This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 03-31-2022 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-0088 Worksheet S Peri od: From 07/01/2021 Parts I-III AND SETTLEMENT SUMMARY 06/30/2022 Date/Time Prepared: 11/29/2022 8:09 am PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 11/29/2022 8: 09 am] Manually prepared cost report use only Ilf this is an amended report enter the number of times the provider resubmitted this cost report [Medicare Utilization. Enter "F" for full or "L" for low. [1] Cost Report Status
[1] As Submitted
[2] Settled without Audit
[3] Settled with Audit
[4] Date Received:
[5] To. NPR Date:
[6] 10. NPR Date:
[7] 11. Contractor's Vendor Code:
[7] 12. [8] Final Report for this Provider CCN
[9] [8] Final Report for this Provider CCN
[10] NPR Date:
[11] 12. Contractor's Vendor Code:
[11] 12. Contractor's Vendor Code:
[12] 13. NPR Date:
[13] 14. Contractor's Vendor Code:
[14] 15. Contractor's Vendor Code:
[15] 16. NPR Date:
[16] 17. Contractor's Vendor Code:
[17] 17. Contractor's Vendor Code:
[18] 18. Contractor's Vendor Code:
[18] 19. NPR Date:
[19] 19. NPR Date:
[19] 19. NPR Date:
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[16] 19. NPR Date:
[17] 19. NPR Date:
[18] 19. NPR Date:
[18] 19. NPR Date:
[18] 19. NPR Date:
[19] 19. NPR Date Contractor use only

number of times reopened = 0-9.

PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)

(3) Settled with Audit

(4) Reopened (5) Amended

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 ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and 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 07/01/2021 and ending 06/30/2022 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		
	1			SI GNATURE STATEMENT	
1	Beck	y Jacobson	, r	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	11/29/2022 08: 09: 35 AM			4

		Title	XVIII					
Cost Center Description	Title V	Part A	Part B	HIT	Title XIX			
	1.00	2.00	3. 00	4. 00	5. 00			
PART III - SETTLEMENT SUMMARY								
1.00 Hospi tal	0	790, 180	-151, 497	0	0	1. 00		
2.00 Subprovider - IPF	0	0	0		0	2. 00		
3.00 Subprovider - IRF	0	14, 013	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	804, 193	-151, 497	0	0	200. 00		
The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.								

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

Health Financial Systems ASCENSION ST. VINCENT ANDERSON In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0088 Peri od: Worksheet S-2 From 07/01/2021 Part I Date/Time Prepared: 06/30/2022 11/29/2022 8:09 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 2015 JACKSON STREET 1.00 PO Box: 1.00 State: IN 2.00 City: ANDERSON Zip Code: 46016 County 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N) Number Number Certi fi ed Type 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 07/01/1966 Ν Р 0 3.00 1 ANDERSON Subprovi der - IPF 4.00 4 00 5.00 Subprovider - IRF BENNETT REHAB CENTER 15T088 26900 5 06/01/1989 Ν Р 0 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF 7 00 7 00 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 10.00 Hospi tal -Based NF 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 14.00 14.00 Hospital-Based Health Clinic - RHC 15.00 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 20.00 Cost Reporting Period (mm/dd/yyyy) 07/01/2021 06/30/2022 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. Did this hospital receive interim uncompensated care payments for this 22.01 Ν Υ 22.01 cost reporting period? Enter in column 1, "Y" for yes or "N" for no 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)

Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) 22.02 22.02 N N 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. Did this hospital receive a geographic reclassification from urban to 22.04 Ν Ν Ν 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, yes or "N" for no. 23 00 Which method is used to determine Medicaid days on lines 24 and/or 25 23 00 3 N 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.

	V	XVIII	XI X	
	1.00	2. 00	3.00	
Prospective Payment System (PPS)-Capital				
Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	Y	N	45.
Us this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.
00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.
00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.
Teaching Hospitals				Ī
Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. 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. 15 If line 56 is yes, is this the first cost reporting period during which residents in approved	N			56.
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.				
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.				58
00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	l N			59

ITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION D	ATA	TA Provider CCN: 15-0088		Peri od: From 07/01/2021 To 06/30/2022	Worksheet S-2 Part I Date/Time Pre 11/29/2022 8:	epare
			NAHE 413.8 Y/N	5 Worksheet A Line #	Pass-Through Qualification Criterion Code	
O American and allied health advertise	(NAUE)		1. 00 Y	2.00	3. 00	(0
O Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413 instructions) Enter "Y" for yes or "N" for no in colis "Y", are you impacted by CR 11642 (or subsequent adjustement? Enter "Y" for yes or "N" for no in col	8.85? (s olumn 1. CR) NAHE	ee If column 1	Y	Y		60.
1 If line 60 is yes, complete columns 2 and 3 for each instructions)		. (see		23. 01	1	60.
, not detrons)	Y/N	IME	Direct GME	IME	Direct GME	
	1. 00	2. 00	3. 00	4.00	5. 00	
O Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in	N			0.00	0.00	61.
column 1. (see instructions) 1 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports						61.
ending and submitted before March 23, 2010. (see instructions) Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of						61.
ACA). (see instructions) 3 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see						61
<pre>instructions) 4 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period (see instructions).</pre>						61
5 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)	÷					61
6 Enter the amount of ACA \$5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61
	Pro	ogram Name	Program Coo	de Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
0 Of the FTEs in line 61.05, specify each new program		1. 00	2. 00	3.00	4.00) 61
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.					0.00	
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.	1			0. 00	0. 00	61
The second residence desired	'			<u> </u>	1.00	
ACA Provisions Affecting the Health Resources and Se	ervi ces A	ıdmi ni strati or	n (HRSA)		1.00	
O Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruction of Enter the number of FTE residents that rotated from	ıcti ons) a Teachi		nter (THC) int		0.00	

Heal th	Financial Systems	ASCENSI ON	ST. VINCENT ANDERSON		In Lie	u of Form CMS-2	2552-10
HOSPI TA	L AND HOSPITAL HEALTH CARE COMPI	EX IDENTIFICATION DA	TA Provi der CC		eriod: fom 07/01/2021 o 06/30/2022	Worksheet S-2 Part I Date/Time Pre 11/29/2022 8:0	pared: 09 am
				Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1. 00	2.00	3.00	
	Section 5504 of the ACA Base Yea			This base year	is your cost r	eporti ng	
64. 00 E i r s	period that begins on or after Jenter in column 1, if line 63 is not the base year period, the numbersident FTEs attributable to rosettings. Enter in column 2 the resident FTEs that trained in your (column 1 divided by (column)	yes, or your facilit ber of unweighted nor tations occurring in number of unweighted ur hospital. Enter ir	ry 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	Unwei ghted	Unwei ghted	Ratio (col. 3/	
				FTES	FTEs in	(col. 3 + col.	
				Nonprovi der Si te	Hospi tal	4))	
		1. 00	2.00	3. 00	4. 00	5.00	
i 5) 26 4 4 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7	Enter in column 1, if line 63 s yes, or your facility trained residents in the base year period, the program name associated with primary care effect for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of 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 column 4, the number of column 4 the number of column 4. The state 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	Unwei ghted FTEs Nonprovi der	Unwei ghted FTEs in Hospi tal		65. 00
				Si te			
le le	Soction EEOA of the ACA Comment	Voor ETE Doo! dont- !	Nonprovi dan Cattina	1.00	2.00	3. 00	
	Section 5504 of the ACA Current beginning on or after July 1, 20		n Nonprovider Setting	SEFFECTIVE TO	r cost reporti	ng periods	
66. 00 E	Enter in column 1 the number of TEs attributable to rotations of Enter in column 2 the number of TEs that trained in your hospit (column 1 divided by (column 1 +	unweighted non-primar ccurring in all nonpr unweighted non-primar al. Enter in column 3	rovider settings. Ty care resident B the ratio of	0.00	0. 00		
		Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3. 00	4. 00	5. 00	
r S S S S S S S S S	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)			0.00	0.00	0. 000000	67.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0088 Peri od: Worksheet S-2 From 07/01/2021 Part I Date/Time Prepared: 06/30/2022 11/29/2022 8:09 am 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS 70.00 70.00 | Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no. If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.

If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most 75.00 Υ 75.00 0 Ν Ν 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) 1.00 Long Term Care Hospital PPS 80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. N 80.00 81.00 | Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter N 81.00 'Y" for yes and "N" for no. TEFRA Providers Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. 85.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section 86.00 86.00 \$413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. 87.00 N XIX 1. 00 2.00 Title V and XIX Services 90.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for Ν Υ 90.00 yes or "N" for no in the applicable column. 91.00 Is this hospital reimbursed for title V and/or XIX through the cost report either in Ν Υ 91.00 full or in part? Enter "Y" for yes or "N" for no in the applicable column. 92.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column. N 92.00 93.00 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter Ν Ν 93.00 Y" for yes or "N" for no in the applicable column. 94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the N N 94.00 applicable column. 95 00 If line 94 is "Y", enter the reduction percentage in the applicable column. 0 00 0 00 95 00 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the 96.00 Ν N 97.00 If line 96 is "Y", enter the reduction percentage in the applicable column. 0.00 0.00 97.00 98.00 Does title V or XIX follow Medicare (title XVIII) for the interns and residents post 98.00 N stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.01 Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. Ν 98.01 C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.02 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 Υ 98.02 Ν for title V, and in column 2 for title XIX. 98.03 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) Ν 98.03 Ν reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of N 98.04 Ν outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on 98.05 Ν Υ Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Υ 98.06 Ν Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Rural Providers 105.00 Does this hospital qualify as a CAH? Ν 105.00 106.00 If this facility qualifies as a CAH, has it elected the all-inclusive method of payment N 106.00 for outpatient services? (see instructions) 107.00 Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) 107.00 Ν Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)

Health Financial Systems ASCENSION ST. VI HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	NCENT ANDERSON Provider C	CN: 15-0088 P	eri od:	u of Form CMS Worksheet S-	
			rom 07/01/2021 o 06/30/2022	Part I Date/Time Pr	
			V	11/29/2022 8 XI X	: 09 am
108.00 is this a rural hospital qualifying for an exception to the	CRNA fee sche	dul e? See 42	1. 00 N	2.00	108. 00
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.				D	
	Physi cal 1.00	0ccupati onal 2.00	Speech 3.00	Respi ratory 4.00	-
109.00 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	109.00
110 00 Did this best the graticists in the Dural Committee Hearth	-1 D		104	1.00	110.00
110.00 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 Worapplicable.	"Y" for yes or	"N" for no. I	f yes,	N	110.00
			1.00	2.00	-
111.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this country for yes or "N" for no in column 1. If the response to continuous integration prong of the FCHIP demo in which this CAH is participated in the control of the co	ost reporting polumn 1 is Y, or rticipating in	period? Enter enter the column 2.	N		111.00
		1.00	2. 00	3.00	+
112.00 Did this hospital participate in the Pennsylvania Rural Heal demonstration for any portion of the current cost reporting Enter "Y" for yes or "N" for no in column 1. If column 1 in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceaparticipation in the demonstration, if applicable.	period? s "Y", enter he	N			112.00
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or	r "N" for no	l N			 0115.00
in column 1. If column 1 is yes, enter the method used (A, I in column 2. If column 2 is "E", enter in column 3 either "for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provide	B, or E only) 93" percent (includes				
the definition in CMS Pub. 15-1, chapter 22, §2208.1. 116.00 Is this facility classified as a referral center? Enter "Y" "N" for no.	,	N			116. 00
117.00 Is this facility legally-required to carry malpractice insular. "Y" for yes or "N" for no.	rance? Enter	Y			117. 00
118.00 s the malpractice insurance a claims-made or occurrence polif the policy is claim-made. Enter 2 if the policy is occurrence.	,	2	2		118. 00
		Premi ums	Losses	Insurance	
		1.00	2.00	3. 00	_
118.01 List amounts of malpractice premiums and paid losses:			0		4 118. 01
			1. 00	2.00	
118.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting schemand amounts contained therein.			N		118. 02
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies provision in ACA §3121 and applicable amendments?	N	N	119. 00		
Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost impla	antable device	s charged to	Υ		121. 00
patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain healthcare related taxes as de Act?Enter "Y" for yes or "N" for no in column 1. If column the Worksheet A line number where these taxes are included.	Y	5.00	122. 00		
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for	or yes and "N"	for no. If	N		125. 00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 f this is a Medicare certified kidney transplant center, en	,				126. 00
in column 1 and termination date, if applicable, in column 1 127.00 If this is a Medicare certified heart transplant center, en	2.				127. 00
in column 1 and termination date, if applicable, in column :	2.				
128.00 f this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column 3	2.				128. 00
129.00 If this is a Medicare certified lung transplant center, ento column 1 and termination date, if applicable, in column 2.	er the certifi	cation date in			129. 00
130.00 If this is a Medicare certified pancreas transplant center,	enter the cer	tification			130.00

Health Financial Systems	ASCENSION ST. \	/INCENT ANDERSON		In Lie	eu of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DATA	Provi der CCI		Peri od:	Worksheet S-	2
				From 07/01/2021 To 06/30/2022		epared:
					11/29/2022 8	8: 09 am
				1. 00	2.00	+
131.00 If this is a Medicare certified int	estinal transplant cent	er, enter the ce	rti fi cati on			131. 00
date in column 1 and termination da			aatian data			122.00
132.00 If this is a Medicare certified isl in column 1 and termination date, i			cation date			132. 00
133.00 Removed and reserved						133. 00
134.00 If this is an organ procurement org		the OPO number i	n column 1			134. 00
and termination date, if applicable All Providers	, In column 2.					
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						
are claimed, enter in column 2 the		. 00	i ons)	3. 00		
If this facility is part of a chain			gh 143 the n		of the	
home office and enter the home offi						
141.00 Name: ST VINCENT HEALTH 142.00 Street: 250 WEST 96TH STREET, SUITE	Contractor's Name:	WPS	Contracto	or's Number: 0810	01	141. 00
2058	FO BOX.					142.00
143.00 Ci ty: INDIANAPOLIS	State:	I N	Zip Code:	462	60	143. 00
					1.00	4
144.00 Are provider based physicians' cost	s included in Worksheet	A?			1. 00 Y	144. 00
				1. 00	2.00	
145.00 If costs for renal services are cla inpatient services only? Enter "Y"						145. 00
no, does the dialysis facility incl						
period? Enter "Y" for yes or "N" f			. 3			
146.00 Has the cost allocation methodology				N		146. 00
Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/dd		15-2, Chapter 4	0, 94020) 11			
у се де се	. , , , , , , , , , , , , , , , , , , ,			_		
	1 1 2 5 1 11/11 6	"11"			1.00	1.17.00
147.00 Was there a change in the statistic 148.00 Was there a change in the order of					N N	147. 00
149.00 Was there a change to the simplifie				no.	N	149. 00
-		Part A	Part B	Title V	Title XIX	
Does this facility contain a provid	or that qualifies for a	1.00	2.00	3.00	4.00	
or charges? Enter "Y" for yes or "N						
155. 00 Hospi tal		N	N	N	N	155. 00
156.00 Subprovi der - IPF		N	N	N	N	156. 00
157. 00 Subprovi der - I RF 158. 00 SUBPROVI DER		N	N	N	N	157. 00 158. 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	
Mul ti campus						
165.00 Is this hospital part of a Multicam	pus hospital that has o	one or more campu	ses in diffe	rent CBSAs?	N	165. 00
Enter "Y" for yes or "N" for no.	Name	County	State Zij	code CBSA	FTE/Campus	
	0	1. 00		3. 00 4. 00	5.00	
166.00 If line 165 is yes, for each					0.0	00 166. 00
campus enter the name in column O, county in column 1, state in						
column 2, zip code in column 3,						
CBSA in column 4, FTE/Campus in						
column 5 (see instructions)						
					1.00	
Health Information Technology (HIT)				t Act		
167.00 s this provider a meaningful user					Y	167. 00
168.00 If this provider is a CAH (line 105 reasonable cost incurred for the HI			16/ is "Y"),	enter the		168. 00
168. 01 If this provider is a CAH and is no			qualify for	a hardship		168. 01
exception under §413.70(a)(6)(ii)?	Enter "Y" for yes or "N	√l" for no. (see i	nstructions)	·		
169.00 If this provider is a meaningful us transition factor. (see instruction		nd is not a CAH (line 105 is '	'N"), enter the	9. 9	99169.00
Transition ractor, (See This Huction	رد				1	1

Health Financial Systems	In Lieu of Form CMS-2552-10				
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	DENTIFICATION DATA	Peri od: From 07/01/2021	Worksheet S-2 Part I		
				Date/Time Pre 11/29/2022 8:	
			Begi nni ng	Endi ng	
			1. 00	2. 00	
170.00 Enter in columns 1 and 2 the EHR beg period respectively (mm/dd/yyyy)			170. 00		
			1. 00	2.00	
171.00 If line 167 is "Y", does this provid	er have any days for	individuals enrolled in	N	0	171. 00
section 1876 Medicare cost plans rep					
"Y" for yes and "N" for no in column	1. If column 1 is ye	es, enter the number of section	n		
1876 Medicare days in column 2. (see	instructions)				

OSPI T	Financial Systems ASCENSION ST. VI AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CN: 15-0088	Peri od: From 07/01/2021 To 06/30/2022		2 epared:
				Y/N	Date	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	l for all NO re	esponses. Ent	1.00 er all dates in	2.00 the	
	Provider Organization and Operation					
00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in a	e beginning of	the cost	N		1.0
	reporting period: IT yes, enter the date of the change in c	2. (300	Y/N	Date	V/I	
			1.00	2. 00	3. 00	
.00	Has the provider terminated participation in the Medicare F yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.	nn 3, "V" for	N Y			2.0
. 00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)					3.0
			Y/N	Туре	Date	
	Financial Data and Darents		1.00	2. 00	3. 00	
00	Financial Data and Reports Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" f or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	for Compiled,	Y	A		4.0
00	Are the cost report total expenses and total revenues differ those on the filed financial statements? If yes, submit rec		N			5. 0
		Legal Oper. 2.00				
00	Approved Educational Activities Column 1: Are costs claimed for a nursing program? Column	2. If yes is	s the provide	r N	I	6.0
00	is the legal operator of the program?	2. IT yes, Is	s the provide	I IN		0.0
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.	e Y		7. 0 8. 0		
00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction		cal education	N		9. 0
0. 00	was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.		the current	N		10. 0
1. 00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	oroved	N)/ (N	11. C
					1. 00	
	Bad Debts					
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.			ost reporting	Y N	12. 0
4. 00	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	ents waived? If	fyes, see in	structions.	N	14.0
5. 00	Did total beds available change from the prior cost reporti				N	15.0
		Y/N	rt A Date	Y/N	t B Date	
		1.00	2.00	3. 00	4. 00	
5. 00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through	Y	10/06/2022	Y	10/06/2022	16.0
7. 00	date of the PS&R Report used in columns 2 and 4 (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If	N		N		17. 0
3. 00	either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R	N		N		18. 0
9. 00	Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R	N		N		19.0
,. 00	Report data for corrections of other PS&R Report	"		IN		17.0

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	^NI- 15 AAOO						
	Fr Tc				Peri od: From 07/01/2021 To 06/30/2022	Worksheet S- Part II Date/Time Pr 11/29/2022 8	epared:	
		pti on	Y/N	Y/N				
20.00 If line 16 or 17 is yes, were adjustments made to PS&R)	1. 00 N	3. 00 N	20.00			
Report data for Other? Describe the other adjustments:			IN	IV	20.00			
	Y/N	Date	Y/N	Date				
	1.00	2.00	3. 00	4. 00				
21.00 Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00			
				1. 00				
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT	T CHILDRENS H	OSPI TALS)						
Capital Related Cost								
22.00 Have assets been relifed for Medicare purposes? If yes, see i				N	22. 00			
23.00 Have changes occurred in the Medicare depreciation expense dureporting period? If yes, see instructions.	ue to apprais	als made dur	ing the cost	N	23. 00			
24.00 Were new leases and/or amendments to existing leases entered lf yes, see instructions	into during	this cost re	porting period?	N	24. 00			
25.00 Have there been new capitalized leases entered into during the instructions.	he cost repor	ting period?	If yes, see	N	25. 00			
26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the instructions.	cost reporti	ng period? I	f yes, see	N	26. 00			
27.00 Has the provider's capitalization policy changed during the copy.	cost reportir	g period? If	yes, submit	N	27. 00			
Interest Expense 28.00 Were new loans, mortgage agreements or letters of credit enterests.	orod into dur	ing the cost	roporting	N	28. 00			
period? If yes, see instructions. 29.00 Did the provider have a funded depreciation account and/or bo		3	. 3	N	29. 00			
treated as a funded depreciation account? If yes, see instruc	ctions		ŕ					
30.00 Has existing debt been replaced prior to its scheduled maturi instructions.	•			N N	30.00			
31.00 Has debt been recalled before scheduled maturity without issuinstructions. Purchased Services	instructions.							
32.00 Have changes or new agreements occurred in patient care servi arrangements with suppliers of services? If yes, see instruct		d through co	ntractual	N	32. 00			
33.00 If line 32 is yes, were the requirements of Sec. 2135.2 appli no, see instructions.		g to competi	tive bidding? If	N	33. 00			
Provi der-Based Physi ci ans								
34.00 Are services furnished at the provider facility under an arra	angement with	provi der-ba	sed physicians?	Υ	34. 00			
If yes, see instructions. 35.00 If line 34 is yes, were there new agreements or amended exist		ts with the	provi der-based	N	35. 00			
physicians during the cost reporting period? If yes, see inst	tructions.		Y/N	Date				
			1. 00	2. 00				
Home Office Costs								
36.00 Were home office costs claimed on the cost report?			Y		36. 00			
37.00 If line 36 is yes, has a home office cost statement been prep	pared by the	home office?	Υ		37. 00			
If yes, see instructions. 38.00 If line 36 is yes, was the fiscal year end of the home office.			N		38. 00			
the provider? If yes, enter in column 2 the fiscal year end of 39.00 If line 36 is yes, did the provider render services to other			, N		39. 00			
40.00 If line 36 is yes, did the provider render services to the ho								
i nstructi ons.								
	1	00	2.	00				
Cost Report Preparer Contact Information								
41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	t name, last name and the title/position KATHY ZAMBOS							
. , , , , , , , , , , , , , , , , , , ,	T VINCENT HEA	LTH			42. 00			
preparer. 43.00 Enter the telephone number and email address of the cost NA	Δ		KATHY. ZAMBOS@A	SCENSION ODG	43.00			
report preparer in columns 1 and 2, respectively.	ri.		INATITI. ZAMIDUSWA	JOLINOT ON. UNU	43.00			

Heal th	Financial Systems ASCENS	ON ST.	VINCE	ENT ANDERSON		In Lie	u of Form CMS-	2552-10
H0SPI	TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTION	NAI RE		Provider CCN:	15-0088	Peri od:	Worksheet S-2	
						From 07/01/2021 To 06/30/2022	Part II Date/Time Pre 11/29/2022 8:	pared: 09 am
				3. 00				
	Cost Report Preparer Contact Information							
41.00	Enter the first name, last name and the title/pos	ition	LE/	AD ANALYST				41.00
	held by the cost report preparer in columns 1, 2,	and 3,						
	respecti vel y.							
42.00	Enter the employer/company name of the cost repor	t						42.00
	preparer.							
43.00	Enter the telephone number and email address of t	he cost	1					43.00
	report preparer in columns 1 and 2, respectively.							

| Period: | Worksheet S-3 | From 07/01/2021 | Part | To 06/30/2022 | Date/Time Prepared:
 Heal th Financial
 Systems
 ASCENSION

 HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX
 STATISTICAL DATA
 Provi der CCN: 15-0088

						To 06/30/202	2 Date/Time Pr 11/29/2022 8	
							I/P Days / 0/	
							Visits / Trip	
	Component	Worksheet A	No.	of Beds	Bed Days	CAH Hours	Title V	
		Line Number			Avai I abl e			
		1.00		2.00	3.00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		123	44, 89	5 0.0	00	1.00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)		ļ.					
2.00	HMO and other (see instructions)		l					2. 00
3. 00	HMO I PF Subprovi der							3. 00
4.00	HMO IRF Subprovider							4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						•	5.00
6.00	Hospital Adults & Peds. Swing Bed NF			400		_		6.00
7.00	Total Adults and Peds. (exclude observation			123	44, 89	5 0.0	00	7. 00
0.00	beds) (see instructions)	24 00		21	7 //	_	10	8.00
8.00	INTENSIVE CARE UNIT	31. 00	'	21	7, 66	5 0.0		
9.00	CORONARY CARE UNIT							9.00
10.00	BURN INTENSIVE CARE UNIT							10.00
11. 00 12. 00	SURGICAL INTENSIVE CARE UNIT		ŀ					11.00
12.00	OTHER SPECIAL CARE (SPECIFY) NURSERY	43. 00	J					12.00
14. 00	Total (see instructions)	43.00	1	144	52, 56	0.0		0 14.00
15. 00	CAH visits		ŀ	144	32, 30	0.0	- 1	0 15.00
16. 00	SUBPROVIDER - IPF		ŀ				'	16.00
17. 00	SUBPROVIDER - I RF	41. 00	J	13	4, 74	5		17.00
18. 00	SUBPROVI DER	41.00	Ί	13	4, 74	3	'	18.00
19. 00	SKILLED NURSING FACILITY		ŀ					19.00
20. 00	NURSING FACILITY		ŀ					20.00
21. 00	OTHER LONG TERM CARE		ŀ					21.00
22. 00	HOME HEALTH AGENCY		i					22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)		ŀ					23. 00
24. 00	HOSPI CE		ŀ					24. 00
24. 10	HOSPICE (non-distinct part)	30. 00	ا					24. 10
25. 00	CMHC - CMHC		Ì					25. 00
26. 00	RURAL HEALTH CLINIC		İ					26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00						26. 25
27.00	Total (sum of lines 14-26)		İ	157				27. 00
28.00	Observation Bed Days							28. 00
29.00	Ambul ance Tri ps							29. 00
30.00	Employee discount days (see instruction)							30. 00
31.00	Employee discount days - IRF							31. 00
32.00	Labor & delivery days (see instructions)			0		0		32. 00
32. 01	Total ancillary labor & delivery room							32. 01
	outpatient days (see instructions)							
33. 00	LTCH non-covered days							33. 00
33. 01	LTCH site neutral days and discharges							33. 01

| In Lieu of Form CMS-2552-10 | Period: | Worksheet S-3 | From 07/01/2021 | Part I | To 06/30/2022 | Date/Time Prepared: | 11/29/2022 8: 09 am Health Financial Systems ASCENSION HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA ASCENSION ST. VINCENT ANDERSON Provider CCN: 15-0088

					1	11/29/2022 8:	09 am
		I/P Days	/ O/P Visits	/ Trips	Full Time I	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6. 00	7. 00	8. 00	9. 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	3, 638	985	22, 776			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, 028	7, 483				2.00
3.00	HMO I PF Subprovi der	(12	0				3.00
4.00	HMO IRF Subprovider	613	464 0	,			4.00
5. 00 6. 00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF	٩	0				5. 00 6. 00
7. 00	Total Adults and Peds. (exclude observation	3, 638	985				7.00
7.00	beds) (see instructions)	3,030	703	22, 170			7.00
8.00	INTENSIVE CARE UNIT	3, 281	198	5, 098			8. 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		553	674			13. 00
14.00	Total (see instructions)	6, 919	1, 736	28, 548	0.00	510. 42	14. 00
15. 00	CAH visits	0	0	C			15. 00
16. 00	SUBPROVIDER - IPF						16. 00
17. 00	SUBPROVI DER - I RF	835	67	2, 221	0.00	12. 86	1
18.00	SUBPROVI DER						18.00
19. 00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21. 00 22. 00	OTHER LONG TERM CARE HOME HEALTH AGENCY						21. 00 22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24. 00	HOSPICE						24. 00
24. 10	HOSPICE (non-distinct part)			222			24. 10
25. 00	CMHC - CMHC						25. 00
26.00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	o	0	C	0.00	0.00	26. 25
27.00	Total (sum of lines 14-26)				0.00	523. 28	27. 00
28. 00	Observation Bed Days		0	1, 570			28. 00
29. 00	Ambul ance Tri ps	0					29. 00
30. 00	Employee discount days (see instruction)			124			30. 00
31. 00	Employee discount days - IRF			27			31. 00
32. 00	Labor & delivery days (see instructions)	0	9	119			32. 00
32. 01	Total ancillary labor & delivery room			C			32. 01
22 00	outpatient days (see instructions)						33. 00
33.00	LTCH non-covered days LTCH site neutral days and discharges	0					33.00
33.01	TETOTI SI LE HEULT di Udys anu ui schal ges	ı 의	l	I	I	I	33.01

 Heal th Financial
 Systems
 ASCENSION

 HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX
 STATISTICAL DATA

Provider CCN: 15-0088

| Peri od: | Worksheet S-3 | From 07/01/2021 | Part I | Date/Time Prepared: |

					00/30/2022	11/29/2022 8:	
		Full Time	<u> </u>	Di sch	arges		
		Equi val ents			_		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12. 00	13. 00	14. 00	15. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)		0	1, 214	212	5, 258	1.00
2.00	HMO and other (see instructions)			1, 046	1, 703		2. 00
3.00	HMO IPF Subprovider				o		3.00
4.00	HMO IRF Subprovider				36		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7. 00	Total Adults and Peds. (exclude observation beds) (see instructions)						7. 00
8.00	INTENSIVE CARE UNIT						8. 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						13. 00
14.00	Total (see instructions)	0.00	0	1, 214	212	5, 258	14. 00
15.00	CAH visits						15. 00
16.00	SUBPROVI DER - I PF						16. 00
17.00	SUBPROVI DER - I RF	0.00	0	74	4	178	17. 00
18.00	SUBPROVI DER						18. 00
19.00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20. 00
21.00	OTHER LONG TERM CARE						21. 00
22.00	HOME HEALTH AGENCY						22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)						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	Ambul ance Tri ps						29. 00
30.00	Employee discount days (see instruction)						30. 00
31.00	Employee discount days - IRF						31. 00
32.00	Labor & delivery days (see instructions)						32. 00
32. 01	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

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION

Provi der CCN: 15-0088

In Lieu of Form CMS-2552-10

Period: Worksheet S-3
From 07/01/2021 Part II
To 06/30/2022 Date/Time Prepared:
11/29/2022 8:09 am

Multiple Reported Corporation Salaries Corporation Corporati							06/30/2022	11/29/2022 8:	
NART II - WAGE DATA					on of Salaries	Sal ari es	Related to	Average Hourly Wage (col. 4 ÷ col. 5)	
Note Part			1 00	2.00				/ 00	
SALABLES		PART II - WAGE DATA	1.00	2.00	3.00	4.00	5. 00	6.00	
Instructions									
2.00 Non-physic cian anesthetist Part	1.00	`	200. 00	49, 275, 651	-104, 750	49, 170, 901	1, 162, 572. 62	42. 29	1. 00
Non-physician anaesthetist Part 0 0 0 0 0 0 0 0 0	2.00	Non-physician anesthetist Part		0	С	0	0. 00	0. 00	2. 00
Admin In Strative 4.0 Physicians - Part A - Teaching 5.00 Physician and Mon Physician and Mon Physician and Mon Physician and Mon Physician and Mon Physician and Mon Physician and Mon Physician and Mon Physician and Mon Physician and Mon Physician and Mon Physician and Mon Physician and Mon Physician and Mon Physician and Mon Physician and Mon Physician Part B B For Responsible Assess MRC and FOHC Responsible A	3.00			0	О	0	0. 00	0. 00	3. 00
Physician and Non	4. 00			78, 887	a	78, 887	443. 81	177. 75	4. 00
Non-physician-Part B for hospital-based RHC and FORC services 1.00 0.00		Physician and Non			1	1			
7.01 Interns & residents (in an approved program) 7.01 Contracted interns and residents (in an approved program) 8.00 Home Office and/or related organization personnel programs) 8.00 Home Office and/or related organization personnel 9.00 SNF 10.00 Excluded area salaries (see 144.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	6. 00	Non-physician-Part B for hospital-based RHC and FQHC		0	C	0	0.00	0.00	6. 00
7.01 Contracted interns and residents (in an approved programs) 8.00 Home office and/or related programs) 8.00 Home office and/or related programs (see and/or related programs) 9.00 SNF (see and/or related programs) 9.00 SNF (see and/or related programs) 9.00 SNF (see and/or related programs) 9.00 SNF (see and/or related programs) 9.00 SNF (see and/or related programs) 9.00 SNF (see and/or related programs) 9.01 Excluded area salaries (see and/or related programs) 9.01 Excluded area salaries (see and/or related programs) 9.01 Excluded area salaries (see and/or related programs) 9.01 Excluded area salaries (see and/or related programs) 9.02 SNF (see and/or related programs) 9.02 SNF (see and/or related programs) 9.02 Contract labor: Physician-Part programs (see and/or related programs) 11.00 Contract labor: Physician-Part programs (see and/or related programs) 12.00 Contract labor: Physician-Part programs (see and/or related programs) 13.00 Contract labor: Physician-Part programs (see and/or related programs) 14.01 Home office and/or related programs (see and/or related programs) 14.01 Home office and/or related programs (see and/or related programs) 14.02 Related organization salaries (see and/or programs) 14.03 Related organization salaries (see and/or programs) 16.00 Home office and/or related programs (see and/or programs) 17.00 Mage-related costs (see and/or programs) 18.00 Mage-related costs (other) 18.00 Mage-related costs (see and/or programs) 18.00 M	7. 00	Interns & residents (in an	21. 00	0	О	o	0. 00	0.00	7. 00
Home office and/or related or pressoned of pressoned or again zation personnel of the pressoned of the pre	7. 01	Contracted interns and residents (in an approved		0	С	0	0.00	0.00	7. 01
10.00 Excluded area salaries (see 5, 204, 349 129, 531 5, 333, 880 116, 427, 79 45.8	8.00	Home office and/or related		16, 540	C	16, 540	1, 002. 68	16. 50	8. 00
OTHER WAGES & RELATED COSTS		Excluded area salaries (see	44. 00	0 5, 204, 349	129, 531	0 5, 333, 880			
11.00 Contract labor: Direct Patient									
management and other management and administrative services	11. 00	Contract labor: Direct Patient		9, 340, 240	C	9, 340, 240	202, 429. 84	46. 14	11. 00
13.00 Contract labor: Physician-Part A - Administrative A - Admi	12. 00	management and other management and administrative		0	О	0	0. 00	0.00	12. 00
14.00 Home office and/or related organization salaries and wage-related costs 14.01 Home office salaries 10,222,774 0 10,222,774 202,821.99 50.4 14.02 Related organization salaries 0 0 0 0 0.00 0.5 15.00 Home office: Physician Part A 0 0 0 0 0 0.00 0.6 16.00 Home office and Contract 0 0 0 0 0 0 0.00 0.6 16.01 Home office organization Part A 0 0 0 0 0 0 0.00 0.6 16.01 Home office organization Part A 0 0 0 0 0 0 0.00 0.6 16.01 Home office contract 0 0 0 0 0 0 0.00 0.6 16.01 Home office contract 0 0 0 0 0 0.00 0.6 16.01 Home office contract 0 0 0 0 0 0.00 0.6 16.01 Home office contract 0 0 0 0 0 0.00 0.6 16.01 Home office contract 0 0 0 0 0 0.00 0.6 16.01 Home office contract 0 0 0 0 0 0.00 0.6 16.01 Home office contract 0 0 0 0 0 0.00 0.6 16.02 Home office contract 0 0 0 0 0 0 0 0 16.03 Home office contract 0 0 0 0 0 0 0 0 0	13. 00	Contract Labor: Physician-Part		1, 428, 729	d	1, 428, 729	18, 131. 58	78. 80	13. 00
14. 01 Home office sal aries 10, 222, 774 0 10, 222, 774 202, 821, 99 50. 4 14. 02 Related organization salaries 0 0 0 0.00 0.00 15. 00 Home office: Physician Part A - Administrative 0 0 0 0 0.00 0.00 16. 00 Home office and Contract Physicians Part A - Teaching 0 0 0 0 0.00 0.00 16. 01 Home office contract Physicians Part A - Teaching 0 0 0 0 0.00 0.00 16. 02 Home office contract Physicians Part A - Teaching 0 0 0 0 0.00 0.00 17. 00 Wage-related costs (core) (see instructions) 14,577,619 0 14,577,619 0 18. 00 Wage-related costs (other) (see instructions) 1,574,456 0 0 0 0 19. 00 Excluded areas 1,574,456 0 1,574,456 0 0 0 20. 00 Non-physician anesthetist Part A Administrative 0 0 0 0 0 22. 01 Physician Part A - Teaching Physician Part B O O O O O O O O O O O O O O O O O O	14. 00	Home office and/or related organization salaries and		0	С	0	0.00	0.00	14. 00
14. 02 Rel ated organization sal aries 0 0 0 0.00 0.00 15. 00 Home office: Physician Part A - Admin istrative 0 0 0 0.00 0.00 16. 00 Home office and Contract Physicians Part A - Teaching 0 0 0 0 0.00 0.00 16. 01 Home office contract Physicians Part A - Teaching 0 0 0 0 0.00 <td>14. 01</td> <td></td> <td></td> <td>10, 222, 774</td> <td></td> <td>10, 222, 774</td> <td>202, 821, 99</td> <td>50. 40</td> <td>14. 01</td>	14. 01			10, 222, 774		10, 222, 774	202, 821, 99	50. 40	14. 01
- Administrative Home office and Contract Physicians Part A - Teaching Home office Physicians Part A - Teaching Home office Contract Physicians Part A - Teaching Home office Contract Physicians Part A - Teaching WAGE-RELATED COSTS 17.00 Wage-related costs (core) (see instructions) 18.00 Wage-related costs (other) (see instructions) 19.00 Excluded areas 1,574,456 0,00 Non-physician anesthetist Part A Non-physician anesthetist Part B 22.00 Physician Part A - Teaching 0,711 O,721 O,732 O,733 O,734 O,734 O,735 O,7	14. 02	Related organization salaries				1	0.00	0.00	14. 02
16.00 Home office and Contract 0 0 0 0 0 0 0 0 0	15. 00			0	0	0	0. 00	0. 00	15. 00
16. 01 Home office Physicians Part A 0 0 0 0.0	16. 00			0	C	0	0.00	0. 00	16. 00
16.02 Home office contract Physicians Part A - Teaching MAGE-RELATED COSTS	16. 01			0	C	0	0.00	0. 00	16. 01
Physicians Part A - Teaching WAGE-RELATED COSTS	16 02			0			0.00	0.00	16. 02
17. 00 Wage-rel ated costs (core) (see instructions) 18. 00 Wage-rel ated costs (other) (see instructions) 19. 00 Excluded areas 20. 00 Non-physician anesthetist Part	10. 02	Physicians Part A - Teaching				<u></u>	0.00	0.00	10.02
18.00 Wage-related costs (other) (see instructions) 1,574,456 0 1,574,456 0 1,574,456 0 0 0 0 0 0 0 0 0	17. 00	Wage-related costs (core) (see		14, 577, 619	О	14, 577, 619			17. 00
19. 00 Excluded areas 20. 00 Non-physician anesthetist Part A 21. 00 Non-physician anesthetist Part B 22. 00 Physician Part A - Administrative 22. 01 Physician Part B 24. 00 Wage-related costs (RHC/FOHC) 25. 50 Home office wage-related 1, 574, 456 0 0 1, 574, 456 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	18. 00	Wage-related costs (other)							18. 00
A Non-physician anesthetist Part B		Excluded areas		1, 574, 456	0	1, 574, 456			19. 00
B 22.00 Physician Part A - Administrative 22.01 Physician Part A - Teaching 23.00 Physician Part B 0 0 0 0 24.00 Wage-related costs (RHC/FQHC) 0 Interns & residents (in an approved program) 25.50 Home office wage-related 3,918,003 0 9,171 0 0 0 0 0 0 0 0 0 3,918,003		Α		0	0	0			20. 00
Administrative 22.01 Physician Part A - Teaching 23.00 Physician Part B 0 0 0 24.00 Wage-related costs (RHC/FQHC) 25.00 Interns & residents (in an approved program) 25.50 Home office wage-related 3,918,003 0 3,918,003		В		_					21.00
23.00 Physician Part B 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		Admi ni strati ve							22. 00
24.00 Wage-related costs (RHC/FQHC) 0 0 0 25.00 Interns & residents (in an approved program) 0 0 0 25.50 Home office wage-related 3,918,003 0 3,918,003		,		0		0			22. 01 23. 00
25. 50 Home office wage-related 3,918,003 0 3,918,003	24. 00	Wage-related costs (RHC/FQHC) Interns & residents (in an		-		0 0			24. 00 25. 00
	25. 50	Home office wage-related		3, 918, 003	d	3, 918, 003			25. 50
25. 51 Related organization 0 0 0	25. 51			0	О	o			25. 51
wage-related (core) 25.52 Home office: Physician Part A	25. 52	Home office: Physician Part A - Administrative -		0	O	0			25. 52

In Lieu of Form CMS-2552-10
Worksheet S-3
Part II
30/2022 Date/Time Prepared:
11/29/2022 8: 09 am
Hours Average Hourly Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION ASCENSION ST. VINCENT ANDERSON Provider CCN: 15-0088 Peri od: From 07/01/2021 To 06/30/2022 Wkst Aline Amount Reclassificati Adjusted Paid Hours

		Wkst. A Line		Reclassi fi cati			Average Hourly	
		Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± 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	410, 102	-391, 041	19, 061	439. 33	43. 39	26. 00
27.00	Administrative & General	5. 00	1, 981, 081	-347, 974	1, 633, 107	48, 877. 59	33. 41	27. 00
28. 00	Administrative & General under		2, 625, 359	0	2, 625, 359	40, 483. 17	64. 85	28. 00
	contract (see inst.)							
29.00	Maintenance & Repairs	6. 00	0	0	0	0.00	0.00	29. 00
30.00	Operation of Plant	7. 00	0	0	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	8. 00	0	0	0	0.00	0.00	31.00
32.00	Housekeepi ng	9. 00	241	2	243	0.00	0.00	32.00
33.00	Housekeeping under contract		2, 360, 992	0	2, 360, 992	88, 021. 75	26. 82	33.00
	(see instructions)							
34.00	Di etary	10.00	0	0	0	0.00	0.00	34.00
35.00	Di etary under contract (see		778, 551	0	778, 551	25, 712. 00	30. 28	35.00
	instructions)							
36.00	Cafeteri a	11. 00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12. 00	0	0	0	0.00	0.00	37.00
38. 00	Nursing Administration	13. 00	1, 730, 159	55, 836	1, 785, 995	40, 591. 24	44.00	38.00
39.00	Central Services and Supply	14. 00	439, 693	1, 594			23. 39	39. 00
40.00	Pharmacy	15. 00	3, 005, 189	28, 159	3, 033, 348	61, 898. 09	49. 01	40.00
41.00	Medical Records & Medical	16. 00	0	0	0	0.00	0.00	41.00
	Records Library							
42.00	Social Service	17. 00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18. 00	0	0	0	0.00	0.00	43.00
	•	. '		•	. '			

Total overhead cost (see

instructions)

7.00

39. 02

7.00

HOSPITAL WAGE INDEX INFORMATION Worksheet S-3 Part III Date/Time Prepared: Provi der CCN: 15-0088 Peri od: From 07/01/2021 To 06/30/2022 11/29/2022 8:09 am Worksheet A Amount Recl assi fi cati Adj usted Pai d Hours Average Hourly Line Number Reported on of Salaries Sal ari es Related to Wage (col. 4 (col . 2 ± col . col. 5) Salaries in (from Works<u>heet A-6)</u> 3) col. 4 1.00 5.00 6.00 2.00 3.00 4.00 PART III - HOSPITAL WAGE INDEX SUMMARY 1.00 Net salaries (see 55, 024, 013 -104, 750 54, 919, 263 1, 315, 786. 86 1.00 41.74 instructions) 2.00 5, 204, 349 129, 531 5, 333, 880 116, 427. 79 45.81 2.00 Excluded area salaries (see instructions) 3.00 Subtotal salaries (line 1 49, 819, 664 -234, 281 49, 585, 383 1, 199, 359. 07 41.34 3.00 minus line 2) 4.00 Subtotal other wages & related 20, 991, 743 20, 991, 743 423, 383. 41 49. 58 4.00 costs (see inst.) Subtotal wage-related costs 5.00 18, 504, 793 C 18, 504, 793 0.00 37. 32 5.00 (see inst.) Total (sum of lines 3 thru 5) 6.00 6.00 89, 316, 200 -234, 281 89, 081, 919 1, 622, 742. 48 54 90

-653, 424

12, 677, 943

324, 885. 78

13, 331, 367

| Peri od: | Worksheet S-3 | From 07/01/2021 | Part IV | To 06/30/2022 | Date/Time Prepared: |

	10 06/30/2022	11/29/2022 8: 0	
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	1, 735, 823	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)		
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	243, 456	7. 00
	HEALTH AND INSURANCE COST		
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)	6, 806, 133	8. 02
8.03	Health Insurance (Purchased)	0	8. 03
9.00	Prescription Drug Plan	1, 764, 588	9. 00
10.00	Dental, Hearing and Vision Plan	143, 215	
11.00	Life Insurance (If employee is owner or beneficiary)	0	11. 00
12.00	Accident Insurance (If employee is owner or beneficiary)	31, 516	12. 00
13.00	Disability Insurance (If employee is owner or beneficiary)	244, 312	13. 00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
15.00	'Workers' Compensation Insurance	191, 217	15. 00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	o	16. 00
	Non cumulative portion)		
	TAXES		
17.00	FICA-Employers Portion Only	3, 520, 765	17. 00
18.00	Medicare Taxes - Employers Portion Only	0	18. 00
19.00	Unempl oyment Insurance	0	19. 00
20.00	State or Federal Unemployment Taxes	4, 617	20. 00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see	0	21. 00
	instructions))		l
22.00	Day Care Cost and Allowances	0	22. 00
23.00	Tuition Reimbursement	14, 986	23. 00
24. 00	Total Wage Related cost (Sum of lines 1 -23)	14, 700, 628	24. 00
	Part B - Other than Core Related Cost		l
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25. 00

ASCENSION ST. VINCENT ANDERSON	In Lieu of Form	CMS-2552-10
Provider CCN: 15-0088	Peri od: Worksheet From 07/01/2021 Part V	S-3
		Provider CCN: 15-0088 Period: Worksheet

		To 06/30/2022	Date/Time Prep 11/29/2022 8:0	
	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	9, 340, 240	14, 700, 628	1. 00
2.00	Hospi tal	9, 340, 240	14, 700, 628	2. 00
3.00	SUBPROVI DER - I PF			3. 00
4.00	SUBPROVI DER - I RF	0	0	4. 00
5.00	Subprovi der - (0ther)	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	Hospi tal -Based HHA			11. 00
12.00	AMBULATORY SURGICAL CENTER (D. P.) I			12.00
13.00	Hospi tal -Based Hospi ce			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15. 00	Hospital-Based Health Clinic FQHC			15. 00
16. 00	Hospi tal -Based-CMHC			16. 00
17. 00	RENAL DIALYSIS I			17. 00
18. 00	0ther	0	0	18. 00

Heal th	Financial Systems ASCENSION ST. VINCENT	Γ ANDERSON	In Lie	eu of Form CMS-2	2552-10	
HOSPI T	TAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0088	Peri od:	Worksheet S-1	0	
			From 07/01/2021 To 06/30/2022	Date/Time Pre	nared:	
			10 00/ 30/ 2022	11/29/2022 8:		
				1. 00		
	Uncompensated and indigent care cost computation					
1. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 div Medicaid (see instructions for each line)	ided by line 202 colu	ımn 8)	0. 239898	1. 00	
2.00	Net revenue from Medicaid			40, 464, 397	2. 00	
3.00	Did you receive DSH or supplemental payments from Medicaid?			Y	3. 00	
4.00	If line 3 is yes, does line 2 include all DSH and/or supplement		cai d?	_	4. 00	
5.00	If line 4 is no, then enter DSH and/or supplemental payments from	om Medicaid		0		
6. 00 7. 00	Medicaid charges Medicaid cost (line 1 times line 6)			166, 617, 508 39, 971, 207		
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of L	ines 2 and 5 if	39, 971, 207	1	
0.00	<pre>< zero then enter zero)</pre>	TITIC / IIITIUS SUII OT T	Thes 2 and 5, 11	Ĭ	0.00	
	Children's Health Insurance Program (CHIP) (see instructions for	r each line)		•		
9.00	Net revenue from stand-alone CHIP			0	9. 00	
10. 00	Stand-alone CHIP charges				10. 00	
11.00	Stand-alone CHIP cost (line 1 times line 10)			l	11.00	
12. 00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9;	if < zero then	0	12. 00	
	<pre>enter zero) Other state or local government indigent care program (see insti</pre>	cuctions for each lin	e)			
13. 00	Net revenue from state or local indigent care program (Not included)			0	13. 00	
14. 00	Charges for patients covered under state or local indigent care			0	•	
	10)					
15. 00	State or local indigent care program cost (line 1 times line 14)			l e	15. 00	
16. 00	Difference between net revenue and costs for state or local ind	igent care program (I	ine 15 minus line	0	16. 00	
	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see					
	instructions for each line)		ingent care program			
17. 00	Private grants, donations, or endowment income restricted to ful	3		l	17. 00	
18. 00	Government grants, appropriations or transfers for support of h		(61:	0		
19. 00	Total unreimbursed cost for Medicaid, CHIP and state and local 8, 12 and 16)	indigent care progra	ims (sum or lines	0	19. 00	
		Uni nsure	d Insured	Total (col. 1		
		patients		+ col . 2)		
	Uncompanyated Care (and instructions for each line)	1.00	2. 00	3. 00		
20. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire fac	ility 16, 197,	456 1, 087, 069	17, 284, 525	20 00	
20.00	(see instructions)	10, 177,	1,007,007	17, 201, 020	20.00	
21. 00	Cost of patients approved for charity care and uninsured discoun	nts (see 3,885,	737 1, 087, 069	4, 972, 806	21. 00	
	instructions)					
22. 00	Payments received from patients for amounts previously written	off as	0 0	0	22. 00	
23. 00	charity care	3, 885,	737 1, 087, 069	4 072 004	22.00	
23.00	Cost of charity care (line 21 minus line 22)	J 3, 000,	1,001,009	4, 972, 806	23.00	
				1. 00		
24. 00	Does the amount on line 20 column 2, include charges for patien	t days beyond a Lengt	h of stay limit	N	24. 00	
25 00	imposed on patients covered by Medicaid or other indigent care		comic Longth of		25 00	
25.00	If line 24 is yes, enter the charges for patient days beyond the stay limit	e murgem care progr	anı S rengtii or		25. 00	
26. 00	Total bad debt expense for the entire hospital complex (see ins	,		7, 863, 494	•	
27. 00	Medicare reimbursable bad debts for the entire hospital complex	•		312, 315	ł	
27. 01	Medicare allowable bad debts for the entire hospital complex (so	ee instructions)		480, 484	1	
28. 00	Non-Medicare bad debt expense (see instructions) Cost of non-Medicare and non-reimbursable Medicare bad debt exp	oneo (eoo instruction	ie)	7, 383, 010	1	
29. 00 30. 00	Cost of uncompensated care (line 23 column 3 plus line 29)	ense (see mistruction	13)	1, 939, 338 6, 912, 144		
	Total unreimbursed and uncompensated care cost (line 19 plus li	ne 30)		6, 912, 144	1	
2	The state of the s	/		-, ,,	,	

	Financial Systems AS SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	SCENSION ST. VIN F FYDENSES	Provider C		eriod:	worksheet A	2552-10
KLULA	STITICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	I LAFLINGES	FI OVI dei Ci	F	rom 07/01/2021		
					o 06/30/2022	Date/Time Pre 11/29/2022 8:	
	Cost Center Description	Sal ari es	0ther		Reclassificati	Reclassified	
				+ col . 2)	ons (See A-6)	Trial Balance (col. 3 +-	
						col . 4)	
	CENEDAL CEDALOE COCT CENTEDO	1.00	2. 00	3. 00	4. 00	5. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT		3, 797, 285	3, 797, 285	-1, 982	3, 795, 303	1.00
1.01	00101 CAP REL COSTS-BLDG & FIXT-MAB		0	C	0	0	1. 01
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	410, 102	7, 952, 976				
5. 00 7. 00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	1, 981, 081	52, 736, 264 5, 466, 190				
8.00	00800 LAUNDRY & LINEN SERVICE	0	861, 958			861, 958	
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	241	2, 892, 187 2, 903, 443	1		2, 892, 430 1, 075, 326	
11. 00	01100 CAFETERI A	0	2, 903, 443	1			1
13.00	01300 NURSING ADMINISTRATION	1, 730, 159	753, 565				1
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	439, 693 3, 005, 189	144, 059 699, 862	1		1	1
16. 00	01600 MEDICAL RECORDS & LIBRARY	3,003,189	6	3, 703, 031	28, 139	3, 733, 210	1
23. 00	02300 ALLIED HEALTH-EMS	0	0	C	0	0	
23. 01 23. 02	02301 ALLIED HEALTH-RAD TECH 02303 ALLIED HEALTH-PHARM RESIDENTS	75, 970 0	33, 642	109, 612		l	1
23. 02	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>			,		25.02
30. 00	03000 ADULTS & PEDIATRICS	12, 842, 521	3, 385, 597				1
31. 00 41. 00	03100 INTENSIVE CARE UNIT 04100 SUBPROVIDER - IRF	5, 034, 603 1, 333, 167	2, 489, 413 277, 845		1		
43. 00	04300 NURSERY	0	277, 043	1, 011, 012			1
	ANCILLARY SERVICE COST CENTERS						1
50. 00 52. 00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	699, 187 1, 412, 307	13, 586, 604 299, 470		1		1
53. 00	05300 ANESTHESI OLOGY	0	277, 470	1, 711, 77	0	0	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 925, 371	1, 005, 205				1
54. 01 54. 02	03440 MAMMOGRAPHY 03450 NUCLEAR MEDICINE - DIAGNOSTIC	269, 885 284, 371	263, 336 636, 570				1
54. 03	03630 ULTRA SOUND	333, 305	88, 720	1			
55. 00	05500 RADI OLOGY-THERAPEUTI C	905, 529	911, 842				1
57. 00 58. 00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	652, 204 292, 494	210, 646 248, 361	1		868, 961 543, 596	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	802, 110	289, 646	1			
60.00	06000 LABORATORY	0	6, 324, 768	1			1
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	1, 344, 893 2, 634, 180	195, 599 571, 466				
67. 00	06700 OCCUPATI ONAL THERAPY	0	0,1,100	0, 200, 010			
68.00	06800 SPEECH PATHOLOGY	0	0	101 (00	314, 027		1
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	121, 641 230, 582	70, 048 327, 889	1			1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4, 685, 468		, ,	l	1
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	4, 897, 421				
73. 00 76. 00	07300 DRUGS CHARGED TO PATIENTS 03190 CHEMOTHERAPY	0 715, 675	19, 644, 532 213, 262				
76. 01	03020 WOUND CARE	435, 834	549, 283				
90. 00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC					0	00.00
90.00	09001 ANDERSON OUTPATIENT CENTER	1, 029, 678	92, 482	1, 122, 160	9, 648		1
90. 02	04950 DI ABETI C EDUCATI ON	0	0	c	0	0	90. 02
90. 03 91. 00	09002 MS CLINIC 09100 EMERGENCY	0 4, 538, 467	0 2, 994, 649	7, 533, 11 <i>6</i>	0 60, 175	0 7, 593, 291	
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	4, 556, 467	2, 994, 049	7, 555, 116	60, 175	7, 593, 291	92.00
	OTHER REIMBURSABLE COST CENTERS				1		
95. 00	O9500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	17, 232	10, 485	27, 717	0	27, 717	95. 00
113. 00	11300 INTEREST EXPENSE		0	C	0	0	113. 00
118.00		45, 497, 671	142, 512, 044	188, 009, 715	-38, 203	187, 971, 512	118. 00
100 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN		0	1 0	0	Ι ο	190. 00
	19100 RESEARCH	80, 744	21, 522	102, 266			
	19200 PHYSICIANS' PRIVATE OFFICES	2, 612, 935	433, 499	1			
	07950 FOUNDATION 07951 CHILDRENS CLINIC	0	0 214	1	_	•	194. 00 194. 01
	07951 CHI EDICING CETHIC	15, 837	5, 498				194. 01
194. 03	07953 SEXUAL ASSAULT PROGRAM	1, 957	147	2, 104	. 18	2, 122	194. 03
	07954 ASPR BIOTERRORISM GRANT 07955 HEALTHY FAMILIES	0 254, 813	440 86, 975	l .			194. 04 194. 05
	07956 DME-HOME CARE	254, 613	-15, 954			-15, 954	
194.07	07957 MARKETI NG	0	0	C	0	0	194. 07
	07958 CORPORATE COMMUNICATIONS	0	0 360	1			194. 08 194. 09
	1: : 1 ??	1 31		1 300		1 300	1

Health Financial Systems AS	SCENSION ST. VI	NCENT ANDERSON		In Lie	eu of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der Co		eri od:	Worksheet A	
				rom 07/01/2021 o 06/30/2022	Date/Time Pre 11/29/2022 8:	
Cost Center Description	Sal ari es	0ther	Total (col. 1	Recl assi fi cati	Recl assi fi ed	
			+ col . 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
					col . 4)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
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	811, 694	79, 462	891, 156	19, 875	911, 031	194. 12
194. 13 07962 I DLE SPACE	0	0	C	0	0	194. 13
200.00 TOTAL (SUM OF LINES 118 through 199)	49, 275, 651	143, 124, 207	192, 399, 858	0	192, 399, 858	200. 00

Provider CCN: 15-0088

Period: Worksheet A From 07/01/2021 Date/Time Prepared: 11/29/2022 8:09 am

			11/29/2022 8: 0	09 am
Cost Center Description	Adjustments	Net Expenses		
		For Allocation		
GENERAL SERVICE COST CENTERS	6. 00	7. 00		
1. 00 00100 CAP REL COSTS-BLDG & FIXT	-520, 087	3, 275, 216		1. 00
1. 01 00101 CAP REL COSTS-BLDG & FLXT-MAB	0	0		1. 01
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	413, 642	8, 329, 806		4.00
5.00 00500 ADMINISTRATIVE & GENERAL	-9, 265, 889	45, 073, 341		5.00
7.00 OO700 OPERATION OF PLANT	-490, 161	4, 976, 029		7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	0	861, 958		8. 00
9. 00 00900 HOUSEKEEPI NG	0	2, 892, 430		9. 00
10. 00 01000 DI ETARY	-333, 616	741, 710		10.00
11. 00 01100 CAFETERI A	142 547	1, 828, 117		11.00
13. 00 01300 NURSI NG ADMINI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY	-143, 547	2, 415, 076		13.00
14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY	-659, 592 -58, 940	-70, 492 3, 674, 270		14. 00 15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	-38, 940	3,074,270		16. 00
23. 00 02300 ALLI ED HEALTH-EMS	o	0		23. 00
23. 01 02301 ALLI ED HEALTH-RAD TECH	o o	136, 188		23. 01
23. 02 02303 ALLIED HEALTH-PHARM RESIDENTS	0	o		23. 02
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS	-389	16, 780, 819		30.00
31. 00 03100 I NTENSI VE CARE UNI T	-379, 264	7, 198, 105		31. 00
41. 00 04100 SUBPROVI DER - RF	0	1, 701, 804		41.00
43. 00 04300 NURSERY	0	269, 936		43. 00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 0PERATI NG ROOM	-793, 521	13, 498, 822		50. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	-24, 285	1, 135, 971		52. 00
53. 00 05300 ANESTHESI OLOGY	-24, 203	1, 133, 771		53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	-1, 748	2, 923, 779		54. 00
54. 01 03440 MAMMOGRAPHY	0	532, 819		54. 01
54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	923, 606		54. 02
54.03 03630 ULTRA SOUND	0	425, 148		54.03
55. 00 05500 RADI OLOGY-THERAPEUTI C	-281	1, 826, 239		55.00
57. 00 05700 CT SCAN	0	868, 961		57. 00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	-5, 112	538, 484		58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	-425	1, 098, 847		59.00
60. 00 06000 LABORATORY	-213	6, 324, 555		60. 00 65. 00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	-1, 639 -6, 808	1, 589, 577 2, 012, 261		66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	-0, 808	897, 848		67. 00
68. 00 06800 SPEECH PATHOLOGY	0	314, 027		68. 00
69. 00 06900 ELECTROCARDI OLOGY	-424	192, 405		69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	-267, 718	292, 914		70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4, 685, 468		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	4, 897, 421		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	19, 644, 532		73.00
76. 00 03190 CHEMOTHERAPY	-893	980, 582		76. 00
76. 01 03020 WOUND CARE	-30, 000	959, 201		76. 01
OUTPATIENT SERVICE COST CENTERS				00.00
90. 00 09000 CLINIC 90. 01 09001 ANDERSON OUTPATIENT CENTER	0 -40, 945	0 1, 090, 863		90. 00 90. 01
90. 02 04950 DI ABETI C EDUCATI ON	-40, 945	1, 090, 863		90.01
90. 03 09002 MS CLINIC	0	0		90. 03
91. 00 09100 EMERGENCY	-1, 212, 989	6, 380, 302		91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, = 1 = , 1 = 1	2, 222, 222		92. 00
OTHER REIMBURSABLE COST CENTERS		'		
95. 00 09500 AMBULANCE SERVICES	-27, 717	0		95.00
SPECIAL PURPOSE COST CENTERS				
113. 00 11300 I NTEREST EXPENSE	0	0		113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-13, 852, 561	174, 118, 951		118. 00
NONREI MBURSABLE COST CENTERS				400.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	102 022		190.00
191.00 19100 RESEARCH 192.00 19200 PHYSLCLANS' PRIVATE OFFICES	0	103, 023		191. 00 192. 00
192.00 19200 PHTSICIANS PRIVATE OFFICES 194.00 07950 FOUNDATION	0	3, 061, 451 0		194. 00
194. 01 07951 CHI LDRENS CLI NI C	0	214		194. 00
194. 02 07952 PSS ADMI NI STRATI ON		21, 483		194. 01
194. 03 07953 SEXUAL ASSAULT PROGRAM	l ol	2, 122		194. 03
194. 04 07954 ASPR BI OTERRORI SM GRANT	l ol	440		194. 04
194. 05 07955 HEALTHY FAMILIES	o	344, 176		194. 05
194.06 07956 DME-HOME CARE	0	-15, 954		194. 06
194. 07 07957 MARKETI NG	0	0		194. 07
194. 08 07958 CORPORATE COMMUNICATIONS	0	0		194. 08
194. 09 07959 MOB	0	360		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 Lie	u of Form CMS-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL E	BALANCE OF EXPENSES	Provi der CC	CN: 15-0088	Peri od: From 07/01/2021 To 06/30/2022	Worksheet A Date/Time Prepared: 11/29/2022 8:09 am

			11/29/2022 8:09 am
Cost Center Description	Adjustments	Net Expenses	
	(See A-8)	For Allocation	
	6. 00	7.00	
194. 12 07963 ADOLESCENT RESIDENTIAL SERVICES	0	911, 031	194. 12
194. 13 07962 I DLE SPACE	0	0	194. 13
200.00 TOTAL (SUM OF LINES 118 through 199)	-13, 852, 561	178, 547, 297	200. 00

Health Financial Systems RECLASSIFICATIONS Peri od: From 07/01/2021 To 06/30/2022 Date/Ti me Prepared: Provider CCN: 15-0088

1.00 (1.00 / 1.00 (Cost Center 2.00 B - INSURANCE EXPENSE RECLASS CAP REL COSTS-BLDG & FIXT TOTALS	Li ne # 3.00	Sal ary 4.00	0ther 5.00	
1.00 (1.00 / 1.00 (2.00 B - INSURANCE EXPENSE RECLASS CAP REL COSTS-BLDG & FIXT	3.00			
1.00 (1.00 / 1.00 (B - INSURANCE EXPENSE RECLASS CAP REL COSTS-BLDG & FIXT		4. 00	5. 00	
1.00 (1.00 / 1.00 (CAP REL COSTS-BLDG & FIXT				
1. 00 / 1. 00 /		4 00	ا		4
1.00 <u>/</u> 1.00 <u>[</u> 1.00 <u>(</u>	IOTALS	1.00	0	574	1.00
1.00 / 1.00 (0	574	_
1. 00 (C - INTEREST EXPENSE	F 00	ما	2 55/	1 1 00
1.00	ADMI NI STRATI VE & GENERAL		0	<u>2, 5</u> 56	1. 00
1.00	TOTALS D - CAFETERI A/DI ETARY RECLASS		······································	2, 556	_
	CAFETERIA	11. 00	0	1, 828, 117	1.00
	TOTALS			1, 828, 117	1.00
	E - LABOR DELIVERY RECLASS		o _l	1,020,117	1
-	ADULTS & PEDIATRICS	30.00	243, 241	51, 578	1.00
	NURSERY	43. 00	222, 712	47, 224	2. 00
	TOTALS		465, 953	98, 802	
F	H - PT_OT_ST RECLASS				1
1.00	OCCUPATI ONAL THERAPY	67.00	737, 790	160, 058	1.00
2.00	SPEECH PATHOLOGY	68. 00	258, 046	55, 981	2. 00
	TOTALS		995, 836	216, 039	_
	J - ADOLESCENT RESIDENTIAL SE	RVICES			
	ADOLESCENT RESIDENTIAL	194. 12	0	12, 269	1.00
	SERVI CES	+			
L	TOTALS		0	12, 269	_
	M - RAD TECH RECLASS	00 041	05 07 1	21	4
	ALLIED HEALTH-RAD TECH	23. 01	2 <u>5, 8</u> 66	0	1. 00
	TOTALS		25, 866	0	-
	O - SYSTEM PROJECTS NURSING ADMINISTRATION	13. 00	56, 007	0	1.00
	CENTRAL SERVICES & SUPPLY	14. 00	1, 228	0	2. 00
	ADULTS & PEDIATRICS	30. 00	144, 492	0	3. 00
	INTENSIVE CARE UNIT	31.00	6, 424	0	4. 00
	SUBPROVI DER – I RF	41.00	78, 707	0	5. 00
	RADI OLOGY-THERAPEUTI C	55. 00	528	0	6. 00
	RESPI RATORY THERAPY	65. 00	1, 372	0	7. 00
	CHEMOTHERAPY	76. 00	45, 832	0	8. 00
	EMERGENCY	91.00	17, 487	0	9. 00
-	TOTALS		352, 077	₀	
C	Q - PHYSICIAN RECLASS				
-	RESPIRATORY THERAPY	<u>65.</u> 00	0	3 <u>6, 7</u> 50	1. 00
-	TOTALS		0	36, 750	_
	T - VACCINE				4
	NURSING ADMINISTRATION	13. 00	2, 903	2, 903	1.00
	ADULTS & PEDIATRICS	30.00	5, 710	5, 710	2. 00
	RADI OLOGY-THERAPEUTI C	55.00	136	136	3. 00
4.00 F 5.00	PHYSICAL THERAPY	66. 00 0. 00	615 0	615	4. 00 5. 00
	TOTALS — — — —		9, 364	<u></u>	3.00
_ <u>_</u>	U - FURLOUGH		7, 304	7, 304	1
	ADMI NI STRATI VE & GENERAL	5. 00	0	4, 627	1.00
	NURSING ADMINISTRATION	13. 00	o	16, 160	2. 00
	CENTRAL SERVICES & SUPPLY	14.00	o	3, 754	3.00
4.00	ADULTS & PEDIATRICS	30.00	o	22, 594	4. 00
5. 00 I	INTENSIVE CARE UNIT	31.00	О	4, 984	5. 00
	SUBPROVI DER - I RF	41.00	0	3, 026	6. 00
	OPERATING ROOM	50.00	0	5, 198	7. 00
	DELIVERY ROOM & LABOR ROOM	52. 00	0	11, 761	8. 00
	RADI OLOGY-DI AGNOSTI C	54.00	0	15, 936	9. 00
	RADI OLOGY-DI AGNOSTI C	54.00	0	2, 931	10.00
I	NUCLEAR MEDICINE -	54. 02	0	1, 771	11. 00
	DI AGNOSTI C	F4 00		4 7//	10.00
	ULTRA SOUND	54. 03	0	1, 766	12.00
	RADI OLOGY-THERAPEUTI C CT SCAN	55. 00 57. 00	O O	7, 046	13.00
	CARDIAC CATHETERIZATION	57. 00 59. 00	0	805 5, 038	14. 00 15. 00
	RESPIRATORY THERAPY	65. 00	0	2, 729	16. 00
	PHYSICAL THERAPY	66. 00	o	13, 351	17. 00
	ELECTROCARDI OLOGY	69. 00	0	1, 718	18. 00
	CHEMOTHERAPY	76. 00	o	5, 069	19. 00
	WOUND CARE	76. 01	o	2, 023	20.00
	ANDERSON OUTPATIENT CENTER	90. 01	o	4, 170	21. 00
	EMERGENCY	91.00	ő	4, 057	22. 00
	PHYSICIANS' PRIVATE OFFICES	192. 00	Ö	950	23. 00
20.00 II	ADOLESCENT RESIDENTIAL	194. 12	o	9, 795	24. 00
	SERVI CES			*	
24.00	SERVICES			151, 259	

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0088

		Increases			
	Cost Center	Li ne #	Sal ary	0ther	
	2. 00	3. 00	4. 00	5. 00	
	W - ACCRUED PTO				
00	EMPLOYEE BENEFITS DEPARTMENT	4.00	5 <u>5, 8</u> 73	0	1
	TOTALS		55, 873	0	
	X - STARP				
00	EMPLOYEE BENEFITS DEPARTMENT	4.00	176	0] 1
00	ADMINISTRATIVE & GENERAL	5. 00	18, 094	О	2
00	HOUSEKEEPI NG	9.00	2	0	3
00	NURSING ADMINISTRATION	13. 00	15, 989	0	4
00	CENTRAL SERVICES & SUPPLY	14.00	4, 120	0	5
00	PHARMACY	15. 00	28, 159	0	6
00	ALLIED HEALTH-RAD TECH	23. 01	710	0	1 7
00	ADULTS & PEDIATRICS	30.00	120, 338	0	3
00	INTENSIVE CARE UNIT	31.00	46, 929	0	0
00	SUBPROVI DER - I RF	41.00	12, 085	0	10
00	OPERATING ROOM	50.00	6, 552	0	1
00	DELIVERY ROOM & LABOR ROOM	52.00	13, 234	O	11
00	RADI OLOGY-DI AGNOSTI C	54.00	17, 886	0	13
00	MAMMOGRAPHY	54. 01	2, 529	0	14
00	NUCLEAR MEDICINE -	54. 02	2, 665	0	11
. 00	DI AGNOSTI C	01.02	2,000	J	
. 00	ULTRA SOUND	54. 03	3, 123	0	10
00	RADI OLOGY-THERAPEUTI C	55. 00	8, 485	0	1
00	CT SCAN	57.00	6, 111	0	18
. 00	MAGNETIC RESONANCE I MAGING	58. 00	2, 741	0	19
. 00	(MRI)	30.00	2, 741	9	'
00	CARDI AC CATHETERI ZATI ON	59.00	7, 516	0	20
00	RESPIRATORY THERAPY	65.00	12, 602	0	2.
00	PHYSI CAL THERAPY	66.00	24, 683	0	22
00	ELECTROCARDI OLOGY	69.00	1, 140	0	2:
00	ELECTROENCEPHALOGRAPHY	70.00	2, 161	0	24
00	CHEMOTHERAPY			0	2!
	WOUND CARE	76. 00 76. 01	6, 706	0	20
00			4, 084	0	1
. 00	ANDERSON OUTPATIENT CENTER	90. 01	9, 648	0	2
00	EMERGENCY	91.00	42, 688	0	28
00	RESEARCH	191.00	757	0	29
00	PHYSICIANS' PRIVATE OFFICES	192. 00	15, 017	0	30
00	PSS ADMINISTRATION	194. 02	148	0	31
. 00	SEXUAL ASSAULT PROGRAM	194. 03	18	0	32
. 00	HEALTHY FAMILIES	194. 05	2, 388	0	33
. 00	ADOLESCENT RESIDENTIAL	194. 12	7, 606	O	34
	SERVICES				
	TOTALS		447, 090	O	

Provider CCN: 15-0088

Peri od: Worksheet A-6 From 07/01/2021 To 06/30/2022 Date/Time Prepared:

In Lieu of Form CMS-2552-10

						11/29/2022	
	Coot Conton	Decreases	Colory	Othon	Mko+ A 7 Dof		
	Cost Center 6.00	Li ne # 7.00	Sal ary 8.00	0ther V 9.00	Wkst. A-7 Ref. 10.00		
	B - INSURANCE EXPENSE RECLASS		0.00	9.00	10.00		
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	574	12		1.00
	TOTALS			574			
	C - INTEREST EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT		0	<u>2, 5</u> 56	11		1. 00
	TOTALS		0	2, 556			
1 00	D - CAFETERI A/DI ETARY RECLASS		ol	1 000 117			1 00
1. 00	TOTALS	10.00	0	<u>1, 828, 1</u> 17 1, 828, 117	0		1. 00
	E - LABOR DELIVERY RECLASS		<u> </u>	1, 020, 117			
1.00	DELIVERY ROOM & LABOR ROOM	52.00	465, 953	98, 802	0		1.00
2.00		0.00	0	0	Ö		2. 00
	TOTALS		465, 953	98, 802			İ
	H - PT_OT_ST RECLASS						
1.00	PHYSI CAL THERAPY	66. 00	995, 836	216, 039	0		1. 00
2.00		0.00	0	0	0		2. 00
	TOTALS	DVILOEC	995, 836	216, 039			
1. 00	J - ADOLESCENT RESIDENTIAL SE ADULTS & PEDIATRICS	30.00	0	12, 269	0		1.00
1.00	TOTALS			12, 269			1.00
	M - RAD TECH RECLASS		<u> </u>	12, 20,			
1.00	RADI OLOGY-DI AGNOSTI C	54.00	25, 866	0	0		1.00
	TOTALS		25, 866				
	O - SYSTEM PROJECTS						
1.00	ADMINISTRATIVE & GENERAL	5. 00	352, 077	0	0		1. 00
2.00		0.00	0	0	0		2.00
3. 00 4. 00		0. 00 0. 00	0	0	0		3. 00 4. 00
5.00		0.00	0	0	0		5. 00
6. 00		0.00	0	0	0		6. 00
7. 00		0.00	o	Ö	Ö		7. 00
8.00		0.00	o	0	0		8. 00
9.00		0.00	0	0	0		9. 00
	TOTALS		352, 077	0			
1 00	Q - PHYSICIAN RECLASS ADMINISTRATIVE & GENERAL	5. 00	ol	36, 750	0		1.00
1. 00	TOTALS			36, 750	— — — 4		1.00
	T - VACCINE		<u> </u>	30, 730			
1.00	ADMINISTRATIVE & GENERAL	5.00	9, 364	0	0		1.00
2.00	NURSING ADMINISTRATION	13.00	2, 903	0	0		2. 00
3.00	ADULTS & PEDIATRICS	30.00	5, 710	0	0		3. 00
4.00	RADI OLOGY-THERAPEUTI C	55. 00	136	0	0		4. 00
5.00	PHYSICAL THERAPY	6600	615	0	0		5. 00
	TOTALS U - FURLOUGH		18, 728	U			
1.00	ADMINISTRATIVE & GENERAL	5, 00	4, 627	0	0		1.00
2.00	NURSI NG ADMI NI STRATI ON	13. 00	16, 160	Ö	o		2. 00
3.00	CENTRAL SERVICES & SUPPLY	14.00	3, 754	0	О		3.00
4.00	ADULTS & PEDIATRICS	30.00	22, 594	0	0		4.00
5.00	INTENSIVE CARE UNIT	31. 00	4, 984	0	0		5. 00
6.00	SUBPROVI DER – I RF	41.00	3, 026	0	0		6. 00
7.00	OPERATING ROOM	50.00	5, 198	0	0		7. 00
8. 00 9. 00	DELIVERY ROOM & LABOR ROOM RADIOLOGY-DIAGNOSTIC	52. 00 54. 00	11, 761 15, 936	0	0		8. 00 9. 00
10.00	MAMMOGRAPHY	54. 00	2, 931	0	0		10.00
11. 00	NUCLEAR MEDICINE -	54. 02	1, 771	0	o		11. 00
	DI AGNOSTI C		<i>'</i>				
12.00	ULTRA SOUND	54. 03	1, 766	0	О		12. 00
13.00	RADI OLOGY-THERAPEUTI C	55.00	7, 046	0	0		13. 00
14.00	CT SCAN	57.00	805	0	0		14. 00
15.00	CARDI AC CATHETERI ZATI ON RESPI RATORY THERAPY	59. 00 65. 00	5, 038	0	0		15. 00
16. 00 17. 00	PHYSICAL THERAPY	65. 00 66. 00	2, 729 13, 351	0	0		16. 00 17. 00
18. 00	ELECTROCARDI OLOGY	69. 00	1, 718	0	0		18. 00
19. 00	CHEMOTHERAPY	76.00	5, 069	0	o		19. 00
20.00	WOUND CARE	76. 01	2, 023	Ö	o		20.00
21. 00	ANDERSON OUTPATIENT CENTER	90. 01	4, 170	0	O		21. 00
22. 00	EMERGENCY	91.00	4, 057	0	О		22. 00
23. 00	PHYSICIANS' PRIVATE OFFICES	192.00	950	0	0		23. 00
24.00	ADOLESCENT RESIDENTIAL	194. 12	9, 795	0	0		24. 00
21.00	ISEDVI CES						
21.00	SERVICES	+	151, 259		+		

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0088 Peri od: Worksheet A-6 From 07/01/2021 To 06/30/2022 Date/Time Prepared:

						0 00, 00, 2022	11/29/2022 8: 09 am
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
	W - ACCRUED PTO						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	<u>55, 8</u> 73			1.00
	TOTALS		0	55, 873			
	X - STARP						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	447, 090	0	0		1. 00
2.00		0.00	0	0	0		2. 00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4. 00
5.00		0.00	o	0	0		5. 00
6.00		0.00	o	0	0		6. 00
7.00		0.00	o	0	0		7. 00
8.00		0.00	o	0	0		8. 00
9.00		0.00	O	0	0		9. 00
10.00		0.00	O	0	0		10.00
11.00		0.00	O	0	0		11.00
12.00		0.00	O	0	0		12. 00
13.00		0.00	0	0	0		13. 00
14.00		0.00	0	0	0		14. 00
15.00		0.00	0	0	0		15. 00
16.00		0.00	0	0	0		16. 00
17.00		0.00	0	0	0		17. 00
18.00		0.00	0	0	0		18. 00
19.00		0.00	0	0	0		19. 00
20.00		0.00	0	0	0		20. 00
21.00		0.00	0	0	0		21. 00
22.00		0.00	O	0	0		22. 00
23.00		0.00	O	0	0		23. 00
24.00		0.00	O	0	0		24. 00
25.00		0.00	O	0	0		25. 00
26.00		0.00	o	0	0		26. 00
27.00		0.00	o	0	0		27. 00
28.00		0.00	o	0	0		28. 00
29.00		0.00	o	0	0		29. 00
30.00		0.00	o	0	0		30.00
31.00		0.00	o	0	0		31.00
32.00		0.00	0	0	0		32.00
33.00		0.00	0	0	0		33.00
34.00		0.00	o	0	0		34.00
	TOTALS	+	447, 090				
500.00	Grand Total: Decreases		2, 456, 809	2, 250, 980			500.00
					'		•

Subtotal (sum of lines 1-7)

Reconciling Items

10.00 Total (line 8 minus line 9)

8.00

9.00

8.00

9.00

10.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provi der CCN: 15-0088 Peri od: Worksheet A-7 From 07/01/2021 Part I 06/30/2022 Date/Time Prepared: 11/29/2022 8:09 am Acqui si ti ons Begi nni ng Purchases Donati on Total Di sposal s and Bal ances Retirements 2.00 3.00 4. 00 1 00 5 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 5, 292, 602 0 0 1.00 1, 171, 786 1, 171, 786 0 2.00 Land Improvements 1, 754, 357 0 2.00 0 3.00 69, 496, 615 428, 735 3.00 Buildings and Fixtures 428, 735 0 0 4.00 Building Improvements 0 4.00 5.00 Fixed Equipment 40, 712, 995 922, 917 0 922, 917 77, 873 5.00 0 6.00 Movable Equipment 61, 619, 356 4, 643, 317 4, 643, 317 3, 891, 343 6.00 0 7.00 HIT designated Assets 0 7.00 0 8.00 Subtotal (sum of lines 1-7) 178, 875, 925 7, 166, 755 7, 166, 755 3, 969, 216 8.00 9.00 Reconciling Items 0 9.00 3<u>, 969, 216</u> Total (line 8 minus line 9) 178, 875, 925 7, 166, 755 10.00 7, 166, 755 0 10.00 Endi ng Bal ance Fully Depreci ated Assets 6.00 7.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 5, 292, 602 0 1.00 2.00 Land Improvements 2, 926, 143 0 2.00 3.00 Buildings and Fixtures 69, 925, 350 0 3.00 0 4.00 Building Improvements 4.00 5.00 Fi xed Equipment 41, 558, 039 0 5.00 Movable Equipment 0 6.00 62, 371, 330 6.00 7.00 HIT designated Assets 0 7. 00

182, 073, 464

182, 073, 464

0

0

Heal th	Financial Systems A	SCENSION ST. VIN	NCENT ANDERSON	N	In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider C		Peri od:	Worksheet A-7	
					From 07/01/2021 To 06/30/2022	Part II Date/Time Pre	nared·
		_			10 00/00/2022	11/29/2022 8:	
			SI	UMMARY OF CAPI	TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see	
	COST CONTON DOSCITIFICATION	Dopi coi ati on	Louse	Tired est	,	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	and 2			
1.00	CAP REL COSTS-BLDG & FLXT	3, 232, 774	C	564, 51	1 0	0	1. 00
1. 01	CAP REL COSTS-BLDG & FLXT-MAB	0	C	0	0	0	1. 01
3.00	Total (sum of lines 1-2)	3, 232, 774	C	564, 51	1 0	0	3. 00
		SUMMARY OF	CAPITAL				
	Cost Center Description	Other	Total (1) (sum	n			
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)	9 ,				
		14.00	15. 00	1			
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 a	and 2			
1.00	CAP REL COSTS-BLDG & FLXT	0	3, 797, 285	5			1.00
1.01	CAP REL COSTS-BLDG & FIXT-MAB	0	C	o			1. 01
3.00	Total (sum of lines 1-2)	0	3, 797, 285	5			3. 00

Heal th	n Financial Systems A	SCENSION ST. VI	NCENT ANDERSON		In Lie	eu of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider Co	F	Period: From 07/01/2021 To 06/30/2022	Worksheet A-7 Part III Date/Time Pre 11/29/2022 8:0	pared:
		COM	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio	Ratio (see instructions)	Insurance	
			Leases	(col . 1 - col . 2)	That detrons,		
		1.00	2.00	3. 00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C						
1.00	CAP REL COSTS-BLDG & FLXT	182, 073, 464	. 0	182, 073, 464			1. 00
1. 01	CAP REL COSTS-BLDG & FIXT-MAB	0	0	(0. 000000		1. 01
3.00	Total (sum of lines 1-2)	182, 073, 464		182, 073, 464			3. 00
		ALLOCA	TION OF OTHER (CAPI TAL	SUMMARY 0	OF CAPITAL	
	Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease	
			Capi tal -Relate				
			d Costs	through 7)			
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C						
1.00	CAP REL COSTS-BLDG & FLXT	0	0	(3, 229, 057	0	1. 00
1. 01	CAP REL COSTS-BLDG & FLXT-MAB	0	0	(0	0	1. 01
3.00	Total (sum of lines 1-2)	0	0	(3, 229, 057	0	3. 00
				JMMARY OF CAPIT			
	Cost Center Description	Interest	Insurance (see			Total (2) (sum	
			instructions)	instructions)	Capi tal -Rel ate		
					d Costs (see	through 14)	
					instructions)		
		11. 00	12. 00	13. 00	14. 00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C						
1.00	CAP REL COSTS-BLDG & FLXT	45, 585	574	1	1	3, 275, 216	1. 00
1. 01	CAP REL COSTS-BLDG & FLXT-MAB	0	0	(,	0	1. 01
3. 00	Total (sum of lines 1-2)	45, 585	574	() 0	3, 275, 216	3. 00

Provider CCN: 15-0088

				T	o 06/30/2022		
				Expense Classification on		11/29/2022 8:0	09 am
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Li ne # 4. 00	Wkst. A-7 Ref. 5.00	
1. 00	Investment income - CAP REL	B B		CAP REL COSTS-BLDG & FIXT	1.00		1. 00
1. 01	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		0	CAP REL COSTS-BLDG &	1. 01	0	1. 01
1.01	COSTS-BLDG & FLXT-MAB (chapter			FI XT-MAB	1.01	J	1.01
2. 00	2) Investment income - CAP REL		0	*** Cost Center Deleted ***	2. 00	0	2. 00
2 00	COSTS-MVBLE EQUIP (chapter 2)	В	70 1/2	ADMINISTRATIVE & CENEDAL	F 00	11	2 00
3. 00	Investment income - other (chapter 2)	В	-70, 163	ADMINISTRATIVE & 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		0		0.00	О	5. 00
6. 00	expenses (chapter 8) Rental of provider space by	-	0		0.00	0	6. 00
	suppliers (chapter 8)		15 225	ADMINISTRATIVE & CENEDAL			
7. 00	Telephone services (pay stations excluded) (chapter	A	- 15, 335	ADMINISTRATIVE & GENERAL	5. 00	0	7. 00
8. 00	21) Tel evi si on and radi o servi ce	A	-6 952	OPERATION OF PLANT	7. 00	0	8. 00
	(chapter 21)	, ,	0, 702				
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	0 -2, 671, 238		0.00	0	9. 00 10. 00
	adj ustment				0.00		11 00
11. 00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11. 00
12. 00	Related organization transactions (chapter 10)	A-8-1	9, 147, 675			0	12. 00
13. 00	Laundry and linen service		0		0.00		
14. 00 15. 00	Cafeteria-employees and guests Rental of quarters to employee		-333, 616 0	DI ETARY	10. 00 0. 00		
	and others		0				
16. 00	Sale of medical and surgical supplies to other than		Ü		0.00	0	16. 00
17. 00	patients Sale of drugs to other than	В	-1 702	PHARMACY	15. 00	0	17. 00
	pati ents						
18. 00	Sale of medical records and abstracts	В	-55, 281	ADMINISTRATIVE & GENERAL	5. 00	0	18. 00
19. 00	Nursing and allied health education (tuition, fees,		0		0.00	0	19. 00
	books, etc.)						
20. 00 21. 00	Vending machines Income from imposition of		0		0. 00 0. 00		
200	interest, finance or penalty		J		0.00		21.00
22. 00	charges (chapter 21) Interest expense on Medicare		0		0.00	0	22. 00
	overpayments and borrowings to repay Medicare overpayments						
23. 00	Adjustment for respiratory	A-8-3	0	RESPIRATORY THERAPY	65.00		23. 00
	therapy costs in excess of limitation (chapter 14)						
24. 00	Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
	therapy costs in excess of limitation (chapter 14)						
25. 00	Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114. 00		25. 00
0.4.00	(chapter 21)			0.4B BEL 000TO BLB0 4 ELVE			
26. 00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1. 00	0	
26. 01	Depreciation - CAP REL COSTS-BLDG & FIXT-MAB			CAP REL COSTS-BLDG & FLXT-MAB	1. 01	0	26. 01
27. 00	Depreciation - CAP REL			*** Cost Center Deleted ***	2.00	О	27. 00
28. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist		0	*** Cost Center Deleted ***	19. 00		28. 00
29. 00	Physicians' assistant		0		0.00	0	29. 00
30. 00	Adjustment for occupational therapy costs in excess of	A-8-3	0	OCCUPATI ONAL THERAPY	67.00		30. 00
30. 99	limitation (chapter 14) Hospice (non-distinct) (see		Λ	ADULTS & PEDIATRICS	30. 00		30. 99
55. 77	instructions)		0	, 155210 a 1251/1111105	30.00		55. //

Health Financial Systems ASCENSION ST. VINCENT ANDERSON In Lieu of Form CMS-2552-10 ADJUSTMENTS TO EXPENSES Provider CCN: 15-0088 Peri od: Worksheet A-8 From 07/01/2021 06/30/2022 Date/Time Prepared: 11/29/2022 8:09 am Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Basis/Code (2) Cost Center Description Cost Center Line # Wkst. A-7 Ref. Amount 1.00 2.00 3.00 4. 00 5.00 31.00 Adjustment for speech OSPEECH PATHOLOGY 31. 00 A-8-3 68.00 pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for 0.00 32.00 Depreciation and Interest 33.00 LEASE INCOME В -483, 209 OPERATION OF PLANT 7.00 33.00 -27, 717 AMBULANCE SERVICES AMBULANCE COST 33.01 R 95.00 0 33.01 33.02 DUES REVENUE В -800 ADMINISTRATIVE & GENERAL 5.00 33.02 PHYSICIAN FUND EXPENSE -7, 349, 561 ADMINI STRATI VE & GENERAL 33.03 Α 5.00 33.03 OTHER ADJUSTMENTS (SPECIFY) 33.04 0.00 33.04 33.05 OTHER ADJUSTMENTS (SPECIFY) 33.05 0 0.00 OTHER ADJUSTMENTS (SPECIFY) 33.06 0.00 33.06 (3)33.07 OTHER ADJUSTMENTS (SPECIFY) 0.00 33.07 OTHER ADJUSTMENTS (SPECIFY) 33.08 0 00 33.08 OTHER ADJUSTMENTS (SPECIFY) 33.09 0.00 33.09 (3) 33. 10 OTHER ADJUSTMENTS (SPECIFY) 0.00 33. 10 (3)OTHER MISCELLANEOUS REVENUE -248, 972 ADMI NI STRATI VE & GENERAL 33 11 В 5.00 33.11 OTHER MI SCELLANEOUS REVENUE -24 INTENSIVE CARE UNIT 31.00 33.12 33.12 В 33. 13 OTHER MI SCELLANEOUS REVENUE В -1, 663 RADI OLOGY-DI AGNOSTI C 54.00 33.13 -5, 112 MAGNETIC RESONANCE I MAGING OTHER MI SCELLANEOUS REVENUE 33. 14 В 58.00 33.14 (MRI) OTHER MI SCELLANEOUS REVENUE -1, 170 RESPIRATORY THERAPY 33.15 В 65.00 0 33.15 OTHER MI SCELLANEOUS REVENUE -6, 808 PHYSI CAL THERAPY 33. 16 33.16 В 66.00 OTHER ADJUSTMENTS (SPECIFY) 33.17 33.17 0.00 (3)**ENTERTAL NMENT** -23, 102 ADMI NI STRATI VE & GENERAL 33 18 Α 5.00 0 33 18 33. 19 ENTERTAI NMENT -710 DELIVERY ROOM & LABOR ROOM 52.00 33.19 33 20 ENTERTAI NMENT Α -632 NURSING ADMINISTRATION 13.00 33. 20 -206 ANDERSON OUTPATIENT CENTER 36, 00 ENTERTAL NMENT 90.01 0 36, 00 Α 36.01 ENTERTAI NMENT Α -389 ADULTS & PEDIATRICS 30.00 36.01 ENTERTAI NMENT -70 RESPIRATORY THERAPY 36.02 Α 65.00 36.02 -56 PHARMACY 36.03 ENTERTAI NMENT 15.00 36.03 Α ENTERTAL NMENT -242 EMERGENCY 91.00 36.04 Α 0 36.04 -16, 349 CAP REL COSTS-BLDG & FIXT 36.05 GAIN/LOSS ON DISPOSAL PPE В 1.00 11 36.05 GAIN/LOSS ON DISPOSAL PPE -4, 948 OPERATING ROOM 36.06 В 50.00 36.06 GAIN/LOSS ON DISPOSAL PPE -106 DELIVERY ROOM & LABOR ROOM 52.00 0 36.07 В 36.07 -85 RADI OLOGY-DI AGNOSTI C GAIN/LOSS ON DISPOSAL PPE 54.00 36.08 R 0 36.08 36.09 GAIN/LOSS ON DISPOSAL PPE В -106 RADI OLOGY-THERAPEUTI C 55.00 36.09 36.10 GAIN/LOSS ON DISPOSAL PPE В -425 CARDIAC CATHETERIZATION 59.00 36.10 GAIN/LOSS ON DISPOSAL PPE -213 LABORATORY 36 11 В 60 00 36 11 -893 CHEMOTHERAPY GAIN/LOSS ON DISPOSAL PPE 36.12 В 76.00 36.12 36. 13 FED SPON PRJC REV В -1, 200 PHARMACY 15.00 36. 13 EQUI PMENT RENTAL -6, 440 OPERATING ROOM 50.00 36.14 В 36.14 CONTRACT SERVICE REVENUE -22, 739 ANDERSON OUTPATIENT CENTER 36.15 В 90.01 36.15 CHARI TABLE CONTRI BUTI ONS -53, 720 NURSING ADMINISTRATION 13.00 36.16 36.16 Α 36. 17 CHARITABLE CONTRIBUTION -20, 893 ADMI NI STRATI VE & GENERAL Α 5.00 36.17 CORPORATE SPONSORSHIPS -3. 433 ADMINISTRATIVE & GENERAL 36 18 Α 5 00 O 36 18 36.19 COMMUNITY BENEFITS Α -2, 800 ADMINISTRATIVE & GENERAL 5.00 36.19 36. 20 SHARED SAVINGS PAYMENT В -505 ADMINISTRATIVE & GENERAL 5.00 36. 20 36. 21 STATE PROGRAM REVENUE В -8,500 ADMINISTRATIVE & GENERAL 5.00 0 36. 21 NONFED STATE SPONSOR -175 RADI OLOGY-THERAPEUTI C 36 22 B 55 00 0 36 22 36.23 OTHER ADJUSTMENTS (SPECIFY) 0.00 36.23 LOBBYING EXPENSE -2, 537 ADMINISTRATIVE & GENERAL 36.24 Α 5.00 36.24 DEPRECIATION AHA LIFE 36. 25 -3,717 CAP REL COSTS-BLDG & FIXT 36. 25 Α 1.00 AD.JUSTMENT PROMOTIONAL ITEMS -26, 244 ADMI NI STRATI VE & GENERAL 36.26 Α 5.00 36.26 36. 27 PROMOTIONAL ITEMS -3, 252 DELIVERY ROOM & LABOR ROOM 52.00 36. 27 Α -20, 217 DELIVERY ROOM & LABOR ROOM

-399RESPIRATORY THERAPY

-5, 195 ADMINI STRATI VE & GENERAL

-424 ELECTROCARDI OLOGY

-10, 904, 629 ADMINI STRATI VE & GENERAL

52.00

65 00

69.00

5.00

5.00

36. 28

36 29

ol

0 36.30

0 36. 31

0 36. 32

CHARITABLE CONTRIBUTIONS

PROMOTIONAL ITEMS

PROMOTIONAL ITEMS

MARKETING EXPENSE

PROVIDER TAX

Α

Α

Α

Α

Α

36. 28

36 29

36.30

36.31

36.32

Health Financial Systems	AS	CENSION ST. VI	NCENT ANDERSON	In Lie	u of Form CMS-2	2552-10
ADJUSTMENTS TO EXPENSES				Peri od:	Worksheet A-8	
				From 07/01/2021 To 06/30/2022	Date/Time Pre 11/29/2022 8:	
			Expense Classification or			
			To/From Which the Amount is	to be Adjusted		
Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
cost conten becomparent	1.00	2.00	3.00	4. 00	5. 00	
36. 33 BILLING ARRANGEMENTS	В	-16, 432	ADMINISTRATIVE & GENERAL	5. 00	0	36. 33
36.34 BILLING ARRANGEMENTS	В	-55, 982	PHARMACY	15. 00	0	36. 34
36. 35 BILLING ARRANGEMENTS	В	-600	OPERATING ROOM	50.00	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)		-13, 852, 561				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 OFFICE COSTS

Provider CCN: 15-0088 | Period: From 07/01/2021 | From 07/01/2021 | To 06/30/2022 | Date/Time Preparation

				Го 06/30/2022	Date/Time Pre 11/29/2022 8:	
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	0 / 4
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUSTM HOME OFFICE COSTS:	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OR	GANIZATIONS OR	CLAI MED	
1.00		ADMINISTRATIVE & GENERAL	HOME OFFICE - CAPITAL	2, 566, 347	0	1. 00
2.00	l control of the cont	li .	HOME OFFICE - INTEREST - CA	67, 203	0	2. 00
3.00			HOME OFFICE - A&G	404	0	3. 00
4. 00			HOME OFFICE - OTHER	40, 863, 910	33, 835, 971	4. 00
4. 01	1	LAUNDRY & LINEN SERVICE	SVH CHARGEBACK	-16, 348	-16, 348	4. 01
4. 02	l control of the cont	l	SVH CHARGEBACK	-33, 504	-33, 504	4. 02
4. 03			SVH CHARGEBACK	-8, 000	-8, 000	4. 03
4. 04			SVH CHARGEBACK	28, 370	28, 370	
4. 05	l control of the cont	l	SVH CHARGEBACK	25, 000	25, 000	4. 05
4. 06			SVH CHARGEBACK	525,000	525, 000	4. 06
4. 07	1		SVH CHARGEBACK	20, 675	20, 675	4. 07
4. 08		1	SVH CHARGEBACK	8, 970	8, 970	
4. 09		1	SVH CHARGEBACK	90,000	90, 000	
4. 10			SVH CHARGEBACK	59, 600	59, 600	
4. 11	1		INTEREST EXPENSE	494, 348	500, 021	4. 11
4. 12		ADMINISTRATIVE & GENERAL	INTEREST EXPENSE	2, 556	0	4. 12
4. 13			HEALTH INSURANCE	7, 326, 204	6, 912, 562	4. 13
4. 14			TRG ADMIN FEES - SUPPLIES	-659, 592	0, 7.2, 002	4. 14
4. 15		NURSING ADMINISTRATION	TRG ADMIN FEES -CONTRACTED L	-89, 195	0	4. 15
4. 16		ADMINISTRATIVE & GENERAL	TRG ADMIN FEES - OTHER	-175, 956	0	4. 16
4. 17	0.00	1	THE TIEM TEES STILL	0	0	4. 17
4. 18	0.00			l ol	0	4. 18
4. 19	0.00			l ol	0	4. 19
4. 20	0.00	1		l ol	0	4. 20
4. 21	0.00			l ol	0	4. 21
4. 22	0.00	I.		l ol	0	
4. 23	0.00			l ol	0	4. 23
4. 24	0.00			ا م	ol	4. 24
4. 25	0.00	li .		ا م	ol	4. 25
5. 00	TOTALS (sum of lines 1-4).			51, 095, 992	41, 948, 317	5. 00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

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

1140 110 0	boon pooted to normaneer //	cor anno i aria, or 2, tho amoun	. c a onab. o o	our a bo illui ou tou illi ool allii i	o. timo parti			
				Related Organization(s) and/	or Home Office			
	Symbol (1)	Name	Percentage of	Name	Percentage of			
	-		Ownershi p		Ownershi p			
	1. 00	2.00	3. 00	4. 00	5. 00			
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:							

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

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

	Comorre under the control					
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	FI NANCI AL				100.00
	non-financial) specify:					

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

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OF

			11/29/2022 8:	: 09 am
	Net	Wkst. A-7 Ref.		
	Adjustments			
	(col. 4 minus			
	col. 5)*			
	6. 00	7. 00		
			MENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED	1
	HOME OFFICE COS			4
1.00	2, 566, 347	0		1.00
2.00	67, 203	0		2. 00
3.00	404	0		3. 00
4.00	7, 027, 939	0		4. 00
4. 01	0	0		4. 01
4. 02	0	0		4. 02
4.03	0	0		4. 03
4.04	0	0		4. 04
4.05	0	0		4. 05
4.06	0	0		4. 06
4.07	0	0		4. 07
4.08	0	0		4. 08
4.09	0	0		4. 09
4.10	0	0		4. 10
4. 11	-5, 673	11		4. 11
4. 12	2, 556	0		4. 12
4.13	413, 642	0		4. 13
4.14	-659, 592	0		4. 14
4. 15	-89, 195	0		4. 15
4. 16	-175, 956	0		4. 16
4. 17	0	0		4. 17
4. 18	0	0		4. 18
4. 19	0	0		4. 19
4. 20	0	0		4. 20
4. 21	0	0		4. 21
4. 22	0	0		4. 22
4. 23	0	0		4. 23
4. 24	0	0		4. 24
4. 25	0	0		4. 25
5.00	9, 147, 675			5. 00

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

Rel ated Organi zati on(s)		
and/or Home Office		
Type of Business		
6. 00		
B. INTERRELATIONSHIP TO RELA	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

6. 00	HOME OFFICE	6.00
7.00	SYSTEM OFFICE	7.00
8.00		8.00
9.00		9.00
10. 00 100. 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.
- $\hbox{B. Corporation, partnership, or other organization has financial interest in provider.}\\$
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT | Peri od: | Worksheet A-8-2 | From 07/01/2021 | To 06/30/2022 | Date/Time Prepared: Provider CCN: 15-0088

					1	To 06/30/2022	2 Date/Time Pre 11/29/2022 8:	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1. 00	2. 00	3.00	4.00	5. 00	6. 00	7. 00	
1.00		INTENSIVE CARE UNIT	379, 240					
2.00	50. 00	OPERATING ROOM	1, 678, 884			246, 400		2. 00
3.00		RADI OLOGY-DI AGNOSTI C	228, 499		,			
4.00	70. 00	ELECTROENCEPHALOGRAPHY	267, 718	267, 718	0	179, 000	0	4. 00
5.00	76. 01	WOUND CARE	30, 000			179, 000		5. 00
6.00	91. 00	EMERGENCY	1, 212, 747	1, 212, 747	0	179, 000	0	6. 00
7.00	0.00		0	0	0	0	0	7. 00
8. 00	0.00		0	0	0	0	0	8. 00
9. 00	0.00		0	0	0	0	0	9. 00
10.00	0.00		0	0	0	0	0	10. 00
200.00			3, 797, 088		· · · · · · · · · · · · · · · · · · ·		16, 800	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of		Physician Cost	
		l denti fi er	Limit	Unadjusted RCE			of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
	4 00			0.00	Educati on	12	44.00	
1 00	1.00	2.00	8.00	9. 00	12. 00	13.00	14.00	1 00
1.00		INTENSIVE CARE UNIT	0 0 0 1 1 1 1					1.00
2.00		OPERATING ROOM	952, 431			0	1	
3.00		RADI OLOGY-DI AGNOSTI C	1, 145, 117			0	0	3. 00
4. 00 5. 00		ELECTROENCEPHALOGRAPHY WOUND CARE	0	0	-	0	0	4. 00 5. 00
		EMERGENCY	0	0	0	0	1	
6. 00 7. 00	0.00	EMERGENCY	0	0	0	0	0	6. 00 7. 00
7. 00 8. 00	0.00		0	0	0	0	0	8. 00
9. 00	0.00				0	0	0	9.00
9. 00 10. 00	0.00				0	0	0	10.00
200.00	0.00		2, 097, 548	104, 878	0	0	0	
200.00	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment	0	200.00
	WKSt. A LITTE #	I denti fi er	Component	Limit	Di sal I owance	Auj us tillerit		
		rdentifier	Share of col.	Limit	Di Sai i Owance			
			14					
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00		
1.00		INTENSIVE CARE UNIT	0					1. 00
2.00		OPERATING ROOM	0	952, 431	0	781, 533		2. 00
3. 00		RADI OLOGY-DI AGNOSTI C	0	1, 145, 117		0		3. 00
4. 00		ELECTROENCEPHALOGRAPHY	0	0		267, 718		4. 00
5. 00		WOUND CARE	0	0	0	30,000	•	5. 00
6. 00		EMERGENCY	l o	0	0	1, 212, 747		6. 00
7. 00	0.00		0	0	0	0		7. 00
8.00	0.00		0	l o	0	o o		8. 00
9. 00	0.00		0	l o	0	o o		9. 00
10. 00	0.00		Ö	l	0	Ō		10.00
200.00			l o	2, 097, 548	0	2, 671, 238	İ	200.00
	. '			, , , , , , , , , , , , , , , , , , , ,			•	

| Peri od: | Worksheet B | From 07/01/2021 | Part | To 06/30/2022 | Date/Time Prepared: | Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS ASCENSION ST. VINCENT ANDERSON Provider CCN: 15-0088

					To 06/30/202	2 Date/Time Pre 11/29/2022 8:	
			CAPI TAL REI	_ATED COSTS		1172772022 0.	
	Cost Center Description	Not Eypopoo	BLDG & FLXT	BLDG &	EMDL OVEE	Cubtotal	
	cost center bescription	Net Expenses for Cost	DLDG & FIXI	FIXT-MAB	EMPLOYEE BENEFITS	Subtotal	
		Allocation			DEPARTMENT		
		(from Wkst A					
		col. 7) 0	1. 00	1. 01	4.00	4A	
	GENERAL SERVICE COST CENTERS	0	1.00	1.01	4.00	47	
1.00	00100 CAP REL COSTS-BLDG & FIXT	3, 275, 216	3, 275, 216				1. 00
1. 01	00101 CAP REL COSTS-BLDG & FIXT-MAB	0	0		0		1. 01
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	8, 329, 806	43, 012		0 8, 372, 81	I	4. 00 5. 00
7.00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	45, 073, 341 4, 976, 029	360, 286 387, 178		0 278, 19	3 45, 711, 820 0 5, 363, 207	7.00
8. 00	00800 LAUNDRY & LINEN SERVICE	861, 958	4, 660		O	0 866, 618	
9.00	00900 HOUSEKEEPI NG	2, 892, 430	69, 293		0 4		9. 00
10.00	01000 DI ETARY	741, 710	71, 599		0	0 813, 309	1
11. 00 13. 00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON	1, 828, 117 2, 415, 076	121, 723 33, 921		0 304, 23	0 1, 949, 840 7 2, 753, 234	
14. 00	01400 CENTRAL SERVICES & SUPPLY	-70, 492	110, 152		0 75, 17		1
15. 00	01500 PHARMACY	3, 674, 270	33, 469		0 516, 71	I	
16.00	01600 MEDICAL RECORDS & LIBRARY	6	36, 213		0	0 36, 219	
23. 00 23. 01	02300 ALLIED HEALTH-EMS 02301 ALLIED HEALTH-RAD TECH	0 136, 188	0 764		0 17, 46	0 8 154, 420	23. 00 23. 01
23. 01	02303 ALLI ED HEALTH-PHARM RESI DENTS	130, 188	0		0 17, 40	0 154, 420	23. 01
	INPATIENT ROUTINE SERVICE COST CENTERS	-	•		-1	-, -	
30. 00	03000 ADULTS & PEDIATRICS	16, 780, 819	454, 742		0 2, 270, 37		
31.00	03100 NTENSIVE CARE UNIT	7, 198, 105	101, 818	•	0 865, 86		1
41. 00 43. 00	04100 SUBPROVI DER - I RF 04300 NURSERY	1, 701, 804 269, 936	69, 453 43, 297		0 242, 05 0 37, 93		41. 00 43. 00
10.00	ANCILLARY SERVICE COST CENTERS	2077700	10,277		0,770	0 0017171	10.00
50.00	05000 OPERATING ROOM	13, 498, 822	333, 352		0 119, 33		
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	1, 135, 971 0	154, 706		0 161, 45	9 1, 452, 136 0 0	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	2, 923, 779	99, 165		0 323, 90		53. 00 54. 00
54. 01	03440 MAMMOGRAPHY	532, 819	0		0 45, 90		1
54. 02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	923, 606	7, 827		0 48, 59		
54. 03	03630 ULTRA SOUND	425, 148	0		0 57, 00		
55. 00 57. 00	05500 RADI OLOGY-THERAPEUTI C 05700 CT SCAN	1, 826, 239 868, 961	3, 827		0 154, 58 0 112, 00		
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	538, 484	6, 966		0 50, 29	I	
59. 00	05900 CARDI AC CATHETERI ZATI ON	1, 098, 847	59, 465		0 137, 05		
60.00	06000 LABORATORY	6, 324, 555	87, 121		0	0 6, 411, 676	
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	1, 589, 577 2, 012, 261	49, 575 68, 501		0 231, 01 0 281, 01		
67. 00	06700 OCCUPATI ONAL THERAPY	897, 848	30, 844		0 125, 68		
68. 00	06800 SPEECH PATHOLOGY	314, 027	10, 786		0 43, 95	7 368, 770	68. 00
69. 00	06900 ELECTROCARDI OLOGY	192, 405	0		0 20, 62		
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	292, 914 4, 685, 468	80, 871		0 39, 64	7 413, 432 0 4, 685, 468	
	07200 I MPL. DEV. CHARGED TO PATTENTS	4, 897, 421	0		0	0 4, 897, 421	
	07300 DRUGS CHARGED TO PATIENTS	19, 644, 532	0		0	0 19, 644, 532	
76. 00	03190 CHEMOTHERAPY	980, 582	0		0 129, 99		
76. 01	03020 WOUND CARE OUTPATIENT SERVICE COST CENTERS	959, 201	21, 530		0 74, 59	4 1, 055, 325	76. 01
90. 00	09000 CLINIC	O	0		0	0 0	90.00
90. 01	09001 ANDERSON OUTPATIENT CENTER	1, 090, 863	24, 308		0 176, 33	5 1, 291, 506	
90. 02	04950 DI ABETI C EDUCATI ON	0	0		0	0	90. 02
90. 03 91. 00	09002 MS CLINIC 09100 EMERGENCY	6, 380, 302	0 157, 206		0 782, 66	0 9 7, 320, 177	90. 03 91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0, 360, 302	137, 200		782,00	7, 320, 177	1
	OTHER REIMBURSABLE COST CENTERS						
95. 00	09500 AMBULANCE SERVI CES	0	0		0 2, 93	5 2, 935	95. 00
112 00	SPECIAL PURPOSE COST CENTERS 11300 NTEREST EXPENSE						113. 00
118. 00		174, 118, 951	3, 137, 630		0 7, 726, 66	8 173, 335, 215	
	NONREI MBURSABLE COST CENTERS	.,	-, -, -,				
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	13, 071		0		190. 00
	19100 RESEARCH	103, 023	12 702		0 13, 88		
	19200 PHYSI CI ANS' PRI VATE OFFI CES 07950 FOUNDATI ON	3, 061, 451 0	12, 703 4, 417		0 447, 49		194.00
	07951 CHI LDRENS CLI NI C	214	0		0		194. 01
	07952 PSS ADMINISTRATION	21, 483	0		0 2, 72		194. 02
	3 O7953 SEXUAL ASSAULT PROGRAM	2, 122	0		0 33		194. 03
	07954 ASPR BIOTERRORISM GRANT 07955 HEALTHY FAMILIES	440 344, 176	70, 085		0 43, 81		194. 04 194. 05
	07956 DME-HOME CARE	-15, 954	, 5, 565		0	0 -15, 954	

Health Financial Systems	ASCENSION ST. VI	NCENT ANDERSON		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC	CN: 15-0088	Peri od: From 07/01/2021 To 06/30/2022	Worksheet B Part I Date/Time Pre 11/29/2022 8:	pared:
		CAPI TAL REL	ATED COSTS		1172772022 0.	O7 dill
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	BLDG & FIXT-MAB	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
	0	1.00	1. 01	4. 00	4A	
194. 07 07957 MARKETI NG	0	0		0 0	0	194. 07
194. 08 07958 CORPORATE COMMUNI CATIONS	0	17, 551		0	17, 551	194. 08
194. 09 07959 MOB	360	0		0		194. 09
194. 10 07960 ASC	0	0		0		194. 10
194. 11 07961 MAB	0	0		0		194. 11
194. 12 07963 ADOLESCENT RESIDENTIAL SERVICES	911, 031	19, 759		0 137, 896		1
194. 13 07962 I DLE SPACE	0	0		0		194. 13
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers		0		0	-	201. 00
202.00 TOTAL (sum lines 118 through 201)	178, 547, 297	3, 275, 216		0 8, 372, 818	178, 547, 297	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0088

					0 06/30/2022	11/29/2022 8:	
	Cost Center Description	ADMI NI STRATI VE		LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL 5.00	7. 00	LINEN SERVICE 8.00	9. 00	10.00	
GI	ENERAL SERVICE COST CENTERS	3.00	7.00	0.00	7. 00	10.00	
	0100 CAP REL COSTS-BLDG & FLXT						1.00
	0101 CAP REL COSTS-BLDG & FIXT-MAB						1. 01
	0400 EMPLOYEE BENEFITS DEPARTMENT	45 711 000					4.00
	0500 ADMINISTRATIVE & GENERAL 0700 OPERATION OF PLANT	45, 711, 820	7 200 E00				5. 00 7. 00
	0800 LAUNDRY & LINEN SERVICE	1, 845, 383 298, 188	7, 208, 590 13, 520	1			8.00
	0900 HOUSEKEEPI NG	1, 019, 090	201, 029		4, 181, 883		9. 00
	1000 DI ETARY	279, 845	207, 718		37, 707	1, 338, 579	10.00
	1100 CAFETERI A	670, 905	353, 135	1	22, 145	0	11.00
13.00 0	1300 NURSING ADMINISTRATION	947, 338	98, 409	0	14, 963	0	13. 00
14.00 0	1400 CENTRAL SERVICES & SUPPLY	39, 511	319, 567	20, 633	49, 677	0	14. 00
	1500 PHARMACY	1, 453, 560	97, 099	1	11, 970	0	15. 00
	1600 MEDI CAL RECORDS & LI BRARY	12, 462	105, 058	0	2, 993	0	16.00
	2300 ALLIED HEALTH-EMS	0	0	0	0	0	23. 00
	2301 ALLIED HEALTH-RAD TECH 2303 ALLIED HEALTH-PHARM RESIDENTS	53, 133 0	2, 216 0	1	0	0	23. 01 23. 02
	NPATIENT ROUTINE SERVICE COST CENTERS	l o	0	0	U _I	0	23.02
	3000 ADULTS & PEDI ATRI CS	6, 711, 640	1, 319, 271	434, 978	1, 850, 693	1, 068, 869	30. 00
	3100 INTENSIVE CARE UNIT	2, 809, 700	295, 388				31.00
41.00 0	4100 SUBPROVI DER - I RF	692, 743	201, 492	45, 097	149, 631	101, 572	41.00
43.00 0	4300 NURSERY	120, 832	125, 610	8, 886	23, 582	0	43. 00
	NCILLARY SERVICE COST CENTERS						
	5000 OPERATING ROOM	4, 800, 463	967, 103				50.00
	5200 DELIVERY ROOM & LABOR ROOM 5300 ANESTHESIOLOGY	499, 654	448, 824	30, 120	100, 253	23, 950	52.00
	5300 ANESTHESTOLOGY 5400 RADI OLOGY-DI AGNOSTI C	1, 151, 590	287, 691	3, 095	104, 742	0	53. 00 54. 00
	3440 MAMMOGRAPHY	199, 129	207, 091	6, 903	8, 978	0	54. 00
	3450 NUCLEAR MEDICINE - DIAGNOSTIC	337, 210	22, 708		8, 978	0	54. 02
	3630 ULTRA SOUND	165, 901	0		0	Ö	54. 03
55.00 0	5500 RADI OLOGY-THERAPEUTI C	681, 567	0	15, 929	8, 978	0	55. 00
	5700 CT SCAN	338, 849	11, 102	57, 654	0	0	57. 00
	5800 MAGNETIC RESONANCE IMAGING (MRI)	204, 984	20, 210	l	8, 978	0	58. 00
	5900 CARDI AC CATHETERI ZATI ON	445, 714	172, 518	1	17, 956	1, 175	59. 00
	6000 LABORATORY	2, 206, 142	252, 752	1	74, 815	0	60.00
1	6500 RESPI RATORY THERAPY	643, 490	143, 825		5, 985	0	65.00
	6600 PHYSI CAL THERAPY 6700 OCCUPATI ONAL THERAPY	812, 645 362, 790	198, 732 89, 483	1		0	66. 00 67. 00
	6800 SPEECH PATHOLOGY	126, 887	31, 292	l	12, 330	0	68.00
	6900 ELECTROCARDI OLOGY	73, 299	01,272	142	89, 779	0	69.00
	7000 ELECTROENCEPHALOGRAPHY	142, 255	234, 618	1	41, 897	102	70.00
71.00 0	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 612, 185	0	0	O	0	71. 00
	7200 IMPL. DEV. CHARGED TO PATIENTS	1, 685, 114	0	0	0	0	72. 00
	7300 DRUGS CHARGED TO PATIENTS	6, 759, 365	0	0	0	0	73. 00
	3190 CHEMOTHERAPY	382, 131	0	21, 075		16, 252	76. 00
	3020 WOUND CARE UTPATIENT SERVICE COST CENTERS	363, 118	62, 463	0	0	0	76. 01
	9000 CLINIC	0	0	0	ol	0	90.00
	9001 ANDERSON OUTPATIENT CENTER	444, 384	70, 522		35, 911	0	90. 01
	4950 DI ABETI C EDUCATION	0	0	Ö	0	Ö	90. 02
	9002 MS CLINIC	o	0	0	О	0	90. 03
	9100 EMERGENCY	2, 518, 741	456, 078	171, 193	421, 959	35, 160	91.00
	9200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	THER REIMBURSABLE COST CENTERS	1 220		1	ام		
	9500 AMBULANCE SERVICES	1, 010	0	0	0	0	95. 00
	PECIAL PURPOSE COST CENTERS 1300 INTEREST EXPENSE			1			113. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	43, 912, 947	6, 809, 433	1, 161, 288	4, 098, 090	1, 338, 579	
	ONREI MBURSABLE COST CENTERS	45, 712, 747	0,007,433	1, 101, 200	4, 070, 070	1, 330, 377	1110.00
	9000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	4, 497	37, 921	0	0	0	190. 00
	9100 RESEARCH	40, 225	0	0	0	0	191. 00
192. 00 1	9200 PHYSICIANS' PRIVATE OFFICES	1, 211, 737	36, 853	0	0	0	192. 00
	7950 FOUNDATION	1, 520	12, 815	1	1, 496		194. 00
	7951 CHI LDRENS CLI NI C	74	0	232	53, 867		194. 01
	7952 PSS ADMINISTRATION	8, 329	0	0	0		194. 02
	7953 SEXUAL ASSAULT PROGRAM	846	0] 0	0		194. 03
	7954 ASPR BIOTERRORISM GRANT 7955 HEALTHY FAMILIES	151	203, 326		0		194. 04 194. 05
	7955 DME-HOME CARE	157, 615 0	2U3, 320 A	0	0		194. 05
	7957 MARKETI NG	0	0	0	0		194. 00
	7958 CORPORATE COMMUNICATIONS	6, 039	50, 917	Ö	2, 993		194. 08
194. 09 0	7959 MOB	124	0	16, 806	·	0	194. 09
	7960 ASC	0	0	0	5, 985		194. 10
194. 11 0	7961 MAB	0	0	0	0	0	194. 11

Health Financial Systems	ASCENSION ST. VINC	ENT ANDERSON	In Lie	u of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-0088	Peri od: From 07/01/2021 To 06/30/2022	Worksheet B Part I Date/Time Prepared:

					11/29/2022 8:	<u>09 am</u>
Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	& GENERAL	PLANT	LINEN SERVICE			
	5.00	7.00	8. 00	9. 00	10.00	
194. 12 07963 ADOLESCENT RESIDENTIAL SERVICES	367, 716	57, 325	0	0	0	194. 12
194. 13 07962 I DLE 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)	45, 711, 820	7, 208, 590	1, 178, 326	4, 181, 883	1, 338, 579	202. 00

Provider CCN: 15-0088

| Peri od: | Worksheet B | From 07/01/2021 | Part | | To 06/30/2022 | Date/Time Prepared: |

			l C	00/30/2022	Date/lime Pre 11/29/2022 8:	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
	1	ADMI NI STRATI ON	SERVICES & SUPPLY		RECORDS & LI BRARY	
	11. 00	13. 00	14. 00	15. 00	16. 00	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
1.01 00101 CAP REL COSTS-BLDG & FIXT-MAB 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						1. 01 4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL						5. 00
7. 00 00700 OPERATION OF PLANT						7. 00
8.00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A	2, 996, 025					11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	132, 573	3, 946, 517	/OF 027			13.00
14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY	61, 608 202, 164	0	605, 827 8, 245	5, 997, 496		14. 00 15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	202, 104	0	0, 243	3, 77 7, 470	156, 732	16. 00
23. 00 02300 ALLI ED HEALTH-EMS	o	o	0	o	0	23. 00
23. 01 02301 ALLIED HEALTH-RAD TECH	8, 858	o	0	o	0	23. 01
23. 02 02303 ALLIED HEALTH-PHARM RESIDENTS	0	0	0	0	0	23. 02
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	909, 713	1, 950, 333	29, 901	0	11, 936	30.00
31. 00 03100 INTENSI VE CARE UNI T	252, 046	747, 975	16, 817	0	5, 411	31.00
41. 00 04100 SUBPROVI DER - I RF 43. 00 04300 NURSERY	87, 377 14, 485	204, 097 39, 642	1, 062 610	0	892 351	41. 00 43. 00
ANCILLARY SERVICE COST CENTERS	14, 400	37, 042	010	<u> </u>	331	43.00
50. 00 05000 OPERATING ROOM	634	159, 802	443, 850	0	29, 184	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	65, 671	202, 489	3, 870	o	985	52. 00
53. 00 05300 ANESTHESI OLOGY	0	0	0	0	0	53. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	186, 078	0	20, 947	0	3, 850	54.00
54. 01 03440 MAMMOGRAPHY	20, 318	0	3, 161	0	871	54. 01
54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC 54. 03 03630 ULTRA SOUND	18, 852 23, 010	0	10, 003 201	0	3, 673 2, 069	54. 02 54. 03
55. 00 05500 RADI OLOGY-THERAPEUTI C	81, 146	0	867	0	6, 784	55. 00
57. 00 05700 CT SCAN	49, 654	o	23	o	3, 820	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	20, 126	o	95	o	655	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	64, 547	109, 300	8, 770	0	5, 435	59. 00
60. 00 06000 LABORATORY	0	0	147	0	19, 408	60.00
65. 00 06500 RESPI RATORY THERAPY	92, 668	0	11, 315	0	4, 475	65.00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	98, 283 67, 977	0	2, 626 1, 183	0	1, 973 816	66. 00 67. 00
68.00 06800 SPEECH PATHOLOGY	23, 774	0	414	0	286	68.00
69. 00 06900 ELECTROCARDI OLOGY	12, 581	o	67	o	273	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	6, 963	o	79	o	878	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	4, 658	71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	4, 731	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	5, 997, 496	23, 578	73.00
76. 00 03190 CHEMOTHERAPY 76. 01 03020 WOUND CARE	78, 621 39, 043	0	5, 586 14, 001	0	1, 948 1, 094	76. 00 76. 01
OUTPATIENT SERVICE COST CENTERS	39, 043	U _I	14, 001	<u> </u>	1, 094	76.01
90. 00 09000 CLI NI C	0	ol	0	ol	0	90. 00
90. 01 09001 ANDERSON OUTPATIENT CENTER	40, 519	О	29	o	846	90. 01
90. 02 04950 DIABETIC EDUCATION	0	0	0	0	0	90. 02
90. 03 09002 MS CLINIC	0	0	0	0	0	90. 03
91. 00 09100 EMERGENCY	272, 789	532, 879	21, 940	0	15, 852	91.00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92. 00
95. 00 09500 AMBULANCE SERVICES	ol	o	0	o	0	95. 00
SPECIAL PURPOSE COST CENTERS	9		<u> </u>			75.00
113. 00 11300 NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	2, 932, 078	3, 946, 517	605, 809	5, 997, 496	156, 732	118. 00
NONRE MBURSABLE COST CENTERS						
190. 00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0		190. 00
191. 00 19100 RESEARCH	6, 813	0	0	0		191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 194. 00 07950 FOUNDATI ON	13, 548 0	0	4	U O		192. 00 194. 00
194. 01 07951 CHI LDRENS CLI NI C	0	0	0	0		194. 00
194. 02 07952 PSS ADMI NI STRATI ON	2, 352	ol	0	ol		194. 02
194.03 07953 SEXUAL ASSAULT PROGRAM	88	Ö	0	Ö		194. 03
194.04 07954 ASPR BIOTERRORISM GRANT	o	o	0	o		194. 04
194. 05 07955 HEALTHY FAMILIES	41, 146	O	14	0		194. 05
194. 06 07956 DME-HOME CARE	0	0	0	0		194. 06
194.07 07957 MARKETI NG	0	0	0	0		194. 07 194. 08
194. 08 07958 CORPORATE COMMUNI CATLONS 194. 09 07959 MOB	0	0	0	0		194. 08
194. 10 07960 ASC	0	0	0	ol O		194. 09
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Health Financial Systems

ASCENSION ST. VINCENT ANDERSON

In Lieu of Form CMS-2552-10

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0088
From 07/01/2021
To 06/30/2022
Date/Time Prepared:

						11/29/2022 8:	09 am
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
			ADMI NI STRATI ON	SERVICES &		RECORDS &	
				SUPPLY		LI BRARY	
		11. 00	13. 00	14.00	15. 00	16.00	
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	I DLE 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, 996, 025	3, 946, 517	605, 827	5, 997, 496	156, 732	202. 00

Provider CCN: 15-0088

| Peri od: | Worksheet B | From 07/01/2021 | Part | | To 06/30/2022 | Date/Time Prepared: |

			10) 06/30/2022	Date/lime Pre 11/29/2022 8:	
Cost Center Description	ALLI ED	ALLI ED	ALLI ED	Subtotal	Intern &	
	HEALTH-EMS	HEALTH-RAD	HEALTH-PHARM		Residents Cost	
		TECH	RESI DENTS		& Post	
					Stepdown Adjustments	
	23. 00	23. 01	23. 02	24. 00	25. 00	
GENERAL SERVICE COST CENTERS	1					
1.00 O0100 CAP REL COSTS-BLDG & FLXT						1. 00
1.01 O0101 CAP REL COSTS-BLDG & FIXT-MAB						1. 01
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00 00500 ADMI NI STRATI VE & GENERAL						5. 00
7. 00 00700 OPERATION OF PLANT						7. 00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG						8.00
10. 00 01000 DI ETARY						9. 00 10. 00
11. 00 01100 CAFETERI A						11.00
13. 00 01300 NURSING ADMINISTRATION						13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY						14. 00
15. 00 01500 PHARMACY						15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY						16. 00
23.00 02300 ALLIED HEALTH-EMS	0					23. 00
23. 01 02301 ALLI ED HEALTH-RAD TECH		218, 627				23. 01
23. 02 02303 ALLIED HEALTH-PHARM RESIDENTS			0			23. 02
I NPATI ENT ROUTI NE SERVI CE COST CENTERS			_1		_	
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	0	33, 793, 267	0	30.00
31. 00 03100 I NTENSI VE CARE UNI T	0	0	-	12, 841, 972	0	31.00
41. 00 04100 SUBPROVI DER - I RF 43. 00 04300 NURSERY	0	0	-	3, 497, 270	0	41.00
43. 00 O4300 NURSERY ANCI LLARY SERVI CE COST CENTERS	l d	U	0	685, 169	0	43. 00
50. 00 05000 OPERATING ROOM	o	0	o	21, 090, 795	0	50. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	Ö	2, 827, 952	0	52. 00
53. 00 05300 ANESTHESI OLOGY	0	0	Ö	0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	38, 742	0	5, 143, 584	0	54.00
54. 01 03440 MAMMOGRAPHY	0	8, 767	О	826, 851	0	54. 01
54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	36, 966	0	1, 419, 009	0	54. 02
54. 03 03630 ULTRA SOUND	0	20, 822	0	694, 827	0	54. 03
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	68, 297	0	2, 844, 395	0	55. 00
57. 00 05700 CT SCAN	0	38, 441	0	1, 484, 335	0	57. 00
58. 00 05800 MAGNETI C RESONANCE I MAGING (MRI)	0	6, 592	0	867, 513	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0	0	2, 120, 785	0	59.00
60. 00 06000 LABORATORY 65. 00 06500 RESPI RATORY THERAPY	0	0	0	8, 964, 940 2, 771, 923	0	60. 00 65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0	0	3, 566, 347	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	Ö	1, 617, 074	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	o	0	Ö	564, 772	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0	389, 169	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	O	0	0	840, 224	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	6, 302, 311	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	6, 587, 266	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		32, 424, 971	0	73. 00
76. 00 03190 CHEMOTHERAPY	0	0	ŭ	1, 616, 194	0	76. 00
76. 01 03020 WOUND CARE	0	0	0	1, 535, 044	0	76. 01
90. 00 09000 CLINIC		٥		0	0	90. 00
90. 01 09001 ANDERSON OUTPATIENT CENTER	0	0	0	1, 883, 717	0	90. 01
90. 02 04950 DI ABETI C EDUCATI ON	0	0	Ö	0,000,717	0	90. 02
90. 03 09002 MS CLINIC	0	0	Ö	0	0	90. 03
91. 00 09100 EMERGENCY	0	0	O	11, 766, 768	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)					0	92. 00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVI CES	0	0	0	3, 945	0	95. 00
SPECIAL PURPOSE COST CENTERS	T		T			
113. 00 11300 INTEREST EXPENSE		210 /27		170 072 200		113. 00
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	0	218, 627	0	170, 972, 389	0	118. 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	O	0	O	55, 489	0	190. 00
191. 00 19100 RESEARCH	0	0	0	163, 944		191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	Ö	4, 783, 795		192. 00
194. 00 07950 FOUNDATION	0	0	Ö	20, 248		194. 00
194. 01 07951 CHI LDRENS CLI NI C	l ol	Ö	o	54, 387		194. 01
194. 02 07952 PSS ADMINISTRATION	o	o	o	34, 887		194. 02
194.03 07953 SEXUAL ASSAULT PROGRAM	0	o	О	3, 392	0	194. 03
194. 04 07954 ASPR BIOTERRORISM GRANT	0	O	0	591		194. 04
194. 05 07955 HEALTHY FAMILIES	0	0	0	860, 175		194. 05
194. 06 07956 DME-HOME CARE	0	0	0	-15, 954		194. 06
194. 07 07957 MARKETI NG	0	0	0	77 500		194. 07
194. 08 07958 CORPORATE COMMUNICATIONS	0	0	0	77, 500	0	194. 08

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS ASCENSION ST. VINCENT ANDERSON Provider CCN: 15-0088

					11/2//2022 0.	0 / Gill
Cost Center Description	ALLI ED	ALLI ED	ALLI ED	Subtotal	Intern &	
	HEALTH-EMS	HEALTH-RAD	HEALTH-PHARM		Residents Cost	
		TECH	RESI DENTS		& Post	
					Stepdown	
					Adjustments	
	23. 00	23. 01	23. 02	24. 00	25. 00	
194. 09 07959 MOB	0	0	0	36, 742	0	194. 09
194. 10 07960 ASC	0	0	0	5, 985	0	194. 10
194. 11 07961 MAB	0	0	0	0	0	194. 11
194. 12 07963 ADOLESCENT RESIDENTIAL SERVICES	0	0	0	1, 493, 727	0	194. 12
194. 13 07962 I DLE 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	218, 627	0	178, 547, 297	0	202. 00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0088

Peri od: Worksheet B From 07/01/2021 Part I To 06/30/2022 Date/Time Prepared:

11/29/2022 8:09 am Cost Center Description Total 26. 00 GENERAL SERVICE COST CENTERS 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 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 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 10.00 11.00 01100 CAFETERI A 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 ALLI ED HEALTH-EMS 23.00 02301 ALLI ED HEALTH-RAD TECH 23 01 23 01 23.02 02303 ALLIED HEALTH-PHARM RESIDENTS 23.02 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 33, 793, 267 30.00 03100 INTENSIVE CARE UNIT 12, 841, 972 31.00 31.00 41.00 04100 SUBPROVIDER - IRF 3, 497, 270 41.00 04300 NURSERY 43.00 685, 169 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 21, 090, 795 50.00 05200 DELIVERY ROOM & LABOR ROOM 2, 827, 952 52.00 52.00 53.00 05300 ANESTHESI OLOGY 53.00 05400 RADI OLOGY-DI AGNOSTI C 54 00 5, 143, 584 54 00 54.01 03440 MAMMOGRAPHY 826, 851 54.01 03450 NUCLEAR MEDICINE - DIAGNOSTIC 54.02 1, 419, 009 54.02 03630 ULTRA SOUND 694, 827 54.03 54.03 05500 RADI OLOGY-THERAPEUTI C 55 00 2, 844, 395 55 00 57.00 05700 CT SCAN 1, 484, 335 57.00 58 00 05800 MAGNETIC RESONANCE I MAGING (MRI) 867, 513 58.00 05900 CARDIAC CATHETERIZATION 59.00 2, 120, 785 59.00 60.00 06000 LABORATORY 8, 964, 940 60.00 06500 RESPIRATORY THERAPY 2, 771, 923 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 3, 566, 347 66.00 06700 OCCUPATI ONAL THERAPY 1,617,074 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 564, 772 68.00 06900 ELECTROCARDI OLOGY 389, 169 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 840, 224 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 6, 302, 311 71.00 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 6, 587, 266 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 32, 424, 971 73.00 03190 CHEMOTHERAPY 1, 616, 194 76.00 76.00 03020 WOUND CARE 76.01 1, 535, 044 76.01 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 90.00 09001 ANDERSON OUTPATIENT CENTER 90.01 90.01 1,883,717 90.02 04950 DIABETIC EDUCATION 90.02 90.03 09002 MS CLINIC 90.03 09100 EMERGENCY 11, 766, 768 91 00 91 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 95.00 3, 945 95.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 170, 972, 389 118.00 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 55, 489 190.00 191. 00 19100 RESEARCH 163, 944 191.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 4, 783, 795 192.00 194. 00 07950 FOUNDATI ON 20, 248 194. 00 194. 01 07951 CHI LDRENS CLI NI C 54, 387 194 01 194. 02 07952 PSS ADMINISTRATION 34, 887 194.02 194.03 07953 SEXUAL ASSAULT PROGRAM 3, 392 194.03 194. 04 07954 ASPR BI OTERRORI SM GRANT 194. 04 591 194.05 07955 HEALTHY FAMILIES 194 05 860, 175 194.06 07956 DME-HOME CARE -15, 954 194.06 194. 07 07957 MARKETI NG 194. 07 194. 08 07958 CORPORATE COMMUNICATIONS 194. 08 77.500 194. 09 07959 MOB 36, 742 194. 09 194. 10 07960 ASC 5, 985 194. 10 194. 11 07961 MAB 194, 11 1, 493, 727 194. 12 07963 ADOLESCENT RESIDENTIAL SERVICES 194. 12

Health Financial Systems	ASCENSION ST.	VINCENT ANDERSON	In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der CCN: 15-0088	Peri od: From 07/01/2021 To 06/30/2022	Worksheet B Part I Date/Time Prep 11/29/2022 8:0	
Cost Center Description	Total 26, 00				

			11/29/2022 8:	<u>09 am</u>
	Cost Center Description	Total		
		26.00		
194. 13 07962	I DLE SPACE	0		194. 13
200. 00	Cross Foot Adjustments	0		200.00
201.00	Negative Cost Centers	0		201.00
202. 00	TOTAL (sum lines 118 through 201)	178, 547, 297		202. 00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 07/01/2021 | Part II | To 06/30/2022 | Date/Time Prepared: | Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0088

					0 06/30/2022	Date/lime Pre 11/29/2022 8:	
			CAPI TAL REI	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	
	GENERAL SERVICE COST CENTERS						
1. 00 1. 01 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00	01100 CAFETERI A	0 2, 556, 347 0 0 0 0 0	43, 012 360, 286 387, 178 4, 660 69, 293 71, 599 121, 723 33, 921		387, 178	43, 012 1, 429 0 0 0 0 0 0 1, 563	9. 00 10. 00 11. 00
14. 00 15. 00 16. 00 23. 00 23. 01 23. 02	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 02300 ALLIED HEALTH-EMS 02301 ALLIED HEALTH-RAD TECH	0 0 0 0 0	110, 152 33, 469 36, 213 0 764	(33, 469	386 2, 654 0 0 90	14. 00 15. 00 16. 00 23. 00 23. 01 23. 02
30. 00 31. 00 41. 00 43. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04100 SUBPROVIDER - IRF 04300 NURSERY	0 0 0 0	454, 742 101, 818 69, 453 43, 297	(454, 742 101, 818 69, 453 1043, 297	11, 665 4, 448 1, 243 195	31. 00 41. 00
50. 00 52. 00 53. 00 54. 01 54. 02 54. 03 55. 00 57. 00 58. 00 60. 00 65. 00 66. 00 67. 00 68. 00 70. 00 71. 00 72. 00 74. 00 76. 01 90. 02 90. 01 90. 02 90. 03	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 03440 MAMMOGRAPHY 03450 NUCLEAR MEDICINE - DI AGNOSTI C 03630 ULTRA SOUND 05500 RADI OLOGY-THERAPEUTI C 05700 CT SCAN 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06600 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 07200 IMPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 073190 CHEMOTHERAPY 03190 CHEMOTHERAPY 03020 WOUND CARE 0UTPATI ENT SERVI CE COST CENTERS 09000 CLI NI C 09001 ANDERSON OUTPATI ENT CENTER	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	333, 352 154, 706 0 99, 165 0 7, 827 0 0 3, 827 6, 966 59, 465 87, 121 49, 575 68, 501 30, 844 10, 786 0 80, 871 0 0 21, 530		6, 966 59, 465 87, 121 49, 575 68, 501 30, 844	236 250 293 794 575 258 704 0 1, 187 1, 443 646 226 106 204 0 0 0 668 383	52. 00 53. 00 54. 00 54. 01 54. 03 55. 00 57. 00 58. 00 60. 00 66. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 76. 01
91. 00 92. 00 95. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	0	157, 206		157, 206	4, 020	92. 00
	SPECIAL PURPOSE COST CENTERS	·					
118. 0	NONREI MBURSABLE COST CENTERS	2, 556, 347	3, 137, 630		5, 693, 977		113. 00 118. 00
191. 0 192. 0 194. 0 194. 0 194. 0 194. 0 194. 0	0 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 0 19100 RESEARCH 0 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 07950 FOUNDATI ON 1 07951 CHI LDRENS CLI NI C 2 07952 PSS ADMI NI STRATI ON 3 07953 SEXUAL ASSAULT PROGRAM 4 07954 ASPR BI OTERRORI SM GRANT 5 07955 HEALTHY FAMI LI ES 6 07956 DME-HOME CARE	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	13, 071 0 12, 703 4, 417 0 0 0 70, 085		13, 071 0 12, 703 0 4, 417 0 0 0 0 0 0 0 70, 085	71 2, 299 0 0 14 2 0 225	190. 00 191. 00 192. 00 194. 00 194. 01 194. 02 194. 03 194. 04 194. 05 194. 06
	7 07957 MARKETI NG	0	0		0 0		194. 06

Health Financial Systems	ASCENSION ST. VINCENT ANDERSON	In Lieu of Form CMS-2552-10		
ALLOCATION OF CAPITAL RELATED COSTS	Provi der CCN: 15-0088	Period: Worksheet B From 07/01/2021 Part II		

				o 06/30/2022	Date/Time Pre 11/29/2022 8:	
		CAPI TAL 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. 08 07958 CORPORATE COMMUNI CATI ONS	0	17, 551	(17, 551	0	194. 08
194. 09 07959 MOB	0	0	(0	0	194. 09
194. 10 07960 ASC	0	0	(0	0	194. 10
194. 11 07961 MAB	0	0	(0		194. 11
194. 12 07963 ADOLESCENT RESIDENTIAL SERVICES	0	19, 759	(19, 759	l	194. 12
194. 13 07962 I DLE SPACE	0	0	(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, 556, 347	3, 275, 216	(5, 831, 563	43, 012	202. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 07/01/2021 | Part II | To 06/30/2022 | Date/Time Prepared: | 11/29/2022 8: 09 am Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0088

				'	00/30/2022	11/29/2022 8:	
	Cost Center Description	ADMI NI STRATI VE		LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL 5.00	PLANT 7. 00	LINEN SERVICE 8.00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS	0.00	7.00	0.00	71.00	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 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	2, 918, 062					4. 00 5. 00
7.00	OO5OO ADMINISTRATIVE & GENERAL OO7OO OPERATION OF PLANT	117, 803	504, 981				7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	19, 035	947	24, 642			8. 00
9. 00	00900 HOUSEKEEPING	65, 055	14, 083		148, 431		9. 00
10.00	01000 DI ETARY	17, 864	14, 551	0	1, 338	105, 352	10. 00
11. 00	01100 CAFETERI A	42, 828	24, 738		786	0	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	60, 475	6, 894	0	531	0	13.00
14. 00 15. 00	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	2, 522 92, 790	22, 387 6, 802	432 0	1, 763 425	0	14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	72, 770	7, 360		106	0	16. 00
23. 00	02300 ALLI ED HEALTH-EMS	0	0	0	0	0	23. 00
23. 01	02301 ALLIED HEALTH-RAD TECH	3, 392	155	0	0	0	23. 01
23. 02	02303 ALLIED HEALTH-PHARM RESIDENTS	0	0	0	0	0	23. 02
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	420, 440	02.417	0.007	/F /00	04.107	20.00
30. 00 31. 00	03000 ADULTS & PEDI ATRI CS 03100 I NTENSI VE CARE UNI T	428, 448 179, 362	92, 416 20, 693		65, 690 11, 684	84, 126 7, 171	30. 00 31. 00
41. 00	04100 SUBPROVI DER – I RF	44, 222	14, 115		5, 311	7, 171	41. 00
43. 00	04300 NURSERY	7, 713	8, 799		837	0	43. 00
	ANCILLARY SERVICE COST CENTERS	,			,		
50.00	05000 OPERATING ROOM	306, 445	67, 748		19, 544	30	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	31, 896	31, 441	630	3, 558	1, 885	52.00
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	73, 514	0 20, 154	0 65	0 3, 718	0	53. 00 54. 00
54. 00	03440 MAMMOGRAPHY	12, 712	20, 134	144	3, 716	0	54. 00
54. 02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	21, 526	1, 591	12	319	0	54. 02
54. 03	03630 ULTRA SOUND	10, 591	0	14	0	0	54. 03
55. 00	05500 RADI OLOGY-THERAPEUTI C	43, 509	0	333	319	0	55. 00
57. 00	05700 CT SCAN	21, 631	778	· ·	0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	13, 085	1, 416		319	0	58. 00
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	28, 453 140, 832	12, 085 17, 706	0	637 2, 655	92 0	59. 00 60. 00
65. 00	06500 RESPIRATORY THERAPY	41, 078	10, 075	_	212	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	51, 876	13, 922	254	2, 774	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	23, 159	6, 269	110	1, 249	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	8, 100	2, 192	21	438	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	4, 679	0	3	3, 187	0	69. 00
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	9, 081 102, 916	16, 436 0	0	1, 487 0	8	70. 00 71. 00
71.00	07200 I MPL. DEV. CHARGED TO PATIENTS	102, 916	0	0	0	0	71.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	431, 472	0	Ö	0	0	73. 00
76. 00	03190 CHEMOTHERAPY	24, 394	0	441	0	1, 279	76. 00
76. 01	03020 WOUND CARE	23, 180	4, 376	0	0	0	76. 01
	OUTPATIENT SERVICE COST CENTERS				ام		
	09000 CLI NI C 09001 ANDERSON OUTPATIENT CENTER	0			-		
90. 01 90. 02	04950 DIABETIC EDUCATION	28, 368	4, 940 0] 0 0	1, 275 0	0	90. 01 90. 02
90. 02	09002 MS CLINIC	0	0	0	0	0	90. 02
	09100 EMERGENCY	160, 788	31, 949	3, 580	14, 977	2, 767	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
	OTHER REIMBURSABLE COST CENTERS			_			
95. 00	09500 AMBULANCE SERVICES	64	0	0	0	0	95. 00
113 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE						113. 00
118.00	1	2, 803, 226	477, 018	24, 286	145, 458	105, 352	
	NONREI MBURSABLE COST CENTERS	2/000/220	1777 010	21,200	1.107.100	100,002	
190.00	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	287	2, 656	0	0	0	190. 00
	19100 RESEARCH	2, 568	0	0	0		191. 00
	19200 PHYSICIANS' PRIVATE OFFICES	77, 353	2, 582	0	0		192. 00
	07950 FOUNDATION	97	898	0	53		194. 00
	07951 CHI LDRENS CLI NI C 07952 PSS ADMI NI STRATI ON	532	0	5	1, 912 0		194. 01 194. 02
	07953 SEXUAL ASSAULT PROGRAM	532	0	0	n		194. 02
	07954 ASPR BIOTERRORI SM GRANT	10	Ö	0	ő		194. 04
	07955 HEALTHY FAMILIES	10, 062	14, 244	0	o		194. 05
	07956 DME-HOME CARE	0	0	0	0		194. 06
	07957 MARKETI NG	0	0	0	0		194. 07
	07958 CORPORATE COMMUNICATIONS 07959 MOB	386	3, 567 0	0 351	106 690		194. 08 194. 09
	07959 MOB 07960 ASC	0	0		212		194. 09
	07961 MAB	0	0		0		194. 11
	·			-			

Health Financial Systems

ASCENSION ST. VINCENT ANDERSON

In Lieu of Form CMS-2552-10

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0088
From 07/01/2021
To 06/30/2022
Date/Time Prepared:

						11/29/2022 8:	09 am
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	PLANT	LINEN SERVICE			
		5. 00	7.00	8. 00	9. 00	10.00	
194. 12 07963	ADOLESCENT RESIDENTIAL SERVICES	23, 474	4, 016	0	0	0	194. 12
194. 13 07962	I DLE 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, 918, 062	504, 981	24, 642	148, 431	105, 352	202. 00

| Peri od: | Worksheet B | From 07/01/2021 | Part II | To 06/30/2022 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS ASCENSION ST. VINCENT ANDERSON Provider CCN: 15-0088

			То	06/30/2022	Date/Time Pre 11/29/2022 8:	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVICES & SUPPLY		RECORDS & LI BRARY	
	11.00	13. 00	14. 00	15. 00	16.00	
GENERAL SERVI CE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FIXT 1.01 00101 CAP REL COSTS-BLDG & FIXT-MAB						1. 00 1. 01
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00 00500 ADMINI STRATI VE & GENERAL						5. 00
7.00 00700 OPERATION OF PLANT						7. 00
8.00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG						9.00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A	190, 075					10. 00 11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON	8, 411	111, 795				13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	3, 909	0	126, 797			14. 00
15. 00 01500 PHARMACY	12, 826	0	1, 726	150, 692		15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY	0	0	0	0	44, 475	16. 00
23. 00 02300 ALLI ED HEALTH-EMS	0	0	0	0	0	23. 00
23. 01 02301 ALLI ED HEALTH-RAD TECH 23. 02 02303 ALLI ED HEALTH-PHARM RESI DENTS	562 0	0	0	0	0 0	23. 01 23. 02
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	<u> </u>	<u> </u>	<u> </u>		23.02
30. 00 03000 ADULTS & PEDI ATRI CS	57, 716	55, 248	6, 258	0	3, 364	30. 00
31.00 03100 INTENSIVE CARE UNIT	15, 990	21, 188	3, 520	0	1, 525	31. 00
41. 00 04100 SUBPROVI DER - RF	5, 543	5, 782	222	0	251	41. 00
43. 00 04300 NURSERY	919	1, 123	128	0	99	43. 00
ANCILLARY SERVICE COST CENTERS 50.00 OPERATING ROOM	40	4, 527	92, 892	0	8, 529	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	4, 166	5, 736	810	0	278	52.00
53. 00 05300 ANESTHESI OLOGY	0	0	0	0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	11, 805	0	4, 384	0	1, 085	54.00
54. 01 03440 MAMMOGRAPHY	1, 289	0	662	0	246	54. 01
54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	1, 196	0	2, 094	0	1, 035	54. 02
54. 03 03630 ULTRA SOUND 55. 00 05500 RADI OLOGY-THERAPEUTI C	1, 460 5, 148	0	42 181	0	583 1, 912	54. 03 55. 00
57. 00 05700 CT SCAN	3, 150		5	0	1, 912	57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	1, 277	l o	20	0	185	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	4, 095	3, 096	1, 836	0	1, 532	59. 00
60. 00 06000 LABORATORY	0	0	31	0	5, 470	60. 00
65. 00 06500 RESPIRATORY THERAPY	5, 879		2, 368	0	1, 261	65. 00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	6, 235 4, 313	0 0	550 248	0	556 230	66. 00 67. 00
68. 00 06800 SPEECH PATHOLOGY	1, 508		87	0	80	68. 00
69. 00 06900 ELECTROCARDI OLOGY	798	o o	14	0	77	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	442	0	17	0	248	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	1, 313	71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1, 333	72.00
73.00 O7300 DRUGS CHARGED TO PATIENTS 76.00 O3190 CHEMOTHERAPY	0 4, 988		1, 169	150, 692 0	6, 645 549	73. 00 76. 00
76. 00 03170 CHEMOTHERAFT 76. 01 03020 WOUND CARE	2, 477		2, 931	0	308	76. 00
OUTPATIENT SERVICE COST CENTERS	_,	-1	_, ,	<u> </u>		
90. 00 09000 CLI NI C	0	0	0	0	0	90. 00
90. 01 09001 ANDERSON OUTPATIENT CENTER	2, 571	0	6	0	238	90. 01
90. 02 04950 DIABETIC EDUCATION 90. 03 09002 MS CLINIC	0	0	0	0	0	90. 02 90. 03
90. 03 09002 MS CLINIC 91. 00 09100 EMERGENCY	17, 306	15, 095	4, 592	0	4, 467	90.03
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	17,300	13, 073	4, 572	O	7, 407	92. 00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0	0	0	0	0	95. 00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 INTEREST EXPENSE	10/ 010	111 705	10/ 700	150 (00	44 475	113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	186, 019	111, 795	126, 793	150, 692	44, 475	118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190. 00
191. 00 19100 RESEARCH	432		Ö	0		191. 00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	859	0	1	0		192. 00
194. 00 07950 FOUNDATI ON	0	0	0	0		194. 00
194. 01 07951 CHI LDRENS CLI NI C	0	0	0	0		194. 01
194. 02 07952 PSS ADMINISTRATION 194. 03 07953 SEXUAL ASSAULT PROGRAM	149	0	0	0		194. 02 194. 03
194.04 07954 ASPR BIOTERRORISM GRANT	0		0	0		194. 03
194. 05 07955 HEALTHY FAMILIES	2, 610		3	0		194. 05
194. 06 07956 DME-HOME CARE	0		Ö	0		194. 06
194. 07 07957 MARKETI NG	0	0	0	0		194. 07
194. 08 07958 CORPORATE COMMUNI CATI ONS	0	0	0	0		194. 08
194. 09 07959 MOB 194. 10 07960 ASC	0	0	0	0		194. 09 194. 10
174. 10 0/900 ASC	1 0	ı o	U	U	0	1174. 10

Heal th Financial Systems ASCENSION ST. VINCENT ANDERSON In Lieu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0088 | Period: From 07/01/2021 | Part II

				rom 0//01/2021		
			7	To 06/30/2022	Date/Time Pre	pared:
					11/29/2022 8:	09 am
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	

						11/27/2022 0.	U7 alli
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
			ADMI NI STRATI ON	SERVICES &		RECORDS &	
				SUPPLY		LI BRARY	
		11. 00	13.00	14. 00	15. 00	16.00	
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	0	0	14, 754	0	0	201. 00
202. 00	TOTAL (sum lines 118 through 201)	190, 075	111, 795	141, 551	150, 692	44, 475	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0088

) 06/30/2022	11/29/2022 8:	
	Cost Center Description	ALLI ED	ALLI ED	ALLI ED	Subtotal	Intern &	
		HEALTH-EMS	HEALTH-RAD	HEALTH-PHARM		Residents Cost	
			TECH	RESI DENTS		& Post	
						Stepdown Adjustments	
		23. 00	23. 01	23. 02	24. 00	25. 00	
	GENERAL SERVICE COST CENTERS				=		
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 HOUSEKEEPI NG						9. 00
10. 00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A						11.00
13. 00	01300 NURSI NG ADMI NI STRATI ON						13.00
14. 00	01400 CENTRAL SERVI CES & SUPPLY						14.00
15.00	01500 PHARMACY						15.00
16. 00 23. 00	01600 MEDI CAL RECORDS & LI BRARY	0					16. 00 23. 00
23. 00	02300 ALLIED HEALTH-EMS 02301 ALLIED HEALTH-RAD TECH	U	4, 963				23. 00
23. 01	02303 ALLIED HEALTH-PHARM RESIDENTS		4, 903	0			23. 01
23.02	I NPATI ENT ROUTI NE SERVI CE COST CENTERS			<u> </u>			23.02
30. 00	03000 ADULTS & PEDIATRICS				1, 268, 770	0	30.00
31. 00	03100 I NTENSI VE CARE UNI T				370, 087	0	31.00
41. 00	04100 SUBPROVI DER - I RF				155, 079	0	41.00
43. 00	04300 NURSERY				63, 296	0	43. 00
10.00	ANCILLARY SERVICE COST CENTERS				00, 2, 0		10.00
50.00	05000 OPERATING ROOM				837, 635	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM				235, 935	0	52.00
53.00	05300 ANESTHESI OLOGY				0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C				215, 554	0	54.00
54. 01	03440 MAMMOGRAPHY				15, 608	0	54. 01
54. 02	03450 NUCLEAR MEDICINE - DIAGNOSTIC				35, 850	0	54. 02
54. 03	03630 ULTRA SOUND				12, 983	0	54. 03
55. 00	05500 RADI OLOGY-THERAPEUTI C				52, 196	0	55. 00
57. 00	05700 CT SCAN				32, 248	0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)				23, 738	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON				111, 995	0	59. 00
60.00	06000 LABORATORY				253, 815	0	60.00
65. 00	06500 RESPI RATORY THERAPY				111, 635	0	65.00
66. 00	06600 PHYSI CAL THERAPY				146, 111	0	66.00
67. 00 68. 00	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY				67, 068	0	67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY				23, 438 8, 864	0	69.00
70. 00	07000 ELECTROENCEPHALOGRAPHY				108, 794	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS			•	104, 229	0	71.00
71.00	07200 I MPL. DEV. CHARGED TO PATIENTS			•	104, 227	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS				588, 809	0	73.00
76. 00	03190 CHEMOTHERAPY				33, 488	0	1
	03020 WOUND CARE				55, 185	0	1
	OUTPATIENT SERVICE COST CENTERS	<u>'</u>			·		
90.00	09000 CLI NI C				0	0	90. 00
	09001 ANDERSON OUTPATIENT CENTER				62, 612	0	90. 01
	04950 DIABETIC EDUCATION				0	0	90. 02
	09002 MS CLINIC				0	0	90. 03
91. 00	09100 EMERGENCY				416, 747	0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)					0	92. 00
05.00	OTHER REIMBURSABLE COST CENTERS						05.00
95. 00	09500 AMBULANCE SERVICES				79	0	95. 00
112 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE				T		112 00
113.00		0	0	О	5, 520, 753	^	113. 00 118. 00
110.00	NONREI MBURSABLE COST CENTERS	U U	U	ıj U	5, 520, 753	U	1110.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN				16, 014	0	190. 00
	19100 RESEARCH				3, 071		191. 00
	19200 PHYSICIANS' PRIVATE OFFICES				95, 797		192.00
	07950 FOUNDATION				5, 465		194. 00
	07951 CHI LDRENS CLI NI C				1, 922		194. 01
	07952 PSS ADMINISTRATION				695		194. 02
	07953 SEXUAL ASSAULT PROGRAM				62		194. 03
	07954 ASPR BIOTERRORI SM GRANT				10		194. 04
	07955 HEALTHY FAMILIES				97, 229		194. 05
	07956 DME-HOME CARE				0		194. 06
	07957 MARKETI NG				0		194. 07
194. 08	07958 CORPORATE COMMUNICATIONS	[21, 610	0	194. 08

Heal th Financial Systems

ASCENSION ST. VINCENT ANDERSON

In Lieu of Form CMS-2552-10

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0088

Peri od:
From 07/01/2021
To 06/30/2022

Date/Time Prepared:

			'	0 00/30/2022	11/29/2022 8:	
Cost Center Description	ALLI ED	ALLI ED	ALLI ED	Subtotal	Intern &	
	HEALTH-EMS	HEALTH-RAD	HEALTH-PHARM		Residents Cost	
		TECH	RESI DENTS		& Post	
					Stepdown	
					Adjustments	
	23. 00	23. 01	23. 02	24.00	25. 00	
194. 09 07959 MOB				1, 049	0	194. 09
194. 10 07960 ASC				212	0	194. 10
194. 11 07961 MAB				0	0	194. 11
194. 12 07963 ADOLESCENT RESIDENTIAL SERVICES				47, 957	0	194. 12
194. 13 07962 I DLE SPACE				0	0	194. 13
200.00 Cross Foot Adjustments	0	4, 963	C	4, 963	0	200. 00
201.00 Negative Cost Centers	0	0	C	14, 754	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	0	4, 963	[c	5, 831, 563	0	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0088

			11/29/2022 8:	
	Cost Center Description	Total		
	CENEDAL CEDALCE COCT CENTEDO	26. 00		
1. 00	GENERAL SERVICE COST CENTERS OO100 CAP REL COSTS-BLDG & FLXT			1.00
1. 01	00101 CAP REL COSTS-BLDG & FLXT-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 HOUSEKEEPI NG			9. 00
10. 00	01000 DI ETARY			10.00
11.00	01100 CAFETERI A			11.00
13. 00 14. 00	01300 NURSI NG ADMINI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY			13. 00 14. 00
	01500 PHARMACY			15. 00
	01600 MEDICAL RECORDS & LIBRARY			16. 00
	02300 ALLI ED HEALTH-EMS			23. 00
23. 01	02301 ALLIED HEALTH-RAD TECH			23. 01
23. 02	02303 ALLIED HEALTH-PHARM RESIDENTS			23. 02
	INPATIENT ROUTINE SERVICE COST CENTERS			
30. 00	03000 ADULTS & PEDI ATRI CS	1, 268, 770		30.00
	03100 INTENSI VE CARE UNIT	370, 087		31.00
41. 00	04100 SUBPROVI DER - I RF	155, 079		41.00
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	63, 296		43. 00
50. 00	05000 OPERATING ROOM	837, 635		50.00
	05200 DELIVERY ROOM & LABOR ROOM	235, 935		52. 00
53. 00	05300 ANESTHESI OLOGY	0		53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	215, 554		54.00
54. 01	03440 MAMMOGRAPHY	15, 608		54. 01
	03450 NUCLEAR MEDICINE - DIAGNOSTIC	35, 850		54. 02
	03630 ULTRA SOUND	12, 983		54. 03
	05500 RADI OLOGY-THERAPEUTI C	52, 196		55. 00
57. 00	05700 CT SCAN	32, 248		57. 00
58. 00 59. 00	05800 MAGNETIC RESONANCE I MAGING (MRI) 05900 CARDIAC CATHETERIZATION	23, 738 111, 995		58. 00 59. 00
60. 00	06000 LABORATORY	253, 815		60.00
65. 00	06500 RESPIRATORY THERAPY	111, 635		65. 00
66. 00	06600 PHYSI CAL THERAPY	146, 111		66.00
67.00	06700 OCCUPATI ONAL THERAPY	67, 068		67. 00
68. 00	06800 SPEECH PATHOLOGY	23, 438		68. 00
	06900 ELECTROCARDI OLOGY	8, 864		69. 00
	07000 ELECTROENCEPHALOGRAPHY	108, 794		70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	104, 229		71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	108, 905 588, 809		73. 00
76. 00	03190 CHEMOTHERAPY	33, 488		76. 00
76. 01	03020 WOUND CARE	55, 185		76. 01
	OUTPATIENT SERVICE COST CENTERS			
	09000 CLI NI C	0		90. 00
	09001 ANDERSON OUTPATIENT CENTER	62, 612		90. 01
	04950 DI ABETI C EDUCATI ON	0		90. 02
	09002 MS CLINIC	0		90. 03
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	416, 747		91. 00 92. 00
92.00	OTHER REIMBURSABLE COST CENTERS			92.00
95 00	09500 AMBULANCE SERVICES	79		95. 00
70.00	SPECIAL PURPOSE COST CENTERS	, ,		70.00
113.00	11300 I NTEREST EXPENSE			113. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	5, 520, 753		118. 00
	NONREI MBURSABLE COST CENTERS			
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	16, 014		190. 00
	19100 RESEARCH	3, 071		191. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	95, 797		192. 00
	07950 FOUNDATION 07951 CHILDRENS CLINIC	5, 465		194. 00
	07951 CHILDRENS CLINIC 07952 PSS ADMINISTRATION	1, 922 695		194. 01 194. 02
	07953 SEXUAL ASSAULT PROGRAM	62		194. 02
	07954 ASPR BIOTERRORISM GRANT	10		194. 03
	07955 HEALTHY FAMILIES	97, 229		194. 05
	07956 DME-HOME CARE	0		194. 06
	07957 MARKETI NG	Ö		194. 07
	07958 CORPORATE COMMUNICATIONS	21, 610		194. 08
	07959 MOB	1, 049		194. 09
	07960 ASC	212		194. 10
	07961 MAB	0		194. 11
194. 12	07963 ADOLESCENT RESIDENTIAL SERVICES	47, 957		194. 12

Health Financia	al Systems A	SCENSION ST. V	INCENT ANDERSON		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF	CAPITAL RELATED COSTS		Provi der CCN:	15-0088	From 07/01/2021 To 06/30/2022	Worksheet B Part II Date/Time Pre 11/29/2022 8:	
Co	st Center Description	Total					

		_	11/29/2022 8: (<u>09 am</u>
	Cost Center Description	Total		
		26. 00		
194. 13 07962	IDLE SPACE	0		194. 13
200. 00	Cross Foot Adjustments	4, 963		200. 00
201. 00	Negative Cost Centers	14, 754		201. 00
202. 00	TOTAL (sum lines 118 through 201)	5, 831, 563		202. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS In Lieu of Form CMS-2552-10 ASCENSION ST. VINCENT ANDERSON Provi der CCN: 15-0088 Peri od: Worksheet B-1 From 07/01/2021 To 06/30/2022 Date/Time Prepared: 11/29/2022 8:09 am CAPITAL RELATED COSTS Cost Center Description BLDG & FIXT BLDG & **EMPLOYEE** Reconciliation ADMINISTRATIVE & GENERAL (ACCUM. COST) BENEFITS (SQUARE FEET) FIXT-MAB DEPARTMENT (SQUARE FEET) (GROSS SALARI ES) 5.00 1.00 1.01 4.00 5A GENERAL SERVICE COST CENTERS
00100 CAP REL COSTS-BLDG & FIXT 1. 00 1.00 471, 575

1. 01	OUTOU CAP REL COSTS-BLDG & FIXT	4/1,5/5					1.00
	00101 CAP REL COSTS-BLDG & FIXT-MAB	0	0	10 151 010			1. 01
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	6, 193	0	49, 151, 840			4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	51, 875	0	1, 633, 107	-45, 711, 820	132, 851, 431	5. 00
7.00	00700 OPERATION OF PLANT	55, 747	0	0	0	5, 363, 207	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	671	0	0	0	866, 618	8. 00
9.00	00900 HOUSEKEEPI NG	9, 977	0	243	0	2, 961, 764	9.00
10.00	01000 DI ETARY	10, 309	0	0	0	813, 309	10.00
11. 00	01100 CAFETERI A	17, 526	o	0	o	1, 949, 840	11.00
13.00	01300 NURSING ADMINISTRATION	4, 884	o	1, 785, 995	o	2, 753, 234	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	15, 860	o	441, 287	ol	114, 831	14.00
15. 00	01500 PHARMACY	4, 819	ol	3, 033, 348	o	4, 224, 458	15.00
16. 00	01600 MEDICAL RECORDS & LIBRARY	5, 214	ol	0	أم	36, 219	16. 00
23. 00	02300 ALLI ED HEALTH-EMS	0,211	ol	0		00,217	23. 00
23. 01	02301 ALLIED HEALTH-RAD TECH	110		102, 546	0	154, 420	23. 01
23. 02	02303 ALLIED HEALTH-PHARM RESIDENTS	0	o	102, 340		0	23. 01
23. 02	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	Ч		U	υĮ	U	23.02
30. 00	03000 ADULTS & PEDIATRICS	65, 475	O	13, 327, 998	0	19, 505, 933	30. 00
31.00	03100 I NTENSI VE CARE UNI T	14, 660	0	5, 082, 972	0	8, 165, 787	31.00
41.00	04100 SUBPROVI DER - I RF	10, 000	0	1, 420, 933	O O	2, 013, 307	41. 00
43. 00	04300 NURSERY	6, 234	0	222, 712	0	351, 171	43.00
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATING ROOM	47, 997	0	700, 541	0	13, 951, 508	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	22, 275	0	947, 827	0	1, 452, 136	52.00
53.00	05300 ANESTHESI OLOGY	0	0	0	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	14, 278	0	1, 901, 455	0	3, 346, 849	54.00
54.01	03440 MAMMOGRAPHY	ol	o	269, 483	O	578, 724	54.01
54. 02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	1, 127	o	285, 265	o	980, 027	54.02
54. 03	03630 ULTRA SOUND	. 0	ol	334, 662	o	482, 156	54. 03
55. 00	05500 RADI OLOGY-THERAPEUTI C	أم	ol	907, 496	ام	1, 980, 827	55. 00
57. 00	05700 CT SCAN	551	o l	657, 510	0	984, 792	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 003	ol	295, 235		595, 742	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	8, 562		804, 588	0	1, 295, 370	59. 00
60.00	06000 LABORATORY			004, 300	0		60.00
		12, 544	o o	9	O O	6, 411, 676	
65. 00	06500 RESPI RATORY THERAPY	7, 138	0	1, 356, 138	U	1, 870, 165	65. 00
66.00	06600 PHYSI CAL THERAPY	9, 863	O O	1, 649, 676	U	2, 361, 778	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	4, 441	()	737, 790	O	1, 054, 372	67. 00
			- ا		-1		
68. 00	06800 SPEECH PATHOLOGY	1, 553	ŏ	258, 046	0	368, 770	68. 00
69. 00	06900 ELECTROCARDI OLOGY	o	0	121, 063	0	213, 028	68. 00 69. 00
69. 00 70. 00		1	0 0		0 0 0		68. 00
69. 00	06900 ELECTROCARDI OLOGY	o	0 0 0	121, 063	0 0 0	213, 028	68. 00 69. 00
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	o	0 0 0	121, 063	0 0 0 0	213, 028 413, 432	68. 00 69. 00 70. 00
69. 00 70. 00 71. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	0 0 0	121, 063	0 0 0 0 0	213, 028 413, 432 4, 685, 468	68. 00 69. 00 70. 00 71. 00
69. 00 70. 00 71. 00 72. 00	06900 ELECTROCARDIOLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	o	0 0 0 0 0 0	121, 063	0 0 0 0 0	213, 028 413, 432 4, 685, 468 4, 897, 421	68. 00 69. 00 70. 00 71. 00 72. 00
69. 00 70. 00 71. 00 72. 00 73. 00 76. 00	06900 ELECTROCARDIOLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 03190 CHEMOTHERAPY	0 11,644 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	121, 063 232, 743 0 0 0 763, 144	0 0 0 0 0	213, 028 413, 432 4, 685, 468 4, 897, 421 19, 644, 532 1, 110, 581	68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 76. 00
69. 00 70. 00 71. 00 72. 00 73. 00	06900 ELECTROCARDIOLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 03190 CHEMOTHERAPY 03020 WOUND CARE	o	0 0 0 0 0 0 0	121, 063 232, 743 0 0	0 0 0 0 0 0	213, 028 413, 432 4, 685, 468 4, 897, 421 19, 644, 532	68. 00 69. 00 70. 00 71. 00 72. 00 73. 00
69. 00 70. 00 71. 00 72. 00 73. 00 76. 00 76. 01	06900 ELECTROCARDIOLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 03190 CHEMOTHERAPY 03020 WOUND CARE 0UTPATIENT SERVICE COST CENTERS	0 11, 644 0 0 0 0 0 3, 100	0 0 0 0 0 0 0 0 0	121, 063 232, 743 0 0 0 763, 144 437, 895	0 0 0 0 0 0 0	213, 028 413, 432 4, 685, 468 4, 897, 421 19, 644, 532 1, 110, 581 1, 055, 325	68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 76. 00 76. 01
69. 00 70. 00 71. 00 72. 00 73. 00 76. 00 76. 01	06900 ELECTROCARDIOLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 03190 CHEMOTHERAPY 03020 WOUND CARE 0UTPATIENT SERVICE COST CENTERS	0 11, 644 0 0 0 0 0 3, 100	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	121, 063 232, 743 0 0 0 763, 144 437, 895	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	213, 028 413, 432 4, 685, 468 4, 897, 421 19, 644, 532 1, 110, 581 1, 055, 325	68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 76. 00 76. 01
69. 00 70. 00 71. 00 72. 00 73. 00 76. 00 76. 01 90. 00 90. 01	06900 ELECTROCARDIOLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 03190 CHEMOTHERAPY 03020 WOUND CARE 0UTPATIENT SERVICE COST CENTERS 09000 CLINIC 09001 ANDERSON OUTPATIENT CENTER	0 11, 644 0 0 0 0 0 3, 100	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	121, 063 232, 743 0 0 0 763, 144 437, 895	0 0 0 0	213, 028 413, 432 4, 685, 468 4, 897, 421 19, 644, 532 1, 110, 581 1, 055, 325 0 1, 291, 506	68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 76. 00 76. 01 90. 00 90. 01
69. 00 70. 00 71. 00 72. 00 73. 00 76. 00 76. 01 90. 00 90. 01 90. 02	06900 ELECTROCARDIOLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 03190 CHEMOTHERAPY 03020 WOUND CARE 0UTPATIENT SERVICE COST CENTERS 09000 CLINIC 09001 ANDERSON OUTPATIENT CENTER	0 11, 644 0 0 0 0 0 3, 100	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	121, 063 232, 743 0 0 0 763, 144 437, 895	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	213, 028 413, 432 4, 685, 468 4, 897, 421 19, 644, 532 1, 110, 581 1, 055, 325 0 1, 291, 506 0	68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 76. 01 90. 00 90. 01 90. 02
69. 00 70. 00 71. 00 72. 00 73. 00 76. 00 76. 01 90. 00 90. 01 90. 02 90. 03	06900 ELECTROCARDIOLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 03190 CHEMOTHERAPY 03020 WOUND CARE 0UTPATIENT SERVICE COST CENTERS 09000 CLINIC 09001 ANDERSON OUTPATIENT CENTER 04950 DIABETIC EDUCATION 09002 MS CLINIC	0 11, 644 0 0 0 0 3, 100	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	121, 063 232, 743 0 0 0 763, 144 437, 895	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	213, 028 413, 432 4, 685, 468 4, 897, 421 19, 644, 532 1, 110, 581 1, 055, 325 0 1, 291, 506 0	68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 76. 00 76. 01 90. 00 90. 01 90. 02 90. 03
69. 00 70. 00 71. 00 72. 00 73. 00 76. 00 76. 01 90. 00 90. 01 90. 02 90. 03 91. 00	06900 ELECTROCARDIOLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 03190 CHEMOTHERAPY 03020 WOUND CARE OUTPATIENT SERVICE COST CENTERS 09000 CLINIC 09001 ANDERSON OUTPATIENT CENTER 04950 DIABETIC EDUCATION 09002 MS CLINIC 09100 EMERGENCY	0 11, 644 0 0 0 0 0 3, 100	0 0 0 0 0 0 0 0	121, 063 232, 743 0 0 0 763, 144 437, 895	0 0 0 0 0 0 0 0	213, 028 413, 432 4, 685, 468 4, 897, 421 19, 644, 532 1, 110, 581 1, 055, 325 0 1, 291, 506 0	68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 76. 00 76. 01 90. 00 90. 01 90. 02 90. 03 91. 00
69. 00 70. 00 71. 00 72. 00 73. 00 76. 00 76. 01 90. 00 90. 01 90. 02 90. 03	06900 ELECTROCARDIOLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 03190 CHEMOTHERAPY 03020 WOUND CARE OUTPATIENT SERVICE COST CENTERS 09000 CLINIC 09001 ANDERSON OUTPATIENT CENTER 04950 DIABETIC EDUCATION 09002 MS CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0 11, 644 0 0 0 0 3, 100	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	121, 063 232, 743 0 0 0 763, 144 437, 895	0 0 0 0 0 0 0 0	213, 028 413, 432 4, 685, 468 4, 897, 421 19, 644, 532 1, 110, 581 1, 055, 325 0 1, 291, 506 0	68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 76. 00 76. 01 90. 00 90. 01 90. 02 90. 03
69. 00 70. 00 71. 00 72. 00 73. 00 76. 01 90. 00 90. 01 90. 02 90. 03 91. 00 92. 00	06900 ELECTROCARDIOLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 03190 CHEMOTHERAPY 03020 WOUND CARE OUTPATIENT SERVICE COST CENTERS 09000 CLINIC 09001 ANDERSON OUTPATIENT CENTER 04950 DIABETIC EDUCATION 09002 MS CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	0 11, 644 0 0 0 0 3, 100	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	121, 063 232, 743 0 0 763, 144 437, 895 0 1, 035, 156 0 4, 594, 585	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	213, 028 413, 432 4, 685, 468 4, 897, 421 19, 644, 532 1, 110, 581 1, 055, 325 0 1, 291, 506 0 0 7, 320, 177	68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 76. 01 90. 00 90. 01 90. 02 90. 03 91. 00 92. 00
69. 00 70. 00 71. 00 72. 00 73. 00 76. 00 90. 01 90. 02 90. 03 91. 00 92. 00	06900 ELECTROCARDIOLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 03190 CHEMOTHERAPY 03020 WOUND CARE OUTPATIENT SERVICE COST CENTERS 09000 CLINIC 09001 ANDERSON OUTPATIENT CENTER 04950 DIABETIC EDUCATION 09002 MS CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	0 11, 644 0 0 0 0 3, 100	0 0 0 0 0 0 0 0 0	121, 063 232, 743 0 0 0 763, 144 437, 895	0 0 0 0 0 0 0 0	213, 028 413, 432 4, 685, 468 4, 897, 421 19, 644, 532 1, 110, 581 1, 055, 325 0 1, 291, 506 0	68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 76. 00 76. 01 90. 00 90. 01 90. 02 90. 03 91. 00
69. 00 70. 00 71. 00 72. 00 73. 00 76. 00 76. 01 90. 00 90. 01 90. 02 90. 03 91. 00 92. 00 95. 00	06900 ELECTROCARDIOLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 03190 CHEMOTHERAPY 03020 WOUND CARE OUTPATIENT SERVICE COST CENTERS 09000 CLINIC 09001 ANDERSON OUTPATIENT CENTER 04950 DIABETIC EDUCATION 09002 MS CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0THER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	0 11, 644 0 0 0 0 3, 100	0 0 0 0 0 0 0 0 0	121, 063 232, 743 0 0 763, 144 437, 895 0 1, 035, 156 0 4, 594, 585	0 0 0 0 0 0 0 0 0	213, 028 413, 432 4, 685, 468 4, 897, 421 19, 644, 532 1, 110, 581 1, 055, 325 0 1, 291, 506 0 0 7, 320, 177	68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 76. 01 90. 00 90. 01 90. 02 90. 03 91. 00 92. 00
69. 00 70. 00 71. 00 72. 00 73. 00 76. 00 76. 01 90. 00 90. 01 90. 02 90. 03 91. 00 92. 00 95. 00	06900 ELECTROCARDIOLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 03190 CHEMOTHERAPY 03020 WOUND CARE OUTPATIENT SERVICE COST CENTERS 09000 CLINIC 09001 ANDERSON OUTPATIENT CENTER 04950 DIABETIC EDUCATION 09002 MS CLINIC 09100 EMERGENCY 09200 DBSERVATION BEDS (NON-DISTINCT PART) 0THER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	0 11, 644 0 0 0 0 0 3, 100	0 0 0 0 0 0 0 0 0 0	121, 063 232, 743 0 0 0 763, 144 437, 895 0 1, 035, 156 0 0 4, 594, 585	0 0 0 0 0 0 0 0 0	213, 028 413, 432 4, 685, 468 4, 897, 421 19, 644, 532 1, 110, 581 1, 055, 325 0 1, 291, 506 0 7, 320, 177	68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 76. 01 90. 00 90. 01 90. 02 90. 03 91. 00 92. 00 95. 00
69. 00 70. 00 71. 00 72. 00 73. 00 76. 00 76. 01 90. 00 90. 01 90. 02 90. 03 91. 00 92. 00 95. 00	06900 ELECTROCARDIOLOGY 07000 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 03190 CHEMOTHERAPY 03020 WOUND CARE OUTPATIENT SERVICE COST CENTERS 09000 CLINIC 09001 ANDERSON OUTPATIENT CENTER 04950 DIABETIC EDUCATION 09002 MS CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS 011300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	0 11, 644 0 0 0 0 3, 100	0 0 0 0 0 0 0 0 0 0	121, 063 232, 743 0 0 763, 144 437, 895 0 1, 035, 156 0 4, 594, 585	0 0 0 0 0 0 0 0 0 0 0	213, 028 413, 432 4, 685, 468 4, 897, 421 19, 644, 532 1, 110, 581 1, 055, 325 0 1, 291, 506 0 0 7, 320, 177	68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 76. 01 90. 00 90. 01 90. 02 90. 03 91. 00 92. 00 95. 00
69. 00 70. 00 71. 00 72. 00 73. 00 76. 00 76. 01 90. 00 90. 01 90. 02 90. 03 91. 00 92. 00 113. 00 118. 00	06900 ELECTROCARDIOLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 03190 CHEMOTHERAPY 03020 WOUND CARE OUTPATIENT SERVICE COST CENTERS 09000 CLINIC 09001 ANDERSON OUTPATIENT CENTER 04950 DIABETIC EDUCATION 09002 MS CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0THER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS 011300 INTEREST EXPENSE DISTORMANDERSON OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	0 11, 644 0 0 0 0 0 3, 100		121, 063 232, 743 0 0 0 763, 144 437, 895 0 1, 035, 156 0 0 4, 594, 585	0 0 0 0 0 0 0 0 0 0 0 0 0 0	213, 028 413, 432 4, 685, 468 4, 897, 421 19, 644, 532 1, 110, 581 1, 055, 325 0 1, 291, 506 0 7, 320, 177	68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 76. 01 90. 00 90. 01 90. 02 90. 03 91. 00 92. 00 95. 00
69. 00 70. 00 71. 00 72. 00 73. 00 76. 00 76. 01 90. 00 90. 01 90. 02 90. 03 91. 00 92. 00 113. 00 118. 00	06900 ELECTROCARDIOLOGY 07000 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 03190 CHEMOTHERAPY 03020 WOUND CARE OUTPATIENT SERVICE COST CENTERS 09000 CLINIC 09001 ANDERSON OUTPATIENT CENTER 04950 DIABETIC EDUCATION 09002 MS CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS 011300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	0 11, 644 0 0 0 0 0 3, 100		121, 063 232, 743 0 0 0 763, 144 437, 895 0 1, 035, 156 0 0 4, 594, 585	0 0 0 0 0 0 0 0 0 0 0	213, 028 413, 432 4, 685, 468 4, 897, 421 19, 644, 532 1, 110, 581 1, 055, 325 0 1, 291, 506 0 7, 320, 177	68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 76. 01 90. 01 90. 01 90. 02 90. 03 91. 00 92. 00 95. 00 113. 00 118. 00
69. 00 70. 00 71. 00 72. 00 73. 00 76. 01 90. 00 90. 01 90. 02 90. 03 91. 00 92. 00 113. 00 118. 00	06900 ELECTROCARDIOLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 03190 CHEMOTHERAPY 03020 WOUND CARE OUTPATIENT SERVICE COST CENTERS 09000 CLINIC 09001 ANDERSON OUTPATIENT CENTER 04950 DIABETIC EDUCATION 09002 MS CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0THER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS 011300 INTEREST EXPENSE DISTORMANDERSON OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	0 11, 644 0 0 0 0 0 3, 100 0 3, 500 0 0 22, 635		121, 063 232, 743 0 0 763, 144 437, 895 0 1, 035, 156 0 4, 594, 585 17, 232	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	213, 028 413, 432 4, 685, 468 4, 897, 421 19, 644, 532 1, 110, 581 1, 055, 325 0 1, 291, 506 0 7, 320, 177 2, 935	68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 76. 01 90. 01 90. 01 90. 02 90. 03 91. 00 92. 00 113. 00 118. 00
69. 00 70. 00 71. 00 72. 00 73. 00 76. 00 90. 01 90. 02 90. 03 91. 00 92. 00 95. 00 113. 00 190. 01 190. 01	06900 ELECTROCARDIOLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 03190 CHEMOTHERAPY 03020 WOUND CARE OUTPATIENT SERVICE COST CENTERS 09000 CLINIC 09001 ANDERSON OUTPATIENT CENTER 04950 DIABETIC EDUCATION 09002 MS CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS 011300 INTEREST EXPENSE 01 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS 019000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0 11, 644 0 0 0 0 3, 100 0 3, 500 0 0 22, 635	0	121, 063 232, 743 0 0 763, 144 437, 895 0 1, 035, 156 0 4, 594, 585 17, 232 45, 358, 671	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	213, 028 413, 432 4, 685, 468 4, 897, 421 19, 644, 532 1, 110, 581 1, 055, 325 0 1, 291, 506 0 7, 320, 177 2, 935 127, 623, 395	68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 76. 01 90. 00 90. 01 90. 02 90. 03 91. 00 92. 00 95. 00 113. 00 118. 00 190. 00 191. 00
69. 00 70. 00 71. 00 72. 00 73. 00 76. 01 90. 00 90. 01 90. 02 90. 03 91. 00 95. 00 113. 01 190. 01 190. 01 191. 01 192. 01	06900 ELECTROCARDIOLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 030190 CHEMOTHERAPY 03020 WOUND CARE OUTPATIENT SERVICE COST CENTERS 09000 CLINIC 09001 ANDERSON OUTPATIENT CENTER 04950 DIABETIC EDUCATION 09002 MS CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0THER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS 011300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117) NONNEI MBURSABLE COST CENTERS 019000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 019100 RESEARCH 019200 PHYSICIANS' PRIVATE OFFICES	0 11, 644 0 0 0 0 3, 100 0 3, 500 0 22, 635 0 451, 765	0	121, 063 232, 743 0 0 0 763, 144 437, 895 0 1, 035, 156 0 4, 594, 585 17, 232 45, 358, 671	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	213, 028 413, 432 4, 685, 468 4, 897, 421 19, 644, 532 1, 110, 581 1, 055, 325 0 1, 291, 506 0 7, 320, 177 2, 935 127, 623, 395 13, 071 116, 906 3, 521, 653	68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 76. 01 90. 00 90. 01 90. 02 90. 03 91. 00 95. 00 113. 00 118. 00 190. 00 191. 00 192. 00
69. 00 70. 00 71. 00 72. 00 73. 00 76. 00 76. 01 90. 01 90. 02 90. 03 91. 00 92. 00 113. 00 118. 00 191. 00 192. 00 194. 00	06900 ELECTROCARDIOLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 03190 CHEMOTHERAPY 03020 WOUND CARE OUTPATIENT SERVICE COST CENTERS 09000 CLINIC 09001 ANDERSON OUTPATIENT CENTER 04950 DI ABETIC EDUCATION 09002 MS CLINIC 09100 EMERGENCY 09200 DBSERVATION BEDS (NON-DISTINCT PART) 0THER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS 011300 INTEREST EXPENSE DINONREIMBURSABLE COST CENTERS 019000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 019200 PHYSICIANS' PRIVATE OFFICES	0 11, 644 0 0 0 0 3, 100 0 3, 500 0 22, 635	0	121, 063 232, 743 0 0 0 763, 144 437, 895 0 1, 035, 156 0 4, 594, 585 17, 232 45, 358, 671	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	213, 028 413, 432 4, 685, 468 4, 897, 421 19, 644, 532 1, 110, 581 1, 055, 325 0 1, 291, 506 0 7, 320, 177 2, 935 127, 623, 395 13, 071 116, 906 3, 521, 653 4, 417	68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 76. 01 90. 00 90. 01 90. 02 90. 03 91. 00 95. 00 113. 00 118. 00 190. 00 191. 00 192. 00 194. 00
69. 00 70. 00 71. 00 72. 00 73. 00 76. 00 76. 01 90. 02 90. 03 91. 00 92. 00 113. 00 118. 00 190. 02 191. 00 192. 00 194. 00 194. 00	06900 ELECTROCARDIOLOGY 07000 ELECTROCARDIOLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 03190 CHEMOTHERAPY 03020 WOUND CARE OUTPATIENT SERVICE COST CENTERS 09000 CLINIC 09001 ANDERSON OUTPATIENT CENTER 04950 DIABETIC EDUCATION 09002 MS CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS 011300 INTEREST EXPENSE DISUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS 019000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 019100 RESEARCH 019200 PHYSICIANS' PRIVATE OFFICES 017950 FOUNDATION 107951 CHILDRENS CLINIC	0 11, 644 0 0 0 0 3, 100 0 3, 500 0 22, 635 0 451, 765	0	121, 063 232, 743 0 0 763, 144 437, 895 0 1, 035, 156 0 4, 594, 585 17, 232 45, 358, 671 0 81, 501 2, 627, 002 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	213, 028 413, 432 4, 685, 468 4, 897, 421 19, 644, 532 1, 110, 581 1, 055, 325 0 1, 291, 506 0 7, 320, 177 2, 935 127, 623, 395 13, 071 116, 906 3, 521, 653 4, 417 214	68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 76. 01 90. 00 90. 01 90. 02 90. 03 91. 00 92. 00 113. 00 118. 00 190. 00 191. 00 191. 00 192. 00 194. 00 194. 00
69. 00 70. 00 71. 00 72. 00 73. 00 76. 00 76. 01 90. 02 90. 03 91. 00 92. 00 113. 00 118. 00 191. 00 192. 00 194. 00 194. 00	06900 ELECTROCARDIOLOGY 07000 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 03190 CHEMOTHERAPY 03020 WOUND CARE OUTPATIENT SERVICE COST CENTERS 09000 CLINIC 09001 ANDERSON OUTPATIENT CENTER 04950 DIABETIC EDUCATION 09002 MS CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) 07HER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS 011300 INTEREST EXPENSE 011300 INTEREST EXPENSE 019000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 019100 RESEARCH 019200 PHYSICIANS' PRIVATE OFFICES 007950 FOUNDATION 107951 CHILDRENS CLINIC	0 11, 644 0 0 0 0 3, 100 0 3, 500 0 22, 635 0 451, 765	0	121, 063 232, 743 0 0 0 763, 144 437, 895 0 1, 035, 156 0 4, 594, 585 17, 232 45, 358, 671 0 81, 501 2, 627, 002 0 0 15, 985	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	213, 028 413, 432 4, 685, 468 4, 897, 421 19, 644, 532 1, 110, 581 1, 055, 325 0 1, 291, 506 0 7, 320, 177 2, 935 127, 623, 395 127, 623, 395 13, 071 116, 906 3, 521, 653 4, 417 214 24, 206	68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 76. 01 90. 00 90. 01 90. 02 90. 03 91. 00 92. 00 113. 00 118. 00 191. 00 191. 00 192. 00 194. 01 194. 01 194. 02
69. 00 70. 00 71. 00 72. 00 73. 00 76. 01 90. 00 90. 01 90. 02 90. 03 91. 00 92. 00 113. 00 191. 00 192. 00 194. 00 194. 00 194. 00 194. 00	06900 ELECTROCARDIOLOGY 07000 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 03190 CHEMOTHERAPY 03020 WOUND CARE OUTPATIENT SERVICE COST CENTERS 09000 CLINIC 09001 ANDERSON OUTPATIENT CENTER 04950 DIABETIC EDUCATION 09002 MS CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS 0 11300 INTEREST EXPENSE 0 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS 0 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 0 19100 RESEARCH 0 19200 PHYSICIANS' PRIVATE OFFICES 0 07950 FOUNDATION 1 07951 CHILDRENS CLINIC 2 07952 PSS ADMINISTRATION 3 07953 SEXUAL ASSAULT PROGRAM	0 11, 644 0 0 0 0 3, 100 0 3, 500 0 0 22, 635 0 1, 882 0 1, 829 636 0 0	0	121, 063 232, 743 0 0 763, 144 437, 895 0 1, 035, 156 0 4, 594, 585 17, 232 45, 358, 671 0 81, 501 2, 627, 002 0 0 15, 985 1, 975	-45, 711, 820	213, 028 413, 432 4, 685, 468 4, 897, 421 19, 644, 532 1, 110, 581 1, 055, 325 0 1, 291, 506 0 0, 7, 320, 177 2, 935 127, 623, 395 13, 071 116, 906 3, 521, 653 4, 417 214 24, 206 2, 458	68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 76. 01 90. 01 90. 01 90. 03 91. 00 92. 00 113. 00 118. 00 190. 00 191. 00 191. 00 192. 00 194. 01 194. 02 194. 03
69. 00 70. 00 71. 00 72. 00 73. 00 76. 01 90. 00 90. 01 90. 03 91. 00 92. 00 95. 00 113. 00 191. 00 194. 00 194. 00 194. 0 194. 0 194. 0	06900 ELECTROCARDIOLOGY 07000 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 03190 CHEMOTHERAPY 03020 WOUND CARE OUTPATIENT SERVICE COST CENTERS 09000 CLINIC 09001 ANDERSON OUTPATIENT CENTER 04950 DIABETIC EDUCATION 09002 MS CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS 011300 INTEREST EXPENSE 0 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS 019000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 019100 RESEARCH 019200 PHYSICIANS' PRIVATE OFFICES 07950 COPPOSO FOUNDATION 07951 CHILDRENS CLINIC 207952 PSS ADMINISTRATION 307953 SEXUAL ASSAULT PROGRAM 407954 ASPR BIOTERRORISM GRANT	0 11, 644 0 0 0 0 3, 100 0 3, 500 0 0 22, 635 0 1, 882 0 1, 829 636 0 0	0	121, 063 232, 743 0 0 763, 144 437, 895 0 1, 035, 156 0 4, 594, 585 17, 232 45, 358, 671 0 81, 501 2, 627, 002 0 0 15, 985 1, 975 0	-45, 711, 820	213, 028 413, 432 4, 685, 468 4, 897, 421 19, 644, 532 1, 110, 581 1, 055, 325 0 1, 291, 506 0 7, 320, 177 2, 935 127, 623, 395 13, 071 116, 906 3, 521, 653 4, 417 214 24, 206 2, 458 440	68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 76. 01 90. 00 90. 01 90. 02 90. 03 91. 00 92. 00 113. 00 118. 00 199. 00 191. 00 191. 00 194. 01 194. 01 194. 02 194. 03 194. 04
69. 00 70. 00 71. 00 72. 00 73. 00 76. 01 90. 00 90. 01 90. 02 90. 03 91. 00 92. 00 95. 00 113. 00 191. 00 194. 00 194. 00 194. 00 194. 00 194. 00	06900 ELECTROCARDIOLOGY 07000 ELECTROCARDIOLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 03190 CHEMOTHERAPY 03020 WOUND CARE OUTPATIENT SERVICE COST CENTERS 09000 CLINIC 09000 MS CLINIC 09000 MS CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0THER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS 011300 INTEREST EXPENSE 0 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS 019000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 019100 RESEARCH 019200 PHYSICIANS' PRIVATE OFFICES 007950 FOUNDATION 0107951 CHILDRENS CLINIC 0107951 CHILDRENS CLINIC 0107955 PSS ADMINISTRATION 0107955 HEALTHY FAMILIES	0 11, 644 0 0 0 0 3, 100 0 3, 500 0 0 22, 635 0 1, 882 0 1, 829 636 0 0 0	0 0 0 0 0 0 0	121, 063 232, 743 0 0 763, 144 437, 895 0 1, 035, 156 0 4, 594, 585 17, 232 45, 358, 671 0 81, 501 2, 627, 002 0 0 15, 985 1, 975 0 257, 201	0 0 0 0 0 0	213, 028 413, 432 4, 685, 468 4, 897, 421 19, 644, 532 1, 110, 581 1, 055, 325 0 1, 291, 506 0 7, 320, 177 2, 935 127, 623, 395 13, 071 116, 906 3, 521, 653 4, 417 214 24, 206 2, 458 440 458, 074	68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 76. 01 90. 00 90. 01 90. 02 90. 03 91. 00 92. 00 113. 00 118. 00 199. 00 191. 00 194. 01 194. 01 194. 02 194. 04 194. 05
69. 00 70. 00 71. 00 72. 00 73. 00 76. 00 90. 01 90. 02 90. 03 91. 00 92. 00 95. 00 113. 00 194. 00 194. 00 194. 00 194. 00 194. 00 194. 00	06900 ELECTROCARDIOLOGY 07000 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 03190 CHEMOTHERAPY 03020 WOUND CARE OUTPATIENT SERVICE COST CENTERS 09000 CLINIC 09001 ANDERSON OUTPATIENT CENTER 04950 DIABETIC EDUCATION 09002 MS CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS 011300 INTEREST EXPENSE 0 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS 019000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 019100 RESEARCH 019200 PHYSICIANS' PRIVATE OFFICES 07950 COPPOSO FOUNDATION 07951 CHILDRENS CLINIC 207952 PSS ADMINISTRATION 307953 SEXUAL ASSAULT PROGRAM 407954 ASPR BIOTERRORISM GRANT	0 11, 644 0 0 0 0 3, 100 0 3, 500 0 0 22, 635 0 1, 882 0 1, 829 636 0 0	0	121, 063 232, 743 0 0 763, 144 437, 895 0 1, 035, 156 0 4, 594, 585 17, 232 45, 358, 671 0 81, 501 2, 627, 002 0 0 15, 985 1, 975 0	-45, 711, 820 -45, 711, 820 0 0 0 0 0 0 0 0 0 15, 954	213, 028 413, 432 4, 685, 468 4, 897, 421 19, 644, 532 1, 110, 581 1, 055, 325 0 1, 291, 506 0 7, 320, 177 2, 935 127, 623, 395 13, 071 116, 906 3, 521, 653 4, 417 214 24, 206 2, 458 440 458, 074	68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 76. 01 90. 00 90. 01 90. 02 90. 03 91. 00 92. 00 113. 00 118. 00 199. 00 191. 00 191. 00 194. 01 194. 01 194. 02 194. 03 194. 04

| Period: | Worksheet B-1 | From 07/01/2021 | To 06/30/2022 | Date/Time Prepared:

				Т	o 06/30/2022	Date/Time Pre 11/29/2022 8:	pared: 09 am
		CAPITAL REL	ATED COSTS				
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	BLDG & FIXT-MAB (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS	Reconci I i ati on	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
				SALARI ES)			
101 07 07 07	THE PURE THE	1.00	1. 01	4.00	5A	5. 00	101 07
194. 07 0795		0 507	0	0	0		194. 07
	B CORPORATE COMMUNICATIONS	2, 527	0	0	0	17, 551	1
194. 09 0795		0	0	0	0		194. 09
194. 10 0796		0	0	0	0		194. 10
194. 11 0796		0	0	0	0		194. 11
	ADOLESCENT RESIDENTIAL SERVICES	2, 845	0	809, 505	0	1, 068, 686	
	2 IDLE SPACE	0	0	0	0	l e	194. 13
200.00	Cross Foot Adjustments					l .	200. 00
201.00	Negative Cost Centers	0.075.047		0 070 040		l	201. 00
202. 00	Cost to be allocated (per Wkst. B, Part I)	3, 275, 216	0	8, 372, 818		45, 711, 820	202.00
203. 00	Unit cost multiplier (Wkst. B, Part I)	6. 945271	0. 000000	0. 170346		0. 344082	203. 00
204.00	Cost to be allocated (per Wkst. B, Part II)			43, 012		2, 918, 062	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part			0. 000875		0. 021965	205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

ASCENSION ST. VINCENT ANDERSON In Lieu of Form CMS-2552-10 Health Financial Systems COST ALLOCATION - STATISTICAL BASIS Provi der CCN: 15-0088 Peri od: Worksheet B-1 From 07/01/2021 To 06/30/2022 Date/Time Prepared: 11/29/2022 8:09 am OPERATION OF LAUNDRY & HOUSEKEEPI NG Cost Center Description DI ETARY CAFETERI A PLANT LINEN SERVICE (HOURS OF (MEALS SERVED) (TOTAL HOURS) (POUNDS OF (SQUARE FEET) SERVICE) LAUNDRY) 7.00 9.00 10.00 11.00 8.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.01 00101 CAP REL COSTS-BLDG & FIXT-MAB 1. 01 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 357, 760 7.00 00800 LAUNDRY & LINEN SERVICE 671 8.00 8.00 712, 365 00900 HOUSEKEEPI NG 9, 977 9.00 69, 870 9.00 10. 00 01000 DI ETARY 10.309 630 104.849 10.00

10.00	01000 DI ETARY	10, 309	0	630	104, 849		10.00
11.00	01100 CAFETERI A	17, 526	0	370	0	917, 316	11. 00
13.00	01300 NURSING ADMINISTRATION	4, 884	0	250	0	40, 591	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	15, 860	12, 474	830	O	18, 863	14.00
15. 00	01500 PHARMACY	4, 819	0	200	0	61, 898	1
16. 00	01600 MEDICAL RECORDS & LIBRARY	5, 214	o	50	o	0.,0,0	1
23. 00	02300 ALLI ED HEALTH-EMS	0,214	0	0	0	0	1
	02301 ALLIED HEALTH-RAD TECH	-1		0	0		1
23. 01	1	110	U	0	0	2, 712	1
23. 02	02303 ALLI ED HEALTH-PHARM RESI DENTS	0	0	U	U	0	23. 02
	INPATIENT ROUTINE SERVICE COST CENTERS						4
30. 00	03000 ADULTS & PEDI ATRI CS	65, 475	262, 969	30, 921	83, 723	278, 534	
31.00	03100 INTENSIVE CARE UNIT	14, 660	77, 712	5, 500	7, 137	77, 171	31.00
41.00	04100 SUBPROVI DER - I RF	10, 000	27, 264	2, 500	7, 956	26, 753	41.00
43.00	04300 NURSERY	6, 234	5, 372	394	0	4, 435	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	47, 997	113, 189	9, 200	30	194	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	22, 275	18, 209	1, 675	1, 876	20, 107	1
		22, 275	18, 209	1, 0/3		•	1
53. 00	05300 ANESTHESI OLOGY	۱	~	U	0	0	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	14, 278	1, 871	1, 750	0	56, 973	1
54. 01	03440 MAMMOGRAPHY	0	4, 173	150	0	6, 221	1
54. 02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	1, 127	358	150	0	5, 772	54. 02
54.03	03630 ULTRA SOUND	0	404	0	0	7, 045	54. 03
55.00	05500 RADI OLOGY-THERAPEUTI C	l ol	9, 630	150	o	24, 845	55. 00
57.00	05700 CT SCAN	551	34, 855	0	ol	15, 203	1
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 003	6, 125	150	o	6, 162	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	8, 562	0, 129	300	92	19, 763	1
			-		i i		
60.00	06000 LABORATORY	12, 544	0	1, 250	0	0	
65. 00	06500 RESPI RATORY THERAPY	7, 138	0	100	0	28, 373	1
66. 00	06600 PHYSI CAL THERAPY	9, 863	7, 341	1, 306	0	30, 092	1
67. 00	06700 OCCUPATI ONAL THERAPY	4, 441	3, 180	588	0	20, 813	67. 00
68.00	06800 SPEECH PATHOLOGY	1, 553	616	206	0	7, 279	68. 00
69. 00	06900 ELECTROCARDI OLOGY	l ol	86	1, 500	o	3, 852	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	11, 644	0	700	8	2, 132	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	o	0	0	2, 102	1
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	٥		0	0	0	72.00
		0	0	0	0	0	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	10 711	0	4 070	0	73. 00
76. 00	03190 CHEMOTHERAPY	0	12, 741	0	1, 273	24, 072	1
76. 01	03020 WOUND CARE	3, 100	0	0	0	11, 954	76. 01
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0	0	0	0	90.00
90. 01	09001 ANDERSON OUTPATIENT CENTER	3, 500	O	600	O	12, 406	90. 01
90. 02	04950 DIABETIC EDUCATION	0	0	0	0	0	1
90. 03	09002 MS CLINIC	ا	ام	0	0	0	1
91. 00	09100 EMERGENCY	22, 635	103, 496	7, 050	2, 754	83, 522	1
92. 00		22, 033	103, 470	7,030	2, 754	03, 322	
92.00	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)						92. 00
	OTHER REIMBURSABLE COST CENTERS		-1	_1	-1		
95. 00	09500 AMBULANCE SERVI CES	0	0	0	0	0	95. 00
	SPECIAL PURPOSE COST CENTERS			,			
113.00	11300 I NTEREST EXPENSE						113. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	337, 950	702, 065	68, 470	104, 849	897, 737	118. 00
	NONREI MBURSABLE COST CENTERS				<u> </u>		
190 00	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	1, 882	0	0	0	0	190. 00
	19100 RESEARCH	1,002	o	0	ol o		191. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	1, 829	Ö	0	0		192. 00
			-	-	9		
	07950 FOUNDATION	636	0	25	U .		194. 00
	07951 CHI LDRENS CLI NI C	0	140	900	O		194. 01
	07952 PSS ADMINISTRATION	0	0	0	0		194. 02
194. 03	07953 SEXUAL ASSAULT PROGRAM	0	0	0	0	27	194. 03
194.04	07954 ASPR BIOTERRORISM GRANT	o	o	0	o	0	194. 04
	07955 HEALTHY FAMILIES	10, 091	O	0	o		194. 05
	07956 DME-HOME CARE	1 0	n	n	ol o		194. 06
	07957 MARKETI NG			Ö	٥		194. 07
	07957 WARRETTING 07958 CORPORATE COMMUNI CATLONS	2 527	ý	50	Š		194. 07
	07958 CORPORATE COMMUNICATIONS	2, 527	10 1/0		Ŏ		
194.09	101A2A MOR	0	10, 160	325	0	0	194. 09

Health Financial Systems	ASCENSION ST. VINCENT ANDERSON	In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Provi der CCN: 15-0088	
		From 07/01/2021

Cost Center Description					T	o 06/30/2022	Date/Time Pre 11/29/2022 8:	
SQUARE FEET CPOUNDS OF LAUNDRYY SERVICE SERV		Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
194.10 07960 ASC 0 0 0 10.00 11.00 194.10 194.11 07961 MAB 0 0 0 0 0 0 194.11 194.12 07963 ADOLESCENT RESIDENTIAL SERVICES 2,845 0 0 0 0 0 194.12 194.13 07962 IDLE SPACE 0 0 0 0 0 0 194.13 200.00 Negative Cost Centers 200.00 Negative Cost to be allocated (per Wkst. B, Part I) 203.00 Unit cost multiplier (Wkst. B, Part II) 205.00 Unit cost multiplier (Wkst. B, Part II) 205.00 Unit cost multiplier (Wkst. B, Part II) 205.00 NAHE adjustment amount to be allocated (per Wkst. D, NAHE unit cost multiplier (Wkst. D, NAHE unit cost multiplier			PLANT	LINEN SERVICE	(HOURS OF	(MEALS SERVED)	(TOTAL HOURS)	
7.00 8.00 9.00 10.00 11.00 11.00 194.10 10.41 10.7961 MAB 0 0 0 0 0 0 194.11 194.12 07963 ADDLESCENT RESIDENTIAL SERVICES 2,845 0 0 0 0 194.13 194.13 07962 IDLE SPACE 0 0 0 0 0 194.13 200.00 Cross Foot Adjustments 200.00 Negative Cost Centers 201.00 Negative Cost to be allocated (per Wkst. B, Part I) 20.149234 1.654104 59.852340 12.766731 3.266077 203.00 204.00 Cost to be allocated (per Wkst. B, Part II) 205.00 Unit cost multiplier (Wkst. B, Part II) 205.00 Unit cost multiplier (Wkst. B, Part II) 206.00 NAHE adjustment amount to be allocated (per Wkst. B, 2) NAHE unit cost multiplier (Wkst. D, 207.00 NAHE unit cost multiplier (Wkst. D, 207.00 NAHE unit cost multiplier (Wkst. D, 207.00 207.00 NAHE unit cost multiplier (Wkst. D, 207.00 NAHE unit cost multiplier (Wkst. D, 207.00 207.00 NAHE unit cost multiplier (Wkst. D, 207.00 NAHE unit cost multiplier (Wkst. D, 207.00 207.00 NAHE unit cost multiplier (Wkst. D, 207.00 207.00 NAHE unit cost multiplier (Wkst. D, 207.00 207.			(SQUARE FEET)	(POUNDS OF	SERVI CE)			
194. 10 07960 ASC 0 0 100 0 0 194. 10 194. 11 07961 MAB 0 0 0 0 0 194. 12 07963 ADOLESCENT RESIDENTIAL SERVICES 2,845 0 0 0 0 194. 13 07962 DIE SPACE 0 0 0 0 194. 13 07962 O 0 0 0 194. 13 07962 O 0 0 194. 13 07962 O 0 0 194. 14 13 07962 O 0 194. 15 O 0 0 194. 16 O 0 0 194. 17 O 0 194. 18 O 0 194. 19 O 0 194. 19 O 0 194. 10 O 0 194. 11 O 0 194. 10 O O 194. 10 O				LAUNDRY)				
194. 11 07961 MAB 0 0 0 0 0 194. 11 194. 12 07963 ADOLESCENT RESIDENTIAL SERVICES 2,845 0 0 0 194. 12 194. 13 07962 IDLE SPACE 0 0 0 0 194. 13 200. 00 201. 00 202. 00 Cost fob allocated (per Wkst. B, Part I) 203. 00 Unit cost multiplier (Wkst. B, Part II) 205. 00 Unit cost multiplier (Wkst. B, Part II) 205. 00 Unit cost multiplier (Wkst. B, Part II) 206. 00 NAHE adjustment amount to be allocated (per Wkst. B, 2) 207. 00 NAHE unit cost multiplier (Wkst. D, 207. 00 NAHE unit cost multiplier (Wkst. D, 207. 00 0 0 0 0 0 0 194. 11 0 0 194. 12 0 0 0 0 0 0 0 194. 12 0 0 0 0 0 0 0 0 194. 12 0 0 0 0 0 0 0 0 0			7. 00	8. 00	9. 00	10.00	11. 00	
194. 12 07963 ADOLESCENT RESIDENTIAL SERVICES 2,845 0 0 0 194. 12 194. 13 07962 1DLE SPACE 0 0 0 194. 13 200. 00 201. 00 0 194. 13 200. 00 201. 00 202. 00 202. 00 203. 00 203. 00 204. 00 204. 00 204. 00 205. 00 205. 00 206. 00 206. 00 206. 00 206. 00 206. 00 207. 00	194. 10	07960 ASC	0	0	100	0	0	194. 10
194. 13 07962 IDLE SPACE 0 0 0 0 0 0 194. 13 200. 00 201. 00 Negative Cost Centers 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	194. 11	07961 MAB	0	0	0	0	0	194. 11
200.00 201.00 202.00 Negative Cost Centers Cost to be allocated (per Wkst. B, Part I) 203.00 204.00 Cost to be allocated (per Wkst. B, Part I) 205.00 Unit cost multiplier (Wkst. B, Part I) 205.00 Unit cost multiplier (Wkst. B, Part I) 206.00 NAHE adjustment amount to be allocated (per Wkst. B, Part I) 207.00 NAHE unit cost multiplier (Wkst. B, Part I) 207.00 NAHE unit cost multiplier (Wkst. B, Part I) 208.00 NAHE unit cost multiplier (Wkst. B, Part I) 209.00 200.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 202.00 202.00 203.00 204.01 205.02 205.03 206.03 206.03 206.03 206.04 207.00 208.00 209.00	194. 12	D7963 ADOLESCENT RESIDENTIAL SERVICES	2, 845	0	0	0	0	194. 12
201.00 202.00 Negative Cost Centers Cost to be allocated (per Wkst. B, Part I) 203.00 Unit cost multiplier (Wkst. B, Part II) 204.00 Cost to be allocated (per Wkst. B, Part II) 205.00 Unit cost multiplier (Wkst. B, Part II) 206.00 NAHE adjustment amount to be allocated (per Wkst. B, Part II) NAHE unit cost multiplier (Wkst. B, Part II) NAHE unit cost multiplier (Wkst. D, Part II) 207.00 NAHE unit cost multiplier (Wkst. D, Part III) 208.00 NAHE unit cost multiplier (Wkst. D, Part III) 209.00 NAHE unit cost multiplier (Wkst. D, Part III) 200.00 NAHE unit cost multiplier (Wkst. D, Part IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII	194. 13	07962 I DLE SPACE	0	0	0	0	0	194. 13
202.00 Cost to be allocated (per Wkst. B, Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 20.149234 1.654104 59.852340 12.766731 3.266077 203.00 Cost to be allocated (per Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II) 205.00 Unit cost multiplier (Wkst. B, Part II) 206.00 WAHE adjustment amount to be allocated (per Wkst. B, NAHE unit cost multiplier (Wkst. D, NAHE unit cost multiplier (Wkst. D, 207.00 NAHE unit cost multiplier (Wkst. D	200.00	Cross Foot Adjustments						200. 00
Part I) Unit cost multiplier (Wkst. B, Part I) 203.00 Cost to be allocated (per Wkst. B, Part II) 205.00 Unit cost multiplier (Wkst. B, Part III) 206.00 NAHE adjustment amount to be allocated (per Wkst. B, Part III) 207.00 NAHE unit cost multiplier (Wkst. D, Part III) 208.00 NAHE unit cost multiplier (Wkst. D, Part IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII	201.00	Negative Cost Centers						201. 00
203.00 Unit cost multiplier (Wkst. B, Part I) 20.149234 1.654104 59.852340 12.766731 3.266077 203.00 Cost to be allocated (per Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II) 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, 207.00 NAHE unit cost multiplier (Wkst. D, 207	202.00	Cost to be allocated (per Wkst. B,	7, 208, 590	1, 178, 326	4, 181, 883	1, 338, 579	2, 996, 025	202. 00
204.00 Cost to be allocated (per Wkst. B, Part II) 205.00 Unit cost multiplier (Wkst. B, Part II) 206.00 NAHE adjustment amount to be allocated (per Wkst. B, P) NAHE unit cost multiplier (Wkst. D, P) Cost to be allocated (per Wkst. B, Part II, 411508 0.034592 0.034592 0.034592 0.004797 0.207208		Part I)						
Part II) Unit cost multiplier (Wkst. B, Part 1. 411508 0. 034592 2. 124388 1. 004797 0. 207208 205. 00 II) NAHE adjustment amount to be allocated (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, 207. 00	203.00	Unit cost multiplier (Wkst. B, Part I)	20. 149234	1. 654104	59. 852340	12. 766731	3. 266077	203. 00
205.00 Unit cost multiplier (Wkst. B, Part II) 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, 207.00	204.00	Cost to be allocated (per Wkst. B,	504, 981	24, 642	148, 431	105, 352	190, 075	204. 00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, 207.00		Part II)						
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00	205.00	Unit cost multiplier (Wkst. B, Part	1. 411508	0. 034592	2. 124388	1. 004797	0. 207208	205. 00
(per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00		11)						
207.00 NÄHE unit cost multiplier (Wkst. D, 207.00	206.00	NAHE adjustment amount to be allocated						206. 00
		(per Wkst. B-2)						
Parts III and IV)	207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
		Parts III and IV)						

		SCENSION ST. VIN		u 15 0000 D		u of Form CMS-	
COSTA	LLOCATION - STATISTICAL BASIS		Provi der CCI		eriod: com 07/01/2021	Worksheet B-1	
				To	06/30/2022	Date/Time Pre 11/29/2022 8:	pared: 09 am
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	ALLI ED	, diii
		ADMI NI STRATI ON	SERVICES & SUPPLY	(COSTED REQUIS.)	RECORDS & LI BRARY	HEALTH-EMS (ASSIGNED	
		(DI RECT NURS.	(COSTED	REQUIS.)	(GROSS	TIME)	
		HRS.)	REQUIS.)		CHARGES)		
	GENERAL SERVICE COST CENTERS	13. 00	14. 00	15. 00	16. 00	23. 00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101 CAP REL COSTS-BLDG & FIXT-MAB						1. 01
4. 00 5. 00	OO4OO						4. 00 5. 00
7. 00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A						10.00
13. 00	01300 NURSI NG ADMI NI STRATI ON	370, 642					13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	11, 731, 003				14. 00
15. 00 16. 00	01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY	0	159, 653	19, 644, 532 0	712, 688, 736		15. 00 16. 00
23. 00	02300 ALLIED HEALTH-EMS		0	0	712,000,730	0	23. 00
23. 01	02301 ALLIED HEALTH-RAD TECH	0	O	0	o		23. 01
23. 02	02303 ALLI ED HEALTH-PHARM RESI DENTS	0	0	0	0		23. 02
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	183, 168	578, 986	0	54, 253, 345	0	30.00
31. 00	03100 NTENSI VE CARE UNI T	70, 247	325, 641	Ö	24, 596, 779	0	
41. 00	04100 SUBPROVI DER - I RF	19, 168	20, 559	0	4, 052, 273	0	41. 00
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	3, 723	11, 818	0	1, 594, 912	0	43. 00
50. 00	05000 OPERATING ROOM	15, 008	8, 594, 510	0	132, 927, 453	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	19, 017	74, 943	0	4, 476, 880	0	
53. 00	05300 ANESTHESI OLOGY	0	405 (10	0	17 400 430	0	
54. 00 54. 01	05400 RADI OLOGY-DI AGNOSTI C 03440 MAMMOGRAPHY	0	405, 619 61, 212	0	17, 498, 630 3, 959, 739	0	
54. 02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	193, 698	Ō	16, 696, 386	0	54. 02
54. 03	03630 ULTRA SOUND	0	3, 897	0	9, 404, 689	0	54. 03
55. 00 57. 00	05500 RADI OLOGY-THERAPEUTI C 05700 CT SCAN	0	16, 787 449	0	30, 836, 583 17, 362, 629	0	55. 00 57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	1, 831	Ö	2, 977, 337	0	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	10, 265	169, 829	0	24, 704, 178	0	
60. 00 65. 00	06000 LABORATORY 06500 RESPI RATORY THERAPY	0	2, 840 219, 102	0	88, 218, 848 20, 341, 215	0	60. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	0	50, 852	0	8, 967, 570	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0	22, 900	0	3, 707, 209	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	8, 009	0	1, 298, 172	0	68. 00
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	0	1, 306 1, 537	0	1, 242, 397 3, 992, 200	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	Ö	21, 174, 981	0	
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	21, 504, 051	0	
73. 00 76. 00	07300 DRUGS CHARGED TO PATIENTS 03190 CHEMOTHERAPY	0	0 108, 156	19, 644, 532 0	107, 171, 213 8, 855, 091	0	
	03020 WOUND CARE		271, 118	0	4, 974, 383	0	
	OUTPATIENT SERVICE COST CENTERS						
90. 00 90. 01	09000 CLINIC 09001 ANDERSON OUTPATIENT CENTER	0	0 566	0	2 045 124	0	
	04950 DI ABETI C EDUCATION		0	0	3, 845, 126 0	0	1
90. 03	09002 MS CLINIC	0	O	0	o	0	90. 03
91.00	09100 EMERGENCY	50, 046	424, 832	0	72, 054, 467	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92.00
95. 00	09500 AMBULANCE SERVICES	0	0	0	0	0	95. 00
	SPECIAL PURPOSE COST CENTERS						
113. 00 118. 00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	370, 642	11, 730, 656	19, 644, 532	712, 688, 736	0	113. 00 118. 00
110.00	NONREI MBURSABLE COST CENTERS	370,042	11, 730, 030	17, 044, 332	712,000,730	0	1110.00
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0		190. 00
	19100 RESEARCH 19200 PHYSLCLANS' PRIVATE OFFICES	0	0 82	0	0		191. 00 192. 00
	07950 FOUNDATION		0	0	ol ol		194. 00
	07951 CHI LDRENS CLI NI C	0	ō	Ō	ō		194. 01
	07952 PSS ADMINISTRATION	0	O	0	0		194. 02
	07953 SEXUAL ASSAULT PROGRAM 07954 ASPR BIOTERRORISM GRANT	0	0	0	0		194. 03 194. 04
	07955 HEALTHY FAMILIES		265	0	o		194. 05
194.06	07956 DME-HOME CARE	0	O	0	o	0	194. 06
	07957 MARKETI NG 07958 CORPORATE COMMUNI CATI ONS	0	0	0	0		194. 07 194. 08
174. 08	1017 200 COM ONATE COMMONITORITONS	<u> </u>	Ч	υ _l	્ય	0	1174.00

COST ALLOCATION - STATISTICAL BASIS		Provi der Co		Peri od:	Worksheet B-1	
				From 07/01/2021		
				To 06/30/2022	Date/Time Prep	pared:
					11/29/2022 8: 0	09 am
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	ALLI ED	
	ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &	HEALTH-EMS	

NURSI NG ADMINISTRATION SERVICES & SUPPLY (COSTED RECORDS & LIBRARY (ASSIGNED (ASS							11/29/2022 8:	
194. 09 07959 MOB 13. 00 14. 00 15. 00 16. 00 23. 00		Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	ALLI ED	
194. 09 07959 MOB			ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &	HEALTH-EMS	
HRS. REQUIS. CHARGES				SUPPLY	REQUIS.)	LI BRARY	(ASSI GNED	
13.00 14.00 15.00 16.00 23.00			(DI RECT NURS.	(COSTED		(GROSS	TIME)	
194. 09 07959 MOB			HRS.)	REQUIS.)		CHARGES)		
194. 10 07960 ASC 0 0 0 0 0 0 0 194. 10 194. 11 07961 MAB 0 0 0 0 0 0 0 0 0 194. 11 194. 12 07963 ADOLESCENT RESIDENTIAL SERVICES 0 0 0 0 0 0 0 194. 12 194. 13 07962 IDLE SPACE 0 0 0 0 0 0 0 194. 12 194. 13 07962 IDLE SPACE 0 0 0 0 0 0 0 194. 12 194. 13 07962 IDLE SPACE 0 0 0 0 0 0 194. 12 194. 13 194			13. 00	14.00	15. 00	16. 00		
194. 11 07961 MAB			0	0	C	0		
194. 12 07963 ADDLESCENT RESIDENTIAL SERVICES 0 0 0 0 0 0 194. 12 194. 13 07962 IDLE SPACE 0 0 0 0 0 0 194. 13 200. 00 201. 00 Negative Cost Centers 202. 00 Cost to be allocated (per Wkst. B, Part I) 203. 00 Unit cost multiplier (Wkst. B, Part II) 205. 00 Unit cost multiplier (Wkst. B, Part II) 205. 00 Unit cost multiplier (Wkst. B, Part II) 206. 00 NAHE adjustment amount to be allocated (per Wkst. D, NAHE unit cost multiplier (Wkst. D, NAHE unit cost multip			0	0	0	0		
194. 13 07962 IDLE SPACE 0 0 0 0 0 0 0 194. 13 200. 00 201. 00 Negative Cost Centers 201. 00 Cost to be allocated (per Wkst. B, Part I) 10. 647787 0. 051643 0. 305301 0. 000220 0. 000000 203. 00 204. 00 0. 000000 205. 00 0. 0000000 205. 00 0. 0000000 205. 00 0. 0000000 205. 00 0. 0000000 207. 00 0. 0000000000000000000000000000	194. 11 0796	I MAB	0	0	0	0	0	194. 11
200.00 201.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, Part I) 203.00 Unit cost multiplier (Wkst. B, Part II) 205.00 Unit cost multiplier (Wkst. B, Part II) 206.00 NAHE adjustment amount to be allocated (per Wkst. D, NAHE unit cost multiplier (Wkst. D, Cross Foot Adjustments 200.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 202.00 202.00 203.00 204.00 205.00 100.000020 0.000000 203.00 204.00 205.00 0.000000 205.00 0.000000 206.00 0.000000 207.00	194. 12 07963	ADOLESCENT RESIDENTIAL SERVICES	0	0	C	0	0	194. 12
201.00 202.00 Regative Cost Centers 202.00 Cost to be allocated (per Wkst. B, Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 204.00 Cost to be allocated (per Wkst. B, Part II) 205.00 Unit cost multiplier (Wkst. B, Part II) 205.00 WAHE adjustment amount to be allocated (per Wkst. B, Part II) 206.00 NAHE unit cost multiplier (Wkst. D, Part II) 207.00 NAHE unit cost multiplier (Wkst. D, Part III) 208.00 NAHE unit cost multiplier (Wkst. D, Part III) 209.00 NAHE unit cost multiplier (Wkst. D, Part III) 200.00 NAHE unit cost multiplier (Wkst. D, Part IIII) 200.00 NAHE unit cost multiplier (Wkst. D, Part IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII	194. 13 07962	IDLE SPACE	0	0	C	0	0	194. 13
202.00 Cost to be allocated (per Wkst. B, Part I) 10.647787 605,827 5,997,496 156,732 0 202.00 203.00 Unit cost multiplier (Wkst. B, Part I) 10.647787 0.051643 0.305301 0.000220 0.000000 203.00 204.00 Cost to be allocated (per Wkst. B, Part II) 111,795 141,551 150,692 44,475 0 204.00 205.00 Unit cost multiplier (Wkst. B, Part II) 111 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, 0.000000 207.00 0.000000 2	200.00	Cross Foot Adjustments						200. 00
Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II) NAHE adjustment amount to be allocated (per Wkst. B, Part II) NAHE unit cost multiplier (Wkst. D, III) NAHE unit cost multiplier (Wkst. D, IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII	201.00	Negative Cost Centers						201. 00
203.00 Unit cost multiplier (Wkst. B, Part I) 10.647787 0.051643 0.305301 0.000220 0.000000 203.00 (204.00 Cost to be allocated (per Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II) 0.301625 0.010809 0.007671 0.000062 0.000000 205.00 (11) NAHE adjustment amount to be allocated (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, 0.000000 207.00	202. 00	Cost to be allocated (per Wkst. B,	3, 946, 517	605, 827	5, 997, 496	156, 732	0	202. 00
204.00 Cost to be allocated (per Wkst. B, Part II) 150,692 44,475 0 204.00 205.00 Unit cost multiplier (Wkst. B, Part II) 0.301625 0.010809 0.007671 0.000062 0.000000 205.00 11) 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, 0.000000 207.00 0.0000000 207.00 0.0000000 207.00 0.000000000000000000000000000000		Part I)						
Part II) Unit cost multiplier (Wkst. B, Part 0.301625 0.010809 0.007671 0.000062 0.000000 205.00 II) 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, 0.000000 207.00	203.00	Unit cost multiplier (Wkst. B, Part I)	10. 647787	0. 051643	0. 305301	0. 000220	0.000000	203. 00
205.00 Unit cost multiplier (Wkst. B, Part 0.301625 0.010809 0.007671 0.000062 0.000000 205.00	204.00	Cost to be allocated (per Wkst. B,	111, 795	141, 551	150, 692	44, 475	0	204. 00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, 0.000000 207.00		Part II)						
206. 00 NAHE adjustment amount to be allocated (per Wkst. B-2) 0 206. 00 207. 00 NAHE unit cost multiplier (Wkst. D, 0.000000 207. 00	205.00		0. 301625	0. 010809	0. 007671	0. 000062	0. 000000	205. 00
(per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 0.000000 207.00		[11]						
207.00 NÄHE unit cost multiplier (Wkst. D, 0.000000 207.00	206. 00						0	206. 00
Parts III and IV)	207. 00	· · · · · · · · · · · · · · · · · · ·					0. 000000	207. 00
		Parts III and IV)						

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS In Lieu of Form CMS-2552-10
Worksheet B-1 Peri od: From 07/01/2021 To 06/30/2022 Date/Ti me Prepared: Provider CCN: 15-0088

				10 06/30/2022 Date/11	2022 8: 09 am
	Cost Center Description	ALLI ED	ALLI ED		
		HEALTH-RAD	HEALTH-PHARM		
		TECH	RESI DENTS		
		(ASSI GNED	(ASSI GNED		
		TIME)	TIME)		
	DENERAL DEPUT DE COOT DENTERO	23. 01	23. 02		
1 00	GENERAL SERVICE COST CENTERS				1.00
1.00	00100 CAP REL COSTS-BLDG & FLXT				1.00
1. 01	00101 CAP REL COSTS-BLDG & FLXT-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 HOUSEKEEPI NG				9. 00
10. 00	01000 DI ETARY				10. 00
11. 00	01100 CAFETERI A				11. 00
13. 00	01300 NURSING ADMINISTRATION				13. 00
	1 1				14. 00
					15. 00
	01600 MEDICAL RECORDS & LIBRARY				16. 00
					23. 00
23. 01	02301 ALLIED HEALTH-RAD TECH	98, 735, 994			23. 01
23. 02	02303 ALLIED HEALTH-PHARM RESIDENTS		0		23. 02
	INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00	03000 ADULTS & PEDIATRICS	0	0		30.00
31.00	03100 INTENSI VE CARE UNI T	0	0		31.00
	1 1	0	0		41.00
43. 00	04300 NURSERY	0	0		43. 00
F0 00	ANCILLARY SERVICE COST CENTERS	ام			
50. 00	05000 OPERATING ROOM	0	0		50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53. 00	05300 ANESTHESI OLOGY	0	0		53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	17, 498, 631	0		54. 00
54. 01	03440 MAMMOGRAPHY	3, 959, 739	0		54. 01
54. 02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	16, 696, 386	0		54. 02
	03630 ULTRA SOUND	9, 404, 689	0		54. 03
55. 00	05500 RADI OLOGY-THERAPEUTI C	30, 836, 583	0		55. 00
57. 00	05700 CT SCAN	17, 362, 629	0		57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	2, 977, 337	0		58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0		59.00
60.00	06000 LABORATORY	0	0		60.00
65. 00	06500 RESPI RATORY THERAPY	0	0		65.00
66.00	06600 PHYSI CAL THERAPY	0	0		66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		67.00
68. 00	06800 SPEECH PATHOLOGY	0	0		68.00
69. 00	06900 ELECTROCARDI OLOGY	0	0		69. 00
		0	0		70.00
		0	0		71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	1	0	0		76.00
/6. 01	03020 WOUND CARE	0	0		76. 01
00 00	OUTPATIENT SERVICE COST CENTERS	ما			00.00
	09000 CLINIC 09001 ANDERSON OUTPATIENT CENTER	0	0		90.00
		0	0		
	04950 DI ABETI C EDUCATI ON	0			90. 02
	09002 MS CLINIC 09100 EMERGENCY	0	0		90. 03 91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		U		91.00
72. UU	OTHER REIMBURSABLE COST CENTERS				92.00
95. 00		0	0		95. 00
95.00	SPECIAL PURPOSE COST CENTERS	U	U _I		95.00
113 00	11300 INTEREST EXPENSE				113. 00
118. 00		98, 735, 994	0		118. 00
, 10.00	NONREI MBURSABLE COST CENTERS	,5, 155, 774	O _I		1 10.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		190. 00
	19100 RESEARCH	0	0		191. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0		192. 00
	07950 FOUNDATION	0	0		194. 00
	07951 CHILDRENS CLINIC	0	0		194. 00
	207951 CHI EDRENS CEI NI C	0	0		194. 01
	307953 SEXUAL ASSAULT PROGRAM	0	0		194. 02
	107954 ASPR BIOTERRORISM GRANT	0	0		194. 03
	07955 HEALTHY FAMILIES	0	0		194. 04
	07956 DME-HOME CARE	0	0		194. 05
	7 07957 MARKETI NG	0	0		194. 00
	07957 MARKETING BO7958 CORPORATE COMMUNICATIONS	0	0		194. 07
		<u> </u>	0		11,74,00

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

Peri od: Worksheet B-1 From 07/01/2021 To 06/30/2022 Date/Time Prepared:

				11/29/2022 8: 09 am
	Cost Center Description	ALLI ED HEALTH-RAD TECH	ALLI ED HEALTH-PHARM RESI DENTS	
		(ASSI GNED	(ASSI GNED	
		TIME)	TIME)	
		23. 01	23. 02	
194. 09 0795	9 MOB	0	0	194. 09
194. 10 0796	O ASC	0	0	194. 10
194. 11 0796	1 MAB	0	0	194. 11
194. 12 0796	3 ADOLESCENT RESIDENTIAL SERVICES	0	0	194. 12
194. 13 0796	2 I DLE SPACE	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)	218, 627	0	202.00
203. 00	Unit cost multiplier (Wkst. B, Part I)	0. 002214	0. 000000	203. 00
204.00	Cost to be allocated (per Wkst. B,	4, 963	0	204. 00
	Part II)			
205.00	Unit cost multiplier (Wkst. B, Part	0. 000050	0. 000000	205. 00
	11)			
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)	0	0	206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)	0. 000000	0. 000000	207.00

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

OMPUTATION O		SCENSION SI. VI				U OI FOIII CW3	2332-10
COMPUTATION	OF RATIO OF COSTS TO CHARGES		Provi der Co	JN: 15-0088	Peri od:	Worksheet C	
					From 07/01/2021 To 06/30/2022	Part I Date/Time Pre	narod:
					10 00/30/2022	11/29/2022 8:	ραιeu. Ng am
			Ti tl o	XVIII	Hospi tal	PPS	07 dili
			11110	AVIII	Costs	113	
	0+ 0+ D!!	T-+-1 C+	Th ! !! #	T-+-1 C+-		T-+-1 C+-	
(Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2. 00	3. 00	4. 00	5. 00	
	ENT ROUTINE SERVICE COST CENTERS						
30.00 03000 /	ADULTS & PEDIATRICS	33, 793, 267		33, 793, 26	7 0	33, 793, 267	30.00
31. 00 03100	INTENSIVE CARE UNIT	12, 841, 972		12, 841, 97	2 0	12, 841, 972	31.00
41.00 04100 3	SUBPROVIDER - IRF	3, 497, 270		3, 497, 27		3, 497, 270	
1 1	NURSERY	685, 169		685, 16		685, 169	
	ARY SERVICE COST CENTERS	000, 107	l .	000, 10		000, 107	10.00
	OPERATING ROOM	21, 090, 795		21, 090, 79	5 0	21, 090, 795	50.00
	DELIVERY ROOM & LABOR ROOM	1	l e				
52.00 05200 1	ANECTHE CLOSE & LABOR ROOM	2, 827, 952	i e	2, 827, 95		2, 827, 952	
	ANESTHESI OLOGY	0	l		0	0	53. 00
	RADI OLOGY-DI AGNOSTI C	5, 143, 584		5, 143, 58		5, 143, 584	
54. 01 03440 1	MAMMOGRAPHY	826, 851		826, 85	1 0	826, 851	54. 01
54.02 03450 1	NUCLEAR MEDICINE - DIAGNOSTIC	1, 419, 009		1, 419, 00	9 0	1, 419, 009	54. 02
54. 03 03630	ULTRA SOUND	694, 827		694, 82	.7 ol	694, 827	54. 03
	RADI OLOGY-THERAPEUTI C	2, 844, 395		2, 844, 39		2, 844, 395	
	CT SCAN	1, 484, 335	l e	1, 484, 33		1, 484, 335	
	MAGNETIC RESONANCE IMAGING (MRI)	867, 513	l e	867, 51		867, 513	•
	CARDIAC CATHETERIZATION	1	l .			· ·	
		2, 120, 785	l .	2, 120, 78		2, 120, 785	
	LABORATORY	8, 964, 940	l .	8, 964, 94		8, 964, 940	1
	RESPI RATORY THERAPY	2, 771, 923				2, 771, 923	
66.00 06600 1	PHYSI CAL THERAPY	3, 566, 347	0	3, 566, 34	.7	3, 566, 347	66. 00
67.00 06700 0	OCCUPATIONAL THERAPY	1, 617, 074	0	1, 617, 07	4 0	1, 617, 074	67.00
68. 00 06800 5	SPEECH PATHOLOGY	564, 772	0	564, 77	2 0	564, 772	68. 00
	ELECTROCARDI OLOGY	389, 169		389, 16	9 0	389, 169	69.00
	ELECTROENCEPHALOGRAPHY	840, 224		840, 22		840, 224	
	MEDICAL SUPPLIES CHARGED TO PATIENTS	6, 302, 311		6, 302, 31		6, 302, 311	
	IMPL. DEV. CHARGED TO PATIENTS	6, 587, 266		6, 587, 26			
						6, 587, 266	
	DRUGS CHARGED TO PATIENTS	32, 424, 971		32, 424, 97		32, 424, 971	
	CHEMOTHERAPY	1, 616, 194		1, 616, 19		1, 616, 194	
	WOUND CARE	1, 535, 044		1, 535, 04	4 0	1, 535, 044	76. 01
	IENT SERVICE COST CENTERS						
90.00 09000 0	CLINIC	0			0	0	90.00
90. 01 09001	ANDERSON OUTPATIENT CENTER	1, 883, 717		1, 883, 71	7 0	1, 883, 717	90. 01
90. 02 04950 [DIABETIC EDUCATION	0			ol ol	0	90. 02
	MS CLINIC	0			0 0	0	1
	EMERGENCY	11, 766, 768		11, 766, 76		11, 766, 768	1
	OBSERVATION BEDS (NON-DISTINCT PART)	2, 179, 223		2, 179, 22			
		2, 179, 223		2, 179, 22	.3	2, 179, 223	92.00
	REI MBURSABLE COST CENTERS					2 2 4 5	
	AMBULANCE SERVICES	3, 945		3, 94	5 0	3, 945	95. 00
	L PURPOSE COST CENTERS	T					l
	INTEREST EXPENSE						113. 00
	Subtotal (see instructions)	173, 151, 612	0	173, 151, 61	2 0	173, 151, 612	
201. 00 I	Less Observation Beds	2, 179, 223		2, 179, 22	3	2, 179, 223	201.00
202. 00	Total (see instructions)	170, 972, 389	0	170, 972, 38	9 0	170, 972, 389	202.00
' '	•	•	•	•	'		•

Heal th	Financial Systems F	ASCENSION ST. VIN	ICENT ANDERSON		In Lie	u of Form CMS-2	2552-10
COMPUT	FATION OF RATIO OF COSTS TO CHARGES		Provi der CO	Provider CCN: 15-0088		Worksheet C	
					From 07/01/2021	Part I	
					To 06/30/2022	Date/Time Pre	pared:
						11/29/2022 8:	09 am_
		_		XVIII	Hospi tal	PPS	
			Charges				
	Cost Center Description	I npati ent	Outpati ent		Cost or Other	TEFRA	
				+ col. 7)	Ratio	Inpati ent	
						Ratio	
		6.00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	51, 168, 757		51, 168, 75	7	I	30. 00
31.00	03100 INTENSIVE CARE UNIT	24, 596, 779		24, 596, 77	9	I	31.00
41.00	04100 SUBPROVI DER - I RF	4, 052, 273		4, 052, 27	3	I	41.00
43.00	04300 NURSERY	1, 594, 912		1, 594, 91		I	43.00
	ANCILLARY SERVICE COST CENTERS	<u>'</u>					ĺ
50.00	05000 OPERATING ROOM	23, 907, 771	109, 019, 682	132, 927, 45	3 0. 158664	0.000000	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	3, 957, 078	519, 802	4, 476, 88	0. 631679	0. 000000	52.00
53. 00	05300 ANESTHESI OLOGY	0	0		0. 000000	0. 000000	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	6, 576, 936	10, 921, 694			0. 000000	
54. 01	03440 MAMMOGRAPHY	16, 385	3, 943, 354			0. 000000	
54. 02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	1, 265, 179	15, 431, 207	16, 696, 38		0. 000000	
54. 02	03630 ULTRA SOUND	1, 508, 740	7, 895, 949	9, 404, 68		0.000000	
55. 00	05500 RADI OLOGY-THERAPEUTI C					0.000000	
		249, 647	30, 586, 936	30, 836, 58			
57. 00	05700 CT SCAN	4, 238, 881	13, 123, 748	17, 362, 62		0.000000	
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	706, 042	2, 271, 295			0. 000000	
59. 00	05900 CARDI AC CATHETERI ZATI ON	6, 432, 905	18, 271, 273	24, 704, 17		0. 000000	
60.00	06000 LABORATORY	33, 619, 369	54, 599, 479			0. 000000	
65. 00	06500 RESPI RATORY THERAPY	17, 482, 580	2, 858, 635			0. 000000	
66. 00	06600 PHYSI CAL THERAPY	2, 793, 843	6, 173, 727	8, 967, 57		0. 000000	
67. 00	06700 OCCUPATI ONAL THERAPY	1, 895, 927	1, 811, 282			0.000000	
68. 00	06800 SPEECH PATHOLOGY	641, 892	656, 280	1, 298, 17	2 0. 435052	0. 000000	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	1, 242, 397	1, 242, 39	7 0. 313240	0.000000	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	146, 766	3, 845, 434	3, 992, 20	0. 210466	0.000000	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	10, 235, 377	10, 939, 604	21, 174, 98	1 0. 297630	0.000000	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	3, 916, 148	17, 587, 903	21, 504, 05	1 0. 306327	0.000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	34, 474, 831	72, 696, 382	107, 171, 21	3 0. 302553	0.000000	73. 00
76.00	03190 CHEMOTHERAPY	73, 355	8, 781, 736			0. 000000	76. 00
76. 01	03020 WOUND CARE	39, 830	4, 934, 553			0. 000000	
70.0.	OUTPATIENT SERVICE COST CENTERS	077000	17 70 17 000	1, 7, 1, 00	0.000070	0.00000	70.0.
90.00	09000 CLI NI C	0	0		0. 000000	0.000000	90.00
90. 01	09001 ANDERSON OUTPATIENT CENTER	8, 699	3, 836, 427	3, 845, 12		0. 000000	
90. 01	04950 DIABETIC EDUCATION	0,077	0,000,427		0. 000000	0.000000	
90. 02	09002 MS CLINIC	0	0		0. 000000	0.000000	
91.00	09100 EMERGENCY	1 "1	ŭ			0.000000	
		20, 493, 643	51, 560, 824				
92. 00	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	888, 445	2, 196, 143	3, 084, 58	8 0. 706488	0. 000000	92. 00
05 00	OTHER REIMBURSABLE COST CENTERS				0 000000	0.000000	05 00
95. 00	09500 AMBULANCE SERVI CES	0	0		0. 000000	0. 000000	95. 00
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE	05/	.==			I	113. 00
200.00		256, 982, 990	455, 705, 746	712, 688, 73	6	I	200. 00
201.00	1					I	201. 00
202.00	Total (see instructions)	256, 982, 990	455, 705, 746	712, 688, 73	6	ı	202. 00

Cost Center Description					To 06/30/2022	Date/Time Prepared: 11/29/2022 8:09 am
NAPATEM ROUTINE SERVICE COST CENTERS 11.00				Title XVIII	Hospi tal	
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30.00 3000 ADULTS & PEDIATRI CS 31.00 31.0		Cost Center Description	PPS Inpatient			
INPATI ENT ROUTINE SERVICE COST CENTERS 30.00 30.00 ADULTS & POIDIATRICS 31.00 40.00 ADULTS & POIDIATRICS 31.00 43.00 INTERSIVE CARE UNIT 41.10 43.00 43.00 INTERSIVE CARE UNIT 43.00 43.00 INTERSIVE CARE UNIT 43.00 43.00 INTERSIVE CARE UNIT 43.00 43.00 INTERSIVE COST CENTERS 43.00 43.						
30.00			11. 00			
31.00 03100 NTENSIVE CARE UNIT						
41.00 04100 SUBPROVI DER - 1 RF 43.00 04300 NURSERY 43.00 04300 NURSERY 43.00 04300 NURSERY 43.00 04300 NURSERY 43.00 05200 DERATI NE ROOM 0.158664 52.00 05200 DERATI NE ROOM 0.631679 52.00 05300 OREATI NE ROOM 0.631679 53.00 05300 ANESTHESI OLOGY 0.000000 53.00 05300 ANESTHESI OLOGY 0.000000 53.00 05300 ANESTHESI OLOGY 0.000000 53.00 05300 ANESTHESI OLOGY 0.000000 53.00 05300 ANESTHESI OLOGY 0.000000 53.00 05300 ANESTHESI OLOGY 0.000000 53.00 05300 ANESTHESI OLOGY 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000						
43. 00 43.00 MURSERY						
AMCILLARY SERVICE COST CENTERS 50.00 50.00 OPERATIN ROOM 0.158664 50.00 50.00 OPERATINE ROOM 0.631679 52.00 05200 OPERATINE ROOM 0.631679 53.00 05300 OPERATINE SERVICE COST CENTERS 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000						
50.00						43. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM 0.631679 52.00						
53.00 05300 ARSTHESI OLOGY 0.000000 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.293942 54.00 54.01 03440 MAMMOGRAPHY 0.208815 54.01 54.02 03450 MLGLEAR MEDI CINE - DI AGNOSTI C 0.084989 54.03 03630 ULTRA SOUND 0.073881 54.03 03630 ULTRA SOUND 0.073881 54.03 03630 ULTRA SOUND 0.073881 55.00 05500 RADI OLOGY-THERAPEUTI C 0.092241 55.00 05500 CADI OLOGY-THERAPEUTI C 0.092241 55.00 05500 CADIN OLOGY-THERAPEUT 0.10622 60.00 05500 CADIN OLOGY-THERAPEUT 0.10622 60.00 05500 CADIN OLOGY-THERAPEUT 0.136271 65.00 05500 CADIN OLOGY-THERAPEUT 0.366271 65.00 05500 CADIN OLOGY-THERAPEUT 0.367504 65.00 05500 CADIN OLOGY-THERAPEUT 0.367504 65.00 05500 CADIN OLOGY-THERAPEUT 0.335240 65.00 05500 CADIN OLOGY-THERAPEUT 0.313240 65.00 05500 CADIN OLOGY-THERAPEUT 0.210466 70.00 07000 ELECTROCARDI OLOGY-THERAPEUT 0.210466 70.00 07000 ELECTROCARDI OLOGY-THERAPEUT 0.210466 70.00 07000 CADIN OLOGY-THERAPEUT 0.210466 70.00 07000 CADIN OLOGY-THERAPEUT 0.210466 70.00 07000 CADIN OLOGY-THERAPEUT 0.210466 70.00 07000 CADIN OLOGY-THERAPEUT 0.20046 70.00 07000 CADIN OLOGY-THE			1			50.00
54. 00			1			l l
54. 01			1			53. 00
54. 02 03450 NULCEAR MEDICINE - DIAGNOSTIC 0. 084989 54. 02 03630 ULTRA SOUND 0. 073881 55. 00 05500 RADI OLLOGY - THERAPEUTIC 0. 092241 55. 00 05700 CT SCAN 0. 085490 57. 00 05700 CT SCAN 0. 085490 57. 00 05900 CARDIAC CATHETERI ZATI ON 0. 085847 58. 00 05800 MAGNETIC RESONANCE I MAGI NG (MRI) 0. 291372 66. 00 06000 LABRORATORY 0. 101622 66. 00 06000 CABRORATORY 0. 101622 66. 00 06000 CABRORATORY THERAPY 0. 136271 65. 00 06000 CABRORATORY 0. 101622 67. 00 0700 00000 00000 CULPATI CONAL THERAPY 0. 397694 66. 00 06000 CABRORATORY 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 00000000			1			54. 00
54. 03 03630 LITRA SOUND 0.073881 54. 03 55. 00 05500 RADI OLOGY-THERAPEUTI C 0.092241 55. 00 57. 00 05700 CT SCAN 0.085490 57. 00 58. 00 05800 MAGNETI C RESONANCE I MAGING (MRI) 0.291372 58. 00 60. 00 06000 CABDI AC CATHETERI ZATION 0.085847 59. 00 60. 00 06000 CABDI AC CATHETERI ZATION 0.085847 69. 00 60. 00 06000 CABDI AC CATHETERI ZATION 0.101622 69. 00 60. 00 06000 RESPIRATORY THERAPY 0.136271 65. 00 60. 00 06000 PHYSI CAL THERAPY 0.397694 66. 00 60. 00 06000 PHYSI CAL THERAPY 0.397694 66. 00 60. 00 06000 SPECH PATHOLOGY 0.436197 67. 00 60. 00 06000 SPECH PATHOLOGY 0.436197 67. 00 60. 00 06000 SPECH PATHOLOGY 0.435052 68. 00 60. 00 07000 CLECTROENCEPHALOGRAPHY 0.210466 70. 00 60. 00 07000 LECTROENCEPHALOGRAPHY 0.210466 70. 00 60. 00 07000 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.306327 72. 00 60. 00 07000 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.306327 72. 00 60. 00 07000 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.306327 72. 00 60. 01 07000 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.306327 72. 00 60. 01 07000 DISPUS CHARGED TO PATI ENTS 0.306327 72. 00 60. 01 07000 DISPUS CHARGED TO PATI ENTS 0.306327 72. 00 60. 01 07000 DISPUS CHARGED TO PATI ENTS 0.306327 72. 00 60. 01 07000 07000 CARBORD TO PATI ENTS 0.306327 72. 00 60. 01 07000 07000 07000 07000 07000 07000 07000 07000 07000 07000 07000 070000 07000 070000 070000 070000 070000 070000 070000 070000 0700000 0700000 0700000 0700000 07000000 07000000 07000000 070000000 070000000 070000000 0700000000	54. 01	03440 MAMMOGRAPHY	0. 208815			54. 01
55. 00 05500 RADI OLOCY-THERAPEUTI C 0.092241 55. 00 57. 00 05700 CT SCAN 0.085490 57. 00 58. 00 05800 MAGNETI C RESONANCE I MAGING (MRI) 0.291372 58. 00 59. 00 05900 CARDI AC CATHETER ZATION 0.085847 59. 00 60. 00 06000 LABORATORY 0.101622 60. 00 66. 00 06000 LABORATORY 0.101622 60. 00 66. 00 06600 PHYSI CAL THERAPY 0.397694 66. 00 68. 00 0600 PHYSI CAL THERAPY 0.397694 66. 00 68. 00 06800 SPECH PATHOLOGY 0.435052 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0.435052 68. 00 70. 00 07000 ELECTROCARDI OLOGY 0.313240 70. 00 71. 00 07000 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.297630 71. 00 72. 00 07200 IMPL DEV CHARGED TO PATI ENTS 0.30533 73. 00 76. 00 0300 ON CHARGE TO PATI ENTS 0.30253 73. 00 76. 00 0300 ON CHARGE TO PATI ENTS 0.30253 73. 00 76. 00 03000 CHARGE TO PATI ENTS 0.308590 76. 00 90. 01 09001 ANDERSON OUTPATI ENT CENTER 0.489897 90. 01 90. 02 09000 CHARGE TO	54. 02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0. 084989			54. 02
57. 00 05700 CT SCAN 0.085490 0.5800	54. 03	03630 ULTRA SOUND	0. 073881			54. 03
58. 00 05900 MAGNETIC RESONANCE IMAGING (MRI) 0. 291372 59. 00 05900 CARDIA C CATHETERI ZATION 0. 085847 59. 00 05900 CARDIA C CATHETERI ZATION 0. 101622 60. 00 06000 LABORATORY 0. 101622 60. 00 06000 LABORATORY 0. 136271 65. 00 06500 RESPI RATORY THERAPY 0. 397694 66. 00 06000 PHYSI CAL THERAPY 0. 397694 66. 00 06000 PHYSI CAL THERAPY 0. 436197 67. 00 06700 OCCUPATIONAL THERAPY 0. 436197 67. 00 06700 OCCUPATIONAL THERAPY 0. 435052 68. 00 06800 SPEECH PATHOLOGY 0. 435052 68. 00 06900 ELECTROCARDI OLOGY 0. 313240 70. 00 07000 ELECTROCARDI OLOGY 0. 313240 70. 00 07000 ELECTROENCEPHALOGRAPHY 0. 210466 70. 00 07000 ELECTROENCEPHALOGRAPHY 0. 210466 70. 00 07000 ELECTROENCEPHALOGRAPHY 0. 210466 70. 00 07000 ELECTROENCEPHALOGRAPHY 0. 210466 70. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 306327 72. 00 07300 DRUGS CHARGED TO PATIENTS 0. 306327 72. 00 07300 DRUGS CHARGED TO PATIENTS 0. 302553 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 302553 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 302553 73. 00 00 07300 DRUGS CHARGED TO PATIENTS 0. 302553 73. 00 00 07300 DRUGS CHARGED TO PATIENTS 0. 302553 73. 00 00 00000 WIDHALD EAVEN 0. 182516 76. 00 000000 PRUGS CHARGED TO PATIENTS 0. 308590 000000 90. 00 00000 90. 00 00000 90. 00 000000 90. 00 000000 90. 00 000000 90. 00 0000000 90. 00 0000000 90. 00 000000 90. 00 000000 90. 00 0000000 90. 00 0000000 90. 00 0000000 90. 00 0000000 90. 00 0000000 90. 00 00000000	55.00	05500 RADI OLOGY-THERAPEUTI C	0. 092241			55. 00
59. 00 05900 CARDI AC CATHITERI ZATI ON 0. 085847 59. 00 00. 00 06000 LABORATORY 0. 101622 60. 00 65. 00 06500 RESPI RATORY THERAPY 0. 37694 65. 00 66. 00 06400 PHYSI CAL THERAPY 0. 397694 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0. 436197 67. 00 68. 00 06800 SPEECH PATHOLOGY 0. 435052 68. 00 69. 00 07000 ELECTROCARDI OLOGY 0. 313240 69. 00 70. 00 07000 ELECTROCREPHALOGRAPHY 0. 210466 70. 00 71. 00 0710 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0. 297630 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0. 302553 73. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 302553 73. 00 76. 01 03190 CHEMOTHERAPY 0. 182516 76. 00 70. 01 09000 CLINI C 0. 308590 76. 00 90. 01 09000 CLINI C 0. 498987 90. 01 90. 02 09490 DI ABETI C EDUCATI ON 0. 000000 90. 02 90. 03 094902 MSERVATI ON BEDS (NON-DI STI NCT PART)	57.00	05700 CT SCAN	0. 085490			57. 00
60. 00 06000 LABORATORY 0. 101622 66. 00 06500 RESPI RATORY THERAPY 0. 136271 66. 00 06600 PHYSI CAL THERAPY 0. 397694 66. 00 06600 PHYSI CAL THERAPY 0. 436197 67. 00 06700 0CCUPATI ONAL THERAPY 0. 436197 67. 00 06900 SPEECH PATHOLOGY 0. 435052 68. 00 06900 ELECTROCARDI OLOGY 0. 313240 69. 00 07000 ELECTROENCEPHAL OGRAPHY 0. 210466 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0. 297630 771. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0. 306327 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0. 306327 72. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 306327 72. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 302553 73. 00 03190 CHEMOTHERAPY 0. 182516 0. 182516 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 00000000	58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 291372			58.00
65. 00 06500 RESPIRATORY THERAPY 0. 136271 65. 00 06600 PHYSI CAL THERAPY 0. 397694 66. 00 06700 OCCUPATI ONAL THERAPY 0. 397694 66. 00 06700 OCCUPATI ONAL THERAPY 0. 436197 67. 00 06800 SPEECH PATHOLOGY 0. 435052 68. 00 06900 ELECTROCARDI OLOGY 0. 313240 69. 00 07000 ELECTROCARDI OLOGY 0. 313240 70. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0. 297630 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0. 306327 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0. 302553 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 302553 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 302553 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 302553 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 308590 76. 00 09000 CLI NI C 0. 000000 090. 01 09001 ANDERSON OUTPATI ENT SERVICE COST CENTERS 0. 489897 90. 01 09001 ANDERSON OUTPATI ENT CENTER 0. 489897 90. 01 09001 ANDERSON OUTPATI ENT CENTER 0. 489897 90. 01 09001 DRUGS CHARGEN CONTROL OF CONT	59. 00	05900 CARDIAC CATHETERIZATION	0. 085847			59.00
66. 00	60.00	06000 LABORATORY	0. 101622			60.00
67. 00	65.00	06500 RESPIRATORY THERAPY	0. 136271			65. 00
68. 00	66. 00	06600 PHYSI CAL THERAPY	0. 397694			66. 00
69. 00 06900 ELECTROCARDI OLOGY 0. 313240 69. 00 70. 00 70. 00 70. 00 70. 00 70. 00 FLECTROENCEPHALOGRAPHY 0. 210466 70. 00	67. 00	06700 OCCUPATIONAL THERAPY	0. 436197			67. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY 0. 210466 70. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0. 297630 71. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 306327 72. 00 07300 DRUGS CHARGED TO PATIENTS 0. 302553 73. 00 03190 CHEMOTHERAPY 0. 182516 76. 00 03020 WOUND CARE 0. 308590 76. 01 00000 CLINIC SERVICE COST CENTERS 0. 000000 09000 CLINIC SERVICE COST CENTERS 0. 000000 09000 CLINIC SERVICE COST CENTER 0. 489897 0. 000000 09000 0. 0000000 090. 02 0. 0000000 090. 02 0. 0000000 090. 02 0. 0000000 090. 02 0. 00000000	68. 00	06800 SPEECH PATHOLOGY	0. 435052			68. 00
71. 00	69. 00	06900 ELECTROCARDI OLOGY	0. 313240			69. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 306327 72. 00 73.00 07300 DRUGS CHARGED TO PATIENTS 0. 302553 73. 00 76. 00 03190 CHEMOTHERAPY 0. 182516 76. 00 03020 WOUND CARE 0. 308590	70. 00	07000 ELECTROENCEPHALOGRAPHY	0. 210466			70.00
73. 00	71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 297630			71.00
76. 00 03190 CHEMOTHERAPY 0. 182516 0. 308590 76. 01 03020 WOUND CARE 0. 308590 76. 01 03020 WOUND CARE 0. 308590 76. 01 07000 CLI NI C 0. 000000 90. 01 09001 ANDERSON OUTPATIENT CENTER 0. 489897 90. 02 04950 DI ABETI C EDUCATI ON 0. 000000 90. 03 09002 MS CLI NI C 0. 000000 90. 03 09002 MS CLI NI C 0. 000000 90. 03 09002 MS CLI NI C 0. 000000 90. 03 09002 MS CLI NI C 0. 000000 90. 03 09002 MS CLI NI C 0. 000000 90. 03 09002 MS CLI NI C 0. 000000 90. 03 09002 MS CLI NI C 0. 000000 90. 03 09002 MS CLI NI C 0. 000000 90. 03 09100 EMERGENCY 0. 163304 91. 00 09100 EMERGENCY 0. 163304 91. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0. 706488 92. 00 07167 MSULANCE SERVI CES 0. 000000 9500 AMBULANCE SERVI CES 0. 0000000 9500 AMBULANCE SERVI CES 0. 000000 9500 AMBULANCE SERVI CES 0. 0000000 9500 AMBULANCE SERVI CES 0	72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 306327			72. 00
76. 01 03020 WOUND CARE 0. 308590 76. 01 90. 00 09000 CLI NI C 0. 000000 90. 01 90. 01 09001 ANDERSON OUTPATIENT CENTER 0. 489897 90. 02 90. 03 09002 MS CLI NI C 0. 000000 90. 03 90. 03 09002 MS CLI NI C 0. 000000 90. 03 91. 00 09100 EMERGENCY 0. 163304 91. 00 92. 00 09200 DESERVATION BEDS (NON-DISTINCT PART) 0. 706488 92. 00 95. 00 09200 AMBULANCE SERVI CES 0. 000000 95. 000000 95. 000000 95. 000000 95. 000000 95. 000000 95. 000000 95. 000000 95. 000000 95. 000000 95. 000000 95. 000000 95. 000000 95. 000000 95. 000000 95. 000000 95. 000000 95. 000000 95. 0000000 95. 0000000 95. 00000000 95. 0000000 95. 0000000 95. 0000000 95. 0000000 95. 0000000 95. 00000000 95. 0000000000	73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 302553			73.00
OUTPATIENT SERVICE COST CENTERS O. 000000	76. 00	03190 CHEMOTHERAPY	0. 182516			76. 00
90. 00	76. 01	03020 WOUND CARE	0. 308590			76. 01
90. 00	İ	OUTPATIENT SERVICE COST CENTERS	·			
90. 02			0. 000000			90.00
90. 02	90. 01	09001 ANDERSON OUTPATIENT CENTER	0. 489897			90. 01
90. 03			0. 000000			90. 02
91. 00			1			90. 03
92. 00			1			91.00
0THER REI MBURSABLE COST CENTERS 95. 00 9500 AMBULANCE SERVI CES 0.000000 95. 00 SPECI AL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113. 00 200. 00 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds 201. 00		· ·	1			92. 00
95. 00 09500 AMBULANCE SERVICES 0. 0000000 95. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113. 00 200. 00 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds 201. 00			21 1 2 2 1 0 0			72. 00
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00			0. 000000			95. 00
113. 00 11300 INTEREST EXPENSE 113. 00 200. 00 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds 201. 00						76. 55
200.00 Subtotal (see instructions) 201.00 Less Observation Beds 200.00						113. 00
201.00 Less Observation Beds 201.00			1			200. 00
	1	,				201. 00
	202.00	Total (see instructions)				202. 00

Health Financial Systems	ASCENSION SI. VI	NCENT ANDERSON		In Lie	u of Form CMS-2	<u> 2552-10</u>
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der C	CN: 15-0088	Period: From 07/01/2021	Worksheet C Part I	
				To 06/30/2022	Date/Time Pre 11/29/2022 8:	pared: 09 am
		Ti tI	e XIX	Hospi tal	Cost	
		·		Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj .		Di sal I owance		
	Part I, col.					
	26)					
	1.00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		ı	1	_1		
30. 00 03000 ADULTS & PEDI ATRI CS	33, 793, 267		33, 793, 26		33, 793, 267	30.00
31. 00 03100 I NTENSI VE CARE UNI T	12, 841, 972		12, 841, 97		12, 841, 972	
41. 00 04100 SUBPROVI DER - RF	3, 497, 270		3, 497, 27		3, 497, 270	
43. 00 04300 NURSERY	685, 169		685, 16	9 0	685, 169	43. 00
ANCILLARY SERVICE COST CENTERS	04 000 705	Г	04 000 70	-l al	04 000 705	
50. 00 05000 OPERATI NG ROOM	21, 090, 795		21, 090, 79		21, 090, 795	
52. 00 05200 DELI VERY ROOM & LABOR ROOM	2, 827, 952		2, 827, 95		2, 827, 952	52.00
53. 00 05300 ANESTHESI OLOGY	0			0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	5, 143, 584		5, 143, 58		5, 143, 584	54.00
54. 01 03440 MAMMOGRAPHY	826, 851		826, 85		826, 851	54. 01
54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	1, 419, 009		1, 419, 00		1, 419, 009	54. 02
54. 03 03630 ULTRA SOUND	694, 827		694, 82		694, 827	54. 03
55. 00 05500 RADI OLOGY-THERAPEUTI C	2, 844, 395		2, 844, 39		2, 844, 395	55.00
57. 00 05700 CT SCAN	1, 484, 335	l e e e e e e e e e e e e e e e e e e e	1, 484, 33		1, 484, 335	57.00
58. 00 05800 MAGNETIC RESONANCE MAGING (MRI)	867, 513		867, 51		867, 513	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	2, 120, 785		2, 120, 78		2, 120, 785	59.00
60. 00 06000 LABORATORY	8, 964, 940		8, 964, 94		8, 964, 940	60.00
65. 00 06500 RESPIRATORY THERAPY	2, 771, 923	0			2, 771, 923	65. 00
66. 00 06600 PHYSI CAL THERAPY	3, 566, 347				3, 566, 347	66.00
67. 00 06700 0CCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	1, 617, 074	0			1, 617, 074	67. 00 68. 00
69. 00 06900 ELECTROCARDI OLOGY	564, 772 389, 169	0	564, 77 389, 16		564, 772 389, 169	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	840, 224					70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	6, 302, 311		840, 22 6, 302, 31		840, 224 6, 302, 311	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	6, 587, 266		6, 587, 26		6, 587, 266	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	32, 424, 971		32, 424, 97		32, 424, 971	73.00
76. 00 03190 CHEMOTHERAPY	1, 616, 194		1, 616, 19		1, 616, 194	76.00
76. 01 03020 WOUND CARE	1, 535, 044		1, 535, 04		1, 535, 044	76. 00
OUTPATIENT SERVICE COST CENTERS	1, 333, 044		1, 333, 04	4 0	1, 333, 044	70.01
90. 00 09000 CLINIC	0			ol ol	0	90.00
90. 01 09001 ANDERSON OUTPATIENT CENTER	1, 883, 717		1, 883, 71		1, 883, 717	90. 01
90. 02 04950 DI ABETI C EDUCATION	1,000,717			, o	1, 000, 717	90. 02
90. 03 09002 MS CLINIC	0			ol ol	0	90. 03
91. 00 09100 EMERGENCY	11, 766, 768		11, 766, 76		11, 766, 768	ł
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 179, 223		2, 179, 22	-	2, 179, 223	
OTHER REIMBURSABLE COST CENTERS		L		-1		
95. 00 09500 AMBULANCE SERVICES	3, 945		3, 94	5 0	3, 945	95.00
SPECIAL PURPOSE COST CENTERS		•	<u> </u>			İ
113.00 11300 I NTEREST EXPENSE						113. 00
200.00 Subtotal (see instructions)	173, 151, 612	0	173, 151, 61	2 0	173, 151, 612	200. 00
201.00 Less Observation Beds	2, 179, 223		2, 179, 22	3	2, 179, 223	201. 00
202.00 Total (see instructions)	170, 972, 389	0	170, 972, 38	9 0	170, 972, 389	202. 00
·				·		

	SCENSION SI. VI			III LI E	u or rorm cws	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CO		Period: From 07/01/2021 Fo 06/30/2022	Worksheet C Part I Date/Time Pre 11/29/2022 8:	pared: 09 am
		Ti †l	e XIX	Hospi tal	Cost	
		Charges	<u> </u>	1.00p. tu.	3001	
Cost Center Description	I npati ent	Outpati ent	Total (col 6	Cost or Other	TEFRA	
oost conten beschiptron	Impatront	outputtent	+ col . 7)	Ratio	Inpati ent	
			' 001. ')	Natio	Ratio	
	6.00	7. 00	8. 00	9. 00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	71.00	0.00	7. 00		
30. 00 03000 ADULTS & PEDI ATRI CS	51, 168, 757		51, 168, 75	7		30.00
31. 00 03100 NTENSI VE CARE UNI T	24, 596, 779		24, 596, 77			31.00
41. 00 04100 SUBPROVI DER - 1 RF	4, 052, 273		4, 052, 27			41.00
43. 00 04300 NURSERY	1, 594, 912		1, 594, 91			43.00
ANCI LLARY SERVI CE COST CENTERS	1, 394, 912		1, 394, 91.	<u> </u>		43.00
50. 00 05000 OPERATING ROOM	22 007 771	100 010 (02	122 027 45	0.150//4	0.000000	50.00
	23, 907, 771	109, 019, 682	132, 927, 45		0.000000	1
52. 00 05200 DELI VERY ROOM & LABOR ROOM	3, 957, 078	519, 802	4, 476, 88		0.000000	
53. 00 05300 ANESTHESI OLOGY	0	0	47 400 40	0. 000000	0. 000000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	6, 576, 936	10, 921, 694	17, 498, 63		0. 000000	
54. 01 03440 MAMMOGRAPHY	16, 385	3, 943, 354	3, 959, 73		0. 000000	
54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	1, 265, 179	15, 431, 207	16, 696, 38		0. 000000	
54. 03 03630 ULTRA SOUND	1, 508, 740	7, 895, 949	9, 404, 68		0. 000000	
55. 00 05500 RADI OLOGY-THERAPEUTI C	249, 647	30, 586, 936	30, 836, 58	0. 092241	0.000000	55. 00
57. 00 05700 CT SCAN	4, 238, 881	13, 123, 748	17, 362, 62	0. 085490	0.000000	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	706, 042	2, 271, 295	2, 977, 33	7 0. 291372	0.000000	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	6, 432, 905	18, 271, 273	24, 704, 17	0. 085847	0.000000	59.00
60. 00 06000 LABORATORY	33, 619, 369	54, 599, 479	88, 218, 84	0. 101622	0.000000	60.00
65. 00 06500 RESPIRATORY THERAPY	17, 482, 580	2, 858, 635	20, 341, 21	0. 136271	0.000000	65.00
66. 00 06600 PHYSI CAL THERAPY	2, 793, 843	6, 173, 727	8, 967, 57		0.000000	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	1, 895, 927	1, 811, 282	3, 707, 20		0.000000	67.00
68. 00 06800 SPEECH PATHOLOGY	641, 892	656, 280	1, 298, 17		0.000000	
69. 00 06900 ELECTROCARDI OLOGY	0	1, 242, 397	1, 242, 39		0. 000000	
70. 00 07000 ELECTROENCEPHALOGRAPHY	146, 766	3, 845, 434	3, 992, 20		0. 000000	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	10, 235, 377	10, 939, 604	21, 174, 98		0. 000000	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	3, 916, 148	17, 587, 903	21, 504, 05		0. 000000	
73. 00 07300 DRUGS CHARGED TO PATIENTS	34, 474, 831	72, 696, 382	107, 171, 21		0. 000000	
76. 00 03190 CHEMOTHERAPY		8, 781, 736			0. 000000	
	73, 355					
76. 01 03020 WOUND CARE	39, 830	4, 934, 553	4, 974, 38	0. 308590	0. 000000	76. 01
OUTPATIENT SERVICE COST CENTERS		^		0.000000	0.000000	00.00
90. 00 09000 CLI NI C	0 (00	0		0.000000	0.000000	
90. 01 09001 ANDERSON OUTPATIENT CENTER	8, 699	3, 836, 427	3, 845, 12		0. 000000	
90. 02 04950 DI ABETI C EDUCATI ON	0	0	1	0.00000	0. 000000	
90. 03 09002 MS CLINIC	0	0		0.00000	0. 000000	
91. 00 09100 EMERGENCY	20, 493, 643	51, 560, 824			0. 000000	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	888, 445	2, 196, 143	3, 084, 58	0. 706488	0.000000	92. 00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0	0		0.000000	0. 000000	95. 00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE						113. 00
200.00 Subtotal (see instructions)	256, 982, 990	455, 705, 746	712, 688, 73	5		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	256, 982, 990	455, 705, 746	712, 688, 73	6		202. 00
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			, ,	1		

				To 06/30/2022	Date/Time Prepared: 11/29/2022 8:09 am
			Title XIX	Hospi tal	Cost
	Cost Center Description	PPS Inpatient			
		Ratio			
		11. 00			
	INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00	03000 ADULTS & PEDIATRICS				30. 0
31. 00	03100 I NTENSI VE CARE UNI T				31.0
41. 00	04100 SUBPROVI DER - I RF				41.0
43. 00	04300 NURSERY				43. 0
	ANCI LLARY SERVI CE COST CENTERS				
50. 00	O5000 OPERATI NG ROOM	0. 000000			50.0
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52. 0
53.00	05300 ANESTHESI OLOGY	0. 000000			53. 0
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.0
54. 01	03440 MAMMOGRAPHY	0. 000000			54.0
54. 02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0. 000000			54.0
54.03	03630 ULTRA SOUND	0. 000000			54.0
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 000000			55.0
57.00	05700 CT SCAN	0. 000000			57.0
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000			58.0
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 000000			59.0
60.00	06000 LABORATORY	0. 000000			60.0
65.00	06500 RESPI RATORY THERAPY	0. 000000			65.0
66.00	06600 PHYSI CAL THERAPY	0. 000000			66.0
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000			67.0
68. 00	06800 SPEECH PATHOLOGY	0. 000000			68.0
69. 00	06900 ELECTROCARDI OLOGY	0. 000000			69. 0
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000			70.0
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71.0
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000			72.0
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.0
76.00	03190 CHEMOTHERAPY	0. 000000			76.0
76. 01	03020 WOUND CARE	0. 000000			76. 0
	OUTPATIENT SERVICE COST CENTERS				
90. 00	09000 CLI NI C	0. 000000			90.0
90. 01	09001 ANDERSON OUTPATIENT CENTER	0. 000000			90.0
	04950 DI ABETI C EDUCATI ON	0. 000000			90.0
90. 03	09002 MS CLINIC	0. 000000			90.0
91. 00	09100 EMERGENCY	0. 000000			91.0
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92. 0
	OTHER REIMBURSABLE COST CENTERS				
95. 00	09500 AMBULANCE SERVI CES	0. 000000			95. 0
	SPECIAL PURPOSE COST CENTERS				
	11300 I NTEREST EXPENSE				113. 0
200.00					200. 0
201.00	1				201. 0
202.00	Total (see instructions)				202. 0

Health Financial Systems A	SCENSION ST. VI	NCENT ANDERSON		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Period: From 07/01/2021 To 06/30/2022	Worksheet D Part I Date/Time Pre 11/29/2022 8:	
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	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	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	_	,				
30.00 ADULTS & PEDIATRICS	1, 268, 770		1, 268, 77			
31.00 INTENSIVE CARE UNIT	370, 087		370, 08			
41. 00 SUBPROVI DER - I RF	155, 079		155, 07			1
43. 00 NURSERY	63, 296		63, 29	674	93. 91	43. 00
200.00 Total (lines 30 through 199)	1, 857, 232		1, 857, 23	2 32, 339		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						1
30.00 ADULTS & PEDIATRICS	3, 638					30. 00
31.00 INTENSIVE CARE UNIT	3, 281					31. 00
41. 00 SUBPROVI DER - I RF	835	58, 300)			41. 00
43. 00 NURSERY	0					43. 00
200.00 Total (lines 30 through 199)	7, 754	486, 044	.[200. 00

		SCENSION ST. VI					eu of Form CMS-	2552-10
APPORT	FIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Pr	ovider C	CN: 15-0088	Peri od: From 07/01/2021 To 06/30/2022	Worksheet D Part II Date/Time Pre 11/29/2022 8:	pared: 09 am
				Titl∈	: XVIII	Hospi tal	PPS	
	Cost Center Description	Capi tal			Ratio of Cos	t Inpatient	Capital Costs	
		Related Cost					(column 3 x	
		(from Wkst. B,			(col . 1 ÷ col	. Charges	column 4)	
		Part II, col.		8)	2)			
		26)						
		1.00	2	. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	T			T		T	
50.00	05000 OPERATING ROOM	837, 635		, 927, 453				
52.00	05200 DELIVERY ROOM & LABOR ROOM	235, 935	1	, 476, 880			l e	
53.00	05300 ANESTHESI OLOGY	0	1	0			1	
54.00	05400 RADI OLOGY-DI AGNOSTI C	215, 554		, 498, 630				
54. 01	03440 MAMMOGRAPHY	15, 608		, 959, 739			0	0 0 .
54. 02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	35, 850		, 696, 386			l .	
54. 03	03630 ULTRA SOUND	12, 983		, 404, 689			0	1 0 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	52, 196		, 836, 583	1			
57. 00	05700 CT SCAN	32, 248		, 362, 629				
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	23, 738		, 977, 337				
59. 00	05900 CARDI AC CATHETERI ZATI ON	111, 995		, 704, 178				
60.00	06000 LABORATORY	253, 815		, 218, 848				60.00
65. 00	06500 RESPI RATORY THERAPY	111, 635	1	, 341, 215	1			1
66. 00	06600 PHYSI CAL THERAPY	146, 111		, 967, 570				
67. 00	06700 OCCUPATI ONAL THERAPY	67, 068	1	, 707, 209	1			
68. 00	06800 SPEECH PATHOLOGY	23, 438		, 298, 172				
69. 00	06900 ELECTROCARDI OLOGY	8, 864		, 242, 397			1	
70. 00	07000 ELECTROENCEPHALOGRAPHY	108, 794		, 992, 200				
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	104, 229		, 174, 981				
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	108, 905		, 504, 051				
73.00	07300 DRUGS CHARGED TO PATIENTS	588, 809		, 171, 213			46, 567	73. 00
76. 00	03190 CHEMOTHERAPY	33, 488		, 855, 091	1		1	
76. 01	03020 WOUND CARE	55, 185	5 4	, 974, 383	0. 0110	94 0	0	76. 01
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLI NI C	0	1	0	0. 00000		1	, , , , , ,
90. 01	09001 ANDERSON OUTPATIENT CENTER	62, 612	2 3	, 845, 126			·	, , , , , ,
	04950 DI ABETI C EDUCATI ON	0		0	0.00000			
0U U3	DODOS MS CLINIC)l	0	0 0000	חמר וחמר	1 ^	0U U3

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81, 819

3, 745, 261

72, 054, 467 3, 084, 588

631, 276, 015

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5, 001, 840

47, 396, 918

501, 385

91.00

92. 00

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0 90.03

269, 473 200. 00

28, 931

13, 299

90. 03 09002 MS CLINIC

91. 00 09100 EMERGENCY

200.00

95. 00 09500 AMBULANCE SERVICES

92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART)
OTHER REIMBURSABLE COST CENTERS

Total (lines 50 through 199)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COST		F	Period: From 07/01/2021 To 06/30/2022	Worksheet D Part III Date/Time Pre 11/29/2022 8:	
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng Program Post-Stepdown Adj ustments	Nursi ng Program	Allied Health Post-Stepdown 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	000000000000000000000000000000000000000	000000000000000000000000000000000000000		0 0 0	0 0 0	31. 00 41. 00 43. 00
200.00 Total (lines 30 through 199)	0		(0		200. 00
Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	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 SUBPROVI DER - IRF	0		24, 346 5, 098 2, 22	0.00	3, 638 3, 281 835	31.00
43. 00 04300 NURSERY		C	674		0	
200.00 Total (lines 30 through 199)		0	32, 339	9	7, 754	200. 00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00					
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					30. 00 31. 00 41. 00 43. 00

Health Financial Systems ASCENSION ST. V APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PA			NT ANDERSON	In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PA	ASS	Provider CCN: 15-0088	Peri od: From 07/01/2021 To 06/30/2022	Worksheet D Part IV Date/Time Prepared:	

Non Physician Anesthetist Cost Center Description Non Physician Anesthetist Cost Cost Non Physician Anesthetist Cost Cost Cost Cost Non Physician Anesthetist Cost Cost Cost Cost Cost Cost Cost Cost Cost Cost Cost Cost Cost Cost Cost Cost Cost	111100011 00010				To 06/30/2022	Date/Time Pre 11/29/2022 8:	
Anesthetist Cost Program Program Program Adjustments Adjus			Title	: XVIII	Hospi tal		
Adjustments	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
Adjustments		Anesthetist	Program	Program	Post-Stepdown		
ANCILLARY SERVICE COST CENTERS		Cost	Post-Stepdown		Adjustments		
ANCI LLARY SERVICE COST CENTERS							
50. 00 50. 00 50. 00		1.00	2A	2. 00	3A	3. 00	
52.00 05200 DELI VERY ROOM & LABOR ROOM 0 0 0 0 0 52.00							
53.00 05300 ANESTHESI OLOGY 0 0 0 0 0 0 53.00		0	0		0	0	
54. 00 05400 RADI OLOCY-DI AGNOSTI C 0 0 0 0 0 38, 742 54. 00 54. 01 03440 MAMMOGRAPHY 0 0 0 0 0 0 8, 767 54. 01 54. 02 03450 NUCLEAR MEDI CI NE - DI AGNOSTI C 0 0 0 0 0 36, 966 54. 03 03630 ULTRA SOUND 0 0 0 0 0 0 20, 822 55. 00 05500 RADI OLOCY-THERAPEUTI C 0 0 0 0 0 68, 297 57. 00 05700 CT SCAN 0 0 0 0 0 0 68, 297 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0 0 0 65, 20 59. 00 05900 CARDI AGO C CATHETERI ZATI ON 0 0 0 0 0 0 60. 00 06000 LABORATORY 0 0 0 0 0 0 0 65. 00 06500 RESPI RATORY THERAPY 0 0 0 0 0 0 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0 0 68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 69. 00 06900 LECTROCARDI OLOGY 0 0 0 0 0 69. 00 06900 LECTROCARDI OLOGY 0 0 0 0 0 70. 00 07000 ELECTROCARDI OLOGY 0 0 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 0 72. 00 07200 IMPL DEV. CHARGED TO PATI ENTS 0 0 0 0 0 73. 00 07300 RUISCAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 0 74. 00 07200 IMPL DEV. CHARGED TO PATI ENTS 0 0 0 0 0 76. 01 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 0 76. 01 07100 07100 07100 07100 07100 07100 76. 01 07100 07100 07100 07100 07100 07100 07100 76. 01 07100 07100 07100 07100 07100 07100 07100 76. 01 07100 07100 07100 07100 07100 07100 77. 00 07100 07100 07100 07100 07100 07100 78. 01 07100 07100 07100 07100 07100 07100 79. 00 07100 07100 07100 07100 07100 07100 79. 00 07100 07100 07100 07100 07100 07100 79. 00 07100 07100 07100 07100 07100 07100 79. 00 07		0	0		0	0	
54. 01 03440 MAMMOGRAPHY 0 0 0 0 0 346, 676 54. 01		0	0		0	0	
54. 02 03450 NUCLEAR MEDI CINE - DI AGNOSTIC 0 0 0 0 0 36, 966 54. 02		0	0		0	38, 742	54.00
54. 03 03630 ILTRA SOUND 0 0 0 0 0 0 0 0 55. 00 05500 ABIO LLOGY-THERAPEUTI C 0 0 0 0 0 0 68. 297 55. 00 05500 CT SCAN 0 0 0 0 0 0 0 38, 441 57. 00 05. 00 05. 00 05. 00 0 0 0 0 0 0 0 0 0		0	0		0	8, 767	
55.00 05500 RADI OLOGY-THERAPEUTI C		0	0		0		
57. 00 05700 CT SCAN 0 0 0 0 0 38, 441 57. 00		0	0		0	20, 822	
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 0 0 6,592 58. 00 59. 00 05900 CARDIAC CATHETERIZATION 0 0 0 0 0 59. 00 60. 00 06000 LABORATORY 0 <t< td=""><td></td><td>0</td><td>0</td><td></td><td>0</td><td>68, 297</td><td>55. 00</td></t<>		0	0		0	68, 297	55. 00
59.00 05900 CARDI AC CATHETERI ZATION 0 0 0 0 0 0 0 0 0		0	0		0		
60.00 06000 LABORATORY 0 0 0 0 0 0 0 0 0		0	0		0	6, 592	58. 00
65. 00 06500 RESPIRATORY THERAPY 0 0 0 0 0 0 0 0 65. 00 66. 00 66. 00 66. 00 PHYSI CAL THERAPY 0 0 0 0 0 0 0 0 66. 00 67. 00 66. 00 67. 00 0CCUPATI ONAL THERAPY 0 0 0 0 0 0 0 0 66. 00 67. 00 6800 SPEECH PATHOLOGY 0 0 0 0 0 0 680. 00 69. 00 69. 00 69. 00 0 0 0 0 0 0 0 0 68. 00 69. 00 69. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0	0		0	0	59. 00
66. 00	60. 00 06000 LABORATORY	0	0		0 0	0	60.00
67. 00	65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65. 00
68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 0 68. 00 69. 00 69. 00 69. 00 69. 00 0 0 0 0 0 0 0 69. 00 69. 00 69. 00 0 0 0 0 0 0 0 0 0 0 69. 00 69. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66. 00
69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0 70. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 72. 00 72. 00 72. 00 72. 00 72. 00 72. 00 72. 00 72. 00 72. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 74. 00	68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68. 00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 71. 00 72. 00 72. 00 72. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 75.	69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 72. 00 73. 00 73. 00 73. 00 73. 00 73. 00 74. 00 0 0 0 0 0 0 0 73. 00 74. 00 75. 00	70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 73. 00 76. 00 03190 CHEMOTHERAPY 0 0 0 0 0 0 76. 00 76. 01 03020 WOUND CARE 0 0 0 0 0 0 0 OUTPATIENT SERVICE COST CENTERS	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71. 00
76. 00 03190 CHEMOTHERAPY 0 0 0 0 0 0 0 76. 00 76. 01 03020 WOUND CARE 0 0 0 0 0 0 0 76. 01 OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC 0 0 0 0 0 0 0 90. 00 90. 01 09001 ANDERSON OUTPATIENT CENTER 0 0 0 0 0 0 0 90. 01 90. 02 04950 DI ABETI C EDUCATION 0 0 0 0 0 0 90. 02 90. 03 09002 MS CLINIC 0 0 0 0 0 0 0 90. 02 91. 00 09100 EMERGENCY 0 0 0 0 0 0 0 91. 00 92. 00 09200 DSSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 0 92. 00 OTHER REIMBURSABLE COST CENTERS	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72. 00
76. 01 03020 WOUND CARE 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73. 00
OUTPATIENT SERVICE COST CENTERS 90. 00 00 00 00 00 00 00	76. 00 03190 CHEMOTHERAPY	0	0		0	0	76. 00
90. 00 09000 CLINIC 0 0 0 0 0 0 90. 00 90. 00 90. 01 90. 01 09001 ANDERSON OUTPATIENT CENTER 0 0 0 0 0 0 90. 01 90. 02 90. 03 09002 MS CLINIC 0 0 0 0 0 0 0 0 90. 03 91. 00 91. 00 91. 00 92. 00 09100 EMERGENCY 0 0 0 0 0 0 0 91. 00 92. 00 09100 EMERGENCY 0 0 0 0 0 92. 00 09100 EMERGENCY 0 0 0 0 0 92. 00 09100 EMERGENCY 0 0 0 0 92. 00 09100 EMERGENCY 0 0 0 0 92. 00 09100 EMERGENCY 0 0 0 0 92. 00 09100 EMERGENCY 0 0 0 0 92. 00 09100 EMERGENCY 0 0 0 0 92. 00 09100 EMERGENCY 95. 00 09500 AMBULANCE SERVICES 95. 00 09500 AMBULANCE SERVICES 95. 00 00 0 0 0 0 0 0 0	76. 01 03020 WOUND CARE	0	0		0 0	0	76. 01
90. 01 09001 ANDERSON OUTPATIENT CENTER 0 0 0 0 0 90. 01 90. 02 04950 DI ABETI C EDUCATION 0 0 0 0 0 90. 03 09002 MS CLINI C 0 0 0 0 0 91. 00 09100 EMRGENCY 0 0 0 0 0 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 0 0 0 0 0THER REI MBURSABLE COST CENTERS 95. 00	OUTPATIENT SERVICE COST CENTERS						
90. 02 04950 DI ABETI C EDUCATION 0 0 0 0 90. 02 90. 03 09002 MS CLINI C 0 0 0 0 0 90. 03 91. 00 09100 EMERGENCY 0 0 0 0 0 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 0 0 0 0 92. 00 0THER REI MBURSABLE COST CENTERS 95. 00		0	0		0 0	0	90.00
90. 03 09002 MS CLINIC 0 0 0 0 90. 03 91. 00 91. 00 92. 00 09200 085ERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 92. 00 070 0	90. 01 09001 ANDERSON OUTPATIENT CENTER	0	0		0 0	0	90. 01
91. 00 09100 EMERGENCY 0 0 0 0 0 91. 00 92. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 92. 00 00 00 00 00 00 00 00	90. 02 04950 DIABETIC EDUCATION	0	0		0	0	90. 02
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 92. 00	90. 03 09002 MS CLINIC	0	0		0	0	90. 03
OTHER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 95. 00	91. 00 09100 EMERGENCY	0	0		0	0	91.00
95. 00 09500 AMBULANCE SERVICES 95. 00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
200. 00 Total (lines 50 through 199) 0 0 0 218, 627 200. 00							
	200.00 Total (lines 50 through 199)	0	0		0 0	218, 627	200.00

Heal th	Financial Systems A	SCENSION ST. VI	NCENT ANDERSON		In Lie	eu of Form CMS-2	2552-10
APPORT	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER H COSTS			CN: 15-0088	Period: From 07/01/2021 To 06/30/2022	Worksheet D Part IV	pared:
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
		Education Cost	1, 2, 3, and	Cost (sum of		(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)		(see	
						instructions)	
		4.00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS				_		
50.00	05000 OPERATI NG ROOM	0	0		0 132, 927, 453		
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 4, 476, 880		
53.00	05300 ANESTHESI OLOGY	0	0		0	0.000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	38, 742				
54. 01	03440 MAMMOGRAPHY	0	8, 767				
54. 02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	36, 966				1
54.03	03630 ULTRA SOUND	0	20, 822	20, 82	9, 404, 689	0. 002214	54. 03
55.00	05500 RADI OLOGY-THERAPEUTI C	0	68, 297	68, 29	7 30, 836, 583	0. 002215	55. 00
57.00	05700 CT SCAN	0	38, 441	38, 44	1 17, 362, 629	0. 002214	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	6, 592	6, 59	2, 977, 337	0. 002214	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 24, 704, 178	0.000000	59. 00
60.00	06000 LABORATORY	0	0		0 88, 218, 848	0.000000	60.00
65.00	06500 RESPI RATORY THERAPY	0	0		0 20, 341, 215	0.000000	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0		0 8, 967, 570	0.000000	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0 3, 707, 209	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	0	0		0 1, 298, 172	0.000000	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0		0 1, 242, 397	0.000000	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 3, 992, 200	0.000000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 21, 174, 981	0.000000	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 21, 504, 051		72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 107, 171, 213		73. 00
76.00	03190 CHEMOTHERAPY	0	0		0 8, 855, 091	0.000000	76. 00
76. 01	03020 WOUND CARE	0	Ō		0 4, 974, 383		
	OUTPATIENT SERVICE COST CENTERS						İ
90.00	09000 CLI NI C	0	0		0 0	0.000000	90.00
00 01	00001 ANDEDCON OUTDATIENT CENTED	1	1		0 0.45 104	0 000000	00 01

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72, 054, 467

631, 276, 015

3, 084, 588

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90. 02

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91.00

92.00

95.00

200. 00

90. 01 | 09001 | ANDERSON OUTPATIENT CENTER 90. 02 | 04950 | DI ABETIC | EDUCATION

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

Total (lines 50 through 199)

90. 03 09002 MS CLINIC

09100 EMERGENCY

95. 00 09500 AMBULANCE SERVICES

91.00

92.00

200.00

Heal th	Financial Systems A	SCENSION ST. VING	`ENT ANDERSON		In Lie	eu of Form CMS-2	2552_10
APPOR1	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF CH COSTS		Provider Co		Period: From 07/01/2021 To 06/30/2022	Worksheet D Part IV Date/Time Pre 11/29/2022 8:	pared:
				XVIII	Hospi tal	PPS	
	Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	3	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
	ANCILLARY SERVICE COST CENTERS	9.00	10. 00	11.00	12.00	13.00	
FO 00	05000 OPERATING ROOM	0. 000000	8, 860, 803		0 22, 546, 383	0	
50. 00 52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	8, 860, 803 7, 129			0	50. 00 52. 00
53. 00	05300 ANESTHESI OLOGY	0. 000000	7, 129 0		0 2, 065		53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0.000000	1, 418, 090		٥	7, 414	
54. 00	03440 MAMMOGRAPHY	0. 002214	1, 410, 0 3 0		0 3, 346, 633	7,414	
54. 02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0. 002214	435, 962	96	-	9, 356	
54. 02	03630 ULTRA SOUND	0. 002214	433, 702 N		0 4, 223, 777	7, 330	54. 02
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 002215	128, 941	28	-	23, 654	
57. 00	05700 CT SCAN	0. 002213	1, 183, 360				
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 002214	183, 350				
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	1, 647, 093		0 3, 834, 469		
60.00	06000 LABORATORY	0. 000000	8, 922, 712		0 5, 104, 262	0	60.00
65. 00	06500 RESPIRATORY THERAPY	0. 000000	4, 532, 805		0 621, 341	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 000000	599, 958		0 55, 442		
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	302, 066		0 10, 511	o o	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	134, 790		0 120, 664	0	68.00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	0		0 0	o o	
70. 00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	55, 191		708, 689	o o	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	2, 477, 548		0 2, 246, 010	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	2, 527, 952		0 4, 086, 304	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	8, 475, 943		0 23, 027, 333	0	73. 00
76.00	03190 CHEMOTHERAPY	0. 000000	0		0 6, 221	0	76. 00
76. 01	03020 WOUND CARE	0. 000000	0		0 0	0	76. 01
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0. 000000	0		0 0	0	90.00
90. 01	09001 ANDERSON OUTPATIENT CENTER	0. 000000	0		0 199, 329	0	90. 01
90. 02	04950 DIABETIC EDUCATION	0. 000000	0		0 0	0	90. 02
90. 03	09002 MS CLINIC	0. 000000	0		0 0	0	90. 03
91. 00	09100 EMERGENCY	0. 000000	5, 001, 840		0 7, 464, 809	0	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	501, 385		0 1, 880, 574	0	92.00

47, 396, 918

95.00 47, 018 200. 00

93, 145, 975

7, 417

200.00

95. 00 09500 AMBULANCE SERVICES

92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART)
OTHER REIMBURSABLE COST CENTERS

Total (lines 50 through 199)

Health Financial Systems	ASCENSION ST. VINCE	NT ANDERSON	In	Lieu of Form CMS-2552-10
ADDODEL ONMENT OF MEDICAL	OTHER HEALTH CERVICES AND MACCINE COST	D: CON 15 0000	D!I	Wasalsalaa - + D

Health Financial Systems A	SCENSION ST. VI	NCENT ANDERSON		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der Co	CN: 15-0088	Peri od:	Worksheet D	
				From 07/01/2021	Part V	
				To 06/30/2022	Date/Time Pre	pared:
		Title	xVIII	Hospi tal	11/29/2022 8: PPS	09 alli
		11 11 0	Charges	nospi tui	Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not	(333 11121)	
	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. 158664	22, 546, 383		0 0	3, 577, 299	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 631679	2, 065		0	1, 304	52. 00
53. 00 05300 ANESTHESI OLOGY	0. 000000	0		0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 293942	3, 348, 835		0	984, 363	54.00
54. 01 03440 MAMMOGRAPHY	0. 208815	0		0	0	54. 01
54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0. 084989	4, 225, 797		0 0	359, 146	54. 02
54.03 03630 ULTRA SOUND	0. 073881	0		0	0	54. 03
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 092241	10, 678, 867		0 0	985, 029	55. 00
57. 00 05700 CT SCAN	0. 085490	2, 504, 444		0 0	214, 105	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 291372	473, 626		0 0	138, 001	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 085847	3, 834, 469		0 0	329, 178	59. 00
60. 00 06000 LABORATORY	0. 101622	5, 104, 262		0 0	518, 705	60.00
65. 00 06500 RESPIRATORY THERAPY	0. 136271	621, 341		0	84, 671	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 397694	55, 442		0	22, 049	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 436197	10, 511		0 0	4, 585	67. 00
68.00 06800 SPEECH PATHOLOGY	0. 435052	120, 664		0	52, 495	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 313240	0		0	0	69. 00
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 210466	708, 689		0	149, 155	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 297630	2, 246, 010		0	668, 480	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 306327	4, 086, 304		0	1, 251, 745	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 302553	23, 027, 333		0 13, 631	6, 966, 989	73. 00
76.00 03190 CHEMOTHERAPY	0. 182516	6, 221		0	1, 135	76. 00
76. 01 03020 WOUND CARE	0. 308590	0		0	0	76. 01
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0. 000000			0 0	0	90.00
90.01 09001 ANDERSON OUTPATIENT CENTER	0. 489897	199, 329		0 0	97, 651	90. 01
90. 02 04950 DI ABETI C EDUCATI ON	0. 000000	0		0 0	0	90. 02
90. 03 09002 MS CLINIC	0. 000000	0		0 0	0	90. 03
91. 00 09100 EMERGENCY	0. 163304	7, 464, 809		0 0	1, 219, 033	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 706488	1, 880, 574		0 0	1, 328, 603	92. 00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0. 000000			0		95. 00
200.00 Subtotal (see instructions)		93, 145, 975		0 13, 631	18, 953, 721	
201.00 Less PBP Clinic Lab. Services-Program				0		201. 00
Only Charges						
202.00 Net Charges (line 200 - line 201)		93, 145, 975	l	0 13, 631	18, 953, 721	202. 00

In Lieu of Form CMS-2552-10
Worksheet D
01/2021 Part V
00/2022 Date/Time Prepared:
11/29/2022 8: 09 am
tal PPS Peri od: From 07/01/2021 To 06/30/2022 Title XVIII Hospi tal Costs

Cost Center Description	Cost Reimbursed Services	Cost Reimbursed Services Not		
	Subject To	Subject To		
	Ded. & Coins.	Ded. & Coins.		
	(see inst.)	(see inst.)		
	6. 00	7. 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 ANESTHESI OLOGY	0	0		53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		54. 00
54. 01 03440 MAMMOGRAPHY	0	0		54. 01
54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	0		54. 02
54.03 03630 ULTRA SOUND	0	0		54. 03
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		55. 00
57.00 05700 CT SCAN	0	0		57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		59. 00
60. 00 06000 LABORATORY	0	0		60. 00
65. 00 06500 RESPI RATORY THERAPY	0	0		65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0		66. 00
67.00 06700 OCCUPATIONAL THERAPY	0	0		67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0		68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0		69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	4, 124		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 CLI NI C	0			90.00
90. 01 09001 ANDERSON OUTPATIENT CENTER	0	0		90. 01
90. 02 04950 DI ABETI C EDUCATI ON	01	0		90. 02
90. 03 09002 MS CLI NI C	01	0		90. 03
91. 00 09100 EMERGENCY	0	-		91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART)	0	0		92. 00
OTHER REI MBURSABLE COST CENTERS				
95. 00 09500 AMBULANCE SERVICES	0			95.00
200.00 Subtotal (see instructions)	0	4, 124		200. 00
201.00 Less PBP Clinic Lab. Services-Program	0			201. 00
Only Charges 202.00 Net Charges (line 200 - line 201)	0	4, 124		202. 00
202.00 Net Charges (Title 200 - Title 201)	ı o	1 4, 124	I	1202.00

	NT OF INPATIENT ANCILLARY SERVICE CAPITA	AL 00313	Component	CN: 15-0088 CCN: 15-T088	Period: From 07/01/2021 To 06/30/2022	11/29/2022 8:	pared: 09 am
				e XVIII	Subprovi der - I RF	PPS	
	Cost Center Description	Capi tal	Total Charges			Capital Costs	
			(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,			. Charges	column 4)	
		Part II, col.	8)	2)			
		26)	0.00	2.00	4.00	F 00	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	LARY SERVICE COST CENTERS						
	OPERATING ROOM	837, 635				167	50.00
	DELIVERY ROOM & LABOR ROOM	235, 935				0	
	ANESTHESI OLOGY	0		, 0,0000		0	
	RADI OLOGY-DI AGNOSTI C	215, 554				487	
	MAMMOGRAPHY	15, 608				0	
	NUCLEAR MEDICINE - DIAGNOSTIC	35, 850				8	54. 0
54. 03 03630	ULTRA SOUND	12, 983			0 0	0	
55.00 05500	RADI OLOGY-THERAPEUTI C	52, 196	30, 836, 583	0. 00169	93 0	0	55. 0
57.00 05700	CT SCAN	32, 248	17, 362, 629	0. 00185	19, 550	36	57.0
8.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	23, 738	2, 977, 337	0. 00797	73 0	0	58. 0
59.00 05900	CARDIAC CATHETERIZATION	111, 995	24, 704, 178	0. 00453	4, 451	20	59.0
50.00 06000	LABORATORY	253, 815	88, 218, 848	0. 00287	77 348, 322	1, 002	60.0
55. 00 06500	RESPI RATORY THERAPY	111, 635	20, 341, 215	0. 00548	107, 303	589	65.0
66. 00 06600	PHYSI CAL THERAPY	146, 111	8, 967, 570	0. 01629	384, 508	6, 265	66.0
57. 00 06700	OCCUPATIONAL THERAPY	67, 068	3, 707, 209	0. 01809	398, 806	7, 215	67.0
8. 00 06800	SPEECH PATHOLOGY	23, 438	1, 298, 172	0. 01805	92, 913	1, 678	68.0
69. 00 06900	ELECTROCARDI OLOGY	8, 864	1, 242, 397	0. 00713	35 0	0	69.0
70. 00 07000	ELECTROENCEPHALOGRAPHY	108, 794			4, 631	126	70.0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	104, 229				273	71.0
	IMPL. DEV. CHARGED TO PATIENTS	108, 905				25	
	DRUGS CHARGED TO PATIENTS	588, 809				954	
	CHEMOTHERAPY	33, 488				0	
	WOUND CARE	55, 185				0	
	TIENT SERVICE COST CENTERS		., ., ., .,				1
	CLINIC	1 0	(0.00000	00	0	90.0
	ANDERSON OUTPATIENT CENTER	62, 612				0	
	DI ABETI C EDUCATION	02,012		1		Ö	90. 0
	MS CLINIC			1			
	EMERGENCY	416, 747	_	1		190	
	OBSERVATION BEDS (NON-DISTINCT PART)	410, 747				0	
	REIMBURSABLE COST CENTERS		3,004,000	, 0.00000	,0	U	72.0
	AMBULANCE SERVICES						95.0

	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF SH COSTS	RVICE OTHER PASS	Component (CCN: 15-T088	Fro To		11/29/2022 8:	pared: 09 am
			Title	XVIII	Sı	ubprovi der - I RF	PPS	
	Cost Center Description	Non Physician Anesthetist Cost	Nursi ng Program Post-Stepdown Adj ustments	Nursi ng Program	F	Post-Stepdown Adjustments	Allied Health	
	ANCILLARY SERVICE COST CENTERS	1.00	2A	2. 00		3A	3. 00	
50. 00	05000 OPERATING ROOM	1 0	0		0	O	0	50. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM		-		0	0	0	52. 00
53. 00	05300 ANESTHESI OLOGY	0	0		0	0	0	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	38, 742	
54. 01	03440 MAMMOGRAPHY	0	o o		0	0	8, 767	
54. 02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	o		0	0	36, 966	
54. 03	03630 ULTRA SOUND	0	0		0	0	20, 822	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0		0	0	68, 297	55.00
7. 00	05700 CT SCAN	0	0		0	0	38, 441	57.0
8. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0	0	6, 592	58.00
9. 00	05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	0	59.00
50.00	06000 LABORATORY	0	0		0	0	0	60.0
55.00	06500 RESPI RATORY THERAPY	0	0		0	0	0	65.0
6. 00	06600 PHYSI CAL THERAPY	0	0		0	0	0	66. 0
7. 00	06700 OCCUPATI ONAL THERAPY	0	0		0	0	0	67.0
8. 00	06800 SPEECH PATHOLOGY	0	0		0	0	0	68. 0
9. 00	06900 ELECTROCARDI OLOGY	0	0		0	0	0	69.0
0.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	0	70.0
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	0	71.0
2. 00 3. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	0	72. 0 73. 0
76.00	03190 CHEMOTHERAPY	0	0		0	0	0	76.0
76. 00	03020 WOUND CARE				0	0	0	76.0
0.01	OUTPATIENT SERVICE COST CENTERS	0	U		U _I		0	70.0
90. 00	09000 CLINIC	0	0		0	O	0	90.0
90. 01	09001 ANDERSON OUTPATIENT CENTER	0	ا		0	ő	0	90.0
90. 02	04950 DI ABETI C EDUCATI ON	0	Ö		0	ol	0	90. 0
0.03	09002 MS CLINIC	0	o		0	O	0	90.0
91. 00	09100 EMERGENCY	0	0		0	o	0	91.0
92.00		0			0		0	92.0
	OTHER REIMBURSABLE COST CENTERS							
95. 00	09500 AMBULANCE SERVI CES							95.00
200.00	Total (lines 50 through 199)	0	0		O	0	218, 627	1200. C

Health Financial Systems	NSCE	ENSION ST VI	NCENT ANDERSON		In lie	eu of Form CMS-2	2552_10
APPORTIONMENT OF INPATIENT/OUTPATIE THROUGH COSTS			Provider CO		Period: From 07/01/2021 To 06/30/2022	Worksheet D Part IV	pared:
			Title	XVIII	Subprovider -	PPS	
Cost Center Description	n	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
	Ed	lucation Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)		(see	
						instructions)	
		4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTE	RS						
50. 00 05000 OPERATI NG ROOM		0	0		0 132, 927, 453		
52. 00 05200 DELI VERY ROOM & LABOR	ROOM	0	0		0 4, 476, 880	0.000000	52. 00
53. 00 05300 ANESTHESI OLOGY		0	0		0 0	0.000000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0	38, 742	38, 74	2 17, 498, 630	0. 002214	54.00
54. 01 03440 MAMMOGRAPHY		0	8, 767	8, 76	7 3, 959, 739	0. 002214	54. 01
54.02 03450 NUCLEAR MEDICINE - DIA	GNOSTI C	0	36, 966	36, 96	6 16, 696, 386	0. 002214	54. 02
54. 03 03630 ULTRA SOUND		0	20, 822	20, 82	2 9, 404, 689	0. 002214	54. 03
55. 00 05500 RADI OLOGY-THERAPEUTI C		0	68, 297	68, 29			55. 00
57. 00 05700 CT SCAN		0	38, 441	38, 44			57.00
58.00 05800 MAGNETIC RESONANCE I MAGNETIC RESONANCE RESONAN	GING (MRI)	0	6, 592	6, 59			
59. 00 05900 CARDI AC CATHETERI ZATI O		0	0		0 24, 704, 178		
60. 00 06000 LABORATORY		0	0		0 88, 218, 848		
65. 00 06500 RESPIRATORY THERAPY		0	0		0 20, 341, 215		
66. 00 06600 PHYSI CAL THERAPY		0	0		0 8, 967, 570		
67. 00 06700 OCCUPATI ONAL THERAPY		0	0		0 3, 707, 209		
68. 00 06800 SPEECH PATHOLOGY		0	0		0 1, 298, 172		
69. 00 06900 ELECTROCARDI OLOGY		0	0		0 1, 242, 397		
70. 00 07000 ELECTROENCEPHALOGRAPHY		0	0		0 3, 992, 200		
71. 00 07100 MEDICAL SUPPLIES CHARG	ED TO PATLENTS	0	0		0 21, 174, 981		
72. 00 07200 I MPL. DEV. CHARGED TO I		0	0		0 21, 504, 051		
73. 00 07300 DRUGS CHARGED TO PATIE		0	Õ		0 107, 171, 213	1	
76. 00 03190 CHEMOTHERAPY		0	0		0 8, 855, 091		
76. 01 03020 WOUND CARE		0	0		0 4, 974, 383		
OUTPATIENT SERVICE COST CENT	FRS	<u> </u>	0		0 4, 774, 303	0.000000	70.01
90. 00 09000 CLINIC	EKS	0	0		0 0	0.000000	90.00
90. 01 09001 ANDERSON OUTPATIENT CEI	NTER	0	0		0 3, 845, 126		
90. 02 04950 DI ABETI C EDUCATION	VIER	0	0		0 3, 043, 120	0. 000000	
90. 03 09002 MS CLINIC		0	0		0 0	0.000000	
91. 00 09100 EMERGENCY		0	0		0 72, 054, 467		
92. 00 09200 OBSERVATI ON BEDS (NON-I	OLSTINCT DART)	0	0		0 3, 084, 588		1
OTHER REIMBURSABLE COST CENT		U	U		0 3,004,300	0.000000	1 72.00
95. 00 09500 AMBULANCE SERVICES	LINO						95. 00
200.00 Total (lines 50 through	h 100)	0	218, 627	218, 62	7 631, 276, 015		200. 00
200. 00 Total (Tries 30 till ough	1 177)	O ₁	210,021	210,02	7, 031, 270, 013	1	1200.00

	ASCENSION ST. VIN	CENT ANDERSON		In Lie	u of Form CMS-	2552-10
PPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	Provi der C	CN: 15-0088	Peri od:	Worksheet D	
HROUGH COSTS		Component	CCN: 15-T088	From 07/01/2021 To 06/30/2022	Part IV Date/Time Pre 11/29/2022 8:	pared: 09 am
			XVIII	Subprovi der - I RF	PPS	
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9. 00	10.00	11. 00	12.00	13. 00	
ANCILLARY SERVICE COST CENTERS						
0.00 05000 OPERATING ROOM	0. 000000	26, 457		0	0	50.00
2.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52. 00
3. 00 05300 ANESTHESI OLOGY	0. 000000	0		0 0	0	53. 00
4. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 002214	39, 506	8	37 0	0	54.00
4. 01 03440 MAMMOGRAPHY	0. 002214	0		o o	0	54. 01
4.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0. 002214	3, 667		8 0	0	54. 02
4. 03 03630 ULTRA SOUND	0. 002214	. 0		ol ol	0	54. 03
5. 00 05500 RADI OLOGY-THERAPEUTI C	0. 002215	0		o o	0	55. 00
7. 00 05700 CT SCAN	0. 002214	19, 550	_	13 0	0	
8.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 002214	. , , 555		o o	0	
9. 00 05900 CARDI AC CATHETERI ZATI ON	0.000000	4, 451		0 0	0	
0. 00 06000 LABORATORY	0. 000000	348, 322		0	0	
5. 00 06500 RESPIRATORY THERAPY	0. 000000	107, 303		0 0	0	
6. 00 06600 PHYSI CAL THERAPY	0. 000000	384, 508			0	
7. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	398, 806		0 0	0	
1	0.000000	•		0 0	0	
		92, 913 0	•	0 0	0	
	0. 000000 0. 000000	-		0 0	0	
		4, 631		0 0	-	
1. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	55, 443		9	0	
2. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	4, 861		0	0	
3. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	173, 693		0	0	
6. 00 03190 CHEMOTHERAPY	0. 000000	0		0	0	
6. 01 03020 WOUND CARE	0. 000000	0		0 0	0	76. 01
OUTPATIENT SERVICE COST CENTERS						
0. 00 09000 CLI NI C	0. 000000	0		0	0	
0.01 09001 ANDERSON OUTPATIENT CENTER	0. 000000	0		0	0	
0.02 04950 DIABETIC EDUCATION	0. 000000	0		0	0	90. 02
0. 03 09002 MS CLINIC	0. 000000	0		0 0	0	90. 03
1. 00 09100 EMERGENCY	0. 000000	32, 905		0 0	0	91.00
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0 0	0	92. 00
OTHER REIMBURSABLE COST CENTERS						
5. 00 09500 AMBULANCE SERVICES						95. 00
00.00 Total (lines 50 through 199)		1, 697, 016	13	88 0		200.00

Health Financial Systems	ASCENSION ST. VINCE	NT ANDERSON	In Lie	u of Form CMS-2552-10
ADDODEL ONMENT OF MEDICAL	OTHER HEALTH CERVILORS AND MAGGINE COST	D ' 1 OON 4E OOOO	D	W

Hear th	Financial Systems A	SCENSION SI. VII	NCENT ANDERSON		In Lie	u of Form CMS-2	<u> 2552-10</u>
APPORT	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider Co		Period: From 07/01/2021 To 06/30/2022	Worksheet D Part V Date/Time Pre 11/29/2022 8:	pared:
			Ti +I	e XIX	Hospi tal	Cost	0 / aiii
			11 (1	Charges	1103pi tai	Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
	cost center beserretron		Services (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not	(300 11131.)	
		Part I, col. 9	11.51.7	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. 158664	0	1, 206, 12	9 0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 631679	0	5, 32	5 0	0	52.00
53.00	05300 ANESTHESI OLOGY	0. 000000	0		0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 293942	0	264, 86	5 0	0	54.00
54.01	03440 MAMMOGRAPHY	0. 208815	0	8, 39	6 0	0	54. 01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0. 084989	0	92, 70	8 0	0	54. 02
54.03	03630 ULTRA SOUND	0. 073881	0	139, 02	1 0	0	54. 03
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 092241	0	855, 94	0 0	0	55. 00
57.00	05700 CT SCAN	0. 085490	0	303, 49		0	57.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 291372	0	22, 75	9 0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 085847	0	316, 85	0 0	0	59.00
60.00	06000 LABORATORY	0. 101622	0	1, 057, 66	4 0	0	60.00
65.00	06500 RESPI RATORY THERAPY	0. 136271	0	66, 00		0	65. 00
66.00	06600 PHYSI CAL THERAPY	0. 397694	0	59, 75		0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 436197	0	27, 01		0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 435052	0	9, 44		0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 313240	0	83		0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 210466	0	32, 19		0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 297630	0	51, 46		0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 306327	0	230, 76		0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 302553	0	771, 72	9 0	0	73. 00
76. 00	03190 CHEMOTHERAPY	0. 182516	0	149, 07		0	76. 00
76. 01	03020 WOUND CARE	0. 308590	0			0	1
	OUTPATIENT SERVICE COST CENTERS			<u> </u>			İ
90.00	09000 CLI NI C	0.000000	0		0 0	0	90.00
90. 01	09001 ANDERSON OUTPATIENT CENTER	0. 489897	0	147, 87	0 0	0	90. 01
90. 02	04950 DIABETIC EDUCATION	0. 000000	0		0 0	0	90. 02
90. 03	09002 MS CLINIC	0. 000000	0		0 0	0	90. 03
91.00	09100 EMERGENCY	0. 163304	0	1, 831, 78	3 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 706488	0	92, 60	5 0	0	92.00
	OTHER REIMBURSABLE COST CENTERS	<u> </u>			•		
95.00	09500 AMBULANCE SERVICES	0.000000	0		0		95. 00
200.00	Subtotal (see instructions)		0	7, 964, 64	2 0	0	200. 00
201.00					0 0		201. 00
	Only Charges						
202.00	Net Charges (line 200 - line 201)		0	7, 964, 64	2 0	0	202. 00

| Peri od: | Worksheet D | From 07/01/2021 | Part V | To 06/30/2022 | Date/Time Prepared:

					To 06/30/2022	Date/Time Pre 11/29/2022 8:	
			Ti tl	e XIX	Hospi tal	Cost	07 diii
		Cos	sts				
	Cost Center Description	Cost	Cost	1			
		Rei mbursed	Reimbursed				
		Servi ces	Servi ces Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)	-			
ΙΔ	NCILLARY SERVICE COST CENTERS	6. 00	7. 00	1			
	05000 OPERATING ROOM	191, 369		N .			50.00
	05200 DELIVERY ROOM & LABOR ROOM	3, 364					52. 00
	05300 ANESTHESI OLOGY	0,304	ĺ				53. 00
	05400 RADI OLOGY-DI AGNOSTI C	77, 855	1	1			54. 00
	03440 MAMMOGRAPHY	1, 753	l e				54. 01
	03450 NUCLEAR MEDICINE - DIAGNOSTIC	7, 879					54. 02
	03630 ULTRA SOUND	10, 271		1			54. 02
	05500 RADI OLOGY-THERAPEUTI C	78, 953					55. 00
	05700 CT SCAN	25, 945		1			57. 00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	6, 631					58. 00
1	05900 CARDI AC CATHETERI ZATI ON	27, 201		1			59. 00
	06000 LABORATORY	107, 482		1			60.00
	06500 RESPI RATORY THERAPY	8, 995	ł	1			65. 00
	06600 PHYSI CAL THERAPY	23, 763		1			66. 00
	06700 OCCUPATI ONAL THERAPY	11, 784		1			67. 00
	06800 SPEECH PATHOLOGY	4, 111		1			68. 00
	06900 ELECTROCARDI OLOGY	261		1			69. 00
1	07000 ELECTROEARD GEOGRAPHY	6, 775		1			70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	15, 316	ł	1			71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	70, 689	ł	1			72.00
	07300 DRUGS CHARGED TO PATIENTS	233, 489	l	1			73. 00
	03190 CHEMOTHERAPY	27, 208	l e	1			76.00
	03020 WOUND CARE	68, 188		1			76. 01
	OUTPATIENT SERVICE COST CENTERS	00, 100		′ 1			70.01
_	09000 CLINIC	0	С				90.00
	09001 ANDERSON OUTPATIENT CENTER	72, 441	ĺ				90. 01
	04950 DIABETIC EDUCATION	0	l c				90. 02
	09002 MS CLINIC	0	l c				90. 03
	09100 EMERGENCY	299, 137	l c				91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	65, 424	l .				92.00
_	THER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES	0					95. 00
200.00	Subtotal (see instructions)	1, 446, 284	C				200.00
201.00	Less PBP Clinic Lab. Services-Program	0					201.00
	Only Charges						
202.00	Net Charges (line 200 - line 201)	1, 446, 284	C)			202. 00

Health Financial Systems	ASCENSION ST. VINCE	ENT ANDERSON	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 15-0088	Peri od: From 07/01/2021	Worksheet D-1	
			To 06/30/2022	Date/Time Pre 11/29/2022 8:	
		Title XVIII	Hospi tal	PPS	
Cost Center Description					
				1. 00	
PART I - ALL PROVIDER COMPONENTS					
I NPATI ENT DAYS					
1 00 Inpatient days (including private room	n days and swing-hed days	s excluding newborn)		24 346	1 1 00

	Title XVIII Hospital	PPS	
	Cost Center Description	1. 00	
	PART I - ALL PROVIDER COMPONENTS	1.00	
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	24, 346	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	24, 346	2. 00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	0	3. 00
4. 00	do not complete this line.	22 77/	4. 00
5. 00	Semi-private room days (excluding swing-bed and observation bed days) Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	22, 776 0	5.00
5.00	reporting period	O	3.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)		
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	O	0.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	3, 638	9. 00
	newborn days) (see instructions)	_	
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11. 00
11.00	December 31 of the cost reporting period (if calendar year, enter 0 on this line)	· ·	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12.00
40.00	through December 31 of the cost reporting period		40.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XLX 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	15. 00
16.00	Nursery days (title V or XIX only)	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
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0.00	18. 00
10.00	report ing period	0.00	10.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0.00	19. 00
	reporting period		
20. 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0. 00	20. 00
21. 00	Total general inpatient routine service cost (see instructions)	33, 793, 267	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	22. 00
	5 x line 17)		
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23. 00
24. 00	x line 18) Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24. 00
24.00	7 x line 19)	O	24.00
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
	x line 20)		
26. 00	Total swing-bed cost (see instructions)	0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	33, 793, 267	27. 00
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
29. 00	Pri vate room charges (excluding swing-bed charges)	0	29. 00
30.00	Semi -pri vate room charges (excluding swing-bed charges)	0	30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33. 00 34. 00	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)	0. 00 0. 00	33. 00 34. 00
35. 00	Average per diem private room cost differential (line 34 x line 31)	0.00	35. 00
36. 00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	33, 793, 267	37. 00
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY DDOCDAM INDATIENT OPERATING COST RECORE DASS THROUGH COST AD HISTMENTS		
38. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost per diem (see instructions)	1, 388. 04	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	5, 049, 690	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40. 00
41. 00	Total Program general inpatient routine service cost (line 39 + line 40)	5, 049, 690	41. 00

Title XVIII Norrage Per Program layer		wof Form CMS-: Worksheet D-1	Period:	ON CCN: 15-00		SCENSION ST. VIN	Financial Systems A TION OF INPATIENT OPERATING COST
1.794/2002 1.01 1			From 07/01/2021	0011. 13 001	Trovider		TION OF THE ATTENT OF ENATITIES COST
Title Will Supplied Program Easily Program Easily Program Easily Program Easily Program Easily			10 06/30/2022				
Impatient Cost Impatient Basys Dices (Col. 1 s		PPS					
1.00 2.00 3.00 4.00 5.00							Cost Center Description
1.00 NUMSERY (title V & XIX only)	1.		1 ÷		пратгент рау	impatrent costi	
Intensive Care Type Inpatient Hospital Units Intensive Care Type Inpatient Hospital Units Intensive Care Type Inpatient Hospital Units Intensive Care Type Inpatient Hospital Units Intensive Care Units Other Many Care Units Other Special Care Unit			4. 00		2. 00	1.00	
MITTERSIVE CARE UNIT 12,841,972 5,098 2,519.02 3,281 8,264,90	0 42.	0	. 00	0		0	
44.00 CORONARY CARE UNIT 46.00 SIBURI INTERSIVE CARE UNIT 47.00 OTHER SPECIAL CARE CORE UNIT 47.00 OTHER SPECIAL CARE CORE UNIT 48.00 Program inpatient ancilitary service cost (Wkst. D-3. col. 3, line 200) 9, 384, 44 9, 00 Program inpatient ancilitary service cost (Wkst. D-3. col. 3, line 200) 9, 384, 44 9, 00 Program inpatient costs (sum of lines 41 through 48) (see instructions) 9, 384, 44 9, 00 Program inpatient costs (sum of lines 41 through 48) (see instructions) 9, 384, 44 9, 00 Program inpatient costs applicable to Program inpatient anciliary services (from Wkst. D, sum of Parts II and 11) 110 Program excludable cost (sum of lines 50 and 51) 150 Total Program excludable cost (sum of lines 50 and 51) 150 Total Program excludable cost (sum of lines 50 and 51) 150 Total Program excludable cost (sum of lines 50 and 51) 150 Total Program excludable cost (sum of lines 52) 150 Total Program excludable cost (sum of lines 52) 150 Total Program excludable cost (sum of lines 52) 150 Total Program excludable cost (sum of lines 52) 150 Total Program excludable cost (sum of lines 52) 150 Total Program excludable cost (sum of lines 52) 150 Total Program excludable cost (sum of lines 52) 150 Total Program excludable cost (sum of lines 52) 150 Total Program excludable cost (sum of lines 52) 150 Total Program excludable cost (sum of lines 52) 150 Total Program excludable cost (sum of lines 52) 150 Total Program excludable cost (sum of lines 52) 150 Total Program excludable cost (sum of lines 52) 150 Total Program excludable cost (sum of lines 52) 150 Total Program excludable cost (sum of lines 52) 150 Total Program excludable cost (sum of lines 52) 150 Total Program excludable cost (sum of lines 52) 150 Total Program excludable cost (sum of lines 52) 150 Total Program inpatient cost (sum of lines 52) 150 Total Program inpatient program inpatient program lines (sum of lines 52) 150 Total Program program inpatient routine costs (sum of lines 54 × 60), or 18 of the target amount (see instructions) 150 Total Program inpatient	05 43.	8 264 905	02 3 291	10 2	5.00	12 8/1 072	
SURN INTENSIVE CARE UNIT	44.	8, 204, 903	. 02 3, 201	2,	5, 07	12, 041, 972	
OTHER SPECIAL CARE (SPECIFY) Cost Center Description 8. 00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200) 8. 01 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200) 9. 384, 44 9. 01 Total Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200) 9. 384, 49 9. 02 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200) 9. 384, 49 9. 06 Program inpatient costs (sum of lines 41 through 48) (see Instructions) 9. 384, 40 9. 07 Program (soch per service) 9. 08 Program (soch per service) 9. 08 Program (soch per service) 9. 08 Program (soch per service) 9. 08 Program (soch per service) 9. 09 Program (soch per service) 9. 09 Program (soch per service) 9. 00 Program (soch per service) 9. 01 Program (soch per service) 9. 01 Program (soch per service) 9. 02 Program (soch per service) 9. 02 Program (soch per service) 9. 03 Program (soch per service) 9. 04 Program (soch per service) 9. 07 Program (soch per service) 9. 07 Program (s	45.						
Cost Center Description 1.00 48.00 Program Inpatient anciliary Service cost (Wist. D-3, col. 3, line 200) 9. 384, 440 00 Total Program Inpatient costs (sum of lines 41 through 48)(seel instructions) 9. 22, 699, 04 PASS THROUGH COST ADJUSTMENTS 10 Pass through costs applicable to Program Inpatient routine services (from Wist. D, sum of Parts I and 227, 74 15.00 Pass through costs applicable to Program Inpatient anciliary services (from Wist. D, sum of Parts II and 276, 89 15.00 Total Program excludable cost (sum of lines 50 and 51) 15.00 Total Program excludable cost (sum of lines 50 and 51) 15.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (fine 40 minus line 52) 15.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (fine 40 minus line 52) 15.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (fine 40 minus line 52) 16.00 Target anexem per discharge 17.00 Total Program inpatient operating cost and target amount (line 56 minus line 53) 17.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 18.00 Bouss payment (see instructions) 18.00 Bouss payment (see instructions) 18.00 Bouss payment (see instructions) 18.00 Bouss payment (see instructions) 18.00 Foreign an instructions Colored Co	46.						
1.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200) 9, 384, 44 9, 00 Total Program inpatient costs (sum of lines 41 through 48) (see instructions) 9, 384, 44 9, 00 Program inpatient costs (sum of lines 41 through 48) (see instructions) 22, 699, 04 22,	47.						
Program inpatient ancillary service cost (Wist. D-3, col. 3, line 200) 49, 384, 44 90 Total Program inpatient costs (sum of lines 41 through 48) (see instructions) 22, 699, 04 285 THROUGH COST ADJUSTNENTS 50, 00 Pass through costs applicable to Program inpatient routine services (from Wist. D, sum of Parts I and III) 51, 00 Pass through costs applicable to Program inpatient ancillary services (from Wist. D, sum of Parts II and III) 51, 00 Pass through costs applicable to Program inpatient ancillary services (from Wist. D, sum of Parts II and III) 51, 00 Pass through costs applicable to Program inpatient ancillary services (from Wist. D, sum of Parts II and III) 51, 00 Program excludable cost (sum of lines 50 and 51) 52, 00 Total Program excludable cost (sum of lines 50 and 51) 53, 00 Total Program excludable cost (sum of lines 50 and 51) 54, 00 Program discharges 55, 00 Target amount per discharge 56, 00 Target amount per discharge 56, 00 Target amount per discharge 57, 00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 58, 00 Bonus payment (see instructions) 59, 00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 60, 00 Interes 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 60, 00 Interes 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 60, 00 Interes 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 60, 00 Interes 53/54 or 55 from the cost reporting period (see instructions) 61, 00 Interes 53/54 or 55 from the cost program (see instructions) 62, 00 Relief payment (see instructions) 63, 00 Interes 53/54 or 55 from the cost program (see instructions) 64, 00 Michael Inpatient routine cost plus incentive payment (see instructions) 65, 00 Michael Inpatient (see instructions) 67, 00 Michael Inpatient (see instructions) 68, 00	+	1 00					cost center bescription
PASS THROUGH COST ADJUSTNEWNS 50. 00 Pass through costs applicable to Program inpatient routine services (from Wkst. D., sum of Parts I and 427, 74 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D., sum of Parts II 276, 89 and IV) 51. 00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D., sum of Parts II 276, 89 and IV) 52. 00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D., sum of Parts II 276, 89 and IV) 53. 00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D., sum of Parts II 276, 89 and IV) 53. 00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D., sum of Parts III 276, 89 and IV) 54. 00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D., sum of Parts III 276, 89 and IV) 55. 00 Parts Advisor (from Parts III) 56. 00 Pass through costs (line 54 x line 55) 57. 00 Pifference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 58. 00 Bonus payment (see instructions) 58. 00 Bonus payment (see instructions) 59. 00 Esser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket ancient basket anc	49 48.	9, 384, 449			line 200)	st. D-3, col. 3,	Program inpatient ancillary service cost (Wk
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D. sum of Parts I and III) 51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D. sum of Parts II 276, 89 and IV) 52.00 Total Program excludable cost (sum of lines 50 and 51) 53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and excluding capital related, non-physician anesthetist, and 21, 994, 41 medical education costs (line 49 minus line 52) 53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 21, 994, 41 medical education costs (line 49 minus line 52) 53.00 Total Program and III of Computation (1998) 55.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 55.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 55.00 Difference between adjusted inpatient operating cost report, updated by the market basket on one market basket on the size of 53% or 55 from the cost reporting period ending 1996, updated and compounded by the market basket on the size of 53% or 55 from the cost reporting period ending 1996, updated and compounded by the market basket on the size of 53% or 55 from the cost reporting period ending 1996, updated and compounded by the market basket on the size of 53% or 55 from the cost reporting 1996, updated and compounded by the market basket on the size of 53% or 55 from the cost reporting 1996, updated and compounded by the market basket on the size of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56) otherwise enter zero (see instructions) 60.00 Total Minus 1997, part of 1997, part of 1997, part of 1997, part of 1997, part of 1997, part of 1997, part of 1997, part of 1997, part of 1997, part of 1997, part of 1997, part of 1997, part of 1997, part of 1997, part of 1997, part of 1997, part of 1997, part	44 49.	22, 699, 044		ons)	see instructi	41 through 48)(:	
111) 5.00 Pass through costs applicable to Program Inpatient ancillary services (from Wist. D., sum of Parts II and IV) 5.00 Total Program excludable cost (sum of Iines 50 and 51) 704,63							
276, 99 and 190 and 19	44 50.	427, 744	um of Parts I and	om Wkst. D	services (fro	atient routine :	
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Health Financial Systems AS	SCENSION ST. VI	NCENT ANDERSON		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der Co		Peri od:	Worksheet D-1	
				From 07/01/2021 To 06/30/2022	Date/Time Pre 11/29/2022 8:	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital -related cost	1, 268, 770	33, 793, 267	0. 03754	5 2, 179, 223	81, 819	90.00
91.00 Nursing Program cost	0	33, 793, 267	0.00000	0 2, 179, 223	0	91. 00
92.00 Allied health cost	0	33, 793, 267	0.00000	0 2, 179, 223	0	92. 00
93.00 All other Medical Education	0	33, 793, 267	0. 00000	0 2, 179, 223	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	Peri od: From 07/01/2021	Worksheet D-1
		Component CCN: 15-T088	To 06/30/2022	Date/Time Prepared: 11/29/2022 8:09 am
		Title XVIII	Subprovider -	PPS

DART 1 - ALL PROVIDER COMPONENTS MART 1 - ALL PROVIDER COMPONENTS 1.00			litie xviii	I RF	PPS	
New York New York		Cost Center Description		TIM	1.00	
MRATIERT DAYS		PART I - ALL PROVIDER COMPONENTS			1.00	
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	3.00		ys). If you have only pr	I vate 100iii days,	U	3.00
reporting period (if calendar year, enter 0 on this line) 7.00 7	4.00		ed days)		2, 221	4. 00
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Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period 0 7.00	6. 00	Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	0	6. 00
Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	7. 00	Total swing-bed NF type inpatient days (including private room	m days) through December	31 of the cost	0	7. 00
Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 0.00	8. 00	Total swing-bed NF type inpatient days (including private room	m days) after December 3	31 of the cost	0	8. 00
10.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) after bed through December 31 of the cost reporting period (see instructions) after December 31 of the cost reporting period (see instructions) after December 31 of the cost reporting period (see instructions) after December 31 of the cost reporting period (see instructions) after December 31 of the cost reporting period (see instructions) after December 31 of the cost reporting period (see instructions) after December 31 of the cost reporting period (see instructions) after December 31 of the cost reporting period (see instructions) after December 31 of the cost reporting period (see instructions) after December 31 of the cost reporting period (see instructions) after December 31 of the cost reporting period (see instructions) after December 31 of the cost reporting period (see instructions) after December 31 of the cost after December 31 of the cost reporting period (see instructions) after December 31 of the cost after December 31 of the cost reporting period (see instructions) after December 31 of the cost reporting period (line 5 x 11 in 13) after December 31 of the cost reporting December 31 of December 31 of the cost reporting December 31 of December 31 of the cost reporting December 31 of December 31 of the cost reporting December 31 of December 31 of December 31 of December 31 of December 31 of December 31 of December 31 of December 31 of Decem	9. 00	Total inpatient days including private room days applicable to	o the Program (excluding	g swing-bed and	835	9. 00
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after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 14.00 14.00 15	13. 00	through December 31 of the cost reporting period	3 .		0	13. 00
15.00 Total nursery days (title V or XIX only) 0 15.00 16.00 16.00 16.00 16.00 16.00 16.00 17.00 17.00 18.00		after December 31 of the cost reporting period (if calendar ye	ear, enter O on this lir	ne)		
16.00 Nursery days (title V or XIX only) SWING BED ADJUSTMENT 17.00 Medicare rate for swi ng-bed SNF services applicable to services through December 31 of the cost reporting period reporting			am (exertaining swring bea	uays)		
17. 00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost 0.00 17. 00 18. 00 18. 00 19.	16. 00	Nursery days (title V or XIX only)			0	16. 00
18. 00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost 0.00 19. 00	17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 c	of the cost	0.00	17. 00
19. 00 Medical d Tate for swing-bed NF services applicable to services through December 31 of the cost reporting period 20. 00 20.	18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0. 00	18. 00
20.00 Medical drate 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) 3, 497, 270 21.00 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 6 x line 18) 25.00 Swing-bed cost applicable to NF type services after 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) 25.00 Swing-bed cost (see instructions) 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) 3, 497, 270 27.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 0, 30.00 Semi-private room charges (excluding swing-bed charges) 0, 30.00 Semi-private room per diem charge (line 29 + line 3) 0, 30.00 Average per diem private room per diem charge (line 29 + line 3) 0, 30.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 0, 35.00 Average per diem private room charge differential (line 34 x line 31) 0, 37.00 Private room cost differential (line 34 x line 35) 0, 37.00 Provate room cost differential adjustment (line 3 x line 35) 0, 37.00 Provate room cost differential adjustment (line 3 x line 35) 0, 37.00 Provate room cost differential (line 3 x line 35) 0, 37.00 Provate general inpatient routine service cost per diem (see instructions) 1, 574.64 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 574.64 38.00 Program general inpatient routin	19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0. 00	19. 00
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 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 Experimental application of the cost reporting period (line 8 x line 20) 28.00 Total swing-bed cost (see instructions) 29.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 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 Average private room per diem charge (line 29 + line 3) 30.00 Average private room per diem charge (line 29 + line 3) 30.00 Average per diem private room per diem charge (line 29 + line 4) 31.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 32.00 Average per diem private room cost differential (line 32 minus line 33) 33.00 Private room cost differential (line 32 minus line 33) 34.00 Average per diem private room cost differential (line 32 minus line 33) 35.00 Private room cost differential (line 32 minus line 33) 36.00 Private room cost differential (line 32 minus line 33) 37.00 Private room cost differential (line 32 minus line 35) 38.00 Average per diem private room cost differential (line 32 minus line 35) 39.00 Program general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 39.00 Program general inpatient routine service cost (line 9 x line 38) 39.00 Medically necess	20. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of t	the cost	0. 00	20. 00
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 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 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) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Average private room per diem charge (line 29 + line 3) 30.00 Average semi-private room per diem charge (line 30 + line 34) 30.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 30.00 Private room cost differential (line 34 x line 31) 30.00 Private room cost differential (line 3 x line 35) 30.00 PROBLEM AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 30.00 Medically necessary private room cost dinpatient 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) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	21. 00	Total general inpatient routine service cost (see instructions			3, 497, 270	21. 00
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 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 0 25.00 x line 20) 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) Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed char	22. 00		er 31 of the cost report	ting period (line	0	22. 00
7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	23. 00		31 of the cost reportin	ng period (line 6	0	23. 00
x line 20) 26. 00 Total swing-bed cost (see instructions) Ceneral 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) Ceneral inpatient routine service charges (excluding swing-bed and observation bed charges) Ceneral inpatient routine service charges (excluding swing-bed charges) Ceneral inpatient routine service cost/charge ratio (line 27 ÷ line 28) Ceneral inpatient routine service cost/charge ratio (line 27 ÷ line 28) Ceneral inpatient routine service cost/charge ratio (line 27 ÷ line 28) Ceneral inpatient routine service cost/charge ratio (line 30 ÷ line 4) Ceneral inpatient routine service cost differential (line 30 ÷ line 4) Ceneral inpatient routine service cost differential (line 34 x line 31) Ceneral inpatient routine service cost differential (line 34 x line 31) Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 497, 270) Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 497, 270) Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 497, 270) Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 497, 270) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost per diem charges Ceneral inpatient routine service cost per diem	24. 00	31.	r 31 of the cost reporti	ng period (line	0	24. 00
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) 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 cost differential (line 34 x line 31) Average per diem private room cost differential (line 34 x line 31) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Private room cost differential adjustment (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 36) Program Inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 497, 270) 37.00 Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3, 497, 270) Average per diem private room cost differential (line 3 x line 31) Average per diem private room cost differential (line 3 x line 31) Average per diem private room cost differential (line 3 x line 31) Average per diem private room cost differential (line 3 x line 31) Average per diem private room cost differential (line 3 x line 31) Average	25. 00	Swing-bed cost applicable to NF type services after December:	31 of the cost reporting	g period (line 8	0	25. 00
PRI VATE ROOM DIFFERENTIAL ADJUSTMENT 28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29. 00 Pri vate room charges (excluding swing-bed charges) 30. 00 Semi-pri vate room charges (excluding swing-bed charges) 31. 00 General inpatient routine service cost/charge ratio (line 27 + line 28) 32. 00 Average pri vate room per diem charge (line 29 + line 3) 32. 00 Average semi-pri vate room per diem charge (line 30 + line 4) 33. 00 Average per diem pri vate room charge differential (line 32 minus line 33) (see instructions) 34. 00 Average per diem pri vate room cost differential (line 34 x line 31) 35. 00 Average per diem pri vate room cost differential (line 34 x line 31) 36. 00 Pri vate 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 3, 497, 270) 37. 00 Average per diem private room cost differential (line 3 x line 35) 38. 00 Average per diem private room cost differential (line 3 x line 35) 38. 00 Average per diem private room cost differential (line 3 x line 35) 39. 00 Frogram Inpatient routine service cost per diem (see instructions) 30. 00 Average per diem charge (line 30 x line 35) 31. 00 Average per diem private room cost differential (line 3 x line 35) 37. 00 General inpatient routine service cost per diem (see instructions) 38. 00 Adjusted general inpatient routine service cost (line 9 x line 38) 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) 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)		Total swing-bed cost (see instructions)				
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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) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 32.00 Average per diem 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) 32.00 Average per diem private room cost differential (line 34 x line 31) 32.00 Private room cost differential adjustment (line 3 x line 35) 33.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 497, 270) 37.00 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) 37.00 Program general inpatient routine service cost (line 9 x line 38) 38.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 31.00 O.00 0.00 0.00 0.00 0.00 0.00 0.00				,		
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35. 00 Average per diem private room cost differential (line 34 x line 31) 0.00 35. 00 36. 00 Private room cost differential adjustment (line 3 x line 35) 0 36. 00 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 497, 270 37. 00) 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) 1, 574. 64 38. 00 39. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40. 00						
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PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,574.64 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38) 1,314,824 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	200	27 minus line 36)			2,, 2,0	21.00
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40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00						
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	Financial Systems AS ATION OF INPATIENT OPERATING COST	SCENSION ST. VII		ON CCN: 15-0088	In Lie	eu of Form CMS-2 Worksheet D-1	
COMITOT	ATTOM OF THE ATTENT OF ENATTING 3037			CCN: 15-T088	From 07/01/2021 To 06/30/2022		
			Ti tl	e XVIII	Subprovi der -	11/29/2022 8: PPS	09 am
	Cost Center Description	Total Inpatient Cost	Total	Average Pe		Program Cost (col. 3 x col.	
		·		col . 2)		4)	
42. 00	NURSERY (title V & XIX only)	1.00	2. 00	3. 00 0 0.	4. 00 00	5.00	42. 00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	O		0 0.	00 0	0	43.00
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	J		0.		,	44. 00 45. 00
46. 00 47. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) Cost Center Description						46. 00 47. 00
	<u> </u>					1.00	
48. 00 49. 00	Program inpatient ancillary service cost (Wks Total Program inpatient costs (sum of lines 4 PASS THROUGH COST ADJUSTMENTS			ons)		512, 382 1, 827, 206	
50. 00	Pass through costs applicable to Program inpa	atient routine	services (fro	om Wkst. D, su	m of Parts I and	58, 300	50. 00
51. 00	Pass through costs applicable to Program inpa and IV)	atient ancillar	y services (1	rom Wkst. D,	sum of Parts II	19, 173	51.00
52. 00 53. 00	Total Program excludable cost (sum of lines ! Total Program inpatient operating cost exclude medical education costs (line 49 minus line !	ding capital re	lated, non-ph	nysi ci an anest	hetist, and	77, 473 1, 749, 733	
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					T 0	54.00
55.00	Target amount per discharge					0.00	
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operati	ng cost and ta	rget amount ((line 56 minus	line 53)	0	
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost reparket basket	porting period	endi ng 1996,	updated and c	ompounded by the	0.00	
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year of line 53/54 is less than the lower of lines which operating costs (line 53) are less than	s 55, 59 or 60	enter the Les	sser of 50% of	the amount by	0.00	
62. 00	amount (line 56), otherwise enter zero (see i Relief payment (see instructions)	nstructions)				0	62. 00
63. 00	Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST					0	63. 00
64. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts through Dece	mber 31 of th	ne cost report	ing period (See	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts after Decemb	er 31 of the	cost reportin	g period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routin CAH (see instructions)	·	·		3,	0	
67. 00	(line 12 x line 19)	-				0	
68. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20) Total title V or XIX swing-bed NF inpatient (·	orting period	0	
	PART III - SKILLED NURSING FACILITY, OTHER NU	IRSING FACILITY	AND ICF/IIE	ONLÝ			
70. 00 71. 00	Skilled nursing facility/other nursing facili Adjusted general inpatient routine service co)		70. 00 71. 00
72. 00 73. 00	Program routine service cost (line 9 x line 3 Medically necessary private room cost applications)	,	(line 14 v l	ine 35)			72. 00 73. 00
74. 00 75. 00	Total Program general inpatient routine servi Capital-related cost allocated to inpatient :	ce costs (line	72 + line 73	3)	Part II, column		74. 00 75. 00
76. 00 77. 00	26, line 45) Per diem capital-related costs (line 75 ÷ line Program capital-related costs (line 9 x line						76. 00 77. 00
78. 00	Inpatient routine service cost (line 74 minus	s line 77)					78. 00
79. 00 80. 00	Aggregate charges to beneficiaries for excess Total Program routine service costs for compa				nus line 79)		79. 00 80. 00
81. 00	Inpatient routine service cost per diem limit	tati on			,		81. 00
82. 00 83. 00	Inpatient routine service cost limitation (li Reasonable inpatient routine service costs (s		•				82. 00 83. 00
84. 00	Program inpatient ancillary services (see ins	structions)	•				84. 00
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85. 00 86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS	THROUGH COST				0	
88. 00	Total observation bed days (see instructions) Adjusted general inpatient routine cost per of	diem (line 27 ÷	line 2)			0.00	88. 00
89. 00	Observation bed cost (line 87 x line 88) (see	e instructions)				0	89. 00

Health Financial Systems A	SCENSION ST. V	I NCEN	T ANDERSON		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		F	Provider CO	CN: 15-0088	Peri od:	Worksheet D-1	
		(Component (CCN: 15-T088	From 07/01/2021 To 06/30/2022	Date/Time Pre 11/29/2022 8:	pared: 09 am_
			Title	XVIII	Subprovi der -	PPS	
	1				I RF		
Cost Center Description	Cost	Rou	tine Cost	column 1 ÷	Total	Observation	
		(fro	m line 21)	column 2	Observati on	Bed Pass	
					Bed Cost (from	Through Cost	
					line 89)	(col. 3 x col.	
						4) (see	
						instructions)	
	1.00		2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST						
90.00 Capital-related cost	155, 07	9	3, 497, 270	0. 04434	13 0	0	90.00
91.00 Nursing Program cost		o	3, 497, 270	0. 00000	00	0	91.00
92.00 Allied health cost		ol	3, 497, 270	0. 00000	00	0	92.00
93.00 All other Medical Education		0	3, 497, 270	0. 00000	00	0	93. 00

Health Financial Systems	ASCENSION ST. VINCE	ENT ANDERSON	In Lie	u of Form CMS-2	2552-10	
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 15-0088	Period: From 07/01/2021	Worksheet D-1		
			To 06/30/2022	Date/Time Prep 11/29/2022 8:0	oared: 09 am	
		Title XIX	Hospi tal	Cost		
Cost Center Description						
				1. 00		
PART I - ALL PROVIDER COMPONENTS						
I NPATI ENT DAYS						
1.00 Inpatient days (including private room	Inpatient days (including private room days and swing-bed days, excluding newborn) 24,3					
2.00 Inpatient days (including private room	n days, excluding swing-l	ped and newborn days)		24, 346	2. 00	
3.00 Private room days (excluding swing-bed	d and observation bed day	ys). If you have only pr	rivate room days,	0	3. 00	

	Cost Center Description	1.00	
	DADT I ALL DROW DED COMPONENTS	1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	24, 346	1. 00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	24, 346	2. 00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	24, 340	3. 00
0.00	do not complete this line.	ĭ	0.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	22, 776	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	Ö	5. 00
	reporting period		
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)		
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
	reporting period		
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line)	985	9. 00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	985	9.00
10. 00	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)	ĭ	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	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
	after 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)	0	14. 00
15. 00	Total nursery days (title V or XIX only)	674	
16. 00	Nursery days (title V or XIX only)	553	16. 00
17 00	SWING BED ADJUSTMENT	0.00	17 00
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0. 00	17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0.00	18. 00
10.00	reporting period	0.00	10.00
19. 00	Medical d rate for swing-bed NF services applicable to services through December 31 of the cost	0.00	19. 00
. , , , ,	reporting period	0.00	. ,
20.00	Medicald 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)	33, 793, 267	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	22. 00
	5 x line 17)	_	
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23. 00
24.00	x line 18)		24.00
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
23.00	x line 20)	٥	23.00
26. 00	Total swing-bed cost (see instructions)	0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	33, 793, 267	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	00/110/201	
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)	ol	29. 00
30.00	Semi - pri vate room charges (excluding swing-bed charges)	ol	30. 00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	31. 00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34. 00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34. 00
35. 00	Average per diem private room cost differential (line 34 x line 31)	0.00	35. 00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	33, 793, 267	37. 00
	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)	1, 388. 04	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	1, 367, 219	39. 00
40. 00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41. 00	Total Program general inpatient routine service cost (line 39 + line 40)	1, 367, 219	41. 00

	Financial Systems A TATION OF INPATIENT OPERATING COST	SCENSION ST. VI	NCENT ANDERSON Provider C	CN: 15-0088	In Lie Period:	u of Form CMS-2 Worksheet D-1	
COMITO	ATTON OF THE ATTENT OF ENATING COST		Trovider co	1	From 07/01/2021 Fo 06/30/2022	Date/Time Pre	pared:
			T: +1	e XIX	Hospi tal	11/29/2022 8: Cost	09 am
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
	p	Inpatient Cost				(col. 3 x col.	
		1.00	2.00	col . 2)	4.00	4)	
42.00	NURSERY (title V & XIX only)	1. 00 685, 169	2. 00 674	3. 00 1, 016. 5	4. 00 7 553	5. 00 562, 163	42.00
42.00	Intensive Care Type Inpatient Hospital Units		074	1,010.5	/ 553	302, 103	42.00
43. 00		12, 841, 972	5, 098	2, 519. 02	2 198	498, 766	43. 00
44. 00	CORONARY CARE UNIT						44. 00
45. 00	BURN INTENSIVE CARE UNIT						45. 00
46.00							46.00
47.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47. 00
	Sect Control Boson Ptron					1. 00	
48. 00	Program inpatient ancillary service cost (Wk					1, 619, 478	•
49. 00	Total Program inpatient costs (sum of lines	41 through 48)(see instructio	ns)		4, 047, 626	49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	ationt routino	corvices (from	Wket D sum	of Darte L and	0	50. 00
30. 00		attent routine	services (IIII	WKSt. D, Suiii	OI Fai ts I aliu	U	30.00
51. 00	Pass through costs applicable to Program inp	atient ancillar	y services (fr	om Wkst. D, su	um of Parts II	0	51.00
FO 5-	and IV)	E0 1 E1					F
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		lated non chi	cician anac+h	otict and	0	
JS. UU	medical education costs (line 49 minus line		nateu, non-pny	SICIAII AIIESTNE	zust, allu		33.00
	TARGET AMOUNT AND LIMIT COMPUTATION	02)					
	Program di scharges						54.00
	Target amount per discharge						55.00
56. 00 57. 00	,	ing cost and ta	raet amount (1	ine 56 minus l	ine 53)	0	56. 00 57. 00
58. 00	Bonus payment (see instructions)	ing cost and ta	inger amount (i	THE 50 IIITHUS I	THE 33)	0	
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	ending 1996, u	pdated and cor	mpounded by the	-	59.00
	market basket						
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line				the amount by	0.00	60. 00 61. 00
61.00	which operating costs (line 53) are less that					U	61.00
	amount (line 56), otherwise enter zero (see instructions)						
62.00 Relief payment (see instructions)							62. 00 63. 00
63.00 Allowable Inpatient cost plus incentive payment (see instructions) PROGRAM INPATIENT ROUTINE SWING BED COST							
64. 00		ts through Dece	mber 31 of the	cost reportir	na period (See	0	64. 00
	instructions) (title XVIII only)				.9 (
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the c	ost reporting	period (See	0	65. 00
66. 00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi</pre>	no costs (lino	64 plus lino 6	5) (+i +l o VVIII	only) For	0	66. 00
00.00	CAH (see instructions)	the costs (Title	04 prus rriie 0	5)(title XVIII	only). To	U	00.00
67. 00	Title V or XIX swing-bed NF inpatient routin	e costs through	December 31 o	f the cost rep	porting period	0	67. 00
	(line 12 x line 19)						,,,,,,,
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	ie costs after D	ecember 31 or	tne cost repor	rting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient	routine costs (line 67 + line	68)		0	69. 00
	PART III - SKILLED NURSING FACILITY, OTHER N	URSING FACILITY	, AND ICF/IID	ONLY			
70.00	Skilled nursing facility/other nursing facil						70.00
71. 00 72. 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		ine /U ÷ line	2)			71. 00 72. 00
73. 00	Medically necessary private room cost applic		ı(line 14 x li	ne 35)			73.00
74. 00	Total Program general inpatient routine serv			•			74. 00
75. 00	Capital -related cost allocated to inpatient	routine service	costs (from W	orksheet B, Pa	art II, column		75. 00
74 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	no 2)					76. 00
76. 00 77. 00	Program capital -related costs (line 9 x line						77.00
78. 00	,						78. 00
79. 00	Aggregate charges to beneficiaries for exces						79. 00
	Total Program routine service costs for comp		ost limitation	(line 78 minu	us line 79)		80. 00 81. 00
81. 00 82. 00							
83. 00	Reasonable inpatient routine service costs (* .				82. 00 83. 00
84. 00	Program inpatient ancillary services (see in		•				84. 00
85. 00	Utilization review - physician compensation						85. 00
86. 00			rough 85)				86. 00
	PART IV - COMPUTATION OF OBSERVATION BED PAS					4 570	07.00
87 NN	lintal observation had days (see instructions					1 5/11	
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per	•	line 2)			1, 570 1, 388. 04	

Health Financial Systems	ASCENSION ST. V	'I NCENT	ANDERSON		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Pr	rovider CO		Peri od:	Worksheet D-1	
					From 07/01/2021 To 06/30/2022	Date/Time Pre 11/29/2022 8:0	
			Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routi	ine Cost	column 1 ÷	Total	Observation	
		(from	line 21)	column 2	Observati on	Bed Pass	
					Bed Cost (from	Through Cost	
					line 89)	(col. 3 x col.	
						4) (see	
						instructions)	
	1.00		2. 00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST						
90.00 Capital-related cost	1, 268, 77	0 3	3, 793, 267	0. 03754	5 2, 179, 223	81, 819	90.00
91.00 Nursing Program cost		0 3	3, 793, 267	0.00000	0 2, 179, 223	0	91.00
92.00 Allied health cost		0 3	3, 793, 267	0. 00000	0 2, 179, 223	0	92.00
93.00 All other Medical Education		0 3	3, 793, 267	0. 00000	2, 179, 223	0	93. 00

Health Financial Systems	ASCENSION ST. VINC	CENT ANDERSON	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0088	Peri od: From 07/01/2021	Worksheet D-1
		Component CCN: 15-T088	To 06/30/2022	Date/Time Prepared: 11/29/2022 8:09 am
		Title XIX	Subprovi der -	Cost

		II the XIX	I RF	COST		
	Cost Center Description					
	PART I - ALL PROVIDER COMPONENTS			1. 00		
	INPATIENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days	s, excluding newborn)		2, 221	1.00	
2.00	Inpatient days (including private room days, excluding swing-b			2, 221	2. 00	
3. 00	Private room days (excluding swing-bed and observation bed day	s). If you have only pri	vate room days,	0	3. 00	
4.00	do not complete this line. Semi-private room days (excluding swing-bed and observation be	ed days)		2, 221	4. 00	
5. 00	Total swing-bed SNF type inpatient days (including private roo		31 of the cost	0	5. 00	
	reporting period			ا		
6.00	Total swing-bed SNF type inpatient days (including private roof reporting period (if calendar year, enter 0 on this line)	om days) after December 3	1 of the cost	0	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	, .,				
8.00	Total swing-bed NF type inpatient days (including private room	n days) after December 31	of the cost	0	8. 00	
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	the Program (excluding	swing_hed and	67	9. 00	
7. 00	newborn days) (see instructions)	the rrogram (exeruaring	Swifing bed and	0,	7. 00	
10.00	Swing-bed SNF type inpatient days applicable to title XVIII or		om days)	0	10.00	
11 00	through December 31 of the cost reporting period (see instruct		om dovo) often		11 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 0 on this line)	om days) arter	0	11. 00	
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI>		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 XI) after December 31 of the cost reporting period (if calendar ve			0	13. 00	
14. 00	Medically necessary private room days applicable to the Progra	-	,	0	14. 00	
15. 00	Total nursery days (title V or XIX only)	(2.12. 22.1.g 2.1.1.g 2.2. 2		674		
16. 00	Nursery days (title V or XIX only)			553	16. 00	
17 00	SWING BED ADJUSTMENT	a through Docombon 21 of	the east	0.00	17. 00	
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through becember 31 of	the cost	0.00	17.00	
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of t	he cost	0.00	18.00	
40.00	reporting period			0.00	40.00	
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s through December 31 of	tne cost	0.00	19. 00	
20. 00						
	reporting period					
21. 00 22. 00	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through Decembe		ng poriod (Line	3, 497, 270 0	21. 00 22. 00	
22.00	5 x line 17)	i 31 of the cost reporti	ng perrou (irne	U	22.00	
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	period (line 6	0	23. 00	
0.4.00	x line 18)	24 6 11			04.00	
24. 00	Swing-bed cost applicable to NF type services through December 7×1 ine 19)	31 of the cost reportin	g period (line	0	24. 00	
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00	
	x line 20)					
26. 00	Total swing-bed cost (see instructions)	Time 21 minus line 24)		0		
27. 00	General inpatient routine service cost net of swing-bed cost (PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	Time 21 minus Time 26)		3, 497, 270	27.00	
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed cha	rges)	0	28. 00	
29. 00	Private room charges (excluding swing-bed charges)			0		
30.00	Semi -private room charges (excluding swing-bed charges)	1: 20)		0	30.00	
31. 00 32. 00	General inpatient routine service cost/charge ratio (line 27 = Average private room per diem charge (line 29 = line 3)	- TTNe 28)		0. 000000 0. 00		
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00		
34.00	Average per diem private room charge differential (line 32 mir	nus line 33)(see instruct	i ons)	0.00		
35. 00	Average per diem private room cost differential (line 34 x lin	ne 31)		0.00		
36.00	Private room cost differential adjustment (line 3 x line 35)		· · · · · · · · · · · · · · · · · · ·	0 107 270	36. 00	
37. 00	General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	inu private room cost dif	remential (line	3, 497, 270	37. 00	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY					
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU					
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 574. 64		
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Program			105, 501 0	39. 00 40. 00	
	Total Program general inpatient routine service cost (line 39	,		105, 501		
	, 5 5 1	,	ı	- = 1 = = 1		

		SCENSION ST. VI				eu of Form CMS-2		
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der C		Peri od: From 07/01/2021	Worksheet D-1		
			Component	CCN: 15-T088	To 06/30/2022	Date/Time Pre 11/29/2022 8:		
			Ti tl	e XIX	Subprovider - IRF	Cost		
	Cost Center Description	Total Inpatient Cost	Total	Average Per	r Program Days	Program Cost (col. 3 x col.		
		·		col . 2)		4)		
42. 00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4. 00 00 0	5. 00	42.00	
	Intensive Care Type Inpatient Hospital Units							
43. 00 44. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT	0	C	0.	00 0	0	43.00	
45. 00	BURN INTENSIVE CARE UNIT						45. 00	
46. 00 47. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00	
	Cost Center Description				,			
48. 00	Program inpatient ancillary service cost (Wks	st. D-3. col. 3	. line 200)			1. 00 38, 908	48. 00	
49. 00	Total Program inpatient costs (sum of lines a PASS THROUGH COST ADJUSTMENTS			ons)		144, 409	1	
50.00	Pass through costs applicable to Program inpa	atient routine	services (from	n Wkst. D, su	m of Parts I and	0	50. 00	
51. 00	Pass through costs applicable to Program inpaland IV)	atient ancillar	y services (fr	om Wkst. D,	sum of Parts II	0	51.00	
52. 00	Total Program excludable cost (sum of lines!					0		
53. 00	Total Program inpatient operating cost exclude medical education costs (line 49 minus line !		lated, non-phy	sician anest	hetist, and	0	53. 00	
E 4 00	TARGET AMOUNT AND LIMIT COMPUTATION						F.4.00	
54. 00 55. 00	Program discharges Target amount per discharge					0.00	54. 00 55. 00	
56. 00	Target amount (line 54 x line 55)			! F/!	l: F2)	0		
57. 00 58. 00	Difference between adjusted inpatient operati Bonus payment (see instructions)	ng cost and ta	rget amount (i	The 50 minus	11 ne 53)	0	57. 00 58. 00	
59. 00	Lesser of lines 53/54 or 55 from the cost reparket basket	porting period	endi ng 1996, ι	ipdated and c	ompounded by the	0.00	59. 00	
60.00	0.00	60.00						
61. 00	0	61. 00						
	which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)							
62. 00 63. 00	l	62. 00 63. 00						
	Allowable Inpatient cost plus incentive paymer PROGRAM INPATIENT ROUTINE SWING BED COST							
64. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts through Dece	mber 31 of the	cost report	ing period (See	0	64. 00	
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the d	ost reportin	g period (See	0	65. 00	
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 6	5)(title XVI	II only). For	0	66. 00	
67 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing	costs through	December 31 o	of the cost n	enorting period	0	67. 00	
07.00	(line 12 x line 19)	e costs till ough	December 31 c	i the cost i	eporting perrou	0	07.00	
68. 00	Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)	e costs after D	ecember 31 of	the cost rep	orting period	0	68. 00	
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NU	•				0	69. 00	
70. 00	Skilled nursing facility/other nursing facility)		70. 00	
71. 00 72. 00	Adjusted general inpatient routine service co Program routine service cost (line 9 x line		ine 70 ÷ line	2)			71. 00 72. 00	
73.00	Medically necessary private room cost applica	able to Program	•	,			73. 00	
74. 00 75. 00	Total Program general inpatient routine servi Capital-related cost allocated to inpatient	•			Part II column		74. 00 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	
78. 00 79. 00	Inpatient routine service cost (line 74 minus	.*	rovi don rocore	le)			78. 00 79. 00	
80.00	Aggregate charges to beneficiaries for excess Total Program routine service costs for compa				nus line 79)		80.00	
81.00								
82. 00 83. 00	Reasonable inpatient routine service cost (•				82. 00 83. 00	
84. 00 85. 00	Program inpatient ancillary services (see in: Utilization review - physician compensation		ne)				84. 00 85. 00	
86. 00	Total Program inpatient operating costs (sum						86.00	
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions)					0	87. 00	
88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷	line 2)			0.00	88. 00	
89. 00	Observation bed cost (line 87 x line 88) (see	e instructions)				0	89. 00	

Health Financial Systems A	SCENSION ST. V	'I NCENT	ANDERSON		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Pı	rovider CC		Peri od:	Worksheet D-1	
					From 07/01/2021		
		Co	omponent (CCN: 15-T088	To 06/30/2022	Date/Time Prep 11/29/2022 8:0	
			Ti tl	e XIX	Subprovi der -	Cost	37 diii
				· //	I RF	0001	
Cost Center Description	Cost	Rout	ine Cost	column 1 ÷	Total	Observati on	
		(from	line 21)	column 2	Observati on	Bed Pass	
					Bed Cost (from	Through Cost	
					line 89)	(col. 3 x col.	
						4) (see	
						instructions)	
	1.00		2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH							
90.00 Capital-related cost	155, 07	9	3, 497, 270	0. 04434	13 0	0	90.00
91.00 Nursing Program cost		0	3, 497, 270	0. 00000	00	0	91.00
92.00 Allied health cost		0	3, 497, 270	0.00000	00	0	92.00
93.00 All other Medical Education		0	3, 497, 270	0.00000	00	0	93.00

	CENSION ST. VINCENT ANDERSON			u of Form CMS-2	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN:		Peri od:	Worksheet D-3	
			From 07/01/2021 To 06/30/2022	Date/Time Pre	narod:
			10 00/30/2022	11/29/2022 8:	09 am
	Title XV	/111	Hospi tal	PPS	
Cost Center Description	Ra-	tio of Cost	Inpati ent	Inpati ent	
	т	To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1. 00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			12, 253, 954		30.00
31. 00 03100 I NTENSI VE CARE UNI T			5, 660, 810		31. 00
41. 00 04100 SUBPROVI DER - RF			0		41. 00
43. 00 04300 NURSERY					43. 00
ANCILLARY SERVICE COST CENTERS		0.450//	4 0 0 0 0 0 0 0	4 405 000	F0 00
50. 00 05000 OPERATING ROOM		0. 15866		1, 405, 890	
52. 00 05200 DELI VERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY		0. 63167		4, 503	
		0.00000		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 29394			
54. 01 03440 MAMMOGRAPHY 54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC		0. 20881 0. 08498		0 37, 052	54. 01 54. 02
54. 03 03630 ULTRA SOUND		0. 08498		37,052	54. 02
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 07388		11, 894	
57. 00 05700 CT SCAN		0. 09224			1
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0. 29137			
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 08584		141, 398	
60. 00 06000 LABORATORY		0. 10162		906, 744	
65. 00 06500 RESPI RATORY THERAPY		0. 10102			
66. 00 06600 PHYSI CAL THERAPY		0. 13027			
67. 00 06700 OCCUPATI ONAL THERAPY		0. 43619			
68. 00 06800 SPEECH PATHOLOGY		0. 43505			
69. 00 06900 ELECTROCARDI OLOGY		0. 31324		0 38, 641	69.00
70. 00 07000 ELECTROEARD GEOGRAPHY		0. 21046		11, 616	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 29763			
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 30632		774, 380	
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 30052		· ·	
76. 00 03190 CHEMOTHERAPY		0. 18251		2, 304, 422	76.00
76. 01 03020 WOUND CARE		0. 30859			76. 00
OUTPATIENT SERVICE COST CENTERS		3. 30037	<u>ا</u> ا		1 , 5. 5 ,
90. 00 09000 CLINIC		0. 00000	0	0	90.00
90. 01 09001 ANDERSON OUTPATIENT CENTER		0. 48989		Ö	
90. 02 04950 DI ABETI C EDUCATION		0. 00000		_	
00 03 00003 WZ CLINIC		0.00000		0	

0.000000

0. 163304

0.706488

5, 001, 840

47, 396, 918

47, 396, 918

501, 385

90.03

91.00

92.00

95.00

201. 00

202. 00

9, 384, 449 200. 00

816, 820

354, 222

09500 AMBULANCE SERVICES

09200 OBSERVATION BEDS (NON-DISTINCT PART)

Net charges (line 200 minus line 201)

Total (sum of lines 50 through 94 and 96 through 98)
Less PBP Clinic Laboratory Services-Program only charges (line 61)

OTHER REIMBURSABLE COST CENTERS

09002 MS CLINIC

09100 EMERGENCY

90.03

91.00

92.00

95.00

200. 00 201. 00

202.00

NPATI ENT	ANCILLARY SERVICE COST APPORTIONMENT	Provider Component (CN: 15-0088 CCN: 15-T088	Period: From 07/ To 06/	/01/2021 /30/2022	Worksheet D-3 Date/Time Pre 11/29/2022 8:	pare
		Title	XVIII	Subprov I R		PPS	
	Cost Center Description		Ratio of Cos To Charges	st Inpa Pro	tient gram rges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.	00	3. 00	
	PATIENT ROUTINE SERVICE COST CENTERS						
	DOO ADULTS & PEDI ATRI CS						30.
	100 INTENSIVE CARE UNIT			1	4// 0/0		31.
	100 SUBPROVI DER – I RF 300 NURSERY			1,	466, 068		41. 43.
	CILLARY SERVICE COST CENTERS						43.
	OOO OPERATING ROOM		0. 1586	64	26, 457	4, 198	50.
	200 DELIVERY ROOM & LABOR ROOM		0. 6316		20, 107	0	
	300 ANESTHESI OLOGY		0.0000		0	0	53.
4.00 054	400 RADI OLOGY-DI AGNOSTI C		0. 2939	42	39, 506	11, 612	54.
	440 MAMMOGRAPHY		0. 2088	15	0	0	54.
	450 NUCLEAR MEDICINE - DIAGNOSTIC		0. 0849		3, 667	312	
	330 ULTRA SOUND		0. 0738		0	0	
	500 RADI OLOGY-THERAPEUTI C		0. 0922		0	0	
	700 CT SCAN		0. 0854		19, 550	1, 671	
	MAGNETIC RESONANCE IMAGING (MRI)		0. 2913 0. 0858		4 451	0	
	POO CARDI AC CATHETERI ZATI ON DOO LABORATORY		0. 0858		4, 451 348, 322	382 35, 397	
	500 RESPI RATORY THERAPY		0. 1016		107, 303	14, 622	
	600 PHYSI CAL THERAPY		0. 1302		384, 508	152, 917	
	700 OCCUPATI ONAL THERAPY		0. 4361		398, 806	173, 958	
	BOO SPEECH PATHOLOGY		0. 4350		92, 913	40, 422	1
	900 ELECTROCARDI OLOGY		0. 3132		0	0	1
	DOO ELECTROENCEPHALOGRAPHY		0. 2104		4, 631	975	70.
1. 00 071	100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 2976	30	55, 443	16, 502	71.
2. 00 072	200 IMPL. DEV. CHARGED TO PATIENTS		0. 3063	27	4, 861	1, 489	72.
3.00 073	BOO DRUGS CHARGED TO PATIENTS		0. 3025		173, 693	52, 551	
	190 CHEMOTHERAPY		0. 1825		0	0	
	D20 WOUND CARE		0. 3085	90	0	0	76.
	TPATIENT SERVICE COST CENTERS		0.0000	00	0	0	-
	DOO CLINIC DO1 ANDERSON OUTPATIENT CENTER		0.0000		0	0	
	DOTIANDERSON OUTPATTENT CENTER PSO DIABETIC EDUCATION		0. 4898 0. 0000		0	0	
	002 MS CLINIC		0.0000		0	0	
	100 EMERGENCY		0. 1633		32, 905	5, 374	
4	200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 7064		32, 703	0, 374	
	HER REIMBURSABLE COST CENTERS		0.7004		<u> </u>	0	1 ′2.
	500 AMBULANCE SERVICES						95.
00.00	Total (sum of lines 50 through 94 and 96 through 98)			1,	697, 016	512, 382	
01.00	Less PBP Clinic Laboratory Services-Program only charges	(line 61)			0	,	201.
02.00	Net charges (line 200 minus line 201)	•		1.	697, 016		202.

Health Financial Systems	ASCENSION ST. V	/INCENT ANDERSON		In Li∈	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provi der CO		Peri od:	Worksheet D-3	
				From 07/01/2021 To 06/30/2022	Date/Time Pre	
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description			Ratio of Cos		I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
LABORT FAIT DOUTLAS OFFILIAS OFFILIAS			1. 00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS				2 000 540		00.00
30. 00 03000 ADULTS & PEDI ATRI CS				3, 089, 543		30.00
31. 00 03100 INTENSIVE CARE UNIT				834, 321		31.00
41. 00 04100 SUBPROVI DER - RF				140 700		41.00
43.00 O4300 NURSERY ANCI LLARY SERVICE COST CENTERS				149, 722		43. 00
50. 00 05000 OPERATING ROOM			0. 15866	4 1, 234, 566	195, 881	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM			0. 63167			50.00
53. 00 05300 ANESTHESI OLOGY			0. 00000		97, 143	53.00
54. 00 05400 RADI OLOGY			0. 29394		101, 804	54.00
54. 01 03440 MAMMOGRAPHY			0. 20881		0	54. 00
54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC			0. 08498		4, 704	54. 02
54. 03 03630 ULTRA SOUND			0. 07388	· ·	7, 652	54. 03
55. 00 05500 RADI OLOGY-THERAPEUTI C			0. 09224		0	55. 00
57. 00 05700 CT SCAN			0. 08549		20, 336	57.00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)			0. 29137	· ·	12, 518	
59. 00 05900 CARDI AC CATHETERI ZATI ON			0. 08584	· ·		
60. 00 06000 LABORATORY			0. 10162	· ·	193, 189	60.00
65. 00 06500 RESPIRATORY THERAPY			0. 13627		103, 058	
66. 00 06600 PHYSI CAL THERAPY			0. 39769			
67. 00 06700 OCCUPATI ONAL THERAPY			0. 43619	· ·		1
68.00 06800 SPEECH PATHOLOGY			0. 43505			
69. 00 06900 ELECTROCARDI OLOGY			0. 31324		0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY			0. 21046		l e	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS			0. 29763	0 393, 825	117, 214	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS			0. 30632		26, 903	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS			0. 30255	3 1, 281, 596	387, 751	73. 00
76.00 03190 CHEMOTHERAPY			0. 18251	6 138	25	76. 00
76. 01 03020 WOUND CARE			0. 30859	0 489	151	76. 01

0.000000

0. 489897

0.000000

0.000000

0. 163304

0.706488

137

1, 644, 220

8, 696, 816

8, 696, 816

90.00

90. 01

90.02

90.03

91.00

92.00

95.00

202.00

67

0

0

1, 619, 478 200. 00 201. 00

268, 508

OUTPATIENT SERVICE COST CENTERS

09001 ANDERSON OUTPATIENT CENTER

OTHER REIMBURSABLE COST CENTERS

09200 OBSERVATION BEDS (NON-DISTINCT PART)

Net charges (line 200 minus line 201)

Total (sum of lines 50 through 94 and 96 through 98)
Less PBP Clinic Laboratory Services-Program only charges (line 61)

04950 DIABETIC EDUCATION

09500 AMBULANCE SERVICES

90.00

90. 01

90.02

90.03

91.00

92.00

95.00

200.00

201. 00 202. 00

09000 CLINIC

09002 MS CLINIC

09100 EMERGENCY

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT Provider		CN: 15-0088	Peri od:	Worksheet D-3	
Co	omponent (CCN: 15-T088	From 07/01/2021 To 06/30/2022	Date/Time Pre 11/29/2022 8:	pare 09 a
	Titl	e XIX	Subprovi der - I RF	Cost	
Cost Center Description		Ratio of Cos To Charges	t Inpatient	Inpatient Program Costs (col. 1 x col.	
		1. 00	2. 00	2) 3. 00	1
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1.00	2.00	3.00	
0. 00 03000 ADULTS & PEDI ATRI CS					30.
. 00 03100 INTENSIVE CARE UNIT					31.
. 00 04100 SUBPROVI DER - I RF			119, 038		41.
3. 00 O4300 NURSERY					43.
ANCI LLARY SERVI CE COST CENTERS 0.00 OFERATI NG ROOM		0. 1586	64 223	35	50.
2. OO 05200 DELI VERY ROOM & LABOR ROOM		0. 6316		l	
8. 00 05300 ANESTHESI OLOGY		0.0000		l .	
. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 2939		416	54
P. 01 03440 MAMMOGRAPHY		0. 2088	15 0	0	54
.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC		0. 0849	89 0	0	54.
. 03 03630 ULTRA SOUND		0. 0738			
. 00 05500 RADI OLOGY-THERAPEUTI C		0. 0922			
. 00 05700 CT SCAN		0. 0854		l .	
.00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0. 2913			
. 00 05900 CARDI AC CATHETERI ZATI ON		0. 0858		0	
. 00 06000 LABORATORY		0. 1016		3, 457	
. 00 06500 RESPI RATORY THERAPY . 00 06600 PHYSI CAL THERAPY		0. 1362 0. 3976		0 12, 033	
1. 00 06000 PHYSICAL THERAPY 1. 00 06700 OCCUPATIONAL THERAPY	-	0. 3976			
. 00 06800 SPEECH PATHOLOGY		0. 4350			
1. 00 06900 SFEECH FAMILEON		0. 3132			
00 07000 ELECTROENCEPHALOGRAPHY		0. 2104		l .	
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 2976		1	
00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 3063			
. 00 07300 DRUGS CHARGED TO PATIENTS		0. 3025		3, 550	73
0. 00 03190 CHEMOTHERAPY		0. 1825	16 0	0	76
. 01 03020 WOUND CARE		0. 3085	90 0	0	76
OUTPATIENT SERVICE COST CENTERS					
00 09000 CLINIC		0.0000			
. 01 O9001 ANDERSON OUTPATIENT CENTER		0. 4898			
. 02 04950 DI ABETI C EDUCATI ON		0.0000			
. 03 09002 MS CLINIC		0.0000			
. 00 09100 EMERGENCY		0. 1633		1	
1. 00 O9200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS		0. 7064	88 0		1 92
5. 00 09500 AMBULANCE SERVICES					95
00.00 Total (sum of lines 50 through 94 and 96 through 98)			122, 877	38, 908	
11.00 Less PBP Clinic Laboratory Services-Program only charges (I	ine 61)		0		201
Net charges (line 200 minus line 201)			122, 877		202

Health Financial Systems	ASCENSION ST.	VINCE	NT ANDERSON		In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT			Provider CCN	l: 15-0088	Peri od: From 07/01/2021 To 06/30/2022	Worksheet E Part A Date/Time Prepared: 11/29/2022 8:09 am

Next A InPACLIENT HOSPITAL SIRVICES LIBRIES PPS				10 00/30/2022	11/29/2022 8:0			
Next A - INVATIBRY MODEL TALL SERVICES UNDER IPPS 0 0 0.00 0.00 1.0			Title XVIII	Hospi tal	PPS			
Next A - INVATIBRY MODEL TALL SERVICES UNDER IPPS 0 0 0.00 0.00 1.0				-	1. 00			
DRS amounts other than outlier payments for discharges occurring prior to October 1 (see 2.808,431 1.01 Instructions) 1.02 IMS amounts other than outlier payments for discharges occurring on or after October 1 (see 8.932,787 1.02 1.03		PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			1.00			
1.02 DRC amounts other than outlier payments for discharges occurring on or after October 1 (see 8,932,787 1.02		DRG amounts other than outlier payments for discharges occurring p						
1.03 10K For Federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (1.03 1.03	1. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see						
1.04 DRG for Federal specific operating payment for Model 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 to October						
2.00 Outlier payments for discharges (see Instructions) 0 2.01	1. 04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after						
2.02 Outlier payment for discharges cocurring prior to October 1 (see Instructions) 199,008 2.03 Outlier payments for discharges occurring on or after October 1 (see instructions) 189,008 2.03 Outlier payments for discharges occurring on or after October 1 (see instructions) 37,007 3.00 Managed Care S intel ated Payments 0.00 3.00 Managed Care S intel ated Payments 0.00 3.00 Managed Care S intel ated Payments 0.00 3.00 Managed Care S intel ated Payments 0.00 3.00 Managed Care S intel ated Payments 0.00 3.00 Managed Care S intel Action (1974) 0.00 0.		Outlier payments for discharges. (see instructions)			0			
2.04 Outlier payments for discharges occurring on or after October 1 (see instructions) 876,888 2.04)		-			
Managed Care Simulated Payments 139.09 4.00	2.03	, ,	•		189, 008	2. 03		
Bed days available divided by number of days in the cost reporting period (see instructions) 139.99 4.00		, , ,	see instructions)		876, 838			
Indirect Medical Education Adjustment								
FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/19/96, (see instructions) FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e) 7.00 MMA Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(1)(8)(1) 0.00 7.01 0.05 \$5.502 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(1)(8)(2) If the cost report straddles July 1, 2011 then see instructions. 8.00 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)(1)(1), 4 FR 26340 (May 12, 1998), and 67 FR 85060 (August 1, 2002). 9.01 10.00	4. 00		g period (see instru	ctions)	139. 09	4. 00		
FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e) 7.00 MMA Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(1) 7.00	5.00	FTE count for allopathic and osteopathic programs for the most rec	cent cost reporting p	period ending on	0. 00	5. 00		
7.00 MMA Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(v)(8)(2) if the cost report straddles July 1, 2011 then see instructions. 0.00 7.00 8.00 All yathment (Increase or decrease) to the FIE count for all opathic 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 50009 (August 1, 2002). 0.00 8.00 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. 0.00 8.01 8.02 The amount of Increase if the hospital was awarded FIE cap slots from a closed teaching hospital under \$5506 of ACA. (see Instructions) 0.00 8.02 9.00 Sum of Ilnes 5 plus 6 minus Ilnes (7 and 7.01) plus/minus Ilnes (8, 8,01 and 8,02) (see 0.00 9.00 10.00 FIE count for allowable FIE (see instructions) 0.00 1.00 1.00 10.00 Current year allowable FIE count for the prior year. 0.00 1.00 1.00 11.00 Current year allowable FIE count for the prior year. 0.00 1.00 1.00 12.00 The count for residents in initial years of the program of the program of the program of the program of the program of the program of the program of the program of the program of the progra	6. 00	FTE count for allopathic and osteopathic programs that meet the co	riteria for an add-o	n to the cap for	0. 00	6. 00		
cost report straddles July 1, 2011 then see instructions. 8.00		MMA Section 422 reduction amount to the IME cap as specified under						
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).	7.01		CFR §412.105(f)(1)(I)	/)(B)(2) If the	0.00	7.01		
8.01 The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report stradies July 1, 2011, see instructions. 1.02 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions) 2.00 Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	8. 00	affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)			0. 00	8. 00		
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. 01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost				8. 01		
9.00 Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see 0.00 9.00 9.00 10.00 FTE count for all opathic and osteopathic programs in the current year from your records 0.00 10.00 10.00 FTE count for residents in dental and podiatric programs. 0.00 12.00 12.00 13.00 14.00 14.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 16.00 1	8. 02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital				8. 02		
10.00 FTE count for allopathic and osteopathic programs in the current year from your records 0.00 10.	9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8	8, 8,01 and 8,02) (see	0. 00	9. 00		
12.00 Current year allowable FTE (see instructions) 0.00 12.00 13.00 10.00 13.00 10.00	10.00		year from your record	ls				
13.00 Total allowable FTE count for the prior year. 0.00 13.00 14.00 14.00 15.00	11. 00	FTE count for residents in dental and podiatric programs.			0.00	11. 00		
14.00 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 I lines 12 through 14 divided by 3. 0.00 15.00 16.00 17.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 19								
therwise enter zero. Sum of lines 12 through 14 divided by 3. 15.00 Sum of lines 12 through 14 divided by 3. Adjustment for residents in initial years of the program 0.00 15.00 Adjustment for residents displaced by program or hospital closure 0.00 17.00 Adjustment for residents displaced by program or hospital closure 0.00 17.00 Adjustment for residents displaced by program or hospital closure 0.00 17.00 Adjustment for residents displaced by program or hospital closure 0.00 17.00 Adjustment for residents displaced by program or hospital closure 0.00 17.00 Adjustment for residents displaced by program or hospital closure 0.00 17.00 Adjustment for residents displaced by program or hospital closure 0.00 17.00 Adjustment for residents displaced by program or hospital closure 0.00 18.00 Current year resident to bed ratio (line 18 divided by line 4). 0.000000 19.00 20.00 Prior year resident to bed ratio (see instructions) 1.00 Enter the lesser of lines 19 or 20 (see instructions) 1.00 IME payment adjustment (see instructions) 1.00 IME payment adjustment (see instructions) 1.00 IME payment adjustment - Managed Care (see instructions) 22.01 IME payment of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 23.00 IME FTE Resident Count Over Cap (see instructions) 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 - 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) 10 Jesproportionate Share Adjustment 10 Jesproportionate Share Adjustment 10 Jesproportionate Share Adjustment 10 Jesproportionate Share Adjustment 11 Jesproportionate Share Adjustment 12 Jesp 33.00 Jesp 33.00 Jesp 33.00 Jesp 33.00 Je								
15. 00 Sum of lines 12 through 14 divided by 3. 0. 00 15. 00 16. 00 16. 00 17. 00 17. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 19.	14.00		nded on or after Sep	ember 30, 1997,	0.00	14.00		
16. 00 Adjustment for residents in initial years of the program 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 dents displaced by program or hospital closure 0.00 17. 00 19. 00 Current year resident to bed ratio (see instructions) 0.000000 19. 00 20. 00 Prior year resident to bed ratio (see instructions) 0.000000 21. 00 21. 00 IME payment adjustment (see instructions) 0.000000 21. 00 22. 01 IME payment adjustment - Managed Care (see instructions) 0.00 22. 01 1 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA 0.00 23. 00 24. 00 IME FTE Resident Count Over Cap (see instructions) 0.00 24. 00 25. 00 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 26. 00 IME payments adjustment factor. (see instructions) 0.000000 26. 00 28. 01 IME add-on adjustment factor. (see instructions) 0.000000 <	15 00				0.00	15 00		
17. 00								
19.00 Current year resident to bed ratio (line 18 divided by line 4). 0.000000 19.00 20.00 Prior year resident to bed ratio (see instructions) 0.000000 20.00 21.00 Enter the lesser of lines 19 or 20 (see instructions) 0.000000 21.00 22.00 IME payment adjustment (see instructions) 0.22.00 1 IME payment adjustment - Managed Care (see instructions) 0.22.01 1 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA 0.00 23.00 (f)(1)(iv)(C) 0.00 24.00 IME FTE Resident Count Over Cap (see instructions) 0.00 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 0.00 26.00 Resident to bed ratio (divide line 25 by line 4) 0.000000 25.00 27.00 IME payments adjustment factor. (see instructions) 0.000000 27.00 28.00 IME add-on adjustment amount (see instructions) 0.28.00 29.00 Total IME payment (sum of lines 22 and 28) 0.29.00 10 bisproportionate Share Adjustment Disproportionate Share Adjustment 30.00 Allowable disproportionate share percentage (see instructions) 21.98		, ,						
20.00 Prior year resident to bed ratio (see instructions) 0.000000 20.00 21.00 Enter the lesser of lines 19 or 20 (see instructions) 0.000000 21.00 22.00 IME payment adjustment (see instructions) 0 22.00 IME payment adjustment - Managed Care (see instructions) 0 22.00 IME payment adjustment - Managed Care (see instructions) 0 22.01 Indirect 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 24.00 25.00 IME FTE Resident Count Over Cap (see instructions) 0.00 24.00 25.00 16 the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 25.00 17.00 18	18.00	Adjusted rolling average FTE count			0.00	18. 00		
21.00 Enter the lesser of lines 19 or 20 (see instructions) 0.000000 21.00	19. 00							
22. 00 IME payment adjustment (see instructions) 1 IME payment adjustment - Managed Care (see instructions) 1 IME payment adjustment - Managed Care (see instructions) 22. 01 Indirect 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) 29. 00 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) Disproportionate Share Adjustment 30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 32. 00 Sum of lines 30 and 31 39. 72 32. 00 31. 00 Allowable disproportionate share percentage (see instructions) 21. 98		` ` ` ` ` ` ` ` ` ` ` ` ` ` ` ` ` ` ` `						
22. 01 IME payment adjustment - Managed Care (see instructions) 0 1 1 1 1 1 1 1 1 1								
Indirect 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 (f)(1)(iv)(C). 24.00 IME FTE Resident Count Over Cap (see instructions) 0.00 24.00 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 payments adjustment amount (see instructions) 0.000000 27.00 IME add-on adjustment amount (see instructions) 0.000000 27.00 IME add-on adjustment amount - Managed Care (see instructions) 0.000000 27.00 Total IME payment (sum of lines 22 and 28) 0.00 Total IME payment (sum of lines 22 and 28) 0.00 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 0.00 Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 7.67 30.00 31.00 Sum of lines 30 and 31 39.77 23.00 33.00 Allowable disproportionate share percentage (see instructions) 21.98 33.00								
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) 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) 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) 21.98 33.00	22.01		the MMA		U	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 0.00 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) 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) 31.00 Sum of lines 30 and 31 32.05 31.00 33.00 Allowable disproportionate share percentage (see instructions) 21.98 33.00	23. 00	Number of additional allopathic and osteopathic IME FTE resident		R 412. 105	0.00	23. 00		
instructions		IME FTE Resident Count Over Cap (see 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) 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 30.00 Allowable disproportionate share percentage (see instructions) 26.00 0.000000 26.00 0.000000 27.00 0.28.01 0.28.01 0.29.00 29.01 29.01 29.01 30.00 29.01 30.00	25. 00		r of line 23 or line	24 (see	0. 00	25. 00		
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) 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) 27.00 28.01 29.0	26 00				0 000000	26 00		
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) 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) 28.00 28.00 29.01 29.00 29.01		,						
28.01 IME add-on adjustment amount - Managed Care (see instructions) 7 Total IME payment (sum of lines 22 and 28) 7 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 8 Disproportionate Share Adjustment 9 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 10 Sum of lines 30 and 31 31.00 Sum of lines 30 and 31 32.00 Allowable disproportionate share percentage (see instructions) 21.98 33.00								
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) 31.00 Percentage of Medicaid patient days (see instructions) 32.05 31.00 32.05 31.00 33.00 Allowable disproportionate share percentage (see instructions) 21.98 33.00	28. 01				0	28. 01		
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) 32.05 31.00 32.05 31.00 32.07 32.00 33.00 Allowable disproportionate share percentage (see instructions) 21.98 33.00	29.00	Total IME payment (sum of lines 22 and 28)			0	29. 00		
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) 32.05 31.00 32.05 31.00 32.05 31.00 33.00 Allowable disproportionate share percentage (see instructions) 21.98 33.00	29. 01				0	29. 01		
31.00 Percentage of Medicaid patient days (see instructions) 32.05 31.00 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 32.05 31.00 32.05 31.00 32.05 31.00	30.00		nt days (see instruc	i ons)	7. 67	30.00		
32.00 Sum of lines 30 and 31 39.72 32.00 Allowable disproportionate share percentage (see instructions) 21.98 33.00			, ,	•				
		Sum of lines 30 and 31						
34.00 Disproportionate share adjustment (see instructions) 645, 180 34.00								
	34. 00	טן sproportionate share adjustment (see instructions)			645, 180	34.00		

CALCU	Financial Systems ASCENSION ST. VIN			u of Form CMS-2	2552-10		
CALCUI	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0088	Period: From 07/01/2021 To 06/30/2022	Worksheet E Part A Date/Time Pre	pared:		
				11/29/2022 8:			
		Title XVIII	Hospi tal	PPS On/After 10/1			
			1. 00	2. 00			
	Uncompensated Care Adjustment						
35. 00	Total uncompensated care amount (see instructions)			7, 192, 008, 710			
35. 01 35. 02	Factor 3 (see instructions) Hospital uncompensated care payment (If line 34 is zero, en	ter zero on this line) (se	0. 000362241 ee 3, 002, 983		35. 01 35. 02		
00.02	2, 201, 000	00.02					
35. 03 36. 00	Total uncompensated care (sum of columns 1 and 2 on line 35.	. 03)	756, 917 2, 427, 849		35. 03 36. 00		
	Additional payment for high percentage of ESRD beneficiary of	discharges (lines 40 throu					
40. 00	Total Medicare discharges (see instructions)		Before 1/1	On/After 1/1	40. 00		
			1. 00	1. 01			
41. 00	Total ESRD Medicare discharges (see instructions)		0		41. 00		
41. 01	Total ESRD Medicare covered and paid discharges (see instruc		0 00	0	41. 01		
42. 00 43. 00	Divide line 41 by line 40 (if less than 10%, you do not qual Total Medicare ESRD inpatient days (see instructions)	irry for adjustment)	0.00		42. 00 43. 00		
44. 00	Ratio of average length of stay to one week (line 43 divided days)	d by line 41 divided by 7	0. 000000		44. 00		
45. 00	Average weekly cost for dialysis treatments (see instruction	ns)	0.00	0.00	45. 00		
46. 00	Total additional payment (line 45 times line 44 times line 4	41. 01)	0		46. 00 47. 00		
47. 00 48. 00							
40.00	only. (see instructions)	siliari i urar 1105pi tars			48. 00		
				Amount			
49. 00	Total payment for inpatient operating costs (see instruction	ne)		1. 00 15, 880, 093	49. 00		
50.00							
51. 00	0	51.00					
52. 00 53. 00	0 26, 096	52. 00 53. 00					
54. 00	592, 302	54. 00					
54. 01	0	54. 01					
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cost of physicians' services in a teaching hospital (see integration)			0	55.00		
56. 00 57. 00	0	56. 00 57. 00					
58. 00	7, 417						
59. 00	17, 482, 414	59. 00					
60. 00 61. 00	Primary payer payments Total amount payable for program beneficiaries (line 59 minu	us line (0)		0 17, 482, 414	60. 00 61. 00		
62. 00	Deductibles billed to program beneficiaries	us Title 60)		1, 360, 452			
63.00 Coinsurance billed to program beneficiaries					63.00		
64.00	Allowable bad debts (see instructions)			187, 966 122, 178			
	65.00 Adjusted reimbursable bad debts (see instructions) 66.00 Allowable bad debts for dual eligible beneficiaries (see instructions)						
	Subtotal (line 61 plus line 65 minus lines 62 and 63)	structions)		65, 362 16, 170, 189			
67.00							
69. 00			instructions)	0	70. 00 70. 50		
68. 00 69. 00 70. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demons	stration) adjustment (see					
68. 00 69. 00 70. 00 70. 50	Rural Community Hospital Demonstration Project (§410A Demons	, ,		0	70. 87		
68. 00 69. 00 70. 00 70. 50 70. 87 70. 88	Rural Community Hospital Demonstration Project (§410A Demons Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only)	n		0	70. 88		
68. 00 69. 00 70. 00 70. 50 70. 87 70. 88 70. 89	Rural Community Hospital Demonstration Project (§410A Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see ins	n		0	70. 88 70. 89		
68. 00 69. 00 70. 00 70. 50 70. 87 70. 88 70. 89 70. 90	Rural Community Hospital Demonstration Project (§410A Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instructions)	n			70. 88 70. 89 70. 90		
68. 00 69. 00 70. 00 70. 50 70. 87 70. 88 70. 89	Rural Community Hospital Demonstration Project (§410A Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see ins	n		0	70. 88 70. 89		
68. 00 69. 00 70. 00 70. 50 70. 87 70. 88 70. 89 70. 90 70. 91	Rural Community Hospital Demonstration Project (§410A 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)	n		0	70. 88 70. 89 70. 90 70. 91 70. 92		

Health Financial Systems	ASCENSION ST. VINCENT ANDERSON			In Lieu of Form CMS-2552-10			
CALCULATION OF REIMBURSEMENT SETTLEMENT	Pı	rovider CCN:	15-0088	Peri od: From 07/01/2021 To 06/30/2022	Worksheet E Part A Date/Time Prepared: 11/29/2022 8:09 am		
		Ti +Lo VI	/1.1.1	Hospi tal	DDC		

				rom 07/01/2021 o 06/30/2022	Part A Date/Time Pre 11/29/2022 8:	
		Title	xVIII	Hospi tal	PPS	
			FFY (уууу)	Amount	
)	1. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in the corresponding federal year for the period prior to 10/1)	column 0		0	0	70. 96
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in the corresponding federal year for the period ending on or afte			0	0	70. 97
70. 98	Low Volume Payment-3	,			0	70. 98
70. 99	HAC adjustment amount (see instructions)				0	70. 99
71. 00	Amount due provider (line 67 minus lines 68 plus/minus lines 69	& 70)			16, 170, 804	
71. 01	Sequestration adjustment (see instructions)				40, 427	
71. 02	Demonstration payment adjustment amount after sequestration				0	
71. 03 72. 00	Sequestration adjustment-PARHM pass-throughs Interim payments				15, 340, 197	71. 03 72. 00
72. 00	Interim payments Interim payments-PARHM				13, 340, 177	72. 00
73. 00	Tentative settlement (for contractor use only)				0	73. 00
73. 01	Tentative settlement-PARHM (for contractor use only)					73. 01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02,	72, and			790, 180	74. 00
	73)					
74. 01	Balance due provider/program-PARHM (see instructions)	415			250 011	74. 01
75. 00	Protested amounts (nonallowable cost report items) in accordance CMS Pub. 15-2, chapter 1, §115.2	e with			350, 911	75. 00
	TO BE COMPLETED BY CONTRACTOR (Lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of	2. 03			0	90.00
	plus 2.04 (see instructions)					
91. 00	Capital outlier from Wkst. L, Pt. I, line 2				0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instruc				0	92.00
93. 00	Capital outlier reconciliation adjustment amount (see instruction				0	93.00
94. 00 95. 00	The rate used to calculate the time value of money (see instructions) Time value of money for operating expenses (see instructions)	tions)			0.00	94. 00 95. 00
96. 00	Time value of money for capital related expenses (see instructions)	ons)			0	96.00
				Prior to 10/1	On/After 10/1	
				1. 00	2. 00	
	HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)			0	0	100. 00
101 00	HVBP Adjustment for HSP Bonus Payment			0.0000000000	0.000000000	101 00
	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions)			0.0000000000		101.00
102.00	HRR Adjustment for HSP Bonus Payment			ı		102.00
103.00	HRR adjustment factor (see instructions)			0.0000	0.0000	103. 00
	HRR adjustment amount for HSP bonus payment (see instructions)			0		104.00
	Rural Community Hospital Demonstration Project (§410A Demonstra	tion) Adju	stment			
200.00	Is this the first year of the current 5-year demonstration peri	od under t	he 21st			200. 00
	Century Cures Act? Enter "Y" for yes or "N" for no.					
201 00	Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line	10)				201. 00
	Medicare discharges (see instructions)	47)				202.00
	Case-mix adjustment factor (see instructions)					203. 00
	Computation of Demonstration Target Amount Limitation (N/A in fi	irst year	of the current	5-year demonst	ration	
	peri od)					
	Medicare target amount					204. 00
	Case-mix adjusted target amount (line 203 times line 204)					205. 00
	Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement					206. 00
	Program reimbursement under the §410A Demonstration (see instru	ctions)				207. 00
	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, I					208. 00
209.00	Adjustment to Medicare IPPS payments (see instructions)					209. 00
	Reserved for future use					210. 00
211.00 Total adjustment to Medicare IPPS payments (see instructions)					211. 00	
212.00	Comparision of PPS versus Cost Reimbursement	1)				212 00
	Total adjustment to Medicare Part A IPPS payments (from line 21 Low-volume adjustment (see instructions)	1)				212. 00 213. 00
	Net Medicare Part A IPPS adjustment (difference between PPS and	cost reim	bursement)			218. 00
2.30	(line 212 minus line 213) (see instructions)		··- <i>,</i>			

Provider CCN: 15-0088

Peri od:

From 07/01/2021

LOW VOLUME CALCULATION EXHIBIT 4

Part A Exhibit 4

Date/Time Prepared: 06/30/2022 11/29/2022 8:09 am Title XVIII Hospi tal Period Prior Total (Col 2 W/S E, Part A Amounts (from Pre/Post Peri od to 10/01 On/After 10/01 line Part A) Entitlement through 4) 0 1 00 2 00 3 00 4 00 5 00 1.00 DRG amounts other than outlier 1.00 1.00 1.01 DRG amounts other than outlier 1.01 2, 808, 431 2, 808, 431 2, 808, 431 1.01 payments for discharges occurring prior to October 1 1 02 8, 932, 787 DRG amounts other than outlier 1 02 8.932.787 8, 932, 787 1 02 payments for discharges occurring on or after October DRG for Federal specific 1.03 0 1.03 1.03 operating payment for Model 4 BPCI occurring prior to October 1 1.04 DRG for Federal specific 1.04 1.04 operating payment for Model 4 BPCI occurring on or after October 1 Outlier payments for 2.00 2.00 2 00 discharges (see instructions) 2.01 Outlier payments for 2.02 2.01 discharges for Model 4 BPCI Outlier payments for 189,008 189, 008 189,008 2.02 2.03 2.02 discharges occurring prior to October 1 (see instructions) 2.03 Outlier payments for 2.04 876, 838 876, 838 876, 838 2.03 discharges occurring on or after October 1 (see instructions) 3.00 3.00 Operating outlier 2.01 0 0 reconciliation 4.00 Managed care simulated 3.00 C 4.00 payments Indirect Medical Education Adjustment 5.00 Amount from Worksheet E, Part 21.00 0.000000 0.000000 0.000000 0.000000 5.00 A, line 21 (see instructions) 0 6.00 IME payment adjustment (see 22.00 0 C 0 6.00 instructions) 6.01 IME payment adjustment for 22.01 C 6. 01 managed care (see instructions) Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 7.00 IME payment adjustment factor 27.00 0.000000 0.000000 0.000000 0.000000 7.00 (see instructions) 8.00 IME adjustment (see 28.00 8.00 instructions) IME payment adjustment add on 8.01 28.01 0 8.01 for managed care (see instructions) 9.00 Total IME payment (sum of 29.00 9.00 C lines 6 and 8) Total IME payment for managed 9.01 29.01 9.01 care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment 10.00 Allowable disproportionate 33 00 0.2198 0.2198 0. 2198 0. 2198 10.00 share percentage (see instructions) Di sproporti onate share 11.00 34.00 645, 180 154, 323 490, 857 645, 180 11.00 adjustment (see instructions) 11. 01 Uncompensated care payments 36.00 2, 427, 849 321, 525 870, 488 1, 192, 013 11.01 Additional payment for high percentage of ESRD beneficiary discharges Total ESRD additional payment 12.00 46.00 0 12.00 C (see instructions) 13 00 47 00 15, 880, 093 3, 473, 287 15, 880, 093 Subtotal (see instructions) 12, 406, 806 13 00 Hospital specific payments 48.00 14.00 14.00 (completed by SCH and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient 15.00 49 00 15, 880, 093 3.473.287 12, 406, 806 15, 880, 093 15.00 operating costs (see instructions) Payment for inpatient program 50.00 976, 506 236, 701 739, 805 976, 506 16.00 capital (from Wkst. L, Pt. I, if applicable)

LOW VOLUME CALCULATION EXHIBIT 4 Provider CCN: 15-0088 Peri od: Worksheet E From 07/01/2021 Part A Exhibit 4
Date/Time Prepared: 06/30/2022 11/29/2022 8:09 am Title XVIII Hospi tal W/S E, Part A Amounts (from Pre/Post Period Prior Total (Col 2 Peri od to 10/01 Part A) On/After 10/01 line Entitlement through 4) 0 1 00 2 00 3 00 4.00 5 00 17.00 Special add-on payments for 54.00 592, 302 100, 920 491, 382 592, 302 17.00 new technologies 17.01 Net organ aquisition cost 17.01 17.02 Credits received from 68.00 17.02 0 0 0 manufacturers for replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation 93.00 0 0 18.00 adjustment amount (see instructions) 19.00 SUBTOTAL 3, 810, 908 13, 637, 993 17, 448, 901 19.00 W/S L, line (Amounts from 0 1.00 2.00 3.00 4. 00 5. 00 Capital DRG other than outlier 20.00 1.00 882, 187 215, 268 666, 919 882, 187 20.00 Model 4 BPCI Capital DRG other 20.01 1 01 20 01 than outlier 3, 415 21.00 Capital DRG outlier payments 2.00 20, 480 17,065 20, 480 21.00 Model 4 BPCI Capital DRG 21.01 2.01 21.01 outlier payments Indirect medical education 22 00 5.00 0.0000 0.0000 0.0000 0.0000 22.00 percentage (see instructions) 23.00 Indirect medical education 6.00 0 0 23.00 adjustment (see instructions) 24.00 Allowable disproportionate 10.00 0.0837 0.0837 0.0837 0.0837 24.00 share percentage (see instructions) 25.00 Di sproporti onate share 11.00 73.839 Ω 18, 018 55.821 73, 839 25.00 adjustment (see instructions) 26.00 Total prospective capital 12.00 976, 506 236, 701 739, 805 976, 506 26.00 payments (see instructions) W/S E, Part A (Amounts to E, line Part A) 5.00 1.00 2.00 3.00 4.00 0 27.00 Low volume adjustment factor 0.000000 0.000000 27.00 28.00 Low volume adjustment 70.96 28.00 (transfer amount to Wkst. E, Pt. A. line) Low volume adjustment 29.00 29.00 70.97 0 (transfer amount to Wkst. E, Pt. A, line)

100.00

100.00 Transfer low volume

adjustments to Wkst. E, Pt. A.

Provider CCN: 15-0088

Peri od:

From 07/01/2021 Part A Exhibit 5 Date/Time Prepared: 06/30/2022 11/29/2022 8:09 am Hospi tal Title XVIII Period to Total (cols. 2 Wkst. E, Pt. Amt. from Peri od on 10/01 A. line Wkst. E, Pt. after 10/01 and 3) A) 2.00 3. 00 0 4.00 1.00 1.00 DRG amounts other than outlier payments 1. 00 1. 00 DRG amounts other than outlier payments for 1.01 1.01 2, 808, 431 2, 808, 431 2, 808, 431 1.01 discharges occurring prior to October 1 1.02 DRG amounts other than outlier payments for 8, 932, 787 8, 932, 787 8, 932, 787 1.02 1.02 discharges occurring on or after October 1 1.03 DRG for Federal specific operating payment 1.03 C 1.03 0 for Model 4 BPCI occurring prior to October DRG for Federal specific operating payment 1.04 1.04 0 1.04 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 03 189 008 189 008 189 008 2 02 prior to October 1 (see instructions) Outlier payments for discharges occurring on 2.03 2.04 876, 838 876, 838 876, 838 2.03 or after October 1 (see instructions) 3.00 Operating outlier reconciliation 2.01 3.00 Managed care simulated payments 4.00 3.00 0 4.00 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) IME payment adjustment (see instructions) 6.00 22.00 0 0 6.00 0 IME payment adjustment for managed care (see 0 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 0 8.01 care (see instructions) Total IME payment (sum of lines 6 and 8) 29.00 9.00 C 0 9.00 Total IME payment for managed care (sum of 9.01 29.01 C 0 9.01 lines 6.01 and 8.01) Disproportionate Share Adjustment 10.00 Allowable disproportionate share percentage 33.00 0.2198 0.2198 0. 2198 10.00 (see instructions) 11.00 Disproportionate share adjustment (see 34.00 645, 180 154, 323 490.857 645, 180 11.00 instructions) 11.01 Uncompensated care payments 36, 00 2, 427, 849 466, 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 46. 00 12.00 instructions) 47.00 13 00 15, 880, 093 3, 618, 187 Subtotal (see instructions) 12, 261, 906 15, 880, 093 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 49.00 15, 880, 093 3, 618, 187 12, 261, 906 15, 880, 093 15.00 15.00 (see instructions) 16.00 50 00 976, 506 739 805 976, 506 16.00 Payment for inpatient program capital (from 236, 701 Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for new technologies 54.00 592, 302 100, 920 491, 382 592, 302 17.00 17.01 Net organ acquisition cost 17.01 Credits received from manufacturers for 68.00 0 17.02 17.02 0 0 replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment 93.00 C 18.00 0 amount (see instructions) 13, 493, 093 19.00 **SUBTOTAL** 3, 955, 808 17, 448, 901 19. 00

Health Financial Systems	ASCENSION ST. VINCENT ANDERSON	In Lieu of Form CMS-2552-10
HOODE TALL ADDITIONS OF THE PROPERTY OF THE	(UAO) DEDUCTION ON OUR ATION EVALUATE D	5

Heal th	Financial Systems AS	SCENSION ST. VI	NCENT ANDERSON		In Li€	eu of Form CMS-2	2552-10
HOSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provider Co		Period: From 07/01/2021 To 06/30/2022	Date/Time Pre 11/29/2022 8:	pared:
			Title	XVIII	Hospi tal	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	882, 187	215, 26	666, 919	882, 187	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0		0	0	20. 01
21.00	Capital DRG outlier payments	2. 00	20, 480	3, 41	17, 065	20, 480	21. 00
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0		0	0	21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0.0000	0.000	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. 0837	0. 083	0. 0837		24. 00
25. 00	Disproportionate share adjustment (see instructions)	11.00	73, 839	18, 01	55, 821	73, 839	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	976, 506	236, 70	739, 805	976, 506	26. 00
		Wkst. E, Pt. A, line	(Amt. from 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	4, 106	4, 10	06	4, 106	30.00
30. 01	HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0		0	0	30. 01
31.00	HRR adjustment (see instructions)	70. 94	-3, 491	-3, 49	21 0	-3, 491	31.00
31. 01	HRR adjustment for HSP bonus payment (see instructions)	70. 91	0	, ,,,,	o o	0	1
	ji nati deti ola)					(Amt. to Wkst.	
		0	1, 00	2.00	3. 00	E, Pt. A) 4.00	
32. 00	HAC Reduction Program adjustment (see	0 70. 99	1.00	2.00	0 0		32.00
100.00	instructions) Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100. 00

Health Financial Systems	ASCENSION ST. VINCE	NT ANDERSON	In Lieu of Form CMS-2552-10		
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 15-0088	Peri od: From 07/01/2021 To 06/30/2022	Worksheet E Part B Date/Time Prepared: 11/29/2022 8: 09 am	
		T: +1 - \/\/\	11! +-1	DDC	

				11/29/2022 8:	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)			4, 124	1.00
2.00	Medical and other services reimbursed under OPPS (see instructi	ons)		18, 906, 703	2. 00
3.00	OPPS payments			14, 406, 534	3. 00
4.00	Outlier payment (see instructions)			96, 096	4. 00
4. 01 5. 00	Outlier reconciliation amount (see instructions) Enter the hospital specific payment to cost ratio (see instruct	i one)		0. 000	4. 01 5. 00
6. 00	Line 2 times line 5	TOTIS)		0.000	6. 00
7. 00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7. 00
8.00	Transitional corridor payment (see instructions)			0	8. 00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV	, col. 13, line 200		47, 018	9. 00
10.00	Organ acquisitions			0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			4, 124	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges				
12. 00	Ancillary service charges			13, 631	12. 00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, lin	ie 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	,		13, 631	14. 00
	Customary charges				
15. 00	Aggregate amount actually collected from patients liable for pa			0	15. 00
16. 00	Amounts that would have been realized from patients liable for		a chargebasis	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)			13, 631	18.00
19. 00	Excess of customary charges over reasonable cost (complete only	if line 18 exceeds lin	e 11) (see	9, 507	19.00
	instructions)		, `		
20. 00	Excess of reasonable cost over customary charges (complete only	if line 11 exceeds lin	e 18) (see	0	20. 00
21 00	instructions)			4 104	21 00
21. 00 22. 00	Lesser of cost or charges (see instructions) Interns and residents (see instructions)			4, 124 0	21. 00 22. 00
23. 00	Cost of physicians' services in a teaching hospital (see instru	uctions)		0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			14, 549, 648	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25. 00	Deductibles and coinsurance amounts (for CAH, see instructions)			0	25. 00
26. 00	Deductibles and Coinsurance amounts relating to amount on line	•	'	2, 742, 784	26. 00
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plinstructions)	us the sum of lines 22	and 23] (see	11, 810, 988	27. 00
28. 00	Direct graduate medical education payments (from Wkst. E-4, lin	ne 50)		0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29. 00
30.00	Subtotal (sum of lines 27 through 29)			11, 810, 988	30.00
31. 00	Primary payer payments			1, 626	
32. 00	Subtotal (line 30 minus line 31)			11, 809, 362	32. 00
22.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	5)		0	22 00
33. 00 34. 00	Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions)			0 289, 670	33. 00 34. 00
35. 00	Adjusted reimbursable bad debts (see instructions)			188, 286	
36. 00	Allowable bad debts for dual eligible beneficiaries (see instru	ıctions)		114, 099	36. 00
37.00	Subtotal (see instructions)			11, 997, 648	37. 00
38. 00	MSP-LCC reconciliation amount from PS&R			-15	
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39. 00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)			0	39. 50
39. 97 39. 98	Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replace	nd devices (see instruct	i ons)	0	39. 97 39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	d devices (see mistract	10113)	0	39. 99
40. 00	Subtotal (see instructions)			11, 997, 663	40.00
40. 01	Sequestration adjustment (see instructions)			29, 994	40. 01
40. 02	Demonstration payment adjustment amount after sequestration			0	40. 02
40. 03	Sequestration adjustment-PARHM pass-throughs			40 440 477	40. 03
41. 00	Interim payments			12, 119, 166	
41. 01 42. 00	Interim payments-PARHM Tentative settlement (for contractors use only)			0	41. 01 42. 00
42. 00	Tentative settlement (for contractors use only)			U	42.00
43. 00	Balance due provider/program (see instructions)			-151, 497	43. 00
43. 01	Balance due provider/program-PARHM (see instructions)				43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2, c	hapter 1,	10, 000	44. 00
	§115. 2				
90. 00	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)			0	90.00
90.00	Outlier reconciliation adjustment amount (see instructions)			0	90.00
92. 00	The rate used to calculate the Time Value of Money			0.00	
93. 00	Time Value of Money (see instructions)			0	93. 00
94. 00	Total (sum of lines 91 and 93)			0	94. 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	Peri od:	Worksheet E	
			From 07/01/2021		
			To 06/30/2022	Date/Time Pre	epared:
				11/29/2022 8:	09 am
		Title XVIII	Hospi tal	PPS	
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days				C	200. 00

ANALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CO	<u> </u>	Period: From 07/01/2021 To 06/30/2022	11/29/2022 8: 0	pared: 09 am
			XVIII	Hospi tal	PPS	
		·	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4. 00	
1. 00 2. 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		15, 340, 19 (7	12, 119, 166 0	1. 00 2. 00
3. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3. 00
3. 01	ADJUSTMENTS TO PROVIDER			O	0	3. 01
3. 02				Ö	0	3. 02
3.03				O	0	3. 03
3.04				O	0	3.04
3.05			(0	0	3. 05
	Provider to Program					
3. 50	ADJUSTMENTS TO PROGRAM			O	0	3. 50
3. 51				O	0	3. 51
3. 52				O	0	3. 52
3. 53 3. 54)	0	3. 53 3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	0	3. 99
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)		15, 340, 19 ⁻	7	12, 119, 166	4. 00
	TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					5. 00
5. 01	TENTATI VE TO PROVI DER			O	0	5. 01
5. 02	TEMMINE TO THOUSER			Ö	0	5. 02
5. 03				Ö	0	5. 03
	Provider to Program					
5.50	TENTATI VE TO PROGRAM			C	0	5. 50
5. 51				O	0	5. 51
5. 52			(O	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			ט	0	5. 99
	5. 50-5. 98)					4 00
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		790, 180		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		, , , , , , ,	<u></u>	151, 497	6. 02
7. 00	Total Medicare program liability (see instructions)		16, 130, 37	7	11, 967, 669	7. 00
7.00	1.111			Contractor	NDD Dato	7.00

8. 00

NPR Date (Mo/Day/Yr)

2.00

Contractor

Number

1. 00

0

8.00 Name of Contractor

Component CCN: 15-T088

Subprovi der -Title XVIII

		Title	XVIII	Subprovi der - I RF	PPS	
		Inpatien	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4. 00	
1. 00 2. 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		1, 540, 270 0		0	1. 00 2. 00
3. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3. 00
3. 01	ADJUSTMENTS TO PROVIDER		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
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3.51			0		0	3. 51
3. 52			0		0	3. 52
3.53			0		0	3. 53
3.54			0		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3. 99
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) TO BE COMPLETED BY CONTRACTOR		1, 540, 270		0	4. 00
5. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					5. 00
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5. 02	TENTATIVE TO TROVIDER		Ö		0	5. 02
5. 03			Ö		Ö	5. 03
	Provider to Program			1		
5.50	TENTATI VE 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		14, 013		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		0		0	6. 02
7. 00	Total Medicare program liability (see instructions)		1, 554, 283		0	7. 00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		()	1. 00	2. 00	
8. 00	Name of Contractor					8. 00

Heal th	Financial Systems ASCENSION ST. VINCE	ENT ANDERSON	In Lie	u of Form CMS-	2552-10
	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-0088 Period: From 07/01/2021 To 06/30/2022				
		Title XVIII	Hospi tal	PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				1
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION	0.0.0	1.		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.				1.00
2. 00	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, and 8	8 through 12, and plus f	or cost		2. 00
2 00	reporting periods beginning on or after 10/01/2013, line 32)				3. 00
3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2					4. 00
4. 00	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines	i, and 8 through 12, and	prus for cost		4.00
5. 00	reporting periods beginning on or after 10/01/2013, line 32) Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5. 00
6. 00	Total hospital charity care charges from Wkst. S-10, col. 3 li	ino 20			6.00
7. 00	CAH only - The reasonable cost incurred for the purchase of co		Wkc+ \$ 2 D+ 1		7.00
7.00	line 168	ertiffed Hill technology	WKS1. 3-2, Pt. 1		7.00
8.00	Calculation of the HIT incentive payment (see instructions)				8. 00
9.00	Sequestration adjustment amount (see instructions)				9. 00
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH	,			1
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
	Other Adjustment (specify)				31.00
32. 00	Balance due provider (line 8 (or line 10) minus line 30 and li	ine 31) (see instruction	s)		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	Peri od:	Worksheet E-3
	Component CCN: 15-T088	From 07/01/2021 To 06/30/2022	
	Component Com 10 1000	10 00/00/2022	11/29/2022 8: 09 am
	Title XVIII	Subprovi der -	PPS
		IRF	

Medicare SSI ratio (IRF PPS only) (see instructions) 0.0198 2.00		I RF		
More Teacher PSP Represent (see instructions) 1,462,083 1,000 1,462,083			1 00	
1.00 Net Federal PPS Payment (see instructions) 1.462,083 1.00 1.00 Net Federal PPS Payments (see instructions) 1.00 0.0116 1.00 0.0116 1.00 0.0116 1.00 0.0116 1.00 0.0116 1.00 0.0116 1.00 0.0116 1.00 0.0116 1.00 0.0116 1.00 0.0116 1.00 0.0116 1.00 0.0116 1.00 0.00 1.00 0.00 1.00 0.00 1.00 0.00 1.00 0.00		PART III - MEDICARE PART A SERVICES - IRE PPS	1.00	
	1.00		1, 462, 083	1. 00
100, 100	2.00			2. 00
0.00 Outlier Payments 0 4.00 0.01 Outlier Payments 0 4.00 0.00 One Unweighted intern and resident FTE count for residents that were displaced by capture to November 15, 2004 (see instructions) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 <td< td=""><td>3.00</td><td></td><td>109, 802</td><td>3. 00</td></td<>	3.00		109, 802	3. 00
to November 15, 2004 (see instructions) 10 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)(1)(i)(f)(f)(f) or (2) (see instructions) 10 New Teaching program adjustment. (see instructions) 10 Current year's unweighted FTE count of 18R excluding FTEs in the new program growth period of a "new teaching program" (see instructions) 10 Current year's unweighted IRE Count for residents within the new program growth period of a "new teaching program" (see instructions) 10 Current year's unweighted IRE Count for residents within the new program growth period of a "new teaching program" (see instructions) 10 Intern and resident count for IRP PS medical education adjustment (see instructions) 10 Teaching Adjustment Factor (see instructions) 10 Teaching Adjustment Factor (see instructions) 11 Total PSP Reyment (see instructions) 11 Total PSP Reyment (see instructions) 11 Total PSP Reyment (see instructions) 12 Total PSP Reyment (see instructions) 13 Total PSP Reyment (see instructions) 14 Total PSP Reyment (see instructions) 15 Total PSP Reyment (see instructions) 15 Total PSP Reyment (see instructions) 16 Total PSP Reyment (see instructions) 17 Total PSP Reyment (see instructions) 18 Total PSP Reyment (see instructions) 19 Total PSP Reyment (see instructions) 10 Total PSP Reyment (see instructions) 10 Total PSP Reyment (see instructions) 11 Total PSP Reyment (see instructions) 12 Total Reyment (see instructions) 13 Total PSP Reyment (see instructions) 14 Total Reyment (see instructions) 15 Total PSP Reyment (see instructions) 15 Total PSP Reyment (see instructions) 16 Total Reyment (see instructions) 17 Total Reyment (see instructions) 18 Total Reyment (see instructions) 18 Total Reyment (see instructions) 19 Total Reyment (see instructions) 19 Total Reyment (see instructions) 10 Total Reyment (see instructions) 10 Tota	4.00			4. 00
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)	5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior	0.00	5. 00
New Teaching program adjustment. (see instructions) 0.00 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	0.00	5. 01
Current year's unweighted FTE count of 1&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions) 0.00	6.00		0.00	6. 00
Current year's unweighted IAR FTE count for residents within the new program growth period of a "new teaching program" (see instructions) 0.00 8.00	7. 00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new	0.00	7. 00
Intern and resident count for IRF PPS medical education adjustment (see instructions) 0.00 9.00	8. 00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new	0.00	8. 00
10.00 Average Dail ty Census (see instructions) 6.084922 10.00 11.00 Teaching AdJustment Factor (see instructions) 0.000000 11.00 12.00 Teaching AdJustment (see instructions) 0.12.00 12.00	9 00		0.00	9 00
11.00 Teaching Adjustment Factor (see instructions) 0.000000 1.00 1.00 1.2				
1, 571, 885 13, 00 10, 140 10, 150 1	12. 00		1	12. 00
14.00 Nursing and Allied Health Managed Care payments (see instruction) 14.00 15.00 0rgan acquisition (Do NOT use THIS LINE) 15.00 0rgan acquisition (Do NOT use THIS LINE) 15.00 16.00 16.00 16.00 16.00 17.00 15.00 16.00 16.00 17				
15.00 organ acquisition (D0 NOT USE THIS LINE) 15.00 0.00				
16.00 Cost of physicians' services in a teaching hospital (see instructions) 0 16.00				
1,501, 885 17,00 1,571, 885 17,00 1,00			0	
1. 202 18. 00 Primary payer payments 1. 202 18. 00 Subtotal (line 17 less line 18).				
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79.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020. 0.000000 99.00	53. 00			53. 00
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19.01 Calculated leaching Adjustment Factor for the current year. (see instructions) 0.000000 99.01				
	99. 01	Calculated leaching Adjustment Factor for the current year. (see instructions)	0.000000	99. 01

Health Financial Systems	ASCENSION ST. VIN	ICENT ANDERSON	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0088	From 07/01/2021	Worksheet E-3 Part VII Date/Time Prepared:

			To 06/30/2022	Date/Time Pre 11/29/2022 8:	pared: 09 am
		Title XIX	Hospi tal	Cost	
			Inpati ent	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVI	CES FOR TITLES V OR XI	X SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		4, 047, 626		1.00
2.00	Medical and other services			1, 446, 284	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3. 00
4.00	Subtotal (sum of lines 1, 2 and 3)		4, 047, 626	1, 446, 284	4. 00
5.00	Inpatient primary payer payments		0		5. 00
6.00	Outpatient primary payer payments			0	6. 00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		4, 047, 626	1, 446, 284	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges				
8.00	Routine service charges		10, 846, 386		8. 00
9.00	Ancillary service charges		8, 696, 816	7, 964, 642	1
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		10 540 000	7.0/4./40	11.00
12. 00	Total reasonable charges (sum of lines 8 through 11)		19, 543, 202	7, 964, 642	12. 00
13. 00	CUSTOMARY CHARGES	norui occ. on o chorac		0	1 12 00
13.00	Amount actually collected from patients liable for payment for s	services on a charge	0	Ü	13. 00
14. 00	Amounts that would have been realized from patients liable for ;	navment for services on	0	0	14. 00
14.00	a charge basis had such payment been made in accordance with 42		U U	Ü	14.00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	OTR 3410. 10(C)	0. 000000	0. 000000	15. 00
16. 00	Total customary charges (see instructions)		19, 543, 202	7, 964, 642	1
17. 00	Excess of customary charges over reasonable cost (complete only	if line 16 exceeds	15, 495, 576	6, 518, 358	l
	line 4) (see instructions)			-, -, -, -, -	
18.00	Excess of reasonable cost over customary charges (complete only	if line 4 exceeds line	0	0	18. 00
	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 instruc	ctions)	0	0	20. 00
21. 00	Cost of covered services (enter the lesser of line 4 or line 16)		4, 047, 626	1, 446, 284	21. 00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be co	ompleted for PPS provid	ers.		
22. 00	Other than outlier payments		0	0	
	Outlier payments		0	0	
24. 00	Program capital payments		0		24. 00
	Capital exception payments (see instructions)		0	_	25. 00
	Routine and Ancillary service other pass through costs		0	0	
	Subtotal (sum of lines 22 through 26)		0	0	
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)		4, 047, 626	1, 446, 284	29. 00
20.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	30.00
30.00	Excess of reasonable cost (from line 18)		9	-	
32. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) Deductibles		4, 047, 626	1, 446, 284 0	
33. 00	Coinsurance		0	0	02.00
	Allowable bad debts (see instructions)		0	0	34. 00
35. 00	Utilization review		0	O	35. 00
36. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 3	33)	4, 047, 626	1, 446, 284	
37. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	30)	1, 017, 020	1, 110, 201	37. 00
38. 00			4, 047, 626	1, 446, 284	•
	Direct graduate medical education payments (from Wkst. E-4)		0	.,	39.00
40. 00	Total amount payable to the provider (sum of lines 38 and 39)		4, 047, 626	1, 446, 284	
41. 00	Interim payments		4, 047, 626	1, 446, 284	•
42. 00	Balance due provider/program (line 40 minus line 41)		0	0	1
43. 00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub 15-2,	Ö	0	1
	chapter 1, §115.2	,			
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Health Financial Systems	ASCENSION ST. VINC	CENT ANDERSON	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0088	Period: From 07/01/2021	Worksheet E-3
		Component CCN: 15-T088		Date/Time Prepared: 11/29/2022 8:09 am
		Title XIX	Subprovi der -	Cost

		II tie xix	I RF	COST	
			Inpati ent	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICE	S FOR TITLES V OR XIX		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES	3 TOK 11 TEE3 V OK XIT	OERVI OEO		
1.00	Inpatient hospital/SNF/NF services		144, 409		1.00
2. 00	Medical and other services		111, 107	0	
3. 00	Organ acquisition (certified transplant centers only)		0	Ü	3.00
4. 00	Subtotal (sum of lines 1, 2 and 3)		144, 409	0	4. 00
5. 00	Inpatient primary payer payments		0	ŭ	5. 00
6.00	Outpatient primary payer payments			0	6.00
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		144, 409	0	
7.00	COMPUTATION OF LESSER OF COST OR CHARGES		1117 107		,
	Reasonable Charges				İ
8.00	Routine service charges		702, 264		8.00
9. 00	Ancillary service charges		122, 877	0	
10.00	Organ acquisition charges, net of revenue		0	_	10.00
11. 00	Incentive from target amount computation		0		11.00
12. 00	Total reasonable charges (sum of lines 8 through 11)		825, 141	0	1
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for ser	vices on a charge	0	0	13.00
	basis	3.			
14.00	Amounts that would have been realized from patients liable for pay	ment for services on	0	0	14. 00
	a charge basis had such payment been made in accordance with 42 CF	R §413.13(e)			
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15. 00
16.00	Total customary charges (see instructions)		825, 141	0	16. 00
17.00	Excess of customary charges over reasonable cost (complete only if	line 16 exceeds	680, 732	0	17. 00
	line 4) (see instructions)				
18.00	Excess of reasonable cost over customary charges (complete only if	Fline 4 exceeds line	0	0	18. 00
	16) (see instructions)				
19. 00	Interns and Residents (see instructions)		0	0	
20.00	Cost of physicians' services in a teaching hospital (see instructi	ons)	0	0	
21. 00	Cost of covered services (enter the lesser of line 4 or line 16)		144, 409	0	21. 00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be comp	leted for PPS provide			
	Other than outlier payments		0	0	
23. 00	Outlier payments		0	0	23. 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	
27. 00	Subtotal (sum of lines 22 through 26)		0	0	
28. 00	Customary charges (title V or XIX PPS covered services only)		o _l	0	1
29. 00	Titles V or XIX (sum of lines 21 and 27)		144, 409	0	29. 00
20.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	20.00
30.00	Excess of reasonable cost (from line 18)		o o	-	
31. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		144, 409	0	31.00
32. 00	Deductibles				
33. 00	Coinsurance		0	0	33. 00 34. 00
35. 00	Allowable bad debts (see instructions) Utilization review		0	U	35.00
36. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		144, 409	0	1
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		144, 409	0	
	Subtotal (line 36 ± line 37)		144, 409	0	38.00
	Direct graduate medical education payments (from Wkst. E-4)		144, 409	Ü	39.00
40. 00	Total amount payable to the provider (sum of lines 38 and 39)		144, 409	0	40.00
41. 00			144, 409	0	41.00
42. 00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43. 00	Protested amounts (nonallowable cost report items) in accordance w	vith CMS Pub 15-2		0	43. 00
10.00	chapter 1, §115. 2	SMO 1 GD 10 2,		O	10.00
	1		1		'

	Financial Systems ASCENSION ST. VINCE		CN: 1E 0000		u of Form CMS-2	
	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT L EDUCATION COSTS	Provider CO		Peri od: From 07/01/2021	Worksheet E-4	
	2 2553/11/61/ 65516			To 06/30/2022	Date/Time Prep 11/29/2022 8:0	
		Title	XVIII	Hospi tal	PPS	07 diii
					1. 00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT				1.00	
1. 00	Unweighted resident FTE count for allopathic and osteopathic p	programs for	cost reporti	ng periods	0. 00	1.00
2. 00	ending on or before December 31, 1996. Unweighted FTE resident cap add-on for new programs per 42 CFR	R 413.79(e)(1) (see instr	uctions)	0. 00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA		0.440 70 ()		0.00	
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
1. 00	Adjustment (plus or minus) to the FTE cap for allopathic and c		programs due	to a Medicare	0. 00	4.00
4. 01	GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f)) ACA Section 5503 increase to the Direct GME FTE Cap (see instr		cost reporti	na periods	0.00	4. 01
	straddling 7/1/2011)		·	0.		
4. 02	ACA Section 5506 number of additional direct GME FTE cap slots periods straddling 7/1/2011)	s (see inst	ructions for	cost reporting	0. 00	4. 02
5. 00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plu	us or minus	line 4 plus l	ines 4.01 and	0. 00	5. 00
4 00	4.02 plus applicable subscripts .00 Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your			woor from your	0.00	6. 00
3. 00	records (see instructions)	or ogranis Tor	the current	year from your	0.00	0.00
7. 00	Enter the lesser of line 5 or line 6		D!	0+1	0.00	7. 00
			Primary Care 1.00	0ther 2.00	Total 3.00	
8. 00	Weighted FTE count for physicians in an allopathic and osteopa	athi c	0.0		0.00	8. 00
9. 00	program for the current year. If line 6 is less than 5 enter the amount from line 8, otherwi	se	0. 0	0.00	0. 00	9.00
	multiply line 8 times the result of line 5 divided by the amou					
0. 00	6. Weighted dental and podiatric resident FTE count for the curre	ent vear		0.00		10.00
10. 01	Unweighted dental and podiatric resident FTE count for the cur			0.00		10. 01
11. 00 12. 00	Total weighted FTE count Total weighted resident FTE count for the prior cost reporting	a voar (soo	0. 0 0. 0			11. 00 12. 00
12.00	instructions)	year (see	0.0	0.00		12.00
13. 00	Total weighted resident FTE count for the penultimate cost represent (see instructions)	oorti ng	0. 0	0.00		13.00
14. 00	Rolling average FTE count (sum of lines 11 through 13 divided	by 3).	0.0	0.00		14.00
15.00	Adjustment for residents in initial years of new programs		0.0			15.00
15. 01 16. 00	Unweighted adjustment for residents in initial years of new pr Adjustment for residents displaced by program or hospital clos		0. 0 0. 0			15. 0° 16. 00
16. 01	Unweighted adjustment for residents displaced by program or ho		0. 0			16. 01
17. 00	closure Adjusted rolling average FTE count		0. 0	0.00		17. 00
	Per resident amount		0. 0			18. 00
19. 00	Approved amount for resident costs			0 0	0	19. 00
					1. 00	
20. 00	Additional unweighted allopathic and osteopathic direct GME FT	ΓE resident	cap slots rec	eived under 42	0. 00	20. 00
21. 00	Sec. 413.79(c)(4) Direct GME FTE unweighted resident count over cap (see instruc	ctions)			0. 00	21. 00
22. 00	Allowable additional direct GME FTE Resident Count (see instru	uctions)			0.00	22. 00
23. 00	Enter the locality adjustment national average per resident am Multiply line 22 time line 23	mount (see i	nstructi ons)		0. 00 0	23. 00 24. 00
	Total direct GME amount (sum of lines 19 and 24)				0	
			Inpatient Par	t Managed Care	Total	
			1. 00	2. 00	3. 00	
2/ 22	COMPUTATION OF PROGRAM PATIENT LOAD	/ 1:	7	4 7		2/ 65
26. 00	Inpatient Days (see instructions) (Title XIX - see S-2 Part IX 3.02, column 2)	k, line	7, 75	7, 641		26. 00
27. 00	Total Inpatient Days (see instructions)		30, 21			27. 00
28. 00 29. 00	Ratio of inpatient days to total inpatient days Program direct GME amount		0. 25663	0. 252896	0	28. 00 29. 00
29. 00 29. 01	Percent reduction for MA DGME					29. 00
	Reduction for direct GME payments for Medicare Advantage Net Program direct GME amount			0	0	30. 00 31. 00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS	Provider CCN: 15-0088	From 07/01/2021 To 06/30/2022	11/29/2022 8:	pared:
	Title XVIII	Hospi tal	PPS	
			1. 00	
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLEDUCATION COSTS)	LE XVIII ONLY (NURSING	PROGRAM AND PARAMED		
32.00 Renal dialysis direct medical education costs (from Wkst. B, and 94)			-	32. 00
33.00 Renal dialysis and home dialysis total charges (Wkst. C, Pt.		es 74 and 94)	0	
34.00 Ratio of direct medical education costs to total charges (lin	ne 32 ÷ line 33)		0. 000000 0	
35.00 Medicare outpatient ESRD charges (see instructions)				
36.00 Medicare outpatient ESRD direct medical education costs (line APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII			0	36. 00
Part A Reasonable Cost	I ONLY			1
37. 00 Reasonable cost (see instructions)			24, 526, 250	37 00
38.00 Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69))		24, 320, 230	1
39.00 Cost of physicians' services in a teaching hospital (see ins			0	
40.00 Primary payer payments (see instructions)	,		1, 202	1
41.00 Total Part A reasonable cost (sum of lines 37 through 39 minu	us line 40)		24, 525, 048	41.00
Part B Reasonable Cost	·			
42.00 Reasonable cost (see instructions)			18, 957, 845	42. 00
43.00 Primary payer payments (see instructions)			1, 626	1
44.00 Total Part B reasonable cost (line 42 minus line 43)			18, 956, 219	
45.00 Total reasonable cost (sum of lines 41 and 44)	44 11 45		43, 481, 267	
46.00 Ratio of Part A reasonable cost to total reasonable cost (li			0. 564037	
47.00 Ratio of Part B reasonable cost to total reasonable cost (lii ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PA			0. 435963	47. 00
48.00 Total program GME payment (line 31)	AKI D		0	48. 00
49.00 Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		-	49.00
50.00 Part B Medicare GME payment (line 47 x 48) (title XVIII only)	, ,			50.00
oo. oo itali b modrodro ome paymore (11110-17-x-10) (erere xviii) only,	Y/N Primary (Care Other	Total	00.00
	0 1.00	2.00	3. 00	
E-4 Calculation - In accordance with the FY 2023 IPPS Final F	Rul e.			
109.00 Enter in column 0, "Y" or "N" to calculate line 9 in accordance the Federal Fiscal Year 2023 Final Rule for cost reporting periods beginning prior to 10/1/2021. (see instructions)	N	0.00	0. 00	109. 00
If line 109 column 0 is Y, you MUST open up the PY and Penultimate			"Y" and cal cul	ate,
then input amounts from line 11 columns 1 & 2 to the CY lines 12 &	13 columns 1 & 2 respec			
122.00 Override of line 22 for cost reporting periods beginning		0. 00		122. 00

Health Financial Systems

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

Provider CCN: 15-0088

Peri od: From 07/01/2021 To 06/30/2022 Worksheet G Date/Time Prepared: 11/29/2022 8:09 am

CIRRENT ASSTTS	oni y)					11/29/2022 8:	09 am
Cash on hard in banks			General Fund		Endowment Fund		
Cash on hand in banks			1.00		3. 00	4.00	
Temporary Investments			I			_	
Notes received 0 0 0 0 0 0 0 0 0			13, 689		0	•	1
4.00		'	0				
Online Company Compa			69 886 872	1	1		
All lowances for uncollectible notes and accounts receivable 4,3,570,621 0 0 0 0 0 0 0 0 0					o o		
Proposid Expenses 0	6.00	Allowances for uncollectible notes and accounts receivable			0	0	6.00
9.00 0 ther current assets 1, 703,594 0 0 0 9.00 10.00			4, 263, 464	. (0		
10.00 Due From other Funds			0)	0	l .	
11.00 Company 12.00 Co			1, 703, 599		0		
FixED_ASSETS			22 000 440	1	-	•	1
12.00 Land improvements	11.00		32, 700, 447		<u> </u>	0	11.00
13.00 Land improvements	12. 00		5, 292, 602	2	0	0	12. 00
15.00 Buildings	13.00	Land improvements	2, 926, 142	2	0	0	13. 00
16.00 Accumul ated depreciation 0 0 0 16.00			0		0	l	1
17.00 Leasehold Improvements			111, 552, 556	1	-		
18.00 Accumul ated depreciation 0 0 0 18.00 19.00 Flaved equipment 0 0 0 0 19.00 1			0	1	-	•	
19.00 Fixed equipment		1	0				
20.00 Accumul ated depreciation 0 0 0 0 20.00		•				l .	
22.00 Accumul ated depreciation 0 0 0 22.00			0		o o	l	
23.00 Waj or movable equipment 62, 828, 972 0 0 23.00	21.00	Automobiles and trucks	0		0	0	21.00
24.00 Accumulated depreciation		•	0	1	0		
25.00 Minor equipment depreciable 0 0 0 25.00		1 3		1	0	•	
26.00 Accumulated depreciation 7.00 HT designated Assets 8.00 0 0 0 0 0 27.00 8.00 Accumulated despreciation 9.00 0 0 0 0 0 0 0 0 27.00 8.00 Accumulated despreciation 9.00 0 0 0 0 0 0 0 0 0 28.00 9.00 Minor equipment-nondepreciable 9.00 Minor equipment-nondepreciable 9.00 Minor equipment-nondepreciable 9.00 Minor equipment-nondepreciable 9.01 Total fixed assets (sum of lines 12-29) 9.02 Minor equipment-nondepreciable 9.01 Minor equipment-nondepreciable 9.01 Minor equipment-nondepreciable 9.02 Minor equipment-nondepreciable 9.02 Minor equipment-nondepreciable 9.03 No.00 THER ASSETS 9.00 No.00 N		•	-128, 274, 381		0		
27.00 HIT designated Assets 0 0 0 0 27.00			0				
28. 00		•					
29.00 Minor equipment-nondepreciable 0 0 0 0 0 0 0 0 0						•	
OTHER ASSETS Investments 0 0 0 0 0 0 0 0 0		·	0		0	•	
31.00 Investments	30.00		54, 325, 891	(0	0	30. 00
32.00 Deposits on Leases			_			_	
33.00 Due from owners/officers			0				
34.00 Other assets 1,459,289 0 0 0 34.00		1 .	0	1	-		
35.00 Total other assets (sum of lines 31-34) 1,459,289 0 0 0 0 35.00			1 459 289	1	1	1	1
Total assets (sum of lines 11, 30, and 35) 88,773,629 0 0 0 36.00					o o	1	
37. 00 Accounts payable	36.00	1		1	0	0	36. 00
38.00 Salaries, wages, and fees payable							
39.00 Payroll taxes payable 0 0 0 0 39.00							
40.00 Notes and I oans payable (short term) 217,695 0 0 0 40.00			5, 5/1, 348	1	-		
Accel erated payments			217 695	1		•	1
42.00 Accelerated payments 0 0 0 0 0 0 0 0 0			217,079				
44.00 Other current liabilities 38,828,175 0 0 0 44.00 45.00 Total current liabilities (sum of lines 37 thru 44) 49,793,918 0 0 0 45.00 46.00 Mortgage payable 13,459,249 0 0 0 0 47.00 48.00 Unsecured loans 0 0 0 0 48.00 49.00 Other long term liabilities 614,054 0 0 0 49.00 50.00 Total long term liabilities (sum of lines 46 thru 49) 14,073,303 0 0 0 50.00 50.00 51.00 Total liabilities (sum of lines 45 and 50) 63,867,221 0 0 51.00 51.00 51.00 52.00 52.00 52.00 52.00 52.00 53.00 52.00 52.00 53.00 52.00 53.00 50.00 53.00 52.00 53.00 52.00 53.00 53.00 52.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 55.0			0			_	
45.00	43.00	Due to other funds	0) (0	0	43. 00
LONG TERM LIABILITIES				•	-		
46.00 Mortgage payable	45. 00		49, 793, 918	3 (0	0	45. 00
47.00 Notes payable 0 0 0 0 0 47.00 48.00 Unsecured loans 0 0 0 0 0 0 48.00 49.00 Other long term liabilities (sum of lines 46 thru 49) 14,073,303 0 0 0 0 50.00 50.00 Total liabilities (sum of lines 45 and 50) 63,867,221 0 0 0 55.00 CAPITAL ACCOUNTS 52.00 General fund balance Specific purpose fund 0 53.00 54.00 Donor created - endowment fund balance - restricted 0 55.00 Donor created - endowment fund balance 0 55.00 Governing body created - endowment fund balance 0 55.00 Plant fund balance - invested in plant 0 57.00 Figure 1 on 1 on 1 on 1 on 1 on 1 on 1 on 1 o	44 00		12 450 240				14 00
48.00 Unsecured Loans 0 0 0 0 0 0 48.00 49.00 Other Long term Liabilities 50.00 Total Long term Liabilities (sum of Lines 46 thru 49) 14,073,303 0 0 0 0 50.00 51.00 CAPITAL ACCOUNTS 52.00 General fund balance 53.00 Specific purpose fund 54.00 Donor created - endowment fund balance - restricted 55.00 Donor created - endowment fund balance - unrestricted 56.00 Governing body created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total Liabilities and fund balances (sum of Lines 51 and 88,773,629 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			13, 439, 249	1	٦		
49.00 Other long term liabilities		1 . 3		1		l .	1
51.00 Total liabilities (sum of lines 45 and 50) 63,867,221 0 0 0 0 51.00 CAPITAL ACCOUNTS 52.00 General fund balance 24,906,408 0 53.00 Specific purpose fund 0 54.00 Donor created - endowment fund balance - restricted 0 0 55.00 Donor created - endowment fund balance - unrestricted 0 0 55.00 Governing body created - endowment fund balance 0 0 56.00 Flant fund balance - invested in plant 0 57.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 0 Total fund balances (sum of lines 52 thru 58) 24,906,408 0 0 0 59.00 60.00 Total liabilities and fund balances (sum of lines 51 and 88,773,629 0 0 0 0 60.00			614, 054			•	
CAPITAL ACCOUNTS 52. 00 General fund bal ance 24,906,408 52.00 53. 00 Specific purpose fund 0 53.00 54. 00 Donor created - endowment fund bal ance - restricted 0 54.00 55. 00 Donor created - endowment fund bal ance - unrestricted 0 55.00 60. 00 Governing body created - endowment fund bal ance 0 56.00 57. 00 Plant fund bal ance - invested in plant 0 57.00 58. 00 Plant fund bal ance - reserve for plant improvement, replacement, and expansion 0 58.00 59. 00 Total fund bal ances (sum of lines 52 thru 58) 24,906,408 0 0 0 59.00 60. 00 Total liabilities and fund bal ances (sum of lines 51 and 88,773,629 0 0 0 60.00	50.00	Total long term liabilities (sum of lines 46 thru 49)	14, 073, 303	(0	0	50. 00
53.00 Specific purpose fund 54.00 Donor created - endowment fund balance - restricted 55.00 Donor created - endowment fund balance - unrestricted 56.00 Governing body created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 20 53.00 54.00 55.00 56.00 56.00 56.00 56.00 56.00 57.00 58.00 57.00 58.00 57.00 58.00 57.00 58.00 59	51. 00		63, 867, 221	(0	0	51.00
54.00 Donor created - endowment fund balance - restricted 55.00 Donor created - endowment fund balance - unrestricted 56.00 Governing body created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 24,906,408 88,773,629 0 54.00 55.00 56.00 57.00 58.00 59.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			24, 906, 408				1
55.00 Donor created - endowment fund balance - unrestricted Governing body created - endowment fund balance Flant fund balance - invested in plant Flant fund balance - reserve for plant improvement, replacement, and expansion For total fund balances (sum of lines 52 thru 58) Total liabilities and fund balances (sum of lines 51 and 24,906,408 88,773,629 55.00 56.00 56.00 57.00 58.00 59.00 59.00 59.00 59.00		1) _		1
56.00 Governing body created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 24,906,408 88,773,629 0 56.00 57.00 58.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				1	0		
57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 88,773,629 0 0 0 60.00					0		1
58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 88,773,629 0 0 0 0 60.00						_	
replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 88,773,629 0 0 0 60.00		· ·		1			
60.00 Total liabilities and fund balances (sum of lines 51 and 88,773,629 0 0 0 60.00		repl acement, and expansion					
					0		1
	60. 00		88, 773, 629	ď	0	0	60.00
		(⁴ ⁰)	I	I	1	I	I

18.00

19.00

0

0

STATEMENT OF CHANGES IN FUND BALANCES Provider CCN: 15-0088 Peri od: Worksheet G-1 From 07/01/2021 06/30/2022 Date/Time Prepared: 11/29/2022 8:09 am General Fund Special Purpose Fund Endowment Fund 1.00 3.00 4. 00 5. 00 2 00 1.00 Fund balances at beginning of period 19, 382, 754 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 29) 11, 476, 955 2.00 30, 859, 709 3.00 Total (sum of line 1 and line 2) 0 3.00 4.00 0 Additions (credit adjustments) (specify) 0 4.00 00000 5.00 0 5.00 6.00 6.00 0 7.00 0 7.00 0 8.00 0 8.00 0 9.00 0 9.00 10.00 Total additions (sum of line 4-9) 10.00 Subtotal (line 3 plus line 10) 30, 859, 709 0 11.00 11.00 12.00 Deductions (debit adjustments) (specify) 0 12.00 13.00 MI SCELLANEOUS 5, 953, 301 13.00 0 14.00 0 0 14.00 0 15.00 0 15.00 16.00 0 0 16.00 17.00 0 17.00 5, 953, 301 18.00 Total deductions (sum of lines 12-17) 18.00 Fund balance at end of period per balance 19.00 24, 906, 408 19.00 sheet (line 11 minus line 18) Endowment Fund Plant Fund 7. 00 8.00 6. 00 1.00 Fund balances at beginning of period 0 0 1.00 Net income (loss) (from Wkst. G-3, line 29) 2.00 2.00 Total (sum of line 1 and line 2) 3.00 0 0 3.00 4.00 Additions (credit adjustments) (specify) 4.00 5.00 0 5.00 0 6.00 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 10.00 0 11.00 11.00 Subtotal (line 3 plus line 10) 0 12.00 Deductions (debit adjustments) (specify) 12.00 MI SCELLANEOUS 13.00 13.00 14.00 0 14.00 0 15.00 15.00 16.00 16.00 17.00 17.00

0

18.00

19.00

Total deductions (sum of lines 12-17)

sheet (line 11 minus line 18)

Fund balance at end of period per balance

Health Financial Systems ASCI STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provi der CCN: 15-0088

		7	o 06/30/2022	Date/Time Pre 11/29/2022 8:	
	Cost Center Description	Inpati ent	Outpati ent	Total	, u
		1, 00	2, 00	3. 00	
	PART I - PATIENT REVENUES	<u> </u>			
	General Inpatient Routine Services				
1.00	Hospi tal	54, 816, 614	ļ.	54, 816, 614	1.00
2.00	SUBPROVI DER - I PF				2.00
3.00	SUBPROVI DER - I RF	3, 945, 532	2	3, 945, 532	3.00
4.00	SUBPROVI DER				4.00
5.00	Swing bed - SNF			0	5. 00
6.00	Swing bed - NF			0	6.00
7.00	SKILLED NURSING FACILITY				7. 00
8.00	NURSING FACILITY				8. 00
9.00	OTHER LONG TERM CARE				9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	58, 762, 146	b	58, 762, 146	10.00
	Intensive Care Type Inpatient Hospital Services				
11. 00	INTENSIVE CARE UNIT	23, 292, 102	2	23, 292, 102	11. 00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15. 00	OTHER SPECIAL CARE (SPECIFY)				15. 00
16. 00	Total intensive care type inpatient hospital services (sum of li	nes 23, 292, 102	2	23, 292, 102	16. 00
	11-15)				
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	82, 054, 248		82, 054, 248	17. 00
18. 00	Ancillary services	177, 197, 954		577, 287, 509	18. 00
19. 00	Outpati ent servi ces		,,	58, 476, 943	
20. 00	RURAL HEALTH CLINIC		-	0	20. 00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	21. 00
22. 00	HOME HEALTH AGENCY				22. 00
23. 00	AMBULANCE SERVICES		이	0	23. 00
24. 00	CMHC				24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00
26. 00	HOSPI CE				26. 00
27. 00	OTHER (SPECIFY)		0	0	27. 00
27. 01	OTHER (SPECIFY)		0	0	27. 01
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to) Wkst. 259, 252, 202	458, 566, 498	717, 818, 700	28. 00
	G-3, line 1) PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		192, 399, 858		29. 00
30. 00	ADD (SPECIFY)				30. 00
31. 00	ADD (SI EGITT)				31. 00
32. 00					32. 00
33. 00					33. 00
34. 00					34. 00
35. 00					35. 00
36. 00	Total additions (sum of lines 30-35)	\	ĺ d		36. 00
37. 00	DEDUCT (SPECIFY)		J		37. 00
38. 00	DEBOOT (SEESTED)		á		38. 00
39. 00					39. 00
40. 00			á		40. 00
41. 00					41. 00
42. 00	Total deductions (sum of lines 37-41)		ا		42. 00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)	(transfer	192, 399, 858		43. 00
	to Wkst. G-3, line 4)		,,		
		•			•

Health Financial Systems	ASCENSION ST. VINCENT ANDERSON	In Lieu of Form CMS-2552-10
STATEMENT OF REVENUES AND EXPENSES	Provi der CCN: 15-0088	Period: Worksheet G-3

Heal th	Financial Systems ASCENSION ST. VIN	CENT ANDERSON	In Lie	u of Form CMS-2	2552-10
	IENT OF REVENUES AND EXPENSES	Provider CCN: 15-0088	Peri od:	Worksheet G-3	
			From 07/01/2021		
			To 06/30/2022		
				11/29/2022 8:)9 am
				1. 00	
1. 00	Total patient revenues (from Wkst. G-2, Part I, column 3, Ii	no 30)		717, 818, 700	1. 00
2. 00	Less contractual allowances and discounts on patients' accou	•		517, 988, 087	2. 00
3. 00	•	IIILS			3. 00
4. 00	Net patient revenues (line 1 minus line 2) Less total operating expenses (from Wkst. G-2, Part II, line	. 42)		199, 830, 613 192, 399, 858	4. 00
5.00	Net income from service to patients (line 3 minus line 4)	: 43)		7, 430, 755	5. 00
5.00	OTHER I NCOME			7, 430, 733	3.00
6. 00	Contributions, donations, bequests, etc			0	6. 00
7. 00	Income from investments			0	7. 00
8. 00	Revenues from telephone and other miscellaneous communication	on sorvicos		0	8. 00
9. 00	Revenue from television and radio service	on services		0	9. 00
				0	
10.00	Purchase di scounts				10.00
11.00	Rebates and refunds of expenses			0	11. 00
	Parking lot receipts				12.00
13.00	Revenue from laundry and linen service			0	13.00
15. 00	Revenue from meals sold to employees and guests			333, 616	
	Revenue from rental of living quarters	+1+:+-		0	15. 00
16.00	Revenue from sale of medical and surgical supplies to other	than patrents		0	16. 00
	Revenue from sale of drugs to other than patients			1, 702	
	Revenue from sale of medical records and abstracts			55, 281	
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00
	Revenue from gifts, flowers, coffee shops, and canteen			-	20.00
	Rental of vending machines			34, 336	
22. 00	Rental of hospital space			609, 621	22. 00
23. 00	Governmental appropriations			0	23. 00
24. 00	LAB SERVI CE REVENUE			0	24. 00
24. 01	SHARED REVENUE			288, 064	24. 01 24. 02
24. 02	OTHER (SPECIFY)			0	
24. 03	GRANTS REVENUE			283, 849	24. 03
24. 04				739, 491	
24. 05	SCHOOL OF RAD TECH			18, 525	
24. 06 24. 07				22 720	24. 06 24. 07
	CONTRACT SERVICE REVENUE			22, 739	24. 07
24. 06	OTHER (SPECIFY)			0 45 220	
	RESEARCH REVENUE			45, 230	
24. 10 24. 11	ASSETS RELEASED FROM RESTRICTED FUND GAIN ON DISPOSAL OF ASSET			38, 056 23, 124	
				· ·	
24. 50	COVID-19 PHE Funding			1, 552, 965	
	Total other income (sum of lines 6-24)			4, 046, 599	
26. 00 27. 00	Total (line 5 plus line 25) EHR			11, 477, 354	
27. 00				0	27. 00
	RESTRUCTURI NG EXPENSE			0	27. 01
	FUND RAISING ACTIVITIES			0	27. 02
27. 03	OTHER EXPENSES			399	
	Total other expenses (sum of line 27 and subscripts)			399	
29.00	Net income (or loss) for the period (line 26 minus line 28)			11, 476, 955	∠9.00

CALCUL	ATION OF CAPITAL PAYMENT	Provider CCN: 15-0088	Peri od:	Worksheet L	
			From 07/01/2021 To 06/30/2022	Parts I-III Date/Time Pre	nared.
			10 00/00/2022	11/29/2022 8:	
	<u> </u>	Title XVIII	Hospi tal	PPS	
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD			1.00	
	CAPI TAL FEDERAL AMOUNT				1
1.00	Capital DRG other than outlier			882, 187	1.00
1.01	Model 4 BPCI Capital DRG other than outlier			0	1. 01
2.00	Capital DRG outlier payments			20, 480	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 re	eporting period (see inst	tructions)	77. 03	
4.00	Number of interns & residents (see instructions)			0.00	
5.00	Indirect medical education percentage (see instructions)			0.00	
6. 00	Indirect medical education adjustment (multiply line 5 by the 1.01) (see instructions)	e sum of lines 1 and 1.01	l, columns 1 and	0	6. 00
7.00	Percentage of SSI recipient patient days to Medicare Part A p 30) (see instructions)	oatient days (Worksheet E	E, part A line	7. 67	7. 00
8. 00	Percentage of Medicaid patient days to total days (see instru	ictions)		32.05	8.00
9. 00	Sum of lines 7 and 8	icti ons)		39.72	
10.00	Allowable disproportionate share percentage (see instructions	:)		8. 37	
11. 00	Disproportionate share adjustment (see instructions)	• •		73, 839	
12. 00	Total prospective capital payments (see instructions)			976, 506	
	DADT II DAVMENT UNDER REACONARIE COCT			1. 00	
1.00	PART II - PAYMENT UNDER REASONABLE COST Program inpatient routine capital cost (see instructions)			0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)			0	
3.00	Total inpatient program capital cost (line 1 plus line 2)			0	
4. 00	Capital cost payment factor (see instructions)			0	
5. 00	Total inpatient program capital cost (line 3 x line 4)			Ö	
	DADT III COMPUTATION OF EVERTION DAVMENTS			1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS			0	1.00
1 00	Program innations capital costs (see instructions)				
1.00	Program inpatient capital costs (see instructions)	res (see instructions)		_	2 00
2.00	Program inpatient capital costs for extraordinary circumstanc	es (see instructions)		0	1
2. 00 3. 00	Program inpatient capital costs for extraordinary circumstand Net program inpatient capital costs (line 1 minus line 2)	es (see instructions)		0	3. 00
2.00 3.00 4.00	Program inpatient capital costs for extraordinary circumstanc Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions)	es (see instructions)		0 0 0.00	3. 00 4. 00
2. 00 3. 00 4. 00 5. 00	Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4)	,		0 0 0. 00 0	3. 00 4. 00 5. 00
2. 00 3. 00 4. 00 5. 00 6. 00	Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in	nstructions)	(line 6)	0 0 0.00	3. 00 4. 00 5. 00 6. 00
2. 00 3. 00 4. 00 5. 00	Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4)	nstructions)	(line 6)	0 0 0. 00 0 0. 00	3. 00 4. 00 5. 00 6. 00 7. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary	nstructions) v circumstances (line 2 x	(line 6)	0 0 0.00 0 0.00	3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary Capital minimum payment level for extraordinary	nstructions) v circumstances (line 2) cable)	ŕ	0 0 0.00 0 0.00 0	3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appli Current year comparison of capital minimum payment level to carryover of accumulated capital minimum payment level over constants.	nstructions) / circumstances (line 2) cable) capital payments (line 8	less line 9)	0.00 0.00 0.00 0.00 0	3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appli Current year comparison of capital minimum payment level to carryover of accumulated capital minimum payment level over comparison to the capital minimum payment level over comparison of capital minimum payment level over comparison to the capital minimum payment level over comparison to the capital minimum payment level over comparison to the capital minimum payment level over comparison to the capital minimum payment level over comparison to the capital minimum payment level over comparison to the capital minimum payment level over comparison to the capital minimum payment level over comparison to the capital minimum payment level over capital minimum payment	nstructions) v circumstances (line 2 x cable) capital payments (line 8 capital payment (from pri	less line 9) or year	0 0.00 0.00 0.00 0 0	3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appli Current year comparison of capital minimum payment level to carryover of accumulated capital minimum payment level over comparison of capital minimum payment level over comparison of capital minimum payment level to capital payments (property level to capital payments).	estructions) v circumstances (line 2 x) cable) capital payments (line 8 capital payment (from pri	less line 9) or year ne 11)	0 0.00 0.00 0.00 0 0	3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00	Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appli Current year comparison of capital minimum payment level to carryover of accumulated capital minimum payment level over comparison to the capital minimum payment level over comparison of capital minimum payment level over comparison to the capital minimum payment level over comparison to the capital minimum payment level over comparison to the capital minimum payment level over comparison to the capital minimum payment level over comparison to the capital minimum payment level over comparison to the capital minimum payment level over comparison to the capital minimum payment level over comparison to the capital minimum payment level over capital minimum payment	estructions) coircumstances (line 2) cable) capital payments (line 8) capital payment (from prince) syments (line 10 plus line the amount on this line	less line 9) or year ne 11)	0 0.00 0.00 0.00 0 0	3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00

15.00 0 16.00 0 17.00

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

15.00 Current year allowable operating and capital payment (see instructions)
16.00 Current year operating and capital costs (see instructions)
17.00 Current year exception offset amount (see instructions)