10.NPR Date:

(1) As Submitted

7. Contractor No.
(2) Settled without Audit
(3) Settled with Audit
(4) Final Report for this Provider CCN
(5) Report for this Provider CCN
(6) Il.Contractor's Vendor Code:
(7) Il.Contractor's Vendor Code:
(8) Il.Contractor's Vendor Code:
(9) Il.Contractor's Vendor Code:
(10) Il.Contractor's Vendor Code:
(11) Il.Contractor's Vendor Code:
(12) Il.Contractor's Vendor Code:
(13) Il.Contractor's Vendor Code:
(14) Il.Contractor's Vendor Code:
(15) Il.Contractor's Vendor Code:
(16) Il.Contractor's Vendor Code:
(17) Il.Contractor's Vendor Code:
(18) Il.Contractor's Vendor Code:
(18) Il.Contractor's Vendor Code:
(19) Il.Contractor's Ve (3) Settled with Audit (4) Reopened (5) Amended

5. [ 1 ]Cost Report Status

ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

6. Date Received:

PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S) MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ASCENSION ST. VINCENT ANDERSON ( 15-0088 ) for the cost reporting period beginning 07/01/2022 and ending 06/30/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONIC				
		1	2	SIGNATURE STATEMENT				
1	Beck	y Jacobson	Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1			
2	Signatory Printed Name	Becky Jacobson			2			
3	Signatory Title	VP OF FINANCE			3			
4	Date	11/22/2023 10:37:56 AM			4			

			Title XVIII				
		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	HOSPITAL	0	682,838	12,728	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	-42,142	0		0	3.00
5.00	SWING BED - SNF	0	0	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
200.00	TOTAL	0	640,696	12,728	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 number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 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.

Contractor

use only

In Lieu of Form CMS-2552-10 Health Financial Systems ASCENSION ST. VINCENT ANDERSON

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0088 Period: Worksheet S-2 From 07/01/2022 Part I Date/Time Prepared: 06/30/2023 11/22/2023 10:37 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: 1.00 Street: 2015 JACKSON STREET PO Box: 1.00 2.00 City: ANDERSON State: IN Zip Code: 46016 County: 2.00 Component Name CCN CBSA Provider Date Payment System (P, T, 0, or N) Number Number Туре Certified XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 ASCENSION ST. VINCENT 150088 26900 1 07/01/1966 Ν 0 3.00 Hospital Р ANDERSON Subprovider - IPF 4.00 4.00 5.00 Subprovider - IRF BENNETT REHAB CENTER 15T088 26900 06/01/1989 5.00 5 Р 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF 7.00 7.00 8.00 Swing Beds - NF 8.00 9.00 Hospital-Based SNF 9.00 10.00 Hospital-Based NF 10.00 11.00 |Hospital-Based OLTC 11.00 12.00 Hospital-Based HHA 12.00 13.00 Separately Certified ASC 13.00 14.00 Hospital-Based Hospice 14.00 15.00 Hospital-Based Health Clinic - RHC 15.00 16.00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital-Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: 2.00 1.00 06/30/2023 20.00 Cost Reporting Period (mm/dd/yyyy) 07/01/2022 20.00 21.00 Type of Control (see instructions) 21.00 1 1.00 2.00 3.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for Υ N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. 22.01 Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no 22.01 Ν for the portion of the cost reporting period occurring prior to October

1. Enter in column 2, "Y" for yes or "N" for no for the portion of the
cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires a final UCP to be Ν 22.02 Ν determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to 22.03 N Ν Ν rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 22.04 Did this hospital receive a geographic reclassification from urban to 22.04 rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 23.00 3 Ν below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.

In Lieu of Form CMS-2552-10 Health Financial Systems ASCENSION ST. VINCENT ANDERSON HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0088 Worksheet S-2 Period: From 07/01/2022 Part I 06/30/2023 Date/Time Prepared: 11/22/2023 10:37 am In-State Medicaid In-State Out-of Out-of Medicaid Medicaid Medicaid State State HMO days paid days eligible Medicaid Medicaid days paid days unpaid eligible days unpaid 1.00 2.00 3.00 4.00 5.00 6.00 24.00 If this provider is an IPPS hospital, enter the 1.170 309 13 6,385 15 24.00 in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state 37 22 0 0 337 25.00 Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5. Urban/Rural S Date of Geogr 1.00 2.00 26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural. 26.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, 27.00 1 enter the effective date of the geographic reclassification in column 2. If this is a sole community hospital (SCH), enter the number of periods SCH status in 35.00 effect in the cost reporting period. Beginning: Ending: 1.00 2.00 36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number 36.00 of periods in excess of one and enter subsequent dates. If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status 0 37.00 is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see 37.01 instructions) If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is 38.00 greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates. Y/N Y/N 1.00 2.00 39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume 39.00 hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions) 40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or Ν 40.00 'N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions) XVIII XIX V 1.00 2.00 3.00 Prospective Payment System (PPS)-Capital 45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance N 45.00 with 42 CFR Section §412.320? (see instructions) 46.00 Is this facility eligible for additional payment exception for extraordinary circumstances Ν Ν Ν 46.00 pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through 47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no. 47.00 Ν 48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. Ν 48.00 Ν Ν Teaching Hospitals Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For 56.00 Ν cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2. 57.00 For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, 57.00 is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N",

complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e )(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y"

58.00

for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.

58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as

defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.

Sp.00   Are costs claimed on line 100 of worksheet A? If yes, complete wkst. D-2, Pt. I.   N	11/22/2	/01/2022 /30/2023	Period: From 07/01,		Provider CC		Financial Systems ASCENSION AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	
1.00   Are costs claimed on line 100 of worksheet A? If yes, complete wkst. D-2, Pt. I.   N   NAHE 413.85   NAHE 413.85   NAHE 413.85   Criter   NAHE 413.85   NAHE 413.85   NAHE 413.85   NAHE 413.85   NAHE 413.85   Criter   NAHE 413.85		1 00						
0.00 Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 1162 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2. If column 1 is "Y", are you impacted by CR 1162 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2. If Column 1 is "Y", are you impacted by CR 1162 (or subsequent CR) NAHE MA payment adjustment? Enter "N" for yes or "N" for no in column 2. If the Boltz of the CR 1162 (or subsequent CR) NAHE MA payment adjustment? Enter the Gls yes, complete columns 2 and 3 for each program. (see  23.01  1.00 Did your hospital receive FTE slots under ACA section 5503? Enter "N" for yes or "N" for no in column 1. (see instructions)  1.01 Enter the average number of unweighted primary care FTES from the hospital": 3 most recent cost reports ending and submitted before March 23, 2010. (see Instructions)  1.01 Enter the base line FTE count for primary care for ETE count (excluding 08/GNX, general surgery FTES, and the current year total unweighted primary care for determining compliance with the 75% test. (see instructions)  1.02 Enter the base line FTE count for primary care for determining compliance with the 75% test. (see instructions)  1.03 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 61.04 minus line 61.03). (see instructions)  1.06 Enter the difference between the baseline primary care for early relief and/or FTES that are nonprimary care for early relief and/or FTES that are nonprimary care for early relief and/or fTES that are nonprimary care for early relief and/or fTES that are nonprimary care for early relief and/or fTES that are nonprimary care for early relief and/or fTES that are nonprimary care for early relief and/or fTES that are nonprimar	2.00			Pt. I.	te Wkst. D-2,	, comple	Are costs claimed on line 100 of Worksheet A? If yes	.00
1.00   Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.857 (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "V", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	Pass-Th Qualific Criterio	ne #						
0.00 Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.857 (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "V", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.  0.01 If line 60 is yes, complete columns 2 and 3 for each program. (see  1.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If column 1. See instructions)  1.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. See instructions)  1.01 Did see instructions and instructions in the lospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)  1.02 Enter the current year total unweighted primary care FTE soft on the lospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)  1.03 Enter the basel ine FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)  1.04 Enter the number of unweighted primary care, or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions)  1.05 Enter the amount of ACA \$5503 award that is being used for cap relief and/or peneral surgery FTE counts (line 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 and/or general surgery. FTE counts (line 61.04 minus line 61.05). (see instructions)  1.00 f the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) in the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the program name. Enter in column 3, the IME FTE	3.0	.00	2.00	1.00				
1.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 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 instructions) 1.02 Enter the current year total unweighted primary care FTE cont (excluding 08/GVN, general surgery FTEs, and primary care FTEs added under section 5503 of 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 instructions) 1.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the 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 61.04 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) 1.00 Enter the amount of ACA \$5503 award that is being used for cap relief and/or FTEs that are nonprimary care and/or general surgery. (see instructions) 1.00 fthe FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program name. Enter in column 2, the program name. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 1, the program name. Enter in column 3, the IME FTE unweighted count. Enter in column 3, the IME FTE unweighted count. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.		Y			e If column 1 MA payment	85? (se umn 1. CR) NAHE nn 2.	any programs that meet the criteria under 42 CFR 413 instructions) Enter "Y" for yes or "N" for no in cois "Y", are you impacted by CR 11642 (or subsequent adjustment? Enter "Y" for yes or "N" for no in colur If line 60 is yes, complete columns 2 and 3 for each	.01 a
1.00 bid your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)  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 instructions)  1.02 Enter the current year total unweighted primary care FTE count (excluding 08/GVN, general surgery FTES, and primary care FTE count (excluding 08/GVN, general surgery FTES, and primary care FTE count (excluding ome) for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)  1.03 Enter the base line FTE count for primary care and/or general surgery FTES and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)  1.06 Enter the difference between the baseline primary care and/or general surgery FTEs counts (line 61.04 minus line 61.03). (see instructions)  1.06 Enter the difference between the baseline primary care and/or general surgery. (see instructions)  1.07 Program Name  1.08 Program Name  1.09 Program Name  1.00 Program Code Unweighted IME FTE counts (line 61.04 minus line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions)  1.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program (see instructions). Enter in column 2, the program and 2, the program code. Enter in column 3, the IME FTE unweighted count.  1.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) enter in column 1, the program name. Enter in column 2, the program code. Enter in column 4, the direct GME FTE unweighted count.  1.21 Of the FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.	Direct	IME	IME	Direct GME	IME	Y/N	THIS CLUCETONS)	
1.00 bid your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 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 instructions) 1.02 Enter the current year total unweighted primary care FTE count (excluding 08/GVN, general surgery FTES, and primary care FTE count (excluding one) for primary care FTE count (excluding one) for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) 1.03 Enter the base line FTE count for primary care and/or general surgery residents, excluding primary care and/or general surgery FTEs and the current year's primary care and/or general surgery FTEs counts (line 61.04 minus line 61.03). (see instructions) 1.06 Enter the difference between the baseline primary care and/or general surgery FTEs counts (line 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)  1.00 of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count.  1.20 of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each new program (see instructions) Enter in column 1, the program name. Enter in column 1, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.	5.0	00	4.00	2 00	2.00	1 00		
Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of 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 instructions)  1.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions)  1.05 Enter the difference between the baseline primary and/or general surgery FTE counts (line 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)  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)  1.00 Unweighted IME FTE Count Directions  1.00 2.00 3.00  1.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program and. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count.  1.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count.  1.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count.  1.20 Of the FTEs in line 61.05, the program code. Enter in column 3, the IME FTE unweighted count.			4.00	3.00	2.00		section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care FTES from the hospital's 3 most recent cost reports	.01 E
and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)  .04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).  .05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03), (see instructions)  .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)  Program Name  Program Code Unweighted IME FTE Count Direct Office of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 3, the IME FTE unweighted count.  .10 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 4, the direct GME FTE unweighted count.  1.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 4, the direct GME FTE unweighted count.							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	.02 E
surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).  Senter 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 61.04 minus line 61.03). (see instructions)  Senter 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)  Program Name  Program Code Unweighted IME FTE Count Direct Office of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 4, the direct GME FTE unweighted count.  20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 4, the direct GME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Enter in column 4, the direct GME FT							and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)	a c
and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)  Better 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)  Program Name  Program Code Unweighted IME FTE Count Direct Office (see instructions)  1.00 2.00 3.00  1.00 5 the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new 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 in column 1, the program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 2, the program name. Enter in column 1, the program name. Enter in column 1, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.							Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the	.04 E
used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)  Program Name  Program Code  Unweighted IME FTE Count  1.00  2.00  3.00  1.00  2.00  3.00  0.00  Program Name  Program Code  Unweighted IME FTE Count  Direct  1.00  2.00  3.00  0.00  1.00  0.00  Direct  1.00  2.00  0							and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)	a F
1.00 2.00 3.00  1.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.  1.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.							used for cap relief and/or FTEs that are nonprimary	ι
1.10 of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.  1.20 of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 4, the direct GME FTE unweighted count.	Direct G Cour	Count D	FTE CO			Pro		
specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.	4.0		3.00	2.00	1.00		of the ETEs in line 61 OF specify each new program	10 0
program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.		0.00					specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME	f c p
		0.00					program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4,	r i E 3
	1.0							,
.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which		which	riod for wh					
your hospital received HRSA PCRE funding (see instructions) .01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital				er (THC) int	g Health Cent	tions) ( Teachir	your hospital received HRSA PCRE funding (see instruc Enter the number of FTE residents that rotated from a	.01 E
during in this cost reporting period of HRSA THC program. (see instructions)  Teaching Hospitals that Claim Residents in Nonprovider Settings  Has your facility trained residents in nonprovider settings during this cost reporting period? Enter					igs	er Setti	Teaching Hospitals that Claim Residents in Nonprovide	7

неаlth	ı Financial Systems	ASCENSION	ST. VINCENT ANDERSON		In Lie	u of Form CMS-2	2552-10
	TAL AND HOSPITAL HEALTH CARE COMP			CN: 15-0088 P	eriod: rom 07/01/2022	Worksheet S-2 Part I	pared:
				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 Base Yea	r FTE Residents in No	onprovider Settings				
64.00	period that begins on or after I Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to ro settings. Enter in column 2 the resident FTEs that trained in yo of (column 1 divided by (column	yes, or your facilit ber of unweighted nor tations occurring in number of unweighted ur hospital. Enter in	ty trained residents n-primary care all nonprovider d non-primary care n column 3 the ratio	0.00	0.00	0.000000	64.00
		Program Name	Program Code	Unweighted FTEs Nonprovider	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
				Site	·		
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	Unweighted	Ratio (col. 1/	65.00
				FTES Nonprovider Site	FTES in Hospital	(col. 1 + col. 2))	
				1.00	2.00	3.00	
	Section 5504 of the ACA Current	Year FTF Residents i	n Nonprovider Setting				
	beginning on or after July 1, 20					g por rout	
66.00	Enter in column 1 the number of FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	ccurring in all nonpount unweighted non-priman al. Enter in column 3 column 2)). (see ins	rovider settings. ry care resident 3 the ratio of structions)	0.00			66.00
		Program Name	Program Code	Unweighted FTEs Nonprovider	Unweighted FTEs in	Ratio (col. 3/ (col. 3 + col. 4))	
				Site	Hospital	7//	
		1.00	2.00	3.00	4.00	5.00	
67.00	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	0.00			67.00

SPIT	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	T ANDERSON Provider CC	N: 15-0088	Period: From 07/01,	From 07/01/2022		n CMS-2 et S-2 me Pre 023 10	pared
						1.00	0	
00	<b>Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 F</b> For a cost reporting period beginning prior to October 1, 2022, MAC to apply the new DGME formula in accordance with the FY 202 (August 10, 2022)?	did you ob	tain permiss	ion from yo		N		68.0
					1.00	2.00	3.00	
	<pre>Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or do</pre>	es it conta	in an TPF SU	hnrovider?	N			70.
00	Enter "Y" for yes or "N" for no.  If line 70 is yes: Column 1: Did the facility have an approved recent cost report filed on or before November 15, 2004? Enter 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter Column 3: If column 2 is Y, indicate which program year began d (see instructions)	GME teachin "Y" for ye residents "Y" for ye	g program in s or "N" for in a new tea s or "N" for	the most no. (see ching no.			0	71.
	Inpatient Rehabilitation Facility PPS							
	Is this facility an Inpatient Rehabilitation Facility (IRF), or subprovider? Enter "Y" for yes and "N" for no.	does it co	ntain an IRF		Y			75.
00	If line 75 is yes: Column 1: Did the facility have an approved recent cost reporting period ending on or before November 15, 2 no. Column 2: Did this facility train residents in a new teachi CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Co indicate which program year began during this cost reporting pe	004? Enter ng program lumn 3: If	"Y" for yes in accordanc column 2 is	or "N" for e with 42 Y,	N	N	0	76.
						1.00	0	
	Long Term Care Hospital PPS  Is this a long term care hospital (LTCH)? Enter "Y" for yes an  Is this a LTCH co-located within another hospital for part or a  "Y" for yes and "N" for no.  TEFRA Providers			g period? E	nter	N N		80 81
00	Is this a new hospital under 42 CFR Section $\S413.40(f)(1)(i)$ TE Did this facility establish a new Other subprovider (excluded u $\S413.40(f)(1)(ii)$ ? Enter "Y" for yes and "N" for no.	nit) under	42 CFR Secti	on	no.	N		85 86
	Is this hospital an extended neoplastic disease care hospital c $1886(d)(1)(B)(vi)$ ? Enter "Y" for yes or "N" for no.	lassified u	nder section			N		87
				Approved Permand Adjustm (Y/N) 1.00	ent ent )	Number Approv Perman Adjustm	ved nent nents	
	Column 1: Is this hospital approved for a permanent adjustment amount per discharge? Enter "Y" for yes or "N" for no. If yes, 89. (see instructions) Column 2: Enter the number of approved permanent adjustments.					2.00		88
			Wkst. A Lin No.			Perman Adjustr Amount Discha	ment ment Per arge	
00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line	number	1.00	2.00		3.00		89
	on which the per discharge permanent adjustment approval was ba Column 2: Enter the effective date (i.e., the cost reporting pe beginning date) for the permanent adjustment to the TEFRA targe per discharge.  Column 3: Enter the amount of the approved permanent adjustment TEFRA target amount per discharge.	sed. riod t amount						
				V 1.00		XIX 2.00		
	Title V and XIX Services							
00	Does this facility have title V and/or XIX inpatient hospital s yes or "N" for no in the applicable column.	ervices? En	ter "Y" for	N		Y		90
	Is this hospital reimbursed for title V and/or XIX through the cost report either in N full or in part? Enter "Y" for yes or "N" for no in the applicable column.							91
00	O Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.							92
	Does this facility operate an ICF/IID facility for purposes of "Y" for yes or "N" for no in the applicable column.		XIX? Enter	N		N		93
	Does title V or XIX reduce capital cost? Enter "Y" for yes, and applicable column.			N		N		94
	If line 94 is "Y", enter the reduction percentage in the applic Does title V or XIX reduce operating cost? Enter "Y" for yes or			0.00 N		0.00 N	0	95 96
	applicable column. If line 96 is "Y", enter the reduction percentage in the applic			0.00		0.0	•	97

Health Financial Systems ASCENSION ST. VIN HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CO		Don	iod:	u of Form CM Worksheet S	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider Co	LN: 13-0088	From To	m 07/01/2022 06/30/2023	Part I Date/Time P 11/22/2023	repared:
				V	XIX	10.37 &
				1.00	2.00	
Does title V or XIX follow Medicare (title XVIII) for the instepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for column 1 for title V, and in column 2 for title XIX.				N	Y	98.00
98.01 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				N	Y	98.01
title XIX.  18.02 Does title V or XIX follow Medicare (title XVIII) for the call bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes o				N	Y	98.02
for title V, and in column 2 for title XIX.  18.03 Does title V or XIX follow Medicare (title XVIII) for a critreimbursed 101% of inpatient services cost? Enter "Y" for year title V and in column 2 for title XIX.	ical access ho s or "N" for n	ospital (CAH) no in column	1	N	N	98.03
for title V, and in column 2 for title XIX.  98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH outpatient services cost? Enter "Y" for yes or "N" for no in	reimbursed 10: column 1 for	1% of title V, and	I	N	N	98.04
in column 2 for title XIX.  98.05 Does title V or XIX follow Medicare (title XVIII) and add bawkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in co	ck the RCE dis	sallowance on itle V, and i	n	N	Y	98.05
column 2 for title XIX.  98.06  Pts. I through IV? Enter "Y" for yes or "N" for no in column column 2 for title XIX.				N	Y	98.06
Rural Providers						
LOS.00 Does this hospital qualify as a CAH?  LO6.00 If this facility qualifies as a CAH, has it elected the all- for outpatient services? (see instructions)	nod of paymen	it	N N		105.00 106.00	
07.00 Column 1: If line 105 is Y, is this facility eligible for contraining programs? Enter "Y" for yes or "N" for no in column Column 2: If column 1 is Y and line 70 or line 75 is Y, do yn approved medical education program in the CAH's excluded IP Enter "Y" for yes or "N" for no in column 2. (see instruction	1. (see inst you train I&Rs F and/or IRF (	tructions) s in an		N		107.0
.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.	CRNA fee sche			N		108.0
	Physical 1.00	Occupationa 2.00	1]	Speech 3.00	Respirator 4.00	У
.09.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N N	N N		N N	N N	109.0
10.00=11.11.1.1.1.1.1.1.1.1.1.1.1.1.1.1.			410.		1.00	110.0
L10.00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter "complete Worksheet E, Part A, lines 200 through 218, and Workapplicable.	Y" for yes or	"N" for no.	if y	es,	N	110.00
			-	1.00	2.00	-
III.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this community for yes or "N" for no in column 1. If the response to contintegration prong of the FCHIP demo in which this CAH is particular all that apply: "A" for Ambulance services; "B" for additional for tele-health services.	st reporting p lumn 1 is Y, o ticipating in	period? Enter enter the column 2.		N		111.00
		1.00		2.00	3.00	
12.00 Did this hospital participate in the Pennsylvania Rural Heal		N				112.00
(PARHM) demonstration for any portion of the current cost reperiod? Enter "Y" for yes or "N" for no in column 1. If co "Y", enter in column 2, the date the hospital began participal demonstration. In column 3, enter the date the hospital ceaparticipation in the demonstration, if applicable.	lumn 1 is ating in the					
(PARHM) demonstration for any portion of the current cost reperiod? Enter "Y" for yes or "N" for no in column 1. If co "Y", enter in column 2, the date the hospital began participhedemonstration. In column 3, enter the date the hospital cear participation in the demonstration, if applicable.  Miscellaneous Cost Reporting Information  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 "9 for short term hospital or "98" percent for long term care (psychiatric, rehabilitation and long term hospitals providers	Tumn 1 is ating in the sed  "N" for no , or E only) 3" percent includes	N				0115.0
(PARHM) demonstration for any portion of the current cost reperiod? Enter "Y" for yes or "N" for no in column 1. If co "Y", enter in column 2, the date the hospital began participe demonstration. In column 3, enter the date the hospital cear participation in the demonstration, if applicable.  Miscellaneous Cost Reporting Information  115.00 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 "9 for short term hospital or "98" percent for long term care (**)	Tumn 1 is ating in the sed  "N" for no , or E only) 3" percent includes s) based on	N N				0115.0

117.00 118.00

117.00 Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.

118.00 Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.

In Lie of Form CMS-2552-10
To 06/30/2023   Date/Time Prepared: 1/22/2023 10/337 am     Premiums
1.00   2.00   3.00
118.01 List amounts of malpractice premiums and paid losses:  1.00
118.01 List amounts of malpractice premiums and paid losses:  118.02 Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.  119.00 DO NOT USE THIS LINE  120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.  120.00 Does the column 2, "Y" for yes or "N" for no.  121.00 Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.  122.00 Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.  123.00 Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no.  126.00 Lift column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a GBA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.  125.00 Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes or "N" for yes o
118.01 List amounts of malpractice premiums and paid losses:  118.02 Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.  119.00 DO NOT USE THIS LINE  120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.  120.00 Does the column 2, "Y" for yes or "N" for no.  121.00 Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.  122.00 Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.  123.00 Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no.  126.00 Lift column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a GBA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.  125.00 Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes or "N" for yes o
118.02 Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.  119.00 NOT USE THIS LINE  120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA S3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA S3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.  121.00 Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.  122.00 Does the cost report contain healthcare related taxes as defined in \$1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the worksheet A line number where these taxes are included.  123.00 Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no.  126.00 It is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.  125.00 Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes  125.00 Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes
Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.  119.00 DO NOT USE THIS LINE  120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA § 3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA § 3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.  121.00 Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.  122.00 Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the worksheet A line number where these taxes are included.  123.00 Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no.  If column 1 is "", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.  Certified Transplant Center Information  125.00 Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes  125.00
Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.  119.00 DO NOT USE THIS LINE  120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions)  Enter in column 2, "y" for yes or "N" for no.  121.00 Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.  122.00 Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.  123.00 Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no.  If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.  Certified Transplant Center Information  125.00 Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes  125.00
and amounts contained therein.  119.00 bo NoT USE THIS LINE  120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions)  Enter in column 2, "Y" for yes or "N" for no.  121.00 Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.  122.00 Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.  123.00 Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no.  If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.  Certified Transplant Center Information  125.00 Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes
120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.  121.00 Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.  122.00 Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.  123.00 Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no.  If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.  Certified Transplant Center Information  125.00 Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes  N 125.00
\$3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.  121.00 Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.  122.00 Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.  123.00 Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no.  If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.  Certified Transplant Center Information  125.00 Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes  N 125.00
Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.  121.00 Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.  122.00 Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.  123.00 Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no.  If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.  Certified Transplant Center Information  125.00 Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes N
Enter in column 2, "Y" for yes or "N" for no.  121.00 Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.  122.00 Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the worksheet A line number where these taxes are included.  123.00 Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no.  If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.  Certified Transplant Center Information  125.00 Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes  N 125.00
patients? Enter "Y" for yes or "N" for no.  122.00 Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.  123.00 Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no.  If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.  Certified Transplant Center Information  125.00 Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes  N 125.00
Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.  123.00 Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no.  If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.  Certified Transplant Center Information  125.00 Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes N
Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.  123.00 pid the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no.  If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.  Certified Transplant Center Information  125.00 Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes N
123.00 bid the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no.  If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.  Certified Transplant Center Information  125.00 Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes N
services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no.  If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.  Certified Transplant Center Information  125.00 Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes N
for yes or "N" for no.  If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.  Certified Transplant Center Information  125.00 Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes N 125.00
If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.  Certified Transplant Center Information  125.00 Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes N 125.00
located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.  Certified Transplant Center Information  125.00 Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes N 125.00
"N" for no.  Certified Transplant Center Information  125.00 Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes N 125.00
125.00 Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes N 125.00
126.00 If this is a Medicare-certified kidney transplant program, enter the certification date   126.00
in column 1 and termination date, if applicable, in column 2.  127.00 If this is a Medicare-certified heart transplant program, enter the certification date 127.00
in column 1 and termination date, if applicable, in column 2.
128.00 If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.
129.00 If this is a Medicare-certified lung transplant program, enter the certification date   129.00
in column 1 and termination date, if applicable, in column 2.  130.00 If this is a Medicare-certified pancreas transplant program, enter the certification 130.00
date in column 1 and termination date, if applicable, in column 2.
131.00 If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.
132.00 If this is a Medicare-certified islet transplant program, enter the certification date 132.00
in column 1 and termination date, if applicable, in column 2.
133.00 Removed and reserved 134.00 If this is a hospital-based organ procurement organization (OPO), enter the OPO number 134.00
in column 1 and termination date, if applicable, in column 2.
All Providers 140.00 Are there any related organization or home office costs as defined in CMS Pub. 15-1, Y 15H046 140.00
chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs
are claimed, enter in column 2 the home office chain number. (see instructions)  1.00 2.00 3.00
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the
home office and enter the home office contractor name and contractor number.   141.00   Name: ST VINCENT HEALTH   Contractor's Name: WPS   Contractor's Number: 08101   141.00   141.
142.00 Street:250 WEST 96TH STREET , SUITE PO Box: 142.00
2058 143.00   Zip Code: 46260   143.00
145.00 city. Indianapolis State. In 21p code. 40200 145.00
1.00 144.00 Are provider based physicians' costs included in Worksheet A? Y 144.00
144.00 Are provider based physicians costs included in worksheet A?
1.00 2.00
145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is
no, does the dialysis facility include Medicare utilization for this cost reporting
period? Enter "Y" for yes or "N" for no in column 2.  146.00 Has the cost allocation methodology changed from the previously filed cost report?  N 146.00
Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If
yes, enter the approval date (mm/dd/yyyy) in column 2.

Health Financial Systems			CENT ANDERSON				u of Form CMS	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DAT	TA	Provider CC	:n: 15-0088	Perio From To	od: Worksheet S- 07/01/2022 Part I 06/30/2023 Date/Time PI 11/22/2023		epared:
							1.00	$\dashv$
147.00 was there a change in the statisti	cal basis? Enter "Y	" for ve	es or "N" for	no.			N N	147.00
148.00 was there a change in the order of	allocation? Enter	"Y" for	yes or "N" fo	r no.			N	148.00
149.00 was there a change to the simplifi	ed cost finding met	hod? Ent	ter "Y" for ye	s or "N" f	or no.		N	149.00
			Part A	Part B		Title V	Title XIX	
			1.00	2.00		3.00	4.00	
Does this facility contain a provor charges? Enter "Y" for yes or '								
155.00 Hospital			N	N		N	N	155.00
156.00 Subprovider - IPF			N	N		N	N	156.00
157.00 Subprovider - IRF			N	N		N	N	157.00
158.00 SUBPROVIDER								158.00
159.00 SNF			N	N		N	N	159.00
160.00 HOME HEALTH AGENCY			N	N		N	N	160.00
161.00 CMHC				N		N	N	161.00
							1.00	
Multicampus								
165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	umpus hospital that	has one	or more campu	ses in dif	ferent (	CBSAs?	N	165.00
	Name		County		Zip Code	_	FTE/Campus	
	0		1.00	2.00	3.00	4.00	5.00	
166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)							0.0	00166.00
							1.00	-
Health Information Technology (HI								
167.00 Is this provider a meaningful user 168.00 If this provider is a CAH (line 10 reasonable cost incurred for the H	05 is "Y") and is a	meaningf	ful user (line			er the	Y	167.00 168.00
168.01 If this provider is a CAH and is rexception under §413.70(a)(6)(ii)?	ot a meaningful use	r, does	this provider			rdship		168.01
169.00 If this provider is a meaningful utransition factor. (see instruction	ıser (line 167 is "Y					enter the	9.9	99169.00
	•				В	eginning	Ending	
						1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR beginning period respectively (mm/dd/yyyy)	eginning date and e	nding da	ate for the re	porting				170.00
						1.00	2.00	
171.00 If line 167 is "Y", does this prov	vider have any davs	for indi	ividuals enrol	led in		N	2.00	0171.00
section 1876 Medicare cost plans n "Y" for yes and "N" for no in colu 1876 Medicare days in column 2. (s	reported on Wkst. S- ımn 1. If column 1 i	3, Pt. 1	ɪ, line 2, col	. 6? Enter				

HOSPIT	Financial Systems  ASCENSION ST. VI AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0088	In Lie	Worksheet S-2	
	·			From 07/01/2022 To 06/30/2023	11/22/2023 10	epared: 0:37 am
				Y/N	Date	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSE	EMENT OUESTION	NAIRE	1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format.			er all dates in t	the	
	COMPLETED BY ALL HOSPITALS Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in o	e beginning of column 2. (see	_instructions)			1.00
			1.00	Date 2.00	V/I 3.00	
2.00	Has the provider terminated participation in the Medicare I yes, enter in column 2 the date of termination and in colur voluntary or "I" for involuntary.		N	2.00	3100	2.00
3.00	Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members of directors through ownership, control, or family and other relationships? (see instructions)		3.00			
			Y/N	Туре	Date	
	Financial Data and Borowto		1.00	2.00	3.00	
4.00	Financial Data and Reports  Column 1: were the financial statements prepared by a Cerr Accountant? Column 2: If yes, enter "A" for Audited, "C" or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.		4.00			
5.00	Are the cost report total expenses and total revenues differ those on the filed financial statements? If yes, submit revenues		N			5.00
	chose on the fired imancial statements: If yes, submit let	concritation.		Y/N	Legal Oper.	
				1.00	2.00	
6.00	Approved Educational Activities  Column 1: Are costs claimed for a nursing program? Column the legal operator of the program?	2: If yes, is	s the provide	r N		6.00
7.00 8.00	Are costs claimed for Allied Health Programs? If "Y" see in were nursing programs and/or allied health programs approve cost reporting period? If yes, see instructions.		7.00 8.00			
9.00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction	ns.		N		9.00
10.00	Was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.			N		10.00
11.00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	I & R 1n an App	provea	N	Y/N	11.00
	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 p	·		ost reporting	Y N	12.00 13.00
14.00	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or coinsurations.	ance amounts wa	aived? If yes	, see	N	14.00
15.00	<pre>Bed Complement Did total beds available change from the prior cost report</pre>	ina period? If	ves. see inst	tructions.	N	15.00
			rt A		t B	
	PS&R Data	Y/N 1.00	Date 2.00	Y/N 3.00	Date 4.00	
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	10/30/2023	Y	10/30/2023	16.00
17.00	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 in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

	Financial Systems ASCENSION ST. VI AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0088	Period:	u of Form CMS- Worksheet S-2				
1031 117	2 AND 1031 THE REPERT ONE REPREDORSEMENT QUESTIONING	Trovider cent 13 0000	From 07/01/2022 To 06/30/2023	Part II Date/Time Pre	epared:			
		Description	Y/N	11/22/2023 10 Y/N	0:37 an			
		0	1.00	3.00				
00 00	If line 16 or 17 is yes, were adjustments made to PS&R	Ů.	N N	N N	20.0			
	Report data for Other? Describe the other adjustments:		IN .	IN	20.00			
	Report adea for seneri seserine ene sener adjustmentes.	Y/N Date	Y/N	Date				
		1.00 2.00	3.00	4.00				
1.00	Was the cost report prepared only using the provider's	N 2100	N		21.0			
	records? If yes, see instructions.							
				1.00				
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHILDRENS HOSPITALS)						
	Capital Related Cost							
	Have assets been relifed for Medicare purposes? If yes, see			N N	22.0			
		curred in the Medicare depreciation expense due to appraisals made during the cost						
	reporting period? If yes, see instructions.							
	Were new leases and/or amendments to existing leases entere	eporting period?	N	24.0				
	If yes, see instructions							
	Have there been new capitalized leases entered into during	r it yes, see	N	25.0				
	instructions.	re voc	N	26.0				
	00 Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.							
		cost manageting married? To	f voc submit	N	27.0			
	copy.  Interest Expense							
	Were new loans, mortgage agreements or letters of credit en	stored into during the cos	troporting	N	28.0			
	period? If yes, see instructions.	rtered firto during the cos	t reporting	IN.	20.0			
	Did the provider have a funded depreciation account and/or	Reserve Fund)	N	29.0				
	treated as a funded depreciation account? If yes, see instr	(coci ve i una)	11	23.0				
	Has existing debt been replaced prior to its scheduled matu		5 500	N	30.0			
	instructions.	, 500	.,	30.0				
	Has debt been recalled before scheduled maturity without is	ssuance of new debt? If ve	s. see	N	31.0			
	instructions.	, , ,	,					
Ī	Purchased Services							
2.00	Have changes or new agreements occurred in patient care ser	vices furnished through c	ontractual	N	32.0			
	arrangements with suppliers of services? If yes, see instru	ıctions.						
3.00	If line 32 is yes, were the requirements of Sec. 2135.2 app	olied pertaining to compet	itive bidding? If	N	33.0			
L	no, see instructions.							
	Provider-Based Physicians							
	Were services furnished at the provider facility under an a	arrangement with provider-	pased physicians?	Υ	34.0			
	If yes, see instructions.							
	If line 34 is yes, were there new agreements or amended exi		provider-based	N	35.0			
	physicians during the cost reporting period? If yes, see in	istructions.						
			Y/N 1.00	Date				
1.	Home Office Costs		1.00	2.00				
H	Were home office costs claimed on the cost report?		Y		36.0			
	were nome office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pr	congrad by the home office			37.0			
	If line 36 is yes, has a nome office cost statement been pr If yes, see instructions.	epared by the nome office	· T		37.0			
	If yes, see instructions. If line 36 is yes , was the fiscal year end of the home off	fice different from that o	f N		38.0			
	the provider? If yes, enter in column 2 the fiscal year end		N N		30.0			
	If line 36 is yes, did the provider render services to othe		s, N		39.0			
	see instructions.	caiii componencis. 11 ye.	·   '		33.0			
	If line 36 is yes, did the provider render services to the	home office? If wes see	N		40.0			
	instructions.	11 yes, see	,,		10.0			
0.00								
0.00					_			
0.00		1.00	2.	00				
0.00	Cost Report Preparer Contact Information	1.00	2.	00				
0.00		1.00 KATHY	ZAMBOS	00	41.0			
1.00				00	41.0			
1.00	Enter the first name, last name and the title/position			00	41.0			
1.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.			00	41.0			
1.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KATHY		00				
1.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.  Enter the employer/company name of the cost report preparer.	KATHY						

Health	ealth Financial Systems ASCENSION ST		VINCENT ANDERSON			In Lieu of Form CMS-2552-1				
HOSPIT	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE			Provider CCN: 15-0088		eriod: rom 07/01/2022 o 06/30/2023	Worksheet S-2 Part II Date/Time Pre 11/22/2023 10	pared:		
				3.00						
	Cost Report Preparer Contact Information									
41.00	Enter the first name, last name and the title/position		LEAD	ANALYST				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 co	st						43.00		
	report preparer in columns 1 and 2, respectively.									

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 15-0088 Period:

From 07/01/2022 Part I Date/Time Prepared: 06/30/2023 11/22/2023 10:37 am I/P Days / O/P Visits / Trips Title V Worksheet A No. of Beds Bed Days CAH/REH Hours Component Line No. Available 2.00 5.00 4.00 1.00 3.00 PART I - STATISTICAL DATA 30.00 123 1.00 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 44,895 0.00 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2.00 HMO and other (see instructions) 2.00 3.00 HMO IPF Subprovider 3.00 4.00 HMO IRF Subprovider 4.00 Hospital Adults & Peds. Swing Bed SNF 0 5.00 5.00 6.00 Hospital Adults & Peds. Swing Bed NF 0 6.00 Total Adults and Peds. (exclude observation 123 44,895 0.00 7.00 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8.00 8.00 31.00 0 21 7.665 0.00 9.00 CORONARY CARE UNIT 9.00 10.00 BURN INTENSIVE CARE UNIT 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 12.00 OTHER SPECIAL CARE (SPECIFY) 12.00 13.00 NURSERY 43.00 0 13.00 Total (see instructions) 144 14.00 14.00 52,560 0.00 CAH visits 15.00 15.00 15.10 REH hours and visits 15.10 16.00 SUBPROVIDER - IPF 16.00 SUBPROVIDER - IRF 17.00 41.00 13 4,745 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 HOSPICE 24.00 24.10 HOSPICE (non-distinct part) 30.00 24.10 25.00 25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC 26.00 26.25 FEDERALLY QUALIFIED HEALTH CENTER 89.00 0 26.25 Total (sum of lines 14-26) 157 27.00 27.00 28.00 Observation Bed Days n 28.00 29.00 Ambulance Trips 29.00 30.00 Employee discount days (see instruction) 30.00 Employee discount days - IRF 31.00 31.00 32.00 Labor & delivery days (see instructions) 0 0 32.00 Total ancillary labor & delivery room outpatient days (see instructions) 32.01 32.01

30.00

33.00

33.01

0 34.00

LTCH non-covered days

LTCH site neutral days and discharges

34.00 | Temporary Expansion COVID-19 PHE Acute Care

33.00

33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0088 Period:

Period: Worksheet S-3
From 07/01/2022 Part I
TO 06/30/2023 Date/Time Prepared:

						11/22/2023 10	:37 am
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equivalents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	2,752	889	20,074	Į.		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)	7,337	6,317				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	781	359	_			4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	(	)		5.00
6.00	Hospital Adults & Peds. Swing Bed NF	2 752	0	(	)		6.00
7.00	Total Adults and Peds. (exclude observation	2,752	889	20,074	•		7.00
0 00	beds) (see instructions)	2 402	210	4 041			0 00
8.00 9.00	INTENSIVE CARE UNIT	2,482	219	4,041	-		8.00 9.00
10.00	CORONARY CARE UNIT						10.00
11.00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		452	547	,		13.00
14.00	Total (see instructions)	5,234	1,560	24,662		483.90	
15.00		3,234	1,300	24,002	0.00	463.30	15.00
15.10	REH hours and visits		ĭ				15.10
16.00							16.00
17.00	SUBPROVIDER - IRF	1,122	37	2,677	0.00	13.51	
18.00		_,		2,0	0.00	25.52	18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00							20.00
21.00							21.00
22.00							22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			140	)		24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	(			
27.00					0.00	497.41	
28.00			0	2,076	6		28.00
29.00		0					29.00
30.00	, , ,			128			30.00
	Employee discount days - IRF			15			31.00
32.00		0	15	116			32.00
32.01				C	)		32.01
22.00	outpatient days (see instructions)						22.00
	LTCH non-covered days	0					33.00
	LTCH site neutral days and discharges Temporary Expansion COVID-19 PHE Acute Care	0					33.01
34.00	Temporary Expansion COVID-19 PHE ACUTE Care	0	0	C	<b>'</b>	l	34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0088

Period: Worksheet S-3
From 07/01/2022 Part I
TO 06/30/2023 Date/Time Prepared:

						, ,	11/22/2023 10	:37 am
		Full Time Equivalents			Disch	arges		
	Component	Nonpaid Workers	Title V		Title XVIII	Title XIX	Total All Patients	
		11.00	12.00		13.00	14.00	15.00	
	PART I - STATISTICAL DATA							
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)			0	1,036	211	5,034	1.00
2.00	HMO and other (see instructions)			ı	1,181	1,652		2.00
3.00	HMO IPF Subprovider				1,101	1,032		3.00
4.00	HMO IRF Subprovider			ı		34		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF			ı		37		5.00
6.00	Hospital Adults & Peds. Swing Bed NF							6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)							7.00
8.00	INTENSIVE CARE UNIT			ı				8.00
9.00	CORONARY CARE UNIT			ı				9.00
10.00	BURN INTENSIVE CARE UNIT			ı				10.00
11.00	SURGICAL INTENSIVE CARE UNIT			ı				11.00
12.00	OTHER SPECIAL CARE (SPECIFY)			ı				12.00
13.00	NURSERY			ı				13.00
14.00	Total (see instructions)	0.00		0	1,036	211	5,034	
15.00	CAH visits				_,		,,,,,,	15.00
15.10	REH hours and visits			i				15.10
16.00	SUBPROVIDER - IPF			i				16.00
17.00	SUBPROVIDER - IRF	0.00		0	95	3	221	17.00
18.00	SUBPROVIDER							18.00
19.00	SKILLED NURSING FACILITY			i				19.00
20.00	NURSING FACILITY			İ				20.00
21.00	OTHER LONG TERM CARE			l				21.00
22.00	HOME HEALTH AGENCY			l				22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)							23.00
24.00	HOSPICE			l				24.00
24.10	HOSPICE (non-distinct part)							24.10
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	Ambulance Trips			ĺ				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	Total ancillary labor & delivery room							32.01
	outpatient days (see instructions)							
33.00	LTCH non-covered days				0			33.00
33.01	LTCH site neutral days and discharges				0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care							34.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0088 Worksheet S-3 Period: From 07/01/2022 Part II 06/30/2023 Date/Time Prepared: 11/22/2023 10:37 am Wkst. A Line Reclassificati Adjusted Paid Hours Average Hourly Amount Number Reported on of Salaries salaries Related to Wage (col. 4 ÷  $(col.2 \pm col.$ (from Wkst. Salaries in col. 5) 3) col. 4 A-66.00 2.00 5.00 1.00 3.00 4.00 PART II - WAGE DATA SALARIES 1.00 Total salaries (see 200.00 45,606,462 50,096 45,656,558 1,034,619.17 44.13 1.00 instructions) 2.00 Non-physician anesthetist Part 0 0 0.00 0.00 2.00 3.00 Non-physician anesthetist Part 0 0.00 0.00 3.00 4.00 52,538 52,538 238.82 219.99 4.00 Physician-Part A -Administrative 4.01 Physicians - Part A - Teaching 0 0 0.00 0.00 4.01 Physician and Non 0 0 0.00 5.00 0.00 5.00 Physician-Part B 6.00 Non-physician-Part B for 0 0.00 0.00 6.00 hospital-based RHC and FQHC services 7.00 Interns & residents (in an 21.00 0 0.00 0.00 7.00 approved program) Contracted interns and 7.01 0.00 0.00 7.01 residents (in an approved programs) 8.00 Home office and/or related 16,540 16,540 1,002.68 16.50 8.00 organization personnel 9.00 44.00 0.00 0.00 9.00 159,119 5,338,033 10.00 Excluded area salaries (see 5,178,914 118,856.05 44.91 10.00 instructions) OTHER WAGES & RELATED COSTS 11.00 Contract labor: Direct Patient 5,706,529 0 5,706,529 121,867.78 46.83 11.00 0.00 0.00 12.00 12.00 Contract labor: Top level 0 management and other management and administrative services 13.00 Contract labor: Physician-Part 1,780,095 0 1,780,095 20,403.58 87.24 13.00 A - Administrative 14.00 Home office and/or related 0.00 0.00 14.00 organization salaries and wage-related costs 52.75 14.01 Home office salaries 11,148,528 211,329.00 11,148,528 14.01 14.02 Related organization salaries 0.00 0.00 14.02 15.00 Home office: Physician Part A 0 0 0.00 0.00 15.00 · Administrative Home office and Contract 0 16.00 0 0.00 0.00 16.00 Physicians Part A - Teaching 16.01 Home office Physicians Part A 0 0.00 0.00 16.01 - Teaching 16.02 0 0.00 0.00 16.02 Home office contract Physicians Part A - Teaching WAGE-RELATED COSTS 11,134,081 0 11,134,081 17.00 Wage-related costs (core) (see 17.00 instructions) 18.00 Wage-related costs (other) 18.00 (see instructions) 19.00 Excluded areas 1,300,212 1,300,212 19.00 20.00 Non-physician anesthetist Part 20.00 21.00 Non-physician anesthetist Part 0 21.00 22.00 Physician Part A -6,095 6,095 22.00 Administrative 22.01 Physician Part A - Teaching 0 0 22.01 23.00 Physician Part B 0 0 23.00 24.00 Wage-related costs (RHC/FQHC) 0 0 24.00 Interns & residents (in an 25.00 0 25.00 0 0 approved program) 25.50 Home office wage-related 3,554,748 0 3,554,748 25.50 (core) 25.51 25.51 Related organization 0 0 wage-related (core) Home office: Physician Part A 0 0 25.52 25.52

- Administrative wage-related (core)

Provider CCN: 15-0088 Period: Worksheet S-3 From 07/01/2022 Part II HOSPITAL WAGE INDEX INFORMATION

					To		Date/Time Pre 11/22/2023 10	
		Wkst. A Line		Reclassificati			Average Hourly	
		Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from Wkst.	$(col.2 \pm col.$	Salaries in	col. 5)	
				A-6)	3)	col. 4		
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A		0	0	0			25.53
	- Teaching - wage-related							
	(core)							
	OVERHEAD COSTS - DIRECT SALARII							
26.00	Employee Benefits Department	4.00	609,795	,	,			26.00
27.00	Administrative & General	5.00	2,093,628		· ' '	,		27.00
28.00	Administrative & General under		2,365,546	0	2,365,546	32,185.50	73.50	28.00
	contract (see inst.)		_	_				
29.00	Maintenance & Repairs	6.00	0	0	0	0.00		29.00
30.00	Operation of Plant	7.00	1,611	13	1,624	36.78		30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00		31.00
32.00	Housekeeping	9.00	0	0	0	0.00		32.00
33.00	Housekeeping under contract		2,418,980	0	2,418,980	84,962.95	28.47	33.00
	(see instructions)							
34.00	Dietary	10.00	0	0	0	0.00		34.00
35.00	Dietary under contract (see instructions)		804,983	0	804,983	25,363.27	31.74	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00		37.00
38.00	Nursing Administration	13.00	1,689,277	141,143	1,830,420			38.00
39.00	Central Services and Supply	14.00	376,431	,	· ' '	,		39.00
40.00	Pharmacy	15.00	3,019,206			,		40.00
41.00	Medical Records & Medical	16.00	0,010,100	0	0,010,110	0.00		41.00
	Records Library	10.00	· ·	Ĭ		0.00	0.00	
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
	Other General Service	18.00	0	o o	o o	0.00		43.00
	1		v	'	·	3.00	3.00	

Health Financial Systems ASCENSION ST. VINCENT ANDERSON In Lieu of Form CMS-2552-10

HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0088 From 07/01/2022 To 06/30/2023 Date/Time Prepared:

11/22/2023 10:37 am Worksheet A Amount Reclassificati Adjusted Paid Hours Average Hourly Line Number Reported on of Salaries salaries Related to Wage (col. 4 ÷  $(col.2 \pm col.$ Salaries in (from col. 5) col. 4 Worksheet A-6) 3) 5.00 6.00 1.00 2.00 4.00 3.00 PART III - HOSPITAL WAGE INDEX SUMMARY 1.00 Net salaries (see 51,179,431 50,096 51,229,527 1,176,128.21 43.56 1.00 instructions) 2.00 5,178,914 159,119 5,338,033 118,856.05 44.91 2.00 Excluded area salaries (see instructions) 3.00 Subtotal salaries (line 1 46,000,517 -109,023 45,891,494 1,057,272.16 43.41 3.00 minus line 2) 4.00 Subtotal other wages & related 18,635,152 18,635,152 353,600.36 52.70 4.00 costs (see inst.) 5.00 Subtotal wage-related costs 14,694,924 0 14,694,924 0.00 32.02 5.00 (see inst.) Total (sum of lines 3 thru 5) 6.00 79,330,593 -109,023 79,221,570 1,410,872.52 56.15 6.00 7.00 Total overhead cost (see 13,379,457 -924,907 12,454,550 299,438.03 41.59 7.00 instructions)

Health Financial Systems	ASCENSION ST. VINCENT ANDERSON	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provider CCN: 15-0088	Period: Worksheet S-3 From 07/01/2022 Part IV
		To 06/30/2023 Date/Time Prenared:

	10 06/30/2023	11/22/2023 10	:37 am
		Amount	
		Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	1,787,054	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		l
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	276,875	7.00
	HEALTH AND INSURANCE COST		l
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	4,064,974	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	1,505,938	9.00
10.00	Dental, Hearing and Vision Plan	129,692	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	0	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	31,004	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	255,066	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00		4,106	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16.00
	Noncumulative portion)		ı
	TAXES		l
	FICA-Employers Portion Only	3,209,854	
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00		3,452	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see	0	21.00
	instructions))		
22.00		0	22.00
	Tuition Reimbursement	10,614	
24.00	Total wage Related cost (Sum of lines 1 -23)	11,278,629	24.00
25.65	Part B - Other than Core Related Cost		25.65
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

Health Financial Systems	ASCENSION ST. VINCENT ANDERSON	In Lieu of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 15-0088	Period: Worksheet S-3 From 07/01/2022 Part V To 06/30/2023 Date/Time Prepared:

		10 00/30/2023	11/22/2023 10	
	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	5,706,529	11,278,629	1.00
2.00	Hospital	5,706,529	11,278,629	2.00
3.00	SUBPROVIDER - IPF			3.00
4.00	SUBPROVIDER - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	SKILLED NURSING FACILITY			8.00
9.00	NURSING FACILITY			9.00
10.00	OTHER LONG TERM CARE I			10.00
11.00	Hospital-Based HHA			11.00
12.00	AMBULATORY SURGICAL CENTER (D.P.) I			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	RENAL DIALYSIS I			17.00
18.00	Other	0	0	18.00

HOSPIT	Financial Systems ASCENSION ST. VINCENT	ANDERSON		u of Form CMS-2	
	AL UNCOMPENSATED AND INDIGENT CARE DATA Pro	ovider CCN: 15-0088	Period:	Worksheet S-10	0
			From 07/01/2022 To 06/30/2023	Date/Time Pre	nared:
			10 00, 30, 2023	11/22/2023 10	
				1.00	
	Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divid	led by line 202 colum	n 8)	0.217135	1.00
	Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid			48,091,355	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			Y	3.00
4.00 5.00	If line 3 is yes, does line 2 include all DSH and/or supplemental If line 4 is no, then enter DSH and/or supplemental payments from		a10?	o	4.00 5.00
6.00	Medicaid charges	i Medicaid		177,118,732	6.00
7.00	Medicaid cost (line 1 times line 6)			38,458,676	
8.00	Difference between net revenue and costs for Medicaid program (li	ne 7 minus sum of li	nes 2 and 5: if	0	8.00
	< zero then enter zero)			_	
	Children's Health Insurance Program (CHIP) (see instructions for	each line)			
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)			0	
12.00	, and the second	ne 11 minus line 9;	if < zero then	0	12.00
	<pre>enter zero) Other state or local government indigent care program (see instru</pre>	stions for each line	`		
13.00	Net revenue from state or local indigent care program (see instru			0	13.00
14.00	Charges for patients covered under state or local indigent care p			0	
11100	10)	rogram (not merade	111 1111105 0 01	Ŭ	11.00
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 indig	gent care program (li	ne 15 minus line	0	16.00
	13; if < zero then enter zero)				
	Grants, donations and total unreimbursed cost for Medicaid, CHIP	and state/local indi	gent care program	ns (see	
17.00	instructions for each line)	·	gent care program		17.00
	<pre>instructions for each line) Private grants, donations, or endowment income restricted to fund</pre>	ling charity care	gent care program		
17.00 18.00 19.00	instructions for each line)	ling charity care		0	18.00
18.00	<pre>instructions for each line) Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos</pre>	ling charity care		0	17.00 18.00 19.00
18.00	<pre>instructions for each line) Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid , CHIP and state and local i</pre>	ling charity care spital operations ndigent care program	s (sum of lines	0 0 0 0 Total (col. 1	18.00
18.00	<pre>instructions for each line) Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid , CHIP and state and local i</pre>	ling charity care spital operations ndigent care program Uninsured patients	s (sum of lines  Insured patients	0 0 0 Total (col. 1 + col. 2)	18.00
18.00	<pre>instructions for each line) Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid , CHIP and state and local i 8, 12 and 16)</pre>	ling charity care spital operations ndigent care program	s (sum of lines	0 0 0 0 Total (col. 1	18.00
18.00	<pre>instructions for each line) Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid , CHIP and state and local i 8, 12 and 16) Uncompensated Care (see instructions for each line)</pre>	ling charity care spital operations ndigent care program  Uninsured patients 1.00	s (sum of lines  Insured patients 2.00	0 0 0 Total (col. 1 + col. 2) 3.00	18.00 19.00
18.00	<pre>instructions for each line) Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid , CHIP and state and local i 8, 12 and 16)  Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facil</pre>	ling charity care spital operations ndigent care program  Uninsured patients 1.00	s (sum of lines  Insured patients 2.00	0 0 0 Total (col. 1 + col. 2) 3.00	18.00 19.00
18.00 19.00	<pre>instructions for each line) Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid , CHIP and state and local i 8, 12 and 16)  Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facil (see instructions)</pre>	ling charity care spital operations ndigent care program  Uninsured patients 1.00  ity 13,405,4	s (sum of lines  Insured patients 2.00  70 981,476	Total (col. 1 + col. 2) 3.00	18.00 19.00
18.00	<pre>instructions for each line) Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid , CHIP and state and local i 8, 12 and 16)  Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facil</pre>	ling charity care spital operations ndigent care program    Uninsured   patients   1.00	s (sum of lines  Insured patients 2.00  70 981,476	Total (col. 1 + col. 2) 3.00	18.00 19.00
18.00 19.00	Instructions for each line)  Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid , CHIP and state and local i 8, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facil (see instructions)  Cost of patients approved for charity care and uninsured discount	Uninsured patients  13,405,4 25 (see 2,910,7	s (sum of lines  Insured patients 2.00  70 981,476	Total (col. 1 + col. 2) 3.00 14,386,946 3,892,273	18.00 19.00 20.00 21.00
18.00 19.00 20.00 21.00 22.00	<pre>instructions for each line) Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid , CHIP and state and local i 8, 12 and 16)  Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of charity care</pre>	Uninsured patients  1.00  ity 13,405,4  cs (see 2,910,7	s (sum of lines  Insured patients 2.00  70 981,476 97 981,476 0 0	Total (col. 1 + col. 2) 3.00 14,386,946 3,892,273	18.00 19.00 20.00 21.00 22.00
18.00 19.00 20.00 21.00 22.00	<pre>instructions for each line) Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid , CHIP and state and local i 8, 12 and 16)  Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of</pre>	Uninsured patients  13,405,4 25 (see 2,910,7	s (sum of lines  Insured patients 2.00  70 981,476 97 981,476 0 0	Total (col. 1 + col. 2) 3.00 14,386,946 3,892,273	18.00 19.00 20.00 21.00 22.00
18.00 19.00 20.00 21.00 22.00	<pre>instructions for each line) Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid , CHIP and state and local i 8, 12 and 16)  Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of charity care</pre>	Uninsured patients  1.00  ity 13,405,4  cs (see 2,910,7	s (sum of lines  Insured patients 2.00  70 981,476 97 981,476 0 0	Total (col. 1 + col. 2) 3.00 14,386,946 3,892,273 0	18.00 19.00 20.00 21.00 22.00
18.00 19.00 20.00 21.00 22.00 23.00	Instructions for each line)  Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i 8, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facil (see instructions)  Cost of patients approved for charity care and uninsured discount instructions)  Payments received from patients for amounts previously written of charity care  Cost of charity care (line 21 minus line 22)	Uninsured   patients   1.00	s (sum of lines  Insured patients 2.00  70 981,476 97 981,476 0 0 97 981,476	0 0 0 Total (col. 1 + col. 2) 3.00 14,386,946 3,892,273 0 3,892,273	18.00 19.00 20.00 21.00 22.00 23.00
18.00 19.00 20.00 21.00 22.00 23.00	Instructions for each line)  Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i 8, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facil (see instructions)  Cost of patients approved for charity care and uninsured discount instructions)  Payments received from patients for amounts previously written of charity care  Cost of charity care (line 21 minus line 22)	Uninsured patients  1.00  ity 13,405,4  ss (see 2,910,7  f as 2,910,7	s (sum of lines  Insured patients 2.00  70 981,476 97 981,476 0 0 97 981,476	Total (col. 1 + col. 2) 3.00 14,386,946 3,892,273 0	18.00 19.00 20.00 21.00 22.00 23.00
18.00 19.00 20.00 21.00 22.00 23.00	Instructions for each line)  Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i 8, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facil (see instructions)  Cost of patients approved for charity care and uninsured discount instructions)  Payments received from patients for amounts previously written of charity care  Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care pr If line 24 is yes, enter the charges for patient days beyond the	Uninsured patients  1.00  1ity 13,405,4  2s (see 2,910,7  The days beyond a length rogram?	s (sum of lines  Insured patients 2.00  70 981,476 97 981,476 0 0 97 981,476 of stay limit	0 0 0 Total (col. 1 + col. 2) 3.00 14,386,946 3,892,273 0 3,892,273	20.00 21.00 23.00 24.00
18.00 19.00 20.00 21.00 22.00 23.00 24.00 25.00	Instructions for each line)  Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i 8, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facil (see instructions)  Cost of patients approved for charity care and uninsured discount instructions)  Payments received from patients for amounts previously written of charity care  Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care profiline 24 is yes, enter the charges for patient days beyond the stay limit	Uninsured patients  1.00  ity  2,910,7  days beyond a length rogram? indigent care program	s (sum of lines  Insured patients 2.00  70 981,476 97 981,476 0 0 97 981,476 of stay limit	0 0 0 0 Total (col. 1 + col. 2) 3.00 14,386,946 3,892,273 0 3,892,273	20.00 21.00 22.00 23.00 24.00 25.00
18.00 19.00 20.00 21.00 22.00 23.00 24.00 25.00 26.00	Instructions for each line)  Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i 8, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facil (see instructions)  Cost of patients approved for charity care and uninsured discount instructions)  Payments received from patients for amounts previously written of Charity care  Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care profiline 24 is yes, enter the charges for patient days beyond the stay limit  Total bad debt expense for the entire hospital complex (see instructions)	Uninsured patients 1.00  ity 13,405,4 is (see 2,910,7 days beyond a length orgram? indigent care program	s (sum of lines  Insured patients 2.00  70 981,476 97 981,476 0 0 97 981,476 of stay limit	0 0 0 0 0 Total (col. 1 + col. 2) 3.00 14,386,946 3,892,273 0 3,892,273 1.00 N 0 7,493,933	20.00 21.00 22.00 23.00 24.00 25.00 26.00
18.00 19.00 20.00 21.00 22.00 23.00 24.00 25.00 26.00 27.00	Instructions for each line)  Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i 8, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facil (see instructions)  Cost of patients approved for charity care and uninsured discount instructions)  Payments received from patients for amounts previously written of charity care  Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care pr If line 24 is yes, enter the charges for patient days beyond the stay limit  Total bad debt expense for the entire hospital complex (see instructions)  Medicare reimbursable bad debts for the entire hospital complex (	ding charity care spital operations ndigent care program  Uninsured patients 1.00  ity 13,405,4  is (see 2,910,7  f as 2,910,7  days beyond a length ogram? indigent care program cuctions) (see instructions)	s (sum of lines  Insured patients 2.00  70 981,476 97 981,476 0 0 97 981,476 of stay limit	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	20.00 21.00 23.00 24.00 25.00 26.00 27.00
18.00 19.00 20.00 21.00 22.00 23.00 24.00 25.00 26.00 27.00 27.01	Instructions for each line)  Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i 8, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facil (see instructions)  Cost of patients approved for charity care and uninsured discount instructions)  Payments received from patients for amounts previously written of charity care  Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care pr If line 24 is yes, enter the charges for patient days beyond the stay limit  Total bad debt expense for the entire hospital complex (see instructions)  Medicare reimbursable bad debts for the entire hospital complex (see	ding charity care spital operations ndigent care program  Uninsured patients 1.00  ity 13,405,4  is (see 2,910,7  f as 2,910,7  days beyond a length ogram? indigent care program cuctions) (see instructions)	s (sum of lines  Insured patients 2.00  70 981,476 97 981,476 0 0 97 981,476 of stay limit	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	20.00 21.00 22.00 23.00 24.00 25.00 26.00 27.00 27.01
18.00 19.00 20.00 21.00 22.00 23.00 24.00 25.00 26.00 27.00 27.01 28.00	Instructions for each line)  Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i 8, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facil (see instructions)  Cost of patients approved for charity care and uninsured discount instructions)  Payments received from patients for amounts previously written of charity care  Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care profiline 24 is yes, enter the charges for patient days beyond the stay limit  Total bad debt expense for the entire hospital complex (see instructioare reimbursable bad debts for the entire hospital complex (see Non-Medicare bad debt expense (see instructions)	days beyond a length rogram? indigent care program? instructions)  see instructions)	s (sum of lines  Insured patients 2.00  70 981,476 97 981,476 0 0 97 981,476  of stay limit m's length of	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	20.00 21.00 22.00 23.00 24.00 25.00 26.00 27.01 28.00
18.00 19.00 20.00 21.00 22.00 23.00 24.00 25.00 27.00 27.01 28.00 29.00	Instructions for each line)  Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i 8, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facil (see instructions)  Cost of patients approved for charity care and uninsured discount instructions)  Payments received from patients for amounts previously written of charity care  Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care profiline 24 is yes, enter the charges for patient days beyond the stay limit  Total bad debt expense for the entire hospital complex (see instructioare reimbursable bad debts for the entire hospital complex (see Non-Medicare bad debt expense (see instructions)	days beyond a length rogram? indigent care program? instructions)  see instructions)	s (sum of lines  Insured patients 2.00  70 981,476 97 981,476 0 0 97 981,476  of stay limit m's length of	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	20.00 21.00 22.00 23.00 24.00 25.00 26.00 27.00 27.01 28.00 29.00

	Financial Systems AS SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	SCENSION ST. VIN	Provider C		eriod:	u of Form CMS- Worksheet A	2552-10
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider C	F	rom 07/01/2022		
				Τ	o 06/30/2023	Date/Time Pre 11/22/2023 10	
	Cost Center Description	Salaries	Other	Total (col. 1	Reclassificati		. 57 am
				+ col. 2)	ons (See A-6)	Trial Balance	
						(col. 3 +-	
		1.00	2.00	2.00	4.00	col. 4)	
	CENERAL CERVICE COCT CENTERS	1.00	2.00	3.00	4.00	5.00	
1.00	GENERAL SERVICE COST CENTERS  00100 CAP REL COSTS-BLDG & FIXT		5,413,227	5,413,227	-4,260	5,408,967	1.00
1.01	00101 CAP REL COSTS-BLDG & FIXT-MAB		0,413,227	3,413,227		0,400,507	1.01
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	609,795	8,513,923	9,123,718	-658,548	8,465,170	
5.00	00500 ADMINISTRATIVE & GENERAL	2,093,628	52,970,948			54,542,719	
7.00	00700 OPERATION OF PLANT	1,611	5,586,433			5,588,057	1
8.00 9.00	00800 LAUNDRY & LINEN SERVICE	0	330,967			330,967	
10.00	00900 HOUSEKEEPING 01000 DIETARY		2,847,481 3,015,699			2,847,481 1,065,960	1
11.00	01100 CAFETERIA	Ö	0,013,033	3,013,033			1
13.00	01300 NURSING ADMINISTRATION	1,689,277	1,024,614	2,713,891			
14.00	01400 CENTRAL SERVICES & SUPPLY	376,431	238,533	614,964	5,834		
15.00	01500 PHARMACY	3,019,206	638,432				
16.00	01600 MEDICAL RECORDS & LIBRARY	0	122	122	0	122	
23.00	02300 ALLIED HEALTH-EMS 02301 ALLIED HEALTH-RAD TECH	86,242	34,605	120,847	24,519	0 145,366	
23.01	INPATIENT ROUTINE SERVICE COST CENTERS	00,242	34,003	120,647	24,319	143,300	23.01
30.00	03000 ADULTS & PEDIATRICS	11,420,420	2,998,406	14,418,826	765,887	15,184,713	30.00
31.00	03100 INTENSIVE CARE UNIT	3,515,464	1,523,419	5,038,883	92,424		31.00
41.00	04100 SUBPROVIDER - IRF	1,122,462	268,921				
43.00	04300 NURSERY	0	0	(	217,112	217,112	43.00
FO 00	ANCILLARY SERVICE COST CENTERS	2 451 202	9,528,177	11 070 200	21 052	12 000 422	FO 00
50.00 52.00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	2,451,203 1,251,289	9,528,177 325,764				1
53.00	05300 ANESTHESIOLOGY	1,231,289	323,704	1,377,033	-303,108	1,013,883	53.00
	05400 RADIOLOGY-DIAGNOSTIC	2,016,033	1,056,888	3,072,921	-3,190	3,069,731	
54.01	03440 MAMMOGRAPHY	293,630	443,273			739,344	1
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	290,438	547,107				1
54.03	03630 ULTRA SOUND	318,787	92,297				
55.00	05500 RADIOLOGY-THERAPEUTIC 05700 CT SCAN	953,649	1,151,350			2,113,050	
57.00 58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	672,415 255,097	88,540 218,892			766,545 483,231	
59.00	05900 CARDIAC CATHETERIZATION	797,846	263,916				
60.00	06000 LABORATORY	0	6,844,234			6,844,234	1
65.00	06500 RESPIRATORY THERAPY	1,184,143	186,473	1,370,616	24,320	1,394,936	
66.00	06600 PHYSICAL THERAPY	460,035	3,953,678	1		2,819,077	66.00
67.00	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY	0	0		_,		
68.00 69.00	06900 ELECTROCARDIOLOGY	130,780	65,151	195,931	433,764 1,087	433,764 197,018	
70.00	07000 ELECTROCARDIOLOGIA	223,169	375,374				
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,731,323			3,731,323	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	5,308,565	5,308,565	0		
	07300 DRUGS CHARGED TO PATIENTS	0	15,565,392			- , ,	
	03190 CHEMOTHERAPY	713,428	220,438				
76.01	03020 WOUND CARE OUTPATIENT SERVICE COST CENTERS	403,291	511,243	914,534	3,456	917,990	76.01
90 00	09000 CLINIC	0	0		0	0	90.00
90.01	09001 ANDERSON OUTPATIENT CENTER	1,183,411	101,017	1,284,428	9,861	-	
	04950 DIABETIC EDUCATION	0	, 0	·	0	0	90.02
90.03	09002 MS CLINIC	0	0	C	0	0	90.03
	09100 EMERGENCY	4,103,072	2,687,795	6,790,867	59,322	6,850,189	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
95 00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	0	1,437	1,437	0	1,437	95.00
33.00	SPECIAL PURPOSE COST CENTERS	<u> </u>	1,437	1,437	ı o	1,437	33.00
113.00	11300 INTEREST EXPENSE		0		0	0	113.00
118.00		41,636,252	138,674,054	180,310,306	-53,538		
	NONREIMBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	100 215	0		190.00
	19100 RESEARCH	83,031	26,284				
	19200 PHYSICIANS' PRIVATE OFFICES 07950 FOUNDATION	2,791,574	393,189	3,184,763			194.00
	07951 CHILDRENS CLINIC		0		ol		194.00
	07952 PSS ADMINISTRATION	43,910	10,654	54,564	365		194.02
194.03	07953 SEXUAL ASSAULT PROGRAM	5,482	400	5,882	46	5,928	194.03
	07954 ASPR BIOTERRORISM GRANT	0	440	1			194.04
	07955 HEALTHY FAMILIES	363,391	132,257				
194.06	07956 DME-HOME CARE 07957 MARKETING	0	2,747 0				194.06 194.07
	07958 CORPORATE COMMUNICATIONS	0	0		1		194.07
	07959 MOB	0	369		1		194.09
	07960 ASC	152	11				194.10
		<u> </u>			,		

Health Finan	cial Systems A	SCENSION ST. VI	NCENT ANDERSON		In Lie	u of Form CMS-2	2552-10
RECLASSIFICA	TION AND ADJUSTMENTS OF TRIAL BALANCE (	OF EXPENSES	Provider Co		eriod:	Worksheet A	
					rom 07/01/2022		
				1	o 06/30/2023		
						11/22/2023 10	:3/ am
	Cost Center Description	Salaries	Other	Total (col. 1	Reclassificati	Reclassified	
				+ col. 2)	ons (See A-6)	Trial Balance	
						(col. 3 +-	
						col. 4)	
		1.00	2.00	3.00	4.00	5.00	
194.11 07961	MAB	0	0	C	0	0	194.11
194.12 07963	ADOLESCENT RESIDENTIAL SERVICES	682,670	75,777	758,447	32,005	790,452	194.12
194.13 07962	IDLE SPACE	0	0	[ c	0	0	194.13
200.00	TOTAL (SUM OF LINES 118 through 199)	45,606,462	139,316,182	184,922,644	. 0	184,922,644	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0088 Period:

Period: From 07/01/2022 To 06/30/2023 Date/Time Prepared: 11/22/2023 10:37 am

			11/22/2023 10	:37 am
Cost Center Description	Adjustments	Net Expenses		
	(See A-8)	For Allocation		
CENERAL CENTRE COST CENTERS	6.00	7.00		
1.00 GENERAL SERVICE COST CENTERS  1.00 O0100 CAP REL COSTS-BLDG & FIXT	-525,588	4,883,379		1.00
1.01   00101 CAP REL COSTS-BLDG & FIXT  1.01   00101 CAP REL COSTS-BLDG & FIXT-MAB	-323,388	4,883,379		1.00
4.00   00400   EMPLOYEE BENEFITS DEPARTMENT	-141,243	8,323,927		4.00
5.00 00500 ADMINISTRATIVE & GENERAL	-16,865,637	37,677,082		5.00
7.00 00700 OPERATION OF PLANT	-359,093	5,228,964		7.00
8.00 00800 LAUNDRY & LINEN SERVICE	0	330,967		8.00
9.00 00900 HOUSEKEEPING	ő	2,847,481		9.00
10.00 01000 DIETARY	-408,873	657,087		10.00
11.00 01100 CAFETERIA	0	1,949,739		11.00
13.00 01300 NURSING ADMINISTRATION	-168,193	2,686,841		13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	-610,317	10,481		14.00
15.00 01500 PHARMACY	-21,669			15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	-88	34		16.00
23.00 02300 ALLIED HEALTH-EMS	0	0		23.00
23.01 02301 ALLIED HEALTH-RAD TECH	-26,774	118,592		23.01
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00 03000 ADULTS & PEDIATRICS	-749	15,183,964		30.00
31.00 03100 INTENSIVE CARE UNIT	-376,860	4,754,447		31.00
41.00   04100   SUBPROVIDER - IRF	0	1,495,157		41.00
43.00   04300   NURSERY	0	217,112		43.00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	-1,208,179	10,792,254		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	-2,153	1,011,732		52.00
53.00   05300   ANESTHESIOLOGY	0	0		53.00
54.00   05400 RADIOLOGY-DIAGNOSTIC	-60,858	3,008,873		54.00
54.01   03440   MAMMOGRAPHY	0	739,344		54.01
54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	839,959		54.02
54.03   03630   ULTRA SOUND	-2,140	411,594		54.03
55.00   05500 RADIOLOGY-THERAPEUTIC	0	2,113,050		55.00
57.00  05700 CT SCAN	0	766,545		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	-6,300	·		58.00
59.00 05900 CARDIAC CATHETERIZATION	-213	1,071,438		59.00
60.00  06000 LABORATORY	0	6,844,234		60.00
65.00 06500 RESPIRATORY THERAPY	-4,643	1,390,293		65.00
66.00 06600 PHYSICAL THERAPY	-10,346			66.00
67.00 06700 OCCUPATIONAL THERAPY	0	1,273,323		67.00
68.00 06800 SPEECH PATHOLOGY	0	433,764		68.00
69.00 06900 ELECTROCARDIOLOGY	-495	196,523		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	-316,826	283,572		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,731,323		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	5,308,565		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	15,565,392		73.00
76.00 03190 CHEMOTHERAPY	-342	952,612		76.00
76.01 03020 WOUND CARE	-20,000	897,990		76.01
OUTPATIENT SERVICE COST CENTERS				00.00
90.00   09000   CLINIC	0	1 244 280		90.00
90.01 09001 ANDERSON OUTPATIENT CENTER 90.02 04950 DIABETIC EDUCATION	-50,009	_	l .	90.01
90.02   04930 DIABETIC EDUCATION   90.03   09002   MS CLINIC	0	0		90.02
	_			
91.00   09100   EMERGENCY	-970,891	5,879,298		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)				92.00
95.00 09500 AMBULANCE SERVICES	-1,437	0		95.00
SPECIAL PURPOSE COST CENTERS	-1,437	ı		93.00
113.00 11300 INTEREST EXPENSE	0	0		113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)		-		118.00
NONREIMBURSABLE COST CENTERS	-22,139,910	130,030,032		1110.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		190.00
191.00 19100  RESEARCH	0	110,005		191.00
192.00 19200  PHYSICIANS' PRIVATE OFFICES	0	3,199,520		192.00
194.00 07950 FOUNDATION	0	3,199,320		194.00
194.01 07951 CHILDRENS CLINIC	0	0		194.00
194.02 07952  PSS ADMINISTRATION		54,929		194.01
194.03 07953  SEXUAL ASSAULT PROGRAM		5,928		194.02
194.04 07954 ASPR BIOTERRORISM GRANT		3,928		194.03
194.05 07955 HEALTHY FAMILIES	0	501,321	l .	194.04
194.06 07956 DME-HOME CARE		2,747	l .	194.05
194.07 07957 MARKETING	0	2,747		194.06
194.08 07958  CORPORATE COMMUNICATIONS	0	0		194.07
194.09 07959  MOB	0	369		194.08
194.10 07960  ASC	0	165		194.10
194.11 07961 MAB	0	0		194.11
194.12 07963 ADOLESCENT RESIDENTIAL SERVICES	0	790,452		194.12
	1	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	I .	1-2

Health Financial Systems	ASCENSION ST. VI	NCENT ANDERSON	In Lieu	of Form CMS-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL	BALANCE OF EXPENSES	Provider CCN: 15-0088	From 07/01/2022 To 06/30/2023	Worksheet A  Date/Time Prepared: 11/22/2023 10:37 am

				11/22/2023 10	:3/ am
Cost Center Description	Adjustments	Net Expenses			
	(See A-8)	For Allocation			
	6.00	7.00			
194.13 07962 IDLE SPACE	0	0			194.13
200.00 TOTAL (SUM OF LINES 118 through 199)	-22,159,916	162,762,728			200.00

RECLASSIFICATIONS

Provider CCN: 15-0088

					11/22/2023 10:3
		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	C - INTEREST EXPENSE				
1.00	ADMINISTRATIVE & GENERAL		0	<u>4,2</u> 60	
	TOTALS		0	4,260	
	D - CAFETERIA/DIETARY RECLASS				
1.00	CAFETERIA	11.00	0	1,949,739	
	TOTALS		0	1,949,739	
	E - LABOR DELIVERY RECLASS		<u>.</u>	<u>.</u>	
1.00	ADULTS & PEDIATRICS	30.00	282,872	73,644	
2.00	NURSERY	43.00	172,264	44,848	
	TOTALS		455,136	118,492	
	H - PT_OT_ST RECLASS				
1.00	OCCUPATIONAL THERAPY	67.00	132,717	1,140,606	
2.00	SPEECH PATHOLOGY	68.00	45,211	388,553	
	TOTALS		177,928	1,529,159	
	J - ADOLESCENT RESIDENTIAL SE	RVTCFS	277,520	2,323,233	
1.00	ADOLESCENT RESIDENTIAL	194.12	0	22,712	
1.00	SERVICES	154.12	Ĭ	22,712	
	TOTALS			$-\frac{1}{22,712}$	
	M - RAD TECH RECLASS		<u> </u>	22,712	
1.00		23.01	23,805	0	
1.00	ALLIED HEALTH-RAD TECH TOTALS		23,805	0	
			23,803	U	
1 00	O - SYSTEM PROJECTS	12 00	122 205	<u></u>	
1.00	NURSING ADMINISTRATION	13.00	122,305	0	
2.00	ADULTS & PEDIATRICS	30.00	276,862	0	
3.00	INTENSIVE CARE UNIT	31.00	40,800	0	
4.00	SUBPROVIDER - IRF	41.00	78,935	0	
5.00	RADIOLOGY-THERAPEUTIC	55.00	119	0	
6.00	RESPIRATORY THERAPY	65.00	3,924	0	
7.00	CHEMOTHERAPY	76.00	12,945	0	
8.00	EMERGENCY	<u>91.</u> 00	<u>1,1</u> 65	0	
	TOTALS		537,055	0	
	Q - PHYSICIAN RECLASS				
1.00	RESPIRATORY THERAPY	<u>65.</u> 00	0	8,663	
	TOTALS		0	8,663	
	W - ACCRUED PTO				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	50,096	0	
	TOTALS		50,096	0	
	X - STARP				
1.00		0.00	0	0	
2.00	l				
	ADMINISTRATIVE & GENERAL	5.00	16,493	0	
3.00	ADMINISTRATIVE & GENERAL OPERATION OF PLANT	5.00 7.00	16,493 13	0	
	1	l l		-	
3.00 4.00	OPERATION OF PLANT	7.00 13.00	13 14,023	0	
3.00 4.00 5.00	OPERATION OF PLANT NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	7.00 13.00 14.00	13 14,023 3,129	0	
3.00 4.00 5.00 6.00	OPERATION OF PLANT NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY	7.00 13.00 14.00 15.00	13 14,023 3,129 25,098	0	
3.00 4.00 5.00 6.00 7.00	OPERATION OF PLANT NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY ALLIED HEALTH-RAD TECH	7.00 13.00 14.00 15.00 23.01	13 14,023 3,129 25,098 714	0	
3.00 4.00 5.00 6.00 7.00 8.00	OPERATION OF PLANT NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY ALLIED HEALTH-RAD TECH ADULTS & PEDIATRICS	7.00 13.00 14.00 15.00 23.01 30.00	13 14,023 3,129 25,098 714 97,387	0	
3.00 4.00 5.00 6.00 7.00 8.00 9.00	OPERATION OF PLANT NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY ALLIED HEALTH-RAD TECH ADULTS & PEDIATRICS INTENSIVE CARE UNIT	7.00 13.00 14.00 15.00 23.01 30.00 31.00	13 14,023 3,129 25,098 714 97,387 29,223	0	
3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00	OPERATION OF PLANT NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY ALLIED HEALTH-RAD TECH ADULTS & PEDIATRICS INTENSIVE CARE UNIT SUBPROVIDER - IRF	7.00 13.00 14.00 15.00 23.01 30.00 31.00 41.00	13 14,023 3,129 25,098 714 97,387 29,223 8,925	0 0 0 0 0 0	1
3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00	OPERATION OF PLANT NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY ALLIED HEALTH-RAD TECH ADULTS & PEDIATRICS INTENSIVE CARE UNIT SUBPROVIDER - IRF OPERATING ROOM	7.00 13.00 14.00 15.00 23.01 30.00 31.00 41.00 50.00	13 14,023 3,129 25,098 714 97,387 29,223 8,925 20,376	0 0 0 0 0 0	1 1
3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00	OPERATION OF PLANT NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY ALLIED HEALTH-RAD TECH ADULTS & PEDIATRICS INTENSIVE CARE UNIT SUBPROVIDER - IRF OPERATING ROOM DELIVERY ROOM & LABOR ROOM	7.00 13.00 14.00 15.00 23.01 30.00 31.00 41.00 50.00 52.00	13 14,023 3,129 25,098 714 97,387 29,223 8,925 20,376 10,402	0 0 0 0 0 0 0	1 1 1
3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00	OPERATION OF PLANT NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY ALLIED HEALTH-RAD TECH ADULTS & PEDIATRICS INTENSIVE CARE UNIT SUBPROVIDER - IRF OPERATING ROOM DELIVERY ROOM & LABOR ROOM RADIOLOGY-DIAGNOSTIC	7.00 13.00 14.00 15.00 23.01 30.00 31.00 41.00 50.00 52.00 54.00	13 14,023 3,129 25,098 714 97,387 29,223 8,925 20,376 10,402 16,621	0 0 0 0 0 0 0	1 1 1 1
3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00	OPERATION OF PLANT NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY ALLIED HEALTH-RAD TECH ADULTS & PEDIATRICS INTENSIVE CARE UNIT SUBPROVIDER - IRF OPERATING ROOM DELIVERY ROOM & LABOR ROOM RADIOLOGY-DIAGNOSTIC MAMMOGRAPHY	7.00 13.00 14.00 15.00 23.01 30.00 31.00 41.00 50.00 52.00 54.00 54.01	13 14,023 3,129 25,098 714 97,387 29,223 8,925 20,376 10,402 16,621 2,441	0 0 0 0 0 0 0 0	1 1 1 1 1
3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00	OPERATION OF PLANT NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY ALLIED HEALTH-RAD TECH ADULTS & PEDIATRICS INTENSIVE CARE UNIT SUBPROVIDER - IRF OPERATING ROOM DELIVERY ROOM & LABOR ROOM RADIOLOGY-DIAGNOSTIC MAMMOGRAPHY NUCLEAR MEDICINE -	7.00 13.00 14.00 15.00 23.01 30.00 31.00 41.00 50.00 52.00 54.00	13 14,023 3,129 25,098 714 97,387 29,223 8,925 20,376 10,402 16,621	0 0 0 0 0 0 0	1 1 1 1
3.00 4.00 5.00 6.00 7.00 8.00 9.00 11.00 12.00 13.00 14.00	OPERATION OF PLANT NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY ALLIED HEALTH-RAD TECH ADULTS & PEDIATRICS INTENSIVE CARE UNIT SUBPROVIDER - IRF OPERATING ROOM DELIVERY ROOM & LABOR ROOM RADIOLOGY-DIAGNOSTIC MAMMOGRAPHY NUCLEAR MEDICINE - DIAGNOSTIC	7.00 13.00 14.00 15.00 23.01 30.00 31.00 41.00 50.00 52.00 54.00 54.01 54.02	13 14,023 3,129 25,098 714 97,387 29,223 8,925 20,376 10,402 16,621 2,441 2,414	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1 1 1 1 1
3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00	OPERATION OF PLANT NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY ALLIED HEALTH-RAD TECH ADULTS & PEDIATRICS INTENSIVE CARE UNIT SUBPROVIDER - IRF OPERATING ROOM DELIVERY ROOM & LABOR ROOM RADIOLOGY-DIAGNOSTIC MAMMOGRAPHY NUCLEAR MEDICINE - DIAGNOSTIC ULTRA SOUND	7.00 13.00 14.00 15.00 23.01 30.00 31.00 41.00 50.00 52.00 54.00 54.01 54.02	13 14,023 3,129 25,098 714 97,387 29,223 8,925 20,376 10,402 16,621 2,441 2,414	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1 1 1 1 1 1
3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00	OPERATION OF PLANT NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY ALLIED HEALTH-RAD TECH ADULTS & PEDIATRICS INTENSIVE CARE UNIT SUBPROVIDER - IRF OPERATING ROOM DELIVERY ROOM & LABOR ROOM RADIOLOGY-DIAGNOSTIC MAMMOGRAPHY NUCLEAR MEDICINE - DIAGNOSTIC ULTRA SOUND RADIOLOGY-THERAPEUTIC	7.00 13.00 14.00 15.00 23.01 30.00 31.00 41.00 50.00 52.00 54.00 54.01 54.02	13 14,023 3,129 25,098 714 97,387 29,223 8,925 20,376 10,402 16,621 2,441 2,414 2,650 7,927	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1 1 1 1 1 1
3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00	OPERATION OF PLANT NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY ALLIED HEALTH-RAD TECH ADULTS & PEDIATRICS INTENSIVE CARE UNIT SUBPROVIDER - IRF OPERATING ROOM DELIVERY ROOM & LABOR ROOM RADIOLOGY-DIAGNOSTIC MAMMOGRAPHY NUCLEAR MEDICINE - DIAGNOSTIC ULTRA SOUND RADIOLOGY-THERAPEUTIC CT SCAN	7.00 13.00 14.00 15.00 23.01 30.00 31.00 41.00 50.00 52.00 54.00 54.01 54.02	13 14,023 3,129 25,098 714 97,387 29,223 8,925 20,376 10,402 16,621 2,441 2,414 2,650 7,927 5,590	000000000000000000000000000000000000000	1 1 1 1 1 1 1
3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00	OPERATION OF PLANT NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY ALLIED HEALTH-RAD TECH ADULTS & PEDIATRICS INTENSIVE CARE UNIT SUBPROVIDER - IRF OPERATING ROOM DELIVERY ROOM & LABOR ROOM RADIOLOGY-DIAGNOSTIC MAMMOGRAPHY NUCLEAR MEDICINE - DIAGNOSTIC ULTRA SOUND RADIOLOGY-THERAPEUTIC CT SCAN MAGNETIC RESONANCE IMAGING	7.00 13.00 14.00 15.00 23.01 30.00 31.00 41.00 50.00 52.00 54.00 54.01 54.02	13 14,023 3,129 25,098 714 97,387 29,223 8,925 20,376 10,402 16,621 2,441 2,414 2,650 7,927	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1 1 1 1 1 1
3.00 4.00 5.00 6.00 7.00 8.00 9.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00	OPERATION OF PLANT NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY ALLIED HEALTH-RAD TECH ADULTS & PEDIATRICS INTENSIVE CARE UNIT SUBPROVIDER - IRF OPERATING ROOM DELIVERY ROOM & LABOR ROOM RADIOLOGY-DIAGNOSTIC MAMMOGRAPHY NUCLEAR MEDICINE - DIAGNOSTIC ULTRA SOUND RADIOLOGY-THERAPEUTIC CT SCAN MAGNETIC RESONANCE IMAGING (MRI)	7.00 13.00 14.00 15.00 23.01 30.00 31.00 41.00 50.00 54.00 54.01 54.02 54.03 55.00 57.00 58.00	13 14,023 3,129 25,098 714 97,387 29,223 8,925 20,376 10,402 16,621 2,441 2,414 2,650 7,927 5,590 2,121	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1 1 1 1 1 1 1 1 1
3.00 4.00 5.00 6.00 7.00 9.00 11.00 12.00 13.00 14.00 15.00 17.00 18.00 19.00	OPERATION OF PLANT NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY ALLIED HEALTH-RAD TECH ADULTS & PEDIATRICS INTENSIVE CARE UNIT SUBPROVIDER - IRF OPERATING ROOM DELIVERY ROOM & LABOR ROOM RADIOLOGY-DIAGNOSTIC MAMMOGRAPHY NUCLEAR MEDICINE - DIAGNOSTIC ULTRA SOUND RADIOLOGY-THERAPEUTIC CT SCAN MAGNETIC RESONANCE IMAGING (MRI) CARDIAC CATHETERIZATION	7.00 13.00 14.00 15.00 23.01 30.00 31.00 41.00 50.00 52.00 54.00 54.01 54.02 54.03 55.00 57.00 58.00	13 14,023 3,129 25,098 714 97,387 29,223 8,925 20,376 10,402 16,621 2,441 2,414 2,650 7,927 5,590 2,121 6,632	000000000000000000000000000000000000000	1 1 1 1 1 1 1 1 1
3.00 4.00 5.00 6.00 7.00 8.00 9.00 11.00 12.00 13.00 14.00 15.00 17.00 18.00 19.00 20.00 21.00	OPERATION OF PLANT NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY ALLIED HEALTH-RAD TECH ADULTS & PEDIATRICS INTENSIVE CARE UNIT SUBPROVIDER - IRF OPERATING ROOM DELIVERY ROOM & LABOR ROOM RADIOLOGY-DIAGNOSTIC MAMMOGRAPHY NUCLEAR MEDICINE - DIAGNOSTIC ULTRA SOUND RADIOLOGY-THERAPEUTIC CT SCAN MAGNETIC RESONANCE IMAGING (MRI) CARDIAC CATHETERIZATION RESPIRATORY THERAPY	7.00 13.00 14.00 15.00 23.01 30.00 31.00 41.00 50.00 52.00 54.00 54.01 54.02 54.03 55.00 57.00 58.00 59.00 65.00	13 14,023 3,129 25,098 714 97,387 29,223 8,925 20,376 10,402 16,621 2,441 2,414 2,650 7,927 5,590 2,121 6,632 9,844		1 1 1 1 1 1 1 1 1 1 2 2
3.00 4.00 5.00 6.00 7.00 8.00 9.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00 22.00	OPERATION OF PLANT NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY ALLIED HEALTH-RAD TECH ADULTS & PEDIATRICS INTENSIVE CARE UNIT SUBPROVIDER - IRF OPERATING ROOM DELIVERY ROOM & LABOR ROOM RADIOLOGY-DIAGNOSTIC MAMMOGRAPHY NUCLEAR MEDICINE - DIAGNOSTIC ULTRA SOUND RADIOLOGY-THERAPEUTIC CT SCAN MAGNETIC RESONANCE IMAGING (MRI) CARDIAC CATHETERIZATION RESPIRATORY THERAPY PHYSICAL THERAPY	7.00 13.00 14.00 15.00 23.01 30.00 31.00 41.00 50.00 52.00 54.00 54.01 54.02 54.03 55.00 57.00 58.00 59.00 65.00 66.00	13 14,023 3,129 25,098 714 97,387 29,223 8,925 20,376 10,402 16,621 2,441 2,414 2,650 7,927 5,590 2,121 6,632 9,844 3,824		1 1 1 1 1 1 1 1 1 2 2 2
3.00 4.00 5.00 6.00 7.00 8.00 9.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00 22.00 23.00	OPERATION OF PLANT NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY ALLIED HEALTH-RAD TECH ADULTS & PEDIATRICS INTENSIVE CARE UNIT SUBPROVIDER - IRF OPERATING ROOM DELIVERY ROOM & LABOR ROOM RADIOLOGY-DIAGNOSTIC MAMMOGRAPHY NUCLEAR MEDICINE - DIAGNOSTIC ULTRA SOUND RADIOLOGY-THERAPEUTIC CT SCAN MAGNETIC RESONANCE IMAGING (MRI) CARDIAC CATHETERIZATION RESPIRATORY THERAPY PHYSICAL THERAPY ELECTROCARDIOLOGY	7.00 13.00 14.00 15.00 23.01 30.00 31.00 41.00 50.00 52.00 54.01 54.02 54.03 55.00 57.00 58.00 59.00 66.00 69.00	13 14,023 3,129 25,098 714 97,387 29,223 8,925 20,376 10,402 16,621 2,441 2,414 2,650 7,927 5,590 2,121 6,632 9,844 3,824 1,087		1 1 1 1 1 1 1 1 1 2 2 2 2 2
3.00 4.00 5.00 6.00 7.00 8.00 9.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 20.00 21.00 22.00 23.00 24.00	OPERATION OF PLANT NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY ALLIED HEALTH-RAD TECH ADULTS & PEDIATRICS INTENSIVE CARE UNIT SUBPROVIDER - IRF OPERATING ROOM DELIVERY ROOM & LABOR ROOM RADIOLOGY-DIAGNOSTIC MAMMOGRAPHY NUCLEAR MEDICINE - DIAGNOSTIC ULTRA SOUND RADIOLOGY-THERAPEUTIC CT SCAN MAGNETIC RESONANCE IMAGING (MRI) CARDIAC CATHETERIZATION RESPIRATORY THERAPY PHYSICAL THERAPY ELECTROCARDIOLOGY ELECTROCARDIOLOGY ELECTROCARDIOLOGY ELECTROCARDIOLOGY PHYSICAL THERAPY ELECTROCARDIOLOGY ELECTROCARDIOLOGY ELECTROCARDIOLOGY	7.00 13.00 14.00 15.00 23.01 30.00 31.00 41.00 50.00 54.01 54.02 54.03 55.00 57.00 58.00 59.00 66.00 69.00 70.00	13 14,023 3,129 25,098 714 97,387 29,223 8,925 20,376 10,402 16,621 2,441 2,414 2,650 7,927 5,590 2,121 6,632 9,844 3,824 1,087 1,855		1 1 1 1 1 1 1 1 1 2 2 2 2 2 2
3.00 4.00 5.00 6.00 7.00 8.00 9.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00 22.00 23.00 24.00 25.00	OPERATION OF PLANT NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY ALLIED HEALTH-RAD TECH ADULTS & PEDIATRICS INTENSIVE CARE UNIT SUBPROVIDER - IRF OPERATING ROOM DELIVERY ROOM & LABOR ROOM RADIOLOGY-DIAGNOSTIC MAMMOGRAPHY NUCLEAR MEDICINE - DIAGNOSTIC ULTRA SOUND RADIOLOGY-THERAPEUTIC CT SCAN MAGNETIC RESONANCE IMAGING (MRI) CARDIAC CATHETERIZATION RESPIRATORY THERAPY PHYSICAL THERAPY ELECTROCARDIOLOGY ELECTROCARDIOLOGY ELECTROCARDIOLOGY CHEMOTHERAPY CHEMOTH	7.00 13.00 14.00 15.00 23.01 30.00 31.00 41.00 50.00 52.00 54.00 54.01 54.02 54.03 55.00 57.00 58.00 66.00 66.00 69.00 70.00 76.00	13 14,023 3,129 25,098 714 97,387 29,223 8,925 20,376 10,402 16,621 2,441 2,414 2,650 7,927 5,590 2,121 6,632 9,844 3,824 1,087 1,855 5,931	000000000000000000000000000000000000000	1 1 1 1 1 1 1 1 1 2 2 2 2 2 2 2
3.00 4.00 5.00 6.00 7.00 8.00 9.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00 22.00 23.00 24.00 25.00 26.00 26.00 26.00 27.00 28.00 29.00 20	OPERATION OF PLANT NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY ALLIED HEALTH-RAD TECH ADULTS & PEDIATRICS INTENSIVE CARE UNIT SUBPROVIDER - IRF OPERATING ROOM DELIVERY ROOM & LABOR ROOM RADIOLOGY-DIAGNOSTIC MAMMOGRAPHY NUCLEAR MEDICINE - DIAGNOSTIC ULTRA SOUND RADIOLOGY-THERAPEUTIC CT SCAN MAGNETIC RESONANCE IMAGING (MRI) CARDIAC CATHETERIZATION RESPIRATORY THERAPY PHYSICAL THERAPY ELECTROCARDIOLOGY ELECTROCARDIOLOGY ELECTROCARDIOLOGY ELECTROCARDIOLOGY PHYSICAL THERAPY ELECTROCARDIOLOGY ELECTROCARDIOLOGY ELECTROCARDIOLOGY	7.00 13.00 14.00 15.00 23.01 30.00 31.00 41.00 50.00 52.00 54.00 54.01 54.02 54.03 55.00 57.00 58.00 66.00 66.00 69.00 70.00 76.00 76.00	13 14,023 3,129 25,098 714 97,387 29,223 8,925 20,376 10,402 16,621 2,441 2,414 2,650 7,927 5,590 2,121 6,632 9,844 3,824 1,087 1,855 5,931 3,352		1 1 1 1 1 1 1 1 2 2 2 2 2 2 2 2
3.00 4.00 5.00 6.00 7.00 8.00 9.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00 22.00 23.00 24.00 25.00 26.00 27.00 27.00	OPERATION OF PLANT NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY ALLIED HEALTH-RAD TECH ADULTS & PEDIATRICS INTENSIVE CARE UNIT SUBPROVIDER - IRF OPERATING ROOM DELIVERY ROOM & LABOR ROOM RADIOLOGY-DIAGNOSTIC MAMMOGRAPHY NUCLEAR MEDICINE - DIAGNOSTIC ULTRA SOUND RADIOLOGY-THERAPEUTIC CT SCAN MAGNETIC RESONANCE IMAGING (MRI) CARDIAC CATHETERIZATION RESPIRATORY THERAPY PHYSICAL THERAPY ELECTROCARDIOLOGY ELECTROCARDIOLOGY ELECTROCARDIOLOGY CHEMOTHERAPY CHEMOTH	7.00 13.00 14.00 15.00 23.01 30.00 31.00 41.00 50.00 52.00 54.00 54.01 54.02 54.03 55.00 57.00 58.00 66.00 69.00 70.00 76.00 76.01 90.01	13 14,023 3,129 25,098 714 97,387 29,223 8,925 20,376 10,402 16,621 2,441 2,414 2,650 7,927 5,590 2,121 6,632 9,844 3,824 1,087 1,855 5,931	000000000000000000000000000000000000000	1 1 1 1 1 1 1 1 2 2 2 2 2 2 2 2 2 2
3.00 4.00 5.00 6.00 7.00 8.00 9.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00 22.00 22.00 23.00 24.00 25.00 26.00 27.00	OPERATION OF PLANT NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY ALLIED HEALTH-RAD TECH ADULTS & PEDIATRICS INTENSIVE CARE UNIT SUBPROVIDER - IRF OPERATING ROOM DELIVERY ROOM & LABOR ROOM RADIOLOGY-DIAGNOSTIC MAMMOGRAPHY NUCLEAR MEDICINE - DIAGNOSTIC ULTRA SOUND RADIOLOGY-THERAPEUTIC CT SCAN MAGNETIC RESONANCE IMAGING (MRI) CARDIAC CATHETERIZATION RESPIRATORY THERAPY PHYSICAL THERAPY ELECTROCARDIOLOGY ELECTROCARDIOLOGY ELECTROENCEPHALOGRAPHY CHEMOTHERAPY WOUND CARE	7.00 13.00 14.00 15.00 23.01 30.00 31.00 41.00 50.00 52.00 54.00 54.01 54.02 54.03 55.00 57.00 58.00 66.00 66.00 69.00 70.00 76.00 76.00	13 14,023 3,129 25,098 714 97,387 29,223 8,925 20,376 10,402 16,621 2,441 2,414 2,650 7,927 5,590 2,121 6,632 9,844 3,824 1,087 1,855 5,931 3,352	000000000000000000000000000000000000000	1 1 1 1 1 1 1 1 2 2 2 2 2 2 2 2
3.00 4.00 5.00 6.00 7.00 8.00 9.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00 22.00 23.00 24.00 25.00 26.00 27.00 28.00 28.00	OPERATION OF PLANT NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY ALLIED HEALTH-RAD TECH ADULTS & PEDIATRICS INTENSIVE CARE UNIT SUBPROVIDER - IRF OPERATING ROOM DELIVERY ROOM & LABOR ROOM RADIOLOGY-DIAGNOSTIC MAMMOGRAPHY NUCLEAR MEDICINE - DIAGNOSTIC ULTRA SOUND RADIOLOGY-THERAPEUTIC CT SCAN MAGNETIC RESONANCE IMAGING (MRI) CARDIAC CATHETERIZATION RESPIRATORY THERAPY PHYSICAL THERAPY ELECTROENCEPHALOGRAPHY CHEMOTHERAPY WOUND CARE ANDERSON OUTPATIENT CENTER	7.00 13.00 14.00 15.00 23.01 30.00 31.00 41.00 50.00 52.00 54.00 54.01 54.02 54.03 55.00 57.00 58.00 66.00 69.00 70.00 76.00 76.01 90.01	13 14,023 3,129 25,098 714 97,387 29,223 8,925 20,376 10,402 16,621 2,441 2,414 2,650 7,927 5,590 2,121 6,632 9,844 3,824 1,087 1,855 5,931 3,352 9,837	000000000000000000000000000000000000000	1 1 1 1 1 1 1 1 2 2 2 2 2 2 2 2 2 2
3.00 4.00 5.00 6.00 7.00 8.00 9.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 20.00 21.00 22.00 23.00 24.00 25.00 26.00 27.00 28.00 29.00 29.00 20	OPERATION OF PLANT NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY ALLIED HEALTH-RAD TECH ADULTS & PEDIATRICS INTENSIVE CARE UNIT SUBPROVIDER - IRF OPERATING ROOM DELIVERY ROOM & LABOR ROOM RADIOLOGY-DIAGNOSTIC MAMMOGRAPHY NUCLEAR MEDICINE - DIAGNOSTIC ULTRA SOUND RADIOLOGY-THERAPEUTIC CT SCAN MAGNETIC RESONANCE IMAGING (MRI) CARDIAC CATHETERIZATION RESPIRATORY THERAPY PHYSICAL THERAPY ELECTROCARDIOLOGY ELECTROCARDIOLOGY ELECTROCNOCHEMOTHERAPY WOUND CARE ANDERSON OUTPATIENT CENTER EMERGENCY	7.00 13.00 14.00 15.00 23.01 30.00 31.00 41.00 50.00 52.00 54.00 54.01 54.02 54.03 55.00 57.00 58.00 66.00 69.00 70.00 76.01 90.01 91.00	13 14,023 3,129 25,098 714 97,387 29,223 8,925 20,376 10,402 16,621 2,441 2,414 2,650 7,927 5,590 2,121 6,632 9,844 3,824 1,087 1,855 5,931 3,352 9,837 34,117		1 1 1 1 1 1 1 1 2 2 2 2 2 2 2 2 2 2 2
3.00 4.00 5.00 6.00 7.00 8.00 9.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 22.00 22.00 23.00 24.00 25.00 26.00 27.00 28.00 29.00 29.00 20	OPERATION OF PLANT NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY ALLIED HEALTH-RAD TECH ADULTS & PEDIATRICS INTENSIVE CARE UNIT SUBPROVIDER - IRF OPERATING ROOM DELIVERY ROOM & LABOR ROOM RADIOLOGY-DIAGNOSTIC MAMMOGRAPHY NUCLEAR MEDICINE - DIAGNOSTIC ULTRA SOUND RADIOLOGY-THERAPEUTIC CT SCAN MAGNETIC RESONANCE IMAGING (MRI) CARDIAC CATHETERIZATION RESPIRATORY THERAPY PHYSICAL THERAPY ELECTROCARDIOLOGY ELECTROCARDIOLOGY ELECTROENCEPHALOGRAPHY CHEMOTHERAPY WOUND CARE ANDERSON OUTPATIENT CENTER EMERGENCY RESEARCH	7.00 13.00 14.00 15.00 23.01 30.00 31.00 41.00 50.00 52.00 54.01 54.02  54.03 55.00 57.00 58.00  69.00 70.00 76.00 76.01 90.01 91.00	13 14,023 3,129 25,098 714 97,387 29,223 8,925 20,376 10,402 16,621 2,441 2,414 2,650 7,927 5,590 2,121 6,632 9,844 3,824 1,087 1,855 5,931 3,352 9,837 34,117 690		1 1 1 1 1 1 1 1 1 2 2 2 2 2 2 2 2 2 2 2
3.00 4.00 5.00 6.00 7.00 8.00 9.00 11.00 12.00 13.00 15.00 16.00 17.00 18.00 19.00 21.00 22.00 24.00 23.00 24.00 25.00 26.00 27.00 28.00 29.00 30.00 31.00	OPERATION OF PLANT NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY ALLIED HEALTH-RAD TECH ADULTS & PEDIATRICS INTENSIVE CARE UNIT SUBPROVIDER - IRF OPERATING ROOM DELIVERY ROOM & LABOR ROOM RADIOLOGY-DIAGNOSTIC MAMMOGRAPHY NUCLEAR MEDICINE - DIAGNOSTIC ULTRA SOUND RADIOLOGY-THERAPEUTIC CT SCAN MAGNETIC RESONANCE IMAGING (MRI) CARDIAC CATHETERIZATION RESPIRATORY THERAPY PHYSICAL THERAPY ELECTROCARDIOLOGY ELECTROCARDIOLOGY ELECTROENCEPHALOGRAPHY CHEMOTHERAPY WOUND CARE ANDERSON OUTPATIENT CENTER EMERGENCY RESEARCH PHYSICIANS' PRIVATE OFFICES PSS ADMINISTRATION	7.00 13.00 14.00 15.00 23.01 30.00 31.00 41.00 50.00 52.00 54.00 54.01 54.02 54.03 55.00 57.00 58.00 66.00 69.00 70.00 76.00 76.01 90.01 91.00 191.00 192.00	13 14,023 3,129 25,098 714 97,387 29,223 8,925 20,376 10,402 16,621 2,441 2,414 2,650 7,927 5,590 2,121 6,632 9,844 3,824 1,087 1,855 5,931 3,352 9,837 34,117 690 13,185		1 1 1 1 1 1 1 1 1 2 2 2 2 2 2 2 2 2 2 2
3.00 4.00 5.00 6.00 7.00 8.00 9.00 11.00 12.00 13.00 14.00	OPERATION OF PLANT NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY ALLIED HEALTH-RAD TECH ADULTS & PEDIATRICS INTENSIVE CARE UNIT SUBPROVIDER - IRF OPERATING ROOM DELIVERY ROOM & LABOR ROOM RADIOLOGY-DIAGNOSTIC MAMMOGRAPHY NUCLEAR MEDICINE - DIAGNOSTIC ULTRA SOUND RADIOLOGY-THERAPEUTIC CT SCAN MAGNETIC RESONANCE IMAGING (MRI) CARDIAC CATHETERIZATION RESPIRATORY THERAPY PHYSICAL THERAPY ELECTROCARDIOLOGY ELECTROCARDIOLOGY ELECTROCARDIOLOGY ELECTROCARDIOLOGY ELECTROCARDIOLOGY ELECTROENCEPHALOGRAPHY CHEMOTHERAPY WOUND CARE ANDERSON OUTPATIENT CENTER EMERGENCY RESEARCH PHYSICIANS' PRIVATE OFFICES	7.00 13.00 14.00 15.00 23.01 30.00 31.00 41.00 50.00 52.00 54.01 54.02 54.03 55.00 57.00 66.00 66.00 69.00 70.00 76.01 90.01 91.00 192.00	13 14,023 3,129 25,098 714 97,387 29,223 8,925 20,376 10,402 16,621 2,441 2,414 2,650 7,927 5,590 2,121 6,632 9,844 3,824 1,087 1,855 5,931 3,352 9,837 34,117 690 13,185		1 1 1 1 1 1 1 1 1 2 2 2 2 2 2 2 2 2 2 2

Health Financial Systems

ASCENSION ST. VINCENT ANDERSON

In Lieu of Form CMS-2552-10

RECLASSIFICATIONS Provider CCN: 15-0088

Period: From 07/01/2022 To 06/30/2023 Date/Time Prepared:

					11/22/2023 10:37 am
		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
35.00	ADOLESCENT RESIDENTIAL	194.12	5,675	0	35.00
	SERVICES	↓	+		
	TOTALS		365,010	0	
	Z - PTO CASH OUT				
1.00	ADMINISTRATIVE & GENERAL	5.00	3,108	0	1.00
2.00	NURSING ADMINISTRATION	13.00	4,815	0	2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	2,705	0	3.00
4.00	PHARMACY	15.00	28,911	0	4.00
5.00	ADULTS & PEDIATRICS	30.00	57,834	0	5.00
6.00	INTENSIVE CARE UNIT	31.00	22,401	0	6.00
7.00	SUBPROVIDER - IRF	41.00	15,914	0	7.00
8.00	OPERATING ROOM	50.00	677	0	8.00
9.00	DELIVERY ROOM & LABOR ROOM	52.00	58	0	9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	3,994	0	10.00
11.00	RADIOLOGY-THERAPEUTIC	55.00	5	0	11.00
12.00	MAGNETIC RESONANCE IMAGING	58.00	7,121	О	12.00
	(MRI)				
13.00	CARDIAC CATHETERIZATION	59.00	3,257	0	13.00
14.00	RESPIRATORY THERAPY	65.00	1,889	0	14.00
15.00	PHYSICAL THERAPY	66.00	108,627	0	15.00
16.00	CHEMOTHERAPY	76.00	212	0	16.00
17.00	WOUND CARE	76.01	104	0	17.00
18.00	ANDERSON OUTPATIENT CENTER	90.01	24	0	18.00
19.00	EMERGENCY	91.00	24,040	0	19.00
20.00	PHYSICIANS' PRIVATE OFFICES	192.00	1,572	0	20.00
21.00	HEALTHY FAMILIES	194.05	2,652	0	21.00
22.00	ADOLESCENT RESIDENTIAL	194.12	3,618	0	22.00
	SERVICES				
	TOTALS		293,538	0	
500.00	Grand Total: Increases		1,902,568	3,633,025	500.00

RECLASSIFICATIONS

Provider CCN: 15-0088

						00/30/2023	11/22/2023 10:37 a
	Cost Conton	Decreases	Calamy	0+600	wks+ 4 7 pof		
	Cost Center 6.00	Line # 7.00	Salary 8.00	Other 9.00	Wkst. A-7 Ref. 10.00		
	C - INTEREST EXPENSE	7.00	0.00	3.00	10100		
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	4,260	11		1.0
	TOTALS		0	4,260			
1.00	<pre>D - CAFETERIA/DIETARY RECLASS DIETARY</pre>	10.00	0	1,949,739	0		1.0
1.00	TOTALS			$\frac{1,949,739}{1,949,739}$			1.0
	E - LABOR DELIVERY RECLASS	L		2,5.5,755	L		
1.00	DELIVERY ROOM & LABOR ROOM	52.00	455,136	118,492			1.0
2.00		0.00	0	0			2.0
	TOTALS		455,136	118,492			
1.00	H - PT_OT_ST RECLASS PHYSICAL THERAPY	66.00	177,928	1,529,159	0		1.0
2.00	THISTORE THERWIT	0.00	0	0	Ö		2.0
	TOTALS		177,928	1,529,159			
	J - ADOLESCENT RESIDENTIAL SE						
1.00	ADULTS & PEDIATRICS TOTALS	30.00	0	$-\frac{22,712}{22,712}$	0		1.0
	M - RAD TECH RECLASS		U	22,712			
1.00	RADIOLOGY-DIAGNOSTIC	54.00	23,805	0	0		1.0
	TOTALS		23,805				
	O - SYSTEM PROJECTS						
1.00 2.00	ADMINISTRATIVE & GENERAL	5.00 0.00	537,055	0	0		1.0
3.00		0.00	0	0	0		3.0
4.00		0.00	ő	0	Ö		4.0
5.00		0.00	0	0	0		5.0
6.00		0.00	0	0	0		6.0
7.00 8.00		0.00	0	0	0		7.0
8.00	TOTALS	0.00	537,055	$ \frac{0}{0}$	<u> </u>		8.0
	Q - PHYSICIAN RECLASS		337,033	- U			
1.00	ADMINISTRATIVE & GENERAL	5.00	0	8,663			1.0
	TOTALS		0	8,663			
1.00	W - ACCRUED PTO EMPLOYEE BENEFITS DEPARTMENT	4.00	0	50,096	0		1.0
1.00	TOTALS			50,096			1.0
	X - STARP			,			
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	365,010	0	0		1.0
2.00		0.00	0	0	0		2.0
3.00 4.00		0.00	0	0	0		3.0
5.00		0.00	ő	ő	Ö		5.0
6.00		0.00	0	0	0		6.0
7.00		0.00	0	0	0		7.0
8.00		0.00	0	0	0		8.0
9.00 10.00		0.00	0	0	0		10.0
11.00		0.00	ő	ő	- 1		11.0
12.00		0.00	0	0	0		12.0
13.00		0.00	0	0	0		13.0
14.00 15.00		0.00	0	0	0		14.0 15.0
16.00		0.00	0	0	0		16.0
17.00		0.00	ŏ	0	o o		17.0
18.00		0.00	0	0	0		18.0
19.00		0.00	0	0	0		19.0
20.00 21.00		0.00	o	0	0		20.0
22.00		0.00 0.00	0	0	0		22.0
23.00		0.00	0	0	Ö		23.0
24.00		0.00	0	0	0		24.0
25.00		0.00	0	0	0		25.0
26.00		0.00	0 0	0	0		26.0
27.00 28.00		0.00	0	0	0		27.0 28.0
29.00		0.00	ő	0	Ö		29.0
30.00		0.00	0	0	0		30.0
31.00		0.00	0	0	0		31.0
32.00		0.00	0	0	0		32.0
33.00 34.00		0.00	0	0	0		33.0 34.0
35.00		0.00	0	0	0		35.0
	TOTALS		365,010	<del>0</del>			33.0
		·	·		,		•

Health Financial Systems

ASCENSION ST. VINCENT ANDERSON

In Lieu of Form CMS-2552-10

RECLASSIFICATIONS

Provider CCN: 15-0088

						11/22/2023 10:3/ am
		Decreases				
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	Z - PTO CASH OUT				_	
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	293,538	(	0	1.00
2.00		0.00	0	(	0	2.00
3.00		0.00	0	(	0	3.00
4.00		0.00	0	(	0	4.00
5.00		0.00	0	(	0	5.00
6.00		0.00	0	(	0	6.00
7.00		0.00	0	(	0	7.00
8.00		0.00	0	(	0	8.00
9.00		0.00	0	(	0	9.00
10.00		0.00	0	(	0	10.00
11.00		0.00	0	(	0	11.00
12.00		0.00	0	(	0	12.00
13.00		0.00	0	(	0	13.00
14.00		0.00	0	(	0	14.00
15.00		0.00	0	(	0	15.00
16.00		0.00	0	(	0	16.00
17.00		0.00	0	(	0	17.00
18.00		0.00	0	(	0	18.00
19.00		0.00	0	(	0	19.00
20.00		0.00	0	(	0	20.00
21.00		0.00	0	(	0	21.00
22.00		0.00	0	(	0	22.00
	TOTALS		293,538			
500.00	Grand Total: Decreases		1,852,472	3,683,121	1	500.00

Health Financial Systems ASCENSION ST. VINCENT ANDERSON

In Lieu of Form CMS-2552-10

| Period: | Worksheet A-7 |
| From 07/01/2022 | Part I |
| To 06/30/2023 | Date/Time Prepared: | RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 15-0088

					10 06/30/2023	11/22/2023 10	
			·	Acquisitions			
		Beginning	Purchases	Donation	Total	Disposals and	
		Balances				Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	5,292,602	0		0	0	1.00
2.00	Land Improvements	2,926,143	42,581		0 42,581	l .	2.00
3.00	Buildings and Fixtures	69,925,350	1,002,034		0 1,002,034	0	3.00
4.00	Building Improvements	0	0		0	0	4.00
5.00	Fixed Equipment	41,558,039	1,866,756		0 1,866,756		5.00
6.00	Movable Equipment	62,371,330	6,322,362		0 6,322,362	9,720,638	
7.00	HIT designated Assets	0	0		0	0	7.00
8.00	Subtotal (sum of lines 1-7)	182,073,464	9,233,733		0 9,233,733	9,720,638	8.00
9.00	Reconciling Items	0	0		0	0	9.00
10.00	Total (line 8 minus line 9)	182,073,464	9,233,733		0 9,233,733	9,720,638	10.00
		Ending Balance	Fully				
			Depreciated				
			Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	5,292,602	0				1.00
2.00	Land Improvements	2,968,724	0				2.00
3.00	Buildings and Fixtures	70,927,384	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	43,424,795	0				5.00
6.00	Movable Equipment	58,973,054	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	181,586,559	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	181,586,559	0				10.00

Health Financial Systems	ASCENSION ST. VINCE	ENT ANDERSON	In Lie	u of Form CMS-2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider CCN: 15-0088	From 07/01/2022	Worksheet A-7 Part II Date/Time Prepared:

				Т	o 06/30/2023	Date/Time Pre 11/22/2023 10	
			SU	MMARY OF CAPIT	ΓAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	4,807,153	0	606,074	0	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT-MAB	0	0	0	0	0	1.01
3.00	Total (sum of lines 1-2)	4,807,153	0	606,074	0	0	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
		Capital-Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	5,413,227				1.00
1.01	CAP REL COSTS-BLDG & FIXT-MAB	0	0				1.01
3.00	Total (sum of lines 1-2)	0	5,413,227				3.00

Healtl	n Financial Systems AS	SCENSION ST. VI	NCENT ANDERSON	I	In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 07/01/2022 To 06/30/2023		
						11/22/2023 10	
		COMI	PUTATION OF RA	TIOS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capitalized	Gross Assets	Ratio (see	Insurance	
			Leases	for Ratio	instructions)		
				(col. 1 - col			
				2)			
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE		1				
1.00	CAP REL COSTS-BLDG & FIXT	181,586,559	0	181,586,55		0	1.00
1.01	CAP REL COSTS-BLDG & FIXT-MAB	0			0.000000		1.01
3.00	Total (sum of lines 1-2)	181,586,559		181,586,55			3.00
		ALLOCA	TION OF OTHER (	CAPITAL	SUMMARY O	F CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capital-Relate				
			d Costs	through 7)			
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	NTERS	,	,			
1.00	CAP REL COSTS-BLDG & FIXT	0	0	1	0 4,807,153	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT-MAB	0	0	1	0	0	1.01
3.00	Total (sum of lines 1-2)	0	0		0 4,807,153	0	3.00
			SI	JMMARY OF CAPI	TAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
			instructions)	instructions)	Capital-Relate	of cols. 9	
					d Costs (see	through 14)	
					instructions)		
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE						
1.00	CAP REL COSTS-BLDG & FIXT	76,226	0	1	0	4,883,379	1.00
1.01	CAP REL COSTS-BLDG & FIXT-MAB	0	0	1	0	0	1.01
3.00	Total (sum of lines 1-2)	76,226	i c	1	0 0	4,883,379	3.00

					To 06/30/2023	Date/Time Pre	pared:
				Expense Classification of Co/From Which the Amount is		11/22/2023 10	:3/ am
				O/FIOII WITTEN THE AMOUNT IS	to be Aujusteu		
	Cost Center Description	Basis/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Line # 4.00	Wkst. A-7 Ref. 5.00	
1.00	Investment income - CAP REL	В		CAP REL COSTS-BLDG & FIXT	1.00		1.00
1 01	COSTS-BLDG & FIXT (chapter 2)		0.5	AP REL COSTS-BLDG &	1 01	0	1 01
1.01	<pre>Investment income - CAP REL COSTS-BLDG &amp; FIXT-MAB (chapter 2)</pre>			IXT-MAB	1.01	0	1.01
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0 *	** Cost Center Deleted ***	2.00	0	2.00
3.00	Investment income - other (chapter 2)	В	-84,212 A	DMINISTRATIVE & GENERAL	5.00	11	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter	A	-15,644 A	DMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	21)   Television and radio service   (chapter 21)	A	-6,731	PERATION OF PLANT	7.00	0	8.00
9.00 10.00	Parking lot (chapter 21) Provider-based physician adjustment	A-8-2	0 -2,944,166		0.00	0	9.00 10.00
11.00	Sale of scrap, waste, etc.		0		0.00	0	11.00
12.00	(chapter 23) Related organization transactions (chapter 10)	A-8-1	2,875,755			0	12.00
	Laundry and linen service		0 -370,438	TETADY	0.00	l	
14.00 15.00	Rental of quarters to employee		-370,436	DIETAKY	10.00 0.00	l	
16.00	supplies to other than		0		0.00	0	16.00
17.00	patients Sale of drugs to other than	В	-28 F	PHARMACY	15.00	0	17.00
18.00	patients Sale of medical records and	В	-140 A	DMINISTRATIVE & GENERAL	5.00	0	18.00
19.00	abstracts Nursing and allied health education (tuition, fees,		0		0.00	0	19.00
20.00	books, etc.)	_	20 425		40.00		20.00
20.00 21.00	Vending machines Income from imposition of	В	-38,435 D	DIETARY	10.00	l	
	interest, finance or penalty charges (chapter 21)						
22.00	overpayments and borrowings to		0		0.00	0	22.00
23.00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	OR	ESPIRATORY THERAPY	65.00		23.00
24.00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	0 F	PHYSICAL THERAPY	66.00		24.00
25.00	limitation (chapter 14) Utilization review -		0 *	** Cost Center Deleted ***	114.00		25.00
26.00	physicians' compensation (chapter 21) Depreciation - CAP REL		0 0	AP REL COSTS-BLDG & FIXT	1.00	0	26.00
	COSTS-BLDG & FIXT Depreciation - CAP REL		0 0	AP REL COSTS-BLDG &	1.01		
	COSTS-BLDG & FIXT-MAB Depreciation - CAP REL			TIXT-MAB ** Cost Center Deleted ***	2.00	0	27.00
28.00	COSTS-MVBLE EQUIP			** Cost Center Deleted ***			28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0 0	CCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	DULTS & PEDIATRICS	30.00		30.99
		· ·	·				

Period: From 07/01/2022

Cost Center Description    Cost Center Description   Basis/Code (2)   Amount   Cost Center   Line #   Wkst. A-7	ef.	:37 am
Cost Center Description  Basis/Code (2) Amount Cost Center Line # Wkst. A-7  1.00 2.00 3.00 4.00 5.00  Adjustment for speech pathology costs in excess of limitation (chapter 14) CAH HIT Adjustment for Depreciation and Interest  33.00 LEASE INCOME  To/From Which the Amount is to be Adjusted  Amount Cost Center Line # Wkst. A-7  0 SPEECH PATHOLOGY 68.00  0 0.00 0.00 0.00 0.00 0.00 0.00 0.	0	
1.00 2.00 3.00 4.00 5.00  31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)  32.00 CAH HIT Adjustment for Depreciation and Interest  33.00 LEASE INCOME B -348,222 OPERATION OF PLANT 7.00	0	
1.00 2.00 3.00 4.00 5.00  31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)  32.00 CAH HIT Adjustment for Depreciation and Interest  33.00 LEASE INCOME B -348,222 OPERATION OF PLANT 7.00	0	
1.00 2.00 3.00 4.00 5.00  31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)  32.00 CAH HIT Adjustment for Depreciation and Interest  33.00 LEASE INCOME B -348,222 OPERATION OF PLANT 7.00	0	
1.00 2.00 3.00 4.00 5.00  31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)  32.00 CAH HIT Adjustment for Depreciation and Interest  33.00 LEASE INCOME B -348,222 OPERATION OF PLANT 7.00	0	
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for Depreciation and Interest 33.00 LEASE INCOME B -348,222 OPERATION OF PLANT 7.00		
pathology costs in excess of limitation (chapter 14)  32.00 CAH HIT Adjustment for Depreciation and Interest  33.00 LEASE INCOME  B -348,222 OPERATION OF PLANT  7.00		
limitation (chapter 14) 32.00 CAH HIT Adjustment for Depreciation and Interest 33.00 LEASE INCOME  B -348,222 OPERATION OF PLANT 7.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest B -348,222 OPERATION OF PLANT 7.00		
33.00 LEASE INCOME B -348,222 OPERATION OF PLANT 7.00		32.00
33.01 AMBULANCE COST B -1,437 AMBULANCE SERVICES 95.00	0	33.00 33.01
33.02 SALE OF MEDICAL RECORDS  B -88 MEDICAL RECORDS & LIBRARY 16.00	0	
33.03 PHYSICIAN FUND EXPENSE A -6,102,184 ADMINISTRATIVE & GENERAL 5.00	0	33.03
33.04 PHYSICIAN FUND EXPENSE A -1,047,854 EMPLOYEE BENEFITS DEPARTMENT 4.00	0	33.04
33.05 SALE OF MEDICAL RECORDS B -1,983 RADIOLOGY-DIAGNOSTIC 54.00	0	
33.06 PATIENT INTEREST INCOME  B -2,296 ADMINISTRATIVE & GENERAL 5.00  33.07 LATE PENALTY FEE  B 117 ADMINISTRATIVE & GENERAL 5.00	0	33.06 33.07
33.08 LATE PENALTY FEE B -4,061 OPERATION OF PLANT 7.00	0	33.07
33.09 VB PHYSICIAN REVENUE B -590 ADMINISTRATIVE & GENERAL 5.00	0	
33.10 TELEPHONE REVENUE B 1,088 ADMINISTRATIVE & GENERAL 5.00	0	33.10
33.11 OTHER MISCELLANEOUS REVENUE B -190 ADMINISTRATIVE & GENERAL 5.00	0	33.11
33.12 OTHER MISCELLANEOUS REVENUE B -3,200 PHARMACY 15.00 33.13 OTHER MISCELLANEOUS REVENUE B -150 RADIOLOGY-DIAGNOSTIC 54.00	0	33.12 33.13
33.14 OTHER MISCELLANEOUS REVENUE B -6,300 MAGNETIC RESONANCE IMAGING 58.00	9	33.14
(MRI)		
33.15 OTHER MISCELLANEOUS REVENUE B -3,060 RESPIRATORY THERAPY 65.00	0	
33.16 OTHER MISCELLANEOUS REVENUE B -10,346 PHYSICAL THERAPY 66.00 0.00	0	33.16 33.17
33.17 OTHER ADJUSTMENTS (SPECIFY) 0 0.00	U	33.17
33.18 ENTERTAINMENT A -24,988 ADMINISTRATIVE & GENERAL 5.00	0	33.18
33.19 ENTERTAINMENT A -79 OPERATION OF PLANT 7.00	0	
33.20 ENTERTAINMENT A -328 NURSING ADMINISTRATION 13.00	0	33.20
36.00 ENTERTAINMENT A -368 ADULTS & PEDIATRICS 30.00 36.01 ENTERTAINMENT A -258 RADIOLOGY-DIAGNOSTIC 54.00	0	36.00 36.01
36.02 ENTERTAINMENT A -342 CHEMOTHERAPY 76.00	0	36.02
36.03 ENTERTAINMENT A -568 ANDERSON OUTPATIENT CENTER 90.01	0	36.03
36.04 ENTERTAINMENT A -245 EMERGENCY 91.00	0	36.04
36.05 GAIN/LOSS ON DISPOSAL PPE B -13 DELIVERY ROOM & LABOR ROOM 52.00 Section 55.00 ACCORDANCE SECTION 59.00	0	36.05 36.06
36.06 GAIN/LOSS ON DISPOSAL PPE B -213 CARDIAC CATHETERIZATION 59.00 Sq. 07 TUITION REVENUE B -26,774 ALLIED HEALTH-RAD TECH 23.01	0	
36.08 TUITION REVENUE B -2,140 ULTRA SOUND 54.03	0	36.08
36.09 MEDICAL STAFF DUES B -100 ADMINISTRATIVE & GENERAL 5.00	0	
36.10 OTHER ADJUSTMENTS (SPECIFY) B 0 0.00	0	36.10
36.11 OTHER ADJUSTMENTS (SPECIFY) B 0.00	0	36.11
36.12 OTHER ADJUSTMENTS (SPECIFY) 0 0.00	0	36.12
(3) 0.00	U	30.12
36.13 OTHER ADJUSTMENTS (SPECIFY) 0 0.00	0	36.13
(3) 36.14 EQUIPMENT RENTAL B -6,262 OPERATING ROOM 50.00	0	36.14
36.15 CONTRACT SERVICE REVENUE B -31,441 ANDERSON OUTPATIENT CENTER 90.01	0	36.15
36.16 CHARITABLE CONTRIBUTIONS A -34,259 NURSING ADMINISTRATION 13.00	0	
36.17 CHARITABLE CONTRIBUTION A -13,463 ADMINISTRATIVE & GENERAL 5.00 36.18 CORPORATE SPONSORSHIPS A -28,125 ADMINISTRATIVE & GENERAL 5.00	0	36.17 36.18
36.19 COMMUNITY BENEFITS A -1,260 ADMINISTRATIVE & GENERAL 5.00	0	36.19
36.20 OTHER ADJUSTMENTS (SPECIFY) 0 0.00	0	
30 31 (3)	_	26 21
36.21 STATE PROGRAM REVENUE B 0 0.00 36.22 BILLING ARRANGEMENTS B -15,540 ADMINISTRATIVE & GENERAL 5.00	0	
36.23 OTHER ADJUSTMENTS (SPECIFY)  0  0 0.00	0	
(3)		
36.24 LOBBYING EXPENSE A -2,625 ADMINISTRATIVE & GENERAL 5.00	0	
36.25 BILLING ARRANGEMENTS B -600 OPERATING ROOM 50.00 36.26 PROMOTIONAL ITEMS A -8,524 ADMINISTRATIVE & GENERAL 5.00	9	36.25 36.26
36.27 PROMOTIONAL ITEMS  A -8,324 ADMINISTRATIVE & GENERAL 5.00  36.27 PROMOTIONAL ITEMS  A -2,140 DELIVERY ROOM & LABOR ROOM 52.00	0	1
36.28 OTHER ADJUSTMENTS (SPECIFY) 0 0.00	0	1
36 20 20 20 20 20 20 20 20 20 20 20 20 20	_	26.22
36.29 PROMOTIONAL ITEMS A -1,259 RESPIRATORY THERAPY 65.00 36.30 PROMOTIONAL ITEMS A -495 ELECTROCARDIOLOGY 69.00	0	36.29 36.30
36.31 PROVIDER TAX  A -13,278,614 ADMINISTRATIVE & GENERAL 5.00	0	
36.32 MARKETING EXPENSE A -5,090 ADMINISTRATIVE & GENERAL 5.00	0	36.32
36.33 MARKETING EXPENSE A -381 ADULTS & PEDIATRICS 30.00	0	
36.34 MARKETING EXPENSE A -324 RESPIRATORY THERAPY 65.00	0	36.34

Health	Financial Systems	AS	CENSION ST. VI	NCENT ANDERSON	In Lie	u of Form CMS-2	2552-10
ADJUST	MENTS TO EXPENSES			Provider CCN: 15-0088	Period:	Worksheet A-8	
					From 07/01/2022 To 06/30/2023		
				Expense Classification of	on Worksheet A		
				To/From Which the Amount i	s to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
36.35	BILLING ARRANGEMENTS	В	-18,441	PHARMACY	15.00	0	36.35
36.36	BILLING ARRANGEMENTS	В	-18,000	ANDERSON OUTPATIENT CENTER	90.01	0	36.36
50.00	TOTAL (sum of lines 1 thru 49)		-22,159,916				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.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME

Provider CCN: 15-0088

Worksheet A-8-1 From 07/01/2022

OFFICE COSTS 06/30/2023 Date/Time Prepared: 11/22/2023 10:37 am Line No. Cost Center Expense Items Amount of Amount Allowable Cost Included in Wks. A, column 3.00 5.00 1.00 2.00 4.00 A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS: HOME OFFICE - CAPITAL HOME OFFICE - INTEREST - CA 1.00 5.00 ADMINISTRATIVE & GENERAL 2,135,369 1.00 2.00 5.00 ADMINISTRATIVE & GENERAL 79,296 0 2.00 3.00 5.00 ADMINISTRATIVE & GENERAL HOME OFFICE - A&G 656 3.00 4.00 5.00 ADMINISTRATIVE & GENERAL HOME OFFICE - OTHER 25,579,265 24,845,688 4.00 4.01 8.00 LAUNDRY & LINEN SERVICE SVH CHARGEBACK -16,348 -16,348 4.01 5.00 ADMINISTRATIVE & GENERAL -33,504 4.02 SVH CHARGERACK -33,504 4.02 4.03 15.00 PHARMACY SVH CHARGEBACK -8,000 -8,000 4.03 4.04 23.01 ALLIED HEALTH-RAD TECH SVH CHARGEBACK 28,370 28,370 4.04 4.05 50.00 OPERATING ROOM SVH CHARGEBACK 490,000 490,000 4.05 54.00 RADIOLOGY-DIAGNOSTIC 4.06 SVH CHARGEBACK 20,675 20.675 4.06 4.07 55.00 RADIOLOGY-THERAPEUTIC SVH CHARGEBACK 8,970 8,970 4.07 4.08 59.00 CARDIAC CATHETERIZATION SVH CHARGEBACK 90,000 90,000 4.08 91.00 EMERGENCY 4.09 52.550 52.500 4.09 SVH CHARGERACK 4.10 1.00 CAP REL COSTS-BLDG & FIXT INTEREST EXPENSE 521,862 525,588 4.10 5.00 ADMINISTRATIVE & GENERAL 4.11 INTEREST EXPENSE 4,260 4.11 7,176,195 4.12 4.00 EMPLOYEE BENEFITS DEPARTMENT HEALTH INSURANCE 6,269,584 4.12 -610,317 4.13 14.00 CENTRAL SERVICES & SUPPLY TRG ADMIN FEES - SUPPLIES 0 4.13 4.14 13.00 NURSING ADMINISTRATION TRG ADMIN FEES - CONTRACTED -133,606 0 4.14 TRG ADMIN FEES - OTHER 4.15 5.00 ADMINISTRATIVE & GENERAL -236,415 4.15 0.00 0 4.16 4.16 0 0 4.17 0.00 0 4.17 0.00 4.18 4.18 0 4.19 0.00 0 4.19 0 4.20 0.00 0 4.20 0 0 4.21 0.00 4.21 4.22 0.00 0 0 4.22 4.23 0.00 0 4.23 0 0 4.24 0.00 4.24 4.25 0.00 0 4.25 TOTALS (sum of lines 1-4). 35,149,278 5.00 32,273,523 5.00 Transfer column 6, line 5 to worksheet A-8, column 2,

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

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

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

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

To this wife of the Avenue of						
6.00	G	ST VINCENT HEAL	100.00	ST VINCENT HEAL	100.00	6.00
7.00	G	ASCENSION HEALT	100.00	ASCENSION HEALT	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	FINANCIAL				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
- 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.

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.

4.17

4.18

4.19

4.20

4.21

4.22

4.23

4.24

4.25

5.00

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

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

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

6.00	HOME OFFICE	6.00
7.00	SYSTEM OFFICE	7.00
8.00		8.00
9.00		9.00
9.00 10.00		10.00
100.00		100.00

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related 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.

4.17

4.18

4.19

4.20

4.21

4.22

4.23

4.24

4.25

5.00

0

0

0

0

0

0

0

0

2,875,755

0

0

0

0

0

0

Provider CCN: 15-0088 Period: Worksheet A-8-2 From 07/01/2022 To 06/30/2023 Date/Time Prepared:

						10 06/30/2023	11/22/2023 10	epared: ):37 am
	Wkst. A Line #	Cost Center/Physician	Total	Professional	Provider	RCE Amount	Physician/Prov	
		Identifier	Remuneration	Component	Component		ider Component	
					· ·		Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	31.00	INTENSIVE CARE UNIT	376,860	376,860	0	197,500	0	1.00
2.00	50.00	OPERATING ROOM	1,566,317	1,201,317	365,000	246,400	8,040	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	348,525	58,467	290,058	271,900	8,760	3.00
4.00	70.00	ELECTROENCEPHALOGRAPHY	316,826	316,826	0	179,000	0	4.00
5.00	76.01	WOUND CARE	20,000	20,000	0	179,000	0	5.00
6.00	91.00	EMERGENCY	970,696	970,696	0	179,000	0	6.00
7.00	0.00		0	, o	0	ĺ , o	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			3,599,224	2,944,166	655,058	_	16.800	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provider	Physician Cost	
		Identifier		Unadjusted RCE	Memberships &	Component	of Malpractice	
				Limit	Continuing	Share of col.	Insurance	
					Education	12		
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00		INTENSIVE CARE UNIT	0	_		ľ	1	
2.00	•	OPERATING ROOM	952,431			0	0	
3.00	1	RADIOLOGY-DIAGNOSTIC	1,145,117	57,256	0	0	0	3.00
4.00	•	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	
5.00		WOUND CARE	0	0	0	0	0	5.00
6.00		EMERGENCY	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	3.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,097,548			0	0	200.00
	Wkst. A Line #		Provider	Adjusted RCE	RCE	Adjustment		
		Identifier	Component	Limit	Disallowance			
			Share of col.					
	1.00	2.00	14 15.00	16.00	17.00	18.00	-	
1.00		INTENSIVE CARE UNIT	13.00					1.00
2.00		OPERATING ROOM	0	952,431	_	1,201,317		2.00
3.00		RADIOLOGY-DIAGNOSTIC	0	1,145,117	0	58,467		3.00
4.00	•	ELECTROENCEPHALOGRAPHY		1,143,117	0	316,826		4.00
5.00		WOUND CARE		0	0	20,000		5.00
6.00		EMERGENCY	0	١	0	970,696		6.00
7.00	0.00		0	١	0	] 3,0,000		7.00
8.00	0.00		0	ا م	0	ا م		8.00
9.00	0.00		0	ا م	0	ا م		9.00
10.00	0.00		0	ا	0	ا		10.00
200.00			0	2,097,548	0	2,944,166		200.00
	•	•	•				•	•

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0088 | Period: From 07/01/2022 | Part I Date/Time Prepared:

					To 06/30/2023	Date/Time Pre 11/22/2023 10	
			CAPITAL REL	ATED COSTS		111/22/2023 10	. 37 &
	Cost Center Description	Net Expenses	BLDG & FIXT	BLDG &	EMPLOYEE	Subtotal	
	cost center bescription	for Cost	BLDG & FIXT	FIXT-MAB	BENEFITS	Subcocar	
		Allocation			DEPARTMENT		
		(from Wkst A col. 7)					
		0	1.00	1.01	4.00	4A	
4 00	GENERAL SERVICE COST CENTERS	4 000 0=0	4 000 070				1 00
$1.00 \\ 1.01$	00100 CAP REL COSTS-BLDG & FIXT 00101 CAP REL COSTS-BLDG & FIXT-MAB	4,883,379	4,883,379		0		1.00 1.01
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	8,323,927	64,131		0 8,388,058		4.00
5.00	00500 ADMINISTRATIVE & GENERAL	37,677,082	537,190		0 289,584	38,503,856	5.00
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	5,228,964 330,967	577,286 6,949		0 298	5,806,548 337,916	7.00 8.00
9.00	00900 HOUSEKEEPING	2,847,481	103,316		0 0	2,950,797	
10.00	01000 DIETARY	657,087	101,887		0 0	758,974	10.00
11.00	01100 CAFETERIA	1,949,739	186,357		0 0	2,136,096	
13.00 14.00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	2,686,841 10,481	50,576 164,238		0 336,296 0 70,232		
15.00	01500 PHARMACY	3,689,978	49,903		0 564,629		1
16.00	01600 MEDICAL RECORDS & LIBRARY	34	53,993		0	54,027	
23.00 23.01	02300 ALLIED HEALTH-EMS 02301 ALLIED HEALTH-RAD TECH	0 118,592	0 1,139		0 0 20,350	0 140,081	23.00
23.01	INPATIENT ROUTINE SERVICE COST CENTERS	110,392	1,139		20,330	140,081	23.01
30.00	03000 ADULTS & PEDIATRICS	15,183,964	696,552		0 2,229,592		1
31.00 41.00	03100 INTENSIVE CARE UNIT 04100 SUBPROVIDER - IRF	4,754,447	151,811 103,555		0 662,863 0 225,291		
	04300 NURSERY	1,495,157 217,112	57,670		0 223,291		
	ANCILLARY SERVICE COST CENTERS		J., J.				
50.00	05000 OPERATING ROOM	10,792,254	497,031		0 454,218		1
52.00 53.00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	1,011,732	219,028 0		0 148,196 0 0	1,378,956	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	3,008,873	147,855		0 369,812	3,526,540	1
54.01	03440 MAMMOGRAPHY	739,344	0		0 54,396		
54.02 54.03	03450 NUCLEAR MEDICINE - DIAGNOSTIC	839,959 411,594	11,671		0 53,805 0 59,056		
55.00	05500 RADIOLOGY-THERAPEUTIC	2,113,050	0		0 176,689		
57.00	05700 CT SCAN	766,545	5,706		0 124,567	896,818	57.00
58.00 59.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	476,931	10,387		0 48,566 0 148,402		
60.00	05900 CARDIAC CATHETERIZATION 06000 LABORATORY	1,071,438 6,844,234	88,663 129,899		0 148,402 0 0	1,308,503 6,974,133	
65.00	06500 RESPIRATORY THERAPY	1,390,293	73,917		0 220,434	1,684,644	65.00
66.00	06600 PHYSICAL THERAPY	2,808,731	100,697		0 72,491		
67.00 68.00	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY	1,273,323 433,764	47,376 16,134		0 24,384 0 8,306		
69.00	06900 ELECTROCARDIOLOGY	196,523	0		0 24,227		
70.00	07000 ELECTROENCEPHALOGRAPHY	283,572	120,579		0 41,343		1
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	3,731,323 5,308,565	0		0 0	3,731,323 5,308,565	
	07300 DRUGS CHARGED TO PATIENTS	15,565,392	0		0 0	15,565,392	
76.00	03190 CHEMOTHERAPY	952,612	0		0 134,582	1,087,194	76.00
76.01	03020 WOUND CARE	897,990	32,102		0 74,730	1,004,822	76.01
90.00	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC	0	0		0 0	0	90.00
90.01	09001 ANDERSON OUTPATIENT CENTER	1,244,280	36,244		0 219,235		
	04950 DIABETIC EDUCATION	0	0		0	0	
90.03 91.00	09002 MS CLINIC 09100 EMERGENCY	5,879,298	234,396		0 0 764,740	0 6,878,434	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	3,073,230	254,550		704,740	0,070,434	1
05.00	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	0	0		0 0	0	95.00
113.00	11300 INTEREST EXPENSE						113.00
118.00		158,096,852	4,678,238		0 7,652,963	157,156,616	118.00
190.00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	19,489		0 0	19.489	190.00
	19100 RESEARCH	110,005	0		0 15,382		
	19200 PHYSICIANS' PRIVATE OFFICES	3,199,520	18,940		0 515,596		
	07950 FOUNDATION 07951 CHILDRENS CLINIC	0	6,586 0		0		194.00 194.01
	07951 CHILDRENS CLINIC	54,929	0		0 8,134	l	194.01
194.03	07953 SEXUAL ASSAULT PROGRAM	5,928	0		0 1,016	6,944	194.03
	07954 ASPR BIOTERRORISM GRANT 07955 HEALTHY FAMILIES	440 501,321	0 104,497		0 0 67,807	440 673,625	194.04
	07955 HEALTHY FAMILIES	2,747	104,497		0 67,807		194.05
	07957 MARKETING	0	0		0 0		194.07

Health Financial Systems	ASCENSION ST. VINCENT ANDERSON	In Lieu of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS	Provider CCN: 15-0088	Period: Worksheet B From 07/01/2022 Part I To 06/30/2023 Date/Time Prepared:

			1	0 06/30/2023	11/22/2023 10	
		CAPITAL REL	LATED COSTS			
Cost Center Description	Net Expenses	BLDG & FIXT	BLDG &	EMPLOYEE	Subtotal	
	for Cost		FIXT-MAB	BENEFITS		
	Allocation			DEPARTMENT		
	(from Wkst A					
	col. 7)					
	0	1.00	1.01	4.00	4A	
194.08 07958 CORPORATE COMMUNICATIONS	0	26,168	0	0	26,168	194.08
194.09 07959 мов	369	0	0	0	369	194.09
194.10 07960 ASC	165	0	0	28	193	194.10
194.11 07961 MAB	0	0	0	0	0	194.11
194.12 07963 ADOLESCENT RESIDENTIAL S	ERVICES 790,452	29,461	0	127,132	947,045	194.12
194.13 07962 IDLE SPACE	0	0	0	0	0	194.13
200.00 Cross Foot Adjustments					0	200.00
201.00 Negative Cost Centers		0	0	0	0	201.00
202.00 TOTAL (sum lines 118 thr	ough 201) 162,762,728	4,883,379	0	8,388,058	162,762,728	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0088

Period: Worksheet B From 07/01/2022 To 06/30/2023 Date/Time Prepared: 11/22/2023 10:37 am

				''	0 06/30/2023	11/22/2023 10	
	Cost Center Description	ADMINISTRATIVE	OPERATION OF	LAUNDRY &	HOUSEKEEPING	DIETARY	
		& GENERAL 5.00	7.00	LINEN SERVICE	9.00	10.00	
GE	NERAL SERVICE COST CENTERS	3.00	7.00	8.00	9.00	10.00	
	0100 CAP REL COSTS-BLDG & FIXT						1.00
	0101 CAP REL COSTS-BLDG & FIXT-MAB						1.01
4.00 00	0400 EMPLOYEE BENEFITS DEPARTMENT						4.00
	0500 ADMINISTRATIVE & GENERAL	38,503,856					5.00
	0700 OPERATION OF PLANT	1,799,263	7,605,811				7.00
	0800 LAUNDRY & LINEN SERVICE	104,709	14,265				8.00
	0900 HOUSEKEEPING	914,358	212,106		4,077,261	1 210 000	9.00
	LOOO DIETARY	235,182	209,173		115,571	1,318,900	10.00
<b>I</b>	L100 CAFETERIA	661,908	382,587		211,385	0	11.00
	L300 NURSING ADMINISTRATION L400 CENTRAL SERVICES & SUPPLY	952,445 75,902	103,832 337,176		57,369 186,295	0	13.00
	L500 PHARMACY	1,333,830	102,450		56,605	0	15.00
	L600 MEDICAL RECORDS & LIBRARY	16,741	110,847		61,245	0	16.00
	2300 ALLIED HEALTH-EMS	0	0	0	0	0	23.00
23.01 02	2301 ALLIED HEALTH-RAD TECH	43,407	2,339	0	1,292	0	23.01
	IPATIENT ROUTINE SERVICE COST CENTERS						
	3000 ADULTS & PEDIATRICS	5,611,754	1,430,001		790,101	1,069,880	
	3100 INTENSIVE CARE UNIT	1,725,692	311,665			89,179	
	1100 SUBPROVIDER - IRF	565,200	212,595			112,494	
	1300   NURSERY   ICILLARY SERVICE COST CENTERS	94,953	118,394	8,953	65,415	0	43.00
	5000 OPERATING ROOM	3,638,936	1,020,394	0	563,784	156	50.00
	5200 DELIVERY ROOM & LABOR ROOM	427,294	449,660		248,445	17,268	
	3300 ANESTHESIOLOGY	0	0	l ő	0	0	53.00
	5400 RADIOLOGY-DIAGNOSTIC	1,092,762	303,544	0	167,713	0	54.00
54.01 03	3440 MAMMOGRAPHY	245,955	0	0	0	0	54.01
	3450 NUCLEAR MEDICINE - DIAGNOSTIC	280,565	23,959	0	13,238	0	54.02
	3630 ULTRA SOUND	145,839	0	0	0	0	54.03
	5500 RADIOLOGY-THERAPEUTIC	709,517	0	0	0	0	55.00
	5700 CT SCAN	277,895	11,714		6,472	0	57.00
	MAGNETIC RESONANCE IMAGING (MRI)	166,053	21,323		11,781	10.087	58.00
	5900 CARDIAC CATHETERIZATION 5000 LABORATORY	405,463 2,161,061	182,024 266,680		100,571 147,345	10,087 0	59.00 60.00
	5500 RESPIRATORY THERAPY	522,017	151,751		83,845	0	1
	6600 PHYSICAL THERAPY	924,001	206,728		114,220	0	66.00
	5700 OCCUPATIONAL THERAPY	416,798	97,262		53,739	0	67.00
	5800 SPEECH PATHOLOGY	141,983	33,122			0	68.00
	5900 ELECTROCARDIOLOGY	68,403	0	0	0	0	69.00
	7000 ELECTROENCEPHALOGRAPHY	138,044	247,546	0	136,773	222	70.00
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1,156,218	0	0	0	0	71.00
	7200 IMPL. DEV. CHARGED TO PATIENTS	1,644,954	0	0	0	0	72.00
	7300 DRUGS CHARGED TO PATIENTS	4,823,217	0	0	0	0	73.00
1	3190 CHEMOTHERAPY	336,887	0	0	0	12,902	
	3020 wound care JTPATIENT SERVICE COST CENTERS	311,362	65,905	0	36,413	0	76.01
	9000 CLINIC	0	0	0	0	0	90.00
1	0001 ANDERSON OUTPATIENT CENTER	464,727	74,408				
	1950 DIABETIC EDUCATION	0	0	l ő	0	0	
	9002 MS CLINIC	0	0	0	o	0	90.03
91.00 09	9100 EMERGENCY	2,131,407	481,210	5,309	265,876	6,712	91.00
92.00 09	0200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	THER REIMBURSABLE COST CENTERS						
	9500 AMBULANCE SERVICES	0	0	0	0	0	95.00
	PECIAL PURPOSE COST CENTERS						112 00
	L300 INTEREST EXPENSE	26 766 702	7 104 660	456 800	2 044 560	1 210 000	113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)  DIREIMBURSABLE COST CENTERS	36,766,702	7,184,660	456,890	3,844,568	1,318,900	1118.00
	0000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	6,039	40,010	0	22,106	0	190.00
	0100 RESEARCH	38,853	40,010	0	22,100		191.00
	2200 PHYSICIANS' PRIVATE OFFICES	1,157,064	38,884	Ŏ	21,484		192.00
	7950 FOUNDATION	2,041	13,521		7,471		194.00
	7951 CHILDRENS CLINIC	0	. 0	0	, o	0	194.01
194.02 07	7952 PSS ADMINISTRATION	19,541	0	0	0		194.02
	7953 SEXUAL ASSAULT PROGRAM	2,152	0	0	0		194.03
	7954 ASPR BIOTERRORISM GRANT	136	0	0	0		194.04
	7955 HEALTHY FAMILIES	208,735	214,530	0	118,531		194.05
	7956 DME-HOME CARE	851	0	0	0		194.06
	7957 MARKETING	0 8 100	0	] 0	0 000		194.07
194.08 07	7958 CORPORATE COMMUNICATIONS	8,109 114	53,723		29,683		194.08 194.09
194.09 07		60	0	0	0		194.09
194.10 07			0	0	0		194.11
	7963 ADOLESCENT RESIDENTIAL SERVICES	293,459	60,483	Ö	33,418		194.12
	,		,				

Health Financial Systems	ASCENSION ST. VINCENT ANDERSON			In Lieu of Form CMS-2552-10		
COST ALLOCATION - GENERAL SERVICE COSTS		Provider Co		From 07/01/2022	Worksheet B Part I Date/Time Pre 11/22/2023 10	

	Cost Center Description	ADMINISTRATIVE	OPERATION OF	LAUNDRY &	HOUSEKEEPING	DIETARY	
		& GENERAL	PLANT	LINEN SERVICE			
		5.00	7.00	8.00	9.00	10.00	
194.13 07962	PIDLE SPACE	0	0	0	0	(	194.13
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0		201.00
202.00	TOTAL (sum lines 118 through 201)	38,503,856	7,605,811	456,890	4,077,261	1,318,900	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0088

Period: Worksheet B
From 07/01/2022 Part I
TO 06/30/2023 Date/Time Prepared:

				10	06/30/2023	11/22/2023 10	
	Cost Center Description	CAFETERIA	NURSING	CENTRAL	PHARMACY	MEDICAL	
			ADMINISTRATION	SERVICES &		RECORDS &	
		11.00	13.00	SUPPLY 14.00	15.00	LIBRARY 16.00	
	GENERAL SERVICE COST CENTERS	11.00	13.00	14.00	13.00	10.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101 CAP REL COSTS-BLDG & FIXT-MAB						1.01
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPING						9.00
10.00	01000 DIETARY						10.00
11.00	01100 CAFETERIA	3,391,976					11.00
13.00	01300 NURSING ADMINISTRATION	168,140	4,355,499				13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	58,831	0	903,155	6 040 700		14.00
15.00	01500 PHARMACY	232,203	0	11,190	6,040,788	242 262	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0	3	0	242,863	
23.00	02300 ALLIED HEALTH-EMS	11 073	0	0	0	0	23.00
23.01	02301 ALLIED HEALTH-RAD TECH   INPATIENT ROUTINE SERVICE COST CENTERS	11,073	υ	0	0	0	23.01
30.00	03000 ADULTS & PEDIATRICS	1,025,452	2,041,830	35,251	0	18,191	30.00
31.00	03100 INTENSIVE CARE UNIT	264,697	695,147	22,280	ő	7,115	ı
41.00	04100 SUBPROVIDER - IRF	107,013	221,585	1,450	Ö	1,768	1
43.00		13,517	38,390	797	0	411	1
	ANCILLARY SERVICE COST CENTERS	- , -			-,		
50.00	05000 OPERATING ROOM	163,438	451,040	684,063	0	49,484	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	68,906	177,424	3,682	0	1,380	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	215,804	0	29,658	0	5,641	
54.01	03440 MAMMOGRAPHY	24,517	0	3,836	0	1,637	
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	21,700	0	16,057	0	5,624	
54.03	03630 ULTRA SOUND	27,944	0	483	0	2,915	
55.00	05500 RADIOLOGY-THERAPEUTIC	94,486	0	1,614	0	11,648	
57.00	05700 CT SCAN	59,593	0	380	0	5,918	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	22,096	112 622	83	0	927	ł
59.00	05900 CARDIAC CATHETERIZATION	73,456	112,622	15,747	0	8,452	1
60.00 65.00	06000 LABORATORY	104 248	0	196	0	30,024	
66.00	06500 RESPIRATORY THERAPY 06600 PHYSICAL THERAPY	104,248 27,045	0	10,959 2,974	0	6,313 3,093	1
67.00	06700 OCCUPATIONAL THERAPY	13,803	0	1,399	0	1,429	1
68.00	06800 SPEECH PATHOLOGY	4,702	0	477	0	487	68.00
69.00	06900 ELECTROCARDIOLOGY	13,879	0	127	0	459	
70.00	07000 ELECTROENCEPHALOGRAPHY	8,263	o o	472	Ö	1,406	ł
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	o	0	0	6,963	ł
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	7,468	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	6,040,788	30,257	73.00
76.00	03190 CHEMOTHERAPY	80,074	0	6,860	0	2,602	76.00
76.01	03020 WOUND CARE	43,163	0	22,352	0	1,969	76.01
	OUTPATIENT SERVICE COST CENTERS	-1	-		-1		
	09000 CLINIC	0	0	0	0		
	09001 ANDERSON OUTPATIENT CENTER	38,495	0	71	0		90.01
	04950 DIABETIC EDUCATION	0	0	0	0	0	
	09002 MS CLINIC	214 004	(17.461	20, 662	0	0	90.03
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	314,984	617,461	30,662	U	27,778	91.00 92.00
32.00	OTHER REIMBURSABLE COST CENTERS						32.00
95.00	09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
33.00	SPECIAL PURPOSE COST CENTERS		٥,	<u> </u>			33.00
113.00	11300 INTEREST EXPENSE						113.00
118.00		3,301,522	4,355,499	903,123	6,040,788	242,863	
	NONREIMBURSABLE COST CENTERS		· · · · · · · · · · · · · · · · · · ·			·	
190.00	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
	19100 RESEARCH	7,943	0	0	0		191.00
	19200 PHYSICIANS' PRIVATE OFFICES	16,095	0	9	0		192.00
	07950 FOUNDATION	0	0	0	0		194.00
	07951 CHILDRENS CLINIC	0	0	0	0		194.01
	07952 PSS ADMINISTRATION	10,364	0	0	0		194.02
	07953 SEXUAL ASSAULT PROGRAM	461	0	0	0		194.03
	07954 ASPR BIOTERRORISM GRANT	0	0	0	0		194.04
	07955 HEALTHY FAMILIES	55,591	0	0	0		194.05
	07956 DME-HOME CARE	0	0	23	0		194.06
	07957 MARKETING 07958 CORPORATE COMMUNICATIONS	0	0	0	0		194.07 194.08
	07958 CORPORATE COMMUNICATIONS	0	٥	0	U A		194.08
	07939 MOB 07960 ASC	0	0	0	0		194.09
	07960 ASC 07961 MAB	0	0	0	0		194.10
		١	o <sub>l</sub>	O <sub>1</sub>	۷	<u> </u>	1-2

Health Financial Systems

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0088
From 07/01/2022
To 06/30/2023
Date/Time Prepared:

					11/22/2023 10	:37 am
Cost Center Description	CAFETERIA	NURSING	CENTRAL	PHARMACY	MEDICAL	
		ADMINISTRATION	SERVICES &		RECORDS &	
			SUPPLY		LIBRARY	
	11.00	13.00	14.00	15.00	16.00	
194.12 07963 ADOLESCENT RESIDENTIAL SERVICE	s 0	0	0	0	0	194.12
194.13 07962 IDLE SPACE	0	0	0	0	0	194.13
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 2	01) 3,391,976	4,355,499	903,155	6,040,788	242,863	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0088

				T	o 06/30/2023	Date/Time Pre 11/22/2023 10	
	Cost Center Description	ALLIED	ALLIED	Subtotal	Intern &	Total	137 4111
		HEALTH-EMS	HEALTH-RAD		Residents Cost		
			TECH		& Post Stepdown		
					Adjustments		
		23.00	23.01	24.00	25.00	26.00	
1 00	GENERAL SERVICE COST CENTERS	I I					1 1 00
$\frac{1.00}{1.01}$	00100 CAP REL COSTS-BLDG & FIXT 00101 CAP REL COSTS-BLDG & FIXT-MAB						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPING						9.00
10.00	01000 DIETARY						10.00
11.00 13.00	01100 CAFETERIA 01300 NURSING ADMINISTRATION						11.00 13.00
14.00	01400 CENTRAL SERVICES & SUPPLY						14.00
	01500 PHARMACY						15.00
16.00	01600 MEDICAL RECORDS & LIBRARY						16.00
	02300 ALLIED HEALTH-EMS	0					23.00
23.01	02301 ALLIED HEALTH-RAD TECH		198,192				23.01
20.00	INPATIENT ROUTINE SERVICE COST CENTERS			20 462 200	٥	20 462 200	30.00
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	0	0	30,463,399 8,924,344	l I	30,463,399 8,924,344	
	04100 SUBPROVIDER - IRF	0	0	3,208,119		3,208,119	
	04300 NURSERY	Ö	ő	647,261	ő	647,261	
	ANCILLARY SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·		,	- 1	, ,	
	05000 OPERATING ROOM	0	0	18,314,798	l I	18,314,798	
	05200 DELIVERY ROOM & LABOR ROOM	0	0	2,773,015	0	2,773,015	
	05300 ANESTHESIOLOGY	0	0	0	0	0	
	05400 RADIOLOGY-DIAGNOSTIC 03440 MAMMOGRAPHY	0	32,588 9,460	5,374,250 1,079,145	0	5,374,250 1,079,145	
	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	32,490	1,299,068	0	1,299,068	
	03630 ULTRA SOUND	Ö	16,841	664,672	Ö	664,672	
55.00	05500 RADIOLOGY-THERAPEUTIC	0	67,266	3,174,270	0	3,174,270	
	05700 CT SCAN	0	34,191	1,292,981	0	1,292,981	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	5,356	763,503	0	763,503	
	05900 CARDIAC CATHETERIZATION	0	0	2,216,925	0	2,216,925	
60.00 65.00	06000 LABORATORY 06500 RESPIRATORY THERAPY	0	0	9,579,439 2,563,777	0	9,579,439 2,563,777	1
66.00	06600 PHYSICAL THERAPY		0	4,259,980	0	4,259,980	
67.00	06700 OCCUPATIONAL THERAPY	Ö	Ö	1,929,513	Ö	1,929,513	
68.00	06800 SPEECH PATHOLOGY	0	0	657,276	0	657,276	1
69.00	06900 ELECTROCARDIOLOGY	0	0	303,618	0	303,618	1
	07000 ELECTROENCEPHALOGRAPHY	0	0	978,220	l I	978,220	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	4,894,504	0	4,894,504	1
73.00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0	6,960,987 26,459,654	0	6,960,987 26,459,654	
76.00	03190 CHEMOTHERAPY	Ö	ő	1,526,519	ő	1,526,519	
	03020 WOUND CARE	0	0	1,485,986			76.01
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLINIC	0	0	2 120 076	0	0	90.00
	09001 ANDERSON OUTPATIENT CENTER 04950 DIABETIC EDUCATION	0	0	2,120,076	0	2,120,076 0	1
	09002 MS CLINIC	l o	o o	0	0	0	1
	09100 EMERGENCY	Ö	Ö	10,759,833	Ö	10,759,833	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
05.00	OTHER REIMBURSABLE COST CENTERS		•				05.00
95.00	09500 AMBULANCE SERVICES   SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	95.00
113.00	11300 INTEREST EXPENSE		T				113.00
118.00		0	198,192	154,675,132	o	154,675,132	
	NONREIMBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	87,644			190.00
	19100 RESEARCH  19200 PHYSICIANS' PRIVATE OFFICES	0	0	172,183		172,183 4,967,592	
	07950 FOUNDATION		0	4,967,592 29,619			194.00
	07951 CHILDRENS CLINIC	0	o o	0	o o		194.01
	07952 PSS ADMINISTRATION	Ö	ő	92,968	l ol		194.02
194.03	07953 SEXUAL ASSAULT PROGRAM	0	0	9,557	0	9,557	194.03
	07954 ASPR BIOTERRORISM GRANT	0	0	576			194.04
	07955 HEALTHY FAMILIES	0	0	1,271,012	0	1,271,012	
	07956 DME-HOME CARE	0	0	3,621	0		194.06
	07957 MARKETING 07958 CORPORATE COMMUNICATIONS	0	0	0 117,683	- 1	117,683	194.07 194.08
	07959 MOB	0	0	483			194.09
	• •	1	*1		1		<u> </u>

Health Financial Systems	ASCENSION ST. VI	NCENT ANDERSON	ı	In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C		Period: From 07/01/2022 To 06/30/2023	Worksheet B Part I Date/Time Pre 11/22/2023 10	
Cost Center Description	ALLIED HEALTH-EMS	ALLIED HEALTH-RAD TECH	Subtotal	Intern & Residents Cost & Post	Total	

					11/22/2023 10	:37 am
Cost Center Description	ALLIED	ALLIED	Subtotal	Intern &	Total	
	HEALTH-EMS	HEALTH-RAD		Residents Cost		
		TECH		& Post		
				Stepdown		
				Adjustments		
	23.00	23.01	24.00	25.00	26.00	
194.10 07960 ASC	0	0	253	0	253	194.10
194.11 07961 MAB	0	0	0	0	0	194.11
194.12 07963 ADOLESCENT RESIDENTIAL SERVICES	0	0	1,334,405	0	1,334,405	194.12
194.13 07962 IDLE SPACE	0	0	0	0	0	194.13
200.00 Cross Foot Adjustments	0	0	0	0	0	200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	0	198,192	162,762,728	0	162,762,728	202.00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 07/01/2022 Part II
To 06/30/2023 Date/Time Prepared: ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0088

					To 06/30/2023	Date/Time Pre 11/22/2023 10	
			CAPITAL REL	LATED COSTS		11/22/2023 10	7.57 aiii
	Cost Center Description	Directly	BLDG & FIXT	BLDG &	Subtotal	EMPLOYEE	
	cost center beser iperon	Assigned New	BEDG & LIXI	FIXT-MAB	Subcocui	BENEFITS	
		Capital				DEPARTMENT	
		Related Costs	1.00	1.01	2A	4.00	
	GENERAL SERVICE COST CENTERS						
$1.00 \\ 1.01$	00100 CAP REL COSTS-BLDG & FIXT 00101 CAP REL COSTS-BLDG & FIXT-MAB						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	64,131		0 64,131	64,131	1
5.00	00500 ADMINISTRATIVE & GENERAL	2,135,369	537,190		0 2,672,559		5.00
7.00	00700 OPERATION OF PLANT	0	577,286		0 577,286	2	1
8.00 9.00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	0	6,949 103,316		0 6,949 0 103,316	0	1
10.00	01000 DIETARY	o o	101,887		0 101,887	Ö	
11.00	01100 CAFETERIA	0	186,357		0 186,357	0	
	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	0	50,576 164,238		0 50,576 0 164,238		1
	01500 PHARMACY	0	49,903		0 49,903	4,318	1
16.00	01600 MEDICAL RECORDS & LIBRARY	0	53,993		0 53,993	0	1
	02300 ALLIED HEALTH-EMS	0	0		0 0	0	
23.01	02301 ALLIED HEALTH-RAD TECH INPATIENT ROUTINE SERVICE COST CENTERS	0	1,139		0 1,139	156	23.01
30.00	03000 ADULTS & PEDIATRICS	0	696,552		0 696,552	17,035	30.00
	03100 INTENSIVE CARE UNIT	0	151,811		0 151,811	5,069	1
	04100 SUBPROVIDER - IRF 04300 NURSERY	0	103,555 57,670		0 103,555 0 57,670		1
43.00	ANCILLARY SERVICE COST CENTERS		37,070		0 37,070	242	43.00
	05000 OPERATING ROOM	0	497,031		0 497,031	3,474	1
	05200 DELIVERY ROOM & LABOR ROOM	0	219,028		0 219,028	1,133	1
	05300 ANESTHESIOLOGY 05400 RADIOLOGY-DIAGNOSTIC	0	147,855		0 0 147,855	0 2,828	
	03440 MAMMOGRAPHY	0	0		0 0	416	1
	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	11,671		0 11,671	411	
	03630 ULTRA SOUND 05500 RADIOLOGY-THERAPEUTIC	0	0		0	452 1,351	1
57.00	05700 CT SCAN	0	5,706		0 5,706	953	1
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	10,387		0 10,387	371	1
	05900 CARDIAC CATHETERIZATION 06000 LABORATORY	0	88,663		0 88,663 0 129,899	1,135 0	
65.00	06500 RESPIRATORY THERAPY	0	129,899 73,917		0 129,899 0 73,917	1,686	
66.00	06600 PHYSICAL THERAPY	0	100,697		0 100,697	554	1
	06700 OCCUPATIONAL THERAPY	0	47,376		0 47,376		1
68.00 69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDIOLOGY	0	16,134		0 16,134	64 185	1
70.00	07000 ELECTROENCEPHALOGRAPHY	0	120,579		0 120,579	316	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	1.2.00
72.00 73.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0 0	1 - 1 - 1
	07300 DRUGS CHARGED TO PATIENTS 03190 CHEMOTHERAPY	0	0		0 0		73.00 76.00
	03020 WOUND CARE	0	32,102		0 32,102		
00.00	OUTPATIENT SERVICE COST CENTERS	1 0					00.00
	09000 CLINIC 09001 ANDERSON OUTPATIENT CENTER	0	0 36,244		0 36,244	0 1,677	
	04950 DIABETIC EDUCATION	ő	0		0 0	0	1
	09002 MS CLINIC	0	0		0 0	0	
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	234,396		0 234,396	5,848	91.00
92.00	OTHER REIMBURSABLE COST CENTERS						92.00
95.00	09500 AMBULANCE SERVICES	0	0		0 0	0	95.00
112.00	SPECIAL PURPOSE COST CENTERS			<u> </u>			112.00
113.00	11300 INTEREST EXPENSE   SUBTOTALS (SUM OF LINES 1 through 117)	2,135,369	4,678,238		0 6,813,607	58 509	113.00 118.00
	NONREIMBURSABLE COST CENTERS	2,233,303	.,0.0,230		0,023,001	30,303	
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	19,489		0 19,489		190.00
	19100 RESEARCH  19200 PHYSICIANS' PRIVATE OFFICES	0	0 18,940		0 0 18,940		191.00 192.00
	07950 FOUNDATION	0	6,586		0 6,586		194.00
194.01	07951 CHILDRENS CLINIC	0	0		0 0	0	194.01
	07952 PSS ADMINISTRATION	0	0		0 0		194.02
	07953 SEXUAL ASSAULT PROGRAM 07954 ASPR BIOTERRORISM GRANT	0	0		0 0		194.03 194.04
194.05	07955 HEALTHY FAMILIES	Ö	104,497		0 104,497	519	194.05
	07956 DME-HOME CARE	0	0		0	0	194.06
	07957 MARKETING 07958 CORPORATE COMMUNICATIONS	0	0 26,168		0 0 26,168		194.07 194.08
134.00	- TOTAL COMMUNICATIONS	1	20,100	<u> </u>	20,100	·	123

				0 06/30/2023	11/22/2023 10	
		CAPITAL REL	ATED COSTS			
Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	BLDG & FIXT-MAB	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
	0	1.00	1.01	2A	4.00	
194.09 07959 MOB	0	0	(	0	0	194.09
194.10 07960 ASC	0	0	C	0	0	194.10
194.11 07961 MAB	0	0	C	0	0	194.11
194.12 07963 ADOLESCENT RESIDENTIAL SERVICES	0	29,461	(	29,461	972	194.12
194.13 07962 IDLE SPACE	0	0	C	0	0	194.13
200.00 Cross Foot Adjustments				0		200.00
201.00 Negative Cost Centers		0	(	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	2,135,369	4,883,379	(	7,018,748	64,131	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0088

Period: Worksheet B From 07/01/2022 Part II To 06/30/2023 Date/Time Prepared:

				''	0 06/30/2023	11/22/2023 10	
	Cost Center Description	ADMINISTRATIVE	OPERATION OF	LAUNDRY &	HOUSEKEEPING	DIETARY	
		& GENERAL	PLANT	LINEN SERVICE	0.00	10.00	
	GENERAL SERVICE COST CENTERS	5.00	7.00	8.00	9.00	10.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101 CAP REL COSTS-BLDG & FIXT-MAB						1.01
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL	2,674,774					5.00
7.00	00700 OPERATION OF PLANT	124,992	702,280				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	7,274	1,317	15,540			8.00
9.00	00900 HOUSEKEEPING	63,519	19,585		186,420	142 022	9.00
10.00		16,338	19,314		5,284	142,823	10.00
11.00 13.00		45,982	35,326	0	9,665	0	11.00
14.00		66,165 5,273	9,587 31,133		2,623 8,518	0	13.00 14.00
15.00		92,659	9,460		2,588	0	15.00
16.00		1,163	10,235		2,800	0	16.00
23.00		0	0	o o	0	0	23.00
	02301 ALLIED HEALTH-RAD TECH	3,015	216	0	59	0	23.01
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00		389,818	132,040			115,857	30.00
31.00		119,881	28,777		7,873	9,657	31.00
41.00		39,263	19,630			12,182	41.00
43.00		6,596	10,932	305	2,991	0	43.00
50.00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	252,791	94,218	0	25,777	17	50.00
52.00		29,683	41,519		11,359	1,870	
53.00		29,083	41,319	0	11,339	1,870	53.00
54.00		75,912	28,028		7,668	0	54.00
54.01		17,086	0	Ö	0	0	54.01
54.02		19,490	2,212	0	605	0	54.02
54.03	03630 ULTRA SOUND	10,131	0	0	0	0	54.03
55.00	05500 RADIOLOGY-THERAPEUTIC	49,289	0	0	0	0	55.00
57.00		19,305	1,082	0	296	0	57.00
58.00		11,535	1,969	0	539	0	58.00
59.00		28,167	16,807	0	4,598	1,092	59.00
60.00		150,125	24,624		6,737	0	60.00
65.00		36,264	14,012		3,834	0	65.00
66.00 67.00		64,189 28,954	19,088 8,981	0	5,222 2,457	0	66.00 67.00
68.00		9,863	3,058		837	0	68.00
69.00		4,752	0,030	0	037	0	69.00
70.00		9,590	22,857	o o	6,254	24	70.00
71.00		80,320	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	114,272	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	335,061	0	0	0	0	73.00
76.00		23,403	0	0	0	1,397	76.00
76.01		21,630	6,085	0	1,665	0	76.01
00.00	OUTPATIENT SERVICE COST CENTERS				ام		00.00
90.00		0 32,284	0 6,870		- 1	0	90.00
90.01	04950 DIABETIC EDUCATION	32,284	0,070	0	1,000	0	90.01
90.02		0	0	0	0	0	90.03
91.00		148,065	44,432	181	12,156	727	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2.0,003	,.52		11,130		92.00
	OTHER REIMBURSABLE COST CENTERS	, ,			,		
95.00	09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
	SPECIAL PURPOSE COST CENTERS						
	0 11300 INTEREST EXPENSE						113.00
118.0		2,554,099	663,394	15,540	175,781	142,823	118.00
100.0	NONREIMBURSABLE COST CENTERS	420	2.604		1 011		100 00
	0 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	420	3,694	0	1,011		190.00
	0 19100 RESEARCH 0 19200 PHYSICIANS' PRIVATE OFFICES	2,699	3,590	0	982		191.00 192.00
	0 07950  FOUNDATION	80,379 142	1,248		342		194.00
	1 07951 CHILDRENS CLINIC	142	1,240	0	0		194.00
	2 07952 PSS ADMINISTRATION	1,357	0	0	0		194.02
	3 07953 SEXUAL ASSAULT PROGRAM	149	0	o o	Ö		194.03
	4 07954 ASPR BIOTERRORISM GRANT	9	0	0	Ö		194.04
	5 07955 HEALTHY FAMILIES	14,500	19,809	0	5,419	0	194.05
194.0	6 07956 DME-HOME CARE	59	0	0	0		194.06
	7 07957 MARKETING	0	0	0	o		194.07
	8 07958 CORPORATE COMMUNICATIONS	563	4,960	0	1,357		194.08
	9 07959  MOB	8	0	0	0		194.09
	0 07960 ASC	4	0	0	0		194.10
	1 07961 MAB 2 07963 ADOLESCENT RESIDENTIAL SERVICES	20,386	0 5,585	0	0 1,528		194.11 194.12
194.1	FIGURES AND THE SERVICES	20,360	3,363	1 0	1,326	0	1+3+.12

Health Financial Systems ASCENSION ST. VINCENT ANDERSON In Lieu of Form CMS-2552-10

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0088 | Period: From 07/01/2022 | To 06/30/2023 | DeteyTime Prepared: 11/22/2023 10:37 am

						11/22/2023 10	. 37 aiii
	Cost Center Description	ADMINISTRATIVE	OPERATION OF	LAUNDRY &	HOUSEKEEPING	DIETARY	
		& GENERAL	PLANT	LINEN SERVICE			
		5.00	7.00	8.00	9.00	10.00	
194.13 07962	IDLE SPACE	0	0	0	0	0	194.13
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	2,674,774	702,280	15,540	186,420	142,823	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0088

Period: Worksheet B From 07/01/2022 Part II To 06/30/2023 Date/Time Prepared:

11/22/2023 10:37 am Cost Center Description PHARMACY CAFETERIA NURSING CENTRAL **MEDICAL** ADMINISTRATION SERVICES & RECORDS & SUPPLY LIBRARY 11.00 13.00 15.00 14.00 16.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00101 CAP REL COSTS-BLDG & FIXT-MAB 1.01 1.01 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 7.00 00700 OPERATION OF PLANT 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPING 9.00 9.00 10.00 01000 DIETARY 10.00 11.00 01100 CAFETERIA 277,330 11.00 01300 NURSING ADMINISTRATION 13,747 145,270 13.00 13.00 4,810 14.00 01400 CENTRAL SERVICES & SUPPLY 214.509 14.00 15.00 01500 PHARMACY 18,985 0 2,658 180,571 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 68,192 16.00 0 02300 ALLIED HEALTH-EMS 0 23.00 0 0 23.00 0 0 23.01 02301 ALLIED HEALTH-RAD TECH 905 0 0 0 23.01 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 83,843 68,102 0 5,121 30.00 03000 ADULTS & PEDIATRICS 8.372 03100 INTENSIVE CARE UNIT 0 31.00 31.00 21,642 23,185 5,292 2,003 41.00 04100 SUBPROVIDER - IRF 8,749 7,391 344 0 498 41.00 43.00 04300 NURSERY 1,105 1,280 189 0 116 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 13,363 15,044 162,475 0 13,752 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 5,634 5,918 875 0 388 52.00 o 53.00 05300 ANESTHESIOLOGY 53.00 0 54.00 05400 RADTOLOGY-DTAGNOSTIC 17.644 0 7,044 1,588 54.00 0 54.01 03440 MAMMOGRAPHY 2,005 0 911 461 54.01 03450 NUCLEAR MEDICINE - DIAGNOSTIC 1,774 3,814 0 54.02 1.583 54.02 ol 54.03 03630 ULTRA SOUND 2,285 0 115 821 54.03 0 55.00 05500 RADIOLOGY-THERAPEUTIC 7.725 0 3.279 55.00 383 1,666 0 57.00 05700 CT SCAN 4,872 0 90 57.00 20 0 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 1.807 0 261 58.00 59.00 05900 CARDIAC CATHETERIZATION 6,006 3,756 3.740 0 2.379 59.00 0 60.00 06000 LABORATORY C 46 8,453 60.00 06500 RESPIRATORY THERAPY 8,523 2,603 0 65.00 0 1.777 65.00 66.00 ol 06600 PHYSICAL THERAPY 2,211 706 871 66.00 0 06700 OCCUPATIONAL THERAPY 67.00 67.00 0 402 1.129 332 0 68.00 06800 SPEECH PATHOLOGY 384 0 113 137 68.00 06900 ELECTROCARDIOLOGY 0 69.00 1.135 30 129 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 676 112 0 396 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0 0 0 0 1.960 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 2,103 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 180,571 8,518 73.00 03190 CHEMOTHERAPY 76.00 6.547 0 1.629 76.00 0 733 76.01 03020 WOUND CARE 3,529 5,309 554 76.01 OUTPATIENT SERVICE COST CENTERS 09000 CLINIC 90.00 0 90.01 09001 ANDERSON OUTPATIENT CENTER 0 90.01 3,147 17 423 90.02 04950 DIABETIC EDUCATION n 0 0 n 90.02 90.03 09002 MS CLINIC 90.03 o 91.00 09100 EMERGENCY 25,753 20,594 7,282 7,820 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 0 0 0 0 95.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 269,935 145,270 214,502 180,571 68,192 118.00 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 0 0 190.00 0 191.00 19100 RESEARCH 649 0 0 0 191.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 1,316 2 0 0 192.00 0 0 194.00 07950 FOUNDATION 0 0 194.00 0 0 194.01 07951 CHILDRENS CLINIC 0 0|194.01n 0 0 194.02 07952 PSS ADMINISTRATION 847 0 0 194.02 0 0 0 194.03 194.03 07953 SEXUAL ASSAULT PROGRAM 38 0 0 194.04 07954 ASPR BIOTERRORISM GRANT 0 0 0 0 194.04 194.05 07955 HEALTHY FAMILIES 0 0 194.05 4,545 0 194.06 07956 DME-HOME CARE 0 0 0 0 194.06 194.07 07957 MARKETING 0 0 0 0 0 194.07 194.08 07958 CORPORATE COMMUNICATIONS 0 0 0 0 0 194.08 194.09 07959 MOB 0 0 0 0 0 194.09 194.10 07960 ASC 0 0 194.10 194.11 07961 MAB 0 0 194.11

Health Financial Systems

ASCENSION ST. VINCENT ANDERSON

In Lieu of Form CMS-2552-10

Provider CCN: 15-0088

Period:
From 07/01/2022
To 06/30/2023

Date/Time Prepared:
11/22/2023 10:37 am

Cost Center Description CAFETERIA NURSING CENTRAL PHARMACY MEDICAL ADMINISTRATION SERVICES & RECORDS & SUPPLY LIBRARY 11.00 13.00 14.00 15.00 16.00 194.12 07963 ADOLESCENT RESIDENTIAL SERVICES 194.13 07962 IDLE SPACE 0 194.12 0 0 0 0 194.13 0 0

145,270

214,509

180,571

277,330

200.00

0 201.00 68,192 202.00

Cross Foot Adjustments Negative Cost Centers

TOTAL (sum lines 118 through 201)

200.00

201.00

202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0088

				Т	o 06/30/2023	Date/Time Pre 11/22/2023 10	
	Cost Center Description	ALLIED	ALLIED	Subtotal	Intern &	Total	
		HEALTH-EMS	HEALTH-RAD TECH		Residents Cost & Post		
			TECH		Stepdown		
					Adjustments		
	GENERAL SERVICE COST CENTERS	23.00	23.01	24.00	25.00	26.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101 CAP REL COSTS-BLDG & FIXT-MAB						1.01
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						7.00 8.00
9.00	00900 HOUSEKEEPING						9.00
10.00	01000 DIETARY						10.00
11.00	01100 CAFETERIA						11.00
13.00 14.00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY						13.00 14.00
15.00	01500 PHARMACY						15.00
16.00	01600 MEDICAL RECORDS & LIBRARY						16.00
23.00	02300 ALLIED HEALTH-EMS	0					23.00
23.01	02301 ALLIED HEALTH-RAD TECH		5,490				23.01
30.00	UNPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS			1,564,117	O	1,564,117	30.00
31.00	03100 INTENSIVE CARE UNIT			377,477		377,477	31.00
41.00	04100 SUBPROVIDER - IRF			200,221		200,221	41.00
43.00	04300 NURSERY			81,426	0	81,426	43.00
50.00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM			1,077,942	O	1,077,942	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM			317,407	0	317,407	52.00
53.00	05300 ANESTHESIOLOGY			0	-	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC			288,567	0	288,567	54.00
54.01	03440 MAMMOGRAPHY			20,879		20,879	54.01
54.02 54.03	03450 NUCLEAR MEDICINE - DIAGNOSTIC 03630 ULTRA SOUND			41,560 13,804	0	41,560 13,804	54.02 54.03
55.00	05500 RADIOLOGY-THERAPEUTIC			62,027	0	62,027	55.00
57.00	05700 CT SCAN			33,970	0	33,970	1
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)			26,889		26,889	58.00
59.00 60.00	05900 CARDIAC CATHETERIZATION 06000 LABORATORY			156,343 319,884		156,343 319,884	59.00 60.00
65.00	06500 RESPIRATORY THERAPY			142,616		142,616	
66.00	06600 PHYSICAL THERAPY			193,538		193,538	
67.00	06700 OCCUPATIONAL THERAPY			89,817		89,817	67.00
68.00	06800 SPEECH PATHOLOGY			30,590		30,590	1
69.00 70.00	06900 ELECTROCARDIOLOGY 07000 ELECTROENCEPHALOGRAPHY			6,231 160,804	0	6,231 160,804	69.00 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS			82,280		82,280	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS			116,375	0	116,375	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS			524,150	0	524,150	73.00
76.00	03190 CHEMOTHERAPY 03020 WOUND CARE			34,738 71,445		34,738 71,445	
70.01	OUTPATIENT SERVICE COST CENTERS		l	71,443	J O	71,443	70.01
90.00	09000 CLINIC			0	0	0	90.00
	09001 ANDERSON OUTPATIENT CENTER			82,542	0	82,542	
	04950 DIABETIC EDUCATION 09002 MS CLINIC			0	0	0	90.02
	09100 EMERGENCY			507,254	0	507,254	1
	09200 OBSERVATION BEDS (NON-DISTINCT PART)			307,23.	Ö	30.,23.	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES			0	0	0	95.00
113.00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE						113.00
118.00		o	o	6,624,893	0	6,624,893	
	NONREIMBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN			24,614		24,614	
	19100 RESEARCH  19200 PHYSICIANS' PRIVATE OFFICES			3,466 109,152		109,152	191.00
194.00	07950 FOUNDATION			8,318		8.318	194.00
	07951 CHILDRENS CLINIC			0			194.01
	07952 PSS ADMINISTRATION			2,266			194.02
	07953 SEXUAL ASSAULT PROGRAM			195	0		194.03
	07954 ASPR BIOTERRORISM GRANT 07955 HEALTHY FAMILIES			9 149,289	0	9 149,289	194.04 194.05
	07956 DME-HOME CARE			149,289			194.06
194.07	07957 MARKETING			0	0	0	194.07
	07958 CORPORATE COMMUNICATIONS			33,048			194.08
194.09	0 07959  мов			8	0	8	194.09

Health Financial Systems	ASCENSION ST. VI	NCENT ANDERSON	N	In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		Period: From 07/01/2022 To 06/30/2023		
Cost Center Description	ALLIED HEALTH-EMS	ALLIED HEALTH-RAD TECH	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	23.00	23.01	24.00	25.00	26.00	

0 0

5,490

5,490

4 194.10 0 194.11 57,932 194.12 0 194.13 5,490 200.00 0 201.00

7,018,748 202.00

57,932

5,490

7,018,748

194.10 07960 ASC 194.11 07961 MAB 194.12 07963 ADOLESCENT RESIDENTIAL SERVICES 194.13 07962 TDLE SPACE

200.00

201.00 202.00 Cross Foot Adjustments
Negative Cost Centers
TOTAL (sum lines 118 through 201)

				Т	o 06/30/2023	Date/Time Pre 11/22/2023 10	
		CAPITAL RE	LATED COSTS			11, 11, 10, 1013 10	
	Cart Cantan Bassadatian	DI DC 9 FTVT	DI DC 0	EMBLOVEE			
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	BLDG & FIXT-MAB	EMPLOYEE BENEFITS	Reconciliation	ADMINISTRATIVE & GENERAL	
		(SQUARE FEET)	(SQUARE FEET)	DEPARTMENT		(ACCUM. COST)	
			(500/1112 / 221)	(GROSS		(1.000111 0001)	
				SALARIES)			
		1.00	1.01	4.00	5A	5.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	471,575					1.00
1.01	00101 CAP REL COSTS-BLDG & FIXT-MAB	471,373	0				1.01
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	6,193	0	45,655,215			4.00
5.00	00500 ADMINISTRATIVE & GENERAL	51,875	0	1,576,174	-38,503,856	124,258,872	5.00
7.00	00700 OPERATION OF PLANT	55,747		1,624	0	5,806,548	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	671		0	0	337,916	
9.00 10.00	00900 HOUSEKEEPING 01000 DIETARY	9,977 9,839		0	0	2,950,797 758,974	9.00
11.00	01100 CAFETERIA	17,996			0	2,136,096	
13.00	01300 NURSING ADMINISTRATION	4,884		1,830,420	0	3,073,713	
14.00	01400 CENTRAL SERVICES & SUPPLY	15,860		382,265		244,951	14.00
15.00	01500 PHARMACY	4,819		3,073,215	0	4,304,510	
16.00	01600 MEDICAL RECORDS & LIBRARY	5,214		0	0	54,027	
23.00	02300 ALLIED HEALTH-EMS	110	0 0		0	140.001	23.00 23.01
23.01	02301 ALLIED HEALTH-RAD TECH INPATIENT ROUTINE SERVICE COST CENTERS	110	0	110,761	. 0	140,081	23.01
30.00	03000 ADULTS & PEDIATRICS	67,264	0	12,135,375	0	18,110,108	30.00
31.00	03100 INTENSIVE CARE UNIT	14,660	0	3,607,888	0	5,569,121	31.00
41.00	04100 SUBPROVIDER - IRF	10,000		, -,		_,,	1
43.00	04300 NURSERY	5,569	0	172,264	0	306,431	43.00
50.00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	47,997	0	2,472,256	0	11,743,503	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	21,151				,,	1
53.00	05300 ANESTHESIOLOGY	0		0		0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	14,278	0	2,012,843	0	3,526,540	54.00
54.01	03440 MAMMOGRAPHY	0	0	296,071		793,740	
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	1,127	0	292,852		905,435	
54.03 55.00	03630 ULTRA SOUND 05500 RADIOLOGY-THERAPEUTIC	0	0	321,437 961,700		470,650 2,289,739	
57.00	05700 CT SCAN	551	0	678,005		896,818	1
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1,003	Ö	264,339		535,884	1
59.00	05900 CARDIAC CATHETERIZATION	8,562	0	807,735		1,308,503	59.00
60.00	06000 LABORATORY	12,544		0	0	6,974,133	
65.00	06500 RESPIRATORY THERAPY	7,138		, ,		1,684,644	
66.00 67.00	06600 PHYSICAL THERAPY 06700 OCCUPATIONAL THERAPY	9,724 4,575		394,558 132,717		2,981,919 1,345,083	
68.00	06800 SPEECH PATHOLOGY	1,558		45,211		458,204	
69.00	06900 ELECTROCARDIOLOGY	0	0	131,867		220,750	
70.00	07000 ELECTROENCEPHALOGRAPHY	11,644	0	225,024	0	445,494	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	3,731,323	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	5,308,565	
	07300 DRUGS CHARGED TO PATIENTS 03190 CHEMOTHERAPY	0		732,516	0	15,565,392 1,087,194	
	03020 WOUND CARE	3,100				, ,	
	OUTPATIENT SERVICE COST CENTERS	,				, ,	
	09000 CLINIC	0		0	0	0	
	09001 ANDERSON OUTPATIENT CENTER	3,500	0	1,193,272	0	1,499,759	
	04950 DIABETIC EDUCATION 09002 MS CLINIC	0	0		0	0	
	09100 EMERGENCY	22,635	0	4,162,394	0	6,878,434	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	22,033		.,202,33		3,5.5,.5.	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
112 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE	1					113.00
118.00		451,765	0	41,654,179	-38,503,856	118,652,760	
	NONREIMBURSABLE COST CENTERS	.52,703		12,001,210	30,303,030		
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	1,882		0	0	·	190.00
	19100 RESEARCH	0	1	83,721		125,387	
	19200 PHYSICIANS' PRIVATE OFFICES	1,829		2,806,331	0	3,734,056	
	07950 FOUNDATION 07951 CHILDRENS CLINIC	636			0		194.00 194.01
	07951 CHILDRENS CLINIC			44,275			194.01
	07953 SEXUAL ASSAULT PROGRAM	0	0	5,528			194.03
194.04	07954 ASPR BIOTERRORISM GRANT	0	0	0	0	440	194.04
	07955 HEALTHY FAMILIES	10,091		369,064		673,625	
	07956 DME-HOME CARE	0		0	-		194.06
194.07	(107957  MARKETING	0	0	0	0	1 0	194.07

Health Financial Systems

ASCENSION ST. VINCENT ANDERSON

In Lieu of Form CMS-2552-10

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0088

Period:
From 07/01/2022
To 06/30/2023

Date/Time Prepared:

				T	0 06/30/2023	Date/Time Prep 11/22/2023 10	
		CAPITAL REL	ATED COSTS			11/22/2023 10	. 37 aiii
		C/11 2 1/12 112					
Cost Center	Description	BLDG & FIXT	BLDG &	EMPLOYEE	Reconciliation	ADMINISTRATIVE	
	·	(SQUARE FEET)	FIXT-MAB	BENEFITS		& GENERAL	
			(SQUARE FEET)	DEPARTMENT		(ACCUM. COST)	
				(GROSS			
				SALARIES)			
		1.00	1.01	4.00	5A	5.00	
194.08 07958 CORPORATE C	OMMUNICATIONS	2,527	0	0	0	26,168	194.08
194.09 07959 мов		0	0	0	0	369	194.09
194.10 07960 ASC		0	0	154	0		194.10
194.11 07961 MAB		0	0	0	0	0	194.11
194.12 07963 ADOLESCENT	RESIDENTIAL SERVICES	2,845	0	691,963	0	947,045	194.12
194.13 07962 IDLE SPACE		0	0	0	0		194.13
200.00 Cross Foot	Adjustments						200.00
201.00 Negative Co	st Centers						201.00
	allocated (per Wkst. B,	4,883,379	0	8,388,058		38,503,856	202.00
Part I)							
	ultiplier (Wkst. B, Part I)	10.355466	0.000000			0.309868	
	allocated (per Wkst. B,			64,131		2,674,774	204.00
Part II)							
	ultiplier (Wkst. B, Part			0.001405		0.021526	205.00
II)							200.00
	ment amount to be allocated						206.00
(per Wkst.							207.00
	ost multiplier (Wkst. D,						207.00
Parts III a	nu iv)						

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0088

Period: Worksheet B-1 From 07/01/2022 To 06/30/2023 Date/Time Prepared:

11/22/2023 10:37 am Cost Center Description OPERATION OF DIETARY LAUNDRY & HOUSEKEEPING CAFETERIA PLANT LINEN SERVICE (SQUARE FEET) (MEALS SERVED) (TOTAL HOURS) (SQUARE FEET) (PATIENT DAYS) 9.00 10.00 11.00 7.00 8.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00101 CAP REL COSTS-BLDG & FIXT-MAB 1.01 1.01 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 7.00 00700 OPERATION OF PLANT 357,760 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 671 27,455 8.00 00900 HOUSEKEEPING 347.112 9.00 9.977 9.00 10.00 01000 DIETARY 9,839 9,839 101,203 10.00 11.00 01100 CAFETERIA 17,996 17,996 890,842 11.00 01300 NURSING ADMINISTRATION 44,159 13.00 4.884 4.884 13.00 0 14.00 01400 CENTRAL SERVICES & SUPPLY 15,860 15,860 0 15,451 14.00 15.00 01500 PHARMACY 4,819 4,819 0 60,984 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY o 16.00 5.214 5.214 02300 ALLIED HEALTH-EMS 0 23.00 23.00 0 0 0 0 23.01 02301 ALLIED HEALTH-RAD TECH 110 110 2,908 23.01 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 67,264 19,880 67,264 82,095 269,317 30.00 03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 31.00 31.00 14,660 4,041 14.660 6,843 69,518 41.00 04100 SUBPROVIDER - IRF 10,000 2,677 10,000 8,632 28,105 41.00 43.00 04300 NURSERY 5,569 538 5,569 0 3,550 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 47.997 47.997 12 42.924 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 21,151 0 21,151 1,325 18,097 52.00 53.00 05300 ANESTHESIOLOGY 0 53.00 54.00 05400 RADTOLOGY-DTAGNOSTIC 14.278 0 14.278 0 56,677 54.00 54.01 03440 MAMMOGRAPHY n 0 n 0 6,439 54.01 5,699 03450 NUCLEAR MEDICINE - DIAGNOSTIC 0 54.02 1.127 1.127 54.02 54.03 03630 ULTRA SOUND 0 0 7,339 54.03 0 0 55.00 05500 RADIOLOGY-THERAPEUTIC 0 0 55.00 0 0 24.815 57.00 05700 CT SCAN 551 0 551 0 15,651 57.00 1,003 0 1,003 0 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 5,803 58.00 59.00 05900 CARDIAC CATHETERIZATION 8.562 0 8.562 774 19,292 59.00 60.00 06000 LABORATORY 12,544 0 12,544 0 60.00 06500 RESPIRATORY THERAPY 7,138 0 7,138 0 27,379 65.00 65.00 66.00 06600 PHYSICAL THERAPY 9,724 9,724 0 7,103 66.00 06700 OCCUPATIONAL THERAPY 0 3,625 67.00 0 4.575 67.00 4.575 68.00 06800 SPEECH PATHOLOGY 1,558 0 1,558 0 1,235 68.00 06900 ELECTROCARDIOLOGY 0 69.00 3,645 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 11.644 0 11.644 17 2,170 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 73.00 03190 CHEMOTHERAPY 21,030 76.00 0 990 76.00 n 76.01 03020 WOUND CARE 3.100 3.100 11,336 76.01 OUTPATIENT SERVICE COST CENTERS 09000 CLINIC 90.00 3,500 90.01 09001 ANDERSON OUTPATIENT CENTER 0 3,500 0 90.01 10,110 90.02 04950 DIABETIC EDUCATION 0 0 90.02 09002 MS CLINIC 90.03 90.03 91.00 09100 EMERGENCY 22,635 319 22,635 515 82,725 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 0 0 0 0 95.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 337,950 27,455 327,302 101,203 867,086 118.00 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 1,882 1,882 0 190.00 191.00 19100 RESEARCH 0 0 2,086 191.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 1.829 1.829 0 4,227 192.00 0 194.00 07950 FOUNDATION 0 0 194.00 636 636 194.01 07951 CHILDRENS CLINIC 0 0|194.010 0 0 194.02 07952 PSS ADMINISTRATION 0 0 0 0 2,722 194.02 0 121 194.03 194.03 07953 SEXUAL ASSAULT PROGRAM 0 0 0 194.04 07954 ASPR BIOTERRORISM GRANT 0 0 0 194.04 0 14,600 194.05 194.05 07955 HEALTHY FAMILIES 10,091 0 10,091 194.06 07956 DME-HOME CARE 0 0 0 194.06 0 0 194.07 07957 MARKETING 0 0 194.07 ol 194.08 07958 CORPORATE COMMUNICATIONS 2,527 0 0 194.08 2.527 194.09 07959 MOB 0 0 0 0 0 194.09 194.10 07960 ASC 0 0 0 194.10 0 194.11 07961 MAB 0 0 0 194.11

Health Financial Systems	Olth Financial Systems ASCENSION ST. VINCENT ANDERSON		In Lieu of Form CMS-2552-10		
COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 15-0088	From 07/01/2022	Worksheet B-1 Date/Time Prepared:	

						11/22/2023 10	:37 am
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPING	DIETARY	CAFETERIA	
		PLANT	LINEN SERVICE	(SQUARE FEET)	(MEALS SERVED)	(TOTAL HOURS)	
		(SQUARE FEET)	(PATIENT DAYS)				
		7.00	8.00	9.00	10.00	11.00	
194.12 07963	ADOLESCENT RESIDENTIAL SERVICES	2,845	0	2,845	0	0	194.12
194.13 07962	IDLE SPACE	0	0	0	0	0	194.13
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B,	7,605,811	456,890	4,077,261	1,318,900	3,391,976	202.00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	21.259534	16.641413	11.746240	13.032222	3.807607	203.00
204.00	Cost to be allocated (per Wkst. B,	702,280	15,540	186,420	142,823	277,330	204.00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	1.962992	0.566017	0.537060	1.411253	0.311312	205.00
	II)						
206.00	NAHE adjustment amount to be allocated						206.00
	(per Wkst. B-2)						
207.00	NAHE unit cost multiplier (Wkst. D,						207.00
	Parts III and IV)						

Provider CCN: 15-0088 Period: Worksheet B-1 From 07/01/2022 To 06/30/2023 Date/Time Prepared: COST ALLOCATION - STATISTICAL BASIS

					To 06/30/2023	Date/Time Pre 11/22/2023 10	
	Cost Center Description	NURSING	CENTRAL	PHARMACY	MEDICAL	ALLIED	. 37 aiii
		ADMINISTRATION	SERVICES &	(COSTED	RECORDS &	HEALTH-EMS	
		(DIRECT NURS.	SUPPLY (COSTED	REQUIS.)	LIBRARY (GROSS	(ASSIGNED TIME)	
		HRS.)	REQUIS.)		CHARGES)	I IML)	
		13.00	14.00	15.00	16.00	23.00	
1 00	GENERAL SERVICE COST CENTERS	T					1 00
$1.00 \\ 1.01$	00100 CAP REL COSTS-BLDG & FIXT 00101 CAP REL COSTS-BLDG & FIXT-MAB						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
8.00 9.00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING						8.00 9.00
10.00	01000 DIETARY						10.00
11.00	01100 CAFETERIA						11.00
13.00	01300 NURSING ADMINISTRATION	379,619	11 002 221				13.00
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0	11,883,221 147,226	15,565,39			14.00 15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	Ö	36		712,345,517		16.00
23.00	02300 ALLIED HEALTH-EMS	0	0		0	0	23.00
23.01	02301 ALLIED HEALTH-RAD TECH	0	0	(	0		23.01
30.00	03000 ADULTS & PEDIATRICS	177,963	463,805		53,346,238	0	30.00
31.00	03100 INTENSIVE CARE UNIT	60,588	293,145		20,865,195	0	31.00
41.00	04100 SUBPROVIDER - IRF	19,313	19,073		5,184,091	0	41.00
43.00	04300 NURSERY	3,346	10,483		1,206,042	0	43.00
50.00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	39,312	9,000,554		145,248,212	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	15,464	48,449		4,045,591	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0		0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	390,228		16,542,312	0	54.00
54.01 54.02	03440 MAMMOGRAPHY 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	50,467 211,269		0 4,801,889 0 16,492,297	0	54.01
54.03	03630 ULTRA SOUND	Ö	6,353		8,548,512	0	54.03
55.00	05500 RADIOLOGY-THERAPEUTIC	0	21,231		34,157,489	0	55.00
57.00	05700 CT SCAN	0	5,001		0 17,355,972 0 2 718 591	0	57.00
58.00 59.00	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION	9,816	1,092 207,193	`	2,718,591 24,784,796	0	58.00 59.00
60.00	06000 LABORATORY	0	2,574		88,047,756	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	144,191	(	18,511,838	0	65.00
66.00	06600 PHYSICAL THERAPY	0	39,133		9,069,180	0	66.00
67.00 68.00	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY	0	18,410 6,271		4,191,817 1,427,964	0	67.00
69.00	06900 ELECTROCARDIOLOGY	Ö	1,667		1,346,819	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	6,215	(	4,124,274	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		20,419,563	0	71.00
72.00 73.00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0	15,565,39	21,901,581 2 88,730,029	0	72.00 73.00
76.00	03190 CHEMOTHERAPY	Ö	90,262		7,631,560	0	76.00
76.01	03020 WOUND CARE	0	294,091	(	5,774,267	0	76.01
00 00	OUTPATIENT SERVICE COST CENTERS		0			0	00 00
90.00	09000 CLINIC 09001 ANDERSON OUTPATIENT CENTER	0	937		4,410,152	0	
90.02	04950 DIABETIC EDUCATION	0	0		0	0	
	09002 MS CLINIC	0	0		0 0	0	
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	53,817	403,438	(	81,461,490	0	91.00 92.00
92.00	OTHER REIMBURSABLE COST CENTERS						92.00
95.00	09500 AMBULANCE SERVICES	0	0	(	0	0	95.00
	SPECIAL PURPOSE COST CENTERS	T					
113.00	11300 INTEREST EXPENSE   SUBTOTALS (SUM OF LINES 1 through 117)	379,619	11,882,794	15,565,39	712,345,517	0	113.00 118.00
110.00	NONREIMBURSABLE COST CENTERS	379,019	11,002,794	13,303,39	2 712,343,317	<u> </u>	1110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	(	0		190.00
	19100 RESEARCH	0	0	(	0		191.00
	19200 PHYSICIANS' PRIVATE OFFICES  07950 FOUNDATION	0	124				192.00 194.00
	U07951 CHILDRENS CLINIC	0	0				194.00
	07952 PSS ADMINISTRATION	Ö	ő				194.02
	07953 SEXUAL ASSAULT PROGRAM	0	0				194.03
	07954 ASPR BIOTERRORISM GRANT 07955 HEALTHY FAMILIES	0	0	!			194.04 194.05
	07956 DME-HOME CARE		303				194.05
194.07	7 07957 MARKETING		0			0	194.07
	07958 CORPORATE COMMUNICATIONS	0	0		0		194.08
194.09	0 07959 мов	0	0	'	0  0	0	194.09

Health Financial Systems	ASCENSION ST. VINCENT ANDERSON	In Lieu of Form CMS-2552-1
COST ALLOCATION - STATISTICAL BASIS	Provider CCN: 15-0088	Period: Worksheet B-1 From 07/01/2022
		FI OIII 07/01/2022

				11	06/30/2023	11/22/2023 10	
	Cost Center Description	NURSING	CENTRAL	PHARMACY	MEDICAL	ALLIED	
		ADMINISTRATION	SERVICES &	(COSTED	RECORDS &	HEALTH-EMS	
			SUPPLY	REQUIS.)	LIBRARY	(ASSIGNED	
		(DIRECT NURS.	(COSTED		(GROSS	TIME)	
		HRS.)	REQUIS.)		CHARGES)		
		13.00	14.00	15.00	16.00	23.00	
194.10 07960	ASC	0	0	0	0	0	194.10
194.11 07961	MAB	0	0	0	0	0	194.11
194.12 07963	ADOLESCENT RESIDENTIAL SERVICES	0	0	0	0	0	194.12
194.13 07962	IDLE SPACE	0	0	0	0	0	194.13
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	4,355,499	903,155	6,040,788	242,863	0	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	11.473343	0.076003	0.388091	0.000341	0.000000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	145,270	214,509	180,571	68,192	0	204.00
205.00	Unit cost multiplier (Wkst. B, Part	0.382673	0.018051	0.011601	0.000096	0.000000	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)					0	206.00
207.00	NAHE unit cost multiplier (Wkst. D,					0.00000	207.00
	Parts III and IV)	1					I

Health Financial Systems ASCENSION ST. VINCENT ANDERSON In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0088 Period: Worksheet B-1

From 07/01/2022 06/30/2023 Date/Time Prepared: 11/22/2023 10:37 am Cost Center Description ALLIED HEALTH-RAD TECH (ASSIGNED TIME) 23.01 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00101 CAP REL COSTS-BLDG & FIXT-MAB 1.01 1.01 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPING 9.00 10.00 01000 DIETARY 10.00 01100 CAFETERIA 11.00 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 15.00 01500 PHARMACY 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 23.00 02300 ALLIED HEALTH-EMS 23.00 23.01 02301 ALLIED HEALTH-RAD TECH 100,617,061 23.01 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 30.00 0 31.00 03100 INTENSIVE CARE UNIT 0 31.00 41.00 04100 SUBPROVIDER - IRF 0 41.00 43.00 04300 NURSERY 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 53.00 05300 ANESTHESIOLOGY 53.00 0 54.00 | 05400 RADIOLOGY-DIAGNOSTIC 16,542,311 54.00 4,801,889 54.01 03440 MAMMOGRAPHY 54.01 54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC 16,492,297 54.02 8,548,512 54.03 | 03630 | ULTRA SOUND 54.03 55.00 05500 RADIOLOGY-THERAPEUTIC 34,157,489 55.00 57.00 05700 CT SCAN 17,355,972 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 2,718,591 58.00 59.00 05900 CARDIAC CATHETERIZATION 0 59.00 06000 LABORATORY 60.00 60.00 65.00 06500 RESPIRATORY THERAPY 0 65.00 06600 PHYSICAL THERAPY 0 66.00 66.00 0 67.00 06700 OCCUPATIONAL THERAPY 67.00 68.00 06800 SPEECH PATHOLOGY 0 68.00 0 06900 ELECTROCARDIOLOGY 69.00 69.00 0 70.00 07000 ELECTROENCEPHALOGRAPHY 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 73.00 76.00 03190 CHEMOTHERAPY 0 76.00 76.01 03020 WOUND CARE 0 76.01 OUTPATIENT SERVICE COST CENTERS 90 00 90.00 09000 CLINIC 0 90.01 09001 ANDERSON OUTPATIENT CENTER 0 90.01 04950 DIABETIC EDUCATION 0 90.02 90.02 90.03 09002 MS CLINIC 0 90.03 91.00 09100 EMERGENCY 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 0 95.00 09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 100,617,061 118.00 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 190.00 191.00 19100 RESEARCH 0 191.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 192.00 0 194.00 194.00 07950 FOUNDATION 194.01 07951 CHILDRENS CLINIC 0 194.01 0 194.02 07952 PSS ADMINISTRATION 194.02 194.03 07953 SEXUAL ASSAULT PROGRAM 0 194.03 194.04 07954 ASPR BIOTERRORISM GRANT 0 194.04 194.05 07955 HEALTHY FAMILIES 0 194.05 194.06 07956 DME-HOME CARE 0 194.06 194.07 07957 MARKETING 0 194.07 194.08 07958 CORPORATE COMMUNICATIONS 0 194.08

194.09

194.09 07959 MOB

Health Financial Systems	ASCENSION ST. VINCE	In Lieu of Form CMS-2552-1		
COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 15-0088	Period: From 07/01/2022	Worksheet B-1
				Date/Time Prepared:

			, ,	11/22/2023 10:37 am
	Cost Center Description	ALLIED HEALTH-RAD TECH (ASSIGNED TIME) 23.01		
194.100	7960 ASC	0		194.10
194.11 0	7961 MAB	0		194.11
194.12 0	7963 ADOLESCENT RESIDENTIAL SERVICES	0		194.12
194.130	7962 IDLE SPACE	0		194.13
200.00	Cross Foot Adjustments			200.00
201.00	Negative Cost Centers			201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	198,192		202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.001970		203.00
204.00	Cost to be allocated (per Wkst. B,	5,490		204.00
	Part II)			
205.00	Unit cost multiplier (Wkst. B, Part	0.000055		205.00
	II)			
206.00	NAHE adjustment amount to be allocated	0		206.00
	(per Wkst. B-2)			
207.00	NAHE unit cost multiplier (Wkst. D,	0.000000		207.00
	Parts III and IV)			

Health Financial Systems	ASCENSION ST. VINCENT ANDERSON	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 15-0088	Period: Worksheet C From 07/01/2022 Part I
		To 06/20/2022 Pate/Time Bronaned:

				ר	o 06/30/2023	Date/Time Pre 11/22/2023 10	
			Title	XVIII	Hospital	PPS	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj.		Disallowance		
		Part I, col.					
		26)					
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	30,463,399		30,463,399	0	30,463,399	30.00
31.00	03100 INTENSIVE CARE UNIT	8,924,344		8,924,344	l 0	8,924,344	31.00
41.00	04100 SUBPROVIDER - IRF	3,208,119		3,208,119	0	3,208,119	41.00
43.00	04300 NURSERY	647,261		647,261	. 0	647,261	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	18,314,798		18,314,798	0	18,314,798	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	2,773,015		2,773,015	6 0	2,773,015	52.00
53.00	05300 ANESTHESIOLOGY	0		(	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	5,374,250		5,374,250	0	5,374,250	54.00
54.01	03440 MAMMOGRAPHY	1,079,145		1,079,145	0	1,079,145	54.01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	1,299,068		1,299,068	0	1,299,068	54.02
54.03	03630 ULTRA SOUND	664,672		664,672	2 0	664,672	54.03
55.00	05500 RADIOLOGY-THERAPEUTIC	3,174,270		3,174,270	0	3,174,270	55.00
57.00	05700 CT SCAN	1,292,981		1,292,981		1,292,981	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	763,503		763,503	0	763,503	58.00
59.00	05900 CARDIAC CATHETERIZATION	2,216,925		2,216,925	0	2,216,925	59.00
60.00	06000 LABORATORY	9,579,439		9,579,439	0	9,579,439	60.00
65.00	06500 RESPIRATORY THERAPY	2,563,777	0	2,563,777	0	2,563,777	65.00
66.00	06600 PHYSICAL THERAPY	4,259,980		4,259,980	0	4,259,980	66.00
67.00	06700 OCCUPATIONAL THERAPY	1,929,513	0	1,929,513	0	1,929,513	67.00
68.00	06800 SPEECH PATHOLOGY	657,276		657,276	6 0	657,276	68.00
69.00	06900 ELECTROCARDIOLOGY	303,618		303,618	0	303,618	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	978,220		978,220	0	978,220	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4,894,504		4,894,504	· 0	4,894,504	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	6,960,987		6,960,987	0	6,960,987	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	26,459,654		26,459,654	· 0	26,459,654	73.00
76.00	03190 CHEMOTHERAPY	1,526,519		1,526,519	0	1,526,519	76.00
76.01	03020 WOUND CARE	1,485,986		1,485,986	0	1,485,986	76.01
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0		(	0	0	90.00
90.01	09001 ANDERSON OUTPATIENT CENTER	2,120,076		2,120,076	6 0	2,120,076	
90.02	04950 DIABETIC EDUCATION	0		(	0	0	90.02
90.03	09002 MS CLINIC	0		(	0	0	90.03
91.00	09100 EMERGENCY	10,759,833		10,759,833	0	10,759,833	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2,855,164		2,855,164	ļ .	2,855,164	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0		(	0	0	95.00
	SPECIAL PURPOSE COST CENTERS	1					
	11300 INTEREST EXPENSE						113.00
200.00		157,530,296		157,530,296		157,530,296	
201.00		2,855,164		2,855,164		2,855,164	
202.00	Total (see instructions)	154,675,132	0	154,675,132	2 0	154,675,132	202.00

					0 06/30/2023	Date/Ilme Pre   11/22/2023 10	
			Title	XVIII	Hospital	PPS	157
			Charges				
	Cost Center Description	Inpatient	Outpatient	Total (col. 6	Cost or Other	TEFRA	İ
	, , , , , , , , , , , , , , , , , , ,			+ col. 7)	Ratio	Inpatient	
						Ratio	
		6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	49,176,044		49,176,044			30.00
31.00	03100 INTENSIVE CARE UNIT	20,865,195		20,865,195			31.00
41.00	04100 SUBPROVIDER - IRF	5,184,091		5,184,091			41.00
43.00	04300 NURSERY	1,206,042		1,206,042			43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	26,040,459	119,207,753			0.000000	
52.00	05200 DELIVERY ROOM & LABOR ROOM	3,616,560	429,031	4,045,591	0.685441	0.000000	1
53.00	05300 ANESTHESIOLOGY	0	0	0	0.000000	0.000000	1
54.00	05400 RADIOLOGY-DIAGNOSTIC	6,047,622	10,494,690		0.324879	0.000000	1
54.01	03440 MAMMOGRAPHY	2,369	4,799,520			0.000000	1
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	1,318,365	15,173,932		0.078768	0.000000	
54.03	03630 ULTRA SOUND	1,492,371	7,056,141		0.077753	0.000000	
55.00	05500 RADIOLOGY-THERAPEUTIC	406,555	33,750,934			0.000000	
57.00	05700 CT SCAN	3,931,629	13,424,343		0.074498	0.000000	1
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	603,423	2,115,168		0.280845	0.000000	
59.00	05900 CARDIAC CATHETERIZATION	6,348,649	18,436,147			0.000000	1
60.00	06000 LABORATORY	32,553,389	55,494,367	88,047,756		0.000000	
65.00	06500 RESPIRATORY THERAPY	15,563,418	2,948,420			0.000000	
66.00	06600 PHYSICAL THERAPY	3,001,887	6,067,293			0.000000	
67.00	06700 OCCUPATIONAL THERAPY	2,265,814	1,926,003		0.460305	0.000000	
68.00	06800 SPEECH PATHOLOGY	789,588	638,376			0.000000	1
69.00	06900 ELECTROCARDIOLOGY	0	1,346,819			0.000000	
70.00	07000 ELECTROENCEPHALOGRAPHY	212,933	3,911,341	4,124,274		0.000000	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	9,352,424	11,067,139		0.239697	0.000000	1
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	4,286,054	17,615,527	21,901,581	0.317830	0.000000	1
73.00	07300 DRUGS CHARGED TO PATIENTS	22,742,500	65,987,529			0.000000	1
76.00	03190 CHEMOTHERAPY	67,275	7,564,285			0.000000	
76.01	03020 WOUND CARE	77,258	5,697,009	5,774,267	0.257346	0.000000	76.01
00 00	OUTPATIENT SERVICE COST CENTERS				0.000000	0.00000	00.00
90.00	09000 CLINIC	0	4 401 600	4 410 153	0.000000	0.000000	1
90.01	09001 ANDERSON OUTPATIENT CENTER	8,464	4,401,688			0.000000	
90.02	04950 DIABETIC EDUCATION	0	0	0	0.00000	0.000000	
90.03	09002 MS CLINIC	10 152 505	0 200 005	01 461 400	0.000000	0.000000	1
91.00	09100 EMERGENCY	18,152,585	63,308,905			0.000000	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1,327,555	2,842,639	4,170,194	0.684660	0.000000	92.00
05.00	OTHER REIMBURSABLE COST CENTERS	0	^		0.000000	0.000000	95.00
95.00	09500 AMBULANCE SERVICES	J U	0	0	0.000000	0.000000	95.00
112 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE	1		I			112 00
200.00		236,640,518	475,704,999	712 245 517			113.00 200.00
200.00		230,040,318	4/3,/04,999	712,345,517			200.00
201.00		236,640,518	475,704,999	712,345,517			201.00
202.00	Total (see mistructions)	230,040,318	473,704,999	112,343,31/	1		1202.00

Health Financial Systems ASCENSION ST. VINCENT ANDERSON In Lieu of Form CMS-2552-10

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0088
Period: From 07/01/2022 TO 06/30/2023 Date/Time Prepared: 11/22/2023 10:37 am

					11/22/2023 10:37 am
			Title XVIII	Hospital	PPS
	Cost Center Description	PPS Inpatient			
		Ratio			
		11.00			
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
41.00	04100 SUBPROVIDER - IRF				41.00
43.00	04300 NURSERY				43.00
	ANCILLARY SERVICE COST CENTERS				
50.00		0.126093			50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.685441			52.00
53.00		0.000000			53.00
54.00		0.324879			54.00
54.01		0.224733			54.01
54.02		0.078768			54.02
	03630 ULTRA SOUND	0.077753			54.03
55.00		0.092930			55.00
57.00		0.074498			57.00
58.00		0.280845			58.00
59.00		0.089447			59.00
60.00		0.108798			60.00
65.00		0.138494			65.00
66.00		0.138494			66.00
67.00		0.469721			67.00
68.00	1	1			68.00
69.00		0.460289 0.225433			69.00
70.00		0.237186			70.00
71.00		0.239697			71.00
72.00 73.00		0.317830			72.00
		0.298204			
76.00		0.200027			76.00
76.01		0.257346			76.01
00 00	OUTPATIENT SERVICE COST CENTERS	0.000000			00.00
90.00		0.000000			90.00
90.01		0.480726			90.01
90.02		0.000000			90.02
90.03		0.000000			90.03
91.00		0.132085			91.00
92.00		0.684660			92.00
	OTHER REIMBURSABLE COST CENTERS				
95.00		0.000000			95.00
	SPECIAL PURPOSE COST CENTERS				
	0 11300 INTEREST EXPENSE				113.00
200.0					200.00
201.0					201.00
202.0	Total (see instructions)				202.00

Health Financial Systems	ASCENSION ST. VINCE	NT ANDERSON	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0088	Period: From 07/01/2022 To 06/30/2023	Worksheet C Part I Date/Time Prepared:

					10 06/30/2023	11/22/2023 10	
			Titl	e XIX	Hospital	Cost	151 4
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	·	(from Wkst. B,			Disallowance		
		Part I, col.	J				
		26)					
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	30,463,399		30,463,39	0	30,463,399	30.00
31.00	03100 INTENSIVE CARE UNIT	8,924,344		8,924,34	1 0	8,924,344	31.00
41.00	04100 SUBPROVIDER - IRF	3,208,119		3,208,119	9 0	3,208,119	41.00
43.00	04300 NURSERY	647,261		647,26	L O	647,261	43.00
	ANCILLARY SERVICE COST CENTERS					·	
50.00	05000 OPERATING ROOM	18,314,798		18,314,79	0	18,314,798	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	2,773,015		2,773,01	5 0	2,773,015	52.00
53.00	05300 ANESTHESIOLOGY	0			0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	5,374,250		5,374,250	o o	5,374,250	54.00
54.01	03440 MAMMOGRAPHY	1,079,145		1,079,14		1,079,145	
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	1,299,068		1,299,06		1,299,068	
54.03	03630 ULTRA SOUND	664,672		664,67		664,672	54.03
55.00	05500 RADIOLOGY-THERAPEUTIC	3,174,270		3,174,27		3,174,270	1
	05700 CT SCAN	1,292,981		1,292,98		1,292,981	1
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	763,503		763,50		763,503	
59.00	05900 CARDIAC CATHETERIZATION	2,216,925		2,216,92		2,216,925	•
60.00	06000 LABORATORY	9,579,439		9,579,43		9,579,439	ł
65.00	06500 RESPIRATORY THERAPY	2,563,777	0			2,563,777	1
66.00	06600 PHYSICAL THERAPY	4,259,980	0	4,259,98		4,259,980	
67.00	06700 OCCUPATIONAL THERAPY	1,929,513	0	1,929,51		1,929,513	•
68.00	06800 SPEECH PATHOLOGY	657,276	0	657,27		657,276	1
69.00	06900 ELECTROCARDIOLOGY	303,618	ŭ	303,61		303,618	1
	07000 ELECTROENCEPHALOGRAPHY	978,220		978,220		978,220	
71.00		4,894,504		4,894,50		4,894,504	1
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	6,960,987		6,960,98		6,960,987	1
73.00	07300 DRUGS CHARGED TO PATIENTS	26,459,654		26,459,65		26,459,654	1
76.00	03190 CHEMOTHERAPY	1,526,519		1,526,51		1,526,519	1
	03020 WOUND CARE	1,485,986		1,485,98	·	1,485,986	
70.01	OUTPATIENT SERVICE COST CENTERS	1,403,300		1,405,50	ν <sub>1</sub>	1,403,300	70.01
90.00		0			0	0	90.00
90.01	09001 ANDERSON OUTPATIENT CENTER	2,120,076		2,120,07		2,120,076	
90.02	04950 DIABETIC EDUCATION	2,120,070		2,120,07		0	90.02
90.03	09002 MS CLINIC	0			ol ol	0	90.03
91.00	09100 EMERGENCY	10,759,833		10,759,83		10,759,833	•
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2,855,164		2,855,16		2,855,164	
32.00	OTHER REIMBURSABLE COST CENTERS	2,033,104		2,055,10	т	2,033,104	32.00
95.00		0			0	0	95.00
33.00	SPECIAL PURPOSE COST CENTERS			<u> </u>	<u> </u>		33.00
113 00	11300 INTEREST EXPENSE						113.00
200.00		157,530,296	0	157,530,29	5 0	157,530,296	
201.00		2,855,164		2,855,16		2,855,164	
202.00	I I	154,675,132	0			154,675,132	
202.00	1.000. (300 111301 40010113)	1 13 1, 0, 3, 132		1 151,075,15	-1	131,073,132	1-32.00

Period: Worksheet C
From 07/01/2022 Part I
To 06/30/2023 Date/Time Prepared: 11/22/2023 10:37 am

						11/22/2023 10	):37 am
			Titl	e XIX	Hospital	Cost	
			Charges				
	Cost Center Description	Inpatient	Outpatient	Total (col.	6 Cost or Other	TEFRA	
		·		+ col. 7)	Ratio	Inpatient	
						Ratio	
		6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·					
30.00	03000 ADULTS & PEDIATRICS	49,176,044		49,176,0	14		30.00
31.00	03100 INTENSIVE CARE UNIT	20,865,195		20,865,19			31.00
41.00	04100 SUBPROVIDER - IRF	5,184,091		5,184,0			41.00
43.00	04300 NURSERY	1,206,042		1,206,0			43.00
.5.00	ANCILLARY SERVICE COST CENTERS			1,200,0	·=		1 .5.00
50.00	05000 OPERATING ROOM	26,040,459	119,207,753	145,248,2	0.126093	0.000000	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	3,616,560	429,031			0.000000	
53.00	05300 ANESTHESIOLOGY	3,010,300	429,031		0.000000		
54.00	05400 RADIOLOGY-DIAGNOSTIC	6,047,622	10,494,690			0.000000	
54.01	03440 MAMMOGRAPHY	2,369	4,799,520			0.000000	1
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	1,318,365	15,173,932			0.000000	1
54.03	03630 ULTRA SOUND	1,492,371	7,056,141			0.000000	1
55.00	05500 RADIOLOGY-THERAPEUTIC	406,555	33,750,934			0.000000	1
57.00	05700 CT SCAN	3,931,629	13,424,343			0.000000	1
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	603,423	2,115,168			0.000000	1
59.00	05900 CARDIAC CATHETERIZATION	6,348,649	18,436,147			0.000000	1
60.00	06000 LABORATORY	32,553,389	55,494,367			0.000000	1
65.00	06500 RESPIRATORY THERAPY	15,563,418	2,948,420			0.000000	
66.00	06600 PHYSICAL THERAPY	3,001,887	6,067,293	9,069,1	30 0.469721	0.000000	66.00
67.00	06700 OCCUPATIONAL THERAPY	2,265,814	1,926,003	4,191,8	L7 0.460305	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	789,588	638,376	1,427,9	0.460289	0.000000	68.00
69.00	06900 ELECTROCARDIOLOGY	0	1,346,819	1,346,83	L9 0.225433	0.000000	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	212,933	3,911,341	4,124,2	74 0.237186	0.000000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	9,352,424	11,067,139	20,419,5	0.239697	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	4,286,054	17,615,527			0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	22,742,500	65,987,529			0.000000	73.00
76.00	03190 CHEMOTHERAPY	67,275	7,564,285			0.000000	
76.01	03020 WOUND CARE	77,258	5,697,009				1
	OUTPATIENT SERVICE COST CENTERS	,255	3,031,003	3,,2	0.123.3.0	0.00000	1
90.00	09000 CLINIC	0	0		0.000000	0.000000	90.00
90.00	09001 ANDERSON OUTPATIENT CENTER	8,464	4,401,688	4,410,1			
90.01	04950 DIABETIC EDUCATION	0,464	4,401,000	4,410,1	0.000000		
90.02	09002 MS CLINIC	0	0		0.000000		
90.03		10 153 505	C2 200 005	01 461 4			
	09100 EMERGENCY	18,152,585	63,308,905				
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1,327,555	2,842,639	4,170,19	0.684660	0.000000	92.00
05.05	OTHER REIMBURSABLE COST CENTERS			1	0 000000	0.000	4
95.00	09500 AMBULANCE SERVICES	0	0		0.000000	0.000000	95.00
	SPECIAL PURPOSE COST CENTERS			ı			1
	11300 INTEREST EXPENSE						113.00
200.00	1 1	236,640,518	475,704,999	712,345,5	L7		200.00
201.00							201.00
202.00	Total (see instructions)	236,640,518	475,704,999	712,345,5	L7		202.00

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0088

Period:
From 07/01/2022
To 06/30/2023 10:37 am

				10 00,00,000	11/22/2023 10:37	am
			Title XIX	Hospital	Cost	
	Cost Center Description	PPS Inpatient				
		Ratio				
		11.00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30	00.0
31.00	03100 INTENSIVE CARE UNIT				31	L.00
41.00	04100 SUBPROVIDER - IRF				41	L.00
43.00	04300 NURSERY				43	3.00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50	00.0
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000			52	2.00
53.00	05300 ANESTHESIOLOGY	0.000000			53	3.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54	1.00
54.01	03440 MAMMOGRAPHY	0.000000				1.01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0.000000				1.02
54.03	03630 ULTRA SOUND	0.000000				1.03
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000			l l	5.00
57.00	05700 CT SCAN	0.000000			l l	7.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000			l l	3.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000			· · · · · · · · · · · · · · · · · · ·	9.00
60.00	06000 LABORATORY	0.000000				0.00
65.00	06500 RESPIRATORY THERAPY	0.000000				5.00
66.00	06600 PHYSICAL THERAPY	0.000000			· · · · · · · · · · · · · · · · · · ·	5.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000			· · · · · · · · · · · · · · · · · · ·	7.00
68.00	06800 SPEECH PATHOLOGY	0.000000				3.00
69.00	06900 ELECTROCARDIOLOGY	0.000000				9.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000				0.00
70.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000				L.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1			l	2.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			· · · · · · · · · · · · · · · · · · ·	3.00
76.00	03190 CHEMOTHERAPY	0.000000				5.00
	03020 WOUND CARE	0.000000				5.01
76.01		0.000000			/0	.01
90.00	09000 CLINIC	0.000000			00	0.00
90.00		0.00000				0.00
90.01	09001 ANDERSON OUTPATIENT CENTER				l	
	04950 DIABETIC EDUCATION	0.000000			l l	0.02
90.03	09002 MS CLINIC	0.000000				0.03
91.00	09100 EMERGENCY	0.000000				L.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92	2.00
05.65	OTHER REIMBURSABLE COST CENTERS	0.00000				
95.00	09500 AMBULANCE SERVICES	0.000000			95	5.00
	SPECIAL PURPOSE COST CENTERS					
	11300 INTEREST EXPENSE					3.00
200.00						0.00
201.00						L.00
202.00	Total (see instructions)				202	2.00

Health Financial Systems	ASCENSION ST. VI	NCENT ANDERSON		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVI	CE CAPITAL COSTS		Provider CCN: 15-0088		Worksheet D Part I Date/Time Pre 11/22/2023 10	
			XVIII	Hospital	PPS	
Cost Center Description	Capital Related Cost	Swing Bed Adjustment	Reduced Capital	Total Patient Days	Per Diem (col. 3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CE	NTERS					
30.00 ADULTS & PEDIATRICS	1,564,117	0	1,564,11			
31.00 INTENSIVE CARE UNIT	377,477		377,47	7 4,041	93.41	31.00
41.00   SUBPROVIDER - IRF	200,221		200,22	1 2,677	74.79	41.00
43.00 NURSERY	81,426		81,42	6 547	148.86	43.00
200.00 Total (lines 30 through 199)	2,223,241		2,223,24	1 29,415		200.00
Cost Center Description	Inpatient	Inpatient				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CE		404 5	.1			
30.00 ADULTS & PEDIATRICS	2,752					30.00
31.00 INTENSIVE CARE UNIT	2,482		1			31.00
41.00 SUBPROVIDER - IRF	1,122		1			41.00
43.00 NURSERY	0	1	1			43.00
200.00 Total (lines 30 through 199)	6,356	510,077	Ί			200.00

	<u> </u>	SCENSION ST. VI			In Lie Period:	u of Form CMS-2	2552-10
APPORT	APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL		Provider C	Provider CCN: 15-0088		Worksheet D Part II	
					From 07/01/2022 To 06/30/2023	Date/Time Pre	pared:
						11/22/2023 10	
				XVIII	Hospital	PPS	
	Cost Center Description	Capital	Total Charges			Capital Costs	
			(from Wkstc,		Program	(column 3 x	
		(from Wkst. B,			. Charges	column 4)	
		Part II, col.	8)	2)			
		26)					
		1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS	T	T	T			
	05000 OPERATING ROOM	1,077,942				61,639	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	317,407				0	52.00
53.00	05300 ANESTHESIOLOGY	0	,	0.00000		0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	288,567				21,477	54.00
54.01	03440 MAMMOGRAPHY	20,879				0	54.01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	41,560	, ,			823	54.02
54.03	03630 ULTRA SOUND	13,804	, ,			0	54.03
55.00	05500 RADIOLOGY-THERAPEUTIC	62,027	, ,			237	55.00
57.00	05700 CT SCAN	33,970				2,044	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	26,889				,	
59.00	05900 CARDIAC CATHETERIZATION	156,343	24,784,796	0.00630	1,561,918	9,853	59.00
60.00	06000 LABORATORY	319,884	88,047,756	0.00363	7,791,172	28,305	60.00
65.00	06500 RESPIRATORY THERAPY	142,616	18,511,838	0.00770	4,118,041	31,725	65.00
66.00	06600 PHYSICAL THERAPY	193,538	9,069,180	0.02134	554,542	11,834	66.00
67.00	06700 OCCUPATIONAL THERAPY	89,817	4,191,817	0.02142	363,487	7,788	67.00
68.00	06800 SPEECH PATHOLOGY	30,590	1,427,964	0.02142	180,410	3,865	68.00
69.00	06900 ELECTROCARDIOLOGY	6,231	1,346,819	0.00462	26 0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	160,804	4,124,274	0.03899	97,667	3,808	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	82,280	20,419,563	0.00402	2,029,327	8,176	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	116,375	21,901,581	0.00531	2,211,208	11,750	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	524,150	88,730,029	0.00590	5,227,531	30,879	73.00
76.00	03190 CHEMOTHERAPY	34,738	7,631,560	0.00455	0	0	76.00
76.01	03020 WOUND CARE	71,445	5,774,267	0.01237	73 0	0	76.01
	OUTPATIENT SERVICE COST CENTERS						
00 00	00000 CLTNTC	0	0	0 00000	0	0	ا مم مم

82,542

507,254

146,596

4,548,248

4,410,152

81,461,490

635,914,145

4,170,194

0.000000

0.018716 0.000000

0.000000

0.006227

0.035153

0

4,136,834

40,057,101

613,262

90.00

90.01 90.02

90.03

91.00

92.00

95.00

0

0

282,837 200.00

25,760

21,558

90.00 09000 CLINIC

90.03 09002 MS CLINIC

91.00 09100 EMERGENCY

200.00

90.01 09001 ANDERSON OUTPATIENT CENTER

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)
OTHER REIMBURSABLE COST CENTERS

Total (lines 50 through 199)

90.02 04950 DIABETIC EDUCATION

95.00 09500 AMBULANCE SERVICES

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHE	R PASS THROUGH COST	TS Provider C		Period: From 07/01/2022 Fo 06/30/2023	Worksheet D Part III Date/Time Pre 11/22/2023 10	
		Title	2 XVIII	Hospital	PPS	
Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdowr Adjustments		All Other Medical Education Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00   03000   ADULTS & PEDIATRICS 31.00   03100   INTENSIVE CARE UNIT 41.00   04100   SUBPROVIDER - IRF 43.00   04300   NURSERY	0 0 0	0 0		0 0 0 0 0	0 0 0	31.00 41.00
200.00 Total (lines 30 through 199)	0			o o		200.00
Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00   03000   ADULTS & PEDIATRICS 31.00   03100   INTENSIVE CARE UNIT 41.00   04100   SUBPROVIDER - IRF 43.00   04300   NURSERY	0	ď	4,04	0.00 0.00	2,752 2,482 1,122 0	31.00 41.00
200.00 Total (lines 30 through 199)		0	29,41	5	6,356	200.00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00					
INPATIENT ROUTINE SERVICE COST CENTERS		ı				4
30.00   03000   ADULTS & PEDIATRICS 31.00   03100   INTENSIVE CARE UNIT 41.00   04100   SUBPROVIDER - IRF 43.00   04300   NURSERY	0					30.00 31.00 41.00 43.00

Health Financial Systems	ASCENSION ST. VINCE	In Lieu of Form CMS-2552-1		
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0088	Period: From 07/01/2022 To 06/30/2023	Worksheet D Part IV Date/Time Prepared:

					10 06/30/2023	11/22/2023 10	pared: :37 am
			Title	XVIII	Hospital	PPS	
	Cost Center Description	Non Physician	Nursing	Nursing	Allied Health	Allied Health	
		Anesthetist	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
		1.00	2A	2.00	3A	3.00	
	ANCILLARY SERVICE COST CENTERS			1			
50.00	05000 OPERATING ROOM	0	0	1	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	1	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	1	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	1	0	32,588	
	03440 MAMMOGRAPHY	0	0	1	0	9,460	
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	0	1	0	32,490	
54.03	03630 ULTRA SOUND	0	0	1	0	16,841	
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	1	0	67,266	
57.00	05700 CT SCAN	0	0	1	0	34,191	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0	5,356	
59.00	05900 CARDIAC CATHETERIZATION	0	0	4	0	0	59.00
60.00	06000 LABORATORY	0	0		0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	4	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	(	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	(	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0		0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	(	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	(	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73.00
76.00	03190 CHEMOTHERAPY	0	0		0	0	76.00
76.01	03020 WOUND CARE	0	0		0	0	76.01
	OUTPATIENT SERVICE COST CENTERS			1	.1		
	09000 CLINIC	0	0		0	0	90.00
90.01	09001 ANDERSON OUTPATIENT CENTER	0	0	4	0	0	90.01
90.02	04950 DIABETIC EDUCATION	0	0	(	0	0	90.02
90.03	09002 MS CLINIC	0	0	(	0	0	90.03
91.00	09100 EMERGENCY	0	0	(	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			)	0	92.00
05.05	OTHER REIMBURSABLE COST CENTERS			1			
95.00	09500 AMBULANCE SERVICES		_			100 100	95.00
200.00	Total (lines 50 through 199)	0	0	ıl (	0	198,192	200.00

Health Financial Systems	ASCENSION ST. VINCENT ANDERSON In Lieu			u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0088	From 07/01/2022 To 06/30/2023	Worksheet D Part IV Date/Time Prepared:

			Т	o 06/30/2023	Date/Time Pre 11/22/2023 10	
		Title	XVIII	Hospital	PPS	. 37 am
Cost Center Description	All Other	Total Cost	Total	Total Charges		
	Medical	(sum of cols.	Outpatient	(from Wkst. C,		
	Education Cost	1, 2, 3, and	Cost (sum of		(col. 5 ÷ col.	
		4)	cols. 2, 3,	8)	7)	
			and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS	-1					
50.00 05000 OPERATING ROOM	0	0	0	145,248,212	0.000000	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	C	4,045,591	0.000000	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	32,588			0.001970	54.00
54.01   03440   MAMMOGRAPHY	0	9,460			0.001970	54.01
54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	32,490			0.001970	54.02
54.03   03630   ULTRA SOUND	0	16,841			0.001970	54.03
55.00 05500 RADIOLOGY-THERAPEUTIC	0	67,266	l '		0.001969	55.00
57.00 05700 CT SCAN	0	34,191			0.001970	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	5,356	5,356		0.001970	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	C	24,784,796		59.00
60.00   06000   LABORATORY	0	0	C	88,047,756	0.000000	60.00
65.00 06500 RESPIRATORY THERAPY	0	0	C	18,511,838	0.000000	65.00
66.00 06600 PHYSICAL THERAPY	0	0	C	9,069,180	0.000000	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		4,191,817	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		1,427,964	0.000000	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		1,346,819	0.000000	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		4,124,274	0.000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		20,419,563	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		21,901,581	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		88,730,029	0.000000	73.00
76.00 03190 CHEMOTHERAPY	0	0		7,631,560		76.00
76.01 03020 WOUND CARE	U	0	<u> </u>	5,774,267	0.000000	76.01
90.00 OUTPATIENT SERVICE COST CENTERS 90.00 OP000 CLINIC	O	0	_	0	0.000000	90.00
90.01 09001 ANDERSON OUTPATIENT CENTER		0		4,410,152	0.000000	90.00
90.02   04950   DIABETIC EDUCATION	0	0		4,410,132	0.000000	90.01
90.03   09002 MS CLINIC	0	0		0	0.000000	90.02
91.00   09100   EMERGENCY		0		81,461,490	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0			0.000000	92.00
OTHER REIMBURSABLE COST CENTERS	ı o	0		4,170,194	0.000000	32.00
95.00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	o	198,192	198,192	635,914,145		200.00
	١	130,132	1 130,132	055,51,175		_ 50.00

Health Financial Systems	ASCENSION ST. VINCE	ENT ANDERSON	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0088	From 07/01/2022 To 06/30/2023	Worksheet D Part IV Date/Time Prepared: 11/22/2023 10:37 am

				7	To 06/30/2023	Date/Time Pre 11/22/2023 10	pared:
-			Title	XVIII	Hospital	PPS	. 37 am
	Cost Center Description	Outpatient	Inpatient	Inpatient	Outpatient	Outpatient	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	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	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0.000000	8,305,997	(	24,602,340	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	(	403	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	(	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.001970	1,231,223	2,426	2,844,717	5,604	54.00
54.01	03440 MAMMOGRAPHY	0.001970	0	(	0	0	54.01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0.001970	326,566	643	3,915,909	7,714	54.02
54.03	03630 ULTRA SOUND	0.001970	0	(	0	0	54.03
55.00	05500 RADIOLOGY-THERAPEUTIC	0.001969	130,356	257	7,833,302	15,424	55.00
57.00	05700 CT SCAN	0.001970	1,044,560	2,058	2,247,678	4,428	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.001970	133,000	262	379,650	748	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	1,561,918	(	3,379,992	0	59.00
60.00	06000 LABORATORY	0.000000	7,791,172	(	5,089,437	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.000000	4,118,041	(	653,707	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	554,542	(	71,058	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	363,487	(	14,189	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	180,410	(	114,283	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	(	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	97,667	(	583,540	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	2,029,327	(	2,028,688	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	2,211,208	(	4,486,812	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	5,227,531	(	20,641,870	0	73.00
	03190 CHEMOTHERAPY	0.000000	0	(	5,713	0	76.00
76.01	03020 WOUND CARE	0.000000	0	(	0	0	76.01
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLINIC	0.000000	0		0	0	90.00
	09001 ANDERSON OUTPATIENT CENTER	0.000000	0		153,566	0	90.01
	04950 DIABETIC EDUCATION	0.000000	0		0	0	90.02
90.03	09002 MS CLINIC	0.000000	0	(	0	0	90.03
91.00	09100 EMERGENCY	0.000000	4,136,834		7,509,845	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	613,262	(	1,886,652	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES		40 057 101			22.22	95.00
200.00	Total (lines 50 through 199)	1	40,057,101	5,646	88,443,351	33,918	200.00

				-	го 06/30/2023	Date/Time Pre 11/22/2023 10	
			Title	2 XVIII	Hospital	PPS	137 4
				Charges		Costs	
	Cost Center Description	Cost to Charge	PS Reimbursed	Cost	Cost	PPS Services	
	·		Services (see	Reimbursed	Reimbursed	(see inst.)	
		Worksheet C,	inst.)	Services	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins.			
				(see inst.)	(see inst.)		
		1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0.126093	24,602,340		~  ~	3,102,183	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.685441	403	l .	0	276	1
53.00	05300 ANESTHESIOLOGY	0.000000	0	1	0	0	53.00
	05400 RADIOLOGY-DIAGNOSTIC	0.324879	2,844,717	[	0	924,189	54.00
54.01	03440 MAMMOGRAPHY	0.224733	0		0	0	54.01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0.078768	3,915,909		0	308,448	54.02
54.03	03630 ULTRA SOUND	0.077753	0	(	0	0	54.03
55.00	05500 RADIOLOGY-THERAPEUTIC	0.092930	7,833,302		0	727,949	55.00
57.00	05700 CT SCAN	0.074498	2,247,678		0	167,448	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.280845	379,650		0	106,623	
59.00	05900 CARDIAC CATHETERIZATION	0.089447	3,379,992		0	302,330	
60.00	06000 LABORATORY	0.108798	5,089,437		0	553,721	
65.00	06500 RESPIRATORY THERAPY	0.138494	653,707		0	90,534	
66.00	06600 PHYSICAL THERAPY	0.469721	71,058		0	33,377	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.460305	14,189	1	0	6,531	
68.00	06800 SPEECH PATHOLOGY	0.460289	114,283	l .	0	52,603	
69.00	06900 ELECTROCARDIOLOGY	0.225433	0		0	0	69.00
	07000 ELECTROENCEPHALOGRAPHY	0.237186	583,540	l .	0	138,408	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.239697	2,028,688		0	486,270	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0.317830	4,486,812		0	1,426,043	
73.00	07300 DRUGS CHARGED TO PATIENTS	0.298204	20,641,870	l .	4,520	6,155,488	
76.00	03190 CHEMOTHERAPY	0.200027	5,713	l .	0	1,143	76.00
76.01	03020 WOUND CARE	0.257346	0	(	0	0	76.01
	OUTPATIENT SERVICE COST CENTERS	0.00000		1			
	09000 CLINIC	0.000000	0	1	0	0	90.00
90.01	09001 ANDERSON OUTPATIENT CENTER	0.480726	153,566	1	0	73,823	
	04950 DIABETIC EDUCATION	0.000000	0	1	0	0	90.02
90.03	09002 MS CLINIC	0.000000	0	1	0	0	90.03
91.00	09100 EMERGENCY	0.132085	7,509,845	l .	0	991,938	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.684660	1,886,652		0	1,291,715	92.00
05.00	OTHER REIMBURSABLE COST CENTERS	0.000000		1	<u> </u>		05 00
	09500 AMBULANCE SERVICES	0.000000	00 442 254		0 4 530	16 041 040	95.00
200.00	, ,		88,443,351	'	4,520	16,941,040	
201.00				1	기 이		201.00
202.00	Only Charges		00 442 251		4 530	16 041 040	202.00
202.00	Net Charges (line 200 - line 201)	1	88,443,351	.	4,520	16,941,040	202.00

In Lieu of Form CMS-2552-10 Health Financial Systems ASCENSION ST. VINCENT ANDERSON APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0088

Period: | Worksheet D | Part V | Date/Time Prepared: | 11/22/2023 10:37 am

						11/22/2023 10	0:37 am
			Title	XVIII	Hospital	PPS	
		Cos	sts				
	Cost Center Description	Cost	Cost				
	'	Reimbursed	Reimbursed				
		Services	Services Not				
		Subject To	Subject To				
			_				
		(see inst.)	(see inst.)				
		6.00	7.00				
	ANCILLARY SERVICE COST CENTERS	0.00	, , , , ,				
50.00	05000 OPERATING ROOM	0	0				50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	1			52.00
	05300 ANESTHESIOLOGY	0	١				53.00
	05400 RADIOLOGY-DIAGNOSTIC	0					54.00
		0	0				
	03440 MAMMOGRAPHY	0	0				54.01
	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	0				54.02
54.03	03630 ULTRA SOUND	0	0				54.03
	05500 RADIOLOGY-THERAPEUTIC	0	0				55.00
57.00	05700 CT SCAN	0	0				57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0				58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0				59.00
60.00	06000 LABORATORY	0	0				60.00
65.00	06500 RESPIRATORY THERAPY	0	0				65.00
66.00	06600 PHYSICAL THERAPY	0	0				66.00
67.00	06700 OCCUPATIONAL THERAPY	0	l ő				67.00
68.00	06800 SPEECH PATHOLOGY	, o	ň				68.00
69.00	06900 ELECTROCARDIOLOGY	0	١				69.00
	07000 ELECTROCARDIOLOGI	0	١				70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0					71.00
		0	0				
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	1 240				72.00
	07300 DRUGS CHARGED TO PATIENTS	0	1,348				73.00
76.00	03190 CHEMOTHERAPY	0	0				76.00
76.01	03020 WOUND CARE	0	0				76.01
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0				90.00
90.01	09001 ANDERSON OUTPATIENT CENTER	0	0				90.01
90.02	04950 DIABETIC EDUCATION	0	0				90.02
90.03	09002 MS CLINIC	0	0				90.03
91.00	09100 EMERGENCY	0	0				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0					95.00
200.00		0	1,348				200.00
201.00		0	1,540				201.00
201.00	Only Charges						1-01.00
202.00		0	1,348				202.00
202.00	ince charges (Time 200)	1 0	1 1,540	I			1202.00

Health	Financial Systems A:	SCENSION ST. VI	NCENT ANDERSON		Tn lie	eu of Form CMS-	2552-10
	TONMENT OF INPATIENT ANCILLARY SERVICE CAPITA		Provider C		Period:	Worksheet D	2332 10
					From 07/01/2022	Part II	
			Component	CCN: 15-T088	To 06/30/2023	Date/Time Pre 11/22/2023 10	pared:
			Title	XVIII	Subprovider -	PPS	. 57 aiii
					IRF		
	Cost Center Description	Capital	Total Charges			Capital Costs	
			(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,	,		. Charges	column 4)	
		Part II, col.	8)	2)			
		26)	2.00	2.00	4.00	5.00	
		1.00	2.00	3.00	4.00	5.00	
FO 00	ANCILLARY SERVICE COST CENTERS	1 077 042	145 240 212	0.0074	22.062	170	
	05000 OPERATING ROOM	1,077,942	' '		- ,	178	
52.00	05200 DELIVERY ROOM & LABOR ROOM	317,407				0	52.00
53.00	05300 ANESTHESIOLOGY	0	· · · · · · · · · · · · · · · · · · ·	0.0000		0	
54.00	05400 RADIOLOGY-DIAGNOSTIC	288,567				661	
54.01	03440 MAMMOGRAPHY	20,879				0	
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	41,560				10	
54.03	03630 ULTRA SOUND	13,804				0	
55.00	05500 RADIOLOGY-THERAPEUTIC	62,027				0	
57.00	05700 CT SCAN	33,970				<b>l</b>	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	26,889				66	
59.00	05900 CARDIAC CATHETERIZATION	156,343				<b>l</b>	
60.00 65.00	06000 LABORATORY	319,884				1,497	
	06500 RESPIRATORY THERAPY	142,616 193,538				1,648	1
66.00 67.00	06600 PHYSICAL THERAPY 06700 OCCUPATIONAL THERAPY	89,817				10,387 11,100	
68.00	06800 SPEECH PATHOLOGY	30,590					
69.00	06900 ELECTROCARDIOLOGY	6,231				2,687	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	160,804				1	
70.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	82,280				448	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	116,375				9	
73.00	07300 DRUGS CHARGED TO PATIENTS	524,150				1,347	
76.00	03190 CHEMOTHERAPY	34,738	' '			0	1
76.00	03020 WOUND CARE	71,445		0.01237		0	
70.01	OUTPATIENT SERVICE COST CENTERS	71,773	3,774,207	0.01237	<u>J</u>	<u> </u>	70.01
90.00	09000 CLINIC	0	0	0.00000	0 0	0	90.00
90.01	09001 ANDERSON OUTPATIENT CENTER	82,542	· · · · · · · · · · · · · · · · · · ·			0	
90.02	04950 DIABETIC EDUCATION	02,342	· ' '			0	90.02
90.03	09002 MS CLINIC	0		0.00000		0	90.03
91.00	09100 EMERGENCY	507,254	· · · · · · · · · · · · · · · · · · ·			199	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0				0	
32.00	OTHER REIMBURSABLE COST CENTERS		1,170,154		<u> </u>	· · · · · · · · ·	1 32.00
95.00	09500 AMBULANCE SERVICES						95.00
200.00		4,401,652	635,914,145		2,237,176	30.519	200.00
	1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	.,,	,,	1	_,,	,525	,

Health Financial Systems	ASCENSION ST. VINCE	ENT ANDERSON	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0088	Period:	Worksheet D
THROUGH COSTS		Component CCN: 15-T088	From 07/01/2022 To 06/30/2023	Part IV   Date/Time Prenared:

11/22/2023 10:37 am Title XVIII Subprovider -IRF Non Physician Nursing Allied Health Allied Health Cost Center Description Nursing Anesthetist Program Program Post-Stepdown Post-Stepdown Cost Adjustments Adjustments 1.00 2.00 3.00 3A ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 0 0 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 52.00 0 53.00 05300 ANESTHESIOLOGY 0 0 0 0 53.00 54.00 | 05400 RADIOLOGY-DIAGNOSTIC 0 0 0 32,588 54.00 54.01 | 03440 | MAMMOGRAPHY 0 0 0 0 9,460 54.01 0 0 0 54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC 32,490 54.02 0 0 54.03 | 03630 | ULTRA SOUND 16,841 54.03 0 0 0 55.00 05500 RADIOLOGY-THERAPEUTIC 0 67,266 55.00 05700 CT SCAN 0 0 34,191 57.00 57.00 58.00 | 05800 | MAGNETIC RESONANCE IMAGING (MRI) 0 5,356 58.00 05900 CARDIAC CATHETERIZATION 59.00 0 0 0 0 0 0 0 0 0 59.00 60.00 60.00 06000 LABORATORY 0 65.00 06500 RESPIRATORY THERAPY 0 65.00 66.00 06600 PHYSICAL THERAPY 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 68.00 69.00 06900 ELECTROCARDIOLOGY 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 70.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 0 0 0 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 72.00 72.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 73.00 03190 CHEMOTHERAPY 0 0 0 76.00 76.00 03020 WOUND CARE 0 0 76.01 0 76.01 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 0 0 0 0 0 90.00 90.01 09001 ANDERSON OUTPATIENT CENTER 0 0 0 90.01 0 90.02 90.02 04950 DIABETIC EDUCATION 0 0 0 0 0 90.03 09002 MS CLINIC 0 0 0 90.03 91.00 | 09100 | EMERGENCY 91.00 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 95.00 09500 AMBULANCE SERVICES

0

0

0

0

198,192 200.00

200.00

Total (lines 50 through 199)

PPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY S HROUGH COSTS	SERVICE OTHER PAS			Period: From 07/01/2022 To 06/30/2023	Worksheet D Part IV Date/Time Pre 11/22/2023 10	pare
		Title	XVIII	Subprovider - IRF	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medical	(sum of cols.	Outpatient	(from Wkst. C,		
	Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	cols. 2, 3,	8)	7)	
			and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS						
0.00  05000 OPERATING ROOM	0	0		0 145,248,212	0.000000	50.
2.00   05200   DELIVERY ROOM & LABOR ROOM	0	0		0 4,045,591	0.000000	52.
3.00  05300 ANESTHESIOLOGY	0	0		0	0.000000	53.
4.00   05400   RADIOLOGY-DIAGNOSTIC	0	32,588	32,58	8 16,542,312	0.001970	54.
4.01  03440 MAMMOGRAPHY	0	9,460	9,46	0 4,801,889	0.001970	54.
4.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	32,490	32,49	0 16,492,297	0.001970	54.
4.03   03630   ULTRA SOUND	0	16,841	16,84	1 8,548,512	0.001970	54
5.00 05500 RADIOLOGY-THERAPEUTIC	0	67,266	67,26	6 34,157,489	0.001969	55
7.00 05700 CT SCAN	0	34,191	34,19	1 17,355,972	0.001970	57
8.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	5,356	5,35	6 2,718,591	0.001970	58
9.00 05900 CARDIAC CATHETERIZATION	0	0		0 24,784,796	0.000000	59
0.00 06000 LABORATORY	0	0		0 88,047,756	0.000000	60
5.00 06500 RESPIRATORY THERAPY	0	0		0 18,511,838	0.000000	1
6.00 06600 PHYSICAL THERAPY	0	0		0 9,069,180		1
7.00 06700 OCCUPATIONAL THERAPY	0	0		0 4,191,817	0.000000	1
8.00 06800 SPEECH PATHOLOGY	0	0		0 1,427,964	0.000000	1
9.00 06900 ELECTROCARDIOLOGY	0	0		0 1,346,819	1	
0.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 4,124,274	0.000000	
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 20,419,563	0.000000	
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	١		0 21,901,581	0.000000	
3.00 07300 DRUGS CHARGED TO PATIENTS	ő	0		0 88,730,029	l	1
6.00 03190 CHEMOTHERAPY	0	1		7,631,560	l	
6.01 03020 WOUND CARE	0	-		0 5,774,267	0.000000	1
OUTPATIENT SERVICE COST CENTERS				5,774,207	0.000000	, , , ,
0.00 09000 CLINIC	0	0		0	0.000000	90.
0.00   09000 CLINIC 0.01   09001 ANDERSON OUTPATIENT CENTER	0			0 4,410,152	0.000000	
0.01   09001 ANDERSON OUTPATIENT CENTER  0.02   04950   DIABETIC EDUCATION	0			0 4,410,132	0.000000	1
0.02 04930 DIABETIC EDUCATION 0.03 09002 MS CLINIC	0	0		0 0	0.000000	
1.00   09100   EMERGENCY	0	1		0 81,461,490	l	1
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0 4,170,194	0.000000	
OTHER REIMBURSABLE COST CENTERS				0 4,170,194	0.000000	1 32
						95
5.00 09500 AMBULANCE SERVICES	1	1	ı	1	ı	1 90

Health Financial Systems	ASCENSION ST. VINCE	ENT ANDERSON	In Lieu of Form CMS-255		
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0088	Period: From 07/01/2022	Worksheet D Part IV	
micodin costs		Component CCN: 15-T088	то 06/30/2023	Date/Time Prepared: 11/22/2023 10:37 am	
		Title XVIII	Subprovider -	PPS	
			TRF		

					11/22/2023 10	:3/ am_
		Title	: XVIII	Subprovider - IRF	PPS	
Cost Center Description	Outpatient	Inpatient	Inpatient	Outpatient	Outpatient	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	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	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0.000000	23,962		0	0	50.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0.000000	0		0	0	52.00
53.00   05300   ANESTHESIOLOGY	0.000000	0		0	0	53.00
54.00   05400 RADIOLOGY-DIAGNOSTIC	0.001970	37,912	7.	5 0	0	54.00
54.01   03440   MAMMOGRAPHY	0.001970	0		0	0	54.01
54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0.001970	3,887		8 0	0	54.02
54.03   03630   ULTRA SOUND	0.001970	0		0	0	54.03
55.00   05500 RADIOLOGY-THERAPEUTIC	0.001969	0		0	0	55.00
57.00  05700 CT SCAN	0.001970	18,140	30	6 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.001970	6,650	1	3 0	0	58.00
59.00   05900 CARDIAC CATHETERIZATION	0.000000	13,290	(	0	0	59.00
60.00   06000   LABORATORY	0.000000	411,960		0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0.000000	213,913		0	0	65.00
66.00 06600 PHYSICAL THERAPY	0.000000	486,738		0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0.000000	518,019		0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0.000000	125,436		0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0.000000	0		0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.000000	4,186		0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	111,289		0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	1,763		0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.000000	228,085		0	0	73.00
76.00   03190   CHEMOTHERAPY	0.000000	0		0	0	76.00
76.01 03020 WOUND CARE	0.000000	0		0	0	76.01
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0.000000	0		0	0	90.00
90.01 09001 ANDERSON OUTPATIENT CENTER	0.000000	0		0	0	90.01
90.02 04950 DIABETIC EDUCATION	0.000000	0		0	0	90.02
90.03 09002 MS CLINIC	0.000000	0		0	0	90.03
91.00   09100   EMERGENCY	0.000000	31,946	(	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	(	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES						95.00
200.00   Total (lines 50 through 199)		2,237,176	133	2 0	0	200.00

06/30/2023 Date/Time Prepared: 11/22/2023 10:37 am Title XIX Hospital Cost Charges Costs Cost Center Description Cost to Charge PPS Reimbursed Cost Cost PPS Services Reimbursed Ratio From Services (see Reimbursed (see inst.) Worksheet C, inst.) Services Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) 3.00 (see inst.) 1.00 2.00 5.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.126093 1,117,497 0 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.685441 0 18,235 0 52.00 53.00 05300 ANESTHESIOLOGY 0 0.000000 0 53.00 0 0 0 54.00 | 05400 | RADIOLOGY-DIAGNOSTIC 0.324879 0 215,235 0 54.00 54.01 | 03440 | MAMMOGRAPHY 0.224733 12,466 0 0 54.01 0 54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC 0.078768 0 116,214 0 54.02 0 0.077753 54.03 03630 ULTRA SOUND 0 107.714 54.03 0 55.00 05500 RADIOLOGY-THERAPEUTIC 0.092930 0 330,219 0 0 55.00 57.00 05700 CT SCAN 0.074498 0 259,956 0 0 0 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0.280845 0 20,562 58.00 0 59.00 05900 CARDIAC CATHETERIZATION 0.089447 0 157,209 0 59.00 06000 LABORATORY 0.108798 0 854,173 0 0 60.00 60.00 0 06500 RESPIRATORY THERAPY 0.138494 44,687 65.00 65.00 0 66.00 06600 PHYSICAL THERAPY 0.469721 0 66.00 72,203 0 67.00 06700 OCCUPATIONAL THERAPY 0.460305 0 34,854 0 0 67.00 06800 SPEECH PATHOLOGY 0.460289 11,873 0 68.00 68.00 0 06900 ELECTROCARDIOLOGY 0 0 69.00 0.225433 460 69.00 07000 ELECTROENCEPHALOGRAPHY 0 61.527 70.00 0.237186 0 70.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.239697 43,808 0 71.00 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.317830 180,047 0 72.00 0 07300 DRUGS CHARGED TO PATIENTS 0 73.00 0.298204 633,138 0 73.00 03190 CHEMOTHERAPY 0 76.00 0.200027 0 78,148 0 76.00 03020 WOUND CARE 0 93,418 0 0 76.01 76.01 0.257346 OUTPATIENT SERVICE COST CENTERS 90.00 0.000000 0 90.00 0 09000 CLINIC 0 90.01 09001 ANDERSON OUTPATIENT CENTER 0.480726 0 212,543 0 0 90.01 90.02 04950 DIABETIC EDUCATION 0.000000 0 90.02 0 90.03 09002 MS CLINIC 0.000000 0 0 90.03 09100 EMERGENCY 0.132085 2,045,224 0 91.00 91.00 n 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.684660 0 75,234 0 0 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0.000000 95.00 0 200.00 Subtotal (see instructions) 0 6,796,644 0 0 200.00 201.00 Less PBP Clinic Lab. Services-Program 0 201.00

0

6,796,644

0

0 202.00

Only Charges

202.00

Net Charges (line 200 - line 201)

In Lieu of Form CMS-2552-10 Health Financial Systems ASCENSION ST. VINCENT ANDERSON APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0088

Period: | Worksheet D | Part V | Date/Time Prepared: | 11/22/2023 10:37 am

					11/22/2023 10	:37 am
		Titl	e XIX	Hospital	Cost	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Services	Services Not				
	Subject To	Subject To				
	Ded. & Coins.					
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	140,909	0				50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	12,499					52.00
53.00 05300 ANESTHESIOLOGY	0	1				53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	69,925	-				54.00
54.01   03440   MAMMOGRAPHY	2,802					54.01
54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	9,154					54.02
54.03  03630   ULTRA SOUND	8,375					54.03
55.00   05500 RADIOLOGY-THERAPEUTIC	30,687					55.00
57.00  05700  CT SCAN	19,366	0				57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	5,775	0				58.00
59.00 05900 CARDIAC CATHETERIZATION	14,062	0				59.00
60.00   06000   LABORATORY	92,932	0				60.00
65.00 06500 RESPIRATORY THERAPY	6,189	0				65.00
66.00 06600 PHYSICAL THERAPY	33,915	0				66.00
67.00 06700 OCCUPATIONAL THERAPY	16,043					67.00
68.00 06800 SPEECH PATHOLOGY	5,465					68.00
69.00 06900 ELECTROCARDIOLOGY	104	-				69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	14,593					70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	10,501					71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	57,224					72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	188,804					73.00
76.00 03190 CHEMOTHERAPY	15,632					76.00
76.01 03020 WOUND CARE	24,041	0				76.01
OUTPATIENT SERVICE COST CENTERS						
90.00  09000   CLINIC	0	0				90.00
90.01 09001 ANDERSON OUTPATIENT CENTER	102,175					90.01
90.02 04950 DIABETIC EDUCATION	0	1				90.02
90.03  09002 MS CLINIC	0	0				90.03
91.00  09100 EMERGENCY	270,143		l .			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	51,510	0				92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES	0					95.00
200.00 Subtotal (see instructions)	1,202,825	0				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)	1,202,825	0				202.00
	, , , , , , , , , , , , , , , , , , , ,		'		'	

Health Financial Systems	ASCENSION ST. VINCE	ENT ANDERSON	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0088	From 07/01/2022 To 06/30/2023	Worksheet D-1 Date/Time Prepared: 11/22/2023 10:37 am
		Title XVIII	Hospital	PPS

PART I - ALL PROVIDER COMPONENTS    PART I - ALL PROVIDER COMPONENTS   1.00			Title XVIII	Hospital	11/22/2023 10 PPS	:37 am
PART I - ALL PROVIDER COMPONENTS		Cost Center Description	TITLE XVIII	ΠΟΣΡΙΤΩΙ	1 773	
IMPARTENT DAYS					1.00	
Impatient days (including private room days and swing-bed days, excluding newborn)   22,150   1.00						
private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.  do not complete this line.  semi-private room days (excluding swing-bed and observation bed days)  semi-private room days (excluding swing-bed and observation bed days)  reporting period (if calendar year, enter 0 on this line)  Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line)  Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  Total saving-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  Total saving-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  Total saving-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  Swing-bed NF type inpatient days applicable to title XVIII only (including private room days)  Swing-bed NF type inpatient days applicable to title XVIII only (including private room days)  Now the property of the cost reporting period (if calendar year, enter 0 on this line)  Swing-bed NF type inpatient days applicable to title XVIII only (including private room days)  After December 31 of the cost reporting period (if calendar year, enter 0 on this line)  After December 31 of the cost reporting period (if calendar year, enter 0 on this line)  After December 31 of the cost reporting period (if calendar year, enter 0 on this line)  After December 31 of the cost reporting period (if calendar year, enter 0 on this line)  After December 31 of the cost reporting period (if calendar year, enter 0 on this line)  After December 31 of the cost reporting period (if calendar year, enter 0	1.00		s, excluding newborn)		22,150	1.00
do not complete this line.  4.00 Semi-private room days (excluding swing-bed and observation bed days)  5.00 Total swing-bed SW type inpatient days (including private room days) after December 31 of the cost  7.00 Total swing-bed SW type inpatient days (including private room days) after December 31 of the cost  7.00 Total swing-bed SW type inpatient days (including private room days) after December 31 of the cost  7.00 Total swing-bed SW type inpatient days (including private room days) after December 31 of the cost  8.00 Total swing-bed SW type inpatient days (including private room days) after December 31 of the cost  7.00 Total swing-bed SW type inpatient days (including private room days) after December 31 of the cost  8.00 Total sing-bed SW type inpatient days (including private room days) after December 31 of the cost  8.00 Total swing-bed SW type inpatient days applicable to title XVIII only (including private room days)  8.00 Swing-bed SW type inpatient days applicable to title XVIII only (including private room days)  8.01 Swing-bed SW type inpatient days applicable to title XVIII only (including private room days)  8.00 Swing-bed SW type inpatient days applicable to title XVIII only (including private room days)  8.01 Swing-bed SW type inpatient days applicable to title XVIII only (including private room days)  8.02 Swing-bed SW type inpatient days applicable to titles V or XX only (including private room days)  8.01 Swing-bed SW type inpatient days applicable to titles V or XX only (including private room days)  8.02 Swing-bed Nr type inpatient days applicable to titles V or XX only (including private room days)  8.01 Swing-bed SW type inpatient days applicable to titles V or XX only (including private room days)  8.02 Swing-bed Nr type inpatient days applicable to titles V or XX only (including private room days)  8.03 Swing-bed Nr type inpatient days applicable to titles V or XX only (including private room days)  8.04 Swing-bed Nr type inpatient days applicable to titles V or XX only (including p						
Semi-private room days (excluding swing-bed and observation bed days)   20,074   4.00	3.00		ys). If you have only pr	ivate room days,	01	3.00
Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost of Poportring period (if calendar year, enter 0 on this line) reportring period (if calendar year, enter 0 on this line) private room days) after December 31 of the cost reportring period (if calendar year, enter 0 on this line) private room days) after December 31 of the cost reportring period (if calendar year, enter 0 on this line) private room days) after December 31 of the cost reportring period (if calendar year, enter 0 on this line) private room days) after December 31 of the cost reportring period (if calendar year, enter 0 on this line) private room days) after December 31 of the cost reportring period (if calendar year, enter 0 on this line) private room days) (see instructions) private room days) after December 31 of the cost reportring period (if calendar year, enter 0 on this line) private room days) after December 31 of the cost reportring period (if calendar year, enter 0 on this line) private room days) after December 31 of the cost reportring period (if calendar year, enter 0 on this line) private room days) after December 31 of the cost reportring period (if calendar year, enter 0 on this line) private room days) after December 31 of the cost reportring period (if calendar year, enter 0 on this line) private room days) after December 31 of the cost reportring period (if calendar year, enter 0 on this line) private room days) after December 31 of the cost reportring period (if calendar year, enter 0 on this line) private room days) after December 31 of the cost reportring period (if calendar year, enter 0 on this line) private room days) after December 31 of the cost private private private private room days (including private room days) after December 31 of the cost private room days (including private room days) after December 31 of the cost private room days (including private room days) after December 31 of the cost private room days (including private room days) after December 31 of the cos	4.00		ed days)		20.074	4.00
rotal swing-bed swr type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  Total swing-bed Nr type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line)  reporting period (if calendar year, enter 0 on this line)  reporting period (if calendar year, enter 0 on this line)  reporting period (if calendar year, enter 0 on this line)  reporting period (if calendar year, enter 0 on this line)  reporting period (if calendar year, enter 0 on this line)  reporting beriod (if calendar year, enter 0 on this line)  reporting beriod (if calendar year, enter 0 on this line)  reporting beriod (if calendar year, enter 0 on this line)  11.00 Swing-bed Nr type inpatient days applicable to title XVII only (including private room days) after 11.00  Swing-bed Nr type inpatient days applicable to title XVII only (including private room days) after 12.00  Swing-bed Nr type inpatient days applicable to title XVII only (including private room days) after 13.00  Swing-bed Nr type inpatient days applicable to titles V or XIX only (including private room days) after 13.00  Swing-bed Nr type inpatient days applicable to titles V or XIX only (including private room days) after 13.00  Swing-bed Nr type inpatient days applicable to titles V or XIX only (including private room days) after 14.00  Medically necessary private room days applicable to the Program (excluding swing-bed days) 0 15.00  SWING SED ADUISMENT  15.00  Medically necessary private room days applicable to services after becember 31 of the cost 16.00  Total general inpatient routine services applicable to services after becember 31 of the cost 16.00  Total general inpatient routine services applicable to services after becember 31 of the cost 16.00  Total general inpatient routine service soat (see instructions) 10.00  Swing-bed cost applicable to Nr type services through becember 31 of the cost reporting period (lin				31 of the cost		
reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed Mr type inpatient days (including private room days) after December 31 of the cost 7.00 Total swing-bed Mr type inpatient days (including private room days) after December 31 of the cost 7.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and 7.752 9.00 8.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and 8.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) 8.01 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) 8.01 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) 8.02 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) 8.03 Swing-bed SMF type inpatient period (if calendar year, enter 0 on this line) 8.04 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 8.05 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 8.06 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 8.07 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 8.08 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 8.09 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 8.10 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 8.11 Swing-bed Swing-bed SWF services applicable to services through December 31 of the cost 8.12 Swing-bed Swing-bed SWF services applicable to services through December 31 of the cost 9.13 Swing-bed Cost applicable to SwF type services after December 31 of the cost reporting period (line 8 x ine 17) 9.14 Swing-bed Cost applicable to SWF type services t						
7.00 rotal swing-bed NF type inpatient days (including private room days) after December 31 of the cost rotal swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) rotal inpatient days including private room days applicable to the Program (excluding swing-bed and 2,752 9.00 rotal inpatient days including private room days applicable to the Program (excluding swing-bed and 2,752 9.00 rotal inpatient days including private room days applicable to the Program (excluding swing-bed and 10.00 swing-bed SNF type inpatient days applicable to trile XVIII only (including private room days) after becember 31 of the cost reporting period (see instructions) rotal private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line) rotal probable NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period tritles V or XIX only (including private room days) rotal swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) rotal swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days) rotal nursery days (title V or XIX only) rotal rota	6.00		om days) after December :	31 of the cost	01	6.00
reporting period  1.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  1.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)  1.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)  1.10 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after on December 31 of the cost reporting period (see instructions)  1.20 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after on through December 31 of the cost reporting period (see instructions)  1.20 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) on through December 31 of the cost reporting period (if calendar year, enter 0 on this line)  1.20 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) on through December 31 of the cost reporting period (if calendar year, enter 0 on this line)  1.20 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) on through December 31 of the cost reporting period (including variety of the cost reporting period (including variety of the cost reporting period (including variety of the	7.00		m davs) through December	31 of the cost	ا o	7.00
reporting period (if calendar year, enter 0 on this line) 9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 10.00 swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions) 13.00 Swing-bed NF type inpatient days applicable to title X or XIX only (including private room days) after through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 16.00 Nursery days (title v or XIX only) 16.00 Nursery days (title v or XIX only) 16.00 Nursery days (title v or XIX only) 17.00 Nursery days (title v or XIX only) 18.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost cost in the cost reporting period (incare rate for swing-bed NF services applicable to services after December 31 of the cost one contribution of the cost reporting period (incare rate for swing-bed NF services applicable to services after December 31 of the cost one contribution of the cost reporting period (incare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line 6 one cost applicable to SNF type services through December 31 of the cost reporting period (line 6 one cost applicable to SNF type services after December 31 of the cost reporting period (line 6 one cost applicable to SNF type services after December 31 of the cost reporting period (line 6 one		reporting period				
Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)   0   10.00	8.00		n days) after December 33	L of the cost	01	8.00
newborn days) (see instructions)  10.00 winsphed SNF type inpatient days applicable to title XVIII only (including private room days) attrough December 31 of the cost reporting period (see instructions)  11.00 winsphed SNF type inpatient days applicable to title XVIII only (including private room days) after pecember 31 of the cost reporting period (if calendar year, enter 0 on this line)  12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  13.00 Strong the pecember 31 of the cost reporting period (if calendar year, enter 0 on this line)  14.00 bedically necessary private room days applicable to titles V or XIX only (including private room days)  15.00 Total nursery days (title V or XIX only)  16.00 bedically necessary private room days applicable to the Program (excluding swing-bed days)  16.00 Nursery days (title V or XIX only)  17.00 bedicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period  18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  19.00 Medicare rate for swing-bed NF services applicable to services through December 31 of the cost reporting period (medicare rate for swing-bed NF services applicable to services through December 31 of the cost reporting period (medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line 6 x N line 18)  20.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x N line 18)  21.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x N line 18)  22.00 Swing-bed cost applicable to SNF type services after December 31 of the cost	9 00		the Program (excluding	swing-hed and	2 752	9 00
through December 31 of the cost reporting period (see instructions)  11.00 Swing-bed SNT type inpatient days applicable to title XVIII only (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line)  13.00 Swing-bed NT type inpatient days applicable to titles V or XIX only (including private room days)  14.00 december 31 of the cost reporting period (if calendar year, enter 0 on this line)  14.00 december 31 of the cost reporting period (if calendar year, enter 0 on this line)  14.00 after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  14.00 after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  15.00 after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  16.00 after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  17.00 after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  18.00 after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  19.00 after December 31 of the cost reporting Dece	3.00		control of the control	Jiiiig Sea and	1	3.00
11.00   Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after   0   11.00	10.00			oom days)	0	10.00
December 31 of the cost reporting period (if calendar year, enter 0 on this line)   12.00   Simple How Five inpatient days applicable to titles V or XIX only (including private room days)   0   12.00     13.00   Simple How Five inpatient days applicable to titles V or XIX only (including private room days)   0   13.00     14.00   After December 31 of the cost reporting period (if calendar year, enter 0 on this line)   0   14.00     15.00   Total nursery days (title V or XIX only)   0   15.00     15.00   Total nursery days (title V or XIX only)   0   15.00     16.00   SWING BED ADJUSTMENT   0   0   0   0   0     17.00   Modicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period   0   0   0   0   0   0   0     18.00   Modicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period   0   0   0   0   0   0   0   0   0	11 00			nom days) after	0	11 00
through December 31 of the cost reporting period after December 31 of the cost reporting period (if calendar year, enter 0 on this line) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 15.00 15.00 Total nursery days (title V or XIX only) 0	11.00			Join days) areer	1	11.00
3.00   Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)   13.00   13.00   14.00   14.00   16.00   1	12.00		x only (including private	e room days)	0	12.00
after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  15.00 15.00 15.00 16.00 16.00 16.00 17.00 16.00 17.00 18.00 19.00 1	13 00		v only (including private	room days)		12 00
14.00   Medically necessary private room days applicable to the Program (excluding swing-bed days)   0   14.00   15.	13.00					13.00
16.00   Nursery days (title v or XIX only)   16.00   16.00   SMIMS BED ADJUSTMENT   17.00   18.00   Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period reporting period   18.00   18.00   19.0		Medically necessary private room days applicable to the Progra				
SWTNG BED ADJUSTMENT						
Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period   18.00   1	16.00				0	16.00
Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period   19.00   19.	17.00		es through December 31 o	f the cost	0.00	17.00
reporting period redicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 21.00 Total general inpatient routine service cost (see instructions) 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 18) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 27.00 Sewing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 28.00 Total swing-bed cost (see instructions) 28.00 Total swing-bed cost (see instructions) 28.00 Total swing-bed cost (see instructions) 28.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  General inpatient routine service charges (excluding swing-bed charges) 29.00 Private room charges (excluding swing-bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Average perivate room per diem charge (line 29 + line 3) 31.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 31.00 Average per diem private room cost differential (line 3 x line 31) 31.00 Average per diem private room cost differential (line 3 x line 31) 31.00 Average per diem private room cost differential (line 3 x line 31) 31.00 Average per diem private room cost differential (line 3 x line 31) 31.00 Average per diem private room cost differential (line 3 x line 31) 31.00 Average per diem private room cost differential (line						
19.00   Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period   20.00   20	18.00		es after December 31 of	the cost	0.00	18.00
reporting period  20.00  20.00  20.00  20.00  21.00  21.00  21.00  21.00  21.00  22.00  22.00  22.00  23.00  23.00  24.00  25.00  25.00  25.00  26.00  27.00  28.00  29.00  29.00  20.00	19.00		s through December 31 of	the cost	0.00	19.00
reporting period Total general inpatient routine service cost (see instructions)  21.00  22.00  30,463,399  21.00  22.00  30,ine 18)  24.00  30,wing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00  30,wing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00  25.00  30,wing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00  30,wing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00  27.00  28.00  29.00  29.00  20.00		reporting period	-			
21.00 Total general inpatient routine service cost (see instructions)  22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 6 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  26.00 Total swing-bed cost (see instructions)  26.00 Total swing-bed cost (see instructions)  27.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  30.00 Average per ivate room per diem charge (line 29 ÷ line 3)  30.00 Average per diem private room charge differential (line 30 ÷ line 4)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 Private room cost differential adjustment (line 3 x line 35)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average	20.00		s after December 31 of th	ne cost	0.00	20.00
22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  27.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average private room per diem charge (line 29 ÷ line 3)  32.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 3 x line 31)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 30,463,399)  37.00 Froyate room cost differential adjustment (line 3 x line 35)  37.00 Program general inpatient routine service cost per diem (see instructions)  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  37.00 Program general inpatient routine service cost (line 9 x line 38)  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	21.00	' 3'	s)		30,463,399	21.00
23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  27.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room per diem charge (line 29 + line 3)  30.00 Average perivate room per diem charge (line 29 + line 3)  30.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 Average per diem private room cost differential (line 34 x line 35)  30.00 Average per diem private room cost differential (line 35 minus line 36)  27 minus line 36)  28.00 Adjusted general inpatient routine service cost per diem (see instructions)  30.00 Adjusted general inpatient routine service cost per diem (see instructions)  30.00 Adjusted general inpatient routine service cost per diem (see instructions)  30.00 Adjusted general inpatient routine service cost per diem (see instructions)  30.00 Adjusted general inpatient routine service cost per diem (see instructions)  30.00 Adjusted general inpatient routine service cost per diem (see instructions)  30.00 Adjusted general inpatient routine service cost per diem (see instructions)  30.00 Adjusted general inpatient routine service cost per diem (see instructions)  30.00 Adjusted general inpatient routine service cost per diem (see instructions)  30.00 Adjusted general inpat	22.00	Swing-bed cost applicable to SNF type services through December		ing period (line		
x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  General inpatient routine service charges (excluding swing-bed and observation bed charges)  28.00 Private room charges (excluding swing-bed charges)  28.00 Semi-private room charges (excluding swing-bed charges)  28.00 Semi-private room charges (excluding swing-bed charges)  28.00 Average private room per diem charge (line 29 + line 3)  38.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  38.00 Average per diem private room cost differential (line 3 x line 31)  29.00 Average per diem private room cost differential (line 3 x line 31)  39.00 Average per diem private room cost differential (line 3 x line 35)  20.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3	22.00		21 of the cost managerin	n nominal (line (		22.00
24.00   Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)   24.00   25.00   x line 20)   25.00   x line 20)   26.00   Total swing-bed cost (see instructions)   26.00   26.00   26.00   27.00	23.00		31 of the Cost reporting	period (Tine 6	) 	23.00
25.00   Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)   25.00   26.00   Total swing-bed cost (see instructions)   0   26.00   27.00   27.00   General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)   30,463,399   27.00   PRIVATE ROOM DIFFERENTIAL ADJUSTMENT   0   28.00   29.00	24.00		r 31 of the cost reporti	ng period (line	0	24.00
x line 20)  26.00 Total swing-bed cost (see instructions)  General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  28.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  30.00 Average private room per diem charge (line 29 ÷ line 3)  31.00 Average semi-private room per diem charge (line 30 ÷ line 4)  32.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 30,463,399)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 30,463,399)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  38.00 Program general inpatient routine service cost per diem (see instructions)  38.00 Program general inpatient routine service cost (line 9 x line 38)  37.84,881 39.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00	25.00	· · · · · · · · · · · · · · · · · · ·				25 00
Total swing-bed cost (see instructions)  General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  General inpatient routine service charges (excluding swing-bed and observation bed charges)  Semi-private room charges (excluding swing-bed charges)  Semi-private room charges (excluding swing-bed charges)  General inpatient routine service cost/charge ratio (line 27 + line 28)  Average private room per diem charge (line 29 + line 3)  Average semi-private room per diem charge (line 30 + line 4)  Average per diem private room cost differential (line 32 minus line 33)(see instructions)  Average per diem private room cost differential (line 34 x line 31)  Average per diem private room cost differential (line 34 x line 31)  Private room cost differential adjustment (line 3 x line 35)  Appears II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Adjusted general inpatient routine service cost per diem (see instructions)  Average general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost (line 9 x line 38)  Program general inpatient routine service cost (line 9 x line 38)  Medically necessary private room cost applicable to the Program (line 14 x line 35)  O doon doon doon doon doon doon doon doo	25.00		31 of the cost reporting	period (line 8	) 	25.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  General inpatient routine service charges (excluding swing-bed and observation bed charges)  9.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  30.00 Average private room per diem charge (line 29 ÷ line 3)  Average semi-private room per diem charge (line 30 ÷ line 4)  Average semi-private room charge differential (line 32 minus line 33)(see instructions)  32.00 Average per diem private room cost differential (line 34 x line 31)  Average per diem private room cost differential (line 34 x line 31)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 30,463,399)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost (line 9 x line 38)  Program general inpatient routine service cost (line 9 x line 38)  Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 28.00  28.00  29.00  20.00  20.00  31.00  0 .00  32.00	26.00				0	26.00
28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 Semi-private room charges (excluding swing-bed charges) 32.00 Average private room per diem charge (line 29 ÷ line 3) 32.00 Average private room per diem charge (line 30 ÷ line 4) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 30,463,399) 37.00 Average per diem private room cost differential (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 30,463,399) 37.00 Average per diem private room cost differential (line 30,463,399) 37.00 General inpatient routine service cost per diem (see instructions) 38.00 Average per diem private room cost differential (line 30,463,399) 37.00 Average per diem private room cost differential (line 30,463,399) 37.00 General inpatient routine service cost per diem (see instructions) 38.00 Average per diem private room cost differential (line 30,463,399) 37.00 Average per diem private room cost differential (line 30,463,399) 37.00 Average per diem private room cost differential (line 30,463,399) 37.00 General inpatient routine service cost per diem (see instructions) 38.00 Average per diem private room cost differential (line 30,463,399) 37.00 Average per diem private room cost differential (line 30,463,399) 37.00 General inpatient routine service cost per diem (see instructions) 38.00 Average per diem private room cost differential (line 30,463,399) 37.00 Average per diem private room cost differential (line 30,463,399) 37.00 Average per diem private room cost differential (line 30,463,399) 37.00 Ave	27.00		(line 21 minus line 26)		30,463,399	27.00
Private room charges (excluding swing-bed charges)  Semi-private room charges (excluding swing-bed charges)  Semi-private room charges (excluding swing-bed charges)  General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  Average private room per diem charge (line 29 ÷ line 3)  Average semi-private room per diem charge (line 30 ÷ line 4)  Average per diem private room charge differential (line 32 minus line 33)(see instructions)  Average per diem private room cost differential (line 34 x line 31)  Private room cost differential adjustment (line 3 x line 35)  General inpatient routine service cost net of swing-bed cost and private room cost differential (line 30,463,399)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 29.00  29.00  30.00  30.00  30.00  30.00  31.00  0.00  32.00	28 00		d and observation had sh	naoc)	0	20 00
30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 30,463,399) 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 30.00 30.00 0.00 32.00 0.00 32.00 0.00 32.00 0.00 33.00 0.00 33.00 0.00 33.00 0.00 33.00 0.00 34.00 34.00 34.00 34.00 0.00 0			a and observation bed the	ir ges)		
Average private room per diem charge (line 29 ÷ line 3)  Average semi-private room per diem charge (line 30 ÷ line 4)  Average per diem private room cost differential (line 32 minus line 33)(see instructions)  Average per diem private room cost differential (line 34 x line 31)  Average per diem private room cost differential (line 34 x line 31)  Private room cost differential adjustment (line 3 x line 35)  General inpatient routine service cost net of swing-bed cost and private room cost differential (line 30,463,399)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  32.00  40.00						
33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 30,463,399)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  Program general inpatient routine service cost (line 9 x line 38)  Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00 33.00  30.00 34.00  30.00 35.00  30.00 35.00  30.00 35.00  30.00 35.00  30.00 36.00  30.463,399  37.00 36.00  30.463,399  37.00 36.00  30.463,399  37.00 36.00  30.463,399  37.00 36.00  30.463,399  37.00 36.00  30.463,399  37.00 36.00  30.463,399  37.00 36.00  30.463,399  37.00 36.00  30.463,399  37.00 36.00  37.00 36.00  30.463,399  37.00 36.00  30.463,399  37.00 36.00  30.00 36.00  30.00 36.00  30.00 36.00  30.00 36.00  30.00 36.00  30.00 36.00  30.00 36.00  30.463,399  30.4	31.00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0.000000	31.00
Average per diem private room charge differential (line 32 minus line 33)(see instructions)  Average per diem private room cost differential (line 34 x line 31)  Private room cost differential adjustment (line 3 x line 35)  General inpatient routine service cost net of swing-bed cost and private room cost differential (line 30,463,399)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00  34.00  34.00  35.00  36.00  37.00  37.00  37.00  37.00  37.00  37.00  37.00  37.00  37.00  40.00	32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.00
Average per diem private room cost differential (line 34 x line 31)  35.00 36.00 Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line 30,463,399)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38)  Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00 35.00 36.00 37.00						
36.00 37.00 Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line 30,463,399)  27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  36.00 37.00				tions)		
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 20,463,399)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  37.00  30,463,399  37.00  31.00  30,463,399  37.00  30,463,399  37.00  30,463,399  37.00  40.00			ne 31)			
27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 39.00 Program general inpatient routine service cost per diem (see instructions) 1,375.32 38.00 Program general inpatient routine service cost (line 9 x line 38) 3,784,881 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00						1
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00	37.00	,	and private room cost di	rrerential (line	30,463,399	37.00
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  38.00 3,784,881 39.00  40.00						-
Adjusted general inpatient routine service cost per diem (see instructions)  1,375.32 38.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  1,375.32 38.00 3,784,881 39.00 40.00			ISTMENTS			1
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 3,784,881 39.00 40.00	38.00				1.375.32	38.00
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00					· ·	1
41.00  Total Program general inpatient routine service cost (line 39 + line 40) 3,784,881   41.00		1				1
	41.00	Total Program general inpatient routine service cost (line 39	+ line 40)		3,784,881	41.00

MCRIF32 - 21.2.177.0

	Financial Systems AS ATION OF INPATIENT OPERATING COST	SCENSION ST. VIN	Provider Co		Period: From 07/01/2022	worksheet D-1	
					To 06/30/2023		
			Title	XVIII	Hospital	11/22/2023 10 PPS	:37 an
	Cost Center Description	Total	Total	Average Per		Program Cost	
		Inpatient CostI	npatient Days	col. 2	÷	(col. 3 x col. 4)	
12.00	NUDCERY (+i+le V & VTV enly)	1.00	2.00	3.00	4.00	5.00	42.00
12.00	NURSERY (title V & XIX only)  Intensive Care Type Inpatient Hospital Units	ı o	0		00  0	0	42.00
13.00	INTENSIVE CARE UNIT	8,924,344	4,041	2,208.	45 2,482	5,481,373	1
14.00 15.00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44.00
16.00	SURGICAL INTENSIVE CARE UNIT						46.0
17.00	OTHER SPECIAL CARE (SPECIFY)						47.0
	Cost Center Description					1.00	
18.00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3,	line 200)			7,406,404	48.0
18.01	Program inpatient cellular therapy acquisition				, column 1)	0	1
19.00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48.01	)(see instruc	tions)		16,672,658	49.0
0.00	Pass through costs applicable to Program inp	atient routine s	ervices (from	Wkst. D, su	m of Parts I and	426,163	50.0
	III)				_		
51.00	Pass through costs applicable to Program inpland IV)	atient ancillary	services (fr	om Wkst. D,	sum of Parts II	288,483	51.0
2.00	Total Program excludable cost (sum of lines					714,646	52.0
3.00	Total Program inpatient operating cost exclu		ated, non-phy	sician anest	hetist, and	15,958,012	53.0
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	02)					-
4.00	Program discharges					0	54.0
55.00	, ,						55.0
55.01	Permanent adjustment amount per discharge Adjustment amount per discharge (contractor	uso only)					55.0 55.0
6.00	Target amount (line 54 x sum of lines 55, 55					0.00	
7.00	Difference between adjusted inpatient operat		get amount (1	ine 56 minus	line 53)	0	1
00.8	Bonus payment (see instructions) Trended costs (lesser of line 53 ÷ line 54,	on 1-no FF from	+ho coc+ nono		andina 1006	0 00	
59.00	updated and compounded by the market basket)	or line 55 from	tne cost repo	rting period	ending 1996,	0.00	59.0
50.00						0.00	60.0
51.00	market basket) Continuous improvement bonus payment (if lin	o 52 · lino 54 i	s loss +han +	ho lowest of	linos 55 plus	0	61.0
01.00	55.01, or line 59, or line 60, enter the les					1	01.0
	53) are less than expected costs (lines 54 $\times$	60), or 1 % of	the target am	ount (line 5	6), otherwise		
52.00	enter zero. (see instructions) Relief payment (see instructions)					0	62.0
3.00	Allowable Inpatient cost plus incentive paym	ent (see instruc	tions)			0	
-4 00	PROGRAM INPATIENT ROUTINE SWING BED COST		h 21 .£ +h.				
04.00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts through Decem	ber 31 of the	cost report	ing period (see	0	64.0
55.00	Medicare swing-bed SNF inpatient routine cos	ts after Decembe	r 31 of the c	ost reportin	g period (See	0	65.0
6.00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	no costs (lino 6	4 nlus lino 6	5)(+i+lo yvr	TT only): for	0	66.0
00.00	CAH, see instructions	ne costs (Tine o	4 plus lille o	J)(CICIE XVI.	ii diliy), ldi	ا ا	00.0
57.00	Title V or XIX swing-bed NF inpatient routing	e costs through	December 31 o	f the cost r	eporting period	0	67.0
58.00	<pre>(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing</pre>	e costs after De	cember 31 of	the cost ren	orting period	0	68.0
	(line 13 x line 20)			·	o. cring per rou		
9.00	Total title V or XIX swing-bed NF inpatient					0	69.0
70.00	PART III - SKILLED NURSING FACILITY, OTHER NI Skilled nursing facility/other nursing facil				)		70.0
71.00	Adjusted general inpatient routine service co	ost per diem (li			-	 	71.0
72.00	Program routine service cost (line 9 x line		(line 14 :: 3'	no 25)		 	72.0
73.00	Medically necessary private room cost application of the program general inpatient routine serv	•					73.0
75.00	Capital-related cost allocated to inpatient				Part II, column		75.0
	26, line 45)	2)					76.0
76.00 77.00	Program capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line					 	76.0
78.00	Inpatient routine service cost (line 74 minu	s line 77)				 	78.0
79.00	Aggregate charges to beneficiaries for exces				nuc line 70)	 	79.0
30.00 31.00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		st iimitation	(Time /8 M1	nus Tine /9)	 	80.0
32.00	Inpatient routine service cost limitation (1						82.0
33.00	Reasonable inpatient routine service costs (		)			 	83.0
34.00 35.00	Program inpatient ancillary services (see in Utilization review - physician compensation		5)			 	84.0
36.00	Total Program inpatient operating costs (sum					<u> </u>	86.0
	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST					4
37.00 38.00	Total observation bed days (see instructions Adjusted general inpatient routine cost per		line 2)			2,076 1,375.32	
	inagastea general impatient loutine cost per	4. CII (11116 Z/ 7	· · · · · · · · /			2,855,164	

Health	Financial Systems	SCENSION ST. VI	NCENT ANDERSON		In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provider CO		Period:	Worksheet D-1	
					From 07/01/2022 Fo 06/30/2023	Date/Time Pre 11/22/2023 10	pared: :37 am
			Title	XVIII	Hospital	PPS	
	Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
			(from line 21)	column 2	Observation	Bed Pass	
					Bed Cost (from	Through Cost	
					line 89)	(col. 3 x col.	
						4) (see	
						instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00	Capital-related cost	1,564,117	30,463,399	0.05134	2,855,164	146,596	90.00
91.00	Nursing Program cost	0	30,463,399	0.000000	2,855,164	0	91.00
92.00	Allied health cost	0	30,463,399	0.000000	2,855,164	0	92.00
93.00	All other Medical Education	0	30,463,399	0.000000	2,855,164	0	93.00

Health Financial Systems	ASCENSION ST. VINCENT AND	ERSON	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi	der CCN: 15-0088	Period: From 07/01/2022	Worksheet D-1
	Compo	ient CCN: 15-T088	то 06/30/2023	Date/Time Prepared: 11/22/2023 10:37 am
		Title XVIII	Subprovider -	PPS

	IRF		
	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS	1.00	
	INPATIENT DAYS		1
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,677	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,677	1
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days	ays, 0	3.00
	do not complete this line.		
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,677	1
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the	cost 0	5.00
6.00	reporting period Total swing-bed SNF type inpatient days (including private room days) after December 31 of the co	st 0	6.00
0.00	reporting period (if calendar year, enter 0 on this line)	30	0.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the co	ost 0	7.00
	reporting period		
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cos	t 0	8.00
	reporting period (if calendar year, enter 0 on this line)		
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed at	nd 1,122	9.00
10.00	newborn days) (see instructions)   Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
10.00	through December 31 of the cost reporting period (see instructions)		10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) af	ter 0	11.00
	December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12.00
12.00	through December 31 of the cost reporting period	0	12 00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title v or XIX only)	0	
16.00		0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0.00	17.00
10.00	reporting period	0.00	10.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0.00	19.00
23.00	reporting period		25.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0.00	20.00
	reporting period		
21.00	Total general inpatient routine service cost (see instructions)	3,208,119	
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period ( $5 \times 1$ )	line 0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (lin	ne 6 0	23.00
	x line 18)		
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (1	ine 0	24.00
	7 x line 19)		
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line	e 8 0	25.00
26.00	x line 20)  Total swing-bed cost (see instructions)	0	26.00
27.00		3,208,119	
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	7 3,200,223	1
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	1
30.00	Semi-private room charges (excluding swing-bed charges)	0	
31.00 32.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  Average private room per diem charge (line 29 ÷ line 3)	0.000000	1
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	1
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	
36.00	Private room cost differential adjustment (line 3 x line 35)	0	1
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (	line 3,208,119	37.00
	27 minus line 36)		1
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		-
38 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Adjusted general inpatient routine service cost per diem (see instructions)	1,198.40	38.00
38.00 39.00	Program general inpatient routine service cost (line 9 x line 38)	1,344,605	1
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	1,344,003	1
	Total Program general inpatient routine service cost (line 39 + line 40)	1,344,605	1
		•	•

Health Financial Systems ASCENSION ST. VINCENT ANDERSON In Lieu of Form CMS-2552-10

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0088 | Period: From 07/01/2022 | To 06/30/2023 | Date/Time Prepared:

11/22/2023 10:37 am Title XVIII Subprovider IRF Cost Center Description Total Total Program Days Program Cost Average Per Inpatient Cost Inpatient Days Diem (col. 1 : (col. 3 x col. col. 2) 4) 1.00 2.00 3.00 4.00 5.00 42.00 NURSERY (title V & XIX only) 0.00 42.00 0 0 0 Intensive Care Type Inpatient Hospital Units 43.00 0 0.00 0 43.00 INTENSIVE CARE UNIT 44.00 CORONARY CARE UNIT 44.00 BURN INTENSIVE CARE UNIT 45.00 45.00 SURGICAL INTENSIVE CARE UNIT 46.00 46.00 47.00 OTHER SPECIAL CARE (SPECIFY) 47.00 Cost Center Description 1.00 719.778 48.00 48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200) Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1) 48.01 48.01 Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions) 2,064,383 49.00 PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and 83,914 50.00 50.00 III) 51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II 30,651 51.00 and IV) 52.00 Total Program excludable cost (sum of lines 50 and 51) 114,565 52.00 53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 1,949,818 53.00 medical education costs (line 49 minus line 52) TARGET AMOUNT AND LIMIT COMPUTATION 54.00 54.00 Program discharges 0 55.00 Target amount per discharge 0.00 55.00 0.00 55.01 Permanent adjustment amount per discharge 55.01 55.02 Adjustment amount per discharge (contractor use only) 0.00 55.02 Target amount (line 54 x sum of lines 55, 55.01, and 55.02) 56.00 56.00 57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 57.00 0 58.00 Bonus payment (see instructions) 0 58.00 Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, 0.00 59.00 59.00 updated and compounded by the market basket) 60.00 Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the 0.00 60.00 market basket) Continuous improvement bonus payment (if line  $53 \div 1$  line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 61.00 0 61.00 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions) Relief payment (see instructions) 62.00 62.00 0 63.00 Allowable Inpatient cost plus incentive payment (see instructions) 0 63.00 PROGRAM INPATIENT ROUTINE SWING BED COST 64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See 64.00 instructions)(title XVIII only) 65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See 0 65.00 instructions)(title XVIII only) 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for 0 66.00 CAH, see instructions Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period 67.00 67.00 (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period 68.00 0 (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 0 PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY 70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 70.00 71.00 71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) 72.00 Program routine service cost (line 9 x line 71) 72.00 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 73.00 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 74.00 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 75.00 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 76.00 77.00 Program capital-related costs (line 9 x line 76) 77.00 78.00 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 80.00 81.00 Inpatient routine service cost per diem limitation 81.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 82.00 83.00 Reasonable inpatient routine service costs (see instructions) 83.00 84.00 Program inpatient ancillary services (see instructions) 84.00 Utilization review - physician compensation (see instructions) 85.00 85.00 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87.00 0.00 88.00 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)

Health	Financial Systems As	SCENSION ST. VI	NCENT ANDERSON		In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provider CC		Period:	Worksheet D-1	
			Component C		From 07/01/2022 To 06/30/2023	Date/Time Pre 11/22/2023 10	
			Title	XVIII	Subprovider -	PPS	
					IRF		
	Cost Center Description						
						1.00	
89.00	Observation bed cost (line 87 x line 88) (se	e instructions)				0	89.00
	Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
			(from line 21)	column 2	Observation	Bed Pass	
					Bed Cost (from	Through Cost	
					line 89)	$(col. 3 \times col.$	
						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	200,221	3,208,119	0.06241	1 0	0	90.00
91.00	Nursing Program cost	0	3,208,119	0.00000	0	0	91.00
92.00	Allied health cost	0	3,208,119	0.00000	0	0	92.00
93.00	All other Medical Education	0	3,208,119	0.00000	0	0	93.00

Health Financial Systems	ASCENSION ST. VINCE	ENT ANDERSON	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0088	From 07/01/2022 To 06/30/2023	Worksheet D-1 Date/Time Prepared: 11/22/2023 10:37 am
		Title XIX	Hospital	Cost

		Title XIX	Hospital	11/22/2023 10 Cost	:37 am
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1.00	
	INPATIENT DAYS				
1.00 2.00 3.00	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-bed and observation bed day do not complete this line.	ped and newborn days)	ivate room days,	22,150 22,150 0	1.00 2.00 3.00
4.00 5.00	Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private roof reporting period		31 of the cost	20,074 0	4.00 5.00
6.00	Total swing-bed SNF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line)	om days) after December 3	31 of the cost	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room reporting period	n days) through December	31 of the cost	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	n days) after December 33	L of the cost	0	8.00
9.00	Total inpatient days including private room days applicable to newborn days) (see instructions)			889	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruct	cions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII or December 31 of the cost reporting period (if calendar year, er	nter O on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period		•	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar yes)	ear, enter O on this line	2)	0	13.00
14.00 15.00	Medically necessary private room days applicable to the Progra Total nursery days (title V or XIX only)	am (excluding swing-bed (	iays)	0 547	14.00 15.00
16.00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			452	
17.00	Medicare rate for swing-bed SNF services applicable to service reporting period	_			17.00
18.00	Medicare rate for swing-bed SNF services applicable to service reporting period				18.00
19.00	Medicaid rate for swing-bed NF services applicable to services reporting period	_			19.00
20.00	Medicaid rate for swing-bed NF services applicable to services reporting period		ne cost		20.00
21.00 22.00	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through Decembe		ing period (line	30,463,399 0	21.00 22.00
23.00	5 x line 17) Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	g period (line 6	0	23.00
24.00	Swing-bed cost applicable to NF type services through December $ 7 \times 1 ^2$ ine 19)	31 of the cost reporting	ng period (line	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 3 x line 20)	31 of the cost reporting	period (line 8	0	25.00
26.00 27.00	Total swing-bed cost (see instructions) [General inpatient routine service cost net of swing-bed cost (	Tine 21 minus line 26)		0 30,463,399	26.00 27.00
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		I	30,103,333	27.00
28.00	General inpatient routine service charges (excluding swing-bed	d and observation bed cha	arges)	0	
29.00	Private room charges (excluding swing-bed charges)			0	29.00
30.00 31.00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 -	line 28)		0.000000	30.00 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	- Title 20)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34.00	Average per diem private room charge differential (line 32 min	nus line 33)(see instruct	rions)	0.00	
35.00	Average per diem private room cost differential (line 34 x lin			0.00	
36.00	Private room cost differential adjustment (line 3 x line 35)	31)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	and private room cost di	fferential (line	30,463,399	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS			
38.00	Adjusted general inpatient routine service cost per diem (see			1,375.32	38.00
39.00	Program general inpatient routine service cost (line 9 x line			1,222,659	39.00
40.00	Medically necessary private room cost applicable to the Progra	•		1 222 650	40.00
41.00	Total Program general inpatient routine service cost (line 39	+ 11ne 40)		1,222,659	41.00

PUT	ATION OF INPATIENT OPERATING COST	SCENSION ST. VINC	Provider Co		Period: From 07/01/2022	worksheet D-1	
					To 06/30/2023	Date/Time Pre 11/22/2023 10	
			Titl	e XIX	Hospital	Cost	
	Cost Center Description	Total Inpatient CostIr	Total	Average Per		Program Cost (col. 3 x col.	
		·		co1. 2)		4)	
00	NUDSERV (+i+lo V & VTV only)	1.00 647,261	2.00	3.00 1,183.2	4.00	5.00 534.847	' 4
00	NURSERY (title V & XIX only)  Intensive Care Type Inpatient Hospital Units	047,201	347	1,103.4	19 432	334,647	"
00	INTENSIVE CARE UNIT	8,924,344	4,041	2,208.4	45 219	483,651	
00 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						4
00	SURGICAL INTENSIVE CARE UNIT				ļ	 	4
00							4
	Cost Center Description					1.00	+
00	Program inpatient ancillary service cost (Wk	st. D-3. col. 3.	line 200)			1.00 1,959,413	3 4
01	Program inpatient cellular therapy acquisition			III, line 10	, column 1)	0	
00	Total Program inpatient costs (sum of lines	41 through 48.01)	(see instruc	tions)		4,200,570	) 4
00	PASS THROUGH COST ADJUSTMENTS  Pass through costs applicable to Program inpo	atient routine se	rvices (from	Wkst D sur	n of Parts T and	0	5
00	III)	actene roactne se		wkst. b, sun	or raits I and		
00	Pass through costs applicable to Program inp	atient ancillary	services (fr	om Wkst. D, s	sum of Parts II	0	) 5
00	and IV) Total Program excludable cost (sum of lines	50 and 51)				0	) 5
00	Total Program inpatient operating cost exclu	ding capital rela	ted, non-phy	sician anestl	netist, and	ő	
	medical education costs (line 49 minus line	52)					
00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	) 5
00	Target amount per discharge					0.00	
01	Permanent adjustment amount per discharge					0.00	
02 00	Adjustment amount per discharge (contractor   Target amount (line 54 x sum of lines 55, 55					0.00	
00	Difference between adjusted inpatient operat		et amount (1	ine 56 minus	line 53)	0	
00	Bonus payment (see instructions)				1	0	
00	Trended costs (lesser of line 53 ÷ line 54, oupdated and compounded by the market basket)	or line 55 from t	the cost repo	rting period	ending 1996,	0.00	) 5
00	Expected costs (lesser of line 53 ÷ line 54,	or line 55 from	prior year c	ost report, i	updated by the	0.00	) 6
•	market basket)	52 7' 54'					
00	Continuous improvement bonus payment (if line 55.01, or line 59, or line 60, enter the less					0	) 6
	53) are less than expected costs (lines 54 x						
00	enter zero. (see instructions)						
00 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instruct	ions)			0	
	PROGRAM INPATIENT ROUTINE SWING BED COST						
00	Medicare swing-bed SNF inpatient routine cos	ts through Decemb	er 31 of the	cost report	ing period (See	0	) (
00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	ts after December	· 31 of the c	ost reporting	period (See	0	) 6
	instructions)(title XVIII only)						
00	Total Medicare swing-bed SNF inpatient routil CAH, see instructions	ne costs (line 64	plus line 6	5)(title XVII	II only); for	0	) 6
00	Title V or XIX swing-bed NF inpatient routing	e costs through [	ecember 31 o	f the cost re	eporting period	0	) 6
00	(line 12 x line 19)	-				-	
00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	e costs after Dec	emper 31 of	tne cost repo	orting period	0	) (
00	Total title V or XIX swing-bed NF inpatient					0	) 6
00	PART III - SKILLED NURSING FACILITY, OTHER NU						4.
00 00	Skilled nursing facility/other nursing faciladjusted general inpatient routine service of	•			,		7 7
00	Program routine service cost (line 9 x line	71)					7
00	Medically necessary private room cost applications						7
00 00	Total Program general inpatient routine serve Capital-related cost allocated to inpatient				Part II. column		7 7
	26, line 45)		Ç <b></b>	, ·	,		
00	Per diem capital-related costs (line 75 ÷ line Program capital-related costs (line 9 x line						7
00 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus						7
00	Aggregate charges to beneficiaries for excess	s costs (from pro					7
00	Total Program routine service costs for compa		st limitation	(line 78 mir	nus line 79)		8
00 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (1						8
00	Reasonable inpatient routine service costs (		1				8
00	Program inpatient ancillary services (see in	structions)					8
00 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						8
00	PART IV - COMPUTATION OF OBSERVATION BED PASS		,gii 03 <i>)</i>				1 °
00 00	Total observation bed days (see instructions	)				2,076	
	Adjusted general inpatient routine cost per	diem (line 27 ÷ 1	ine 2)		!	1,375.32	2   8

<u>Health</u>	Financial Systems A	SCENSION ST. VI	NCENT ANDERSON		In Lie	u of Form CMS-2	2552-10
COMPUT	TATION OF INPATIENT OPERATING COST		Provider CO		Period: From 07/01/2022	Worksheet D-1	
				•	го 06/30/2023	Date/Time Pre 11/22/2023 10	
			Titl	e XIX	Hospital	Cost	
	Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
			(from line 21)	column 2	Observation	Bed Pass	
					Bed Cost (from	Through Cost	
					line 89)	(col. 3 x col.	
						4) (see	
						instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00	Capital-related cost	1,564,117	30,463,399	0.05134	4 2,855,164	146,596	90.00
91.00	Nursing Program cost	0	30,463,399	0.00000	2,855,164	0	91.00
92.00	Allied health cost	0	30,463,399	0.00000	2,855,164	0	92.00
93.00	All other Medical Education	0	30,463,399	0.00000	2,855,164	0	93.00

Health Financial Systems	ASCENSION ST. VINCENT ANDERSON	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0088	Period: From 07/01/2022	Worksheet D-1
	Component CCN: 15-T088		
	Title XIX	Subprovider -	Cost
		IRF	

	IRF			
	Cost Center Description		_	
	PART I - ALL PROVIDER COMPONENTS	1.0	0	
	INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,677	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,677	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room	days,	0	3.00
	do not complete this line.			
4.00	Semi-private room days (excluding swing-bed and observation bed days)		2,677	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the	cost	0	5.00
6.00	reporting period Total swing-bed SNF type inpatient days (including private room days) after December 31 of the co	05+	0	6.00
6.00	reporting period (if calendar year, enter 0 on this line)	JSC	۷	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the	cost	0	7.00
	reporting period		ا	
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the co	st	0	8.00
	reporting period (if calendar year, enter 0 on this line)			
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed	and	37	9.00
10.00	newborn days) (see instructions)   Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)		0	10.00
10.00	through December 31 of the cost reporting period (see instructions)		ď	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) a	fter	0	11.00
	December 31 of the cost reporting period (if calendar year, enter 0 on this line)			
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days	)	0	12.00
	through December 31 of the cost reporting period			
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	)	0	13.00
14.00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Medically necessary private room days applicable to the Program (excluding swing-bed days)		٥	14.00
15.00	Total nursery days (title V or XIX only)			15.00
16.00				16.00
	SWING BED ADJUSTMENT			
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost		0.00	17.00
	reporting period			
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost		0.00	18.00
19.00	reporting period Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost		0 00	19.00
19.00	reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost		0.00	20.00
	reporting period			
21.00	Total general inpatient routine service cost (see instructions)		08,119	
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period	(line	0	22.00
23.00	5 x line 17)  Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (1)	ino 6	0	23.00
23.00	x line 18)	THE 0	ď	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (	line	0	24.00
	7 x line 19)			
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (li	ne 8	0	25.00
26.00	x line 20)			26.00
26.00 27.00		3 2	0 08,119	26.00
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		00,119	27.00
28.00			0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.	000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	
34.00 35.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)  Average per diem private room cost differential (line 34 x line 31)		0.00	
36.00	Private room cost differential adjustment (line 3 x line 35)		0.00	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential	(line 3.2	08,119	37.00
	27 minus line 36)			
	PART II - HOSPITAL AND SUBPROVIDERS ONLY			
26	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		100	20.5
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		198.40	
39.00 40.00	Program general inpatient routine service cost (line 9 x line 38) Medically necessary private room cost applicable to the Program (line 14 x line 35)		44,341	39.00 40.00
	Total Program general inpatient routine service cost (line 39 + line 40)		44,341	
00	1.1.1. 1.1.g general impactance roughly between costs (fille 55 f fille 165	ı	, 5 . 1	

Health Financial Systems

COMPUTATION OF INPATIENT OPERATING COST

ASCENSION ST. VINCENT ANDERSON

Provider CCN: 15-0088
Component CCN: 15-0088

Title XIX

Cost Center Description

Total
Inpatient Cost Inpatient DaysDiem (col. 1 ÷

In Lieu of Form CMS-2552-10

Worksheet D-1
From 07/01/2022
To 06/30/2023
Date/Time Prepared: 11/22/2023 10:37 am

Program Days
Frogram Cost
(col. 3 x col.)

-			Title	e XIX	Subprovider -	11/22/2023 10 Cost	:37 am
	Cost Center Description	Total	Total	Average Per	IRF Program Days	Program Cost	
		Inpatient CostIn				(col. 3 x col. 4)	
12.00		1.00	2.00	3.00	4.00	5.00	42.00
42.00	NURSERY (title V & XIX only)  Intensive Care Type Inpatient Hospital Units	0	0	0.00	0	0	42.00
43.00	INTENSIVE CARE UNIT	0	0	0.00	) 0	0	43.00
44.00	CORONARY CARE UNIT		Ĭ	0.00		١	44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00							47.00
	Cost Center Description					1.00	
48.00	Program inpatient ancillary service cost (Wks	t D=3 col 3	line 200)			1.00	48.00
48.01	Program inpatient cellular therapy acquisition	, ,		II. line 10.	column 1)	20,403	48.01
49.00	Total Program inpatient costs (sum of lines				,	72,750	49.00
	PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpa	atient routine se	rvices (from	Wkst. D, sum	of Parts I and	0	50.00
51.00	III)  Pass through costs applicable to Program inpa	ntiont ancillary	sorvices (fr	m wks+ D su	m of Darts II	0	51.00
31.00	and IV)	acrent anciriary	services (iii	JIII WKSC. D, SU	III OI PAILS II	١	31.00
52.00	Total Program excludable cost (sum of lines !	50 and 51)				0	52.00
53.00	Total Program inpatient operating cost exclude	ding capital rela	ted, non-phys	ician anesthe	tist, and	0	53.00
	medical education costs (line 49 minus line 5	52)					
54.00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	   54.00
55.00	Target amount per discharge						55.00
55.01	Permanent adjustment amount per discharge						55.01
55.02	Adjustment amount per discharge (contractor u	use only)				1	55.02
56.00	Target amount (line 54 x sum of lines 55, 55					0	56.00
57.00	Difference between adjusted inpatient operat	ing cost and targ	et amount (1i	ne 56 minus 1	ine 53)	0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, o	or line 55 from t	ne cost repor	ting period e	nding 1996,	0.00	59.00
60.00	updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54,	or line 55 from	orior year co	ost report, up	dated by the	0.00	60.00
C1 00	market basket)		7 +b +l		da FF		61 00
61.00	Continuous improvement bonus payment (if line 55.01, or line 59, or line 60, enter the less 53) are less than expected costs (lines 54 x	ser of 50% of the	amount by wh	nich operating	costs (line	0	61.00
62.00	<pre>enter zero. (see instructions) Relief payment (see instructions)</pre>					0	62.00
63.00	Allowable Inpatient cost plus incentive payme	ent (see instruct	ions)				
05.00	PROGRAM INPATIENT ROUTINE SWING BED COST	(500 150. 400					05.00
64.00	Medicare swing-bed SNF inpatient routine cost	s through Decemb	er 31 of the	cost reportin	g period (See	0	64.00
65.00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cost</pre>	s after December	31 of the co	st reporting	period (See	0	65.00
	instructions)(title XVIII only)						
66.00	Total Medicare swing-bed SNF inpatient routin	ne costs (line 64	plus line 65	<pre>5)(title XVIII</pre>	only); for	0	66.00
67.00	CAH, see instructions	sacto through D	acamban 21 ad	. + h	ontina noniod		67.00
67.00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	costs through D	ecember, or 01	the cost rep	or tring per roa	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine	costs after Dec	ember 31 of 1	he cost repor	ting period	0	68.00
69.00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient I					0	69.00
70.00	PART III - SKILLED NURSING FACILITY, OTHER NU						70.00
70.00 71.00	Skilled nursing facility/other nursing facil- Adjusted general inpatient routine service co						70.00
72.00	Program routine service cost (line 9 x line 2		2 70 ÷ 1111e 2	.)			72.00
73.00	Medically necessary private room cost applica		line 14 x lir	ne 35)			73.00
74.00	Total Program general inpatient routine serv			,			74.00
75.00	Capital-related cost allocated to inpatient	outine service c	osts (from Wo	rksheet B, Pa	rt II, column		75.00
	26, line 45)						
76.00 77.00	Per diem capital-related costs (line 75 ÷ line Program capital-related costs (line 9 x line						76.00 77.00
77.00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus						78.00
79.00	Aggregate charges to beneficiaries for excess		vider records	;)			79.00
80.00	Total Program routine service costs for compa				s line 79)		80.00
81.00	Inpatient routine service cost per diem limit			-	•		81.00
82.00	Inpatient routine service cost limitation (1						82.00
83.00	Reasonable inpatient routine service costs (s						83.00
84.00	Program inpatient ancillary services (see ins						84.00
85.00	Utilization review - physician compensation						85.00
86.00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		uyn 85)				86.00
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per o		ine 2)				88.00
		·					

Health Financial Systems	SCENSION ST. VI	NCENT ANDERSON		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period:	Worksheet D-1	
		Component C		From 07/01/2022 To 06/30/2023		pared: :37 am
		Titl	e XIX	Subprovider -	Cost	
				IRF		
Cost Center Description						
					1.00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions)				0	89.00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observation	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			<u>.</u>		
90.00 Capital-related cost	200,221	3,208,119	0.06241	1 0	0	90.00
91.00 Nursing Program cost	0	3,208,119	0.00000	0	0	91.00
92.00 Allied health cost	0	3,208,119	0.00000	0	0	92.00
93.00 All other Medical Education	0	3,208,119	0.00000	0	0	93.00

Health Financial Systems	ASCENSION ST. VINCE	ENT ANDERSON		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider Co		Period: From 07/01/2022	Worksheet D-3	
				то 06/30/2023		
		Title	XVIII	Hospital	PPS	
Cost Center Description			Ratio of Cos	t Inpatient	Inpatient	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	

	Cost Center Description	Ratio of Cost	Inpatient	Inpatient	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			ı	
30.00	03000 ADULTS & PEDIATRICS		9,782,435		30.00
	03100 INTENSIVE CARE UNIT		4,713,625		31.00
41.00	04100 SUBPROVIDER - IRF		0		41.00
43.00	04300 NURSERY				43.00
	ANCILLARY SERVICE COST CENTERS				
	05000 OPERATING ROOM	0.126093	8,305,997	1,047,328	
	05200 DELIVERY ROOM & LABOR ROOM	0.685441	0	0	52.00
	05300 ANESTHESIOLOGY	0.000000	0	0	53.00
	05400 RADIOLOGY-DIAGNOSTIC	0.324879	1,231,223	399,998	
	03440 MAMMOGRAPHY	0.224733	0	0	54.01
	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0.078768	326,566	25,723	
	03630 ULTRA SOUND	0.077753	0	0	54.03
	05500 RADIOLOGY-THERAPEUTIC	0.092930	130,356		
	05700 CT SCAN	0.074498	1,044,560		
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.280845	133,000	37,352	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.089447	1,561,918	139,709	59.00
60.00	06000 LABORATORY	0.108798	7,791,172	847,664	60.00
65.00	06500 RESPIRATORY THERAPY	0.138494	4,118,041	570,324	65.00
66.00	06600 PHYSICAL THERAPY	0.469721	554,542	260,480	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.460305	363,487	167,315	67.00
68.00	06800 SPEECH PATHOLOGY	0.460289	180,410	83,041	68.00
69.00	06900 ELECTROCARDIOLOGY	0.225433	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.237186	97,667	23,165	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.239697	2,029,327	486,424	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0.317830	2,211,208	702,788	72.00
	07300 DRUGS CHARGED TO PATIENTS	0.298204	5,227,531	1,558,871	73.00
	03190 CHEMOTHERAPY	0.200027	0	0	76.00
76.01	03020 WOUND CARE	0.257346	0	0	76.01
	OUTPATIENT SERVICE COST CENTERS			<u>'</u>	
90.00	09000 CLINIC	0.000000	0	0	90.00
90.01	09001 ANDERSON OUTPATIENT CENTER	0.480726	0	0	90.01
	04950 DIABETIC EDUCATION	0.000000	0	0	90.02
90.03	09002 MS CLINIC	0.000000	0	0	90.03
91.00	09100 EMERGENCY	0.132085	4,136,834	546,414	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.684660	613,262		
	OTHER REIMBURSABLE COST CENTERS		<u> </u>	· · · · · · · · · · · · · · · · · · ·	
95.00	09500 AMBULANCE SERVICES				95.00
200.00			40,057,101	7,406,404	
201.00			, ,		201.00
202.00			40,057,101		202.00
		1	-,,	1	

	Financial Systems  ENT ANCILLARY SERVICE COST APPORTIONMENT	ASCENSION ST. VINCENT ANDERSO Provider (	CN: 15-0088	Period:	worksheet D-3	
			CCN: 15-T088	From 07/01/2022 To 06/30/2023		
				, ,	11/22/2023 10	
		Titl	e XVIII	Subprovider - IRF	PPS	
	Cost Center Description		Ratio of Cos		Inpatient	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1.00	2.00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS				T	
0.00	03000 ADULTS & PEDIATRICS					30.
1.00	03100 INTENSIVE CARE UNIT			2 442 224		31.
1.00	04100 SUBPROVIDER - IRF			2,110,831		41.
3.00	04300 NURSERY					43.
	ANCILLARY SERVICE COST CENTERS		0.1000	22 22	2 024	
0.00	05000 OPERATING ROOM		0.1260	,		1
2.00	05200 DELIVERY ROOM & LABOR ROOM		0.6854			1 -
	05300 ANESTHESIOLOGY		0.0000		0	
	05400 RADIOLOGY-DIAGNOSTIC		0.3248		· ·	1
	03440 MAMMOGRAPHY		0.2247		0	
	03450 NUCLEAR MEDICINE - DIAGNOSTIC		0.0787	,	306	
	03630 ULTRA SOUND 05500 RADIOLOGY-THERAPEUTIC		0.0777		0	
	05700 CT SCAN		0.0929		1	1
8.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0.2808	,		
9.00	05900 CARDIAC CATHETERIZATION		0.0894	,		
0.00	06000 LABORATORY		0.10879	,		
5.00	06500 RESPIRATORY THERAPY		0.1384	,	,	
6.00	06600 PHYSICAL THERAPY		0.4697	,		1
7.00	06700 OCCUPATIONAL THERAPY		0.4603	,	- ,	
8.00	06800 SPEECH PATHOLOGY		0.4602	,	,	
	06900 ELECTROCARDIOLOGY		0.2254			1
	07000 ELECTROCARDIOLOGI		0.2371		1	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.2396			
	07200 IMPL. DEV. CHARGED TO PATIENTS		0.3178	,		1
3.00	07300 DRUGS CHARGED TO PATIENTS		0.29820	,		1
6.00	03190 CHEMOTHERAPY		0.2000			
6.01	03020 WOUND CARE		0.2573			
	OUTPATIENT SERVICE COST CENTERS			-,		1
0.00	09000 CLINIC		0.0000	00 0	0	90.
	09001 ANDERSON OUTPATIENT CENTER		0.4807		0	
	04950 DIABETIC EDUCATION		0.0000		0	90.
	09002 MS CLINIC		0.0000	00 0	0	90.
1.00	09100 EMERGENCY		0.1320		4,220	91.
2.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0.6846			
	OTHER REIMBURSABLE COST CENTERS					1
- 00	09500 AMBILLANCE SERVICES					95

95.00 719,778 200.00

201.00

2,237,176

2,237,176

95.00 09500 AMBULANCE SERVICES
200.00 Total (sum of lines

201.00

202.00

Total (sum of lines 50 through 94 and 96 through 98)

Net charges (line 200 minus line 201)

Less PBP Clinic Laboratory Services-Program only charges (line 61)

Health Financial Systems	ASCENSION ST. VINCE	NT ANDERSON		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider Co		Period: From 07/01/2022	Worksheet D-3	
				то 06/30/2023	Date/Time Pre 11/22/2023 10	pared: :37 am
		Titl	e XIX	Hospital	Cost	
Cost Center Description			Ratio of Cost	t Inpatient	Inpatient	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1.00	2.00	3.00	

	Cost Center Description	Ratio of Cost	Inpatient	Inpatient	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
	NPATIENT ROUTINE SERVICE COST CENTERS				
	03000 ADULTS & PEDIATRICS		3,375,799		30.00
	3100 INTENSIVE CARE UNIT		1,747,865		31.00
	04100 SUBPROVIDER - IRF		0		41.00
_	04300 NURSERY		85,838		43.00
	NCILLARY SERVICE COST CENTERS	,			
	05000 OPERATING ROOM	0.126093	1,354,352		
	05200 DELIVERY ROOM & LABOR ROOM	0.685441	255,051	174,822	52.00
	05300 ANESTHESIOLOGY	0.000000	0	0	53.00
	05400 RADIOLOGY-DIAGNOSTIC	0.324879	438,887	142,585	
	03440 MAMMOGRAPHY	0.224733	0	0	54.01
54.02 0	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0.078768	0	0	54.02
	03630 ULTRA SOUND	0.077753	132,656	10,314	54.03
55.00 0	05500 RADIOLOGY-THERAPEUTIC	0.092930	4,576	425	55.00
57.00 0	05700 CT SCAN	0.074498	317,665	23,665	57.00
58.00 0	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.280845	63,225	17,756	58.00
	05900 CARDIAC CATHETERIZATION	0.089447	409,338	36,614	59.00
60.00 0	06000 LABORATORY	0.108798	2,577,633	280,441	60.00
65.00 0	06500 RESPIRATORY THERAPY	0.138494	994,629	137,750	65.00
	06600 PHYSICAL THERAPY	0.469721	135,021	63,422	66.00
	06700 OCCUPATIONAL THERAPY	0.460305	63,520		67.00
	06800 SPEECH PATHOLOGY	0.460289	21,639		68.00
	06900 ELECTROCARDIOLOGY	0.225433	0	0	69.00
	07000 ELECTROENCEPHALOGRAPHY	0.237186	22,135	5,250	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.239697	389,651	93,398	
	07200 IMPL. DEV. CHARGED TO PATIENTS	0.317830	94,806		72.00
	07300 DRUGS CHARGED TO PATIENTS	0.298204	1,684,043		73.00
	03190 CHEMOTHERAPY	0.200027	1,356		76.00
	03020 WOUND CARE	0.257346	1,086		76.01
	OUTPATIENT SERVICE COST CENTERS	0.23.3.0	2,000	2.3	
	09000 CLINIC	0.000000	0	0	90.00
	09001 ANDERSON OUTPATIENT CENTER	0.480726	1,568		90.01
	04950 DIABETIC EDUCATION	0.000000	1,500	0	90.02
	09002 MS CLINIC	0.000000	0	0	90.03
	09100 EMERGENCY	0.132085	1,736,561		
	19200 OBSERVATION BEDS (NON-DISTINCT PART)	0.684660	1,730,301	0	92.00
	OTHER REIMBURSABLE COST CENTERS	0.004000			32.00
	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		10,699,398	1,959,413	
200.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		10,033,330	1,333,413	200.00
201.00	Net charges (line 200 minus line 201)		10,699,398		201.00
202.00	INEL CHAIGES (TIME 200 MIMUS TIME 201)	1	10,033,390	I	1202.00

Health Financial Systems ASCENSION ST. VI INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		CN: 15-0088	Period:	worksheet D-3	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN. 13-0066	From 07/01/2022	worksneet D-3	)
	Component	CCN: 15-T088	то 06/30/2023	Date/Time Pre 11/22/2023 10	
	Tit <sup>*</sup>	le XIX	Subprovider - IRF	Cost	
Cost Center Description		Ratio of Cos	t Inpatient	Inpatient	
		To Charges		Program Costs	
			Charges	(col. 1 x col.	
		1 00	2.00	2)	
TAIDATTENT DOUTTNE CEDVICE COCT CENTERS		1.00	2.00	3.00	-
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS					30.0
31.00   03100   INTENSIVE CARE UNIT					31.0
41.00 04100 SUBPROVIDER - IRF			137,230		41.0
43.00   04300   NURSERY			157,230		43.0
ANCILLARY SERVICE COST CENTERS					1 .5.0
0.00 05000 OPERATING ROOM		0.1260	93 0	0	50.0
52.00 05200 DELIVERY ROOM & LABOR ROOM		0.6854			
3.00 05300 ANESTHESIOLOGY		0.0000		l	
64.00 05400 RADIOLOGY-DIAGNOSTIC		0.3248		396	54.0
4.01 03440 MAMMOGRAPHY		0.2247	33 0	0	54.0
4.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC		0.0787	68 0	0	54.0
4.03   03630   ULTRA SOUND		0.0777	53 0	0	54.0
5.00   05500 RADIOLOGY-THERAPEUTIC		0.0929	30 0	0	55.0
7.00   05700   CT   SCAN		0.0744	98 0	0	57.0
8.00   05800   MAGNETIC RESONANCE IMAGING (MRI)		0.2808	45 0	0	58.0
9.00   05900   CARDIAC CATHETERIZATION		0.0894	47 0	0	59.0
0.00   06000   LABORATORY		0.1087			
55.00 06500 RESPIRATORY THERAPY		0.1384			
6.00 06600 PHYSICAL THERAPY		0.4697			
7.00 06700 OCCUPATIONAL THERAPY		0.4603			
8.00 06800 SPEECH PATHOLOGY		0.4602	,		
9.00 06900 ELECTROCARDIOLOGY		0.2254		1	
0.00 07000 ELECTROENCEPHALOGRAPHY		0.2371		1	
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.2396		1	
2.00  07200 IMPL. DEV. CHARGED TO PATIENTS 3.00  07300 DRUGS CHARGED TO PATIENTS		0.3178		1	
3.00   07300   DRUGS CHARGED TO PATIENTS 6.00   03190   CHEMOTHERAPY		0.2982			
6.01   03020   WOUND CARE		0.2573			
OUTPATIENT SERVICE COST CENTERS		0.2373	40  0		70.0
0.00 09000 CLINIC		0.0000	00 0	0	90.0
0.01 09001 ANDERSON OUTPATIENT CENTER		0.4807			
0.02 04950 DIABETIC EDUCATION		0.0000			
0.03   09002 MS CLINIC		0.0000		1	
1.00   09100   EMERGENCY		0.1320			
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0.6846		l	
OTHER REIMBURSABLE COST CENTERS					1
5.00 09500 AMBULANCE SERVICES					95.0
Total (sum of lines 50 through 94 and 96 through 98)			86,560	28,409	
01.00 Less PBP Clinic Laboratory Services-Program only char	ges (line 61)		0	· '	201.0
Net charges (line 200 minus line 201)			86,560		202.0

Less PBP Clinic Laboratory Services-Program only charges (line 61) Net charges (line 200 minus line 201)

86,560

95.00 28,409 200.00 201.00 202.00

202.00

DAT A - JUPATIENT INCOPTIAL SERVICES UNDER PPS   1.00		Title XVIII HO	spital	PPS	:37 am
NAT A - IMPATIENT MOSPITAL SERVICES UNDER PEPS					
1.00   Dec Amounts other than outlier payments for discharges occurring prior to October 1 (see   2,737,701   1.01   1.02   1.02   1.02   1.02   1.02   1.02   1.02   1.02   1.02   1.02   1.03   1.02   1.03   1.02   1.03   1.02   1.03   1.02   1.03   1.				1.00	
1.01   DoG amounts other than outlier payments for discharges occurring on or after October 1 (see   2,379,703   1.01   Instructions)   1.02   Instructions)   1.03   Instructions   1.03   Instructions   1.03   Instructions   1.03   Instructions   1.03   Instructions   1.04   Instructions   1.05   Instructions   1.05   Instructions   1.05   Instructions   1.06   Instructions   1.07   Instruct	1 00			0	1 00
1.02   1.03   1.02   1.03   1.02   1.03   1.02   1.03   1.02   1.03   1.02   1.03		DRG amounts other than outlier payments for discharges occurring prior to October 1 (see		· ·	1
1.00   DRC for fedderal specific operating payment for Nodel 4 BPCI for discharges occurring prior to October   0   1.03	1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see		7,505,313	1.02
1.04   Okt for federal specific operating payment for wodel 4 BPCI for discharges occurring on or after   0   1.04	1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior t	o October	0	1.03
2.00   Outlier payments for discharges. (see instructions)	1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or a	fter	0	1.04
outlier payment for discharges corunting prior to October 1 (see instructions)  outlier payments for discharges occurring prior to October 1 (see instructions)  outlier payments for discharges occurring prior to October 1 (see instructions)  Managed care simulated symments when the cost reporting period (see instructions)  outlier payments of discharges occurring on or after october 1 (see instructions)  outlier payments of outlier payments for discharges occurring period (see instructions)  outlier of the count for allocation Adjustment  or before 1/31/1996 (see instructions)  or before 1/31/1996 (		Outlier payments for discharges. (see instructions)		0	ı
2.03   Outlier payments for discharges occurring prior to October 1 (see instructions)   407,555   2.04				· ·	1
Sampaged Care Simulated Payaments   0, 3.00	2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)		58,686	2.03
Bed days available divided by number of days in the cost reporting period (see instructions)   137.93   4.00					-
modiffect Medical Education Adjustment  5.00   FEC count for allogathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)  5.01   FEC count for allogathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)  5.02   FEC count for allogathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)  5.02   FEC count for allogathic and steep as specified under 42 (FE \$412.105(f)(1)(iv)(8)(1)   0.00   0.				· ·	1
FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/311/996, (see instructions)  7.00 or Defore 12/311/996, (see instructions)  7.01 period for the CAD of the CAD of the CAD 2021 (see instructions)  7.02 or Defore 12/311/996, (see instructions)  7.03 or Defore 12/311/996, (see instructions)  7.04 period for the CAD 2011 (see instructions)  7.05 may section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(i)(i)(8)(1)  7.06 period for the CAD 2011 (see instructions)  7.07 may section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(i)(i)(2)(1) free color for cost reports creadiles July 1, 2011 then see instructions)  7.01 may section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(i)(i)(2)(1) free color for cost reports created an ureal react for Medicare Local affiliated programs FTE limitation(s) for rural and 87 re 49975 (August 10, 2022) (see instructions)  8.01 Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 2640 (May 12, 1998), and 67 FR 3096 (August 1, 2003). marded FTE cap slots under \$5503 of the ACA. If the cost under \$5506 of ACA. (see instructions)  8.02 the amount of increase if the hespital was awarded FTE cap slots under \$126 of the CAA 2021 (see instructions)  8.03 sum of ine 20, plus finis 6, plus lines 6, 26 through 6.49, minus lines 7 and 7.01, plus or under \$5506 of ACA. (see instructions)  8.04 sum of ine 20, plus finis 6, plus lines 6, 26 through 6.49, minus lines 7 and 7.01, plus or 10.00 incount of increase if the hespital was awarded FTE cap slots under \$126 of the CAA 2021 (see instructions)  8.00 in or ine 20, plus finis 1 ine 3, plus lines 6, 26 through 6.49, minus lines 7 and 7.01, plus or 10.00 incount of increase if the hespital was awarded FTE cap slots under \$126 of the CAA 2021 (see instructions)  8.01 in or	4.00			137.93	4.00
FIG. Cap Adjustment for qualifing hospitals under \$131 of the CAA 2021 (see instructions)  6.00 FIG. Count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 (FR 413.79(e)  6.00 FIG. Rural track program FIE cap limitation adjustment after the cap-building window closed under \$127 of the CAA 2021 (see instructions)  7.00 FIG. School (See instructions)  7.01 FIG. School (See instructions)  7.02 Adjustment (increase or decrease) to the hospital's rural track program FIE limitation(GS) for rural track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b) and 87 fr. 49075 (August 10, 2022) (see instructions)  8.01 FIG. School (Increase or decrease) to the hospital vas awarded FIE cap slots under \$5503 of the ACA. If the cost report straddles July 1, 2011 awas awarded FIE cap slots under \$5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.  8.02 The amount of increase if the hospital was awarded FIE cap slots under \$5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.  8.03 The amount of increase if the hospital was awarded FIE cap slots under \$126 of the CAA 2021 (see 1.00 of	5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period	ending on	0.00	5.00
new programs in accordance with 42 CFR 413.79(e) 6.26 kural track programs FTE cap limitation adjustment after the cap-building window closed under \$127 of the CAA 2021 (see instructions) 7.00 MMA Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(8)(2) If the 0.00 7.01 cost report straddies July 1, 2011, then see instructions. 7.02 Adjustment (increase or decrease) to the hospital's rural track programs FI limitation(s) for rural and 57 FR 49075 (August 10, 2022) (see instructions) 8.00 Adjustment (increase or decrease) to the FIE count for allopathic and osteopathic programs for affiniated programs in accordance with 413.75(b) adjustment (increase or decrease) to the FIE count for allopathic and osteopathic programs for affiniated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002). 8.01 The amount of increase if the hospital was awarded FIE cap slots under \$ 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions awarded FIE cap slots under \$ 5506 of ACA. (see instructions) 8.01 The amount of increase if the hospital was awarded FIE cap slots under \$126 of the CAA 2021 (see 0.00 8.21 mount of increase if the hospital was awarded FIE cap slots under \$126 of the CAA 2021 (see 0.00 8.21 mount of increase if the hospital was awarded FIE cap slots under \$126 of the CAA 2021 (see 0.00 8.21 mount of increase if the hospital was awarded FIE cap slots under \$126 of the CAA 2021 (see 0.00 8.21 mount of increase if the hospital was awarded FIE cap slots under \$126 of the CAA 2021 (see 0.00 8.21 mount of increase if the hospital was awarded FIE cap slots under \$126 of the CAA 2021 (see 0.00 8.21 mount of increase if the hospital was awarded FIE cap slots under \$126 of the CAA 2021 (see 0.00 8.21 mount of increase if the hospital was awarded FIE cap slots under \$126 of the CAA 2021 (see 0.00 8.21 mount of increase if the slope increase if the slope increase if the slope increase increase inc	5.01			0.00	5.01
the CAA 2021 (see instructions)  7.00 MA Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(8)(1)  7.01 ACA \$ 5503 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(8)(2) If the cook cost report straddles unly 1, 2011 then see instructions.  7.02 Adjustment (increase or decrease) to the hospital 's rural track programs fire limitation(s) for rural track programs with a rural track for Medicare Gde Affiliated programs in accordance with 413.75(b) and 57 FR 4075 (August 10, 2022) (See instructions) and 57 FR 4075 (August 10, 2022) (See instructions) and 57 FR 50069 (August 1, 2002).  8.00 Affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1988), and 67 FR 50069 (August 1, 2002).  8.11 The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.  8.02 Hamount of increase if the hospital was awarded FTE cap slots under § 5506 of ACA. (See instructions)  8.11 The amount of increase if the hospital was awarded FTE cap slots under \$126 of the CAA 2021 (See instructions) and the following structions are sufficiently as a fire following struction and structions are sufficiently as a fire following struction and structions are sufficiently as a fire following struction and structions are sufficiently as a fire following struction and structions are sufficiently as a fire following struction and structions are sufficiently as a fire following struction and structions are sufficiently as a fire following struction and structions are sufficiently as a fire following struction and structions are sufficiently sufficiently as a fire following struction and structions are sufficiently as a fire f	6.00		e cap for	0.00	6.00
ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(8)(2) If the cost report straddles July 1, 2011 then see instructions.  Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural and 87 FR 49075 (August 10, 2022) (see instructions)  And 87 FR 49075 (August 10, 2022) (see instructions)  Algustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1989), and 67 FR 50069 (August 1, 2002).  10	6.26		§127 of	0.00	6.26
cost report straddles July 1, 2011 then see instructions.  1.02 Ajustment (increase or decrease) to the hospital's rural track programs FTE limitation(s) for rural track programs with a rural track for Medicare (ME affiliated programs in accordance with 413,75(b) and 87 FR4 49075 (August 10, 2022) (see instructions)  1.00 Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 FK 413.75(b), 413.79(c)2(iv), 64 FR 26340 (May 12, 1998), and 67 FR 30068 (August 1, 2002).  1.00 Ajustment (increase in the following see instructions)  1.00 The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.  1.01 The amount of increase if the hospital was awarded FTE cap slots under § 126 of the CAA 2021 (see under § 5506 of AcA. (see instructions)  1.00 The amount of increase if the hospital was awarded FTE cap slots under § 126 of the CAA 2021 (see under § 5506 of AcA. (see instructions)  1.00 The amount of increase if the hospital was awarded FTE cap slots under § 126 of the CAA 2021 (see under § 5506 of AcA. (see instructions)  1.00 The amount of increase if the hospital was awarded FTE cap slots under § 126 of the CAA 2021 (see under § 5506 of AcA. (see instructions)  1.00 The amount of increase if the hospital was awarded FTE cap slots under § 126 of the CAA 2021 (see under § 5506 of AcA. (see instructions)  1.00 The amount of increase if the hospital was awarded FTE cap slots under § 126 of the CAA 2021 (see under § 5506 of AcA. (see instructions)  1.00 The amount of increase if the hospital was awarded FTE cap slots under § 126 of the CAA 2021 (see under § 5506 of AcA. (see instructions)  1.00 The count for residents and osteopathic programs in the current year from your records  1.00 The count for residents and osteopathic programs in the current year from your records  1.00 The count for the prior year from your year allowable FTE count for the pri					1
track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)  8.00 Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 FEF 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).  8.01 The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.  8.02 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)  8.11 The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)  9.00 Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plughminus line 8, plus lines 8.01 through 8.27 (see instructions)  10.00 FTE count for allopathic and osteopathic programs in the current year from your records  10.00 Test count for allowable FTE count for or the penultimate year if that year ended on or after September 30, 1997, 100 11.00  11.00 Test count for allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, 100 14.00  11.01 Test allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, 100 14.00  11.02 Test allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, 100 14.00  11.00 Test allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, 100 14.00  11.00 Test penultimate the penultimate year if that year ended on or after September 30, 1997, 100 14.00  11.00 Test penultimate the penultimate year if that year ended on or after September 30, 1997, 100 14.00  11.00 Test penultimate the penultimate year if that year ended on or after September 30, 1997, 100 14.00  11.00 Test penultimat	7.02	cost report straddles July 1, 2011 then see instructions.			
Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).  **Round of 7 FR 50069 (August 1, 2002).  **Banount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.  **Round of Increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)  **Round of Increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)  **Banount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)  **Banount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)  **Banount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)  **Banount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)  **Banount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)  **Banount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)  **Banount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)  **Banount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)  **Banount of increase if the hospital program in the current year from your records  **Banount of increase if the slots of the program of the spital closure slots under September 30, 1997, once 14.00  **Banount of increase if the slots of the program of hospital closure  **Banount of increase if the slots of the program of hospital closure  **Banount of increase if the slots of the program of hospital closure  **Banount of increase if the slots of the program increase instructions)  *		track programs with a rural track for Medicare GME affiliated programs in accordance with 41			
1998), and 67 FR 50069 (August 1, 2002). 8.01 The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions. 8.02 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital 0.00 8.02 under § 5506 of ACA. (see instructions) 8.21 The amount of increase if the hospital was awarded FTE cap slots under \$126 of the CAA 2021 (see instructions) 8.21 The amount of increase if the hospital was awarded FTE cap slots under \$126 of the CAA 2021 (see instructions) 8.21 The amount of increase if the hospital was awarded FTE cap slots under \$126 of the CAA 2021 (see instructions) 8.21 The amount of increase if the hospital was awarded FTE cap slots under \$126 of the CAA 2021 (see instructions) 8.22 10.00 The count for allopathic and osteopathic programs in the current year from your records 8.22 11.00 11.00 The count for residents in dental and podiatric programs in the current year from your records 8.23 11.00 11.00 Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, 0.00 11.00 Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, 0.00 11.00 Total allowable FTE count for the program (see instructions) 11.00 11.0	8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs f		0.00	8.00
report straddles July 1, 2011, see instructions.  8.02 He amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)  8.21 He amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)  8.21 me amount of increase if the hospital was awarded FTE cap slots under \$126 of the CAA 2021 (see instructions)  8.22 minus line 7.02, plus/minus line 8, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)  8.00 minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)  8.01 minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)  8.00 current year allowable FTE count for the prior year.  8.01 current year allowable FTE count for the prior year.  8.02 current year allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, oldo 11.00  8.01 current year lines 12 through 14 divided by 3.  8.02 current year lines 12 through 14 divided by 3.  8.03 current year residents in initial years of the program (see instructions)  8.04 dijustment for residents displaced by program or hospital closure  8.04 current year resident to bed ratio (line 18 divided by line 4).  8.05 current year resident to bed ratio (line 18 divided by line 4).  8.06 current year resident to bed ratio (line 18 divided by line 4).  8.07 current year resident to bed ratio (see instructions)  8.08 current year resident to lone ratio (line 18 divided by line 4).  8.00 current year resident to lone ratio (line 18 divided by line 4).  8.00 current year resident to lone ratio (line 18 divided by line 4).  8.00 current year resident to lone ratio (line 18 divided by line 4).  8.00 current year resident to lone ratio (line 18 divided by line 4).  8.00 current year resident count over Cap (see instructions)  8.00 current year resident count over Cap (see instructions)  8.0	8.01	1998), and 67 FR 50069 (August 1, 2002).	-	0.00	8.01
Under § \$506 of ACA. (See instructions)   8.21   8.21   The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see		report straddles July 1, 2011, see instructions.			
instructions		under § 5506 of ACA. (see instructions)			
minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)   0.00   10.00   11.00		instructions)			
11.00   FTE count for residents in dental and podiatric programs.   0.00   11.00   12.00   12.00   13.00   13.00   13.00   15.00   1		minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)	p.us 0.		
13.00 Total allowable FTE count for the prior year. 14.00 Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, 0.00 14.00 otherwise enter zero. 15.00 Sum of lines 12 through 14 divided by 3. 16.00 Adjustment for residents in initial years of the program (see instructions) 0.00 16.00 17.00 Adjustment for residents displaced by program or hospital closure 0.00 17.00 18.00 Adjustment for residents displaced by program or hospital closure 0.00 17.00 18.00 Adjustment for residents displaced by program or hospital closure 0.00 18.00 18.00 18.00 19.00 Adjustment for residents displaced by program or hospital closure 0.00 18.00 18.00 18.00 18.00 18.00 19.00 19.00 Prior year resident to bed ratio (see instructions) 0.000000 19.00					1
Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.  15.00 Sum of lines 12 through 14 divided by 3.  16.00 Adjustment for residents in initial years of the program (see instructions)  17.00 Adjustment for residents displaced by program or hospital closure  19.00 Current year resident to bed ratio (line 18 divided by line 4).  19.00 Current year resident to bed ratio (see instructions)  19.00 Enter the lesser of lines 19 or 20 (see instructions)  10.00 ImE payment adjustment (see instructions)  10.00 ImE payment adjustment - Managed Care (see instructions)  10.00 ImE payment adjustment - Managed Care (see instructions)  10.00 Ime free Resident Count Over Cap (see instructions)  10.00 Ime payment adjustment on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)  10.00 Ime payments adjustment factor. (see instructions)  10.0	12.00				1
otherwise enter zero.  Sum of lines 12 through 14 divided by 3.  15.00 Adjustment for residents in initial years of the program (see instructions)  17.00 Adjustment for residents displaced by program or hospital closure  O.00 17.00 Adjustment for residents displaced by program or hospital closure  O.00 17.00 Adjustment for residents displaced by program or hospital closure  O.00 17.00 Current year resident to bed ratio (line 18 divided by line 4).  O.000000 19.00 Current year resident to bed ratio (see instructions)  O.000000 20.00 Prior year resident to bed ratio (see instructions)  O.000000 20.00 Prior year resident to bed ratio (see instructions)  O.000000 20.00 Prior year resident to bed ratio (see instructions)  O.000000 20.00 Prior year resident to bed ratio (see instructions)  O.000000 20.00 Prior year resident to bed ratio (see instructions)  O.000000 20.00 Prior year resident to bed ratio (see instructions)  O.000000 20.00 Prior year resident to bed ratio (see instructions)  O.000000 20.00 Prior year resident to bed ratio (see instructions)  IME payment adjustment (see instructions)  O.000000 22.00 Prior year resident dedical Education Adjustment for the Add-on for § 422 of the MMA  Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f(1)(iv)(v)(c).  Aumber of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f(1)(iv)(c).  IME FTE Resident Count Over Cap (see instructions)  O.000000 25.00 IME famount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see one of the prior of the Add-on adjustment factor. (see instructions)  O.000000 25.00 IME payment sadjustment factor. (see instructions)  O.000000 26.00 IME payment sadjustment factor. (see instructions)  O.000000 27.00 IME payment (sum of lines 22 and 28)  O.000000 28.01 IME add-on adjustment amount - Managed Care (see instructions)  O.000000 29.01 Prior of the Add-on adjustment factor. (see instructions)  O.000000 29.01 Prior of the Add-on adjust		· · ·			1
15.00 Sum of lines 12 through 14 divided by 3. 16.00 Adjustment for residents displaced by program or hospital closure 17.00 Adjustment for residents displaced by program or hospital closure 18.00 Adjusted rolling average FTE count 19.00 Current year resident to bed ratio (line 18 divided by line 4). 19.00 Current year resident to bed ratio (see instructions) 19.00 Enter the lesser of lines 19 or 20 (see instructions) 19.00 Image payment adjustment (see instructions) 19.00 Image payment adjustment (see instructions) 19.00 Image payment adjustment for the Add-on for \$422 of the MMA 19.00 Image payment adjustment for the Add-on for \$422 of the MMA 19.00 Image payment adjustment for the Add-on for \$422 of the MMA 19.00 Image payment adjustment for the Add-on for \$420 of the MMA 19.00 Image payment adjustment for the Add-on for \$420 of the MMA 19.00 Image payment adjustment for the Add-on for \$420 of the MMA 19.00 Image payment adjustment for the Add-on for \$420 of the MMA 19.00 Image payment adjustment for the Add-on for \$420 of the MMA 19.00 Image payment for the Add-on for \$420 of the MMA 19.00 Image payment for the Add-on for \$420 of the MMA 19.00 Image payment for the Add-on for \$420 of the MMA 19.00 Image payment for the Add-on for \$420 of the MMA 19.00 Image payment for the Add-on for \$420 of the MMA 19.00 Image payment for the Add-on for \$420 of the MMA 19.00 Image payment for the Add-on for \$420 of the MMA 19.00 Image payment for for the Add-on for \$420 of the MMA 19.00 Image payment for for the Add-on for \$420 of the MMA 19.00 Image payment for for the Add-on for \$420 of the MMA 19.00 Image payment for for the Add-on for \$420 of the MMA 19.00 Image payment for for the Add-on for \$420 of the MMA 19.00 Image payment for for the Add-on for \$420 of the MMA 19.00 Image payment for for the Add-on for \$420 of the MMA 19.00 Image payment for for the Add-on for \$420 of the MMA 19.00 Image payment for for the Add-on for \$420 of the MMA 19.00 Image payment for for the Add-on for \$420 of the MMA 19.00 Image payment f	14.00		30, 1997,	0.00	14.00
16.00   Adjustment for residents in initial years of the program (see instructions)   0.00   16.00   17.00   Adjustment for residents displaced by program or hospital closure   0.00   17.00   18.00   17.00   18.00   19.0	15.00			0.00	15.00
18.00 Adjusted rolling average FTE count 19.00 Current year resident to bed ratio (line 18 divided by line 4). 19.00 Current year resident to bed ratio (see instructions) 20.00 Prior year resident to bed ratio (see instructions) 21.00 Enter the lesser of lines 19 or 20 (see instructions) 22.00 IME payment adjustment (see instructions) 22.01 IME payment adjustment - Managed Care (see instructions) 22.01 Ime payment adjustment adjustment for the Add-on for § 422 of the MMA 23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(c). 24.00 IME FTE Resident Count over Cap (see instructions) 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 28.01 IME add-on adjustment amount (see instructions) 28.01 IME add-on adjustment amount - Managed Care (see instructions) 29.00 Total IME payment (sum of lines 22 and 28) 29.01 Total IME payment (sum of lines 22 and 28) 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 29.01 Disproportionate Share Adjustment  Percentage of Medicaid patient days (see instructions) 31.69 31.00 31.00 Allowable disproportionate share percentage (see instructions) 21.25 33.00	16.00	Adjustment for residents in initial years of the program (see instructions)			
19.00 Current year resident to bed ratio (line 18 divided by line 4).  20.00 Prior year resident to bed ratio (see instructions)  21.00 Enter the lesser of lines 19 or 20 (see instructions)  22.00 IME payment adjustment (see instructions)  22.01 IME payment adjustment — Managed Care (see instructions)  23.00 IME payment adjustment — Managed Care (see instructions)  23.00 (f)(1)(iv)(c)  24.00 IME FTE Resident Count Over Cap (see instructions)  25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see  26.00 Resident to bed ratio (divide line 25 by line 4)  27.00 IME payments adjustment factor. (see instructions)  28.01 IME payments adjustment factor. (see instructions)  28.01 IME add-on adjustment amount (see instructions)  28.01 IME add-on adjustment amount — Managed Care (see instructions)  28.01 IME add-on adjustment amount — Managed Care (see instructions)  29.01 Total IME payment — Managed Care (see instructions)  20.02 IME payment — Managed Care (see instructions)  20.03 IME payment — Managed Care (see instructions)  20.04 IME payment — Managed Care (see instructions)  20.05 IME add-on adjustment amount — Managed Care (see instructions)  20.06 IME payment — Managed Care (see instructions)  20.07 IME payment — Managed Care (see instructions)  20.08 IME add-on adjustment amount — Managed Care (see instructions)  20.09 IME payment — Managed Care (see instructions)  20.00 IME payment — Managed Care (see instructions)  20.00 IME payment — Managed Care (see instructions)  20.00 IME payment — Managed Care (see instructions)  20.00 IME payment — Managed Care (see instructions)  20.00 IME payment — Managed Care (see instructions)  20.00 IME payment — Managed Care (see instructions)  20.00 IME payment — Managed Care (see instructions)  20.00 IME payment — Managed Care (see instructions)  20.00 IME payment — Managed Care (see instructions)  20.00 IME payment — Managed Care (see instructions)  20.00 IME payment — Managed Care (see instructions)  20.00 IME payment — Managed Car					1
20.00 Prior year resident to bed ratio (see instructions) 21.00 Enter the lesser of lines 19 or 20 (see instructions) 22.01 IME payment adjustment (see instructions) 22.01 IME payment adjustment — Managed Care (see instructions) 22.01 IME payment adjustment — Managed Care (see instructions) 22.01 IME payment adjustment — Managed Care (see instructions) 22.01 IME payment adjustment — Managed Care (see instructions) 23.00 Value of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 24.00 IME FTE Resident Count Over Cap (see instructions) 25.00 IME admontt on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 28.00 IME add-on adjustment amount (see instructions) 28.01 IME add-on adjustment amount (see instructions) 28.01 IME add-on adjustment amount — Managed Care (see instructions) 28.01 IME payment (sum of lines 22 and 28) 29.01 Total IME payment — Managed Care (see instructions) 29.00 Total IME payment — Managed Care (see instructions) 29.01 Total IME payment — Managed Care (sum of lines 22.01 and 28.01) 29.01 Disproportionate Share Adjustment  Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31.00 Sum of lines 30 and 31 31.00 Allowable disproportionate share percentage (see instructions) 31.00 Allowable disproportionate share percentage (see instructions) 20.00 Sum of lines 30 and 31 41lowable disproportionate share percentage (see instructions) 20.00 Prior to the first of the MMA 22.00 Prior to the Managed Care (see instructions) 20.00 Prior to the Managed Care (see instructions) 31.00 Allowable disproportionate share percentage (see instructions) 31.00 Prior to the first day of the MMA 32.00 Prior to the Managed Care (see instructions) 31.00 Prior					1
21.00 Enter the lesser of lines 19 or 20 (see instructions)  22.00 IME payment adjustment (see instructions)  1ME payment adjustment - Managed Care (see instructions)  1ndirect Medical Education Adjustment for the Add-on for § 422 of the MMA  23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105  24.00 IME FTE Resident Count Over Cap (see instructions)  25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see  26.00 Resident to bed ratio (divide line 25 by line 4)  27.00 IME payments adjustment factor. (see instructions)  28.00 IME add-on adjustment amount (see instructions)  28.01 IME add-on adjustment amount (see instructions)  29.00 Total IME payment (sum of lines 22 and 28)  29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  29.01 Disproportionate Share Adjustment  Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  30.00 Sum of lines 30 and 31  Allowable disproportionate share percentage (see instructions)  21.25 33.00					
Z2.00   IME payment adjustment (see instructions)   0   22.00					
Timbirect Medical Education Adjustment for the Add-on for § 422 of the MMA  23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 0.00 23.00 (f)(1)(iv)(c).  24.00 IME FTE Resident Count Over Cap (see instructions)  If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 25.00 instructions)  26.00 Resident to bed ratio (divide line 25 by line 4) 0.000000 26.00 IME payments adjustment factor. (see instructions) 0.000000 27.00 IME add-on adjustment amount (see instructions) 0.000000 27.00 IME add-on adjustment amount (see instructions) 0.28.00 IME add-on adjustment amount - Managed Care (see instructions) 0.28.00 IME payment (sum of lines 22 and 28) 0.29.00 Total IME payment (sum of lines 22 and 28) 0.29.00 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 0.29.01 Disproportionate Share Adjustment  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31.69 31.00 Sum of lines 30 and 31 38.83 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 21.25 33.00					1
Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105  (f)(1)(iv)(c).  24.00  IME FTE Resident Count Over Cap (see instructions)  If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see  0.00 25.00  instructions)  Resident to bed ratio (divide line 25 by line 4)  27.00  IME payments adjustment factor. (see instructions)  IME add-on adjustment amount (see instructions)  IME add-on adjustment amount (see instructions)  IME add-on adjustment amount - Managed Care (see instructions)  10 28.01  10 Total IME payment ( sum of lines 22 and 28)  10 Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  Disproportionate Share Adjustment  Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  30.00  Sum of lines 30 and 31  31.00  33.00  Allowable disproportionate share percentage (see instructions)  21.25  33.00	22.01			0	22.01
24.00 IME FTE Resident Count Over Cap (see instructions) 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 25.00 instructions) 26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 28.00 IME add-on adjustment amount (see instructions) 28.01 IME add-on adjustment amount - Managed Care (see instructions) 28.01 IME add-on adjustment amount - Managed Care (see instructions) 29.00 Total IME payment (sum of lines 22 and 28) 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 29.01 Disproportionate Share Adjustment  Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 30.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 21.25 33.00	23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.	105	0.00	23.00
instructions) Resident to bed ratio (divide line 25 by line 4)  27.00 IME payments adjustment factor. (see instructions)  28.00 IME add-on adjustment amount (see instructions)  28.01 IME add-on adjustment amount - Managed Care (see instructions)  29.00 Total IME payment (sum of lines 22 and 28)  29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  Disproportionate Share Adjustment  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  30.00 Sum of lines 30 and 31  31.00 Allowable disproportionate share percentage (see instructions)  31.00 Allowable disproportionate share percentage (see instructions)  26.00  27.00  28.00  28.01  29.00  29.00  29.00  30		IME FTE Resident Count Over Cap (see instructions)			1
27.00 IME payments adjustment factor. (see instructions)  28.00 IME add-on adjustment amount (see instructions)  28.01 IME add-on adjustment amount - Managed Care (see instructions)  28.01 IME add-on adjustment amount - Managed Care (see instructions)  28.01 Total IME payment (sum of lines 22 and 28)  29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  29.01 Disproportionate Share Adjustment  Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  30.00 Percentage of Medicaid patient days (see instructions)  31.69 31.00  32.00 Sum of lines 30 and 31  33.00 Allowable disproportionate share percentage (see instructions)  27.00 28.00  29.01 29.00  29.01 29.01  29.01 20.01  20.01 20.01  20.02 20.01  20.02 20.01  20.02 20.01  20.03 20.01  20.04 20.01  20.05 20.01  20.07 20.01  20.08 20.01  20.09 20.01  20.00 20.01		instructions)	e		
28.00 IME add-on adjustment amount (see instructions)  28.01 IME add-on adjustment amount - Managed Care (see instructions)  29.00 Total IME payment (sum of lines 22 and 28)  29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  Disproportionate Share Adjustment  Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  30.00 Percentage of Medicaid patient days (see instructions)  31.00 Sum of lines 30 and 31  33.00 Allowable disproportionate share percentage (see instructions)  28.00 29.01 29.00 29.00 29.01 29.0					l
28.01 IME add-on adjustment amount - Managed Care (see instructions)  7 Total IME payment (sum of lines 22 and 28)  29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  7 Disproportionate Share Adjustment  Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  30.00 Percentage of Medicaid patient days (see instructions)  31.00 Sum of lines 30 and 31  31.00 Allowable disproportionate share percentage (see instructions)  32.00 Allowable disproportionate share percentage (see instructions)  33.00					ł
29.00 Total IME payment ( sum of lines 22 and 28) 0 29.00  Total IME payment – Managed Care (sum of lines 22.01 and 28.01) 0 29.01  Disproportionate Share Adjustment  Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 7.14  30.00 Percentage of Medicaid patient days (see instructions) 31.00  32.00 Sum of lines 30 and 31 38.83 32.00  33.00 Allowable disproportionate share percentage (see instructions) 21.25 33.00				-	
Disproportionate Share Adjustment  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  31.00 Percentage of Medicaid patient days (see instructions)  32.00 Sum of lines 30 and 31  33.00 Allowable disproportionate share percentage (see instructions)  31.00 Sum of lines 30 and 31  32.00 Sum of lines 30 and 31  33.00 Allowable disproportionate share percentage (see instructions)  33.00 Sum of lines 30 and 31				-	1
30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31.00 Percentage of Medicaid patient days (see instructions) 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 31.00 Sum of lines 30 and 31 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 30.00 Percentage of SSI recipient patient days (see instructions) 31.69 Sum of lines 30 and 31 32.00 Sum of lines 30 and 31 33.00 Percentage of SSI recipient patient days (see instructions) 31.69 Sum of lines 30 and 31 32.00 Sum of lines 30 and 31		Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
31.00 Percentage of Medicaid patient days (see instructions) 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 31.69 31.00 38.83 32.00 21.25 33.00	20.00			7 1 4	20.00
32.00 Sum of lines 30 and 31 38.83 32.00 Allowable disproportionate share percentage (see instructions) 21.25 33.00					1
33.00 Allowable disproportionate share percentage (see instructions) 21.25 33.00					
34.00   Disproportionate share adjustment (see instructions) 525,142 34.00					
	34.00	Disproportionate share adjustment (see instructions)		525,142	34.00

	Financial Systems ASCENSION ST. VIN ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0088	Period:	u of Form CMS-2 Worksheet E	2332
LCO	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN. 13-0088	From 07/01/2022 To 06/30/2023	Part A	pare
		-1.7		11/22/2023 10	:37
		Title XVIII	Hospital	On/After 10/1	
			1.00	2.00	
	Uncompensated Care Payment Adjustment				
	Total uncompensated care amount (see instructions)			6,874,403,459	
.01	· · · · · · · · · · · · · · · · · · ·	this lin	0.000310627	0.000291857	
.02	Hospital UCP, including supplemental UCP (If line 34 is zero (see instructions)	, enter zero on this lin	e) 2,234,032	2,006,341	35
.03	Pro rata share of the hospital UCP, including supplemental U	ICP (see instructions)	563,099	1,500,633	35
.00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)	•	2,063,732		36
	Additional payment for high percentage of ESRD beneficiary d	ischarges (lines 40 thro			
.00	Total Medicare discharges (see instructions)		0		40
			Before 1/1 1.00	On/After 1/1 1.01	
.00	Total ESRD Medicare discharges (see instructions)		1.00	0	41
	Total ESRD Medicare covered and paid discharges (see instruc	tions)	0	0	
.00	Divide line 41 by line 40 (if less than 10%, you do not qual	ify for adjustment)	0.00		42
	Total Medicare ESRD inpatient days (see instructions)		0		43
.00	Ratio of average length of stay to one week (line 43 divided days)	I by Tine 41 divided by 7	0.000000		44
.00		15)	0.00	0.00	45
.00			0		46
	Subtotal (see instructions)		12,940,131		47
.00	Hospital specific payments (to be completed by SCH and MDH,	small rural hospitals	0		48
	only.(see instructions)			Amount	
				1.00	
.00				12,940,131	
.00			)	809,400	
.00	Exception payment for inpatient program capital (Wkst. L, Pt Direct graduate medical education payment (from Wkst. E-4, 1			0	
.00		The 49 see Histituctions)	•	9,273	
.00				175,522	
.01				0	
.00		69)		0	
.01				0	
.00	Cost of physicians' services in a teaching hospital (see int Routine service other pass through costs (from Wkst. D, Pt.		through 35)	0	
	Ancillary service other pass through costs from Wkst. D, Pt.		ciii ougii 55).	5,646	
.00				13,939,972	
.00				0	1 -
.00		is line 60)		13,939,972	
.00				1,150,356 28,547	
.00	' 3			126,754	
	Adjusted reimbursable bad debts (see instructions)			82,390	
.00	Allowable bad debts for dual eligible beneficiaries (see ins	tructions)		81,627	
	Subtotal (line 61 plus line 65 minus lines 62 and 63)			12,843,459	
.00	Credits received from manufacturers for replaced devices for	• •		0	
	Outlier payments reconciliation (sum of lines 93, 95 and 96) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	. (FOI SCH SEE HISTIUCTIO	115)	0	
	Rural Community Hospital Demonstration Project (§410A Demons	tration) adjustment (see	instructions)	0	
.00	N95 respirator payment adjustment amount (see instructions)	•		0	70
.00 .50 .75		1		0	70
.00 .50 .75 .87	Demonstration payment adjustment amount before sequestration			0	70
.00 .50 .75 .87	Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only)	·+ ··· · · · · · · · · · · · · · · · ·			
.00 .50 .75 .87 .88	Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see ins	tructions)		0	70
.00 .50 .75 .87 .88 .89	Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instructions)	tructions)		0	70 70
.00 .50 .75 .87 .88 .89	Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instructions) HSP bonus payment HVBP adjustment amount (see instructions)	tructions)		0 0	70 70 70
0.00 0.50 0.75 0.87 0.88 0.89 0.90 0.91	Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instructions) HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)	tructions)		0	70 70 70 70
.00 .50 .75 .87 .88 .90 .91 .92 .93	Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instructions) HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions) HVBP payment adjustment amount (see instructions)	tructions)		0 0 0 -77,361	7 7 7 7 7

Health Financial Systems	ASCENSION ST. VINCE	NT ANDERSON	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0088	Period: From 07/01/2022 To 06/30/2023	Worksheet E Part A Date/Time Prepared:

			7	o 06/30/2023		
		T-1-10	VA/TTT	uo anital	11/22/2023 10	:37 a
		TILIE	XVIII	Hospital (yyyy)	PPS Amount	
		ŀ		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in c	column 0		0	0	70.9
0.50	the corresponding federal year for the period prior to 10/1)				ŭ	' ' '
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in c	column 0		0	0	70.9
	the corresponding federal year for the period ending on or after					
70.98	Low Volume Payment-3			0	0	70.9
70.99	HAC adjustment amount (see instructions)				0	70.9
1.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69	& 70)			12,766,098	71.0
1.01	Sequestration adjustment (see instructions)				255,322	71.
1.02	Demonstration payment adjustment amount after sequestration				0	71.
1.03	Sequestration adjustment-PARHM pass-throughs					71.
	Interim payments				11,827,938	72.
	Interim payments-PARHM					72.
	Tentative settlement (for contractor use only)				0	
	Tentative settlement-PARHM (for contractor use only)					73.
4.00	Balance due provider/program (line 71 minus lines 71.01, 71.02,	72, and			682,838	74.
	73)					
	Balance due provider/program-PARHM (see instructions)					74.
75.00	Protested amounts (nonallowable cost report items) in accordance	e with			323,651	75.
	CMS Pub. 15-2, chapter 1, §115.2					
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96) Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of	2 02			0	90.
,0.00	plus 2.04 (see instructions)	2.03			U	90.
1.00	Capital outlier from Wkst. L, Pt. I, line 2				0	91.
	Operating outlier reconciliation adjustment amount (see instruct	tions)			0	
	Capital outlier reconciliation adjustment amount (see instruction				0	
	The rate used to calculate the time value of money (see instruct				0.00	1
	Time value of money for operating expenses (see instructions)				0	1
	Time value of money for capital related expenses (see instruction	ons)			0	96.
				Prior to 10/1	On/After 10/1	
				1.00	2.00	
	HSP Bonus Payment Amount					
.00.00	HSP bonus amount (see instructions)			0	0	100.
	HVBP Adjustment for HSP Bonus Payment					
	HVBP adjustment factor (see instructions)			0.0000000000	0.0000000000	
	HVBP adjustment amount for HSP bonus payment (see instructions)			0		
				U U	0	102.
	HRR Adjustment for HSP Bonus Payment			-		
.03.00	HRR adjustment factor (see instructions)			0.0000	0.0000	103.
.03.00 .04.00	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions)			-	0.0000	103.
.03.00 .04.00	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstrat			0.0000	0.0000	103. 104.
.03.00 .04.00	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstrat Is this the first year of the current 5-year demonstration perio			0.0000	0.0000	103. 104.
.03.00 .04.00	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstrat Is this the first year of the current 5-year demonstration perio Century Cures Act? Enter "Y" for yes or "N" for no.			0.0000	0.0000	103. 104.
.03.00 .04.00	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstrat Is this the first year of the current 5-year demonstration perio Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement	od under t		0.0000	0.0000	103. 104. 200.
03.00 .04.00 .00.00	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstrat Is this the first year of the current 5-year demonstration perio Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 4	od under t		0.0000	0.0000	200. 201.
.03.00 .04.00 .00.00 .01.00 .02.00	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstrat Is this the first year of the current 5-year demonstration perio Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 4 Medicare discharges (see instructions)	od under t		0.0000	0.0000	103. 104. 200. 201. 202.
03.00 .04.00 .00.00 .01.00 .02.00 .03.00	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstrat Is this the first year of the current 5-year demonstration perio Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 4 Medicare discharges (see instructions) Case-mix adjustment factor (see instructions)	od under t	he 21st	0.0000	0.0000	103. 104. 200. 201. 202.
03.00 .04.00 .00.00 .00.00 .00.00 .00.00	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstrat Is this the first year of the current 5-year demonstration perio Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 4 Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in fi	od under t	he 21st	0.0000	0.0000	103. 104. 200. 201. 202.
03.00 .04.00 00.00 01.00 02.00 03.00	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstrat Is this the first year of the current 5-year demonstration period Century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement  Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 4 Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in fi period)	od under t	he 21st	0.0000	0.0000 0	103. 104. 200. 201. 202. 203.
03.00 04.00 00.00 01.00 02.00 03.00	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstrat Is this the first year of the current 5-year demonstration period Century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement  Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 4 Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in fi period) Medicare target amount	od under t	he 21st	0.0000	0.0000 0	103. 104. 200. 201. 202. 203.
03.00 04.00 00.00 01.00 02.00 03.00 04.00 05.00	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstrat Is this the first year of the current 5-year demonstration period Century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement  Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 4 Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in fi period)	od under t	he 21st	0.0000	0.0000 0	103. 104. 200. 201. 202. 203.
.03.00 .04.00 .00.00 .00.00 .02.00 .03.00 .04.00 .05.00	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstrat Is this the first year of the current 5-year demonstration period Century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement  Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 4 Medicare discharges (see instructions) Case-mix adjustment factor (see instructions)  Computation of Demonstration Target Amount Limitation (N/A in fi period)  Medicare target amount Case-mix adjusted target amount (line 203 times line 204)	od under t	he 21st	0.0000	0.0000 0	103. 104. 200. 201. 202. 203.
03.00 04.00 00.00 01.00 02.00 03.00 04.00 05.00 06.00	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstrat Is this the first year of the current 5-year demonstration period century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement  Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 4 Medicare discharges (see instructions) Case-mix adjustment factor (see instructions)  Computation of Demonstration Target Amount Limitation (N/A in fiperiod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205)	dunder t	he 21st	0.0000	0.0000 0	103. 104. 200. 201. 202. 203. 204. 205. 206.
03.00 .04.00 .00.00 .00.00 .02.00 .03.00 .04.00 .05.00 .06.00	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions)  Rural Community Hospital Demonstration Project (§410A Demonstrat  Is this the first year of the current 5-year demonstration period century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement  Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 4 Medicare discharges (see instructions) Case-mix adjustment factor (see instructions)  Computation of Demonstration Target Amount Limitation (N/A in fiperiod)  Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205)  Adjustment to Medicare Part A Inpatient Reimbursement	descriptions)	he 21st	0.0000	0.0000 0	103. 104. 200. 201. 202. 203. 204. 205. 206.
03.00 .04.00 .00.00 .00.00 .02.00 .03.00 .04.00 .05.00 .06.00	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions)  Rural Community Hospital Demonstration Project (§410A Demonstrat  Is this the first year of the current 5-year demonstration periocentury Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement  Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 4 Medicare discharges (see instructions) Case-mix adjustment factor (see instructions)  Computation of Demonstration Target Amount Limitation (N/A in fiperiod)  Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205)  Adjustment to Medicare Part A Inpatient Reimbursement  Program reimbursement under the §410A Demonstration (see instructions)	descriptions)	he 21st	0.0000	0.0000 0	200. 201. 202. 203. 204. 205. 206.
203.00 204.00 200.00 201.00 202.00 203.00 204.00 205.00 206.00 207.00 208.00 209.00	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstrat Is this the first year of the current 5-year demonstration period Century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement  Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 4 Medicare discharges (see instructions) Case-mix adjustment factor (see instructions)  Computation of Demonstration Target Amount Limitation (N/A in fi period)  Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205)  Adjustment to Medicare Part A Inpatient Reimbursement  Program reimbursement under the §410A Demonstration (see instruction) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, li	descriptions)	he 21st	0.0000	0.0000 0	103. 104. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209.
03.00 04.00 01.00 02.00 03.00 04.00 05.00 06.00 07.00 08.00 09.00 10.00	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstrat Is this the first year of the current 5-year demonstration period Century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement  Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 4 Medicare discharges (see instructions) Case-mix adjustment factor (see instructions)  Computation of Demonstration Target Amount Limitation (N/A in fi period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205)  Adjustment to Medicare Part A Inpatient Reimbursement  Program reimbursement under the §410A Demonstration (see instruct Medicare Part A inpatient service costs (from Wkst. E, Pt. A, li Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions)	descriptions)	he 21st	0.0000	0.0000 0	201. 202. 203. 204. 205. 207. 208. 209. 210.
03.00 04.00 01.00 02.00 03.00 04.00 05.00 06.00 07.00 08.00 09.00 11.00	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstrat Is this the first year of the current 5-year demonstration period century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement  Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 4 Medicare discharges (see instructions) Case-mix adjustment factor (see instructions)  Computation of Demonstration Target Amount Limitation (N/A in fiperiod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, liandjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement	definitions) inst year of	he 21st	0.0000	0.0000 0	103. 104. 200. 201. 202. 203. 204. 205. 206. 207. 209. 210. 211.
03.00 .04.00 .00.00 .00.00 .00.00 .00.00 .00.00 .00.00	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstrat Is this the first year of the current 5-year demonstration period century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement  Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 4 Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in fiperiod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instruct Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line 211)	definitions) inst year of	he 21st	0.0000	0.0000 0	201. 202. 203. 204. 205. 206. 209. 210. 211.
.03.00 .04.00 .00.00 .00.00 .00.00 .00.00 .00.00 .00.00	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstrat Is this the first year of the current 5-year demonstration perio Century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement  Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 4 Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in fi period)  Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205)  Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instruct Medicare Part A inpatient service costs (from Wkst. E, Pt. A, li Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line 211 Low-volume adjustment (see instructions)	descriptions (included the second control of	of the current	0.0000	0.0000 0	103. 104. 200. 201. 202. 203. 204. 205. 206. 209. 210. 211.
03.00 04.00 00.00 01.00 02.00 03.00 04.00 05.00 06.00 07.00 08.00 09.00 11.00 12.00 13.00	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstrat Is this the first year of the current 5-year demonstration period century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement  Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 4 Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in fiperiod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instruct Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line 211)	descriptions (included the second control of	of the current	0.0000	0.0000 0	201. 202. 203. 204. 205. 206. 209. 210. 211.

					Te	06/30/2023	Date/Time Prep   11/22/2023 10	
				Title	XVIII	Hospital	PPS	
			Amounts (from	Pre/Post	Period Prior	Period	Total (Col 2	
		line 0	E, Part A) 1.00	Entitlement 2.00	to 10/01 3.00	0n/After 10/01 4.00	through 4) 5.00	
1.00	DRG amounts other than outlier		0	0		0	0	1.00
	payments							
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	2,379,703	0	2,379,703		2,379,703	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October	1.02	7,505,313	0		7,505,313	7,505,313	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00						2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to	2.03	58,686	0	58,686		58,686	2.02
2.03	October 1 (see instructions) Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	407,555	0		407,555	407,555	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
	Indirect Medical Education Adju	ustment						
5.00	Amount from Worksheet E, Part	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	A, line 21 (see instructions)  IME payment adjustment (see	22.00	0	0	0	0	0	6.00
6.01	instructions) IME payment adjustment for managed care (see	22.01	0	0	0	0	0	6.01
	instructions)							
	Indirect Medical Education Adj							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
10	Disproportionate Share Adjustme		0.010-1	A = 1 = =	2 2 2 2 2	A ====		10.05
10.00	Allowable disproportionate share percentage (see	33.00	0.2125	0.2125	0.2125	0.2125		10.00
11.00	<pre>instructions) Disproportionate share adjustment (see instructions)</pre>	34.00	525,142	0	126,422	398,720	525,142	11.00
11.01	Uncompensated care payments  Additional payment for high pe	36.00	2,063,732 RD beneficiary (	0 discharges	321,525	870,488	1,192,013	11.01
12.00		46.00	0	0	0	0	0	12.00
	(see instructions)							
13.00 14.00	(completed by SCH and MDH, small rural hospitals only.)	47.00 48.00	12,940,131	0	, ,	10,053,795 0	12,940,131 0	
15.00	operating costs (see	49.00	12,940,131	0	2,886,336	10,053,795	12,940,131	15.00
16.00	<pre>instructions) Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)</pre>	50.00	809,400	0	195,836	613,564	809,400	16.00
	•		. ,	'	. '	'		•

						To 06/30/2023		
				Title	XVIII	Hospital	PPS	. 57 am
		W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Period	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
17.00	Special add-on payments for new technologies	54.00	175,522	0	21,27	7 154,245	175,522	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced	68.00	0	0		0	0	17.02
18.00	devices for applicable MS-DRGs Capital outlier reconciliation adjustment amount (see	93.00	0	0		0 0	0	18.00
19.00	instructions) SUBTOTAL			0	3,103,44	9 10,821,604	13,925,053	19 00
13100	JOBIOME	W/S L, line	(Amounts from L)		3,103,11	10,021,001	13,323,033	13.00
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	742,588	0	180,98		742,588	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0		0 0	0	
21.00	Capital DRG outlier payments	2.00	6,068	0	4	6,020	6,068	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0		0	0	
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0		0	0	
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0818	0.0818	0.081	8 0.0818		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	60,744	0	14,80	45,940	60,744	25.00
26.00	Total prospective capital payments (see instructions)	12.00	809,400	0	195,83	613,564	809,400	26.00
			(Amounts to E,					
		line	Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00 28.00	Low volume adjustment factor Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0.00000	0.000000	0	27.00 28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

06/30/2023 11/22/2023 10:37 am Hospital Title XVIII Period to Total (cols. 2 Wkst. E, Pt. Amt. from Period on A, line Wkst. E, Pt. 10/01 after 10/01 and 3) 2.00 3.00 0 1.00 4.00 1.00 DRG amounts other than outlier payments 1.00 1.00 DRG amounts other than outlier payments for 1.01 1.01 2,379,703 2,379,703 2,379,703 1.01 discharges occurring prior to October 1 1.02 DRG amounts other than outlier payments for 1.02 7.505.313 7.505.313 1.02 7,505,313 discharges occurring on or after October 1 1.03 DRG for Federal specific operating payment 1.03 0 1.03 0 for Model 4 BPCI occurring prior to October DRG for Federal specific operating payment 1.04 1.04 O 1.04 0 for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for discharges (see 2.00 2.00 instructions) 2.01 Outlier payments for discharges for Model 4 2.02 2.01 **BPCI** 2.02 Outlier payments for discharges occurring 2.03 58,686 58.686 58.686 2.02 prior to October 1 (see instructions) 2.03 Outlier payments for discharges occurring on 2.04 407,555 407,555 407,555 2.03 or after October 1 (see instructions) 3.00 Operating outlier reconciliation 2.01 0 3.00 Managed care simulated payments 4.00 4.00 3.00 0 Indirect Medical Education Adjustment 5.00 Amount from Worksheet E, Part A, line 21 21.00 0.000000 0.000000 0.000000 5.00 (see instructions) 6.00 IME payment adjustment (see instructions) 22.00 0 0 n 6.00 IME payment adjustment for managed care (see 6.01 22.01 0 0 6.01 instructions) Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 7.00 IME payment adjustment factor (see 27.00 0.000000 0.000000 0.000000 7.00 instructions) 8.00 IME adjustment (see instructions) 28.00 8.00 0 0 0 0 8.01 IME payment adjustment add on for managed 28.01 0 n 8.01 care (see instructions) Total IME payment (sum of lines 6 and 8) 29.00 9.00 9.00 Total IME payment for managed care (sum of 9.01 29.01 0 0 0 9.01 lines 6.01 and 8.01) Disproportionate Share Adjustment 10.00 Allowable disproportionate share percentage 33.00 0.2125 0.2125 0.2125 10.00 (see instructions) 11.00 Disproportionate share adjustment (see 34.00 525.142 126,422 398.720 525.142 11.00 instructions) 11.01 Uncompensated care payments 36.00 2.063.732 466,425 1,821,010 2,287,435 11.01 Additional payment for high percentage of ESRD beneficiary discharges 12.00 Total ESRD additional payment (see 12.00 46.00 instructions) 47.00 13.00 12,940,131 3,031,236 9,908,895 Subtotal (see instructions) 12,940,131 13.00 14.00 Hospital specific payments (completed by SCH 48.00 14.00 and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs 15.00 49.00 12,940,131 3,031,236 9,908,895 12,940,131 15.00 (see instructions) 16.00 Payment for inpatient program capital (from 50.00 809,400 195,836 613,564 809,400 16.00 Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for new technologies 54.00 175,522 21,277 154,245 175,522 17.00 17.01 Net organ acquisition cost 17.01 Credits received from manufacturers for 17.02 68.00 0 0 17.02 0 replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment 93.00 0 18.00 0 amount (see instructions) 19.00 SUBTOTAL 3,248,349 10,676,704 13,925,053 19.00

Health Financial Systems A	SCENSION ST. VI	NCENT ANDERSON		In Lie	u of Form CMS-	2552-10
HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	ATION EXHIBIT 5	Provider Co		Period: From 07/01/2022	Worksheet E	t 5 pared:
		Title	XVIII	Hospital	PPS	
	Wkst. L, line	(Amt. from				
		Wkst. L)				
	0	1.00	2.00	3.00	4.00	
20.00 Capital DRG other than outlier	1.00	742,588	180,98	4 561,604	742,588	20.00
20.01 Model 4 BPCI Capital DRG other than outlier	1.01	0		0	0	20.01

		Wkst. L, line	(Amt. from				
			Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	742,588	180,984	561,604	742,588	
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	6,068	48	6,020	6,068	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0818	0.0818	0.0818		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	60,744	14,804	45,940	60,744	25.00
26.00	Total prospective capital payments (see instructions)	12.00	809,400	195,836	613,564	809,400	26.00
		Wkst. E, Pt.	(Amt. from				
		A, line	Wkst. E, Pt.				
			A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	0	0	0	0	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-77,361	0	-77,361	-77,361	
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0		32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

Health Financial Systems	ASCENSION ST. VINCE	ENT ANDERSON	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0088	Period: From 07/01/2022 To 06/30/2023	Worksheet E Part B Date/Time Prepared: 11/22/2023 10:37 am

-	Title XVIII Hospital	PPS	. 37 aiii
		1.00	
1 00	PART B - MEDICAL AND OTHER HEALTH SERVICES	1 240	1 00
1.00 2.00	Medical and other services (see instructions)   Medical and other services reimbursed under OPPS (see instructions)	1,348 16,907,122	
3.00	OPPS or REH payments	14,272,483	
4.00	Outlier payment (see instructions)	65,620	
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00 7.00	Line 2 times line 5 Sum of lines 3, 4, and 4.01, divided by line 6	0.00	6.00 7.00
8.00	Transitional corridor payment (see instructions)	0.00	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	33,918	
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	1,348	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
12.00	Reasonable charges Ancillary service charges	4 520	12.00
13.00		4,320	13.00
14.00			14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebas	is 0	16.00
17.00	had such payment been made in accordance with 42 CFR §413.13(e) Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17 00
18.00	Total customary charges (see instructions)	4,520	
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see	3,172	
	instructions)		
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see	0	20.00
21.00	instructions)	1 348	21.00
22.00		0	
23.00		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	14,372,021	24.00
25 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		25 00
25.00 26.00	Deductibles and coinsurance amounts (for CAH, see instructions)  Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	2,611,997	25.00 26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see		
	instructions)	,,	
28.00		0	28.00
28.50	REH facility payment amount		28.50
29.00 30.00		11,761,372	
31.00	Subtotal (sum of lines 27, 28, 28.50 and 29) Primary payer payments	1,761,372	
32.00	Subtotal (line 30 minus line 31)	11,759,758	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
	Composite rate ESRD (from Wkst. I-5, line 11)	0	
34.00 35.00		330,409 214,766	
	Allowable bad debts for dual eligible beneficiaries (see instructions)	229,031	
	Subtotal (see instructions)	11,974,524	
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	
39.50	Prioneer ACO demonstration payment adjustment (see instructions)		39.50
39.75 39.97	N95 respirator payment adjustment amount (see instructions)  Demonstration payment adjustment amount before sequestration	0	39.75 39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	11,974,524	
40.01		239,490	
40.02		0	
40.03 41.00		11,722,306	40.03 41.00
	Interim payments-PARHM	11,722,300	41.01
42.00		0	
42.01	Tentative settlement-PARHM (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	12,728	
43.01	1 1 2 1 2	35 000	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	25,000	44.00
	TO BE COMPLETED BY CONTRACTOR		
	Original outlier amount (see instructions)	0	90.00
	Outlier reconciliation adjustment amount (see instructions)	0	
	The rate used to calculate the Time Value of Money		92.00
	Time Value of Money (see instructions) Total (sum of lines 91 and 93)	0	93.00 94.00
	1.22. (2 2	1	

Health Financial Systems	ASCENSION ST. VINCE	ENT ANDERSON	In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0088	Period: From 07/01/2022 To 06/30/2023	Worksheet E Part B Date/Time Pro 11/22/2023 10	
		Title XVIII	Hospital	PPS	
				1.00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days				(	200.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0088
Period:
From 07/01/2022
To 06/30/2023 10:37 am

					11/22/2023 10	:37 am
			XVIII	Hospital	PPS	
		Inpatier	nt Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		11,827,93	8	11,722,306	1.00
2.00	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,			0	0	2.00
3.00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate					3.00
	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	3.01
3.02				0	0	3.02
3.03				0	0	3.03
3.04				0	0	3.04
3.05				0	0	3.05
2 50	Provider to Program					2 50
3.50 3.51	ADJUSTMENTS TO PROGRAM			0	0	3.50 3.51
3.52				0		3.52
3.53				0		3.53
3.54				0		3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0		3.99
	3.50-3.98)		11 027 02			
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)		11,827,93	00	11,722,306	4.00
	TO BE COMPLETED BY CONTRACTOR		1			
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider		1			
5.01	TENTATIVE TO PROVIDER			0	0	5.01
5.02				0	0	5.02
5.03				0	0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM			0	0	5.50
5.51				0	0	5.51
5.52				0	0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		682,83	8	12,728	6.01
6.02	SETTLEMENT TO PROGRAM			0	0	6.02
7.00	Total Medicare program liability (see instructions)		12,510,77	'6	11,735,034	7.00
			,	Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

In Lieu of Form CMS-2552-10 Health Financial Systems ASCENSION ST. VINCENT ANDERSON Period: Worksheet E-1
From 07/01/2022 Part I
TO 06/30/2023 Date/Time Prepared: 11/22/2023 10:37 am ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-0088

Component CCN: 15-T088

Title XVIII Subprovider -PPS

		11116	XVIII	IRF	PPS	
		Inpatien	t Part A		rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,108,731	-	0	1.00
2.00	Interim payments payable on individual bills, either		[ C	)	0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
2 00	write "NONE" or enter a zero					3.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate					3.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider	l	l			
3.01	ADJUSTMENTS TO PROVIDER		C	)	0	3.0
3.02	ABSOSTMENTS TO TROTESER		ĺ		Ö	3.02
3.03			ĺ		Ö	3.03
3.04			ĺ		0	3.04
3.05			l c	)	0	3.0
	Provider to Program			<b>'</b>		
3.50	ADJUSTMENTS TO PROGRAM		C	)	0	3.50
3.51			[ c	)	0	3.5
3.52			C	)	0	3.5
3.53			C	)	0	3.5
3.54			[ C		0	3.5
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		[ C	)	0	3.99
	3.50-3.98)				_	
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		2,108,731	-	0	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropriate) TO BE COMPLETED BY CONTRACTOR					ļ
5.00	List separately each tentative settlement payment after					5.00
3.00	desk review. Also show date of each payment. If none,					3.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					ĺ
5.01	TENTATIVE TO PROVIDER		C	)	0	5.03
5.02			l	)	0	5.02
5.03			l c	)	0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		C	)	0	5.50
5.51			[ c	)	0	5.5
5.52			[ C	)	0	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		[ C	)	0	5.99
	5.50-5.98)					
6.00	Determined net settlement amount (balance due) based on					6.00
c 01	the cost report. (1)		,	J	0	6.0
6.01	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM		42,142		0	6.01
7.00	Total Medicare program liability (see instructions)		2,066,589			
7.00	Tiotal Medicale program frability (see mistructions)		2,000,385	Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
			)	1.00	2.00	
		· ·				8.00

Health Financial Systems	ASCENSION ST. VINC	ENT ANDERSON	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HI		Provider CCN: 15-0088	Period: From 07/01/2022 To 06/30/2023	Worksheet E-1 Part II Date/Time Pre 11/22/2023 10	pared:
		Title XVIII	Hospital	PPS	
				1.00	
TO BE COMPLETED BY CONTRACTOR FOR NONSTA	NDARD COST REPORTS				

		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. S-3, Pt. I col. 15 line 14	ı	1.00
2.00	Medicare days (see instructions)	ı	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	ı	3.00
4.00	Total inpatient days (see instructions)	ı	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	ı	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	ı	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I	ı	7.00
	line 168	ı	
8.00	Calculation of the HIT incentive payment (see instructions)	ı	8.00
9.00	Sequestration adjustment amount (see instructions)	ı	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)	ı	30.00
31.00	Other Adjustment (specify)	ı	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	i	32.00

Health Financial Systems	ASCENSION ST. VINCENT ANDERSON	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0088  Component CCN: 15-T088	Period: From 07/01/2022 To 06/30/2023	
	Title XVIII	Subprovider - IRF	PPS

	IRF		
		1.00	
	DART TYT MEDICADE DARY A SERVICES. THE DRS	1.00	
1.00	PART III - MEDICARE PART A SERVICES - IRF PPS  Net Federal PPS Payment (see instructions)	2,005,926	1.0
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0234	ı
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	102,904	
1.00	Outlier Payments	13,966	
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prio		
	to November 15, 2004 (see instructions)		3.0
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	5.0
5.00	New Teaching program adjustment. (see instructions)	0.00	6.0
.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new		
	teaching program" (see instructions)		
3.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00	8.0
.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9.0
10.00		7.334247	ı
1.00	Teaching Adjustment Factor (see instructions)	0.000000	
2.00		0.000000	12.0
3.00		2,122,796	
4.00		2,122,730	1
5.00		\ \	15.0
6.00		0	
7.00		2,122,796	
8.00		0	1
9.00		2,122,796	
	Deductibles	14,136	
1.00		2,108,660	
2.00	Coinsurance	4,668	22.0
3.00	Subtotal (line 21 minus line 22)	2,103,992	
4.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	7,138	24.0
5.00	Adjusted reimbursable bad debts (see instructions)	4,640	25.0
6.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	4,640	26.0
7.00	Subtotal (sum of lines 23 and 25)	2,108,632	27.0
8.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28.0
9.00	Other pass through costs (see instructions)	132	29.0
0.00	Outlier payments reconciliation	0	30.0
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.0
1.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.5
1.98	· · · · · · · · · · · · · · · · · · ·	0	31.9
1.99	, , , , , , , , , , , , , , , , , , , ,	0	
2.00		2,108,764	32.0
2.01		42,175	
2.02		0	
	Interim payments	2,108,731	
4.00	· · · · · · · · · · · · · · · · · · ·	0	
5.00		-42,142	
6.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	42,927	36.0
	TO BE COMPLETED BY CONTRACTOR		1
0.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	13,966	50.0
1.00	Outlier reconciliation adjustment amount (see instructions)	0	51.0
2.00		0.00	52.0
3.00		0	53.0
	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (T THE COVID-19 PHE)	HE END OF	
9.00	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.	0.000000	99 n
	Calculated Teaching Adjustment Factor for the current year. (see instructions)	0.000000	
	- and a second s	, 0.000000	, ,,,,,,

Health Financial Systems	ASCENSION ST. VINCE	NT ANDERSON	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0088	Period: From 07/01/2022 To 06/30/2023	Worksheet E-3 Part VII Date/Time Prepared: 11/22/2023 10:37 am

			, ,	11/22/2023 10	:37 am
		Title XIX	Hospital	Cost	
		·	Inpatient	Outpatient	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV	VICES FOR TITLES V OR XIX			
	COMPUTATION OF NET COST OF COVERED SERVICES	VICED FOR TITLES V OR XEX	DERVICES		1
1.00	Inpatient hospital/SNF/NF services		4,200,570		1.00
	Medical and other services		4,200,370	1 202 025	
2.00				1,202,825	2.0
3.00	Organ acquisition (certified transplant programs only)		4 200 570	4 202 025	3.0
4.00	Subtotal (sum of lines 1, 2 and 3)		4,200,570	1,202,825	4.0
5.00	Inpatient primary payer payments		0		5.0
6.00	Outpatient primary payer payments			0	6.0
7.00	Subtotal (line 4 less sum of lines 5 and 6)		4,200,570	1,202,825	7.0
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges				
8.00	Routine service charges		10,846,386		1 8.0
9.00	Ancillary service charges		10,699,398	6,796,644	9.0
10.00	Organ acquisition charges, net of revenue		0	0,100,011	10.0
11.00	Incentive from target amount computation				11.0
12.00	Total reasonable charges (sum of lines 8 through 11)		21,545,784	6,796,644	
12.00			21,343,784	6,796,644	12.0
12.00	CUSTOMARY CHARGES				12.0
13.00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13.0
	basis			_	
14.00	Amounts that would have been realized from patients liable for		0	0	14.0
	a charge basis had such payment been made in accordance with 4	2 CFR §413.13(e)			
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	
16.00	Total customary charges (see instructions)		21,545,784	6,796,644	
17.00	Excess of customary charges over reasonable cost (complete only	y if line 16 exceeds	17,345,214	5,593,819	17.0
	line 4) (see instructions)				ĺ
18.00	Excess of reasonable cost over customary charges (complete only	y if line 4 exceeds line	0	0	18.0
	16) (see instructions)				l
19.00	Interns and Residents (see instructions)		ol	ol	19.0
20.00	Cost of physicians' services in a teaching hospital (see instru	uctions)	0	0	20.0
21.00	Cost of covered services (enter the lesser of line 4 or line 1		4,200,570	1,202,825	
21.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be			1,202,023	
22.00	Other than outlier payments	compresed for 113 provide	0	0	22.0
23.00	Outlier payments		0	0	
24.00	Program capital payments		0	۷	24.0
			0		
25.00	Capital exception payments (see instructions)		0	_	25.0
26.00	Routine and Ancillary service other pass through costs		0	0	
27.00	Subtotal (sum of lines 22 through 26)		0	0	
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.0
29.00	Titles V or XIX (sum of lines 21 and 27)		4,200,570	1,202,825	29.0
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	0	30.0
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		4,200,570	1,202,825	31.0
32.00	Deductibles		, , , , ,	, , , ,	
33.00	Coinsurance		0	ő	
34.00	Allowable bad debts (see instructions)		٥	ő	
35.00	Utilization review		0	٩	35.0
		22)	4 300 570	1 202 025	
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	4,200,570	1,202,825	
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	37.0
38.00	Subtotal (line 36 ± line 37)		4,200,570	1,202,825	
	Direct graduate medical education payments (from Wkst. E-4)		0		39.0
39.00			4,200,570	1,202,825	40.0
39.00 40.00	Total amount payable to the provider (sum of lines 38 and 39)		4,200,370	-,,,	
	Total amount payable to the provider (sum of lines 38 and 39) Interim payments		4,200,570	1,202,825	41.0
40.00					
40.00 41.00	Interim payments	ce with CMS Pub 15-2.		1,202,825	42.0

Health Financial Systems	ASCENSION ST. VINCENT	T ANDERSON	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT			From 07/01/2022	
		Title XIX	Subprovider -	Cost

PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			IRF		
PART VIT - CALCULATION OF RETMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES   COMPUTATION OF IRET COST OF COWERD SERVICES   1.00   1.			Inpatient	Outpatient	
COMPUTATION OF NET COST OF COVERED SERVICES   1.00   1.0			1.00	2.00	
1.00		PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX	SERVICES		
Medical and other services   0   3.00   3.		COMPUTATION OF NET COST OF COVERED SERVICES			
3.00   organ acquisition (certified transplant programs only)			72,750		1
Subtotal (sum of lines 1, 2 and 3)   72,750   0   4.00	2.00			0	
Topatient primary payer payments   0   0   6.00		3	0		
Computation   Computation			72,750	0	1
Subtotal (line 4 less sum of lines 5 and 6)   72,750   0   7.00			0		1
COMPUTATION OF LESSER OF COST OR CHARGES   Reasonable Charges   Reasonable Charges   Routine service charges   702,264   8.00   9.00   Ancillary service charges   8.00   Ancillary service charges   8.00   9.00   10.00				-	
Reasonable Charges	7.00		72,750	0	7.00
Routine service charges   702,264   8.00   Ancillary service charges   86,560   0 9.00   10.					
9.00   Ancillary service charges   86,560   0   9.00   10.00					
10.00   11.0			· · · · · · · · · · · · · · · · · · ·		1
11.00 Incentive from target amount computation 788,824 0 12.00  Total reasonable charges (sum of lines 8 through 11) 788,824 0 12.00  CUSTOWARY CHARGES  13.00 Amount actually collected from patients liable for payment for services on a charge basis Amounts that would have been realized from patients liable for payment for services on a 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 0.000000 0.000000 15.00 16.00 Total customary charges (see instructions) 788,824 0 16.00 17.00 Excess of customary charges over reasonable cost (complete only if line 16 exceeds 716,074 0 17.00 18.00 Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions) 0 18.00 19.00 Cost of physicians' services in a teaching hospital (see instructions) 0 0 19.00 20.00 Cost of physicians' services in a teaching hospital (see instructions) 0 0 20.00 21.00 Cost of covered services (enter the lesser of line 4 or line 16) 72,750 0 21.00 22.00 Outlier payments 0 0 22.00 24.00 PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.  22.00 Outlier payments 0 0 22.00 24.00 Program capital payments (see instructions) 0 0 26.00 25.00 Coutine and Ancillary service other pass through costs 0 0 0 26.00 26.00 Routine and Ancillary service other pass through costs 0 0 0 27.00 28.00 Customary charges (title V or XIX PPS covered services only) 72,750 0 29.00 27.00 Excess of reasonable cost (from line 18) 72,750 0 31.00 28.00 Excess of reasonable cost (from line 18) 10.00 28.00 Excess of reasonable cost (from line 18) 10.00 28.00 Excess of reasonable cost (from line 18) 10.00 28.00 Excess of reasonable cost (from line 18) 10.00 28.00 Excess of reasonable cost (from line 18) 10.00 28.00 Excess of reasonable cost (from line 18) 10.00 28.00 Excess of reasonable cost (from line 18) 10.00 28.00 Excess of reasonable cost (from line 18) 10.00 28.00 Excess of reasonable cost (from line 18)			86,560	0	
12.00			0		
CUSTOMARY CHARGES  13.00 Amount actually collected from patients liable for payment for services on a charge basis  14.00 Amounts that would have been realized from patients liable for payment for services on 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 0.000000 0.000000 15.00  16.00 Total customary charges (see instructions) 788,824 0 16.00  17.00 Excess of customary charges over reasonable cost (complete only if line 16 exceeds 716,074 0 17.00 line 4) (see instructions)  18.00 Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)  19.00 Interns and Residents (see instructions) 0 0 19.00 20.00 Cost of physicians' services in a teaching hospital (see instructions) 0 0 20.00 Cost of physicians' services in a teaching hospital (see instructions) 0 20.00 Cost of covered services (enter the lesser of line 4 or line 16) 72,750 0 21.00 PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.  22.00 Other than outlier payments 0 22.00 Cutlier payments 0 22.00 23.00 Cutlier payments 0 24.00 25.00 Capital exception payments (see instructions) 0 26.00 Routline and Ancillary service other pass through costs 0 0 27.00 Subtotal (sum of lines 22 through 26) 0 28.00 Cuttomary charges (title v or XIX PPS covered services only) 72,750 0 28.00 Computation of REMBURSEMENT SETTLEMENT 0 0 0 30.00 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 72,750 0 31.00 31.00 31.00 30.00 31.00 30.00 31.00 30.00 31.00 30.00 31.00 30.00 31.00 30.00 31.00 30.00 31.00 30.00 31.00 30.00 31.00 30		,	· · · · · · · · · · · · · · · · · · ·		
Amount actually collected from patients liable for payment for services on a charge basis  14.00 Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)  15.00 Ratio of line 13 to line 14 (not to exceed 1.000000)  10.00	12.00		788,824	0	12.00
basis Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)  15.00 Ratio of line 13 to line 14 (not to exceed 1.000000) Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete only if line 16 exceeds T16.074 T17.00 Excess of reasonable cost over customary charges (complete only if line 4 exceeds line life (see instructions) T18.00 Excess of reasonable cost over customary charges (complete only if line 4 exceeds line life (see instructions) T19.00 Interns and Residents (see instructions) T19.00 Cost of physicians' services in a teaching hospital (see instructions) Cost of covered services (enter the lesser of line 4 or line 16) T27.750 T21.00 PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.  T22.00 Other than outlier payments Outlie	42.00				42.00
Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)  1.00 Ratio of line 13 to line 14 (not to exceed 1.000000)  1.00 Excess of customary charges (see instructions)  1.00 Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)  1.00 Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)  1.00 Interns and Residents (see instructions)  1.00 Cost of physicians' services in a teaching hospital (see instructions)  2.00 Cost of covered services (enter the lesser of line 4 or line 16)  2.00 PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.  2.00 Outlier payments  2.00 Outlier payments  2.00 Capital exception payments (see instructions)  2.00 Capital exception payments (see instructions)  2.00 Routine and Ancillary service other pass through costs  2.00 Excess of reasonable cost (rime 18)  3.00 Outlier Nor REIMBURSEMENT SETILEMENT  COMPUTATION OF REIMBURSEMENT SETILEMENT  5.00 CAPITATION OF REIMBURSEMENT SETILEMENT  5.00 CAPITATION OF RESONABLE COST (1000000)  2.00 CAPITATION OF REIMBURSEMENT SETILEMENT  5.00 CAPITATION OF Ines 19 and 20, plus 29 minus lines 5 and 6)  2.00 Capital (sum of lines 19 and 20, plus 29 minus lines 5 and 6)  2.00 Capital (sum of lines 19 and 20, plus 29 minus lines 5 and 6)  2.00 Capital (sum of lines 19 and 20, plus 29 minus lines 5 and 6)  2.00 Capital (sum of lines 19 and 20, plus 29 minus lines 5 and 6)  2.00 Capital (sum of lines 19 and 20, plus 29 minus lines 5 and 6)  2.00 Capital (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	13.00		O	0	13.00
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)  16.00 Total customary charges (see instructions)  Excess of customary charges over reasonable cost (complete only if line 16 exceeds  716,074  17.00 Excess of reasonable cost over customary charges (complete only if line 4 exceeds line  16) (see instructions)  18.00 Excess of reasonable cost over customary charges (complete only if line 4 exceeds line  16) (see instructions)  19.00 Interns and Residents (see instructions)  10.00 Cost of physicians' services in a teaching hospital (see instructions)  10.00 Cost of covered services (enter the lesser of line 4 or line 16)  10.00 PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.  10.00 Cutlier payments  10.00 Cutlier payments  10.00 Cutlier payments  10.00 Capital exception payments (see instructions)  10.00 Capital exception payments (see instructions)  10.00 Customary charges (citle v or XIX PPS covered services only)  10.00 Customary charges (title v or XIX PPS covered services only)  10.00 COMPUTATION OF REIMBURSEMENT SETTLEMENT  10.00 Customary charges (plus 29 minus lines 5 and 6)  10.00 Customary charges (plus 29 minus lines 5 and 6)  10.00 Customary charges (plus 29 minus lines 5 and 6)  10.00 Customary charges (plus 29 minus lines 5 and 6)  10.00 Customary charges (plus 29 minus lines 5 and 6)  10.00 Customary charges (plus 29 minus lines 5 and 6)  10.00 Customary charges (plus 29 minus lines 5 and 6)  10.00 Customary charges (plus 20 customary charges (plus 29 minus lines 5 and 6)  10.00 Customary charges (plus 29 minus lines 5 and 6)  10.00 Customary charges (plus 29 minus lines 5 and 6)  10.00 Customary charges (plus 4 creations)  11.00 Customary charges (plus 4 (plus 29 minus lines 5 and 6)  12.00 Customary charges (plus 4 (plus 20 minus lines 5 and 6)  13.00 Customary charges (plus 4 (plus 20 minus lines 5 and 6)  15.00 Customary charges (plus 4 (plus 20 minus lines 5 and 6	14.00		0	0	14.00
15.00				-	
17.00   Excess of customary charges over reasonable cost (complete only if line 16 exceeds   116,074   0   17.00     18.00   Excess of reasonable cost over customary charges (complete only if line 4 exceeds line   0   18.00     16) (see instructions)	15.00		0.000000	0.000000	15.00
17.00   Excess of customary charges over reasonable cost (complete only if line 16 exceeds   116,074   0   17.00     18.00   Excess of reasonable cost over customary charges (complete only if line 4 exceeds line   0   18.00     16) (see instructions)	16.00	Total customary charges (see instructions)	788,824	0	16.00
Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions) 19.00 Interns and Residents (see instructions) 20.00 Cost of physicians' services in a teaching hospital (see instructions) 20.00 Cost of covered services (enter the lesser of line 4 or line 16)  PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.  22.00 Outlier payments Outlier payments Outlier payments Outlier payments Ocapital exception payments (see instructions) Capital exception payments (see instructions) Capital exception payments (see instructions) Capital exception payments (see instructions) Customary charges (title v or XIX PPS covered services only) Titles V or XIX (sum of lines 21 and 27)  COMPUTATION OF REIMBURSEMENT SETTLEMENT  Excess of reasonable cost (from line 18) Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)  19.00	17.00			0	17.00
16) (see instructions)		line 4) (see instructions)			
19.00   Interns and Residents (see instructions)   0   0   19.00   20.00   2	18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line	0	0	18.00
20.00   Cost of physicians' services in a teaching hospital (see instructions)   0   0   20.00		16) (see instructions)			
21.00   Cost of covered services (enter the lesser of line 4 or line 16)   72,750   0   21.00			0		
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			ا با ا		
22.00   Other than outlier payments   0   0   22.00	21.00			0	21.00
23.00   Outlier payments   0   0   23.00					
24.00       Program capital payments       0       24.00         25.00       Capital exception payments (see instructions)       0       25.00         26.00       Routine and Ancillary service other pass through costs       0       0       26.00         27.00       Subtotal (sum of lines 22 through 26)       0       0       27.00         28.00       Customary charges (title V or XIX PPS covered services only)       0       0       28.00         29.00       Titles V or XIX (sum of lines 21 and 27)       72,750       0       29.00         COMPUTATION OF REIMBURSEMENT SETTLEMENT       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)       72,750       0       31.00			· · · · · · · · · · · · · · · · · · ·		
25.00   Capital exception payments (see instructions)   25.00   26.00   Routine and Ancillary service other pass through costs   0   0   26.00   27.00   28.00		1 ' '	- 1	0	
26.00 Routine and Ancillary service other pass through costs 27.00 Subtotal (sum of lines 22 through 26) 28.00 Customary charges (title V or XIX PPS covered services only) 29.00 Titles V or XIX (sum of lines 21 and 27)  COMPUTATION OF REIMBURSEMENT SETTLEMENT  Excess of reasonable cost (from line 18) 30.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)  26.00 27.00 28.00 27.00 28.00 29.00 29.00 29.00 20.00			0		1
27.00   Subtotal (sum of lines 22 through 26)			0		•
28.00   Customary charges (title V or XIX PPs covered services only)			0	-	
29.00 Titles V or XIX (sum of lines 21 and 27) 72,750 0 29.00 COMPUTATION OF REIMBURSEMENT SETTLEMENT  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) 72,750 0 31.00			0		
COMPUTATION OF REIMBURSEMENT SETTLEMENT  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) 72,750 0 31.00					
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) 72,750 0 31.00	29.00		72,750	0	29.00
31.00   Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 72,750 0 31.00	20.00		٥	0	20 00
		· · · · · · · · · · · · · · · · · · ·	· · · · · · · · · · · · · · · · · · ·		
52.00   Deductibles					
33.00   Coinsurance   0   0   33.00				-	
34.00 Allowable bad debts (see instructions)			- 1		
35.00 Utilization review 0 35.00			0	O	
36.00   Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 72,750 0 36.00			72 750	0	1
37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  0 0 1 37.00			72,730		
38.00   Subtotal (line 36 ± line 37)   72,750   0   38.00		, , , , ,	72 750		
39.00   Direct graduate medical education payments (from Wkst. E-4)		,	72,730	Ŭ	
40.00   Total amount payable to the provider (sum of lines 38 and 39)  72,750 0 40.00			72.750	n	
41.00 Interim payments 72,750 0 41.00					
42.00 Balance due provider/program (line 40 minus line 41) 0 42.00			l I		
43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 43.00					•
chapter 1, §115.2		, , , , , , , , , , , , , , , , , , , ,			

Health	Financial Systems ASCENSION ST. VINC	ENT ANDERSON	In Lie	u of Form CMS-2	2552-10
	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT AL EDUCATION COSTS	Provider CCN: 15-0088	Period: From 07/01/2022 To 06/30/2023	Worksheet E-4 Date/Time Prep 11/22/2023 10	pared:
		Title XVIII	Hospital	PPS	
				1.00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1.00	Unweighted resident FTE count for allopathic and osteopathic ending on or before December 31, 1996.	programs for cost report	ing periods	0.00	1.00
1.01	FTE cap adjustment under §131 of the CAA 2021 (see instruction	ns)		0.00	1.01
2.00	Unweighted FTE resident cap add-on for new programs per 42 CF		ructions)	0.00	2.00
2.26	Rural track program FTE cap limitation adjustment after the c			0.00	2.26
	the CAA 2021 (see instructions)				
3.00	Amount of reduction to Direct GME cap under section 422 of MM	A		0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance instructions for cost reporting periods straddling 7/1/2011)	with 42 CFR §413.79 (m)	. (see	0.00	3.01
3.02	Adjustment (increase or decrease) to the hospital's rural tra	ck FTE limitation(s) for	rural track	0.00	3.02
	programs with a rural track Medicare GME affiliation agreemen	t in accordance with 413	.75(b) and 87 FR		
4 00	49075 (August 10, 2022) (see instructions)			0.00	4 00
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f)		to a medicare	0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see inst		ing periods	0.00	4.01
7.01	straddling 7/1/2011)	ruccions for cost report	ing periods	0.00	7.01
4 00				0.00	4 00

0.00

0.00

0.00

0.00

1.00

0.00 20.00

0.00 21.00

0.00 22.00

23.00

0 25.00

0.00

0 24.00

4.02

4.21

5.00

6.00

ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting

FTE adjusted cap (line 1 plus and 1.01, plus line 2, plus lines 2.26 through 2.49, minus lines 3 and

Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your

The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see

20.00 | Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42

21.00 Direct GME FTE unweighted resident count over cap (see instructions)

22.00 | Allowable additional direct GME FTE Resident Count (see instructions)

23.00 | Enter the locality adjustment national average per resident amount (see instructions)

3.01, plus or minus line 3.02, plus or minus line 4, plus lines 4.01 through 4.27

0.00	records (see instructions)	the current year	ai iiolii youi	0.00	0.00
7.00	Enter the lesser of line 5 or line 6			0.00	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	weighted FTE count for physicians in an allopathic and osteopathic	0.00	0.00	0.00	8.00
	program for the current year.				
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise	0.00	0.00	0.00	9.00
	multiply line 8 times the result of line 5 divided by the amount on line				
	6. For cost reporting periods beginning on or after October 1, 2022, or				
	if Worksheet S-2, Part I, line 68, is "Y", see instructions.				
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00		10.01
11.00	Total weighted FTE count	0.00	0.00		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see	0.00	0.00		12.00
	instructions)				
13.00	Total weighted resident FTE count for the penultimate cost reporting	0.00	0.00		13.00
44.00	year (see instructions)				44.00
	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.00	0.00		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital	0.00	0.00		16.01
47.00	closure				4 = 00
17.00	Adjusted rolling average FTE count	0.00	0.00		17.00
	Per resident amount	0.00	0.00		18.00
	Per resident amount under §131 of the CAA 2021	0.00	0.00		18.01
19.00	Approved amount for resident costs	0	0	0	19.00

Sec. 413.79(c)(4)

24.00 | Multiply line 22 time line 23

25.00 Total direct GME amount (sum of lines 19 and 24)

4.02

4.21

5.00

6.00

periods straddling 7/1/2011)

instructions)

	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provider C	CN: 15-0088	Period: From 07/01/2022	Worksheet E-4	,
DICAI	L EDUCATION COSTS			To 06/30/2023	Date/Time Pre 11/22/2023 10	
		Title	XVIII	Hospital	PPS	
			Inpatient Pa		Total	
			A			
			1.00	2.00	3.00	
	COMPUTATION OF PROGRAM PATIENT LOAD					4
	<pre>Inpatient Days (see instructions) (Title XIX - see S-2 Part IX 3.02, column 2)</pre>	K, line	6,3			26.
	Total Inpatient Days (see instructions)		26,9			27
	Ratio of inpatient days to total inpatient days		0.2362	0.301695		28
	Program direct GME amount			0	0	29
	Percent reduction for MA DGME				_	29
	Reduction for direct GME payments for Medicare Advantage			0	0	1
.00	Net Program direct GME amount				0	31
					1.00	
- 1	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE EDUCATION COSTS)	XVIII ONLY	(NURSING PRO	OGRAM AND PARAMED	DICAL	
	Renal dialysis direct medical education costs (from Wkst. B, F	Pt. T. SUM C	of col. 20 and	1 23. lines 74	0	32
- 1	and 94)	-, ·		,	_	
	Renal dialysis and home dialysis total charges (Wkst. C, Pt. 1			74 and 94)	0	33
	Ratio of direct medical education costs to total charges (line	e 32 ÷ line	33)		0.000000	
	Medicare outpatient ESRD charges (see instructions)				0	
	Medicare outpatient ESRD direct medical education costs (line		35)		0	36
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII	ONLY				4
	Part A Reasonable Cost Reasonable cost (see instructions)				10 727 041	4
	Organ acquisition and HSCT acquisition costs (see instructions	- \			18,737,041 0	
	Cost of physicians' services in a teaching hospital (see instructions				0	
	Primary payer payments (see instructions)	uccions)			0	
	Total Part A reasonable cost (sum of lines 37 through 39 minus	s line 40)			18,737,041	1
	Part B Reasonable Cost					
.00	Reasonable cost (see instructions)				16,942,388	42
.00	Primary payer payments (see instructions)				1,614	43
00	Total Part B reasonable cost (line 42 minus line 43)				16,940,774	44
	Total reasonable cost (sum of lines 41 and 44)				35,677,815	
	Ratio of Part A reasonable cost to total reasonable cost (line				0.525173	
	Ratio of Part B reasonable cost to total reasonable cost (line		45)		0.474827	47
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PAR	RT B			_	٠.
	Total program GME payment (line 31)	(				48
	Part A Medicare GME payment (line 46 x 48) (title XVIII only) Part B Medicare GME payment (line 47 x 48) (title XVIII only)				0	1
	PALL B MEDICALE GME DAVMENT CLINE 4/ X 451 CLITTE XVIII ONIV)	CSEE INSTIT	11 1 1 1 1 1 1 1 1		()	

Health	Financial Systems ASC	CENSION ST. VINCE	NT ANDERSON	In Lie	u of Form CMS-2	552-10
OUTLIE	ER RECONCILIATION AT TENTATIVE SETTLEMENT		Provider CCN: 15-0088	Period: From 07/01/2022	Worksheet E-5	
				To 06/30/2023	Date/Time Prep 11/22/2023 10:	
			Title XVIII		PPS	
					1.00	
TO BE COMPLETED BY CONTRACTOR						
1.00 Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)					0	1.00
2.00   Capital outlier from Wkst. L, Pt. I, line 2				0	2.00	
3.00 Operating outlier reconciliation adjustment amount (see instructions)					0	3.00
4.00 Capital outlier reconciliation adjustment amount (see instructions)					0	4.00
5.00 The rate used to calculate the time value of money (see instructions)					0.00	5.00
6.00	Time value of money for operating expenses (se	ee instructions)			0	6.00
7.00	Time value of money for capital related expens	ses (see instruct	tions)		0	7.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

Period: From 07/01/2022 To 06/30/2023 Date/Time Prepared: 11/22/2023 10:37 am

on ry)			'	0 00, 30, 2023	11/22/2023 10	:37 am
		General Fund	Specific Purpose Fund	Endowment Fund		
	I	1.00	2.00	3.00	4.00	
1.00	CURRENT ASSETS	25 002	1		0	1 1 00
2.00	Cash on hand in banks	25,892			0	1.00
	Temporary investments	0			0	
3.00	Notes receivable	62 244 755			0	3.00
4.00	Accounts receivable	62,244,755			0	4.00
5.00	Other receivable	4,745,754		0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-43,306,767			0	6.00
7.00	Inventory	4,522,239			0	7.00
8.00	Prepaid expenses	1 510 763			0	8.00
9.00 10.00	Other current assets Due from other funds	1,518,763			0	9.00
	Total current assets (sum of lines 1-10)	20 750 636			-	
11.00	FIXED ASSETS	29,750,636		)  0	U	11.00
12.00	Land	5,292,602		0	0	12.00
13.00	Land improvements	2,968,724		_	0	13.00
14.00	Accumulated depreciation	2,900,724		-		14.00
15.00	Buildings	114,421,345	1		0	15.00
16.00	Accumulated depreciation	114,421,343			0	16.00
17.00	Leasehold improvements	0			0	17.00
18.00	Accumulated depreciation	0			0	18.0
	Fixed equipment	0			-	
19.00 20.00		0			0	19.0
20.00	Accumulated depreciation Automobiles and trucks	0			0	20.0
		0			0	
22.00	Accumulated depreciation	60,176,114				22.00
23.00	Major movable equipment				0	23.0
24.00	Accumulated depreciation	-124,567,181			0	24.0
25.00	Minor equipment depreciable	0				25.0
26.00 27.00	Accumulated depreciation	0			0	26.0
	HIT designated Assets	0				27.0
28.00	Accumulated depreciation	0			0	28.0
29.00	Minor equipment-nondepreciable	F0 201 604				29.0
30.00	Total fixed assets (sum of lines 12-29)	58,291,604	<u> </u>	)  0	U	30.00
31.00	OTHER ASSETS Investments			0	0	31.00
32.00	Deposits on leases	0			0	32.00
33.00	Due from owners/officers	0			0	33.00
34.00	Other assets	636,034			0	34.0
35.00	Total other assets (sum of lines 31-34)	636,034			0	35.0
36.00	Total assets (sum of lines 11, 30, and 35)	88,678,274		-		36.0
30.00	CURRENT LIABILITIES	00,070,274		, 0	U	30.0
37.00	Accounts payable	3,637,806		0	0	37.0
38.00	Salaries, wages, and fees payable	3,815,517			0	38.00
39.00	Payroll taxes payable	3,013,317			0	39.0
40.00	Notes and loans payable (short term)	221 604			0	40.0
41.00	Deferred income	221,694			0	41.0
42.00	Accelerated payments	0	١	,	U	42.0
43.00	Due to other funds	0		0	0	43.0
44.00	Other current liabilities	24,169,410			0	44.0
45.00		31,844,427				
43.00	Total current liabilities (sum of lines 37 thru 44)  LONG TERM LIABILITIES	31,044,427		)  0	U	43.0
46.00	Mortgage payable	13,236,189		0	0	46.00
47.00	Notes payable	13,230,109			-	47.0
	Unsecured loans	0		-		
48.00		CO1 003		1		48.0
49.00	Other long term liabilities	601,993		-	0	49.0
50.00	Total long term liabilities (sum of lines 46 thru 49)	13,838,182				50.0
F1 00		45,682,609	<u> </u>	0	0	51.0
51.00	Total liabilities (sum of lines 45 and 50)					
	CAPITAL ACCOUNTS	42 005 665	I			F2 A
52.00	CAPITAL ACCOUNTS General fund balance	42,995,665				
52.00 53.00	CAPITAL ACCOUNTS General fund balance Specific purpose fund	42,995,665	C	)		53.0
52.00 53.00 54.00	CAPITAL ACCOUNTS  General fund balance  Specific purpose fund  Donor created - endowment fund balance - restricted	42,995,665		0		53.0 54.0
52.00 53.00 54.00 55.00	CAPITAL ACCOUNTS  General fund balance Specific purpose fund Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted	42,995,665		0		53.0 54.0 55.0
52.00 53.00 54.00 55.00 56.00	CAPITAL ACCOUNTS  General fund balance Specific purpose fund Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted Governing body created - endowment fund balance	42,995,665		0 0 0	_	53.0 54.0 55.0 56.0
52.00 53.00 54.00 55.00 56.00 57.00	CAPITAL ACCOUNTS  General fund balance Specific purpose fund Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted Governing body created - endowment fund balance Plant fund balance - invested in plant	42,995,665		0 0 0	0	53.0 54.0 55.0 56.0 57.0
52.00 53.00 54.00 55.00 56.00	CAPITAL ACCOUNTS  General fund balance Specific purpose fund Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted Governing body created - endowment fund balance Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement,	42,995,665		0 0 0	0	53.0 54.0 55.0 56.0 57.0
52.00 53.00 54.00 55.00 56.00 57.00 58.00	CAPITAL ACCOUNTS  General fund balance Specific purpose fund Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted Governing body created - endowment fund balance Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement, replacement, and expansion		C	0 0 0	0	53.0 54.0 55.0 56.0 57.0 58.0
52.00 53.00 54.00 55.00 56.00 57.00	CAPITAL ACCOUNTS  General fund balance Specific purpose fund Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted Governing body created - endowment fund balance Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement,	42,995,665 42,995,665 88,678,274	C	0 0 0		52.00 53.00 54.00 55.00 56.00 57.00 58.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0088

Period: Worksheet G-1 From 07/01/2022 To 06/30/2023 Date/Time Prepared:

				' '	00/30/2023	11/22/2023 10	
		Genera	l Fund	Special Pu	rpose Fund	Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		24,906,408		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		11,969,091				2.00
3.00	Total (sum of line 1 and line 2)		36,875,499		0		3.00
4.00	Additions (credit adjustments) (specify)	0	, ,	0		0	4.00
5.00	TRANSFER RESTRICTED FUNDS	6,120,166		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		6,120,166		0		10.00
11.00	Subtotal (line 3 plus line 10)		42,995,665		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	MISCELLANEOUS	0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance		42,995,665		0		19.00
	sheet (line 11 minus line 18)		-7				
		Endowment Fund	Plant	Funa			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	o		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00	TRANSFER RESTRICTED FUNDS		0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00	MISCELLANEOUS		0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance	0		0			19.00
	sheet (line 11 minus line 18)						

Period: Worksheet G-2 From 07/01/2022 Parts I & II To 06/30/2023 Date/Time Prepared:

PART I - PATIENT REVENUES   1.00   2.00   3.00				-	00,50,2025	11/22/2023 10	:37 am	
PART I - PATTENT REVENUES   General Inpatient Rowline Services   Services		Cost Center Description	In	patient	Outpatient			
Common   C				1.00	2.00	3.00		
MOSPITAT		PART I - PATIENT REVENUES						
2.00   SUBPROVIDER		General Inpatient Routine Services						
3.00   SUBPROVIDER   SIRE   S.035,978   S.035,978   S.035,978   S.00	1.00	Hospital	5	1,457,527		51,457,527	1.00	
4.00   SUBPROVIDER		SUBPROVIDER - IPF						
S.00	3.00	SUBPROVIDER - IRF		5,035,978		5,035,978	3.00	
5.00   Swing Ded - NF   SWING FACILITY	4.00	SUBPROVIDER						
3.00   NURSING FACILITY	5.00	Swing bed - SNF		0			5.00	
NURSING FACILITY		-		0		0		
9.00								
10.00   Total general inpatient care services (sum of lines 1-9)   56,493,505   56,493,505   10.00								
Intensive Care Type Inpatient Hospital Services								
11.00   INTENSIVE CARE UNIT   19,544,506   19,544,506   1.00   12.00   1.00	10.00			6,493,505		56,493,505	10.00	
12.00   CORONARY CARE UNIT   13.00								
13.00   BURN INTENSIVE CARE UNIT   30RGICAL INTENSIVE CARE UNIT   14.00   15.00   16.00   16.00   17			1	L9,544,506		19,544,506		
14.00   SURGICAL INTENSIVE CARE UNIT   14.00   15.00   16.00   17.01								
15.00   THER SPECIAL CARE (SPECIFY)   Total intensive care type inpatient hospital services (sum of lines 19,544,506   19,544,506   11-15)   Total inpatient routine care services (sum of lines 10 and 16)   76,038,011   76,03								
16.00   Total intensive care type inpatient hospital services (sum of lines   19,544,506   10.00   11-15   10.00   11-15   10.00   11-15   10.00   11-15   10.00   11-15   10.00   11-15   10.00   11-15   10.00   11-15   10.00   11-15   10.00   11-15   10.00   11-15   10.00   11-15   10.00   11-15   10.00   11-15   10.00   11-15   10.00   11-15   10.00   1								
11-15    Total inpatient routine care services (sum of lines 10 and 16)   Total inpatient routine care services (sum of lines 10 and 16)   Total inpatient routine care services (sum of lines 10 and 16)   Total additions (sum of lines 30-35)   Total additions (sum of lines 37-41)   Total additions (sum of lines 37-41)   Total additions (sum of lines 29 and 36 minus line 42)(transfer of lines 42) (transfer of lines 144,922,644   South of lines 43,00   Total additions (sum of lines 37-41)   Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer of lines 144,922,644   South of lines 42,00   Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer of lines 144,922,644   South of lines 44,000   Total additions (sum of lines 29 and 36 minus line 42) (transfer of lines 144,922,644   South of lines 44,000   Total addition (sum of lines 29 and 36 minus line 42) (transfer of lines line 42) (transfer of lines lines line 42) (transfer of lines lines line 42) (transfer of lines						40 544 500		
17.00   Total inpatient routine care services (sum of lines 10 and 16)   76,038,011   17.00   18.00   Ancillary services   0   70,426,657   70,426,657   19.00   0   0   0   0   0   0   0   0   0	16.00	1 ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '	nes 1	19,544,506		19,544,506	16.00	
18.00   Ancillary services   162,707,268   408,465,406   571,172,674   18.00   19.00   10.00	17 00		-	26 020 011		76 020 011	17 00	
19.00   Outpatient services   0   70,426,657   70,426,657   20.00		· · · · · · · · · · · · · · · · · · ·	10	0,030,011	100 165 106	′ ′		
20.00   RURAL HEALTH CLINIC   FEDERALLY QUALIFIED HEALTH CENTER   0 0 0 0 0 0 21.00			1 70			′ ′		
21.00   FEDERALLY QUALIFIED HEALTH CENTER   0 0 0 0 0 21.00   22.00   HOME HEALTH AGENCY   22.00   HOME HEALTH AGENCY   22.00   23.00   24.00   25.00   24.00   25.00   24.00   25.00   26.00   26.00   26.00   25.00   26.00   25.00   26.00   27.0		· •		•	70,420,037			
22.00   HOME HEALTH AGENCY				0	0			
23.00 AMBULANCE SERVICES 0 0 0 0 0 23.00 24.00 CMHC 24.00 CMHC 25.00 AMBULATORY SURGICAL CENTER (D.P.) 25.00 26.00 HOSPICE 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				U	٩	U		
24.00   CMHC   AMBULATORY SURGICAL CENTER (D.P.)   25.00   25.00   25.00   26.00   26.00   26.00   27.				0	0	٥		
25.00 AMBULATORY SURGICAL CENTER (D.P.) 26.00 HOSPICE 27.00 OTHER (SPECIFY) 0 0 0 0 0 27.00 27.01 OTHER (SPECIFY) 0 0 0 0 0 0 27.00 27.01 Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. 238,745,279 478,892,063 717,637,342 28.00 29.00 ADD (SPECIFY) 0 184,922,644 29.00 31.				O	ď	o l		
26.00   HOSPICE   OTHER (SPECIFY)   O O O O O O O O O O O O O O O O O O								
27.00   OTHER (SPECIFY)   0   0   0   0   27.00								
27.01 OTHER (SPECIFY)  28.00 Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. 238,745,279 478,892,063 717,637,342 28.00 717,637,342 28.00 717,637,342 28.00 717,637,342 28.00 717,637,342 28.00 717,637,342 717,637,				0	0	0		
28.00 Total patient revenues (sum of lines 17-27)(transfer column 3 to wkst. G-3, line 1)  PART II - OPERATING EXPENSES  Operating expenses (per Wkst. A, column 3, line 200)  ADD (SPECIFY)  ADD (SPECIFY)  Total additions (sum of lines 30-35)  DEDUCT (SPECIFY)  Total deductions (sum of lines 37-41)  Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer)  238,745,279  478,892,063  717,637,342  28.00  717,637,342  29.00  30.00  31.00  30.00  31.00  30.00  31.00  32.00  33.00  34.00  35.00  36.00  37.00  37.00  38.00  37.00  38.00  39.00  40.00  41.00  42.00  Total deductions (sum of lines 37-41)  Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer)  184,922,644  478,892,063  717,637,342  29.00  30.00  30.00  30.00  31.00  31.00  32.00  33.00  32.00  33.00  34.00  35.00  36.00  37.00  37.00  37.00  37.00  38.00  40.00  41.00  42.00  Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer)				0	Ö	0		
G-3, line 1)  PART II - OPERATING EXPENSES  Operating expenses (per wkst. A, column 3, line 200) 30.00 31.00 32.00 33.00 33.00 34.00 35.00 36.00 Total additions (sum of lines 30-35) DEDUCT (SPECIFY)  Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer  184,922,644  29.00 184,922,644  29.00 30.00 30.00 30.00 31.00 31.00 31.00 32.00 33.00 34.00 35.00 36.00 36.00 36.00 36.00 36.00 37.00 36.00 37.00 38.00 39.00 40.00 41.00 42.00 43.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer  184,922,644 43.00			wkst. 23	88.745.279	478.892.063	717.637.342		
PART II - OPERATING EXPENSES  Operating expenses (per wkst. A, column 3, line 200)  ADD (SPECIFY)  ADD (SPECIFY				,,	,,	, ,		
29.00 Operating expenses (per wkst. A, column 3, line 200)  30.00 ADD (SPECIFY)  ADD (SPECIFY)  0 30.00 31.00 31.00 31.00 32.00 32.00 33.00 32.00 33.00 33.00 33.00 33.00 33.00 34.00 0 33.00 34.00 35.00 36.00 50			<u>'</u>		'			
31.00 32.00 33.00 33.00 34.00 35.00 35.00 36.00 Total additions (sum of lines 30-35) DEDUCT (SPECIFY)  DEDUCT (SPECIFY)  Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer)  O  31.00 32.00 33.00 33.00 33.00 34.00 35.00 0 36.00 37.00 0 38.00 0 0 0 0 40.00 41.00 42.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer)  184,922,644	29.00				184,922,644		29.00	
32.00 33.00 34.00 35.00 36.00 Total additions (sum of lines 30-35) DEDUCT (SPECIFY)  0 37.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer)  0 32.00 33.00 33.00 34.00 35.00 36.00 37.00 37.00 38.00 0 0 0 0 0 40.00 41.00 42.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer)  184,922,644	30.00	ADD (SPECIFY)		0			30.00	
33.00 34.00 35.00 36.00 Total additions (sum of lines 30-35) DEDUCT (SPECIFY)  0 37.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer)  33.00 34.00 35.00 36.00 37.00 37.00 38.00 0 0 39.00 40.00 41.00 42.00 184,922,644	31.00			0			31.00	
34.00 35.00 36.00 Total additions (sum of lines 30-35) 37.00 DEDUCT (SPECIFY) 0 37.00 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer) 0 34.00 35.00 0 36.00 0 37.00 0 38.00 0 40.00 0 40.00 41.00 42.00 184,922,644	32.00			0			32.00	
35.00 36.00 37.00 38.00 39.00 40.00 41.00 42.00 Total additions (sum of lines 30-35)  Total additions (sum of lines 30-35)  Total additions (sum of lines 30-35)  0 37.00 38.00 0 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer)  0 35.00 36.00 37.00 0 38.00 0 0 40.00 41.00 0 42.00 184,922,644	33.00			0			33.00	
36.00 Total additions (sum of lines 30-35) 37.00 BDUCT (SPECIFY) 0 37.00 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer) 36.00 36.00 37.00 0 38.00 0 0 0 40.00 41.00 42.00 184,922,644	34.00			0			34.00	
37.00 DEDUCT (SPECIFY) 0 37.00 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 184,922,644 43.00	35.00			0			35.00	
38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 184,922,644 43.00	36.00	Total additions (sum of lines 30-35)			0		36.00	
39.00   39.00   40.00   41.00   41.00   42.00   Total deductions (sum of lines 37-41)   43.00   Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer   184,922,644   43.00		DEDUCT (SPECIFY)		0				
40.00   40.00   41.00   41.00   42.00   Total deductions (sum of lines 37-41)   43.00   Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer   184,922,644   43.00				0				
41.00 42.00 Total deductions (sum of lines 37-41) 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 184,922,644 43.00	39.00			0			39.00	
42.00 Total deductions (sum of lines 37-41) 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer   184,922,644   43.00				-				
43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 184,922,644 43.00				0				
					0			
to Wkst. G-3, line 4)	43.00		transfer		184,922,644		43.00	
		to Wkst. G-3, line 4)	1					

Health	Financial Systems	ASCENSION ST. VINC	ENT ANDERSON	In Lie	u of Form CMS-2	2552-10
STATE	MENT OF REVENUES AND EXPENSES		Provider CCN: 15-0088	Period: From 07/01/2022	Worksheet G-3	
					Date/Time Prep 11/22/2023 10	
					1.00	
1.00	Total patient revenues (from Wkst. G-2, F	Part I, column 3, lin	e 28)		717,637,342	1.00
2.00	Less contractual allowances and discounts	s on patients' accoun	ts		523,166,673	2.00
3.00	Net patient revenues (line 1 minus line 2	2)			194,470,669	3.00
4.00	Less total operating expenses (from Wkst.	. G-2, Part II, line	43)		184,922,644	4.00
5 00	Net income from service to nationts (line	3 minus line 4)			9 548 025	5 00

1.00				
100   Less contractual allowances and discounts on patients' accounts   194,470,669   3.00     194,470,669   3.00   184,922,644   4.00     194,470,669   3.00   184,922,644   4.00     194,870,669   3.00   184,922,644   4.00     194,870,669   3.00   184,922,644   4.00     194,870,689   3.00   184,922,644   4.00     194,870,689   3.00   184,922,644   4.00     194,870,689   3.00   184,922,644   4.00     194,870,689   3.00   184,922,644   4.00     194,870,689   3.00   184,922,644   4.00     194,870,689   3.00   184,922,644   4.00     194,870,689   3.00   184,922,644   4.00     194,870,689   3.00   184,922,644   4.00     194,870,689   3.00   184,922,644   4.00     194,870,689   3.00   184,922,644   4.00     194,870,689   3.00   184,922,644   4.00     194,870,689   3.00   3.00   4.00     194,870,689   3.00   3.00   4.00     194,870,689   3.00   3.00   4.00     194,870,689   3.00   3.00   4.00     194,870,689   3.00   3.00   4.00     194,870,689   3.00   3.00   4.00     194,870,689   3.00   3.00   4.00     194,870,689   3.00   3.00   4.00     194,870,689   3.00   3.00   4.00     194,870,689   3.00   3.00   4.00     194,870,689   3.00   3.00   4.00     194,870,689   3.00   3.00   4.00     194,870,699   3.00   3.00   4.00     194,870,699   3.00   3.00   4.00     194,870,699   3.00   3.00   4.00     194,870,699   3.00   3.00   4.00     194,870,699   3.00   3.00   4.00     194,870,699   3.00   3.00   4.00     194,870,699   3.00   3.00   4.00     194,870,699   3.00   3.00   4.00     194,870,699   3.00   3.00   4.00     194,870,699   3.00   3.00   4.00     194,870,699   3.00   3.00   4.00     194,870,699   3.00   3.00   4.00     194,870,699   3.00   3.00   4.00     194,870,699   3.00   3.00   4.00     194,870,699   3.00   3.00   4.00     194,870,699   3.00   3.00   4.00     194,870,699   3.00   3.00   4.00     194,870,699   3.00   3.00     194,870,699   3.00   3.00     194,870,699   3.00   3.00     194,870,699   3.00   3.00     194,870,699   3.00   3.00     194,870,699   3.00   3.00     194,870,699   3.00   3.00     194,87			1.00	
3.00   Ret patient revenues (line 1 minus line 2)   184,470,669   3.00   184,470,669   3.00   184,870,669   3.00   184,870,669   3.00   184,870,669   3.00   184,870,669   3.00   184,870,669   3.00   184,870,669   3.00   184,870,669   3.00   184,870,669   3.00   184,870,669   3.00   184,870,870,870   3.00	1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	717,637,342	1.00
Less total operating expenses (from wkst. G-2, Part II, line 43)   184,922,644   5.00   CTHER INCOME   9,548,025   5.00   CTHER INCOME   9,548,025   5.00   CTHER INCOME   9,548,025   5.00   CTHER INCOME   0   0,00   0	2.00	Less contractual allowances and discounts on patients' accounts	523,166,673	2.00
Net income from service to patients (line 3 minus line 4)   9,548,025   0.00	3.00	Net patient revenues (line 1 minus line 2)	194,470,669	3.00
	4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	184,922,644	4.00
Contributions, donations, bequests, etc	5.00	Net income from service to patients (line 3 minus line 4)	9,548,025	5.00
	6.00	Contributions, donations, bequests, etc	0	6.00
9.00       Revenue from television and radio service       0       9.00         10.00       Purchase discounts       0       10.00         11.00       Rebates and refunds of expenses       0       11.00         12.00       Parking lot receipts       0       12.00         14.00       Revenue from laundry and linen service       0       13.00         14.00       Revenue from meals sold to employees and guests       370,438       14.00         15.00       Revenue from sale of medical and surgical supplies to other than patients       0       15.00         16.00       Revenue from sale of medical and surgical supplies to other than patients       28       17.00         18.00       Revenue from sale of medical records and abstracts       2,210       18.00         19.00       Tuition (fees, sale of textbooks, uniforms, etc.)       0       19.00         19.00       Tuition (fees, sale of textbooks, uniforms, etc.)       0       19.00         19.00       Revenue from gale of medical and surgical supplies to other than patients       2,210       18.00         19.00       Revenue from sale of medical and surgical supplies to other than patients       2,20       18.00         19.00       Revenue from sale of deducts       0       19.00         19.00 <td< td=""><td>7.00</td><td></td><td>0</td><td>7.00</td></td<>	7.00		0	7.00
10.00   Purchase discounts   10.00   10.00   Parkates and refunds of expenses   0   1.00   1.00   Parking lot receipts   0   1.00   Parking lot receipts	8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
100   Rebates and refunds of expenses   0   100   Parking lot receipts   0   1200   1300   Revenue from laundry and linen service   0   1300   1300   Revenue from laundry and linen service   370,438   1400   1500   Revenue from meals sold to employees and guests   370,438   1400   1500   Revenue from meals sold to employees and guests   370,438   1400   1500   Revenue from sale of drugs to other than patients   0   1500   1600   Revenue from sale of drugs to other than patients   28   1700   1800   Revenue from sale of drugs to other than patients   28   1700   1800   Revenue from sale of drugs to other than patients   28   1700   1900   1000   Revenue from sale of freely sold to the proof of the proof o	9.00	Revenue from television and radio service	0	9.00
12.00	10.00	Purchase discounts	0	10.00
13.00       Revenue from laundry and linen service       0       13.00         14.00       Revenue from meals sold to employees and guests       370,438       14.00         15.00       Revenue from rental of living quarters       0       15.00         16.00       Revenue from sale of medical and surgical supplies to other than patients       0       16.00         17.00       Revenue from sale of fugs to other than patients       28       17.00         18.00       Revenue from sale of medical records and abstracts       2,210       18.00         19.00       Tuition (fees, sale of textbooks, uniforms, etc.)       0       19.00         21.00       Rental of vending machines       38,435       21.00         22.00       Rental of hospital space       469,623       22.00         23.00       Governmental appropriations       0       23.00         24.01       SHARED REVENUE       0       24.00         24.02       THER (SPECIFY)       0       24.02         24.03       GRANTS REVENUE       391,495       24.03         24.05       SCHOOL OF RAD TECH       391,491       24.05         24.06       OTHER (SPECIFY)       0       24.05         24.07       CONTRACT SERVICE REVENUE       31,441	11.00	Rebates and refunds of expenses	0	11.00
1.4.00     Revenue from meals sold to employees and guests     370,438     14.00       1.5.00     Revenue from sale of medical and surgical supplies to other than patients     0     16.00       17.00     Revenue from sale of medical and surgical supplies to other than patients     2.8     17.00       18.00     Revenue from sale of medical records and abstracts     2.2,10     18.00       19.00     Tuition (fees, sale of textbooks, uniforms, etc.)     0     19.00       20.00     Revenue from gifts, flowers, coffee shops, and canteen     0     20.00       21.00     Rental of vending machines     38.43     21.00       22.00     Rental of hospital space     469,623     22.00       24.00     LAB SERVICE REVENUE     0     24.00       24.01     SHARED REVENUE     0     24.02       24.02     OTHER (SPECIFY)     0     24.02       24.03     GRANTS REVENUE     391,195     24.04       24.04     MISC REVENUE     391,195     24.05       24.07     CONTRACT SERVICE REVENUE     31,441     24.05       24.07     CONTRACT SERVICE REVENUE     28,357     24.09       24.09     RESEARCH REVENUE     28,357     24.09       24.10     GAIN ON DISPOSAL OF ASSET     22,25     24.11       26.00     T	12.00	Parking lot receipts	0	12.00
15.00   Revenue from rental of living quarters   0   15.00   16.00   Revenue from sale of medical and surgical supplies to other than patients   0   16.00	13.00	Revenue from laundry and linen service	0	13.00
16.00       Revenue from sale of medical and surgical supplies to other than patients       0       16.00         17.00       Revenue from sale of drugs to other than patients       28       17.00         18.00       Revenue from sale of medical records and abstracts       2,210       18.00         19.00       Tuition (fees, sale of textbooks, uniforms, etc.)       0       19.00         20.00       Revenue from gifts, flowers, coffee shops, and canteen       0       20.00         22.00       Rental of vending machines       38,435       21.00         23.00       Governmental appropriations       469,623       22.00         24.01       LAB SERVICE REVENUE       0       24.00         24.01       HARED REVENUE       405,463       24.01         24.02       CHIER (SPECIFY)       0       0       24.02         24.03       GRANTS REVENUE       391,195       24.03         24.05       SCHOOL OF RAD TECH       28,914       24.03         24.05       THER (SPECIFY)       0       24.03         24.07       CONTRACT SERVICE REVENUE       31,441       24.07         24.08       THER (SPECIFY)       0       24.08         24.09       RESEARCH REVENUE       28,914       24.03     <	14.00	Revenue from meals sold to employees and guests	370,438	14.00
17.00   Revenue from sale of drugs to other than patients   Revenue from sale of medical records and abstracts   2,210   18.00   19.	15.00	Revenue from rental of living quarters	0	15.00
18.00       Revenue from sale of medical records and abstracts       2,210       18.00         19.00       Tuition (fees, sale of textbooks, uniforms, etc.)       0       19.00         20.00       Revenue from gifts, flowers, coffee shops, and canteen       38,435       21.00         21.00       Rental of vending machines       38,435       21.00         22.00       Rental of hospital space       469,623       22.00         24.00       LAB SERVICE REVENUE       0       24.00         24.01       SHARED REVENUE       405,40       24.01         24.02       OTHER (SPECIFY)       0       24.02         24.03       GRANTS REVENUE       391,195       24.03         24.04       MISC REVENUE       391,195       24.03         24.04       MISC REVENUE       391,195       24.03         24.05       SCHOOL OF RAD TECH       28,197       24.05         24.06       OTHER (SPECIFY)       0       24.06         24.07       CONTRACT SERVICE REVENUE       31,441       24.05         24.09       RESEARCH REVENUE       28,357       24.09         24.10       ASSEFIS RELEASED FROM RESTRICTED FUND       204,411       24.0         24.10       ASSEFIS RELEASED FROM RESTRI	16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
19.00   Tuition (fees, sale of textbooks, uniforms, etc.)   19.00   20.00   Revenue from gifts, flowers, coffee shops, and canteen   0   20.00   20.	17.00	Revenue from sale of drugs to other than patients	28	17.00
20.00       Revenue from gifts, flowers, coffee shops, and canteen       0       20.00         21.00       Rental of vending machines       38,435       21.00         22.00       Rental of hospital space       469,623       22.00         23.00       Governmental appropriations       0       23.00         24.01       LAB SERVICE REVENUE       0       24.00         24.01       SHARED REVENUE       405,463       24.01         24.02       OTHER (SPECIFY)       0       24.02         24.03       GRANTS REVENUE       453,093       24.03         24.04       HXSC REVENUE       453,093       24.03         24.04       HXSC REVENUE       391,195       24.04         24.05       OTHER (SPECIFY)       0       24.05         24.06       OTHER (SPECIFY)       0       24.05         24.07       CONTRACT SERVICE REVENUE       31,441       24.05         24.08       OTHER (SPECIFY)       0       24.08         24.09       RESEARCH REVENUE       38,357       24.09         24.10       ASSETS RELEASED FROM RESTRICTED FUND       28,357       24.09         24.11       GAIN ON DISPOSAL OF ASSET       25       24.11         25.	18.00	Revenue from sale of medical records and abstracts	2,210	18.00
21.00       Rental of vending machines       38,435       21.00         22.00       Rental of hospital space       469,623       22.00         23.00       Governmental appropriations       0       23.00         24.00       LAB SERVICE REVENUE       0       24.00         24.01       SHARED REVENUE       405,463       24.01         24.02       OTHER (SPECIFY)       405,403       24.02         24.03       GRANTS REVENUE       391,195       24.03         24.04       MISC REVENUE       391,195       24.04         24.05       SCHOOL OF RAD TECH       391,195       24.04         24.06       OTHER (SPECIFY)       0       24.05         24.07       CONTRACT SERVICE REVENUE       31,441       24.07         24.09       RESEARCH REVENUE       31,441       24.07         24.09       RESEARCH REVENUE       28,357       24.08         24.10       ASSETS RELEASED FROM RESTRICTED FUND       204,411       24.10         24.11       GAIN ON DISPOSAL OF ASSET       20,40       24.21         25.00       Total other income (sum of lines 6-24)       2,423,833       25.00         26.00       Total other income (sum of lines 6-24)       2,23       2,7	19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
21.00       Rental of vending machines       38,435       21.00         22.00       Rental of hospital space       469,623       22.00         23.00       Governmental appropriations       0       23.00         24.00       LAB SERVICE REVENUE       0       24.00         24.01       SHARED REVENUE       405,463       24.01         24.02       OTHER (SPECIFY)       405,403       24.02         24.03       GRANTS REVENUE       391,195       24.03         24.04       MISC REVENUE       391,195       24.04         24.05       SCHOOL OF RAD TECH       391,195       24.04         24.06       OTHER (SPECIFY)       0       24.05         24.07       CONTRACT SERVICE REVENUE       31,441       24.07         24.09       RESEARCH REVENUE       31,441       24.07         24.09       RESEARCH REVENUE       28,357       24.08         24.10       ASSETS RELEASED FROM RESTRICTED FUND       204,411       24.10         24.11       GAIN ON DISPOSAL OF ASSET       20,40       24.21         25.00       Total other income (sum of lines 6-24)       2,423,833       25.00         26.00       Total other income (sum of lines 6-24)       2,23       2,7	20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
23.00	21.00		38,435	21.00
23.00       Governmental appropriations       0       23.00         24.00       LAB SERVICE REVENUE       0       24.00         24.01       SHARED REVENUE       405,463       24.01         24.02       OTHER (SPECIFY)       0       24.02         24.03       GRANTS REVENUE       453,093       24.04         24.04       MISC REVENUE       391,195       24.04         24.05       SCHOOL OF RAD TECH       28,914       24.05         24.06       OTHER (SPECIFY)       0       24.06         24.07       CONTRACT SERVICE REVENUE       31,441       24.07         24.08       OTHER (SPECIFY)       0       24.08         24.09       RESEARCH REVENUE       31,441       24.07         24.09       RESEARCH REVENUE       28,357       24.09         24.10       ASSETS RELEASED FROM RESTRICTED FUND       204,411       24.10         24.11       GAIN ON DISPOSAL OF ASSET       225,411       24.50         25.00       Total other income (sum of lines 6-24)       2,423,833       25.00         25.00       Total (line 5 plus line 25)       11,971,858       26.00         27.01       RESTRUCTURING EXPENSE       0       27.00 <t< td=""><td>22.00</td><td>Rental of hospital space</td><td>469,623</td><td>22.00</td></t<>	22.00	Rental of hospital space	469,623	22.00
24.00       LAB SERVICE REVENUE       0       24.00         24.01       SHARED REVENUE       405,463       24.01         24.02       OTHER (SPECIFY)       0       24.02         24.03       GRANTS REVENUE       391,195       24.04         24.04       MISC REVENUE       391,195       24.04         24.05       SCHOOL OF RAD TECH       28,914       24.05         24.00       OTHER (SPECIFY)       0       24.06         24.07       CONTRACT SERVICE REVENUE       31,441       24.07         24.08       OTHER (SPECIFY)       0       24.08         24.09       RESEARCH REVENUE       28,357       24.09         24.10       ASSETS RELEASED FROM RESTRICTED FUND       204,411       24.10         24.11       GAIN ON DISPOSAL OF ASSET       225,241.11       24.50         25.00       Total other income (sum of lines 6-24)       2,423,833       25.00         25.00       Total (line 5 plus line 25)       11,971,858       26.00         27.01       RESTRUCTURING EXPENSE       0       27.01         27.02       FUND RATSING ACTIVITIES       0       27.02         27.02       TOTHER EXPENSES       2,767       27.03         2	23.00	· · · · ·		
24.01       SHARED REVENUE       405,463       24.01         24.02       OTHER (SPECIFY)       0       24.02         24.03       GRANTS REVENUE       453,093       24.03         24.04       MISC REVENUE       391,195       24.04         24.05       SCHOOL OF RAD TECH       28,914       24.05         24.06       OTHER (SPECIFY)       0       24.06         24.07       CONTRACT SERVICE REVENUE       31,441       24.07         24.08       OTHER (SPECIFY)       0       24.08         24.09       RESEARCH REVENUE       28,357       24.09         24.10       ASSETS RELEASED FROM RESTRICTED FUND       204,411       24.10         24.11       GAIN ON DISPOSAL OF ASSET       225       24.11         24.50       COVID-19 PHE Funding       0       24.50         25.00       Total other income (sum of lines 6-24)       2,423,833       25.00         27.00       EHR       0       27.00         27.01       RESTRUCTURING EXPENSE       0       27.01         27.02       FUND RAISING ACTIVITIES       0       27.02         27.03       TOTHER EXPENSES       2,767       27.03         28.00       Total other expense	24.00		0	24.00
24.02       OTHER (SPECIFY)       0       24.02         24.03       GRANTS REVENUE       453,093       24.03         24.04       MISC REVENUE       391,195       24.04         24.05       SCHOOL OF RAD TECH       28,914       24.05         24.06       OTHER (SPECIFY)       0       24.06         24.07       CONTRACT SERVICE REVENUE       31,441       24.07         24.08       OTHER (SPECIFY)       0       24.08         24.09       RESEARCH REVENUE       28,357       24.09         24.10       ASSETS RELEASED FROM RESTRICTED FUND       204,411       24.10         24.11       GAIN ON DISPOSAL OF ASSET       204,411       24.10         25.00       Total other income (sum of lines 6-24)       24.23,833       25.00         25.00       Total other income (sum of lines 6-24)       2,423,833       25.00         27.00       EHR       0       27.00         27.01       RESTRUCTURING EXPENSE       0       27.01         27.02       FUND RAISING ACTIVITIES       0       27.03         27.03       TOTAL Other expenses (sum of line 27 and subscripts)       2,767       28.00			405.463	1
24.03       GRANTS REVENUE       453,093       24.03         24.04       MISC REVENUE       391,195       24.04         24.05       SCHOOL OF RAD TECH       28,914       24.05         24.06       OTHER (SPECIFY)       0       24.05         24.07       CONTRACT SERVICE REVENUE       31,441       24.07         24.08       OTHER (SPECIFY)       0       24.08         24.09       RESEARCH REVENUE       28,357       24.09         24.10       ASSETS RELEASED FROM RESTRICTED FUND       204,411       24.10         24.11       GAIN ON DISPOSAL OF ASSET       225       24.11         24.50       COVID-19 PHE Funding       0       24.50         25.00       Total other income (sum of lines 6-24)       2,423,833       25.00         26.00       Total (line 5 plus line 25)       2,423,833       25.00         27.01       RESTRUCTURING EXPENSE       0       27.01         27.02       FUND RAISING ACTIVITIES       0       27.02         27.03       OTHER EXPENSES       2,767       27.03         28.00       Total other expenses (sum of line 27 and subscripts)       2,767       28.00	24.02			1
24.04       MISC REVENUE       391,195       24.04         24.05       SCHOOL OF RAD TECH       28,914       24.05         24.06       OTHER (SPECIFY)       0       24.06         24.07       CONTRACT SERVICE REVENUE       31,441       24.07         24.08       OTHER (SPECIFY)       0       24.08         24.09       RESEARCH REVENUE       28,357       24.09         24.10       ASSETS RELEASED FROM RESTRICTED FUND       204,411       24.10         24.11       GAIN ON DISPOSAL OF ASSET       225       24.11         25.00       Total other income (sum of lines 6-24)       2,423,833       25.00         25.00       Total (line 5 plus line 25)       11,971,858       26.00         27.00       EHR       0       27.00         27.01       RESTRUCTURING EXPENSE       0       27.01         27.02       FUND RAISING ACTIVITIES       0       27.01         27.03       OTHER EXPENSES       2,767       27.03         28.00       Total other expenses (sum of line 27 and subscripts)       2,767       28.00			453.093	ı
24.05       SCHOOL OF RAD TECH       28,914       24.05         24.06       OTHER (SPECIFY)       0       24.06         24.07       CONTRACT SERVICE REVENUE       31,441       24.07         24.08       OTHER (SPECIFY)       0       24.08         24.09       RESEARCH REVENUE       28,357       24.09         24.10       ASSETS RELEASED FROM RESTRICTED FUND       204,411       24.10         24.11       GAIN ON DISPOSAL OF ASSET       225       24.11         24.50       COVID-19 PHE Funding       0       24.50         25.00       Total other income (sum of lines 6-24)       2,423,833       25.00         26.00       Total (line 5 plus line 25)       11,971,858       26.00         27.01       RESTRUCTURING EXPENSE       0       27.02         27.02       FUND RAISING ACTIVITIES       0       27.01         27.03       OTHER EXPENSES       2,767       27.03         28.00       Total other expenses (sum of line 27 and subscripts)       2,767       28.00				1
24.06       OTHER (SPECIFY)       0       24.06         24.07       CONTRACT SERVICE REVENUE       31,441       24.07         24.08       OTHER (SPECIFY)       0       24.08         24.09       RESEARCH REVENUE       28,357       24.09         24.10       ASSETS RELEASED FROM RESTRICTED FUND       204,411       24.10         24.11       GAIN ON DISPOSAL OF ASSET       225       24.11         24.50       COVID-19 PHE Funding       0       24.50         25.00       Total other income (sum of lines 6-24)       2,423,833       25.00         26.00       Total (line 5 plus line 25)       11,971,858       26.00         27.01       RESTRUCTURING EXPENSE       0       27.01         27.02       FUND RAISING ACTIVITIES       0       27.01         27.03       OTHER EXPENSES       2,767       27.03         28.00       Total other expenses (sum of line 27 and subscripts)       2,767       28.00				
24.07       CONTRACT SERVICE REVENUE       31,441       24.07         24.08       OTHER (SPECIFY)       0       24.08         24.09       RESEARCH REVENUE       28,357       24.09         24.10       ASSETS RELEASED FROM RESTRICTED FUND       204,411       24.10         24.11       GAIN ON DISPOSAL OF ASSET       225       24.11         24.50       COVID-19 PHE Funding       0       24.50         25.00       Total other income (sum of lines 6-24)       2,423,833       25.00         26.00       Total (line 5 plus line 25)       11,971,858       26.00         27.00       EHR       0       27.00         27.01       RESTRUCTURING EXPENSE       0       27.01         27.02       FUND RAISING ACTIVITIES       0       27.01         27.03       OTHER EXPENSES       2,767       27.03         28.00       Total other expenses (sum of line 27 and subscripts)       2,767       28.00				1
24.08       OTHER (SPECIFY)       0       24.08         24.09       RESEARCH REVENUE       28,357       24.09         24.10       ASSETS RELEASED FROM RESTRICTED FUND       204,411       24.10         24.11       GAIN ON DISPOSAL OF ASSET       225       24.11         24.50       COVID-19 PHE Funding       0       24.50         25.00       Total other income (sum of lines 6-24)       2,423,833       25.00         26.00       Total (line 5 plus line 25)       11,971,858       26.00         27.00       EHR       0       27.00         27.01       RESTRUCTURING EXPENSE       0       27.01         27.02       FUND RAISING ACTIVITIES       0       27.01         27.03       OTHER EXPENSES       2,767       27.03         28.00       Total other expenses (sum of line 27 and subscripts)       2,767       28.00	24.07		31,441	24.07
24.09       RESEARCH REVENUE       28,357       24.09         24.10       ASSETS RELEASED FROM RESTRICTED FUND       204,411       24.10         24.11       GAIN ON DISPOSAL OF ASSET       225       24.11         24.50       COVID-19 PHE Funding       0       24.50         25.00       Total other income (sum of lines 6-24)       2,423,833       25.00         26.00       Total (line 5 plus line 25)       11,971,858       26.00         27.01       EHR       0       27.00         27.02       FUND RAISING ACTIVITIES       0       27.02         27.03       OTHER EXPENSES       2,767       27.03         28.00       Total other expenses (sum of line 27 and subscripts)       2,767       28.00	24.08			
24.11       GAIN ON DISPOSAL OF ASSET       225       24.11         24.50       COVID-19 PHE Funding       0       24.50         25.00       Total other income (sum of lines 6-24)       2,423,833       25.00         26.00       Total (line 5 plus line 25)       11,971,858       26.00         27.00       EHR       0       27.00         27.01       RESTRUCTURING EXPENSE       0       27.00         27.02       FUND RAISING ACTIVITIES       0       27.02         27.03       OTHER EXPENSES       2,767       27.03         28.00       Total other expenses (sum of line 27 and subscripts)       2,767       28.00	24.09		28,357	24.09
24.11       GAIN ON DISPOSAL OF ASSET       225       24.11         24.50       COVID-19 PHE Funding       0       24.50         25.00       Total other income (sum of lines 6-24)       2,423,833       25.00         26.00       Total (line 5 plus line 25)       11,971,858       26.00         27.00       EHR       0       27.00         27.01       RESTRUCTURING EXPENSE       0       27.00         27.02       FUND RAISING ACTIVITIES       0       27.02         27.03       OTHER EXPENSES       2,767       27.03         28.00       Total other expenses (sum of line 27 and subscripts)       2,767       28.00	24.10	ASSETS RELEASED FROM RESTRICTED FUND	204.411	24.10
24.50       COVID-19 PHE Funding       0       24.50         25.00       Total other income (sum of lines 6-24)       2,423,833       25.00         26.00       Total (line 5 plus line 25)       11,971,858       26.00         27.00       EHR       0       27.00         27.01       RESTRUCTURING EXPENSE       0       27.01         27.02       FUND RAISING ACTIVITIES       0       27.02         27.03       OTHER EXPENSES       2,767       27.03         28.00       Total other expenses (sum of line 27 and subscripts)       2,767       28.00	24.11			
25.00 Total other income (sum of lines 6-24) 26.00 Total (line 5 plus line 25) 27.00 EHR 27.01 RESTRUCTURING EXPENSE 27.02 FUND RAISING ACTIVITIES 27.03 OTHER EXPENSES 27.03 OTHER EXPENSES 28.00 Total other expenses (sum of line 27 and subscripts) 27.02 END Total other expenses (sum of line 27 and subscripts) 27.03 OTHER EXPENSES 27.03 OTHER EXPENSES 27.03 OTHER EXPENSES				
26.00       Total (line 5 plus line 25)       11,971,858   26.00         27.00       EHR       0   27.00         27.01       RESTRUCTURING EXPENSE       0   27.01         27.02       FUND RAISING ACTIVITIES       0   27.02         27.03       OTHER EXPENSES       2,767   27.03         28.00       Total other expenses (sum of line 27 and subscripts)       2,767   28.00			2.423.833	
27.00       EHR       0       27.00         27.01       RESTRUCTURING EXPENSE       0       27.01         27.02       FUND RAISING ACTIVITIES       0       27.02         27.03       OTHER EXPENSES       2,767       27.03         28.00       Total other expenses (sum of line 27 and subscripts)       2,767       28.00				
27.01       RESTRUCTURING EXPENSE       0       27.01         27.02       FUND RAISING ACTIVITIES       0       27.02         27.03       OTHER EXPENSES       2,767       27.03         28.00       Total other expenses (sum of line 27 and subscripts)       2,767       28.00				
27.02       FUND RAISING ACTIVITIES       0       27.02         27.03       OTHER EXPENSES       2,767       27.03         28.00       Total other expenses (sum of line 27 and subscripts)       2,767       28.00				
27.03       OTHER EXPENSES       2,767       27.03         28.00       Total other expenses (sum of line 27 and subscripts)       2,767       28.00				
28.00 Total other expenses (sum of line 27 and subscripts) 2,767 28.00				
29.00   Net Income (or 1088) for the period (inte 20 minus line 20)		Net income (or loss) for the period (line 26 minus line 28)	11,969,091	

usalah sinansial susama	ACCENCION CT. VING	TENT ANDERSON	<b>.</b>		) 
Health Financial Systems	ASCENSION ST. VINC			u of Form CMS-2	2552-IU
CALCULATION OF CAPITAL PAYMENT		Provider CCN: 15-0088	Period:	Worksheet L	
			From 07/01/2022		
			To 06/30/2023		pared:
				11/22/2023 10	:37 am
		Title XVIII	Hospital	PPS	
·					
				1.00	
PART I - FULLY PROSPECTIVE METHOD					
CAPITAL FEDERAL AMOUNT					
1.00 Capital DRG other than outlier				742,588	1.00
1.01   Model 4 BPCI Capital DRG other th	an outlier			0	1.01
2 00 Canital DRC outlier nayments				6 068	2 00

	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	742,588	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	6,068	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	66.74	3.00
4.00	Number of interns & residents (see instructions)	0.00	
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	7.14	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	31.69	8.00
9.00	Sum of lines 7 and 8	38.83	9.00
10.00	Allowable disproportionate share percentage (see instructions)	8.18	10.00
11.00	Disproportionate share adjustment (see instructions)	60,744	11.00
12.00	Total prospective capital payments (see instructions)	809,400	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
		1.00	
1 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS		1 00
1.00	Program inpatient capital costs (see instructions)	0	
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	
3.00	Net program inpatient capital costs (line 1 minus line 2)	0.00	
4.00	Applicable exception percentage (see instructions)	0.00	
5.00	Capital cost for comparison to payments (line 3 x line 4)	1	
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	1	
8.00	Capital minimum payment level (line 5 plus line 7)	0	
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	1 -0.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period	0	14.00

15.00 0 16.00 0 17.00

(if line 12 is negative, enter the amount on this line)

17.00 | Current year exception offset amount (see instructions)

15.00 Current year allowable operating and capital payment (see instructions)
16.00 Current year operating and capital costs (see instructions)