Health Financial Systems ASCENSION ST VINCENT SETON SPECIALTY In Lieu of Form CMS-2552-10 This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 03-31-2022 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 15-2020 Worksheet S Peri od. From 07/01/2020 Parts I-III AND SETTLEMENT SUMMARY 06/30/2021 Date/Time Prepared: То 11/16/2021 11:30 am PART I - COST REPORT STATUS Provi der 1. [ X ] Electronically prepared cost report Date: 11/16/2021 Time: 11:30 am ] Manually prepared cost report use only 2. ľ ] If this is an amended report enter the number of times the provider resubmitted this cost report ] Medicare Utilization. Enter "F" for full or "L" for low. 3 0 Ē 4 [ 

 [1] Cost Report Status
 6. Date Received:

 (1) As Submitted
 7. Contractor No.

 (2) Settled without Audit
 8. [N] Initial Report for this Provider CCN

 (3) Settled with Audit
 9. [N] Final Report for this Provider CCN

 Contractor 5. use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened (5) Amended PART II - CERTIFICATION MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL. CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OF INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT. CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S) I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ASCENSION ST VINCENT SETON SPECIALTY ( 15-2020 ) for the cost reporting period beginning 07/01/2020 and ending 06/30/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations. [X] I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature. BETHANY MORROW (Signed) Officer or Administrator of Provider(s) VICE PRESIDENT OF FINANCE Title 11/16/2021 11: 30: 43 AM Date Title XVIII Title V Part B Cost Center Description Part A HIT Title XIX 1.00 2.00 3.00 4.00 5.00 PART III - SETTLEMENT SUMMARY 1.00 -17,959 0 0 Hospi tal 0 -24 1.00 Subprovider - IPF 0 2 00 2 00 C 0 0 3.00 Subprovider - IRF 0 С 0 0 3.00

200.00 Total -17,959 0 200.00 0 -24 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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	TAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	AIA  I	Provider CC	N: 15-2020	Period: From 07/01		Workshe Part I	et S-2	
						/2021	Date/Ti 11/16/2		
		In-State Medicaid paid days	l n-State Medi cai d el i gi bl e unpai d days	Out-of State Medicaid paid days	State Medi cai d el i gi bl e unpai d	Medicai HMO day	d 0 /s Mec c	ther li cai d lays	
1 00	If this provider is an IPPS hospital, enter the	1.00	2.00	3.00	4.00	5.00	0	5. 00 C	24.0
4.00	in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 2, out-of-state Medicaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0		0		0		24. (
					Urban/Ru				
6.00	Enter your standard geographic classification (not wa	age) status	at the bec	inning of t	1.00 he	1	2.	00	26.0
	cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifi	r rural. age) status r "2" for r ication in d	at the enc ural. If ap column 2.	l of the cos pplicable,	t	1			27.0
5.00	If this is a sole community hospital (SCH), enter the effect in the cost reporting period.	e number of	periods SC	CH status in		0			35.0
					Begi nni		Endi		
5. 00	Enter applicable beginning and ending dates of SCH s	tatus. Subs	cript line	36 for numb	1.00	)	2.	00	36.
7.00	of periods in excess of one and enter subsequent date If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period.		r of period	ls MDH statu	S	0			37.
	Is this hospital a former MDH that is eligible for the accordance with FY 2016 OPPS final rule? Enter "Y" for instructions)	or yes or "	N" for no.	(see					37.
3. 00	If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.								38.
					Y/N 1.00		Y/ 2.0		-
	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions)	), (İi), or the mileage ii)? Enter	(iii)? Ent requiremer in column 2	er in colum nts in ? "Y" for ye	n s		Ν		39.0
0. 00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.	ber 1. Ente	r"Y" for y				N		40.0
						V	XVIII 2.00	XI X 3.00	-
						1 1.00	1 2.00		
	Prospective Payment System (PPS)-Capital					1.00			45
	Does this facility qualify and receive Capital paymen with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce	eption for	extraordi na	ary circumst	ances	N N	N N	N	45. 46.
5. 00	Does this facility qualify and receive Capital paymen with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exco pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III.	eption for t. L, Pt. I	' extraordina II and Wkst	ary circumst :. L-1, Pt.	ances I through	N	N N	N	46.
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USPI TAL	AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ТА	Provider C		eriod:	Worksheet S-2	
				T	rom 07/01/2020 o 06/30/2021	Part I Date/Time Pre	pare
				NAHE 413.85	Worksheet A	11/16/2021 11 Pass-Through	: 30
				Y/N	Line #	Qualification Criterion Code	
.00 Ar	re you claiming nursing and allied health education	(NAHE)	costs for	1.00 N	2.00	3.00	60.
an in is	ny programs that meet the criteria under 42 CFR 413. Instructions) Enter "Y" for yes or "N" for no in col 5 "Y", are you impacted by CR 11642 (or subsequent C	85? (s umn 1. CR) NAHE	ee lf column 1				00.
ad	ljustement? Enter "Y" for yes or "N" for no in colu	Imn 2. Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	1
	d your hospital receive FTE slots under ACA	N			0.00	0.00	61.
	ection 5503? Enter "Y" for yes or "N" for no in Dumn 1. (see instructions)						
	ter the average number of unweighted primary care						61.
	Es from the hospital's 3 most recent cost reports						
	ding and submitted before March 23, 2010. (see						
	nstructions) Ner the current year total unweighted primary care						61.
	E count (excluding OB/GYN, general surgery FTEs,						01.
	nd primary care FTEs added under section 5503 of						
AC	CA). (see instructions)						
	ter the base line FTE count for primary care						61
	nd/or general surgery residents, which is used for etermining compliance with the 75% test. (see						
	istructions)						
	ter the number of unweighted primary care/or						61
	irgery allopathic and/or osteopathic FTEs in the						
	<pre>irrent cost reporting period.(see instructions). iter the difference between the baseline primary</pre>						61
	d/or general surgery FTEs and the current year's						
	imary care and/or general surgery FTE counts (line						
	.04 minus line 61.03). (see instructions)						
	iter the amount of ACA §5503 award that is being						61.
	ed for cap relief and/or FTEs that are nonprimary ne or general surgery. (see instructions)						
Jea		Pro	gram Name	Program Code	Unweighted IME	Unweighted	
					FTE Count	Direct GME FTE	
			1.00	2.00	3.00	Count 4.00	-
10 Of	the FTEs in line 61.05, specify each new program		1.00	2.00	0.00		61
sp	becialty, if any, and the number of FTE residents						
	or each new program. (see instructions) Enter in						
	olumn 1, the program name. Enter in column 2, the orgram code. Enter in column 3, the IME FTE						
	weighted count. Enter in column 4, the direct GME						
	E unweighted count.						
	the FTEs in line 61.05, specify each expanded				0.00	0.00	61
	ogram specialty, if any, and the number of FTE						
	esidents for each expanded program. (see estructions) Enter in column 1, the program name.						
	iter in column 2, the program code. Enter in column						
3,	the IME FTE unweighted count. Enter in column 4,						
th	ne direct GME FTE unweighted count.						
						1.00	1
AC	CA Provisions Affecting the Health Resources and Ser						
			in this cost	reporting peri	od for which	0.00	62
00 En	ter the number of FTE residents that your hospital		111 111 3 0031	· • • • • • • • • • • • • • • • • • • •			
00 En yo	our hospital received HRSA PCRE funding (see instruc	tions)		1 31	your bosnital	0.00	62
00 En yo 01 En		ti ons) Teachi	ng Health Cen	ter (THC) into	your hospital	0.00	62.
00 En yo 01 En du Te	our hospital received HRSA PCRE funding (see instruct oter the number of FTE residents that rotated from a uring in this cost reporting period of HRSA THC prog eaching Hospitals that Claim Residents in Nonprovide	ctions) a Teachi gram. (s er Setti	ng Health Cen <u>ee instructio</u> ngs	ter (THC) into ns)	- ·	0.00	62
00 En yo 01 En du Te 00 Ha	our hospital received HRSA PCRE funding (see instruc- nter the number of FTE residents that rotated from a uring in this cost reporting period of HRSA THC prog- eaching Hospitals that Claim Residents in Nonprovide s your facility trained residents in nonprovider see	ctions) a Teachi gram. (s er Setti ettings	ng Health Cen ee instruction ngs during this co	ter (THC) into ns) ost reporting p	period? Enter	0. 00 N	
00 En yo 01 En du Te 00 Ha	our hospital received HRSA PCRE funding (see instruct oter the number of FTE residents that rotated from a uring in this cost reporting period of HRSA THC prog eaching Hospitals that Claim Residents in Nonprovide	ctions) a Teachi gram. (s er Setti ettings	ng Health Cen ee instruction ngs during this co	ter (THC) into ns) ost reporting p 67. (see instru	period? Enter uctions)	N	63.
00 En yo 01 En du Te 00 Ha	our hospital received HRSA PCRE funding (see instruc- nter the number of FTE residents that rotated from a uring in this cost reporting period of HRSA THC prog- eaching Hospitals that Claim Residents in Nonprovide s your facility trained residents in nonprovider see	ctions) a Teachi gram. (s er Setti ettings	ng Health Cen ee instruction ngs during this co	ter (THC) into ns) ost reporting p	period? Enter uctions) Unweighted		63.
00 En yo 01 En du Te 00 Ha	our hospital received HRSA PCRE funding (see instruc- nter the number of FTE residents that rotated from a uring in this cost reporting period of HRSA THC prog- eaching Hospitals that Claim Residents in Nonprovide s your facility trained residents in nonprovider see	ctions) a Teachi gram. (s er Setti ettings	ng Health Cen ee instruction ngs during this co	ter (THC) into ns) ost reporting p 67. (see instru Unweighted	period? Enter uctions) Unweighted	N Ratio (col. 1/	63.
00 En yo 01 En du Te 00 Ha	our hospital received HRSA PCRE funding (see instruc- nter the number of FTE residents that rotated from a uring in this cost reporting period of HRSA THC prog- eaching Hospitals that Claim Residents in Nonprovide s your facility trained residents in nonprovider see	ctions) a Teachi gram. (s er Setti ettings	ng Health Cen ee instruction ngs during this co	ter (THC) into ns) ost reporting p 67. (see instru Unweighted FTEs Nonprovider Site	period? Enter uctions) Unweighted FTEs in Hospital	N Ratio (col. 1/ (col. 1 + col. 2))	63
00 En yo 01 En du <u>Te</u> 00 Ha "Y	bur hospital received HRSA PCRE funding (see instruc- nter the number of FTE residents that rotated from a uring in this cost reporting period of HRSA THC prog aching Hospitals that Claim Residents in Nonprovide is your facility trained residents in nonprovider se "for yes or "N" for no in column 1. If yes, comple	tions) a Teachi g <u>ram. (s</u> er <u>Setti</u> ettings ete line	ng Health Cen ee instruction ngs during this c s 64 through	ter (THC) into ns) ost reporting p 67. (see instru Unweighted FTEs Nonprovider Site 1.00	period? Enter uctions) Unweighted FTEs in Hospital 2.00	N Ratio (col. 1/ (col. 1 + col. 2)) 3.00	63
00 En yo 01 En du Te 00 Ha "Y	bur hospital received HRSA PCRE funding (see instruc- ther the number of FTE residents that rotated from a uring in this cost reporting period of HRSA THC proc eaching Hospitals that Claim Residents in Nonprovide is your facility trained residents in nonprovider se "for yes or "N" for no in column 1. If yes, comple ection 5504 of the ACA Base Year FTE Residents in No	tions) a Teachi gram. (s er Setti ettings ete line	ng Health Cen ee instruction ngs during this co s 64 through ler Settings	ter (THC) into ns) ost reporting p 67. (see instru Unweighted FTEs Nonprovider Site 1.00	period? Enter uctions) Unweighted FTEs in Hospital 2.00	N Ratio (col. 1/ (col. 1 + col. 2)) 3.00	63.
. 00 En yo . 01 En du Te . 00 Ha "Y	bur hospital received HRSA PCRE funding (see instruc- nter the number of FTE residents that rotated from a uring in this cost reporting period of HRSA THC prog aching Hospitals that Claim Residents in Nonprovide is your facility trained residents in nonprovider se "for yes or "N" for no in column 1. If yes, comple	ctions) a Teachi gram. (s er Setti ettings ete line onprovic re June	ng Health Cen ee instruction ngs during this co s 64 through er Settings 30, 2010.	ter (THC) into ns) ost reporting p 67. (see instru Unweighted FTEs Nonprovider Site 1.00	period? Enter actions) Unweighted FTEs in Hospital 2.00 is your cost r	N Ratio (col. 1/ (col. 1 + col. 2)) 3.00 reporting	63.
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00 En yo 01 En du Te 00 Ha "Y 00 En i n re	bur hospital received HRSA PCRE funding (see instruc- neter the number of FTE residents that rotated from a <u>uring in this cost reporting period of HRSA THC prog</u> aching Hospitals that Claim Residents in Nonprovide as your facility trained residents in nonprovider se <u>"for yes or "N" for no in column 1. If yes, comple</u> ection 5504 of the ACA Base Year FTE Residents in No eriod that begins on or after July 1, 2009 and befor ther in column 1, if line 63 is yes, or your facilit a the base year period, the number of unweighted nor esident FTEs attributable to rotations occurring in	ctions) Teachi ram. (s <u>ram. (s</u> <u>r Setti</u> ettings <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u> <u>ettings</u>	ng Health Cen ee instruction ngs during this co s 64 through ler Settings 30, 2010. ed residents y care provider	ter (THC) into ns) bost reporting p 67. (see instru Unweighted FTEs Nonprovider Site 1.00 This base year	period? Enter actions) Unweighted FTEs in Hospital 2.00 is your cost r	N Ratio (col. 1/ (col. 1 + col. 2)) 3.00 reporting	63.
. 00 En yo . 01 En . 00 Ha . 00 Ha . 00 En i n se	bur hospital received HRSA PCRE funding (see instruc- ther the number of FTE residents that rotated from a dring in this cost reporting period of HRSA THC proc- eaching Hospitals that Claim Residents in Nonprovide is your facility trained residents in nonprovider see "for yes or "N" for no in column 1. If yes, comple end that begins on or after July 1, 2009 and befor ther in column 1, if line 63 is yes, or your facilit to the base year period, the number of unweighted nor seident FTEs attributable to rotations occurring in ettings. Enter in column 2 the number of unweighted	ctions) a Teachi <u>gram. (ser Setti</u> <u>ser Setti</u> titings <u>ete line</u> <u>onprovic</u> <u>re June</u> y train a-primar all non-pri	ng Heal th Cen ee instruction ngs during this co s 64 through ler Settings 30, 2010. ed residents y care provider imary care	ter (THC) into ns) bost reporting p 67. (see instru Unweighted FTEs Nonprovider Site 1.00 This base year	period? Enter actions) Unweighted FTEs in Hospital 2.00 is your cost r	N Ratio (col. 1/ (col. 1 + col. 2)) 3.00 reporting	63.
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		ATA Provider (		riod: om 07/01/2020	Worksheet S-2 Part I	2
			Tc			epared
	Program Name	Program Code	Unweighted	Unwei ghted	Ratio (col. 3/	
			FTEs Nonprovider	FTEs in Hospital	(col. 3 + col. 4))	
			Si te	nospi tai	4))	
	1.00	2.00	3.00	4.00	5.00	
00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column			0.00	0.00	D 0. 00000C	0 65.0
5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			Unwei ghted FTEs Nonprovi der	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			Si te		0.00	-
Section 5504 of the ACA Current	(ear FTF Residents i	n Nonprovider Settin	<u> </u>	2.00 r.cost.reporti	<u>3.00</u>	
FTEs attributable to rotations of Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 +	unweighted non-prima al. Enter in column	ry care resident 3 the ratio of	Unweighted FTEs Nonprovider	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
			016			
00 Enton in origina 1	1.00	2.00	Si te 3. 00	4.00	5.00	-
00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	1.00	2.00		4.00 0.00		0 67.
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	1.00	2.00	3.00		0. 000000	67.
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	25		3.00 0.00	0.00	D 0. 000000	-
<pre>name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)</pre>	2S /chiatric Facility ( the facility have a efore November 15, 2 umn 2: Did this fac ≳ 412.424 (d)(1)(iii :ate which program y	IPF), or does it com n approved GME teach 004? Enter "Y" for y ility train resident )(D)? Enter "Y" for y	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	0.00 1.00 1.00 rovi der? N he most b. (see i ng b.	D 0. 000000	70.
<pre>name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)</pre>	2S cchiatric Facility ( the facility have a efore November 15, 2 umn 2: Did this fac 2 412.424 (d)(1)(iii cate which program y y PPS nabilitation Facilit	IPF), or does it com n approved GME teachi 004? Enter "Y" for y ility train residents )(D)? Enter "Y" for y ear began during this	3.00 0.00 tain an IPF subp ing program in t yes or "N" for m s in a new teach yes or "N" for m s cost reporting	0.00 1.00 1.00 rovi der? N he most b. (see i ng b.	0 2.00 3.00	70.0

Health Financial Systems ASCENSION ST VINCENT SETON SPECIALTY In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-2020 Peri od: Worksheet S-2 From 07/01/2020 Part I 06/30/2021 Date/Time Prepared: То 11/16/2021 11:30 am 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 γ 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 Ν Υ 90 00 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 "Y" for yes or "N" for no in the applicable column. 92.00 Ν 92.00 93.00 Ν Ν 93.00 94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the Ν Ν 94 00 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 Ν 98.00 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. Ν 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 Ν 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 Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in Ν 98.05 Ν column 2 for title XIX. 98.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Ν Ν 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? Ν 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 109.00 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 appl i cabl e.

Health Financial Systems	ASCENSION ST VINCENT SE	TON SPECIAL	_TY	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DATA	Provider CC		eriod: rom 07/01/2020 o 06/30/2021	Worksheet S-2 Part I Date/Time Pre 11/16/2021 11	epared:
				1.00	2.00	-
111.00 If this facility qualifies as a CAH, Health Integration Project (FCHIP) of "Y" for yes or "N" for no in column integration prong of the FCHIP demo Enter all that apply: "A" for Ambula for tele-health services.	lemonstration for this cost 1. If the response to colum in which this CAH is partic	reporting p nn 1 is Y, e cipating in	period? Enter enter the column 2.	N	2.00	111.00
			1.00	2.00	3.00	-
112.00 Did this hospital participate in the demonstration for any portion of the Enter "Y" for yes or "N" for no in c in column 2, the date the hospital b demonstration. In column 3, enter t participation in the demonstration, Miscellaneous Cost Reporting Informa	e current cost reporting per column 1. If column 1 is "Y megan participating in the he date the hospital ceased if applicable.	iod? (", enter	N			112.00
115.00 Is this an all-inclusive rate provid		l" for no	N		(	115.00
in column 1. If column 1 is yes, ent in column 2. If column 2 is "E", ent for short term hospital or "98" perc psychiatric, rehabilitation and long the definition in CMS Pub.15-1, chap	er the method used (A, B, c er in column 3 either "93" ent for long term care (inc i term hospitals providers)	or E only) percent ludes				
116.00 Is this facility classified as a ref		yes or	N			116.00
"N" for no. 117.00 s this facility legally-required to	carry malpractice insuranc	e? Enter	Y			117.00
"Y" for yes or "N" for no. 118.00 Is the malpractice insurance a claim			2			118.00
if the policy is claim-made. Enter 2	if the policy is occurrence	e.	Premiums	Losses	Insurance	
118.01 List amounts of malpractice premiums	and paid losses:		1.00 C	2.00	3.00	3118.01
118.02 Are malpractice premiums and paid lo	sses reported in a cost cer	nter other t	han the	1.00 N	2.00	118.02
Administrative and General? If yes, and amounts contained therein. 119.00D0 NOT USE THIS LINE						119.00
120.00 Is this a SCH or EACH that qualifies §3121 and applicable amendments? (se "N" for no. Is this a rural hospital Hold Harmless provision in ACA §3121 Enter in column 2, "Y" for yes or "N	e instructions) Enter in co with < 100 beds that quali and applicable amendments?	lumn 1, "Y" fies for th	for yes or Ne Outpatient	Ν	Ν	120.00
121.00 Did this facility incur and report of patients? Enter "Y" for yes or "N" f	osts for high cost implanta	nble devices	s charged to	N		121.00
122.00 Does the cost report contain healthc		ed in §1903(	(w)(3) of the	N		122.00
Act?Enter "Y" for yes or "N" for no the Worksheet A line number where th Transplant Center Information		s "Y", enter	r in column 2			
125.00 Does this facility operate a transpl yes, enter certification date(s) (mm		es and "N"	for no. If	N		125.00
126.00 If this is a Medicare certified kidr	ey transplant center, enter	the certif	fication date			126.00
in column 1 and termination date, if 127.00 If this is a Medicare certified hear	t transplant center, enter	the certifi	cation date			127.00
in column 1 and termination date, if 128.00 If this is a Medicare certified live		the certifi	cation date			128.00
in column 1 and termination date, if 129.00 If this is a Medicare certified lunc		he certific	ation date in			129.00
column 1 and termination date, if ap 130.00 If this is a Medicare certified pand		er the cert	ification			130.00
date in column 1 and termination dat 131.00 If this is a Medicare certified inte	e, if applicable, in column	n 2.				131.00
date in column 1 and termination dat	e, if applicable, in column	n 2.				
132.00 f this is a Medicare certified isle in column 1 and termination date, if			cation udle			132.00
133.00 Removed and reserved 134.00 If this is an organ procurement orga and termination date, if applicable,	nization (OPO), enter the C in column 2.	)PO number i	n column 1			133.00 134.00
All Providers 140.00 Are there any related organization c	r home office costs as defi	ned in CMS	Pub. 15-1.	Y	15H046	140.00
chapter 10? Enter "Y" for yes or "N" are claimed, enter in column 2 the h	for no in column 1. If yes	s, and home	office costs			

lealth Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLI	ASCENSION ST ' EX IDENTIFICATION DAT		Provi der CC			ri od:	Lieu of Form CM Worksheet S	
					Fr To	om 07/01/20 06/30/20		
1.00		2.00				3.00		11.50 a
If this facility is part of a cha					he nam	e and addre	ess of the	
home office and enter the home of 41.00Name: ASCENSION ST VINCENT	<u>fice contractor name</u> Contractor's Na		itractor numbe		cactor'	s Numbor: 0	0101	141.0
41.00 Name: ASCENSION ST VINCENT 42.00 Street: 250 WEST 96TH STREET	PO Box:	ame: wPS		Conti	actor	s Number: O	101	141.0
43. 00 City: INDIANAPOLIS	State:	IN		Zip	Code:	4	6290	143.0
	·							
							1.00	
44.00 Are provider based physicians' co	sts included in works	sneet A?					N	144. (
					ŀ	1.00	2.00	_
45.00 If costs for renal services are c inpatient services only? Enter "Y no, does the dialysis facility in period? Enter "Y" for yes or "N" 46.00 Has the cost allocation methodolo	" for yes or "N" for clude Medicare utili; for no in column 2. gy changed from the p	no in c zation f previous	olumn 1. lf c or this cost ly filed cost	olumn 1 reporting report?	g	Y		145. (
Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/			-2, chapter 4	0, §4020	)  f			_
							1.00	-
47.00Was there a change in the statist	ical basis? Enter "Y	" for ye	s or "N" for	no.			N	147.
48.00Was there a change in the order o	f allocation? Enter '	"Y" for	yes or "N" fo	or no.	-		N	148.
49.00 Was there a change to the simplif	ied cost finding meth	nod? Ent	er "Y" for ye Part A	s or "N" Part		o. Title V	N Title XIX	149.
			1.00	2. 0		<u> </u>	4.00	-
Does this facility contain a prov	ider that qualifies	for an e						
or charges? Enter "Y" for yes or	"N" for no for each	componen			B. (S			
55.00Hospital			N	N		N	N	155.
56.00 Subprovider - IPF 57.00 Subprovider - IRF			N N	N N		N N	N N	156. 157.
58. 00 SUBPROVI DER			N .	IN IN		14	IN IN	157.
59. 00 SNF			N	N		Ν	N	159.
60.00 HOME HEALTH AGENCY			N	N		Ν	N	160.
61.00 CMHC				N		N	N	161. (
							1.00	-
Multicampus								
65.00 Is this hospital part of a Multic	ampus hospital that I	has one	or more campu	ises in d	i fferer	nt CBSAs?	N	165.0
Enter "Y" for yes or "N" for no.	Name		County	State	Zip(	Code CBS/	A FTE/Campus	:
	0		1.00	2.00	3.0			<u></u>
66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)							0.	00 166. (
							1.00	
Health Information Technology (HI						Act		
67.00 Is this provider a meaningful use 68.00 If this provider is a CAH (line 1 reasonable cost incurred for the	05 is "Y") and is a m	meani ngf	ul user (line			enter the	N	167. 168.
68.01 If this provider is a CAH and is	not a meaningful use	r, does	this provider			hardshi p		168.
exception under §413.70(a)(6)(ii)						·) ont	ha	001/0
69.00 If this provider is a meaningful		) and i	s not a CAH (	iine 105	15 "N'	), enter t	ne 0.	00169. (
ITANSI ITON TACTOR I SEE INSTRUCT						Begi nni ng	g Endi ng	
transition factor. (see instructi						1.00	2.00	
								170. (
· · ·	beginning date and er	ndi ng da	te for the re	eporting				
70.00 Enter in columns 1 and 2 the EHR	begi nni ng date and ei	ndi ng da	te for the re	eporting	-	1.00	2.00	

ealth Financial Systems ASCE OSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QU	ENSION ST VINCEN ESTIONNAIRE			Peri od:	worksheet S-	
				From 07/01/2020 To 06/30/2021	Part II	
				10 00/30/2021	11/16/2021 1	
				Y/N	Date	
				1.00	2.00	
General Instruction: Enter Y for all YES res mm/dd/yyyy format.	sponses. Enter M	N for all NU re	esponses. Ente	r all dates in <sup>-</sup>	the	
COMPLETED BY ALL HOSPITALS						-
Provider Organization and Operation						
00 Has the provider changed ownership immediate				N		1.00
reporting period? If yes, enter the date of	the change in o	column 2. (see				
			Y/N 1.00	Date 2.00	V/I 3.00	
00 Has the provider terminated participation in	n the Medicare (	Program? If	N 1.00	2.00	3.00	2.00
yes, enter in column 2 the date of terminati						2.00
voluntary or "I" for involuntary.						
00 Is the provider involved in business transa			N			3.00
contracts, with individuals or entities (e.g						
or medical supply companies) that are relate officers, medical staff, management personne						
of directors through ownership, control, or						
rel ati onshi ps? (see i nstructi ons)	raming and othe					
			Y/N	Туре	Date	
			1.00	2.00	3.00	
Financial Data and Reports Column 1: Were the financial statements pro	aparad by a Car	tified Dublie	Y	A		4.00
Accountant? Column 2: If yes, enter "A" for			T T	A		4.00
or "R" for Reviewed. Submit complete copy of						
column 3. (see instructions) If no, see inst						
00 Are the cost report total expenses and total			N			5.00
those on the filed financial statements? If	yes, submit red	conciliation.		N/ /NI		
				Y/N 1.00	Legal Oper. 2.00	_
Approved Educational Activities				1.00	2.00	
00 Column 1: Are costs claimed for nursing scl	hool? Column 2:	lf yes, is th	ne provider is	N		6.00
the legal operator of the program?						
00 Are costs claimed for Allied Health Program				N		7.00
00 Were nursing school and/or allied health pro		and/or renewed	during the	N		8.00
cost reporting period? If yes, see instruct 00 Are costs claimed for Interns and Residents		araduata media	al education	N		9.00
program in the current cost report? If yes,		0		IN		7.00
00 Was an approved Intern and Resident GME prog			the current	N		10.00
cost reporting period? If yes, see instruct						
00 Are GME cost directly assigned to cost center		I & R in an App	proved	N		11.00
Teaching Program on Worksheet A? If yes, se	e instructions.				Y/N	
					1.00	
Bad Debts						
00 Is the provider seeking reimbursement for ba	ad debts? If yes	s, see instruct	tions.		Y	12.00
00 If line 12 is yes, did the provider's bad de	ebt collection p	policy change c	during this co	st reporting	N	13.00
period? If yes, submit copy.			- ·			1 4 4 4 4
00 If line 12 is yes, were patient deductibles Bed Complement	and/or co-payme	ents waived? It	yes, see ins	tructions.	N	14.00
.00 Did total beds available change from the pri	ior cost reporti	ing period? If	ves, see inst	ructions.	N	15.00
			rt A		t B	10100
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
PS&R Data			00 (00 (0001		00 (00 (0001	- 4/ 00
00 Was the cost report prepared using the PS&R If either column 1 or 3 is yes, enter the pa		Y	09/03/2021	Y	09/03/2021	16.00
date of the PS&R Report used in columns 2 a						
instructions)						
00 Was the cost report prepared using the PS&R	Report for	N		N		17.00
totals and the provider's records for allocation						
either column 1 or 3 is yes, enter the paid	-τnrough date					
in columns 2 and 4. (see instructions) 00 If line 16 or 17 is yes, were adjustments ma	ade to PS&R	N		N		18.00
Report data for additional claims that have		11		IN		10.00
but are not included on the PS&R Report use						
cost report? If yes, see instructions.						
00 If line 16 or 17 is yes, were adjustments ma	ade to PS&R	N		N		19.00
<b>,</b>						
Report data for corrections of other PS&R Re information? If yes, see instructions.	eport					

Health Financial Systems

In Lieu of Form CMS-2552-10

Health Financial Systems ASCENSION SI VINCE	NT SETON SPECT	ALIY	In Lie	eu of Form CM	S-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider (	CCN: 15-2020	Period: From 07/01/2020 To 06/30/2021	Date/Time P	repared:
	Descr	iption	Y/N	11/16/2021 Y/N	11:30 am
		0	1.00	3.00	
20.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		0	N	N	20.00
	Y/N	Date	Y/N	Date	
	1.00	2.00	3.00	4.00	
1.00 Was the cost report prepared only using the provider's	N		N		21.00
records? If yes, see instructions.					
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	EDT CHILDRENS I			1.00	
Capital Related Cost	ETT CHTEDRENS I	IOSITIALS)			
2.00 Have assets been relifed for Medicare purposes? If yes, se	e instructions			N	22.00
3.00 Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	due to apprai	sals made dur	ing the cost	N	23.00
4.00 Were new leases and/or amendments to existing leases enter If yes, see instructions	N	24.00			
5.00 Have there been new capitalized leases entered into during instructions.	N	25.00			
b. 00 Were assets subject to Sec. 2314 of DEFRA acquired during t instructions.	Ν	26.00			
7.00 Has the provider's capitalization policy changed during th copy.	e cost reporti	ng period? If	yes, submit	Ν	27.00
Interest Expense 3.00 Were new Loans, mortgage agreements or letters of credit e	ntered into du	ring the cost	reporting	N	28.00
period? If yes, see instructions. 2.00 Did the provider have a funded depreciation account and/or		0		N	29.00
treated as a funded depreciation account? If yes, see inst 0.00 Has existing debt been replaced prior to its scheduled mat	ructions			N	30.00
instructions. 1.00 Has debt been recalled before scheduled maturity without i	5	5		N	31.00
instructions.	ssuance of new	debt? IT yes	, see	IN .	31.00
2.00 Have changes or new agreements occurred in patient care se	rvices furnish	ed through co	ntractual	N	32.00
arrangements with suppliers of services? If yes, see instr 3.00 If line 32 is yes, were the requirements of Sec. 2135.2 ap		ng to competi	tive bidding? If	N	33.00
no, see instructions. Provider-Based Physicians					_
4.00 Are services furnished at the provider facility under an a	rrangement wit	h provider-ba	sed physi ci ans?	N	34.00
5.00 If line 34 is yes, were there new agreements or amended ex		nts with the	provi der-based	N	35.00
physicians during the cost reporting period? If yes, see i	nstructions.	_	Y/N	Date	
			1.00	2.00	
Home Office Costs					
6.00 Were home office costs claimed on the cost report? 7.00 If line 36 is yes, has a home office cost statement been p	repared by the	home office?	Y Y		36.00 37.00
If yes, see instructions. 8.00 If line 36 is yes , was the fiscal year end of the home of					38.00
the provider? If yes, enter in column 2 the fiscal year en 9.00 If line 36 is yes, did the provider render services to oth	d of the home (	offi ce.			39.00
see instructions. 0.00   f line 36 is yes, did the provider render services to the	·	5	N N		40.00
instructions.		. , ,03, 300	14		10.00
	1	. 00	2.	00	
Cost Report Preparer Contact Information 1.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	JILL		HILL		41.00
respectively. 2.00 [Enter the employer/company name of the cost report	ASCENSION ST V	/I NCENT			42.00
preparer. 3.00 Enter the telephone number and email address of the cost	317-583-3519		JI LL. HI LL1@ASC	ENSI ON. ORG	43.00
report preparer in columns 1 and 2, respectively.					

Heal th	Financial Systems ASCENS	ION ST VINCEN	T SETON SPECIALTY	In Lie	u of Form CMS-	2552-10
H0SPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUEST	LI ONNAI RE	Provider CCN: 15-2020	Period: From 07/01/2020	Worksheet S-2 Part II	
				To 06/30/2021		pared: : <u>30 am</u>
			3.00			
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/	′position	MANAGER			41.00
	held by the cost report preparer in columns 1,	2, and 3,				
	respecti vel y.					
42.00	Enter the employer/company name of the cost re	eport				42.00
	preparer.	-				
43.00	Enter the telephone number and email address o	of the cost				43.00
	report preparer in columns 1 and 2, respective	el y.				

<sup>11/16/2021 11: 30</sup> am D: \Shared drives\Finance\_Net Revenue\_IN - Acute\Reimbursement\Cost Reports\FY2021\Seton\152020.FY2021.mcrx

	Financial Systems ASCEN AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	ISION ST VINCEN AL DATA	Provi der C		Peri od:	u of Form CMS-: Worksheet S-3	
					From 07/01/2020 To 06/30/2021	Part I Date/Time Pre	
					10 00/30/2021	11/16/2021 11	
						I/P Days / O/P	
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
		Line Number		Avai I abl e			
1 00	Userital Adults & Dada (aslumas E. (. 7 and	1.00	2.00	3.00	4.00	5.00	1.00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and	30.00	72	26, 2	80 0.00	0	1.00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation		72	26, 2	80 0.00	0	7.00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGI CAL I NTENSI VE CARE UNI T						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		70	26.2	0.00	0	13.00
14.00 15.00	Total (see instructions) CAH visits		72	26, 2	80 0.00	0	
16.00	SUBPROVIDER - IPF					0	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)	30. 00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC					_	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00	= 0			0	
27.00	Total (sum of lines 14-26)		72			_	27.00
28.00 29.00	Observation Bed Days					0	28.00 29.00
30.00	Ambulance Trips Employee discount days (see instruction)						30.00
30.00	Employee discount days (see fistruction) Employee discount days - IRF						30.00
32.00	Labor & delivery days (see instructions)		0		0		32.00
32.00	Total ancillary labor & delivery room		0		0		32.00
52.01	outpatient days (see instructions)						52.01
33.00	LTCH non-covered days						33.00
	LTCH site neutral days and discharges						33.01

10SPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CO	CN: 15-2020		iod: m 07/01/2020 06/30/2021	Worksheet S-3 Part I Date/Time Pre 11/16/2021 11	pared:
		I/P Days	/ O/P Visits	/ Trips		Full Time E		
	Component	Title XVIII	Title XIX	Total All Patients		otal Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00		9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	4, 654	103		99			1.00
2.00	HMO and other (see instructions)	2, 239	1, 056					2.00
3.00	HMO I PF Subprovi der	0	0					3.00
4.00 5.00	HMO IRF Subprovider	0	0		~			4.00
5.00 5.00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF	0	0		0			5.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	4, 654	103		-			7.00
3.00	INTENSIVE CARE UNIT							8.00
9.00	CORONARY CARE UNI T							9.0
0.00	BURN INTENSIVE CARE UNIT							10.0
11.00	SURGICAL INTENSIVE CARE UNIT							11.0
12.00	OTHER SPECIAL CARE (SPECIFY)							12.0
13.00	NURSERY		100	10.00			100.00	13.0
14.00	Total (see instructions)	4, 654	103			0.00	129.64	
15.00 16.00	CAH visits SUBPROVIDER - IPF	U	0		0			15.0 16.0
17.00	SUBPROVIDER - IRF							17.0
8.00	SUBPROVI DER							18.0
9.00	SKILLED NURSING FACILITY							19.0
20.00	NURSING FACILITY							20.0
21.00	OTHER LONG TERM CARE							21.0
2.00	HOME HEALTH AGENCY							22.0
3. 00	AMBULATORY SURGICAL CENTER (D. P.)							23.0
4. 00	HOSPI CE							24.0
24.10	HOSPICE (non-distinct part)				0			24.1
25.00	CMHC - CMHC							25.0
26.00	RURAL HEALTH CLINIC							26.0
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0.00	0.00	
27.00	Total (sum of lines 14-26)					0.00	129.64	
28.00	Observation Bed Days		0		0			28.0
9.00	Ambulance Trips	0			0			29. C
30.00 31.00	Employee discount days (see instruction) Employee discount days - IRF				0			30.0
32.00	Labor & delivery days (see instructions)	0	0		0			31.0
32.00 32.01	Total ancillary labor & delivery room	0	0		0			32.0
2.01	outpatient days (see instructions)							32.0
33.00	LTCH non-covered days	О						33.0
	LTCH site neutral days and discharges	0						33.0

	Financial Systems ASCEN AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	ISION ST VINCENT AL DATA	Provider CC		Period: From 07/01/2020 To 06/30/2021	u of Form CMS-2 Worksheet S-3 Part I Date/Time Pre 11/16/2021 11	pared:
		Full Time Equivalents		Di s	charges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT		0	1:	36 1 50 31 0 0	339	1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
$\begin{array}{c} 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 15.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 20.\ 00\\ 21.\ 00\\ 22.\ 00\\ 23.\ 00\\ 24.\ 00\\ 24.\ 10 \end{array}$	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF 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)	0. 00	0	1:	36 1	339	10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00 23. 00 24. 00 24. 10
25. 00 26. 00 26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 01 33. 00 33. 01	CMHC - CMHC RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days LTCH site neutral days and discharges	0.00 0.00			0		25.00 26.00 26.25 27.00 28.00 29.00 30.00 31.00 32.00 32.01 33.00 33.01

	J	ISION ST VINCENT				u of Form CMS-	2552-10
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	F EXPENSES	Provider CO	CN: 15-2020	Period: From 07/01/2020	Worksheet A	
					To 06/30/2021		pared: :30 am
	Cost Center Description	Sal ari es	Other	Total (col.	1 Reclassi fi cati		
	·			+ col. 2)	ons (See A-6)	Trial Balance	
						(col. 3 +-	
						col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT		735, 124				
2.00	00200 CAP REL COSTS-MVBLE EQUIP		214, 932	214, 93			
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	64, 998	1, 989, 609			_, ,	1
5.00	00500 ADMI NI STRATI VE & GENERAL	352, 735	5, 710, 043				1
7.00	00700 OPERATION OF PLANT	284	968, 273	968, 5			
8.00	00800 LAUNDRY & LINEN SERVICE	0	0		0 0	-	
9.00	00900 HOUSEKEEPI NG	0	468, 062	468, 00		468, 062	
10.00	01000 DI ETARY	0	646, 039			646, 039	1
13.00	01300 NURSI NG ADMI NI STRATI ON	375, 406	158, 657	534, 00		001/000	1
15.00	01500 PHARMACY	930, 396	1, 249, 185	2, 179, 58	31 0	2, 179, 581	15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	0		0 0	0	
17.00	01700 SOCI AL SERVI CE	0	0		0 0	0	17.00
18.00	01851 PASTORAL CARE	0	0		0 0	0	18.00
	INPATIENT ROUTINE SERVICE COST CENTERS	r				1	
30.00	03000 ADULTS & PEDIATRICS	6, 225, 234	1, 851, 321	8, 076, 5	55 870	8, 077, 425	30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	149, 767	60, 523				
54.00	05400 RADI OLOGY-DI AGNOSTI C	80, 083	11, 375				1
54.01	03630 ULTRA SOUND	10, 372	1, 867	12, 23	39 0	12, 239	
57.00	05700 CT SCAN	0	0		0 0	0	
60.00	06000 LABORATORY	0	157, 392	157, 39	92 0	157, 392	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	-	63.00
65.00	06500 RESPI RATORY THERAPY	1, 281, 097	252, 841	1, 533, 93	38 1, 507	1, 535, 445	65.00
66.00	06600 PHYSI CAL THERAPY	283, 020	22, 617	305, 63	37 0	305, 637	66.00
67.00	06700 OCCUPATI ONAL THERAPY	295, 209	21, 540	316, 74	19 0	316, 749	67.00
68.00	06800 SPEECH PATHOLOGY	201, 785	17, 919	219, 70	04 0	219, 704	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	1, 674	103	1, 7	77 0	1, 777	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	12, 844	164, 380	177, 22	24 0	177, 224	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
74.00	07400 RENAL DI ALYSI S	0	547, 129	547, 12	29 0	547, 129	74.00
	SPECIAL PURPOSE COST CENTERS					1	
	11300 INTEREST EXPENSE		0		0 0		113.00
118.00		10, 264, 904	15, 248, 931	25, 513, 83	35 0	25, 513, 835	118.00
	NONREI MBURSABLE COST CENTERS					I	
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190.00
	19100 RESEARCH	0	0		0 0		191.00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0		0 0		192.00
	19300 NONPALD WORKERS	0	0		0 0		193.00
	07950 BI OTERRORI SM GRANT	0	0		0 0		194.00
	07951 MARKETI NG	0	0		0 0		194.01
200.00	TOTAL (SUM OF LINES 118 through 199)	10, 264, 904	15, 248, 931	25, 513, 83	35 0	25, 513, 835	200.00

Heal th	Fi nanci al	Systems	

 Heal th Financial Systems
 ASCENSION ST VINCENT SETON SPECIALTY

 RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES
 Provider CCN: 15-2020
 Period:

In Lieu of Form CMS-2552-10 Worksheet A

REULA	SSIFICATION AND ADJUSIMENTS OF TRIAL BALANCE O	F EXPENSES	Provider Co	JN: 15-2020	From 07/01/2020	WORKSNEEL A
						Date/Time Prepared: 11/16/2021 11:30 am
	Cost Center Description	Adjustments	Net Expenses			11/10/2021 11:30 dill
		(See A-8)	For Allocation			
		6.00	7.00	1		
-	GENERAL SERVICE COST CENTERS					
1.00	00100 CAP REL COSTS-BLDG & FIXT	-20, 148	3 714, 976			1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	C	214, 932			2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	16, 038	2, 070, 645			4.00
5.00	00500 ADMINISTRATIVE & GENERAL	-807, 372	5, 253, 029			5.00
7.00	00700 OPERATION OF PLANT	C	968, 557			7.00
8.00	00800 LAUNDRY & LINEN SERVICE	C	0 0			8.00
9.00	00900 HOUSEKEEPI NG	C	468,062			9.00
10.00	01000 DI ETARY	-72, 718	573, 321			10.00
13.00	01300 NURSING ADMINISTRATION					13.00
15.00	01500 PHARMACY	C				15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0			16.00
17.00		0	-			17.00
18.00						18.00
10.00	INPATIENT ROUTINE SERVICE COST CENTERS		<u>л 0</u>			10.00
30.00		-178	8, 077, 247			30.00
30.00	ANCI LLARY SERVICE COST CENTERS	170	0,077,247	1		30.00
50.00		C	210, 290			50.00
54.00						54.00
54.00	03630 ULTRA SOUND		12, 239	•		54.00
57.00			0			57.00
60.00	06000 LABORATORY		157, 392			60.00
63.00			137, 372			63.00
65.00	06500 RESPI RATORY THERAPY		1, 535, 445			65.00
66.00			305, 637			66.00
67.00	06700 OCCUPATI ONAL THERAPY		316, 749			67.00
68.00			219, 704			68.00
69.00			219,704			69.00
70.00			1,777			70.00
70.00						
72.00			) 177, 224 ) 0			71.00 72.00
72.00						72.00
73.00			-			73.00
74.00	SPECIAL PURPOSE COST CENTERS	(	547, 129			74.00
112 0	0 11300 INTEREST EXPENSE	C	0 0			113.00
118.0		-884, 378				118.00
110.0	NONREI MBURSABLE COST CENTERS	-004, 370	24,029,437			118.00
100 0	019000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	C				190.00
	019000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 019100 RESEARCH					190.00
	019100 RESEARCH 019200 PHYSI CLANS' PRI VATE OFFI CES					
			0			192.00
	0 19300 NONPALD WORKERS					193.00
	0 07950 BI OTERRORI SM GRANT		0			194.00
	107951 MARKETING	004.070				194.01
200.0	0   TOTAL (SUM OF LINES 118 through 199)	-884, 378	3 24, 629, 457	I		200.00

Heal th	Financial Systems	ASCE	NSION ST VINCEN	T SETON SPECIA	ALTY	In Lie	u of Form CMS	-2552-10
RECLAS	SIFICATIONS			Provider C	CN: 15-2020	Period: From 07/01/2020	Worksheet A-	6
						To 06/30/2021	Date/Time Pr 11/16/2021 1	
		Increases						
	Cost Center	Line #	Sal ary	Other				
	2.00	3.00	4.00	5.00				
	A - PANDEMIC SALARY RECLASS			· · · · · · · · · · · · · · · · · · ·				
1.00	ADULTS & PEDIATRICS	30.00	870	0				1.00
2.00	RESPI RATORY THERAPY	65.00	1, 138	0				2.00
	TOTALS	+	2,008					1
	B - FURLOUGH RECLASS		•					1
1.00	ADULTS & PEDIATRICS	30.00	0	870				1.00
2.00	RESPI RATORY THERAPY	65.00	0	776				2.00
	TOTALS			1, 646				
	D - VACCINE RECLASS							
1.00	RESPI RATORY THERAPY	65.00	369	0				1.00
	TOTALS		369	0				
	E - VACCINE TO WKRS COMP	· · ·						1
1.00	RESPI RATORY THERAPY	65.00	0	369				1.00
	TOTALS			369				
500.00	Grand Total: Increases		2, 377	2, 015				500.00
	1							

2.00	Heal th	Financial Systems	ASCE	NSION ST VINCEN	T SETON SPECI	ALTY	In Lie	u of Form CMS	-2552-10
To         06/30/2021         Date/Time Prepared: 11/16/2021         Date/Time Prepared: 10.00         Distarce         Distarce <t< td=""><td>RECLASS</td><td>SEFECATIONS</td><td></td><td></td><td>Provi der (</td><td>CCN: 15-2020</td><td></td><td></td><td>6</td></t<>	RECLASS	SEFECATIONS			Provi der (	CCN: 15-2020			6
Cost Center         Line #         Sal ary         Other         Wkst. A-7 Ref.           6.00         7.00         8.00         9.00         10.00           A - PANDEMIC SALARY RECLASS								Date/Time Pr	epared: 1:30 am
6.00         7.00         8.00         9.00         10.00           A - PANDEMIC SALARY RECLASS			Decreases						
A - PANDEMIC SALARY RECLASS           1.00         ADMI NI STRATI VE & GENERAL         5.00         2,008         0         0         1.0           2.00		Cost Center	Line #	Sal ary	0ther	Wkst. A-7 Ret	F.		
1.00       ADMI NI STRATI VE & GENERAL       5.00       2,008       0       0       0       2.00         2.00       TOTALS       0.00       0       0       0       0       2.00         B - FURLOUGH RECLASS       0       0       0       0       0       2.00         ADULTS & PEDI ATRI CS       30.00       870       0       0       1.00         2.00       RESPIRATORY THERAPY       65.00       776       0       0       2.00         D - VACCINE RECLASS       1.646       0       1.00       1.00       1.00       1.00         ADMI NI STRATI VE & GENERAL       5.00       369       0       0       1.00         I.00       ADMI NI STRATI VE & GENERAL       5.00       369       0       0       1.00         I.00       RESPIRATORY THERAPY       65.00       369       0       0       1.0         I.00       RESPIRATORY THERAPY       65.00       369       0       0       1.0         I.00       RESPIRATORY THERAPY       65.00       369       0       0       1.0		6.00	7.00	8.00	9.00	10.00			
2.00		A - PANDEMIC SALARY RECLASS							
TOTALS         2,008         0         1           B - FURLOUGH RECLASS         30.00         870         0         0         1.00           ADULTS & PEDIATRICS         30.00         870         0         0         2.00           2.00         RESPIRATORY THERAPY         65.00         776         0         0         2.0           TOTALS         1.646         0         1         0         2.0         2.0           D - VACCINE RECLASS         1.646         0         1         1.00	1.00	ADMINISTRATIVE & GENERAL	5.00	2, 008	C	)	0		1.00
B - FURLOUGH RECLASS           1.00         ADULTS & PEDIATRICS         30.00         870         0         0         1.00           2.00         RESPIRATORY THERAPY        65.00         776         0         0         2.00           TOTALS        1.646         0        0         2.0         2.0           D - VACCINE RECLASS        1.646         0        0         1.0           1.00         ADMINI STRATI VE & GENERAL        5.00        369         0        0           1.00         RESPIRATORY THERAPY        65.00        369         0        0         1.0           1.00         RESPIRATORY THERAPY        65.00        369         0        0         1.0           1.00         RESPIRATORY THERAPY        65.00        369         0	2.00		0.00	0	C	)	0		2.00
1.00       ADULTS & PEDIATRICS       30.00       870       0       0       1.0         2.00       RESPIRATORY_THERAPY65.00       776       0       0       2.0         TOTALS       1.646       0       0       2.0         D - VACCINE RECLASS       369       0       0       1.0         1.00       ADMINISTRATIVE & GENERAL       5.00       369       0       0       1.0         E - VACCINE TO WKRS COMP       369       0       0       0       1.0       1.0         1.00       RESPIRATORY THERAPY       65.00       369       0       0       1.0         1.00       RESPIRATORY THERAPY       65.00       369       0       0       1.0		TOTALS		2,008	c	)			1
2.00       RESPIRATORY_THERAPY65.00       776       0       0       2.0         TOTALS       1,646       0       1       1.646       0       2.0         D - VACCINE RECLASS       1.00       369       0       0       1.0         TOTALS       369       0       0       1.0       1.0         TOTALS       369       0       1.0       1.0       1.0         TOTALS       369       0       1.0       1.0       1.0         TOTALS       369       0       0       1.0       1.0         TOTALS       369       0       0       1.0       1.0         TOTALS       369       0       0       0       1.0         TOTALS       369       0       0       0       1.0		B - FURLOUGH RECLASS							1
TOTALS         1.646         0         1           D - VACCINE RECLASS         D         1.646         0         1           1.00         ADMINISTRATIVE & GENERAL         5.00         369         0         0         1.00           TOTALS         369         0         0         0         1.00         1.00           E - VACCINE TO WKRS COMP         1.00         369         0         0         1.00           1.00         RESPIRATORY THERAPY         65.00         369         0         0         1.00	1.00	ADULTS & PEDIATRICS	30.00	870	C	)	0		1.00
D - VACCI NE RECLASS           1.00         ADMI NI STRATI VE & GENERAL         5.00         369         0         0         1.0           TOTALS         369         0         0         0         1.0           E - VACCI NE TO WKRS COMP         65.00         369         0         0         1.0           1.00         RESPIRATORY THERAPY         65.00         369         0         0         1.0	2.00	RESPI RATORY THERAPY	65.00	776	C	)	0		2.00
1.00       ADMI NI STRATI VE & GENERAL       5.00       369       0       0       1.0         TOTALS       369       0       0       0       1.0         E - VACCI NE TO WKRS COMP       65.00       369       0       0       1.0         1.00       RESPIRATORY THERAPY       65.00       369       0       0       1.0         1.00       TOTALS       369       0       0       0       1.0		TOTALS		1, 646	c	)			
TOTALS       369       0       1         E - VACCINE TO WKRS COMP       65.00       369       0       0       0       1.00         RESPIRATORY THERAPY       65.00       369       0       0       0       1.00		D - VACCINE RECLASS					· ·		1
E         -         VACCI NE         TO WKRS         COMP           1.00         RESPIRATORY         THERAPY        65.00        369        0        0        0        0         1.0           TOTALS        369        0        0        0        0         1.0	1.00	ADMI NI STRATI VE & GENERAL	5.00	369	C	)	0		1.00
1.00         RESPIRATORY THERAPY        65.00        369        0        0        0        0         1.0           TOTALS        369        0        0        0        0        0        0         1.0		TOTALS		369	c	)			
TOTALS		E - VACCINE TO WKRS COMP							1
	1.00	RESPI RATORY THERAPY	65.00	369	C	)	0		1.00
		TOTALS		369	c	)	7		1
500.00 Jorand Total: Decreases [ 4, 392] 0 500.0	500.00	Grand Total: Decreases		4, 392	C	)			500.00

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

RECONC				SN. 13-2020	From 07/01/2 To 06/30/2	2020 Part 2021 Date/	I Time Prep /2021 11:	
				Acqui si ti on	S		/2021 11.	<u>30 alli</u>
		Begi nni ng	Purchases	Donation	Total	Di spos	als and	
		Bal ances					ements	
		1.00	2.00	3.00	4.00	5.	. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	F BALANCES		_				
1.00	Land	847, 629	0		0	0	0	1.00
2.00	Land Improvements	3, 157	0		0	0	0	2.00
3.00	Buildings and Fixtures	15, 901, 288	0		0	0	0	3.00
4.00	Building Improvements	436, 760	0		0	0	0	4.00
5.00	Fixed Equipment	1,077,430	8, 584		0 8	, 584	0	5.00
6.00	Movable Equipment	5, 242, 473	710, 562		0 710	, 562	0	6.00
7.00	HIT designated Assets	0	0		0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	23, 508, 737	719, 146		0 719	, 146	0	8.00
9.00	Reconciling Items	0	0		0	0	0	9.00
10.00	Total (line 8 minus line 9)	23, 508, 737	719, 146		0 719	, 146	0	10.00
		Endi ng Bal ance						
			Depreci ated					
			Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE							
1.00	Land	847, 629	0					1.00
2.00	Land Improvements	3, 157	0					2.00
3.00	Buildings and Fixtures	15, 901, 288	0					3.00
4.00	Building Improvements	436, 760	0					4.00
5.00	Fixed Equipment	1, 086, 014	0					5.00
6.00	Movable Equipment	5, 953, 035	0					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	24, 227, 883	0					8.00
9.00	Reconciling Items	0	0					9.00
10.00	Total (line 8 minus line 9)	24, 227, 883	0					10.00

Heal th	Financial Systems ASCE	NSION ST VINCEN	T SETON SPECIA	LTY	In Lie	u of Form CMS-	2552-10
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provider CC		Period:	Worksheet A-7	
					From 07/01/2020 To 06/30/2021		nared
					10 00/00/2021	11/16/2021 11	:30 am
			SL	JMMARY OF CAPI	TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
					instructions)	· · · · · · · · · · · · · · · · · · ·	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR						
1.00	CAP REL COSTS-BLDG & FIXT	722, 227		12, 89	7 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	213, 760			0 0	1, 172	
3.00	Total (sum of lines 1-2)	935, 987		12, 89	7 0	1, 172	3.00
		SUMMARY O					
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	735, 124				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	214, 932				2.00
3.00	Total (sum of lines 1-2)	0	950, 056				3.00

Health Financial Systems ASCE	NSION ST VINCEN	IT SETON SPECIA	LTY	In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C	1	Period: From 07/01/2020 Fo 06/30/2021	Worksheet A-7 Part III Date/Time Prep 11/16/2021 11:	pared:
	COM	PUTATION OF RAT	FI OS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CI		-			-	
1.00 CAP REL COSTS-BLDG & FIXT	17, 188, 834		17, 188, 834			1.00
2.00 CAP REL COSTS-MVBLE EQUIP	7,039,048		7,039,048			2.00
3.00 Total (sum of lines 1-2)	24, 227, 882	TION OF OTHER (	24, 227, 882			3.00
	ALLUCA	TION OF OTHER O	APITAL	SUIVIVIARY U	F CAPI TAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capital-Relate d Costs	cols. 5 through 7)			
	6,00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS C		1.00	0.00	7.00	10.00	
1.00 CAP REL COSTS-BLDG & FIXT	0	0	(	722, 227	0	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00 Total (sum of lines 1-2)	0	0	(	935, 987	0	3.00
		SL	JMMARY OF CAPI	TAL		
Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
		instructions)	instructions)	Capi tal -Rel ate	of cols. 9	
				d Costs (see	through 14)	
	11.00	12.00	13.00	instructions) 14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CI		12.00	13.00	14.00	15.00	
1.00 CAP REL COSTS-BLDG & FIXT	-7, 251	0		0 0	714, 976	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	0		1, 17			2.00
3.00 Total (sum of lines 1-2)	-7, 251	0				3.00

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

From 07/01/2003         Departure Prepared (1) 100         Departure (1) is to be All scale (1) 100         Departure (1) is to be All scale		Financial Systems MENTS TO EXPENSES	ASCEN	SION ST VINCEN	IT SETON SPECIALTY Provider CCN: 15-2020	In Lie Period:	u of Form CMS-2 Worksheet A-8	2552-10
Cost Denter Description         Sol MODUL (2)         Amount         Dist Conternation on Munchment A         Next         A.7 Brf           1:00         Transmitter I recent - CAR BFI (2000)         8	Absost					From 07/01/2020	Date/Time Prep	
Cost Denter Beschiption         Besi S/Code (2)         Amount         Cost Denter         Line 3         Bit A / Cole         Amount           1.00         Lob 2.00         2.00         Cost Center         1.00         4.00         5.00         1.00         1.00         5.00         1.00 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>11/10/2021 11.</td> <td>30 alli</td>							11/10/2021 11.	30 alli
Tool         Treestment         Income         2.00         3.00         4.00         5.00           2.00         20333-BLDG & F.M.I. (Chapter 2)         8         -19.99 CAP REL COSTS-MORA ELU         5.00         11         1.00           2.00         Capta Marking F.OMP (Chapter 2)         8         -2.99 (AUM IN STRATIVE & GENERAL         5.00         11         3.00           3.00         Investment Income - other         8         -2.99 (AUM IN STRATIVE & GENERAL         5.00         11         3.00           4.00         Macauge (Chapter 2)         110         0         0.00         0.00         4.00           5.00         Bernital of provider space by         0         0.00         0.00         6.00         4.00           6.00         Rerial of provider space by         0         0.00         0.00         6.00         4.00           7.00         Telephone services (pay secoluly)         0         0.00						s to be Aujusteu		
Tool         Treestment         Income         2.00         3.00         4.00         5.00           2.00         20333-BLDG & F.M.I. (Chapter 2)         8         -19.99 CAP REL COSTS-MORA ELU         5.00         11         1.00           2.00         Capta Marking F.OMP (Chapter 2)         8         -2.99 (AUM IN STRATIVE & GENERAL         5.00         11         3.00           3.00         Investment Income - other         8         -2.99 (AUM IN STRATIVE & GENERAL         5.00         11         3.00           4.00         Macauge (Chapter 2)         110         0         0.00         0.00         4.00           5.00         Bernital of provider space by         0         0.00         0.00         6.00         4.00           6.00         Rerial of provider space by         0         0.00         0.00         6.00         4.00           7.00         Telephone services (pay secoluly)         0         0.00		Cost Center Description	Basis/Code (2)	Amount	Cost Center	line #	Wkst A-7 Ref	
2.000375-BLOG & FIXT (chapter 2)         0         0         2.00           3.00         CONST MULT FIXT (chapter 2)         B         -200 AUBLINISTATIVE & GENERAL         5.00         111         3.00           4.00         Trade, quantity, and time all constraints (chapter 2)         B         -200 AUBLINISTATIVE & GENERAL         5.00         0.00         0         4.00           5.00         Response (chapter 2)         0         0         0.00         0         6.00           6.00         Response (chapter 2)         0         0         0.00         0         6.00           6.00         Retail of provider space by construct (cpy 1)         0         0         0.00         <	1.00	· · · · · · · · · · · · · · · · · · ·	1.00	2.00	3.00	4.00	5.00	1 00
SOLST MURIT FLORE         CONSTRUCT FLORE         SOL         THE ACCENT ACCEN	1.00		В	- 19, 987	CAP REL CUSIS-BLDG & FIXI	1.00		1.00
3.00         Investment income - other         B         -200 ADMINISTRATIVE & GENERAL         5.00         11         3.00           4.00         Irrade, quantity, and time         0         0.00 <td>2.00</td> <td></td> <td></td> <td>C</td> <td>CAP REL COSTS-MVBLE EQUIP</td> <td>2.00</td> <td>0</td> <td>2.00</td>	2.00			C	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
4.00         Trade, quantity, and time discounts (chapter 8) 5.00         0         0.00         0.00         0         4.00           5.00         Martunds, and rebates, of other subject or provider space by supplifiers (chapter 8) 7.00         0         0.00         0.00         0         6.00           7.00         Tele phone services (pay straines excludes) (chapter 21)         0         0.00         0.00         0         7.00           0.00         Parking 161 (chapter 21)         0         0.00         0.00         0         1.00           1.00         Parking 161 (chapter 21)         0         0.00         0         1.00           1.00         Restrain 101 (chapter 21)         0         0.00         0         1.00           1.00         Restrain 101 (chapter 21)         0         0.00         0         1.00           1.00         Restrain 101 (chapter 21)         0         0.00         0         1.00           1.00         Restrain 101 (chapter 21)         0         0         0.00         0         1.00           1.00         Restrain 101 (chapter 10)         0         0.00         0         1.00         1.00           1.00         Sale of medical and surgical         0         0.00         0 <td>3.00</td> <td>Investment income - other</td> <td>В</td> <td>-296</td> <td>ADMI NI STRATI VE &amp; GENERAL</td> <td>5.00</td> <td>11</td> <td>3.00</td>	3.00	Investment income - other	В	-296	ADMI NI STRATI VE & GENERAL	5.00	11	3.00
5.00         Refunds and relates of expenses by consistent of expenses (chapter 9) and chapter 10 and chapter 11 and chapter 12 and chapter	4.00	Trade, quantity, and time		C		0.00	0	4.00
6.00         Neintel of provider space by supplies (chapter 8) (Chapter 21)         0         0.00         0         6.00         0         7.00           8.00         Tel ophene service (Chapter 21)         0         0.00         0         8.00         0         8.00         0         8.00         0         8.00         0         8.00         0         8.00         0         8.00         0         8.00         0         8.00         0         8.00         0         8.00         0         8.00         0         8.00         0         8.00         0         8.00         0         9.00         9.00         9.00         9.00         9.00         0         9.00         9.00         0         10.00         0         10.00         0         10.00 <t< td=""><td>5.00</td><td></td><td></td><td>C</td><td></td><td>0.00</td><td>0</td><td>5.00</td></t<>	5.00			C		0.00	0	5.00
Number         Suppliars         Chapter         O         O         Picture         O         O         Picture         Pict	6.00			0		0.00	0	6 00
stations excluded) (chopter 21)         0         0.00         0.10         0.00         0.00         0.10         0.00         0.10         0.00         <		suppliers (chapter 8)		-				
chapter 21)         chapter 21)         0         0.00         0.10.00         0.	7.00	stations excluded) (chapter		Ŭ		0.00	0	7.00
9.00         Perking lot (chapter 21)         0         0         0.00         0.10.00         0.00         0.00         0.00         0.10.00         0.00         0.00         0.10.00         0.00         0.10.00         0.00         0.10.00         0.00         0.10.00         0.00         0.10.00         0.00         0.10.00         0.00         0.10.00         0.00         0.10.00         0.10.00         0.10.00         0.10.00         0.00         0.10.00         0.00         0.10.00         0.00         0.15.00         0.00         0.17.00         0.00         0.17.00         0.00         0.17.00         0.00         0.17.00         0.00         0.17.00         0.00         0.17.00         0.00         0.17.00         0.00         0.17.00         0.00         0.17.00         0.00         0.17.00         0.00         0.17.00         0.00         0.00         0.17.00         0.00         0.00	8.00			0		0.00	0	8.00
11.00       Sale of scrap, waste, etc. (chapter 23)       0		Parking lot (chapter 21) Provider-based physician	A-8-2			0.00		9. 00 10. 00
12.00         Related organization transactions (chapter 10)         A-8-1         -778, 621         0         0         12.00         0         0.00         0         13.00         0         12.00         0         0.00         0         13.00         0         0.00         0         13.00         0         0.00         0         13.00         0         0.00         0         13.00         0         0.00         0         15.00         0         0.00         0         15.00         0 <td>11.00</td> <td>Sale of scrap, waste, etc.</td> <td></td> <td>0</td> <td></td> <td>0.00</td> <td>0</td> <td>11.00</td>	11.00	Sale of scrap, waste, etc.		0		0.00	0	11.00
13.00         Laundry and Linen service         0         0         0         0         13.00         0         14.00         0	12.00	Related organization	A-8-1	-778, 621			о	12.00
15:00       Rental of quarters to employee and others       0       0.00       0       15:00         16:00       Sale of medical and surgical surgical surgical surgical surgical records and patients       0       0.00       0       16:00         10:00       Sale of drugs to other than patients       0       0.00       0       16:00         10:00       Sale of medical records and abstracts       0       0.00       0       18:00         10:00       Nursing and allied heal th education (tulition, fees, books, etc.)       0       0       0.00       0       19:00         20:00       Vending machines       B       -1,509 DI ETARY       10:00       0       20:00         10:01       Inceme from imposition of under from imposition of under suppress (chapter 21)       0       0       0       21:00         22:00       Interest expense on Medicare overpayments and surger chapter 14)       0       0       23:00       22:00         24:00       Adjustment for physical A-8-3       0       PHYSICAL THERAPY       66:00       24:00         11:1ation (chapter 14)       0       0       0       0       0       25:00       0       27:00       27:00       27:00       27:00       27:00       27:00       27:00       27:00		Laundry and linen service	5					13.00
16.00Sale of medical and surgical patients00.00016.0017.00Sale of drugs to other than patients00.00017.0018.00Sale of medical records and abstracts00.000.00018.0018.00Sale of medical records and abstracts00.000.00018.0019.00Wursing and allied health education (tuition, fees, books, etc.)000.00019.0020.00Vending machines edication efrom imposition of overpayments and borrowings to repay Medicare overpayments therapy costs in excess of limitation (chapter 14)000.00022.0024.00Adjustment for physical (chapter 21)A-8-3000.00022.0025.00Himitation (chapter 14) limitation (chapter 14)000022.0026.00Depreciation - CAP REL (costs-BLDG & FIXT OB 000024.0024.0027.00Depreciation - CAP REL (costs-BLDG & FIXT OB 000026.00026.0027.00Depreciation - CAP REL (costs-MWBLE EQUIP OB 0000027.00027.0028.00Non-physician A-8-3 (chapter 21)000000029.0020.01Operceiation - CAP REL (costs-MWBLE EQUIP (costs-MWBLE EQUIP0000000020.02Operceiatio		Rental of quarters to employee						14.00 15.00
17.00Sale of drugs to other than patients.00.00017.0018.00Sale of medical records and abstracts.00.00018.0019.00Nursing and allied heal th education (tuition, fees, books, etc.)00.00019.0020.00Vending machinesB-1,509 DIETARY10.00020.0021.00Income from imposition of interest, finance or penalty charges (chapter 21)00.00021.0022.00Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments00.00022.0023.00Adjustment for respiratory therapy costs in excess of timination (chapter 14)A-8-300000024.0024.00Adjustment for physical therapy costs in excess of timination (chapter 14)A-8-300024.00024.0025.00Utilization review physicians' compensation (Chapter 21)0*** Cost Center Deleted ***114.0025.0026.00Depreciation - CAP REL costS-BLDG & FIXT0024.00020.00027.00Depreciation - CAP REL costS-BLDG & FIXT0026.00020.0027.00Depreciation - CAP REL costS-MUBL EOUIP0020.00027.0028.00Nonphysicican Archaets000029.00020.0029.00Adjustment for cocupational transt assistant	16. 00	Sale of medical and surgical		C		0.00	о	16.00
18.00 abstractsSale of medical records and advantation00.00018.0019.00 books, etc.)Nursing and allied health education (tuition, fees, books, etc.)000.00019.0020.00 vorang machinesB-1,509 DI ETARY10.00020.00021.0020.00 charges (chapter 21) charges (chapter 21)B-1,509 DI ETARY00022.0022.00 vorapyments therapy costs in excess of limitation (chapter 14)A-8-300022.0024.00 therapy costs in excess of limitation (chapter 14)A-8-30024.0023.0025.00 bysiciansCapter 31A-8-30024.0024.0026.00 costs in excess of limitation (chapter 14)A-8-30024.0025.0026.00 costs-BUDG & FIXT costs-REDG & FIXT0*** Cost Center Deleted ***114.0025.0027.00 costs-BUDG & FIXT costs-Setter 21)0*** Cost Center Deleted ***114.0026.0026.00 costs-BUDG & FIXT costs-Setter 21)0CAP REL costs-MVBLE EQUIP2.00027.0026.00 costs-BUDG & FIXT costs-setter 21)000029.00029.0027.00 costs-BUDG & FIXT costs-setter 21)000029.00029.0029.00 costs-BUDG & FIXT costs-setter 21)000029.000029.002	17.00	Sale of drugs to other than		O		0.00	о	17.00
19.00Nursing and allied health education (tuition, fees, books, etc.)000.00019.0020.00Vending machinesB-1,509 DIETARY10.00020.0020.01Vending machinesB-1,509 DIETARY10.00021.0010.00Interest, finance or penalty charges (chapter 21)0000022.0022.00Interest expense on Medicare orepay Medicare overpayments therapy costs in excess of limitation (chapter 14)00023.0023.0024.00Adjustment for respiratory therapy costs in excess of limitation (chapter 14)A-8-300***66.0024.0025.00Utilization review - physician's compensation (chapter 21)0*** Cost Center Deleted ****11.0025.0027.00Depreciation - CAP REL costs-BLDG & FIXT0CAP REL COSTS-BLDG & FIXT026.0026.00Non-physician Anesthetist o (chapter 21)0*** Cost Center Deleted ****19.0028.0028.00Non-physician Anesthetist o (chapter 14)0*** Cost Center Deleted ****19.0028.0029.00Physicians' assistant o therapy costs in excess of limitation (chapter 14)A-8-3000029.00Physicians' assistant o therapy costs in excess of limitation (chapter 14)A-8-300029.0030.00Adjustment for oscupational instructions)A-8-3000 <td>18.00</td> <td>Sale of medical records and</td> <td></td> <td>0</td> <td></td> <td>0.00</td> <td>0</td> <td>18.00</td>	18.00	Sale of medical records and		0		0.00	0	18.00
20.00Vending machinesB-1,509 DI ETARY10.00020.0021.00Income from imposition of interest, finance or penality charges (chapter 21)000021.0022.00Interest, finance or penality charges (chapter 21)00000022.0023.00Adjustment for respiratory therapy costs in excess of limitation (chapter 14)A-8-300024.00024.0024.00Adjustment for physical therapy costs in excess of limitation (chapter 14)A-8-300024.0024.0025.00Utilization review - physicians - compensation (chapter 21)0-** Cost Center Deleted ***114.0025.0027.00Depreciation - CAP REL coSTS-BLDG & FIXT0CAP REL COSTS-BLDG & FIXT1.00026.0027.00Depreciation - CAP REL coSTS-BLDG & FIXT0CAP REL COSTS-MVBLE EQUIP2.00027.0028.00Non-physician - Sasistant therapy costs in excess of uthation (chapter 14)-030.00Adjustment for occupational instructions)A-8-30OCCUPATIONAL THERAPY65.0028.0030.00Adjustment for occupational instructions)A-8-30OCCUPATIONAL THERAPY67.0030.0030.00Adjustment for speech instructions)A-8-30OCCUPATIONAL THERAPY67.0030.0031.00CAH HIT Adjustment for Depreciation and InterestA-8-3	19. 00	Nursing and allied health		O		0.00	О	19. 00
21.00Income from imposition of interest, finance or penalty charges (chapter 21)00021.0022.00Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments00022.0023.00Adjustment for respiratory therapy costs in excess of limitation (chapter 14)A-8-300023.0024.00Adjustment for physical therapy costs in excess of limitation (chapter 14)A-8-30024.0025.00Utilization review - physiclans' compensation (Chapter 21)A-8-30024.0026.00Depreciation - CAP REL COSTS-BLDG & FIXT0CAP REL COSTS-BLDG & FIXT1.00026.0027.00Depreciation - CAP REL costs-WBLE EQUIP0CAP REL COSTS-MUBLE EQUIP2.0027.0028.00Non-physician Anesthetist therapy costs in excess of initiation (chapter 14)0028.00028.0030.00Adjustment for occupational therapy costs in excess of initiation (chapter 14)A-8-300000030.00Adjustment for oscepational therapy costs in excess of initiation (chapter 14)A-8-30000000030.00Adjustment for speech pathology costs in excess of initiation (chapter 14)A-8-300000000031.00Adjustment for pathology costs in excess of imitation (chapter 14)A-8-30<	20.00		В	-1.509	DI FTARY	10.00	0	20.00
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23.00Adjustment for respiratory therapy costs in excess of limitation (chapter 14)A-8-3ORESPIRATORY THERAPY65.0023.0024.00Adjustment for physical therapy costs in excess of limitation (chapter 14)A-8-3OPHYSICAL THERAPY66.0024.0025.00Utilization review - physicians' compensation (Chapter 21)A-8-3OPHYSICAL THERAPY66.0024.0026.00Depreciation - CAP REL COSTS-BLDG & FIXTO CAP REL COSTS-BLDG & FIXT1.00026.0027.00Depreciation - CAP REL COSTS-MVBLE EQUIPOCAP REL COSTS-MVBLE EQUIP2.00027.0028.00Non-physician AnesthetistO cAP REL COSTS-MVBLE EQUIP2.00027.0029.00Physicians' assistantO00.00029.0030.00Adjustment for occupational therapy costs in excess of limitation (chapter 14)A-8-3OCCUPATIONAL THERAPY67.0030.0030.99Hospic ce (non-distinct) (see instructions)A-8-3OSPEECH PATHOLOGY68.0031.0031.00CAH HIT Adjustment for Depreciation and Interest0OSPEECH PATHOLOGY68.00032.00	22.00	overpayments and borrowings to		C		0.00	0	22.00
24.00Adjustment for physicalA-8-3OPHYSICAL THERAPY66.0024.00therapy costs in excess of limitation (chapter 14)0*** Cost Center Deleted ***114.0025.0025.00Utilization review - physicians' compensation (chapter 21)0*** Cost Center Deleted ***114.0025.0026.00Depreciation - CAP REL COSTS-BLDG & FIXT0CAP REL COSTS-BLDG & FIXT1.00026.0027.00Depreciation - CAP REL COSTS-MVBLE EQUIP0CAP REL COSTS-MVBLE EQUIP2.00027.0028.00Non-physician Anesthetist0*** Cost Center Deleted ***19.0028.0029.00Physicians' assistant00029.0030.00Adjustment for occupational instructions)A-8-300029.0031.00Adjustment for speech pathology costs in excess of limitation (chapter 14)A-8-30SPEECH PATHOLOGY68.0031.0032.00CAH HIT Adjustment for pathology costs in excess of limitation ad Interest000032.00	23.00	Adjustment for respiratory therapy costs in excess of	A-8-3	O	RESPI RATORY THERAPY	65.00		23.00
25.00Utilization review - physicians' compensation (chapter 21)0*** Cost Center Deleted ***114.0025.0026.00Depreciation - CAP REL COSTS-BLDG & FIXT0 CAP REL COSTS-BLDG & FIXT1.00026.0027.00Depreciation - CAP REL COSTS-MVBLE EQUIP0 CAP REL COSTS-MVBLE EQUIP2.00027.0028.00Non-physicians' assistant0 *** Cost Center Deleted ***19.0028.0029.00Physicians' assistant00029.0030.00Adjustment for occupational therapy costs in excess of instructions)A-8-300031.00Adjustment for speech pathol ogy costs in excess of limitation (chapter 14)A-8-30030.0030.9932.00CAH HIT Adjustment for perciation and InterestA-8-300023.00	24.00	Adjustment for physical therapy costs in excess of	A-8-3	C	PHYSICAL THERAPY	66.00		24.00
(chapter 21)0026.00Depreciation - CAP REL COSTS-BLDG & FIXT0026.0027.00Depreciation - CAP REL COSTS-WBLE EQUIP0027.0028.00Non-physician Anesthetist0027.0028.00Non-physician Anesthetist0028.0029.00Physicians' assistant0029.0030.00Adjustment for occupational therapy costs in excess of instructions)A-8-300031.00Adjustment for speech pathol ogy costs in excess of limitation (chapter 14)A-8-30030.9932.00CAH HIT Adjustment for pathol ogy costs in excess of limitation (chapter 14)A-8-30031.0032.00CAH HIT Adjustment for pathol ogy costs in excess of limitation (chapter 14)000032.00CAH HIT Adjustment for pathol ogy costs in excess of limitation (chapter 14)000032.00CAH HIT Adjustment for pathol ogy costs in excess of limitation (chapter 14)0000032.00CAH HIT Adjustment for pathol ogy costs in excess of limitation and Interest000 <t< td=""><td>25. 00</td><td>Utilization review -</td><td></td><td>O</td><td>*** Cost Center Deleted ***</td><td>114.00</td><td></td><td>25.00</td></t<>	25. 00	Utilization review -		O	*** Cost Center Deleted ***	114.00		25.00
27. 00Depreciation - CAP REL COSTS-MVBLE EQUIP2. 00027. 0028. 00Non-physician Anesthetist0*** Cost Center Deleted ***19. 0028. 0029. 00Physicians' assistant00029. 0030. 00Adjustment for occupational therapy costs in excess of instructions)A-8-300029. 0031. 00Adjustment for speech pathology costs in excess of limitation (chapter 14)A-8-30030. 9930. 9931. 00Adjustment for speech pathology costs in excess of limitation (chapter 14)A-8-30SPEECH PATHOLOGY68. 0031. 0032. 00CAH HIT Adjustment for Depreciation and Interest0000032. 00	26.00	(chapter 21) Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	о	26.00
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therapy costs in excess of limitation (chapter 14)30. 9930. 99Hospice (non-distinct) (see instructions)31. 00Adjustment for speech pathology costs in excess of 	29.00	Physicians' assistant	٨٥٥	0		0.00	0	29.00
30. 99Hospice (non-distinct) (see instructions)OADULTS & PEDIATRICS30. 0030. 9931. 00Adjustment for speech pathology costs in excess of limitation (chapter 14)A-8-3OSPEECH PATHOLOGY68. 0031. 0032. 00CAH HIT Adjustment for Depreciation and Interest000.00032. 00	30.00	therapy costs in excess of	H-0-3	U	UCCULATIONAL INEKAMY	67.00		30.00
31. 00 pathology costs in excess of limitation (chapter 14)A-8-30 SPEECH PATHOLOGY68. 0031. 0032. 00CAH HIT Adjustment for Depreciation and Interest000.00032. 00	30. 99	Hospice (non-distinct) (see		C	ADULTS & PEDI ATRI CS	30.00		30. 99
32. 00     CAH HIT Adjustment for     0     0.00     0     32. 00       Depreciation and Interest     0     0     0     0     32. 00	31. 00	Adjustment for speech pathology costs in excess of	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
Depreciation and Interest	32.00			0		0.00	0	32.00
		Depreciation and Interest	В			5.00		

### ASCENSION ST VINCENT SETON SPECIALTY

#### \_\_\_\_ 1 -

Health Financial Systems ASCENSION ST VINCENT SETON SPECIALTY In Lieu of							2552-10
ADJUST	MENTS TO EXPENSES			Provider CCN: 15-2020	Peri od:	Worksheet A-8	
					From 07/01/2020 To 06/30/2021	Date/Time Pre 11/16/2021 11	
				Expense Classification of	on Worksheet A		
				To/From Which the Amount i	s to be Adjusted		
	Cost Center Description	Basis/Code (2)		Cost Center		Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	PROMOTIONAL ITEMS	A	-455	ADMI NI STRATI VE & GENERAL	5.00	0	33.01
33.02	LOBBYING OFFSET	A	-474	ADMI NI STRATI VE & GENERAL	5.00	0	33.02
33.03	ENTERTAI NMENT	A	-193	ADMI NI STRATI VE & GENERAL	5.00	0	33.03
33.04	ENTERTAI NMENT	A	-178	ADULTS & PEDIATRICS	30.00	0	33.04
33.05	CHARI TY EXPENSE	A	-5, 106	ADMI NI STRATI VE & GENERAL	5.00	0	33.05
33.06	PATIENT INTEREST INCOME	В	-4, 435	ADMI NI STRATI VE & GENERAL	5.00	0	33.06
50.00	TOTAL (sum of lines 1 thru 49)		-884, 378				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(2) Additional ediustrate results are be mediated and there and subparients thereafted.

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

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

Heal th	Financial Systems	ASCENSION ST VINCE	NT SETON SPECIALTY	In Li	eu of Form CMS-	2552-10
STATEM OFFICE	ENT OF COSTS OF SERVICES FROM COSTS	RELATED ORGANIZATIONS AND HO		Period: From 07/01/2020		
				To 06/30/2021	Date/Time Pre 11/16/2021 11	
	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	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED O	RGANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:					
1.00			HOME OFFICE CAPITAL	409, 127		1.00
2.00			HOME OFFICE INTEREST-CAPITAL		0	2.00
3.00			HOME OFFICE INTEREST -A&G	135		3.00
3.01			HOME OFFICE OTHER	3, 332, 922		3.01
3.02		EMPLOYEE BENEFITS DEPARTMENT	SVH CHARGEBACK	36, 774		3.02
3.03			SVH CHARGEBACK	1, 500		
3.04		-	SVH CHARGEBACK	11, 500		3.04
3.05			SVH CHARGEBACK	5, 355		3.05
3.06			SVH CHARGEBACK	13, 018		3.06
3.07			SVH CHAGEBACK	14, 221		3.07
3.08			SVH CHARGEBACK	14, 221		3.08
3.10			SVH CHARGEBACK	14, 221		3.10
3.11		CAP REL COSTS-BLDG & FIXT	INTEREST EXPENSE	12, 736		3. 11
3.13		ADMINISTRATIVE & GENERAL	INTEREST EXPENSE	161		3.13
3.14			HEALTH INSURANCE	1, 673, 086	1, 657, 048	3.14
4.00	0.00			0	0	4.00
4.01	0.00			0	0	4.01
4.02	0.00			0	0	4.02
4.03	0.00			0	0	4.03
4.04	0.00			0	0	4.04
4.05	0.00			0	0	4.05
5.00	TOTALS (sum of lines 1-4).			5, 546, 228	6, 324, 849	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.

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

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

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

i ci ilibui	Sellent under tritte Aviiri.				
6.00	G	ST VINCENT HEAL	100.00	0.00	6.00
7.00	G	ASCENSI ON	100.00	0.00	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.

					10 00/00/2021	11/16/2021 11:30 am
	Net	Wkst. A-7 Ref.				
	Adjustments					
	(col. 4 minus					
	col. 5)*					
	6.00	7.00				
			MENTS REQUIRED AS A RESULT OF TRA	NSACTIONS WITH RELATED O	RGANIZATIONS OR C	LAIMED
	HOME OFFICE CO					
1.00	409, 127					1.00
2.00	7, 251					2.00
3.00	135					3.00
3.01	-1, 211, 172	0				3. 0
3.02	0	0				3. 02
3.03	0	0				3. 03
3.04	0	0				3. 04
3.05	0	0				3. 0
3.06	0	0				3.00
3.07	0	0				3.0
3.08	0	0				3.08
3.10	0	0				3.10
3.11	-161					3. 1
3.13	161					3. 1:
3.14	16, 038	0				3. 14
4.00	0	0				4.00
4.01	0	0				4.0
4.02	0	0				4. 02
4.03	0	0				4.03
4.04	0	0				4.04
4.05	0	0				4. 0
5.00	-778, 621					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

has not	t been posted to Worksheet A,	col umns 1	and/or 2,	the amount	allowable	should be	e indicated	in column 4	of this part.	
	Related Organization(s)									
	and/or Home Office									
	Turne of Ducinees	1								
	Type of Business									
		-								
	6.00									
	B. INTERRELATIONSHIP TO RELAT	TED ORGANI	ZATI ON(S)	AND/OR HOME	OFFI CE:					

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

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

6.00	6.00							
7.00	7.00							
8.00	8.00							
9.00	9.00							
10.00	10.00							
100.00	100.00							
(1) lies the following symbols to indicate interpolationship to related argonizations:								

(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.

COST ALLOCATION - GENERAL SERVICE COSTS		Provi der CC	CN: 15-2020 F	Period: From 07/01/2020 O 06/30/2021		pared:
		CAPI TAL REL	ATED COSTS			
Cost Center Description	Net Expenses for Cost	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFI TS	Subtotal	
	Allocation (from Wkst A col. 7)			DEPARTMENT		
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS				1		
1.00 00100 CAP REL COSTS-BLDG & FIXT	714, 976	714, 976				1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP	214, 932	_	214, 932			2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	2,070,645	0	-			4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL	5, 253, 029	48, 661	14, 628		5, 387, 457	5.00
7.00 00700 OPERATION OF PLANT	968, 557	35, 826				7.00
8.00 00800 LAUNDRY & LINEN SERVICE	0					8.00
9. 00 00900 HOUSEKEEPI NG	468, 062	8, 125				9.00
10. 00  01000 DI ETARY 13. 00  01300 NURSI NG ADMI NI STRATI ON	573, 321 534, 063	28, 998 36, 388			611, 036	
15. 00 01500 PHARMACY	2, 179, 581	36, 388 17, 027				
16. 00 01600 MEDICAL RECORDS & LIBRARY	2, 179, 581	7, 736				16.00
17. 00 01700 SOCIAL SERVICE	0	4, 250				17.00
18. 00 01851 PASTORAL CARE	0	5, 244				
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		0,211	1,070	, <u> </u>	0,020	10.00
30. 00 03000 ADULTS & PEDI ATRI CS	8,077,247	479, 203	144, 057	1, 264, 011	9, 964, 518	30.00
ANCI LLARY SERVI CE COST CENTERS			. <u>·</u>		·	1
50. 00 05000 OPERATI NG ROOM	210, 290	5, 128	1, 542	30, 410	247, 370	50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	91, 458	9, 219	2, 771	16, 261	119, 709	54.00
54.01 03630 ULTRA SOUND	12, 239	0				
57.00 05700 CT SCAN	0	2, 449				
60. 00 06000 LABORATORY	157, 392	2, 002			159, 996	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		-	0	63.00
65. 00 06500 RESPI RATORY THERAPY	1, 535, 445	3, 630				
66.00 06600 PHYSI CAL THERAPY	305,637	5, 085				66.00
67.00 06700 OCCUPATI ONAL THERAPY	316, 749				383, 304	
68. 00 06800 SPEECH PATHOLOGY	219, 704	5, 071			267, 271	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		-	0	
70.00     07000     ELECTROENCEPHALOGRAPHY       71.00     07100     MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 777 177, 224	0		) 340 2,608		
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 2,008	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0			0	
74. 00 07400 RENAL DIALYSIS	547, 129	0				
SPECIAL PURPOSE COST CENTERS	017,127	<u> </u>		<u>,                                     </u>	017,127	7 1. 00
113. 00 11300 I NTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	24, 629, 457	714, 976	214, 932	2, 070, 645	24, 629, 457	
NONREI MBURSABLE COST CENTERS	· · · · · ·		· · ·			1
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(	0 0	0	190.00
191. 00 19100 RESEARCH	0	0	( C	0 0	0	191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	C	0 0		192.00
193.00 19300 NONPALD WORKERS	0	0	C	0 0		193.00
194.0007950 BIOTERRORISM GRANT	0	0	0	0 0		194.00
194. 01 07951 MARKETI NG	0	0	0	0 0		194. 01
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)	24, 629, 457	714, 976	214, 932	2, 070, 645	24, 629, 457	202.00

Heal th Financi	al Systems	
GOOT ALL CONTLO	0505041	0.5

In Lieu of Form CMS-2552-10

		NSTUN ST VINCEN			In Lie	U OT FORM CMS-	2552-10
COST A	ALLOCATION - GENERAL SERVICE COSTS		Provider C		eri od:	Worksheet B	
					rom 07/01/2020	Part I	
				T	o 06/30/2021	Date/Time Pre	epared:
	Cost Center Description	ADMI NI STRATI VE		LAUNDRY &	HOUSEKEEPI NG	11/16/2021 11 DI ETARY	. 30 alli
	cost center bescription		PLANT		HUUSEKEEPING	DIETAKT	
		& GENERAL 5.00	7.00	LINEN SERVICE 8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS	5.00	7.00	0.00	9.00	10.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT			1			1.00
2.00	00200 CAP REL COSTS-BEDG & TTXT						2.00
2.00 4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
4.00 5.00	00500 ADMINISTRATIVE & GENERAL	5, 387, 457					5.00
5.00 7.00	00700 OPERATION OF PLANT						7.00
		284, 243					
8.00	00800 LAUNDRY & LINEN SERVICE	2,130					8.00
9.00	00900 HOUSEKEEPING	134,008				074 404	9.00
10.00	01000 DI ETARY	171,080				871, 484	
13.00	01300 NURSI NG ADMI NI STRATI ON	184, 122				0	
15.00	01500 PHARMACY	669, 341				0	
16.00	01600 MEDI CAL RECORDS & LI BRARY	2, 817				0	
17.00	01700 SOCIAL SERVICE	1, 547				0	
18.00	01851 PASTORAL CARE	1, 909	10, 807	0	5, 353	0	18.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	2, 789, 911	987, 656	21, 791	489, 207	871, 484	30.00
	ANCI LLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	69, 260	10, 569	0	5, 235	0	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	33, 517	19, 001	0	9, 412	0	54.00
54.01	03630 ULTRA SOUND	4,016	0	0	0	0	54.01
57.00	05700 CT SCAN	892	5, 047	0	2, 500	0	57.00
60.00	06000 LABORATORY	44, 796	4, 127	0	2, 044	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500 RESPI RATORY THERAPY	504,072	7, 482	0	3, 706	0	65.00
66.00	06600 PHYSI CAL THERAPY	103, 515	10, 480	0	5, 191	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	107, 319	10, 480	0	5, 191	0	67.00
68.00	06800 SPEECH PATHOLOGY	74,832	10, 451	0	5, 176	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	593	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	50, 350		0	0	0	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0		0	0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	
74.00	07400 RENAL DIALYSIS	153, 187	0	0	0	0	74.00
	SPECIAL PURPOSE COST CENTERS		-	-	-	-	
113 00	11300 INTEREST EXPENSE						113.00
118.00		5, 387, 457	1, 299, 454	21, 791	629, 382	871, 484	
110.00	NONREI MBURSABLE COST CENTERS	0,007,107	1,2,7,101	21,771	027,002	071,101	110.00
100 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
	19100 RESEARCH	0					191.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		-		192.00
	19300 NONPALD WORKERS	0	0	0	0		193.00
	07950 BI OTERRORI SM GRANT	0	0	0	0		194.00
	07950 BIOTERRORTSM GRANT			0	0		194.00
200.00		0	0		0	0	200.00
200.00		_	_	_		~	200.00
		E 207 457	1, 299, 454	0 21 701	420,202		•
202.00	TOTAL (sum lines 118 through 201)	5, 387, 457	1, 299, 454	21, 791	629, 382	871, 484	1202.00

In Lieu of Form CMS-2552-10

Heal th	Financial Systems ASCE	NSION ST VINCENT	T SETON SPECIA	LTY	In Lie	u of Form CMS-	2552-10
	LLOCATION - GENERAL SERVICE COSTS		Provider C		Period:	Worksheet B	
					From 07/01/2020	Part I	
					To 06/30/2021	Date/Time Pre	pared:
						11/16/2021 11 OTHER GENERAL	: 30 am
						SERVICE	
	Cost Center Description	NURSI NG	PHARMACY	MEDI CAL	SOCIAL SERVICE		
	cost center bescription	ADMI NI STRATI ON	PHARMACY	RECORDS &	SUCIAL SERVICE	PASTURAL CARE	
		ADMINI STRATI UN					
		12.00	15.00	LI BRARY	17.00	18.00	
	GENERAL SERVICE COST CENTERS	13.00	15.00	16.00	17.00	18.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT			1			1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
4.00 5.00	00500 ADMINISTRATIVE & GENERAL						5.00
3.00 7.00	00700 OPERATION OF PLANT						7.00
7.00 8.00	00800 LAUNDRY & LINEN SERVICE						8.00
8.00 9.00							9.00
	00900 HOUSEKEEPI NG 01000 DI ETARY						10.00
		052,000					1
	01300 NURSI NG ADMI NI STRATI ON	953, 880	2 112 454				13.00
	01500 PHARMACY	0	3, 112, 456				15.00
	01600 MEDICAL RECORDS & LIBRARY	0	0	00,77			16.00
	01700 SOCIAL SERVICE	0	0		0 20, 170		17.00
18.00	01851 PASTORAL CARE	0	0		0 0	24, 889	18.00
	INPATIENT ROUTINE SERVICE COST CENTERS	1					
30.00	03000 ADULTS & PEDIATRICS	848, 646	0	15, 66	4 20, 170	24, 889	30.00
	ANCI LLARY SERVICE COST CENTERS	1		1			
	05000 OPERATING ROOM	4, 719	0			0	
	05400 RADI OLOGY-DI AGNOSTI C	0	0				
	03630 ULTRA SOUND	0	0	-		0	
	05700 CT SCAN	0	0			0	
	06000 LABORATORY	0	0			0	
	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0	63.00
	06500 RESPI RATORY THERAPY	37, 088	0			0	
	06600 PHYSI CAL THERAPY	883	0			0	
	06700 OCCUPATI ONAL THERAPY	15, 684	0			0	
	06800 SPEECH PATHOLOGY	46, 860	0		-	0	
	06900 ELECTROCARDI OLOGY	0	0		0 0	0	
	07000 ELECTROENCEPHALOGRAPHY	0	0		8 0	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	81	7 0	0	
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	
	07300 DRUGS CHARGED TO PATIENTS	0	3, 112, 456	3, 98	4 0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	85	1 0	0	74.00
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	953, 880	3, 112, 456	36, 71	8 20, 170	24, 889	118.00
	NONREI MBURSABLE COST CENTERS						
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190. 00
	19100 RESEARCH	0	0		0 0	0	191.00
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0	0	192.00
193.00	19300 NONPALD WORKERS	0	0		0 0	0	193.00
194.00	07950 BI OTERRORI SM GRANT	0	0		0 0	0	194.00
	07951 MARKETI NG	0	0		0 0	0	194.01
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0		0 0	0	201.00
202.00	5	953, 880	3, 112, 456	36, 71	8 20, 170		
				•			•

Heal th	Fi nanci al	Systems	
A T200		- CENERAL	SEDVI

## ASCENSION ST VINCENT SETON SPECIALTY In Lieu of Form CMS-2552-10

Health Financial Systems ASCEN	VSION ST VINCEN	T SETON SPECIA	LTY	In Lieu	of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CO	CN: 15-2020	Period: V	Vorksheet B	
				From 07/01/2020 F	Part I	
				To 06/30/2021 [	Date/Time Pre	pared:
					1/16/2021 11	<u>30 am</u>
Cost Center Description	Subtotal	Intern &	Total			
		Residents Cost				
		& Post				
		Stepdown				
		Adjustments				
	24.00		24.00	_		
	24.00	25.00	26.00			
GENERAL SERVICE COST CENTERS	1	1	1			
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL						5.00
7.00 00700 OPERATION OF PLANT						7.00
8.00 00800 LAUNDRY & LINEN SERVICE						8.00
						9.00
10. 00 01000 DI ETARY						10.00
13.00 01300 NURSING ADMINISTRATION						13.00
15.00 01500 PHARMACY						15.00
16.00 01600 MEDI CAL RECORDS & LI BRARY						16.00
17.00 01700 SOCIAL SERVICE						17.00
18. 00 01851 PASTORAL CARE						18.00
INPATIENT ROUTINE SERVICE COST CENTERS						10.00
	44 000 004		1 1 000 00			~~ ~~
30. 00 03000 ADULTS & PEDI ATRI CS	16, 033, 936	0	16, 033, 93	36		30.00
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATI NG ROOM	338, 046	0	338, 04	16		50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	181, 903	0	181, 90	03		54.00
54.01 03630 ULTRA SOUND	18, 549	0	18, 54	19		54.01
57.00 05700 CT SCAN	11, 781	0				57.00
60. 00 06000 LABORATORY	215,002					60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	213,002	0		0		63.00
	-			-		
65. 00 06500 RESPIRATORY THERAPY	2, 360, 618					65.00
66. 00 06600 PHYSI CAL THERAPY	490, 533					66.00
67.00 06700 OCCUPATI ONAL THERAPY	522, 807	0	522, 80	07		67.00
68.00 06800 SPEECH PATHOLOGY	404, 958	0	404, 95	58		68.00
69.00 06900 ELECTROCARDI OLOGY	0	0		0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	2, 718	0	2, 71	18		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	230, 999					71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	200, 777	0				72.00
	2 114 440			10		73.00
	3, 116, 440					
74.00 07400 RENAL DI ALYSI S	701, 167	0	701, 16	o/		74.00
SPECIAL PURPOSE COST CENTERS						
113.0011300 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	24, 629, 457	0	24, 629, 45	57		118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0		190. 00
191. 00 19100 RESEARCH	0			0		191.00
	0			0		
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0				192.00
193. 00 19300 NONPALD WORKERS	0	0		0		193.00
194. 00 07950 BI OTERRORI SM GRANT	0			0		194.00
194. 01 07951 MARKETI NG	0	0		0		194.01
200.00 Cross Foot Adjustments	0	0		0		200. 00
201.00 Negative Cost Centers	0	0		0		201.00
202.00 TOTAL (sum lines 118 through 201)	24, 629, 457			-		201.00
	27,027,437	0	1 27,027,40	· ·		202.00

	ON OF CAPITAL RELATED COSTS		Provi der CC	CN: 15-2020 F	Period: From 07/01/2020 Fo 06/30/2021	Worksheet B Part II Date/Time Pre 11/16/2021 11	
			CAPI TAL REL	ATED COSTS			
	Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
		0	1.00	2.00	2A	4.00	
G	ENERAL SERVICE COST CENTERS				-		
1.00 0	0100 CAP REL COSTS-BLDG & FIXT						1.00
	0200 CAP REL COSTS-MVBLE EQUIP						2.00
	0400 EMPLOYEE BENEFITS DEPARTMENT	0	0	(	0 0	0	4.00
	0500 ADMINISTRATIVE & GENERAL	409, 127	48, 661	14, 628			
	0700 OPERATION OF PLANT	0	35, 826	10, 770		0	
	0800 LAUNDRY & LINEN SERVICE	0	5, 849	1, 758		0	
	0900 HOUSEKEEPI NG	0	8, 125	2, 442		0	
	1000 DI ETARY	0	28, 998	8, 717			
	1300 NURSING ADMINISTRATION	0	36, 388			0	
	1500 PHARMACY	0	17, 027	5, 119			
	1600 MEDI CAL RECORDS & LI BRARY	0	7, 736	2, 325		0	
	1700 SOCIAL SERVICE	0	4, 250			0	
	1851 PASTORAL CARE	0	5, 244	1, 576	6, 820	0	18.00
	NPATIENT ROUTINE SERVICE COST CENTERS		470,000	144.05	1 (22.240		1 20 00
	3000 ADULTS & PEDIATRICS	0	479, 203	144, 05	623, 260	0	30.00
	NCI LLARY SERVI CE COST CENTERS 5000 OPERATI NG ROOM	0	5, 128	1, 542	2 6, 670	0	50.00
	5400 RADI OLOGY-DI AGNOSTI C	0	5, 128 9, 219			0	
	3630 ULTRA SOUND	0	9,219	2, 77		0	
	5700 CT SCAN	0	2, 449	736			
	6000 LABORATORY	0	2, 449	602		0	•
	6300 BLOOD STORING, PROCESSING & TRANS.	0	2,002	(		0	
	6500 RESPI RATORY THERAPY	0	3, 630	1, 09	-	0	65.00
	6600 PHYSI CAL THERAPY	0	5,085			0	
	6700 OCCUPATI ONAL THERAPY	0	5, 085			0	
	6800 SPEECH PATHOLOGY	0	5, 071	1, 524			•
	6900 ELECTROCARDI OLOGY	0	0	(		0	
	7000 ELECTROENCEPHALOGRAPHY	0	0	(	0 0	0	70.00
71.00 0	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(	0 0	0	71.00
72.00 0	7200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(	0 0	0	72.00
73.00 0	7300 DRUGS CHARGED TO PATIENTS	0	0	(	0 0	0	73.00
74.00 0	7400 RENAL DIALYSIS	0	0	(	0 0	0	74.00
S	PECIAL PURPOSE COST CENTERS						
	1300 INTEREST EXPENSE						113.00
118.00 N	SUBTOTALS (SUM OF LINES 1 through 117) ONREIMBURSABLE COST CENTERS	409, 127	714, 976	214, 932	2 1, 339, 035	0	118.00
	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(	0 0	0	190. 00
	9100 RESEARCH	0	0	(	0 0		191.00
	9200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	(	0 0		192.00
193.001	9300 NONPAID WORKERS	0	0	(	0 0		193.00
	7950 BI OTERRORI SM GRANT	0	0	(	0 0		194.00
	7951 MARKETI NG	0	0	(	0 0	0	194. 01
200.00	Cross Foot Adjustments				0		200.00
201.00	Negative Cost Centers		0	(	0 0		201.00
202.00	TOTAL (sum lines 118 through 201)	409, 127	714, 976	214, 932	2 1, 339, 035	0	202.00

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ASCENSI ON	ST	<b>VI NCENT</b>	SETON	SPECI ALTY

In Lieu of Form CMS-2552-10

ALLOCATION OF CAPITAL RELATED COSTS		Provider CO	CN: 15-2020 F F T	Period: From 07/01/2020 To 06/30/2021	Worksheet B Part II Date/Time Pre 11/16/2021 11	pared:
Cost Center Description	ADMI NI STRATI VE		LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	& GENERAL	PLANT	LINEN SERVICE			
	5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	170 144					4.00
5.00 00500 ADMINI STRATI VE & GENERAL	472, 416					5.00
7.00 00700 OPERATION OF PLANT	24, 924			,		7.00
8.00 00800 LAUNDRY & LI NEN SERVI CE	187					8.00
9. 00 00900 HOUSEKEEPI NG	11, 751		(		F7 000	9.00
	15,002				57, 099	1
13. 00 01300 NURSI NG ADMI NI STRATI ON	16, 145				0	
15. 00 01500 PHARMACY	58, 693		(		0	
16. 00 01600 MEDI CAL RECORDS & LI BRARY	247		(		0	16.00
17.00 01700 SOCIAL SERVICE	136		(		0	
18.00 01851 PASTORAL CARE	167	595	(	) 198	0	18.00
INPATIENT ROUTINE SERVICE COST CENTERS	244 (44	E 4 250	0.45	10.0/2	F7 000	20.00
30. 00 03000 ADULTS & PEDIATRICS	244, 644	54, 359	8, 457	18, 063	57, 099	30.00
ANCI LLARY SERVICE COST CENTERS 50.00 05000 OPERATI NG ROOM	( 072	502	(	102	0	50.00
	6, 073 2, 939		(		0	
54. 00  05400  RADI OLOGY-DI AGNOSTI C 54. 01  03630  ULTRA SOUND	2, 939				0	54.00 54.01
57. 00  05700 CT_SCAN	78				0	
60. 00 06000 LABORATORY	3, 928				0	60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	3, 928	0			0	63.00
65. 00 06500 RESPIRATORY THERAPY	44, 201	412			0	65.00
66. 00 06600 PHYSI CAL THERAPY	9,077				0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	9,077				0	67.00
68. 00 06800 SPEECH PATHOLOGY	6, 562				0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0, 502	0			0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	52	0			0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4, 415	0			0	70.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	4,413	0		° i	0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0				0	
74. 00 07400 RENAL DI ALYSI S	13, 433	0	(	° I	0	
SPECIAL PURPOSE COST CENTERS	15,455	0		<u> </u>	0	74.00
113. 00 11300 I NTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	472, 416	71, 520	8, 457	23, 240	57 099	118.00
NONREI MBURSABLE COST CENTERS	172,110	71,020	0, 107	20,210	07,077	110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(	0 0	0	190.00
191. 00 19100 RESEARCH	0		(			191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	(			192.00
193. 00 19300 NONPALD WORKERS	0	0	(	-		193.00
194. 00 07950 BI OTERRORI SM GRANT	0	n	(	° °		194.00
194. 01 07951 MARKETI NG	0	0	(	o o		194.01
200.00 Cross Foot Adjustments					Ū	200.00
201.00 Negative Cost Centers	0	0	(	o o	0	201.00
202.00 TOTAL (sum lines 118 through 201)	472, 416	71, 520	8, 457	23, 240		202.00
		•				•

Heal th	Financial Systems ASCE	NSION ST VINCENT	SETON SPECIA	LTY	In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS			Provider CO		Peri od:	Worksheet B	
12200111					rom 07/01/2020	Part II	
				T	o 06/30/2021	Date/Time Pre	pared:
						11/16/2021 11	<u>:30 am</u>
						OTHER GENERAL	
						SERVI CE	
	Cost Center Description	NURSI NG	PHARMACY	MEDI CAL	SOCI AL SERVI CE	PASTORAL CARE	
		ADMI NI STRATI ON		RECORDS &			
				LI BRARY			
		13.00	15.00	16.00	17.00	18.00	
	GENERAL SERVICE COST CENTERS	,		I			
	DO100 CAP REL COSTS-BLDG & FIXT						1.00
	DO200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 0	DO400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 (	DO500 ADMINISTRATIVE & GENERAL						5.00
7.00	DO700 OPERATION OF PLANT						7.00
8.00	DO800 LAUNDRY & LINEN SERVICE						8.00
9.00	DO900 HOUSEKEEPI NG						9.00
	D1000 DI ETARY						10.00
	D1300 NURSI NG ADMI NI STRATI ON	68, 972					13.00
	D1500 PHARMACY	00, 772	83, 412				15.00
		0	03, 412		,		16.00
	D1600 MEDICAL RECORDS & LIBRARY	-	-				
	D1700 SOCIAL SERVICE	0	0				17.00
	D1851 PASTORAL CARE	0	0	C	0 0	7, 780	18.00
	NPATIENT ROUTINE SERVICE COST CENTERS	1					
	D3000 ADULTS & PEDIATRICS	61, 363	0	4, 913	6, 305	7, 780	30.00
	ANCILLARY SERVICE COST CENTERS	,					
	D5000 OPERATI NG ROOM	341	0			0	
	D5400 RADI OLOGY-DI AGNOSTI C	0	0			0	
	D3630 ULTRA SOUND	0	0	59	0	0	54.01
57.00 (	D5700 CT SCAN	0	0	49	0	0	57.00
60.00	D6000 LABORATORY	0	0	1, 260	0	0	60.00
63.00	D6300 BLOOD STORING, PROCESSING & TRANS.	0	0	C	0 0	0	63.00
65.00	06500 RESPI RATORY THERAPY	2, 682	0	2, 466	0	0	65.00
66.00	06600 PHYSI CAL THERAPY	64	0	233	0	0	66,00
	06700 OCCUPATI ONAL THERAPY	1, 134	0			0	67.00
	D6800 SPEECH PATHOLOGY	3, 388	0			0	68.00
	D6900 ELECTROCARDI OLOGY	0	0			0	
	D7000 ELECTROENCEPHALOGRAPHY	0	0	-		0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	_	-	0	
	07200 IMPL. DEV. CHARGED TO PATIENTS		0				1
		0	-	-		0	
	D7300 DRUGS CHARGED TO PATIENTS	0	83, 412			0	
	07400 RENAL DIALYSIS	0	0	265	0	0	74.00
	SPECIAL PURPOSE COST CENTERS	1		1			
	11300 INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	68, 972	83, 412	11, 477	6, 305	7, 780	118.00
ſ	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		-		190. 00
	19100 RESEARCH	0	0	-	0		191.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	C	0 0	0	192.00
	19300 NONPALD WORKERS	0	0	0	0 0	0	193.00
194.000	07950 BI OTERRORI SM GRANT	0	0	C	0	0	194.00
	07951 MARKETI NG	0	0	c c	0		194.01
200.00	Cross Foot Adjustments		-				200.00
201.00	Negative Cost Centers	0	0	0	0	n	201.00
202.00	TOTAL (sum lines 118 through 201)	68, 972	83, 412	11, 477	6, 305		202.00
0			,	, ,	2, 500	.,	

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### ASCENSION ST VINCENT SETON SPECIALTY IN Lieu of Form CMS-2552-10

	STON ST VINCEN				
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC	N: 15-2020	Period: Worksheet E	3
				From 07/01/2020 Part II To 06/30/2021 Date/Time F	
				To 06/30/2021 Date/Time F	Prepared:
				11/16/2021	11:30 am
Cost Center Description	Subtotal	Intern &	Total		
		Residents Cost			
		& Post			
		Stepdown			
		Adjustments			
	24.00		24.00	_	
	24.00	25.00	26.00		
GENERAL SERVICE COST CENTERS					
1.00 00100 CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00 00500 ADMI NI STRATI VE & GENERAL					5.00
7.00 00700 OPERATION OF PLANT					7.00
8.00 00800 LAUNDRY & LINEN SERVICE					8.00
9. 00 00900 HOUSEKEEPI NG					9.00
10. 00 01000 DI ETARY					10.00
13.00 01300 NURSING ADMINISTRATION					13.00
15. 00 01500 PHARMACY					15.00
16. 00 01600 MEDICAL RECORDS & LIBRARY					16.00
17.00 01700 SOCIAL SERVICE					17.00
18.00 01851 PASTORAL CARE					18.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS	1, 086, 243	0	1, 086, 24	3	30.00
ANCI LLARY SERVICE COST CENTERS	.,	-	.,,	-	
50. 00 05000 OPERATING ROOM	14, 137	0	14, 13	7	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	16, 405	0	16, 40		54.00
54.01 03630 ULTRA SOUND	411	0	41		54.01
57.00 05700 CT SCAN	3, 682	0	3, 68	32	57.00
60. 00 06000 LABORATORY	8,094	0	8, 09	94	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	63.00
65. 00 06500 RESPI RATORY THERAPY	54, 619	0	54, 61		65.00
66. 00 06600 PHYSI CAL THERAPY		0			66.00
	16, 757		16, 75		
67.00 06700 OCCUPATI ONAL THERAPY	18, 185	0	18, 18		67.00
68.00 06800 SPEECH PATHOLOGY	17, 426	0	17, 42	26	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	54	0	5	4	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4,670	0	4, 67		71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	4,070	0	4,07	0	72.00
	-		04.45		
73.00 07300 DRUGS CHARGED TO PATIENTS	84,654	0	84,65		73.00
74.00 07400 RENAL DIALYSIS	13, 698	0	13, 69	28	74.00
SPECIAL PURPOSE COST CENTERS					
113.00 11300 INTEREST EXPENSE					113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 339, 035	0	1, 339, 03	15	118.00
NONREI MBURSABLE COST CENTERS	1,007,000	0	1,007,00		
	0	0			100.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0	190.00
191. 00 19100 RESEARCH	0	0		0	191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0	192.00
193. 00 19300 NONPAI D WORKERS	0	0		0	193.00
194. 00 07950 BI OTERRORI SM GRANT	0	0		0	194.00
194. 01 07950 BTOTERKORTSM GRANT	0	0		0	194.00
	0	-		-	
200.00 Cross Foot Adjustments	0	0		0	200.00
201.00 Negative Cost Centers	0	0		0	201.00
202.00 TOTAL (sum lines 118 through 201)	1, 339, 035	0	1, 339, 03	5	202.00
					•

# ASCENSION ST VINCENT SETON SPECIALTY Provider CCN: 15-2020 Period:

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

COST ALLOCATION - STATISTICAL BASIS	Provider CO	Provider CCN: 15-2020		Worksheet B-1		
				From 07/01/2020 To 06/30/2021		pared:
	CAPITAL REL	ATED COSTS			11/16/2021 11	:30 am
Cost Center Description	BLDG & FI XT (SQUARE FEET)	MVBLE EQUI P (SQUARE FEET)	EMPLOYEE BENEFI TS DEPARTMENT (GROSS SALARI ES)	Reconci I i ati on	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	
	1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FIXT	49, 633					1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP		49, 633				2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	0	0				4.00
5. 00 00500 ADMINI STRATI VE & GENERAL	3, 378	3, 378				1
7.00 00700 OPERATION OF PLANT	2, 487	2, 487				1
8.00 00800 LAUNDRY & LINEN SERVICE	406	406		-		1
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY	564 2, 013	564 2, 013			478, 629 611, 036	1
13. 00 01300 NURSING ADMINISTRATION	2, 526	2, 526		-	657, 615	1
15. 00 01500 PHARMACY	1, 182	1, 182				
16. 00 01600 MEDICAL RECORDS & LIBRARY	537	537	(		10, 061	1
17.00 01700 SOCIAL SERVICE	295	295	(	0 0		1
18.00 01851 PASTORAL CARE	364	364	(	0 0	6, 820	18.00
INPATIENT ROUTINE SERVICE COST CENTERS	1 1			1		
30. 00 03000 ADULTS & PEDI ATRI CS ANCI LLARY SERVI CE COST CENTERS	33, 266	33, 266	6, 225, 234	t 0	9, 964, 518	30.00
50. 00 05000 OPERATI NG ROOM	356	356	149, 76	7 0	247, 370	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	640	640				1
54. 01 03630 ULTRA SOUND	0	0				1
57.00 05700 CT SCAN	170	170			3, 185	1
60. 00 06000 LABORATORY	139	139	(	0 0	159, 996	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	(	0 0	0	63.00
65. 00 06500 RESPI RATORY THERAPY	252	252			1, 800, 361	1
66. 00 06600 PHYSI CAL THERAPY	353	353				1
67.00 06700 OCCUPATI ONAL THERAPY	353	353			383, 304	1
68. 00 06800 SPEECH PATHOLOGY	352	352				1
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		-		
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0	1, 674 12, 844		2, 117 179, 832	1
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	12,04		032	1
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		-		1
74. 00 07400 RENAL DIALYSIS	0	0				
SPECIAL PURPOSE COST CENTERS	· · ·					
113.0011300 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	49, 633	49, 633	10, 197, 89	-5, 387, 457	19, 242, 000	118.00
NONREI MBURSABLE COST CENTERS		0				100.00
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 191. 00 19100 RESEARCH	0	0				190.00 191.00
191. 00 19100 RESEARCH 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		-		191.00
193. 00 19300 NONPALD WORKERS	0	0				193.00
194. 00 07950 BI OTERRORI SM GRANT	0	0		-		194.00
194. 01 07951 MARKETI NG	0	0				194.01
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B,	714, 976	214, 932	2, 070, 64	5	5, 387, 457	202.00
Part I) 203.00 Unit cost multiplier (Wkst. B, Part I)	14. 405255	4. 330425	0. 203040		0. 279984	202 00
204.00 Cost to be allocated (per Wkst. B,	14. 405255	4. 330423	0.203040		472, 416	1
Part II)					472,410	204.00
205.00 Unit cost multiplier (Wkst. B, Part			0. 000000	D	0. 024551	205.00
206.00 NAHE adjustment amount to be allocated						206. 00
207.00 NAHE unit cost multiplier (Wkst. D,						207.00
Parts III and IV)						207.00

OST ALLOCA	TION - STATISTICAL BASIS		Provider C	F	Period: From 07/01/2020 Fo 06/30/2021	Worksheet B-1 Date/Time Pre	pared
	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (SQUARE FEET)	DI ETARY (TOTAL PATI ENT DAYS)	(DIRECT NURS.	
		7.00	0.00	0.00	10.00	HRS. )	
CENE		7.00	8.00	9.00	10.00	13.00	
.00         00100           .00         00200           .00         00400           .00         00500           .00         00700           .00         00700           .00         00900           .00         01000           .00         01300           .00         01500           .00         01600           .00         01500           .00         01600           .00         01500           .00         01600           .00         01700           8.00         0185	RAL SERVICE COST CENTERS         CAP REL COSTS-BLDG & FIXT         CAP REL COSTS-MVBLE EQUIP         D EMPLOYEE BENEFITS DEPARTMENT         D ADMINISTRATIVE & GENERAL         OPERATION OF PLANT         D LAUNDRY & LINEN SERVICE         D HOUSEKEEPING         D IETARY         NURSING ADMINISTRATION         D PHARMACY         MEDICAL RECORDS & LIBRARY         SOCIAL SERVICE         1 PASTORAL CARE	43, 768 406 564 2, 013 2, 526 1, 182 537 295 364	5 100 6 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0	42, 798 2, 013 2, 526 1, 182 533 295 364	3     12, 899       6     0       2     0       7     0       5     0	224, 790 0 0 0 0 0 0	15. 16. 17.
	FIENT ROUTINE SERVICE COST CENTERS		-		1		
	ADULTS & PEDIATRICS	33, 266	100	33, 266	5 12, 899	199, 991	30.
	LARY SERVICE COST CENTERS	356	0	356	5 0	1, 112	50.
	RADI OLOGY-DI AGNOSTI C	640				0	
	ULTRA SOUND	0	0	C	0 0	0	54.
	D CT SCAN	170		170		0	
	DLABORATORY	139		139		0	
	D BLOOD STORING, PROCESSING & TRANS.	0		C		0	
	D RESPI RATORY THERAPY	252		252		8, 740	
	D PHYSI CAL THERAPY	353		353		208	
	OCCUPATIONAL THERAPY	353		353		3, 696	
	SPEECH PATHOLOGY	352		352		11, 043	
	D ELECTROCARDI OLOGY D ELECTROENCEPHALOGRAPHY	0				0	
	MEDICAL SUPPLIES CHARGED TO PATIENTS	0				0	
	IMPL. DEV. CHARGED TO PATIENTS	0				0	
	D DRUGS CHARGED TO PATIENTS					0	
	RENAL DI ALYSI S	0	-			0	
	AL PURPOSE COST CENTERS		,				1
	INTEREST EXPENSE						1113
8.00	SUBTOTALS (SUM OF LINES 1 through 117)	43, 768	100	42, 798	12, 899	224, 790	118
NONRI	I MBURSABLE COST CENTERS						1
0.001900	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0 0	C	0 0	0	190
1.001910	RESEARCH	0	0 0	C	0 0	0	191
2.00 1920	PHYSI CLANS' PRI VATE OFFI CES	0	0 0	0	0 0	0	192
	NONPAID WORKERS	0	0 0	0	0 0	0	193
	D BI OTERRORI SM GRANT	0		C	0 0		194
	1 MARKETI NG	0	0 0	C	0 0	0	194
0.00	Cross Foot Adjustments						200
1.00	Negative Cost Centers						201
2.00 3.00	Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part I)	1, 299, 454 29. 689591				953, 880 4. 243427	
4.00	Cost to be allocated (per Wkst. B, Part II)	71, 520				4. 243427 68, 972	
05.00	Unit cost multiplier (Wkst. B, Part II)	1. 634071	84. 570000	0. 543016	4. 426622	0. 306829	
06.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206
07.00	NAHE unit cost multiplier (Wkst. D,	1	1				207

Heal th	Finar	cial Systems ASCEN	ISION ST VINCENT	SETON SPECIA	LTY	In Lie	u of Form CMS-255	2-10
COST A	LLOCA	TION - STATISTICAL BASIS		Provider C	CN: 15-2020	Period:	Worksheet B-1	
						From 07/01/2020 To 06/30/2021	Date/Time Prepar	-ed·
							11/16/2021 11:30	
						OTHER GENERAL		
		Cost Center Description	PHARMACY	MEDI CAL		SERVICE E PASTORAL CARE		
		cost center bescription	(COSTED	RECORDS &	SUCIAL SERVIC	(TOTAL PATIENT		
			REQUIS.)	LIBRARY	(TOTAL PATIEN	· ·		
			ŕ	(GROSS	DAYS)	,		
			45.00	CHARGES)	17.00	10.00		
	GENER	AL SERVICE COST CENTERS	15.00	16.00	17.00	18.00		
1.00		CAP REL COSTS-BLDG & FIXT						1.00
2.00		CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	1	ADMINISTRATIVE & GENERAL						5.00
7.00	1	OPERATION OF PLANT						7.00
8.00		LAUNDRY & LINEN SERVICE						8.00
9.00	1	HOUSEKEEPI NG DI ETARY						9.00
10. 00 13. 00		NURSING ADMINISTRATION						0.00 3.00
		PHARMACY	100					5.00
16.00		MEDICAL RECORDS & LIBRARY	0	98, 799, 416				6.00
		SOCIAL SERVICE	0	C	12, 89	9		7.00
18.00	01851	PASTORAL CARE	0	C		12, 899	18	8.00
		IENT ROUTINE SERVICE COST CENTERS	r		T			
30.00		ADULTS & PEDIATRICS LARY SERVICE COST CENTERS	0	42, 201, 549	12, 89	9 12, 899	30	0.00
50.00		OPERATING ROOM	0	2, 399, 958	2	0 0	50	0. 00
		RADI OLOGY-DI AGNOSTI C	0	710, 958				4.00
54.01		ULTRA SOUND	0	504, 861		0 0		4.01
57.00		CT SCAN	0	421, 012		o o	5	7.00
60.00		LABORATORY	0	10, 858, 313		o c	60	0. 00
63.00		BLOOD STORING, PROCESSING & TRANS.	0	C		0 C		3.00
65.00		RESPI RATORY THERAPY	0	21, 262, 029		0 0		5.00
66.00		PHYSICAL THERAPY	0	2,008,572				6.00 7.00
67.00 68.00		OCCUPATIONAL THERAPY SPEECH PATHOLOGY	0	2, 228, 246 989, 690				7.00 8.00
69.00	1	ELECTROCARDI OLOGY	0	,0,,0,0				9.00
		ELECTROENCEPHALOGRAPHY	Ő	20, 945		0 0		0.00
71.00		MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2, 197, 346		o o	7	1.00
		IMPL. DEV. CHARGED TO PATIENTS	0	C		0 0	72	2.00
		DRUGS CHARGED TO PATIENTS	100	10, 709, 534		0 0		3.00
74.00		RENAL DI ALYSI S	0	2, 286, 403		0 0	74	4.00
112 00		AL PURPOSE COST CENTERS					111	3.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100	98, 799, 416	12, 89	9 12, 899		8.00
		I MBURSABLE COST CENTERS			,			
		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	C		0 0		0.00
		RESEARCH	0	C		0 0		1.00
		PHYSI CLANS' PRI VATE OFFI CES	0	C		0 0		2.00
		NONPAI D WORKERS	0	C		0 0		3.00
		BIOTERRORI SM GRANT MARKETI NG	0					4.00 4.01
200.00		Cross Foot Adjustments	0	Ĺ		5		4.01 0.00
200.00		Negative Cost Centers						1.00
202.00		Cost to be allocated (per Wkst. B,	3, 112, 456	36, 718	20, 17	24, 889		2.00
		Part I)						
203.00		Unit cost multiplier (Wkst. B, Part I)	31, 124. 560000	0. 000372				3.00
204.00		Cost to be allocated (per Wkst. B,	83, 412	11, 477	6, 30	5 7, 780	204	4.00
205.00		Part II) Unit cost multiplier (Wkst. B, Part	834. 120000	0. 000116	0. 48879	8 0. 603148	201	5.00
200.00			001.120000	3. 000110	0.40077	0.000140	20.	5.00
206.00	)	NAHE adjustment amount to be allocated					200	6. 00
207 00		(per Wkst. B-2)					00	7 00
207.00	, 	NAHE unit cost multiplier (Wkst. D, Parts III and IV)					20	7.00
	1		ı I		I	1	I	

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	F	Period: From 07/01/2020 Fo 06/30/2021	Worksheet C Part I Date/Time Pre 11/16/2021 11	
		Title	XVIII	Hospi tal	PPS	
				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 CEN	ERS					
30. 00 03000 ADULTS & PEDI ATRI CS	16, 033, 936	5	16, 033, 936	6 0	16, 033, 936	30.00
ANCI LLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	338, 046	5	338, 046	6 0	338, 046	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	181, 903	3	181, 903	3 0	181, 903	54.00
54.01 03630 ULTRA SOUND	18, 549	9	18, 549	9 0	18, 549	54.01
57.00 05700 CT SCAN	11, 78	1	11, 78	1 0	11, 781	57.00
60. 00 06000 LABORATORY	215, 002	2	215, 002	2 0	215, 002	60.00
63.00 06300 BLOOD STORING, PROCESSING & T	RANS. 0		(	0 0	0	63.00
65. 00 06500 RESPI RATORY THERAPY	2, 360, 618	3  C	2, 360, 618	3 0	2, 360, 618	65.00
66. 00 06600 PHYSI CAL THERAPY	490, 533	3 C	490, 533	3 0	490, 533	
67.00 06700 OCCUPATI ONAL THERAPY	522, 80	7  C	522, 807	7 0	522, 807	67.00
68.00 06800 SPEECH PATHOLOGY	404, 958	3 C	404, 958	3 0	404, 958	
69. 00 06900 ELECTROCARDI OLOGY	(		(	0 0	0	07.00
70.00 07000 ELECTROENCEPHALOGRAPHY	2, 718		2, 718			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO F	ATI ENTS 230, 999	9	230, 999	9 0	230, 999	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	S (		(	0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	3, 116, 440		3, 116, 440	0 0	3, 116, 440	73.00
74.00 07400 RENAL DIALYSIS	701, 16	7	701, 167	7 0	701, 167	74.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113.00
200.00 Subtotal (see instructions)	24, 629, 45	7 C	24, 629, 45	7 0	,,	
201.00 Less Observation Beds	(	ו	(			201.00
202.00  Total (see instructions)	24, 629, 45	7  C	24, 629, 45	7 0	24, 629, 457	202.00

Health Financial Systems ASCEN	ISTON ST VINCEN	I SETUN SPECIA	LIY	In Lie	U OT FORM CMS	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CC		Period: From 07/01/2020 To 06/30/2021	Worksheet C Part I Date/Time Pre 11/16/2021 11	
		Title	XVIII	Hospi tal	PPS	
		Charges				
Cost Center Description	Inpati ent	Outpati ent		Cost or Other	TEFRA	
			+ col. 7)	Rati o	Inpati ent	
					Ratio	
	6.00	7.00	8.00	9.00	10.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS				-1		
30. 00 03000 ADULTS & PEDI ATRI CS	42, 201, 549		42, 201, 54	9		30.00
ANCI LLARY SERVICE COST CENTERS		-		-		
50. 00 05000 OPERATI NG ROOM	2, 399, 958	0	2, 399, 95		0.00000	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	710, 958	0	710, 95		0.000000	54.00
54. 01 03630 ULTRA SOUND	504, 861	0	504, 86		0.00000	
57. 00 05700 CT SCAN	421, 012	0	421, 01		0.00000	
60. 00 06000 LABORATORY	10, 858, 313	0	10, 858, 31		0.00000	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0.00000	0.00000	
65. 00 06500 RESPI RATORY THERAPY	21, 253, 346	8, 683	21, 262, 02		0.00000	65.00
66. 00 06600 PHYSI CAL THERAPY	2,008,572	0	2, 008, 57		0.00000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	2, 228, 246	0	2, 228, 24		0.00000	67.00
68.00 06800 SPEECH PATHOLOGY	989, 690	0	989, 69		0.00000	
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0.00000	0.00000	
70. 00 07000 ELECTROENCEPHALOGRAPHY	20, 945	0	20, 94		0.000000	
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	2, 196, 280	1, 066	2, 197, 34		0.00000	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 0.00000	0.000000	
73. 00 07300 DRUGS CHARGED TO PATIENTS	10, 701, 900	7,634	10, 709, 53		0.00000	
74.00 07400 RENAL DI ALYSI S	2, 286, 403	0	2, 286, 40	3 0. 306668	0. 000000	74.00
SPECIAL PURPOSE COST CENTERS	I I					
113.00 11300 INTEREST EXPENSE						113.00
200.00 Subtotal (see instructions)	98, 782, 033	17, 383	98, 799, 41	6		200.00
201.00 Less Observation Beds	00 700 000	47.000	00 700 11			201.00
202.00  Total (see instructions)	98, 782, 033	17, 383	98, 799, 41	6		202.00

Health Financial Systems ASCE	NSION SI VINCENI	SETON SPECIALTY	In Lieu	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-2020	Peri od:	Worksheet C	
			From 07/01/2020 To 06/30/2021	Part I Date/Time Pre	narod
			10 00/30/2021	11/16/2021 11	
		Title XVIII	Hospi tal	PPS	<u></u>
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
ANCI LLARY SERVI CE COST CENTERS	1				
50. 00 05000 OPERATI NG ROOM	0. 140855				50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 255856				54.00
54.01 03630 ULTRA SOUND	0. 036741				54.01
57.00 05700 CT SCAN	0. 027983				57.00
60. 00 06000 LABORATORY	0. 019801				60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000				63.00
65. 00 06500 RESPI RATORY THERAPY	0. 111025				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 244220				66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 234627				67.00
68.00 06800 SPEECH PATHOLOGY	0. 409177				68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000				69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 129768				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 105126				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 290997				73.00
74.00 07400 RENAL DIALYSIS	0. 306668				74.00
SPECIAL PURPOSE COST CENTERS					
113.00 11300 INTEREST EXPENSE					113.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)					202.00

		From 07/01/2020 To 06/30/2021	Part I Date/Time Pre 11/16/2021 11	
Ti	tle XIX	Hospi tal	Cost	
		Costs		
Cost Center Description Total Cost Therapy Limi	t Total Costs		Total Costs	
(from Wkst. B, Adj. Part I, col.		Di sal I owance		
1.00 2.00	3.00	4,00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	0.00		0.00	
30. 00 03000 ADULTS & PEDI ATRI CS 16, 033, 936	16, 033, 93	36 0	0	30.00
ANCI LLARY SERVI CE COST CENTERS				1
50. 00 05000 OPERATI NG ROOM 338, 046	338, 04	6 0	0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 181, 903	181, 90	03 0	0	54.00
54. 01 03630 ULTRA SOUND 18, 549	18, 54	19 0	0	54.01
57.00 05700 CT SCAN 11,781	11, 78	31 0	0	57.00
60. 00 06000 LABORATORY 215, 002	215, 00	02 0	0	60.00
63.00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0		0 0	0	63.00
65. 00 06500 RESPI RATORY THERAPY 2, 360, 618	0 2, 360, 61		0	65.00
66.00 06600 PHYSI CAL THERAPY 490, 533	0 490, 53		0	
67. 00 06700 OCCUPATI ONAL THERAPY 522, 807	0 522, 80		0	67.00
68.00 06800 SPEECH PATHOLOGY 404, 958	0 404, 95	58 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY 0		0 0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY 2, 718	2, 71		0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 230, 999	230, 99	99 0	0	1 1 1 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0		0 0	0	
73. 00 07300 DRUGS CHARGED TO PATIENTS 3, 116, 440	3, 116, 44		0	10100
74. 00 07400 RENAL DI ALYSI S 701, 167	701, 16	o7 0	0	74.00
SPECIAL PURPOSE COST CENTERS				
113.00 11300 INTEREST EXPENSE				113.00
200.00         Subtotal (see instructions)         24, 629, 457	0 24, 629, 45	57 0		200.00
201.00 Less Observation Beds 0		0		201.00
202.00   Total (see instructions) 24,629,457	0 24, 629, 45	0	0	202.00

Health Financial Systems ASCE	VSION SI VINCEN			In Lie	U OF FORM CMS	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period:	Worksheet C	
				From 07/01/2020		
				To 06/30/2021		
					11/16/2021 11	:30 am
			e XIX	Hospi tal	Cost	
		Charges				
Cost Center Description	I npati ent	Outpati ent		Cost or Other	TEFRA	
			+ col. 7)	Ratio	I npati ent	
					Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS	,					
30. 00 03000 ADULTS & PEDIATRICS	42, 201, 549		42, 201, 54	9		30.00
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATI NG ROOM	2, 399, 958	0	2, 399, 95	8 0. 140855	0.00000	50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	710, 958	0	710, 95	8 0. 255856	0.00000	54.00
54.01 03630 ULTRA SOUND	504, 861	0	504, 86	1 0. 036741	0.000000	54.01
57.00 05700 CT SCAN	421, 012	0	421, 01	2 0. 027983	0.00000	57.00
60. 00 06000 LABORATORY	10, 858, 313	0	10, 858, 31	3 0. 019801	0.000000	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0.000000	0.00000	63.00
65. 00 06500 RESPI RATORY THERAPY	21, 253, 346	8, 683	21, 262, 02	9 0. 111025	0.00000	65.00
66. 00 06600 PHYSI CAL THERAPY	2,008,572	0	2, 008, 57	2 0. 244220	0.00000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	2, 228, 246	0	2, 228, 24	6 0. 234627	0.00000	67.00
68.00 06800 SPEECH PATHOLOGY	989, 690	0	989, 69	0. 409177	0.00000	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0.000000	0.00000	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	20, 945	0	20, 94	5 0. 129768	0.000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 196, 280	1, 066	2, 197, 34	6 0. 105126	0.000000	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0.000000	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	10, 701, 900	7, 634	10, 709, 53	4 0. 290997	0.000000	73.00
74.00 07400 RENAL DIALYSIS	2, 286, 403	0	2, 286, 40	3 0. 306668	0.000000	74.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 I NTEREST EXPENSE						113.00
200.00 Subtotal (see instructions)	98, 782, 033	17, 383	98, 799, 41	6		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	98, 782, 033	17, 383	98, 799, 41	6		202.00
				1		

nearth financial Systems ASCE	NOTON OF VINCENT	SETON STECTAETT		1 01 1 01 III CM3-25	JJZ-
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-2020	Peri od:	Worksheet C	
			From 07/01/2020	Part I	
			To 06/30/2021	Date/Time Prepa	
			lla ani tal	11/16/2021 11:3	<u>30 ai</u>
		Title XIX	Hospi tal	Cost	
Cost Center Description	PPS Inpatient				
	Ratio				
INDATIENT DOUTINE CEDVICE COST CENTEDO	11.00				
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS					30. C
ANCI LLARY SERVICE COST CENTERS					30. U
50. 00 05000 OPERATING ROOM	0.000000				50. C
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0.000000				50. C
					54. (
	0.000000				
57.00 05700 CT SCAN	0.000000				57.0
	0.000000				60.
53.00 06300 BLOOD STORING, PROCESSING & TRANS.	0.000000				63. (
55.00 06500 RESPIRATORY THERAPY	0.000000				65. (
6. 00 06600 PHYSI CAL THERAPY	0. 000000				66. (
57.00 06700 OCCUPATI ONAL THERAPY	0. 000000				67. (
8.00 06800 SPEECH PATHOLOGY	0. 000000				68. (
9. 00 06900 ELECTROCARDI OLOGY	0. 000000				69. (
0.00 07000 ELECTROENCEPHALOGRAPHY	0. 000000				70. (
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71. (
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000				72. (
73.00 07300 DRUGS CHARGED TO PATIENTS	0.000000				73. (
74. 00 07400 RENAL DI ALYSI S	0.000000				74.(
SPECIAL PURPOSE COST CENTERS	1 1				
13.00 11300 INTEREST EXPENSE					13. (
200.00 Subtotal (see instructions)					200. (
201.00 Less Observation Beds					201. (
202.00   Total (see instructions)				20	202.0

Health Financial Systems AS	SCENSION ST VINCENT SETON SPECIALTY In Lieu of Form					2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPIT	AL COSTS	Provider C		Period: From 07/01/2020 To 06/30/2021		pared: :30 am
		Title	2 XVIII	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B,	Swing Bed Adjustment	Reduced Capital Related Cost	Days	Per Diem (col. 3 / col. 4)	
	Part II, col. 26)		(col. 1 - col 2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	1, 086, 243	0	1, 086, 24	3 12, 899	84. 21	30.00
200.00 Total (lines 30 through 199)	1, 086, 243		1, 086, 24	3 12, 899		200.00
Cost Center Description	I npati ent	Inpati ent				
	Program days					
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	4,654	391, 913				30.00
200.00 Total (lines 30 through 199)	4,654	391, 913				200. 00

Health Financial Systems ASCE	NSION ST VINCEN	IT SETON SPECIA	LTY	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provider C		Period: From 07/01/2020 To 06/30/2021	Worksheet D Part II Date/Time Pre 11/16/2021 11	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capital	Total Charges			Capital Costs	
	(from Wkst. B,	(from Wkst. C, Part I, col.		. Program . Charges	(column 3 x column 4)	
	Part II, col.		2)	. charges		
	26)	0)	2)			
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATI NG ROOM	14, 137	2, 399, 958	0. 00589	1 986, 509	5, 812	50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	16, 405					
54.01 03630 ULTRA SOUND	411					
57.00 05700 CT SCAN	3, 682					57.00
60. 00 06000 LABORATORY	8, 094	10, 858, 313			3, 188	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.00000		0	63.00
65. 00 06500 RESPI RATORY THERAPY	54, 619					65.00
66. 00 06600 PHYSI CAL THERAPY	16, 757					66.00
67.00 06700 OCCUPATI ONAL THERAPY	18, 185					67.00
68.00 06800 SPEECH PATHOLOGY	17, 426	989, 690			5, 814	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0.00000		0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	54					70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4, 670	2, 197, 346			1, 887	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.00000		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	84, 654					
74.00 07400 RENAL DIALYSIS	13, 698					
200.00  Total (lines 50 through 199)	252, 792	56, 597, 867		20, 338, 120	90, 105	200. 00

Health Financial Systems ASCE	NSION ST VINCEN	IT SETON SPECIA	LTY	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COS			Period: From 07/01/2020 Fo 06/30/2021	Date/Time Pre 11/16/2021 11	
			XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS 200. 00 Total (lines 30 through 199)	0	0	(	0 0 0 0	0	30.00 200.00
Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS			•			
30.00 03000 ADULTS & PEDIATRICS 200.00 Total (lines 30 through 199)	0	0	12, 89 12, 89			30.00 200.00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00					
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS						30.00
200.00   03000 ADDELS & PEDIATRICS 200.00     Total (lines 30 through 199)	0					200.00

Health Financial Systems ASCE	NSION ST VINCEN	IT SETON SPECIA	LTY	In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	S Provider C		Period:	Worksheet D	
THROUGH COSTS				From 07/01/2020		
				To 06/30/2021	Date/Time Prep 11/16/2021 11:	
		Title	× XVIII	Hospi tal	PPS	. <u>30 alli</u>
Cost Center Description	Non Physician			Allied Health		
		Post-Stepdown		Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS		1				
50. 00 05000 OPERATI NG ROOM	0	0	1	0 0	0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
54.01 03630 ULTRA SOUND	0	0		0 0	0	54.01
57.00 05700 CT SCAN	0	0		0 0	0	57.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0	63.00
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 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0		0 0	0	74.00
200.00   Total (lines 50 through 199)	0	0	1	0 0	0	200. 00

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Health Financial Systems ASCE	NSION ST VINCEN	T SETON SPECIA	LTY	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI	RVICE OTHER PASS	S Provider C		Period:	Worksheet D	
THROUGH COSTS				From 07/01/2020 To 06/30/2021		nared
				10 00/ 30/ 2021	11/16/2021 11	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
	Education Cost	1, 2, 3, and	Cost (sum of		(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 SERVICE COST CENTERS				0 000 050	0.00000	50.00
50. 00 05000 OPERATING ROOM	0	0		2, 399, 958		50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 710, 958		54.00
54. 01 03630 ULTRA SOUND	0	0		504, 861		54.01
57.00 05700 CT SCAN	0	0		0 421, 012		57.00
	0	0		0 10, 858, 313		60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0.00000	63.00
65. 00 06500 RESPI RATORY THERAPY	0	0		21, 262, 029		65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		2,008,572		66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		2, 228, 246		67.00
68. 00 06800 SPEECH PATHOLOGY	0	0		989, 690		68.00
	0	0			0.00000	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		20, 945		70.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0		2, 197, 346		71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0			0.00000	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 10, 709, 534		73.00
74.00 07400 RENAL DIALYSIS	0	0		2, 286, 403		
200.00   Total (lines 50 through 199)	0	0		56, 597, 867		200. 00

Health Financial Systems ASCE	NSION ST VINCENT	SETON SPECIA	LTY	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	Provider CO		Period: From 07/01/2020	Worksheet D Part IV	
THROUGH COSTS				To 06/30/2021	Date/Time Pre	nared
				10 00/00/2021	11/16/2021 11	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Outpati ent	Inpatient	Inpatient	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.		Costs (col. 8	3	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVICE COST CENTERS			1	-1 -	-	
50. 00 05000 OPERATING ROOM	0. 000000	986, 509		0 0	0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	285, 883		0 0	0	54.00
54.01 03630 ULTRA SOUND	0. 000000	264, 412		0 0	0	54.01
57.00 05700 CT SCAN	0. 000000	177, 050		0 0	0	57.00
60. 00 06000 LABORATORY	0. 000000	4, 279, 412		0 0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0 0	0	63.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	7,032,663		0 8, 683	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	708, 712		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	804, 739		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	330, 181		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	0		0 0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	18, 087		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	887, 779		0 1, 066	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	3, 717, 601		0 5, 748	0	73.00
74.00 07400 RENAL DIALYSIS	0. 000000	845, 092		0 0	0	74.00
200.00 Total (lines 50 through 199)		20, 338, 120		0 15, 497	0	200.00

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Health Financial Systems ASCE	NSION ST VINCEN	T SETON SPECIA	LTY	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Period: From 07/01/2020 To 06/30/2021	Worksheet D Part V Date/Time Pre 11/16/2021 11	
		Title	e XVIII	Hospi tal	PPS	
			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	Subject To		
			Ded. & Coins.	Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 140855	0		0 0	0	
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 255856	0		0 0	0	54.00
54.01 03630 ULTRA SOUND	0. 036741	0		0 0	0	54.01
57.00 05700 CT SCAN	0. 027983	0		0 0	0	57.00
60. 00 06000 LABORATORY	0. 019801	0		0 0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0 0	0	63.00
65. 00 06500 RESPI RATORY THERAPY	0. 111025	8, 683		0 0	964	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 244220	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 234627	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 409177	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	0		0 0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 129768	0		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 105126	1, 066		0 0	112	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 290997	5, 748		0 1, 886	1, 673	73.00
74.00 07400 RENAL DIALYSIS	0. 306668	0		0 0	0	74.00
200.00 Subtotal (see instructions)		15, 497		0 1, 886	2, 749	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		15, 497		0 1, 886	2, 749	202.00

Health Financial Systems ASCEN	SION ST VINCENT	SETON SPECIAL	LTY	In Lieu of Form CMS-2552-10			
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CC		Period: From 07/01/2020 To 06/30/2021	Worksheet D Part V Date/Time Pre 11/16/2021 11		
		Title	XVIII	Hospi tal	PPS		
	Cos	ts					
Cost Center Description	Cost	Cost					
	Reimbursed	Reimbursed					
	Servi ces	Services Not					
	Subject To	Subject To					
		Ded. & Coins.					
	(see inst.)	(see inst.)					
	6.00	7.00					
ANCI LLARY SERVI CE COST CENTERS						-	
50.00 O5000 OPERATING ROOM	0	0				50.00	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00	
54.01 03630 ULTRA SOUND	0	0				54.01	
57.00 05700 CT SCAN	0	0				57.00	
60. 00 06000 LABORATORY	0	0				60.00	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0				63.00	
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 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	549				73.00	
74.00 07400 RENAL DIALYSIS	0	0				74.00	
200.00 Subtotal (see instructions)	0	549				200.00	
201.00 Less PBP Clinic Lab. Services-Program	0					201.00	
Only Charges							
202.00 Net Charges (line 200 - line 201)	0	549				202.00	

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Health Financial Systems ASC	ASCENSION ST VINCENT SETON SPECIALTY In Lieu of Form CM					
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider C	Provider CCN: 15-2020		Worksheet D Part I Date/Time Pre 11/16/2021 11	pared: :30 am
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Capital Related Cost (from Wkst. B,	Swing Bed Adjustment	Reduced Capital Related Cost	Days	Per Diem (col. 3 / col. 4)	
	Part II, col. 26)		(col. 1 - col 2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS		•	•	·		
30.00 ADULTS & PEDIATRICS	1, 086, 243	0	1, 086, 24	3 12, 899	84.21	30.00
200.00 Total (lines 30 through 199)	1, 086, 243		1, 086, 24	3 12, 899		200.00
Cost Center Description	Inpatient Program days	Inpatient Program		-		
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	103	8, 674				30.00
200.00 Total (lines 30 through 199)	103	8, 674				200. 00

Health Financial Systems ASCE	NSION ST VINCEN	SION ST VINCENT SETON SPECIALTY			In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provider C		Period: From 07/01/2020 To 06/30/2021	Worksheet D Part II Date/Time Pre 11/16/2021 11		
		Titl	e XIX	Hospi tal	Cost		
Cost Center Description	Capi tal	Total Charges		t Inpatient	Capital Costs		
		(from Wkst. C,		Program	(column 3 x		
	(from Wkst. B,		(col. 1 ÷ col	. Charges	column 4)		
	Part II, col.	8)	2)				
	26)						
	1.00	2.00	3.00	4.00	5.00		
ANCI LLARY SERVICE COST CENTERS							
50. 00 05000 OPERATING ROOM	14, 137						
54.00 05400 RADI OLOGY-DI AGNOSTI C	16, 405					54.00	
54.01 03630 ULTRA SOUND	411					54.01	
57.00 05700 CT SCAN	3, 682					57.00	
60. 00 06000 LABORATORY	8, 094	10, 858, 313			136	60.00	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.00000		0	63.00	
65. 00 06500 RESPI RATORY THERAPY	54, 619					65.00	
66. 00 06600 PHYSI CAL THERAPY	16, 757					66.00	
67.00 06700 OCCUPATI ONAL THERAPY	18, 185					67.00	
68.00 06800 SPEECH PATHOLOGY	17, 426	989, 690			116	68.00	
69. 00 06900 ELECTROCARDI OLOGY	0	0	0.00000		0	69.00	
70. 00 07000 ELECTROENCEPHALOGRAPHY	54		0. 00257		0	70.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4, 670	2, 197, 346	0. 00212	5 14,072	30	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.00000	0 0	0	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	84, 654	10, 709, 534	0.00790	5 209, 452	1, 656	73.00	
74.00 07400 RENAL DIALYSIS	13, 698	2, 286, 403	0.00599	1 0	0	74.00	
200.00 Total (lines 50 through 199)	252, 792	56, 597, 867		848, 660	3, 454	200. 00	

Health Financial Systems ASCE	NSION ST VINCEN	IT SETON SPECIA	LTY	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER P	ASS THROUGH COS			Period: From 07/01/2020 To 06/30/2021	Date/Time Pre 11/16/2021 11	
	-		e XIX	Hospi tal	Cost	
Cost Center Description	Nursing School	Nursing School	Allied Healt	Allied Health	All Other	
	Post-Stepdown		Post-Stepdow	n Cost	Medi cal	
	Adjustments		Adjustments		Education Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS	_					
30. 00 03000 ADULTS & PEDI ATRI CS	0	0		0 0	0	30.00
200.00 Total (lines 30 through 199)	0	0		0 0	0	200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patien <sup>-</sup>	Per Diem (col.	I npati ent	
	Adj ustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,	-			
	instructions)	minus col. 4)				
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	12, 89	9 0.00	103	30.00
200.00 Total (lines 30 through 199)		0	12, 89	9	103	200.00
Cost Center Description	I npati ent		•	·		
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0					30.00
200.00 Total (lines 30 through 199)	0					200.00

Health Financial Systems ASCE	u of Form CMS-2	2552-10				
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	S Provider C		Period:	Worksheet D	
THROUGH COSTS				From 07/01/2020		aarad.
				To 06/30/2021	Date/Time Pre 11/16/2021 11	
		Titl	e XIX	Hospi tal	Cost	<u>. 50 ulli</u>
Cost Center Description	Non Physician	Nursing School	Nursing Schoo	Allied Health	Allied Health	
		Post-Stepdown		Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	C		0 0	0	50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0	)	0 0	0	54.00
54.01 03630 ULTRA SOUND	0	0		0 0	0	54.01
57.00 05700 CT SCAN	0	0		0 0	0	57.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0	63.00
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 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0		0 0	0	74.00
200.00 Total (lines 50 through 199)	0	0		0 0	0	200. 00

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Health Financial Systems ASCE	In Lie	u of Form CMS-2	2552-10			
				Period:	Worksheet D	
THROUGH COSTS				From 07/01/2020 To 06/30/2021		narod
			10 00/ 30/ 2021	11/16/2021 11		
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
	Education Cost	1, 2, 3, and	Cost (sum of		(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			1			
50. 00 05000 OPERATING ROOM	0	0		2, 399, 958		50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 710, 958		54.00
54. 01 03630 ULTRA SOUND	0	0		504, 861		54.01
57. 00 05700 CT SCAN	0	0		0 421, 012		57.00
60. 00 06000 LABORATORY	0	0		0 10, 858, 313		
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0.00000	63.00
65. 00 06500 RESPI RATORY THERAPY	0	0		21, 262, 029		
66. 00 06600 PHYSI CAL THERAPY	0	0		2, 008, 572		66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		2, 228, 246		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		989, 690		68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0.00000	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		20, 945		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		2, 197, 346		
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0.00000	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 10, 709, 534		73.00
74.00 07400 RENAL DI ALYSI S	0	0		2, 286, 403		
200.00  Total (lines 50 through 199)	0	0		56, 597, 867		200.00

Health Financial Systems ASCENSION ST VINCENT SETON SPECIALTY In Lieu of Form CMS-2552-							
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	RVICE OTHER PASS	Provider CO	CN: 15-2020	Period: From 07/01/2020 To 06/30/2021	Worksheet D Part IV Date/Time Pre 11/16/2021 11		
			e XIX	Hospi tal	Cost		
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent		
	Ratio of Cost	Program	Program	Program	Program		
	to Charges	Charges	Pass-Through		Pass-Through		
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9		
	7)		x col. 10)		x col. 12)		
	9.00	10.00	11.00	12.00	13.00		
ANCI LLARY SERVI CE COST CENTERS	TT		1				
50.00 05000 OPERATI NG ROOM	0. 000000	6, 730		0 0	-	50.00	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	3, 872		0 0	0	54.00	
54.01 03630 ULTRA SOUND	0. 000000	8, 160		0 0	0	54.01	
57.00 05700 CT SCAN	0. 000000	5, 950		0 0	0	57.00	
60. 00 06000 LABORATORY	0. 000000	182, 351		0 0	0	60.00	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0 0	0	63.00	
65. 00 06500 RESPI RATORY THERAPY	0. 000000	363, 729		0 0	0	65.00	
66. 00 06600 PHYSI CAL THERAPY	0. 000000	25, 213		0 0	0	66.00	
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	22, 532		0 0	0	67.00	
68.00 06800 SPEECH PATHOLOGY	0. 000000	6, 599		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	14, 072		0 0	0	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0	0	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	209, 452		0 0	0	73.00	
74.00 07400 RENAL DIALYSIS	0. 000000	0		0 0	0	74.00	
200.00 Total (lines 50 through 199)		848, 660		0 0	0	200. 00	

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ASCENSI ON	ST	<b>VI NCENT</b>	SETON	SPECI ALTY	

	Financial         Systems         ASCENSION         ST         VINCENT           ATION         OF         INPATIENT         OPERATING         COST         C	Provider CCN: 15-2020	Peri od:	u of Form CMS-2 Worksheet D-1	
			From 07/01/2020 To 06/30/2021	Date/Time Pre	
			10 06/30/2021	11/16/2021 11	
	Cost Center Description	Title XVIII	Hospi tal	PPS	
				1.00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				-
00	Inpatient days (including private room days and swing-bed day	ys, excluding newborn)		12, 899	1 1.
00	Inpatient days (including private room days, excluding swing-	bed and newborn days)		12, 899	
00	Private room days (excluding swing-bed and observation bed da	ays). If you have only pr	rivate room days,	0	3
00	do not complete this line. Semi-private room days (excluding swing-bed and observation b	ped days)		12, 899	4
00	Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	0	
~~	reporting period		21 -6	0	
00	Total swing-bed SNF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line)	bolin days) al ter becember	31 OF THE COST	0	6
00	Total swing-bed NF type inpatient days (including private roc	om days) through December	31 of the cost	0	7
~~	reporting period			0	
00	Total swing-bed NF type inpatient days (including private roc reporting period (if calendar year, enter 0 on this line)	om days) arter December 3	or the cost	0	8
00	Total inpatient days including private room days applicable t	to the Program (excluding	g swing-bed and	4,654	9
00	newborn days) (see instructions)	anly (including private a	and and a	0	10
. 00	Swing-bed SNF type inpatient days applicable to title XVIII of through December 31 of the cost reporting period (see instruc		oom days)	0	10
. 00	Swing-bed SNF type inpatient days applicable to title XVIII o	only (including private m	room days) after	0	11
00	December 31 of the cost reporting period (if calendar year, e		a ream day(c)	0	11
. 00	Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period	x only (Including privat	.e room days)	0	12
. 00	Swing-bed NF type inpatient days applicable to titles V or XI			0	13
00	after December 31 of the cost reporting period (if calendar y			0	1.1
00 00	Medically necessary private room days applicable to the Progr Total nursery days (title V or XIX only)	"am (excluding swing-bed	days)	0	
	Nursery days (title V or XIX only)			0	
~ ~	SWING BED ADJUSTMENT		<u></u>		
. 00	Medicare rate for swing-bed SNF services applicable to servic reporting period	ces through December 31 d	of the cost	0.00	11/
00	Medicare rate for swing-bed SNF services applicable to servic	ces after December 31 of	the cost	0.00	18
. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	es through December 31 of	f the cost	0.00	19
. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	os after December 21 of t	ho cost	0.00	20
. 00	reporting period	es arter becember 51 01	the cost	0.00	20
. 00	Total general inpatient routine service cost (see instruction			16, 033, 936	
. 00	Swing-bed cost applicable to SNF type services through Decemb 5 x line 17)	per 31 of the cost report	ing period (line	0	22
. 00	Swing-bed cost applicable to SNF type services after December	- 31 of the cost reportir	ng period (line 6	0	23
	x line 18)		3 I X	-	
. 00	Swing-bed cost applicable to NF type services through December 7 x line 19)	er 31 of the cost reporti	ng period (line	0	24
. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25
	x line 20)				
. 00 .	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		0 16, 033, 936	
. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			10,033,730	2'
	General inpatient routine service charges (excluding swing-be	ed and observation bed ch	narges)		28
. 00	Private room charges (excluding swing-bed charges)			0	
. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.000000	
00	Average private room per diem charge (line 29 ÷ line 3)	.,		0.00	32
. 00	Average semi-private room per diem charge (line 30 ÷ line 4)		ati ana)	0.00	
00 00	Average per diem private room charge differential (line 32 mi Average per diem private room cost differential (line 34 x li		strons)	0.00 0.00	
. 00	Private room cost differential adjustment (line 3 x line 35)			0.00	
. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	16, 033, 936	
	27 minus line 36)				1
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	JUSTMENTS			
. 00	Adjusted general inpatient routine service cost per diem (see			1, 243. 04	38
. 00					1 00
. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progr			5, 785, 108 0	

lealth Financial Sys	tems AS(	CENSION ST VINCEN	T SETON SPECIA	LTY	ln Li€	eu of Form CMS-	2552-		
COMPUTATION OF INPAT	IENT OPERATING COST		Provider C		Period:	Worksheet D-1	1		
					From 07/01/2020 To 06/30/2021		narod		
					10 00/ 30/ 2021	11/16/2021 11			
				× XVIII	Hospi tal	PPS			
Cost Ce	iter Description	Total	Total	Average Per	Program Days	Program Cost			
		Inpatient Cost	Inpatient Days		÷	(col. 3 x col.			
		1.00	2.00	<u>col.2)</u> 3.00	4.00	4) 5.00	+		
42.00 NURSERY (titl	eV&XIX only)	1.00	2.00	3.00	4.00	5.00	42. (		
	e Type Inpatient Hospital Uni	ts		1					
3.00 INTENSIVE CAR	E UNIT						43.0		
4.00 CORONARY CARE							44.0		
5.00 BURN INTENSIV							45.0		
	NSIVE CARE UNIT						46. (		
7.00 OTHER SPECIAL	CARE (SPECIFY)						47.0		
COST CE	ter bescription					1.00			
8.00 Program inpat	ient ancillary service cost (	Wkst. D-3, col. 3	, line 200)			3, 025, 954	48.0		
	inpatient costs (sum of line			ns)		8, 811, 062	49. (		
	COST ADJUSTMENTS								
0	costs applicable to Program i	npatient routine	services (from	ıWkst. D, sum	of Parts I and	391, 913	3 50.0		
						00.405			
51.00 Pass through and IV)	costs applicable to Program i	npatient anciiiar	y services (tr	OM WKST. D, SL	um of Parts II	90, 105	5 51.0		
	excludable cost (sum of line	s 50 and 51)				482, 018	52.0		
	inpatient operating cost exc		lated non-phy	vsician anesth∉	etist and	8, 329, 044			
5	tion costs (line 49 minus line	5 1							
	AND LIMIT COMPUTATION	·							
4.00 Program disch						0			
	per di scharge					0.00			
U U	(line 54 x line 55)					0			
	tween adjusted inpatient oper	ating cost and ta	rget amount (I	ine 56 minus I	ine 53)	0			
	(see instructions)	reporting period	anding 1004	undated and as	mounded by the	0.00			
9.00 Lesser of lir market basket									
	es 53/54 or 55 from prior yea	r cost report up	dated by the m	arket basket		0.00	60.		
	is less than the lower of li				the amount by	0			
	ng costs (line 53) are less t								
amount (line	56), otherwise enter zero (se	e instructions)			Ū				
	t (see instructions)					0			
	atient cost plus incentive pa	yment (see instru	ictions)			0	63. (		
	ENT ROUTINE SWING BED COST	acto through Doco	mbor 21 of the		a poriod (Soo	0	64. (		
	g-bed SNF inpatient routine c (title XVIII only)	osts through bece		cost reportir	ig period (see	0	04.0		
	g-bed SNF inpatient routine c	osts after Decemb	er 31 of the c	ost reporting	period (See	0	65. (		
instructions)	(title XVIII only)			1 5					
6.00 Total Medicar	e swing-bed SNF inpatient rou	tine costs (line	64 plus line 6	5)(title XVIII	only). For	0	66. (		
CAH (see inst									
	X swing-bed NF inpatient rout	ine costs through	December 31 c	of the cost rep	porting period	0	67.0		
(line 12 x li	· ·	ina agata aftar D	acombor 21 of	the east range	ting ported	0			
	X swing-bed NF inpatient rout	The costs after D	ecember 31 of	the cost repor	ting period	0	68. (		
(line 13 x li 59.00  Total title V	or XIX swing-bed NF inpatien	t routine costs (	line 67 + line	e 68)		0	69. (		
	LLED NURSING FACILITY, OTHER					-			
	ng facility/other nursing fac						70. (		
	ral inpatient routine service		ine 70 ÷ line	2)			71.		
5	ne service cost (line 9 x lin	· ·		25			72.		
	essary private room cost appl	-					73.		
Ų	general inpatient routine se ed cost allocated to inpatien	•			art II column		74.		
26, line 45)	su cost an ocateu to impatien	L TOULTHE SELVICE	- CUSIS (ITUII M	UNINSHEEL B, Pa	artir, corunn		75.		
	tal-related costs (line 75 ÷	line 2)					76.		
	al-related costs (line 9 x li						77.		
	tine service cost (line 74 mi						78.		
9.00 Aggregate cha	rges to beneficiaries for exc	ess costs (from p	rovider record	ls)			79.		
Ū	routine service costs for co	•	ost limitation	ι (line 78 minι	us line 79)		80.		
	tine service cost per diem li		`				81.		
	tine service cost limitation	•					82.		
3.00  Reasonable ir	patient routine service costs	•	is)				83.		
	ient ancillary services (see		une)				84. 85.		
4.00 Program inpat	eview - physician compensatio						85.		
4.00 Program inpat 5.00 Utilization r	Innatient operating costs (c					1	- 00.		
84.00 Program inpat 85.00 Utilization r 86.00 <u>Total Program</u>	inpatient operating costs (s PUTATION OF OBSERVATION BED PA		5 7						
34.00Program inpat35.00Utilization r36.00Total ProgramPART IV - COM	INPATION OF OBSERVATION BED P Tion bed days (see instruction	ASS THROUGH COST				0	87.		
4.00 Program inpat 5.00 Utilization r 6.00 PART IV - COM 7.00 Total observa	PUTATION OF OBSERVATION BED PA	ASS THROUGH COST ns)					) 87. ) 88.		

Health Financial Systems ASCE	ASCENSION ST VINCENT SETON SPECIALTY In Lieu of Form CMS-2					
COMPUTATION OF INPATIENT OPERATING COST				Period: From 07/01/2020	Worksheet D-1	
				To 06/30/2021	Date/Time Pre 11/16/2021 11	pared: :30 am_
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST					
90.00 Capital-related cost	1, 086, 243	16, 033, 936	0.06774	6 0	0	90.00
91.00 Nursing School cost	0	16, 033, 936	0.00000	0 0	0	91.00
92.00 Allied health cost	0	16, 033, 936	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	16, 033, 936	0. 00000	0 0	0	93.00

<sup>11/16/2021 11: 30</sup> am D: \Shared drives\Finance\_Net Revenue\_IN - Acute\Reimbursement\Cost Reports\FY2021\Seton\152020.FY2021.mcrx

## ASCENSION ST VINCENT SETON SPECIALTY

In Lieu of Form CMS-2552-10

<u>Heal th</u>	Financial Systems ASCENSION ST VINCENT S	SETON SPECIALTY	In Lie	u of Form CMS-2	<u>2552-10</u>
COMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-2020	Period: From 07/01/2020	Worksheet D-1	
			To 06/30/2021	Date/Time Pre	pared:
				11/16/2021 11	
	Cost Center Description	Title XIX	Hospi tal	Cost	
	cost center bescription			1.00	
	PART I - ALL PROVIDER COMPONENTS				
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			12, 899	1.00
2.00 3.00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed day		rivate room days	12, 899 0	2.00 3.00
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)		12, 899	4.00
5.00	Total swing-bed SNF type inpatient days (including private roo	om days) through Decembe	er 31 of the cost	0	5.00
6.00	reporting period Total swing-bed SNF type inpatient days (including private roo	om davc) after Decomber	21 of the cost	0	6.00
0.00	reporting period (if calendar year, enter 0 on this line)	on days) at ter becenber	ST OF THE COST	0	0.00
7.00	Total swing-bed NF type inpatient days (including private room	m days) through December	31 of the cost	0	7.00
	reporting period				
8.00	Total swing-bed NF type inpatient days (including private room	m days) after December 3	31 of the cost	0	8.00
9.00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	o the Program (excluding	swing_bed and	103	9.00
7.00	newborn days) (see instructions)		g sinnig bed and	100	7.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII on		room days)	0	10.00
	through December 31 of the cost reporting period (see instruc				
11.00	Swing-bed SNF type inpatient days applicable to title XVIII on December 31 of the cost reporting period (if calendar year, en		room days) arter	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX		te room days)	0	12.00
	through December 31 of the cost reporting period		5.		
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13.00
14.00	after December 31 of the cost reporting period (if calendar ye Medically necessary private room days applicable to the Progra			0	14.00
14.00	Total nursery days (title V or XIX only)	am (excluding swing-bed	uays)	0	15.00
16.00	Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 d	of the cost	0.00	17.00
18.00	reporting period Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18.00
101 00	reporting period			0100	10100
19.00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	f the cost	0.00	19.00
20.00	reporting period	c ofter December 21 of t	the cost	0.00	20.00
20.00	Medicaid rate for swing-bed NF services applicable to services reporting period	Salter December 31 01	the cost	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions	s)		16, 033, 936	21.00
22.00	Swing-bed cost applicable to SNF type services through December	er 31 of the cost report	ting period (line	0	22.00
22.00	5 x line 17) Swing-bed cost applicable to SNF type services after December	21 of the east reporting	a ported (line (	0	22.00
23.00	x line 18)	ST OF THE COST TEPOLITY	ig period (The o	0	23.00
24.00	Swing-bed cost applicable to NF type services through December	r 31 of the cost reporti	ng period (line	0	24.00
	7 x line 19)				
25.00	Swing-bed cost applicable to NF type services after December 3 x line 20)	31 of the cost reporting	g period (line 8	0	25.00
26.00	Total swing-bed cost (see instructions)			0	26.00
27.00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		16, 033, 936	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	narges)	0	28.00
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	
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34.00	Average per diem private room charge differential (line 32 min		ctions)	0.00	
35.00 36.00	Average per diem private room cost differential (line 34 x lin Private room cost differential adjustment (line 3 x line 35)	ne 31)		0. 00 0	35.00 36.00
37.00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	16, 033, 936	
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU			1, 243. 04	20 00
38 00				1. 243. 04	1 JO. UU
38.00 39.00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line				
38. 00 39. 00 40. 00	Program general inpatient routine service cost per drem (see Medically necessary private room cost applicable to the Program	38)		128, 033 0	

Heal th	Fi nanci al	Systems	

alth Financial Systems	ASCENSION ST VINCENT	SETON SPECIA	LTY .	In Lie	eu of Form CMS-2	2552
OMPUTATION OF INPATIENT OPERATING COST		Provider CC		Peri od:	Worksheet D-1	l
				From 07/01/2020 To 06/30/2021		
				To 06/30/2021	Date/Time Pre 11/16/2021 11	
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
	Inpatient Costli	npatient Days		÷	(col. 3 x col.	
			col. 2)		4)	
	1.00	2.00	3.00	4.00	5.00	
.00 NURSERY (title V & XIX only) Intensive Care Type Inpatient Hos	ni tal Uni ta				l	42
.00 INTENSIVE CARE UNIT						4
. OO CORONARY CARE UNIT			1			4
00 BURN INTENSIVE CARE UNIT			1			4
00 SURGI CAL INTENSI VE CARE UNI T						4
00 OTHER SPECIAL CARE (SPECIFY)			1		ĺ	4
Cost Center Description						
					1.00	
00 Program inpatient ancillary serv					122, 973	
.00 Total Program inpatient costs (si	<u>m of lines 41 through 48)(s</u>	ee instructio	ns)		251,006	49
PASS THROUGH COST ADJUSTMENTS		1 (6				
.00 Pass through costs applicable to	Program inpatient routine s	services (from	Wkst. D, sum	of Parts I and	0	50
.00 Pass through costs applicable to	Program inpationt ancillary	sorvicos (fr	om What D a	um of Parts II	0	5
and IV)		Services (II	JIII WKSt. D, S			1
2.00 Total Program excludable cost (s	m of lines 50 and 51)				0	52
8.00 Total Program inpatient operation		ated, non-phy	sician anesth	etist, and	0	
medical education costs (line 49	minus line 52)	1.3				
TARGET AMOUNT AND LIMIT COMPUTATI	NC					
.00 Program discharges					0	
.00 Target amount per discharge					0.00	
. 00 Target amount (line 54 x line 55					0	
. 00 Difference between adjusted inpa	ient operating cost and tar	get amount (I	ine 56 minus	line 53)	0	
. 00 Bonus payment (see instructions)	the cost reporting period a	nding 1004 u	ndated and co	mounded by the	0	
.00 Lesser of lines 53/54 or 55 from market basket	the cost reporting period e	andi ng 1996, iu	puated and co	inpounded by the	0.00	'  <sup>5</sup>
. 00 Lesser of lines 53/54 or 55 from	prior year cost report upd	lated by the m	arket basket		0.00	6
.00 If line 53/54 is less than the lo				the amount by	0	
which operating costs (line 53)						
amount (line 56), otherwise ente				5	1	
2.00 Relief payment (see instructions)					0	
.00 Allowable Inpatient cost plus in		tions)			0	63
PROGRAM INPATIENT ROUTINE SWING E						
.00 Medicare swing-bed SNF inpatient	routine costs through Decem	iber 31 of the	cost reporti	ng period (See	0	64
. 00 Medicare swing-bed SNF inpatient	routing costs after Decembe	r 21 of the e	oct roporting	pariad (Saa	0	65
instructions) (title XVIII only)	Toutifie costs after beceilibe		JSt Teporting	perrou (see		
5.00 Total Medicare swing-bed SNF inp	tient routine costs (line 6	4 plus line 6	5)(title XVII	lonly) For	0	66
CAH (see instructions)			5)((1110))(111)		Ĭ	
.00 Title V or XIX swing-bed NF inpa	ient routine costs through	December 31 o	f the cost re	porting period	0	6
(line 12 x line 19)	-					
8.00 Title V or XIX swing-bed NF inpa	ient routine costs after De	ecember 31 of	the cost repo	rting period	0	68
(line 13 x line 20)					-	
. 00 Total title V or XIX swing-bed N			,		0	6
PART III - SKILLED NURSING FACILI						1 -,
00 Skilled nursing facility/other n 00 Adjusted general inpatient routi						7(   7 <sup>.</sup>
.00 Adjusted general inpatient routin .00 Program routine service cost (lin		ne 70 - Tine	2)			7
. 00 Medically necessary private room	•	(line 14 x li	ne 35)		1	7
.00 Total Program general inpatient			,		1	7
. 00 Capital -related cost allocated to			orksheet B, P	art II, column	1	7
26, line 45)					1	
.00 Per diem capital-related costs (	ine 75 ÷ line 2)				1	7
.00 Program capital-related costs (1	ne 9 x line 76)					7
.00 Inpatient routine service cost (						7
.00 Aggregate charges to beneficiari			•			7
.00  Total Program routine service cos	•	ost limitation	(line 78 min	us line 79)		8
						8
	•					8
.00 Inpatient routine service cost i		5)				8
.00 Inpatient routine service cost I .00 Reasonable inpatient routine serv	-				1	8
<ul> <li>.00 Inpatient routine service cost i</li> <li>.00 Reasonable inpatient routine service</li> <li>.00 Program inpatient ancillary service</li> </ul>	ces (see instructions)			1	1	
<ul> <li>.00 Inpatient routine service cost i</li> <li>.00 Reasonable inpatient routine service</li> <li>.00 Program inpatient ancillary service</li> <li>.00 Utilization review - physician cost</li> </ul>	ces (see instructions) mpensation (see instruction					
<ul> <li>.00 Inpatient routine service cost I</li> <li>.00 Reasonable inpatient routine service</li> <li>.00 Program inpatient ancillary service</li> <li>.00 Utilization review - physician control</li> <li>.00 Total Program inpatient operation</li> </ul>	ces (see instructions) mpensation (see instruction costs (sum of lines 83 thr					
<ul> <li>2.00 Inpatient routine service cost i</li> <li>2.00 Reasonable inpatient routine service</li> <li>2.00 Program inpatient ancillary service</li> <li>2.00 Utilization review - physician control</li> <li>2.00 Total Program inpatient operation</li> <li>2.00 PART IV - COMPUTATION OF OBSERVATION</li> </ul>	ces (see instructions) mpensation (see instruction costs (sum of lines 83 thr ION BED PASS THROUGH COST					8!
<ul> <li>.00 Inpatient routine service cost I</li> <li>.00 Reasonable inpatient routine service</li> <li>.00 Program inpatient ancillary service</li> <li>.00 Utilization review - physician control</li> <li>.00 Total Program inpatient operation</li> </ul>	ces (see instructions) mpensation (see instruction costs (sum of lines 83 thr ION BED PASS THROUGH COST nstructions)	rough 85)			0	80 81 81

Health Financial Systems ASCE	NSION ST VINCEN	T SETON SPECIA	LTY	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 07/01/2020	Worksheet D-1	
				To 06/30/2021	Date/Time Pre 11/16/2021 11	pared: :30 am_
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	1, 086, 243	16, 033, 936	0.06774	6 0	0	90.00
91.00 Nursing School cost	0	16, 033, 936	0.00000	0 0	0	91.00
92.00 Allied health cost	0	16, 033, 936	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	16, 033, 936	0. 00000	0 0	0	93.00

<sup>11/16/2021 11: 30</sup> am D: \Shared drives\Finance\_Net Revenue\_IN - Acute\Reimbursement\Cost Reports\FY2021\Seton\152020.FY2021.mcrx

Health Financial Systems ASCENSION ST VIN	CENT SETON SPECIA	LTY	In Lie	eu of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C		Period: From 07/01/2020 To 06/30/2021		epared:
	Title	XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cos To Charges	Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1	44.040.005		0.0.00
30. 00 03000 ADULTS & PEDIATRICS			14, 919, 635		30.00
ANCI LLARY SERVICE COST CENTERS 50. 00 05000 OPERATI NG ROOM		0. 14085	986, 509	138, 955	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 25585			•
54.01 03630 ULTRA SOUND		0. 03674			•
57.00 05700 CT SCAN		0. 02798			•
60. 00 06000 LABORATORY		0. 01980	4, 279, 412	84, 737	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.		0.00000	0 0	0	63.00
65. 00 06500 RESPI RATORY THERAPY		0. 11102	7, 032, 663	780, 801	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 24422	708, 712	173, 082	66.00
67.00 06700 OCCUPATI ONAL THERAPY		0. 23462	804, 739	188, 813	67.00
68.00 06800 SPEECH PATHOLOGY		0. 40917	7 330, 181	135, 102	68.00
69. 00 06900 ELECTROCARDI OLOGY		0.00000	0 0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY		0. 12976	8 18, 087	2, 347	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 10512	887, 779	93, 329	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0.00000	0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 29099	3, 717, 601	1, 081, 811	73.00
74. 00 07400 RENAL DIALYSIS		0. 30666	845, 092	259, 163	74.00
200.00 Total (sum of lines 50 through 94 and 96 through 98			20, 338, 120	3, 025, 954	200.00
201.00 Less PBP Clinic Laboratory Services-Program only ch	narges (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)			20, 338, 120		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT         Provider CN: 15-2020         Period: From 07/01/2020 To 06/30/2021         Worksheet D-3 Date/Time Prepared: 11/16/2021 11: 30 and Date/Time Prepared: 11/16/2021 11: 30 and Date/Time Prepared: 11/16/2021 11: 30 and Date/Time Prepared: 11/16/2021 11: 30 and Program Costs (col. 1 x col. 2)         Worksheet D-3 Date/Time Prepared: 11/16/2021 11: 30 and Program Costs (col. 1 x col. 2)           0         S0000 ADULTS & PEDI ATRICS ANCILLARY SERVICE COST CENTERS         Inpatient Program Costs (col. 1 x col. 2)         Program Costs (col. 1 x col. 2)         30.00           30.00         03000 ADULTS & PEDI ATRICS ANCILLARY SERVICE COST CENTERS         0.140855         6,730         948         50.00           54.00         05400 RADI COST OCT SCAN         0.140855         6,730         948         50.00           54.00         05400 RADI COST OCT SCAN         0.036741         8,160         300.05         46.00           54.00         05400 RADI COST OCT SCAN         0.014885         6,730         948         50.00           54.00         05400 RADI COST OCT SCAN         0.027983         5,950         1.66         57.00           65.00         06500 COST ORT NG, PROCESSI NG & TRANS.         0.019801         182.351         3.611         60.00           66.00         06600 SPECH PATHORY THERAPY         0.244220         25.213         6.158         66.00 <th>Health Financial Systems</th> <th>ASCENSION ST VINCENT SETON SPECIA</th> <th>LTY</th> <th>In Lie</th> <th>u of Form CMS-</th> <th>2552-10</th>	Health Financial Systems	ASCENSION ST VINCENT SETON SPECIA	LTY	In Lie	u of Form CMS-	2552-10
To         06/30/2021         Date/Time Prepared: 11/16/2021 11:30 am           Title XIX         Hospital         Cost           Inpatient To Charges         Inpatient Program Costs Col. 1 x col. 2)           InvATLENT ROUTINE SERVICE COST CENTERS           1.00         2.00         3.00           3.00 <t< td=""><td>INPATIENT ANCILLARY SERVICE COST APPORTIONMENT</td><td>Provider C</td><td></td><td></td><td>Worksheet D-3</td><td></td></t<>	INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C			Worksheet D-3	
Image: Construction         Title XIX         Hospital         Cost Conter Description           To Charges         Charges         Inpatient Program Costs (col. 1 x col. 2)         Inpatient Program Costs (col. 1 x col. 2)           30.00         03000  ADULTS & PEDIATRICS         1.00         2.00         3.00           ANCILLARY SERVICE COST CENTERS         1.00         452,093         30.00           50.00         05000 (DERATING ROOM         0.140855         6,730         948         50.00           54.00         05000 (DGGV-DIARICS         0.140855         6,730         948         50.00           54.00         05000 (DGGV-DIARICS         0.140855         6,730         948         50.00           54.00         05000 (DGGV-DIARICSY         0.140855         6,730         948         50.00           54.00         05000 (DGGV-DIARICSY         0.140855         6,730         948         50.00           54.00         05000 (DABORATORY         0.027983         5,950         166         57.00           65.00         06500 RESPIRATORY THERAPY         0.111025         363,729         40,833         65.00           66.00         06600 SPEECH PATHOLOCY         0.049077         6,599         2,700         68.00         68.00         <					Dato/Timo Pro	narod
Title XIX         Hospital         Cost           Cost Center Description         Ratio of Cost To Charges         Inpatient Program Charges         Inpatient Program Charges         Inpatient Program Charges           0.00         03000 ADULTS & PEDIATRICS         1.00         2.00         3.00           0.00         05400 ADULTS & PEDIATRICS         452,093         30.00           0.00         05400 RADIOLOGY-DIAGNOSTIC         0.140855         6,730         948         50.00           54.00         05400 RADIOLOGY-DIAGNOSTIC         0.255856         3,872         991         54.00           54.01         03330 ULTRA SOUND         0.0140855         6,730         948         50.00           57.00         05700 CT SCAN         0.02783         5,950         166         57.00           63.00         06300 BLOD STORI NG, PROCESSING & TRANS.         0.011025         363.729         40.33         65.00           65.00         06600 OPEPATIORY THERAPY         0.244220         25.213         6,158         66.00           66.00         06600 SPEELRATORY THERAPY         0.244220         25.213         6,158         66.00           67.00         06600 SPEELCH PATHORY THERAPY         0.244220         25.213         6,158         66.00				10 00/ 30/ 2021		
INPATIENT ROUTINE SERVICE COST CENTERS         Program Costs (col 1 x col 2)           1.00         2.00         3.00           0.00         03000 ADULTS & PEDIATRICS         452.093         30.00           ANCILLARY SERVICE COST CENTERS         0.140855         6,730         948         50.00           50.00         05000         0PERATING ROOM         0.140855         6,730         948         50.00           54.00         05400 RADIOLOGY-DIAGNOSTI C         0.255856         3,872         941         50.00           54.00         05400 RADIOLOGY-DIAGNOSTI C         0.255856         3,872         941         50.00           54.00         05400 RADIOLOGY-DIAGNOSTI C         0.036741         8,160         300         54.01           57.00         05700 CT SCAN         0.019801         182,351         3,611         60.00           60.00         06000 LABORTORY         0.0111025         363,729         40.383         65.00           64.00         06500 RESPI RATORY THERAPY         0.244220         25.213         6.1586         60.00           67.00         06700 OCUPATI ONAL THERAPY         0.234627         22.532         5.287         67.00           68.00         06800 SPEECH PATHOLOCY         0.000000		Titl	e XIX	Hospi tal		
INPATIENT ROUTINE SERVICE COST CENTERS         Configes	Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
INPATI ENT ROUTI NE SERVI CE COST CENTERS         1.00         2.00         3.00           30.00         03000 ADULTS & PEDI ATRI CS         452,093         30.00           ANCI LLARY SERVI CE COST CENTERS         0.140855         6,730         948         50.00           50.00         05000 OPERATI NG ROOM         0.140855         6,730         948         50.00           54.01         03330         ULTRA SOUND         0.255856         3,872         991         54.00           57.00         05700         CT SCAN         0.036741         8,160         300         54.01           60.00         06000         LABORATORY         0.014801         182,351         3,611         60.00           63.00         06300         BLODD STORI NG, PROCESSI NG & TRANS.         0.000000         0         63.00           65.00         06500         RESPI RATORY THERAPY         0.111025         363,729         40,383         65.00           66.00         06000         PHYSI CAL THERAPY         0.244220         25,213         6,158         66.00           67.00         06700         DCUPATI ONAL THERAPY         0.244220         25,213         67.00         68.00         68.00         68.00         69.00         69.00			To Charges			
INPATI ENT ROUTI NE SERVI CE COST CENTERS           30. 00         03000  ADULTS & PEDI ATRI CS         452,093         30. 00           ANCI LLARY SERVI CE COST CENTERS         0. 140855         6,730         948         50. 00           50. 00         05000 OPERATI NG ROOM         0. 140855         6,730         948         50. 00           54. 00         05400 RADI OLOGY-DI AGNOSTI C         0. 255856         3,872         991         54. 01           55. 00         05700 CT SCAN         0. 036741         8. 160         300         54. 01           57. 00         05700 CT SCAN         0. 027983         5,950         166         57. 00           63. 00         06300 BLORD STORI NG, PROCESSI NG & TRANS.         0. 019801         182,351         3,611         60. 00           65. 00         06600 PHYSI CAL THERAPY         0. 111025         363,729         40,383         65. 00           66. 00         06600 PHYSI CAL THERAPY         0. 244220         25,213         6,158         66. 00           67. 00         06700 OCCUPATI ONAL THERAPY         0. 244220         25,213         6,158         66. 00           69. 00         06800 SPEECH PATHOLOGY         0. 409177         6,599         2,700         68. 00           69. 00 </td <td></td> <td></td> <td></td> <td>Charges</td> <td></td> <td></td>				Charges		
INPATI ENT ROUTINE SERVICE COST CENTERS         452,093         30.00           30.00         03000[ADULTS & PEDIATRICS ANCILLARY SERVICE COST CENTERS         452,093         30.00           50.00         05000[OPERATING ROOM         0.140855         6,730         948         50.00           54.00         05400[RADIOLOGY-DIAGNOSTIC         0.255856         3,872         991         54.01           54.01         03630         ULTRA SOUND         0.036741         8,160         300         54.01           57.00         05700[CT SCAN         0.027983         5,950         166         57.00           60.00         06000         LABORATORY         0.019801         182,351         3,611         60.00           63.00         06300         BLODD STORING, PROCESSING & TRANS.         0.019801         182,351         3,611         60.00           64.00         06600         PHYSICAL THERAPY         0.111025         363,729         40,383         65.00         66.00         66.00         0.6700         0.0244220         25,213         6,158         66.00         66.00         66.00         67.00         68.00         69.00         0.234627         22,532         5,287         67.00         68.00         69.00         0.129768 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td></t<>						
30. 00       O3000 ADULTS & PEDIATRICS       452,093       30. 00         ANCI LLARY SERVICE COST CENTERS       50. 00       05.000 (PERATI NG ROOM       0.140855       6,730       948       50. 00         54. 00       05400 RADI LOCY-DI AGNOSTI C       0.255856       3,872       991       54. 00         57. 00       05700 CT SCAN       0.036741       8,160       300       54. 01         57. 00       05700 CT SCAN       0.027983       5,950       166       57. 00         60.00       LABORATORY       0.019801       182,351       3, 611       60. 00         63.00       06300 BLODD STORI NG, PROCESSI NG & TRANS.       0.000000       0       63.00         65.00       06500 RESPI RATORY THERAPY       0.111025       363,729       40,383       65. 00         66.00       06600 PHYSI CAL THERAPY       0.244220       25,213       6,158       66. 00         67. 00       06700       0CUPATI ONAL THERAPY       0.244220       25,213       6,158       66. 00         69. 00       06800 SPEECH PATHOLOGY       0.409177       6,599       2,700       68. 00       69. 00       0       70. 00       69. 00       0       71. 00       69. 00       71. 00       71. 00       71. 00			1.00	2.00	3.00	
ANCI LLARY SERVICE COST CENTERS           50. 00         05000         OPERATI NG ROOM         0.140855         6,730         948         50. 00           54. 00         05400         RADI OLOGY-DI AGNOSTI C         0.255856         3,872         991         54. 00           54. 01         03630         JULTRA SOUND         0.036741         8,160         300         54. 01           57. 00         05700         CT SCAN         0.027983         5,950         166         57. 00           60. 00         06600         LABORATORY         0.019801         182, 351         3,611         60. 00           63. 00         06600         RESPI RATORY THERAPY         0.244220         25,213         6,158         66. 00           64. 00         06600         PHYSI CAL THERAPY         0.234627         22,532         5,287         67. 00           65. 00         06600         SPECH PATHOLOGY         0.244220         25,213         6,158         66. 00           69. 00         06900         ELECTROCARDI OLOGY         0.24627         22,532         5,287         67. 00           69. 00         06900         ELECTROCARDARDY         0.129768         0         0         70. 00           71. 00			1	150.000		
50.00         05000         0PERATING ROOM         0.140855         6,730         948         50.00           54.00         05400         RADI OLOGY-DI AGNOSTI C         0.255856         3.872         991         54.00           54.01         03630         ULTRA SOUND         0.036741         8,160         300         54.01           57.00         CT SCAN         0.027983         5,950         166         57.00           60.00         06300         LABORATORY         0.019801         182,351         3,611         60.00           63.00         06500         RESPI RATORY THERAPY         0.027983         5,950         166         63.00           66.00         04500         RESPI RATORY THERAPY         0.234627         22,521         6,158         66.00           66.00         O6500         CCUPATI ONAL THERAPY         0.234627         22,532         5,287         67.00         68.00         69.00         0.00000         0         69.00         69.00         69.00         69.00         69.00         69.00         69.00         69.00         69.00         69.00         69.00         70.00         68.00         0         70.00         68.00         0         70.00         69.00         70.				452, 093		30.00
54.00       05400       RADI OLOGY - DI AGNOSTI C       0.255856       3,872       991       54.00         54.01       03630       ULTRA SOUND       0.036741       8,160       300       54.01         57.00       05700       CT SCAN       0.027983       5,950       1.66       57.00         60.00       04000       LABORATORY       0.019801       182,351       3,611       60.00         63.00       06300       BLODD STORI NG, PROCESSI NG & TRANS.       0.000000       0       63.00         65.00       06500       RESPI RATORY THERAPY       0.111025       363,729       40,383       65.00         66.00       06600       PHYSI CAL THERAPY       0.244220       25,213       6,158       66.00         67.00       0C02UPATI ONAL THERAPY       0.234627       22,532       5,287       67.00         68.00       06900       ELECTROCENDI OLOGY       0.000000       0       0       69.00         70.00       07000       ELECTROCARDI OLOGY       0.105126       14,072       1,479       71.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0.105126       14,072       1,479       71.00         72.00       07300			0.44005	- ( 700)	0.40	50.00
54.01       03630       ULTRA SOUND       0.036741       8,160       300       54.01         57.00       05700       CT SCAN       0.027983       5,950       166       57.00         60.00       06000       LABORATORY       0.019801       182.351       3,611       60.00         63.00       06300       BLOOD STORING, PROCESSING & TRANS.       0.000000       0       0       63.00         65.00       06500       RESPI RATORY THERAPY       0.244220       25,213       6,158       66.00         66.00       06600       PHYSI CAL THERAPY       0.234627       22,532       5,287       67.00         67.00       06700       OCCUPATI ONAL THERAPY       0.11025       363,729       40,383       65.00         68.00       06800       SPECH PATHOLOGY       0.234627       22,532       5,287       67.00         69.00       06900       ELECTROCARDI OLOGY       0.000000       0       0       69.00         70.00       07000       ELECTROCARDI OLOGY       0.129768       0       0       70.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0.100126       14,072       1,479       71.00         72.00						
57.00       05700       CT SCAN       0.027983       5,950       166       57.00         60.00       06000       LABORATORY       0.019801       182,351       3,611       60.00         63.00       06300       BLOOD STORI NG, PROCESSI NG & TRANS.       0.000000       0       63.00         65.00       06500       RESPI RATORY THERAPY       0.111025       363,729       40,383       65.00         66.00       06600       PHYSI CAL THERAPY       0.244220       25,213       6,158       66.00         67.00       06700       OCCUPATI ONAL THERAPY       0.244220       25,213       6,158       66.00         68.00       06800       SPEECH PATHOLOGY       0.409177       6,599       2,700       68.00         69.00       06900       ELECTROCARDI OLOGY       0.105126       14,072       1,479       71.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0.105126       14,072       1,479       71.00         72.00       07300       RENAL DI ALYSI S       0.290997       209,452       60,90       73.00         73.00       07400       RENAL DI ALYSI S       0.306668       0       0       74.00         200.00       <						
60.00       06000       LABORATORY       0.019801       182,351       3,611       60.00         63.00       06300       BLOOD STORING, PROCESSING & TRANS.       0.000000       0       63.00         65.00       06500       RESPIRATORY THERAPY       0.111025       363,729       40,383       65.00         66.00       06600       PHYSI CAL THERAPY       0.244220       25,213       6,158       66.00         67.00       06700       OCUPATI ONAL THERAPY       0.244220       25,213       6,158       66.00         68.00       06800       SPECH PATHOLOGY       0.409177       6,599       2,700       68.00         69.00       06900       ELECTROCARDI OLOGY       0.000000       0       0       69.00         71.00       07000       ELECTROCARDI OLOGY       0.105126       14,072       1,479       71.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0.105126       14,072       1,479       71.00         72.00       07300       DRUGS CHARGED TO PATI ENTS       0.290997       209,452       60,90       73.00         74.00       07400       RENAL DI ALYSI S       0.306668       0       0       74.00         200.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>						
63.00       06300       BLOOD STORI NG, PROCESSI NG & TRANS.       0.000000       0       63.00         65.00       06500       RESPI RATORY THERAPY       0.111025       363,729       40,383       65.00         66.00       06600       PHYSI CAL THERAPY       0.244220       25,213       6,158       66.00         67.00       06700       OCCUPATI ONAL THERAPY       0.234627       22,532       5,287       67.00         68.00       06800       SPEECH PATHOLOGY       0.409177       6,599       2,700       68.00         69.00       06900       ELECTROCARDI OLOGY       0.000000       0       0       69.00         70.00       07000       ELECTROENCEPHALOGRAPHY       0.129768       0       0       70.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENTS       0.105126       14,072       1,479       71.00         72.00       07300       DRUGS CHARGED TO PATIENTS       0.290997       209,452       60,505       73.00         74.00       07400       RENAL DI ALYSI S       0.306668       0       0       74.00         200.00       Less PBP Clinic Laboratory Services-Program only charges (line 61)       0       201.00       201.00						
65.00       06500       RESPI RATORY THERAPY       0.111025       363,729       40,383       65.00         66.00       06600       PHYSI CAL THERAPY       0.244220       25,213       6,158       66.00         67.00       06700       OCCUPATI ONAL THERAPY       0.234627       22,532       5,287       67.00         68.00       06800       SPEECH PATHOLOGY       0.409177       6,599       2,700       68.00         69.00       06900       ELECTROCARDI OLOGY       0.000000       0       0       69.00         70.00       07000       ELECTROENCEPHALOGRAPHY       0.129768       0       0       70.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0.105126       14,072       1,479       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0.290997       209,452       60,950       73.00         73.00       07400       RENAL DI ALYSI S       0.306668       0       0       74.00         200.00       Total (sum of lines 50 through 94 and 96 through 98)       848,660       122,973       200.00         201.00       Less PBP Clinic Laboratory Services-Program only charges (line 61)       0       201.00       201.00       201.00						•
66.00       06600       PHYSI CAL THERAPY       0.244220       25, 213       6, 158       66.00         67.00       06700       0CCUPATI ONAL THERAPY       0.234627       22, 532       5, 287       67.00         68.00       06800       SPEECH PATHOLOGY       0.409177       6, 599       2, 700       68.00         69.00       06900       ELECTROCARDI OLOGY       0.000000       0       0       69.00         70.00       07000       ELECTROENCEPHALOGRAPHY       0.129768       0       0       70.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0.105126       14, 072       1, 479       71.00         72.00       07200       IMPL.       DEV. CHARGED TO PATI ENTS       0.290997       209, 452       60, 950       73.00         73.00       07400       RENAL DI ALYSI S       0.30668       0       0       74.00         200.00       Total (sum of lines 50 through 94 and 96 through 98)       848, 660       122, 973       200.00       201.00       201.00       201.00       0       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>						
67.00       06700       OCCUPATIONAL THERAPY       0.234627       22,532       5,287       67.00         68.00       06800       SPEECH PATHOLOGY       0.409177       6,599       2,700       68.00         69.00       06900       ELECTROCARDIOLOGY       0.000000       0       0       69.00         70.00       07000       ELECTROENCEPHALOGRAPHY       0.129768       0       0       70.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENTS       0.105126       14,072       1,479       71.00         72.00       07200       IMPL.       DEV. CHARGED TO PATIENTS       0.290997       209,452       60,950       73.00         73.00       07300       RENAL DI ALYSI S       0.306668       0       0       74.00         200.00       Ess PBP Clinic Laboratory Services-Program only charges (line 61)       0       201.00       201.00       201.00       201.00       0       122,973       200.00						
68.00       06800       SPEECH PATHOLOGY       0.409177       6,599       2,700       68.00         69.00       06900       ELECTROCARDIOLOGY       0.000000       0       0       69.00         70.00       07000       ELECTROENCEPHALOGRAPHY       0.129768       0       0       70.00         71.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENTS       0.105126       14,072       1,479       71.00         72.00       07200       IMPL.       DEV. CHARGED TO PATIENTS       0.290997       209,452       60,950       73.00         73.00       07400       RENAL DIALYSIS       0.306668       0       0       74.00         200.00       Total (sum of lines 50 through 94 and 96 through 98)       848,660       122,973       200.00         201.00       Less PBP Clinic Laboratory Services-Program only charges (line 61)       0       201.00       201.00						•
69.00       06900       ELECTROCARDIOLOGY       0.000000       0       0       69.00         70.00       07000       ELECTROENCEPHALOGRAPHY       0.129768       0       70.00         71.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENTS       0.105126       14,072       1,479       71.00         72.00       07200       IMPL.       DEV. CHARGED TO PATIENTS       0.000000       0       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0.290997       209,452       60,950       73.00         74.00       07400       RENAL DIALYSIS       0.306668       0       0       74.00         200.00       Less PBP Clinic Laboratory Services-Program only charges (line 61)       0       201.00       201.00						
70. 00         07000         ELECTROENCEPHALOGRAPHY         0.129768         0         70. 00           71. 00         07100         MEDI CAL SUPPLIES CHARGED TO PATIENTS         0.105126         14,072         1,479         71. 00           72. 00         07200         IMPL. DEV. CHARGED TO PATIENTS         0.000000         0         72. 00           73. 00         07300         DRUGS CHARGED TO PATIENTS         0.290997         209,452         60,950         73. 00           74. 00         07400         RENAL DI ALYSI S         0.306668         0         0         74. 00           200. 00         Less PBP Clinic Laboratory Services-Program only charges (line 61)         0         020. 00         201. 00         201. 00         0         201. 00         0         201. 00         0         201. 00         0         201. 00         0         201. 00         0         201. 00         0         201. 00         0         201. 00         0         201. 00         0         201. 00         0         201. 00         0         201. 00         0         201. 00         0         201. 00         201. 00         0         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00						•
71.00         07100         MEDI CAL SUPPLIES CHARGED TO PATIENTS         0.105126         14,072         1,479         71.00           72.00         07200         IMPL. DEV. CHARGED TO PATIENTS         0.000000         0         72.00           73.00         07300         DRUGS CHARGED TO PATIENTS         0.290997         209,452         60,950         73.00           74.00         07400         RENAL DI ALYSI S         0.306668         0         0         74.00           200.00         Total (sum of lines 50 through 94 and 96 through 98)         848,660         122,973         200.00           201.00         Less PBP Clinic Laboratory Services-Program only charges (line 61)         0         0         201.00					-	
72. 00         07200         IMPL.         DEV.         CHARGED TO PATIENTS         0.000000         0         72. 00           73. 00         07300         DRUGS CHARGED TO PATIENTS         0.290997         209, 452         60, 950         73. 00           74. 00         07400         RENAL DI ALYSI S         0.306668         0         0         74. 00           200. 00         Total (sum of lines 50 through 94 and 96 through 98)         848, 660         122, 973         200. 00           201. 00         Less PBP Clinic Laboratory Services-Program only charges (line 61)         0         201. 00					0	
73. 00         07300         DRUGS CHARGED TO PATIENTS         0. 290997         209, 452         60, 950         73. 00           74. 00         07400         RENAL DI ALYSIS         0. 306668         0         0         74. 00           200. 00         Total (sum of lines 50 through 94 and 96 through 98)         848, 660         122, 973         200. 00           201. 00         Less PBP Clinic Laboratory Services-Program only charges (line 61)         0         0         201. 00		IS				
74. 00         07400         RENAL DIALYSIS         0. 306668         0         74. 00           200. 00         Total (sum of lines 50 through 94 and 96 through 98)         848, 660         122, 973         200. 00           201. 00         Less PBP Clinic Laboratory Services-Program only charges (line 61)         0         201. 00					-	
200.00         Total (sum of lines 50 through 94 and 96 through 98)         848,660         122,973         200.00           201.00         Less PBP Clinic Laboratory Services-Program only charges (line 61)         0         201.00						•
201.00       Less PBP Clinic Laboratory Services-Program only charges (line 61)       0       201.00			0. 30666		0	
				848, 660	122, 973	
202.00  Net charges (line 200 minus line 201)   848,660   202.00				0		
	202.00  Net charges (line 200 minus line 2	01)		848, 660		202.00

	Financial Systems ASCENSION ST VINCENT S			eu of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-2020	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part B Date/Time Prep	pared:
		Title XVIII		11/16/2021 11 PPS	
			Hospi tal	PP3	
				1.00	
1.00	PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions)			549	1.00
2.00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instruct	tions)		2, 749	
3.00	OPPS payments			1, 974	
4.00 4.01	Outlier payment (see instructions) Outlier reconciliation amount (see instructions)			0	4.00 4.01
5.00	Enter the hospital specific payment to cost ratio (see instruct	ctions)		0.000	
6.00	Line 2 times line 5			0	
7.00 8.00	Sum of lines 3, 4, and 4.01, divided by line 6 Transitional corridor payment (see instructions)			0. 00 0	
9.00	Ancillary service other pass through costs from Wkst. D, Pt. 1	IV, col. 13, line 200		0	
10.00	Organ acqui si ti ons			0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES			549	11.00
	Reasonabl e charges				
12.00	Ancillary service charges	(0)			12.00
13.00 14.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, li Total reasonable charges (sum of lines 12 and 13)	ne 69)		0 1, 886	13.00 14.00
14.00	Customary charges			1,000	14.00
15.00	Aggregate amount actually collected from patients liable for p	5	0	0	
16.00	Amounts that would have been realized from patients liable for had such payment been made in accordance with 42 CFR §413.13(		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)			1, 886	
19.00	Excess of customary charges over reasonable cost (complete onl instructions)	y IT line 18 exceeds li	ne II) (see	1, 337	19.00
20.00	Excess of reasonable cost over customary charges (complete onl instructions)	yifline 11 exceeds li	ne 18) (see	0	20. 00
21.00	Lesser of cost or charges (see instructions)			549	
22.00 23.00	Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see instr	quetione)		0	22.00 23.00
23.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	uctions)		1, 974	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00 26.00	Deductibles and coinsurance amounts (for CAH, see instructions Deductibles and Coinsurance amounts relating to amount on line	-	cuctions)	0 294	
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)	•		2, 229	
~~ ~~	instructions)	50)			
28.00 29.00	Direct graduate medical education payments (from Wkst. E-4, li ESRD direct medical education costs (from Wkst. E-4, line 36)	ne 50)		0	
30.00	Subtotal (sum of lines 27 through 29)			2, 229	
31.00	Primary payer payments			0	
32.00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVIO	CES)		2, 229	32.00
	Composite rate ESRD (from Wkst. I-5, line 11)				33.00
34.00 35.00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			0	
36.00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	
37.00	Subtotal (see instructions)			2, 229	
38.00 39.00	MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
39.50	Pioneer ACO demonstration payment adjustment (see instructions	s)		Ű	39.50
39.97	Demonstration payment adjustment amount before sequestration			0	-
39. 98 39. 99	Partial or full credits received from manufacturers for replace RECOVERY OF ACCELERATED DEPRECIATION	ced devices (see instruc	ctions)	0	
40.00	Subtotal (see instructions)			2, 229	-
40. 01	Sequestration adjustment (see instructions)			0	40. 01
40.02	Demonstration payment adjustment amount after sequestration			0	40. 02 40. 03
40. 03 41. 00	Sequestration adjustment-PARHM pass-throughs Interim payments			2, 253	
41.01	Interim payments-PARHM				41.01
42.00 42.01	Tentative settlement (for contractors use only) Tentative settlement-PARHM (for contractor use only)			0	42.00 42.01
42.01	Balance due provider/program (see instructions)			-24	
43.01	Balance due provider/program-PARHM (see instructions)				43.01
44.00	Protested amounts (nonallowable cost report items) in accordar §115.2	nce with CMS Pub. 15-2,	chapter 1,	0	44.00
90.00	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)			0	90.00
90.00 91.00	Outlier reconciliation adjustment amount (see instructions)			0	
92.00	The rate used to calculate the Time Value of Money			0.00	
	Time Value of Money (see instructions) Total (sum of lines 91 and 93)			0	
71.00				. 01	1 / 1.00

ANALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC	CN: 15-2020	Period: From 07/01/2020 To 06/30/2021		pared:
			XVIII	Hospi tal	PPS	
		I npati en	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		8, 425, C	185 0	2, 253 0	1.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3.00
3.01	ADJUSTMENTS TO PROVIDER	01/06/2021	53, 4	00	0	3.01
3.02				0	0	3.02
3.03				0	0	3. 03 3. 04
3.04 3.05				0	0	3.02
0.00	Provider to Program			<u> </u>		0.00
3.50	ADJUSTMENTS TO PROGRAM			0	0	3.50
3.51				0	0	3.5
3.52				0	0	3.5
3.53 3.54				0	0	3.5 3.5
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		53, 4	-	0	3.99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		8, 478, 4	85	2, 253	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.0
5. 01	Program to Provider TENTATIVE TO PROVIDER			0	0	5.0
5.01	TENTATIVE TO PROVIDER			0	0	5.0
5.03				0	0	5.0
	Provider to Program					
5.50	TENTATI VE TO PROGRAM			0	0	5.5
5.51 5.52				0	0	5.5 5.5
5.99	Subtotal (sum of lines 5.01–5.49 minus sum of lines			0	0	5.9
5. 00	5.50-5.98) Determined net settlement amount (balance due) based on					6. 0
5. 01	the cost report. (1) SETTLEMENT TO PROVIDER			0	0	6.0
5. 01 5. 02	SETTLEMENT TO PROVIDER		17.9	59	24	6.0 6.0
7.02	Total Medicare program liability (see instructions)		8, 460, 5		2, 229	7.0
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0	)	1.00	2.00	

ALCULATION	OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-2020	Period: From 07/01/2020 To 06/30/2021	Worksheet E-3 Part IV Date/Time Pre 11/16/2021 11	pare
		Title XVIII	Hospi tal	PPS	
				1.00	
PART I	V - MEDICARE PART A SERVICES - LTCH PPS			1.00	<u> </u>
.00 Net Fe	ederal PPS Payments (see instructions)			7, 919, 321	1 1.
.01 Full s	standard payment amount			6, 640, 537	1.
.02 Short	stay outlier standard payment amount			1, 278, 784	1.
.03 Site r	neutral payment amount - Cost			0	1.
.04 Siter	neutral payment amount - IPPS comparable			0	1.
.00 Outlie	er Payments			1, 025, 819	2.
.00 Total	PPS Payments (sum of lines 1 and 2)			8, 945, 140	3
	ng and Allied Health Managed Care payments (see i	instructions)		0	4
	acquisition (DO NOT USE THIS LINE)	,			5
	of physicians' services in a teaching hospital (s	see instructions)		0	6
	tal (see instructions)	,		8, 945, 140	7
	ry payer payments			12,000	8
	tal (line 7 less line 8).			8, 933, 140	
	ti bl es			1, 484	
	tal (line 9 minus line 10)			8, 931, 656	
. 00 Coi nsi				692, 478	
	tal (line 11 minus line 12)			8, 239, 178	
	able bad debts (exclude bad debts for profession	al services) (see instructions)		340, 535	
	ted reimbursable bad debts (see instructions)			221, 348	
	able bad debts for dual eligible beneficiaries (	see instructions)		227, 252	
	tal (sum of lines 13 and 15)	,		8, 460, 526	
	t graduate medical education payments (from Wkst.	E-4 line 49)		0	18
	pass through costs (see instructions)			0	19
	er payments reconciliation			0	20
	ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	21
	er ACO demonstration payment adjustment (see ins	tructions)		0	21
	stration payment adjustment amount before seques			0	
	amount payable to the provider (see instructions			8, 460, 526	
	stration adjustment (see instructions)			0	22
	stration payment adjustment amount after sequest	ration		0	
	im payments			8, 478, 485	
	tive settlement (for contractor use only)			0	24
	ce due provider/program (line 22 minus lines 22.0	01, 22,02, 23 and 24)		-17,959	
1	sted amounts (nonallowable cost report items) in		chapter 1,	0	26
TO BE	COMPLETED BY CONTRACTOR				
).00 Origin	nal outlier amount from Wkst. E-3, Pt IV, line 2	(see instructions)		1, 025, 819	50
1.00 Outlie	er reconciliation adjustment amount (see instruc	tions)		0	51
2.00 The ra	ate used to calculate the Time Value of Money (se	ee instructions)		0.00	52
2 00   Time \	Value of Money (see instructions)			0	53

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	TON SPECIALTY Provider CCN: 15-2020	Peri od:	Worksheet E-3	2552
ALCOL			From 07/01/2020 To 06/30/2021	Part VII Date/Time Pre	pare
		Title XIX	Hospi tal	11/16/2021 11 Cost	: 30
			Inpati ent	Outpati ent	
			1.00	2.00	-
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV	/ICES FOR TITLES V OR >			
	COMPUTATION OF NET COST OF COVERED SERVICES				
00	Inpatient hospital/SNF/NF services		251, 006		1
00	Medical and other services			0	2
00	Organ acquisition (certified transplant centers only)		0		3
00	Subtotal (sum of lines 1, 2 and 3)		251, 006	0	
00	Inpatient primary payer payments		0	_	5
00	Outpatient primary payer payments		054.00/	0	6
00	Subtotal (line 4 less sum of lines 5 and 6)		251, 006	0	7
	COMPUTATION OF LESSER OF COST OR CHARGES				+
00	Reasonable Charges Routine service charges		452, 093		8
00	Ancillary service charges		452, 093 848, 660	0	
	Organ acquisition charges, net of revenue		048,000	0	10
	Incentive from target amount computation		0		11
	Total reasonable charges (sum of lines 8 through 11)		1, 300, 753	0	
	CUSTOMARY CHARGES		.,		1
. 00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13
	basi s			_	
. 00	Amounts that would have been realized from patients liable for a charge basis had such payment been made in accordance with 42		on 0	0	14
. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	2 CIR 3413. 13(e)	0.000000	0,000000	15
	Total customary charges (see instructions)		1, 300, 753	0.000000	16
. 00	Excess of customary charges over reasonable cost (complete only	vifline 16 exceeds	1, 049, 747	0	
	line 4) (see instructions)	· · · · · · · · ·			
3. 00	Excess of reasonable cost over customary charges (complete only	y if line 4 exceeds lir	ne 0	0	18
	16) (see instructions)				
	Interns and Residents (see instructions)		0	0	19
	Cost of physicians' services in a teaching hospital (see instru		0	0	20
. 00	Cost of covered services (enter the lesser of line 4 or line 10		251,006	0	21
00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be of	completed for PPS provi		0	1
	Other than outlier payments Outlier payments		0	0	
	Program capital payments		0	0	24
	Capital exception payments (see instructions)		0		25
	Routine and Ancillary service other pass through costs		0	0	26
	Subtotal (sum of lines 22 through 26)		0	0	27
	Customary charges (title V or XIX PPS covered services only)		0	0	28
	Titles V or XIX (sum of lines 21 and 27)		251, 006	0	29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
0. 00	Excess of reasonable cost (from line 18)		0	0	30
. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		251, 006	0	31
. 00	Deducti bl es		0	0	
	Coinsurance		0	0	
	Allowable bad debts (see instructions)		0	0	
. 00	Utilization review	22)	0	0	35
. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and other AD HISTMENTS (SEE LINETHICTIONS) (SPECIEV)	33)	251, 006	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		251 004	0	37
. 00	Subtotal (line $36 \pm \text{line } 37$ ) Direct graduate modical education payments (from Wket E 4)		251, 006	0	
	Direct graduate medical education payments (from Wkst. E-4) Total amount payable to the provider (sum of lines 38 and 39)		251,006	0	39
				0	40
. 00	Interim payments Balance due provider/program (line 40 minus line 41)		251, 006	0	
2.00 3.00	Protested amounts (nonallowable cost report items) in accordance	ce with CMS Dub 15-2	0	0	42
J. UU	chapter 1, §115.2	SS WITH SWS FUD 13-2,	0	0	43

	Financial         Systems         ASCENSION         ST VINCENT           E         SHEET (If you are nonproprietary and do not maintain         Ascension         Ascension         Ascension	Provider CC		Period:	eu of Form CMS-2 Worksheet G	
und-t nly)	ype accounting records, complete the General Fund column			rom 07/01/2020 o 06/30/2021		
		General Fund	Specific Purpose Fund	Endowment Fund	11/16/2021 11 Plant Fund	: 30
		1.00	2.00	3.00	4.00	
00	CURRENT ASSETS	500				1 1
00 00	Cash on hand in banks Temporary investments	500		-	0	
00	Notes receivable	0			0	
00	Accounts receivable	23, 501, 788	(	-	0	
00	Other receivable	0		-	0	
00	Allowances for uncollectible notes and accounts receivable	-12, 774, 418	C	0	0	
00	Inventory	456, 313	C	0 0	0	7
00	Prepaid expenses	0	C	0 0	0	8
00	Other current assets	619, 710	C	-	0	
	Due from other funds	0	C	-	0	
. 00	Total current assets (sum of lines 1-10)	11, 803, 893		00	0	11
00	FIXED ASSETS	047 (20				1 1 2
. 00 . 00	Land Land improvements	847, 629 3, 157			0	
	Accumulated depreciation	-3, 157			0	
	Buildings	15, 901, 288			0	
	Accumulated depreciation	-10, 466, 309			0	
	Leasehold improvements	436, 760			0	
	Accumulated depreciation	-53, 700	C	0	0	
	Fixed equipment	1, 086, 014	C	0 0	0	19
0. 00	Accumulated depreciation	-1,014,842	C	0 0	0	20
	Automobiles and trucks	0	C	0 0	0	21
	Accumulated depreciation	0	C	-	0	
	Major movable equipment	5, 953, 035	C	-	0	
	Accumulated depreciation	-4, 918, 937	0		0	
	Minor equipment depreciable	0	0	, ,	0	
	Accumulated depreciation	0		, i	0	
	HIT designated Assets Accumulated depreciation	0			0	
	Mi nor equi pment-nondepreci abl e	0		-	0	
	Total fixed assets (sum of lines 12-29)	7, 770, 938				
. 00	OTHER ASSETS	1,110,100				
. 00	Investments	0	C	0 0	0	31
2. 00	Deposits on Leases	0	C	0 0	0	32
. 00	Due from owners/officers	0	C	0 0	0	33
I. 00	Other assets	0	C	0 0	0	34
5.00	Total other assets (sum of lines 31-34)	0	C	0 0	0	35
b. 00	Total assets (sum of lines 11, 30, and 35)	19, 574, 831	(	0 0	0	36
	CURRENT LI ABI LI TI ES			1		
	Accounts payable	325, 964	0			
	Salaries, wages, and fees payable	970, 322	0		0	
	Payroll taxes payable Notes and Loans payable (short term)	0	0	0	0	
	Deferred income	0			0	
	Accel erated payments	0		0	0	41
	Due to other funds	0	C	0	0	
	Other current liabilities	3, 598, 069	-	-		
	Total current liabilities (sum of lines 37 thru 44)	4, 894, 355				
	LONG TERM LIABILITIES	.,		·		
b. 00	Mortgage payable	0	(	) 0	0	46
. 00	Notes payable	0	C	0 0	0	47
3. 00	Unsecured Loans	0	C	0 0	0	48
9.00	Other long term liabilities	573, 808	C	0 0	0	49
	Total long term liabilities (sum of lines 46 thru 49)	573, 808			0	
. 00	Total liabilities (sum of lines 45 and 50)	5, 468, 163		0 0	0	51
	CAPI TAL ACCOUNTS					
	General fund balance	14, 106, 668				52
	Specific purpose fund		C			53
	Donor created - endowment fund balance - restricted			0	1	54
	Donor created - endowment fund balance - unrestricted			0		55
5.00 7.00	Governing body created - endowment fund balance			0	0	
1.1.1	Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement,				0	
			1		, U	1 50
					ļ ,	
	replacement, and expansion Total fund balances (sum of lines 52 thru 58)	14, 106, 668	C	0	0	59

	Financial Systems ASCEN ENT OF CHANGES IN FUND BALANCES	NSION ST VINCENT	Provi der CC		Peri od: From 07/01/2020 To 06/30/2021	Date/Time Pre	pared:
		General	Fund	Speci al	Purpose Fund	11/16/2021 11 Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
$\begin{array}{c} 1.00\\ 2.00\\ 3.00\\ 4.00\\ 5.00\\ 6.00\\ 7.00\\ 8.00\\ 9.00\\ 10.00\\ 11.00\\ 12.00\\ 13.00\\ 14.00\\ 15.00\\ 16.00\\ 17.00\\ 18.00\\ 19.00\\ \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)		0 6, 829, 532 7, 277, 136 14, 106, 668 14, 106, 668 14, 106, 668 0 14, 106, 668	3.00			$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ \end{array}$
		Endowment Fund	Pl ant	Fund		1	
1 00	Fund belonger at beginning of seried	6.00	7.00	8.00	0		1.00
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0 0 0 0 0		0		1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	00	0 0 0 0 0 0		0		10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00
18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0			0 0		18.00 19.00

Health Financial Systems         ASCENSION ST VINCENT           STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES		Provider CCN: 15-2020		Period: From 07/01/2020		Worksheet G-2 Parts   &	
				То	06/30/2021	Date/Time Pre 11/16/2021 11	
	Cost Center Description		Inpatient		Outpatient	Total	
	cost center bescription		1.00		2.00	3.00	
	PART I - PATIENT REVENUES		1.00		2.00	3.00	
	General Inpatient Routine Services						-
1.00	Hospi tal		42 4EE 4	0.2		12 455 492	1.00
			42, 455, 6	82		42, 455, 682	
2.00	SUBPROVIDER - IPF						2.00
3.00	SUBPROVIDER - IRF						3.00
4.00	SUBPROVIDER						4.00
5.00	Swing bed - SNF			0		0	
6.00	Swing bed - NF			0		0	
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)		42, 455, 6	82		42, 455, 682	10.00
	Intensive Care Type Inpatient Hospital Services						
11.00	INTENSIVE CARE UNIT						11.00
12.00	CORONARY CARE UNIT						12.00
13.00	BURN INTENSIVE CARE UNIT						13.00
14.00	SURGI CAL I NTENSI VE CARE UNI T						14.00
15.00	OTHER SPECIAL CARE (SPECIFY)						15.00
16.00	Total intensive care type inpatient hospital services (sum o	flines		0		0	•
101.00	11-15)			Ŭ		Ũ	
17.00	Total inpatient routine care services (sum of lines 10 and 1	6)	42, 455, 6	82		42, 455, 682	17.00
18.00	Ancillary services	0)	55, 175, 1		17, 383	55, 192, 524	
19.00	Outpatient services		33, 173, 1	0	0	03, 172, 324	1
20.00	RURAL HEALTH CLINIC			0	0	0	
20.00	FEDERALLY QUALIFIED HEALTH CENTER			0	0	0	
21.00	HOME HEALTH AGENCY			U	0	0	21.00
23.00	AMBULANCE SERVICES						23.00
24.00							24.00
25.00	AMBULATORY SURGICAL CENTER (D. P. )						25.00
26.00	HOSPI CE						26.00
27.00	OTHER (SPECIFY)			0	0	0	
28.00	Total patient revenues (sum of lines 17-27)(transfer column	3 to Wkst.	97, 630, 8	23	17, 383	97, 648, 206	28.00
	G-3, line 1)						
	PART II - OPERATING EXPENSES		1				
29.00	Operating expenses (per Wkst. A, column 3, line 200)				25, 513, 835		29.00
30.00	ADD (SPECIFY)			0			30.00
31.00				0			31.00
32.00				0			32.00
33.00				0			33.00
34.00				0			34.00
35.00				0			35.00
36.00	Total additions (sum of lines 30-35)				0		36.00
37.00	DEDUCT (SPECI FY)			0			37.00
38.00				0			38.00
39.00				0			39.00
40.00				0			40.00
41.00				0			41.00
42.00	Total deductions (sum of lines 37-41)			-	Ω		42.00
	Total operating expenses (sum of lines 29 and 36 minus line	(1) (transfor			25, 513, 835		43.00
43.00	I TOTAL ODELATITIO EXDELISES (SUII OF TITLES 24 AUG 30 MITTOS TITLE)	4270000000					

Health Financial Systems         ASCENSION ST VINCENT SETON SPECIALTY           STATEMENT OF REVENUES AND EXPENSES         Provider CCN: 15-2020		Peri od:	Worksheet G-3		
			From 07/01/2020	Date/Time Pre	
	To 06/30/2021				pared: :30 am
		· · · · · ·			
				1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, lin			97, 648, 206	
2.00	Less contractual allowances and discounts on patients' account	nts		64, 304, 068	
3.00	Net patient revenues (line 1 minus line 2)			33, 344, 138	
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		25, 513, 835	
5.00	Net income from service to patients (line 3 minus line 4)			7, 830, 303	5.00
	OTHER I NCOME		1		
6.00	Contributions, donations, bequests, etc			0	
7.00	Income from investments			0	7.00
8.00	Revenues from telephone and other miscellaneous communication	n servi ces		0	
9.00	Revenue from television and radio service			0	
10.00	Purchase di scounts			0	
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	
14.00	Revenue from meals sold to employees and guests			71, 209	
15.00				0	
16.00	Revenue from sale of medical and surgical supplies to other t	han patients		0	
17.00	Revenue from sale of drugs to other than patients			0	
18.00	Revenue from sale of medical records and abstracts			0	
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
21.00	Rental of vending machines			1, 509	
22.00	Rental of hospital space			0	22.00
23.00	Governmental appropriations			0	23.00
24.00	PATIENT INTEREST INCOME			4, 435	24.00
24.01	HHS STIMULUS OP REV 30B			1, 915	24.01
24.02	FOUNDATION INTERCOMPANY TRANSFER			50, 460	24.02
24.50	COVI D-19 PHE Fundi ng			-682, 695	24.50
25.00	Total other income (sum of lines 6-24)			-553, 167	25.00
26.00	Total (line 5 plus line 25)			7, 277, 136	26.00
27.00	OTHER EXPENSES (SPECIFY)			0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)			0	28.00
20 00	Net income (or loss) for the period (line 26 minus line 28)			7, 277, 136	29 00