 562		347	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·					1
30. 00 03000 ADULTS & PEDI ATRI CS	394, 887	189, 110	56, 350	262, 667	168, 933	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0		0 0	0	31.00
35.00 02040 DETOXIFICATION INTENSIVE CARE UNIT	0	0) (0 0	0	35.00
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	265, 565					50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	528, 396	162, 934	6, 03	3 60, 333		54.00
56. 00 05600 RADI OI SOTOPE	0	0		0 0		56.00
57.00 05700 CT SCAN	0	0		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0 0	-	58.00
60. 00 06000 LABORATORY	508, 301	71, 351		0 10, 270		60.00
65. 00 06500 RESPIRATORY THERAPY	281, 328			4, 416	0	65.00
66. 00 06600 PHYSI CAL THERAPY	205, 889					66.00
67.00 06700 OCCUPATI ONAL THERAPY	16, 180					67.00
	15, 180	0			0	68.00
	0				0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	103, 981					70.00 71.00
72. 00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	84, 220	°				72.00
PATIENTS	04, 220	0	/	0	0	12.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 164	0		46, 540	0	73.00
76. 00 03610 SLEEP LAB	14, 963	-				76.00
76. 01 03480 ONCOLOGY	117, 963			2, 332		76.01
OUTPATIENT SERVICE COST CENTERS	1,			_,	-	
90. 00 09000 CLINIC	123, 750	46, 993	2, 31	2 63, 260	0	90.00
91.00 09100 EMERGENCY	1,082,888					91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS		•			•	1
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	6, 165, 624	1, 582, 510	125, 810	0 676, 215	168, 933	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	916			0 0		190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	21, 817			0 0		192.00
194.0007950 MARKETI NG	1, 987			D 496		194.00
194. 01 07951 FOUNDATI ON	840			347		194.01
194. 02 07952 CLINIC	0	0		0 0		194. 02
194. 03 07953 VACANT	0	0		0 0	0	194.03
200.00 Cross Foot Adjustments	_	_		_	_	200.00
201.00 Negative Cost Centers	0				0	201.00
202.00 TOTAL (sum lines 118 through 201)	6, 191, 184	1, 889, 636	125, 810	677, 058	168, 933	202.00

		ASCENSION ST. V	INCENT MERCY		In Lie	u of Form CMS-	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provider CC	1	Period: From 07/01/2020 Fo 06/30/2021	Date/Time Pre	pared:
	Cost Center Description	CAFETERI A	NURSI NG	PHARMACY	MEDI CAL	11/23/2021 3: SOCI AL SERVI CE	53 pm
			ADMI NI STRATI ON		RECORDS & LI BRARY		
		11.00	13.00	15.00	16.00	17.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 5.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						4.00 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	555, 712					11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	140, 397	4 77 (00)			13.00
15.00 16.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	0	0	4, 776, 92			15.00
17.00	01700 SOCIAL SERVICE	19, 499	0		0 84,604 0 0	197, 241	17.00
17.00	INPATIENT ROUTINE SERVICE COST CENTERS	17,477	0			177,241	17.00
30.00	03000 ADULTS & PEDIATRICS	97, 493	28, 010	() 3, 538	191, 312	30.00
31.00	03100 I NTENSI VE CARE UNI T	0	0	(0 0	0	31.00
35.00	02040 DETOXIFICATION INTENSIVE CARE UNIT	0	0	(0 0	0	35.00
50.00	ANCI LLARY SERVICE COST CENTERS	50.404	00.005		40.50/		50.00
50.00	05000 OPERATING ROOM	58, 496	20, 385		12, 526		50.00
54.00 56.00	05400 RADI OLOGY-DI AGNOSTI C 05600 RADI OI SOTOPE	87, 744	245 0) 22, 959) 0		54.00 56.00
57.00	05700 CT SCAN	0	0			0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	58.00
60.00	06000 LABORATORY	0	0	(13, 584	0	60.00
65.00	06500 RESPI RATORY THERAPY	58, 496	15, 282	(2, 488	0	65.00
66.00	06600 PHYSI CAL THERAPY	48, 747	0	(2, 976		66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	(208		67.00
68.00	06800 SPEECH PATHOLOGY	0	0	(137		68.00
69.00 70.00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	0	0	(0	69.00 70.00
70.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(0	71.00
72.00	07200 I MPLANTABLE DEVICES CHARGED TO	0	0	(0 0	0	72.00
	PATIENTS						
73.00	07300 DRUGS CHARGED TO PATIENTS	19, 499	0	4, 776, 92		0	73.00
76.00	03610 SLEEP LAB	0	0		355		76.00
76.01	03480 ONCOLOGY OUTPATIENT SERVICE COST CENTERS	29, 248	12, 711		2,045	0	76.01
90.00	09000 CLINIC	29, 248	10, 663	(1, 912	0	90.00
91.00	09100 EMERGENCY	107, 242	53, 101		21,876		•
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS						
118.00		555, 712	140, 397	4, 776, 92	84,604	197, 241	118.00
100.00	NONREI MBURSABLE COST CENTERS						100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0	0	(190. 00 192. 00
	07950 MARKETI NG	0	0	(192.00
	07951 FOUNDATI ON	0	0	(194.00
	07952 CLINIC	Ő	Ö	(0		194.02
194.03	07953 VACANT	О	0	(0 0	0	194. 03
200.00							200. 00
201.00		0	0	(0		201.00
202.00	TOTAL (sum lines 118 through 201)	555, 712	140, 397	4, 776, 92	84, 604	197, 241	∠UZ. UU

COST ALLOCATION - GENERAL SERVICE	COSTS		Provider CO	CN: 15-1	1308	Period:	Worksheet B	
Sector denetive service						From 07/01/2020 To 06/30/2021) Part I	enared
							11/23/2021 3	
Cost Center Descript	ion	Subtotal	Intern &	To	otal			
		R	esidents Cost					
			& Post					
			Stepdown Adjustments					
	_	24.00	25.00	26	. 00	_		
GENERAL SERVICE COST CENTE	RS	24.00	23.00	20				
. 00 00100 NEW CAP REL COSTS-BL								1.0
2.00 00200 NEW CAP REL COSTS-MV	BLE EQUIP							2.0
1.00 00400 EMPLOYEE BENEFITS DE	PARTMENT							4.
5.00 00500 ADMINISTRATIVE & GEN	ERAL							5.
00700 OPERATION OF PLANT								7.
3.00 00800 LAUNDRY & LINEN SERV	ICE							8.
0.00 00900 HOUSEKEEPI NG								9.
0. 00 01000 DI ETARY								10.
1. 00 01100 CAFETERIA								11.
3.00 01300 NURSING ADMINISTRATI	ON							13.
15.00 01500 PHARMACY								15.
6.00 01600 MEDICAL RECORDS & LI	BRARY							16.
17.00 01700 SOCIAL SERVICE								17.
INPATIENT ROUTINE SERVICE	COST CENTERS							
30. 00 03000 ADULTS & PEDIATRICS		2, 337, 708	0	2	, 337, 70	8		30.
31.00 03100 INTENSIVE CARE UNIT		0	0			0		31.
5.00 02040 DETOXIFICATION INTEN	SIVE CARE UNIT	0	0			0		35.
ANCILLARY SERVICE COST CEN	TERS	· · · · ·						
0.00 05000 OPERATING ROOM		1, 343, 520	0	1,	, 343, 52	0		50.
54. 00 05400 RADI OLOGY-DI AGNOSTI C		2, 133, 688	0	2	, 133, 68	8		54.
56. 00 05600 RADI OI SOTOPE		0	0			0		56.
57.00 05700 CT SCAN		0	0			0		57.
58.00 05800 MAGNETIC RESONANCE II	MAGING (MRI)	0	0			0		58.
50. 00 06000 LABORATORY		1, 820, 440	0	1,	, 820, 44	0		60.
55. 00 06500 RESPI RATORY THERAPY		1, 091, 239	0	1,	, 091, 23	9		65.
6. 00 06600 PHYSI CAL THERAPY		946, 529	0		946, 52	9		66.
7.00 06700 OCCUPATIONAL THERAPY		61, 622	0		61, 62	2		67.
8.00 06800 SPEECH PATHOLOGY		51, 660	0		51, 66	0		68.
9. 00 06900 ELECTROCARDI OLOGY		0	0			0		69.
0.00 07000 ELECTROENCEPHALOGRAP		0	0			0		70.
1.00 07100 MEDICAL SUPPLIES CHA		352, 925	0		352, 92			71.
2.00 07200 IMPLANTABLE DEVICES	CHARGED TO	285, 852	0		285, 85	2		72.
PATIENTS								
73.00 07300 DRUGS CHARGED TO PAT	IENTS	4, 846, 916	0	4	, 846, 91			73.
6.00 03610 SLEEP LAB		76, 203	0		76, 20			76.
76. 01 03480 0NC0L0GY		457, 953	0		457, 95	3		76.
OUTPATIENT SERVICE COST CE	NTERS					- [
20. 00 09000 CLINIC		574, 411	0		574, 41			90.
1.00 09100 EMERGENCY		4, 238, 216	0		, 238, 21	6		91.
22.00 09200 OBSERVATION BEDS (NO			0					92.
SPECIAL PURPOSE COST CENTE		00 (10 000						-
18.00 SUBTOTALS (SUM OF LI		20, 618, 882	0	20	, 618, 88	2		118.
NONREI MBURSABLE COST CENTE		14 110			14 14	0		-
90. 00 19000 GI FT, FLOWER, COFFEE		14, 119	0		14, 11			190.
92. 00 19200 PHYSI CI ANS' PRI VATE	JFFICES	336, 196	0		336, 19			192.
94. 00 07950 MARKETI NG		31, 109	0		31, 10			194.
94. 01 07951 FOUNDATI ON		13, 299	0		13, 29	9		194.
94. 02 07952 CLINIC		0	0			U		194.
94. 03 07953 VACANT		0	0			U		194.
200.00 Cross Foot Adjustmen		0	0			0		200.
201.00Negative Cost Center202.00TOTAL (sum lines 118		0	0			0		201.
		21, 013, 605	0	i 21	, 013, 60			202.

		ASCENSION ST. V	INCENT MERCY		In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider CC		Period: From 07/01/2020 To 06/30/2021	Worksheet B Part II Date/Time Pre 11/23/2021 3:	pared: 53 pm
			CAPI TAL REL	ATED COSTS		1172372021 3.	
	Cost Center Description	Directly Assigned New Capital Related Costs	NEW BLDG & FIXT	NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
		0	1.00	2.00	2A	4.00	
	GENERAL SERVICE COST CENTERS	1					
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 4.00	00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	0	0		0 0	0	2.00 4.00
4.00 5.00	00500 ADMINI STRATI VE & GENERAL	351, 246	233, 716	10, 95	-	0	
7.00	00700 OPERATION OF PLANT	331, 240	146, 596	8, 41		0	
8.00	00800 LAUNDRY & LINEN SERVICE	0	9, 014		0 9,014	0	
9.00	00900 HOUSEKEEPI NG	0	5, 494		0 5, 494	0	
	01000 DI ETARY	0	14, 948		0 14, 948	0	
	01100 CAFETERIA	0	9, 480		0 9, 480	0	11.00
	01300 NURSING ADMINISTRATION	0	9, 305	22, 49		0	13.00
	01500 PHARMACY	0	8, 406	66, 32		0	15.00
	01600 MEDI CAL RECORDS & LI BRARY	0	12, 780		0 12,780	0	16.00
	01700 SOCIAL SERVICE	0	2, 304		0 2, 304	0	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	0	37, 679	72, 95	5 110, 634	0	30.00
31.00	03100 INTENSIVE CARE UNIT	0	0		0 0	0	31.00
35.00	02040 DETOXIFICATION INTENSIVE CARE UNIT	0	0		0 0	0	35.00
	ANCILLARY SERVICE COST CENTERS	-					
	05000 OPERATING ROOM	0	50, 569	92, 79		0	
	05400 RADI OLOGY-DI AGNOSTI C	0	32, 464	222, 82		0	54.00
	05600 RADI OI SOTOPE	0	0		0 0	0	56.00
	05700 CT SCAN	0	0		0 0	0	
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0 0 0	0	58.00
	06000 LABORATORY 06500 RESPI RATORY THERAPY	0	14, 216 11, 097		,	0	60.00 65.00
	06600 PHYSICAL THERAPY	0	33, 350	22, 29 17		0	66.00
	06700 OCCUPATI ONAL THERAPY	0	1, 178		0 1, 178	0	67.00
	06800 SPEECH PATHOLOGY	0	1, 170		0 1,170	0	68.00
	06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	
	07200 IMPLANTABLE DEVICES CHARGED TO	0	0		0 0	0	72.00
	PATI ENTS						
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
	03610 SLEEP LAB	0	4, 724	4	9 4, 773	0	76.00
76.01	03480 ONCOLOGY	0	2, 239		0 2, 239	0	76.01
	OUTPATIENT SERVICE COST CENTERS	1					
	09000 CLINIC	0	9, 363		0 9, 363	0	
	09100 EMERGENCY	0	46, 700	30, 16	6 76, 866	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
110 00	SPECIAL PURPOSE COST CENTERS	251.24/	(05 (00	E 40. 45		0	110 00
118.00		351, 246	695, 622	549, 45	1, 596, 326	0	118.00
100 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2, 194		0 2, 194	0	190.00
	19200 PHYSI CLANS' PRI VATE OFFICES	0	2, 194 52, 232		0 52, 232		190.00
	07950 MARKETI NG	0	4, 756		0 4, 756		192.00
	07951 FOUNDATI ON	0	2, 012		0 2,012		194.00
	07952 CLINIC		2,012		0 2,012		194.01
	07953 VACANT	0	0		0 0		194.02
200.00			0		0	0	200.00
200.00			0		0 0	0	201.00
202.00		351, 246	756, 816	549, 45	1, 657, 520		202.00
							•

Heal th	Financial Systems	ASCENSION ST.	VINCENT MERCY		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS			Provider C		eriod:	Worksheet B	
					rom 07/01/2020 0 06/30/2021	Part II Date/Time Pre	pared.
			_			11/23/2021 3:	
	Cost Center Description	ADMI NI STRATI VE		LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	PLANT	LINEN SERVICE	0.00	10.00	
		5.00	7.00	8.00	9.00	10.00	
1.00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-BEDG & TTXT						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	595, 912					5.00
7.00	00700 OPERATION OF PLANT	53, 586					7.00
8.00	00800 LAUNDRY & LINEN SERVICE	2, 285					8.00
9.00	00900 HOUSEKEEPI NG	17, 961					9.00
10.00	01000 DI ETARY	2,663	8, 282	0	0	25, 893	10.00
11.00	01100 CAFETERI A	14, 410	5, 252	0	0	0	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	2,626	5, 155	0	46	0	13.00
15.00	01500 PHARMACY	134, 276	4, 657	0	0	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	517				0	16.00
17.00	01700 SOCIAL SERVICE	4, 703	1, 276	0	15	0	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS			1			-
30.00	03000 ADULTS & PEDI ATRI CS	38, 008				25, 893	30.00
31.00	03100 INTENSIVE CARE UNIT	0				0	31.00
35.00	02040 DETOXIFICATION INTENSIVE CARE UNIT	0	0	0 0	0	0	35.00
F0 00	ANCI LLARY SERVI CE COST CENTERS		20.010	2.050	2 425	0	
50.00 54.00	05000 OPERATI NG ROOM 05400 RADI OLOGY-DI AGNOSTI C	25, 561 50, 859				0	50.00 54.00
54.00 56.00	05600 RADI OLOGY - DI AGNOSTI C	50, 859		/81		0	54.00
57.00	05700 CT SCAN				0	0	57.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0		-	0	0	58.00
60.00	06000 LABORATORY	48, 924	-	· · · · · · · · · · · · · · · · · · ·	-	0	60.00
65.00	06500 RESPIRATORY THERAPY	27,078				0	65.00
66.00	06600 PHYSI CAL THERAPY	19,817				0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	1, 557	652			0	67.00
68.00	06800 SPEECH PATHOLOGY	1, 461	C			0	68.00
69.00	06900 ELECTROCARDI OLOGY	0	C	0 0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0 0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	10,008	0	0	0	0	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO	8, 106	0	0 0	0	0	72.00
	PATIENTS						
73.00	07300 DRUGS CHARGED TO PATIENTS	112		0		0	73.00
76.00	03610 SLEEP LAB	1, 440				0	76.00
76.01	03480 ONCOLOGY	11, 354	1, 240	0 0	98	0	76.01
00.00	OUTPATIENT SERVICE COST CENTERS	11 011	F 100	200	0 (71	0	
90.00	09000 CLINIC	11, 911				0	90.00
91.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	104, 229	25, 874	2, 579	5, 080	0	91.00
92.00	SPECIAL PURPOSE COST CENTERS						92.00
118.00		593, 452	174, 697	16, 293	28, 549	25 803	118.00
110.00	NONREIMBURSABLE COST CENTERS	575,452	174,097	10, 293	20, 347	25, 075	1110.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	88	1, 215	i O	0	0	190.00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	2, 100					192.00
	07950 MARKETI NG	191			21		194.00
	07951 FOUNDATI ON	81			15		194.01
	07952 CLINIC	0			0		194.02
	07953 VACANT	0	0	0	0		194.03
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers	0		0	0		201.00
202.00) TOTAL (sum lines 118 through 201)	595, 912	208, 601	16, 293	28, 585	25, 893	202.00

Health Fina	ancial Systems	ASCENSION ST. V	INCENT MERCY		In Lie	u of Form CMS-	2552-10
ALLOCATION	OF CAPITAL RELATED COSTS		Provider CC	CN: 15-1308	Period: From 07/01/2020 To 06/30/2021	Worksheet B Part II Date/Time Pre 11/23/2021 3:	epared: 53 pm
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	
		11.00	13.00	15.00	16.00	17.00	
	RAL SERVICE COST CENTERS	I					
2.00 0020 4.00 0040 5.00 0050 7.00 0070 8.00 0080 9.00 0090	00 NEW CAP REL COSTS-BLDG & FIXT 00 NEW CAP REL COSTS-MVBLE EQUIP 00 EMPLOYEE BENEFITS DEPARTMENT 00 ADMINISTRATIVE & GENERAL 00 OPERATION OF PLANT 00 LAUNDRY & LINEN SERVICE 00 HOUSEKEEPING						1.00 2.00 4.00 5.00 7.00 8.00 9.00
11.00 0110 13.00 0130 15.00 0150	00 DI ETARY 00 CAFETERI A 00 NURSI NG ADMI NI STRATI ON 00 PHARMACY	29, 142 0 0	39, 625 0	213, 66			10. 00 11. 00 13. 00 15. 00
	00 MEDICAL RECORDS & LIBRARY 00 SOCIAL SERVICE	0 1, 023	0 0		0 20, 472 0 0	9, 321	16.00 17.00
30.00 0300	ATLENT ROUTINE SERVICE COST CENTERS	5, 113	7, 905		0 855	9, 041	30.00
	DO INTENSIVE CARE UNIT 40 DETOXIFICATION INTENSIVE CARE UNIT	0	0		0 0 0 0	0	31.00 35.00
	LLARY SERVICE COST CENTERS		-		-		
	DO OPERATING ROOM	3, 068	5, 753		0 3, 029	0	
	00 RADI OLOGY-DI AGNOSTI C	4, 601	69		0 5, 566	0	
	DO RADI OI SOTOPE	0	0		0 0	0	56.00
	DO CT SCAN	0	0		0 0	0	57.00 58.00
	DO MAGNETIC RESONANCE IMAGING (MRI) DO LABORATORY	0	0		0 3, 285	0	60.00
	DO RESPIRATORY THERAPY	3,068	4, 313		0 602	0	65.00
	DO PHYSI CAL THERAPY	2, 556	4, 313		0 720	0	
	DO OCCUPATIONAL THERAPY	2,000	0		0 50	0	
	DO SPEECH PATHOLOGY	0	0		0 33	0	
	DO ELECTROCARDI OLOGY	0	0		0 0	0	
	DO ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
71.00 0710	DO MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00 0720	00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0		0 0	0	72.00
	DO DRUGS CHARGED TO PATIENTS	1, 023	0	213, 66		0	
	30 ONCOLOGY	0 1, 534	0 3, 587		0 86 0 494	0	
	PATIENT SERVICE COST CENTERS						
	DO CLINIC	1, 534	3, 010		0 462	0	90.00
	DO EMERGENCY	5, 622	14, 988		0 5, 290	280	
	00 OBSERVATI ON BEDS (NON-DI STI NCT PART)						92.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	29, 142	39, 625	213, 66	8 20, 472	0 221	118.00
	REIMBURSABLE COST CENTERS	27, 142	37, 025	213, 00	20,472	9, 321	1110.00
190 00 1900	OO GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190.00
	DO PHYSI CI ANS' PRI VATE OFFI CES	0	0		0 0		192.00
	50 MARKETI NG	0	0		0 0		194.00
	51 FOUNDATI ON	0	0		0 0		194.01
194. 02 0795		0	0		0 0	0	194. 02
194.030795		0	0		0 0	0	194. 03
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0		0 0		201.00
202.00	TOTAL (sum lines 118 through 201)	29, 142	39, 625	213, 66	20, 472	9, 321	202.00

Heal th Financi		ASCENSION ST. VI				eu of Form CMS-2552-10
ALLOCATION OF	CAPI TAL RELATED COSTS		Provider CO	CN: 15-1308	Period: From 07/01/2020	Worksheet B D Part II
					To 06/30/2021	1 Date/Time Prepared: 11/23/2021 3:53 pm
C	ost Center Description	Subtotal	Intern &	Total		(11/20/2021 0100 pm
		R	esidents Cost & Post			
			Stepdown			
			Adjustments			
		24.00	25.00	26.00		
	SERVICE COST CENTERS	1		1		1.00
	EW CAP REL COSTS-BLDG & FIXT EW CAP REL COSTS-MVBLE EQUIP					1.00
	MPLOYEE BENEFITS DEPARTMENT					4.00
	DMINISTRATIVE & GENERAL					5.00
	PERATION OF PLANT					7.00
8.00 00800 L	AUNDRY & LINEN SERVICE					8.00
	OUSEKEEPING					9.00
10.00 01000 D						10.00
						11.00
	URSING ADMINISTRATION					13.00
15.00 01500 P 16.00 01600 M	EDICAL RECORDS & LIBRARY					15. 00 16. 00
	OCIAL SERVICE					17.00
	NT ROUTINE SERVICE COST CENTERS					17.00
	DULTS & PEDIATRICS	236, 712	0	236, 7	712	30.00
	NTENSI VE CARE UNI T	0	0		0	31.00
	ETOXIFICATION INTENSIVE CARE UNIT	0	0		0	35.00
ANCI LLA	RY SERVICE COST CENTERS					
50.00 05000 0		214, 272	0	214, 2	272	50.00
	ADI OLOGY-DI AGNOSTI C	337, 699	0			54.00
	ADI OI SOTOPE	0	0		0	56.00
57.00 05700 C		0	0		0	57.00
1 1	AGNETIC RESONANCE IMAGING (MRI)	0	0		0	58.00
	ABORATORY	74, 736	0	74,7		60.00
1 1	ESPI RATORY THERAPY HYSI CAL THERAPY	74, 787 77, 039	0	74, 7 77, 0		65. 00 66. 00
	CCUPATIONAL THERAPY	3, 513	0			67.00
	PEECH PATHOLOGY	1, 494	0			68.00
	LECTROCARDI OLOGY	0	0	1, 7	0	69.00
	LECTROENCEPHALOGRAPHY	0	0		0	70.00
1 1	EDICAL SUPPLIES CHARGED TO PATIENTS	10, 008	0	10, 0	008	71.00
	MPLANTABLE DEVICES CHARGED TO	8, 106	0			72.00
P	ATIENTS					
	RUGS CHARGED TO PATIENTS	216, 768	0			73.00
	LEEP LAB	9, 000	0			76.00
76.01 03480 0		20, 546	0	20, 5	546	76. 01
	ENT SERVICE COST CENTERS	24,420		24.4	120	
90.00 09000 C		34, 438	0			90.00
91.00 09100 E		240, 808	0		308	91.00 92.00
	BSERVATION BEDS (NON-DISTINCT PART) PURPOSE COST CENTERS	<u> </u>	0	1		92.00
	UBTOTALS (SUM OF LINES 1 through 117)	1, 559, 926	0	1, 559, 9	926	118.00
	BURSABLE COST CENTERS	.,		.,,	- 1	
	IFT, FLOWER, COFFEE SHOP & CANTEEN	3, 497	0	3, 4	497	190. 00
	HYSICIANS' PRIVATE OFFICES	83, 271	0			192.00
194.0007950 M	ARKETI NG	7,603	0	7,6	503	194.00
194.0107951 F		3, 223	0	3, 2	223	194.01
194.0207952C		0	0		0	194. 02
194.0307953 V		0	0		0	194. 03
	ross Foot Adjustments	0	0		0	200.00
	egative Cost Centers	0	0		0	201.00
202.00 T	OTAL (sum lines 118 through 201)	1, 657, 520	0	1, 657, 5	520	202.00

	ancial Systems ATION - STATISTICAL BASIS	ASCENSION ST.	Provider CO		'eri od:	u of Form CMS- Worksheet B-1	
					rom 07/01/2020 o 06/30/2021	Date/Time Pre	pare
		CAPITAL REI	LATED COSTS			11/23/2021 3:	53 p
	Cost Center Description	NEW BLDG & FI XT (SQUARE	NEW MVBLE EQUIP (DIRECT COST)	EMPLOYEE BENEFI TS DEPARTMENT (GROSS	Reconci I i ati on	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	
		FEET)		SALARI ES)		·	
CENI		1.00	2.00	4.00	5A	5.00	-
	ERAL SERVICE COST CENTERS	116, 959					1 1.
	DO NEW CAP REL COSTS-MVBLE EQUIP	1107707	546, 641				2
	DO EMPLOYEE BENEFITS DEPARTMENT	0	0	4, 434, 718			4
	DO ADMI NI STRATI VE & GENERAL	36, 119		327, 197	-		
	00 OPERATION OF PLANT	22,655			0	1, 332, 898	
	DO LAUNDRY & LINEN SERVICE DO HOUSEKEEPING	1, 393 849			0	56, 832 446, 769	
	DO DI ETARY	2, 310			0	66, 244	
	DO CAFETERIA	1, 465		C C	0	358, 424	
	DO NURSING ADMINISTRATION	1, 438		10, 280	0	65, 320	
00 0150	DO PHARMACY	1, 299	65, 989	215, 410	0	3, 339, 751	15
	DO MEDICAL RECORDS & LIBRARY	1, 975		C	-	12, 859	
	DO SOCIAL SERVICE	356	0	85, 202	0	116, 974	17
	ATIENT ROUTINE SERVICE COST CENTERS	F 000	70 501	F70 (00		0.45 400	1 20
	DO ADULTS & PEDIATRICS DO INTENSIVE CARE UNIT	5, 823		578, 628 C		945, 408	
	40 DETOXIFICATION INTENSIVE CARE UNIT	0			-	0	
	LLARY SERVICE COST CENTERS	0	0		0	0	
	DO OPERATING ROOM	7, 815	92, 323	366, 555	0	635, 794	50
	DO RADI OLOGY-DI AGNOSTI C	5, 017		697, 568		1, 265, 044	
00 0560	DO RADI OI SOTOPE	0	0	C	0	0	56
	DO CT SCAN	0	0	C	0	0	
	DO MAGNETIC RESONANCE IMAGING (MRI)	0		C	0	0	
		2, 197		0	0	1, 216, 934	
		1, 715				673, 532	
	DO PHYSI CAL THERAPY DO OCCUPATI ONAL THERAPY	5, 154 182		335, 274 28, 598		492, 922 38, 738	
	DO SPEECH PATHOLOGY	0		26, 856		36, 343	
	DO ELECTROCARDI OLOGY	0	0	20,000		00,010	
	DO ELECTROENCEPHALOGRAPHY	0	0	C	0	0	
. 00 0710	DO MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	C	0	248, 944	71
. 00 0720	DO IMPLANTABLE DEVICES CHARGED TO	0	0	C	0	201, 632	72
	PATIENTS	_		_	_		
	DO DRUGS CHARGED TO PATIENTS	0	0			2, 786	
	IO SLEEP LAB 30 ONCOLOGY	730 346		23, 246 190, 909		35, 824 282, 417	
	PATIENT SERVICE COST CENTERS	540	0	190, 909	0	202, 417	- 70
		1, 447	0	201, 673	0	296, 273	1 90
00 0910	DO EMERGENCY	7, 217					
. 00 0920	OO OBSERVATION BEDS (NON-DISTINCT PART)						92
	CIAL PURPOSE COST CENTERS						
8.00	SUBTOTALS (SUM OF LINES 1 through 117)	107, 502	546, 641	4, 434, 718	-6, 191, 184	14, 761, 227	118
	REIMBURSABLE COST CENTERS					0.404	1.00
	DO GIFT, FLOWER, COFFEE SHOP & CANTEEN	339					
	00 PHYSICIANS' PRIVATE OFFICES 50 MARKETING	8, 072 735			0	52, 232 4, 756	
	51 FOUNDATION	311			0	2, 012	
	52 CLINIC	0			0		194
	53 VACANT	0	0	C	0		194
0. 00	Cross Foot Adjustments						200
1.00	Negative Cost Centers						201
2.00	Cost to be allocated (per Wkst. B,	756, 816	549, 458	1, 389, 697		6, 191, 184	202
	Part I)	/ 470700	1 005450	0 0400/0		0 447/00	000
3.00	Unit cost multiplier (Wkst. B, Part I)	6. 470780	1. 005153	0. 313368		0. 417690	
4.00	Cost to be allocated (per Wkst. B, Part II)					595, 912	204
5.00	Unit cost multiplier (Wkst. B, Part			0.00000		0. 040203	205
				0.000000		0. 040203	200
	NAHE adjustment amount to be allocated						206
6.00							1
6. 00 7. 00	(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,						207

COST A		cial Systems ION - STATISTICAL BASIS	ASCENSION ST. '	Provi der CO		Period: From 07/01/2020	u of Form CMS-: Worksheet B-1	
						o 06/30/2021	Date/Time Pre 11/23/2021 3:	
		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (HOURS OF SERVI CE)	DI ETARY (PATI ENT DAYS)	CAFETERI A (FTE)	
			7.00	8.00	9.00	10.00	11.00	
1.00		AL SERVICE COST CENTERS NEW CAP REL COSTS-BLDG & FIXT						1 1.0
2.00 4.00 5.00 7.00 8.00 9.00	00200 00400 00500 00700 00800 00900	NEW CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL OPERATION OF PLANT LAUNDRY & LINEN SERVICE HOUSEKEEPING	58, 185 1, 393 849	174, 916 22, 393	13, 646			2. 0 4. 0 5. 0 7. 0 8. 0 9. 0
10.00 11.00			2,310		0		57	10.0
13.00		CAFETERIA NURSI NG ADMI NI STRATI ON	1, 465 1, 438		22		57 0	11. C
		PHARMACY	1, 299		(0	15.0
16.00		MEDICAL RECORDS & LIBRARY	1, 975		45		0	
17.00	01700	SOCIAL SERVICE	356	0	7	0	2	17.0
30.00	03000	ENT ROUTI NE SERVI CE COST CENTERS ADULTS & PEDI ATRI CS	5, 823	78, 343	5, 294	701	10	30. 0
		INTENSIVE CARE UNIT	0		C		0	31.0
35.00		DETOXIFICATION INTENSIVE CARE UNIT	0	0		0 0	0	35.0
		LARY SERVICE COST CENTERS	7, 815	22, 008	1 4 20	0		50. 0
50.00 54.00		RADI OLOGY-DI AGNOSTI C	5, 017				6	50.0
56.00		RADI OI SOTOPE	0,017		1,210		0	56.0
57.00		CT SCAN	0	0	0		0	57.0
58.00		MAGNETIC RESONANCE IMAGING (MRI)	0	-			0	58.0
60.00		LABORATORY	2, 197	0	207		0	60. C
65.00	06500	RESPI RATORY THERAPY	1, 715	0	89	0	6	65.0
66.00		PHYSI CAL THERAPY	5, 154				5	66.0
67.00		OCCUPATIONAL THERAPY	182		C		0	67.0
68.00		SPEECH PATHOLOGY	0	-	0		0	68.0
69.00 70.00		ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY	0	0		-	0	69.0
70.00		MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		-	0	70.0
72.00		IMPLANTABLE DEVICES CHARGED TO	0	0		-	0	72.0
		PATIENTS	-	-	-		-	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	938	0	2	73.0
76.00	03610	SLEEP LAB	730	432	21	0	0	76.0
76.01		ONCOLOGY	346	0	47	0	3	76.0
~~ ~~		TIENT SERVICE COST CENTERS		0.015	4.075			
			1,447				3	90.0
91.00 92.00		EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART)	7, 217	27, 688	2, 425	0	11	91.0
72.00		AL PURPOSE COST CENTERS						72.0
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	48, 728	174, 916	13, 629	701	57	118. 0
		MBURSABLE COST CENTERS					-	
		GIFT, FLOWER, COFFEE SHOP & CANTEEN	339					190. C
		PHYSICIANS' PRIVATE OFFICES	8,072					192. 0
		MARKETI NG	735		10			194.0
		FOUNDATI ON CLI NI C	311			0		194. C
		VACANT		-				194.0
200.00		Cross Foot Adjustments					0	200. 0
201.00		Negative Cost Centers	1					201.0
202.00		Cost to be allocated (per Wkst. B, Part I)	1, 889, 636	125, 810	677, 058	168, 933	555, 712	202. 0
203.00		Unit cost multiplier (Wkst. B, Part I)	32. 476343	0. 719260	49. 615858	240. 988588	9, 749. 333333	203.0
204.00		Cost to be allocated (per Wkst. B, Part II)	208, 601				29, 142	
205.00		Unit cost multiplier (Wkst. B, Part II)	3. 585134	0. 093148	2. 094753	36. 937233	511. 263158	205. 0
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 0
207.00		NAHE unit cost multiplier (Wkst. D,						207.0
	1	Parts III and IV)	1			1		1 7

Heal th	Financial Systems	ASCENSION ST. \	VINCENT MERCY		In Lieu	u of Form CMS-2552-10
	LOCATION - STATISTICAL BASIS		Provider CC		eriod: rom 07/01/2020	Worksheet B-1
					o 06/30/2021	Date/Time Prepared: 11/23/2021 3:53 pm
	Cost Center Description	NURSI NG ADMI NI STRATI ON	PHARMACY	MEDI CAL RECORDS &	SOCI AL SERVI CE	
		ADMINI STRATI UN	(COSTED REQUI S.)	LIBRARY	(TIME SPENT)	
		(DI RECT NRSI NG HRS)		(GROSS CHARGES)		
		13.00	15.00	16.00	17.00	
	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP					2.00
	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL					4.00 5.00
	00700 OPERATION OF PLANT					7.00
	00800 LAUNDRY & LINEN SERVICE					8.00
	00900 HOUSEKEEPI NG 01000 DI ETARY					9.00 10.00
11.00	01100 CAFETERI A					11.00
	01300 NURSI NG ADMI NI STRATI ON 01500 PHARMACY	57, 813 0	100			13.00 15.00
	01600 MEDI CAL RECORDS & LI BRARY	0	0	57, 786, 180		16.00
	01700 SOCIAL SERVICE	0	0	0	4, 990	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	11, 534	o	2, 416, 627	4, 840	30.00
31.00	03100 I NTENSI VE CARE UNI T	0	0	0	0	31.00
	02040 DETOXIFICATION INTENSIVE CARE UNIT ANCILLARY SERVICE COST CENTERS	0	0	0	0	35.00
	05000 OPERATI NG ROOM	8, 394	0	8, 555, 844	0	50.00
	05400 RADI OLOGY-DI AGNOSTI C	101	0	15, 679, 526	0	54.00
	05600 RADI OI SOTOPE 05700 CT SCAN	0	0	0	0	56.00 57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
		0	0	9, 278, 590	0	60.00
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	6, 293 0	0	1, 699, 380 2, 032, 837	0	65. 00 66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	142, 108	0	67.00
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	0	93, 631 0	0	68.00 69.00
	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	100	0	0	73.00
	03610 SLEEP LAB 03480 ONCOLOGY	0 5, 234	0	242, 449 1, 396, 853	0	76. 00 76. 01
	OUTPATIENT SERVICE COST CENTERS	5,234	<u> </u>	1, 390, 633	0	70.01
	09000 CLINIC	4, 391	0	1, 305, 831	0	90.00
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	21, 866	0	14, 942, 504	150	91.00 92.00
	SPECIAL PURPOSE COST CENTERS					
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	57, 813	100	57, 786, 180	4, 990	118.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0	192.00
	07950 MARKETI NG 07951 FOUNDATI ON	0	0	0	0	194. 00 194. 01
	07952 CLINIC	0	0	0	0	194. 02
194.03 200.00	07953 VACANT	0	0	0	0	194.03
200.00	Cross Foot Adjustments Negative Cost Centers					200. 00 201. 00
202.00	Cost to be allocated (per Wkst. B,	140, 397	4, 776, 927	84, 604	197, 241	202.00
203.00	Part I) Unit cost multiplier (Wkst. B, Part I)	2. 428468	47, 769. 270000	0.001464	39. 527255	203.00
203.00	Cost to be allocated (per Wkst. B,	39, 625		20, 472		203.00
205 00	Part II)	0 (05200	2 124 400000			005 00
205.00	Unit cost multiplier (Wkst. B, Part II)	0. 685399	2, 136. 680000	0. 000354	1.867936	205.00
206.00	NAHE adjustment amount to be allocated					206.00
207.00	(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,					207.00
	Parts III and IV)					

Health Financial Systems	ASCENSION ST. \	/INCENT MERCY		In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 15-1308		Worksheet C 1/2020 Part I 0/2021 Date/Time Prepare 11/23/2021 3:53 p	
· · · · · · · · · · · · · · · · · · ·	1	Title	XVIII	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS			1			
30. 00 03000 ADULTS & PEDI ATRI CS	2, 337, 708		2, 337, 70		0	
31.00 03100 I NTENSI VE CARE UNI T	- 0			0 0	0	
35. 00 02040 DETOXIFICATION INTENSIVE CARE UNI	T 0			0 0	0	35.00
ANCI LLARY SERVICE COST CENTERS 50.00 05000 OPERATI NG ROOM	1, 343, 520		1, 343, 52	20 0	0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 133, 688		2, 133, 68		0	
56. 00 05600 RADIOLOGI - DI AGNOSTI C	2, 133, 000		2, 155, 00	0 0	0	56.00
57. 00 05700 CT SCAN	0				0	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0			0 0	0	
60. 00 06000 LABORATORY	1, 820, 440		1, 820, 44	10 0	0	
65. 00 06500 RESPI RATORY THERAPY	1, 091, 239				0	65.00
66.00 06600 PHYSI CAL THERAPY	946, 529	0	946, 52		0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	61, 622	0	61, 62	22 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	51, 660	0	51, 60	50 0	0	68.00
69.00 06900 ELECTROCARDI OLOGY	0			0 0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0			0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIE			352, 92	25 0	0	
72. 00 07200 I MPLANTABLE DEVICES CHARGED TO PATIENTS	285, 852		285, 85	52 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	4, 846, 916		4, 846, 9	16 0	0	
76.00 03610 SLEEP LAB	76, 203		76, 20		0	
76. 01 03480 ONCOLOGY	457, 953		457, 95	53 0	0	76.01
OUTPATIENT SERVICE COST CENTERS			1			
90. 00 09000 CLI NI C	574, 411		574, 41		0	
91.00 09100 EMERGENCY	4, 238, 216		4, 238, 2		0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PA			789, 82		0	
200.00 Subtotal (see instructions)	21, 408, 702		,, .			200.00
201.00 Less Observation Beds	789, 820		789, 82			201.00
202.00 Total (see instructions)	20, 618, 882	0	20, 618, 88	32 0	0	202.00

Health Financial Systems	ASCENSION ST. V	INCENT MERCY		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 07/01/2020 To 06/30/2021	Date/Time Pre 11/23/2021 3:	epared: 53 pm
			e XVIII	Hospi tal	Cost	
		Charges				
Cost Center Description	Inpati ent	Outpati ent	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA Inpatient Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	1, 583, 777		1, 583, 7	7		30.00
31.00 03100 INTENSIVE CARE UNIT	0			0		31.00
35.00 02040 DETOXIFICATION INTENSIVE CARE UNIT	0			0		35.00
ANCILLARY SERVICE COST CENTERS				_		
50.00 05000 OPERATI NG ROOM	356, 437	8, 199, 407				
54.00 05400 RADI OLOGY-DI AGNOSTI C	403, 113	15, 276, 413	15, 679, 52		0.00000	
56. 00 05600 RADI OI SOTOPE	0	0		0 0.000000		
57.00 05700 CT SCAN	0	0		0 0. 000000		
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0. 000000		
60. 00 06000 LABORATORY	621,067	8, 657, 523				
65. 00 06500 RESPI RATORY THERAPY	222, 923	1, 476, 457				
66. 00 06600 PHYSI CAL THERAPY	102, 457	1, 930, 380	2, 032, 83			
67.00 06700 OCCUPATI ONAL THERAPY	46, 156	95, 952				
68.00 06800 SPEECH PATHOLOGY	18, 273	75, 358	93, 63	0. 551740	0.00000	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	C		0 0.000000		
70.00 07000 ELECTROENCEPHALOGRAPHY	0	C		0 0.000000		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	166, 054	1, 243, 123				
72.00 07200 I MPLANTABLE DEVICES CHARGED TO PATIENTS	4, 986	82, 823	87, 80	3. 255384	0.00000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	792, 885	12,002,896	12, 795, 78	0. 378790	0.000000	73.00
76.00 03610 SLEEP LAB	0	242, 449				
76.01 03480 ONCOLOGY	0	1, 396, 853	1, 396, 8	0. 327846	0.000000	76.01
OUTPATIENT SERVICE COST CENTERS	-1 -1	.,	1 ./			1
90. 00 09000 CLI NI C	2, 739	1, 303, 092	1, 305, 83	0. 439882	0.00000	90.00
91.00 09100 EMERGENCY	145, 794	14, 796, 710				
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	64, 165	768, 685				
200.00 Subtotal (see instructions)	4, 530, 826	67, 548, 121				200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	4, 530, 826	67, 548, 121	72, 078, 94	17		202.00

Health Financial Systems	ASCENSION ST. VIN	VCENT MERCY	In Lieu of Form CMS-2552-10			
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1308	Peri od: From 07/01/2020 To 06/30/2021	Worksheet C Part I Date/Time Pre 11/23/2021 3:		
		Title XVIII	Hospi tal	Cost		
Cost Center Description	PPS Inpatient					
	Ratio					
	11.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS					30.00	
31.00 03100 INTENSIVE CARE UNIT					31.00	
35.00 02040 DETOXIFICATION INTENSIVE CARE UNIT					35.00	
ANCI LLARY SERVI CE COST CENTERS	· ·					
50.00 05000 OPERATI NG ROOM	0. 000000				50.00	
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00	
56. 00 05600 RADI OI SOTOPE	0. 000000				56.00	
57.00 05700 CT SCAN	0. 000000				57.00	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000				58.00	
60. 00 06000 LABORATORY	0. 000000				60.00	
65. 00 06500 RESPI RATORY THERAPY	0.000000				65.00	
66.00 06600 PHYSI CAL THERAPY	0.000000				66,00	
67.00 06700 OCCUPATI ONAL THERAPY	0.000000				67.00	
68.00 06800 SPEECH PATHOLOGY	0.000000				68,00	
69. 00 06900 ELECTROCARDI OLOGY	0. 000000				69.00	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000				70.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71.00	
72.00 07200 IMPLANTABLE DEVICES CHARGED TO	0. 000000				72.00	
PATIENTS	01000000				12.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00	
76.00 03610 SLEEP LAB	0.000000				76.00	
76. 01 03480 ONCOLOGY	0.000000				76.01	
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0.000000				90.00	
91. 00 09100 EMERGENCY	0. 000000				91.00	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000				92.00	
200.00 Subtotal (see instructions)	0.000000				200.00	
201.00 Less Observation Beds					200.00	
202.00 Total (see instructions)					201.00	
	i l				1-52.00	

Health Financial Systems	ASCENSION ST.	VINCENT MERCY		In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: Worksheet C From 07/01/2020 Part I To 06/30/2021 Date/Time Prep 11/23/2021 3: 1		pared: 53 pm
		Titl	e XIX	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1	i	1	_		
30. 00 03000 ADULTS & PEDI ATRI CS	2, 337, 708		2, 337, 70	8 0	2, 337, 708	
31.00 03100 I NTENSI VE CARE UNI T	0			0 0	0	
35.00 02040 DETOXIFICATION INTENSIVE CARE UNIT	0			0 0	0	35.00
ANCI LLARY SERVI CE COST CENTERS	1	1	1			
50.00 05000 OPERATI NG ROOM	1, 343, 520		1, 343, 52		1, 343, 520	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 133, 688		2, 133, 68	8 0	2, 133, 688	
56. 00 05600 RADI OI SOTOPE	0			0 0	0	
57.00 05700 CT SCAN	0			0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0			0 0	0	
60. 00 06000 LABORATORY	1, 820, 440		1, 820, 44		1, 820, 440	•
65. 00 06500 RESPI RATORY THERAPY	1, 091, 239		1, 091, 23		1, 091, 239	
66. 00 06600 PHYSI CAL THERAPY	946, 529		946, 52		946, 529	
67.00 06700 OCCUPATI ONAL THERAPY	61, 622		61, 62		61, 622	
68.00 06800 SPEECH PATHOLOGY	51, 660	0	51, 66	0 0	51, 660	
69. 00 06900 ELECTROCARDI OLOGY	0			0 0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0			0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	352, 925		352, 92		352, 925	
72. 00 07200 I MPLANTABLE DEVICES CHARGED TO PATIENTS	285, 852		285, 85		285, 852	
73.00 07300 DRUGS CHARGED TO PATIENTS	4, 846, 916		4, 846, 91		4, 846, 916	
76.00 03610 SLEEP LAB	76, 203		76, 20		76, 203	
76. 01 03480 ONCOLOGY	457, 953		457, 95	3 0	457, 953	76.01
OUTPATIENT SERVICE COST CENTERS	1	I	1			
90. 00 09000 CLINIC	574, 411		574, 41			
91.00 09100 EMERGENCY	4, 238, 216		4, 238, 21		4, 238, 216	•
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	789, 820		789, 82		789, 820	
200.00 Subtotal (see instructions)	21, 408, 702		,		,,	
201.00 Less Observation Beds	789, 820		789, 82		789, 820	
202.00 Total (see instructions)	20, 618, 882	0	20, 618, 88	2 0	20, 618, 882	202.00

Health Financial Systems		ASCENSION ST. V	INCENT MERCY		ln Li€	eu of Form CMS-	2552-10
COMPUTATION OF RATIO OF C	COMPUTATION OF RATIO OF COSTS TO CHARGES		F		Period: From 07/01/2020 To 06/30/2021	Date/Time Pre 11/23/2021 3:	epared: 53 pm
				e XIX	Hospi tal	Cost	
Cost Center E	escription	Inpati ent	Charges Outpatient	+ col. 7)	6 Cost or Other Ratio	TEFRA Inpatient Ratio	
	CONTRACT OF ACT	6.00	7.00	8.00	9.00	10.00	
	SERVICE COST CENTERS	1 500 777		1 500 7	77		1 20 00
30.00 03000 ADULTS & PEDI 31.00 03100 INTENSIVE CAR		1, 583, 777		1, 583, 7			30.00
	N INTENSIVE CARE UNIT	0			0		31.00
ANCI LLARY SERVICE (U U			0		35.00
50. 00 05000 OPERATI NG ROC		356, 437	8, 199, 407	8, 555, 8	0. 157030	0.00000	50.00
54. 00 05400 RADI OLOGY-DI A		403, 113	15, 276, 413				
56. 00 05600 RADI 0I SOTOPE		0	0	10,0,7,0	0 0.00000		
57.00 05700 CT SCAN		0	0		0 0.000000		
	NANCE IMAGING (MRI)	0	0)	0 0.000000		
60.00 06000 LABORATORY	` ,	621,067	8, 657, 523	9, 278, 5	0. 196198	0. 000000	60.00
65. 00 06500 RESPI RATORY T	HERAPY	222, 923	1, 476, 457	1, 699, 3	0. 642139	0. 000000	65.00
66.00 06600 PHYSI CAL THER	APY	102, 457	1, 930, 380	2, 032, 8	0. 465620	0. 000000	66.00
67.00 06700 0CCUPATI ONAL		46, 156	95, 952	142, 10	0. 433628	0.000000	67.00
68.00 06800 SPEECH PATHOL		18, 273	75, 358	93, 6			
69.00 06900 ELECTROCARDI C		0	0		0 0.000000		
70.00 07000 ELECTROENCEPH		0	0		0 0.000000		
	IES CHARGED TO PATIENTS	166, 054	1, 243, 123				
72.00 07200 I MPLANTABLE D PATI ENTS		4, 986	82, 823				
73.00 07300 DRUGS CHARGED	TO PATIENTS	792, 885	12, 002, 896				
76.00 03610 SLEEP LAB		0	242, 449				
76.01 03480 ONCOLOGY		0	1, 396, 853	1, 396, 8	0. 327846	0.00000	76.01
OUTPATIENT SERVICE	COST CENTERS	0.700		1 005 0			
90.00 09000 CLINIC		2,739	1, 303, 092				
91.00 09100 EMERGENCY	EDS (NON DISTINCT DADT)	145, 794	14, 796, 710				
	EDS (NON-DISTINCT PART)	64, 165	768, 685			0. 000000	92.00
200.00Subtotal (see201.00Less Observat	instructions)	4, 530, 826	67, 548, 121	72, 078, 94	+ /		200.00
201.00 Total (see in		4, 530, 826	67, 548, 121	72, 078, 94	47		201.00

Health Financial Systems	ASCENSION ST. VII	NCENT MERCY	In Lieu of Form CMS-2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1308	Peri od: From 07/01/2020 To 06/30/2021	Worksheet C Part I Date/Time Pre 11/23/2021 3:	
		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
31.00 03100 INTENSIVE CARE UNIT					31.00
35.00 02040 DETOXIFICATION INTENSIVE CARE UNIT					35.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATI NG ROOM	0. 000000				50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
56. 00 05600 RADI OI SOTOPE	0. 000000				56.00
57.00 05700 CT SCAN	0. 000000				57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000				58.00
60. 00 06000 LABORATORY	0. 000000				60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000				66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000				67.00
68.00 06800 SPEECH PATHOLOGY	0.000000				68.00
69.00 06900 ELECTROCARDI OLOGY	0.000000				69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.000000				70.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0.000000				71.00
72.00 07200 I MPLANTABLE DEVICES CHARGED TO	0. 000000				72.00
PATIENTS					
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
76.00 03610 SLEEP LAB	0. 000000				76.00
76. 01 03480 ONCOLOGY	0. 000000				76.01
OUTPATIENT SERVICE COST CENTERS	- I I				
90. 00 09000 CLINIC	0.000000				90.00
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.	VINCENT MERCY		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider CO		Period: From 07/01/2020 To 06/30/2021	Worksheet D Part II Date/Time Pre 11/23/2021 3:	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATI NG ROOM	214, 272	8, 555, 844	0. 02504	4 173, 850	4, 354	50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	337, 699	15, 679, 526	0. 02153	8 93, 785	2, 020	54.00
56. 00 05600 RADI OI SOTOPE	0	0	0. 00000	0 0	0	56.00
57.00 05700 CT SCAN	0	0	0.00000	0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0. 00000	0 0	0	58.00
60.00 06000 LABORATORY	74, 736	9, 278, 590	0. 00805	5 166, 424	1, 341	60.00
65. 00 06500 RESPI RATORY THERAPY	74, 787	1, 699, 380	0.04400	62, 809	2, 764	65.00
66.00 06600 PHYSI CAL THERAPY	77,039	2, 032, 837	0. 03789	7 25, 399	963	66.00
67.00 06700 OCCUPATI ONAL THERAPY	3, 513			1 14, 299	353	67.00
68.00 06800 SPEECH PATHOLOGY	1, 494	93, 631	0. 01595	6 3, 658	58	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0. 00000	0 0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0. 00000	0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	10,008	1, 409, 177			445	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO	8, 106					72.00
PATIENTS	-,			.,		
73.00 07300 DRUGS CHARGED TO PATIENTS	216, 768	12, 795, 781	0. 01694	1 341, 510	5, 786	73.00
76.00 03610 SLEEP LAB	9,000				0	76.00
76. 01 03480 ONCOLOGY	20, 546				0	76.01
OUTPATIENT SERVICE COST CENTERS		.,		-		
90. 00 09000 CLI NI C	34, 438	1, 305, 831	0. 02637	2 0	0	90.00
91. 00 09100 EMERGENCY	240, 808				0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	79,976					
200.00 Total (lines 50 through 199)	1, 403, 190			952, 378		
				1		

Health Financial Systems	ASCENSION ST. \	/INCENT MERCY		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	EVICE OTHER PASS			Period: From 07/01/2020 To 06/30/2021	Date/Time Pre 11/23/2021 3:	
			XVIII	Hospi tal	Cost	
Cost Center Description				Allied Health	Allied Health	
	Anesthetist	Post-Stepdown		Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	0	C		0 0	0	50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
56. 00 05600 RADI 0I SOTOPE	0	C		0 0	0	56.00
57.00 05700 CT SCAN	0	C		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	C		0 0	0	58.00
60. 00 06000 LABORATORY	0	C		0 0	0	60,00
65. 00 06500 RESPI RATORY THERAPY	0	C		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66,00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72. 00 07200 I MPLANTABLE DEVICES CHARGED TO	0	0		0 0	0	72.00
PATIENTS	0	Ŭ		0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
76.00 03610 SLEEP LAB	0	0		0 0	0	76.00
76. 01 03480 ONCOLOGY	0	0		0 0	0	76.01
OUTPATIENT SERVICE COST CENTERS				0 0		/0.01
90. 00 09000 CLINIC	0	0		0 0	0	90.00
91. 00 09100 EMERGENCY	0				0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0		0	0	
200.00 Total (lines 50 through 199)	0	0		0 0	-	200.00
	1 0		1	0	0	200.00

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Health Financial Systems	ASCENSION ST. \	/INCENT MERCY		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVICE OTHER PASS	S Provider C		Period: From 07/01/2020 To 06/30/2021		
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
	Education Cost				(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 8, 555, 844		
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 15, 679, 526		
56. 00 05600 RADI OI SOTOPE	0	0		0 0	0.000000	
57.00 05700 CT SCAN	0	0		0 0	0.000000	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0.000000	
60. 00 06000 LABORATORY	0	0		0 9, 278, 590		
65. 00 06500 RESPI RATORY THERAPY	0	0		0 1, 699, 380		
66. 00 06600 PHYSI CAL THERAPY	0	0		0 2, 032, 837		
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 142, 108		
68.00 06800 SPEECH PATHOLOGY	0	0		0 93, 631		
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0. 000000	
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0. 000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 1, 409, 177		
72.00 07200 I MPLANTABLE DEVI CES CHARGED TO	0	0		0 87, 809	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 12, 795, 781	0. 000000	73.00
76. 00 03610 SLEEP LAB	0	0		0 242, 449		
76. 01 03480 ONCOLOGY	0	0		0 1, 396, 853		76.01
OUTPATIENT SERVICE COST CENTERS	-	-		.,		
90. 00 09000 CLI NI C	0	0		0 1, 305, 831	0.00000	90.00
91. 00 09100 EMERGENCY	0	0		0 14, 942, 504		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	Ö		0 832, 850		
200.00 Total (lines 50 through 199)	0	Ő		0 70, 495, 170		200.00
			•			•

Health Financial Systems	ASCENSION ST. VI	NCENT MERCY		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS		Provider CO	Provider CCN: 15-1308		Worksheet D Part IV Date/Time Pre 11/23/2021 3:	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Throug	n Charges	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						
50.00 05000 OPERATING ROOM	0. 000000	173, 850		0 0	0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	93, 785		0 0	0	54.00
56. 00 05600 RADI OI SOTOPE	0. 000000	0		0 0	0	56.00
57.00 05700 CT SCAN	0. 000000	0		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0		0 0	0	58.00
60. 00 06000 LABORATORY	0. 000000	166, 424		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	62, 809		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	25, 399		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	14, 299		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	3, 658		0 0	0	68.00
69.00 06900 ELECTROCARDI OLOGY	0. 000000	0		0 0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	62, 611		0 0	0	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO	0. 000000	1, 656		0 0	0	72.00
PATIENTS						
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	341, 510	1	0 0	0	73.00
76.00 03610 SLEEP LAB	0. 000000	0	1	0 0	0	76.00
76. 01 03480 ONCOLOGY	0. 000000	0	1	0 0	0	76.01
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLINIC	0. 000000	0		0 0	0	90.00
91.00 09100 EMERGENCY	0. 000000	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	6, 377		0 0	0	92.00
200.00 Total (lines 50 through 199)		952, 378		0 0	0	200. 00

Health Financial System	S	ASCENSION ST.	VINCENT MERCY		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICA	L, OTHER HEALTH SERVICES AND) VACCINE COST	Provider C	CN: 15-1308	Period: From 07/01/2020 To 06/30/2021	Worksheet D Part V Date/Time Pre 11/23/2021 3:	
			Title	XVIII	Hospi tal	Cost	
				Charges		Costs	
Cost Center	Description	Cost to Charge		Cost	Cost	PPS Services	
			Services (see	Reimbursed	Reimbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins			
				(see inst.)	(see inst.)		
		1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE		1					
50.00 05000 OPERATING F		0. 157030	0	1, 947, 9		0	
54.00 05400 RADI OLOGY-E		0. 136081	0	3, 297, 93	29 0	0	54.00
56.00 05600 RADI 0I SOTOF	PE	0. 000000			0 0	0	56.00
57.00 05700 CT SCAN		0. 000000			0 0	0	57.00
	SONANCE IMAGING (MRI)	0. 000000	0		0 0	0	58.00
60.00 06000 LABORATORY		0. 196198	-	2, 190, 5		0	60.00
65. 00 06500 RESPI RATORY		0. 642139		369, 40		0	65.00
66.00 06600 PHYSI CAL TH		0. 465620		380, 50	55 0	0	66.00
67.00 06700 0CCUPATI ONA		0. 433628		31, 34	45 0	0	67.00
68.00 06800 SPEECH PATH		0. 551740		20, 10	01 0	0	68.00
69.00 06900 ELECTROCARE	OLOGY	0. 000000	0		0 0	0	69.00
70.00 07000 ELECTROENCE	PHALOGRAPHY	0. 000000	0		0 0	0	70.00
71.00 07100 MEDICAL SUF	PLIES CHARGED TO PATIENTS	0. 250448	0	331, 59	99 0	0	71.00
72.00 07200 I MPLANTABLE	DEVICES CHARGED TO	3. 255384	0	23, 6	12 0	0	72.00
PATI ENTS							
73.00 07300 DRUGS CHARG	GED TO PATIENTS	0. 378790		4, 407, 7		0	73.00
76.00 03610 SLEEP LAB		0. 314305		2,00		0	76.00
76.01 03480 ONCOLOGY		0. 327846	0	249, 63	28 0	0	76.01
OUTPATIENT SERVIC	CE COST CENTERS						
90. 00 09000 CLINIC		0. 439882		, .		0	
91.00 09100 EMERGENCY		0. 283635				0	
	I BEDS (NON-DISTINCT PART)	0. 948334	0	245, 2	55 0	0	
	see instructions)		0	16, 179, 7	74 1, 129	0	200. 00
	inic Lab. Services-Program				0 0		201.00
Only Charge							
202.00 Net Charges	s (line 200 - line 201)		0	16, 179, 7	1, 129	0	202.00

Health Financial Systems	ASCENSION ST.	VINCENT MERCY		In Lie	u of Form CMS-	-2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-1308	Peri od: From 07/01/2020 To 06/30/2021	Worksheet D Part V Date/Time Pre 11/23/2021 3:	epared: 53 pm
		Title	e XVIII	Hospi tal	Cost	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.) 6.00	(see inst.) 7.00	-			
ANCI LLARY SERVI CE COST CENTERS	0.00	7.00				-
50. 00 05000 OPERATI NG ROOM	305, 887	0				50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	448, 785		•			54.00
56. 00 05600 RADI 0I SOTOPE	0	0	•			56.00
57. 00 05700 CT SCAN	0	0				57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0				58.00
60. 00 06000 LABORATORY	429, 781	0				60,00
65. 00 06500 RESPI RATORY THERAPY	237, 207	0				65.00
66. 00 06600 PHYSI CAL THERAPY	177, 199	0				66.00
67.00 06700 OCCUPATI ONAL THERAPY	13, 592	0				67.00
68.00 06800 SPEECH PATHOLOGY	11, 091	0				68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	83, 048					71.00
72. 00 07200 I MPLANTABLE DEVICES CHARGED TO	76, 866	0				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	1, 669, 612	204				73.00
76. 00 03610 SLEEP LAB	629					76.00
76. 01 03480 ONCOLOGY	81, 840		1			76.01
OUTPATIENT SERVICE COST CENTERS	017010					/ 0/ 0/
90. 00 09000 CLINIC	94, 364	260				90.00
91.00 09100 EMERGENCY	699, 890					91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	232, 584	0				92.00
200.00 Subtotal (see instructions)	4, 562, 375	464				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges	4 5 40 075					
202.00 Net Charges (line 200 - line 201)	4, 562, 375	464				202.00

Health Financial Systems	ASCENSION ST. \	/INCENT MERCY		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CO	CN: 15-1308 CCN: 15-Z308	Period: From 07/01/2020 To 06/30/2021	Worksheet D Part V Date/Time Pre 11/23/2021 3:	
		Title	XVIII	Swing Beds - SNF		
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To			
			Ded. & Coins			
			(see inst.)			
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATI NG ROOM	0. 157030	0		0 0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 136081	0		0 0	0	54.00
56. 00 05600 RADI 0I SOTOPE	0. 000000	0		0 0	0	56.00
57.00 05700 CT SCAN	0. 000000	0		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0		0 0	0	58.00
60. 00 06000 LABORATORY	0. 196198	0		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 642139	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 465620	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 433628	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 551740	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	0		0 0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 250448	0		0 0	0	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO	3. 255384	0		0 0	0	72.00
PATIENTS						
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 378790	0		0 0	0	
76.00 03610 SLEEP LAB	0. 314305	0		0 0	0	76.00
76. 01 03480 ONCOLOGY	0. 327846	0		0 0	0	76.01
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0. 439882	0		0 0	0	
91. 00 09100 EMERGENCY	0. 283635	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 948334	0		0 0	0	92.00
200.00 Subtotal (see instructions)		0		0 0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		0		0 0	0	202.00

Health Financial Systems	ASCENSION ST.	VINCENT MERCY		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CC	CN: 15-1308	Peri od:	Worksheet D	
		Component (CN: 15-7308	From 07/01/2020 To 06/30/2021	Part V Date/Time Pre	nared
		component c	50N. 13 2300	10 00/ 30/ 2021	11/23/2021 3:	53 pm
	•	Title	XVIII	Swing Beds - SNF	Cost	
		sts				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To Ded. & Coins.	Subject To Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCI LLARY SERVI CE COST CENTERS	0.00	7.00				
50. 00 05000 OPERATI NG ROOM	0	0				50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
56. 00 05600 RADI OI SOTOPE	0	0				56.00
57.00 05700 CT SCAN	0	0				57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0				58.00
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
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO	0	0				72.00
PATIENTS	_					
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0				73.00
76.00 03610 SLEEP LAB	0	0				76.00
76. 01 03480 ONCOLOGY OUTPATI ENT SERVICE COST CENTERS	0	0				76.01
90. 00 09000 CLINIC	0	0				90.00
90. 00 109000 CETNIC 91. 00 109100 EMERGENCY	0	0				90.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0					91.00
200.00 Subtotal (see instructions)	0					200.00
201.00 Less PBP Clinic Lab. Services-Program	0	0				200.00
Only Charges	0					201.00
202.00 Net Charges (line 200 - line 201)	0	0				202.00

Health Financial Systems	ASCENSION ST. VI	NCENT MERCY		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	R PASS THROUGH COSTS			Period: From 07/01/2020 To 06/30/2021	Worksheet D Part III Date/Time Pre 11/23/2021 3:	
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Nursing School Nu Post-Stepdown Adjustments		Post-Stepdow Adjustments	n Cost	All Other Medical Education Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS				1		
30.00 03000 ADULTS & PEDIATRICS 31.00 03100 INTENSIVE CARE UNIT 35.00 02040 DETOXIFICATION INTENSIVE CARE UNIT 200.00 Total (lines 30 through 199)	0 0 0	0 0 0 0		0 0 0 0 0 0	0 0 0	31.00
Cost Center Description	Swing-Bed	Total Costs	Total Patien	Per Diem (col.	Inpati ent	200100
	Adjustment (s Amount (see 1	sum of cols. through 3, inus col. 4)	Days	5 ÷ col. 6)	Program Days	
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS 31.00 03100 INTENSIVE CARE UNIT 35.00 02040 DETOXIFICATION INTENSIVE CARE UNIT 200.00 Total (lines 30 through 199)	0	0 0 0	1, 12	0 0.00 0 0.00	0 0	31.00
Cost Center Description	I npati ent Program Pass-Through Cost (col. 7 x col. 8) 9.00			<u> </u>	,	200.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 35. 00 02040 DETOXIFICATION INTENSIVE CARE UNIT	000000000000000000000000000000000000000					30.00 31.00 35.00
200.00 Total (lines 30 through 199)	0					200.00

Health Financial Systems	ASCENSION ST. \	/INCENT MERCY		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	VICE OTHER PASS			Period: From 07/01/2020 To 06/30/2021	Date/Time Pre 11/23/2021 3:	
			e XIX	Hospi tal	Cost	
Cost Center Description	Non Physician	Nursing School	Nursing Schoo	Allied Health	Allied Health	
	Anesthetist	Post-Stepdown		Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0		0 0	0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
56. 00 05600 RADI 0I SOTOPE	0	0		0 0	0	56.00
57.00 05700 CT SCAN	0	0		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	58.00
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
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72. 00 07200 I MPLANTABLE DEVICES CHARGED TO	0	0		0 0	0	72.00
PATIENTS	Ū	0		с с	, i i i i i i i i i i i i i i i i i i i	12:00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
76. 00 03610 SLEEP LAB	0	0		0 0	0	76.00
76. 01 03480 ONCOLOGY	0	0		0 0	0	76.01
OUTPATIENT SERVICE COST CENTERS		0		<u> </u>		70.01
90. 00 09000 CLINIC	0	0		0 0	0	90.00
91. 00 09100 EMERGENCY	0	0		0 0	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		ő	0	
200.00 Total (lines 50 through 199)	0	Λ		0 0	-	200.00
	۱ V		I	S ₁ 0	, v	200.00

^{11/23/2021 3:53} pm Y: \28650 - St. Vincent Mercy\300 - Medicare Cost Report\20210630\HFS\28650-21.mcrx

Health Financial Systems	ASCENSION ST. \	/INCENT MERCY		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SET THROUGH COSTS	RVICE OTHER PASS			Period: From 07/01/2020 To 06/30/2021		
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
	Education Cost		Cost (sum of		(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATI NG ROOM	0	0		0 8, 555, 844		50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 15, 679, 526		54.00
56. 00 05600 RADI OI SOTOPE	0	0		0 0	0. 000000	56.00
57.00 05700 CT SCAN	0	0		0 0	0. 000000	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0. 000000	58.00
60. 00 06000 LABORATORY	0	0		0 9, 278, 590		60.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 1, 699, 380		65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 2, 032, 837		
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 142, 108		
68.00 06800 SPEECH PATHOLOGY	0	0		0 93, 631	0. 000000	
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0. 000000	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0. 000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 1, 409, 177		
72. 00 07200 I MPLANTABLE DEVI CES CHARGED TO	0	0		0 87, 809	0.00000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 12, 795, 781	0. 000000	73.00
76. 00 03610 SLEEP LAB	0	0		0 242, 449		76.00
76. 01 03480 ONCOLOGY	0	0		0 1, 396, 853		76.01
OUTPATI ENT SERVICE COST CENTERS			1	.,	01000000	
90. 00 09000 CLINIC	0	0		0 1, 305, 831	0.00000	90.00
91. 00 09100 EMERGENCY	0	0		0 14, 942, 504		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 832, 850		
200.00 Total (lines 50 through 199)	0	0		0 70, 495, 170		200.00
		0	1			

Health Financial Systems	ASCENSION ST. VI	NCENT MERCY		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	Provider CC		Period: From 07/01/2020 To 06/30/2021	Worksheet D Part IV Date/Time Pre 11/23/2021 3:	
		Ti tl	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	n Charges	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					
50.00 05000 OPERATI NG ROOM	0. 000000	0		0 0	0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	18, 005		0 0	0	54.00
56. 00 05600 RADI OI SOTOPE	0. 000000	0		0 0	0	56.00
57.00 05700 CT SCAN	0. 000000	0		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000	0		0 0	0	58.00
60. 00 06000 LABORATORY	0. 000000	15, 519		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	796		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	2, 091		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
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		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, 443		0 0	0	73.00
76.00 03610 SLEEP LAB	0. 000000	0		0 0	0	76.00
76. 01 03480 ONCOLOGY	0. 000000	0		0 0	0	76.01
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0. 000000	0		0 0	0	90.00
91.00 09100 EMERGENCY	0. 000000	15, 868		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0 0	0	92.00
200.00 Total (lines 50 through 199)		58, 722		0 0	0	200. 00

Heal th	Fi nanci	al	Systems		
COMPUT	ATION O	= 1	NPATIENT	OPERATI NG	

ASCENSI ON	ST.	VI NCENT	MERCY	

In Lieu of Form CMS-2552-10

leal th	Financial Systems ASCENSION ST. VIN	CENT MERCY	In Lie	u of Form CMS-	2552-1
COMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-1308	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Pre	pared:
		Title XVIII	Hospi tal	11/23/2021 3: Cost	53 pm
	Cost Center Description		nospi tai	0031	
				1.00	
	PART I - ALL PROVIDER COMPONENTS				-
1 00	INPATIENT DAYS	c oveluding newbern)		1 202	1 1 00
1.00 2.00	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-b			1, 293 1, 128	•
3.00	Private room days (excluding private room days, excluding swing-		rivate room davs	1, 128	
5.00	do not complete this line.	ys). It you have only p	rvate room days,	0	0.00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		698	4.0
5.00	Total swing-bed SNF type inpatient days (including private roo	om days) through Decembe	er 31 of the cost	42	5.0
	reporting period				
5.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December	31 of the cost	100	6.0
7.00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room	m days) through December	- 31 of the cost	12	7.0
. 00	reporting period		of of the cost	12	/.0
3. 00	Total swing-bed NF type inpatient days (including private room	m days) after December 3	31 of the cost	11	8.0
	reporting period (if calendar year, enter 0 on this line)				
9.00	Total inpatient days including private room days applicable to	o the Program (excluding	g swing-bed and	238	9.0
10.00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII or	alv (including private)	and and	42	10.0
10.00	through December 31 of the cost reporting period (see instruct		uays)	42	10.0
11.00	Swing-bed SNF type inpatient days applicable to title XVIII or		room davs) after	57	11.0
	December 31 of the cost reporting period (if calendar year, er	nter 0 on this line)	5 ,		
12.00	Swing-bed NF type inpatient days applicable to titles V or XI>	X only (including privat	te room days)	0	12.0
13.00	through December 31 of the cost reporting period	V oply (including privat	to room day(c)	0	12 0
13.00	Swing-bed NF type inpatient days applicable to titles V or XI) after December 31 of the cost reporting period (if calendar ye			0	13.0
4.00	Medically necessary private room days applicable to the Progra	am (excluding swing-bed	days)	0	14.0
	Total nursery days (title V or XIX only)		•	0	15.0
6.00	Nursery days (title V or XIX only)			0	16.0
17 00	SWING BED ADJUSTMENT	- three boots and a 21	£ +b+		1 17 0
17.00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 d	or the cost		17.0
18.00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost		18.0
	reporting period				
19.00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	f the cost	216.95	19.0
20.00	reporting period Medicaid rate for swing-bed NF services applicable to services	s after December 21 of t	the cost	216.95	20.0
20.00	reporting period	s al tel becember 51 01	the cost	210. 75	20.0
21.00	Total general inpatient routine service cost (see instructions	s)		2, 337, 708	21.0
22.00	Swing-bed cost applicable to SNF type services through December	er 31 of the cost report	ting period (line	0	22.0
	5 x line 17)				00.0
23.00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reportin	ng period (line 6	0	23.0
24.00	Swing-bed cost applicable to NF type services through December	r 31 of the cost reporti	ng period (line	2,603	24.0
	7 x line 19)	•	51 (
25.00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	g period (line 8	2, 386	25.0
26.00	x line 20) Total swing-bed cost (see instructions)			265, 813	26.0
27.00	General inpatient routine service cost net of swing-bed cost ((line 21 minus line 26)		2, 071, 895	
_/. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			2,011,070	27.0
28.00	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	narges)	0	28.0
	Private room charges (excluding swing-bed charges)			0	
30.00	Semi-private room charges (excluding swing-bed charges)			0	
1.00	General inpatient routine service cost/charge ratio (line 27 -	÷line 28)		0.000000	
3.00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 0.00	
4.00	Average per diem private room charge differential (line 32 mir	nus line 33)(see instrud	ctions)	0.00	
35.00	Average per diem private room cost differential (line 34 x lir		-	0.00	1
36.00	Private room cost differential adjustment (line 3 x line 35)			0	
37.00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	2, 071, 895	37.0
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				-
	PART IT - HUSPITAL AND SUBPROVIDERS UNLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	JSTMENTS			1
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 836. 79	38.0
	Program general inpatient routine service cost (line 9 x line			437, 156	
10.00	Medically necessary private room cost applicable to the Progra			0	
41.00	Total Program general inpatient routine service cost (line 39			437, 156	

MPUI	ATION OF INPATIENT OPERATING COST		Provider C	CN: 15-1308	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Pre	
						11/23/2021 3:	
	Cost Conton Description	Tatal		XVIII	Hospital	Cost	
	Cost Center Description	Total Inpatient Costl	Total npatient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
. 00	NURSERY (title V & XIX only)						42.
	Intensive Care Type Inpatient Hospital Units						
. 00	INTENSIVE CARE UNIT	0	C	0.0	0 00	C	
. 00	CORONARY CARE UNIT						44.
. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45.
. 00		0	C	0.	0 0	C	
00	Cost Center Description	0		, U	50 0		, ,,
						1.00	
00	Program inpatient ancillary service cost (Wks					289, 571	
00	Total Program inpatient costs (sum of lines 4	41 through 48)(s	see instructio	ons)		726, 727	49
~~	PASS THROUGH COST ADJUSTMENTS						
00	Pass through costs applicable to Program inpa	atient routine s	services (tron	n WKST. D, SUI	n of Parts I and	C	50
00	Pass through costs applicable to Program inpa	atient ancillary	v services (fr	om Wkst D 4	sum of Parts II	C	51
00	and IV)		y 301 11 003 (11				1 .
00	Total Program excludable cost (sum of lines !	50 and 51)				C	52
00	Total Program inpatient operating cost exclud		lated, non-phy	/sician anestl	netist, and	C	53
	medical education costs (line 49 minus line !	52)					_
00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					C	
00 00	Target amount per discharge					0.00	
00	Target amount (line 54 x line 55)					0.00	
00	Difference between adjusted inpatient operati	ing cost and tai	raet amount (I	ine 56 minus	line 53)	C C	
00	Bonus payment (see instructions)		g			0	
00	Lesser of lines 53/54 or 55 from the cost re	porting period e	ending 1996, ι	updated and co	ompounded by the	0.00	59
	market basket						
00	Lesser of lines 53/54 or 55 from prior year of					0.00	
00	If line 53/54 is less than the lower of lines					C) 61
	which operating costs (line 53) are less than amount (line 56), otherwise enter zero (see i		s (TTHES 54 X	60), OI 1% O	the target		
00	Relief payment (see instructions)					C	62
00	Allowable Inpatient cost plus incentive payme	ent (see instru	ctions)			C	63
	PROGRAM INPATIENT ROUTINE SWING BED COST						
00	Medicare swing-bed SNF inpatient routine cos	ts through Decer	mber 31 of the	e cost reporti	ng period (See	77, 145	64
00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	te after Decomb	or 21 of the c	cost roportin	a poriod (Soo	104, 697	65
00	instructions) (title XVIII only)				g period (see	104, 097	05
00	Total Medicare swing-bed SNF inpatient routin	ne costs (line d	64 plus line 6	55)(title XVI)	I only). For	181, 842	2 66
	CAH (see instructions)				57		
. 00	Title V or XIX swing-bed NF inpatient routine	e costs through	December 31 c	of the cost re	eporting period	C	67
~ ~	(line 12 x line 19)						
00	Title V or XIX swing-bed NF inpatient routine	e costs after De	ecember 31 of	the cost repo	orting period	0	68
. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient (routine costs (l	line 67 + line	a 68)		C	69
00	PART III - SKILLED NURSING FACILITY, OTHER NU	,		/			1 01
00	Skilled nursing facility/other nursing facili	•)		70
00	Adjusted general inpatient routine service co	ost per diem (li	ine 70 ÷ line	2)			71
00	Program routine service cost (line 9 x line	,	<i></i>				72
00	Medically necessary private room cost applica	<u> </u>	•	,			73
00	Total Program general inpatient routine servi	•			Dart II column		74
00	Capital-related cost allocated to inpatient (26, line 45)	outine service	CUSIS (TROM V	IOIKSNEET B, I	artir, corumn		75
00	Per diem capital-related costs (line 75 ÷ lin	ne 2)					76
00	Program capital -related costs (line 9 x line						77
00	Inpatient routine service cost (line 74 minus						78
00	Aggregate charges to beneficiaries for excess	• •		· · · · · · · · · · · · · · · · · · ·			79
00	Total Program routine service costs for compa		ost limitation	n (line 78 min	nus line 79)		80
00	Inpatient routine service cost per diem limit		\ \				81
00 00	Inpatient routine service cost limitation (li						82
00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see ins		5)				83
00	Utilization review - physician compensation		ns)				85
00	Total Program inpatient operating costs (sum						86
-	PART IV - COMPUTATION OF OBSERVATION BED PASS						
. 00	Total observation bed days (see instructions))				430	
00	Adjusted general inpatient routine cost per o	diem (line 27 ÷	line 2)			1, 836. 79	88
00 00	Observation bed cost (line 87 x line 88) (see					789, 820	

Health Financial Systems	ASCENSION ST.	VINCENT MERCY		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period:	Worksheet D-1	
				From 07/01/2020 To 06/30/2021	Date/Time Pre 11/23/2021 3:	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	236, 712	2, 337, 708	0. 10125	8 789, 820	79, 976	90.00
91.00 Nursing School cost	0	2, 337, 708	0.00000	0 789, 820	0	91.00
92.00 Allied health cost	0	2, 337, 708	0.00000	0 789, 820	0	92.00
93.00 All other Medical Education	0	2, 337, 708	0.00000			93.00

ASCENSI ON	ST.	VI NCENT	MERCY	

	Financial Systems ASCENSION ST. VI ATION OF INPATIENT OPERATING COST	NCENT MERCY Provider CCN: 15-1308	In Lie Period:	u of Form CMS-2 Worksheet D-1	
			From 07/01/2020 To 06/30/2021		pared:
	Cost Center Description	Title XIX	Hospi tal	Cost	
				1.00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed day			1, 293	1.00
2.00 3.00	Inpatient days (including private room days, excluding swing Private room days (excluding swing-bed and observation bed da do not complete this line.		rivate room days,	1, 128 0	2.00 3.00
4.00 5.00	Semi-private room days (excluding swing-bed and observation I Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	698 71	4. 00 5. 00
6.00	reporting period Total swing-bed SNF type inpatient days (including private re reporting period (if calendar year, enter 0 on this line)	oom days) after December	31 of the cost	71	6. 00
7.00	Total swing-bed NF type inpatient days (including private ro	om days) through Decembe	r 31 of the cost	12	7.00
8.00	reporting period Total swing-bed NF type inpatient days (including private row reporting period (if calendar year, enter 0 on this line)	om days) after December 3	31 of the cost	11	8. 00
9.00	Total inpatient days including private room days applicable newborn days) (see instructions)	0	5 6	9	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII of through December 31 of the cost reporting period (see instruct		room days)	0	10. 00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII December 31 of the cost reporting period (if calendar year,	only (including private	room days) after	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or X through December 31 of the cost reporting period		te room days)	0	12.00
	Swing-bed NF type inpatient days applicable to titles V or X after December 31 of the cost reporting period (if calendar	year, enter 0 on this li	ne)	0	13.00
	Medically necessary private room days applicable to the Prog Total nursery days (title V or XIX only)	ram (excluding swing-bed	days)	0	
	Nursery days (title V or XIX only)			0	
17.00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to servic	ces through December 31 (of the cost		17.00
	reporting period Medicare rate for swing-bed SNF services applicable to service	0			18.00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	es through December 31 o	f the cost	216. 95	19.00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	es after December 31 of 1	the cost	216. 95	20. 00
21. 00 22. 00	reporting period Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decem		ting period (line	2, 337, 708 0	21. 00 22. 00
23.00	5 x line 17) Swing-bed cost applicable to SNF type services after December		0.1	0	23.00
24.00	x line 18) Swing-bed cost applicable to NF type services through December	er 31 of the cost report	ng period (line	2, 603	24.00
25.00	7 x line 19) Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reporting	g period (line 8	2, 386	25.00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		265, 813 2, 071, 895	26. 00 27. 00
28.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 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
31.00	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0. 000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
33.00 34.00	Average per diem private room charge differential (line 32 m	inus line 33)(see instru	ctions)	0.00 0.00	
35.00	Average per diem private room cost differential (line 34 x li			0.00	
36. 00 37. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost 27 minutine 2(2)	and private room cost d	fferential (line	0 2, 071, 895	36.00 37.00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY	WOTHENTO			
38.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD. Adjusted general inpatient routine service cost per diem (ser			1, 836. 79	38.00
39.00	Program general inpatient routine service cost (line 9 x line	e 38)		16, 531	39.00
40.00	Medically necessary private room cost applicable to the Prog	•		0	40.00
41.00	Total Program general inpatient routine service cost (line 3	9 + IIIIE 40)		16, 531	41.00

JMPUT	ATION OF INPATIENT OPERATING COST		Provider C	CN: 15-1308	Period: From 07/01/2020	Worksheet D-1	l
					To 06/30/2021	Date/Time Pre 11/23/2021 3:	epare 53 p
		Tatal		e XIX	Hospi tal	Cost	
	Cost Center Description	Total Inpatient Costli	Total npatient Days			Program Cost (col. 3 x col.	
		1.00	2.00	col. 2) 3.00	4.00	4) 5.00	
. 00	NURSERY (title V & XIX only)						42.
. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	0	0	0.0	0 00	0	43.
. 00	CORONARY CARE UNIT	0	0	0.0	0		44.
. 00	BURN INTENSIVE CARE UNIT						45.
. 00	SURGICAL INTENSIVE CARE UNIT						46.
. 00	DETOXIFICATION INTENSIVE CARE UNIT Cost Center Description	0	0	0.0	00	0	47.
	· · · ·					1.00	
. 00	Program inpatient ancillary service cost (Wks					13, 922	
. 00	Total Program inpatient costs (sum of lines 4	41 through 48)(s	ee instructio	ons)		30, 453	49
. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpa	atient routine s	ervices (from	Wkst. D. sur	n of Parts I and	0	50
. 00	Pass through costs applicable to Program inpa and IV)	atient ancillary	services (fr	om Wkst. D, s	sum of Parts II	0	51
. 00	Total Program excludable cost (sum of lines !	50 and 51)				0	52
. 00	Total Program inpatient operating cost exclude		ated, non-phy	sician anesti	netist, and	0	53.
	medical education costs (line 49 minus line 5 TARGET AMOUNT AND LIMIT COMPUTATION	52)					
. 00	Program di scharges					0	54
. 00	Target amount per discharge					0.00	
. 00	Target amount (line 54 x line 55)					0	56
. 00	Difference between adjusted inpatient operati	ng cost and tar	get amount (I	ine 56 minus	line 53)	0	
. 00 . 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost rep	orting pariod a	ading 1004 i	indated and c	mounded by the	0.00	
. 00	market basket	borting period e	iui iig 1990, t	ipuateu anu co	hipounded by the	0.00	09
. 00	Lesser of lines 53/54 or 55 from prior year of					0.00	
. 00	If line 53/54 is less than the lower of lines					0	61
	which operating costs (line 53) are less than amount (line 56), otherwise enter zero (see i		(TINES 54 X	60), or 1% of	the target		
. 00	Relief payment (see instructions)	hatr dotronay				o	62
. 00	Allowable Inpatient cost plus incentive payme	ent (see instruc	tions)			0	63
. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cost	ts through Docom	oor 21 of the	cost roporti	na pariod (Saa	0	64
. 00	instructions) (title XVIII only)	ts through becen		cost reporti	ng period (see		04
. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decembe	r 31 of the c	ost reporting	g period (See	0	65
00	instructions) (title XVIII only)		4				
. 00	Total Medicare swing-bed SNF inpatient routin CAH (see instructions)	ne costs (line 6	4 plus line 6	5)(TITIE XVII	I ONLY). FOR	0	66
. 00	Title V or XIX swing-bed NF inpatient routine	e costs through	December 31 c	of the cost re	eporting period	o	67
	(line 12 x line 19)					_	
8. 00	Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)	e costs after De	cember 31 of	the cost repo	orting period	0	68
. 00	Total title V or XIX swing-bed NF inpatient i	routine costs (I	ne 67 + line	e 68)		0	69
	PART III - SKILLED NURSING FACILITY, OTHER NU	JRSING FACILITY,	AND ICF/IID	ONLY		I I	
. 00	Skilled nursing facility/other nursing facili	2					70
. 00 . 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		ne /U ÷ line	2)			71
. 00	Medically necessary private room cost application	,	(line 14 x li	ne 35)			73
. 00	Total Program general inpatient routine servi						74
. 00	Capital-related cost allocated to inpatient	routine service	costs (from W	lorksheet B, F	Part II, column		75
. 00	26, line 45) Per diem capital-related costs (line 75 ÷ lin	ne 2)					76
. 00	Program capital -related costs (line 9 x line						77
. 00	Inpatient routine service cost (line 74 minus	s line 77)					78
00	Aggregate charges to beneficiaries for excess	• •					79
00	Total Program routine service costs for compa Inpatient routine service cost per diem limit		si iimitation	i (iine /8 mir	ius i i ne 79)		80
. 00	Inpatient routine service cost per drem finm						82
. 00	Reasonable inpatient routine service costs (s)				83
. 00	Program inpatient ancillary services (see in						84
. 00	Utilization review - physician compensation						85
. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS						86
. 00	Total observation bed days (see instructions)					430	87
3. 00	Adjusted general inpatient routine cost per o		ine 2)			1, 836. 79	
. 00	Observation bed cost (line 87 x line 88) (see					789, 820	

Health Financial Systems	ASCENSION ST.	VINCENT MERCY		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period:	Worksheet D-1	
				From 07/01/2020 To 06/30/2021	Date/Time Pre 11/23/2021 3:	
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	236, 712	2, 337, 708	0. 10125	8 789, 820	79, 976	90.00
91.00 Nursing School cost	0	2, 337, 708	0.00000	0 789, 820	0	91.00
92.00 Allied health cost	0	2, 337, 708	0.00000	0 789, 820	0	92.00
93.00 All other Medical Education	0	2, 337, 708	0.00000			93.00

Health Financial Systems ASCENSION S	T. VINCENT MERCY		In Lie	eu of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1308	Peri od:	Worksheet D-3	3
			From 07/01/2020		
			To 06/30/2021	Date/Time Pre 11/23/2021 3:	
	Title	e XVIII	Hospi tal	Cost	55 pili
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
		J	Charges	(col. 1 x col.	
			3	2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS				•	
30. 00 03000 ADULTS & PEDI ATRI CS			419, 157		30.00
31. 00 03100 I NTENSI VE CARE UNI T			0		31.00
35. 00 02040 DETOXIFICATION INTENSIVE CARE UNIT			0		35.00
ANCI LLARY SERVI CE COST CENTERS					1
50. 00 05000 OPERATI NG ROOM		0. 1570	30 173, 850	27, 300	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1360	93, 785	12, 762	54.00
56. 00 05600 RADI OI SOTOPE		0.0000	0 00	0	56.00
57. 00 05700 CT SCAN		0.0000	0 00	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0.0000	0 00	0	58.00
60. 00 06000 LABORATORY		0. 1961	98 166, 424	32, 652	60.00
65. 00 06500 RESPI RATORY THERAPY		0. 6421	62, 809	40, 332	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 46562	20 25, 399	11, 826	66.00
67.00 06700 OCCUPATI ONAL THERAPY		0. 4336	28 14, 299	6, 200	67.00
68.00 06800 SPEECH PATHOLOGY		0. 5517	40 3, 658	2, 018	68.00
69. 00 06900 ELECTROCARDI OLOGY		0.0000	0 00	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0.0000	0 00	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 2504	48 62, 611	15, 681	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS		3. 2553	34 1, 656	5, 391	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 3787	90 341, 510	129, 361	73.00
76.00 03610 SLEEP LAB		0. 31430	05 0	0	76.00
76. 01 03480 ONCOLOGY		0. 3278	46 0	0	76.01
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C		0. 4398	32 0	0	90.00
91. 00 09100 EMERGENCY		0. 2836	35 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 9483	34 6, 377	6, 048	92.00
200.00 Total (sum of lines 50 through 94 and 96 through 9			952, 378	289, 571	200. 00
201.00 Less PBP Clinic Laboratory Services-Program only d	charges (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)			952, 378		202.00

Health Financial Systems ASCENSION ST. VINC				Li e	u of Form CMS-:	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CO	CN: 15-1308	Period: From 07/01/2	000	Worksheet D-3	3
	Component (CCN: 15-Z308	To 06/30/2		Date/Time Pre	pared.
	oomponent (2000	10 00/00/2	021	11/23/2021 3:	
	Title	XVIII	Swing Beds -			
Cost Center Description		Ratio of Cos			Inpati ent	
		To Charges			Program Costs	
			Charges		(col. 1 x col.	
					2)	
		1.00	2.00		3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS					1	30.0
31. 00 03100 I NTENSI VE CARE UNI T					1	31.0
35. 00 02040 DETOXIFICATION INTENSIVE CARE UNIT						35.0
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 0PERATI NG ROOM		0. 1570	20 5	520	867	50.0
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1370		520 196		
56. 00 05600 RADIOLOGI-DIAGNOSTIC		0. 1380		190	0	
57. 00 05700 CT SCAN		0.0000		0	0	
58.00 05800 MAGNETIC RESONANCE I MAGI NG (MRI)		0.0000		0	0	
60. 00 06000 LABORATORY		0. 1961		456	-	
65. 00 06500 RESPIRATORY THERAPY		0. 6421				
66. 00 06600 PHYSI CAL THERAPY		0. 4656				
67. 00 06700 OCCUPATIONAL THERAPY		0. 4336				
68. 00 06800 SPEECH PATHOLOGY		0. 5517		711	3, 151	
69. 00 06900 ELECTROCARDI OLOGY		0.0000		0	0	
70. 00 07000 ELECTROENCEPHALOGRAPHY		0.0000		0	0	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 2504		613	-	
72. 00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS		3. 2553		0	0	
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 3787		405	9, 623	
76. 00 03610 SLEEP LAB		0. 3143		0	0	
76. 01 03480 ONCOLOGY		0. 3278		0	0	
OUTPATIENT SERVICE COST CENTERS		010270				
90. 00 09000 CLINIC		0. 4398	82	0	0	90.0
91. 00 09100 EMERGENCY		0. 2836		o	0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 9483		522	1, 443	92.0
200.00 Total (sum of lines 50 through 94 and 96 through 98)			129,			
201.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)			0		201.0
202.00 Net charges (line 200 minus line 201)	. ,		129,	967		202.0

Health Financial Systems ASCENSION ST. VINC	ENT MERCY		In Li	eu of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1308	Peri od:	Worksheet D-3	;
			From 07/01/2020 To 06/30/2021		narod
			10 00/ 30/ 2021	11/23/2021 3:	
	Ti tl	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	
INPATIENT ROUTINE SERVICE COST CENTERS		1			
30. 00 03000 ADULTS & PEDI ATRI CS			23, 429		30.00
31.00 O3100 I NTENSI VE CARE UNI T			(31.00
35.00 02040 DETOXIFICATION INTENSIVE CARE UNIT			()	35.00
ANCI LLARY SERVI CE COST CENTERS		0 1570	20		1 50 00
50. 00 05000 0PERATI NG ROOM 54. 00 05400 RADI 0LOGY-DI AGNOSTI C		0. 15703		0 0 5 2,450	
56. 00 05600 RADIOLOGY-DIAGNOSTIC		0. 13808		2,450	
57. 00 05700 CT SCAN		0.0000			
57.00 05700 CT SCAN 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0.0000			
60. 00 06000 LABORATORY		0. 1961		-	
65. 00 06500 RESPIRATORY THERAPY		0. 1981			•
66. 00 06600 PHYSI CAL THERAPY		0. 46562			
67. 00 06700 OCCUPATI ONAL THERAPY		0. 4030		0 0	
68. 00 06800 SPEECH PATHOLOGY		0. 5517			
69. 00 06900 ELECTROCARDI OLOGY		0.0000			
70. 00 07000 ELECTROENCEPHALOGRAPHY		0.0000			
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 2504			
72.00 07200 I MPLANTABLE DEVICES CHARGED TO PATIENTS		3. 2553			
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 3787		-	
76.00 03610 SLEEP LAB		0. 31430			
76. 01 03480 ONCOLOGY		0. 3278			
OUTPATI ENT SERVICE COST CENTERS		0.0270		<u>, </u>	/0.01
90. 00 09000 CLINIC		0. 4398	32 (90.00
91. 00 09100 EMERGENCY		0. 2836		-	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 9483			
200.00 Total (sum of lines 50 through 94 and 96 through 98)			58, 722	13. 922	200.00
201.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)		(201.00
202.00 Net charges (line 200 minus line 201)			58, 722	2	202.00

	Financial Systems ASCENSION ST. VINCEM			u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT PI	rovider CCN: 15-1308	Period: From 07/01/2020 To 06/30/2021	Date/Time Pre	
		Title XVIII	Hospi tal	11/23/2021 3: Cost	53 pm
			·		
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)	```		4, 562, 839	
2.00 3.00	Medical and other services reimbursed under OPPS (see instruction OPPS payments	ns)		0	
4.00	Outlier payment (see instructions)			0	
4.01	Outlier reconciliation amount (see instructions)	ano)		0	
5.00 6.00	Enter the hospital specific payment to cost ratio (see instructi Line 2 times line 5	ons)		0.000	•
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7.00
8.00 9.00	Transitional corridor payment (see instructions) Ancillary service other pass through costs from Wkst. D, Pt. IV,	col 12 Lino 200		0	
10.00	Organ acquisitions	col. 13, 111e 200		0	
11.00	Total cost (sum of lines 1 and 10) (see instructions)			4, 562, 839	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges				
12.00	Ancillary service charges			0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line	69)		0	
14.00	Total reasonable charges (sum of lines 12 and 13) Customary charges			0	14.00
15.00	Aggregate amount actually collected from patients liable for pay			0	
16.00	Amounts that would have been realized from patients liable for p had such payment been made in accordance with 42 CFR §413.13(e)	ayment for services of	on a chargebasis	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17.00
18.00	Total customary charges (see instructions)			0	
19.00	Excess of customary charges over reasonable cost (complete only instructions)	if line 18 exceeds li	ne 11) (see	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only	ifline 11 exceeds li	ne 18) (see	0	20.00
21 00	instructions)			4 (00 4/7	21 00
21.00 22.00	Lesser of cost or charges (see instructions) Interns and residents (see instructions)			4, 608, 467 0	
23.00	Cost of physicians' services in a teaching hospital (see instruc	tions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	24.00
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)			27, 187	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 2			2, 729, 463	
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plu instructions)	s the sum of lines 22	2 and 23] (see	1, 851, 817	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line	50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
30. 00 31. 00	Subtotal (sum of lines 27 through 29) Primary payer payments			1, 851, 817 529	1
32.00	Subtotal (line 30 minus line 31)			1, 851, 288	•
22.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		0	33.00
33.00 34.00	Composite rate ESRD (from Wkst. 1-5, line 11) Allowable bad debts (see instructions)			980, 526	
35.00	Adjusted reimbursable bad debts (see instructions)			637, 342	
36.00 37.00	Allowable bad debts for dual eligible beneficiaries (see instruc Subtotal (see instructions)	tions)		551, 174 2, 488, 630	
38.00	MSP-LCC reconciliation amount from PS&R			2, 100, 000	
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
39. 50 39. 97	Pioneer ACO demonstration payment adjustment (see instructions) Demonstration payment adjustment amount before sequestration			0	39.50 39.97
39.98	Partial or full credits received from manufacturers for replaced	devices (see instruc	ctions)	0	
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0	-
40. 00 40. 01	Subtotal (see instructions) Sequestration adjustment (see instructions)			2, 488, 630 0	
40. 02	Demonstration payment adjustment amount after sequestration			0	
40.03	Sequestration adjustment-PARHM pass-throughs			2 502 510	40.03
41.00 41.01	Interim payments Interim payments-PARHM			2, 582, 519	41.00
42.00	Tentative settlement (for contractors use only)			0	
42. 01 43. 00	Tentative settlement-PARHM (for contractor use only) Balance due provider/program (see instructions)			-93, 889	42.01 43.00
43.00 43.01	Balance due provider/program-PARHM (see instructions)			-93, 089	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance	with CMS Pub. 15-2,	chapter 1,	0	
	§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	
92.00 93.00	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)			0.00	92.00 93.00
	Total (sum of lines 91 and 93)				94.00

				From 07/01/2020 To 06/30/2021		pared
		Title	XVIII	Hospi tal	Cost	
		Inpatien	t Part A		rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00	Total interim payments paid to provider		644, 8	70	2, 582, 519	1. (
00	Interim payments payable on individual bills, either			0	0	2.0
	submitted or to be submitted to the contractor for					1
	services rendered in the cost reporting period. If none,					i i
	write "NONE" or enter a zero					
00	List separately each retroactive lump sum adjustment					3.
	amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each					1
	payment. If none, write "NONE" or enter a zero. (1)					1
	Program to Provider				L	
01	ADJUSTMENTS TO PROVI DER			0	0	3.
02				0	0	3.
03				0	0	3.
04				0	0	3.
05				0	0	3.
	Provider to Program					
50	ADJUSTMENTS TO PROGRAM			0	0	3.
51				0	0	
52				0	0	3.
53 54				0	0	3. 3.
99	Subtotal (sum of lines 3.01–3.49 minus sum of lines			0	0	3.
77	3. 50-3. 98)			0	0	3.
00	Total interim payments (sum of lines 1, 2, and 3.99)		644, 8	70	2, 582, 519	4.
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR	1				
00	List separately each tentative settlement payment after					5.
	desk review. Also show date of each payment. If none,					i i
	write "NONE" or enter a zero. (1) Program to Provider					
01	TENTATI VE TO PROVIDER			0	0	5
02				0	0	5
03				0	0	
	Provider to Program	I				
50	TENTATI VE TO PROGRAM			0	0	5
51				0	0	5
52				0	0	5
99	Subtotal (sum of lines 5.01–5.49 minus sum of lines			0	0	5
~~	5. 50-5. 98)					
00	Determined net settlement amount (balance due) based on the cost report. (1)					6
01	SETTLEMENT TO PROVIDER		19, 1	00	0	6
02	SETTLEMENT TO PROVIDER		17, 1	0	93, 889	6
02	Total Medicare program liability (see instructions)		663, 9		2, 488, 630	
			000,7	Contractor	NPR Date	ŕ
				Number	(Mo/Day/Yr)	
		()	1.00	2.00	

ALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider C	CN: 15-1308 CCN: 15-Z308		riod: om 07/01/2020 06/30/2021		
		component	SCN: 13-2300		00/ 30/ 2021	11/23/2021 3:	53 pn
			XVIII	Sw	ing Beds - SNF		
		Inpatien	t Part A		Par	tВ	
		mm/dd/yyyy	Amount		mm/dd/yyyy	Amount	
		1.00	2.00		3.00	4.00	
00	Total interim payments paid to provider		263, 5	38		C	1.
00	Interim payments payable on individual bills, either			0		C	2.
	submitted or to be submitted to the contractor for						
	services rendered in the cost reporting period. If none,						
~ ~	write "NONE" or enter a zero						
00	List separately each retroactive lump sum adjustment						3.
	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	1	1				
D1	ADJUSTMENTS TO PROVIDER			0		C	3.
)2				0		C	
)3				0		C	3.
)4				0		C	
)5				0		C	3.
	Provider to Program	1	1				
0	ADJUSTMENTS TO PROGRAM			0		0	
1				0		0	
52 53				0 0		0	
53 54				0			
9 9	Subtotal (sum of lines 3.01–3.49 minus sum of lines			0		0	
<i>,</i>	3. 50-3. 98)			Ŭ		Ŭ	
00	Total interim payments (sum of lines 1, 2, and 3.99)		263, 5	538		C	4.
	(transfer to Wkst. E or Wkst. E-3, line and column as						
	appropri ate)						
	TO BE COMPLETED BY CONTRACTOR	1					
00	List separately each tentative settlement payment after						5
	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						
	Program to Provider						
)1	TENTATI VE TO PROVI DER			0		C	5
2				0		C	
3				0		C	5
	Provider to Program						
0	TENTATI VE TO PROGRAM			0		0	
1				0		0	
2	Subtatal (sum of lines E 01 E 40 minut sum of lin			0		0	
9	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0		0	5.
0	Determined net settlement amount (balance due) based on						6.
	the cost report. (1)						0.
)1	SETTLEMENT TO PROVIDER			0		C	6.
)2	SETTLEMENT TO PROGRAM		29, 4	62		0	
00	Total Medicare program liability (see instructions)		234, C)76		C	7.
					Contractor	NPR Date	
					Number	(Mo/Day/Yr)	
		()		1.00	2.00	

Heal th	Financial Systems ASCENSION ST. VIN	CENT MERCY	In Lie	u of Form CMS-	2552-10	
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1308	Peri od:	Worksheet E-	1	
			From 07/01/2020			
			To 06/30/2021	Date/Time Pre 11/23/2021 3:		
		Title XVIII	Hospi tal	Cost		
				1.00		
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				_	
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				1.00	
	1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14					
2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12						
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00	
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	-12			4.00	
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00	
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 l	ine 20			6.00	
7.00	CAH only - The reasonable cost incurred for the purchase of c	ertified HIT technology	Wkst. S-2, Pt. I		7.00	
	line 168					
8.00	Calculation of the HIT incentive payment (see instructions)				8.00	
9.00	Sequestration adjustment amount (see instructions)				9.00	
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00	
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH					
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	

LCULA	Financial Systems ASCENSION ST. VINC TION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provi der CCN: 15-1308	Peri od:	u of Form CMS-2 Worksheet E-2	
		Component CCN: 15-Z308	From 07/01/2020 To 06/30/2021	Date/Time Pre	
		Title XVIII	Swing Beds - SNF	11/23/2021 3: Cost	53 p
			Part A	Part B	
			1.00	2.00	
	OMPUTATION OF NET COST OF COVERED SERVICES		100 (/0	0	
	npatient routine services - swing bed-SNF (see instructions)		183, 660	0	
	npatient routine services - swing bed-NF (see instructions) Ancillary services (from Wkst. D-3, col. 3, line 200, for Part	A and sum of Wkst D	48, 674	0	2. 3.
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swin			0	3.
	nstructions)				
01	Nursing and allied health payment-PARHM (see instructions)				3.
	Per diem cost for interns and residents not in approved teachi	ng program (see		0.00	4.
	nstructions)		99	0	
	Program days nterns and residents not in approved teaching program (see in	structions)	99	0	
	Itilization review - physician compensation - SNF optional met		0	0	7
	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		232, 334	0	
00 F	Primary payer payments (see instructions)		0	0	9.
	Subtotal (line 8 minus line 9)		232, 334	0	
	Deductibles billed to program patients (exclude amounts applic	able to physician	0	0	11
	professional services)		222.224	0	12
	Subtotal (line 10 minus line 11) Coinsurance billed to program patients (from provider records)	(exclude coi psurance	232, 334	0	
	for physician professional services)		0	0	
	30% of Part B costs (line 12 x 80%)			0	14
. 00 5	Subtotal (see instructions)		232, 334	0	15
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
	Pioneer ACO demonstration payment adjustment (see instructions				16
	Rural community hospital demonstration project (§410A Demonstra adjustment (see instructions)	ation) payment	0		16
	Demonstration payment adjustment amount before sequestration		0	0	16
	Allowable bad debts (see instructions)		2, 680	0	
. 01 🖌	Adjusted reimbursable bad debts (see instructions)		1, 742	0	17
	Allowable bad debts for dual eligible beneficiaries (see instr	uctions)	0	0	
	Total (see instructions)		234, 076	0	
	Sequestration adjustment (see instructions)		0	0	
	Demonstration payment adjustment amount after sequestration) Sequestration adjustment-PARHM pass-throughs		0	0	19
	Sequestration for non-claims based amounts (see instructions)		0	0	
	nterim payments		263, 538	0	
01	nterim payments-PARHM				20
	Tentative settlement (for contractor use only)		0	0	
	Fentative settlement-PARHM (for contractor use only)	40.05.00 (.04)	00.440	0	21
	Balance due provider/program (line 19 minus lines 19.01, 19.02 Balance due provider/program-PARHM (see instructions)	, 19.25, 20, and 21)	-29, 462	0	22
	Protested amounts (nonallowable cost report items) in accordan	ce with CMS Pub 15-2	0	0	
	chapter 1, §115.2			Ū	
R	ural Community Hospital Demonstration Project (§410A Demonstra	ation) Adjustment			
	s this the first year of the current 5-year demonstration per	iod under the 21st			200
	Century Cures Act? Enter "Y" for yes or "N" for no.				
	ost Reimbursement Medicare swing-bed SNF inpatient routine service costs (from W	kst D_1 Pt line			201
	56 (title XVIII hospital))				201
2.00 1	Medicare swing-bed SNF inpatient ancillary service costs (from	Wkst. D-3, col. 3, lir	ie		202
	200 (title XVIII swing-bed SNF))				
	Fotal (sum of lines 201 and 202)				203
	Aedicare swing-bed SNF discharges (see instructions) computation of Demonstration Target Amount Limitation (N/A in 1	first year of the curre	nt 5-vear demonst	ration	204
	eriod)		ant o year demonst		
	Medicare swing-bed SNF target amount				205
	Medicare swing-bed SNF inpatient routine cost cap (line 205 ti				206
	djustment to Medicare Part A Swing-Bed SNF Inpatient Reimburse				
	Program reimbursement under the §410A Demonstration (see instr	-	1		207
	<pre>Medicare swing-bed SNF inpatient service costs (from Wkst. E-2 and 3)</pre>	, cor. r, sum of lines	1		208
	Adjustment to Medicare swing-bed SNF PPS payments (see instruc	tions)			209
	Reserved for future use				210
С	comparision of PPS versus Cost Reimbursement				
5 00[]	Fotal adjustment to Medicare swing-bed SNF PPS payment (line 2	09 plus line 210) (see			215

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-1308	Peri od: From 07/01/2020 To 06/30/2021	Worksheet E-3 Part V Date/Time Pre 11/23/2021 3:	pare
		Title XVIII	Hospi tal	Cost	
				1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDIO	CAPE DART A SERVICES _ COS		1.00	
. 00	Inpatient services	CARE FART A SERVICES - COS		726, 727	1.
. 00	Nursing and Allied Health Managed Care payment (see instru	uctions)		120, 121	
. 00	Organ acquisition			0	
. 00	Subtotal (sum of lines 1 through 3)			726, 727	
. 00	Primary payer payments			0	5.
. 00	Total cost (line 4 less line 5). For CAH (see instruction	s)		733, 994	
	COMPUTATION OF LESSER OF COST OR CHARGES			,	
	Reasonabl e charges				1
. 00	Routi ne servi ce charges			0	7.
. 00	Ancillary service charges			0	8
. 00	Organ acquisition charges, net of revenue			0	9
0. 00	Total reasonable charges			0	10
	Customary charges				
1.00	Aggregate amount actually collected from patients liable			0	
2.00	Amounts that would have been realized from patients liable		on a charge basis	0	12
	had such payment been made in accordance with 42 CFR 413.	13(e)		0 00000	1 4 0
3.00 4.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000	
4.00 5.00	Total customary charges (see instructions)	a anly if line 14 exceeds li	(coo	0	
5.00	Excess of customary charges over reasonable cost (complete instructions)	e only if the 14 exceeds if	ne o) (see	0	15
6.00	Excess of reasonable cost over customary charges (complete	e only if line 6 exceeds li	ne 14) (see	0	16
0.00	instructions)			0	''
7.00	Cost of physicians' services in a teaching hospital (see	instructions)		0	17
	COMPUTATION OF REIMBURSEMENT SETTLEMENT	·			1
8.00	Direct graduate medical education payments (from Workshee	t E-4, line 49)		0	18
9.00	Cost of covered services (sum of lines 6, 17 and 18)			733, 994	
0. 00	Deductibles (exclude professional component)			72, 224	
1. 00	Excess reasonable cost (from line 16)			0	
2.00	Subtotal (line 19 minus line 20 and 21)			661, 770	
3.00	Coinsurance			0	
4.00	Subtotal (line 22 minus line 23)			661, 770	
5.00	Allowable bad debts (exclude bad debts for professional se	ervices) (see instructions)		3, 384	
6.00 7.00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see	i notructi onc)		2, 200 83	
7.00 8.00	Subtotal (sum of lines 24 and 25, or line 26)	instructions)		663, 970	
9.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			003, 970	
9.50	Pioneer ACO demonstration payment adjustment (see instruc	tions)		0	
9.99	Demonstration payment adjustment amount before sequestrat			0	
). 00	Subtotal (see instructions)			663, 970	
D. 01	Sequestration adjustment (see instructions)			000, 770	
). 02	Demonstration payment adjustment amount after sequestration	on		0	
0.03	Sequestration adjustment-PARHM			Ũ	30
1.00	Interim payments			644, 870	
1.01	Interim payments-PARHM				31
2.00	Tentative settlement (for contractor use only)			0	32
2. 01	Tentative settlement-PARHM (for contractor use only)				32
3.00	Balance due provider/program (line 30 minus lines 30.01,			19, 100	33
3. 01	Balance due provider/program-PARHM (lines 2, 3, 18, and 2	6, minus lines 30.03, 31.01,	, and 32.01)		33
4.00	Protested amounts (nonallowable cost report items) in acc			0	34

To 6/6/30/2021 Detect DART VII - CALCULATION OF REINBURSDIEMT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES Inpati ent Outpet COMPUTION OF REINBURSDIEMT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES 30, 452 Dimodical and other services 30, 453 1.00 Dimodical and other services 30, 453 0.00 Urganical (sum of lines 1, 2 and 3) 20, 453 0.00 Unpatient primary payer payments 0 0.00 Subtotal (sum of lines 5 and 6) 30, 453 0.00 Unpatient primary payer payments 0 0.00 Compatients 1/2/2/2/2 0.00 Dretal charges (sem offines 8 through 11) <		nancial Systems ASCENSION ST. VING ON OF REIMBURSEMENT SETTLEMENT	Peri od:	Worksheet E-3		
THE XIX Hospital Inpatient Outpath PART VI - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES 1.00 2.0 COMPUTATION OF NET COST OF COVERED SERVICES 30.453 30.453 1.00 Automation of NET COST OF COVERED SERVICES 30.453 2.00 Medical and other services 30.453 3.00 Organ acquisition (certified transplant centers only) 0 5.01 Inpatient primary payer payments 0 6.00 Outpatient primary payer payments 0 7.00 Subtotal (sum of LESSER OF COST OR CHARGES 23.429 7.00 Moutine service charges 23.429 8.00 Routine service charges 23.429 7.00 Organ acquisition charges, net of revenue 0 10.01 Intentive From target anount computation 80 11.00 Incentive From target anount computation 80 12.00 Incentive From target anount computation 82.151 13.00 Ancentive From target anount computation 82.151 14.00 Ancentive From target anount computation				From 07/01/2020 To 06/30/2021	Part VII Date/Time Pre 11/23/2021 3:	pared: 53 pm
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES COMPUTATION OF NET COST OF COVERED SERVICES 30,453 Lo Inpatient hospital (19%)//F services 30,453 2.00 Wedical and other services 30,453 00 Organ acquisition (certified transplant centers only) 0 5.01 Inpatient primary payer payments 0 0.020 000000000000000000000000000000000000			Title XIX	Hospi tal	Cost	
PART VI I - CALCULATION OF RETINBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES COMPUTATION OF RETINBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES 300 1000 Inpatient hospital/SW/WF services 30,453 200 Medical and other services 30,453 300 Organ acquisition (certified transplant centers only) 0 400 Subtotal (sum of lines 1, 2 and 3) 30,453 500 Inpatient primary payer payments 0 600 Outpatient primary payer payments 0 7.00 Subtotal (sum of lines 5, 2 and 3) 30,453 600 Outpatient primary payer payments 0 7.00 Subtotal (sum of lines S and 6) 30,453 600 Outpatient service charges 23,429 9.00 Ancillary service charges 0 10.00 Incentive from target amount computation 0 10.00 Incentive from target amount computation 0 10.00 Incentive from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e) 0 10.00 Total customary charges ov					Outpati ent	
COMPUTATION OF NET COST OF COVERED SERVICES 10 Inpatient hospital (1) SNF/KF services 30, 453 2.00 Medical and other services 30, 453 2.00 Dirgan acquisition (certified transplant centers only) 0 3.00 Dirgan acquisition (certified transplant centers only) 0 4.00 Subtotal (sum of lines 1, 2 and 3) 30, 453 5.00 Inpatient primary payer payments 0 6.00 Outpatient primary payer payments 0 7.0 Subtotal (sum of lines 5 and 6) 30, 453 COMPUTATION OF LESSER OF COST OR CHARGES 8 Reasonable Charges 58, 722 0.00 Organ acquisition charges, net of revenue 0 1.00 Incentive From target aneunt computation 0 0 Total reasonable charges (sum of lines 8 through 11) 82, 151 0 Mount actual ty collected from patients liable for payment for services on a charge 0 14.00 Mount actual ty collected from patients liable for payment for services on a charge 0 15.00 Ratio of Lines 3 through cost acost acostance with 42 CFR §413.13(c) 0.000000<					2.00	
1.00 Inpatient hospital/SR/NF services 30,453 200 Medical and other services 30,453 200 Unpatient primary payre payments 0 200 Updatient primary payre payments 0 200 Updatient primary payre payments 0 200 Outpatient primary payre payments 0 200 Reasonable Charges 23,429 200 Ancillary service charges 23,429 200 Ancillary service charges 23,429 200 Incentive from target amount computation 0 11.00 Incentive from target amount computation 0 21.00 Incentive from target from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR \$413.13(e) 0 200 Total customary charges (see instructions) 0 0 21.00 Total customary charges ord reasonable cost over customary charges (complete only if line 4 exceeds line to (see instructions) 0 21.00 Total customary charges ord in a eaching hospital (see instructions) 0 22.00 Total experime payments 0 0 23.00 Total customary charges ord in a each of ine			RVICES FOR TITLES V OR X	IX SERVICES		-
2:00 Medical and other services 0 3:00 Organ acquisition (certified transplant centers only) 0 4:00 Subtotal (sum of lines 1, 2 and 3) 30, 453 0:01 Uptatient primary payer payments 0 0:02 Subtotal (sum of lines 5, 2 and 6) 30, 453 0:03 Subtotal (sum of lines 5 and 6) 30, 453 0:04 Reasonable charges 23, 429 0:00 Ancillary service charges 58, 722 0:00 Organ acquisition charges, net of revenue 0 0:11 Total reasonable charges (sum of lines 8 through 11) 82, 151 0:01 Total reasonable charges (sum of lines 8 through 11) 82, 151 0:02 Ancist that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413, 13(e) 0 1:00 Incentive from target amount computation 0 0 1:00 Incentive from target sized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413, 13(e) 0 1:00 Incentive from target sized from patients liable for payment for services on a charge basis services instructions) 0 1:0				00.450		1 1 00
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23.00Outlier payments024.00Program capital payments025.00Capital exception payments (see instructions)026.00Routine and Ancillary service other pass through costs027.00Subtotal (sum of lines 22 through 26)028.00Customary charges (title V or XIX PPS covered services only)029.00Titles V or XIX (sum of lines 21 and 27)30, 453COMPUTATION OF REIMBURSEMENT SETTLEMENT30.00Excess of reasonable cost (from line 18)031.00Subtotal (sum of lines 19 and 20, pl us 29 minus lines 5 and 6)30, 45332.00Deductibles033.00Coinsurance034.00Allowable bad debts (see instructions)035.00Utilization review036.00Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)30, 45337.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)038.00Subtotal (line 36 ± line 37)30, 45339.00Direct graduate medical education payments (from Wkst. E-4)0			completed for PPS provi			
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25.00Capital exception payments (see instructions)026.00Routine and Ancillary service other pass through costs027.00Subtotal (sum of lines 22 through 26)028.00Customary charges (title V or XIX PPS covered services only)029.00Titles V or XIX (sum of lines 21 and 27)30, 453COMPUTATION OF REIMBURSEMENT SETTLEMENT30.00Excess of reasonable cost (from line 18)31.00Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)032.00Deductibles033.00Coinsurance034.00Allowable bad debts (see instructions)035.00Utilization review036.00Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)30, 45337.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)038.00Subtotal (line 36 ± line 37)30, 45339.00Direct graduate medical education payments (from Wkst. E-4)0					0	23.00
26.00Routine and Ancillary service other pass through costs027.00Subtotal (sum of lines 22 through 26)028.00Customary charges (title V or XIX PPS covered services only)029.00Titles V or XIX (sum of lines 21 and 27)30, 453COMPUTATION OF REIMBURSEMENT SETTLEMENT30.00Excess of reasonable cost (from line 18)31.00Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)032.00Deductibles033.00Coinsurance034.00Allowable bad debts (see instructions)035.00Utilization review036.00Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)30, 45337.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)038.00Subtotal (line 36 ± line 37)30, 45339.00Direct graduate medical education payments (from Wkst. E-4)0		0 1 1 5		0		24.00 25.00
27.00Subtotal (sum of lines 22 through 26)028.00Customary charges (title V or XIX PPS covered services only)029.00Titles V or XIX (sum of lines 21 and 27)30,453COMPUTATION OF REIMBURSEMENT SETTLEMENT30.00Excess of reasonable cost (from line 18)31.00Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)32.00Deductibles033.00Coinsurance034.00Allowable bad debts (see instructions)035.00Utilization review036.00Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)30,45337.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)038.00Subtotal (line 36 ± line 37)30,45339.00Direct graduate medical education payments (from Wkst. E-4)0				0	0	•
28.00Customary charges (title V or XIX PPS covered services only)029.00Titles V or XIX (sum of lines 21 and 27) COMPUTATION OF RELIMBURSEMENT SETTLEMENT30, 45330.00Excess of reasonable cost (from line 18)031.00Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)30, 45332.00Deductibles033.00Coinsurance034.00Allowable bad debts (see instructions)035.00Utilization review036.00Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)30, 45337.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)038.00Subtotal (line 36 ± line 37)30, 45339.00Direct graduate medical education payments (from Wkst. E-4)0		· · ·		-	0	•
29.00Titles V or XIX (sum of lines 21 and 27)30,453COMPUTATION OF REIMBURSEMENT SETTLEMENT30.00Excess of reasonable cost (from line 18)031.00Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)30,45332.00Deductibles033.00Coinsurance034.00Allowable bad debts (see instructions)035.00Utilization review036.00Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)30,45337.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)038.00Subtotal (line 36 ± line 37)30,45339.00Direct graduate medical education payments (from Wkst. E-4)0		3		°	0	28.00
30.00Excess of reasonable cost (from line 18)031.00Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)30, 45332.00Deductibles033.00Coinsurance034.00Allowable bad debts (see instructions)035.00Utilization review036.00Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)30, 45337.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)038.00Subtotal (line 36 ± line 37)30, 45339.00Direct graduate medical education payments (from Wkst. E-4)0				30, 453	0	
31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 30, 453 32.00 Deductibles 0 33.00 Coinsurance 0 34.00 Allowable bad debts (see instructions) 0 35.00 Utilization review 0 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 30, 453 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 38.00 Subtotal (line 36 ± line 37) 30, 453 39.00 Direct graduate medical education payments (from Wkst. E-4) 0	COMF	IPUTATION OF REIMBURSEMENT SETTLEMENT				1
32.00Deductibles033.00Coinsurance034.00Allowable bad debts (see instructions)035.00Utilization review036.00Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)30, 45337.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)038.00Subtotal (line 36 ± line 37)30, 45339.00Direct graduate medical education payments (from Wkst. E-4)0	Exc	cess of reasonable cost (from line 18)		0	0	30.00
33.00Coinsurance034.00Allowable bad debts (see instructions)035.00Utilization review036.00Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)30, 45337.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)038.00Subtotal (line 36 ± line 37)30, 45339.00Direct graduate medical education payments (from Wkst. E-4)0)		0	
34.00Allowable bad debts (see instructions)035.00Utilization review036.00Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)30, 45337.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)038.00Subtotal (line 36 ± line 37)30, 45339.00Direct graduate medical education payments (from Wkst. E-4)0					0	
35.00Utilization review036.00Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)30, 45337.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)038.00Subtotal (line 36 ± line 37)30, 45339.00Direct graduate medical education payments (from Wkst. E-4)0				0	0	
36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 30,453 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 38.00 Subtotal (line 36 ± line 37) 30,453 39.00 Direct graduate medical education payments (from Wkst. E-4) 0		· · · · · · · · · · · · · · · · · · ·		0	0	•
37.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)038.00Subtotal (line 36 ± line 37)30,45339.00Direct graduate medical education payments (from Wkst. E-4)0				30 453	0	35.00 36.00
38.00Subtotal (line 36 ± line 37)30,45339.00Direct graduate medical education payments (from Wkst. E-4)0				30, 433 N	0	37.00
39.00 Direct graduate medical education payments (from Wkst. E-4) 0	, , , ,			30, 453	0	38.00
5				0	Ū	39.00
		5		30, 453	0	•
41.00 Interim payments 30,453					0	41.00
42.00 Balance due provider/program (line 40 minus line 41) 0		1 5			0	1
43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 chapter 1, §115.2			nce with CMS Pub 15-2,	0	0	43.00

ALANCE	Financial Systems ASCENSION ST. V SHEET (If you are nonproprietary and do not maintain no accounting records complete the Constal Fund column	Provider CO		eriod: rom 07/01/2020	u of Form CMS-2 Worksheet G	
una-ty nly)	pe accounting records, complete the General Fund column			o 06/30/2021	Date/Time Pre 11/23/2021 3:	
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS Cash on hand in banks	450	56, 782	0	0	1 1.
	Temporary investments	0	0	0	0	
1 00	Notes receivable	0	0	0	0	3.
	Accounts receivable	6, 457, 539	0	0	0	4
	Other receivable	567, 217	0	0	0	
	Allowances for uncollectible notes and accounts receivable Inventory	-3, 666, 253 518, 864		0	0 0	
	Prepaid expenses	518, 804 0		0	0	
	Other current assets	0	0	0	0	
	Due from other funds	0	0	0	0	10
00	Total current assets (sum of lines 1-10)	3, 877, 817	56, 782	0	0	11
	I XED ASSETS					
	Land	465, 381	0		0	12
	Land improvements	589, 752	0	0	0	13
	Accumulated depreciation Buildings	-422,065	0	0	0	14
	Accumulated depreciation	13, 353, 069 -8, 202, 450		0	0	16
	Leasehold improvements	-8, 202, 430 9, 926, 251		0	0	17
	Accumul ated depreciation	-5, 763, 534	0	0	0	18
	Fixed equipment	3, 832, 878	0	0	0	19
	Accumulated depreciation	-2, 566, 664	0	0	0	20
. 00 /	Automobiles and trucks	43, 897	0	0	0	21
	Accumulated depreciation	-43, 897	0	0	0	22
	Major movable equipment	7, 966, 732	0	0	0	23
	Accumulated depreciation	-6, 279, 055	0	0	0	24
	Minor equipment depreciable	146, 521	0	0	0	25
	Accumulated depreciation HIT designated Assets	-146, 521	0	0	0	26
	Accumul ated depreciation	0	0	0	0	28
	Mi nor equi pment-nondepreci abl e	0	0	0	0	29
	Total fixed assets (sum of lines 12-29)	12, 900, 295	0	0	0	30
	THER ASSETS					
. 00 🗍	Investments	0	0	0	0	31
	Deposits on Leases	0	0	0	0	32
	Due from owners/officers	0	0	0	0	33
	Other assets	24, 336	0	0	0	34
	Total other assets (sum of lines 31-34)	24, 336	0	0	0	35
	Total assets (sum of lines 11, 30, and 35)	16, 802, 448	56, 782	0	0	36
	CURRENT LI ABI LI TI ES	724 070	0	0	0	37
	Accounts payable Salaries, wages, and fees payable	734, 878 701, 426	0		0	38
	Payroll taxes payable	01, 420	0		0	
	Notes and Loans payable (short term)	0	0	0	0	40
	Deferred income	113, 629	0	0	0	
. 00 /	Accelerated payments	0				42
. 00 [Due to other funds	3, 441, 149	0	0	0	43
	Other current liabilities	1, 472, 452	0		0	
-	Total current liabilities (sum of lines 37 thru 44)	6, 463, 534	0	0	0	45
	ONG TERM LIABILITIES					
	Mortgage payable	10 100 225	0	0	0	
	Notes payable Jnsecured Loans	10, 198, 325	0	0	0	47
	Other long term liabilities	120, 275		0	0	40
	Total long term liabilities (sum of lines 46 thru 49)	10, 318, 600	0	0	0	50
	Total liabilities (sum of lines 45 and 50)	16, 782, 134	0	0	0	51
	CAPITAL ACCOUNTS			-		
. 00 🔽	General fund balance	20, 314				52
	Specific purpose fund		56, 782			53
	Donor created - endowment fund balance - restricted			0		54
	Donor created - endowment fund balance - unrestricted			0		55
1	Governing body created - endowment fund balance			0	-	56
	Plant fund balance - invested in plant				0	57
	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58
	Total fund balances (sum of lines 52 thru 58)	20, 314	56, 782	0	0	59
	Total liabilities and fund balances (sum of lines 51 and	16, 802, 448	56, 782		0	
		-,, .10				т `

	Financial Systems IENT OF CHANGES IN FUND BALANCES	ASCENSION ST. VI	Provider CC	N. 15_1308	Period:	u of Form CMS-2 Worksheet G-1	2552-10
STATEN	IENT OF CHANGES IN FUND BALANCES				From 07/01/2020 To 06/30/2021	Date/Time Pre 11/23/2021 3:	
		General	Fund	Special F	Purpose Fund	Endowment Fund	
1		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		-57, 087 3, 095, 086		41, 675		1.00 2.00
2.00 3.00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)		3,095,088		41, 675		2.00
3.00 4.00	Transfer From Affiliates	-3, 056, 418	3,037,999		41, 075	0	4.00
4.00 5.00		-3, 030, 418			0	0	5.00
6.00		0			0	0	6.00
7.00	Released Operating	38, 736			4	0	7.00
8.00	Other	00,700		22, 20		0	8.00
9.00	Rounding	-3			0	0	9.00
10.00	Total additions (sum of line 4-9)		-3,017,685		22, 204	_	10.00
11.00	Subtotal (line 3 plus line 10)		20, 314		63, 879		11.00
12.00	Deductions (debit adjustments) (specify)	0			0	0	12.00
13.00		0			0	0	13.00
14.00		0			0	0	14.00
15.00	Released Operating	0		7,09	7	0	15.00
16.00		0			0	0	16.00
17.00	Roundi ng	0			0	0	17.00
18.00	Total deductions (sum of lines 12-17)		0		7, 097		18.00
19.00	Fund balance at end of period per balance		20, 314		56, 782		19.00
	sheet (line 11 minus line 18)	Endowment Fund	PI ant	Fund			
			Trant	T UTU	-		
	L	6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0			0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				~		2.00
3.00	Total (sum of line 1 and line 2)	0	0		0		3.00
4.00	Transfer From Affiliates		0				4.00 5.00
F 00			-				5.00
5.00			0				4 00
6.00	Palessad Operating		0				6.00
6. 00 7. 00	Released Operating Other		0 0 0				7.00
6.00 7.00 8.00	Other		0 0 0 0				7.00 8.00
6.00 7.00 8.00 9.00	Other Roundi ng	0	0 0 0		0		7.00 8.00 9.00
6.00 7.00 8.00 9.00 10.00	Other Rounding Total additions (sum of line 4-9)	0	0 0 0 0		0		7.00 8.00 9.00 10.00
6.00 7.00 8.00 9.00	Other Rounding Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)	-	0 0 0 0		0		7.00 8.00 9.00
6.00 7.00 8.00 9.00 10.00 11.00	Other Rounding Total additions (sum of line 4-9)	-	0 0 0 0 0				7.00 8.00 9.00 10.00 11.00
6.00 7.00 8.00 9.00 10.00 11.00 12.00	Other Rounding Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)	-	0 0 0 0 0				7.00 8.00 9.00 10.00 11.00 12.00
6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00	Other Rounding Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)	-	0 0 0 0 0 0				7.00 8.00 9.00 10.00 11.00 12.00 13.00
$\begin{array}{c} 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ \end{array}$	Other Rounding Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	-	0 0 0 0 0 0 0 0				7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00
$\begin{array}{c} 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ \end{array}$	Other Rounding Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	-					7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00
$\begin{array}{c} 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$	Other Rounding Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Released Operating	-					7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00
$\begin{array}{c} 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ \end{array}$	Other Rounding Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Released Operating Rounding	Ō			0		7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00

		VINCENT MERCY			u of Form CMS-2	
STATEN	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider C	CN: 15-1308	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					
	General Inpatient Routine Services					
1.00	Hospi tal		2, 558, 24	18	2, 558, 248	1.00
2.00	SUBPROVIDER - IPF					2.00
3.00	SUBPROVIDER - IRF					3.00
4.00	SUBPROVI DER					4.00
5.00	Swing bed - SNF			0	0	5.00
6.00	Swing bed - NF			0	0	6.00
7.00	SKILLED NURSING FACILITY					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, 558, 24	18	2, 558, 248	10.00
	Intensive Care Type Inpatient Hospital Services				_	
11.00	INTENSIVE CARE UNIT			0	0	11.00
12.00	CORONARY CARE UNI T					12.00
13.00	BURN INTENSIVE CARE UNIT					13.00
14.00	SURGI CAL I NTENSI VE CARE UNI T					14.00
15.00	DETOXIFICATION INTENSIVE CARE UNIT			0	0	15.00
16.00	Total intensive care type inpatient hospital services (sum	oflines		0	0	16.00
	11-15)					
17.00	Total inpatient routine care services (sum of lines 10 and	16)	2, 558, 24		2, 558, 248	
18.00	Ancillary services		2, 733, 32			
19.00	Outpatient services		212, 69	98 16, 864, 049	17, 076, 747	
20.00	RURAL HEALTH CLINIC			0 0		
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0 0	0	
22.00	HOME HEALTH AGENCY					22.00
23.00	AMBULANCE SERVI CES					23.00
24.00	СМНС					24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)					25.00
26.00	HOSPICE					26.00
27.00	OTHER (SPECIFY)			0 0	0	
28.00	Total patient revenues (sum of lines 17-27)(transfer colum	n 3 to Wkst.	5, 504, 26	66, 574, 680	72, 078, 947	28.00
	G-3, line 1)					
	PART II - OPERATING EXPENSES		1	01.050.050		
29.00	Operating expenses (per Wkst. A, column 3, line 200)			21, 859, 852		29.00
30.00	ADD (SPECI FY)			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 39.00				0		38.00
				0		39.00
				0		40.00
40.00						
40. 00 41. 00	Total deductions (sum of lines 27 (1)			0		41.00
40.00 41.00 42.00	Total deductions (sum of lines 37-41)	(12)(transfer		0		42.00
40. 00 41. 00	Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus lin to Wkst. G-3, line 4)	e 42)(transfer		0 0 21, 859, 852		

Heal th	Financial Systems	ASCENSION ST. VINC	ENT MERCY	In Lie	u of Form CMS-2	2552-10	
STATEMENT OF REVENUES AND EXPENSES			Provider CCN: 15-1308	Peri od:	Worksheet G-3		
				From 07/01/2020	.		
				To 06/30/2021	Date/Time Prep 11/23/2021 3:5		
1.00	Total patient revenues (from Wkst. G-2, Pa	rt I, column 3, line	28)		72, 078, 947	1.00	
2.00	Less contractual allowances and discounts on patients' accounts					2.00	
3.00	Net patient revenues (line 1 minus line 2)		23, 447, 031	3.00			
4.00	Less total operating expenses (from Wkst. (3)		21, 859, 852	4.00	
5.00	Net income from service to patients (line 3	3 minus line 4)			1, 587, 179	5.00	
	OTHER INCOME						
6.00	Contributions, donations, bequests, etc				-4, 571	6.00	
7.00	Income from investments				0	7.00	
8.00	Revenues from telephone and other miscella	neous communication	servi ces		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	Parking lot receipts				0	12.00	
13.00	Revenue from laundry and linen service				0	13.00	
14.00	Revenue from meals sold to employees and gu	uests			44, 997	14.00	
15.00	Revenue from rental of living quarters				0	15.00	
	Revenue from sale of medical and surgical s		an patients		0	16.00	
17.00	Revenue from sale of drugs to other than pa				2, 593	17.00	
18.00	Revenue from sale of medical records and al				3, 262	18.00	
19.00	Tuition (fees, sale of textbooks, uniforms,				0	19.00	
20.00	Revenue from gifts, flowers, coffee shops,	and canteen			0	20.00	
21.00	Rental of vending machines				0	21.00	
22.00	Rental of hospital space				58, 723	22.00	
23.00	Governmental appropriations				0	23.00	
24.00	Other Revenue				70, 049		
	Net assets released from restrictions				-18, 035		
24.02	Servi ce Charges				- 398		
24.03	State Program Revenue				83, 333	24.03	
	COVID-19 PHE Funding				1, 267, 954		
25.00	Total other income (sum of lines 6-24)				1, 507, 907		
26.00	Total (line 5 plus line 25)				3, 095, 086		
	OTHER EXPENSES (SPECIFY)				0	27.00	
28.00	Total other expenses (sum of line 27 and su				0	28.00	
29.00	Net income (or loss) for the period (line 2	26 minus line 28)			3, 095, 086	29.00	