ASCENSION ST. VINCENT KOKOMO In Lieu of Form CMS-2552-10 Health Financial Systems This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395q). OMB NO. 0938-0050 EXPIRES 09-30-2025 Worksheet S HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 15-0010 Period: From 07/01/2022 Parts I-III AND SETTLEMENT SUMMARY 06/30/2023 Date/Time Prepared: то 11/21/2023 1:47 pm PART I - COST REPORT STATUS Provider 1.[X] Electronically prepared cost report Date: 11/21/2023 Time: 1:47 pm use only]Manually prepared cost report 2. ſ 3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report 4. [F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no. 6. Date Received: Contractor 5. [1] Cost Report Status 10.NPR Date: (2) As Submittleu /. Contractor No.
(2) Settled without Audit 8. [N] Initial Report for this Provider CCN
(3) Settled with Audit 9. [N] Final Report for this Provider CCN
(4) Reonened
(5) Reonene use only (4) Reopened (5) Amended PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S) MISREPRESENTATION OF FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OF INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND

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

ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ASCENSION ST. VINCENT KOKOMO (15-0010) for the cost reporting period beginning 07/01/2022 and ending 06/30/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONIC			
	1		2	SIGNATURE STATEMENT			
1	Beck	y Jacobson	Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1		
2	Signatory Printed Name	Becky Jacobson			2		
3	Signatory Title	VP OF FINANCE			3		
4	Date	11/21/2023 01:47:52 PM			4		

			Title	XVIII			
		Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	397,963	29,169	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	-24,575	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	373,388	29,169	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

	AL AND HOSPITAL HEALTH CARE COMPLEX	LECTION ICATION	SUL		er CCN:		Period: From 07/01/ To 06/30/	2022	Workshe Part I Date/Ti 11/21/2	ime Pre	pare
	1.00		2.00		3.00		4	4.00	, ,		
	Hospital and Hospital Health Care Co										
	Street:1907 WEST SYCAMORE City: KOKOMO	PO BO State		zip Code	• 16001	Count	y: HOWARD				1
0		Component		CCN	CBSA	Provider		Pavme	nt Syst	em (P.	2
		component	. Nume	Number	Number	Туре	Certified	-	0, or		
								V	XVIII		1
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00	
_	Hospital and Hospital-Based Componen			1							
0	Hospital	ASCENSION ST. KOKOMO	VINCENT	150010	29020	1	07/01/1966	N	P	0	3
)	Subprovider – IPF	KUKUMU									4
)	Subprovider – IRF	ASCENSION ST.	VINCENT	15т010	29020	5	07/01/2002	N	Р	0	5
		KOKOMO REHAB									
C	Subprovider - (Other)										6
0	Swing Beds - SNF										7
	Swing Beds - NF										8
	Hospital-Based SNF Hospital-Based NF										9
	Hospital-Based OLTC										11
	Hospital-Based HHA										12
00	Separately Certified ASC										13
	Hospital-Based Hospice										14
	Hospital-Based Health Clinic - RHC										15
	Hospital-Based Health Clinic - FQHC Hospital-Based (CMHC) I										16 17
	Renal Dialysis										18
	Other										19
							From:		То	:	
							1.00		2.0		20
	Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions)						07/01/20	022	06/30/	2023	20
50	Type of control (see instructions)										21
						1.00	2.00		3.0	00	
٦O	Inpatient PPS Information Does this facility qualify and is it	currently not	aiving no	vmonte for		Y	N	-			22
50	disproportionate share hospital adju					1	N N				22
	§412.106? In column 1, enter "Y" fo	r yes or "N" f	or no. Is	this							
	facility subject to 42 CFR Section §	412.106(c)(2)(Pickle am	endment							
	hospital?) In column 2, enter "Y" fo			-	_						
)1	Did this hospital receive interim UC this cost reporting period? Enter in					Y	Y				22
	for the portion of the cost reportin										
	1. Enter in column 2, "Y" for yes or										
	cost reporting period occurring on o				-						
	instructions)		_								
)2	Is this a newly merged hospital that	requires a fi	nal UCP t	o be		N	N				22
	determined at cost report settlement 1, "Y" for yes or "N" for no, for th	<pre>(see instruct e portion of +</pre>	tions) En	ter in col	umn						
	period prior to October 1. Enter in				no.						
	for the portion of the cost reportin				,						
)3	Did this hospital receive a geograph					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				·						
	reporting period occurring on or aft										
		100 but not mo	re than 4	99 beds (a	-						
	Does this hospital contain at least		in column	3, "Y" fo	r						
	Does this hospital contain at least counted in accordance with 42 CFR 41	2.105)? Enter									22
14	Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no.		ation for	m urban +-	1						
)4	Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Did this hospital receive a geograph	ic reclassific			as			1			22
)4	Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OMB	ic reclassific delineations	for stati	stical are							
)4	Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OMB adopted by CMS in FY 2021? Enter in for the portion of the cost reportin	ic reclassific delineations column 1, "Y" g period prior	for stati for yes o to Octob	stical are r "N" for er 1. Ente	no						
)4	Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OMB adopted by CMS in FY 2021? Enter in for the portion of the cost reportin in column 2, "Y" for yes or "N" for	ic reclassific delineations column 1, "Y" g period prior no for the por	for stati for yes o to Octob tion of t	stical are r "N" for er 1. Ente he cost	no						
)4	Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OMB adopted by CMS in FY 2021? Enter in for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft	ic reclassific delineations column 1, "Y" g period prior no for the por er October 1.	for stati for yes o to Octobe tion of t (see inst	stical are r "N" for er 1. Ente he cost ructions)	no r						
)4	Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OMB adopted by CMS in FY 2021? Enter in for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least	ic reclassific delineations column 1, "Y" g period prior no for the por er October 1. 100 but not mo	for stati for yes o to Octob tion of t (see inst re than 4	stical are r "N" for er 1. Ente he cost ructions) 99 beds (a	no r s						
)4	Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OMB adopted by CMS in FY 2021? Enter in for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41	ic reclassific delineations column 1, "Y" g period prior no for the por er October 1. 100 but not mo	for stati for yes o to Octob tion of t (see inst re than 4	stical are r "N" for er 1. Ente he cost ructions) 99 beds (a	no r s						
	Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OMB adopted by CMS in FY 2021? Enter in for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least	ic reclassific delineations column 1, "Y" g period prior no for the por er October 1. 100 but not mo 2.105)? Enter	for stati for yes o to Octobe tion of t (see inst re than 4 in colum	stical are r "N" for er 1. Ente he cost ructions) 99 beds (a n 3, "Y" f	no r s or		3 N				
	Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OMB adopted by CMS in FY 2021? Enter in for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no.	ic reclassific delineations column 1, "Y" g period prior no for the por er October 1. 100 but not mo 2.105)? Enter dicaid days on	for stati for yes o to Octobe tion of t (see inst re than 4 in colum	stical are r "N" for er 1. Ente he cost ructions) 99 beds (a n 3, "Y" f and/or 25	no r s or		3 N				23
	Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OMB adopted by CMS in FY 2021? Enter in for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Which method is used to determine Me	ic reclassific delineations column 1, "Y" g period prior no for the por er October 1. 100 but not mo 2.105)? Enter dicaid days on of admission, of identifying	for stati for yes o to Octob tion of t (see inst re than 4 in colum lines 24 2 if cens the days	stical are r "N" for er 1. Ente he cost ructions) 99 beds (a n 3, "Y" f and/or 25 us days, o in this c	no r s or r 3		3 N				

OSPIT	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ATA	Provider CC	CN: 15-0010	Period:	1/2022		eet S-2	2
					From 07/0 To 06/3			ime Pre 2023 1:	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medica HMO da	id (ys Me	other dicaid days	
		1.00	2.00	3.00	4.00	5.00		6.00	
	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				0		230	(24.0
	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.							6 -	
					Urban/R	ural S 00		f Geogr 00	·
6.00	Enter your standard geographic classification (not w		at the beg	jinning of 1		1			26.0
	cost reporting period. Enter "1" for urban or "2" fo Enter your standard geographic classification (not w reporting period. Enter in column 1, "1" for urban o enter the effective date of the geographic reclassif	age) status r "2" for r ication in	ural. If ap column 2.	plicable,		1			27.0
5.00	If this is a sole community hospital (SCH), enter th effect in the cost reporting period.	e number of	periods SC	CH status 11	1	0			35.0
	· · · · · · · · · · · · · · · · · · ·				Begin			ing: 00	-
5.00	Enter applicable beginning and ending dates of SCH s		cript line	36 for num		00	۷.	00	36.
7.00	of periods in excess of one and enter subsequent dat If this is a Medicare dependent hospital (MDH), ente		r of period	s MDH statu	IS	0			37.
	is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for t accordance with FY 2016 OPPS final rule? Enter "Y" f	he MDH tran	sitional pa	ayment in					37.
3.00	instructions) If line 37 is 1, enter the beginning and ending date greater than 1, subscript this line for the number o enter subsequent dates.								38.
					Y/			/N 00	_
	Does this facility qualify for the inpatient hospita hospitals in accordance with 42 CFR §412.101(b)(2)(i 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions)), (ii), or the mileage ii)? Enter	(iii)? Ent requiremen in column 2	cer in colur nts in ? "Y" for ye	ime N in 25			N	39.
0.00	Is this hospital subject to the HAC program reductio "N" for no in column 1, for discharges prior to Octo no in column 2, for discharges on or after October 1	ber 1. Ente	r "Y" for y			1	I	N	40.
						V 1.00	XVIII 2.00		-
	Prospective Payment System (PPS)-Capital						2.00	1 3.00	
5.00	Does this facility qualify and receive Capital payme with 42 CFR Section §412.320? (see instructions)	nt for disp	roportionat	e share in	accordance	N	Y	N	45.
5.00	Is this facility eligible for additional payment exc pursuant to 42 CFR §412.348(f)? If yes, complete wks Pt. III.					N	N	N	46.
	Is this a new hospital under 42 CFR §412.300(b) PPS					N	N	N	47.
3.00	Is the facility electing full federal capital paymen Teaching Hospitals	t? Enter "	Y" for yes	or "N" tor	no.	N	N	N	48.
.00	Is this a hospital involved in training residents in periods beginning prior to December 27, 2020, enter cost reporting periods beginning on or after Decembe the instructions. For column 2, if the response to c involved in training residents in approved GME progr and are you are impacted by CR 11642 (or applicable "Y" for yes; otherwise, enter "N" for no in column 2	"Y" for yes r 27, 2020, olumn 1 is ams in the CRs) MA dir	or "N" for under 42 C "Y", or if prior year	no in colu FR 413.78(H this hospin or penultin	umn 1. For (2), see al was nate year,	N			56.
00	For cost reporting periods beginning prior to Decemb is this the first cost reporting period during which at this facility? Enter "Y" for yes or "N" for no i residents start training in the first month of this	er 27, 2020 residents n column 1.	in approved If column ing period?	I GME progra 1 is "Y", (P Enter "Y	ums trained lid				57.

OSPIT	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ТА	Provider Co	F	Period: From 07/01/2022 To 06/30/2023	11/21/2023 1:	pared
					V 1.00	XVIII XIX 0 2.00 3.00	
9.00	Are costs claimed on line 100 of worksheet A? If yes	. comp	lete Wkst. D-2	, Pt. I.	1.00	5 2.00 5.00	59.0
	,	<u>,</u>		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
				1.00	2.00	3.00	
	Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in col is "Y", are you impacted by CR 11642 (or subsequent C adjustment? Enter "Y" for yes or "N" for no in colum If line 60 is yes, complete columns 2 and 3 for each	85? (9 umn 1. CR) NAHI in 2.	see If column 1 E MA payment	Y	N 23.00		60.0
5.01	instructions)						00.0
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports	N			0.00	0.00	61.0
1.02	ending and submitted before March 23, 2010. (see instructions) Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of						61.0
.03	ACA). (see instructions) Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see						61.
.04	instructions) Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61.
	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) Enter the amount of ACA §5503 award that is being						61.0
	used for cap relief and/or FTEs that are nonprimary						01.
	care or general surgery. (see instructions)	Pr	ogram Name	Program Code	Unweighted IME	Unweighted	
					FTE Count	Direct GME FTE Count	
10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME		1.00	2.00	3.00	4.00	61.
20	FTE unweighted count. Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.
	· · · · · · · · · · · · · · · · · · ·					1.00	
	ACA Provisions Affecting the Health Resources and Ser						
.00	Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruct		d in this cost	reporting per	iod for which	0.00	62.0
2.01	Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog	ı Teach Iram. (s	<u>see instructio</u>		your hospital	0.00	62.0
.00	Teaching Hospitals that Claim Residents in Nonprovide Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple	ettings	during this co			N	63.

SPI	TAL AND HOSPITAL HEALTH CARE COMPI	LEX IDENTIFICATION DA	TA Provider C		eriod:	Worksheet S-2	
				F	rom 07/01/2022 o 06/30/2023	Part I Date/Time Pre 11/21/2023 1:	
				Unweighted	Unweighted	Ratio (col. 1/	
				FTES Nonprovider	FTEs in Hospital	(col. 1 + col. 2))	
				Site	HOSPILAI	2))	
				1.00	2.00	3.00	1
	Section 5504 of the ACA Base Yea	r FTE Residents in No	onprovider Settings				
	period that begins on or after J			-	-		
.00	Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to ro settings. Enter in column 2 the resident FTEs that trained in yo of (column 1 divided by (column	ber of unweighted nor tations occurring in number of unweighted ur hospital. Enter ir	-primary care all nonprovider d non-primary care n column 3 the ratio	0.00	0.00	0.00000	64.00
		Program Name	Program Code	Unweighted	Unweighted	Ratio (col. 3/	,
		riogram Mane		FTES	FTES in	(col. 3 + col.	
				Nonprovider	Hospital	4))	
				Site			
		1.00	2.00	3.00	4.00	5.00]
.00	Enter in column 1, if line 63			0.00	0.00	0.00000	65.00
	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)			Unweighted	Unweighted FTEs in	Ratio (col. 1/ (col. 1 + col.	
				Nonprovider	Hospital	2))	
				Site	nosprear		
				1.00	2.00	3.00	1
	Section 5504 of the ACA Current	Year FTE Residents in	n Nonprovider Setting				
. 00	beginning on or after July 1, 20	10	-	0.00			
.00	FTEs attributable to rotations o Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	ccurring in all nonpr unweighted non-primar al. Enter in column 3	rovider settings. ry care resident 3 the ratio of	0.00	0.00	0.00000	00.00
	Corumn I arviaed by (corumn I +	Program Name	Program Code	Unweighted	Unweighted	Ratio (col. 3/	,
				FTES	FTES in	(col. 3 + col.	
				Nonprovider	Hospital	4))	
				Site			
		1.00	2.00	3.00	4.00	5.00	
.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	2.00		0.00			67.00

Health	Financial Systems ASCENSION ST. VINCENT KOKOMO		Ir	n Lieu	u of Form	1 CMS-2	2552-10
	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0010		iod: m 07/01/ 06/30/	2022	Workshee Part I Date/Tir 11/21/20	et S-2 ne Prep	pared:
					1.0	0	
68.00	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (Augus For a cost reporting period beginning prior to October 1, 2022, did you obtain perm MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 8 (August 10, 2022)?	ission	from you		N		68.00
			-	1.00	2.00	3.00	
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF	subaro	ovider2	N			70.00
	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program			IN		0	
/1.00	recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" Column 3: If column 2 is Y, indicate which program year began during this cost repo (see instructions)	for no. teachir for no.	. (see ng			0	71.00
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			N	N	0	76.00
	recent cost reporting period ending on or before November 15, 2004? Enter "Y" for y no. Column 2: Did this facility train residents in a new teaching program in accord CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 indicate which program year began during this cost reporting period. (see instructi	ance wi is Y,					
				-	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.						80.00
	Is this a LTCH co-located within another hospital for part or all of the cost repor "Y" for yes and "N" for no. TEFRA Providers	ting pe	eriod? Er	nter	N N		80.00 81.00
	Is this a new hospital under 42 CFR Section $413.40(f)(1)(i)$ TEFRA? Enter "Y" for Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Se $413.40(f)(1)(i)$? Enter "Y" for yes and "N" for no.		"N" for	no.	N		85.00 86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under sect $1886(d)(1)(B)(vi)$? Enter "Y" for yes or "N" for no.	ion			Ν		87.00
		4	Approved Permane Adjustme (Y/N) 1.00	nt ent	Number Approv Perman Adjustm 2.00	ved lent lents	
88.00	Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and 89. (see instructions)	line	1.00		2.00		88.00
	Column 2: Enter the number of approved permanent adjustments.	ine F	ffective	Date	Approv	ved	
	No.			Date	Adjust Adjust Amount Discha	ent ment Per	
89.00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line number	0.00	2.00		3.0		89.00
	column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the					Ū	
	TEFRA target amount per discharge.		V		XIX		
	Title V and VTV Convious		1.00		2.0		
90.00	Title V and XIX Services Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" f	or	N		Y		90.00
91.00	yes or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through the cost report either i	n	Ν		Y		91.00
92.00	full or in part? Enter "Y" for yes or "N" for no in the applicable column. Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see				N		92.00
93.00	instructions) Enter "Y" for yes or "N" for no in the applicable column. Does this facility operate an ICF/IID facility for purposes of title V and XIX? Ent	er	N		N		93.00
94.00	"Y" for yes or "N" for no in the applicable column. Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the		N		N		94.00
	applicable column. If line 94 is "Y", enter the reduction percentage in the applicable column. Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the		0.00 N		0.0 N	0	95.00 96.00
97.00	applicable column. If line 96 is "Y", enter the reduction percentage in the applicable column.		0.00		0.0	0	97.00

ealth Financial Systems ASCENSION ST. V IOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C	CN: 15-0010	Period: From 07/01/2022 To 06/30/2023	u of Form CMS Worksheet S- Part I Date/Time Pr 11/21/2023 1	2 epared
			V	XIX	_
18.00 Does title V or XIX follow Medicare (title XVIII) for the i	ntowns and was	idante nost	1.00	2.00	0.00
stepdown adjustments on wkst. B, Pt. I, col. 25? Enter "Y" column 1 for title V, and in column 2 for title XIX.	for yes or "N"	for no in	N	Y	98.0
18.01 Does title V or XIX follow Medicare (title XVIII) for the r C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for t title XIX.	itle V, and in	column 2 for		Y	98.0
18.02 Does title V or XIX follow Medicare (title XVIII) for the c bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes for title V, and in column 2 for title XIX.	or "N" for no	in column 1	N	Y	98.0
18.03 Does title V or XIX follow Medicare (title XVIII) for a cri reimbursed 101% of inpatient services cost? Enter "Y" for y for title V, and in column 2 for title XIX.				N	98.
18.04 Does title V or XIX follow Medicare (title XVIII) for a CAH outpatient services cost? Enter "Y" for yes or "N" for no i in column 2 for title XIX.			Ν	N	98.
18.05 Does title V or XIX follow Medicare (title XVIII) and add b Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 2 for title XIX.			Y	98.	
18.06 Does title V or XIX follow Medicare (title XVIII) when cost Pts. I through IV? Enter "Y" for yes or "N" for no in colum column 2 for title XIX.		Ν	Y	98.	
Rural Providers					-
.05.00 Does this hospital qualify as a CAH? .06.00 If this facility qualifies as a CAH, has it elected the all for outpatient services? (see instructions)	-inclusive met	hod of paymen	t		105. 106.
07.00 Column 1: If line 105 is Y, is this facility eligible for c training programs? Enter "Y" for yes or "N" for no in colum Column 2: If column 1 is Y and line 70 or line 75 is Y, do approved medical education program in the CAH's excluded I	n 1. (see ins you train I&R PF and/or IRF	tructions) s in an			107.
Enter "Y" for yes or "N" for no in column 2. (see instruct 08.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	CRNA fee sche	1	N		108.
	Physical 1.00	Occupationa		Respiratory 4.00	-
.09.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	1.00	Occupationa 2.00	1 Speech 3.00	Respiratory 4.00	
therapy services provided by outside supplier? Enter "Y"	1.00			4.00	
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	1.00 al Demonstrati "Y" for yes or	2.00 on project (§ "N" for no.	3.00 410A If yes,		109.
<pre>therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy10.00 Did this hospital participate in the Rural Community Hospit Demonstration)for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and worksheet E, Part A, lines 200 th</pre>	1.00 al Demonstrati "Y" for yes or	2.00 on project (§ "N" for no.	3.00 410A If yes, ugh 215, as	4.00 1.00 N	109.
<pre>therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy10.00 Did this hospital participate in the Rural Community Hospit Demonstration)for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and worksheet E, Part A, lines 200 th</pre>	1.00 al Demonstrati "Y" for yes or orksheet E-2, 1 the Frontier C cost reporting column 1 is Y, irticipating in	2.00 on project (§ "N" for no. ines 200 thro ommunity period? Enter enter the column 2.	3.00 410A If yes, ugh 215, as 1.00 N	4.00	 109. 110. 111.
<pre>therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy. 10.00 Did this hospital participate in the Rural Community Hospit Demonstration)for the current cost reporting period? Enter complete worksheet E, Part A, lines 200 through 218, and wo applicable. 11.00 If this facility qualifies as a CAH, did it participate in 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 pa Enter all that apply: "A" for Ambulance services; "B" for a </pre>	1.00 al Demonstrati "Y" for yes or orksheet E-2, 1 the Frontier C cost reporting column 1 is Y, irticipating in	2.00 on project (§ "N" for no. ines 200 thro ommunity period? Enter enter the column 2.	3.00 410A If yes, ugh 215, as 1.00 N	4.00 1.00 N	109. 110.
<pre>therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy. 10.00 Did this hospital participate in the Rural Community Hospit Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable. 11.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this c "Y" for yes or "N" for no in column 1. If the response to c integration prong of the FCHIP demo in which this CAH is pa Enter all that apply: "A" for Ambulance services; "B" for a for tele-health services. 12.00 Did this hospital participate in the Pennsylvania Rural Hea (PARHM) demonstration for any portion of the current cost r period? Enter "Y" for yes or "N" for no in column 1. If c "Y", enter in column 2, the date the hospital began partici demonstration. In column 3, enter the date the hospital ce</pre>	1.00 al Demonstrati "Y" for yes or rksheet E-2, 1 the Frontier C cost reporting column 1 is Y, urticipating in dditional beds alth Model reporting column 1 is pating in the	2.00 on project (§ "N" for no. ines 200 thro ommunity period? Enter enter the column 2. ; and/or "C"	3.00 410A If yes, ugh 215, as 1.00 N	4.00 1.00 N 2.00	
<pre>therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy. 10.00 Did this hospital participate in the Rural Community Hospit Demonstration)for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable. 11.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this c "Y" for yes or "N" for no in column 1. If the response to c integration prong of the FCHIP demo in which this CAH is pa Enter all that apply: "A" for Ambulance services; "B" for a for tele-health services. 12.00 Did this hospital participate in the Pennsylvania Rural Hea (PARHM) demonstration for any portion of the current cost r period? Enter "Y" for yes or "N" for no in column 1. If c "Y", enter in column 2, the date the hospital began partici demonstration. In column 3, enter the date the hospital ce participation in the demonstration, if applicable.</pre>	1.00 al Demonstrati "Y" for yes or rksheet E-2, 1 the Frontier C cost reporting column 1 is Y, urticipating in dditional beds alth Model reporting column 1 is pating in the	2.00 on project (§ "N" for no. ines 200 thro ommunity period? Enter enter the column 2. ; and/or "C" 1.00	3.00 410A If yes, ugh 215, as 1.00 N	4.00 1.00 N 2.00	
<pre>therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy. 10.00 Did this hospital participate in the Rural Community Hospit Demonstration)for the current cost reporting period? Enter complete worksheet E, Part A, lines 200 through 218, and wo applicable. 11.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this c "Y" for yes or "N" for no in column 1. If the response to c integration prong of the FCHIP demo in which this CAH is pa Enter all that apply: "A" for Ambulance services; "B" for a for tele-health services. 12.00 Did this hospital participate in the Pennsylvania Rural Hea (PARHM) demonstration for any portion of the current cost r period? Enter "Y" for yes or "N" for no in column 1. If c "Y", enter in column 2, the date the hospital began partici demonstration. In column 3, enter the date the hospital ce participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information 15.00 Is this an all-inclusive rate provider? Enter "Y" for yes c in column 1. If column 1 is yes, enter the method used (A, in column 2. If column 2 is "E", enter in column 3 either " for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provide</pre>	1.00 al Demonstrati "Y" for yes or rksheet E-2, 1 the Frontier C cost reporting column 1 is Y, rticipating in dditional beds alth Model reporting column 1 is pating in the ased or "N" for no B, or E only) 93" percent (includes	2.00 on project (§ "N" for no. ines 200 thro ommunity period? Enter enter the column 2. ; and/or "C" 1.00	3.00 410A If yes, ugh 215, as 1.00 N	4.00 1.00 N 2.00 3.00	109. 110. 111. 111.
 therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy. 10.00 Did this hospital participate in the Rural Community Hospit Demonstration) for the current cost reporting period? Enter complete worksheet E, Part A, lines 200 through 218, and wo applicable. 11.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this c "Y" for yes or "N" for no in column 1. If the response to integration prong of the FCHIP demo in which this CAH is pa Enter all that apply: "A" for Ambulance services; "B" for a for tele-health services. 12.00 Did this hospital participate in the Pennsylvania Rural Hea (PARHM) demonstration for any portion of the current cost r period? Enter "Y" for yes or "N" for no in column 1. If c "Y", enter in column 2, the date the hospital began partici demonstration. In column 3, enter the date the hospital ce participation in the demonstration is column 1. If column 1 is yes, enter the method used (A, in column 1. If column 1 is yes, enter the method used (A, in column 2. If column 2 is "E", enter in colum 3 either " for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provide the definition in CMS Pub.15-1, chapter 22, §2208.1. 	1.00 al Demonstrati "Y" for yes or orksheet E-2, 1 the Frontier C cost reporting column 1 is Y, irticipating in dditional beds alth Model reporting column 1 is pating in the ased or "N" for no B, or E only) 93" percent (includes rrs) based on	2.00 on project (§ "N" for no. ines 200 thro ommunity period? Enter enter the column 2. ; and/or "C" 1.00 N	3.00 410A If yes, ugh 215, as 1.00 N	4.00 1.00 N 2.00 3.00	109. 110.
 therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy. 10.00 Did this hospital participate in the Rural Community Hospit Demonstration) for the current cost reporting period? Enter complete worksheet E, Part A, lines 200 through 218, and Wo applicable. 11.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this c "Y" for yes or "N" for no in column 1. If the response to c integration prong of the FCHIP demo in which this CAH is pa Enter all that apply: "A" for Ambulance services; "B" for a for tele-health services. 12.00 Did this hospital participate in the Pennsylvania Rural Hea (PARHM) demonstration for any portion of the current cost r period? Enter "Y" for yes or "N" for no in column 1. If c "Y", enter in column 2, the date the hospital began partici demonstration. In column 3, enter the date the hospital ce participation in the demonstration if applicable. Miscellaneous Cost Reporting Information 15.00 Is this an all-inclusive rate provider? Enter "Y" for yes c in column 1. If column 1 is yes, enter the method used (A, in column 2. If column 2 is "E", enter in column 3 either " for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provide the definition in CMS Pub.15-1, chapter 22, §2208.1. 16.00 Is this facility classified as a referral center? Enter "Y" 	1.00 al Demonstrati "Y" for yes or orksheet E-2, 1 the Frontier C cost reporting column 1 is Y, irticipating in additional beds alth Model reporting column 1 is pating in the tased or "N" for no B, or E only) 93" percent (includes irs) based on for yes or irance? Enter	2.00 on project (§ "N" for no. ines 200 thro ommunity period? Enter enter the column 2. ; and/or "C" 1.00 N	3.00 410A If yes, ugh 215, as 1.00 N	4.00 1.00 N 2.00 3.00	109. 110. 1110. 1111. 1112. 0 1115.

alth Financial Systems ASCENSION ST. VINC	<u>ENT KOKOMO</u> Provider CC		Period: From 07/01/2022 To 06/30/2023		5-2 Prepared
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
18.01 List amounts of malpractice premiums and paid losses:			0 0	956,8	354 118.0
			1.00	2.00	
18.02 Are malpractice premiums and paid losses reported in a cost cen Administrative and General? If yes, submit supporting schedula and amounts contained therein.			N		118.0
19.00 DO NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold H. §3121 and applicable amendments? (see instructions) Enter in co "N" for no. Is this a rural hospital with < 100 beds that qual Hold Harmless provision in ACA §3121 and applicable amendments" Enter in column 2, "Y" for yes or "N" for no.	olumn 1, "Y' ifies for th	" for yes or ne Outpatient	N	N	119.0 120.0
21.00 Did this facility incur and report costs for high cost implant: patients? Enter "Y" for yes or "N" for no.	able devices	s charged to	Y		121.0
22.00 Does the cost report contain healthcare related taxes as define Act?Enter "Y" for yes or "N" for no in column 1. If column 1 i			Y	5.00	122.0
<pre>the Worksheet A line number where these taxes are included. 23.00 Did the facility and/or its subproviders (if applicable) purch services, e.g., legal, accounting, tax preparation, bookkeepin management/consulting services, from an unrelated organization for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., g professional services expenses, for services purchased from un located in a CBSA outside of the main hospital CBSA? In column "N" for no.</pre>	g, payroll, ? In column reater than related orga	and/or 1, enter "Y" 50% of total anizations			123.0
Certified Transplant Center Information 25.00 Does this facility operate a Medicare-certified transplant cen	ter? Enter '	"Y" for ves	N		125.0
and "N" for no. If yes, enter certification date(s) (mm/dd/yyy 26.00 If this is a Medicare-certified kidney transplant program, ent	/) below.	-			126.0
in column 1 and termination date, if applicable, in column 2. 27.00 If this is a Medicare-certified heart transplant program, ente	r the certif	fication date			127.0
in column 1 and termination date, if applicable, in column 2. 28.00 If this is a Medicare-certified liver transplant program, ente in column 1 and termination date, if applicable, in column 2.	r the certif	fication date			128.0
9.00 If this is a Medicare-certified lung transplant program, enter in column 1 and termination date, if applicable, in column 2.	the certifi	ication date			129.
30.00 If this is a Medicare-certified pancreas transplant program, en date in column 1 and termination date, if applicable, in column		rtification			130.
31.00 If this is a Medicare-certified intestinal transplant program, date in column 1 and termination date, if applicable, in column	enter the o 1 2.				131.
If this is a Medicare-certified islet transplant program, ente in column 1 and termination date, if applicable, in column 2.	r the certi	fication date			132.
33.00 Removed and reserved 34.00 If this is a hospital-based organ procurement organization (OPI in column 1 and termination date, if applicable, in column 2. All Providers	D), enter th	ne OPO number			133. 134.
40.00 Are there any related organization or home office costs as def chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes are claimed, enter in column 2 the home office chain number. (s	s, and home	office costs	Y	15н046	140.
1.00 2.00 If this facility is part of a chain organization, enter on lin home office and enter the home office contractor name and cont		er.			
H1.00 Name: ST VINCENT HEALTH Contractor's Name: WPS H2.00 Street: 250 W 96TH STREET, SUITE 215 PO Box:		Contracto	or's Number:0810)1	141.
3.00 City: INDIANAPOLIS State: IN		Zip Code:	4626	50	143.
				1.00	-
4.00 Are provider based physicians' costs included in Worksheet A?				Y	144.0
			1.00	2.00	_
I5.00 If costs for renal services are claimed on Wkst. A, line 74, a inpatient services only? Enter "Y" for yes or "N" for no in co no, does the dialysis facility include Medicare utilization fo population for the service or "N" for no in column.	lumn 1. If d	column 1 is	Y	N	145.
period? Enter "Y" for yes or "N" for no in column 2. 46.00 Has the cost allocation methodology changed from the previously Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15- yes, enter the approval date (mm/dd/yyyy) in column 2.			N		146.

Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLE		VINCENT KOKOMO Provider C	CN: 15-0010	Period		u of Form CMS Worksheet S-	
				From 0	7/01/2022 6/30/2023	Part I	epared
						1.00	-
47.00 was there a change in the statist	cal basis? Enter "Y" for	yes or "N" for	no.			N	147.0
48.00 was there a change in the order of	allocation? Enter "Y" f	for yes or "N" f	² or no.			N	148.0
49.00 was there a change to the simplif	ed cost finding method?	Enter "Y" for y	es or "N" f	or no.		N	149.0
		Part A	Part B	; Т	itle V	Title XIX	
		1.00	2.00		3.00	4.00	_
Does this facility contain a prov or charges? Enter "Y" for yes or '							
55.00 Hospital		N	N		N	N	155.0
.56.00 Subprovider - IPF		N	N		Ν	N	156.0
.57.00 Subprovider - IRF		N	N		N	N	157.0
58.00 SUBPROVIDER							158.0
59.00 SNF		N	N		N	N	159.0
L60.00 HOME HEALTH AGENCY		N	N		N	N	160.0
61.00 CMHC			N		N	N	101.0
						1.00	
Multicampus						1	
65.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	impus hospital that has c	one or more camp	ouses in dif	ferent CE	3SAs?	N	165.0
	Name	County		Zip Code	CBSA	FTE/Campus	
	0	1.00	2.00	3.00	4.00	5.00	
66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.0	00166.0
					1	1.00	-
Health Information Technology (HI) incentive in the Ameri	ican Recovery ar	nd Reinvestr	nent Act			
.67.00 Is this provider a meaningful user	under §1886(n)? Enter	"Y" for yes or	"N" for no.			Y	167.0
68.00 If this provider is a CAH (line 10			ne 167 is "Y	"), enter	r the		168.0
reasonable cost incurred for the H							
68.01 If this provider is a CAH and is r					dship		168.0
exception under §413.70(a)(6)(ii) 69.00 If this provider is a meaningful u	ıser (line 167 is "Y") ar				enter the	9.9	99169.0
transition factor. (see instructio	ons)			Bo	qinning	Ending	_
				Бе	1.00	2.00	-
70.00 Enter in columns 1 and 2 the EHR b period respectively (mm/dd/yyyy)	eginning date and ending	date for the r	reporting		1.00	2.00	170.0
					1 00	2.00	_
71 00 tf line 167 is Wyll door this way	ridan hava are dava f	ndividu-1-			1.00	2.00	0171 0
L71.00 If line 167 is "Y", does this prov section 1876 Medicare cost plans n "Y" for yes and "N" for no in colu 1876 Medicare days in column 2. (s	reported on Wkst. S-3, Pt mn 1. If column 1 is yes	. I, line 2, co	ol. 6? Enter		Ν		0171.0

HOSPIT	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0010	Period: From 07/01/2022 To 06/30/2023		
					11/21/2023 1	
				Y/N 1.00	Date 2 00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSE	MENT OUESTION		1.00	2.00	-
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS			er all dates in t	:he	
	Provider Organization and Operation					-
L.00	Has the provider changed ownership immediately prior to the	e beginning of	the cost	N		1.00
	reporting period? If yes, enter the date of the change in o		instructions)			
			Y/N	Date	V/I	
.00	Has the provider terminated participation in the Medicare F	Program? 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.	nn 3, "∨" for				
3.00	Is the provider involved in business transactions, includir contracts, with individuals or entities (e.g., chain home or or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members of of directors through ownership, control, or family and other relationships? (see instructions)	offices, drug der or its of the board	Y			3.00
			Y/N	Туре	Date	
			1.00	2.00	3.00	
	Financial Data and Reports		1			
.00	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, ailable in	Y	A		4.00
.00	Are the cost report total expenses and total revenues different those on the filed financial statements? If yes, submit rec		N			5.0
			1	Y/N 1.00	Legal Oper. 2.00	
	Approved Educational Activities					
5.00	Column 1: Are costs claimed for a nursing program? Column the legal operator of the program?	2: If yes, 19	s the provide	r N		6.0
.00 .00	Are costs claimed for Allied Health Programs? If "Y" see ir Were nursing programs and/or allied health programs approve		ved during the	Y N		7.0
.00	cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved		cal education	N		9.0
.0.00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated of cost reporting period? If yes, see instructions.		the current	Ν		10.0
1.00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	E & R in an App	proved	N		11.0
					Y/N 1.00	
	Bad Debts				1.00	
	Is the provider seeking reimbursement for bad debts? If yes				Y	12.0
	If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.				Ν	13.0
.4.00	If line 12 is yes, were patient deductibles and/or coinsura instructions. Bed Complement	ance amounts wa	aived? If yes	, see	N	14.0
5.00	Did total beds available change from the prior cost reporti	ing period? If	yes, see ins	tructions.	N	15.0
		Par	rt A	Par	tВ	
		Y/N	Date	Y/N	Date	
	PS&R Data	1.00	2.00	3.00	4.00	
6.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through	Y	09/18/2023	Y	09/18/2023	16.0
7.00	date of the PS&R Report used in columns 2 and 4 .(see instructions) Was the cost report prepared using the PS&R Report for	N		N		17.0
	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)					
8.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions	N		N		18.0
9.00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		Ν		19.0

Health	Financial	Systems
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In Lieu of Form CMS-2552-10

Health	Financial Systems ASCENSION ST.	VINCENT KOKOMO		In Lie	eu of Form CM	s-2552-10
HOSPIT	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C		Period: From 07/01/2022 To 06/30/2023		repared:
			iption	Y/N	Y/N	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:)	1.00 N	3.00 N	20.00
	Report data for other: Describe the other adjustments.	Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00		N		N		21.00
	records? If yes, see instructions.					
			`		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC Capital Related Cost	EPT CHILDRENS H	OSPITALS)			
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		als made duri	na the cost		23.00
	reporting period? If yes, see instructions.					
24.00	Were new leases and/or amendments to existing leases enter	ed into during	this cost rep	orting period?		24.00
	If yes, see instructions	-				
25.00		the cost repor	ting period?	If yes, see		25.00
26.00	instructions. Were assets subject to Sec.2314 of DEFRA acquired during t	he cost reporti	ng period? If	yes, see		26.00
	instructions.					
27.00	Has the provider's capitalization policy changed during th copy.	e cost reportin	g period? If	yes, submit		27.00
	Interest Expense					
28.00	were new loans, mortgage agreements or letters of credit e	ntered into dur	ing the cost	reporting		28.00
20.00	period? If yes, see instructions.	band funda (Da	ht Comiso De	comic Fund)		20.00
29.00	Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see inst		DL Service Re	serve Fund)		29.00
30.00	Has existing debt been replaced prior to its scheduled mat		debt? If yes,	see		30.00
31.00	instructions. Has debt been recalled before scheduled maturity without i	ssuance of now	dobt? If yos	500		31.00
51.00	instructions.	ssuance of new	debt: 11 yes,	366		51.00
	Purchased Services				1	
32.00	Have changes or new agreements occurred in patient care se arrangements with suppliers of services? If yes, see instr		d through cor	tractual		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 ap		q to competit	ive bidding? If		33.00
	no, see instructions.					
	Provider-Based Physicians	· · ·			1	
34.00	Were services furnished at the provider facility under an	arrangement wit	h provider-ba	sed physicians?		34.00
35.00	If yes, see instructions. If line 34 is yes, were there new agreements or amended ex	isting agreemen	ts with the r	rovider-based		35.00
55.00	physicians during the cost reporting period? If yes, see i			novider based		55.00
				Y/N	Date	
	Home Office Costs			1.00	2.00	
				Y		36.00
	If line 36 is yes, has a home office cost statement been p	repared by the	home office?	Ŷ		37.00
38.00	If yes, see instructions. If line 36 is yes , was the fiscal year end of the home of	fice different	from that of	N		38.00
	the provider? If yes, enter in column 2 the fiscal year en	d of the home o	ffice.			
39.00	If line 36 is yes, did the provider render services to oth see instructions.	er chain compon	ents? If yes,	N		39.00
40.00	If line 36 is yes, did the provider render services to the instructions.	home office?	If yes, see	Ν		40.00
			00		00	
	Cost Report Preparer Contact Information	1.	00	2	.00	
41.00	Enter the first name, last name and the title/position	JILL		HILL		41.00
	held by the cost report preparer in columns 1, 2, and 3,					
42.00	respectively. Enter the employer/company name of the cost report	ти			42.00	
42.00	preparer.	ASCENSION HEAL	IN			42.00
43.00	report preparer in columns 1 and 2, respectively.	NOT APPLICABLE		JILL.HILL1@ASC	CENSION.ORG	43.00

Health F	Financial Systems	ASCENSION ST.	VINC	ENT KOKOM	10		In Lieu	u of Form CMS-	2552-10
HOSPITA	IL AND HOSPITAL HEALTH CARE REIMBURSEMENT Q	JESTIONNAIRE		Provider	CCN: 15-0010	Peri From To	od: 07/01/2022 06/30/2023	Worksheet S-2 Part II Date/Time Pre 11/21/2023 1:	pared:
					3.00				
C	Cost Report Preparer Contact Information				5.00				
ł	Enter the first name, last name and the tit held by the cost report preparer in columns respectively.			AGER NET AGEMENT	REVENUE				41.00
42.00 E	Enter the employer/company name of the cost preparer.	report							42.00
43.00 E	Enter the telephone number and email addres report preparer in columns 1 and 2, respect								43.00

	Financial Systems A TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	SCENSION ST. V	Provider C	CNI 15-0010	Period:	u of Form CMS-2 Worksheet S-3	
HUSPII	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider Co	LN: 15-0010	From 07/01/2022	Part I	
					то 06/30/2023	Date/Time Pre 11/21/2023 1:4	
						I/P Days / O/P Visits / Trips	
	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH/REH Hours	Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	PART I - STATISTICAL DATA Hospital Adults & Peds. (columns 5, 6, 7 and	30.00	98	35,77	0.00	0	1.00
1.00	8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	50		0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation		98	35,77	0.00	0	7.00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	31.00	13	4,74	5 0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00 13.00	OTHER SPECIAL CARE (SPECIFY)	43.00				0	12.00
14.00	NURSERY Total (see instructions)	43.00	111	40 51	.5 0.00	-	14.00
15.00	CAH visits		TTT	40,51		0	15.00
15.10	REH hours and visits					0	15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	41.00	18	6,57	0	0	
18.00	SUBPROVIDER				-		18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	80.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26)	89.00	129			0	26.25
27.00	Observation Bed Days		129			0	27.00
29.00	Ambulance Trips					0	29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		8	2,92	0		32.00
32.01	Total ancillary labor & delivery room		0				32.01
	outpatient days (see instructions)						
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30.00	0		0	0	34.00

PART I - Hospital 8 exclud Hospice for the for the 1.00 Hospice for the for the 1.00 HMO and 3.00 HMO IRF 1.00 Hospital 5.00 Hospital 0.00 Hospital 0.00 Beds) (s 3.00 0.00 BURN INT 1.00 SURGICAL 2.00 0.00 SUBROVI 5.00 CAH visi 5.00 SUBPROVI 8.00 SUBPROVI 8.00 SUBPROVI 8.00 SUBPROVI 8.00 SUBPROVI 9.00 SKILLED 00.00 1.00 CMAC 6.00<	ND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC		Period: From 07/01/2022 To 06/30/2023	Worksheet S-3 Part I Date/Time Pre 11/21/2023 1:	pared
PART I - Hospital 8 exclud Hospice for the for the 1.00 Hospice for the for the 1.00 HMO and 3.00 HMO IRF 1.00 Hospital 5.00 Hospital 0.00 Hospital 0.00 Beds) (s 3.00 0.00 BURN INT 1.00 SURGICAL 2.00 0.00 SUBROVI 5.00 CAH visi 5.00 SUBPROVI 8.00 SUBPROVI 8.00 SUBPROVI 8.00 SUBPROVI 8.00 SUBPROVI 9.00 SKILLED 00.00 1.00 CMAC 6.00<		I/P Days	/ O/P Visits	/ Trips	Full Time B	Equivalents	
00 Hospital 8 exclud Hospice for the for the 00 HMO and 00 HMO IPF 00 HMO IRF 00 HOSpital 00 INTENSIV 00 CORONARY 00 BURN INT 00 SURGICAL 200 OTHER SF 00 NURSERY 00 SUBPROVI 00 CAH visi 00 SUBPROVI 00 SU	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
00 Hospital 8 exclud Hospice for the for the 00 HMO and 00 HMO IPF 00 HMO IRF 00 HOSpital 00 INTENSIV 00 CORONARY 00 BURN INT 00 SURGICAL 200 OTHER SF 00 NURSERY 00 SUBPROVI 00 CAH visi 00 SUBPROVI 00 SU		6.00	7.00	8.00	9.00	10.00	
8 excluc Hospice for the 100 HMO and 100 HMO IPF 100 HMO IPF 100 HOSpital 100 SUBPONI 11.00 SUBPROVI 12.00 CAH VISI 5.00 CAH VISI 5.00 CAH VISI 5.00 SUBPROVI 3.00 SUBPROVI 3.00 SUBPROVI 3.00 SUBPROVI 3.00 MOSLLED 0.000 SUBPROVI 3.00 AMBULATC 4.10	I - STATISTICAL DATA		1		-1		
2.00 HMO and 8.00 HMO IPF 1.00 HMO IRF 5.00 Hospital 5.00 Hospital 5.00 Hospital 5.00 Total Ad beds) (s) 5.00 INTENSIV 0.00 CORONARY 0.00 SURN INT 1.00 SURGICAL 2.00 OTHER SF 3.00 NURSERY 4.00 Total (s) 5.10 REH hour 6.00 SUBPROVI 7.00 SUBPROVI 8.00 SUBPROVI 9.00 SKILLED 0.00 NURSING 11.00 SHUELD 0.00 NURSING 11.00 SHILED 0.00 NURSING 12.00 HOME HEA 23.00 AMBULATC 44.00 HOSPICE 5.00 CMFC - C 60.00 Employee 10 Emp	oital Adults & Peds. (columns 5, 6, 7 and cclude Swing Bed, Observation Bed and pice days)(see instructions for col. 2	4,348	226	13,61	6		1.0
8.00 HMO IPF 4.00 HMO IRF 5.00 Hospital 5.00 Hospital 5.00 Total Ac beds) (s) 5.00 INTENSIV 5.00 CORONARY 5.00 SUBPROVI 5.00 CONTERSP 3.00 NURSERY 4.00 Total 5.10 REH hour 6.00 SUBPROVI 7.00 SUBPROVI 7.00 SUBPROVI 8.00 SUBPROVI 8.00 SUBPROVI 9.00 SKILLED 9.00 SKILLED 9.00 MORSING 1.00 OTHER LC 24.00 HOSPICE 44.10 HOSPICE 5.00 CMHC - C 6.00 RURAL HE 6.25 FEDERALL 7.00 Total 58.00 Observat 60.00 Employee 1.00 Emplo	the portion of LDP room available beds)	4 627	4 000				
1.00 HMO IRF 5.00 Hospital 5.00 Hospital 5.00 Total Ac beds) (s) 5.00 INTENSIV 5.00 CORONARY 5.00 CORONARY 5.00 CORONARY 5.00 CORONARY 5.00 CORONARY 5.00 CAH VISI 5.10 REH hour 6.00 SUBPROVI 7.00 SUBPROVI 7.00 SUBPROVI 7.00 SUBPROVI 8.00 NURSING 9.00 SKILLED 9.00 SKILLED 9.00 MBULATC 24.00 HOSPICE 25.00 CMHC - C 26.00 RURAL HE 27.00 Total (s) 28.00 Observat 29.00 Ambulance 29.00 Ambulance 29.00 Ambulance 20.00 Employee 30.00	and other (see instructions)	4,637	4,008				2.0
5.00 Hospital 5.00 Hospital 6.00 Total Ac beds) (s 7.00 Total Ac beds) (s 7.00 Total Ac beds) (s 8.00 INTENSIV 0.00 CORONARY 1.00 SURGICAL 2.00 OTHER SF 3.00 NURSERY 4.00 Total (s 5.00 CAH visi 5.10 REH hour 6.00 SUBPROVI 7.00 SUBPROVI 9.00 SKILLED 00.00 NURSING 1.00 OTHER LC 2.00 HOME HEA 3.00 AMBULATC 24.00 HOSPICE 25.00 CMHC - C 66.00 RURAL HE 25.00 CMHC - C 66.00 RURAL HE 29.00 Ambulanc 60.00 Employee 1.00 Em	IPF Subprovider	751	0				3.0
5.00 Hospital 7.00 Total AC beds) (s 0.00 Total AC beds) (s 0.00 INTENSIV 0.00 BURN INT 1.00 SURGICAL 2.00 OTHER SF 3.00 NURSERY 4.00 Total (s 5.00 CAH visi 5.10 REH hour 6.00 SUBPROVI 7.00 SUBPROVI 7.00 SUBPROVI 6.00 NURSING 0.00 OTHER LC 2.00 HOME HEA 3.00 AMBULATC 4.10 HOSPICE 5.00 CMHC - C 6.00 RURAL HE 5.00 CMHC - C 6.00 RURAL HE 5.00 CMHC - C 6.00 RURAL HE 6.00 BURAL 6.00 BURAL 6.00 Employee 1.00 Employee </td <td>IRF Subprovider</td> <td>751</td> <td>230</td> <td></td> <td>0</td> <td></td> <td>4.0</td>	IRF Subprovider	751	230		0		4.0
7.00 Total Action beds) (s) beds) (s) 0.00 CORONARY 0.00 BURN INT 1.100 SURGICAL 2.00 OTHER SP 3.00 NURSERY 4.00 Total (s) 5.00 CAH visi 5.10 REH hour 6.00 SUBPROVI 7.00 SUBPROVI 7.00 SUBPROVI 8.00 SUBPROVI 9.00 SKILLED 0.00 OTHER LC 2.00 HOME HEA 3.00 AMBULATC 4.00 HOSPICE 5.00 CMHC - C 6.00 RURAL HE 5.00 CMHC - C 6.00 RURAL HE 5.00 CMHC - C 6.00 RURAL HE 5.00 CMHC - C 6.00 BURAL HE 7.00 Total (s) 8.00 Observat 9.00	vital Adults & Peds. Swing Bed SNF	0	0		0		5.0
beds) (s 8.00 INTENSIV 9.00 CORONARY 0.00 BURN INT 11.00 SURGICAL 2.00 OTHER SF 3.00 NURSERY 4.00 Total (s 5.00 CAH visi 5.10 REH hour 6.00 SUBPROVI 7.00 SUBPROVI 8.00 SKILLED 9.00 SKILLED 9.00 SKILLED 21.00 HOME HEA 23.00 AMBULATC 24.00 HOSPICE 24.00 HOSPICE 25.00 CMHC - C 26.00 RURAL HE 25.00 CMHC - I 27.00 Total (s 28.00 Observat 29.00 Ambulance 29.00 Ambulance 20.00 Employee 21.00 Employee	vital Adults & Peds. Swing Bed NF Al Adults and Peds. (exclude observation	4,348	226	13,61	•		6.0
B.00 INTENSIV 0.00 CORONARY 0.00 BURN INT 1.100 SURGICAL 2.000 OHRN INT 1.100 SURGICAL 2.000 OHER SP 3.00 NURSERY 4.00 Total (s 5.00 CAH visi 5.10 REH hour 6.00 SUBPROVI 7.00 SUBPROVI 8.00 SUBPROVI 9.00 SKILLED 9.00 SKILLED 0.00 NURSING 1.00 OTHER LC 2.00 HOME HEA 3.00 AMBULATC 4.10 HOSPICE 5.00 CMHC - C 5.00 CMHC - I 5.00	s) (see instructions)	4,540	220	15,01	.0		/ /.0
0.00 CORONARY 0.00 BURN INT 1.00 SURGICAL 2.00 OTHER SF 3.00 NURSERY 4.00 Total (S 5.00 CAH visi 5.10 REH hour 6.00 SUBPROVI 7.00 SUBPROVI 9.00 SKILLED 00.00 NURSING 1.00 OTHER LC 2.00 HOME HEA 3.00 AMBULATC 24.10 HOSPICE 5.00 CMHC - C 26.00 RURAL HE 27.00 Total (S 28.00 Observat 29.00 Ambulanc 29.00 Ambulanc 29.00 Ambulanc 20.00 Employee 20.00 Labor &	ENSIVE CARE UNIT	572	210	2,14	5		8.0
0.00 BURN INT 1.00 SURGICAL 2.00 OTHER SF 3.00 NURSERY 4.00 Total (sc 5.00 CAH visi 5.10 REH hour 6.00 SUBPROVI 7.00 SUBPROVI 7.00 SUBPROVI 9.00 SKILLED 0.00 NURSING 1.00 OTHER LC 2.00 HOME HEA 3.00 AMBULATC 24.00 HOSPICE 25.00 CMHC - C 26.00 RURAL HE 27.00 Total (sc 28.00 Observat 29.00 Ambulanc 29.00 Ambulanc 29.00 Employee 31.00 Employee 32.00 Absultance	DNARY CARE UNIT	572	210	2,17	5		9.0
1.00 SURGICAL 2.00 OTHER SF 3.00 NURSERY 4.00 Total (s 5.00 CAH visi 5.10 REH hour 6.00 SUBPROVI 7.00 SUBPROVI 9.00 SKILLED 0.00 NURSING 1.00 OTHER LC 2.00 HOME HEA 3.00 AMBULATC 4.00 HOSPICE 4.10 HOSPICE 5.00 CMHC - C 6.00 RURAL HE 6.25 FEDERALL 7.00 Total (s 8.00 Observat 9.00 Ambulanc 0.00 Employee 1.00 Employee 2.00 Labor &	I INTENSIVE CARE UNIT						10.0
2.00 OTHER SF 3.00 NURSERY 4.00 Total (s 5.00 CAH visi 5.10 REH hour 6.00 SUBPROVI 7.00 SUBPROVI 9.00 SKILLED 0.00 NURSIG 1.00 OTHER LC 2.00 HOME HEA 3.00 AMBULATC 4.00 HOSPICE 4.10 HOSPICE 5.00 CMHC - C 6.00 RURAL HE 6.25 FEDERALL 7.00 Total (s 8.00 Observat 9.00 Ambloge 1.00 Employee 1.00 Employee 2.00 Labor &	GICAL INTENSIVE CARE UNIT						11.0
3.00 NURSERY 4.00 Total (s 5.00 CAH visi 5.10 REH hour 6.00 SUBPROVI 7.00 SUBPROVI 8.00 SUBPROVI 9.00 SKILLED 0.00 NURSING 1.00 OTHER LC 2.00 HOME HEA 3.00 AMBULATC 4.10 HOSPICE 5.00 CMHC - C 6.00 RURAL HE 6.25 FEDERALL 7.00 Total (s 8.00 Observat 9.00 Ambulanc 0.00 Employee 1.00 Employee 2.00 Labor &	R SPECIAL CARE (SPECIFY)						12.0
4.00 Total (s 5.00 CAH visi 5.10 REH hour 6.00 SUBPROVI 7.00 SUBPROVI 8.00 SUBPROVI 9.00 SKILLED 0.00 NURSING 1.00 OTHER LC 2.00 HOME HEA 3.00 AMBULATC 4.00 HOSPICE 4.10 HOSPICE 5.00 CMHC - C 6.00 RURAL HE 6.25 FEDERALL 7.00 Total (s 8.00 Observat 9.00 Ambulanc 9.00 Ambulance 9.00 Ambulance 9.00 Employee 1.00 Employee 2.00 Labor &			62	1,19	2		13.0
5.00 CAH visi 5.10 REH hour 6.00 SUBPROVI 7.00 SUBPROVI 8.00 SUBPROVI 9.00 SKILLED 0.00 NURSING 1.00 OTHER LC 2.00 HOME HEA 3.00 AMBULATC 4.00 HOSPICE 4.10 HOSPICE 5.00 CMHC - C 6.00 RURAL HE 6.25 FEDERALL 7.00 Total (s 8.00 Observat 9.00 Ambulanc 0.00 Employee 2.00 Labor &	al (see instructions)	4,920	498	16,95		405.99	
5.10 REH hour 6.00 SUBPROVI 7.00 SUBPROVI 8.00 SUBPROVI 9.00 SKILLED 0.00 NURSING 1.00 OTHER LC 2.00 HOME HEA 3.00 AMBULATC 4.00 HOSPICE 4.10 HOSPICE 5.00 CMHC - C 6.00 RURAL HE 6.25 FEDERALL 7.00 Total (s 8.00 Observat 9.00 Ambulanc 0.00 Employee 2.00 Labor &		0	0		0		15.0
6.00 SUBPROVI 7.00 SUBPROVI 8.00 SUBPROVI 9.00 SKILLED 0.00 NURSING 1.00 OTHER LC 2.00 HOME HEA 3.00 AMBULATC 4.00 HOSPICE 4.10 HOSPICE 5.00 CMHC - C 6.00 RURAL HE 6.25 FEDERALL 7.00 Total (s 8.00 Observat 9.00 Ambulanc 0.00 Employee 1.00 Employee 2.00 Labor &	hours and visits				-		15.
7.00 SUBPROVI 8.00 SUBPROVI 9.00 SKILLED 0.00 NURSING 1.00 OTHER LC 2.00 HOME HEA 3.00 AMBULATC 4.00 HOSPICE 4.10 HOSPICE 5.00 CMHC - C 6.00 RURAL HE 6.25 FEDERALL 7.00 Total (s 8.00 Observat 9.00 Ambulanc 0.00 Employee 1.00 Employee 2.00 Labor &	PROVIDER - IPF						16.0
8.00 SUBPROVI 9.00 SKILLED 0.00 NURSING 1.00 OTHER LC 2.00 HOME HEA 3.00 AMBULATC 4.00 HOSPICE 5.00 CMHC - C 6.00 RURAL HE 6.25 FEDERALL 7.00 Total (s 8.00 Observat 9.00 Ambulanc 0.00 Employee 1.00 Employee 2.00 Labor &	PROVIDER - IRF	1,858	53	3,68	3 0.00	0.00	17.0
0.00 NURSING 1.00 OTHER LC 2.00 HOME HEA 3.00 AMBULATC 4.00 HOSPICE 4.10 HOSPICE 5.00 CMHC - C 6.00 RURAL HE 6.25 FEDERALL 7.00 Total (s 8.00 Observat 9.00 Ambulanc 0.00 Employee 1.00 Employee 2.00 Labor &	PROVIDER						18.0
1.00 OTHER LC 2.00 HOME HEA 3.00 AMBULATC 4.00 HOSPICE 4.10 HOSPICE 5.00 CMHC - C 6.00 RURAL HE 6.25 FEDERALL 7.00 Total (s 8.00 Observat 9.00 Ambulance 0.00 Employee 1.00 Labor &	LED NURSING FACILITY						19.
2.00 HOME HEA 3.00 AMBULATC 4.00 HOSPICE 5.00 CMHC - C 6.00 RURAL HE 6.25 FEDERALL 7.00 Total (s 8.00 Observat 9.00 Ambulanc 0.00 Employee 1.00 Employee 2.00 Labor &	SING FACILITY						20.0
3.00 AMBULATC 4.00 HOSPICE 4.10 HOSPICE 5.00 CMHC - C 6.00 RURAL HE 6.25 FEDERALL 7.00 Total (s 8.00 Observat 9.00 Ambulance 0.00 Employee 1.00 Employee 2.00 Labor &	ER LONG TERM CARE						21.
4.00 HOSPICE 4.10 HOSPICE 5.00 CMHC - C 6.00 RURAL HE 6.25 FEDERALL 7.00 Total (s 8.00 Observat 9.00 Ambulance 9.00 Employee 1.00 Employee 2.00 Labor &	HEALTH AGENCY						22.
4.10 HOSPICE 5.00 CMHC - C 6.00 RURAL HE 6.25 FEDERALL 7.00 Total (s 8.00 Observat 9.00 Ambulanc 0.00 Employee 1.00 Employee 2.00 Labor &	JLATORY SURGICAL CENTER (D.P.)						23.
5.00 CMHC - C 6.00 RURAL HE 6.25 FEDERALL 7.00 Total (s 8.00 Observat 9.00 Ambulanc 0.00 Employee 1.00 Employee 2.00 Labor &	PICE						24.
6.00 RURAL HE 6.25 FEDERALL 7.00 Total (s 8.00 Observat 9.00 Ambulanc 0.00 Employee 2.00 Labor &	PICE (non-distinct part)			7	6		24.
6.25 FEDERALL 7.00 Total (s 8.00 Observat 9.00 Ambulanc 0.00 Employee 1.00 Employee 2.00 Labor &	C – CMHC						25.0
7.00Total (s8.00Observat9.00Ambulanc0.00Employee1.00Employee2.00Labor &	AL HEALTH CLINIC						26.0
8.00 Observat 9.00 Ambulanc 0.00 Employee 1.00 Employee 2.00 Labor &	RALLY QUALIFIED HEALTH CENTER	0	0		0.00	0.00	26.
9.00 Ambulanc 0.00 Employee 1.00 Employee 2.00 Labor &	al (sum of lines 14-26)				0.00	405.99	
0.00 Employee 1.00 Employee 2.00 Labor &	ervation Bed Days		0	98	2		28.
1.00 Employee 2.00 Labor &	llance Trips	2,639					29.
2.00 Labor &	oyee discount days (see instruction)				9		30.
	oyee discount days - IRF			1			31.0
2.01 Total ar	or & delivery days (see instructions)	0	0	1,41			32.0
	al ancillary labor & delivery room				0		32.
	oatient days (see instructions)						
	I non-covered days	0					33.
	I site neutral days and discharges Dorary Expansion COVID-19 PHE Acute Care	0	o		0		33.0

HOSPIT	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider C	CN: 15-0010	Period: From 07/01/2022 To 06/30/2023	Worksheet S-3 Part I Date/Time Pre 11/21/2023 1:4	pared:
		Full Time Equivalents		Dis	charges		
	Component	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,10	54 51	4,675	1.00
2.00	HMO and other (see instructions)			90	1,361		2.00
3.00	HMO IPF Subprovider				1, 501		3.00
4.00	HMO IRF Subprovider				16		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF				10		5.00
5.00	Hospital Adults & Peds. Swing Bed SM						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
3.00	INTENSIVE CARE UNIT						8.0
9.00	CORONARY CARE UNIT						9.0
10.00	BURN INTENSIVE CARE UNIT						10.0
11.00	SURGICAL INTENSIVE CARE UNIT						11.0
12.00	OTHER SPECIAL CARE (SPECIFY)						12.0
13.00	NURSERY						13.0
14.00	Total (see instructions)	0.00	0	1,16	54 51	4,675	14.0
15.00	CAH visits						15.0
15.10	REH hours and visits						15.1
16.00	SUBPROVIDER - IPF						16.0
17.00	SUBPROVIDER - IRF	0.00	0	15	53 3	269	17.0
18.00	SUBPROVIDER						18.0
19.00	SKILLED NURSING FACILITY						19.0
20.00	NURSING FACILITY						20.0
21.00	OTHER LONG TERM CARE						21.0
22.00	HOME HEALTH AGENCY						22.0
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.0
24.00	HOSPICE						24.0
24.10	HOSPICE (non-distinct part)						24.1
25.00	CMHC - CMHC						25.0
26.00	RURAL HEALTH CLINIC						26.0
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.2
27.00	Total (sum of lines 14-26)	0.00					27.0
28.00	Observation Bed Days						28.0
29.00	Ambulance Trips						29.0
30.00	Employee discount days (see instruction)						30.0
31.00	Employee discount days - IRF						31.0
32.00	Labor & delivery days (see instructions)						32.0
32.01	Total ancillary labor & delivery room						32.0
	outpatient days (see instructions)						
33.00	LTCH non-covered days				0		33.0
33.01	LTCH site neutral days and discharges				0		33.0
34 00	Temporary Expansion COVID-19 PHE Acute Care						34.

PIT	AL WAGE INDEX INFORMATION			Provider C		Period: From 07/01/2022 To 06/30/2023	Worksheet S-3 Part II Date/Time Pre 11/21/2023 1:4	par
		Wkst. A Line Number	Amount Reported	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	
	PART II - WAGE DATA SALARIES							1
o	Total salaries (see	200.00	34,547,074	170,595	34,717,66	9 846,935.00	40.99	1 :
D	instructions) Non-physician anesthetist Part		(0 0		0.00	0.00	1
0	A Non-physician anesthetist Part		(0		0 0.00	0.00	
5	B Physician-Part A -		55,616	5 O	55,61	6 278.00		
1	Administrative							
1	Physicians - Part A - Teaching Physician and Non		(-		0 0.00 0 0.00		
	Physician-Part B					0.00	0.00	
0	Non-physician-Part B for hospital-based RHC and FQHC		(0		0.00	0.00	(
b	services Interns & residents (in an	21.00	(0		0.00	0.00	
1	approved program) Contracted interns and residents (in an approved		C	0		0.00	0.00	
0	programs) Home office and/or related		(0		0.00	0.00	
0	organization personnel SNF	44.00	(0		0.00	0.00	
00	Excluded area salaries (see instructions)		4,394,845	297,838	4,692,68			
	OTHER WAGES & RELATED COSTS		899,804	0	899,80	4 5 257 00	171 12	1.
00	Contract labor: Direct Patient Care		899,802		899,80	4 5,257.90	171.13	1 ±.
00	Contract labor: Top level management and other management and administrative		C	0		0.00	0.00	1
00	services Contract labor: Physician-Part A - Administrative		271,623	0	271,62	3 2,258.82	120.25	1
00	Home office and/or related organization salaries and		C	0		0.00	0.00	1
01	wage-related costs Home office salaries		9,248,470	0	9,248,47	0 175,285.00	52.76	1
02	Related organization salaries		9,240,470			0 175,285.00		
00	Home office: Physician Part A - Administrative		(0		0.00	0.00	1
00	Home office and Contract Physicians Part A - Teaching		(0		0.00	0.00	1
01	Home office Physicians Part A - Teaching		(0		0.00	0.00	1
02	Home office contract Physicians Part A - Teaching		(0 0		0.00	0.00	1
	WAGE-RELATED COSTS Wage-related costs (core) (see		8,417,121	. 0	8,417,12	1		1
00	instructions) Wage-related costs (other)							1
	(see instructions)							
00 00	Excluded areas Non-physician anesthetist Part		1,308,730 (0 0	1,308,73	0 0		1
00	A Non-physician anesthetist Part		C	0		о		2
00	B Physician Part A -		15,829	0	15,82	9		2
)1	Administrative Physician Part A - Teaching		ſ			0		2
	Physician Part B		90,533	0	90,53	3		2
	Wage-related costs (RHC/FQHC)		0	0		0		2
00	Interns & residents (in an approved program)		(0		U		2
50	Home office wage-related (core)		(0		0		2
51	Related organization		(0		0		2
52	wage-related (core) Home office: Physician Part A - Administrative -		(0		0		2

	Financial Systems	A	SCENSION SI. V	INCENT KOKOMO			u of Form CMS-2	
HOSPIT	AL WAGE INDEX INFORMATION			Provider Co	CN: 15-0010	Period: From 07/01/2022 To 06/30/2023	Worksheet S-3 Part II Date/Time Pre 11/21/2023 1:	pared:
		Wkst. A Line	Amount	Reclassificati	Adjusted	Paid Hours	Average Hourly	
		Number	Reported	on of Salaries	Salaries	Related to	Wage (col. 4 ÷	
				(from Wkst.	$(col.2 \pm col$		col. 5)	
				A-6)	3)	col. 4		
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A		0	0		0		25.53
	- Teaching - wage-related							
	(core)							
	OVERHEAD COSTS - DIRECT SALARIE							
26.00	Employee Benefits Department	4.00	782,384	· · ·	,	· ·		26.00
27.00	Administrative & General	5.00	1,669,489	,	, ,			27.00
28.00	Administrative & General under		847,154	0	847,15	5,030.00	168.42	28.00
	contract (see inst.)							
29.00	Maintenance & Repairs	6.00	0	0		0 0.00		29.00
30.00	Operation of Plant	7.00	0	0		0 0.00		30.00
31.00	Laundry & Linen Service	8.00	0	0		0 0.00		31.00
32.00	Housekeeping	9.00	0	0		0 0.00		32.00
33.00	Housekeeping under contract (see instructions)		1,422,992	0	1,422,99	49,329.00	28.85	33.00
34.00	Dietary	10.00	0	0		0 0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		0	0		0 0.00	0.00	35.00
36.00	Cafeteria	11.00	0	0		0 0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0		0 0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,742,607	90,445	1,833,05	47,385.00	38.68	38.00
39.00	Central Services and Supply	14.00	196,130		198,75			39.00
40.00	Pharmacy	15.00	1,723,775					40.00
41.00	Medical Records & Medical	16.00	0	0		0.00		
	Records Library							
42.00	Social Service	17.00	0	0		0.00	0.00	42.00
43.00	Other General Service	18.00	0	0		0 0.00	0.00	43.00

Health	Financial Systems	۵	SCENSION ST. V	INCENT KOKOMO		In Lie	u of Form CMS-2	2552-10
HOSPIT	AL WAGE INDEX INFORMATION			Provider Co		Period: From 07/01/2022 To 06/30/2023		
		Worksheet A		Reclassificati			Average Hourly	
		Line Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from	$(col.2 \pm col.2)$		col. 5)	
		1.00	2.00	Worksheet A-6) 3.00	3)	<u>col. 4</u> 5.00	6.00	
	PART III - HOSPITAL WAGE INDEX		2.00	5.00	4.00	5.00	6.00	
1.00	Net salaries (see	SUMMART	36,817,220	170,595	36,987,81	5 901,294.00	41.04	1.00
1.00	instructions)		50,817,220	170,393	50, 507, 61	5 501,254.00	41.04	1.00
2.00	Excluded area salaries (see instructions)		4,394,845	297,838	4,692,68	3 150,233.00	31.24	2.00
3.00	Subtotal salaries (line 1 minus line 2)		32,422,375	-127,243	32,295,13	2 751,061.00	43.00	3.00
4.00	Subtotal other wages & related costs (see inst.)		10,419,897	0	10,419,89	7 182,801.72	57.00	4.00
5.00	Subtotal wage-related costs (see inst.)		8,432,950	0	8,432,95	0.00	26.11	5.00
6.00	Total (sum of lines 3 thru 5)		51,275,222	-127,243	51,147,97	9 933,862.72	54.77	6.00
7.00	Total overhead cost (see instructions)		8,384,531	-691,349	7,693,18	2 164,421.00	46.79	7.00

ACDTT	AL MACE BELATER COSTS	Provider CCN: 15-0010	Period:	Worksheet S-3	
JSPII	AL WAGE RELATED COSTS	Provider CCN: 15-0010	From 07/01/2022		
			To 06/30/2023		pared
			, ,	11/21/2023 1:	47 pr
				Amount	
				Reported	
				1.00	
	PART IV - WAGE RELATED COSTS				
	Part A - Core List				
~~	RETIREMENT COST			1 701 000	1
.00	401K Employer Contributions			1,761,633	
.00	Tax Sheltered Annuity (TSA) Employer Contribution			0	2.
.00	Nonqualified Defined Benefit Plan Cost (see instructions)			198,462	3.
.00	Qualified Defined Benefit Plan Cost (see instructions)			0	4.
00	PLAN ADMINISTRATIVE COSTS (Paid to External Organization) 401K/TSA Plan Administration fees			0	-
.00				0	5.
.00	Legal/Accounting/Management Fees-Pension Plan			0	6.
.00	Employee Managed Care Program Administration Fees			0	7.
00	HEALTH AND INSURANCE COST			0	
00	Health Insurance (Purchased or Self Funded)			0	8.
01	Health Insurance (Self Funded without a Third Party Adminis			0	8
02	Health Insurance (Self Funded with a Third Party Administra	itor)		3,595,760	
.03	Health Insurance (Purchased)			0	
00	Prescription Drug Plan			1,196,724	
.00	Dental, Hearing and Vision Plan			114,879	
00	Life Insurance (If employee is owner or beneficiary)			56,409	
.00	Accident Insurance (If employee is owner or beneficiary)			0	
3.00	Disability Insurance (If employee is owner or beneficiary)			290,470	
.00	Long-Term Care Insurance (If employee is owner or beneficia 'Workers' Compensation Insurance	(Fy)		0 -2,025	
5.00 5.00	Retirement Health Care Cost (Only current year, not the ext	maandinany account north	d by FACD 106	-2,025	16
5.00	Noncumulative portion)	raoruinary accruai require	EU DY FASE 106.	0	10.
7 00	FICA-Employers Portion Only			2,602,202	17
3.00	Medicare Taxes - Employers Portion Only			2,002,202	
9.00	Unemployment Insurance			0	
0.00	State or Federal Unemployment Taxes			2,536	
	OTHER			2,550	20.
00	Executive Deferred Compensation (Other Than Retirement Cost	Reported on lines 1 through	igh 4 above (see	0	21
	instructions))	. Reported on Thies I through	ign r above. (See	0	
.00	Day Care Cost and Allowances			0	22
	Tuition Reimbursement			15,161	
	Total Wage Related cost (Sum of lines 1 -23)			9,832,211	
	Part B - Other than Core Related Cost			5,052,211	

Health	Financial Systems	ASCENSION ST. VINCENT KOKOMO	In Lie	u of Form CMS-	2552-10
HOSPIT	AL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 15-0010	Period:	Worksheet S-3	
			From 07/01/2022		
			то 06/30/2023	Date/Time Pre 11/21/2023 1:	
	Cost Center Description		Contract Labor		
	cost center beschiption		1.00	2.00	
	PART V - Contract Labor and Benefit Cost		1.00	2.00	
	Hospital and Hospital-Based Component Ident	ification:			
1.00	Total facility's contract labor and benefi		0	0	1.00
2.00	Hospital		0	0	2.00
3.00	SUBPROVIDER - IPF				3.00
4.00	SUBPROVIDER - IRF		0	0	4.00
5.00	Subprovider - (Other)		0	0	5.00
6.00	Swing Beds - SNF		0	0	6.00
7.00	Swing Beds - NF		0	0	7.00
8.00	SKILLED NURSING FACILITY				8.00
9.00	NURSING FACILITY				9.00
10.00	OTHER LONG TERM CARE I				10.00
11.00	Hospital-Based HHA				11.00
12.00	AMBULATORY SURGICAL CENTER (D.P.) I				12.00
13.00	Hospital-Based Hospice				13.00
14.00	Hospital-Based Health Clinic RHC				14.00
15.00	Hospital-Based Health Clinic FQHC				15.00
16.00	Hospital-Based-CMHC				16.00
17.00	RENAL DIALYSIS I		0	0	17.00
18.00	Other		0	0	18.00

пеатти	Financial Systems ASCENSION ST. VINCEN	ΝΤ ΚΟΚΟΜΟ	In Lie	eu of Form CMS-2	2552-10
		Provider CCN: 15-0010	Period:	Worksheet S-1	
			From 07/01/2022	Data /Time Data	
			то 06/30/2023	Date/Time Pre 11/21/2023 1:	
				1.00	
	Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 div	ided by line 202 colum	n 8)	0.192142	1.00
2 22	Medicaid (see instructions for each line)			14 000 010	
2.00	Net revenue from Medicaid			14,096,910	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	-1		N	3.00
4.00 5.00	If line 3 is yes, does line 2 include all DSH and/or supplemental fline 4 is no, then enter DSH and/or supplemental payments from		alu?	0	5.00
6.00	Medicaid charges	on Meurcaru		125,001,931	6.00
7.00	Medicaid cost (line 1 times line 6)			24,018,121	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of li	nes 2 and 5: if	9,921,211	
	< zero then enter zero)				
	Children's Health Insurance Program (CHIP) (see instructions for	r each line)			
9.00	Net revenue from stand-alone CHIP			0	9.00
10.00	Stand-alone CHIP charges			0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)			0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9;	if < zero then	0	12.00
	enter zero) Other state or local government indigent care program (see inst	nuctions for each line			
13.00	Net revenue from state or local indigent care program (Net inclu			0	13.00
14.00	Charges for patients covered under state or local indigent care			0	14.00
200					
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 ind	igent care program (li	ne 15 minus line	0	16.00
	13; if < zero then enter zero)				
	Grants, donations and total unreimbursed cost for Medicaid, CHI				
		P and state/local indi	gent care progra	ms (see	
17 00	instructions for each line)		gent care progra		17 00
17.00	instructions for each line) Private grants, donations, or endowment income restricted to fun	nding charity care	gent care progra	0	
17.00 18.00 19.00	instructions for each line) Private grants, donations, or endowment income restricted to fun Government grants, appropriations or transfers for support of he	nding charity care ospital operations		0	18.00
18.00	instructions for each line) Private grants, donations, or endowment income restricted to fun	nding charity care ospital operations indigent care program		0 0 9,921,211	18.00
18.00	instructions for each line) Private grants, donations, or endowment income restricted to fur Government grants, appropriations or transfers for support of he Total unreimbursed cost for Medicaid , CHIP and state and local	nding charity care ospital operations indigent care program Uninsured	s (sum of lines	0 0 9,921,211 Total (col. 1	18.00
18.00	instructions for each line) Private grants, donations, or endowment income restricted to fur Government grants, appropriations or transfers for support of he Total unreimbursed cost for Medicaid , CHIP and state and local	nding charity care ospital operations indigent care program Uninsured patients	s (sum of lines Insured patients	0 0 9,921,211 Total (col. 1 + col. 2)	18.00
18.00	instructions for each line) Private grants, donations, or endowment income restricted to fur Government grants, appropriations or transfers for support of he Total unreimbursed cost for Medicaid , CHIP and state and local 8, 12 and 16)	nding charity care ospital operations indigent care program Uninsured	s (sum of lines	0 0 9,921,211 Total (col. 1	18.00
18.00	<pre>instructions for each line) Private grants, donations, or endowment income restricted to fur Government grants, appropriations or transfers for support of he Total unreimbursed cost for Medicaid , CHIP and state and local 8, 12 and 16) Uncompensated Care (see instructions for each line)</pre>	nding charity care ospital operations indigent care program Uninsured patients 1.00	s (sum of lines Insured patients 2.00	0 9,921,211 Total (col. 1 + col. 2) 3.00	18.00 19.00
18.00	<pre>instructions for each line) Private grants, donations, or endowment income restricted to fur Government grants, appropriations or transfers for support of h Total unreimbursed cost for Medicaid , CHIP and state and local 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire fact</pre>	nding charity care ospital operations indigent care program Uninsured patients 1.00	s (sum of lines Insured patients 2.00	0 9,921,211 Total (col. 1 + col. 2) 3.00	18.00 19.00
18.00	<pre>instructions for each line) Private grants, donations, or endowment income restricted to fur Government grants, appropriations or transfers for support of he Total unreimbursed cost for Medicaid , CHIP and state and local 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire fact (see instructions)</pre>	nding charity care ospital operations indigent care program Uninsured patients 1.00 ility 6,954,1	s (sum of lines Insured patients 2.00 11 1,054,141	0 0 9,921,211 Total (col. 1 + col. 2) 3.00 8,008,252	18.00 19.00 20.00
18.00 19.00 20.00	<pre>instructions for each line) Private grants, donations, or endowment income restricted to fur Government grants, appropriations or transfers for support of h Total unreimbursed cost for Medicaid , CHIP and state and local 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire fact</pre>	nding charity care ospital operations indigent care program Uninsured patients 1.00 ility 6,954,1	s (sum of lines Insured patients 2.00 11 1,054,141	0 0 9,921,211 Total (col. 1 + col. 2) 3.00 8,008,252	18.00 19.00 20.00
18.00 19.00 20.00	<pre>instructions for each line) Private grants, donations, or endowment income restricted to fur Government grants, appropriations or transfers for support of he Total unreimbursed cost for Medicaid , CHIP and state and local 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire face (see instructions) Cost of patients approved for charity care and uninsured discounts</pre>	nding charity care ospital operations indigent care program Uninsured patients 1.00 ility 6,954,1 nts (see 1,336,1	s (sum of lines Insured patients 2.00 11 1,054,141	0 0 9,921,211 Total (col. 1 + col. 2) 3.00 8,008,252	18.00 19.00 20.00 21.00
18.00 19.00 20.00 21.00 22.00	<pre>instructions for each line) Private grants, donations, or endowment income restricted to fur Government grants, appropriations or transfers for support of he Total unreimbursed cost for Medicaid , CHIP and state and local 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire fact (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of Charity care</pre>	nding charity care ospital operations indigent care program Uninsured patients 1.00 ility 6,954,1 nts (see 1,336,1 off as	s (sum of lines Insured patients 2.00 11 1,054,141 77 1,054,141 0 0	0 0 9,921,211 Total (col. 1 + col. 2) 3.00 8,008,252 2,390,318 0	18.00 19.00 20.00 21.00 22.00
18.00 19.00 20.00 21.00	<pre>instructions for each line) Private grants, donations, or endowment income restricted to fur Government grants, appropriations or transfers for support of he Total unreimbursed cost for Medicaid , CHIP and state and local 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire fac: (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of </pre>	nding charity care ospital operations indigent care program Uninsured patients 1.00 ility 6,954,1 nts (see 1,336,1	s (sum of lines Insured patients 2.00 11 1,054,141 77 1,054,141 0 0	0 0 9,921,211 Total (col. 1 + col. 2) 3.00 8,008,252 2,390,318 0	18.00 19.00 20.00 21.00 22.00
18.00 19.00 20.00 21.00 22.00	<pre>instructions for each line) Private grants, donations, or endowment income restricted to fur Government grants, appropriations or transfers for support of he Total unreimbursed cost for Medicaid , CHIP and state and local 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire fact (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of Charity care</pre>	nding charity care ospital operations indigent care program Uninsured patients 1.00 ility 6,954,1 nts (see 1,336,1 off as	s (sum of lines Insured patients 2.00 11 1,054,141 77 1,054,141 0 0	0 0 9,921,211 Total (col. 1 + col. 2) 3.00 8,008,252 2,390,318 0 2,390,318	18.00 19.00 20.00 21.00 22.00
18.00 19.00 20.00 21.00 22.00 23.00	<pre>instructions for each line) Private grants, donations, or endowment income restricted to fur Government grants, appropriations or transfers for support of he Total unreimbursed cost for Medicaid , CHIP and state and local 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire face (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of charity care Cost of charity care (line 21 minus line 22)</pre>	nding charity care ospital operations indigent care program Uninsured patients 1.00 ility 6,954,1 nts (see 1,336,1 off as 1,336,1	s (sum of lines Insured patients 2.00 11 1,054,141 77 1,054,141 0 0 77 1,054,141	0 0 9,921,211 Total (col. 1 + col. 2) 3.00 8,008,252 2,390,318 0 2,390,318 1.00	18.00 19.00 20.00 21.00 22.00 23.00
18.00 19.00 20.00 21.00 22.00	<pre>instructions for each line) Private grants, donations, or endowment income restricted to fur Government grants, appropriations or transfers for support of he Total unreimbursed cost for Medicaid , CHIP and state and local 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire fac: (see instructions) Cost of patients approved for charity care and uninsured discours instructions) Payments received from patients for amounts previously written of Charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patients</pre>	nding charity care ospital operations indigent care program Uninsured patients 1.00 ility 6,954,1 nts (see 1,336,1 off as 1,336,1 t days beyond a length	s (sum of lines Insured patients 2.00 11 1,054,141 77 1,054,141 0 0 77 1,054,141	0 0 9,921,211 Total (col. 1 + col. 2) 3.00 8,008,252 2,390,318 0 2,390,318	18.00 19.00 20.00 21.00 22.00
18.00 19.00 20.00 21.00 22.00 23.00	<pre>instructions for each line) Private grants, donations, or endowment income restricted to fur Government grants, appropriations or transfers for support of he Total unreimbursed cost for Medicaid , CHIP and state and local 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire face (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of charity care Cost of charity care (line 21 minus line 22)</pre>	nding charity care ospital operations indigent care program Uninsured patients 1.00 ility 6,954,1 nts (see 1,336,1 off as 1,336,1 t days beyond a length program?	s (sum of lines Insured patients 2.00 11 1,054,141 77 1,054,141 0 0 77 1,054,141 of stay limit	0 0 9,921,211 Total (col. 1 + col. 2) 3.00 8,008,252 2,390,318 0 2,390,318 1.00	18.00 19.00 20.00 21.00 22.00 23.00 24.00
18.00 19.00 20.00 21.00 23.00 24.00	<pre>instructions for each line) Private grants, donations, or endowment income restricted to fur Government grants, appropriations or transfers for support of he Total unreimbursed cost for Medicaid , CHIP and state and local 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire fac: (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of Charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care in </pre>	nding charity care ospital operations indigent care program Uninsured patients 1.00 ility 6,954,1 nts (see 1,336,1 off as 1,336,1 t days beyond a length program?	s (sum of lines Insured patients 2.00 11 1,054,141 77 1,054,141 0 0 77 1,054,141 of stay limit	0 0 9,921,211 Total (col. 1 + col. 2) 3.00 8,008,252 2,390,318 0 2,390,318 1.00 N	18.00 19.00 20.00 21.00 22.00 23.00 24.00
18.00 19.00 20.00 21.00 22.00 23.00 24.00 25.00 26.00	<pre>instructions for each line) Private grants, donations, or endowment income restricted to fur Government grants, appropriations or transfers for support of he Total unreimbursed cost for Medicaid , CHIP and state and local 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire face (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care p If line 24 is yes, enter the charges for patient days beyond the stay limit Total bad debt expense for the entire hospital complex (see instructions)</pre>	nding charity care ospital operations indigent care program Uninsured patients 1.00 ility 6,954,1 nts (see 1,336,1 off as 1,336,1 t days beyond a length program? e indigent care progra	s (sum of lines Insured patients 2.00 11 1,054,141 77 1,054,141 0 0 77 1,054,141 of stay limit	0 0 9,921,211 Total (col. 1 + col. 2) 3.00 8,008,252 2,390,318 0 2,390,318 1.00 N	18.00 19.00 20.00 21.00 22.00 23.00 24.00 25.00
18.00 19.00 20.00 21.00 22.00 23.00 24.00 25.00 26.00 27.00	<pre>instructions for each line) Private grants, donations, or endowment income restricted to fur Government grants, appropriations or transfers for support of he Total unreimbursed cost for Medicaid , CHIP and state and local 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire face (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care p If line 24 is yes, enter the charges for patient days beyond the stay limit Total bad debt expense for the entire hospital complex (see instructions) </pre>	nding charity care ospital operations indigent care program Uninsured patients 1.00 ility 6,954,1 nts (see 1,336,1 off as 1,336,1 t days beyond a length program? e indigent care progra tructions) (see instructions)	s (sum of lines Insured patients 2.00 11 1,054,141 77 1,054,141 0 0 77 1,054,141 of stay limit	0 0 9,921,211 Total (col. 1 + col. 2) 3.00 8,008,252 2,390,318 0 2,390,318 1.00 N 0 5,179,657 189,639	18.00 19.00 20.00 21.00 22.00 23.00 23.00 25.00 26.00 27.00
18.00 19.00 20.00 21.00 22.00 23.00 24.00 25.00 26.00 27.00 27.01	<pre>instructions for each line) Private grants, donations, or endowment income restricted to fur Government grants, appropriations or transfers for support of he Total unreimbursed cost for Medicaid , CHIP and state and local 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire face (see instructions) Cost of patients approved for charity care and uninsured discourd instructions) Payments received from patients for amounts previously written of charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care p If line 24 is yes, enter the charges for patient days beyond the stay limit Total bad debt expense for the entire hospital complex (see instructions) Medicare allowable bad debts for the entire hospital complex (see</pre>	nding charity care ospital operations indigent care program Uninsured patients 1.00 ility 6,954,1 nts (see 1,336,1 off as 1,336,1 t days beyond a length program? e indigent care progra tructions) (see instructions)	s (sum of lines Insured patients 2.00 11 1,054,141 77 1,054,141 0 0 77 1,054,141 of stay limit	0 0 9,921,211 Total (col. 1 + col. 2) 3.00 8,008,252 2,390,318 0 2,390,318 1.00 N 0 5,179,657 189,639 291,751	18.00 19.00 20.00 21.00 22.00 23.00 23.00 25.00 26.00 27.00 27.01
18.00 19.00 20.00 21.00 22.00 23.00 24.00 25.00 26.00 27.00 27.01 28.00	<pre>instructions for each line) Private grants, donations, or endowment income restricted to fur Government grants, appropriations or transfers for support of he Total unreimbursed cost for Medicaid , CHIP and state and local 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire fac: (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care If line 24 is yes, enter the charges for patient days beyond the stay limit Total bad debt expense for the entire hospital complex (see inst Medicare allowable bad debts for the entire hospital complex (see Non-Medicare bad debt expense (see instructions)</pre>	nding charity care ospital operations indigent care program Uninsured patients 1.00 ility 6,954,1 nts (see 1,336,1 off as 1,336,1 t days beyond a length program? e indigent care progra tructions) (see instructions) ee instructions)	s (sum of lines Insured patients 2.00 11 1,054,141 77 1,054,141 0 0 77 1,054,141 of stay limit m's length of	0 0 9,921,211 Total (col. 1 + col. 2) 3.00 8,008,252 2,390,318 0 2,390,318 1.00 N 0 5,179,657 189,639 291,751 4,887,906	18.00 19.00 20.00 21.00 22.00 23.00 23.00 24.00 25.00 26.00 27.01 28.00
18.00 19.00 20.00 21.00 22.00 23.00 24.00 25.00 26.00 27.00 27.01 28.00 29.00	<pre>instructions for each line) Private grants, donations, or endowment income restricted to fur Government grants, appropriations or transfers for support of he Total unreimbursed cost for Medicaid , CHIP and state and local 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire fact (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care If line 24 is yes, enter the charges for patient days beyond the stay limit Total bad debt expense for the entire hospital complex (see inst Medicare allowable bad debts for the entire hospital complex (see Non-Medicare and non-reimbursable Medicare bad debt expense Cost of non-Medicare and non-reimbursable Medicare bad debt expense Cost of non-Medicare and non-reimbursable Medicare bad debt expense Cost of non-Medicare and non-reimbursable Medicare bad debt expense Cost of non-Medicare and non-reimbursable Medicare bad debt expense Cost of non-Medicare and non-reimbursable Medicare bad debt expense Cost of non-Medicare and non-reimbursable Medicare bad debt expense Cost of non-Medicare and non-reimbursable Medicare bad debt expense Cost of non-Medicare and non-reimbursable Medicare bad debt expense Cost of non-Medicare and non-reimbursable Medicare bad debt expense Cost of non-Medicare and non-reimbursable Medicare bad debt expense Cost of non-Medicare and non-reimbursable Medicare bad debt expense Cost of non-Medicare and non-reimbursable Medicare bad debt expense Cost of non-Medicare and non-reimbursable Medicare bad debt expense Cost of non-Medicare and non-reimbursable Medicare bad debt expense Cost of non-Medicare and non-reimbursable Medicare bad debt expense Cost of non-Medicare and non-reimbursable Medicare bad debt expense Cos</pre>	nding charity care ospital operations indigent care program Uninsured patients 1.00 ility 6,954,1 nts (see 1,336,1 off as 1,336,1 t days beyond a length program? e indigent care progra tructions) (see instructions) ee instructions)	s (sum of lines Insured patients 2.00 11 1,054,141 77 1,054,141 0 0 77 1,054,141 of stay limit m's length of	0 0 9,921,211 Total (col. 1 + col. 2) 3.00 8,008,252 2,390,318 0 2,390,318 1.00 N 0 5,179,657 189,639 291,751 4,887,906 1,041,284	18.00 19.00 20.00 21.00 22.00 23.00 24.00 25.00 26.00 27.00 27.01 28.00 29.00
18.00 19.00 20.00 21.00 22.00 23.00 24.00 25.00 26.00 27.00 27.01 28.00 29.00 30.00	<pre>instructions for each line) Private grants, donations, or endowment income restricted to fur Government grants, appropriations or transfers for support of he Total unreimbursed cost for Medicaid , CHIP and state and local 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire fac: (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care If line 24 is yes, enter the charges for patient days beyond the stay limit Total bad debt expense for the entire hospital complex (see inst Medicare allowable bad debts for the entire hospital complex (see Non-Medicare bad debt expense (see instructions)</pre>	nding charity care ospital operations indigent care program Uninsured patients 1.00 ility 6,954,1 nts (see 1,336,1 off as 1,336,1 t days beyond a length program? e indigent care progra tructions) (see instructions) ee instructions) eense (see instructions	s (sum of lines Insured patients 2.00 11 1,054,141 77 1,054,141 0 0 77 1,054,141 of stay limit m's length of	0 0 9,921,211 Total (col. 1 + col. 2) 3.00 8,008,252 2,390,318 0 2,390,318 1.00 N 0 5,179,657 189,639 291,751 4,887,906	18.00 19.00 20.00 21.00 22.00 23.00 24.00 25.00 26.00 27.01 28.00 29.00 30.00

CLASS	Financial Systems A SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	SCENSION ST. VI EXPENSES	Provider C	CN: 15-0010	Period:	u of Form CMS-2 Worksheet A	
					From 07/01/2022 To 06/30/2023	Date/Time Pre 11/21/2023 1:	
	Cost Center Description	Salaries	Other	Total (col. : + col. 2)	L Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1.00	2.00	3.00	4.00	5.00	<u> </u>
	GENERAL SERVICE COST CENTERS		4 000 741	4 000 74	1 5 110	4 002 625	1
	00100 CAP REL COSTS-BLDG & FIXT		4,008,741			4,003,625	
	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	702 204	3,547,579			3,547,579 7,904,578	
	00500 ADMINISTRATIVE & GENERAL	782,384 1,669,489	7,820,572				
	00700 OPERATION OF PLANT	1,009,489	46,742,970 4,846,980			48,114,496 4,846,980	
	00800 LAUNDRY & LINEN SERVICE	0	387,727			850,432	
	00900 HOUSEKEEPING	0	1,647,623			1,239,655	
	01000 DIETARY	0	2,613,865			1,402,848	
	01100 CAFETERIA	0	2,013,803		0 1,211,017	1,211,017	
	01300 NURSING ADMINISTRATION	1,742,607	541,734			2,380,046	
	01400 CENTRAL SERVICE & SUPPLY	196,130	134,424			333,180	
	01500 PHARMACY	1,723,775	478,116			2,224,722	
	01600 MEDICAL RECORDS & LIBRARY	1,723,773	478,110			37	
	02300 ALLIED HEALTH RAD TECH PROGRAM	96,166	36,358			321,576	
	INPATIENT ROUTINE SERVICE COST CENTERS	90,100	50,556	152,52	4 109,032	521,570	23
	03000 ADULTS & PEDIATRICS	6,663,955	1,433,654	8,097,60	9 735,521	8,833,130	30
	03100 INTENSIVE CARE UNIT	1,678,981	449,023			2,198,116	
	04100 SUBPROVIDER - IRF	1,181,360	137,246	, ,	,	1,378,181	
	04300 NURSERY	1,101,500	157,240		0 558,397	558,397	
- H	ANCILLARY SERVICE COST CENTERS	0	0		550,557	550,557	1 73
	05000 OPERATING ROOM	3,014,800	3,155,273	6,170,07	3 43,372	6,213,445	50
	05200 DELIVERY ROOM & LABOR ROOM	1,997,695	546,033			1,568,447	
	05400 RADIOLOGY-DIAGNOSTIC	1,686,798	970,573			2,479,407	
	03630 ULTRA SOUND	331,597	37,799			372,718	
	05600 RADIOISOTOPE	653,241	386,894			1,047,059	
	05700 CT SCAN	766,732	108,786			883,199	
	05800 MAGNETIC RESONANCE IMAGING (MRI)	337,617	40,017	377,63		381,016	
	06000 LABORATORY	0	6,368,970			6,368,970	
.00	06500 RESPIRATORY THERAPY	1,473,115	252,030			1,741,291	
	06600 PHYSICAL THERAPY	605,283	4,595,994			3,912,970	
.00	06700 OCCUPATIONAL THERAPY	0	0		0 1,273,796	1,273,796	67
	06800 SPEECH PATHOLOGY	0	0		0 171,344	171,344	68
.00	06900 ELECTROCARDIOLOGY	332,231	78,333	410,56	4 9,249	419,813	69
.00	07000 ELECTROENCEPHALOGRAPHY	535,857	136,590	672,44	7 -3,037	669,410	70
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,413,615	1,413,61	5 0	1,413,615	71
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	3,757,136		6 0	3,757,136	72
	07300 DRUGS CHARGED TO PATIENTS	0	16,200,372	16,200,37	2 0	16,200,372	73
	07400 RENAL DIALYSIS	0	314,149		9 0	314,149	
.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	870,756	83,101	953,85	7 9,662	963,519	76
	03190 CHEMOTHERAPY	634,740	95,320	730,06	0 12,574	742,634	76
.02	03330 ENDOSCOPY	0	0		0 0	0	76
	03950 WOUND CARE CENTER	273,756	494,456	768,21	2 3,966	772,178	76
	DUTPATIENT SERVICE COST CENTERS			-			
	09100 EMERGENCY	2,180,690	2,291,741	4,472,43	1 43,887	4,516,318	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						4
-	09500 AMBULANCE SERVICES	2,583,573	773,467	3,357,04	0 46,837	3,403,877	95
	SPECIAL PURPOSE COST CENTERS	24 012 220	110 027 200	150 040 63	C 5 340	150 025 270	1110
.00	SUBTOTALS (SUM OF LINES 1 through 117)	34,013,328	116,927,298	150,940,62	6 -5,348	150,935,278	1118
	NONREIMBURSABLE COST CENTERS	381,150	2 024 000	2 216 02	0 2 910	3,219,849	102
	19200 PHYSICIANS' PRIVATE OFFICES 19201 ASC MOB	501,130	2,834,880			2,950	
	19201 ASC MOB 19202 EDUCATION CENTER	0	2,950 15,179			2,950	
	19202 EDUCATION CENTER 19203 MARKETING	0	13,1/9	13,1/			192
	19300 NONPAID WORKERS	0	0				192
	07950 FOUNDATION	0	0		0 0		193
	07950 FOUNDATION 07951 GIFT SHOP	0	0				194
	07951 GIFT SHOP 07952 CLINIC OF HOPE	152,596	0 36,145	188,74	1 1,529	190,270	
+.02	TOTAL (SUM OF LINES 118 through 199)	34,547,074	36,145 119,816,452			154,363,526	
1							

CLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CCN: 1	5-0010	Period:	Worksheet A
					From 07/01/2022 To 06/30/2023	Date/Time Prepar
	Cost Center Description	Adjustments	Net Expenses			11/21/2023 1:47
	cost center bescription		For Allocation			
		6.00	7.00			
	GENERAL SERVICE COST CENTERS					
00	00100 CAP REL COSTS-BLDG & FIXT	-629,945	3,373,680			1
00	00200 CAP REL COSTS-MVBLE EQUIP	-36,863	3,510,716			2
00	00400 EMPLOYEE BENEFITS DEPARTMENT	-501,213	7,403,365			4
00	00500 ADMINISTRATIVE & GENERAL	-17,449,352	30,665,144			5
00	00700 OPERATION OF PLANT	-4,733	4,842,247			7
00	00800 LAUNDRY & LINEN SERVICE	0	, .			8
00	00900 HOUSEKEEPING	0	,,			g
.00	01000 DIETARY	-76,909				10
.00	01100 CAFETERIA	-425,154				11
.00	01300 NURSING ADMINISTRATION	-118,732				13
.00	01400 CENTRAL SERVICE & SUPPLY	-541,806				14
.00	01500 PHARMACY	0				15
.00	01600 MEDICAL RECORDS & LIBRARY	0	- · ·			16
.00	02300 ALLIED HEALTH RAD TECH PROGRAM	-23,579	297,997			23
	INPATIENT ROUTINE SERVICE COST CENTERS	10.000				
	03000 ADULTS & PEDIATRICS	-19,968				30
00	03100 INTENSIVE CARE UNIT	-678				31
.00	04100 SUBPROVIDER - IRF	0	,,.			41
.00	04300 NURSERY	0	558,397			43
	ANCILLARY SERVICE COST CENTERS		F 01F 001			
	05000 OPERATING ROOM	-297,554				50
.00	05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC	-48,414				52
		-272,698				54
.01	03630 ULTRA SOUND	-2,140				54
.00	05600 RADIOISOTOPE 05700 CT SCAN	18 -902				56
.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	-902				58
.00	06000 LABORATORY	0				60
.00	06500 RESPIRATORY THERAPY	0				65
.00	06600 PHYSICAL THERAPY	-3,845				66
.00	06700 OCCUPATIONAL THERAPY	0				67
.00	06800 SPEECH PATHOLOGY	0				68
.00	06900 ELECTROCARDIOLOGY	0				69
.00	07000 ELECTROENCEPHALOGRAPHY	0	,			70
.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0				71
.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0				72
.00	07300 DRUGS CHARGED TO PATIENTS	0				73
.00	07400 RENAL DIALYSIS	0				74
	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	-9,500				76
.00	03190 CHEMOTHERAPY	-11,030				76
.01	03330 ENDOSCOPY	-11,030				76
.02	03950 WOUND CARE CENTER	0				76
.05	OUTPATIENT SERVICE COST CENTERS	0	112,110			70
.00	09100 EMERGENCY	-777,556	3,738,762			91
.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	-777,550	5,750,702			92
.00	OTHER REIMBURSABLE COST CENTERS	I				
.00	09500 AMBULANCE SERVICES	27,717	3,431,594			95
	SPECIAL PURPOSE COST CENTERS	27,717	5,151,551			
8.00		-21,224,836	129,710,442			118
5.00	NONREIMBURSABLE COST CENTERS	21,227,000	123,710,772			
2.00	19200 PHYSICIANS' PRIVATE OFFICES	0	3,219,849			192
	19201 ASC MOB	0				192
	19202 EDUCATION CENTER	0	15,179			192
	19203 MARKETING	0	13,173			192
	19300 NONPAID WORKERS	0	0			192
	07950 FOUNDATION		0			193
	07951 GIFT SHOP		0			194
-+.UI		0				
	07952 CLINIC OF HOPE	0	190,270			194

	Financial Systems	A	SCENSION ST. VI				eu of Form CMS-2552-1
ECLAS	SIFICATIONS			Provider CCM	N: 15-0010	Period: From 07/01/2022	Worksheet A-6
						To 06/30/2023	Date/Time Prepared 11/21/2023 1:47 pm
		Increases					
	Cost Center 2.00	Line #	Salary	Other 5 00			
	A - LAUNDRY RECLASS	3.00	4.00	5.00			
.00	LAUNDRY & LINEN SERVICE	8.00	0	462,705			1.0
.00		0.00	0	0			2.0
.00		0.00	0	0			3.0
.00		0.00	0	0			4.0
			0	462,705			
.00	B - NURSERY RECLASS ADULTS & PEDIATRICS	30.00	385,600	105,397			1.0
.00	NURSERY	43.00	438,532	119,865			2.0
	0		824,132	225,262			
	C - CAFETERIA RECLASS	1		1			
.00	CAFETERIA	<u>11.00</u>		1,211,017			1.0
	D - PT_OT_SPEECH RECLASS		0	1,211,017			
.00	OCCUPATIONAL THERAPY	67.00	148,234	1,125,562			1.0
.00	SPEECH PATHOLOGY	68.00	19,940	151,404			2.0
	0		168,174	1,276,966			
	E - RADIOLOGY TECHNICIAN RECL						
.00	ALLIED HEALTH RAD TECH	23.00	188,089	0			1.0
	PROGRAM	+	188,089	— — <u> </u>			
	F - INTEREST EXPENSE A&G		100,009	U			
.00	ADMINISTRATIVE & GENERAL	5.00	0	5,116			1.0
	0		0	5,116			
	G - PTO SALARY ACCRUAL			1			
.00	EMPLOYEE BENEFITS DEPARTMENT		170,595	0			1.0
			170,595	Ō			
.00	H - STARP SALARY RECLASS EMPLOYEE BENEFITS DEPARTMENT	4.00	2,526	0			1.0
.00	ADMINISTRATIVE & GENERAL	5.00	16,726	0			2.0
.00	NURSING ADMINISTRATION	13.00	17,458	0			3.0
.00	CENTRAL SERVICE & SUPPLY	14.00	1,965	0			4.0
.00	PHARMACY	15.00	17,270	0			5.0
.00	ALLIED HEALTH RAD TECH	23.00	963	0			6.0
.00	PROGRAM	30.00	66 799	0			7.0
.00	ADULTS & PEDIATRICS INTENSIVE CARE UNIT	31.00	66,788 16,821	0			8.0
.00	SUBPROVIDER - IRF	41.00	11,835	0			9.0
0.00	OPERATING ROOM	50.00	30,198	0			10.0
L.00	DELIVERY ROOM & LABOR ROOM	52.00	20,014	0			11.0
2.00	RADIOLOGY-DIAGNOSTIC	54.00	16,899	0			12.0
3.00	ULTRA SOUND	54.01	3,322	0			13.0
1.00	RADIOISOTOPE	56.00 57.00	6,544 7,681	0			14.0
5.00	CT SCAN MAGNETIC RESONANCE IMAGING	58.00	3,382	0			16.0
	(MRI)	50.00	5,502	0			10.0
7.00	RESPIRATORY THERAPY	65.00	14,758	0			17.0
3.00	PHYSICAL THERAPY	66.00	6,064	0			18.0
9.00	ELECTROCARDIOLOGY	69.00	3,328	0			19.0
0.00		70.00	5,368	0			20.0
1.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.00	8,724	0			21.0
2.00	CHEMOTHERAPY	76.01	6,359	0			22.0
3.00	WOUND CARE CENTER	76.03	2,743	0			23.0
4.00	EMERGENCY	91.00	21,847	0			24.0
5.00	AMBULANCE SERVICES	95.00	25,883	0			25.0
5.00	PHYSICIANS' PRIVATE OFFICES	192.00	3,819	0			26.0
7.00	CLINIC OF HOPE	194.02	1,529	<u>0</u>			27.0
			340,814	0			
00	J - PTO PAYOUT RECLASS ADMINISTRATIVE & GENERAL	5.00	3,582	0			1.0
00	NURSING ADMINISTRATION	13.00	6,206	0			2.0
00	CENTRAL SERVICE & SUPPLY	14.00	661	0			3.0
00	PHARMACY	15.00	5,561	0			4.0
.00	ADULTS & PEDIATRICS	30.00	45,316	0			5.0
00	INTENSIVE CARE UNIT	31.00	23,144	0			6.0
.00	SUBPROVIDER - IRF	41.00	7,013	0			7.0
.00	OPERATING ROOM	50.00	13,174	0			8.0
.00 0.00	DELIVERY ROOM & LABOR ROOM RADIOLOGY-DIAGNOSTIC	52.00 54.00	7,409 3,863	0			9.0 10.0
L.00	RADIOLOGY-DIAGNOSTIC	56.00	3,803	0			10.0
2.00	RESPIRATORY THERAPY	65.00	1,388	0			12.0
3.00	PHYSICAL THERAPY	66.00	184,615	0			13.0
4.00	ELECTROCARDIOLOGY	69.00	5,921	0			14.0

Health	Financial Systems	۵	SCENSION ST. V	INCENT KOKOMO		In Lie	u of Form CMS-	2552-10
RECLAS	SIFICATIONS			Provider C	CN: 15-0010	Period: From 07/01/2022 To 06/30/2023	Worksheet A-6 Date/Time Pre	epared:
		Increases					11/21/2023 1	47 pm
	Cost Center	Line #	Salary	Other				
	2.00	3.00	4.00	5.00				
15.00	ELECTROENCEPHALOGRAPHY	70.00	1,624	0				15.00
16.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.00	938	0				16.00
17.00	CHEMOTHERAPY	76.01	6,215	0				17.00
18.00	WOUND CARE CENTER	76.03	1,223	0				18.00
19.00	EMERGENCY	91.00	20,903	0				19.00
20.00	AMBULANCE SERVICES	95.00	20,954	0				20.00
	0		360,090	0				
	K - SYSTEM PROJECTS							
1.00	NURSING ADMINISTRATION	13.00	66,781	5,260				1.00
2.00	ADULTS & PEDIATRICS	30.00	122,752	9,668				2.00
3.00	INTENSIVE CARE UNIT	31.00	27,946	2,201				3.00
4.00	SUBPROVIDER - IRF	41.00	37,753	2,974				4.00
5.00	DELIVERY ROOM & LABOR ROOM	52.00	43,281	3,409				5.00
6.00	PHYSICAL THERAPY	66.00	95	7				6.00
7.00	ELECTROENCEPHALOGRAPHY	70.00	114	9				7.00
8.00	EMERGENCY	91.00	1,054	83				8.00
	0		299,776	23,611				
500.00	Grand Total: Increases		2,351,670	3,204,677				500.00

SSIFICATIONS			INCENT KOKOMO Provider (CCN: 15-0010	Period:	u of Form CMS-2552- Worksheet A-6
					From 07/01/2022 To 06/30/2023	Date/Time Prepared 11/21/2023 1:47 pm
	Decreases				1	
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref	· _	
6.00 A - LAUNDRY RECLASS	7.00	8.00	9.00	10.00		
HOUSEKEEPING	9.00	0	407,968		0	1.0
RADIOLOGY-DIAGNOSTIC	54.00	0	10,637		0	2.0
PHYSICAL THERAPY	66.00	0	33,948		0	3.0
ELECTROENCEPHALOGRAPHY		0	10,152 462,705		0	4.0
B - NURSERY RECLASS		U	402,703			
DELIVERY ROOM & LABOR ROOM	52.00	824,132	225,262		0	1.0
	0.00	0	0		o	2.0
0		824,132	225,262			
C - CAFETERIA RECLASS DIETARY	10.00	0	1,211,017	•	0	1.0
0		— — — o	1,211,017			1.0
D - PT_OT_SPEECH RECLASS			_,,	1	1	
PHYSICAL THERAPY	66.00	168,174	1,276,966		0	1.0
	0.00	0	0		o	2.0
0 E - RADIOLOGY TECHNICIAN R		168,174	1,276,966			
RADIOLOGY-DIAGNOSTIC	54.00	188,089	0		0	1.0
0		188,089	ö			
F - INTEREST EXPENSE A&G				1		
CAP REL COSTS-BLDG & FIXT		0	5,116		1	1.0
		0	5,116	j		
G - PTO SALARY ACCRUAL EMPLOYEE BENEFITS DEPARTME	NT 4.00	0	170,595		0	1.0
0	4.00	— — — 0	170,595			1.0
H - STARP SALARY RECLASS			210,000			
EMPLOYEE BENEFITS DEPARTME		340,814	0		0	1.0
	0.00	0	0		0	2.0
	0.00	0	0		0	3.0
	0.00	0	0 0		0	4.0
	0.00	0	0		0	6.0
	0.00	Ő	0		0	7.0
	0.00	0	0		0	8.0
	0.00	0	0		0	9.0
	0.00	0	0		0	10.0
	0.00	0	0		0	11.0
	0.00	0	0		0	12.0
	0.00	Ő	0		o	14.0
	0.00	0	0		0	15.0
	0.00	0	0		0	16.0
	0.00	0	0		0	17.0
	0.00	0	0		0	18.0
	0.00	0	0		0	20.0
	0.00	Ő	0		0	21.0
	0.00	0	0		0	22.0
	0.00	0	0		0	23.0
	0.00	0	0		0	24.0
	0.00	0	0		0	25.0
	0.00	0	0 0		0	26.0
0		340,814			Ĭ	27.0
J - PTO PAYOUT RECLASS		5.5,011			1	
EMPLOYEE BENEFITS DEPARTME		360,090	0		0	1.0
	0.00	0	0		0	2.0
	0.00	0	0		0	3.
	0.00	0	0		0	4.
	0.00	0	0		0	6.
	0.00	ő	0		0	7.
	0.00	0	0		0	8.
	0.00	0	0		0	9.
	0.00	0	0		0	10.
	0.00	0	0		0	11.
	0.00	0	0		0	12.
	0.00	0	0		0	13.0
	0.00	0	0		0	15.0
	0.00	Ő	0		0	16.0
1	0.00	0	0		0	17.0
	0.00	0	0		0	18.0

Health	Financial Systems		ASCENSION ST. VI	NCENT KOKOMO		In Lie	u of Form CMS	-2552-10
RECLAS	SIFICATIONS			Provider	CCN: 15-0010	Period: From 07/01/2022	Worksheet A-	6
						To 06/30/2023	Date/Time Pr 11/21/2023 1	epared: :47 pm
		Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref	⁼.		
	6.00	7.00	8.00	9.00	10.00			
19.00		0.00	0	C)	0		19.00
20.00		0.00	0	C)	0		20.00
	0		360,090	C)			
	K - SYSTEM PROJECTS							
1.00	ADMINISTRATIVE & GENERAL	5.00	299,776	23,611	_	0		1.00
2.00		0.00	0	C)	0		2.00
3.00		0.00	0	C)	0		3.00
4.00		0.00	0	C		0		4.00
5.00		0.00	0	C		0		5.00
6.00		0.00	0	C		0		6.00
7.00		0.00	0	C		0		7.00
8.00		0.00	0	C)	0		8.00
	0		299,776	23,611	-			
500.00	Grand Total: Decreases		2,181,075	3,375,272	2			500.00

		ASCENSION ST. V					u of Form CMS-2	
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provider CO	CN: 15-0010		iod:	Worksheet A-7	
					Fro To	m 07/01/2022 06/30/2023		nared·
					10	00/ 50/ 2025	11/21/2023 1:	47 pm
				Acquisition	s			
		Beginning	Purchases	Donation		Total	Disposals and	
		Balances					Retirements	
		1.00	2.00	3.00		4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE							
1.00	Land	671,919	0		0	0	146,640	1.00
2.00	Land Improvements	2,316,541	0		0	0	0	2.00
3.00	Buildings and Fixtures	58,341,179	720,593		0	720,593	1,084,603	3.00
4.00	Building Improvements	25,171,802	6,510,992		0	6,510,992	0	4.00
5.00	Fixed Equipment	20,718,982	0		0	0	0	5.00
6.00	Movable Equipment	52,581,896	1,482,457		0	1,482,457	8,216,623	6.00
7.00	HIT designated Assets	0	0		0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	159,802,319	8,714,042		0	8,714,042	9,447,866	8.00
9.00	Reconciling Items	0	0		0	0	0	9.00
10.00	Total (line 8 minus line 9)	159,802,319	8,714,042		0	8,714,042	9,447,866	10.00
		Ending Balance	Fully					
			Depreciated					
			Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE							
1.00	Land	525,279	0					1.00
2.00	Land Improvements	2,316,541	0					2.00
3.00	Buildings and Fixtures	57,977,169	0					3.00
4.00	Building Improvements	31,682,794	0					4.00
5.00	Fixed Equipment	20,718,982	0					5.00
6.00	Movable Equipment	45,847,730	0					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	159,068,495	0					8.00
9.00	Reconciling Items	0	0					9.00
10.00	Total (line 8 minus line 9)	159,068,495	0					10.00

Health	Financial Systems	ASCENSION ST. V	INCENT KOKOMO		In Lie	u of Form CMS-2	2552-10
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provider CO		Period:	Worksheet A-7	
					rom 07/01/2022 0 06/30/2023		nared
					0075072025	11/21/2023 1:	
			SU	IMMARY OF CAPI	TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see	
		bep. ceraeron	20000	2	instructions)	instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 a	nd 2	1		
1.00	CAP REL COSTS-BLDG & FIXT	2,995,119	417,951	564,128	3 0	31,543	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	3,510,560	37,019	(0 0	0	2.00
3.00	Total (sum of lines 1-2)	6,505,679	454,970	564,128	3 0	31,543	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
		Capital-Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	4,008,741				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	3,547,579				2.00
3.00	Total (sum of lines 1-2)	0	7,556,320				3.00

Health	n Financial Systems	ASCENSION ST. \				u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 07/01/2022 To 06/30/2023		pared:
		СОМ	PUTATION OF RAT	TIOS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capitalized	Gross Assets	Ratio (see	Insurance	
			Leases	for Ratio	instructions)		
				(col. 1 - col			
				2)			
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS	CENTERS	1				
1.00	CAP REL COSTS-BLDG & FIXT	0	0		0 1.000000		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0.000000		2.00
3.00	Total (sum of lines 1-2)	0	0		0 1.000000	0	3.00
		ALLOCA	TION OF OTHER (CAPITAL	SUMMARY C	F CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capital-Relate				
			d Costs	through 7)			
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS	CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT	C	0		0 2,995,119	417,951	1.00
2.00	CAP REL COSTS-MVBLE EOUIP	0	0		0 3,473,697	37,019	2.00
3.00	Total (sum of lines 1-2)	C	0		6,468,816	, ,	3.00
			SU	JMMARY OF CAPI			
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
		2			Capital-Relate		
					d Costs (see	through 14)	
					instructions)		
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS						
1.00	CAP REL COSTS-BLDG & FIXT	-70,933	0	31,54	3 0	3,373,680	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	,	0		0 0	3,510,716	2.00
3.00	Total (sum of lines 1-2)	-70,933	0	31,54	3 0	6,884,396	3.00
5.00		10,555	'I 0	J J1, J4	5	0,004,000	5.00

JUST	MENTS TO EXPENSES			F	Period: From 07/01/2022	Worksheet A-8	
					o 06/30/2023	Date/Time Pre 11/21/2023 1:4	
				Expense Classification on To/From Which the Amount is			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
00	Investment income - CAP REL	1.00 B	2.00	3.00 CAP REL COSTS-BLDG & FIXT	4.00	5.00	1.
00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL			CAP REL COSTS-MVBLE EQUIP	2.00	0	
00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other	В	C	ADMINISTRATIVE & GENERAL	5.00	0	3
00	(chapter 2) Trade, quantity, and time		C		0.00	0	4
00	discounts (chapter 8) Refunds and rebates of		C		0.00	0	5
	expenses (chapter 8) Rental of provider space by		(0	
00	suppliers (chapter 8)				0.00		
00	Telephone services (pay stations excluded) (chapter 21)		C		0.00	0	7
00	Television and radio service (chapter 21)	А	-9,964	ADMINISTRATIVE & GENERAL	5.00	0	8
00 .00	Parking lot (chapter 21) Provider-based physician	A-8-2	0 2,231,261-		0.00	0 0	-
.00	adjustment Sale of scrap, waste, etc.		C		0.00	0	11
.00	(chapter 23) Related organization transactions (chapter 10)	A-8-1	2,760,082			0	12
.00	Laundry and linen service		(0.00	0	
	Cafeteria-employees and guests Rental of quarters to employee		-425,154 (CAFETERIA	11.00 0.00	0 0	
.00	and others Sale of medical and surgical supplies to other than		C		0.00	0	16
.00	patients Sale of drugs to other than patients		C		0.00	0	17
.00	Sale of medical records and abstracts	В	-632	ADMINISTRATIVE & GENERAL	5.00	0	18
.00	Nursing and allied health education (tuition, fees, books, etc.)		C		0.00	0	19
.00	Vending machines	В		DIETARY	10.00	0	
.00	Income from imposition of interest, finance or penalty charges (chapter 21)		l		0.00	0	22
.00	Interest expense on Medicare overpayments and borrowings to		C		0.00	0	22
.00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	C	RESPIRATORY THERAPY	65.00		23
.00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	C	PHYSICAL THERAPY	66.00		24
.00	limitation (chapter 14) Utilization review - physicians' compensation		C	*** Cost Center Deleted ***	114.00		25
.00	(chapter 21) Depreciation - CAP REL		C	CAP REL COSTS-BLDG & FIXT	1.00	0	26
.00	COSTS-BLDG & FIXT Depreciation - CAP REL COSTS-MVBLE EQUIP		C	CAP REL COSTS-MVBLE EQUIP	2.00	0	27
	Non-physician Anesthetist		C	*** Cost Center Deleted ***	19.00 0.00	0	28
	Physicians' assistant Adjustment for occupational therapy costs in excess of	A-8-3	C	OCCUPATIONAL THERAPY	67.00	0	30
.99	limitation (chapter 14) Hospice (non-distinct) (see		C	ADULTS & PEDIATRICS	30.00		30
.00	instructions) Adjustment for speech pathology costs in excess of	A-8-3	C	SPEECH PATHOLOGY	68.00		31
.00	limitation (chapter 14) CAH HIT Adjustment for		C		0.00	0	32
	Depreciation and Interest LOBBYING EXPENSE OFFSET	А	20 120	ADMINISTRATIVE & GENERAL	5.00		33

	Financial Systems	A	SCENSION ST. V	INCENT KOKOMO		u of Form CMS-2	
ADJUST	MENTS TO EXPENSES			Provider CCN: 15-0010	Period:	Worksheet A-8	
					From 07/01/2022 To 06/30/2023	Date/Time Pre 11/21/2023 1:	
				Expense Classification o	n Worksheet A		47 pili
				To/From Which the Amount is			
					j		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
22.01	1	1.00	2.00	3.00	4.00	5.00	
33.01	BUILDING RENTAL INCOME	В	-24,598	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	PROPERTY MGMT BUILDING RENTAL INCOME	В	16 209		5.00	0	33.02
33.02	PROPERTY MGMT	ь	-10,298	ADMINISTRATIVE & GENERAL	5.00	0	35.02
33.03	MISC. INCOME SURGERY	В	-208	OPERATING ROOM	50.00	0	33.03
33.04	MISC. INCOME PATIENT INTEREST	В		ADMINISTRATIVE & GENERAL	5.00	0	1
	INCOME	_	,			-	
33.05	MISC. INCOME RECYCLING	В	-428	OPERATION OF PLANT	7.00	0	33.0
33.06	MISC. INCOME SALE OF SCRAP	В	-86	OPERATION OF PLANT	7.00	0	33.0
33.07	MISC. INCOME MEDICAL AFFAIRS	В	-9,420	ADMINISTRATIVE & GENERAL	5.00	0	33.0
	DUES						
33.08	MISC. INCOME SOUTHWAY REHAB	В	-1,680	PHYSICAL THERAPY	66.00	0	33.0
33.09	MISC. INCOME MAMMMOGRAPHY	В		RADIOLOGY-DIAGNOSTIC	54.00	0	00.0
33.10	MISC. INCOME FOREST PARK REHAB		,	PHYSICAL THERAPY	66.00		
33.11	MISC. INCOME RAD TECH TUITION	В	-23,138	ALLIED HEALTH RAD TECH	23.00	0	33.1
22 12			2 1 4 0	PROGRAM	54.01		22.1
33.12 33.13		В	,	ULTRA SOUND	54.01	0	00.1
33.14	MISC. INCOME MEALS ON WHEELS	B		DIETARY	10.00	9	
55.14	MISC. INCOME GAIN ON SALE OF ASSETS	Б	-30,803	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.14
33.15	MISC INCOME PERU REHAB	В	-140	PHYSICAL THERAPY	66.00	0	33.1
34.00	PROVIDER TAX EXPENSE	A		ADMINISTRATIVE & GENERAL	5.00	0	
34.01	PHYSICIAN FUND EXPENSE	A		ADMINISTRATIVE & GENERAL	5.00	0	34.0
34.02	PHYSICIAN FUND EXPENSE	A		EMPLOYEE BENEFITS DEPARTMEN		0	
34.03		А		ADULTS & PEDIATRICS	30.00	0	1
34.04	MID LEVEL PROVIDER OFFSET	А		INTENSIVE CARE UNIT	31.00	0	34.0
34.05	MID LEVEL PROVIDER OFFSET	A		PSYCHIATRIC/PSYCHOLOGICAL	76.00	0	34.0
				SERVICES			
34.06	ANDERSON AMBULANCE EXPENSES	A		AMBULANCE SERVICES	95.00	0	
35.00	TELEVISION EXPENSE UTILITIES	A		OPERATION OF PLANT	7.00	0	35.0
35.01	INTEREST INCOME	В	,	ADMINISTRATIVE & GENERAL	5.00		
35.02	BAD DEBT NON-PATIENT	A	-8,630	CHEMOTHERAPY	76.01	0	35.02
25 02	CHEMOTHERAPY		2 1 6 2		F 00		25 0
35.03	ENTERTAINMENT ADMINISTRATION	A	,	ADMINISTRATIVE & GENERAL	5.00	0	1 33.0.
35.04	ENTERTAINMENT LABOR AND	A	-7,463	NURSING ADMINISTRATION	13.00	0	35.04
35.05	DELIVERY DONATIONS	А	-6.000	ADMINISTRATIVE & GENERAL	5.00	0	35.0
35.05	DONATIONS	A	,	NURSING ADMINISTRATION	13.00		35.0
50.00	TOTAL (sum of lines 1 thru 49)		-21,224,836		13.00	0	50.0
50.00	(Transfer to Worksheet A,		21,227,030				50.0
	column 6, line 200.)						

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

Health	Financial Systems	ASCENSION ST.	VINCENT KOKOMO	In Lie	u of Form CMS-	2552-10
STATEM	ENT OF COSTS OF SERVICES FROM COSTS	RELATED ORGANIZATIONS AND HOM		Period: From 07/01/2022 To 06/30/2023	Date/Time Pre	pared:
	1 4 4 4 4 4	Cont. Conton	European Thomas	Amount of	11/21/2023 1:	47 pm
	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in	
					Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTM	IENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED O	RGANIZATIONS OR	CLAIMED	
	HOME OFFICE COSTS:					
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HEALTH INSURANCE	5,879,356	5,136,583	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE CAPITAL	1,772,411	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE INTEREST EXPENSE	65,817	0	3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE INTEREST EXPENSE	544	0	3.01
3.02	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE OTHER	20,361,437	19,395,429	3.02
3.04	15.00	PHARMACY	SVH CHARGEBACK	-16,639	-16,639	3.04
3.05	23.00	ALLIED HEALTH RAD TECH PROGR	SVH CHARGEBACK	28,370	28,370	3.05
3.06	54.00	RADIOLOGY-DIAGNOSTIC	SVH CHARGEBACK	45,675	45,675	3.06
3.07	56.00	RADIOISOTOPE	SVH CHARGEBACK	10,437	10,437	3.07
3.08	69.00	ELECTROCARDIOLOGY	SVH CHARGEBACK	5,000	5,000	3.08
3.09	69.00	ELECTROCARDIOLOGY	SVH CHARGEBACK	5,000	5,000	3.09
3.10	194.02	CLINIC OF HOPE	SVH CHARGEBACK	1,307,129	1,307,129	3.10
3.12	5.00	ADMINISTRATIVE & GENERAL	INTEREST EXPENSE A&G	4,572	0	3.12
3.13	1.00	CAP REL COSTS-BLDG & FIXT	INTEREST EXPENSE	560,128	564,128	3.13
4.00	5.00	ADMINISTRATIVE & GENERAL	TRG ADMINISTRATIVE FEES	-139,968	0	4.00
4.01	13.00	NURSING ADMINISTRATION	TRG ADMINISTRATIVE FEES	-106,269	0	4.01
4.02	14.00	CENTRAL SERVICE & SUPPLY	TRG ADMINISTRATIVE FEES	-541,806	0	4.02
5.00	TOTALS (sum of lines 1-4).			29,241,194	26,481,112	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

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

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

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

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

reimbursement under title xviII.			
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) was the falle day sumbals to indicate internal	stienship to polyted experience.		

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

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

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

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

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

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

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

Health Financial Systems	ASCENSION ST. VING	In Lieu of Form CMS-2552-1		
STATEMENT OF COSTS OF SERVICES F OFFICE COSTS	FROM RELATED ORGANIZATIONS AND HOME	Provider CCN: 15-0010	Period: From 07/01/2022 To 06/30/2023	Worksheet A-8-1 Date/Time Prepared: 11/21/2023 1:47 pm

					11/21/2023 1:	47 pm
	Net	Wkst. A-7 Ref.				
	Adjustments					
	(col. 4 minus					
	col. 5)*					
	6.00	7.00				
	A. COSTS INCUR	RED AND ADJUSTM	ENTS REQUIRED AS A RESULT OF	RANSACTIONS WITH RELATED (DRGANIZATIONS OR CLAIMED	
	HOME OFFICE CO	STS:				
1.00	742,773	0				1.00
2.00	1,772,411	0				2.00
3.00	65,817	11				3.00
3.01	544	0				3.01
3.02	966,008	0				3.02
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
3.12	4,572	0				3.12
3.13	-4,000					3.13
4.00	-139,968					4.00
4.01	-106,269					4.01
4.02	-541,806					4.02
5.00	2,760,082					5.00
5.00	2,700,002					5.00

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate.Positive amounts increase cost and negative amounts decrease cost.For related organization or home office cost which have been detailed by a contract of the second of the second second

nas not	been posted to worksheet A,	columns	1 and/or	2, 1	the amount	a llowable	should b	e indicated	in column	4 OT this	part.	
	Related Organization(s)											
	and/or Home Office											
	,											
	Type of Business											
	Type of Busiliess											
	6.00											
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:											

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

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

6.00		6.00
7.00		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 organization.

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

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

	Financial Systems		ASCENSION ST.	VINCENT KOKOMO	CNI 15 0010		eu of Form CMS-	
PROVIDE	R BASED PHYSICIAN	ADJUSTMENT		Provider (Period: From 07/01/2022		
						то 06/30/2023	B Date/Time Pre 11/21/2023 1:	
	Wkst. A Line #	Cost Center/Physician	Total	Professional	Provider	RCE Amount	Physician/Prov	
		Identifier	Remuneration	Component	Component		ider Component	
	1.00	2.00	3.00	4.00	5.00	6.00	Hours 7.00	
1.00	5.00 DR.		294,847					1.00
2.00	23.00 dr.		441			0	0	
3.00	50.00 DR.		166,114			211,500		
4.00 5.00	54.00 DR. 56.00 DR.		34		-	0	0	4.00 5.00
6.00	57.00 DR.		902					6.00
7.00	76.01DR.		2,400			0	0	7.00
8.00	30.00 dr.		300				0	8.00
9.00	52.00 DR.		19,950				0	9.00
10.00 11.00	54.00 DR. 91.00 DR.		229,032			0	0	10.00 11.00
12.00	54.00 DR.		36,128			0	0	12.00
13.00	91.00 dr.		489,298			0	0	13.00
14.00	5.00 dr.		582,000			0	0	14.00
15.00	50.00 DR.		159,500			0	0	15.00
16.00 17.00	52.00 DR. 54.00 DR.		28,464 6,692		-	-		16.00 17.00
200.00	J4.00DK.	4	2,304,342			, v	-	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provider	Physician Cost	
		Identifier	Limit		Memberships &	Component	of Malpractice	
				Limit	Continuing Education	Share of col. 12	Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00 DR.		75,957					
2.00	23.00 DR.		0	-	C	-	-	2.00
3.00 4.00	50.00 DR. 54.00 DR.		28,268	1,413			0	3.00 4.00
5.00	56.00 DR.			-	-		0	5.00
6.00	57.00 DR.		0	0	C	0	0	6.00
7.00	76.01DR.		0	U U	C		0	7.00
8.00	30.00 DR.		0	-	-		0	8.00
9.00 10.00	52.00 DR. 54.00 DR.			u u			0	9.00 10.00
11.00	91.00 DR.		0	-	C C		0	11.00
12.00	54.00 dr.	L	0	0	C	0	0	12.00
13.00	91.00 DR.		0	0	C	0	0	13.00
14.00	5.00 DR. 50.00 DR.			0		0	0	14.00
15.00 16.00	52.00 DR.			-		0		15.00 16.00
17.00	54.00 DR.		0		C C	0	0	17.00
200.00			104,225		C		0	200.00
	Wkst. A Line #	Cost Center/Physician	Provider	Adjusted RCE	RCE	Adjustment		
		Identifier	Component Share of col.	Limit	Disallowance			
			14					
1.00	1.00	2.00	15.00	16.00	17.00	18.00		1.00
1.00 2.00	5.00 DR. 23.00 DR.		0					1.00 2.00
3.00	50.00 DR.		0		-			3.00
4.00	54.00 DR.		0		27,510	34		4.00
5.00	56.00 DR.	E	0		C	-18		5.00
6.00	57.00 DR.		0					6.00
7.00 8.00	76.01DR. 30.00DR.		0					7.00 8.00
9.00	52.00 DR.							9.00
10.00	54.00 DR.		0					10.00
11.00	91.00 dr.	К	0	0	C	288,258		11.00
12.00	54.00 DR.		0		C			12.00
13.00	91.00 DR.		0					13.00
14.00 15.00	5.00 DR. 50.00 DR.		0					14.00 15.00
16.00	52.00 DR.		0			· · · ·		16.00
17.00	54.00 DR.		0	0	C	6,692		17.00
200.00			0	104,225	27,348	2,231,261		200.00

COST A	Financial Systems	ASCENSION ST. V	Provider CC	N: 15-0010	eriod:	u of Form CMS- Worksheet B	2552-10
COUT AI	LEGENTION GENERAL SERVICE COSTS			F	rom 07/01/2022	Part I	nore d
				Т	o 06/30/2023	Date/Time Pre 11/21/2023 1:	
			CAPITAL REL	ATED COSTS			
	Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
		for Cost			BENEFITS		
		Allocation			DEPARTMENT		
		(from Wkst A col. 7)					
		0	1.00	2.00	4.00	4A	
	GENERAL SERVICE COST CENTERS		2 272 600		1		1
	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP	3,373,680 3,510,716	3,373,680	2 510 716			1.00
	00400 EMPLOYEE BENEFITS DEPARTMENT	7,403,365	130,496	3,510,716			4.00
	00500 ADMINISTRATIVE & GENERAL	30,665,144	510,108	34,283		31,513,403	
	00700 OPERATION OF PLANT	4,842,247	468,137	53,101		5,363,485	
	00800 LAUNDRY & LINEN SERVICE	850,432	5,273	0	-	855,705	
	00900 HOUSEKEEPING 01000 DIETARY	1,239,655 1,325,939	20,511 52,982	0 11,208	-	1,260,166 1,390,129	
	01100 CAFETERIA	785,863	64,230	10,869		860,962	1
	01300 NURSING ADMINISTRATION	2,261,314	55,588	131,207		2,848,827	
	01400 CENTRAL SERVICE & SUPPLY	-208,626	0	77,432		-87,745	
	01500 PHARMACY	2,224,722	32,563	6,972		2,646,077	1
	01600 MEDICAL RECORDS & LIBRARY	37	24,908	2,276		27,221	
	02300 ALLIED HEALTH RAD TECH PROGRAM INPATIENT ROUTINE SERVICE COST CENTERS	297,997	9,120	0	62,351	369,468	23.00
	03000 ADULTS & PEDIATRICS	8,813,162	299,713	128,327	1,592,415	10,833,617	30.00
	03100 INTENSIVE CARE UNIT	2,197,438	57,369	79,530		2,716,220	
	04100 SUBPROVIDER - IRF	1,378,181	138,110	490		1,787,408	
1	04300 NURSERY	558,397	16,378	22,150	95,866	692,791	43.00
	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	5,915,891	336,409	532,502	668,538	7,453,340	50.00
	05200 DELIVERY ROOM & LABOR ROOM	1,520,033	33,225	59,276		1,884,539	
	05400 RADIOLOGY-DIAGNOSTIC	2,206,709	242,476	648,922		3,430,274	
	03630 ULTRA SOUND	370,578	0	103,401		547,195	
	05600 RADIOISOTOPE	1,047,077	20,358	483,125		1,694,877	
	05700 CT SCAN	882,297	0	0 235,756	,	1,051,589 691,317	
	05800 MAGNETIC RESONANCE IMAGING (MRI) 06000 LABORATORY	381,016 6,368,970	80,415	2,978		6,452,363	
	06500 RESPIRATORY THERAPY	1,741,291	12,592	34,633		2,114,079	
	06600 PHYSICAL THERAPY	3,909,125	73,442	19,762	137,260	4,139,589	66.00
	06700 OCCUPATIONAL THERAPY	1,273,796	31,514	6,702		1,344,417	
	06800 SPEECH PATHOLOGY	171,344	10,586	901	· · ·	187,190	
	06900 ELECTROCARDIOLOGY 07000 ELECTROENCEPHALOGRAPHY	419,813 669,410	40,747 27,769	126,775 17,263		661,985 833,138	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1,413,615	43,862	1,821		1,459,298	
	07200 IMPL. DEV. CHARGED TO PATIENTS	3,757,136	0	0		3,757,136	
	07300 DRUGS CHARGED TO PATIENTS	16,200,372	0	0	-	16,200,372	
	07400 RENAL DIALYSIS	314,149	0	12 272	-	314,149	
	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES 03190 CHEMOTHERAPY	954,019 731,604	46,732 0	12,272 476,217		1,205,489 1,349,328	
	03330 ENDOSCOPY	0	0	470,217	0	1, 545, 520	
	03950 WOUND CARE CENTER	772,178	30,537	8,083	60,712	871,510	
	OUTPATIENT SERVICE COST CENTERS		100.001				
91.00	09100 EMERGENCY	3,738,762	196,864	102,706	486,290	4,524,622	
	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS					0	92.00
	09500 AMBULANCE SERVICES	3,431,594	40,391	68,614	575,026	4,115,625	95.00
	SPECIAL PURPOSE COST CENTERS						
118.00		129,710,442	3,153,405	3,499,554	7,416,011	129,361,155	118.00
	NONREIMBURSABLE COST CENTERS 19200 PHYSICIANS' PRIVATE OFFICES	3,219,849	207,969	2,108	84,157	3,514,083	102 00
	19200 PHYSICIANS PRIVATE OFFICES	2,950	207,909	2,108			192.00
	19202 EDUCATION CENTER	15,179	0	0,110			192.02
192.03	19203 MARKETING	0	0	0	0	0	192.03
193.00	19300 NONPAID WORKERS	0	0	0	0		193.00
	07950 FOUNDATION	0	1,832	0	-		194.00
194.00		1 ()	10,474	0	0	10,474	194.01
194.00 194.01	07951 GIFT SHOP 07952 CLINIC OF HOPE	190 270	í n	906	22 602	224 860	194 02
194.00 194.01	07952 CLINIC OF HOPE	190,270	0	906	33,693	224,869 0	200.00
194.00 194.01 194.02	07952 CLINIC OF HOPE Cross Foot Adjustments Negative Cost Centers	190,270	0	906 0	33,693 0	0	200.00 201.00

COST A	ALLOCATION - GENERAL SERVICE COSTS		Provider C	CN: 15-0010	Period: From 07/01/2022 To 06/30/2023	Worksheet B Part I Date/Time Pre 11/21/2023 1:	pared: 47 pm
	Cost Center Description	ADMINISTRATIVE	PLANT	LAUNDRY & LINEN SERVIC		DIETARY	
	GENERAL SERVICE COST CENTERS	5.00	7.00	8.00	9.00	10.00	
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 ADMINISTRATIVE & GENERAL	31,513,403					5.00
7.00	00700 OPERATION OF PLANT	1,661,752	7,025,237				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	265,121	16,355				8.00
9.00	00900 HOUSEKEEPING	390,433	63,619		0 1,714,218		9.00
10.00	01000 DIETARY	430,699	164,337		0 40,561	2,025,726	
11.00	01100 CAFETERIA	266,749	199,225		0 49,172	0	
13.00	01300 NURSING ADMINISTRATION	882,644	172,419		0 42,556	0	
14.00	01400 CENTRAL SERVICE & SUPPLY	0	0		0 0	0	
15.00	01500 PHARMACY	819,826	101,001		0 24,929	0	
16.00 23.00	01600 MEDICAL RECORDS & LIBRARY	8,434	77,259		0 19,069 0 6,982	0	
23.00	02300 ALLIED HEALTH RAD TECH PROGRAM INPATIENT ROUTINE SERVICE COST CENTERS	114,471	28,289		0 6,982	0	23.00
30.00	03000 ADULTS & PEDIATRICS	3,356,547	929,630	750,33	229,450	1,336,611	30.00
31.00	03100 INTENSIVE CARE UNIT	841,558	177,944			210,563	1
41.00	04100 SUBPROVIDER - IRF	553,787	428,380			361,540	
43.00	04300 NURSERY	214,645	50,801				
19100	ANCILLARY SERVICE COST CENTERS	211,015	50,001	05,00	12,555	117,012	13100
50.00	05000 OPERATING ROOM	2,309,246	1,043,451		0 257,540	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	583,881	103,054		0 25,436	0	1
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,062,792	752,096		0 185,631	0	54.00
54.01	03630 ULTRA SOUND	169,536	0		0 0	0	54.01
56.00	05600 RADIOISOTOPE	525,119	63,146		0 15,586	0	56.00
57.00	05700 CT SCAN	325,811	0		0 0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	214,189	0		0 0	0	58.00
60.00	06000 LABORATORY	1,999,116	249,425		0 61,563	0	
65.00	06500 RESPIRATORY THERAPY	654,999	39,056		0 9,640	0	
66.00	06600 PHYSICAL THERAPY	1,282,556	227,798		0 56,225	0	
67.00	06700 OCCUPATIONAL THERAPY	416,537	97,749		0 24,126	0	
68.00	06800 SPEECH PATHOLOGY	57,997	32,836		0 8,104	0	
69.00	06900 ELECTROCARDIOLOGY	205,101	126,386		0 31,194	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	258,129	86,131		0 21,259	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	452,130	136,047		0 33,579	0	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1,164,062	0		0 0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	5,019,272	0		0 0	0	
76.00	07400 RENAL DIALYSIS 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	97,332	144 051		-	0	
76.00	03190 CHEMOTHERAPY	373,493 418,058	144,951		0 35,777 0 0	0	
76.01	03330 ENDOSCOPY	410,030	0		0 0	0	
76.03	03950 WOUND CARE CENTER	270,017	94,718		0 23,378		1
10.05	OUTPATIENT SERVICE COST CENTERS	270,017	51,710		23,570	v	10.05
91.00	09100 EMERGENCY	1,401,850	610,618		0 150,712	0	91.00
92.00		_,,	,			-	92.00
	OTHER REIMBURSABLE COST CENTERS	1		1			
95.00	09500 AMBULANCE SERVICES	1,275,132	125,281		0 30,922	0	95.00
	SPECIAL PURPOSE COST CENTERS			•			
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	30,343,021	6,342,002	1,137,18	1,545,582	2,025,726	118.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	1,088,758	645,064		0 159,214	0	192.00
	19201 ASC MOB	3,438	0		0 0		192.01
	19202 EDUCATION CENTER	4,703	0		0 0	0	192.02
	19203 MARKETING	0	0		0 0	0	192.03
	19300 NONPAID WORKERS	0	0		0 0		193.00
	07950 FOUNDATION	568	5,683		0 1,403		194.00
194.01	07951 GIFT SHOP	3,245	32,488		0 8,019		194.01
194.02	2 07952 CLINIC OF HOPE	69,670	0		0 0	0	194.02
200.00							200.00
201.00		0	0		0 0		201.00
) TOTAL (sum lines 118 through 201)	31,513,403	7,025,237	1,137,18	1,714,218	2,025,726	202 00

COST /	ALLOCATION - GENERAL SERVICE COSTS		Provider CC		Period: From 07/01/2022 To 06/30/2023	Worksheet B Part I Date/Time Pre 11/21/2023 1:	pared: 47 pm
	Cost Center Description	CAFETERIA	NURSING	CENTRAL SERVICE & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
	GENERAL SERVICE 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 ADMINISTRATIVE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPING						9.00
10.00	01000 DIETARY						10.00
11.00	01100 CAFETERIA	1,376,108					11.00
13.00	01300 NURSING ADMINISTRATION	92,399	4,038,845				13.00
14.00	01400 CENTRAL SERVICE & SUPPLY	17,271	4,050,045	-70,47	1		14.00
15.00	01500 PHARMACY	64,569	23,092	70,47	0 3,679,494		15.00
		04,309	23,092			121 002	1
16.00	01600 MEDICAL RECORDS & LIBRARY	12 040	°,			131,983	
23.00	02300 ALLIED HEALTH RAD TECH PROGRAM	12,848	0		0 0	0	23.00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	261 027	1 402 607			6 440	20.00
30.00	03000 ADULTS & PEDIATRICS	361,937	1,482,697		0 0	6,448	1
31.00	03100 INTENSIVE CARE UNIT	81,939	441,358		0 0	2,106	
41.00	04100 SUBPROVIDER - IRF	67,703	335,933		0 0	1,657	1
43.00	04300 NURSERY	18,618	135,726		0 0	525	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	122,703	568,486		0 0	20,630	
52.00	05200 DELIVERY ROOM & LABOR ROOM	55,549	363,223		0 0	3,832	
54.00	05400 RADIOLOGY-DIAGNOSTIC	76,095	14,573		0 0	5,419	
54.01	03630 ULTRA SOUND	9,997	0		0 0	1,418	54.01
56.00	05600 RADIOISOTOPE	33,132	21,895		0 0	5,312	56.00
57.00	05700 CT SCAN	27,726	0		0 0	3,207	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	14,090	0		0 0	666	58.00
60.00	06000 LABORATORY	0	680		0 0	18,417	60.00
65.00	06500 RESPIRATORY THERAPY	69,317	25,514		0 0	3,178	65.00
66.00	06600 PHYSICAL THERAPY	0	0		0 0	2,714	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0		0 0	1,038	67.00
68.00	06800 SPEECH PATHOLOGY	0	0		0 0	169	
69.00	06900 ELECTROCARDIOLOGY	14,978	30,824		0 0	3,189	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	28,604	0		0 0	1,475	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	3,882	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	3,359	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 3,679,494	16,471	
74.00	07400 RENAL DIALYSIS	0	0		0 0	346	1
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	51,941	14,701		0 0	462	1
76.01	03190 CHEMOTHERAPY	33,227	93,507		0 0	1,791	
76.02	03330 ENDOSCOPY	00,221	0		0 0	0	1
	03950 WOUND CARE CENTER	15,397	32,673		0 0		76.03
10.05	OUTPATIENT SERVICE COST CENTERS	10,007	52,075			2,001	10.05
91 00	09100 EMERGENCY	98,479	439,177		0 0	17,083	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	50,115	133,177		°	17,005	92.00
52.00	OTHER REIMBURSABLE COST CENTERS		I				52.00
05 00	09500 AMBULANCE SERVICES	0	0		0 0	4,508	95.00
93.00	SPECIAL PURPOSE COST CENTERS	U	0		0 0	4,308	95.00
118.00		1,368,519	4,024,059		0 3,679,494	131,983	110 00
110.00		1,300,319	4,024,039		0 5,079,494	151,905	110.00
102 00	NONREIMBURSABLE COST CENTERS	0	0			0	192.00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0		0 0		
	19201 ASC MOB	0	0		0 0		192.01
	19202 EDUCATION CENTER	0	0		0 0		192.02
	19203 MARKETING	0	0		0 0		192.03
	19300 NONPAID WORKERS	0	0		0 0		193.00
	07950 FOUNDATION	0	0		0 0		194.00
	07951 GIFT SHOP	0	0		0 0		194.01
	07952 CLINIC OF HOPE	7,589	14,786		0 0	0	194.02
	Cross Foot Adjustments						200.00
200.00							
200.00	Negative Cost Centers	0	0	-70,47 -70,47		0 131,983	201.00

COST A	ALLOCATION - GENERAL SERVICE COSTS		Provider C		Period: From 07/01/2022 To 06/30/2023	Worksheet B Part I Date/Time Prepared 11/21/2023 1:47 pm
	Cost Center Description	ALLIED HEALTH RAD TECH PROGRAM	Subtotal	Intern & Residents Cos & Post Stepdown Adjustments	Total t	
		23.00	24.00	25.00	26.00	
	GENERAL SERVICE COST CENTERS	т т		Т		
1.00	00100 CAP REL COSTS-BLDG & FIXT					1.0
2.00	00200 CAP REL COSTS-MVBLE EQUIP					2.0
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					4.0
5.00	00500 ADMINISTRATIVE & GENERAL					5.0
7.00	00700 OPERATION OF PLANT					7.0
3.00	00800 LAUNDRY & LINEN SERVICE					8.0
9.00	00900 HOUSEKEEPING					9.0
10.00	01000 DIETARY					10.0
11.00	01100 CAFETERIA					11.0
13.00	01300 NURSING ADMINISTRATION					13.0
14.00	01400 CENTRAL SERVICE & SUPPLY					14.0
15.00	01500 PHARMACY					15.0
16.00	01600 MEDICAL RECORDS & LIBRARY					16.0
23.00	02300 ALLIED HEALTH RAD TECH PROGRAM	532,058				23.0
	INPATIENT ROUTINE SERVICE COST CENTERS	,				
30.00	03000 ADULTS & PEDIATRICS	0	19,287,269	9	0 19,287,269	30.0
31.00		0	4,633,812		0 4,633,812	31.0
41.00		0	3,845,098		0 3,845,098	41.0
43.00		0	1,308,344		0 1,308,344	43.0
+3.00	ANCILLARY SERVICE COST CENTERS	U U	1,300,344	r j	1,300,344	
50.00	05000 OPERATING ROOM	0	11,775,396		0 11,775,396	50.0
52.00		0			, ,,	52.0
		-	3,019,514			
54.00	05400 RADIOLOGY-DIAGNOSTIC	179,934	5,706,814	1	0 5,706,814	54.0
54.01		47,082	775,228		0 775,228	54.0
56.00		176,404	2,535,471		0 2,535,471	56.0
57.00	05700 CT SCAN	106,514	1,514,847		0 1,514,847	57.0
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	22,124	942,386		0 942,386	58.0
60.00	06000 LABORATORY	0	8,781,564		0 8,781,564	60.0
65.00	06500 RESPIRATORY THERAPY	0	2,915,783	3	0 2,915,783	65.0
66.00	06600 PHYSICAL THERAPY	0	5,708,882	2	0 5,708,882	66.0
67.00	06700 OCCUPATIONAL THERAPY	0	1,883,867	7	0 1,883,867	67.0
68.00	06800 SPEECH PATHOLOGY	0	286,296	5	0 286,296	68.0
69.00	06900 ELECTROCARDIOLOGY	0	1,073,657	7	0 1,073,657	69.0
70.00	07000 ELECTROENCEPHALOGRAPHY	0	1,228,736	5	0 1,228,736	70.0
71.00		0	2,084,936		0 2,084,936	71.0
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	4,924,557		0 4,924,557	72.0
73.00	07300 DRUGS CHARGED TO PATIENTS	0	24,915,609		0 24,915,609	73.0
74.00		0	411,827		0 411,827	74.0
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	1,826,814		0 1,826,814	76.0
	03190 CHEMOTHERAPY	0				76.0
		0	1,895,911		0 1,895,911 0 0	
	03330 ENDOSCOPY		1 210 274			76.0
10.03	03950 WOUND CARE CENTER	0	1,310,374	+	0 1,310,374	76.0
	OUTPATIENT SERVICE COST CENTERS		= 242 544			
	09100 EMERGENCY	0	7,242,541		0 7,242,541	91.0
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				0	92.0
	OTHER REIMBURSABLE COST CENTERS			1		
95.00	09500 AMBULANCE SERVICES	0	5,551,468	3	0 5,551,468	95.0
	SPECIAL PURPOSE COST CENTERS			1		
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	532,058	127,387,001	L	0 127,387,001	118.0
	NONREIMBURSABLE COST CENTERS					
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	5,407,119	9	0 5,407,119	192.0
192.01	L 19201 ASC МОВ	0	14,536	5	0 14,536	
	19202 EDUCATION CENTER	0	19,882		0 19,882	192.0
	19203 MARKETING	0	20,002		0 0	192.0
	19300 NONPAID WORKERS	0	() ()		0 0	192.0
	07950 FOUNDATION	0	9,486		0 9,486	193.0
		0				
	LO7951 GIFT SHOP	U	54,226		0 54,226	194.0
	2 07952 CLINIC OF HOPE	0	316,914	+	0 316,914	194.0
200.00		0	0	2	0 0	200.0
	Negative Cost Contons		-70,474	11	0 -70,474	1201 (
201.00 202.00		532,058	133,138,690		0 133,138,690	201.0

	То		From 07/01/2022 To 06/30/2023	Part II Date/Time Prep			
			CAPITAL REL	ATED COSTS		11/21/2023 1:4	47 pm
		Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		0	1.00	2.00	2A	4.00	
-	GENERAL SERVICE COST CENTERS						
	00100 CAP REL COSTS-BLDG & FIXT						1.0
	00200 CAP REL COSTS-MVBLE EQUIP	0	120 400		0 130,496	120 406	2.0
	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	1,772,411	130,496 510,108	34,28		130,496 5,264	4.0
	00700 OPERATION OF PLANT	1,772,411	468,137	53,10		5,204	7.0
	00800 LAUNDRY & LINEN SERVICE	0	5,273		0 5,273	0	8.0
	00900 HOUSEKEEPING	0	20,511		0 20,511	0	9.0
	01000 DIETARY	0	52,982	11,20		0	10.0
	01100 CAFETERIA	0	64,230	10,86		0	11.0
	01300 NURSING ADMINISTRATION	0	55,588	131,20		6,942	13.0
	01400 CENTRAL SERVICE & SUPPLY	0	0	77,43		753	14.0
	01500 PHARMACY	0	32,563	6,97		6,614	15.0
6.00	01600 MEDICAL RECORDS & LIBRARY	0	24,908	2,27	6 27,184	0	16.0
3.00	02300 ALLIED HEALTH RAD TECH PROGRAM	0	9,120		0 9,120	1,080	23.0
	INPATIENT ROUTINE SERVICE COST CENTERS						1
	03000 ADULTS & PEDIATRICS	0	299,713	128,32		27,572	30.0
1	03100 INTENSIVE CARE UNIT	0	57,369	79,53		6,615	
	04100 SUBPROVIDER - IRF	0	138,110	49		4,688	
	04300 NURSERY	0	16,378	22,15	0 38,528	1,661	43.
-	ANCILLARY SERVICE COST CENTERS		226 400	522 50		11.501	
	05000 OPERATING ROOM	0	336,409	532,50		11,581	50.
	05200 DELIVERY ROOM & LABOR ROOM	0	33,225	59,27		4,712	52.
	05400 RADIOLOGY-DIAGNOSTIC 03630 ULTRA SOUND	0	242,476	648,92 103,40		5,754 1,268	
	05600 RADIOISOTOPE	0	20,358	483,12		2,500	
	05700 CT SCAN	0	20,330		0 000,400	2,933	
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	235,75	0	1,291	58.
	06000 LABORATORY	0	80,415	2,97		1,231	60.
	06500 RESPIRATORY THERAPY	Ő	12,592	34,63		5,640	
	06600 PHYSICAL THERAPY	0	73,442	19,76		2,378	
	06700 OCCUPATIONAL THERAPY	0	31,514	6,70		561	67.
	06800 SPEECH PATHOLOGY	0	10,586	90		76	68.
	06900 ELECTROCARDIOLOGY	0	40,747	126,77	5 167,522	1,293	69.
0.00	07000 ELECTROENCEPHALOGRAPHY	0	27,769	17,26	3 45,032	2,056	70.
1.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	43,862	1,82	1 45,683	0	71.
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(0 0	0	72.
	07300 DRUGS CHARGED TO PATIENTS	0	0	(0 0	0	73.
	07400 RENAL DIALYSIS	0	0	(0 0	0	74.
	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	46,732	12,27		3,334	
	03190 CHEMOTHERAPY	0	0	476,21	7 476,217	2,451	
	03330 ENDOSCOPY	0	0	0.00	0 0	1 052	76.
	03950 WOUND CARE CENTER	0	30,537	8,08	3 38,620	1,052	76.
	OUTPATIENT SERVICE COST CENTERS 09100 EMERGENCY	0	196,864	102,70	6 299,570	8,424	91.
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	190,004	102,70	299,370	0,424	91.
	OTHER REIMBURSABLE COST CENTERS				0		92.
	09500 AMBULANCE SERVICES	0	40,391	68,61	4 109,005	9,961	95.
	SPECIAL PURPOSE COST CENTERS		10,331	00,01	1 100,000	5,501	
18.00		1,772,411	3,153,405	3,499,55	4 8,425,370	128,454	118.
Ţ	NONREIMBURSABLE COST CENTERS				· · · · · ·		
€2.00	19200 PHYSICIANS' PRIVATE OFFICES	0	207,969	2,10	8 210,077	1,458	192.
	19201 ASC MOB	0	0	8,14	8 8,148		192.
	19202 EDUCATION CENTER	0	0	(0 0		192.
	19203 MARKETING	0	0	(0 0		192.
	19300 NONPAID WORKERS	0	0	(0 0		193.
	07950 FOUNDATION	0	1,832		0 1,832		194.
	07951 GIFT SHOP	0	10,474		0 10,474		194.
	07952 CLINIC OF HOPE	0	0	90	6 906		194
00.00					0		200.
01.00	Negative Cost Centers		0		J 0	0	201.

	TION OF CAPITAL RELATED COSTS		Provider Co		Period: From 07/01/2022 To 06/30/2023	Worksheet B Part II Date/Time Pre 11/21/2023 1:4	pared: 47 pm
	Cost Center Description	ADMINISTRATIVE & GENERAL	PLANT	LAUNDRY & LINEN SERVICE		DIETARY	
	GENERAL SERVICE COST CENTERS	5.00	7.00	8.00	9.00	10.00	
.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
.00	00500 ADMINISTRATIVE & GENERAL	2,322,066					5.00
.00	00700 OPERATION OF PLANT	122,448	643,686				7.00
.00	00800 LAUNDRY & LINEN SERVICE	19,536	1,498	26,30	7		8.00
.00	00900 HOUSEKEEPING	28,770	5,829		0 55,110		9.00
0.00	01000 DIETARY	31,737	15,057		0 1,304	112,288	10.00
1.00	01100 CAFETERIA	19,656	18,254		0 1,581	0	11.00
3.00	01300 NURSING ADMINISTRATION	65,039	15,798		0 1,368	0	13.00
4.00	01400 CENTRAL SERVICE & SUPPLY	0	0		0 0	0	14.00
5.00	01500 PHARMACY	60,410	9,254		0 801	0	15.00
	01600 MEDICAL RECORDS & LIBRARY	621	7,079		0 613 0 224	0	16.00
	02300 ALLIED HEALTH RAD TECH PROGRAM INPATIENT ROUTINE SERVICE COST CENTERS	8,435	2,592		0 224	0	23.00
	03000 ADULTS & PEDIATRICS	247,331	85,177	17,35	8 7,377	74,089	30.00
1.00	03100 INTENSIVE CARE UNIT	62,011	16,304	2,73		11,672	31.00
1.00	04100 SUBPROVIDER - IRF	40,807	39,250			20,041	41.00
	04300 NURSERY	15,816				6,486	
	ANCILLARY SERVICE COST CENTERS		.,	_,			
0.00	05000 OPERATING ROOM	170,160	95,605		0 8,278	0	50.00
2.00	05200 DELIVERY ROOM & LABOR ROOM	43,024	9,442		0 818	0	52.00
4.00	05400 RADIOLOGY-DIAGNOSTIC	78,313	68,911		0 5,968	0	54.0
4.01	03630 ULTRA SOUND	12,492	0		0 0	0	54.03
6.00	05600 RADIOISOTOPE	38,694	5,786		0 501	0	56.0
7.00	05700 CT SCAN	24,008	0		0 0	0	57.0
8.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	15,783	0		0 0	0	58.00
0.00	06000 LABORATORY	147,307	22,854		0 1,979	0	60.00
5.00	06500 RESPIRATORY THERAPY	48,264	3,578		0 310	0	65.00
6.00	06600 PHYSICAL THERAPY	94,507	20,872		0 1,808	0	66.00
7.00	06700 OCCUPATIONAL THERAPY	30,693	8,956		0 776	0	67.0
8.00	06800 SPEECH PATHOLOGY	4,274	3,009		0 261	0	68.0
9.00		15,113	11,580		0 1,003	0	69.0
0.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	19,021 33,316	7,892 12,465		0 683 0 1,080	0	70.0
	07200 IMPL. DEV. CHARGED TO PATIENTS	85,775	12,403		0 1,080	0	72.0
	07300 DRUGS CHARGED TO PATIENTS	369,811	0		0 0	0	72.0
	07400 RENAL DIALYSIS	7,172	0		0 0	0	74.0
	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	27,521	13,281		0 1,150	0	76.00
	03190 CHEMOTHERAPY	30,805	0		0 0	0	76.0
6.02	03330 ENDOSCOPY	0	0		0 0	0	76.0
6.03	03950 WOUND CARE CENTER	19,897	8,679		0 752	0	76.0
	OUTPATIENT SERVICE COST CENTERS		· · · · ·				1
	09100 EMERGENCY	103,297	55,948		0 4,845	0	91.00
2.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.0
	OTHER REIMBURSABLE COST CENTERS						
5.00	09500 AMBULANCE SERVICES	93,960	11,479		0 994	0	95.0
	SPECIAL PURPOSE COST CENTERS						
18.00		2,235,824	581,084	26,30	7 49,688	112,288	118.00
	NONREIMBURSABLE COST CENTERS	00.007	F0 101		0 5 440		102 0
	19200 PHYSICIANS' PRIVATE OFFICES	80,227	59,104		0 5,119		192.0
	19201 ASC MOB 19202 EDUCATION CENTER	253	0		0 0		192.0
		347	0		0 0		192.0
	19203 MARKETING	0	0		0		192.0 193.0
	19300 NONPAID WORKERS	0	U 5 1		0 0		193.0
	07950 FOUNDATION 07951 GIFT SHOP	42	521 2,977		0 45 0 258		194.0
	07951 GIFT SHOP	5,134	2,9//		0 258		194.0
01 A7	IV/ 3JZICLINIC UP HUPE	5,134	0		v V		
						1	200 0
94.02 00.00 01.00	Cross Foot Adjustments		0		0		200.0

ALLOC	ATION OF CAPITAL RELATED COSTS		Provider CC	:N: 15-0010	Period: From 07/01/2022 To 06/30/2023	Worksheet B Part II Date/Time Pre 11/21/2023 1:	epared: 47 pm
	Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICE & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
	GENERAL SERVICE 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 ADMINISTRATIVE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPING						9.00
10.00	01000 DIETARY						10.00
11.00	01100 CAFETERIA	114,590					11.00
13.00	01300 NURSING ADMINISTRATION	7,694	1 1				13.00
14.00	01400 CENTRAL SERVICE & SUPPLY	1,438		79,62	2		14.00
15.00	01500 PHARMACY	5,377	1,622	75,02	0 123,613		15.00
16.00		0	1,022		0 123,013	25 407	
	01600 MEDICAL RECORDS & LIBRARY	-	-			35,497	
23.00	02300 ALLIED HEALTH RAD TECH PROGRAM	1,070	0		0 0	0	23.00
	INPATIENT ROUTINE SERVICE COST CENTERS	20, 120	104 124			1 750	20.00
30.00		30,139			0 0	1,750	1
31.00	03100 INTENSIVE CARE UNIT	6,823			0 0	571	
41.00	04100 SUBPROVIDER - IRF	5,638			0 0	450	
43.00	04300 NURSERY	1,550	9,532		0 0	142	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	10,218	39,923		0 0	5,282	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	4,626	25,508		0 0	1,040	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	6,337	1,023		0 0	1,470	54.00
54.01	03630 ULTRA SOUND	832	0		0 0	385	54.01
56.00	05600 RADIOISOTOPE	2,759	1,538		0 0	1,441	56.00
57.00	05700 CT SCAN	2,309			0 0	870	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1,173	0		0 0	181	1
60.00	06000 LABORATORY	0	48		0 0	4,997	
65.00	06500 RESPIRATORY THERAPY	5,772	1,792		0 0	862	1
66.00	06600 PHYSICAL THERAPY	0	1,152		0 0	736	
67.00	06700 OCCUPATIONAL THERAPY	0	0		0 0	282	
68.00	06800 SPEECH PATHOLOGY	0	0		0 0	46	
69.00	06900 ELECTROCARDIOLOGY	1,247	2 165		0	865	
					0 0		
70.00	07000 ELECTROENCEPHALOGRAPHY	2,382	0		0 0	400	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	1,053	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	912	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 123,613	4,470	
74.00	07400 RENAL DIALYSIS	0	0		0 0	94	1
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	4,325			0 0	125	1
76.01	03190 CHEMOTHERAPY	2,767	6,567		0 0	486	76.01
76.02	03330 ENDOSCOPY	0			0 0	0	
76.03	03950 WOUND CARE CENTER	1,282	2,295		0 0	728	76.03
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	8,200	30,842		0 0	4,636	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0	0		0 0	1,223	95.00
	SPECIAL PURPOSE COST CENTERS	1				,	
118.0		113,958	282,598		0 123,613	35,497	118.00
	NONREIMBURSABLE COST CENTERS						
192 0	19200 PHYSICIANS' PRIVATE OFFICES	0	0		0 0	0	192.00
	19201 ASC MOB	ů ů	0		0 0		192.01
	19202 EDUCATION CENTER	0	0		0 0		192.02
	19202 EDUCATION CENTER 3 19203 MARKETING	0	0				192.02
		0	0				
	19300 NONPAID WORKERS	0	0		0		193.00
	07950 FOUNDATION	0	0		0		194.00
	107951 GIFT SHOP	0	0		0 0		194.01
	2 07952 CLINIC OF HOPE	632	1,038		0 0	0	194.02
200.00							200.00
201 0	Negative Cost Centers	0	0	79,62	23 0	0	201.00
201.0							202.00

ALLOCA	I Financial Systems ATION OF CAPITAL RELATED COSTS	ASCENSION ST. VI		CN: 15-0010	Period: From 07/01/2022	u of Form CMS-2552 Worksheet B Part II
					To 06/30/2023	Date/Time Prepar 11/21/2023 1:47
	Cost Center Description	ALLIED HEALTH RAD TECH PROGRAM	Subtotal	Intern & Residents Cos & Post Stepdown Adjustments		,,,,,,,,,
		23.00	24.00	25.00	26.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT					1
2.00	00200 CAP REL COSTS-BEDG & FIXT					2
.00	00400 EMPLOYEE BENEFITS DEPARTMENT					4
.00	00500 ADMINISTRATIVE & GENERAL					5
.00	00700 OPERATION OF PLANT					7
3.00	00800 LAUNDRY & LINEN SERVICE					8
9.00	00900 HOUSEKEEPING					g
L0.00	01000 DIETARY					10
L1.00	01100 CAFETERIA					11
L3.00	01300 NURSING ADMINISTRATION					13
L4.00	01400 CENTRAL SERVICE & SUPPLY					14
L5.00	01500 PHARMACY					15
L6.00	01600 MEDICAL RECORDS & LIBRARY					16
23.00		22,521				23
	INPATIENT ROUTINE SERVICE COST CENTERS	· · ·				
30.00	03000 ADULTS & PEDIATRICS		1,022,957	7	0 1,022,957	30
31.00	03100 INTENSIVE CARE UNIT		276,036	5	0 276,036	31
41.00	04100 SUBPROVIDER - IRF		281,160		0 281,160	41
13.00	04300 NURSERY		80,293	3	0 80,293	43
	ANCILLARY SERVICE COST CENTERS	-1				
0.00	05000 OPERATING ROOM		1,209,958		0 1,209,958	50
2.00			181,671		0 181,671	52
64.00	05400 RADIOLOGY-DIAGNOSTIC		1,059,174		0 1,059,174	54
54.01			118,378		0 118,378	54
56.00			556,702		0 556,702	56
57.00	05700 CT SCAN		30,120		0 30,120	57
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		254,184		0 254,184	58
50.00	06000 LABORATORY		260,578		0 260,578	60
55.00	06500 RESPIRATORY THERAPY		113,443		0 113,443	65
56.00	06600 PHYSICAL THERAPY		213,505		0 213,505	66
57.00	06700 OCCUPATIONAL THERAPY		79,484		0 79,484	67
68.00	06800 SPEECH PATHOLOGY		19,153		0 19,153	68
59.00	06900 ELECTROCARDIOLOGY		200,788		0 200,788	69
70.00	07000 ELECTROENCEPHALOGRAPHY		77,466		0 77,466	70
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		93,597		0 93,597	71
72.00			86,687		0 86,687	72
73.00	07300 DRUGS CHARGED TO PATIENTS		497,894		0 497,894	73
	07400 RENAL DIALYSIS		7,266		0 7,266	74
	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES		109,772		0 109,772	76
76.01			519,293		0 519,293	76
			72 201		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	76
6.03	03950 WOUND CARE CENTER OUTPATIENT SERVICE COST CENTERS		73,305		0 73,305	76
91.00			515,762		0 515,762	91
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		515,702	-	0 515,762	92
92.00	OTHER REIMBURSABLE COST CENTERS				U	
95.00	09500 AMBULANCE SERVICES		226,622		0 226,622	95
5.00	SPECIAL PURPOSE COST CENTERS	1 1	220,022	-1		
118.00		0	8,165,248	3	0 8,165,248	118
	NONREIMBURSABLE COST CENTERS		· · · ·			
	19200 PHYSICIANS' PRIVATE OFFICES		355,985	5	0 355,985	192
L92.01	1 19201 ASC MOB		8,401	L	0 8,401	192
	2 19202 EDUCATION CENTER		347		0 347	192
L92.03	3 19203 MARKETING		C		0 0	192
.93.00	19300 NONPAID WORKERS		C		0 0	193
.94.00	07950 FOUNDATION		2,440		0 2,440	194
L94.01	107951 GIFT SHOP		13,948		0 13,948	194
	2 07952 CLINIC OF HOPE		8,294		0 8,294	194
200.00		22,521	22,521		0 22,521	200
201.00		0	79,623		0 79,623	201
			-,	7	0 8,656,807	

	Financial Systems LOCATION - STATISTICAL BASIS	ASCENSION ST. \	Provider C	CN: 15-0010 F	eriod:	worksheet B-1	
					rom 07/01/2022 o 06/30/2023		
		CAPITAL RE	LATED COSTS			11/21/2023 1:	47
	Cost Coston Deceminting						
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS	Reconciliation	ADMINISTRATIVE & GENERAL	
		(SQUARE FEET)	(DOLLAR VALUE)	DEPARTMENT		(ACCUM. COST)	
				(GROSS			
				SALARIES)			
		1.00	2.00	4.00	5A	5.00	
	ENERAL SERVICE COST CENTERS	1	1				
	00100 CAP REL COSTS-BLDG & FIXT	331,432					
	00200 CAP REL COSTS-MVBLE EQUIP		3,307,094				
	00400 EMPLOYEE BENEFITS DEPARTMENT	12,820		34,463,068		4.04 =4.0 000	
	00500 ADMINISTRATIVE & GENERAL	50,113		1,390,021	-31,513,403		
	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	45,990			0	5,363,485 855,705	
	00900 HOUSEKEEPING	2,015			0	1,260,166	
	01000 DIETARY	5,205			0	1,390,129	
	01100 CAFETERIA	6,310			0	860,962	
	01300 NURSING ADMINISTRATION	5,461			0	2,848,827	
	01400 CENTRAL SERVICE & SUPPLY	0				0	
	D1500 PHARMACY	3,199				2,646,077	
	01600 MEDICAL RECORDS & LIBRARY	2,447			0	27,221	
	2300 ALLIED HEALTH RAD TECH PROGRAM	896	5 0	285,218	0	369,468	2
	INPATIENT ROUTINE SERVICE COST CENTERS	1	1		1		
	3000 ADULTS & PEDIATRICS	29,444	,			.,,.	
	03100 INTENSIVE CARE UNIT	5,636		, ,		, , , ,	
	04100 SUBPROVIDER - IRF	13,568		1,237,961		_,,	
	04300 NURSERY	1,609	20,865	438,532	0	692,791	4
	NCILLARY SERVICE COST CENTERS	33,049	501,617	3,058,172	0	7,453,340	5
	05200 DELIVERY ROOM & LABOR ROOM	3,264				1,884,539	
	05400 RADIOLOGY-DIAGNOSTIC	23,821				3,430,274	
	03630 ULTRA SOUND	23,021					
	05600 RADIOISOTOPE	2,000				1,694,877	
	05700 CT SCAN	2,000		774,413		1,051,589	
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	222,082	340,999		691,317	
	06000 LABORATORY	7,900		C	0	6,452,363	
00 0	06500 RESPIRATORY THERAPY	1,237		1,489,261	. 0	2,114,079	
.00 0	06600 PHYSICAL THERAPY	7,215	18,616	627,883	0	4,139,589	6
.00 0	06700 OCCUPATIONAL THERAPY	3,096	6,313	148,234	. 0	1,344,417	6
	06800 SPEECH PATHOLOGY	1,040	849	19,940	0	187,190	6
	06900 ELECTROCARDIOLOGY	4,003	3 119,422	, ,		661,985	6
	07000 ELECTROENCEPHALOGRAPHY	2,728		542,963		833,138	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4,309	1,715	C	0	_,,	
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	C	0	3,757,136	
	07300 DRUGS CHARGED TO PATIENTS	0	-		0		
	07400 RENAL DIALYSIS	0	-	-	° °	51.,1.5	
	3550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	4,591				,,	
	03190 CHEMOTHERAPY 03330 ENDOSCOPY			647,314	0	, ,	
	3330 ENDOSCOPY 33950 WOUND CARE CENTER	3,000	-	277,722	-	-	
	DUTPATIENT SERVICE COST CENTERS	5,000	// /,014	2//,/22	0	071,310	11
	09100 EMERGENCY	19,340	96,749	2,224,494	0	4,524,622	9
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	10,040				.,	9
	THER REIMBURSABLE COST CENTERS						1
	09500 AMBULANCE SERVICES	3,968	64,634	2,630,410	0	4,115,625	9
	SPECIAL PURPOSE COST CENTERS	· · · · ·	· · · · ·				1
3.00	SUBTOTALS (SUM OF LINES 1 through 117)	309,792	3,296,580	33,923,974	-31,425,658	97,935,497	111
N	IONREIMBURSABLE COST CENTERS						
	L9200 PHYSICIANS' PRIVATE OFFICES	20,431			0	3,514,083	
	L9201 ASC MOB	0	7,675	C	0	11,098	
	L9202 EDUCATION CENTER	C	0	C	0	15,179	
	L9203 MARKETING	0	0	C	0		19
	19300 NONPAID WORKERS	190	-		0		19
	7950 FOUNDATION	180			0	1,832	
	07951 GIFT SHOP	1,029		-	0	10,474	
	07952 CLINIC OF HOPE	C	853	154,125	0	224,869	
00.0	Cross Foot Adjustments						20
L.00 2.00	Negative Cost Centers Cost to be allocated (per Wkst. B,	2 272 600	2 510 716	7 522 061		31,513,403	20
	Part I)	3,373,680	3,510,716	7,533,861	•	51,515,405	20
3.00	Unit cost multiplier (Wkst. B, Part I)	10.179102	1.061571	0.218607	,	0.309827	20
4.00	Cost to be allocated (per Wkst. B,	10.175102		130,496		2,322,066	
	Part II)			1,10,450		2,522,000	_
5.00	Unit cost multiplier (Wkst. B, Part			0.003787	,	0.022830	20
	II)						1

Health Financ	ial Systems A	ASCENSION ST. V	INCENT KOKOMO		In Lie	u of Form CMS-	2552-10
COST ALLOCATI	ON - STATISTICAL BASIS		Provider CO		Period: From 07/01/2022	Worksheet B-1	
					то 06/30/2023		
		CAPITAL REI	ATED COSTS				
C	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliation	-	
		(SQUARE FEET)	(DOLLAR VALUE)	BENEFITS		& GENERAL	
				DEPARTMENT		(ACCUM. COST)	
				(GROSS			
				SALARIES)			
		1.00	2.00	4.00	5A	5.00	
206.00 N	IAHE adjustment amount to be allocated						206.00
	(per Wkst. B-2)						
	AHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

OST AL	LOCATION - STATISTICAL BASIS		Provider C	CN: 15-0010	Period: From 07/01/2022	Worksheet B-1	-
					To 06/30/2023	Date/Time Pre 11/21/2023 1:	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPING	DIETARY	CAFETERIA	47
		PLANT	LINEN SERVICE		(TOTAL PATIENT	(ASSIGNED	
		(SQUARE FEET)	(TOTAL PATIENT DAYS)		DAYS)	TIME)	
		7.00	8.00	9.00	10.00	11.00	-
C	GENERAL SERVICE COST CENTERS	1					
1	00100 CAP REL COSTS-BLDG & FIXT						
	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2
	00500 ADMINISTRATIVE & GENERAL						5
	00700 OPERATION OF PLANT	222,509					7
	00800 LAUNDRY & LINEN SERVICE	518		i			8
	00900 HOUSEKEEPING	2,015					9
	01000 DIETARY	5,205				705 711	10
	01100 CAFETERIA 01300 NURSING ADMINISTRATION	6,310 5,461		-,		705,711 47,385	
	01400 CENTRAL SERVICE & SUPPLY	5,401				47,383	
	01500 PHARMACY	3,199				33,113	
.00 0	01600 MEDICAL RECORDS & LIBRARY	2,447				0	16
-	02300 ALLIED HEALTH RAD TECH PROGRAM	896	0	89	6 0	6,589	23
	INPATIENT ROUTINE SERVICE COST CENTERS	20.444	10.010	20.44	4 10 010	105 010	1
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	29,444 5,636				185,612 42,021	
	04100 SUBPROVIDER – IRF	13,568				42,021 34,720	
	04300 NURSERY	1,609				9,548	
-	ANCILLARY SERVICE COST CENTERS	_,	_,			-,	
	05000 OPERATING ROOM	33,049	0	33,04	9 0	62,926] 50
	05200 DELIVERY ROOM & LABOR ROOM	3,264				28,487	
	05400 RADIOLOGY-DIAGNOSTIC	23,821		- / -		39,024	
	03630 ULTRA SOUND	2 000	-	1	0 0 0 0	5,127	
	05600 RADIOISOTOPE 05700 CT SCAN	2,000			0 0	16,991 14,219	
	05800 MAGNETIC RESONANCE IMAGING (MRI)				0 0	7,226	
	06000 LABORATORY	7,900				0	60
.00 0	06500 RESPIRATORY THERAPY	1,237				35,548	6
	06600 PHYSICAL THERAPY	7,215		.,		0	66
	06700 OCCUPATIONAL THERAPY	3,096				0	67
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDIOLOGY	1,040		, .		0	68
	07000 ELECTROEARDIOLOGY 07000 ELECTROENCEPHALOGRAPHY	4,003			-	7,681 14,669	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4,309		_,		0	71
	07200 IMPL. DEV. CHARGED TO PATIENTS	C			0 0	0	72
	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73
	07400 RENAL DIALYSIS	C	0		0 0	0	74
	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	4,591		4,59		26,637	
	03190 CHEMOTHERAPY 03330 ENDOSCOPY				0 0	17,040	
	03950 WOUND CARE CENTER	3,000	, i i i i i i i i i i i i i i i i i i i		~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~	Ũ	
	DUTPATIENT SERVICE COST CENTERS	-,	-		-, -,	.,	
1.00	09100 EMERGENCY	19,340	0	19,34	0 0	50,503	91
	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS	2.000		2.00			1
	09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	3,968	0	3,96	8 0	0	95
8.00	SUBTOTALS (SUM OF LINES 1 through 117)	200,869	20,636	198,33	6 20,636	701,819	1118
	NONREIMBURSABLE COST CENTERS	200,003	20,000	1 190,99	20,030	701,015	1
2.00	19200 PHYSICIANS' PRIVATE OFFICES	20,431	0	20,43	1 0	0	192
	19201 ASC MOB	C			0 0		192
	19202 EDUCATION CENTER	0	0		0 0		192
	19203 MARKETING		0		0 0	0	192 193
	19300 NONPAID WORKERS 07950 FOUNDATION	180		18			19
	07951 GIFT SHOP	1,029		1,02			194
	07952 CLINIC OF HOPE	0	Ő	_,02	o o	3,892	
0.00	Cross Foot Adjustments					_ , _ ,	200
1.00	Negative Cost Centers						201
2.00	Cost to be allocated (per Wkst. B,	7,025,237	1,137,181	1,714,21	8 2,025,726	1,376,108	202
13 00	Part I)	21 57000	EE 100059	7 70275	00 164664	1 040000	20-
)3.00)4.00	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	31.572822 643,686					
-T.UU	Part II)	040,000	20,307	33,11	,200	114,390	202
05.00	Unit cost multiplier (Wkst. B, Part	2.892854	1.274811	0.25052	7 5.441365	0.162375	205
	II)						
06.00	NAHE adjustment amount to be allocated						206
07.00	(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,						207
1.00	Parts III and IV)						1201

DST ALL	LOCATION - STATISTICAL BASIS		Provider CC	N: 15-0010	Period: From 07/01/2022	Worksheet B-1	
					To 06/30/2023	Date/Time Pre 11/21/2023 1:	par 47
	Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICE & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	ALLIED HEALTH RAD TECH PROGRAM (ASSIGNED TIME)	
		13.00	14.00	15.00	16.00	23.00	
G	ENERAL SERVICE COST CENTERS						
1	0100 CAP REL COSTS-BLDG & FIXT						1
1	0200 CAP REL COSTS-MVBLE EQUIP						2
	0400 EMPLOYEE BENEFITS DEPARTMENT						4
00 0	0500 ADMINISTRATIVE & GENERAL						5
00 00	0700 OPERATION OF PLANT						7
00 0	0800 LAUNDRY & LINEN SERVICE						8
1	0900 HOUSEKEEPING						9
	1000 DIETARY						10
	1100 CAFETERIA						11
	1300 NURSING ADMINISTRATION	570,361					13
	1400 CENTRAL SERVICE & SUPPLY	570,501	8,801,806				14
	1500 PHARMACY	-		16 200 2	7.2		15
		3,261	53,754	16,200,37			
	1600 MEDICAL RECORDS & LIBRARY	0	29		0 662,982,687	00 510 111	16
	2300 ALLIED HEALTH RAD TECH PROGRAM	0	0		0 0	80,510,114	23
	NPATIENT ROUTINE SERVICE COST CENTERS	202 22-			0 22 400 25-		1
	3000 ADULTS & PEDIATRICS	209,385	342,449		0 32,400,865	0	30
	3100 INTENSIVE CARE UNIT	62,328	132,984		0 10,582,420		31
	4100 SUBPROVIDER - IRF	47,440	22,970		0 8,329,010	0	41
.00 0	4300 NURSERY	19,167	27,266		0 2,636,491	0	43
A	NCILLARY SERVICE COST CENTERS						
.00 0	5000 OPERATING ROOM	80,281	1,917,259		0 103,420,371	0	50
.00 0	5200 DELIVERY ROOM & LABOR ROOM	51,294	72,967		0 19,257,080	0	52
	5400 RADIOLOGY-DIAGNOSTIC	2,058	470,092		0 27,230,588		54
1	3630 ULTRA SOUND	0	11,205		0 7,123,983		
	5600 RADIOISOTOPE	3,092	61,088		0 26,691,426		
	15700 CT SCAN	5,052	4,760			16,116,544	
					, . , .		
1	5800 MAGNETIC RESONANCE IMAGING (MRI)	0	16,092		0 3,347,573	3,347,573	58
	6000 LABORATORY	96	3,128		0 92,545,346	0	60
	6500 RESPIRATORY THERAPY	3,603	76,526		0 15,967,522	0	65
.00 0	6600 PHYSICAL THERAPY	0	12,098		0 13,637,350	0	66
.00 0	6700 OCCUPATIONAL THERAPY	0	4,103		0 5,214,251	0	67
.00 0	6800 SPEECH PATHOLOGY	0	552		0 851,738	0	68
.00 0	6900 ELECTROCARDIOLOGY	4,353	34,090		0 16,025,803	0	69
.00 0	7000 ELECTROENCEPHALOGRAPHY	0	53,737		0 7,413,735	0	70
.00 0	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,282,468		0 19,506,483	0	71
.00 0	7200 IMPL. DEV. CHARGED TO PATIENTS	0	3,757,136		0 16,881,765	0	72
.00 0	7300 DRUGS CHARGED TO PATIENTS	0	0	16,200,37		0	73
	7400 RENAL DIALYSIS	0	2,569	,,-	0 1,738,438	0	74
	3550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,076	48		0 2,321,912	0	
	3190 CHEMOTHERAPY		33,667				
		13,205	55,007				1
	3330 ENDOSCOPY	0			0 0	0	
	3950 WOUND CARE CENTER	4,614	65,705		0 13,473,437	0	76
	UTPATIENT SERVICE COST CENTERS						
	9100 EMERGENCY	62,020	270,875		0 85,846,551	0	
	9200 OBSERVATION BEDS (NON-DISTINCT PART)						92
	THER REIMBURSABLE COST CENTERS	· ·			-1		1
	9500 AMBULANCE SERVICES	0	69,276		0 22,652,797	0	95
	PECIAL PURPOSE COST CENTERS						
8.00	SUBTOTALS (SUM OF LINES 1 through 117)	568,273	8,798,893	16,200,37	72 662,982,687	80,510,114	118
N	ONREIMBURSABLE COST CENTERS						
	9200 PHYSICIANS' PRIVATE OFFICES	0	0		0 0		192
2.01	9201 ASC MOB	0	0		0 0	0	192
	9202 EDUCATION CENTER	0	10		0 0	0	192
	9203 MARKETING	0	0		0 0	0	192
	9300 NONPAID WORKERS	0	0		0 0		193
	7950 FOUNDATION	0	0		0 0		194
	7951 GIFT SHOP	0			0		194
	7951 GIFT SHOP 7952 CLINIC OF HOPE	2,088	2,903		0		194
		2,008	2,903		0	0	
0.00	Cross Foot Adjustments						200
1.00 2.00	Negative Cost Centers Cost to be allocated (per Wkst. B,	4,038,845	-70,474	3,679,49	94 131,983	532,058	201 202
	Part I)			.			
3.00	Unit cost multiplier (Wkst. B, Part I)	7.081208	0.00000	0.22712			
4.00	Cost to be allocated (per Wkst. B,	283,636	79,623	123,61	L3 35,497	22,521	204
- 00	Part II)	0 407000	0.000010	0 0070	0 000051	0 000000	20.
5.00	Unit cost multiplier (Wkst. B, Part II)	0.497292	0.009046	0.00763	0.000054	0.000280	205
6.00	NAHE adjustment amount to be allocated					0	206
0.001	, , , , , , , , , , , , , , , , , , ,	1			1	, v	

Health Financial Systems	ASCENSION ST. VI	INCENT KOKOMO		In Lieu of Form CMS-2552		
COST ALLOCATION - STATISTICAL BASIS		Provider C	CN: 15-0010	Period: From 07/01/2022	Worksheet B-1	
				то 06/30/2023	Date/Time Pre 11/21/2023 1:	
Cost Center Description	NURSING	CENTRAL	PHARMACY	MEDICAL	ALLIED HEALTH	
	ADMINISTRATION	SERVICE &	(COSTED	RECORDS &	RAD TECH	
		SUPPLY	REQUIS.)	LIBRARY	PROGRAM	
	(DIRECT NURS.	(COSTED		(GROSS	(ASSIGNED	
	HRS.)	REQUIS.)		CHARGES)	TIME)	
	13.00	14.00	15.00	16.00	23.00	
207.00 NAHE unit cost multiplier (Wkst. D,					0.00000	207.00
Parts III and IV)						

		ASCENSION SI. V	INCENT KOKOMO			u of Form CMS-2	2552-10
COMPUTA	TION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0010	Period: From 07/01/2022 To 06/30/2023	Worksheet C Part I Date/Time Pre 11/21/2023 1:	pared: 47 pm
			Title	XVIII	Hospital	PPS	
					Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col.	Therapy Limit Adj.	Total Costs	RCE Disallowance	Total Costs	
		26)					
		1.00	2.00	3.00	4.00	5.00	
I	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	19,287,269		19,287,2	69 0	19,287,269	30.00
31.00 0	03100 INTENSIVE CARE UNIT	4,633,812		4,633,8		4,633,812	
)4100 SUBPROVIDER - IRF	3,845,098		3,845,0		3,845,098	
	04300 NURSERY	1,308,344		1,308,3		1,308,344	
	NCILLARY SERVICE COST CENTERS	_,,.	l	_,,.		_,,.	
	05000 OPERATING ROOM	11,775,396		11,775,3	96 27,348	11,802,744	50.00
	05200 DELIVERY ROOM & LABOR ROOM	3,019,514		3,019,5		3,019,514	
)5400 RADIOLOGY-DIAGNOSTIC	5,706,814		5,706,8		5,706,814	
	03630 ULTRA SOUND	775,228		775,2		775,228	
	05600 RADIOISOTOPE	2,535,471		2,535,4		2,535,471	
	05700 CT SCAN	1,514,847		1,514,8		1,514,847	
	05800 MAGNETIC RESONANCE IMAGING (MRI)	942,386		942,3		942,386	
	06000 LABORATORY	8,781,564		8,781,5		8,781,564	
	06500 RESPIRATORY THERAPY	2,915,783	0	, ,		2,915,783	
	D6600 PHYSICAL THERAPY	5,708,882	0			5,708,882	
	06700 OCCUPATIONAL THERAPY	1,883,867	0	1,883,8		1,883,867	
	06800 SPEECH PATHOLOGY	286,296	0	286,2		286,296	
	06900 ELECTROCARDIOLOGY	1,073,657	-	1,073,6		1,073,657	
	07000 ELECTROENCEPHALOGRAPHY	1,228,736		1,228,7		1,228,736	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2,084,936		2,084,9		2,084,936	
	07200 IMPL. DEV. CHARGED TO PATIENTS	4,924,557		4,924,5		4,924,557	
	07300 DRUGS CHARGED TO PATIENTS	24,915,609		24,915,6		24,915,609	
	07400 RENAL DIALYSIS	411,827		411,8		411,827	
	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,826,814		1,826,8		1,826,814	
	03190 CHEMOTHERAPY	1,895,911		1,895,9		1,895,911	
	03330 ENDOSCOPY	0			0 0	1,000,011	76.02
	03950 WOUND CARE CENTER	1,310,374		1,310,3	74 0	1,310,374	
	DUTPATIENT SERVICE COST CENTERS	_,,		_,,		_,,	
-	09100 EMERGENCY	7,242,541		7,242,54	41 0	7,242,541	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1,297,448		1,297,4		1,297,448	
	OTHER REIMBURSABLE COST CENTERS	_,,		_,,		_,,,	1
	09500 AMBULANCE SERVICES	5,551,468		5,551,4	68 0	5,551,468	95.00
200.00	Subtotal (see instructions)	128,684,449					
201.00	Less Observation Beds	1,297,448		1,297,4		1,297,448	
		_,, _,		127,387,0		127,414,349	

OMPUT	TATION OF RATIO OF COSTS TO CHARGES		Provider CO	CN: 15-0010	Period:	Worksheet C	
					From 07/01/2022 To 06/30/2023	Part I Date/Time Pre 11/21/2023 1:	pared
			Title	XVIII	Hospital	PPS	
			Charges				
	Cost Center Description	Inpatient	Outpatient	Total (col.	6 Cost or Other	TEFRA	
				+ col. 7)	Ratio	Inpatient	
						Ratio	
		6.00	7.00	8.00	9.00	10.00	
0 00	INPATIENT ROUTINE SERVICE COST CENTERS	20 742 251		20 742 20	· 1		1 20 0
0.00	03000 ADULTS & PEDIATRICS	29,743,351		29,743,35			30.0
1.00	03100 INTENSIVE CARE UNIT	10,582,420		10,582,42		1	31.0
1.00	04100 SUBPROVIDER - IRF	8,329,010		8,329,01		1	41.0
3.00	04300 NURSERY	2,636,491		2,636,49) <u> </u>		43.0
0.00	ANCILLARY SERVICE COST CENTERS	27,088,334	76,332,037	103,420,37	1 0.113860	0.000000	50.0
2.00	05200 DELIVERY ROOM & LABOR ROOM	18,256,850	1,000,230			0.000000	
4.00	05400 RADIOLOGY-DIAGNOSTIC	2,498,687	24,731,901			0.000000	
4.00	03630 ULTRA SOUND	1,650,489	5,473,494			0.000000	
6.00	05600 RADIOISOTOPE	453,339	26,238,087	26,691,42		0.000000	
7.00	05700 CT SCAN	4,248,930	11,867,614			0.000000	
8.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	4,248,930	2,616,108			0.000000	
6.00	06000 LABORATORY	34,286,929	58,258,417	92,545,34		0.000000	
5.00	06500 RESPIRATORY THERAPY	9,735,177	6,232,345			0.000000	
6.00	06600 PHYSICAL THERAPY	3,411,918	10,225,432			0.000000	
57.00	06700 OCCUPATIONAL THERAPY	3,390,188	1,824,063			0.000000	
8.00	06800 SPEECH PATHOLOGY	620,462	231,276			0.000000	
9.00	06900 ELECTROCARDIOLOGY	3,329,644	12,696,159			0.000000	
0.00	07000 ELECTROENCEPHALOGRAPHY	417,820	6,995,915			0.000000	
1.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	8,156,681	11,349,802	, ,		0.000000	
2.00	07200 IMPL. DEV. CHARGED TO PATIENTS	7,408,108	9,473,657	, ,		0.000000	
3.00	07300 DRUGS CHARGED TO PATIENTS	16,154,847	66,616,124			0.000000	
4.00	07400 RENAL DIALYSIS	1,353,774	384,664			0.000000	
6.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,984	2,319,928			0.000000	
6.01	03190 CHEMOTHERAPY	62,182	8,936,055				
6.02	03330 ENDOSCOPY	02,102	0,550,055	0,550,25	0 0.000000	0.000000	
	03950 WOUND CARE CENTER	70,707	13,402,730	13,473,43		0.000000	
0.05	OUTPATIENT SERVICE COST CENTERS	70,707	15,402,750	15,475,4.	0.097230	0.00000	1 /0.
1.00	09100 EMERGENCY	18,914,958	66,931,593	85,846,55	0.084366	0.000000	91.
2.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	485,913	2,171,601				
2.00	OTHER REIMBURSABLE COST CENTERS		2,1/1,001	2,057,51	0.700219	0.00000	1 52.
5.00	09500 AMBULANCE SERVICES	14,518	22,638,279	22,652,79	0,245068	0.00000	95.
200.00		214,035,176	448,947,511			0.00000	200.
01.00		,000,10	,,,,,,,,,,,	001,002,00			201.
02.00		214,035,176	448,947,511	662,982,68	27	1	202.0

DMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0010	Period: From 07/01/2022 To 06/30/2023	Worksheet C Part I Date/Time Pr 11/21/2023 1	epared :47 pm
		Title XVIII	Hospital	PPS	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
0.00 03000 ADULTS & PEDIATRICS					30.0
1.00 03100 INTENSIVE CARE UNIT					31.0
1.00 04100 SUBPROVIDER - IRF					41.0
3.00 04300 NURSERY					43.0
ANCILLARY SERVICE COST CENTERS					
0.00 05000 OPERATING ROOM	0.114124				50.0
2.00 05200 DELIVERY ROOM & LABOR ROOM	0.156800				52.0
4.00 05400 RADIOLOGY-DIAGNOSTIC	0.209574				54.
4.01 03630 ULTRA SOUND	0.108819				54.
6.00 05600 RADIOISOTOPE	0.094992				56.
7.00 05700 CT SCAN	0.093993				57.
8.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.281513				58.
0.00 06000 LABORATORY	0.094889				60.
5.00 06500 RESPIRATORY THERAPY	0.182607				65.
6.00 06600 PHYSICAL THERAPY	0.418621				66.
7.00 06700 OCCUPATIONAL THERAPY	0.361292				67.
8.00 06800 SPEECH PATHOLOGY	0.336132				68.
9.00 06900 ELECTROCARDIOLOGY	0.066996				69.
0.00 07000 ELECTROENCEPHALOGRAPHY	0.165738				70.
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.106884				71.
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.291709				72.
3.00 07300 DRUGS CHARGED TO PATIENTS	0.301019				73.
4.00 07400 RENAL DIALYSIS	0.236895				74.
6.00 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.786771				76.
6.01 03190 CHEMOTHERAPY	0.210698				76.
6.02 03330 ENDOSCOPY	0.000000				76.
6.03 03950 WOUND CARE CENTER	0.097256				76.
OUTPATIENT SERVICE COST CENTERS					
1.00 09100 EMERGENCY	0.084366				91.
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.488219				92.
OTHER REIMBURSABLE COST CENTERS					
5.00 09500 AMBULANCE SERVICES	0.245068				95.
00.00 Subtotal (see instructions)					200.
01.00 Less Observation Beds					201.
02.00 Total (see instructions)					202.

Health Financial Systems		ABCENDION DIT V	INCENT KOKOMO			u of Form CMS-2	2332-10
COMPUTATION OF RATIO OF COSTS TO	CHARGES		Provider C		Period: From 07/01/2022 To 06/30/2023	Worksheet C Part I Date/Time Pre 11/21/2023 1:	pared: 47 pm
			Titl	e XIX	Hospital	Cost	
					Costs		
Cost Center Descripti	on	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj.		Disallowance		
		Part I, col.					
		26) 1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE O	OST CENTERS	1.00	2.00	5.00	4.00	5.00	
30.00 03000 ADULTS & PEDIATRICS		19,287,269		19,287,26	9 0	19,287,269	30.00
31.00 03100 INTENSIVE CARE UNIT		4,633,812		4,633,81		4,633,812	
41.00 04100 SUBPROVIDER - IRF		3,845,098		3,845,09		3,845,098	
43.00 04300 NURSERY		1,308,344		1,308,34		1,308,344	
ANCILLARY SERVICE COST CENT	FERS	_,,.		_,,.		_,,	1
50.00 05000 OPERATING ROOM		11,775,396		11,775,39	27,348	11,802,744	50.00
52.00 05200 DELIVERY ROOM & LABOR	ROOM	3,019,514		3,019,51	.4 0	3,019,514	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC		5,706,814		5,706,81	.4 0	5,706,814	54.00
54.01 03630 ULTRA SOUND		775,228		775,22	8 0	775,228	54.01
56.00 05600 RADIOISOTOPE		2,535,471		2,535,47	'1 0	2,535,471	56.00
57.00 05700 CT SCAN		1,514,847		1,514,84	7 0	1,514,847	57.00
58.00 05800 MAGNETIC RESONANCE IM	AGING (MRI)	942,386		942,38	6 0	942,386	58.00
60.00 06000 LABORATORY		8,781,564		8,781,56	64 0	8,781,564	60.00
65.00 06500 RESPIRATORY THERAPY		2,915,783	0	,,		2,915,783	
66.00 06600 PHYSICAL THERAPY		5,708,882	0	5,708,88		5,708,882	
67.00 06700 OCCUPATIONAL THERAPY		1,883,867	0	1,883,86		1,883,867	
68.00 06800 SPEECH PATHOLOGY		286,296	0	286,29		286,296	
69.00 06900 ELECTROCARDIOLOGY		1,073,657		1,073,65		1,073,657	
70.00 07000 ELECTROENCEPHALOGRAPH		1,228,736		1,228,73		1,228,736	
71.00 07100 MEDICAL SUPPLIES CHAR		2,084,936		2,084,93		2,084,936	
72.00 07200 IMPL. DEV. CHARGED TO		4,924,557		4,924,55		4,924,557	1
73.00 07300 DRUGS CHARGED TO PATI	ENTS	24,915,609		24,915,60		24,915,609	
74.00 07400 RENAL DIALYSIS		411,827		411,82		411,827	•
76.00 03550 PSYCHIATRIC/PSYCHOLOG	ICAL SERVICES	1,826,814		1,826,81		1,826,814	
76.01 03190 CHEMOTHERAPY		1,895,911		1,895,91		1,895,911	
76.02 03330 ENDOSCOPY		0			0 0	0	76.02
76.03 03950 WOUND CARE CENTER		1,310,374		1,310,37	4 0	1,310,374	76.03
OUTPATIENT SERVICE COST CEN	TERS	7 242 541		7 242 54	1 0	7 242 541	91.00
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON	DICTINCT DART)	7,242,541		7,242,54		, ,-	
92.00 09200 OBSERVATION BEDS (NON OTHER REIMBURSABLE COST CEN		1,297,448		1,297,44	0	1,297,448	92.00
95.00 09500 AMBULANCE SERVICES		5,551,468		5,551,46	0	5,551,468	95 00
200.00 Subtotal (see instruc	tions)	128,684,449					
				1,297,44		1,297,448	
201.00 Less Observation Beds		1,297,448		1 1 29 / 1/	X		1201 00

OMPUT	TATION OF RATIO OF COSTS TO CHARGES		Provider CO	CN: 15-0010	Period:	Worksheet C	
					From 07/01/2022 To 06/30/2023	Part I Date/Time Pre 11/21/2023 1:	pared
			Titl	e XIX	Hospital	Cost	17 pm
			Charges	4			
	Cost Center Description	Inpatient	Outpatient	Total (col.	6 Cost or Other	TEFRA	
				+ col. 7)	Ratio	Inpatient	
						Ratio	
		6.00	7.00	8.00	9.00	10.00	
0 00	INPATIENT ROUTINE SERVICE COST CENTERS	20 742 251		20 742 20	-1		1 20 0
0.00	03000 ADULTS & PEDIATRICS	29,743,351		29,743,35			30.0
1.00	03100 INTENSIVE CARE UNIT	10,582,420		10,582,42			31.0
1.00	04100 SUBPROVIDER - IRF	8,329,010		8,329,01			41.0
3.00		2,636,491		2,636,49			43.0
0.00	ANCILLARY SERVICE COST CENTERS	27,088,334	76,332,037	103,420,37	0.113860	0.000000	50.0
2.00	05200 DELIVERY ROOM & LABOR ROOM	18,256,850	1,000,230			0.000000	
4.00	05400 RADIOLOGY-DIAGNOSTIC	2,498,687	24,731,901			0.000000	
4.00	03630 ULTRA SOUND	1,650,489	5,473,494			0.000000	
6.00	05600 RADIOISOTOPE	453,339	26,238,087	26,691,42		0.000000	
7.00	05700 CT SCAN	4,248,930	11,867,614			0.000000	
8.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	4,248,930	2,616,108			0.000000	
0.00	06000 LABORATORY	34,286,929	58,258,417	92,545,34		0.000000	
5.00	06500 RESPIRATORY THERAPY	9,735,177	6,232,345			0.000000	
6.00	06600 PHYSICAL THERAPY	3,411,918	10,225,432			0.000000	
7.00	06700 OCCUPATIONAL THERAPY	3,390,188	1,824,063			0.000000	
8.00	06800 SPEECH PATHOLOGY	620,462	231,276			0.000000	
9.00	06900 ELECTROCARDIOLOGY	3,329,644	12,696,159			0.000000	
0.00	07000 ELECTROEARDIOLOGY	417,820	6,995,915			0.000000	
1.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	8,156,681	11,349,802	, ,		0.000000	
2.00	07200 IMPL. DEV. CHARGED TO PATIENTS	7,408,108	9,473,657	, ,		0.000000	
3.00	07300 DRUGS CHARGED TO PATIENTS	16,154,847	66,616,124			0.000000	
4.00	07400 RENAL DIALYSIS	1,353,774	384,664			0.000000	
6.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,984	2,319,928			0.000000	
6.01	03190 CHEMOTHERAPY	62,182	8,936,055				
6.02	03330 ENDOSCOPY	02,102	0,550,055	0,550,25	0 0.000000	0.000000	
	03950 WOUND CARE CENTER	70,707	13,402,730	13,473,43		0.000000	
0.05	OUTPATIENT SERVICE COST CENTERS	70,707	15,402,750	15,475,4.	0.097230	0.00000	/0.
1.00	09100 EMERGENCY	18,914,958	66,931,593	85,846,55	0.084366	0.000000	91.
2.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	485,913	2,171,601				
2.00	OTHER REIMBURSABLE COST CENTERS		2,111,001	2,057,55	0.400215	0.00000	1 52.
5.00	09500 AMBULANCE SERVICES	14,518	22,638,279	22,652,79	0.245068	0.00000	95.
00.00		214,035,176	448,947,511			0.00000	200.
01.00		211,000,170	,,,,,,,,,,,	002,002,00			201.
02.00		214,035,176	448,947,511	662,982,68	7		202.

DMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0010	Period: From 07/01/2022 To 06/30/2023	Worksheet C Part I Date/Time Pr 11/21/2023 1	epared :47 pm
		Title XIX	Hospital	Cost	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
0.00 03000 ADULTS & PEDIATRICS					30.0
1.00 03100 INTENSIVE CARE UNIT					31.0
1.00 04100 SUBPROVIDER - IRF					41.0
3.00 04300 NURSERY					43.0
ANCILLARY SERVICE COST CENTERS					
0.00 05000 OPERATING ROOM	0.000000				50.0
2.00 05200 DELIVERY ROOM & LABOR ROOM	0.00000				52.0
4.00 05400 RADIOLOGY-DIAGNOSTIC	0.000000				54.
4.01 03630 ULTRA SOUND	0.000000				54.
6.00 05600 RADIOISOTOPE	0.000000				56.
7.00 05700 CT SCAN	0.000000				57.
8.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000				58.
0.00 06000 LABORATORY	0.000000				60.
5.00 06500 RESPIRATORY THERAPY	0.000000				65.
6.00 06600 PHYSICAL THERAPY	0.000000				66.
7.00 06700 OCCUPATIONAL THERAPY	0.000000				67.
8.00 06800 SPEECH PATHOLOGY	0.000000				68.
9.00 06900 ELECTROCARDIOLOGY	0.000000				69.
0.00 07000 ELECTROENCEPHALOGRAPHY	0.000000				70.
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000				71.
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000				72.
3.00 07300 DRUGS CHARGED TO PATIENTS	0.000000				73.
4.00 07400 RENAL DIALYSIS	0.000000				74.
6.00 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000				76.
6.01 03190 CHEMOTHERAPY	0.000000				76.
6.02 03330 ENDOSCOPY	0.000000				76.
6.03 03950 WOUND CARE CENTER	0.000000				76.
OUTPATIENT SERVICE COST CENTERS					
1.00 09100 EMERGENCY	0.000000				91.
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000				92.
OTHER REIMBURSABLE COST CENTERS					
5.00 09500 AMBULANCE SERVICES	0.000000				95.
00.00 Subtotal (see instructions)					200.
01.00 Less Observation Beds					201.
02.00 Total (see instructions)					202.

MCRIF32 - 21.2.177.0

Health Financial Systems	ASCENSION ST. W	INCENT KOKOMO		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS				Worksheet D Part I Date/Time Pre 11/21/2023 1:	
			XVIII	Hospital	PPS	
Cost Center Description	Capital Related Cost	Swing Bed Adjustment	Reduced Capital	Days	Per Diem (col. 3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1		- 1-	1	
30.00 ADULTS & PEDIATRICS	1,022,957		1,022,95			•
31.00 INTENSIVE CARE UNIT	276,036		276,03			•
41.00 SUBPROVIDER - IRF	281,160		281,16	· · ·		
43.00 NURSERY	80,293		80,29			•
200.00 Total (lines 30 through 199)	1,660,446		1,660,44	6 21,618		200.00
Cost Center Description	Inpatient	Inpatient				
	Program days	Program				
		Capital Cost				
		(col. 5 x col. 6)				
	6.00	7.00	-			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	4,348	304,708				30.00
31.00 INTENSIVE CARE UNIT	572	73,611				31.00
41.00 SUBPROVIDER - IRF	1,858	141,840)			41.00
43.00 NURSERY	0	0)			43.00
200.00 Total (lines 30 through 199)	6,778	520,159				200.00

Health Financial Systems	ASCENSION ST. V	INCENT KOKOMO		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVIC	E CAPITAL COSTS	Provider C	CN: 15-0010	Period:	Worksheet D	
				From 07/01/2022 To 06/30/2023	Part II Date/Time Pre	narodi
				10 00/30/2023	11/21/2023 1:	47 nm
		Title	XVIII	Hospital	PPS	
Cost Center Description	Capital	Total Charges			Capital Costs	
		(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,			l. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	1,209,958					
52.00 05200 DELIVERY ROOM & LABOR ROOM	181,671					
54.00 05400 RADIOLOGY-DIAGNOSTIC	1,059,174			,		
54.01 03630 ULTRA SOUND	118,378					
56.00 05600 RADIOISOTOPE	556,702			· · ·	,	
57.00 05700 CT SCAN	30,120					
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI						
60.00 06000 LABORATORY	260,578					
65.00 06500 RESPIRATORY THERAPY	113,443	15,967,522		, ,	15,407	
66.00 06600 PHYSICAL THERAPY	213,505	13,637,350	0.0156	56 738,319	11,559	66.00
67.00 06700 OCCUPATIONAL THERAPY	79,484	5,214,251	0.01524			67.00
68.00 06800 SPEECH PATHOLOGY	19,153	851,738	0.02248	37 129,949	2,922	68.00
69.00 06900 ELECTROCARDIOLOGY	200,788	16,025,803	0.01252	1,927,341	24,148	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	77,466	7,413,735	0.01044	163,540	1,709	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	IENTS 93,597	19,506,483	0.00479	2,546,207	12,217	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	86,687	16,881,765	0.0051	35 2,108,691	10,828	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	497,894	82,770,971	0.00603	L5 4,614,968	27,759	73.00
74.00 07400 RENAL DIALYSIS	7,266	1,738,438	0.00418	30 389,418	1,628	74.00
76.00 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVI	CES 109,772	2,321,912	0.0472	77 0	0	76.00
76.01 03190 CHEMOTHERAPY	519,293	8,998,237	0.0577	L1 3,348	193	76.01
76.02 03330 ENDOSCOPY	0	C	0.0000	0 0	0	76.02
76.03 03950 WOUND CARE CENTER	73,305	13,473,437	0.00544	41 58,560	319	76.03
OUTPATIENT SERVICE COST CENTERS						1
91.00 09100 EMERGENCY	515,762	85,846,551	0.00600	6,019,039	36,162	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT						
OTHER REIMBURSABLE COST CENTERS	· · · · · ·		•			1
95.00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	6,346,994	589,038,618		43,282,984	342,818	200.00

Health Financial Systems	ASCENSION ST. V				u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COST			Period: From 07/01/2022 To 06/30/2023	Date/Time Pre 11/21/2023 1:	epared: 47 pm
		Title	e XVIII	Hospital	PPS	
Cost Center Description	Nursing	Nursing		h Allied Health	All Other	
	Program	Program	Post-Stepdow		Medical	
	Post-Stepdown		Adjustments		Education Cost	
	Adjustments					
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS			1			
30.00 03000 ADULTS & PEDIATRICS	0	0)	0 0	0	
31.00 03100 INTENSIVE CARE UNIT	0	0		0 0	0	
41.00 04100 SUBPROVIDER - IRF	0	0		0 0	0	
43.00 04300 NURSERY	0	0		0 0	0	43.00
200.00 Total (lines 30 through 199)	0	0)	0 0		200.00
Cost Center Description	Swing-Bed	Total Costs		t Per Diem (col.	Inpatient	
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS			1			
30.00 03000 ADULTS & PEDIATRICS	0	0	14,59			
31.00 03100 INTENSIVE CARE UNIT		0	2,14			
41.00 04100 SUBPROVIDER - IRF	0	0	3,68		,	41.00
43.00 04300 NURSERY		0	1,19			
200.00 Total (lines 30 through 199)		0	21,61	.8	6,778	200.00
Cost Center Description	Inpatient					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS	1					
30.00 03000 ADULTS & PEDIATRICS	0					30.00
31.00 03100 INTENSIVE CARE UNIT	0					31.00
41.00 04100 SUBPROVIDER - IRF	0					41.00
43.00 04300 NURSERY 200.00 Total (lines 30 through 199)	0					43.00

Health Financial Systems	ASCENSION ST. V	INCENT KOKOMO		In Li	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY S THROUGH COSTS	SERVICE OTHER PAS	S Provider CO	CN: 15-0010	Period: From 07/01/2022 To 06/30/2023		pared: 47 pm
		Title	XVIII	Hospital	PPS	_
Cost Center Description	Non Physician	Nursing	Nursing	Allied Health	Allied Health	
	Anesthetist	Program	Program	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
	1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0		0 0	-	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0 0	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		0 0	179,934	54.00
54.01 03630 ULTRA SOUND	0	0		0 (47,082	54.01
56.00 05600 RADIOISOTOPE	0	0		0 (176,404	56.00
57.00 05700 CT SCAN	0	0		0 (106,514	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	1	0 0	22,124	58.00
60.00 06000 LABORATORY	0	0		0 0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0	0		0 0	0 0	65.00
66.00 06600 PHYSICAL THERAPY	0	0		0 0	0 0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		0 0	o o	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 (0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 (0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0		73.00
74.00 07400 RENAL DIALYSIS	0	0		0	ol o	74.00
76.00 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0		0	ol o	76.00
76.01 03190 CHEMOTHERAPY	0	n n		0 0	ol o	76.01
76.02 03330 ENDOSCOPY	0	0		0		76.02
76.03 03950 WOUND CARE CENTER	0	0		0 0		76.02
OUTPATIENT SERVICE COST CENTERS		ŪŪ	I		, <u> </u>	10.05
91.00 09100 EMERGENCY	0	0		0 (0 0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
OTHER REIMBURSABLE COST CENTERS			1	v i	0	1 52.00
95.00 09500 AMBULANCE SERVICES						95.00
SSIGS SSIGNBOLANCE SERVICES	0	0	1	0 0	1	200.00

		ASCENSION ST. V				u of Form CMS-2	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PAS	S Provider C	CN: 15-0010	Period:	Worksheet D	
THROUG	GH COSTS				From 07/01/2022 To 06/30/2023	Part IV Date/Time Pre	narod·
					10 00/30/2023	11/21/2023 1:	
				XVIII	Hospital	PPS	
	Cost Center Description	All Other	Total Cost	Total	Total Charges		
		Medical	(sum of cols.	Outpatient	(from Wkst. C,		
		Education Cost	1, 2, 3, and	Cost (sum of		(col. 5 ÷ col.	
			4)	cols. 2, 3,	8)	7)	
				and 4)		(see	
						instructions)	
		4.00	5.00	6.00	7.00	8.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0		0 103,420,371		
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 19,257,080		
	05400 RADIOLOGY-DIAGNOSTIC	0	179,934				
54.01	03630 ULTRA SOUND	0	47,082				
56.00	05600 RADIOISOTOPE	0	176,404	176,40	26,691,426	0.006609	
57.00	05700 CT SCAN	0	106,514	106,51	.4 16,116,544	0.006609	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	22,124	22,12	3,347,573	0.006609	58.00
60.00	06000 LABORATORY	0	0		0 92,545,346	0.00000	60.00
65.00	06500 RESPIRATORY THERAPY	0	0		0 15,967,522	0.00000	65.00
66.00	06600 PHYSICAL THERAPY	0	0		0 13,637,350	0.00000	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0		0 5,214,251	0.00000	67.00
68.00	06800 SPEECH PATHOLOGY	0	0		0 851,738	0.00000	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0		0 16,025,803	0.00000	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 7,413,735	0.00000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 19,506,483	0.00000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 16,881,765	0.00000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 82,770,971	0.00000	73.00
74.00	07400 RENAL DIALYSIS	0	0		0 1,738,438	0.00000	74.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0		0 2,321,912	0.00000	76.00
76.01	03190 CHEMOTHERAPY	0	0		0 8,998,237	0.00000	76.01
76.02	03330 ENDOSCOPY	0	0		0 0	0.000000	76.02
76.03	03950 WOUND CARE CENTER	0	0		0 13,473,437	0.000000	76.03
	OUTPATIENT SERVICE COST CENTERS						1
91.00	09100 EMERGENCY	0	0		0 85,846,551	0.00000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0 2,657,514		92.00
	OTHER REIMBURSABLE COST CENTERS						1
95.00	09500 AMBULANCE SERVICES						95.00
200.00		0	532,058	532,05	589,038,618		200.00

Health Financial Systems	ASCENSION ST. VI	NCENT KOKOMO		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS	VICE OTHER PASS	Provider C	CN: 15-0010	Period: From 07/01/2022 To 06/30/2023	Worksheet D Part IV Date/Time Pre 11/21/2023 1:	pared: 47 pm
		Title	XVIII	Hospital	PPS	<u> 17 piii</u>
Cost Center Description	Outpatient	Inpatient	Inpatient	Outpatient	Outpatient	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	n Charges	Pass-Through	
	(col. 6 ÷ col.	-	Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0.000000	8,743,420		0 17,887,915	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.000000	55,124		0 1,427	0	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.006608	795,112	5,2	2,701,704	17,853	54.00
54.01 03630 ULTRA SOUND	0.006609	419,516	2,7	^{'3} 916,298	6,056	54.01
56.00 05600 RADIOISOTOPE	0.006609	54,815	30	8,857,093	58,537	56.00
57.00 05700 CT SCAN	0.006609	1,414,830	9,3	2,540,255	16,789	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.006609	192,850	1,2	5 578,524	3,823	58.00
60.00 06000 LABORATORY	0.000000	10,137,449		0 6,072,066	0	60.00
65.00 06500 RESPIRATORY THERAPY	0.000000	2,168,460		0 118,048	0	65.00
66.00 06600 PHYSICAL THERAPY	0.000000	738,319		0 29,784	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0.000000	498,238		0 7,707	0	67.00
68.00 06800 SPEECH PATHOLOGY	0.000000	129,949		0 5,219	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0.000000	1,927,341		0 5,387,159	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.000000	163,540		0 155,514	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	2,546,207		0 2,239,578	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	2,108,691		0 2,779,294	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.000000	4,614,968		0 15,738,594	0	73.00
74.00 07400 RENAL DIALYSIS	0.000000	389,418		0 0	0	74.00
76.00 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0		0 36,750	0	76.00
76.01 03190 CHEMOTHERAPY	0.000000	3,348		0 2,212,272	0	76.01
76.02 03330 ENDOSCOPY	0.000000	0		0 0	0	76.02
76.03 03950 WOUND CARE CENTER	0.000000	58,560		0 4,387,915	0	76.03
OUTPATIENT SERVICE COST CENTERS		,				1
91.00 09100 EMERGENCY	0.000000	6,019,039		0 10,912,093	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	103,790		0 1,522,822	0	92.00
OTHER REIMBURSABLE COST CENTERS						1
95.00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)		43,282,984	19,03	85,088,031	103,058	200.00

APPORTIO	DNMENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provider C	CN: 15-0010	Period: From 07/01/2022 To 06/30/2023	Worksheet D Part V Date/Time Pre 11/21/2023 1:	epared: 47 pm
			Title	XVIII	Hospital	PPS	
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
		Worksheet C,	inst.)	Services	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins			
				(see inst.)			
		1.00	2.00	3.00	4.00	5.00	
	NCILLARY SERVICE COST CENTERS			1			
	5000 OPERATING ROOM	0.113860	, , ,		0 0	2,036,718	
	5200 DELIVERY ROOM & LABOR ROOM	0.156800			0 0	224	
	5400 RADIOLOGY-DIAGNOSTIC	0.209574			0 0	566,207	
	3630 ULTRA SOUND	0.108819	, , ,		0 0	99,711	
	5600 RADIOISOTOPE	0.094992	, , ,		0 0	841,353	
	5700 CT SCAN	0.093993			0 0	238,766	
	5800 MAGNETIC RESONANCE IMAGING (MRI)	0.281513	/ -		0 0	162,862	
	6000 LABORATORY	0.094889			0 0	576,172	
	6500 RESPIRATORY THERAPY	0.182607			0 0	21,556	
66.00 0	6600 PHYSICAL THERAPY	0.418621	29,784		0 0	12,468	66.00
	6700 OCCUPATIONAL THERAPY	0.361292	7,707		0 0	2,784	67.00
68.00 0	6800 SPEECH PATHOLOGY	0.336132	5,219		0 0	1,754	68.00
69.00 0	6900 ELECTROCARDIOLOGY	0.066996	5,387,159		0 0	360,918	69.00
70.00 0	7000 ELECTROENCEPHALOGRAPHY	0.165738	155,514		0 0	25,775	70.00
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.106884	2,239,578		0 0	239,375	71.00
72.00 0	7200 IMPL. DEV. CHARGED TO PATIENTS	0.291709	2,779,294		0 0	810,745	72.00
73.00 0	7300 DRUGS CHARGED TO PATIENTS	0.301019	15,738,594		0 3,693	4,737,616	
74.00 0	7400 RENAL DIALYSIS	0.236895	0		0 0	0	74.00
76.00 0	3550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.786771	36,750		0 0	28,914	76.00
76.01 0	3190 CHEMOTHERAPY	0.210698	2,212,272		0 0	466,121	76.01
76.02 0	3330 ENDOSCOPY	0.000000	0		0 0	0	76.02
76.03 0	3950 WOUND CARE CENTER	0.097256	4,387,915		0 0	426,751	76.03
0	UTPATIENT SERVICE COST CENTERS						
91.00 0	9100 EMERGENCY	0.084366	10,912,093		0 0	920,610	91.00
92.00 0	9200 OBSERVATION BEDS (NON-DISTINCT PART)	0.488219	1,522,822		0 0	743,471	92.00
0	THER REIMBURSABLE COST CENTERS	·					
95.00 0	9500 AMBULANCE SERVICES	0.245068			0		95.00
200.00	Subtotal (see instructions)		85,088,031		0 3,693	13,320,871	200.00
201.00	Less PBP Clinic Lab. Services-Program				0 0		201.00
	Only Charges						
	Net Charges (line 200 - line 201)		85,088,031	1	0 3,693	13,320,871	

PPORTIONM	ancial Systems ENT OF MEDICAL, OTHER HEALTH SERVICES AND	ASCENSION ST. V VACCINE COST		CN: 15-0010	In Lie Period: From 07/01/2022 To 06/30/2023	Worksheet D Part V Date/Time Pro 11/21/2023 1	epared: :47 pm
			Title	XVIII	Hospital	PPS	
		COS	sts				
	Cost Center Description	Cost	Cost				
		Reimbursed	Reimbursed				
		Services	Services Not				
		Subject To	Subject To				
		Ded. & Coins.					
		(see inst.) 6.00	(see inst.) 7.00	-			
ANCI	LLARY SERVICE COST CENTERS	6.00	7.00				_
	00 OPERATING ROOM	0	C				50.0
	00 DELIVERY ROOM & LABOR ROOM	0					52.0
	00 RADIOLOGY-DIAGNOSTIC	0					54.0
	30 ULTRA SOUND	0					54.0
	00 RADIOISOTOPE	0					56.0
	00 CT SCAN	0					57.0
	00 MAGNETIC RESONANCE IMAGING (MRI)	0					58.0
	00 LABORATORY	0					60.0
	00 RESPIRATORY THERAPY	0					65.0
	00 PHYSICAL THERAPY	0	0				66.0
	00 OCCUPATIONAL THERAPY	0	0				67.0
	00 SPEECH PATHOLOGY	0	i c				68.0
	00 ELECTROCARDIOLOGY	0	Ċ)			69.0
	0 ELECTROENCEPHALOGRAPHY	0	Ċ)			70.0
	00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C)			71.0
2.00 0720	00 IMPL. DEV. CHARGED TO PATIENTS	0	C)			72.0
3.00 0730	00 DRUGS CHARGED TO PATIENTS	0	1,112				73.0
4.00 0740	00 RENAL DIALYSIS	0	C				74.0
6.00 0355	50 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	C				76.0
6.01 0319	0 CHEMOTHERAPY	0	C				76.0
	30 ENDOSCOPY	0	C				76.0
6.03 0395	50 WOUND CARE CENTER	0	C				76.0
	PATIENT SERVICE COST CENTERS	1					
	00 EMERGENCY	0					91.0
	00 OBSERVATION BEDS (NON-DISTINCT PART)	0	C				92.0
	R REIMBURSABLE COST CENTERS						-
	00 AMBULANCE SERVICES	0					95.0
00.00	Subtotal (see instructions)	0	1,112				200.0
01.00	Less PBP Clinic Lab. Services-Program	0					201.0
	Only Charges						

Health Financial Systems	ASCENSION ST. V				u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS		CCN:15-T010	Period: From 07/01/2022 To 06/30/2023	Worksheet D Part II Date/Time Pre 11/21/2023 1:	
		Title	XVIII	Subprovider - IRF	PPS	
Cost Center Description	Capital	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,			l. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	1,209,958				415	
52.00 05200 DELIVERY ROOM & LABOR ROOM	181,671				0	
54.00 05400 RADIOLOGY-DIAGNOSTIC	1,059,174				2,965	
54.01 03630 ULTRA SOUND	118,378				0	54.01
56.00 05600 RADIOISOTOPE	556,702	26,691,426	0.0208	57 0	0	56.00
57.00 05700 CT SCAN	30,120	16,116,544	0.0018			57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	254,184			31 20,900	1,587	58.00
60.00 06000 LABORATORY	260,578	92,545,346	0.0028	1,084,162	3,053	60.00
65.00 06500 RESPIRATORY THERAPY	113,443	15,967,522	0.0071	172,981	1,229	65.00
66.00 06600 PHYSICAL THERAPY	213,505	13,637,350	0.0156	56 998,572	15,634	66.00
67.00 06700 OCCUPATIONAL THERAPY	79,484	5,214,251	0.0152	44 812,052	12,379	67.00
68.00 06800 SPEECH PATHOLOGY	19,153	851,738	0.0224	95,634	2,151	68.00
69.00 06900 ELECTROCARDIOLOGY	200,788	16,025,803	0.0125	68,384	857	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	77,466	7,413,735	0.0104	49 14,097	147	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	93,597	19,506,483	0.0047	98 191,763	920	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	86,687	16,881,765	0.0051	35 10,159	52	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	497,894	82,770,971	0.0060	15 389,278	2,342	73.00
74.00 07400 RENAL DIALYSIS	7,266	1,738,438	0.0041	30 76,953	322	74.00
76.00 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	109,772	2,321,912	0.0472	77 0	0	76.00
76.01 03190 CHEMOTHERAPY	519,293			11 0	0	76.01
76.02 03330 ENDOSCOPY	0				0	76.02
76.03 03950 WOUND CARE CENTER	73,305	13,473,437			0	76.03
OUTPATIENT SERVICE COST CENTERS		, .,				1
91.00 09100 EMERGENCY	515,762	85,846,551	0.0060	28,285	170	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0				-	
OTHER REIMBURSABLE COST CENTERS		,,				1
95.00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	6,278,180	589,038,618		4,121,200	44,309	

Health Financial Sys	tems	ASCENSION ST. V	INCENT KOKOMO			In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INP	ATIENT/OUTPATIENT ANCILLARY S	ERVICE OTHER PASS	S Provider C	CN: 15-0010		riod:	Worksheet D	
THROUGH COSTS						om 07/01/2022	Part IV	
			Component	CCN:15-T010	То	06/30/2023	Date/Time Pre 11/21/2023 1:	pared: 47 pm
			Title	XVIII	S	ubprovider -	PPS	•
						IRF		
Cost Cer	iter Description	Non Physician		Nursing			Allied Health	
		Anesthetist	Program	Program	1	Post-Stepdown		
		Cost	Post-Stepdown			Adjustments		
			Adjustments					
		1.00	2A	2.00		3A	3.00	
	/ICE COST CENTERS							
50.00 05000 OPERATIN		0	0		0	0	0	50.00
	ROOM & LABOR ROOM	0	0		0	0	0	52.00
54.00 05400 RADIOLOG	GY-DIAGNOSTIC	0	0		0	0	179,934	54.00
54.01 03630 ULTRA SC	DUND	0	0		0	0	47,082	54.01
56.00 05600 RADIOISC	DTOPE	0	0		0	0	176,404	56.00
57.00 05700 CT SCAN		0	0		0	0	106,514	57.00
58.00 05800 MAGNETIC	RESONANCE IMAGING (MRI)	0	0		0	0	22,124	58.00
60.00 06000 LABORATO	DRY	0	0		0	0	0	60.00
65.00 06500 RESPIRAT	ORY THERAPY	0	0		0	0	0	65.00
66.00 06600 PHYSICAL		0	0		0	0	0	66.00
67.00 06700 OCCUPATI		0	0		0	0	0	67.00
68.00 06800 SPEECH F		0	0		0	0	0	68.00
69.00 06900 ELECTRO		0	0		0	0	0	69.00
	NCEPHALOGRAPHY	0	0		0	0	0	70.00
	SUPPLIES CHARGED TO PATIENTS	0	0		0	0	0	71.00
	V. CHARGED TO PATIENTS	0	0		õ	0	0	72.00
	ARGED TO PATIENTS	0	0		õ	0	0	73.00
74.00 07400 RENAL DI		0	0		õ	0	0	74.00
	RIC/PSYCHOLOGICAL SERVICES	0	0		õ	0	0	76.00
76.01 03190 CHEMOTHE		0	0		õ	ů 0	0	76.01
76.02 03330 ENDOSCOF		0			0	0	0	76.02
76.03 03950 WOUND CA		0	0		õ	0	0	76.03
	RVICE COST CENTERS	0	, v		0	U	0	10.05
91.00 09100 EMERGENO		0	0		0	0	0	91.00
	ION BEDS (NON-DISTINCT PART)	0	-		0	0	0	92.00
	SABLE COST CENTERS	0	I	I	U		0	92.00
95.00 09500 AMBULANC								95.00
	ines 50 through 199)	0	0		0	0	532,058	
	mes so through 199)	0	0	I	U	0	352,058	1200.00

Health Financial Systems	ASCENSION ST. V	INCENT KOKOMO		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVICE OTHER PASS	Component	ССN: 15-Т010	Period: From 07/01/2022 To 06/30/2023		epared: 47 pm
		Title	XVIII	Subprovider - IRF	PPS	
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medical	(sum of cols.	Outpatient	(from Wkst. C,		
	Education Cost		Cost (sum of		(col. 5 ÷ col.	
		4)	cols. 2, 3,	8)	7)	
			and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS	-	-	1			
50.00 05000 OPERATING ROOM	0	0		0 103,420,371		
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 19,257,080		
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	179,934				
54.01 03630 ULTRA SOUND	0	47,082				
56.00 05600 RADIOISOTOPE	0	176,404	176,40	4 26,691,426		
57.00 05700 CT SCAN	0	106,514	106,51	4 16,116,544	0.006609	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	22,124	22,12	4 3,347,573	0.006609	58.00
60.00 06000 LABORATORY	0	0		0 92,545,346	0.000000	60.00
65.00 06500 RESPIRATORY THERAPY	0	0		0 15,967,522	0.000000	65.00
66.00 06600 PHYSICAL THERAPY	0	0		0 13,637,350	0.000000	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		0 5,214,251	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	1	0 851,738	0.000000	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		0 16,025,803	0.000000	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 7,413,735	0.000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 19,506,483	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 16,881,765		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 82,770,971	0.000000	73.00
74.00 07400 RENAL DIALYSIS	0	0		0 1,738,438		
76.00 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0		0 2,321,912		76.00
76.01 03190 CHEMOTHERAPY	0	0		0 8,998,237		
76.02 03330 ENDOSCOPY	0	0		0 0	0.000000	
76.03 03950 WOUND CARE CENTER	0	0		0 13,473,437		
OUTPATIENT SERVICE COST CENTERS		v		15,115,157	0.000000	10.05
91.00 09100 EMERGENCY	0	0		0 85,846,551	0.00000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	-		0 2,657,514		
OTHER REIMBURSABLE COST CENTERS	0	0	1	2,007,014	0.00000	52.00
95.00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	0	532,058	532,05	8 589,038,618		200.00
	0	1 332,030	, ,,,,,	555,050,010	I	1200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS Provider CCN: 15-0010 Component CCN: 15-7010 Period: Provider CN: 15-7010 Worksheet D From 06/30/2023 Part IV Date/Time Prepared: To 06/30/2023 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) 50.00 052000 DEELATERY ROOM 0 000000 0.000000 0 0 35,471 0 0 0 0 0 50.00 51.00 052000 DEELATERY ROOM 0 000000 0.006609 0 0 0 0 0 0 56.00 51.00 05000 RADIOLOGY-DEGNOSTIC 0 000000 0.006609 0 0 0 0 0 0 56.00 50.00 05000 RADIOLOGY-DERATORY 0 0.000000 0 0 0 56.00 0 0 0 0 0 0 0	Health Financial Systems	ASCENSION ST. VI	NCENT KOKOMO		In Lie	u of Form CMS-2	2552-10
Ancture Cost 2 Component CCN: 15-T010 To 06/30/2023 Date/Time Prepared: 11/21/2023 1:47 pm Title XVIII Subprovider - IRF PS Cost Center Description Outpatient Ratio of Cost to Charges (col. 6 + col. 7) Inpatient Program Pass-Through Charges Outpatient Program Pass-Through Costs (col. 9 Outpatient Program Pass-Through Costs (col. 9 Outpatient Program Pass-Through Costs (col. 9 00 0	APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	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 (col. 6 + col. 7 Inpatient Program Charges (col. 6 + col. 7 Program Pass-Through Costs (col. 8 Outpatient Program Charges (col. 6 + col. 7 Outpatient Program Charges Program Charges (col. 6 + col. 7 Outpatient Program Charges Program Charges (col. 9 Outpatient Program Charges Program Charges 50.00 05000 05200 05200 0 <t< td=""><td>THROUGH COSTS</td><td></td><td></td><td></td><td></td><td></td><td></td></t<>	THROUGH COSTS						
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) Unpatient Program (Charges (col. 6 + col. 7) Outpatient Program (Charges (col. 2) Outpatient Program (Charges (col. 2) <thoutpatient (col.</thoutpatient 			Component	ссм: 15-т010	то 06/30/2023	Date/Time Pre	pared:
Cost Center Description Outpatient Ratio of Cost to charges (col. 6 + col. 7) Inpatient Program charges (col. 10) Inpatient Program cs col. 10) Outpatient Program Pass=Through Costs (col. 9 x col. 10) Outpatient Program charges 50.00 ANCILLARY SERVICE COST CENTERS 0.000000 11.00 12.00 13.00 50.00 D5000 DELTCERY ROM & LABOR ROM 0.000000 0 0 0 0 54.00 D5000 DELTCERY ROM & LABOR ROM 0.000608 76,229 504 0 0 52.00 56.00 D5000 RADITSOTOPE 0.006609 0 0 0 56.00 0 0 56.00 56.00 0 0 56.00 56.00 66.00 65.00 </td <td></td> <td></td> <td>Title</td> <td>XVIII</td> <td>Subprovider -</td> <td></td> <td>47 pili</td>			Title	XVIII	Subprovider -		47 pili
Image: state of the construction of cost of cos							
Image: Coll of a coll o	Cost Center Description						
ANCTLLARY SERVICE COST CENTERS Costs (col. 8 x col. 10) Costs (col. 9 x col. 12) ANCTLLARY SERVICE COST CENTERS 9.00 10.00 11.00 12.00 13.00 ANCTLLARY SERVICE COST CENTERS 0 0 0 0 0 50.00 05000 (DECRATING ROM 0.000000 35,471 0 0 0 52.00 54.00 05400 (RADIOLOGY-DIAGNOSTIC 0.006608 76,229 504 0 54.00 54.01 03630 (LITRA SOUND 0.006609 0 0 0 54.00 55.00 05600 (RADIOLOGY-DIAGNOSTIC 0.006609 66.00 0 0 0 54.00 56.00 05600 (RADIOLOGY-DIAGNOSTIC 0.006609 10.084.162 0 0 0 58.00 05600 (RESPIRATORY THERAPY 0.000000 172,981 0 0 66.00 66.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 <			5		5		
ARCILLARY SERVICE COST CENTERS x col. 120 x col. 120 50.00 05000 0PERATING ROOM 0.000000 35,471 0 <td></td> <td></td> <td>Charges</td> <td></td> <td></td> <td></td> <td></td>			Charges				
ANCILLARY SERVICE COST CENTERS 9.00 10.00 11.00 12.00 13.00 50.00 05000 OPERATING ROM 0.000000 35,471 0 0 0 50.00 52.00 052000 PELIVERY ROOM & LABOR ROOM 0.000000 0 0 0 0 52.00 54.00 05400 RADICLOGY-DIAGNOSTIC 0.006609 0 0 0 54.00 54.01 06300 ULTRA SOUND 0.006609 0 0 0 54.01 56.00 05000 CT SCAN 0.006609 0 0 0 55.00 57.00 05700 CT SCAN 0.006609 46,280 306 0 58.00 60.00 06500 RESPIRATORY THERAPY 0.000000 12,881 0 0 66.00 06500 RESPIRATORY THERAPY 0.000000 12,952 0 0 66.00 06600 06500 RESPIRATORY THERAPY 0.000000 12,952 0 0 66.00 000000 06500 RESPIRATORY THERAPY 0.000000 93,354					8		
ANCILLARY SERVICE COST CENTERS 0 <th< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></th<>							
50.00 OFERATING ROOM 0.000000 35,471 0 0 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0 0 0 0 52.00 54.00 05400 RADIOLOGY-DIAGNOSTIC 0.006609 0 0 0 54.01 54.01 03630 ULTRA SOUND 0.006609 0 0 0 54.01 56.00 05000 RADIOSTOPE 0.006609 0 0 0 55.00 57.00 05700 CT SCAN 0.006609 20,900 138 0 58.00 0.000 LABARCHEY 0.000000 1/084,162 0 0 60.00 66.00 06500 RESPIRATORY 0.000000 1/084,162 0 0 66.00 65.00 65.00 66.00 65.00 66.00 67.00 0 67.00 66.00 67.00 0 67.00 0 67.00 0 67.00 68.00 69.00 69.00 69.0		9.00	10.00	11.00	12.00	13.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0 0 0 52.00 54.00 05400 RADIOLOGY-DIAGNOSTIC 0.006608 76,229 504 0 0 54.00 56.00 05600 RADIOLOGY-DIAGNOSTIC 0.006609 0 0 0 56.00 57.00 05700 CT SCAN 0.006609 46,280 306 0 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0.006609 20,900 138 0 58.00 60.00 06000 LABORATORY 0.000000 172,981 0 0 66.00 65.00 06500 RESPIRATORY THERAPY 0.000000 98,572 0 0 66.00 67.00 06500 SPECH PATHOLOGY 0.000000 12,953 0 0 68.00 06300 ELECTROCARDIOLOGY 0.000000 14,097 0 0 68.00 07000 ELECTROCARDIOLOGY 0.000000 14,097 0 0 70.00 71.00 7000 MBULS CHARGED TO PATIENTS <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>							
54.00 05400 RADIOLOGY-DIAGNOSTIC 0.006608 76,229 504 0 54.00 54.01 03630 ULTRA SOUND 0.006609 0 0 0 54.01 56.00 0500 RADIOLOGY-DIAGNOSTIC 0.006609 0 0 0 54.01 57.00 05700 CT SCAN 0.006609 46,280 306 0 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0.006609 20,900 138 0 58.00 60.00 06000 Loborntory 0.000000 1,084,162 0 0 65.00 65.00 06500 RESPIRATORY THERAPY 0.000000 98,572 0 0 66.00 66.00 67.00 06700 CCUPATIONAL THERAPY 0.000000 812,052 0 0 68.00 68.00 68.00 68.00 68.00 68.00 69.00 68.00 68.00 68.00 69.00 68.00 69.00 0 0 68.00 69.00 0 71.00 71.00 71.00 71.00 71.00 72			35,471			-	
54.01 03630 ULTRA SOUND 0.006609 0 0 0 54.01 56.00 05600 RADIDISOTOPE 0.006609 0 0 0 55.00 57.00 05700 CT SCAN 0.006609 20,900 138 0 56.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0.006609 20,900 138 0 0 58.00 60.00 06000 LABORATORY 0.000000 1,084,162 0 0 0 65.00 65.00 06500 PHYSICAL THERAPY 0.000000 172,981 0 0 66.00 66.00 06600 PCUPATIONAL THERAPY 0.000000 998,572 0 0 66.00 06700 0CUPATIONAL THERAPY 0.000000 95,634 0 0 66.00 06800 SPECH PATHOLOGY 0.000000 68,384 0 0 0 70.00 71.00 07100 ELECTROARDIDLOGY 0.000000 191,763 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIE			0			-	
56.00 0500 RADIOISOTOPE 0.006609 0 0 0 56.00 57.00 05700 CT SCAN 0.006609 46,280 306 0 0 57.00 68.00 05000 LABORATORY 0.000600 1,84,162 0 0 0 60.00 65.00 06500 RESPIRATORY THERAPY 0.000000 172,981 0 0 66.00 66.00 06700 CCUPATIONAL THERAPY 0.000000 985,572 0 0 0 67.00 06700 OCCUPATIONAL THERAPY 0.000000 812,052 0 0 0 67.00 06800 SPEECH PATHOLOGY 0.000000 843,452 0 0 0 67.00 07000 ELCTROCARDIOLOGY 0.000000 68,384 0 0 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 14,097 0 0 72.00 73.00 07300 DRUS CHARGED TO PATIENTS 0.000000 10,159 0 0 73.00 74.00 RENAL DIALYSIS<			76,229	50	04 0	-	
57.00 05700 CT SCAN 0.006609 46,280 306 0 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0.006609 20,900 138 0 0 58.00 60.00 LABORATORY 0.000000 1,084,162 0 0 0 65.00 65.00 06500 RESPIRATORY THERAPY 0.000000 172,981 0 0 65.00 66.00 06600 PHYSICAL THERAPY 0.000000 98,572 0 0 66.00 67.00 0C700 CCUPATIONAL THERAPY 0.000000 812,052 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0.000000 812,052 0 0 68.00 69.00 69.00 0CUPATIONAL THERAPY 0.000000 812,052 0 0 67.00 67.00 67.00 67.00 68.00 69.00 0 67.00 67.00 69.00 0 67.00 69.00 0 67.00 69.00 0 70.00 70.00 71.00 70.00 71.00 70.00 71			0		0 0	-	
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76.00 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES 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 0 0 0 76.03 OUTPATIENT SERVICE COST CENTERS OUTPATIENT SERVICE COST CENTERS 91.00 99100 EMERGENCY 0.000000 28,285 0 0 91.00 92.00 0BSERVATION BEDS (NON-DISTINCT PART) 0.000000 0 0 0 92.00 09100 EMENGENCS 0 0 0 0 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 95.00	73.00 07300 DRUGS CHARGED TO PATIENTS	0.000000	389,278		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 76.02 76.03 03950 WOUND CARE CENTER 0.000000 0 0 0 76.03 OUTPATIENT SERVICE COST CENTERS OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 0.000000 28,285 0 0 91.00 92.00 0BSERVATION BEDS (NON-DISTINCT PART) 0.000000 0 0 0 0 91.00 95.00 09500 AMBULANCE SERVICES 95.00 95.00 95.00 95.00	74.00 07400 RENAL DIALYSIS	0.000000	76,953		0 0	0	74.00
76.02 03330 ENDOSCOPY 0.00000 0 0 0 76.02 76.03 03950 WOUND CARE CENTER 0.000000 0 0 0 0 76.03 OUTPATIENT SERVICE COST CENTERS 0 0 0 0 0 91.00 91.00 09100 EMERGENCY 0.000000 28,285 0 0 0 91.00 92.00 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 0 0 0 92.00 04THER REIMBURSABLE COST CENTERS 95.00 0 0 0 95.00	76.00 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0		0 0	0	76.00
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OUTPATIENT SERVICE COST CENTERS 0 0 91.00 91.00 09100 EMERGENCY 0.000000 28,285 0 0 0 91.00 92.00 09500 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 0 0 0 0 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 95.00	76.02 03330 ENDOSCOPY	0.000000	0		0 0	0	76.02
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92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.00000 0 0 0 92.00 OTHER REIMBURSABLE COST CENTERS 95.00	OUTPATIENT SERVICE COST CENTERS	· · ·					1
OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00	91.00 09100 EMERGENCY	0.000000	28,285		0 0	0	91.00
95.00 09500 AMBULANCE SERVICES 95.00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000				0	92.00
	OTHER REIMBURSABLE COST CENTERS	· · · ·					
200,00 Total (lines 50 through 100) (121,200 048 0 0 0 0	95.00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199) 4,121,200 948 0 0/200.00	200.00 Total (lines 50 through 199)		4,121,200	94	18 0	0	200.00

.00 .00 .00 .00 .00 .00	Cost Center Description ART I - ALL PROVIDER COMPONENTS NPATIENT DAYS Inpatient days (including private room days and swing-bed da Inpatient days (including private room days, excluding swing Private room days (excluding swing-bed and observation bed d to not complete this line. Semi-private room days (excluding swing-bed and observation	-bed and newborn days)	Hospital	PPS 1.00	
1 00 00 00 00 00 00 00 00	ART I - ALL PROVIDER COMPONENTS NPATIENT DAYS inpatient days (including private room days and swing-bed da inpatient days (including private room days, excluding swing private room days (excluding swing-bed and observation bed d io not complete this line. isemi-private room days (excluding swing-bed and observation	-bed and newborn days)		1.00	1
1 00 00 00 00 00 00 00	NPATIENT DAYS Inpatient days (including private room days and swing-bed da Inpatient days (including private room days, excluding swing Private room days (excluding swing-bed and observation bed d to not complete this line. Semi-private room days (excluding swing-bed and observation	-bed and newborn days)			
.00 .00 .00 .00 .00 .00 .00	Inpatient days (including private room days, excluding swing Private room days (excluding swing-bed and observation bed d to not complete this line. Semi-private room days (excluding swing-bed and observation	-bed and newborn days)			
00 1 00 2 00 -	Private room days (excluding swing-bed and observation bed d to not complete this line. Gemi-private room days (excluding swing-bed and observation			14,598	
00 - 00 -	lo not complete this line. Semi-private room days (excluding swing-bed and observation	iays). If you nave only pi		14,598	
00 - 00 - 00 -	semi-private room days (excluding swing-bed and observation		nvate room days,	0	3
00		bed days)		13,616	4
00 -	otal swing-bed SNF type inpatient days (including private r	room days) through Decembe	er 31 of the cost	0	5
	eporting period Total swing-bed SNF type inpatient days (including private r	and dave) often December	21 of the cost	0	6
	reporting period (if calendar year, enter 0 on this line)	oom days) arter becember	SI OI LIE COSL	0	0
	Total swing-bed NF type inpatient days (including private ro	oom days) through December	r 31 of the cost	0	7
	reporting period				
	otal swing-bed NF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line)	oom days) after December 3	31 of the cost	0	8
	otal inpatient days including private room days applicable	to the Program (excluding	a swing-bed and	4,348	9
1	newborn days) (see instructions)			.,	
	wing-bed SNF type inpatient days applicable to title XVIII		room days)	0	10
	hrough December 31 of the cost reporting period (see instru wing-bed SNF type inpatient days applicable to title XVIII		room days) after	0	11
	becember 31 of the cost reporting period (if calendar year,		oom days) arter	0	
	wing-bed NF type inpatient days applicable to titles V or $ imes$	(IX only (including privat	te room days)	0	12
	hrough December 31 of the cost reporting period wing-bed NF type inpatient days applicable to titles V or X	(TV only (including privat	to noom days)	0	12
	of the cost reporting period (if calendar			0	13
	ledically necessary private room days applicable to the Prog			0	14
	otal nursery days (title V or XIX only)			0	15
	<pre>lursery days (title V or XIX only) WING BED ADJUSTMENT</pre>			0	16
	MING BED ADJUSIMENT Medicare rate for swing-bed SNF services applicable to servi	ces through December 31 (of the cost	0.00	17
1	reporting period	-			
	Medicare rate for swing-bed SNF services applicable to servi reporting period	ces after December 31 of	the cost	0.00	18
	Medicaid rate for swing-bed NF services applicable to servic	es through December 31 of	f the cost	0.00	19
	reporting period				
	<pre>Medicaid rate for swing-bed NF services applicable to servic reporting period</pre>	ces after December 31 of 1	che cost	0.00	20
	otal general inpatient routine service cost (see instructio	ons)		19,287,269	21
	wing-bed cost applicable to SNF type services through Decem		ting period (line	0	22
	x line 17)				
	wing-bed cost applicable to SNF type services after Decembe (line 18)	er 31 of the cost reportin	ig period (line 6	0	23
	wing-bed cost applicable to NF type services through Decemb	per 31 of the cost report	ing period (line	0	24
	'x line 19)				
	wing-bed cost applicable to NF type services after December (line 20)	r 31 of the cost reporting	j period (line 8	0	25
1	otal swing-bed cost (see instructions)			0	26
1	General inpatient routine service cost net of swing-bed cost	: (line 21 minus line 26)		19,287,269	27
	RIVATE ROOM DIFFERENTIAL ADJUSTMENT	and an all all and an All and and an			20
	General inpatient routine service charges (excluding swing-b Private room charges (excluding swing-bed charges)	ded and observation bed cr	larges)	0	28
	Semi-private room charges (excluding swing bed charges)			0	
.00 0	General inpatient routine service cost/charge ratio (line 27	′÷line 28)		0.000000	31
	verage private room per diem charge (line 29 ÷ line 3)			0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
	werage per diem private room charge differential (line 32 m werage per diem private room cost differential (line 34 x l			0.00	
	Private room cost differential adjustment (line 3 x line 35)			0.00	36
.00	General inpatient routine service cost net of swing-bed cost		ifferential (line	19,287,269	
	77 minus line 36)				
	ART II - HOSPITAL AND SUBPROVIDERS ONLY ROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD	UUSTMENTS			
	djusted general inpatient routine service cost per diem (se			1,321.23	38
.00	program general inpatient routine service cost (line 9 x lin	ne 38)		5,744,708	39
	Medically necessary private room cost applicable to the Prog Total Program general inpatient routine service cost (line 3			0 5,744,708	40

	Financial Systems A TION OF INPATIENT OPERATING COST	ASCENSION ST. V	Provider C		Period:	worksheet D-1	
				٢	From 07/01/2022 To 06/30/2023		
		7		XVIII	Hospital	PPS	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷	Program Days ÷	Program Cost (col. 3 x col.	
		1.00	2.00	col. 2)	1.00	4)	-
.00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	42
	Intensive Care Type Inpatient Hospital Units	0	0	0.00	<u>, 0</u>	0	44
	INTENSIVE CARE UNIT	4,633,812	2,145	2,160.29	9 572	1,235,686	43
	CORONARY CARE UNIT						44
	BURN INTENSIVE CARE UNIT						45
	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46
.00	Cost Center Description						/
	·					1.00	
	Program inpatient ancillary service cost (Wks			TTT 1:00 10		6,391,737	
	Program inpatient cellular therapy acquisitic Total Program inpatient costs (sum of lines 4				column 1)	0 13,372,131	
	PASS THROUGH COST ADJUSTMENTS	+i chrough +o.c				, 572,151	1 7.
- E	Pass through costs applicable to Program inpa	atient routine	services (from	Wkst. D, sum	of Parts I and	378,319	50
	III)				6		
	Pass through costs applicable to Program inpa and IV)	atient ancillar	y services (fr	om Wkst. D, su	um of Parts II	361,833	51
.00	Total Program excludable cost (sum of lines !	50 and 51)				740,152	52
	Total Program inpatient operating cost exclu		lated, non-phy	sician anesthe	etist, and	12,631,979	53
-	medical education costs (line 49 minus line ! FARGET AMOUNT AND LIMIT COMPUTATION	52)				l	-
	Program discharges					0	5
.00	Target amount per discharge					0.00	5
	Permanent adjustment amount per discharge					0.00	
	Adjustment amount per discharge (contractor u					0.00	
	Target amount (line 54 x sum of lines 55, 55 Difference between adjusted inpatient operat			ino 56 minus -	line 53)	0	
	Bonus payment (see instructions)	ing cost and ta	liget amount (1	The 50 millios	The 55)	0	
	Trended costs (lesser of line 53 ÷ line 54, (or line 55 from	the cost repo	rting period e	ending 1996,	0.00	
	updated and compounded by the market basket)						
	Expected costs (lesser of line 53 ÷ line 54,	or line 55 fro	m prior year c	ost report, up	dated by the	0.00	60
.00	market basket) Continuous improvement bonus payment (if line 53 \div line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise						
	enter zero. (see instructions)		j		,		
	Relief payment (see instructions)					0	
	Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru				0	6
	Medicare swing-bed SNF inpatient routine cost	ts through Dece	mber 31 of the	cost reportir	ng period (See	0	64
	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cost	ts after Decomb	or 31 of the c	ost roporting	noriod (soo	0	6
	instructions)(title XVIII only)	ts arter becent	er si or che c	Use reporting	period (see	l	' ⁰ .
.00	Total Medicare swing-bed SNF inpatient routin	ne costs (line	64 plus line 6	5)(title XVII)	[only); for	0	66
	CAH, see instructions Title V or XIX swing-bed NF inpatient routing	o costs through	December 21 o	f the cost rou	onting pariod	0	67
	(line 12 x line 19)	e costs through	December 31 0		Joi chig per lou		10
	Title V or XIX swing-bed NF inpatient routing	e costs after D	ecember 31 of	the cost repor	rting period	0	68
	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient (routing costs (line 67 + line	68)		0	69
	PART III - SKILLED NURSING FACILITY, OTHER NU					0	1 0.
.00	Skilled nursing facility/other nursing facil	ity/ICF/IID rou	tine service c	ost (line 37)			70
	Adjusted general inpatient routine service co		ıne 70 ÷ line	2)			7
	Program routine service cost (line 9 x line 3 Medically necessary private room cost applica) (line 14 v li	ne 35)			7
	Total Program general inpatient routine serv					1	7
.00	Capital-related cost allocated to inpatient				art II, column	1	7
	26, line 45)	2)					_
	Per diem capital-related costs (line 75 ÷ lin Program capital-related costs (line 9 x line						7
	Inpatient routine service cost (line 74 minus					1	7
	Aggregate charges to beneficiaries for excess		rovider record	s)		1	7
	Total Program routine service costs for compa		ost limitation	(line 78 minu	ıs line 79)		8
	Inpatient routine service cost per diem limit		`				8
	Inpatient routine service cost limitation (l Reasonable inpatient routine service costs (82
	Program inpatient ancillary services (see in:					1	84
	Utilization review - physician compensation		ns)			1	8
.00	Total Program inpatient operating costs (sum	of lines 83 th				L	86
	PART IV - COMPUTATION OF OBSERVATION BED PASS					000	87
	Total observation bed days (see instructions) Adjusted general inpatient routine cost per o		line 2)			982 1,321.23	
	Observation bed cost (line 87 x line 88) (see					1,297,448	

Health Financial Systems	ASCENSION ST. V	INCENT KOKOMO		In Lieu of Form CMS-2552		
COMPUTATION OF INPATIENT OPERATING COST				Period: From 07/01/2022	Worksheet D-1	
				го 06/30/2023	Date/Time Pre 11/21/2023 1:	
	Title	XVIII	Hospital	PPS		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observation	Bed Pass	
				Bed Cost (from		
				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	1,022,957	19,287,269	0.05303	3 1,297,448	68,814	90.00
91.00 Nursing Program cost	0	19,287,269	0.00000	1,297,448	0	91.00
92.00 Allied health cost	0	19,287,269	0.00000	1,297,448	0	92.00
93.00 All other Medical Education	0	19,287,269	0.00000	1,297,448	0	93.00

MPUT.	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0010	Period: From 07/01/2022	Worksheet D-1	
		Component CCN: 15-T010	то 06/30/2023	Date/Time Pre 11/21/2023 1:4	
		Title XVIII	Subprovider - IRF	PPS	
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				-
00	INPATIENT DATS Inpatient days (including private room days and swing-bed day	s, excluding newborn)		3,683	1 1
00	Inpatient days (including private room days, excluding swing-			3,683	
00	Private room days (excluding swing-bed and observation bed da	ys). 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 b	ad days)		3,683	4
00	Total swing-bed SNF type inpatient days (including private ro		r 31 of the cost	5,085	
	reporting period			-	-
00	Total swing-bed SNF type inpatient days (including private ro	om 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 roo	m dave) through December	21 of the cost	0	7
00	reporting period	in days) chrough becember	SI OI LINE COSL	0	<i>'</i>
00	Total swing-bed NF type inpatient days (including private roo	m 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 t newborn days) (see instructions)	o the Program (excluding	swing-bed and	1,858	9
0.00	Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private r	oom davs)	0	10
	through December 31 of the cost reporting period (see instruc	tions)			
.00	Swing-bed SNF type inpatient days applicable to title XVIII o		oom days) after	0	11
2.00	December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to titles V or XI	-	e room days)	0	12
	through December 31 of the cost reporting period	x only (meruanig privat	c room days)	0	1 12
3.00	Swing-bed NF type inpatient days applicable to titles V or XI			0	13
	after December 31 of the cost reporting period (if calendar y			0	14
	Medically necessary private room days applicable to the Progr Total nursery days (title V or XIX only)	am (excluding swing-bed	days)	0	
	Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT		1		
2.00	Medicare rate for swing-bed SNF services applicable to servic reporting period	es through December 31 o	f the cost	0.00	17
3.00	Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost	0.00	18
	reporting period				
9.00	Medicaid rate for swing-bed NF services applicable to service	s through December 31 of	the cost	0.00	19
0.00	reporting period Medicaid rate for swing-bed NF services applicable to service	s after December 31 of t	he cost	0.00	20
	reporting period			0.00	20
	Total general inpatient routine service cost (see instruction			3,845,098	
2.00	Swing-bed cost applicable to SNF type services through Decemb	er 31 of the cost report	ing period (line	0	22
3.00	5 x line 17) Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	a period (line 6	0	23
	x line 18)		g per lou (l'ille o	0	20
1.00	Swing-bed cost applicable to NF type services through Decembe	r 31 of the cost reporti	ng period (line	0	24
5.00	7 x line 19) Swing-bed cost applicable to NF type services after December	21 of the cost reporting	pariad (line 8	0	25
	x line 20)	SI OF the cost reporting	period (The 8	0	23
5.00	Total swing-bed cost (see instructions)			0	26
7.00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		3,845,098	27
.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	d and observation hed ch	arges)	0	28
	Private room charges (excluding swing-bed charges)	and observation bed ch	aiges)	0	
	Semi-private room charges (excluding swing-bed charges)			0	
	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0.000000	
	Average private room per diem charge (line 29 ÷ line 3)			0.00	
.00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mi	nus line 33)(see instruc	tions)	0.00 0.00	
.00	Average per diem private room cost differential (line 34 x li	ne 31)		0.00	
5.00	Private room cost differential adjustment (line 3 x line 35)			0	36
7.00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	3,845,098	37
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	USTMENTS			1
	Adjusted general inpatient routine service cost per diem (see	instructions)		1,044.01	38
	Program general inpatient routine service cost (line 9 x line			1,939,771	39
	Medically necessary private room cost applicable to the Progr	2 1 1 1 1 1		0	40

MPUI	ATION OF INPATIENT OPERATING COST		Provider C	CN: 15-0010	Period:	Worksheet D-1	L
			Component	ссм: 15-т010	From 07/01/2022 To 06/30/2023	Date/Time Pre	
			Title	2 XVIII	Subprovider -	11/21/2023 1: PPS	47 pr
	Cost Center Description	Total	Total	Average Per	IRF Program Days	Program Cost	
		Inpatient CostIn				(col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	42
2.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	C	0.	00 0	0	42.
3.00	INTENSIVE CARE UNIT	0	C	0.	00 0	0	43.
1.00	CORONARY CARE UNIT						44.
.00	BURN INTENSIVE CARE UNIT						45.
.00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46.
.00	Cost Center Description			1			47.
0.0			11			1.00	40
3.00 3.01	Program inpatient ancillary service cost (wk Program inpatient cellular therapy acquisiti			TTT line 10	column 1)	1,076,450	
.00	Total Program inpatient costs (sum of lines				, corumn 1)	3,016,221	
	PASS THROUGH COST ADJUSTMENTS						
.00	Pass through costs applicable to Program inp	atient routine s	ervices (from	ı Wkst. D, su	m of Parts I and	141,840	50.
.00	III) Pass through costs applicable to Program inp	atient ancillarv	services (fr	om Wkst. D.	sum of Parts II	45,257	51.
	and IV)	-		,			
.00	Total Program excludable cost (sum of lines		ated and i	eieien en ei	hotict	187,097	
.00	Total Program inpatient operating cost exclu medical education costs (line 49 minus line		aceu, non-phy	sician anest	netist, and	2,829,124	53.
	TARGET AMOUNT AND LIMIT COMPUTATION					·	
	Program discharges						54
.00 .01	Target amount per discharge Permanent adjustment amount per discharge					0.00	
.02	Adjustment amount per discharge (contractor	use only)				0.00	
.00	Target amount (line 54 x sum of lines 55, 55					0	
.00	Difference between adjusted inpatient operat	ing cost and tar	get amount (1	ine 56 minus	line 53)	0	
.00	Bonus payment (see instructions) Trended costs (lesser of line 53 ÷ line 54,	or line 55 from	the cost repo	orting period	ending 1996.	0.00	
	updated and compounded by the market basket)				,		
.00	D0 Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)						
.00	Continuous improvement bonus payment (if lin 55.01, or line 59, or line 60, enter the les 53) are less than expected costs (lines 54 x enter zero. (see instructions)	ser of 50% of th	e amount by w	hich operati	ng costs (line	0	61
	Relief payment (see instructions)					0	
.00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instruc	tions)			0	63
.00	Medicare swing-bed SNF inpatient routine cos	ts through Decem	ber 31 of the	e cost report	ing period (See	0	64
	instructions)(title XVIII only)	•					
.00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decembe	r 31 of the d	cost reportin	g period (See	0	65
.00	Total Medicare swing-bed SNF inpatient routi	ne costs (line 6	4 plus line 6	5)(title XVI	II only); for	0	66
	CAH, see instructions						
.00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through I	December 31 d	or the cost r	eporting period	0	67
.00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after De	cember 31 of	the cost rep	orting period	0	68
.00	Total title V or XIX swing-bed NF inpatient					0	69
.00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil)		70
.00	Adjusted general inpatient routine service c				,		70
.00	Program routine service cost (line 9 x line	71)					72
00	Medically necessary private room cost applic						73
00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient				Part II, column		74
.00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76
.00	Program capital-related costs (line 9 x line						77
00	Inpatient routine service cost (line 74 minu	s line 77)					78
00	Aggregate charges to beneficiaries for exces				nuc line 70)		79
00 00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		st limitation	i (ine /s mi	nus inne 79)		80
.00	Inpatient routine service cost limitation (1						82
.00	Reasonable inpatient routine service costs (see instructions)				83
.00	Program inpatient ancillary services (see in		-)				84
.00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85
	PART IV - COMPUTATION OF OBSERVATION BED PAS		5 7				
00	Total observation bed days (see instructions					0	87

Health Financial Systems	ASCENSION ST. V	INCENT KOKOMO		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO	CN: 15-0010	Period:	Worksheet D-1	
		Component (ССМ: 15-ТО10	From 07/01/2022 To 06/30/2023	Date/Time Pre 11/21/2023 1:	pared: 47 pm
		Title	Title XVIII		PPS	
				IRF		
Cost Center Description						
					1.00	
89.00 Observation bed cost (line 87 x line 88) (see	0	89.00				
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observation	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital-related cost	281,160	3,845,098	0.07312	22 0	0	90.00
91.00 Nursing Program cost	0	3,845,098	0.0000	0 0	0	91.00
92.00 Allied health cost	0	3,845,098	0.0000	0 0	0	92.00
93.00 All other Medical Education	0	3,845,098		0 00	0	93.00

MPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0010	Period: From 07/01/2022 To 06/30/2023	Worksheet D-1 Date/Time Pre 11/21/2023 1:	pare
		Title XIX	Hospital	Cost	
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS		1		
00	INPATIENT DAYS Inpatient days (including private room days and swing-bed day	(s excluding newborn)		14,598	1
00	Inpatient days (including private room days and swing bed day Inpatient days (including private room days, excluding swing-			14,598	
00	Private room days (excluding swing-bed and observation bed da		rivate room days,	0	
	do not complete this line.				
00	Semi-private room days (excluding swing-bed and observation b			13,616	
00	Total swing-bed SNF type inpatient days (including private ro reporting period	om days) through becemb	er si of the cost	0	5
00	Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6
	reporting period (if calendar year, enter 0 on this line)				
00	Total swing-bed NF type inpatient days (including private roo	om days) through Decembe	r 31 of the cost	0	7
00	reporting period Total swing-bed NF type inpatient days (including private roo	m days) after December	31 of the cost	0	8
	reporting period (if calendar year, enter 0 on this line)	in days) areer becember		Ŭ	"
00	Total inpatient days including private room days applicable t	o the Program (excludin	g swing-bed and	226	9
00	newborn days) (see instructions)			0	1.0
.00	Swing-bed SNF type inpatient days applicable to title XVIII o through December 31 of the cost reporting period (see instruc		room days)	0	10
.00	Swing-bed SNF type inpatient days applicable to title XVIII o		room days) after	0	11
	December 31 of the cost reporting period (if calendar year, e	enter 0 on this line)			
.00	Swing-bed NF type inpatient days applicable to titles V or XI	x only (including priva	te room days)	0	12
.00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI	x only (including prive	te room dave)	0	13
.00	after December 31 of the cost reporting period (if calendar y			0	11
.00	Medically necessary private room days applicable to the Progr	ram (excluding swing-bed	days)	0	
.00	Total nursery days (title V or XIX only)			1,192	
.00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			62	16
.00	Medicare rate for swing-bed SNF services applicable to servic	es through December 31	of the cost	0.00	17
	reporting period				
.00	Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost	0.00	18
.00	reporting period Medicaid rate for swing-bed NF services applicable to service	es through December 31 o	f the cost	0.00	19
	reporting period				
.00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of	the cost	0.00	20
.00	reporting period Total general inpatient routine service cost (see instruction			19,287,269	21
.00	Swing-bed cost applicable to SNF type services through Decemb	-	ting period (line	19,287,209	
	5 x line 17)		enig per loa (Thie	Ũ	
.00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporti	ng period (line 6	0	23
.00	x line 18) Swing-bed cost applicable to NF type services through Decembe	or 31 of the cost report	ing pariod (line	0	24
.00	7 x line 19)		ing period (Time	0	27
.00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	g period (line 8	0	25
~~	x line 20)			0	1 20
.00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		19,287,269	26
.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			19,207,209	1 - 1
.00	General inpatient routine service charges (excluding swing-be	ed and observation bed c	harges)	0	
	Private room charges (excluding swing-bed charges)			0	
. 00 . 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	· lina 28)		0 0.000000	
.00	Average private room per diem charge (line 29 ÷ line 3)	÷ THe 28)		0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
.00	Average per diem private room charge differential (line 32 mi		ctions)	0.00	34
.00	Average per diem private room cost differential (line 34 x li	ne 31)		0.00	
	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost	and private room cost d	ifferential (line)	0 19 287 269	
.00	27 minus line 36)	and private room cost d	inerencial (ine	19,287,269	3/
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ				
	Adjusted general inpatient routine service cost per diem (see			1,321.23	
	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progr			298,598 0	
	meancarry necessary private room cost appricable to the Progr	α_{IIII} (IIIIE IH X IIIIE 33)		0	1 40

OMPUT	Financial Systems A ATION OF INPATIENT OPERATING COST	ASCENSION ST. V	Provider Co	CN: 15-0010	Period:	eu of Form CMS-2 Worksheet D-1	
					From 07/01/2022 To 06/30/2023	Date/Time Pre 11/21/2023 1:4	
	Cost Contor Description	Total		e XIX	Hospital	Cost	
	Cost Center Description	Total Inpatient Cost		Average Per Diem (col. 1		Program Cost (col. 3 x col.	
		input tene cost	inputient buys	col. 2)		4)	
		1.00	2.00	3.00	4.00	5.00	
2.00	NURSERY (title V & XIX only)	1,308,344	1,192	1,097.0	60 62	68,051	42.0
2 00	Intensive Care Type Inpatient Hospital Units	4 (22 012	2 145	2 100 2	210	452.001	1 42 0
4.00	INTENSIVE CARE UNIT CORONARY CARE UNIT	4,633,812	2,145	2,160.2	29 210	453,661	43.0
5.00	BURN INTENSIVE CARE UNIT						44.0
	SURGICAL INTENSIVE CARE UNIT						46.0
	OTHER SPECIAL CARE (SPECIFY)						47.0
	Cost Center Description						
0.00			11			1.00	10
8.00 8.01	Program inpatient ancillary service cost (Wks Program inpatient cellular therapy acquisition			TTT line 10	column 1)	909,102 0	48. 48.
	Total Program inpatient costs (sum of lines 4				, corumn 1)	1,729,412	
	PASS THROUGH COST ADJUSTMENTS		2)(000 11001 40			1,120,122	
0.00	Pass through costs applicable to Program inpa	atient routine	services (from	Wkst. D, sur	n of Parts I and	0	50.
	III)				6		
1.00	Pass through costs applicable to Program inpa and IV)	atient ancillar	y services (fr	om Wkst. D, s	sum 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 exclude		lated, non-phy	sician anestl	netist, and	0	53.
	medical education costs (line 49 minus line !	52)					
	TARGET AMOUNT AND LIMIT COMPUTATION						
	Program discharges					0	-
	Target amount per discharge Permanent adjustment amount per discharge					0.00	
	Adjustment amount per discharge (contractor u	use only)				0.00	
	Target amount (line 54 x sum of lines 55, 55					0	56.
7.00	Difference between adjusted inpatient operat	ing cost and ta	rget amount (1	ine 56 minus	line 53)	0	57.
8.00	Bonus payment (see instructions)					0	58.
9.00	Trended costs (lesser of line 53 ÷ line 54, o	or line 55 from	the cost repo	rting period	ending 1996,	0.00	59.
0.00	updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54,	or line 55 fro	m prior year c	ost report	indated by the	0.00	60.
0.00	market basket)	01 11112 33 110	in prior year c	.03t Teport, t	ipuated by the	0.00	00.
1.00	Continuous improvement bonus payment (if line 55.01 , or line 59 , or line 60 , enter the less 53) are less than expected costs (lines 54×54)	ser of 50% of t	he amount by w	hich operati	ng costs (line	0	61.
	enter zero. (see instructions)						
	Relief payment (see instructions)	ant (can inctru	ations)			0	-
3.00	Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru				0	63.
4.00	Medicare swing-bed SNF inpatient routine cost	ts through Dece	mber 31 of the	cost report	ing period (See	0	64.
	instructions)(title XVIII only)						
5.00	Medicare swing-bed SNF inpatient routine cost	ts after Decemb	er 31 of the c	ost reporting	g period (See	0	65.
6 00	instructions)(title XVIII only)	a costa (lina	64 mlue line 6		T only), for	0	66
6.00	Total Medicare swing-bed SNF inpatient routin CAH, see instructions	ie costs (Time	o4 plus line o	s)(title XVI	LI ONTY); TOP	0	66.
7.00	Title V or XIX swing-bed NF inpatient routing	e costs through	December 31 o	of the cost re	eporting period	0	67.
	(line 12 x line 19)	5					
8.00	Title V or XIX swing-bed NF inpatient routine	e costs after D	ecember 31 of	the cost repo	orting period	0	68.
9.00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routing costs (lino 67 lino	68)		0	69.
5.00	PART III - SKILLED NURSING FACILITY, OTHER NU					· · · · ·	05.
0.00	Skilled nursing facility/other nursing facil)		70.
1.00	Adjusted general inpatient routine service co	ost per diem (1	ine 70 ÷ line	2)			71.
2.00	Program routine service cost (line 9 x line)		(2)				72.
3.00	Medically necessary private room cost applica	5	•				73.
4.00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient				Part II column		74.
	26, line 45)	outile service	C03C3 (110m W	or concert b, i	art II, corumn		15.
5.00	Per diem capital-related costs (line 75 ÷ lin	ne 2)					76.
7.00	Program capital-related costs (line 9 x line						77.
	Inpatient routine service cost (line 74 minus			->			78.
9.00	Aggregate charges to beneficiaries for excess				aus line 70)		79.
).00 L.00	Total Program routine service costs for compa Inpatient routine service cost per diem limit		ust inmitation	(inte /o mli	ius i i ile 79)		80. 81.
2.00	Inpatient routine service cost per diem rimit Inpatient routine service cost limitation (1:)				82.
3.00	Reasonable inpatient routine service costs (83.
4.00	Program inpatient ancillary services (see in	structions)					84.
	Utilization review - physician compensation						85.
6.00	Total Program inpatient operating costs (sum		rough 85)				86.
7.00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions)					982	87.
7.00 8.00	Adjusted general inpatient routine cost per o		line 2)			1,321.23	
		e instructions)				1,297,448	

Health Financial Systems	ASCENSION ST. V	INCENT KOKOMO		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 07/01/2022	Worksheet D-1	
				го 06/30/2023	Date/Time Pre 11/21/2023 1:	
		Titl	e XIX	Hospital	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observation	Bed Pass	
				Bed Cost (from		
				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	1,022,957	19,287,269	0.05303	3 1,297,448	68,814	90.00
91.00 Nursing Program cost	0	19,287,269	0.00000	1,297,448	0	91.00
92.00 Allied health cost	0	19,287,269	0.00000	1,297,448	0	92.00
93.00 All other Medical Education	0	19,287,269	0.00000	1,297,448	0	93.00

OMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0010	Period: From 07/01/2022	Worksheet D-1	
		Component CCN: 15-T010	то 06/30/2023	Date/Time Pre 11/21/2023 1:4	
		Title XIX	Subprovider - IRF	Cost	
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
00	Inpatient days (including private room days and swing-bed day	ys, excluding newborn)		3,683	1 1
00	Inpatient days (including private room days, excluding swing			3,683	
00	Private room days (excluding swing-bed and observation bed da	ays). 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 l	and days)		3,683	4
00	Total swing-bed SNF type inpatient days (including private ro		r 31 of the cost	5,005	
	reporting period				
00	Total swing-bed SNF type inpatient days (including private ro	oom 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 roo	om days) through December	31 of the cost	0	7
00	reporting period	sin days) through becember	SI OF the cost	0	'
.00	Total swing-bed NF type inpatient days (including private roo	om days) after December 3	1 of the cost	0	8
.00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable	to the Brogram (aveluding	swing-bod and	53	g
.00	newborn days) (see instructions)		swillg-bed allu	C C	
0.00	Swing-bed SNF type inpatient days applicable to title XVIII of		oom days)	0	10
1 00	through December 31 of the cost reporting period (see instruction Swing-bed SNF type inpatient days applicable to title XVIII of the second se		and dave) often	0	11
.00	December 31 of the cost reporting period (if calendar year, o		oom days) after	0	111
2.00	Swing-bed NF type inpatient days applicable to titles V or X		e room days)	0	12
	through December 31 of the cost reporting period				
3.00	Swing-bed NF type inpatient days applicable to titles V or X: after December 31 of the cost reporting period (if calendar v			0	13
1.00	Medically necessary private room days applicable to the Progr			0	14
5.00	Total nursery days (title V or XIX only)			1,192	
5.00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			62	16
7.00	Medicare rate for swing-bed SNF services applicable to servio	ces through December 31 c	of the cost	0.00	17
	reporting period				
3.00	Medicare rate for swing-bed SNF services applicable to service reporting period	ces after December 31 of	the cost	0.00	17
9.00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 of	the cost	0.00	19
0.00	reporting period Medicaid rate for swing-bed NF services applicable to service	as after December 31 of t	he cost	0.00	20
	reporting period			0.00	
	Total general inpatient routine service cost (see instruction	-		3,845,098	
2.00	Swing-bed cost applicable to SNF type services through Deceml 5 x line 17)	per 31 of the cost report	ing period (line	0	22
3.00	Swing-bed cost applicable to SNF type services after December	r 31 of the cost reportin	g period (line 6	0	23
	x line 18)				
4.00	Swing-bed cost applicable to NF type services through December 7 x line 19)	er 31 of the cost reporti	ng period (line	0	24
5.00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25
	x line 20)				
5.00 7.00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		0 3,845,098	
.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(The 21 milds The 20)	<u> </u>	5,845,098	21
	General inpatient routine service charges (excluding swing-be	ed and observation bed ch	arges)	0	28
	Private room charges (excluding swing-bed charges)			0	
0.00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	∸ line 28)		0 0.000000	
	Average private room per diem charge (line 29 ÷ line 3)			0.00	
.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33
	Average per diem private room charge differential (line 32 m		tions)	0.00	
5.00 5.00	Average per diem private room cost differential (line 34 x l ⁻ Private room cost differential adjustment (line 3 x line 35)	ine 31)		0.00	
7.00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	3,845,098	
	27 minus line 36)	•]
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	ILICTMENTS			
.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD: Adjusted general inpatient routine service cost per diem (see			1,044.01	38
	Program general inpatient routine service cost (line 9 x line			55,333	
0.00	Medically necessary private room cost applicable to the Prog	ram (line 14 x line 35)		0	40
00	Total Program general inpatient routine service cost (line 39	9 + line 40)		55,333	41

OMPUT	Financial Systems ATION OF INPATIENT OPERATING COST	ASCENSION ST. VI		CN: 15-0010	Period:	worksheet D-1	
			Component	ссм: 15-т010	From 07/01/2022 To 06/30/2023	Date/Time Pre	
			Titl	le XIX	Subprovider -	11/21/2023 1: Cost	47 pm
	Cost Center Description	Total	Total	Average Per	IRF Program Days	Program Cost	
		Inpatient CostI	npatient Days	Diem (col. 1 col. 2)	÷	(col. 3 x col. 4)	
2 00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	42.0
2.00	Intensive Care Type Inpatient Hospital Units		0	. 0.	00 0	0	72.0
	INTENSIVE CARE UNIT	0	0	0.	00 0	0	1
4.00	CORONARY CARE UNIT						44.0
5.00							45.0
	OTHER SPECIAL CARE (SPECIFY)						47.0
	Cost Center Description					1.00	
8.00	Program inpatient ancillary service cost (Wk	st. D-3. col. 3.	line 200)			1.00	48.0
8.01	Program inpatient cellular therapy acquisiti			III, line 10	, column 1)	0	1
9.00	Total Program inpatient costs (sum of lines	41 through 48.01)(see instruc	tions)		88,549	49.0
0.00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	ationt routing c	anvicas (from	what D au	m of Parts I and	0	50.0
0.00	III)	actent fouchie s	ervices (IIO	wkst. D, su	II OI PAILS I ANU	0	50.0
1.00	Pass through costs applicable to Program inp	atient ancillary	services (fr	rom Wkst. D,	sum of Parts II	0	51.0
2 00	and IV)	[0, and [1])				0	E2 (
2.00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		ated. non-nhv	/sician anest	hetist. and	0	
	medical education costs (line 49 minus line		,				
4 00	TARGET AMOUNT AND LIMIT COMPUTATION						
	Program discharges Target amount per discharge						54.
5.01							55.
5.02	5						55.
5.00	5		act amount (1	ling F6 minus	ling E2)	0	
3.00	Bonus payment (see instructions)	ing cost and tar	get amount (1	ine so minus	The 55)	0	
9.00	Trended costs (lesser of line 53 ÷ line 54,	or line 55 from	the cost repo	orting period	ending 1996,	0.00	
0 00	updated and compounded by the market basket)						60
0.00	Expected costs (lesser of line 53 ÷ line 54, market basket)	or line 55 from	prior year o	cost report,	updated by the	0.00	60.
1.00		ser of 50% of th	e amount by w	which operati	ng costs (line	0	61.0
	Relief payment (see instructions)					0	
3.00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instruc	tions)			0	63.
4.00		ts through Decem	ber 31 of the	e cost report	ing period (See	0	64.
- 00	instructions)(title XVIII only)	the officer proceeder	- 21 - 5 + 6				65
5.00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts atter Decembe	r 31 of the c	cost reportin	g period (See	0	65.
6.00	Total Medicare swing-bed SNF inpatient routi	ne costs (line 6	4 plus line 6	5)(title XVI	II only); for	0	66.
7.00	CAH, see instructions Title V or XIX swing-bed NF inpatient routin	a costa through	December 21 -	of the cost -	enorting pariod	0	67.
	(line 12 x line 19)	ie costs tillough	December 31 (ine cost f	eporting period	0	07.1
8.00		e costs after De	cember 31 of	the cost rep	orting period	0	68.
9.00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (1	ine 67 + line	2 68)		0	69.0
	PART III - SKILLED NURSING FACILITY, OTHER N	URSING FACILITY,	AND ICF/IID	ONLY			
0.00	Skilled nursing facility/other nursing facil)		70.
1.00	Adjusted general inpatient routine service c Program routine service cost (line 9 x line		ne /0 ÷ line	۷)			71.
3.00	Medically necessary private room cost applic		(line 14 x li	ine 35)			73.
4.00	Total Program general inpatient routine serv	vice costs (line	72 + line 73))	•		74.
5.00	Capital-related cost allocated to inpatient 26, line 45)	routine service	costs (from W	vorksheet B,	Part II, column		75.
5.00	Per diem capital-related costs (line 75 ÷ li						76.
7.00							77.
3.00 9.00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		ovider record	15)			78.
0.00					nus line 79)		80.
.00	Inpatient routine service cost per diem limi	tation			-		81.
	Inpatient routine service cost limitation (1						82.
3.00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in		J				83. 84.
5.00			s)				85.
6.00	Total Program inpatient operating costs (sum	of lines 83 thr					86.
7.00	PART IV - COMPUTATION OF OBSERVATION BED PAS Total observation bed days (see instructions					0	87.0
	inclai observation bed days (see institutions	· /				0.00	107.

Health Financial Systems	ASCENSION ST. V	INCENT KOKOMO		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO	CN: 15-0010	Period:	Worksheet D-1	
		Component (ССМ: 15-ТО10	From 07/01/2022 To 06/30/2023	Date/Time Prep 11/21/2023 1:4	
		Titl	e XIX	Subprovider -	Cost	
				IRF		
Cost Center Description						
					1.00	
89.00 Observation bed cost (line 87 x line 88) (see	e instructions))			0	89.00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observation	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital-related cost	281,160	3,845,098	0.07312	22 0	0	90.00
91.00 Nursing Program cost	0	3,845,098	0.0000	0 00	0	91.00
92.00 Allied health cost	0	3,845,098	0.0000	0 00	0	92.00
93.00 All other Medical Education	0	3,845,098		0 0	0	93.00

	Financial Systems ASCENSION ST. ENT ANCILLARY SERVICE COST APPORTIONMENT	VINCENT KOKOMO Provider C	CN: 15-0010	Period:	worksheet D-3	
	LAN ANCIELANT SERVICE COST ATTORTIONMENT	riovider e	CN. 15 0010	From 07/01/2022	worksheet b 5	
				то 06/30/2023	Date/Time Pre 11/21/2023 1:	pare
		Title	e XVIII	Hospital	PPS	47 pi
	Cost Center Description		Ratio of Cos		Inpatient	
			To Charges	Program	Program Costs	
					(col. 1 x col.	
				J	2)	
			1.00	2.00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS					
	03000 ADULTS & PEDIATRICS			9,761,226		30.
31.00	03100 INTENSIVE CARE UNIT			2,968,400		31.
1.00	04100 SUBPROVIDER - IRF			0		41.
13.00	04300 NURSERY					43.
	ANCILLARY SERVICE COST CENTERS					
	05000 OPERATING ROOM		0.1141	-, -, -	997,834	
	05200 DELIVERY ROOM & LABOR ROOM		0.1568		8,643	
	05400 RADIOLOGY-DIAGNOSTIC		0.2095	,	166,635	
	03630 ULTRA SOUND		0.1088		45,651	
	05600 RADIOISOTOPE		0.0949		5,207	
	05700 CT SCAN		0.0939		132,984	
	05800 MAGNETIC RESONANCE IMAGING (MRI)		0.2815	13 192,850	54,290	58.
50.00	06000 LABORATORY		0.0948	39 10,137,449	961,932	60.
55.00	06500 RESPIRATORY THERAPY		0.1826	2,168,460	395,976	65.
	06600 PHYSICAL THERAPY		0.4186	738,319	309,076	66.
	06700 OCCUPATIONAL THERAPY		0.3612	92 498,238	180,009	67.
	06800 SPEECH PATHOLOGY		0.3361	32 129,949	43,680	68.
59.00	06900 ELECTROCARDIOLOGY		0.0669	96 1,927,341	129,124	69.
70.00	07000 ELECTROENCEPHALOGRAPHY		0.1657	38 163,540	27,105	70.
1.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.1068	2,546,207	272,149	71.
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		0.2917	2,108,691	615,124	72.
73.00	07300 DRUGS CHARGED TO PATIENTS		0.3010	4,614,968	1,389,193	73.
	07400 RENAL DIALYSIS		0.2368	95 389,418	92,251	74.
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES		0.7867	71 0	0	76.
76.01	03190 CHEMOTHERAPY		0.2106	98 3,348	705	76.
76.02	03330 ENDOSCOPY		0.0000	0 00	0	76.
76.03	03950 WOUND CARE CENTER		0.0972	56 58,560	5,695	76.
	OUTPATIENT SERVICE COST CENTERS					
	09100 EMERGENCY		0.0843		507,802	91.
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0.4882	19 103,790	50,672	92.
	OTHER REIMBURSABLE COST CENTERS					
	09500 AMBULANCE SERVICES					95.
200.00				43,282,984	6,391,737	
201.00		rges (line 61)		0		201.
202.00	Net charges (line 200 minus line 201)			43,282,984		202.

	Financial Systems ASCENSION ST. VINC					u of Form CMS-	
AT I	IENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CO	CN: 15-0010		riod:	Worksheet D-3	
		Component (ссм:15-т010	TO	om 07/01/2022 06/30/2023	Date/Time Pre	narodi
		componente	CCN. 15-1010	10	00/ 30/ 2023	11/21/2023 1:	
		Title	XVIII	S	ubprovider -	PPS	
					IRF		
	Cost Center Description		Ratio of Cos		Inpatient	Inpatient	
			To Charges		Program	Program Costs	
					Charges	(col. 1 x col.	
			1.00		2.00	2) 3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS		1.00		2.00	5.00	
00	03000 ADULTS & PEDIATRICS						30.00
00	03100 INTENSIVE CARE UNIT						31.00
00	04100 SUBPROVIDER - IRF				4,188,120		41.00
00	04300 NURSERY				.,200,220		43.00
	ANCILLARY SERVICE COST CENTERS		1				
00			0.1141	24	35,471	4,048	50.00
00	05200 DELIVERY ROOM & LABOR ROOM		0.1568	00	0	0	52.00
00	05400 RADIOLOGY-DIAGNOSTIC		0.2095	74	76,229	15,976	54.00
01	03630 ULTRA SOUND		0.1088	19	0	0	1
00	05600 RADIOISOTOPE		0.0949	92	0	0	56.00
00	05700 CT SCAN		0.0939	93	46,280	4,350	57.00
00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0.2815	13	20,900	5,884	58.00
00	06000 LABORATORY		0.0948	89	1,084,162	102,875	60.00
00	06500 RESPIRATORY THERAPY		0.1826	07	172,981	31,588	65.00
00	06600 PHYSICAL THERAPY		0.4186	21	998,572	418,023	66.00
00	06700 OCCUPATIONAL THERAPY		0.3612	92	812,052	293,388	67.0
00	06800 SPEECH PATHOLOGY		0.3361	.32	95,634	32,146	68.0
00	06900 ELECTROCARDIOLOGY		0.0669	96	68,384	4,581	69.00
00	07000 ELECTROENCEPHALOGRAPHY		0.1657	38	14,097	2,336	
00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.1068		191,763	20,496	
00	07200 IMPL. DEV. CHARGED TO PATIENTS		0.2917	'09	10,159		72.00
00	07300 DRUGS CHARGED TO PATIENTS		0.3010		389,278	117,180	
	07400 RENAL DIALYSIS		0.2368	95	76,953	18,230	
00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES		0.7867		0	0	
	03190 CHEMOTHERAPY		0.2106		0	0	
02	03330 ENDOSCOPY		0.0000		0	0	76.02
03	03950 WOUND CARE CENTER		0.0972	56	0	0	76.03
~ ~	OUTPATIENT SERVICE COST CENTERS		0.0040		20.205	2.200	
00	09100 EMERGENCY		0.0843		28,285	2,386	
00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0.4882	19	0	0	92.00
20	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES		1				95.00
.00					4 121 200	1 076 450	
		(line 61)			4,121,200	1,076,450	200.00
		(TIME DI)			4 121 200		201.00
.00		(line 61)				0 4,121,200	0 4,121,200

	Financial Systems ASCENS: CENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0010	Period:	Worksheet D-3	2552-
	LERT ANGELEART SERVICE COST ATTORTIONMENT		CN. 15 0010	From 07/01/2022 To 06/30/2023	Date/Time Pre 11/21/2023 1:	pared
		Titl	e XIX	Hospital	Cost	17 pi
	Cost Center Description		Ratio of Cos		Inpatient	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
				_	2)	
	I		1.00	2.00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS					
				937,489		30.
31.00	03100 INTENSIVE CARE UNIT			301,482		31.
41.00	04100 SUBPROVIDER - IRF			0		41.
43.00				267,670		43.
	ANCILLARY SERVICE COST CENTERS		0 1120/	750 207	0.0 452	-
50.00	05000 OPERATING ROOM		0.11386		86,452	
52.00	05200 DELIVERY ROOM & LABOR ROOM		0.15680		117,296	
	05400 RADIOLOGY-DIAGNOSTIC		0.20957	.,	23,207	
	03630 ULTRA SOUND		0.10881	,	8,150	
	05600 RADIOISOTOPE		0.09499		4	
57.00	05700 CT SCAN		0.09399		21,314	
58.00			0.28151		9,962	
50.00 55.00	06000 LABORATORY 06500 RESPIRATORY THERAPY		0.09488	,,	144,775 58,338	
56.00	06600 PHYSICAL THERAPY		0.18260		32,054	
57.00	06700 OCCUPATIONAL THERAPY		0.36129		3,321	
58.00	06800 SPEECH PATHOLOGY		0.33612		1,403	
	06900 ELECTROCARDIOLOGY		0.06699	, -	7,734	
	07000 ELECTROENCEPHALOGRAPHY		0.16573		2,831	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.10688		30,655	
	07200 IMPL. DEV. CHARGED TO PATIENTS		0.29170		75,987	
73.00	07300 DRUGS CHARGED TO PATIENTS		0.30101		179,378	
	07400 RENAL DIALYSIS		0.23689		8,113	
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES		0.78677		0,113	
	03190 CHEMOTHERAPY		0.21069	-	275	
	03330 ENDOSCOPY		0.00000	,	0	
	03950 WOUND CARE CENTER		0.09725		387	
0.05	OUTPATIENT SERVICE COST CENTERS		0.0372.	5,577	507	/0.
91.00	09100 EMERGENCY		0.08436	56 1,155,277	97,466	91.
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0.48821		0	
	OTHER REIMBURSABLE COST CENTERS				Ŭ	1
95.00	09500 AMBULANCE SERVICES					95.
200.00		ough 98)		6,360,851	909,102	
201.00				0	,	201.
202.00		,,,		6,360,851		202.

	Financial Systems ASCENSION ST. VINCE		SN 15 0010		u of Form CMS-2	
INPAIL	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provider Co	LN: 15-0010	Period: From 07/01/2022	Worksheet D-3	
		Component (ссм: 15-т010	To 06/30/2023	Date/Time Pre	pared
					11/21/2023 1:	
		Titl	e XIX	Subprovider -	Cost	
				IRF		1
	Cost Center Description		Ratio of Cos To Charges		Inpatient Program Costs	
			To charges	5	(col. 1 x col.	
				Charges	2)	
			1.00	2.00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2100	5100	
30.00	03000 ADULTS & PEDIATRICS					30.0
31.00	03100 INTENSIVE CARE UNIT					31.0
41.00	04100 SUBPROVIDER - IRF			114,995		41.0
43.00	04300 NURSERY			,		43.0
	ANCILLARY SERVICE COST CENTERS		I		1	
50.00	05000 OPERATING ROOM		0.1138	60 0	0	50.0
52.00	05200 DELIVERY ROOM & LABOR ROOM		0.1568	00 0	0	52.0
54.00	05400 RADIOLOGY-DIAGNOSTIC		0.2095	74 342	72	54.0
54.01	03630 ULTRA SOUND		0.1088	19 0	0	54.
56.00	05600 RADIOISOTOPE		0.0949	92 0	0	56.
57.00	05700 CT SCAN		0.0939	93 0	0	57.
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0.2815	13 0	0	58.
50.00	06000 LABORATORY		0.0948	89 21,462	2,037	60.
65.00	06500 RESPIRATORY THERAPY		0.1826			65.
56.00	06600 PHYSICAL THERAPY		0.4186	21 28,909	12,102	66.
67.00	06700 OCCUPATIONAL THERAPY		0.3612	92 26,579	9,603	67.
58.00	06800 SPEECH PATHOLOGY		0.3361	32 637	214	68.
59.00	06900 ELECTROCARDIOLOGY		0.0669	96 0	0	69.
70.00	07000 ELECTROENCEPHALOGRAPHY		0.1657	38 0	0	70.0
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.1068	84 0	0	71.
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		0.2917		0	1
73.00	07300 DRUGS CHARGED TO PATIENTS		0.3010			73.
74.00	07400 RENAL DIALYSIS		0.2368	95 19,068	4,517	74.
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES		0.7867	71 0	0	76.
76.01	03190 CHEMOTHERAPY		0.2106	98 0	0	76.
76.02	03330 ENDOSCOPY		0.0000			
76.03	03950 WOUND CARE CENTER		0.0972	56 0	0	76.
	OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY		0.0843			
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0.4882	19 0	0	92.
	OTHER REIMBURSABLE COST CENTERS					
	09500 AMBULANCE SERVICES					95.
200.00				114,587	33,216	
201.00		(line 61)		0		201.
202.00	Net charges (line 200 minus line 201)			114,587		202.

		/01/2022 /30/2023	Date/Time Pre 11/21/2023 1:	pared:
		1tai	PPS	
			1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		-	
$1.00 \\ 1.01$	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurring prior to October 1 (see		03,053,005	1.00
1.01	instructions)		3,033,003	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see		7,751,429	1.02
1 0 2	instructions)	Octobor	0	1 02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to 1 (see instructions)	occoper	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or aft	er	0	1.04
2 00	October 1 (see instructions)			2 00
2.00 2.01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount		0	2.00
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)		37,718	
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		13,485	
3.00 4.00	Managed Care Simulated Payments Bed days available divided by number of days in the cost reporting period (see instructions)		0 116.10	3.00
4.00	Indirect Medical Education Adjustment		110.10	4.00
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period er	nding on	0.00	5.00
- 01	or before 12/31/1996. (see instructions)			5.04
5.01 6.00	FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions) FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the	can for	0.00	
0.00	new programs in accordance with 42 CFR 413.79(e)	Cap 101	0.00	0.00
6.26	Rural track program FTE cap limitation adjustment after the cap-building window closed under	127 of	0.00	6.26
	the CAA 2021 (see instructions)			
7.00 7.01	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR $\frac{11}{10}$ (1)(iv)(E		0.00	
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) cost report straddles July 1, 2011 then see instructions.	II the	0.00	7.01
7.02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for	rural	0.00	7.02
	track programs with a rural track for Medicare GME affiliated programs in accordance with 413.	75(b)		
0 00	and 87 FR 49075 (August 10, 2022) (see instructions)		0.00	0 00
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12		0.00	8.00
	1998), and 67 FR 50069 (August 1, 2002).	• •		
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If t	he cost	0.00	8.01
8.02	report straddles July 1, 2011, see instructions. The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospit	- 1	0.00	8.02
0.02	under § 5506 of ACA. (see instructions)		0.00	0.02
8.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (s	see	0.00	8.21
9.00	instructions) Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, pl	us or	0.00	9.00
5.00	minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)	45 01	0.00	5.00
10.00			0.00	10.00
	FTE count for residents in dental and podiatric programs.			11.00
	Current year allowable FTE (see instructions)			12.00
13.00 14.00). 1997.		13.00
200	otherwise enter zero.	, 2000,		
15.00				15.00
16.00				16.00
17.00 18.00				17.00 18.00
19.00			0.000000	
20.00			0.000000	
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	
22.00			0	
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
23.00	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.10)5	0.00	23.00
	(f)(1)(iv)(C).	-		
24.00				24.00
25.00			0.00	25.00
26.00	instructions) Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00			0.000000	1
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01			0	28.01
29.00			0	29.00 29.01
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment		0	29.01
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		2.94	30.00
31.00	Percentage of Medicaid patient days (see instructions)			31.00
32.00				32.00
33.00 34.00	Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions)		318,191	33.00
51100			1 510,151	1 3 1.00

LCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0010	Period: From 07/01/2022 To 06/30/2023	Worksheet E Part A Date/Time Prep 11/21/2023 1:4	
		Title XVIII	Hospital	PPS	- <i>1</i> piii
				On/After 10/1	
			1.00	2.00	
	Uncompensated Care Payment Adjustment				
	Total uncompensated care amount (see instructions)			6,874,403,459	
	Factor 3 (see instructions)		0.000200783	0.000200349	
.02	Hospital UCP, including supplemental UCP (If line 34 is zero, (see instructions)	enter zero on this line	e) 1,444,031	1,377,280	35.0
.03	Pro rata share of the hospital UCP, including supplemental UCP	(see instructions)	363,975	1,030,130	35.0
	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)		1,394,105		36.0
	Additional payment for high percentage of ESRD beneficiary dis	charges (lines 40 throu			
00	Total Medicare discharges (see instructions)	. .	0		40.0
			Before 1/1	On/After 1/1	
			1.00	1.01	
	Total ESRD Medicare discharges (see instructions)		0	0	
	Total ESRD Medicare covered and paid discharges (see instructi		0	0	41.
00 00	Divide line 41 by line 40 (if less than 10%, you do not qualif Total Medicare ESRD inpatient days (see instructions)	y for aujustment)	0.00		42.
00	Ratio of average length of stay to one week (line 43 divided b	y line 41 divided by 7	0.000000		44.
	days)	, the in arviaca by 7	0.00000		
00	Average weekly cost for dialysis treatments (see instructions)		0.00	0.00	45.
00	Total additional payment (line 45 times line 44 times line 41.	01)	0		46.
00	Subtotal (see instructions)		12,567,933		47.
00	Hospital specific payments (to be completed by SCH and MDH, sm	all rural hospitals	0		48.
	only.(see instructions)			Amount	
				Amount 1.00	
00	Total payment for inpatient operating costs (see instructions)			12,567,933	49.
00	Payment for inpatient program capital (from Wkst. L, Pt. I and		1	857,791	
00	Exception payment for inpatient program capital (Wkst. L, Pt.			0	51.
00	Direct graduate medical education payment (from Wkst. E-4, lin	e 49 see instructions)		0	52.
00	Nursing and Allied Health Managed Care payment			3,830	
00	Special add-on payments for new technologies			47,234	
	Islet isolation add-on payment			0	54
00 01	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69 Cellular therapy acquisition cost (see instructions))		0	55
00	Cost of physicians' services in a teaching hospital (see intru	(ctions)		0	56
00	Routine service other pass through costs (from Wkst. D, Pt. II		hrough 35).	0	57
00	Ancillary service other pass through costs from Wkst. D, Pt. I			19,015	
00	Total (sum of amounts on lines 49 through 58)			13,495,803	59
00	Primary payer payments			0	60
00	Total amount payable for program beneficiaries (line 59 minus	line 60)		13,495,803	
	Deductibles billed to program beneficiaries			1,319,356	
00	Coinsurance billed to program beneficiaries Allowable bad debts (see instructions)			78,181	
	Adjusted reimbursable bad debts (see instructions)			86,867 56,464	
	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		30,785	
	Subtotal (line 61 plus line 65 minus lines 62 and 63)			12,154,730	
00	Credits received from manufacturers for replaced devices for a	applicable to MS-DRGs (s	see instructions)	0	1
00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(0	69
00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70
50	Rural Community Hospital Demonstration Project (§410A Demonstr	ation) adjustment (see	instructions)	0	70
75 07	N95 respirator payment adjustment amount (see instructions)			0	70.
87 88	Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only)			0	70.
89	Pioneer ACO demonstration payment adjustment amount (see instr	uctions)		0	70.
	HSP bonus payment HVBP adjustment amount (see instructions)	accions)		0	1
	HSP bonus payment HRR adjustment amount (see instructions)			0	70.
91				0	70.
	Bundled Model 1 discount amount (see instructions)				
92	HVBP payment adjustment amount (see instructions)			0	70.
93 94				-10,871	

ALCULA	Financial Systems ASCENSION ST. VIN TION OF REIMBURSEMENT SETTLEMENT	Provider C	CN: 15-0010	Period: From 07/01/2022 To 06/30/2023	u of Form CMS-7 Worksheet E Part A Date/Time Pre 11/21/2023 1:	parec
		Title	XVIII	Hospital	PPS	
				<u>((yyyy)</u> 0	Amount 1.00	
0.96	Low volume adjustment for federal fiscal year (yyyy) (Enter i	in column O		0	0	70.
	the corresponding federal year for the period prior to $10/1$)			Ũ	Ŭ	10.
	Low volume adjustment for federal fiscal year (yyyy) (Enter i	in column O		0	0	70.
	the corresponding federal year for the period ending on or af	fter 10/1)				
	Low Volume Payment-3			0	0	
	HAC adjustment amount (see instructions)	~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~			0	70.
	Amount due provider (line 67 minus lines 68 plus/minus lines Sequestration adjustment (see instructions)	69 & 70)			12,143,859	
	Demonstration payment adjustment amount after sequestration				242,877	1
	Sequestration adjustment-PARHM pass-throughs				0	71.
	Interim payments				11,503,019	
	Interim payments-PARHM				,,.	72.
3.00	Tentative settlement (for contractor use only)				0	73.
	Tentative settlement-PARHM (for contractor use only)					73.
	Balance due provider/program (line 71 minus lines 71.01, 71.0)2, 72, and			397,963	74.
	73) Balance due provider/program-PARHM (see instructions)					74.
	Protested amounts (nonallowable cost report items) in accorda	ance with			236,437	
	CMS Pub. 15-2, chapter 1, §115.2	ance when			250,157	' ' '
E	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.
	plus 2.04 (see instructions)					0.1
	Capital outlier from Wkst. L, Pt. I, line 2				0	
	Operating outlier reconciliation adjustment amount (see instr Capital outlier reconciliation adjustment amount (see instruc				0	
	The rate used to calculate the time value of money (see instruct				0.00	
	Time value of money for operating expenses (see instructions)				0	1
6.00	Time value of money for capital related expenses (see instruc	tions)			0	96.
				Prior to 10/1	, , ,	
-	HSP Bonus Payment Amount			1.00	2.00	
	HSP bonus amount (see instructions)			0	0	100.
	HVBP Adjustment for HSP Bonus Payment				-	
01.00	HVBP adjustment factor (see instructions)			0.000000000	0.000000000	101.
	HVBP adjustment amount for HSP bonus payment (see instructior	ıs)		0	0	102.
	HRR Adjustment for HSP Bonus Payment					
	HRR adjustment factor (see instructions)			0.0000	0.0000	
	HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst		stmont	0	0	104.
	Is this the first year of the current 5-year demonstration pe					200.
	Century Cures Act? Enter "Y" for yes or "N" for no.					
	Cost Reimbursement					
	Medicare inpatient service costs (from Wkst. D-1, Pt. II, lir	ne 49)				201.
	Medicare discharges (see instructions)					202.
	Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in	first yoar	of the curre	nt 5-year demonst	ration	203.
	period)	i i i i se yeai	or the curre	and 5-year demonst		
	Medicare target amount					204.
	Case-mix adjusted target amount (line 203 times line 204)					205.
4.00)				206.
4.00 5.00 6.00	Medicare inpatient routine cost cap (line 202 times line 205)					207
94.00 95.00 96.00	Adjustment to Medicare Part A Inpatient Reimbursement					207.
4.00 5.00 6.00 7.00	Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst					200
04.00 05.00 06.00 07.00 08.00	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,					208.
04.00 05.00 06.00 07.00 08.00 09.00	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)					209.
94.00 95.00 96.00 97.00 98.00 99.00	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	line 59)				209. 210.
94.00 95.00 96.00 97.00 98.00 99.00 0.00 1.00	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)	line 59)				
04.00 05.00 06.00 07.00 08.00 09.00 .0.00 .1.00 .2.00	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 Total adjustment to Medicare Part A IPPS payments (from line	, line 59)				209 210 211 211
4.00 5.00 6.00 7.00 8.00 9.00 0.00 1.00 2.00 3.00	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	211)				209 210 211

VC	DLUME CALCULATION EXHIBIT 4			Provider Co		Period: From 07/01/2022		
						то 06/30/2023	Date/Time Pre 11/21/2023 1:	
				Title	XVIII	Hospital	PPS	-11
		, . ,	Amounts (from	Pre/Post	Period Prior		Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01		-
)	DRG amounts other than outlier	0	1.00	2.00	3.00	4.00	5.00	+
)	payments	1.00	0	0		0 0	0	
1	DRG amounts other than outlier payments for discharges	1.01	3,053,005	0	3,053,00	5	3,053,005	
2	occurring prior to October 1 DRG amounts other than outlier payments for discharges	1.02	7,751,429	0		7,751,429	7,751,429	,
	occurring on or after October 1							
3	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	0	
1	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after	1.04	0	0		0	0	
)	October 1 Outlier payments for	2.00						
L	discharges (see instructions) Outlier payments for discharges for Model 4 BPCI	2.02	0	0		0 0	0	1
2	discharges for Model 4 BPCI Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	37,718	0	37,71	.8	37,718	
3	Outlier payments for discharges occurring on or after October 1 (see	2.04	13,485	0		13,485	13,485	
)	instructions) Operating outlier	2.01	0	0		0 0	0)
)	reconciliation Managed care simulated payments	3.00	0	0		0 0	0	
	Indirect Medical Education Adju	Istment			1			1
)	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.00000	0.00000	0.000000		
)	IME payment adjustment (see instructions)	22.00	0	0		0 0	0	
1	IME payment adjustment for managed care (see instructions)	22.01	0	0		0 0	0	
	Indirect Medical Education Adju							
)	IME payment adjustment factor	27.00	0.00000	0.00000	0.00000	0.000000		
)	(see instructions) IME adjustment (see	28.00	0	0		0 0	0	,
1	instructions) IME payment adjustment add on for managed care (see	28.01	0	0		0 0	0	
)	instructions) Total IME payment (sum of lines 6 and 8)	29.00	0	0		0 0	0	'
L	Total IME payment for managed care (sum of lines 6.01 and	29.01	0	0		0 0	0	
	8.01) Disproportionate Share Adjustme	nt			l			-
00	Allowable disproportionate share percentage (see	33.00	0.1178	0.1178	0.117	78 0.1178		1:
00	instructions) Disproportionate share adjustment (see instructions)	34.00	318,191	0	89,91	.1 228,280	318,191	
01	Additional payment for high per	36.00 centage of ESI	1,394,105 D beneficiary	0 discharges	363,97	1,030,130	1,394,105	:
	Total ESRD additional payment (see instructions)	46.00	0	0		0 0) :
00 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	47.00 48.00	12,567,933 0	0 0	3,544,60	9999,023,324 0000	12,567,933 0	
00	(see instructions) Total payment for inpatient operating costs (see	49.00	12,567,933	0	3,544,60	9,023,324	12,567,933	:
00	<pre>instructions) Payment for inpatient program capital (from wkst. L, Pt. I, if applicable)</pre>	50.00	857,791	0	244,02	613,767	857,791	

Health	Financial Systems	A	ASCENSION ST. V	INCENT KOKOMO		In Lie	u of Form CMS-2	2552-10
LOW VO	LUME CALCULATION EXHIBIT 4			Provider CO	CN: 15-0010	Period: From 07/01/2022 To 06/30/2023		pared:
				Title	XVIII	Hospital	PPS	
		W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Period	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
17.00	Special add-on payments for new technologies	54.00	47,234	0	20,77	9 26,456	47,235	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0		0 0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)		0	0		0 0	0	18.00
19.00	SUBTOTAL			0	3,809,41	.2 9,663,547	13,472,959	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	809,996	0	229,32	7 580,669	809,996	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0		0 0	0	20.01
21.00	Capital DRG outlier payments	2.00	1,625	0	1,62	5 0	1,625	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0		0 0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000				22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0		0 0		
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0570	0.0570	0.057	0.0570		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	46,170	0	13,07	33,098	46,170	25.00
26.00	Total prospective capital payments (see instructions)	12.00	857,791	0	244,02	4 613,767	857,791	26.00
		line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00 28.00	Low volume adjustment factor Low volume adjustment (transfer amount to Wkst. E,	70.96			0.00000	0.00000	0	27.00 28.00
29.00	Pt. A, line) Low volume adjustment (transfer amount to Wkst. E,	70.97				0	0	29.00
100.00	Pt. A, line) Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

SPI	TAL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	FION EXHIBIT 5			Period: From 07/01/2022 To 06/30/2023	Worksheet E Part A Exhibit Date/Time Prep 11/21/2023 1:4	pared
			Title		Hospital	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	DRG amounts other than outlier payments	1.00					1.(
01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	3,053,005	3,053,00	5	3,053,005	1.
02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	7,751,429		7,751,429	7,751,429	1.
03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	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	0		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	37,718	37,71	8	37,718	2.
03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	13,485		13,485	13,485	2.
00	Operating outlier reconciliation	2.01	0		0 0	0	3.
00	Managed care simulated payments	3.00	0		0 0	0	4.
00	Indirect Medical Education Adjustment Amount from Worksheet E, Part A, line 21	21.00	0.000000	0.00000	0 0.000000		5
00	(see instructions) IME payment adjustment (see instructions)	22.00	0		o o	0	6.
01	IME payment adjustment for managed care (see instructions)	22.01	0		0 0	0	6
	Indirect Medical Education Adjustment for the						
00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.00000	0.000000		7
0	IME adjustment (see instructions)	28.00	0		0 0	0	8
)1	IME payment adjustment add on for managed care (see instructions)	28.01	0		0 0	0	8
00	Total IME payment (sum of lines 6 and 8)	29.00	0		0 0	0	9
)1	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0		0 0	0	9
	Disproportionate Share Adjustment						
00	Allowable disproportionate share percentage (see instructions)	33.00	0.1178	0.117	8 0.1178		10
.00		34.00	318,191	89,91	1 228,280	318,191	11
01		36.00	1,394,105	363,97	5 1,030,130	1,394,105	11
.00		46.00			0 0	0	12
.00	Subtotal (see instructions)	47.00	12,567,933	3,544,60	9 9,023,324	12,567,933	
00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0		0 0	0	14
00		49.00	12,567,933	3,544,60	9 9,023,324	12,567,933	15
00		50.00	857,791	244,02	4 613,767	857,791	16
00 01	Special add-on payments for new technologies	54.00	47,234	20,77	9 26,455	47,234	17 17
.02		68.00	0		0 0	0	
. 00		93.00	0		0 0	0	18
	SUBTOTAL		1	3,809,41	2 9,663,546	13,472,958	

	Financial Systems	ASCENSION ST. V		-N • 15-0010	In Lie Period:	worksheet E	2552-10
1103711	AL ACQUIRED CONDITION (TAC) REDUCTION CALCULA			EN. 15-0010	From 07/01/2022 To 06/30/2023	Part A Exhibi	pared:
			Title	XVIII	Hospital	PPS	F
		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	809,996				20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	,	0 0	0	1
21.00	Capital DRG outlier payments	2.00	1,625	1,62	25 0	1,625	
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	, -	0 0	0	
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.000	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	0.0570	0.05	0.0570		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	46,170	13,0	33,098	46,170	25.00
26.00	Total prospective capital payments (see instructions)	12.00	857,791	244,02	613,767	857,791	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0		0	0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	0		0 0	0	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0		0 0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-10,871	-1,53	-9,334	-10,871	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0		0 0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99			0 0	0	
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Ν				100.00

	Financial Systems ASCENSION ST. VINC ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0010	Period: From 07/01/2022	u of Form CMS-2 Worksheet E Part B	
			то 06/30/2023	Date/Time Pre 11/21/2023 1:4	
		Title XVIII	Hospital	PPS	
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
.00	Medical and other services (see instructions)			1,112	1.0
.00 .00	Medical and other services reimbursed under OPPS (see instruct OPPS or REH payments	cions)		13,217,813 14,032,886	
.00	Outlier payment (see instructions)			80,586	
.01	Outlier reconciliation amount (see instructions)			0	4.0
.00 .00	Enter the hospital specific payment to cost ratio (see instruc Line 2 times line 5	ctions)		0.000	1
.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
.00	Transitional corridor payment (see instructions)			0	8.0
.00	Ancillary service other pass through costs from Wkst. D, Pt. I Organ acquisitions	V, col. 13, line 200		103,058 0	
L.00	Total cost (sum of lines 1 and 10) (see instructions)			1,112	
	COMPUTATION OF LESSER OF COST OR CHARGES			,	
2 00	Reasonable charges Ancillary service charges			3,693	1 1 2 0
3.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, li	ne 69)		5,095	
	Total reasonable charges (sum of lines 12 and 13)			3,693	
- 00	Customary charges		a sharara haada		1 1 5 6
5.00	Aggregate amount actually collected from patients liable for p Amounts that would have been realized from patients liable for			0	
	had such payment been made in accordance with 42 CFR §413.13(e				
7.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	
3.00 9.00	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete onl	v if line 18 exceeds l	ine 11) (see	3,693 2,581	
	instructions)	-		2,502	
0.00	Excess of reasonable cost over customary charges (complete onl	y if line 11 exceeds l	ine 18) (see	0	20.0
L.00	instructions) Lesser of cost or charges (see instructions)			1,112	21.0
	Interns and residents (see instructions)			_,0	
	Cost of physicians' services in a teaching hospital (see instr	ructions)		0	
1.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			14,216,530	24.0
5.00	Deductibles and coinsurance amounts (for CAH, see instructions	;)		0	25.0
5.00	Deductibles and Coinsurance amounts relating to amount on line			2,485,957	
7.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) p instructions)	olus the sum of lines 2	2 and 23] (see	11,731,685	27.0
3.00	Direct graduate medical education payments (from Wkst. E-4, li	ne 50)		0	28.0
3.50	REH facility payment amount				28.5
9.00	ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27, 28, 28.50 and 29)			0 11,731,685	
L.00	Primary payer payments			3,444	
2.00	Subtotal (line 30 minus line 31)			11,728,241	32.0
3.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVIC Composite rate ESRD (from Wkst. I-5, line 11)	ES)		0	33.0
4.00	Allowable bad debts (see instructions)			202,672	
5.00	Adjusted reimbursable bad debts (see instructions)			131,737	
5.00	Allowable bad debts for dual eligible beneficiaries (see instr Subtotal (see instructions)	uctions)		99,502 11,859,978	
3.00	MSP-LCC reconciliation amount from PS&R			-12	
9.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
9.50 9.75	Pioneer ACO demonstration payment adjustment (see instructions N95 respirator payment adjustment amount (see instructions)	5)		0	39.5
9.97	Demonstration payment adjustment amount (see instructions)			0	
9.98	Partial or full credits received from manufacturers for replac	ed devices (see instru	ctions)	0	
9.99	RECOVERY OF ACCELERATED DEPRECIATION			11 850 000	
).00).01	Subtotal (see instructions) Sequestration adjustment (see instructions)			11,859,990 237,200	
0.02	Demonstration payment adjustment amount after sequestration			0	
	Sequestration adjustment-PARHM pass-throughs			11 502 621	40.0
	Interim payments Interim payments-PARHM			11,593,621	41.0
	Tentative settlement (for contractors use only)			0	
2.01	Tentative settlement-PARHM (for contractor use only)				42.0
3.00 3.01	Balance due provider/program (see instructions) Balance due provider/program-PARHM (see instructions)			29,169	43.0
4.00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub. 15-2,	chapter 1,	25,000	
	§115.2	,			
	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)			0	90.0
	Outlier reconciliation adjustment amount (see instructions)			0	
1.00				0 00	92.0
	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)			0.00	

Health Financial Systems	ASCENSION ST. VINCENT KOKOMO	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0010	Period: From 07/01/2022 To 06/30/2023		
	Title XVIII	Hospital	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		Period: From 07/01/2022 To 06/30/2023		pared:
			XVIII	Hospital	PPS	
		Inpatien	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		11,503,0	19	11,593,621	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider			-		
3.01 3.02 3.03 3.04	ADJUSTMENTS TO PROVIDER			0 0 0 0	0 0 0 0	3.01 3.02 3.03 3.04
3.05				0	0	3.05
	Provider to Program			-1	-	
3.50 3.51 3.52 3.53	ADJUSTMENTS TO PROGRAM			0 0 0	0 0 0	3.50 3.51 3.52 3.53
3.53 3.54 3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0 0	0	3.54 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)		11,503,0	19	11,593,621	4.00
	TO BE COMPLETED BY CONTRACTOR	I			1	
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					5.00
5.01	TENTATIVE TO PROVIDER			0	0	5.01
5.02				0 0	0	5.02
5.50	Provider to Program TENTATIVE TO PROGRAM			0	0	5.50
5.50	IENIAIIVE IU PRUGRAM			0	0	5.50
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
5.00 5.01	Determined net settlement amount (balance due) based on the cost report. (1) SETTLEMENT TO PROVIDER		397,9	63	29,169	6.0
6.02	SETTLEMENT TO PROGRAM		557,5	0	25,105	6.02
7.00	Total Medicare program liability (see instructions)		11,900,9	82	11,622,790	
				Contractor Number 1.00	NPR Date (Mo/Day/Yr)	
	Name of Contractor	(1.00	2.00	8.00

ALY5	IS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		CN: 15-0010 CCN: 15-T010	Period: From 07/01/202 To 06/30/202		epare
		Title	e XVIII	Subprovider - IRF		
		Inpatier	it Part A		ırt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
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		3,332,7	47 0	0	2.
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.
11	Program to Provider		1	0		
)1)2	ADJUSTMENTS TO PROVIDER			0	0	
)2)3				0	0	
)4				0	0	
)5				0	0	-
	Provider to Program		1	•		
0	ADJUSTMENTS TO PROGRAM			0	0	3
1				0	0	3
52				0	0) 3
53				0	0) 3
54				0	0	-
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0) 3
	3.50-3.98)					
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)		3,332,7	47	0	4
	TO BE COMPLETED BY CONTRACTOR		I			
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none,					5
	write "NONE" or enter a zero. (1) Program to Provider					-
)1	TENTATIVE TO PROVIDER		I	0	0	5
)2				0	0	
)3				0	0	
	Provider to Program					1
50	TENTATIVE TO PROGRAM			0	0	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	0	5
00	Determined net settlement amount (balance due) based on the cost report. (1)					6
)1	SETTLEMENT TO PROVIDER			0	0	
)2	SETTLEMENT TO PROGRAM		24,5		0	-
00	Total Medicare program liability (see instructions)		3,308,1		0	7
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	

Health	Financial Systems ASCENSION ST. VIN	CENT KOKOMO	In Lie	u of Form CMS	-2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0010	Period: From 07/01/2022 To 06/30/2023	Worksheet E- Part II Date/Time Pr 11/21/2023 1	epared:
		Title XVIII	Hospital	PPS	
				1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS	1			_
1 00	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		14		1 00
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.	5-5, PL. 1 COL. 15 TIME	2 14		1.00
2.00	Medicare days (see instructions)				3.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				4.00
4.00	Total inpatient days (see instructions)				
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 1				6.00
7.00	CAH only - The reasonable cost incurred for the purchase of c line 168	ertified HIT technology	Wkst. S-2, Pt. I		7.00
8.00	Calculation of the HIT incentive payment (see instructions)				8.00
9.00	Sequestration adjustment amount (see instructions)				9.00
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & 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 l	ine 31) (see instruction	is)		32.00

LCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0010 Component CCN: 15-T010	Period: From 07/01/2022 To 06/30/2023	Worksheet E-3 Part III Date/Time Pre 11/21/2023 1:	pare
		Title XVIII	Subprovider -	PPS	47 p
			IRF		
				1.00	
00	PART III - MEDICARE PART A SERVICES - IRF PPS Net Federal PPS Payment (see instructions)			3,314,231	1
00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0036	
00	Inpatient Rehabilitation LIP Payments (see instructions)			82,193	
00	Outlier Payments			1,324	
00	Unweighted intern and resident FTE count in the most recen	t cost reporting period en	ding on or prior	0.00	
01	to November 15, 2004 (see instructions)	for and dente that		0.00	
01	Cap increases for the unweighted intern and resident FTE c			0.00	5
	program or hospital closure, that would not be counted wit CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	nout a temporary cap aujust	ment under 42		
00	New Teaching program adjustment. (see instructions)			0.00	6
00	Current year's unweighted FTE count of I&R excluding FTEs	in the new program growth p	eriod of a "new	0.00	
	teaching program" (see instructions)			0.00	'
00	Current year's unweighted I&R FTE count for residents with	in the new program growth p	eriod of a "new	0.00	8
	teaching program" (see instructions)				
00	Intern and resident count for IRF PPS medical education ad	justment (see instructions)		0.00	9
.00	Average Daily Census (see instructions)			10.090411	
.00	Teaching Adjustment Factor (see instructions)			0.000000	
.00	Teaching Adjustment (see instructions)			0	
.00	Total PPS Payment (see instructions)			3,397,748	
.00	Nursing and Allied Health Managed Care payments (see instr	uction)		0	
.00	Organ acquisition (DO NOT USE THIS LINE) Cost of physicians' services in a teaching hospital (see i	nctructions)		0	1:
2.00	Subtotal (see instructions)			3,397,748	
3.00	Primary payer payments			5,557,740	18
.00	Subtotal (line 17 less line 18).			3,397,748	
0.00	Deductibles			20,448	
.00	Subtotal (line 19 minus line 20)			3,377,300	21
.00	Coinsurance			4,000	22
.00	Subtotal (line 21 minus line 22)			3,373,300	
.00	Allowable bad debts (exclude bad debts for professional se	rvices) (see instructions)		2,212	
.00	Adjusted reimbursable bad debts (see instructions)			1,438	
.00	Allowable bad debts for dual eligible beneficiaries (see i	nstructions)		0	26
.00	Subtotal (sum of lines 23 and 25)	line (0)		3,374,738	
.00	Direct graduate medical education payments (from Wkst. E-4 Other pass through costs (see instructions)	, The 49)		0 948	28
.00	Outlier payments reconciliation			948	30
.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	3
. 50	Pioneer ACO demonstration payment adjustment (see instruct	ions)		0	31
.98	Recovery of accelerated depreciation.	/		0	31
. 99	Demonstration payment adjustment amount before sequestrati	on		0	31
.00	Total amount payable to the provider (see instructions)			3,375,686	
.01				67,514	
2.02	Demonstration payment adjustment amount after sequestratio	n		0	
.00				3,332,747	
.00	Tentative settlement (for contractor use only)	202 22 and 24		0	
.00	Balance due provider/program (line 32 minus lines 32.01, 3 Protested amounts (nonallowable cost report items) in acco		chanter 1	-24,575	
.00	§115.2	Tuance with CMS Pub. 13-2,	chapter 1,	0	30
	TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount from Wkst. E-3, Pt. III, line 4	、 、		1,324	
00	Outlier reconciliation adjustment amount (see instructions)		0 0.00	
2.00 8.00	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)				52
.00	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020	AND BEGINNING ON OR BEFORE	MAY 11, 2023 (THE		
	THE COVID-19 PHE)		mi 20 2020	0.000000	
00	Teaching Adjustment Factor for the cost reporting period i	<pre>mmediately preceding Februa . (see instructions)</pre>	ry 29, 2020.	0.000000	99

LCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0010	Period:	Worksheet E-3	
			From 07/01/2022 To 06/30/2023	Part VII Date/Time Pre 11/21/2023 1:4	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV	ICES FOR TITLES V OR >	XIX SERVICES		-
	COMPUTATION OF NET COST OF COVERED SERVICES		1 720 412		1 1 (
00 00	Inpatient hospital/SNF/NF services Medical and other services		1,729,412	0	1.0
00	Organ acquisition (certified transplant programs only)		0	0	2.
00	Subtotal (sum of lines 1, 2 and 3)		1,729,412	0	4.
00	Inpatient primary payer payments		1,110,111		5.
00	Outpatient primary payer payments			0	6.
00	Subtotal (line 4 less sum of lines 5 and 6)		1,729,412	0	7.
	COMPUTATION OF LESSER OF COST OR CHARGES				1
	Reasonable Charges				
	Routine service charges		0		8.
00	Ancillary service charges		6,360,851	0	9.
	Organ acquisition charges, net of revenue		0		10.
	Incentive from target amount computation		0		11.
.00	Total reasonable charges (sum of lines 8 through 11)		6,360,851	0	12.
00	CUSTOMARY CHARGES	convisos on a change	0	0	13.
.00	Amount actually collected from patients liable for payment for basis	services on a charge	0	0	12.
.00	Amounts that would have been realized from patients liable for	navment for services (0 0	0	14.
.00	a charge basis had such payment been made in accordance with 42			0	_ <u> </u>
.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.00000	15.
.00	Total customary charges (see instructions)		6,360,851	0	16.
.00	Excess of customary charges over reasonable cost (complete only	if line 16 exceeds	4,631,439	0	17
	line 4) (see instructions)				
.00	Excess of reasonable cost over customary charges (complete only	if line 4 exceeds lin	ne 0	0	18.
	16) (see instructions)				
	Interns and Residents (see instructions)		0	0	19.
	Cost of physicians' services in a teaching hospital (see instru		1 720 412	0	
	Cost of covered services (enter the lesser of line 4 or line 16 PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be co		1,729,412	0	21
	Other than outlier payments	Simpleted for PPS prov	ol	0	22
	Outlier payments		0	0	
	Program capital payments		0	0	24.
	Capital exception payments (see instructions)		0		25
	Routine and Ancillary service other pass through costs		0	0	-
.00	Subtotal (sum of lines 22 through 26)		0	0	27
	Customary charges (title V or XIX PPS covered services only)		0	0	28.
.00	Titles V or XIX (sum of lines 21 and 27)		1,729,412	0	29.
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
.00	Excess of reasonable cost (from line 18)		0	0	30.
.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		1,729,412	0	
	Deductibles		0	0	-
	Coinsurance		0	0	
	Allowable bad debts (see instructions)		0	0	34
.00	Utilization review	22)	0		35.
.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	1,729,412	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		1 730 413	0	
	Subtotal (line 36 ± line 37) Direct graduate medical education payments (from Wkst. E-4)		1,729,412	0	
.00	5		1 720 /12	0	39 40
.00	Total amount payable to the provider (sum of lines 38 and 39) Interim payments		1,729,412	0	40.
.00	Balance due provider/program (line 40 minus line 41)		1,729,412	0	41.
.00	Protested amounts (nonallowable cost report items) in accordance	e with CMS pub 15_7	0	0	42.
.00	chapter 1, §115.2	e with the Pub 10-2,	0	0	+3.

CUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0010	Period:	Worksheet E-3	
		Component CCN:15-T010	From 07/01/2022 To 06/30/2023	Part VII Date/Time Prep 11/21/2023 1:4	par 47
		Title XIX	Subprovider - IRF	Cost	- 1
		<u> </u>	Inpatient	Outpatient	
			1.00	2.00	-
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	RVICES FOR TITLES V OR X	IX SERVICES		-
	COMPUTATION OF NET COST OF COVERED SERVICES Inpatient hospital/SNF/NF services		99 E40		1 1
0 0	Medical and other services		88,549	0	
	Organ acquisition (certified transplant programs only)		0	0	
0	Subtotal (sum of lines 1, 2 and 3)		88,549	0	
0	Inpatient primary payer payments		00, 545	0	
	Outpatient primary payer payments		0	0	
0	Subtotal (line 4 less sum of lines 5 and 6)		88,549	0	
	COMPUTATION OF LESSER OF COST OR CHARGES		00, 545	0	ł i
	Reasonable Charges				1
0	Routine service charges		0		1.8
0	Ancillary service charges		114,587	0	
	Organ acquisition charges, net of revenue		114, 307	0	1
	Incentive from target amount computation		0		1
	Total reasonable charges (sum of lines 8 through 11)		114,587	0	
	CUSTOMARY CHARGES		114, 507	0	1 *
	Amount actually collected from patients liable for payment for	services on a charge	0	0	1
00	basis	services on a charge	0	0	1
00	Amounts that would have been realized from patients liable for	r payment for services o	n 0	0	1
	a charge basis had such payment been made in accordance with 4			°,	-
00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.00000	0.00000	1
	Total customary charges (see instructions)		114,587	0	
	Excess of customary charges over reasonable cost (complete on)	lv if line 16 exceeds	26,038	0	
	line 4) (see instructions)		20,000	°,	-
00	Excess of reasonable cost over customary charges (complete on)	lv if line 4 exceeds lin	e 0	0	1
	16) (see instructions)	,			
00	Interns and Residents (see instructions)		0	0	1
00	Cost of physicians' services in a teaching hospital (see instr	ructions)	0	0	2
00	Cost of covered services (enter the lesser of line 4 or line 1	L6)	88,549	0	2
1	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	completed for PPS provi	ders.		1
	Other than outlier payments		0	0	2
00	Outlier payments		0	0	2
00	Program capital payments		0		2
00	Capital exception payments (see instructions)		0		2
00	Routine and Ancillary service other pass through costs		0	0	2
00	Subtotal (sum of lines 22 through 26)		0	0	2
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)		88,549	0	2
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
00	Excess of reasonable cost (from line 18)		0	0	3
00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6))	88,549	0	3
00	Deductibles		0	0	3
00	Coinsurance		0	0	3
00	Allowable bad debts (see instructions)		0	0	3
	Utilization review		0		3
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	88,549	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
	Subtotal (line 36 ± line 37)		88,549	0	3
	Direct graduate medical education payments (from Wkst. E-4)		0		3
	Total amount payable to the provider (sum of lines 38 and 39)		88,549	0	
00	Interim payments		88,549	0	4
	Balance due provider/program (line 40 minus line 41)		0	0	42
	Protested amounts (nonallowable cost report items) in accordar		0	U.,	1

Health	Financial Systems AS	SCENSION ST. VINC	CENT KOKOMO	In Lie	u of Form CMS-2	552-10
OUTLI	ER RECONCILIATION AT TENTATIVE SETTLEMENT		Provider CCN: 15-0010	Period:	Worksheet E-5	
				From 07/01/2022 To 06/30/2023	Date/Time Prep 11/21/2023 1:4	
			Title XVIII		PPS	
					1.00	
	TO BE COMPLETED BY CONTRACTOR					
1.00	Operating outlier amount from Wkst. E, Pt. A,	line 2, or sum of	of 2.03 plus 2.04 (see i	nstructions)	0	1.00
2.00	Capital outlier from Wkst. L, Pt. I, line 2				0	2.00
3.00	Operating outlier reconciliation adjustment an	mount (see instru	uctions)		0	3.00
4.00	Capital outlier reconciliation adjustment amou	unt (see instruct	tions)		0	4.00
5.00	The rate used to calculate the time value of m	money (see instru	uctions)		0.00	5.00
6.00	Time value of money for operating expenses (se	ee instructions)			0	6.00
7.00	Time value of money for capital related expense		tions)		0	7.00
				,		

	E SHEET (If you are nonproprietary and do not maintain	Provider C	CN: 15-0010	Period: From 07/01/2022	Worksheet G	
nd-t ly)	ype accounting records, complete the General Fund column			To 06/30/2023		pare
		General Fund	Specific	Endowment Fund	<u>11/21/2023 1:</u> Plant Fund	<u>47 r</u>
		1.00	Purpose Fund 2.00	3.00	4.00	<u> </u>
	CURRENT ASSETS		1			
00	Cash on hand in banks	315,593	(0 0	0	
00	Temporary investments	0		0 0	0	
00	Notes receivable			0	0	
00 00	Accounts receivable Other receivable	21,910,304			0	
00	Allowances for uncollectible notes and accounts receivable	381,721			0	
00	Inventory	2,359,373			0	1
00	Prepaid expenses	0		o o	0	
00	Other current assets	3,571,889		0 0	0	
.00	Due from other funds	0		0 0	0	10
.00	Total current assets (sum of lines 1-10)	28,538,880	(0 0	0	11
	FIXED ASSETS					
.00	Land	525,279	1	0 0	0	
.00	Land improvements	2,316,541	. (0 0	0	
	Accumulated depreciation				0	
.00	Buildings	89,006,541			0	15
.00	Accumulated depreciation Leasehold improvements	653,423			0	16
	Accumulated depreciation	055,425			0	18
	Fixed equipment	20,718,982			0	
	Accumulated depreciation	0		0	ů 0	1 -
	Automobiles and trucks	2,210,983		0 0	0	
.00	Accumulated depreciation	0	(0 0	0	22
.00	Major movable equipment	43,132,559		0 0	0	23
	Accumulated depreciation	0	(0 0	0	24
	Minor equipment depreciable	0		0 0	0	1
	Accumulated depreciation	0		0 0	0	26
	HIT designated Assets			0	0	
	Accumulated depreciation	-122,081,559			0	1
	Minor equipment-nondepreciable Total fixed assets (sum of lines 12-29)	213,718 36,696,467			0	
.00	OTHER ASSETS	50,090,407		0	0	1 3(
.00	Investments	175,068		0 0	0	3:
	Deposits on leases	1,171,895		0 0	0	
.00	Due from owners/officers	0		0 0	0	33
.00	Other assets	268,618		0 0	0	34
.00	Total other assets (sum of lines 31-34)	1,615,581		0 0	0	
.00	Total assets (sum of lines 11, 30, and 35)	66,850,928	(0 0	0	36
	CURRENT LIABILITIES				-	
	Accounts payable	2,770,212		0 0	0	
.00	Salaries, wages, and fees payable Payroll taxes payable	2,012,885 186,998			0	1
	Notes and loans payable (short term)	100,990	1		0	
	Deferred income				0	
	Accelerated payments				0	42
	Due to other funds	16,859,899		0 0	0	
	Other current liabilities	5,494,968		0 0	0	
.00	Total current liabilities (sum of lines 37 thru 44)	27,324,962	(0 0	0	45
	LONG TERM LIABILITIES					
.00	Mortgage payable	237,950		0 0	0	
.00	Notes payable	0		0 0	0	
.00	Unsecured loans	14,206,750		0	0	1
.00	Other long term liabilities	3,062,411			0	
.00	5	17,507,111			0	
. 00	Total liabilities (sum of lines 45 and 50) CAPITAL ACCOUNTS	44,832,073	1 (0 0	0	51
.00	General fund balance	22,018,855				52
.00	Specific purpose fund	,010,000				53
	Donor created - endowment fund balance - restricted		Ì	0		54
.00	Donor created - endowment fund balance - unrestricted			0		5
	Governing body created - endowment fund balance			0		56
.00	Plant fund balance - invested in plant				0	
.00	Plant fund balance - reserve for plant improvement,				0	58
	replacement, and expansion	_				
.00	Total fund balances (sum of lines 52 thru 58)	22,018,855		0 0	0	
.00	Total liabilities and fund balances (sum of lines 51 and	66,850,928	i (0 0	0	60

	· · · · · · · · · · · · · · · · · · ·	ASCENSION SI. VI	NCENT KOKOMO	N. 15 0010	D.		eu of Form CM		552-10
STATE	IENT OF CHANGES IN FUND BALANCES		Provider CC	:N: 15-0010	Pe Fr To	riod: om 07/01/2022 06/30/2023	Worksheet Date/Time 11/21/2023	Prep	
		General	Fund	Special	Pur	pose Fund	Endowment Fi	und	
		1.00	2.00	3.00		4.00	5.00		
1.00	Fund balances at beginning of period	1.00	12,660,652	5.00		4.00		-	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		15,107,482			0			2.00
3.00	Total (sum of line 1 and line 2)		27,768,134			0			3.00
4.00	Additions (credit adjustments) (specify)	0	27,700,154		0	0		0	4.00
5.00		0			0			ŏ	5.00
6.00		0			0			0	6.00
7.00		0			õ			ŏ	7.00
8.00		0			0			0	8.00
9.00		0			0			0	9.00
10.00	Total additions (sum of line 4-9)	0	0		0	0		Ŭ,	10.00
11.00	Subtotal (line 3 plus line 10)		27,768,134			0			11.00
12.00	TRANSFER TO ALPHA	5,750,033	27,700,134		0	0		0	12.00
13.00	TRANSFER TO ALPHA	3,730,033			0			0	13.00
14.00		0			0			0	14.00
		0			0			0	15.00
15.00 16.00		0			0			0	16.00
17.00		0			0			0	17.00
	Total deductions (sum of lines 12 17)	0			0	0		0	18.00
18.00 19.00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance		5,750,033			0			19.00
19.00	sheet (line 11 minus line 18)		22,018,101			0			19.00
		Endowment Fund	Plant	Fund					
1.00	Fund balances at beginning of period	Endowment Fund 6.00 0	Plant 7.00	Fund 8.00	0				1.00
	· · · · · · · · · · · · · · · · · · ·	6.00			0				
2.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)	6.00			0				2.00
2.00 3.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)	6.00			Ŭ			-	2.00
2.00 3.00 4.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29)	6.00	7.00		Ŭ			-	2.00 3.00 4.00
2.00 3.00 4.00 5.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)	6.00	7.00		Ŭ			-	2.00 3.00 4.00 5.00
2.00 3.00 4.00 5.00 6.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)	6.00	7.00		Ŭ				2.00 3.00 4.00 5.00 6.00
2.00 3.00 4.00 5.00 6.00 7.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)	6.00	7.00		Ŭ				2.00 3.00 4.00 5.00 6.00 7.00
2.00 3.00 4.00 5.00 6.00 7.00 8.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)	6.00	7.00		Ŭ				2.00 3.00 4.00 5.00 6.00 7.00 8.00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)	6.00	7.00		Ŭ				2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	6.00	7.00		0				2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00	Fund balances at beginning of period Net income (loss) (from wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9)	6.00	7.00		0				2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00	Fund balances at beginning of period Net income (loss) (from wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)	6.00	7.00 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
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00	Fund balances at beginning of period Net income (loss) (from wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)	6.00	7.00 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
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	Fund balances at beginning of period Net income (loss) (from wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)	6.00	7.00 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
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	Fund balances at beginning of period Net income (loss) (from wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)	6.00	7.00 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
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	Fund balances at beginning of period Net income (loss) (from wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)	6.00	7.00 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
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	Fund balances at beginning of period Net income (loss) (from wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) TRANSFER TO ALPHA	6.00 0 0 0	7.00 0 0 0 0 0 0 0		0				2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 11.00 13.00 13.00 14.00 15.00 16.00
3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00	Fund balances at beginning of period Net income (loss) (from wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)	6.00	7.00 0 0 0 0 0 0 0		0				1.00 2.00 3.00 4.00 5.00 6.00 7.00 10.00 11.00 12.00 13.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 15.00 19.00

STATE	MENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider C	CN: 15-0010	Period: From 07/01/2022 To 06/30/2023	Worksheet G-2 Parts I & II Date/Time Pre 11/21/2023 1:	pared
	Cost Center Description		Inpatient	Outpatient	Total	
	·		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				·	
	General Inpatient Routine Services					
.00	Hospital		32,865,6	82	32,865,682	1.
.00	SUBPROVIDER - IPF					2.
.00	SUBPROVIDER - IRF		8,329,0	10	8,329,010	3.
.00	SUBPROVIDER					4.
.00	Swing bed - SNF			0	0	5.
5.00	Swing bed - NF			0	0	6.
2.00	SKILLED NURSING FACILITY					7.
3.00	NURSING FACILITY					8.
00.0	OTHER LONG TERM CARE					9.
L0.00			41,194,6	92	41,194,692	10.
	Intensive Care Type Inpatient Hospital Services		1		1	
1.00			10,582,4	20	10,582,420	
.2.00						12.
.3.00						13.
4.00						14.
.5.00						15.
.6.00		n of lines	10,582,4	20	10,582,420	16.
7 00	11-15)	1.10	F1 777 1	10	F1 777 110	17
7.00		a 16)	51,777,1		51,777,112	
.8.00			162,212,2		, ,	
19.00 20.00				0 408,447,121		
20.00				0 0	-	
22.00				0 0	0	21.
22.00			14,5	18 22,638,279	22,652,797	
24.00			14,5	10 22,030,279	22,032,797	23.
25.00						24.
26.00						26.
27.00			597,1	05 2,527,653	3,124,758	
28.00		nn 3 to Wkst	214,600,9			
.0.00	G-3, line 1)	111 5 CO WK5C.	214,000,5	+7 +55,014,571	040,210,510	20.
	PART II - OPERATING EXPENSES		1			
9.00				154,363,526		29.
80.00				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 (SPECIFY)			0		37.
8.00				0		38.
9.00				0		39.
0.00				0		40.
1.00				0		41.
2.00				0		42.
3.00		ne 42)(transfer		154,363,526		43.
	to Wkst. G-3, line 4)					1

 Less contractual al Net patient revenue Less total operatin Net income from ser OTHER INCOME Contributions, dona Income from investm Revenues from telep 	ues (from Wkst. G-2, Part I, colu lowances and discounts on patient s (line 1 minus line 2) g expenses (from Wkst. G-2, Part vice to patients (line 3 minus li	ts' accounts	From 07/01/2022 To 06/30/2023	Date/Time Prep 11/21/2023 1:4 1.00	
 Less contractual al Net patient revenue Less total operatin Net income from ser OTHER INCOME Contributions, dona Income from investm Revenues from telep 	lowances and discounts on patient s (line 1 minus line 2) g expenses (from Wkst. G-2, Part	ts' accounts			
 Less contractual al Net patient revenue Less total operatin Net income from ser OTHER INCOME Contributions, dona Income from investm Revenues from telep 	lowances and discounts on patient s (line 1 minus line 2) g expenses (from Wkst. G-2, Part	ts' accounts			1
 Less contractual al Net patient revenue Less total operatin Net income from ser OTHER INCOME Contributions, dona Income from investm Revenues from telep 	lowances and discounts on patient s (line 1 minus line 2) g expenses (from Wkst. G-2, Part	ts' accounts		648,215,518	1.0
0 Net patient revenue 1 Less total operatin Net income from ser 0 THER INCOME 0 Contributions, dona 1 Income from investm 0 Revenues from telep	s (line 1 minus line 2) g expenses (from Wkst. G-2, Part			481,034,396	
0 Less total operatin 0 Net income from ser 0 OTHER INCOME 0 Contributions, dona 1 ncome from investm 0 Revenues from telep	g expenses (from Wkst. G-2, Part			167,181,122	3.
0 Net income from ser 0THER INCOME 0 Contributions, dona 1 Income from investm 0 Revenues from telep		II. line 43)		154,363,526	
0 Contributions, dona 0 Income from investm 0 Revenues from telep				12,817,596	
0 Income from investm 0 Revenues from telep					
0 Revenues from telep	tions, bequests, etc			0	
				0	
0 Povonuo from tolovi	none and other miscellaneous comm	nunication services		0	
1	sion and radio service			0	9.
00 Purchase discounts				0	
00 Rebates and refunds				0	11.
00 Parking lot receipt				0	
00 Revenue from laundr				0	13.
	sold to employees and guests			425,154	
00 Revenue from rental	5 1			0	
	f medical and surgical supplies t	to other than patients		0	
	f drugs to other than patients			0	
	f medical records and abstracts			632	
	of textbooks, uniforms, etc.)			0	
	flowers, coffee shops, and cante	een		0	20.
00 Rental of vending m				1,779	
00 Rental of hospital 00 Governmental approp				399,543 0	
00 MISCELLANEOUS REVEN				4,865	
01 CONTRACT SERVICE RE				4,805	24
02 FOUNDATION IC TRANS				17,935	
03 IC RENTAL INCOME	EKS			124,596	
04 OTHER (SPECIFY)				0	1
05 GAIN ON SALE OF ASS	ETS			36,863	
06 PAIENT INTEREST INC				13,637	
07 LATE PENALTY FEES				814	
08 INDIANA NCLAIMED PR	DPERTY			177,338	
09 MEDICAL STAFF DUES				9,420	24.
10 RECYCLING REVENUE				428	24.
11 UNITED HOSPITAL LAU	NDRY INCOME			-7,999	24.
12 CLINICAL TRIAL REVE	NE			6,000	24.
13 VALUE BASED IC REVE	NUE			291,550	
14 FEDERAL SPONSORED P				521,870	24.
15 NET ASSETS RLD RES	FND			7,720	
16 SCRAP REVENUE				86	
17 STATE SPONSORED PRO	JECT REVENUE				
18 OTHER (SPECIFY)				0	
19 OTHER (SPECIFY)				0	
20 MEALS ON WHEELS				75,130	
21 SEMINAR REVENUE				25,278	
22 OTHER (SPECIFY)					
23 OTHER (SPECIFY)	_			0	
50 COVID-19 PHE Fundin				95,873	
00 Total other income				2,289,886	
00 Total (line 5 plus				15,107,482	
00 OTHER EXPENSES (SPE				0	
	s (sum of line 27 and subscripts)) for the period (line 26 minus l			15,107,482	

ALCUL	ATION OF CAPITAL PAYMENT	Provider CCN: 15-0010	Period: From 07/01/2022 To 06/30/2023	Worksheet L Parts I-III Date/Time Pre 11/21/2023 1:	
		Title XVIII	Hospital	PPS	
				1.00	
	PART I - FULLY PROSPECTIVE METHOD				
	CAPITAL FEDERAL AMOUNT				
.00	Capital DRG other than outlier			809,996	
.01	Model 4 BPCI Capital DRG other than outlier			0	
.00	Capital DRG outlier payments			1,625	
.01	Model 4 BPCI Capital DRG outlier payments			0	
.00	Total inpatient days divided by number of days in the cost re	porting period (see inst	ructions)	47.32	
.00	Number of interns & residents (see instructions)			0.00	
.00	Indirect medical education percentage (see instructions)		_	0.00	
.00	<pre>Indirect medical education adjustment (multiply line 5 by the 1.01)(see instructions)</pre>			0	
.00	Percentage of SSI recipient patient days to Medicare Part A p 30) (see instructions)		E, part A line	2.94	
.00	Percentage of Medicaid patient days to total days (see instru	ctions)		24.41	
.00	Sum of lines 7 and 8			27.35	
0.00	Allowable disproportionate share percentage (see instructions)		5.70	
1.00	Disproportionate share adjustment (see instructions)			46,170	
2.00	Total prospective capital payments (see instructions)			857,791	12.
				1.00	<u> </u>
	PART II - PAYMENT UNDER REASONABLE COST			1.00	
.00	Program inpatient routine capital cost (see instructions)			0	11.
.00	Program inpatient ancillary capital cost (see instructions)			0	2
.00	Total inpatient program capital cost (line 1 plus line 2)			0	
.00	Capital cost payment factor (see instructions)			0	
.00	Total inpatient program capital cost (line 3 x line 4)			0	
				1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS			1.00	
.00	Program inpatient capital costs (see instructions)			0	1 1
.00	Program inpatient capital costs for extraordinary circumstanc	es (see instructions)		0	
.00	Net program inpatient capital costs (line 1 minus line 2)			0	-
.00	Applicable exception percentage (see instructions)			0.00	
.00	Capital cost for comparison to payments (line 3 x line 4)			0.00	
.00	Percentage adjustment for extraordinary circumstances (see in	structions)		0.00	
.00	Adjustment to capital minimum payment level for extraordinary	-	(line 6)	0.00	
.00	Capital minimum payment level (line 5 plus line 7)			0	
.00	Current year capital payments (from Part I, line 12, as appli	cable)		0	
0.00	Current year comparison of capital minimum payment level to c		less line 9)	0	
1.00	Carryover of accumulated capital minimum payment level over c Worksheet L, Part III, line 14)		-	0	
2.00	Net comparison of capital minimum payment level to capital pa	yments (line 10 plus lir	ne 11)	0	12.
3.00	Current year exception payment (if line 12 is positive, enter			0	
4.00	Carryover of accumulated capital minimum payment level over c			0	
	(if line 12 is negative, enter the amount on this line)		sector	Ũ	
5.00	Current year allowable operating and capital payment (see ins	tructions)		0	15
				•	1 - 2
	Current year operating and capital costs (see instructions)			0	16