Health Financial Systems ASCENSION S	F. VINCENT	КОКОМО	In Lie	u of Form CMS-255	2-10
This report is required by law (42 USC 1395g; 42 CFR 413.20(b) payments made since the beginning of the cost reporting period				FORM APPROVED OMB NO. 0938-005 EXPIRES 03-31-20	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFIC AND SETTLEMENT SUMMARY	ATI ON Pro	ovider CCN: 15-0010	Period: From 07/01/2021 To 06/30/2022	Worksheet S Parts I-III Date/Time Prepar 11/28/2022 1:52	
PART I - COST REPORT STATUS					
Provider       1. [X] Electronically prepared cost report         use only       2. [] Manually prepared cost report         3. [0] If this is an amended report enter the r	number of	times the provider re	Date: 11/28/2 esubmitted this co		2 pm
4. [F] Medicare Utilization. Enter "F" for full         Contractor         use only         5. [1] Cost Report Status         6. Date Received:         (1) As Submitted         7. Contractor No.         (2) Settled without Audit         8. [N] Initial Report         (3) Settled with Audit         (4) Reopened         (5) Amended	port for t	10.N 11.C his Provider CCN 12.[		or Code: lumn 1 is 4: Ente wes reopened = 0-9	
PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINI MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINE			DUNISHABLE BY CRIM		
ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTL ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.	LAW. FURT	HERMORE, IF SERVICES	G IDENTIFIED IN TH	IIS REPORT WERE	
CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRA	TOR OF PR	OVI DER(S)			
I HEREBY CERTIFY that I have read the above certificat electronically filed or manually submitted cost report Statement of Revenue and Expenses prepared by ASCENSIC period beginning 07/01/2021 and ending 06/30/2022 and statement are true, correct, complete and prepared fro applicable instructions, except as noted. I further ce regarding the provision of health care services, and t provided in compliance with such laws and regulations.	and submi N ST. VING to the bes om the bool ertify that hat the se	tted cost report and CENT KOKOMO (15-0010 st of my knowledge and ks and records of the t I am familiar with	d the Balance Shee D) for the cost n nd belief, this re e provider in acco the laws and regu	et and reporting eport and ordance with ulations	
SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	C1.01	ELECTRONI C		
1	2		NATURE STATEMENT		
Becky Jacobson	Y	I have read and agrees statement. I certify signature on this ce binding equivalent of	y that I intend my ertification be th	/ electronic ne legally	1
2 Signatory Printed Name Becky Jacobson					2

		Title	XVIII			
Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospi tal	0	269, 901	-85, 874	0	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	3, 408	0		0	3.00
5.00 Swing Bed - SNF	0	0	0		0	5.00
6.00 Swing Bed - NF	0				0	6.00
200. 00 Total	0	273, 309	-85, 874	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.

3 Signatory Title

4 Date

VP - FINANCE

11/28/2022 01: 52: 42 PM

	AL AND HOSPITAL HEALTH CARE COMPLEX	DENTIFICATION	IDATA	Provid	er CCN:		Period: From 07/01/	2021	Part I	et S-2	
								2022	Date/Ti 11/28/2		
	1.00		2.00		3.00		2	1.00	11/20/2	022 1.	
0	Hospital and Hospital Health Care Co Street: 1907 WEST SYCAMORE	mplex Address PO Bo									1.
0	City: KOKOMO		e: IN	Zip Cod	e: 46901	Count	y: HOWARD				2
		Componen	t Name	CCN	CBSA	Provi der	Date		nt Syst		
				Number	Number	Туре	Certified	I, V	0, or XVIII	N) XIX	-
		1.00	0	2.00	3.00	4.00	5.00	6.00		8.00	
_	Hospital and Hospital-Based Componen			450040						-	
0	Hospi tal	ASCENSION ST. KOKOMO	VINCENT	150010	29020	1	07/01/1966	N	P	0	3
0	Subprovider - IPF										4
0	Subprovider - IRF	ASCENSION ST. KOKOMO REHAB	VI NCENT	15T010	29020	5	07/01/2002	Ν	P	0	5
0	Subprovider - (Other)	KOKOWO KEHAD									6
0	Swing Beds - SNF										7
0 0	Swing Beds - NF Hospital-Based SNF										8
00	Hospi tal -Based NF										10
00	Hospital-Based OLTC										11
00 00	Hospi tal-Based HHA Separately Certified ASC										12   13
00	Hospi tal -Based Hospi ce										14
00	Hospital-Based Health Clinic - RHC										15
00	Hospital-Based Health Clinic - FQHC Hospital-Based (CMHC) I										16   17
00	Renal Dialysis										18
00	Other										19
							From: 1.00				1
	Cost Reporting Period (mm/dd/yyyy)						07/01/20	021	06/30/		20
00	Type of Control (see instructions)						1				21
						1.00	2.00		3.0	0	1
~~	Inpatient PPS Information										
00	Does this facility qualify and is it disproportionate share hospital adju					Y	N				22
	§412.106? In column 1, enter "Y" fo	r yes or "N" t	for no. Is	thi s							
	facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fo			endment							
01	Did this hospital receive interim un			ts for thi	s	Y	Y				22
	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				001						
02	Is this a newly merged hospital that payments to be determined at cost re					Ν	N				22
	Enter in column 1, "Y" for yes or "N				5)						
	cost reporting period prior to Octob	er 1. Enter in	n column 2	"Y" for							
	or "N" for no, for the portion of th October 1.	e cost reporti	ng period	on or aft	er						
03	Did this hospital receive a geograph	ic reclassifi	cation from	m urban to		Ν	N		Y		22
	rural as a result of the OMB standar										
	adopted by CMS in FY2015? Enter in c for the portion of the cost reportin										
	in column 2, "Y" for yes or "N" for	no for the po	rtion of th	ne cost							
	reporting period occurring on or aft Does this hospital contain at least		•		_						
	counted in accordance with 42 CFR 41										
~ 4	yes or "N" for no.					N					
04	Did this hospital receive a geograph rural as a result of the revised OMB					Ν	N		N		22
	adopted by CMS in FY 2021? Enter in	column 1, "Y"	for yes o	r "N" for	no						
	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	100 but not mo	ore than 4	99 beds (a							
	counted in accordance with 42 CFR 41 yes or "N" for no.	2.105)? Enter	r in colum	า3, "Y" f	or						
	Which method is used to determine Me	dicaid days or	n lines 24	and/or 25			3 N				23
00		- · · · ·			- 2		1				1
00	below? In column 1, enter 1 if date										
00	below? In column 1, enter 1 if date if date of discharge. Is the method reporting period different from the	ofidentifying	g the days	in this c							

IUSPI	Financial Systems ASCENSION ASCENSION ASCENSION DA	TA I	Provider CC	N: 15-0010	Peri od:	04 (07 -		ksheet	S-2	
						30/2022	2 Date 11/2	e/Time 28/202	2 1:5	bared: 52 pm
		ln-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medi cai d el i gi bl e unpai d	Medic HMO d		Othe Medic day	aid	
		1.00	2.00	3.00	4.00	5.0		6.0		
4.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	419	0		1!	5 4	4, 061 245		0	24. C 25. C
	Inno para ana errgibre but unpara days in cordinin 5.				Urban/	'Rural S	S Date	e of G	eogr	
( 00	Enter when the dead account is a local first in (act w					. 00	1	2.00		24.0
26.00 27.00	Enter your standard geographic classification (not wa cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or	rural. age) status r "2" for ru	at the end ural. If ap	l of the cos			1		-	26. 0 27. 0
5. 00	enter the effective date of the geographic reclassifi If this is a sole community hospital (SCH), enter the effect in the cost reporting period.			CH status ir	1		0			35. 0
						nni ng:	E	ndi ng	:	
6.00	Enter applicable beginning and ending dates of SCH st	atus. Subs	cript line	36 for numb		. 00		2.00		36.0
7. 00	of periods in excess of one and enter subsequent date If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period.		r of period	ls MDH statu	IS		0			37. (
7.01	Is this hospital a former MDH that is eligible for th accordance with FY 2016 OPPS final rule? Enter "Y" fo instructions)									37. (
8.00	If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.									38. (
						<u>//N</u>		Y/N 2.00		
9.00	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet t accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions)	i, (ii), or the mileage i)? Enter i	(iii)? Ent requiremen n column 2	er in colum nts in ? "Y" for ye	ime in :S	N		N		39. C
0. 00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.	per 1. Ente	r "Y" for y			N		N		40. (
						V 1. C			XIX . 00	
5.00	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymer	nt for disp	coportionat	e share in	accordance			Y	N	45. C
6. 00	with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce	eption for a	extraordi na	nry circumst	ances	N		N	N	46. (
	pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III.		nter "Y for	yes or "N"	for no.	N		N	N	47. (
	Is this a new hospital under 42 CFR §412.300(b) PPS of			or "N" for	no.	N		N	N	48. 56.
. 00	Is the facility electing full federal capital payment Teaching Hospitals	:? Enter "	4		for ves (	or N				
8. 00 5. 00	Is the facility electing full federal capital payment 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 pr year, and are you are impacted by CR 11642 (or applic Enter "Y" for yes; otherwise, enter "N" for no in col	approved G e to column cograms in cable CRs) f umn 2.	ME programs 1 is "Y", the prior y MA direct G	? Enter "Y" or if this vear or penu GME payment	hospital Iltimate reduction					
8. 00 6. 00	Is the facility electing full federal capital payment 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 pr year, and are you are impacted by CR 11642 (or applic Enter "Y" for yes; otherwise, enter "N" for no in col	approved G approved G a to column cograms in r cable CRs) I umn 2. beriod durin yes or "N" th of this o (", complete	ME programs 1 is "Y", the prior y MA direct G ng which re ' for no in cost report e Worksheet	? Enter "Y" or if this wear or penu SME payment esidents in a column 1. ing period?	hospital Itimate reduction approved If column Enter "Y	2				57.0
	Is the facility electing full federal capital payment 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 pr year, and are you are impacted by CR 11642 (or applic Enter "Y" for yes; otherwise, enter "N" for no in col If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "N	approved G approved G to column rograms in - cable CRs) ! umn 2. period durin ryes or "N" ch of this d (", complet , if applic pursement for	ME programs 1 is "Y", the prior y MA direct G ng which re ' for no in 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 cc	hospital Itimate reduction approved If column Enter " Iumn 2 is	2				

IOSPI TAL A	AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ΓΑ	Provider CO	F	Period: From 07/01/2021 To 06/30/2022	11/28/2022 1:	pared:
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
				1.00	2.00	3.00	
any ins is ' adju 0.01  f	you claiming nursing and allied health education programs that meet the criteria under 42 CFR 413. tructions) Enter "Y" for yes or "N" for no in col "Y", are you impacted by CR 11642 (or subsequent C ustement? Enter "Y" for yes or "N" for no in col line 60 is yes, complete columns 2 and 3 for each	85? (s umn 1. R) NAHE mn 2.	see If column 1 E MA payment	Y	Y 23. 00	1	60. ( 60. (
ji ns	tructions)	Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
sec	your hospital receive FTE slots under ACA tion 5503? Enter "Y" for yes or "N" for no in umn 1. (see instructions)	N			0.00		61. C
FTE	er the average number of unweighted primary care s from the hospital's 3 most recent cost reports ing and submitted before March 23, 2010. (see tructions)						61. (
FTE and	er the current year total unweighted primary care count (excluding OB/GYN, general surgery FTEs, primary care FTEs added under section 5503 of ). (see instructions)						61. (
1.03 Ente and dete	er the base line FTE count for primary care /or general surgery residents, which is used for ermining compliance with the 75% test. (see tructions)						61. (
1.04 Ente surg curi	er the number of unweighted primary care/or gery allopathic and/or osteopathic FTEs in the rent cost reporting period.(see instructions).						61.
and, pri r	er the difference between the baseline primary /or general surgery FTEs and the current year's mary care and/or general surgery FTE counts (line 04 minus line 61.03). (see instructions)						61.0
used	er the amount of ACA §5503 award that is being d for cap relief and/or FTEs that are nonprimary e or general surgery. (see instructions)						61.
		Pro	ogram Name	Program Lode	Unweighted IME FTE Count	Direct GME FTE Count	
			1.00	2.00	3.00	4.00	
spec for colu prog unwe	the FTEs in line 61.05, specify each new program cialty, if any, and the number of FTE residents each new program. (see instructions) Enter in umn 1, the program name. Enter in column 2, the gram code. Enter in column 3, the IME FTE eighted count. Enter in column 4, the direct GME unweighted count.				0.00	0.00	61.
1.20 Of prog resi ins Ente 3,	the FTEs in line 61.05, specify each expanded gram specialty, if any, and the number of FTE idents for each expanded program. (see tructions) Enter in column 1, the program name. er in column 2, the program code. Enter in column the IME FTE unweighted count. Enter in column 4, direct GME FTE unweighted count.				0.00	0. 00	61. :
						1.00	
2.00 Ente	Provisions Affecting the Health Resources and Ser er the number of FTE residents that your hospital	trai nec			iod for which	0.00	62. (
2.01 Énte duri	r hospital received HRSA PCRE funding (see instructer the number of FTE residents that rotated from a ing in this cost reporting period of HRSA THC program.	Teachi ram. (s	see instruction		your hospital	0.00	62. 0
	ching Hospitals that Claim Residents in Nonprovide your facility trained residents in nonprovider se for yes or "N" for no in column 1. If yes, comple	ttings	during this co			N	63. (

alth Financial Systems )SPITAL AND HOSPITAL HEALTH CARE COMPLI		ST. VINCENT KOKOMO A Provider CO	CN: 15-0010 Pe	eri od:	u of Form CMS- Worksheet S-2	
STITLE AND HOST THE HEALTH OAKE COM E				rom 07/01/2021	Part I	epared:
		l	Unweighted	Unwei ghted	Ratio (col. 1/	/
			FTES	FTEs in	(col. 1 + col.	
			Nonprovider Site	Hospi tal	2))	
			1.00	2.00	3.00	-
Section 5504 of the ACA Base Year	ETE Residents in Non	nrovider Settings				
period that begins on or after Ju			ini s base year	is your cost i	eporting	
1.00 Enter in column 1, if line 63 is in the base year period, the numb resident FTEs attributable to rot settings. Enter in column 2 the resident FTEs that trained in you of (column 1 divided by (column 1	yes, or your facility er of unweighted non- ations occurring in a number of unweighted r hospital. Enter in o	trained residents primary care II nonprovider non-primary care column 3 the ratio	0. 00	0. OC	0. 000000	ō 64. OC
	Program Name	Program Code	Unweighted	Unweighted	Ratio (col. 3/	/
			FTES	FTEs in	(col. 3 + col.	
			Nonprovi der	Hospi tal	4))	
_			Site		5.00	4
5.00 Enter in column 1, if line 63	1.00	2.00	3.00	4.00	5.00 0.000000	
<pre>is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)</pre>			Unwei ghted	Unwei ghted	Ratio (col. 1/	
			FTEs Nonprovi der Si te 1.00	FTEs in Hospital 2.00	(col. 1 + col. 2)) 3.00	
Section 5504 of the ACA Current Y	ear FTF Residents in	Nonprovider Setting				
beginning on or after July 1, 201	0					
b. 00 Enter in column 1 the number of u FTEs attributable to rotations oc Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 +	curring in all nonprov nweighted non-primary I. Enter in column 3	vider settings. care resident the ratio of	0.00	0.00	0. 000000	66.00
	Program Name	Program Code	Unweighted	Unweighted	Ratio (col. 3/	/
	Ŭ	Ũ	FTEs	FTEs in	(col. 3 + col.	
			Nonprovi der	Hospi tal	4))	
			Si te			
	1.00	2.00	3.00	4.00	5.00	
7.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column			0.00	0. 00	0. 000000	, o <i>1</i> . U

	Financial Systems ASCENSION ST. VINCENT KOKOMO	l i	<u>ı Lieu</u>	of For	m CMS-	2552-10
HOSPI T	F	eriod: rom 07/01/ o 06/30/	2021   2022	Workshe Part I Date/Ti	me Pre	pared:
				11/28/2		
	Inpatient Psychiatric Facility PPS		1.00	2.00	3.00	
70.00	ls this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subp Enter "Y" for yes or "N" for no.	provi der?	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in $\cdot$				0	71.00
	recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for u 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teacl	no. (see ning				
	program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for y Column 3: If column 2 is Y, indicate which program year began during this cost reporting	10.				
	(see instructions)	g period.	L			-
75.00	Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF		Y			75.00
76.00	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	N	N	0	76.00
70.00	recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or	- "N" for			0	/0.00
	no. Column 2: Did this facility train residents in a new teaching program in accordance 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)		L			
				1.0	0	
80.00	Long Term Care Hospital PPS Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N		80.00
	Is this a LTCH co-located within another hospital for part or all of the cost reporting	period? Ei	nter	Ν		81.00
	"Y" for yes and "N" for no. TEFRA Provi ders					
	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes o Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section		no.	N		85.00 86.00
	\$413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.					
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			N		87.00
		V 1.00		XI 2. C		
90.00	Title V and XIX Services Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for	N		Y		90.00
01 00	yes or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through the cost report either in	N		Y		91.00
	full or in part? Enter "Y" for yes or "N" for no in the applicable column.					
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N		92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the	N		Ν		94.00
95.00	applicable column. If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.0	0	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		Ν		96.00
	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.0	0	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in	N		Y		98.00
08 01	column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst.	N		Y		98.01
90.01	C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for					70.01
98. 02	title XIX. Does title V or XIX follow Medicare (title XVIII) for the calculation of observation	N		Y		98.02
	bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					
98. 03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH)	N		Ν		98.03
	reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and	N		N		98.04
	in column 2 for title XIX.			.,		0.000
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in	N		Y		98.05
98 06	column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D,	N		Y		98.06
70.00	Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in					/0.00
	column 2 for title XIX. Rural Providers	I				
	Does this hospital qualify as a CAH? If this facility qualifies as a CAH, has it elected the all-inclusive method of payment	N				105.00
	for outpatient services? (see instructions)					
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions)					107.00
	Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)?					
	Enter "Y" for yes or "N" for no in column 2. (see instructions)					

Health Financial Systems ASCENSION ST. VI	NCENT KOKOMO		In Lieu	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CO		eriod: com 07/01/2021 o 06/30/2022	Worksheet S-2 Part I Date/Time Pre 11/28/2022 1:	epared:
	·		V	XIX	_
108.00 Is this a rural hospital gualifying for an exception to the	CRNA fee sche	dul e? See 42	1.00 N	2.00	108.00
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			Crass	Desalastere	
	Physi cal 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00	-
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.				1.00	109.00
110.00 Did this hospital participate in the Rural Community Hospita Demonstration)for the current cost reporting period? Enter " complete Worksheet E, Part A, lines 200 through 218, and Wor applicable.	Y" for yes or	"N" for no. If	yes,	N	110.00
			1.00	2.00	_
111.00 If this facility qualifies as a CAH, did it participate in t Health Integration Project (FCHIP) demonstration for this co "Y" for yes or "N" for no in column 1. If the response to co integration prong of the FCHIP demo in which this CAH is par Enter all that apply: "A" for Ambulance services; "B" for ad for tele-health services.	ost reporting p Dumn 1 is Y, o ticipating in	period? Enter enter the column 2.	N	2.00	111.00
		1.00	2.00	3.00	-
112.00 Did this hospital participate in the Pennsylvania Rural Heal demonstration for any portion of the current cost reporting Enter "Y" for yes or "N" for no in column 1. If column 1 is in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceal participation in the demonstration, if applicable.	period? ; "Y", enter ne	N			112.00
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or	"N" for no	N			0115.00
in column 1. If column 1 is yes, enter the method used (A, B in column 2. If column 2 is "E", enter in column 3 either "9 for short term hospital or "98" percent for long term care ( psychiatric, rehabilitation and long term hospitals provider	3, or E only) 23" percent i ncludes				
the definition in CMS Pub. 15-1, chapter 22, §2208.1. 116.00   s this facility classified as a referral center? Enter "Y"	for yes or	N			116. 00
"N" for no. 117.00   s this facility legally-required to carry malpractice insur	ance? Enter	Y			117.00
"Y" for yes or "N" for no. 118.00 Is the malpractice insurance a claims-made or occurrence pol if the policy is claim-made. Enter 2 if the policy is occurr		2			118.00
In the porrey is cranin-linade. Enter 2 in the porrey is occurr	ence.	Premi ums	Losses	Insurance	
		1.00	2.00	3.00	-
118.01 List amounts of malpractice premiums and paid losses:		0			3 118. 01
			1.00	2.00	-
118.02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein.			N	2.00	118. 02
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA \$3121 and applicable amendment Extension and applicable amendment.	n column 1, "Y Nalifies for th	" for yes or he Outpatient	Ν	Ν	119.00 120.00
Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost impla	intable device	s charged to	Y		121.00
patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included.			Y	5.00	122.00
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for	or yes and "N"	for no. If	N		125.00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, en					126.00
in column 1 and termination date, if applicable, in column 2 127.00 If this is a Medicare certified heart transplant center, ent	2.				127.00
in column 1 and termination date, if applicable, in column 2 128.00 If this is a Medicare certified liver transplant center, ent	2.				128.00
in column 1 and termination date, if applicable, in column 2 129.00  f this is a Medicare certified lung transplant center, enter	2.				129.00
column 1 and termination date, if applicable, in column 2. 130.00 [If this is a Medicare certified pancreas transplant center,					130.00
date in column 1 and termination date, if applicable, in col					

alth Financial Systems DSPITAL AND HOSPITAL HEALTH CARE COMPLE		<u>ST. VINCENT KOKOMO</u> A Provider	CCN: 15-0010	Peri od:		Worksheet S-2	
					7/01/2021 5/30/2022		
					1 00	Part I         Date/Time Pr         11/28/2022         2.00         2.00         11/28/2022         2.00         2.00         15H046         01         60         1.00         Y         2.00         1.00         Y         2.00         1.00         Y         2.00         N	-
31.00 If this is a Medicare certified in			certi fi cati o		1.00	2.00	131. (
date in column 1 and termination c 32.00 If this is a Medicare certified is in column 1 and termination date,	let transplant cente	r, enter the certi	fication dat	e			132. 0
33.00 Removed and reserved	TT appricable, Th co	TUIIIT 2.					133. (
34.00 If this is an organ procurement or and termination date, if applicabl All Providers		ter the OPO number	in column 1				134. (
40.00 Are there any related organization chapter 10? Enter "Y" for yes or " are claimed, enter in column 2 the	N" for no in column	1. If yes, and hom umber. (see instru	e office cos	ts	Y	15H046	140. (
1.00	n anganization onto	2.00	augh 142 the		3.00	of the	
If this facility is part of a chai home office and enter the home off	n organization, ente Fice contractor name	and contractor nur	rougn 143 the nber.	name and	address	or the	
1.00 Name: ST VINCENT HEALTH	Contractor's Na			ctor's Nu	mber: 0810	)1	141. (
I2.00 Street:250 W 96TH STREET, SUITE 2 <sup>-</sup> I3.00 City: INDIANAPOLIS	15 PO Box: State:	IN	Zip Co	de:	4626	50	142.0
	jotato.				1020		
4 00 ma providen brand studiets	to included in We to	boot A2					144
14.00 Are provider based physicians' cos	ats included in works	neel A?				Y	144. (
					1.00	2.00	
5.00 If costs for renal services are cl inpatient services only? Enter "Y" no, does the dialysis facility inc period? Enter "Y" for yes or "N"	for yes or "N" for lude Medicare utiliz	no in column 1. If	column 1 is		Y		145.0
6.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no ir yes, enter the approval date (mm/c	y changed from the p n column 1. (See CMS			lf	Ν		146.
						1.00	-
7.00Was there a change in the statisti	cal basis? Enter "Y"	for yes or "N" fo	nr no.				147.0
18.00 Was there a change in the order of							148.
19.00 Was there a change to the simplifi	ed cost finding meth	Part A	yes or "N" f Part B		itle V		149.
		1.00	2.00		3.00	4.00	
Does this facility contain a provi or charges? Enter "Y" for yes or "	der that qualifies f	or an exemption fi	om the appli	cation of	the lowe	er of costs	
5. 00Hospi tal		N	N N	. (366 42	N		155.
6.00 Subprovi der – IPF		N	N		Ν		156.
7.00 Subprovider - IRF 8.00 SUBPROVIDER		N	N		Ν	N	157. 158.
9. 00 SNF		N	N		Ν	N	150.
O. OO HOME HEALTH AGENCY		N	N		Ν		160.
1.00 CMHC			N		N		161.
Multicampus						1.00	
5.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	· ·						165.
	Name O	County 1.00	State 2.00	Zip Code 3.00	CBSA 4.00		-
6.00 fline 165 is yes, for each	0	1.00	2.00	3.00	4.00		0166.
campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3,							
CBSA in column 4, FTE/Campus in column 5 (see instructions)							
Health Information Tachnology (113	() incentive in the A	mari can Pocovors	and Pointact	ont Act		1.00	
Health Information Technology (HI 7.00 s this provider a meaningful user				ent ACT		Y	167.
8.00 If this provider is a CAH (line 10	05 is "Y") and is a m	eaningful user (li		"), enter	the		168.
reasonable cost incurred for the H							110
	not a meaningful upon	doos this provis	lor qualify f	or a hard	chin		
8.01 f this provider is a CAH and is r exception under §413.70(a)(6)(ii)? 9.00 f this provider is a meaningful u	'Enter "Y" for yes o	r "N" for no. (see	instruction	s)	•		168. 9169.

Health Financial Systems	ASCENSION ST. VIN	NCENT KOKOMO	In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DATA		Period:	Worksheet S-2	
			rom 07/01/2021		
			To 06/30/2022	Date/Time Pre	
				11/28/2022 1:	<u>52 pm</u>
			Begi nni ng	Endi ng	
			1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR be	ginning date and ending da	ate for the reporting			170.00
period respectively (mm/dd/yyyy)	0 0 0				
			1.00	2.00	1
171.00 If line 167 is "Y", does this provi	der have any days for indi	viduals enrolled in	N	0	171.00
section 1876 Medicare cost plans re	ported on Wkst. S-3, Pt. I	, line 2, col. 6? Enter			
"Y" for yes and "N" for no in colum	n 1. lfcolumn 1 is yes, e	enter the number of section	1		
1876 Medicare days in column 2. (se					

DSPI I.	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0010	Period: From 07/01/2021 To 06/30/2022	Worksheet S- Part II Date/Time Pro 11/28/2022 1	epared
				Y/N	Date 2,00	
	General Instruction: Enter Y for all YES responses. Enter N	for all NO ro	sponsos Ent	1.00	2.00	
	mm/dd/yyyy format.		sponses. Lint		ne	
	COMPLETED BY ALL HOSPITALS					
	Provider Organization and Operation					
00	Has the provider changed ownership immediately prior to the			N		1.0
	reporting period? If yes, enter the date of the change in c	olumn 2. (see		·	N//1	_
			Y/N 1.00	Date 2.00	V/I 3.00	
00	Has the provider terminated participation in the Medicare P	rogram? If	1.00 N	2.00	3.00	2.0
	yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.	ın 3, "V" for				
00	Is the provider involved in business transactions, includin contracts, with individuals or entities (e.g., chain home o or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members o of directors through ownership, control, or family and othe relationships? (see instructions)	iffices, drug ler or its if the board	Y			3. (
			Y/N	Туре	Date	
			1.00	2.00	3.00	
00	Financial Data and Reports Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" f or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	for Compiled, ilable in	Y	A		4.0
00	Are the cost report total expenses and total revenues diffe those on the filed financial statements? If yes, submit rec		N			5.0
				Y/N	Legal Oper.	
	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	r N		6.0
00 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing programs and/or allied health programs approve cost reporting period? If yes, see instructions.		ved during the	e N		7.0
00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction		al education	N		9.0
D. 00	Was an approved Intern and Resident GME program initiated o cost reporting period? If yes, see instructions.		he current	N		10.0
1.00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	N		11. (
					Y/N 1.00	-
	Bad Debts					
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.			ost reporting	Y N	12. ( 13. (
4. 00	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	ents waived? If	°yes, see in:	structions.	Ν	14. (
5.00	Did total beds available change from the prior cost reporti	<u> </u>	yes, see ins t A	tructions. Par	N t B	15. (
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
5. 00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through	Y	10/06/2022	Y	10/06/2022	16. (
7.00	date of the PS&R Report used in columns 2 and 4 .(see instructions) Was the cost report prepared using the PS&R Report for	N		N		17.
. 00	totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	I NI		IN		17.
3. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	Ν		Ν		18.
9.00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R	N		N		19.

Health Financial Systems

#### ASCENSION ST. VINCENT KOKOMO

In Lieu of Form CMS-2552-10

Heal th	Financial Systems ASCENSION ST.	VINCENT KOKOMO		In Lie	u of Form CM	S-2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider (	F	Period: From 07/01/2021 To 06/30/2022	Date/Time P	repared:
		Doscr	intion	Y/N	11/28/2022 Y/N	1:52 pm
		Desci	<u>ription</u> 0	1.00	3.00	_
20.00	If line 16 or 17 is yes, were adjustments made to PS&R		0	N	S. 00	20.00
20.00	Report data for Other? Describe the other adjustments:			IN	IN	20.00
	Report data for other? bescribe the other adjustments.	Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's	N	2.00	N	4.00	21.00
21.00	records? If yes, see instructions.	IN IN		IN		21.00
					1.00	
-	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	EPT CHILDRENS	HOSPLTALS)			
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, se	e instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense			na the cost		23.00
20.00	reporting period? If yes, see instructions.			ig the cost		20.00
24.00	Were new leases and/or amendments to existing leases enter	ed into durina	this cost rend	orting period?		24.00
21.00	If yes, see instructions	cu mto uumg	1113 0031 1000	n tring period.		21.00
25.00	Have there been new capitalized leases entered into during	the cost repo	rting period?	f ves see		25.00
20.00	instructions.		r tring period. I	, yes, see		20.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during t	he cost report	ing period? If	VAS SAA		26.00
20.00	instructions.		ing poirtour ri	J007 000		20100
27.00	Has the provider's capitalization policy changed during th	ne cost reporti	na period? If v	ves. submit		27.00
	copy.		512 22 5			
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit e	entered into du	ring the cost r	reporting		28.00
	period? If yes, see instructions.		5	5		
29.00	Did the provider have a funded depreciation account and/or	bond funds (D	ebt Service Res	serve Fund)		29.00
	treated as a funded depreciation account? If yes, see inst	ructions		,		
30.00	Has existing debt been replaced prior to its scheduled mat		debt? If yes,	see		30.00
	instructions.	-	-			
31.00	Has debt been recalled before scheduled maturity without i	ssuance of new	debt? If yes,	see		31.00
	instructions.					
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care se		ed through cont	ractual		32.00
	arrangements with suppliers of services? If yes, see instr					
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 ap	plied pertaini	ng to competiti	ve bidding? If		33.00
	no, see instructions.					
	Provi der-Based Physi ci ans				-	
34.00	Are services furnished at the provider facility under an a	arrangement wit	h provider-base	ed physi ci ans?		34.00
	lf yes, see instructions.					
35.00	If line 34 is yes, were there new agreements or amended ex		nts with the pr	rovi der-based		35.00
	physicians during the cost reporting period? If yes, see i	nstructions.				
				Y/N	Date	
				1.00	2.00	_
24 22	Home Office Costs					
	Were home office costs claimed on the cost report?	,		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been p	prepared by the	nome office?	Y		37.00
	If yes, see instructions.					
38.00	If line 36 is yes, was the fiscal year end of the home of			N		38.00
20.00	the provider? If yes, enter in column 2 the fiscal year er If line 36 is yes, did the provider render services to oth			NI		20.00
39.00	5	ier chai'n compo	nents? IT yes,	N		39.00
40.00	see instructions.	home office?		N		40.00
40.00	If line 36 is yes, did the provider render services to the	e nome office?	ri yes, see	N		40.00
	instructions.					
		1	. 00	2	00	
	Cost Report Preparer Contact Information	-		Ζ.	00	
11 00	Enter the first name, last name and the title/position	luu				11 00
41.00	held by the cost report preparer in columns 1, 2, and 3,	JILL		HILL		41.00
	respectively.					
12 00		ASCENSION DEA	ТЦ			12 00
42.00	Enter the employer/company name of the cost report	ASCENSION HEA				42.00
12 00	preparer.		-			12 00
43.00	Enter the telephone number and email address of the cost	NOT APPLICABL	E	JI LL. HI LL1@ASC	ENSTON. UKG	43.00
	report preparer in columns 1 and 2, respectively.	I		T		11

Heal th	Financial Systems ASCENSION ST.	VINCENT KOKOMO	In Lie	u of Form CMS-2	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0010	Period: From 07/01/2021	Worksheet S-2 Part	
			To 06/30/2022		
		3.00			
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position	MANAGER NET REVENUE			41.00
	held by the cost report preparer in columns 1, 2, and 3,	MANAGEMENT			
	respecti vel y.				
42.00	Enter the employer/company name of the cost report				42.00
	preparer.				
43.00	Enter the telephone number and email address of the cost				43.00
	report preparer in columns 1 and 2, respectively.				

iospi t	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	CN: 15-0010	Period: From 07/01/2021 To 06/30/2022	Worksheet S-3 Part I Date/Time Pre 11/28/2022 1:	pared:
						I/P Days / O/P Visits / Trips	
	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	Title V	
	1	1.00	2.00	3.00	4.00	5.00	
2. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions)	30. 00	98	35, 7	70 0.00	0	2. 00
3. 00 4. 00	HMO I PF Subprovi der HMO I RF Subprovi der						3.0 4.0
5.00 5.00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF					0	5.00 6.00
. 00	Total Adults and Peds. (exclude observation beds) (see instructions)		98	35, 7	70 0.00	0	7.0
3. 00 9. 00 0. 00 1. 00	INTEŃSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT	31.00	13	4, 7	45 0.00	0	8. 0 9. 0 10. 0 11. 0
2.00	OTHER SPECIAL CARE (SPECIFY)	10.00					12.0
3.00	NURSERY	43.00		10 5	1.5 0.00	0	13.00
4.00 5.00	Total (see instructions) CAH visits		111	40, 5	15 0.00	0	14.0 15.0
6.00	SUBPROVI DER – I PF					0	16.0
7.00	SUBPROVIDER - IRF	41.00	18	6, 5	70	0	17.0
8.00	SUBPROVI DER		-				18.0
9.00	SKILLED NURSING FACILITY						19.0
20.00	NURSING FACILITY						20. C
21.00	OTHER LONG TERM CARE						21.0
22.00	HOME HEALTH AGENCY						22.0
23.00	AMBULATORY SURGICAL CENTER (D. P. )						23.0
4.00	HOSPI CE						24.0
4.10	HOSPICE (non-distinct part)	30. 00					24.1 25.0
5.00 6.00	CMHC - CMHC RURAL HEALTH CLINIC						25.0
6.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.
7.00	Total (sum of lines 14-26)	09.00	129			0	27.0
8.00	Observation Bed Days		127			0	28.
9.00	Ambulance Trips						29.0
0.00	Employee discount days (see instruction)						30.0
1.00	Employee discount days - IRF						31. (
2.00	Labor & delivery days (see instructions)		8	2, 9	20		32. (
2. 01	Total ancillary labor & delivery room outpatient days (see instructions)						32. (
3. 00	LTCH non-covered days						33. (
3. 01	LTCH site neutral days and discharges						33.

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	N: 15-0010	Period: From 07/01/202 To 06/30/202		epared:
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Intern	s Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	4, 925	231	14, 7(	)1		1.00
2.00	HMO and other (see instructions)	5, 159	3, 997				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	727	245				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0		0		5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0		0		6.00
7.00	Total Adults and Peds. (exclude observation	4, 925	231	14, 70	01		7.00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	754	190	2, 70	01		8.00
9.00	CORONARY CARE UNI T						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGI CAL INTENSI VE CARE UNI T						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)				_		12.00
13.00	NURSERY		88	1, 3			13.00
14.00	Total (see instructions)	5, 679	509	18, 7 <sup>-</sup>		0 456.38	
15.00	CAH visits	0	0		0		15.00
16.00	SUBPROVIDER - IPF	1.045	1.4	2.40		1/ 50	16.00
17.00	SUBPROVIDER - IRF	1, 945	14	3, 48	34 O. C	0 16.52	
18.00 19.00	SUBPROVIDER SKILLED NURSING FACILITY						18.00
20.00	NURSING FACILITY						20.00
20.00	OTHER LONG TERM CARE						20.00
22.00	HOME HEALTH AGENCY						21.00
22.00	AMBULATORY SURGICAL CENTER (D. P. )						23.00
24.00	HOSPI CE						24.00
24.10	HOSPICE (non-distinct part)				0		24.10
25.00	CMHC - CMHC				0		25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0.0	0 0.00	
27.00	Total (sum of lines 14-26)				0.0	0 472.90	27.00
28.00	Observation Bed Days		0	90	05		28.00
29.00	Ambul ance Trips	2, 890					29.00
30. 00	Employee discount days (see instruction)			10	90		30.00
31.00	Employee discount days - IRF				0		31.00
32.00	Labor & delivery days (see instructions)	0	0	1, 4	77		32.00
32. 01	Total ancillary labor & delivery room				0		32.01
	outpatient days (see instructions)						
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	CN: 15-0010	Period: From 07/01/2021 To 06/30/2022	Worksheet S-3 Part I Date/Time Pre 11/28/2022 1:	pared: 52 pm
		Full Time Equivalents		Di s	charges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed SNF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)		0	1, 2!		4, 640	1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00
13.00 14.00 15.00	NURSERY Total (see instructions) CAH visits	0. 00	0	1, 2	50 56	4, 640	13.00 14.00 15.00
16.00 17.00 18.00 19.00 20.00 21.00 22.00 23.00 24.00 24.00 25.00 26.00 26.00 26.00 28.00 29.00 30.00 31.00 32.00	SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room	0.00 0.00 0.00	0	1!	53 1	260	16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00 23. 00 24. 00 24. 10 25. 00 26. 00 26. 00 26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00
33. 00 33. 01	outpatient days (see instructions) LTCH non-covered days LTCH site neutral days and discharges				0 0		33. 00 33. 01

SPI T.	Financial Systems AL WAGE INDEX INFORMATION			Provider C		<u>In Lie</u> Period: From 07/01/2021	Worksheet S-3 Part II	
						06/30/2022		
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)			Average Hourly Wage (col. 4 ÷ col. 5)	
	PART II - WAGE DATA	1.00	2.00	3.00	4.00	5.00	6.00	-
	SALARI ES							
00	Total salaries (see	200.00	38, 701, 462	3, 711	38, 705, 173	930, 619. 00	41. 59	1
0	instructions) Non-physician anesthetist Part		C	0	0	0.00	0.00	
0	A Non-physician anesthetist Part		C	0	C	0.00	0.00	
0	B Physician-Part A - Administrative		229, 819	0	229, 819	1, 308. 00	175. 70	
1	Administrative Physicians - Part A - Teaching		C	0	0	0.00	0.00	) .
0	Physician and Non		265, 477	0	265, 477	1, 517. 00	175.00	) !
0	Physician-Part B Non-physician-Part B for hospital-based RHC and FQHC		C	0	C	0.00	0.00	
0	services Interns & residents (in an	21.00	C	0	C	0.00	0.00	) .
1	approved program) Contracted interns and residents (in an approved		C	0	C	0.00	0.00	
0	programs) Home office and/or related		C	0	0	0.00	0.00	
0	organization personnel SNF	44.00	C	0		0.00	0.00	
00	Excluded area salaries (see instructions)	44.00	4, 102, 642	194, 884	4, 297, 526			
00	OTHER WAGES & RELATED COSTS Contract Labor: Direct Patient		2, 548, 557	0	2, 548, 557	28, 111. 51	90.66	5 1
00	Care Contract Labor: Top Level		2, 348, 337					
00	management and other management and administrative services					0.00	0.00	
00	Contract Labor: Physician-Part A - Administrative		C	0	C	0.00	0.00	1
00	Home office and/or related organization salaries and		C	0	C	0.00	0.00	1
01	wage-related costs Home office salaries		8,097,745	о	8, 097, 745	160, 679. 00	50.40	) 1
02	Related organization salaries		C, 211, 11	0	C	0.00	0.00	1
00	Home office: Physician Part A - Administrative		C	0	C	0.00	0.00	1
00	Home office and Contract		C	0	C	0.00	0.00	1
01	Physicians Part A - Teaching Home office Physicians Part A		C	0		0.00	0.00	) 1
	- Teaching							
02	Home office contract Physicians Part A - Teaching WAGE-RELATED COSTS			0	(	0.00	0.00	1
00	Wage-related costs (core) (see instructions)		11, 036, 766	0	11, 036, 766			1
00	Wage-related costs (other) (see instructions)							1
00 00	Excluded areas Non-physician anesthetist Part		1, 198, 718 C	0 0	1, 198, 718 (	3		1
00	A Non-physician anesthetist Part B		C	0	c	)		2
00	Þ Physician Part A - Administrative		65, 539	0	65, 539			2
01	Physician Part A - Teaching			0				2
00 00 00	Physician Part B Wage-related costs (RHC/FQHC) Interns & residents (in an		75, 708 C C		75, 708 C			2 2 2
50	approved program) Home office wage-related		3, 136, 159	0	3, 136, 159			2
51	(core) Related organization wage-related (core)		C	0	C	)		2
52	wage-related (core) Home office: Physician Part A - Administrative -		C	0	C			2

Heal th	Financial Systems	A	SCENSION ST. V	INCENT KOKOMO		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION			Provider C		Period: From 07/01/2021 To 06/30/2022	Worksheet S-3 Part II Date/Time Pre 11/28/2022 1:	pared:
		Wkst. A Line Number		Reclassificati on of Salaries (from Wkst. A-6)		Related to	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0		0		25.53
	OVERHEAD COSTS - DIRECT SALARIE							
26.00	Employee Benefits Department	4.00	517, 482					
27.00	Administrative & General	5.00	1, 953, 849	-269, 410				
28.00	Administrative & General under contract (see inst.)		758, 534	0	758, 53	4, 749. 00	159. 72	28.00
29.00	Maintenance & Repairs	6.00	0	0		0 0.00	0.00	29.00
30.00	Operation of Plant	7.00	0	0		0 0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	0	0		0 0.00	0.00	31.00
32.00	Housekeepi ng	9.00	0	0		0 0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		1, 266, 286	0	1, 266, 28	54, 582. 00	23. 20	33.00
34.00	Dietary	10.00	0	0		0 0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		893, 805	0	893, 80	36, 392. 00		
36.00	Cafeteri a	11.00	0	0		0 0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0		0 0.00	0.00	37.00
38.00	Nursing Administration	13.00	1, 726, 777	63, 252	1, 790, 02	44, 132. 00	40. 56	38.00
39.00	Central Services and Supply	14.00	0	0		0 0.00	0.00	39.00
40.00	Pharmacy	15.00	1, 606, 373	18, 624	1, 624, 99	32, 423. 00	50. 12	40.00
41.00	Medi cal Records & Medi cal Records Library	16.00	0	0		0 0.00	0.00	41.00
42.00	Social Service	17.00	0	0		0 0.00	0.00	42.00
43.00	Other General Service	18.00	0	0		0 0.00	0.00	43.00

Heal th	Financial Systems	Ą	SCENSION ST. V	INCENT KOKOMO		In Lie	eu of Form CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION			Provider CO		Period:	Worksheet S-3	
						From 07/01/2021 To 06/30/2022		hared
							11/28/2022 1:	
		Worksheet A		Recl assi fi cati			Average Hourly	
		Line Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from	(col.2 ± col.		col. 5)	
				Worksheet A-6)		col. 4		
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY		1				
1.00	Net salaries (see		41, 354, 610	3, 711	41, 358, 32	1 1, 024, 825. 00	40.36	1.00
	instructions)							
2.00	Excluded area salaries (see		4, 102, 642	194, 884	4, 297, 52	6 89, 511. 00	48. 01	2.00
	instructions)							
3.00	Subtotal salaries (line 1		37, 251, 968	-191, 173	37, 060, 79	5 935, 314. 00	39.62	3.00
1 00	minus line 2)		40 (4( 000		40 (4( 00	100 700 51	F ( 00	4 00
4.00	Subtotal other wages & related		10, 646, 302	0	10, 646, 30	2 188, 790. 51	56.39	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		14, 238, 464	0	14, 238, 46	4 0.00	38. 42	5.00
( 00	(see inst.)		(0 10/ 70/	101 170		1 1 1 24 1 04 51	FF 11	( 00
6.00	Total (sum of lines 3 thru 5)		62, 136, 734					6.00
7.00	Total overhead cost (see		8, 723, 106	-514, 612	8, 208, 49	4 202, 427. 00	40. 55	7.00
	instructions)					1		

	Financial Systems ASCENSION ST. VINC AL WAGE RELATED COSTS	Provider CCN: 1	15-0010	Peri od:	worksheet S-3	
				From 07/01/2021		
				To 06/30/2022	Date/Time Pre 11/28/2022 1:	
					Amount	
					Reported	
					1.00	
	PART IV - WAGE RELATED COSTS					
	Part A - Core List					
	RETI REMENT COST					
0C	401K Employer Contributions				1, 890, 657	1
00	Tax Sheltered Annuity (TSA) Employer Contribution				0	2
00	Nonqualified Defined Benefit Plan Cost (see instructions)				0	3
00	Qualified Defined Benefit Plan Cost (see instructions)				0	4
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)					
00	401K/TSA Plan Administration fees				0	5
00	Legal /Accounting/Management Fees-Pension Plan				0	6
00	Employee Managed Care Program Administration Fees				224, 595	7
	HEALTH AND INSURANCE COST				1	
00	Health Insurance (Purchased or Self Funded)				0	
D1	Health Insurance (Self Funded without a Third Party Administra				0	8
02	Health Insurance (Self Funded with a Third Party Administrator	~)			4, 428, 631	8
03	Heal th Insurance (Purchased)				0	8
00	Prescription Drug Plan				1, 101, 580	
. 00	Dental, Hearing and Vision Plan				129, 487	
00	Life Insurance (If employee is owner or beneficiary)				69, 276	
. 00	Accident Insurance (If employee is owner or beneficiary)					12
. 00	Disability Insurance (If employee is owner or beneficiary)				289, 334	
. 00	Long-Term Care Insurance (If employee is owner or beneficiary)	)			0	
. 00	'Workers' Compensation Insurance Retirement Health Care Cost (Only current year, not the extrac	and name accord	nogui no	d by FACD 10/	12, 711	
. 00	Non cumulative portion)	ordinary accruai	require	U DY FASE 100.	0	16
	TAXES					
. 00	FICA-Employers Portion Only				0	17
00	Medicare Taxes - Employers Portion Only				2, 876, 151	
00	Unemployment Insurance					19
	State or Federal Unemployment Taxes				112	
00	OTHER				112	
00	Executive Deferred Compensation (Other Than Retirement Cost Re	eported on lines	s 1 throu	igh 4 above. (see	0	21
	instructions))			J		
00	Day Care Cost and Allowances				0	22
00	Tuition Reimbursement				14, 232	23
00	Total Wage Related cost (Sum of lines 1 -23)				11, 036, 766	24
	Part B - Other than Core Related Cost					
00	OTHER WAGE RELATED COSTS (SPECIFY)					25

Heal th	Financial Systems	ASCENSION ST. VI	NCENT KOKOMO	In Lie	u of Form CMS-2	2552-10
HOSPI T	AL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 15-0010	Peri od:	Worksheet S-3	
				From 07/01/2021	Part V	
				To 06/30/2022		
	Cost Center Description			Contract Labor	11/28/2022 1: Benefit Cost	52 pili
	cost center bescription			1.00	2.00	
	PART V - Contract Labor and Benefit Cost			1.00	2.00	
	Hospital and Hospital-Based Component Ident	tification:				
1.00	Total facility's contract labor and benefi			0	0	1.00
2.00	Hospi tal	1 0031		0	0	2.00
3.00	SUBPROVIDER - IPF			0	0	3.00
4.00	SUBPROVIDER - IRF			0	0	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			0	0	8.00
9,00	NURSING FACILITY					9.00
10,00	OTHER LONG TERM CARE I					10.00
11.00	Hospi tal -Based HHA					11.00
12.00	AMBULATORY SURGICAL CENTER (D. P.) I					12.00
13.00	Hospi tal -Based Hospi ce					13.00
14.00	Hospital-Based Health Clinic RHC					14.00
15.00	Hospital-Based Health Clinic FQHC					15.00
16.00	Hospi tal -Based-CMHC					16.00
17.00	RENAL DIALYSIS I			0	0	
18.00	Other			0	0	18.00
10.00				0	0	1 10.00

Heal th	Financial Systems ASCENSION ST. VINCENT KOKO	OMO	In Lie	eu of Form CMS-:	2552-10
		er CCN: 15-0010	Peri od:	Worksheet S-1	0
			From 07/01/2021 To 06/30/2022		pared:
				11/28/2022 1:	
				1.00	
	Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by	y line 202 colum	ın 8)	0. 214746	1.00
	Medicaid (see instructions for each line)			1	
2.00	Net revenue from Medicaid			13, 490, 692	
3.00 4.00	Did you receive DSH or supplemental payments from Medicaid? If line 3 is yes, does line 2 include all DSH and/or supplemental paym	monte from Modic	ch icc		3.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medi			0	
6.00	Medi cai d charges			109, 432, 478	
7.00	Medicaid cost (line 1 times line 6)			23, 500, 187	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7	minus sum of li	nes 2 and 5; if	10, 009, 495	8.00
	< zero then enter zero)	1:			
9.00	Children's Health Insurance Program (CHIP) (see instructions for each Net revenue from stand-alone CHIP	TTne)		0	9.00
10.00	Stand-al one CHIP charges			0	
11.00	Stand-alone CHIP cost (line 1 times line 10)			0	
12.00	Difference between net revenue and costs for stand-alone CHIP (line 1)	1 minus line 9;	if < zero then	0	12.00
	enter zero)				
10.00	Other state or local government indigent care program (see instruction				1 1 2 . 00
13.00 14.00	Net revenue from state or local indigent care program (Not included on Charges for patients covered under state or local indigent care progra			0	13.00 14.00
14.00	10)		i i i i i i i i i i i i i i i i i i i	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)			0	15.00
16.00	Difference between net revenue and costs for state or local indigent of	care program (li	ne 15 minus line	0	16.00
	13; if < zero then enter zero)	/			
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and s instructions for each line)	state/local indi	gent care progra	ms (see	
17.00	Private grants, donations, or endowment income restricted to funding of	charity care		0	17.00
18.00	Government grants, appropriations or transfers for support of hospital	5		0	
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indige	ent care program	ns (sum of lines	10, 009, 495	19.00
	8, 12 and 16)	Uni nsured	Insured	Total (col. 1	
		patients	patients	+ col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)			1	
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	7, 503, 1	04 814, 367	8, 317, 471	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (se	ee 1, 611, 2	814, 367	2, 425, 629	21.00
	instructions)		_		
22.00	Payments received from patients for amounts previously written off as		0 C	0	22.00
23.00	charity care Cost of charity care (line 21 minus line 22)	1, 611, 2	814, 367	2, 425, 629	23.00
				1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days imposed on patients covered by Medicaid or other indigent care program		i of stay limit	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indig	gent care progra	m's length of	0	25.00
24 00	stay limit			4 254 450	24 00
26.00 27.00	Total bad debt expense for the entire hospital complex (see instruction Medicare reimbursable bad debts for the entire hospital complex (see in			6, 254, 458 178, 787	
27.00	Medicare allowable bad debts for the entire hospital complex (see ins:			275, 056	
28.00	Non-Medicare bad debt expense (see instructions)			5, 979, 402	
	Non-Medicare bad debt expense (see instructions) Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see	see instructions	5)	5, 979, 402	
28.00 29.00 30.00		see instructions	)		29.00 30.00

	Financial Systems A SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	SCENSION ST. VI EXPENSES	Provider CC		Period:	u of Form CMS-2 Worksheet A	2002-10
					rom 07/01/2021 0 06/30/2022	Date/Time Pre 11/28/2022 1:	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT		3, 689, 983	3, 689, 983	3 -2, 743	3, 687, 240	1.00
2.00	00200 CAP REL COSTS-BEDG & TTXT		4, 219, 523	4, 219, 523		4, 219, 523	2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	517, 482	7, 460, 893	7, 978, 375		7, 562, 749	4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	1, 953, 849	45, 123, 156	47,077,005		46, 811, 221	5.00
7.00	00700 OPERATION OF PLANT	0	4, 565, 104	4, 565, 104		4, 565, 104	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	О	0	(	462, 705	462, 705	8.00
9.00	00900 HOUSEKEEPI NG	0	2, 143, 858	2, 143, 858		1, 735, 889	9.00
10.00	01000 DI ETARY	0	2, 498, 205	2, 498, 205		1, 427, 220	
11.00	01100 CAFETERI A	0	0	(	.,	1, 070, 985	
13.00	01300 NURSI NG ADMI NI STRATI ON	1, 726, 777	401, 980	2, 128, 757		2, 200, 314	13.00
15.00	01500 PHARMACY	1, 606, 373	166, 171	1, 772, 544			15.00
16.00 23.00	01600 MEDICAL RECORDS & LIBRARY 02300 ALLIED HEALTH RAD TECH PROGRAM	0 93, 459	0	100 17	-	0 230, 199	16.00 23.00
23.00	INPATIENT ROUTINE SERVICE COST CENTERS	93, 439	35, 716	129, 175	101, 024	230, 199	23.00
30.00	03000 ADULTS & PEDI ATRI CS	7, 243, 797	1, 747, 496	8, 991, 293	649, 129	9, 640, 422	30.00
31.00	03100 I NTENSI VE CARE UNI T	2, 368, 152	702, 846	3, 070, 998		3, 115, 019	1
41.00	04100 SUBPROVI DER – I RF	1, 133, 368	132, 474	1, 265, 842		1, 338, 729	
43.00	04300 NURSERY	0	0	(			43.00
	ANCILLARY SERVICE COST CENTERS						]
50.00	05000 OPERATI NG ROOM	3, 167, 629	2, 363, 193	5, 530, 822			
52.00	05200 DELIVERY ROOM & LABOR ROOM	2, 209, 422	425, 280	2, 634, 702			52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 617, 348	770, 535	2, 387, 883			
54.01	03630 ULTRA SOUND	348, 236	39, 168	387, 404		391, 332	54.01
56.00	05600 RADI OI SOTOPE	658, 588	368, 123	1, 026, 71			
57.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	646, 445	78, 564	725, 009		732, 300	
58.00 59.00	05900 CARDIAC CATHETERIZATION	327, 006 323	43, 463 7, 730	370, 469 8, 053		374, 157 8, 057	58.00 59.00
60.00	06000 LABORATORY	166, 377	6, 333, 351	6, 499, 728		6, 501, 605	60.00
65.00	06500 RESPI RATORY THERAPY	1, 446, 629	298, 691	1, 745, 320		1, 761, 636	1
66.00	06600 PHYSI CAL THERAPY	3, 379, 864	475, 051	3, 854, 915		2, 689, 665	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	(		1, 006, 554	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	(	164, 419	164, 419	68.00
69.00	06900 ELECTROCARDI OLOGY	326, 334	71, 514	397, 848	3, 681	401, 529	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	545, 770	169, 500	715, 270		711, 275	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	205, 242	858, 908	1, 064, 150			
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	3, 135, 688	3, 135, 688		3, 135, 688	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	13, 585, 760	13, 585, 760		13, 585, 760	
74.00 76.00	07400 RENAL DI ALYSI S 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0 770, 302	287, 633	287, 633 835, 613		287, 633	74.00
76.00	03190 CHEMOTHERAPY	727,872	65, 311 7, 539, 954	8, 267, 826			1
	03330 ENDOSCOPY	8,469	21, 224	29, 693			
	03950 WOUND CARE CENTER	197, 830	746, 926	944, 756			1
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	2, 432, 704	1, 355, 596	3, 788, 300	27, 023	3, 815, 323	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS				1		
95.00	09500 AMBULANCE SERVICES	2,047,427	386, 452	2, 433, 879		2, 456, 972	
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0	0	(	0 0	0	98.00
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE	07 070 074	0	(	-		113.00
118.00		37, 873, 074	112, 315, 020	150, 188, 094	4 -1, 664	150, 186, 430	118.00
102 00	NONREI MBURSABLE COST CENTERS 19200 PHYSI CLANS' PRI VATE OFFI CES	645, 352	2, 640, 064	3, 285, 416	663	3, 286, 079	102 00
192.00	19200 PHYSICIANS PRIVATE OFFICES	040, 302	2, 640, 064 -8, 706	3, 285, 410		3, 288, 079 -8, 706	
	19201 ASC MOB 19202 EDUCATION CENTER	0	-8, 706 14, 824	-8,700 14,824		-8,706 14,824	
	19203 MARKETI NG	0	14, 024 Ω	14, 02	) n		192.02
	19300 NONPALD WORKERS	0	0	(			193.00
193.00		U	0				
	07950 FOUNDATI ON	O	0	(	0	0	194.00
194.00	07950 FOUNDATION 07951 GIFT SHOP	0	0	(		0	194. 00 194. 01
194.00 194.01	07951 GIFT SHOP 07952 CLINIC OF HOPE	0 0 183, 036	0 0 35, 270	( ( 218, 306	-	0 0 219, 307 153, 697, 934	194. 01 194. 02

	Financial Systems SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	ASCENSION ST. V OF EXPENSES	INCENT KOKOMO Provider CC	N: 15-0010	In Li	eu of Form CMS- Worksheet A	2552-10
					From 07/01/2021 To 06/30/2022		epared:
	Cost Center Description	Adjustments	Net Expenses			111/28/2022 1.	52 pill
		(See A-8) 6.00	For Allocation 7.00				
	GENERAL SERVICE COST CENTERS	0.00	7.00				
1.00	00100 CAP REL COSTS-BLDG & FIXT	-536, 686	3, 150, 554				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	0	4, 219, 523				2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	353, 353	7, 916, 102				4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	-11, 908, 166	34, 903, 055				5.00
7.00	00700 OPERATION OF PLANT	-47, 490	4, 517, 614				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	462, 705				8.00
9.00	00900 HOUSEKEEPI NG	0	1, 735, 889				9.00
10.00	01000 DI ETARY	-75, 905	1, 351, 315				10.00
11.00		-368, 048					11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	-176, 530					13.00
15.00		0	7, 107, 017				15.00
16.00 23.00	01600 MEDICAL RECORDS & LIBRARY 02300 ALLIED HEALTH RAD TECH PROGRAM	-15, 545	214, 654				16.00 23.00
23.00	INPATIENT ROUTINE SERVICE COST CENTERS	-15, 545	214,054				_ 23.00
30.00	03000 ADULTS & PEDI ATRI CS	-1,093	9, 639, 329				30.00
31.00		-7, 929					31.00
41.00	04100 SUBPROVIDER - IRF	0	1, 338, 729				41.00
43.00	04300 NURSERY	0	490, 015				43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	-11, 981	5, 554, 424				50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	-37					52.00
54.00		-177, 485					54.00
54.01	03630 ULTRA SOUND	0	391, 332				54.01
56.00	05600 RADI OI SOTOPE	0	1,034,129				56.00
57.00	05700 CT SCAN	0	732, 300				57.00
58.00 59.00	05800 MAGNETIC RESONANCE I MAGI NG (MRI)	0	374, 157				58.00 59.00
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	-97, 267	8, 057 6, 404, 338				60.00
65.00	06500 RESPI RATORY THERAPY		1, 761, 636				65.00
66.00	06600 PHYSI CAL THERAPY	-5, 766					66.00
67.00	06700 OCCUPATI ONAL THERAPY	0,700	1,006,554				67.00
68.00		0	164, 419				68.00
69.00	06900 ELECTROCARDI OLOGY	0	401, 529				69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	711, 275				70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1, 066, 465				71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	3, 135, 688				72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	13, 585, 760				73.00
74.00		0	287, 633				74.00
76.00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	-23, 500					76.00
76.01	03190 CHEMOTHERAPY	-367, 131	2, 592, 790				76.01
76. 02 76. 03	03330 ENDOSCOPY 03950 WOUND CARE CENTER	0					76.02 76.03
70.03	OUTPATIENT SERVICE COST CENTERS	0	940, 907				_ /0.03
91 00	09100 EMERGENCY	-175,000	3, 640, 323				91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0,010,020				92.00
	OTHER REIMBURSABLE COST CENTERS		1 1				
95.00	09500 AMBULANCE SERVICES	27, 343	2, 484, 315				95.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0	0				98.00
	SPECIAL PURPOSE COST CENTERS	- <b>F</b>					
	11300 INTEREST EXPENSE	0					113.00
118.00		-13, 614, 863	136, 571, 567				118.00
100 -	NONREI MBURSABLE COST CENTERS	-	0.00/.0=-				100.00
	19200 PHYSICIANS' PRIVATE OFFICES	0					192.00
	I 19201 ASC MOB 2 19202 EDUCATI ON CENTER	0	-,				192.01
	19202 EDUCATION CENTER 19203 MARKETING		14, 824 0				192. 02 192. 03
	0 19203 MARKETTING 0 19300 NONPALD WORKERS		0				192.03
	07950 FOUNDATI ON						193.00
	07951 GI FT SHOP	0	0				194.00
	207952 CLINIC OF HOPE	0	219, 307				194.02
200.00		-13, 614, 863					200.00
	· · · · · · · · · · · · · · · · · · ·						

Heal th	Fi nanci al	Systems
RECLAS	SLELCATION	IS

### ASCENSION ST. VINCENT KOKOMO Provider CCN: 15-0010 Period:

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

RECLAS	SIFICATIONS			Provider CCN	15-0010	Peri od:	Worksheet A-	-6
						From 07/01/2021 To 06/30/2022	Date/Time Pr	
		Increases					11/28/2022 1	1:52 pm
	Cost Center	Line #	Salary	Other				
	2.00 A - LAUNDRY RECLASS	3.00	4.00	5.00				
1.00	LAUNDRY & LINEN SERVICE	8.00	0	462, 705				1.00
2.00		0.00	0	0				2.00
3.00 4.00		0.00	0	0				3.00
4.00	TOTALS		<u>o</u>	462, 705				4.00
	B - NURSERY RECLASS		V	402,703				
1.00	ADULTS & PEDIATRICS	30.00	388, 961	74, 752				1.00
2.00	NURSERY	43.00	411,023	7 <u>8, 9</u> 92				2.00
			799, 984	153, 744				-
1.00	C – CAFETERIA RECLASS CAFETERIA	11.00	0	1,070,985				1.00
	TOTALS		<u>_</u>	1, 070, 985				
	D - PT_OT_SPEECH RECLASS							
1.00	OCCUPATI ONAL THERAPY	67.00	883, 657	122, 897				1.00
2.00	SPEECH PATHOLOGY	<u></u>	<u> </u>	2 <u>0, 075</u> 142, 972				2.00
	E - RADI OLOGY TECHNI CI AN RECL	ASS	1, 028, 001	142, 972				
1.00	ALLIED HEALTH RAD TECH	23.00	99, 970	0				1.00
	PROGRAM							
	TOTALS		99, 970	0				_
1.00	F - INTEREST EXPENSE A&G ADMINISTRATIVE & GENERAL	5.00	0	2, 743				1.00
1.00	TOTALS		0	2,743				1.00
	G - PTO SALARY ACCRUAL		1					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	<u> </u>	0				1.00
	TOTALS		88, 548	0				-
1.00	H - STARP SALARY RECLASS EMPLOYEE BENEFITS DEPARTMENT	4.00	1, 136	0				1.00
2.00	ADMI NI STRATI VE & GENERAL	5.00	15, 859	0				2.00
3.00	NURSING ADMINISTRATION	13.00	19, 476	0				3.00
4.00	PHARMACY	15.00	18, 118	0				4.00
5.00	ALLIED HEALTH RAD TECH	23.00	1, 054	0				5.00
6.00	ADULTS & PEDIATRICS	30.00	81, 689	0				6.00
7.00	INTENSIVE CARE UNIT	31.00	26, 621	0				7.00
8.00	SUBPROVI DER – I RF	41.00	12, 783	0				8.00
9.00	OPERATING ROOM	50.00	35, 330	0				9.00
10. 00 11. 00	DELIVERY ROOM & LABOR ROOM RADIOLOGY-DIAGNOSTIC	52.00 54.00	24, 920 18, 242	0				10.00
12.00	ULTRA SOUND	54.01	3, 928	Ö				12.00
13.00	RADI OI SOTOPE	56.00	7, 418	0				13.00
14.00	CT SCAN	57.00	7, 291	0				14.00
15.00	MAGNETIC RESONANCE I MAGI NG	58.00	3, 688	0				15.00
16.00	(MRI) CARDIAC CATHETERIZATION	59.00	4	0				16.00
17.00	RESPI RATORY THERAPY	65.00	16, 316	0				17.00
18.00	PHYSI CAL THERAPY	66.00	38, 121	0				18.00
19.00	ELECTROCARDI OLOGY	69.00	3, 681	0				19.00
20. 00 21. 00	ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO	70.00 71.00	6, 156 2, 315	0				20.00
21.00	PATI ENTS	/1.00	2, 515	0				21.00
22.00	PSYCHI ATRI C/PSYCHOLOGI CAL	76.00	8, 688	0				22.00
00.00	SERVICES		7					00.00
23.00 24.00	CHEMOTHERAPY ENDOSCOPY	76. 01 76. 02	7, 944 96	0				23.00 24.00
24.00 25.00	WOUND CARE CENTER	76.02	2, 231	0				24.00
26.00	LABORATORY	60.00	1, 877	Ő				26.00
27.00	EMERGENCY	91.00	27, 023	0				27.00
28.00	AMBULANCE SERVICES	95.00	23, 093	0				28.00
29.00	PHYSICIANS' PRIVATE OFFICES	192.00	663 1 001	0				29.00
30.00	CLINIC OF HOPE	194.02	<u>1, 001</u> 416, 762	<u>0</u>				30.00
	I - SCK RECLASS							
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	883				1.00
2.00	NURSING ADMINISTRATION	13.00	0	8, 305				2.00
3.00	ADULTS & PEDIATRICS	30. 00 31. 00	0	26, 981				3.00
4.00 5.00	I NTENSI VE CARE UNI T SUBPROVI DER – I RF	41.00	0	7, 533 1, 456				4.00
6.00	OPERATI NG ROOM	50.00	0	4, 979				6.00
7.00	DELIVERY ROOM & LABOR ROOM	52.00	0	8, 948				7.00
8.00	RADI OLOGY-DI AGNOSTI C	54.00	0	7,057				8.00
9.00	RADI OI SOTOPE	56.00	0	5, 240				9.00

## Health Financial Systems RECLASSIFICATIONS

# ASCENSION ST. VINCENT KOKOMO Provider CCN: 15-0010 Period:

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

11202/10					From 07/01/2021		0
					To 06/30/2022	Date/Time Pr 11/28/2022 1	
		Increases					
	Cost Center	Line #	Salary	Other			
	2. 00	3.00	4.00	5.00			
10.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	1, 547			10.00
11.00	RESPI RATORY THERAPY	65.00	0	1, 407			11.00
12.00	PHYSI CAL THERAPY	66.00	0	4, 544			12.00
13.00	ELECTROENCEPHALOGRAPHY	70.00	0	1, 977			13.00
14.00	CHEMOTHERAPY	76.01	0	1, 001			14.00
15.00	LABORATORY	60.00	0	651			15.00
16.00	AMBULANCE SERVICES	95.00	0	1, 502			16.00
17.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	826			17.00
	TOTALS		0	84, 837			
	J - CHEMOTHERAPY PHARMACEUTIC	CAL RECLASS					
1.00	PHARMACY		0	<u>5, 315, 8</u> 49			1.00
	TOTALS		0	5, 315, 849			
	K - SYSTEM PROJECTS						_
1.00	ADMI NI STRATI VE & GENERAL	5.00	674	0			1.00
2.00	NURSING ADMINISTRATION	13.00	52, 081	0			2.00
3.00	PHARMACY	15.00	506	0			3.00
4.00	ADULTS & PEDIATRICS	30.00	103, 727	0			4.00
5.00	INTENSIVE CARE UNIT	31.00	17, 400	0			5.00
6.00	SUBPROVI DER – I RF	41.00	60, 104	0			6.00
7.00	DELIVERY ROOM & LABOR ROOM	52.00	48, 765	0			7.00
8.00	OPERATING ROOM	50.00	253	0			8.00
9.00	PHYSICAL THERAPY	<u>    66.</u> 00	<u> </u>	0			9.00
	TOTALS		285, 060	0			
500.00	Grand Total: Increases		2, 718, 325	7, 233, 835			500.00

CLAS	Financial Systems SIFICATIONS		SCENSION ST. VI		CCN: 15-0010	Period: From 07/01/2021	u of Form CMS-25 Worksheet A-6	/02 10
						To 06/30/2022	Date/Time Prepa 11/28/2022 1:52	
	Cost Center	Decreases Li ne #	Salary	Other	Wkst. A-7 Ref	-   -		
	6.00	7.00	Sal ary 8.00	9.00	10.00	<u>.</u>		
20	A - LAUNDRY RECLASS	0.00		407.0(0				1 00
00 00	HOUSEKEEPI NG RADI OLOGY-DI AGNOSTI C	9.00 54.00	0	407, 969 10, 637		0		1.00 2.00
00	PHYSICAL THERAPY	66.00	0	33, 948		0		3.00
00		<u>70.</u> 00	0	1 <u>0, 1</u> 51		Q		4.00
	TOTALS B - NURSERY RECLASS		0	462, 705				
00	DELIVERY ROOM & LABOR ROOM	52.00	799, 984	153, 744		0		1.00
00	TOTALS	0.00	00000	0 153, 744		0		2.00
	C - CAFETERIA RECLASS		777,704	155,744				
00	DI ETARY	10.00	0	<u>1, 070, 9</u> 85		0		1.00
	TOTALS D - PT_OT_SPEECH RECLASS		0	1, 070, 985				
00	PHYSICAL THERAPY	66.00	1, 028, 001	142, 972		0		1.00
00		0.00	0	0		<u>o</u>		2.00
	TOTALS E - RADIOLOGY TECHNICIAN RECLA	SS	1, 028, 001	142, 972				
00	RADI OLOGY-DI AGNOSTI C	54.00	99, 970	0		0		1.00
	TOTALS		99, 970	0				
00	F - INTEREST EXPENSE A&G CAP REL COSTS-BLDG & FIXT	1.00	0	2, 743	1	1		1.00
-	TOTALS			2,743		1		
20	G - PTO SALARY ACCRUAL	4.00		00 540		0		1 00
00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	8 <u>8, 5</u> 48 88, 548		0		1.00
	H - STARP SALARY RECLASS				1	1		
00 00	EMPLOYEE BENEFITS DEPARTMENT	4.00 0.00	416, 762 0	0		0		1.00 2.00
0		0.00	0	0		0		3.00
0		0.00	О	0		0		4.00
) )		0.00 0.00	0	0		0		5.00 6.00
5		0.00	0	0		0		7.00
D		0.00	О	0		0		8.00
) 00		0.00 0.00	0	0		0		9.00 10.00
00		0.00	0	0		0		11.00
00		0.00	0	0		0		12.0
)0 )0		0.00 0.00	0	0		0		13.0 14.0
00		0.00	0	0		0		15.0
00		0.00	0	0		0		16.0
00 00		0. 00 0. 00	0 O	0		0		17.0 18.0
00		0.00	Ö	0		0		19.0
00		0.00	0	0		0		20.0
00 00		0. 00 0. 00	0	0		0		21.0 22.0
00		0.00	Ö	0		0		23.0
00		0.00	0	0		0		24.0
00 00		0. 00 0. 00	0 0	0		0		25.0 26.0
00		0.00	Ö	0		0	:	27.0
00		0.00	0	0		0		28.0
00 00		0. 00 0. 00	0	0 0		0		29.00 30.00
	TOTALS		416, 762	0		1		
0	I - SCK RECLASS	E OO	000	0		0		1 00
0	ADMI NI STRATI VE & GENERAL NURSI NG ADMI NI STRATI ON	5.00 13.00	883 8, 305	0		0		1.00 2.00
C	ADULTS & PEDIATRICS	30.00	26, 981	0		0		3.0
0 0	I NTENSI VE CARE UNI T SUBPROVI DER – I RF	31.00 41.00	7, 533 1, 456	0 0		0		4.0 5.0
0	OPERATING ROOM	41.00 50.00	4, 979	0		0		5.00 6.00
C	DELIVERY ROOM & LABOR ROOM	52.00	8, 948	0		0		7.0
0 0	RADI OLOGY-DI AGNOSTI C RADI OI SOTOPE	54.00 56.00	7, 057 5, 240	0		0		8.0 9.0
00	MAGNETIC RESONANCE IMAGING	58.00 58.00	5, 240	0		0		9.00
	(MRI)							
00	RESPI RATORY THERAPY PHYSI CAL THERAPY	65.00 66.00	1, 407 4, 544	0 0		0		11.00 12.00
00	ELECTROENCEPHALOGRAPHY	66.00 70.00	4, 544 1, 977	0		0		12.00
. 00	CHEMOTHERAPY	76.01	1,001	0		0		14.00

### MCRI F32 - 17. 12. 175. 4

Heal th	Financial Systems		ASCENSION ST. V	INCENT KOKOMO		In Lie	u of Form CMS	-2552-10
RECLAS	SIFICATIONS			Provider (	CCN: 15-0010	Peri od:	Worksheet A-	6
						From 07/01/2021		
						To 06/30/2022	Date/Time Pr 11/28/2022 1	
		Decreases					11/28/2022 1	: 52 pm
	Cost Center	Li ne #	Salary	Other	Wkst. A-7 Rei	e		
	6. 00	7.00	8.00	9,00	10.00	· · ·		
15.00	LABORATORY	60.00	651	7.00	10.00	0		15.00
16.00	AMBULANCE SERVICES	95.00	1, 502	0		0		16.00
17.00	PHYSICIANS' PRIVATE OFFICES	192.00	826	0		0		17.00
17.00			84,837	0	)			17.00
	J - CHEMOTHERAPY PHARMACEUTIC	CAL RECLASS	01,007					1
1.00	CHEMOTHERAPY	76.01	0	5, 315, 849	)	0		1.00
	TOTALS			5, 315, 849		-		1
	K - SYSTEM PROJECTS		i		1			
1.00	ADMI NI STRATI VE & GENERAL	5.00	285, 060	0	)	0		1.00
2.00		0.00	0	0	)	0		2.00
3.00		0.00	0	0	)	0		3.00
4.00		0.00	0	0	)	0		4.00
5.00		0.00	0	0	)	0		5.00
6.00		0.00	0	0	)	0		6.00
7.00		0.00	0	0	)	0		7.00
8.00		0.00	0	0		0		8.00
9.00		0.00	0	0	)	0		9.00
	TOTALS		285, 060	ō	)			
500.00	Grand Total: Decreases		2, 714, 614	7, 237, 546				500.00
						-		

Heal th	Financial Systems	ASCENSION ST. V	INCENT KOKOMO			In Lie	u of Form CMS-2	2552-10
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provider CO	CN: 15-0010		riod: om 07/01/2021 06/30/2022		pared:
				Acqui si ti on			11/28/2022 1:	52 pm
		Begi nni ng	Purchases	Donati on	<u> </u>	Total	Di sposal s and	
		Bal ances	i di chases	bonation		Total	Retirements	
		1.00	2.00	3.00		4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	BALANCES						
1.00	Land	671, 919	0		0	0	0	1.00
2.00	Land Improvements	1, 934, 722	381, 820		0	381, 820	0	2.00
3.00	Buildings and Fixtures	54, 713, 594	7, 158		0	7, 158	132, 717	3.00
4.00	Building Improvements	27, 964, 926	1, 018, 285		0	1, 018, 285	58, 264	4.00
5.00	Fixed Equipment	21, 083, 741	0		0	0	364, 759	5.00
6.00	Movable Equipment	53, 435, 683	2, 129, 533		0	2, 129, 533	2, 983, 322	6.00
7.00	HIT designated Assets	0	0		0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	159, 804, 585	3, 536, 796		0	3, 536, 796	3, 539, 062	8.00
9.00	Reconciling Items	0	0		0	0	0	9.00
10.00	Total (line 8 minus line 9)	159, 804, 585	3, 536, 796		0	3, 536, 796	3, 539, 062	10.00
		Ending Balance	Fully					
		Ŭ	Depreci ated					
			Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET							
1.00	Land	671, 919	0					1.00
2.00	Land Improvements	2, 316, 542	0					2.00
3.00	Buildings and Fixtures	54, 588, 035	0					3.00
4.00	Building Improvements	28, 924, 947	0					4.00
5.00	Fixed Equipment	20, 718, 982	0					5.00
6.00	Movable Equipment	52, 581, 894	0					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	159, 802, 319	0					8.00
9.00	Reconciling Items	0	0					9.00
10.00	Total (line 8 minus line 9)	159, 802, 319	0					10.00

Heal th	Financial Systems	ASCENSION ST. V	INCENT KOKOMO		In Lie	eu of Form CMS-2	2552-10
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provider CC		Period: From 07/01/2021	Worksheet A-7 Part II	
					To 06/30/2022	Date/Time Pre	
				JMMARY OF CAPI		11/28/2022 1:	52 pm
			30	JIVIIVIART OF CAPT	TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
					instructions)		
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	2, 719, 903	395, 474	536, 68	6 0	37, 920	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	3, 571, 014	427,009		0 0	9, 463	2.00
3.00	Total (sum of lines 1-2)	6, 290, 917	822, 483	536, 68	6 0	47, 383	3.00
		SUMMARY C	F CAPITAL				
	Cost Center Description		Total (1) (sum				
		Capi tal -Rel ate					
		d Costs (see	through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	3, 689, 983				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	212, 037	4, 219, 523				2.00
3.00	Total (sum of lines 1-2)	212,037	7, 909, 506				3.00
			•				•

Health Financial Systems	ASCENSION ST. V	INCENT KOKOMO		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C	F 1	Period: From 07/01/2021 To 06/30/2022		
	COMI	PUTATION OF RAT	FI OS	ALLOCATION OF	OTHER CAPI TAL	
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)		Insurance	
PART III - RECONCILIATION OF CAPITAL COSTS C	1.00	2.00	3.00	4.00	5.00	
1.00 CAP REL COSTS-BLDG & FIXT 2.00 CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)	0 0 0	0 0 TION OF OTHER (	CAPI TAL	0 1.000000 0.000000 1.000000 SUMMARY 0	0 0	1.00 2.00 3.00
Cost Center Description	Taxes	Other Capi tal -Rel ate 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 CI 1. 00 CAP REL COSTS-BLDG & FIXT	ENTERS			2, 719, 903	395, 474	1.00
2.00 CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)	0			3, 571, 014 6, 290, 917		2.00 3.00
		SL	JMMARY OF CAPI			
Cost Center Description	Interest	Insurance (see instructions)		Other Capital-Relate d Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CI1.00CAP REL COSTS-BLDG & FIXT2.00CAP REL COSTS-MVBLE EQUIP3.00Total (sum of lines 1-2)	ENTERS -2, 743 0 -2, 743	0	9, 463	3 212, 037		1.00 2.00 3.00

	Financial Systems MENTS TO EXPENSES	A:	SCENSION ST. V	INCENT KOKOMO Provider CCN: 15-0010	Peri od:	u of Form CMS-2 Worksheet A-8	2552-10
					From 07/01/2021 To 06/30/2022	Date/Time Prep 11/28/2022 1:	
				Expense Classification o To/From Which the Amount is			<u>52 pm</u>
	Cost Center Description	Basis/Code (2)	Amount	Cost Center		Wkst. A-7 Ref.	
1.00	Investment income - CAP REL	1.00 B	<u>2.00</u> -530,596	3.00 CAP REL COSTS-BLDG & FIXT	4.00	5.00 11	1.00
2.00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other	В		ADMI NI STRATI VE & GENERAL	5.00		3.00
4.00	(chapter 2) Trade, quantity, and time		0		0.00		4.00
5.00	di scounts (chapter 8) Refunds and rebates of		0		0.00		5. 00
	expenses (chapter 8)		0				
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00		6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-9, 674	ADMI NI STRATI VE & GENERAL	5.00	0	8.00
9.00 10.00	Parking Lot (chapter 21) Provi der-based physici an adjustment	A-8-2	0 -744, 346		0.00	0 0	9. 00 10. 00
11.00	Sale of scrap, waste, etc.		0		0.00	0	11.00
12.00	(chapter 23) Related organization transactions (chapter 10)	A-8-1	5, 333, 962			0	12.00
13.00 14.00	Laundry and linen service Cafeteria-employees and guests	В	000269	CAFETERI A	0.00 11.00		
15.00	Rental of quarters to employee		-308, 048		0.00		
16.00	and others Sale of medical and surgical supplies to other than		0		0.00	0	16.00
17.00	patients Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and	В	-1, 066	ADMI NI STRATI VE & GENERAL	5.00	0	18.00
19. 00	abstracts Nursing and allied health education (tuition, fees,		0		0.00	0	19. 00
20.00	books, etc.) Vending machines	В		DI ETARY	10.00		
21.00	interest, finance or penalty		0		0.00	0	21.00
22.00	charges (chapter 21) Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22.00
23.00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPI RATORY THERAPY	65.00		23.00
24.00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	limitation (chapter 14) Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114.00		25.00
26.00	(chapter 21) Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	COSTS-BLDG & FIXT Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	COSTS-MVBLE EQUIP Non-physician Anesthetist		0	*** Cost Center Deleted ***	* 19.00		28.00
29. 00 30. 00	Physicians' assistant Adjustment for occupational therapy costs in excess of	A-8-3	0	OCCUPATI ONAL THERAPY	0.00 67.00		29. 00 30. 00
30. 99	limitation (chapter 14) Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
31.00	instructions) Adjustment for speech	A-8-3		SPEECH PATHOLOGY	68.00		31.00
	pathology costs in excess of limitation (chapter 14)						
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00		
33.00	LOBBYING EXPENSE OFFSET	A	-1, 774	ADMI NI STRATI VE & GENERAL	5.00	0	33.00

Heal th	Fi nanci a	al Systems
AD JUST	MENTS TO	EXPENSES

#### ASCENSION ST. VINCENT KOKOMO

In Lieu of Form CMS-2552-10

	H,	SCENSION SI. V				
ADJUSTMENTS TO EXPENSES			F	Period: rom 07/01/2021	Worksheet A-8	
			[ ]	To 06/30/2022	Date/Time Pre 11/28/2022 1:	
			Expense Classification on	Worksheet A		
			To/From Which the Amount is	to be Adjusted		
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	
3. 01 BUILDING RENTAL INCOME	В	-14, 954	CHEMOTHERAPY	76.01	0	33.
CHEMOTHERAPY						
3. 02 BUILDING RENTAL INCOME	В	-16, 298	OPERATION OF PLANT	7.00	0	33.
3.03 MISC. INCOME ADMIN & GENERAL	В	101 /25	ADMI NI STRATI VE & GENERAL	5.00	0	33.
33. 04 MISC. INCOME HUMAN RESOURCES	B		EMPLOYEE BENEFITS DEPARTMENT			
3. 05 MISC. INCOME RECYCLING	B		OPERATION OF PLANT	7.00		
3. 06 MISC. INCOME MEDICAL AFFAIRS	В		ADMI NI STRATI VE & GENERAL	5.00		
3. 07 MISC. INCOME MEDICAL AFFAIRS	В		ADMI NI STRATI VE & GENERAL	5.00		
DUES						
3.08 MISC. INCOME SOUTHWAY REHAB	В	-3, 566	PHYSICAL THERAPY	66.00	0	33.
3.09 MISC. INCOME FORESTPARK REHAB			PHYSI CAL THERAPY	66.00		
3.10 MISC. INCOME PATIENT INT, INC	В		ADMI NI STRATI VE & GENERAL	5.00		
3.11 MISC. INCOME RAD TECH TUITION	В		ALLIED HEALTH RAD TECH	23.00	0	33.
	D		PROGRAM	7/ 01		22
3. 12 MISC. INCOME CHEMOTHERAPY	В		CHEMOTHERAPY	76.01		
3. 13MISC. INCOME MEALS ON WHEELS3. 14MISC. INCOME IC RENTAL INCOME	B B	-74,092	OPERATION OF PLANT	10.00		
4. 00 PROVIDER TAX EXPENSE	A		ADMI NI STRATI VE & GENERAL	5.00		
4. 01 PHYSICIAN FUND EXPENSE	A		ADMI NI STRATI VE & GENERAL	5.00		
4. 02 MID LEVEL PROVIDER OFFSET	A		ADULTS & PEDIATRICS	30.00		
4. 03 MID LEVEL PROVIDER OFFSET	A		INTENSIVE CARE UNIT	31.00		
4.04 MID LEVEL PROVIDER OFFSET	A		PSYCHI ATRI C/PSYCHOLOGI CAL	76.00		
			SERVI CES			
4.05 MID LEVEL PROVIDER OFFSET	A		LABORATORY	60.00		
4.06 ANDERSON AMBULANCE EXPENSES	A		AMBULANCE SERVICES	95.00		
5.00 TELEVISION EXPENSE UTILITIES	A		OPERATION OF PLANT	7.00		
5. 01 BAD DEBT NON-PATIENT DIETARY	A		DI ETARY	10.00		
5. 02 BAD DEBT NON-PATI ENT	A	-3, 650	CHEMOTHERAPY	76.01	0	35.
CHEMOTHERAPY 5. 03 ENTERTAL NMENT ADMI NI STRATI ON	А	_1 635	ADMI NI STRATI VE & GENERAL	5.00	0	35.
5. 04 ENTERTAINMENT LABOR AND	A		DELIVERY ROOM & LABOR ROOM	52.00		
DELIVERY		-57		52.00		
5. 05 ENTERTAI NMENT CHEMOTHERAPY	А	-249	CHEMOTHERAPY	76.01	0	35.
5. 06 ENTERTALNMENT AMBULANCE	A		AMBULANCE SERVICES	95.00		35.
5.07 MARKETING INFUSION SERVICES	A	-45	CHEMOTHERAPY	76.01	0	35.
5. 08 DONATI ONS	A		NURSING ADMINISTRATION	13.00		
5. 09 DONATI ONS	A	-10, 000	NURSING ADMINISTRATION	13.00		
5. 10 OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	35.
		40 (44 6/6				50
50.00 TOTAL (sum of lines 1 thru 49)		-13, 614, 863				50.
(Transfer to Worksheet A, column 6, line 200.)						
				1	L	I

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.(2) Basis for adjustment (see instructions).

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

Heal th	Financial Systems	ASCENSION ST.	VINCENT KOKOMO	In Lie	eu of Form CMS-	2552-10
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HO		Peri od:	Worksheet A-8	8-1
OFFICE	COSTS			From 07/01/2021 To 06/30/2022	Date/Time Pre	narod
				10 00/30/2022	11/28/2022 1:	
	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	
	A. COSTS INCURRED AND ADJUST	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OF	RGANIZATIONS OR	CLAIMED	
1.00	HOME OFFICE COSTS:	EMPLOYEE BENEFITS DEPARTMENT		6, 258, 826	5, 905, 448	1.00
2.00			HOME OFFICE CAPITAL	2, 031, 873	5, 905, 446 0	2.00
3.00			HOME OFFICE INTEREST EXPENSE		0	3.00
3.00		ADMINISTRATIVE & GENERAL	HOME OFFICE INTEREST EXPENSE		0	3.00
3.02		ADMINI STRATI VE & GENERAL	HOME OFFICE OTHER	31, 244, 534	27, 655, 412	3.02
3.03			SVH CHARGEBACK	2,468	2,468	3.03
3.04			SVH CHARGEBACK	-24,000	-24,000	3.04
3.05	23.00	ALLIED HEALTH RAD TECH PROGR		28, 370	28, 370	3.05
3.06	54.00	RADI OLOGY-DI AGNOSTI C	SVH CHARGEBACK	41, 540	41, 540	3.06
3.07	56.00	RADI OI SOTOPE	SVH CHARGEBACK	10, 437	10, 437	3.07
3.08	59.00	CARDI AC CATHETERI ZATI ON	SVH CHARGEBACK	5,000	5,000	3.08
3.09	69.00	ELECTROCARDI OLOGY	SVH CHARGEBACK	5,000	5,000	3.09
3.10			SVH CHARGEBACK	100	100	3.10
3.11		PHYSICIANS' PRIVATE OFFICES	SVH CHARGEBACK	1, 843, 224	1, 843, 224	3. 11
3.12			INTEREST EXPENSE A&G	2, 743	0	3. 12
3.13		CAP REL COSTS-BLDG & FIXT	INTEREST EXPENSE	530, 596	536, 686	3.13
4.00		ADMINISTRATIVE & GENERAL	TRG ADMINISTRATIVE FEES	-505, 863	0	4.00
4.01		ADMINISTRATIVE & GENERAL	TRG ADMINISTRATIVE FEES	-26, 750	0	4.01
4.02		NURSING ADMINISTRATION	TRG ADMINISTRATIVE FEES	-157,979	0	4.02
5.00	TOTALS (sum of lines 1-4).			41, 343, 647	36, 009, 685	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

1103 110	L DEEL POSTEU TO MOLKSHEET A,	corumns ranu/or z, the amoun	it allowable sh	ouru be murcateu micorumin 4	or this part.	
				Related Organization(s) and/	or Home Office	
	Symbol (1)	Name	Percentage of	Name	Percentage of	
	Symbol (1)	Name		Name		
			Ownership		Ownershi p	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HO	ME OFFICE:			

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

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

rerinbur			
6.00	В	0.00 SVH HOME OFFICE 100.00	6.00
7.00		0.00 0.00	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 provider.

Health Financial Systems	ASCENSION ST. VINC	ENT KOKOMO	In Lieu	u of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES F OFFICE COSTS	ROM RELATED ORGANIZATIONS AND HOME	Provider CCN: 15-0010	From 07/01/2021	Worksheet A-8-1
				Date/Time Prepared:

							11/28/202	<u>2 1:52 pm</u>
	Net	Wkst. A-7 Ref.						
	Adjustments							
	(col. 4 minus							
	col. 5)*							
	6.00	7.00						
			MENTS REQUIRED AS A RESU	LT OF TRAN	SACTIONS WITH REL	ATED OF	GANIZATIONS OR CLAIMED	
	HOME OFFICE CO							
1.00	353, 378							1.00
2.00	2, 031, 873							2.00
3.00	53, 208							3.00
3.01	320							3. 01
3.02	3, 589, 122	0						3. 02
3.03	0	0						3. 03
3.04	0	0						3.04
3.05	0	0						3.05
3.06	0	0						3.06
3.07	0	0						3.07
3.08	0	0						3. 08
3.09	0	0						3.09
3.10	0	0						3. 10
3.11	0	0						3. 11
3.12	2,743	0						3. 12
3.13	-6, 090	11						3.13
4.00	-505, 863	0						4.00
4.01	-26, 750	0						4.01
4.02	-157, 979	0						4.02
5.00	5, 333, 962							5.00
* The	amounts on line	es 1-4 (and sub	scripts as appropriate)	are trans	ferred in detail t	to Work	sheet A. column 6. lines a	IS

\* 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

nas not	been posted to worksheet A,	cordinas r and/or z, the amount arrowable should be rhulcated rif cordinar 4 or this part.	
	Related Organization(s)		
	and/or Home Office		
	Type of Business	1	
	6. 00	1	
	B. INTERRELATIONSHIP TO RELA	TED ORGANIZATION(S) AND/OR HOME OFFICE:	
	B. INTERRELATIONSHIP TO RELA	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

6.00	6.00
7.00 8.00 9.00 10.00	7.00
8.00	8.00
9.00	9.00
10.00	10.00
100.00	100.00

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

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
 B. Corporation, partnership, or other organization has financial interest in provider.

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

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

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

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

Heal th	Fi nanci a	I Systems	
	ED DACED	DUVELCLAN	

### ASCENSION ST. VINCENT KOKOMO In Lieu of Form CMS-2552-10

PROVI DE	R BASED PHYSICI	AN ADJUSTMENT		Provider (		Period:	Worksheet A-8	3-2
						From 07/01/2021 To 06/30/2022	Date/Time Pre	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		Identifier	Remunerati on	Component	Component		ider Component	
							Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00		ADMINISTRATIVE & GENERAL	459, 212		194, 619	211, 500	1, 375	1.00
2.00	50.000	OPERATING ROOM	35, 200	0	35, 200	246, 400	196	2.00
3.00		RADI OLOGY-DI AGNOSTI C	177, 485		(	0 0	0	3.00
4.00		RADI OI SOTOPE	-25, 250		-25, 250	0 0	-114	4.00
5.00	91.00 E	EMERGENCY	175, 000	175, 000	(	0 0	0	5.00
6.00		_ABORATORY	157, 487	0	157, 487	211, 500	954	6.00
7.00	0.00		0	0	(	0 0	0	7.00
8.00	0.00		0	0	(	0 0	0	8.00
9.00	0.00		0	0	(	0 0	0	9.00
10.00	0.00		0	0	(	0 0	0	10.00
200.00			979, 134		362, 056	5	2, 411	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		Identifier	Limit	Unadjusted RCE			of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00		ADMINISTRATIVE & GENERAL	139, 814	6, 991	(	-	0	1.00
2.00		DPERATING ROOM	23, 219	1, 161	(	-	0	2.00
3.00		RADI OLOGY-DI AGNOSTI C	0	0	(	-	0	3.00
4.00		RADI OI SOTOPE	0	0	(	0	0	4.00
5.00		EMERGENCY	0	0	(	0	0	5.00
6.00		_ABORATORY	97, 005	4, 850	(	0 0	0	6.00
7.00	0.00		0	0	(	0 0	0	7.00
8.00	0.00		0	0	(	0 0	0	8.00
9.00	0.00		0	0	(	0 0	0	9.00
10.00	0.00		0	0	(	0 0	0	10.00
200.00			260, 038			-	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1.00	2.00	14 15.00	16.00	17.00	18.00		
1.00		ADMINISTRATIVE & GENERAL	13.00					1.00
2.00		OPERATING ROOM	0	23, 219				2.00
3.00		RADI OLOGY - DI AGNOSTI C		23, 219	11, 90			3.00
4.00		RADI OI SOTOPE		0				4.00
4.00 5.00		EMERGENCY	0	0		175,000		4.00 5.00
6.00		_ABORATORY		97,005	60, 482			5.00 6.00
7.00	0.00			77,003	00, 402			7.00
7.00 8.00	0.00					, v		
8.00 9.00	0.00			0				8.00 9.00
	0.00		0	0				
10.00	0.00		0	240.020	-	-		10.00 200.00
200.00	I I		0	260, 038	127, 268	3 744, 346		200.00

In Lieu of Form CMS-2552-10 Worksheet B

COST ALLOCATION - GENERAL SERVICE COSTS		Provider C	F	eriod: rom 07/01/2021 o 06/30/2022	Worksheet B Part I Date/Time Pre	
		CAPI TAL REI	LATED COSTS		11/28/2022 1:	52 pm
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFI TS DEPARTMENT	Subtotal	
	col. 7)					
GENERAL SERVI CE COST CENTERS	0	1.00	2.00	4.00	4A	
1.00 00100 CAP REL COSTS-BLDG & FIXT	3, 150, 554	3, 150, 554	1			1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP	4, 219, 523		4, 219, 523			2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	7, 916, 102	121, 865			05 770 4/7	4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL 7. 00 00700 OPERATI ON OF PLANT	34, 903, 055 4, 517, 614	476, 368 437, 176			35, 772, 167 5, 018, 612	5.00 7.00
8.00 00800 LAUNDRY & LINEN SERVICE	462, 705	4, 924			467, 629	1
9. 00 00900 HOUSEKEEPI NG	1, 735, 889	19, 154	c	0	1, 755, 043	•
10. 00 01000 DI ETARY	1, 351, 315	49, 478			1, 415, 250	•
11. 00 01100 CAFETERIA 13. 00 01300 NURSI NG ADMI NI STRATI ON	702, 937 2, 023, 784	59, 982 51, 912			774, 997 2, 606, 968	•
15. 00 01500 PHARMACY	7, 107, 017	30, 409			7, 484, 940	
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	23, 261			25, 997	
23. 00 02300 ALLIED HEALTH RAD TECH PROGRAM	214, 654	8, 517	C	40, 588	263, 759	23.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS           30. 00         03000 ADULTS & PEDI ATRI CS	9, 639, 329	279, 891	152, 177	1, 626, 021	11, 697, 418	30.00
31. 00 03100 I NTENSI VE CARE UNI T	3, 107, 090	53, 575			3, 758, 096	
41.00 04100 SUBPROVIDER - IRF	1, 338, 729	128, 976	589	251, 439	1, 719, 733	
43. 00 04300 NURSERY	490, 015	15, 295	22, 560	85, 780	613, 650	43.00
ANCI LLARY SERVI CE COST CENTERS	5, 554, 424	310, 358	632, 169	667, 465	7, 164, 416	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	1, 754, 622	310, 338			2, 170, 669	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 118, 033	226, 440			3, 443, 417	
54.01 03630 ULTRA SOUND	391, 332	0	124, 278	73, 496	589, 106	
56. 00 05600 RADI 0I SOTOPE	1,034,129	19, 012	580, 667		1, 771, 709	
57.00 05700 CT SCAN 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	732, 300 374, 157	0	283, 354		868, 733 726, 203	
59. 00 05900 CARDI AC CATHETERI ZATI ON	8, 057	3, 802			28, 625	
60. 00 06000 LABORATORY	6, 404, 338	75, 096			6, 517, 991	
65. 00 06500 RESPI RATORY THERAPY	1, 761, 636	11, 759			2, 120, 040	1
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	2,683,899	68, 585 29, 430			3, 273, 531	
68. 00 06800 SPEECH PATHOLOGY	1, 006, 554 164, 419	29, 430 9, 886			1, 229, 001 205, 834	
69. 00 06900 ELECTROCARDI OLOGY	401, 529	38, 052			644, 127	•
70. 00 07000 ELECTROENCEPHALOGRAPHY	711, 275	25, 932			872, 729	•
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	1,066,465	40, 961			1, 245, 997	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	3, 135, 688 13, 585, 760	0		0	3, 135, 688 13, 585, 760	
74. 00 07400 RENAL DIALYSIS	287, 633	0	c c	0	287, 633	
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	820, 801	43, 642	14, 749	162, 574	1, 041, 766	
76. 01 03190 CHEMOTHERAPY	2, 592, 790	0			3, 318, 508	
76. 02 03330 ENDOSCOPY 76. 03 03950 WOUND CARE CENTER	29, 789 946, 987	0 28, 518			39, 422 1, 026, 972	76.02 76.03
OUTPATIENT SERVICE COST CENTERS	940, 987	20, 510	9,713	41,752	1, 020, 972	70.03
91. 00 09100 EMERGENCY	3, 640, 323	183, 844	123, 442	513, 340	4, 460, 949	91.00
92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)					0	92.00
OTHER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVI CES	2, 484, 315	37, 719	82, 467	431, 800	3, 036, 301	95.00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	2,404,315	37, 719			3, 030, 301	
SPECIAL PURPOSE COST CENTERS			-			
113.00 11300 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	136, 571, 567	2, 944, 846	4, 206, 108	7, 864, 909	136, 179, 386	118.00
NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	3, 286, 079	194, 215	2, 534	134, 650	3, 617, 478	192 00
192. 01 19201 ASC MOB	-8, 706	0	9, 793			192.00
192.02 19202 EDUCATI ON CENTER	14, 824	0	C			192. 02
192. 03 19203 MARKETI NG	0	0	C	0		192.03
193. 00 19300 NONPAI D WORKERS 194. 00 07950 FOUNDATI ON	0	0		0		193.00
194. 01 07950 FOUNDATION 194. 01 07951 GIFT SHOP	0	1, 711 9, 782		0		194. 00 194. 01
194. 02 07952 CLINIC OF HOPE	219, 307	0	1, 088	38, 408	258, 803	
200.00 Cross Foot Adjustments					0	200. 00
201.00 Negative Cost Centers	140 000 074	0		0		201.00
202.00  TOTAL (sum lines 118 through 201)	140, 083, 071	3, 150, 554	4, 219, 523	8, 037, 967	140, 083, 071	202.00

Health Financial Systems	ASCENSION ST. VI				u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CO		eriod: rom 07/01/2021 o 06/30/2022	Worksheet B Part I Date/Time Pre	pared:
Cost Center Description	ADMI NI STRATI VE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	11/28/2022 1: DI ETARY	<u>52 pm</u>
	5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS						
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 ADMINI STRATI VE & GENERAL 7. 00 00700 OPERATI ON OF PLANT	35, 772, 167 1, 721, 073	6, 739, 685				5.00 7.00
8.00 00800 LAUNDRY & LINEN SERVICE	160, 368	15, 690				8.00
9. 00 00900 HOUSEKEEPI NG	601, 871	61, 033		2, 615, 595		9.00
10. 00 01000 DI ETARY	485, 343	157, 657			2, 058, 250	10.00
11. 00 01100 CAFETERI A	265, 776	191, 127	0	0	0	11.00
13.00 01300 NURSING ADMINISTRATION	894, 028	165, 411	0	2, 003	0	13.00
15.00 01500 PHARMACY	2, 566, 870	96, 896		0	0	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	8, 915	74, 118			0	16.00
23. 00 02300 ALLIED HEALTH RAD TECH PROGRAM INPATIENT ROUTINE SERVICE COST CENTERS	90, 453	27, 139	0	0	0	23.00
30. 00 03000 ADULTS & PEDI ATRI CS	4, 011, 489	891, 844	205, 570	761, 045	1, 362, 927	30.00
31. 00 03100 I NTENSI VE CARE UNI T	1, 288, 794	170, 712			250, 409	31.00
41.00 04100 SUBPROVIDER - IRF	589, 762	410, 968			323, 001	41.00
43. 00 04300 NURSERY	210, 444	48, 736	8, 407	103, 395	121, 913	43.00
ANCI LLARY SERVI CE COST CENTERS			-	i		
50. 00 05000 OPERATING ROOM	2, 456, 950	988, 921	6, 441	400, 551	0	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM 54. 00 05400 RADIOLOGY-DIAGNOSTIC	744, 405 1, 180, 879	98, 865			0	52.00 54.00
54. 01 03630 ULTRA SOUND	202, 027	721, 526 0			0	54.00 54.01
56. 00 05600 RADI OI SOTOPE	607, 586	60, 579			0	56.00
57. 00 05700 CT SCAN	297, 922	0		0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	249, 043	0	1, 894	0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	9, 817	12, 116			0	59.00
	2, 235, 267	239, 287			0	60.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	727, 042 1, 122, 618	37, 468 218, 539			0	65.00 66.00
67. 00 06700 OCCUPATIONAL THERAPY	421, 471	93, 776			0	67.00
68. 00 06800 SPEECH PATHOLOGY	70, 588	31, 501			0	68.00
69. 00 06900 ELECTROCARDI OLOGY	220, 896	121, 249			0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	299, 292	82, 630	0	34, 047	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		130, 517			0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1,075,347	0			0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 74. 00 07400 RENAL DIALYSIS	4, 659, 066	0		30, 041	0	73.00 74.00
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	98, 640 357, 261	139,059	-	13, 352 26, 703	0	76.00
76. 01 03190 CHEMOTHERAPY	1, 138, 042	0			0	76.01
76. 02 03330 ENDOSCOPY	13, 519	0	0	0	0	76.02
76.03 03950 WOUND CARE CENTER	352, 188	90, 868	0	42, 725	0	76.03
OUTPATIENT SERVICE COST CENTERS	1 500 000		00.405			
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 529, 829	585, 799	98, 435	240, 330	0	91.00 92.00
OTHER REIMBURSABLE COST CENTERS	)					92.00
95. 00 09500 AMBULANCE SERVICES	1, 041, 263	120, 189	829	0	0	95.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0			0	98.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 1	17) 34, 433, 444	6, 084, 220	643, 687	2, 615, 595	2, 058, 250	118.00
NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	1, 240, 571	618, 845	0	0	0	192. 00
192. 01 19201 ASC MOB	373	018, 845				192.00
192. 02 19202 EDUCATI ON CENTER	5, 084	0	0	0		192.02
192. 03 19203 MARKETI NG	0	0	0	0	0	192.03
193. 00 19300 NONPAI D WORKERS	0	0	0	0	0	193.00
194. 00 07950 FOUNDATI ON	587	5, 452		0		194.00
194. 01 07951 GI FT SHOP	3, 355	31, 168		0		194.01
194.02 07952 CLINIC OF HOPE 200.00  Cross Foot Adjustments	88, 753	0	0	0		194. 02 200. 00
200.00 ICTOSS FOOT Adjustments 201.00 Negative Cost Centers	0	Ο	n	0	n	200.00
202.00 TOTAL (sum lines 118 through 201)	35, 772, 167	6, 739, 685	643, 687	2, 615, 595	2, 058, 250	
<b>3</b> ,						

Health Financial Systems	ASCENSION ST. \	/INCENT KOKOMO		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC	F	eriod: rom 07/01/2021 o 06/30/2022	Worksheet B Part I Date/Time Pre 11/28/2022 1:	pared:
Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	PHARMACY	MEDI CAL RECORDS & LI BRARY	ALLIED HEALTH RAD TECH PROGRAM	
	11.00	13.00	15.00	16.00	23.00	
GENERAL SERVICE COST CENTERS	1	1				
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUI P						2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMINISTRATIVE & GENERAL						4.00 5.00
7. 00 00700 OPERATION OF PLANT						7.00
8.00 00800 LAUNDRY & LINEN SERVICE						8.00
9.00 00900 HOUSEKEEPI NG						9.00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERIA	1, 231, 900					11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	66, 943					13.00
	49, 182		10, 219, 033			15.00
16.00 01600 MEDICAL RECORDS & LIBRARY 23.00 02300 ALLIED HEALTH RAD TECH PROGRAM	3, 481		0		384, 832	16.00 23.00
INPATIENT ROUTINE SERVICE COST CENTERS	5,401	ч <u> </u>	0	0	304, 032	23.00
30. 00 03000 ADULTS & PEDI ATRI CS	293, 201	1, 348, 091	0	5, 839	0	30.00
31.00 03100 INTENSIVE CARE UNIT	74, 899	404, 151	0	2, 296	0	31.00
41.00 04100 SUBPROVIDER - IRF	52, 266	307, 613	0		0	41.00
43. 00 04300 NURSERY	11, 105	5 105, 330	0	473	0	43.00
ANCI LLARY SERVI CE COST CENTERS	100,100	500 550	-	44 474		50.00
50. 00 05000 OPERATING ROOM	103, 483 48, 495		0		0	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM 54. 00 05400 RADI 0LOGY-DI AGNOSTI C	48, 495		0		0 117, 213	52.00 54.00
54. 01 03630 ULTRA SOUND	8, 657		0		40, 660	•
56. 00 05600 RADI OI SOTOPE	27, 826	1	0		129, 335	•
57.00 05700 CT SCAN	19, 610		0		80, 145	•
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	10, 439	0	0		17, 479	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	Ģ	-,	0	-	0	59.00
60. 00 06000 LABORATORY	10, 456		0		0	60.00
65. 00 06500 RESPI RATORY THERAPY	49, 132		0		0	65.00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	97, 338 36, 642	1 1	0		0	66.00 67.00
68. 00 06800 SPEECH PATHOLOGY	5, 986	1	0		0	68.00
69. 00 06900 ELECTROCARDI OLOGY	11, 733	1 1	0		0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	23, 232		0		0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	13, 599	0	0	3, 334	0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	C		0		0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0		10, 219, 033		0	73.00
74. 00 07400 RENAL DI ALYSI S 76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	31, 415		0	-	0	74.00
76. 01 03190 CHEMOTHERAPY	28, 311		0		0	76.00
76. 02 03330 ENDOSCOPY	296		0		0	76.02
76.03 03950 WOUND CARE CENTER	8, 684					•
OUTPATIENT SERVICE COST CENTERS	1			1		
91.00 09100 EMERGENCY	76, 373	402, 160	0	12, 212	0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES	0		0	3, 508	0	95.00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS		<u>,                                     </u>			0	/0.00
113.00 11300 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 224, 487	3, 684, 834	10, 219, 033	109, 698	384, 832	118.00
NONREI MBURSABLE COST CENTERS						
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0		0			192.00
192. 01 19201 ASC MOB	0		0	0		192.01
192. 02 19202 EDUCATI ON CENTER 192. 03 19203 MARKETI NG			0			192. 02 192. 03
193. 00 19300 NONPALD WORKERS			0	0		193.00
194. 00 07950 FOUNDATI ON	0	o o	0	0		194.00
194. 01 07951 GI FT SHOP	C	0 0	0	0		194. 01
194. 02 07952 CLINIC OF HOPE	7,413	3 13, 539	0	0		194.02
200.00 Cross Foot Adjustments			_	_		200.00
201.00Negative Cost Centers202.00TOTAL (sum lines 118 through 201)	1, 231, 900	) 0 3, 735, 353	0 10, 219, 033	0 109, 698		201.00
202.00 TITL (3011 THES TO THOUGH 201)	1,231,900	າ 3,730,303	10, 217, 033	107,090	1 304, 032	1202.00

Health Financial Systems	ASCENSION ST.	/INCENT KOKOMO		In Lieu of Form C	MS-2552-10
COST ALLOCATI ON - GENERAL SERVI CE COSTS		Provider CC	F	eriod: Worksheet rom 07/01/2021 Part I o 06/30/2022 Date/Time	Prepared:
Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	11/28/2022	2 1:52 pm
	24.00	25.00	26.00		
GENERAL         SERVI CE         COST         CENTERS           1.00         00100         CAP         REL         COSTS-BLDG         & FIXT		[ [			1.00
2.00 00200 CAP REL COSTS MVBLE EQUIP					2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00 00500 ADMINI STRATI VE & GENERAL					5.00
7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE					7.00 8.00
9. 00 00900 HOUSEKEEPING					9.00
10. 00 01000 DI ETARY					10.00
11. 00 01100 CAFETERI A					11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON					13.00
15. 00  01500  PHARMACY 16. 00  01600  MEDI CAL_RECORDS_&_LI BRARY					15.00 16.00
23. 00 02300 ALLIED HEALTH RAD TECH PROGRAM					23.00
INPATIENT ROUTINE SERVICE COST CENTERS		11			20100
30. 00 03000 ADULTS & PEDI ATRI CS	20, 577, 424		20, 577, 424		30.00
31.00 03100 I NTENSI VE CARE UNI T	6, 204, 438	1 1	6, 204, 438		31.00
41. 00 04100 SUBPROVI DER – I RF 43. 00 04300 NURSERY	3, 610, 271	1 1	3, 610, 271		41.00 43.00
ANCI LLARY SERVICE COST CENTERS	1, 223, 453		1, 223, 453		43.00
50. 00 05000 OPERATI NG ROOM	11, 646, 985	j 0	11, 646, 985		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	3, 726, 805		3, 726, 805		52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	5, 597, 946	1	5, 597, 946		54.00
54. 01 03630 ULTRA SOUND 56. 00 05600 RADI 0I SOTOPE	854, 506	1 1	854, 506		54.01 56.00
57. 00 05700 CT SCAN	2, 651, 607 1, 276, 409	-	2, 651, 607 1, 276, 409		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	1,005,664	1	1,005,664		58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	67, 329	0	67, 329		59.00
60. 00 06000 LABORATORY	9, 102, 896	1 1	9, 102, 896		60.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	2, 964, 351 4, 727, 867	1 1	2, 964, 351 4, 727, 867		65.00 66.00
67. 00 06700 OCCUPATIONAL THERAPY	1, 783, 143		4, 727, 887		67.00
68. 00 06800 SPEECH PATHOLOGY	323, 141		323, 141		68.00
69. 00 06900 ELECTROCARDI OLOGY	1, 030, 713	1 1	1, 030, 713		69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	1, 313, 252	1	1, 313, 252		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 905, 668 4, 213, 326		1, 905, 668		71.00
73. 00 07200 DRUGS CHARGED TO PATIENTS	28, 506, 912	1	4, 213, 326 28, 506, 912		73.00
74. 00 07400 RENAL DI ALYSI S	399, 895	1 1	399, 895		74.00
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	1, 614, 077		1, 614, 077		76.00
76. 01 03190 CHEMOTHERAPY	4, 572, 396		4, 572, 396		76.01
76.02 03330 ENDOSCOPY 76.03 03950 WOUND CARE CENTER	64, 257 1, 554, 358		64, 257 1, 554, 358		76. 02 76. 03
OUTPATIENT SERVICE COST CENTERS	1, 334, 330		1, 334, 330		/0.03
91.00 09100 EMERGENCY	7, 406, 087	/ 0	7, 406, 087		91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)		0			92.00
OTHER REIMBURSABLE COST CENTERS	4 202 000		4 202 000		05.00
95.00 09500 AMBULANCE SERVICES 98.00 09850 OTHER REIMBURSABLE COST CENTERS	4, 202, 090	1 1	4, 202, 090 0		95.00 98.00
SPECIAL PURPOSE COST CENTERS		<u>/</u>	0		70.00
113.00 11300 INTEREST EXPENSE					113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	134, 127, 266	0	134, 127, 266		118.00
NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	5, 513, 874	4 O	5, 513, 874		192.00
192. 00 19200 PHYSICIANS PRIVATE OFFICES	1,460	1 1	5, 513, 874		192.00
192. 02 19202 EDUCATI ON CENTER	19, 908		19, 908		192.02
192. 03 19203 MARKETI NG	0	0	0		192.03
193.00 19300 NONPALD WORKERS	(		0	1	193.00
194. 00 07950 FOUNDATI ON 194. 01 07951 GLFT SHOP	7, 750 44, 305	1 1	7, 750 44, 305		194.00 194.01
194. 02 07952 CLINIC OF HOPE	368, 508	1 1	44, 305 368, 508		194.01
200.00 Cross Foot Adjustments	(	1 1	000,000		200.00
201.00 Negative Cost Centers	0	0 0	0		201.00
202.00   TOTAL (sum lines 118 through 201)	140, 083, 071	0	140, 083, 071		202.00

ealth Financial Systems LLOCATION OF CAPITAL RELATED		ASCENSION ST. V	Provider CO		Period: From 07/01/2021 To 06/30/2022	Worksheet B Part II Date/Time Pre 11/28/2022 1:	epared:
			CAPI TAL REL	ATED COSTS		11/28/2022 1:	<u>52 piii</u>
Cost Center Desc	ription	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
			1.00	2.00	2A	4.00	
GENERAL SERVICE COST C	ENTERS						
.00         00100         CAP         REL         COSTS-BLI           .00         00200         CAP         REL         COSTS-MVI           .00         00400         EMPLOYEE         BENEFIT           .00         00500         ADMI NI STRATI VE &           .00         00700         OPERATI ON OF PLAI           .00         00800         LAUNDRY & LI NEN           .00         00900         HOUSEKEEPI NG           .00         01000         DI ETARY	BLE EQUI P S DEPARTMENT GENERAL NT	0 2, 031, 873 0 0 0 0 0	121, 865 476, 368 437, 176 4, 924 19, 154 49, 478	41, 20 63, 82	2 500, 998 0 4, 924 0 19, 154	121, 865 5, 330 0 0 0 0 0 0	5. 0 7. 0 8. 0 9. 0
1.00 01100 CAFETERIA 3.00 01300 NURSING ADMINISTI 5.00 01500 PHARMACY 6.00 01600 MEDICAL RECORDS 3 3.00 02300 ALLIED HEALTH RAI	& LI BRARY		59, 982 51, 912 30, 409 23, 261 8, 517	12, 07 157, 69 8, 38 2, 73	7 209, 609 0 38, 789	0 5, 664 5, 141 0 615	13. 0 15. 0 16. 0
INPATIENT ROUTINE SERV		· · · · ·	0,01,	· · · · · · · · · · · · · · · · · · ·		010	
0.00 03000 ADULTS & PEDIATR 1.00 03100 INTENSIVE CARE UI 1.00 04100 SUBPROVIDER - IRI 3.00 04300 NURSERY	NI T F	0 0 0	279, 891 53, 575 128, 976 15, 295	152, 17 95, 58 58 22, 56	7 149, 162 9 129, 565	7, 608 3, 812	31.0 41.0
ANCI LLARY SERVICE COST 0.00 05000 OPERATI NG ROOM 2.00 05200 DELI VERY ROOM & I	LABOR ROOM	0	310, 358 31, 027	632, 16 77, 36	3 108, 390		52.0
4. 00 05400 RADI OLOGY-DI AGNO 4. 01 03630 ULTRA SOUND 6. 00 05600 RADI OI SOTOPE	SIIC	0 0 0	226, 440 0 19, 012	779, 93 124, 27 580, 66	8 124, 278 7 599, 679	2, 091	54. C 56. C
7. 00 05700 CT SCAN 8. 00 05800 MAGNETIC RESONAN 9. 00 05900 CARDIAC CATHETER		0 0 0	0 0 3, 802	283, 35 16, 69	B 20, 500	2, 068 1, 041 1	58. 0 59. 0
0. 00 06000 LABORATORY 5. 00 06500 RESPI RATORY THER/ 6. 00 06600 PHYSI CAL THERAPY	APY	0 0 0	75, 096 11, 759 68, 585	3, 57 41, 62 22, 88	5 53, 384	530 4, 624 7, 552	65.0
7. 00 06700 OCCUPATI ONAL THE 8. 00 06800 SPEECH PATHOLOGY 9. 00 06900 ELECTROCARDI OLOG <sup>3</sup>		0 0 0	29, 430 9, 886 38, 052	8, 60 1, 40 135, 67	5 11, 291	2, 796 457 1, 044	68. (
0.00 07000 ELECTROENCEPHALO 1.00 07100 MEDICAL SUPPLIES 2.00 07200 IMPL. DEV. CHARGE 3.00 07300 DRUGS CHARGED TO	CHARGED TO PATIENTS ED TO PATIENTS	000000000000000000000000000000000000000	25, 932 40, 961 0 0	(	4 136, 215 0 0 0 0	1, 740 657 0 0	71. 72. 73.
4. 00 07400 RENAL DI ALYSI S 6. 00 03550 PSYCHI ATRI C/PSYCI 6. 01 03190 CHEMOTHERAPY 6. 02 03330 ENDOSCOPY	HOLOGI CAL SERVI CES	0 0 0	0 43, 642 0 0		4 572, 364	0 2, 465 2, 325 27	76. 76.
6. 03 03950 WOUND CARE CENTER OUTPATI ENT SERVICE COS		0	28, 518	9, 71	5 38, 233	633	76.
1.00 09100 EMERGENCY 2.00 09200 OBSERVATION BEDS OTHER REIMBURSABLE COS		0	183, 844	123, 44	2 307, 286	7, 783	91. ( 92. (
5. 00 09500 AMBULANCE SERVI CI 8. 00 09850 OTHER REI MBURSABI SPECI AL PURPOSE COST C	ES LE COST CENTERS	0	37, 719 0		7 120, 186 0 0	6, 546 0	98. (
13. 00 11300 I NTEREST EXPENSE 18. 00 SUBTOTALS (SUM OI NONREI MBURSABLE COST C	F LINES 1 through 117) ENTERS	2, 031, 873	2, 944, 846	4, 206, 10	8 9, 182, 827	119, 242	113. 118.
92. 00 19200 PHYSI CLANS' PRI V 92. 01 19201 ASC MOB 92. 02 19202 EDUCATI ON CENTER 92. 03 19203 MARKETI NG		0 0 0 0	194, 215 0 0 0	2, 53 9, 79 (		0 0 0	192. 192. 192.
93. 00 19300 NONPAI D WORKERS 94. 00 07950 FOUNDATI ON 94. 01 07951 GI FT SHOP 94. 02 07952 CLI NI C OF HOPE		0 0 0	0 1, 711 9, 782 0	( ( ( 1, 08)	0 0 0 1, 711 0 9, 782 8 1, 088	0 0	193. 194. 194. 194.
00.00Cross Foot Adjus01.00Negative Cost Cer02.00TOTAL (sum lines	nters	2, 031, 873	0 3, 150, 554	4, 219, 52	0 0 0 3 9, 401, 950		200. 201. 202.

	Financial Systems	ASCENSION ST. VI	Provi der C	F	Period: From 07/01/2021 To 06/30/2022	u of Form CMS-: Worksheet B Part II Date/Time Pre	
	Cost Center Description	& GENERAL	OPERATION OF PLANT	LAUNDRY & LI NEN SERVI CE		11/28/2022 1: DI ETARY	52 pm
	CENEDAL SEDVICE COST CENTEDS	5.00	7.00	8.00	9.00	10.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FLXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 CAP REL COSTS-MVBLE EQUIP						1.00
4.00 5.00 7.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	2, 554, 776 122, 916	623, 914				4.00 5.00 7.00
3.00 9.00 10.00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY	11, 453 42, 985 34, 662	1, 452 5, 650 14, 595	5, 474	4 73, 263	113, 192	8.00 9.00 10.00
11.00 13.00 15.00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01500 PHARMACY	18, 981 63, 850 183, 321	17, 693 15, 313 8, 970	(	56	0 0 0	11.00 13.00 15.00
16. 00 23. 00	01600 MEDICAL RECORDS & LIBRARY 02300 ALLIED HEALTH RAD TECH PROGRAM	637 6, 460	8, 970 6, 861 <u>2, 512</u>		19	0 0 0	16.00 23.00
00 00	INPATIENT ROUTINE SERVICE COST CENTERS	204 402	00 5/1	E (0	7 01 017	74.052	
30.00 31.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	286, 493 92, 043	82, 561 15, 803			74, 953 13, 771	30.00 31.00
41.00	04100 SUBPROVI DER – I RF	42, 120	38, 045			17, 763	
43.00	04300 NURSERY	15,030	4, 512	233	3 2, 896	6, 705	43.00
50.00	ANCI LLARY SERVICE COST CENTERS	175, 471	91, 549	178	3 11, 219	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	53, 164	9, 152			0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	84, 336	66, 794			0	54.0
54.01	03630 ULTRA SOUND	14, 428	0			0	54.0
56.00 57.00	05600 RADI 0I SOTOPE 05700 CT SCAN	43, 393 21, 277	5, 608 0			0	56.0 57.0
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	17, 786	0			0	58.0
59.00	05900 CARDI AC CATHETERI ZATI ON	701	1, 122			0	59.0
50.00	06000 LABORATORY	159, 639	22, 152			0	60.0
65.00		51, 924	3, 469			0	65.0
56.00 57.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	80, 175 30, 101	20, 231 8, 681			0	66.0 67.0
58.00	06800 SPEECH PATHOLOGY	5, 041	2, 916			0	68.0
69.00	06900 ELECTROCARDI OLOGY	15, 776	11, 224			0	69.0
70. 00	07000 ELECTROENCEPHALOGRAPHY	21, 375	7, 649			0	70. C
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	30, 517	12, 082			0	71. C
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	76, 799	0			0	72. C
73.00 74.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	332, 733 7, 045	0		2 841 0 374	0	73. C
76.00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	25, 515	12, 873			0	76.0
76.01	03190 CHEMOTHERAPY	81, 277	0			0	76. C
76. 02	03330 ENDOSCOPY	966	0			0	76.0
76. 03	03950 WOUND CARE CENTER	25, 153	8, 412	(	0 1, 197	0	76. C
91.00	OUTPATIENT SERVICE COST CENTERS	109, 258	54, 229	2, 726	6, 732	0	91.0
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1077200	017227		0,,02	0	92.0
	OTHER REIMBURSABLE COST CENTERS	1					
95.00	09500 AMBULANCE SERVICES	74, 365	11, 126			0	95.0
98.00	09850 OTHER REIMBURSABLE COST CENTERS SPECIAL PURPOSE COST CENTERS	0	0	(	0 0	0	98.0
113.00	11300 I NTEREST EXPENSE						113.0
118.00	NONREI MBURSABLE COST CENTERS	2, 459, 166	563, 236			113, 192	1
	19200 PHYSICIANS' PRIVATE OFFICES	88, 599	57, 288				192.0
	19201 ASC MOB 19202 EDUCATI ON CENTER	27 363	0				192. 0 192. 0
	19203 MARKETI NG	0	0		0		192.0
	19300 NONPALD WORKERS	0	0		o o		193.0
	07950 FOUNDATI ON	42	505		0 0	0	194.0
	07951 GI FT SHOP	240	2, 885	(	0 0		194.0
	07952 CLINIC OF HOPE	6, 339	0	(	0 1	0	194.0
200. 00 201. 00			Ω			0	200. 0 201. 0
	TOTAL (sum lines 118 through 201)	2, 554, 776	623, 914	17, 829	73, 263		

	Financial Systems A TION OF CAPITAL RELATED COSTS	ASCENSION ST. \	/INCENT KOKOMO Provider CO		eri od:	u of Form CMS-2 Worksheet B	2552-10
					rom 07/01/2021	Part II	pared: 52 nm
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	PHARMACY	MEDI CAL RECORDS & LI BRARY	ALLIED HEALTH RAD TECH PROGRAM	
		11.00	13.00	15.00	16.00	23.00	
1 00	GENERAL SERVICE COST CENTERS	[					1 1 00
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY	400 704					10.00
11.00	01100 CAFETERIA	108, 734					11.00
13.00 15.00	01300 NURSING ADMINISTRATION 01500 PHARMACY	5, 909 4, 341		242, 263			13.00 15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	4, 341 C		242, 203	33, 514		16.00
23.00	02300 ALLIED HEALTH RAD TECH PROGRAM	307		0	00,011	18, 411	23.00
	INPATIENT ROUTINE SERVICE COST CENTERS			-	-		
30.00	03000 ADULTS & PEDI ATRI CS	25, 880	108, 414	0	1, 792		30.00
31.00	03100 I NTENSI VE CARE UNI T	6, 611		0	705		31.00
41.00	04100 SUBPROVI DER – I RF	4, 613		0	389		41.00
43.00	04300 NURSERY	980	8, 471	0	145		43.00
F0 00	ANCI LLARY SERVICE COST CENTERS	0.124	40.070	0	4.070		50.00
50. 00 52. 00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	9,134		0	4, 972		50.00 52.00
52.00 54.00	05400 RADI OLOGY-DI AGNOSTI C	4,280 5,445		0	1, 004 1, 246		52.00
54.00 54.01	03630 ULTRA SOUND	764		0	432		54.00
56.00	05600 RADI OI SOTOPE	2, 456		0	1, 375		56.00
57.00	05700 CT SCAN	1, 731		0	852		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	921	0	0	186		58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	1	274	0	2		59.00
60.00	06000 LABORATORY	923		0	4, 915		60.00
65.00	06500 RESPI RATORY THERAPY	4, 337		0	879		65.00
66.00	06600 PHYSI CAL THERAPY	8, 592		0	764		66.00
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	3, 234 528		0	282 46		67.00 68.00
69.00	06900 ELECTROCARDI OLOGY	1,036		0	783		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	2, 051		0	406		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 200		0	1, 023		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	C	0	0	689		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	C		242, 263	3, 970		73.00
74.00	07400 RENAL DI ALYSI S	C	, i i i i i i i i i i i i i i i i i i i	0	83		74.00
76.00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	2,773		0	241		76.00
76. 01 76. 02	03190 CHEMOTHERAPY 03330 ENDOSCOPY	2, 499 26		0	586 3		76.01
	03950 WOUND CARE CENTER	767					76.02
70.00	OUTPATIENT SERVICE COST CENTERS	, , , ,	2,100		721		/ 0. 00
91.00	09100 EMERGENCY	6, 741	32, 342	0	3, 747		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	C		0	1, 076		95.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	C	0 0	0	0		98.00
112 00	SPECIAL PURPOSE COST CENTERS						1112 00
113.00	11300 INTEREST EXPENSE	109 090	204 220	242 242	22 E14	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	108, 080	296, 338	242, 263	33, 514	0	118.00
192 00	19200 PHYSI CLANS' PRI VATE OFFI CES	C	2,974	0	0		192.00
	19201 ASC MOB	C		0	0		192.01
	19202 EDUCATION CENTER	C	0	0	0		192.02
	19203 MARKETI NG	C	0	0	0		192.03
	19300 NONPALD WORKERS	C	0	0	0		193.00
	07950 FOUNDATI ON	C	0	0	0		194.00
	07951 GLET SHOP	C	0	0	0		194. 01 194. 02
				0	0		110/1 (17)
194.02	07952 CLINIC OF HOPE	654	1, 089	0	0	10 /11	
	Cross Foot Adjustments	004 C	1,009	0	0	18, 411	200. 00 201. 00

Heal th	Fi nanc	ial Syst	ems
ALL 004			

Health Financial Systems ALLOCATION OF CAPITAL RELATED COSTS	ASCENSION ST. V	/INCENT KOKOMO Provider CC		Period:	i of Form CMS-2552-10 Worksheet B
				o 06/30/2022	Part II Date/Time Prepared:
Cost Center Description	Subtotal	Intern &	Total		<u>11/28/2022 1:52 pm</u>
		Residents Cost & Post			
		Stepdown			
	24.00	Adjustments 25.00	26.00	-	
GENERAL SERVICE COST CENTERS	21.00	20.00	20.00		
1.00 00100 CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT					2.00
5. 00 00500 ADMI NI STRATI VE & GENERAL					5.00
7.00 00700 OPERATION OF PLANT					7.00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG					8.00 9.00
10. 00 01000 DI ETARY					10.00
11. 00 01100 CAFETERIA 13. 00 01300 NURSING ADMINISTRATION					11.00 13.00
13. 00 01300 NURSI NG ADMI NI STRATI ON 15. 00 01500 PHARMACY					15.00
16.00 01600 MEDI CAL RECORDS & LI BRARY					16.00
23. 00 02300 ALLIED HEALTH RAD TECH PROGRAM					23.00
30. 00 03000 ADULTS & PEDIATRICS	1, 063, 834	0	1, 063, 834	l l	30.00
31. 00 03100 I NTENSI VE CARE UNI T	325, 333	0	325, 333	3	31.00
41. 00 04100 SUBPROVI DER - I RF	266, 805		266, 805		41.00
43. 00 04300 NURSERY ANCI LLARY SERVICE COST CENTERS	78, 127	0	78, 127	1	43.00
50. 00 05000 OPERATI NG ROOM	1, 286, 148		1, 286, 148		50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	218, 093	1	218, 093		52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 54. 01 03630 ULTRA SOUND	1, 171, 665		1, 171, 665 141, 369		54.00 54.01
56. 00 05600 RADI 0I SOTOPE	657,055	0	657, 055		56.00
57.00 05700 CT SCAN	26, 128		26, 128		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 59.00 05900 CARDIAC CATHETERIZATION	303, 340 22, 975		303, 340 22, 975		58.00 59.00
60. 00 06000 LABORATORY	269, 216	1	269, 216		60.00
65. 00 06500 RESPI RATORY THERAPY	120, 620		120, 620		65.00
66. 00 06600 PHYSICAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	209, 160 83, 161		209, 160 83, 161		66.00 67.00
68. 00 06800 SPEECH PATHOLOGY	20, 533		20, 533		68.00
69. 00 06900 ELECTROCARDI OLOGY	205, 734		205, 734		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	80, 856 184, 069		80, 856 184, 069		70.00 71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	77, 489		77, 489		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	579, 809		579, 809		73.00
74. 00 07400 RENAL DI ALYSI S 76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	7, 502 104, 189		7, 502 104, 189		74.00 76.00
76. 01 03190 CHEMOTHERAPY	665, 937		665, 937		76.01
76. 02 03330 ENDOSCOPY	9, 753		9, 753		76.02
76. 03 03950 WOUND CARE CENTER OUTPATI ENT SERVICE COST CENTERS	77,722	0	77, 722	2	76.03
91. 00 09100 EMERGENCY	530, 844	0	530, 844	l I	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)		0			92.00
OTHER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES	213, 322	0	213, 322		95.00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0		210, 022		98.00
SPECIAL PURPOSE COST CENTERS		1			112.00
113.00 11300 INTEREST EXPENSE 118.00 SUBTOTALS (SUM OF LINES 1 through 117	) 9,000,788	0	9, 000, 788	3	113.00 118.00
NONREI MBURSABLE COST CENTERS	, , , , , , , , , , , , , , , , , , , ,		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	347,651		347, 651		192.00
192. 01 19201 ASC MOB 192. 02 19202 EDUCATI ON CENTER	9, 820		9, 820 363		192. 01 192. 02
192. 03 19203 MARKETI NG	0		(		192. 03
193. 00 19300 NONPALD WORKERS	0	0	0		193.00
194. 00 07950 FOUNDATI ON 194. 01 07951 GLFT SHOP	2, 258 12, 907		2, 258 12, 907		194. 00 194. 01
194. 02 07952 CLINIC OF HOPE	9, 752		9, 752		194. 02
200.00 Cross Foot Adjustments	18, 411		18, 411		200.00
201.00Negative Cost Centers202.00TOTAL (sum lines 118 through 201)	0 9, 401, 950	0	0 9, 401, 950		201.00 202.00
	,,,,	, q	,,, ,	1	1202.00

## ASCENSION ST. VINCENT KOKOMO

earth	Financial Systems	ASCENSION ST. V	INCENT KOKOMO		In Lie	eu of Form CMS-2	2552
	LLOCATION - STATISTICAL BASIS		Provider C	CN: 15-0010 F	Period:	Worksheet B-1	
					rom 07/01/2021		
					o 06/30/2022	Date/Time Pre 11/28/2022 1:	
		CAPITAL RE	LATED COSTS			111/20/2022 1.	12 0
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliation		
		(SQUARE FEET)	(DOLLAR VALUE)	BENEFITS		& GENERAL	
				DEPARTMENT		(ACCUM. COST)	
				(GROSS			
				SALARI ES)			
		1.00	2.00	4.00	5A	5.00	-
00	GENERAL SERVICE COST CENTERS	221 422			1		1 1
00		331, 432					1.
00	00200 CAP REL COSTS-MVBLE EQUIP	40.000	3, 307, 095				2
00	00400 EMPLOYEE BENEFITS DEPARTMENT	12, 820				404 040 004	4
00	00500 ADMI NI STRATI VE & GENERAL	50, 113					
00 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	45, 990					
00	00900 HOUSEKEEPING	518 2, 015		0			
	01000 DI ETARY					1, 755, 043	
	01100 CAFETERIA	5,205				1, 415, 250	
	01300 NURSI NG ADMI NI STRATI ON	6, 310				774, 997 2, 606, 968	
. 00	01500 PHARMACY	5, 461					
	01600 MEDICAL RECORDS & LIBRARY	3, 199 2, 447				7, 484, 940	
	02300 ALLIED HEALTH RAD TECH PROGRAM	896					
. 00	INPATIENT ROUTINE SERVICE COST CENTERS	090	0	174, 403	<u>'</u> U	203, 759	- 23
. 00	03000 ADULTS & PEDIATRICS	29, 444	119, 270	7, 791, 193	3 0	11, 697, 418	30
	03100 I NTENSI VE CARE UNI T	5, 636					
	04100 SUBPROVI DER – I RF	13, 568					
	04300 NURSERY	1, 609					
	ANCI LLARY SERVICE COST CENTERS	.,,	11/002			0107000	1.0
. 00	05000 OPERATI NG ROOM	32, 649	495, 469	3, 198, 233	3 0	7, 164, 416	50
	05200 DELIVERY ROOM & LABOR ROOM	3, 264					
	05400 RADI OLOGY-DI AGNOSTI C	23, 821					
	03630 ULTRA SOUND	0	97, 404				
	05600 RADI OI SOTOPE	2,000					
	05700 CT SCAN	0	0			868, 733	
. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	222, 082			726, 203	
. 00	05900 CARDI AC CATHETERI ZATI ON	400				28, 625	
. 00	06000 LABORATORY	7,900				6, 517, 991	
. 00	06500 RESPIRATORY THERAPY	1, 237					
. 00	06600 PHYSI CAL THERAPY	7, 215				3, 273, 531	
. 00	06700 OCCUPATI ONAL THERAPY	3, 096					
. 00	06800 SPEECH PATHOLOGY	1,040			1 O	205, 834	
. 00	06900 ELECTROCARDI OLOGY	4,003			اo ا	644, 127	69
. 00	07000 ELECTROENCEPHALOGRAPHY	2, 728				872, 729	70
. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4, 309	74, 656	207, 557	0	1, 245, 997	71
. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	C	0 0	3, 135, 688	72
. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	c	0 0	13, 585, 760	73
. 00	07400 RENAL DIALYSIS	0	0	C	0 0	287, 633	74
. 00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	4, 591	11, 560	778, 990	o l	1, 041, 766	76
. 01	03190 CHEMOTHERAPY	0	448, 596	734, 815	5 0	3, 318, 508	76
. 02	03330 ENDOSCOPY	0	6, 149	8, 565	5 0	39, 422	76
. 03	03950 WOUND CARE CENTER	3,000	7, 614	200, 061	0	1, 026, 972	76
	OUTPATIENT SERVICE COST CENTERS						1
	09100 EMERGENCY	19, 340	96, 749	2, 459, 727	7 0	4, 460, 949	
. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			L		L	92
<i>.</i>	OTHER REIMBURSABLE COST CENTERS						4.
	09500 AMBULANCE SERVICES	3, 968					
. 00	09850 OTHER REIMBURSABLE COST CENTERS	0	0	C	0 0	0	98
a	SPECIAL PURPOSE COST CENTERS			1	1		1110
	11300 INTEREST EXPENSE		2 00/ 501	07 /05 F ··		100 107 010	113
8.00		) 309, 792	3, 296, 581	37, 685, 543	3 -35, 772, 167	100, 407, 219	1,18
	NONREI MBURSABLE COST CENTERS	00.401	1.001	115 405	,	0 / 17 /70	1100
	19200 PHYSICIANS' PRIVATE OFFICES	20, 431				3, 617, 478	192
	19201 ASC MOB		7,675		-	1, 087	
	19202 EDUCATION CENTER		0	0	í ú	14, 824	
	19203 MARKETI NG		0				192
	19300 NONPALD WORKERS	100	0		í O		193
	07950 FOUNDATI ON	180		0		1, 711	
		1,029		-		9, 782	
	07952 CLINIC OF HOPE	0	853	184, 037	0	258, 803	
0.00						ł	200
1.00				0 057 -		05 355	201
2.00		3, 150, 554	4, 219, 523	8, 037, 967	1	35, 772, 167	202
	Part I)					0 0 000	
	Unit cost multiplier (Wkst. B, Part I)	) 9. 505884	1. 275900	0. 208698	i I	0. 342938	203
)3.00 )4.00				121, 865		2, 554, 776	0 -

Health Financial Systems	ASCENSION ST. V	INCENT KOKOMO		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider C	Provider CCN: 15-0010		Worksheet B-1	
	_			From 07/01/2021 To 06/30/2022	Date/Time Pre 11/28/2022 1:	
	CAPI TAL REI	LATED COSTS				
Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFI TS	Reconciliation	ADMI NI STRATI VE & GENERAL	
			DEPARTMENT (GROSS		(ACCUM. COST)	
			SALARI ES)			
	1.00	2.00	4.00	5A	5.00	
205.00 Unit cost multiplier (Wkst. B, Part			0. 00316	4	0. 024492	205.00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

SI ALL	OCATION - STATISTICAL BASIS		Provider C		eriod: rom 07/01/2021	Worksheet B-1	
				Т	06/30/2022	Date/Time Pre 11/28/2022 1:	
	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF	HOUSEKEEPI NG (HOURS OF SERVI CE)	DI ETARY (TOTAL PATI ENT DAYS)	CAFETERIA (MEALS SERVED)	
		7.00	LAUNDRY) 8.00	9.00	10.00	11.00	
	NERAL SERVICE COST CENTERS						
00 00 00 00 00 00	0100 CAP REL COSTS-BLDG & FIXT 0200 CAP REL COSTS-MVBLE EQUIP 0400 EMPLOYEE BENEFITS DEPARTMENT 0500 ADMINISTRATIVE & GENERAL 0700 OPERATION OF PLANT	222, 509 518	494 702				1 2 4 5 7 8
00 00	0800 LAUNDRY & LINEN SERVICE 0900 HOUSEKEEPING 1000 DIETARY	2, 015 5, 205	486, 702 149, 445 0				9 10
		6, 310	0	0	-	812, 129	
	I 300 NURSI NG ADMI NI STRATI ON I 500 PHARMACY	5, 461 3, 199		150		44, 132 32, 423	
	1600 MEDICAL RECORDS & LIBRARY	2, 447	0	50	-	0	
	2300 ALLIED HEALTH RAD TECH PROGRAM	896	0	0	0	2, 295	23
	IPATI ENT ROUTI NE SERVI CE COST CENTERS 3000 ADULTS & PEDI ATRI CS	29, 444	155, 433	57,000	14, 701	193, 294	30
	3100 I NTENSI VE CARE UNI T	5, 636				49, 377	
	100 SUBPROVI DER – I RF	13, 568		15, 000		34, 456	
		1, 609	6, 357	7, 744	1, 315	7, 321	43
	ICI LLARY SERVI CE COST CENTERS	32, 649	4, 870	30, 000	0	68, 221	50
	5200 DELIVERY ROOM & LABOR ROOM	3, 264	17, 232			31, 970	
	5400 RADI OLOGY-DI AGNOSTI C	23, 821	11, 407	3, 050	-	40, 672	
	3630 ULTRA SOUND	0	3,000			5, 707	
	5600 RADI OI SOTOPE 5700 CT SCAN	2,000	5, 460	2, 250 0		18, 344 12, 928	
	5800 MAGNETIC RESONANCE IMAGING (MRI)	0	1, 432	0	-	6, 882	
	5900 CARDI AC CATHETERI ZATI ON	400	0	1, 000		6	
		7,900	359	6, 200		6, 893	
	5500 RESPI RATORY THERAPY 5600 PHYSI CAL THERAPY	1, 237 7, 215	330 0	300 1,000		32, 390 64, 170	
1	5700 OCCUPATI ONAL THERAPY	3, 096	0	100		24, 156	
	5800 SPEECH PATHOLOGY	1, 040	305	650		3, 946	
		4,003 2,728	0	400 2, 550		7,735	
	7000 ELECTROENCEPHALOGRAPHY 7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4, 309	0 7,676		-	15, 316 8, 965	
	7200 IMPL. DEV. CHARGED TO PATIENTS	0	34	0		0	
	7300 DRUGS CHARGED TO PATIENTS	0	54	2, 250		0	
	7400 RENAL DI ALYSI S 3550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	4, 591	0 2, 742	1, 000 2, 000		0 20, 710	
	3190 CHEMOTHERAPY	0	0			18, 664	
02 03	3330 ENDOSCOPY	0	0	-	-	195	
	3950 WOUND CARE CENTER JTPATIENT SERVICE COST CENTERS	3,000	0	3, 200	0	5, 725	76
	P100 EMERGENCY	19, 340	74, 428	18,000	0	50, 349	9.
00 09 01	02000 OBSERVATION BEDS (NON-DISTINCT PART) THER REIMBURSABLE COST CENTERS					· · · · · · · · · · · · · · · · · · ·	92
	2500 AMBULANCE SERVICES 2850 OTHER REIMBURSABLE COST CENTERS	3, 968	627 0	0		0	
	PECIAL PURPOSE COST CENTERS	0	0	0	0	0	70
	1300 INTEREST EXPENSE						113
3. 00	SUBTOTALS (SUM OF LINES 1 through 117)	200, 869	486, 702	195, 900	22, 201	807, 242	118
	DNRETMBURSABLE COST CENTERS D200 PHYSICIANS' PRIVATE OFFICES	20, 431	0	0	0	0	192
	2201 ASC MOB	0	0	0			192
1	202 EDUCATION CENTER	0	0	0			192
		0	0	0	0		192
	2300 NONPALD WORKERS 7950 FOUNDATI ON	180			0		193 194
	7951 GIFT SHOP	1,029	0	0	0		194
	7952 CLINIC OF HOPE	0	0	0	0	4, 887	
). 00 I. 00	Cross Foot Adjustments						200 201
2.00	Negative Cost Centers Cost to be allocated (per Wkst. B, Part I)	6, 739, 685	643, 687	2, 615, 595	2, 058, 250	1, 231, 900	
3.00 4.00	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II)	30. 289494 623, 914	1. 322548 17, 829			1. 516877 108, 734	
5.00	Unit cost multiplier (Wkst. B, Part   )	2. 803994	0. 036632	0. 373982	5. 098509	0. 133888	205
5.00	NAHE adjustment amount to be allocated						206

Health Financial Systems A	ASCENSION ST. V	INCENT KOKOMO		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS			Period:	Worksheet B-1		
				From 07/01/2021 To 06/30/2022	Date/Time Pre 11/28/2022 1:	
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
	PLANT	LINEN SERVICE	(HOURS OF	(TOTAL PATI ENT	(MEALS SERVED)	
	(SQUARE FEET)	(POUNDS OF	SERVI CE)	DAYS)		
		LAUNDRY)				
	7.00	8.00	9.00	10.00	11.00	
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

	Financial Systems // LLOCATION - STATISTICAL BASIS	ASCENSION ST. VI	Provi der CC		Period: From 07/01/2021	u of Form CMS-2552- Worksheet B-1
					To 06/30/2022	Date/Time Prepared
	Cost Center Description	NURSI NG ADMI NI STRATI ON (DI RECT NURS. HRS.) 13.00	PHARMACY (COSTED REQUI S. ) 15. 00	MEDI CAL RECORDS & LI BRARY (GROSS CHARGES) 16. 00	ALLI ED HEALTH RAD TECH PROGRAM (ASSI GNED TIME) 23.00	11/28/2022 1:52 pm
1 00	GENERAL SERVICE COST CENTERS					1.0
11.00 13.00 15.00 16.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 02300 ALLIED HEALTH RAD TECH PROGRAM INPATIENT ROUTINE SERVICE COST CENTERS	576, 065 3, 261 0 0	13, 585, 760 0 0	624, 586, 43	0 0 75, 777, 792	1. 0 2. 0 4. 0 5. 0 7. 0 8. 0 9. 0 10. 0 11. 0 13. 0 15. 0 16. 0 23. 0
30. 00	03000 ADULTS & PEDIATRICS	207, 902	0	33, 176, 78	8 0	30.0
41.00	03100 INTENSIVE CARE UNIT 04100 SUBPROVIDER - IRF 04300 NURSERY	62, 328 47, 440 16, 244	0 0 0	13, 047, 82 7, 212, 06 2, 686, 32	3 0	31. ( 41. ( 43. (
50.00	ANCI LLARY SERVICE COST CENTERS	78, 583	0	96, 016, 29	7 0	50.0
54.00 54.01 56.00 57.00 58.00 59.00 59.00 50.00 55.00	05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC 03630 ULTRA SOUND 05600 RADIOISOTOPE 05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION 06000 LABORATORY 06500 RESPIRATORY THERAPY 06600 PHYSICAL THERAPY	55, 701 2, 058 0 3, 092 0 0 525 96 3, 603 0		18, 595, 78 23, 082, 53 8, 007, 11 25, 463, 25 15, 782, 74 3, 442, 13 35, 24 91, 011, 41 16, 273, 12 14, 142, 75	1         23, 082, 532           8         8, 007, 118           9         25, 463, 259           9         15, 782, 749           4         3, 442, 134           5         0           8         0           7         0	52. C 54. C 54. C 56. C 57. C 58. C 59. C 60. C 65. C 66. C
57.00 58.00 59.00 70.00 71.00 72.00 73.00 74.00 76.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 07200 IMPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0 0 3, 827 0 0 0 0 0 0 2, 076	0 0 0 0 13, 585, 760 0 0	5, 214, 25 851, 73 14, 501, 57 7, 513, 38 18, 943, 16 12, 762, 08 73, 525, 63 1, 536, 73 4, 467, 66	1     0       8     0       9     0       1     0       3     0       3     0       6     0       1     0       2     0	67. 0 68. 0 69. 0 70. 0 71. 0 73. 0 73. 0 74. 0 76. 0
	03190 CHEMOTHERAPY 03330 ENDOSCOPY	13, 205 1, 698	0	10, 854, 57 57, 53		76.0 76.0
	03950 WOUND CARE CENTER OUTPATI ENT SERVICE COST CENTERS	4, 614	0	17, 060, 96		76.0
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	62, 021	0	69, 388, 09	6 0	91. C 92. C
	09500 AMBULANCE SERVICES 09850 OTHER REIMBURSABLE COST CENTERS SPECIAL PURPOSE COST CENTERS	0	0 0	19, 933, 61	5 0 0 0	95. C 98. C
118.00	NONREI MBURSABLE COST CENTERS	568, 274	13, 585, 760	624, 586, 43	0 75, 777, 792	113. ( 118. (
192.01 192.02 192.03 193.00 194.00 194.01	19200 PHYSI CLANS' PRI VATE OFFI CES 19201 ASC MOB 19202 EDUCATI ON CENTER 19203 MARKETI NG 19300 NONPAI D WORKERS 07950 FOUNDATI ON 07951 GLFT SHOP 07952 CLINIC OF HOPE	5, 703 0 0 0 0 0 0 2, 088			0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	192. ( 192. ( 192. ( 192. ( 193. ( 193. ( 194. ( 194. ( 194. (
200.00 201.00 202.00	Cross Foot Adjustments Negative Cost Centers	3, 735, 353	10, 219, 033	109, 69	8 384, 832	200. 0 201. 0 202. 0
203.00 204.00	Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	6. 484256 300, 401	0. 752187 242, 263	0. 00017 33, 51	6 0. 005078	203. 0 204. 0
205.00	Part II) Unit cost multiplier (Wkst. B, Part II)	0. 521471	0. 017832	0. 00005	4 0.000243	205. 0

Health Financial Systems	ASCENSION ST. V	NCENT KOKOMO	In Lieu of Form CMS-2552-10			
COST ALLOCATION - STATISTICAL BASIS		Provider C	CN: 15-0010	Peri od:	Worksheet B-1	
				From 07/01/2021 To 06/30/2022	Date/Time Pre	narod:
			_	10 00/30/2022	11/28/2022 1:	
Cost Center Description	NURSI NG	PHARMACY	MEDI CAL	ALLI ED HEALTH		
	ADMI NI STRATI ON	(COSTED	RECORDS &	RAD TECH		
		REQUIS.)	LI BRARY	PROGRAM		
	(DI RECT NURS.		(GROSS	(ASSI GNED		
	HRS.)		CHARGES)	TIME)		
	13.00	15.00	16.00	23.00		
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)				0		206.00
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0. 000000		207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CO	CN: 15-0010	Period: From 07/01/2021 To 06/30/2022	Worksheet C Part I Date/Time Pre 11/28/2022 1:	pared 52 pm
		Title	XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1					
0.00 03000 ADULTS & PEDIATRICS	20, 577, 424		20, 577, 42		20, 577, 424	
1.00 03100 INTENSIVE CARE UNIT	6, 204, 438		6, 204, 4		6, 204, 438	
1. 00 04100 SUBPROVI DER – I RF	3, 610, 271		3, 610, 2		3, 610, 271	
.3. 00 04300 NURSERY	1, 223, 453		1, 223, 4	53 0	1, 223, 453	43.0
ANCI LLARY SERVI CE COST CENTERS		I				4
0.00 05000 OPERATING ROOM	11, 646, 985		11, 646, 9		11, 658, 966	
2.00 05200 DELIVERY ROOM & LABOR ROOM	3, 726, 805		3, 726, 80		3, 726, 805	
4.00 05400 RADI OLOGY-DI AGNOSTI C	5, 597, 946		5, 597, 9		5, 597, 946	
4.01 03630 ULTRA SOUND	854, 506		854, 50		854, 506	
66. 00 05600 RADI OI SOTOPE	2, 651, 607		2, 651, 60		2, 651, 607	
57.00 05700 CT SCAN	1, 276, 409		1, 276, 40		1, 276, 409	
8.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 005, 664		1, 005, 6		1, 005, 664	
9.00 05900 CARDI AC CATHETERI ZATI ON	67, 329		67, 3		67, 329	
0. 00 06000 LABORATORY	9, 102, 896		9, 102, 8		9, 163, 378	
5. 00 06500 RESPI RATORY THERAPY	2, 964, 351	0			2, 964, 351	
6. 00 06600 PHYSI CAL THERAPY	4, 727, 867	0			4, 727, 867	
7. 00 06700 OCCUPATI ONAL THERAPY	1, 783, 143	0	1, 783, 1		1, 783, 143	
8.00 06800 SPEECH PATHOLOGY	323, 141	0	323, 14		323, 141	
9.00 06900 ELECTROCARDI OLOGY	1, 030, 713		1, 030, 7		1, 030, 713	
0.00 07000 ELECTROENCEPHALOGRAPHY	1, 313, 252		1, 313, 2		1, 313, 252	
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 905, 668		1, 905, 6		1, 905, 668	
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	4, 213, 326		4, 213, 3		4, 213, 326	
3.00 07300 DRUGS CHARGED TO PATIENTS	28, 506, 912		28, 506, 9		28, 506, 912	
4.00 07400 RENAL DIALYSIS	399, 895		399, 89	95 0	399, 895	
6.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	1, 614, 077		1, 614, 0		1, 614, 077	
6. 01 03190 CHEMOTHERAPY	4, 572, 396		4, 572, 39		4, 572, 396	
6. 02 03330 ENDOSCOPY	64, 257		64, 2		64, 257	
6.03 03950 WOUND CARE CENTER	1, 554, 358		1, 554, 3	58 0	1, 554, 358	76.0
OUTPATIENT SERVICE COST CENTERS	-		-			
1.00 09100 EMERGENCY	7, 406, 087		7, 406, 08		7, 406, 087	
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 193, 297		1, 193, 2	97	1, 193, 297	92.
OTHER REIMBURSABLE COST CENTERS			L			4
5. 00 09500 AMBULANCE SERVICES	4, 202, 090		4, 202, 0		4, 202, 090	
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0			0 0	0	98.
SPECIAL PURPOSE COST CENTERS		1				4
13.00 11300 INTEREST EXPENSE						113.
Subtotal (see instructions)	135, 320, 563	0			135, 393, 026	
201.00 Less Observation Beds	1, 193, 297		1, 193, 29		1, 193, 297	
202.00 Total (see instructions)	134, 127, 266	0	134, 127, 20	66 72, 463	134, 199, 729	1202

Heal th Financia	I Syste	ms			
COMPLITATION OF	PATIO (	)E	27200	ΤO	CH

Heal th Fi	inancial Systems	ASCENSION ST. V	INCENT KOKOMO		In Lie	u of Form CMS-	2552-10
COMPUTAT	ION OF RATIO OF COSTS TO CHARGES		Provider CO	CN: 15-0010	Peri od:	Worksheet C	
					From 07/01/2021	Part I	
					To 06/30/2022	Date/Time Pre 11/28/2022 1:	pared:
			Title	XVIII	Hospi tal	PPS	sz pili
			Charges			115	
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
				+ col. 7)	Ratio	Inpatient	
						Ratio	
		6.00	7.00	8.00	9.00	10.00	
LN	NPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03	3000 ADULTS & PEDIATRICS	30, 768, 844		30, 768, 84	4		30.00
31.00 03	3100 I NTENSI VE CARE UNI T	13, 047, 820		13, 047, 82	0		31.00
41.00 04	4100 SUBPROVI DER – I RF	7, 212, 063		7, 212, 06	3		41.00
43.00 04	4300 NURSERY	2, 686, 323		2, 686, 32	3		43.00
AN	NCILLARY SERVICE COST CENTERS						
	5000 OPERATING ROOM	25, 331, 287	70, 685, 010	96, 016, 29	7 0. 121302	0. 000000	50.00
52.00 05	5200 DELIVERY ROOM & LABOR ROOM	17, 482, 366	1, 113, 419	18, 595, 78	5 0. 200411	0.000000	52.00
	5400 RADI OLOGY-DI AGNOSTI C	2, 737, 803	20, 344, 728	23, 082, 53	0. 242519	0. 000000	54.00
54.01 03	3630 ULTRA SOUND	1, 937, 877	6, 069, 241	8, 007, 11	8 0. 106718	0.00000	54.01
56.00 05	5600 RADI OI SOTOPE	120, 790	25, 342, 469	25, 463, 25	9 0. 104135	0. 000000	56.00
57.00 05	5700 CT SCAN	4, 215, 168	11, 567, 581	15, 782, 74	9 0. 080874	0. 000000	57.00
58.00 05	5800 MAGNETIC RESONANCE IMAGING (MRI)	726, 099	2, 716, 035	3, 442, 13	4 0. 292163	0. 000000	58.00
	5900 CARDI AC CATHETERI ZATI ON	35, 245	0	35, 24	5 1. 910314	0. 000000	59.00
60.00 06	6000 LABORATORY	36, 321, 959	54, 689, 459	91, 011, 41	8 0. 100019	0. 000000	60.00
65.00 06	6500 RESPI RATORY THERAPY	10, 563, 632	5, 709, 495	16, 273, 12	7 0. 182162	0. 000000	65.00
66.00 06	6600 PHYSI CAL THERAPY	4, 120, 668	10, 022, 089			0. 000000	66.00
67.00 06	6700 OCCUPATI ONAL THERAPY	3, 390, 188	1, 824, 063	5, 214, 25	0. 341975	0. 000000	67.00
68.00 06	6800 SPEECH PATHOLOGY	620, 462	231, 276			0. 000000	68.00
69.00 06	6900 ELECTROCARDI OLOGY	2, 920, 978	11, 580, 601	14, 501, 57	9 0. 071076	0. 000000	69.00
70.00 07	7000 ELECTROENCEPHALOGRAPHY	437, 204	7, 076, 177	7, 513, 38	0. 174788	0.00000	70.00
71.00 07	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	9, 212, 303	9, 730, 860	18, 943, 16	3 0. 100599	0.000000	71.00
	7200 IMPL. DEV. CHARGED TO PATIENTS	6, 286, 459	6, 475, 624	12, 762, 08	3 0. 330144	0.000000	72.00
73.00 07	7300 DRUGS CHARGED TO PATIENTS	24, 391, 016	49, 134, 620	73, 525, 63	6 0. 387714	0.000000	73.00
74.00 07	7400 RENAL DIALYSIS	1, 475, 196	61, 535	1, 536, 73	1 0. 260224	0.00000	74.00
76.00 03	3550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	4, 467, 662	4, 467, 66	2 0. 361280	0.000000	76.00
76.01 03	3190 CHEMOTHERAPY	314, 210	10, 540, 365	10, 854, 57	5 0. 421241	0.000000	76.01
76.02 03	3330 ENDOSCOPY	38, 032	19, 506	57, 53	8 1. 116775	0.000000	76.02
76.03 03	3950 WOUND CARE CENTER	89, 403	16, 971, 565	17, 060, 96	8 0. 091106	0.00000	76.03
OL	JTPATIENT SERVICE COST CENTERS	_					
	9100 EMERGENCY	17, 138, 306	52, 249, 790	69, 388, 09	6 0. 106734	0.00000	91.00
92.00 09	9200 OBSERVATION BEDS (NON-DISTINCT PART)	386, 295	2, 021, 649	2, 407, 94	4 0. 495567	0.00000	92.00
	THER REIMBURSABLE COST CENTERS						
	9500 AMBULANCE SERVICES	3, 788	19, 929, 827	19, 933, 61			•
	9850 OTHER REIMBURSABLE COST CENTERS	0	0		0 0.000000	0.00000	98.00
	PECIAL PURPOSE COST CENTERS						
	1300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	224, 011, 784	400, 574, 646	624, 586, 43	0		200. 00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	224, 011, 784	400, 574, 646	624, 586, 43	0		202.00

Health Financial Systems	ASCENSION ST. VIN	ICENT KOKOMO	In Lieu of Form CMS-2552-10			
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0010	Peri od:	Worksheet C		
			From 07/01/2021	Part I		
			To 06/30/2022	Date/Time Prepared:		
		Title XVIII	Hospi tal	11/28/2022 1:52 pm PPS		
Cost Center Description	PPS Inpatient		nospitai	113		
Cost Center Description	Ratio					
	11.00					
INPATIENT ROUTINE SERVICE COST CENTERS	11100					
30. 00 03000 ADULTS & PEDI ATRI CS				30.00		
31.00 03100 INTENSIVE CARE UNIT				31.00		
41.00 04100 SUBPROVIDER - IRF				41.00		
43.00 04300 NURSERY				43.00		
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0. 121427			50.00		
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 200411			52.00		
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 242519			54.00		
54.01 03630 ULTRA SOUND	0. 106718			54.01		
56. 00 05600 RADI OI SOTOPE	0. 104135			56.00		
57. 00 05700 CT SCAN	0. 080874			57.00		
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 292163			58.00		
59. 00 05900 CARDI AC CATHETERI ZATI ON	1. 910314			59.00		
60. 00 06000 LABORATORY	0. 100684			60.00		
65. 00 06500 RESPI RATORY THERAPY	0. 182162			65.00		
66. 00 06600 PHYSI CAL THERAPY	0. 334296			66.00		
67. 00 06700 OCCUPATI ONAL THERAPY	0. 341975			67.00		
68. 00 06800 SPEECH PATHOLOGY	0. 379390			68.00		
69. 00 06900 ELECTROCARDI OLOGY	0. 071076			69.00		
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 174788			70.00		
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 100599			71.00		
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 330144			72.00		
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 387714			73.00		
74. 00 07400 RENAL DI ALYSI S	0. 260224			74.00		
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 361280			76.00		
76. 01 03190 CHEMOTHERAPY	0. 421241			76.01		
76. 02 03330 ENDOSCOPY	1. 116775			76.02		
76.03 03950 WOUND CARE CENTER	0.091106			76.03		
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	0. 106734			91.00		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 495567			92.00		
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0. 210804			95.00		
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0. 000000			98.00		
SPECIAL PURPOSE COST CENTERS						
113.00 11300 I NTEREST EXPENSE				113.00		
200.00 Subtotal (see instructions)				200.00		
201.00 Less Observation Beds				201.00		
202.00 Total (see instructions)				202.00		

COMPUTA	TION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0010	Peri od: From 07/01/2021 To 06/30/2022	Worksheet C Part I Date/Time Pre 11/28/2022 1:	pared 52 pm
			Titl	e XIX	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Di sal I owance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
	NPATIENT ROUTINE SERVICE COST CENTERS	1					4
	3000 ADULTS & PEDIATRICS	20, 577, 424		20, 577, 42		20, 577, 424	
	3100 I NTENSI VE CARE UNI T	6, 204, 438		6, 204, 43		6, 204, 438	
	4100 SUBPROVI DER – I RF	3, 610, 271		3, 610, 27		3, 610, 271	
	4300 NURSERY	1, 223, 453		1, 223, 45	53 0	1, 223, 453	43. C
	NCI LLARY SERVI CE COST CENTERS						4
	5000 OPERATI NG ROOM	11, 646, 985		11, 646, 98		11, 658, 966	
	5200 DELIVERY ROOM & LABOR ROOM	3, 726, 805		3, 726, 80		3, 726, 805	
	5400 RADI OLOGY-DI AGNOSTI C	5, 597, 946		5, 597, 94		5, 597, 946	
	3630 ULTRA SOUND	854, 506		854, 50		854, 506	
	5600 RADI OI SOTOPE	2, 651, 607		2, 651, 60		2, 651, 607	
	5700 CT SCAN	1, 276, 409		1, 276, 40		1, 276, 409	
	5800 MAGNETIC RESONANCE IMAGING (MRI)	1,005,664		1,005,66		1,005,664	
	5900 CARDI AC CATHETERI ZATI ON	67, 329		67, 32		67, 329	
		9, 102, 896		9, 102, 89		9, 163, 378	
		2, 964, 351	0			2, 964, 351	
		4, 727, 867	0			4, 727, 867	
	6700 OCCUPATI ONAL THERAPY	1, 783, 143	0	1, 783, 14		1, 783, 143	
		323, 141	0	323, 14		323, 141	
		1,030,713		1, 030, 7		1,030,713	
	7000 ELECTROENCEPHALOGRAPHY	1, 313, 252		1, 313, 25		1, 313, 252	
	7100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	1, 905, 668		1, 905, 66		1, 905, 668	
	7200 I MPL. DEV. CHARGED TO PATIENTS 7300 DRUGS CHARGED TO PATIENTS	4, 213, 326		4, 213, 32		4, 213, 326	
	17300 DRUGS CHARGED TO PATTENTS 17400 RENAL DIALYSIS	28, 506, 912 399, 895		28, 506, 91 399, 89		28, 506, 912 399, 895	
	3550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	1, 614, 077		1, 614, 07		1, 614, 077	
	3190 CHEMOTHERAPY	4, 572, 396		4, 572, 39		4, 572, 396	
	3330 ENDOSCOPY	64, 257		4, 572, 54		4, 372, 390	
	3950 WOUND CARE CENTER	1, 554, 358		1, 554, 35		1, 554, 358	
	UTPATIENT SERVICE COST CENTERS	1, 334, 330		1, 334, 30	0	1, 334, 330	1 /0. (
	19100 EMERGENCY	7, 406, 087		7, 406, 08	37 0	7, 406, 087	91.0
	9200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 193, 297		1, 193, 29		1, 193, 297	
	THER REIMBURSABLE COST CENTERS	1, 175, 277		1, 175, 2	//	1, 175, 277	72. (
	19500 AMBULANCE SERVICES	4, 202, 090		4, 202, 09	0 0	4, 202, 090	95. (
	19850 OTHER REIMBURSABLE COST CENTERS	4, 202, 090		7,202,0	0 0	4, 202, 070	
	PECIAL PURPOSE COST CENTERS	U	I		<u> </u>	0	1 /0.
	1300 I NTEREST EXPENSE						1113.
200.00	Subtotal (see instructions)	135, 320, 563	0	135, 320, 56	53 72, 463	135, 393, 026	
201.00	Less Observation Beds	1, 193, 297		1, 193, 29		1, 193, 297	
202.00	Total (see instructions)	134, 127, 266	0				

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

Health Financial Systems	ASCENSION ST. V	INCENT KOKOMO		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CO	CN: 15-0010	Period:	Worksheet C	
				rom 07/01/2021	Part I	
				To 06/30/2022	Date/Time Pre 11/28/2022 1:	pared:
			e XIX	Hospi tal	Cost	sz pili
		Charges		licopi tui	0001	
Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
			+ col. 7)	Rati o	Inpati ent	
					Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	30, 768, 844		30, 768, 84			30.00
31.00 03100 INTENSIVE CARE UNIT	13, 047, 820		13, 047, 820	C		31.00
41. 00 04100 SUBPROVIDER – IRF	7, 212, 063		7, 212, 06	3		41.00
43. 00 04300 NURSERY	2, 686, 323		2, 686, 32	3		43.00
ANCI LLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	25, 331, 287	70, 685, 010			0. 000000	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	17, 482, 366	1, 113, 419			0. 000000	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 737, 803	20, 344, 728	23, 082, 53		0. 000000	54.00
54.01 03630 ULTRA SOUND	1, 937, 877	6, 069, 241	8, 007, 11		0.000000	54.01
56. 00 05600 RADI OI SOTOPE	120, 790	25, 342, 469	25, 463, 25		0. 000000	56.00
57.00 05700 CT SCAN	4, 215, 168	11, 567, 581	15, 782, 74	9 0. 080874	0.00000	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	726, 099	2, 716, 035	3, 442, 13		0. 000000	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	35, 245	0	35, 24		0. 000000	59.00
60. 00 06000 LABORATORY	36, 321, 959	54, 689, 459	91, 011, 41		0.000000	60.00
65. 00 06500 RESPI RATORY THERAPY	10, 563, 632	5, 709, 495	16, 273, 12		0.000000	1
66. 00 06600 PHYSI CAL THERAPY	4, 120, 668	10, 022, 089	14, 142, 75		0.00000	
67.00 06700 OCCUPATI ONAL THERAPY	3, 390, 188	1, 824, 063			0. 000000	67.00
68.00 06800 SPEECH PATHOLOGY	620, 462	231, 276			0.000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	2, 920, 978	11, 580, 601	14, 501, 57		0.000000	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	437, 204	7, 076, 177	7, 513, 38		0. 000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		9, 730, 860	18, 943, 16		0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	6, 286, 459	6, 475, 624	12, 762, 08		0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	24, 391, 016	49, 134, 620	73, 525, 63		0. 000000	73.00
74.00 07400 RENAL DIALYSIS	1, 475, 196	61, 535	1, 536, 73		0. 000000	74.00
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	4, 467, 662	4, 467, 66		0.00000	
76. 01 03190 CHEMOTHERAPY	314, 210	10, 540, 365	10, 854, 57		0. 000000	•
76. 02 03330 ENDOSCOPY	38, 032	19, 506	57, 53		0.00000	76. 02
76.03 03950 WOUND CARE CENTER	89, 403	16, 971, 565	17, 060, 96	0. 091106	0.00000	76.03
OUTPATIENT SERVICE COST CENTERS	I I					
91.00 09100 EMERGENCY	17, 138, 306	52, 249, 790				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	) 386, 295	2, 021, 649	2, 407, 94	4 0. 495567	0.00000	92.00
OTHER REIMBURSABLE COST CENTERS		40.000.55-	10.000		0.000	0.5.05
95.00 09500 AMBULANCE SERVICES	3, 788	19, 929, 827	19, 933, 61			95.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		0. 000000	0.00000	98.00
SPECIAL PURPOSE COST CENTERS						110.00
113.00 11300 INTEREST EXPENSE	004 044 704	400 574 444	104 504 10			113.00
200.00 Subtotal (see instructions)	224, 011, 784	400, 574, 646	624, 586, 430	J		200.00
201.00 Less Observation Beds	004 011 704	400 574 444				201.00
202.00  Total (see instructions)	224, 011, 784	400, 574, 646	624, 586, 430	ן ע		202.00

Heal th	Fi nan	ici a	I Syst	ems			
COMPLIE		0F	RATIO	OF	COSTS	ΤO	CHARG

Health Financial Systems		ASCENSION ST. VIN	NCENT KOKOMO	In Lieu of Form CMS-2552-10			
COMPUTATION OF RAT	IO OF COSTS TO CHARGES		Provider CCN: 15-0010	Period: From 07/01/2021 To 06/30/2022	Worksheet C Part I Date/Time Prepa		
				To 06/30/2022	11/28/2022 1:52	neu: . pm	
			Title XIX	Hospi tal	Cost		
Cost (	Center Description	PPS Inpatient					
		Ratio					
		11.00					
	DUTINE SERVICE COST CENTERS						
	S & PEDIATRICS					30. 00	
	SIVE CARE UNIT					31.00	
41.00 04100 SUBPRO						41.00	
43.00 04300 NURSEF					4	43.00	
	ERVICE COST CENTERS						
50.00 05000 0PERAT		0.000000				50.00	
	RY ROOM & LABOR ROOM	0. 000000				52.00	
	LOGY – DI AGNOSTI C	0. 000000				54.00	
54.01 03630 ULTRA		0. 000000				54.01	
56.00 05600 RADI 0I		0. 000000				56.00	
57.00 05700 CT SCA		0. 000000				57.00	
	FIC RESONANCE IMAGING (MRI)	0. 000000				58.00	
	AC CATHETERI ZATI ON	0. 000000			5	59.00	
60. 00 06000 LABORA	ATORY	0. 000000			6	50.00	
65.00 06500 RESPI F	RATORY THERAPY	0. 000000			6	65.00	
66.00 06600 PHYSI 0		0. 000000				66.00	
	ATIONAL THERAPY	0. 000000				57.00	
68.00 06800 SPEECH	I PATHOLOGY	0. 000000			6	68.00	
69.00 06900 ELECTR	ROCARDI OLOGY	0. 000000			6	69.00	
70.00 07000 ELECTF	ROENCEPHALOGRAPHY	0. 000000			7	70.00	
71.00 07100 MEDI CA	AL SUPPLIES CHARGED TO PATIENTS	0. 000000			7	71.00	
72.00 07200 IMPL.	DEV. CHARGED TO PATIENTS	0. 000000			7	72.00	
73.00 07300 DRUGS	CHARGED TO PATIENTS	0. 000000			7	73.00	
74.00 07400 RENAL	DI ALYSI S	0. 000000			7	74.00	
76.00 03550 PSYCHI	ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000			7	76.00	
76.01 03190 CHEMOT	THERAPY	0. 000000			7	76. 01	
76.02 03330 ENDOSC		0. 000000			7	76. 02	
76.03 03950 WOUND	CARE CENTER	0. 000000			7	76. 03	
	SERVICE COST CENTERS						
91.00 09100 EMERGE	ENCY	0. 000000			9	91.00	
	ATION BEDS (NON-DISTINCT PART)	0. 000000			9	92.00	
OTHER REIMBU	JRSABLE COST CENTERS						
95.00 09500 AMBULA	ANCE SERVICES	0. 000000			9	95.00	
98.00 09850 OTHER	REIMBURSABLE COST CENTERS	0. 000000			9	98.00	
	POSE COST CENTERS						
113.00 11300 I NTERE						13.00	
200.00 Subtot	tal (see instructions)					00.00	
	Observation Beds				20	01.00	
202.00 Total	(see instructions)				20	02.00	

Health Financial Systems	ASCENSION ST. V	INCENT KOKOMO		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITA	_ COSTS			Period: From 07/01/2021 To 06/30/2022	Date/Time Pre 11/28/2022 1:	
			e 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, 063, 834	C	1, 063, 83	4 15, 606	68.17	30.00
31.00 INTENSIVE CARE UNIT	325, 333		325, 33	3 2, 701	120.45	31.00
41. 00 SUBPROVIDER - IRF	266, 805	C	266, 80	5 3, 484	76.58	41.00
43.00 NURSERY	78, 127		78, 12	7 1, 315	59.41	43.00
200.00 Total (lines 30 through 199)	1, 734, 099		1, 734, 09	9 23, 106		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	4, 925	335, 737	7			30.00
31.00 INTENSIVE CARE UNIT	754	90, 819				31.00
41.00 SUBPROVIDER - IRF	1, 945	148, 948	3			41.00
43.00 NURSERY	0					43.00
200.00 Total (lines 30 through 199)	7,624	575, 504	L			200.00

Health Financial Systems	ASCENSION ST. V	INCENT KOKOMO		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider CO		Period: From 07/01/2021 To 06/30/2022	Worksheet D Part II Date/Time Pre 11/28/2022 1:	pared: 52 pm
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,			. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1		r	1		
50.00 05000 OPERATI NG ROOM	1, 286, 148				133, 205	
52.00 05200 DELIVERY ROOM & LABOR ROOM	218, 093					
54.00 05400 RADI OLOGY-DI AGNOSTI C	1, 171, 665					
54.01 03630 ULTRA SOUND	141, 369				10, 183	
56. 00 05600 RADI OI SOTOPE	657,055					56.00
57.00 05700 CT SCAN	26, 128					
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	303, 340	3, 442, 134	0. 08812	26 224, 200	19, 758	
59. 00 05900 CARDI AC CATHETERI ZATI ON	22, 975	35, 245	0. 65186	30, 928	20, 161	59.00
60. 00 06000 LABORATORY	269, 216			58 11, 367, 622	33, 625	60.00
65. 00 06500 RESPI RATORY THERAPY	120, 620	16, 273, 127	0. 00741	2 2, 406, 173	17, 835	65.00
66. 00 06600 PHYSI CAL THERAPY	209, 160	14, 142, 757	0. 01478	914, 881	13, 530	66.00
67.00 06700 OCCUPATI ONAL THERAPY	83, 161	5, 214, 251	0. 01594	760, 207	12, 125	67.00
68.00 06800 SPEECH PATHOLOGY	20, 533	851, 738	0. 02410	07 175, 446	4, 229	68.00
69. 00 06900 ELECTROCARDI OLOGY	205, 734	14, 501, 579	0. 01418	1, 795, 626	25, 475	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	80, 856	7, 513, 381	0. 01076	213, 306	2, 296	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	184,069	18, 943, 163	0. 00971	7 2, 924, 149	28, 414	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	77, 489	12, 762, 083	0.00607	2, 753, 986	16, 722	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	579, 809	73, 525, 636	0. 00788	6, 959, 375	54, 882	73.00
74.00 07400 RENAL DIALYSIS	7, 502				2, 129	
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	104, 189	4, 467, 662	0. 02332		0	76.00
76. 01 03190 CHEMOTHERAPY	665, 937				372	
76. 02 03330 ENDOSCOPY	9, 753				3, 728	76.02
76.03 03950 WOUND CARE CENTER	77, 722				0	
OUTPATIENT SERVICE COST CENTERS					-	
91. 00 09100 EMERGENCY	530, 844	69, 388, 096	0.00765	5, 809, 832	44, 445	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	61, 692				2, 816	
OTHER REI MBURSABLE COST CENTERS	0.,072	2, 10, 7, 71	0.02002	107,707	2,010	1
95. 00 09500 AMBULANCE SERVICES						95.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0. 00000	0 0	0	98.00
200.00 Total (lines 50 through 199)	7, 115, 059	-		50, 056, 661	-	

Health Financial Systems	ASCENSION ST. VI	ΙΝΟΕΝΤ ΚΟΚΟΜΟ		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE	E OTHER PASS THROUGH COST		F	Period: From 07/01/2021 To 06/30/2022	Date/Time Pre 11/28/2022 1:	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng	Allied Health	Allied Health	All Other	
	Program	Program	Post-Stepdown	Cost	Medi cal	
	Post-Stepdown		Adjustments		Education Cost	
	Adjustments					
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENT	ERS					
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	) (	0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0	(	0 0	0	31.00
41.00 04100 SUBPROVIDER - IRF	0	0	(	0 0	0	41.00
43.00 04300 NURSERY	o	0		0 0	l o	43.00
200.00 Total (lines 30 through 199)	0	0	(	0 0	0	200.00
Cost Center Description	Swing-Bed	Total Costs	Total Patient	Per Diem (col.	Inpati ent	
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,		, , , , , , , , , , , , , , , , , , ,		
	instructions)	minus col. 4)				
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENT	ERS					
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	15, 606	6 0.00	4, 925	30.00
31.00 03100 INTENSIVE CARE UNIT		0	2, 70'	0.00	754	31.00
41.00 04100 SUBPROVIDER - IRF	0	0	3, 484	0.00	1, 945	41.00
43.00 04300 NURSERY		0	1, 315	0.00	0	43.00
200.00   Total (lines 30 through 199)		0	23, 106	5	7, 624	200.00
Cost Center Description	I npati ent			•		
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENT	ERS					
30. 00 03000 ADULTS & PEDI ATRI CS	0					30.00
31.00 03100 INTENSIVE CARE UNIT	0					31.00
41.00 04100 SUBPROVIDER - IRF	0					41.00
43.00 04300 NURSERY	o					43.00
200.00 Total (lines 30 through 199)	0					200.00
	1 -1					

Health Financial Systems	ASCENSION ST. V	INCENT KOKOMO		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	RVICE OTHER PASS			Period: From 07/01/2021 To 06/30/2022	2 Date/Time Pre 11/28/2022 1:	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Post-Stepdown Adjustments	Allied Health	
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	0	I	0 (	0 0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 (	0 0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 (	117, 213	54.00
54.01 03630 ULTRA SOUND	0	0		0 (	40, 660	54.01
56. 00 05600 RADI 0I SOTOPE	0	0		0 (	129, 335	56.00
57.00 05700 CT SCAN	0	0		0 (	80, 145	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 (	17, 479	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 (	0 0	59.00
60. 00 06000 LABORATORY	0	0		0 (	0 0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 (	0 0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 (	0 0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 (	0 0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 (	0 0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 (	0 0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 (	0 0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0 0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0 0	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0 0	
74.00 07400 RENAL DIALYSIS	0	0		0 0	0 0	
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0 0	0 0	
76. 01 03190 CHEMOTHERAPY	0	0		0 0	0 0	76.01
76. 02 03330 ENDOSCOPY	0	0		0 0	0 0	
76.03 03950 WOUND CARE CENTER	0	0		0 (	0 0	76.03
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	0			0 0		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
OTHER REIMBURSABLE COST CENTERS			1		1	
95. 00 09500 AMBULANCE SERVI CES						95.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		0 0	-	
200.00  Total (lines 50 through 199)	0	0	1	0	384, 832	200. 00

ealth Financial Systems PPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	ASCENSION ST. V		CN: 15-0010	Peri od:	eu of Form CMS-2 Worksheet D	
HROUGH COSTS				From 07/01/2021	Part IV	
				To 06/30/2022		
					11/28/2022 1:	52 pm
			XVIII	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medical	(sum of cols.	Outpatient Cost (sum of	(from Wkst. C,	to Charges (col. 5 ÷ col.	
	Education Cost	1, 2, 3, and 4)	cols. 2, 3,	8)		
		4)	and 4)	0)	7) (see	
			and 4)		instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS	4.00	5.00	0.00	7.00	0.00	
0. 00 05000 OPERATING ROOM	0	0		0 96, 016, 297	0, 000000	50.0
2.00 05200 DELIVERY ROOM & LABOR ROOM	0			0 18, 595, 785		
4. 00 05400 RADI OLOGY-DI AGNOSTI C	0	117, 213				
4. 01  03630  ULTRA_SOUND	0	40, 660				
6. 00 05600 RADI 0I SOTOPE	0	129, 335				
7. 00 05700 CT SCAN	0	80, 145				
	0					
8.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	17, 479				
9. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 35, 245		
	0	0		0 91, 011, 418		
5. 00 06500 RESPI RATORY THERAPY	0	0		0 16, 273, 127		
6.00 06600 PHYSI CAL THERAPY	0	0		0 14, 142, 757		
7.00 06700 OCCUPATIONAL THERAPY	0	0		0 5, 214, 251		
8.00 06800 SPEECH PATHOLOGY	0	0		0 851, 738		
9. 00 06900 ELECTROCARDI OLOGY	0	0		0 14, 501, 579		
0.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 7, 513, 381	0.000000	
1. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0		0 18, 943, 163		
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 12, 762, 083		
3. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 73, 525, 636		
4. 00 07400 RENAL DIALYSIS	0	0		0 1, 536, 731		
6. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0 4, 467, 662		
6. 01 03190 CHEMOTHERAPY	0	0		0 10, 854, 575		
6. 02 03330 ENDOSCOPY	0	0		0 57, 538		
6.03 03950 WOUND CARE CENTER	0	0		0 17, 060, 968	0.000000	76. (
OUTPATIENT SERVICE COST CENTERS	-	-				1
1.00 09100 EMERGENCY	0			0 69, 388, 096		
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 2, 407, 944	0.000000	92.0
OTHER REIMBURSABLE COST CENTERS		1				
5. 00 09500 AMBULANCE SERVI CES						95.
8.00 09850 OTHER REIMBURSABLE COST CENTERS	0			0 0		
00.00 Total (lines 50 through 199)	0	384, 832	384, 83	2 550, 937, 765		200. 0

Health Financial Systems	ASCENSION ST. VI	NCENT KOKOMO		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	Provider C	CN: 15-0010	Peri od:	Worksheet D	
THROUGH COSTS				From 07/01/2021 To 06/30/2022	Part IV	
				To 06/30/2022	Date/Time Pre 11/28/2022 1:	
		Title	XVIII	Hospi tal	PPS	52 piii
Cost Center Description	Outpati ent	Inpati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Throug		Pass-Through	
	(col. 6 ÷ col.	5	Costs (col.		Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVICE COST CENTERS	· · ·		•			
50.00 05000 OPERATING ROOM	0. 000000	9, 944, 345		0 18, 624, 980	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	112, 269	1	0 0	0	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 005078	941, 283	4, 7	3, 800, 162	19, 297	54.00
54.01 03630 ULTRA SOUND	0.005078	576, 772	2, 9	29 1, 174, 109	5, 962	54.01
56. 00 05600 RADI 0I SOTOPE	0.005079	37, 468	1	90 8, 545, 560	43, 403	56.00
57.00 05700 CT SCAN	0.005078	1, 534, 682	7, 7	2, 691, 643	13, 668	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.005078	224, 200		38 657, 206	3, 337	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0.000000	30, 928		0 0	0	59.00
60. 00 06000 LABORATORY	0.000000	11, 367, 622		0 6, 521, 274	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0.000000	2, 406, 173		0 132, 165	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0.000000	914, 881		0 40, 930	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0.000000	760, 207		0 16, 762	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	175, 446		0 9, 096	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0.000000	1, 795, 626		0 5, 070, 255	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.000000	213, 306		0 147,773	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	2,924,149		0 1, 982, 511	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	2, 753, 986		0 2, 465, 670	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.000000	6, 959, 375		0 17, 789, 666	0	73.00
74.00 07400 RENAL DIALYSIS	0. 000000	436, 153		0 0	0	74.00
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0.000000	0		0 6, 300	0	76.00
76.01 03190 CHEMOTHERAPY	0. 000000	6, 058		0 3, 801, 013	0	76.01
76. 02 03330 ENDOSCOPY	0. 000000	21, 993	1	0 5, 256	0	76.02
76.03 03950 WOUND CARE CENTER	0. 000000	0		0 4, 937, 421	0	76.03
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	0.000000	5, 809, 832		0 9, 484, 078	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	109, 907	1	0 1, 674, 893	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0. 000000	0		0 0	0	98.00
200.00 Total (lines 50 through 199)		50, 056, 661	16, 8	30 89, 578, 723	85, 667	200. 00

		ASCENSION ST. V			In Lie	u of Form CMS-	2552-10
APPORTI ONME	ENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-0010	Peri od:	Worksheet D	
					From 07/01/2021 To 06/30/2022	Part V Date/Time Pre	narod
					10 00/ 30/ 2022	11/28/2022 1:	52 pm
-			Title	e XVIII	Hospi tal	PPS	<u>02 piii</u>
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
		Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9	· · · ·	Subject To	Subject To		
				Ded. & Coi ns	. Ded. & Coins.		
				(see inst.)	(see inst.)		
		1.00	2.00	3.00	4.00	5.00	
ANCI	LLARY SERVICE COST CENTERS						
50.00 0500	O OPERATING ROOM	0. 121302	18, 624, 980	)	0 0	2, 259, 247	50.00
52.00 0520	O DELIVERY ROOM & LABOR ROOM	0. 200411	0	)	0 0	0	52.00
54.00 0540	0 RADI OLOGY-DI AGNOSTI C	0. 242519	3, 800, 162		0 0	921, 611	54.00
54.01 0363	O ULTRA SOUND	0. 106718	1, 174, 109	,	0 0	125, 299	54.01
56.00 0560	0 RADI 0I SOTOPE	0. 104135	8, 545, 560		0 0	889, 892	56.00
	O CT SCAN	0. 080874	2, 691, 643		0 0	217, 684	57.00
58.00 0580	O MAGNETIC RESONANCE IMAGING (MRI)	0. 292163	657, 206		0 0	192, 011	58.00
	O CARDI AC CATHETERI ZATI ON	1. 910314			0 0	0	59.00
60.00 0600	0 LABORATORY	0. 100019	6, 521, 274		0 0	652, 251	60.00
65.00 0650	0 RESPI RATORY THERAPY	0. 182162	132, 165		0 0	24, 075	65.00
66.00 0660	O PHYSI CAL THERAPY	0. 334296			0 0	13, 683	66.00
67.00 0670	O OCCUPATIONAL THERAPY	0. 341975	16, 762		0 0	5, 732	67.00
68.00 0680	O SPEECH PATHOLOGY	0. 379390	9, 096	,	0 0	3, 451	68.00
69.00 0690	0 ELECTROCARDI OLOGY	0. 071076	5, 070, 255		0 0	360, 373	69.00
70.00 0700	0 ELECTROENCEPHALOGRAPHY	0. 174788	147, 773		0 0	25, 829	70.00
71.00 0710	O MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 100599	1, 982, 511		0 0	199, 439	71.00
72.00 0720	OIMPL. DEV. CHARGED TO PATIENTS	0. 330144	2, 465, 670	)	0 0	814, 026	72.00
73.00 0730	O DRUGS CHARGED TO PATIENTS	0. 387714	17, 789, 666	,	0 5, 306	6, 897, 303	73.00
	O RENAL DI ALYSI S	0. 260224		)	0 0	0	1
76.00 0355	0 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 361280	6, 300	)	0 0	2, 276	76.00
76.01 0319	O CHEMOTHERAPY	0. 421241	3, 801, 013		0 0	1, 601, 143	76.01
76.02 0333	0 ENDOSCOPY	1. 116775	5, 256	,	0 0	5, 870	76.02
76.03 0395	O WOUND CARE CENTER	0. 091106			0 0	449, 829	76.03
OUTP	ATIENT SERVICE COST CENTERS						
91.00 0910	0 EMERGENCY	0. 106734	9, 484, 078	1	0 0	1, 012, 274	91.00
92.00 0920	O OBSERVATION BEDS (NON-DISTINCT PART)	0. 495567	1, 674, 893		0 0	830, 022	92.00
OTHE	R REIMBURSABLE COST CENTERS			·			
95.00 0950	O AMBULANCE SERVI CES	0. 210804			0		95.00
98.00 0985	O OTHER REIMBURSABLE COST CENTERS	0. 000000	C		0 0	0	98.00
200.00	Subtotal (see instructions)		89, 578, 723		0 5, 306	17, 503, 320	200.00
201.00	Less PBP Clinic Lab. Services-Program				0 0		201.00
	Only Charges						
202.00	Net Charges (line 200 - line 201)		89, 578, 723		0 5, 306	17, 503, 320	202.00

Health Financial Systems	ASCENSION ST. V	INCENT KOKOMO		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-0010	Period: From 07/01/2021 To 06/30/2022	Worksheet D Part V Date/Time Pre	epared:
					11/28/2022 1:	52 pm
			XVIII	Hospi tal	PPS	
	Cos		-			
Cost Center Description	Cost	Cost				
	Reimbursed Services	Reimbursed Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCI LLARY SERVI CE COST CENTERS	0.00	7.00	1			
50. 00 05000 OPERATING ROOM	0	0				50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0		•			52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
54. 01 03630 ULTRA SOUND	0	0				54.01
56. 00 05600 RADI OI SOTOPE	0	0				56.00
57. 00 05700 CT SCAN	0	0				57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0				58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0				59.00
60. 00 06000 LABORATORY	0	0				60.00
65. 00 06500 RESPIRATORY THERAPY	0	0				65.00
66. 00 06600 PHYSI CAL THERAPY	0	0				66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0				67.00
68. 00 06800 SPEECH PATHOLOGY	0	0				68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	2, 057				73.00
74.00 07400 RENAL DIALYSIS	0	0	1			74.00
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0				76.00
76. 01 03190 CHEMOTHERAPY	0	0				76.01
76. 02 03330 ENDOSCOPY	0	0				76.02
76.03 03950 WOUND CARE CENTER	0	0				76.03
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	0	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0					95.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0				98.00
200.00 Subtotal (see instructions)	0	2, 057				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)	0	2, 057				202.00

Health Financial Systems	ASCENSION ST. V	INCENT KOKOMO		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C	CN: 15-0010	Peri od:	Worksheet D	
		Component	CCN: 15-T010	From 07/01/2021 To 06/30/2022	Part II Date/Time Pre	narodi
		component	CCN. 15-1010	10 00/30/2022	11/28/2022 1:	
		Title	× XVIII	Subprovider -	PPS	
				I RF		
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,			. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1 00/ 1/0	<u> </u>	0.0400		0.01	1
50. 00 05000 OPERATI NG ROOM	1, 286, 148					•
52.00 05200 DELIVERY ROOM & LABOR ROOM	218, 093				-	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 171, 665					54.00
54. 01 03630 ULTRA SOUND	141, 369					
56. 00 05600 RADI OI SOTOPE	657,055				-	56.00
57.00 05700 CT SCAN	26, 128					57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	303, 340					
59. 00 05900 CARDI AC CATHETERI ZATI ON	22, 975				-	59.00
	269, 216					
65. 00 06500 RESPI RATORY THERAPY	120, 620					
66.00 06600 PHYSI CAL THERAPY	209, 160					
67.00 06700 OCCUPATI ONAL THERAPY	83, 161	5, 214, 251			13, 666	
68.00 06800 SPEECH PATHOLOGY	20, 533					
69. 00 06900 ELECTROCARDI OLOGY	205, 734					
70.00 07000 ELECTROENCEPHALOGRAPHY	80, 856					
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	184,069				1, 646	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	77, 489				32	
73.00 07300 DRUGS CHARGED TO PATIENTS	579, 809					•
74.00 07400 RENAL DIALYSIS	7, 502				613	
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 76. 01 03190 CHEMOTHERAPY	104, 189				0	76.00
	665, 937				0	
76.02 03330 ENDOSCOPY	9, 753				0	76.02
76. 03 03950 WOUND CARE CENTER OUTPATIENT SERVICE COST CENTERS	77, 722	17, 060, 968	0.0045	131		76.03
	E20.044	(0, 200, 00/	0.007/1	7 01/	(0	01 00
	530, 844					91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) OTHER REI MBURSABLE COST CENTERS	0	2,407,944	0.0000	0	0	92.00
			1			95.00
95. 00 09500 AMBULANCE SERVICES 98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0.0000	0	0	•
200.00 Total (lines 50 through 199)	7,053,367		010000	3, 988, 150	-	
200.00   TOLAT (TTHES SO LITOUGH 199)	/,000,30/	000, 937, 705	I	3, 900, 150	40,840	1200. 00

Health Financial Systems ASCENSION ST. VINCENT KOKOMO In Lieu						S-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PASS	S Provider C	CN: 15-0010	Peri od:	Worksheet D	
THROUGH COSTS		Component (	CCN: 15-T010	From 07/01/2 To 06/30/2		
		Title	Title XVIII		- PPS	
Cost Center Description	Non Physician	Nursi ng	Nursi ng		Ith Allied Healt	:h
	Anestheti st	Program	Program	Post-Stepd		
	Cost	Post-Stepdown		Adj ustmen	ts	
	1.00	Adjustments 2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS	1.00	ZA	2.00	3A	3.00	
50. 00 05000 OPERATING ROOM	0	0		0	0	0 50,00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	0 52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0 117, 2	
54. 01 03630 ULTRA SOUND	0	0		0	0 40,6	
56. 00 05600 RADI OI SOTOPE	0	0		0	0 129, 3	
57. 00 05700 CT SCAN	0	0		0	0 80, 1	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0	0 17,4	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	0 59.00
60. 00 06000 LABORATORY	0	0		0	0	0 60.00
65. 00 06500 RESPIRATORY THERAPY	0	0		0	0	0 65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0	0	0 66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0	0	0 67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0	0	0 68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0	0	0 69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	0 70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1	0	0	0 71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	1	0	0	0 72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	0 73.00
74.00 07400 RENAL DIALYSIS	0	0		0	0	0 74.00
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0	0	0 76.00
76. 01 03190 CHEMOTHERAPY	0	0		0	0	0 76.01
76. 02 03330 ENDOSCOPY	0	0		0	0	0 76.02
76.03 03950 WOUND CARE CENTER	0	0		0	0	0 76.03
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	0	0		0	0	0 91.00
92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0			0		0 92.00
OTHER REIMBURSABLE COST CENTERS						- 05 00
95. 00 09500 AMBULANCE SERVICES		_				95.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		0	0 294.9	0 98.00
200.00  Total (lines 50 through 199)	0	0	I	0	0 384, 8	32 200. 00

		ASCENSION ST. V				u of Form CMS-	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	S Provider CO	CN: 15-0010	Period:	Worksheet D	
THROUG	GH COSTS		Component		From 07/01/2021	Part IV	norod.
			component (	CCN: 15-T010	To 06/30/2022	Date/Time Pre 11/28/2022 1:	52 nm
			Title	XVIII	Subprovider -	PPS	02 pm
					I RF		
	Cost Center Description	All Other	Total Cost	Total	Total Charges		
		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)	cols. 2, 3,	8)	7)	
				and 4)		(see	
						instructions)	
		4.00	5.00	6.00	7.00	8.00	
	ANCI LLARY SERVI CE COST CENTERS	1			-		
50.00	05000 OPERATING ROOM	0	0		0 96, 016, 297	0.000000	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 18, 595, 785	0.00000	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	117, 213	117, 21	3 23, 082, 531	0.005078	54.00
54.01	03630 ULTRA SOUND	0	40, 660	40, 66	0 8, 007, 118	0.005078	54.01
56.00	05600 RADI OI SOTOPE	0	129, 335	129, 33	5 25, 463, 259	0.005079	56.00
57.00	05700 CT SCAN	0	80, 145	80, 14		0.005078	
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	17, 479			0.005078	
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 35, 245	0. 000000	
60.00	06000 LABORATORY	0	0		0 91, 011, 418	0. 000000	
65.00	06500 RESPI RATORY THERAPY	0	0		0 16, 273, 127	0. 000000	
66.00	06600 PHYSI CAL THERAPY	0	0		0 14, 142, 757	0. 000000	
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0 14, 142, 757	0. 000000	
68.00	06800 SPEECH PATHOLOGY	0	0			0. 000000	
		0	0		0 851, 738		
69.00	06900 ELECTROCARDI OLOGY	0	0		0 14, 501, 579	0.00000	
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 7, 513, 381	0.00000	
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0		0 18, 943, 163	0.00000	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 12, 762, 083	0.00000	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 73, 525, 636	0.000000	
74.00	07400 RENAL DIALYSIS	0	0		0 1, 536, 731	0.000000	
76.00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0 4, 467, 662	0.000000	
76. 01	03190 CHEMOTHERAPY	0	0		0 10, 854, 575	0.00000	
76. 02	03330 ENDOSCOPY	0	0		0 57, 538	0.00000	76.02
76.03	03950 WOUND CARE CENTER	0	0		0 17, 060, 968	0.000000	76.03
	OUTPATIENT SERVICE COST CENTERS						
	09100 EMERGENCY	0	0		0 69, 388, 096	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 2, 407, 944	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVI CES						95.00
	09850 OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0.000000	98.00
98.00	107030 UTTER RETWOORSADEL COST GENTERS		0				

APPORT ONLERT OF INPATIENT OUTPATIENT ANCILLARY SERVICE OTHER PASS         Provider CCN: 15-0010         Period: From 07/01/2021         Worksheet 0 11/2022         Worksheet 0 11/202         Worksheet 0 11/2022         Worksheet 0 11/2022         Worksheet 0 11/2022         Worksheet 0 11/2022         Worksheet 0 11/2022         Worksheet 0 11/202         Worksheet 0 11/202         Worksheet 0 11/202         Worksheet 0 11/202         Worksheet 0 11/2022         Worksheet 0 11/202         Worksheet 0 11/202         Worksheet 0 11/202         Worksheet 0 1/202	Health Financial Systems	ASCENSION ST. VI	NCENT KOKOMO		In Lie	eu of Form CMS-	2552-10
Ancient Store         Component CN: 15-1010         To         06/30/2022         Date/Time Prepared: 17/22/2022         Date/Time Prepared: 17/22/2022         Date/Time Prepared: 17/22/2022           Cost Center Description         Outpatient to Charges (col. 6 + col. 7)         Inpatient Program Pass-Through Costs (col. 8 x col. 10)         Outpatient Program Pass-Through Costs (col. 9 x col. 12)         Outpatient Program Pass-Through Costs (col. 9 x col. 12)         Outpatient Program Pass-Through Costs (col. 9 x col. 12)           0.0000000         0	APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEA	RVICE OTHER PASS	Provider C	CN: 15-0010			
Cost Center Description         Outpatient Ratio of Cost to Charges (col. 6 + col. 7)         Inpatient Program Charges (col. 6 + col. 7)         Inpatient Program Charges (col. 6 + col. 7)         Inpatient Program Charges         Outpatient Program Charges         Program Pass-Through Costs (col. 9 x col. 12)           50.00         05000         OPERATING ROM 000000         0.000000         11.00         12.00         13.00           50.00         05000         OPERATING ROM 000000         0.000000         0	THROUGH COSTS		Component	CON. 15 TO10	From 07/01/2021	Part IV	narod
Cost Center Description         Outpatient Ratio of Cost to Charges (col. 6 + col. 7)         Inpatient Program Pass-Through Costs (col. 9 x col. 10)         Outpatient Program Pass-Through Costs (col. 9 x col. 12)           50.00         05400 ARDIOLOCY-DIAGNOSTIC         0.000000         15.010         0         0         56.00           51.00         05400 RADIOLOCY-DIAGNOSTIC         0.005078         64.600         328         0         0         54.00           50.00         05600 MADINISTIC RESONANCE INAGING (MRI)         0.005078         13.80         0         0         55.00         0         57.00           50.00         05600 MADIATHETER ZATIEN         0.000000         1, 22, 660         0         0         0         0         0         0         0         0			component	JCN. 15-1010	10 00/30/2022		
Cost Center Description         Outpatient Ratio of Cost to Charges (col. 6 + col. 7)         inpatient Program (Charges (col. 6 + col. 7)         Inpatient Program Pass-Through Costs (col. 8 × col. 10)         Outpatient Program Pass-Through Costs (col. 9 × col. 12)         Outpatient Program Charges         Outpatient Program Charges           50. 00         05000 (DPEATING ROM 05000 (DPELIVERY NOM & LABOR ROM 0 00000 (DELIVERY NEAR 0 0 0 (DELIVERY NEAR 0 0			Title	XVIII	Subprovider -		
Ratio of Cost (col. 6 + col. 7)         Program (charges) (col. 10)         Program (col. 10)						-	
Image: the second sec	Cost Center Description						
Image: construct of the construction of the							
T)         x col. 10)         x col. 12)           ANCI LLARY SERVICE COST CENTERS         9.00         11.00         12.00         13.00           50.00         05000 (PERATING ROM         0.000000         0         0         0         52.00           50.00         05000 (DelLiVERY ROM & LABOR ROM         0.000000         0         0         0         52.00           54.00         054.00         DELVICERY ROM & LABOR ROM         0.005078         18.066         92         0         0         54.00           54.00         05400 IRADI 0I SOTOPE         0.005078         18.066         92         0         0         54.00           56.00         05700 CT SCAN         0.005078         12.350         63         0         57.00           59.00         05900 CARDIA CATHERI ZATION         0.000000         1.029,660         0         0         66.00           60.00         06600 REPI RATORY THERAPY         0.000000         1.23823         0         0         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         67.00         66.00         66.00         66.00         67.00         66.00         67.00         66.00         67.00         66			Charges				
NOT         11.00         12.00         13.00           50.00         05000         OPERATI NG ROOM         0.000000         0         0         0         50.00           52.00         05200         DEL VERY ROM & LABOR ROOM         0.000000         0         0         0         52.00           54.00         05400         RADO RAD DLOGOV-DI AGNOSTI C         0.005078         646,600         3228         0         0         54.01           56.00         DS700         CT AS SOUND         0.005078         18,066         92         0         0         56.00           57.00         DS700         CT SCAN         0.005078         30,600         155         0         57.00           58.00         OS600         RABRETI C RESONANCE I MAGI NG (MRI )         0.005078         30,600         155         0         0         59.00         50.00         66.00         66.00         66.00         66.00         66.00					8		
ANCI LLARY SERVICE COST CENTERS           ANCI LLARY SERVICE COST CENTERS           05000 OPERATI NG ROOM         0.00000           05000 OPERATI NG ROOM         0.00000           05000 DELI VERY ROOM & LABOR ROOM         0.000000           05000 DELI VERY ROOM & LABOR ROOM         0.005078           05100 DELI VERY ROOM & LABOR ROOM         0.005078           05000 CT SCAN         0.005078           005000 CT SCAN         0.005078           005000 CARDI AC CATHETERI ZATI ON         0.005078           000000 LABORATORY         0.000000           0.000000 LECTRCACABDI LOGY         0.000000           0.000000 LECTRCACABDI LOGY         0.000000           0.000000 SEECH PATIONAL THERAPY         0.000000           0.000000 LABORATORY         0.000000           0.000000 LECTRCACABDI LOGY         0.000000           0.000000 LECTRCACABDI LOGY         0			10.00				
50.00         OFERATINC ROOM         0.000000         15,010         0         0         50.00         S0.00		9.00	10.00	11.00	12.00	13.00	
52.00       05200       DELIVERY ROOM & LABOR ROOM       0.000000       0       0       52.00         54.00       05400       RADI OLOGY-DI AGNOSTIC       0.005078       64,600       328       0       0       54.01         54.00       05600       RADI OLOGY-DI AGNOSTIC       0.005078       18,066       92       0       54.01         56.00       05600       RADI OLSOTOPE       0.005079       0       0       0       56.00         57.00       05700       CT SCAN       0.005078       30,600       155       0       57.00         58.00       05800       MAGNETI C RESONANCE I MAGI NG (MRI )       0.005078       12,350       63       0       0       59.00         00000       000000       0       0       0       0       0       59.00       66.00       67.00       66.00       67.00       66.00       67.00 <td></td> <td>0.000000</td> <td>15 010</td> <td></td> <td>0</td> <td></td> <td></td>		0.000000	15 010		0		
54.00       05400       RADI 0L0GY - DI AGNOSTI C       0.005078       64,600       328       0       0       54.00         54.01       03630       ULTRA SOUND       0.005078       18,066       92       0       0       56.01         57.00       05700       CT SCAN       0.005078       30,600       155       0       0       57.00         58.00       05900       CARDI AC CATHETERI ZATI ON       0.00000       0       0       0       59.00         60.00       06000       ARDORTORY       0.000000       1,029,660       0       0       66.00       66.00         65.00       06000       RSPI RATORY THERAPY       0.000000       123,823       0       0       66.00       67.00       66.00       66.00       67.00       66.00							
54.01       03630       ULTRA SOUND       0.005078       18,066       92       0       0       54.01         56.00       05000       RADI 01 SOTOPE       0.005079       0       0       0       55.00         57.00       05700       CT SCAN       0.005078       30,600       155       0       0       58.00         58.00       05900       CARDI AC CATHETERI ZATI 0N       0.00000       0       0       0       0       59.00         60.00       06000       LABORATORY       0.000000       1,029,660       0       0       0       66.00       67.00       66.00       67.00       66.00       67.00       66.00       67.00       66.00       67.00       66.00       67.00       67.00       67.00       67.00			-				
56.00       05600       RADI 0I SOTOPE       0.005079       0       0       0       56.00         57.00       05700       CT SCAN       0.005078       30,600       155       0       0       57.00         58.00       05800       MAGNETI C RESONANCE I MAGI NG (MRI )       0.005078       30,600       155       0       0       58.00         59.00       CARDI AC CATHETERI ZATI ON       0.000000       0       0       0       0       59.00         65.00       06500       RSPI RATORY       0.000000       1,029,660       0       0       66.00         66.00       06600       PHYSI CAL THERAPY       0.000000       948,748       0       0       66.00         67.00       06700       OCUPATI ONAL THERAPY       0.000000       46,522       0       0       67.00         68.00       06800       SPECH PATHOLOGY       0.000000       5,360       0       0       70.00       70.00         71.00       DTOLO TALORANCH IMAGED TO PATI ENTS       0.000000       5,262       0       0       71.00       71.00         72.00       IMPL. DEV. CHARGED TO PATI ENTS       0.000000       5,262       0       0       72.00       73.00 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td>u u</td> <td></td>						u u	
57.00       05700       CT SCAN       0.005078       30,600       155       0       57.00         58.00       MAGNETI C RESONANCE I MAGI NG (MRI )       0.005078       12,350       63       0       0       58.00         60.00       0.6000       LABORATORY       0.000000       0       0       0       60.00         66.00       0.6000       LABORATORY       0.000000       1,029,660       0       0       60.00         67.00       0.6000       RSPI RATORY THERAPY       0.000000       123,823       0       0       66.00         66.00       06600       PHYSI CAL THERAPY       0.000000       856,847       0       0       67.00         67.00       06700       0CCUPATI ONAL THERAPY       0.000000       123,543       0       0       68.00         68.00       0EECH PATHOLOGY       0.000000       46,522       0       0       69.00       71.00         71.00       MDI CAL SUPPLIES CHARGED TO PATI ENTS       0.000000       5,360       0       0       72.00         73.00       DRUS CHARGED TO PATI ENTS       0.000000       5,262       0       0       73.00         74.00       OT400       REAL DI ALYSI S       0.0000						, i i i i i i i i i i i i i i i i i i i	
58.00       05800       MAGNETIC RESONANCE I MAGING (MRI)       0.005078       12,350       63       0       58.00         59.00       05900       CARDIAC CATHETERIZATION       0.000000       0       0       0       59.00         60.00       06000       LABORATORY       0.000000       1,029,660       0       0       0       60.00         65.00       06500       RESPI RATORY THERAPY       0.000000       123,823       0       0       65.00         66.00       06600       PHYSI CAL THERAPY       0.000000       856,847       0       0       66.00         67.00       06800       SPECH PATHOLOGY       0.000000       143,543       0       0       0       68.00         69.00       07000       ELECTROCARDIOLOGY       0.000000       5,360       0       0       71.00         71.00       07100       MEICAL SUPPLIES CHARGED TO PATIENTS       0.000000       5,362       0       0       71.00         72.00       DRUGS CHARGED TO PATIENTS       0.000000       5,262       0       0       73.00         73.00       OT400       REMACED TO PATIENTS       0.000000       125,572       0       0       74.00         76.01 <td></td> <td></td> <td>0</td> <td></td> <td></td> <td>u u</td> <td></td>			0			u u	
59:00       05900       CARDI AC CATHETERI ZATI ON       0.000000       0       0       0       59:00         60:00       DABORATORY       0.000000       1,029,660       0       0       60:00         65:00       06500       RESPI RATORY THERAPY       0.000000       123,823       0       0       65:00         66:00       06000       CCUPATI ONAL THERAPY       0.000000       948,748       0       0       66:00         67:00       06700       0CCUPATI ONAL THERAPY       0.000000       856,847       0       0       68:00         69:00       06900       ELECTROCARDI OLOGY       0.000000       46,522       0       0       69:00         70:00       07000       ELECTROCARDI OLOGY       0.000000       5,360       0       0       70:00         71:00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0.000000       5,262       0       0       72:00       0       72:00       0       72:00       0       72:00       0       72:00       0       72:00       0       72:00       0       72:00       0       72:00       0       72:00       0       72:00       0       72:00       0       72:00       0 <td></td> <td></td> <td></td> <td></td> <td></td> <td>, i i i i i i i i i i i i i i i i i i i</td> <td></td>						, i i i i i i i i i i i i i i i i i i i	
60.00         06000         LABORATORY         0.00000         1,029,660         0         0         60.00           65.00         06500         RESPI RATORY THERAPY         0.00000         123,823         0         0         66.00           66.00         06700         OCCUPATI ONAL THERAPY         0.000000         948,748         0         0         67.00           67.00         06700         OCCUPATI ONAL THERAPY         0.000000         856,847         0         0         67.00           68.00         6800         SPEECH PATHOLOGY         0.000000         123,543         0         0         68.00           69.00         CLECTROCARDI OLOGY         0.000000         46,522         0         0         0         69.00           71.00         O7100         REDI CAL SUPPLI ES CHARGED TO PATI ENTS         0.000000         5,360         0         0         0         71.00           71.00         O7200         IMEL CAL SUPPLI ES CHARGED TO PATI ENTS         0.000000         5,262         0         0         0         72.00           73.00         O7200         IMELS CHARGED TO PATI ENTS         0.000000         0         0         73.00         73.00         74.00         0         74.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td>u u</td> <td></td>						u u	
65.00       06500       RESPI RATORY THERAPY       0.00000       123,823       0       0       65.00         66.00       06600       PHYSI CAL THERAPY       0.00000       948,748       0       0       66.00         67.00       0CCUPATI ONAL THERAPY       0.00000       856,847       0       0       67.00         68.00       06800       SPEECH PATHOLOGY       0.00000       856,847       0       0       68.00         69.00       06900       ELECTROCARDI OLOGY       0.000000       46,522       0       0       68.00         70.00       07000       ELECTROCARDI OLOGY       0.000000       169,364       0       0       71.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0.000000       169,364       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0.000000       404,876       0       0       73.00       73.00         74.00       OT400       RENAL DI ALYSI S       0.000000       0       0       0       76.01         76.01       03950       WOUND CARE CENTER       0.000000       0       0       0       76.02         76.02       0330			-			u u	
66.00       06600       PHYSI CAL THERAPY       0.00000       948,748       0       0       66.00         67.00       06700       0CCUPATI ONAL THERAPY       0.000000       856,847       0       0       67.00         68.00       06800       SPEECH PATHOLOGY       0.000000       123,543       0       0       68.00         69.00       06900       ELECTROCARDI OLOGY       0.000000       46,522       0       0       69.00         0.0100       PLECTROENCEPHALOGRAPHY       0.000000       5,360       0       0       70.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0.000000       169,364       0       0       72.00         73.00       DRUGS CHARGED TO PATI ENTS       0.000000       5,262       0       0       73.00         74.00       07400       RENAL DI ALYSIS       0.000000       125,572       0       0       74.00         76.01       03190       CHEMOTHERAPY       0.000000       0       0       0       76.01         76.02       0330       ENDOSCOPY       0.000000       0       0       0       0       76.02         76.03       03950       WOUND CARE CENTER <t< td=""><td></td><td></td><td></td><td></td><td>-</td><td>, i i i i i i i i i i i i i i i i i i i</td><td></td></t<>					-	, i i i i i i i i i i i i i i i i i i i	
67.00       06700       OCCUPATI ONAL THERAPY       0.000000       856,847       0       0       67.00         68.00       06800       SPEECH PATHOLOGY       0.000000       123,543       0       0       0       68.00         69.00       06900       ELECTROCARDI OLOGY       0.000000       46,522       0       0       0       69.00         07.000       ELECTROCARDI OLOGY       0.000000       5,360       0       0       70.00         71.00       O7000       ELECTROCARGED TO PATI ENTS       0.000000       169,364       0       0       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0.000000       5,262       0       0       73.00         73.00       07300       DRUSS CHARGED TO PATI ENTS       0.000000       125,572       0       0       73.00         74.00       0350       PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES       0.000000       0       0       0       76.00         76.01       03190       CHEMOTHERAPY       0.000000       0       0       0       0       76.02         76.02       03350       PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES       0.000000       0       0       0       76.02						u u	
68.00       06800       SPEECH PATHOLOGY       0.000000       123,543       0       0       68.00         69.00       06900       ELECTROCARDIOLOGY       0.000000       46,522       0       0       69.00         70.00       07000       ELECTROENCEPHALOGRAPHY       0.000000       5,360       0       0       70.00         71.00       O7100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0.000000       5,262       0       0       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0.000000       5,262       0       0       73.00         74.00       07400       RENAL DI ALYSI S       0.000000       125,572       0       0       74.00         76.01       03190       CHEMOTHERAPY       0.000000       0       0       0       76.00         76.02       03330       ENDOSCOPY       0.000000       0       0       0       76.01         71.00       07100       EMERGENCY       0.000000       0       0       0       76.03         76.03       0330       ENDOSCOPY       0.000000       0       0       0       0       76.03         71.00       09100       EMERGENCY						, i i i i i i i i i i i i i i i i i i i	
69.00       06900       ELECTROCARDIOLOGY       0.000000       46,522       0       0       0       0       0         70.00       07000       ELECTROENCEPHALOGRAPHY       0.000000       5,360       0       0       0       70.00         71.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENTS       0.000000       169,364       0       0       0       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0.000000       5,262       0       0       0       72.00         73.00       07400       RENAL DIALYSIS       0.000000       404,876       0       0       0       73.00         74.00       07400 RENAL DIALYSIS       0.000000       125,572       0       0       74.00         76.00       0350       PSYCHIATRIC/PSYCHOLOGICAL SERVICES       0.000000       0       0       0       76.00         76.01       03190       CHEMOTHERAPY       0.000000       0       0       0       76.02         76.03       03950       WOUND CARE CENTER       0.000000       0       0       0       0       91.00         76.03       09200       DBERVATION BEDS (NON-DISTINCT PART)       0.000000       0 <t< td=""><td></td><td></td><td></td><td></td><td>-</td><td>, i i i i i i i i i i i i i i i i i i i</td><td></td></t<>					-	, i i i i i i i i i i i i i i i i i i i	
70.00       07000       ELECTROENCEPHALOGRAPHY       0.000000       5, 360       0       0       0       70.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0.000000       169, 364       0       0       0       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0.000000       5, 262       0       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0.000000       404, 876       0       0       0       73.00         74.00       07400       RENAL DI ALYSI S       0.000000       125, 572       0       0       0       74.00         76.01       03500       PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES       0.000000       0       0       0       76.00         03510       CHEMOTHERAPY       0.000000       0       0       0       0       76.01         76.01       03190       CHEMOTHERAPY       0.000000       0       0       0       0       76.02         76.03       03950       WOUND CARE CENTER       0.000000       131       0       0       0       76.03         017400       D9100       EMERGENCY       0.0000000       7, 8					-	, i i i i i i i i i i i i i i i i i i i	
71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0.000000       169, 364       0       0       0       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0.000000       5, 262       0       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0.000000       404, 876       0       0       0       73.00         74.00       O7400       RENAL DI ALYSI S       0.000000       125, 572       0       0       0       74.00         76.00       03550       PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES       0.000000       0       0       0       76.00         76.01       03190       CHEMOTHERAPY       0.000000       0       0       0       76.00         76.02       03330       ENDOSCOPY       0.000000       0       0       0       76.02         76.03       03950       WOUND CARE CENTER       0.000000       131       0       0       0       76.03         791.00       09100       EMERGENCY       0.000000       7,816       0       0       0       0       0         700       09200       OBSERVATI ON BEDS (NON-DI STI NCT PART)       0.000000					-	-	•
72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0.000000       5,262       0       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0.000000       404,876       0       0       0       73.00         74.00       07400       RENAL DI ALYSIS       0.000000       125,572       0       0       0       74.00         76.00       03550       PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES       0.000000       0       0       0       76.00         76.01       03190       CHEMOTHERAPY       0.000000       0       0       0       76.00         76.02       03330       ENDOSCOPY       0.000000       0       0       0       76.01         76.02       03350       WOUND CARE CENTER       0.000000       0       0       0       76.02         76.03       03950       WOUND CARE CENTER       0.000000       131       0       0       0       76.03         71.00       09100       EMERGENCY       0.000000       7,816       0       0       0       91.00         71.00       09200       OBSERVATI ON BEDS (NON-DI STI NCT PART)       0.000000       0       0       0       0						, s	
73.00       07300       DRUGS CHARGED TO PATIENTS       0.000000       404,876       0       0       73.00         74.00       07400       RENAL DI ALYSI S       0.000000       125,572       0       0       0       74.00         76.00       03550       PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES       0.000000       0       0       0       0       76.00         76.01       03190       CHEMOTHERAPY       0.000000       0       0       0       76.01         76.02       03330       ENDOSCOPY       0.000000       0       0       0       0       76.02         76.02       03950       WOUND CARE CENTER       0.000000       0       0       0       0       76.02         76.03       03950       WOUND CARE COST CENTER       0.000000       131       0       0       0       76.03         71.00       09100       EMEGENCY       0.000000       7,816       0       0       91.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       9					0 0	0	
74.00       07400       RENAL DI ALYSI S       0.000000       125, 572       0       0       0       74.00         76.00       03550       PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES       0.000000       0       0       0       76.00         76.01       03190       CHEMOTHERAPY       0.000000       0       0       0       76.01         76.02       03330       ENDOSCOPY       0.000000       0       0       0       76.02         76.03       03950       WOUND CARE CENTER       0.000000       131       0       0       0       76.03         0170-1       ENT SERVI CE COST CENTER       0.000000       131       0       0       0       91.00         09100       EMEGENCY       0.000000       7,816       0       0       91.00       92					0 0	0	•
76.00       03550       PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES       0.000000       0       0       0       76.00         76.01       03190       CHEMOTHERAPY       0.000000       0       0       0       76.01         76.02       03330       ENDOSCOPY       0.000000       0       0       0       0       76.02         76.03       03950       WOUND CARE CENTER       0.000000       131       0       0       0       76.03         0176.01       0176.02       0.000000       0       0       0       0       0       76.02         76.03       03950       WOUND CARE CENTER       0.000000       131       0       0       0       76.03         01747       ENT SERVI CE COST CENTERS       0.000000       7,816       0       0       91.00       92.00       9200       0858741 ON BEDS (NON-DI STI NCT PART)       0.000000       0       0       0       92.00         09200       0BSERVATI ON BEDS (NON-DI STI NCT PART)       0.000000       0       0       0       0       92.00         09200       OBSERVATI ON BEDS (NON-DI STI NCT PART)       0.000000       0       0       0       0       92.00         95.00 <td< td=""><td></td><td></td><td></td><td></td><td>0 0</td><td>0</td><td>73.00</td></td<>					0 0	0	73.00
76. 01       03190       CHEMOTHERAPY       0.000000       0       0       0       76. 01         76. 02       03330       ENDOSCOPY       0.000000       0       0       0       0       76. 02         76. 03       03950       WOUND CARE CENTER       0.000000       131       0       0       0       76. 02         76. 03       03950       WOUND CARE CENTER       0.000000       131       0       0       0       76. 03         0UTPATI ENT SERVICE COST CENTERS       0.000000       7, 816       0       0       0       91. 00         92. 00       09200       OBSERVATI ON BEDS (NON-DI STI NCT PART)       0.000000       7, 816       0       0       0       92. 00         09200       OBSERVATI ON BEDS (NON-DI STI NCT PART)       0.000000       0       0       0       0       0       0         95. 00       09500       AMBULANCE SERVI CES       95. 00       95. 00       98. 00       0       0       0       98. 00			125, 572		0 0	-	
76. 02       03330       ENDOSCOPY       0.000000       0       0       0       0       76. 02         76. 03       03950       WOUND CARE CENTER       0.000000       131       0       0       0       76. 02         001741       ENT SERVICE COST CENTERS       0.000000       131       0       0       0       91. 00         91. 00       09100       EMERGENCY       0.000000       7, 816       0       0       0       91. 00         92. 00       09200       OBSERVATI ON BEDS (NON-DI STI NCT PART)       0.000000       0       0       0       0       92. 00         07HER       REI MBURSABLE       COST CENTERS       0.000000       0       0       0       92. 00         95. 00       09500       AMBULANCE SERVICES       0.000000       0       0       0       95. 00       98. 00       0       0       0       98. 00			0		0 0	0	76.00
76. 03       03950       WOUND CARE CENTER       0.00000       131       0       0       0       76. 03         OUTPATI ENT SERVICE COST CENTERS       0.000000       7, 816       0       0       0       91. 00         91. 00       09100       EMERGENCY       0.000000       7, 816       0       0       0       91. 00         92. 00       09200       0BSERVATI ON BEDS (NON-DI STI NCT PART)       0.000000       0       0       0       92. 00         0THER REI MBURSABLE COST CENTERS       0.000000       0       0       0       95. 00       95. 00       95. 00       98. 00       0       0       0       0       95. 00       98. 00       0       0       0       0       98. 00			0		0	u u	
OUTPATI ENT SERVICE COST CENTERS         O         <			-				
91.00         09100         EMERGENCY         0.000000         7,816         0         0         0         91.00           92.00         09200         0BSERVATI ON BEDS (NON-DI STI NCT PART)         0.000000         0         0         0         0         92.00           0THER         REI MBURSABLE         COST CENTERS         0.000000         0         0         0         95.00         95.00         95.00         96.00         0         0         0         96.00         98.00         0         0         0         98.00         0         0         0         98.00         0         0         0         98.00         0         0         0         0         98.00         0         0         0         0         98.00         0         0         0         0         98.00         0         0         0         0         0         98.00		0.000000	131		0 0	0	76.03
92.00         09200         0BSERVATI ON BEDS (NON-DI STI NCT PART)         0.000000         0         0         0         0         92.00           0THER         REI MBURSABLE COST CENTERS         0.000000         0         0         0         0         95.00         95.00         95.00         95.00         95.00         98.00         0         0         0         0         96.00         98.00         98.00         98.00         0         0         0         0         98.00         98.00         0         0         0         0         98.00         98.00         0         0         0         98.00         0         0         0         0         98.00         0         0         0         0         98.00							
OTHER         REI MBURSABLE         COST         CENTERS           95. 00         09500         AMBULANCE         SERVI CES         95. 00           98. 00         09850         OTHER         REI MBURSABLE         COST         CENTERS         0. 000000         0         0         0         98. 00			7, 816				
95.00         09500         AMBULANCE SERVICES         95.00         98.00         09850         OTHER REI MBURSABLE COST CENTERS         0.000000         0         0         0         98.00         98.00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0		0 0	0	92.00
98. 00 09850 OTHER REI MBURSABLE COST CENTERS 0. 000000 0 0 0 98. 00							
200.00           Total (lines 50 through 199)           3,988,150         638         0         0/200.00		0. 000000	0				•
	200.00  Total (lines 50 through 199)		3, 988, 150	6	38 C	0	200.00

ASCENSI ON	ST.	VI NC	ENT	KOKOM	C		
			Dura	and all and a	CON	1 -	~

In Lieu of Form CMS-2552-10

OMPUT	Financial Systems ASCENSION ST.	VINCENT KOKOMO	In Lie	u of Form CMS-2	2552
	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0010	Peri od:	Worksheet D-1	
			From 07/01/2021 To 06/30/2022	Date/Time Pre	nare
			10 00/30/2022	11/28/2022 1:	
		Title XVIII	Hospi tal	PPS	
	Cost Center Description	· ·			
				1.00	
	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS				
	Inpatient days (including private room days and swing-bed			15, 606	1.
00	Inpatient days (including private room days, excluding sw			15, 606	2.
00	Private room days (excluding swing-bed and observation be	d days). If you have only p	rivate room days,	0	3.
	do not complete this line.				
00	Semi-private room days (excluding swing-bed and observati			14, 701	4.
00	Total swing-bed SNF type inpatient days (including privat	e room days) through Decemb	er 31 of the cost	0	5.
~ ~	reporting period				
00	Total swing-bed SNF type inpatient days (including privat		31 of the cost	0	6
~~	reporting period (if calendar year, enter 0 on this line)		04 6 11		_
00	Total swing-bed NF type inpatient days (including private	room days) through Decembe	r 31 of the cost	0	7
~~	reporting period		04 6 11 1		
00	Total swing-bed NF type inpatient days (including private	room days) after December	31 of the cost	0	8
00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicab	La ta tha Deservant (such unling	a and a hard and	4, 925	9.
00	newborn days) (see instructions)	Te to the Program (excludin	g swing-bed and	4, 925	9
. 00	Swing-bed SNF type inpatient days applicable to title XVI	IL only (including private	room dave)	0	10
. 00	through December 31 of the cost reporting period (see ins		room uays)	0	
. 00	Swing-bed SNF type inpatient days applicable to title XVI		room dave) after	0	11
. 00	December 31 of the cost reporting period (if calendar yea		room days) arter	0	''
. 00	Swing-bed NF type inpatient days applicable to titles V o		te room dave)	0	12
. 00	through December 31 of the cost reporting period	T XIX only (Ther during priva	te room days)	0	'2
. 00	Swing-bed NF type inpatient days applicable to titles V o	r XIX only (including priva	te room days)	0	13
. 00	after December 31 of the cost reporting period (if calend			0	
. 00	Medically necessary private room days applicable to the P			0	14
	Total nursery days (title V or XIX only)		uujo)	0	15
	Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT				
. 00	Medicare rate for swing-bed SNF services applicable to se	rvices through December 31	of the cost	0.00	17
	reporting period				
. 00	Medicare rate for swing-bed SNF services applicable to se	rvices after December 31 of	the cost	0.00	18
	reporting period				
. 00	Medicaid rate for swing-bed NF services applicable to ser	vices through December 31 c	f the cost	0.00	19
	reporting period				
. 00	Medicaid rate for swing-bed NF services applicable to ser	vices after December 31 of	the cost	0.00	20
	reporting period				
. 00	Total general inpatient routine service cost (see instruc			20, 577, 424	
. 00	Swing-bed cost applicable to SNF type services through De	cember 31 of the cost repor	ting period (line	0	22
	5 x line 17)				
. 00	Swing-bed cost applicable to SNF type services after Dece	mber 31 of the cost reporti	ng period (line 6	0	23
~~	x line 18)				
. 00	Swing-bed cost applicable to NF type services through Dec	ember 31 of the cost report	ing period (line	0	24
00	7 x line 19)	han 21 of the east reportin	a ported (line 0	0	25
. 00	Swing-bed cost applicable to NF type services after Decem	bei 31 01 the cost reportin	y perioù (inne o	0	20
. 00	x line 20) Total swing-bed cost (see instructions)			0	26
	Total swing-bed cost (see first detrois)	ost (lino 21 minus lino 26)		20, 577, 424	
	Conoral inpationt routing convice cost not of swing bod c			20, 377, 424	21
	General inpatient routine service cost net of swing-bed c				I
. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	· · · · · · · · · · · · · · · · · · ·	harges)	0	20
. 00 . 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swin	· · · · · · · · · · · · · · · · · · ·	harges)	0	
. 00 . 00 . 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swin Private room charges (excluding swing-bed charges)	· · · · · · · · · · · · · · · · · · ·	harges)	0	29
. 00 . 00 . 00 . 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swin Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)	g-bed and observation bed c	harges)	0	29 30
. 00 . 00 . 00 . 00 . 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swin Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line	g-bed and observation bed c	harges)	0 0 0. 000000	29 30 31
00 00 00 00 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swin Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line Average private room per diem charge (line 29 ÷ line 3)	g-bed and observation bed c 27 ÷ line 28)	harges)	0 0 0. 000000 0. 00	29 30 31 32
. 00 . 00 . 00 . 00 . 00 . 00 . 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swin Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line	g-bed and observation bed c 27 ÷ line 28) 4)		0 0 0. 000000 0. 00 0. 00	32 33
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swin Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line Average per diem private room charge differential (line 3	g-bed and observation bed c 27 ÷ line 28) 4) 2 minus line 33)(see instru		0 0.000000 0.00 0.00 0.00 0.00	29 30 31 32 33 34
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swin Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line Average per diem private room charge differential (line 34	g-bed and observation bed c 27 ÷ line 28) 4) 2 minus line 33)(see instru x line 31)		0 0.000000 0.00 0.00 0.00 0.00	29 30 31 32 33 34 35
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swin Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge differential (line 30 ÷ line Average per diem private room cost differential (line 34 Private room cost differential adjustment (line 3 x line	g-bed and observation bed c 27 ÷ line 28) 4) 2 minus line 33)(see instru x line 31) 35)	ctions)	0 0.000000 0.00 0.00 0.00 0.00 0.00	29 30 31 32 33 34 35 36
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swin Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line Average per diem private room charge differential (line 3 Average per diem private room cost differential (line 34 Private room cost differential adjustment (line 3 x line General inpatient routine service cost net of swing-bed c	g-bed and observation bed c 27 ÷ line 28) 4) 2 minus line 33)(see instru x line 31) 35)	ctions)	0 0.000000 0.00 0.00 0.00 0.00	29 30 31 32 33 34 35 36
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swin Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line Average per diem private room charge differential (line 3 Average per diem private room cost differential (line 34 Private room cost differential djustment (line 3 x line General inpatient routine service cost net of swing-bed c 27 minus line 36)	g-bed and observation bed c 27 ÷ line 28) 4) 2 minus line 33)(see instru x line 31) 35)	ctions)	0 0.000000 0.00 0.00 0.00 0.00 0.00	29 30 31 32 33 34 35 36
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swin Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line Average per diem private room charge differential (line 3 Average per diem private room cost differential (line 34 Private room cost differential (line 3 × line General inpatient routine service cost net of swing-bed c 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY	g-bed and observation bed c 27 ÷ line 28) 4) 2 minus line 33)(see instru x line 31) 35) ost and private room cost d	ctions)	0 0.000000 0.00 0.00 0.00 0.00 0.00	29 30 31 32 33 34 35 36
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swin Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line Average per diem private room charge differential (line 34 Private room cost differential (line 34 Private room cost differential (line 3 × line General inpatient routine service cost net of swing-bed c 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST	g-bed and observation bed c 27 ÷ line 28) 4) 2 minus line 33)(see instru x line 31) 35) ost and private room cost d ADJUSTMENTS	ctions)	0 0.00000 0.00 0.00 0.00 0 20,577,424	29 30 31 32 33 34 35 36 37
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swin Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line Average per diem private room charge differential (line 34 Private room cost differential (line 34 Private room cost differential (line 3 x line General inpatient routine service cost net of swing-bed c 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST Adjusted general inpatient routine service cost per diem	g-bed and observation bed c 27 ÷ line 28) 4) 2 minus line 33)(see instru x line 31) 35) ost and private room cost d ADJUSTMENTS (see instructions)	ctions)	0 0.000000 0.00 0.00 0.00 0.00 0.20,577,424	29 30 31 32 33 34 35 36 37 38
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swin Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line Average per diem private room charge differential (line 34 Private room cost differential (line 34 Private room cost differential (line 3 × line General inpatient routine service cost net of swing-bed c 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST	g-bed and observation bed c 27 ÷ line 28) 4) 2 minus line 33)(see instru x line 31) 35) ost and private room cost d ADJUSTMENTS (see instructions) line 38)	ctions)	0 0.00000 0.00 0.00 0.00 0 20,577,424	29 30 31 32 33 34 35 36 37 38 38 39

MPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 07/01/2021	Worksheet D-1	
				To 06/30/2022	11/28/2022 1:	
Cost Center Description	Total Inpatient Costl	Total	XVIII Average Per Diem (col. 1 col. 2)	Hospital Program Days ÷	PPS Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
.00 NURSERY (title V & XIX only)	0	0	0.0	0 0	C	9 42.
Intensive Care Type Inpatient Hospital Units	6, 204, 438	2, 701	2, 297. 0	9 754	1, 732, 006	43
. 00 CORONARY CARE UNI T	0,201,100	2,701	2,277.0	,,,,,	1,702,000	44
. OO BURN INTENSIVE CARE UNIT						45
. 00 SURGI CAL I NTENSI VE CARE UNI T						46
. 00 OTHER SPECIAL CARE (SPECIFY)						47
Cost Center Description					1.00	
.00 Program inpatient ancillary service cost (Wks	st. D-3, col. 3,	line 200)			8, 869, 389	9 48
.00 Total Program inpatient costs (sum of lines 4			ns)		17, 095, 303	
PASS THROUGH COST ADJUSTMENTS					1	
.00 Pass through costs applicable to Program inpa	atient routine s	services (from	Wkst. D, sum	of Parts I and	426, 556	50
III) .00 Pass through costs applicable to Program inpa	tiont ancillary	, sarvicas (fr	om What D s	m of Parts II	515, 364	1 51
and IV)					313, 304	
.00 Total Program excludable cost (sum of lines 5					941, 920	52
.00 Total Program inpatient operating cost exclud		ated, non-phy	sician anesth	etist, and	16, 153, 383	3 53
medical education costs (line 49 minus line 5 TARGET AMOUNT AND LIMIT COMPUTATION	52)					-
. 00 Program di scharges					C	54
.00 Target amount per discharge					0.00	
.00 Target amount (line 54 x line 55)					C	
.00 Difference between adjusted inpatient operati	ng cost and tar	-get amount (I	ine 56 minus	line 53)	C	
.00 Bonus payment (see instructions)	onting poriod a	anding 100/	ndated and an	mayinded by the		
.00 Lesser of lines 53/54 or 55 from the cost rep market basket	orting period e	enaling 1996, u	puated and co	ipounded by the	0.00	1 29
.00 Lesser of lines 53/54 or 55 from prior year of	cost report, upo	dated by the m	arket basket		0.00	60
.00 If line 53/54 is less than the lower of lines					C	61
which operating costs (line 53) are less than		s (lines 54 x	60), or 1% of	the target		
amount (line 56), otherwise enter zero (see i .00 Relief payment (see instructions)	instructions)				c	62
.00 Allowable Inpatient cost plus incentive payme	ent (see instruc	ctions)				
PROGRAM INPATIENT ROUTINE SWING BED COST		·			1	
.00 Medicare swing-bed SNF inpatient routine cost	s through Decem	nber 31 of the	cost reporti	ng period (See	C	64
instructions)(title XVIII only) .00 Medicare swing-bed SNF inpatient routine cost	s after Decembe	er 31 of the c	ost reporting	neriod (See	C	65
instructions) (title XVIII only)			ost reporting			
.00 Total Medicare swing-bed SNF inpatient routir	ne costs (line é	54 plus line 6	5)(title XVII	l only). For	C	66
CAH (see instructions)		<b>D</b> 1 01	с.н			
.00  Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through	December 31 o	f the cost re	porting period	C	) 67
.00 Title V or XIX swing-bed NF inpatient routine	e costs after De	ecember 31 of	the cost repo	rtina period	c c	68
(line 13 x line 20)			·	51		
.00 Total title V or XIX swing-bed NF inpatient r					C	) 69
PART III - SKILLED NURSING FACILITY, OTHER NU .00 Skilled nursing facility/other nursing facili						70
.00  Skilled nursing facility/other nursing facili .00  Adjusted general inpatient routine service co	5		. ,			71
.00 Program routine service cost (line 9 x line 7			,			72
.00 Medically necessary private room cost applica	able to Program		ne 35)			73
.00 Total Program general inpatient routine servi	•					74
.00 Capital-related cost allocated to inpatient r 26, line 45)	outine service	COSTS (From W	υrκsneet B, P	artii, column		75
.00 Per diem capital-related costs (line 75 ÷ lir	ne 2)					76
.00 Program capital -related costs (line 9 x line						77
00 Inpatient routine service cost (line 74 minus						78
.00 Aggregate charges to beneficiaries for excess				(a + b + a - 70)		79
.00 Total Program routine service costs for compa .00 Inpatient routine service cost per diem limit		SC II MI TATION	(IIIe /8 mIN	us ITTHE (4)		80
.00 Inpatient routine service cost per drem rimit		1				82
.00 Reasonable inpatient routine service costs (s						83
.00 Program inpatient ancillary services (see ins						84
.00 Utilization review - physician compensation (						85
.00 Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		ougn 85)			1	86
.00 Total observation bed days (see instructions)					905	5 87
.00 Adjusted general inpatient routine cost per d		line 2)			1, 318. 56	
naj de ted general inspatiente i editine eest per e						

Health Financial Systems	ASCENSION ST. V	INCENT KOKOMO		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 07/01/2021	Worksheet D-1	
				To 06/30/2022	Date/Time Pre 11/28/2022 1:	
	Title XVIII		XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	1, 063, 834	20, 577, 424	0. 05169	9 1, 193, 297	61, 692	90.00
91.00 Nursing Program cost	0	20, 577, 424	0.00000	0 1, 193, 297	0	91.00
92.00 Allied health cost	0	20, 577, 424	0.00000	0 1, 193, 297	0	92.00
93.00 All other Medical Education	0	20, 577, 424	0.00000			93.00

MPUT/	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0010 Component CCN: 15-T010	Peri od: From 07/01/2021 To 06/30/2022	Worksheet D-1 Date/Time Pre 11/28/2022 1:	pare
	Cash Cashan Daarai ati an	Title XVIII	Subprovider -	PPS	
	Cost Center Description			1.00	
	PART I – ALL PROVIDER COMPONENTS INPATIENT DAYS				-
	Inpatient days (including private room days and swing-bed da	ays, excluding newborn)		3, 484	1
00	Inpatient days (including private room days, excluding swing	g-bed and newborn days)		3, 484	2
00	Private room days (excluding swing-bed and observation bed o	days). If you have only pr	ivate room days,	0	3
00	do not complete this line. Semi-private room days (excluding swing-bed and observation	bed days)		3, 484	4
20	Total swing-bed SNF type inpatient days (including private r		r 31 of the cost	3, 404	
	reporting period				
00	Total swing-bed SNF type inpatient days (including private r	room days) after December	31 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private ro	and days) through December	21 of the cost	0	5
50	reporting period	Join days) thi bugh becember	ST OF THE COST	0	'
00	Total swing-bed NF type inpatient days (including private ro	oom days) after December 3	1 of the cost	0	8
	reporting period (if calendar year, enter 0 on this line)			1 0 1 5	
00	Total inpatient days including private room days applicable newborn days) (see instructions)	to the Program (excluding	swing-bed and	1, 945	9
00	Swing-bed SNF type inpatient days applicable to title XVIII	only (including private r	oom days)	0	10
	through December 31 of the cost reporting period (see instru		, , , , , , , , , , , , , , , , , , ,		
	Swing-bed SNF type inpatient days applicable to title XVIII December 31 of the cost reporting period (if calendar year,		oom days) after	0	11
	Swing-bed NF type inpatient days applicable to titles V or >		e room days)	0	12
	through December 31 of the cost reporting period	3 . 0 .	3 ,	0	1 12
00	Swing-bed NF type inpatient days applicable to titles V or >			0	13
00	after December 31 of the cost reporting period (if calendar Medically necessary private room days applicable to the Prog			0	14
	Total nursery days (title V or XIX only)	gram (excruding swing-bed	uays)	0	
	Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT		<u>C 11 1 1</u>	0.00	
00	Medicare rate for swing-bed SNF services applicable to servi reporting period	ces through December 31 c	r the cost	0.00	
00	Medicare rate for swing-bed SNF services applicable to servi	ces after December 31 of	the cost	0.00	18
	reporting period			0.00	
00	Medicaid rate for swing-bed NF services applicable to servic reporting period	ces through December 31 of	the cost	0.00	19
00	Medicaid rate for swing-bed NF services applicable to servic	ces after December 31 of t	he cost	0.00	20
	reporting period				
	Total general inpatient routine service cost (see instructio		ing pariod (line	3, 610, 271	
00	Swing-bed cost applicable to SNF type services through Decem 5 x line 17)	mber 31 of the cost report	ing period (line	0	22
00	Swing-bed cost applicable to SNF type services after Decembe	er 31 of the cost reportin	g period (line 6	0	23
	x line 18)			_	
00	Swing-bed cost applicable to NF type services through Decemb 7 x line 19)	per 31 of the cost reporti	ng period (line	0	24
00	Swing-bed cost applicable to NF type services after December	r 31 of the cost reporting	period (line 8	0	25
	x line 20)				
	Total swing-bed cost (see instructions)	t (line 21 minus line 24)		0	
1	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	t (The 21 minus The 26)		3, 610, 271	27
	General inpatient routine service charges (excluding swing-b	ped and observation bed ch	arges)	0	28
	Private room charges (excluding swing-bed charges)			0	29
	Semi-private room charges (excluding swing-bed charges)			0	30
	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3)	/ ÷ 11 ne 28)		0. 000000 0. 00	
	Average semi-private room per diem charge (line 20 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)	)		0.00	
	Average per diem private room charge differential (line 32 n		tions)	0.00	
	Average per diem private room cost differential (line 34 x l			0.00	
	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing bed cost		fforential (line)	0	36
00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	i and private room cost di		3, 610, 271	3/
ľ	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
[	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AL		1		
	Adjusted general inpatient routine service cost per diem (se			1,036.24	
	Program general inpatient routine service cost (line 9 x lir Medically necessary private room cost applicable to the Proc			2, 015, 487 0	
				0	1 +0

WPUL	ATION OF INPATIENT OPERATING COST		Provider C	CN: 15-0010	Peri od:	Worksheet D-1	-2552 1
			Component	CCN: 15-T010	From 07/01/2021 To 06/30/2022	Date/Time Pre	
			Title	e XVIII	Subprovider -	11/28/2022 1: PPS	52
	Cost Center Description	Total	Total	Average Per	IRF Program Days	Program Cost	
		Inpatient Cost		Diem (col. 1		(col. 3 x col.	
		1.00	2.00	col. 2) 3.00	4.00	4) 5.00	
. 00	NURSERY (title V & XIX only)	0	C	0.	00 0	C	) 42
. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	0	C	0.	00 0	l c	0 43
-	CORONARY CARE UNI T	0		0.	00 0		44
	BURN INTENSIVE CARE UNIT						45
	SURGI CAL I NTENSI VE CARE UNI T						46
. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47
	cost center bescription					1.00	-
00	Program inpatient ancillary service cost (Wks	st. D-3, col. 3	, line 200)			1, 022, 299	9 48
	Total Program inpatient costs (sum of lines 4	11 through 48)(	see instructio	ons)		3, 037, 786	5 49
	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpa	tiont routing	convisor (from		m of Dorte L and	149.040	3 50
00	(111)		Services (110	WKSL D, SU	II OF PAILS F ANU	148, 948	
00	Pass through costs applicable to Program inpa	atient ancillar	y services (fr	rom Wkst. D,	sum of Parts II	46, 478	3 5'
	and IV)						_
. 00	Total Program excludable cost (sum of lines 5		lated non nh	volaian anaat	hatiat and	195, 426	
. 00	Total Program inpatient operating cost exclude medical education costs (line 49 minus line 5		nateu, non-pny		netist, anu	2, 842, 360	5
	TARGET AMOUNT AND LIMIT COMPUTATION						
	Program discharges					C	
	Target amount per discharge Target amount (line 54 x line 55)					0.00	
	Difference between adjusted inpatient operati	ng cost and ta	rget amount (I	ine 56 minus	line 53)		
	Bonus payment (see instructions)	5	5 .		,	C	58
. 00	Lesser of lines 53/54 or 55 from the cost rep	porting period	endi ng 1996, ι	updated and c	ompounded by the	0.00	) 5'
. 00	market basket Lesser of lines 53/54 or 55 from prior year o	rost report un	dated by the m	narket hasket		0.00	) 6
	If line 53/54 is less than the lower of lines				the amount by	0.00	
	which operating costs (line 53) are less than		s (lines 54 x	60), or 1% o	f the target		
00	amount (line 56), otherwise enter zero (see i	nstructions)					
	Relief payment (see instructions) Allowable Inpatient cost plus incentive payme	ent (see instru	ictions)				
	PROGRAM INPATIENT ROUTINE SWING BED COST						
. 00	Medicare swing-bed SNF inpatient routine cost	ts through Dece	ember 31 of the	e cost report	ing period (See	C	) 64
. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cost	ts after Decemb	or 31 of the c	cost reportin	a period (See		) 65
. 00	instructions) (title XVIII only)				g period (see		10.
. 00	Total Medicare swing-bed SNF inpatient routir	ne costs (line	64 plus line 6	55)(title XVI	ll only). For	C	66
00	CAH (see instructions)	acto through	December 21	f the east m	operting period		
. 00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through	December 31 C	or the cost r	eporting period	C	67
. 00	Title V or XIX swing-bed NF inpatient routine	e costs after D	ecember 31 of	the cost rep	orting period	c c	68
	(line 13 x line 20)						
	Total title V or XIX swing-bed NF inpatient r					C	0 69
	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facili				)		70
	Adjusted general inpatient routine service co	2		•	, ,		7
	Program routine service cost (line 9 x line 7			25)			72
	Medically necessary private room cost applica						73
	Total Program general inpatient routine servi Capital-related cost allocated to inpatient r				Part II, column		75
	26, line 45)						
	Per diem capital-related costs (line 75 ÷ lin						70
	Program capital-related costs (line 9 x line 76) Inpatient routine service cost (line 74 minus line 77)						7
	Aggregate charges to beneficiaries for excess		orovi der record	ls)			7
	Total Program routine service costs for compa				nus line 79)		8
	Inpatient routine service cost per diem limit		、 、				8
	Inpatient routine service cost limitation (li						82
	Reasonable inpatient routine service costs (s Program inpatient ancillary services (see ins		15)				8
	Utilization review - physician compensation (		ons)				8!
. 00	Total Program inpatient operating costs (sum	of lines 83 th					86
	PART IV - COMPUTATION OF OBSERVATION BED PASS					-	
	Total observation bed days (see instructions) Adjusted general inpatient routine cost per o		line 2)			0.00	
	najastea generar ripatrent routrie cost per (	ar Gin (TTTHC ∠7 →	1110 21			0.00	1 00

Health Financial Systems	ASCENSION ST.	/INCENT KOKOMO		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider C		Period: From 07/01/2021	Worksheet D-1	
		Component	CCN: 15-T010	To 06/30/2022	Date/Time Pre 11/28/2022 1:	pared: 52 pm
		Title	e XVIII	Subprovider - IRF	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observation	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST			· · · · · · · · · · · · · · · · · · ·		
90.00 Capital-related cost	266, 805	3, 610, 271	0. 07390	2 0	0	90.00
91.00 Nursing Program cost	0	3, 610, 271	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	3, 610, 271	0. 00000	0 0	0	92.00
93.00 All other Medical Education	(	3, 610, 271	0. 00000	0 0	0	93.00

	Financial Systems ASCENSION ST. ATION OF INPATIENT OPERATING COST	VINCENT KOKOMO Provider CCN: 15-0010	In Lie Period:	u of Form CMS-2 Worksheet D-1	
			From 07/01/2021 To 06/30/2022	Date/Time Pre 11/28/2022 1:	
		Title XIX	Hospi tal	Cost	
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS				
1.00	INPATIENT DAYS Inpatient days (including private room days and swing-bed	d davs, excluding newborn)		15, 606	1.00
2.00 3.00	Inpatient days (including private room days, excluding sw Private room days (excluding swing-bed and observation be	ving-bed and newborn days)	rivate room days,	15, 606 0	2.00 3.00
4.00 5.00	do not complete this line. Semi-private room days (excluding swing-bed and observati Total swing-bed SNF type inpatient days (including privat		er 31 of the cost	14, 701 0	4.00 5.00
6.00	reporting period Total swing-bed SNF type inpatient days (including privat reporting period (if calendar year, enter 0 on this line)		31 of the cost	0	6.00
7.00	Total swing-bed NF type inpatient days (including private reporting period		r 31 of the cost	0	7.00
8.00	Total swing-bed NF type inpatient days (including private reporting period (if calendar year, enter 0 on this line)		31 of the cost	0	8.00
9.00	Total inpatient days including private room days applicat newborn days) (see instructions)	0		231	9.00
10. 00 11. 00	Swing-bed SNF type inpatient days applicable to title XVI through December 31 of the cost reporting period (see ins Swing-bed SNF type inpatient days applicable to title XVI	structions)	5 /	0	
12.00	December 31 of the cost reporting period (if calendar yea Swing-bed NF type inpatient days applicable to titles V of	ar, enter 0 on this line)	3	0	
	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V of	or XIX only (including privat	te room days)	0	13.00
	after December 31 of the cost reporting period (if calend Medically necessary private room days applicable to the F	dar year, enter O on this lin Program (excluding swing-bed	ne) days)	0	
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only) SWING BED ADJUSTMENT			1, 315 88	
17.00	Medicare rate for swing-bed SNF services applicable to se reporting period	ervices through December 31 o	of the cost	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to se reporting period	ervices after December 31 of	the cost	0.00	18.00
	Medicaid rate for swing-bed NF services applicable to ser reporting $\ensuremath{period}$	U U			19.00
	Medicaid rate for swing-bed NF services applicable to ser reporting period		the cost	0.00	
21. 00 22. 00	Total general inpatient routine service cost (see instruct Swing-bed cost applicable to SNF type services through $Decent transformation 5  ext{ x line 17}$ )		ting period (line	20, 577, 424 0	
23.00	Swing-bed cost applicable to SNF type services after ${\sf Dece}(x)$ line 18)			0	23.00
24.00	Swing-bed cost applicable to NF type services through Dec 7 x line 19)		0 1 1	0	
25. 00 26. 00	Swing-bed cost applicable to NF type services after Decem x line 20) Total swing-bed cost (see instructions)	NUEL 31 OF THE COST REPORTING	j perioù (line 8	0	
27.00	General inpatient routine service cost net of swing-bed co PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	cost (line 21 minus line 26)		20, 577, 424	1
28.00	General inpatient routine service charges (excluding swir	ng-bed and observation bed ch	narges)	0	
29.00 30.00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29.00 30.00
30.00	General inpatient routine service cost/charge ratio (line	e 27 ÷ line 28)		0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)	2		0.00	
33.00	Average semi-private room per diem charge (line 2) + line 3)	2 4)		0.00	
34.00	Average per diem private room charge differential (line 3		ctions)	0.00	
35.00	Average per diem private room cost differential (line 34			0.00	
36.00	Private room cost differential adjustment (line 3 x line			0.00	36.00
37. 00 37. 00	General inpatient routine service cost net of swing-bed of 27 minus line 36)	-	fferential (line	20, 577, 424	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				-
20 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST			1 210 57	20 00
38. 00 39. 00	Adjusted general inpatient routine service cost per diem Program general inpatient routine service cost (line 9 x	, ,		1, 318. 56 304, 587	38.00 39.00
39.00 40.00	Medically necessary private room cost applicable to the F	-		304, 587	40.00
	Total Program general inpatient routine service cost (lin	<b>3</b> ,		304, 587	

OMPUT	ATION OF INPATIENT OPERATING COST		Provider CC		Period: From 07/01/2021	Worksheet D-1	
					To 06/30/2022		
			Titl	e XIX	Hospi tal	11/28/2022 1: Cost	52 pr
	Cost Center Description	Total Inpatient CostI 1.00	Total	Average Per	Program Days		
2.00	NURSERY (title V & XIX only)	1, 223, 453	1, 315	930. 3			42.
	Intensive Care Type Inpatient Hospital Unit	S					
	INTENSIVE CARE UNIT	6, 204, 438	2, 701	2, 297. 0	9 190	436, 447	
	CORONARY CARE UNIT						44.
	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45.
	OTHER SPECIAL CARE (SPECIFY)						47.
	Cost Center Description						
00	Description in a start and the second second (W		1.1.1.1.200)			1.00	40
	Program inpatient ancillary service cost (W Total Program inpatient costs (sum of lines			ns)		770, 536 1, 593, 443	
. 00	PASS THROUGH COST ADJUSTMENTS	41 through 40) (3		13)		1, 373, 443	47.
0. 00	Pass through costs applicable to Program in	patient routine s	ervices (from	Wkst. D, sum	of Parts I and	0	50.
. 00	Pass through costs applicable to Program in and IV)	patient ancillary	services (fr	om Wkst. D, si	um of Parts II	0	51.
2.00	Total Program excludable cost (sum of lines	50 and 51)				0	52.
3. 00	Total Program inpatient operating cost excl	uding capital rel	ated, non-phy	sician anesth	etist, and	0	
	medical education costs (line 49 minus line	52)				i	
I. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54
	Target amount per discharge					0.00	
	Target amount (line 54 x line 55)					0	56
	Difference between adjusted inpatient opera	ting cost and tar	get amount (I	ine 56 minus	ine 53)	0	
3.00 9.00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost r	operting period o	nding 1004 u	adated and ca	mounded by the	0.00	
. 00	market basket	eporting period e	inui ng 1990, u	puateu anu coi	ipounded by the	0.00	59
0. 00	Lesser of lines 53/54 or 55 from prior year	cost report, upd	lated by the m	arket basket		0.00	60
1.00	If line 53/54 is less than the lower of lin					0	61.
	which operating costs (line 53) are less th amount (line 56), otherwise enter zero (see		(lines 54 x	60), or 1% of	the target		
2.00	Relief payment (see instructions)	Thistructrons)				0	62.
	Allowable Inpatient cost plus incentive pay	ment (see instruc	tions)			0	63.
	PROGRAM INPATIENT ROUTINE SWING BED COST		- 04 C II				
1.00	Medicare swing-bed SNF inpatient routine co instructions)(title XVIII only)	sts through Decem	iber 31 of the	cost reportin	ng period (See	0	64.
5.00	Medicare swing-bed SNF inpatient routine co	sts after Decembe	r 31 of the c	ost reporting	period (See	0	65.
	instructions)(title XVIII only)					_	
5.00	Total Medicare swing-bed SNF inpatient rout	ine costs (line 6	4 plus line 6	5)(title XVII	only). For	0	66.
7.00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routi	ne costs through	December 31 o	f the cost re	porting period	0	67.
	(line 12 x line 19)	0			0.1	-	
8.00	Title V or XIX swing-bed NF inpatient routi	ne costs after De	cember 31 of	the cost repo	rting period	0	68.
0 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (1	ino 67 + lino	68)		0	69.
7.00	PART III - SKILLED NURSING FACILITY, OTHER			,		0	1 0 /.
	Skilled nursing facility/other nursing faci						70.
	Adjusted general inpatient routine service		ne 70 ÷ line	2)			71.
	Program routine service cost (line 9 x line Medically necessary private room cost appli		(line 14 v li	ne 35)			72.
1. 00	Total Program general inpatient routine ser					1	74.
	Capital-related cost allocated to inpatient	•	,	orksheet B, Pa	art II, column	1	75.
	26, line 45)	ing 2)					_,
	Per diem capital-related costs (line 75 ÷ l Program capital-related costs (line 9 x lin						76
	Inpatient routine service cost (line 74 min					1	78
. 00	Aggregate charges to beneficiaries for exce	,	ovider record	s)			79
. 00	Total Program routine service costs for com	•	st limitation	(line 78 min	us line 79)		80
	Inpatient routine service cost per diem lim						81
	Inpatient routine service cost limitation ( Reasonable inpatient routine service costs					1	82
. 00	Program inpatient ancillary services (see i	•	,			1	84
	Utilization review - physician compensation	(see instruction					85
6.00	Total Program inpatient operating costs (su		ough 85)			L	86
7.00	PART IV - COMPUTATION OF OBSERVATION BED PAR Total observation bed days (see instruction					905	87.
	Adjusted general inpatient routine cost per		lino 2)			1, 318. 56	
3.00	Aujusteu general inpatrent routine cost per					1, 510. 50	

Health Financial Systems	ASCENSION ST. \	/INCENT KOKOMO		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 07/01/2021	Worksheet D-1	
				To 06/30/2022	Date/Time Pre 11/28/2022 1:	
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	1, 063, 834	20, 577, 424	0. 05169	9 1, 193, 297	61, 692	90.00
91.00 Nursing Program cost	C	20, 577, 424	0.00000	0 1, 193, 297	0	91.00
92.00 Allied health cost	C	20, 577, 424	0.00000	0 1, 193, 297	0	92.00
93.00 All other Medical Education	C	20, 577, 424	0.00000			93.00

WPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0010 Component CCN: 15-T010	Peri od: From 07/01/2021 To 06/30/2022	Worksheet D-1 Date/Time Pre 11/28/2022 1:	par
		Title XIX	Subprovider -	Cost	_
	Cost Center Description		-	1.00	
	PART I – ALL PROVIDER COMPONENTS INPATIENT DAYS				+
	Inpatient days (including private room days and swing-bed da	ivs, excluding newborn)		3, 484	1 1
00	Inpatient days (including private room days, excluding swing			3, 484	
00	Private room days (excluding swing-bed and observation bed d	lays). If you have only pr	ivate room days,	0	3
20	do not complete this line.			2 404	
00	Semi-private room days (excluding swing-bed and observation Total swing-bed SNF type inpatient days (including private r		r 31 of the cost	3, 484 0	
	reporting period	com days) thi ough becchibe	i of the cost	0	
00	Total swing-bed SNF type inpatient days (including private r	room days) after December	31 of the cost	0	6
	reporting period (if calendar year, enter 0 on this line)				
00	Total swing-bed NF type inpatient days (including private ro reporting period	oom days) through December	31 of the cost	0	7
00	Total swing-bed NF type inpatient days (including private ro	oom days) after December 3	1 of the cost	0	8
	reporting period (if calendar year, enter 0 on this line)			-	
00	Total inpatient days including private room days applicable	to the Program (excluding	swing-bed and	14	Ş
00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII	only (including private -	norm davic)	0	10
00	through December 31 of the cost reporting period (see instru		oom days)	0	10
00	Swing-bed SNF type inpatient days applicable to title XVIII		oom days) after	0	11
	December 31 of the cost reporting period (if calendar year,		•		
00	Swing-bed NF type inpatient days applicable to titles V or X	(IX only (including privat	e room days)	0	12
00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or X	(IX only (including privat	e room days)	0	13
00	after December 31 of the cost reporting period (if calendar			0	
	Medically necessary private room days applicable to the Prog			0	14
	Total nursery days (title V or XIX only)			1, 315	
	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			88	16
	Medicare rate for swing-bed SNF services applicable to servi	ces through December 31 o	f the cost	0.00	1 17
	reporting period				
00	Medicare rate for swing-bed SNF services applicable to servi	ces after December 31 of	the cost	0.00	18
00	reporting period Medicaid rate for swing-bed NF services applicable to servic	es through December 31 of	the cost	0.00	10
00	reporting period			0.00	
00	Medicaid rate for swing-bed NF services applicable to servic	es after December 31 of t	he cost	0.00	20
00	reporting period			3, 610, 271	1 21
	Total general inpatient routine service cost (see instructio Swing-bed cost applicable to SNF type services through Decem		ing period (line	3, 010, 271	
00	5 x line 17)		rig period (rine	0	22
00	Swing-bed cost applicable to SNF type services after Decembe	er 31 of the cost reportin	g period (line 6	0	23
00	x line 18) Swing-bed cost applicable to NF type services through Decemb	or 21 of the east report	ng pariod (line	0	
00	7 x line 19)	el 31 01 the cost reporti	ng period (inne	0	24
00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25
~~	x line 20)				
	Total swing-bed cost (see instructions)	(line 21 minus line 24)		0	
	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(TTTTE 21 IIITTIds TTTTE 20)		3, 610, 271	21
	General inpatient routine service charges (excluding swing-b	ed and observation bed ch	arges)	0	28
00	Private room charges (excluding swing-bed charges)			0	29
	Semi-private room charges (excluding swing-bed charges)			0	
	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3)	÷line 28)		0.000000	
	Average semi-private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
	Average per diem private room charge differential (line 32 m		tions)	0.00	
00	Average per diem private room cost differential (line 34 x l	ine 31)		0.00	35
	Private room cost differential adjustment (line 3 x line 35)		Committee (1)	0	
00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost di	TTERENTIAL (LINE	3, 610, 271	37
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD	JUSTMENTS			
00	Adjusted general inpatient routine service cost per diem (se	e instructions)		1,036.24	
00	Program general inpatient routine service cost (line 9 x lin	ne 38)		14, 507	
	Medically necessary private room cost applicable to the Prog	/ · · · · · · · · · · · · · · · · · · ·		0	40

OMPUT/	Financial Systems A ATION OF INPATIENT OPERATING COST		Provider C	CN: 15-0010	Peri od:	eu of Form CMS- Worksheet D-1	
			Component	CCN: 15-T010	From 07/01/2021 To 06/30/2022		
			Titl	e XIX	Subprovider -	11/28/2022 1: Cost	52
	Cost Center Description	Total	Total	Average Pe	IRF Program Days	Program Cost	
			Inpatient Days	Diem (col. 1		(col. 3 x col.	
		1.00	2.00	col. 2) 3.00	4.00	4) 5. 00	
. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	C	0.	00 0	C	) 42
. 00	INTENSIVE CARE UNIT	0	C	0.	00 0	C	) 43
. 00	CORONARY CARE UNI T						44
. 00 . 00	BURN INTENSIVE CARE UNIT						45
	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46
	Cost Center Description					1.00	
. 00	Program inpatient ancillary service cost (Wks	st D-3 col 3	3 Line 200)			1.00	5 48
	Total Program inpatient costs (sum of lines 4			ins)		28, 733	
00	PASS THROUGH COST ADJUSTMENTS						
. 00	Pass through costs applicable to Program inpa	atient routine	services (Trom	IWKST. D, SU	m of Parts I and	C	50
. 00	Pass through costs applicable to Program inpa	atient ancillar	ry services (fr	om Wkst. D,	sum of Parts II	c c	51
. 00	and IV) Total Program excludable cost (sum of lines {	(0, and E1)				C	52
2.00 3.00	Total Program inpatient operating cost exclude		elated, non-phy	sician anest	hetist, and		
	medical education costs (line 49 minus line 5						
. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					C	) 54
5.00	Target amount per discharge					0.00	
. 00	Target amount (line 54 x line 55)					C	
	Difference between adjusted inpatient operati	ng cost and ta	arget amount (I	ine 56 minus	line 53)	0	
. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost rep	porting period	ending 1996 i	indated and c	ompounded by the	0.00	
. 00	market basket	bor tring period	churng 1770, c		ompounded by the	0.00	1
0. 00	Lesser of lines 53/54 or 55 from prior year of					0.00	
. 00	If line 53/54 is less than the lower of lines which operating costs (line 53) are less than					C	) 6'
	amount (line 56), otherwise enter zero (see i		LS (TTHES 54 X	00), 01 1% 0	i the target		
2.00	Relief payment (see instructions)					( C	
3. 00	Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	uctions)			C	) 63
. 00	Medicare swing-bed SNF inpatient routine cost	ts through Dece	ember 31 of the	cost report	ing period (See	0	0 64
	instructions)(title XVIII only)						
5. 00	Medicare swing-bed SNF inpatient routine cost instructions) (title XVIII only)	ts after Decemb	per 31 of the c	ost reportin	g period (See	C	65
5. 00	Total Medicare swing-bed SNF inpatient routin	ne costs (line	64 plus line 6	5)(title XVI	II only). For	C	66
	CAH (see instructions)			<b>C</b> 11 1			
7.00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through	n December 31 c	of the cost r	eporting period	C	67
3. 00	Title V or XIX swing-bed NF inpatient routine	e costs after [	December 31 of	the cost rep	orting period	C	68
	(line 13 x line 20)			(0)			
9.00	Total title V or XIX swing-bed NF inpatient m PART III - SKILLED NURSING FACILITY, OTHER NU					C	0 69
. 00	Skilled nursing facility/other nursing facili				)		70
. 00	Adjusted general inpatient routine service co		ine 70 ÷ line	2)			71
. 00	Program routine service cost (line 9 x line 7 Medically necessary private room cost applica		n (line 14 x li	ne 35)			72
. 00	Total Program general inpatient routine servi	ce costs (line	e 72 + line 73)	,			74
5.00	Capital-related cost allocated to inpatient (	routine service	e costs (from W	lorksheet B,	Part II, column		75
. 00	26, line 45) Per diem capital-related costs (line 75 ÷ lin	ne 2)					76
. 00	Program capital -related costs (line 9 x line						7
. 00	Inpatient routine service cost (line 74 minus						78
. 00 . 00	Aggregate charges to beneficiaries for excess Total Program routine service costs for compa				nus line 70)		80
. 00	Inpatient routine service costs for compa				nao i i no <i>17)</i>		8
. 00	Inpatient routine service cost limitation (li	ne 9 x line 81					82
. 00	Reasonable inpatient routine service costs (s		ıs)				83
. 00 . 00	Program inpatient ancillary services (see ins Utilization review - physician compensation		ns)				84
5.00 5.00	Total Program inpatient operating costs (sum						86
	PART IV - COMPUTATION OF OBSERVATION BED PASS	THROUGH COST					
7.00 3.00	Total observation bed days (see instructions)		ling 2)			0.00	
/. UU	Adjusted general inpatient routine cost per of Observation bed cost (line 87 x line 88) (see						89

Health Financial Systems	ASCENSION ST.	/INCENT KOKOMO		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider C		Period: From 07/01/2021	Worksheet D-1	
		Component	CCN: 15-T010	To 06/30/2022	Date/Time Pre 11/28/2022 1:	
		Tit	le XIX	Subprovider - IRF	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	) column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	266, 805	3, 610, 27 <sup>-</sup>	0. 07390	02 0	0	90.00
91.00 Nursing Program cost	0	3, 610, 27 <sup>-</sup>	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	3, 610, 27	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	3, 610, 27	0. 00000	0 00	0	93.00

Health Financial Systems ASCENSION ST. VINCENT KOK	OMO	In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT Provid	er CCN: 15-0010	Peri od:	Worksheet D-3	
		From 07/01/2021 To 06/30/2022	Date/Time Pre	narod
		10 00/30/2022	11/28/2022 1:	52 pm
	itle XVIII	Hospi tal	PPS	<u>oz p</u>
Cost Center Description	Ratio of Cos		Inpati ent	
	To Charges	Program	Program Costs	
	Ŭ	Charges	(col. 1 x col.	
			2)	
	1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS		10, 378, 364		30.00
31. 00 03100 I NTENSI VE CARE UNI T		3, 664, 382		31.00
41.00 04100 SUBPROVIDER - IRF		0		41.00
43. 00 04300 NURSERY				43.00
ANCI LLARY SERVI CE COST CENTERS				
50.00 05000 OPERATING ROOM	0. 1214		1, 207, 512	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.2004			
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 2425		228, 279	
54.01 03630 ULTRA SOUND	0. 1067		61, 552	
56. 00 05600 RADI 0I SOTOPE	0. 1041			
57.00 05700 CT SCAN	0. 0808		124, 116	1
58.00 05800 MAGNETIC RESONANCE I MAGI NG (MRI)	0. 2921		65, 503	
59. 00 05900 CARDIAC CATHETERIZATION	1. 9103			
60. 00 06000 LABORATORY	0. 1006		1, 144, 538	
65. 00 06500 RESPI RATORY THERAPY	0. 1821		438, 313	
66. 00 06600 PHYSI CAL THERAPY	0. 3342		305, 841	
67.00 06700 OCCUPATI ONAL THERAPY	0. 3419		259, 972	1
68.00 06800 SPEECH PATHOLOGY	0. 3793		66, 562	
69. 00 06900 ELECTROCARDI OLOGY	0.0710		127, 626	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 1747		37, 283	1
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0. 1005			
72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS	0. 3301		909, 212	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 3877		2, 698, 247	
74.00 07400 RENAL DIALYSIS	0. 2602		113, 497	
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0.3612		0	
76.01 03190 CHEMOTHERAPY	0. 4212		2, 552	
76. 02 03330 ENDOSCOPY	1. 1167		24, 561	
76. 03 03950 WOUND CARE CENTER	0. 0911	06 0	0	76.03
	0.10/7	F 000 000	(00.107	01 00
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART)	0. 1067			1
OTHER REIMBURSABLE COST CENTERS	0. 4955	109,907	54, 466	92.00
95. 00 09500 AMBULANCE SERVICES			[	95.00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0,0000	0	0	
200.00 Total (sum of lines 50 through 94 and 96 through 98)	0.0000	50, 056, 661	8, 869, 389	
201.00 Less PBP Clinic Laboratory Services-Program only charges (line	61)	JU, UJU, 001	0, 007, 389	200.00
202.00 Net charges (line 200 minus line 201)		50, 056, 661		201.00
202. 00 Inter charges (The 200 initials Fille 201)	I	50,050,001	l	1202.00

Health Financial Systems	ASCENSION ST. VINCENT	кокомо		In Lie	u of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORT	I ONMENT Pro	vider CO		Peri od:	Worksheet D-3	
	Com	ponent (		From 07/01/2021 To 06/30/2022	Date/Time Pre 11/28/2022 1:	
		Ti tl e	XVIII	Subprovider - IRF	PPS	<u>02 pm</u>
Cost Center Description			Ratio of Cos		Inpatient	
Cost center beschiption			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
				g	2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CE	NTERS					
30. 00 03000 ADULTS & PEDI ATRI CS						30.00
31.00 03100 INTENSIVE CARE UNIT						31.00
41.00 04100 SUBPROVIDER - IRF				4, 088, 788		41.00
43.00 04300 NURSERY						43.00
ANCI LLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM			0. 12142	15, 010	1, 823	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM			0. 20041	1 0	0	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C			0. 24251	9 64, 600	15, 667	54.00
54.01 03630 ULTRA SOUND			0. 10671	8 18, 066	1, 928	54.01
56. 00 05600 RADI OI SOTOPE			0. 10413	5 0	0	56.00
57.00 05700 CT SCAN			0. 08087	4 30, 600	2, 475	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING	(MRI)		0. 29216		3, 608	
59.00 05900 CARDI AC CATHETERI ZATI ON			1. 91031		0	
60. 00 06000 LABORATORY			0. 10068			
65. 00 06500 RESPI RATORY THERAPY			0. 18216			
66. 00 06600 PHYSI CAL THERAPY			0. 33429		317, 163	
67.00 06700 OCCUPATI ONAL THERAPY			0. 34197		293, 020	
68.00 06800 SPEECH PATHOLOGY			0. 37939			
69. 00 06900 ELECTROCARDI OLOGY			0. 07107		3, 307	
70.00 07000 ELECTROENCEPHALOGRAPHY			0. 17478			
71.00 07100 MEDICAL SUPPLIES CHARGED TO			0. 10059			
72.00 07200 I MPL. DEV. CHARGED TO PATIE	NTS		0. 33014			
73.00 07300 DRUGS CHARGED TO PATIENTS			0. 38771			
74.00 07400 RENAL DIALYSIS	50// 050		0. 26022		32, 677	
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL S	ERVICES		0. 36128		0	
76. 01 03190 CHEMOTHERAPY			0. 42124		0	
76. 02 03330 ENDOSCOPY			1. 11677		0	
76. 03 03950 WOUND CARE CENTER OUTPATI ENT SERVICE COST CENTERS			0.09110	6 131	12	76.03
91. 00 09100 EMERGENCY			0. 10673	4 7, 816	834	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTI	NCT DADT)		0. 10673			
OTHER REIMBURSABLE COST CENTERS	NCT PART)		0.49550	0	0	92.00
95. 00 09500 AMBULANCE SERVICES			[		[	95.00
95. 00 09500 AMBULANCE SERVICES 98. 00 09850 OTHER REIMBURSABLE COST CEN	TEDS		0.00000	0 0	0	
200.00 Total (sum of lines 50 thro			0.00000	3, 988, 150	-	
	Services-Program only charges (li	ne 61)		3, 966, 150	1, 022, 299	200.00
202.00 Net charges (line 200 minus	5 5 5 5			3, 988, 150		201.00
	1110 2017	I	I	5,700,150	I	1202.00

	nancial Systems ASCENSION ST. VIN T ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0010	Peri od:	u of Form CMS-2 Worksheet D-3	
				From 07/01/2021		
				To 06/30/2022	Date/Time Pre 11/28/2022 1:	
		Titl	e XIX	Hospi tal	Cost	52 piii
	Cost Center Description		Ratio of Cos		Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
				5	2)	
			1.00	2.00	3.00	
	PATIENT ROUTINE SERVICE COST CENTERS			_		
	000 ADULTS & PEDIATRICS			574, 154		30.0
31.00 03	100 INTENSIVE CARE UNIT			370, 266		31.0
1.00 04	100 SUBPROVI DER – I RF			0		41.0
	300 NURSERY			191, 636		43.0
	CILLARY SERVICE COST CENTERS					
	000 OPERATING ROOM		0. 12130		112, 673	
	200 DELIVERY ROOM & LABOR ROOM		0. 20041	1 501, 668	100, 540	52. C
54.00 05	400 RADI OLOGY-DI AGNOSTI C		0. 24251	9 78, 098	18, 940	54.C
54.01 03	630 ULTRA SOUND		0. 10671	8 53, 441	5, 703	54.0
56.00 05	600 RADI OI SOTOPE		0. 10413	85 0	0	56.0
	700 CT SCAN		0.08087	128, 808	10, 417	57.0
58.00 05	800 MAGNETIC RESONANCE IMAGING (MRI)		0. 29216	19, 843	5, 797	58.0
	900 CARDI AC CATHETERI ZATI ON		1. 91031	4 0	0	59. C
	000 LABORATORY		0. 10001	9 1, 039, 837	104, 003	60. C
5.00 06	500 RESPI RATORY THERAPY		0. 18216	245, 923	44, 798	65.0
6. 00 06	600 PHYSI CAL THERAPY		0. 33429	45, 472	15, 201	66.0
57.00 06	700 OCCUPATI ONAL THERAPY		0. 34197	10, 501	3, 591	67.0
8.00 06	800 SPEECH PATHOLOGY		0. 37939	90 54	20	68.0
9.00 06	900 ELECTROCARDI OLOGY		0.07107	6 81, 905	5, 821	69.0
70.00 07	000 ELECTROENCEPHALOGRAPHY		0. 17478	17, 700	3, 094	70.0
1.00 07	100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 10059	260, 621	26, 218	71.0
2.00 07	200 IMPL. DEV. CHARGED TO PATIENTS		0. 33014	4 178, 327	58, 874	72.0
73.00 07	300 DRUGS CHARGED TO PATIENTS		0. 38771	4 402, 324	155, 987	73.0
4.00 07	400 RENAL DIALYSIS		0. 26022	36, 556	9, 513	74.0
76.00 03	550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0. 36128	30 O	0	76.0
	190 CHEMOTHERAPY		0. 42124		1, 056	76.0
76. 02 03	330 ENDOSCOPY		1. 11677		3, 458	76.0
76. 03 03	950 WOUND CARE CENTER		0.09110	06 0	0	76.0
OU.	TPATIENT SERVICE COST CENTERS		•			
91.00 09	100 EMERGENCY		0. 10673	794, 794	84, 832	91.0
2.00 09	200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 49556	07 0	0	92.0
	HER REIMBURSABLE COST CENTERS					1
	500 AMBULANCE SERVI CES					95.0
8.00 09	850 OTHER REIMBURSABLE COST CENTERS		0.00000	0 0	0	98.0
200.00	Total (sum of lines 50 through 94 and 96 through 98)			4, 830, 339	770, 536	200.0
201.00	Less PBP Clinic Laboratory Services-Program only charge	s (line 61)		0		201.0
202.00	Net charges (line 200 minus line 201)		1	4, 830, 339		202.0

NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0010	Peri od:	Worksheet D-3	8
			From 07/01/2021		
	Component	CCN: 15-T010	To 06/30/2022	Date/Time Pre 11/28/2022 1:	
	Ti tl	e XIX	Subprovider -	Cost	02 pm
		1	IRF		
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges		Program Costs	
			Charges	(col. 1 x col. 2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS					30. 0
31. 00 03100 INTENSIVE CARE UNIT					31.0
11.00 04100 SUBPROVIDER - IRF			30, 352		41.0
13.00 04300 NURSERY				<u> </u>	43.0
ANCI LLARY SERVI CE COST CENTERS					
50.00 OPERATING ROOM		0. 1213		49	
52.00 O5200 DELIVERY ROOM & LABOR ROOM		0.2004		-	
54. 00 O5400 RADI OLOGY-DI AGNOSTI C		0. 2425			
54. 01 03630 ULTRA SOUND		0. 1067		61	
56. 00 05600 RADI 0I SOTOPE		0.1041		-	
57.00  05700 CT SCAN 58.00  05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 0808		0	
58. 00  05800  MAGNETI C RESONANCE I MAGI NG (MRI) 59. 00  05900  CARDI AC CATHETERI ZATI ON		1. 9103			
50. 00 06000 LABORATORY		0. 1000		-	
55. 00 06500 RESPIRATORY THERAPY		0. 1000			
56. 00 06600 PHYSI CAL THERAPY		0. 3342			
57. 00 06700 OCCUPATI ONAL THERAPY		0.3419			
58.00 06800 SPEECH PATHOLOGY		0. 3793			
59. 00 06900 ELECTROCARDI OLOGY		0.0710		0	
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 1747		0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 1005		3	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 3301	44 676	223	72.0
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 3877			
74.00 07400 RENAL DIALYSIS		0. 2602	24 16, 344	4, 253	74.0
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0.3612	80 0	0	76.0
76. 01 03190 CHEMOTHERAPY		0. 4212	41 0	0	76.0
76. 02 03330 ENDOSCOPY		1. 1167	75 0	0	76.0
76.03 03950 WOUND CARE CENTER		0. 0911	06 0	0	76.0
OUTPATIENT SERVICE COST CENTERS		<b>.</b>			
91.00 09100 EMERGENCY		0. 1067			
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 4955	67 0	0	92.0
		-			05 0
25.00 09500 AMBULANCE SERVICES		0.0000	~ ~		95.0
98.00 09850 OTHER REIMBURSABLE COST CENTERS	\ \	0.0000		0	
200.00 Total (sum of lines 50 through 94 and 96 through 98 201.00 Less PBP Clinic Laboratory Services-Program only ch			58, 245	14, 226	200. 0

	Financial Systems ASCENSION ST. VINC ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0010	Period: From 07/01/2021	u of Form CMS-: Worksheet E Part A			
			To 06/30/2022	Date/Time Pre 11/28/2022 1:	pare		
		Title XVIII	Hospi tal	PPS	1		
				1.00			
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS						
00 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurr	ing prior to October 1 (	see	0 2, 961, 788	1.		
02							
03	instructions) DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)						
04	1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI for October 1 (see instructions)	or di scharges occurri ng	on or after	0	1.		
00	Outlier payments for discharges. (see instructions)				2.		
01 02	Outlier reconciliation amount Outlier payment for discharges for Model 4 BPCI (see instruct	ions)		0	2.		
02	Outlier payments for discharges occurring prior to October 1			71, 185			
04	Outlier payments for discharges occurring on or after October			229, 596			
00	Managed Care Simulated Payments			0	3.		
00	Bed days available divided by number of days in the cost repo Indirect Medical Education Adjustment	rting period (see instru	ictions)	116. 52	4		
00	FTE count for all opathic and osteopathic programs for the most or before 12/31/1996. (see instructions)	t recent cost reporting	period ending on	0.00	5.		
00	FTE count for allopathic and osteopathic programs that meet the new programs in accordance with 42 CFR 413.79(e)	he criteria for an add-o	n to the cap for	0.00	6		
00 01	MMA Section 422 reduction amount to the IME cap as specified ACA § 5503 reduction amount to the IME cap as specified under			0.00 0.00	7		
00	cost report straddles July 1, 2011 then see instructions. Adjustment (increase or decrease) to the FTE count for allopa		, , , , ,	0.00			
00	affiliated programs in accordance with 42 CFR 413.75(b), 413. 1998), and 67 FR 50069 (August 1, 2002).		5	0.00			
01	The amount of increase if the hospital was awarded FTE cap slo report straddles July 1, 2011, see instructions.	ots under § 5503 of the	ACA. If the cost	0.00	8		
02	The amount of increase if the hospital was awarded FTE cap slo under § 5506 of ACA. (see instructions)	ots from a closed teachi	ng hospital	0.00	8		
00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line instructions)	es (8, 8,01 and 8,02) (	see	0.00	9		
0. 00	FTE count for allopathic and osteopathic programs in the curre	ent year from your recor	ds	0.00			
. 00	FTE count for residents in dental and podiatric programs.			0.00 0.00			
. 00	Current year allowable FTE (see instructions) Total allowable FTE count for the prior year.			0.00			
. 00	Total allowable FTE count for the penultimate year if that year	ar ended on or after Sep	otember 30, 1997,	0.00			
5.00	otherwise enter zero. Sum of lines 12 through 14 divided by 3.			0.00	1 1 F		
b. 00	Adjustment for residents in initial years of the program			0.00			
. 00	Adjustment for residents displaced by program or hospital closed	sure		0.00			
. 00	Adjusted rolling average FTE count			0.00			
. 00	Current year resident to bed ratio (line 18 divided by line 4)	).		0.00000			
. 00	Prior year resident to bed ratio (see instructions)			0.00000			
. 00	Enter the lesser of lines 19 or 20 (see instructions)			0.000000			
. 00	IME payment adjustment (see instructions)			0			
. 01	IME payment adjustment - Managed Care (see instructions) Indirect Medical Education Adjustment for the Add-on for § 42:	2 of the MMA		0	22		
. 00	Number of additional allopathic and osteopathic IME FTE reside (f)(1)(iv)(C).	ent cap slots under 42 (	FR 412.105	0.00	23		
. 00	IME FTE Resident Count Over Cap (see instructions)			0.00			
. 00	If the amount on line 24 is greater than -O-, then enter the instructions)	lower of line 23 or line	e 24 (see	0.00	25		
. 00	Resident to bed ratio (divide line 25 by line 4)			0.000000			
. 00	IME payments adjustment factor. (see instructions)			0.000000			
. 00	IME add-on adjustment amount (see instructions)	\ \		0	28		
. 01 . 00	IME add-on adjustment amount - Managed Care (see instructions) Total IME payment ( sum of lines 22 and 28)	)		0	28		
. 00 . 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.0	1)		0			
00	Disproportionate Share Adjustment Percentage of SSI recipient patient days to Medicare Part A pa	atient dave (coo inctrus	tions)	דה ר	20		
	Percentage of SSI recipient patient days to Medicare Part A pa Percentage of Medicaid patient days (see instructions)	attent days (see instruc		2.87			
. 00 2. 00	Sum of lines 30 and 31			22. 11 24. 98			
2.00 3.00	Allowable disproportionate share percentage (see instructions)	)		9.82			
	Disproportionate share adjustment (see instructions)	/		295, 037			

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0010	Peri od: From 07/01/2021 To 06/30/2022	Worksheet E Part A Date/Time Prep 11/28/2022 1:5	
	Title XVIII	Hospi tal	PPS	
		Prior to 10/1 1.00	0n/After 10/1 2.00	
Uncompensated Care Adjustment		1.00	2.00	
5.00 Total uncompensated care amount (see instructions)		8, 290, 014, 521	7, 192, 008, 710	35.0
5.01 Factor 3 (see instructions)		0. 000232246	0. 000200783	35.0
5.02 Hospital uncompensated care payment (If line 34 is zero	, enter zero on this line) (se	ee 1, 925, 321	1, 444, 033	35.0
instructions)	nt amount (coo i netructione)	485, 287	1, 080, 057	35.0
5.03 Pro rata share of the hospital uncompensated care payme 6.00 Total uncompensated care (sum of columns 1 and 2 on lin		1, 565, 344	1, 060, 057	36.0
Additional payment for high percentage of ESRD beneficia				50.0
0.00 Total Medicare discharges (see instructions)		0		40.0
		Before 1/1	On/After 1/1	
		1.00	1.01	
1.00 Total ESRD Medicare discharges (see instructions)		0	0	41.0
1.01 Total ESRD Medicare covered and paid discharges (see in	-	0	0	41. C 42. C
2.00  Divide line 41 by line 40 (if less than 10%, you do not 3.00  Total Medicare ESRD inpatient days (see instructions)	quarity for adjustment)	0.00		42.0
4.00 Ratio of average length of stay to one week (line 43 di	vided by line 41 divided by 7	0. 000000		44.0
days)				
5.00 Average weekly cost for dialysis treatments (see instru		0.00	0.00	
6.00 Total additional payment (line 45 times line 44 times l	ine 41.01)	0		46. C
7.00 Subtotal (see instructions)		14, 178, 963		47.0
8.00 Hospital specific payments (to be completed by SCH and only. (see instructions)	MDH, SMAIT FUFAI NOSPITAIS	0		48.0
			Amount	
			1.00	
9.00 Total payment for inpatient operating costs (see instru	-		14, 178, 963	
0.00 Payment for inpatient program capital (from Wkst. L, Pt		)	966, 568	
<ol> <li>Description payment for inpatient program capital (Wkst.</li> <li>Direct graduate medical education payment (from Wkst. E</li> </ol>			0	51. 0 52. 0
3.00 Nursing and Allied Health Managed Care payment	-4, THE 49 SEE HISTIUCTIONS).		3, 830	52.0
4.00 Special add-on payments for new technologies			276, 650	54.0
4.01 Islet isolation add-on payment			0	54.0
5.00 Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1,			0	55.0
6.00 Cost of physicians' services in a teaching hospital (se	-		0	56. (
7.00 Routine service other pass through costs (from Wkst. D,		through 35).	0	57.0
8.00 Ancillary service other pass through costs from Wkst. D 9.00 Total (sum of amounts on lines 49 through 58)	, PL. IV, COL. IT TIME 200)		16, 830 15, 442, 841	58. ( 59. (
0.00 Primary payer payments			13, 442, 041	60. (
1.00 Total amount payable for program beneficiaries (line 59	minus line 60)		15, 442, 841	61. (
2.00 Deductibles billed to program beneficiaries	,		1, 422, 620	62. (
3.00 Coinsurance billed to program beneficiaries			16, 565	63. (
4.00 Allowable bad debts (see instructions)			105, 647	64.0
5.00 Adjusted reimbursable bad debts (see instructions)			68, 671	
6.00  Allowable bad debts for dual eligible beneficiaries (se	-		15, 780 14, 072, 327	
<b>o</b> ,		see instructions)	14, 072, 327	68.0
7.00 Subtotal (line 61 plus line 65 minus lines 62 and 63)	s for applicable to MS_DRGs («			69.0
7.00 Subtotal (line 61 plus line 65 minus lines 62 and 63) 8.00 Credits received from manufacturers for replaced device		ns)	0	
<ul> <li>7.00 Subtotal (line 61 plus line 65 minus lines 62 and 63)</li> <li>8.00 Credits received from manufacturers for replaced device</li> <li>9.00 Outlier payments reconciliation (sum of lines 93, 95 an</li> </ul>		is)	0	70.0
<ul> <li>7.00 Subtotal (line 61 plus line 65 minus lines 62 and 63)</li> <li>8.00 Credits received from manufacturers for replaced device</li> <li>9.00 Outlier payments reconciliation (sum of lines 93, 95 an</li> <li>0.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)</li> </ul>	d 96). (For SCH see instruction		-	
<ul> <li>7.00 Subtotal (line 61 plus line 65 minus lines 62 and 63)</li> <li>8.00 Credits received from manufacturers for replaced device</li> <li>9.00 Outlier payments reconciliation (sum of lines 93, 95 an</li> <li>0.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)</li> <li>0.50 Rural Community Hospital Demonstration Project (§410A D</li> <li>0.87 Demonstration payment adjustment amount before sequestr</li> </ul>	d 96).(For SCH see instruction emonstration) adjustment (see ation		0 0 0	70. ( 70. § 70. §
<ul> <li>7.00 Subtotal (line 61 plus line 65 minus lines 62 and 63)</li> <li>8.00 Credits received from manufacturers for replaced device</li> <li>9.00 Outlier payments reconciliation (sum of lines 93, 95 an OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)</li> <li>9.50 Rural Community Hospital Demonstration Project (§410A D</li> <li>9.87 Demonstration payment adjustment amount before sequestr</li> <li>9.88 SCH or MDH volume decrease adjustment (contractor use o</li> </ul>	d 96).(For SCH see instruction emonstration) adjustment (see ation nly)		0	70. 70. 70. 70.
<ul> <li>7.00 Subtotal (line 61 plus line 65 minus lines 62 and 63)</li> <li>8.00 Credits received from manufacturers for replaced device</li> <li>9.00 Outlier payments reconciliation (sum of lines 93, 95 an</li> <li>0.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)</li> <li>9.50 Rural Community Hospital Demonstration Project (§410A D</li> <li>0.87 Demonstration payment adjustment amount before sequestr</li> <li>9.88 SCH or MDH volume decrease adjustment (contractor use o</li> <li>9.89 Pioneer ACO demonstration payment adjustment amount (se</li> </ul>	d 96).(For SCH see instruction emonstration) adjustment (see ation nly) e instructions)		0 0 0	70. 70. 70. 70. 70.
<ul> <li>7.00 Subtotal (line 61 plus line 65 minus lines 62 and 63)</li> <li>8.00 Credits received from manufacturers for replaced device</li> <li>9.00 Outlier payments reconciliation (sum of lines 93, 95 an</li> <li>0.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)</li> <li>0.50 Rural Community Hospital Demonstration Project (§410A D</li> <li>0.87 Demonstration payment adjustment amount before sequestr</li> <li>9.88 SCH or MDH volume decrease adjustment (contractor use o</li> <li>9.90 HSP bonus payment HVBP adjustment amount (see instructi</li> </ul>	d 96).(For SCH see instruction emonstration) adjustment (see ation nly) e instructions) ons)		0 0 0 0	70. 70. 70. 70. 70. 70.
<ul> <li>7.00 Subtotal (line 61 plus line 65 minus lines 62 and 63)</li> <li>8.00 Credits received from manufacturers for replaced device</li> <li>9.00 Outlier payments reconciliation (sum of lines 93, 95 an)</li> <li>0.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)</li> <li>Rural Community Hospital Demonstration Project (§410A D</li> <li>0.87 Demonstration payment adjustment amount before sequestr</li> <li>8.88 SCH or MDH volume decrease adjustment (contractor use o</li> <li>0.89 Pioneer ACO demonstration payment adjustment amount (see instructi</li> <li>0.90 HSP bonus payment HRR adjustment amount (see instructio</li> </ul>	d 96).(For SCH see instruction emonstration) adjustment (see ation nly) e instructions) ons)		0 0 0 0 0 0	70. 70. 70. 70. 70. 70. 70.
<ul> <li>7.00 Subtotal (line 61 plus line 65 minus lines 62 and 63)</li> <li>8.00 Credits received from manufacturers for replaced device</li> <li>9.00 Outlier payments reconciliation (sum of lines 93, 95 an</li> <li>0.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)</li> <li>Rural Community Hospital Demonstration Project (§410A D</li> <li>0.87 Demonstration payment adjustment amount before sequestr</li> <li>0.88 SCH or MDH volume decrease adjustment (contractor use o</li> <li>0.89 Pioneer ACO demonstration payment adjustment amount (see instruction</li> <li>0.91 HSP bonus payment HRR adjustment amount (see instruction</li> <li>0.92 Bundled Model 1 discount amount (see instructions)</li> </ul>	d 96).(For SCH see instruction emonstration) adjustment (see ation nly) e instructions) ons)		0 0 0 0 0 0 0	70. 0 70. 8 70. 8 70. 8 70. 9 70. 9 70. 9
<ul> <li>7.00 Subtotal (line 61 plus line 65 minus lines 62 and 63)</li> <li>8.00 Credits received from manufacturers for replaced device</li> <li>9.00 Outlier payments reconciliation (sum of lines 93, 95 an</li> <li>0.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)</li> <li>Rural Community Hospital Demonstration Project (§410A D</li> <li>0.87 Demonstration payment adjustment amount before sequestr</li> <li>0.88 SCH or MDH volume decrease adjustment (contractor use o</li> <li>0.89 Pioneer ACO demonstration payment adjustment amount (see instructi</li> <li>0.91 HSP bonus payment HRR adjustment amount (see instructio</li> </ul>	d 96).(For SCH see instruction emonstration) adjustment (see ation nly) e instructions) ons)		0 0 0 0 0 0	70.0 70.8 70.8 70.8 70.9 70.9 70.9 70.9 70.9

	ATION OF REIMBURSEMENT SETTLEMENT	Provider C		Period: From 07/01/2021 To 06/30/2022	Worksheet E Part A Date/Time Pre 11/28/2022 1:	
		Title	XVIII	Hospi tal	PPS	
			FFY	(уууу) 0	Amount 1.00	
0. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter i	in column O		0	0	70.9
0.07	the corresponding federal year for the period prior to 10/1)			0	0	70.0
0. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter i the corresponding federal year for the period ending on or a			0	0	70.9
D. 98	Low Volume Payment-3				0	70.9
D. 99	HAC adjustment amount (see instructions)				0	70.9
1.00	Amount due provider (line 67 minus lines 68 plus/minus lines	69 & 70)			14, 065, 241	
1.01	Sequestration adjustment (see instructions)				35, 163	
1.02	Demonstration payment adjustment amount after sequestration				0	71.0
1.03 2.00	Sequestration adjustment-PARHM pass-throughs				12 740 177	71.0 72.0
2.00	Interim payments Interim payments-PARHM				13, 760, 177	72.0
3.00	Tentative settlement (for contractor use only)				0	
3.01	Tentative settlement-PARHM (for contractor use only)				0	73.0
4.00	Balance due provider/program (line 71 minus lines 71.01, 71.0	02, 72, and			269, 901	74.0
	73)					
4. 01	Balance due provider/program-PARHM (see instructions)					74.0
5.00	Protested amounts (nonallowable cost report items) in accorda	ance with			214, 102	75.0
	CMS Pub. 15-2, chapter 1, §115.2					
D. 00	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96) Operating outlier amount from Wkst. E, Pt. A, line 2, or sum	of 2.03	[		0	90.0
5.00	plus 2.04 (see instructions)	01 2.05			0	70.0
1.00	Capital outlier from Wkst. L, Pt. I, line 2				0	91.0
2.00	Operating outlier reconciliation adjustment amount (see inst	ructions)			0	92.0
3.00	Capital outlier reconciliation adjustment amount (see instruc	ctions)			0	93.0
	The rate used to calculate the time value of money (see inst				0.00	
5.00	Time value of money for operating expenses (see instructions)				0	95.0
6.00	Time value of money for capital related expenses (see instruc	ctions)		Prior to 10/1	0	96.0
				1.00	2.00	
	HSP Bonus Payment Amount					
00 00						
JU. UU	HSP bonus amount (see instructions)			0	0	100. 0
	HVBP Adjustment for HSP Bonus Payment					
01.00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions)			0. 000000000	0.000000000	101. C
01.00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction	ns)			0.000000000	101. C
01.00 02.00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment	ns)		0.0000000000000000000000000000000000000	0.0000000000000000000000000000000000000	101. 0 102. 0
01.00 02.00 03.00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions)			0. 0000000000 0 0. 0000	0. 000000000 0 0. 0000	101. C 102. C 103. C
01.00 02.00 03.00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions)	s)	stment	0.0000000000000000000000000000000000000	0. 000000000 0 0. 0000	101. C 102. C
01.00 02.00 03.00 04.00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions)	s) tration) Adju		0. 0000000000 0 0. 0000	0. 000000000 0 0. 0000 0	101. 0 102. 0 103. 0 104. 0
01.00 02.00 03.00 04.00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no.	s) tration) Adju		0. 0000000000 0 0. 0000	0. 000000000 0 0. 0000 0	101. ( 102. ( 103. ( 104. (
01.00 02.00 03.00 04.00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement	s) tration) Adju eriod under t		0. 0000000000 0 0. 0000	0. 000000000 0 0. 0000 0	101. ( 102. ( 103. ( 104. ( 200. (
01.00 02.00 03.00 04.00 00.00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, III	s) tration) Adju eriod under t		0. 0000000000 0 0. 0000	0. 000000000 0 0. 0000 0	101. ( 102. ( 103. ( 104. ( 200. ( 201. (
01.00 02.00 03.00 04.00 00.00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions)	s) tration) Adju eriod under t		0. 0000000000 0 0. 0000	0. 000000000 0 0. 0000 0	101. 0 102. 0 103. 0 104. 0 200. 0 201. 0 202. 0
01.00 02.00 03.00 04.00 00.00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions)	s) tration) Adju eriod under t ne 49)	he 21st	0.0000000000000000000000000000000000000	0.0000000000000000000000000000000000000	101. 0 102. 0 103. 0 104. 0 200. 0 201. 0 202. 0
01.00 02.00 03.00 04.00 00.00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in	s) tration) Adju eriod under t ne 49)	he 21st	0.0000000000000000000000000000000000000	0.0000000000000000000000000000000000000	101. 0 102. 0 103. 0 104. 0 200. 0 201. 0 202. 0
01.00 02.00 03.00 04.00 00.00 00.00 01.00 02.00 03.00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions)	s) tration) Adju eriod under t ne 49)	he 21st	0.0000000000000000000000000000000000000	0.000000000 0 0.0000 0	101. C 102. C 103. C 200. C 201. C 202. C 203. C
01.00 02.00 03.00 04.00 00.00 01.00 02.00 03.00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration procentury Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period)	s) tration) Adju eriod under t ne 49)	he 21st	0.0000000000000000000000000000000000000	0.000000000 0 0.0000 0	101. C 102. C 103. C
01.00 02.00 03.00 04.00 00.00 01.00 02.00 03.00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pro Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount	s) tration) Adju eriod under t ne 49) n first year	he 21st	0.0000000000000000000000000000000000000	0.000000000 0 0.0000 0	101. 0 102. 0 103. 0 104. 0 200. 0 201. 0 202. 0 203. 0
01.00 02.00 04.00 00.00 01.00 02.00 03.00 04.00 05.00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration po Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement	s) tration) Adju eriod under t ne 49) n first year )	he 21st	0.0000000000000000000000000000000000000	0.000000000 0 0.0000 0	101. 0 102. 0 103. 0 200. 0 201. 0 202. 0 203. 0 203. 0 204. 0 205. 0 206. 0
D1.00         D2.00         D3.00         D4.00         D0.00         D1.00         D1.00         D1.00         D1.00         D1.00         D1.00         D1.00         D1.00         D1.00         D2.00         D3.00         D4.00         D5.00         D6.00         D7.00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions)	s) tration) Adju eriod under t ne 49) n first year ) tructions)	he 21st	0.0000000000000000000000000000000000000	0.000000000 0 0.0000 0	101. 0 102. 0 103. 0 200. 0 201. 0 202. 0 203. 0 204. 0 205. 0 206. 0 206. 0
01.00 02.00 03.00 04.00 00.00 01.00 02.00 03.00 04.00 05.00 06.00 06.00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pro- Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A,	s) tration) Adju eriod under t ne 49) n first year ) tructions)	he 21st	0.0000000000000000000000000000000000000	0.000000000 0 0.0000 0	101. 0 102. 0 103. 0 200. 0 201. 0 202. 0 203. 0 204. 0 205. 0 206. 0 206. 0 207. 0 208. 0
D1. 00         D2. 00         D3. 00         D4. 00         D0. 00         D1. 00         D1. 00         D2. 00         D3. 00         D4. 00         D5. 00         D5. 00         D6. 00         D7. 00         D7. 00         D8. 00         D9. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Is this the first year of the current 5-year demonstration project (§410A Demonstration Project (§410A Demonstration project Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare inpatient routine cost cap (line 202 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions)	s) tration) Adju eriod under t ne 49) n first year ) tructions)	he 21st	0.0000000000000000000000000000000000000	0.000000000 0 0.0000 0	101. ( 102. ( 103. ( 200. ( 202. ( 202. ( 203. ( 204. ( 205. ( 206. ( 207. ( 208. ( 209. ( 209. ()
01.00 02.00 03.00 00.00 00.00 01.00 02.00 02.00 02.00 04.00 05.00 06.00 07.00 08.00 09.00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration po Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use	s) tration) Adju eriod under t ne 49) n first year ) tructions) , line 59)	he 21st	0.0000000000000000000000000000000000000	0.000000000 0 0.0000 0	101. ( 102. ( 103. ( 200. ( 200. ( 202. ( 203. ( 205. ( 205. ( 205. ( 206. ( 207. ( 208. ( 209. ( 209. ( 209. ( 209. ( 209. ( 200. ()))))))))))))))))))))))))))))))))))
01.00 02.00 03.00 00.00 00.00 01.00 02.00 02.00 02.00 04.00 05.00 06.00 07.00 08.00 09.00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration payment Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Case-mix adjustment factor (see instructions) Case-mix adjustment factor (see instructions) Case-mix adjustment factor (see instructions) Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions)	s) tration) Adju eriod under t ne 49) n first year ) tructions) , line 59)	he 21st	0.0000000000000000000000000000000000000	0.000000000 0 0.0000 0	101. 0 102. 0 103. 0 200. 0 201. 0 202. 0 203. 0 204. 0 205. 0 206. 0 207. 0
01. 00 02. 00 03. 00 04. 00 01. 00 02. 00 02. 00 03. 00 04. 00 05. 00 05. 00 05. 00 07. 00 08. 00 07. 00 09. 00 11. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pro- Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement	s) tration) Adju eriod under t ne 49) n first year ) tructions) , line 59)	he 21st	0.0000000000000000000000000000000000000	0.000000000 0 0.0000 0	101. ( 102. ( 103. ( 200. ( 200. ( 202. ( 203. ( 205. ( 205. ( 205. ( 206. ( 207. ( 208. ( 209. ( 209. ( 209. ( 209. ( 209. ( 200. ()))))))))))))))))))))))))))))))))))
01. 00 02. 00 03. 00 04. 00 00. 00 01. 00 02. 00 02. 00 05. 00 05. 00 06. 00 07. 00 08. 00 09. 00 10. 00 11. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration payment Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Case-mix adjustment factor (see instructions) Case-mix adjustment factor (see instructions) Case-mix adjustment factor (see instructions) Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions)	s) tration) Adju eriod under t ne 49) n first year ) tructions) , line 59)	he 21st	0.0000000000000000000000000000000000000	0.000000000 0 0.0000 0 cration	101. ( 102. ( 103. ( 200. ( 201. ( 202. ( 203. ( 205. ( 205. ( 205. ( 205. ( 205. ( 206. ( 207. ( 208. ( 209. ( 211. (

I VO	Financial Systems LUME CALCULATION EXHIBIT 4		ASCENSION ST. V	Provider CC	Fr Tc	eriod: com 07/01/2021 o 06/30/2022	u of Form CMS-2 Worksheet E Part A Exhibi Date/Time Prep 11/28/2022 1:	t 4 par
		W/S E, Part A line	Amounts (from E, Part A)	Title Pre/Post Entitlement	Period Prior	Hospital Period Dn/After 10/01	PPS Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
0	DRG amounts other than outlier payments	1.00	0	0	0	0	0	
1	DRG amounts other than outlier payments for discharges	1. 01	2, 961, 788	0	2, 961, 788		2, 961, 788	
2	occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	9, 056, 013	0		9, 056, 013	9, 056, 013	
3	1 DRG for Federal specific operating payment for Model 4 BPCL occurring prior to	1. 03	0	0	0		0	
4	October 1 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0	0		0	0	
0	Outlier payments for discharges (see instructions)	2.00						
1	Outlier payments for	2.02	0	0	0	0	0	
2	discharges for Model 4 BPCI Outlier payments for discharges occurring prior to	2.03	71, 185	О	71, 185		71, 185	
3	October 1 (see instructions) Outlier payments for discharges occurring on or after October 1 (see	2.04	229, 596	0		229, 596	229, 596	
)	instructions) Operating outlier reconciliation	2. 01	0	0	0	0	0	
C	Managed care simulated payments	3.00	0	0	0	0	0	
~	Indirect Medical Education Adju		0,000000	0.000000	0,000000	0,000000		
) )	Amount from Worksheet E, Part A, line 21 (see instructions) IME payment adjustment (see	21.00 22.00	0. 000000	0. 000000 0	0. 000000	0. 000000	0	
1	instructions) IME payment adjustment for managed care (see instructions)	22. 01	0	0	0	0	0	
	Indirect Medical Education Adju	ustment for the	e Add-on for Se	ction 422 of th	ne MMA			
)	IME payment adjustment factor (see instructions)	27.00	0. 000000	0. 000000	0. 000000	0. 000000	_	
)	IME adjustment (see instructions) IME payment adjustment add on	28.00 28.01	0	0	0	0	0	
	for managed care (see instructions)				Ū			
0	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	
1	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	
00	Disproportionate Share Adjustme		0.0000	0.0000	0.0000	0.0000		1
00	Allowable disproportionate share percentage (see instructions)	33.00	0. 0982	0. 0982	0. 0982	0. 0982		1
00	Disproportionate share adjustment (see instructions)	34.00	295, 037	0	72, 712	222, 325	295, 037	
	Uncompensated care payments Additional payment for high per		1, 565, 344 RD benefi ci ary	~	485, 287	1, 080, 056	1, 565, 343	
00	Total ESRD additional payment (see instructions) Subtotal (see instructions)	46.00 47.00	0 14, 178, 963	0	0 3, 590, 972	0 10, 587, 991	0 14, 178, 963	
00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	14, 178, 903	0	3, 390, 972 0	0 0	14, 178, 903 0	1
00	Total payment for inpatient operating costs (see	49.00	14, 178, 963	О	3, 590, 972	10, 587, 991	14, 178, 963	1
00	instructions) Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	966, 568	0	240, 255	726, 313	966, 568	1

	Financial Systems	A	SCENSION ST. V				u of Form CMS-2	2552-10
LOW VO	LUME CALCULATION EXHIBIT 4			Provider CC	CN: 15-0010	Period: From 07/01/2021 To 06/30/2022	Worksheet E Part A Exhibi Date/Time Pre 11/28/2022 1:	pared:
				Title	XVIII	Hospi tal	PPS	
			Amounts (from	Pre/Post	Period Prio		Total (Col 2	
		line 0	E, Part A)	Entitlement	to 10/01	0n/After 10/01		
47.00		-	1.00	2.00	3.00	4.00	5.00	17.00
17.00	Special add-on payments for new technologies	54.00	276, 650	0	90, 1	75 186, 475	276, 650	17.00
17.01	Net organ aguisition cost							17.01
17.02	Credits received from	68.00	0	0		0 0	0	
17.02	manufacturers for replaced	00.00	Ŭ	0		0		17.02
	devices for applicable MS-DRGs							
18.00	Capital outlier reconciliation		0	0		0 0	0	18.00
10.00	adjustment amount (see	75.00	U	0		0		10.00
	i nstructi ons)							
19.00	SUBTOTAL			0	3, 921, 40	11, 500, 779	15, 422, 181	19.00
		W/S L, line	(Amounts from					
			L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	901, 496	0	224, 14	46 677, 350	901, 496	20.00
20. 01	Model 4 BPCI Capital DRG other	1.01	0	0		0 0	0	20. 01
	than outlier							
21.00	Capital DRG outlier payments	2.00	18, 284	0	4, 4			
21.01	Model 4 BPCI Capital DRG	2. 01	0	0		0 0	0	21.0
	outlier payments							
22.00	Indirect medical education	5.00	0. 0000	0.0000	0.000	0.0000		22.00
	percentage (see instructions)			-		_	_	
23.00	Indirect medical education	6.00	0	0		0 0	0	23.00
	adjustment (see instructions)							
24.00	Allowable disproportionate	10.00	0. 0519	0. 0519	0.05	0. 0519		24.00
	share percentage (see							
	instructions)							
25.00	Disproportionate share	11.00	46, 788	0	11, 63	33 35, 155	46, 788	25.00
	adjustment (see instructions)							
26.00	Total prospective capital	12.00	966, 568	0	240, 25	55 726, 313	966, 568	26.00
	payments (see instructions)							
		W/S E, Part A						
		line 0	Part A)	2.00	2.00	4.00	F 00	
07.00		0	1.00	2.00	3.00	4.00	5.00	07.00
27.00	Low volume adjustment factor	70.0/			0.0000			27.00
28.00	Low volume adjustment	70.96				0	0	28.00
	(transfer amount to Wkst. E,							
	Pt. A, line)	70.07						
29.00	Low volume adjustment	70.97				0	0	29.00
	(transfer amount to Wkst. E,							
400 07	Pt. A, line)		<i></i>					100 0
100.00	Transfer low volume		Y					100.00
	adjustments to Wkst. E, Pt. A.					1		1

SPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5			Period: From 07/01/2021 To 06/30/2022	Date/Time Prep 11/28/2022 1:5	pared
				XVIII	Hospi tal	PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
00 01	DRG amounts other than outlier payments DRG amounts other than outlier payments for	1. 00 1. 01	2, 961, 788	2, 961, 78	38	2, 961, 788	1. ( 1. (
02	discharges occurring prior to October 1 DRG amounts other than outlier payments for	1.02	9, 056, 013		9, 056, 013	9, 056, 013	1. (
03	discharges occurring on or after October 1 DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	1.03	0		0	0	1.
04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	О		0	0	1.
00	Outlier payments for discharges (see instructions)	2.00					2.
01	Outlier payments for discharges for Model 4 BPCI	2.02	0		0 0	0	2.
02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	71, 185	71, 18	35	71, 185	2.
03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	229, 596		229, 596	229, 596	2.
00	Operating outlier reconciliation	2.01	0		0 0	0	3.
00	Managed care simulated payments	3.00	0		0 0	0	4.
0	Indirect Medical Education Adjustment Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0. 000000	0.00000	0.00000		5.
)0 )1	IME payment adjustment (see instructions) IME payment adjustment for managed care (see	22.00 22.01	0 0		0 0 0 0	0 0	6. 6.
	instructions)						
0	Indirect Medical Education Adjustment for the	27,00	0. 000000	0.0000	0.00000		-
0	IME payment adjustment factor (see instructions)			0.00000			7.
)0 )1	IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions)	28. 00 28. 01	0		0 0 0 0	0 0	8
)0 )1	Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of	29. 00 29. 01	0		0 0	0	9. 9.
, ,	Di sproporti onate Share Adjustment	27.01			0		
00	Al I owable disproporti onate share percentage	33.00	0. 0982	0.098	0. 0982		10.
00	(see instructions) Disproportionate share adjustment (see	34.00	295, 037	72, 71			
01	instructions) Uncompensated care payments	36.00	1, 565, 344	485, 28			
	Additional payment for high percentage of ESR						
00	Total ESRD additional payment (see instructions)	46.00	0		0 0	0	12
00 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see	47.00 48.00	14, 178, 963 0	3, 590, 97	10, 587, 991 0 0	14, 178, 963 0	13 14
00	instructions) Total payment for inpatient operating costs (see instructions)	49.00	14, 178, 963	3, 590, 97	10, 587, 991	14, 178, 963	15
00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	966, 568	240, 25	5 726, 313	966, 568	16
00 01	Special add-on payments for new technologies Net organ acquisition cost	54.00	276, 650	90, 17	75 186, 475	276, 650	17. 17.
02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0		0 0		17.
00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0		0 0	0	18
	SUBTOTAL		1	3, 921, 40	11, 500, 779	15, 422, 181	

Health Financial Systems	ASCENSION ST. V	INCENT KOKOMO		In Lie	eu of Form CMS-	2552-10
HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provider CC		Period: From 07/01/2021 To 06/30/2022		pared:
		Title	XVIII	Hospi tal	PPS	
	Wkst. L, line	(Amt. from Wkst. L)				
	0	1.00	2.00	3.00	4.00	
20.00 Capital DRG other than outlier	1.00	901, 496	224, 14	46 677, 350	901, 496	20.00
20.01 Model 4 BPCI Capital DRG other than outlier	1.01	0		0 0	0	20.01
21.00 Capital DRG outlier payments	2.00	18, 284	4, 4	76 13, 808	18, 284	21.00
21.01 Model 4 BPCI Capital DRG outlier payments	2.01	0		0 0	0	
22.00 Indirect medical education percentage (see	5.00	0. 0000	0.000	0. 0000		22.00
23.00 Indirect medical education adjustment (see instructions)	6.00	0		0 0	0	23.00
24.00 Allowable disproportionate share percentage (see instructions)	10.00	0. 0519	0. 05 <sup>.</sup>	0. 0519		24.00
25.00 Disproportionate share adjustment (see instructions)	11.00	46, 788	11, 6	33 35, 155	46, 788	25.00
26.00 Total prospective capital payments (see instructions)	12.00	966, 568	240, 2	55 726, 313	966, 568	26.00
	Wkst. E, Pt.	(Amt. from				
	A, line	Wkst. E, Pt. A)				
	0	1.00	2.00	3.00	4.00	
27.00	0	1.00	2.00	0.00	1.00	27.00
28.00 Low volume adjustment prior to October 1	70, 96	0		0	0	
29.00 Low volume adjustment on or after October 1	70.97	0		0	0	
30.00 HVBP payment adjustment (see instructions)	70.93	-2,464	-2, 4	54 0	-2, 464	
30.01 HVBP payment adjustment for HSP bonus	70.90	2, 101	2, 1		0	1
payment (see instructions)	/0./0	Ŭ		0	0	00.01
31.00  HRR adjustment (see instructions)	70, 94	-4, 622		0 -4, 622	-4 622	31.00
31.01 HRR adjustment for HSP bonus payment (see instructions)	70. 91	0		0 0	0	
					(Amt. to Wkst.	
					E, Pt. A)	
	0	1.00	2.00	3.00	4.00	
32.00 HAC Reduction Program adjustment (see instructions)	70.99			0 0		32.00
100.00 Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100. 00

	Financial Systems ASCENSION ST. VINCER ATION OF REIMBURSEMENT SETTLEMENT F	NI KOKOMO Provider CCN: 15-0010	Peri od:	wof Form CMS-2 Worksheet E	2552-10
			From 07/01/2021 To 06/30/2022		pared:
			llacaital	11/28/2022 1: PPS	52 pm
		Title XVIII	Hospi tal	PP3	
				1.00	
4 00	PART B - MEDICAL AND OTHER HEALTH SERVICES			0.057	1 4 00
1.00 2.00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instruction	ons)		2, 057 17, 417, 653	
3.00	OPPS payments			15, 451, 298	
4.00	Outlier payment (see instructions)			120, 903	
4. 01 5. 00	Outlier reconciliation amount (see instructions) Enter the hospital specific payment to cost ratio (see instruct	ions)		0.000	
6.00	Line 2 times line 5	10113)		0.000	
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
8.00	Transitional corridor payment (see instructions)	aal 12 Lina 200		0	
9. 00 10. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV Organ acquisitions	, col. 13, line 200		85, 667 0	
11.00	Total cost (sum of lines 1 and 10) (see instructions)			2, 057	
	COMPUTATION OF LESSER OF COST OR CHARGES				
12.00	Reasonable charges Ancillary service charges			5 206	12.00
12.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, lin	e 69)		0	
14.00	Total reasonable charges (sum of lines 12 and 13)	,		5, 306	14.00
15 00	Customary charges			0	15 00
15.00 16.00	Aggregate amount actually collected from patients liable for pay Amounts that would have been realized from patients liable for	yment for services on navment for services o	a charge basis	0	
10.00	had such payment been made in accordance with 42 CFR §413.13(e)	payment for services e	in a chargebasi s	Ū	10.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	
18.00 19.00	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete only	if line 18 exceeds li	ng 11) (soo	5, 306 3, 249	
19.00	instructions)	IT THE TO EXCEEDS IT	116 11) (See	3, 249	19.00
20.00	Excess of reasonable cost over customary charges (complete only	ifline 11 exceeds li	ne 18) (see	0	20.00
21.00	instructions) Lesser of cost or charges (see instructions)			2, 057	21.00
22.00	Interns and residents (see instructions)			2,037	
23.00	Cost of physicians' services in a teaching hospital (see instru	ctions)		0	
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			15, 657, 868	24.00
25.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance amounts (for CAH, see instructions)			0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line	24 (for CAH, see instr	ructions)	2, 776, 288	
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) pl	us the sum of lines 22	and 23] (see	12, 883, 637	27.00
28.00	instructions) Direct graduate medical education payments (from Wkst. E-4, lin	e 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
30.00	Subtotal (sum of lines 27 through 29)			12, 883, 637	
31.00 32.00	Primary payer payments Subtotal (line 30 minus line 31)			113 12, 883, 524	
02.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES	S)		12,000,021	02.00
	Composite rate ESRD (from Wkst. I-5, line 11)			0	
34.00 35.00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			168, 419 109, 472	
36.00	Allowable bad debts for dual eligible beneficiaries (see instru	ctions)		70, 192	
37.00	Subtotal (see instructions)			12, 992, 996	
38.00	MSP-LCC reconciliation amount from PS&R			0	
39.00 39.50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions)			0	39.00 39.50
39.97	Demonstration payment adjustment amount before sequestration			0	
39. 98	Partial or full credits received from manufacturers for replace	d devices (see instruc	tions)	0	
39. 99 40. 00	RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions)			0 12, 992, 996	
40.00 40.01	Sequestration adjustment (see instructions)			32, 482	
40. 02	Demonstration payment adjustment amount after sequestration			0	
40.03	Sequestration adjustment-PARHM pass-throughs			10.01/.000	40.03
41.00 41.01	Interim payments Interim payments-PARHM			13, 046, 388	41.00
42.00	Tentative settlement (for contractors use only)			0	
42.01	Tentative settlement-PARHM (for contractor use only)				42.01
43.00	Balance due provider/program (see instructions)			-85, 874	
43.01 44.00	Balance due provider/program-PARHM (see instructions) Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2	chapter 1.	0	43.01
	§115. 2		· ····· ·/		
00.00	TO BE COMPLETED BY CONTRACTOR			0	00.00
	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)			0	
92.00					92.00
93.00	Time Value of Money (see instructions)			0	
	Total (sum of lines 91 and 93)			ı 0	94.00

Health Financial Systems	ASCENSION ST. VINC	CENT KOKOMO	In Lie	u of Form CMS-:	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0010	Period: From 07/01/2021	Worksheet E	
				Date/Time Pre 11/28/2022 1:	
		Title XVIII	Hospi tal	PPS	
				1.00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days				0	200.00

ANALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC	CN: 15-0010	Period: From 07/01/2021 To 06/30/2022		
			XVIII	Hospi tal	PPS	
		I npati en	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00 2.00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		13, 760, 1	77 0	13, 046, 388 0	1.00 2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3. 00
3.01	ADJUSTMENTS TO PROVIDER			0	0	3. 01
3.02				0	0	3. 02
3.03 3.04				0	0	3. 03 3. 04
3.04				0	0	3.04
0.00	Provider to Program					0.00
3.50	ADJUSTMENTS TO PROGRAM			0	0	3.50
3.51				0	0	3.51
3.52 3.53				0	0	3.52 3.53
3.53 3.54				0	0	3.53
3.99	Subtotal (sum of lines 3.01–3.49 minus sum of lines 3.50–3.98)			0	0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		13, 760, 1	77	13, 046, 388	4.00
5.00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after					5.00
5.00	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					5.00
5.01	TENTATI VE TO PROVI DER			0	0	5.01
5.02				0	0	5. 02
5.03				0	0	5.03
F F 0	Provider to Program TENTATIVE TO PROGRAM			0	0	
5.50 5.51	ITENTATIVE TU PRUGRAM			0	0	5.50 5.51
5.52				0	0	5. 52
5.99	Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98)			0	0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		269, 9		0	6.01
6.02 7.00	SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions)		14, 030, 0	0	85, 874 12, 960, 514	6.02 7.00
7.00	The arrived care program mabinity (see histructions)		14, 030, 0	Contractor Number	NPR Date (Mo/Day/Yr)	7.00
		C	)	1, 00	2.00	
8.00	Name of Contractor					8.00

IALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC Component C	CN: 15-0010 CCN: 15-T010	Period: From 07/01/202 To 06/30/202		epare
		Title	XVIII	Subprovider - IRF		F
		I npati en	t Part A		art B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		3, 482, 2	0		
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3.
01	ADJUSTMENTS TO PROVIDER		[	0		3.
02				0		
)3				0		
)4				0	(	) 3
)5				0	(	) 3
	Provider to Program					
0	ADJUSTMENTS TO PROGRAM			0	(	
51 52				0		
o∠ 53				0		
53 54				0		
99	Subtotal (sum of lines 3.01–3.49 minus sum of lines 3.50–3.98)			0	(	
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		3, 482, 2	55	(	) 4
	TO BE COMPLETED BY CONTRACTOR				-	
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5
	Program to Provider				_	_
)1	TENTATI VE TO PROVI DER			0	0	
)2 )3				0		
5	Provider to Program				1 (	쒸
50	TENTATI VE TO PROGRAM			0	(	5 5
51				0	0	
52				0	0	
9	Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98)			0	(	
00	Determined net settlement amount (balance due) based on the cost report. (1)				_	6
)1	SETTLEMENT TO PROVIDER		3, 4	UB	(	
)2 )0	SETTLEMENT TO PROGRAM		3, 485, 6	62		
50	Total Medicare program liability (see instructions)		3, 483, 6	Contractor	NPR Date	/ /
				Number	(Mo/Day/Yr)	
		(	1	1.00	2.00	

Health Financial Systems ASCENSION ST. VINCENT KOKOMO In Lieu of Form C	CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-0010 Period: Worksheet From 07/01/2021 Part II To 06/30/2022 Date/Time	
	2 1:52 pm
	PS
1.00	
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS	
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION	
1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	1.00
2.00 Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, and 8 through 12, and plus for 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 line 20	6.00
7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	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
I NPATI ENT HOSPI TAL SERVI CES UNDER THE I PPS & CAH	
30.00 Initial/interim HIT payment adjustment (see instructions)	30.00
31.00 Other Adjustment (specify)	31.00
32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	32.00

LCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0010	Period: From 07/01/2021	Worksheet E-3 Part III	
		Component CCN: 15-T010	To 06/30/2022	Date/Time Pre 11/28/2022 1:	
		Title XVIII	Subprovider - IRF	PPS	
				1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS			1.00	
00	Net Federal PPS Payment (see instructions)			3, 421, 947	] ·
00	Medicare SSI ratio (IRF PPS only) (see instructions)			0. 0326	
00	Inpatient Rehabilitation LIP Payments (see instructions)			112, 240	
)0 )0	Outlier Payments Unweighted intern and resident FTE count in the most rece	ent cost reporting period en	ding on or prior	0 0.00	Ę
01	to November 15, 2004 (see instructions) Cap increases for the unweighted intern and resident FTE program or hospital closure, that would not be counted wi			0.00	5
0	CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00	
00 00	New Teaching program adjustment. (see instructions) Current year's unweighted FTE count of I&R excluding FTEs	s in the new program growth p	eriod of a "new	0.00	
,0	teaching program" (see instructions)			0.00	
00	Current year's unweighted I&R FTE count for residents wit teaching program" (see instructions)	thin the new program growth p	eriod of a "new	0.00	;
0	Intern and resident count for IRF PPS medical education a	adjustment (see instructions)		0.00	
00	Average Daily Census (see instructions)			9.545205	
00	Teaching Adjustment Factor (see instructions)			0.000000	
00	Teaching Adjustment (see instructions)			0	
00	Total PPS Payment (see instructions)	truction)		3, 534, 187	1
00 00	Nursing and Allied Health Managed Care payments (see inst Organ acquisition (DO NOT USE THIS LINE)			0	1
00	Cost of physicians' services in a teaching hospital (see	instructions)		0	
00	Subtotal (see instructions)			3, 534, 187	
00	Primary payer payments			10,000	
00	Subtotal (line 17 less line 18).			3, 524, 187	
00	Deducti bl es			19, 652	2
00	Subtotal (line 19 minus line 20)			3, 504, 535	
00	Coinsurance			11, 418	
00	Subtotal (line 21 minus line 22)			3, 493, 117	
00 00	Allowable bad debts (exclude bad debts for professional s Adjusted reimbursable bad debts (see instructions)	services) (see instructions)		990 644	
00	Allowable bad debts for dual eligible beneficiaries (see	instructions)		044	2
00	Subtotal (sum of lines 23 and 25)			3, 493, 761	
00	Direct graduate medical education payments (from Wkst. E-	-4. line 49)		0, 170, 701	
00	Other pass through costs (see instructions)			638	
00	Outlier payments reconciliation			0	3
00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	3
50	Pioneer ACO demonstration payment adjustment (see instruc	ctions)		0	3
98	Recovery of accel erated depreciation.			0	3
99	Demonstration payment adjustment amount before sequestrat	tion		0	
00 01	Total amount payable to the provider (see instructions) Sequestration adjustment (see instructions)			3, 494, 399 8, 736	
02	Demonstration payment adjustment amount after sequestrati	on		0, 730	
02	Interim payments	011		3, 482, 255	
00	Tentative settlement (for contractor use only)			0, 102, 200	
00	Balance due provider/program (line 32 minus lines 32.01,	32.02, 33, and 34)		3, 408	
00	Protested amounts (nonallowable cost report items) in acc §115.2	cordance with CMS Pub. 15-2,	chapter 1,	0	3
_	TO BE COMPLETED BY CONTRACTOR				4
00	Original outlier amount from Wkst. E-3, Pt. III, line 4	、 、		0	
00	Outlier reconciliation adjustment amount (see instruction	1S <i>)</i>		0	5
00	The rate used to calculate the Time Value of Money			0.00	
00	Time Value of Money (see instructions) FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020			0 0 DHF	5
		immediately preceding Februa		0.000000	9

LCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0010	Peri od:	Worksheet E-3	2552
			From 07/01/2021 To 06/30/2022	Part VII Date/Time Prep 11/28/2022 1:5	pare 52 r
		Title XIX	Hospi tal	Cost	<u> </u>
			I npati ent	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVI	ICES FOR TITLES V OR X	(IX SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
	Inpatient hospital/SNF/NF services		1, 593, 443		1
	Medical and other services			0	2
	Organ acquisition (certified transplant centers only)		0		3
	Subtotal (sum of lines 1, 2 and 3)		1, 593, 443	0	4
	Inpatient primary payer payments		0	0	5
	Outpatient primary payer payments		1 502 442	0	6
	Subtotal (line 4 less sum of lines 5 and 6) COMPUTATION OF LESSER OF COST OR CHARGES		1, 593, 443		
	Reasonable Charges				
	Routi ne servi ce charges		0		8
	Ancillary service charges		4, 830, 339	0	9
	Organ acquisition charges, net of revenue		0	J	10
	Incentive from target amount computation		0		11
	Total reasonable charges (sum of lines 8 through 11)		4, 830, 339	0	12
Ì	CUSTOMARY CHARGES				1
00	Amount actually collected from patients liable for payment for s	services on a charge	0	0	13
	basi s				
	Amounts that would have been realized from patients liable for		on 0	0	14
	a charge basis had such payment been made in accordance with 42	CFR §413.13(e)			
	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0.00000	
	Total customary charges (see instructions)	if line 14 exceede	4, 830, 339	0	16
	Excess of customary charges over reasonable cost (complete only line 4) (see instructions)	IT The to exceeds	3, 236, 896	0	17
	Excess of reasonable cost over customary charges (complete only	if line 4 exceeds lin	0	0	18
00	16) (see instructions)			0	
00	Interns and Residents (see instructions)		0	0	19
	Cost of physicians' services in a teaching hospital (see instruct	ctions)	0	0	20
	Cost of covered services (enter the lesser of line 4 or line 16)		1, 593, 443	0	21
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be co		ders.		
00	Other than outlier payments		0	0	22
	Outlier payments		0	0	23
	Program capital payments		0		24
	Capital exception payments (see instructions)		0		25
	Routine and Ancillary service other pass through costs		0	0	26
	Subtotal (sum of lines 22 through 26)		0	0	27
	Customary charges (title V or XIX PPS covered services only)		1 502 442	0	28
	Titles V or XIX (sum of lines 21 and 27) COMPUTATION OF REIMBURSEMENT SETTLEMENT		1, 593, 443	0	29
	Excess of reasonable cost (from line 18)		0	0	30
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		1, 593, 443	0	31
	Deducti bl es		0	0	32
	Coinsurance		0	0	
	Allowable bad debts (see instructions)		0	0	
	Utilization review		0	-	35
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 3	33)	1, 593, 443	0	36
00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37
00	Subtotal (line 36 ± line 37)		1, 593, 443	0	38
	Direct graduate medical education payments (from Wkst. E-4)		0		39
00	Total amount payable to the provider (sum of lines 38 and 39)		1, 593, 443	0	40
	Interim payments		1, 593, 443	0	41
00					
00 00	Balance due provider/program (line 40 minus line 41) Protested amounts (nonallowable cost report items) in accordance		0	0	42 43

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0010	Period: From 07/01/2021	Worksheet E-3 Part VII	
		Component CCN: 15-T010	To 06/30/2022	Date/Time Prep 11/28/2022 1:	
		Title XIX	Subprovider - IRF	Cost	
			Inpatient 1.00	Outpatient 2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SE	ERVICES FOR TITLES V OR X		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
00	Inpatient hospital/SNF/NF services		28, 733		1
00	Medical and other services			0	
00	Organ acquisition (certified transplant centers only)		0		3
00 00	Subtotal (sum of lines 1, 2 and 3)		28, 733	0	4
00	Inpatient primary payer payments Outpatient primary payer payments		0	0	l
00	Subtotal (line 4 less sum of lines 5 and 6)		28, 733	0	
00	COMPUTATION OF LESSER OF COST OR CHARGES		20, 733	0	1
	Reasonabl e Charges				
00	Routi ne servi ce charges		0		18
00	Ancillary service charges		58, 245	0	9
0. 00	Organ acquisition charges, net of revenue		0		10
. 00	Incentive from target amount computation		0		1
. 00	Total reasonable charges (sum of lines 8 through 11)		58, 245	0	12
00	CUSTOMARY CHARGES			0	1 1
. 00	Amount actually collected from patients liable for payment for basis	or services on a charge	0	0	13
. 00	Amounts that would have been realized from patients liable for	or payment for services o	n 0	0	14
. 00	a charge basis had such payment been made in accordance with			0	1.
. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0.00000	15
. 00	Total customary charges (see instructions)		58, 245	0	10
. 00	Excess of customary charges over reasonable cost (complete or	nly if line 16 exceeds	29, 512	0	1
	line 4) (see instructions)				
. 00	Excess of reasonable cost over customary charges (complete or	nly if line 4 exceeds lin	e 0	0	18
. 00	16) (see instructions) Interns and Residents (see instructions)		0	0	19
0.00	Cost of physicians' services in a teaching hospital (see ins	tructions)	0	0	20
. 00	Cost of covered services (enter the lesser of line 4 or line		28, 733	0	
. 00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be			0	1
. 00	Other than outlier payments		0	0	22
8. 00	Outlier payments		0	0	23
. 00	Program capital payments		0		24
. 00	Capital exception payments (see instructions)		0		25
. 00	Routine and Ancillary service other pass through costs		0	0	
. 00	Subtotal (sum of lines 22 through 26)		0	0	27
. 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)		28, 733	0	29
. 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Excess of reasonable cost (from Line 18)		0	0	30
. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and (	6)	28, 733	0	
	Deductibles	<i></i>	20, 733	0	
. 00	Coi nsurance		0	0	
. 00	Allowable bad debts (see instructions)		0	0	34
. 00	Utilization review		0		35
. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	nd 33)	28, 733	0	36
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
. 00	Subtotal (line 36 ± line 37)		28, 733	0	
. 00	Direct graduate medical education payments (from Wkst. E-4)	<b>、</b>	0		39
. 00	Total amount payable to the provider (sum of lines 38 and 39)	)	28, 733	0	
. 00	Interim payments		28, 733	0	4
. 00	Balance due provider/program (line 40 minus line 41)	appen with CMS Duck 15 2	0	0	
3. 00	Protested amounts (nonallowable cost report items) in accorda	ance with two Pub 15-2,	0	0	43

nd-t	E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column	Provider C	F	Period: From 07/01/2021 To 06/30/2022	Worksheet G Date/Time Pre	nar
у)		General Fund	Specific Purpose Fund	Endowment Fund	11/28/2022 1: Pl ant Fund	52
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS		1	-1 -1		ł.,
00	Cash on hand in banks	17,039		0 0	0	
00	Temporary investments	0		0 0	0	
00	Notes receivable			0 0	0	
)0 )0	Accounts receivable Other receivable	21, 728, 844 3, 248, 834			0	
00	Allowances for uncollectible notes and accounts receivable	3, 240, 034			0	
00	Inventory	2, 361, 203			0	
00	Prepaid expenses	2, 301, 203			0	
00	Other current assets	222, 306	(	0	0	1
00	Due from other funds	69, 376		0 0	0	10
00	Total current assets (sum of lines 1-10)	27, 647, 602	(	o o	0	1 1
	FIXED ASSETS					
00	Land	671, 919	(	0 C	0	12
00	Land improvements	2, 316, 541	(	0 0	0	13
00	Accumulated depreciation	0		0 0	0	
00	Buildings	82, 859, 559	(	0 0	0	
00	Accumulated depreciation	0	(	0	0	
00	Leasehold improvements	653, 423			0	
00 00	Accumulated depreciation Fixed equipment				0	
00	Accumulated depreciation	20, 718, 982			0	
	Automobiles and trucks	1, 628, 533			0	
00	Accumulated depreciation	1, 020, 333			0	1 -
	Major movable equipment	50, 113, 349		0 0	0	
00	Accumul ated depreciation	0	(	0	0	
00	Minor equipment depreciable	0		0 0	0	
00	Accumulated depreciation	0	(	0 0	0	20
00	HIT designated Assets	0	(	0 0	0	2
00	Accumulated depreciation	-124, 618, 142	(	0 C	0	28
00	Mi nor equi pment-nondepreci abl e	2,061,345	(	0 0	0	29
00	Total fixed assets (sum of lines 12-29)	36, 405, 509	(	0 0	0	30
	OTHER ASSETS			11		
00	Investments	175, 068		0 0	0	
00	Deposits on Leases	1, 137, 539		0 0	0	
00	Due from owners/officers	0		0 0	0	
00 00	Other assets Total other assets (sum of lines 31-34)	32, 534			0	
00	Total assets (sum of lines 11, 30, and 35)	1, 345, 141 65, 398, 252			0	
00	CURRENT LIABILITIES	03, 396, 232	<u> </u>	<u> </u>	0	1 30
00	Accounts payable	4, 012, 360	(	0 0	0	37
00	Salaries, wages, and fees payable	3, 214, 033	1	0 0	0	
00	Payroll taxes payable	704, 073		0 0	0	
00	Notes and Loans payable (short term)	0	(	0 0	0	
00	Deferred income	0	(	o c	0	
00	Accelerated payments	0				42
00	Due to other funds	15, 892, 216	(	0 0	0	43
00	Other current liabilities	6, 415, 121	(	0 0	0	
00	Total current liabilities (sum of lines 37 thru 44)	30, 237, 803	(	0 0	0	4
	LONG TERM LIABILITIES		1			
00	Mortgage payable	0		0 0	0	
00	Notes payable	5, 068, 092		0 0	0	
00	Unsecured Loans	14, 446, 166			0	
00 00	Other long term liabilities	2, 985, 539			0	
00	Total long term liabilities (sum of lines 46 thru 49) Total liabilities (sum of lines 45 and 50)	22, 499, 797			0	
00	CAPITAL ACCOUNTS	52, 737, 600	L(	<u> </u>	0	4 2
00	General fund balance	12, 660, 652				5
00	Specific purpose fund	.2,000,002		b		53
00	Donor created - endowment fund balance - restricted			0		54
00	Donor created - endowment fund balance - unrestricted			0		55
00	Governing body created - endowment fund balance			0		56
00	Plant fund balance - invested in plant				0	
	Plant fund balance - reserve for plant improvement,				0	
00						
00	replacement, and expansion					
00	Total liabilities and fund balances (sum of lines 52 thru 58) Total liabilities and fund balances (sum of lines 51 and	12, 660, 652 65, 398, 252		o c	0 0	

		ASCENSION ST. VII					u of Form CMS-	
STATEM	ENT OF CHANGES IN FUND BALANCES		Provider CC	CN: 15-0010		riod: om 07/01/2021 06/30/2022	Worksheet G-1 Date/Time Pre 11/28/2022 1:	epared:
		General	Fund	Speci al	Purp	oose Fund	Endowment Fund	
1 00	Fund halanage at heginning of pariod	1.00	2.00	3.00		4.00	5.00	1.00
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) OTHER ACTIVITY Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) TRANSFER TO ALPHA Total deductions (sum of lines 12-17) Fund balance at end of period per balance	175, 068 0 0 0 0 14, 531, 438 0 0 0 0 0 0	1, 461, 360 25, 555, 661 27, 017, 021 175, 068 27, 192, 089 14, 531, 438 12, 660, 651		0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0		$\begin{array}{c} 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$
	sheet (line 11 minus line 18)	Endowment Fund	PI ant	Fund				
		6.00	7.00	8.00				
1.00	Fund balances at beginning of period	0.00	7.00	8.00	0			1.00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) OTHER ACTIVITY	0	0 0 0 0 0 0		0			2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) TRANSFER TO ALPHA	0	0 0 0 0 0 0		0			10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00
18.00 19.00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	000			0 0			18.00 19.00

TATEN	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider CC	N: 15-0010	Period: From 07/01/2021 To 06/30/2022	Worksheet G-2 Parts I & II Date/Time Pre 11/28/2022 1:	pared
	Cost Center Description		Inpati ent	Outpati ent	Total	
			1.00	2.00	3.00	
	PART I – PATIENT REVENUES					
	General Inpatient Routine Services	I				
. 00	Hospi tal		33, 455, 16	57	33, 455, 167	1.0
. 00	SUBPROVIDER - IPF					2.0
. 00	SUBPROVIDER - IRF		7, 212, 06	53	7, 212, 063	3.0
. 00	SUBPROVI DER					4.0
. 00	Swing bed - SNF			0	0	
. 00	Swing bed - NF			0	0	
. 00	SKILLED NURSING FACILITY					7.0
. 00	NURSING FACILITY					8.0
. 00	OTHER LONG TERM CARE					9.0
0. 00	Total general inpatient care services (sum of lines 1-9)		40, 667, 23	30	40, 667, 230	10.0
	Intensive Care Type Inpatient Hospital Services					
1.00	INTENSIVE CARE UNIT		13, 047, 82	20	13, 047, 820	11. (
2.00	CORONARY CARE UNIT					12. (
3.00	BURN INTENSIVE CARE UNIT					13. (
4.00	SURGI CAL I NTENSI VE CARE UNI T					14.0
5.00	OTHER SPECIAL CARE (SPECIFY)					15.0
6. 00	Total intensive care type inpatient hospital services (sum of	oflines	13, 047, 82	20	13, 047, 820	16.0
	11-15)					
7.00	Total inpatient routine care services (sum of lines 10 and 1	6)	53, 715, 05	50	53, 715, 050	17.0
8.00	Ancillary services		170, 298, 88	36 0	170, 298, 886	18.0
9.00	Outpatient services			0 381, 071, 628	381, 071, 628	19. (
0. 00	RURAL HEALTH CLINIC			0 0	0	20.0
1.00	FEDERALLY QUALIFIED HEALTH CENTER			0 0	0	21. (
2.00	HOME HEALTH AGENCY					22. (
3.00	AMBULANCE SERVICES		3, 78	19, 929, 827	19, 933, 615	23. (
4.00	СМНС					24.0
5.00	AMBULATORY SURGICAL CENTER (D. P.)					25.0
6.00	HOSPI CE					26.0
7.00	PHYSICIAN PRIVATE OFFICE		458, 20	955, 657	1, 413, 857	27.
7.01	CLINIC OF HOPE			0 146, 073	146, 073	27.
8.00	Total patient revenues (sum of lines 17-27)(transfer column	3 to Wkst.	224, 475, 92	402, 103, 185	626, 579, 109	28.
	G-3, line 1)					
	PART II - OPERATING EXPENSES					
9.00	Operating expenses (per Wkst. A, column 3, line 200)			153, 697, 934		29.
0. 00	ADD (SPECIFY)			0		30.
1. 00				0		31.
2.00				0		32.
3.00				0		33.
4.00				0		34.
5.00				0		35.
6.00	Total additions (sum of lines 30-35)			0		36.
7.00	DEDUCT (SPECI FY)			0		37.
8.00				0		38.
9.00				0		39.
0. 00				0		40.
1.00				0		41.
2.00	Total deductions (sum of lines 37-41)			0		42.
3.00	Total operating expenses (sum of lines 29 and 36 minus line	42)(transfer		153, 697, 934		43.
	to Wkst. G-3, line 4)	, , ,				1

Heal th	Financial Systems ASCENSION ST. VI	ΝCΕΝΤ ΚΟΚΟΜΟ	Inlie	u of Form CMS-2	2552-10
	IENT OF REVENUES AND EXPENSES	Provider CCN: 15-0010	Peri od:	Worksheet G-3	
0171120			From 07/01/2021		
			To 06/30/2022		
				11/28/2022 1:	52 pm
				1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, li	ne 28)		626, 579, 109	1.00
2.00	Less contractual allowances and discounts on patients' accou	-		451, 461, 993	2.00
3.00	Net patient revenues (line 1 minus line 2)			175, 117, 116	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	e 43)		153, 697, 934	4.00
5.00	Net income from service to patients (line 3 minus line 4)			21, 419, 182	5.00
	OTHER INCOME				
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	n 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	Revenue from Laundry and Linen service			0	13.00
14.00	Revenue from meals sold to employees and guests			368, 048	14.00
15.00	Revenue from rental of living quarters			0	15.00
16.00	Revenue from sale of medical and surgical supplies to other	than patients		0	16.00
17.00	Revenue from sale of drugs to other than patients			0	17.00
18.00	Revenue from sale of medical records and abstracts			1, 066	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
21.00	Rental of vending machines			1, 811	21.00
22.00	Rental of hospital space			110, 840	22.00
23.00	Governmental appropriations			0	23.00
24.00	MI SCELLANEOUS REVENUE			218, 805	24.00
24.01	IC RENTAL INCOME			124, 596	
24.02	FOUNDATION IC TRANSFER			167, 646	
24.03	GAIN/(LOSS) ON DISPOSAL OF ASSETS			-6, 328	
24.04	PATIENT INTEREST INCOME			7, 378	
24.05	MEDI CAL AFFAI RS ADMI NI STRATI VE FEES			216, 631	24.05
24.06	SEMINARS TUITION REVENUE			15, 545	
24.07	IIUE INCOME LOSS			43, 395	
24.08	I C SHARED SAVINGS REVENUE ACO			265, 338	
24.09	STATE SPONSORED PROJECT REVENUE			81, 269	24.09
24.10	FEDERAL SPONSORED PROJECT REVENUE			456, 749	
24.11	RENTAL INCOME			346, 258	
	MEALS ON WHEELS			74, 090	
24.50	COVI D-19 PHE Funding			1, 643, 342	
25.00	Total other income (sum of lines 6-24)			4, 136, 479	25.00
26.00	Total (line 5 plus line 25)			25, 555, 661	
27.00	OTHER EXPENSES (SPECIFY)			0	27.00
	Total other expenses (sum of line 27 and subscripts)			0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)			25, 555, 661	29.00

Heal th	Financial Systems ASCENSIC	ON ST. VIN	CENT KOKOMO	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF CAPITAL PAYMENT		Provider CCN: 15-0010	Period: From 07/01/2021 To 06/30/2022		
			Title XVIII	Hospi tal	PPS	
					1 00	
	PART I - FULLY PROSPECTIVE METHOD				1.00	
	CAPITAL FEDERAL AMOUNT					
1.00	Capital DRG other than outlier				901, 496	1.00
1.01						1.01
2.00	Capital DRG outlier payments		18, 284	2.00		
2.01	Model 4 BPCI Capital DRG outlier payments				0	2.01
3.00	Total inpatient days divided by number of days in th	he cost re	eporting period (see inst	ructions)	52.24	3.00
4.00	Number of interns & residents (see instructions)				0.00	4.00
5.00	Indirect medical education percentage (see instructi	ions)			0.00	5.00
6.00	Indirect medical education adjustment (multiply line 1.01)(see instructions)	e 5 by the	e sum of lines 1 and 1.01	, columns 1 and	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare 30) (see instructions)	e Part A p	oatient days (Worksheet E	, part A line	2.87	7.00
8.00	Percentage of Medicaid patient days to total days (s	see instru	uctions)		22.11	8.00
9.00	Sum of lines 7 and 8				24.98	9.00
10.00	Allowable disproportionate share percentage (see ins	structions	5)		5.19	10.00
11.00	Disproportionate share adjustment (see instructions)	)			46, 788	11.00

- 12.00 Total prospective capital payments (see instructions)

		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00

966, 568 12.00

0 11.00

0 12.00

0 13.00

10.00 0

- 9.00 Current year capital payments (from Part I, line 12, as applicable) 10.00 Current year comparison of capital minimum payment level to capital payments (line 8 less line 9) 11.00 Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)
- Net comparison of capital minimum payment level to capital payments (line 10 plus line 11) 12.00 Current year exception payment (if line 12 is positive, enter the amount on this line) Carryover of accumulated capital minimum payment level over capital payment for the following period 13.00
- 14.00 0 14.00 (if line 12 is negative, enter the amount on this line) 15.00 Current year allowable operating and capital payment (see instructions) 0 15.00 16.00 Current year operating and capital costs (see instructions) 0 16.00 0 17.00
- 17.00 Current year exception offset amount (see instructions)