Health Financial Systems AS	SCENSION ST. VIN	CENT ANDERSON		In Lie	u of Form CMS-2	2552-10
This report is required by law (42 USC 1395g; 42 CF						
payments made since the beginning of the cost repor	ting period bein	ng deemed over	payments (42 US	C 1395g).	OMB NO. 0938-0	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPO		N Provider CC	N: 15 0099 Do	ri od:	EXPIRES 03-31- Worksheet S	-2022
AND SETTLEMENT SUMMARY	KI CEKITICATIO	FIOVIDEI CC		om 07/01/2020	Parts I-III	
			То	06/30/2021	Date/Time Prep	
PART I - COST REPORT STATUS					11/23/2021 1:2	<u>22 pm</u>
Provider 1. [X] Electronically prepared cost	report			Date: 11/23/2	2021 Time: 1	:22 pm
use only 2. [] Manually prepared cost report				54(0) 17,20,2		· == p
3. [0] If this is an amended report	enter the numbe	r of times the	provider resub	mitted this c	ost report	
4. [F] Medicare Utilization. Enter "		"L" for low.				
	Recei ved:		10. NPR		0	
use only (1) As Submitted 7. Contr (2) Settled without Audit 8. [N]	actor No. Initial Report	for this Provi	der CCN 12 [0	ractor's Vende	or code: Jump 1 is 4 · Fi	4 nter
(3) Settled with Audit 9. [N]	Final Report fo	r this Provide	r CCN		mes reopened = (
(4) Reopened						
(5) Amended						
PART II - CERTIFICATION MISREPRESENTATION OF FALSIFICATION OF ANY INFORMATI						
ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UND						
PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY O						
ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MA				,		
CERTIFICATION BY CHIEF FINANCIAL OFFICER OF	ADMINI STRATOR	OF PROVIDER(S)				
I HEREBY CERTIFY that I have read the above			that I have eva	mined the acc	ompanyi ng	
electronically filed or manually submitted					1 5 5	
Expenses prepared by ASCENSION ST. VINCENT						
07/01/2020 and ending 06/30/2021 and to the						
correct, complete and prepared from the boo						
instructions, except as noted. I further o						
provision of health care services, and that	the services i	dentified in t	his cost report	were provide	din	
compliance with such laws and regulations.						
[X]I have read and agree with the above of						
signature on this certification statem	ent to be the I	egally binding	equivalent of	my original s	ignature.	
	(Si gne	/	IACOBSON			
		Offi ce	er or Administra	ator of Provic	ler(s)	
		VP OF F Title	TNANCE			
		ntre				
		11/23/2	2021 01:22:36 PN	1		
		Date				
		Title			T	
Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
PART III - SETTLEMENT SUMMARY	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital	0	640, 286	-304, 845	0	0	1.00
2.00 Subprovi der – LPF	0	040, 200	-304, 045	0	0	2.00

2.00		0	0	0		U	2.00
3.00	Subprovider - IRF	0	37, 432	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	677, 718	-304,845	0	0	200.00
The ab	ove amounts represent "due to" or "due from"	the applicable	program for th	ne element of t	he above comple	ex indicated.	
Accord	ling to the Paperwork Reduction Act of 1995 in	o persons are r	required to res	nond to a coll	ection of infor	mation unless i	i t

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.

SPI	Financial Systems TAL AND HOSPITAL HEALTH CARE COMPLEX	ASCENSION ST. VI				Peri od:		Workshe		2552
						From 07/01/ To 06/30/		Part I Date/Ti	me Pre	pare
	1.00	2.00		3.00		,	1.00	11/23/2	2021 1:	22 p
	Hospital and Hospital Health Care Co			3.00			4.00			
00	Street: 2015 JACKSON STREET	PO Box:								1.
00	City: ANDERSON	State: IN	Zip Cod	e: 46016	Count	ty:				2.
		Component Name	CCN	CBSA	Provi der			nt Syst		
			Number	Number	- Туре	Certified		0, or		4
		1.00	0.00	0.00	1.00		V	XVIII		-
	Hospital and Hospital-Based Componer	1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	-
00	Hospi tal	ASCENSION ST. VINCENT	150088	26900	1	07/01/1966	Ν	Р	0	3.
0		ANDERSON	100000	20,000				.		
00	Subprovider - IPF									4.
00	Subprovider - IRF	BENNETT REHAB CENTER	15T088	26900	5	06/01/1989	N	P	0	5
00	Subprovider - (Other)									6.
00	Swing Beds - SNF									7.
00	Swing Beds - NF									8
00 00	Hospi tal-Based SNF Hospi tal-Based NF									9.
. 00										11
00	Hospital -Based HHA									12
	Separately Certified ASC									13
00	Hospi tal -Based Hospi ce									14
	Hospital-Based Health Clinic - RHC									15
	Hospital-Based Health Clinic - FQHC									16
00										17
	Renal Dialysis Other									18
00	other	I	1		-	From:		То		17
						1.00		2.0		1
	Cost Reporting Period (mm/dd/yyyy)					07/01/2	020	06/30/	/2021	20
00	Type of Control (see instructions)					1				21
				-	1.00	2.00		3. (00	1
	Inpatient PPS Information									
. 00					Y	N				22
	disproportionate share hospital adju			8						
	§412.106? In column 1, enter "Y" for facility subject to 42 CFR Section §									
	hospital?) In column 2, enter "Y" fo		enument							
01	Did this hospital receive interim un		ts for thi	s	Ν	Y				22
	cost reporting period? Enter in colu	mn 1, "Y" for yes or "N	" for no f	or						
	the portion of the cost reporting pe									
	Enter in column 2, "Y" for yes or "N			cost						
00	reporting period occurring on or aft				N	N				1 22
02	Is this a newly merged hospital that payments to be determined at cost re				Ν	N				22
	Enter in column 1, "Y" for yes or "N									
	cost reporting period prior to Octob									
	or "N" for no, for the portion of th									
	October 1.									
03	Did this hospital receive a geograph				Ν	N		N		22
	rural as a result of the OMB standar adopted by CMS in FY2015? Enter in c									
	for the portion of the cost reportin									1
	in column 2, "Y" for yes or "N" for									
	reporting period occurring on or aft									1
	Does this hospital contain at least									1
	counted in accordance with 42 CFR 41	2.105)? Enter in column	3, "Y" fo	or						
04	yes or "N" for no.	is real assification for	m urban +-							1 22
υ4	Did this hospital receive a geograph rural as a result of the revised OMB									22
	adopted by CMS in FY 2021? Enter in									
	for the portion of the cost reportin									
	in column 2, "Y" for yes or "N" for	no for the portion of t	he cost							1
	reporting period occurring on or aft									
	Does this hospital contain at least									
		2 105)? Enter in colum	n 3, "Y" 1	or						1
	counted in accordance with 42 CFR 41									
00	yes or "N" for no.	-	and/or of			2 N				1 22
00	yes or "N" for no. Which method is used to determine Me	dicaid days on lines 24				3 N				23
00	yes or "N" for no. Which method is used to determine Me below? In column 1, enter 1 if date	dicaid days on lines 24 of admission, 2 if cens	us days, d	or 3		3 N				23
00	yes or "N" for no. Which method is used to determine Me	dicaid days on lines 24 of admission, 2 if cens of identifying the days	us days, o in this o	or 3		3 N				23

SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION	DATA	Provider CC	N: 15-0088	Period:		Workshe		
				From 07/0 To 06/3	0/2021	Part I Date/Ti <u>11/23/2</u>		
	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medi cai d el i gi bl e unpai d	Medicai HMO day	/s Med	ther li cai d lays	
	1.00	2.00	3.00	4.00	5.00	6	5.00	1
 .00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in colu 4, Medicaid HMO paid and eligible but unpaid days column 5, and other Medicaid days in column 6. .00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid days in c	in 38 te			53	6, 5 5	563	15	5 24. (25. (
Medicaid eligible unpaid days in column 4, Medicai HMO paid and eligible but unpaid days in column 5.				Urban/R	ural S [Date of	Geogr	
				1. (2.0		
.00 Enter your standard geographic classification (not cost reporting period. Enter "1" for urban or "2"	for rural.				1			26.
.00 Enter your standard geographic classification (not reporting period. Enter in column 1, "1" for urban enter the effective date of the geographic reclass	or"2" for r ification in	ural. If ap column 2.	plicable,					27.
.00 If this is a sole community hospital (SCH), enter effect in the cost reporting period.				Begi ni	0 ni na:	Endi	na.	35.
			0/ 6	1. (2.		
.00 Enter applicable beginning and ending dates of SCH of periods in excess of one and enter subsequent d	ates.	·						36.
 .00 If this is a Medicare dependent hospital (MDH), en is in effect in the cost reporting period. .01 Is this hospital a former MDH that is eligible for endependence with V2024 (2025 final rule). 	the MDH tran	sitional pa	yment in	15	0			37. 37.
 accordance with FY 2016 OPPS final rule? Enter "Y" instructions) .00 If line 37 is 1, enter the beginning and ending da greater than 1, subscript this line for the number enter subsequent dates. 	tes of MDH st	atus. Ifli	ne 37 is					38.
				Y/		Y/		
.00 Does this facility qualify for the inpatient hospi hospitals in accordance with 42 CFR §412.101(b)(2) 1 "Y" for yes or "N" for no. Does the facility mee accordance with 42 CFR 412.101(b)(2)(i), (ii), or or "N" for no. (see instructions)	(i), (ii), or t the mileage	(iii)? Ent requiremer	er in colum nts in	In		<u>2.</u> N		39.
.00 Is this hospital subject to the HAC program reduct "N" for no in column 1, for discharges prior to Oc no in column 2, for discharges on or after October	tober 1. Ente	r"Y" for y				Ν		40.
	·			·	V 1.00	XVIII 2.00	XI X 3.00	
Prospective Payment System (PPS)-Capital		roporti opat	e share in	accordance	N	Y	N	45.
.00 Does this facility qualify and receive Capital pay	ment for disp							14
 .00 Does this facility qualify and receive Capital pay with 42 CFR Section §412.320? (see instructions) .00 Is this facility eligible for additional payment e pursuant to 42 CFR §412.348(f)? If yes, complete W 	xception for	extraordi na	nry circumst		N	N	N	40.
 .00 Does this facility qualify and receive Capital pay with 42 CFR Section §412.320? (see instructions) .00 Is this facility eligible for additional payment e pursuant to 42 CFR §412.348(f)? If yes, complete W Pt. III. .00 Is this a new hospital under 42 CFR §412.300(b) PP 	xception for kst. L, Pt. I S capital? E	extraordina II and Wkst nter "Y for	nry circumst :. L-1, Pt. · yes or "N"	I through for no.	N N N	N N N	N N N	47.
 .00 Does this facility qualify and receive Capital pay with 42 CFR Section §412.320? (see instructions) .00 Is this facility eligible for additional payment e pursuant to 42 CFR §412.348(f)? If yes, complete W Pt. III. .00 Is this a new hospital under 42 CFR §412.300(b) PP .00 Is the facility electing full federal capital paym Teaching Hospitals .00 Is this a hospital involved in training residents "N" for no in column 1. For column 2, if the respowas involved in training residents in approved GME year, and are you are impacted by CR 11642 (or app 	xception for kst. L, Pt. I S capital? E ent? Enter " in approved G nse to column programs in licable CRs)	extraordina II and Wkst nter "Y for Y" for yes ME programs 1 is "Y", the prior y	ry circumst . L-1, Pt. or "N" for ? Enter "Y" or if this rear or penu	I through for no. no. for yes or hospital Iltimate	N	N	N	47. 48.
 .00 Does this facility qualify and receive Capital pay with 42 CFR Section §412.320? (see instructions) .00 Is this facility eligible for additional payment e pursuant to 42 CFR §412.348(f)? If yes, complete W Pt. III. .00 Is this a new hospital under 42 CFR §412.300(b) PP .00 Is the facility electing full federal capital paym Teaching Hospitals .00 Is this a hospital involved in training residents "N" for no in column 1. For column 2, if the respowas involved in training residents in approved GME 	xception for kst. L, Pt. I S capital? E ent? Enter " in approved G nse to column programs in licable CRs) column 2. g period duri for yes or "N onth of this "Y", complet	extraordina II and Wkst nter "Y for Y" for yes ME programs 1 is "Y", the prior y WA direct C ng which re " for no ir cost report e Worksheet	yes or "N" or "N" for ? Enter "Y" or if this wear or penu SME payment esidents in a column 1. ;ing period?	I through for no. no. for yes or hospital Itimate reduction? approved If column ? Enter "Y	- N - N	N	N	46. 47. 48. 56. 57.
 .00 Does this facility qualify and receive Capital pay with 42 CFR Section §412.320? (see instructions) .00 Is this facility eligible for additional payment e pursuant to 42 CFR §412.348(f)? If yes, complete W Pt. III. .00 Is this a new hospital under 42 CFR §412.300(b) PP .00 Is the facility electing full federal capital paym Teaching Hospitals .00 Is this a hospital involved in training residents "N" for no in column 1. For column 2, if the respowas involved in training residents in approved GME year, and are you are impacted by CR 11642 (or app Enter "Y" for yes; otherwise, enter "N" for no in CI If line 56 is yes, is this the first cost reportin GME programs trained at this facility? Enter "Y" is "Y" did residents start training in the first m for yes or "N" for no in column 2. If column 2 is 	xception for kst. L, Pt. I S capital? E ent? Enter " in approved G nse to column programs in licable CRs) column 2. g period duri for yes or "N onth of this "Y", complet II, if appli imbursement f	extraordina II and Wkst nter "Y for Y" for yes ME programs 1 is "Y", the prior y MA direct G mg which re " for no ir cost report e Worksheet cable. or physicia	ary circumst L-1, Pt. yes or "N" or "N" for 	I through for no. no. for yes or hospital litimate reduction? approved If column? Enter "Y' Jumn 2 is	- N - N	N	N	47. 48. 56.

SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provider C		eriod: rom 07/01/2020 p 06/30/2021	Worksheet S-2 Part I Date/Time Pre 11/23/2021 1:	pared:
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
			1.00	2.00	3.00	
 0.00 Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in col is "Y", are you impacted by CR 11642 (or subsequent C adjustement? Enter "Y" for yes or "N" for no in colu If line 60 is yes, complete columns 2 and 3 for each instructions) 	85? (s umn 1. R) NAHE mn 2. program	see If column 1 E MA payment m. (see	Y	Y 23. 00		60. 00
0.02 f line 60 is yes, complete columns 2 and 3 for each instructions)	progran Y/N	n. (see	Direct GME	23. 01	1 Direct GME	60. 02
	1.00	2.00	3.00	4.00	5.00	(1.0)
 .00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) .01 Enter the average number of unweighted primary care 	N			0. OC	0.00	61.00
FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						
.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see						61. 03
 instructions) .04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 						61. 04
.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61. 05
.06 Enter the amount of ACA \$5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)			Descusor Code			61.00
	PI	ogram Name			Direct GME FTE Count	
.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME		1.00	2.00	3.00	<u>4.00</u> 0.00	61. 10
FTE unweighted count. .20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0. 00	61. 20
ACA Provisions Affecting the Health Resources and Ser		Admi ni strati or	(HRSA)		1.00	
2.00 Enter the number of FTE residents that your hospital	trai neo			od for which	0.00	62.00
your hospital received HRSA PCRE funding (see instruct 2.01 Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog Toaching Hespitals that Claim Recidents in Neoprovide	Teachi ram. (s	<u>see instructio</u>		your hospital	0.00	62. 01
Teaching Hospitals that Claim Residents in Nonprovide 8.00 Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple	ttings	during this c			N	63. 0

	Financial Systems TAL AND HOSPITAL HEALTH CARE COMPI	EX IDENTIFICATION DA	TA Provider C		eri od:	Worksheet S-2	-
					rom 07/01/2020 o 06/30/2021	Part I Date/Time Pre 11/23/2021 1:	epared: 22 pm
				Unwei ghted	Unweighted	Ratio (col. 1/	
				FTEs Nonprovider	FTEs in Hospital	(col. 1 + col. 2))	
				Site	nospi tai	2))	
				1.00	2.00	3.00	1
	Section 5504 of the ACA Base Yea	r FTE Residents in No	onprovider Settings				
	period that begins on or after J						
4.00	Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to ro settings. Enter in column 2 the resident FTEs that trained in yo of (column 1 divided by (column	per of unweighted nor tations occurring in number of unweighted ur hospital. Enter in	-primary care all nonprovider d non-primary care n column 3 the ratio	0.00	0.00	0. 000000	64.00
		Program Name	Program Code	Unweighted	Unweighted	Ratio (col. 3/	/
		3		FTEs	FTEs in	(col. 3 + col.	
				Nonprovi der	Hospi tal	4))	
				Si te			
		1.00	2.00	3.00	4.00	5.00	
5.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00 Unweighted FTEs Nonprovider Site	0.00 Unweighted FTEs in Hospital	0.000000 Ratio (col. 1/ (col. 1 + col. 2))	
					0.00	0.00	4
	Section 5504 of the ACA Current	Vear FTF Posidonte :	n Nonnrovidor Sotting	1.00	2.00	3.00	
	beginning on or after July 1, 20		n Nonprovider Setting	SEllective I	Si cost reporti	ng perrous	
5.00	Enter in column 1 the number of FTEs attributable to rotations o Enter in column 2 the number of FTEs 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. ry care resident 3 the ratio of	0.00	0. OC	0. 000000	66.0
		Program Name	Program Code	Unweighted	Unweighted	Ratio (col. 3/	/
		Ŭ		FTEs	FTEs in	(col. 3 + col.	
				Nonprovi der	Hospi tal	4))	
				Site			
7.00	Enter in column 1, the program	1.00	2.00	3.00	4.00 0.00	5.00 0.000000	17.7
	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						

Heal th	Financial Systems ASCENSION ST. VINCENT ANDERSON		1	n Lieu	of For	m CMS-2	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN:	F	Period: From 07/01/ To 06/30/	2020	Workshe Part I Date/Ti	et S-2	
					11/23/2		
				1.00	2.00	3.00	
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain	an IPF sub	provi der?	N			70.00
71 00	Enter "Y" for yes or "N" for no. If line 70 is yes: Column 1: Did the facility have an approved GME teaching	nrogram in	the most			0	71.00
/1.00	recent cost report filed on or before November 15, 2004? Enter "Y" for yes	or "N" for	no. (see			0	71.00
	42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes						
	Column 3: If column 2 is Y, indicate which program year began during this cos (see instructions)	st reportin	g period.				
	Inpatient Rehabilitation Facility PPS				1		
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it conta subprovider? Enter "Y" for yes and "N" for no.	ain an IRF		Y			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching recent cost reporting period ending on or before November 15, 2004? Enter "Y			N	N	0	76.00
	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 col indicate which program year began during this cost reporting period. (see in:		,				
		,		·	1.0		
	Long Term Care Hospital PPS				1.0	10	
80.00 81.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. Is this a LTCH co-located within another hospital for part or all of the cos	t reporting	period? F	nter	N N		80.00 81.00
01.00	"Y" for yes and "N" for no.						01.00
85.00	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.	N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.	CFR Sectio	n				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under	er section			Ν		87.00
	1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		V		XL	x	
	Title V and XIX Services		1.00		2.0	0	
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter	r "Y" for	N		Y		90.00
91.00	yes or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through the cost report e	ither in	N		Y		91.00
	full or in part? Enter "Y" for yes or "N" for no in the applicable column. Are title XIX NF patients occupying title XVIII SNF beds (dual certification)				N		92.00
	instructions) Enter "Y" for yes or "N" for no in the applicable column.						
93.00	Does this facility operate an ICF/IID facility for purposes of title V and X "Y" for yes or "N" for no in the applicable column.	IX? Enter	N		N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in applicable column.	n the	N		Ν		94.00
	If line 94 is "Y", enter the reduction percentage in the applicable column.		0.00		0.0		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in applicable column.	n the	N		N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column. Does title V or XIX follow Medicare (title XVIII) for the interns and reside	nte nost	0.00		0.0	0	97.00 98.00
96.00	stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for		N		T		96.00
98. 01	column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for the reporting of charge	es on Wkst.	N		Y		98.01
	C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in col title XIX.						
98. 02	Does title V or XIX follow Medicare (title XVIII) for the calculation of obse		N		Y		98. 02
	bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in a for title V, and in column 2 for title XIX.	column 1					
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hosp reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no		N		Ν		98. 03
	for title V, and in column 2 for title XIX.						
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for ti		N		N		98. 04
00 05	in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) and add back the RCE disal		N		Y		98.05
90.05	Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title						70.05
98.06	column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wi	kst. D,	N		Y		98.06
	Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, a column 2 for title XIX.	and in					
	Rural Providers		1	I			
	Does this hospital qualify as a CAH? If this facility qualifies as a CAH, has it elected the all-inclusive method	of payment	N				105.00 106.00
	for outpatient services? (see instructions)						
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement training programs? Enter "Y" for yes or "N" for no in column 1. (see instruct	ctions)	N				107.00
	Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in approved medical education program in the CAH's excluded IPF and/or IRF uni						
	Enter "Y" for yes or "N" for no in column 2. (see instructions)	. ,					

Health Financial Systems	ASCENSION ST. VIN	ICENT ANDERSON		In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENT	IFICATION DATA	Provider CC		eriod: com 07/01/2020 o 06/30/2021	Worksheet S-2 Part I Date/Time Pre 11/23/2021 1:	epared:
				V 1.00	XI X 2.00	-
108.00 Is this a rural hospital qualifying for a		CRNA fee sched	dule? See 42	N 1.00	2.00	108.00
CFR Section §412.113(c). Enter "Y" for ye	es or "N" for no.	Physi cal	Occupati onal	Speech	Respi ratory	
	-	1.00	2.00	3.00	4.00	1
109.00 If this hospital qualifies as a CAH or a therapy services provided by outside supp for yes or "N" for no for each therapy.		Ν	N	N	N	109.00
110,00 Did this best to set in the Dur		L Demension		04	1.00	110.00
110.00 Did this hospital participate in the Rura Demonstration) for the current cost report complete Worksheet E, Part A, lines 200 t applicable.	ing period? Enter "	Y" for yes or	"N" for no. If	yes,	N	110.00
				1.00	2.00	-
111.00 If this facility qualifies as a CAH, did Health Integration Project (FCHIP) demons "Y" for yes or "N" for no in column 1. If integration prong of the FCHIP demo in wh Enter all that apply: "A" for Ambulance s for tele-health services.	tration for this co the response to co ich this CAH is par	st reporting p lumn 1 is Y, e ticipating in	period? Enter enter the column 2.	N		111.00
			1.00	2.00	3.00	-
112.00 Did this hospital participate in the Penn demonstration for any portion of the curr Enter "Y" for yes or "N" for no in column in column 2, the date the hospital began demonstration. In column 3, enter the da participation in the demonstration, if ap	ent cost reporting 1. If column 1 is participating in th te the hospital cea	period? "Y", enter e	N	2.00	3.00	112.00
Miscellaneous Cost Reporting Information	nton "V" for yoo or	"N" far no	N			
115.00 Is this an all-inclusive rate provider? E in column 1. If column 1 is yes, enter th in column 2. If column 2 is "E", enter in for short term hospital or "98" percent f psychiatric, rehabilitation and long term	e method used (A, B column 3 either "9 for long term care (hospitals provider	, or E only) 3" percent includes	N			0115.00
the definition in CMS Pub. 15-1, chapter 2 116.00 Is this facility classified as a referral "N" for no.		for yes or	N			116. 00
117.00 Is this facility legally-required to carr	y malpractice insur	ance? Enter	Y			117.00
"Y" for yes or "N" for no. 118.00 Is the malpractice insurance a claims-mac if the policy is claim-made. Enter 2 if t		2	2			118.00
	<u></u>		Premi ums	Losses	Insurance	
			1.00	2.00	3.00	-
118.01 List amounts of malpractice premiums and	paid losses:		0			0118.01
				1.00	2.00	-
118.02 Are malpractice premiums and paid losses Administrative and General? If yes, subm and amounts contained therein.	•			N	2.00	118.02
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for §3121 and applicable amendments? (see ins "N" for no. Is this a rural hospital with Hold Harmless provision in ACA §3121 and	tructions) Enter in < 100 beds that qu applicable amendmen	column 1, "Y alifies for th	' for yes or ne Outpatient	Ν	Ν	119.00 120.00
Enter in column 2, "Y" for yes or "N" for 121.00 Did this facility incur and report costs patients? Enter "Y" for yes or "N" for no	for high cost impla	ntable devices	s charged to	Y		121.00
122.00 Does the cost report contain heal thcare r Act?Enter "Y" for yes or "N" for no in co the Worksheet A line number where these t	elated taxes as def lumn 1. If column 1			Y	5.00	122.00
Transplant Center Information 125.00 Does this facility operate a transplant of	enter? Enter "V" fo	r ves and "N"	for no lf	N		125.00
yes, enter certification date(s) (mm/dd/y	yyy) below.			111		
126.00 If this is a Medicare certified kidney tr in column 1 and termination date, if appl			nication date			126.00
127.00 If this is a Medicare certified heart tra	nsplant center, ent	er the certifi	cation date			127.00
in column 1 and termination date, if appl 128.00 If this is a Medicare certified liver tra in column 1 and termination date, if appl	nsplant center, ent	er the certifi	cation date			128. 00
129.00 If this is a Medicare certified lung tran column 1 and termination date, if applica	splant center, ente ble, in column 2.	r the certific				129.00
130.00 If this is a Medicare certified pancreas date in column 1 and termination date, if			ti fi cati on			130.00

	EX IDENTIFICATION DA	ATA Provider CCN:	15-0088		/01/2020 /30/2021	Worksheet S-2 Part I Date/Time Pro 11/23/2021 1	epared:
					1.00	2.00	-
31.00 f this is a Medicare certified i			ti fi cati on			2.00	131. 0
date in column 1 and termination 32.00 If this is a Medicare certified i	slet transplant cen	ter, enter the certifica	ation date				132. 0
in column 1 and termination date, 33.00Removed and reserved	it applicable, in	column 2.					133. 0
34.00 If this is an organ procurement o and termination date, if applicab All Providers		enter the OPO number in	column 1				134. 0
40.00 Are there any related organization chapter 10? Enter "Y" for yes or are claimed, enter in column 2 th	"N" for no in colum	n 1. If yes, and home of number. (see instruction	ffice cost	s	Y	154046	140. 0
<u> </u>	ain organization en	2.00 ter on lines 141 throug	h 143 the	name and	3.00 address	of the	
home office and enter the home of	fice contractor nam	e and contractor number					
41.00Name: ST VINCENT HEALTH 42.00Street:250WEST 96TH STREET , SUI 2058	Contractor's TE PO Box:	Name: WPS	Contrac	tor's Num	nber: 0810)1	141. 0 142. 0
43.00 City: INDIANAPOLIS	State:	I N	Zip Cod	e:	4626	0	143.0
						1.00	_
44.00 Are provider based physicians' co	sts included in Wor	ksheet A?				Y	144. 0
					1 00	2.00	_
45.00 If costs for renal services are c	laimed on Wkst. A.	line 74, are the costs i	for		1.00	2.00	145.0
inpatient services only? Enter "Y no, does the dialysis facility in period? Enter "Y" for yes or "N" 46.00Has the cost allocation methodolo	" for yes or "N" fo nclude Medicare util for no in column 2 pay changed from the	r no in column 1. If col ization for this cost re previously filed cost n	lumn 1 is eporting report?		N		146. 0
Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/			, §4020) I	f		1.00	_
47.00 Was there a change in the statist	ical basis? Enter "'	Y" for ves or "N" for no	0.			1.00 N	147.0
48.00Was there a change in the order o	of allocation? Enter	"Y" for yes or "N" for	no.			Ν	148.0
49.00 Was there a change to the simplif	<u>ied cost finding me</u>	thod? Enter "Y" for yes Part A	or "N" fo Part B		tle V	N Title XIX	149. C
		1.00	2.00		3.00		
						4.00	
Does this facility contain a prov		for an exemption from	the applic		the lowe	er of costs	-
or charges? Enter "Y" for yes or 55.00 Hospi tal		for an exemption from	the applic		the lowe	er of costs 1.13) N	
or charges? Enter "Y" for yes or 55.00Hospi tal 56.00Subprovi der - IPF		for an exemption from component for Part A a N N	the applic <u>nd Part B.</u> N N		the lowe CFR §413 N N	er of costs 13) N N	156. C
or charges? Enter "Y" for yes or 55.00 Hospi tal 56.00 Subprovi der - IPF 57.00 Subprovi der - IRF		for an exemption from component for Part A a N	the applic nd Part B. N		the lowe CFR §413 N	er of costs 1.13) N	156. 0 157. 0
or charges? Enter "Y" for yes or 55.00 Hospi tal 56.00 Subprovi der - IPF 57.00 Subprovi der - IRF 58.00 SUBPROVI DER 59.00 SNF		for an exemption from component for Part A a N N N N	the applic n <u>d Part B.</u> N N N		the lowe CFR §413 N N N N	r of costs 3.13) N N N N	156. 0 157. 0 158. 0 159. 0
or charges? Enter "Y" for yes or 55.00 Hospi tal 56.00 Subprovi der - IPF 57.00 Subprovi der - IRF 58.00 SUBPROVI DER 59.00 SNF 60.00 HOME HEALTH AGENCY		for an exemption from component for Part A a N N N	the applic n <u>d Part B.</u> N N N N		the lowe CFR §413 N N N N N	r of costs .13) N N N N N	156. 0 157. 0 158. 0 159. 0 160. 0
or charges? Enter "Y" for yes or 55.00 Hospi tal 56.00 Subprovi der - IPF 57.00 Subprovi der - IRF 58.00 SUBPROVI DER 59.00 SNF 60.00 HOME HEALTH AGENCY		for an exemption from component for Part A a N N N N	the applic n <u>d Part B.</u> N N N		the lowe CFR §413 N N N N	r of costs 3.13) N N N N	156. 0 157. 0 158. 0 159. 0 160. 0
or charges? Enter "Y" for yes or 55.00 Hospital 56.00 Subprovider - IPF 57.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 SNF 60.00 HOME HEALTH AGENCY 61.00 CMHC Multicampus 65.00 Is this hospital part of a Multic	"N" for no for each	for an exemption from <u>component for Part A a</u> N N N N N	the applic nd Part B. N N N N N N N	(See 42	the Iowe <u>CFR §413</u> N N N N N N	r of costs 3.13) N N N N N N N	156.0 157.0 158.0 159.0 160.0 161.0
or charges? Enter "Y" for yes or 55.00 Hospi tal 56.00 Subprovi der - IPF 57.00 Subprovi der - IRF 58.00 SUBPROVI DER 59.00 SNF 60.00 HOME HEALTH AGENCY 61.00 CMHC Mul ti campus	"N" for no for each ampus hospital that	for an exemption from component for Part A a N N N N N N N N N N N N N	the applic nd Part B. N N N N N N es in diff	(See 42	the Iowe <u>CFR §413</u> N N N N SAs? <u>CBSA</u>	r of costs .13) N N N N N 1.00 FTE/Campus	156.0 157.0 158.0 159.0 160.0 161.0
or charges? Enter "Y" for yes or 55.00 Hospital 66.00 Subprovider - IPF 57.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 SNF 50.00 HOME HEALTH AGENCY 51.00 CMHC 55.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no.	"N" for no for each	for an exemption from component for Part A a N N N N N N N N N N N N N	the applic nd Part B. N N N N N N es in diff	(See 42	the Iowe <u>CFR §413</u> N N N N N SAS?	r of costs . 13) N N N N N N 1.00 FTE/Campus 5.00	156. (157. (158. (159. (160. (161. (165. (165. (
or charges? Enter "Y" for yes or 55.00 Hospital 56.00 Subprovider - IPF 57.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 SNF 50.00 HOME HEALTH AGENCY 51.00 CMHC 55.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no.	"N" for no for each ampus hospital that	for an exemption from component for Part A a N N N N N N N N N N N N N	the applic nd Part B. N N N N N N es in diff	(See 42	the Iowe <u>CFR §413</u> N N N N SAs? <u>CBSA</u>	r of costs . 13) N N N N N N 1.00 FTE/Campus 5.00	156. 0 157. 0 158. 0 159. 0 160. 0 161. 0 165. 0
or charges? Enter "Y" for yes or 55.00 Hospital 56.00 Subprovider - IPF 57.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 SNF 50.00 HOME HEALTH AGENCY 51.00 CMHC 55.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no. 56.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in	"N" for no for each ampus hospital that	for an exemption from component for Part A a N N N N N N N N N N N N N	the applic nd Part B. N N N N N N es in diff	(See 42	the Iowe <u>CFR §413</u> N N N N SAs? <u>CBSA</u>	r of costs .13) N N N N N 1.00 FTE/Campus 5.00 0.0	156. 0 157. 0 158. 0 159. 0 160. 0 161. 0 165. 0
or charges? Enter "Y" for yes or 55.00 Hospital 56.00 Subprovider - IPF 57.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 SNF 60.00 HOME HEALTH AGENCY 61.00 CMHC Multicampus 65.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no. 66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI	<pre>"N" for no for each campus hospital that</pre>	for an exemption from component for Part A a N N N N N N N N N N N N N	the applic nd Part B. N N N N N N N State Z 2.00 Rei nvestme	(See 42 erent CB: i p Code 3.00	the Iowe <u>CFR §413</u> N N N N SAs? <u>CBSA</u>	r of costs .13) N N N N .1.00 	156. 0 157. 0 158. 0 159. 0 160. 0 161. 0 165. 0 165. 0 0 166. 0
or charges? Enter "Y" for yes or 55.00 Hospital 56.00 Subprovider - IPF 57.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 SNF 60.00 HOME HEALTH AGENCY 61.00 CMHC	<pre>"N" for no for each "ampus hospital that</pre>	for an exemption from component for Part A a N N N N N N N N N N N N N	the applic nd Part B. N N N N N N N N State Z 2.00 Reinvestme " for no.	ip Code 3.00	the I owe <u>CFR §413</u> N N N N SAS? <u>CBSA</u> <u>4.00</u>	r of costs .13) N N N N N 1.00 FTE/Campus 5.00 0.0	155. 0 156. 0 157. 0 159. 0 159. 0 160. 0 161. 0 165. 0 165. 0 0 166. 0

Health Financial Systems	ASCENSION ST.	VINCENT ANDERSON	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DATA		Period:	Worksheet S-2	
			rom 07/01/2020		
			o 06/30/2021	Date/Time Pre	
				11/23/2021 1:	<u>22 pm</u>
			Begi nni ng	Endi ng	
			1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR be	ginning date and endi	ng date for the reporting			170.00
period respectively (mm/dd/yyyy)					
			1.00	2.00]
171.00 If line 167 is "Y", does this provi	der have any days for	individuals enrolled in	N	C	171.00
section 1876 Medicare cost plans re	ported on Wkst. S-3,	Pt. I, line 2, col. 6? Enter			
"Y" for yes and "N" for no in colum	n 1. lf column 1 is y	es, enter the number of section			
1876 Medicare days in column 2. (se	e instructions)				

	Financial Systems ASCENSION ST. VI AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNALRE		CN: 15-0088	<u>In Lie</u> Period: From 07/01/2020 To 06/30/2021		2 epared:
				Y/N	Date	
				1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter M mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Describer Operation and Operation	N for all NO re	esponses. Enter	r all dates in 1	the	-
	Provider Organization and Operation Has the provider changed ownership immediately prior to the	e beginning of	the cost	N		1.00
	reporting period? If yes, enter the date of the change in o	column 2. (see			N/ /1	
			Y/N 1.00	Date 2.00	V/I 3.00	
	Has the provider terminated participation in the Medicare I yes, enter in column 2 the date of termination and in colur voluntary or "I" for involuntary.	Program?lf nn 3, "V" for	N	2.00	0.00	2.00
3.00	Is the provider involved in business transactions, includin contracts, with individuals or entities (e.g., chain home of or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members of of directors through ownership, control, or family and othe relationships? (see instructions)	offices, drug der or its of the board	Y			3.00
			Y/N	Туре	Date	
			1.00	2.00	3.00	
4.00	Financial Data and Reports Column 1: Were the financial statements prepared by a Cer Accountant? Column 2: If yes, enter "A" for Audited, "C" to or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	for Compiled,	Y	A		4.00
5.00	Are the cost report total expenses and total revenues diffe those on the filed financial statements? If yes, submit ree		N			5.00
				Y/N 1.00	Legal Oper. 2.00	
	Approved Educational Activities			1.00	2.00	
6.00	Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	5	ne provider is			6.00
8.00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.	and/or renewed	0	Y N		7.00 8.00
	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction		al education	Ν		9.00
10.00	Was an approved Intern and Resident GME program initiated (cost reporting period? If yes, see instructions.		he current	Ν		10.00
11.00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	l & R in an App	proved	Ν		11.00
					Y/N 1.00	
	Bad Debts				1.00	-
13.00	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.			st reporting	Y N	12.00 13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	ents waived? If	⁻yes, see ins	tructions.	N	14.00
15.00	Did total beds available change from the prior cost reporti		<u>yes, see inst</u> t A		N N	15.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
16.00	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 date of the PS&R Report used in columns 2 and 4 .(see	Y	10/07/2021	Y	10/07/2021	16.00
17.00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	N		N		17.00
18.00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	Ν		Ν		18.00
	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		Ν		19.00

ASCENSI ON	ST.	VI NCENT	ANDERSON

Heal th	Financial Systems ASCENSION ST. V	INCENT ANDERSON		In Lie	u of Form CMS	-2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0088	Period: From 07/01/2020	Worksheet S- Part II	2
				To 06/30/2021	Date/Time Pr 11/23/2021 1	
		Descri	iption	Y/N	Y/N	
		(C	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	Ν	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	01.00
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 (EXC	EPT CHILDRENS H	OSPI TALS)			
	Capital Related Cost					
	Have assets been relifed for Medicare purposes? If yes, se				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense	due to apprais	als made duri	ng the cost	N	23.00
24.00	reporting period? If yes, see instructions. Were new leases and/or amendments to existing leases enter	ed into during	this cost ren	orting period?	N	24.00
24.00	If yes, see instructions	eu mito during	this cost rep	or tring period:	IN IN	24.00
25.00	Have there been new capitalized leases entered into during	the cost repor	ting period?	lfyes, see	N	25.00
26.00	instructions. Were assets subject to Sec.2314 of DEFRA acquired during t	he cost reporti	ng period? If	ves, see	N	26.00
	instructions.		0.			
27.00	Has the provider's capitalization policy changed during th copy.	e cost reportin	ig period? IT	yes, submit	N	27.00
28.00	Interest Expense Were new Loans, mortgage agreements or Letters of credit e	ntered into dur	ing the cost	reporting	N	28.00
29.00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or		0		N	29.00
29.00	treated as a funded depreciation account? If yes, see inst		DI SEIVICE RE	serve Fund)	IN .	29.00
30.00	Has existing debt been replaced prior to its scheduled mat instructions.	urity with new	debt? If yes,	see	N	30.00
31.00	Has debt been recalled before scheduled maturity without i	ssuance of new	debt? If yes,	see	Ν	31.00
	instructions. Purchased Services					-
32.00	Have changes or new agreements occurred in patient care se	rvi ces furni she	d through con	tractual	N	32.00
33.00	arrangements with suppliers of services? If yes, see instr If line 32 is yes, were the requirements of Sec. 2135.2 ap		a to compotit	ivo bidding? If	N	33.00
55.00	no, see instructions.					33.00
	Provi der-Based Physi ci ans		· · · ·			
34.00	Are services furnished at the provider facility under an a If yes, see instructions.	rrangement with	provi der-bas	ed physi ci ans?	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended ex physicians during the cost reporting period? If yes, see i		ts with the p	rovi der-based	Ν	35.00
	physicians during the cost reporting portour in you, cost			Y/N	Date	
				1.00	2.00	
0/ 00	Home Office Costs					
36.00 37.00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been p	repared by the	home office?	Y Y		36.00 37.00
	If yes, see instructions.					
38.00	If line 36 is yes, was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year en			N		38.00
39.00	If line 36 is yes, did the provider render services to oth see instructions.	er chain compon	ents? If yes,	Ν		39.00
40.00	If line 36 is yes, did the provider render services to the	home office?	lf yes, see	Ν		40.00
	instructions.					
		1.	00	2.	00	
41.00	Cost Report Preparer Contact Information Enter the first name, last name and the title/position	КАТНҮ		ZAMBOS		41 00
41.00	held by the cost report preparer in columns 1, 2, and 3, respectively.					41.00
42.00	Enter the employer/company name of the cost report	ST VINCENT HEA	LTH			42.00
43.00	preparer. Enter the telephone number and email address of the cost	765-623-4573		KATHY. ZAMBOS@A	SCENSI ON. ORG	43.00
	report preparer in columns 1 and 2, respectively.					

Heal th	Financial Systems ASCENSION ST.	VI	NCENT ANDERSON	In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0088	Period: From 07/01/2020	Worksheet S-2 Part II	
					Date/Time Pre 11/23/2021 1:	
			3.00			
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position		LEAD ANALYST			41.00
	held by the cost report preparer in columns 1, 2, and 3					
	respecti vel y.					
42.00	Enter the employer/company name of the cost report					42.00
	preparer.					
43.00	Enter the telephone number and email address of the cos	t				43.00
	report preparer in columns 1 and 2, respectively.					

	Financial Systems AS	CENSION ST. VII	Provi der CC	N. 15_0088	Peri od:	eu of Form CMS-2 Worksheet S-3	
1105111	AL AND HOST THE HEALTH CARE COMPLEX STATISTIC	AL DATA		. 13-0000	From 07/01/2020	Part I	
					To 06/30/2021	Date/Time Pre 11/23/2021 1:	
						I/P Days / 0/P	
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
		Line Number		Avai I abl e			
		1.00	2.00	3.00	4.00	5.00	1
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00	123	44, 89	95 0.00	0	1.00
	8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2.00
3.00	HMO I PF Subprovi der						3.00
4.00	HMO I RF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation		123	44, 89	95 0.00	0	7.00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	31.00	21	7,60	65 0.00	0	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)	10.00					12.00
13.00	NURSERY	43.00	144	F2 F	0 0 00	0	13.00
14.00 15.00	Total (see instructions) CAH visits		144	52, 50	50 0.00	0	14.00
16.00	SUBPROVIDER - IPF					0	16.00
17.00	SUBPROVIDER - IRF	41.00	13	4, 74	15	0	17.00
18.00	SUBPROVIDER	41.00	15	4,7	10		18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)	30. 00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00	457			0	
27.00	Total (sum of lines 14-26)		157			0	27.00
28.00	Observation Bed Days					0	28.00
29.00 30.00	Ambulance Trips Employee discount days (see instruction)						29.00
31.00	Employee discount days (see first detron)						31.00
32.00	Labor & delivery days (see instructions)		0		0		32.00
32.00	Total ancillary labor & delivery room		0		Ĭ		32.00
52.01	outpatient days (see instructions)						52.01
33.00	LTCH non-covered days						33.00
33 01	LTCH site neutral days and discharges						33.01

IOSPI TAL AN	D HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	CN: 15-0088	Period: From 07/01/2020 To 06/30/2021	Worksheet S-3 Part I Date/Time Pre 11/23/2021 1:	pared:
		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	
8 exc Hospi	ital Adults & Peds. (columns 5, 6, 7 and clude Swing Bed, Observation Bed and ice days)(see instructions for col. 2 the portion of LDP room available beds)	3, 875	1, 229	21, 18			1.00
	and other (see instructions)	6, 134	6, 524				2.00
	I PF Subprovi der	0	0				3.00
	IRF Subprovi der	491	577				4.00
	ital Adults & Peds. Swing Bed SNF	0	0		0		5.00
. 00 Hospi	ital Adults & Peds. Swing Bed NF		0		0		6.00
	Adults and Peds. (exclude observation	3, 875	1, 229	21, 18	32		7.00
) (see instructions) NSIVE CARE UNIT	3, 495	138	4, 57	70		8.00
	NARY CARE UNIT	3,495	130	4, 57	7		9.0
	INTENSIVE CARE UNIT						10.0
	ICAL INTENSIVE CARE UNIT						11.0
	R SPECIAL CARE (SPECIFY)						12.0
3. 00 NURSE			513	64	13		13.0
	(see instructions)	7, 370	1, 880	26, 40		559.57	14.0
	visits	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	000	20, 10	0	007.07	15.0
	ROVIDER – IPF		Ū				16.0
	ROVIDER – IRF	1, 125	38	2,60	0.00	11.28	17. C
1	ROVI DER						18.0
1	LED NURSING FACILITY						19.0
0. 00 NURSI	ING FACILITY						20.0
1. 00 OTHER	R LONG TERM CARE						21.0
2.00 HOME	HEALTH AGENCY						22.0
3. 00 AMBUL	LATORY SURGICAL CENTER (D. P.)						23.0
4.00 H0SPI	ICE						24.0
4. 10 HOSPI	ICE (non-distinct part)			15	53		24. ⁻
5.00 CMHC	- CMHC						25.0
6. 00 RURAL	L HEALTH CLINIC						26.0
6.25 FEDEF	RALLY QUALIFIED HEALTH CENTER	0	0		0 0.00	0.00	26.2
	l (sum of lines 14-26)				0.00	570.85	
	rvation Bed Days		0	1, 09	90		28.0
	ance Trips	0					29.0
	oyee discount days (see instruction)			14			30.0
	oyee discount days - IRF				28		31.0
	r & delivery days (see instructions)	0	15	14			32.0
	ancillary labor & delivery room				0		32.0
	atient days (see instructions)						
	non-covered days	0					33.0
3.01 LTCH	site neutral days and discharges	0					33.

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider C	CN: 15-0088	Period: From 07/01/2020 To 06/30/2021	Worksheet S-3 Part I Date/Time Pre 11/23/2021 1:	pared:
		Full Time Equivalents		Di s	charges		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers	10.00	10.00	14.00	Patients	
1 00	Userital Adulta & Dada (aslumas E. (. 7 and	11.00	12.00	13.00	14.00	15.00	1 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)		U			5, 322	1.00
2.00	HMO and other (see instructions)			1, 0			2.00
3.00	HMO I PF Subprovider				0		3.00
4.00 5.00	HMO IRF Subprovider				39		4.00 5.00
5.00 6.00	Hospital Adults & Peds. Swing Bed SNF 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	SURGI CAL INTENSI VE CARE UNI T						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	1, 4	257	5, 322	
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0			004	16.00
17.00	SUBPROVIDER - IRF	0.00	0		93 3	204	17.00
18.00 19.00	SUBPROVIDER SKILLED NURSING FACILITY						18.00 19.00
20.00	NURSING FACILITY						20.00
20.00	OTHER LONG TERM CARE						20.00
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 Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32. 01 33. 00	Total ancillary labor & delivery room outpatient days (see instructions)				0		32. 01 33. 00
33. UU	LTCH non-covered days				U		<u>3</u> 3.00

	Financial Systems AL WAGE INDEX INFORMATION	AS	CENSION ST. VI	NCENT ANDERSON Provider CC	N. 15,0000	In Lie Period:	worksheet S-3	
πυσρί Γ	AL WAGE INDEX INFORMATION				F	'eriod: From 07/01/2020 To 06/30/2021	Part II Date/Time Pre	pared:
		Wkst. A Line	Amount	Recl assi fi cati	Adjusted	Paid Hours	11/23/2021 1: Average Hourly	
		Number	Reported	on of Salaries (from Wkst.	Salaries (col.2 ± col.		Wage (col. 4 ÷ col. 5)	
		1.00	2.00	A-6) 3.00	<u>3)</u> 4. 00	5.00	6.00	
	PART II - WAGE DATA SALARIES							-
1.00	Total salaries (see	200. 00	39, 529, 979	25, 733	39, 555, 712	1, 119, 293. 30	35. 34	1.00
2.00	instructions) Non-physician anesthetist Part		0	0	C	0.00	0.00	2.00
3.00	A Non-physician anesthetist Part		0	0	C	0.00	0.00	3. 00
4.00	Physician-Part A - Administrative		50, 137	0	50, 137	417.81	120. 00	4.00
4.01 5.00	Physicians - Part A - Teaching Physician and Non		0 0	-	C			
6.00	Physician-Part B Non-physician-Part B for hospital-based RHC and FOHC		0	0	C	0.00	0. 00	6.00
7.00	services Interns & residents (in an approved program)	21.00	0	0	C	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	C	0.00	0. 00	7.01
8.00	Home office and/or related organization personnel		16, 540	0	16, 540	1, 168. 08	14. 16	8. 00
9. 00 10. 00	SNF Excluded area salaries (see instructions)	44.00	0 4, 556, 883	0 -42, 952	(4, 513, 931	0. 00 120, 715. 87		
11 00	OTHER WAGES & RELATED COSTS		(10(700		(10(70)	105 010 04	21.21	
11. 00 12. 00	Contract Labor: Direct Patient Care Contract Labor: Top Level		6, 106, 732	0	6, 106, 732			11.00 12.00
12.00	management and other management and administrative services		0	0		0.00	0.00	12.00
13.00	Contract Labor: Physician-Part A - Administrative		4, 264, 481	0	4, 264, 481	43, 806. 19	97.35	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	C	0.00	0.00	14.00
	Home office salaries		11, 057, 084	0	11, 057, 084			14.01
14. 02 15. 00	Related organization salaries Home office: Physician Part A		0	0	(0.00		14.02
	- Administrative Home office and Contract		0	0	ſ	0.00		16.00
16. 01	Physicians Part A - Teaching Home office Physicians Part A		0	0	(0.00		16.01
	- Teaching Home office contract		0	0	ſ			16. 02
10. 02	Physicians Part A - Teaching WAGE-RELATED COSTS						0.00	
17.00	Wage-related costs (core) (see instructions)		11, 413, 355	0	11, 413, 355	5		17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19. 00 20. 00	Excluded areas Non-physician anesthetist Part		1, 337, 849 0	0 0	1, 337, 849 (19.00 20.00
21.00	A Non-physician anesthetist Part		0	о	C			21.00
22.00	B Physician Part A - Administrative		6, 303	0	6, 303			22.00
22.01	Physician Part A - Teaching		0	0	(22.01
23.00 24.00 25.00	Physician Part B Wage-related costs (RHC/FQHC) Interns & residents (in an		0	0	(23.00 24.00 25.00
25.00 25.50	approved program) Home office wage-related		3, 751, 934		3, 751, 934			25.00
25. 50	(core) Related organization		0, 701, 734	0	5, 751, 754			25.50
25. 51	wage-related (core) Home office: Physician Part A		0		r			25. 51
20.02	- Administrative - wage-related (core)		0		C			20.02

HOSPITAL WAGE INDEX INFORMATION Provider CN: 15-008 Period: From 07/01/2020 To 06/30/2021 Worksheet S-3 To 06/30/2021 Worksheet S-3 Date/Time Prepared: 1023/2021.1:22 pm 25-53 Home office: Physicians Part A - Teaching - wage-related (core) Amount Number Reclassificati (from Wkst. -6) Adjusted Salaries in col. 4 Average Hourly Related to Salaries in col. 4 25.53 25-53 Home office: Physicians Part A - Teaching - wage-related (core) 0 0 0 0 25.53 26-00 Employee Benefits Department 2.276,039 2.076,039 0 2.5.63 39.75 26.00 20 Administrative & General contract (see inst.) 6.00 0	Heal th	Financial Systems	AS	CENSION ST. VI	NCENT ANDERSON		In Lie	eu of Form CMS-:	2552-10
$ \begin{array}{ c c c c c c c c c c c c c c c c c c c$					Provider C		From 07/01/2020	Part II Date/Time Pre	pared:
$ \begin{array}{ c c c c c c c c c c c c c c c c c c c$			Wkst. A Line	Amount	Reclassi fi cati	Adj usted	Paid Hours	Average Hourly	
Image: Contract (see inst.) Co			Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
Image: constraint of the					(from Wkst.	(col.2 ± col.	Salaries in	col. 5)	
25. 53 Home office: Physicians Part A - Teaching - wage-related (core) 0 0 0 0 0 0 0 25. 53 25. 53 Home office: Physicians Part A - Teaching - wage-related (core) 0 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>									
- Teaching - wage-rel ated (core) - Teaching - wage-rel ated (core)<			1.00	2.00	3.00	4.00	5.00	6.00	
(core) OVERHEAD COSTS DIRECT SALARIES 26.00 Employee Benefits Department 4.00 295,149 -279,823 15,326 385.58 39.75 26.00 27.00 Administrative & General 5.00 2,576,475 -832,886 1,743,589 56,052.02 31.11 27.00 28.00 Administrative & General under 2,276,039 0 2,276,039 34,121.26 66.70 28.00 29.00 Maintenance & Repairs 6.00 0 0 0.00 0.00 29.00 30.00 Operation of Plant 7.00 0 0 0 0.00 0.00 31.00 22.00 Housekeeping 9.00 0 0 0.00 0.00 31.00 23.00 Housekeeping 9.00 0 0 0.00 0.00 32.00 34.00 Dietary 10.00 0 0 0 0.00 0.00 33.00 35.00 Caffeteria 11.00 0				0	0		0		25. 53
OVERHÉAD COSTS - DI RECT SALARI ÉS 26.00 Employee Benefits Department 4.00 295, 149 -279, 823 15, 326 385.58 39.75 26.00 27.00 Admin istrative & General 5.00 2, 576, 475 -832, 886 1, 743, 589 56, 052.02 31.11 27.00 28.00 Admin istrative & General under contract (see inst.) 2, 276, 039 0 2, 276, 039 34, 121.26 66.70 29.00 29.00 Maintenance & Repairs 6.00 0 0 0 0.00 0.00 29.00 31.00 Laundry & Linen Service 8.00 0 0 0 0.00 0.00 20.00 32.00 Housekeeping 9.00 0 0 0 0.00 0.00 32.00 33.00 Housekeeping under contract (see instructions) 791, 457 0 791, 457 28.025.88 28.24 35.00 34.00 Dietary under contract (see instructions) 791, 457 0 791, 457 28.025.88 28.24 35.00									
26.00 Employee Benefits Department 4.00 295, 149 -279, 823 15, 326 385, 58 39, 75 26.00 27.00 Administrative & General 5.00 2, 576, 475 -832, 886 1, 743, 589 56, 052.02 31.11 27.00 28.00 Administrative & General under contract (see inst.) 2, 276, 039 0 2, 276, 039 34, 121.26 66.70 28.00 29.00 Maintenance & Repairs 6.00 0 0 0 0.00 0.00 29.00 31.00 Laundry & Linen Service 8.00 0 0 0 0.00 0.00 31.00 32.00 Housekeeping 9.00 0 0 0.00 0.00 32.00 34.00 Dietary 10.00 0 0 0.00 0.00 33.00 35.00 Dietary under contract (see instructions) 791, 457 0 791, 457 28, 025.88 28.24 35.00 36.00 Cafeteria 11.00 0 0 0									
27.00 Administrative & General under contract (see inst.) 5.00 2,576,475 -832,886 1,743,589 56,052.02 31.11 27.00 28.00 Administrative & General under contract (see inst.) 2,276,039 0 2,276,039 34,121.26 66.70 28.00 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 30.00 33.00 Housekeeping 9.00 0 0 0 0.00 32.00 34.00 Di etary under contract (see instructions) 2,097,647 0 2,097,647 83,689.36 25.06 33.00 34.00 Di etary under contract (see instructions) 791,457 0 791,457 28,025.88 28.24 35.00 36.00 Cafeteria 11.00 0 0 0 0.00 0.00 36.00 37.00 Maintenance of Personnel </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>•</td> <td></td>								•	
28.00 Administrative & General under contract (see inst.) 2,276,039 2,276,039 34,121.26 66.70 28.00 29.00 Maintenance & Repairs 6.00 0 0 0 0.00 29.00 30.00 Operation of Plant 7.00 0 0 0 0.00 20.00 31.00 Laundry & Linen Service 8.00 0 0 0.00 0.00 30.00 32.00 Housekeeping 9.00 0 0 0 0.00 0.00 31.00 33.00 Housekeeping under contract (see instructions) 2,097,647 0 2,097,647 83,689.36 25.06 33.00 34.00 Di etary 10.00 0 0 0 0.00 0.00 34.00 35.00 Di etary 10.00 0 0 0 0.00 0.00 34.00 36.00 Cafteria 11.00 0 0 0 0.00 0.00 37.00 38.00 Nursing Administration 13.00 1,620,273 48,346 1,668,619 43,065.15 38.75 <									
contract (see inst.) contract (see inst.) contract (see inst.) contract (see inst.) 29.00 Maintenance & Repairs 6.00 0 0 0.00 0.00 0.00 29.00 30.00 Operation of Plant 7.00 0 0 0.00 0.00 30.00 31.00 Laundry & Linen Service 8.00 0 0 0.00 0.00 31.00 32.00 Housekeeping 9.00 0 0 0 0.00 32.00 33.00 Housekeeping under contract (see instructions) 2,097,647 0 2,097,647 83,689.36 25.06 33.00 35.00 Di etary 10.00 0 0 0 0.00 0.00 34.00 35.00 Di etary under contract (see instructions) 791,457 0 791,457 28,025.88 28.24 35.00 36.00 Cafeteria 11.00 0 0 0 0.00 0.00 30.03 37.00 38.00 Nursing Administratio					-832, 886				
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 30.00 31.00 Laundry & Linen Service 8.00 0 0 0 0.00 30.00 32.00 Housekeeping 9.00 0 0 0 0.00 31.00 33.00 Housekeeping under contract 2,097,647 0 2,097,647 83,689.36 25.06 33.00 34.00 Dietary under contract (see 791,457 0 791,457 28,025.88 28.24 35.00 35.00 Dietary under contract (see 791,457 0 791,457 28,025.88 28.24 35.00 36.00 Cafeteria 11.00 0 0 0 0.00 0.00 36.00 37.00 Maintenance of Personnel 12.00 0 0 0.00 0.00 37.00 38.00 Nursing Administration 13.00 1,620,273 48,346 1,668,619 43,065.15 38.75				2, 276, 039	0	2, 276, 03	9 34, 121. 26	66. 70	28.00
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 Housekeeping 9.00 0 0 0 0.00 0.00 32.00 33.00 Housekeeping under contract (see instructions) 2,097,647 0 2,097,647 83,689.36 25.06 33.00 34.00 Dietary 10.00 0 0 0 0.00 0.00 34.00 35.00 Dietary under contract (see instructions) 791,457 0 791,457 28,025.88 28.24 35.00 36.00 Cafeteria 11.00 0 0 0 0.00 37.00 38.00 Nursing Administration 13.00 1,620,273 48,346 1,668,619 43,065.15 38.75 38.00 39.00 Central Services and Supply 14.00 395,289 6,430 401,719 19,369.77 20									
31.00 Laundry & Linen Service 8.00 0 0 0 0.00 0.00 31.00 32.00 Housekeeping 9.00 0 0 0 0.00 32.00 33.00 Housekeeping under contract (see instructions) 2,097,647 0 2,097,647 83,689.36 25.06 33.00 34.00 Dietary under contract (see instructions) 10.00 0 0 0 0.00 34.00 35.00 Dietary under contract (see instructions) 10.00 0 0 0 0.00 34.00 36.00 Cafeteria 11.00 0 0 0 0.00 0.00 36.00 37.00 Maintenance of Personnel 12.00 0 0 0 0.00 0.00 36.00 38.00 Nursi ng Administration 13.00 1,620,273 48,346 1,668,619 43,065.15 38.75 38.00 39.00 Central Services and Supply 14.00 395,289 6,430 401,719 19,369.77 20.74 39.00 41.00 Pharmacy 15.00 2,728,316				0	0				
32.00 Housekeeping 9.00 0 0 0 0.00 32.00 33.00 Housekeeping under contract (see instructions) 2,097,647 0 2,097,647 83,689.36 25.06 33.00 34.00 Dietary 10.00 0 0 0 0 0.00 34.00 35.00 Dietary under contract (see instructions) 791,457 0 791,457 28,025.88 28.24 35.00 36.00 Cafeteria 11.00 0 0 0 0.00 0.00 36.00 37.00 Maintenance of Personnel 12.00 0 0 0 0.00 36.00 38.00 Nursi ng Administration 13.00 1,620,273 48,346 1,668,619 43,065.15 38.75 38.00 39.00 Central Services and Supply 14.00 395,289 6,430 401,719 19,369.77 20.74 39.00 40.00 Pharmacy 15.00 2,728,316 28,732 2,757,048 61,105.13 45.12 40.00 41.00 Social Service 17.00 0 <t< td=""><td></td><td></td><td></td><td>0</td><td>0</td><td></td><td></td><td></td><td></td></t<>				0	0				
33.00 Housekeeping under contract (see instructions) 2,097,647 0 2,097,647 83,689.36 25.06 33.00 34.00 Dietary 10.00 0 0 0 0 0.00 34.00 35.00 Dietary under contract (see instructions) 10.00 0 0 0 0 0.00 34.00 36.00 Cafeteria 11.00 0 0 0 0 0.00 36.00 36.00 Cafeteria 11.00 0 0 0 0.00 0.00 36.00 37.00 Maintenance of Personnel 12.00 0 0 0 0.00 37.00 38.00 Nursing Administration 13.00 1,620,273 48,346 1,668,619 43,065.15 38.75 38.00 39.00 Central Services and Supply 14.00 395,289 6,430 401,719 19,369.77 20.74 39.00 40.00 Pharmacy 15.00 2,728,316 28,732 2,757,048 61,105.13 45.12 40.00 41.00 Medical Records & Medical 16.00	31.00	Laundry & Linen Service		0	0				
(see instructions) 10.00 0 0 0 0 0.00 34.00 34.00 Dietary under contract (see instructions) 10.00 0 0 0 0 0.00 34.00 35.00 Dietary under contract (see instructions) 791,457 0 791,457 28,025.88 28.24 35.00 36.00 Cafeteria 11.00 0 0 0 0.00 36.00 37.00 Maintenance of Personnel 12.00 0 0 0 0.00 37.00 38.00 Nursi ng Admini strati on 13.00 1,620,273 48,346 1,668,619 43,065.15 38.75 38.00 39.00 Central Services and Supply 14.00 395,289 6,430 401,719 19,369.77 20.74 39.00 40.00 Pharmacy 15.00 2,728,316 28,732 2,757,048 61,105.13 45.12 40.00 41.00 Medical Records & Medical Records Library 16.00 0 0 0 <			9.00	0	0				
34.00 Dietary 10.00 0 0 0 0.00 34.00 35.00 Dietary under contract (see instructions) 791,457 0 791,457 28,025.88 28.24 35.00 36.00 Cafeteria 11.00 0 0 0 0 0.00 36.00 37.00 Maintenance of Personnel 12.00 0 0 0 0.00 37.00 38.00 Nursing Administration 13.00 1,620,273 48,346 1,668,619 43,065.15 38.75 38.00 39.00 Central Services and Supply 14.00 395,289 6,430 401,719 19,369.77 20.74 39.00 41.00 Medical Records & Medical 16.00 0<	33.00	Housekeeping under contract		2,097,647	0	2, 097, 64	7 83, 689. 36	25.06	33.00
35.00 Dietary under contract (see instructions) 791,457 0 791,457 28,025.88 28.24 35.00 36.00 Cafeteria 11.00 0 0 0 0.00 36.00 37.00 Maintenance of Personnel 12.00 0 0 0 0.00 37.00 38.00 Nursing Administration 13.00 1,620,273 48,346 1,668,619 43,065.15 38.75 38.00 39.00 Central Services and Supply 14.00 395,289 6,430 401,719 19,369.77 20.74 39.00 40.00 Pharmacy 15.00 2,728,316 28,732 2,757,048 61,105.13 45.12 40.00 41.00 Medical Records & Medical 16.00 0 0 0.00 0.00 41.00 42.00 Social Service 17.00 0 0 0 0.00 0.00 42.00									
instructions) instructions) instructions) 36.00 Cafeteria 11.00 0 0 0 0.00 36.00 37.00 Maintenance of Personnel 12.00 0 0 0 0.00 37.00 38.00 Nursing Administration 13.00 1, 620, 273 48, 346 1, 668, 619 43, 065.15 38.75 38.00 39.00 Central Services and Supply 14.00 395, 289 6, 430 401, 719 19, 369.77 20.74 39.00 40.00 Pharmacy 15.00 2, 728, 316 28, 732 2, 757, 048 61, 105.13 45.12 40.00 41.00 Medical Records & Medical 0 0 0 0.00 41.00 42.00 Social Service 17.00 0 0 0 0.00 0.00 42.00			10.00	-	0				
36.00 Cafeteria 11.00 0 0 0 0.00 36.00 37.00 Maintenance of Personnel 12.00 0 0 0 0 0.00 37.00 38.00 Nursi ng Administrati on 13.00 1,620,273 48,346 1,668,619 43,065.15 38.75 38.00 39.00 Central Services and Supply 14.00 395,289 6,430 401,719 19,369.77 20.74 39.00 40.00 Pharmacy 15.00 2,728,316 28,732 2,757,048 61,105.13 45.12 40.00 41.00 Medical Records & Medical 16.00 0 0 0 0.00 41.00 42.00 Social Service 17.00 0 0 0 0.00 0.00 42.00				791, 457	0	791, 45	7 28, 025. 88	28. 24	35.00
37.00 Maintenance of Personnel 12.00 0 0 0 0.00 37.00 38.00 Nursing Administration 13.00 1,620,273 48,346 1,668,619 43,065.15 38.75 38.00 39.00 Central Services and Supply 14.00 395,289 6,430 401,719 19,369.77 20.74 39.00 40.00 Pharmacy 15.00 2,728,316 28,732 2,757,048 61,105.13 45.12 40.00 41.00 Medical Records & Medical Records & Medical Records & Ibrary 17.00 0 0 0 0.00 0.00 41.00 42.00 Social Service 17.00 0 0 0 0.00 0.00 42.00									
38.00 Nursing Administration 13.00 1,620,273 48,346 1,668,619 43,065.15 38.75 38.00 39.00 Central Services and Supply 14.00 395,289 6,430 401,719 19,369.77 20.74 39.00 40.00 Pharmacy 15.00 2,728,316 28,732 2,757,048 61,105.13 45.12 40.00 41.00 Medical Records & Medical Records & Medical Info.00 0 0 0 0.00 0.00 41.00 42.00 Social Service 17.00 0 0 0 0.00 0.00 42.00				0	0				
39.00 Central Services and Supply 14.00 395,289 6,430 401,719 19,369.77 20.74 39.00 40.00 Pharmacy 15.00 2,728,316 28,732 2,757,048 61,105.13 45.12 40.00 41.00 Medical Records & Medical Records & Medical Library 16.00 0 0 0 0.00 0.00 41.00 42.00 Social Service 17.00 0 0 0 0.00 0.00 42.00				0	0				
40.00 Pharmacy 15.00 2,728,316 28,732 2,757,048 61,105.13 45.12 40.00 41.00 Medical Records & Medical Records & Medical Records Library 16.00 0 0 0 0 0.00 41.00 42.00 Social Service 17.00 0 0 0 0.00 0.00 42.00	38.00	Nursing Administration	13.00	1, 620, 273	48, 346	1, 668, 61	9 43, 065. 15	38. 75	38.00
41. 00 Medi cal Records & Medi cal 16. 00 0 0 0 0.00 41. 00 Records Library 42. 00 Social Service 17. 00 0 0 0 0.00 42. 00	39.00	Central Services and Supply	14.00	395, 289	6, 430	401, 71	9 19, 369. 77	20. 74	39.00
Records Library 10 0 0 0 0 0 0 0 0 0 0 42.00 0	40.00	Pharmacy	15.00	2, 728, 316	28, 732	2, 757, 04	8 61, 105. 13	45.12	40.00
42.00 Social Service 17.00 0 0 0 0.00 42.00	41.00	Medical Records & Medical	16. 00	0	0		0.00	0.00	41.00
43.00 Other General Service 18.00 0 0 0 0 0.00 43.00	42.00	Social Service	17.00	0	0		0.00	0.00	42.00
	43.00	Other General Service	18.00	0	0		0.00	0.00	43.00

Heal th	Financial Systems	AS	CENSION ST. VI	NCENT ANDERSON		In Lie	eu of Form CMS-2	2552-10
HOSPI	FAL WAGE INDEX INFORMATION			Provider CO		Period: From 07/01/2020 To 06/30/2021	Date/Time Pre	
		Warkahaat A	Amount	Deel eesi fi eeti	Adiustad	Doi d Houro	11/23/2021 1:	
		Worksheet A		Reclassi fi cati			Average Hourly	
		Line Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from	(col . 2 ± col .		col. 5)	
		1.00		Worksheet A-6)	,	<u>col.</u> 4	(00	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY				-		
1.00	Net salaries (see		44, 678, 582	25, 733	44, 704, 31	5 1, 263, 961. 72	35.37	1.00
	instructions)							
2.00	Excluded area salaries (see		4, 556, 883	-42, 952	4, 513, 93	1 120, 715. 87	37.39	2.00
	instructions)							
3.00	Subtotal salaries (line 1		40, 121, 699	68, 685	40, 190, 38	4 1, 143, 245. 85	35. 15	3.00
	minus line 2)							
4.00	Subtotal other wages & related		21, 428, 297	0	21, 428, 29	7 456, 115. 03	46. 98	4.00
	costs (see inst.)		,,	-	,,			
5.00	Subtotal wage-related costs		15, 171, 592	0	15, 171, 59	2 0.00	37.75	5.00
5.00	(see inst.)		15, 171, 572	0	15, 171, 57	0.00	57.75	5.00
6.00	Total (sum of lines 3 thru 5)		76, 721, 588	68, 685	76, 790, 27	3 1, 599, 360. 88	48.01	6.00
7.00	Total overhead cost (see		12, 780, 645	-1, 029, 201	11, 751, 44	4 325, 814. 15	36.07	7.00
	instructions)			I				

Heal th	Financial Systems ASCENSION ST.	VINCENT ANDERSON	In Lie	u of Form CMS-2	2552-10
HOSPI T	AL WAGE RELATED COSTS	Provider CCN: 15-0088	Peri od:	Worksheet S-3	
			From 07/01/2020	Part IV	
			To 06/30/2021	Date/Time Pre	
				<u>11/23/2021 1:</u> Amount	22 pm
				Reported	
				1.00	
	PART IV - WAGE RELATED COSTS			1.00	
	Part A - Core List				
	RETI REMENT COST				
1.00	401K Employer Contributions			1, 729, 760	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			0	2.00
3.00	Nongualified Defined Benefit Plan Cost (see instructions))		0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)			0	4.00
1.00	PLAN ADMINI STRATI VE COSTS (Paid to External Organization)				1.00
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			316, 981	7.00
7.00	HEALTH AND INSURANCE COST			510, 701	7.00
8.00	Health Insurance (Purchased or Self Funded)			0	8.00
8.01	Health Insurance (Self Funded without a Third Party Admin	nistrator)		0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administ			4, 385, 791	
8.03	Heal th Insurance (Purchased)			4, 303, 777	
9.00	Prescription Drug Plan			1, 634, 354	
10.00	Dental, Hearing and Vision Plan			1, 034, 334	
11.00	Life Insurance (If employee is owner or beneficiary)			157, 884	
12.00	Accident Insurance (If employee is owner or beneficiary)			30, 343	
12.00	Disability Insurance (If employee is owner or beneficiary)			233, 515	
14.00	Long-Term Care Insurance (If employee is owner or benefic	urary)		0	
15.00	'Workers' Compensation Insurance		L LU FACD 10/	181, 469	
16.00	Retirement Health Care Cost (Only current year, not the e	extraordinary accruai require	a by FASB 106.	0	16.00
	Non cumulative portion) TAXES				
17 00	FICA-Employers Portion Only			2, 841, 461	17 00
18.00	Medicare Taxes - Employers Portion Only			0	18.00
19.00	Unemployment Insurance			0	
20.00	State or Federal Unemployment Taxes			49, 749	20.00
21 00	OTHER		alle Allehaura (anal	0	01 00
21.00	Executive Deferred Compensation (Other Than Retirement Constructions))	ost Reported on Times I throu	gn 4 above. (see	0	21.00
22 00	Day Care Cost and Allowances			0	22.00
	Tuition Reimbursement			33, 281	
	Total Wage Related cost (Sum of lines 1 -23)			33, 281 11, 594, 588	
24.00	Part B - Other than Core Related Cost			11, 394, 588	24.00
25 00	OTHER WAGE RELATED COSTS (SPECIFY)				25.00
25.00	UTHEN WHOL NELATED CUSTS (SPECITT)		I		20.00

Heal th	Financial Systems	ASCENSI ON ST.	VINCENT ANDERSON	In Lie	u of Form CMS-2	2552-10
HOSPI 1	AL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 15-0088	Peri od:	Worksheet S-3	
				From 07/01/2020	Part V	
				To 06/30/2021	Date/Time Pre 11/23/2021 1:	
	Cost Center Description			Contract Labor	Benefit Cost	
				1.00	2.00	
	PART V - Contract Labor and Benefit Cost					
	Hospital and Hospital-Based Component Ide	nti fi cati on:				1
1.00	Total facility's contract labor and benef	it cost		6, 106, 732	11, 594, 588	1.00
2.00	Hospi tal			6, 106, 732	11, 594, 588	2.00
3.00	Subprovider - IPF					3.00
4.00	Subprovider - IRF			0	0	4.00
5.00	Subprovider - (Other)			0	0	5.00
6.00	Swing Beds - SNF			0	0	6.00
7.00	Swing Beds - NF			0	0	7.00
8.00	Hospital-Based SNF					8.00
9.00	Hospital-Based NF					9.00
10.00	Hospital-Based OLTC					10.00
11.00	Hospital-Based HHA					11.00
12.00	Separately Certified ASC					12.00
13.00	Hospital-Based Hospice					13.00
14.00	Hospital-Based Health Clinic RHC					14.00
15.00	Hospital-Based Health Clinic FQHC					15.00
16.00	Hospital-Based-CMHC					16.00
17.00	Renal Dialysis					17.00
18.00	Other			0	0	18.00

Heal th	Financial Systems ASCENSION ST. VINCENT	F ANDERSON		In Lie	u of Form CMS-2	2552-10
		Provider CCN	N: 15-0088	Peri od:	Worksheet S-1	0
				From 07/01/2020		
				To 06/30/2021	Date/Time Pre	
					11/23/2021 1:	
					1.00	
	Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divi	ided by lin	e 202 column	8)	0. 225909	1.00
	Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid				33, 926, 042	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 supplementa	al payments	from Medica	i d?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments fro	om Medicaid			0	5.00
6.00	Medi cai d charges				160, 543, 051	6.00
7.00	Medicaid cost (line 1 times line 6)				36, 268, 120	7.00
8.00	Difference between net revenue and costs for Medicaid program (I	line 7 minu	s sum of lin	es 2 and 5; if	2, 342, 078	8.00
	<pre>< zero then enter zero) Children's Health Insurance Program (CHIP) (see instructions for</pre>	a aaab lina	<u>۱</u>			
9.00	Net revenue from stand-al one CHIP	each i i ne)		0	9.00
9.00 10.00	Stand-al one CHIP charges					9.00 10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)				0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (I	line 11 min	us line 9 i	f < zero then	0	12.00
.2.00	enter zero)			2010 11011	, i i i i i i i i i i i i i i i i i i i	12.00
	Other state or local government indigent care program (see instr	ructions fo	r each line)		•	
13.00	Net revenue from state or local indigent care program (Not inclu				0	
14.00	Charges for patients covered under state or local indigent care	program (N	ot included	in lines 6 or	0	14.00
						45 00
15.00	State or local indigent care program cost (line 1 times line 14)		(1)	45	0	15.00
16.00	Difference between net revenue and costs for state or local indi 13; if < zero then enter zero)	igent care	program (III	e 15 minus line	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIF	and state	/local_indig	ent care program	IS (See	
	instructions for each line)	una otato	, roodi i riidi g	one our o progra		
17.00	Private grants, donations, or endowment income restricted to fur	nding chari	ty care		0	17.00
18.00	Government grants, appropriations or transfers for support of he	ospital ope	rations		0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local	indigent c	are programs	(sum of lines	2, 342, 078	19.00
	8, 12 and 16)				T b b c b c	
			Uni nsured pati ents	Insured	Total (col. 1 + col. 2)	
		-	1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)	I	1.00	2.00	3.00	
20.00	Charity care charges and uninsured discounts for the entire faci	ility	13, 638, 83	2 1, 061, 752	14, 700, 584	20.00
	(see instructions)	.,	-, ,			
21.00	Cost of patients approved for charity care and uninsured discour	nts (see	3, 081, 13	5 1, 061, 752	4, 142, 887	21.00
	instructions)					
22.00	Payments received from patients for amounts previously written of	off as		0 0	0	22.00
22 00	charity care		3, 081, 13	5 1, 061, 752	4, 142, 887	22.00
23.00	Cost of charity care (line 21 minus line 22)		3, 081, 13	5 1,001,752	4, 142, 887	23.00
					1.00	
24.00	Does the amount on line 20 column 2, include charges for patien	t davs bevo	nd a length	of stay limit	N 11.00	24.00
	imposed on patients covered by Medicaid or other indigent care					
25.00	If line 24 is yes, enter the charges for patient days beyond the	e indigent	care program	s length of	0	25.00
	stay limit					
26.00	Total bad debt expense for the entire hospital complex (see ins				9,007,268	
27.00	Medicare reimbursable bad debts for the entire hospital complex				331, 876	
27.01	Medicare allowable bad debts for the entire hospital complex (se	ee instruct	ions)		510, 578	
28.00	Non-Medicare bad debt expense (see instructions)		notruoti >		8, 496, 690	
29.00 30.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expe Cost of uncompensated care (line 23 column 3 plus line 29)	ense (see l	instructions)		2, 098, 181 6, 241, 068	
	Total unreimbursed and uncompensated care cost (line 19 plus lin	ne 30)			8, 583, 146	
51.00	The car and an				1 0,000,140	01.00

	Financial Systems AS SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	SCENSION ST. VIN F EXPENSES	Provider CC	F	eriod: rom 07/01/2020	u of Form CMS-: Worksheet A	
					06/30/2021	Date/Time Pre 11/23/2021 1:	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00 1.01	00100 CAP REL COSTS-BLDG & FIXT 00101 CAP REL COSTS-BLDG & FIXT-MAB		3, 405, 751	3, 405, 751	-5, 265 0	3, 400, 486 0	1
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	295, 149	8, 456, 346	8, 751, 495	-	8, 435, 473	
5.00	00500 ADMI NI STRATI VE & GENERAL	2, 576, 475	49, 393, 892	51, 970, 367	-1, 011, 573	50, 958, 794	
7.00	00700 OPERATION OF PLANT	0	5, 542, 213	5, 542, 213		5, 563, 913	
8.00 9.00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	0	575, 578 2, 503, 793	575, 578 2, 503, 793		575, 578 2, 531, 874	
10.00	01000 DI ETARY	0	2, 569, 662	2, 569, 662		1, 063, 062	
11.00	01100 CAFETERI A	0	0	0	1, 506, 922	1, 506, 922	11.00
13.00	01300 NURSING ADMINISTRATION	1, 620, 273	830, 990	2, 451, 263		2, 528, 708	
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	395, 289 2, 728, 316	148, 837 188, 513	544, 126 2, 916, 829		550, 556 2, 945, 561	
16.00	01600 MEDICAL RECORDS & LIBRARY	2,720,310	1, 204	1, 204		2, 943, 301	
23.00	02300 ALLIED HEALTH-EMS	171, 050	30, 896			37, 666	1
23.01	02301 ALLIED HEALTH-RAD TECH	83, 205	34, 646		23, 894	141, 745	
23. 02	02303 ALLIED HEALTH-PHARM RESIDENTS	0	0	0	0	0	23.02
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	9, 218, 797	1, 884, 443	11, 103, 240	661, 196	11, 764, 436	30.00
31.00	03100 I NTENSI VE CARE UNI T	3, 390, 549	1, 498, 763	4, 889, 312	73, 618	4, 962, 930	
41.00	04100 SUBPROVI DER – I RF	850, 992	91, 952	942, 944	69, 512	1, 012, 456	
43.00	04300 NURSERY	0	0	0	195, 222	195, 222	43.00
50.00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM	E77 2E4	14 200 429	14 977 094	0 502	14 007 547	50.00
50.00 52.00	05200 DELIVERY ROOM & LABOR ROOM	577, 356 1, 105, 667	14, 300, 628 205, 625	14, 877, 984 1, 311, 292		14, 887, 567 890, 774	
53.00	05300 ANESTHESI OLOGY	0	200, 020	0	0	0	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 640, 362	1, 111, 049	2, 751, 411	-5, 823	2, 745, 588	
54.01	03440 MAMMOGRAPHY	222, 725	243, 334	466, 059		468, 388	
54. 02 54. 03	03450 NUCLEAR MEDICINE - DIAGNOSTIC 03630 ULTRA SOUND	245, 270 352, 940	638, 709 106, 020	883, 979 458, 960		886, 543 462, 650	
55.00	05500 RADI OLOGY-THERAPEUTI C	823, 088	1, 070, 246	1, 893, 334		1, 966, 170	
57.00	05700 CT SCAN	504, 852	209, 299		5, 278	719, 429	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	242, 374	317, 873	560, 247		562, 781	
59.00	05900 CARDI AC CATHETERI ZATI ON	762, 807	334, 428			1, 107, 156	
60. 00 65. 00	06000 LABORATORY 06500 RESPI RATORY THERAPY	0 894, 971	7, 272, 710 166, 840	7, 272, 710 1, 061, 811	0 49, 516	7, 272, 710 1, 111, 327	
66.00	06600 PHYSI CAL THERAPY	2, 488, 989	595, 498	3, 084, 487		1, 983, 456	
67.00	06700 OCCUPATI ONAL THERAPY	0	0	0	867, 762	867, 762	
68.00	06800 SPEECH PATHOLOGY	0	0	0	260, 802	260, 802	
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	109, 622 207, 095	76, 911 328, 064	186, 533 535, 159		187, 679 537, 614	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	207, 095	3, 864, 831	3, 864, 831	2,455	3, 864, 831	
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	4, 809, 769		-	4, 809, 769	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	18, 445, 709			18, 445, 709	
76.00	03190 CHEMOTHERAPY	672, 516	242, 083	914, 599		1, 029, 310	
76. 01	03020 WOUND CARE OUTPATIENT SERVICE COST CENTERS	252, 419	481, 084	733, 503	2, 639	736, 142	76.01
90.00	09000 CLINIC	0	0	0	0	0	90.00
90. 01	09001 ANDERSON OUTPATIENT CENTER	768, 259	59, 898	828, 157	8, 033	836, 190	
	04950 DI ABETI C EDUCATI ON	0	0	0	0	0	
90. 03 91. 00	09002 MS CLINIC 09100 EMERGENCY	0 2, 876, 936	0 1, 545, 512	0 4, 422, 448	0 373, 563	0 4, 796, 011	
91.00 92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 870, 930	1, 545, 512	4, 422, 440	373, 303	4, 790, 011	91.00
	OTHER REIMBURSABLE COST CENTERS	1					
95.00	09500 AMBULANCE SERVICES	31, 154	13, 105	44, 259	0	44, 259	95.00
112 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE		0	0		0	1112 00
113.00	SUBTOTALS (SUM OF LINES 1 through 117)	36, 109, 497	0 133, 596, 704	169, 706, 201	0 -48, 998	169, 657, 203	113.00 118.00
100 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
	19000 RESEARCH	79, 623	14,042	93, 665			190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	2, 263, 606	398, 217	2, 661, 823		2, 679, 219	
	07950 FOUNDATI ON	0	5	5	0		194.00
	07951 CHI LDRENS CLI NI C	0	0	0	0		194.01
	07952 PSS ADMINISTRATION 07953 SEXUAL ASSAULT PROGRAM	100, 524 4, 730	7, 422 346	107, 946 5, 076		108, 997	194. 02 194. 03
	07953 SEXUAL ASSAULT PROGRAM 07954 ASPR BI OTERRORI SM GRANT	4,730	440	440			194.03
194.05	07955 HEALTHY FAMILIES	253, 323	90, 801	344, 124		346, 981	
	07956 DME-HOME_CARE	0	15, 079	15, 079	0		194.06
	07957 MARKETING	0	0	0	0		194.07
	07958 CORPORATE COMMUNICATIONS 07959 MOB	0	0 395	395	0		194.08 194.09
177.07	···· 0D	י ע ע	575	373 \Cost Reports\	I V		1, 1, 1, 0, 0, 0, 0, 0, 0, 0, 0, 0, 0, 0, 0, 0,

Health Financial Systems AS	SCENSION ST. V	NCENT ANDERSON		In Lie	u of Form CMS-	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider C		eriod:	Worksheet A	
				rom 07/01/2020 o 06/30/2021	Date/Time Pre 11/23/2021 1:	
Cost Center Description	Sal ari es	Other	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	0	0	0	194.10
194. 11 07961 MAB	(0 0	0	0	0	194.11
194. 12 07963 ADOLESCENT RESIDENTIAL SERVICES	718, 676	74, 143	792, 819	26, 813	819, 632	194.12
194.13 07962 I DLE SPACE	(0	0	0	0	194.13
200.00 TOTAL (SUM OF LINES 118 through 199)	39, 529, 979	134, 197, 594	173, 727, 573	0	173, 727, 573	200. 00

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			ASCENSION ST. VI	NCENT ANDERSON		In Lie	eu of Form CMS-2	2552-10
RECLAS	SIFICA	ATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provider C	CN: 15-0088	Period: From 07/01/2020 To 06/30/2021	Worksheet A Date/Time Prep 11/23/2021 1:2	
		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation				
			6.00	7.00				
1 00		AL SERVICE COST CENTERS	475.074	2 024 (10	1			1 00
1.00 1.01		CAP REL COSTS-BLDG & FIXT CAP REL COSTS-BLDG & FIXT-MAB	-475, 876		1			1.00 1.01
4.00		EMPLOYEE BENEFITS DEPARTMENT	71, 210	-				4.00
4.00 5.00		ADMINISTRATIVE & GENERAL	-7, 585, 591					5.00
7.00		OPERATION OF PLANT	-488, 038		1			7.00
8.00		LAUNDRY & LINEN SERVICE	400,000		1			8.00
9.00		HOUSEKEEPING	-800					9.00
10.00		DIETARY	-294, 587					10.00
11.00		CAFETERIA	C	1, 506, 922				11.00
		NURSING ADMINISTRATION	-162, 728	2, 365, 980				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	C	550, 556	1			14.00
15.00	01500	PHARMACY	-10, 427	2, 935, 134				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-16, 330	-15, 126				16.00
		ALLIED HEALTH-EMS	-2, 004	35, 662				23.00
		ALLIED HEALTH-RAD TECH	C	1 11, 110				23.01
23.02		ALLIED HEALTH-PHARM RESIDENTS	C	00				23.02
		IENT ROUTINE SERVICE COST CENTERS	-	1	1			
		ADULTS & PEDIATRICS	-2, 004		1			30.00
		INTENSIVE CARE UNIT	-375, 825					31.00
41.00		SUBPROVIDER - IRF	C					41.00
43.00		NURSERY	C	195, 222				43.00
50.00		LARY SERVICE COST CENTERS	1 246 440	12 541 127	1			
52.00		DELIVERY ROOM & LABOR ROOM	-1, 346, 440					50.00 52.00
52.00		ANESTHESI OLOGY	-13,030	011,144				52.00
54.00	1	RADI OLOGY-DI AGNOSTI C	-1,800	2, 743, 788				54.00
54.00		MAMMOGRAPHY	1,000		1			54.00
		NUCLEAR MEDICINE - DIAGNOSTIC		886, 543	1			54.02
54.03		ULTRA SOUND		462, 650	1			54.03
		RADI OLOGY-THERAPEUTI C	-15, 422		1			55.00
57.00		CT SCAN	C	719, 429	1			57.00
58.00		MAGNETIC RESONANCE IMAGING (MRI)	-4, 861		1			58.00
59.00	05900	CARDI AC CATHETERI ZATI ON	C	1, 107, 156				59.00
60.00	06000	LABORATORY	-40, 384	7, 232, 326				60.00
65.00	06500	RESPI RATORY THERAPY	-657	1, 110, 670				65.00
66.00	06600	PHYSI CAL THERAPY	-16, 714	1, 966, 742				66.00
67.00		OCCUPATI ONAL THERAPY	C	867, 762				67.00
68.00		SPEECH PATHOLOGY	C	260, 802	1			68.00
		ELECTROCARDI OLOGY	-334					69.00
	1	ELECTROENCEPHALOGRAPHY	-278, 353					70.00
71.00		MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	C	3, 864, 831				71.00
		IMPL. DEV. CHARGED TO PATIENTS	0	4, 809, 769	1			72.00
		DRUGS CHARGED TO PATIENTS		18, 445, 709	1			73.00
		CHEMOTHERAPY WOUND CARE	25.000	1, 029, 310 701, 142				76.00 76.01
70.01		TI ENT SERVICE COST CENTERS	- 35, 000	///////////////////////////////////////				70.01
00 00								90.00
		ANDERSON OUTPATIENT CENTER	-55, 335	780, 855				90.00
		DI ABETI C EDUCATI ON	00,000) ,00,000				90.01
		MS CLINIC						90.02
		EMERGENCY	-914, 145	3, 881, 866				91.00
		OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		REIMBURSABLE COST CENTERS		1				
95.00	09500	AMBULANCE SERVICES	-44, 259	0	1			95.00
	SPECI	AL PURPOSE COST CENTERS						l
113.00	11300	INTEREST EXPENSE	C	0 0				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-12, 109, 734	157, 547, 469				118.00
	NONRE	IMBURSABLE COST CENTERS						
		GIFT, FLOWER, COFFEE SHOP, & CANTEEN	C	0 0				190.00
		RESEARCH	C	94, 497				191.00
		PHYSICIANS' PRIVATE OFFICES	C	2, 679, 219				192.00
		FOUNDATION	C	5				194.00
		CHILDRENS CLINIC	C	0				194.01
		PSS ADMINISTRATION	C	108, 997	1			194. 02
		SEXUAL ASSAULT PROGRAM	C	5, 125	1			194.03
		ASPR BIOTERRORI SM GRANT	C	440				194.04
		HEALTHY FAMILIES	C	346, 981	•			194.05
		DME-HOME CARE	C	15, 079	1			194.06
		MARKETING	C	0	•			194.07
		CORPORATE COMMUNICATIONS	C	0 0				194. 08
194.09			C	395				194.09
194.10			C	0				194. 10
194.11			C	0				194.11
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ASCENSION ST. VINCENT ANDERSON

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 Systems
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 RECLASSIFICATION
 AND
 ADJUSTMENTS
 OF
 TRIAL
 BALANCE
 OF
 EXPENSES

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In Lieu of Form CMS-2552-10

Health Financial Systems AS	SCENSION ST. V	I NCE	NT ANDERSON		In Lieu	u of Form CMS-	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES		Provider CO	CN: 15-0088		Worksheet A	
					From 07/01/2020 To 06/30/2021	Date/Time Pro 11/23/2021 1:	
Cost Center Description	Adjustments	Ne	et Expenses				
	(See A-8)	For	Allocation				
	6.00		7.00				
194. 12 07963 ADOLESCENT RESIDENTIAL SERVICES	(0	819, 632				194.12
194. 13 07962 I DLE SPACE	(D	0				194.13
200.00 TOTAL (SUM OF LINES 118 through 199)	-12, 109, 73	4	161, 617, 839				200. 00

	SIFICATIONS	A3	CENSION SI. VII	Provi der CCN: 15-00		Worksheet A-6
1120210					From 07/01/2020 To 06/30/2021	Date/Time Prepared:
					10 06/ 30/ 2021	11/23/2021 1:22 pm
	Cost Conton	Increases	Calory	Othor		
	Cost Center 2.00	Li ne # 3.00	Salary 4.00	0ther 5.00		
	B - INSURANCE EXPENSE RECLASS					
1.00	CAP_REL_COSTS_BLDG_&_FIXT		0	569		1.00
	TOTALS		0	569		
1.00	C - INTEREST EXPENSE ADMINISTRATIVE & GENERAL	5.00	0	5, 834		1.00
1.00	TOTALS		— — — <u> </u>	5, 834		1.00
	D - CAFETERIA/DIETARY RECLASS		Ĩ	I		
1.00	CAFETERI A	<u>11.</u> 00		<u>1, 506, 922</u> 1, 506, 922		1.00
	E - LABOR DELIVERY RECLASS		0	1, 500, 922		
1.00	ADULTS & PEDIATRICS	30.00	202, 303	37, 623		1.00
2.00	NURSERY	43.00	16 <u>4, 6</u> 09	<u> </u>		2.00
	TOTALS H - PT_OT_ST RECLASS		366, 912	68, 236		
1.00	OCCUPATIONAL THERAPY	67.00	700, 230	167, 532		1.00
2.00	SPEECH PATHOLOGY	68.00	210, 451	50, 351		2.00
	TOTALS		910, 681	217, 883		
1 00	J - ADOLESCENT RESIDENTIAL SE ADOLESCENT RESIDENTIAL		0	10 (50		1.00
1.00	SERVICES	194.12	0	18, 658		1.00
	TOTALS	<u> </u>		18, 658		
	M - RAD TECH RECLASS	<u>_</u>				
1.00	ALLI ED_HEALTH-RAD_TECH TOTALS	23.01	- 23,024	<u>0</u>		1.00
	0 - SYSTEM PROJECTS		23, 024	0		
1.00	NURSI NG ADMI NI STRATI ON	13.00	30, 443	0		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	619	0		2.00
3.00	PHARMACY	15.00	206	0		3.00
4.00 5.00	ADULTS & PEDIATRICS INTENSIVE CARE UNIT	30. 00 31. 00	297, 117 29, 120	0		4.00
6.00	SUBPROVI DER – I RF	41.00	58, 796	0		6.00
7.00	RESPI RATORY THERAPY	65.00	723	0		7.00
8.00	CHEMOTHERAPY	76.00	105, 823	0		8.00
9.00 10.00	EMERGENCY PHYSICIANS' PRIVATE OFFICES	91.00 192.00	159, 921 49	0		9.00
10.00	TOTALS		682, 817	<u>0</u>		10.00
	Q - PHYSICIAN RECLASS					
1.00	RESPIRATORY_THERAPY		0	<u>38, 138</u>		1.00
	TOTALS R - SECURITY OFFICERS TO ED		0	38, 138		
1.00	EMERGENCY	91.00	166, 067	<u>0</u> 0		1.00
	TOTALS		166, 067	0		
1.00	S - PANDEMIC NURSING ADMINISTRATION	13.00	28, 689	0		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	1, 678	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	33, 789	0		3.00
4.00	INTENSIVE CARE UNIT	31.00	8, 255	0		4.00
5.00 6.00	SUBPROVIDER – IRF OPERATING ROOM	41.00 50.00	1, 844 3, 546	0		5.00
7.00	DELIVERY ROOM & LABOR ROOM	52.00	1, 439	0		7.00
8.00	RADI OLOGY-DI AGNOSTI C	54.00	224	0		8.00
9.00	CARDIAC CATHETERIZATION	59.00	1, 945	0		9.00
10.00		65.00	1, 298	0		10.00
11. 00 12. 00	PHYSI CAL THERAPY ELECTROENCEPHALOGRAPHY	66.00 70.00	1, 016 290	0		11.00
13.00	CHEMOTHERAPY	76.00	1, 168	0		13.00
14.00	EMERGENCY	91.00	17, 168	0		14.00
15.00	HEALTHY FAMILIES	194.05	144	0		15.00
16.00	ADOLESCENT RESIDENTIAL	194.12	641	0		16.00
17.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	О	85, 973		17.00
18.00	OPERATION OF PLANT	7.00	О	21, 700		18.00
19.00	HOUSEKEEPI NG	9.00	0	28, 081		19.00
20.00 21.00	DI ETARY ADULTS & PEDI ATRI CS	10. 00 30. 00	0	322 10, 694		20.00
200	TOTALS		103, 134	146, 770		21.00
	T - VACCINE					
1.00	NURSING ADMINISTRATION	13.00	1, 372	0		1.00
2.00 3.00	ADULTS & PEDIATRICS	30. 00 31. 00	1, 941 793	0		2.00
4.00	SUBPROVI DER – I RF	41.00	156	0		4.00
5.00	DELIVERY ROOM & LABOR ROOM	52.00	1, 631	0		5.00
6.00	PHYSICAL THERAPY	66.00 76.00	493	0		6.00
7.00	CHEMOTHERAPY	76.00	689	0		7.00

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

Health Financial Systems RECLASSIFICATIONS

ASCENSION ST. VINCENT ANDERSON Provider CCN: 15-0088 Period:

In Lieu of Form CMS-2552-10 Worksheet A-6

0.00 DUPLOYEE EVENT TO DEPARTMENT 4.00 0 51 0 0.00 NURS NG APPINISTICS 30.00 0 1.322 11 11.00 NURS NG APPINISTICS 30.00 0 1.631 11 11.00 DELIVERY ROM A LABOR ROM 5.00 0 1.607 10 10 12.00 DERIVERS ROM STATION 13.00 0 2.7.227 2 <td< th=""><th>RECLASS</th><th>SI FI CATI ONS</th><th></th><th></th><th>Provider C</th><th>CN: 15-0088</th><th>Period: From 07/01/2020 To 06/30/2021</th><th>Worksheet A- Date/Time Pr</th><th>repared:</th></td<>	RECLASS	SI FI CATI ONS			Provider C	CN: 15-0088	Period: From 07/01/2020 To 06/30/2021	Worksheet A- Date/Time Pr	repared:
L L L L O 4.00 5.00 0.00 DERADYEE BENETT SEPARTNENT 4.00 0 5.00 <t< th=""><th></th><th></th><th></th><th></th><th></th><th></th><th></th><th>11/23/2021 1</th><th>1:22 pm</th></t<>								11/23/2021 1	1:22 pm
8.00 HEALTHY FAMILLES 144 00 64 0 9.00 HUNCHS ENERTIS DEPARTMENT 4.00 0.51 0.11 110.00 MIRSING ADMI (NS 10A110A 13.00 0 1.272 11 110.00 MIRSING ADMI (NS 10A110A 13.00 0 1.272 11 120.00 MIRSING ADMI (NS 10A110A 13.00 0 1.733 11 130.00 SUPPROVIDER - 1.8F 41.00 0 1.561 11 140.00 DELLTHY FOOM LADOR MOW 52.00 0 1.431 11 150.00 MIRSING ADMI (NS 10A110A 13.00 0 2.772 2 2 100.00 MIRSING ADMI (NS 10A110A 13.00 0 2.727 2 2 100.00 MIRSING ADMIN (NS 10A110A 13.00 0 1.459 2 2 100.00 MIRSING ADMIN (NS 10A110A 13.00 0 1.4272 2 2 100.00 MIRSING ADMIN (NS 10A110A 10.00 1.439 2 2									
9.00 BIRLOVEE ERKETTS DEPARTMENT 4.00 0 51 BIRLOVEE ERKETTS DEPARTMENT 4.00 0 1.322 10.00 BIRLOVEE F. IRF 3.00 0 1.322 11.00 AVAILSTATUCS 3.0.00 0 1.322 11.01 AVAILSTATUCS 3.0.00 0 1.322 11.01 AVAILSTATUCS 3.0.00 0 1.441 11.01 AVAILSTATUCS 3.0.00 0 1.441 11.01 AVAILSTATUCS 3.0.00 0 1.441 11.01 AVAILSTATUCS 4.000 1.00 1.007 11.00 AVAILSTATUCS 4.000 1.000 11.0	8.00								8.00
10.00 NURSING ADMI INSTRATION 13.00 0 1.372 11 10.00 AQUETS APELIATRICS 50.00 0 1.441 11 11.00 AQUETS APELIATRICS 50.00 1.461 11 11.00 DELEVERY PORM & LABOR ROOM 52.00 0 1.631 11 11.00 DELEVERY PORM & LABOR ROOM 52.00 0 1.631 11 11.00 DELEVERY PORM & LABOR ROOM 52.00 0 1.631 11 11.00 DELATINY FAMI LES 194.00 0 689 17 11.00 ADMININSTRATIVE A CREERAL 5.00 0 1.007 1.007 11.00 ADMININSTRATIVE A CREERAL 5.00 0 1.439 1.001 11.00 ADMININSTRATIVE A CREERAL 5.00 0 1.439 1.001 11.00 DELIVEEY PORM & LABOR ROOM 22.00 0 1.439 1.001 11.00 DELIVEEY PORM & LABOR ROOM 22.00 0 1.44971 1.001 11.00 <td></td> <td></td> <td></td> <td></td> <td>-</td> <td></td> <td></td> <td></td> <td>9.00</td>					-				9.00
11.00 ADULTS & PEDIATRICS 30.00 0 1,941 11 12.00 INTENSIVE CARE, UNIT 31.00 0 783 783 13.00 SUPPROVIDER - I RF 41.00 0 1660 11 13.00 SUPPROVIDER - I RF 41.00 0 1660 11 13.00 CHEADTHEADA I ASIGN ROOM 56.00 649 11 14.00 CHEADTHEADA I ASIGN ROOM 50.00 649 11 15.00 HEALTHE FAULLIES -194.00 -0 649 16.00 CHEADTHEADA I SUPPLY 7,139 7,100 7 17.00 HEALTHE FAULLIES -94.00 0 1,537 17.00 DELLISEN FAULTIES -94.00 0 1,537 17.00 DELLISEN FAULTIES -94.00 0 1,537 17.00 DELLISEN FORDINA I AL 194.00 0 1,537 17.00 DELLISEN FORDINA I AL 194.00 0 1,537 17.00 DELLISEN FORDINA I AL 194.00 0 1,537 17.00 DELLISEN FORDINADIA 190				-					10.00
12.00 INTERSIVE CARE UNIT 31.00 0 773 14.00 DELVMEY NOM & LADOR ROW 52.00 0 1.63 14.00 DELVMEY NOM & LADOR ROW 52.00 0 1.63 17.00 HALTHY FAMULIES 194.00 0 1.63 17.00 HALTHY FAMULIES 194.00 0 1.63 17.00 HALTHY FAMULIES 194.00 0 1.03 17.00 HALTHY FAMULIES 194.00 0 1.00 1.01 ARMINISTRATV & GENERAL 5.00 0 1.007 1 1.02 MINISTRATV & GENERAL 5.00 0 1.007 1 1.00 DIRING NGA MERON 52.00 0 1.439 1 1.00 DIRING NGA V 76.00 0 1.168 7 1.00 DIRING NGA V 76.00 0 1.168 7 1.00 DIRING NGA V 76.00 0 1.449 1 1.00 DIRING NGA V 9.00 1.144 10 1 1.00 DIRING NGA V 9.00									11.00
14.00 DELUVEEY ROOM & LABOR ROOM 52.00 0 1.631 14 15.00 PENSIGNAL INFRAPY 76.00 0 6493 15 16.00 CHBUTHERAPY 76.00 0 6493 16 17.00 HEALT FRAML IES 77.190 7.100 17 17.00 HEALT FRAML IES 7.190 7.100 17 17.00 HEALT FRAML IES 7.100 7.100 17 17.00 HEALT FRAML IES 5.00 0 1.007 17 17.00 HEALT FRAML IES 5.00 0 1.007 1.007 1.007 17.00 HEALT FRAML IES 5.00 0 1.439 1.00 1.439 17.00 CHEUTHERAPY 76.00 0 1.439 1.00 1.001 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>12.00</td>									12.00
15.00 PHYSICAL THEARPY 66.00 0 433 17.00 HEALTHY FAULIES 76.00 0 649 17.00 HEALTHY FAULIES 71.139 77.139 77.170 17.00 HEALTHY FAULIES 71.139 77.139 77.170 17.00 AUMINISTRATIVE A GENERAL 5.00 0 22,782 2.00 NUSING CARE UNIT 31.00 0 22,782 3.00 ADULTS & FEDIATRICS 30.00 0 22,782 3.00 ADULTS & FEDIATRICS 30.00 0 1.587 3.00 ADULTS & TEDIATRICS 30.00 0 1.489 4.00 DEFECTENT RESTORMANDER - 1.18 41.00 0 1.489 7.00 ADULTS SCOTT RESTORMANDER - 1.18 0 6.233 0 7.01 ADULTS SCOTT RESTORMANDER - 1.18 0 6.42.33 0 7.00 ADULTS SCOTT RESTORMANDER - 1.18 0 6.42.33 0 7.01 ALED REPRIST DEPARTMENT 4.00 1.22.223 0	13.00	SUBPROVI DER – I RF	41.00	0					13.00
10. 00 CHONTHERAPY 76. 00 0 649 11 17. 00 HALT FRAULES 924.05 0 7,190 7 <td< td=""><td>14.00</td><td>DELIVERY ROOM & LABOR ROOM</td><td>52.00</td><td>0</td><td>1, 631</td><td></td><td></td><td></td><td>14.00</td></td<>	14.00	DELIVERY ROOM & LABOR ROOM	52.00	0	1, 631				14.00
17.00 HEALTHY FAULUES 194.05 0 -64 17.00 - FURLOUGH - - - 1.00 ADDIN STATU & COLENT 5.00 0 22.727 23 1.00 ADDIN STATU & CALENT 31.00 0 22.727 23 1.00 MARSIN KE CARE INFT 31.00 0 1.557 26 1.00 DELEVER POOL & LABOR ROOM 52.00 0 1.459 6 1.00 DELEVER POOL & LABOR ROOM 52.00 0 1.458 6 1.00 DELEVER POOL & LABOR ROOM 52.00 0 1.458 6 1.00 MADLESCENT RESIDENTIAL 194.12 0 64.230 0 1 1.01 MADLESCENT RESIDENTIAL 194.12 0 64.230 0 1 1 1 1 122.223 0 0 1 <td></td> <td></td> <td></td> <td>-</td> <td></td> <td></td> <td></td> <td></td> <td>15.00</td>				-					15.00
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SERVICES	8.00	EMERGENCY	91.00	0	14, 971				8.00
TOTALS 0 09 93 51 I.00 RADIOLGOY-THERAPEUTIC 55.00 -64.230 0 TOTALS - - - - 0 W - ACCRUED PTO - - - 0 0 0 TOTALS - 122.223 0 0 0 0 0 1.00 EMPLOYEE BENEFITS DEPARTMENT - 122.223 0	9.00		194.12	0	641				9.00
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I.00 RADIOLOGY-THERAPEUTIC 55.00 64.230 0 W - ACCRUED PTO - </td <td></td> <td></td> <td></td> <td>0</td> <td>89, 351</td> <td></td> <td></td> <td></td> <td>_</td>				0	89, 351				_
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DI AGNOSTI C 54.03 3,690 0 15.00 ULTRA SOUND 54.03 3,690 0 16.00 RADI OLOGY-THERAPEUTI C 55.00 8,606 0 17.00 CT SCAN 57.00 5,278 0 18.00 CARDI AC CATHETERI ZATI ON 59.00 7,976 0 19.00 RESPI RATORY THERAPY 65.00 9,357 0 20.00 PHYSI CAL THERAPY 66.00 26.024 0 21.00 ELECTROCARDI OLOGY 69.00 1,146 0 21 23.00 CHEMOTHERAPY 70.00 2,165 0 22 24.00 WOUND CARE 76.01 2,639 0 24 25.00 ANDERSON OUTPATI ENT CENTER 90.01 8,033 0 26 26.00 RADI OLOGY-DI AGNOSTI C 54.00 16,977 0 27 28.00 PHYSI CAL THER OFFI CES 192.00 17,347 0 26 29.00 PSS ADMI NI STRATI ON 194.02									13.00
15.00 ULTRA SOUND 54.03 3,690 0 15 16.00 RADI OLOGY-THERAPEUTI C 55.00 8,606 0 16 17.00 CT SCAN 57.00 5,278 0 17 18.00 CARDI AC CATHETERI ZATI ON 59.00 7,976 0 18 19.00 RESPI RATORY THERAPY 65.00 9,357 0 17 20.00 PHYSI CAL THERAPY 66.00 26,024 0 20 20 21.00 ELECTROCARDI OLOGY 69.00 1,146 0 21 22 23.00 CHEMOTHERAPY 76.00 7,031 0 23 24 24 24 24 24 0 23 25 00 ANDERSON OUTPATI ENT CENTER 90.01 24 24 24 24 24 24 25 26 24 25 26 24 25 24 24 24 24 24 24 24 24 25 26 27 27 27 27 27 27 26 26 27 <t< td=""><td>14.00</td><td></td><td>54.02</td><td>2, 564</td><td>0</td><td></td><td></td><td></td><td>14.00</td></t<>	14.00		54.02	2, 564	0				14.00
16.00 RADI OLOGY-THERAPEUTI C 55.00 8,606 0 16 17.00 CT SCAN 57.00 5,278 0 17 18.00 CARDI AC CATHETERI ZATI ON 59.00 7,976 0 18 19.00 RESPI RATORY THERAPY 65.00 9,357 0 16 20.00 PHYSI CAL THERAPY 66.00 26,024 0 20 21.00 ELECTROCARDI OLOGY 69.00 1,146 0 21 22.00 ELECTROCCARDI OLOGY 69.00 1,146 0 22 23.00 CHEMOTHERAPY 76.00 7,031 0 22 24.00 WOUND CARE 76.01 2,639 0 24 25.00 RADERSON OUTPATI ENT CENTER 90.01 8,033 0 25 26.00 RADI OLOGY-DI AGNOSTI C 54.00 16,977 0 26 27.00 RESEARCH 191.00 832 0 27 28.00 PHYSI CLI ANS' PRI VATE OFFI CES 192.00 17,347 0 26 29.00 PSS ADMI NI STRATI O	15 00		E4 02	2 400	0				15.00
17.00 CT SCAN 57.00 5,278 0 17 18.00 CARDI AC CATHETERI ZATI ON 59.00 7,976 0 18 19.00 RESPI RATORY THERAPY 65.00 9,357 0 19 20.00 PHYSI CAL. THERAPY 66.00 26,024 0 20 21.00 ELECTROCARDI OLOGY 69.00 1,146 0 21 22.00 ELECTROENCEPHALOGRAPHY 70.00 2,165 0 22 23.00 CHEMOTHERAPY 76.00 7,031 0 23 24.00 WOUND CARE 76.01 2,639 0 24 25.00 ANDERSON OUTPATI ENT CENTER 90.01 8,033 0 25 26.00 RADI OLOGY-DI AGNOSTI C 54.00 16,977 0 26 27.00 RESEARCH 191.00 832 0 27 28.00 PHYSI CI ANS' PRI VATE OFFI CES 192.00 17,347 0 26 29.00 PSS ADMI NI STRATI ON 194.02 1,051 0 33 33 33 33 33 </td <td></td> <td></td> <td></td> <td></td> <td>-</td> <td></td> <td></td> <td></td> <td>16.00</td>					-				16.00
18.00 CARDI AC CATHETERI ZATI ON 59.00 7,976 0 18 19.00 RESPI RATORY THERAPY 65.00 9,357 0 19 20.00 PHYSI CAL THERAPY 66.00 26,024 0 20 21.00 ELECTROCARDI OLOGY 69.00 1,146 0 22 22.00 ELECTROENCEPHALOGRAPHY 70.00 2,165 0 22 23.00 CHEMOTHERAPY 76.00 7,031 0 23 24.00 WOUND CARE 76.01 2,639 0 24 25.00 ANDERSON OUTPATI ENT CENTER 90.01 8,033 0 25 26.00 RADI OLOGY-DI AGNOSTI C 54.00 16,977 0 26 27.00 RESEARCH 191.00 832 0 27 29.00 PSS ADMI NI STRATI ON 194.02 1,051 0 30 30.00 SEXUAL ASSAULT PROGRAM 194.03 49 0 30 30 31.00 HEALTHY FAMI LLES 194.05 2,649 0 31 32 33 33									17.00
19.00 RESPI RATORY THERAPY 65.00 9,357 0 19 20.00 PHYSI CAL THERAPY 66.00 26,024 0 20 21.00 ELECTROCARDI OLOGY 69.00 1,146 0 21 22.00 ELECTROCARDI OLOGY 69.00 1,146 0 21 22.00 ELECTROENCEPHALOGRAPHY 70.00 2,165 0 22 23.00 CHEMOTHERAPY 76.00 7,031 0 23 24.00 WOUND CARE 76.01 2,639 0 24 25.00 ANDERSON OUTPATI ENT CENTER 90.01 8,033 0 25 26.00 RADI OLOGY-DI AGNOSTI C 54.00 16,977 0 26 27.00 RESEARCH 191.00 832 0 27 28.00 PHYSI CIANS' PRI VATE OFFI CES 192.00 17,347 0 26 29.00 PSS ADMI NI STRATI ON 194.02 1,051 0 30 31.00 MGAULT YENGRAM 194.03 49 0 31 32.00 ADOLESCENT RESI DENTI A									18.00
20.00 PHYSI CAL THERAPY 66.00 26,024 0 20 21.00 ELECTROCARDI OLOGY 69.00 1,146 0 21 22.00 ELECTROENCEPHALOGRAPHY 70.00 2,165 0 22 23.00 CHEMOTHERAPY 76.00 7,031 0 23 24.00 WOUND CARE 76.01 2,639 0 24 25.00 ANDERSON OUTPATI ENT CENTER 90.01 8,033 0 25 26.00 RADI OLOGY-DI AGNOSTI C 54.00 16,977 0 26 28.00 PHYSI CI ANS' PRI VATE OFFICES 192.00 17,347 0 26 29.00 PSS ADMI NI STRATI ON 194.02 1,051 0 27 30.00 SEXUAL ASSAULT PROGRAM 194.03 49 0 30 31.00 HEALTHY FAMI LI ES 194.05 2,649 0 31 32 32.00 ADOLESCENT RESIDENTI AL 194.12 7,514 0 32 33 33 33 33 33 34.00 EMERGENCY 91.00 30,407									19.00
22.00 ELECTROENCEPHALOGRAPHY 70.00 2,165 0 22 23.00 CHEMOTHERAPY 76.00 7,031 0 23 24.00 WOUND CARE 76.01 2,639 0 24 25.00 ANDERSON OUTPATI ENT CENTER 90.01 8,033 0 25 26.00 RADI OLOGY-DI AGNOSTI C 54.00 16,977 0 26 27.00 RESEARCH 191.00 832 0 27 28.00 PHYSI CI ANS' PRI VATE OFFI CES 192.00 17,347 0 26 29.00 PSS ADMI NI STRATI ON 194.02 1,051 0 30 30 30.00 SEXUAL ASSAULT PROGRAM 194.03 49 0 30 30 31.00 HEALTHY FAMI LI ES 194.05 2,649 0 31 32 33 32 33 33 33 32.00 ADOLESCENT RESI DENTI AL 194.12 7,514 0 32 33 33 33 33 33 33.00 MAGNETI C RESONANCE I MAGI NG 58.00 2,534	20.00				0				20.00
23.00 CHEMOTHERAPY 76.00 7,031 0 23 24.00 WOUND CARE 76.01 2,639 0 24 25.00 ANDERSON OUTPATIENT CENTER 90.01 8,033 0 25 26.00 RADIOLOGY-DIAGNOSTIC 54.00 16,977 0 26 27.00 RESEARCH 191.00 832 0 27 28.00 PHYSICIANS' PRIVATE OFFICES 192.00 17,347 0 28 29.00 PSS ADMINISTRATION 194.02 1,051 0 30 30 30.00 SEXUAL ASSAULT PROGRAM 194.03 49 0 30 30 31.00 HEALTHY FAMILIES 194.05 2,649 0 31 32 32.00 ADOLESCENT RESIDENTIAL 194.12 7,514 0 32 33 33 33 33 33.00 MAGNETIC RESONANCE I MAGI NG 58.00 2,534 0 33 33 33 34.00 EMERGENCY 91.00 30,407 0 34 402,205 0 10	21.00	ELECTROCARDI OLOGY	69.00	1, 146	0				21.00
24.00 WOUND CARE 76.01 2,639 0 24.00 ANDERSON OUTPATIENT CENTER 90.01 8,033 0 25.00 ANDERSON OUTPATIENT CENTER 90.01 8,033 0 25.00 RADI OLOGY-DI AGNOSTI C 54.00 16,977 0 26.00 RADI OLOGY-DI AGNOSTI C 54.00 16,977 0 26.00 RESEARCH 191.00 832 0 27.00 RESEARCH 191.00 832 0 27.00 28.00 PHYSI CI ANS' PRI VATE OFFI CES 192.00 17,347 0 26.00 29.00 PSS ADMI NI STRATI ON 194.02 1,051 0 29.00 29.00 SEXUAL ASSAULT PROGRAM 194.03 49 0 30.00 30.00 SEXUAL ASSAULT PROGRAM 194.05 2,649 0 31.00 HEALTHY FAMI LI ES 194.05 2,649 0 32.00 ADOLESCENT RESI DENTI AL 194.12 7,514 0 32.01 32.01 33.00 MAGNETI C RESONANCE I MAGI NG 58.00 2,534 0 33.00 33.00 MAGNETI C RESONANCE I MAGI NG 58.00 2,534 0 33.00 34.00 402,205 0 34.00 3		ELECTROENCEPHALOGRAPHY	70.00	2, 165	0				22.00
25.00 ANDERSON OUTPATIENT CENTER 90.01 8,033 0 25 26.00 RADIOLOGY-DIAGNOSTIC 54.00 16,977 0 26 27.00 RESEARCH 191.00 832 0 27 28.00 PHYSICIANS' PRIVATE OFFICES 192.00 17,347 0 28 29.00 PSS ADMINISTRATION 194.02 1,051 0 30 31 30.00 SEXUAL ASSAULT PROGRAM 194.03 49 0 31 31 31.00 HEALTHY FAMILIES 194.05 2,649 0 31 32 32.00 ADOLESCENT RESIDENTIAL 194.12 7,514 0 32 33.00 MAGNETIC RESONANCE I MAGING 58.00 2,534 0 33 34.00 EMERGENCY 91.00 30,407 0 0 34 402,205 0 0 30,407 0 0 34					-				23.00
26.00 RADI OLOGY-DI AGNOSTI C 54.00 16,977 0 26 26 0 RESEARCH 191.00 832 0 27 28 0 27 28 0 27 28 0 27 28 0 27 28 0 27 28 0 27 28 0 27 28 27 28 0 27 28 0 27 28 0 27 28 0 27 28 0 27 28 0 27 28 0 27 28 0 27 28 0 27 28 27 0 29 0 35 26 0 26 29 0 30 30 29 0 30 29 0 30 30 29 0 30 30 29 0 30 30 29 0 30 30 29 0 31 31 31 31 31 31 31 31 31 31 31 31 31 31 31 </td <td></td> <td></td> <td></td> <td></td> <td>-</td> <td></td> <td></td> <td></td> <td>24.00</td>					-				24.00
27.00 RESEARCH 191.00 832 0 27 28.00 PHYSI CLANS' PRI VATE OFFICES 192.00 17,347 0 28 29.00 PSS ADMI NI STRATI ON 194.02 1,051 0 29 30.00 SEXUAL ASSAULT PROGRAM 194.03 49 0 30 30 31.00 HEALTHY FAMI LIES 194.05 2,649 0 31 31 32.00 ADDLESCENT RESI DENTI AL 194.12 7,514 0 32 33.00 MAGNETI C RESONANCE I MAGI NG 58.00 2,534 0 33 34.00 EMERGENCY 91.00 30,407 0 0 402,205 0 30 402,205 0 0 34					-				25.00
28.00 PHYSICIANS' PRIVATE OFFICES 192.00 17,347 0 28.00 PSS ADMINISTRATION 194.02 1,051 0 29.00 29.00 PSS ADMINISTRATION 194.02 1,051 0 29.00 30.00 SEXUAL ASSAULT PROGRAM 194.03 49 0 30.00 31.00 HEALTHY FAMILIES 194.05 2,649 0 31.00 31.00 HEALTHY FAMILIES 194.12 7,514 0 32.00 32.00 ADOLESCENT RESIDENTIAL 194.12 7,514 0 32.00 33.00 MAGNETIC RESONANCE I MAGI NG 58.00 2,534 0 33.00 33.00 MAGNETIC RESONANCE I MAGI NG 58.00 2,534 0 33.00 34.00 EMERGENCY 91.00 30,407 0 0 34.00 34.00 MERGENCY 91.00 402,205 0 0 34.00 34.00 91.00									26.00 27.00
29.00 PSS ADMI NI STRATI ON 194.02 1,051 0 29 30.00 SEXUAL ASSAULT PROGRAM 194.03 49 0 30 31.00 HEALTHY FAMI LI ES 194.05 2,649 0 31 32.00 ADDLESCENT RESI DENTI AL 194.12 7,514 0 32 33.00 MAGNETI C RESONANCE I MAGI NG 58.00 2,534 0 33 34.00 EMERGENCY					-				27.00
30.00 SEXUAL ASSAULT PROGRAM 194.03 49 0 30 31.00 HEALTHY FAMILIES 194.05 2,649 0 31 32.00 ADDLESCENT RESIDENTIAL 194.12 7,514 0 32 33.00 MAGNETIC RESONANCE I MAGI NG 58.00 2,534 0 33 34.00 EMERGENCY					-				29.00
31.00 HEALTHY FAMILIES 194.05 2,649 0 31 32.00 ADOLESCENT RESIDENTIAL 194.12 7,514 0 32 33.00 MAGNETIC RESONANCE I MAGI NG 58.00 2,534 0 33 34.00 EMERGENCY					0				30.00
32. 00 ADOLESCENT RESIDENTIAL 194. 12 7, 514 0 32 33. 00 MAGNETIC RESONANCE I MAGI NG 58. 00 2, 534 0 33 34. 00 EMERGENCY					Ő				31.00
SERVICES MAGNETIC RESONANCE I MAGI NG 58.00 2,534 0 33 34.00 EMERGENCY					0				32.00
34. 00 (MRI) EMERGENCY 91. 00 30, 407 0 TOTALS 91. 00 30, 407 0									
34. 00 EMERGENCY	33.00		58.00	2, 534	0				33.00
TOTALS 402, 205 0	24.00		01.00	20 107					24.00
	34.00		91.00		श्र				34.00
	500 00				2 000 551				500.00
	555.00	le and rotar. Thereases	i I	2,070,402	2,077,001				1 555. 00

SIFICATIONS			Provider (CCN: 15-0088	Period: From 07/01/2020	Worksheet A-6
					To 06/30/2021	
	Decreases					11/23/2021 1:22 p
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref	· .	
	7.00	8.00	9.00	10.00		
B - I NSURANCE EXPENSE RECLASS ADMI NI STRATI VE & GENERAL	5.00	0	569	1	2	1
TOTALS		of	<u>569</u>		2	1.
C - INTEREST EXPENSE	I					
CAP_REL_COSTS_BLDG_&_FIXT	1.00	0	<u>5, 8</u> 34		1	1
TOTALS		0	5, 834			
D - CAFETERI A/DI ETARY RECLASS	10.00		4 504 000			
DI ETARY	<u> </u>	0	<u>1, 506, 922</u> 1, 506, 922		0	1
E - LABOR DELIVERY RECLASS		<u>Ч</u>	1, 500, 922			
DELIVERY ROOM & LABOR ROOM	52.00	366, 912	68, 236		0	1
	0.00	0	0		0	2
TOTALS		366, 912	68, 236			
H - PT_OT_ST RECLASS				[-	
PHYSICAL THERAPY	66.00	910, 681	217, 883		0	1
TOTALS		0	0		0	2
J - ADOLESCENT RESIDENTIAL SE		910, 681	217, 883	<u> </u>		
ADULTS & PEDIATRICS	30.00	0	18, 658		0	1
TOTALS		of	18,658		7	
M - RAD TECH RECLASS		-				
RADI OLOGY-DI AGNOSTI C	54.00	23, 024	0		0	1
TOTALS		23, 024	0			
0 - SYSTEM PROJECTS			-		-	
ADMI NI STRATI VE & GENERAL	5.00	682, 817	0		0	1
	0. 00 0. 00	0	0		0	2
	0.00	0	0		0	4
	0.00	0	0		0	5
	0.00	o	0		0	6
	0.00	0	0		0	7
	0.00	О	0		0	8
	0.00	0	0		0	9
	0.00	0	0		0	10
TOTALS		682, 817	0			
Q - PHYSICIAN RECLASS ADMINISTRATIVE & GENERAL	5.00	0	38, 138		0	1
TOTALS		— — — 0	3 <u>8, 138</u> 38, 13838		<u>u</u>	
R - SECURITY OFFICERS TO ED	I	<u> </u>	50, 150			
ALLIED HEALTH-EMS	23.00	166, 067	0		0	1
TOTALS		166, 067	ō		7	
S - PANDEMIC				1		
ADMI NI STRATI VE & GENERAL	5.00	103, 134	146, 770	1	2	1
	0.00	0	0		0	2
	0. 00 0. 00	0	0		0	3
	0.00	0	0		0	5
	0.00	0	0		0	6
	0.00	o	0		0	7
	0.00	О	0		0	8
	0.00	о	0		0	9
	0.00	О	0		0	10
	0.00	0	0		0	11
	0. 00 0. 00	0	0		0	12
	0.00		0		0	13
	0.00		0		0	14
	0.00	ő	0		0	16
	0.00	ō	0		0	17
	0.00	о	0		0	18
	0.00	о	0		0	19
	0.00	0	0		0	20
		0	0	<u> </u>	0	21
TOTALS		103, 134	146, 770			
T – VACCINE ADMINISTRATIVE & GENERAL	5.00	7, 139	51		0	1
NURSING ADMINISTRATION	13.00	1, 372	51		0	2
ADULTS & PEDIATRICS	30.00	1, 941	0		0	3
INTENSIVE CARE UNIT	31.00	793	0		0	4
SUBPROVI DER – I RF	41.00	156	0		0	5
DELIVERY ROOM & LABOR ROOM	52.00	1, 631	0		0	6
PHYSI CAL THERAPY	66.00	493	0		0	7
CHEMOTHERAPY	76.00	689	0		0	8
HEALTHY FAMILIES	194.05	64	0		0	9

ASCENSION ST. VINCENT ANDERSON

In Lieu of Form CMS-2552-10 Worksheet A-6

Heal th	Financial Systems	A	SCENSION ST. VIN	NCENT ANDERSO	N	In Lie	u of Form CMS-2	2552-10
RECLAS	SIFICATIONS			Provider (CCN: 15-0088	Peri od:	Worksheet A-6	
						From 07/01/2020		
						To 06/30/2021	Date/Time Pre 11/23/2021 1:	
		Decreases			1		11/23/2021 1.	
	Cost Center	Li ne #	Salary	Other	Wkst. A-7 Ref.			
	6.00	7.00	8.00	9.00	10, 00	·		
10.00	0.00	0.00	0	C		0		10.00
11.00		0.00	0	C		0		11.00
12.00		0.00	Ő	0		o		12.00
13.00		0.00	0	0				13.00
14.00		0.00	0	0				14.00
15.00		0.00	0	0				15.00
16.00		0.00	0	0		0		16.00
17.00		0.00	0	0		0		17.00
17.00	TOTALS		14, 278	51				17.00
	U - FURLOUGH	I	11,270	01				
1.00	ADMI NI STRATI VE & GENERAL	5.00	1, 007	C		0		1.00
2.00	NURSI NG ADMI NI STRATI ON	13.00	27, 727	C		0		2.00
3.00	ADULTS & PEDIATRICS	30.00	32, 586	0				3.00
4.00	INTENSIVE CARE UNIT	31.00	8, 255					4.00
5.00	SUBPROVI DER – I RF	41.00	1, 557					5.00
6.00	DELIVERY ROOM & LABOR ROOM	52.00	1, 439	0				6.00
7.00	CHEMOTHERAPY	76.00	1, 168	0				7.00
8.00	EMERGENCY	91.00	14, 971					8.00
8.00 9.00	ADOLESCENT RESIDENTIAL	194.12				0		8.00 9.00
9.00	SERVICES	174.12	641	C C				9.00
	TOTALS		89, 351	— — — ā	<u> </u>	-		
	V - SEVERANCE	I	07, 331		1			
1.00	ADMI NI STRATI VE & GENERAL	5.00	64, 230	C		0		1.00
1.00	TOTALS		64, 230	0		<u></u>		1.00
	W - ACCRUED PTO		04, 230					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	122, 223		0		1.00
1.00	TOTALS			122, 223	<u> </u>	<u>-</u>		1.00
	X - STARP		U	122, 223				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	402, 205	0		0		1.00
2.00	EWILLOTEL DENEITIS DELARTMENT	0.00	402, 205	0		0		2.00
3.00		0.00	0	0		0		3.00
4.00		0.00	0	0				4.00
5.00		0.00	Ő	0		0		5.00
6.00		0.00	Ő	0		0		6.00
7.00		0.00	0	0		0		7.00
8.00		0.00	Ő	0		0		8.00
9.00		0.00	0	0		0		9.00
10.00		0.00	Ő	0				10.00
11.00		0.00	0	0				11.00
12.00		0.00	0	0		0		12.00
13.00		0.00	Ő	0				13.00
14.00		0.00	0	0		0		14.00
15.00		0.00	Ő	0		0		15.00
16.00		0.00	0	C		0		16.00
17.00		0.00	0	0				17.00
18.00		0.00	0	0		0		18.00
19.00		0.00	0	0		o		19.00
20.00		0.00	0	0		0		20.00
21.00		0.00	0	0		0		21.00
22.00		0.00	0	0		0		22.00
23.00		0.00	0	0		0		23.00
24.00		0.00	0	0		0		24.00
25.00		0.00	0	0		0		25.00
26.00		0.00	0	0		0		26.00
27.00		0.00	0			0		27.00
28.00		0.00	0			0		28.00
28.00 29.00		0.00	0			0		28.00 29.00
29.00 30.00		0.00	0			0		29.00 30.00
30.00		0.00	0			0		30.00 31.00
32.00		0.00	0			0		31.00
32.00 33.00		0.00	0					32.00 33.00
33.00 34.00		0.00	0					33.00 34.00
34. UU	TOTALS		402, 205		<u> </u>			34.00
500 00	Grand Total: Decreases		2, 822, 699	2, 125, 284		-		500.00
500.00	prana rotar. Decreases	I	2, 022, 079	2, 123, 204	1	1	ļ	300.00

Heal th	Financial Systems AS	SCENSION ST. VI	NCENT ANDERSON			In Lie	u of Form CMS-2	2552-10
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provider CC		То	od: 07/01/2020 06/30/2021	Worksheet A-7 Part I Date/Time Pre 11/23/2021 1:	pared:
				Acquisition	IS			
		Begi nni ng	Purchases	Donati on		Total	Disposals and	
		Bal ances					Retirements	
		1.00	2.00	3.00		4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET							
1.00	Land	5, 292, 602	0		0	0	0	1.00
2.00	Land Improvements	1, 752, 365			0	1, 991	0	2.00
3.00	Buildings and Fixtures	68, 545, 996	950, 619		0	950, 619	0	3.00
4.00	Building Improvements	0	0		0	0	0	4.00
5.00	Fixed Equipment	34, 984, 535			0	5, 745, 130		
6.00	Movable Equipment	60, 220, 152	1, 706, 935		0	1, 706, 935	307, 732	6.00
7.00	HIT designated Assets	0	0		0	0	0	1.00
8.00	Subtotal (sum of lines 1-7)	170, 795, 650	8, 404, 675		0	8, 404, 675	324, 400	8.00
9.00	Reconciling Items	0	0		0	0	0	9.00
10.00	Total (line 8 minus line 9)	170, 795, 650	8, 404, 675		0	8, 404, 675	324, 400	10.00
		Endi ng Bal ance	Fully					
			Depreciated					
			Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET							
1.00	Land	5, 292, 602	0					1.00
2.00	Land Improvements	1, 754, 356	0					2.00
3.00	Buildings and Fixtures	69, 496, 615	0					3.00
4.00	Building Improvements	0	0					4.00
5.00	Fixed Equipment	40, 712, 997	0					5.00
6.00	Movable Equipment	61, 619, 355	0					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	178, 875, 925	0					8.00
9.00	Reconciling Items	0	0					9.00
10.00	Total (line 8 minus line 9)	178, 875, 925	0					10.00

Heal th	Financial Systems AS	SCENSION ST. VI	NCENT ANDERSON		In Lie	eu of Form CMS-2	2552-10
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provider CO		Period: From 07/01/2020 To 06/30/2021		pared:
			SL	JMMARY OF CAPI	TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	2, 889, 400	0	516, 35	1 0	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT-MAB	0	0		0 0	0	1.01
3.00	Total (sum of lines 1-2)	2, 889, 400	0	516, 35	1 0	0	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum	1			
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	3, 405, 751				1.00
1.01	CAP REL COSTS-BLDG & FIXT-MAB	0	0				1.01
3.00	Total (sum of lines 1-2)	0	3, 405, 751				3.00

Health Financial S	ystems A	SCENSION ST. VI	NCENT ANDERSON		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF	CAPI TAL COSTS CENTERS		Provider CO		Period: From 07/01/2020 To 06/30/2021	Date/Time Pre 11/23/2021 1:	oared:
		COM	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
Cost (Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col 2)	instructions)	Insurance	
	RECONCILIATION OF CAPITAL COSTS C	1.00	2.00	3.00	4.00	5.00	
1.00 CAP REL COS 1.01 CAP REL COS	TS-BLDG & FIXT TS-BLDG & FIXT-MAB of lines 1-2)	178, 875, 925 0 178, 875, 925	0	178, 875, 92	0 0. 000000 5 1. 000000	0	1. 00 1. 01 3. 00
Cost (Center Description	Taxes	Other Capi tal -Rel ate d Costs	Total (sum of cols. 5 through 7)	f Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	RECONCILIATION OF CAPITAL COSTS C TS-BLDG & FIXT	ENTERS	0		0 2, 880, 412	0	1.00
1.01 CAP REL COS	TS-BLDG & FIXT-MAB of lines 1-2)	0			0 2, 880, 412 0 2, 880, 412	0	1.00 1.01 3.00
(SL	JMMARY OF CAPI			
Cost (Center Description	Interest	Insurance (see instructions)		Other Capital-Relate d Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
1.00 CAP REL COS 1.01 CAP REL COS	RECONCILIATION OF CAPITAL COSTS C TS-BLDG & FIXT TS-BLDG & FIXT-MAB of lines 1-2)	ENTERS 43, 629 0 43, 629	0		0 0 0 0 0 0	0	1. 00 1. 01 3. 00

Heal th	Fi nar	ici al	Systems
AD JUST	MENTS	ΤO	FXPENSES

	Financial Systems	AS	CENSION ST. VI	NCENT ANDERSON	In Lie	eu of Form CMS-2	2552-10
ADJUST	MENTS TO EXPENSES				Period: From 07/01/2020	Worksheet A-8	
					To 06/30/2021	Date/Time Pre	pared:
	· · · ·			Expense Classification or	Worksheet A	11/23/2021 1:2	22 pm
				To/From Which the Amount is			
	Cost Center Description		Amount	Cost Center		Wkst. A-7 Ref.	
1.00	Investment income - CAP REL	1.00 B	2.00	3.00 CAP REL COSTS-BLDG & FIXT	4.00	5.00	1.00
	COSTS-BLDG & FIXT (chapter 2)		1017 001				
1.01	Investment income - CAP REL		0	CAP REL COSTS-BLDG &	1.01	0	1.01
	COSTS-BLDG & FIXT-MAB (chapter 2)			FI XT-MAB			
2.00	Investment income - CAP REL		0	*** Cost Center Deleted ***	2.00	0	2.00
0.00	COSTS-MVBLE EQUIP (chapter 2)		FF 007		5.00		
3.00	Investment income - other (chapter 2)	В	-55, 297	ADMINISTRATIVE & GENERAL	5.00	11	3.00
4.00	Trade, quantity, and time		0		0.00	0	4.00
	discounts (chapter 8)						
5.00	Refunds and rebates of expenses (chapter 8)		0)	0.00	0	5.00
6.00	Rental of provider space by		0		0.00	0	6.00
7	suppliers (chapter 8)		40.074		5.00		7 00
7.00	Telephone services (pay stations excluded) (chapter	A	-19, 874	ADMINISTRATIVE & GENERAL	5.00	0	7.00
	21)						
8.00	Tel evi si on and radio servi ce	A	-6, 519	OPERATION OF PLANT	7.00	0	8.00
9.00	(chapter 21) Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provi der-based physician	A-8-2	-2, 968, 221	-	0.00	0	9.00 10.00
	adjustment						
11.00	Sale of scrap, waste, etc.		0		0.00	0	11.00
12.00	(chapter 23) Related organization	A-8-1	9, 204, 109			0	12.00
	transactions (chapter 10)		.,,				
13.00	Laundry and linen service	P	0		0.00		
14.00 15.00	Cafeteria-employees and guests Rental of quarters to employee		-294, 587		10.00 0.00		14.00 15.00
101.00	and others		c.		0.00	Ŭ	101.00
16.00	Sale of medical and surgical		0		0.00	0	16.00
	supplies to other than patients						
17.00	Sale of drugs to other than	В	-8, 944	PHARMACY	15.00	0	17.00
10.00	patients	В	15 000		1/ 00		10.00
18.00	Sale of medical records and abstracts	В	-15, 290	MEDI CAL RECORDS & LI BRARY	16.00	0	18.00
19.00	Nursing and allied health		0		0.00	0	19.00
	education (tuition, fees,						
20.00	books, etc.) Vending machines		0		0.00	0	20.00
	Income from imposition of		0		0.00		21.00
	interest, finance or penalty						
22 00	charges (chapter 21) Interest expense on Medicare		O		0.00	0	22.00
22.00	overpayments and borrowings to		Ū		0.00	Ŭ	22.00
	repay Medicare overpayments				(5.00		
23.00	Adjustment for respiratory therapy costs in excess of	A-8-3	U	RESPI RATORY THERAPY	65.00		23.00
	limitation (chapter 14)						
24.00	Adjustment for physical	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
	therapy costs in excess of limitation (chapter 14)						
25.00	Utilization review -		0	*** Cost Center Deleted ***	114.00		25.00
	physicians' compensation						
26.00	(chapter 21) Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1 00	0	26.00
∠0.00	COSTS-BLDG & FIXT		U	TAL COSTS-DEDG & FIAT	1.00	0	20.00
26. 01	Depreciation - CAP REL		0	CAP REL COSTS-BLDG &	1.01	0	26. 01
27.00	COSTS-BLDG & FIXT-MAB Depreciation - CAP REL		0	FIXT-MAB *** Cost Center Deleted ***	2.00	0	27.00
27.00	COSTS-MVBLE EQUIP		U		2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***			28.00
29.00	Physicians' assistant	٨٥٦	0		0.00		
30.00	Adjustment for occupational therapy costs in excess of	A-8-3	U	OCCUPATI ONAL THERAPY	67.00		30.00
	limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
	instructions)	I		I	I	I	

Health Financial Syste

Health Financial Systems	ASC	CENSION ST. VI	NCENT ANDERSON	In Lie	u of Form CMS-2	2552-10
ADJUSTMENTS TO EXPENSES			Provider CCN: 15-0088	Period: From 07/01/2020	Worksheet A-8	
				To 06/30/2021	Date/Time Pre 11/23/2021 1:	
			Expense Classification o		11/23/2021 1.	22 pm
			To/From Which the Amount is	s to be Adjusted		
Cost Center Description		Amount 2.00	Cost Center 3.00	Line # 4.00	Wkst. A-7 Ref. 5.00	
31.00 Adjustment for speech	1.00 A-8-3		SPEECH PATHOLOGY	4.00		31.00
pathology costs in excess of limitation (chapter 14)						
32.00 CAH HIT Adjustment for		0		0.00	0	32.00
Depreciation and Interest 33.00 LEASE INCOME	В	401 E10	OPERATION OF PLANT	7.00	0	33.00
33. 01 AMBULANCE COST	B		AMBULANCE SERVICES	95.00		33.00
33.02 OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33. 02
(3) 33.03 OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33. 03
(3)	_					
33. 04 FOUNDATI ON TRANSFER 33. 05 FOUNDATI ON TRANSFER	BB		ADMI NI STRATI VE & GENERAL NURSI NG ADMI NI STRATI ON	5.00 13.00		33.04 33.05
33. 06 FOUNDATION TRANSFER	B		INTENSIVE CARE UNIT	31.00		33.06
33.07 FOUNDATION TRANSFER	В		DELIVERY ROOM & LABOR ROOM	52.00		33.07
33. 08 FOUNDATI ON TRANSFER 33. 09 FOUNDATI ON TRANSFER	B			55.00		33.08 33.09
33. 09 FOUNDATI ON TRANSFER 33. 10 FOUNDATI ON TRANSFER	В		PHYSICAL THERAPY EMERGENCY	66.00 91.00		33.09
33. 11 OTHER MI SCELLANEOUS REVENUE	B		ADMI NI STRATI VE & GENERAL	5.00		33.11
33. 12 OTHER MI SCELLANEOUS REVENUE	В		MEDI CAL RECORDS & LI BRARY	16.00		33.12
33. 13OTHER MI SCELLANEOUS REVENUE33. 14OTHER MI SCELLANEOUS REVENUE	BB		ALLI ED HEALTH-EMS RADI OLOGY-DI AGNOSTI C	23.00 54.00		33. 13 33. 14
33. 15 OTHER MI SCELLANEOUS REVENUE	B		RADI OLOGY-THERAPEUTI C	55.00		33.15
33. 16 OTHER MI SCELLANEOUS REVENUE	В	-4, 861	MAGNETIC RESONANCE I MAGING	58.00	0	33. 16
33. 17 OTHER MI SCELLANEOUS REVENUE	В	-14, 362	(MRI) PHYSICAL THERAPY	66.00	0	33. 17
33. 18 ENTERTAL NMENT	A		DELIVERY ROOM & LABOR ROOM	52.00		33.18
33. 19 ENTERTAI NMENT 33. 20 ENTERTAI NMENT	A		ADULTS & PEDIATRICS RESPIRATORY THERAPY	30.00 65.00		33. 19 33. 20
36. 00 ENTERTAI NMENT	A		ADMI NI STRATI VE & GENERAL	5.00		36.00
36. 01 ENTERTAI NMENT	A	-56	NURSING ADMINISTRATION	13.00	0	36. 01
36. 02 ENTERTAL NMENT	A		PHARMACY	15.00		36.02
36. 03 ENTERTAI NMENT 36. 04 ENTERTAI NMENT	A		EMERGENCY ALLIED HEALTH-EMS	91.00 23.00		36. 03 36. 04
36.05 OTHER ADJUSTMENTS (SPECIFY)		0		0.00		36.05
(3) 36. 06 OTHER ADJUSTMENTS (SPECI FY)		0		0.00	0	36.06
(3)					_	
36. 07 DUES REVENUE 36. 08 ENTERTAI NMENT	B A		ADMINISTRATIVE & GENERAL EMERGENCY	5.00 91.00		
36. 09 OTHER ADJUSTMENTS (SPECIFY)	A	-203		0.00		
(3)						
36. 10 PHYSICIAN FUND EXPENSE	A		ADMINI STRATI VE & GENERAL	5.00		
36. 11 PROVI DER TAX EXPENSE 36. 12 MARKETI NG EXPENSE	A A		ADMI NI STRATI VE & GENERAL ADMI NI STRATI VE & GENERAL	5.00 5.00		36. 11 36. 12
36. 13 OTHER ADJUSTMENTS (SPECIFY)		0		0.00		36. 13
(3) 36. 14 EQUI PMENT RENTAL	В	-6 680	OPERATING ROOM	50.00	0	36. 14
36. 15 CONTRACT SERVICE REVENUE	B		ANDERSON OUTPATIENT CENTER	90.01		
36. 16 CHARI TABLE CONTRI BUTI ONS	А		NURSING ADMINISTRATION	13.00		36.16
36. 17CHARI TABLECONTRI BUTI ON36. 18CORPORATESPONSORSHI PS	A A		ADMI NI STRATI VE & GENERAL ADMI NI STRATI VE & GENERAL	5.00		36. 17 36. 18
36. 19 COMMUNITY BENEFITS	A		ADMINI STRATI VE & GENERAL	5.00		36.19
36. 20 SHARED SAVI NGS PAYMENT	В		ADMI NI STRATI VE & GENERAL	5.00		36.20
36. 21 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	36. 21
36. 22 OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	36. 22
(3) 36. 23 GAIN/LOSS ON DISPOSAL PPE	В	- 800	HOUSEKEEPI NG	9.00	0	36. 23
36. 24 LOBBYING EXPENSE	A		ADMI NI STRATI VE & GENERAL	5.00		36.23
36.25 DEPRECIATION AHA LIFE	A		CAP REL COSTS-BLDG & FIXT	1.00		36. 25
ADJUSTMENT 36. 26 PROMOTI ONAL I TEMS	А	-21, 406	ADMI NI STRATI VE & GENERAL	5.00	0	36. 26
36. 27 PROMOTIONAL ITEMS	A	-1, 990	DELIVERY ROOM & LABOR ROOM	52.00	0	36. 27
36. 28 PROMOTIONAL ITEMS	A		NURSING ADMINISTRATION	13.00		36.28
36.29 PROMOTIONAL ITEMS 36.30 PROMOTIONAL ITEMS	A A		RESPI RATORY THERAPY ELECTROCARDI OLOGY	65.00 69.00		36.29 36.30
36. 31 PRINT SHOP REVENUE	B		ADMI NI STRATI VE & GENERAL	5.00		
36. 32 LAB	В	-116	LABORATORY	60.00		
36.33 BILLING ARRANGEMENTS 11/23/2021 1:22 pm D:\Shared drives\	В	-4, 187	ADMI NI STRATI VE & GENERAL	5.00	0	36.33

Heal th	Financial Systems	ASCENSION ST. VINCENT ANDERSON			In Lieu of Form CMS-2552-10		
ADJUST	MENTS TO EXPENSES			Provider CCN: 15-0088	Period:	Worksheet A-8	
					From 07/01/2020 To 06/30/2021	Date/Time Pre 11/23/2021 1:2	
				Expense Classification of	n Worksheet A		
				To/From Which the Amount is	s to be Adjusted		
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
36.34	BILLING ARRANGEMENTS	В	-1, 343	PHARMACY	15.00	0	36.34
36.35	BILLING ARRANGEMENTS	В	-600	OPERATING ROOM	50.00	0	36.35
36.36	BILLING ARRANGEMENTS	В	-8, 949	ANDERSON OUTPATIENT CENTER	90.01	0	36.36
50.00	TOTAL (sum of lines 1 thru 49)		-12, 109, 734				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

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

B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

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

Heal th	Financial Systems	ASCENSION ST. V	VINCENT ANDERSON	In Li	eu of Form CMS-:	2552-10
STATEM OFFICE	ENT OF COSTS OF SERVICES FROM COSTS	RELATED ORGANIZATIONS AND HO		Period: From 07/01/2020 To 06/30/2021		pared:
	Line No.	Cost Center	Expense I tems	Amount of Allowable Cost	Amount Included in Wks. A, column	
	1.00	2.00	3.00	4,00	5 5.00	
	A. COSTS INCURRED AND ADJUSTN HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE - CAPITAL	2, 791, 050	0	1.00
2.00		ADMINISTRATIVE & GENERAL	HOME OFFICE - INTEREST - CA			2.00
3.00		ADMINISTRATIVE & GENERAL	HOME OFFICE - A&G	919	-	3.00
4.00		ADMINISTRATIVE & GENERAL	HOME OFFICE - OTHER	38, 048, 506		4.00
4.01			SVH CHARGEBACK	4, 135		4.01
4.02		ADMINISTRATIVE & GENERAL	SVH CHARGEBACK	-33, 504		4.02
4.03		PHARMACY	SVH CHARGEBACK	-8, 000		4.03
4.04		ALLIED HEALTH-RAD TECH	SVH CHARGEBACK	28, 370		4.04
4.05		INTENSIVE CARE UNIT	SVH CHARGEBACK	25,000		4.05
4.06		OPERATING ROOM	SVH CHARGEBACK	250, 000		4.06
4.07		RADI OLOGY-DI AGNOSTI C	SVH CHARGEBACK	97, 229		4.07
4.08		RADI OLOGY-THERAPEUTI C	SVH CHARGEBACK	8, 970		4.08
4.09		CARDI AC CATHETERI ZATI ON	SVH CHARGEBACK	90,000		4.09
4.10		EMERGENCY	SVH CHARGEBACK	-14,600		4.10
4.11		CAP REL COSTS-BLDG & FIXT	INTEREST EXPENSE	461,054		4.11
4.12		ADMINISTRATIVE & GENERAL	INTEREST EXPENSE	5,834		4.12
4.13 4.14		EMPLOYEE BENEFITS DEPARTMENT LAUNDRY & LINEN SERVICE	HEALTH INSURANCE SVH CHARGEBACK	7, 428, 947		4.13 4.14
4.14 4.15	0.00		SVH CHARGEBACK	-16, 348	-16, 348 0	4.14 4.15
4.15	0.00				0	4.15
4.10	0.00				0	4.10
4.17	0.00				0	4.17
4.10	0.00				0	4.10
4.20	0.00				0	4.20
4.21	0.00				0	4. 21
4.22	0.00				0	4. 22
4.23	0.00				0	4.23
4.24	0.00			0	0	4.24
4.25	0.00				0	4.25
5.00	TOTALS (sum of lines 1-4).			49, 217, 025	40, 012, 916	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

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

			Related Organization(s) and/	or Home Office	
			0 17		
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.

1 CT IIIDUT						
6.00	G	ST VINCENT HEAL	100.00	ST VINCENT HEAL	100.00	6.00
7.00	G	ASCENSION HEALT	100.00	ASCENSION HEALT	100.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or	FINANCIAL				100.00
	non-financial) specify:					

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

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

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

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

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

Heal th	Financial Syste	ems	ASCENSION ST. VINC	ENT ANDERSON	In Lie	u of Form CMS-2552-10
STATEM OFFICE	COSTS		RELATED ORGANIZATIONS AND HOME	Provider CCN: 15-0088	Period: From 07/01/2020 To 06/30/2021	Worksheet A-8-1 Date/Time Prepared: 11/23/2021 1:22 pm
	Net	Wkst. A-7 Ref.				
	Adjustments					
	(col. 4 minus					
	col. 5)*		_			
	6.00	7.00				
	A. COSTS INCUR HOME OFFICE CO		MENTS REQUIRED AS A RESULT OF TRA	NSACTIONS WITH RELATED	ORGANIZATIONS OR (CLAI MED
1.00	2, 791, 050	0				1.00
2.00	49, 463					2.00
3.00	919	0				3.00
4.00	6, 291, 467	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, 834	11				4. 11
4.12	5, 834	0				4. 12
4.13	71, 210	0				4. 13
4.14	0	0				4.14
4.15	0	0				4. 15
4.16	0	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

* 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, column 1 and/or 2, the amount allowable should be indicated in column 4 of this part

nas not	Deen posted to worksheet A,	cordinins i and/or z, the amount arrowable should be indicated in cordinin 4 or this part.	
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	51		
	6, 00		
	B. INTERRELATIONSHIP TO RELAT	ED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

6.00 HOM	IE OFFICE	6.00							
7.00 SYS	STEM OFFICE	7.00							
8.00		8.00							
9.00		9.00							
10.00		10.00							
100.00		100.00							
(1) llso the	o following cymbols to ind	licata interrelationship to related organizations:							

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

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

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

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

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

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

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

4.25

5.00

0

9, 204, 109

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Heal th Financial Systems

ASCENSION ST. VINCENT ANDERSON

In Lieu of Form CMS-2552-10

	R BASED PHYSIC			Provi der C		Peri od:	Worksheet A-8	8-2
						From 07/01/2020 To 06/30/2021	Date/Time Pre 11/23/2021 1:	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		Identifier	Remunerati on	Component	Component		ider Component	
							Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00		INTENSIVE CARE UNIT	369, 782	369, 782	0	1717000	0	1.00
2.00		OPERATING ROOM	2, 195, 637	1, 162, 200			7, 230	2.00
3.00		RADI OLOGY-DI AGNOSTI C	235, 966		235, 966		8, 874	3.00
4.00		LABORATORY	40, 268			,	0	4.00
5.00		ELECTROENCEPHALOGRAPHY	278, 353			1111000	0	5.00
6.00		WOUND CARE	35,000		0	1111000	0	6.00
7.00		EMERGENCY	905, 658	905, 658	0	211, 500	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			4, 060, 664		1, 269, 403			200.00
	Wkst. A Line #		Unadjusted RCE		Cost of		Physician Cost	
		ldenti fi er	Limit	Unadjusted RCE			of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00		INTENSIVE CARE UNIT	0	-	-		0	1.00
2.00		OPERATING ROOM	856, 477			-	0	2.00
3.00		RADI OLOGY-DI AGNOSTI C	1, 160, 019		0	0	0	3.00
4.00			0	0	0	0	0	4.00
5.00		ELECTROENCEPHALOGRAPHY	0	0	0	0	0	5.00
6.00		WOUND CARE	0	0	0	0	0	6.00
7.00		EMERGENCY	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	100.005	0	0	0	10.00
200.00			2, 016, 496			0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		Identifier	Component	Limit	Di sal I owance			
			Share of col. 14					
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00		I NTENSI VE CARE UNI T	15.00		17.00			1.00
2.00		OPERATING ROOM		-	0			2.00
2.00		RADI OLOGY-DI AGNOSTI C		1, 160, 019		1, 339, 100		2.00
3.00 4.00		LABORATORY	0	1, 100, 019	0	°		3.00 4.00
4.00 5.00		ELECTROENCEPHALOGRAPHY	0	0	0	278, 353		4.00 5.00
5.00 6.00		WOUND CARE		0		278, 353 35, 000		5.00 6.00
			0	0				
7.00 8.00	0.00	EMERGENCY	0	0		905, 658		7.00 8.00
			0	0		0		
9.00	0.00		0	-	3	, i i i i i i i i i i i i i i i i i i i		9.00
10.00	0.00		0	°	0 176, 960	, i		10.00
200.00		1	1 0	2, 016, 496	176, 960	2, 968, 221		200.00

COST /	ALLOCATION - GENERAL SERVICE COSTS		Provider CC	CN: 15-0088	Peri From To	od: n 07/01/2020 06/30/2021	Worksheet B Part I Date/Time Pre	pared:
			CAPI TAL REL	ATED COSTS			11/23/2021 1:	22 pm
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A	BLDG & FIXT	BLDG & FIXT-MAB		EMPLOYEE BENEFI TS DEPARTMENT	Subtotal	
		col. 7)	1.00	1.01		4.00	4A	
	GENERAL SERVICE COST CENTERS	0	1.00	1.01		4.00	4A	
1.00	00100 CAP REL COSTS-BLDG & FIXT	2, 924, 610	2, 924, 610					1.00
1.01	00101 CAP REL COSTS-BLDG & FIXT-MAB	0	0		0	0 545 072		1.01
4.00 5.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	8, 506, 683 43, 373, 203			0 0	8, 545, 073 376, 807	44, 026, 945	4.00 5.00
7.00	00700 OPERATION OF PLANT	5,075,875			0	370,007	5, 421, 444	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	575, 578			0	0	624, 369	
9.00	00900 HOUSEKEEPI NG	2, 531, 074			0	0	2, 592, 920	1
10.00 11.00	01000 DI ETARY 01100 CAFETERI A	768, 475 1, 506, 922			0 0	0	837, 177 1, 610, 772	10.00 11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	2, 365, 980			0	360, 605	2, 756, 860	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	550, 556			0	86, 815		1
15.00	01500 PHARMACY	2, 935, 134			0	595, 826		
16.00	01600 MEDICAL RECORDS & LIBRARY 02300 ALLIED HEALTH-EMS	-15, 126			0	0	17, 195	1
23. 00 23. 01	02300 ALLIED HEALTH-EMS	35, 662 141, 745			0 0	1, 463 23, 145		23.00 23.01
23.02	02303 ALLI ED HEALTH-PHARM RESIDENTS	0	0		0	20, 110	0	23.02
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00		11, 762, 432			0	2, 121, 296		30.00
31.00 41.00	03100 I NTENSI VE CARE UNI T 04100 SUBPROVI DER – I RF	4, 587, 105 1, 012, 456			0 0	746, 686 198, 560		
43.00	04300 NURSERY	195, 222	36, 828		0	35, 574		43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	13, 541, 127			0	126, 843		50.00
52.00 53.00	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	877, 744	137, 683 0		0 0	162, 151	1, 177, 578 0	52.00 53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 743, 788	88, 508		0	353, 240	3, 185, 536	54.00
54.01	03440 MAMMOGRAPHY	468, 388			0	48, 636	517, 024	54.01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	886, 543			0	53, 559		54.02
54.03 55.00	03630 ULTRA SOUND	462,650			0 0	77, 071	539, 721	54.03
55.00	05500 RADI OLOGY-THERAPEUTI C 05700 CT SCAN	1, 950, 748 719, 429			0	193, 618 110, 244	2, 144, 366 833, 089	55.00 57.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	557, 920			0	52, 927	617,064	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	1, 107, 156			0	166, 994	1, 327, 225	59.00
60.00		7, 232, 326			0	105 071	7, 310, 085	1
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	1, 110, 670 1, 966, 742			0 0	195, 871 346, 932	1, 350, 789 2, 376, 010	1
67.00	06700 OCCUPATI ONAL THERAPY	867,762			0	151, 327	1, 046, 742	
68.00	06800 SPEECH PATHOLOGY	260, 802			0	45, 481	314, 596	68.00
69.00		187, 345			0	23, 938		1
	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	259, 261 3, 864, 831	72, 180 0		0	45, 286 0	376, 727 3, 864, 831	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	4, 809, 769	0		0	0	4, 809, 769	
73.00	07300 DRUGS CHARGED TO PATIENTS	18, 445, 709			0	0	18, 445, 709	73.00
76.00	03190 CHEMOTHERAPY	1,029,310			0	169, 726		1
76.01	03020 WOUND CARE OUTPATIENT SERVICE COST CENTERS	701, 142	19, 217		0	55, 121	775, 480	76.01
90.00		0	0		0	0	0	90.00
90. 01	09001 ANDERSON OUTPATIENT CENTER	780, 855	21, 696		0	167, 764	970, 315	
90.02	04950 DI ABETI C EDUCATI ON	0	0		0	0	0	90.02
90. 03 91. 00	09002 MS CLINIC 09100 EMERGENCY	3, 881, 866	0 139, 506		0	699, 230	0 4, 720, 602	90.03 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	3,001,000	137, 300		Ŭ	077, 230	4, 720, 002	
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0	0		0	6, 733	6, 733	95.00
113 00	SPECIAL PURPOSE COST CENTERS							113.00
118.00		157, 547, 469	2, 800, 446		0	7, 799, 469	156, 677, 701	
	NONREI MBURSABLE COST CENTERS							
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	11, 666		0	0	11, 666	
	19100 RESEARCH	94, 497			0	17, 387	111, 884	1
	0 19200 PHYSICIANS' PRIVATE OFFICES 0 07950 FOUNDATION	2, 679, 219 5	11, 338 3, 942		0	492, 947 0	3, 183, 504 3, 947	192.00
194.0	07951 CHI LDRENS CLI NI C	0	0		0	Ō	0	194. 01
	2 07952 PSS ADMINI STRATI ON	108, 997			0	21, 951		1
	3 07953 SEXUAL ASSAULT PROGRAM 4 07954 ASPR BI OTERRORI SM GRANT	5, 125 440			0	1, 033 0		194. 03 194. 04
194.04	07954 ASPR BIOTERRORISM GRANT 07955 HEALTHY FAMILIES	440 346, 981	62, 553		0	55, 349	440 464, 883	
	507956 DME-HOME CARE	15, 079			0	0		194.06
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Health Financial Systems	ASCENSION ST. VI	NCENT ANDERSON		In Lie	eu of Form CMS-:	2552-10
COST ALLOCATI ON - GENERAL SERVI CE COSTS				Period: From 07/01/2020 To 06/30/2021		
		CAPI TAL REL	ATED COSTS			
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	BLDG & FIXT-MAB	EMPLOYEE BENEFI TS DEPARTMENT	Subtotal	
	0	1.00	1.01	4.00	4A	
194. 07 07957 MARKETING 194. 08 07958 CORPORATE COMMUNICATIONS 194. 09 07959 MOB 194. 10 07960 ASC 194. 12 07961 MAB 194. 12 07963 ADOLESCENT RESIDENTIAL SERVICES 194. 13 07962 IDLE SPACE 200. 00 Cross Foot Adjustments 201. 00 Negative Cost Centers	0 0 395 0 819, 632 0	0		0 0 0 0 0 0 0 0 0 0 0 156, 937 0 0 0 0	15, 665 395 0 994, 205 0 0	194. 07 194. 08 194. 09 194. 10 194. 11 194. 12 194. 13 200. 00 201. 00
202.00 TOTAL (sum lines 118 through 201)	161, 617, 839	2, 924, 610		0 8, 545, 073	161, 617, 839	202.00

00 0 01 0 00 0 00 0 00 0	Cost Center Description	ADMI NI STRATI VE & GENERAL 5. 00	OPERATI ON OF PLANT 7.00	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	
00 0 01 0 00 0 00 0 00 0						1	
00 0 01 0 00 0 00 0 00 0		,	7.00	8.00	9.00	10.00	-
01 0 00 0 00 0	ADDAD DEL ADOTO BLOG & ELVE						
00 0 00 0 00 0	00100 CAP REL COSTS-BLDG & FIXT						1.
00 00 00 0	00101 CAP REL COSTS-BLDG & FIXT-MAB						1.
00 0	00400 EMPLOYEE BENEFITS DEPARTMENT	11.00/.015					4.
	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	44, 026, 945					5.
	00800 LAUNDRY & LINEN SERVICE	2, 029, 832 233, 769	7, 451, 276 160, 602	1, 018, 740			8
	00900 HOUSEKEEPING	970, 810		1, 010, 740			9
	01000 DI ETARY	313, 446	226, 141	0			
	01100 CAFETERIA	603, 086		0			
00 0	01300 NURSING ADMINISTRATION	1, 032, 190	99, 655	0	15, 926	0) 13
00 0	01400 CENTRAL SERVICES & SUPPLY	275, 446	323, 612	17, 839	40, 133	0) 14
00 0	01500 PHARMACY	1, 333, 204	98, 328	0	12, 741	0) 15
	01600 MEDI CAL RECORDS & LI BRARY	6, 438		0			
	02300 ALLIED HEALTH-EMS	14, 202	2, 653	0	-	-	
	02301 ALLIED HEALTH-RAD TECH	61, 991	2, 244	0		-	
	02303 ALLIED HEALTH-PHARM RESIDENTS	0	0	0	0 0	0	23
	INPATIENT ROUTINE SERVICE COST CENTERS	E 250 0(0	1 242 254	276 404	1 272 075	1 107 026	1 20
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	5, 350, 968 2, 031, 038		376, 484 111, 134			
	04100 SUBPROVIDER – IRF	2, 031, 038 476, 623					
	04300 NURSERY	100, 201	121, 222	7, 340			
	ANCI LLARY SERVI CE COST CENTERS			7, 340			1 '
	05000 OPERATI NG ROOM	5, 228, 794	979, 344	161, 870	586, 063	517	50
	05200 DELIVERY ROOM & LABOR ROOM	440, 895	453, 199	25, 965			
00 0	05300 ANESTHESI OLOGY	0	0	0	0	0	53
00 0	05400 RADI OLOGY-DI AGNOSTI C	1, 192, 690	291, 332	3, 039	111, 479	0	54
	03440 MAMMOGRAPHY	193, 578		6, 046			
	03450 NUCLEAR MEDICINE - DIAGNOSTIC	354, 597	22, 996	534			
	03630 ULTRA SOUND	202,076	0	587		-	
	05500 RADI OLOGY-THERAPEUTI C	802, 868		13, 772			
	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	311, 915	11, 243	49, 795		-	
	05900 CARDIAC CATHETERIZATION	231, 034 496, 924	20, 465 174, 701	8, 338 0		2, 255	
	06000 LABORATORY	2, 736, 954		0			
	06500 RESPI RATORY THERAPY	505, 746		0			
	06600 PHYSI CAL THERAPY	889, 597	205, 185	10, 552			
	06700 OCCUPATI ONAL THERAPY	391, 909					
	06800 SPEECH PATHOLOGY	117, 787	27, 362	798			68
00 0	06900 ELECTROCARDI OLOGY	79, 106	0	123	95, 554	0) 69
	07000 ELECTROENCEPHALOGRAPHY	141, 050	237, 587	0	44, 592		
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 447, 024		0	-		
	07200 IMPL. DEV. CHARGED TO PATIENTS	1, 800, 816	0	0	0	-	
	07300 DRUGS CHARGED TO PATIENTS	6, 906, 193		0	0	0	
	03190 CHEMOTHERAPY	448, 929		18, 221			
	03020 WOUND CARE	290, 346	63, 253	0	0 0	0) 76
	OUTPATIENT SERVICE COST CENTERS			<u>^</u>	0	0	90
	09000 ANDERSON OUTPATIENT CENTER	363, 294	71, 415	0	38, 222		
	04950 DI ABETI C EDUCATI ON	0000, 2,74	0	0	0, 222	0	
	09002 MS CLINIC	0	0	0	, o	0	
	09100 EMERGENCY	1, 767, 431	459, 198	148, 007	449, 103	-	
00	09200 OBSERVATION BEDS (NON-DISTINCT PART)					<u> </u>	92
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES	2, 521	0	0	0	0	95
	SPECIAL PURPOSE COST CENTERS						4
	11300 INTEREST EXPENSE	10 177 010	7 9 4 9 5 7 9		0 (70 101		113
3.00		42, 177, 318	7, 042, 578	1, 004, 011	3, 678, 121	1, 409, 380	118
	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	4 2/0	20 /01			0	1100
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 19100 RESEARCH	4, 368 41, 890		0) 190) 191
	19200 PHYSI CLANS' PRI VATE OFFI CES	1, 191, 929		0) 192
	07950 FOUNDATION	1, 191, 929		0 0	1, 593) 194
F. OOM	07951 CHI LDRENS CLI NI C	0	0	200			194
	07952 PSS ADMINI STRATI ON	49, 028	-	0	0		194
1. 01 0	07953 SEXUAL ASSAULT PROGRAM	2, 306		0	0		194
1.010 1.020				0	0		194
4.010 4.020 4.030	07954 ASPR BI OTERRORI SM GRANT	165	0	0			1
4. 01 0 4. 02 0 4. 03 0 4. 04 0 4. 05 0	07954 ASPR BIOTERRORI SM GRANT 07955 HEALTHY FAMILIES	165 174, 056		0	0		
4.01 4.02 4.03 4.04 4.04 4.05 4.05 4.06	07954 ASPR BIOTERRORISM GRANT 07955 HEALTHY FAMILIES 07956 DME-HOME CARE		205, 900	0	0	0) 194) 194
4.01 4.02 4.03 4.04 4.04 4.05 4.05 4.06 4.07	07954 ASPR BIOTERRORI SM GRANT 07955 HEALTHY FAMILIES 07956 DME-HOME CARE 07957 MARKETING	174, 056 6, 156 0	205, 900 4, 489 0	0		0) 194) 194
4.01 4.02 4.03 4.04 4.05 4.05 4.06 4.07 4.07 4.08	07954 ASPR BI OTERRORI SM GRANT 07955 HEALTHY FAMILLES 07956 DME-HOME CARE 07957 MARKETI NG 07958 CORPORATE COMMUNI CATI ONS	174, 056 6, 156 0 5, 865	205, 900 4, 489 0 51, 562	0 0 0 0	0 0 0 0 3, 185	0 0 0) 194) 194) 194
4.01 4.02 4.03 4.04 4.05 4.05 4.05 4.06 4.07 4.08 4.08 4.09 0	07954 ASPR BIOTERRORI SM GRANT 07955 HEALTHY FAMILIES 07956 DME-HOME CARE 07957 MARKETING	174, 056 6, 156 0	205, 900 4, 489 0 51, 562	0 0 0 0 14, 529		0 0 0) 194) 194

 194. 10/07/061 MAB
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Health Financial Systems	ASCENSI ON ST. VI	NCENT ANDERSON		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C	CN: 15-0088	Period:	Worksheet B	
				From 07/01/2020		
				To 06/30/2021		
					11/23/2021 1:	<u>22 pm</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	372, 238	58, 050		0 0	C	194.12
194.1307962 IDLE SPACE	0	0		0 0	0	194.13
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0		0 0	C	201.00
202.00 TOTAL (sum lines 118 through 201)	44, 026, 945	7, 451, 276	1, 018, 74	0 3, 767, 304	1, 409, 380	202.00

		SCENSION ST. VI		NI: 15 0000 D		u of Form CMS-2	2552-10
CUST P	LLOCATION - GENERAL SERVICE COSTS		Provider CC	F	eriod: rom 07/01/2020 o 06/30/2021	Worksheet B Part I Date/Time Pre	pared:
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES &	PHARMACY	11/23/2021 1: MEDI CAL RECORDS &	22 pm
		11.00	13.00	SUPPLY 14.00	15.00	LI BRARY 16.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
1.01 4.00	00101 CAP REL COSTS-BLDG & FIXT-MAB 00400 EMPLOYEE BENEFITS DEPARTMENT						1.01 4.00
4.00 5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG 01000 DI ETARY						9.00
10. 00 11. 00	01100 CAFETERIA	2, 577, 222					10.00
13.00	01300 NURSI NG ADMI NI STRATI ON	117, 918	4, 022, 549				13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	53, 038		1, 445, 753			14.00
15.00 16.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	167, 281 0	0	13, 643		133, 217	15.00 16.00
23.00	02300 ALLIED HEALTH-EMS	16, 894	0	11 140		155, 217	1
23.01	02301 ALLIED HEALTH-RAD TECH	17, 976	0	0		0	•
23.02	02303 ALLIED HEALTH-PHARM RESIDENTS	0	0	0	0	0	23.02
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	770, 240	2,003,463	54, 810	0	9, 229	30.00
31.00	03100 I NTENSI VE CARE UNI T	228,908		38, 533		4,050	
41.00	04100 SUBPROVI DER – I RF	73, 817	203, 962	3, 242	0	865	41.00
43.00		11, 886	44, 794	1, 509	0	255	43.00
50.00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM	2, 316	144, 557	1, 082, 876	0	25, 743	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	57, 164	179, 991	6, 771		833	•
53.00	05300 ANESTHESI OLOGY	0	0	0	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	147,947	0	51, 451		3, 475	
54. 01 54. 02	03440 MAMMOGRAPHY 03450 NUCLEAR MEDICINE - DIAGNOSTIC	17, 091 15, 947	0	5, 514 24, 797		772 2, 930	•
54.02	03630 ULTRA SOUND	22, 165	0	582		1, 697	•
55.00	05500 RADI OLOGY-THERAPEUTI C	64, 105	0	2, 485		6, 127	
57.00	05700 CT SCAN	39, 331	0	8		2, 971	
58.00 59.00	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION	16, 106 56, 668	0 112, 032	283 31, 307		594 4, 426	•
60.00	06000 LABORATORY	0	0	261	0	16, 613	•
65.00	06500 RESPI RATORY THERAPY	70, 808	0	18, 522		3, 100	65.00
66.00	06600 PHYSI CAL THERAPY	85, 208	0	7, 999		1, 773	
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	54, 453 16, 366	0	3, 549 1, 067		714 215	•
69.00	06900 ELECTROCARDI OLOGY	10,049	0	230		253	
70.00	07000 ELECTROENCEPHALOGRAPHY	6, 109	0	588		876	•
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0	0			71.00
	07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS	0	0	0	Ŭ		72.00 73.00
76.00	03190 CHEMOTHERAPY	74, 746		17, 424			76.00
76.01	03020 WOUND CARE	23, 792	0	19, 420	0	607	76.01
90.00	OUTPATIENT SERVICE COST CENTERS	0	0	0		0	90.00
90.00 90.01	09001 ANDERSON OUTPATIENT CENTER	30, 308	0	386		647	
	04950 DIABETIC EDUCATION	0	0	0	0	0	
90.03	09002 MS CLINIC	0	0	0	0	0	
91.00 92.00	09100 EMERGENCY 09200 OBSERVATI ON BEDS (NON-DI STINCT PART)	247, 344	597, 883	58, 274	0	15, 109	91.00 92.00
72.00	OTHER REIMBURSABLE COST CENTERS	<u> </u>	I				72.00
95.00	09500 AMBULANCE SERVI CES	0	0	0	0	0	95.00
110.00	SPECIAL PURPOSE COST CENTERS	[I				112 00
113.00 118.00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	2, 515, 981	4, 022, 549	1, 445, 682	5, 186, 029	133, 217	113.00
110.00	NONREI MBURSABLE COST CENTERS	2, 313, 701	4,022,347	1, 443, 002	3, 100, 027	133, 217	1110.00
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0			190.00
		5, 712	0	0			191.00
	19200 PHYSI CLANS' PRI VATE OFFI CES 07950 FOUNDATI ON	10, 284 0	0	10 0	0		192.00 194.00
	07951 CHI LDRENS CLI NI C	0	0	0	0		194.00
194.02	07952 PSS ADMINI STRATI ON	9, 041	0	0	0	0	194. 02
	07953 SEXUAL ASSAULT PROGRAM	271	0	0	0		194.03
	07954 ASPR BI OTERRORI SM GRANT 07955 HEALTHY FAMI LI ES	0 35, 933	0	0 61	0		194.04 194.05
	07955 HEALTHY FAMILIES 07956 DME-HOME CARE	33, 933	0	01	0		194.05
194.07	07957 MARKETI NG	0	0	0	0	0	194.07
	07958 CORPORATE COMMUNICATIONS	0	0	0	0		194.08
	07959 MOB 07960 ASC	0	0	0	0		194.09 194.10
174.10		0	U U	0	l U	0	1174.10

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Health Financial Systems	u of Form CMS-:	2552-10				
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC		Period:	Worksheet B	
				From 07/01/2020 To 06/30/2021	Part Date/Time Pre	pared [.]
					11/23/2021 1:	
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	C	0	(0 0	0	194.11
194. 12 07963 ADOLESCENT RESIDENTIAL SERVICES	C	0	(0 0	0	194.12
194. 13 07962 I DLE SPACE	C	0	(0 0	0	194.13
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	C	0	(0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	2, 577, 222	4, 022, 549	1, 445, 753	5, 186, 029	133, 217	202.00

ST A	LLOCAT	TION - GENERAL SERVICE COSTS		Provider CO	1	Period: From 07/01/2020 To 06/30/2021	Worksheet B Part I Date/Time Pre 11/23/2021 1:	par 22
		Cost Center Description	ALLI ED HEALTH-EMS	ALLI ED HEALTH-RAD TECH	ALLI ED HEALTH-PHARM RESI DENTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			23.00	23.01	23.02	24.00	25.00	
00		AL SERVICE COST CENTERS						.
01 00 00 00 00 00	00101 00400 00500 00700 00800	CAP REL COSTS BLDG & FIXT-MAB EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL OPERATION OF PLANT LAUNDRY & LINEN SERVICE HOUSEKEEPING						
. 00	1	DIETARY						10
. 00								1
	1	NURSI NG ADMI NI STRATI ON CENTRAL SERVI CES & SUPPLY						13
		PHARMACY						15
		MEDICAL RECORDS & LIBRARY						16
. 00		ALLIED HEALTH-EMS	71, 820					23
		ALLIED HEALTH-RAD TECH		247, 783				23
. 02		ALLIED HEALTH-PHARM RESIDENTS				0		23
. 00		ADULTS & PEDIATRICS	o	0		0 26, 681, 960	0	30
		I NTENSI VE CARE UNI T	0	0		0 9, 314, 677	0	
	1	SUBPROVIDER - IRF	0	0		0 2, 560, 012	0	4
. 00		NURSERY	0	0		0 578, 528	0	43
00		LARY SERVICE COST CENTERS	0	0			0	
. 00 . 00	1	DELIVERY ROOM & LABOR ROOM	0	0		0 22, 177, 577 0 2, 482, 389	0	
00	1	ANESTHESI OLOGY	0	0		0 2,402,507	0	
	1	RADI OLOGY-DI AGNOSTI C	0	46, 371		5, 033, 320	0	
01	03440	MAMMOGRAPHY	0	10, 307		0 759, 887	0	54
		NUCLEAR MEDICINE - DIAGNOSTIC	0	39, 103		0 1, 417, 547	0	-
	1	ULTRA SOUND	0	22, 649		0 789, 477 0 3 125 053	0	
00	1	RADI OLOGY-THERAPEUTI C CT SCAN	0	81, 775 39, 648		0 3, 125, 053 0 1, 288, 000	0	
00		MAGNETIC RESONANCE IMAGING (MRI)	0	7, 930		0 911, 369	0	
00	1	CARDI AC CATHETERI ZATI ON	0	0		0 2, 224, 649	0	
00		LABORATORY	0	0		0 10, 399, 492	0	
. 00			0	0		0 2, 100, 981	0	
00		PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	0	0		0 3, 620, 788 0 1, 612, 651	0	
00		SPEECH PATHOLOGY	0	0		0 484, 115	0	
00		ELECTROCARDI OLOGY	0	0		0 396, 598	0	
00	07000	ELECTROENCEPHALOGRAPHY	0	0		0 807, 529	0	70
		MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 5, 315, 697	0	
		IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	0	0		0 6, 614, 269 0 30, 557, 911	0	72
		CHEMOTHERAPY	0	0		0 1, 763, 985	0	
		WOUND CARE	0	0		0 1, 172, 898		
		TIENT SERVICE COST CENTERS	1 1		1			
		CLINIC	0	0				90
	1	ANDERSON OUTPATIENT CENTER DI ABETI CEDUCATION	0	0		0 1, 474, 587 0 0	0	
		MS CLINIC	0	0		0 0	0	
		EMERGENCY	71, 820	0		0 8, 578, 952	0	
00		OBSERVATION BEDS (NON-DISTINCT PART)					0	92
00		REIMBURSABLE COST CENTERS				0 0 0 1		
υU		AMBULANCE SERVICES AL PURPOSE COST CENTERS	0	0		0 9, 254	0	95
3.00		INTEREST EXPENSE						1113
3. 00	NONRE	SUBTOTALS (SUM OF LINES 1 through 117) IMBURSABLE COST CENTERS	71, 820	247, 783		0 154, 254, 152	0	118
		GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		0 54, 435		190 191
		RESEARCH PHYSI CI ANS' PRI VATE OFFI CES	0	0		0 159, 486 0 4, 423, 046		192
		FOUNDATION	0	0		0 4, 423, 040		194
1.01	07951	CHILDRENS CLINIC	0	0		0 57, 532	0	194
		PSS ADMINISTRATION	0	0		0 189, 017		194
		SEXUAL ASSAULT PROGRAM	0	0		0 8, 735		194
		ASPR BIOTERRORI SM GRANT HEALTHY FAMILIES	0	0		0 605 0 880, 833		194 194
		DME-HOME CARE	0	0		0 880, 833		194
	07957	MARKETING	0	0		0 0		194
		CORPORATE COMMUNI CATI ONS			1	0 76, 277		194

Health Financial Systems	ASCENSION ST. VI	NCENT ANDERSON		In Lie	u of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C	CN: 15-0088	Peri od:	Worksheet B
				From 07/01/2020 To 06/30/2021	Part I Date/Time Prepared:
				10 00/ 30/ 2021	11/23/2021 1:22 pm
Cost Center Description	ALLI ED	ALLI ED	ALLI ED	Subtotal	Intern &
	HEALTH-EMS	HEALTH-RAD	HEALTH-PHAR	N	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 35, 775	0 194. 09
194. 10 07960 ASC	0	0		0 6, 370	0 194. 10
194. 11 07961 MAB	0	0		0 0	0 194. 11
194. 12 07963 ADOLESCENT RESIDENTIAL SERVICES	0	0		0 1, 424, 493	0 194. 12
194.13 07962 I DLE SPACE	0	0	1	0 0	0 194. 13
200.00 Cross Foot Adjustments	0	0	1	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)	71, 820	247, 783		0 161, 617, 839	0 202.00

CUST	ALLUCATION - GENERAL SERVICE CUSIS		Provider CCN: 15-0088	From 07/01/2020 Part I To 06/30/2021 Date/Time Pr 11/23/2021 1	epared: ·22 nm
	Cost Center Description	Total			
	GENERAL SERVICE COST CENTERS	26.00			
1.00	00100 CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101 CAP REL COSTS-BLDG & FIXT-MAB				1.01
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500 ADMINI STRATI VE & GENERAL				5.00
7.00	00700 OPERATION OF PLANT				7.00
8.00 9.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG				8.00 9.00
10.00	01000 DI ETARY				10.00
11.00	01100 CAFETERIA				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 MEDI CAL RECORDS & LI BRARY				16.00
23. 00 23. 01	02300 ALLIED HEALTH-EMS 02301 ALLIED HEALTH-RAD TECH				23.00 23.01
23.01					23.01
20.02	INPATIENT ROUTINE SERVICE COST CENTERS				20.02
30.00	03000 ADULTS & PEDI ATRI CS	26, 681, 960			30.00
31.00	03100 I NTENSI VE CARE UNI T	9, 314, 677			31.00
41.00	04100 SUBPROVIDER - IRF	2, 560, 012			41.00
43.00	04300 NURSERY	578, 528			43.00
50.00	ANCI LLARY SERVICE COST CENTERS	00 177 577			
50.00 52.00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	22, 177, 577 2, 482, 389			50.00 52.00
53.00	05300 ANESTHESI OLOGY	2,402,309			53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	5,033,320			54.00
54.01	03440 MAMMOGRAPHY	759, 887			54.01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	1, 417, 547			54.02
54.03		789, 477			54.03
55.00	05500 RADI OLOGY-THERAPEUTI C	3, 125, 053			55.00
57.00 58.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 288, 000 911, 369			57.00 58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	2, 224, 649			59.00
60.00	06000 LABORATORY	10, 399, 492			60.00
65.00	06500 RESPI RATORY THERAPY	2, 100, 981			65.00
66.00	06600 PHYSI CAL THERAPY	3, 620, 788			66.00
67.00	06700 OCCUPATI ONAL THERAPY	1, 612, 651			67.00
68.00	06800 SPEECH PATHOLOGY	484, 115			68.00
69.00 70.00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	396, 598 807, 529			69.00 70.00
70.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	5, 315, 697			71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	6, 614, 269			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	30, 557, 911			73.00
76.00	03190 CHEMOTHERAPY	1, 763, 985			76.00
76.01	03020 WOUND CARE	1, 172, 898			76.01
00.00	OUTPATIENT SERVICE COST CENTERS	0			
90. 00 90. 01	09000 CLINIC 09001 ANDERSON OUTPATIENT CENTER	0 1, 474, 587			90.00 90.01
	04950 DI ABETI C EDUCATI ON	1, 474, 587			90.01
	09002 MS CLINIC	Ő			90.03
91.00		8, 578, 952			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				92.00
	OTHER REIMBURSABLE COST CENTERS	0.054			
95.00	09500 AMBULANCE SERVICES	9, 254			95.00
113 00	SPECIAL PURPOSE COST CENTERS				113.00
118.00		154, 254, 152			118.00
	NONREI MBURSABLE COST CENTERS				
190.00	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	54, 435			190.00
	19100 RESEARCH	159, 486			191.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	4, 423, 046			192.00
	07950 FOUNDATION	19, 995 57, 522			194.00
	07951 CHI LDRENS CLI NI C 207952 PSS ADMI NI STRATI ON	57, 532 189, 017			194.01 194.02
	07952 PSS ADMINISTRATION	8, 735			194.02
	07954 ASPR BIOTERRORI SM GRANT	605			194.04
194.05	07955 HEALTHY FAMILIES	880, 833			194.05
	07956 DME-HOME CARE	27, 088			194.06
	07957 MARKETING	0			194.07
	07958 CORPORATE COMMUNICATIONS	76, 277			194.08
	07959 MOB 07960 ASC	35, 775			194. 09 194. 10
	07960 ASC 07961 MAB	6, 370 0			194. 10 194. 11
	207963 ADOLESCENT RESIDENTIAL SERVICES	1, 424, 493			194.11
44 (00 /					1

Health Financial Systems	ASCENSION ST.	VI NCE	ENT ANDERSON	In Lieu	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 15-0088	Period:	Worksheet B	
				From 07/01/2020		
				To 06/30/2021	Date/Time Pro	epared:
					11/23/2021 1:	<u>22 pm</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)	161, 617, 8	339				202.00

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Heal th	Financial Systems A	SCENSION ST. VI	NCENT ANDERSON		In Li€	eu of Form CMS-	2552-10
	TION OF CAPITAL RELATED COSTS		Provider CC	CN: 15-0088	Period: From 07/01/2020 To 06/30/2021	Worksheet B Part II	pared:
	Cost Center Description	Directly Assigned New Capital Related Costs	CAPI TAL REL BLDG & FI XT	LATED COSTS BLDG & FIXT-MAB	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		0	1.00	1.01	2A	4.00	
1 00	GENERAL SERVICE COST CENTERS					1	1 1 00
1.00 1.01 4.00 5.00 7.00 8.00	00100 CAP REL COSTS-BLDG & FIXT 00101 CAP REL COSTS-BLDG & FIXT-MAB 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	0 2, 791, 050 0 0	38, 390 276, 935 345, 569 48, 791		0 38, 390 0 3, 067, 985 0 345, 569 0 48, 791	1, 693 0 0	7.00 8.00
9.00 10.00 11.00 13.00 14.00	00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY		61, 846 68, 702 103, 850 30, 275 98, 314		0 61, 846 0 68, 702 0 103, 850 0 30, 275 0 98, 314	0 0 1, 620	
15.00 16.00 23.00 23.01 23.02	01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 02300 ALLI ED HEALTH-EMS 02301 ALLI ED HEALTH-RAD TECH 02303 ALLI ED HEALTH-PHARM RESI DENTS		29, 872 32, 321 806 682 0		0 29,872 0 32,321 0 806 0 682 0 0	0 7 104	15.00 16.00 23.00 23.01 23.02
30. 00 31. 00 41. 00 43. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS 03100 I NTENSI VE CARE UNI T 04100 SUBPROVI DER - I RF 04300 NURSERY		408, 081 90, 875 61, 989 36, 828		0 408, 081 0 90, 875 0 61, 989 0 36, 828	3, 355 892	31.00 41.00
50. 00 52. 00 53. 00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM 05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	0	297, 527 137, 683		0 297, 527 0 137, 683 0 0		
54. 00 54. 01 54. 02	05400 RADI OLOGY-DI AGNOSTI C 03440 MAMMOGRAPHY 03450 NUCLEAR MEDICINE - DI AGNOSTI C	0	88, 508 0 6, 986		0 88,508 0 0 0 6,986	1, 587 219 241	54.00 54.01 54.02
54.03 55.00 57.00 58.00	03630 ULTRA SOUND 05500 RADI OLOGY-THERAPEUTI C 05700 CT SCAN 05800 MAGNETI C RESONANCE I MAGI NG (MRI)	0	0 0 3, 416 6, 217		0 0 0 0 0 0 3, 416 0 6, 217	870 870 495	55.00 57.00
59.00 60.00 65.00 66.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	53, 075 77, 759 44, 248 62, 336		0 53,075 0 77,759 0 44,248 0 62,336	0 880	60. 00 65. 00
67.00 68.00 69.00 70.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY		27, 653 27, 653 8, 313 0 72, 180		0 27, 653 0 8, 313 0 0 72, 180	680 204 108	67.00 68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0 0 0 0	0 0 0				71.00 72.00 73.00
76. 01 90. 00	03020 WOUND CARE OUTPATIENT SERVICE COST CENTERS 09000 CLINIC	0	19, 217		0 19, 217 0 C	0	90.00
90. 01 90. 02 90. 03 91. 00	09001 ANDERSON OUTPATIENT CENTER 04950 DIABETIC EDUCATION 09002 MS CLINIC 09100 EMERGENCY	0 0 0	21, 696 0 0 139, 506		0 21,696 0 0 0 0 0 139,506	0000	90. 02 90. 03
92.00 95.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	0	0		0 0	30	92.00 95.00
113.00 118.00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	2, 791, 050	2, 800, 446		0 5, 591, 496	35, 039	113. 00 118. 00
191.00 192.00	19000 GI FT, FLOWER, COFFEE SHOP, & CANTEEN 19100 RESEARCH 19200 PHYSI CI ANS' PRI VATE OFFI CES	000000000000000000000000000000000000000	11, 666 0 11, 338		0 11, 666 0 0 0 11, 338	78 78 2, 215	190. 00 191. 00 192. 00
194.01 194.02	07950 FOUNDATION 07951 CHILDRENS CLINIC 07952 PSS ADMINISTRATION 07052 SEVIAL ASSAULT DEOCEAM	000000000000000000000000000000000000000	3, 942 0 0		0 3, 942 0 0 0 0 0 0	0 99	194.00 194.01 194.02
194.04 194.05	07953 SEXUAL ASSAULT PROGRAM 07954 ASPR BIOTERRORI SM GRANT 07955 HEALTHY FAMILIES 07956 DME-HOME CARE		0 0 62, 553 1, 364		0 0 0 0 0 0 0 62, 553 0 1, 364	0 249	194.03 194.04 194.05 194.06
194.07	07957 MARKETI NG	0	0		0 0		194.07

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Health Financial Systems	ASCENSION ST. VINCENT ANDERSON			In Lieu of Form CMS-2552-10		
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC		Period:	Worksheet B	
				From 07/01/2020 To 06/30/2021	Part II Date/Time Prep	pared:
					11/23/2021 1:2	
		CAPI TAL REL	ATED COSTS			
Cast Cantan Decarintian	Dimonthy			Cubtatal		
Cost Center Description	Directly Assigned New	BLDG & FIXT	BLDG & FIXT-MAB	Subtotal	EMPLOYEE BENEFITS	
	Capi tal				DEPARTMENT	
	Rel ated Costs				DELYNCIMENT	
	0	1.00	1.01	2A	4.00	
194. 08 07958 CORPORATE COMMUNI CATI ONS	0	15, 665		0 15, 665	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 0	-	194.11
194. 12 07963 ADOLESCENT RESIDENTIAL SERVICES	0	17, 636		0 17,636		194.12
194. 13 07962 I DLE SPACE	0	0		0 0	-	194.13
200.00Cross Foot Adjustments201.00Negative Cost Centers				0		200.00
<u> </u>	2, 791, 050	2 024 410				201.00
202.00 TOTAL (sum lines 118 through 201)	2, 791, 050	2, 924, 610		0 5, 715, 660	38, 390	202.00

Heal th Financia	al Syste	ems	
ALLOCATION OF (CAPI TAL	RELATED	COSTS

cui ti	n Financial Systems	ASCENSION ST. VI	NCENT ANDERSON		In Lie	eu of Form CMS-2	<u>2552-</u>
LLOC	ATION OF CAPITAL RELATED COSTS		Provider CO	CN: 15-0088 P F T	eriod: rom 07/01/2020 o 06/30/2021	Worksheet B Part II Date/Time Prep 11/23/2021 1:2	
	Cost Center Description	ADMI NI STRATI VE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	
		5.00	7.00	8.00	9.00	10.00	
. 00 . 01 . 00 . 00 . 00 . 00 . 00 1. 00 3. 00 4. 00 5. 00 6. 00 3. 00 3. 00 3. 01 3. 02	01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 02300 ALLIED HEALTH-EMS 02301 ALLIED HEALTH-RAD TECH	3, 069, 678 141, 527 16, 299 67, 688 21, 855 42, 049 71, 968 19, 205 92, 956 449 990 4, 322	487, 096 10, 499 13, 308 14, 783 22, 346 6, 514 21, 155 6, 428 6, 955 173 147	75, 589 0 0 0 0 1, 324	142, 842 1, 237 816 604 1, 522 483 121 0 0 0	106, 577 0 0 0 0 0 0 0 0 0 0	11. 13. 14. 15. 16. 23. 23.
3. UZ	INPATIENT ROUTINE SERVICE COST CENTERS	0	0	0	0		23.
0.00 1.00 1.00 3.00	03000 ADULTS & PEDIATRICS 03100 I NTENSI VE CARE UNI T 04100 SUBPROVI DER – I RF 04300 NURSERY	373, 088 141, 611 33, 232 6, 986	19, 554 13, 338	8, 246 2, 893	52, 092 13, 284 6, 038 899	83, 772 6, 881 9, 544 0	31. 41.
0.00	ANCILLARY SERVICE COST CENTERS	364, 569	64, 021	12, 011	22, 221	39	50.
2.00 3.00 4.00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	304, 509 30, 741 0 83, 158	29, 626 0	1, 927 0	4, 034 4, 227	2, 542 0 0	52. 53.
4.01		13, 497		449	362	0	
4. 02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	24, 724	1, 503	40	362	0	54.
4. 03		14, 089		44	0	0	
6.00		55,979		1,022	362	0	
7.00 3.00		21, 748 16, 108			0 362	0	
<i>7.</i> 00		34, 647		019	725	171	
D. 00		190, 830		0	3, 019	0	
5.00		35, 262		0	242	0	
6.00		62, 026			1, 686	0	
7.00		27, 325		340	746	0	
3.00		8, 213		59	225	0	
7.00 0.00		5, 516 9, 834		9	3, 623 1, 691	0	
1.00			13, 331	0	1,071	0	
2.00		125, 559	0	0	0	0	
3. 00	07300 DRUGS CHARGED TO PATIENTS	481, 493		0	0	0	73
5.00		31, 301		1,002	0	207	
5. 01	03020 WOUND CARE	20, 244	4, 135	0	0	0	76
). 00	OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	90
). 00		25, 330	4, 668		1, 449	0	
	04950 DI ABETI C EDUCATI ON	0	0	0	0	0	
0. 03		0	0	0	0	0	90
I. 00		123, 231	30, 018	10, 982	17, 028	3, 341	
2.00		RT)				L	92
5. 00	OTHER REIMBURSABLE COST CENTERS	176	0	0	0	0	95
. 00	SPECIAL PURPOSE COST CENTERS	170	0	0	0	0	. 75
3.00 8.00	0 11300 INTEREST EXPENSE	117) 2, 940, 716	460, 379	74, 496	139, 460		113 118
90.00	0 19000 GIFT, FLOWER, COFFEE SHOP, & CANT	EEN 305	2, 510	0	0	0	190
	0 19100 RESEARCH	2, 921		0	0		191
	0 19200 PHYSICIANS' PRIVATE OFFICES	83, 105			0	0	192
	0 07950 FOUNDATI ON	103			60		194
	1 07951 CHI LDRENS CLI NI C	0	-	15	2, 174		194 194
	2 07952 PSS ADMINISTRATION 3 07953 SEXUAL ASSAULT PROGRAM	3, 418 161			0		194
	4 07954 ASPR BI OTERRORI SM GRANT	11		n 0	0		194
	5 07955 HEALTHY FAMILIES	12, 136		0	0		194
4.00	6 07956 DME-HOME CARE	429		0	0	0	194
	7 07957 MARKETI NG	0	0	0	0		194
	8 07958 CORPORATE COMMUNICATIONS	409		0	121		194
	9 07959 MOB	10	0	1, 078	785		194 194
		~					
94.10	0 07960 ASC 1 07961 MAB	0	0	0	242		194

Health Financial Systems	ASCENSION ST. VI	NCENT ANDERSON		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		Peri od:	Worksheet B	
				rom 07/01/2020		
			T	o 06/30/2021	Date/Time Pre	
					11/23/2021 1:	22 pm
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	25, 954	3, 795	C	0 0	0	194. 12
194.13 07962 I DLE SPACE	0	0	C	0 0	0	194.13
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	C	0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	3, 069, 678	487, 096	75, 589	142, 842	106, 577	202.00

	Financial Systems AS TION OF CAPITAL RELATED COSTS	SCENSION ST. VI	NCENT ANDERSON Provider CC	N: 15-0088 Pe Fr Tc	eriod: com 07/01/2020	u of Form CMS-: Worksheet B Part II Date/Time Pre 11/23/2021 1:	pared:
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	
	GENERAL SERVICE COST CENTERS	11.00	13.00	14.00	15.00	16.00	
23. 00 23. 01	00100 CAP REL COSTS-BLDG & FIXT 00101 CAP REL COSTS-BLDG & FIXT-MAB 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 02300 ALLIED HEALTH-EMS 02301 ALLIED HEALTH-PHARM RESIDENTS	169, 061 7, 735 3, 479 10, 973 0 1, 108 1, 179 0	118, 716 0 0 0 0 0	145, 389 1, 372 14 0 0	144, 761 0 0 0 0 0	35, 784 0 0 0	23. 00 23. 01
30, 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	50, 526	59, 129	5, 512	0	2, 461	30.00
30.00 31.00 41.00 43.00	03100 I NTENSI VE CARE UNI T 04100 SUBPROVI DER – I RF 04300 NURSERY	15, 016 4, 842 780	21, 717 6, 019	3, 312 3, 875 326 152	0 0 0	1, 080 231 68	
50.00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM	152	4, 266	108, 896	0	7, 122	50.00
52.00 53.00 54.00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	3, 750 3, 750 0 9, 705	5, 312 0	681 0 5, 174	0 0 0	7, 122 222 0 927	52.00 53.00 54.00
54.01	03440 MAMMOGRAPHY	1, 121		555	0	206	54.01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	1,046		2, 494	0	781	54.02
54.03 55.00	03630 ULTRA_SOUND 05500 RADI OLOGY-THERAPEUTI C	1, 454 4, 205		59 250	0	453 1, 634	54.03 55.00
57.00	05700 CT SCAN	2, 580	1 1	230	0	792	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 057	1 1	29	0	158	
59.00	05900 CARDI AC CATHETERI ZATI ON	3, 717		3, 148	0	1, 180	
60.00 65.00	06000 LABORATORY 06500 RESPI RATORY THERAPY	0 4, 645	-	26 1, 863	0	4, 430 827	60.00 65.00
66.00	06600 PHYSI CAL THERAPY	5, 590		804	0	473	66.00
67.00	06700 OCCUPATI ONAL THERAPY	3, 572		357	0	191	67.00
68.00	06800 SPEECH PATHOLOGY	1,074		107	0	57	68.00
69.00 70.00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	659 401	0	23 59	0	68 234	69.00 70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	1, 025	1
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0		0	0	982	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0	0	144, 761	5, 328	
	03190 CHEMOTHERAPY 03020 WOUND CARE	4, 903 1, 561		1, 752 1, 953	0	490 162	
70101	OUTPATIENT SERVICE COST CENTERS	1,001		.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		102	/ 0/ 0/
		0	0	0	0	0	90.00
	09001 ANDERSON OUTPATIENT CENTER 04950 DIABETIC EDUCATION	1, 988	0	39 0	0	173 0	90. 01 90. 02
	09002 MS CLINIC	0	0	0	0	0	
	09100 EMERGENCY	16, 225	17, 645	5, 860	0	4, 029	
	09200 OBSERVATI ON BEDS (NON-DI STINCT PART) OTHER REIMBURSABLE COST CENTERS						92.00
	09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
	SPECIAL PURPOSE COST CENTERS			-			
	11300 I NTEREST EXPENSE		110 -11	4.15 0.00		ar 70 <i>1</i>	113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	165, 043	118, 716	145, 382	144, 761	35, 784	118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
191.00	19100 RESEARCH	375		0	0	0	191.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	675		1	0		192.00
	07950 FOUNDATI ON 07951 CHI LDRENS CLI NI C	0	0	0	0		194. 00 194. 01
194.02	07952 PSS ADMI NI STRATI ON	593		0	Ō	0	194. 02
	07953 SEXUAL ASSAULT PROGRAM	18	0	0	0		194.03
	07954 ASPR BIOTERRORI SM GRANT 07955 HEALTHY FAMILIES	0 2, 357	0	0	0		194. 04 194. 05
	07956 DME-HOME CARE	2, 357	0	0	0		194.05
194.07	07957 MARKETI NG	0	0	0	Ō	0	194. 07
	07958 CORPORATE COMMUNI CATI ONS	0	0	0	0		194.08
	07959 MOB 07960 ASC		0	0	0		194. 09 194. 10
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Health Financial Systems	ASCENSION ST. V	INCENT ANDERSON		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CO		Period:	Worksheet B	
				From 07/01/2020		nored.
		_		Го 06/30/2021	Date/Time Pre 11/23/2021 1:	
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	(o o	(0 0	0	194.13
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	(0 0	(0 0	4, 063	201.00
202.00 TOTAL (sum lines 118 through 201)	169, 06	1 118, 716	145, 389	9 144, 761	39, 847	202.00

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ALLOCA	TION OF CAPITAL RELATED COSTS		Provider CO		eriod: rom 07/01/2020 o 06/30/2021	Worksheet B Part II Date/Time Pre 11/23/2021 1:	
	Cost Center Description	ALLI ED HEALTH-EMS	ALLI ED HEALTH-RAD TECH	ALLI ED HEALTH-PHARM RESI DENTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		23.00	23.01	23.02	24.00	25.00	
1.00 1.01 4.00 5.00 7.00 8.00 9.00 10.00 11.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 00101 CAP REL COSTS-BLDG & FIXT-MAB 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA						1. 00 1. 0 ⁻ 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00
13. 00 14. 00 15. 00 16. 00 23. 00 23. 01 23. 02	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 02300 ALLI ED HEALTH-EMS 02301 ALLI ED HEALTH-PHARM RESI DENTS 1NPATI ENT ROUTI NE SERVI CE COST CENTERS	3, 098	6, 434	0			13. 00 14. 00 15. 00 16. 00 23. 00 23. 00 23. 02
30. 00	03000 ADULTS & PEDI ATRI CS				1, 159, 927	0	30.00
31.00 41.00 43.00	03100 I NTENSI VE CARE UNI T 04100 SUBPROVI DER - I RF 04300 NURSERY				325, 494 139, 344 55, 664	0 0 0	41.00
50.00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM				881, 394	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM				217, 247	0	
53.00	05300 ANESTHESI OLOGY				0	0	
54.00 54.01	05400 RADI OLOGY-DI AGNOSTI C 03440 MAMMOGRAPHY				212, 556 16, 409		54.00 54.0
54.01	03450 NUCLEAR MEDICINE - DIAGNOSTIC				38, 177		54.02
54.03	03630 ULTRA SOUND				16, 445	0	54.0
55.00	05500 RADI OLOGY-THERAPEUTI C				64, 322	0	55.00
57.00	05700 CT SCAN				33, 462	0	57.00
58.00 59.00	05800 MAGNETI C RESONANCE I MAGI NG (MRI) 05900 CARDI AC CATHETERI ZATI ON				26, 126 112, 139	0	58.00 59.00
60.00	06000 LABORATORY				292, 796		60.0
65.00	06500 RESPI RATORY THERAPY				97, 488		65.0
66.00	06600 PHYSI CAL THERAPY				148, 670		66.0
67.00	06700 OCCUPATIONAL THERAPY				66, 814	0	67.0
68.00 69.00					20, 041	0	68.0 69.0
70.00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY				10, 006 100, 133	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS				100, 100		
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS				126, 541	0	1
	07300 DRUGS CHARGED TO PATIENTS				631, 582		
	03190 CHEMOTHERAPY				40, 848		
/6. 01	03020 WOUND CARE OUTPATIENT SERVICE COST CENTERS				47, 520	0	76.0
90.00	09000 CLINIC				0	0	90.0
90. 01	09001 ANDERSON OUTPATIENT CENTER				56, 097	0	
	04950 DI ABETI C EDUCATI ON				0	0	
	09002 MS CLINIC				0	0	
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)				371, 007	0	
72.00	OTHER REIMBURSABLE COST CENTERS					0	72.00
95.00	09500 AMBULANCE SERVICES				206	0	95.00
	SPECIAL PURPOSE COST CENTERS						-
113.00 118.00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	0	0	0	5, 410, 371		113. 0 118. 0
190.00	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN				14, 481		190. 00
	19100 RESEARCH				3, 374		191.00
	19200 PHYSI CLANS' PRI VATE OFFI CES				99, 774		192.00 194.00
	07950 FOUNDATI ON 07951 CHI LDRENS CLI NI C				4, 953 2, 189		194.00
	07951 CHILDRENS CLINIC				4, 110		194.0
194.03	07953 SEXUAL ASSAULT PROGRAM				184		194. 0
194.04	07954 ASPR BI OTERRORI SM GRANT				11	0	194. 04
194.05	07955 HEALTHY FAMILIES				90, 761		194. 05
	07956 DME-HOME CARE				2, 086		194.00
	07957 MARKETING 07958 CORPORATE COMMUNICATIONS				0 19, 566		194.0 [°] 194.08
					17,000	. 0	11/4.00

Health Financial Systems	ASCENSION ST. VI	NCENT ANDERSON		In Lie	u of Form CMS-2552	2-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CO	CN: 15-0088	Period:	Worksheet B	
				From 07/01/2020 To 06/30/2021	Part II Date/Time Prepare	ed.
					11/23/2021 1:22	
Cost Center Description	ALLI ED	ALLI ED	ALLI ED	Subtotal	Intern &	
	HEALTH-EMS	HEALTH-RAD	HEALTH-PHAR	Λ	Residents Cost	
		TECH	RESI DENTS		& Post	
					Stepdown	
					Adjustments	
	23.00	23.01	23.02	24.00	25.00	
194. 09 07959 MOB				1, 873	0 194	4.09
194. 10 07960 ASC				242	0 194	4. 10
194. 11 07961 MAB				0	0 194	4.11
194. 12 07963 ADOLESCENT RESIDENTIAL SERVICES				48, 090	0 194	4.12
194.13 07962 I DLE SPACE				0	0 194	4.13
200.00 Cross Foot Adjustments	3, 098	6, 434		0 9, 532	0 200	D. 00
201.00 Negative Cost Centers	0	0		0 4,063	0 201	1.00
202.00 TOTAL (sum lines 118 through 201)	3, 098	6, 434		0 5, 715, 660	0 202	2.00

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Cost Center Description Total 26.00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.01 00101 CAP REL COSTS-BLDG & FIXT-MAB 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMI NI STRATI VE & GENERAL 7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE 9.00 00900 HOUSEKEEPI NG 10.00 01100 CAFETERI A 13.00 01300 NURSI NG ADMI NI STRATI ON 14.00 01400 CENTRAL SERVI CES & SUPPLY 15.00 01500 PHARMACY 16.00 01600 MEDI CAL RECORDS & LI BRARY 23.01 02301 ALLI ED HEALTH-RAD TECH 23.02 02303 ALLI ED HEALTH-RAD TECH 23.01 02301 ALLI ED HEALTH-PHARM RESIDENTS INPATI ENT ROUTI NE SERVI CE COST CENTERS 10.00 03100 INTENSI VE CARE UNI T 13.00 03100 INTENSI VE CARE UNI T 13.00 03100 INTENSI VE CARE UNI T 14.100 04100 SUBPROVI DER - I RF 13.00 03100 UNRSERY	11/23/2021 1: 22 pm 1. C 1. C 4. C 5. C 7. C 8. C 9. C 10. C 11. C 13. C 14. C 13. C 14. C 23. C 24. C 54. C 55
GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.01 00101 CAP REL COSTS-BLDG & FIXT 1.01 00100 CAP REL COSTS-BLDG & FIXT-MAB 4.00 00400 EMPLOYEE BENEFI TS DEPARTMENT 5.00 00500 ADMI NI STRATI VE & GENERAL 7.00 00700 OPERATI NO OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE 9.00 00900 HOUSEKEEPI NG 10.00 01000 DI ETARY 11.00 011000 CAFETERI A 13.00 01300 NURSI NG ADMI NI STRATI ON 14.00 01400 CENTRAL SERVI CES & SUPPLY 15.00 01500 PHARMACY 16.00 01600 MEDI CAL RECORDS & LI BRARY 23.01 02301 ALLI ED HEALTH-EMS 23.01 02303 ALLI ED HEALTH-RAD TECH 23.02 02303 ALLI ED HEALTH-RM RESI DENTS INPATI ENT ROUTI NE SERVI CE COST CENTERS 30.00 03000 INUTSS & PEDI ATRI CS 30.00 03000 ADULTS & PEDI ATRI CS 30.00 03000 INTERSI VE CARE UNI T 325, 494 41.00 04100 SUBPROVI DER - I RF 30.00	1. 0 4. 0 5. 0 7. 0 8. 0 9. 0 10. 0 11. 0 13. 0 14. 0 15. 0 15. 0 23. 0 25. 0
1.00 00100 CAP REL COSTS-BLDG & FIXT 1.01 00101 CAP REL COSTS-BLDG & FIXT-MAB 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMINISTRATIVE & GENERAL 700 7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE 9.00 00900 HOUSEKEEPING 1100 11.00 01100 CAFETERIA 13.00 01300 NURSING ADMINISTRATION 14.00 01400 CENTRAL SERVICES & SUPPLY 15.00 01500 PHARMACY 16.00 01600 MEDI CAL RECORDS & LI BRARY 23.01 02301 ALLI ED HEALTH-EMS 23.02 02303 ALLI ED HEALTH-PHARM RESI DENTS INPATI ENT ROUTI NE SERVI CE COST CENTERS 1, 159, 927 30.00 03000 ADULTS & PEDI ATRI CS 1, 159, 927 31.00 03100 INTENSI VE CARE UNI T 325, 494 41.00 04100 SUBPROVIDER - I RF 139, 344 43.00 04300 NURSERY 55, 664 ANCI LLARY SERVI CE COST CENTERS 53.00 05300<	1. 0 4. 0 5. 0 7. 0 8. 0 9. 0 10. 0 11. 0 13. 0 14. 0 15. 0 15. 0 23. 0 25. 0
4.00 00400 EMPLOYEE BENEFI TS DEPARTMENT 5.00 00500 ADMI NI STRATI VE & GENERAL 7.00 00700 OPERATI ON OF PLANT 8.00 00800 LAUNDRY & LI NEN SERVI CE 9.00 00900 HOUSEKEEPI NG 10.00 01000 DI ETARY 11.00 01100 CAFETERI A 13.00 01400 CENTRAL SERVI CES & SUPPLY 15.00 01500 PHARMACY 15.00 01500 PHARMACY 15.00 01500 PHARMACY 16.00 01600 MEDI CAL RECORDS & LI BRARY 23.00 02300 ALLI ED HEALTH-EMS 23.01 02301 ALLI ED HEALTH-EMS 23.01 02301 ALLI ED HEALTH-PHARM RESI DENTS INPATI ENT ROUTI NE SERVI CE COST CENTERS 10.00 03000 ADULTS & PEDI ATRI CS 1.00 03100 I NTENSI VE CARE UNI T 3.020 04100 SUBPROVI DER - I RF 1.00 04300 NURSERY 4.100 04100 SUBPROVI DER - I RF 1.00 05200 DELI VERY ROOM & LABOR ROOM 2.17, 247 5.00 05200 DELI VERY ROOM & LABOR ROOM 2.17, 247 5.00 05400 RADI OLOGY -DI AGNOSTI C 5.00 05400 RADI OLOGY -DI AGNOSTI C	4. 0 5. 0 7. 0 8. 0 9. 0 10. 0 11. 0 13. 0 14. 0 15. 0 16. 0 23. 0
5.00 00500 ADMI NI STRATI VE & GENERAL	5. C 7. C 8. C 9. C 10. C 11. C 13. C 14. C 15. C 23. C 25.
7.00 00700 OPERATI ON OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE 9.00 00900 HOUSEKEEPI NG 10.00 01000 DI ETARY 11.00 01100 CAFETERIA 13.00 01300 NURSI NG ADMI NI STRATI ON 14.00 01400 CENTRAL SERVI CES & SUPPLY 15.00 01600 MEDI CAL RECORDS & LI BRARY 23.00 02300 ALLI ED HEALTH-EMS 23.01 02301 ALLI ED HEALTH-PHARM RESI DENTS 1NPATI ENT ROUTI NE SERVI CE COST CENTERS 1, 159, 927 31.00 03000 ADULTS & PEDI ATRI CS 31.00 03100 INTENSI VE CARE UNI T 325, 494 13.9, 344 3400 04300 NURSERY 3500 05000 OPERATI NG ROOM 35100 05000 DELIVERY ROOM & LABOR ROOM 217, 247 35200 05300 ANESTHESI OLOGY 0 364.00 05400 RADI OLOGY-DI AGNOSTI C 212, 556 364.01 03440 MAMMOGRAPHY 16, 409 364.02 03450	7. 0 8. 0 9. 0 10. 0 11. 0 13. 0 14. 0 15. 0 16. 0 23. 0 23. 0 23. 0 30. 0 31. 0 41. 0 43. 0 50. 0 52. 0 53. 0 54. 0 54. 0
.00 00800 LAUNDRY & LINEN SERVICE .00 00900 HOUSEKEEPING .00 01000 DIETARY 1.00 01100 CAFETERIA 3.00 01300 NURSI NG ADMINISTRATION 4.00 01400 CENTRAL SERVICES & SUPPLY 5.00 01500 PHARMACY 6.00 01600 MEDICAL RECORDS & LIBRARY 3.01 02300 ALLI ED HEALTH-EMS 3.01 02303 ALLI ED HEALTH-PHARM RESIDENTS INPATI ENT ROUTI NE SERVICE COST CENTERS 1, 159, 927 1.00 03100 INTENSI VE CARE UNI T 3.01 02300 ADULTS & PEDI ATRICS 1, 159, 927 1.00 03100 INTENSI VE CARE UNI T 325, 494 1.00 04100 SUBPROVI DER - I RF 139, 344 3.00 04300 NURSERY 55, 664 ANCI LLARY SERVI CE COST CENTERS 0 0 0.00 05000 OPERATI NG ROOM 217, 247 3.00 05300 ANESTHESI OLOGY 0 4.00 05400 ANESTHESI OLOGY 0 <td>8. C 9. C 10. C 11. C 13. C 14. C 23. C 25. C 25</td>	8. C 9. C 10. C 11. C 13. C 14. C 23. C 25. C 25
00 00900 HOUSEKEEPING Image: style	9. 0 10. 0 11. 0 13. 0 14. 0 15. 0 23.
0.00 01000 DI ETARY Image: constraint of the second	10. 0 11. 0 13. 0 14. 0 15. 0 23. 0 24. 0 25. 0 25
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3.00 01300 NURSI NG ADMI NI STRATI ON	13. 0 14. 0 15. 0 16. 0 23. 0 23. 0 23. 0 30. 0 31. 0 41. 0 43. 0 50. 0 52. 0 54. 0 54. 0
4. 00 01400 CENTRAL SERVICES & SUPPLY 5. 00 01500 PHARMACY 6. 00 01600 MEDICAL RECORDS & LIBRARY 3. 00 02300 ALLIED HEALTH-EMS 3. 01 02301 ALLIED HEALTH-PHARM RESIDENTS 1 NPATIENT ROUTINE SERVICE COST CENTERS 1 INPATIENT ROUTINE SERVICE COST CENTERS 1.00 03000 ADULTS & PEDIATRICS 1.00 03100 INTENSIVE CARE UNIT 3.00 04300 NURSERY 3.00 04300 NURSERY 4.00 05400 APERATING ROOM 2.00 05200 DELIVERY ROOM & LABOR ROOM 2.00 05200 DELIVERY ROOM & LABOR ROOM 2.00 05400 ANESTHESI OLOGY 0.00 05400 RADIOGY-DIAGNOSTIC 4.01 03440 MAMMOGRAPHY 4.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC 4.03 03630 ULTRA SOUND	14. C 15. C 16. C 23. C 23. C 23. C 23. C 30. C 31. C 41. C 43. C 50. C 52. C 53. C 54. C 54. C
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3.00 02300 ALLI ED HEALTH-EMS	16. C 23. C 23. C 23. C 23. C 30. C 31. C 41. C 43. C 52. C 53. C 54. C 54. C 54. C
3.01 02301 ALLI ED HEALTH-RAD TECH 02303 ALLI ED HEALTH-PHARM RESIDENTS 1.02 02303 ALLI ED HEALTH-PHARM RESIDENTS 1, 159, 927 1.00 03000 ADULTS & PEDI ATRI CS 1, 159, 927 1.00 03100 INTENSI VE CARE UNI T 325, 494 1.00 04100 SUBPROVI DER - I RF 139, 344 3.00 04300 NURSERY 55, 664 ANCI LLARY SERVI CE COST CENTERS 0.00 05000 OPERATI NG ROOM 881, 394 2.00 05200 DELI VERY ROOM & LABOR ROOM 217, 247 3.00 05300 ANESTHESI OLOGY 0 4.00 05400 RADI OLOGY-DI AGNOSTI C 212, 556 4.01 03440 MAMMOGRAPHY 16, 409 4.02 03450 NUCLEAR MEDI CI NE - DI AGNOSTI C 38, 177 4.03 03630 ULTRA SOUND 16, 445	23. C 23. C 23. C 31. C 41. C 43. C 50. C 52. C 53. C 54. C 54. C
3. 02 02303 ALLI ED HEALTH-PHARM RESIDENTS INPATI ENT ROUTI NE SERVI CE COST CENTERS 0.00 03000 ADULTS & PEDI ATRI CS 1, 159, 927 1.00 03100 INTENSI VE CARE UNI T 325, 494 1.00 04100 SUBPROVI DER - I RF 139, 344 0.00 04300 NURSERY 55, 664 ANCI LLARY SERVI CE COST CENTERS 401 05400 0.00 05000 OPERATI NG ROOM 881, 394 2.00 05200 DELI VERY ROOM & LABOR ROOM 217, 247 3.00 05400 ANESTHESI OLOGY 0 4.00 05400 RADI OLOGY-DI AGNOSTI C 212, 556 4.01 03440 MAMMOGRAPHY 16, 409 4.02 03450 NUCLEAR MEDI CI NE - DI AGNOSTI C 38, 177 4.03 03630 ULTRA SOUND 16, 445	23. 0 30. 0 31. 0 41. 0 43. 0 50. 0 52. 0 53. 0 54. 0 54. 0
INPATI ENT ROUTI NE SERVI CE COST CENTERS 0.00 03000 ADULTS & PEDI ATRI CS 1, 159, 927 1.00 03100 INTENSI VE CARE UNI T 325, 494 1.00 04100 SUBPROVI DER - IRF 139, 344 3.00 04300 NURSERY 55, 664 ANCI LLARY SERVI CE COST CENTERS 000 05000 OPERATI NG ROOM 217, 247 3.00 05200 DELI VERY ROOM & LABOR ROOM 217, 247 0 3.00 05300 ANESTHESI OLOGY 0 0 4.00 05400 RADI OLOGY-DI AGNOSTI C 212, 556 4.01 03440 MAMMOGRAPHY 16, 409 4.02 03450 NUCLEAR MEDI CI NE - DI AGNOSTI C 38, 177 4.03 03630 ULTRA SOUND 16, 445	30. 0 31. 0 41. 0 43. 0 50. 0 52. 0 53. 0 54. 0 54. 0
00.00 03000 ADULTS & PEDIATRICS 1, 159, 927 11.00 03100 INTENSIVE CARE UNIT 325, 494 11.00 04100 SUBPROVIDER - IRF 139, 344 04300 NURSERY 55, 664 ANCILLARY SERVICE COST CENTERS 60.00 05000 05000 OPERATING ROOM 881, 394 22.00 05200 DELIVERY ROOM & LABOR ROOM 217, 247 33.00 05300 ANESTHESI OLOGY 0 44.00 05400 RADI OLOGY-DI AGNOSTI C 212, 556 44.01 03440 MAMMOGRAPHY 16, 409 44.02 03450 NUCLEAR MEDICINE - DI AGNOSTI C 38, 177 44.03 03630 ULTRA SOUND 16, 445	31. 0 41. 0 43. 0 50. 0 52. 0 53. 0 54. 0 54. 0 54. 0
11.00 03100 INTENSIVE CARE UNIT 325,494 11.00 04100 SUBPROVI DER - IRF 139,344 13.00 04300 NURSERY 55,664 ANCILLARY SERVICE COST CENTERS 00 05000 OPERATING ROOM 12.00 05200 DELIVERY ROOM & LABOR ROOM 217,247 13.00 05300 ANESTHESI OLOGY 0 04.00 05400 RADI OLOGY-DI AGNOSTI C 212,556 14.01 03440 MAMMOGRAPHY 16,409 14.02 03630 ULTRA SOUND 16,445	31. 0 41. 0 43. 0 50. 0 52. 0 53. 0 54. 0 54. 0 54. 0
1.00 04100 SUBPROVI DER - I RF 139, 344 3.00 04300 NURSERY 55, 664 ANCI LLARY SERVI CE COST CENTERS 0.00 05000 OPERATI NG ROOM 881, 394 2.00 05200 DELI VERY ROOM 217, 247 3.00 05300 ANESTHESI OLOGY 0 4.00 05400 RADI OLOGY-DI AGNOSTI C 212, 556 4.01 03440 MAMMOGRAPHY 16, 409 4.02 03450 NUCLEAR MEDI CI NE - DI AGNOSTI C 38, 177 4.03 03630 ULTRA SOUND 16, 445 16, 445	41. C 43. C 50. C 52. C 53. C 54. C 54. C 54. C
3. 00 04300 NURSERY 55, 664 ANCI LLARY SERVICE COST CENTERS 881, 394 0. 00 05000 OPERATI NG ROOM 881, 394 2. 00 05200 DELI VERY ROOM & LABOR ROOM 217, 247 3. 00 05400 ANESTHESI OLOGY 0 4. 00 05400 RADI OLOGY-DI AGNOSTI C 212, 556 4. 01 03440 MAMMOGRAPHY 16, 409 4. 02 03450 NUCLEAR MEDI CI NE - DI AGNOSTI C 38, 177 4. 03 03630 ULTRA SOUND 16, 445	43. C 50. C 52. C 53. C 54. C 54. C
ANCI LLARY SERVICE COST CENTERS 0.00 05000 OPERATI NG ROOM 881, 394 2.00 05200 DELI VERY ROOM 217, 247 3.00 05300 ANESTHESI OLOGY 0 4.00 05400 RADI OLOGY-DI AGNOSTI C 212, 556 4.01 03440 MAMMOGRAPHY 16, 409 4.02 03450 NUCLEAR MEDI CI NE - DI AGNOSTI C 4.03 03630 ULTRA SOUND 16, 445	50. C 52. C 53. C 54. C 54. C
0.00 05000 0PERATING ROOM 881, 394 2.00 05200 DELIVERY ROOM & LABOR ROOM 217, 247 3.00 05300 ANESTHESI OLOGY 0 4.00 05400 RADI OLOGY-DI AGNOSTI C 212, 556 4.01 03440 MAMMOGRAPHY 16, 409 4.02 03450 NUCLEAR MEDI CINE - DI AGNOSTI C 38, 177 4.03 03630 ULTRA SOUND 16, 445	52. C 53. C 54. C 54. C
32.00 05200 DELI VERY ROOM & LABOR ROOM 217, 247 33.00 05300 ANESTHESI OLOGY 0 44.00 05400 RADI OLOGY-DI AGNOSTI C 212, 556 44.01 03440 MAMMOGRAPHY 16, 409 44.02 03450 NUCLEAR MEDI CI NE - DI AGNOSTI C 38, 177 44.03 03630 ULTRA SOUND 16, 445	52. C 53. C 54. C 54. C
33.00 05300 ANESTHESI OLOGY 0 44.00 05400 RADI OLOGY-DI AGNOSTI C 212, 556 44.01 03440 MAMMOGRAPHY 16, 409 44.02 03450 NUCLEAR MEDI CI NE - DI AGNOSTI C 38, 177 44.03 03630 ULTRA SOUND 16, 445	53. C 54. C 54. C
44. 00 05400 RADI OLOGY-DI AGNOSTI C 212, 556 44. 01 03440 MAMMOGRAPHY 16, 409 44. 02 03450 NUCLEAR MEDI CI NE - DI AGNOSTI C 38, 177 44. 03 03630 ULTRA SOUND 16, 445	54. C 54. C
4. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC 38, 177 4. 03 03630 ULTRA SOUND 16, 445	
4. 03 03630 ULTRA SOUND 16, 445	1
	54. C
	54. C
55. 00 05500 RADI OLOGY - THERAPEUTI C 64, 322	55.0
77. 00 [05700] CT SCAN 33, 462	57.0
8. 00 [05800] MAGNETI C RESONANCE I MAGI NG (MRI) 26, 126	58. C
9. 00 05900 CARDI AC CATHETERI ZATI ON 112, 139 0. 00 06000 LABORATORY 292, 796	59. C 60. C
5. 00 06500 RESPI RATORY THERAPY 97, 488	65.0
56. 00 06600 PHYSI CAL THERAPY 148, 670	66.0
7. 00 06700 OCCUPATIONAL THERAPY 66, 814	67.0
8.00 06800 SPEECH PATHOLOGY 20, 041	68. C
99. 00 06900 ELECTROCARDI OLOGY 10, 006	69. C
'0.00 O7000 ELECTROENCEPHALOGRAPHY 100, 133	70.0
1. 00 07100 MEDI CAL_SUPPLIES_CHARGED_TO_PATIENTS 101, 916	71. C
12. 00 072001 IMPL DEV. CHARGED TO PATI ENTS 126, 541	72.0
3. 00 07300 DRUGS CHARGED TO PATI ENTS 631, 582	73.0
6. 00 03190 CHEMOTHERAPY 40, 848 6. 01 03020 WOUND_CARE 47, 520	76. C 76. C
OUTPATIENT SERVICE COST CENTERS	70.0
	90.0
0. 01 09001 ANDERSON OUTPATI ENT CENTER 56, 097	90.0
0. 02 04950 DI ABETI C EDUCATI ON 0	90.0
20. 03 09002 MS CLINIC 0	90. C
1. 00 09100 EMERGENCY 371, 007	91. C
22.00 09200 0BSERVATION BEDS (NON-DISTINCT PART)	92.0
OTHER REIMBURSABLE COST CENTERS	
25. 00 09500 AMBULANCE SERVICES 206	95. 0
SPECIAL PURPOSE COST CENTERS	112.0
13.00 11300 INTEREST EXPENSE 18.00 SUBTOTALS (SUM OF LINES 1 through 117) 5,410,371	113. C 118. C
18.00 SUBTOTALS (SUM OF LINES 1 through 117) 5, 410, 371 NONREI MBURSABLE COST CENTERS	118.0
90. 00 19000 GI FT, FLOWER, COFFEE SHOP, & CANTEEN 14, 481	
91. 00 19100 RESEARCH 3, 374	191. C
92. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 99, 774	192. 0
94. 00 07950 FOUNDATI ON 4, 953	194. C
94. 01 07951 CHI LDRENS CLI NI C 2, 189	194. C
94. 02 07952 PSS_ADMINI STRATI ON 4, 110	194. C
94. 03 07953 SEXUAL ASSAULT PROGRAM 184	194. C
94. 04 07954 ASPR BI OTERRORI SM GRANT 11	194. C
94. 05 07955 HEALTHY FAMILLIES 90, 761	194. C
94. 06 07956 DME-HOME CARE 2, 086	194. C
94. 07 07957 MARKETI NG 0	194. C
94. 08 07958 CORPORATE_COMMUNICATIONS 19, 566 94. 09 07959 MOB 1, 873	194. C 194. C
94. 10 07960 ASC [242]	194. (
94. 11 07961 MAB 0	194. 1
94. 12 07963 ADOLESCENT RESIDENTIAL SERVICES 48, 090	194. 1

Health Financial Systems	ASCENSION ST. VIN	ICENT ANDERSON	In Lieu of Form CMS-2552-10			
ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0088	Period:	Worksheet B		
			From 07/01/2020			
			To 06/30/2021	Date/Time Prepa		
				11/23/2021 1:22	<u>2 pm</u>	
Cost Center Description	Total					
	26.00					
194. 13 07962 I DLE SPACE	0			1	94.13	
200.00 Cross Foot Adjustments	9, 532			2	200.00	
201.00 Negative Cost Centers	4, 063			2	01.00	
202.00 TOTAL (sum lines 118 through 201)	5, 715, 660			2	02.00	

-	ALLOCATION - STATISTICAL BASIS	SCENSION SI. VI	Provi der C		Peri od:	Worksheet B-1	
CUST	ALLUCATION - STATISTICAL DASIS		Provider C		rom 07/01/2020		
					o 06/30/2021	Date/Time Pre	
			ATED COSTS			11/23/2021 1:	22 pm
		CAPITAL REL	LATED COSTS				
	Cost Center Description	BLDG & FIXT	BLDG &	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
	cost center bescription	(SQUARE FEET)	FIXT-MAB	BENEFITS	Reconciliation	& GENERAL	
			(SQUARE FEET)	DEPARTMENT		(ACCUM. COST)	
			(SUUARE ILLI)	(GROSS		(ACCOM. COST)	
				SALARI ES)			
		1.00	1.01	4.00	5A	5.00	<u> </u>
	GENERAL SERVICE COST CENTERS	1.00	1.01	4.00	54	5.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT	471, 797					1.00
1.01	00101 CAP REL COSTS-BLDG & FIXT-MAB	0					1.01
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	6, 193			5		4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	44, 675				117, 590, 894	
7.00	00700 OPERATION OF PLANT	55, 747					
8.00	00800 LAUNDRY & LINEN SERVICE	7,871			-		
9.00	00900 HOUSEKEEPI NG	9, 977			0		
10.00	01000 DI ETARY	11, 083			0		
11.00	01100 CAFETERI A	16, 753			0		
13.00	01300 NURSING ADMINISTRATION	4, 884		1, 668, 619	0		
14.00	01400 CENTRAL SERVICES & SUPPLY	15, 860					
15.00	01500 PHARMACY	4, 819					
16.00	01600 MEDICAL RECORDS & LIBRARY	5, 214					
23.00	02300 ALLIED HEALTH-EMS	130		6, 770	0 0		
23.01	02301 ALLI ED HEALTH-RAD TECH	110					
23.02		0					
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS				· · · · · ·		1
30.00		65, 832	0	9, 815, 807	7 0	14, 291, 809	30.00
31.00		14,660					
41.00	04100 SUBPROVIDER - IRF	10,000					
43.00		5, 941					
	ANCI LLARY SERVICE COST CENTERS						
50.00		47, 997	0	586, 939	9 0	13, 965, 497	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	22, 211	0	750, 315	5 0	1, 177, 578	52.00
53.00	05300 ANESTHESI OLOGY	0	0				
54.00	05400 RADI OLOGY-DI AGNOSTI C	14, 278	0	1, 634, 539) O	3, 185, 536	54.00
54.01	03440 MAMMOGRAPHY	0					
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	1, 127	0				1
54.03	03630 ULTRA SOUND	0					
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0				
57.00	05700 CT SCAN	551	0				
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1,003					
59.00	05900 CARDI AC CATHETERI ZATI ON	8, 562					
60.00	06000 LABORATORY	12, 544					
65.00	06500 RESPI RATORY THERAPY	7, 138	0	906, 349) O	1, 350, 789	65.00
66.00	06600 PHYSI CAL THERAPY	10, 056	0	1, 605, 348	3 0	2, 376, 010	66.00
67.00	06700 OCCUPATI ONAL THERAPY	4, 461	0	700, 230	0 0		
68.00	06800 SPEECH PATHOLOGY	1, 341	0	210, 451	0	314, 596	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0	110, 768	3 0	211, 283	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	11, 644	0	209, 550	0 0	376, 727	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0 0	0 0	3, 864, 831	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0 0	0 0	4, 809, 769	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0 0	0 0	18, 445, 709	73.00
76.00	03190 CHEMOTHERAPY	0	0	785, 370	0 0	1, 199, 036	76.00
76.01	03020 WOUND CARE	3, 100	0	255, 058	3 0	775, 480	76.01
	OUTPATIENT SERVICE COST CENTERS			1		1	4
90.00	09000 CLI NI C	0					
90. 01	09001 ANDERSON OUTPATIENT CENTER	3, 500	0	776, 292	2 0		
90.02		0	0	0	-	0	
90.03		0	0		0 0		
91.00	09100 EMERGENCY	22, 505	0	3, 235, 528	3 0	4, 720, 602	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS				1		
95.00	09500 AMBULANCE SERVI CES	0	0	31, 154	1 0	6, 733	95.00
	SPECIAL PURPOSE COST CENTERS	i	1	1		i	
	D 11300 I NTEREST EXPENSE						113.00
118.0		451, 767	0	36, 090, 269	-44, 026, 945	112, 650, 756	118.00
	NONREI MBURSABLE COST CENTERS	1	t	1	t	1	4
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	1, 882			-		190.00
	0 19100 RESEARCH	0	-				
	19200 PHYSI CLANS' PRI VATE OFFI CES	1, 829		2, 281, 002	2 0		
	07950 FOUNDATI ON	636		0	-		194.00
	1 07951 CHI LDRENS CLI NI C	0	0	0			194.01
	2 07952 PSS ADMINI STRATI ON	0	0	101, 575		130, 948	
	3 07953 SEXUAL ASSAULT PROGRAM	0	0	4, 779			194. 03
	4 07954 ASPR BI OTERRORI SM GRANT	0	-	0	-		194.04
	507955 HEALTHY FAMILIES	10, 091					
194.0	5 07956 DME-HOME CARE	220	0	0	0 0	16, 443	194.06
44 /00	(2021 1:22 pm D:\Shared drives\Finance Net Pev						

Health Finar	icial Systems AS	SCENSION ST. VI	NCENT ANDERSON		In Lie	eu of Form CMS-	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provider CC		Period: From 07/01/2020	Worksheet B-1	
					To 06/30/2021		
		CAPI TAL REL	ATED COSTS				
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	BLDG & FIXT-MAB (SQUARE FEET)	EMPLOYEE BENEFI TS DEPARTMENT (GROSS SALARI ES)	Reconciliation	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	
		1.00	1.01	4.00	5A	5.00	
194.07 07957		0	0	(0 0		194.07
	CORPORATE COMMUNI CATI ONS	2, 527	0	(0 0		194.08
194.0907959		0	0	(0 0		194.09
194. 10 07960		0	0	(0 0		194. 10
194. 11 07961		0	0	(0 0		194.11
	ADOLESCENT RESIDENTIAL SERVICES	2, 845	0	726, 19	0 0	994, 205	
194. 13 07962		0	0	(0 0	0	194. 13
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	2, 924, 610	0	8, 545, 07	3	44, 026, 945	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	6. 198874	0. 000000	0. 21611	C	0. 374408	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			38, 39	D	3, 069, 678	204.00
205.00	Unit cost multiplier (Wkst. B, Part			0.00097	1	0. 026105	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

	Financial Systems A: LOCATION - STATISTICAL BASIS	SCENSION ST. VI	Provider C	CN: 15-0088 P F	Period: rom 07/01/2020 o 06/30/2021	wof Form CMS- Worksheet B-1 Date/Time Pre	
	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LI NEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (HOURS OF SERVI CE)	DI ETARY (MEALS SERVED)	11/23/2021 1: CAFETERI A	
		7.00	8.00	9.00	10.00	11.00	
	GENERAL SERVICE COST CENTERS						
01 00 00 00 00	00100 CAP REL COSTS-BLDG & FIXT 00101 CAP REL COSTS-BLDG & FIXT-MAB 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	365, 182 7, 871 9, 977	928, 914 0				1.0 1.0 4.0 5.0 7.0 8.0 9.0
). 00 . 00 3. 00	01000 DI ETARY 01100 CAFETERIA 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	11, 083 16, 753 4, 884 15, 860	0 0 0 16, 266	512 338 250	98, 125 0 0	941, 232 43, 065 19, 370	10. 0 11. 0 13. 0
5.00 5.00 8.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 02300 ALLIED HEALTH-EMS	4, 819 5, 214 130	10, 200 0 0 0	200	0	61, 093 0 6, 170	15. 0 16. 0 23. 0
3. 02	02301 ALLI ED HEALTH-RAD TECH 02303 ALLI ED HEALTH-PHARM RESIDENTS I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	110 0 65, 832	0 0 343, 288		-	6, 565 0 281, 300	23.0
. 00 . 00 3. 00	03100 I NTENSI VE CARE UNI T 04100 SUBPROVI DER – I RF 04300 NURSERY	14, 660 10, 000 5, 941	101, 335 35, 552 6, 693	5, 500 2, 500	6, 335 8, 787	83, 600 26, 959	31. 0 41. 0
). 00 2. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	47, 997 22, 211 0	147, 597 23, 676 0	1, 670		846 20, 877 0	52.0
I. 00 I. 01 I. 02	05400 RADIOLOGY-DIAGNOSTIC 03440 MAMMOGRAPHY 03450 NUCLEAR MEDICINE - DIAGNOSTIC	14, 278 0 1, 127	2, 771 5, 513 487	150 150	0	54, 032 6, 242 5, 824	54.0 54.0
5.00 7.00	03630 ULTRA SOUND 05500 RADIOLOGY-THERAPEUTIC 05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	0 0 551 1,003	535 12, 558 45, 404 7, 603	150 0	0	8, 095 23, 412 14, 364 5, 882	55. 0 57. 0
9.00).00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06500 RESPI RATORY THERAPY	8, 562 12, 544 7, 138	0 0 0 0	300 1, 250	157 0	20, 696 0 25, 860	59. (60. (
7.00 3.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	10, 056 4, 461 1, 341 0	9, 622 4, 173 728 112	309	0	31, 119 19, 887 5, 977 3, 670	67.0 68.0
). 00 . 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	11, 644 0 0	0	700	0	2, 231	70.0
5. 00 5. 01	07300 DRUGS CHARGED TO PATIENTS 03190 CHEMOTHERAPY 03020 WOUND CARE DUTPATIENT SERVICE COST CENTERS	0 0 3, 100	0 16, 614 0		0 264 0	0 27, 298 8, 689	76.
). 00). 01). 02	09000 CLINIC 09001 ANDERSON OUTPATIENT CENTER 04950 DIABETIC EDUCATION	0 3, 500 0	0 0 0	0 600 0	-	0 11, 069 0	90. 90.
. 00 . 00	09002 MS CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	22, 505	134, 957	7, 050	3, 076	0 90, 333	
	09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE	0	0	0	0	0	95. 113.
0. 00	SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	345, 152	915, 484 0	0	1	0	190.
2.00 4.00	19100 RESEARCH 19200 PHYSI CLANS' PRI VATE OFFI CES 07950 FOUNDATION	0 1, 829 636	0 0 0	0 25	0		192. 194.
4.02 4.03	07951 CHI LDRENS CLI NI C 07952 PSS ADMI NI STRATI ON 07953 SEXUAL ASSAULT PROGRAM 07954 ASPR BI OTERRORI SM GRANT	0 0 0	182 0 0 0			3, 302 99	194. 194. 194. 194.
4. 05 4. 06	07955 HEALTHY FAMILIES 07956 DME-HOME CARE 07957 MARKETING	10, 091 220 0	0 0 0			13, 123 0	
	07958 CORPORATE COMMUNI CATI ONS 07959 MOB	2, 527 0	0 13, 248	50 325			194. 194.

 194.09
 09/07959
 MOB
 0
 13, 248
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 194.00

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Health Finan	cial Systems A	SCENSION ST. VI	NCENT ANDERSON		In Lie	u of Form CMS-	2552-10
COST ALLOCAT	TION – STATI STI CAL BASI S				Period: From 07/01/2020 To 06/30/2021		
	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	SERVI CE)	(MEALS SERVED)		
		7.00	8.00	9.00	10.00	11.00	
194. 10 07960		0	0	100	0 0		194. 10
194. 11 07961	MAB	0	0	C	0 0	0	194. 11
194. 12 07963	ADOLESCENT RESIDENTIAL SERVICES	2, 845	0	C	0 0	0	194. 12
194.13 07962	194.13 07962 I DLE SPACE		0	C	0 0	0	194.13
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	7, 451, 276	1, 018, 740	3, 767, 304	1, 409, 380	2, 577, 222	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	20. 404281	1. 096700	63. 702531	14.363108	2. 738137	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	487, 096	75, 589	142, 842	106, 577	169, 061	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	1. 333844	0. 081374	2. 415360	1. 086135	0. 179617	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

	nancial Systems AS DCATION - STATISTICAL BASIS	SCENSION ST. VII	NCENT ANDERSON Provider CC	N: 15-0088	Period:	u of Form CMS-: Worksheet B-1	2552-10
					From 07/01/2020 To 06/30/2021	Date/Time Pre 11/23/2021 1:	
	Cost Center Description	NURSI NG ADMI NI STRATI ON (DI RECT NURS. HRS.) 13.00	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S.) 14.00	PHARMACY (COSTED REQUI S.) 15. 00	MEDI CAL RECORDS & LI BRARY (GROSS CHARGES) 16.00	ALLIED HEALTH-EMS (ASSIGNED TIME) 23.00	
	NERAL SERVICE COST CENTERS						1 00
$\begin{array}{ccccc} 1 & 01 & 00 \\ 4 & 00 & 00 \\ 5 & 00 & 00 \\ 7 & 00 & 00 \\ 8 & 00 & 00 \\ 9 & 00 & 00 \\ 10 & 00 & 01 \\ 11 & 00 & 01 \\ 13 & 00 & 01 \\ 14 & 00 & 01 \\ 15 & 00 & 01 \\ 16 & 00 & 01 \\ 23 & 01 & 02 \\ 23 & 01 & 02 \\ 23 & 02 & 02 \end{array}$	1100 CAP REL COSTS-BLDG & FIXT 101 CAP REL COSTS-BLDG & FIXT-MAB 1400 EMPLOYEE BENEFITS DEPARTMENT 1500 ADMINISTRATIVE & GENERAL 1700 OPERATION OF PLANT 1800 LAUNDRY & LINEN SERVICE 1900 HOUSEKEEPING 100 CAFETERIA 300 NURSING ADMINISTRATION 400 CENTRAL SERVICES & SUPPLY 500 PHARMACY 600 MEDICAL RECORDS & LIBRARY 301 ALLIED HEALTH-EMS 303 ALLIED HEALTH-PHARM RESIDENTS PATIENT ROUTINE SERVICE COST CENTERS	389, 826 0 0 0 0 0 0 0	11, 238, 485 106, 052 84 1, 085 0 0		7 0 682, 816, 847 0 0 0 0 0 0	100	$\begin{array}{c} 1.\ 00\\ 1.\ 01\\ 4.\ 00\\ 5.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 23.\ 01\\ 23.\ 02\\ \end{array}$
30.00 03	000 ADULTS & PEDIATRICS	194, 156	426, 061		0 47, 330, 420	0	30.00
	100 I NTENSI VE CARE UNI T 100 SUBPROVI DER – I RF	71, 313 19, 766	299, 537 25, 204		0 20, 767, 672 0 4, 438, 087	0 0	31.00 41.00
	300 NURSERY	4, 341	11, 728		0 1, 306, 888	0	43.00
	CILLARY SERVICE COST CENTERS	14,009	8, 417, 704		0 131, 646, 949	0	50.00
	2000 DELIVERY ROOM & LABOR ROOM 3000 ANESTHESIOLOGY	17, 443	52, 633 0		0 4, 271, 447 0 0	0	52.00
	400 RADI OLOGY-DI AGNOSTI C	0	399, 953		0 17, 821, 308	0	53.00 54.00
54.01 03	440 MAMMOGRAPHY	0	42, 865		0 3, 961, 312	0	54.01
	450 NUCLEAR MEDICINE - DIAGNOSTIC 630 ULTRA SOUND	0	192, 755 4, 522		0 15, 027, 929 0 8, 704, 352	0	54.02 54.03
	1500 RADI OLOGY-THERAPEUTI C	0	19, 315		0 31, 418, 986	0	55.00
	700 CT SCAN	0	65		0 15, 237, 610	0	57.00
	800 MAGNETIC RESONANCE IMAGING (MRI) 900 CARDIAC CATHETERIZATION	0 10, 857	2, 203 243, 362		0 3, 047, 621 0 22, 699, 907	0	58.00 59.00
	000 LABORATORY	10, 857	243, 302		0 85, 196, 849	0	60.00
65.00 06	500 RESPI RATORY THERAPY	0	143, 977		0 15, 895, 746	0	65.00
	600 PHYSI CAL THERAPY 700 OCCUPATI ONAL THERAPY	0	62, 177		0 9, 090, 613 0 3, 663, 848	0	66.00
	100 OCCUPATIONAL THERAPY 1800 SPEECH PATHOLOGY	0	27, 585 8, 291		0 3, 663, 848 0 1, 101, 151	0	67.00 68.00
69.00 06	900 ELECTROCARDI OLOGY	0	1, 785		0 1, 299, 082	0	69.00
		0	4, 574		0 4, 494, 236	0	10100
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS 200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 19, 703, 947 0 18, 893, 465	0	71.00 72.00
73.00 07	300 DRUGS CHARGED TO PATIENTS	0	0	18, 441, 25	7 102, 463, 440	0	73.00
	190 CHEMOTHERAPY 1020 WOUND CARE	0	135, 442 150, 957		0 9, 419, 811 0 3, 112, 040	0 0	76.00 76.01
	TPATIENT SERVICE COST CENTERS	<u> </u>	150, 957		0 3, 112, 040	0	70.01
	2000 CLINIC	0	0		0 0	0	90.00
	001 ANDERSON OUTPATIENT CENTER 950 DIABETIC EDUCATION	0	3, 001		0 3, 318, 750	0	90. 01 90. 02
	002 MS CLINIC	0	0		0 0	0	90.02
	100 EMERGENCY	57, 941	452, 991		0 77, 483, 381	100	
	200 OBSERVATION BEDS (NON-DISTINCT PART) HER REIMBURSABLE COST CENTERS						92.00
	1500 AMBULANCE SERVICES	0	0		0 0	0	95.00
	ECIAL PURPOSE COST CENTERS						110.00
113.0011	300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	389, 826	11, 237, 933	18, 441, 25	7 682, 816, 847	100	113.00 118.00
NO	NREIMBURSABLE COST CENTERS						
	0000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 1000 RESEARCH	0	0		0 0		190. 00 191. 00
	200 PHYSI CLANS' PRI VATE OFFI CES	0	78		0 0		191.00
194.0007	950 FOUNDATI ON	Ō	Ō		0 0	0	194.00
	951 CHI LDRENS CLI NI C	0	0		0 0		194. 01 194. 02
	952 PSS ADMINISTRATION 953 SEXUAL ASSAULT PROGRAM	0	0		0 0		194. 02 194. 03
194.0407	954 ASPR BI OTERRORI SM GRANT	Ő	Ö		o o	0	194. 04
	955 HEALTHY FAMILIES	0	474		0 0		194.05
	956 DME-HOME CARE 957 MARKETI NG	0	0		0 0		194. 06 194. 07
	958 CORPORATE COMMUNICATIONS	0	0		0 0		194. 08

Health Finan	cial Systems A	SCENSION ST. VI	NCENT ANDERSON		In Lieu of Form CMS-2552-10			
COST ALLOCAT	TION - STATISTICAL BASIS		Provider CC		Period:	Worksheet B-1		
					From 07/01/2020 To 06/30/2021	Date/Time Pre 11/23/2021 1:		
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	ALLI ED		
		ADMI NI STRATI ON		(COSTED	RECORDS &	HEALTH-EMS		
			SUPPLY	REQUIS.)	LI BRARY	(ASSI GNED		
		(DI RECT NURS.	(COSTED		(GROSS	TIME)		
		HRS.)	REQUIS.)		CHARGES)			
		13.00	14.00	15.00	16.00	23.00		
194.0907959		0	0	(0 0		194.09	
194. 10 07960		0	0		0 0		194. 10	
194. 11 07961		0	0	(0 0		194. 11	
	ADOLESCENT RESIDENTIAL SERVICES	0	0	(0 0		194. 12	
194. 13 07962		0	0	(0 0	0	194. 13	
200.00	Cross Foot Adjustments						200.00	
201.00	Negative Cost Centers						201.00	
202.00	Cost to be allocated (per Wkst. B,	4, 022, 549	1, 445, 753	5, 186, 02	9 133, 217	71, 820	202.00	
	Part I)							
203.00	Unit cost multiplier (Wkst. B, Part I)							
204.00	Cost to be allocated (per Wkst. B,	118, 716	145, 389	144, 76	1 39, 847	3, 098	204.00	
	Part II)							
205.00	Unit cost multiplier (Wkst. B, Part	0. 304536	0. 012937	0. 00785	0. 000052	30. 980000	205.00	
	11)							
206.00	NAHE adjustment amount to be allocated					0	206.00	
	(per Wkst. B-2)							
207.00	NAHE unit cost multiplier (Wkst. D,					0. 000000	207.00	
	Parts III and IV)						1	

Health Financial Systems AS COST ALLOCATION - STATISTICAL BASIS COST	SCENSION ST. VI	NCENT ANDERSON Provi der CCN:	15-0088	In Lie Period: From 07/01/2020	u of Form CMS-255 Worksheet B-1	52-1
				To 06/30/2021	Date/Time Prepar	
Cost Center Description	ALLI ED HEALTH-RAD TECH (ASSI GNED TI ME)	ALLI ED HEALTH-PHARM RESI DENTS (ASSI GNED TI ME)		1	11/23/2021 1:22	piii
GENERAL SERVICE COST CENTERS	23.01	23.02				
1.00 00100 CAP REL COSTS-BLDG & FIXT 1.01 00101 CAP REL COSTS-BLDG & FIXT-MAB 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMINISTRATIVE & GENERAL 7.00 00700 OPERATION OP PLANT 8.00 00800 LAUNDRY & LINEN SERVICE 9.00 00900 HOUSEKEEPING 01000 DI ETARY 11.00 01100 CAFETERIA A					1	1.0 1.0 5.0 7.0 8.0 9.0 0.0 1.0
13.00 01300 NURSI NG ADMI NI STRATI ON 14.00 01400 CENTRAL SERVICES & SUPPLY 15.00 01500 PHARMACY 16.00 01600 MEDI CAL RECORDS & LI BRARY 23.00 02300 ALLI ED HEALTH-EMS 23.02 02301 ALLI ED HEALTH-PHARM RESI DENTS	95, 219, 118	0			1 1 1 2 2	3.0 4.0 5.0 6.0 23.0 23.0 23.0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 O3000 ADULTS & PEDI ATRICS 31.00 03100 INTENSIVE CARE UNIT 41.00 04100 SUBPROVIDER - IRF 43.00 04300 NURSERY	0 0 0				3	30.00 31.00 11.00 13.00
43.00 D4300 NURSERY ANCI LLARY SERVI CE COST CENTERS ANCI LLARY SERVI CE COST CENTERS 50.00 O5000 OPERATI NG ROOM 52.00 D5200 DELI VERY ROOM & LABOR ROOM 53.00 O5300 ANESTHESI OLOGY 54.01 O3440 MAMMOGRAPHY 54.02 O3450 NUCLEAR MEDICI NE - DI AGNOSTI C 54.03 O3630 ULTRA SOUND 55.00 O5500 RADI OLOGY-THERAPEUTI C 57.00 O5700 CT SCAN 58.00 O5800 MAGNETI C RESONANCE I MAGI NG (MRI) 59.00 O5900 CARDI AC CATHETERI ZATI ON 60.00 O6600 PHYSI CAL THERAPY 61.00 O6600 PHYSI CAL THERAPY 65.00 OSEDCH PATHOLOGY 68.00 O6800 SPEECH PATHOLOGY 69.00 O6900 ELECTROCARDI OLOGY 70.00 O7000 ELECTROCARDI OLOGY 70.00 O7100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 73.00 O7300 DRUGS CHARGED TO PATI ENTS 73.00 O7300 DRUGS CHARGED TO PATI ENTS 74.01 O3020 WOUND CARE 017001 ANDERSON OUTPATI ENT CENTERS 90.00 <	0 0 0 17, 821, 308 3, 961, 312 15, 027, 929 8, 704, 352 31, 418, 986 15, 237, 610 3, 047, 621 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5	13.0 13.0 14.0 15.0 15.0 15.0 15.0 15.0 15.0 15.0 15.0 15.0 15.0 15.0 15.0 15.0 15.0 15.0 15.0 15.0 15.0 10.0 <t< td=""></t<>
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						2.00
OTHER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVI CES	0	0			9	95.00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 INTEREST EXPENSE 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) NONREL MBURSABLE COST CENTERS	95, 219, 118				11	3. 0 8. 0
190. 00 19000 GI FT, FLOWER, COFFEE SHOP, & CANTEEN 191. 00 19100 RESEARCH 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 194. 00 07950 FOUNDATI ON 194. 01 07951 CHI LDRENS CLI NI C 194. 02 07952 PSS ADMI NI STRATI ON 194. 03 07953 SEXUAL ASSAULT PROGRAM 194. 04 07954 ASPR BI OTERRORI SM GRANT 194. 05 07955 HEALTHY FAMILIES		0 0 0 0 0 0 0			19 19 19 19 19 19 19 19	90.0 91.0 92.0 94.0 94.0 94.0 94.0 94.0
194. 05 07955 HEALTHY FAMILIES 194. 06 07956 DME-HOME CARE 194. 07 07957 MARKETING 194. 08 07958 CORPORATE COMMUNICATIONS		0 0 0		s\FY2021\Andersor	19 19 19	94.0 94.0 94.0 94.0

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Health Financial Systems		ASCENSION ST. VINCENT ANDERSON			In Lieu of Form CMS-2552-10		
COST ALLOCAT	ION - STATISTICAL BASIS		Provider C	CN: 15-0088	Peri od:	Worksheet B-1	
					From 07/01/2020 To 06/30/2021	Date/Time Pre 11/23/2021 1:	
	Cost Center Description	ALLI ED	ALLI ED				
		HEALTH-RAD TECH	HEALTH-PHARM RESI DENTS				
		(ASSI GNED	(ASSI GNED				
		TIME)	TIME)				
		23.01	23.02				
194.0907959	MOB	0	0				194.09
194. 10 07960	ASC	0	0				194.10
194. 11 07961	MAB	0	0				194.11
	ADOLESCENT RESIDENTIAL SERVICES	0	0				194. 12
194. 13 07962		0	0				194. 13
	Cross Foot Adjustments						200.00
	Negative Cost Centers						201.00
	Cost to be allocated (per Wkst. B, Part I)	247, 783	0				202.00
	Unit cost multiplier (Wkst. B, Part I)	0. 002602	0. 000000				203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	6, 434	0				204.00
205.00	Unit cost multiplier (Wkst. B, Part	0. 000068	0. 000000				205. 00
	NAHE adjustment amount to be allocated (per Wkst. B-2)	0	0				206. 00
	NAHE unit cost multiplier (Wkst. D, Parts III and IV)	0. 000000	0. 000000				207. 00

Heal th	leal th Financial		ıl Syst	Systems			
COMPLIE		OF	DATIO	OF	COSTS	ΤO	0

ASCENSI ON	ST.	VI NCENT	ANDERSON

In Lieu of Form CMS-2552-10

	SCENSION ST. VI					2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0088	Peri od:	Worksheet C	
				From 07/01/2020 To 06/30/2021	Part I Date/Time Pre 11/23/2021 1:	
				10 06/30/2021	Date/lime Pre	pared:
					11/23/2021 1:	22 pm
		litle	XVIII	Hospi tal	PPS	
				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	1.00	2.00	0.00	1.00	0.00	
30. 00 03000 ADULTS & PEDIATRICS	26, 681, 960	1	26, 681, 90	0 0	26, 681, 960	30.00
31. 00 03100 I NTENSI VE CARE UNI T	9, 314, 677		9, 314, 6			
41.00 04100 SUBPROVIDER – IRF	2, 560, 012		2, 560, 01			
43. 00 04300 NURSERY	578, 528		578, 52	28 0	578, 528	43.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	22, 177, 577		22, 177, 5	77 176, 960	22, 354, 537	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	2, 482, 389		2, 482, 38	39 0	2, 482, 389	52.00
53.00 05300 ANESTHESI OLOGY	0		,,	0 0		1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	5, 033, 320		5, 033, 32	-	-	•
54. 01 03440 MAMMOGRAPHY						
	759, 887		759, 88			
54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	1, 417, 547		1, 417, 54			
54.03 03630 ULTRA SOUND	789, 477		789, 4			
55. 00 05500 RADI OLOGY-THERAPEUTI C	3, 125, 053		3, 125, 0	53 0	3, 125, 053	55.00
57.00 05700 CT SCAN	1, 288, 000		1, 288, 00	0 0	1, 288, 000	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	911, 369		911, 30	59 O	911, 369	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	2, 224, 649		2, 224, 64			
60. 00 06000 LABORATORY	10, 399, 492		10, 399, 49			
65. 00 06500 RESPI RATORY THERAPY	2, 100, 981					
			1 1			
66. 00 06600 PHYSI CAL THERAPY	3, 620, 788					•
67.00 06700 OCCUPATI ONAL THERAPY	1, 612, 651	0	.,			
68.00 06800 SPEECH PATHOLOGY	484, 115		484, 11			•
69. 00 06900 ELECTROCARDI OLOGY	396, 598		396, 59	98 0	396, 598	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	807, 529		807, 52	29 0	807, 529	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	5, 315, 697		5, 315, 69	97 0	5, 315, 697	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	6, 614, 269		6, 614, 20			
73. 00 07300 DRUGS CHARGED TO PATIENTS	30, 557, 911		30, 557, 9			
76. 00 03190 CHEMOTHERAPY	1, 763, 985		1, 763, 98			
	1, 172, 898		1, 172, 89	78 0	1, 172, 898	76.01
OUTPATIENT SERVICE COST CENTERS	-			-1 -	-	
90. 00 09000 CLINIC	0			0 0		
90.01 09001 ANDERSON OUTPATIENT CENTER	1, 474, 587		1, 474, 58	37 0	1, 474, 587	90.01
90. 02 04950 DIABETIC EDUCATION	0			0 0	0	90.02
90. 03 09002 MS CLINIC	0			0 0	0	90.03
91. 00 09100 EMERGENCY	8, 578, 952		8, 578, 9	52 0	8, 578, 952	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 305, 820		1, 305, 82		1, 305, 820	
OTHER REIMBURSABLE COST CENTERS	1,000,020	I	1,000,02	-0	1,000,020	,2.00
95. 00 09500 AMBULANCE SERVICES	9, 254		9, 2	54 0	9, 254	95.00
	9,234		9,23	04	9,204	95.00
SPECIAL PURPOSE COST CENTERS						112 00
113.00 11300 INTEREST EXPENSE	455 550 555	-	455 550		455 304 000	113.00
200.00 Subtotal (see instructions)	155, 559, 972					
201.00 Less Observation Beds	1, 305, 820		1, 305, 82		1, 305, 820	
202.00 Total (see instructions)	154, 254, 152	0	154, 254, 15	52 176, 960	154, 431, 112	202.00

Heal th	Fi nar	ici a	I Syst	ems			
COMPLIT		0E	DATIO		COSTS	ΤO	(

OTHER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 00 0 0 0.00000 SPECI AL PURPOSE COST CENTERS 113.00 INTEREST EXPENSE 0 0	Heal th	Financial Systems	ASCENSION ST. VI	NCENT ANDERSON	In Lieu of Form CMS-2552-10			
Impatient It it e xviii Hospit isi Hospit isi PPS Impatient Outpatient Outpatient Total (col. 6) Cast or 0ther Ratio TEFRA Inpatient 0.00 03000 ADULTS & PEDIATRICS 44, 564, 402 44, 564, 402 0.00 10.00 30.00 03000 ADULTS & PEDIATRICS 44, 564, 402 20, 767, 672 20, 767, 672 20, 767, 672 20, 767, 672 20, 767, 672 20, 767, 672 4, 438, 087 41.00 SUBPRIVIESER 11/280, 688 11, 366, 688 1, 366, 688 0.00000 0.00000 50.00 OSCOO DELIVERY KOM & LABOR ROOM 2, 781, 775 490, 27, 42, 71, 447 0. 881459 0.00000 51.00 05200 DELIVERY KOM & LABOR ROOM 3, 781, 175 490, 27, 42, 71, 447 0. 894332 0.00000 54.00 DS400 MARSHESHESIOLOGY THER ROOM 1, 659, 658 71, 702, 154 0.094343 0.00000 55.00 DS500 DESON DUCLEAR MEDICHE - DIAGNOSTIC 1, 659, 658 71, 723, 743 0.094342 0.00000 56.00 DS700 CT SCM 3, 699, 452 11, 658, 558 <t< td=""><td colspan="2">COMPUTATION OF RATIO OF COSTS TO CHARGES</td><td></td><td>Provider C</td><td>CN: 15-0088</td><td>Peri od:</td><td>Worksheet C</td><td></td></t<>	COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider C	CN: 15-0088	Peri od:	Worksheet C	
Impatient It it e xviii Hospit isi Hospit isi PPS Impatient Outpatient Outpatient Total (col. 6) Cast or 0ther Ratio TEFRA Inpatient 0.00 03000 ADULTS & PEDIATRICS 44, 564, 402 44, 564, 402 0.00 10.00 30.00 03000 ADULTS & PEDIATRICS 44, 564, 402 20, 767, 672 20, 767, 672 20, 767, 672 20, 767, 672 20, 767, 672 20, 767, 672 4, 438, 087 41.00 SUBPRIVIESER 11/280, 688 11, 366, 688 1, 366, 688 0.00000 0.00000 50.00 OSCOO DELIVERY KOM & LABOR ROOM 2, 781, 775 490, 27, 42, 71, 447 0. 881459 0.00000 51.00 05200 DELIVERY KOM & LABOR ROOM 3, 781, 175 490, 27, 42, 71, 447 0. 894332 0.00000 54.00 DS400 MARSHESHESIOLOGY THER ROOM 1, 659, 658 71, 702, 154 0.094343 0.00000 55.00 DS500 DESON DUCLEAR MEDICHE - DIAGNOSTIC 1, 659, 658 71, 723, 743 0.094342 0.00000 56.00 DS700 CT SCM 3, 699, 452 11, 658, 558 <t< td=""><td></td><td></td><td></td><td></td><td></td><td>From 07/01/2020</td><td>Part I</td><td></td></t<>						From 07/01/2020	Part I	
Cost Center Description Inpatient Outpatient Total (col. 6 + col. 7) Cost or Other Ratio Impatient Ratio 0.00 03000 ADULTS & PEDIATRI CS 6.00 7.00 8.00 9.00 10.00 30.00 03000 ADULTS & PEDIATRI CS 44,564,402 20.767,672 20.767,672 10.00 41.00 04100 SUBPROV DER 1.86,888 1.306,888 0.0000 9.000 10.00 0.01 05000 PEDIATINE SCRUCE COST CENTERS 1.306,888 1.306,888 0.000000 0.000000 0.02000 DELVEYR PK NOW & LABOR ROOM 25,585,766 106,061,183 131,646,949 0.168463 0.000000 53.00 DELVEYR PK NOW & LABOR ROOM 3.781,175 480,0272 4,271,447 0.581159 0.000000 54.01 03400 RAUDICLARY SERVICE COST CENTERS 0.000000 0.000000 0.000000 0.000000 53.00 DELVEYR NOR MALEAN SOUND 1,620,198 7.1437,000000 0.128204 0.000000 0.000000 54.00 OS400 ALIZAN SOUND <						To 06/30/2021	Date/Time Pre	epared:
Cost Center Description Charges Charges Cost Center Ratio TEFRA Inpatient 0.00 03000 ADULTS & PEDIATRICS 6.00 7.00 8.00 9.00 10.00 10.00 03000 ADULTS & PEDIATRICS 44.564.402 20.76.7672 20.767.672 20.767.672 30.00 04100 SUBPROVIDER - IRF 4.438.087 4.438.087 4.438.087 30.00 05200 DELIVERY SERVICE COST CENTERS 1.306.888 1.306.888 0.000000 30.00 05200 DELIVERY ROOM 2.5585.766 106.061.183 131.646.949 0.168463 0.00000 30.00 05200 DELIVERY ROOM 2.5585.766 106.061.183 131.646.949 0.00000 0.00000 30.00 05300 DELIVERY ROOM 2.5245.3988 3.981.312 0.168463 0.00000 40.03200 DELIVERY ROOM 1.4590 E891 13.788.310 0.00000 0.00000 0.00000 51.00 05500 ADIOLOGY-DIAGNOSTIC 1.259 619 13.788.310 15.027.929 0.094328 0.00000 52.00 05500 ADIOLOGY-THERAPEUTIC 3.779.43					XV/LLL	Hocpi tol		22 pm
Cost Center Description Inpatient Outpatient Total (col. 6) Cost or Other Ratio INPATIENT ROUTINE SERVICE COST CENTERS 6.00 7.00 8.00 9.00 10.00 1000 03000 (INTENS VE CAPE UNIT 20, 767, 672 20, 767, 672 44, 564, 402 20, 767, 672 10.00 10.00 1000 04000 SUPPROVINES VE CAPE UNIT 20, 767, 672 44, 8564, 002 44, 8564, 002 10.00 10.00 100 04100 SUPPROVINES (FY 1, 306, 888 1, 306, 888 1, 306, 888 1, 306, 888 0.00000 50: 00 05000 DELATING ROOM 25, 585, 766 106, 061, 182 131, 646, 949 0.168463 0.00000 51: 00 05000 DELATING ROOM 3, 781, 175 490, 272, 4271, 447 0. 581159 0.00000 0.00000 52: 00 05300 DELI VERY ROOM & LABOR ROOM 3, 781, 175 490, 272, 924 0.958, 988 0.961, 332 0.1182, 334, 348 0.00000 54: 00 05400 RADI LOGY - DI AGNOSTIC 1, 259, 619 13, 77, 943 31, 41, 943 0.09649 0.00000 55: 00 05500 RADI LOGY - THERAPEUTIC 377, 943 31, 41, 948, 958 0.096494							PP3	
Image: Instruction of the service cost centers 6.00 7.00 8.00 9.00 10.00 30.00 03000 ADULTS & PEDIATRICS 44,564,402 44,564,402 20,767,672 20,721,443,086 0,00000 20,000000 20,000000 <t< td=""><td></td><td>Cast Contor Description</td><td>Innationt</td><td></td><td>Total (col</td><td>Cost or Other</td><td>TEEDA</td><td></td></t<>		Cast Contor Description	Innationt		Total (col	Cost or Other	TEEDA	
INPATIENT ROUTINE SERVICE COST CENTERS Retio Retio 0.00 03000 ADULTS & PEDIATRICS 44, 564, 402 44, 564, 402 11.00 03100 INTENSIVE CARE UNIT 20, 767, 672 20, 767, 672 11.00 03100 INTENSIVE CARE UNIT 20, 767, 672 20, 767, 672 11.00 04300 NURSERY 1, 306, 888 1, 306, 888 ANCILLARY SERVICE COST CENTERS 1, 306, 888 1, 31, 446, 949 0. 168463 50.00 05200 DERATING ROM 25, 595, 766 106, 061, 183 131, 446, 949 0. 68463 50.00 05200 ADERATING ROM 2, 585, 766 106, 061, 183 131, 446, 949 0. 68463 0.00000 51.00 05200 ADERATING ROM 2, 524, 33, 956, 988 3, 961, 312 0.00000 0.00000 0.00000 52.00 05200 RADICOGY 0 0 0 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.00000 0.00000 0.000000 0.000000 0.00000 0.		cost center bescription	inpatient	outpatrent				
INPATIENT ROUTINE SERVICE COST CENTERS 6.00 7.00 8.00 9.00 10.00 30.00 03000 (ADULTS & PEDIATRICS 44, 564, 402 44, 564, 402 20, 767, 672 20, 762, 723 0 <t< td=""><td></td><td></td><td></td><td></td><td>+ COL. 7)</td><td>Ratio</td><td></td><td></td></t<>					+ COL. 7)	Ratio		
IMPATIENT ROUTINE SERVICE COST CENTERS 00 03000 001000 ADUTAS SPEDIATRICS 44, 564, 402 44, 564, 402 31.00 03100 INTENSIVE CARE UNIT 20, 767, 672 20, 767, 672 4, 438, 087 41.00 SUBPROVIDER - IRF 4, 438, 087 4, 438, 087 4, 438, 087 A3.00 G4300, NURSERY DISON UNDER - IRF 1, 306, 888 1, 306, 888 ANCILLARY SERVICE COST CENTERS			6.00	7 00	8.00	0 00		
30.00 00000 AUTLIS & PEDIATRI CS 44, 564, 402 44, 564, 402 31.00 00100 INTENSI VE CARE UNIT 20, 767, 672 20, 767, 672 41.00 04300 NURSERY 1, 306, 888 1, 306, 888 ANCIL LARY SERVICE COST CENTERS 1, 306, 888 1, 306, 688 ANCIL LARY SERVICE COST CENTERS 0 0 0.00000 50.00 05000 DELIVERY NOOM & LABOR ROOM 25, 585, 766 106, 061, 183 131, 646, 949 0. 168463 0.00000 53.00 05300 ANESTHESI OLOCY 0 0 0.000000 0.000000 0.000000 54.01 03430 NUCLEAR MEDI CI NE - DI AGNOSTI C 1, 459, 658 17, 783, 310 15, 207, 929 0.094328 0.00000 55.00 0500 RADI DLOCY-THERAPEUTI C 377, 943 31, 041, 043 31, 418, 966 0.099649 0.00000 58.00 05000 RESPI RATORY THERAPUTI C 377, 943 31, 041, 043 31, 418, 966 0.090649 0.00000 59.00 05000 RADI RUCCY-THERAPUTI C 377, 943 31, 041, 043 31, 418, 966 0.099649 0.00000 58.00 050500 RESPI RATORY THERAPUTI N 5, 755, 716	ī	NPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	0.00	7.00	10.00	
11 00 0x100 INTENSIVE CARE. UNIT 20, 767, 672 20, 767, 672 11 00 0x1000 SUBPROVIDER - 1 RF 4, 438, 087 1, 306, 888 ANCILLARY SERVICE COST CENTERS 1, 306, 888 1, 306, 888 0.000000 000 05000 DPERATING ROOM 25, 585, 766 106, 061, 183 131, 646, 949 0. 168463 0.00000 0100 05000 DPERATING ROOM 3, 781, 175 490, 272 4, 271, 447 0. 581159 0.00000 0300 05300 ANSTHESIOLOGY 0 0.000000 0.000000 0.000000 0.000000 54. 00 05400 RADI OLOGY-DIAGNOSTI C 1, 259, 619 13, 768, 310 15, 027, 929 0.94328 0.00000 54. 02 03450 NULLEAR MEDICINE - DI AGNOSTI C 1, 259, 619 13, 768, 310 15, 027, 929 0.994328 0.00000 55. 00 05500 RADI DLOCY-THERAPEUTI C 377, 943 31, 041, 043 31, 418, 986 0.990649 0.00000 57. 00 05700 CLEAR MEDICINE - MAGI NG (MRI) 692, 257 2, 355, 654 3, 047, 621 0.99403 0.00000 59. 00			44 564 402		44 564 40	12		30.00
41.00 0x100/SUBPROVIDER - 1 RF 4.438,087 4.438,087 4.438,087 43.00 0x000/NURSERY 1,306,888 1,306,888 ANCILLARY SERVICE COST CENTERS 1,306,888 1,306,888 50.00 05000/DELIVERY NOM & LABOR ROM 25,585,766 106,061,183 131,646,949 0.168463 0.00000 53.00 05300/RADELIVERY NOM & LABOR ROM 3,781,175 4900,272 4,271,447 0.581159 0.00000 54.01 03400 RADILOGY-DI AGNOSTIC 6,362,450 11,458,858 78,821,308 0.282433 0.00000 54.01 03440 MANGGRAPHY 2,324 3,958,988 3,961,312 0.994328 0.00000 54.01 03440 MANGGRAPHY 2,324 3,768,170 15,027,99 0.994328 0.00000 55.00 03500 RADILOGY-THERAPEUTIC 1,602,198 7,102,154 8,704,352 0.0090440 0.00000 56.00 05500 RADILOGY-THERAPEUTIC 377,943 31,410,43 31,413,986 0.999464 0.00000 57.00 05000 RESPI RATORY 602,2567 2,555,544 3,047,621 0.999433 0.00000								31.00
43.00 043200 VIRSERY 1, 306, 888 1, 306, 888 50.00 05000 OPERATING ROM 25, 585, 766 106, 061, 183 131, 646, 949 0. 168463 0.00000 50.00 05000 OPERATING ROM 3, 781, 175 490, 272 4, 271, 447 0. 581159 0.00000 53.00 05300 ANCI LARY SERVICE COST 6, 362, 450 11, 458, 858 17, 821, 308 0.282433 0.00000 54.00 05400 RADIOLCEAR MEDICINE - DI AGNOSTIC 1, 259, 619 13, 768, 310 15, 027, 929 0.094328 0.00000 54.03 03630 ULTRA SOUND 1, 602, 198 77, 102, 154 8, 704, 352 0.090699 0.00000 55.00 05500 RADI LOGY - THERAPEUTIC 37, 94, 31, 041, 043 31, 418, 986 0.099464 0.00000 56.00 05600 MADI LCAR THERIZATION 5, 725, 295 16, 574, 612 22, 699, 907 0.098003 0.00000 59.00 04801 AC CATHETRER ZATION 5, 725, 295 16, 574, 612 22, 649, 907 0.098003 0.00000 <								41.00
ANCL LLARY SERVICE COST CENTERS 000 005000 OPERATING ROOM 25,585,766 106,061,183 131,646,949 0.168463 0.00000 52.00 05300 ANESTHESI OLGGY 0 0 0 0.00000 0.00000 0.00000 0.00000 53.00 05400 RADI OLGGY -DI AGNOSTIC 6,362,450 11,458,856 17,821,308 0.282433 0.00000 <								43.00
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52:00 DS200 DELIVERY ROM & LABOR ROOM 3, 781, 175 490, 272 4, 271, 447 0, 581 159 0, 00000 53:00 DS300 ANESTHESI OLOGY 0 0 0 0, 000000 0, 000000 54:00 DS400 RADI OLOGY-DI AGNOSTI C 6, 362, 450 11, 458, 858 17, 821, 308 0, 222433 0, 00000 54:01 D3440 MAMMOGRAPHY 2, 324 3, 956, 988 3, 961, 312 0. 191827 0, 00000 54:00 DS400 RADI OLOGY-THERAPEUTI C 1, 602, 198 7, 102, 154 8, 704, 352 0. 090699 0, 00000 55:00 DS500 RADI OLOGY-THERAPEUTI C 377, 943 31, 041, 043 31, 418, 986 0. 09464 0, 00000 58:00 OS500 CARD AC CATHETERI ZATI ON 5, 725, 259 16, 974, 612 22, 699, 907 0. 098003 0, 00000 60:00 G6000 RESPI RATORY THERAPY 13, 172, 433 2, 723, 313 15, 895, 746 0, 132173 0, 00000 60:00 G6000 PHY THEAPY 2, 904, 565 1, 597, 848 0, 4122044 0, 00000 0, 00000 0, 000000 0, 00			25 595 766	106 061 102	121 646 04	0 0 169/62	0,00000	50.00
53.00 OS300 ANESTHESI OLOGY O O O O 0.000000 0.000000 54.00 05400 RADI OLOGY-DI AGNOSTI C 6, 362, 450 11, 458, 858 17, 821, 308 0.282433 0.00000 54.02 03440 MAMMOGRAPHY 2, 324 3, 958, 988 3, 961, 312 0.919827 0.00000 54.02 03440 MAMMOGRAPHY 1, 259, 619 13, 768, 310 15, 027, 929 0.994328 0.00000 55.00 05500 RADI OLOGY-THERAPEUTI C 377, 943 31, 041, 043 31, 418, 986 0.099464 0.00000 57.00 05500 CRDI AC CATHETERI ZATI ON 5, 725, 255 16, 974, 612 22, 269, 907 0.98003 0.00000 68.00 06500 RESPI RATORY 13, 1651, 133 53, 545, 716 85, 196, 849 0.122064 0.00000 66.00 06600 PRSPI RATORY 18, 172, 433 2, 723, 313 15, 197, 746 0.398300 0.00000 67.00 06600 PRSPI RATORY 2, 006, 202 6, 184, 411 9, 909, 613 0.398300 0.00000 68.00 06600								
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54.01 03440 MAMMOGRAPHY 2,324 3,958,988 3,961,312 0.191827 0.00000 54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC 1,259,619 13,768,310 15,027,929 0.094328 0.00000 55.00 05500 RADIOLOCY-THERAPEUTIC 377,943 31,041,043 31,418,986 0.099464 0.00000 57.00 05500 RADIOLOCY-THERAPEUTIC 377,943 31,041,043 31,418,986 0.09464 0.00000 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 692,567 2,355,054 3,047,621 0.299043 0.00000 60.00 06000 LABORATORY 31,122,433 2,723,313 15,849 0.122064 0.00000 66.00 06500 RESPI RATORY THERAPY 2,004,565 1,659,283 3,663,848 0.40152 0.00000 68.00 06600 PHYSI CAL THERAPY 2,004,565 1,659,283 3,663,848 0.400152 0.00000 68.00 06600 ELECTROEADIOLOGY 422,342 638,809 1,101,151 0.439645 0.00000 00 07000 ELECT			-	-				
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200 00 [Subtata] (coo instructions) [222 202 004] 440 522 052 (02 014 047]								113.00
	200.00	Subtotal (see instructions)	233, 283, 894	449, 532, 953	682, 816, 84	7		200.00
201.00 Less Observation Beds								201.00
202.00 Total (see instructions) 233, 283, 894 449, 532, 953 682, 816, 847	202.00	Total (see instructions)	233, 283, 894	449, 532, 953	682, 816, 84	7		202.00

Heal th	Financial Systems A	SCENSION ST. VINC	CENT ANDERSON	In Lie	u of Form CMS-	2552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0088	Peri od:	Worksheet C	
				From 07/01/2020	Part I	nored.
				To 06/30/2021	Date/Time Pre 11/23/2021 1:	22 nm
			Title XVIII	Hospi tal	PPS	22 piii
	Cost Center Description	PPS Inpatient				
		Ratio				
		11.00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS					30.00
	03100 I NTENSI VE CARE UNI T					31.00
	04100 SUBPROVI DER – I RF					41.00
43.00	04300 NURSERY					43.00
	ANCILLARY SERVICE COST CENTERS					
	05000 OPERATI NG ROOM	0. 169807				50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 581159				52.00
53.00	05300 ANESTHESI OLOGY	0. 000000				53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 282433				54.00
54.01	03440 MAMMOGRAPHY	0. 191827				54.01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0. 094328				54.02
54.03	03630 ULTRA SOUND	0. 090699				54.03
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 099464				55.00
57.00	05700 CT SCAN	0. 084528				57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 299043				58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 098003				59.00
60.00	06000 LABORATORY	0. 122064				60.00
65.00	06500 RESPI RATORY THERAPY	0. 132173				65.00
66.00	06600 PHYSI CAL THERAPY	0. 398300				66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 440152				67.00
68.00	06800 SPEECH PATHOLOGY	0. 439645				68.00
69.00	06900 ELECTROCARDI OLOGY	0. 305291				69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 179681				70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 269778				71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 350082				72.00
	07300 DRUGS CHARGED TO PATIENTS	0. 298232				73.00
	03190 CHEMOTHERAPY	0. 187263				76.00
76.01	03020 WOUND CARE	0. 376890				76.01
	OUTPATIENT SERVICE COST CENTERS					
	09000 CLI NI C	0. 000000				90.00
	09001 ANDERSON OUTPATIENT CENTER	0. 444320				90.01
	04950 DIABETIC EDUCATION	0. 000000				90.02
	09002 MS CLINIC	0. 000000				90.03
	09100 EMERGENCY	0. 110720				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 472094				92.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVI CES	0. 000000				95.00
	SPECIAL PURPOSE COST CENTERS					
	11300 INTEREST EXPENSE					113.00
200.00						200.00
201.00						201.00
202.00	Total (see instructions)					202.00

Heal th	Fi nar	ici a	ıl Syst	ems			
COMPLIE		OF	DATIO	OF	COSTS	ΤO	0

ASCENSI ON	ST.	VI NCENT	ANDERSON

In Lieu of Form CMS-2552-10

	SCENSION ST. VI					2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0088	Peri od:	Worksheet C	
				From 07/01/2020 To 06/30/2021	Part I	
				10 06/30/2021	Part I Date/Time Pre 11/23/2021 1:	pared:
					11/23/2021 1:	22 pm
			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.	naj.		bi sui i ondrice		
	26)				-	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1					
30. 00 03000 ADULTS & PEDIATRICS	26, 681, 960		26, 681, 96	0 0	26, 681, 960	30.00
31.00 03100 INTENSIVE CARE UNIT	9, 314, 677		9, 314, 6	77 0	9, 314, 677	31.00
41.00 04100 SUBPROVIDER - IRF	2, 560, 012		2, 560, 0			
43. 00 04300 NURSERY	578, 528		578, 52			
	570, 520		570, 52	0 0	570, 520	43.00
ANCI LLARY SERVI CE COST CENTERS	00 477 577		00 477 5	17 17 0(0	00.054.507	50.00
50. 00 05000 OPERATI NG ROOM	22, 177, 577		22, 177, 5			
52.00 05200 DELIVERY ROOM & LABOR ROOM	2, 482, 389		2, 482, 38	39 0	2, 482, 389	52.00
53.00 05300 ANESTHESI OLOGY	0			0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	5,033,320		5, 033, 32	20 0	5, 033, 320	54.00
54. 01 03440 MAMMOGRAPHY	759, 887		759, 88			
54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	1, 417, 547		1, 417, 54			
54.03 03630 ULTRA SOUND	789, 477		789, 4			
55. 00 05500 RADI OLOGY-THERAPEUTI C	3, 125, 053		3, 125, 0			
57.00 05700 CT SCAN	1, 288, 000		1, 288, 00	0 0	1, 288, 000	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	911, 369		911, 30	59 O	911, 369	58.00
59.00 05900 CARDI AC CATHETERI ZATI ON	2, 224, 649		2, 224, 64			
60. 00 06000 LABORATORY	10, 399, 492		10, 399, 49			
65. 00 06500 RESPI RATORY THERAPY	2, 100, 981	0	1 1			
66. 00 06600 PHYSI CAL THERAPY	3, 620, 788					•
67.00 06700 OCCUPATI ONAL THERAPY	1, 612, 651	0	1, 612, 6	51 0	1, 612, 651	67.00
68.00 06800 SPEECH PATHOLOGY	484, 115	0	484, 11	15 0	484, 115	68.00
69. 00 06900 ELECTROCARDI OLOGY	396, 598		396, 59	98 0	396, 598	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	807, 529		807, 52			
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	5, 315, 697		5, 315, 69			•
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	6, 614, 269		6, 614, 20			
73.00 07300 DRUGS CHARGED TO PATIENTS	30, 557, 911		30, 557, 9			
76.00 03190 CHEMOTHERAPY	1, 763, 985		1, 763, 98	35 0	1, 763, 985	76.00
76.01 03020 WOUND CARE	1, 172, 898		1, 172, 89	98 0	1, 172, 898	76.01
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLINIC	0			0 0	0	90.00
90. 01 09001 ANDERSON OUTPATIENT CENTER	1, 474, 587		1, 474, 58	-		
	1		1, 4/4, 30			
90. 02 04950 DIABETIC EDUCATION	0			0 0	-	
90. 03 09002 MS CLINIC	0			0 0	0	90.03
91.00 09100 EMERGENCY	8, 578, 952		8, 578, 9	52 0	8, 578, 952	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 305, 820		1, 305, 82	20	1, 305, 820	92.00
OTHER REIMBURSABLE COST CENTERS			, , .			
95. 00 09500 AMBULANCE SERVICES	9, 254		9, 2	54 0	9, 254	95.00
	9,234		9,23	04	9,204	95.00
SPECIAL PURPOSE COST CENTERS						440
113.0011300 INTEREST EXPENSE						113.00
200.00 Subtotal (see instructions)	155, 559, 972	0	155, 559, 9	72 176, 960	155, 736, 932	200.00
201.00 Less Observation Beds	1, 305, 820		1, 305, 82	20	1, 305, 820	
202.00 Total (see instructions)	154, 254, 152					
		-		.,		

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COMPLIT		0E	DATIO		COSTS	ΤO	(

COMPLIE			VCENT ANDERSON			u of Form CMS-2	2002-10
COMPUTE	ATION OF RATIO OF COSTS TO CHARGES		Provider CO		Peri od:	Worksheet C	
					From 07/01/2020	Part I	
					To 06/30/2021	Date/Time Pre	pared:
						11/23/2021 1:	22 pm
				e XIX	Hospi tal	Cost	-
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
				+ col. 7)	Ratio	Inpati ent	
						Ratio	
		6.00	7.00	8.00	9.00	10.00	
1	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	44, 564, 402		44, 564, 40	2		1 30. OC
31.00	03100 INTENSIVE CARE UNIT	20, 767, 672		20, 767, 67	2	1	31.00
	04100 SUBPROVI DER – I RF	4, 438, 087		4, 438, 08		1	41.00
	04300 NURSERY	1, 306, 888		1, 306, 88		1	43.00
	ANCI LLARY SERVI CE COST CENTERS	1, 300, 000		1, 300, 00	0		45.00
	05000 OPERATI NG ROOM	25, 585, 766	106, 061, 183	131, 646, 94	9 0. 168463	0. 000000	50.00
	05200 DELIVERY ROOM & LABOR ROOM	3, 781, 175	490, 272	4, 271, 44		0.00000	
	05300 ANESTHESI OLOGY	0	0		0 0.00000	0.00000	53.00
	05400 RADI OLOGY-DI AGNOSTI C	6, 362, 450	11, 458, 858	17, 821, 30		0.00000	
	03440 MAMMOGRAPHY	2, 324	3, 958, 988	3, 961, 31		0. 000000	
54.02	03450 NUCLEAR MEDICINE – DIAGNOSTIC	1, 259, 619	13, 768, 310	15, 027, 92	9 0. 094328	0.000000	54.02
54.03	03630 ULTRA SOUND	1, 602, 198	7, 102, 154	8, 704, 35	2 0. 090699	0.000000	54.03
55.00	05500 RADI OLOGY-THERAPEUTI C	377, 943	31, 041, 043	31, 418, 98	6 0. 099464	0.000000	55.00
57.00	05700 CT SCAN	3, 699, 452	11, 538, 158	15, 237, 61	0 0. 084528	0.000000	57.00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	692, 567	2, 355, 054	3, 047, 62		0.000000	
	05900 CARDI AC CATHETERI ZATI ON	5, 725, 295	16, 974, 612	22, 699, 90		0. 000000	
	06000 LABORATORY	31, 651, 133	53, 545, 716	85, 196, 84		0. 000000	
	06500 RESPI RATORY THERAPY	13, 172, 433	2, 723, 313			0.000000	
	06600 PHYSI CAL THERAPY	2, 906, 202	6, 184, 411	9, 090, 61		0.000000	66.00
	06700 OCCUPATI ONAL THERAPY	2,004,565	1, 659, 283	3, 663, 84		0.000000	67.00
	06800 SPEECH PATHOLOGY	462, 342	638, 809	1, 101, 15		0.000000	
	06900 ELECTROCARDI OLOGY	0	1, 299, 082	1, 299, 08		0.00000	
	07000 ELECTROENCEPHALOGRAPHY	244, 814	4, 249, 422	4, 494, 23		0.00000	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	9, 693, 316	10, 010, 631	19, 703, 94		0. 000000	
	07200 IMPL. DEV. CHARGED TO PATIENTS	6, 153, 339	12, 740, 126	18, 893, 46	5 0. 350082	0. 000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	27, 161, 635	75, 301, 805	102, 463, 44	0 0. 298232	0.000000	73.00
76.00	03190 CHEMOTHERAPY	84, 823	9, 334, 988	9, 419, 81	1 0. 187263	0.000000	76.00
76.01	03020 WOUND CARE	22, 689	3, 089, 351	3, 112, 04	0 0. 376890	0.000000	76.0
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLINIC	0	0		0 0.000000	0. 000000	90.00
	09001 ANDERSON OUTPATIENT CENTER	2, 253	3, 316, 497	3, 318, 75		0. 000000	
	04950 DI ABETI C EDUCATI ON	2,233	3, 310, 497		0 0. 000000	0.000000	
	09002 MS CLINIC	0	0		0.000000		
	09002 MS CLINIC 09100 EMERGENCY		0			0.000000	
		18, 818, 086	58, 665, 295	77, 483, 38		0.000000	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	740, 426	2,025,592	2, 766, 01	8 0. 472094	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS	TT					
	09500 AMBULANCE SERVICES	0	0		0 0. 000000	0. 000000	95.00
	SPECIAL PURPOSE COST CENTERS	r			-T		
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	233, 283, 894	449, 532, 953	682, 816, 84	7		200.00
		1					201.00
201.00	Less Observation Beds	1					201.00

Heal th	Financial Systems	ASCENSION ST. VINC	CENT ANDERSON	In Lie	u of Form CMS-	2552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0088	Peri od:	Worksheet C	
				From 07/01/2020	Part I	
				To 06/30/2021	Date/Time Pre	epared:
				lle entited	11/23/2021 1:	22 pm
	Cret Creter Description	DDC Langt ant	Title XIX	Hospi tal	Cost	
	Cost Center Description	PPS Inpatient				
		Ratio				
	LNDATIENT DOUTINE CEDVILOE OOCT OFNITEDO	11.00				-
	INPATIENT ROUTINE SERVICE COST CENTERS					
	03000 ADULTS & PEDIATRICS					30.00
	03100 I NTENSI VE CARE UNI T					31.00
	04100 SUBPROVI DER – I RF					41.00
43.00	04300 NURSERY					43.00
	ANCI LLARY SERVI CE COST CENTERS					
	05000 OPERATING ROOM	0. 000000				50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52.00
53.00	05300 ANESTHESI OLOGY	0. 000000				53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
54.01	03440 MAMMOGRAPHY	0. 000000				54.01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0. 000000				54.02
	03630 ULTRA SOUND	0. 000000				54.03
	05500 RADI OLOGY-THERAPEUTI C	0. 000000				55.00
	05700 CT SCAN	0. 000000				57.00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000				58.00
						•
	05900 CARDI AC CATHETERI ZATI ON	0. 000000				59.00
	06000 LABORATORY	0. 000000				60.00
65.00	06500 RESPI RATORY THERAPY	0. 000000				65.00
	06600 PHYSI CAL THERAPY	0.00000				66.00
	06700 OCCUPATI ONAL THERAPY	0. 000000				67.00
	06800 SPEECH PATHOLOGY	0. 000000				68.00
	06900 ELECTROCARDI OLOGY	0. 000000				69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000				70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000				72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
76.00	03190 CHEMOTHERAPY	0. 000000				76.00
76.01	03020 WOUND CARE	0. 000000				76.01
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0. 000000				90.00
90.01	09001 ANDERSON OUTPATIENT CENTER	0. 000000				90.01
	04950 DIABETIC EDUCATION	0. 000000				90.02
	09002 MS CLINIC	0.000000				90.03
	09100 EMERGENCY	0.000000				91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000				92.00
72.00	OTHER REIMBURSABLE COST CENTERS	0.000000				72.00
95.00	09500 AMBULANCE SERVICES	0.000000				95.00
70.00	SPECIAL PURPOSE COST CENTERS	0.000000				
113 00	11300 I NTEREST EXPENSE					113.00
200.00						200.00
200.00						200.00
201.00						201.00
202.00		ļ ļ				1202. UU

Health Financial Systems A	ASCENSION ST. VINCENT ANDERSON In Lieu of Fo					2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider C		Period: From 07/01/2020 To 06/30/2021	Date/Time Pre 11/23/2021 1:	
			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	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	1, 159, 927	0	1, 159, 92	7 22, 272	52.08	30.00
31. 00 INTENSIVE CARE UNIT	325, 494		325, 49	4 4, 579	71.08	31.00
41.00 SUBPROVIDER – IRF	139, 344	0	139, 34	4 2,604	53. 51	41.00
43.00 NURSERY	55, 664		55, 66	4 643	86.57	43.00
200.00 Total (lines 30 through 199)	1, 680, 429		1, 680, 42	9 30, 098		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						
30. 00 ADULTS & PEDIATRICS	3, 875					30.00
31. 00 INTENSIVE CARE UNIT	3, 495	248, 425				31.00
41.00 SUBPROVIDER - IRF	1, 125	60, 199	•			41.00
43.00 NURSERY	0	0)			43.00
200.00 Total (lines 30 through 199)	8, 495	510, 434				200. 00

Health Financial Systems A	SCENSION ST. VI	NCENT ANDERSON		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C	CN: 15-0088	Period:	Worksheet D	
				From 07/01/2020 To 06/30/2021	Part II	norod.
				10 06/30/2021	Date/Time Pre 11/23/2021 1:	22 nm
		Title	xvi i	Hospi tal	PPS	22 pm
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,		(col. 1 ÷ col		column 4)	
	Part II, col.	8)	2)	5	,	
	26)	,				
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	881, 394	131, 646, 949	0.00669	8, 702, 200	58, 261	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	217, 247	4, 271, 447	0. 05086	3, 509	178	52.00
53. 00 05300 ANESTHESI OLOGY	0	0	0. 00000	0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	212, 556	17, 821, 308	0. 01192	1, 177, 287	14, 042	54.00
54.01 03440 MAMMOGRAPHY	16, 409	3, 961, 312	0. 00414		0	54.01
54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	38, 177	15, 027, 929	0.00254	0 355, 390	903	54.02
54.03 03630 ULTRA SOUND	16, 445	8, 704, 352	0. 00188	430, 177	813	54.03
55. 00 05500 RADI OLOGY-THERAPEUTI C	64, 322			40, 743	83	55.00
57.00 05700 CT SCAN	33, 462			1, 137, 053	2, 497	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	26, 126	3, 047, 621	0.00857	3 159,600		58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	112, 139					
60. 00 06000 LABORATORY	292, 796				33, 784	60.00
65. 00 06500 RESPI RATORY THERAPY	97, 488				25, 288	
66. 00 06600 PHYSI CAL THERAPY	148,670				10, 657	66.00
67.00 06700 OCCUPATI ONAL THERAPY	66, 814					
68.00 06800 SPEECH PATHOLOGY	20, 041					
69. 00 06900 ELECTROCARDI OLOGY	10,006				0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	100, 133				1, 542	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	101, 916				13, 127	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	126, 541				18, 258	
73. 00 07300 DRUGS CHARGED TO PATIENTS	631, 582					
76. 00 03190 CHEMOTHERAPY	40, 848					76.00
76. 01 03020 WOUND CARE	47, 520					76.01
OUTPATIENT SERVICE COST CENTERS	11/020	0,112,010	010102	0,010		/ 0/ 0/
90. 00 09000 CLINIC	0	0	0.0000	0 0	0	90.00
90. 01 09001 ANDERSON OUTPATIENT CENTER	56,097	3, 318, 750			0	90.01
90. 02 04950 DI ABETI C EDUCATI ON	0				0	90.02
90. 03 09002 MS CLINIC	0	-			0	90.03
91. 00 09100 EMERGENCY	371,007	-	0. 00478		25, 629	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	56, 767				0	92.00
OTHER REIMBURSABLE COST CENTERS	00,707	2,700,010	0.02002			1 2.00
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	3, 786, 503	611, 739, 798		47, 017, 128	268, 867	

Health Financial Systems	ASCENSION ST. VI	NCENT ANDERSON		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COS			Period: From 07/01/2020 To 06/30/2021	Date/Time Pre 11/23/2021 1:	
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	Nursing School	Allied Health	Allied Health	All Other	
	Post-Stepdown		Post-Stepdowr		Medi cal	
	Adjustments		Adjustments		Education Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		·	·			
30. 00 03000 ADULTS & PEDI ATRI CS	0	0		0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	l o		o o	0	31.00
41. 00 04100 SUBPROVIDER - IRF	0	0		0	0	41.00
43. 00 04300 NURSERY	0			- - -	0	
200.00 Total (lines 30 through 199)	0				-	200.00
Cost Center Description	Swing-Bed	Total Costs	Total Patient	Per Diem (col.	Inpati ent	200.00
obst conter beschiption	Adj ustment	(sum of cols.	Days	$5 \div col. 6)$	Program Days	
	Amount (see	1 through 3,	buys	0 . 001. 0)	l logi all' bays	
		minus col. 4)				
	4,00	5.00	6,00	7.00	8,00	
INPATIENT ROUTINE SERVICE COST CENTERS		0.00	0.00	1100	0,00	
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	22, 27	2 0.00	3, 875	30.00
31. 00 03100 I NTENSI VE CARE UNI T		0	4, 57			
41. 00 04100 SUBPROVI DER – I RF	0		2,60			
43. 00 04300 NURSERY			64			
200.00 Total (lines 30 through 199)			30,09			200.00
Cost Center Description	I npati ent	0	J 30, 07	J	0,473	200.00
cost center bescription	Program					
	Pass-Through					
	Cost (col. 7 x					
	cost (cor. 7 x					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS	7.00		-			
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
31. 00 03100 I NTENSI VE CARE UNI T						31.00
41. 00 04100 SUBPROVI DER – I RF						41.00
						41.00
	0					
200.00 Total (lines 30 through 199)	1 0					200. 00

Health Financial Systems AS	SCENSION ST. VI	NCENT ANDERSON		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	VICE OTHER PASS	S Provider C		Peri od: From 07/01/2020 To 06/30/2021	Worksheet D Part IV Date/Time Pre	pared:
		T: +1 -		11	11/23/2021 1:	22 pm_
Cast Caston Description	New Division at an		XVIII	Hospi tal	PPS	
Cost Center Description		Post-Stepdown		Allied Health Post-Stepdown	Allied Health	
	Cost	Adj ustments		Adj ustments		
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS	1.00	211	2.00	6/1	0.00	
50. 00 05000 OPERATI NG ROOM	0	0		0 0	0	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	
53.00 05300 ANESTHESI OLOGY	0	0		0 0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	46, 371	
54. 01 03440 MAMMOGRAPHY	0	C		0 0	10, 307	
54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	C)	0 0	39, 103	
54. 03 03630 ULTRA SOUND	0	C)	0 0	22, 649	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	C)	0 0	81, 775	
57. 00 05700 CT SCAN	0	C		0 0	39, 648	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	C		0 0	7, 930	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	C		0 0	0	59.00
60. 00 06000 LABORATORY	0	C		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	C)	0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	C)	0 0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	C)	0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	C)	0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	C		0 0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	C		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C		0 0	0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	C		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C		0 0	0	73.00
76. 00 03190 CHEMOTHERAPY	0	C		0 0	0	
76. 01 03020 WOUND CARE	0	0		0 0	0	76.01
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0		0 0	0	
90.01 09001 ANDERSON OUTPATIENT CENTER	0	0		0 0	0	
90. 02 04950 DIABETIC EDUCATION	0	0		0 0	0	
90. 03 09002 MS CLINIC	0	0		0 0	0	
91.00 09100 EMERGENCY	0	0		0 0	71, 820	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
OTHER REIMBURSABLE COST CENTERS	1		1	T	I	
95.00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	0	0	1	0 0	319, 603	200.00

Health Financial Systems A	SCENSION ST. VI	NCENT ANDERSON		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS	RVICE OTHER PASS	S Provider C	CN: 15-0088	Period: From 07/01/2020 To 06/30/2021	Worksheet D Part IV Date/Time Pre 11/23/2021 1:	pared: 22 pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpatient	(from Wkst. C,		
	Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see	
			, í		instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	0		0 131, 646, 949	0.00000	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 4, 271, 447	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	46, 371	46, 3	17, 821, 308	0.002602	54.00
54. 01 03440 MAMMOGRAPHY	0	10, 307				
54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	39, 103			0.002602	
54. 03 03630 ULTRA SOUND	0	22, 649			0.002602	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	81, 775			0.002602	
57. 00 05700 CT SCAN	0	39, 648			0.002603	57.00
	0					
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	7, 930	7, 93		0.002602	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 22, 699, 907	0.000000	
60. 00 06000 LABORATORY	0	0		0 85, 196, 849	0.00000	
65. 00 06500 RESPI RATORY THERAPY	0	0		0 15, 895, 746	0.00000	
66. 00 06600 PHYSI CAL THERAPY	0	0		0 9, 090, 613	0.00000	
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 3, 663, 848	0.00000	
68.00 06800 SPEECH PATHOLOGY	0	0		0 1, 101, 151	0. 000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 1, 299, 082	0.000000	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 4, 494, 236	0.000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 19, 703, 947	0.00000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 18, 893, 465	0.00000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 102, 463, 440	0.00000	73.00
76.00 03190 CHEMOTHERAPY	0	0	1	0 9, 419, 811	0.00000	76.00
76.01 03020 WOUND CARE	0	0		0 3, 112, 040	0.000000	76.01
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0		0 0	0.00000	90.00
90. 01 09001 ANDERSON OUTPATIENT CENTER	0	0		0 3, 318, 750	0.000000	90.01
90. 02 04950 DIABETIC EDUCATION	0	0		0 0	0. 000000	
90. 03 09002 MS CLINIC	0	n		0 0	0.000000	
91. 00 09100 EMERGENCY	0	71, 820	71, 82		0.000927	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0 2, 766, 018	0.000000	•
OTHER REIMBURSABLE COST CENTERS	0	0		2,700,010	0.00000	/2.00
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	0	319, 603	319, 60	03 611, 739, 798		200.00
200.00 110tal (11163 30 till 0491 177)	0	1 317,003	1 317,00	Jon 1, 137, 190	I	200.00

52.00 05200 DELI VERY ROOM & LABOR ROOM 0.000000 0<		2	SCENSION ST. VIN	ICENT ANDERSON		In Lie	u of Form CMS-:	2552-10
Andown Bool 3 To 06/30/2021 Bate/Time Prepara Program Program Program Program Program Program Pass-Through Casts (col. 8 Date/Time Preparat Program Program Program Program Program Program Program Pass-Through Casts (col. 8 Date/Time Preparat Program Program Program Program Program Program Pass-Through Casts (col. 8 Date/Time Preparat Program Program Program Program Program Program Pass-Through Casts (col. 9 Date/Time Preparat Program Program Program Program Program Program Program Pass-Through Casts (col. 9 Date/Time Preparat Program Program Program Program Program Program Pass-Through Casts (col. 9 Date/Time Preparat Program Program Program Program Program Program Program Pass-Through Casts (col. 9 Date/Time Preparat Program Program Program Program Program Program Program Pass-Through Casts (col. 9 Date/Time Preparat Program Progra			RVICE OTHER PASS	Provider C	CN: 15-0088			
Cost Center Description Title XVIII Hospital PPS ACLLLARY SERVICE COST CENTERS Inpatient Costs (col. 6 + col. 7) Inpatient Program (Charges (col. 6 + col. 7) Inpatient Program (Charges (col. 6 + col. 7) Utpatient Program (Charges (col. 8 + col. 10) Outpatient Program (Charges (col. 8 + col. 10) Outpatient Program (Charges (col. 6 + col. 8) Outpatient Program (Charges (col. 6 + col. 8) Outpatient Program (Charges (col. 6 + col. 8) Outpatient Program (Charges (col. 8 + col. 10) Outpatient Program (Charges (col. 8 + col. 10) Outpatient Program (Charges (col. 8 + col. 10) Outpatient Program (Charges (col. 8) Outpatient Program (Charges (col. 8) Outpatient Program (Charges (col. 8) Outpatient Program (Charges (col. 8) Outpatient Program (Charges (col. 6 + col. 8)	THROUG	H CUSIS					Date/Time Pre	pared:
Cost Center Description Outpatient Ratio of Cost (col. 6 * col. 7) Inpatient Program (Charges) (col. 6 * col. 7) Inpatient Program (Charges) (cot. 6 * col. 7) Inpatient Program (Charges) (cot. 6 * col. 7) Outpatient Program (Charges) (cot. 6 * col. 7) Outpatient Program (Charges) (cot. 10) Outpatient Program (Charges) (cot. 00) Outpatient Program (Charges) (cot. 00)							11/23/2021 1:	22 pm
Ratio of Cost to Charges (col. 6 + col. 7) Program (charges) Pro								
Image: Col. 6 + col. 7 Charges (col. 6 + col. 7) Pass-Through (cots (col. 8) (col. 9) Charges (col. 10) Pass-Through (cots (col. 9) ANCILLARY SERVICE COST CENTERS 9.00 10.00 11.00 12.00 13.00 50.00 05000 (DEFRATING ROOM 0.000000 8,702,200 0 22,986,818 0 52 51.00 05300 (ANESTHESI OLOGY 0.000000 0 0 0 0 52 54.00 05400 (RAU OLAGV-PH ROM & LABOR ROOM 0.002602 0 0 0 52 0 0 0 0 0 0 52 0 05300 (ANESTHESI OLOGY 0.002602 0 0 0 0 52 0 0 0 0 0 0 52 0 05400 (RAU OLAGV-PI AGROSTI C 0.002602 355,990 925 3,756,258 9,774 54 53 0 05500 (RAD IOLOGY-THERAPEUTI C 0.002602 1,337,053 2,959 2,507,549 6,525 57 59 0 05500 (AGRO MAGNETI C RESONANCE IMAGI NG (MRI) 0.002602		Cost Center Description						
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7) x col 100 12.0 ANCI LLARY SERVICE COST CENTERS 9.00 10.00 11.00 12.00 13.00 50.00 05000 0PERATI NG ROOM 0.000000 8,702,200 0 22,986,818 0 55 53.00 05300 ANESTHESI OLOGY 0.000000 3,509 0 958 0 55 54.00 05400 RADI OLGGY-JI AGNOSTI C 0.002602 0 0 0 0 54 54.01 03440 MAMGRAPHY 0.002602 0 0 0 0 54 50.00 05500 RADI OLGY-THERAPEUTI C 0.002602 430,177 1,119 1,117,23 2,914 54 50.00 05500 RADI OLGY-THERAPEUTI C 0.002602 143,017 106 8,501,144 22,128 55 50.00 05500 CRDI AC CARDHETERIZATI ON 0.002602 159,600 415 536,246 1,395 55 50.00 05500 CRDI AC CARDHETERIZATI ON 0.000000 1,611,406 0				charges				
ANCI LLARY SERVICE COST CENTERS 9.00 10.00 11.00 12.00 13.00 ANCI LLARY SERVICE COST CENTERS 0 0 0.00000 0 22,986,818 0 55 50.00 05000 DELIVERY ROM & LABOR ROM 0.000000 3,509 0 958 0 55 53.00 05400 RESTHESI OLOGY 0.002602 1,177,287 3,063 2,427,259 6,316 54 54.00 05400 RAMIDI LORY-DI AGNOSTI C 0.002602 0 0 0 0 0 55 54.01 03440 MAMMOGRAPHY 0.002602 430,177 1,119 1,19,723 2,914 54 54.02 03630 ULTRA SOUND 0.002602 155,900 925 3,756,256 9,774 54 50.00 05500 RADI OLOGY-THERAPEUTI C 0.002602 159,600 415 556,246 1,395 55 50.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0.002602 159,600 415 556,246 1,395			· · · · · · · · · · · · · · · · · · ·					
ANCI LLARY SERVICE COST CENTERS Image: Control of the co				10.00		12.00		
52.00 05200 DELI VERY ROOM & LABOR ROOM 0.000000 3,509 0 958 0 52 53.00 05300 ANESTHESI OLOGY 0.000000 0 0 0 0 0 0 0 0 0 53 54.00 05400 RADI DLOGY-DI AGNOSTI C 0.002602 0 0 0 0 54 54.02 03450 NUCLEAR MEDI CINE - DI AGNOSTI C 0.002602 430, 177 1, 119 1, 119, 723 2, 914 54 55.00 05500 RADI OLOGY-THERAPEUTI C 0.002602 1, 137, 053 2, 959 2, 507, 549 6, 525 55 57.00 05700 CT SCAN 0.002602 1, 137, 053 2, 959 2, 507, 549 6, 525 55 59.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0.002602 159, 600 415 536, 246 1, 37, 953 2, 959 2, 507, 549 6, 525 55 59.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0.002000 1, 611, 406 0 3, 149, 410 0 55 60.00 06000		ANCI LLARY SERVI CE COST CENTERS	1					
53.00 05300 ANESTHESI OLOGY 0.000000 0 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.002602 1,177,287 3,063 2,427,259 6,316 54.01 54.01 03440 MAMMOGRAPHY 0.002602 0 0 0 54.01 54.02 03450 NUCLEAR MEDI CI NE - DI AGNOSTI C 0.002602 355,390 925 3,756,258 9,774 54.54 54.03 03330 ULTRA SOUND 0.002602 430,177 1,119 1,119,723 2,914 54.55 57.00 05500 RADI OLOGY-THERAPEUTI C 0.002602 1,517,053 2,959 2,507,549 6,525 57 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0.002602 1,59,600 415 536,246 1,395 58 60.00 06500 RABORATORY 0.000000 9,829,460 0 6,008,743 0 66 61.00 06500 RESPI RATORY THERAPY 0.000000 4,123,275 0 741,625 0 67 62.00 06600 <td>50.00</td> <td>05000 OPERATING ROOM</td> <td>0. 000000</td> <td>8, 702, 200</td> <td></td> <td>0 22, 986, 818</td> <td>0</td> <td>50.00</td>	50.00	05000 OPERATING ROOM	0. 000000	8, 702, 200		0 22, 986, 818	0	50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C 0.002602 1, 177, 287 3, 063 2, 427, 259 6, 316 54 54.01 03440 MAMMOGRAPHY 0.002602 0 0 0 54 54.02 03450 NUCLEAR NEDI CI NE - DI AGNOSTI C 0.002602 430, 177 1, 119 1, 119, 723 2, 914 54 54.02 03630 ULTRA SOUND 0.002602 430, 177 1, 119 1, 119, 723 2, 914 54 55.00 05500 RADI OLOGY-THERAPEUTI C 0.002602 1, 37, 053 2, 959 2, 507, 549 6, 525 57 58.00 05800 MAONETI C RESONANCE I MAGI NG (MRI) 0.002602 159, 600 415 536, 246 1, 95 56 59.00 05900 CATH ACTHETERI ZATI ON 0.000000 9, 829, 460 0 6,008, 743 0 60 60 60 60 60 60 60 60 60 66 66 60 60 60 60 60 60 60 60 60 60 60 60 60 60	52.00		0. 000000	3, 509		0 958	0	52.00
54. 01 03440 MAMMOGRAPHY 0.002602 0 0 0 54 54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC 0.002602 355, 390 925 3, 756, 258 9, 774 54 54. 03 03630 ULTRA SOUND 0.002602 430, 177 1, 119 1, 119, 723 2, 914 54 55. 00 05500 RADI OLOGY -THERAPEUTIC 0.002602 4, 0, 743 106 8, 501, 144 22, 128 55 57. 00 05700 CT SCAN 0.002602 1, 137, 053 2, 959 2, 507, 549 6, 525 57 58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0.002602 159, 600 415 536, 246 1, 395 58 60. 00 06000 LABORATORY 0.000000 9, 829, 460 0 6, 008, 743 0 66 61.00 06000 RESPI RATORY THERAPY 0.000000 4, 123, 275 0 741, 625 0 67 66. 00 06600 PHYSI CAL THERAPY 0.000000 55, 089 0 118, 247 0 68 66	53.00	05300 ANESTHESI OLOGY		0			0	53.00
54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC 0.002602 355,390 925 3,756,258 9,774 54 54.03 03630 ULTRA SOUND 0.002602 430,177 1,119 1,119,723 2,914 54 55.00 RADIOLOGY-THERAPEUTIC 0.002602 40,743 106 8,501,144 22,914 55 57.00 O5700 CT SCAN 0.002602 1,137,053 2,959 2,507,549 6,525 57 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0.002602 159,600 415 536,246 1,395 58 60.00 06000 CARDIAC CATHETERIZATION 0.000000 9,829,460 0 6,008,743 0 65 65.00 06500 RESPI RATORY THERAPY 0.000000 4,123,275 0 741,625 0 66 66.00 06600 PHYSI CAL THERAPY 0.000000 316,215 0 10,101 0 67 67.00 06000 0 0 00000 0 0 392,458 0 66 60.00	54.00			1, 177, 287	3, 06	3 2, 427, 259	6, 316	54.00
54.03 03630 ULTRA SOUND 0.002602 430,177 1,119 1,119,723 2,914 54 55.00 05500 RADI OLOGY-THERAPEUTI C 0.002603 40,743 106 8,501,144 22,128 55 57.00 05700 CT SCAN 0.002602 1,137,053 2,959 2,507,549 6,525 55 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0.002602 159,600 415 536,246 1,395 55 59.00 05900 CARDI AC CATHETERI ZATI ON 0.000000 1,611,406 0 3,149,410 0 55 60.00 06000 LABORATORY 0.000000 4,123,275 0 741,655 0 66 64.00 06500 RESPI RATORY THERAPY 0.000000 316,215 0 10,101 0 67 66 0 06000 PHYSI CAL THERAPY 0.000000 316,215 0 10,101 0 67 67 0 06900 ELECTROCARDI OLOGY 0.000000 0 392,458 0 69 0 069000 0 392,458				0		0 0	0	
55.00 05500 RADI OLOGY-THERAPEUTI C 0.002603 40,743 106 8,501,144 22,128 55 57.00 05700 CT SCAN 0.002602 1,137,053 2,959 2,507,549 6,525 57 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0.002602 159,600 415 536,246 1,395 58 59.00 05900 CARDI AC CATHETERI ZATI ON 0.000000 1,611,406 0 3,149,410 0 56 60.00 06000 LABORATORY 0.000000 9,829,460 0 66,008,773 0 66 65.00 06500 RESPI RATORY THERAPY 0.000000 41,123,275 0 741,625 0 66 66.00 06600 PHYSI CAL THERAPY 0.000000 316,215 0 10,101 0 67 68.00 06900 ELECTROCARDI OLOGY 0.000000 0 0 392,458 0 67 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 2,538,146 0 2,574,631 0 72 71.00								54.02
57.00 05700 CT SCAN 0.002602 1, 137, 053 2, 959 2, 507, 549 6, 525 57 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0.002602 159, 600 415 536, 246 1, 395 58 59.00 05900 CARDI AC CATHETERI ZATI ON 0.000000 1, 611, 406 0 3, 149, 410 0 56 60.00 06000 LABORATORY 0.000000 9, 829, 460 0 6, 008, 743 0 66 65.00 06500 RESPI RATORY THERAPY 0.000000 4, 123, 275 0 741, 625 0 65 66.00 06400 PHYSI CAL THERAPY 0.000000 651, 654 0 41, 712 0 66 67.00 06700 CCUPATI ONAL THERAPY 0.000000 55,089 0 118, 247 0 67 69.00 06900 ELECTROENCEPHALOGGY 0.000000 0 32, 458 0 67 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 2, 538, 146 0 2, 189, 474 0 77 73.00 2, 574, 631<								54.03
58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0.002602 159,600 415 536,246 1,395 58 59.00 05900 CARDI AC CATHETERI ZATI ON 0.000000 1,611,406 0 3,149,410 0 59 60.00 06000 LABORATORY 0.000000 9,829,460 0 6,008,743 0 60 65.00 06500 RESPI RATORY THERAPY 0.000000 4,123,275 0 741,625 0 65 66.00 06600 PHYSI CAL THERAPY 0.000000 316,215 0 10,101 67 67.00 06700 OCCUPATI ONAL THERAPY 0.000000 55,089 0 118,247 0 68 69.00 06900 ELECTROCARDI OLOGY 0.000000 0 392,458 0 67 71.00 O7100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.000000 2,538,146 0 2,189,474 0 73 72.00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0.000000 7,713,890								
59.00 05900 CARDI AC CATHETERI ZATI ON 0.000000 1, 611, 406 0 3, 149, 410 0 59 60.00 06000 LABORATORY 0.000000 9, 829, 460 0 6, 008, 743 0 60 65.00 06500 RESPI RATORY THERAPY 0.000000 4, 123, 275 0 741, 625 0 65 66.00 06600 PHYSI CAL THERAPY 0.000000 651, 654 0 41, 712 0 66 67.00 06700 0CCUPATI ONAL THERAPY 0.000000 316, 215 0 10, 101 0 67 68.00 06800 SPEECH PATHOLOGY 0.000000 0 392, 458 0 68 69.00 06900 ELECTROCARDI OLOGY 0.000000 0 392, 458 0 69 70.00 07000 ELECTROCARPHALOGRAPHY 0.000000 2, 538, 146 0 2, 189, 474 0 71 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.000000 2, 725, 877 0 2, 574, 631 0 73 73.00 07300 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>57.00</td></td<>								57.00
60.00 06000 LABORATORY 0.000000 9, 829, 460 0 6, 008, 743 0 66 65.00 06500 RESPI RATORY THERAPY 0.000000 4, 123, 275 0 741, 625 0 65 66.00 06600 PHYSI CAL THERAPY 0.000000 651, 654 0 41, 712 0 66 67.00 06700 0CCUPATI ONAL THERAPY 0.000000 316, 215 0 10, 101 0 67 68.00 06800 SPEECH PATHOLOGY 0.000000 55, 089 0 118, 247 0 68 69.00 06900 ELECTROCARDI OLOGY 0.000000 0 392, 458 0 69 70.00 07000 ELECTROCNCEPHALOGRAPHY 0.000000 69, 212 0 76, 740 0 71 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.000000 2, 538, 146 0 2, 189, 474 0 71 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 7, 713, 890 0 29, 214, 043 0 73 76.01 030								
65.00 06500 RESPI RATORY THERAPY 0.000000 4, 123, 275 0 741, 625 0 65 66.00 06600 PHYSI CAL THERAPY 0.000000 651, 654 0 41, 712 0 66 67.00 06700 OCCUPATI ONAL THERAPY 0.000000 316, 215 0 10, 101 0 67 68.00 06800 SPEECH PATHOLOGY 0.000000 55, 089 0 118, 247 0 68 69.00 06900 ELECTROCARDI OLOGY 0.000000 0 0 392, 458 0 69 70.00 07000 ELECTROCARDI OLOGY 0.000000 69, 212 0 767, 740 0 70 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.000000 2, 538, 146 0 2, 189, 474 0 71 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 7, 713, 890 0 29, 214, 043 0 73 73.00 03190 CHEMOTHERAPY 0.000000 19, 053 0 1, 501, 538 0 76							-	59.00
66.00 06600 PHYSI CAL THERAPY 0.000000 651, 654 0 41, 712 0 66 67.00 06700 OCCUPATI ONAL THERAPY 0.000000 316, 215 0 10, 101 0 67 68.00 06800 SPEECH PATHOLOGY 0.000000 55, 089 0 118, 247 0 68 69.00 06900 ELECTROCARDI OLOGY 0.000000 0 0 392, 458 0 67 70.00 07000 ELECTROCARDI OLOGY 0.000000 69, 212 0 767, 740 0 70 71.00 07100 MEDL CAL SUPPLI ES CHARGED TO PATI ENTS 0.000000 2, 538, 146 0 2, 189, 474 0 71 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 2, 725, 877 0 2, 574, 631 0 73 73.00 03190 CHEMOTHERAPY 0.000000 19, 053 0 1, 501, 538 0 76 0 0320 WOUND CARE 0.000000 5, 048 0 406, 365 0 76 0 03200								60.00
67.00 06700 OCCUPATI ONAL THERAPY 0.000000 316,215 0 10,101 0 67.07 68.00 06800 SPEECH PATHOLOGY 0.000000 55,089 0 118,247 0 68.06 69.00 06900 ELECTROCARDI OLOGY 0.000000 0 0 392,458 0 67.07 70.00 07000 ELECTROCARDI OLOGY 0.000000 69,212 0 76.7740 0 77.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 2,738,146 0 2,574,631 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 7,713,890 0 29,214,043 0 73.00 76.00 03190 CHEMOTHERAPY 0.000000 19,053 0 1,501,538 0 76.00 03020 WOUND CARE 0.000000 5,048 0 406,365 0 76.00 09000 CLI NI C 0.000000 0 0 0 0 0 90.00 90.01 09001 ANDERSON OUTPATI ENT CENTE						,	-	65.00
68.00 06800 SPEECH PATHOLOGY 0.000000 55,089 0 118,247 0 68 69.00 06900 ELECTROCARDI OLOGY 0.000000 0 0 392,458 0 69 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 69,212 0 767,740 0 70 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 2,538,146 0 2,189,474 0 71 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 2,725,877 0 2,574,631 0 72 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 7,713,890 0 29,214,043 0 73 76.01 03020 WOUND CARE 0.000000 19,053 0 1,501,538 0 76 70.00 09000 CLINIC 0.000000 5,048 0 406,365 0 76 70.00 09000 CLINIC 0.000000 0 0 0 90 90 0							-	66.00
69.00 06900 ELECTROCARDI OLOGY 0.000000 0 392,458 69 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 69,212 767,740 77 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 2,538,146 0 2,189,474 0 71 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 2,725,877 0 2,574,631 0 72 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 7,713,890 0 29,214,043 0 73 76.01 03020 WOUND CARE 0.000000 19,053 0 1,501,538 0 76 00000 03020 WOUND CARE 0.000000 5,048 0 406,365 0 76 90.00 09000 CLI NI C 0.000000 0 0 0 90 90 180,904 90 90								67.00
70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 69,212 0 767,740 0 70 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.000000 2,538,146 0 2,189,474 0 71 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 2,725,877 0 2,574,631 0 72 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 7,713,890 0 29,214,043 0 73 76.00 03100 CHEMOTHERAPY 0.000000 19,053 0 1,501,538 0 76 76.01 03020 WOUND CARE 0.000000 5,048 0 406,365 0 76 90.00 09000 CLINIC 0.000000 0 0 0 0 90 0 90 0 90 90 180,904 90 90							-	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 2,538,146 0 2,189,474 0 71 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 2,725,877 0 2,574,631 0 72 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 7,713,890 0 29,214,043 0 73 76.00 03100 CHEMOTHERAPY 0.000000 19,053 0 1,501,538 0 76 76.01 03020 WOUND CARE 0.000000 5,048 0 406,365 0 76 001TPATIENT SERVICE COST CENTERS 0.000000 0 0 0 0 0 90 0 9000 0 0 90 0 90 0 90 0 180,904 90 90				0			-	69.00 70.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 2,725,877 0 2,574,631 0 72 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 7,713,890 0 29,214,043 0 73 76.00 03100 CHEMOTHERAPY 0.000000 19,053 0 1,501,538 0 76 003020 WOUND CARE 0.000000 5,048 0 406,365 0 76 00TPATIENT SERVICE COST CENTERS 0.000000 0 0 0 0 90 0 9000 180,904 90 90							-	70.00
73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 7,713,890 0 29,214,043 0 73 76.00 03190 CHEMOTHERAPY 0.000000 19,053 0 1,501,538 0 76 76.01 03020 WOUND CARE 0.000000 5,048 0 406,365 0 76 00 07000 CLINIC 0.000000 0 0 0 90 90 9001 ANDERSON OUTPATIENT CENTER 0.000000 0 0 90 90 0 180,904 90 90							-	72.00
76.00 03190 CHEMOTHERAPY 0.000000 19,053 0 1,501,538 0 76 76.01 03020 WOUND CARE 0.000000 5,048 0 406,365 0 76 0UTPATI ENT SERVICE COST CENTERS 0.000000 5,048 0 0 0 76 90.00 09000 CLINIC 0.000000 0 0 0 90 90 90.01 09001 ANDERSON OUTPATIENT CENTER 0.000000 0 0 180,904 0 90							-	73.00
76. 01 03020 WOUND_CARE 0.000000 5,048 0 406,365 0 76 0UTPATI ENT_SERVICE_COST_CENTERS 0.000000 5,048 0 406,365 0 76							-	
OUTPATI ENT_SERVICE_COST_CENTERS 90. 00 09000 CLINIC 0.000000 0 0 0 90 90 90. 01 09001 ANDERSON_OUTPATIENT_CENTER 0.000000 0 0 0 90 90								
90.00 09000 CLINIC 0.00000 0 0 0 90 90 90.01 09001 ANDERSON OUTPATIENT CENTER 0.000000 0 0 180,904 0 90	70.01		0.000000	0,010		0 100,000	<u> </u>	70.01
90. 01 09001 ANDERSON OUTPATIENT CENTER 0. 000000 0 0 180, 904 0 90	90.00		0, 000000	0		0 0	0	90.00
				0			-	90.01
90. 02 1049501 DEADETEC EDUCATION I U. UUUUUUI UI	90.02	04950 DIABETIC EDUCATION	0. 000000	0		0 0	0	90.02
				0		0 0		90.03
	91.00	09100 EMERGENCY	0. 000927	5, 352, 844	4, 96		9, 263	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0. 000000 0 0 344, 925 0 92	92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0 344, 925	0	92.00
OTHER REIMBURSABLE COST CENTERS								
								95.00
200.00 Total (lines 50 through 199) 47,017,128 13,549 99,470,145 58,315 200	200.00) Total (lines 50 through 199)		47, 017, 128	13, 54	9 99, 470, 145	58, 315	200.00

APPORTI ONMI	ENT OF MEDICAL, OTHER HEALTH SERVICES AND) VACCINE COST	Provider C		Period: From 07/01/2020 To 06/30/2021	Worksheet D Part V Date/Time Pre 11/23/2021 1:	pared: 22 pm
			Title	× XVIII	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description		PPS Reimbursed		Cost	PPS Services	
		Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To			
				Ded. & Coins			
				(see inst.)			
		1.00	2.00	3.00	4.00	5.00	
	LLARY SERVICE COST CENTERS	0.1/0//0		1		0.070.100	1
	O OPERATING ROOM	0. 168463			0 0	3, 872, 428	
	0 DELIVERY ROOM & LABOR ROOM	0. 581159			0 0	557	
	0 ANESTHESI OLOGY	0. 000000			0 0	0	
	0 RADI OLOGY-DI AGNOSTI C	0. 282433			0 0	685, 538	
	O MAMMOGRAPHY	0. 191827			0 0	0	
	O NUCLEAR MEDICINE - DIAGNOSTIC	0. 094328			0 0	354, 320	
	OULTRA SOUND	0. 090699			0 0	101, 558	
	0 RADI OLOGY-THERAPEUTI C	0. 099464			0 0	845, 558	
	0 CT SCAN	0. 084528			0 0	211, 958	
	0 MAGNETIC RESONANCE IMAGING (MRI)	0. 299043			0 0	160, 361	
	O CARDI AC CATHETERI ZATI ON	0. 098003			0 0	308, 652	
	O LABORATORY	0. 122064			0 0	733, 451	
	0 RESPI RATORY THERAPY	0. 132173			0 0	98, 023	
	0 PHYSI CAL THERAPY	0. 398300			0 0	16, 614	
	0 OCCUPATIONAL THERAPY	0. 440152			0 0	4, 446	
	0 SPEECH PATHOLOGY	0. 439645			0 0	51, 987	
		0. 305291			0 0	119, 814	
		0. 179681			0 0	137, 948	
	0 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 269778				590, 672	
	0 IMPL. DEV. CHARGED TO PATIENTS	0. 350082			0 0 0 16, 985	901, 332	
	0 DRUGS CHARGED TO PATIENTS 0 CHEMOTHERAPY	0. 298232				8, 712, 562	
	O WOUND CARE	0. 187263			0 0	281, 183	
	ATIENT SERVICE COST CENTERS	0. 370690	406, 365	1	0 0	153, 155	70.01
	OCLINIC	0. 000000	0		0 0	0	90.00
	1 ANDERSON OUTPATIENT CENTER	0. 444320			0 0	80, 379	
	O DI ABETI C EDUCATI ON	0. 444320			0 0	0, 379	
	2 MS CLINIC	0. 000000			0 0	0	
	00 EMERGENCY	0. 110720			0 0	1, 106, 345	
	0 OBSERVATION BEDS (NON-DISTINCT PART)	0. 472094			0 0	162, 837	
	R REIMBURSABLE COST CENTERS	0. 472094	1 544, 925	1	0 0	102, 037	72.00
	0 AMBULANCE SERVICES	0. 000000			0		95.00
200.00	Subtotal (see instructions)	0.00000	99, 470, 145		0 16, 985	19, 691, 678	
201.00	Less PBP Clinic Lab. Services-Program		77,470,143		0 10, 985	17,071,070	200.00
01.00	Only Charges				0		201.00
		1	1	1	1		1

PPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provider CO	CN: 15-0088	Period: From 07/01/2020 To 06/30/2021	Worksheet D Part V Date/Time Pro 11/23/2021 1	epared: :22 pm
		Title	XVIII	Hospi tal	PPS	_
	Cos					
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To Ded. & Coins.				
	Ded. & Coins. (see inst.)	(see inst.)				
	6.00	<u>(see mst.)</u> 7.00				
ANCILLARY SERVICE COST CENTERS	0.00	7.00				
0. 00 05000 OPERATI NG ROOM	0	0				50.00
2. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
3. 00 05300 ANESTHESI OLOGY	0	0				53.00
4. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
4. 01 03440 MAMMOGRAPHY	0	0				54.00
4. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	0				54.02
4. 03 03630 ULTRA SOUND	0	0				54.02
5. 00 05500 RADI OLOGY-THERAPEUTI C	0	0				55.00
7. 00 05700 CT SCAN	0	0				57.00
8.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0				58.00
9. 00 05900 CARDI AC CATHETERI ZATI ON	0	0				59.00
0. 00 06000 LABORATORY	0	0				60.00
5. 00 06500 RESPIRATORY THERAPY	0	0				65.00
6. 00 06600 PHYSI CAL THERAPY	0	0				66.00
7.00 06700 OCCUPATI ONAL THERAPY	0	0				67.00
8.00 06800 SPEECH PATHOLOGY	0	0				68.00
9. 00 06900 ELECTROCARDI OLOGY	0	0				69.00
0. 00 07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
3.00 07300 DRUGS CHARGED TO PATIENTS	0	5, 065				73.00
6.00 03190 CHEMOTHERAPY	0	0				76.00
6.01 03020 WOUND CARE	0	0				76.01
OUTPATIENT SERVICE COST CENTERS						
0. 00 09000 CLINIC	0	0				90.00
0.01 09001 ANDERSON OUTPATIENT CENTER	0	0				90.01
0. 02 04950 DIABETIC EDUCATION	0	0				90. 02
0. 03 09002 MS CLINIC	0	0				90.03
1.00 09100 EMERGENCY	0	0				91.00
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	l			92.00
OTHER REIMBURSABLE COST CENTERS	· · · · · ·					
5. 00 09500 AMBULANCE SERVICES	0					95.00
00.00 Subtotal (see instructions)	0	5, 065				200.00
01.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
02.00 Net Charges (line 200 - line 201)	0	5, 065				202.00

Health Financial Systems A	SCENSION ST. VI	NCENT ANDERSON		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C	CN: 15-0088	Period:	Worksheet D	
				From 07/01/2020	Part II	
		Component	CCN: 15-T088	To 06/30/2021	Date/Time Pre 11/23/2021 1:	pared: 22 nm
		Title	× XVIII	Subprovider -	PPS	22 piii
				I RF		
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,		(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS		101 (1(010	0.00//			
50. 00 05000 OPERATI NG ROOM	881, 394				323	
52.00 05200 DELIVERY ROOM & LABOR ROOM	217, 247				0	52.00
53. 00 05300 ANESTHESI OLOGY	0	,	0.0000		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	212, 556				508	54.00
54. 01 03440 MAMMOGRAPHY	16, 409				0	54.01
54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	38, 177				18	
54.03 03630 ULTRA SOUND	16, 445				65	
55. 00 05500 RADI OLOGY-THERAPEUTI C	64, 322				0	55.00
57.00 05700 CT SCAN	33, 462				60	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	26, 126				114	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	112, 139	22, 699, 907	0.00494	40 21, 457	106	59.00
60. 00 06000 LABORATORY	292, 796	85, 196, 849	0.0034	37 455, 036	1, 564	60.00
65. 00 06500 RESPI RATORY THERAPY	97, 488			33 115, 993	711	65.00
66. 00 06600 PHYSI CAL THERAPY	148, 670	9, 090, 613	0. 0163	54 527, 316	8, 624	66.00
67.00 06700 OCCUPATI ONAL THERAPY	66, 814	3, 663, 848	0. 0182	36 547, 011	9, 975	67.00
68.00 06800 SPEECH PATHOLOGY	20, 041	1, 101, 151	0. 01820	00 135, 461	2, 465	68.00
69. 00 06900 ELECTROCARDI OLOGY	10,006	1, 299, 082	0.00770	02 0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	100, 133	4, 494, 236	0. 0222	30 15, 300	341	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	101, 916	19, 703, 947	0.0051	72 58, 899	305	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	126, 541	18, 893, 465	0.0066	98 9, 882	66	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	631, 582			209, 853	1, 294	73.00
76.00 03190 CHEMOTHERAPY	40, 848				0	76.00
76.01 03020 WOUND CARE	47, 520				0	76.01
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0	0.0000	0 00	0	90.00
90. 01 09001 ANDERSON OUTPATIENT CENTER	56,097	3, 318, 750			0	90.01
90. 02 04950 DIABETIC EDUCATION	0				0	90.02
90. 03 09002 MS CLINIC	0	-			0	90.03
91.00 09100 EMERGENCY	371,007	-			56	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0				0	92.00
OTHER REIMBURSABLE COST CENTERS		2,,00,010	0.0000			1
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	3, 729, 736	611, 739, 798		2, 280, 632	26, 595	
		1 3.1., 1.8., 1.70	I	2,200,002	20,070	

APPORT IONNERT OF INPATIENT/OUTPATIENT ANCIELARY SERVICE OTHER PASS Provider CCN: 15-008 Period: From 0/01/2020 To 06/30/2021 Worksheet D Provider CCN: 15-708 Worksheet D From 0/01/2020 Worksheet D Provider CCN: 15-708 THE UP INFORMALING ROW 50:00 Non Physician Nursing School Nursing School Nursing School Nursing School Nursing School Nursing School All Heal th Post: 55 epadom 20:00 A		SCENSION ST. VI			In Lie	u of Form CMS-	2552-10
Component CCN: 15-TOBB To 06/33/2021 Date/Time Prepared: 11/23/2021 Date/Tim/23/2021 Date/Time Prepared: 11/23/202	APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI	RVICE OTHER PASS	S Provider C	CN: 15-0088			
Cost Center Description Non Physician Nursing School Nursing Schol Nursing School Nursing School Nurscharget Nursing	THROUGH COSTS		Component	CON. 15 TOOD			norod
Title XVIII Subprovider - IR PPS Cost Center Description Non Physician Nursing School Adjustments Allied Health Adjustments Allied Health Adjustments ANCILLARY SERVICE COST CENTERS 1.00 2A 2.00 3A 50.00 00000 PERATING ROOM 00000 ANESTHESI DLOGY 0 0 0 0 0 50.00 50.00 00000 ANESTHESI DLOGY 0 0 0 0 0 53.00 50.00 52.00 53.00 0 0 0 0 0 0 0 53.00 54.01 54.01 54.01 54.01 54.02 54.03 54.02 54.03 54.01 54.01 54.01 54.01 54.01 54.03 54.02 54.03 54.03 54.02 54.03 54.02 56.00 <t< td=""><td></td><td></td><td>component</td><td>CCN: 15-1088</td><td>10 06/30/2021</td><td>11/23/2021 1·</td><td>22 nm</td></t<>			component	CCN: 15-1088	10 06/30/2021	11/23/2021 1·	22 nm
Cost Center Description Non Physician Nursing School Nursing School Alied Halt I i de Health Anesthetist Cost Non Physician Nursing School Nursing School Alied Halt I i de Health Post-Stepdown Adjustments 50.00 05000 (0PERATING ROM 0000 (0ERATING ROM 0000 (0ERATIN			Title	XVIII	Subprovider -		
Anesthetist Post-Stepdown Adjustments Post-Stepdown Adjustments Post-Stepdown Adjustments ANCLLLARY SERVICE COST CENTERS 1.00 2A 2.00 3A 50.00 05000 OPERATING ROOM 0 0 0 0 0 50.00 50.00 05000 OPERATING ROOM 0 0 0 0 0 50.00 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0 0 50.00 52.00 0 0 0 0 0 52.00 0 0 0 0 0 0 0 0 0 52.00 0 0 0 0 0 0 0 0 0 0 0 0 0 53.00 54.01 344.01 0							
Cost Adjustments Adjustments Adjustments 1.00 2.00 3A 3.00 ANCLLLARY SERVICE COST CENTERS 0	Cost Center Description	Non Physician	Nursing School	Nursing Scho	ol Allied Health	Allied Health	
I 1 00 2A 2 00 3A 3 00 50 005000 OSD000 OEBATTING ROM 0		Anestheti st	Post-Stepdown		Post-Stepdown		
ANCILLARY SERVICE COST CENTERS Image: Cost Ce		Cost	Adjustments		Adjustments		
50:00 050000 0FERATING ROM 0 0 0 0 0 0 0 0 0 50:00 05200 00 52:00 52:00 52:00 52:00 0 52:00 0 52:00 53:00 00 0		1.00	2A	2.00	3A	3.00	
52.00 OS200 DELIVERY ROM & LABOR ROM 0 0 0 0 52.00 53.00 54.01 54.01 54.01 54.01 54.01 54.01 54.01 54.01 54.01 55.00	ANCI LLARY SERVI CE COST CENTERS	· ·		•			
53.00 INSETHESI 0LOCY 0 0 0 0 53.00 54.00 05400 RADI 0LOGY-DI AGNOSTI C 0 0 0 46.371 54.00 54.01 03440 MAMMOGRAPHY 0 0 0 39.103 54.01 54.02 03450 NUCLEAR MEDI CINE - DI AGNOSTI C 0 0 0 39.103 54.01 54.03 03500 NESSON RADI 0LOGY-THERAPEUTI C 0 0 0 28.07 55.00 0500 CABI 0LOGY-THERAPEUTI C 0 0 0 39.648 57.00 56.00 57.00 0500 CABI AC CATHERAPEUTI C 0 0 0 0 7.90 58.00 59.00 059.00 05900 CABI AC CATHERER ZATI ON 0	50.00 05000 OPERATING ROOM	0	C		0 0	0	50.00
54. 00 05400 RADIOLOCY-DIAGNOSTIC 0 0 46. 371 54. 00 54. 01 03440 MAMMOGRAPHY 0 0 0 10, 307 54. 00 54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC 0 0 0 22, 649 54. 03 54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC 0 0 0 22, 649 54. 03 55. 00 DS500 RADIOLOCY-THERAPEUTIC 0 0 0 39, 648 57. 00 57. 00 OS700 CT SCAN 0 0 0 39, 648 57. 00 58. 00 OS800 CARDIACCATHETERIZATION 0 0 0 0 59. 00 60. 00 O6000 RESPI RATORY THERAPY 0 0 0 0 66. 00 66. 00 06000 PHYSICAL THERAPY 0 0 0 0 67. 00 67. 00 OCOO 0 0 0 0 0 0 0 0 0 68. 00 ORGON SPECH PATHOLOCY 0 0 0<	52.00 05200 DELIVERY ROOM & LABOR ROOM	0	C		0 0	0	52.00
54.01 03440 MANMOGRAPHY 0 0 0 0 10, 307 54.02 54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC 0 0 0 39, 103 54.02 54.03 03630 ULTRA SOUND 0 0 0 22, 649 35.00 0 0 0 22, 649 55.00 0 55.00 0 0 0 0 39, 103 54.02 57.00 05700 CT SCAN 0 0 0 0 39, 648 57.00 58.00 05900 CARDI AC CATHETERI ZATI ON 0 <td>53. 00 05300 ANESTHESI OLOGY</td> <td>0</td> <td>C</td> <td></td> <td>0 0</td> <td>0</td> <td>53.00</td>	53. 00 05300 ANESTHESI OLOGY	0	C		0 0	0	53.00
54.01 03440 MANMOGRAPHY 0 0 0 0 10, 307 54.02 54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC 0 0 0 39, 103 54.02 54.03 03630 ULTRA SOUND 0 0 0 22, 649 35.00 0 0 0 22, 649 55.00 0 55.00 0 0 0 0 39, 103 54.02 57.00 05700 CT SCAN 0 0 0 0 39, 648 57.00 58.00 05900 CARDI AC CATHETERI ZATI ON 0 <td>54. 00 05400 RADI OLOGY-DI AGNOSTI C</td> <td>0</td> <td>C</td> <td></td> <td>0 0</td> <td>46, 371</td> <td>54.00</td>	54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C		0 0	46, 371	54.00
54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC 0 0 39, 103 54. 02 54. 02 03630 ULTRA SOUND 0 0 0 22, 649 54. 03 55. 00 05500 RADI LOGY-THERAPEUTIC 0 0 0 39, 103 54. 03 57. 00 05700 CT SCAN 0 0 0 39, 648 57. 00 58. 00 05900 CARDIAC CATHETERIZATION 0 0 0 7, 930 58. 00 60. 00 06900 CARDIAC CATHETERIZATION 0 0 0 0 60. 00 60. 00 66. 00 <t< td=""><td></td><td>0</td><td>0</td><td></td><td>0 0</td><td></td><td></td></t<>		0	0		0 0		
54.03 03630 ULTRA SOUND 0 0 22,649 54.03 55.00 0500 RADI OLOGY-THERAPEUTI C 0 0 0 81,775 55.00 57.00 05700 CT SCAN 0 0 0 39,648 57.00 58.00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 7,930 58.00 59.00 06000 LABORATORY 0 0 0 0 60.00 60.00 60.00 60.00 60.00 65.00 65.00 6500 RESPI RATORY THERAPY 0 0 0 0 66.00 67.00 66.00 67.00 66.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00		0	0		0 0		
55.00 0500 RADI OLOGY-THERAPEUTI C 0 0 0 39,648 57.00 57.00 05700 CT SCAN 0 0 0 39,648 57.00 58.00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 79.00 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 59.00 60.00 0 0.00 0 0 0 0 0 60.00 60.00 0.00 0.00 0 0 0 0 0 60.00 61.00 0.000 0.00 0 0 0 0 0 66.00 66.00 0.000 0 0 0 0 0 66.00 66.00 67.00 0.000 0 0 0 0 0 67.00 67.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 69.00 69.00 69.00 71.00 70.00 69.00 71.00 71.00 70.00 71.00 </td <td></td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td></td> <td></td>		0	0		0 0		
57.00 05700 CT SCAN 0 0 39,648 57.00 58.00 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0 7,930 58.00 60.00 06000 LABORATORY 0 0 0 0 59.00 60.00 06000 LABORATORY 0 0 0 0 60.00 66.00 06500 RESPI RATORY THERAPY 0 0 0 0 66.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 0 66.00 67.00 06000 CCUPATI ONAL THERAPY 0 0 0 0 67.00 68.00 08600 SPECH PATHOLOGY 0 0 0 68.00 69.00 70.00 ELECTROENCERPHALOGRAPHY 0 0 0 0 72.00 71.00 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 72.00 73.00 OT300 DRUGS CHARGED TO PATI ENTS 0 0 0 73.00 76.01 03202 (WOUND CARE 0 <		0	0		0 0		
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 0 7,930 58.00 59.00 05900 CARDIA C CATHETERIZATION 0 0 0 0 59.00 60.00 06000 LABORATORY 0 0 0 0 60.00 65.00 06500 RESPI RATORY THERAPY 0 0 0 0 66.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 0 66.00 67.00 067000 CCUPATI ONAL THERAPY 0 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 68.00 68.00 69.00 0 0 0 69.00 69.00 0 0 0 0 0 0 0 71.00 0		0			0 0		
59.00 05900 CARDIAC CATHETERIZATION 0 0 0 0 59.00 60.00 06000 LABORATORY 0		0	0		0 0		
60.00 06000 LABORATORY 0		0	0		0 0		
65.00 06500 RESPI RATORY THERAPY 0 0 0 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 0 66.00 67.00 0CCUPATI ONAL THERAPY 0 0 0 0 66.00 67.00 0CCUPATI ONAL THERAPY 0 0 0 0 66.00 68.00 0SECH PATHOLOGY 0 0 0 0 68.00 0 69.00 06900 ELECTROCARDI OLOGY 0 0 0 0 69.00 70.00 REDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 73.00 73.00 73.00 73.00 03190 CHEMTHERAPY 0 0 0 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 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.		0	0		0 0		
66.00 06600 PHYSI CAL THERAPY 0 0 0 0 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 69.00 69.00 0 0 0 69.00 69.00 0 0 0 69.00 69.00 69.00 0 0 0 69.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 71.00 70.00 71.00 70.00 72.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 74.00 74.00 74.00 74.00 74.00 </td <td></td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td>-</td> <td></td>		0	0		0 0	-	
67.00 06700 0CCUPATI ONAL THERAPY 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 0 69.00 70.00 OCODE ELECTROCARDI OLOGY 0 0 0 0 69.00 70.00 OTOO ELECTROCARDI OLOGY 0 0 0 0 70.00 71.00 OTOO ELECTROCARDEMALOGRAPHY 0 0 0 0 71.00 72.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 73.00 76.01 03020 WOUND CARE 0 0 0 76.00 90.00 090001 CLINIC 0 0 0 0 90.00 90.01 ANDERSON OUTPATI ENT CENTER 0 0 0 0 90.00 90.02 04950 DLABETI C EDUCAT		0	U		0 0	-	
68.00 06800 SPEECH PATHOLOGY 0 0 0 68.00 69.00 06900 ELECTROCARDIOLOGY 0 0 0 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 70.00 71.00 O7100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 73.00 76.00 03190 CHEMOTHERAPY 0 0 0 0 76.00 76.01 03020 WOUND CARE 0 0 0 0 76.01 04000 CLINIC 0 0 0 0 0 90.01 05000 Q0000 CLINIC 0 0 0 90.02 90.02 90.02 04950 DI ABETIC EDUCATION 0 0 0 0 90.02 91.00 09		0	0		0 0		
69.00 06900 ELECTROCARDI OLOGY 0		0	C		0 0	-	
70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 73.00 76.00 03190 CHEMOTHERAPY 0 0 0 0 76.00 03202 WOUND CARE 0 0 0 0 0 76.00 03202 WOUND CARE 0 0 0 0 0 76.00 04.00 09000 CLI NI C 0 0 0 0 76.00 90.00 09001 ANDERSON OUTPATIENT CENTER 0 0 0 0 90.00 90.01 09001 ANDERSON OUTPATIENT CENTER 0 0 0 90.02 90.02 04950 DI ABETI C EDUCATI ON 0 0 0 0 90.02 <t< td=""><td></td><td>0</td><td>C</td><td></td><td>0 0</td><td></td><td></td></t<>		0	C		0 0		
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 73.00 76.00 03190 CHEMOTHERAPY 0 0 0 0 76.00 76.01 03020 WOUND CARE 0 0 0 0 0 76.00 70.02 WOUND CARE 0 0 0 0 0 0 76.00 70.01 03020 WOUND CARE 0 0 0 0 76.00 70.02 WOUND CARE 0 0 0 0 0 76.00 70.02 VOUND CARE 0 0 0 0 0 76.00 70.02 VOUND CARE 0 0 0 0 90.00 90.00 90.00 09000 ANDERSON OUTPATIENT CENTER 0 0 0 90.00 90.02		0	C		0 0		
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 73.00 76.00 03190 CHEMOTHERAPY 0 0 0 0 76.00 76.00 03020 WOUND CARE 0 0 0 0 76.00 03020 WOUND CARE 0 0 0 0 0 0 76.00 04000 CLINIC 0 0 0 0 0 90.00 90.00 90.00 OPOOL LINIC 0 0 0 0 90.00 90.00 90.01 ANDERSON OUTPATIENT CENTER 0 0 0 90.00 90.00 90.02 04950 DI ABETI C EDUCATION 0 0 0 90.02 90.03 90.03 09002 MS CLINIC 0 0 0 0 90.03 91.00 91.00 EMERGENCY 0 0 0 91.00 92.00 OBSERVATION BEDS (NON-DISTINCT P		0	0		0 0	0	
73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 73.00 76.00 03190 CHEMOTHERAPY 0 0 0 0 76.00 76.01 03020 WOUND CARE 0 0 0 0 0 76.00 70.01 03020 WOUND CARE 0 0 0 0 0 76.00 70.02 VUTPATIENT SERVICE COST CENTERS 0 0 0 0 0 76.01 70.01 09000 CLINIC 0 0 0 0 90.00 90.02 09001 ANDERSON OUTPATIENT CENTER 0 0 0 90.01 90.02 04950 DI ABETIC EDUCATION 0 0 0 90.02 90.02 MS CLINIC 0 0 0 0 90.02 90.03 09002 MS CLINIC 0 0 0 90.02 90.03 09020 MS CLINIC 0 0 0 90.02 91.00 09200 DISERVATION BEDS (NON-DISTINCT PART) 0 <td></td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td>0</td> <td>71.00</td>		0	0		0 0	0	71.00
76.00 03190 CHEMOTHERAPY 0 0 0 0 0 0 76.00 90.00		0	0		0 0	0	
76.01 03020 WOUND CARE 0	73.00 07300 DRUGS CHARGED TO PATIENTS	0	C		0 0	0	73.00
OUTPATI ENT SERVICE COST CENTERS 90.00 09000 CLINIC 0 0 0 0 0 90.00 90.01 09001 ANDERSON OUTPATIENT CENTER 0 0 0 0 0 0 90.01 90.02 04950 DI ABETI C EDUCATION 0 0 0 0 0 90.02 90.03 09002 MS CLINIC 0 0 0 0 90.03 91.00 09100 EMERGENCY 0 0 0 0 91.00 92.00 0BSERVATION BEDS (NON-DISTINCT PART) 0 0 0 92.00 <t< td=""><td>76.00 03190 CHEMOTHERAPY</td><td>0</td><td>C</td><td></td><td>0 0</td><td>0</td><td>76.00</td></t<>	76.00 03190 CHEMOTHERAPY	0	C		0 0	0	76.00
90.00 09000 CLINIC 0 0 0 0 0 0 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.02 90.03 90.02 90.03 90.02 90.03 90.00 0 90.03 90.03 90.00 90.03 91.00 91.00 91.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.	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 DLABETIC EDUCATION 0 0 0 0 90.02 90.03 09002 MS CLINIC EDUCATION 0 0 0 0 90.03 91.00 09100 EMERGENCY 0 0 0 71,820 91.00 92.00 09200 DBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 92.00 </td <td>OUTPATIENT SERVICE COST CENTERS</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>	OUTPATIENT SERVICE COST CENTERS						
90.02 04950 DLABETIC EDUCATION 0	90. 00 09000 CLINIC	0	0		0 0	0	90.00
90.03 09002 MS CLINIC 0 0 0 0 90.03 91.00 09100 EMERGENCY 0 0 0 0 71,820 91.00 92.00 09500 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 92.00 0THER REI MBURSABLE COST CENTERS 95.00 95.00 95.00 95.00 95.00	90.01 09001 ANDERSON OUTPATIENT CENTER	0	C		0 0	0	90.01
90.03 09002 MS CLINIC 0 0 0 0 90.03 91.00 09100 EMERGENCY 0 0 0 0 71,820 91.00 92.00 09500 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 92.00 0THER REI MBURSABLE COST CENTERS 95.00 95.00 95.00 95.00 95.00		0	C		0 0	0	90.02
91.00 09100 EMERGENCY 0 0 0 71,820 91.00 92.00 0BSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 0 92.00 0THER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00		0	C		0 0	0	
92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 92. 00 0THER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 95. 00 95. 00		0	0		0 0		
OTHER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00		0	Ū				
95.00 09500 AMBULANCE SERVICES 95.00					- 1		1
							95.00
	200.00 Total (lines 50 through 199)	0	0		0 0	319 603	

Health Financial Systems A	SCENSION ST. VI	NCENT ANDERSON		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEA	RVICE OTHER PASS	S Provider C	CN: 15-0088	Peri od:	Worksheet D	
THROUGH COSTS		Composit		From 07/01/2020	Part IV	
		Component	CCN: 15-T088	Го 06/30/2021	Date/Time Pre 11/23/2021 1:	22 nm
		Title	XVIII	Subprovider -	PPS	22 piii
				IRF		
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
	Education Cost	1, 2, 3, and	Cost (sum of		(col. 5 ÷ col.	
		4)	cols. 2, 3,	8)	7)	
			and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVICE COST CENTERS	-	-				
50.00 05000 OPERATING ROOM	0	0		131, 646, 949		•
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0		4, 271, 447	0.00000	•
53. 00 05300 ANESTHESI OLOGY	0	0		0 0		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	46, 371	46, 37			
54. 01 03440 MAMMOGRAPHY	0	10, 307	10, 30		0.002602	
54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	39, 103				•
54. 03 03630 ULTRA SOUND	0	22, 649				
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	81, 775				
57. 00 05700 CT SCAN	0	39, 648				
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	7, 930			0.002602	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		22, 699, 907		
60. 00 06000 LABORATORY	0	0		0011701017		
65. 00 06500 RESPI RATORY THERAPY	0	0		15, 895, 746		
66. 00 06600 PHYSI CAL THERAPY	0	0		9, 090, 613		
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0	0		3, 663, 848	0. 000000 0. 000000	
	0			1, 101, 151		
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	0			1, 299, 082		
	0			4, 494, 236	0. 000000	
	0			19, 703, 947		
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	0			18, 893, 465		
73.00 07300 DR0GS CHARGED TO PATTENTS 76.00 03190 CHEMOTHERAPY	0			0 102, 463, 440 9, 419, 811		
76. 01 03020 WOUND CARE	0			3, 112, 040		
OUTPATIENT SERVICE COST CENTERS	0	0		5, 112, 040	0.00000	70.01
90. 00 09000 CLINIC	0	0			0. 000000	90.00
90. 01 09001 ANDERSON OUTPATIENT CENTER	0	0		3, 318, 750		
90. 02 04950 DI ABETI C EDUCATI ON	0			0 3, 318, 750	0. 000000	
90. 03 09002 MS CLINIC					0. 000000	•
91. 00 09100 EMERGENCY		71, 820	71, 82	77, 483, 381	0. 000927	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		, i, 020		2, 766, 018		•
OTHER REIMBURSABLE COST CENTERS	0	. 0	I	2,700,010	0.00000	/2.00
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	0	319, 603	319, 60	611, 739, 798		200.00
	1 0	1 017,000	1 017,00		I	1-00.00

Health Financial Systems A	SCENSION ST. VINC	ENT ANDERSON		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEA	RVICE OTHER PASS	Provider CO	CN: 15-0088	Peri od:	Worksheet D	
THROUGH COSTS		Component (CCN: 15-T088	From 07/01/2020 To 06/30/2021	Part IV Date/Time Pre	nared
		componente	. 13 1000	10 00/30/2021	11/23/2021 1:	22 pm
		Title	XVIII	Subprovider -	PPS	
Cost Contas Description	Outrat: ant	I nun att and	1	I RF	Outrationt	
Cost Center Description	Outpatient Ratio of Cost	Inpatient Program	Inpatient Program	Outpatient Program	Outpatient Program	
	to Charges	Charges	Pass-Throug		Pass-Through	
	$(col. 6 \div col.)$	charges	Costs (col.		Costs (col. 9	
	7)		x col. 10)	0	x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0. 000000	48, 301		0 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 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. 002602	42, 625	1	11 0	0	54.00
54.01 03440 MAMMOGRAPHY	0. 002602	0		0 0	0	54.01
54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0. 002602	7, 110		19 0	0	54.02
54.03 03630 ULTRA SOUND	0. 002602	34, 201		89 0	0	54.03
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 002603	0		0 0	0	55.00
57.00 05700 CT SCAN	0.002602	27, 200		71 0	0	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 002602	13, 300		35 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	0. 000000 0. 000000	21, 457		0 0 0 0	0	59.00
60. 00 06000 LABORATORY 65. 00 06500 RESPI RATORY THERAPY	0. 000000	455, 036 115, 993		0 0	0	60.00 65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	527, 316		0 0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	547, 011		0 0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0.000000	135, 461		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	133, 401		0 0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0, 000000	15, 300		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	58, 899		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	9, 882		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	209, 853		0 0	0	73.00
76.00 03190 CHEMOTHERAPY	0. 000000	0		0 0	0	76.00
76.01 03020 WOUND CARE	0. 000000	0		0 0	0	76.01
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0. 000000	0		0 0	0	90.00
90. 01 09001 ANDERSON OUTPATIENT CENTER	0. 000000	0		0 0	0	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	0.000927	11, 687		11 0	0	91.00
92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0.000000	0		0 0	0	92.00
0THER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES	1					95.00
95.00 09500 AMBULANCE SERVICES 200.00 Total (lines 50 through 199)		2, 280, 632	2	36 0	0	200.00
		2,200,032	3	JU U	0	200.00

APPORT	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-0088	Period: From 07/01/2020 To 06/30/2021	Worksheet D Part V Date/Time Pre 11/23/2021 1:	
			Titl	e XIX	Hospi tal	Cost	
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins			
				(see inst.)			
		1.00	2.00	3.00	4.00	5.00	
	ANCI LLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0. 168463				0	
	05200 DELIVERY ROOM & LABOR ROOM	0. 581159				0	
53.00	05300 ANESTHESI OLOGY	0. 000000			0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 282433	0	331, 5	14 0	0	54.00
54.01	03440 MAMMOGRAPHY	0. 191827	0	10, 8	26 0	0	54.01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0. 094328	0	167, 59	92 0	0	54.02
54.03	03630 ULTRA SOUND	0. 090699	0	180, 49	94 0	0	54.03
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 099464	0	457, 3	36 0	0	55.00
57.00	05700 CT SCAN	0. 084528	0	377, 59	95 0	0	57.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 299043	0	47,48	37 0	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 098003	0	329, 9	90 0	0	59.00
60.00	06000 LABORATORY	0. 122064	0	1, 395, 4	51 0	0	60.00
65.00	06500 RESPI RATORY THERAPY	0. 132173	0	40, 50	62 0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0. 398300	0	83, 20	0 00	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 440152	0	37, 5	53 0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0. 439645	0			0	68.00
69.00	06900 ELECTROCARDI OLOGY	0. 305291	0	2, 8	28 0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 179681	0	21, 5	73 0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 269778	0			0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 350082	0			0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 298232	0	1, 246, 9	40 0	0	73.00
76.00	03190 CHEMOTHERAPY	0. 187263	0	146, 04	43 0	0	76.00
	03020 WOUND CARE	0. 376890	0	80, 14	48 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. 444320		135, 33	26 0	0	90.01
	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. 110720	0	3, 108, 8	11 0	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 472094	0			0	92.00
	OTHER REIMBURSABLE COST CENTERS	1	1	· · ·			
	09500 AMBULANCE SERVICES	0. 000000	0		0		95.00
200.00			Ö		-	0	200.00
201.00	Less PBP Clinic Lab. Services-Program		ĺ		0 0	0	201.00
	Only Charges						
	Net Charges (line 200 - line 201)	1	0	10, 116, 10	02 0		202.00

APPORTI ONM	IENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CC	CN: 15-0088	Period: From 07/01/2020 To 06/30/2021	Worksheet D Part V Date/Time Pr 11/23/2021 1	
			Ti tl	e XIX	Hospi tal	Cost	
		Cos	sts				
	Cost Center Description	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.) 6.00	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.) 7.00				
	I LLARY SERVI CE COST CENTERS	0.00	7.00				
	00 OPERATI NG ROOM	249, 960	0				50.00
	00 DELIVERY ROOM & LABOR ROOM	16, 485	0				52.00
	00 ANESTHESI OLOGY	10, 405	0				53.00
	00 RADI OLOGY-DI AGNOSTI C	93, 630	0				54.00
	40 MAMMOGRAPHY	2,077	0				54.00
	50 NUCLEAR MEDICINE - DIAGNOSTIC	15,809	0				54.02
	30 ULTRA SOUND	16, 371	0				54.02
	00 RADI OLOGY-THERAPEUTI C	45, 493	0				55.00
	DO CT SCAN	31, 917	0				57.00
	DO MAGNETIC RESONANCE IMAGING (MRI)	14, 201	0				58.00
	DO CARDI AC CATHETERI ZATI ON	32, 340	0				59.00
	DO LABORATORY	170, 334	0				60.00
	00 RESPIRATORY THERAPY	5, 361	0				65.00
	00 PHYSI CAL THERAPY	33, 139	0				66.00
	00 OCCUPATI ONAL THERAPY	16, 529	0				67.00
68.00 0680	DO SPEECH PATHOLOGY	4, 962	0				68.00
	00 ELECTROCARDI OLOGY	863	0				69.00
70.00 0700	00 ELECTROENCEPHALOGRAPHY	3, 876	0				70.00
71.00 0710	00 MEDICAL SUPPLIES CHARGED TO PATIENTS	35, 985	0				71.00
72.00 0720	00 IMPL. DEV. CHARGED TO PATIENTS	59, 429	0				72.00
	DO DRUGS CHARGED TO PATIENTS	371, 877	0				73.00
	90 CHEMOTHERAPY	27, 348	0				76.00
	20 WOUND CARE	30, 207	0				76.01
	PATIENT SERVICE COST CENTERS						
	DO CLINIC	0	0				90.00
	01 ANDERSON OUTPATIENT CENTER	60, 128	0				90.01
	50 DIABETIC EDUCATION	0	0				90.02
	02 MS CLINIC	0	0				90.03
		344, 208	0				91.00
	00 OBSERVATION BEDS (NON-DISTINCT PART)	41, 649	0				92.00
	ER REIMBURSABLE COST CENTERS						
	00 AMBULANCE SERVICES	0					95.00
200.00	Subtotal (see instructions)	1, 724, 178	0				200.00
201.00	Less PBP Clinic Lab. Services-Program	0					201.00
1	Only Charges						1

Health Financial Syste

ASCENSI ON ST.	VINCEN	t and	DERS	ON		
				0.011	4 -	00

IN 1.00 In 2.00 In 3.00 Pr 4.00 Sc 5.00 To 6.00 To 7.00 To 7.00 To 9.00 To 10.00 St 11.00 St 12.00 St 13.00 St	Cost Center Description ART I - ALL PROVIDER COMPONENTS VPATIENT DAYS npatient days (including private room days and swing-bed days npatient days (including private room days, excluding swing-bed rivate room days (excluding swing-bed and observation bed day o not complete this line. emi-private room days (excluding swing-bed and observation bed otal swing-bed SNF type inpatient days (including private root eporting period otal swing-bed SNF type inpatient days (including private root eporting period otal swing-bed NF type inpatient days (including private root eporting period otal swing-bed NF type inpatient days (including private root eporting period otal swing-bed NF type inpatient days (including private root eporting period otal swing-bed NF type inpatient days (including private root eporting period otal inpatient days including private room days applicable to ewborn days) (see instructions) wing-bed SNF type inpatient days applicable to title XVIII or hrough December 31 of the cost reporting period (if calendar year, ere wing-bed NF type inpatient days applicable to title XVIII or hrough December 31 of the cost reporting period wing-bed NF type inpatient days applicable to titles V or XIX hrough December 31 of the cost reporting period wing-bed NF type inpatient days applicable to titles V or XIX hrough December 31 of the cost reporting period	bed and newborn days) ys). If you have only pr ed days) om days) through December on days) after December a days) after December 3 o the Program (excluding hly (including private r ions) hly (including private r hter 0 on this line)	r 31 of the cost 31 of the cost 31 of the cost 1 of the cost swing-bed and oom days)	Date/Time Preg 11/23/2021 1: 2 PPS 1.00 22, 272 22, 272 22, 272 0 21, 182 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	22 pr 1. 2. 3. 4. 5. 6. 7. 8.
IN 1.00 In 2.00 In 3.00 Pr 4.00 Sc 5.00 To 6.00 To 7.00 To 7.00 To 9.00 To 10.00 St 11.00 St 12.00 St 13.00 St	ART I - ALL PROVIDER COMPONENTS NPATIENT DAYS npatient days (including private room days and swing-bed days npatient days (including private room days, excluding swing-bed rivate room days (excluding swing-bed and observation bed o not complete this line. emi-private room days (excluding swing-bed and observation bed otal swing-bed SNF type inpatient days (including private room eporting period otal swing-bed SNF type inpatient days (including private room eporting period (if calendar year, enter 0 on this line) otal swing-bed NF type inpatient days (including private room eporting period otal swing-bed NF type inpatient days (including private room eporting period otal swing-bed NF type inpatient days (including private room eporting period otal swing-bed NF type inpatient days (including private room eporting period otal swing-bed NF type inpatient days (including private room eporting period otal swing-bed NF type inpatient days (including private room eporting period) inpatient days including private room days applicable to the wborn days) (see instructions) wing-bed SNF type inpatient days applicable to title XVIII on hrough December 31 of the cost reporting period (if calendar year, en wing-bed NF type inpatient days applicable to title XVIII on hrough December 31 of the cost reporting period wing-bed NF type inpatient days applicable to titles V or XIX hrough December 31 of the cost reporting period wing-bed NF type inpatient days applicable to titles V or XIX hrough December 31 of the cost reporting period	s, excluding newborn) bed and newborn days) rs). If you have only pr bed days) om days) through December om days) after December a days) after December 3 b the Program (excluding nly (including private r ther 0 on this line)	ivate room days, r 31 of the cost 31 of the cost 31 of the cost 1 of the cost 1 of the cost swing-bed and oom days)	PPS 1.00 22,272 22,272 0 21,182 0 0 0 0 0 3,875 0	1. 2. 3. 4. 5. 6. 7. 8.
IN IN 1.00 In 2.00 In 3.00 Pr da da 5.00 Ta 6.00 Ta 7.00 Ta 7.00 Ta 7.00 Ta 7.00 Ta 9.00 Ta 11.00 Su 12.00 Su 13.00 Su	ART I - ALL PROVIDER COMPONENTS NPATIENT DAYS npatient days (including private room days and swing-bed days npatient days (including private room days, excluding swing-bed rivate room days (excluding swing-bed and observation bed o not complete this line. emi-private room days (excluding swing-bed and observation bed otal swing-bed SNF type inpatient days (including private room eporting period otal swing-bed SNF type inpatient days (including private room eporting period (if calendar year, enter 0 on this line) otal swing-bed NF type inpatient days (including private room eporting period otal swing-bed NF type inpatient days (including private room eporting period otal swing-bed NF type inpatient days (including private room eporting period otal swing-bed NF type inpatient days (including private room eporting period otal swing-bed NF type inpatient days (including private room eporting period otal swing-bed NF type inpatient days (including private room eporting period) inpatient days including private room days applicable to the wborn days) (see instructions) wing-bed SNF type inpatient days applicable to title XVIII on hrough December 31 of the cost reporting period (if calendar year, en wing-bed NF type inpatient days applicable to title XVIII on hrough December 31 of the cost reporting period wing-bed NF type inpatient days applicable to titles V or XIX hrough December 31 of the cost reporting period wing-bed NF type inpatient days applicable to titles V or XIX hrough December 31 of the cost reporting period	bed and newborn days) ys). If you have only pr ed days) om days) through December on days) after December a days) after December 3 o the Program (excluding hly (including private r ions) hly (including private r hter 0 on this line)	r 31 of the cost 31 of the cost 31 of the cost 1 of the cost swing-bed and oom days)	22, 272 22, 272 22, 272 0 21, 182 0 0 0 0 0 3, 875 0	2. 3. 4. 5. 6. 7. 8.
I. 00 In 2. 00 In 3. 00 Pri 4. 00 Sc 5. 00 Tc 6. 00 Tc 7. 00 Tc 8. 00 Tc 7. 00 Tc 9. 00 Tc 10. 00 Sc 11. 00 Sc 12. 00 Sc 13. 00 Sc	NPATIENT DAYS npatient days (including private room days and swing-bed days npatient days (including private room days, excluding swing-b rivate room days (excluding swing-bed and observation bed day o not complete this line. emi-private room days (excluding swing-bed and observation bed otal swing-bed SNF type inpatient days (including private rooc eporting period otal swing-bed SNF type inpatient days (including private rooc eporting period (if calendar year, enter 0 on this line) otal swing-bed NF type inpatient days (including private roor eporting period otal swing-bed NF type inpatient days (including private roor eporting period otal swing-bed NF type inpatient days (including private roor eporting period otal swing-bed NF type inpatient days (including private roor eporting period otal swing-bed NF type inpatient days (including private roor eporting period otal swing-bed NF type inpatient days (including private roor eporting period (if calendar year, enter 0 on this line) otal inpatient days including private room days applicable to ewborn days) (see instructions) wing-bed SNF type inpatient days applicable to title XVIII or hrough December 31 of the cost reporting period (if calendar year, en wing-bed NF type inpatient days applicable to title V or XIX hrough December 31 of the cost reporting period wing-bed NF type inpatient days applicable to titles V or XIX hrough December 31 of the cost reporting period	bed and newborn days) ys). If you have only pr ed days) om days) through December on days) after December a days) after December 3 o the Program (excluding hly (including private r ions) hly (including private r hter 0 on this line)	r 31 of the cost 31 of the cost 31 of the cost 1 of the cost swing-bed and oom days)	22, 272 0 21, 182 0 0 0 0 3, 875 0	2. 3. 4. 5. 6. 7. 8.
1.00 In 2.00 In 3.00 Ph da da 4.00 Se 5.00 Ta 5.00 Ta 6.00 Ta 6.00 Ta 7.00 Ta 7.00 Ta 9.00 Ta 10.00 Su 11.00 Su 12.00 Su 13.00 Su	npatient days (including private room days and swing-bed days npatient days (including private room days, excluding swing-be rivate room days (excluding swing-bed and observation bed day o not complete this line. emi-private room days (excluding swing-bed and observation be otal swing-bed SNF type inpatient days (including private roo eporting period otal swing-bed SNF type inpatient days (including private roo eporting period otal swing-bed NF type inpatient days (including private roo eporting period otal swing-bed NF type inpatient days (including private roo eporting period otal swing-bed NF type inpatient days (including private room eporting period otal swing-bed NF type inpatient days (including private room eporting period otal swing-bed NF type inpatient days (including private room eporting period otal inpatient days including private room days applicable to ewborn days) (see instructions) wing-bed SNF type inpatient days applicable to title XVIII on hrough December 31 of the cost reporting period (see instruct wing-bed NF type inpatient days applicable to title XVIII or hrough December 31 of the cost reporting period wing-bed NF type inpatient days applicable to title V III or wing-bed NF type inpatient days applicable to title V III or wing-bed NF type inpatient days applicable to titles V or XIX hrough December 31 of the cost reporting period wing-bed NF type inpatient days applicable to titles V or XIX	bed and newborn days) ys). If you have only pr ed days) om days) through December on days) after December a days) after December 3 o the Program (excluding hly (including private r ions) hly (including private r hter 0 on this line)	r 31 of the cost 31 of the cost 31 of the cost 1 of the cost swing-bed and oom days)	22, 272 0 21, 182 0 0 0 0 3, 875 0	2. 3. 4. 5. 6. 7. 8.
2.00 In 3.00 Pn da da 4.00 Se 5.00 Ta 5.00 Ta 6.00 Ta 7.00 Ta 7.00 Ta 6.00 Ta 7.00 Ta 10.00 Su 11.00 Su 12.00 Su 13.00 Su	npatient days (including private room days, excluding swing-brivate room days (excluding swing-bed and observation bed day o not complete this line. emi-private room days (excluding swing-bed and observation bed otal swing-bed SNF type inpatient days (including private root eporting period otal swing-bed SNF type inpatient days (including private root eporting period (if calendar year, enter 0 on this line) otal swing-bed NF type inpatient days (including private root eporting period (if calendar year, enter 0 on this line) otal swing-bed NF type inpatient days (including private root eporting period otal swing-bed NF type inpatient days (including private root eporting period otal inpatient days including private root this line) otal inpatient days including private root days applicable to ewborn days) (see instructions) wing-bed SNF type inpatient days applicable to title XVIII on hrough December 31 of the cost reporting period (if calendar year, en wing-bed NF type inpatient days applicable to title XVIII or hrough December 31 of the cost reporting period (if calendar year, en wing-bed NF type inpatient days applicable to titles V or XIX hrough December 31 of the cost reporting period wing-bed NF type inpatient days applicable to titles V or XIX	bed and newborn days) ys). If you have only pr ed days) om days) through December on days) after December a days) after December 3 o the Program (excluding hly (including private r ions) hly (including private r hter 0 on this line)	r 31 of the cost 31 of the cost 31 of the cost 1 of the cost swing-bed and oom days)	22, 272 0 21, 182 0 0 0 0 3, 875 0	2. 3. 4. 5. 6. 7. 8.
4. 00 Se 5. 00 Te 5. 00 Te 7. 00 Te 7. 00 Te 7. 00 Te 7. 00 Te 10. 00 Se 11. 00	emi-private room days (excluding swing-bed and observation be otal swing-bed SNF type inpatient days (including private roo otal swing-bed SNF type inpatient days (including private roo otal swing-bed SNF type inpatient days (including private roo eporting period (if calendar year, enter 0 on this line) otal swing-bed NF type inpatient days (including private room eporting period otal swing-bed NF type inpatient days (including private room eporting period otal swing-bed NF type inpatient days (including private room eporting period (if calendar year, enter 0 on this line) otal inpatient days including private room days applicable to ewborn days) (see instructions) wing-bed SNF type inpatient days applicable to title XVIII on hrough December 31 of the cost reporting period (see instruct wing-bed NF type inpatient days applicable to title XVIII on ecember 31 of the cost reporting period wing-bed NF type inpatient days applicable to title VVIII on wing-bed NF type inpatient days applicable to titles V or XIX hrough December 31 of the cost reporting period wing-bed NF type inpatient days applicable to titles V or XIX	om days) through Decembe om days) after December n days) through December n days) after December 3 o the Program (excluding nly (including private r ions) nly (including private r nter 0 on this line)	31 of the cost 31 of the cost 1 of the cost swing-bed and oom days)	0 0 0 3, 875 0	5. 6. 7. 8.
x. 00 Tot regardless x. 00 State regardless	otal swing-bed SNF type inpatient days (including private roo eporting period (if calendar year, enter 0 on this line) otal swing-bed NF type inpatient days (including private room eporting period otal swing-bed NF type inpatient days (including private room eporting period (if calendar year, enter 0 on this line) otal inpatient days including private room days applicable to ewborn days) (see instructions) wing-bed SNF type inpatient days applicable to title XVIII on hrough December 31 of the cost reporting period (see instruct wing-bed SNF type inpatient days applicable to title XVIII or ecember 31 of the cost reporting period (if calendar year, en wing-bed NF type inpatient days applicable to title VVIII or hrough December 31 of the cost reporting period wing-bed NF type inpatient days applicable to titles V or XIX hrough December 31 of the cost reporting period wing-bed NF type inpatient days applicable to titles V or XIX	n days) through December n days) after December 3 o the Program (excluding nly (including private r ions) nly (including private r nter 0 on this line)	31 of the cost 1 of the cost swing-bed and room days)	0 0 3, 875 0	7. 8.
7.00 To 8.00 To 9.00 To 0.00 To 1.00 So 1.00 So 1.0	otal swing-bed NF type inpatient days (including private room eporting period otal swing-bed NF type inpatient days (including private room eporting period (if calendar year, enter 0 on this line) otal inpatient days including private room days applicable to ewborn days) (see instructions) wing-bed SNF type inpatient days applicable to title XVIII or hrough December 31 of the cost reporting period (see instruct wing-bed SNF type inpatient days applicable to title XVIII or hrough December 31 of the cost reporting period (see instruct wing-bed SNF type inpatient days applicable to title XVIII or ecember 31 of the cost reporting period (if calendar year, er wing-bed NF type inpatient days applicable to titles V or XIX hrough December 31 of the cost reporting period wing-bed NF type inpatient days applicable to titles V or XIX	n days) after December 3 o the Program (excluding nly (including private r ions) nly (including private r nter 0 on this line)	1 of the cost swing-bed and oom days)	0 3, 875 0	8.
3.00 Top 0.00 Top 0.00 Top 0.00 Si 1.00 Si 2.00 Si 3.00 Si	otal swing-bed NF type inpatient days (including private room eporting period (if calendar year, enter 0 on this line) otal inpatient days including private room days applicable to ewborn days) (see instructions) wing-bed SNF type inpatient days applicable to title XVIII or hrough December 31 of the cost reporting period (see instruct wing-bed SNF type inpatient days applicable to title XVIII or ecember 31 of the cost reporting period (if calendar year, er wing-bed NF type inpatient days applicable to titles V or XIX hrough December 31 of the cost reporting period wing-bed NF type inpatient days applicable to titles V or XIX hrough December 31 of the cost reporting period	o the Program (excluding nly (including private r :ions) nly (including private r nter 0 on this line)	swing-bed and oom days)	3, 875 0	
0.00 Sv 1.00 Sv 2.00 Sv 3.00 Sv at	ewborn days) (see instructions) wing-bed SNF type inpatient days applicable to title XVIII or hrough December 31 of the cost reporting period (see instruct wing-bed SNF type inpatient days applicable to title XVIII or ecember 31 of the cost reporting period (if calendar year, en wing-bed NF type inpatient days applicable to titles V or XIX hrough December 31 of the cost reporting period wing-bed NF type inpatient days applicable to titles V or XIX	nly (including private r ions) nly (including private r nter 0 on this line)	room days)	0	-
1.00 Sv 2.00 Sv 3.00 Sv at	hrough December 31 of the cost reporting period (see instruct wing-bed SNF type inpatient days applicable to title XVIII or ecember 31 of the cost reporting period (if calendar year, er wing-bed NF type inpatient days applicable to titles V or XIX hrough December 31 of the cost reporting period wing-bed NF type inpatient days applicable to titles V or XIX	ions) Ny (including private r Nter 0 on this line)	•		9.
2.00 Sv 11 3.00 Sv at	ecember 31 of the cost reporting period (if calendar year, er wing-bed NF type inpatient days applicable to titles V or XIX hrough December 31 of the cost reporting period wing-bed NF type inpatient days applicable to titles V or XIX	nter 0 on this line)	oom days) after	, ^l	
3.00 Sv at	hrough December 31 of the cost reporting period wing-bed NF type inpatient days applicable to titles V or XIX	confy (including privat		0	
at		(only (including privat	•	0	
	fter December 31 of the cost reporting period (if calendar ye edically necessary private room days applicable to the Progra	ear, enter O on this lin	e)	0	14
5.00 To	ursery days (title V or XIX only)			0	15
SW	NING BED ADJUSTMENT	a through December 21 a	f the east	0.00	1
re	edicare rate for swing-bed SNF services applicable to service eporting period edicare rate for swing-bed SNF services applicable to service	0		0. 00 0. 00	
re	edicaid rate for swing-bed NF services applicable to services edicaid rate for swing-bed NF services applicable to services			0.00	
re	eporting period edicaid rate for swing-bed NF services applicable to services	C C		0.00	
1. 00 To	eporting period otal general inpatient routine service cost (see instructions wing-bed cost applicable to SNF type services through Decembe		ing period (line	26, 681, 960 0	21. 22.
5	x line 17) wing-bed cost applicable to SNF type services after December	•	0.1		
	line 18) wing-bed cost applicable to NF type services through December	· 31 of the cost reporti	ng period (line	0	24.
	x line 19) wing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25.
6.00 To	line 20) otal swing-bed cost (see instructions)			0	26.
PF	eneral inpatient routine service cost net of swing-bed cost (RIVATE ROOM DIFFERENTIAL ADJUSTMENT			26, 681, 960	
	eneral inpatient routine service charges (excluding swing-bed rivate room charges (excluding swing-bed charges)	and observation bed ch	arges)	0	
	emi-private room charges (excluding swing-bed charges)			0	
	eneral inpatient routine service cost/charge ratio (line 27 ÷	- line 28)		0.000000	
	verage private room per diem charge (line 29 ÷ line 3)			0.00	
א OO A'	verage semi-private room per diem charge (line 30 ÷ line 4)			0.00	33.
יA 00 A	verage per diem private room charge differential (line 32 min	nus line 33)(see instruc	tions)	0.00	34.
	verage per diem private room cost differential (line 34 x lin			0.00	35.
5.00 Pi 7.00 Ge	rivate room cost differential adjustment (line 3 x line 35) eneral inpatient routine service cost net of swing-bed cost a		fferential (line	0 26, 681, 960	36 37
PA	7 minus line 36) ART II - HOSPITAL AND SUBPROVIDERS ONLY				
	ROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU			1 100	
	djusted general inpatient routine service cost per diem (see			1, 198. 00	
	rogram general inpatient routine service cost (line 9 x line			4, 642, 250	
	edically necessary private room cost applicable to the Progra	am (line 14 x line 35) + line 40)		0 4, 642, 250	40.

	ATION OF INPATIENT OPERATING COST		Provider C		Period: From 07/01/2020	Worksheet D-1	
					To 06/30/2021		
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Costl	Total npatient Days	Average Per Diem (col. 1 col. 2)	5	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	-
. 00	NURSERY (title V & XIX only)	0	0	0.0	0 0	0	42.
	Intensive Care Type Inpatient Hospital Units	0.044.477				7 400 500	1
00	INTENSIVE CARE UNIT	9, 314, 677	4, 579	2,034.2	3, 495	7, 109, 599	
00 00	CORONARY CARE UNI T BURN INTENSIVE CARE UNI T						44.
00	SURGI CAL I NTENSI VE CARE UNI T						46
	OTHER SPECIAL CARE (SPECIFY)						47
	Cost Center Description					1.00	
00	Program inpatient ancillary service cost (Wks	st D_3 col 3	line 200)	-		1.00 8,908,478	48
00	Total Program inpatient costs (sum of lines			ns)		20, 660, 327	
	PASS THROUGH COST ADJUSTMENTS	<u></u>					
00	Pass through costs applicable to Program inpa	atient routine :	services (from	ı Wkst. D, sum	of Parts I and	450, 235	50
00)	stiont oncillor	(comulaco (fr	am Wkat D	um of Dorto II	202 414	E1
00	Pass through costs applicable to Program inpa and IV)	atient anci i arț	y services (Tr	UNI WKST. D, S	oun of Parts II	282, 416	51
00	Total Program excludable cost (sum of lines !	50 and 51)				732, 651	52
00	Total Program inpatient operating cost exclude	ding capital re	ated, non-phy	sician anesth	etist, and	19, 927, 676	
	medical education costs (line 49 minus line !	52)					
00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54
00	Target amount per discharge					0.00	
00	Target amount (line 54 x line 55)					0	56
00	Difference between adjusted inpatient operati	ing cost and ta	rget amount (I	ine 56 minus	line 53)	0	
00	Bonus payment (see instructions)					0	
00	Lesser of lines 53/54 or 55 from the cost rep market basket	borting period (ending 1996, u	poated and co	mpounded by the	0.00	59
00	Lesser of lines 53/54 or 55 from prior year of	cost report, up	dated by the m	arket basket		0.00	60
00	If line 53/54 is less than the lower of lines					0	61
	which operating costs (line 53) are less than		s (lines 54 x	60), or 1% of	the target		
00	amount (line 56), otherwise enter zero (see i Relief payment (see instructions)	nstructions)				0	62
00	Allowable Inpatient cost plus incentive payme	ent (see instru	ctions)			0	
	PROGRAM INPATIENT ROUTINE SWING BED COST						
00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of the	e cost reporti	ng period (See	0	64
00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the c	ost reporting	period (See	0	65
00	instructions) (title XVIII only)			ost reporting			
00	Total Medicare swing-bed SNF inpatient routin	ne costs (line (64 plus line 6	5)(title XVII	l only). For	0	66
~~	CAH (see instructions)		D	£ +b +			
00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through	December 31 0	or the cost re	eporting period	0	67
00	Title V or XIX swing-bed NF inpatient routine	e costs after D	ecember 31 of	the cost repo	orting period	0	68
	(line 13 x line 20)						
00	Total title V or XIX swing-bed NF inpatient			,		0	69
00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facili						70
00	Adjusted general inpatient routine service of						71
00	Program routine service cost (line 9 x line	71)					72
00	Medically necessary private room cost applica	U U	•	,			73
00 00	Total Program general inpatient routine servi				Part II column		74
00	Capital-related cost allocated to inpatient (26, line 45)	outine service	COSTS (ITOIN W	ULKSHEEL D, P			/5
00	Per diem capital-related costs (line 75 ÷ lin	ne 2)					76
00	Program capital-related costs (line 9 x line						77
00	Inpatient routine service cost (line 74 minus	,	covidor record	le)			78
00 00	Aggregate charges to beneficiaries for excess Total Program routine service costs for compa			· · · · · · · · · · · · · · · · · · ·	us line 79)		79
00	Inpatient routine service cost per diem limit						81
00	Inpatient routine service cost limitation (li)				82
00	Reasonable inpatient routine service costs (s		s)				83
00	Program inpatient ancillary services (see ins		ac)				84
00 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85
50	PART IV - COMPUTATION OF OBSERVATION BED PASS		sagn 00)			1	
00	Total observation bed days (see instructions))				1, 090	
00	Adjusted general inpatient routine cost per o		line 2)			1, 198. 00	
00	Observation bed cost (line 87 x line 88) (see					1, 305, 820	

Health Financial Systems A	SCENSION ST. V	INCENT ANDERSON		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider C		Period: From 07/01/2020	Worksheet D-1	
				To 06/30/2021	Date/Time Pre 11/23/2021 1::	
		Titl€	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, 159, 92	7 26, 681, 960	0. 04347	2 1, 305, 820	56, 767	90.00
91.00 Nursing School cost		26, 681, 960	0. 00000	0 1, 305, 820	0	91.00
92.00 Allied health cost		26, 681, 960	0. 00000	0 1, 305, 820	0	92.00
93.00 All other Medical Education		26, 681, 960	0. 00000	0 1, 305, 820	0	93.00

MPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0088 Component CCN: 15-T088	Peri od: From 07/01/2020 To 06/30/2021 Subprovi der -	Worksheet D-1 Date/Time Pre 11/23/2021 1:: PPS	pare
	Cost Center Description		I RF	PPS	
	·			1.00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				-
00	Inpatient days (including private room days and swing-bed day	vs excluding newborn)		2,604	1 1.
00	Inpatient days (including private room days, excluding swing-			2,604	
00	Private room days (excluding swing-bed and observation bed da		ivate room days,	0	
	do not complete this line.				
00	Semi-private room days (excluding swing-bed and observation b		- 01 -6	2, 604	4
00	Total swing-bed SNF type inpatient days (including private ro reporting period	oom days) through Decembe	r 31 of the cost	0	5
00	Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6
	reporting period (if calendar year, enter 0 on this line)			-	
00	Total swing-bed NF type inpatient days (including private roo	om days) through December	31 of the cost	0	7
	reporting period				
00	Total swing-bed NF type inpatient days (including private roo reporting period (if calendar year, enter 0 on this line)	om days) after December 3	1 of the cost	0	8
00	Total inpatient days including private room days applicable 1	to the Program (excluding	swing-bed and	1, 125	9
	newborn days) (see instructions)		, ing ibu and	., .20	Ĺ
. 00	Swing-bed SNF type inpatient days applicable to title XVIII of		oom days)	0	10
	through December 31 of the cost reporting period (see instruct				
00	Swing-bed SNF type inpatient days applicable to title XVIII of December 31 of the cost reporting period (if calendar year, e		oom days) arter	0	11
. 00	Swing-bed NF type inpatient days applicable to titles V or XI		e room days)	0	12
	through December 31 of the cost reporting period	3 . 0 .	3 ,	0	
. 00	Swing-bed NF type inpatient days applicable to titles V or XI			0	13
~ ~	after December 31 of the cost reporting period (if calendar y				
	Medically necessary private room days applicable to the Progr	ram (excluding swing-bed	days)	0	
	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	
. 00	SWING BED ADJUSTMENT		I	0	1 10
. 00	Medicare rate for swing-bed SNF services applicable to service	ces through December 31 o	f the cost	0.00	17
	reporting period				
. 00	Medicare rate for swing-bed SNF services applicable to servic	ces after December 31 of	the cost	0.00	18
. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	es through December 31 of	the cost	0.00	19
	reporting period			0100	
. 00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of t	he cost	0.00	20
~~	reporting period	、 、		0 5 (0 01 0	0.1
. 00 . 00	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decemb		ing pariod (line	2, 560, 012 0	
. 00	5 x line 17)	bei 31 01 the cost report	riig period (rine	0	22
. 00	Swing-bed cost applicable to SNF type services after December	r 31 of the cost reportin	g period (line 6	0	23
	x line 18)				
. 00	Swing-bed cost applicable to NF type services through December	er 31 of the cost reporti	ng period (line	0	24
. 00	7 x line 19) Swing had cost applicable to NE type conviges after December	21 of the cost reporting	pariod (line 9	0	25
. 00	Swing-bed cost applicable to NF type services after December x line 20)	ST OF the cost reporting	period (Trile o	0	25
. 00	Total swing-bed cost (see instructions)			0	26
. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		2, 560, 012	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
	General inpatient routine service charges (excluding swing-be	ed and observation bed ch	arges)	0	
	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	
	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0. 000000	
	Average private room per diem charge (line 29 ÷ line 3)	- /		0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
	Average per diem private room charge differential (line 32 mi		tions)	0.00	
	Average per diem private room cost differential (line $34 \times 1i$	ine 31)		0.00	
. 00 . 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	0 2, 560, 012	
. 00	27 minus line 36)	and private room cost ur		2, 300, 012	37
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ				
				000 44	1 20
00	Adjusted general inpatient routine service cost per diem (see			983.11	
00 00		e 38)		983. 11 1, 105, 999 0	39

OMPUT	Financial Systems A ATION OF INPATIENT OPERATING COST		Provider C	CN: 15-0088	Period: From 07/01/2020	eu of Form CMS- Worksheet D-1	
			Component	CCN: 15-T088	To 06/30/2021	Date/Time Pre	
			Title	e XVIII	Subprovi der –	11/23/2021 1: PPS	22
	Cost Center Description	Total	Total	Average Per	IRF Program Days	Program Cost	
	cost center bescription	Inpatient Cost	Inpatient Days	Diem (col. 1 col. 2)	÷	(col. 3 x col. 4)	
00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00 00 C	5.00) 42
. 00	Intensive Care Type Inpatient Hospital Units		0	0.		<u>/</u>	42
. 00	INTENSIVE CARE UNIT	0	0	0.	00 C) C	
. 00 . 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44
. 00	SURGI CAL I NTENSI VE CARE UNI T						40
. 00	OTHER SPECIAL CARE (SPECIFY)						47
	Cost Center Description					1.00	
. 00	Program inpatient ancillary service cost (Wk	st. D-3. col. 3	. Line 200)			1.00 699,599	9 48
. 00	Total Program inpatient costs (sum of lines			ons)		1, 805, 598	
	PASS THROUGH COST ADJUSTMENTS						
. 00	Pass through costs applicable to Program inp	atient routine	services (from	i Wkst. D, su	m of Parts I and	60, 199	9 50
. 00	Pass through costs applicable to Program inp	atient ancillar	y services (fr	om Wkst. D,	sum of Parts II	26, 931	1 51
	and IV)		•				_
2.00 3.00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		lated non nhy	cician anost	botict and	87, 130	
,. 00	medical education costs (line 49 minus line		τάτου, ποπ-μηγ	sician anest	notist, anu	1, 718, 468	1 33
	TARGET AMOUNT AND LIMIT COMPUTATION					1	
. 00 . 00	Program discharges Target amount per discharge					0.00	
. 00	Target amount (line 54 x line 55)					0.00	
. 00	Difference between adjusted inpatient operat	ing cost and ta	rget amount (I	ine 56 minus	line 53)	0	
. 00	Bonus payment (see instructions)					0	
. 00	Lesser of lines 53/54 or 55 from the cost re market basket	porting period	ending 1996, u	pdated and c	ompounded by the	0.00	59
. 00	Lesser of lines 53/54 or 55 from prior year	cost report, up	dated by the m	narket basket		0.00	60
. 00	If line 53/54 is less than the lower of line					C) 6'
	which operating costs (line 53) are less tha amount (line 56), otherwise enter zero (see		s (lines 54 x	60), or 1% o	f the target		
. 00	Relief payment (see instructions)					0	62
. 00	Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)			C) 63
. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Doco	mbor 21 of the		ing pariod (Saa	0	0 64
. 00	instructions) (title XVIII only)	tis through bece		cost report	ing period (see		
6. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the c	ost reportin	g period (See	C	65
. 00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi</pre>	ne costs (line	64 nlus line 6	5)(title XVI	ll only) For		66
. 00	CAH (see instructions)			S)(the xi	rr onry). ron		
. 00	Title V or XIX swing-bed NF inpatient routin	e costs through	December 31 c	of the cost r	eporting period	0	67
3. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	e costs after D	ecember 31 of	the cost ren	orting period	0	68
5.00	(line 13 x line 20)			the cost rep	or tring period		
. 00	Total title V or XIX swing-bed NF inpatient						69
0. 00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil)		70
. 00	Adjusted general inpatient routine service c	3)		71
. 00	Program routine service cost (line 9 x line						72
. 00	Medically necessary private room cost applic Total Program general inpatient routine serv	0	•				73
. 00	Capital -related cost allocated to inpatient				Part II, column		75
	26, line 45)				,		
. 00 . 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76
. 00	Inpatient routine service cost (line 74 minu						78
00	Aggregate charges to beneficiaries for exces		rovider record	ls)			79
. 00	Total Program routine service costs for comp		ost limitation	line 78 mi	nus line 79)		80
. 00 . 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I)				81
. 00	Reasonable inpatient routine service cost (83
. 00	Program inpatient ancillary services (see in	istructions)					84
. 00	Utilization review - physician compensation						85
. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PAS					I	86
. 00	Total observation bed days (see instructions					0	0 87
3.00	Adjusted general inpatient routine cost per		line 2)			0.00	
(10)	Observation bed cost (line 87 x line 88) (se	e instructions)				1 0	8 (0

Health Financial Systems A	SCENSION ST.	VINC	ENT ANDERSON		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST			Provider CC		Period: From 07/01/2020	Worksheet D-1	
			Component (CCN: 15-T088	To 06/30/2021	Date/Time Pre 11/23/2021 1:	
			Title	XVIII	Subprovider - IRF	PPS	
Cost Center Description	Cost	R	outine Cost	column 1 ÷	Total	Observati on	
		(f	rom 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	139, 3	44	2, 560, 012	0. 05443	31 0	0	90.00
91.00 Nursing School cost		0	2, 560, 012	0.00000	0 0	0	91.00
92.00 Allied health cost		0	2, 560, 012	0.0000	0 0	0	92.00
93.00 All other Medical Education		0	2, 560, 012	0.0000	0 0	0	93.00

ASCENSI ON S	ST. V	I NCE	NT A	١ND	ERS(DN	
			-				 _

	Financial Systems ASCENSION ST. VINC ATION OF INPATIENT OPERATING COST	ENT ANDERSON Provider CCN: 15-0088	In Lie Period:	u of Form CMS-: Worksheet D-1	
			From 07/01/2020 To 06/30/2021	Date/Time Pre 11/23/2021 1:	
	Cost Center Description	Title XIX	Hospi tal	Cost	
	cost center bescription			1.00	
	PART I - ALL PROVIDER COMPONENTS				-
1.00	INPATIENT DAYS Inpatient days (including private room days and swing-bed day	s. excluding newborn)		22, 272	1.00
2.00 3.00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed da	bed and newborn days)	ivate room days,	22, 272 0	2.00 3.00
4.00 5.00	do not complete this line. Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro		r 31 of the cost	21, 182 0	4.00 5.00
6.00	reporting period Total swing-bed SNF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line)	om days) after December	31 of the cost	0	6.00
7.00	Total swing-bed NF type inpatient days (including private roo reporting period	m days) through December	31 of the cost	0	7.00
8.00	Total swing-bed NF type inpatient days (including private roo reporting period (if calendar year, enter 0 on this line)	5.1		0	8.00
9.00	Total inpatient days including private room days applicable t newborn days) (see instructions)	5 . 5	5	1, 229	
10. 00 11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o through December 31 of the cost reporting period (see instruc Swing-bed SNF type inpatient days applicable to title XVIII o	tions)	5	0	
12.00	December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to titles V or XI	nter 0 on this line)	5 .	0	
	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI	X only (including privat	e room days)	0	
	after December 31 of the cost reporting period (if calendar y Medically necessary private room days applicable to the Progr	ear, enter 0 on this lin am (excluding swing-bed	e) days)	0	
	Total nursery days (title V or XIX only) Nursery days (title V or XIX only) SWING BED ADJUSTMENT			643 513	1
17.00	Medicare rate for swing-bed SNF services applicable to servic reporting period	es through December 31 c	f the cost	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to servic reporting period	es after December 31 of	the cost	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to service reporting period	s through December 31 of	the cost	0.00	19.00
	Medicaid rate for swing-bed NF services applicable to service reporting period		he cost	0.00	
21. 00 22. 00	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decemb 5 x line 17)		ing period (line	26, 681, 960 0	1
23.00	Swing-bed cost applicable to SNF type services after December x line 18) $$		51 (0	23.00
	Swing-bed cost applicable to NF type services through Decembe 7 x line 19)		0 1 1	0	
25.00	Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions)	31 of the cost reporting	period (line 8	0	
	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		26, 681, 960	
	General inpatient routine service charges (excluding swing-be	d and observation bed ch	arges)	0	
29.00 30.00	Private room charges (excluding swing-bed charges)			0	29.00 30.00
30.00 31.00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	÷line 28)		0. 000000	1
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.000000	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
	Average per diem private room charge differential (line 32 mi	nus line 33)(see instruc	tions)	0.00	
35.00	Average per diem private room cost differential (line 34 x li		<i>,</i>	0.00	
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 27 minus line 36)	and private room cost di	fferential (line	26, 681, 960	1
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				-
38.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ			1 100 00	38.00
	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line			1, 198. 00 1, 472, 342	
	Medically necessary private room cost applicable to the Progr	-		1, 472, 342	
	Total Program general inpatient routine service cost (line 39			1, 472, 342	1

MPUT	ATION OF INPATIENT OPERATING COST		Provider CO	CN: 15-0088	Peri od:	Worksheet D-1	
					From 07/01/2020 To 06/30/2021	Date/Time Pre 11/23/2021 1:	
				e XIX	Hospi tal	Cost	
	Cost Center Description	Total Inpatient Costl	Total	Average Per		Program Cost (col. 3 x col.	
			npatrent bays	col. 2)	-	4)	
		1.00	2.00	3.00	4.00	5.00	
. 00	NURSERY (title V & XIX only)	578, 528	643	899.	73 513		42.
	Intensive Care Type Inpatient Hospital Units						
. 00	INTENSIVE CARE UNIT	9, 314, 677	4, 579	2,034.2	22 138	280, 722	43.
. 00	CORONARY CARE UNIT						44.
. 00	BURN INTENSIVE CARE UNIT						45
. 00	SURGICAL INTENSIVE CARE UNIT						46
. 00	OTHER SPECIAL CARE (SPECIFY)						47
	Cost Center Description					1 00	
. 00	Program inpatient ancillary service cost (Wks	st D-3 col 3	line 200)			1.00 1,995,167	48
. 00	Total Program inpatient costs (sum of lines			ns)		4, 209, 792	
00	PASS THROUGH COST ADJUSTMENTS			113)		4,207,172	/
. 00	Pass through costs applicable to Program inpa	atient routine s	services (from	Wkst. D. sur	of Parts I and	0	50
. 00	Pass through costs applicable to Program inpa	atient ancillary	/ services (fr	om Wkst. D, s	sum of Parts II	0	51
	and IV)						
. 00	Total Program excludable cost (sum of lines !					0	
. 00	Total Program inpatient operating cost exclud		ated, non-phy	si ci an anestr	netist, and	0	53
	medical education costs (line 49 minus line 5 TARGET AMOUNT AND LIMIT COMPUTATION	JZ J					-
. 00	Program di scharges					0	54
. 00	Target amount per discharge					0.00	
. 00	Target amount (line 54 x line 55)					0.00	
. 00	Difference between adjusted inpatient operati	ing cost and tar	rget amount (l	ine 56 minus	line 53)	0	
. 00	Bonus payment (see instructions)		g			0	
. 00	Lesser of lines 53/54 or 55 from the cost rep	porting period e	ending 1996, u	pdated and co	ompounded by the	0.00	
	market basket	5 1	5		, ,		
. 00	Lesser of lines 53/54 or 55 from prior year of					0.00	60
. 00	If line 53/54 is less than the lower of line					0	61
	which operating costs (line 53) are less than		s (lines 54 x	60), or 1% of	f the target		
~~	amount (line 56), otherwise enter zero (see i	instructions)					
. 00	Relief payment (see instructions)	ant (and instruc	ti ana)			0	
. 00	Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST					0	63
. 00	Medicare swing-bed SNF inpatient routine cost	ts through Decem	ber 31 of the	cost reporti	na period (See	0	64
	instructions) (title XVIII only)	to through booon		0001 10001 11	ng por rou (occ	0	
. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decembe	er 31 of the c	ost reporting	period (See	0	65
	instructions)(title XVIII only)						
. 00	Total Medicare swing-bed SNF inpatient routin	ne costs (line 6	64 plus line 6	5)(title XVII	l only). For	0	66
	CAH (see instructions)						
. 00	Title V or XIX swing-bed NF inpatient routine	e costs through	December 31 o	f the cost re	eporting period	0	67
00	(line 12 x line 19)	a anata aftar Da	combor 11 of	the east read	sting pariod	0	1 40
. 00	Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)	e costs after De	ecember 31 01	the cost repo	bring period	0	68
. 00	Total title V or XIX swing-bed NF inpatient	routine costs (l	ine 67 + line	68)		0	69
	PART III - SKILLED NURSING FACILITY, OTHER NU	`		/			
. 00	Skilled nursing facility/other nursing facili	ty/ICF/IID rout	tine service c	ost (line 37)			70
. 00	Adjusted general inpatient routine service co						71
. 00	Program routine service cost (line 9 x line	71)					72
. 00	Medically necessary private room cost application	able to Program	(line 14 x li	ne 35)			73
. 00	Total Program general inpatient routine servi						74
. 00	Capital-related cost allocated to inpatient	routine service	costs (from W	orksheet B, F	Part II, column		75
00	26, line 45)	22.2)					
. 00	Per diem capital related costs (line 75 ÷ lin						76
. 00	Program capital -related costs (line 9 x line	,					77
. 00	Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess		ovider record	c)			79
00	Total Program routine service costs for compa			•	nus line 79)		80
00	Inpatient routine service cost per diem limit						81
00	Inpatient routine service cost per dicimitation (li)				82
00	Reasonable inpatient routine service costs (83
. 00	Program inpatient ancillary services (see ins		,				84
. 00	Utilization review - physician compensation		ıs)				85
. 00	Total Program inpatient operating costs (sum						86
	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST					
. 00	Total observation bed days (see instructions)					1, 090	
	Adjusted general inpatient routine cost per o	diem (line 27 ÷	line 2)			1, 198. 00	88
. 00 . 00	Observation bed cost (line 87 x line 88) (see	•				1, 305, 820	

Health Financial Systems At	SCENSION ST. V	INCENT ANDERSO	N	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider (Peri od:	Worksheet D-1	
				From 07/01/2020 To 06/30/2021	Date/Time Pre 11/23/2021 1:	
		Tit	le XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)) column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST	·				
90.00 Capital-related cost	1, 159, 92	7 26, 681, 960	0. 04347	2 1, 305, 820	56, 767	90.00
91.00 Nursing School cost		0 26, 681, 960	0. 00000	1, 305, 820	0	91.00
92.00 Allied health cost		0 26, 681, 960	0. 00000	1, 305, 820	0	92.00
93.00 All other Medical Education		0 26, 681, 960	0.00000	1, 305, 820	0	93.00

MPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0088 Component CCN: 15-T088	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prep 11/23/2021 1:2	pare
		Title XIX	Subprovider - IRF	Cost	
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS				
00	INPATIENT DAYS Inpatient days (including private room days and swing-bed day	vs excluding newborn)		2, 604	1.
00	Inpatient days (including private room days and swing bed day Inpatient days (including private room days, excluding swing-			2,604	2.
00	Private room days (excluding swing-bed and observation bed da	5,	ivate room days,	0	3.
	do not complete this line.				
00 00	Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro		r 21 of the cost	2, 604	4
50	reporting period	Join days) thi ough beceinbe	I SI UI LIE COSL	0	
00	Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6
	reporting period (if calendar year, enter 0 on this line)	-			
00	Total swing-bed NF type inpatient days (including private roo	om days) through December	31 of the cost	0	7
00	reporting period Total swing-bed NF type inpatient days (including private roo	om davs) after December 3	1 of the cost	0	8
50	reporting period (if calendar year, enter 0 on this line)	ulter becember 5		0	
00	Total inpatient days including private room days applicable t	to the Program (excluding	swing-bed and	38	9
. -	newborn days) (see instructions)				
. 00	Swing-bed SNF type inpatient days applicable to title XVIII of through December 31 of the cost reporting period (see instruct		oom days)	0	10
. 00	Swing-bed SNF type inpatient days applicable to title XVIII of		oom days) after	0	11
	December 31 of the cost reporting period (if calendar year, e			-	
. 00	Swing-bed NF type inpatient days applicable to titles V or XI	IX only (including privat	e room days)	0	12
00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI	V oply (including privat	a raam daya)	0	12
. 00	after December 31 of the cost reporting period (if calendar y			0	13
. 00	Medically necessary private room days applicable to the Progr			0	14
	Total nursery days (title V or XIX only)	. 5 5	5,	643	15
. 00	Nursery days (title V or XIX only)			513	16
. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to servic	and through December 21 a	f the cost	0.00	17
. 00	reporting period	ces through becember 31 0	T the cost	0.00	''
. 00	Medicare rate for swing-bed SNF services applicable to service	ces after December 31 of	the cost	0.00	18
	reporting period				
. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	es through December 31 of	the cost	0.00	19
. 00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of t	he cost	0.00	20
	reporting period				
. 00	Total general inpatient routine service cost (see instruction			2, 560, 012	
. 00	Swing-bed cost applicable to SNF type services through Decemb 5 x line 17)	ber 31 of the cost report	ing period (line	0	22
. 00	Swing-bed cost applicable to SNF type services after December	r 31 of the cost reportin	a period (line 6	0	23
	x line 18)		g por lou (i i i o o		
. 00	Swing-bed cost applicable to NF type services through Decembe	er 31 of the cost reporti	ng period (line	0	24
00	7 x line 19)				0.5
. 00	Swing-bed cost applicable to NF type services after December x line 20)	31 OF the cost reporting	period (The 8	0	25
. 00	Total swing-bed cost (see instructions)			0	26
. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		2, 560, 012	27
00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
	General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges)	ed and observation bed ch	arges)	0	
. 00	Semi-private room charges (excluding swing-bed charges)			0	
	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0. 000000	
. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32
	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
	Average per diem private room charge differential (line 32 mi		tions)	0.00	
. 00	Average per diem private room cost differential (line 34 x li	1110 31)		0.00 0	
. 00 . 00	Private room cost differential adjustment (line 3 x line 35)			2, 560, 012	
. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (linel		
. 00 . 00 . 00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost di	fferential (line	_,	
00 00 00	General inpatient routine service cost net of swing-bed cost 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY		fferential (line	_,	
. 00 . 00 . 00 . 00	General inpatient routine service cost net of swing-bed cost 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	JUSTMENTS			
. 00 . 00 . 00 . 00	General inpatient routine service cost net of swing-bed cost 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ Adjusted general inpatient routine service cost per diem (see	JUSTMENTS e instructions)		983. 11	38
. 00 . 00 . 00 . 00	General inpatient routine service cost net of swing-bed cost 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	JUSTMENTS e instructions) e 38)			38 39

OMPUT	Financial Systems AS ATION OF INPATIENT OPERATING COST	CENSION ST. VI	Provider C		Peri od:	eu of Form CMS- Worksheet D-1	
			Component	CCN: 15-T088	From 07/01/2020 To 06/30/2021	Date/Time Pre	
			Titl	e XIX	Subprovider -	11/23/2021 1: Cost	22 p
	Cost Center Description	Total	Total	Average Pe	IRF Program Days	Program Cost	
	·	Inpatient Cost	Inpatient Days			(col. 3 x col. 4)	
	F	1.00	2.00	3.00	4.00	5.00	
2. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0.	00 0	C) 42.
8.00	INTENSIVE CARE UNIT	0	C	0.	00 0	C	43.
. 00	CORONARY CARE UNIT						44
. 00 . 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45
. 00 . 00	OTHER SPECIAL CARE (SPECIFY)						47
	Cost Center Description					1.00	
. 00	Program inpatient ancillary service cost (Wks	st. D-3, col. 3	, line 200)			1.00	2 48
. 00	Total Program inpatient costs (sum of lines 4			ons)		93, 880) 49
. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpa	atient routine	services (from	n Wkst. D, su	m of Parts I and	C	50
00							
. 00	Pass through costs applicable to Program inpa and IV)	atient anciiar	y services (fr	OM WKST. D,	sum of Parts II	C) 51
2.00	Total Program excludable cost (sum of lines !					C	
8. 00	Total Program inpatient operating cost exclud medical education costs (line 49 minus line 5		elated, non-phy	sician anest	hetist, and	C	53
	TARGET AMOUNT AND LIMIT COMPUTATION	/				1	
. 00 . 00	Program discharges Target amount per discharge					0.00	
. 00	Target amount (line 54 x line 55)					0.00	
. 00	Difference between adjusted inpatient operati	ng cost and ta	irget amount (I	ine 56 minus	line 53)	C	
. 00	Bonus payment (see instructions)					C	
. 00	Lesser of lines 53/54 or 55 from the cost rep market basket	porting period	ending 1996, L	ipdated and c	ompounded by the	0.00	59
. 00	Lesser of lines 53/54 or 55 from prior year of	cost report, up	dated by the m	narket basket		0.00	60
. 00	If line 53/54 is less than the lower of lines					C) 61
	which operating costs (line 53) are less than amount (line 56), otherwise enter zero (see i		is (lines 54 x	60), or 1% c	f the target		
2. 00	Relief payment (see instructions)	hotr dotronoy				c c	62
. 00	Allowable Inpatient cost plus incentive payme	ent (see instru	ictions)			C	63
. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cost	ts through Dece	mber 31 of the	e cost report	ing period (See	l c	64
	instructions)(title XVIII only)	0		•	0.1		
5.00	Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only)	ts after Decemb	er 31 of the c	cost reportin	g period (See	C) 65
. 00	Total Medicare swing-bed SNF inpatient routin	ne costs (line	64 plus line 6	5)(title XVI	II only). For	C	66
7.00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routine	a costa through	December 21	f the cost r	operting period		67
. 00	(line 12 x line 19)	e costs through	December 31 C	in the cost i	eporting period		
8. 00	Title V or XIX swing-bed NF inpatient routine	e costs after D	ecember 31 of	the cost rep	orting period	C	68
. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient n	routine costs (line 67 + line	e 68)		C) 69
	PART III - SKILLED NURSING FACILITY, OTHER NU					1	
0. 00 . 00	Skilled nursing facility/other nursing facili Adjusted general inpatient routine service co)		70
. 00	Program routine service cost (line 9 x line 1		The 70 ÷ The	2)			72
. 00	Medically necessary private room cost applica	able to Program	n (line 14 x li	ne 35)			73
. 00	Total Program general inpatient routine servi				Dort II oolumn		74
. 00	Capital-related cost allocated to inpatient r 26, line 45)	outine service	COSIS (ITOM W	IOFKSheet B,	Part II, corumn		/5
. 00	Per diem capital-related costs (line 75 ÷ lin						76
. 00 . 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus						77
. 00	Aggregate charges to beneficiaries for excess		orovider record	ls)			79
. 00	Total Program routine service costs for compa	arison to the c			nus line 79)		80
. 00	Inpatient routine service cost per diem limit		`				81
2.00 3.00	Inpatient routine service cost limitation (li Reasonable inpatient routine service costs (s						82
. 00	Program inpatient ancillary services (see ins		/				84
5.00	Utilization review - physician compensation	(see instructio					85
. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		rough 85)				86
. 00	Total observation bed days (see instructions)					C	87
3. 00	Adjusted general inpatient routine cost per o	diem (line 27 ÷				0.00	88 0
00	Observation bed cost (line 87 x line 88) (see	e instructions)				[C) 89

Health Financial Systems A	SCENSION ST.	VINCE	ENT ANDERSON		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST			Provider CC		Period: From 07/01/2020	Worksheet D-1	
			Component (To 06/30/2021	Date/Time Pre 11/23/2021 1:2	oared: 22 pm
			Titl	e XIX	Subprovider - IRF	Cost	
Cost Center Description	Cost	R	outine Cost	column 1 ÷	Total	Observati on	
		(fi	rom 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	139, 3	44	2, 560, 012	0. 05443	31 0	0	90.00
91.00 Nursing School cost		0	2, 560, 012	0.00000	0 0	0	91.00
92.00 Allied health cost		0	2, 560, 012	0.0000	0 0	0	92.00
93.00 All other Medical Education		0	2, 560, 012	0.00000	0 0	0	93.00

Health Financial Systems ASCENSION ST. VIN	CENT ANDERSON	l	In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0088	Period:	Worksheet D-3	
			From 07/01/2020 To 06/30/2021	Date/Time Pre 11/23/2021 1:	pared: 22 pm
	Title	e XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1			
30. 00 03000 ADULTS & PEDI ATRI CS			7, 102, 832		30.00
31.00 03100 I NTENSI VE CARE UNI T			10, 987, 087		31.00
41. 00 04100 SUBPROVI DER - I RF			0		41.00
43. 00 04300 NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS		0.1(00)		1 477 (04	
50. 00 05000 OPERATING ROOM 52. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 16980		1, 477, 694	
52. 00 05200 DELIVERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESIOLOGY				2,039	•
53. 00 105300 ANESTHESTOLOGY 54. 00 105400 RADI OLOGY-DI AGNOSTI C		0.0000		222 505	
54. 00 105400 RADIOLOGY-DIAGNOSTIC 54. 01 103440 MAMMOGRAPHY		0. 28243		332, 505	•
54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC		0. 19182		0 33, 523	
54. 02 103430 NUCLEAR MEDICINE - DIAGNOSTIC 54. 03 103630 ULTRA SOUND		0.09432		39,017	
55. 00 05500 RADI OLOGY-THERAPEUTI C		0.09946		4, 052	
57. 00 05700 CT_SCAN		0. 09940		4, 052 96, 113	
57.00 105700 CT SCAN 58.00 105800 MAGNETIC RESONANCE IMAGING (MRI)		0. 29904		47, 727	
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 09800		157, 923	
60. 00 06000 LABORATORY		0. 12206		1, 199, 823	•
65. 00 06500 RESPI RATORY THERAPY		0. 13217		544, 986	•
66. 00 06600 PHYSI CAL THERAPY		0. 39830		259, 554	
67. 00 06700 OCCUPATI ONAL THERAPY		0. 44015		139, 183	
68. 00 06800 SPEECH PATHOLOGY		0. 43964		24, 220	
69. 00 06900 ELECTROCARDI OLOGY		0. 30529		0	1
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 17968		12, 436	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 2697		684, 736	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0.35008		954, 280	•
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 29823		2, 300, 529	
76.00 03190 CHEMOTHERAPY		0. 18726		3, 568	
76. 01 03020 WOUND CARE		0. 37689	5,048	1, 903	
OUTPATIENT SERVICE COST CENTERS		•		· · ·	1
90. 00 09000 CLINIC		0.0000	0 00	0	90.00
90.01 09001 ANDERSON OUTPATIENT CENTER		0. 44432	20 0	0	90.01
90. 02 04950 DIABETIC EDUCATION		0.0000	0 0	0	90.02
90. 03 09002 MS CLINIC		0.00000	0 0	0	90.03
91. 00 09100 EMERGENCY		0. 11072	5, 352, 844	592, 667	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0.47209	94 0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95. 00 09500 AMBULANCE SERVICES					95.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)			47, 017, 128	8, 908, 478	
201.00 Less PBP Clinic Laboratory Services-Program only charge	es (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)		1	47, 017, 128		202.00

	Financial Systems ASCENSION ST. VIN ENT ANCILLARY SERVICE COST APPORTIONMENT			Peri od:	u of Form CMS-2 Worksheet D-3	
INFAII	ENT ANGIELART SERVICE COST AFFORTIONMENT	FIOVIDEI C		From 07/01/2020	WOLKSHEEL D-3	
		Component		To 06/30/2021	Date/Time Pre 11/23/2021 1:	pared: 22 pm
		Title	e XVIII	Subprovider -	PPS	
	Cost Center Description		Ratio of Cos		Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
			1.00	2.00	2)	
	INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30.00	03000 ADULTS & PEDIATRICS		1			30.00
31.00	03100 INTENSIVE CARE UNIT					31.00
41.00	04100 SUBPROVIDER - IRF			1 000 010		41.00
41.00				1, 880, 218		41.00
43.00	ANCI LLARY SERVI CE COST CENTERS		1			43.00
50.00	05000 OPERATI NG ROOM		0. 16980	48, 301	8, 202	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		0. 58115		0, 202	52.00
53.00	05300 ANESTHESI OLOGY		0. 00000		0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 28243		12,039	
54.00	03440 MAMOGRAPHY		0. 28243		12,039	54.0
54.01	03450 NUCLEAR MEDICINE - DIAGNOSTIC		0. 19182		671	54.02
54.02	03630 ULTRA SOUND		0. 09069		3, 102	
55.00	05500 RADI OLOGY-THERAPEUTI C		0. 09946		3, 102	55.00
57.00	05700 CT SCAN		0. 08452		2, 299	
58.00	05800 MAGNETIC RESONANCE I MAGI NG (MRI)		0. 29904		3, 977	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON		0. 09800		2, 103	
60.00	06000 LABORATORY		0. 12206		55, 544	
65.00	06500 RESPI RATORY THERAPY		0. 13217		15, 331	
66.00	06600 PHYSI CAL THERAPY		0. 39830		210, 030	
67.00	06700 OCCUPATI ONAL THERAPY		0. 44015		240, 768	
68.00	06800 SPEECH PATHOLOGY		0. 43964		59, 555	
69.00	06900 ELECTROCARDI OLOGY		0. 30529		0	69.0
70.00	07000 ELECTROENCEPHALOGRAPHY		0. 17968		2, 749	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 26977		15, 890	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS		0. 35008		3, 460	
73.00	07300 DRUGS CHARGED TO PATIENTS		0. 29823	209, 853	62, 585	73.0
76.00	03190 CHEMOTHERAPY		0. 18726		0	76.00
76.01	03020 WOUND CARE		0. 37689	0 0	0	76.0 [.]
	OUTPATIENT SERVICE COST CENTERS					1
90.00	09000 CLI NI C		0.00000	0 0	0	90.00
90. 01	09001 ANDERSON OUTPATIENT CENTER		0. 44432	20 0	0	90. 0 [.]
90. 02	04950 DI ABETI C EDUCATI ON		0.00000	0 0	0	90.0
90.03	09002 MS CLINIC		0.00000	0 0	0	90.03
91.00	09100 EMERGENCY		0. 11072	20 11, 687	1, 294	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 47209	04 0	0	92.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVI CES					95.00
200.00				2, 280, 632	699, 599	200.00
201.00	5 5 5 5	es (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)			2, 280, 632		202.00

leal th Financial Systems ASCENSION ST. VINCENT		N 45 0000		u of Form CMS-	
NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	ovider CC	CN: 15-0088	Period: From 07/01/2020	Worksheet D-3	
			To 06/30/2021	Date/Time Pre 11/23/2021 1:	
	Ti †I	e XIX	Hospi tal	Cost	22 piii
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
		J		(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
INPATI ENT ROUTI NE SERVI CE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			2, 247, 622		30.0
31. 00 03100 I NTENSI VE CARE UNI T			1, 271, 741		31.0
11.00 04100 SUBPROVIDER - IRF			0		41.0
43. 00 04300 NURSERY			190, 069		43.0
ANCI LLARY SERVI CE COST CENTERS		0.1(04	() 1 044 007	210,002	
50. 00 05000 OPERATI NG ROOM		0. 1684		310, 802	
52. 00 05200 DELIVERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY		0.5811		90, 873	
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C		0.0000		0	
54. 01 03400 MAMMOGRAPHY		0. 28243 0. 19183		113, 238 0	
54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC		0. 1918.		4, 318	1
54. 03 03630 ULTRA SOUND		0.0943		8, 046	
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 0908		1, 706	
57. 00 05700 CT SCAN		0. 0845		22, 709	
58. OO OS5800 MAGNETIC RESONANCE IMAGING (MRI)		0. 2990		18, 052	
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 0980		32, 761	
50. 00 06000 LABORATORY		0. 1220			
55. 00 06500 RESPI RATORY THERAPY		0. 1321		98, 142	
66.00 06600 PHYSI CAL THERAPY		0. 39830		33, 376	
57. 00 06700 OCCUPATI ONAL THERAPY		0. 4401		3, 109	
8. 00 06800 SPEECH PATHOLOGY		0. 4396		3, 851	
99. 00 06900 ELECTROCARDI OLOGY		0.3052		0	
0.00 07000 ELECTROENCEPHALOGRAPHY		0. 1796		5, 782	
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 2697		71, 216	71. (
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0.3500		191, 339	
3.00 07300 DRUGS CHARGED TO PATIENTS		0. 2982	32 1, 757, 765	524, 222	73.0
6. 00 03190 CHEMOTHERAPY		0. 1872	63 4, 568	855	76.0
6. 01 03020 WOUND CARE		0. 3768	90 355	134	76. (
OUTPATIENT SERVICE COST CENTERS					
0. 00 09000 CLINIC		0.0000			
0. 01 09001 ANDERSON OUTPATIENT CENTER		0.4443		134	
0. 02 04950 DIABETIC EDUCATION		0.0000		0	
0. 03 09002 MS CLINIC		0.0000		0	
1.00 09100 EMERGENCY		0. 1107:			
22.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 4720	94 0	0	92. (
OTHER REIMBURSABLE COST CENTERS					
25.00 09500 AMBULANCE SERVICES			40.404.555		95.0
Total (sum of lines 50 through 94 and 96 through 98)			10, 604, 180	1, 995, 167	
201.00 Less PBP Clinic Laboratory Services-Program only charges (I	ıne 61)		0		201.0
202.00 Net charges (line 200 minus line 201)			10, 604, 180		202.0

	ANCI LLARY SERVICE COST APPORTIONMENT	Provider C		Peri od:	u of Form CMS-2 Worksheet D-3	
	ANCIELARI SERVICE COST AFFORTIONWENT	FIOVICEI C		From 07/01/2020	WOLKSHEEL D-3	
		Component		To 06/30/2021	Date/Time Pre 11/23/2021 1:	
		Titl	e XIX	Subprovider - IRF	Cost	
	Cost Center Description		Ratio of Cos		Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
			1.00		2)	
			1.00	2.00	3.00	
	ATIENT ROUTINE SERVICE COST CENTERS					1 20 00
	00 ADULTS & PEDIATRICS					30.00
	00 I NTENSI VE CARE UNI T			101 (00		31.00
	00 SUBPROVIDER – IRF 00 NURSERY			191, 688		41.00
	I LLARY SERVICE COST CENTERS		I			43.00
	00 OPERATING ROOM		0. 16846	3 7, 180	1, 210	50.00
	OO DELIVERY ROOM & LABOR ROOM		0. 58115		1, 210	
	00 ANESTHESI OLOGY		0.00000		0	
	00 RADI OLOGY-DI AGNOSTI C		0. 28243		446	
	40 MAMMOGRAPHY		0. 19182		440	
	50 NUCLEAR MEDICINE - DIAGNOSTIC		0. 09432		0	
	30 ULTRA SOUND		0. 09069		127	
	00 RADI OLOGY-THERAPEUTI C		0. 09946		0	
	OO CT SCAN		0. 08452		72	
	00 MAGNETIC RESONANCE I MAGING (MRI)		0. 29904		0	
	00 CARDI AC CATHETERI ZATI ON		0.09800		0	59.00
	00 LABORATORY		0. 12206		3, 562	
65.00 065	00 RESPI RATORY THERAPY		0. 13217		0	65.00
66.00 066	00 PHYSI CAL THERAPY		0. 39830	49, 320	19, 644	66.0
67.00 067	00 OCCUPATI ONAL THERAPY		0. 44015	51, 996	22, 886	67.0
68.00 068	00 SPEECH PATHOLOGY		0. 43964	5 8, 990	3, 952	68.0
69.00 069	00 ELECTROCARDI OLOGY		0. 30529	0 0	0	69.0
70.00 070	00 ELECTROENCEPHALOGRAPHY		0. 17968	0 0	0	70.0
	00 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 26977		0	
	00 IMPL. DEV. CHARGED TO PATIENTS		0. 35008		0	1
	00 DRUGS CHARGED TO PATIENTS		0. 29823		4, 623	
	90 CHEMOTHERAPY		0. 18726		0	
	20 WOUND CARE		0. 37689	0 0	0	76.0
	PATIENT SERVICE COST CENTERS			-	-	
			0.00000		0	
	01 ANDERSON OUTPATIENT CENTER		0. 44432		0	
	50 DI ABETI C EDUCATI ON		0.00000		0	
			0.00000		0	
	00 EMERGENCY		0. 11072		0	
	00 OBSERVATION BEDS (NON-DISTINCT PART)		0. 47209	04 0	0	92.00
	ER REI MBURSABLE COST CENTERS OO AMBULANCE SERVI CES					95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)			144 005	56, 522	
200.00	Less PBP Clinic Laboratory Services-Program only charg	es (line 61)		166, 005	50, 5ZZ	200.00
						1211 11

To 0.6/30/2021 DuitorTime Prepare District Net 1110 Hospital Prepare Prepare 100 District Net Prepare 100 District Net District Net 101 District Net District Net 101 District Net District Net 101 District Net District Net 102 District Net District Net 103 District Net District Net 104 District Net District Net 105 District Net District Net 104 District Net District Net 105 District Net District Net 104 District Net District Net 105 District Net District Net 106 District Net District Net 107 District Net Distris 108		Financial Systems ASCENSION ST. VINCE ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0088	Period: From 07/01/2020	u of Form CMS-2 Worksheet E Part A	<u>2002-1</u>
Title X0111 HeapItal PFS 1.00 Title X01110 HeapItal PFS 1.01 DBG anounts Other Than Outliner payments 0 1 0					Date/Time Pre	
NAT A - INVATION FOOT TAL SERVICES UNDER IPPS 0 100 Bits downs to ther than outli or payments for discharges occurring prior to 0ctober 1 (see 3,600,952 1.00 Discounts other than outlier payments for discharges occurring on or atter 0ctober 1 (see 9,934,572 1.00 Discounts other than outlier payments for discharges occurring on or atter 0ctober 1 (see 9,934,572 1.00 Discounts other than outlier payments for discharges occurring on or atter 0 1.01 Discounts other than outlier payments for discharges occurring on or atter 0 1.02 Discounts other than outlier payments for discharges occurring on or atter 0 1.10 Discounts other than outlier payments for discharges occurring on or atter 0 1.10 Discount for discharges cocurring prior to 0ctober 1 1.20 Dittier payments for discharges cocurring prior to 0ctober 1 (see 1 2.00 Dittier payments for discharges cocurring prior to 0ctober 1 (see 0 2.01 Dittier payments for discharges cocurring prior to 0ctober 1 (see 1 2.02 Dittier payments for discharges cocurring prior to 0ctober 1 (see 1 2.02 Dittier payments for discharges cocurring prior to 0ctober 1 (see 1 2.00 Dittier payments for discharges cocurring prior to 0ctober 1 (see 1 2.00 Dittier payments for discharges cocu			Title XVIII	Hospi tal		
PART A - INVATION ROSPITAL SERVICES UNDER IPPS 0 100 Bick Accounts Other than outlier payments for discharges occurring prior to October 1 (see 3,600,952 1. 1.101 DRG accounts other than outlier payments for discharges occurring on or after October 1 (see 9,934,572 1. 1.202 DRG accounts other than outlier payments for discharges occurring on or after October 1 (see 9,934,572 1. 1.302 DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after 0 october 1 (see instructions) 0 1.402 Dutlier payments for discharges (see instructions) 0 2.000 Qutlier payments for discharges occurring prior to October 1 (see instructions) 0 2.01 Qutlier payments for discharges occurring prior to October 1 (see instructions) 0 2.02 Qutlier payments for discharges occurring prior to October 1 (see instructions) 0 2.03 Qutlier payments for discharges occurring prior to Decemp 1 (see instructions) 0 3.000 Regress available divided by number of days in the cost reporting period (see instructions) 0 4.000 FTE count for allogating and setsepathic programs for the most reporting period (see instructions) 0.00 7.00 RMA Social Account on account to the Use gas specified ander 42 CRF 4612.106(C)(10)(10)(8)(2) (1) 0.00 7.00 RMA Social Account on allogatis andosequality programs for the most reporting payment f					1.00	
1.01 DRG amounts other than outlier payments for discharges occurring on or after October 1 (see 3,660,952 1. 1.02 DRG amounts other than outlier payments for discharges occurring on or after October 1 (see 9,934,572 1. 1.03 DRG amounts other than outlier payments for Model 4 BPCI for discharges occurring on or after October 1 (see instructions) 0 0 2.00 Dutlier payments for discharges. (see instructions) 0 0 2.03 Dutlier payments for discharges. (see instructions) 0 0 2.03 Dutlier payments for discharges occurring prior to October 1 (see instructions) 94,749 0 2.04 Dutlier payments for discharges occurring prior to October 1 (see instructions) 94,749 0 2.04 Dutlier payments for discharges occurring prior to October 1 (see instructions) 94,749 0 3.00 Deriver payments for discharges occurring prior to October 1 (see instructions) 94,749 0 3.00 Dutlier payments for discharges occurring prior to October 1 (see instructions) 94,749 0 3.00 Dutlier payments for discharges occurring prior to October 1 (see instructions) 0.00 0 3.00 Dutlier payments for discharges occuring prior to October 1 (see instructions)						
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1.33 DBG for Tederal specific operating payment for Model 4 BPC1 for discharges occurring prior to 0 ctober 0 1 1.34 DBG for Tederal specific operating payment for Model 4 BPC1 for discharges occurring on or after 0 0 1.35 DBG for Tederal specific operating payment for Model 4 BPC1 (see instructions) 0 2 2.01 Outlier resemell attion amount 0 2 2.03 Quitier resemell attion amount 0 2 2.04 Outlier payments for discharges occurring on or after October 1 (see instructions) 547,745 2 3.00 Ronaged Care Simulated Payments 100 100 100 100 100 100 100 100 100 100 100 100 00 0 00	1. 02	DRG amounts other than outlier payments for discharges occurri	ng on or after October	1 (see	9, 934, 572	1. 02
1.04 DRS for Tederal specific operating payment for Model 4 BPCI for discharges occurring on or after 0 0 2.00 Duttlier payments for discharges. (see instructions) 2 2.00 Duttlier payments for discharges occurring on or after October 1 (see instructions) 8 2.00 Duttlier payments for discharges occurring on or after October 1 (see instructions) 84.691 2.00 Duttlier payments for discharges occurring on or after October 1 (see instructions) 547.745 2.00 Dettier payments for discharges occurring on or after October 1 (see instructions) 140.59 3.00 Minaged Care Simulated Payments 140.59 4.00 File count for allopathic and osteopathic programs for the most recent cost reporting period ending on new programs in accordance with 42 CFR 412.105(f)(1)(v)(b)(1) 0.00 7.00 MA Section 422 reduction amount to the ME cap as specified under 42 CFR 541.05(f)(1)(v)(b)(1) 0.00 7.01 ACA 5 SSO reduction amount to the ME cap as specified under 42 CFR 541.05(f)(1)(v)(b)(1) 0.00 7.01 ACA 5 SSO reduction amount to the ME cap as specified under 42 CFR 541.05(f)(1)(v)(b)(1) 0.00 7.02 ACA 5 SSO reduction amount to the ME cap as specified under 42 CFR 541.05(f)(1)(v)(b)(1) 0.00 7.03 ACA 5 SSO deduction amount to releaded FE cap s	1.03	DRG for federal specific operating payment for Model 4 BPCI for	or discharges occurring	prior to October	0	1. 03
2.00 Outlier payments for discharges courring period to 0ctober 1 (see instructions) 0 2 2.01 Outlier payments for discharges occurring period to 0ctober 1 (see instructions) 0 2 2.01 Outlier payments for discharges occurring period to 0ctober 1 (see instructions) 0 2 2.02 Outlier payments for discharges occurring period to 0ctober 1 (see instructions) 140 93 3.00 Indirect Mail cal. Education Adjustmenti 140 93 1.01 Intercount for allopaptic programs for the most reporting period (see instructions) 0 0.01 Intercount for allopaptic programs for the most reporting period (see instructions) 0 0 0.01 Intercount for allopaptic programs for the most reporting period (see instructions) 0 0 0.01 Intercount for allopaptic programs for the most reporting period (see instructions) 0 0 0.01 Intercount for allopaptic programs for the most reporting period (see instructions) 0 0 0.02 Intercount for allopaptic programs for the most reporting period (see instructions) 0 0 0.03 Intercount for allopaptic programs for the most reporting period (see instructions) 0 0 0.04 Intemount of increase if the	1.04	DRG for federal specific operating payment for Model 4 BPCI for	or discharges occurring	on or after	0	1. 04
2.02 Outlier payment for discharges occurring prior to October 1 (see instructions) 0 2. 2.03 Outlier payments for discharges occurring prior to October 1 (see instructions) 547,745 2. 3.00 Red days avail able divided Payments 0. 3.4.00 Red days avail able divided Payments 0.3. 4.00 Red days avail able divided Payments 0.3. 140.59 4. 5.00 FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996 (see instructions) 0.00 5. 6.00 FTE count for allopathic and osteopathic crograms for the most recent cost reporting period ending on or cost report stradies July 1, 2011 then see instructions. 0.00 6. 7.01 ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the oor affiliated programs in accordance with 42 CFR §413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12. 0.00 8. 0.10 The amount of increase or decrease) it the hospital X13.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12. 0.00 8. 0.00 FTE count for allopathic and osteopathic programs. 0.00 8. 0.00 10. 0.00 The amount of increase if the hospital Was awarded FTE cap slots from a closed teaching hospital under 5 5503 of AA. (see instructions)		Outlier payments for discharges. (see instructions)			0	2.00 2.01
2.04 Outlier payments for discharges occurring on or after October'I (see instructions) 547,745 2 3.00 Managed Care Simulated Payments 03 4.00 Bed days available divided by number of days in the cost reporting period (see instructions) 140.59 5.00 File count for all opathic and osteopathic programs for the nest recent cost reporting period ending on or before 12/31/1996 (see instructions) 0.00 6.00 File count for all opathic and osteopathic programs that meet the criteria for an add-on to the cap for here and steopathic and osteopathic programs for cost report stradies July 1, 2011 then see instructions. 0.00 7.01 ACA § 5503 reduction amount to the IFE count for all opathic and osteopathic programs for apport stradies July 1, 2011 then see instructions. 0.00 8.00 Adjustment (increase or decrease) to the FIE coupt for all opathic and osteopathic programs for apport stradies July 1, 2022. 0.00 8.01 The amount of increase if the hespital was awarded FIE cap slots from a closed teaching hospital under § 5503 of the ACA. If the cost under § 5503 of the S AC. (see instructions) 0.00 9.00 Start of all owable FIE count for relice oparas in the current year from your records 0.00 0.00 10.00 FIE count for relice oparase or the program or hospital (count or all owable FIE count for the penital and podiatric programs. 0.00 0.00			ons)			2.02
3.00 Wanaged Care Simulated Payments 0 3.00 4.00 Bed days available divided by number of days in the cost reporting period (see instructions) 140.59 4.01 Teff Ecount Tor allopathic and ostepathic programs for the most recent cost reporting period ending on or before 12/3/1996 (see instructions) 0.00 5.00 6.01 The count for allopathic and ostepathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(c) 0.00 6.00 7.00 MAA \$5503 reduction amount to the INE cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(1) 0.00 7.01 8.01 AcA \$5503 reduction amount to the INE cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) 0.00 8.01 8.01 AcA \$5503 reduction amount to the INE cap as specified under \$2 CFR \$412.105(f)(1)(iv)(B)(2) 0.00 8.01 8.01 The amount of increase if the hospital was awarded FE cap slots under \$5503 of the ACA. If the cost report stradid solut) 1, 2011, see instructions. 0.00 8.02 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 0.00 9.01 9.01 Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8, 01 and 8, 02) (see 1.000) 0.00 10.00 9.02 Sum of lines 5 plus 6 minus lines (7 a						2.03
4.00 Bed days available divided by number of days in the cost reporting period (see instructions) 140.59 4. 5.00 FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996 (see instructions) 0.00 5. 6.00 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 417.197(e) 0.00 6. 7.00 MAA Section 422 reduction amount to the INE cap as specified under 42 CFR 5412.105(f)(1)(i)(8)(8)(1) 0.00 7. 7.01 ACA 5503 reduction amount to the INE cap as specified under 42 CFR 5412.105(f)(1)(i)(8)(2) If the 0.00 7. 7.01 MAA 5503 reduction amount to the INE cap as specified under 42 CFR 5412.105(f)(1)(i)(8)(2) If the 0.00 7. 8.01 The amount of increase if the hospital was marded FTE cap slots under 55503 of the ACA. If the cost 1.000. 8. 8.02 The amount of increase if the hospital was marded FTE cap slots from a closed teaching hospital under 5 5506 of ACA. (see instructions) 0.00 8.02 The amount of increase instructions) 0.00 9.00 FTE count for residents in dental and podiatric programs. 0.00 10.00 FTE count for residents in initial years of the program. 0.00 10.00 The amount of increase			1 (see instructions)			2.04 3.00
5.00 FTE count for all opathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996 (see instructions) 0.00 5.00 6.00 FTE count for all opathic 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) 0.00 6.00 7.00 MAA Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(v)(B)(2) If the cost report straddles July 1, 2011 then see instructions. 0.00 7.00 0.01 Action amount for the IME cap as specified under 42 CFR \$412.105(f)(1)(v)(B)(2) If the cost report straddles July 1, 2011 then see instructions. 0.00 8.01 0.02 Adj ustment (increase of decrease) to the FTE count for allopathic and osteopathic programs for the ACA. If the cost under \$5503 of the ACA. If the cost under \$5503 of the ACA. If the cost under \$5506 of ACA. (see Instructions) 0.00 8.01 0.03 FTE count for allopathic and osteopathic programs in the current year from your records 0.00 0.00 0.04 FTE count for residents in indental and pool atric programs. 0.00 1.00 0.00 1.000 FTE count for residents in initial years of the program 0.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 0.00 1.00 0.00<		Bed days available divided by number of days in the cost repor	rting period (see instru	ictions)		4.00
6.00 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) 0.00 6.00 7.00 7.00 MAA Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions. 0.00 7.00 0.01 Adjustment (increase) of the FE count for allopathic and osteopathic programs for accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 44 FR 26340 (May 12, 1998), and 67 FR 50009 (August 1, 2002). 0.00 8. 0.02 Max increase I for the hospital was awarded FE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions. 0.00 8. 0.03 Sim of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8. 8.01 and 8.02) (see instructions) 0.00 1.000 0.04 Gustment for residents in dental and podiatric programs. 0.00 1.000 1.000 1.000 1.00001 <td< td=""><td>5.00</td><td></td><td>t recent cost reporting</td><td>period ending on</td><td>0.00</td><td>5.00</td></td<>	5.00		t recent cost reporting	period ending on	0.00	5.00
7.00 MAX Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(1) 0.00 7. 7.01 ACA § 5503 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions. 0.00 7. 8.0 Adjustment (increase) of the FIE count for allopathic and osteopathic programs for report straddles July 1, 2011, see instructions. 0.00 8. 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. 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 10.00 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 10.00 10.00 FIE count for the programs in the current year from your records 0.00 10.00 11.00 FIE count for the prolutimate year if that year ended on or after September 30, 1997, otherwise enter zero. 0.00 11.00 12.00 Carrent year residents di splaced by program on hospital closure 0.000 10.00 11.00 13.00 Total allowable FIE count for the prol years 0.000 0.000000 0.000000	6.00		ne criteria for an add-c	n to the cap for	0.00	6.00
7.01 ACA § 5503 reduction amount to the INE cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) if the cost report straddles July 1, 2011 then see instructions. 0.00 7. 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)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002). 0.00 8. 8.10 ha amount or increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost under § 5506 of ACA. (see instructions. 0.00 8. 8.20 ha amount or increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions) 0.00 9. 9.05 spin of lines 5 puis 6 ninus lines (7 and 7.01) plus/ninus lines (8, 8, 01 and 8, 02) (see instructions) 0.00 9. 10.00 FTE count for residents in dental and podiatric programs. 0.00 10.00 11.00 0.00 11.00 0.00 12. 0.00 12. 0.00 12. 0.00 12. 0.00 12. 0.00 12. 0.00 12. 0.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 <t< td=""><td>7 00</td><td></td><td>under 12 CER 8/12 105(f)</td><td>$(1)(i_{1})(B)(1)$</td><td>0.00</td><td>7.00</td></t<>	7 00		under 12 CER 8/12 105(f)	$(1)(i_{1})(B)(1)$	0.00	7.00
8.00 Adjustment (Increase or decrease) to the FTE count for allopathic and ostepopthic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002). 0.00 8. 8.01 The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost under § 5505 of ACA. (see instructions. 0.00 8. 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) 0.00 8. 9.05 Sum of lines 5 July 1, 2011, see instructions. 0.00 9. 9.00 Sum of lines (7 and 7.01) plus/minus lines (8, 8, 01 and 8, 02) (see 0.00 9. 9.00 FTE count for religentic programs in the current year from your records 0.00 10.00 9.00 TTE count for the prior year. 0.00 10.00 11.0		ACA § 5503 reduction amount to the IME cap as specified under				7.00
8.01The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.0.008.8.02The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)0.008.9.00Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)0.009.10.00FTE count for allopathic and osteopathic programs in the current year from your records 0.000.0010.11.00FTE count for residents in dental and podiatric programs. 0.000.0011.12.00Current year allowable FTE count for the prior year. 0.000.0013.14.00Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, 0.000.0014.0.00Adjustment for residents displaced by program or hospital closure 0.000.0017.15.00Sum of ilines 19 or 20 (see instructions) 0.000.000.0016.00Enter the lesser of lines 19 or 20 (see instructions) 0.0000000.0017.00Adjustment adjustment for the Ado-n for § 422 of the MMA0.0022.01IME payment adjustment for the Ado-n for § 422 of the MMA0.00000023.00II for additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (r)(1/v)(C).0.0024.01IME FTE Resident Count Over Cap (see instructions) 0.0000000.0025.02IME add-on adjustment for the Add-on for § 422 of the MMA0.00000	8.00	Adjustment (increase or decrease) to the FTE count for allopa affiliated programs in accordance with 42 CFR 413.75(b), 413.		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) 0.00 8. 9.00 Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions) 0.00 10. 10.00 FTE count for allopathic and osteopathic programs in the current year from your records 0.00 10. 11.00 FTE count for residents in dental and podiatric programs. 0.00 11. 12.00 Current year allowable FTE count for the prior year. 0.00 13. 13.00 Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero. 0.00 14. 15.00 Sum of lines 12 through 14 divided by 3. 0.00 16. 16.00 Adjustment for residents in initial years of the program 0.00 16. 17.00 Adjusted rolling average FTE count 0.00 18. 19.00 Current year resident to bed ratio (line 18 divided by line 4). 0.0000000 20. 10.00 Enter the lesser of lines 19 or 20 (see instructions) 0.22. 0.00 22. 10.01 Enter the lesser of lines 10 inter the resident down for 5 422 of the MMA 0.000000 22.	8.01	The amount of increase if the hospital was awarded FTE cap slo	ACA. If the cost	0.00	8. 01	
9.00Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see0.009.10.00FTE count for allopathic and osteopathic programs in the current year from your records0.0010.11.00FTE count for residents in dental and podiatric programs.0.0010.12.00Current year allowable FTE count for the prior year.0.0012.13.00Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997.0.0014.15.00Sum of lines 12 through 14 divided by 3.0.0016.0.0015.16.00Adjustment for residents in initial years of the program0.0016.0.0017.17.00Current year allowable FTE count0.0018.0.0018.19.00Current year resident to bed ratio (see instructions)0.0000.00.10.00FTE resident to bed ratio (see instructions)0.00000020.22.01IME payment adjustment (see instructions)0.0222.10.01Immer of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.1050.00(f)(1)(iv)(C).0.0.0.00000023.23.00Numer of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.1050.00(f)(1)(iv)(C).0.0.0.00000024.24.00IME rETE Resident Count Over Cap (see instructions)0.23.25.00IME amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see0	8. 02	The amount of increase if the hospital was awarded FTE cap slo	0.00	8. 02		
11.00FTE count for residents in dental and podiatric programs.0.0011.11.00Current year allowable FTE (see instructions)0.0012.12.00Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997.0.0013.13.00Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997.0.0014.15.00Sum of lines 12 through 14 divided by 3.0.0015.0.0015.16.00Adjustment for residents in initial years of the program0.0016.0.0017.18.00Adjustment for resident to bed ratio (line 18 divided by line 4).0.0000000.0018.19.00Current year resident to bed ratio (see instructions)0.0000000.0.0.20.00Prior year resident to bed ratio (see instructions)0.0000000.0.0.21.00Enter the lesser of lines 19 or 20 (see instructions)0.0.0.0.0.22.01IME payment adjustment for the Add-on for § 422 of the MMA0.0.00000023.0.0.0.23.0.0.0.0.23.0.0.0.0.23.0.0.0.23.0.0.0.23.0.0.0.23.0.0.0.0.23.0.0.0.0.23.0.0.0.0.23.0.0.0.0.0.0.0.0.0.0.	9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line	es (8, 8,01 and 8,02) (see	0.00	9.00
12.00Current year allowable FTE (see instructions)0.0012.13.00Total allowable FTE count for the prior year.0.0013.14.00Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.0.0014.15.00Sum of lines 12 through 14 divided by 3.0.0015.16.00Adjustment for residents in initial years of the program usted rolling average FTE count0.0015.17.00Adjustment for resident to bed ratio (line 18 divided by line 4).0.0016.17.00Prior year resident to bed ratio (see instructions)0.00000019.10.00Prior year resident to bed ratio (see instructions)0.00000012.11.00IME payment adjustment (see instructions)0.00000012.12.00IME payment adjustment (see instructions)0.22.0.00000012.12.00IME payment adjustment - Managed Care (see instructions)0.000.0012.10IME FTE Resident Count Over Cap (see instructions)0.0000021.14.00IME add-on adjustment factor. (see instructions)0.00000022.15.00IME add-on adjustment factor. (see instructions)0.00000024.25.00IME add-on adjustment amount - Managed Care (see instructions)0.00000027.28.00IME add-on adjustment amount - Managed Care (see instructions)0.28.0.29.29.00Total IME payment - Managed Care (see instructions)0.28.0.29.29.00Total IME payment -			ent year from your recor	ds		
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otherwise enter zero.015.00Sum of lines 12 through 14 divided by 3.0.0015.00Adj ustment for residents in initial years of the program0.0017.00Adj ustment for residents displaced by program or hospital closure0.0017.00Adj usted rolling average FTE count0.0018.00Adj uster resident to bed ratio (line 18 divided by line 4).0.000000019.00Current year resident to bed ratio (see instructions)0.000000020.00Prior year resident to bed ratio (see instructions)0.00000021.00Enter the lesser of lines 19 or 20 (see instructions)0.00000022.01IME payment adj ustment (see instructions)0.00000022.01IME payment adj ustment for the Add-on for § 422 of the MMA23.00Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.1050.0024.00IME track line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see0.0025.00If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see0.0026.00Resident to bed ratio (divide line 25 by line 4)0.00000027.00IME add-on adj ustment factor. (see instructions)028.00IME add-on adj ustment amount (see instructions)029.00Total IME payment a (sum of lines 22 and 28)029.01Total IME payment (sum of lines 22 and 28)029.02Total IME payment (sum of lines 22 and 28)029.03Total IME payment (sum of lines 22 and 28)	13.00				0.00	13.00
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17.00Adjustment for residents displaced by program or hospital closure0.0017.18.00Adjusted rolling average FTE count0.0018.19.00Current year resident to bed ratio (line 18 divided by line 4).0.00000019.00Prior year resident to bed ratio (see instructions)0.00000021.00Enter the lesser of lines 19 or 20 (see instructions)0.00000022.01IME payment adjustment (see instructions)0.22101IME payment adjustment - Managed Care (see instructions)023.00Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.1050.0017.10(i) (C).0.00000024.24.00IME FTE Resident Count Over Cap (see instructions)0.00000025.00If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see0.0026.00Resident to bed ratio (divide line 25 by line 4)0.00000027.01IME add-on adjustment factor. (see instructions)028.00IME add-on adjustment amount (see instructions)028.00IME add-on adjustment amount (see instructions)029.00Total IME payment (sum of lines 22 and 28)029.01Total IME payment - Managed Care (see instructions)029.02Total IME payment - Managed Care (see instructions)029.01Total IME payment - Managed Care (see instructions)029.02Total IME payment - Managed Care (see instructions)020.01Percentage of SSI recipient patient days						
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Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA23.00Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412. 1050.0023.00(f) (1) (iv) (C)24.00IME FTE Resident Count Over Cap (see instructions)0.0025.00If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see0.0026.00Resident to bed ratio (divide line 25 by line 4)0.00000026.00Resident to bed ratio (divide line 25 by line 4)0.00000027.00IME payments adjustment factor. (see instructions)0.00000028.00IME add-on adjustment amount (see instructions)029.00Total IME payment (sum of lines 22 and 28)029.01Total IME payment - Managed Care (sum of lines 22.01 and 28.01)029.02Disproportionate Share Adjustment5.7530.00Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)31.5431.00Allowable disproportionate share percentage (see instructions)37.2933.00Allowable disproportionate share percentage (see instructions)37.2933.00Allowable disproportionate share percentage (see instructions)37.29						
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24.00IME FTE Resident Count Over Cap (see instructions)0.0024.25.00If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see0.0025.1 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see0.0025.26.00Resident to bed ratio (divide line 25 by line 4)0.00000026.27.00IME payments adjustment factor. (see instructions)0.00000027.28.00IME add-on adjustment amount (see instructions)028.29.00Total IME payment (sum of lines 22 and 28)029.29.01Total IME payment - Managed Care (sum of lines 22.01 and 28.01)029.Disproportionate Share Adjustment5.7530.31.00Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)5.7530.32.00Sum of lines 30 and 3137.2932.33.00Allowable disproportionate share percentage (see instructions)20. 20.	23.00	Number of additional allopathic and osteopathic IME FTE reside		FR 412.105	0.00	23.00
instructions)026.00Resident to bed ratio (divide line 25 by line 4)0.00000026.01IME payments adjustment factor. (see instructions)0.00000027.02IME add-on adjustment amount (see instructions)028.01IME add-on adjustment amount - Managed Care (see instructions)028.01IME add-on adjustment amount - Managed Care (see instructions)029.00Total IME payment (sum of lines 22 and 28)029.01Total IME payment - Managed Care (sum of lines 22.01 and 28.01)029.01Disproportionate Share Adjustment030.00Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)5.7531.00Sum of lines 30 and 3137.2933.00Allowable disproportionate share percentage (see instructions)37.2033.00Allowable disproportionate share percentage (see instructions)20.20		IME FTE Resident Count Over Cap (see instructions)				
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28.00IME add-on adjustment amount (see instructions)028.28.01IME add-on adjustment amount - Managed Care (see instructions)028.29.00Total IME payment (sum of lines 22 and 28)029.70Total IME payment - Managed Care (sum of lines 22.01 and 28.01)029.Disproportionate Share Adjustment029.9.00Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)5.7530.31.00Percentage of Medicaid patient days (see instructions)31.5431.32.00Sum of lines 30 and 3137.2932.33.00Allowable disproportionate share percentage (see instructions)20.2033.00Sum of lines share percentage (see instructions)20.20						
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Disproportionate Share Adjustment30.00Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)5.7530.31.00Percentage of Medicaid patient days (see instructions)31.5431.32.00Sum of lines 30 and 3137.2932.33.00Allowable disproportionate share percentage (see instructions)20.2033.	29.00	Total IME payment (sum of lines 22 and 28)			0	29.00
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32.00 Sum of Lines 30 and 31 37.29 32. 33.00 Allowable disproportionate share percentage (see instructions) 20.20 33.		Percentage of SSI recipient patient days to Medicare Part A pa	atient days (see instruc	tions)		
33.00 Allowable disproportionate share percentage (see instructions) 20.20 33.						
1 203 LAT 3A		Allowable disproportionate share percentage (see instructions; Disproportionate share adjustment (see instructions))			

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0088	Peri od:	Worksheet E	2552-
			From 07/01/2020 To 06/30/2021	Part A Date/Time Pre	
		Title XVIII	Hospi tal	11/23/2021 1: PPS	22 pi
			Prior to 10/1		
			1.00	2.00	
	Uncompensated Care Adjustment				
5.00	Total uncompensated care amount (see instructions)			8, 290, 014, 521	
5.01 5.02	Factor 3 (see instructions) Hospital uncompensated care payment (If line 34 is zero,	enter zero on this line) (se	0. 000225025 e 1, 879, 094	0. 000362241 3, 002, 985	35. 35.
0. 02	instructions)		1,077,074	3,002,703	33.
5.03	Pro rata share of the hospital uncompensated care payment		472, 340	2, 246, 068	35.
5.00	Total uncompensated care (sum of columns 1 and 2 on line		2, 718, 408		36
0. 00	Additional payment for high percentage of ESRD beneficiar Total Medicare discharges, excluding MS-DRGs 652, 682, 68		ign 46) 0		40
. 00	instructions)	55, 004 and 005. (See	0		40
			Before 1/1	On/After 1/1	
1 00			1.00	1.01	41
1. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 68 instructions)	32, 683, 684 an 685. (see	0	0	41.
1.01	Total ESRD Medicare covered and paid discharges excluding	g MS-DRGs 652, 682, 683, 684	0	0	41
	an 685. (see instructions)				
2.00	Divide line 41 by line 40 (if less than 10%, you do not c		0.00		42
3. 00	Total Medicare ESRD inpatient days excluding MS-DRGs 652 instructions)	2, 682, 683, 684 all 685. (See	e 0		43
4. 00	Ratio of average length of stay to one week (line 43 divi	ded by line 41 divided by 7	0.00000		44
	days)				
5.00 5.00	Average weekly cost for dialysis treatments (see instruct Total additional payment (line 45 times line 44 times lin		0.00	0.00	45
. 00 . 00	Subtotal (see instructions)	le 41.01)	17, 569, 912		40
3.00	Hospital specific payments (to be completed by SCH and ME)H, small rural hospitals	0		48
	only. (see instructions)	-			
				Amount 1.00	
9.00	Total payment for inpatient operating costs (see instruct	tions)		17, 569, 912	49
. 00	Payment for inpatient program capital (from Wkst. L, Pt.			1, 131, 293	
. 00	Exception payment for inpatient program capital (Wkst. L,			0	
2.00	Direct graduate medical education payment (from Wkst. E-4 Nursing and Allied Health Managed Care payment	 Line 49 see instructions). 		0 35, 012	
. 00	Special add-on payments for new technologies			173, 098	
. 01	Islet isolation add-on payment			0	
. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, li	ne 69)		0	55
. 00	Cost of physicians' services in a teaching hospital (see			0	56
7.00	Routine service other pass through costs (from Wkst. D, F		hrough 35).	12 540	57 58
3.00 9.00	Ancillary service other pass through costs from Wkst. D, Total (sum of amounts on lines 49 through 58)	Pt. TV, COL. 11 TTHE 200)		13, 549 18, 922, 864	
). 00	Primary payer payments			11, 103	
I. 00	Total amount payable for program beneficiaries (line 59 m	ninus line 60)		18, 911, 761	61
2.00	Deductibles billed to program beneficiaries			1, 401, 980	
3.00	Coinsurance billed to program beneficiaries			41,077	
1.00 5.00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			167, 748 109, 036	
5.00	Allowable bad debts for dual eligible beneficiaries (see	instructions)		95, 692	
. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	-		17, 577, 740	
. 00	Credits received from manufacturers for replaced devices			0	
. 00	Outlier payments reconciliation (sum of lines 93, 95 and	96). (For SCH see instruction	IS)	0	
). 00). 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Dem	nonstration) adjustment (see	instructions)	0	70
). 87	Demonstration payment adjustment amount before sequestrat	· · ·		0	70
). 88	SCH or MDH volume decrease adjustment (contractor use onl	y)		0	70
). 89	Pioneer ACO demonstration payment adjustment amount (see			_	70
). 90	HSP bonus payment HVBP adjustment amount (see instruction			0	
	HSP bonus payment HRR adjustment amount (see instructions Bundled Model 1 discount amount (see instructions)	>)		0	
				0	1 '
D. 91 D. 92 D. 93	HVBP payment adjustment amount (see instructions)			2, 758	70
). 92). 93). 94				-19, 331	

ALCULA	TION OF REIMBURSEMENT SETTLEMENT	Provider C		Period: From 07/01/2020	Worksheet E Part A	
				To 06/30/2021	Date/Time Pre 11/23/2021 1:	pareo 22 pr
		Title	XVIII	Hospi tal	PPS	
			FFY	(уууу)	Amount	
0.96 L	ow volume adjustment for federal fiscal year (yyyy) (Enter i	n column 0		0	1.00	70.
	the corresponding federal year for the period prior to 10/1)			0	0	/0.
	ow volume adjustment for federal fiscal year (yyyy) (Enter i			0	0	70.
	the corresponding federal year for the period ending on or af	fter 10/1)			_	
	Low Volume Payment-3				0	
	HAC adjustment amount (see instructions) Amount due provider (line 67 minus lines 68 plus/minus lines	40 º 70)			0 17, 561, 167	70.
	Sequestration adjustment (see instructions)	07 a 70)			17, 301, 107	
	Demonstration payment adjustment amount after sequestration				0	
	Sequestration adjustment-PARHM pass-throughs					71.
2.00 1	nterim payments				16, 920, 881	72.
	nterim payments-PARHM					72.
	Tentative settlement (for contractor use only)				0	
	Tentative settlement-PARHM (for contractor use only)	00 70 and			(40.00)	73.
	Balance due provider/program (line 71 minus lines 71.01, 71.0 73)	02, 72, and			640, 286	74.
	al ance due provider/program-PARHM (see instructions)					74.
	Protested amounts (nonallowable cost report items) in accorda	ance with			438, 811	
C	CMS Pub. 15-2, chapter 1, §115.2					
	O BE COMPLETED BY CONTRACTOR (lines 90 through 96)		1			
	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum	of 2.03			0	90.
	olus 2.04 (see instructions)				0	01
	Capital outlier from Wkst. L, Pt. I, line 2 Operating outlier reconciliation adjustment amount (see instr	cuctions)			0	
	Capital outlier reconciliation adjustment amount (see instruc	,			0	
	The rate used to calculate the time value of money (see instruct				0.00	
	Time value of money for operating expenses (see instructions)				0	
5.00 T	Time value of money for capital related expenses (see instruc	ctions)			0	96
				Prior to 10/1 1.00		<u> </u>
Н	SP Bonus Payment Amount			1.00	2.00	
	ISP bonus amount (see instructions)			0	0	100
	VBP Adjustment for HSP Bonus Payment				-	1
1.00 H	IVBP adjustment factor (see instructions)			0.000000000	0.000000000	101
2.00 <u>H</u>	IVBP adjustment amount for HSP bonus payment (see instruction	ns)		0	0	102
	RR Adjustment for HSP Bonus Payment					ł.,
	IRR adjustment factor (see instructions)	`		0.0000	0.0000	
	IRR adjustment amount for HSP bonus payment (see instructions ural Community Hospital Demonstration Project (§410A Demonst		ictmont	0	0	104
	s this the first year of the current 5-year demonstration pe					200
	Century Cures Act? Enter "Y" for yes or "N" for no.		.110 2131			200
С	ost Reimbursement					201
C	ost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin	ne 49)				202
1.00 N 2.00 N	Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions)	ne 49)				
1.00 M 2.00 M 3.00 C	Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions)					
1.00 M 2.00 M 3.00 C	Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) omputation of Demonstration Target Amount Limitation (N/A in		of the curren	t 5-year demonst	ration	
1.00 M 2.00 M 3.00 C	Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) omputation of Demonstration Target Amount Limitation (N/A in eriod)		of the curren	t 5-year demonst		203
1.00 M 2.00 M 3.00 C 4.00 M	Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) omputation of Demonstration Target Amount Limitation (N/A in eriod) Medicare target amount		of the curren	t 5-year demonst		203 204
1.00 M 2.00 M 3.00 C 4.00 M 5.00 C	Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) omputation of Demonstration Target Amount Limitation (N/A in eriod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204)	n first year	of the curren	t 5-year demonst		203 204 205
1.00 M 2.00 M 3.00 C 4.00 M 5.00 C 6.00 M	Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) omputation of Demonstration Target Amount Limitation (N/A in eriod) Medicare target amount	n first year	of the curren	t 5-year demonst		203 204 205
C C C C C C C C C C C C C C C C C C C	Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) omputation of Demonstration Target Amount Limitation (N/A in eriod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) djustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst) tructions)	of the curren	t 5-year demonst		203 204 205 206 207
C C C C C C C C C C C C C C C C C C C	Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) omputation of Demonstration Target Amount Limitation (N/A in eriod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) djustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A,) tructions)	of the curren	t 5-year demonst		203 204 205 206 207 208
C C C C S O C C D C D C D C D C D C D C C D C	Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) omputation of Demonstration Target Amount Limitation (N/A in eriod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) djustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions)) tructions)	of the curren	t 5-year demonst		203 204 205 206 207 208 209
C C C C S O C D C D C D C D C D C D C C D C	Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) omputation of Demonstration Target Amount Limitation (N/A in eriod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) djustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use	tructions)	of the curren	t 5-year demonst		203 204 205 206 207 208 209 210
C C C C C C C C C C C C C C C C C C C	Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) omputation of Demonstration Target Amount Limitation (N/A in eriod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) djustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Fotal adjustment to Medicare IPPS payments (see instructions)	tructions)	of the curren	t 5-year demonst		203 204 205 206 207 208 209 210
C C C C C C C C C C C C C C C C C C C	Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) omputation of Demonstration Target Amount Limitation (N/A in eriod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) djustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) omparision of PPS versus Cost Reimbursement	tructions) line 59)	of the curren	t 5-year demonst		203 204 205 206 207 208 209 210 211
C C C C C C C C C C C C C C C C C C C	Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) omputation of Demonstration Target Amount Limitation (N/A in eriod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) djustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) omparision of PPS versus Cost Reimbursement Fotal adjustment to Medicare Part A IPPS payments (from line	tructions) line 59)	of the curren	t 5-year demonst		203 204 205 206 207 208 209 210 211
C 1.00 M 2.00 M 3.00 C 6.00 M 5.00 C 6.00 M 7.00 F 8.00 M 9.00 A 0.00 C 1.00 T 2.00 T 3.00 L	Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) omputation of Demonstration Target Amount Limitation (N/A in eriod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) djustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) omparision of PPS versus Cost Reimbursement	tructions) line 59)		t 5-year demonst		203 204 205 206 207 208 209 210 211

	Financial Systems	AS	SCENSION ST. VI		N 15 0000 D		u of Form CMS-2	2552-10
LOW VO	LUME CALCULATION EXHIBIT 4			Provider CC		eriod: rom 07/01/2020 o 06/30/2021	Worksheet E Part A Exhibi Date/Time Prep 11/23/2021 1:2	pared:
				Title	XVIII	Hospi tal	PPS	
		W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	0n/After 10/01	through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier	1.00	0	0	0	0	0	1.00
1.01	payments DRG amounts other than outlier payments for discharges	1.01	3, 600, 952	0	3, 600, 952		3, 600, 952	1. 01
1. 02	occurring prior to October 1 DRG amounts other than outlier	1. 02	9, 934, 572	0		9, 934, 572	9, 934, 572	1. 02
	payments for discharges occurring on or after October 1							
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	O	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	O	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00						2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	84, 691	0	84, 691		84, 691	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	547, 745	0		547, 745	547, 745	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
5.00	Indirect Medical Education Adju Amount from Worksheet E, Part	21.00	0. 000000	0. 000000	0.00000	0. 000000		5.00
6.00	A, line 21 (see instructions) IME payment adjustment (see	21.00	0.000000	0.000000	0.000000	0.000000	0	6.00
6. 01	instructions) IME payment adjustment for managed care (see	22.01	0	0	0	0	0	6. 01
	instructions)							
	Indirect Medical Education Adju							
7.00	IME payment adjustment factor	27.00	0. 000000	0. 000000	0.000000	0. 000000		7.00
8.00	(see instructions) IME adjustment (see	28.00	0	о	0	0	0	8.00
8. 01	instructions) IME payment adjustment add on for managed care (see	28.01	0	0	0	0	0	8. 01
9.00	instructions) Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9. 01	Total IME payment for managed care (sum of lines 6.01 and	29.01	0	о	0	0	0	9. 01
	8.01)							
10. 00	Disproportionate Share Adjustme Allowable disproportionate share percentage (see	33.00	0. 2020	0. 2020	0. 2020	0. 2020		10. 00
11.00	instructions) Disproportionate share	34.00	683, 544	0	181, 848	501, 696	683, 544	11.00
11.01	adjustment (see instructions) Uncompensated care payments	36.00	2, 718, 408		321, 525	870, 488	1, 192, 013	11. 01
12.00	Additional payment for high per Total ESRD additional payment (see instructions)	46.00	0 beneficiary	di scharges 0	0	0	0	12. 00
13.00 14.00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	47.00 48.00	17, 569, 912 0	0 0	4, 189, 016 0	13, 380, 896 0		13. 00 14. 00
15.00	(see instructions) Total payment for inpatient operating costs (see	49.00	17, 569, 912	О	4, 189, 016	13, 380, 896	17, 569, 912	15.00
16.00	instructions) Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1, 131, 293	0	307, 956	823, 337	1, 131, 293	16. 00

Heal th	Financial Systems	AS	SCENSION ST. VI	NCENT ANDERSON		In Lie	eu of Form CMS-2	2552-10
LOW VOLUME CALCULATION EXHIBIT 4				Provider CC		Peri od: Worksheet E From 07/01/2020 Part A Exhib To 06/30/2021 Date/Time Print 11/23/2021		pared:
					XVIII	Hospi tal	PPS	
		W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01		
		0	1.00	2.00	3.00	4.00	5.00	
17.00	Special add-on payments for new technologies	54.00	173, 098	0		0 173, 098	173, 098	
	Net organ aquisition cost							17.01
17. 02	Credits received from manufacturers for replaced	68.00	0	0		0 0	0	17.02
18.00	devices for applicable MS-DRGs Capital outlier reconciliation		0	0		o c	0	18.00
	adjustment amount (see instructions)							
19.00	SUBTOTAL			0	4, 496, 97	2 14, 377, 331	18, 874, 303	19.00
		W/S L, line	(Amounts from L)					
	<u>I</u>	0	1.00	2.00	3.00	4.00	5.00	
20. 00 20. 01	Capital DRG other than outlier Model 4 BPCI Capital DRG other than outlier		1, 041, 664 0	0		0 757, 714 0 0	1, 041, 664 0	20. 00 20. 01
21.00	Capital DRG outlier payments	2.00	7, 963	0	1, 74	4 6, 219	7,963	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	0		0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0. 0000	0. 0000	0.000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0		0 0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0. 0784	0. 0784	0. 078	4 0. 0784		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	81, 666	0	22, 26	2 59, 404	81, 666	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1, 131, 293	0	307, 95	6 823, 337	1, 131, 293	26.00
		W/S E, Part A line	Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0. 00000	0. 000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 96				C	0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E,	70. 97				0	0	29.00
100.00	Pt. A, line) Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100. 00

			NCENT ANDERSON		In Lie	eu of Form CMS-2	2552-10
HOSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provider CC		Period: From 07/01/2020	Worksheet E Part A Exhibi	+ 5
					Fo 06/30/2021	Date/Time Pre	pared:
			Titlo	XVIII	Hospi tal	11/23/2021 1:2 PPS	22 pm
		Wkst. E, Pt.	Amt. from	Period to	Period on	Total (cols. 2	
		A, line	Wkst. E, Pt. A)	10/01	after 10/01	and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	3, 600, 952	3, 600, 95	2	3, 600, 952	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	9, 934, 572		9, 934, 572	9, 934, 572	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	1.03	0	(0	0	1. 03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1. 04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	(0 0	0	2. 01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	84, 691	84, 69	1	84, 691	2. 02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	547, 745		547, 745	547, 745	2. 03
3.00	Operating outlier reconciliation	2.01	0	(o o	0	3.00
4.00	Managed care simulated payments	3.00	0	(0 0	0	4.00
5.00	Indirect Medical Education Adjustment Amount from Worksheet E, Part A, line 21	21.00	0. 000000	0. 00000	0. 000000		E 00
5.00	(see instructions)	21.00	0. 000000	0.00000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0		0 0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	(0 0	0	6. 01
	Indirect Medical Education Adjustment for the	e Add-on for Se	ection 422 of t	he MMA			
7.00	IME payment adjustment factor (see	27.00	0. 000000	0. 00000	0. 000000		7.00
8.00	instructions) IME adjustment (see instructions)	28.00	0		0 0	0	8.00
8.00	IME payment adjustment add on for managed care (see instructions)	28.00	0			0	8.00
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	(o o	0	9.00
9.01	Total IME payment for managed care (sum of	29.01	0	(0 0	0	9.01
	lines 6.01 and 8.01) Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage	33.00	0. 2020	0. 202	0. 2020		10.00
11.00	(see instructions) Disproportionate share adjustment (see	34.00	683, 544	181, 84	501, 696	683, 544	11.00
11.01	instructions) Uncompensated care payments	36.00	2, 718, 408	466, 42	5 1, 821, 010	2, 287, 435	11.01
12.00	Additional payment for high percentage of ESF Total ESRD additional payment (see	46.00	di scharges 0	(0 0	0	12.00
13.00	instructions) Subtotal (see instructions)	47.00	17, 569, 912	4, 333, 91	13, 235, 996	17, 569, 912	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see	48.00	0	(0	0	
15.00	instructions) Total payment for inpatient operating costs	49.00	17, 569, 912	4, 333, 91	5 13, 235, 996	17, 569, 912	15.00
16.00	(see instructions) Payment for inpatient program capital (from	50.00	1, 131, 293	307, 95	823, 337	1, 131, 293	16.00
17. 00 17. 01	Wkst. L, Pt. I, if applicable) Special add-on payments for new technologies Net organ acquisition cost	54.00	173, 098	(0 173, 098	173, 098	17.00 17.01
17.01	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	О	(o o	0	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	(o o	0	18.00
19.00	SUBTOTAL			4, 641, 87	2 14, 232, 431	18, 874, 303	19.00

Heal th	Financial Systems AS	SCENSION ST. VI	NCENT ANDERSON		In Lie	eu of Form CMS-2	2552-10
HOSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provider C	CN: 15-0088	Period: From 07/01/2020 To 06/30/2021		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	1, 041, 664	283, 9	50 757, 714	1, 041, 664	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1.01	0		0 0	0	20.01
21.00	Capital DRG outlier payments	2.00	7, 963	1, 74	6, 219	7, 963	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0		0 0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.000	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. 0784	0. 078	0. 0784		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	81, 666	22, 20	52 59, 404	81, 666	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1, 131, 293	307, 9	6 823, 337	1, 131, 293	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	2, 758	-11, 50	14, 265	2, 758	30.00
30. 01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0		0 0	0	
31.00	HRR adjustment (see instructions)	70, 94	-19, 331	-7,20	-12, 129	-19, 331	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70. 91	0		o c	0	1
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
	HAC Reduction Program adjustment (see instructions)	70. 99			0 0	0	
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100. 00

	Financial Systems ASCENSION ST. VINCE ATION OF REIMBURSEMENT SETTLEMENT	ENT ANDERSON Provider CCN: 15-0088	In Lie Period: From 07/01/2020 To 06/30/2021		pared:
		Title XVIII	Hospi tal	PPS	
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00 2.00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instruct	tions)		5, 065 19, 633, 363	
3.00	OPPS payments			16, 391, 407	
4.00	Outlier payment (see instructions)			115, 632	
4.01	Outlier reconciliation amount (see instructions)	ati ana)		0	
5.00 6.00	Enter the hospital specific payment to cost ratio (see instruction Line 2 times line 5			0.000	
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
8.00	Transitional corridor payment (see instructions)			0	
9.00 10.00	Ancillary service other pass through costs from Wkst. D, Pt. Organ acquisitions	IV, COL. 13, LINE 200		58, 315 0	9.00 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			5, 065	
	COMPUTATION OF LESSER OF COST OR CHARGES				
12.00	Reasonable charges Ancillary service charges			16, 985	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	ine 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			16, 985	14.00
15 00	Customary charges				15 00
15.00 16.00	Aggregate amount actually collected from patients liable for Amounts that would have been realized from patients liable for			0	15.00 16.00
10.00	had such payment been made in accordance with 42 CFR §413.13(in a chargebasi s		10.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	
18.00 19.00	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete on	lvifling 18 exceeds li	ng 11) (soo	16, 985 11, 920	
19.00	instructions)	Ty IT THE TO EXCEEds IT	116 11) (366	11, 720	19.00
20.00	Excess of reasonable cost over customary charges (complete on	ly if line 11 exceeds li	ne 18) (see	0	20.00
21.00	instructions) Lesser of cost or charges (see instructions)			5, 065	21.00
21.00	Interns and residents (see instructions)			0	
23.00	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			16, 565, 354	24.00
25.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance amounts (for CAH, see instruction:	s)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line	-	uctions)	3, 137, 352	
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)	plus the sum of lines 22	and 23] (see	13, 433, 067	27.00
28.00	instructions) Direct graduate medical education payments (from Wkst. E-4, I	ine 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
30.00	Subtotal (sum of lines 27 through 29)			13, 433, 067	
31.00 32.00	Primary payer payments Subtotal (line 30 minus line 31)			892 13, 432, 175	
52.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVIC	CES)		10, 402, 170	52.00
	Composite rate ESRD (from Wkst. I-5, line 11)			0	
34.00 35.00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			342, 830 222, 840	
36.00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		205, 885	
37.00	Subtotal (see instructions)			13, 655, 015	37.00
38.00 39.00	MSP-LCC reconciliation amount from PS&R			0	
39.00 39.50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction:	s)		0	39.00 39.50
39.97	Demonstration payment adjustment amount before sequestration	-)		0	
39.98	Partial or full credits received from manufacturers for replace	ced devices (see instruc	tions)	0	
39. 99 40. 00	RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions)			0 13, 655, 015	39.99 40.00
40.00	Sequestration adjustment (see instructions)			0	
40. 02	Demonstration payment adjustment amount after sequestration			0	40. 02
40.03	Sequestration adjustment-PARHM pass-throughs			12 050 0/0	40.03
41.00 41.01	Interim payments Interim payments-PARHM			13, 959, 860	41.00
42.00	Tentative settlement (for contractors use only)			0	
42.01	Tentative settlement-PARHM (for contractor use only)			201.015	42.01
43.00 43.01	Balance due provider/program (see instructions) Balance due provider/program-PARHM (see instructions)			-304, 845	43.00 43.01
44.00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-2,	chapter 1,	0	
	\$115.2				
90.00	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)			0	90.00
90.00 91.00	Outlier reconciliation adjustment amount (see instructions)			0	
92.00	The rate used to calculate the Time Value of Money				92.00
	Time Value of Money (see instructions) Total (sum of lines 91 and 93)			0	93.00 94.00
, 4. 00				. 0	1 / 7.00

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ANALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC	-	Period: From 07/01/2020 To 06/30/2021		
		Title	XVIII	Hospi tal	PPS	•
		I npati ent	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		16, 839, 28	1	13, 852, 860	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		(C	0	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)					3.00
	Program to Provider			-1		
3.01	ADJUSTMENTS TO PROVIDER	02/03/2021	81, 60		107, 000	3.0
3.02				2	0	3.02 3.03
3.03 3.04					0	3.0
3.04				0	0	3.0
0.00	Provider to Program	1		5		0.00
3.50	ADJUSTMENTS TO PROGRAM		(D	0	3.5
3.51				C	0	3.5
3.52				C	0	3.5
3.53				D	0	3.5
3.54 3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		81, 60		0 107, 000	3.5 3.9
5.99	3. 50-3. 98)		81,000	J	107,000	3.9
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)		16, 920, 88	1	13, 959, 860	4. 0
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.0
5. 01	Program to Provider TENTATIVE TO PROVIDER				0	5.0
5.01	TENTATIVE TO PROVIDER			0	0	5.0
5.02				0	0	5.0
	Provider to Program					
5.50	TENTATI VE TO PROGRAM			C	0	5.5
5. 51				C	0	5.5
5.52				D	0	5.5
5. 99 5. 00	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Determined net settlement amount (balance due) based on		(0	5.9 6.0
o. 01	the cost report. (1) SETTLEMENT TO PROVIDER		640, 28	6	0	6.0
b. 02	SETTLEMENT TO PROGRAM			0	304, 845	6.0
7.00	Total Medicare program liability (see instructions)		17, 561, 16	-	13, 655, 015	7.0
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	

Title XVIII Subprovider - IPS Inpatient Part A PPS 00 Total interim payments paid to provider 1.00 2.00 1.987,320 0 0.00 00 Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, payment IF none, write "NONE" or enter a zero. 1.987,320 0 0 0 100 Lisser for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program 0	LYSI	S OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider C Component	CN: 15-0088 CCN: 15-T088	Period: From 07/01/202 To 06/30/202		epared
Inpatient Part A Part B Impdd/yyyy Amount mm/dd/yyyy Amount 00 Total interim payments payable on individual bills, either services rendered in the cost reporting period. If none, write "MONE" or enter a zero 1,997,320 0 0 00 List separately each netroactive iump sun adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "MONE" or enter a zero. (1) 1 9 0 0 0 010 AJJUSTMENTS TO PROVIDER 0 0 0 0 0 0 02 AJJUSTMENTS TO PROGRAM 0 <th></th> <th></th> <th>Titl€</th> <th>e XVIII</th> <th></th> <th>PPS</th> <th></th>			Titl€	e XVIII		PPS	
00 Total interim payments paid to provider 1.00 2.00 3.00 4.00 00 Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero. 1.987.30 0 00 Itst 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. 0 0 01 ADJUSTMENTS TO PROVIDER 0 0 03 0 0 0 04 0 0 0 050 Provider to Program 0 0 04 0 0 0 051 0 0 0 052 0 0 0 053 0.01 interim payments (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 0 0 054 0 0 0 0 055 0 0 0 0 054 0 0 0 0 055 0 0 0 0 056 0 0 0 0 057 0 0 0 0 058 0 0			I npati er	nt Part A		art B	
00 Total interim payments paid to provider 1,987,320 0 00 Interim payments paid to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 0 0 01 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) 0 0 02 0 0 0 0 030 0 0 0 0 04 0 0 0 0 05 ADJUSTMENTS TO PROVIDER 0 0 0 0 04 0 0 0 0 0 0 05 ADJUSTMENTS TO PROCRAM 0		-					
00 Interlin payments payable on individual bills, either submitted or tobe submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero. 0 00 List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)		-	1.00				
amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider ADJUSTMENTS TO PROVIDER 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0	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, 987, 3			
ADJUSTMENTS TO PROVIDER 0 0 0 00 0 0 0 0 01 ADJUSTMENTS TO PROVIDER 0 0 0 02 0 0 0 0 0 03 0 0 0 0 0 0 04 0 0 0 0 0 0 0 05 ADJUSTMENTS TO PROGRAM 0 0 0 0 0 0 50 ADJUSTMENTS TO PROGRAM 0 <td></td> <td>for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)</td> <td></td> <td></td> <td></td> <td></td> <td></td>		for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
03 0 0 0 04 0 0 0 0 0 0 0 0 ADJUSTMENTS TO PROGRAM 0 0 0 0 0 0 </td <td></td> <td></td> <td></td> <td></td> <td>0</td> <td>(</td> <td>3.</td>					0	(3.
04 0 0 0 Provider to Program 0 0 05 ADJUSTMENTS TO PROGRAM 0 0 06 0 0 0 07 ADJUSTMENTS TO PROGRAM 0 0 08 0 0 0 09 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 0 0 00 Total interim payments (sum of lines 1, 2, and 3.99) 1,987,320 0 01 Total separately each tentative settlement payment after 0 0 01 List separately each tentative settlement payment after 0 0 02 Itentative settlement payment. If none, write "NONE" or enter a zero. (1) 0 0 01 TENTATIVE TO PROVIDER 0 0 02 O 0 0 03 0 0 0 04 0 0 0 05 TENTATIVE TO PROGRAM 0 0 06 0 0 0 07 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.01-5.49 minus sum of lines 5.01-5.98) 0 0 08 Determined net settlement amount (balance due) based on the cost report. (1) 0 0 08 StTLEMENT TO PROGRAM							
05 0 0 0 07 Provider to Program 0 0 07 0 0 0 08 0 0 0 09 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 0 0 0 00 1.987,320 0 0 0 01 Total interim payments (sum of lines 1, 2, and 3.99) 1,987,320 0 0 01 Total comportiate) 0 0 0 02 10 BE COMPLETED BY CONTRACTOR 0 0 0 01 TentArtive ro Provider 0 0 0 02 0 0 0 0 03 0 0 0 0 04 0 0 0 0 05 10 BE COMPLETED BY CONTRACTOR 0 0 0 01 TENTATIVE TO PROVIDER 0 0 0 02 0 0 0 0 0 03 0 0 0 0 0 04 0 0 0 0 0 05 10 Program 0 0 0 0 05 10 Program					-		
Provider to Program 0 0 ADJUSTMENTS TO PROGRAM 0 0 50 ADJUSTMENTS TO PROGRAM 0 0 52 0 0 0 53 0 0 0 54 0 0 0 55 0 0 0 54 0 0 0 55 0 0 0 54 0 0 0 55 0 0 0 56 0 0 0 57 7.98) 1,987,320 0 50 Total interim payments (sum of lines 1, 2, and 3.99) 1,987,320 0 50 Total otherative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) 0 0 50 TENTATIVE TO PROVIDER 0 0 0 50 TENTATIVE TO PROVIDER 0 0 0 51 0 0 0 0 0 52 50 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.01-5.49 mi							
ADJUSTMENTS TO PROGRAM 0 0 51 0 0 52 0 0 53 0 0 54 0 0 9 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 0 0 00 Total interim payments (sum of lines 1, 2, and 3.99) 1, 987, 320 0 10 B COMPLETED BY CONTRACTOR 0 0 00 1:st separately each tentative settlement payment after desk review. Al so show date of each payment. If none, write "NONE" or enter a zero. (1) 0 0 Program to Provider 0 0 0 01 TENTATIVE TO PROVIDER 0 0 02 0 0 0 03 0 0 0 0 04 0 0 0 0 04 0 0 0 0 050 0 0 0 0 050 0 0 0 0 0 051 0 0 0 0 0 0 052	Ĭ	Provider to Program		1	0		
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33 0 0 34 0 0 35 0 0 34 0 0 9 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 1,987,320 0 00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wsst. E-3, line and column as appropriate) 1,987,320 0 01 D BE COMPLETED BY CONTRACTOR							
54 0 0 99 Subtotal (sum of lines 3. 01-3. 49 minus sum of lines 3. 50-3. 98) 0 1, 987, 320 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) 1, 987, 320 0 01 To BE COMPLETED BY CONTRACTOR 0 0 02 Is separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) 0 0 01 Program to Provider 0 0 02 0 0 0 03 0 0 0 04 0 0 0 05 TENTATI VE TO PROVIDER 0 0 06 0 0 0 07 Subtotal (sum of lines 5.01-5. 49 minus sum of lines 5. 50-5. 98) 0 0 09 Subtotal (sum of lines 5.01-5. 49 minus sum of lines 5. 50-5. 98) 0 0 00 0 0 0 01 SETTLEMENT TO PROGRAM 0 0 02 37, 432 0 0 03 0 2, 024, 752 0							
99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 0 0 0 00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) 1,987,320 0 01 Total ECOMPLETED BY CONTRACTOR 0 0 02 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) 0 0 01 TENTATIVE TO PROVIDER 0 0 02 0 0 0 03 Provider to Program 0 0 04 0 0 0 05 TENTATIVE TO PROGRAM 0 0 06 0 0 0 07 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 0 0 09 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 37,432 0 00 Determined net settlement amount (balance due) based on the cost report. (1) 37,432 0 01 SETTLEMENT TO PROGRAM 0 0 0 02 SETTLEMENT TO PROGRAM 0 0 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></td<>							
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) 1, 987, 320 0 10 DE COMPLETED BY CONTRACTOR	9						
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) Image: Constraint of the settlement area on the settlement payment. If none, write "NONE" or enter a zero. (1) Program to Provider 0 0 01 TENTATIVE TO PROVIDER 0 0 02 0 0 0 03 0 0 0 04 0 0 0 050 TENTATIVE TO PROVIDER 0 0 060 TENTATIVE TO PROGRAM 0 0 07 TENTATIVE TO PROGRAM 0 0 081 0 0 0 092 0 0 0 01 0 0 0 02 0 0 0 033 0 0 0 0 04 TENTATIVE TO PROGRAM 0 0 0 050 Subtotal (sum of lines 5.01-5.49 minus sum of lines 0 0 0 051 0 0 0 0 0 052 0 0		(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1, 987, 3	20	(0 4
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider Program to Provider 0 11 TENTATI VE TO PROVIDER 02 0 03 0 04 0 050 0 050 0 051 0 052 0 053 0 054 0 055 0 056 0 057 0 058 0 059 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 00 0 01 0 02 0 03 0 04 0 050 0 051 0 052 0 053 0 054 0 055 50-5.98) 06 0 07 37, 432 08 0 09 SETTLEMENT TO PROGRAM 00 0							5
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5100520029Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)0020Determined net settlement amount (balance due) based on the cost report. (1)0020SETTLEMENT TO PROVIDER 2037,432020Total Medicare program liability (see instructions)2,024,7520Contractor				1			
5.50-5.98) 00 Determined net settlement amount (balance due) based on the cost report. (1) 01 SETTLEMENT TO PROVIDER 02 SETTLEMENT TO PROGRAM 00 Total Medicare program liability (see instructions) 00 Contractor	1	TENTATIVE TU PROGRAM			0	0	5
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02 SETTLEMENT TO PROGRAM 0 0 0 00 Total Medicare program liability (see instructions) 2,024,752 0 Contractor NPR Date		the cost report. (1)					6
DO Total Medicare program liability (see instructions) 2,024,752 0 Contractor NPR Date				37, 4			-
Contractor NPR Date				2 024 7	0		
	<u> </u>	Total medical e program frability (see fristractions)		2,024,7	Contractor	NPR Date	
0 1.00 2.00		_		0	Number	(Mo/Day/Yr)	

Heal th	Financial Systems ASCENSION ST. VINCE	ENT ANDERSON	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0088	Peri od:	Worksheet E-1	
			From 07/01/2020 To 06/30/2021		nared
			10 00/ 30/ 2021	11/23/2021 1:	
		Title XVIII	Hospi tal	PPS	
				1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				-
4 00	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		44		1 1 00
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.		14		1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8	-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 [6.00
7.00	CAH only - The reasonable cost incurred for the purchase of c	ertified HIT technology	Wkst. S-2, Pt. I		7.00
	line 168				
8.00	Calculation of the HIT incentive payment (see instructions)				8.00
9.00	Sequestration adjustment amount (see instructions)				9.00
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
	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 l	ine 31) (see instruction	s)		32.00

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0088	Period: From 07/01/2020		
		Component CCN: 15-T088	To 06/30/2021	Date/Time Pre 11/23/2021 1:	
		Title XVIII	Subprovider - IRF	PPS	
				1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS				
00	Net Federal PPS Payment (see instructions)			1, 883, 851	1
00 00	Medicare SSI ratio (IRF PPS only) (see instructions) Inpatient Rehabilitation LIP Payments (see instructions)			0. 0163 138, 463	
00	Outlier Payments			26, 532	
00	Unweighted intern and resident FTE count in the most rece	ent cost reporting period en	ding on or prior	0.00	5
00	to November 15, 2004 (see instructions)	sine obset i opoi ti ng poi rod sin	ang on or prior	0100	
01	Cap increases for the unweighted intern and resident FTE	count for residents that wer	e displaced by	0.00	5
	program or hospital closure, that would not be counted wi	thout a temporary cap adjust	ment under 42		
	CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)				
00	New Teaching program adjustment. (see instructions)			0.00	6
00	Current year's unweighted FTE count of I&R excluding FTEs	s in the new program growth p	eriod of a "new	0.00	
00	teaching program" (see instructions)	this the new presson growth p	ariad of a "now	0.00	
00	Current year's unweighted I&R FTE count for residents wit teaching program" (see instructions)	unin the new program growth p	errou or a new	0.00	8
00	Intern and resident count for IRF PPS medical education a	adiustment (see instructions)		0.00	
0. 00	Average Daily Census (see instructions)			7. 134247	
. 00	Teaching Adjustment Factor (see instructions)			0.000000	
. 00	Teaching Adjustment (see instructions)			0	1
. 00	Total PPS Payment (see instructions)			2, 048, 846	1
. 00	Nursing and Allied Health Managed Care payments (see inst	truction)		0	1
. 00	Organ acquisition (DO NOT USE THIS LINE)				1
. 00	Cost of physicians' services in a teaching hospital (see	instructions)		0	1
. 00	Subtotal (see instructions)			2, 048, 846	
. 00	Primary payer payments			0	18
. 00	Subtotal (line 17 less line 18).			2, 048, 846	
. 00 . 00	Deductibles Subtotal (line 19 minus line 20)			17, 124 2, 031, 722	
. 00	Coi nsurance			7, 306	
. 00	Subtotal (line 21 minus line 22)			2, 024, 416	
. 00	Allowable bad debts (exclude bad debts for professional s	services) (see instructions)		2, 021, 110	2
. 00	Adjusted reimbursable bad debts (see instructions)	,		0	2
. 00	Allowable bad debts for dual eligible beneficiaries (see	instructions)		0	2
. 00	Subtotal (sum of lines 23 and 25)			2, 024, 416	2
. 00	Direct graduate medical education payments (from Wkst. E-	-4, line 49)		0	2
. 00	Other pass through costs (see instructions)			336	
. 00	Outlier payments reconciliation			0	30
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	3
. 50	Pioneer ACO demonstration payment adjustment (see instruct			0	3
. 99	Demonstration payment adjustment amount before sequestrat	LI ON		0	3
. 00 . 01	Total amount payable to the provider (see instructions) Sequestration adjustment (see instructions)			2, 024, 752 0	
. 01	Demonstration payment adjustment amount after sequestrati	on		0	
002	Interim payments			1, 987, 320	
. 00	Tentative settlement (for contractor use only)			0	34
. 00	Balance due provider/program (line 32 minus lines 32.01,	32.02, 33, and 34)		37, 432	
. 00	Protested amounts (nonallowable cost report items) in acc		chapter 1,	27, 881	36
	§115. 2		•		
	TO BE COMPLETED BY CONTRACTOR				
. 00	Original outlier amount from Wkst. E-3, Pt. III, line 4			26, 532	50
. 00 . 00	Outlier reconciliation adjustment amount (see instruction	าร)		0	51
	The rate used to calculate the Time Value of Money			0.00	151

ALCULA	TION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0088	Period: From 07/01/2020	Worksheet E-3 Part VII	
			To 06/30/2021	Date/Time Pre 11/23/2021 1:	
		Title XIX	Hospi tal	Cost	
			Inpatient 1.00	Outpatient 2.00	
F	ART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV	LCES FOR TITLES V OR X		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES				1
	Inpatient hospital/SNF/NF services		4, 209, 792		1 1.
00 1	Medical and other services			1, 724, 178	2.
00 0	Organ acquisition (certified transplant centers only)		0		3
00 S	Subtotal (sum of lines 1, 2 and 3)		4, 209, 792	1, 724, 178	4
	Inpatient primary payer payments		0		5
	Outpatient primary payer payments			0	-
	Subtotal (line 4 less sum of lines 5 and 6)		4, 209, 792	1, 724, 178	7
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e Charges				
	Routine service charges		10, 846, 386		8
	Ancillary service charges		10, 604, 180	10, 116, 102	
	Organ acquisition charges, net of revenue		0		10
	Incentive from target amount computation		01 450 544	40 444 400	11
	Total reasonable charges (sum of lines 8 through 11)		21, 450, 566	10, 116, 102	12
	CUSTOMARY CHARGES Amount actually collected from patients liable for payment for	annui ann an abanna	0	0	1 1 2
	valiount actuarry corrected from patrents frable for payment for	services on a charge	0	0	13
	Amounts that would have been realized from patients liable for	navment for services o	0	0	14
	a charge basis had such payment been made in accordance with 42		0	0	14
	Ratio of line 13 to line 14 (not to exceed 1.000000)	CIR 3413. 13(e)	0. 000000	0, 000000	15
	Total customary charges (see instructions)		21, 450, 566	10, 116, 102	
	Excess of customary charges over reasonable cost (complete only	if line 16 exceeds	17, 240, 774	8, 391, 924	
	line 4) (see instructions)			0,0,1,721	.,
	Excess of reasonable cost over customary charges (complete only	if line 4 exceeds lin	ie 0	0	18
	16) (see instructions)				
. 00	Interns and Residents (see instructions)		0	0	19
. 00 0	Cost of physicians' services in a teaching hospital (see instru	ctions)	0	0	20
. 00 0	Cost of covered services (enter the lesser of line 4 or line 16)	4, 209, 792	1, 724, 178	21
F	ROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be c	ompleted for PPS provi	ders.		
. 00 🛛	Other than outlier payments	· · · ·	0	0	22
. 00 0	Outlier payments		0	0	23
. 00 I	Program capital payments		0		24
. 00	Capital exception payments (see instructions)		0		25
	Routine and Ancillary service other pass through costs		0	0	26
	Subtotal (sum of lines 22 through 26)		0	0	1
	Customary charges (title V or XIX PPS covered services only)		0	0	28
	Titles V or XIX (sum of lines 21 and 27)		4, 209, 792	1, 724, 178	29
-	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
	Excess of reasonable cost (from line 18)		0	0	30
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		4, 209, 792	1, 724, 178	
	Deducti bl es		0	0	
	Coinsurance		0	0	1 00
	Allowable bad debts (see instructions)		0	0	
	Jtilization review	22)	0		35
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	4, 209, 792	1, 724, 178	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37
	Subtotal (line 36 ± line 37)		4, 209, 792	1, 724, 178	
	Direct graduate medical education payments (from Wkst. E-4)		0	1 704 470	39
	Total amount payable to the provider (sum of lines 38 and 39)		4, 209, 792	1, 724, 178	
	Interim payments		4, 209, 792	1, 724, 178	
	Balance due provider/program (line 40 minus line 41)		0	0	
. 00	Protested amounts (nonallowable cost report items) in accordanc	e with CMS Pub 15-2,	0	0	43

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0088	Period: From 07/01/2020	Worksheet E-3 Part VII	
		Component CCN: 15-T088	To 06/30/2021	Date/Time Pre 11/23/2021 1:	
		Title XIX	Subprovider - IRF	Cost	
			I npati ent	Outpati ent	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SE	RVICES FOR TITLES V OR X	1.00	2.00	-
	COMPUTATION OF NET COST OF COVERED SERVICES				
00	Inpatient hospital/SNF/NF services		93, 880		1 1
00	Medical and other services			0	
00	Organ acquisition (certified transplant centers only)		0		3
00	Subtotal (sum of lines 1, 2 and 3)		93, 880	0	4
00	Inpatient primary payer payments		0		5
00	Outpatient primary payer payments			0	
00	Subtotal (line 4 less sum of lines 5 and 6)		93, 880	0	7
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e Charges				
00	Routine service charges		702, 264		8
00	Ancillary service charges		166, 005	0	
. 00	Organ acquisition charges, net of revenue		0		10
. 00	Incentive from target amount computation		0		1
. 00	Total reasonable charges (sum of lines 8 through 11)		868, 269	0	12
~~	CUSTOMARY CHARGES			0	1 1
. 00	Amount actually collected from patients liable for payment for basis	or services on a charge	0	0	13
. 00	Amounts that would have been realized from patients liable fo	or payment for services o	n 0	0	14
00	a charge basis had such payment been made in accordance with	1 3	0	0	'
. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	42 CIR 3413.13(6)	0, 000000	0.000000	1!
. 00	Total customary charges (see instructions)		868, 269	0.000000	
. 00	Excess of customary charges over reasonable cost (complete on	nlvifline 16 exceeds	774, 389	0	
	line 4) (see instructions)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	0	
. 00	Excess of reasonable cost over customary charges (complete on	nly if line 4 exceeds lin	e O	0	18
	16) (see instructions)	5			
. 00	Interns and Residents (see instructions)		0	0	19
. 00	Cost of physicians' services in a teaching hospital (see inst	tructions)	0	0	20
. 00	Cost of covered services (enter the lesser of line 4 or line		93, 880	0	21
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	e completed for PPS provi	ders.		
. 00	Other than outlier payments		0	0	
. 00	Outlier payments		0	0	
. 00	Program capital payments		0		24
. 00	Capital exception payments (see instructions)		0		2
. 00	Routine and Ancillary service other pass through costs		0	0	
. 00	Subtotal (sum of lines 22 through 26)		0	0	
. 00	Customary charges (title V or XIX PPS covered services only)		0	0	
. 00	Titles V or XIX (sum of lines 21 and 27) COMPUTATION OF REIMBURSEMENT SETTLEMENT		93, 880	0	20
. 00	Excess of reasonable cost (from line 18)		0	0	30
. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6	5)	93, 880	0	
	Deductiblies)	⁹ 3, 000	0	
. 00	Coinsurance		0	0	
00	Allowable bad debts (see instructions)		0	0	
00	Utilization review		0	0	3!
. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 an	nd 33)	93, 880	0	
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	<i>,</i>	0	0	
. 00	Subtotal (line 36 \pm line 37)		93, 880	0	
. 00	Direct graduate medical education payments (from Wkst. E-4)		0	-	30
. 00	Total amount payable to the provider (sum of lines 38 and 39)	1	93, 880	0	
. 00	Interim payments		93, 880	0	
. 00	Balance due provider/program (line 40 minus line 41)		0	0	
	Protested amounts (nonallowable cost report items) in accorda		0	0	43

I RECT	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provider CO	CN: 15-0088	Peri od:	Worksheet E-4	
EDI CA	L EDUCATION COSTS			From 07/01/2020 To 06/30/2021	Date/Time Pre	
		Title	XVIII	Hospi tal	11/23/2021 1:: PPS	22 pi
		in the		- Hospi tui	1 110	
					1.00	
. 00	COMPUTATION OF TOTAL DIRECT GME AMOUNT Unweighted resident FTE count for allopathic and osteopathic	programs for	cost reporti	ng periods	0.00	1.
. 00	ending on or before December 31, 1996. Unweighted FTE resident cap add-on for new programs per 42 CF	P /13 70(a)(1) (see instr	uctions)	0.00	2.
. 00	Amount of reduction to Direct GME cap under section 422 of MM		1) (366 1131		0.00	
01	Direct GME cap reduction amount under ACA §5503 in accordance		§413.79 (m).	(see	0.00	3.
. 00	instructions for cost reporting periods straddling 7/1/2011) Adjustment (plus or minus) to the FTE cap for allopathic and		programs due	to a Medicare	0.00	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 inst straddling 7/1/2011)		cost reporti	ng periods	0.00	4.
02	ACA Section 5506 number of additional direct GME FTE cap slot periods straddling 7/1/2011)	ts (see inst	ructions for	cost reporting	0.00	4.
. 00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 pl 4.02 plus applicable subscripts		·		0.00	5.
00	Unweighted resident FTE count for allopathic and osteopathic records (see instructions)	programs for	the current	year from your	0.00	
. 00	Enter the lesser of line 5 or line 6		Primary Care	e Other	0.00 Total	7.
			1.00	2.00	3.00	
00	Weighted FTE count for physicians in an allopathic and osteop	oathi c	0.0	0.00	0.00	8.
00	program for the current year. If line 6 is less than 5 enter the amount from line 8, otherw multiply line 8 times the result of line 5 divided by the amo		0.0	00 0.00	0.00	9
	6.					
). 00). 01	Weighted dental and podiatric resident FTE count for the curr Unweighted dental and podiatric resident FTE count for the cu			0. 00 0. 00		10 10
. 00 2. 00	Total weighted FTE count Total weighted resident FTE count for the prior cost reportir	ng year (see	0.0 0.0			11 12
3. 00	instructions) Total weighted resident FTE count for the penultimate cost re year (see instructions)	eporting	0.0	00 0.00		13
4. 00	Rolling average FTE count (sum of lines 11 through 13 divided	1 by 3).	0.0	0.00		14
5.00	Adjustment for residents in initial years of new programs	5	0.0	0.00		15
5. 01	Unweighted adjustment for residents in initial years of new p		0.0			15
. 00	Adjustment for residents displaced by program or hospital clo		0.0			16
b. 01	Unweighted adjustment for residents displaced by program or h	nospi tal	0.0	0.00		16
. 00	Adjusted rolling average FTE count		0.0	0.00		17
3. 00	Per resident amount		0.0	0.00		18
9.00	Approved amount for resident costs			0 0	0	19
					1.00	
0. 00		TE resident	cap slots rec	eived under 42	0.00	20
I. 00	Sec. 413.79(c)($\overline{4}$) Direct GME FTE unweighted resident count over cap (see instru	uctions)			0.00	21
2.00	Allowable additional direct GME FTE Resident Count (see instr				0.00	
3.00	Enter the locality adjustment national average per resident a		nstructions)		0.00	
. 00	Multiply line 22 time line 23	(000 1			0	
. 00	Total direct GME amount (sum of lines 19 and 24)				0	
			Inpatient Par A	rt Managed Care	Total	
			1.00	2.00	3.00	
. 00	COMPUTATION OF PROGRAM PATIENT LOAD Inpatient Days (see instructions) (Title XIX - see S-2 Part I	X, line	8, 49	95 6, 625		26
. 00	3.02, column 2) Total Inpatient Days (see instructions)		28, 51	0 28, 510		27
3.00	Ratio of inpatient days to total inpatient days		0. 29796			28
9.00	Program direct GME amount			0 0	0	
9. 01	Percent reduction for MA DGME					29.
0 00	Reduction for direct GME payments for Medicare Advantage			0	0	30.
0. 00	······································					31

Heal th	Financial Systems ASCENSION ST. VINCE	ENT ANDERSON	In Lie	u of Form CMS-2	2552-10
DI RECT	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provider CCN: 15-0088	Peri od:	Worksheet E-4	
MEDI CA	L EDUCATION COSTS		From 07/01/2020 To 06/30/2021	Date/Time Pre	oorod.
			To 06/30/2021	11/23/2021 1:	
		Title XVIII	Hospi tal	PPS	
		· .			
				1.00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE	E XVIII ONLY (NURSING SC	HOOL AND PARAMEDI	CAL	
	EDUCATION COSTS)				
32.00	Renal dialysis direct medical education costs (from Wkst. B, F	Pt. I, sum of col. 20 an	d 23, lines 74	0	32.00
	and 94)			_	
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I		74 and 94)	-	33.00
34.00	Ratio of direct medical education costs to total charges (line	e 32 ÷ líne 33)		0.00000	
35.00	Medicare outpatient ESRD charges (see instructions)			0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line			0	36.00
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII	UNLY			
27 00	Part A Reasonable Cost		I	22.4/5.025	27 00
37.00	Reasonable cost (see instructions)			22, 465, 925	
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)	susti and)		0	38.00 39.00
39.00 40.00	Cost of physicians' services in a teaching hospital (see instr Primary payer payments (see instructions)	uctions)		0 11. 103	
40.00	Total Part A reasonable cost (sum of lines 37 through 39 minus	a line (0)		22, 454, 822	
41.00	Part B Reasonable Cost	s THe 40)		22, 434, 622	41.00
42.00	Reasonable cost (see instructions)			19, 696, 743	12 00
43.00	Primary payer payments (see instructions)			892	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)			19, 695, 851	
45.00	Total reasonable cost (sum of lines 41 and 44)			42, 150, 673	
46.00	Ratio of Part A reasonable cost to total reasonable cost (line	e 41 ÷ line 45)		0. 532727	
47.00	Ratio of Part B reasonable cost to total reasonable cost (line			0. 467273	
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PAR				
48.00	Total program GME payment (line 31)			0	48.00
	Part A Medicare GME payment (line 46 x 48) (title XVIII only)	(see instructions)		0	49.00
	Part B Medicare GME payment (line 47 x 48) (title XVIII only)			0	50.00

	Financial Systems ASCENSION ST. VI SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column	Provider C	CN: 15-0088 F	Period: From 07/01/2020 To 06/30/2021	Worksheet G Date/Time Pre 11/23/2021 1:	pare 22 r
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
	Cash on hand in banks	10, 670	(0 0	0	1
00	Temporary investments	0		0 0	0	2
	Notes receivable	0		0 0	0	3
	Accounts receivable	61, 145, 878		0 0	0	
	Other receivable	60, 622		- -	0	
	Allowances for uncollectible notes and accounts receivable Inventory	-37, 538, 711 4, 352, 049		- -	0	
	Prepaid expenses	4, 352, 049			0	
	Other current assets	6, 990, 469		0	0	
	Due from other funds	0	(0 0	0	10
00	Total current assets (sum of lines 1-10)	35, 020, 977		0 0	0	11
	FIXED ASSETS					
	Land	5, 292, 602		0 0	0	12
	Land improvements	1, 754, 357		0 0	0	13
	Accumulated depreciation	0	(- -	0	14
	Buildings Accumulated depreciation	110, 278, 777	(0	15
	Accumulated depreciation Leasehold improvements				0	16
	Accumul ated depreciation				0	18
	Fixed equipment	0		0	0	19
	Accumulated depreciation	0	(0	0	20
. 00	Automobiles and trucks	0		0 0	0	21
	Accumulated depreciation	0	0	0 0	0	22
	Major movable equipment	63, 824, 210		0 0	0	23
	Accumulated depreciation	-126, 319, 236	(0	0	24
	Minor equipment depreciable	0			0	25
	Accumulated depreciation HIT designated Assets	0			0	26
	Accumul ated depreciation	0			0	28
	Mi nor equi pment-nondepreci abl e	0		0 0	0	29
	Total fixed assets (sum of lines 12-29)	54, 830, 710		0 0	0	30
	OTHER ASSETS					
	Investments	0	0		0	31
	Deposits on Leases	0	(° I	0	32
	Due from owners/officers		(0	33
	Other assets Total other assets (sum of lines 31-34)	2, 463, 743 2, 463, 743		-	0	34
	Total assets (sum of lines 11, 30, and 35)	92, 315, 430			0	
	CURRENT LI ABI LI TI ES	72, 313, 430			0	1
	Accounts payable	4, 556, 085	(0 0	0	1 37
	Salaries, wages, and fees payable	4, 465, 079		0 0	0	38
	Payroll taxes payable	0	(0 0	0	
	Notes and loans payable (short term)	223, 165		0 0	0	
	Deferred income	0	(0 0	0	
	Accelerated payments	0			0	42
	Due to other funds Other current liabilities	48, 576, 830			0	
	Total current liabilities (sum of lines 37 thru 44)	57, 821, 159			0	
	LONG TERM LI ABI LI TI ES	57, 021, 137			0	1 7.
-	Mortgage payable	14, 497, 463	(0 0	0	46
	Notes payable	0		0 0	0	47
	Unsecured Loans	0		0 0	0	48
	Other long term liabilities	614, 054		-	0	
	Total long term liabilities (sum of lines 46 thru 49)	15, 111, 517		-	0	
	Total liabilities (sum of lines 45 and 50)	72, 932, 676	(0 0	0	51
	CAPITAL ACCOUNTS General fund balance	10 202 754				1 61
	Specific purpose fund	19, 382, 754				52
	Donor created - endowment fund balance - restricted					54
	Donor created - endowment fund balance - unrestricted			0		55
	Governing body created - endowment fund balance			0		56
	Plant fund balance - invested in plant				0	
	Plant fund balance - reserve for plant improvement,				0	
	replacement, and expansion					
	Total fund balances (sum of lines 52 thru 58)	19, 382, 754		0	0	
00	Total liabilities and fund balances (sum of lines 51 and	92, 315, 430	. ()I O	0	60

CTATEN	· · · · · · · · · · · · · · · · · · ·	SCENSION ST. VIN		N. 15 0000	De		u of Form CMS-	
STATEN	IENT OF CHANGES IN FUND BALANCES		Provider CC	N: 15-0088		eriod: om 07/01/2020 0 06/30/2021	Worksheet G- Date/Time Pro 11/23/2021 1:	epared:
		General	Fund	Speci al	Pur	pose Fund	Endowment Fund	
1 00	Fund halanass at basinning of pariod	1.00	2.00	3.00		4.00	5.00	1 00
1.00 2.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29)		15, 857, 419 28, 701, 921			0		1.00 2.00
3.00	Total (sum of line 1 and line 2)		44, 559, 340		~	0		3.00
4.00 5.00	Additions (credit adjustments) (specify)	0			0			
5.00 6.00		0			0			
7.00		0			0			
8.00		0			0		C	8.00
9.00		0			0		(9.00
10.00	Total additions (sum of line 4-9)		0			0		10.00
11.00	Subtotal (line 3 plus line 10)		44, 559, 340			0		11.00
12.00	Deductions (debit adjustments) (specify)	0			0		(
13.00	MI SCELLANEOUS	25, 176, 586			0		0	
14.00 15.00		0			0			
16.00		0			0			
17.00		0			0			
18.00	Total deductions (sum of lines 12-17)		25, 176, 586			0		18.00
19.00	Fund balance at end of period per balance		19, 382, 754			0		19.00
	sheet (line 11 minus line 18)							
		Endowment Fund	<u>Pl ant</u>	Fund				
		6.00	7.00	8.00				
1.00	Fund balances at beginning of period	0			0			1.00
2.00	[Net income (loss) (from Wkst (-3 line 20)							
	Net income (loss) (from Wkst. G-3, line 29)				~			2.00
3.00	Total (sum of line 1 and line 2)	0	0		0			3.00
3.00 4.00		0	0		0			3.00 4.00
3.00 4.00 5.00	Total (sum of line 1 and line 2)	0	0 0 0		0			3.00 4.00 5.00
3.00 4.00	Total (sum of line 1 and line 2)	0	0		0			3.00 4.00
3.00 4.00 5.00 6.00	Total (sum of line 1 and line 2)	o	0		0			3.00 4.00 5.00 6.00
3.00 4.00 5.00 6.00 7.00 8.00 9.00	Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	o	0 0 0					3.00 4.00 5.00 6.00 7.00 8.00 9.00
3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00	Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9)	0	0 0 0 0		0			3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00
$\begin{array}{c} 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ \end{array}$	Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)	0 0 0	0 0 0 0 0					3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00
$\begin{array}{c} 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ \end{array}$	Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0 0 0	0 0 0 0 0		0			3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00
$\begin{array}{c} 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ \end{array}$	Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)	0 0 0			0			3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
$\begin{array}{c} 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ \end{array}$	Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0 0 0	0 0 0 0 0 0 0 0 0		0			3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00
$\begin{array}{c} 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00 \end{array}$	Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0 0 0			0			3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00
$\begin{array}{c} 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ \end{array}$	Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0 0 0			0			3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00
$\begin{array}{c} 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$	Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0 0 0			0			3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00
$\begin{array}{c} 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00 \end{array}$	Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) MISCELLANEOUS	0 0			0 0			3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00

	Health Financial Systems ASCENSION ST. VINCENT ANDE STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provid			Period:	u of Form CMS-2552-1 Worksheet G-2	
STATEN	IENT OF PATTENT REVENUES AND OPERATING EXPENSES	Provider C		From 07/01/2020 To 06/30/2021	Parts I & II Date/Time Pre 11/23/2021 1:	pared:
	Cost Center Description		Inpati ent	Outpati ent	Total	
			1.00	2.00	3.00	
	PART I - PATIENT REVENUES					
1.00	General Inpatient Routine Services Hospital		44, 302, 8	27	44, 302, 837	1.00
2.00	SUBPROVI DER – I PF		44, 302, 8	57	44, 302, 037	2.00
3.00	SUBPROVIDER - IRF		4, 448, 8	49	4, 448, 849	
4.00	SUBPROVI DER				1, 110, 017	4.00
5.00	Swing bed - SNF			0	0	5.00
6.00	Swing bed - NF			0	0	6.00
7.00	SKILLED NURSING FACILITY					7.00
8.00	NURSING FACILITY					8.00
9.00	OTHER LONG TERM CARE					9.00
10.00	Total general inpatient care services (sum of lines 1-9)		48, 751, 6	86	48, 751, 686	10.00
	Intensive Care Type Inpatient Hospital Services					
11.00	I NTENSI VE CARE UNI T		19, 511, 6	29	19, 511, 629	
12.00	CORONARY CARE UNIT					12.00
13.00	BURN INTENSIVE CARE UNIT					13.00
14.00 15.00	SURGI CAL INTENSIVE CARE UNIT					14.00 15.00
15.00	OTHER SPECIAL CARE (SPECIFY) Total intensive care type inpatient hospital services (sum o	flipoc	10 511 4	20	10 E11 400	
10.00	11-15)	I THES	19, 511, 6	29	19, 511, 629	10.00
17.00	Total inpatient routine care services (sum of lines 10 and 1	6)	68, 263, 3	15	68, 263, 315	17.00
18.00	Ancillary services	0)	148, 404, 4		540, 462, 077	
19.00	Outpatient services			0 79, 493, 670	79, 493, 670	
20.00	RURAL HEALTH CLINIC			0 0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0 0	0	21.00
22.00	HOME HEALTH AGENCY					22.00
23.00	AMBULANCE SERVI CES			0 0	0	23.00
24.00	СМНС					24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)					25.00
26.00	HOSPI CE					26.00
27.00	OTHER (SPECI FY)			0 0	0	
27.01	OTHER (SPECIFY)		04/ //7 7	0 0	0	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column G-3, line 1)	3 to WKST.	216, 667, 7	47 471, 551, 315	688, 219, 062	28.00
	PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)			173, 727, 573		29.00
30.00	ADD (SPECIFY)			0		30.00
31.00				0		31.00
32.00				0		32.00
33.00				0		33.00
34.00				0		34.00
35.00				0		35.00
36.00	Total additions (sum of lines 30-35)			0		36.00
37.00	DEDUCT (SPECI FY)			0		37.00
38.00				0		38.00
39.00				0		39.00
40.00				0		40.00
41.00 42.00	Total deductions (sum of lines 37-41)			0		41.00
42.00	Total operating expenses (sum of lines 29 and 36 minus line	42)(transfer		173, 727, 573		42.00
-5.00	to Wkst. G-3, Line 4)		1	115,121,515		I 73.00

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 07/01/2020 To 06/30/2021	Date/Time Pre 11/23/2021 1:	
				1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, li			688, 219, 062	1.00
2.00	Less contractual allowances and discounts on patients' accou	nts		493, 326, 863	2.00
3.00	Net patient revenues (line 1 minus line 2)			194, 892, 199	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		173, 727, 573	4.00
5.00	Net income from service to patients (line 3 minus line 4)			21, 164, 626	5.00
(00	OTHER I NCOME				(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 communicatio	n services		0	8.00
9.00	Revenue from tel evision and radio service			0	9.00
10.00 11.00	Purchase di scounts			0	10. 00 11. 00
12.00	Rebates and refunds of expenses Parking lot receipts			0	12.00
12.00	Revenue from Laundry and Linen service			0	12.00
13.00	Revenue from meals sold to employees and guests			294, 587	
14.00	Revenue from rental of living quarters			294, 567	14.00
16.00	Revenue from sale of medical and surgical supplies to other	than nationts		0	16.00
17.00	Revenue from sale of drugs to other than patients	than patrents		6, 944	
	Revenue from sale of medical records and abstracts			15, 290	
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			13, 270	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
20.00	Rental of vending machines			35, 472	
22.00	Rental of hospital space			602, 920	
23.00	Governmental appropriations			002, 720	23.00
24.00	LAB SERVI CE REVENUE			116	
24.01	SHARED REVENUE			315, 134	
24.02	OTHER (SPECIFY)			010, 101	24.02
24.03	GRANTS REVENUE			388, 002	
24.04	MISC REVENUE			328, 062	
24.05	SCHOOL OF RAD TECH			28, 657	
24.06	OTHER (SPECIFY)			0	24.06
24.07	CONTRACT SERVICE REVENUE			46, 386	
24.08	OTHER (SPECIFY)			0	24.08
	RESEARCH REVENUE			95, 668	
24.10	ASSETS RELEASED FROM RESTRICTED FUND			55, 292	24.10
24.11	GAIN ON DISPOSAL OF ASSET			800	24. 11
24.50	COVI D-19 PHE Fundi ng			5, 330, 416	24.50
25.00	Total other income (sum of lines 6-24)			7, 543, 746	25.00
26.00	Total (line 5 plus line 25)			28, 708, 372	26.00
27.00	EHR			0	27.00
27.01	RESTRUCTURI NG EXPENSE			0	27.01
	FUND RAISING ACTIVITIES			0	27.02
27.03				6, 451	
28.00	Total other expenses (sum of line 27 and subscripts)			6, 451	
29.00	Net income (or loss) for the period (line 26 minus line 28)			28, 701, 921	29.00

ALCULATION OF CAPITAL PAYMENT		Period: From 07/01/2020 To 06/30/2021	Worksheet L Parts I-III Date/Time Pre 11/23/2021 1:3			
	Title XVIII	Hospi tal	PPS			
			1.00			
PART I - FULLY PROSPECTIVE METHOD						
	CAPITAL FEDERAL AMOUNT					
	Capital DRG other than outlier					
01 Model 4 BPCI Capital DRG other than outlier			0			
00 Capital DRG outlier payments			7, 963			
01 Model 4 BPCI Capital DRG outlier payments			0			
00 Total inpatient days divided by number of days		uctions)	71.37			
00 Number of interns & residents (see instruction	·		0.00			
00 Indirect medical education percentage (see ins		columno 1 and	0.00			
.00 Indirect medical education adjustment (multipl	y line 5 by the sum of lines I and I.UI,	corumns r and	0	6.		
1.01)(see instructions) .00 Percentage of SSI recipient patient days to Me	dicara Part A patient days (Workshoot F	part A lino	5.75	7.		
30) (see instructions)						
	Percentage of Medicaid patient days to total days (see instructions)					
.00 Sum of lines 7 and 8				8.		
D. 00 Allowable disproportionate share percentage (s	ee instructions)		37.29 7.84			
1.00 Disproportionate share adjustment (see instruc			81, 666			
2.00 Total prospective capital payments (see instru	· · · · · · · · · · · · · · · · · · ·		1, 131, 293			
			1,101,270			
			1.00			
PART II - PAYMENT UNDER REASONABLE COST						
.00 Program inpatient routine capital cost (see in	structions)		0	1 1.		
.00 Program inpatient ancillary capital cost (see			0	2.		
.00 Total inpatient program capital cost (line 1 p	lus line 2)		0	3		
.00 Capital cost payment factor (see instructions)			0	4.		
.00 Total inpatient program capital cost (line 3 x	line 4)		0	5.		
			1.00			
PART III - COMPUTATION OF EXCEPTION PAYMENTS						
00 Program inpatient capital costs (see instructi	ons)		0	1.		
00 Program inpatient capital costs for extraordir	ary circumstances (see instructions)		0	2		
00 Net program inpatient capital costs (line 1 mi	nus line 2)		0	3		
00 Applicable exception percentage (see instructi	ons)		0.00	4		
00 Capital cost for comparison to payments (line	3 x line 4)		0	5		
00 Percentage adjustment for extraordinary circum	stances (see instructions)		0.00	6		
00 Adjustment to capital minimum payment level for	r extraordinary circumstances (line 2 x	line 6)	0	7		
00 Capital minimum payment level (line 5 plus lin	e 7)		0			
00 Current year capital payments (from Part I, li			0			
).00 Current year comparison of capital minimum pay			0			
 Carryover of accumulated capital minimum payme Worksheet L, Part III, line 14) 	nt level over capital payment (from prio	r year	0	11.		
2.00 Net comparison of capital minimum payment leve			0			
3.00 Current year exception payment (if line 12 is			0			
4.00 Carryover of accumulated capital minimum payme		llowing period	0	14		
(if line 12 is negative, enter the amount on t						
5.00 Current year allowable operating and capital p	avment (see instructions)		0	15		
, , , , , , , , , , , , , , , , , , ,	3	1				
0.00 Current year operating and capital costs (see .00 Current year exception offset amount (see inst	instructions)		0			