This re	Financial Systems ASCENSION Seport is required by law (42 USC 1395g; 42 CFR 413.20(b) as made since the beginning of the cost reporting period). Failur	e to report can resul	t in all interim	J OF Form CMS-25 FORM APPROVED OMB NO. 0938-00 EXPIRES 03-31-2	050
	AL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFIC TLEMENT SUMMARY	CATION Pr	ovider CCN: 15-1308	Period: From 07/01/2021 To 06/30/2022	Worksheet S Parts I-III Date/Time Prepa 11/29/2022 9:14	
PART I	- COST REPORT STATUS					
Provi de use onl		number of or "L" f	times the provider re or low.	Date: 11/29/20		14 am
Contrad use onl		oort for t rt for thi	11.C his Provider CCN 12.[r Code: lumn 1 is 4: En es reopened = 0	
PART II	- CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMIN	STRATOR O	R PROVIDER(S)			
MI SREP ADMI NI S PROVI DE	RESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINE STRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL D OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTL STRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.	D IN THIS LAW. FUR	COST REPORT MAY BE P THERMORE, IF SERVICES	IDENTIFIED IN TH	IS REPORT WERE	
	CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTR	ATOR OF PR	OVI DER(S)			
	I HEREBY CERTIFY that I have read the above certificate electronically filed or manually submitted cost repor- Statement of Revenue and Expenses prepared by ASCENSI period beginning 07/01/2021 and ending 06/30/2022 and statement are true, correct, complete and prepared from applicable instructions, except as noted. I further corregarding the provision of health care services, and provided in compliance with such laws and regulations	t and subm DN ST. VIN to the be om the boo ertify tha that the s	itted cost report and CENT MERCY (15-1308 st of my knowledge ar ks and records of the t I am familiar with	d the Balance Shee) for the cost re nd belief, this re e provider in acco the laws and regu	et and eporting eport and ordance with Ilations	
S	IGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	CHECKBOX		ELECTRONI C		
	1	2		IATURE STATEMENT		
1	Christopher Hons	Y	I have read and agree statement. I certify signature on this ce	/that I intend my	el ectroni c	1

	011130		binding equivalent of my original signature.	
2	Signatory Printed Name	Christopher Hons		2
3	Signatory Title	VP OF FINANCE		3
4	Date	11/29/2022 09:14:44 AM		4
			·	

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	46, 369	-208, 309	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	-2,635	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	43, 734	-208, 309	0	0	200.00

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

	AL AND HOSPITAL HEALTH CARE COMPLEX	UENTIFICATION DATA	Provio	ler CCN:		Period: From 07/01/ To 06/30/	2021 2022	Workshe Part I Date/Ti 11/29/2	me Pre	pared
	1.00	2.00		3.00		4	4.00			
	Hospital and Hospital Health Care Co									
00	Street: 1331 SOUTH A ST.	PO Box:								1. (
00	City: ELWOOD	State: IN		e: 46036-		y: MADI SON	-			2. (
		Component Name	CCN	CBSA	Provi der			nt Syst		
			Number	Number	Туре	Certified		0, or	1	4
		1.00	0.00	0.00	1.00	5.00	V	XVIII	XIX	4
	Uponital and Uponital Deced Company	1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
00	Hospital and Hospital-Based Componen		151200	26000	1	07/01/2001	N	0	0	
00	Hospi tal	ASCENSION ST. VINCENT MERCY	151308	26900	1	07/01/2001	N	0	0	3.
00	Subprovider - IPF	MERCI								4.
00	Subprovider - IRF									5.
00	Subprovider - (Other)		457000	0,000		07 /01 /0001				6.
00	Swing Beds - SNF	ASCENSION ST. VINCENT	15Z308	26900		07/01/2001	N	0	N	7.
		MERCY SWING								
00	Swing Beds - NF									8.
00	Hospital-Based SNF									9.
00	Hospital-Based NF									10.
00	Hospital-Based OLTC									11.
00										12.
00	Separately Certified ASC									13.
	Hospi tal -Based Hospi ce									14.
00										15
00										16
00	Hospital-Based (CMHC) I									17.
00	Renal Dialysis									18.
00	Other									19.
						From:		То	:	
						1.00		2.0	00	
	Cost Reporting Period (mm/dd/yyyy)					07/01/20)21	06/30/	/2022	20.
00	Type of Control (see instructions)					1				21.
					1.00	2.00		3.0	00	
	Inpatient PPS Information									
00	Does this facility qualify and is it				N	N				22.
	disproportionate share hospital adju	stment, in accordance wi	th 42 CFI	2						
	§412.106? In column 1, enter "Y" fo									
	facility subject to 42 CFR Section §		endment							
	hospital?) In column 2, enter "Y" fo	r yes or "N" for no.								
01	Did this hospital receive interim un	compensated care paymen [.]	ts for thi	s	N	N				22.
	cost reporting period? Enter in colu	mn 1, "Y" for yes or "N'	' for no t	For						
	the portion of the cost reporting pe	riod occurring prior to	October '							
	Entor in column 2 "V" for yos or "N									
	Linter in corumn 2, i nor yes or in	" for no for the portion								
	reporting period occurring on or aft	•	n of the d							
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	AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	N ST. VINCE	Provider CC	N: 15-1308	Peri od:		Norkshe	eet S-2	
						D/2022	<u>11/29/2</u>	me Pre 2022 9:	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicai HMO day	s Med	ther Ji cai d Jays	
1.00 If	this provider is an IPPS hospital, enter the	1.00	2.00	3.00	4.00	5.00	0	<u>5.00</u>	24.0
in- Mec out 4, col 5.00 If Mec out Mec	-state Medicaid paid days in column 1, in-state dicaid eligible unpaid days in column 2, t-of-state Medicaid paid days in column 3, t-of-state Medicaid eligible unpaid days in column Medicaid HMO paid and eligible but unpaid days in lumn 5, and other Medicaid days in column 6. This provider is an IRF, enter the in-state dicaid paid days in column 1, the in-state dicaid eligible unpaid days in column 2, t-of-state Medicaid days in column 2, t-of-state Medicaid days in column 3, out-of-state dicaid eligible unpaid days in column 4, Medicaid 0 paid and eligible but unpaid days in column 5.	0	0		o		0		25.
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5.00 Ent	ter your standard geographic classification (not wa	ane) status	at the bec	unning of t	1. C	1	2.0	00	26.
7.00 Ent rep	st reporting period. Enter "1" for urban or "2" for ter your standard geographic classification (not wa porting period. Enter in column 1, "1" for urban or ter the effective date of the geographic reclassifi	rural. age) status r "2" for r	at the enc ural. If ap	l of the cos		1			27.0
5.00 If	'this is a sole community hospital (SCH), enter the fect in the cost reporting period.			H status ir	1	О			35.
					Beginn 1.0		Endi 2. (-
	ter applicable beginning and ending dates of SCH st		cript line	36 for numb			2.0	50	36.
.00 f	periods in excess of one and enter subsequent date this is a Medicare dependent hospital (MDH), enter in effect in the cost reporting period.		r of perioc	ls MDH statu	IS	О			37.
aco i na	this hospital a former MDH that is eligible for th cordance with FY 2016 OPPS final rule? Enter "Y" fo structions)	or yes or "	N" for no.	(see					37.
gre	I line 37 is 1, enter the beginning and ending dates eater than 1, subscript this line for the number of ter subsequent dates.								38.
					Y/I 1. C		Y/ 2. (-
	es this facility qualify for the inpatient hospital spitals in accordance with 42 CFR §412.101(b)(2)(i)		diustment f		ime N		<u> </u>		39.
1 " acc	"Y" for yes or "N" for no. Does the facility meet t cordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii "N" for no. (see instructions)	the mileage	(iii)? Ent requiremer	ıts in					
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OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	INCENT MERCY Provider CO		eriod: rom 07/01/2021	Worksheet S-2 Part I	2552-1
			T		Date/Time Pre	
			NAHE 413.85	Worksheet A	11/29/2022 9: Pass-Through	14 am
			Y/N	Line #	Qualification Criterion Code	
			1.00	2.00	3.00	
0.00 Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in col is "Y", are you impacted by CR 11642 (or subsequent C	85? (s umn 1. CR) NAHE	ee lf column 1	N			60. (
adjustement? Enter "Y" for yes or "N" for no in colu	umn 2. Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 	N			0.00	0.00	61. (
1.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see						61. (
instructions) 1.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of						61. (
 ACA). (see instructions) 1.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see 						61. (
instructions) 1.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the						61. (
current cost reporting period. (see instructions). 1.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line						61.
 61.04 minus line 61.03). (see instructions) 1.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) 						61.
	Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
 10 Of the FTEs in line 61.05, specify each new program special ty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 1.20 Of the FTEs in line 61.05, specify each expanded program special ty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. 				0.00		61.
the direct GME FTE unweighted count.						
					1.00	
ACA Provisions Affecting the Health Resources and Sev 2.00 Enter the number of FTE residents that your hospital				ad far which	0.00	62.0
your hospital received HRSA PCRE funding (see instruct 2.01 Enter the number of FTE residents that rotated from a	ctions) a Teachi	ng Health Cen [.]	ter (THC) into			62.
during in this cost reporting period of HRSA THC prog Teaching Hospitals that Claim Residents in Nonprovide 3.00 Has your facility trained residents in nonprovider se	er Setti ettings	ngs during this co	ost reporting p		N	63.
"Y" for yes or "N" for no in column 1. If yes, comple	ete line	s 64 through (67. (see instru Unweighted FTEs		Ratio (col. 1/ (col. 1 + col.	
			Nonprovider Site	Hospi tal	2))	
Section 5504 of the ACA Base Year FTE Residents in No period that begins on or after July 1, 2009 and befor			1.00 This base year	2.00 is your cost r	3.00 reporting	
4.00 Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted nor	ty train n-primar	ed residents y care	0.00	0.00	0. 000000	64.
resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter in	l non-pr	imary care				

		ATA Provider C		eriod: om 07/01/2021	Worksheet S-2 Part I	
			Tc			
	Program Name	Program Code	Unweighted FTEs Nonprovider	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	′
-	1.00	2.00	Si te 3. 00	4.00	5.00	-
.00 Enter in column 1, if line 63	1.00	2.00	0.00	0.00		65.0
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3						
divided by (column 3 + column 4)). (see instructions)						
(4)). (see histractions)		1	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
Section 5504 of the ACA Current Y beginning on or after July 1, 201		n Nonprovider Setting	gsEffective fo	r cost reporti	ing periods	
.00 Enter in column 1 the number of u FTEs attributable to rotations oc Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 +	ccurring in all nonp inweighted non-prima I. Enter in column	rovider settings. ry care resident 3 the ratio of	0.00 Unweighted FTEs Nonprovider	0.00 Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
			Si to			
	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		<u>4.00</u> 0.00		67. C
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	0.00	0. 000000	67.0
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)	25		3.00 0.00	0.00		-
name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	≥S rchiatric Facility (3.00 0.00	0.00	0. 000000	-
<pre>name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)</pre>	2S /chiatric Facility (the facility have a 2Fore November 15, 2 umn 2: Did this fac ≷ 412.424 (d)(1)(iii ;ate which program y	IPF), or does it cont n approved GME teachi 004? Enter "Y" for y ility train residents)(D)? Enter "Y" for y	3.00 0.00 tain an IPF subp ng program in t yes or "N" for n s in a new teach yes or "N" for n	0.00 1.0 rovider? N he most o. (see ing o.	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 fore November 15, 2 umn 2: Did this fac 2 412.424 (d)(1)(iii ate which program y / PPS nabilitation Facilit	IPF), or does it cont 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 ng program in t yes or "N" for m s in a new teach yes or "N" for m s cost reporting	0.00 1.0 rovider? N he most o. (see ing o.	0 2.00 3.00	70. C

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C	CN: 15-1308	Period: From 07/01/2021 To 06/30/2022	Worksheet S-2 Part I Date/Time Pre 11/29/2022 9:	epared
				1.00	-
Long Term Care Hospital PPS				1.00	
 D. 00 Is this a long term care hospital (LTCH)? Enter "Y" for yes I. 00 Is this a LTCH co-located within another hospital for part o "Y" for yes and "N" for no. 			ng period? Enter	N N	80. C 81. C
TEFRA Providers 5.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) 5.00 Did this facility establish a new Other subprovider (exclude		2		N	85. C
§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. 7.00 Is this hospital an extended neoplastic disease care hospita	ŗ			N	87.0
1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			V	XIX	
			1.00	2.00	-
Title V and XIX Services					
0.00 Does this facility have title V and/or XIX inpatient hospita	I services? E	nter "Y" for	N	Y	90. (
yes or "N" for no in the applicable column. 1.00 Is this hospital reimbursed for title V and/or XIX through t			N	Y	91. (
full or in part? Enter "Y" for yes or "N" for no in the appl 2.00 Are title XIX NF patients occupying title XVIII SNF beds (du				Y	92.0
instructions) Enter "Y" for yes or "N" for no in the applica				1	72.0
3.00 Does this facility operate an ICF/IID facility for purposes "Y" for yes or "N" for no in the applicable column.	of title V an	d XIX? Enter	N	N	93. (
4.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, applicable column.	and "N" for n	o in the	N	N	94. (
5.00 If line 94 is "Y", enter the reduction percentage in the app	licable colum	n.	0.00	0.00	95. (
5.00 Does title V or XIX reduce operating cost? Enter "Y" for yes applicable column.	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the N				
7.00 If line 96 is "Y", enter the reduction percentage in the app	licable colum	n.	0.00	0.00	97.
0 Does title V or XIX follow Medicare (title XVIII) for the interns and residents post N 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.					98.
3.01 Does title V or XIX follow Medicare (title XVIII) for the re C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for ti				Y	98.
title XIX. 3.02 Does title V or XIX follow Medicare (title XVIII) for the ca bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes o			Ν	Y	98.
for title V, and in column 2 for title XIX. 3.03 Does title V or XIX follow Medicare (title XVIII) for a crit reimbursed 101% of inpatient services cost? Enter "Y" for ye				Ν	98.
for title V, and in column 2 for title XIX. 3.04 Does title V or XIX follow Medicare (title XVIII) for a CAH outpatient services cost? Enter "Y" for yes or "N" for no in			N	Ν	98.
in column 2 for title XIX. 3.05 Does title V or XIX follow Medicare (title XVIII) and add ba Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in c				Y	98.
 column 2 for title XIX. 3.06 Does title V or XIX follow Medicare (title XVIII) when cost Pts. I through IV? Enter "Y" for yes or "N" for no in column column 2 for title XIX. 			Ν	Y	98.
Rural Providers					105
D5.00 Does this hospital qualify as a CAH? D6.00 If this facility qualifies as a CAH, has it elected the all-	inclusive met	hod of paymer	nt N		105. 106.
for outpatient services? (see instructions) 07.00 Column 1: If line 105 is Y, is this facility eligible for co training programs? Enter "Y" for yes or "N" for no in column	1. (see ins	tructions)	Ν		107.
Column 2: If column 1 is Y and line 70 or line 75 is Y, do approved medical education program in the CAH's excluded IP Enter "Y" for yes or "N" for no in column 2. (see instructi	F and/or IRF				
08.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		dul e? See 42	2 N		108.
	Physi cal	Occupation		Respi ratory	-
09.00 If this hospital qualifies as a CAH or a cost provider, are	1.00 N	2.00 N	3.00 N	4.00 N	109.
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	IN		111	IN	109.1
				1.00	-
10.00Did this hospital participate in the Rural Community Hospita	L Demonstrati	on project (8	\$410A	1.00 N	110. (
Demonstration) for the current cost reporting period? Enter " complete Worksheet E, Part A, lines 200 through 218, and Wor	Y" for yes or	"N" for no.	lf yes,	11	

alth Financial Systems ASCENSION ST. VI DSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CC	CN: 15-1308	Peri od:	eu of Form CMS Worksheet S-	
			From 07/01/202 To 06/30/202		
		I		1172772022 7	
11.00 If this facility qualifies as a CAH, did it participate in th Health Integration Project (FCHIP) demonstration for this cos "Y" for yes or "N" for no in column 1. If the response to col integration prong of the FCHIP demo in which this CAH is part Enter all that apply: "A" for Ambulance services; "B" for add for tele-health services.	st reporting p umn 1 is Y, e icipating in	period? Enter enter the column 2.	1.00 N	2.00	111. (
		1.00	2.00	3.00	-
12.00 Did this hospital participate in the Pennsylvania Rural Healt demonstration for any portion of the current cost reporting p Enter "Y" for yes or "N" for no in column 1. If column 1 is in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceas participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information	oeriod? "Y", enter e	N			112. (
15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or in column 1. If column 1 is yes, enter the method used (A, B, in column 2. If column 2 is "E", enter in column 3 either "93 for short term hospital or "98" percent for long term care (i psychiatric, rehabilitation and long term hospitals providers the definition in CMS Pub. 15-1, chapter 22, §2208.1.	or E only) 5" percent ncludes 5) based on	N			0115.
16.00 Is this facility classified as a referral center? Enter "Y" f "N" for no.	for yes or	N			116. (
7.00 Is this facility legally-required to carry malpractice insura "Y" for yes or "N" for no.	nce? Enter	Y			117.
18.00 Is the malpractice insurance a claims-made or occurrence poli if the policy is claim-made. Enter 2 if the policy is occurred			2		118.
8.01 List amounts of malpractice premiums and paid losses:		Premi ums 1.00 146,4	Losses 2.00	3.00	0118.
8.02 Are malpractice premiums and paid losses reported in a cost of Administrative and General? If yes, submit supporting schedu and amounts contained therein.			1.00 N	2.00	118.
9. 00 D0 NOT USE THIS LINE 0. 00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qua Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.	column 1, "Y" difies for th	' for yes or ne Outpatient		N	119. 120.
1.00Did this facility incur and report costs for high cost implan patients? Enter "Y" for yes or "N" for no.	ntable devices	s charged to	Y		121.
2. 00 Does the cost report contain healthcare related taxes as defi Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information				5.00	122.
5.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 5.00 If this is a Medicare certified kidney transplant center, ent in column 1 and termination date, if applicable, in column 2.	er the certif		N		125. 126.
7.00 If this is a Medicare certified heart transplant center, enter in column 1 and termination date, if applicable, in column 2.	er the certifi	cation date			127.
3.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2.	er the certifi				128.
0.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2.			n		129.
0.00 If this is a Medicare certified pancreas transplant center, e date in column 1 and termination date, if applicable, in colum.00 If this is a Medicare certified intestinal transplant center,	ımn 2.				130.
	imn 2.				132.
date in column 1 and termination date, if applicable, in colu		cation uate	1	1	
 date in column 1 and termination date, if applicable, in colu 2.00 If this is a Medicare certified islet transplant center, enter in column 1 and termination date, if applicable, in column 2. 3.00 Removed and reserved 4.00 If this is an organ procurement organization (0P0), enter the and termination date, if applicable, in column 2. 	er the certifi				133. 134.

OSPITAL AND HOSPITAL HEALTH CARE COMPLE		ATA	ICENT MERCY Provider CO	CN: 15-1308		: 7/01/2021 6/30/2022	u of Form CMS- Worksheet S-2 Part I Date/Time Pre 11/29/2022 9:	2 epared:
<u> </u>	in organization on	<u>2.00</u>	nes 141 thro	uah 1/3 th/	name an	3.00 d.address	of the	
home office and enter the home of					and ine an	u adul ess	or the	
41.00 Name: ASCENSION ST. VINCENT	Contractor's N				ctor's Nu	umber: 0800	1	141. 0
42.00 Street: 250 WEST 96TH STREET SUITE	1						_	142.00
43.00 City: INDIANAPOLIS	State:	IN		Zip Co	de:	4626	0	143.00
							1.00	-
44.00 Are provider based physicians' cos	sts included in Work	ksheet A?					Y	144.00
		. 74				1.00	2.00	1.45 0
 45.00 If costs for renal services are clipatient services only? Enter "Y" no, does the dialysis facility inceperiod? Enter "Y" for yes or "N" 46.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/d) 	" for yes or "N" for clude Medicare utili for no in column 2. gy changed from the n column 1. (See CMS	r no in co ization fo previousl S Pub. 15–	olumn 1. lf o or this cost y filed cos [.]	column 1 is reporting t report?		Ν		145. 0
							1.00	4
47.00Was there a change in the statisti 48.00Was there a change in the order of							N N	147.0 148.0
48.00 was there a change in the order of 49.00 Was there a change to the simplifi					or no		N	148.0
			Part A	Part B		ītle V	Title XIX	
			1.00	2.00		3.00	4.00	
Does this facility contain a prov								
or charges? Enter "Y" for yes or ' 55.00Hospital	"N" for no for each	componen	<u>t for Part A</u> N	and Part E	3. (See 4	<u>2 CFR §413</u> N	. 13) N	155. 0
56.00 Subprovider - IPF			N	N N		N	N	156. 0
57.00 Subprovi der – I RF			N	N		N	N	157. C
58. 00 SUBPROVI DER								158.0
59.00 SNF			N	N		N	N	159.0
60.00HOME HEALTH AGENCY 61.00CMHC			N	N N		N N	N N	160. 0 161. 0
						IN .	14	101.0
							1.00	
Multicampus					E	204-2	N	1/5 0
65.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	ampus nospitai that	nas one o	or more campi	uses in dit	Terent C	3SAS?	N	165.0
	Name		County	State	Zip Code	CBSA	FTE/Campus	
	0		1.00	2.00	3.00	4.00	5.00	
66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)							0.00	0 166. 0
							1.00	
Health Information Technology (HI					nent Act			
57.00 s this provider a meaningful user 58.00 f this provider is a CAH (line 10 reasonable cost incurred for the H	05 is "Y") and is a	meani ngfu	ul user (line		"), ente	r the	Y	167. C
58.01 If this provider is a CAH and is r				r qualify f	or a har	dshi p		168. 0
exception under §413.70(a)(6)(ii)	? Enter "Y" for yes	or "N" fo	or no. (see i	instruction	s)	•		
		(") and is	s not a CAH	(line 105 i	s "N"), (enter the	0.0	0169. C
59.00 If this provider is a meaningful u	JII3)				Be	ai nni ng	Endi ng	
						1.00	¥	1
59.00 If this provider is a meaningful u						1.00	2.00	
59.00 If this provider is a meaningful to transition factor. (see instruction	beginning date and e	endi ng dat	te for the re	eporting		1.00	2.00	170. C
69.00 If this provider is a meaningful to transition factor. (see instruction 70.00 Enter in columns 1 and 2 the EHR H	beginning date and e	endi ng dat	te for the re	eporting		1.00	2.00	170. 0

	Financial Systems ASCENSION ST. V AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-1308	Peri od:	u of Form CMS Worksheet S-	
				From 07/01/2021 To 06/30/2022	Part II	epared
		I		Y/N	Date	. 14 ai
	General Instruction: Enter Y for all YES responses. Enter N	for all NO ro	choncoc Ent	1.00	2.00	
	mm/dd/yyyy format.		sponses. Litt		ine	
	COMPLETED BY ALL HOSPITALS					
00	Provider Organization and Operation Has the provider changed ownership immediately prior to the	beginning of	the cost	N		1.
	reporting period? If yes, enter the date of the change in co	olumn 2. (see	instructions			
			Y/N	Date	V/I	_
00	Has the provider terminated participation in the Medicare Pr	rogram?lf	1.00 N	2.00	3.00	2.
	yes, enter in column 2 the date of termination and in column voluntary or "I" for involuntary.	n 3, "V" for				
00	Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home of or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members of of directors through ownership, control, or family and other relationships? (see instructions)	fices, drug er or its the board	N			3.
			Y/N	Туре	Date	
			1.00	2.00	3.00	
00	Financial Data and Reports Column 1: Were the financial statements prepared by a Certi Accountant? Column 2: If yes, enter "A" for Audited, "C" fo or "R" for Reviewed. Submit complete copy or enter date avai column 3. (see instructions) If no, see instructions.	or Compiled,	Y	A		4
00	Are the cost report total expenses and total revenues differ those on the filed financial statements? If yes, submit reco		N			5
				Y/N 1.00	Legal Oper. 2.00	+
	Approved Educational Activities					
00	Column 1: Are costs claimed for a nursing program? Column 2 is the legal operator of the program?	2: If yes, is	the provide	r N		6
00	Are costs claimed for Allied Health Programs? If "Y" see ins	structions.		Ν		7
00	Were nursing programs and/or allied health programs approved	d and∕or renew	ed during th	e N		8
00	cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved g	graduate medic	al education	Ν		9
00	program in the current cost report? If yes, see instructions Was an approved Intern and Resident GME program initiated or	S.		Ν		10
. 00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	N		11
					Y/N 1.00	+
	Bad Debts				1.00	
	Is the provider seeking reimbursement for bad debts? If yes, If line 12 is yes, did the provider's bad debt collection poperiod? If yes, submit copy.			ost reporting	Y N	12
00	If line 12 is yes, were patient deductibles and/or co-paymer Bed Complement				N	14
00	Did total beds available change from the prior cost reportin				Y + P	15
		Y/N	t A Date	Y/N	<u>t B</u> Date	-
		1.00	2.00	3.00	4.00	
00	PS&R Data Was the cost report prepared using the PS&R Report only?	Y	10/07/2022	Y	10/07/2022	16
	If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions)					
00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Ν		Ν		17
00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	Ν		N		18
	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R	Ν		Ν		19

Heal th Financial	Systems
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Health Financial Systems ASCENSIO	N ST. V	/INCENT MERCY		In Lie	u of Form CM	S-2552-1
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAI		Provider CO		Period: From 07/01/2021	Worksheet S Part II	
				To 06/30/2022		
		Descri		Y/N	Y/N	
	0 D	()	1.00	3.00	0.0.0
20.00 If line 16 or 17 is yes, were adjustments made to PS& Report data for Other? Describe the other adjustments				Ν	Ν	20.00
	-	Y/N 1.00	Date 2.00	Y/N 3.00	Date 4.00	
21.00 Was the cost report prepared only using the provider'	's	N 1.00	2.00	N	4.00	21.00
records? If yes, see instructions.						_
					1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY Capital Related Cost	Y (EXCE	PT CHILDRENS H	OSPI TALS)			_
2.00 Have assets been relifed for Medicare purposes? If ye	es. see	instructions			N	22.00
3.00 Have changes occurred in the Medicare depreciation ex			als made duri	ng the cost	N	23.0
reporting period? If yes, see instructions. 4.00 Were new leases and/or amendments to existing leases	entere	ed into during	this cost rep	orting period?	Ν	24.0
If yes, see instructions 25.00 Have there been new capitalized leases entered into c	duri na	the cost repor	ting period?	lf ves, see	Ν	25.0
instructions.	0		0.1	5		
6.00 Were assets subject to Sec. 2314 of DEFRA acquired dur instructions.	ring th	e cost reporti	ng period? If	yes, see	N	26.0
17.00 Has the provider's capitalization policy changed duri copy.	ing the	e cost reportin	g period? If	yes, submit	Ν	27.0
Interest Expense						
8.00 Were new loans, mortgage agreements or letters of cre period? If yes, see instructions.	edit en	itered into dur	ing the cost	reporting	N	28.0
9.00 Did the provider have a funded depreciation account a			bt Service Re	serve Fund)	Ν	29.0
treated as a funded depreciation account? If yes, see Has existing debt been replaced prior to its schedule			debt? If yes,	see	Ν	30. 0
instructions. 1.00 Has debt been recalled before scheduled maturity with	hout is	suance of new	debt? If yes,	see	Ν	31.0
instructions. Purchased Services						-
2.00 Have changes or new agreements occurred in patient ca			d through con	tractual	Ν	32.0
arrangements with suppliers of services? If yes, see 3.00 If line 32 is yes, were the requirements of Sec. 2135 no, see instructions.			g to competit	ive bidding? If	Ν	33. C
Provi der-Based Physi ci ans						
4.00 Are services furnished at the provider facility under If yes, see instructions.	r an ar	rangement with	provi der-bas	ed physi ci ans?	Y	34. C
5.00 If line 34 is yes, were there new agreements or ameno physicians during the cost reporting period? If yes,	ded exi	sting agreemen	ts with the p	rovi der-based	Y	35. C
physicians during the cost reporting period: in yes,	300 III			Y/N	Date	
Home Office Costs				1.00	2.00	
6.00 Were home office costs claimed on the cost report?				Y		36.0
7.00 If line 36 is yes, has a home office cost statement k	been pr	epared by the	home office?	Y		37.0
If yes, see instructions. 8.00 If line 36 is yes , was the fiscal year end of the ho	ome off	ice different	from that of	Ν		38. C
9.00 If line 36 is yes, did the provider render services t				Ν		39.0
see instructions.			5			
0.00 If line 36 is yes, did the provider render services 1 instructions.	to the	nome office?	IT yes, see	N		40. C
		1.	00	2	00	_
Cost Report Preparer Contact Information						
1.00 Enter the first name, last name and the title/positic held by the cost report preparer in columns 1, 2, and		JILL		HILL		41.0
Inter the employer/company name of the cost report		ASCENSI ON				42.0
preparer. 13.00 Enter the telephone number and email address of the c	cost	N/A		JI LL. HI LL1@ASC	ENSI ON. ORG	43.0
report preparer in columns 1 and 2, respectively.						

Heal th	Financial Systems ASCENSION ST.	VINCENT MERCY	In Lie	u of Form CMS-:	2552-10
H0SPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1308	Period: From 07/01/2021	Worksheet S-2 Part II	
			To 06/30/2022		pared: <u>14 am</u>
		3.00			
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position	MANAGER OF REIMBURSEMENT			41.00
	held by the cost report preparer in columns 1, 2, and 3,				
	respectively.				
42.00	Enter the employer/company name of the cost report				42.00
	preparer.				
43.00	Enter the telephone number and email address of the cost				43.00
	report preparer in columns 1 and 2, respectively.				

^{11/29/2022 9:14} am Y: \28650 - St. Vincent Mercy\300 - Medicare Cost Report\20220630\HFS\20220630 St. Vincent Mercy.mcrx

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	CN: 15-1308	Peri od:	Worksheet S-3	;
					From 07/01/202 To 06/30/2022		
						I/P Days / O/P Visits / Trips	
	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00	18	6, 5		0 0	1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2.00
3.00	HMO I PF Subprovi der						3.00
4.00	HMO I RF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	
6.00	Hospital Adults & Peds. Swing Bed NF		10	(F		0	
7.00	Total Adults and Peds. (exclude observation		18	6, 5	70 24, 048. 0	0 0	7.00
8.00	beds) (see instructions) INTENSIVE CARE UNIT	31.00	0		0 0.0	o l	8.00
9.00	CORONARY CARE UNIT	31.00	0		0.0		9.00
9.00 10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGI CAL I NTENSI VE CARE UNI T						11.00
12.00	DETOXIFICATION INTENSIVE CARE UNIT	35.00	0		0 0.0	0 0	
13.00	NURSERY	55.00	0		0.0		13.00
14.00	Total (see instructions)		18	6, 5	70 24, 048. 0	o l	
15.00	CAH visits			0,0	21,01010	0	
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						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	
27.00	Total (sum of lines 14-26)		18				27.00
28.00	Observation Bed Days					0	
29.00	Ambul ance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF		_				31.00
32.00	Labor & delivery days (see instructions)		0		0		32.00
32.01	Total ancillary labor & delivery room						32.01
33.00	outpatient days (see instructions) LTCH non-covered days						22 00
					1	1	33.00

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	CN: 15-1308	Period: From 07/01/2021 To 06/30/2022	Worksheet S-3 Part I Date/Time Pre 11/29/2022 9:	pared:
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00 2.00 3.00 4.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider	277 413 0 0	27 127 0 0	90	77		1.00 2.00 3.00 4.00
5.00 6.00 7.00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation	26 303	0 0 27	1, 04	97 0 94		5.00 6.00 7.00
8.00 9.00 10.00 11.00 12.00	beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT DETOXIFICATION INTENSIVE CARE UNIT	0	0		0		8.00 9.00 10.00 11.00
12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00	NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE	303 5, 971	27 515	1, 00 29, 7	94 0.00	64. 75	13.00
22.00 23.00 24.00 24.10 25.00 26.00	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC				0		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	FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room	0 0 0	0	3.	0 0.00 0.00 25 5 0 0 0		26.25
33. 00 33. 01	outpatient days (see instructions) LTCH non-covered days LTCH site neutral days and discharges	0 0					33. 0 33. 0

HOSPI T	Financial Systems / AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC/	ASCENSION ST. VI AL DATA	Provider C	CN: 15-1308	Period: From 07/01/2021 To 06/30/2022	Worksheet S-3 Worksheet S-3 Part I Date/Time Pre 11/29/2022 9:	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	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2		0		74 15		1.00
2.00	for the portion of LDP room available beds) HMO and other (see instructions)				96 31 0		2.00
3.00 4.00 5.00	HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF				0		3.00 4.00 5.00
6.00 7.00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions)						6.00 7.00
8.00 9.00	INTENSIVE CARE UNIT CORONARY CARE UNIT						8.00 9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	DETOXIFICATION INTENSIVE CARE UNIT						12.00
13.00 14.00	NURSERY	0, 00	0		74 15	270	13.00 14.00
14.00	Total (see instructions) CAH visits	0.00	0		74 13	270	14.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00 24.00	AMBULATORY SURGI CAL CENTER (D. P.) HOSPI CE						23.00 24.00
24.00 24.10	HOSPICE (non-distinct part)						24.00
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambul ance Tri ps						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32. 01 33. 00	Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days				0		32. 01 33. 00
	LTCH site neutral days and discharges				0		33.01

Heal th	Ith Financial Systems ASCENSION ST. VINCENT MERCY In Lieu of Form CMS-2552-10									
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CC		Peri od:	Worksheet S-1	C				
				From 07/01/2021 To 06/30/2022	Date/Time Pre	arod				
				10 00/30/2022	11/29/2022 9:					
					1.00					
	Uncompensated and indigent care cost computation									
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 div	ided by li	ne 202 column	8)	0. 311077	1.00				
	Medicaid (see instructions for each line)				1 000 540					
2.00	Net revenue from Medicaid				1, 938, 519	2.00				
3.00 4.00	Did you receive DSH or supplemental payments from Medicaid? If line 3 is yes, does line 2 include all DSH and/or supplement	al novmant	s from Modica	1 42	N	3.00 4.00				
4.00 5.00	If line 4 is no, then enter DSH and/or supplemental payments fr			iu?	0	4.00 5.00				
6.00	Medi cai d charges	om meurcar	u		19, 312, 105	6.00				
7.00	Medicaid cost (line 1 times line 6)		6, 007, 552	7.00						
8.00	Difference between net revenue and costs for Medicaid program (es 2 and 5; if	4, 069, 033							
	< zero then enter zero)									
	Children's Health Insurance Program (CHIP) (see instructions fo	r each line	e)							
9.00	Net revenue from stand-alone CHIP				0	9.00				
10.00	Stand-alone CHIP charges				0	10.00				
11.00	Stand-alone CHIP cost (line 1 times line 10)			с н	0	11.00				
12.00	Difference between net revenue and costs for stand-alone CHIP (enter zero)	line 11 mi	nus line 9; i	f < zero then	0	12.00				
	Other state or local government indigent care program (see inst	ructions fo	or each line)							
13.00	Net revenue from state or local indigent care program (Net incl				0	13.00				
14.00	Charges for patients covered under state or local indigent care				0	14.00				
	10)	p. 29 (-					
15.00	State or local indigent care program cost (line 1 times line 14)			0	15.00				
16.00	Difference between net revenue and costs for state or local ind	igent care	program (lin	e 15 minus line	0	16.00				
	13; if < zero then enter zero)	-								
	Grants, donations and total unreimbursed cost for Medicaid, CHI	P and state	e/local indig	ent care program	ns (see					
17.00	instructions for each line) Private grants, donations, or endowment income restricted to fu	nding char	ity caro		0	17.00				
18.00	Government grants, appropriations or transfers for support of h				0	18.00				
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local			(sum of lines	4, 069, 033					
	8, 12 and 16)			(.,,					
			Uni nsured	Insured	Total (col. 1					
			patients	pati ents	+ col. 2)					
			1.00	2.00	3.00					
20.00	Uncompensated Care (see instructions for each line)		(0/ 00		1 107 050	20.00				
20.00	Charity care charges and uninsured discounts for the entire fac (see instructions)	ility	686, 90	2 501, 056	1, 187, 958	20.00				
21.00	Cost of patients approved for charity care and uninsured discou	nts (see	213, 67	9 501, 056	714, 735	21.00				
21.00	instructions)	1113 (300	215,07	, 501, 656	/14,755	21.00				
22.00	Payments received from patients for amounts previously written	off as		0 0	0	22.00				
	chari ty care									
23.00	Cost of charity care (line 21 minus line 22)		213, 67	9 501, 056	714, 735	23.00				
				<u> </u>	1.00					
24.00	Does the amount on line 20 column 2, include charges for patien		ond a length	of stay limit	N	24.00				
25.00	imposed on patients covered by Medicaid or other indigent care program? 0 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of									
23.00	stay limit									
26.00	Total bad debt expense for the entire hospital complex (see ins	tructions)			1, 641, 229	26.00				
27.00	Medicare reimbursable bad debts for the entire hospital complex		ructions)		217, 714					
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions) 334,944 27.0									
28.00	Non-Medicare bad debt expense (see instructions)				1, 306, 285	28.00				
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt exp	ense (see	instructions)		523, 585					
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)				1, 238, 320					
31.00	Total unreimbursed and uncompensated care cost (line 19 plus li	ne 30)			5, 307, 353	31.00				

Heal th	Financial Systems	ASCENSION ST. VI	NCENT MERCY		In Lie	eu of Form CMS-:	2552-10
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	F EXPENSES	Provider C	CN: 15-1308	Period:	Worksheet A	
				-	From 07/01/2021 To 06/30/2022	Date/Time Pre	pared:
						11/29/2022 9:	
	Cost Center Description	Sal ari es	Other		Recl assi fi cati	Recl assi fi ed	
				+ 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	2.00	0.00	1.00	0.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT		1, 265, 639	1, 265, 639	9 0	1, 265, 639	1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP		581, 510			581, 510	•
3.00	00300 OTHER CAPITAL RELATED COSTS		0	(0 0	0	3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	102, 340	1, 402, 321	1, 504, 66	1 0	1, 504, 661	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	393, 977	5, 620, 314			6, 014, 291	•
7.00	00700 OPERATION OF PLANT	0	1, 194, 100			1, 194, 100	•
8.00	00800 LAUNDRY & LINEN SERVICE	0	0	(48, 261	•
9.00	00900 HOUSEKEEPI NG	0	637, 474			589, 213	•
10.00	01000 DI ETARY	0	503, 525				•
11.00		0 51 257	11				•
13.00	01300 NURSI NG ADMI NI STRATI ON	51, 357 229, 834	12,068			63, 425	•
15.00 16.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	229, 834	3, 432, 129		3 -65 0 0	3, 661, 898 0	1
17.00	01700 SOCIAL SERVICE	101, 409	35, 889		0	137, 298	•
17.00	INPATIENT ROUTINE SERVICE COST CENTERS	101, 409	33,007	137,270	5 0	137,270	17.00
30.00	03000 ADULTS & PEDI ATRI CS	901, 525	333, 692	1, 235, 21	7 - 396	1, 234, 821	30.00
31.00	03100 I NTENSI VE CARE UNI T	01,020	000,072		0 0	0	
35.00	02040 DETOXIFICATION INTENSIVE CARE UNIT	0	0		0 0		
	ANCILLARY SERVICE COST CENTERS	-1					1
50.00	05000 OPERATING ROOM	392, 885	237, 754	630, 639	- 395, 889	234, 750	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	859, 302	46, 740	906, 042	-3,060	902, 982	54.00
56.00	05600 RADI OI SOTOPE	0	0		0 0	0	56.00
57.00	05700 CT SCAN	0	0	(0 0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	· ·	0 0	0	58.00
60.00	06000 LABORATORY	0	1, 383, 193			1, 383, 193	•
65.00	06500 RESPI RATORY THERAPY	483, 495	28, 503			511, 998	•
66.00	06600 PHYSI CAL THERAPY	339, 925	21, 428			355, 482	•
67.00	06700 OCCUPATIONAL THERAPY	20, 838	0	20, 83		26, 709	
68.00	06800 SPEECH PATHOLOGY	28, 028	0	28, 028		28, 028	•
69.00		0	0		0	0	
70.00 71.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	29, 944	29, 94	414,007	443, 951	
72.00	07200 I MPLANTABLE DEVICES CHARGED TO	0	344, 235			344, 235	•
72.00	PATIENTS	0	544, 255	544, 25,	0	544, 255	/2.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	3, 343	3, 343	3 0	3, 343	73.00
76.00	03610 SLEEP LAB	12, 894	1, 547			14, 441	1
76.01	03480 ONCOLOGY	241, 434	38, 065		9 0	279, 499	1
	OUTPATIENT SERVICE COST CENTERS						1
90.00	09000 CLI NI C	231, 404	35, 152	266, 550	6 -7, 596	258, 960	90.00
91.00	09100 EMERGENCY	1, 336, 646	1, 697, 126	3, 033, 772	2 -7, 001	3, 026, 771	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS				-		
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	5, 727, 293	18, 885, 702	24, 612, 99	5 0	24, 612, 995	118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(0 0	0	190.00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0		0 0		192.00
	07950 MARKETI NG	0	0		0 0		194.00
	07951 FOUNDATI ON	0	0		0 0		194.01
	07952 CLI NI C	0	0	(0 0		194. 02
	07953 VACANT	0	0	(0 0		194.03
200.00	TOTAL (SUM OF LINES 118 through 199)	5, 727, 293	18, 885, 702	24, 612, 99	5 0	24, 612, 995	200. 00

Heal th	Financial Systems	ASCENSION ST. \	VINCENT MERCY		In Lie	u of Form CMS-	2552-10
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CC	N: 15-1308	Peri od:	Worksheet A	
					From 07/01/2021	Data /Tima Dra	nored.
					To 06/30/2022	Date/Time Pre 11/29/2022 9:	
	Cost Center Description	Adjustments	Net Expenses			11/2//2022 /.	
	···· · · · · · · · · · · · · · · · · ·		For Allocation				
		6.00	7.00				
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	-373, 172	892, 467				1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP	0	581, 510				2.00
3.00	00300 OTHER CAPITAL RELATED COSTS	0	0				3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	47, 308	1, 551, 969				4.00
5.00	00500 ADMINISTRATIVE & GENERAL	436, 038	6, 450, 329				5.00
7.00	00700 OPERATION OF PLANT	0	1, 194, 100				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	48, 261				8.00
9.00	00900 HOUSEKEEPI NG	0	589, 213				9.00
10.00	01000 DI ETARY	0	65, 230				10.00
11.00	01100 CAFETERI A	-46, 148	392, 158				11.00
13.00	01300 NURSING ADMINISTRATION	-3,857	59, 568				13.00
15.00	01500 PHARMACY	-5,366	3, 656, 532				15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	0				16.00
17.00	01700 SOCIAL SERVICE	1, 767	139, 065				17.00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	-278, 800	956, 021				30.00
31.00	03100 I NTENSI VE CARE UNI T	0	0				31.00
35.00	02040 DETOXIFICATION INTENSIVE CARE UNIT	0	0				35.00
	ANCI LLARY SERVICE COST CENTERS	-					
50.00	O5000 OPERATING ROOM	0	234, 750				50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	-3, 809	899, 173				54.00
56.00	05600 RADI OI SOTOPE	0	0				56.00
57.00	05700 CT SCAN	0	0				57.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0				58.00
60.00	06000 LABORATORY	-180	1, 383, 013				60.00
65.00	06500 RESPI RATORY THERAPY	0	511, 998				65.00
66.00	06600 PHYSI CAL THERAPY	0	355, 482				66.00
67.00	06700 OCCUPATIONAL THERAPY	0	26, 709				67.00
68.00	06800 SPEECH PATHOLOGY	0	28, 028				68.00
69.00	06900 ELECTROCARDI OLOGY	0	0				69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	-45, 858	398, 093				71.00
72.00	07200 I MPLANTABLE DEVI CES CHARGED TO PATI ENTS	0	344, 235				72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	2 242				73.00
76.00	03610 SLEEP LAB	0	3, 343 14, 441				76.00
76.00	03480 ONCOLOGY	0	279, 499				76.00
70.01	OUTPATIENT SERVICE COST CENTERS	0	217,477				70.01
90.00	09000 CLINIC	0	258, 960				90.00
90.00 91.00	09100 EMERGENCY	0	3, 026, 771				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	3, 020, 771				92.00
72.00	SPECIAL PURPOSE COST CENTERS		<u> </u>				72.00
118.00		-272,077	24, 340, 918				118.00
110.00	NONREI MBURSABLE COST CENTERS	272,077	21,010,710				
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190.00
	19200 PHYSI CLANS' PRI VATE OFFICES	0	0				192.00
	07950 MARKETI NG	0	0				194.00
	07951 FOUNDATI ON	0	0				194.00
	07952 CLINIC	0	0				194.02
	07953 VACANT	0	0				194.03
200.00		-272,077	24, 340, 918				200.00

Heal th	Financial Systems		ASCENSION ST.	VINCENT MERCY		In Lie	u of Form CMS	-2552-10
RECLAS	SIFICATIONS			Provider (Provider CCN: 15-1308 Period:		Worksheet A-	6
						From 07/01/2021 To 06/30/2022	Date/Time Pr 11/29/2022 9	epared: :14 am
		Increases						
	Cost Center	Line #	Sal ary	Other				
	2.00	3.00	4.00	5.00				
	A – CAFETERIA				1			_
1.00	CAFETERI A	<u>11.</u> 00	0	43 <u>8, 2</u> 95				1.00
	TOTALS		0	438, 295				_
	B - Laundry		-1		1			
1.00	LAUNDRY & LINEN SERVICE		0	48, 261				1.00
	TOTALS		0	48, 261				_
4 00	D - Billable Med Supplies	74.00		44.4 007	1			1 00
1.00	MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	71.00		414, 007				1.00
2.00	PATTENTS							2.00
3.00								3.00
4.00								4.00
5.00								5.00
6.00								6.00
			— — — ₀	414,007	-			
	E - OCCUPATIONAL THERAPY RECL	ASS						1
1.00	OCCUPATI ONAL THERAPY	67.00	5, 871					1.00
			5, 871	0				
500.00	Grand Total: Increases		5, 871	900, 563				500.00

Heal th	Financial Systems		ASCENSION ST. VI	NCENT MERCY		In Lie	u of Form CMS-2552-	10
RECLAS	SIFICATIONS			Provider (CCN: 15-1308	Peri od:	Worksheet A-6	_
						From 07/01/2021 To 06/30/2022	Date/Time Prepared 11/29/2022 9:14 am	l: n
		Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref			
	6.00	7.00	8.00	9.00	10.00			
	A – CAFETERIA							
1.00	DI ETARY		0	43 <u>8, 2</u> 95	j	0	1.0	00
	TOTALS		0	438, 295)			
	B - Laundry							
1.00	HOUSEKEEPI NG	9.00	0	48, 261		0	1.0	00
	TOTALS		0	48, 261				
	D - Billable Med Supplies							
1.00	PHARMACY	15.00		65)		1.0	00
2.00	ADULTS & PEDIATRICS	30.00		396	0		2.0	00
3.00	OPERATING ROOM	50.00		395, 889			3.0	00
4.00	RADI OLOGY-DI AGNOSTI C	54.00		3, 060)		4.0	00
5.00	EMERGENCY	91.00		7, 001			5.0	00
6.00		90.00		<u>7, 5</u> 96			6.0	00
			0	414, 007	7			
	E - OCCUPATIONAL THERAPY RECL	ASS						
1.00	PHYSICAL THERAPY	66.00	5, 871				1.0	00
			5, 871	0	,			
500.00	Grand Total: Decreases		5, 871	900, 563	8		500.0	00

Heal th	Financial Systems	ASCENSION ST. V	/INCENT MERCY		In Lie	eu of Form CMS-2	2552-10
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provider CC		Period: From 07/01/2021 To 06/30/2022		
				Acqui si ti on:			
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1.00	Land	465, 381	0		0 0	0 0	1.00
2.00	Land Improvements	589, 750	231, 526		0 231, 526	0	2.00
3.00	Buildings and Fixtures	13, 353, 069	0		0 0	0 0	3.00
4.00	Building Improvements	9, 926, 251	3, 934		0 3, 934	l 0	4.00
5.00	Fixed Equipment	3, 832, 878	699, 821		0 699, 821	0	5.00
6.00	Movable Equipment	8, 157, 149	0		0 0	134, 089	6.00
7.00	HIT designated Assets	0	0		0 0	0 0	7.00
8.00	Subtotal (sum of lines 1-7)	36, 324, 478	935, 281		0 935, 281	134, 089	8.00
9.00	Reconciling Items	0	0		0 0	0 0	9.00
10.00	Total (line 8 minus line 9)	36, 324, 478	935, 281		0 935, 281	134, 089	10.00
		Ending Balance	Fully				
		5	Depreciated				
			Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES					
1.00	Land	465, 381	0				1.00
2.00	Land Improvements	821, 276	0				2.00
3.00	Buildings and Fixtures	13, 353, 069	0				3.00
4.00	Building Improvements	9, 930, 185	0				4.00
5.00	Fixed Equipment	4, 532, 699	0				5.00
6.00	Movable Equipment	8, 023, 060	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	37, 125, 670	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	37, 125, 670	0				10.00

^{11/29/2022 9:14} am Y: \28650 - St. Vincent Mercy\300 - Medicare Cost Report\20220630\HFS\20220630 St. Vincent Mercy.mcrx

Heal th	Financial Systems	ASCENSION ST. \	/INCENT MERCY		In Lieu of Form CMS-2552-10		
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provider CC		Peri od:	Worksheet A-7	
					From 07/01/2021 To 06/30/2022		narod
					10 00/30/2022	11/29/2022 9:	
			SU	IMMARY OF CAPI	TAL		
				r	- F		
	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	NEW CAP REL COSTS-BLDG & FIXT	892, 345		373, 17	3 0	121	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	512, 665			0 0	0	2.00
3.00	Total (sum of lines 1-2)	1, 405, 010		373, 17	3 0	121	3.00
		SUMMARY 0	F CAPITAL				
	Cost Center Description		Total (1) (sum				
		Capi tal -Rel ate					
		d Costs (see	through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM					
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1, 265, 639	1			1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	581, 510				2.00
3.00	Total (sum of lines 1-2)	0	1, 847, 149				3.00

Health Financial Systems	ASCENSI ON ST.	VINCENT MERCY		In Lie	u of Form CMS-2	552-10	
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 07/01/2021 To 06/30/2022			
	COM	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPI TAL		
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance		
		Leases	for Ratio (col. 1 - col 2)	instructions)			
	1.00	2.00	3.00	4.00	5.00		
PART III - RECONCILIATION OF CAPITAL COSTS C							
1.00 NEW CAP REL COSTS-BLDG & FIXT	14, 639, 726				0	1.00	
2.00 NEW CAP REL COSTS-MVBLE EQUIP	22, 485, 944		,, .		0	2.00	
3.00 Total (sum of lines 1-2)	37, 125, 670		37, 125, 67			3.00	
	ALLOCA	ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL					
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease		
		Capi tal -Rel ate					
		d Costs	through 7)				
	6.00	7.00	8.00	9.00	10.00		
PART III - RECONCILIATION OF CAPITAL COSTS C	1	-					
1.00 NEW CAP REL COSTS-BLDG & FIXT	0	0		0 892, 345		1.00	
2.00 NEW CAP REL COSTS-MVBLE EQUIP	0	0		0 512, 665		2.00	
3.00 Total (sum of lines 1-2)	0	1 <u>0</u>		0 1, 405, 010	68, 845	3.00	
		SU	JMMARY OF CAPI	TAL			
Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum		
		instructions)	instructions)				
				d Costs (see	through 14)		
	44.00	10.00	10.00	instructions)	45.00		
	11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS C 1.00 NEW CAP REL COSTS-BLDG & FIXT		0	12	1 0	892, 467	1.00	
2.00 NEW CAP REL COSTS-BLDG & FIXT		0			581, 510	2.00	
3.00 Total (sum of lines 1-2)	1	0		-	1, 473, 977	2.00 3.00	
	1	1 0	1 12	·i 0	, , , , , , , , , , , , , , , , , , , ,	5.00	

	MENTS TO EXPENSES			F	eriod: rom 07/01/2021 o 06/30/2022	Worksheet A-8 Date/Time Pre	parad
						11/29/2022 9:	
			-	Expense Classification on To/From Which the Amount is			
	Cost Center Description		Amount	Cost Center		Wkst. A-7 Ref.	
. 00	Investment income - NEW CAP	1.00 B	2.00	3.00 NEW CAP REL COSTS-BLDG &	4.00	5.00 11	1.0
	REL COSTS-BLDG & FIXT (chapter 2)	5		FIXT			
. 00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.0
. 00	Investment income - other	В	-10, 575	ADMI NI STRATI VE & GENERAL	5.00	0	3. 0
. 00	(chapter 2) Trade, quantity, and time		0		0.00	0	4.0
. 00	discounts (chapter 8) Refunds and rebates of		0		0.00	0	5.0
. 00	expenses (chapter 8) Rental of provider space by		0		0.00	0	6.0
. 00	suppliers (chapter 8)		0		0.00	0	0.0
. 00	Tel ephone services (pay stations excluded) (chapter 21)	В	-7, 194/	ADMI NI STRATI VE & GENERAL	5.00	0	7.0
. 00	Television and radio service (chapter 21)		О		0.00	0	8. 0
. 00	Parking lot (chapter 21)		0		0.00	0	
0. 00	Provider-based physician adjustment	A-8-2	-282, 609			0	10. 0
1.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.0
2. 00	Related organization transactions (chapter 10)	A-8-1	1, 807, 913			0	12.0
	Laundry and linen service		0		0.00	0	13.0
4.00 5.00	Cafeteria-employees and guests Rental of quarters to employee	В	-46, 1480	CAFETERIA	11.00 0.00	0	
5. 00	and others Sale of medical and surgical		0		0.00		16.0
	supplies to other than patients						
. 00	Sale of drugs to other than patients	В	-5, 366	PHARMACY	15.00	0	17.0
8.00	Sale of medical records and		0		0.00	0	18.0
9. 00	abstracts Nursing and allied health education (tuition, fees,		0		0.00	0	19. 0
0 00	books, etc.) Vending machines		0		0.00	0	20. C
	Income from imposition of interest, finance or penalty		0		0.00	0	
. 00	charges (chapter 21) Interest expense on Medicare		0		0.00	0	22.0
	overpayments and borrowings to repay Medicare overpayments						
. 00	Adjustment for respiratory therapy costs in excess of	A-8-3	OF	RESPI RATORY THERAPY	65.00		23.0
. 00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	OF	PHYSI CAL THERAPY	66.00		24.0
. 00	limitation (chapter 14) Utilization review –		0	*** Cost Center Deleted ***	114.00		25.0
	physicians' compensation (chapter 21)						
o. 00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT			NEW CAP REL COSTS-BLDG & FLXT	1.00	0	26. C
. 00	Depreciation - NEW CAP REL		10	NEW CAP REL COSTS-MVBLE	2.00	0	27. C
3. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist			EQUIP *** Cost Center Deleted ***	19.00		28.0
9.00	Physicians' assistant		0		0.00	0	
0. 00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	00	OCCUPATI ONAL THERAPY	67.00		30. C
D. 99	Hospice (non-distinct) (see		o	ADULTS & PEDIATRICS	30.00		30. 9
1. 00	instructions) Adjustment for speech pathology costs in excess of	A-8-3	0	SPEECH PATHOLOGY	68.00		31. 0

Health Financial Systems		ASCENSION ST.	VINCENT MERCY	In Lie	eu of Form CMS-2	2552-10
ADJUSTMENTS TO EXPENSES				Peri od:	Worksheet A-8	
				From 07/01/2021		
				To 06/30/2022	Date/Time Prep 11/29/2022 9:	
	Expense Classification on Worksheet A					
			To/From Which the Amount is			
				, , , , , , , , , , , , , , , , , , ,		
Cost Center Description	Basis/Code (2)		Cost Center		Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	
32.00 CAH HIT Adjustment for		0		0.00	0	32.00
Depreciation and Interest						
33.00 Admin Revenue	В		ADMINISTRATIVE & GENERAL	5.00		33.00
33.01 LAB REVENUE	В	-180	LABORATORY	60.00		33.01
33.02 Social Service	В		SOCI AL SERVI CE	17.00		33.02
33.06 Lobbyi ng	A		ADMI NI STRATI VE & GENERAL	5.00		33.06
33.09 Bad Debt	A		ADMI NI STRATI VE & GENERAL	5.00		33.09
33.10 Med Affairs Admin	A		EMPLOYEE BENEFITS DEPARTMEN			33. 10
33.11 Med Affairs Admin	A	-14, 899	ADMI NI STRATI VE & GENERAL	5.00	0	33. 11
33.12 Provider Tax	A	-1, 202, 579	ADMI NI STRATI VE & GENERAL	5.00	0	33. 12
33.13 Advertising	A	-100	ADMINISTRATIVE & GENERAL	5.00	0	33. 13
33.16 Physician Fund Expense	A	-142, 467	ADMI NI STRATI VE & GENERAL	5.00	0	33. 16
50.00 TOTAL (sum of lines 1 thru 49)	-272, 077				50.00
(Transfer to Worksheet A,						
column 6, line 200.)						

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.

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

Heal th	Financial Systems	ASCENSION ST.	VINCENT MERCY	In Lieu of Form CMS-2552-10			
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOM		Period:	Worksheet A-8	-1	
OFFICE	COSTS			From 07/01/2021 To 06/30/2022		pared: 14 am	
	Line No.	Cost Center	Expense Items	Amount of	Amount		
				Allowable Cost	Included in		
					Wks. A, column		
					5		
	1.00	2.00	3.00	4.00	5.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS: 1.00 5.00 ADMINISTRATIVE & GENERAL Home Office - Capital 329.046 0							
1 00				220.04/	0	1 00	
1.00			Home Office - Capital		-	1.00	
2.00			Home Office - Interest	8, 668		2.00	
3.00			Home Office - Other	5, 614, 622		3.00	
3.01		EMPLOYEE BENEFITS DEPARTMENT		2, 751	2, 751	3.01	
3.02			SVH CHARGEBACKS 4, 000			3.02	
3.03			SVH CHARGEBACKS	11,004		3.03	
3.04			SVH CHARGEBACKS 3, 7			3.04	
3.05			SVH CHARGEBACKS	12, 300		3.05	
3.06		EMPLOYEE BENEFITS DEPARTMENT		839, 070		3.06	
3.07		NEW CAP REL COSTS-BLDG & FIX		368, 938		3.07	
3.08			Interest Expense	1, 907		3.08	
3.09		MEDICAL SUPPLIES CHARGED TO	TRG Admin Fees – Supplies	-45, 858	0	3.09	
3.10			TRG Admin Fees - Contracted	-3, 857		3.10	
3.11	5.00	ADMINISTRATIVE & GENERAL	TRG Admin Fees - Other	-38, 906	0	3. 11	
4.00	0.00			0	0	4.00	
5.00	TOTALS (sum of lines 1-4).			7, 107, 429	5, 299, 516	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.

 	· · · · · · · · · · · · · · · · · · ·			or this part.	
			Related Organization(s) and/	or Home Office	
			3 ()		
Symbol (1)	Name	Percentage of	Name	Percentage of	
Symbol (1)	Name		Name		
		Ownership		Ownershi p	
1.00	2.00	3.00	4.00	5.00	
B. INTERRELATIONSHIP TO RELAT	ED ORGANIZATION(S) AND/OR HO	ME OFFICE:	•		

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

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

rerinbur						
6.00	G	ASCENSION SVH	100.00	ASCENSION SVH	100. 00	6.00
7.00	G	ASCENSI ON	100.00	ASCENSI ON	100.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or	HOME OFFICE				100.00
	non-financial) specify:					

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

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

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

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

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

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

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

Health Financial Systems	ASCENSION ST. VIN	CENT MERCY	In Lieu	In Lieu of Form CMS-2552-10	
STATEMENT OF COSTS OF SERVICES FROM OFFICE COSTS	RELATED ORGANIZATIONS AND HOME	Provider CCN: 15-1308	Period: From 07/01/2021	Worksheet A-8-1	
			To 06/30/2022	Date/Time Prepared:	

					11/29/2022 9:	14 am
	Net	Wkst. A-7 Ref.				
	Adjustments					
	(col. 4 minus					
	col. 5)*					
	6.00	7.00				
	A. COSTS INCUR	RED AND ADJUSTN	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED C	RGANIZATIONS OR CLAIMED	
	HOME OFFICE CO	STS:				
1.00	329, 046	0				1.00
2.00	8, 668					2.00
3.00	1, 513, 772	0				3.00
3.01	0	0				3. 01
3.02	0	0				3. 02
3.03	0	0				3.03
3.04	0	0				3.04
3.05	0	0				3.05
3.06	47, 375	0				3.06
3.07	-4, 234	11				3.07
3.08	1,907	0				3.08
3.09	-45, 858	0				3.09
3.10	-3, 857	0				3.10
3.11	-38, 906	0				3. 11
4.00	0	0				4.00
5.00	1, 807, 913					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 Workchoot A columns 1 and/or 2 the amount allowable should be indic

nas not	been posted to worksneet A,	corumns r and/or 2,	the amount	allowable should	be indicated	In column 4	or this part.	
	Related Organization(s)							
	and/or Home Office							
	Type of Business	1						
	51							
	6, 00							
	B. INTERRELATIONSHIP TO RELA	FD ORGANIZATION(S)	AND/OR HOME	OFFLCE:				

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

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

rerinbur									
6.00	ADMI NI STRATI ON	6	6.00						
7.00	ADMI NI STRATI ON	7	7.00						
8.00		8	8.00						
9.00 10.00		9	9.00						
10.00		10	0. 00						
100.00		100	0.00						

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

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

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

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

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

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

Heal th	Financial Syste	ems	ASCENSION ST.	VINCENT MERCY		In Lie	eu of Form CMS-	2552-10
PROVI DE	ER BASED PHYSIC		Provider CCN: 15-1308		Period: Worksheet A- From 07/01/2021 Date/Time Pr To 06/30/2022 Date/Time Pr 11/29/2022 9		epared:	
	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component		Physician/Prov ider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00		ADULTS & PEDIATRICS	278, 800	278, 800	(0 0	0	1.00
2.00		RADI OLOGY-DI AGNOSTI C	3, 809					2.00
3.00		EMERGENCY	1, 294, 513	0	1, 294, 513	3 0	0	3.00
4.00	0.00		0	0		-	-	4.00
5.00	0.00		0	0	(0	5.00
6.00	0.00		0	0			0	6.00
7.00	0.00		0	0	(0 0	0	7.00
8.00	0.00		0	0		0 0	0	8.00
9.00	0.00		0	0		0 0	0	9.00
10.00	0.00		0	0		0 0	0	10.00
200.00			1, 577, 122					200.00
	Wkst. A Line #		Unadjusted RCE		Cost of		Physician Cost	
		Identifier	Limit	Unadjusted RCE			of Malpractice	
				Limit	Conti nui ng Educati on	Share of col. 12	Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00		ADULTS & PEDIATRICS	0.00	0				1.00
2.00		RADI OLOGY-DI AGNOSTI C		0				2.00
3.00		EMERGENCY	0	0			0	3.00
4.00	0.00		0	0		0	0	4.00
5.00	0.00		0	0		0 0	0	5.00
6.00	0.00		0	0	(0 0	0	6.00
7.00	0.00		0	0	(0 0	0	7.00
8.00	0.00		0	0	(0 0	0	8.00
9.00	0.00		0	0	(0 0	0	9.00
10.00	0.00		0	0	(0 0	0	10.00
200.00			C	0		,	0	200.00
	Wkst. A Line #	5	Provi der	Adjusted RCE	RCE	Adjustment		
		Identifier	Component	Limit	Di sal I owance			
			Share of col. 14					
	1.00	2.00	14	16.00	17.00	18.00		
1.00		ADULTS & PEDIATRICS	13.00					1.00
2.00		RADI OLOGY-DI AGNOSTI C		0				2.00
3.00		EMERGENCY	0	-				3.00
4.00	0.00		0	0				4.00
5.00	0.00			0				5.00
6.00	0.00			0		-		6.00
7.00	0.00			0		0		7.00
8.00	0.00		0	0	(0		8.00
9.00	0.00		0	0	(0		9.00
10.00	0.00		0	0	(0		10.00
200.00			0	0		282, 609		200.00

Health Fina	ancial Systems	ASCENSION ST. V	INCENT MERCY		In Lie	u of Form CMS-:	2552-10
COST ALLOC	ATI ON – GENERAL SERVI CE COSTS		Provider CC		Period: From 07/01/2021 To 06/30/2022	Worksheet B Part I Date/Time Pre 11/29/2022 9:	pared: 14 am
			CAPI TAL REL	ATED COSTS			
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	NEW BLDG & FIXT	NEW MVBLE EQUI P	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		0	1.00	2.00	4.00	4A	
	RAL SERVICE COST CENTERS	892, 467	892, 467				1.00
2.00 0020 4.00 0040 5.00 0050	00 NEW CAP REL COSTS-DEDG & TTAT 00 NEW CAP REL COSTS-MVBLE EQUIP 10 EMPLOYEE BENEFITS DEPARTMENT 10 ADMINISTRATIVE & GENERAL 10 OPERATION OF PLANT	581, 510 1, 551, 969 6, 450, 329 1, 194, 100	0 275, 613 172, 871	581, 51 8, 90	0 1, 551, 969 0 108, 701	6, 834, 643 1, 375, 880	2.00 4.00 5.00
9.00 0090 10.00 0100 11.00 0110	00 LAUNDRY & LINEN SERVICE 00 HOUSEKEEPING 00 DIETARY 00 CAFETERIA	48, 261 589, 213 65, 230 392, 158	10, 629 6, 478 17, 627 11, 179	10, 57	0 0	58, 890 595, 691 93, 433 403, 337	9.00 10.00 11.00
15.00 0150 16.00 0160 17.00 0170	00 NURSI NG ADMI NI STRATI ON 00 PHARMACY 00 MEDI CAL RECORDS & LI BRARY 00 SOCI AL SERVI CE TI ENT ROUTI NE SERVI CE COST CENTERS	59, 568 3, 656, 532 0 139, 065	10, 973 9, 912 15, 070 2, 716			107, 089 3, 785, 776 15, 070 169, 761	15.00
30. 00 0300 31. 00 0310 35. 00 0204	00 ADULTS & PEDIATRICS 00 INTENSIVE CARE UNIT 10 DETOXIFICATION INTENSIVE CARE UNIT LLARY SERVICE COST CENTERS	956, 021 0 0	44, 433 0 0		9 248, 738 0 0 0 0	1, 317, 431 0 0	30. 00 31. 00 35. 00
50.00 0500 54.00 0540 56.00 0560 57.00 0570	DO OPERATING ROOM DO RADIOLOGY-DIAGNOSTIC DO RADIOISOTOPE DO CT SCAN DO MAGNETIC RESONANCE IMAGING (MRI)	234, 750 899, 173 0 0	59, 633 38, 283 0 0	99, 41 271, 69		502, 202 1, 446, 237 0 0 0	50.00 54.00 56.00 57.00 58.00
60.00 0600 65.00 0650 66.00 0660 67.00 0670	00 LABORATORY 10 LABORATORY 10 RESPI RATORY THERAPY 10 PHYSI CAL THERAPY 10 OCCUPATI ONAL THERAPY 10 OCCUPATI ONAL THERAPY 10 SPEECH PATHOLOGY	1, 383, 013 511, 998 355, 482 26, 709	16, 764 13, 086 39, 328 1, 389 0		3 92, 168 0 7, 369	1, 399, 777 675, 039 487, 141 35, 467	60.00 65.00 66.00 67.00
69.00 0690 70.00 0700 71.00 0710	00 SEECT PATHOLOGY 00 ELECTROCARDI OLOGY 00 ELECTROENCEPHALOGRAPHY 00 MEDI CAL SUPPLIES CHARGED TO PATIENTS 10 IMPLANTABLE DEVICES CHARGED TO PATIENTS	28, 028 0 398, 093 344, 235	0 0 0 0		0 7,733 0 0 0 0 0 0 0 0 0 0	35, 761 0 398, 093 344, 235	70. 00 71. 00
76.00 036 ² 76.01 0348	DO DRUGS CHARGED TO PATIENTS O SLEEP LAB O ONCOLOGY ATIENT SERVICE COST CENTERS	3, 343 14, 441 279, 499	0 5, 570 2, 640	4	0 0 9 3, 558 0 66, 614	3, 343 23, 618 348, 753	76.00
90.00 0900 91.00 0910 92.00 0920		258, 960 3, 026, 771	11, 041 55, 070	27, 61	0 63, 846 0 368, 791	333, 847 3, 478, 242 0	91.00
118.00 NONF	SUBTOTALS (SUM OF LINES 1 through 117) REIMBURSABLE COST CENTERS	24, 340, 918	820, 305	581, 51		24, 268, 756	
192.00 1920 194.00 0795	53 VACANT	0 0 0 0 0	2, 587 61, 594 5, 608 2, 373 0 0		0 0 0 0 0 0 0 0 0 0 0 0	61, 594 5, 608 2, 373 0 0	190. 00 192. 00 194. 00 194. 01 194. 02 194. 03
200.00 201.00 202.00	Cross Foot Adjustments Negative Cost Centers TOTAL (sum lines 118 through 201)	24, 340, 918	0 892, 467	581, 51	0 0 0 1, 551, 969	0	200. 00 201. 00

Heal th	n Financial Systems	ASCENSION ST.	VINCENT MERCY		In Lie	u of Form CMS-:	2552-10
COST	ALLOCATION - GENERAL SERVICE COSTS		Provider C		eriod:	Worksheet B	
					rom 07/01/2021 o 06/30/2022	Part I Date/Time Pre	pared:
		· ·				11/29/2022 9:	
	Cost Center Description	ADMI NI STRATI VE		LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL 5.00	PLANT 7.00	LINEN SERVICE 8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS	3.00	1.00	0.00	7.00	10.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINI STRATI VE & GENERAL	6, 834, 643					5.00
7.00	00700 OPERATION OF PLANT	537, 159					7.00
8.00 9.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	22, 991					8.00
9.00	01000 DI ETARY	232, 564 36, 477				205, 859	9.00 10.00
11.00	01100 CAFETERI A	157, 467			-	205, 859	11.00
13.00		41, 809			1, 402	0	13.00
15.00	01500 PHARMACY	1, 478, 010				0	15.00
16.00		5, 883			-	0	16.00
17.00		66, 277	11, 705	C	409	0	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS	1					
30.00	03000 ADULTS & PEDIATRICS	514, 340				205, 859	30.00
31.00		0				0	31.00
35.00		0	C	C	0	0	35.00
F0 00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM	10/ 0/5	254 044	14, 472	104 (55	0	
50.00 54.00	05400 RADI OLOGY-DI AGNOSTI C	196, 065 564, 627				0	50.00 54.00
56.00	05600 RADI OLOGI - DI AGNOSTI C	011111111111111111111111111111111111111		0, 300		0	56.00
57.00	05700 CT SCAN	0	0		0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	C	0	0	58.00
60.00	06000 LABORATORY	546, 488	72, 234	C	13, 257	0	60.00
65.00	06500 RESPI RATORY THERAPY	263, 543	56, 387	C	5, 723	0	65.00
66.00	06600 PHYSI CAL THERAPY	190, 185				0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	13, 847				0	67.00
68.00	06800 SPEECH PATHOLOGY	13, 961		C	0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0	-		0	0	69.00
70.00 71.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0 155, 420	-		0	0	70.00 71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATTENTS	134, 393			0	0	72.00
72.00	PATIENTS	134, 373			0	0	72.00
73.00		1, 305	c c	c	60, 036	0	73.00
76.00		9, 221		547		0	76.00
76. 01	03480 ONCOLOGY	136, 157	11, 376	C	2, 978	0	76.01
	OUTPATIENT SERVICE COST CENTERS	1	1	1	1		
90.00		130, 338				0	90.00
91.00		1, 357, 944	237, 285	21, 878	155, 172	0	91.00
92.00							92.00
118.0	SPECIAL PURPOSE COST CENTERS 0 SUBTOTALS (SUM OF LINES 1 through 117)	6, 806, 471	1, 602, 106	127, 681	876, 427	205, 859	110 00
110.0	NONREI MBURSABLE COST CENTERS	0, 800, 471	1,002,100	127,001	070,427	205, 659	110.00
190 0	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,010	11, 146	C	0	0	190.00
192.0	0 19200 PHYSICIANS' PRIVATE OFFICES	24, 047					192.00
194.0	0 07950 MARKETI NG	2, 189			584		194.00
	1 07951 FOUNDATI ON	926			409		194. 01
	2 07952 CLINIC	0	0	C	0		194. 02
	3 07953 VACANT	0	0	C	0	0	194. 03
200.0							200.00
201.0		0			0 077 420	0	201.00
202.0	0 TOTAL (sum lines 118 through 201)	6, 834, 643	1, 913, 039	127, 681	877, 420	205, 859	1202. UU

		ASCENSION ST. V				u of Form CMS-2	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provider CC	N: 15-1308	Period: From 07/01/2021 To 06/30/2022	Worksheet B Part I Date/Time Pre 11/29/2022 9:	pared: 14 am
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	
		11.00	13.00	15.00	16.00	17.00	
1 00	GENERAL SERVICE COST CENTERS						1 1 00
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 4.00	00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00
4.00 5.00	00500 ADMINISTRATIVE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERI A	608, 971					11.00
13.00	01300 NURSING ADMINISTRATION	0	197, 579				13.00
15.00	01500 PHARMACY	21, 749	0	5, 328, 24			15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	0		0 88, 808		16.00
17.00	01700 SOCIAL SERVICE	10, 874	7, 697		0 0	266, 723	17.00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	100 745	E4 024		0 4 1 2 2	250 705	20.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 I NTENSI VE CARE UNI T	108, 745 0	54, 024 0		0 4, 122 0 0	258, 705 0	30.00
31.00	02040 DETOXIFICATION INTENSIVE CARE UNIT	0	0		0 0	0	35.00
33.00	ANCI LLARY SERVICE COST CENTERS	0	0		<u> </u>	0	33.00
50.00	05000 OPERATING ROOM	54, 372	25, 907		0 11, 962	0	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	97,870	20,707		0 22, 780	0	54.00
56.00	05600 RADI OI SOTOPE	0	0		0 0	0	56.00
57.00	05700 CT SCAN	0	0		0 0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	58.00
60.00	06000 LABORATORY	0	0		0 14, 518	0	60.00
65.00	06500 RESPI RATORY THERAPY	65, 247	15, 573		0 3, 445	0	65.00
66.00	06600 PHYSI CAL THERAPY	54, 372	0		0 2,774	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0		0 224	0	67.00
68.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	0		0 154 0 0	0	68.00
69.00 70.00	07000 ELECTROCARDI OLOGY	0	0		0 0	0	69.00 70.00
70.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00	07200 I MPLANTABLE DEVICES CHARGED TO	0	0		0 0	0	72.00
	PATIENTS	-	-			-	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	5, 328, 24	14 0	0	73.00
76.00	03610 SLEEP LAB	0	0		0 310	0	76.00
76.01	03480 ONCOLOGY	32, 623	14, 703		0 2, 272	0	76.01
~~ ~~	OUTPATIENT SERVICE COST CENTERS		10.770		0 1 744	-	
90.00		32, 623	12, 770		0 1, 714	0	90.00
91.00 92.00	09100 EMERGENCY	130, 496	66, 828		0 24, 533	8, 018	91.00 92.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS						92.00
118.00		608, 971	197, 579	5, 328, 24	14 88, 808	266, 723	1118 00
110.00	NONREI MBURSABLE COST CENTERS	000, 971	177, 377	5, 520, 24	00,000	200, 723	1 10.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0		192.00
	07950 MARKETI NG	0	0		0 0		194.00
194.00	07951 FOUNDATI ON	0	0		0 0	0	194.01
						0	194.02
194. 01 194. 02	07952 CLI NI C	0	0		0		
194. 01 194. 02 194. 03	07952 CLI NI C 07953 VACANT	0	0 0		0 0		194.03
194.01 194.02 194.03 200.00	07952 CLINIC 07953 VACANT Cross Foot Adjustments	0	0 0		0 0	0	194. 03 200. 00
194. 01 194. 02 194. 03	07952 CLINIC 07953 VACANT Cross Foot Adjustments Negative Cost Centers	0 0 608, 971	0 0 0 197, 579	5, 328, 24	0 0 0 0 14 88,808	0	194. 03 200. 00 201. 00

COST ALLOCATION	- GENERAL SERVICE COSTS	ASCENSION ST. VI	Provider CC	N. 15 1200	Peri od:	eu of Form CMS-2552 Worksheet B
COST ALLOCATION	- GENERAL SERVICE CUSIS		Provider CC	N: 15-1308	From 07/01/2021 To 06/30/2022	Part
Cos	t Center Description	Subtotal R	Intern & esidents Cost & Post Stepdown Adjustments	Total		111/27/2022 7. 14 2
		24.00	25.00	26.00		
GENERAL S	ERVICE COST CENTERS		•			
1.00 00100 NEW 2.00 00200 NEW 4.00 00400 EMPI 5.00 00500 ADMI 7.00 00700 OPEI 8.00 00800 LAUI 9.00 00900 HOUS 10.00 01000 DI 11.00 01100 CAFI	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP OYEE BENEFITS DEPARTMENT NISTRATIVE & GENERAL RATION OF PLANT NDRY & LINEN SERVICE SEKEEPING FARY ETERIA SING ADMINISTRATION					1 2 4 5 7 8 9 10 11 11
	CAL RECORDS & LI BRARY					15 16
	AL SERVICE ROUTINE SERVICE COST CENTERS					17
	_TS & PEDIATRICS	3, 040, 689	0	3, 040, 6	689	30
	ENSIVE CARE UNIT	0,040,007	0	5, 040, 0	0	31
	DXIFICATION INTENSIVE CARE UNIT	0	0		0	35
	SERVICE COST CENTERS					
	RATING ROOM	1, 166, 581	0	1, 166, 5		50
	OLOGY-DI AGNOSTI C	2, 382, 772	0	2, 382, 1		54
6. 00 05600 RADI		0	0		0	56
	NETIC RESONANCE IMAGING (MRI)	0	0		0	57
50.00 06000 LAB		2,046,274	0	2, 046, 2	8	60
	PIRATORY THERAPY	1, 084, 957	0	1, 084, 9		65
	SI CAL THERAPY	945, 169	0	945,		66
	JPATI ONAL THERAPY	56, 398	0	56, 3		67
	ECH PATHOLOGY	49, 876	0	49,8		68
9.00 06900 ELEC	CTROCARDI OLOGY	0	0		0	69
0.00 07000 ELE	CTROENCEPHALOGRAPHY	0	0		0	70
	CAL SUPPLIES CHARGED TO PATIENTS	553, 513	0	553, 5	513	71
	ANTABLE DEVICES CHARGED TO	478, 628	0	478, 6	628	72
	ENTS					
	GS CHARGED TO PATIENTS	5, 392, 928	0	5, 392, 9		73
6.00 03610 SLEI		59,040	0	59, (76
6. 01 03480 ONCO	T SERVICE COST CENTERS	548, 862	U	548,8	802	
0.00 09000 CLI		642, 575	0	642, 5	575	90
09100 EMER		5, 480, 396	0	5, 480, 3		91
	ERVATION BEDS (NON-DISTINCT PART)	0,100,070	0	07 1007 1		92
	URPOSE COST CENTERS	· · ·				
18.00 SUB	TOTALS (SUM OF LINES 1 through 117)	23, 928, 658	0	23, 928, 0	658	118
	RSABLE COST CENTERS					
	T, FLOWER, COFFEE SHOP & CANTEEN	14, 743	0	14, 1	743	190
	SICIANS' PRIVATE OFFICES	351, 037	0	351, (192
94.0007950 MARI		32, 547	0	32, 5		194
94.0107951 FOU		13, 933	0	13, 9	933	194
94. 02 07952 CLI I	NI C	0	0		0	194
94. 03 07953 VAC		0	0		0	194
	ss Foot Adjustments	0	0		0	200
	ative Cost Centers	0	0		0	201
202.00 TOT/	AL (sum lines 118 through 201)	24, 340, 918	0	24, 340, 9	918	202

	Financial Systems	ASCENSION ST. V				u of Form CMS-2	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider C	F	Period: From 07/01/2021 To 06/30/2022	Worksheet B Part II Date/Time Pre 11/29/2022 9:	
			CAPI TAL REL	ATED COSTS		11/29/2022 9.	
	Cost Center Description	Directly Assigned New Capital Related Costs	NEW BLDG & FIXT	NEW MVBLE EQUI P	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
		0	1.00	2.00	2A	4.00	
1 00	GENERAL SERVICE COST CENTERS	I					1 00
1.00 2.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP						1.00 2.00
2.00 4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0	C	0	0	4.00
4.00 5.00	00500 ADMINISTRATIVE & GENERAL	329,046	0 275 412		-	0	4.00 5.00
5.00 7.00	00700 OPERATION OF PLANT	329,040	275, 613	8,909		0	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	172, 871	0, 909 C		0	8.00
8.00 9.00		0	10, 629			0	
	00900 HOUSEKEEPING	0	6, 478	-	-,	-	9.00
10.00	01000 DI ETARY	0	17,627	10, 576		0	10.00
11.00		0	11, 179	0		0	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	10, 973	22, 378		0	13.00
15.00	01500 PHARMACY	0	9, 912	55, 919		0	15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	15, 070			0	16.00
17.00	01700 SOCI AL SERVI CE	0	2, 716	C	2, 716	0	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS	-				-	
30.00	03000 ADULTS & PEDI ATRI CS	0	44, 433	68, 239		0	30.00
31.00	03100 I NTENSI VE CARE UNI T	0	0	C		0	31.00
35.00	02040 DETOXIFICATION INTENSIVE CARE UNIT	0	0	C	0 0	0	35.00
	ANCILLARY SERVICE COST CENTERS	т — т		r	,		
50.00	05000 OPERATI NG ROOM	0	59, 633	99, 419		0	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	38, 283	271, 693	309, 976	0	54.00
56.00	05600 RADI OI SOTOPE	0	0	C	0 0	0	56.00
57.00	05700 CT SCAN	0	0	C	0 0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	C	0 0	0	58.00
60.00	06000 LABORATORY	0	16, 764	C	16, 764	0	60.00
65.00	06500 RESPI RATORY THERAPY	0	13, 086	16, 555	29, 641	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	39, 328	163	39, 491	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	1, 389	l c	1, 389	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	Ċ		0	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0	l c	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	Ċ	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	Ċ	0	0	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO	0	0	Ċ	0	0	72.00
	PATIENTS						
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	l c	0 0	0	73.00
76.00	03610 SLEEP LAB	0	5, 570	49	5, 619	0	76.00
76.01	03480 ONCOLOGY	0	2, 640			0	76.01
	OUTPATIENT SERVICE COST CENTERS	-	_/ - · · ·	-	_, _,	-	
90.00	09000 CLINIC	0	11, 041	C	11,041	0	90.00
	09100 EMERGENCY	0	55, 070			0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)				0	-	92.00
	SPECIAL PURPOSE COST CENTERS	1 1			-1		
118.00		329,046	820, 305	581, 510	1, 730, 861	0	118.00
	NONREI MBURSABLE COST CENTERS	02,7010	0207000	001/010	1, 100,001		
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2, 587	C	2, 587	0	190.00
	19200 PHYSI CLANS' PRI VATE OFFICES	0	61, 594				192.00
	07950 MARKETI NG	0	5, 608				192.00
	07951 FOUNDATI ON	0	2, 373				194.00
	07951 FOUNDATION 07952 CLINIC	0	2, 3/3				194. 01 194. 02
		0	0	-	-		194. 02 194. 03
	07953 VACANT	0	0	C	0		
200.00			~		0		200.00
201.00		220.04/		E01 E10	-		201.00
202.00	TOTAL (sum lines 118 through 201)	329, 046	892, 467	581, 510	1, 803, 023	0	202.00

Heal th	Financial Systems	ASCENSION ST.	VINCENT MERCY		In Lie	eu of Form CMS-	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider C	CN: 15-1308	Period: From 07/01/2021 To 06/30/2022	Worksheet B Part II Date/Time Pre 11/29/2022 9:	
	Cost Center Description	ADMI NI STRATI VE & GENERAL	OPERATION OF PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		5.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS		•			•	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	604, 659					5.00
7.00	00700 OPERATION OF PLANT	47, 523					7.00
8.00	00800 LAUNDRY & LINEN SERVICE	2,034	5, 490		53		8.00
9.00	00900 HOUSEKEEPI NG	20, 575					9.00
10.00	01000 DI ETARY	3, 227	9, 104		0 0		10.00
11.00	01100 CAFETERI A	13, 931	5, 773		0 0	0	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	3, 699			0 53	0	13.00
15.00	01500 PHARMACY	130, 754			0 0	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	521			0 111	0	16.00
			7,783				
17.00	01700 SOCIAL SERVICE	5, 864	1, 403	4	0 16	0	17.00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	45 504	22.040		10 10 005	40.524	200.00
30.00	03000 ADULTS & PEDIATRICS	45, 504	22, 948				30.00
31.00	03100 INTENSIVE CARE UNIT	0			0 0		31.00
35.00	02040 DETOXIFICATION INTENSIVE CARE UNIT	0	0		0 0	0	35.00
	ANCI LLARY SERVICE COST CENTERS	17.044	00.700				
50.00	05000 OPERATING ROOM	17, 346					50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	49, 953				0	54.00
56.00	05600 RADI OI SOTOPE	0	0		0 0	0	56.00
57.00	05700 CT SCAN	0	0		0 0	0	57.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0 0	0	58.00
60.00	06000 LABORATORY	48, 348			0 505	0	60.00
65.00	06500 RESPI RATORY THERAPY	23, 316			0 218		65.00
66.00	06600 PHYSI CAL THERAPY	16, 826					66.00
67.00	06700 OCCUPATI ONAL THERAPY	1, 225		12	25 0	0	67.00
68.00	06800 SPEECH PATHOLOGY	1, 235	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	13, 750	0		0 0	0	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO	11, 890	0)	0 0	0	72.00
	PATIENTS						
73.00	07300 DRUGS CHARGED TO PATIENTS	115	0		0 2, 287	0	73.00
76.00	03610 SLEEP LAB	816	2, 877	-	78 51	0	76.00
76.01	03480 ONCOLOGY	12, 046	1, 364		0 113	0	76.01
	OUTPATIENT SERVICE COST CENTERS		_			_	
90.00	09000 CLI NI C	11, 531	5, 703	3.	10 3, 105	0	90.00
91.00	09100 EMERGENCY	120, 138	28, 442	3, 1	11 5, 910	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS						1
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	602, 167	192, 035	18, 15	53 33, 382	40, 534	118.00
	NONREI MBURSABLE COST CENTERS						1
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	89	1, 336		0 0	0	190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	2, 127			0 0		192.00
194.00	07950 MARKETI NG	194			0 22		194.00
	07951 FOUNDATI ON	82			0 16		194.01
	207952 CLINIC	0	1 ., 220		0 0		194.02
	07953 VACANT				0 0		194.02
200.00							200.00
200.00		0			0 0		200.00
201.00		604, 659	229, 303	18, 15	-		202.00
202.00		1 004,007	1 227, 303	1 10, 10	55, 420	1 40,004	1-02.00

Heal th	Financial Systems	ASCENSION ST. VI	NCENT MERCY		In Lie	u of Form CMS-	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provi der CCI		Period: From 07/01/2021 To 06/30/2022	Worksheet B Part II Date/Time Pre 11/29/2022 9:	pared: 14 am
	Cost Center Description	CAFETERI A Al	NURSI NG DMI NI STRATI ON	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	
		11.00	13.00	15.00	16.00	17.00	
1 00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT						1 1 00
1.00 2.00	00200 NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERI A	30, 883					11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	42, 770				13.00
15.00	01500 PHARMACY	1, 103	0	202, 80			15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	0		0 23, 485	10.01/	16.00
17.00	01700 SOCIAL SERVICE	551	1, 666		0 0	12, 216	17.00
30, 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	5, 515	11, 694		0 1,090	11, 849	30.00
30.00	03100 I NTENSI VE CARE UNI T	5, 515	0		0 1,090	0	31.00
35.00	02040 DETOXIFICATION INTENSIVE CARE UNIT	0	0		0 0	0	
00100	ANCI LLARY SERVICE COST CENTERS	<u> </u>			0 0		
50.00	05000 OPERATI NG ROOM	2, 757	5, 608		0 3, 164	0	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	4, 963	17		0 6,025	0	54.00
56.00	05600 RADI OI SOTOPE	0	0		0 0	0	56.00
57.00	05700 CT SCAN	0	0		0 0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	58.00
60.00	06000 LABORATORY	0	0		0 3, 840	0	60.00
65.00		3, 309	3, 371		0 911	0	65.00
66.00	06600 PHYSI CAL THERAPY	2, 757	0		0 734	0	
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0		0 59 0 41	0	1
69.00	06900 ELECTROCARDI OLOGY	0	0		0 0	0	1
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	1
72.00	07200 I MPLANTABLE DEVICES CHARGED TO	Ő	Ő		0 0	0	1
	PATIENTS						
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	202, 80	07 0	0	73.00
76.00	03610 SLEEP LAB	0	0		0 82	0	
76.01	03480 ONCOLOGY	1, 654	3, 183		0 601	0	76.01
00.00	OUTPATIENT SERVICE COST CENTERS	1 (54	0.7/4		0 450		00.00
90.00 91.00	09000 CLINIC 09100 EMERGENCY	1,654	2,764		0 453 0 6.485	0	1
91.00 92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	6, 620	14, 467		0 6, 485	367	91.00 92.00
92.00	SPECIAL PURPOSE COST CENTERS						92.00
118.00		30, 883	42, 770	202, 80	23, 485	12 216	118.00
	NONREI MBURSABLE COST CENTERS	00,000	12,770	202,00	20,100	12,210	1.101.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190.00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0		0 0		192.00
	07950 MARKETI NG	0	0		0 0		194.00
	07951 FOUNDATI ON	0	0		0 0		194.01
	07952 CLI NI C	0	0		0 0		194.02
	07953 VACANT	0	0		0 0	0	194.03
200.00						_	200.00
201.00			40 770	202.02			201.00
202.00	TOTAL (sum lines 118 through 201)	30, 883	42, 770	202, 80	23, 485	12, 216	202.00

Health Financial Systems	ASCENSION ST. V	INCENT MERCY		In Lieu of	Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN		Period: Worl From 07/01/2021 Par To 06/30/2022 Date	ksheet B
Cost Center Description	Subtotal F	Intern & Residents Cost & Post Stepdown Adjustments	Total		
	24.00	25.00	26.00		
GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 2.00 00200 NEW CAP REL COSTS-BLDG & FIXT 2.00 00200 NEW CAP REL COSTS-BLDG & FIXT 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMI NI STRATI VE & GENERAL 7.00 00700 OPERATI ON OF PLANT 8.00 00800 LAUNDRY & LI NEN SERVICE 9.00 00900 HOUSEKEEPI NG 10.00 01000 DI ETARY 11.00 01100 CAFETERIA 13.00 01300 NURSI NG ADMI NI STRATI ON 15.00 01500 PHARMACY 16.00 MEDI CAL RECORDS & LI BRARY					$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 4.\ 00\\ 5.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$
17. 00 01700 SOCI AL SERVI CE					17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS	271, 424	0	271, 42		30.00
31.00 03100 INTENSIVE CARE UNIT 35.00 02040 DETOXIFICATION INTENSIVE CARE UNIT	0	0		0	31.00 35.00
ANCI LLARY SERVICE COST CENTERS	<u> </u>	0		0	33.00
50. 00 05000 0PERATI NG ROOM 54. 00 05400 RADI 0LOGY-DI AGNOSTI C 56. 00 05600 RADI 0I SOTOPE	224, 769 394, 862 0	0 0 0		2 0	50.00 54.00 56.00
57.00 05700 CT SCAN 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 60.00 06000 LABORATORY 65.00 06500 RESPIRATORY THERAPY	0 0 78, 115 67, 525	0 0 0 0	78, 11 67, 52	5	57.00 58.00 60.00 65.00
66. 00 06600 PHYSI CAL THERAPY	82, 823	0	82, 82		66.00
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	3, 515 1, 276	0	3, 51 1, 27		67.00 68.00
69. 00 06900 ELECTROCARDI OLOGY	1,270	0		0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	13, 750	0	13, 75	0	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO	11, 890	0	11, 89	0	72.00
PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	205, 209	o	205, 20	0	73.00
76. 00 03610 SLEEP LAB	9, 523	0	9, 52		76.00
76. 01 03480 ONCOLOGY	21, 601	0	21,60		76.01
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C	36, 561	0	36, 56	1	90.00
91.00 09100 EMERGENCY	268, 220	0	268, 22	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1 (01 0(2	0	1 (01 0)	2	110.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	1, 691, 063	U	1, 691, 06	3	118.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,012	0	4, 01	2	190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	95, 530	0	95, 53		192.00
194. 00 07950 MARKETI NG	8, 721	0	8, 72		194.00
194. 01 07951 FOUNDATI ON	3, 697	0	3, 69	7	194.01
194. 02 07952 CLI NI C	0	0		0	194. 02
194. 03 07953 VACANT	0	0		0	194.03
200.00 Cross Foot Adjustments	0	0		0	200.00
201.00Negative Cost Centers202.00TOTAL (sum lines 118 through 201)	0	0	1, 803, 02	0	201.00 202.00
	1,003,023	ų	1,000,02		1202.00

	ncial Systems ATLON - STATISTICAL BASIS	ASCENSION ST.	VINCENT MERCY Provider CO	N. 15-1308 E	In Lie Period:	u of Form CMS-2 Worksheet B-1	
CUST ALLUCA	ATTON - STATISTICAL DASIS		FIOVIDEI CO	F	rom 07/01/2021		
					o 06/30/2022	Date/Time Pre 11/29/2022 9:	
		CAPI TAL REI	_ATED COSTS				
	Cost Center Description	NEW BLDG &	NEW MVBLE	EMPLOYEE	Reconci l i ati on	ADMI NI STRATI VE	
	·	FLXT	EQUI P	BENEFITS		& GENERAL	
		(SQUARE FEET)	(DIRECT COST)	DEPARTMENT (GROSS		(ACCUM. COST)	
		1221)		SALARI ES)		0031)	
		1.00	2.00	4.00	5A	5.00	
	RAL SERVICE COST CENTERS	116, 959					1.00
	ONEW CAP REL COSTS-BEDG & TTAT	110, 939	581, 511				2.00
	O EMPLOYEE BENEFITS DEPARTMENT	0	0	5, 624, 953			4.00
	O ADMINISTRATIVE & GENERAL	36, 119		393, 977	-6, 834, 643	17, 506, 275	
	O OPERATION OF PLANT	22, 655		C	0	1, 375, 880	
	0 LAUNDRY & LI NEN SERVI CE 0 HOUSEKEEPI NG	1, 393 849				58, 890 595, 691	
	0 DI ETARY	2, 310	10, 576	C	0	93, 433	
11.00 0110	O CAFETERI A	1, 465	0	C	0 0	403, 337	
	O NURSI NG ADMI NI STRATI ON	1, 438		51, 357		107, 089	
	O PHARMACY O MEDI CAL RECORDS & LI BRARY	1, 299		229, 834		3, 785, 776 15, 070	
	0 SOCIAL SERVICE	1, 975 356		101, 409	, o	169, 761	
	TIENT ROUTINE SERVICE COST CENTERS	000		101, 107		107,701	17.00
	0 ADULTS & PEDIATRICS	5, 823	68, 239	901, 525	i 0	1, 317, 431	30.00
	O I NTENSI VE CARE UNI T	0	0	C	-	0	31.00
	O DETOXIFICATION INTENSIVE CARE UNIT	0	0	C	0 0	0	35.00
	O OPERATING ROOM	7, 815	99, 419	392, 885	0	502, 202	50.00
	O RADI OLOGY-DI AGNOSTI C	5,017		859, 302		1, 446, 237	54.00
	0 RADI OI SOTOPE	0	0	C	0	0	
	O CT SCAN	0	0	C	0	0	
	O MAGNETIC RESONANCE IMAGING (MRI) O LABORATORY	2, 197	0			0 1, 399, 777	58.00 60.00
	O RESPI RATORY THERAPY	1, 715		483, 495	0	675, 039	
	0 PHYSI CAL THERAPY	5, 154		334, 054		487, 141	
	O OCCUPATIONAL THERAPY	182	0	26, 709		35, 467	
	O SPEECH PATHOLOGY	0	0	28, 028		35, 761	
	0 ELECTROCARDI OLOGY 0 ELECTROENCEPHALOGRAPHY		0			0	
	O MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	C	0	398, 093	
	O IMPLANTABLE DEVICES CHARGED TO	0	0	C	0	344, 235	72.00
70.00.0700	PATIENTS					0.040	70.00
	0 DRUGS CHARGED TO PATIENTS 0 SLEEP LAB	730	0 49	12, 894		3, 343 23, 618	
	0 ONCOLOGY	346		241, 434		348, 753	
	ATIENT SERVICE COST CENTERS	,		,		,	
90.00 0900		1, 447					
	O EMERGENCY	7, 217	27, 610	1, 336, 646	0	3, 478, 242	
	0 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	107, 502	581, 511	5, 624, 953	-6, 834, 643	17, 434, 113	118.00
	EIMBURSABLE COST CENTERS						
	O GIFT, FLOWER, COFFEE SHOP & CANTEEN	339		C			190.00
	O PHYSICIANS' PRIVATE OFFICES O MARKETING	8,072		C		61, 594	
	1 FOUNDATI ON	735	0	C			194. 00 194. 01
194.020795		0	0	C	0		194.02
194.030795		0	0	C	0 0	0	194. 03
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	002 447	E01 E10	1 551 040		(024 (42	201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	892, 467	581, 510	1, 551, 969		6, 834, 643	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	7. 630597	0. 999998	0. 275908	3	0. 390411	203.00
204.00	Cost to be allocated (per Wkst. B,			C		604, 659	
005 00	Part II)						005 -
205.00	Unit cost multiplier (Wkst. B, Part II)			0.00000		0.034540	205. 00
206.00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207 00	NAHE unit cost multiplier (Wkst. D,						207.00
207.00	Parts III and IV)						

		cial Systems TON - STATISTICAL BASIS	ASCENSION ST. '	Provi der C		eriod: rom 07/01/2021	u of Form CMS- Worksheet B-1	
						o 06/30/2022	Date/Time Pre 11/29/2022 9:	parec 14 am
		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (HOURS OF SERVI CE)	DI ETARY (PATI ENT DAYS)	CAFETERI A (FTE)	
			7.00	8.00	9.00	10.00	11.00	
1.00		AL SERVICE COST CENTERS						1 1.0
2.00 4.00 5.00 7.00 8.00	00200 00400 00500 00700	NEW CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL OPERATION OF PLANT LAUNDRY & LINEN SERVICE	58, 185 1, 393					2. (4. (5. (7. (8. (
9.00		HOUSEKEEPI NG	849	13, 991	15, 024			9. (
10.00		DIETARY	2, 310		C			10. (
11.00			1, 465		C		56	
13.00 15.00	1	NURSI NG ADMI NI STRATI ON PHARMACY	1,438		24		0	13.0
16.00		MEDICAL RECORDS & LIBRARY	1, 299 1, 975		50		2	
17.00		SOCIAL SERVICE	356		7	0	1	17. (
		I ENT ROUTI NE SERVI CE COST CENTERS						
30.00		ADULTS & PEDIATRICS	5, 823	31, 091	5, 801	1, 002	10	30. (
31.00	03100	INTENSIVE CARE UNIT	0		C		0	31. (
35.00		DETOXIFICATION INTENSIVE CARE UNIT	0	0	C	0	0	35. (
F0 00	-	LARY SERVICE COST CENTERS	7.045	0.500	4 700			1 50 /
50.00 54.00		OPERATING ROOM	7,815				5 9	50.0
54.00 56.00		RADI OLOGY-DI AGNOSTI C RADI OI SOTOPE	5,017		1, 333 C		9	54. (56. (
57.00		CT SCAN					0	57.0
58.00		MAGNETIC RESONANCE IMAGING (MRI)	0				0	58.0
60.00		LABORATORY	2, 197		227		0	60.0
65.00		RESPI RATORY THERAPY	1, 715		98		6	65.0
66.00	06600	PHYSI CAL THERAPY	5, 154	7, 158	520	0	5	66. (
67.00	06700	OCCUPATI ONAL THERAPY	182	577	C	0	0	67.0
68.00	1	SPEECH PATHOLOGY	0		C		0	68. (
69.00		ELECTROCARDI OLOGY	0		C	0	0	69.0
70.00			0	0		-	0	70.0
71.00 72.00		MEDICAL SUPPLIES CHARGED TO PATIENTS IMPLANTABLE DEVICES CHARGED TO		-		-	0	71.0
72.00	07200	PATIENTS		0		0	0	/2.
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1, 028	0	0	73. (
76.00		SLEEP LAB	730	360	23		0	76.0
76. 01	03480	ONCOLOGY	346	0	51	0	3	76. (
		TIENT SERVICE COST CENTERS						
90.00		CLINIC	1, 447				3	90.0
91.00		EMERGENCY	7, 217	14, 404	2, 657	0	12	
92.00		OBSERVATION BEDS (NON-DISTINCT PART) AL PURPOSE COST CENTERS						92. (
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	48, 728	84, 061	15, 007	1, 002	56	118. (
0. 00		IMBURSABLE COST CENTERS	+0,720	1 04,001	15,007	1,002	50	1.10.1
190.00		GIFT, FLOWER, COFFEE SHOP & CANTEEN	339	0	C	0	0	190. (
		PHYSICIANS' PRIVATE OFFICES	8, 072					192. (
		MARKETING	735		10			194. (
		FOUNDATION	311		7	0		194. (
			0		C	0		194. (
194.03 200.00		VACANT Cross Foot Adjustments	0	0	C	0	0	194. (
200.00		Cross Foot Adjustments Negative Cost Centers						200. (201. (
202.00		Cost to be allocated (per Wkst. B, Part I)	1, 913, 039	127, 681	877, 420	205, 859	608, 971	
203.00		Unit cost multiplier (Wkst. B, Part I)	32. 878560	1. 518909	58.401225	205. 448104	10, 874. 482143	203. (
204.00		Cost to be allocated (per Wkst. B, Part II)	229, 303				30, 883	
205.00		Unit cost multiplier (Wkst. B, Part II)	3. 940930	0. 215950	2. 224441	40. 453094	551. 482143	
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206. (
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. (

	ncial Systems TION - STATISTICAL BASIS	ASCENSION ST. V	Provider CC		Period:	u of Form CMS-255 Worksheet B-1
				F	rom 07/01/2021	
				1	o 06/30/2022	Date/Time Prepar 11/29/2022 9:14
	Cost Center Description	NURSI NG ADMI NI STRATI ON	PHARMACY	MEDI CAL	SOCIAL SERVICE	
		ADMINI STRATTON	(COSTED REQUIS.)	RECORDS & LI BRARY	(TIME SPENT)	
		(DI RECT	iniziation of y	(GROSS		
		NRSING HRS)		CHARGES)		
		13.00	15.00	16.00	17.00	
	AL SERVICE COST CENTERS	1			1	
	NEW CAP REL COSTS-BLDG & FIXT					
	EMPLOYEE BENEFITS DEPARTMENT					
	ADMINI STRATI VE & GENERAL					
	OPERATION OF PLANT					
. 00 00800	LAUNDRY & LINEN SERVICE					
	HOUSEKEEPING					
	DIETARY					1
		71 774				1
) NURSI NG ADMI NI STRATI ON) PHARMACY	71, 774	100			1
	MEDICAL RECORDS & LIBRARY	0	0	61, 315, 491		1
	SOCIAL SERVICE	2, 796	0	(1
I NPA	IENT ROUTINE SERVICE COST CENTERS					
	ADULTS & PEDIATRICS	19, 625	0	2, 846, 718	4, 840	3
	INTENSIVE CARE UNIT	0	0	0		3
	DETOXIFICATION INTENSIVE CARE UNIT	0	0	(0 0	3
	LARY SERVICE COST CENTERS	9, 411	0	8, 261, 011	0	5
	RADI OLOGY-DI AGNOSTI C	28	0	15, 731, 967		5
5.00 0560	RADI OI SOTOPE	0	0	13, 731, 707	0	5
	CT SCAN	0	0	C	0	5
3. 00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	C	0 0	5
06000	LABORATORY	0	0	10, 026, 515	5 0	6
	RESPI RATORY THERAPY	5, 657	0	2, 379, 144		6
	PHYSICAL THERAPY	0	0	1, 915, 574		6
	OCCUPATIONAL THERAPY SPEECH PATHOLOGY	0	0	154, 487 106, 586		6
	ELECTROCARDI OLOGY	0	0	100, 560		6
	ELECTROENCEPHALOGRAPHY	0	0	(0	7
	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	C	0 0	7
2.00 07200	IMPLANTABLE DEVICES CHARGED TO	0	0	C	0 0	7
	PATIENTS					
	DRUGS CHARGED TO PATIENTS	0	100)	0	7
	SLEEP LAB	0	0	213, 803		7
) ONCOLOGY ATLENT SERVICE COST CENTERS	5, 341	0	1, 568, 946	0	7
		4, 639	0	1, 183, 718	3 0	9
	EMERGENCY	24, 277	0	16, 927, 022		9
	OBSERVATION BEDS (NON-DISTINCT PART)					9
	AL PURPOSE COST CENTERS	1 1			1	
18.00	SUBTOTALS (SUM OF LINES 1 through 117)	71, 774	100	61, 315, 491	4, 990	11
	I MBURSABLE COST CENTERS		0			10
	GIFT, FLOWER, COFFEE SHOP & CANTEEN PHYSICIANS' PRIVATE OFFICES	0	0	(19 19
	MARKETING	0	0	ſ		19
	FOUNDATION	0	0	(19
94. 02 07952		0	0	(0	19
4. 03 0795	3 VACANT	0	0	C	0	19
0.00	Cross Foot Adjustments					20
01.00	Negative Cost Centers		F 007			20
02.00	Cost to be allocated (per Wkst. B,	197, 579	5, 328, 244	88, 808	266, 723	20
03. 00	Part I) Unit cost multiplier (Wkst. B, Part I)	2. 752793	53, 282. 440000	0. 001448	53. 451503	20
03.00 04.00	Cost to be allocated (per Wkst. B,	2. 752793 42, 770	53, 282. 440000 202, 807	23, 485		20
5 7. 00	Part II)	42,770	202,007	23, 400	12,210	20
05.00	Unit cost multiplier (Wkst. B, Part	0. 595898	2, 028. 070000	0.000383	2. 448096	20
	11)					
06.00	NAHE adjustment amount to be allocated					20
07.00	(per Wkst. B-2)					
	NAHE unit cost multiplier (Wkst. D,	1			1	20

Health Financial Systems	ASCENSION ST.	VINCENT MERCY		In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 07/01/2021 To 06/30/2022	11/29/2022 9:	pared: 14 am
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Costs RCE Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	3, 040, 689		3, 040, 68	9 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0			0 0	0	31.00
35.00 02040 DETOXIFICATION INTENSIVE CARE UNIT	0			0 0	0	35.00
ANCILLARY SERVICE COST CENTERS	1	1				
50.00 05000 OPERATI NG ROOM	1, 166, 581		1, 166, 58		0	
54.00 05400 RADI OLOGY-DI AGNOSTI C	2, 382, 772		2, 382, 77	2 0	0	54.00
56. 00 05600 RADI 0I SOTOPE	0			0 0	0	56.00
57.00 05700 CT SCAN	0			0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0			0 0	0	•
60. 00 06000 LABORATORY	2, 046, 274		2, 046, 27		0	60.00
65. 00 06500 RESPI RATORY THERAPY	1, 084, 957		1, 084, 95		0	65.00
66. 00 06600 PHYSI CAL THERAPY	945, 169		945, 16		0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	56, 398		56, 39		0	
68.00 06800 SPEECH PATHOLOGY	49, 876	0	49, 87	6 0	0	
69. 00 06900 ELECTROCARDI OLOGY	0			0 0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0		FF0 F	0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	553, 513		553, 51		0	
72.00 07200 I MPLANTABLE DEVICES CHARGED TO PATIENTS	478, 628		478, 62		0	
73.00 07300 DRUGS CHARGED TO PATIENTS	5, 392, 928		5, 392, 92		0	
76.00 03610 SLEEP LAB	59, 040		59, 04		0	
76. 01 03480 0NC0L0GY	548, 862		548, 86	2 0	0	76.01
OUTPATIENT SERVICE COST CENTERS	1				-	
90. 00 09000 CLINIC	642, 575		642, 57		0	
91.00 09100 EMERGENCY	5, 480, 396		5, 480, 39		0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	696, 423		696, 42		0	
200.00 Subtotal (see instructions)	24, 625, 081		,,			200.00
201.00 Less Observation Beds	696, 423		696, 42			201.00
202.00 Total (see instructions)	23, 928, 658	0	23, 928, 65	8 0	0	202.00

Health Financial Systems	ASCENSION ST. V	INCENT MERCY		ln Li€	eu of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 07/01/2021 To 06/30/2022	11/29/2022 9:	epared: 14 am
			e XVIII	Hospi tal	Cost	
Cost Center Description	I npati ent	Charges Outpati ent	+ col. 7)	6 Cost or Other Ratio	TEFRA Inpatient Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	2, 132, 076		2, 132, 0			30.00
31.00 03100 INTENSIVE CARE UNIT	0			0		31.00
35. 00 02040 DETOXIFICATION INTENSIVE CARE UNIT	0			0		35.00
ANCI LLARY SERVI CE COST CENTERS	F02.270		0.0(1.0)	0 141015	0.00000	50.00
50. 00 05000 OPERATI NG ROOM 54. 00 05400 RADI OLOGY-DI AGNOSTI C	593, 279	7,667,732				
56. 00 05600 RADIOLOGY-DIAGNOSTIC	551, 810	15, 180, 158	15, 731, 9	0. 151461 0. 000000		
57. 00 05700 CT SCAN	0	0		0 0.000000		
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0.000000		
60. 00 06000 LABORATORY	940, 649	9, 085, 866	10, 026, 5 ⁻			
65. 00 06500 RESPIRATORY THERAPY	587, 388	1, 791, 756				
66. 00 06600 PHYSI CAL THERAPY	132, 616	1, 782, 958				
67. 00 06700 OCCUPATI ONAL THERAPY	33, 670	120, 817				
68. 00 06800 SPEECH PATHOLOGY	26, 685	79, 901				
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0. 000000		
70.00 07000 ELECTROENCEPHALOGRAPHY	0	C		0 0.000000		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	421, 495	1, 607, 777	2, 029, 2			71.00
72.00 07200 I MPLANTABLE DEVICES CHARGED TO PATIENTS	5, 714	87, 647			0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	992, 142	12, 491, 716	13, 483, 8	58 0. 3 999 54	0. 000000	73.00
76.00 03610 SLEEP LAB	0	213, 803	213, 80	0. 276142	0. 000000	76.00
76. 01 03480 ONCOLOGY	2, 369	1, 566, 577	1, 568, 9	0. 349828	0. 000000	76.01
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	12, 969	1, 170, 749				
91.00 09100 EMERGENCY	370, 557	16, 556, 465				
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	73, 950	640, 692			0.00000	
200.00 Subtotal (see instructions)	6, 877, 369	70, 044, 614	76, 921, 98	33		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	6, 877, 369	70, 044, 614	76, 921, 98	33	l	202.00

Health Financial Systems	ASCENSION ST. VI	VCENT MERCY	In Lie	u of Form CMS-25	52-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1308	Peri od: From 07/01/2021 To 06/30/2022	Worksheet C Part I Date/Time Prepa 11/29/2022 9:14	
		Title XVIII	Hospi tal	Cost	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
31.00 03100 INTENSIVE CARE UNIT				3	31.00
35.00 02040 DETOXIFICATION INTENSIVE CARE UNIT				3	35.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATI NG ROOM	0. 000000			Ę	50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			Ę	54.00
56. 00 05600 RADI OI SOTOPE	0. 000000			5	56.00
57.00 05700 CT SCAN	0. 000000			5	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000			Ę	58.00
60. 00 06000 LABORATORY	0. 000000			6	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000			6	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			6	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0.000000				67.00
68.00 06800 SPEECH PATHOLOGY	0.000000				68.00
69.00 06900 ELECTROCARDI OLOGY	0.000000			e	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.000000				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71.00
72.00 07200 I MPLANTABLE DEVICES CHARGED TO	0. 000000				72.00
PATIENTS	0100000				. 2. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
76.00 03610 SLEEP LAB	0.000000				76.00
76. 01 03480 ONCOLOGY	0.000000				76.01
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC	0. 000000				90.00
91. 00 09100 EMERGENCY	0. 000000				91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0, 000000				92.00
200.00 Subtotal (see instructions)	0.00000				2.00 20.00
201.00 Less Observation Beds					D1.00
202.00 Total (see instructions)					02.00
	I I			20	

Health Financial Systems	ASCENSION ST.	VINCENT MERCY		In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 07/01/2021 To 06/30/2022	Worksheet C Part I Date/Time Pre 11/29/2022 9:	pared: 14 am
	-	Titl	e XIX	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1					
30. 00 03000 ADULTS & PEDIATRICS	3, 040, 689		3, 040, 68		3, 040, 689	
31.00 03100 INTENSIVE CARE UNIT	0			0 0	0	
35. 00 02040 DETOXIFICATION INTENSIVE CARE UNIT	0			0 0	0	35.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 0PERATI NG ROOM	1, 166, 581		1, 166, 58	1 0	1, 166, 581	50.00
50. 00 05000 0PERATI NG_ROOM 54. 00 05400 RADI 0LOGY-DI AGNOSTI C	2, 382, 772		2, 382, 77		2, 382, 772	1
56. 00 05600 RADI OLOGY-DI AGNOSTI C	2, 382, 772		2, 382, 77	2 0	2, 382, 772	
57. 00 05700 CT SCAN	0				0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0				0	
60. 00 06000 LABORATORY	2, 046, 274		2, 046, 27	0 0	2, 046, 274	
65. 00 06500 RESPIRATORY THERAPY	1, 084, 957		1, 084, 95		1, 084, 957	
66. 00 06600 PHYSI CAL THERAPY	945, 169		945, 16		945, 169	•
67. 00 06700 OCCUPATI ONAL THERAPY	56, 398		56, 39		56, 398	
68. 00 06800 SPEECH PATHOLOGY	49,876		49, 87		49, 876	
69. 00 06900 ELECTROCARDI OLOGY	0	-	,	0 0	0	
70.00 07000 ELECTROENCEPHALOGRAPHY	0			0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	553, 513		553, 51	3 0	553, 513	71.00
72.00 07200 I MPLANTABLE DEVICES CHARGED TO PATIENTS	478, 628		478, 62	8 0	478, 628	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	5, 392, 928		5, 392, 92	8 0	5, 392, 928	73.00
76.00 03610 SLEEP LAB	59, 040		59, 04	0 0	59, 040	76.00
76. 01 03480 ONCOLOGY	548, 862		548, 86	2 0	548, 862	76.01
OUTPATIENT SERVICE COST CENTERS		-				
90. 00 09000 CLI NI C	642, 575		642, 57		642, 575	
91. 00 09100 EMERGENCY	5, 480, 396		5, 480, 39		5, 480, 396	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	696, 423		696, 42		696, 423	
200.00 Subtotal (see instructions)	24, 625, 081		,,		24, 625, 081	
201.00 Less Observation Beds	696, 423		696, 42		696, 423	
202.00 Total (see instructions)	23, 928, 658	0	23, 928, 65	8 0	23, 928, 658	202.00

	2	ASCENSION ST. V				u of Form CMS-	2552-10
COMPUTATI O	N OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-1308	Period: From 07/01/2021	Worksheet C Part I	
					To 06/30/2022	Date/Time Pre	epared:
					11	11/29/2022 9:	14 am
			Charges	e XIX	Hospi tal	Cost	
	Cost Center Description	Inpatient	Outpati ent	Total (col	6 Cost or Other	TEFRA	
	cost center bescription	Inpatrent	outpatrent	+ col. 7	Ratio	Inpatient	
					hatro	Ratio	
		6.00	7.00	8.00	9.00	10.00	
I NPA	TIENT ROUTINE SERVICE COST CENTERS						
30.00 0300	0 ADULTS & PEDIATRICS	2, 132, 076		2, 132, 0	76		30.00
31.00 0310	O INTENSIVE CARE UNIT	0			0		31.00
35.00 0204	O DETOXIFICATION INTENSIVE CARE UNIT	0			0		35.00
ANCI	LLARY SERVICE COST CENTERS			_			
50.00 0500	O OPERATING ROOM	593, 279	7, 667, 732	8, 261, 0	0. 141215	0.00000	50.00
54.00 0540	0 RADI OLOGY-DI AGNOSTI C	551, 810	15, 180, 158	15, 731, 9	68 0. 151461	0.00000	
	0 RADI OI SOTOPE	0	0		0 0.000000		
	OCT SCAN	0	0		0 0. 000000		
	O MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0. 000000		
	0 LABORATORY	940, 649	9, 085, 866				
	0 RESPI RATORY THERAPY	587, 388	1, 791, 756				
	0 PHYSI CAL THERAPY	132, 616	1, 782, 958				
	O OCCUPATIONAL THERAPY	33, 670	120, 817				
	O SPEECH PATHOLOGY	26, 685	79, 901				
	0 ELECTROCARDI OLOGY	0	0		0 0.00000		
	0 ELECTROENCEPHALOGRAPHY	0	0		0 0.00000		
	0 MEDICAL SUPPLIES CHARGED TO PATIENTS	421, 495	1, 607, 777				
72.00 0720	O IMPLANTABLE DEVICES CHARGED TO	5, 714	87, 647	93, 3	5. 126637	0.000000	72.00
73.00 0730	DO DRUGS CHARGED TO PATIENTS	992, 142	12, 491, 716	13, 483, 8	0. 399954	0.000000	73.00
	OSLEEP LAB	992, 142	213, 803				
	O SLEEP LAB	2,369	1, 566, 577				
	ATIENT SERVICE COST CENTERS	2, 309	1, 500, 577	1, 500, 7	+0 0. 349020	0.00000	70.01
	DO CLINIC	12, 969	1, 170, 749	1, 183, 7	0. 542845	0.000000	90.00
	O EMERGENCY	370, 557	16, 556, 465				
	O OBSERVATION BEDS (NON-DISTINCT PART)	73, 950	640, 692				
200.00	Subtotal (see instructions)	6, 877, 369	70, 044, 614				200.00
201.00	Less Observation Beds	2,211,007					201.00
202.00	Total (see instructions)	6, 877, 369	70, 044, 614	76, 921, 9	33		202.00

Health Financial Systems	ASCENSION ST. VII	NCENT MERCY	ENT MERCY In Lieu of Form CMS-2552-10				
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1308	Period: From 07/01/2021 To 06/30/2022	Worksheet C Part I Date/Time Pre 11/29/2022 9:			
		Title XIX	Hospi tal	Cost			
Cost Center Description	PPS Inpatient						
	Ratio						
	11.00						
INPATIENT ROUTINE SERVICE COST CENTERS	1						
30. 00 03000 ADULTS & PEDI ATRI CS					30.00		
31.00 03100 INTENSIVE CARE UNIT					31.00		
35.00 02040 DETOXIFICATION INTENSIVE CARE UNIT					35.00		
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	0. 000000				50.00		
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00		
56. 00 05600 RADI OI SOTOPE	0. 000000				56.00		
57.00 05700 CT SCAN	0. 000000				57.00		
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000				58.00		
60. 00 06000 LABORATORY	0. 000000				60.00		
65. 00 06500 RESPI RATORY THERAPY	0. 000000				65.00		
66. 00 06600 PHYSI CAL THERAPY	0. 000000				66.00		
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000				67.00		
68.00 06800 SPEECH PATHOLOGY	0. 000000				68.00		
69.00 06900 ELECTROCARDI OLOGY	0,000000				69.00		
70.00 07000 ELECTROENCEPHALOGRAPHY	0.000000				70.00		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71.00		
72.00 07200 I MPLANTABLE DEVICES CHARGED TO	0. 000000				72.00		
PATIENTS							
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00		
76.00 03610 SLEEP LAB	0. 000000				76.00		
76. 01 03480 ONCOLOGY	0.000000				76.01		
OUTPATIENT SERVICE COST CENTERS							
90, 00 09000 CLINIC	0.000000				90.00		
91. 00 09100 EMERGENCY	0. 000000				91.00		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000				92.00		
200.00 Subtotal (see instructions)	0.000000				200.00		
201.00 Less Observation Beds					201.00		
202.00 Total (see instructions)					202.00		
	I I				1-02.00		

Health Financial Systems	ASCENSION ST.	VINCENT MERCY		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C		Period: From 07/01/2021 To 06/30/2022	Worksheet D Part II Date/Time Pre 11/29/2022 9:	
			XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATI NG ROOM	224, 769	8, 261, 011	0. 02720	8 70, 531	1, 919	50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	394, 862	15, 731, 968	0. 02509	9 85, 978	2, 158	54.00
56. 00 05600 RADI OI SOTOPE	0	0	0. 00000	0 0	0	56.00
57.00 05700 CT SCAN	0	0	0.00000	0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.00000	0 0	0	58.00
60. 00 06000 LABORATORY	78, 115	10, 026, 515	0.00779	221, 336	1, 724	60.00
65. 00 06500 RESPI RATORY THERAPY	67, 525	2, 379, 144	0. 02838			65.00
66.00 06600 PHYSI CAL THERAPY	82, 823			7 26, 936	1, 165	66,00
67.00 06700 OCCUPATI ONAL THERAPY	3, 515					
68.00 06800 SPEECH PATHOLOGY	1, 276					68,00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0.00000		0	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0.00000		0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	13, 750	2,029,272			604	71.00
72.00 07200 I MPLANTABLE DEVICES CHARGED TO	11, 890				0	72.00
PATIENTS	11,070	,0,001	0.12/00	.0	Ŭ	/2.00
73.00 07300 DRUGS CHARGED TO PATIENTS	205, 209	13, 483, 858	0. 01521	9 247, 305	3, 764	73.00
76.00 03610 SLEEP LAB	9, 523				0	76.00
76. 01 03480 ONCOLOGY	21,601				0	76.01
OUTPATIENT SERVICE COST CENTERS	21,001	1,000,710	0.01070			
90, 00 09000 CLINIC	36, 561	1, 183, 718	0. 03088	7 1, 049	32	90.00
91. 00 09100 EMERGENCY	268, 220				68	
92. 00 09200 OBSERVATION BEDS (NON-DI STINCT PART)	62, 166					
200.00 Total (lines 50 through 199)	1, 481, 805			889, 596		
	., 101, 000	1	I		10,001	1200.00

Health Financial Systems	ASCENSION ST. \	INCENT MERCY		In Lieu of Form CMS-2552-10			
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 15-1308		Worksheet D Part IV Date/Time Pre 11/29/2022 9:	pared: 14 am	
		Title	XVIII	Hospi tal	Cost		
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health		
	Anesthetist	Program	Program	Post-Stepdown			
	Cost	Post-Stepdown		Adjustments			
		Adjustments					
	1.00	2A	2.00	3A	3.00		
ANCI LLARY SERVI CE COST CENTERS							
50.00 05000 OPERATI NG ROOM	0	0		0 0	0	50.00	
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00	
56. 00 05600 RADI OI SOTOPE	0	0		0 0	0	56.00	
57.00 05700 CT SCAN	0	0		0 0	0	57.00	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	58.00	
60. 00 06000 LABORATORY	0	0		0 0	0	60.00	
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00	
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00	
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00	
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00	
69.00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00	
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00	
72.00 07200 IMPLANTABLE DEVICES CHARGED TO	0	0		0 0	0	72.00	
PATIENTS		-					
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00	
76.00 03610 SLEEP LAB	0	0		0 0	0	76.00	
76. 01 03480 ONCOLOGY	0	0		0 0	0	76.01	
OUTPATIENT SERVICE COST CENTERS	· · · · · ·						
90. 00 09000 CLINIC	0	0		0 0	0	90.00	
91. 00 09100 EMERGENCY	0	0		0 0	0	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	-		0	0	92.00	
200.00 Total (lines 50 through 199)	0	0		0 0		200.00	
				·		•	

APPORTI ONENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS Provider CCN: 15-1308 Period: From 07/01/2021 To 00/30/2022 Part IV Date/Time Prepared: 00/30/2022 Part IV Date/Time Prepared: 01/22/202 9: 14 am 11/22/202 9: 14 am Image: Cost Center Description All Other Medical Education Cost Total Cost (sum of cols. 4) Total Cost (sum of cols. 2, 3, and 4) Total Cost (sum of cols. 2, 3, and 4) Part I, col. 8) Part I, col. 7/0 Cost (set (sum of cols. 2, 3, and 4) ANCILLARY SERVICE COST CENTERS 4.00 5.00 6.00 7.00 8.00 ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 15.731.968 0.000000 56.00 50.00 056000 RESPIRATING ROOM 0<	Health Financial Systems	ASCENSION ST. \	/INCENT MERCY		In Lie	eu of Form CMS-2	2552-10
Ancolar Gold S To 06/30/2022 Date/Time Prepared: 11/29/2022 9: 14 an 11/29/2022 9: 14 an Cost Date/Time Prepared: 11/29/2022 9: 14 an Cost Cost Center Description All Other Medical Education Cost Total Cost (sum of cols. 4) Total Cost (sum of cols. 2, 3, and 4) Hospital Cost (sum of cols. 2, 3, and 4) Ratio of Cost to Charges to Cost (sum of cols. 2, 3, and 4) ANCILLARY SERVICE COST CENTERS 4.00 5.00 6.00 7.00 8.00 50.00 05000 OPERATING ROOM 0 05400 RADIOLOGY-DI AGNOSTIC 0 0 8.261,011 0.000000 54.00 50.00 05600 RADIOLOGY-DI AGNOSTIC 0 0 0 0.000000 55.00 50.00 05600 RADIOLOGY-DI AGNOSTIC 0 0 0 0.000000 55.00 50.00 05600 RADIOLOGY-DI AGNOSTIC 0 0 0 0.000000 55.00 50.00 05600 RADIOLOGY-DI AGNOSTIC 0 0 0 0.000000 55.00 60.00 0 0 0 0 0.000000 55.00 0 60.00 0 0 0 0 0 0.0000000 56.00		RVICE OTHER PASS	6 Provider C				
Cost Center Description All Other Medical Education Cost Total Cost (sum of cols. 1, 2, 3, and 4) Total Cost (sum of cols. 2, 3, and 4) Hospital Total Charges (col, 5 + col, 7) (col, 5 + col, 7) 50.00 05000 PERATING ROOM 05000 PERATING ROOM 54.00 05400 GRADI 0100Y-DI ARNOSTIC 0 0 7.00 8.00 50.00 05000 GRADI 0100Y-DI ARNOSTIC 0 0 0 15, 731, 968 0.000000 56.00 54.00 05600 RADI 0100Y-DI ARNOSTIC 0 0 0 0 0 0.000000 56.00 55.00 05600 RADI 0100Y-DI ARNOSTIC 0 0 0 0 0.000000 54.00 56.00 05600 RADI 0100Y-DI ARNOSTIC 0 0 0 0 0 0.000000 54.00 56.00 06500 RADI 0100Y 0 0 0 0 0 0 0 0 0 0 0 0 0.000000 54.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td>Date/Time Pre</td> <td>pared: 14 am</td>						Date/Time Pre	pared: 14 am
Medical Education Cost (sum of cols. 1, 2, 3, and 4) Outpatient Cost (sum of cols. 2, 3, and 4) (from Wkst. [°] C, Part I, col. 8) to Charges (col. 5 + col. 7) (see Instructions) ANCILLARY SERVICE COST CENTERS 4.00 5.00 6.00 7.00 8.00 50.00 05000 (DPERATING ROM 0 0 0 15,731,968 0.000000 50.00 54.00 05000 (DPERATING ROM 0 0 0 0 0 0.000000 51.00 54.00 05000 (DPERATING ROM 0 0 0 0 0 0.000000 52.00 50.00 05000 (AD IOSTOPE 0 0 0 0 0 0 0.000000 53.00 50.00 05700 (CT SCAN 0 0 0 0 0 0 0.000000 58.00 60.00 06000 (ABORATORY 0 0 0 0 0.000000 65.00 57.00 57.00 57.00 57.44 0.000000 65.00 60.00 06000 (ABORATORY 0 0			Title	XVIII	Hospi tal		
Education Cost 1, 2, 3, and 4) Cost (sum of cols. 2, 3, and 4) Part I, col. 8) (col. 5 + col. 7) (see instructions) ANCI LLARY SERVICE COST CENTERS 4.00 5.00 6.00 7.00 8.00 50.00 05000 OPERATING ROOM 0 0 0 8.261,011 0.000000 5.00 54.00 05400 RADI LOCGY-DI AGNOSTI C 0 0 0 0 0.000000 5.00 55.00 05500 (RADI OLOGY-DI AGNOSTI C 0 0 0 0 0.000000 5.00 56.00 05500 (AGNETI C RESONANCE I MAGI NG (MRI) 0 0 0 0.000000 56.00 58.00 05600 RESPI RATORY THERAPY 0 0 0 0.000000 65.00 66.00 06500 RESPI RATORY THERAPY 0 0 0 0 0.000000 65.00 65.00 06500 RESPI RATORY THERAPY 0 0 0 0 0.000000 65.00 66.00 06500 OCCUPATI ONAL THERAPY 0 0 0 0.000	Cost Center Description	All Other	Total Cost				
ANCI LLARY SERVICE COST CENTERS 4.00 50.00 6.00 7.00 8.00 50.00 05000 OPERATING ROOM 0 0 0 8.00 7.00 8.00 50.00 05000 OPERATING ROOM 0 0 0 8.261,011 0.000000 50.00 54.00 05400 RADI OLOGY - DI AGNOSTI C 0 0 0 0 0.000000 51.00 50.00 05600 RADI OLOGY - DI AGNOSTI C 0 0 0 0.000000 51.00 0.000000 51.00 0.000000 51.00 0.000000 51.00 0.000000 51.00 0.000000 51.00 0.000000 51.00 0.000000 51.00 0.000000 51.00 0.000000 51.00 0.000000 51.00 0.000000 51.00 0.000000 51.00 0.000000 51.00 0.000000 51.00 0.000000 51.00 0.000000 51.00 0.000000 51.00 0.000000 51.00 0.00000 51.00 0.000000 61.00 0.000000 61.00 0.0000							
Image: Note of the second se		Education Cost	1, 2, 3, and				
ANCI LLARY SERVICE COST CENTERS 4.00 5.00 6.00 7.00 8.00 50.00 05000 OPERATI NG ROM 0 0 0 8.261,011 0.000000 50.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 15,731,968 0.000000 56.00 55.00 05500 RADI OLOGY-DI AGNOSTI C 0 0 0 0.000000 56.00 56.00 05500 RADI OLOGY-DI AGNOSTI C 0 0 0 0.000000 56.00 57.00 05700 CT SCAN 0 0 0 0.000000 57.00 0 0.0000000 57.00 0.0000000 57.00 0.000000000000000000 58.00 0.00000000000000000000000000000000000			4)		8)		
ANCI LLARY SERVICE COST CENTERS ANCI LLARY SERVICE COST CENTERS 0 05000 (PERATI NG ROOM) 0 0 0 8, 261, 011 0.000000 50.00 54.00 05400 (RADI OLOGY-DI AGNOSTI C) 0 0 0 15, 731, 968 0.000000 54.00 56.00 05500 (T SCAN) 0 0 0 0 0.000000 56.00 57.00 05700 (T SCAN) 0 0 0 0 0.000000 58.00 60.00 06000 LABORATORY 0 0 0 0.000000 58.00 0.000000 58.00 0.000000 65.00 0.000000 58.00 0.000000 58.00 0.000000 66.00 0 0.000000 65.00 0.000000 66.00 0 0.000000 66.00 0 0.000000 66.00 0 0.000000 66.00 0 0.000000 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 0 0.000000				and 4)			
ANCI LLARY SERVICE COST CENTERS 50. 00 05000 OPERATI NG ROM 0 0 0 8, 261, 011 0.000000 50. 00 54. 00 05400 RADI OLGAY-DI AGNOSTI C 0 0 0 15, 731, 968 0.000000 56. 00 56. 00 05600 RADI OL GAY-DI AGNOSTI C 0 0 0 0.000000 56. 00 57. 00 05700 CT SCAN 0 0 0 0.000000 56. 00 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0 0.000000 58. 00 60. 00 06500 RESPI RATORY THERAPY 0 0 0 10, 026, 515 0.000000 65. 00 66. 00 06500 RESPI RATORY THERAPY 0 0 0 1, 915, 574 0.000000 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 0 0 0.000000 68. 00 69. 00 06900 ELECT ROACRPHALOGRAPHY 0 0 0 0.000							
50.00 05000 OPERATI NG ROOM 0 0 8, 261, 011 0.000000 50.00 54.00 05400 RADI 0L 0GY-DI AGNOSTI C 0 0 0 15, 731, 968 0.000000 54.00 56.00 RADI 0L OGY-DI AGNOSTI C 0 0 0 0 0.000000 56.00 57.00 OS700 CT SCAN 0 0 0 0.000000 56.00 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0 0.000000 58.00 60.00 66000 LABGRATORY 0 0 0 0.000000 56.00 65.00 06500 RESPI RATORY THERAPY 0 0 0 1, 915, 574 0.000000 66.00 66.00 06700 0CUPATI ONAL THERAPY 0 0 0 154, 487 0.000000 67.00 68.00 SPEECH PATHOLOGY 0 0 0 0 0.000000 68.00 69.00 06900 ELECTROCARDI 0LOGY 0		4.00	5.00	6.00	7.00	8.00	
54.00 05400 RADI 0LOGY-DI AGNOSTI C 0 0 15, 731, 968 0.000000 54.00 55.00 05600 RADI 0I SOTOPE 0 0 0 0.000000 56.00 57.00 05700 CT SCAN 0 0 0 0.000000 57.00 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0.000000 58.00 60.00 06000 LABORATORY 0 0 0 0.000000 65.00 65.00 RESPI RATORY THERAPY 0 0 0 10, 026, 515 0.000000 66.00 66.00 06500 RESPI RATORY THERAPY 0 0 1, 915, 574 0.000000 66.00 67.00 06700 OCUPATI ONAL THERAPY 0 0 0 154, 487 0.000000 67.00 68.00 06800 SPECH PATHOLOGY 0 0 0 0.000000 68.00 70.00 07000 ELCTROCARDI OLOGY 0 0 0 0.000000 70.00 71.00 07100 MEDICAL SUPPLI ES CHARGED						0.00000	
56.00 05600 RADIOISOTOPE 0 0 0 0.000000 56.00 57.00 05700 CT SCAN 0 0 0 0.000000 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 0 0.000000 58.00 60.00 06000 LABORATORY 0 0 0 0.000000 65.00 65.00 06500 RESPI RATORY THERAPY 0 0 0 2,379,144 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 11,915,574 0.000000 66.00 67.00 06700 0CUPATI ONAL THERAPY 0 0 0 154,487 0.000000 68.00 68.00 06800 SPECH PATHOLOGY 0 0 0 0.000000 68.00 69.00 06900 ELECTROCARDIOLOGY 0 0 0 0.000000 70.00 70.00 07000 ELECTROCARDIOLOGY 0		0	0				
57.00 05700 CT SCAN 0 0 0 0.000000 57.00 58.00 05800 MAGNETIC RESONANCE I MAGI NG (MRI) 0 0 0 0.000000 58.00 60.00 06000 LABORATORY 0 0 0 0.000000 58.00 60.00 06000 LABORATORY 0 0 0 0.000000 60.00 65.00 06000 RESPI RATORY THERAPY 0 0 0 10,026,515 0.000000 66.00 66.00 06600 PHYSI CAL THERAPY 0 0 1,915,574 0.000000 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0 0 0 154,487 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 0.000000 68.00 69.00 O6900 ELECTROCARDI OLOGY 0 0 0 0.000000 70.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0.000000 72.00 71.00 07100 MEDI CAL S		0	0		0 15, 731, 968		
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 0 0 0.000000 58.00 60.00 06000 LABORATORY 0 0 0 10,026,515 0.000000 60.00 65.00 06500 RESPIRATORY THERAPY 0 0 0 2,379,144 0.000000 65.00 66.00 06600 PHYSICAL THERAPY 0 0 0 1,915,574 0.000000 66.00 67.00 0CUPATI ONAL THERAPY 0 0 0 154,487 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 106,586 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 0.000000 70.00 70.00 07000 ELECTROCARDI OLOGY 0 0 0 0.000000 71.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0.000000 73.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 13,483,858 0.000000		0	0		0 0		
60.00 06000 LABORATORY 0 0 10, 026, 515 0.00000 60.00 65.00 06500 RESPI RATORY THERAPY 0 0 0 2, 379, 144 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 1, 915, 574 0.000000 66.00 67.00 06700 CCUPATI ONAL THERAPY 0 0 0 154, 487 0.000000 67.00 68.00 06800 SPECH PATHOLOGY 0 0 0 106, 586 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 0 0.00000 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0.000000 70.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 2, 029, 272 0.000000 71.00 72.00 07200 IMPLANTABLE DEVI CES CHARGED TO 0 0 13, 483, 858 0.000000 73.00 74.1 ENTS 0 0 0 0 1, 568,		0	0		0 0		
65.00 06500 RESPI RATORY THERAPY 0 0 2, 379, 144 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 1, 915, 574 0.000000 66.00 67.00 0CCUPATI ONAL THERAPY 0 0 0 154, 487 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 106, 586 0.000000 69.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 0.000000 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0.000000 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0.000000 71.00 72.00 07200 IMPLANTABLE DEVI CES CHARGED TO 0 0 0 93, 361 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 13, 483, 858 0.000000 76.00 76.01 03480 ONCOLOGY 0 0 0 1, 183, 718		0	0		0 10 00 15		
66.00 06600 PHYSI CAL THERAPY 0 0 1,915,574 0.000000 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0 0 0 154,487 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 106,586 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 0 0.000000 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0.000000 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 2,029,272 0.000000 71.00 72.00 07300 INUFANTABLE DEVI CES CHARGED TO 0 0 0 2,00000 73.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 213,803 0.000000 76.00 74.00 03480 ONCOLOGY 0 0 0 1,183,718 0.000000 76.01 74.00 09000 CLI NI C 0 0 0 0		0	0				
67.00 06700 OCUPATIONAL THERAPY 0 0 154,487 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 106,586 0.000000 68.00 69.00 06900 ELECTROCARDIOLOGY 0 0 0 0 0.000000 69.00 70.00 07000 ELECTROCARDIOLOGY 0 0 0 0.000000 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 2,029,272 0.000000 71.00 72.00 07200 IMPLANTABLE DEVICES CHARGED TO 0 0 0 93,361 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 213,803 0.000000 73.00 76.00 03610 SLEEP LAB 0 0 0 1,183,718 0.000000 76.01 04340 NCOLOGY 0 0 0 1,183,718 0.000000 76.01 90.00 09000 CLI NI C 0 0 0 1,183,718		0	0				
68.00 06800 SPEECH PATHOLOGY 0 0 0 106,586 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0.000000 69.00 70.00 OTOO ELECTROCARDI OLOGY 0 0 0 0 0.000000 69.00 71.00 OTIO MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 2,029,272 0.000000 71.00 72.00 O7200 IMPLANTABLE DEVI CES CHARGED TO 0 0 0 93,361 0.000000 72.00 73.00 O7300 DRUGS CHARGED TO PATI ENTS 0 0 0 213,803 0.000000 73.00 76.00 03610 SLEEP LAB 0 0 0 213,803 0.000000 76.01 04800 NCOLOGY 0 0 0 1,183,718 0.000000 76.01 04100 OP100 EMERGENCY 0 0 0 1,183,718 0.000000 70.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)		0	0				
69.00 06900 ELECTROCARDI OLOGY 0 0 0 0.000000 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0.000000 70.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 2,029,272 0.000000 71.00 72.00 07200 IMPLANTABLE DEVI CES CHARGED TO 0 0 0 93,361 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 13,483,858 0.000000 73.00 76.01 03610 SLEEP LAB 0 0 0 213,803 0.000000 76.00 76.01 03480 ONCOLOGY 0 0 0 1,568,946 0.000000 76.01 00 0 0 0 0 0 1,183,718 0.000000 90.00 90.00 09100 EMERGENCY 0 0 0 16,927,022 0.000000 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 <td< td=""><td></td><td>0</td><td>0</td><td></td><td></td><td></td><td></td></td<>		0	0				
70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0.00000 70.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 2,029,272 0.000000 71.00 72.00 07200 IMPLANTABLE DEVICES CHARGED TO 0 0 0 93,361 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 13,483,858 0.000000 73.00 76.01 03610 SLEEP LAB 0 0 0 213,803 0.000000 76.00 76.01 03480 ONCOLOGY 0 0 1,568,946 0.000000 76.01 00 0 0 0 0 1,568,946 0.000000 76.01 01 0480 ONCOLOGY 0 0 1,183,718 0.000000 90.00 91.00 09100 EMERGENCY 0 0 0 16,927,022 0.000000 91.00 92.00 OBS		0	0		0 106, 586		
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 2,029,272 0.000000 71.00 72.00 07200 IMPLANTABLE DEVICES CHARGED TO 0 0 0 93,361 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 13,483,858 0.000000 73.00 76.00 03610 SLEEP LAB 0 0 0 213,803 0.000000 76.00 76.01 03480 ONCOLOGY 0 0 1,183,718 0.000000 76.01 00TPATI ENT SERVICE COST CENTERS 0 0 0 1,183,718 0.000000 90.00 91.00 09100 EMERGENCY 0 0 0 16,927,022 0.000000 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 714,642 0.000000 92.00		0	0		0 0		
72. 00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS 0 0 93, 361 0.000000 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 13, 483, 858 0.000000 73. 00 76. 00 03610 SLEEP LAB 0 0 0 213, 803 0.000000 76. 00 76. 01 03480 ONCOLOGY 0 0 0 1, 568, 946 0.000000 76. 01 00TPATIENT SERVICE COST CENTERS 0 0 0 1, 183, 718 0.000000 90. 00 90. 00 09000 CLINIC 0 0 0 16, 927, 022 0.000000 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 714, 642 0.000000 92. 00		0	0		0 0		
PATI ENTS O O 13, 483, 858 0.00000 73.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 13, 483, 858 0.000000 73.00 76.00 03480 ONCOLOGY 0 0 213, 803 0.000000 76.00 0400 0 0 0 0 0 76.00 76.00 0400 00000 0 1,568,946 0.000000 76.00 04000 011,817,718 0.000000 76.01 76.01 09000 CLI NI C 0 0 0 1,183,718 0.000000 91.00 09100 EMERGENCY 0 0 16,927,022 0.000000 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 714,642 0.000000 92.00		0	0				
76. 00 03610 SLEEP LAB 0 0 213, 803 0.000000 76. 00 76. 01 03480 ONCOLOGY 0 0 0 1, 568, 946 0.000000 76. 01 0UTPATI ENT SERVICE COST CENTERS 0 0 0 1, 183, 718 0.000000 90. 00 90. 00 09000 CLI NI C 0 0 0 16, 927, 022 0.000000 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 714, 642 0.000000 92. 00		0	0		0 93, 361	0. 000000	72.00
76. 01 03480 ONCOLOGY 0 1,568,946 0.000000 76. 01 OUTPATI ENT SERVICE COST CENTERS 0 0 1,183,718 0.000000 90. 00 90. 00 90. 00 90. 00 90. 00 90. 00 91. 00 91. 00 0 0 16, 927, 022 0.000000 91. 00 92. 00 92.00 058RVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 714, 642 0.000000 92. 00	73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 13, 483, 858	0. 000000	73.00
OUTPATI ENT_SERVICE_COST_CENTERS 90.00 09000 CLINIC 0 0 1, 183, 718 0. 00000 90. 00 91.00 09100 EMERGENCY 0 0 16, 927, 022 0. 000000 91. 00 92.00 09200 OBSERVATI ON_BEDS (NON-DI STINCT_PART) 0 0 0 714, 642 0. 000000 92. 00	76.00 03610 SLEEP LAB	0	0		0 213, 803	0. 000000	76.00
90. 00 09000 CLINIC 0 0 1,183,718 0.000000 90. 00 91. 00 09100 EMERGENCY 0 0 0 16,927,022 0.000000 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 0 0 0 714,642 0.000000 92. 00	76. 01 03480 ONCOLOGY	0	0		0 1, 568, 946	0. 000000	76.01
91.00 09100 EMERGENCY 0 0 16, 927, 022 0.000000 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 714, 642 0.000000 92.00							
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 714, 642 0. 000000 92. 00	90. 00 09000 CLINIC	0	0		0 1, 183, 718	0.000000	90.00
	91. 00 09100 EMERGENCY	0	0		0 16, 927, 022	0.000000	91.00
200.00 Total (lines 50 through 199) 0 0 0 74,789,907 200.00		0	0		0 714, 642	0.000000	92.00
	200.00 Total (lines 50 through 199)	0	0		0 74, 789, 907		200. 00

Health Financial Systems	ASCENSION ST. VI	NCENT MERCY		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 15-1308		Worksheet D Part IV Date/Time Pre 11/29/2022 9:	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Outpati ent	Inpatient	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Throug	n Charges	Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 O5000 OPERATI NG ROOM	0. 000000	70, 531		0 0	0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	85, 978		0 0	0	54.00
56. 00 05600 RADI OI SOTOPE	0. 000000	0		0 0	0	56.00
57.00 05700 CT SCAN	0. 000000	0		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0		0 0	0	58.00
60.00 06000 LABORATORY	0. 000000	221, 336		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	124, 945		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	26, 936		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	8, 576		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	6, 198		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	89, 191		0 0	0	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO	0, 000000	0		0 0	0	72.00
PATIENTS				-	-	
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	247, 305		0 0	0	73.00
76.00 03610 SLEEP LAB	0. 000000	0		0 0	0	76.00
76. 01 03480 ONCOLOGY	0. 000000	0		0 0	0	76.01
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0. 000000	1,049		0 0	0	90.00
91.00 09100 EMERGENCY	0. 000000	4, 271		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	3, 280		0 0	0	92.00
200.00 Total (lines 50 through 199)		889, 596		0 0	0	200.00
	· · · ·		•		•	•

Health Financial Systems	ASCENSION ST.	VINCENT MERCY		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-1308	Period: From 07/01/2021	Worksheet D Part V	
				To 06/30/2022	Date/Time Pre	
				11	11/29/2022 9:	14 am
			XVIII	Hospi tal	Cost Costs	
Cost Center Description	Cost to Charge	DDS Doimbursod	Charges Cost	Cost	PPS Services	
cost center bescription	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not	(300 1131.)	
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS		-	-			
50.00 05000 OPERATING ROOM	0. 141215		., .==,		0	
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 151461		3, 028, 32	24 0	0	54.00
56. 00 05600 RADI OI SOTOPE	0. 000000			0 0	0	56.00
57.00 05700 CT SCAN	0. 000000			0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000			0 0	0	58.00
60. 00 06000 LABORATORY	0. 204086		2, 031, 94		0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 456028		427, 30		0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 493413		441, 14		0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 365066	0	17, 90		0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 467941	0	19, 81		0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	-		0 0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			0 0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 272764	-	207, 25		0	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO	5. 126637	0	23, 27	/2 0	0	72.00
PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	0. 399954		2 472 2	15 81	0	73.00
73.00 07300 DR0GS CHARGED TO PATTENTS 76.00 03610 SLEEP LAB	0. 399954		3, 473, 3 ⁻ 6, 84		0	76.00
76. 01 03480 0NC0L0GY	0. 349828		21, 90		0	76.00
OUTPATIENT SERVICE COST CENTERS	0. 349020	0	21, 90	0	0	70.01
90. 00 09000 CLINIC	0. 542845	0	166, 98	32 134	0	90.00
91. 00 09100 EMERGENCY	0. 323766		2, 158, 19		0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 974506		127, 6		0	
200.00 Subtotal (see instructions)		0	13, 580, 33		-	200.00
201.00 Less PBP Clinic Lab. Services-Program		Ĭ	,	0 0	0	201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		0	13, 580, 33	35 215	0	202.00

Health Financial Systems	ASCENSION ST.	VINCENT MERCY		In Lie	u of Form CMS	-2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-1308	Peri od: From 07/01/2021 To 06/30/2022	Worksheet D Part V Date/Time Pr 11/29/2022 9	epared: :14 am
		Title	XVIII	Hospi tal	Cost	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.) 6.00	(see inst.) 7.00				
ANCI LLARY SERVI CE COST CENTERS	0.00	7.00				_
50. 00 05000 OPERATING ROOM	201, 712	0				50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	458, 673					54.00
56. 00 05600 RADI 0I SOTOPE	430,073					56.00
57. 00 05700 CT SCAN	0	0				57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0				58.00
60. 00 06000 LABORATORY	414, 692	0				60,00
65. 00 06500 RESPI RATORY THERAPY	194, 863					65.00
66. 00 06600 PHYSI CAL THERAPY	217,666	0				66.00
67.00 06700 OCCUPATI ONAL THERAPY	6, 559	0				67.00
68.00 06800 SPEECH PATHOLOGY	9, 270	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	56, 533					71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO	119, 307	0				72.00
PATIENTS						
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 389, 166					73.00
76.00 03610 SLEEP LAB	1,890					76.00
76. 01 03480 ONCOLOGY	7, 662	0				76. 01
OUTPATI ENT SERVICE COST CENTERS 90. 00 09000 CLINIC	00.445	73				
90. 00 109000 CETNIC 91. 00 109100 EMERGENCY	90, 645 698, 749					90.00 91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	124, 420					91.00
200.00 Subtotal (see instructions)	3, 991, 807					200.00
201.00 Less PBP Clinic Lab. Services-Program	3, 331, 807					200.00
Only Charges						201.00
202.00 Net Charges (line 200 - line 201)	3, 991, 807	105				202.00

Health Financial Systems		ASCENSION ST. \	/INCENT MERCY		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHE	R HEALTH SERVICES AND	VACCINE COST	Provider C		Period: From 07/01/2021	Worksheet D Part V	
			Component		To 06/30/2022		pared:
			•			11/29/2022 9:	14 am
			Title		<u>Swing Beds - SNF</u>		
				Charges	0.1	Costs	
Cost Center Descri	ption	Cost to Charge Ratio From	Services (see	Cost Reimbursed	Cost Reimbursed	PPS Services (see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not	(see inst.)	
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins.			
				(see inst.)	(see inst.)		
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST	CENTERS						
50.00 05000 OPERATI NG ROOM		0. 141215	0		0 0	0	50.00
54.00 05400 RADI OLOGY-DI AGNOST	TIC .	0. 151461	0		0 0	0	54.00
56. 00 05600 RADI 0I SOTOPE		0. 000000	0		0 0	0	56.00
57.00 05700 CT SCAN		0. 000000	0		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE	IMAGING (MRI)	0. 000000	0		0 0	0	58.00
60.00 06000 LABORATORY		0. 204086	0		0 0	0	60.00
65.00 06500 RESPI RATORY THERAF	γ	0. 456028	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 493413	0		0 0	0	66.00
67.00 06700 OCCUPATIONAL THERA	/PY	0. 365066	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY		0. 467941	0		0 0	0	68.00
69.00 06900 ELECTROCARDI OLOGY		0. 000000			0 0	0	
70.00 07000 ELECTROENCEPHALOGE		0. 000000	0		0 0	0	1 0.00
71.00 07100 MEDICAL SUPPLIES 0		0. 272764	0		0 0	0	
72.00 07200 IMPLANTABLE DEVICE	S CHARGED TO	5. 126637	0		0 0	0	72.00
PATI ENTS							
73.00 07300 DRUGS CHARGED TO F	PATTENTS	0. 399954	0		0 0	0	
76.00 03610 SLEEP LAB		0. 276142	0		0 0	0	
76. 01 03480 ONCOLOGY		0. 349828	0		0 0	0	76.01
OUTPATIENT SERVICE COST	CENTERS	0.540045					
90. 00 09000 CLI NI C		0. 542845			0 0	0	
91.00 09100 EMERGENCY	NON DICTINCT DADT)	0. 323766			0 0	0	
92.00 09200 OBSERVATION BEDS (200.00 Subtotal (see inst		0. 974506	0		0 0	0	92.00 200.00
	ib. Services-Program		0			0	200.00
201.00 Less PBP CITRIC La Only Charges	ib. Services-Program				0		201.00
202.00 Net Charges (Line	200 - Line 201)		0		o o	0	202.00
	200 1110 2017	I I	0	I	~i 0	0	1-02.00

Health Financial Systems	ASCENSION ST.	VINCENT MERCY		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-1308	Period: From 07/01/2021	Worksheet D Part V	
		Component	CCN: 15-Z308	To 06/30/2022	Date/Time Pro	epared:
					11/29/2022 9:	14 am
			XVIII	Swing Beds - SNF	Cost	
	Cos		-			
Cost Center Description	Cost	Cost				
	Reimbursed Services	Reimbursed Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
	6,00	7.00	-			
ANCI LLARY SERVI CE COST CENTERS	0.00	7.00	1			
50. 00 05000 OPERATING ROOM	0	0				50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
56. 00 05600 RADI OI SOTOPE	0	0				56.00
57. 00 05700 CT SCAN	0	0				57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0				58.00
60. 00 06000 LABORATORY	0	0				60.00
65. 00 06500 RESPI RATORY THERAPY	0	0				65.00
66. 00 06600 PHYSI CAL THERAPY	0	0				66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0				67.00
68.00 06800 SPEECH PATHOLOGY	0	0				68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO	0	0				72.00
PATI ENTS						
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0				73.00
76.00 03610 SLEEP LAB	0	0				76.00
76. 01 03480 ONCOLOGY	0	0				76. 01
OUTPATIENT SERVICE COST CENTERS	1		1			
90. 00 09000 CLI NI C	0	0				90.00
91.00 09100 EMERGENCY	0	0				91.00
92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0	0				92.00
200.00 Subtotal (see instructions)	0	0				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
0nl y Charges 202.00 Net Charges (line 200 - line 201)	_	_				202.00
202.00 [Net Glarges (The 200 - The 201)	0	0	1			1202.00

Health Financial Systems	ASCENSION ST. V			In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE	OTHER PASS THROUGH COST			Period: From 07/01/2021 To 06/30/2022	Worksheet D Part III Date/Time Pre 11/29/2022 9:	epared: 14 am
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Nursi ng	Nursi ng	Allied Health	Allied Health	All Other	
	Program	Program	Post-Stepdowr	Cost	Medi cal	
	Post-Stepdown	-	Adjustments		Education Cost	
	Adjustments					
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTE	RS				•	
30. 00 03000 ADULTS & PEDI ATRI CS	0	0		0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0		0 0	0	31.00
35.00 02040 DETOXIFICATION INTENSIVE CARE	UNIT O	0		0 0	0	35.00
200.00 Total (lines 30 through 199)	0	0		0 0	0	200.00
Cost Center Description	Swing-Bed	Total Costs	Total Patient	Per Diem (col.	Inpatient	
	Adjustment	(sum of cols.	Days	5 ÷ col, 6)	Program Days	
	Amount (see	1 through 3,		· · · ·		
		minus col. 4)				
	4,00	5.00	6,00	7.00	8,00	
INPATIENT ROUTINE SERVICE COST CENTE	RS					
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	1, 32	2 0.00	27	30.00
31.00 03100 INTENSIVE CARE UNIT		0		0.00	l o	31.00
35.00 02040 DETOXIFICATION INTENSIVE CARE	UNIT	0		0.00	0	35.00
200.00 Total (lines 30 through 199)		0	1, 32			200.00
Cost Center Description	I npati ent		.,	_		
p	Program					
	Pass-Through					
	Cost (col. 7 x					
	col . 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTE						
30. 00 03000 ADULTS & PEDI ATRI CS	0					30.00
31. 00 03100 I NTENSI VE CARE UNI T	0					31.00
35. 00 02040 DETOXIFICATION INTENSIVE CARE						35.00
200.00 Total (lines 30 through 199)						200.00
	I O					1200.00

Health Financial Systems	ASCENSION ST. V	INCENT MERCY		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	VICE OTHER PASS			Period: From 07/01/2021 To 06/30/2022	Worksheet D Part IV Date/Time Pre 11/29/2022 9:	
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	Anesthetist	Program	Program	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATI NG ROOM	0	0		0 0	0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
56. 00 05600 RADI OI SOTOPE	0	0		0 0	0	56.00
57.00 05700 CT SCAN	0	0		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	58.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69.00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO	0	0		0 0	0	72.00
PATIENTS						
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
76.00 03610 SLEEP LAB	0	0		0 0	0	76.00
76. 01 03480 ONCOLOGY	0	0		0 0	0	76.01
OUTPATIENT SERVICE COST CENTERS				- I		
90. 00 09000 CLINIC	0	0		0 0	0	90.00
91.00 09100 EMERGENCY	0	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
200.00 Total (lines 50 through 199)	0	0		0 0	0	200. 00

Health Financial Systems	ASCENSION ST. \	/INCENT MERCY		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SET THROUGH COSTS	RVICE OTHER PASS	6 Provider C		Period: From 07/01/2021	Worksheet D Part IV	
				To 06/30/2022	Date/Time Pre	pared:
					11/29/2022 9:	14 am
			e XIX	Hospi tal	Cost	
Cost Center Description	All Other	Total Cost	Total	Total Charges		
	Medical	(sum of cols.	Outpatient	(from Wkst. C,		
	Education Cost		Cost (sum of		(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see instructions)	
	4.00	5.00	6,00	7.00	8.00	
ANCI LLARY SERVICE COST CENTERS	4.00	5.00	0.00	7.00	0.00	
50. 00 05000 OPERATING ROOM		0		0 8, 261, 011	0. 000000	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 15, 731, 968		54.00
56. 00 05600 RADI 0LOGT-DI AGNOSTI C	0	0		0 13, 731, 900	0.000000	56.00
57. 00 05700 CT SCAN	0	0		0 0	0.000000	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0			0.000000	57.00
60. 00 06000 LABORATORY	0	0		0 10, 026, 515		60.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 2, 379, 144		65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 2, 379, 144		66.00
67. 00 06700 0CCUPATI ONAL THERAPY	0	0		0 1, 915, 374		67.00
68. 00 06800 SPEECH PATHOLOGY	0	0		0 106, 586		
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 100, 560	0.000000	
70. 00 07000 ELECTROEARDI OLOGI 70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0.000000	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 2,029,272		
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0		0 2, 029, 272 0 93, 361	0.000000	71.00
PATIENTS	0	0		93, 301	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 13, 483, 858	0. 000000	73.00
76. 00 03610 SLEEP LAB	0	0		0 13, 403, 030		76.00
76. 01 03480 ONCOLOGY	0	0		0 1, 568, 946		76.01
OUTPATIENT SERVICE COST CENTERS	0	0		0 1, 300, 940	0.000000	70.01
90. 00 09000 CLINIC	0	0		0 1, 183, 718	0. 000000	90.00
91. 00 09100 EMERGENCY		0		0 16, 927, 022		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 10, 927, 022		
200.00 Total (lines 50 through 199)	0	0		0 74, 789, 907		200.00
	ц	0	I			200.00

Health Financial Systems	ASCENSION ST. VI	NCENT MERCY		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS	RVICE OTHER PASS	Provider CO		Period: From 07/01/2021 To 06/30/2022	Worksheet D Part IV Date/Time Pre 11/29/2022 9:	
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Outpatient	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Throug	n Charges	Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVICE COST CENTERS						
50.00 05000 OPERATI NG ROOM	0. 000000	10, 579		0 0	0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	62, 804		0 0	0	54.00
56. 00 05600 RADI OI SOTOPE	0. 000000	0		0 0	0	56.00
57.00 05700 CT SCAN	0. 000000	0		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0		0 0	0	58.00
60. 00 06000 LABORATORY	0. 000000	58, 409		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	15, 044		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	1, 049		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0.000000	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0.000000	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0.000000	0		0 0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		0 0	0	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO	0. 000000	0		0 0	0	72.00
PATIENTS						
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	48, 638	1	0 0	0	73.00
76.00 03610 SLEEP LAB	0.000000	0	1	0 0	0	76.00
76. 01 03480 ONCOLOGY	0.000000	0	1	0 0	0	76.01
OUTPATIENT SERVICE COST CENTERS	· ·					1
90. 00 09000 CLINIC	0.000000	0		0 0	0	90.00
91.00 09100 EMERGENCY	0. 000000	74, 758		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0 0	0	92.00
200.00 Total (lines 50 through 199)		271, 281		0 0	0	200. 00

Heal th	Fi nano	ci al	Systems		
COMPUT	ATLON	OF I	NPATI ENT	OPERATI NG	1

ASCENSI ON S	T. VINO	CENT	MERCY	(
		-		0.011	

In Lieu of Form CMS-2552-10

ealth	Financial Systems ASCENSION ST. VIN	NCENT MERCY	In Lie	u of Form CMS-2	2552
OMPUTA	TION OF INPATIENT OPERATING COST	Provider CCN: 15-1308	Peri od:	Worksheet D-1	
			From 07/01/2021 To 06/30/2022	Date/Time Pre	nard
			10 00/30/2022	11/29/2022 9:	
		Title XVIII	Hospi tal	Cost	
	Cost Center Description				
	•			1.00	
	PART I – ALL PROVIDER COMPONENTS				
	NPATIENT DAYS				
	Inpatient days (including private room days and swing-bed day			1, 419	
	Inpatient days (including private room days, excluding swing-			1, 322	
00	Private room days (excluding swing-bed and observation bed da	iys). If you have only p	rivate room days,	0	3
00	do not complete this line. Semi-private room days (evaluding swing had and ebservation b	ad dave)		997	4
00	Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro		or 21 of the cost	26	
00	reporting period	on days) through becens	er 51 of the cost	20	
00	Total swing-bed SNF type inpatient days (including private ro	om davs) after December	31 of the cost	71	6
	reporting period (if calendar year, enter 0 on this line)				
00	Total swing-bed NF type inpatient days (including private roo	m days) through Decembe	r 31 of the cost	0	7
	reporting period				
00	Total swing-bed NF type inpatient days (including private roo	m days) after December	31 of the cost	0	8
	reporting period (if calendar year, enter 0 on this line)				
00	Total inpatient days including private room days applicable t	o the Program (excludin	g swing-bed and	277	9
00	newborn days) (see instructions)				
	Swing-bed SNF type inpatient days applicable to title XVIII o through December 31 of the cost reporting period (see instruc		room days)	26	10
	Swing-bed SNF type inpatient days applicable to title XVIII o		room days) after	0	11
. 00	December 31 of the cost reporting period (if calendar year, e		room days) arter	0	''
. 00	Swing-bed NF type inpatient days applicable to titles V or XI		te room davs)	0	12
	through December 31 of the cost reporting period	5 (5)			
. 00	Swing-bed NF type inpatient days applicable to titles V or XI			0	13
	after December 31 of the cost reporting period (if calendar y				
	Medically necessary private room days applicable to the Progr	am (excluding swing-bed	days)	0	1
	Total nursery days (title V or XIX only)			0	
	Nursery days (title V or XIX only)			0	16
	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to servic	as through December 21	of the cost		1 17
. 00	reporting period	es through becember 31			''
. 00	Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost		18
	reporting period				
. 00	Medicaid rate for swing-bed NF services applicable to service	s through December 31 o	f the cost	231.10	19
	reporting period				
. 00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of	the cost	231.10	20
00	reporting period	、 、		0.040.400	
	Total general inpatient routine service cost (see instruction		the second set (1) as	3, 040, 689	
. 00	Swing-bed cost applicable to SNF type services through Decemb 5 x line 17)	er 31 of the cost repor	ting period (line	0	22
. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporti	na period (line 6	0	23
	x line 18)			0	20
. 00	Swing-bed cost applicable to NF type services through Decembe	er 31 of the cost report	ing period (line	0	24
	7 x line 19)		0, ,		
6.00	Swing-bed cost applicable to NF type services after December	31 of the cost reportin	g period (line 8	0	25
	x line 20)				
	Total swing-bed cost (see instructions)			207, 855	
	General inpatient routine service cost net of swing-bed cost	(The 21 minus The 26)		2, 832, 834	21
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	d and observation had a	harges)	0	28
	Private room charges (excluding swing-bed charges)	a and observation bed c	nai yes)	0	
	Semi-private room charges (excluding swing bed charges)			0	
	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.00000	
	Average private room per diem charge (line 29 ÷ line 3)			0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
00	Average per diem private room charge differential (line 32 mi	nus line 33)(see instru	ctions)	0.00	34
	Average per diem private room cost differential (line 34 x li	ne 31)		0.00	
	Private room cost differential adjustment (line 3 x line 35)			0	
. 00	General inpatient routine service cost net of swing-bed cost	and private room cost d	ifferential (line	2, 832, 834	37
ļ	27 minus line 36)				-
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	LICTMENTS			-
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ			2, 142. 84	2
				Z, 14Z. 84	1 30
. 00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line				30
3.00 9.00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progr	38)		593, 567 0	

MPUT	ATION OF INPATIENT OPERATING COST		Provider C	CN: 15-1308	Period: From 07/01/2021	Worksheet D-1	
					To 06/30/2022	Date/Time Pre 11/29/2022 9:	epare 14 a
		7-4-1		XVIII	Hospi tal	Cost	
	Cost Center Description	Total Inpatient Costl	Total npatient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
00	NURSERY (title V & XIX only)						42
00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	0	0	0.	00 0	0	43
00	CORONARY CARE UNIT	0	0	0.	00 0		44
00	BURN INTENSIVE CARE UNIT						45
00	SURGI CAL INTENSI VE CARE UNI T						46
00		0	0	0.	00 0	0	47
	Cost Center Description					1.00	+
00	Program inpatient ancillary service cost (Wks	st. D-3, col. 3,	line 200)			272, 841	48
00	Total Program inpatient costs (sum of lines			ns)		866, 408	49
	PASS THROUGH COST ADJUSTMENTS					Γ	
00	Pass through costs applicable to Program inpa	atient routine s	ervices (from	Wkst. D, su	m of Parts I and	0	50
00	Pass through costs applicable to Program inpa	atient ancillary	services (fr	om Wkst D	sum of Parts II	0	51
	and IV)		(-	
00	Total Program excludable cost (sum of lines !	,				0	
00	Total Program inpatient operating cost exclud		ated, non-phy	sician anest	hetist, and	0	53
	medical education costs (line 49 minus line ! TARGET AMOUNT AND LIMIT COMPUTATION	DZ)					
00	Program di scharges					0	54
00	Target amount per discharge					0.00	55
00	Target amount (line 54 x line 55)					0	
00	Difference between adjusted inpatient operation	ng cost and tar	get amount (I	ine 56 minus	line 53)	0	
00 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost rep	orting period e	nding 1996 u	ndated and c	omnounded by the	0.00	
00	market basket	boi tring period e	nurng 1770, u		shipodrided by the	0.00	<u> </u>]
00	Lesser of lines 53/54 or 55 from prior year of					0.00	60
00	If line 53/54 is less than the lower of line					0	61
	which operating costs (line 53) are less than amount (line 56), otherwise enter zero (see i		(lines 54 x	60), or 1% o	f the target		
00	Relief payment (see instructions)	histi deti olisj				0	62
00	Allowable Inpatient cost plus incentive payme	ent (see instruc	tions)			0	63
	PROGRAM INPATIENT ROUTINE SWING BED COST						÷
00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through Decem	ber 31 of the	cost report	ing period (See	55, 714	64
00	Medicare swing-bed SNF inpatient routine cos	ts after Decembe	r 31 of the c	ost reportin	a period (See	o	65
	instructions)(title XVIII only)						
00	Total Medicare swing-bed SNF inpatient routin	ne costs (line 6	4 plus line 6	5)(title XVI	ll only). For	55, 714	66
. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing	costs through	Docombor 21 c	f the cost r	oporting poriod	0	67
. 00	(line 12 x line 19)	e costs through	December 31 C	i the cost i	eporting period		/ ⁰ /
00	Title V or XIX swing-bed NF inpatient routine	e costs after De	cember 31 of	the cost rep	orting period	0	68
~ ~	(line 13 x line 20)			()			
. 00	Total title V or XIX swing-bed NF inpatient N PART III - SKILLED NURSING FACILITY, OTHER NU					0	69
00	Skilled nursing facility/other nursing facili)		7 70
00	Adjusted general inpatient routine service co				, ,		71
00	Program routine service cost (line 9 x line			\			72
00	Medically necessary private room cost applicated	0	•	ne 35)			73
00 00	Total Program general inpatient routine servi Capital-related cost allocated to inpatient i	•		orksheet B	Part II. column		74
00	26, line 45)	220110 301 1100		2. noncot D,			'
00	Per diem capital-related costs (line 75 ÷ lin						76
00	Program capital -related costs (line 9 x line	,					77
00 00	Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess		ovider record	c)			78
00	Total Program routine service costs for compa	• •			nus line 79)		80
00	Inpatient routine service cost per diem limi			(81
00	Inpatient routine service cost limitation (li	ne 9 x line 81)					82
00	Reasonable inpatient routine service costs ()				83
00	Program inpatient ancillary services (see ins		c)				84
00 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85
50	PART IV - COMPUTATION OF OBSERVATION BED PASS					1	
00	Total observation bed days (see instructions))				325	
. 00	Adjusted general inpatient routine cost per of Observation bed cost (line 87 x line 88) (see	•	line 2)			2, 142. 84 696, 423	
00							

Health Financial Systems	ASCENSION ST.	VINCENT MERCY		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period:	Worksheet D-1	
				From 07/01/2021 To 06/30/2022	Date/Time Prep 11/29/2022 9:	pared: 14 am
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	271, 424	3, 040, 689	0. 08926	4 696, 423	62, 166	90.00
91.00 Nursing Program cost	0	3, 040, 689	0.00000	0 696, 423	0	91.00
92.00 Allied health cost	0	3, 040, 689	0.00000	0 696, 423	0	92.00
93.00 All other Medical Education	0	3, 040, 689	0.00000	0 696, 423	0	93.00

^{11/29/2022 9:14} am Y: \28650 - St. Vincent Mercy\300 - Medicare Cost Report\20220630\HFS\20220630 St. Vincent Mercy.mcrx

Health Financial Systems

ASCENSION ST.	VI NCENT	MERCY	
	-		

In Lieu of Form CMS-2552-10

leal th	Financial Systems ASCENSION ST. VIN	NCENT MERCY	In Lie	u of Form CMS-2	2552-
COMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-1308	Peri od:	Worksheet D-1	
			From 07/01/2021 To 06/30/2022	Date/Time Pre	naroc
			10 00/30/2022	11/29/2022 9:	
		Title XIX	Hospi tal	Cost	
	Cost Center Description				
				1.00	
	PART I - ALL PROVIDER COMPONENTS				-
00	INPATIENT DAYS			1 410	1
. 00 . 00	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing-			1, 419 1, 322	
. 00	Private room days (excluding swing-bed and observation bed da		rivate room davs	1, 322	
. 00	do not complete this line.	iys). Thiybu have only pr	rvate room days,	0	5.
. 00	Semi-private room days (excluding swing-bed and observation b	ped davs)		997	4.
00	Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	48	5.
	reporting period				
. 00	Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	49	6.
00	reporting period (if calendar year, enter 0 on this line)	m dava) through December	a 21 of the east	0	-
. 00	Total swing-bed NF type inpatient days (including private roo reporting period	Sin days) through becember	31 OF THE COST	0	7.
. 00	Total swing-bed NF type inpatient days (including private roo	om days) after December :	31 of the cost	0	8.
. 00	reporting period (if calendar year, enter 0 on this line)	algo) al tel becember (0	0.
. 00	Total inpatient days including private room days applicable t	to the Program (excluding	g swing-bed and	27	9.
	newborn days) (see instructions)		_		
0. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		room days)	0	10.
1 00	through December 31 of the cost reporting period (see instruc	ctions)		0	1.1
1. 00	Swing-bed SNF type inpatient days applicable to title XVIII o December 31 of the cost reporting period (if calendar year, e		room days) arter	0	11.
2.00	Swing-bed NF type inpatient days applicable to titles V or XI		te room davs)	0	12.
2.00	through December 31 of the cost reporting period		to room dayoy		
3. 00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including priva	te room days)	0	13.
	after December 31 of the cost reporting period (if calendar y				
	Medically necessary private room days applicable to the Progr	ram (excluding swing-bed	days)	0	
	Total nursery days (title V or XIX only)			0	
6. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16.
7.00	Medicare rate for swing-bed SNF services applicable to servic	ces through December 31 (of the cost		17.
7.00	reporting period				
8.00	Medicare rate for swing-bed SNF services applicable to servic	ces after December 31 of	the cost		18.
	reporting period				
9.00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 of	f the cost	231.10	19.
0. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	s ofter December 21 of :	the cost	231.10	20
0.00	reporting period	es al tel December 31 01		231.10	20.
1.00	Total general inpatient routine service cost (see instruction	าร)		3, 040, 689	21.
2.00	Swing-bed cost applicable to SNF type services through Decemb		ting period (line	0	
	5 x line 17)		0 1 1		
3.00	Swing-bed cost applicable to SNF type services after December	- 31 of the cost reportio	ng period (line 6	0	23.
	x line 18)				
4.00	Swing-bed cost applicable to NF type services through Decembe	er 31 of the cost report	ng period (line	0	24.
5.00	7 x line 19) Swing-bed cost applicable to NF type services after December	31 of the cost reporting	n period (line 8	0	25.
	x line 20)			0	20.
6.00	Total swing-bed cost (see instructions)			207, 855	26.
7.00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		2, 832, 834	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
3.00	General inpatient routine service charges (excluding swing-be	ed and observation bed cl	narges)	0	
	Private room charges (excluding swing-bed charges)			0	
). 00 I. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	\div Line 28)		0 0. 000000	
2.00	Average private room per diem charge (line 29 ÷ line 3)	- 1111e 20)		0.00000	
. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
. 00	Average per diem private room charge differential (line 32 mi	nus line 33)(see instruc	ctions)	0.00	
5.00	Average per diem private room cost differential (line 34 x li			0.00	
5.00	Private room cost differential adjustment (line 3 x line 35)			0	
7.00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	2, 832, 834	37.
	27 minus line 36)				1
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	LICTMENTC			-
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ Adjusted general inpatient routine service cost per diem (see			2 142 04	20
2 00		FINSTIUCTIONS)		2, 142. 84	
				57 857	1 20
9.00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progr	2 38)		57, 857 0	

OMPUT	ATION OF INPATIENT OPERATING COST		Provider C	CN: 15-1308	Peri od:	Worksheet D-1	
					From 07/01/2021 To 06/30/2022	Date/Time Pre	epare
						11/29/2022 9:	
	Cost Center Description	Total	Total	e XIX Average Per	Hospital Program Days	Cost Program Cost	
		Inpatient Cost				(col. 3 x col.	
		1.00		col . 2)	1.00	4)	
2.00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	42.
. 00	Intensive Care Type Inpatient Hospital Units			1			
. 00	INTENSIVE CARE UNIT	0	С	0.	00 0	0	
1.00	CORONARY CARE UNIT						44.
5.00 5.00	BURN INTENSIVE CARE UNIT						45.
. 00		0	C	0.	00 0	0	
	Cost Center Description				<u>.</u>		
2 00	Program inpatient ancillary service cost (Wk	ct D 2 col 2	Line 200)			1.00	48.
8.00 9.00	Total Program inpatient costs (sum of lines			ons)		73, 961 131, 818	
	PASS THROUGH COST ADJUSTMENTS	······································		,			
0. 00	Pass through costs applicable to Program inp	atient routine s	ervices (from	n Wkst. D, su	m of Parts I and	0	50.
1.00	<pre>III) Pass through costs applicable to Program inp</pre>	atient ancillary	services (fr	om Wkst D	sum of Parts II	0	51.
1.00	and IV)		301 11 003 (11	on with D,			/ 51.
2.00	Total Program excludable cost (sum of lines					0	
3.00	Total Program inpatient operating cost exclu medical education costs (line 49 minus line		ated, non-phy	/si ci an anest	hetist, and	0	53.
	TARGET AMOUNT AND LIMIT COMPUTATION	52)				I	
1.00	Program di scharges					0	
6.00	Target amount per discharge					0.00	
0. 00 . 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and tar	aet amount (l	ine 56 minus	line 53)	0	
. 00 3. 00	Bonus payment (see instructions)	ring cost and tar	get amount (i		11116 33)	0	
. 00	Lesser of lines 53/54 or 55 from the cost re	porting period e	nding 1996, ι	updated and c	ompounded by the	0.00	59
). 00	market basket Lesser of lines 53/54 or 55 from prior year	cost roport und	atod by the m	arkat backat		0.00	60
1.00	If line 53/54 is less than the lower of line					0.00	
	which operating costs (line 53) are less that	n expected costs					
0.00	amount (line 56), otherwise enter zero (see	instructions)				0	62.
2.00 3.00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instruc	tions)				
	PROGRAM INPATIENT ROUTINE SWING BED COST					-	
4.00	Medicare swing-bed SNF inpatient routine cos	ts through Decem	ber 31 of the	e cost report	ing period (See	0	64.
5.00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decembe	r 31 of the c	ost reportin	a period (See	0	65.
	instructions) (title XVIII only)			ione i opor trin	g por lou (occ		
b. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line 6	4 plus line 6	5)(title XVI	ll only). For	0	66.
7.00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	e costs through	December 31 c	of the cost r	eporting period	0	67.
/.00	(line 12 x line 19)	e costs through	December 31 c	of the cost is	eporting period		/ 0/.
3. 00	Title V or XIX swing-bed NF inpatient routin	e costs after De	cember 31 of	the cost rep	orting period	0	68.
9.00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routino coste (l	ino 67 i lino	5 69)		0	69.
7.00	PART III - SKILLED NURSING FACILITY, OTHER N					0	/ 07.
0. 00	Skilled nursing facility/other nursing facil	ity/ICF/IID rout	ine service o	cost (line 37)		70
. 00	Adjusted general inpatient routine service of		ne 70 ÷ line	2)			71
2.00 3.00	Program routine service cost (line 9 x line Medically necessary private room cost applic	,	(line 14 x li	ne 35)			72
. 00	Total Program general inpatient routine serv						74
5.00	Capital-related cost allocated to inpatient	routine service	costs (from V	Vorksheet B,	Part II, column		75
. 00	26, line 45) Per diem capital related costs (line 75 ÷ li	no 2)					76
5.00 7.00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						77
. 00	Inpatient routine service cost (line 74 minu	s line 77)					78
. 00	Aggregate charges to beneficiaries for exces	• •					79
. 00 . 00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		st limitation	ı (IINE /8 mi	nus line /9)		80
. 00	Inpatient routine service cost per diem rim						82
. 00	Reasonable inpatient routine service costs (see instructions					83
. 00	Program inpatient ancillary services (see in						84
5.00 5.00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85
. 00	PART IV - COMPUTATION OF OBSERVATION BED PAS					1	
7.00	Total observation bed days (see instructions)				325	
3.00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se		line 2)			2, 142. 84 696, 423	
. 00	(1)						

Health Financial Systems	ASCENSION ST.	/INCENT MERCY		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period:	Worksheet D-1	
				From 07/01/2021 To 06/30/2022	Date/Time Pre 11/29/2022 9:	pared: 14 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	271, 424	3, 040, 689	0. 08926	4 696, 423	62, 166	90.00
91.00 Nursing Program cost	0	3, 040, 689	0.00000	0 696, 423	0	91.00
92.00 Allied health cost	0	3, 040, 689	0.00000	0 696, 423	0	92.00
93.00 All other Medical Education	0	3, 040, 689	0. 00000	0 696, 423	0	93.00

^{11/29/2022 9:14} am Y: \28650 - St. Vincent Mercy\300 - Medicare Cost Report\20220630\HFS\20220630 St. Vincent Mercy.mcrx

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT Provider CON: 15-1308 Period: From 07/01/2021 Period: To 06/30/2022 Norksheet D-3 Cost Center Description Title XVIII Hospital Cost	Health Financial Systems ASCENSION ST. VIN	CENT MERCY		In Lie	eu of Form CMS-	2552-10
Image: Control of Control control of Control of Control of Control of Contro	INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1308		Worksheet D-3	3
Intervention Title XVIII Hospital Cost Cost Center Description Ratio of Cost To Charges Inpatient Program Charges Inpatient Program Charges Inpatient Program Charges Inpatient Program Costs (cl. 1 x col. 2) 0.00 03000 3000 ADULTS & PEDIATRICS 1.00 2.00 3.00 31.00 03000 INTENSIVE CARE UNIT 516.794 30.00 35.00 02000 DETORTICATION INTENSIVE CARE UNIT 0 31.00 ANCILLARY SERVICE COST CENTERS 0.141215 70.531 9.960 50.00 50.00 05000 RADIO RADIOLIST & PEDIATRICS 0.141215 70.531 9.960 50.00 516.0700 0.141215 70.531 9.960 50.00 56.00 0.000000 0 0 57.00 56.00 05600 RADIO ISOTOPE 0.0000000 0 0 58.00 66000 Apstication (MRI) 0.0000000 0 58.00 66.00 066000 RESPI RATORY THERAPY 0.456028 124.945 56.978 65.00					Data /Tima Dra	nored
Cost Center Description Title XVIII Hospital Cost Neth of Cost Inpatient Program Charges Inpatient Program (Cost Inpatient Inpatient				10 06/30/2022		
INPATIENT ROUTINE SERVICE COST CENTERS To Charges Program Charges Program (col. 1 x col. 2) 30.00 03000 ADULTS & PEDIATRICS 1.00 2.00 3.00 31.00 03000 INTENSIVE CARE UNIT 0 31.00 31.00 35.00 02040 DETOXI FI CATION INTENSIVE CARE UNIT 0 31.00 31.00 4NCILLARY SERVICE COST CENTERS 0 1.51661 85,978 13.022 54.00 56.00 05000 OPERATING ROM 0.141215 70.531 9.960 50.00 56.00 05000 RADIOLOCY-DI AGNOSTIC 0.151461 85,978 13.022 54.00 56.00 05000 RADIOLOCY-DI AGNOSTIC 0.000000 0 0 58.00 60.00 05000 RADIOLOCY-DI AGNOSTIC 0.000000 0 58.00 60.00 05000 RESINTATORY<		Title	e XVIII	Hospi tal		<u> </u>
INPATLENT ROUTINE SERVICE COST CENTERS Charges (col 1 x col 2) 1.00 2.00 3.00 31.00 03000 ADULTS & PEDIATICS 516,794 30.00 31.00 03000 ADULTS & PEDIATICS 0 31.00 31.00 05000 OPECATINENSIVE CARE UNIT 0 35.00 ANCILLARY SERVICE COST CENTERS 0 1115 70.531 9.960 50.00 05000 OPECATING ROM 0.141215 70.531 9.960 50.00 05000 OPECATING ROM 0.151461 85.978 13.022 54.00 56.00 05400 RADIOLOGY-DIAGNOSTIC 0.151461 85.978 13.022 54.00 56.00 05600 OCOLABORATORY 0.000000 0 0 57.00 57.00 05700 CT SCAN 0.000000 0 0 58.00 66.00 06500 RESPI RATORY THERAPY 0.465028 124.945 56.978 65.00 67.00 06700 CULCHATIONAL THERAPY 0.345066 8.576 3.131<67.00	Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
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67.00 06700 0CCUPATIONAL THERAPY 0.365066 8,576 3,131 67.00 68.00 06800 SPEECH PATHOLOGY 0.467941 6,198 2,900 68.00 69.00 06900 ELECTROCARDIOLOGY 0.000000 0 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0 0 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.272764 89,191 24,328 71.00 72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS 5.126637 0 0 72.00 73.00 03610 SLEEP LAB 0.276142 0 0 76.00 76.01 03480 ONCOLOGY 0.349828 0 0 76.00 76.01 03480 ONCOLOGY 0.349828 0 0 76.01 0047000 09000 CLINIC 0.542845 1,049 56.99 90.00 76.01 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.323766 4,271 1,383 91.00 92.00 092000						
68.00 06800 SPEECH PATHOLOGY 0.467941 6, 198 2, 900 68.00 69.00 06900 ELECTROCARDIOLOGY 0.000000 0 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0 0 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.272764 89, 191 24, 328 71.00 72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS 5.126637 0 0 72.00 73.00 03610 SLEEP LAB 0.2776142 0 0 76.00 76.01 03480 ONCOLOGY 0.349954 247, 305 98, 911 73.00 76.01 03480 ONCOLOGY 0.349828 0 0 76.00 70.00 09000 CLI NI C 0.542845 1, 049 56.9 90.00 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.323766 4, 271 1, 383 91.00 92.000 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.974506 3, 280 3, 196 92.00 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td></td<>						
69.00 06900 ELECTROCARDIOLOGY 0.000000 0 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0 0 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.272764 89,191 24,328 71.00 72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS 5.126637 0 0 72.00 73.00 07300 RUGS CHARGED TO PATIENTS 0.399954 247,305 98,911 73.00 76.00 03610 SLEEP LAB 0.276142 0 0 76.00 76.01 03480 ONCOLOGY 0.349828 0 0 76.01 0480 0VOLOGY 0.349828 0 0 76.01 04900 CLINIC 0.542845 1,049 56.99 90.00 91.00 09200 DESERVATION BEDS (NON-DISTINCT PART) 0.323766 4,271 1,383 91.00 92.00 09200 DESERVATION BEDS (NON-DISTINCT PART) 0.974506 3,280 3,196 92.00 200.00 Less PBP Clinic Laboratory Services						
70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.272764 89,191 24,328 71.00 72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS 5.126637 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.399954 247,305 98,911 73.00 76.00 03610 SLEEP LAB 0.276142 0 0 76.00 76.01 03480 ONCOLOGY 0.349828 0 0 76.00 90.00 09000 CLINIC 0.542845 1,049 569 90.00 91.00 09100 EMERGENCY 0.323766 4,271 1,383 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 0.974506 3,280 3,196 92.00 200.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00 201.00						
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.272764 89, 191 24, 328 71.00 72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS 5.126637 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.399954 247, 305 98, 911 73.00 76.00 03610 SLEEP LAB 0.276142 0 0 76.00 76.01 03480 ONCOLOGY 0.349828 0 0 76.01 001700 UTPATIENT SERVICE COST CENTERS 0.349828 0 0 76.01 90.00 09000 CLINIC 0.542845 1,049 569 90.00 91.00 09100 EMERGENCY 0.323766 4,271 1,383 91.00 92.00 09200 OBSERVATION BEDS (NON-DI STINCT PART) 0.974506 3,280 3,196 92.00 200.00 Total (sum of lines 50 through 94 and 96 through 98) 889,596 272,841 200.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 0.01.00 0.01.00 0.01.00 0.0					-	
72. 00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS 5. 126637 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 399954 247, 305 98, 911 73. 00 76. 00 03610 SLEEP LAB 0. 276142 0 0 76. 00 70. 00 03480 ONCOLOGY 0. 349828 0 0 76. 01 001PATIENT SERVICE COST CENTERS 0. 542845 1, 049 56. 9 90. 00 90. 00 09100 EMERGENCY 0. 323766 4, 271 1, 383 91. 00 92. 00 09200 DBSERVATI ON BEDS (NON-DI STINCT PART) 0. 974506 3, 280 3, 196 92. 00 200. 00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201. 00 201. 00					,	
73.00 07300 DRUGS CHARGED TO PATIENTS 0.399954 247,305 98,911 73.00 76.00 03610 SLEEP LAB 0.276142 0 0 76.00 76.01 03480 ONCOLOGY 0.349828 0 0 76.01 001PATIENT SERVICE COST CENTERS 0.542845 1,049 56.9 90.00 90.00 09100 EMERGENCY 0.323766 4,271 1,383 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.974506 3,280 3,196 92.00 200.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00 201.00 201.00						
76.00 03610 SLEEP LAB 0.276142 0 0 76.00 76.01 03480 ONCOLOGY 0.349828 0 0 76.01 0UTPATI ENT SERVICE COST CENTERS 0 0 76.01 0 76.01 76.01 90.00 09000 CLINIC 0.542845 1,049 56.9 90.00 91.00 09100 EMERGENCY 0.323766 4,271 1,383 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.974506 3,280 3,196 92.00 200.00 Total (sum of lines 50 through 94 and 96 through 98) 0 0 201.00 201.00 201.00 201.00 0 201.00 201.00 0 201.00 0 201.00 0 201.00 0 201.00 0 201.00 0 0 201.00						
76. 01 03480 ONCOLOGY 0.349828 0 0 76. 01 0UTPATI ENT SERVICE COST CENTERS 0 0 76. 01 0 0 90. 00 0 0 90. 00 0 0 90. 00 0 90. 00 0 1, 049 56. 9 90. 00 91. 00 0.323766 4, 271 1, 383 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 0. 974506 3, 280 3, 196 92. 00 201. 00 201. 00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 0 201. 00 201. 00						
OUTPATI ENT SERVICE COST CENTERS 90.00 09000 CLINIC 0.542845 1,049 569 90.00 91.00 09100 EMERGENCY 0.323766 4,271 1,383 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 0.974506 3,280 3,196 92.00 200.00 Total (sum of lines 50 through 94 and 96 through 98) 889,596 272,841 200.00 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00					-	
90. 00 09000 CLINIC 0.542845 1,049 569 90. 00 91. 00 09100 EMERGENCY 0.323766 4,271 1,383 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 0.974506 3,280 3,196 92. 00 200. 00 Total (sum of lines 50 through 94 and 96 through 98) 889,596 272,841 200. 00 201. 00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201. 00			0. 34982	28 0	0	76.01
91. 00 09100 EMERGENCY 0.323766 4, 271 1, 383 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 0.974506 3, 280 3, 196 92. 00 200. 00 Total (sum of lines 50 through 94 and 96 through 98) 889, 596 272, 841 200. 00 201. 00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201. 00						
92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0. 974506 3, 280 3, 196 92. 00 200. 00 Total (sum of lines 50 through 94 and 96 through 98) 201. 00 889, 596 272, 841 200. 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) 889, 596 272, 841 200.00 201.00 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. 97450			
				889, 596	272, 841	
202.00 Net charges (line 200 minus line 201) 889,596 202.00		s (line 61)		0		
	202.00 Net charges (line 200 minus line 201)		1	889, 596	l	202.00

	er CCN: 15-13				
Compon			eriod:	Worksheet D-3	
	ent CCN: 15-Z		rom 07/01/2021 o 06/30/2022		narod
	III CON. 15-2	300 1	0 00/30/2022	11/29/2022 9:	
]	itle XVIII	Sv	ving Beds - SNI		
Cost Center Description	Ratio o	f Cost	Inpati ent	I npati ent	
	To Cha	arges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
	1. (00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS			1	1	
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
31. 00 03100 I NTENSI VE CARE UNI T					31.00
35. 00 02040 DETOXIFICATION INTENSIVE CARE UNIT					35.00
ANCI LLARY SERVICE COST CENTERS 50. 00 05000 OPERATI NG ROOM		141015			50.00
50. 00 05000 0PERATI NG ROOM 54. 00 05400 RADI 0LOGY-DI AGNOSTI C		141215			
54. 00 05400 RADI 0L0GY-DI AGNOSTI C 56. 00 05600 RADI 0I SOTOPE		151461 000000			
57. 00 05700 CT SCAN		000000			1
57.00 05700 CT SCAN 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		000000			
60. 00 06000 LABORATORY		204086		-	
65. 00 06500 RESPI RATORY THERAPY		456028			1
66. 00 06600 PHYSI CAL THERAPY		493413			
67. 00 06700 OCCUPATI ONAL THERAPY		365066			
68. 00 06800 SPEECH PATHOLOGY		467941			
69. 00 06900 ELECTROCARDI OLOGY		000000		0	1
70. 00 107000 ELECTROCARDI DEGOT		000000			1
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		272764		-	
72. 00 07200 I MPLANTABLE DEVICES CHARGED TO PATIENTS		126637			1
73. 00 07300 DRUGS CHARGED TO PATIENTS		399954		-	
76. 00 03610 SLEEP LAB		276142			1
76. 01 03480 ONCOLOGY		349828		-	
OUTPATI ENT SERVICE COST CENTERS		017020		<u>, </u>	10.01
90. 00 09000 CLI NI C	0.	542845	C	0 0	90.00
91. 00 09100 EMERGENCY		323766		0	1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		974506		0	92.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)			30, 068	10, 366	200.00
201.00 Less PBP Clinic Laboratory Services-Program only charges (line	1)		C		201.00
202.00 Net charges (line 200 minus line 201)			30, 068	3	202.00

Health Financial Systems ASCENSION ST. VINC	ENT MERCY		In Lie	eu of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1308	Peri od:	Worksheet D-3	;
			From 07/01/2021 To 06/30/2022		nared
			10 00/30/2022	11/29/2022 9:	
	Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	0.00	2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS		1	69, 228	1	30.00
31. 00 03100 I NTENSI VE CARE UNI T			09, 220		31.00
35. 00 02040 DETOXIFICATION INTENSIVE CARE UNIT			0		35.00
ANCI LLARY SERVICE COST CENTERS		1		1	33.00
50. 00 05000 OPERATI NG ROOM		0. 1412	10, 579	1, 494	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1514	62, 804	9, 512	54.00
56. 00 05600 RADI 0I SOTOPE		0.0000	0 00	0	56.00
57.00 05700 CT SCAN		0.0000	0 00	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0.0000	0 0	0	58.00
60. 00 06000 LABORATORY		0. 2040	36 58, 409	11, 920	60.00
65. 00 06500 RESPI RATORY THERAPY		0. 4560			65.00
66. 00 06600 PHYSI CAL THERAPY		0. 4934		518	
67. 00 06700 OCCUPATI ONAL THERAPY		0.3650		0	
68.00 06800 SPEECH PATHOLOGY		0. 46794		0	
69. 00 06900 ELECTROCARDI OLOGY		0.0000		C	
70. 00 07000 ELECTROENCEPHALOGRAPHY		0.0000		C	1 1 0 . 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 2727		C	
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS		5. 1266		C	
73.00 O7300 DRUGS CHARGED TO PATIENTS		0. 3999			
76.00 03610 SLEEP LAB		0. 2761		-	
76. 01 03480 ONCOLOGY		0. 3498	28 0	C	76.01
0UTPATI ENT_SERVI CE_COST_CENTERS 90. 00 09000 CLI NI C		0 5420		0	90.00
90. 00 109000 CLINIC 91. 00 109100 EMERGENCY		0. 5428 0. 3237		-	
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 32370		24,204	
200.00 Total (sum of lines 50 through 94 and 96 through 98)		0. 97450	271, 281	-	200.00
201.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)		2/1,201	13,901	200.00
202.00 Net charges (line 200 minus line 201)			271, 281		201.00
		I	271,201	I	1-02.00

	Financial Systems ASCENSION ST. VINC			u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1308	Period: From 07/01/2021 To 06/30/2022	Date/Time Pre	
. <u> </u>		Title XVIII	Hospi tal	11/29/2022 9: Cost	<u>14 am</u>
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00 2.00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instruct	i onc)		3, 991, 912 0	
2.00 3.00	OPPS payments	10115)		0	
4.00	Outlier payment (see instructions)			0	
4.01 5.00	Outlier reconciliation amount (see instructions) Enter the hospital specific payment to cost ratio (see instruc	tions)		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	
9.00	Ancillary service other pass through costs from Wkst. D, Pt. I	V, col. 13, line 200		0	9.00
10. 00 11. 00	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)			0 3, 991, 912	
111.00	COMPUTATION OF LESSER OF COST OR CHARGES				
12.00	Reasonable charges Ancillary service charges			0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, li	ne 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13) Customary charges			0	14.00
15.00	Aggregate amount actually collected from patients liable for p	ayment for services on	a charge basi s	0	15.00
16.00	Amounts that would have been realized from patients liable for had such payment been made in accordance with 42 CFR §413.13(e		n 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)		11) (0	
19.00	Excess of customary charges over reasonable cost (complete onl instructions)	y IT II ne 18 exceeds II	ne II) (see	0	19.00
20.00	Excess of reasonable cost over customary charges (complete onl	y if line 11 exceeds li	ne 18) (see	0	20.00
21.00	instructions) Lesser of cost or charges (see instructions)			4, 031, 831	21.00
22.00	Interns and residents (see instructions)			0	
23.00 24.00	Cost of physicians' services in a teaching hospital (see instr Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	uctions)		0	
05 00	COMPUTATION OF REIMBÜRSEMENT SETTLEMENT	、 、			05.00
25.00 26.00	Deductibles and coinsurance amounts (for CAH, see instructions Deductibles and Coinsurance amounts relating to amount on line	-	uctions)	32, 292 2, 240, 580	1
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) p	•	· ·	1, 758, 959	27.00
28.00	instructions) Direct graduate medical education payments (from Wkst. E-4, li	ne 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
30. 00 31. 00	Subtotal (sum of lines 27 through 29) Primary payer payments			1, 758, 959 3	
32.00	Subtotal (line 30 minus line 31)			1, 758, 956	
33 00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVIC Composite rate ESRD (from Wkst. I-5, line 11)	ES)		0	33.00
34.00	Allowable bad debts (see instructions)			317, 232	
35.00 36.00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instr	uctions)		206, 201 180, 122	
37.00	Subtotal (see instructions)			1, 965, 157	
38. 00 39. 00	MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
39.00 39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.00
39.97	Demonstration payment adjustment amount before sequestration		+:)	0	
39. 98 39. 99	Partial or full credits received from manufacturers for replac RECOVERY OF ACCELERATED DEPRECIATION	ed devices (see instruc	tions)	0	
40.00	Subtotal (see instructions)			1, 965, 157	
40. 01 40. 02	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration			4, 913	
40.03	Sequestration adjustment-PARHM pass-throughs				40. 03
41.00 41.01	Interim payments Interim payments-PARHM			2, 168, 553	41.00
42.00	Tentative settlement (for contractors use only)			0	42.00
42. 01 43. 00	Tentative settlement-PARHM (for contractor use only) Balance due provider/program (see instructions)			-208, 309	42.01 43.00
43.01	Balance due provider/program-PARHM (see instructions)			200, 309	43.01
44.00	Protested amounts (nonallowable cost report items) in accordan §115.2	ce with CMS Pub. 15-2,	chapter 1,	25, 000	44.00
	TO BE COMPLETED BY CONTRACTOR			l	
	Original outlier amount (see instructions)			0	
91.00 92.00	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0.00	
93.00	Time Value of Money (see instructions)			0	
94. UU	Total (sum of lines 91 and 93)			1 0	94.00

Health Financial Systems	ASCENSION ST. VIN	ICENT MERCY	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-1308	Period: From 07/01/2021	Worksheet E	
				Date/Time Pre	pared:
				11/29/2022 9:	14 am
		Title XVIII	Hospi tal	Cost	
				1.00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days				0	200. 00

^{11/29/2022 9:14} am Y: \28650 - St. Vincent Mercy\300 - Medicare Cost Report\20220630\HFS\20220630 St. Vincent Mercy.mcrx

ANALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC	CN: 15-1308	Period: From 07/01/2021 To 06/30/2022	Worksheet E-1 Part I Date/Time Prep 11/29/2022 9:	pared:
			XVIII	Hospi tal	Cost	
		I npati en	t Part A	Par	тB	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00 2.00 3.00	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 List separately each retroactive lump sum adjustment		747, 6	65 0	2, 100, 553 0	1.00 2.00 3.00
	amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER			0 08/25/2022	68, 000	
3.02				0	0	
3.03 3.04				0	0	3.03 3.04
3.04				0	0	
0.00	Provider to Program	11				
3.50	ADJUSTMENTS TO PROGRAM			0	0	
3.51				0	0	
3.52 3.53				0	0	3.52 3.53
3.53				0	0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	68, 000	
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)		747, 6	65	2, 168, 553	4.00
5.00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after					5.00
5.00	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
5.01	Program to Provider TENTATIVE TO PROVIDER			0	0	5.01
5.02				0	0	
5.03				0	0	
	Provider to Program	1		_		_
5.50 5.51	TENTATI VE TO PROGRAM			0	0	
5.51 5.52				0	0	
5.99	Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98)			0	0	5.9
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6. 01	SETTLEMENT TO PROVIDER		46, 30		0	6. 0 [.]
6.02	SETTLEMENT TO PROGRAM		70 4 . 0	0	208, 309	
7.00	Total Medicare program liability (see instructions)		794, 03	34 Contractor	1,960,244 NPR Date	7.00
				Number	(Mo/Day/Yr)	
		C)	1,00	2.00	

VALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider C Component (CN: 15-1308 CCN: 15-Z308	Period: From 07/01/202 To 06/30/202	2 Date/Time Pre	epared
					11/29/2022 9:	14 an
			e XVIII it Part A	Swing Beds - Sl	NF <u>Cost</u> art B	
		l				
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		68, 0	99 0	0	
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3.
01	ADJUSTMENTS TO PROVIDER			0	0	3.
02				0	0	
03				0	0	
04				0	0	
05	Provider to Program			0	0	3.
50	ADJUSTMENTS TO PROGRAM			0	0	3
51				0	0	
52				0	0	
53				0	0	
54 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	
77	3. 50-3. 98)			0	0	
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)		68, 0'	99	0	4
	TO BE COMPLETED BY CONTRACTOR	1	1		-	
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
01	Program to Provider TENTATIVE TO PROVIDER		1	0	0	5
02				0	0	
03				0	0	
	Provider to Program	1				
50 E 1	TENTATI VE TO PROGRAM			0	0	
51 52				0	0	
99	Subtotal (sum of lines 5.01–5.49 minus sum of lines			0	0	
00	5.50-5.98) Determined net settlement amount (balance due) based on the cost report. (1)					6
01	SETTLEMENT TO PROVIDER			0	0	6
02	SETTLEMENT TO PROGRAM		2, 6	-	0	
00	Total Medicare program liability (see instructions)		65, 4		0	
			2	Contractor Number	NPR Date (Mo/Day/Yr)	
00	Name of Contractor	(0	1.00	2.00	8

Heal th	ealth Financial Systems ASCENSION ST. VINCENT MERCY In Lieu			u of Form CMS-	2552-10			
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1308	Period: From 07/01/2021	Worksheet E-1 Part II				
			To 06/30/2022					
	11/29/2022							
				1.00				
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS							
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION							
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.				1.00			
2.00								
	reporting periods beginning on or after 10/01/2013, line 32)							
3.00								
4.00								
	reporting periods beginning on or after 10/01/2013, line 32)							
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00			
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 l				6.00 7.00			
7.00	.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168							
8.00	Calculation of the HIT incentive payment (see instructions)				8.00			
9.00	Sequestration adjustment amount (see instructions)				9.00			
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00			
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH							
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00			
31.00	Other Adjustment (specify)				31.00			
32.00	Balance due provider (line 8 (or line 10) minus line 30 and l	ine 31) (see instruction	s)		32.00			

	Financial Systems ASCENSION ST. VINCEN TION OF REIMBURSEMENT SETTLEMENT - SWING BEDS PI	rovider CCN: 15-1308	Peri od:	u of Form CMS-2 Worksheet E-2	
	Ca	omponent CCN: 15-Z308	From 07/01/2021 To 06/30/2022	Date/Time Pre	
		Title XVIII	Swing Beds - SNF	11/29/2022 9: Cost	14 am
			Part A	Part B	
6	ANDURATION OF NET OACT OF CONFEED OFDINIOFO		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES		56, 271	0	1. (
	Inpatient routine services - swing bed-SM (see instructions)		50, 271	0	2.0
. 00 /	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-		10, 470	0	3. (
1	instructions)				
1	Nursing and allied health payment-PARHM (see instructions)			0.00	3.0
	Per diem cost for interns and residents not in approved teaching instructions)	program (see		0.00	4.0
1	Program days		26	0	5.0
	Interns and residents not in approved teaching program (see inst	ructions)		0	
	Jtilization review - physician compensation - SNF optional metho		0		7.(
. 00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		66, 741	0	8. (
	Primary payer payments (see instructions)		0	0	9. (
	Subtotal (line 8 minus line 9)		66, 741	0	10. (
	Deductibles billed to program patients (exclude amounts applicab	le to physician	0	0	11. (
	orofessional services) Subtotal (line 10 minus line 11)		66, 741	0	12. (
	Coinsurance billed to program patients (from provider records) (exclude coi nsurance	1, 113	0	
	for physician professional services)	exclude corrisorance	1, 113	0	15.0
	80% of Part B costs (line 12 x 80%)			0	14. (
5.00	Subtotal (see instructions)		65, 628	0	15.0
6.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.0
	Pioneer ACO demonstration payment adjustment (see instructions)				16.
	Rural community hospital demonstration project (§410A Demonstrat	ion) payment	0		16.
	adjustment (see instructions)				
	Demonstration payment adjustment amount before sequestration		0	0	
	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)		0	0	
	Allowable bad debts for dual eligible beneficiaries (see instruc	tions)	0	0	
	Total (see instructions)		65, 628	0	
	Sequestration adjustment (see instructions)		164	0	
	Demonstration payment adjustment amount after sequestration)		0	0	19.
9.03	Sequestration adjustment-PARHM pass-throughs				19.
9. 25	Sequestration for non-claims based amounts (see instructions)		0	0	19.
1	Interim payments		68, 099	0	
	Interim payments-PARHM				20.
1	Tentative settlement (for contractor use only)		0	0	
	Tentative settlement-PARHM (for contractor use only)		0 / 05		21.
1	Balance due provider/program (line 19 minus lines 19.01, 19.02,	19.25, 20, and 21)	-2, 635	0	
1	Balance due provider/program-PARHM (see instructions) Protested amounts (nonallowable cost report items) in accordance	with CMS Dub 15.2	0	0	22. 23.
	chapter 1, §115.2	with cm3 Fub. 15-2,	0	0	23.
F	Rural Community Hospital Demonstration Project (§410A Demonstrat	ion) Adjustment			
00.00	Is this the first year of the current 5-year demonstration perio	d under the 21st			200.
	Century Cures Act? Enter "Y" for yes or "N" for no.				
	Cost Reimbursement				
	Medicare swing-bed SNF inpatient routine service costs (from Wks	t. D-1, Pt. II, line			201.
	66 (title XVIII hospital)) Medicare swing-bed SNF inpatient ancillary service costs (from W	kst D_3 col 3 lin	0		202.
	200 (title XVIII swing-bed SNF))	KSt. D-3, COI. 3, ITH	C		202.
	Total (sum of lines 201 and 202)				203.
04.00	Medicare swing-bed SNF discharges (see instructions)				204.
C	Computation of Demonstration Target Amount Limitation (N/A in fi	rst year of the curre	nt 5-year demonst	ration	1
	period)				
	Medicare swing-bed SNF target amount				205.
	Medicare swing-bed SNF inpatient routine cost cap (line 205 time				206.
	djustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursem، Program reimbursement under the §410A Demonstration (see instruc				207
	5	,	1		207.
	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, and 3)	COL 1, SUIL OF FITTES	'		208.
	Adjustment to Medicare swing-bed SNF PPS payments (see instructi	ons)			209.
	Reserved for future use				210.
C	Comparision of PPS versus Cost Reimbursement				
	Total adjustment to Medicare swing-bed SNF PPS payment (line 209	plus line 210) (see			215.

ALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 15-1308	Period: From 07/01/2021 To 06/30/2022	Worksheet E-3 Part V Date/Time Prep 11/29/2022 9:	pare
		Title XVIII	Hospi tal	Cost	
				1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDIC	APE DAPT A SERVICES - COST		1.00	
. 00	Inpatient services	ARE TART A SERVICES - COST		866, 408	1 1
. 00	Nursing and Allied Health Managed Care payment (see instru	ictions)		000, 400	2
. 00	Organ acqui si ti on			0	3
. 00	Subtotal (sum of lines 1 through 3)			866, 408	
. 00	Primary payer payments			1, 421	5
. 00	Total cost (line 4 less line 5). For CAH (see instructions	5)		873, 651	
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e charges				1
. 00	Routi ne servi ce charges			0	17
. 00	Ancillary service charges			0	8
. 00	Organ acquisition charges, net of revenue				9
0. 00	Total reasonable charges			0	10
	Customary charges				
1.00	Aggregate amount actually collected from patients liable f	1 5	Ų	0	
2.00	Amounts that would have been realized from patients liable	1 3	on a charge basis	0	12
	had such payment been made in accordance with 42 CFR 413.1	13(e)			
3.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.00000	
4.00	Total customary charges (see instructions)			0	14
5.00	Excess of customary charges over reasonable cost (complete	e only if line 14 exceeds li	ne 6) (see	0	15
	instructions)				
6.00	Excess of reasonable cost over customary charges (complete	e only if line 6 exceeds iir	ne 14) (see	0	16
7.00	instructions) Cost of physicians' services in a teaching hospital (see i	netructions)		0	17
7.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	1 ''
3. 00	Direct graduate medical education payments (from Worksheet	t F-4. line 49)		0	18
9.00	Cost of covered services (sum of lines 6, 17 and 18)			873, 651	
0.00	Deductibles (exclude professional component)			89, 140	
1.00	Excess reasonable cost (from line 16)			0	21
2.00	Subtotal (line 19 minus line 20 and 21)			784, 511	22
3.00	Coinsurance			0	23
1.00	Subtotal (line 22 minus line 23)			784, 511	24
5.00	Allowable bad debts (exclude bad debts for professional se	ervices) (see instructions)		17, 712	25
5.00	Adjusted reimbursable bad debts (see instructions)			11, 513	26
7.00	Allowable bad debts for dual eligible beneficiaries (see i	nstructions)		12, 016	27
3.00	Subtotal (sum of lines 24 and 25, or line 26)			796, 024	28
9.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	29
9.50	Pioneer ACO demonstration payment adjustment (see instruct	tions)		0	29
9. 98	Recovery of accelerated depreciation.			0	29
9. 99	Demonstration payment adjustment amount before sequestrati	on		0	29
D. 00	Subtotal (see instructions)			796, 024	
0.01	Sequestration adjustment (see instructions)			1, 990	
). 02	Demonstration payment adjustment amount after sequestration	on		0	
0.03					30
. 00	Interim payments			747, 665	
1.01	Interim payments-PARHM			~	31
2.00	Tentative settlement (for contractor use only)			0	
2. 01	Tentative settlement-PARHM (for contractor use only)	20.02.21 and 22)		44 040	32
2 00	Balance due provider/program (line 30 minus lines 30.01, 3			46, 369	
3.00	Delence due provider (program DADUM (1) === 0, 0, 10, 10)	(minue lines 20 02 24 24			
3.00 3.01 4.00	Balance due provider/program-PARHM (lines 2, 3, 18, and 26 Protested amounts (nonallowable cost report items) in acco			25, 000	33

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1308	Period: From 07/01/2021 To 06/30/2022	Worksheet E-3 Part VII Date/Time Pre	pared:
		Title XIX	Hospi tal	11/29/2022 9: Cost	14 811
			Inpatient	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVI	CES FOR TITLES V OR X	IX SERVICES		-
1 00	COMPUTATION OF NET COST OF COVERED SERVICES		101.010		1 4 00
1.00 2.00	Inpatient hospital/SNF/NF services Medical and other services		131, 818	0	1.00
2.00	Organ acquisition (certified transplant centers only)		0	0	3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		131, 818	0	•
5.00	Inpatient primary payer payments		0	0	5.00
6.00	Outpatient primary payer payments			0	•
7.00	Subtotal (line 4 less sum of lines 5 and 6)		131, 818	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e Charges				
8.00	Routine service charges		69, 228		8.00
9.00	Ancillary service charges		271, 281	0	
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00 12.00	Incentive from target amount computation		240 500	0	11.00
12.00	Total reasonable charges (sum of lines 8 through 11) CUSTOMARY CHARGES		340, 509	0	12.00
13.00	Amount actually collected from patients liable for payment for s	services on a charge	0	0	13.00
10.00	basi s	services on a charge	Ŭ	0	10.00
14.00	Amounts that would have been realized from patients liable for p	payment for services o	n 0	0	14.00
	a charge basis had such payment been made in accordance with 42	CFR §413.13(e)			
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0.00000	15.00
	Total customary charges (see instructions)		340, 509	0	
17.00	Excess of customary charges over reasonable cost (complete only	if line 16 exceeds	208, 691	0	17.00
10 00	line 4) (see instructions)	if line 4 exceede lin		0	10 00
18.00	Excess of reasonable cost over customary charges (complete only 16) (see instructions)	IT THE 4 exceeds ITT	e 0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instruc	ctions)	0	0	
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		131, 818	0	•
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be co				1
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
	Capital exception payments (see instructions)		0	_	25.00
26.00	Routine and Ancillary service other pass through costs		0	0	
27.00 28.00	Subtotal (sum of lines 22 through 26) Customary charges (title V or XIX PPS covered services only)		0	0	
	Titles V or XIX (sum of lines 21 and 27)		131, 818	0	•
27.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		131,010	0	2 7.00
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		131, 818	0	
32.00	Deducti bl es		0	0	32.00
33.00	Coinsurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 3	33)	131, 818	0	•
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
38.00	Subtotal (line 36 ± line 37)		131, 818	0	
39.00 40.00	Direct graduate medical education payments (from Wkst. E-4) Total amount payable to the provider (sum of lines 38 and 39)		0 131, 818	0	39.00 40.00
40.00	Interim payments		131, 818	0	
41.00	Balance due provider/program (line 40 minus line 41)		131,010	0	1
43.00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub 15-2	0	0	1
	chapter 1, §115.2		0	Ũ	1

	Financial Systems ASCENSION ST. V E SHEET (If you are nonproprietary and do not maintain	Provi der C		eriod: rom 07/01/2021	u of Form CMS-: Worksheet G	
ind-t il y)	ype accounting records, complete the General Fund column		T		Date/Time Pre 11/29/2022 9:	
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
00	Cash on hand in banks	450	63, 989	0	0	1.0
00	Temporary investments	0	0	0	0	2.0
00	Notes receivable	0	0	0	0	3.0
00	Accounts receivable	7, 446, 648	0	0	0	4.0
00 00	Other receivable Allowances for uncollectible notes and accounts receivable	881, 810 -4, 465, 977	0	0	0	
00	Inventory	457, 120	0	0	0	
00	Prepaid expenses	0	0	0	0	
00	Other current assets	0	0	0	0	9. C
0. 00	Due from other funds	0	0	0	0	10.0
. 00	Total current assets (sum of lines 1-10)	4, 320, 051	63, 989	0	0	11. C
2. 00	FI XED ASSETS Land	465, 381	0	ol	0	12. C
3. 00 3. 00	Land improvements	821, 276	0	0	0	13.0
	Accumulated depreciation	-468, 083	0	0	0	
5.00	Bui I di ngs	13, 353, 069	0	0	0	15. C
. 00	Accumulated depreciation	-8, 450, 786	0	0	0	16.0
. 00	Leasehold improvements	9, 930, 186	0	0	0	17.0
3.00	Accumulated depreciation	-6, 182, 417	0	0	0	18.0
). 00). 00	Fixed equipment	4, 532, 698 -2, 745, 772	0	0	0	19.0 20.0
	Accumulated depreciation Automobiles and trucks	-2, 745, 772 43, 897	0	0	0	20.0
	Accumulated depreciation	-43, 897	0	0	0	22.0
	Major movable equipment	7, 832, 643	-	0	0	23.0
. 00	Accumulated depreciation	-6, 791, 720	0	0	0	24.0
	Minor equipment depreciable	146, 521	0	0	0	25.0
. 00	Accumulated depreciation	-146, 521	0	0	0	26.0
	HIT designated Assets	0	0	0	0	27.0
3.00 9.00	Accumulated depreciation Minor equipment-nondepreciable	0	0	0	0	28.0
). 00	Total fixed assets (sum of lines 12-29)	12, 296, 475	0	0	0	30.0
	OTHER ASSETS					
	Investments	0	0	0	0	31.0
2.00	Deposits on Leases	0	0	0	0	32.0
8.00	Due from owners/officers	0	0	0	0	33.0
. 00 . 00	Other assets Total other assets (sum of lines 31-34)	22, 329 22, 329	0	0	0	34. 0 35. 0
5.00 5.00	Total assets (sum of lines 11, 30, and 35)	16, 638, 855	0	0	0	36. 0
. 00	CURRENT LI ABI LI TI ES	10, 030, 033	03, 707	0	0	30. (
. 00	Accounts payable	956, 265	0	0	0	37.0
8.00	Salaries, wages, and fees payable	739, 653	0	0	0	38. (
0. 00	Payroll taxes payable	0	0	0	0	
	Notes and Loans payable (short term)	0	0	0	0	40.
. 00 2. 00	Deferred income Accelerated payments	349, 879	0	0	0	41.
3. 00 3. 00	Due to other funds	1, 974, 073	0	0	0	
. 00	Other current liabilities	825, 788	0	0	0	
5.00	Total current liabilities (sum of lines 37 thru 44)	4, 845, 658	0	0	0	
	LONG TERM LIABILITIES					
. 00	Mortgage payable	0	0	0	0	
. 00	Notes payable	10, 044, 816	0	0	0	47.0
3.00 9.00	Unsecured Loans	0	0	0	0	
). 00	Other long term liabilities Total long term liabilities (sum of lines 46 thru 49)	21, 105 10, 065, 921	0	0	0	49. 50.
. 00	Total liabilities (sum of lines 45 and 50)	14, 911, 579	0	0	0	50.
	CAPITAL ACCOUNTS	11,711,077				
2. 00	General fund balance	1, 727, 276				52.
. 00	Specific purpose fund		63, 989			53.
. 00	Donor created - endowment fund balance - restricted			0		54.
5.00	Donor created - endowment fund balance - unrestricted			0		55.
o. 00 7. 00	Governing body created - endowment fund balance			0	0	56. 57.
3. 00	Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement,				0	57.
. 00	replacement, and expansion				0	50.
. 00	Total fund balances (sum of lines 52 thru 58)	1, 727, 276	63, 989	0	0	59.

		ASCENSION ST. VI				eu of Form CMS-2	2552-10
STATE	IENT OF CHANGES IN FUND BALANCES		Provider CO		Period: From 07/01/2021	Worksheet G-1	
					To 06/30/2022	Date/Time Prep 11/29/2022 9:	
		General	Fund	Special P	Purpose Fund	Endowment Fund	
	1	1.00	2.00	3.00	4.00	5.00	
1.00 2.00	Fund balances at beginning of period		20, 314		56, 782		1.00 2.00
2.00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)		1, 789, 519 1, 809, 833		56, 782		2.00
4.00	Transfer From Affiliates	-82, 556	1,007,000		0 30, 702	0	4.00
5.00		0			0	Ő	5.00
6.00		0			0	0	6.00
7.00	Released Operating	0			6	0	7.00
8.00	Other	0		13, 00	0	0	8.00
9.00	Roundi ng	0			0	0	9.00
10.00	Total additions (sum of line 4-9)		-82, 556		13, 006		10.00
11.00	Subtotal (line 3 plus line 10)		1, 727, 277		69, 788		11.00
12.00	Deductions (debit adjustments) (specify)	0			0	0	12.00
13.00		0			0	0	13.00
14.00		0			0	0	14.00
15.00	Released Operating	0		5, 79	9	0	15.00
16.00		0			0	0	16.00
17.00	Roundi ng	1			0	0	17.00
18.00	Total deductions (sum of lines 12-17)		1		5, 799		18.00
19.00	Fund balance at end of period per balance		1, 727, 276		63, 989		19.00
	sheet (line 11 minus line 18)	Endowment Fund	Pl ant	Fund			
		6.00	7.00	8.00			
1.00 2.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29)	0			0		1.00 2.00
3.00	Total (sum of line 1 and line 2)	0			0		3.00
4.00	Transfer From Affiliates	U	0		0		4.00
5.00			0				5.00
6.00			0				6.00
7.00	Released Operating		0				7.00
8.00	Other		0				8.00
9.00	Rounding		0				9.00
9.00	Total additions (sum of line 4-9)	0			0		10.00
					0		11.00
10.00	Subtotal (line 3 plus line 10)	0			1		12.00
9.00 10.00 11.00 12.00		0	0				
10. 00 11. 00	Subtotal (line 3 plus line 10)	O	0 0				13.00
10. 00 11. 00 12. 00	Subtotal (line 3 plus line 10)	0	0 0 0				
10. 00 11. 00 12. 00 13. 00	Subtotal (line 3 plus line 10)	0	0 0 0 0				13.00
10.00 11.00 12.00 13.00 14.00 15.00 16.00	Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0	0 0 0 0 0				13.00 14.00 15.00 16.00
10.00 11.00 12.00 13.00 14.00 15.00	Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Released Operating Rounding	0	0 0 0 0 0 0 0				13. 00 14. 00 15. 00
10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00	Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Released Operating Rounding Total deductions (sum of lines 12-17)	0	0 0 0 0 0 0		0		13.00 14.00 15.00 16.00 17.00 18.00
10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00	Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Released Operating Rounding	0	0 0 0 0 0 0		0 0		13.00 14.00 15.00 16.00 17.00

Health Financial Systems ASCENSION ST. VI STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES		VINCENT MERCY Provider C	CN: 15-1308	Peri od:	eu of Form CMS- Worksheet G-2	
				From 07/01/2021 To 06/30/2022		
	Cost Center Description		I npati ent	Outpati ent	Total	
	1		1.00	2.00	3.00	
	PART I - PATIENT REVENUES					-
	General Inpatient Routine Services			1		
1.00	Hospi tal		2, 666, 0	37	2, 666, 037	•
2.00	SUBPROVIDER - I PF					2.00
3.00	SUBPROVIDER - IRF					3.00
4.00	SUBPROVI DER			0		4.00
5.00	Swing bed - SNF			0	0	
6.00 7.00	Swing bed - NF SKILLED NURSING FACILITY			0	0	6. 00 7. 00
8.00	NURSING FACILITY					8.00
9.00	OTHER LONG TERM CARE					9.00
10.00	Total general inpatient care services (sum of lines 1-9)		2, 666, 0	37	2, 666, 037	
10.00	Intensi ve Care Type Inpatient Hospital Services		2,000,0	57	2,000,037	10.00
11.00	INTENSIVE CARE UNIT			0	0	11.00
12.00	CORONARY CARE UNIT			0	0	12.00
13.00	BURN INTENSIVE CARE UNIT					13.00
14.00	SURGI CAL INTENSIVE CARE UNIT					14.00
15.00	DETOXIFICATION INTENSIVE CARE UNIT			0	0	
16.00	Total intensive care type inpatient hospital services (sum	oflines		0	0	
	11-15)	01 11100		0		
17.00	Total inpatient routine care services (sum of lines 10 and	16)	2, 666, 0	37	2, 666, 037	17.00
18.00	Ancillary services	- /	4, 287, 8			•
19.00	Outpatient services		457, 4	76 18, 365, 703	18, 823, 179	19.00
20.00	RURAL HEALTH CLINIC			0 (0 0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0 0	o o	21.00
22.00	HOME HEALTH AGENCY					22.00
23.00	AMBULANCE SERVICES					23.00
24.00	СМНС					24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)					25.00
26.00	HOSPI CE					26.00
27.00	OTHER (SPECIFY)			0 0	0 0	
28.00	Total patient revenues (sum of lines 17-27)(transfer column	n 3 to Wkst.	7, 411, 3	29 69, 510, 652	2 76, 921, 981	28.00
	G-3, line 1)					
	PART II - OPERATING EXPENSES		1		-1	
29.00	Operating expenses (per Wkst. A, column 3, line 200)			24, 612, 995	D .	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 35.00				0		34.00 35.00
36.00	Total additions (sum of lines 20.25)			-		36.00
36.00	Total additions (sum of lines 30-35) DEDUCT (SPECIFY)			0		36.00
38.00				0		38.00
39.00				0		39.00
40.00				0		40.00
40.00				0		40.00
42.00	Total deductions (sum of lines 37-41)			~ (42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line	e 42)(transfer		24, 612, 995		43.00
			1		-1	1 .0.00

Heal th	Financial Systems	ASCENSION ST. VIN	CENT MERCY	In Lie	u of Form CMS-2	2552-10
STATEN	IENT OF REVENUES AND EXPENSES		Provider CCN: 15-1308	Peri od:	Worksheet G-3	
				From 07/01/2021		
				To 06/30/2022	Date/Time Prep 11/29/2022 9:2	
			·			
1.00					1.00	1 00
1.00	Total patient revenues (from Wkst. G-2, Pa				76, 921, 981	1.00
2.00	Less contractual allowances and discounts		ts		51, 447, 101	2.00
3.00	Net patient revenues (line 1 minus line 2)		12)		25, 474, 880	3.00
4.00 5.00	Less total operating expenses (from Wkst.		43)		24, 612, 995	4.00
5.00	Net income from service to patients (line OTHER INCOME	3 minus line 4)			861, 885	5.00
6.00	Contributions, donations, bequests, etc				-12, 886	6.00
7.00	Income from investments				-12, 880	7.00
7.00 8.00	Revenues from telephone and other miscella	noous communication	sorvi cos		0	7.00 8.00
9.00	Revenue from television and radio service	medus communication	Services		0	9.00
7.00 10.00	Purchase di scounts				0	9.00 10.00
11.00	Rebates and refunds of expenses				0	11.00
12.00	Parking lot receipts				0	12.00
12.00	Revenue from Laundry and Linen service				0	12.00
14.00	Revenue from meals sold to employees and g	llests			46, 148	
15.00	Revenue from rental of living guarters	00313			40, 140	15.00
16.00	Revenue from sale of medical and surgical	supplies to other th	nan natients		0	16.00
17.00	Revenue from sale of drugs to other than p		ian patronto		5,052	
18.00	Revenue from sale of medical records and a				0,002	18.00
19.00	Tuition (fees, sale of textbooks, uniforms				0	19.00
20.00	Revenue from gifts, flowers, coffee shops,				0	20.00
21.00	Rental of vending machines				0	21.00
22.00	Rental of hospital space				58, 586	22.00
23.00	Governmental appropriations				0	23.00
24.00	Other Revenue				90, 608	
24.01	Net assets released from restrictions				5, 799	24.01
24.03	State Program Revenue				116, 667	24.03
24.50	COVI D-19 PHE Fundi ng				617, 660	24.50
25.00	Total other income (sum of lines 6-24)				927, 634	25.00
26.00	Total (line 5 plus line 25)				1, 789, 519	26.00
27.00	OTHER EXPENSES (SPECI FY)				0	27.00
28.00	Total other expenses (sum of line 27 and s	ubscripts)			0	28.00
29.00	Net income (or loss) for the period (line	26 minus line 28)			1, 789, 519	29.00