This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 03-31-2022 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-0181 Worksheet S Peri od: From 07/01/2021 Parts I-III AND SETTLEMENT SUMMARY 06/30/2022 Date/Time Prepared: 11/21/2022 11:32 am PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 11/21/2022 Time: 11:32 am] Manually prepared cost report use only Ilf this is an amended report enter the number of times the provider resubmitted this cost report [Medicare Utilization. Enter "F" for full or "L" for low. [1] Cost Report Status
[1] As Submitted
[2] Settled without Audit
[3] Settled with Audit
[4] Date Received:
[5] To. NPR Date:
[6] 10. NPR Date:
[7] 11. Contractor's Vendor Code:
[7] 12. [8] Final Report for this Provider CCN
[9] [8] Final Report for this Provider CCN
[10] NPR Date:
[11] 12. Contractor's Vendor Code:
[11] 12. Contractor's Vendor Code:
[12] 13. NPR Date:
[13] 14. Contractor's Vendor Code:
[14] 15. Contractor's Vendor Code:
[15] 16. NPR Date:
[16] 17. Contractor's Vendor Code:
[17] 17. Contractor's Vendor Code:
[18] 18. Contractor's Vendor Code:
[18] 19. NPR Date:
[19] 19. NPR Date:
[19] 19. NPR Date:
[10] 19. NPR Date:
[10] 19. NPR Date:
[10] 19. NPR Date:
[11] 19. NPR Date:
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[14] 19. NPR Date:
[15] 19. NPR Date:
[16] 19. NPR Date:
[17] 19. NPR Date:
[18] 19. NPR Date:
[18] 19. NPR Date:
[18] 19. NPR Date:
[19] 19. NPR Date Contractor use only

number of times reopened = 0-9.

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

(3) Settled with Audit

(4) Reopened (5) Amended

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ASCENSION ST. VINCENT FISHERS (15-0181) for the cost reporting period beginning 07/01/2021 and ending 06/30/2022 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONI C					
		1	2	SI GNATURE STATEMENT					
1	Becky Jacobson			I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1				
2	Signatory Printed Name	Becky Jacobson			2				
3	Signatory Title	VP - FINANCE			3				
4	Date	11/21/2022 11: 32: 24 AM			4				

			Title	XVIII			
Cost Center Description		Title V	Part A	Part B	HIT	Title XIX	
	· ·		2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	-123, 085	34, 910	0	0	1. 00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3. 00
5.00	Swing Bed - SNF	0	0	0		0	5. 00
6.00	Swing Bed - NF	0				0	6. 00
12.00	CMHC I	0		0		0	12.00
200.00	Total	0	-123, 085	34, 910	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

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

-	Ith Financial Systems ASCENSION ST. VINCENT FISHER PITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider					lı Period: From 07/01/			of Form CMS-2 Worksheet S-2	
						To 06/30/	Date/Time Prepa 11/21/2022 11:3			
	1.00	2.00		3. 00			4. 00	11/21/2	022 11	: 32 am
	Hospital and Hospital Health Care Co									1.00
1. 00 2. 00	Street: 13861 OLIO RD City: FISHERS	PO Box: State: IN	Zip Code	e: 46037	Count	y: HAMILTON				1.00
	,	Component Name	CCN	CBSA	Provi der	Date	Payme	nt Syst		
			Number	Number	Туре	Certi fi ed	V,	0, or	N) XIX	-
		1. 00	2.00	3. 00	4.00	5. 00	6. 00	7. 00	8.00	
	Hospital and Hospital-Based Componen		150101	0.4000		05 (40 (0040				
3. 00	Hospi tal	ASCENSION ST. VINCENT FISHERS	150181	26900	1	05/13/2013	N	P	0	3.00
4.00	Subprovider - IPF									4. 00
5. 00 6. 00	Subprovi der - IRF Subprovi der - (Other)									5. 00 6. 00
7. 00	Swing Beds - SNF									7. 00
8.00	Swing Beds - NF									8. 00
9.00	Hospi tal Based SNF									9.00
10. 00 11. 00	Hospi tal -Based NF Hospi tal -Based OLTC									10.00
12. 00	Hospi tal -Based HHA									12.00
	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice Hospital-Based Health Clinic - RHC									14. 00 15. 00
16. 00	Hospital -Based Health Clinic - FQHC									16. 00
	Hospital-Based (CMHC) I									17. 00
18. 00 19. 00										18.00
19.00	other					From:		То	 :	19.00
						1. 00		2.0		
	Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions)					07/01/2	021	06/30/	′2022	20.00
21.00	Type of control (see this fructions)									21.00
	T				1. 00	2. 00		3. 0	00	
22. 00	Inpatient PPS Information Does this facility qualify and is it	currently receiving nav	ments for		Y	N				22. 00
22.00	disproportionate share hospital adju				į.	l N				22.00
	§412.106? In column 1, enter "Y" fo									
	facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fo		endment							
22. 01	Did this hospital receive interim un		ts for thi	s	Υ	Y				22. 01
	cost reporting period? Enter in colu									
	the portion of the cost reporting pe Enter in column 2, "Y" for yes or "N									
	reporting period occurring on or aft			051						
22. 02	Is this a newly merged hospital that	requires final uncomper	nsated car		N	N				22. 02
	payments to be determined at cost re Enter in column 1, "Y" for yes or "N			s)						
	cost reporting period prior to Octob			yes						
	or "N" for no, for the portion of th									
22 03	October 1. Did this hospital receive a geograph	ic reclassification from	m urhan to		N	l N		N		22. 03
22.03	rural as a result of the OMB standar				IV	"		IV.		22.03
	adopted by CMS in FY2015? Enter in c									
	for the portion of the cost reportin in column 2, "Y" for yes or "N" for			r						
	reporting period occurring on or aft									
	Does this hospital contain at least									
	counted in accordance with 42 CFR 41 ves or "N" for no.	2.105)? Enter in column	3, "Y" fo	r						
22. 04	Did this hospital receive a geograph	ic reclassification from	m urban to		N	N		N		22. 04
	rural as a result of the revised OMB									
	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 the	ne cost							
	reporting period occurring on or aft	er October 1. (see insti	ructions)							
	Does this hospital contain at least counted in accordance with 42 CFR 41									
	yes or "N" for no.	250). Enter in corum	. 5, 1 1	-						
23. 00	Which method is used to determine Me					3 N				23. 00
	below? In column 1, enter 1 if date if date of discharge. Is the method									
	reporting period different from the	method used in the prior	r cost							
	reporting period? In column 2, ente	r "Y" for yes or "N" for	r no.	I						

	10 00/30/2022 Bate/11/me 11/21/202:										
		In-State	In-State	Out-of	Out-of	Medi ca	id C)ther			
		Medi cai d	Medicaid	State	State	HMO da		di cai d			
		paid days	eligible unpaid	Medicaid paid days	Medicaid eligible			days			
			days	para days	unpai d						
		1.00	2. 00	3. 00	4. 00	5. 00		6. 00	1		
24. 00	If this provider is an IPPS hospital, enter the	84					750		24.00		
	in-state Medicaid paid days in column 1, in-state										
	Medicaid eligible unpaid days in column 2,										
	out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column										
	4, Medicaid HMO paid and eligible but unpaid days in										
	column 5, and other Medicaid days in column 6.										
25. 00	If this provider is an IRF, enter the in-state	0	0	0	0		0		25. 00		
	Medicaid paid days in column 1, the in-state										
	Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state										
	Medicaid eligible unpaid days in column 4, Medicaid										
	HMO paid and eligible but unpaid days in column 5.										
						Rural S					
04.00					1.	00	2.	00	04.00		
26. 00	Enter your standard geographic classification (not wo cost reporting period. Enter "1" for urban or "2" fo		at the beg	jinning of 1	:he	1			26. 00		
27 00	Enter your standard geographic classification (not w		at the end	of the cos	st	1			27. 00		
55	reporting period. Enter in column 1, "1" for urban o	r"2" for r	ural. If ap]					
	enter the effective date of the geographic reclassif	ication in	column 2.								
35. 00	If this is a sole community hospital (SCH), enter the	e number of	periods SC	CH status ir	n	0			35. 00		
	effect in the cost reporting period.				Begi n	ni na:	Endi	na.			
					1.			00	1		
36. 00	Enter applicable beginning and ending dates of SCH s	tatus. Subs	cript line	36 for numb					36. 00		
	of periods in excess of one and enter subsequent date	es.									
37. 00	If this is a Medicare dependent hospital (MDH), ente	r the numbe	r of period	ls MDH statu	IS	0			37. 00		
37 ∩1	is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for t	he MDH tran	sitional na	wment in					37. 01		
37.01	accordance with FY 2016 OPPS final rule? Enter "Y" for								37.01		
	instructions)	y ·		(
38. 00	If line 37 is 1, enter the beginning and ending date								38. 00		
	greater than 1, subscript this line for the number of	f periods i	n excess of	one and							
	enter subsequent dates.				Y,	/N	V	/N			
					1.			00			
39. 00	Does this facility qualify for the inpatient hospita	l payment a	djustment f	or low volu		J		V	39. 00		
	hospitals in accordance with 42 CFR §412.101(b)(2)(i				ın						
	1 "Y" for yes or "N" for no. Does the facility meet										
	accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions)	II)? Enter	in column ∠	y ror ye	es						
40. 00		n adiustmen	t? Enter "Y	" for ves o	or \	,	1	V	40.00		
	"N" for no in column 1, for discharges prior to Octo										
	no in column 2, for discharges on or after October 1	. (see inst	ructions)				1	1			
						V 1 00	XVIII		-		
	Prospective Payment System (PPS)-Capital					1.00	2. 00	3.00			
45. 00	Does this facility qualify and receive Capital payment	nt for disp	roporti onat	e share in	accordance	N	N	N	45. 00		
	with 42 CFR Section §412.320? (see instructions)		,								
46. 00	Is this facility eligible for additional payment exc					N	N	N	46. 00		
	pursuant to 42 CFR §412.348(f)? If yes, complete Wks	t. L, Pt. I	II and Wkst	. L-1, Pt.	I through						
47.00	Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS	canital? E	ntor "V for	we or "N"	for no	N	N	N	47. 00		
	pro tili s a new nospital under 42 cik 9412. 300(b) FF3		-		N	N	N	48. 00			
	Is the facility electing full federal capital navmen	t? Enter "'	O Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.								
		t? Enter "	1 101 y 03	01 14 101							
	Teachi ng Hospi tal s				for yes o	r N			56. 00		
48. 00	Teaching Hospitals Is this a hospital involved in training residents in "N" for no in column 1. For column 2, if the response	approved G e to column	ME programs 1 is "Y",	? Enter "Y' or if this	hospi tal	r N			56. 00		
48. 00	Teaching Hospitals Is this a hospital involved in training residents in "N" for no in column 1. For column 2, if the response was involved in training residents in approved GME p	approved G e to column rograms in	ME programs 1 is "Y", the prior y	? Enter "Y' or if this year or penu	hospital ıltimate	r N			56. 00		
48. 00	Teaching Hospitals Is this a hospital involved in training residents in "N" for no in column 1. For column 2, if the response was involved in training residents in approved GME p year, and are you are impacted by CR 11642 (or applie	approved G e to column rograms in cable CRs) I	ME programs 1 is "Y", the prior y	? Enter "Y' or if this year or penu	hospital ıltimate	r N			56. 00		
48. 00 56. 00	Teaching Hospitals Is this a hospital involved in training residents in "N" for no in column 1. For column 2, if the response was involved in training residents in approved GME p	approved G e to column rograms in cable CRs) I	ME programs 1 is "Y", the prior y MA direct G	s? Enter "Y' or if this year or penu GME payment	hospital Iltimate reduction?	r N			56. 00		
48. 00 56. 00	Teaching Hospitals Is this a hospital involved in training residents in "N" for no in column 1. For column 2, if the response was involved in training residents in approved GME p year, and are you are impacted by CR 11642 (or applienter "Y" for yes; otherwise, enter "N" for no in co	approved G e to column rograms in cable CRs) lumn 2. period duri	ME programs 1 is "Y", the prior y MA direct G	s? Enter "Y' or if this year or penu GME payment esidents in	hospital Iltimate reduction?						
48. 00 56. 00	Teaching Hospitals Is this a hospital involved in training residents in "N" for no in column 1. For column 2, if the response was involved in training residents in approved GME pyear, and are you are impacted by CR 11642 (or applicant of the pyear of t	approved G e to column rograms in s cable CRs) I lumn 2. period duri r yes or "N th of this	ME programs 1 is "Y", the prior y MA direct G ng which re " for no ir cost report	er? Enter "Y' or if this wear or penu ome payment esidents in n column 1.	hospital Iltimate reduction? approved If column Character "Y	1					
48. 00 56. 00	Teaching Hospitals Is this a hospital involved in training residents in "N" for no in column 1. For column 2, if the response was involved in training residents in approved GME pyear, and are you are impacted by CR 11642 (or applicant Enter "Y" for yes; otherwise, enter "N" for no in column 11 in 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mon for yes or "N" for no in column 2. If column 2 is "	approved GI e to column rograms in a cable CRs) lumn 2. period duri r yes or "N th of this of	ME programs 1 is "Y", the prior y MA direct G ng which re " for no ir cost report e Worksheet	er? Enter "Y' or if this wear or penu ome payment esidents in n column 1.	hospital Iltimate reduction? approved If column Character "Y	1					
48. 00 56. 00 57. 00	Teaching Hospitals Is this a hospital involved in training residents in "N" for no in column 1. For column 2, if the response was involved in training residents in approved GME p year, and are you are impacted by CR 11642 (or applie Enter "Y" for yes; otherwise, enter "N" for no in co If line 56 is yes, is this the first cost reporting of GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mon for yes or "N" for no in column 2. If column 2 is " "N", complete Wkst. D, Parts III & IV and D-2, Pt. I	approved Gi e to column rograms in cable CRs) lumn 2. period duri r yes or "N th of this Y", complet l, if appli	ME programs 1 is "Y", the prior y MA direct G ng which re " for no ir cost report e Worksheet cable.	? Enter "Y' or if this year or penu ME payment esidents in a column 1. ing period? E-4. If co	hospital ultimate reduction? approved If column Enter "Y olumn 2 is	1			57. 00		
48. 00 56. 00 57. 00	Teaching Hospitals Is this a hospital involved in training residents in "N" for no in column 1. For column 2, if the response was involved in training residents in approved GME pyear, and are you are impacted by CR 11642 (or applicant Enter "Y" for yes; otherwise, enter "N" for no in column 11 in 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mon for yes or "N" for no in column 2. If column 2 is "	approved Gi e to column rograms in cable CRs) i lumn 2. period duri r yes or "N th of this y", complete l, if applio	ME programs 1 is "Y", the prior y MA direct G ng which re cost report e Worksheet cable. or physicia	? Enter "Y' or if this year or penu ME payment esidents in a column 1. ing period? E-4. If co	hospital ultimate reduction? approved If column Enter "Y olumn 2 is	1					

	Financial Systems ASCENSION FAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATE		Provider CO	CN: 15-0181	Peri od:	u of Form CMS-2 Worksheet S-2	
/3111	AL AND HOST FAC HEALTH CARE COMMERCY TO ENTITION DA	in.	Trovider co	SN. 13-0101	From 07/01/2021 To 06/30/2022	Part I Date/Time Pre 11/21/2022 11	pare
				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 adjustments.	85? (s∈ umn 1. R) NAHE	ee If column 1	N			60.
	adjustement? Enter "Y" for yes or "N" for no in colu	Y/N	IME	Direct GME	IME	Direct GME	
		1. 00	2. 00	3. 00	4. 00	5. 00	1
. 00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.
01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61
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
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
04	instructions) Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61
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
06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61
		Pro	gram Name	Program Cod		Unweighted Direct GME FTE Count	
10	Of the FTEs in line 61.05, specify each new program		1.00	2. 00	3.00	4. 00	61
	specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.						
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
						1.00	
00	ACA Provisions Affecting the Health Resources and Ser Enter the number of FTE residents that your hospital				riod for which	0.00	62
	your hospital received HRSA PCRE funding (see instruc Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog	tions) Teachir ram. (se	ng Health Cen ee instruction	ter (THC) int		0.00	
00		ttings o	during this co			N	63
	"Y" for yes or "N" for no in column 1. If yes, comple	te lines	s 64 through (67. (see inst Unweighted FTEs Nonprovider Site	Unweighted FTEs in	Ratio (col. 1/ (col. 1 + col. 2))	,
	Section 5504 of the ACA Base Year FTE Residents in No			1.00 This base yea	2.00 ar is your cost r	3.00 reporting	
	period that begins on or after July 1, 2009 and befor Enter in column 1, if line 63 is yes, or your facilit	e June :	30, 2010.	0.			64

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0181 Peri od: Worksheet S-2 From 07/01/2021 Part I Date/Time Prepared: 06/30/2022 11/21/2022 11 32 am Program Code Unwei ghted Unwei ghted Program Name Ratio (col. 3/ (col. 3 + col FTEs FTEs in Hospi tal 4)) Nonprovi der Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 is yes, or your facility 0. 00 0. 00 0.000000 65.00 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) Unwei ghted Unwei ghted Ratio (col. 1/ FTEs FTEs in (col. 1 + col Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 0. 00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Unwei ghted Ratio (col. 3/ Program Code Unwei ahted FTES FTEs in (col. 3 + col Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3. 00 4.00 5.00 67.00 Enter in column 1, the program 0.000000 67.00 0.00 0.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)) (see instructions) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 Enter "Y" for yes or "N" for no. 71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most O 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF N 75.00 subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for 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 column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der CC	CN: 15-0181	Peri od: From 07/01/2021 To 06/30/2022	Worksheet S-2 Part I Date/Time Pre 11/21/2022 11	epared:	
				1. 00		
Long Term Care Hospital PPS 0.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes 1.00 Is this a LTCH co-located within another hospital for part of "Y" for yes and "N" for no.			ng period? Enter	N N	80. 00 81. 00	
TEFRA Providers 5.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) 6.00 Did this facility establish a new Other subprovider (exclude §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				N	85. 00 86. 00	
7.00 Is this hospital an extended neoplastic disease care hospital 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	ı	N	87. 00			
1000(d)(1)(b)(vi): Litter i ioi yes or in ioi iio.			V	XI X		
Title V and XIX Services			1. 00	2. 00		
0.00 Does this facility have title V and/or XIX inpatient hospita	al services? Er	nter "Y" for	N	Υ	90.00	
yes or "N" for no in the applicable column. 1.00 Is this hospital reimbursed for title V and/or XIX through			N	Υ	91. 00	
full or in part? Enter "Y" for yes or "N" for no in the appl 2.00 Are title XIX NF patients occupying title XVIII SNF beds (du	ual certificati			N	92. 00	
instructions) Enter "Y" for yes or "N" for no in the application 3.00 Does this facility operate an ICF/IID facility for purposes		d XIX? Enter	N	N	93. 00	
"Y" for yes or "N" for no in the applicable column. 4.00 Does title V or XIX reduce capital cost? Enter "Y" for yes,	and "N" for no	in the	N	N	94. 00	
applicable column. 5.00 If line 94 is "Y", enter the reduction percentage in the application applicable applic			0. 00	0.00	95. 00	
6.00 Does title V or XIX reduce operating cost? Enter "Y" for yes applicable column.	s or "N" for no	o in the	N	N	96.00	
7.00 If line 96 is "Y", enter the reduction percentage in the app			0.00	0. 00	97. 00	
8.00 Does title V or XIX follow Medicare (title XVIII) for the instepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y"			N	Y	98. 00	
column 1 for title V, and in column 2 for title XIX. 8.01 Does title V or XIX follow Medicare (title XVIII) for the root, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title XIX.				Y	98. 01	
8.02 Does title V or XIX follow Medicare (title XVIII) for the countries bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes of for title V, and in column 2 for title XIX.			N	Y	98. 02	
8.03 Does title V or XIX follow Medicare (title XVIII) for a cri- reimbursed 101% of inpatient services cost? Enter "Y" for ya for title V, and in column 2 for title XIX.				N	98. 03	
8.04 Does title V or XIX follow Medicare (title XVIII) for a CAH outpatient services cost? Enter "Y" for yes or "N" for no ii in column 2 for title XIX.			N	N	98. 04	
8.05 Does title V or XIX follow Medicare (title XVIII) and add b Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in a column 2 for title XIX.				Y	98. 05	
8.06 Does title V or XIX follow Medicare (title XVIII) when cost Pts. I through IV? Enter "Y" for yes or "N" for no in column column 2 for title XIX.			N	Y	98. 06	
Rural Providers			N		105.00	
05. 00 Does this hospital qualify as a CAH? 06. 00 If this facility qualifies as a CAH, has it elected the all-for outpatient services? (see instructions)	-inclusive meth	nod of paymen	nt N		105. 00 106. 00	
07.00 Column 1: If line 105 is Y, is this facility eligible for or training programs? Enter "Y" for yes or "N" for no in column Column 2: If column 1 is Y and line 70 or line 75 is Y, do approved medical education program in the CAH's excluded II		107. 00				
Enter "Y" for yes or "N" for no in column 2. (see instruction 08.00 is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	3.00 Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42					
	Physi cal	Occupationa		Respiratory		
09.00 f this hospital qualifies as a CAH or a cost provider, are	1. 00	2.00	3.00	4.00	109.00	
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.						

	1.00	
110.00 Did this hospital participate in the Rural Community Hospital Demonstration project (§410A	N	110.00
Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes,		
complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as		1
appl i cabl e.		

	er CCN: 15-0181	Peri od:	u of Form CMS-2552 Worksheet S-2		
		From 07/01/202 To 06/30/202			
II.00 If this facility qualifies as a CAH, did it participate in the Frontie Health Integration Project (FCHIP) demonstration for this cost reporti "Y" for yes or "N" for no in column 1. If the response to column 1 is integration prong of the FCHIP demo in which this CAH is participating Enter all that apply: "A" for Ambulance services; "B" for additional b for tele-health services.	ng period? Ente Y, enter the jin column 2.	1.00 N	2.00	111. (
	1.00	2. 00	3.00	-	
12.00 Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information	N	2.00	3.00	112.	
Is.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for r in column 1. If column 1 is yes, enter the method used (A, B, or E onl in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based of the definition in CMS Pub. 15-1, chapter 22, §2208.1.	y) :			0115.	
16.00 s this facility classified as a referral center? Enter "Y" for yes or "N" for no.	- N			116.	
17.00 s this facility legally-required to carry malpractice insurance? Ente	er Y			117.	
"Y" for yes or "N" for no. 18.00 Is the malpractice insurance a claims-made or occurrence policy? Enter if the policy is claim-made. Enter 2 if the policy is occurrence.	- 1	2		118.	
in the porrey is craim made. Effect 2 in the porrey is occurrence.	Premi ums	Losses	Insurance		
	1. 00	2.00	3.00		
18.01 List amounts of malpractice premiums and paid losses:	1.00	0	_	37 118.	
		1.00	2.00		
8.02 Are malpractice premiums and paid losses reported in a cost center oth Administrative and General? If yes, submit supporting schedule listing and amounts contained therein.		N		118.	
9.00 DO NOT USE THIS LINE (0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless §3121 and applicable amendments? (see instructions) Enter in column 1, "N" for no. Is this a rural hospital with < 100 beds that qualifies for Hold Harmless provision in ACA §3121 and applicable amendments? (see i Enter in column 2, "Y" for yes or "N" for no.	"Y" for yes or or the Outpatien		N	119. 120.	
1.00 Did this facility incur and report costs for high cost implantable dev	vices charged to	Y		121.	
patients? Enter "Y" for yes or "N" for no. $2.00\mathrm{Does}$ the cost report contain healthcare related taxes as defined in §1			5. 00	122.	
Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enthe Worksheet A line number where these taxes are included. Transplant Center Information	enter in column :	2		_	
5.00 Does this facility operate a transplant center? Enter "Y" for yes and	"N" for no. If	N		125.	
yes, enter certification date(s) (mm/dd/yyyy) below. 6.00 If this is a Medicare certified kidney transplant center, enter the ce	ertification date	е		126.	
in column 1 and termination date, if applicable, in column 2. 7.00 If this is a Medicare certified heart transplant center, enter the cer	tification date			127	
in column 1 and termination date, if applicable, in column 2. 8.00 f this is a Medicare certified liver transplant center, enter the cer				128	
in column 1 and termination date, if applicable, in column 2.					
9.00 If this is a Medicare certified lung transplant center, enter the cert column 1 and termination date, if applicable, in column 2.	TITICATION date	ın		129	
0.00 If this is a Medicare certified pancreas transplant center, enter the date in column 1 and termination date, if applicable, in column 2.	certi fi cati on			130.	
1.00 If this is a Medicare certified intestinal transplant center, enter th	ne certification			131.	
date in column 1 and termination date, if applicable, in column 2. (2.00) If this is a Medicare certified islet transplant center, enter the cer in column 1 and termination date, if applicable, in column 2.	tification date			132.	
3.00 Removed and reserved	per in column 1			133. 134.	
34.00 If this is an organ procurement organization (0P0), enter the 0P0 number and termination date, if applicable, in column 2. All Providers				_	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0181 Peri od: Worksheet S-2 From 07/01/2021 Part I Date/Time Prepared: To 06/30/2022 11/21/2022 11:32 am 3.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number 141 00 Name: ST VINCENT HEALTH Contractor's Name: WPS Contractor's Number: 8101 141 00 142.00 Street: 250 WEST 96TH STREET, SUITE 215 PO Box: 142.00 143.00 City: INDIANAPOLIS 46260 143. 00 Zip Code: 1.00 144.00 Are provider based physicians' costs included in Worksheet A? 144. 00 γ 1. 00 2.00 145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for 145 00 inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost allocation methodology changed from the previously filed cost report? 146.00 Ν Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. 1.00 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. 147. 00 Ν N 148 00 149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no Ν 149.00 Part A Part B Title V Title XIX 1.00 2.00 3.00 4.00 Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) 155.00 Hospi tal 155.00 Ν N 156.00 Subprovi der - IPF Ν Ν Ν Ν 156.00 157.00 Subprovi der - IRF 157 00 N Ν Ν N 158. 00 SUBPROVI DER 158. 00 159.00 SNF Ν Ν Ν 159. 00 Ν 160.00 HOME HEALTH AGENCY 160.00 Ν Ν Ν Ν 161.00 CMHC <u>161.</u> 00 Ν Ν N 1.00 Multicampus 165.00 s this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? N 165.00 Enter "Y" for yes or "N" for no. Name County State Zip Code CBSA FTE/Campus 0 1.00 2.00 3.00 4.00 5.00 166.00 If line 165 is yes, for each 0.00 166.00 campus enter the name in column O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) 1.00 Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act 167.00 s this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no. 167 00 168.00 of this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the 168.00 reasonable cost incurred for the HIT assets (see instructions) 168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions) 168.01 169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the 9. 99169. 00 transition factor. (see instructions) Begi nni ng Endi ng 1.00 2.00 170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting 170. 00 period respectively (mm/dd/yyyy) 1.00 2.00 171.00|If line 167 is "Y", does this provider have any days for individuals enrolled in 0171.00 N section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)

SPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider Co	CN: 15-0181	Period: From 07/01/2021 To 06/30/2022	Worksheet S-2 Part II Date/Time Pro 11/21/2022 1	epare
				Y/N	Date	
	General Instruction: Enter Y for all YES responses. Enter N	for all NO re	sponses Ent	1.00	2.00 the	
	mm/dd/yyyy format.					
	COMPLETED BY ALL HOSPITALS Provider Organization and Operation					
00	Has the provider changed ownership immediately prior to the	beginning of	the cost	N		1.
	reporting period? If yes, enter the date of the change in c	olumn 2. (see	instructions Y/N	Date	V/I	
			1.00	2. 00	3. 00	
00	Has the provider terminated participation in the Medicare P yes, enter in column 2 the date of termination and in column voluntary or "I" for involuntary.		N			2.
00	Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home of or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members of of directors through ownership, control, or family and othe relationships? (see instructions)	ffices, drug er or its f the board	N			3.
	Terationships: (See Thatructions)		Y/N	Туре	Date	
	Financial Data and Departs		1. 00	2. 00	3. 00	
00	Financial Data and Reports Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" for "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions	or Compiled,	Y	A		4
00	Are the cost report total expenses and total revenues diffe those on the filed financial statements? If yes, submit rec		N			5
				Y/N 1. 00	Legal Oper. 2.00	
	Approved Educational Activities			1.00	2.00	
00	Column 1: Are costs claimed for a nursing program? Column is the legal operator of the program?	2: If yes, is	the provide	er N		6
00	Are costs claimed for Allied Health Programs? If "Y" see in: Were nursing programs and/or allied health programs approve		ed during th	ne N		7
00	cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction.		al education	N N		9
00	Was an approved Intern and Resident GME program initiated o cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I	r renewed in t		N N		10
. 00	Teaching Program on Worksheet A? If yes, see instructions.	a K III ali App	n oveu	IV.		
					Y/N 1.00	
	Bad Debts				1.00	
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.			cost reporting	Y N	12
00	If line 12 is yes, were patient deductibles and/or co-payme	nts waived? If	yes, see ir	nstructions.	N	_ 14
00	Bed Complement Did total beds available change from the prior cost reporti	na period? If	ves. see ins	structions.	N	15
			t A		t B	
		Y/N 1. 00	2. 00	Y/N 3. 00	Date 4.00	
	PS&R Data					
00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see instructions)	Υ	10/07/2022	2 Y	10/07/2022	16
00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	N		N		17
00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	N		N		18
. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R	N		N		19

HOSPITAL AND HOSPITAL HEALTH CARE REINBURGERENT QUESTIONNAIRE Provider CON: 15-0181 Period Provider CON: 105-0182 Period Provider CON: 105-0182 Period Provider CON: 105-0182 Period Provider Con: 107-01720 Period Pe	Heal th	Financial Systems ASCENSION ST. VI	INCENT FISHERS		In Lie	u of Form CM	S-2552-10		
Description	HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der Co	CN: 15-0181	From 07/01/2021	Part II Date/Time P	repared:		
1.00 Filine 16 or 17 is yes, were adjustments made to PSAR Report data for Other? Describe the other adjustments: Y/R Bate Y/R Date						Y/N			
Report data for Other? Describe the other adjustments: V/N	20.00	If line 1/ or 17 is use were adjustments made to DCOD	()			20.00		
21.00 Was the cost report prepared only using the provider's N 2.00 3.00 4.00 2.00 1.00 1.00 1.00 1.00 1.00 1.00 1	20.00				IN	IN IN	20.00		
21.00 Was the cost report prepared only using the provider's N N 21.00 COMPLETED BY COST RELIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)			Y/N	Date	Y/N	Date			
Precords? If yes, see Instructions 1.00		In the second se		2. 00		4. 00			
Completed BY COST RETURBURSED AND TERRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) Copited Related CoSt 22.00 Have assets been relifed for Medicare purposes? If yes, see instructions 23.00 Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions 24.00 Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions 25.00 Have the relieve and capitalized leases entered into during the cost reporting period? If yes, see instructions 26.00 Were assets subject to Sec 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions. 27.00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy interest Expense 28.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions. 29.00 Did the provider have a funded depreciation account? If yes, see instructions. 29.00 Did the provider have a funded depreciation account? If yes, see instructions. 29.00 Did the provider have a funded depreciation account? If yes, see instructions. 30.00 Has existing the been replaced prior to its scheduled maturity with new debt? If yes, see instructions. 31.00 Has existing the been replaced prior to its scheduled maturity with new debt? If yes, see instructions. 32.00 Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. 32.00 Have changes or new agreements occurred in patient care services furnished through contractual arrangement with provider-based physicians? If yes, see instructions. 33.00 If I line 32 is yes, were the requirements of Sec. 2135. 2 applied pertaining to competitive bidding? If yes, see instructions. 44.00 Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions. 45.00	21. 00		N		N		21. 00		
COMPLETED BY COST RETURBURSED AND TERRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) Capit tal Related Cost 22.00 Have assets been relifed for Medicare purposes? If yes, see instructions 23.00 Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions. 24.00 Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions. 25.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions. 27.00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy. 28.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, submit copy. 29.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, submit copy. 29.00 Were assets subject to Sec. 2314 or DEFRA acquired during the cost reporting period? If yes, submit copy. 29.00 Were men loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions. 29.00 Did the provider have a funded depreciation account? If yes, see instructions. 29.00 Did the provider have a funded depreciation account? If yes, see instructions. 30.00 Instructions. 30.00 Has edisting to been repolated prior to its scheduled maturity with new debt? If yes, see instructions. 30.00 Has edisting to been repolated prior to its scheduled maturity with new debt? If yes, see instructions. 30.00 Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. 30.00 Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. 30.00 If I line 31 is yes, were the requirements of Sec. 2135, 2 applied pertaining to competitive bidding? If yes, see									
22.00 lave assets been relifed for Medicare purposes? If yes, see instructions 22.00 23.00 lave changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions. 24.00 Were new leases and/or amendments to existing leases entered into during this cost reporting period? 24.00 Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see 25.00 Nave there been new capital ized leases entered into during the cost reporting period? If yes, see 25.00 Were assets, subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see 26.00 Instructions 27.00 Instructio		COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE							
23.00 Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.									
reporting period? If yes, see instructions. 24.00 Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see Instructions. 25.00 Have there been new capitalized leases entered into during the cost reporting period? If yes, see Instructions. 26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see Instructions. 27.00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy. 28.00 Event the provider's capitalization policy changed during the cost reporting period? If yes, submit copy. 29.00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) period? If yes, see Instructions. 29.00 Did set sixtling debt been replaced prior to its scheduled maturity with new debt? If yes, see Instructions. 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see Instructions. 32.00 Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. 32.00 Have changes or new agreements or Sec. 2135.2 applied pertaining to competitive bidding? If no. see Instructions are instructions. 34.00 Are services. Finally and the provider facility under an arrangement with provider-based physicians? 35.00 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians or in yes and the provider facility under an arrangement with the provider-based physicians or physicians during the cost reporting period? If yes, see instructions. 36.00 Were home office costs claimed on the cost report? 37.00 If line 36 is yes, has a home office cost statement been prepared by the home office? 38.00 If line 36 is yes, and the provider render services to the home office? 39.00 If line 36 is yes, did the provider render services to the home office? 39.00 If line 36 is yes, did th									
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38.00 If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office. 39.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see 1.00 2.00 Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report ST. VINCENT HEALTH 42.00 Enter the telephone number and email address of the cost NA JILL. HILL@ASCENSION. ORG 43.00	37.00		cpared by tile	nome office?	'		37.00		
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see instructions. If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report ST. VINCENT HEALTH 42.00 Enter the telephone number and email address of the cost NA JILL. HILL@ASCENSION.ORG 43.00	20.00				N		20.00		
40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 instructions. 1.00 2.00	39.00		er charn compon	ents: II yes	, IN		39.00		
Cost Report Preparer Contact Information 41.00 Enter the first name, I ast name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 42.00 Enter the employer/company name of the cost report ST. VINCENT HEALTH 43.00 Enter the telephone number and email address of the cost NA ST. VINCENT HEALTH JILL. HILL@ASCENSION. ORG 43.00	40.00		home office?	If yes, see	N		40.00		
Cost Report Preparer Contact Information 41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 42.00 Enter the employer/company name of the cost report preparer. 43.00 Enter the telephone number and email address of the cost NA JILL. HILL@ASCENSION. ORG 43.00		instructions.							
Cost Report Preparer Contact Information 41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 42.00 Enter the employer/company name of the cost report preparer. 43.00 Enter the telephone number and email address of the cost NA JILL. HILL@ASCENSION. ORG 43.00			1	00	2	00			
41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 42.00 Enter the employer/company name of the cost report preparer. 43.00 Enter the telephone number and email address of the cost NA HILL 41.00 42.00 JILL. HILL ASSCENSION. ORG 43.00		Cost Report Preparer Contact Information	1.		2.				
respectively. 42.00 Enter the employer/company name of the cost report preparer. 43.00 Enter the telephone number and email address of the cost NA JILL. HILL@ASCENSION. ORG 43.00	41. 00	Enter the first name, last name and the title/position	JI LL		HI LL		41. 00		
42.00 Enter the employer/company name of the cost report ST. VINCENT HEALTH 42.00 preparer. 43.00 Enter the telephone number and email address of the cost NA JILL. HILL@ASCENSION. ORG 43.00		1 ' '							
preparer. 43.00 Enter the telephone number and email address of the cost NA JILL. HILL@ASCENSION. ORG 43.00	42 00		ST VINCENT HE	AI TH			42 00		
43.00 Enter the telephone number and email address of the cost NA UILL. HILL®ASCENSION. ORG 43.00	12.00		O VINOLINI IIL				12.00		
report preparer in columns 1 and 2, respectively.	43.00	Enter the telephone number and email address of the cost	NA		JI LL. HI LL@ASCE	NSI ON. ORG	43.00		
		report preparer in columns 1 and 2, respectively.	I		I		II		

Health Financial Systems ASCENSION ST. VI			VINCENT FISHERS				In Lieu of Form CMS-2552-10				
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE				Provi der	CCN: 15-01		eri od:		Worksheet S-2	!	
								7/01/2021 5/30/2022	Part II Date/Time Pre	nared.	
						'		57 507 2022	11/21/2022 11	: 32 am	
				3	. 00						
	Cost Report Preparer Contact Information										
41.00	Enter the first name, last name and the tit	le/position	RE	I MBURSEMENT	MANAGER					41. 00	
	held by the cost report preparer in columns	1, 2, and 3,									
	respecti vel y.										
42.00	Enter the employer/company name of the cost	report								42. 00	
	preparer.										
43.00	Enter the telephone number and email address									43. 00	
	report preparer in columns 1 and 2, respect	i vel y.									

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

 HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX
 STATISTICAL DATA
 Provider CCN: 15-0181

					-	То	06/30/2022	Date/Time Pro		
								I/P Days / 0/F		<u></u>
								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		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		46	16, 79	0	0.00	C	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)									00
3.00	HMO IPF Subprovider									00
4.00	HMO IRF Subprovider									00
5.00	Hospital Adults & Peds. Swing Bed SNF							C		00
6.00	Hospital Adults & Peds. Swing Bed NF							C		00
7.00	Total Adults and Peds. (exclude observation			46	16, 79	0	0. 00	C	7.	00
	beds) (see instructions)	04.00				_		_		
8. 00	INTENSIVE CARE UNIT	31. 00		0		0	0.00	C		00
9.00	CORONARY CARE UNIT	32. 00		0		0	0.00	C		00
10.00	BURN INTENSIVE CARE UNIT	33. 00		0		0	0.00	C		
11.00	SURGICAL INTENSIVE CARE UNIT	34. 00		0	1	0	0. 00	С	1	
12.00	OTHER SPECIAL CARE (SPECIFY)	40.00							12.	
13.00	NURSERY	43. 00		4.	47.70	_	0.00	C		
14. 00	Total (see instructions)			46	16, 79	U	0. 00	C		
15.00	CAH visits							C		
16.00	SUBPROVI DER - I PF								16.	
17. 00	SUBPROVIDER - I RF								17.	
18.00	SUBPROVI DER								18.	
19.00	SKILLED NURSING FACILITY								19.	
20.00	NURSING FACILITY								20.	
21. 00	OTHER LONG TERM CARE								21.	
22. 00	HOME HEALTH AGENCY								23.	
23. 00 24. 00	AMBULATORY SURGICAL CENTER (D. P.) HOSPICE								24.	
24. 00	HOSPICE (non-distinct part)	30. 00	ŀ						24.	
25. 00	CMHC - CMHC	99. 00						C		
26. 00	RURAL HEALTH CLINIC	99.00							26.	
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00						C	1	
27. 00	Total (sum of lines 14-26)	07.00		46					27.	
28. 00	Observation Bed Days			40				C	1	
29. 00	Ambul ance Tri ps								29.	
30.00	Employee discount days (see instruction)		ŀ						30.	
31. 00	Employee discount days - IRF								31.	
32. 00	Labor & delivery days (see instructions)			0		0			32.	
32. 01	Total ancillary labor & delivery room			0					32.	
52. 01	outpatient days (see instructions)								52.	٥.
33.00	LTCH non-covered days								33.	00
	LTCH site neutral days and discharges		1						33.	
	3	'			•	'	'	1		

33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0181

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

11/21/2022 11:32 am Full Time Equivalents I/P Days / O/P Visits / Trips Title XVIII Title XIX Total All Total Interns Employees On Component Pati ents & Residents Payrol I 6.00 7.00 8.00 9.00 10.00 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 771 52 3, 075 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 00 425 750 3.00 HMO IPF Subprovider 3.00 HMO IRF Subprovider 4.00 0 4.00 Hospital Adults & Peds. Swing Bed SNF 0 0 5.00 5.00 Hospital Adults & Peds. Swing Bed NF 6.00 C 0 6.00 7.00 Total Adults and Peds. (exclude observation 771 52 3,075 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8.00 0 0 8.00 CORONARY CARE UNIT 9.00 0 0 0 9.00 10.00 BURN INTENSIVE CARE UNIT 0 C 0 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 0 0 11.00 12.00 OTHER SPECIAL CARE (SPECIFY) 12.00 13.00 NURSERY 38 1.213 13.00 14.00 Total (see instructions) 771 90 4, 288 0.00 151.07 14.00 CAH visits 15.00 15.00 SUBPROVIDER - IPF 16.00 16.00 SUBPROVIDER - IRF 17.00 17.00 18.00 SUBPROVI DER 18.00 19.00 SKILLED NURSING FACILITY 19.00 20 00 NURSING FACILITY 20 00 21.00 OTHER LONG TERM CARE 21.00 22.00 HOME HEALTH AGENCY 22.00 23.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 HOSPI CE 24.00 24 00 24. 10 HOSPICE (non-distinct part) 24.10 CMHC - CMHC 0 0.00 0.00 25.00 25.00 26, 00 RURAL HEALTH CLINIC 26, 00 FEDERALLY QUALIFIED HEALTH CENTER 0.00 0 26.25 C 0.00 26.25 27.00 Total (sum of lines 14-26) 0.00 151.07 27.00 28.00 Observation Bed Days 884 28.00 29.00 Ambul ance Trips 29.00 30.00 Employee discount days (see instruction) 164 30.00 31.00 Employee discount days - IRF 31.00 Labor & delivery days (see instructions) 32.00 32.00 0 560 0 Total ancillary labor & delivery room 32.01 C 32.01 outpatient days (see instructions) 33.00 LTCH non-covered days 33.00

33.01 LTCH site neutral days and discharges

| Peri od: | Worksheet S-3 | From 07/01/2021 | Part | To 06/30/2022 | Date/Time Prepared:
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 Systems
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 HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX
 STATISTICAL DATA
 Provider CCN: 15-0181

				To	06/30/2022	Date/Time Prep 11/21/2022 11:	
		Full Time	<u>'</u>	Di sch	arges		
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12. 00	13. 00	14. 00	15. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		(248	21	1, 474	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
2. 00	for the portion of LDP room available beds) HMO and other (see instructions)			137	309		2. 00
3. 00	HMO IPF Subprovider			137	309		3. 00
4. 00	HMO IRF Subprovider				0		4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF				ď		5. 00
6. 00	Hospital Adults & Peds. Swing Bed NF						6. 00
7. 00	Total Adults and Peds. (exclude observation						7. 00
7.00	beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8. 00
9. 00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0. 00	(248	21	1, 474	14.00
15.00	CAH visits						15.00
16.00	SUBPROVI DER - I PF						16.00
17.00	SUBPROVI DER - I RF						17.00
18.00	SUBPROVI DER						18.00
19. 00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY						22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24. 00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC	0. 00					25. 00
26. 00	RURAL HEALTH CLINIC	0.00					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 29. 00	Observation Bed Days						28. 00 29. 00
30.00	Ambulance Trips						29. 00 30. 00
31.00	Employee discount days (see instruction) Employee discount days - IRF						30.00
32.00	Labor & delivery days (see instructions)						32.00
32. 00	Total ancillary labor & delivery room						32. 00 32. 01
32.01	outpatient days (see instructions)						32.01
33. 00	LTCH non-covered days			0			33. 00
	,						33. 01
				. 9	ı	ı	

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0181

					'	0 06/30/2022	Date/lime Pre 11/21/2022 11	
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst.	Sal ari es (col. 2 ± col.	Related to Salaries in	Average Hourly Wage (col. 4 ÷ col. 5)	
		1. 00	2. 00	A-6) 3.00	3) 4.00	col . 4 5. 00	6. 00	
	PART II - WAGE DATA		2.00	0.00		0.00	0.00	
1. 00	SALARIES Total salaries (see	200. 00	14, 277, 410	-81, 042	14, 196, 368	291, 963. 59	48. 62	1.00
2. 00	instructions) Non-physician anesthetist Part	200.00	14, 277, 410	01,042		0.00		
3. 00	A Non-physician anesthetist Part		0	0	0	0. 00		
4. 00	B Physician-Part A -		45, 875	0	45, 875	307. 16	149. 35	4.00
4. 01	Administrative Physicians - Part A - Teaching		0	0	0	0.00		
5. 00	Physician and Non Physician-Part B		53, 000		53, 000			
6. 00	Non-physician-Part B for hospital-based RHC and FQHC		0	0	0	0.00	0.00	6.00
7. 00	services Interns & residents (in an approved program)	21. 00	0	0	0	0.00	0. 00	7. 00
7. 01	Contracted interns and residents (in an approved programs)		0	o	0	0.00	0.00	7. 01
8. 00	Home office and/or related organization personnel		97, 637	0	97, 637	2, 545. 95	38. 35	8. 00
9. 00 10. 00	SNF Excluded area salaries (see	44. 00	0 3, 301	0 24	1	0. 00 46. 81	0. 00 71. 03	
	instructions) OTHER WAGES & RELATED COSTS		•		·			-
11. 00	Contract labor: Direct Patient Care		621, 378	0	621, 378	4, 840. 48	128. 37	11. 00
12. 00	Contract labor: Top level management and other management and administrative		0	0	0	0.00	0.00	12.00
13. 00	services Contract Labor: Physician-Part A - Administrative		643, 375	0	643, 375	20, 895. 42	30. 79	13. 00
14. 00	Home office and/or related organization salaries and		0	0	0	0.00	0. 00	14. 00
14. 01 14. 02 15. 00	wage-related costs Home office salaries Related organization salaries Home office: Physician Part A - Administrative		3, 065, 453 0 0	0 0	0	60, 819. 28 0. 00 0. 00	0. 00	
16. 00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0. 00	16. 00
16. 01	Home office Physicians Part A - Teaching		0	0	0	0.00	0. 00	16. 01
16. 02	Home office contract Physicians Part A - Teaching WAGE-RELATED COSTS		0	0	0	0.00	0.00	16. 02
17. 00	Wage-related costs (core) (see instructions)		2, 592, 631	0	2, 592, 631			17. 00
18. 00	Wage-related costs (other) (see instructions)							18. 00
19. 00 20. 00	Excluded areas Non-physician anesthetist Part		604 0	0	604 0			19. 00 20. 00
21. 00	A Non-physician anesthetist Part		0	0	0			21. 00
22. 00	Physician Part A - Administrative		8, 390	0	8, 390			22. 00
22. 01 23. 00 24. 00	Physician Part A - Teaching Physician Part B Wage-related costs (RHC/FQHC)		9, 694	0	9, 694			22. 01 23. 00 24. 00
25. 00	Interns & residents (in an approved program)		0	0	0			25. 00
25. 50	Home office wage-related (core)		1, 156, 556	0	1, 156, 556			25. 50
25. 51	Related organization wage-related (core)		0	0	0			25. 51
25. 52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25. 52

17.00

18.00

0.00 42.00

0.00 43.00

HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0181 Peri od: Worksheet S-3 From 07/01/2021 Part II 06/30/2022 Date/Time Prepared: 11/21/2022 11:32 am Wkst. A Line Amount Recl assi fi cati Adj usted Paid Hours Average Hourly Number on of Salaries Sal ari es Related to Wage (col. 4 Reported col . 5) (from Wkst. (col . 2 ± col . Salaries in A-6)3) col. 4 1.00 2.00 5.00 6.00 3.00 4.00 25.53 Home office: Physicians Part A 0 25.53 - Teaching - wage-related (core) OVERHÉAD COSTS - DIRECT SALARIES 26.00 4. 00 138, 617 -138, 617 26.00 Employee Benefits Department O 00 0.00 27.00 Administrative & General 5.00 527, 788 1, 263 529, 051 10, 866. 81 48. 69 27.00 28.00 Administrative & General under 366, 713 366, 713 2, 098. 02 174. 79 28.00 contract (see inst.) Maintenance & Repairs 6.00 29.00 0.00 0.00 29.00 0 0 0 0 Operation of Plant 0 0 0.00 30.00 7.00 0.00 30.00 31.00 Laundry & Linen Service 8.00 0 0 0 0.00 0.00 31.00 Housekeepi ng 32.00 9.00 0 0.00 0.00 32.00 Housekeeping under contract 477, 993 17, 364. 00 33.00 0 477.993 27. 53 33.00 (see instructions) 34.00 Di etary 10.00 0.00 0.00 34.00 Di etary under contract (see instructions) 7, 344. 01 33. 40 35.00 245, 273 0 245, 273 35.00 36.00 Cafeteri a 11.00 0 0.00 0.00 36.00 0 0 Maintenance of Personnel 37.00 12.00 0 r Λ 0.00 0.00 37.00 38.00 Nursing Administration 13.00 942, 816 1,725 944, 541 18, 916. 55 49. 93 38.00 39.00 Central Services and Supply 14.00 56, 948 -218 56, 730 0.00 0.00 39.00 609, 175 605, 887 12, 729. 95 40.00 Pharmacy 15.00 3, 288 47.85 40.00 41.00 Medical Records & Medical 16.00 0 0.00 0.00 41.00

0

0

0

ol

0

0

0.00

0.00

Records Library Social Service

43.00 Other General Service

42.00

Total overhead cost (see

instructions)

7.00

46. 59

7.00

HOSPITAL WAGE INDEX INFORMATION Worksheet S-3 Part III Date/Time Prepared: Provider CCN: 15-0181 Peri od: From 07/01/2021 To 06/30/2022 11/21/2022 11:32 am Worksheet A Amount Recl assi fi cati Adj usted Pai d Hours Average Hourly Line Number Reported on of Salaries Sal ari es Related to Wage (col. 4 (col . 2 ± col . col. 5) (from Salaries in Worksheet A-6) 3) col. 4 1.00 2.00 4.00 5.00 6.00 3.00 PART III - HOSPITAL WAGE INDEX SUMMARY 1.00 Net salaries (see 15, 216, 752 -81, 042 15, 135, 710 315, 906. 78 47. 91 1.00 instructions) 2.00 Excluded area salaries (see 3, 301 3, 325 46.81 71. 03 2.00 24 instructions) 3.00 Subtotal salaries (line 1 15, 213, 451 -81, 066 15, 132, 385 315, 859. 97 47.91 3.00 minus line 2) 4.00 Subtotal other wages & related 4, 330, 206 4, 330, 206 86, 555. 18 50.03 4.00 costs (see inst.) Subtotal wage-related costs 5.00 3, 757, 577 3, 757, 577 0.00 24.83 5.00 (see inst.) Total (sum of lines 3 thru 5) 6.00 6.00 23, 301, 234 -81, 066 23, 220, 168 402, 415. 15 57 70

3, 362, 035

-132, 559

3, 229, 476

69, 319. 34

| Peri od: | Worksheet S-3 | From 07/01/2021 | Part IV | To 06/30/2022 | Date/Time Prepared: | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 11/2021 | 1 Provider CCN: 15-0181

	10 06/30/2022	11/21/2022 11:	
		Amount	OL GIII
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	447, 450	1. 00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	o	2. 00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	o	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	o	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5. 00
6.00	Legal /Accounting/Management Fees-Pension Plan	o	6. 00
7.00	Employee Managed Care Program Administration Fees	68, 752	7. 00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8. 00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	o	8. 01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	662, 483	8. 02
8.03	Health Insurance (Purchased)	o	8. 03
9.00	Prescription Drug Plan	320, 290	9. 00
10.00	Dental, Hearing and Vision Plan	34, 719	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	7, 350	11. 00
12.00	Accident Insurance (If employee is owner or beneficiary)	o	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	63, 318	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	42, 056	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16.00
	Non cumulative portion)		
	TAXES		
17.00	FICA-Employers Portion Only	953, 577	17. 00
18. 00	Medicare Taxes - Employers Portion Only	0	18. 00
19. 00	Unempl oyment Insurance	0	19. 00
20.00	State or Federal Unemployment Taxes	894	20. 00
	OTHER		
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see	0	21. 00
	instructions))		
22. 00	Day Care Cost and Allowances	0	22. 00
23. 00		10, 430	
24. 00	Total Wage Related cost (Sum of lines 1 -23)	2, 611, 319	24. 00
	Part B - Other than Core Related Cost		
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)	ļ	25. 00

Health Financial Systems	ASCENSION ST. VINCENT FISHERS	In Lieu	u of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-0181		Worksheet S-3
		From 07/01/2021	
		To 0//20/2022	Doto/Time Drangrad.

			o 06/30/2022	Date/lime Prep 11/21/2022 11:	
	Cost Center Description		Contract Labor		32 dill
	<u> </u>		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost				
	Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost		621, 378	2, 611, 319	1.00
2.00	Hospi tal		621, 378	2, 611, 319	2.00
3.00	SUBPROVI DER - I PF				3.00
4.00	SUBPROVI DER - I RF				4.00
5.00	Subprovi der - (Other)		0	0	5.00
6.00	Swing Beds - SNF		0	0	6.00
7.00	Swing Beds - NF		0	0	7.00
8.00	SKILLED NURSING FACILITY				8.00
9.00	NURSING FACILITY				9.00
10.00	OTHER LONG TERM CARE I				10.00
11. 00	Hospi tal -Based HHA				11.00
12.00	AMBULATORY SURGICAL CENTER (D. P.) I				12.00
13.00	Hospi tal -Based Hospi ce				13.00
14.00	Hospi tal -Based Heal th Clinic RHC				14.00
15. 00	Hospi tal -Based Heal th Clinic FQHC				15.00
16.00	Hospi tal -Based-CMHC		0	0	16.00
17. 00	RENAL DIALYSIS I		0	0	17.00
18. 00	Other		0	0	18.00

Heal th	Financial Systems	ASCENSION ST. VINC	FNT FLSHERS	In Li	eu of Form CMS-2	2552-10		
	AL UNCOMPENSATED AND INDIGENT CARE DATA	ACCENCION CIT VINO	Provider CCN: 15-018		Worksheet S-1			
				From 07/01/202				
				To 06/30/202	2 Date/Time Pre 11/21/2022 11			
	Uncomposited and indicent care cost comp	ıtati on			1. 00			
1. 00	Uncompensated and indigent care cost compu Cost to charge ratio (Worksheet C, Part I		vided by line 202 co	Lumn 8)	0. 213862	1.00		
1.00	Medicaid (see instructions for each line)	TITIC 202 COT UIIII 5 GI	vided by iiiie 202 co	r diliir 0)	0.213002	1.00		
2.00	Net revenue from Medicaid				3, 042, 676	2. 00		
3.00	Did you receive DSH or supplemental paymer				N	3. 00		
4.00	If line 3 is yes, does line 2 include all		. 3	di cai d?		4.00		
5. 00 6. 00	If line 4 is no, then enter DSH and/or sup Medicaid charges	ppiementai payments i	rom Medicaid		33, 497, 618	5. 00 6. 00		
7. 00	Medicald charges Medicald cost (line 1 times line 6)				7, 163, 868	7.00		
8. 00	Difference between net revenue and costs 1	for Medicaid program	(line 7 minus sum of	lines 2 and 5: if	4, 121, 192			
	< zero then enter zero)	. 0						
	Children's Health Insurance Program (CHIP)) (see instructions f	for each line)					
9.00	Net revenue from stand-alone CHIP				0			
10. 00 11. 00	Stand-alone CHIP charges Stand-alone CHIP cost (line 1 times line 1	10)			0 0			
12. 00	Difference between net revenue and costs 1		(line 11 minus line	0. if / zero then	0	•		
12.00	enter zero)	TOT Stand arone citr	(TITIC TT IIITIUS TITIC	7, TT \ Zero then		12.00		
	Other state or local government indigent o	care program (see ins	tructions for each I	i ne)				
13.00	Net revenue from state or local indigent of				1	13. 00		
14. 00	Charges for patients covered under state of	or local indigent car	re program (Not inclu	ded in lines 6 or	0	14. 00		
15. 00	10) State or local indigent care program cost	(line 1 times line 1	14)		0	15. 00		
16. 00	Difference between net revenue and costs 1			(line 15 minus line	1	16.00		
	13; if < zero then enter zero)							
	Grants, donations and total unreimbursed of	cost for Medicaid, Ch	IIP and state/local i	ndi gent care progra	ims (see			
17. 00	instructions for each line) Private grants, donations, or endowment in	ncomo rostrictod to t	Funding charity care		1 0	17. 00		
18. 00	Government grants, appropriations or trans				0	ı		
19. 00	Total unreimbursed cost for Medicaid , CHI			rams (sum of lines	4, 121, 192	1		
	8, 12 and 16)		Uni navo		T-+-1 (1 1			
			Uni nsur pati en		Total (col. 1 + col. 2)			
			1.00		3.00			
	Uncompensated Care (see instructions for e	each line)						
20. 00	Charity care charges and uninsured discour	nts for the entire fa	acility 4,10	1, 886 447, 07	7 4, 548, 963	20. 00		
21. 00	(see instructions) Cost of patients approved for charity care	e and uninsured disco	nunts (see 87	7, 238 447, 07	7 1, 324, 315	21 00		
21.00	instructions)	c and anningared ar sec	Junta (acc 07	7,230	1, 324, 313	21.00		
22. 00	Payments received from patients for amount	ts previously writter	n off as	0	0	22. 00		
22.00	charity care	22)	0.7	7 220 447 07	1 224 245	22.00		
23. 00	Cost of charity care (line 21 minus line 2	22)	8/	7, 238 447, 07	7 1, 324, 315	23.00		
					1. 00			
24. 00	Does the amount on line 20 column 2, inclu	ude charges for patie	ent days beyond a Len	gth of stay limit	N	24. 00		
25. 00	imposed on patients covered by Medicaid or other indigent care program? 25.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of							
	stay limit					25. 00		
26. 00	Total bad debt expense for the entire hosp				3, 710, 309			
27. 00 27. 01	Medicare reimbursable bad debts for the endicare allowable bad debts for the entire				52, 333 80, 511	27. 00 27. 01		
27. 01 28. 00	Non-Medicare bad debt expense (see instruc		(SEE THISTI WELLOHS)		3, 629, 798			
29. 00	Cost of non-Medicare and non-reimbursable	-	pense (see instructi	ons)	804, 454	1		
30.00	Cost of uncompensated care (line 23 column			*	2, 128, 769	1		
31. 00	Total unreimbursed and uncompensated care	cost (line 19 plus l	i ne 30)		6, 249, 961	31.00		

	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	E FYDENSES	Provi der Co	^N: 15_0191 E	Peri od:	Worksheet A	2332-10
NECLAS	STITEATION AND ADJUSTMENTS OF TRIAL BALANCE O	I LAI LINGLO	110videi C	F	rom 07/01/2021		
				1	o 06/30/2022		
	Cost Center Description	Sal ari es	Other	Total (col 1	Recl assi fi cati	11/21/2022 11 Reclassi fi ed	. 32 alli
	oost conten boscii pti on	Sur ur res	Other	+ col . 2)	ons (See A-6)	Trial Balance	
				,	,	(col. 3 +-	
						col . 4)	
	T	1.00	2. 00	3. 00	4. 00	5. 00	
1 00	GENERAL SERVI CE COST CENTERS		F 004 0F0	F 204 056		E 004 0E0	4 00
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP		5, 324, 959 1, 780, 165			5, 324, 959 1, 780, 165	1
3.00	00300 OTHER CAP REL COSTS		1, 760, 105	1, 760, 103		1, 780, 103	1
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	138, 617	2, 101, 917	2, 240, 534	-101, 080	_	1
5.00	00500 ADMINISTRATIVE & GENERAL	527, 788	15, 166, 293			15, 696, 942	
7.00	00700 OPERATION OF PLANT	0	2, 104, 674	2, 104, 674	0	2, 104, 674	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	146, 190			146, 190	1
9.00	00900 HOUSEKEEPI NG	0	576, 188			576, 188	
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	0	702, 847 0				1
13. 00	01300 NURSI NG ADMI NI STRATI ON	942, 816	103, 406	1	1		1
14. 00	01400 CENTRAL SERVICES & SUPPLY	56, 948	4, 559				•
15. 00	01500 PHARMACY	605, 887	40, 406				
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	0		0	0	1
17. 00	01700 SOCIAL SERVICE	0	0	C	0	0	17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	1, 783, 935	792, 578	2, 576, 513	455, 700	3, 032, 213	
31.00	03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT	0	0		0	0	
32. 00 33. 00	03300 BURN INTENSIVE CARE UNIT		0			0	32. 00 33. 00
34. 00	03400 SURGI CAL INTENSIVE CARE UNIT		0			0	
43. 00	04300 NURSERY	0	0		439, 279	-	1
	ANCILLARY SERVICE COST CENTERS				,		1
50.00	05000 OPERATING ROOM	1, 777, 135	1, 809, 952	3, 587, 087	12, 503	3, 599, 590	50. 00
51.00	05100 RECOVERY ROOM	0	0	C	0	0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	2, 254, 062	915, 748	3, 169, 810	-865, 697	2, 304, 113	1
53.00	05300 ANESTHESI OLOGY	0	0	4 400 046	0	0	53.00
54. 00 54. 01	05400 RADI OLOGY-DI AGNOSTI C 03630 ULTRA SOUND	762, 692 182, 769	369, 527 19, 263			1, 137, 750 203, 357	1
56. 00	05600 RADI OI SOTOPE	102, 709	19, 203 N	202, 032	1, 325	203, 357	1
56. 01	05601 ONCOLOGY	285, 627	104, 404	390, 031	1	392, 102	
57. 00	05700 CT SCAN	604, 545	91, 579	1		700, 508	1
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	245, 421	27, 246				1
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	C	0	0	59. 00
60.00	06000 LABORATORY	0	2, 338, 257	2, 338, 257	0	2, 338, 257	1
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	(0	0	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0	
64. 00 65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	636, 508	74, 183	710, 691	4, 616	715, 307	64. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	1, 209, 624	158, 220				
67. 00	06700 OCCUPATI ONAL THERAPY	20, 270	2, 860			23, 277	1
68. 00	06800 SPEECH PATHOLOGY	93, 715	66, 776				
	06900 ELECTROCARDI OLOGY	217, 598	71, 561	289, 159	1, 478	290, 637	
	07000 ELECTROENCEPHALOGRAPHY	0	0	C	0	0	
71. 00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	713, 805			713, 805	
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	2, 244, 498			2, 244, 498	
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	4, 846, 814	4, 846, 814		4, 846, 814 0	
75.00	07500 ASC (NON-DISTINCT PART)	0	0			0	
73.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>			,		73.00
91. 00	09100 EMERGENCY	1, 928, 152	732, 083	2, 660, 235	13, 982	2, 674, 217	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		,	, ,		,	92.00
	OTHER REIMBURSABLE COST CENTERS						1
99. 00	09900 CMHC	0	0	(0	0	99. 00
	SPECIAL PURPOSE COST CENTERS			1			
118.00		14, 274, 109	43, 430, 958	57, 705, 067	-24	57, 705, 043	1118. 00
100.00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		0			0	100 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		0		0		190. 00 191. 00
	19200 PHYSICIANS' PRIVATE OFFICES	3, 301	14, 576	17, 877			192. 00
	19300 NONPALD WORKERS	0,001	0 11, 070	17,077			193. 00
	07950 COMMUNITY EDUCATION	o	0				194. 00
	07951 MARKETI NG	0	0	C	0		194. 01
	07952 SC MGMT SVH TANDEM CASTLETON	0	-350				194. 02
	07953 SC MGMT SVH TANDEM	0	213				194. 03
	07954 SC MGMT SVH TANDEM AVON	0	744				194. 04
	07955 SC MGMT TANDEM NOBLESVILLE W	0	26				194. 05
194. 06 200. 00	07956 SC MGMT SVH TANDEM PLAINFIELD TOTAL (SUM OF LINES 118 through 199)	14, 277, 410	-206 43, 445, 961				194. 06
200. UC	TIDIAL (SUM OF LINES TTO LITTUUGH 199)	14, 277, 410	43, 443, 901] 31, 123, 3/1	0	01, 123, 3/1	1200.00

 Health Financial
 Systems
 ASCENSION ST

 RECLASSIFICATION
 AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0181

Peri od: From 07/01/2021 To 06/30/2022 Date/Ti me Prepared: 11/21/2022 11:32 am

			11/21/2022 11	:32 am
Cost Center Description	Adjustments	Net Expenses		
	(See A-8) 6.00	For Allocation 7.00		
GENERAL SERVICE COST CENTERS	0.00	7.00		
1.00 O0100 CAP REL COSTS-BLDG & FLXT	-2, 950	5, 322, 009		1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP	-8, 364	1, 771, 801		2. 00
3.00 00300 OTHER CAP REL COSTS	0	O		3. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	109, 950	1		4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL	-2, 427, 797			5. 00
7. 00 00700 OPERATION OF PLANT	-720			7. 00
8.00 00800 LAUNDRY & LINEN SERVICE 9.00 00900 HOUSEKEEPING	0	146, 190 576, 188		8. 00 9. 00
10. 00 01000 DI ETARY	0			10.00
11. 00 01100 CAFETERI A	-93, 191	281, 291		11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	-22, 949			13. 00
14. 00 01400 CENTRAL SERVI CES & SUPPLY	0			14. 00
15. 00 01500 PHARMACY	0	650, 687		15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	0		16. 00
17.00 01700 SOCIAL SERVICE	0	0		17. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	70.000	0.050.004		
30. 00 03000 ADULTS & PEDI ATRI CS	-78, 829			30.00
31. 00 03100 INTENSIVE CARE UNIT	0			31. 00 32. 00
32. 00 03200 CORONARY CARE UNIT 33. 00 03300 BURN INTENSIVE CARE UNIT	0	1		33.00
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T	0	0		34.00
43. 00 04300 NURSERY	0	439, 279		43. 00
ANCI LLARY SERVI CE COST CENTERS		1077277		1 .0. 00
50. 00 05000 OPERATI NG ROOM	-260, 659	3, 338, 931		50.00
51.00 05100 RECOVERY ROOM	0	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	-413, 346	1, 890, 767		52. 00
53. 00 05300 ANESTHESI OLOGY	0	0		53. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	-50, 643	1, 087, 107		54.00
54. 01 03630 ULTRA SOUND	0	203, 357		54. 01
56. 00 05600 RADI 01 SOTOPE 56. 01 05601 ONCOLOGY	-14, 300	377, 802		56. 00 56. 01
57. 00 05700 CT SCAN	- 14, 300 -6, 272			57.00
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	-3, 470			58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	1		59. 00
60. 00 06000 LABORATORY	0	2, 338, 257		60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		63. 00
64. 00 06400 I NTRAVENOUS THERAPY	0	0		64. 00
65. 00 06500 RESPIRATORY THERAPY	0	715, 307		65. 00
66. 00 06600 PHYSI CAL THERAPY	0	1, 376, 616		66.00
67. 00 06700 0CCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0	23, 277 161, 171		67. 00 68. 00
69. 00 06900 SELECTI FATHOLOGY	0			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	270,037		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	713, 805		71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	1		72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	4, 846, 814		73. 00
74. 00 07400 RENAL DI ALYSI S	0			74. 00
75. 00 07500 ASC (NON-DISTINCT PART)	0	0		75. 00
OUTPATIENT SERVICE COST CENTERS		0 (74 047		04.00
91. 00 09100 EMERGENCY	0	2, 674, 217		91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS				92.00
99. 00 09900 CMHC	0	0		99. 00
SPECIAL PURPOSE COST CENTERS		<u> </u>		77.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-3, 273, 540	54, 431, 503		118. 00
NONREI MBURSABLE COST CENTERS				
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190. 00
191. 00 19100 RESEARCH	0	1		191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0			192. 00
193. 00 19300 NONPAI D WORKERS	0	1		193. 00
194. 00 07950 COMMUNITY EDUCATION	0	0		194. 00
194. 01 07951 MARKETING	0	0		194. 01
194.02 07952 SC MGMT SVH TANDEM CASTLETON 194.03 07953 SC MGMT SVH TANDEM	0	0 213		194. 02 194. 03
194.04 07953 SC MGMT SVH TANDEM 194.04 07954 SC MGMT SVH TANDEM AVON	0	744		194. 03
194.05 07955 SC MGMT TANDEM NOBLESVILLE W	0			194. 04
194.06 07956 SC MGMT SVH TANDEM PLAINFIELD	0	1		194. 06
200.00 TOTAL (SUM OF LINES 118 through 199)	-3, 273, 540	1		200.00
				-

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0181

					To 06/30/2022 Date/Time Pro 11/21/2022 11	
		Increases			1172172022	102 0
	Cost Center	Li ne #	Sal ary	Other		
	2. 00	3.00	4. 00	5. 00		
	A - GENERAL SALARY ACCRUAL					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	3 <u>7, 5</u> 37		1. 00
	0		0	37, 537]
	B - CAFETERIA RECLASS					
1.00	CAFETERI A	11. 00	0	37 <u>4, 4</u> 82		1.00
	0		0	374, 482		
	C - NURSERY RECLASS					
1. 00	ADULTS & PEDIATRICS	30. 00	325, 414	117, 350		1. 00
2.00	NURSERY	43.00	330, 563	10 <u>8, 7</u> 16		2. 00
	0		655, 977	226, 066		_
	D - FURLOUGH PAY RECLASS					4
1. 00	ADMINISTRATIVE & GENERAL	5. 00	0	1, 598		1.00
2.00	NURSING ADMINISTRATION	13. 00	0	5, 112		2. 00
3.00	CENTRAL SERVICES & SUPPLY	14. 00	0	241		3. 00
4.00	PHARMACY	15. 00	0	1, 106		4. 00
5. 00	ADULTS & PEDIATRICS	30.00	0	2, 191		5. 00
6.00	OPERATING ROOM	50.00	0	11, 954		6. 00
7. 00	DELIVERY ROOM & LABOR ROOM	52. 00	0	5, 875		7. 00
8.00	RADI OLOGY-DI AGNOSTI C	54. 00	0	2, 961		8. 00
9. 00	CT SCAN	57. 00	0	1, 178		9. 00
10. 00	MAGNETIC RESONANCE I MAGING	58. 00	0	2, 706		10. 00
	(MRI)		_			
11. 00	PHYSI CAL THERAPY	66.00	0	3, 113		11.00
12. 00	EMERGENCY	<u>91.</u> 00	0	<u>1, 686</u>		12. 00
	0	100	0	39, 721		-
4 00	E - VACCINE TO WORK COMP RECL		ما	200		4
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	390		1.00
2.00	OPERATING ROOM	50.00	0	2, 852		2.00
3. 00	RADI OLOGY-DI AGNOSTI C	54.00		$\frac{542}{2724}$		3. 00
	U		0	3, 784		-
1 00	F - NON-REIMB RECLASS SC MGMT SVH TANDEM CASTLETON	104 02	ما	250		1 00
1. 00 2. 00	SC MGMT SVH TANDEM CASTLETON	194. 02	0	350 206		1.00
2.00	PLAINFIELD	194. 06	۷	206		2. 00
	TOTALS	+				
	G - STARP RECLASS		<u> </u>	330		-
1.00	ADMI NI STRATI VE & GENERAL	5.00	2, 861	0		1.00
2. 00	NURSI NG ADMI NI STRATI ON	13. 00	6, 837	Ö		2. 00
3. 00	CENTRAL SERVICES & SUPPLY	14. 00	413	0		3. 00
4. 00	PHARMACY	15. 00	4, 394	0		4. 00
5. 00	ADULTS & PEDIATRICS	30.00	12, 936	0		5. 00
6. 00	OPERATING ROOM	50.00	12, 503	0		6. 00
7. 00	DELIVERY ROOM & LABOR ROOM	52.00	16, 346	0		7. 00
8. 00	RADI OLOGY-DI AGNOSTI C	54.00	5, 531	0		8. 00
9. 00	ULTRA SOUND	54. 01	1, 325	0		9. 00
10.00	ONCOLOGY	56. 01	2, 071	0		10.00
11. 00	CT SCAN	57. 00	4, 384	0		11. 00
12. 00	MAGNETIC RESONANCE I MAGING	58. 00	1, 780	0		12. 00
	(MRI)		.,	٥		
13.00	RESPIRATORY THERAPY	65. 00	4, 616	0		13. 00
14. 00	PHYSI CAL THERAPY	66.00	8, 772	Ö		14. 00
15. 00	OCCUPATI ONAL THERAPY	67. 00	147	Ô		15. 00
16. 00	SPEECH PATHOLOGY	68. 00	680	n		16. 00
17. 00	ELECTROCARDI OLOGY	69. 00	1, 478	n		17. 00
18. 00	EMERGENCY	91.00	13, 982	Ö		18. 00
19. 00	PHYSICIANS' PRIVATE OFFICES	192. 00	24	Ö		19. 00
	TOTALS	+	101, 080	— — <u> </u>		
500.00	Grand Total: Increases		757, 057	682, 146		500.00
			'			•

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0181

						To 06/30/2022 Date/lime 11/21/2022	
		Decreases		'			1 02 0
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref	:]	
	6. 00	7. 00	8. 00	9. 00	10. 00		
	A - GENERAL SALARY ACCRUAL						
1. 00	EMPLOYEE BENEFITS DEPARTMENT		3 <u>7, 5</u> 37			<u>o</u>	1. 00
	0		37, 537)		
4 00	B - CAFETERI A RECLASS	40.00	ما	074 400			1.00
1. 00	DI ETARY	1000		374, 482		<u>o</u>	1. 00
	C - NURSERY RECLASS		υĮ	374, 482	4		
1. 00	DELIVERY ROOM & LABOR ROOM	52.00	655, 977	226, 066		0	1.00
2. 00	DEEL VERT ROOM & EABOR ROOM	0.00	033, 777	220, 000		0	2. 00
2.00			655, 977	226, 066			2.00
	D - FURLOUGH PAY RECLASS		000, 777	220,000	/		
1.00	ADMI NI STRATI VE & GENERAL	5. 00	1, 598	C)	0	1. 00
2.00	NURSING ADMINISTRATION	13.00	5, 112	C		o	2. 00
3.00	CENTRAL SERVICES & SUPPLY	14.00	241	C		o	3. 00
4.00	PHARMACY	15. 00	1, 106	C		0	4. 00
5.00	ADULTS & PEDIATRICS	30. 00	2, 191	C		0	5. 00
6.00	OPERATING ROOM	50. 00	11, 954	C		0	6. 00
7. 00	DELIVERY ROOM & LABOR ROOM	52. 00	5, 875	C		0	7. 00
8.00	RADI OLOGY-DI AGNOSTI C	54.00	2, 961	C		0	8. 00
9.00	CT SCAN	57. 00	1, 178	C		0	9. 00
10.00	MAGNETIC RESONANCE I MAGING	58. 00	2, 706	C)	O	10. 00
11. 00	(MRI) PHYSICAL THERAPY	66. 00	3, 113	C		o	11. 00
12. 00	EMERGENCY	91.00	1, 686	C		0	12. 00
12.00	0		39, 721				12.00
	E - VACCINE TO WORK COMP RECLA	ASS	*****	-	- [
1.00	CENTRAL SERVICES & SUPPLY	14. 00	390	C		0	1. 00
2.00	OPERATING ROOM	50.00	2, 852	C		0	2. 00
3.00	RADI OLOGY-DI AGNOSTI C	54.00	542	0)	<u>o</u>	3. 00
	0		3, 784)		
	F - NON-REIMB RECLASS	100.00	ما	050			
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	350		0	1.00
2. 00	PHYSICIANS' PRIVATE OFFICES TOTALS	192.00	0			0	2. 00
	G - STARP RECLASS		<u> </u>	550)		
1. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	101, 080	C		ol	1.00
2. 00	Zim Zovez Benervio Bennikiment	0.00	0	C		o	2. 00
3.00		0.00	o	C		o	3. 00
4.00		0.00	О	C		o	4. 00
5.00		0.00	0	C		O	5. 00
6.00		0.00	0	C		0	6. 00
7.00		0.00	0	C		0	7. 00
8. 00		0. 00	0	C		0	8. 00
9.00		0.00	0	C		0	9. 00
10.00		0.00	0	C		0	10.00
11.00		0. 00 0. 00	0	C		0	11.00
12. 00 13. 00		0.00	0			0	12. 00 13. 00
14. 00		0.00	o	C	1	o	14. 00
15. 00		0.00	0	C		o o	15. 00
16. 00		0.00	ő	C		o o	16. 00
17. 00		0.00	ol	C		o o	17. 00
18. 00		0.00	ol	C		o o	18. 00
19.00		0.00		C)	O	19. 00
	TOTALS		101, 080				
500.00	Grand Total: Decreases		838, 099	601, 104	l		500.00

Subtotal (sum of lines 1-7)

Reconciling Items

10.00 Total (line 8 minus line 9)

8.00

9.00

8.00

9.00

10.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 15-0181 Peri od: Worksheet A-7 From 07/01/2021 Part I 06/30/2022 Date/Time Prepared: 11/21/2022 11:32 am Acqui si ti ons Begi nni ng Di sposal s and Purchases Donati on Total Bal ances Retirements 2.00 3.00 4. 00 1 00 5 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 10, 871, 320 0 1.00 0 215, 387 2.00 Land Improvements 22, 176 215, 387 0 2.00 0 3.00 45, 613, 806 1, 227, 677 1, 227, 677 3.00 Buildings and Fixtures 0 0 4.00 Building Improvements 853, 803 0 4.00 5.00 Fixed Equipment 1, 788, 011 0 5.00 0 6.00 Movable Equipment 23, 506, 538 538, 477 538, 477 432, 022 6.00 0 7.00 HIT designated Assets 0 7.00 0 8.00 Subtotal (sum of lines 1-7) 82, 655, 654 1, 981, 541 1, 981, 541 432, 022 8.00 9.00 Reconciling Items 0 9.00 432, 022 Total (line 8 minus line 9) 1, 981, 541 10.00 82, 655, 654 1, 981, 541 0 10.00 Endi ng Bal ance Fully Depreci ated Assets 6.00 7.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 10, 871, 320 0 1.00 2.00 Land Improvements 0 2.00 237, 563 3.00 Buildings and Fixtures 46, 841, 483 0 3.00 0 4.00 Building Improvements 853, 803 4.00 5.00 Fi xed Equipment 1, 788, 011 0 5.00 Movable Equipment 0 6.00 23, 612, 993 6.00 7.00 HIT designated Assets 0 7.00

84, 205, 173

84, 205, 173

0

0

Health Financial Systems	ASCENSION ST. VI	NCENT FISHERS		In Lie	eu of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der CC		Peri od:	Worksheet A-7	
				From 07/01/2021 To 06/30/2022		narod:
				10 06/30/2022	Date/Time Prep 11/21/2022 11:	32 am_
		SU	JMMARY OF CAPI	TAL		
Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see	1
				instructions)	instructions)	
	9. 00	10. 00	11. 00	12. 00	13. 00	
PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1 00 CAP REL COSTS-BLDG & FLXT	1 723 837	3 596 139		0	483	1 1 00

	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see	
					instructions)	instructions)	
		9. 00	10.00	11.00	12. 00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FLXT	1, 723, 837	3, 596, 139	C	0	483	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	1, 680, 695	97, 340	C	0	2, 130	2. 00
3.00	Total (sum of lines 1-2)	3, 404, 532	3, 693, 479	C	0	2, 613	3. 00
		SUMMARY 0	F CAPITAL				
	Cost Center Description	0ther	Total (1) (sum				
		Capi tal -Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	IN 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FLXT	4, 500	5, 324, 959				1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1, 780, 165				2. 00
3.00	Total (sum of lines 1-2)	4, 500	7, 105, 124				3. 00
3.00	Total (sum of Tines 1-2)	4,500	7, 105, 124				3.00

Health Financial Systems A	SCENSION ST. VI	INCENT FISHERS		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS			Period: From 07/01/2021 To 06/30/2022	Worksheet A-7 Part III Date/Time Prep 11/21/2022 11:	pared:	
	COME	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	
DART III DECONOLILATION OF CARLTAL COCTO OF	1.00	2.00	3. 00	4. 00	5. 00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	60, 592, 180		60, 592, 18	0. 719578	0	1. 00
2. 00 CAP REL COSTS-BLDG & TTXT	23, 612, 993	l e	23, 612, 99		0	2. 00
3.00 Total (sum of lines 1-2)	84, 205, 173	l .	84, 205, 17		0	3. 00
5. 55 1.51d. (Sdm. 61. 1.1165 2)		TION OF OTHER (F CAPITAL	0.00
Cost Center Description	Taxes	Other Capital-Relate d Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
	6. 00	7. 00	8. 00	9. 00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	NTERS			_		
1.00 CAP REL COSTS-BLDG & FIXT	0	·		0 1, 720, 887		1. 00
2.00 CAP REL COSTS-MVBLE EQUIP	0	0	1	0 1, 672, 331	97, 340	2. 00
3.00 Total (sum of lines 1-2)	0	0	IMMADY OF CARL	0 3, 393, 218	3, 693, 479	3. 00
		50	JMMARY OF CAPI	IAL		
Cost Center Description	Interest	Insurance (see			Total (2) (sum	
		instructions)	instructions)	Capi tal -Rel ate		
				d Costs (see instructions)	through 14)	
	11. 00	12.00	13.00	14. 00	15. 00	
PART III - RECONCILIATION OF CAPITAL COSTS CE		12.00	10.00	11100	101.00	
1.00 CAP REL COSTS-BLDG & FLXT	0	0	48	3 4, 500	5, 322, 009	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	0	0	2, 13		1, 771, 801	2.00
3.00 Total (sum of lines 1-2)	0	0	2, 61	4, 500	7, 093, 810	3. 00

Health Financial Systems ASCENSION ST. VINCENT FISHERS In Lieu of Form CMS-2552-10 ADJUSTMENTS TO EXPENSES Provider CCN: 15-0181 Peri od: Worksheet A-8 From 07/01/2021 06/30/2022 Date/Time Prepared: 11/21/2022 11:32 am Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Cost Center Description Basis/Code (2) Cost Center Line # Wkst. A-7 Ref. Amount 1.00 2.00 3.00 4.00 5.00 1.00 Investment income - CAP REL OCAP REL COSTS-BLDG & FIXT 1. 00 1.00 COSTS-BLDG & FIXT (chapter 2) 2.00 Investment income - CAP REL OCAP REL COSTS-MVBLE EQUIP 2.00 2.00 COSTS-MVBLE EQUIP (chapter 2) 3.00 Investment income - other В -20, 273 ADMINI STRATI VE & GENERAL 5.00 3.00 (chapter 2) Trade, quantity, and time 4 00 4 00 0 0 00 discounts (chapter 8) 5.00 Refunds and rebates of 0.00 5.00 expenses (chapter 8) Rental of provider space by 6.00 0.00 6.00 suppliers (chapter 8) Tel ephone servi ces (pay 7.00 0.00 7.00 stations excluded) (chapter 21) 8.00 Tel evi si on and radio servi ce 0.00 8.00 (chapter 21) Parking lot (chapter 21) 9.00 9.00 0.00 -826, 613 10.00 Provi der-based physi ci an A-8-2 10.00 adj ustment 11.00 Sale of scrap, waste, etc. 0.00 11.00 (chapter 23) Related organization 12.00 A-8-1 2, 486, 500 12.00 transactions (chapter 10) 13 00 Laundry and linen service 0 00 13 00 14.00 Cafeteria-employees and guests В -93, 191 CAFETERI A 11.00 14.00 Rental of quarters to employee 15.00 15.00 0.00 and others 16.00 0 0.00 16.00 Sale of medical and surgical supplies to other than pati ents 17.00 Sale of drugs to other than 0.00 0 17.00 pati ents 18.00 Sale of medical records and 0.00 18.00 abstracts Nursing and allied health 19 00 19 00 0 00 education (tuition, fees, books, etc.) 20.00 20.00 Vending machines 0.00 21.00 Income from imposition of В -720 OPERATION OF PLANT 21.00 7.00 interest, finance or penalty charges (chapter 21) 22.00 Interest expense on Medicare 0 0.00 22.00 overpayments and borrowings to repay Medicare overpayments 23.00 Adjustment for respiratory A-8-3 ORESPIRATORY THERAPY 65.00 23.00 therapy costs in excess of limitation (chapter 14) 24.00 Adjustment for physical A-8-3 OPHYSICAL 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 (chapter 21) Depreciation - CAP REL OCAP REL COSTS-BLDG & FIXT 26.00 1.00 26.00 COSTS-BLDG & FLXT Depreciation - CAP REL OCAP REL COSTS-MVBLE EQUIP 27.00 2.00 27.00

0 *** Cost Center Deleted ***

O OCCUPATIONAL THERAPY

OADULTS & PEDIATRICS

OSPEECH PATHOLOGY

19.00

0.00

67.00

30.00

68.00

0.00

28.00

29.00

30.00

30.99

31.00

32.00

COSTS-MVBLE EQUIP

instructions)

Non-physician Anesthetist Physicians' assistant

Adjustment for occupational

therapy costs in excess of limitation (chapter 14)

Hospice (non-distinct) (see

pathology costs in excess of limitation (chapter 14)

Adjustment for speech

CAH HIT Adjustment for

Depreciation and Interest

A-8-3

A-8-3

28.00

29.00

30.00

30.99

31.00

32.00

Provi der CCN: 15-0181 Peri od: Worksheet A-8 From 07/01/2021 | To 06/30/2022 | Date/Time Prepared:

					10 00/30/2022	11/21/2022 11	
				Expense Classification on	Worksheet A		
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basi s/Code (2)		Cost Center		Wkst. A-7 Ref.	
		1.00	2. 00	3. 00	4. 00	5. 00	
33.00		В	-101, 378	ADMINISTRATIVE & GENERAL	5. 00	0	33. 00
	/ CORP						
33. 01	MISC INCOME - PATIENT INTEREST			ADMINISTRATIVE & GENERAL	5. 00		
33. 02	IC SHARED SAV REV ACO	В		ADMINISTRATIVE & GENERAL	5. 00		33. 02
33. 03	ENTERTAINMENT - ADMIN	A	· ·	ADMINISTRATIVE & GENERAL	5. 00		33. 03
33. 04	ENTERTAINMENT - NURSING ADMIN	A	-265	NURSING ADMINISTRATION	13. 00	0	33. 04
33. 05	ENTERTALNMENT - SURGERY	A	-678	OPERATING ROOM	50.00	0	33. 05
33.06	ENTERTALNMENT - RADIOLOGY	Α	-149	RADI OLOGY-DI AGNOSTI C	54.00	0	33. 06
33. 07	ENTERTAINMENT - INFUSION	Α	-79	ONCOLOGY	56. 01	0	33. 07
33.08	PHYS FUND EXP	Α	-2, 052, 665	ADMINISTRATIVE & GENERAL	5. 00	0	33. 08
33.09	PROMOTIONAL ITEMS - ADMIN	Α	-1, 481	ADMINISTRATIVE & GENERAL	5. 00	0	33. 09
33. 10	COMMUNITY BENEFIT EXP - NURS	Α	-2, 513	NURSING ADMINISTRATION	13.00	0	33. 10
	ADMI N						
33. 11	LOBBYING EXPENSE	Α	-678	ADMINISTRATIVE & GENERAL	5. 00	0	33. 11
33. 12	MEDICALD PROVIDER TAX	A	-2, 497, 193	ADMINISTRATIVE & GENERAL	5. 00	0	33. 12
33. 13	MISC INCOME - RENTAL INCOME -	В	-2, 950	CAP REL COSTS-BLDG & FIXT	1.00	9	33. 13
	BLDG						
33. 14	MISC INCOME - GAIN ON SALE	В	-8, 364	CAP REL COSTS-MVBLE EQUIP	2.00	9	33. 14
50.00	TOTAL (sum of lines 1 thru 49)		-3, 273, 540				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.

Worksheet A-8-1

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

				10 06/30/2022	11/21/2022 11	
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	
			·	Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4. 00	5. 00	
		MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OR	GANIZATIONS OR	CLAIMED	
	HOME OFFICE COSTS:					
1. 00	I		HOME OFFICE - BENEFITS	1, 947, 380	1, 837, 430	1. 00
2.00	l I	ADMINISTRATIVE & GENERAL	HOME OFFICE - CAPITAL	769, 552	0	2. 00
3.00		ADMINISTRATIVE & GENERAL	HOME OFFICE - INTEREST	20, 273		3. 00
3. 01		ADMINISTRATIVE & GENERAL	HOME OFFICE - OTHER	12, 213, 094		
3.02	l I	ADMINISTRATIVE & GENERAL	ST. VINCENT HEALTH CHARGEBAC	3, 630	3, 630	
3.05		PHARMACY	ST. VINCENT HEALTH CHARGEBAC	5, 500		
3.07		ADULTS & PEDIATRICS	ST. VINCENT HEALTH CHARGEBAC	78, 829		
3. 10	54. 00		ST. VINCENT HEALTH CHARGEBAC	62, 769		
3. 12			ST VINCENT HEALTH CHARGEBACK	65, 125	65, 125	3. 12
3. 13	69. 00	ELECTROCARDI OLOGY	ST VINCENT HEALTH CHARGEBACK	16, 272	16, 272	3. 13
3. 15	91.00	EMERGENCY	ST VINCENT HEALTH CHARGEBACK	7, 300	7, 300	3. 15
3. 16	0.00		ST VINCENT HEALTH CHARGEBACK	0	0	3. 16
3. 17	5. 00	ADMINISTRATIVE & GENERAL	TRG ADMIN FEES - SUPPLIES	-282, 331	0	3. 17
3. 18	13.00	NURSING ADMINISTRATION	TRG ADMIN FEES - CONTRACTED	-20, 171	0	3. 18
4.00		ADMINISTRATIVE & GENERAL	TRG ADMIN FEES - OTHER	-79, 614	0	4. 00
5.00	TOTALS (sum of lines 1-4).			14, 807, 608	12, 321, 108	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

1100 110	be been posted to worksheet h, cordinas i ana or 2, the amount arrowable should be indicated in cordinar i or this part.								
				Related Organization(s) and/or Home Office					
	Symbol (1)	Name	Percentage of	Name	Percentage of				
	J Syllibol (1)	Name		Ivallie					
			Ownershi p		Ownershi p				
	1. 00	2. 00	3. 00	4. 00	5. 00				
	B. INTERRELATIONSHIP TO RELAT	ED ORGANIZATION(S) AND/OR HO	ME OFFICE:						

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

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

6.00	В	ST. VINCENT HEA	100.00 ST. VINCENT HEA	100.00	6. 00
7.00	В	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				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 organi zati on.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provi der.

2.00 0 3.00 20, 273 3.00 3.01 1, 968, 841 0 3.01 3.02 0 3.02 0 0 3 05 0 3 05 3.07 0 3.07 3.10 0 0 3. 10 0 0 3 12 3 12 0 0 3.13 3.13 3.15 0 0 3. 15 0 3.16 0 3. 16 0 -282 331 3 17 3 17 3.18 -20, 171 3. 18 4.00 -79, 614 4.00 5.00 2.486.500 5.00

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

Polistad Organization(s)	
Rel ated Organization(s)	
and/or Home Office	
Type of Business	
6. 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.

	HOME OFFICE	6.00
	HOME OFFICE	7.00
8.00		8.00
9.00		9.00
8. 00 9. 00 10. 00		10.00
100.00		100.00

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

 D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organi zati on.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provi der

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT | Peri od: | Worksheet A-8-2 | From 07/01/2021 | To 06/30/2022 | Date/Ti me Prepared: Provider CCN: 15-0181

Wikst: A Line # Cost Center/Physician Identifier Component Component						-	Го 06/30/2022	Date/Time Pre	
Identifier Remuneration Component Component Identifier Remuneration Component Rours Identifier Identifier Rours Identifier Ide		Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount		. 02 4111
1.00									
1.00 30.00 ADULTS & PEDIATRICS 78,829 78,829 91 440,363 246,400 19,774 2.00 3.00 52.00 DELIVERY ROOM & LABOR ROOM 413,346 413,346 40 0 0 0 19,774 2.00 5.00 56.01 ADULTS & PEDIATRICS 70,887 43,558 27,329 271,900 156 4.00 5.00 56.01 ADULTS & PEDIATRICS 70,887 43,558 27,329 271,900 156 5.00 50.00 57.00 CT SCAN 6,272 6,272 0 0 0 0 0 0 0 0 0					·	·		Hours	
2.00 50.00 50.00 52.00 51.00 52.00 52.00 52.00 52.00 52.00 54.00 54.00 54.00 54.00 54.00 54.00 56.00 5							6. 00	7. 00	
3.00 52.00 DELIVERY ROOM & LABOR ROOM 413, 346 0 0 0 0 0 3.00									
4.00				1			246, 400	19, 774	
S. 00				1			0		
Continuing Con				1					
R. 00				1					
S. 00							_		
9.00			(MRI)	3, 470	3, 470	0	0	0	
10.00				0	0	0	0	0	
Nest A Line Cost Center/Physician 1, 304, 248 805, 456 498, 792 20,096 200,000				0	0	0	0	0	
Wkst. A Line # Cost Center/Physician Identifier Unadjusted RCE Limit Cost of Unadjusted RCE Limit Cost of Unadjusted RCE Limit Cost of Education Share of col. Share of col. Insurance Education Share of col. Insurance Insuran		0.00		0	0	0	0	0	
Identifier	200.00								200. 00
1.00		Wkst. A Line #							
1.00			Identifier	Limit					
1.00					LIMIT			Insurance	
1.00		1 00	2.00	8 00	9 00			14.00	
2. 00	1 00			0.00					1 00
3.00				2 342 459					
4.00 54.00 RADI OLOGY - DI AGNOSTI C 20,393 1,020 0 0 0 0 0 0 0 0 0			1	2,012,107	0		_	0	
5. 00				20 393	1 020	_	0	o o	
6. 00				1			0	0	
7.00				0	1		0	0	
8.00	7.00	58. 00		0	0	0	0	0	7. 00
9.00	0.00								0.00
10.00				0	0	0	0	0	
200.00				0	0	0	· · · · · · · · · · · · · · · · · · ·	0	
Wkst. A Line # Cost Center/Physician Identifier Component Share of col. 14 14 14 15 100 15 100 15 100 16 100 17 100 18 100		0.00		0 270 721	110 007	0	1	0	
Identifier Component Share of col. Li mi t Share of col. 1.00 15.00 16.00 17.00 18.00 1.00 2.00 15.00 16.00 17.00 18.00 1.00 2.00 30.00 ADULTS & PEDIATRICS 0 0 0 0 78,829 1.00 2.00 3.00 52.00 DELIVERY ROOM 0 0 2,342,459 0 259,981 2.00 3.00 52.00 DELIVERY ROOM & LABOR ROOM 0 0 0 0 413,346 3.00 4.00 54.00 RADIOLOGY-DIAGNOSTIC 0 20,393 6,936 50,494 4.00 5.00 56.01 ONCOLOGY 0 16,879 14,221 14,221 5.00 6.00 57.00 CT SCAN 0 0 0 0 6,272 6.00 7.00 58.00 MAGNETIC RESONANCE I MAGING 0 0 0 0 3,470 7.00 8.00 0.00 0 0 0 0 9.00 10.00 0 0 0 0 0 0 9.00 10.00 1	200.00	Wko+ Aline#	Cost Conton (Dhysi si an					0	200.00
Share of col. 14		WKSt. A LITTE #			1 -		Auj us tillerit		
14			i denti i i ei		LIIIII	Di Sai i Owance			
1.00									
1.00 30.00 ADULTS & PEDIATRICS 0 0 0 78,829 1.00		1, 00	2.00		16, 00	17. 00	18. 00		
3. 00 52. 00 DELI VERY ROOM & LABOR ROOM 0 0 0 0 413, 346 3. 00 4. 00 54. 00 RADI OLOGY-DI AGNOSTI C 0 20, 393 6, 936 50, 494 4. 00 5. 00 56. 01 ONCOLOGY 0 16, 879 14, 221 14, 221 5. 00 6. 00 57. 00 CT SCAN 0 0 0 6, 272 6. 00 7. 00 MAGNETI C RESONANCE I MAGI NG 0 0 0 3, 470 7. 00 8. 00 9. 00 0 0 0 0 9. 00 10. 00 0 0 0 0 0 0 0 0	1. 00			0					1. 00
4. 00	2.00	50.00	OPERATING ROOM	0	2, 342, 459	0	259, 981		2. 00
5. 00 56. 01 ONCOLOGY 0 16, 879 14, 221 14, 221 5. 00 6. 00 57. 00 CT SCAN 0 0 0 6, 272 6. 00 7. 00 58. 00 MAGNETI C RESONANCE I MAGI NG 0 0 0 3, 470 7. 00 8. 00 0. 00 0 0 0 0 0 9. 00 0. 00 0 0 0 0 0 10. 00 0. 00 0 0 0 0 10. 00 0. 00 0 0 0 10. 00 0 0 0 0 10. 00 0 0 0 0 10. 00 0 0 0 10. 00 0 0 0 10. 00 0 0 0 10. 00 0 0 0 10. 00 0 0 0 10. 00 0 0 10. 00 0 0 10. 00 0 0 0 10. 00 0 0 0 10. 00 0 0 0 10. 00 0 0 10. 00 0 0 0 10. 00 0 0 0 10. 00 0 0 0 10. 00 0 0 0 10. 00 0 0 0 10. 00 0 0 0 10. 00 0 0 10. 00 0 0	3.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	413, 346		3. 00
5. 00 56. 01 ONCOLOGY 0 16, 879 14, 221 14, 221 5. 00 6. 00 57. 00 CT SCAN 0 0 0 6, 272 6. 00 7. 00 58. 00 MAGNETI C RESONANCE I MAGI NG 0 0 0 3, 470 7. 00 8. 00 0. 00 0 0 0 0 0 9. 00 0. 00 0 0 0 0 0 10. 00 0. 00 0 0 0 0 10. 00 0. 00 0 0 0 10. 00 0 0 0 0 10. 00 0 0 0 0 10. 00 0 0 0 10. 00 0 0 0 10. 00 0 0 0 10. 00 0 0 0 10. 00 0 0 0 10. 00 0 0 10. 00 0 0 10. 00 0 0 0 10. 00 0 0 0 10. 00 0 0 0 10. 00 0 0 10. 00 0 0 0 10. 00 0 0 0 10. 00 0 0 0 10. 00 0 0 0 10. 00 0 0 0 10. 00 0 0 0 10. 00 0 0 10. 00 0 0	4.00	54.00	RADI OLOGY-DI AGNOSTI C	0	20, 393	6, 936	50, 494		4.00
7. 00	5.00			0					5. 00
8. 00	6.00	57. 00	CT SCAN	0	0	0	6, 272		6. 00
8. 00 0. 00 9. 00 0. 00 10. 00 0 0 0 <td>7. 00</td> <td>58. 00</td> <td></td> <td>0</td> <td>0</td> <td>0</td> <td>3, 470</td> <td></td> <td>7. 00</td>	7. 00	58. 00		0	0	0	3, 470		7. 00
9.00 0.00 0 0 0 0 9.00 10.00 0 0 0 0 0 10.00	8 00	0.00			_	0	_		8 00
10.00 0.00 10.00									
			l .				l 0		
		3.00			2, 379, 731	21, 157	826, 613		

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0181 Peri od: Worksheet B From 07/01/2021 Part I Date/Time Prepared: 06/30/2022 11/21/2022 11:32 am CAPITAL RELATED COSTS Net Expenses BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Subtotal Cost Center Description for Cost **BENEFITS** DEPARTMENT Allocation (from Wkst A col. 7) 1.00 2.00 4. 00 4A GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 5, 322, 009 5, 322, 009 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 1, 771, 801 1, 771, 801 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 2, 249, 404 52, 614 17, 516 2, 319, 534 4.00 00500 ADMINISTRATIVE & GENERAL 13, 978, 475 5 00 467, 312 155 577 86, 441 5 00 13, 269, 145 7.00 00700 OPERATION OF PLANT 2, 103, 954 701, 221 233, 450 0 3, 038, 625 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 146, 190 146, 190 8.00 00900 HOUSEKEEPI NG 576, 188 60, 516 20, 147 o 656, 851 9.00 9.00 01000 DI ETARY 29, 434 328, 365 446, 212 10 00 10.00 88, 413 0 11.00 01100 CAFETERI A 281, 291 100, 809 33, 561 415, 661 11.00 01300 NURSING ADMINISTRATION 1, 030, 110 1, 207, 220 13.00 17, 092 5,690 154, 328 13.00 01400 CENTRAL SERVICES & SUPPLY 61, 920 26, 787 8, 918 9, 269 14.00 106, 894 14.00 15, 734 813, 214 15.00 01500 PHARMACY 650, 687 47, 261 99, 532 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 6, 312 2, 101 8, 413 16.00 01700 SOCIAL SERVICE 17.00 3, 938 1, 311 5, 249 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 2, 953, 384 799, 987 266, 333 346, 403 4, 366, 107 30.00 03100 INTENSIVE CARE UNIT 31.00 31.00 0 32.00 03200 CORONARY CARE UNIT 0 Ω 0 0 0 32.00 33.00 03300 BURN INTENSIVE CARE UNIT 0 0 0 33.00 C 0 34.00 03400 SURGICAL INTENSIVE CARE UNIT Λ 0 34.00 04300 NURSERY 43.00 439, 279 83, 111 27,669 54,010 604, 069 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 3, 338, 931 529, 545 176, 296 289, 988 4, 334, 760 05100 RECOVERY ROOM 51.00 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 1, 890, 767 436, 815 145, 424 262, 820 2, 735, 826 52.00 53.00 05300 ANESTHESI OLOGY 53.00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 1,087,107 246, 254 81, 983 124, 947 1, 540, 291 54.00 03630 ULTRA SOUND 54.01 203, 357 22, 368 7, 447 30, 079 263, 251 54.01 56.00 05600 RADI OI SOTOPE 56.00 0 05601 ONCOLOGY 377, 802 102, 652 47 007 561, 636 56, 01 34.175 56 01 57.00 05700 CT SCAN 694, 236 56, 249 18, 726 99, 300 868, 511 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 39, 948 58.00 270, 977 34, 966 11,641 357, 532 58.00 05900 CARDIAC CATHETERIZATION 59.00 59.00 06000 LABORATORY 2, 338, 257 2, 410, 339 60.00 54,078 18,004 0 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS C 0 0 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 63.00 06400 INTRAVENOUS THERAPY 64 00 64 00 0 06500 RESPIRATORY THERAPY 65.00 715, 307 11, 209 3, 732 104, 753 835, 001 65.00 1, 887, 668 66.00 06600 PHYSI CAL THERAPY 1, 376, 616 234, 439 78, 049 198, 564 66.00 06700 OCCUPATIONAL THERAPY 67.00 23, 277 5, 706 1, 900 3, 336 34, 219 67.00 06800 SPEECH PATHOLOGY 229 999 68 00 161, 171 40.066 13, 339 15, 423 68 00 69.00 06900 ELECTROCARDI OLOGY 290, 637 79, 400 26, 434 35, 795 432, 266 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 70.00 C C 713, 805 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 713, 805 0 0 71.00 0 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 2, 244, 498 72.00 72 00 2, 244, 498 Ω 73.00 07300 DRUGS CHARGED TO PATIENTS 4, 846, 814 0 0 0 4, 846, 814 73.00 07400 RENAL DIALYSIS 74.00 0 74.00 07500 ASC (NON-DISTINCT PART)
OUTPATIENT SERVICE COST CENTERS 0 75.00 0 75.00 91.00 09100 EMERGENCY 2, 674, 217 384, 403 127, 975 317, 048 3, 503, 643 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0 92.00 OTHER REIMBURSABLE COST CENTERS 99.00 09900 CMHC 0 0 0 0 99.00 0 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 54, 431, 503 1, 562, 566 2, 318, 991 53, 593, 239 118. 00 118.00 4, 693, 523 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 0 0 191. 00 19100 RESEARCH 0 0 191.00 0 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 628, 486 209, 235 855, 609 192. 00 17, 345 543 193. 00 19300 NONPALD WORKERS C 0 0 193.00 0 194.00 07950 COMMUNITY EDUCATION 0 194.00 0 0 194. 01 07951 MARKETI NG 0 0 0 0 194. 01 194. 02 07952 SC MGMT SVH TANDEM CASTLETON 0 C 0 0 194, 02 194.03 07953 SC MGMT SVH TANDEM 0 0 213 213 194.03 194.04 07954 SC MGMT SVH TANDEM AVON 744 0 0 744 194. 04 194.05 07955 SC MGMT TANDEM NOBLESVILLE W 0 26 194. 05 26 194.06 07956 SC MGMT SVH TANDEM PLAINFIELD 0 194.06 0 200.00 Cross Foot Adjustments 0 200.00

Health Financial Systems	ASCENSION ST. VINCENT FISHERS			In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS	Provi der CCN: 15-0181		Period: Worksheet E From 07/01/2021 Part I To 06/30/2022 Date/Time F		pared:		
		CAPLTAL REI	ATED COSTS		11/21/2022 11	:32 am	
Cost Center Description	Net Expenses for Cost	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS	Subtotal		
	Allocation			DEPARTMENT			
	(from Wkst A						
	col . 7)	1.00	2.00	4. 00	4A		
201.00 Negative Cost Centers	U	1.00	2.00	0 4.00		201. 00	
202.00 TOTAL (sum lines 118 through 201)	54, 449, 831	5, 322, 009	1, 771, 80	2, 319, 534	_		

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0181

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 07/01/2021 | Part I | To 06/30/2022 | Date/Time Prepared: | 11/21/2022 11: 32 am

					11/21/2022 11	:32 am
Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
·	& GENERAL	PLANT	LINEN SERVICE			
	5. 00	7. 00	8. 00	9. 00	10.00	
GENERAL SERVICE COST CENTERS	0.00	7.00	0.00	7.00		
1. 00 00100 CAP REL COSTS-BLDG & FLXT						1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00 00500 ADMINISTRATIVE & GENERAL	13, 978, 475					5. 00
7.00 00700 OPERATION OF PLANT	1, 049, 517	4, 088, 142				7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	50, 493		196, 683			8. 00
9. 00 00900 HOUSEKEEPI NG	226, 871	60, 328		948, 527		9. 00
	1			20, 756	709, 225	
10. 00 01000 DI ETARY	154, 118	88, 139				1
11. 00 01100 CAFETERI A	143, 566	100, 497		23, 666	0	1
13.00 O1300 NURSING ADMINISTRATION	416, 964	17, 039	0	4, 013	0	13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY	36, 920	26, 703	0	6, 289	0	14.00
15. 00 01500 PHARMACY	280, 878	47, 115	l o	11, 095	0	15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	2, 906	6, 292		1, 482	0	16. 00
17. 00 01700 SOCI AL SERVI CE	1, 813	3, 926		925	0	17. 00
	1,013	3, 720	1 0	723		17.00
INPATIENT ROUTINE SERVICE COST CENTERS	1 500 040	707 500	15 700	407.00/	500.004	
30. 00 03000 ADULTS & PEDI ATRI CS	1, 508, 018	797, 502	45, 703	187, 806	599, 891	1
31.00 03100 INTENSIVE CARE UNIT	0	0	0	0	0	31.00
32. 00 03200 CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00 03300 BURN INTENSIVE CARE UNIT	l ol	0	0	ol	0	33.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT		0	0	0	0	34.00
43. 00 04300 NURSERY	208, 641	82, 854	5, 337	19, 512	0	43. 00
ANCI LLARY SERVI CE COST CENTERS	200, 041	02, 034	5, 557	17, 312		45.00
	4 407 404	F07.000	20.00/	404 040		F0 00
50. 00 05000 OPERATI NG ROOM	1, 497, 191	527, 902		124, 318	0	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0	51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	944, 932	435, 460	28, 054	102, 548	109, 334	52. 00
53. 00 05300 ANESTHESI OLOGY	0	0	0	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	532, 004	245, 490	22, 136	57, 812	0	54.00
54. 01 03630 ULTRA SOUND	90, 925	22, 299		5, 251	0	54. 01
56. 00 05600 RADI OI SOTOPE	70, 725	22,277	3, 727	3, 231	0	56.00
	400 005	400.004	_	04 000		1
56. 01 05601 0NCOLOGY	193, 985	102, 334		24, 099	0	56. 01
57. 00 05700 CT SCAN	299, 977	56, 075	0	13, 205	0	57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	123, 489	34, 858	0	8, 209	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59. 00
60. 00 06000 LABORATORY	832, 512	53, 910	0	12, 696	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	002,012	00,7.0	٥	.2,0,0	0	62. 00
· · · · · · · · · · · · · · · · · · ·		0		0	0	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	U		63.00
64. 00 06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64. 00
65. 00 06500 RESPI RATORY THERAPY	288, 403	11, 175	0	2, 632	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	651, 985	233, 712	0	55, 038	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	11, 819	5, 688	0	1, 339	0	67.00
68. 00 06800 SPEECH PATHOLOGY	79, 440	39, 942		9, 406	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	149, 301	79, 154		18, 640	0	
+ I		77, 134		10, 040		
	0	U	0	U O	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	246, 543	0	0	O	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	775, 232	0	0	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 674, 041	0	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	O	0	0	0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	o	0	0	0	0	75. 00
OUTPATIENT SERVICE COST CENTERS	-1		-			1
91. 00 09100 EMERGENCY	1, 210, 130	383, 211	45, 323	90, 244	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 210, 130	303, 211	45, 525	70, 244	Ü	92.00
						92.00
OTHER REIMBURSABLE COST CENTERS				ام		
99. 00 09900 CMHC	0	0	0	0	0	99. 00
SPECIAL PURPOSE COST CENTERS						1
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	13, 682, 614	3, 461, 605	196, 683	800, 981	709, 225	118. 00
NONREI MBURSABLE COST CENTERS						1
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
191. 00 19100 RESEARCH	ol	0	0	0	0	191. 00
192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES	295, 521	626, 537	_	147, 546		192. 00
	1	020, 337		147, 540		192.00
193. 00 19300 NONPALD WORKERS	0	0]	اِ		
194. 00 07950 COMMUNITY EDUCATION	0	0	0	0		194. 00
194. 01 07951 MARKETI NG	0	0	0	0		194. 01
194.02 07952 SC MGMT SVH TANDEM CASTLETON	0	0	0	0	0	194. 02
194.03 07953 SC MGMT SVH TANDEM	74	0	o	ol	0	194. 03
194.04 07954 SC MGMT SVH TANDEM AVON	257	n	n	n		194. 04
194. 05 07955 SC MGMT TANDEM NOBLESVILLE W	207	0	l o	n		194. 05
194.06 07956 SC MGMT SVH TANDEM PLAINFIELD	7	0		9		194. 05
	ا	U	١	٩	Ü	
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0	0	0		201. 00
202.00 TOTAL (sum lines 118 through 201)	13, 978, 475	4, 088, 142	196, 683	948, 527	709, 225	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0181

| In Lieu of Form CMS-2552-10 | Period: Worksheet B | From 07/01/2021 Part I | To 06/30/2022 Date/Time Prepared: 11/21/2022 11:32 am

				00/ 30/ 2022	11/21/2022 11:	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVICES &		RECORDS &	
	11 00	12.00	SUPPLY	15.00	LI BRARY	
GENERAL SERVICE COST CENTERS	11. 00	13.00	14. 00	15. 00	16. 00	
1.00 00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00 00200 CAP REL COSTS-BLDG & TTXT						2. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00 00500 ADMI NI STRATI VE & GENERAL						5. 00
7. 00 00700 OPERATION OF PLANT						7. 00
8. 00 00800 LAUNDRY & LI NEN SERVI CE						8. 00
9. 00 00900 HOUSEKEEPI NG						9.00
10. 00 01000 DI ETARY	(02.200					10.00
11. 00 01100 CAFETERI A	683, 390	1				11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	46, 402	1	47/ 00/			13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	21 22/	_	176, 806	1 100 004		14. 00
15. 00 01500 PHARMACY	31, 226	6, 017	539	1, 190, 084	10.000	15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0		0	U	19, 093	16. 00
17. 00 01700 SOCIAL SERVICE	0	oj Oj	0	U	0	17. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	404 075	470 540	4 000		4 047	00.00
30. 00 03000 ADULTS & PEDI ATRI CS	104, 375	478, 540	6, 923	0	1, 317	30.00
31. 00 03100 INTENSI VE CARE UNIT	0		0	0	0	31. 00
32. 00 03200 CORONARY CARE UNIT	0		0	0	0	32. 00
33. 00 03300 BURN INTENSIVE CARE UNIT	0		0	0	0	33.00
34. 00 03400 SURGI CAL INTENSIVE CARE UNIT	00 (00		4 700	0	0	34.00
43. 00 04300 NURSERY	23, 622	! 0	1, 790	0	404	43.00
ANCILLARY SERVICE COST CENTERS	0/ 050	240 044	0.4.000		F 04.4	F0 00
50. 00 05000 OPERATI NG ROOM	86, 958	340, 844	34, 388	0	5, 216	50.00
51. 00 05100 RECOVERY ROOM	0	0	0	0	0	51. 00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	67, 872	498, 351	2, 181	0	1, 161	52. 00
53. 00 05300 ANESTHESI OLOGY	0	0	0	0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	46, 976		5, 713	0	929	54. 00
54. 01 03630 ULTRA SOUND	9, 404	982	141	0	240	54. 01
56. 00 05600 RADI 0I SOTOPE	0	0	0	0	0	56. 00
56. 01 05601 0NCOLOGY	19, 667		1, 279	0	263	56. 01
57. 00 05700 CT SCAN	33, 087		1, 325	0	558	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	12, 456	1, 869	182	0	154	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	이	0	0	0	59.00
60. 00 06000 LABORATORY	0	0	22	0	1, 535	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64. 00 06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	27, 858	123	1, 250	0	192	65.00
66. 00 06600 PHYSI CAL THERAPY	82, 622	0	896	0	492	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	1, 018	0	0	0	12	67.00
68.00 06800 SPEECH PATHOLOGY	5, 835	0	2, 146	0	66	68.00
69. 00 06900 ELECTROCARDI OLOGY	12, 814	1, 951	1, 829	0	525	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	ol ol	25, 971	0	573	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	ol ol	84, 532	0	658	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	ol ol	0	1, 186, 189	1, 504	73.00
74. 00 07400 RENAL DI ALYSI S	0	ol	0	0	0	74.00
75. 00 07500 ASC (NON-DISTINCT PART)	0	ol	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	71, 198	340, 598	5, 377	0	3, 294	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS			<u> </u>	·		
99. 00 09900 CMHC	0	0	0	0	0	99.00
SPECIAL PURPOSE COST CENTERS		'		'		
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	683, 390	1, 691, 638	176, 484	1, 186, 189	19, 093	118. 00
NONREI MBURSABLE COST CENTERS		, , , , , , , , , , , ,		, ,	,	
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	ol	0	0	0	190. 00
191. 00 19100 RESEARCH	0	1	0	0		191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	ol ol	322	3, 895		192. 00
193. 00 19300 NONPALD WORKERS	0		0	0,0,0		193. 00
194. 00 07950 COMMUNI TY EDUCATI ON	n	ا م	n	ol ol		194. 00
194. 01 07951 MARKETI NG	0		0	o l		194. 01
194.02 07952 SC MGMT SVH TANDEM CASTLETON	0		0	0		194. 01
194. 03 07953 SC MGMT SVH TANDEM	0		0	0		194. 02
194. 04 07954 SC MGMT SVH TANDEM AVON	0	ا م	0	0		194. 03
194. 05 07955 SC MGMT TANDEM NOBLESVILLE W	0		0	0		194. 05
194.06 07956 SC MGMT TANDEW NOBLESVILLE W	0		0	0		194. 05
200.00 Cross Foot Adjustments	U	7	٥	٩		200. 00
201.00 Negative Cost Centers	0	ار	0			200.00
202.00 TOTAL (sum lines 118 through 201)	683, 390	1, 691, 638	176, 806	1, 190, 084	19, 093	
202.00 TOTAL (Sum TITIES TTO EMOUGH 201)	000, 070	1,071,030	170,000	1, 170, 004	17,073	_52.00

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0181 Peri od: Worksheet B From 07/01/2021 Part I Date/Time Prepared: 06/30/2022 11/21/2022 11:32 am Cost Center Description SOCIAL SERVICE Intern & Total Subtotal Residents Cost & Post Stepdown Adjustments 17.00 24.00 25.00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1 00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11 00 11 00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16 00 16 00 17.00 01700 SOCIAL SERVICE 11, 913 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 8, 104, 725 30.00 03000 ADULTS & PEDIATRICS 30.00 8,543 8, 104, 725 0 03100 INTENSIVE CARE UNIT 0 31.00 31.00 32.00 03200 CORONARY CARE UNIT 0 0 0 32.00 C 03300 BURN INTENSIVE CARE UNIT 33.00 0 0 0 33.00 03400 SURGICAL INTENSIVE CARE UNIT 0 34 00 34 00 0 04300 NURSERY 43.00 3, 370 949, 599 0 949, 599 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 6, 991, 503 0 6, 991, 503 50.00 0 05100 RECOVERY ROOM 0 51 00 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 000000000000000000000000 4, 925, 719 4, 925, 719 52.00 05300 ANESTHESI OLOGY 0 53.00 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 2, 462, 553 2, 462, 553 54.00 03630 ULTRA SOUND 0 54.01 398, 220 398, 220 54.01 56.00 05600 RADI OI SOTOPE 0 56.00 05601 ONCOLOGY 903, 263 56. 01 903, 263 56.01 1, 283, 899 57.00 05700 CT SCAN 1, 283, 899 0 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 58 00 538, 749 538, 749 58 00 05900 CARDIAC CATHETERIZATION 59.00 59.00 06000 LABORATORY 60.00 3, 311, 014 0 3, 311, 014 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62.00 62.00 0 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 63.00 64.00 06400 I NTRAVENOUS THERAPY 0 64.00 06500 RESPIRATORY THERAPY 1, 166, 634 65.00 1, 166, 634 65.00 06600 PHYSI CAL THERAPY 2, 912, 413 0 2, 912, 413 66.00 66.00 67.00 06700 OCCUPATIONAL THERAPY 54, 095 54, 095 67.00 68.00 06800 SPEECH PATHOLOGY 366, 834 366, 834 68.00 06900 ELECTROCARDI OLOGY 696, 480 69.00 696, 480 69.00 0 70.00 07000 ELECTROENCEPHALOGRAPHY 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 986, 892 986, 892 71.00 0 07200 IMPL. DEV. CHARGED TO PATIENTS 3, 104, 920 3, 104, 920 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 7, 708, 548 7, 708, 548 73.00 74.00 07400 RENAL DIALYSIS 74.00 07500 ASC (NON-DISTINCT PART) 75.00 75.00 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 0 5, 653, 018 0 5, 653, 018 91.00 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 99 00 0 0 0 0 99 00 09900 CMHC SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 11, 913 52, 519, 078 0 52, 519, 078 118.00 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN O 190 00 191. 00 19100 RESEARCH 0 191.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 1, 929, 430 0 1, 929, 430 192.00 193. 00 19300 NONPALD WORKERS 0 0 0 0 0 193.00 194. 00 07950 COMMUNITY EDUCATION 0 0 194 00 C 194. 01 07951 MARKETI NG 0 0 0 194.01 194.02 07952 SC MGMT SVH TANDEM CASTLETON 194. 02 0 0 194.03 07953 SC MGMT SVH TANDEM 287 0 287 194. 03 194.04 07954 SC MGMT SVH TANDEM AVON 0 1,001 0 1,001 194.04 194.05 07955 SC MGMT TANDEM NOBLESVILLE W 0 194.05 35 35 194.06 07956 SC MGMT SVH TANDEM PLAINFIELD 0 C 0 0 194. 06 0 200.00 Cross Foot Adjustments 200. 00 C 0 201.00 Negative Cost Centers 201. 00 202.00 TOTAL (sum lines 118 through 201) 11.913 54, 449, 831 54, 449, 831 202.00

| Peri od: | Worksheet B | From 07/01/2021 | Part II | To 06/30/2022 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0181

				Ť	o 06/30/2022	Date/Time Pre 11/21/2022 11	
			CAPI TAL REI	LATED COSTS		11/21/2022 11	. 32 aiii
	Coot Conton Decement on	Di mantlu	BLDG & FIXT	MANDLE FOLLID	Subtotal	EMDL OVEE	
	Cost Center Description	Directly Assigned New	BLDG & FIXI	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
		Capi tal				DEPARTMENT	
		Related Costs 0	1.00	2.00	2.4	4.00	
	GENERAL SERVICE COST CENTERS	0	1. 00	2. 00	2A	4. 00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUI P		50 (4)		70.400	70.400	2.00
4. 00 5. 00	OO400	769, 552	52, 614 467, 312			70, 130 2, 614	1
7. 00	00700 OPERATION OF PLANT	0	701, 221	233, 450		0	1
8.00	00800 LAUNDRY & LINEN SERVICE	O	0	C	0	0	
9.00	00900 HOUSEKEEPI NG	0	60, 516			0	
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	0	88, 413 100, 809		117, 847 134, 370	0	
13. 00	01300 NURSI NG ADMI NI STRATI ON	Ö	17, 092			4, 666	1
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	26, 787			280	1
15. 00 16. 00	01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY	0	47, 261 6, 312			3, 009 0	15. 00 16. 00
	01700 SOCIAL SERVICE		3, 938				17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	0	799, 987	266, 333	1, 066, 320	10, 475	
31. 00 32. 00	03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT	0	0	C	0	0	
33. 00	03300 BURN INTENSIVE CARE UNIT	l o	0	Č	o o	0	1
34.00	03400 SURGICAL INTENSIVE CARE UNIT	o	0	C	0	0	34. 00
43. 00	04300 NURSERY	0	83, 111	27, 669	110, 780	1, 633	43. 00
50. 00	ANCI LLARY SERVI CE COST CENTERS O5000 OPERATI NG ROOM	O	529, 545	176, 296	705, 841	8, 768	50.00
51. 00	05100 RECOVERY ROOM	O	027,010	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	0	0	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	436, 815	145, 424	582, 239	7, 946	1
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0	0 246, 254	81, 983	0 328, 237	0 3, 778	
54. 01	03630 ULTRA SOUND	0	22, 368		29, 815	909	1
56. 00	05600 RADI OI SOTOPE	o	0	C	0	0	56. 00
56. 01	05601 ONCOLOGY	0	102, 652			1, 421	56. 01
57. 00 58. 00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	56, 249 34, 966			3, 002 1, 208	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	l o	0 1, 700	11,011	0	0	1
60.00	06000 LABORATORY	0	54, 078	18, 004		0	
62. 00 63. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	C	0	0	62. 00 63. 00
64. 00	06400 I NTRAVENOUS THERAPY		0		0	0	64.00
65. 00	06500 RESPIRATORY THERAPY	0	11, 209	3, 732	14, 941	3, 167	1
66. 00	06600 PHYSI CAL THERAPY	0	234, 439			6, 003	1
67. 00 68. 00	O6700 OCCUPATI ONAL THERAPY O6800 SPEECH PATHOLOGY	0	5, 706 40, 066			101 466	1
69. 00	06900 ELECTROCARDI OLOGY	0	79, 400				1
	07000 ELECTROENCEPHALOGRAPHY	o	0	C	0	0	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	C	0	0	
	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73.00
	07400 RENAL DIALYSIS	0	0	d	0	0	1
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	C	0	0	75. 00
91. 00	OUTPATIENT SERVICE COST CENTERS 09100 EMERGENCY	0	384, 403	127, 975	512, 378	9, 586	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		304, 403	127, 975	0		92. 00
	OTHER REIMBURSABLE COST CENTERS						
99. 00	09900 CMHC	0	0	C	0	0	99. 00
118. 00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	769, 552	4, 693, 523	1, 562, 566	7, 025, 641	70 114	118. 00
	NONREI MBURSABLE COST CENTERS	7077002	170707020	1,002,000	., 020, 011	70,	1.10.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C	0		190. 00
	19100 RESEARCH 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0 628, 486	209, 235	0 837, 721		191. 00 192. 00
	19300 NONPALD WORKERS	0	020, 400	209, 235	037, 721		192.00
	07950 COMMUNITY EDUCATION	0	0	C	0		194. 00
	07951 MARKETI NG	0	0	C	0		194. 01
	07952 SC MGMT SVH TANDEM CASTLETON 07953 SC MGMT SVH TANDEM	0	0		0		194. 02 194. 03
	07954 SC MGMT SVH TANDEM AVON		0				194. 03
194.05	07955 SC MGMT TANDEM NOBLESVILLE W	0	0	C	0	0	194. 05
	07956 SC MGMT SVH TANDEM PLAINFIELD	0	0	C	0	0	194. 06
200. 00 201. 00			0	c		n	200. 00 201. 00
	1 13=	<u> </u>		1	<u> </u>	<u> </u>	

Health Financial Systems A	SCENSION ST. VI	NCENT FISHERS		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der CO		Period: From 07/01/2021	Worksheet B	
					Date/Time Pre 11/21/2022 11	pared: :32 am
		CAPI TAL REL	LATED COSTS			
Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
	0	1.00	2.00	2A	4. 00	
202.00 TOTAL (sum lines 118 through 201)	769, 552	5, 322, 009	1, 771, 80	1 7, 863, 362	70, 130	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0181

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 07/01/2021 | Part II | To 06/30/2022 | Date/Time Prepared: 11/21/2022 11: 32 am

					11/21/2022 11	:32 am
Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	& GENERAL	PLANT	LINEN SERVICE			
	5. 00	7. 00	8. 00	9. 00	10. 00	
GENERAL SERVICE COST CENTERS						
1.00 O0100 CAP REL COSTS-BLDG & FLXT						1. 00
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMINISTRATIVE & GENERAL	1, 395, 055					5. 00
7. 00 00700 OPERATION OF PLANT	104, 741	1, 039, 412	,			7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE	1		5, 039			8.00
	5, 039			440 750		
9. 00 00900 HOUSEKEEPI NG	22, 642	15, 338		118, 758		9. 00
10. 00 01000 DI ETARY	15, 381	22, 409		2, 599	158, 236	
11. 00 01100 CAFETERI A	14, 328	25, 551	0	2, 963	0	11. 00
13.00 O1300 NURSING ADMINISTRATION	41, 613	4, 332	2 0	502	0	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	3, 685	6, 789	0	787	0	14. 00
15. 00 01500 PHARMACY	28, 031	11, 979		1, 389	0	15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	290			186	0	16. 00
17. 00 01700 SOCIAL SERVICE	181	998		116	0	17. 00
	101	990	0	110	U	17.00
INPATIENT ROUTINE SERVICE COST CENTERS	450 500	000 7/0		00 544	100.010	
30. 00 03000 ADULTS & PEDI ATRI CS	150, 500	202, 768	1, 170	23, 514	133, 842	
31.00 03100 I NTENSI VE CARE UNIT	0	0) 0	0	0	31. 00
32. 00 03200 CORONARY CARE UNIT	0	0	0	0	0	32. 00
33.00 03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	ol	0	34.00
43. 00 04300 NURSERY	20, 822	21, 066	137	2, 443	0	43.00
ANCI LLARY SERVI CE COST CENTERS	20,022	2.,000	107	27		10.00
50. 00 05000 OPERATING ROOM	149, 419	134, 219	1, 023	15, 565	0	50.00
	147, 417	134, 217	1,023	15, 505		1
	١	0	1	10.000	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	94, 304	110, 716		12, 839	24, 394	
53. 00 05300 ANESTHESI OLOGY	0	0) 0	0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	53, 094	62, 416	567	7, 238	0	54.00
54. 01 03630 ULTRA SOUND	9, 074	5, 670	147	657	0	54. 01
56. 00 05600 RADI 0I SOTOPE	0	0	ol o	ol	0	56.00
56. 01 05601 0NCOLOGY	19, 360	26, 018	0	3, 017	0	56. 01
57. 00 05700 CT SCAN	29, 938	14, 257		1, 653	0	57.00
	The state of the s				0	1
	12, 324	8, 863		1, 028		58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	
60. 00 06000 LABORATORY	83, 084	13, 707	0	1, 590	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62. 00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0	ol o	ol	0	64. 00
65. 00 06500 RESPI RATORY THERAPY	28, 782	2, 841	0	329	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	65, 068	59, 421		6, 891	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	1, 180			168	0	67.00
	1			l l		1
68. 00 06800 SPEECH PATHOLOGY	7, 928	10, 155		1, 178	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	14, 900	20, 125	0	2, 334	0	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0) 0	0	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	24, 605	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	77, 368	0	0	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	167, 076	0	0	ol	0	73. 00
74. 00 07400 RENAL DI ALYSI S	0	0		0	0	
75. 00 07500 ASC (NON-DISTINCT PART)	0	Ö	o o	o	0	
OUTPATIENT SERVICE COST CENTERS	U	0	,	Ο _Ι		75.00
	100 771	07 401	1 1/1	11 200		01 00
91. 00 09100 EMERGENCY	120, 771	97, 431	1, 161	11, 299	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
OTHER REIMBURSABLE COST CENTERS						1
99. 00 09900 CMHC	0	0	0	0	0	99. 00
SPECIAL PURPOSE COST CENTERS						1
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 365, 528	880, 115	5, 039	100, 285	158, 236	1118. 00
NONREI MBURSABLE COST CENTERS	,					
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	٥	0	190. 00
191. 00 19100 RESEARCH	0	0	0	0		191.00
	-	450.007	-	40 470		
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	29, 493	159, 297	0	18, 473		192. 00
193.00 19300 NONPALD WORKERS	0	0	0	0		193. 00
194.00 07950 COMMUNITY EDUCATION	0	0	0	0		194. 00
194. 01 07951 MARKETI NG	0	0	0	o	0	194. 01
194.02 07952 SC MGMT SVH TANDEM CASTLETON	0	0	0	ol	0	194. 02
194. 03 07953 SC MGMT SVH TANDEM	7	i n	م ا	ol o		194. 03
194. 04 07954 SC MGMT SVH TANDEM AVON	26	١	م م	o o		194. 04
194. 05 07955 SC MGMT TANDEM NOBLESVILLE W	20					194. 04
			<u> </u>	ol ol		
194. 06 07956 SC MGMT SVH TANDEM PLAINFIELD	0	0	0	이	0	194. 06
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0	0	0		201. 00
202.00 TOTAL (sum lines 118 through 201)	1, 395, 055	1, 039, 412	5, 039	118, 758	158, 236	202. 00
				·		

| Peri od: | Worksheet B | From 07/01/2021 | Part II | To 06/30/2022 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0181

				To	06/30/2022	Date/Time Pre 11/21/2022 11	
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	JZ dili
		11. 00	13. 00	14. 00	15. 00	16. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						4. 00 5. 00
7. 00 8. 00	OO7OO OPERATION OF PLANT OO8OO LAUNDRY & LINEN SERVICE						7. 00 8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY						9. 00 10. 00
11. 00 13. 00	O1100 CAFETERI A O1300 NURSI NG ADMI NI STRATI ON	177, 212 12, 033	1				11. 00 13. 00
14. 00 15. 00	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	0 8, 097	0 306	47, 246 144	115, 950		14. 00 15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	О	0	0	10, 489	16. 00
17.00	01700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS	0	l ol	U		0	17.00
30.00	03000 ADULTS & PEDIATRICS	27, 066	24, 308	1, 850	0	726	30. 00
31. 00 32. 00	03100 INTENSIVE CARE UNIT	0	0	0	0	0	31. 00 32. 00
33.00	03300 BURN INTENSIVE CARE UNIT	0	o	Ō	ō	0	33. 00
34. 00 43. 00	03400 SURGI CAL INTENSIVE CARE UNIT 04300 NURSERY	0 6, 125	0	0 478	0	0 223	34. 00 43. 00
F0 00	ANCILLARY SERVICE COST CENTERS	00.540	47.040	0.400	ما	0.040	F0 00
50. 00 51. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM	22, 549 0	17, 313 0	9, 189 0	0	2, 840 0	50. 00 51. 00
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	17, 600	25, 314	583	o	640 0	52. 00 53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	12, 181	569	1, 526	ő	512	54. 00
54. 01 56. 00	03630 ULTRA SOUND 05600 RADI OI SOTOPE	2, 439 0	50	38	0	132 0	54. 01 56. 00
56. 01	05601 ONCOLOGY	5, 100	ō	342	ő	145	56. 01
57. 00 58. 00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	8, 580 3, 230	1	354 49	0	307 85	57. 00 58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	3, 230	0	0	o	0	59.00
60.00	06000 LABORATORY	0	0	6	o	846	60.00
62. 00 63. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS.	0		0	ol Ol	0	62. 00 63. 00
64.00	06400 I NTRAVENOUS THERAPY	0	0	0	o	0	64. 00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	7, 224 21, 425	6 0	334 239	0 0	106 271	65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	264	O	0	o	7	67. 00
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	1, 513 3, 323		573 489	0	36 289	68. 00 69. 00
70. 00	07000 ELECTROCARDI GEOGRAPHY	0, 323	0	0	ő	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	6, 940	o	316	71.00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0 0	22, 589 0	0 115, 570	363 829	1
74.00	07400 RENAL DIALYSIS	0	1	0	0	0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART) OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	75. 00
	09100 EMERGENCY	18, 463	17, 301	1, 437	0	1, 816	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92.00
99. 00	09900 CMHC SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	99. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	177, 212	85, 928	47, 160	115, 570	10, 489	118. 00
100.00	NONREI MBURSABLE COST CENTERS	0		0	ما	0	100 00
	1900 GIFT, FLOWER, COFFEE SHOP & CANTEEN 1910 RESEARCH	0		0	0 0		190. 00 191. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	o	86	380	0	192. 00
	19300 NONPALD WORKERS 07950 COMMUNITY EDUCATION	0	0	0	0		193. 00 194. 00
	07951 MARKETI NG	ő	o o	o	ő		194. 01
	07952 SC MGMT SVH TANDEM CASTLETON	0	0	0	o		194. 02 194. 03
	07953 SC MGMT SVH TANDEM 07954 SC MGMT SVH TANDEM AVON			0	ol Ol		194. 03
194. 05	07955 SC MGMT TANDEM NOBLESVILLE W	o	0	ō	ō	0	194. 05
194. 06 200. 00	07956 SC MGMT SVH TANDEM PLAINFIELD Cross Foot Adjustments	0	0	0	0	0	194. 06 200. 00
201.00	Negative Cost Centers	О	О	О	О		201. 00
202.00	TOTAL (sum lines 118 through 201)	177, 212	85, 928	47, 246	115, 950	10, 489	202. 00

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0181 Peri od: Worksheet B From 07/01/2021 Part II 06/30/2022 Date/Time Prepared: 11/21/2022 11:32 am Cost Center Description SOCIAL SERVICE Intern & Total Subtotal Residents Cost & Post Stepdown Adjustments 17.00 24.00 25.00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1 00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11 00 11 00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16 00 16 00 17.00 01700 SOCIAL SERVICE 6,544 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 1, 647, 232 30.00 03000 ADULTS & PEDIATRICS 30.00 4 693 1,647,232 0 03100 INTENSIVE CARE UNIT 0 31.00 31.00 32.00 03200 CORONARY CARE UNIT 0 0 0 32.00 C 03300 BURN INTENSIVE CARE UNIT 33.00 0 0 0 33.00 03400 SURGICAL INTENSIVE CARE UNIT 0 34 00 34 00 0 0 04300 NURSERY 43.00 1,851 165, 558 0 165, 558 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 1, 066, 726 0 1, 066, 726 50.00 0 05100 RECOVERY ROOM 0000000000000000000000000 51 00 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 877, 294 877, 294 52.00 05300 ANESTHESI OLOGY 0 53.00 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 470, 118 54.00 470.118 54.00 03630 ULTRA SOUND 0 54.01 48, 931 48, 931 54.01 56.00 05600 RADI OI SOTOPE 0 56.00 05601 ONCOLOGY 192, 230 192, 230 56. 01 56.01 57.00 05700 CT SCAN 0 133, 633 57.00 133, 633 0 05800 MAGNETIC RESONANCE I MAGING (MRI) 58 00 73, 489 73, 489 58 00 05900 CARDIAC CATHETERIZATION 59.00 59.00 06000 LABORATORY 60.00 171, 315 0 171, 315 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62.00 62.00 0 63.00 06300 BLOOD STORING, PROCESSING & TRANS. Ω 0 63.00 64.00 06400 I NTRAVENOUS THERAPY 0 64.00 06500 RESPIRATORY THERAPY 57, 730 57, 730 65.00 65.00 06600 PHYSI CAL THERAPY 471, 806 0 471, 806 66.00 66.00 67.00 06700 OCCUPATIONAL THERAPY 10, 772 0 10,772 67.00 68.00 06800 SPEECH PATHOLOGY 75, 254 75, 254 68.00 06900 ELECTROCARDI OLOGY 148, 475 0 69.00 148, 475 69.00 0 70.00 07000 ELECTROENCEPHALOGRAPHY 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 31, 861 31, 861 71.00 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 100, 320 100, 320 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 283, 475 283, 475 73.00 74.00 07400 RENAL DIALYSIS 0 0 74.00 07500 ASC (NON-DISTINCT PART) 0 75.00 75.00 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 0 791, 643 0 791, 643 91.00 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 99 00 0 0 0 0 99 00 09900 CMHC SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 6, 544 6, 817, 862 0 6, 817, 862 118.00 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN O 190 00 191. 00 19100 RESEARCH 0 191.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 1, 045, 466 0 1, 045, 466 192.00 193. 00 19300 NONPALD WORKERS 0 0 0 0 0 193.00 194. 00 07950 COMMUNITY EDUCATION 0 0 194 00 Ω 194. 01 07951 MARKETI NG 0 0 0 194.01 194. 02 194.02 07952 SC MGMT SVH TANDEM CASTLETON 0 0 7 194.03 07953 SC MGMT SVH TANDEM 0 194. 03 194.04 07954 SC MGMT SVH TANDEM AVON 0 26 0 26 194.04 194.05 07955 SC MGMT TANDEM NOBLESVILLE W 0 194. 05 194.06 07956 SC MGMT SVH TANDEM PLAINFIELD 0 0 0 0 194. 06 0 200.00 Cross Foot Adjustments 0 200. 00 C 201.00 Negative Cost Centers 201.00 202.00 TOTAL (sum lines 118 through 201) 6.544 7, 863, 362 7, 863, 362 202.00

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0181 Peri od: Worksheet B-1 From 07/01/2021 06/30/2022 Date/Time Prepared: 11/21/2022 11:32 am CAPITAL RELATED COSTS BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Reconciliation ADMINISTRATIVE Cost Center Description (SQUARE FEET) (SQUARE FEET) BENEFITS & GENERAL (ACCUM. COST) DEPARTMENT (GROSS SALARI ES) 1.00 2.00 5A 5. 00 4.00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 210 802 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 210, 802 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 2,084 2, 084 14, 196, 368 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 18 510 18, 510 529, 051 -13, 978, 475 40 471 356 5 00 7.00 00700 OPERATION OF PLANT 27, 775 27, 775 3, 038, 625 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 146, 190 8.00 0 00900 HOUSEKEEPI NG 2, 397 2, 397 0 656, 851 9.00 9.00 01000 DI ETARY 10.00 3 502 0 446, 212 10 00 3.502 3, 993 11.00 01100 CAFETERI A 3, 993 415, 661 11.00 01300 NURSING ADMINISTRATION o 1, 207, 220 13.00 677 677 944, 541 13.00 0 01400 CENTRAL SERVICES & SUPPLY 106, 894 14.00 1.061 1.061 56, 730 14.00 813, 214 15.00 01500 PHARMACY 1,872 1,872 609, 175 15 00 16.00 01600 MEDICAL RECORDS & LIBRARY 250 250 0 8, 413 16.00 C 01700 SOCIAL SERVICE 5, 249 17.00 156 156 0 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 31, 687 31, 687 2, 120, 094 0 4, 366, 107 30.00 03100 INTENSIVE CARE UNIT 0 31.00 31.00 0 32.00 03200 CORONARY CARE UNIT 0 C 0 0 0 32.00 33.00 03300 BURN INTENSIVE CARE UNIT 0 0 0 33.00 C 0 34.00 03400 SURGICAL INTENSIVE CARE UNIT Λ Λ 0 Λ 34.00 330, 563 04300 NURSERY 0 43.00 3, 292 3, 292 604, 069 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 20.975 20, 975 1, 774, 832 0 4, 334, 760 05100 RECOVERY ROOM 51.00 0 51.00 0 05200 DELIVERY ROOM & LABOR ROOM 52.00 17, 302 17, 302 1, 608, 556 0 2, 735, 826 52.00 53.00 05300 ANESTHESI OLOGY 53.00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 9.754 9, 754 764, 720 1, 540, 291 54.00 03630 ULTRA SOUND 0 54.01 886 886 184, 094 263, 251 54.01 56.00 05600 RADI OI SOTOPE 0 56.00 05601 ONCOLOGY 4.066 4.066 287, 698 561, 636 56, 01 56 01 57.00 05700 CT SCAN 2, 228 2, 228 607, 751 868, 511 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 1, 385 1, 385 244, 495 0 357, 532 58.00 05900 CARDIAC CATHETERIZATION 59.00 59.00 06000 LABORATORY 0 2, 410, 339 60.00 2, 142 2, 142 60.00 0 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0 63.00 0 06400 INTRAVENOUS THERAPY 64 00 0 64 00 0 06500 RESPIRATORY THERAPY 65.00 444 444 641, 124 835, 001 65.00 1, 887, 668 66.00 06600 PHYSI CAL THERAPY 9, 286 9, 286 1, 215, 283 66.00 06700 OCCUPATIONAL THERAPY 67.00 226 226 20, 417 0 34, 219 67.00 06800 SPEECH PATHOLOGY 229, 999 68 00 1 587 94 395 68 00 1.587 69.00 06900 ELECTROCARDI OLOGY 3, 145 3, 145 219,076 432, 266 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 70.00 0 0 0 713, 805 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 71.00 0 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 72 00 Ω 2, 244, 498 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 o 4, 846, 814 73.00 07400 RENAL DIALYSIS 0 74.00 0 74.00 07500 ASC (NON-DISTINCT PART)
OUTPATIENT SERVICE COST CENTERS 75.00 0 0 75.00 91.00 09100 EMERGENCY 15, 226 15, 226 1, 940, 448 0 3, 503, 643 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 99.00 09900 CMHC 0 0 0 0 0 99.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 185, 908 185, 908 14, 193, 043 -13, 978, 475 118.00 39, 614, 764 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 0 191. 00 19100 RESEARCH 0 0 191.00 0 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 24, 894 24, 894 3, 325 0 855, 609 192. 00 193. 00 19300 NONPALD WORKERS 0 0 C 0 193.00 194.00 07950 COMMUNITY EDUCATION 0 0 0 194.00 0 0 194. 01 07951 MARKETI NG 0 0 0 194. 01 194. 02 07952 SC MGMT SVH TANDEM CASTLETON 0 C 0 0 194, 02 0 0 194.03 07953 SC MGMT SVH TANDEM 0 213 194.03 194.04 07954 SC MGMT SVH TANDEM AVON 0 0 0 744 194. 04 194.05 07955 SC MGMT TANDEM NOBLESVILLE W 26 194. 05 0 194.06 07956 SC MGMT SVH TANDEM PLAINFIELD 0 194.06 0 200.00 Cross Foot Adjustments 200.00

Health Financial Systems A	SCENSION ST. VINC	ENT FISHERS		In Lie	eu of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CC		Period: From 07/01/2021	Worksheet B-1	
				To 06/30/2022	Date/Time Prep 11/21/2022 11:	
	CAPITAL RELAT	ED COSTS				
Cost Contor Doscription	DIDC 0 FLVT M	VDLE FOLLD	EMDL OVEE	Doconci Li ati on	ADMINI CTDATIVE	

						11/21/2022 11	<u>:32 am</u>
		CAPITAL REL	LATED COSTS				
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
		(SQUARE FEET)	(SQUARE FEET)	BENEFITS		& GENERAL	
				DEPARTMENT		(ACCUM. COST)	
				(GROSS			
				SALARI ES)			
		1.00	2. 00	4. 00	5A	5. 00	
201.00	Negative Cost Centers						201. 00
202.00	Cost to be allocated (per Wkst. B,	5, 322, 009	1, 771, 801	2, 319, 534		13, 978, 475	202. 00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	25. 246482	8. 405048	0. 163389	1	0. 345392	203. 00
204.00	Cost to be allocated (per Wkst. B,			70, 130		1, 395, 055	204. 00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part			0. 004940)	0. 034470	205. 00
	[11]						
206.00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						

Health Financial Systems ASCENSION ST. VINCENT FISHERS In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0181 Peri od: Worksheet B-1 From 07/01/2021 06/30/2022 Date/Time Prepared: 11/21/2022 11 32 am Cost Center Description OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A (SQUARE FEET) (MEALS SERVED) (MEALS SERVED) PLANT LINEN SERVICE (SQUARE FEET) (POUNDS OF LAUNDRY) 7.00 10.00 11.00 8.00 9.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7.00 162, 433 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 186, 573 8.00 00900 HOUSEKEEPI NG 9.00 2.397 4, 247 160, 036 9.00 10.00 01000 DI ETARY 3,502 C 3,502 9,088 10.00 11.00 01100 CAFETERI A 3,993 3, 993 278, 603 11.00 01300 NURSING ADMINISTRATION 18, 917 677 0 13.00 13.00 677 C 14.00 01400 CENTRAL SERVICES & SUPPLY 1,061 C 1,061 0 14.00 15.00 01500 PHARMACY 1,872 1,872 12, 730 15.00 01600 MEDICAL RECORDS & LIBRARY C 0 16.00 250 250 16.00 0 01700 SOCIAL SERVICE 17.00 156 C 156 0 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 31, 687 43, 353 31, 687 7, 687 42, 551 30.00 03100 INTENSIVE CARE UNIT 31 00 0 0 31 00 0 32.00 03200 CORONARY CARE UNIT 0 C 0 0 0 32.00 03300 BURN INTENSIVE CARE UNIT 0 0 0 0 0 33.00 33.00 34.00 03400 SURGICAL INTENSIVE CARE UNIT 0 34.00 0 43.00 04300 NURSERY 3 292 5 063 9, 630 43 00 3 292 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 20, 975 37, 874 20, 975 35, 451 50.00 51 00 05100 RECOVERY ROOM 51 00 0 05200 DELIVERY ROOM & LABOR ROOM 52.00 17, 302 26, 612 17, 302 1, 401 27,670 52.00 53.00 05300 ANESTHESI OLOGY 53.00 0 05400 RADI OLOGY-DI AGNOSTI C 54.00 9,754 20, 998 9, 754 0 19, 151 54.00 54 01 03630 ULTRA SOUND 0 54 01 886 5, 433 886 3,834 56.00 05600 RADI OI SOTOPE 0 0 56.00 05601 ONCOLOGY 4,066 0 8, 018 56.01 0 4,066 56.01 57.00 05700 CT SCAN 2.228 0 2, 228 0 0 0 0 0 0 13, 489 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 5, 078 58.00 1, 385 Ω 1, 385 58 00 59.00 05900 CARDIAC CATHETERIZATION 59.00 0 06000 LABORATORY 60.00 2, 142 2, 142 0 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 0 0 0 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 0 0 0 63.00 64.00 06400 I NTRAVENOUS THERAPY 64.00 0 65.00 06500 RESPIRATORY THERAPY 444 444 0 11, 357 65.00 06600 PHYSI CAL THERAPY 9, 286 33, 683 66.00 9.286 66,00 06700 OCCUPATIONAL THERAPY 67.00 226 226 415 67.00 68.00 06800 SPEECH PATHOLOGY 1,587 1, 587 0 0 0 2, 379 68.00 69.00 06900 ELECTROCARDI OLOGY 3, 145 5, 224 69.00 3.145 07000 ELECTROENCEPHALOGRAPHY 70.00 0 0 0 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0 C 0 Ω 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 72.00 0 0 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 73.00 0 0 0 74.00 07400 RENAL DIALYSIS r 0 0 74.00 07500 ASC (NON-DISTINCT PART) 75.00 0 75.00 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 15, 226 42.993 15, 226 0 29.026 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 99.00 09900 CMHC 0 0 0 0 0 99.00

SPECI	AL PURPOSE COST CENTERS						
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	137, 539	186, 573	135, 142	9, 088	278, 603 118. 00	0
NONRE	IMBURSABLE COST CENTERS						
190. 00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0 190. 00	0
191. 00 19100	RESEARCH	0	0	0	0	0 191. 00	0
192. 00 19200	PHYSICIANS' PRIVATE OFFICES	24, 894	0	24, 894	0	0 192. 00	0
193. 00 19300	NONPALD WORKERS	0	0	0	0	0 193. 00	0
194. 00 07950	COMMUNITY EDUCATION	0	0	0	0	0 194. 00	0
194. 01 07951	I MARKETI NG	0	0	0	0	0 194. 0°	1
194. 02 07952	SC MGMT SVH TANDEM CASTLETON	0	0	0	0	0 194. 02	2
194. 03 07953	B SC MGMT SVH TANDEM	0	0	0	0	0 194. 03	3
194. 04 07954	SC MGMT SVH TANDEM AVON	0	0	0	0	0 194. 04	4
194. 05 07955	SC MGMT TANDEM NOBLESVILLE W	0	0	0	0	0 194. 05	5
194. 06 07956	SC MGMT SVH TANDEM PLAINFIELD	0	0	0	0	0 194. 0	6
200. 00	Cross Foot Adjustments					200. 00	0
201. 00	Negative Cost Centers					201. 00	0
202. 00	Cost to be allocated (per Wkst. B,	4, 088, 142	196, 683	948, 527	709, 225	683, 390 202. 00	0
	Part I)						

Health Fina	ncial Systems A	SCENSION ST. VI	NCENT FISHERS		In Lie	u of Form CMS-2	2552-10
COST ALLOCA	ATION - STATISTICAL BASIS		Provi der CO		Peri od:	Worksheet B-1	
					From 07/01/2021 Fo 06/30/2022	Date/Time Pre 11/21/2022 11	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		PLANT	LINEN SERVICE	(SQUARE FEET)	(MEALS SERVED)	(MEALS SERVED)	
		(SQUARE FEET)	(POUNDS OF				
			LAUNDRY)				
		7. 00	8. 00	9. 00	10.00	11. 00	
203. 00	Unit cost multiplier (Wkst. B, Part I)	25. 168174	1. 054188	5. 926960	78. 039723	2. 452917	203. 00
204.00	Cost to be allocated (per Wkst. B,	1, 039, 412	5, 039	118, 75	158, 236	177, 212	204. 00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	6. 399020	0. 027008	0. 74207	1 17. 411532	0. 636074	205. 00
	[11]						
206. 00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						
ļ	Tarts III and IV)	ļ			Ţ		

	•	ASCENSION SI. VI		N 45 0404		eu of Form CMS	
COST A	LLOCATION - STATISTICAL BASIS		Provi der CC		Period: From 07/01/2021	Worksheet B-1	
					To 06/30/2022		
	Coot Conton Decemintion	NUDCLNC	CENTRAL	PHARMACY	MEDICAL	11/21/2022 11	: 32 am
	Cost Center Description	NURSI NG ADMI NI STRATI ON	SERVICES &	(COSTED	MEDI CAL RECORDS &	SOCIAL SERVICE	
		ADMINITOR OF THE COLUMN	SUPPLY	REQUIS.)	LI BRARY	(TOTAL PATIENT	
		(DI RECT NURS.	(COSTED	,	(GROSS	DAYS)	
		HRS.)	REQUIS.)		CHARGES)	ĺ	
		13.00	14.00	15. 00	16.00	17. 00	
	GENERAL SERVICE COST CENTERS	T T			Т	Г	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00 4. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2. 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						9. 00
10.00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A						11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	123, 983	4 (04 4//				13.00
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0 441	4, 694, 466	1 014 01	4		14.00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	441	14, 317 0	4, 846, 81	0 245, 574, 437		15. 00 16. 00
	01700 SOCIAL SERVICE	0	0		0 243, 374, 437	l	ı
.,, 00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	٥١		<u> </u>	1,7200	
30.00	03000 ADULTS & PEDIATRICS	35, 073	183, 809		0 16, 883, 216	3, 075	30.00
31.00	03100 INTENSIVE CARE UNIT	0	o		0	0	31. 00
32.00	03200 CORONARY CARE UNIT	0	0		0	0	32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0		0	0	33. 00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0		0 0	0	34.00
43. 00	04300 NURSERY	0	47, 516		0 5, 185, 724	1, 213	43. 00
50. 00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM	24, 981	913, 044		0 67, 675, 694	0	50.00
51. 00	05100 RECOVERY ROOM	24, 701	713, 044		0 07, 073, 074	0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	36, 525	57, 897		0 14, 883, 051	Ō	52. 00
53.00	05300 ANESTHESI OLOGY	0	o		0 0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	821	151, 676		0 11, 905, 767	0	54. 00
54. 01	03630 ULTRA SOUND	72	3, 735		0 3, 080, 664	0	54. 01
56. 00	05600 RADI OI SOTOPE	0	0		0 0	0	56.00
56. 01 57. 00	05601 ONCOLOGY	0	33, 965		0 3, 375, 347	0	56. 01
58.00	05700 CT SCAN	818 137	35, 188 4, 830		0 7, 149, 426 0 1, 967, 961	0	57. 00 58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	137	4, 030		0 1, 907, 901	0	59.00
60.00	06000 LABORATORY	o	586		0 19, 678, 304	Ō	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	o		0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0	63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0	0		0	0	64. 00
65. 00	06500 RESPIRATORY THERAPY	9	33, 198		0 2, 465, 435	1	65. 00
66. 00 67. 00	06600 PHYSI CAL THERAPY	0	23, 794		0 6, 301, 991	0	66.00
68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	56, 970		0 153, 154 0 847, 352	l	67. 00 68. 00
	06900 ELECTROCARDI OLOGY	143	48, 560		0 6, 726, 659		1
	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	Ö	•
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	689, 558		0 7, 342, 104	0	1
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	2, 244, 498		0 8, 440, 739	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	4, 830, 95	0 19, 283, 177	l	
74. 00	07400 RENAL DI ALYSI S	0	0		0	1	
75.00	07500 ASC (NON-DISTINCT PART)	J O	O ₁		0 0	0	75. 00
01 00	OUTPATIENT SERVICE COST CENTERS 09100 EMERGENCY	24, 963	142, 763		0 42, 228, 672	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	24, 703	142, 703		42, 220, 072	0	92.00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
99. 00	09900 CMHC	0	0		0 0	0	99. 00
	SPECIAL PURPOSE COST CENTERS						
118.00	, ,	123, 983	4, 685, 904	4, 830, 95	0 245, 574, 437	4, 288	118. 00
400.00	NONREI MBURSABLE COST CENTERS		ما				1400 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19100 RESEARCH	0	0		0 0	•	190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES		8, 562	15, 86	-		191. 00 192. 00
	19300 NONPALD WORKERS		0, 302	13, 00	0 0	•	193. 00
	07950 COMMUNITY EDUCATION	0	o		o o		194. 00
	07951 MARKETI NG	0	o		0		194. 01
194. 02	07952 SC MGMT SVH TANDEM CASTLETON	0	O		0 0	0	194. 02
	07953 SC MGMT SVH TANDEM	0	o		0 0		194. 03
	07954 SC MGMT SVH TANDEM AVON	0	0		0		194. 04
	07955 SC MGMT TANDEM NOBLESVILLE W	0	0		0		194. 05
194.06	07956 SC MGMT SVH TANDEM PLAINFIELD Cross Foot Adjustments	0	O		0		194. 06 200. 00
200.00	1 1						201.00
_000	1 19-1. 12 1351 55155	ı	ı		Ţ	ı	, 00

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0181 Period: From 07/01/2021 To 06/30/2022 Date/Time Prepare 11/21/2022 11: 32 Cost Center Description NURSING ADMINISTRATION SERVICES & (COSTED RECORDS & (COSTED RE	
To 06/30/2022 Date/Time Prepare 11/21/2022 11: 32 Cost Center Description NURSING CENTRAL PHARMACY ADMINISTRATION SERVICES & (COSTED RECORDS & COSTED RECORDS	
ADMINISTRATION SERVICES & (COSTED RECORDS &	
SUPPLY REQUIS.) LIBRARY (TOTAL PATIENT)	
(DI RECT NURS. (COSTED (GROSS DAYS)	
HRS.) REQUIS.) CHARGES)	
13.00 14.00 15.00 16.00 17.00	
202.00 Cost to be allocated (per Wkst. B, 1,691,638 176,806 1,190,084 19,093 11,913 202	. 00
Part I)	
203.00 Unit cost multiplier (Wkst. B, Part I) 13.644112 0.037663 0.245539 0.000078 2.778218 203	. 00
204.00 Cost to be allocated (per Wkst. B, 85,928 47,246 115,950 10,489 6,544 204	. 00
Part II)	
205.00 Unit cost multiplier (Wkst. B, Part 0.693063 0.010064 0.023923 0.000043 1.526119 205	. 00
206.00 NAHE adjustment amount to be allocated 206	. 00
(per Wkst. B-2)	
	. 00
Parts III and IV)	

Health Financial Systems	ASCENSION ST. VINCENT FISHERS	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0181	Peri od:	Worksheet C

From 07/01/2021 | Part I 06/30/2022 Date/Time Prepared: 11/21/2022 11:32 am Title XVIII Hospi tal Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs from Wkst. B, Adj Di sal I owance Part I, col. 26) 4. 00 1.00 2.00 3.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 30 00 03000 ADULTS & PEDIATRICS 8, 104, 725 8, 104, 725 8, 104, 725 03100 INTENSIVE CARE UNIT 0 31.00 31.00 03200 CORONARY CARE UNIT 0 0 0 32.00 O 32.00 0 03300 BURN INTENSIVE CARE UNIT 0 33.00 0 33.00 0 34.00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 0 0 34.00 43.00 04300 NURSERY 949, 599 949, 599 949, 599 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATI NG ROOM 50.00 50.00 6, 991, 503 6, 991, 503 0 6, 991, 503 51.00 05100 RECOVERY ROOM 0 0 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 4, 925, 719 4, 925, 719 0 4, 925, 719 52.00 05300 ANESTHESI OLOGY 53.00 53.00 0 2, 469, 489 05400 RADI OLOGY-DI AGNOSTI C 2, 462, 553 2, 462, 553 54.00 6, 936 54.00 54.01 03630 ULTRA SOUND 398, 220 398, 220 398, 220 54.01 05600 RADI OI SOTOPE 56.00 56.00 917, 484 05601 ONCOLOGY 903.263 56 01 903 263 14 221 56 01 57.00 05700 CT SCAN 1, 283, 899 1, 283, 899 1, 283, 899 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 538, 749 538, 749 0 538, 749 58.00 0 05900 CARDIAC CATHETERIZATION 59.00 59.00 0 06000 LABORATORY 3, 311, 014 3, 311, 014 3, 311, 014 60 00 60 00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 63.00 0 06400 INTRAVENOUS THERAPY 64 00 64 00 0 0 06500 RESPIRATORY THERAPY 65.00 1, 166, 634 1, 166, 634 1, 166, 634 65.00 66.00 06600 PHYSI CAL THERAPY 2, 912, 413 2, 912, 413 2, 912, 413 66.00 06700 OCCUPATIONAL THERAPY 67.00 54,095 54, 095 0 54, 095 67.00 68 00 06800 SPEECH PATHOLOGY 366, 834 366, 834 366, 834 68 00 69.00 06900 ELECTROCARDI OLOGY 696, 480 696, 480 696, 480 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 70.00 0 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 986, 892 986, 892 986, 892 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 3, 104, 920 3, 104, 920 3, 104, 920 72 00 72.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 7, 708, 548 7, 708, 548 7, 708, 548 73.00 07400 RENAL DIALYSIS 74.00 0 74.00 07500 ASC (NON-DISTINCT PART)
OUTPATIENT SERVICE COST CENTERS 75.00 0 75.00 0 91.00 09100 EMERGENCY 5, 653, 018 5, 653, 018 0 5, 653, 018 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1,809,689 1, 809, 689 1, 809, 689 92.00 OTHER REIMBURSABLE COST CENTERS 99 00 09900 CMHC Λ 99 00 200.00 Subtotal (see instructions) 54, 328, 767 54, 328, 767 21, 157 54, 349, 924 200. 00 201.00 Less Observation Beds 1, 809, 689 1, 809, 689 1, 809, 689 201. 00 52, 540, 235 202. 00 202.00 Total (see instructions) 52, 519, 078 52, 519, 078 21, 157

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0181 Peri od: Worksheet C From 07/01/2021 Part I Date/Time Prepared: 06/30/2022 11/21/2022 11:32 am Title XVIII Hospi tal PPS Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other TFFRA + col . 7) Ratio Inpati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 13, 319, 702 13, 319, 702 30.00 30.00 03000 ADULTS & PEDIATRICS 31.00 03100 INTENSIVE CARE UNIT 31.00 C 03200 CORONARY CARE UNIT 0 0 32.00 32.00 33.00 03300 BURN INTENSIVE CARE UNIT 0 0 33.00 03400 SURGICAL INTENSIVE CARE UNIT 34.00 0 0 34 00 43.00 04300 NURSERY 5, 185, 724 5, 185, 724 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.103309 0.000000 50.00 13, 922, 387 53, 753, 307 67, 675, 694 05100 RECOVERY ROOM 51.00 0.000000 0.000000 51.00 14, 883, 051 52.00 05200 DELIVERY ROOM & LABOR ROOM 14, 640, 311 242, 740 0.330962 0.000000 52.00 53.00 05300 ANESTHESI OLOGY 0.000000 0.000000 53.00 05400 RADI OLOGY-DI AGNOSTI C 11, 515, 927 11, 905, 767 0.206837 54.00 389.840 0.000000 54.00 54.01 03630 ULTRA SOUND 96,822 2, 983, 842 3, 080, 664 0.129264 0.000000 54.01 05600 RADI OI SOTOPE 0.000000 0.000000 56.00 56.00 05601 ONCOLOGY 20, 813 3, 354, 534 3, 375, 347 0.267606 0.000000 56.01 56.01 05700 CT SCAN 7, 149, 426 0.179581 57 00 534.539 6, 614, 887 0.000000 57 00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 57,658 1, 910, 303 1, 967, 961 0. 273760 0.000000 58.00 05900 CARDIAC CATHETERIZATION 0.000000 59.00 0.000000 59.00 06000 LABORATORY 5, 914, 448 13, 763, 856 19, 678, 304 60.00 0.168257 0.000000 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0.000000 0.000000 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0.000000 0.000000 63.00 64.00 06400 INTRAVENOUS THERAPY 0.000000 0.000000 64.00 06500 RESPIRATORY THERAPY 702.157 1, 763, 278 2 465 435 0 473196 0 000000 65 00 65 00 66.00 06600 PHYSI CAL THERAPY 356, 495 5, 945, 496 6, 301, 991 0.462142 0.000000 66.00 06700 OCCUPATIONAL THERAPY 89, 576 63, 578 153, 154 0.353207 0.000000 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 8, 389 838, 963 847, 352 0.432918 0.000000 68.00 06900 FLECTROCARDI OLOGY 69.00 438, 330 6, 288, 329 6, 726, 659 0.103540 0.000000 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0.000000 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 2, 923, 243 4, 418, 861 7, 342, 104 0.134415 0.000000 71.00 72 00 07200 IMPL. DEV. CHARGED TO PATIENTS 1 309 441 7, 131, 298 8, 440, 739 0.367849 0.000000 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 3, 940, 114 15, 343, 063 19, 283, 177 0.399755 0.000000 73.00 07400 RENAL DIALYSIS 0.000000 0.000000 74.00 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0.000000 0.000000 75.00 OUTPATIENT SERVICE COST CENTERS 38, 923, 075 91.00 09100 EMERGENCY 3, 305, 597 42, 228, 672 0.133867 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 2, 929, 510 0.507838 0.000000 92.00 634,004 3, 563, 514 92.00 OTHER REIMBURSABLE COST CENTERS 99. 00 99.00 1099001 CMHC 200.00 Subtotal (see instructions) 67, 789, 590 177, 784, 847 245, 574, 437 200.00 201.00 Less Observation Beds 201.00

67, 789, 590

177, 784, 847

245, 574, 437

202.00

Total (see instructions)

Health Financial Systems	ASCENSION ST. VINC	ENT FISHERS	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0181	From 07/01/2021	Worksheet C Part I Date/Time Prepared:

					11/21/2022 11	1:32 am
			Title XVIII	Hospi tal	PPS	
	Cost Center Description	PPS Inpatient	·			
		Ratio				
		11.00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS					30.00
31.00	03100 INTENSIVE CARE UNIT					31.00
32.00	03200 CORONARY CARE UNIT					32. 00
33.00	03300 BURN INTENSIVE CARE UNIT					33. 00
34.00	03400 SURGICAL INTENSIVE CARE UNIT					34. 00
43.00	04300 NURSERY					43.00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0. 103309				50. 00
51.00	05100 RECOVERY ROOM	0. 000000				51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 330962				52.00
53.00	05300 ANESTHESI OLOGY	0. 000000				53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 207420				54.00
54. 01	03630 ULTRA SOUND	0. 129264				54. 01
56.00	05600 RADI 0I SOTOPE	0. 000000				56.00
56. 01	05601 ONCOLOGY	0. 271819				56. 01
57.00	05700 CT SCAN	0. 179581				57.00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 273760				58. 00
	05900 CARDI AC CATHETERI ZATI ON	0. 000000				59.00
	06000 LABORATORY	0. 168257				60.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000				62.00
	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000				63.00
	06400 I NTRAVENOUS THERAPY	0. 000000				64.00
	06500 RESPI RATORY THERAPY	0. 473196				65.00
	06600 PHYSI CAL THERAPY	0. 462142				66.00
	06700 OCCUPATI ONAL THERAPY	0. 353207				67. 00
	06800 SPEECH PATHOLOGY	0. 432918				68. 00
	06900 ELECTROCARDI OLOGY	0. 103540				69.00
	07000 ELECTROENCEPHALOGRAPHY	0. 000000				70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 134415				71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 367849				72. 00
	07300 DRUGS CHARGED TO PATIENTS	0. 399755				73. 00
	07400 RENAL DIALYSIS	0. 000000				74. 00
	07500 ASC (NON-DISTINCT PART)	0. 000000				75. 00
	OUTPATIENT SERVICE COST CENTERS	0.00000				10.00
	09100 EMERGENCY	0. 133867				91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 507838				92. 00
	OTHER REIMBURSABLE COST CENTERS	0.007000				72.00
	09900 CMHC					99. 00
200.00						200. 00
201.00	Less Observation Beds					201. 00
202.00	l control of the cont					202. 00
_02.00	1.222. (333 1.134 434 313)	1				1-02.00

Health Financial Systems	ASCENSION ST. VINCENT FISHERS	In Lie	In Lieu of Form CMS-2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0181	Peri od:	Worksheet C		

From 07/01/2021 | Part I 06/30/2022 Date/Time Prepared: 11/21/2022 11:32 am Title XIX Hospi tal Cost Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs from Wkst. B, Adj Di sal I owance Part I, col. 26) 2.00 4. 00 1.00 3.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 30 00 03000 ADULTS & PEDIATRICS 8, 104, 725 8, 104, 725 8, 104, 725 03100 INTENSIVE CARE UNIT 0 31.00 31.00 03200 CORONARY CARE UNIT 0 0 0 32.00 O 32.00 0 03300 BURN INTENSIVE CARE UNIT 0 0 33.00 33.00 0 34.00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 0 0 34.00 43.00 04300 NURSERY 949, 599 949, 599 949, 599 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATI NG ROOM 50.00 50.00 6, 991, 503 6, 991, 503 0 6, 991, 503 51.00 05100 RECOVERY ROOM 0 0 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 4, 925, 719 4, 925, 719 0 4, 925, 719 52.00 05300 ANESTHESI OLOGY 53.00 53.00 0 2, 469, 489 05400 RADI OLOGY-DI AGNOSTI C 2, 462, 553 2, 462, 553 54.00 6, 936 54.00 54.01 03630 ULTRA SOUND 398, 220 398, 220 398, 220 54.01 05600 RADI OI SOTOPE 56.00 56.00 917, 484 05601 ONCOLOGY 903.263 56 01 903 263 14 221 56 01 57.00 05700 CT SCAN 1, 283, 899 1, 283, 899 1, 283, 899 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 538, 749 538, 749 0 538, 749 58.00 0 05900 CARDIAC CATHETERIZATION 59.00 59.00 0 06000 LABORATORY 3, 311, 014 3, 311, 014 3, 311, 014 60 00 60 00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 63.00 0 06400 INTRAVENOUS THERAPY 64 00 64 00 0 0 06500 RESPIRATORY THERAPY 65.00 1, 166, 634 1, 166, 634 1, 166, 634 65.00 66.00 06600 PHYSI CAL THERAPY 2, 912, 413 2, 912, 413 2, 912, 413 66.00 06700 OCCUPATIONAL THERAPY 67.00 54,095 54, 095 0 54, 095 67.00 68 00 06800 SPEECH PATHOLOGY 366, 834 366, 834 366, 834 68 00 69.00 06900 ELECTROCARDI OLOGY 696, 480 696, 480 696, 480 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 70.00 0 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 986, 892 986, 892 986, 892 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 3, 104, 920 3, 104, 920 3, 104, 920 72 00 72.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 7, 708, 548 7, 708, 548 7, 708, 548 73.00 07400 RENAL DIALYSIS 74.00 0 74.00 07500 ASC (NON-DISTINCT PART)
OUTPATIENT SERVICE COST CENTERS 75.00 0 75.00 0 91.00 09100 EMERGENCY 5, 653, 018 5, 653, 018 0 5, 653, 018 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1,809,689 1, 809, 689 1, 809, 689 92.00 OTHER REIMBURSABLE COST CENTERS 99 00 09900 CMHC Λ 99 00 200.00 Subtotal (see instructions) 54, 328, 767 54, 328, 767 21, 157 54, 349, 924 200. 00 201.00 Less Observation Beds 1, 809, 689 1, 809, 689 1, 809, 689 201. 00 52, 540, 235 202. 00 202.00 Total (see instructions) 52, 519, 078 52, 519, 078 21, 157

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provi der Co		Period: From 07/01/2021 To 06/30/2022	Worksheet C Part I Date/Time Pre 11/21/2022 11	pared:
				e XIX	Hospi tal	Cost	
			Charges				
	Cost Center Description	I npati ent	Outpati ent		Cost or Other	TEFRA	
				+ col. 7)	Ratio	Inpati ent	
		(00	7. 00	0.00	9. 00	Ratio	
	INPATIENT ROUTINE SERVICE COST CENTERS	6. 00	7.00	8. 00	9.00	10. 00	
30. 00	03000 ADULTS & PEDIATRICS	13, 319, 702		13, 319, 70	2		30. 00
31. 00	03100 NTENSI VE CARE UNI T	13, 317, 702		13, 317, 70	0		31. 00
32. 00	03200 CORONARY CARE UNIT				0		32.00
33. 00	03300 BURN INTENSIVE CARE UNIT				0		33. 00
34. 00	03400 SURGI CAL INTENSI VE CARE UNI T				0		34. 00
43. 00	04300 NURSERY	5, 185, 724		5, 185, 72	4		43. 00
10.00	ANCILLARY SERVICE COST CENTERS	0, 100, 72 1		0, 100, 72	- 1		10.00
50. 00	05000 OPERATI NG ROOM	13, 922, 387	53, 753, 307	67, 675, 69	4 0. 103309	0. 000000	50.00
51. 00	05100 RECOVERY ROOM	0	0	1 .,,	0.000000	0. 000000	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	14, 640, 311	242, 740	14, 883, 05		0. 000000	
53. 00	05300 ANESTHESI OLOGY	0	0	.,	0. 000000	0. 000000	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	389, 840	11, 515, 927	11, 905, 76		0. 000000	
54. 01	03630 ULTRA SOUND	96, 822	2, 983, 842			0.000000	54. 01
56.00	05600 RADI OI SOTOPE	O	0		0.000000	0.000000	56. 00
56. 01	05601 ONCOLOGY	20, 813	3, 354, 534	3, 375, 34	7 0. 267606	0.000000	56. 01
57.00	05700 CT SCAN	534, 539	6, 614, 887	7, 149, 42	6 0. 179581	0. 000000	57.00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	57, 658	1, 910, 303	1, 967, 96	1 0. 273760	0. 000000	
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0. 000000	0. 000000	59. 00
60.00	06000 LABORATORY	5, 914, 448	13, 763, 856	19, 678, 30	4 0. 168257	0. 000000	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0. 000000	0.000000	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0. 000000	0. 000000	63. 00
64.00	06400 I NTRAVENOUS THERAPY	0	0		0. 000000	0. 000000	64. 00
65. 00	06500 RESPI RATORY THERAPY	702, 157	1, 763, 278			0. 000000	
66. 00	06600 PHYSI CAL THERAPY	356, 495	5, 945, 496			0.000000	
67. 00	06700 OCCUPATI ONAL THERAPY	89, 576	63, 578			0. 000000	
68. 00	06800 SPEECH PATHOLOGY	8, 389	838, 963	847, 35	2 0. 432918	0. 000000	
69. 00	06900 ELECTROCARDI OLOGY	438, 330	6, 288, 329			0. 000000	
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0		0. 000000	0. 000000	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 923, 243	4, 418, 861	7, 342, 10		0. 000000	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	1, 309, 441	7, 131, 298			0. 000000	
73.00	07300 DRUGS CHARGED TO PATIENTS	3, 940, 114	15, 343, 063			0. 000000	
74. 00	07400 RENAL DIALYSIS	0	0		0. 000000	0. 000000	
75. 00	07500 ASC (NON-DISTINCT PART)	0	0		0. 000000	0. 000000	75. 00
	OUTPATIENT SERVICE COST CENTERS						
91. 00	09100 EMERGENCY	3, 305, 597	38, 923, 075			0. 000000	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	634, 004	2, 929, 510	3, 563, 51	4 0. 507838	0. 000000	92.00
00.6-	OTHER REIMBURSABLE COST CENTERS		_		al		
	09900 CMHC	0	0	0.45 57,	U		99. 00
200.00	,	67, 789, 590	177, 784, 847	245, 574, 43	/		200. 00
201.00	l l	(7 700 500	177 704 047	045 574 40	7		201. 00
202.00	Total (see instructions)	67, 789, 590	177, 784, 847	245, 574, 43	/		202. 00

Health Financial Systems	ASCENSION ST. VINCE	NT FISHERS	u of Form CMS-2552-10	
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0181	From 07/01/2021	Worksheet C Part I Date/Time Prepared:

INPATIENT ROUTINE SERVICE COST CENTERS 11.00					10 00/30/2022	11/21/2022 11: 32 am
INPATIENT ROUTINE SERVICE COST CENTERS 11.00				Title XIX	Hospi tal	
INPATI ENT. ROUTINE. SERVICE COST CENTERS 30.00 330000 ADULTS & PEDI ATRIC S 30.00 31.00 330000 ADULTS & PEDI ATRIC S 33.00 33		Cost Center Description	PPS Inpatient			
INPATI ENT ROUTINE SERVICE COST CENTERS 30.00 31.00 03100 ADULTS & PEDI ATRIC S 31.00 31.00 31.00 03100 INTENSI VE CARE UNIT 32.00 33.00 33.00 33.00 BURNI INTENSI VE CARE UNIT 33.00 33.00 33.00 BURNI INTENSI VE CARE UNIT 33.40 33.00 33.00 BURNI INTENSI VE CARE UNIT 33.40 33.00 33.00 BURNI INTENSI VE CARE UNIT 33.40 33.00 33.00 33.00 BURNI INTENSI VE CARE UNIT 33.40 33.00 33		'				
30.00 03000 ADULTS & PEDI ATRIC S 31.00 31.00 310.00 INTENSI VE CARE UNIT 32.00 32.00 03200 CORONARY CARE UNIT 32.00 33.00 03300 04300 03300 04300 03300 04300 03300 04300 03300 04300 03300 04300 03300 04300 03300 04300 03300 04300 03300 04300 03300 04300 03300 04300 03300 04300 03300 04300 03300 04300 03300 03300 04300 03300			11.00			
31 00 03100 INTENSI VE CARE UNIT 32 00 23 00 2300 CORDINARY CARE UNIT 32 00 33 00 23 00		INPATIENT ROUTINE SERVICE COST CENTERS				
32.00 03200 CORDNARY CARE UNIT	30. 00	03000 ADULTS & PEDIATRICS				30.00
32.00 03200 CORDNARY CARE UNIT	31. 00	03100 INTENSIVE CARE UNIT				31.00
33. 00 03300 BURN INTENSIVE CARE UNIT 33. 00 43.00 04300 SURGICAL INTENSIVE CARE UNIT 34.00 43.00 04300 NURSERY 34.00 43.00 04300 NURSERY 34.00 43.0						l l
34. 00 03400 SURGI CAL INTENSIVE CARE UNIT						
43. 00						
ANCILLARY SERVICE COST CENTERS						l l
SO.00 OSOOO OSOOO OSOOO OSOOOO OSOOOO OSOOOO OSOOO OSOOOO OSOOOO OSOOO OSOOO OSOOOO OSOOOO OSOOO OSOOO OSOOO OSOOOO OSOOOOO OSOOOO OSOOOOO OSOOOO OSOOOO OSOOOO OSOOOO OSOOOO OSOOOO OSOOOOO OSOOOOOO OSOOOOOO OSOOOOO OSOOOOOO OSOOOOOO OSOOOOOO OSOOOOOO OSOOOOOO OSOOOOOO OSOOOOOO OSOOOOOO OSOOOOOO OSOOOOOOO OSOOOOOO OSOOOOOOO OSOOOOOOO OSOOOOOO OSOOOOOOOO						10.00
51.00 05200 05200 DELIVERY ROOM & LABOR ROOM 0.000000 05200 05200 DELIVERY ROOM & LABOR ROOM 0.0000000 0.0000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000			0.000000			50.00
S2.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 53.00 05300 05300 05400 RADI OLOGY-DI AGNOSTI C 0.000000 54.01 03630 ULTRA SOUND 0.000000 54.01 03630 ULTRA SOUND 0.000000 54.01 05601 05000 RADI OLOGY-DI AGNOSTI C 0.000000 54.01 05601 05000 RADI OLOGY-DI AGNOSTI C 0.000000 54.01 05601 05000 CARDI OLOGY-DI AGNOSTI C 0.000000 56.01 05601 0NCOLOGY 0.000000 56.01 05601 0NCOLOGY 0.000000 55.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0.000000 57.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0.000000 59.00 05900 CARDI AC CATHETERI ZATI ON 0.000000 59.00 05900 CARDI AC CATHETERI ZATI ON 0.000000 59.00 05900 CARDI AC CATHETERI ZATI ON 0.000000 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.000000 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.000000 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.000000 063.00 06400 NORWANDUS THERAPY 0.000000 063.00 06500 RESPI RATORY THERAPY 0.000000 06500 06500 RESPI RATORY THERAPY 0.000000 06500 06600 PHYSI CAL THERAPY 0.000000 06500 06600 PHYSI CAL THERAPY 0.000000 06700 0CCUPATI ONAL THERAPY 0.000000 06700 0CCUPATI ONAL THERAPY 0.000000 068.00 06900 06900 06900 ELECTROCRADI OLOGY 0.000000 071.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 07100 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 07200 IMPL. DEV. CHARGED TO PATI ENTS			1			
53.00 05300 ANESTHESI OLOGY 0.000000 53.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 54.00 05600 RADI OLOGY-DI AGNOSTI C 0.000000 55.00 05600 RADI OLOGY 0.000000 55.00 05601 0NCOLOGY 0.000000 55.00 05700 0T SCAN 0.000000 55.00 05700 0T SCAN 0.000000 55.00 05700 0T SCAN 0.000000 55.00 05900 CARDIA C CATHETERI ZATI ON 0.000000 59.00 05900 CARDIA C CATHETERI ZATI ON 0.000000 05900 0ARDIA C CATHETERI ZATI ON 0.000000 05900 0ARDIA C CATHETERI ZATI ON 0.000000 0.000000 0.00000 0.0000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000			1			
54. 00 036400 RADI OLOGY—DI AGNOSTI C 0.000000 54. 01 54. 01 03630 ULTRA SOUND 0.000000 55. 01 55. 01 05601 00COLOGY 0.000000 55. 01 55. 01 05501 00COLOGY 0.000000 55. 01 57. 00 05700 CT SCAN 0.000000 57. 00 58. 00 05800 MAGNETI C RESONANCE MAGI NG (MRI) 0.000000 58. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0.000000 59. 00 60. 00 06000 LABORATORY 0.000000 62. 00 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.000000 63. 00 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0.000000 64. 00 64. 00 06400 INTRAVENOUS THERAPY 0.000000 64. 00 65. 00 06500 RESPI RATORY THERAPY 0.000000 65. 00 66. 00 06600 OCCUPATI ONAL THERAPY 0.000000 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0.000000 68. 00 68. 00 06900 ELECTROCARDI OLOGY 0.000000 69. 00 69. 00 06900 ELECTROCARDI OLOGY 0.000000 70. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 0.000000 71. 00 71. 00 07000 RUIS CHARGED TO PATI ENTS 0.000000 71. 00 71. 00 07000 RUIS CHARGED TO PATI ENTS 0.000000 73. 00 75. 00 07500 ASC (NON-DISTINCT PART) 0.000000 75. 00 75. 00 07500 ASC (NON-DISTINCT PART) 0.000000 75. 00 75. 00 07500 ASC (NON-DISTINCT PART) 0.000000 75. 00 75. 00 07500 ASC (NON-DISTINCT PART) 0.000000 75. 00 75. 00 07500 ASC (NON-DISTINCT PART) 0.000000 75. 00 75. 00 07500 ASC (NON-DISTINCT PART) 0.000000 75. 00 75. 00 07500 ASC (NON-DISTINCT PART) 0.000000 0.000000 0.00000 0.000000 0.000000 0.000000 0.000000 0.00000000			1			
54. 01 03630 ULTRA SOUND 0.000000 54. 01 56. 00 05600 RADI OISTOPE 0.000000 55. 00 57. 00 05700 CT SCAN 0.000000 57. 00 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0.000000 57. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0.000000 59. 00 60. 00 06000 LABORATORY 0.000000 60. 00 62. 00 06200 WHOLE BLODD & PACKED RED BLOOD CELLS 0.000000 62. 00 63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 63. 00 64. 00 06400 INTRAVENOUS THERAPY 0.000000 63. 00 65. 00 06500 RESPI RATORY THERAPY 0.000000 65. 00 66. 00 06600 PHYSI CAL THERAPY 0.000000 65. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0.000000 67. 00 68. 00 06800 SEECH PATHOLOGY 0.000000 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0.000000 69. 00 70. 00 07000 ELECTROCARDI OLOGY 0.000000 71. 00 71. 00 07100 MEDI CAL SUPPLIES CHA			1			
56. 00		l e e e e e e e e e e e e e e e e e e e	1			
56. 01 05601 0NCOLOGY 0.000000 55. 00 57. 00 5700 CT SCAN 0.000000 57. 00 59. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0.000000 59. 00 05900 CARDI AC CATHETERI ZATI ON 0.000000 59. 00 60.						
57. 00						l l
58.00 05800 MAGNETI C RESONANCE I MAGING (MRI) 0.000000 0.000000 0.59.00 0.5900 0.5900 0.5900 0.5900 0.5900 0.000000 0.000000 0.00000 0.0000000 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000						· · · · · · · · · · · · · · · · · · ·
59. 00 05900 CARDI AC CATHETERI ZATI ON 0.000000 59. 00 60. 00 06000 LABORATORY 0.000000 60. 00 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.000000 62. 00 63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 63. 00 64. 00 06400 INTRAVENOUS THERAPY 0.000000 64. 00 65. 00 06500 RESPI RATORY THERAPY 0.000000 66. 00 66. 00 06600 06600 PHYSI CAL THERAPY 0.000000 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0.000000 67. 00 68. 00 06800 SPECH PATHOLOGY 0.000000 67. 00 69. 00 06900 ELECTROCARDI OLOGY 0.000000 68. 00 69. 00 07000 ELECTROCARDI OLOGY 0.000000 69. 00 71. 00 07000 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 70. 00 72. 00 07200 IMPL DEV. CHARGED TO PATI ENTS 0.000000 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 73. 00 74. 00 07400 RENAL DI LALYSI S 0.000000 73. 00 75. 00 07500 ASC (NON-DI STI NCT PART) 0.000000 92. 00						
60. 00 06000 LABORATORY 0. 000000 60. 00			1			
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.000000 63.00 63.00 63.00 63.00 63.00 63.00 64.00 65.00 64.00 65.00 65.00 66.						· · · · · · · · · · · · · · · · · · ·
63. 00						
64. 00		l				
65. 00			1			· · · · · · · · · · · · · · · · · · ·
66. 00		l control of the cont				
67. 00						65. 00
68. 00	66. 00	06600 PHYSI CAL THERAPY	0. 000000			66. 00
69. 00 06900 06900 06900 0700000 0700000 0700000 0700000 0700000 0700000 07000000 07000000 07000000 07000000 07000000 07000000 070000000 07000000 070000000 070000000 070000000 070000000 070000000 0700000000	67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000			67.00
70. 00 07000 ELECTROENCEPHALOGRAPHY 0. 000000 70. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 72. 00 72. 00 72. 00 72. 00 73. 00 73. 00 73. 00 73. 00 74. 00 74. 00 74. 00 75.	68. 00	06800 SPEECH PATHOLOGY	0. 000000			68. 00
71. 00	69. 00	06900 ELECTROCARDI OLOGY	0. 000000			69. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 73. 00 73. 00 73. 00 73. 00 74. 00 74. 00 74. 00 74. 00 75. 00 75. 00 07500 ASC (NON-DISTINCT PART) 0.000000 75. 00 000000 000000 000000 000000 000000	70. 00	07000 ELECTROENCEPHALOGRAPHY	0. 000000			70.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0.000000 73. 00 74. 00 74. 00 75. 00 07500 ASC (NON-DISTINCT PART) 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000	71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71.00
74. 00	72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72. 00
75. 00 07500 ASC (NON-DISTINCT PART) 0. 000000 75. 00 OUTPATIENT SERVICE COST CENTERS 91. 00 09100 EMERGENCY 0. 000000 91. 00 OTHER REIMBURSABLE COST CENTERS 99. 00 09900 CMHC 99. 00 Subtotal (see instructions) 200. 00 Less Observation Beds 201. 00	73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 000000			73. 00
OUTPATIENT SERVICE COST CENTERS O. 000000 91.00	74. 00	07400 RENAL DIALYSIS	0. 000000			74.00
OUTPATIENT SERVICE COST CENTERS O. 000000 91.00	75. 00	07500 ASC (NON-DISTINCT PART)	0. 000000			75. 00
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 0.0000000 92. 00 0THER REIMBURSABLE COST CENTERS 99. 00 200. 00 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds 201. 00		OUTPATIENT SERVICE COST CENTERS	<u> </u>			
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 0.0000000 92. 00 0THER REIMBURSABLE COST CENTERS 99. 00 200. 00 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds 201. 00	91. 00	09100 EMERGENCY	0, 000000			91.00
OTHER REIMBURSABLE COST CENTERS 99.00 09900 CMHC 99.00 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00						l l
99. 00						72.00
200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00						99.00
201.00 Less Observation Beds 201.00						
						l l

Health Financial Systems A	SCENSION ST. V	INCENT FISHERS		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider Co		Period: From 07/01/2021 To 06/30/2022		pared: :32 am
		Title	: XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	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, 647, 232	0	1, 647, 23	2 3, 959	416. 07	30. 00
31.00 INTENSIVE CARE UNIT	0			0 0	0.00	31. 00
32. 00 CORONARY CARE UNIT	0			0 0	0.00	32. 00
33.00 BURN INTENSIVE CARE UNIT	0			0 0	0.00	33. 00
34.00 SURGICAL INTENSIVE CARE UNIT	0			0 0	0.00	34.00
43. 00 NURSERY	165, 558		165, 55	8 1, 213	136. 49	43.00
200.00 Total (lines 30 through 199)	1, 812, 790		1, 812, 79	0 5, 172		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	771	320, 790				30. 00
31.00 INTENSIVE CARE UNIT	0	0				31. 00
32. 00 CORONARY CARE UNIT	0	0				32. 00
33.00 BURN INTENSIVE CARE UNIT	0	0				33. 00
34.00 SURGICAL INTENSIVE CARE UNIT	0	0				34.00
43. 00 NURSERY	0	0				43. 00
200.00 Total (lines 30 through 199)	771	320, 790				200. 00

Health Financial Systems	ASCENSION ST. VINC	ENT FISHERS	In Lieu	ı of Form CMS-2552-10
APPORTIONMENT OF INPATIENT ANCILLARY	SERVICE CAPITAL COSTS	Provider CCN: 15-0181		Worksheet D
			From 07/01/2021	Part II

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS			Provider CCN: 15-0181			pared: :32 am
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,	Part I, 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			1			
50. 00 05000 OPERATI NG ROOM	1, 066, 726	67, 675, 694				50.00
51.00 05100 RECOVERY ROOM	0	0	0.00000		0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	877, 294	14, 883, 051			0	52. 00
53. 00 05300 ANESTHESI OLOGY	0	0	0.00000		0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	470, 118		1			54. 00
54. 01 03630 ULTRA SOUND	48, 931	3, 080, 664			0	54. 01
56. 00 05600 RADI OI SOTOPE	0	0	0. 00000		0	56. 00
56. 01 05601 0NCOLOGY	192, 230		1		0	56. 01
57. 00 05700 CT SCAN	133, 633					57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	73, 489	1, 967, 961			1	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0. 00000		0	59. 00
60. 00 06000 LABORATORY	171, 315	19, 678, 304			12, 521	60. 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0. 00000		0	62. 00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0. 00000		0	63. 00
64.00 06400 I NTRAVENOUS THERAPY	0	0	0.00000		0	64. 00
65. 00 06500 RESPI RATORY THERAPY	57, 730		1			65. 00
66. 00 06600 PHYSI CAL THERAPY	471, 806	6, 301, 991			9, 378	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	10, 772	153, 154				67. 00
68. 00 06800 SPEECH PATHOLOGY	75, 254	847, 352	1			68. 00
69. 00 06900 ELECTROCARDI OLOGY	148, 475	6, 726, 659			6, 031	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0. 00000		0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	31, 861	7, 342, 104				71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	100, 320	8, 440, 739	0. 01188	85 810, 332	9, 631	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	283, 475	19, 283, 177			11, 531	
74.00 07400 RENAL DIALYSIS	0	0	0.00000	0 0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0.00000	0 0	0	75. 00
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	791, 643					
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	367, 807	3, 563, 514	0. 10321	5 178, 161		
200.00 Total (lines 50 through 199)	5, 372, 879	227, 069, 011		9, 788, 606	171, 888	200. 00

Health Financial Systems APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASCENSION ST. V ASS THROUGH COS			In Lie Period: From 07/01/2021 To 06/30/2022	worksheet D Part III Date/Time Pre	epared:
		Ti tl e	XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng Program Post-Stepdown	Nursi ng Program	Allied Health Post-Stepdown Adjustments	Allied Health	All Other Medical Education Cost	
	Adjustments					
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1	1			1	
30. 00 03000 ADULTS & PEDI ATRI CS	0			0		
31. 00 03100 I NTENSI VE CARE UNI T	0	0	•	0		1
32. 00 03200 CORONARY CARE UNIT	0	0)	0	0	
33.00 03300 BURN INTENSIVE CARE UNIT	0	0)	0 0	0	
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	0)	0	0	
43. 00 04300 NURSERY	0	0)	0	0	
200.00 Total (lines 30 through 199)	0	0)	0 0		200. 00
Cost Center Description	Swi ng-Bed	Total Costs		Per Diem (col.	Inpati ent	
	Adjustment	(sum of cols.	Days	5 ÷ col . 6)	Program Days	
	Amount (see	1 through 3,				
		minus col. 4)		7.00		
INDATION DOUTING CEDALCE COCT CENTEDS	4. 00	5. 00	6. 00	7. 00	8. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	1 0	1 0	3, 95	0 00	771	20.00
	0	0	1			30. 00 31. 00
			1	0.00		
32. 00 03200 CORONARY CARE UNIT			1	0.00		0 = 1 = 0
33. 00 03300 BURN INTENSIVE CARE UNIT			1	0.00		
34. 00 03400 SURGICAL INTENSIVE CARE UNIT			1	0.00		
43. 00 04300 NURSERY		0	1 ., = .			
200.00 Total (lines 30 through 199)		0	5, 17	2	//1	200. 00
Cost Center Description	I npati ent					
	Program					
	Pass-Through Cost (col. 7 x					
	,					
	col. 8) 9.00					
INPATIENT ROUTINE SERVICE COST CENTERS	9.00					
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
31. 00 03100 NTENSI VE CARE UNI T		ł .				31.00
•	0					
32. 00 03200 CORONARY CARE UNIT	_					32.00
33. 00 03300 BURN INTENSIVE CARE UNIT	0					33.00
34. 00 03400 SURGI CAL INTENSI VE CARE UNI T	0					34.00
43. 00 04300 NURSERY	0					43. 00
200.00 Total (lines 30 through 199)	0	1				200. 00

Health Financial Systems	ASCENSION ST. VINC	u of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0181		Worksheet D
THROUGH COSTS			From 07/01/2021	

111100011 00010			-	To 06/30/2022	Date/Time Pre 11/21/2022 11	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician Anesthetist	Nursi ng Program	Nursi ng Program	Post-Stepdown	Allied Health	
	Cost	Post-Stepdown Adjustments		Adjustments		
	1.00	2A	2.00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0		0	0	50.00
51.00 05100 RECOVERY ROOM	0	0		0	0	51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	52. 00
53. 00 05300 ANESTHESI OLOGY	0	0)	0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0)	0	0	54. 00
54.01 03630 ULTRA SOUND	0	0)	0	0	54. 01
56. 00 05600 RADI 0I SOTOPE	0	0)	0	0	56. 00
56. 01 05601 0NC0L0GY	0	0)	0	0	56. 01
57.00 05700 CT SCAN	0	0)	0	0	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0)	0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0)	0	0	59. 00
60. 00 06000 LABORATORY	0	0)	0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0)	0	0	62. 00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0	63. 00
64. 00 06400 I NTRAVENOUS THERAPY	0	0		0	0	64. 00
65. 00 06500 RESPIRATORY THERAPY	0	0		0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0)	0	0	66. 00
67. 00 06700 OCCUPATI 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	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73. 00
74.00 07400 RENAL DIALYSIS	0	0		0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0		0	0	75. 00
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	0	0)	0	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92. 00
200.00 Total (lines 50 through 199)	0	0)	0 0	0	200. 00

Heal th Financial	Systems		ASCENSION ST. VI	NCENT FISHERS		In Lieu of Form CMS-2552-10		
APPORTI ONMENT OF	I NPATI ENT/OUTPATI ENT	ANCI LLARY SE	RVICE OTHER PASS	Provider Co		Peri od:	Worksheet D	
THROUGH COSTS						From 07/01/2021		
						To 06/30/2022	Date/Time Pre	
							11/21/2022 11	:32 am_
				Title	XVIII	Hospi tal	PPS	
Cost	Center Description		All Other	Total Cost	Total	Total Charges	Ratio of Cost	
			Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
			Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	

		Title	XVIII	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
	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	
					instructions)	
	4.00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0	67, 675, 694	0.000000	
51.00 05100 RECOVERY ROOM	0	0	0	0	0.000000	51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	14, 883, 051	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	0	0	11, 905, 767	0.000000	54.00
54. 01 03630 ULTRA SOUND	0	0	0	3, 080, 664	0.000000	54. 01
56. 00 05600 RADI 0I SOTOPE	0	0	0	0	0.000000	56. 00
56. 01 05601 0NC0L0GY	0	0	0	3, 375, 347	0.000000	56. 01
57. 00 05700 CT SCAN	0	0	0	7, 149, 426	0.000000	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	1, 967, 961	0.000000	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0. 000000	59. 00
60. 00 06000 LABORATORY	0	0	0	19, 678, 304	0. 000000	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0. 000000	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0. 000000	63. 00
64. 00 06400 I NTRAVENOUS THERAPY	0	0	0	0	0. 000000	64.00
65. 00 06500 RESPIRATORY THERAPY	0	0	0	2, 465, 435		
66. 00 06600 PHYSI CAL THERAPY	0	0	0	6, 301, 991		
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	153, 154	0. 000000	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	0	847, 352		68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0	6, 726, 659	0. 000000	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0. 000000	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	7, 342, 104		
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	8, 440, 739		72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	19, 283, 177		
74. 00 07400 RENAL DI ALYSI S	0	0	0	0	0. 000000	
75. 00 07500 ASC (NON-DISTINCT PART)	0	0	0	0	0. 000000	
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	0	0	0	42, 228, 672	0.000000	91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	ا م	Ö			
200.00 Total (lines 50 through 199)		0	ı			200. 00
	'	1	١		1	

Heal th	Financial Systems A	SCENSION ST. VIN	NCENT FISHERS		In Lie	u of Form CMS-2	2552-10
APPORT	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER H COSTS		Provi der CC		Period: From 07/01/2021 To 06/30/2022	Worksheet D Part IV Date/Time Pre 11/21/2022 11	pared:
				XVIII	Hospi tal	PPS	
	Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through		Pass-Through	
		(col . 6 ÷ col .		Costs (col.	3	Costs (col. 9	
		7)	40.00	x col. 10)	10.00	x col . 12)	
	ANOULL ARV CERVI OF COCT CENTERS	9. 00	10.00	11. 00	12.00	13. 00	
F0 00	ANCILLARY SERVICE COST CENTERS	0.000000	4 070 445		10 504 004		F0 00
50.00	05000 OPERATI NG ROOM	0. 000000	4, 073, 145		0 10, 534, 024		50.00
51.00	05100 RECOVERY ROOM	0. 000000	0		0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	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. 000000	220, 208		0 1, 563, 603		54.00
54. 01	03630 ULTRA SOUND	0. 000000	0		0 258, 012	0	54. 01
56.00	05600 RADI OI SOTOPE	0. 000000	0		0	0	56.00
56. 01	05601 ONCOLOGY	0. 000000	0		0 513, 246		56. 01
57. 00	05700 CT SCAN	0. 000000	183, 600		0 1, 150, 627	0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000	17, 100		0 300, 578		58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0	0	59. 00
60.00	06000 LABORATORY	0. 000000	1, 438, 241		0 2, 621, 362	0	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	0		0	0	62. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0	0	63. 00
64.00	06400 I NTRAVENOUS THERAPY	0. 000000	0		0	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	0. 000000	176, 780		0 46, 986	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 000000	125, 267		0 45, 271	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	29, 314		0 10, 726	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	3, 912		0 60, 264	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	273, 228		0 1, 295, 771	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	469, 152		0 1, 049, 951	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	810, 332		0 2, 106, 153		72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	784, 361		0 3, 569, 407	0	73. 00
74.00	07400 RENAL DIALYSIS	0. 000000	0		0	0	74.00

0. 000000

0. 000000

0.000000

1, 005, 805

178, 161 9, 788, 606

4, 591, 441

30, 687, 200

969, 778

0

0 0 0

0 75. 00

0 91.00

0 92.00

0 200. 00

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

Total (lines 50 through 199)

07500 ASC (NON-DISTINCT PART)
OUTPATIENT SERVICE COST CENTERS

91. 00 09100 EMERGENCY

75.00

Health Financial Systems	ASCENSION ST. VINC	ENT FISHERS	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0181	Peri od:	Worksheet D

From 07/01/2021 | Part V | To 06/30/2022 | Date/Time Prepared: 11/21/2022 11:32 am Title XVIII Hospi tal Charges Costs Cost to Charge PPS Reimbursed Cost Center Description Cost Cost PPS Services Ratio From Services (see Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1. 00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 103309 10, 534, 024 1, 088, 259 50.00 0 51.00 05100 RECOVERY ROOM 0.000000 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0. 330962 0 52 00 52 00 Ω 0 0 0 53.00 05300 ANESTHESI OLOGY 0.000000 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0. 206837 1, 563, 603 0 323, 411 54.00 258, 012 0 54.01 03630 ULTRA SOUND 0.129264 0 33, 352 54 01 0 05600 RADI OI SOTOPE 56.00 0.000000 56.00 56.01 05601 ONCOLOGY 0. 267606 513, 246 137, 348 56.01 1, 150, 627 0 57.00 05700 CT SCAN 0.179581 0 206, 631 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58 00 0 273760 300, 578 82, 286 58 00 59.00 05900 CARDIAC CATHETERIZATION 0.000000 Ω 59.00 06000 LABORATORY 0. 168257 2, 621, 362 0 0 0 0 0 0 0 0 441, 063 60.00 60.00 0 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.000000 62.00 0 62.00 0 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 0.000000 0 63.00 64.00 06400 I NTRAVENOUS THERAPY 0.000000 0 0 64.00 06500 RESPIRATORY THERAPY 0. 473196 46, 986 22, 234 65.00 65.00 06600 PHYSI CAL THERAPY 45, 271 0 20, 922 66.00 0.462142 66, 00 06700 OCCUPATIONAL THERAPY 0 67.00 0.353207 10, 726 3, 788 67.00 68.00 06800 SPEECH PATHOLOGY 0. 432918 60, 264 26, 089 68.00 06900 ELECTROCARDI OLOGY 1, 295, 771 0 69.00 0.103540 0 134, 164 69.00 0 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 70.00 0 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 1, 049, 951 71.00 0. 134415 141, 129 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.367849 2, 106, 153 0 0 774, 746 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 0.399755 3, 569, 407 954 1, 426, 888 73.00 07400 RENAL DIALYSIS 0 74.00 0.000000 0 74.00 0 0 75.00 07500 ASC (NON-DISTINCT PART) 0.000000 0 0 75.00 OUTPATIENT SERVICE COST CENTERS 0 91.00 09100 EMERGENCY 0. 133867 4, 591, 441 614, 642 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 92.00 0.507838 969, 778 492, 490 92.00 0 200.00 Subtotal (see instructions) 30, 687, 200 954 5, 969, 442 200. 00 0 201.00 Less PBP Clinic Lab. Services-Program 0 201.00 Only Charges 202.00 Net Charges (line 200 - line 201) 30, 687, 200 0 954 5, 969, 442 202. 00

From 07/01/2021 Part V 06/30/2022 Date/Time Prepared: 11/21/2022 11:32 am Title XVIII Hospi tal PPS Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 51.00 05100 RECOVERY ROOM 00000000000000000000000000 0 51.00 52. 00 05200 DELIVERY ROOM & LABOR ROOM 0 52 00 53. 00 | 05300 | ANESTHESI OLOGY 0 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 54. 01 03630 ULTRA SOUND 0 54.01 05600 RADI OI SOTOPE 0 56.00 56.00 56. 01 05601 ONCOLOGY 0 56.01 05700 CT SCAN 0 57.00 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 58 00 58 00 59.00 05900 CARDIAC CATHETERIZATION 0 59.00 60.00 06000 LABORATORY 0 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 0 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 63.00 63.00 64.00 06400 I NTRAVENOUS THERAPY 0 64.00 06500 RESPIRATORY THERAPY 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 0 66.00 06700 OCCUPATI ONAL THERAPY 0 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 0 68.00 06900 ELECTROCARDI OLOGY 0 69.00 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 381 73.00 74.00 07400 RENAL DIALYSIS 74.00 0 07500 ASC (NON-DISTINCT PART) 75.00 0 75.00

0 0 0

0

Ω

381

381

91.00

92.00

200. 00 201. 00

202. 00

OUTPATIENT SERVICE COST CENTERS

Only Charges

09200 OBSERVATION BEDS (NON-DISTINCT PART)

Net Charges (line 200 - line 201)

Less PBP Clinic Lab. Services-Program

Subtotal (see instructions)

09100 EMERGENCY

91.00

92.00

200.00

201.00

Health Financial Systems	ASCENSION ST. VINCE	ASCENSION ST. VINCENT FISHERS		In Lieu of Form CMS-2552-10	
ADDODTIONMENT OF MEDICAL	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0181	Dari ad:	Workshoot D	

From 07/01/2021 Part V 06/30/2022 Date/Time Prepared: 11/21/2022 11:32 am Title XIX Hospi tal Cost Charges Costs Cost to Charge PPS Reimbursed Cost Center Description Cost Cost PPS Services Ratio From Services (see Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1. 00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 103309 145, 389 0 50.00 51.00 05100 RECOVERY ROOM 0.000000 51.00 05200 DELIVERY ROOM & LABOR ROOM 0. 330962 52 00 0 52 00 2.155 0 53.00 05300 ANESTHESI OLOGY 0.000000 0 C 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0. 206837 46, 046 0 54.00 54.01 03630 ULTRA SOUND 0.129264 0 16, 251 0 54 01 05600 RADI OI SOTOPE 56.00 0.000000 0 0 56.00 56.01 05601 ONCOLOGY 0. 267606 3, 154 0 56.01 57.00 05700 CT SCAN 0.179581 37, 183 0 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0. 273760 58 00 58 00 11, 264 0 59.00 05900 CARDIAC CATHETERIZATION 0.000000 0 59.00 60.00 06000 LABORATORY 0.168257 148, 021 0 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.000000 62.00 0 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 63.00 0.000000 0 0 64.00 06400 I NTRAVENOUS THERAPY 0.000000 0 0 64.00 06500 RESPIRATORY THERAPY 0. 473196 14, 276 65.00 65.00 06600 PHYSI CAL THERAPY 0.462142 66.00 211, 560 0 66, 00 06700 OCCUPATIONAL THERAPY 67.00 0.353207 0 67.00 68.00 06800 SPEECH PATHOLOGY 0. 432918 27,665 68.00 06900 ELECTROCARDI OLOGY 69.00 0.103540 93, 318 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0 70.00 C 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0.134415 19, 437 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.367849 173 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0.399755 22, 300 73.00 07400 RENAL DIALYSIS 0 74.00 0.000000 0 74.00 0 07500 ASC (NON-DISTINCT PART) 75.00 0.000000 0 0 0 75.00 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 0. 133867 0 484.746 0 0 91.00 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0.507838 10.038 92.00 C Ol 200.00 Subtotal (see instructions) 1, 292, 976 0 200. 00 o 201.00 Less PBP Clinic Lab. Services-Program 0 201.00 Only Charges 202.00 Net Charges (line 200 - line 201) 1, 292, 976 0 202.00 0

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

				To 06/30/2022	Date/Time Prepare 11/21/2022 11:32	
		Ti tI	e XIX	Hospi tal	Cost	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
ANOLULARY OFRIVAE COOT OFFITERS	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS	15.000					
50. 00 05000 OPERATI NG ROOM	15, 020	0				0.00
51. 00 05100 RECOVERY ROOM	0	0	1			1.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	713	0				2. 00
53. 00 05300 ANESTHESI OLOGY	0 504	0				3. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	9, 524	0	1			1. 00
54. 01 03630 ULTRA SOUND	2, 101	0				4. 01
56. 00 05600 RADI 0I SOTOPE	0	0			l l	5. 00
56. 01 05601 0NCOLOGY	844	0	1			5. 01
57. 00 05700 CT SCAN	6, 677	0				7. 00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	3, 084	0			l l	3. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	24 004		1			9. 00
60. 00 06000 LABORATORY 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	24, 906	0				0. 00 2. 00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0			l l	2. 00 3. 00
64. 00 06400 I NTRAVENOUS THERAPY	0	0	1			4. 00
65. 00 06500 RESPI RATORY THERAPY	6, 755	0	1			5. 00
66. 00 06600 PHYSI CAL THERAPY	97, 771	0	1			5. 00
67. 00 06700 OCCUPATI ONAL THERAPY	77,771	Ö	1			7. 00
68. 00 06800 SPEECH PATHOLOGY	11, 977	Ö	1			3. 00
69. 00 06900 ELECTROCARDI OLOGY	9, 662	Ö	1			9. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	7,002	Ö	1			0. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 613	Ö				1. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	64	Ö				2. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	8, 915	Ö	,			3. 00
74. 00 07400 RENAL DI ALYSI S	o	O	,		74	4. 00
75. 00 07500 ASC (NON-DISTINCT PART)	o	O	1		75	5. 00
OUTPATIENT SERVICE COST CENTERS	<u> </u>					
91. 00 09100 EMERGENCY	64, 891	C			91	1.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	5, 098	0)		92	2. 00
200.00 Subtotal (see instructions)	270, 615	0)		200	0. 00
201.00 Less PBP Clinic Lab. Services-Program	0				201	1. 00
Only Charges						
202.00 Net Charges (line 200 - line 201)	270, 615	0	1		202	2. 00

Health Financial Systems	ASCENSION ST. VINC	ENT FISHERS	In Lie	u of Form CMS-:	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0181	Peri od: From 07/01/2021	Worksheet D-1	
				Date/Time Pre	
		Title XVIII	Hospi tal	PPS	
Cost Contar Deceriation					

		Title XVIII	Hospi tal	PPS	. 32 alli
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
1. 00 2. 00	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-b			3, 959 3, 959	1. 00 2. 00
3. 00	Private room days (excluding swing-bed and observation bed day		vate room days.	3, 434	3.00
	do not complete this line.	, Jan 1 1 3 1			
4.00	Semi-private room days (excluding swing-bed and observation be		- 21 -6	3, 075	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private roc reporting period	om days) through December	31 of the cost	0	5. 00
6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December 3	31 of the cost	0	6. 00
7.00	reporting period (if calendar year, enter 0 on this line)		21 -6	0	7 00
7. 00	Total swing-bed NF type inpatient days (including private room reporting period	r days) through becember	31 Of the Cost	0	7. 00
8.00	Total swing-bed NF type inpatient days (including private room	n days) after December 3°	1 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)			774	0.00
9. 00	Total inpatient days including private room days applicable to newborn days) (see instructions)	the Program (excluding	swing-bed and	771	9. 00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private ro	oom days)	0	10.00
11 00	through December 31 of the cost reporting period (see instruct		> -64	0	11 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or December 31 of the cost reporting period (if calendar year, er		oom days) arter	0	11. 00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12. 00
12.00	through December 31 of the cost reporting period	/		0	12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar ye			0	13. 00
14.00	Medically necessary private room days applicable to the Progra			0	14. 00
15. 00	Total nursery days (title V or XIX only)			0	15. 00
16. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 of	f the cost	0.00	17. 00
	reporting period				
18. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es after December 31 of t	the cost	0. 00	18. 00
19. 00	Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	0.00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	after December 31 of th	ne cost	0.00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions	.)		8, 104, 725	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		na period (line	6, 104, 725 0	22.00
	5 x line 17)	•			
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	g period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December 7×1 ine 19)	31 of the cost reportin	ng period (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)	31 of the cost reporting	period (line 8	0	25. 00
26. 00	Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost ((line 21 minus line 26)		8, 104, 725	27. 00
28. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	l and observation had cha	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	and observation bed cha	in ges)	0	29.00
30.00	Semi -pri vate room charges (excluding swing-bed charges)			0	30.00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0.000000	31. 00
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0. 00	32. 00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34. 00	Average per diem private room charge differential (line 32 mir		tions)	0.00	
35.00	Average per diem private room cost differential (line 34 x line 25)	le 31)		0.00	ł
36. 00 37. 00	Private room cost differential adjustment (line 3 x line 35)	and private room cost dit	fforontial (line	8, 104, 725	36. 00 37. 00
37.00	General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	ina private room cost ari	recential (TIME	0, 104, 725	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		'		
00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU				00
38. 00	Adjusted general inpatient routine service cost per diem (see			2, 047. 16	1
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Program	•		1, 578, 360 0	39. 00 40. 00
	Total Program general inpatient routine service cost (line 39	,		1, 578, 360	ł
	, J. J	/	ı	, ,	

OIVIFUI	ATION OF INPATIENT OPERATING COST		Provi der (CCN: 15-0181	Peri od:	Worksheet D-1	2552-
01					From 07/01/2021		
					To 06/30/2022	Date/Time Pre 11/21/2022 11	
			Ti tl	e XVIII	Hospi tal	PPS	. 52 0
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost	npatient Day		÷	(col. 3 x col.	
		1.00	2.00	col . 2) 3.00	4. 00	4) 5. 00	
2. 00	NURSERY (title V & XIX only)	0		0. 0.			42.
	Intensive Care Type Inpatient Hospital Unit						
3. 00	INTENSIVE CARE UNIT	0		0.			1
4. 00	CORONARY CARE UNIT	0		0.		-	
5.00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT	0		0. 0.		0	
	OTHER SPECIAL CARE (SPECIFY)		· ·	0.	00	0	47.
	Cost Center Description			•			
	15					1. 00	
8. 00	Program inpatient ancillary service cost (W Total Program inpatient costs (sum of lines			ana)		1, 827, 810	
9. 00	PASS THROUGH COST ADJUSTMENTS	5 41 till ough 46) (:	see mstructi	0115)		3, 406, 170	49.1
0. 00	Pass through costs applicable to Program in	patient routine s	services (fro	m Wkst. D, su	m of Parts I and	320, 790	50.
	[111)	•					
1. 00	Pass through costs applicable to Program in	patient ancillary	services (f	rom Wkst. D,	sum of Parts II	171, 888	51.
2. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				492, 678	52.
3. 00	Total Program inpatient operating cost excl	,	ated, non-ph	ysician anest	hetist, and	2, 913, 492	
	medical education costs (line 49 minus line						
4 00	TARGET AMOUNT AND LIMIT COMPUTATION						
4. 00 5. 00	Program discharges Target amount per discharge					0.00	
6. 00	Target amount (line 54 x line 55)					0.00	1
7. 00	Difference between adjusted inpatient opera	iting cost and tai	get amount (line 56 minus	line 53)	0	1
8. 00	Bonus payment (see instructions)					0	
9. 00	Lesser of lines 53/54 or 55 from the cost r	reporting period (endi ng 1996,	updated and c	ompounded by the	0.00	59.
0. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost report und	dated by the	market basket		0.00	60.
1. 00	If line 53/54 is less than the lower of lin					0	1
	which operating costs (line 53) are less th		s (lines 54 x	60), or 1% o	f the target [*]		
2 00	amount (line 56), otherwise enter zero (see	e instructions)					(2)
2. 00 3. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive pay	ment (see instru	rtions)			0	
	PROGRAM INPATIENT ROUTINE SWING BED COST		51.01.0)				00.
4. 00	Medicare swing-bed SNF inpatient routine co	sts through Decer	mber 31 of th	e cost report	ing period (See	0	64.
5. 00	instructions) (title XVIII only)	ata aftar Dagamb	n 21 o€ +bo	acat ranantin	a naminal (Coo	0	/ -
5.00	Medicare swing-bed SNF inpatient routine co instructions)(title XVIII only)	ists after Decembe	el 31 Ol tile	cost reporting	g perrou (see		65.
6. 00	Total Medicare swing-bed SNF inpatient rout	ine costs (line	64 plus line	65)(title XVI	II only). For	0	66.
	CAH (see instructions)					_	
7. 00	Title V or XIX swing-bed NF inpatient routi (line 12 x line 19)	ne costs through	December 31	of the cost r	eporting period	0	67.
8. 00	Title V or XIX swing-bed NF inpatient routi	ne costs after De	ecember 31 of	the cost rep	ortina period	0	68.
	(line 13 x line 20)				g p		
9. 00	Total title V or XIX swing-bed NF inpatient					0	69.
0. 00	PART III - SKILLED NURSING FACILITY, OTHER Skilled nursing facility/other nursing faci)	I	70.
1. 00	Skilled nursing facility/other nursing faci Adjusted general inpatient routine service				,		71.
2. 00	Program routine service cost (line 9 x line		5 . 11110	7			72.
3. 00	Medically necessary private room cost appli		•				73.
4.00	Total Program general inpatient routine ser				Dont II!		74.
5. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	costs (from	worksneet B,	Part II, Column		75.
6. 00	Per diem capital-related costs (line 75 ÷ l	ine 2)					76.
7. 00	Program capital-related costs (line 9 x lin						77.
3. 00	Inpatient routine service cost (line 74 min		:	-1->			78.
0.00	Aggregate charges to beneficiaries for exce	·			nus lina 70)		79. 80.
. 00	Total Program routine service costs for com Inpatient routine service cost per diem lim	•	ost iiiiii tatiO	11 (11116 /0 IIII	ilus IIIIC /7)		81.
2. 00	Inpatient routine service cost limitation ()				82.
3. 00	Reasonable inpatient routine service costs	(see instructions					83.
1.00	Program inpatient ancillary services (see i		>				84.
5.00	Utilization review - physician compensation						85. 86.
U. UU	Total Program inpatient operating costs (su PART IV - COMPUTATION OF OBSERVATION BED PA		ougn ob)			<u> </u>	1 00.
7. 00	Total observation bed days (see instruction					884	87.
						0 047 44	1 00
8. 00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (s	•	line 2)			2, 047. 16 1, 809, 689	

Health Financial Systems A	SCENSION ST. V	INCENT FISHERS		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 07/01/2021 To 06/30/2022	Date/Time Prep 11/21/2022 11	pared: :32 am_
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital -related cost	1, 647, 232	8, 104, 725	0. 203243	1, 809, 689	367, 807	90. 00
91.00 Nursing Program cost	0	8, 104, 725	0.00000	1, 809, 689	0	91.00
92.00 Allied health cost	0	8, 104, 725	0.00000	1, 809, 689	0	92.00
93.00 All other Medical Education	0	8, 104, 725	0. 000000	1, 809, 689	0	93. 00

Health Financial Systems	ASCENSION ST. VINC	ENT FISHERS	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 15-0181	Peri od: From 07/01/2021	Worksheet D-1	
			To 06/30/2022	Date/Time Pre 11/21/2022 11	
		Title XIX	Hospi tal	Cost	
Cost Center Description					

DATE ALL PROVIDER COMPONENTS 1.00			Title XIX	Hospi tal	11/21/2022 11: Cost	:32 am_
IMPATITION DAYS IMPATITION		Cost Center Description	THE ATA	1103pi tai	0031	
		DADT I ALL DDOWNER CONDONENTS			1. 00	
Impatient days (Including private room days and seing-bed days, excluding newborn) 3,959 1,00						1
Private room days (excluding swing-bed and observation bed days). If you have only private room days. 4.00 Semi-private room days (excluding swing-bed and observation bed days). 5.00 Total swing-bed SWF type inputient days (including private room days) through December 31 of the cost reporting period (if call endar year, enter 0 on this line). 7.00 Total swing-bed SWF type inputient days (including private room days) after December 31 of the cost reporting period (if call endar year, enter 0 on this line). 7.00 Total swing-bed WF type inputient days (including private room days) after December 31 of the cost reporting period (if call endar year, enter 0 on this line). 8.00 Total swing-bed WF type inputient and the swing-bed to the Program (excluding swing-bed and newborn days) (see instructions). 8.00 Swing-bed WF type inputient days applicable to title XVIII only (including private room days) after meetorm days). 9.00 Swing-bed SWF type inputient days applicable to title XVIII only (including private room days) after only through December 31 of the cost reporting period (see instructions). 10.00 Swing-bed SWF type inputient days applicable to title XVIII only (including private room days) after only through December 31 of the cost reporting period (see instructions). 11.00 Swing-bed SWF type inputient days applicable to title XVIII only (including private room days) after only through December 31 of the cost reporting period (including private room days). 12.00 Swing-bed SWF type inputient days applicable to title XVIII only (including private room days). 13.01 Swing-bed SWF type inputient days applicable to title XVIII only (including private room days). 13.00 Swing-bed SWF type inputient days applicable to title XVIII only (including private room days). 13.01 Swing-bed SWF type inputient days applicable to title XVIII only (including private room days). 13.01 Swing-bed SWF type inputient days applicable to title XVIII only (including private room days). 13.02 Swing-bed SWF type inputient days	1.00		s, excluding newborn)		3, 959	1.00
do not complete this line. 4. OS Sell-private room days (excluding swing-bed and observation bed days) 5.00 Intal swing-bed SW type inpatient days. (Including private room days) after December 31 of the cost 7. 00 Total swing-bed SW type inpatient days. (Including private room days) after December 31 of the cost 7. 00 Total swing-bed SW type inpatient days. (Including private room days) after December 31 of the cost 7. 00 Total swing-bed SW type inpatient days. (Including private room days) through December 31 of the cost 7. 00 Total swing-bed SW type inpatient days. (Including private room days) after December 31 of the cost 7. 00 Total swing-bed SW type inpatient days. (Including private room days) after December 31 of the cost 7. 00 Total Inpatient days including private room days after December 31 of the cost 7. 00 Swing-bed SW type inpatient days applicable to the Program (excluding swing-bed and nexestor days) (see instructions) 8. 00 Swing-bed SW type inpatient days applicable to title XWIII only (Including private room days) 9. 00 Swing-bed SW type inpatient days applicable to title XWIII only (Including private room days) 9. 01 Swing-bed SW type inpatient days applicable to title XWIII only (Including private room days) 9. 02 Swing-bed SW type inpatient days applicable to title XWIII only (Including private room days) 9. 03 Swing-bed SW type inpatient days applicable to title XWIII only (Including private room days) 9. 04 Swing-bed SW type inpatient days applicable to title XWIII only (Including private room days) 9. 05 Swing-bed NY type inpatient days applicable to title XWIII only (Including private room days) 9. 07 Swing-bed NY type inpatient days applicable to title XWIII only (Including private room days) 9. 08 Swing-bed NY type inpatient days applicable to title XWIII only (Including private room days) 9. 08 Swing-bed NY type inpatient days applicable to services applicable to services applicable to services applicable to services after December 31 of the cost 9. 00 Total swing-bed SW swing-bed						
Semi_private room days (excluding swing-bed and observation bed days) 2,225 4,00	3.00		/s). If you have only pr	ivate room days,	850	3.00
reporting period (1 real endar year, enter 0 on this line) 7. 00 Total saing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (1 real endar year, enter 0 on this line) 8. 00 Period saing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (1 real endar year, enter 0 on this line) 9. 00 Iotal inpatient days including private room days after December 31 of the cost reporting period (1 real endar year, enter 0 on this line) 10. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 10. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after becamber 31 of the cost reporting period (3 rein title XVIII only (including private room days) after 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 10.00 Swing-bed SNF type inpatient days applicable to titles XVIII only (including private room days) after 10.00 Swing-bed SNF type inpatient days applicable to titles XVIII only (including private room days) after 10.00 Swing-bed SNF type inpatient days applicable to titles XVIII only (including private room days) after 10.00 Swing-bed SNF type inpatient days applicable to titles XVIII only (including private room days) after 10.00 Swing-bed SNF type pratient days applicable to titles XVIII only (including private room days) after 10.00 Swing-bed SNF type private room days applicable to the Program (excluding swing-bed days) 11.213 is. 00 Swing-bed SWIII only (including private room days) 11.213 is. 00 Swing-bed SWIII only (including private room days) 11.213 is. 00 SWING-BOWN (including private room days) 11.213 is. 00 SWING-BOWN (including SWING-BOWN (including SWING-BOWN (including SWING-BOWN (including SWING-BOWN (including SWING-BOWN (including SWING-BOWN (includin	4.00		ed days)		2, 225	4. 00
Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if c alendar year, enter 0 on this line)	5.00		om days) through Decembe	r 31 of the cost	0	5. 00
reporting period (if follandar year, enter 0 on this line) 7.00 Total saving-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period in the cost reporting period (including private room days) applicable to the Program (excluding swing-bed and newtorn days) (see Instructions) 10.00 Swing-bed SNF type Inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 10.00 Swing-bed SNF type Inpatient days applicable to title XVIII only (including private room days) 10.00 Swing-bed SNF type Inpatient days applicable to titles V or XIX only (including private room days) 10.00 Swing-bed SNF type Inpatient days applicable to titles V or XIX only (including private room days) 10.00 Swing-bed SNF type Inpatient days applicable to the Program (excluding swing-bed days) 10.00 Swing-bed SNF type Inpatient days applicable to the Program (excluding swing-bed days) 10.00 Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed days) 10.00 Swing-bed SNF type private room days applicable to the Program (excluding swing-bed days) 10.00 Swing-bed SNF services applicable to services through December 31 of the cost 10.00 Swing-bed SNF services applicable to services after December 31 of the cost 10.00 Swing-bed SNF services applicable to services after December 31 of the cost 10.00 Swing-bed SNF services applicable to services after December 31 of the cost 10.00 Swing-bed SNF services applicable to services after December 31 of the cost 10.00 Swing-bed SNF services after December 31 of the cost reporting period (line SNF type services after December 31 of the cost reporting period (line SNF type services after December	6 00		om days) after December	21 of the cost	0	6 00
reporting period 8. 00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9. 00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 10. 00 Swing-bed SNF type impatient days applicable to title XVIII only (including private room days) after properties of the cost reporting period (see instructions) 11. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see instructions) 12. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (in calendar year, enter 0 on this line) 13. 00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 14. 00 Medically necessary private room days applicable to titles V or XIX only (including private room days) 12.20 of Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed days) 12.31 is. 00 of Total nursery days (title V or XIX only) 13.00 of Swing-bed SNF type inpatient on XIX only) 13.00 of Total nursery days (title V or XIX only) 13.00 of Total nursery days (title V or XIX only) 13.00 of Total nursery days (title V or XIX only) 13.00 of Total nursery days (title V or XIX only) 13.00 of Total nursery days (title V or XIX only) 13.00 of Total nursery days (title V or XIX only) 13.00 of Total nursery days (title V or XIX only) 13.00 of Total nursery days (title V or XIX only) 13.00 of Total nursery days (title V or XIX only) 13.00 of Total nursery days (title V or XIX only) 13.00 of Total nursery days (title V or XIX only) 13.00 of Total nursery days (title V or XIX only) 13.00 of Total nursery 13.00 of Total nursery 13.00 of Total nursery 13.00 of Total nur	0.00		olli days) arter beceilber	31 Of the cost	O ₁	0.00
Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if Calendar year, enter 0 on this line)	7. 00		n days) through December	31 of the cost	0	7. 00
reporting period (if calendar year, enter 0 on this line) 10.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see Instructions) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 or the cost reporting period (see Instructions) 11.00 Swing-bed SNF type inpatient days applicable to 11tle XVIII only (including private room days) after through December 31 or the cost reporting period (see Instructions) 12.00 Swing-bed SNF type inpatient days applicable to 11tle XVIII only (including private room days) after through December 31 or the cost reporting period (see Instructions) 13.00 Swing-bed SNF type inpatient days applicable to 11tle XVIII only (including private room days) after December 31 or the cost reporting period (if calendar year, enter 0 on this line) 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 15.00 Total nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only) 17.01 Nursery days (title V or XIX only) 18.00 Medically necessary private room days applicable to services through December 31 of the cost reporting period (see a period on Medicald rate for swing-bed SNF services applicable to services after December 31 of the cost 0.00 period on Medicald rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 period on Medicald rate for swing-bed NF services through December 31 of the cost reporting period (line 6 on NF type services through December 31 of the cost reporting period (line 6 on NF type services through December 31 of the cost reporting period (line 6 on NF type services through December 31 of the cost reporting period (line 6 on NF type services after December 31 of the cost reporting period (line 6 on NF ty	8 00	' 3 '	n days) after December 3	1 of the cost	0	8 00
Total inpatient days: Including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 0.00	0.00		arter becember 3	i or the cost	٥	0.00
10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 10.00 10.00	9.00	Total inpatient days including private room days applicable to	the Program (excluding	swi ng-bed and	52 ¹	9. 00
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December 31 of the cost reporting period (if calendar year, enter 0 on this line)	10.00			oon days)	٥	10.00
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26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERNTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Average per diem private room cost differential (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 8, 104, 725) Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	25. 00		31 of the cost reporting	period (line 8	0	25. 00
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PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 + line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 8, 104, 725) 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 176, 932 28.00 176, 932 29.00 176, 932 30.00 45.80705 31.00 45.80705 31.00 32.0		,	(ling 21 minus ling 26)			
29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 8, 104, 725) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 29.00 29.00 176, 932 30.00	27.00		(Title 21 IIII lus Title 20)		0, 104, 723	27.00
30. 00 Semi-private room charges (excluding swing-bed charges) 31. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32. 00 Average private room per diem charge (line 29 ÷ line 3) 33. 00 Average semi-private room per diem charge (line 30 ÷ line 4) 34. 00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35. 00 Average per diem private room cost differential (line 34 x line 31) 36. 00 Private room cost differential adjustment (line 3 x line 35) 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 8, 104, 725) 37. 00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38. 00 Adjusted general inpatient routine service cost (line 9 x line 38) 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 176, 932 30. 00 45. 807005 31. 00 0. 00 32. 00 0. 00 34. 00			d and observation bed ch	arges)		
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 8, 104, 725) 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 45.807005 31.00 45.807005 32.00 32.00 34.00 35.00 36.00 37.00 38.104,725 37.00 38.00 40.00					-	
32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 36.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 8, 104, 725) 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 .00 32.00 79.52 33.00 34.00 35.00 36.00 36.00 37.00 38.00 37.00		, , , , , , , , , , , , , , , , , , , ,	: line 28)			
33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 8, 104, 725) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost (line 9 x line 38) Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 79.52 33.00 79.52 33.00 34.00 35.00 36.00 37.00 27 minus line 36) PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 79.52 33.00 34.00 35.00 36.00 37.00 37.00			11116 20)			1
34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 34.00 35.00 0.00 35.00 0.00 36.00 37.00 27 minus line 36) 8, 104, 725 37.00 27.00 0.00 0.00 0.00 0.00 0.00 0.00		, , , , , , , , , , , , , , , , , , , ,				1
35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 8, 104, 725) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 35.00 37.00 2,047.16 38.00 40.00		, , , , , , , , , , , , , , , , , , , ,	nus line 33)(see instruc	tions)		1
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 37.00 8, 104, 725 37.00	35.00				0.00	35. 00
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 2,047.16 38.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		, , , , , , , , , , , , , , , , , , ,			0	36. 00
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 2,047.16 38.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	37. 00		and private room cost di	fferential (line	8, 104, 725	37. 00
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 7.047.16 38.00 106,452 39.00 106,4						1
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 2,047.16 38.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 2,047.16 38.00 106,452 39.00 40.00			JSTMENTS			1
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	38. 00				2, 047. 16	38. 00
	39. 00	Program general inpatient routine service cost (line 9 x line	38)		106, 452	39. 00
41.00 Iotal Program general inpatient routine service cost (line 39 + line 40) 106,452 41.00		, , , , , , , , , , , , , , , , , , , ,	•			
	41. 00	lotal Program general inpatient routine service cost (line 39	+ line 40)		106, 452	41.00

COMPUT	ATION OF INPATIENT OPERATING COST		Provi der CCI	N: 15-0181	Peri od:	Worksheet D-1	2552-1
30m 01	ATTOM OF THE ATTEM OF ENTITIES GOOT		Trovider oo	. 10 0101	From 07/01/2021 To 06/30/2022		pared:
			Title		Hospi tal	Cost	
	Cost Center Description	Total Inpatient Costl	Total npatient Days[Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
10.00	THIRDSERV (1:11 N a MIX 1)	1.00	2.00	3.00	4. 00	5. 00	40.00
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Unit	949, 599	1, 213	782.	85 38	29, 748	42.00
43. 00	INTENSIVE CARE UNIT	0	0	0.	00 0	0	43.00
44. 00	CORONARY CARE UNIT	O	0	0.	00 0	0	44.00
45. 00	BURN INTENSIVE CARE UNIT	0	0	0.		1	45.00
	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)	0	0	0.	00 0	0	46. 00
47.00	Cost Center Description					1.00	47.00
48. 00	Program inpatient ancillary service cost (Wkst. D-3, col. 3,	line 200)			271, 682	48. 00
49. 00	Total Program inpatient costs (sum of line: PASS THROUGH COST ADJUSTMENTS	s 41 through 48)(s	ee instruction	is)		407, 882	49. 00
50. 00	Pass through costs applicable to Program in [III]	npatient routine s	ervices (from	Wkst. D, su	m of Parts I and	0	50.00
51. 00	Pass through costs applicable to Program in and IV)	npatient ancillary	services (fro	om Wkst. D,	sum of Parts II	0	51.00
52.00	Total Program excludable cost (sum of lines		otod '	.lala= - ''	hotiot!	0	
53. 00	Total Program inpatient operating cost excluded in the medical education costs (line 49 minus line target AMOUNT AND LIMIT COMPUTATION		ated, non-phys	arcian anesti	metist, and	0	53.00
54. 00	Program discharges					0	54.0
55. 00	Target amount per discharge					0. 00	
56. 00	Target amount (line 54 x line 55)				1: 52)	0	
57. 00 58. 00	Difference between adjusted inpatient opera Bonus payment (see instructions)	ating cost and tar	get amount (11	ne 56 minus	11 ne 53)	0	
59. 00	Lesser of lines 53/54 or 55 from the cost market basket	reporting period e	endi ng 1996, up	dated and c	ompounded by the		
60.00	Lesser of lines 53/54 or 55 from prior year	r cost report, upo	lated by the ma	rket basket		0.00	60.0
61. 00	If line 53/54 is less than the lower of line 53/					0	61.0
	which operating costs (line 53) are less the amount (line 56), otherwise enter zero (see		(lines 54 x 6	0), or 1% o	f the target		
62. 00	Relief payment (see instructions)	e mstructrons)				0	62. 0
63. 00	Allowable Inpatient cost plus incentive par	yment (see instruc	tions)			0	63. 0
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine co	nsts through Decem	her 31 of the	cost report	ing period (See	0	64. 0
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine co	· ·		•		0	
66. 00	instructions) (title XVIII only)			•		0	
	Total Medicare swing-bed SNF inpatient rou CAH (see instructions)		•				
67. 00	(line 12 x line 19)	-				0	
	Title V or XIX swing-bed NF inpatient rout (line 13 x line 20)				orting period	0	
	Total title V or XIX swing-bed NF inpatien PART III - SKILLED NURSING FACILITY, OTHER	NURSING FACILITY,	AND ICF/IID 0	NLY		0	
70. 00 71. 00	Skilled nursing facility/other nursing facili	-		•)		70.00
72.00	Program routine service cost (line 9 x line		70 - TINE 2	.,			72.00
73. 00	Medically necessary private room cost appl		(line 14 x lin	ie 35)			73.00
74.00	Total Program general inpatient routine se	,		under hand De 1	D		74.00
75. 00	Capital-related cost allocated to inpatien 26, line 45)		costs (from Wo	rksheet B, I	rart II, column		75.00
76. 00 77. 00	Program capital-related costs (line 75 ÷ Program capital-related costs (line 9 x line)						76. 0
78. 00	Inpatient routine service cost (line 74 min						78.0
79. 00	Aggregate charges to beneficiaries for exce	ess costs (from pr					79. 0
30. 00 31. 00	Total Program routine service costs for collinpatient routine service cost per diem lin	•	st limitation	(line 78 mi)	nus line 79)		80. 0 81. 0
32. 00	Inpatient routine service cost per drem in						82.0
33. 00	Reasonable inpatient routine service costs						83. 0
84.00	Program inpatient ancillary services (see		- \				84. 0
35.00 36.00	Utilization review - physician compensation Total Program inpatient operating costs (s						85. 0
50.00	PART IV - COMPUTATION OF OBSERVATION BED PART		ougii oo)				1 00.0
	Total observation bed days (see instruction					884	87. 0
37. 00 38. 00	Adjusted general inpatient routine cost per					2, 047. 16	88. 0

Health Financial Systems A	SCENSION ST. V	INCENT FISHERS		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 07/01/2021 To 06/30/2022	Date/Time Pre 11/21/2022 11	pared: :32 am_
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital-related cost	1, 647, 232	8, 104, 725	0. 20324	1, 809, 689	367, 807	90.00
91.00 Nursing Program cost	0	8, 104, 725	0.00000	0 1, 809, 689	0	91.00
92.00 Allied health cost	0	8, 104, 725	0.00000	0 1, 809, 689	0	92.00
93.00 All other Medical Education	0	8, 104, 725	0. 00000	1, 809, 689	0	93. 00

Health Financial	Systems	ASCENSION ST. VINCE	NT FISHERS		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provi der CCN: 15-0181		Peri od:	Worksheet D-3	
					From 07/01/2021 To 06/30/2022	Date/Time Pre 11/21/2022 11	pared: :32 am
			Titl∈	XVIII	Hospi tal	PPS	
Cos	t 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	
	ROUTINE SERVICE COST CENTERS						
	LTS & PEDI ATRI CS				2, 430, 549		30. 00
1 1	ENSIVE CARE UNIT				0		31. 00
32. 00 03200 COR					0		32. 00
1 1	N INTENSIVE CARE UNIT				0		33. 00
34. 00 03400 SUR	GICAL INTENSIVE CARE UNIT				0		34. 00
43. 00 04300 NUR	SERY						43.00
ANCI LLARY	SERVICE COST CENTERS						
50. 00 05000 OPE	RATING ROOM			0. 10330	9 4, 073, 145	420, 793	50.00
51. 00 05100 REC	OVERY ROOM			0.00000	0 0	0	51.00
52 00 05200 DEL	IVERY ROOM & LABOR ROOM			0.33096	2 0	0	52 00

Health Financial Systems	ASCENSION ST. VINCENT FISHERS			In Lieu of Form CMS-2552-10			
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provi der Co		Peri od: From 07/01/2021	Worksheet D-3		
				To 06/30/2022	Date/Time Prep 11/21/2022 11:	pared: :32 am	
		Ti tl	e XIX	Hospi tal	Cost		
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		

	Title		Hospi tal	Cost	
Cost Center Description	R	Ratio of Cost	I npati ent	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					
30. 00 03000 ADULTS & PEDI ATRI CS			176, 932		30.00
31. 00 03100 I NTENSI VE CARE UNIT			0		31.00
32. 00 03200 CORONARY CARE UNIT			0		32.00
33. 00 03300 BURN INTENSIVE CARE UNIT			0		33.00
34. 00 03400 SURGI CAL I NTENSI VE CARE UNIT			0		34.00
43. 00 04300 NURSERY			2, 099		43.00
ANCI LLARY SERVI CE COST CENTERS					
50. 00 05000 OPERATI NG ROOM		0. 103309	471, 589	48, 719	50.00
51. 00 05100 RECOVERY ROOM		0.000000	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 330962	332, 526	110, 053	52.00
53. 00 05300 ANESTHESI OLOGY		0.000000	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 206837	6, 487	1, 342	54.00
54. 01 03630 ULTRA SOUND		0. 129264	2, 519	326	54. 01
56. 00 05600 RADI 0I SOTOPE		0.000000	0	0	56.00
56. 01 05601 0NCOLOGY		0. 267606	0	0	56. 01
57. 00 05700 CT SCAN		0. 179581	16, 449	2, 954	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0. 273760	1, 016	278	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0.000000	0	0	59.00
60. 00 06000 LABORATORY		0. 168257	168, 718	28, 388	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0.000000	0	0	62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0.000000	0	0	63.00
64. 00 06400 I NTRAVENOUS THERAPY		0.000000	0	0	64.00
65. 00 06500 RESPI RATORY THERAPY		0. 473196	18, 853	8, 921	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 462142	5, 399	2, 495	66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 353207	1, 607	568	67.00
68. 00 06800 SPEECH PATHOLOGY		0. 432918	0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY		0. 103540	13, 232	1, 370	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0.000000	0	0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 134415	118, 716	15, 957	71.00
72.00 07200 MPL. DEV. CHARGED TO PATIENTS		0. 367849	1, 058	389	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 399755	85, 644	34, 237	73.00
74. 00 07400 RENAL DI ALYSI S		0.000000	0	0	74.00
75. 00 07500 ASC (NON-DISTINCT PART)		0. 000000	0	0	75.00
OUTPAȚI ENT SERVI CE COST CENTERS					
91. 00 09100 EMERGENCY		0. 133867	117, 172	15, 685	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 507838	0	0	92.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)			1, 360, 985	271, 682	
201.00 Less PBP Clinic Laboratory Services-Program only charges	s (line 61)		0		201. 00
202.00 Net charges (line 200 minus line 201)			1, 360, 985		202. 00

Health Financial Systems	ASCENSION ST. VINCEN	NT FISHERS	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	F	Provider CCN: 15-0181	Peri od: From 07/01/2021 To 06/30/2022	Worksheet E Part A Date/Time Prepared: 11/21/2022 11:32 am

PARE A - INPATIENT HISPITIAL SERVICES UNDER IPPS 1.00			T1.11 >0.01.11		11/21/2022 11	: 32 am
No. DRR A - IMPATIBIT MOSPITAL SERVICES WIDER IPPS			Title XVIII	Hospi tal	PPS	
1.00 BisS Amounts other than outli er payments for discharges occurring prior to October 1 (see 7,0,922 1.00 1.					1. 00	
DRS amounts other than outlier payments for discharges occurring onto 10 botober 1 (see 750, 932 1.01						
1.02 BRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions) 1.02		DRG amounts other than outlier payments for discharges occurri	ng prior to October 1 (s	see		•
1.03 10 10 10 10 10 10 10	1. 02		ing on or after October	1 (see	1, 460, 817	1. 02
1.04 Oktober 1 (see Instructions) 2.00 Oktober 1 (see Instructions) 2.00 Oktion poyents for discharges (see Instructions) 0.00	1. 03		or discharges occurring p	orior to October	0	1. 03
2.00 Outlier payments for discharges, (see instructions)	1. 04		or discharges occurring (on or after	0	1. 04
2.01 Outlier resonabilitation amount 0 2.01	2. 00	, ,				2. 00
2.03 Outlier payments for discharges occurring prior to October 1 (see instructions) 0 2.04 Outlier payments for discharges occurring on an after October 1 (see instructions) 0 2.04 Outlier payments for discharges occurring on an after October 1 (see instructions) 0 3.00 Outlier payments for discharges occurring on an after October 1 (see instructions) 0 3.00 Outlier payments for disvaled by murber of days in the cost reporting period (see instructions) 0 3.00 Outlier payments and outlier payments are considered in the Cost of t					0	
2.04 Outlier payments for discharges occurring on or after October 1 (see instructions) 0 2.04		, ,	•		-	1
Managed Care Simulated Payments 3.5.08 4.08 24.58 4.00 8ed days available id vided by number of days in the cost reporting period (see instructions) 42.58 4.00					-	
Red days available divided by number of days in the cost reporting period (see instructions) 42.58 4.00		, ,	1 (see instructions)		-	1
Indirect Medical Education Adjustment		, ,	sting posied (occ instru	ationa)	-	
FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/19/96, (see instructions)	4.00		tring period (see riistru	zti ons)	43. 30	4.00
new programs in accordance with 42 CFR 413.79(e) 7.00 MA Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) if the cost cost report straddles July 1, 2011 then see instructions 7.01	5. 00	FTE count for allopathic and osteopathic programs for the mos	t recent cost reporting p	period ending on	0.00	5. 00
ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(1)(8)(2) If the cost report straddles July 1, 2011 then see instructions.	6. 00		ne criteria for an add-o	n to the cap for	0. 00	6. 00
cost report straddles July 1, 2011 then see instructions. 8. 00 All ustment (increase or decrease) to the FTE count for all opathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413, 75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50009 (August 1, 2002). 8. 01 The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions. 8. 02 The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost under § 5506 of ACA. (see Instructions) 8. 02 Instructions 9. 00 Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see 0.00 9.00 instructions) 9. 00 FTE count for all opathic and osteopathic programs in the current year from your records 9. 00 Current year allowable FTE (see Instructions) 9. 01 Current year allowable FTE (see Instructions) 9. 02 Current year allowable FTE count for the preparams in the current year from your records 9. 00 11.00 Total all owable FTE count for the preparam in the current year from your records 9. 00 12. 00 Current year allowable FTE count for the preparam in the current year from your records 9. 00 12. 00 Total all owable FTE count for the preparam in the current year from your records 9. 00 12. 00 Total allowable FTE count for the preparam in the current year from your records 9. 00 12. 00 Total allowable FTE count for the preparam in the current year from your records 9. 00 12. 00 Total allowable FTE count for the preparam in the current year from your records 9. 00 12. 00 Total allowable FTE count for the preparam in the current year from your records 9. 00 12. 00 Total allowable FTE count for the preparam in the current year from your records 9. 00 12. 00 Total allowable TTE Count for the preparam in the current year from your records 9. 00 12. 00 Total allowable TTE count for the preparam in the current year from your records 9. 02 15. 00 Total allowable fTTE count for the preparam in the		l				•
affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50040 (August 1, 2002).		cost report straddles July 1, 2011 then see instructions.				
8. 01 The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions. 8. 02 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions) 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) 10. 00 FTE count for allopathic and osteopathic programs in the current year from your records 0. 00 10.	8.00	affiliated programs in accordance with 42 CFR 413.75(b), 413.			0.00	8.00
B. 02 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	8. 01	The amount of increase if the hospital was awarded FTE cap slo	ots under § 5503 of the A	ACA. If the cost	0. 00	8. 01
9.00 Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see 0.00 9.00 10.00 FTE count for all opathic and osteopathic programs in the current year from your records 0.00 10.00 11.00 12.00 Current year allowable FTE (see instructions) 0.00 12.00 13.00 13.00 14.0	8. 02	The amount of increase if the hospital was awarded FTE cap slo	ots from a closed teachin	ng hospital	0. 00	8. 02
10.00 FTE count for allopathic and osteopathic programs in the current year from your records 10.00 10	9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line	es (8, 8,01 and 8,02) (9	see	0. 00	9. 00
12.00 Current year allowable FTE (see instructions) 0.00 12.00 13.00 10.00	10.00	l	ent year from your record	ds	0.00	10. 00
13.00 Total allowable FTE count for the prior year. 0.00 13.00 14.00 Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, 0.00 14.00 14.00 14.00 15.00	11. 00	FTE count for residents in dental and podiatric programs.			0.00	11. 00
14.00						
Otherwise enter zero. Sum of lines 12 through 14 divided by 3. 0.00 15.00 16.00 16.00 16.00 16.00 17.00 Adj ustment for residents in initial years of the program 0.00 17.00 18.00 20.00		' '				1
15. 00 Sum of lines 12 through 14 divided by 3. 0. 00 15. 00 16. 00 16. 00 16. 00 17. 00 18. 00 19.	14. 00		ar ended on or after Sep	tember 30, 1997,	0.00	14.00
16. 00 Adjustment for residents in initial years of the program 0.00 16. 00 17. 00 Adjustment for residents displaced by program or hospital closure 0.00 17. 00 18. 00 Adjusted rolling average FTE count 0.00 18. 00 19. 00 Current year resident to bed ratio (see instructions) 0.000000 19. 00 20. 00 Prior year resident to bed ratio (see instructions) 0.000000 20. 00 21. 00 Enter the lesser of lines 19 or 20 (see instructions) 0.000000 21. 00 22. 01 IME payment adjustment (see instructions) 0.000000 22. 00 22. 01 IME payment adjustment - Managed Care (see instructions) 0.00 22. 01 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA 0.00 22. 01 23. 00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 25. 00 25. 00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 25. 00 26. 00 Resident to bed ratio (divide line 25 by line 4) 0.000000 27. 00 28. 01 IME payments adjustment factor. (see instructions) 0.28. 00	15 00				0.00	15 00
17.00 Adjustment for residents displaced by program or hospital closure 0.00 17.00 18.00 Adjusted rolling average FTE count 0.00 18.00 19.00 0.00 19.00 0.00 19.00 0.00 19.00 0.00 19.00 0.00 19.00 0.00 19.00 0.00 19.00 0.00 19.00 0.00 19.00 0.00 19.00 0.00 19.00 0.00 19.00 0.00 19.00 0.00 19.00 0.00 19.00 0.00 19.00 0.00 19.00 0.00 19.00 0.00 19.00 10.00 19.00 10.00 19.00 10.00 19.00 10.00 19.00 10.00 19.00 10.00 19.00 10.00 19.00 10.00 10.00 10.00 10.00 19.00 10.00						1
18. 00 Adjusted rolling average FTE count 0.00 18. 00 19. 00 Current year resident to bed ratio (line 18 divided by line 4). 0.000000 19. 00 20. 00 Prior year resident to bed ratio (see instructions) 0.000000 20. 00 21. 00 Enter the lesser of lines 19 or 20 (see instructions) 0.000000 21. 00 22. 00 IME payment adjustment (see instructions) 0.000000 22. 00 11 ME payment adjustment - Managed Care (see instructions) 0.000000 22. 00 12. 01 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA 0.000000 23. 00 23. 00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 0.00 23. 00 (f)(1)(iv)(C). 0.000000 24. 00 25. 00 16 the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 25. 00 25. 00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 25. 00 26. 00 Resident to bed ratio (divide line 25 by line 4) 0.000000 26. 00 27. 00 IME payments adjustment amount (see instructions) 0.000000 27. 00		, ,	sure			1
20.00 Prior year resident to bed ratio (see instructions) 0.000000 20.00 21.00 Enter the lesser of lines 19 or 20 (see instructions) 0.000000 21.00 0.000000 21.00 0.000000 21.00 0.000000 21.00 0.000000 22.00 0.000000 21.00 0.000000 22.00 0.0000000 0.00000000	18.00	Adjusted rolling average FTE count			0.00	18. 00
21.00 Enter the lesser of lines 19 or 20 (see instructions) 22.00 IME payment adjustment (see instructions) 1 IME payment adjustment - Managed Care (see instructions) 1 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA 23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 24.00 IME FTE Resident Count Over Cap (see instructions) 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 28.00 IME add-on adjustment amount (see instructions) 29.00 IME add-on adjustment amount (see instructions) 20.00 IME payment (sum of lines 22 and 28) 29.01 Total IME payment (sum of lines 22 and 28) 29.01 Total IME payment - Managed Care (see instructions) 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 30.00 Sum of lines 30 and 31 Allowable disproportionate share percentage (see instructions) 4.48 33.00	19. 00	Current year resident to bed ratio (line 18 divided by line 4)).			
22.00 IME payment adjustment (see instructions) 1 IME payment adjustment - Managed Care (see instructions) 1 IME payment adjustment - Managed Care (see instructions) 1 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA 23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 24.00 IME FTE Resident Count Over Cap (see instructions) 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 10.00 25.00 instructions) 26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 28.01 IME add-on adjustment amount (see instructions) 29.00 Total IME payment (sum of lines 22 and 28) 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment 30.00 Sum of lines 30 and 31 31.00 Sum of lines 30 and 31 Allowable disproportionate share percentage (see instructions) 4.48 33.00		, , , , , , , , , , , , , , , , , , ,				
22. 01 IME payment adjustment - Managed Care (see instructions)						
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 24.00 IME FTE Resident Count Over Cap (see instructions) 10.00 24.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 25.00 instructions) 26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 28.00 IME payments adjustment factor. (see instructions) 29.00 IME add-on adjustment amount (see instructions) 20.00 IME add-on adjustment amount (see instructions) 20.00 IME add-on adjustment amount - Managed Care (see instructions) 20.00 IME payment (sum of lines 22 and 28) 20.00 ITotal IME payment (sum of lines 22 and 28) 20.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment 20.00 Sum of lines 30 and 31 20.00 Sum of lines 30 and 31 21.00 Allowable disproportionate share percentage (see instructions) 21.00 Allowable disproportionate share percentage (see instructions) 22.00 Allowable disproportionate share percentage (see instructions) 23.00 Allowable disproportionate share percentage (see instructions)						
Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 23.00 (f)(1)(iv)(C). 24.00 IME FTE Resident Count Over Cap (see instructions) 1 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 1 Imes payments adjustment factor. (see instructions) 26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 28.00 IME add-on adjustment amount (see instructions) 29.00 Total IME payment (sum of lines 22 and 28) 29.00 Total IME payment (sum of lines 22 and 28) 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment 30.00 Percentage of Medicaid patient days (see instructions) 31.00 Sum of lines 30 and 31 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 4.48 33.00	22. 01		2 of the MMA		0	22.01
24.00 IME FTE Resident Count Over Cap (see instructions) 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 28.00 IME add-on adjustment amount (see instructions) 28.01 IME add-on adjustment amount - Managed Care (see instructions) 29.00 IME add-on adjustment amount - Managed Care (see instructions) 29.01 Total IME payment (sum of lines 22 and 28) 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 29.01 Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31.00 Percentage of Medicaid patient days (see instructions) 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 4.48 33.00	23. 00	Number of additional allopathic and osteopathic IME FTE reside		FR 412. 105	0. 00	23. 00
25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 25.00 instructions) Resident to bed ratio (divide line 25 by line 4) 1ME payments adjustment factor. (see instructions) 1ME add-on adjustment amount (see instructions) 1ME add-on adjustment amount - Managed Care (see instructions) 28.00 IME add-on adjustment amount - Managed Care (see instructions) 1ME add-on adjustment amount - Managed Care (see instructions) 1 Total IME payment (sum of lines 22 and 28) 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment 20.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 1 1.28 30.00 31.00 Sum of lines 30 and 31 32.00 Allowable disproportionate share percentage (see instructions) 4.48 33.00	24. 00	` , ` , ` , ` ,			0.00	24. 00
26.00 Resident to bed ratio (divide line 25 by line 4) 0.000000 26.00 27.00 IME payments adjustment factor. (see instructions) 0.000000 27.00 28.00 IME add-on adjustment amount (see instructions) 0 28.00 28.01 IME add-on adjustment amount - Managed Care (see instructions) 0 28.01 29.00 Total IME payment (sum of lines 22 and 28) 0 29.00 29.01 Disproportionate Share Adjustment 29.01 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 1.28 30.00 31.00 Percentage of Medicaid patient days (see instructions) 16.76 31.00 32.00 Sum of lines 30 and 31 18.04 32.00 33.00 Allowable disproportionate share percentage (see instructions) 4.48 33.00	25. 00	If the amount on line 24 is greater than -O-, then enter the	ower of line 23 or line	24 (see		1
27.00 IME payments adjustment factor. (see instructions) 0.000000 27.00 28.00 IME add-on adjustment amount (see instructions) 0.28.00 28.01 IME add-on adjustment amount - Managed Care (see instructions) 0.28.01 29.00 Total IME payment (sum of lines 22 and 28) 0.29.00 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 0.00 Disproportionate Share Adjustment 9.00 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 1.28 30.00 31.00 Percentage of Medicaid patient days (see instructions) 16.76 31.00 32.00 Sum of lines 30 and 31 18.04 32.00 33.00 Allowable disproportionate share percentage (see instructions) 4.48 33.00	26. 00				0. 000000	26. 00
28.01 IME add-on adjustment amount - Managed Care (see instructions) 0 28.01 29.00 Total IME payment (sum of lines 22 and 28) 0 29.00 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 0 29.01 Disproportionate Share Adjustment 0 29.01 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 1.28 30.00 31.00 Percentage of Medicaid patient days (see instructions) 16.76 31.00 32.00 Sum of lines 30 and 31 18.04 32.00 33.00 Allowable disproportionate share percentage (see instructions) 4.48 33.00	27.00				0.000000	27. 00
29.00 Total IME payment (sum of lines 22 and 28) 0 29.00 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 0 29.01 Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 1.28 30.00 Percentage of Medicaid patient days (see instructions) 16.76 31.00 Sum of lines 30 and 31 18.04 32.00 Allowable disproportionate share percentage (see instructions) 4.48 33.00	28.00	IME add-on adjustment amount (see instructions)			0	28. 00
29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31. 00 Percentage of Medicaid patient days (see instructions) 32. 00 Sum of lines 30 and 31 33. 00 Allowable disproportionate share percentage (see instructions) 30. 01 Percentage of Medicaid patient days (see instructions) 31. 02 Sum of lines 30 and 31 32. 03 Allowable disproportionate share percentage (see instructions) 33. 00 Allowable disproportionate share percentage (see instructions))		0	
Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31.00 Percentage of Medicaid patient days (see instructions) 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 34.48 33.00						•
30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31.00 Percentage of Medicaid patient days (see instructions) 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 1.28 30.00 16.76 31.00 18.04 32.00 4.48 33.00	29. 01	· •	1)		0] 29. 01
31.00 Percentage of Medicaid patient days (see instructions) 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 16.76 31.00 18.04 32.00 4.48 33.00	30 00		atient days (see instruc	tions)	1 28	30.00
32.00 Sum of Lines 30 and 31 18.04 32.00 Allowable disproportionate share percentage (see instructions) 4.48 33.00			acronic days (see mistruc	1 0113)		1
33.00 Allowable disproportionate share percentage (see instructions) 4.48 33.00						1
34.00 Disproportionate share adjustment (see instructions) 24,772 34.00)			ı
	34.00	Disproportionate share adjustment (see instructions)			24, 772	34.00

ALCUI	n Financial Systems ASCENSION ST. VI LATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0181	Peri od:	Worksheet E	
			From 07/01/2021 To 06/30/2022	Part A Date/Time Pre 11/21/2022 11	
		Title XVIII	Hospi tal	PPS	. 32
			Prior to 10/1	On/After 10/1	
			1. 00	2. 00	
00	Uncompensated Care Adjustment		0.000.014.504	7 400 000 740	۱ ۵۰
. 00	,			7, 192, 008, 710	
. 01 . 02		ator zoro on this line) (s	0. 000152517 ee 1, 264, 365	l	
. 02	instructions)	itel zelo oli tilis i ille) (s	1, 204, 303	0/1, /62	33
. 03		amount (see instructions)	318, 690	502, 456	35
. 00			821, 146		36
	Additional payment for high percentage of ESRD beneficiary	discharges (lines 40 thro			
. 00	Total Medicare discharges (see instructions)		0		40
			Before 1/1 1.00	0n/After 1/1 1.01	
00	Total ESRD Medicare discharges (see instructions)		1.00		41
. 01	Total ESRD Medicare covered and paid discharges (see instru	uctions)	Ö		
. 00	Divide line 41 by line 40 (if less than 10%, you do not qua	•	0.00		42
. 00	Total Medicare ESRD inpatient days (see instructions)	,	0		43
. 00		ed by line 41 divided by 7	0. 000000		44
00	days)	>	0.00	0.00	
. 00 . 00	, ,	•	0.00	0.00	45
. 00		41.01)	3, 057, 667		47
. 00	Hospital specific payments (to be completed by SCH and MDH,	small rural hospitals	0,007,007		48
	only. (see instructions)				'
				Amount	
	T. I. C.			1.00	4.0
. 00	Total payment for inpatient operating costs (see instruction Payment for inpatient program capital (from Wkst. L, Pt. I	•	`	3, 057, 667 170, 463	
. 00		• • • • • • • • • • • • • • • • • • • •		170, 463	
. 00				Ö	
. 00	Nursing and Allied Health Managed Care payment	,		0	
. 00	Special add-on payments for new technologies			0	54
. 01	1 3			0	
. 00	, , , , , , , , , , , , , , , , , , , ,	•		0	
. 00 . 00	Cost of physicians' services in a teaching hospital (see in Routine service other pass through costs (from Wkst. D, Pt.	•	through 2E)	0	
. 00	, , ,		tili ougii 35).	0	
. 00	Total (sum of amounts on lines 49 through 58)			3, 228, 130	
. 00				12, 772	
. 00	Total amount payable for program beneficiaries (line 59 min	nus line 60)		3, 215, 358	6
. 00	1 3			293, 800	
. 00	1 3			5, 266	
. 00				25, 147	
. 00	, ,	nstructions)		16, 346 15, 192	
. 00		1311 4311 3113)		2, 932, 638	
. 00		or applicable to MS-DRGs (see instructions)	0	
. 00	Outlier payments reconciliation (sum of lines 93, 95 and 96	6).(For SCH see instruction	ns)	0	69
00				0	
50	, , , ,		instructions)	0	
. 87	Demonstration payment adjustment amount before sequestration			0	1
. 88 . 89	37			0	70
		•		0	
90	HSP bonus payment HRR adjustment amount (see instructions)	•		0	1
	, , , , , , , , , , , , , , , , , , , ,			Ö	1
. 91	pariar ca moder i ar scourt amount (see riisti acti ons)				
). 90). 91). 92). 93	· · · · · · · · · · · · · · · · · · ·			11, 076	70
. 91 . 92 . 93 . 94	HVBP payment adjustment amount (see instructions)			-2, 800	

11721/2072 11:32 as					o 06/30/2022	Date/Time Pre	
FFY (ywyy)			Title	XVIII	Hospi tal		: 32 alli
1.90 1.90							
the corresponding federal year for the period prior to 10/1) 70 97 [Low volume aglistement for rederal fiscal year (yyyy) (Enter in column 0 0 0 70, 97 70 97 [Low volume aglistement for rederal fiscal year (yyy)) (Enter in column 0 0 0 70, 97 70 98 [Mac Aglistment about (See Instructions) 11, 46 70 71 99 [Mac Aglistment about (See Instructions) 11, 46 70 71 99 [Mac Aglistment about (See Instructions) 11, 46 70 71 90 [Mac Aglistment about (See Instructions) 11, 46 70 71 90 [Mac Aglistment about (See Instructions) 12, 242 71.01 71 01 Sequestration and justment (See Instructions) 7, 24 71.01 71 02 Sequestration and justment face Instructions) 7, 27 71 03 Sequestration and justment Apparatus throughs 7, 27 72 07 [Inter in payments 8] 3, 045, 266 72 73 05 [Inter in payments 8] 3, 045, 266 72 74 06 [Mac Aglistment (For contractor use only) 7, 27 75 07 [Mac Aglistment Apparatus 8] 3, 045, 266 72 75 08 [Mac Aglistment Apparatus 8] 7, 27 76 08 [Mac Aglistment Apparatus 8] 7, 27 77 09 [Mac Aglistment Apparatus 8] 7, 27 78 09 [Mac Aglistment Apparatus 8] 7, 27 79 10 [Mac Aglistment Apparatus 8] 7, 27 70 [Mac Aglistment Apparatus 8] 7, 27 70 [Mac Aglistment Apparatus 8] 7, 27 71 09 [Mac Aglistment Apparatus 8] 7, 27 72 10 [Mac Aglistment Apparatus 8] 7, 27 73 10 [Mac Aglistment 8] 7, 27 74 10 [Mac Aglistment 8] 7, 27 75 10						1. 00	
Low volume adjustment for Tederal Fiscal year (yyyy) (Enter in column 0 0 0 70.77	70. 96		column 0)	0	70. 96
the corresponding Federal year for the period ending on or after 10/1) 70. 8 Low Volume Payment-1 9. 70. 80 Low Volume Payment-1 9. 70. 80 Low Volume Payment-1 9. 70. 90 Low Volume Payment-1 9. 70. 91 Low Payment 9. 70. 10 L	70 07		column 0		,	0	70 07
1.0 90 90 90 90 90 90 90	70. 97			']	U	70.97
11,499 9.99 7.99 HAC adjustment amount (see instructions) 1,499 9.99 7.90 7.00 Amount due provider (line 67 minus lines 69 & 70) 2,292,465 71.00 71.01 71.01 71.02 Penotration adjustment adjustment amount after sequestration 7.324 71.01 71.02 Penotration payments and justment amount after sequestration 7.324 71.01 71.03	70. 98		51 10/1)			0	70. 98
1.01 Sequestration adjustment (see instructions)						11, 469	
71.02 Demonstration payment adjustment amount after sequestration	71. 00	Amount due provider (line 67 minus lines 68 plus/minus lines 69	9 & 70)				
71.03 Sequestration adjustment-PARHM pass-throughs 7.03 7.03 7.07 7.00 Interim payments 3.045, 206 7.20 Interim payments 3.045, 206 7.20 1.00 7.20 7.20 1.00 7.20		1 '				7, 324	
1.0						0	
Interim payments-PARHM 772.01 773.00 Tentative settlement-PARHM (for contractor use only) 7.3.00 Tentative settlement-PARHM (for contractor use only) 7.3.00 7						2 045 207	
73.00 Tentative settlement (for contractor use only) 0 73.01 Tentative settlement -PARIM (for contractor use only) 73.01 Tentative settlement -PARIM (for contractor use only) 73.01		, , ,				3, 045, 206	
Tentative settlement-PARNM (for contractor use only)		1				0	
14.00 Bal ance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73.08) -123,085 74.00 74.01 7						O	
73			72, and			-123, 085	
75.00 Protested amounts (nonal lowable cost report items) in accordance with							
CMS Pub. 15-2, chapter 1, \$115.2 10 B COMPLETED BY CONTRACTOR (lines 90 through 96) 90.00 90.0	74. 01	Balance due provider/program-PARHM (see instructions)					
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LOW VOLUME CALCULATION EXHIBIT 4 Provider CCN: 15-0181 From 07/01/2021 Part A Exhibit 4 Date/Time Prepared: 06/30/2022 11/21/2022 11: 32 am Title XVIII Hospi tal Period Prior Total (Col 2 W/S E, Part A Amounts (from Pre/Post Peri od to 10/01 On/After 10/01 line Part A) Entitlement through 4) 0 1 00 2 00 3 00 4 00 5 00 1.00 DRG amounts other than outlier 1.00 1.00 1.01 DRG amounts other than outlier 1.01 750, 932 750, 932 750, 932 1.01 payments for discharges occurring prior to October 1 1 02 DRG amounts other than outlier 1 02 1, 460, 817 1, 460, 817 1, 460, 817 1 02 payments for discharges occurring on or after October DRG for Federal specific 1.03 0 1.03 1.03 operating payment for Model 4 BPCI occurring prior to October 1 1.04 DRG for Federal specific 1.04 1.04 operating payment for Model 4 BPCI occurring on or after October 1 Outlier payments for 2.00 2.00 2 00 discharges (see instructions) 2.01 Outlier payments for 2.02 2.01 discharges for Model 4 BPCI Outlier payments for 2.02 2.03 2.02 discharges occurring prior to October 1 (see instructions) 2.03 Outlier payments for 2.04 2.03 discharges occurring on or after October 1 (see instructions) 3.00 3.00 Operating outlier 2.01 reconciliation 4.00 Managed care simulated 3.00 C 4.00 payments Indirect Medical Education Adjustment 5.00 Amount from Worksheet E, Part 21.00 0.000000 0.000000 0.000000 0.000000 5.00 A, line 21 (see instructions) 0 6.00 IME payment adjustment (see 22.00 0 C 0 6.00 instructions) 6.01 IME payment adjustment for 22.01 C 6. 01 managed care (see instructions) Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 7.00 IME payment adjustment factor 27.00 0.000000 0.000000 0.000000 0.000000 7.00 (see instructions) 8.00 IME adjustment (see 28.00 8.00 instructions) IME payment adjustment add on 8.01 28.01 0 8.01 for managed care (see instructions) 9.00 Total IME payment (sum of 29.00 9.00 C lines 6 and 8) Total IME payment for managed 9.01 29.01 9.01 care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment 10.00 Allowable disproportionate 33 00 0.0448 0.0448 0.0448 0.0448 10.00 share percentage (see instructions) Di sproporti onate share 11.00 34.00 24, 772 24, 772 11.00 8, 411 16, 361 adjustment (see instructions) 11. 01 Uncompensated care payments 36.00 821, 146 318, 690 502, 456 821, 146 11.01 Additional payment for high percentage of ESRD beneficiary discharges Total ESRD additional payment 12.00 46.00 0 12.00 (see instructions) 13 00 47 00 3, 057, 667 1,078,033 1, 979, 634 3, 057, 667 Subtotal (see instructions) 13 00 Hospital specific payments 48.00 14.00 14.00 (completed by SCH and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient 15.00 49 00 3.057.667 Ω 1,078,033 1, 979, 634 3, 057, 667 15.00 operating costs (see instructions) Payment for inpatient program 50.00 170, 463 58, 694 111, 769 170, 463 16.00 capital (from Wkst. L, Pt. I, if applicable)

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LOW VOLUME CALCULATION EXHIBIT 4 Provider CCN: 15-0181 From 07/01/2021 Part A Exhibit 4 06/30/2022 Date/Time Prepared: 11/21/2022 11: 32 am Title XVIII Hospi tal W/S E, Part A Amounts (from Pre/Post Period Prior Total (Col 2 Peri od to 10/01 Part A) On/After 10/01 line Entitlement through 4) 4 00 0 1 00 2 00 3 00 5 00 17.00 Special add-on payments for 54.00 17.00 new technologies 17.01 Net organ aquisition cost 17.01 17.02 Credits received from 68.00 17.02 0 manufacturers for replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation 93.00 0 18.00 adjustment amount (see instructions) 19.00 SUBTOTAL 1, 136, 727 2, 091, 403 3, 228, 130 19.00 W/S L, line (Amounts from 0 1.00 2.00 3.00 4. 00 5. 00 Capital DRG other than outlier 20.00 1.00 170, 463 58, 694 111, 769 170, 463 20.00 Model 4 BPCI Capital DRG other 20.01 1 01 0 20.01 than outlier 21.00 Capital DRG outlier payments 2.00 0 0 0 21.00 Model 4 BPCI Capital DRG 21.01 2.01 21.01 outlier payments Indirect medical education 22 00 5.00 0.0000 0.0000 0.0000 0.0000 22.00 percentage (see instructions) 23.00 Indirect medical education 6.00 C 0 23.00 adjustment (see instructions) 24.00 Allowable disproportionate 10.00 0.0000 0.0000 0.0000 0.0000 24.00 share percentage (see instructions) 25.00 Di sproporti onate share 11.00 0 0 25.00 C 0 adjustment (see instructions) 26.00 Total prospective capital 12.00 170, 463 58, 694 111, 769 170, 463 26.00 payments (see instructions) W/S E, Part A (Amounts to E, line Part A) 5.00 2.00 3.00 4.00 0 1.00 27.00 Low volume adjustment factor 0.000000 0.000000 27.00 28.00 Low volume adjustment 70.96 28.00 (transfer amount to Wkst. E, Pt. A. line) Low volume adjustment 29.00 29.00 70.97 0 (transfer amount to Wkst. E, Pt. A, line) 100.00 Transfer low volume 100.00 adjustments to Wkst. E, Pt. A.

Provider CCN: 15-0181

Peri od:

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

From 07/01/2021 Part A Exhibit 5 Date/Time Prepared: 06/30/2022 11/21/2022 11: 32 am Hospi tal Title XVIII Period to Total (cols. 2 Wkst. E, Pt. Amt. from Peri od on 10/01 A. line Wkst. E, Pt. after 10/01 and 3) A) 2.00 3. 00 4. 00 0 1.00 1.00 DRG amounts other than outlier payments 1.00 1. 00 DRG amounts other than outlier payments for 1.01 1.01 750, 932 750, 932 750, 932 1.01 discharges occurring prior to October 1 DRG amounts other than outlier payments for 1.02 1, 460, 817 1, 460, 817 1.02 1, 460, 817 1.02 discharges occurring on or after October 1 1.03 DRG for Federal specific operating payment 1.03 C 1.03 0 for Model 4 BPCI occurring prior to October DRG for Federal specific operating payment 1.04 1.04 0 1.04 for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for discharges (see 2.00 2.00 instructions) 2.01 Outlier payments for discharges for Model 4 2.02 O 2.01 **BPCI** 2 02 Outlier payments for discharges occurring 2 03 O Ω 2 02 prior to October 1 (see instructions) Outlier payments for discharges occurring on 2.03 2.04 0 2.03 or after October 1 (see instructions) 3.00 Operating outlier reconciliation 2.01 0 3.00 Managed care simulated payments 4.00 3.00 0 4.00 Indirect Medical Education Adjustment 5.00 Amount from Worksheet E, Part A, line 21 21.00 0.000000 0.000000 0.000000 5.00 (see instructions) IME payment adjustment (see instructions) 6.00 22.00 0 0 0 6.00 IME payment adjustment for managed care (see 0 6.01 22.01 0 0 6.01 instructions) Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 7.00 IME payment adjustment factor (see 27. 00 0.000000 0.000000 0.000000 7.00 instructions) 8 00 IME adjustment (see instructions) 28 00 8 00 0 0 0 0 8.01 IME payment adjustment add on for managed 28.01 0 0 8.01 care (see instructions) Total IME payment (sum of lines 6 and 8) 29.00 9.00 C 0 9.00 Total IME payment for managed care (sum of 9.01 29.01 C 0 9.01 lines 6.01 and 8.01) Disproportionate Share Adjustment 10.00 Allowable disproportionate share percentage 33.00 0.0448 0.0448 0.0448 10.00 (see instructions) 11.00 Disproportionate share adjustment (see 34.00 24.772 8.411 16, 361 24.772 11.00 instructions) 11.01 Uncompensated care payments 36, 00 821, 146 318, 690 502, 456 821, 146 11.01 Additional payment for high percentage of ESRD beneficiary discharges 12.00 Total ESRD additional payment (see 46. 00 12.00 instructions) 47.00 13 00 3, 057, 667 1, 078, 033 1, 979, 634 3, 057, 667 Subtotal (see instructions) 13 00 14.00 Hospital specific payments (completed by SCH 48.00 14.00 and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs 49.00 3, 057, 667 1, 078, 033 1, 979, 634 3, 057, 667 15.00 15.00 (see instructions) 16.00 Payment for inpatient program capital (from 50 00 170, 463 58, 694 170, 463 16.00 111, 769 Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for new technologies 54.00 17.00 C 17.01 Net organ acquisition cost 17.01 Credits received from manufacturers for 68.00 0 17.02 17.02 0 replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment 93.00 0 18.00 amount (see instructions) 19.00 **SUBTOTAL** 1, 136, 727 2, 091, 403 3, 228, 130 19.00

Health Financial Systems	ASCENSION ST. VINC	ENT FISHERS	In Lie	u of Form CMS-2552-10
HOSPITAL ACQUIRED CONDITION (HAC)	REDUCTION CALCULATION EXHIBIT 5	Provider CCN: 15-0181		Worksheet E

06/30/2022 Date/Time Prepared: 11/21/2022 11:32 am Title XVIII Hospi tal PPS Wkst. L, line (Amt. from L) Wkst. 2.00 3. 00 4.00 n 1 00 20.00 Capital DRG other than outlier 1.00 170, 463 58, 694 111, 769 170, 463 20.00 20.01 Model 4 BPCI Capital DRG other than outlier 1.01 20.01 21.00 Capital DRG outlier payments 2.00 0 0 21.00 21.01 Model 4 BPCI Capital DRG outlier payments 2.01 21.01 0 0 0 22.00 Indirect medical education percentage (see 5.00 0.0000 0.0000 0.0000 22.00 instructions) 23. 00 23.00 Indirect medical education adjustment (see 6.00 instructions) 0.0000 0.0000 0.0000 24.00 24.00 Allowable disproportionate share percentage 10 00 (see instructions) 25.00 Disproportionate share adjustment (see 11.00 0 25.00 instructions) Total prospective capital payments (see 12.00 170, 463 58, 694 111, 769 170, 463 26.00 instructions) Wkst. E, Pt. (Amt. from Wkst. E, Pt. A, line 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 28.00 29.00 Low volume adjustment on or after October 1 70.97 29.00 HVBP payment adjustment (see instructions) 70. 93 11, 076 11, 076 0 11, 076 30.00 30.00 HVBP payment adjustment for HSP bonus 30.01 70.90 0 30.01 payment (see instructions) 70.94 31.00 HRR adjustment (see instructions) -2,800 -901 -1, 899 -2, 800 31.00 31.01 HRR adjustment for HSP bonus payment (see 70. 91 31.01 instructions) (Amt. to Wkst. Pt. A) Ε. 3.00 0 1.00 2.00 4.00 32.00 HAC Reduction Program adjustment (see 70.99 11, 469 11, 469 32.00 instructions) 100.00 Transfer HAC Reduction Program adjustment to 100.00 Υ Wkst. E, Pt. A.

Health Financial Systems	ASCENSION ST. VINCENT FISHERS	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0181	Peri od: From 07/01/2021 To 06/30/2022	Worksheet E Part B Date/Time Prepared: 11/21/2022 11:32 am

NATE NOTE AL ADD OTHER MEATH SERVICES 1.00			Title XVIII	Hospi tal	11/21/2022 11 PPS	:32 am
Note				1.0001 tai		
		DADT D. MEDICAL AND OTHER HEALTH CERVICES			1. 00	
	1 00				381	1 00
3.1.05 DPS payments						
0.11 0.11						1
Enter the hospital specific payment to cost ratio (see instructions)	4.00	Outlier payment (see instructions)			31, 495	4. 00
Line 2 times Line 5 0 0.00		, , , , , , , , , , , , , , , , , , ,				
2.00 Sum of lines 3, 4, and 4.01, divided by line 6 0.00 7.00)			1
Transit lonal corridor payment (see Instructions) 0 8.00 0.00						1
Ancil lary service other pass through costs from West. D. Pt. 1V, col. 13, line 200 0,000 0,000 10,000						1
10.00 Organ acquisitions 0 10.00			13 line 200			1
1.0 Total cost (sum of lines 1 and 10) (see Instructions) 30 11.00			. 13, Title 200		_	
Reasonable charges		9 1				1
12.00 Ancillary service charges 754 12.00 13.00 Organ acquisition charges (From Wist. D-4, Pt. 111, col. 4, line 69) 0.13.00 0.13.		COMPUTATION OF LESSER OF COST OR CHARGES]
13.00 Organ acquisition chargées (from Wist. D-4, Pt. III. col. 4, line 69) 0 13.00						1
14.00 Total reasonable charges (sum of lines 12 and 13) 25.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 15.00 Aggregate amount actually collected from patients liable for payment for services on a chargebasis 0 15.00 16.00 Aggregate amount actually collected from patients liable for payment for services on a chargebasis 0 15.00 16.0						1
Distorary_charges			1			1
15.00 Aggregate amount actually collected from patients Hable for payment for services on a charge basis 0 15.00	14.00				954	14.00
16.00 Amounts that would have been realized from patients liable for payment for services on a chargebasis 0 16.00 17.00 1	15 00		t for services on a	charge basis	0	15 00
had such payment been made in accordance with 42 CFR §413.13(e)						
18.00 Total customary charges (see instructions) 954 18.00 1				3		
19.00 Excess of customarry charges over reasonable cost (complete only if line 18 exceeds line 11) (see 573 19.00 Instructions) 20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see 0 20.00 20.	17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17. 00
Instructions		y y				1
20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions) 20.00	19. 00		ine 18 exceeds lir	ne 11) (see	573	19.00
Instructions 331 21.00	20.00	· · · · · · · · · · · · · · · · · · ·	lino 11 ovecode liu	20 10) (600	0	20.00
21.00 Lesser of cost or charges (see instructions) 33 21.00 22.00 23.00 Cost of physicians' services in a teaching hospital (see instructions) 0.23.00 23.00 24.00 Total prospective payment (sum of lines 3.4, 4.01, 8 and 9) 4,790,072 24.00 25.00 Cost of physicians' services in a teaching hospital (see instructions) 25.00 25.00 26	20.00		THE TI EXCEEUS ITI	ie 10) (see	U	20.00
23.00 Cost of physicians' services in a teaching hospital (see instructions) 2.3.00 23.00 24.00 Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) 4,790,072 24.00 24.00 COMPUTATION OF RELIMBURSEMENT SETTLEMENT 25.00 Deducti Dies and col insurance amounts (for CAH, see instructions) 802,290 26.00 26.00 Deducti Dies and col insurance amounts relating to amount on Line 24 (for CAH, see instructions) 802,290 26.00 27.00 Deducti Dies and Col insurance amounts relating to amount on Line 24 (for CAH, see instructions) 802,290 26.00 27.00 Instructions 27.00 Direct graduate medical education payments (from Wkst. E-4, Line 50) 0 28.00 29.00 28.00 Direct graduate medical education costs (from Wkst. E-4, Line 36) 0 29.00 28.00 29.00 28.00 Direct graduate medical education costs (from Wkst. E-4, Line 36) 0 29.00 28.00 29.00 29.00 28.00 29.00 29.00 28.00 29.00 2	21. 00				381	21. 00
24. 00 Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) 4, 790,072 24. 00	22.00	Interns and residents (see instructions)			0	22. 00
COMPUTATION OF REIMBURSEMENT SETILEMENT	23. 00	Cost of physicians' services in a teaching hospital (see instruction	ıs)		0	23. 00
25.00 Deductibles and coinsurance amounts (for CAH, see instructions) 0.0 25.00	24. 00				4, 790, 072	24. 00
26. 00 Deductible sand Colinsurance amounts relating to amount on line 24 (for CAH, see instructions) 802,290 26. 00 27. 00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions) 3,988,163 27. 00 28. 00 Direct graduate medical education payments (from Wkst. E-4, line 50) 0 28. 00 29. 00 Subtotal (sum of lines 27 through 29) 3,988, 63 0.00 30. 00 Subtotal (line 30 minus line 31) 313 31. 00 30. 00 Subtotal (line 30 minus line 31) 0 3,988, 032 32. 00 30. 00 Composite rate ESR0 (from Wkst. I -5, line 11) 0 33. 00 33. 00 30. 00 All owable bad debts (see instructions) 55. 364 34. 00 30. 00 Alj usted reimbursable bad debts (see instructions) 35. 00 30. 00 MSP-LCC reconcilitation amount from PS&R 4,024,019 30. 00 MSP-LCC reconcilitation amount before sequestration 39. 50 30. 97 Pomonstration payment adjustment see instructions) 39. 90 90. 00 The RADUSINEMENTS (SEE InSTRUCTIONS) (SPECIFY) 39. 90 <t< td=""><td>05.00</td><td></td><td></td><td></td><td></td><td>05.00</td></t<>	05.00					05.00
27. 00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see 3,988,163 27. 00 1 1 1 1 1 1 1 1 1			for CAU soo instri	ictions)		
Instructions 28.00 29.00 ESRD direct medical education costs (from Wkst. E-4, line 50) 0.0 28.00 29.00 ESRD direct medical education costs (from Wkst. E-4, line 36) 0.0 29.00 2						
29.00 ESRD direct medical education costs (from Wkst. E-4, line 36) 0 29.00 3.988.163 30.00 3.00 3.00 3.988.103 3.988.103 3.100 7 primary payer payments 131 31.00 32.00 3.988.032 32.00 3	27.00	= '	10 04 01 111100 22	aa 20] (000	37 7337 133	27.00
30. 00 Subtotal (sum of lines 27 through 29) 3, 988, 163 30. 00 Primary payer payments 31 31. 00 32. 00 Subtotal (line 30 minus line 31) 31. 00 33. 00 Subtotal (line 30 minus line 31) 33. 00 Subtotal (line 30 minus line 31) 33. 00 Subtotal (line 30 minus line 31) 0. 00 0. 0	28. 00	Direct graduate medical education payments (from Wkst. E-4, line 50))		0	28. 00
131 31 00 20 20 20 20 20 20	29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29. 00
Subtotai (i ine 30 minus line 31) 3,988,032 32.00		,				1
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 0 0 0 0 0 0 0 0 0						1
33.00 Composite rate ESRD (From Wkst. I - 5, line 11)	32.00				3, 988, 032	32.00
34.00	33 00				0	33 00
35.00						1
36.00 Al Jowable bad debts for dual eligible beneficiaries (see instructions) 28,930 36.00 37.00 Subtotal (see instructions) 4,024,019 37.00 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.50 39.97 Demonstration payment adjustment amount before sequestration 0 39.97 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.99 40.00 Subtotal (see instructions) 4,024,019 39.99 40.01 Sequestration adjustment (see instructions) 10,060 40.01 40.02 Demonstration payment adjustment amount after sequestration 0 40.02 40.03 Sequestration adjustment (see instructions) 10,060 40.01 41.00 Interim payments 3,979,049 41.00 41.01 Interim payments 3,979,049 41.01 41.01 Tentative settlement (for contractors use only) 0 42.00 42.01 Tentative settlement (for contractors use only) 34.00 43.00 Balance due provider/program (see instructions) 34.00 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 515.2 710 BE COMPLETED BY CONTRACTOR 44.00 <tr< td=""><td></td><td>· · · · · · · · · · · · · · · · · · ·</td><td></td><td></td><td></td><td>1</td></tr<>		· · · · · · · · · · · · · · · · · · ·				1
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39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.98 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.98 39.99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 40.00 39.90 40.00 39.90 40.00 39.90 40.00 39.90 40.00 40					4, 024, 019	37. 00
39.50 Pi oneer ACO demonstration payment adjustment (see instructions) 39.50 39.97 39.97 39.98 39.98 39.98 39.99 30.99 3						
39. 97 Demonstration payment adjustment amount before sequestration 0 39. 97 39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39. 98 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 0 39. 99 40. 00 Subtotal (see instructions) 4,024,019 40. 00 40. 01 Sequestration adjustment (see instructions) 10,060 40. 01 40. 02 Demonstration payment adjustment amount after sequestration 0 40. 02 40. 03 Sequestration adjustment-PARHM pass-throughs 0 40. 03 41. 01 Interim payments 3, 979, 049 41. 00 41. 01 Interim payments-PARHM 41. 00 41. 00 42. 01 Tentative settlement (for contractors use only) 0 42. 00 43. 00 Bal ance due provider/program (see instructions) 34, 910 43. 00 43. 01 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 0 40. 00 5115. 2 To BE COMPLETED BY CONTRACTOR 0 90. 00 91. 00 90. 00 Outlier reconciliation adjustment amount (see instructions)					0	
39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39. 98 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 0 39. 99 40. 00 Subtotal (see instructions) 4, 024, 019 40. 00 40. 01 Sequestration adjustment (see instructions) 10, 060 40. 01 40. 02 Demonstration payment adjustment amount after sequestration 0 40. 02 40. 03 Sequestration adjustment-PARHM pass-throughs 40. 03 41. 00 Interim payments 3, 979, 049 41. 00 41. 01 Interim payments-PARHM 41. 00 41. 01 42. 00 Tentative settlement (for contractors use only) 0 42. 00 43. 01 Bal ance due provider/program (see instructions) 34. 910 43. 00 43. 01 Bal ance due provider/program (see instructions) 34. 00 44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44. 00 91. 00 Original outlier amount (see instructions) 0 90. 00 90. 00 The rate used to calculate the Time Value of Money 0. 00 92. 00 <td></td> <td></td> <td></td> <td></td> <td></td> <td>1</td>						1
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40. 03 Sequestration adjustment-PARHM pass-throughs 40. 03 41. 00 41. 00 41. 01 Interim payments 41. 01 Interim payments 42. 01 Tentative settlement (for contractors use only) 42. 01 Tentative settlement-PARHM (for contractor use only) 42. 01 43. 00 Balance due provider/program (see instructions) 34, 910 43. 00 43. 01 Balance due provider/program-PARHM (see instructions) 43. 01 44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44. 00 91. 00 00						1
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42.01 Tentative settlement-PARHM (for contractor use only) 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 43.01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, TO BE COMPLETED BY CONTRACTOR 90.00 Outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 42.01 42.01 42.01 42.01 62.01 63.00 63.00 63.00 63.00 64.00 64.00 64.00 65.00 66.00 67.						41. 01
43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 43.01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 34,910 43.00 43.01 43.00 90.00 91.00 92.00					0	1
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90.00Original outlier amount (see instructions)090.0091.00Outlier reconciliation adjustment amount (see instructions)091.0092.00The rate used to calculate the Time Value of Money0.0092.00		TO BE COMPLETED BY CONTRACTOR				
92.00 The rate used to calculate the Time Value of Money 0.00 92.00		Original outlier amount (see instructions)				
		· · · · · · · · · · · · · · · · · · ·				
93.00 TITINE VALUE OF MONEY (See INSTRUCTIONS)		· · · · · · · · · · · · · · · · · · ·				
94. 00 Total (sum of lines 91 and 93)						1
71. 00 10 tal. (Sum of 111105 71 and 70)	74.00	Total (Sam Of Times /1 and /0)			0	1 /4.00

Health Financial Systems	ASCENSION ST. VINC	ENT FISHERS	In Lie	u of Form CMS	-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT			Worksheet E		
			From 07/01/2021		
			To 06/30/2022	Date/Time Pr	epared:
				11/21/2022 1	1:32 am
		Title XVIII	Hospi tal	PPS	
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days				(0 200. 00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-0181 Peri od: Worksheet E-1 From 07/01/2021 Part I 06/30/2022 Date/Time Prepared: 11/21/2022 11:32 am Title XVIII Hospi tal PPS Part B Inpatient Part A mm/dd/yyyy mm/dd/yyyy Amount Amount 1.00 2.00 3.00 4.00 1.00 Total interim payments paid to provider 3, 045, 206 3, 979, 049 1. 00 2.00 Interim payments payable on individual bills, either 2.00 submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 3.00 List separately each retroactive lump sum adjustment 3.00 amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3.01 ADJUSTMENTS TO PROVIDER 0 0 3.01 0 3.02 0 3.02 3.03 0 3.03 0 3.04 0 0 3.04 3.05 0 0 3.05 Provider to Program 3.50 ADJUSTMENTS TO PROGRAM 0 0 3.50 3.51 0 3.51 0 0 3.52 3.52 3.53 0 3.53 0 0 3.54 0 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 0 Ω 3.99 3.50-3.98) 3, 045, 206 3, 979, 049 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropri ate) TO BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after 5.00 desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 TENTATIVE TO PROVIDER 0 0 5.01 5.02 0 0 5.02 0 5.03 0 5.03 Provider to Program 5.50 TENTATI VE TO PROGRAM 0 0 5.50 5.51 0 0 5. 51 0 5.52 0 5.52 0 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 0 5.99 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on 6.00 the cost report. (1)

34, 910

4, 013, 959

NPR Date (Mo/Day/Yr)

2 00

123, 085

Contractor

Number

1 00

2, 922, 121

0

6.01

6.02

7.00

8.00

SETTLEMENT TO PROVIDER

Total Medicare program liability (see instructions)

SETTLEMENT TO PROGRAM

8.00 Name of Contractor

6.01

6 02

7.00

Heal th	Financial Systems ASCENSION ST. VINC	CENT FISHERS	Inlie	u of Form CMS-	2552-10
	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-0181 Period: From 07/01/2021 To 06/30/2022 Period: From 07/01/2021 Period:				
		Title XVIII	Hospi tal	PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				1
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				4
1. 00	Total hospital discharges as defined in AARA §4102 from Wkst.	The state of the s			1. 00
2.00	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, and	8 through 12, and plus f	or cost		2. 00
	reporting periods beginning on or after 10/01/2013, line 32)				
3. 00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3. 00
4.00	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines	1, and 8 through 12, and	plus for cost		4. 00
	reporting periods beginning on or after 10/01/2013, line 32)				
5. 00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5. 00
6. 00	Total hospital charity care charges from Wkst. S-10, col. 3 l				6. 00
7. 00	CAH only - The reasonable cost incurred for the purchase of c line 168	ertified HIT technology	Wkst. S-2, Pt. I		7. 00
8.00	Calculation of the HIT incentive payment (see instructions)				8.00
9. 00	Sequestration adjustment amount (see instructions)				9.00
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00
10.00	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH	(See That detrons)			10.00
30 00	Initial/interim HIT payment adjustment (see instructions)				30.00
	Other Adjustment (specify)				31. 00
	Balance due provider (line 8 (or line 10) minus line 30 and l	ine 31) (see instruction	s)		32. 00
			•		

Health Financial Systems	ASCENSION ST. VINCENT FI	SHERS	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi	der CCN: 15-0181	Peri od: From 07/01/2021 To 06/30/2022	Worksheet E-3 Part VII Date/Time Prepared: 11/21/2022 11:32 am

			Го 06/30/2022	Date/Time Prep 11/21/2022 11	
		Title XIX	Hospi tal	Cost	
			Inpatient	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVI	CES FOR TITLES V OR XIX	SERVI CES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		407, 882		1. 00
2.00	Medical and other services			270, 615	2. 00
3.00	Organ acquisition (certified transplant centers only)		0		3. 00
4.00	Subtotal (sum of lines 1, 2 and 3)		407, 882	270, 615	4. 00
5.00	Inpatient primary payer payments		0		5. 00
6.00	Outpatient primary payer payments			0	6. 00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		407, 882	270, 615	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges				
8.00	Routi ne servi ce charges		0		8. 00
9.00	Ancillary service charges		1, 360, 985	1, 292, 976	9. 00
10.00	Organ acquisition charges, net of revenue		0		10.00
11. 00	Incentive from target amount computation		0		11. 00
12.00	Total reasonable charges (sum of lines 8 through 11)		1, 360, 985	1, 292, 976	12. 00
	CUSTOMARY CHARGES				
13. 00	Amount actually collected from patients liable for payment for s	services on a charge	0	0	13. 00
	basis				
14. 00	Amounts that would have been realized from patients liable for p		0	0	14. 00
45.00	a charge basis had such payment been made in accordance with 42	CFR §413. 13(e)			45.00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	
16.00	Total customary charges (see instructions)	. 6 1 . 4	1, 360, 985	1, 292, 976	16. 00
17. 00	Excess of customary charges over reasonable cost (complete only	IT line 16 exceeds	953, 103	1, 022, 361	17. 00
10.00	line 4) (see instructions) Excess of reasonable cost over customary charges (complete only	if line 4 evenede line	0	0	10 00
18. 00	16) (see instructions)	II Time 4 exceeds Time	٩	U	18. 00
19. 00	Interns and Residents (see instructions)		0	0	19. 00
20. 00	Cost of physicians' services in a teaching hospital (see instruc	ctions)		0	20.00
21. 00	Cost of covered services (enter the lesser of line 4 or line 16)		407, 882	270, 615	
21.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be co			270, 013	21.00
22. 00	Other than outlier payments	mpreted for 113 provide	0	0	22. 00
	Outlier payments			0	23. 00
24. 00	Program capital payments			O	24. 00
25. 00					25. 00
	Routine and Ancillary service other pass through costs		0	0	26. 00
	Subtotal (sum of lines 22 through 26)		0	0	27. 00
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	28. 00
	Titles V or XIX (sum of lines 21 and 27)		407, 882	270, 615	
27.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		1077 002	2,0,010	27.00
30. 00	Excess of reasonable cost (from line 18)		0	0	30. 00
31. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		407, 882	270, 615	
32. 00	Deducti bl es		0	0	32. 00
33. 00	Coinsurance		0	0	33. 00
34. 00			0	0	34. 00
35. 00			0	_	35. 00
36. 00			407, 882	270, 615	
37. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37. 00
38. 00	, , , ,		407, 882	270, 615	
	Direct graduate medical education payments (from Wkst. E-4)		0	.,	39. 00
40. 00			407, 882	270, 615	
41. 00			407, 882	270, 615	
42. 00	Balance due provider/program (line 40 minus line 41)		0	0	42. 00
43. 00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub 15-2.	o	0	43. 00
	chapter 1, §115.2				
				'	•

Health Financial Systems ASCENSION ST.

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

Provider CCN: 15-0181

Peri od: From 07/01/2021 To 06/30/2022 Worksheet G Date/Ti me Prepared: 11/21/2022 11:32 am

oni y)			'	007 007 2022	11/21/2022 11	: 32 am
		General Fund	Speci fi c	Endowment Fund		
		1.00	Purpose Fund 2.00	3. 00	4. 00	
-	CURRENT ASSETS					
1.00	Cash on hand in banks	1, 396		0	0	1
2. 00 3. 00	Temporary investments	0			0	
4. 00	Notes recei vabl e Accounts recei vabl e	24, 183, 519	1		0	
5. 00	Other recei vable	24, 103, 317			Ö	
6. 00	Allowances for uncollectible notes and accounts receivable	-12, 202, 920		o o	Ō	
7.00	Inventory	1, 579, 502	2	0	0	
8.00	Prepai d expenses	0	(0	0	
9.00	Other current assets	1, 963, 351		0	0	
10.00	Due from other funds Total current assets (sum of lines 1-10)	15 504 040		0	0	1
11. 00	FIXED ASSETS	15, 524, 848		J _I U	0	11. 00
12. 00	Land	10, 871, 320		0	0	12. 00
13.00	Land improvements	237, 563		0	0	
14.00	Accumulated depreciation	-43, 742	2	0	0	14. 00
15. 00	Bui I di ngs	45, 069, 250	1	0	0	
16.00	Accumulated depreciation	-13, 878, 472	1	0	0	1
17. 00 18. 00	Leasehold improvements	853, 803	1	1 "	0 0	
19. 00	Accumulated depreciation Fixed equipment	-853, 803 3, 560, 245	1	1	0	
20. 00	Accumulated depreciation	-2, 529, 097	1		0	
21. 00	Automobiles and trucks	0	1	o o	Ö	
22.00	Accumul ated depreciation	O		0	0	
23. 00	Maj or movable equipment	23, 559, 193	(0	0	23. 00
24.00	Accumulated depreciation	-18, 489, 088	3	0	0	
25. 00	Mi nor equi pment depreci abl e	0)	0	0	
26. 00	Accumulated depreciation	0		0	0	
27. 00 28. 00	HIT designated Assets Accumulated depreciation	0			0	
29. 00	Mi nor equi pment-nondepreci abl e		1			
30. 00	Total fixed assets (sum of lines 12-29)	48, 357, 172	1			
	OTHER ASSETS	,				
31. 00	Investments	5, 825	(0	-	
32.00	Deposits on Leases	0)	1	0	
33. 00	Due from owners/officers	0	1	0	0	1
34. 00 35. 00	Other assets Total other assets (sum of Lines 21 24)	8, 681, 319	•	1 "	0	
36. 00	Total other assets (sum of lines 31-34) Total assets (sum of lines 11, 30, and 35)	8, 687, 144 72, 569, 164	1	٦ - ١		
30. 00	CURRENT LIABILITIES	72,307,104		<u> </u>		30.00
37. 00	Accounts payable	1, 905, 128	3	0	0	37. 00
38.00	Salaries, wages, and fees payable	1, 225, 168	3	0	0	38. 00
39. 00	Payroll taxes payable	0) (0	0	1
40.00	Notes and Loans payable (short term)	0		0	0	
41.00	Deferred income	0)	O O	0	
42. 00 43. 00	Accel erated payments Due to other funds	0			0	42. 00 43. 00
44. 00	Other current liabilities	11, 725, 521				
45. 00	Total current liabilities (sum of lines 37 thru 44)	14, 855, 817	•	o o		
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	(٦ - ١	0	
47. 00	Notes payable	0	1	0		1
48. 00	Unsecured Loans	0 00/ 017			-	
49. 00 50. 00	Other long term liabilities Total long term liabilities (sum of lines 46 thru 49)	8, 986, 917 8, 986, 917		ا ا	0	1
51. 00	Total liabilities (sum of lines 45 and 50)	23, 842, 734				
01.00	CAPITAL ACCOUNTS	20,012,701		<u> </u>		01.00
52.00	General fund balance	48, 726, 430)			52. 00
53.00	Specific purpose fund					53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55. 00	Donor created - endowment fund balance - unrestricted			0		55. 00
56. 00 57. 00	Governing body created - endowment fund balance			0	_	56.00
57.00	Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement,		1		0	
55. 00	replacement, and expansion					30.00
59. 00	Total fund balances (sum of lines 52 thru 58)	48, 726, 430) (0	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	72, 569, 164	. (0	0	60.00
	[59]		1			

15.00

16.00

17.00

18.00

19.00

In Lieu of Form CMS-2552-10 Health Financial Systems ASCENSION ST. VINCENT FISHERS STATEMENT OF CHANGES IN FUND BALANCES Provider CCN: 15-0181 Peri od: Worksheet G-1 From 07/01/2021 06/30/2022 Date/Time Prepared: 11/21/2022 11:32 am General Fund Special Purpose Fund Endowment Fund 1.00 3.00 4. 00 5. 00 2 00 1.00 Fund balances at beginning of period 49, 258, 448 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 29) 23, 327, 044 2.00 3.00 Total (sum of line 1 and line 2) 72, 585, 492 0 3.00 4.00 Additions (credit adjustments) (specify) 0 4.00 0 0 0 0 0 5.00 0 5.00 6.00 6.00 0 7.00 0 7.00 0 8.00 0 8.00 0 9.00 0 9.00 10.00 Total additions (sum of line 4-9) 10.00 Subtotal (line 3 plus line 10) 72, 585, 492 0 11.00 11.00 12.00 NET ASSET TRANS TO FROM ALPHA 23, 859, 061 0 12.00 13.00 13.00 14.00 0 14.00 0 0 0 0 15.00 0 15.00 16.00 0 16.00 17.00 17.00 23, 859, 061 18.00 Total deductions (sum of lines 12-17) 18.00 Fund balance at end of period per balance 19.00 48, 726, 431 19.00 sheet (line 11 minus line 18) Endowment Fund Plant Fund 7. 00 8.00 6. 00 1.00 Fund balances at beginning of period 0 0 1.00 Net income (loss) (from Wkst. G-3, line 29) 2.00 2.00 Total (sum of line 1 and line 2) 3.00 0 0 3.00 4.00 Additions (credit adjustments) (specify) 4.00 5.00 0 5.00 0 6.00 6.00 7.00 0 7 00 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 4-9) 0 0 10.00 11.00 0 Subtotal (line 3 plus line 10) 0 11.00 12.00 NET ASSET TRANS TO FROM ALPHA 12.00 13.00 13.00 14.00 0 14.00

0

0

0

0

15.00

16.00

17.00

18.00

19.00

Total deductions (sum of lines 12-17)

sheet (line 11 minus line 18)

Fund balance at end of period per balance

Health Financial Systems ASC STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0181

			T	06/30/2022	Date/Time Prep 11/21/2022 11	
	Cost Center Description		Inpati ent	Outpati ent	Total	
	'		1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES					
	General Inpatient Routine Services					
1.00	Hospi tal		18, 505, 426		18, 505, 426	1. 00
2.00	SUBPROVI DER - I PF					2. 00
3.00	SUBPROVI DER - I RF					3. 00
4.00	SUBPROVI DER					4. 00
5. 00	Swing bed - SNF		0		0	5. 00
6.00	Swing bed - NF		0		0	
7. 00	SKILLED NURSING FACILITY					7. 00
8.00	NURSING FACILITY					8. 00
9.00	OTHER LONG TERM CARE		40 505 407		40 505 407	9. 00
10. 00	Total general inpatient care services (sum of lines 1-9)		18, 505, 426		18, 505, 426	10. 00
11 00	Intensive Care Type Inpatient Hospital Services INTENSIVE CARE UNIT		0		0	11. 00
11. 00 12. 00	CORONARY CARE UNIT		0		0	12.00
13. 00	BURN INTENSIVE CARE UNIT		0		0	
14. 00	SURGICAL INTENSIVE CARE UNIT		0		0	
15. 00	OTHER SPECIAL CARE (SPECIFY)		O		U	15. 00
16. 00	Total intensive care type inpatient hospital services (sum of	lines	0		0	
10.00	11-15)	111103	O		O	10.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)		18, 505, 426		18, 505, 426	17. 00
18. 00	Ancillary services		45, 344, 563	135, 932, 262	181, 276, 825	
19. 00	Outpati ent servi ces		3, 939, 601	41, 852, 585	45, 792, 186	
20.00	RURAL HEALTH CLINIC		0	0	0	20. 00
21.00	FEDERALLY QUALIFIED HEALTH CENTER		0	o	0	21. 00
22.00	HOME HEALTH AGENCY					22. 00
23.00	AMBULANCE SERVICES					23. 00
24.00	CMHC			o	0	24. 00
25.00	AMBULATORY SURGICAL CENTER (D. P.)					25. 00
26.00	HOSPI CE					26. 00
27. 00	OTHER (SPECIFY)		0	0	0	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst.	67, 789, 590	177, 784, 847	245, 574, 437	28. 00
	G-3, line 1)					
	PART II - OPERATING EXPENSES					
29. 00	Operating expenses (per Wkst. A, column 3, line 200)			57, 723, 371		29. 00
30.00	ADD (SPECIFY)		0			30.00
31. 00			0			31.00
32. 00			0			32.00
33.00			0			33.00
34. 00 35. 00			0			34. 00 35. 00
36. 00	Total additions (sum of lines 30-35)		U	0		36.00
37. 00	DEDUCT (SPECIFY)		0	U U		37. 00
38. 00	DEDUCT (SECTED)		0			38.00
39. 00		ŀ	0			39. 00
40. 00			0			40.00
41. 00			n			41. 00
42. 00	Total deductions (sum of lines 37-41)		Ü	o		42. 00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer		57, 723, 371		43. 00
	to Wkst. G-3, line 4)					
				•		

Health Financial Systems	ASCENSION ST. VINCENT FISHERS	In Lieu of Form CMS-2552-10
STATEMENT OF REVENUES AND EXPENSES	Provi der CCN: 15-0181	Period: Worksheet G-3 From 07/01/2021
		To 06/30/2022 Date/Time Prepared:

STATEMENT OF REVENUES AND EXPENSES		Provider CCN: 15-0181	Peri od:	Worksheet G-3	
			From 07/01/2021 To 06/30/2022	Date/Time Pre	pared:
				11/21/2022 11	
1.00				1.00	4 00
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line			245, 574, 437	1.00
2. 00	Less contractual allowances and discounts on patients' accoun	ts		166, 058, 809	•
3. 00	Net patient revenues (line 1 minus line 2)			79, 515, 628	1
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		57, 723, 371	4. 00
5. 00	Net income from service to patients (line 3 minus line 4)			21, 792, 257	5. 00
	OTHER I NCOME				, ,,
6.00	Contributions, donations, bequests, etc			0	6.00
7.00	Income from investments			0	7.00
8.00	Revenues from telephone and other miscellaneous communication	services		0	8.00
9.00	Revenue from television and radio service			0	9.00
10.00	Purchase di scounts			0	10.00
11.00	Rebates and refunds of expenses			0	11.00
12.00	Parking lot receipts			0	12.00
13. 00 14. 00	Revenue from laundry and linen service Revenue from meals sold to employees and guests			93, 191	13. 00 14. 00
15. 00				93, 191	
	Revenue from rental of living quarters	han nationta		0	15.00
16.00	Revenue from sale of medical and surgical supplies to other the	nan patrents		0	16.00
17. 00 18. 00	Revenue from sale of drugs to other than patients			0	17. 00 18. 00
19. 00	Revenue from sale of medical records and abstracts Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00
20. 00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
21. 00	Rental of vending machines			0	20.00
22. 00	Rental of hospital space			695, 882	
23. 00	Governmental appropriations			095, 882	23. 00
24. 00	FOUNDATION REVENUE			10, 000	
24. 00	OTHER (SPECIFY)			10, 000	24. 00
24. 01	OTHER (SPECIFY)			0	24. 01
24. 02	OTHER (SPECIFY)			0	24. 02
24. 03	OTHER (SPECIFY)			0	24. 03
24. 05	UNCLAIMED PROPERTY EXEMPTIONS			93, 184	
24. 06	LATE PENALTY FEES			2, 745	•
24. 07	OTHER MISC REVENUE			101, 378	1
24. 08	PATIENT INTEREST INCOME			4, 317	1
24. 09	OTHER (SPECIFY)			7, 317	24. 09
24. 10	IC SHARED SAV REV ACO			143, 940	
24. 11	GAIN ON SALE DISPOSAL PPE			8, 364	ı
24. 50	COVI D-19 PHE Funding			381, 786	•
25. 00	Total other income (sum of lines 6-24)			1, 534, 787	1
26. 00	Total (line 5 plus line 25)			23, 327, 044	26.00
27. 00	OTHER (SPECIFY)			0	27. 00
28. 00	Total other expenses (sum of line 27 and subscripts)			0	28. 00
	Net income (or loss) for the period (line 26 minus line 28)			23, 327, 044	
			· ·	-, - ,	

		From 07/01/2021			
			To 06/30/2022	Date/Time Prep 11/21/2022 11	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD			1.00	
	CAPITAL FEDERAL AMOUNT				1
1. 00	Capital DRG other than outlier			170, 463	1.0
1. 01	Model 4 BPCI Capital DRG other than outlier			0	1.0
2. 00	Capital DRG outlier payments			0	2.0
2. 01	Model 4 BPCI Capital DRG outlier payments			0	
3. 00	Total inpatient days divided by number of days in the cost reporting period (see instructions)			10. 41	
4. 00	Number of interns & residents (see instructions)			0.00	
5.00	Indirect medical education percentage (see instructions)			0.00	
6. 00	Indirect medical education adjustment (multiply line 5 by the	sum of lines 1 and 1.0°	1, columns 1 and	0	6.0
7. 00	1.01)(see instructions) Percentage of SSI recipient patient days to Medicare Part A p	ationt days (Workshoot)	E part Alipo	0.00	7.0
7.00	30) (see instructions)	attent days (worksheet i	L, part A fille	0.00	/.0
8. 00	Percentage of Medicaid patient days to total days (see instru	ctions)		0.00	8.0
9. 00	Sum of lines 7 and 8			0.00	
10. 00	Allowable disproportionate share percentage (see instructions)		0.00	
11. 00	Disproportionate share adjustment (see instructions)			0	11.0
12. 00				170, 463	12.0
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
1. 00	Program inpatient routine capital cost (see instructions)			0	1
2. 00	Program inpatient ancillary capital cost (see instructions)			0	
3.00	Total inpatient program capital cost (line 1 plus line 2)			0	1 0.0
4.00	Capital cost payment factor (see instructions)			0	
5. 00	Total inpatient program capital cost (line 3 x line 4)			0	5.0
				1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
	Program inpatient capital costs (see instructions)			0	1
				0	2.0
2.00	Program inpatient capital costs for extraordinary circumstance	es (see instructions)		_	1
2. 00 3. 00	Net program inpatient capital costs (line 1 minus line 2)	es (see instructions)		0	3.0
2. 00 3. 00 4. 00	Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions)	es (see instructions)		0 0. 00	3. 0 4. 0
2. 00 3. 00 4. 00 5. 00	Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4)	,		0 0. 00 0	3. 0 4. 0 5. 0
2. 00 3. 00 4. 00 5. 00 6. 00	Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in	structions)	v lino ()	0 0. 00 0 0. 00	3. 0 4. 0 5. 0 6. 0
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary	structions)	x line 6)	0. 00 0. 00 0. 00 0. 00	3. 0 4. 0 5. 0 6. 0 7. 0
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7)	structions) circumstances (line 2 x	x line 6)	0. 00 0. 00 0. 00 0. 00 0	3. 0 4. 0 5. 0 6. 0 7. 0 8. 0
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appli	structions) circumstances (line 2 ;	,	0. 00 0. 00 0. 00 0. 00	3. 0 4. 0 5. 0 6. 0 7. 0 8. 0 9. 0
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00	Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appli Current year comparison of capital minimum payment level to capi	structions) circumstances (line 2) cable) apital payments (line 8	less line 9)	0.00 0.00 0.00 0.00 0	3. 0 4. 0 5. 0 6. 0 7. 0 8. 0 9. 0 10. 0
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appli	structions) circumstances (line 2) cable) apital payments (line 8	less line 9)	0.00 0.00 0.00 0.00 0	3. 0 4. 0 5. 0 6. 0 7. 0 8. 0 9. 0 10. 0
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appli Current year comparison of capital minimum payment level to carryover of accumulated capital minimum payment level over contents.	structions) circumstances (line 2 cable) apital payments (line 8 apital payment (from pri	less line 9) or year	0.00 0.00 0.00 0.00 0	3. 0 4. 0 5. 0 6. 0 7. 0 8. 0 9. 0 10. 0 11. 0
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appli Current year comparison of capital minimum payment level to carryover of accumulated capital minimum payment level over comparison to the capital minimum payment level over capital minimum payment leve	structions) circumstances (line 2 ; cable) apital payments (line 8 apital payment (from pri	less line 9) for year ne 11)	0.00 0.00 0.00 0 0 0	3. C 4. C 5. C 6. C 7. C 8. C 9. C 10. C 11. C

15.00 0 16. 00 0 17. 00

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

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