PART II - CERTIFICATION

(3) Settled with Audit

(4) Reopened (5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by BALL MEMORIAL HOSPITAL (15-0089) for the cost reporting period beginning 01/01/2017 and ending 12/31/2017 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.

]I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

(Si aned)

Officer or Administrator of Provider(s)

number of times reopened = 0-9.

CHIEF FINANCIAL OFFICER

Title

Date

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1.00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	726, 839	308, 512	0	0	1. 00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	24, 221	-17		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	751, 060	308, 495	0	0	200.00

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

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

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20.00 Cost Reporting Period (mm/dd/yyyy) 21.00 Type of Control (see instructions) 22.00 Does this facility quality and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "V" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(-)(2)(Pickle amendment hospital?) In column 2, enter "V" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(-)(2)(Pickle amendment hospital?) In column 2, enter "V" for yes or "N" for no. The portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no. For the portion of the cost reporting period occurring prior of the portion of the cost reporting period occurring on or after October 1. 22.02 Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost reporting period or in or five cost reporting period or or after October 1. 22.03 bid this hospital receive a geographic reclassification from urban to rural as a result or after October 1. 22.03 bid this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in PY2015? Enter in column 1, "" for yes or "N" for no. for the portion of the cost reporting period or after October 1. Enter in column 2, "Y" for yes or "N" for no. for the portion of the cost reporting period or or after October 1. Enter in column 3, "" for yes or "N" for no. for the portion of the cost reporting period occurring on or after October 1. 23.00 White Art 2, 165? Enter in column 3, "" for yes or "N" for no. for the portion of the cost reporting period occurring on or after October 1. 24.00 If this provider is an IPPS hospital, enter the load days in column 2, enter "" for yes or "N" for no. 25.00 White Art 2, 165 Period Courring on or after October 1. See instructions) Does this bid days and the occurrence of the occurrence of the occurrence of t	19.00	Utner						From:		To		19.00
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22.01 bid this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "V" for yes or "N" for no, for the portion of the cost reporting period or or after October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period on or after October 1. Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period or 10 October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period or 10 October 1. Enter in column 3, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no for the portion of the cost reporting period didays on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of diskarge. Is the method of identifying the days in this cost reporting period different from the ethod upset in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no. 23.00 Which method is used to determine Medicaid days on in the set of the dedicaid paid days in column 2, enter "Y" for yes or "N" for no. 10.00 If this provider is an IFPS hospital, enter the label of the point of the cost reporting period didays in column 3, unt-of-state Medicaid days in column 1, the in-state Medicaid el						2. 106(c)((2) (Pi ckl e					
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hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no. In-State In-State Medicaid												
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23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no. In-State In-State In-State Medicaid State Medicaid Gays					untea i	in accord	dance witr	1				
method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no. In-State Medicaid Poid days In-State Medicaid Poid days Medicaid Poid Poid Poid Poid Poid Poid Poid Po	23. 00	Which method is used to determine Me	dicaid days on li	nes 24 and					3	N		23. 00
used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no. In-State Medicaid												
In-State Medicaid												
paid days eligible unpaid days eligible unpaid days eligible unpaid days 1.00 2.00 3.00 4.00 5.00 6.00 24.00 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 3, out-of-state Medicaid eligible unpaid days in column 6. 25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid paid days in column 2, out-of-state Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid Medicaid eligible unpaid days in column 4, Medicaid				In-State	In-St	ate 0	ut-of	Out-of N				
24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 4, Medicaid paid days in column 6. 25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 6. 25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid Medicaid eligible unpaid days in column 4, Medicaid					1				HMO day			
24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid paid days in column 6. 25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 4, Medicaid paid days in column 6. 25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid paid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid Medicaid eligible unpaid days in column 4, Medicaid				paru uays						"	ays	
24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid paid days in column 2, out-of-state Medicaid eligible unpaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid Medicaid eligible unpaid days in column 4, Medicaid								9				
in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid		I										
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out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid												
4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid												
column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid												
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid Medicaid eligible unpaid days in column 4, Medicaid												
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	25. 00	If this provider is an IRF, enter th	e in-state	22		33	O	o	2	216		25. 00
out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid												
Medicaid eligible unpaid days in column 4, Medicaid												
IHMU naid and eligible but unnaid days in column 5		Medicaid eligible unpaid days in col	umn 4, Medicaid									
nimo para ana erigibre bat anpara days in cordini 3.		µнмо рагd and errgible but unpaid day	s in column 5.					I				

	Financial Systems AL AND HOSPITAL HEALTH CARE COMP			L HOSPITAL Provider C	CN: 15-0089	Peri od:	u of Form CMS-2 Worksheet S-2	
						From 01/01/2017 To 12/31/2017	Part I Date/Time Pre 5/24/2018 5:0	pared:
			Y/N	IME	Direct GME	IME	Direct GME	
			1. 00	2. 00	3. 00	4.00	5. 00	
	Enter the number of unweighted p surgery allopathic and/or osteop current cost reporting period (s Enter the difference between the	athic FTEs in the ee instructions).						61. 04
	and/or general surgery FTEs and primary care and/or general surge61.04 minus line 61.03). (see in	the current year's ery FTE counts (line						01.00
	Enter the amount of ACA §5503 aw used for cap relief and/or FTEs care or general surgery. (see in	that are nonprimary						61. 06
	, , , ,	,	Pro	ogram Name	Program Cod	e Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
(4 40	06 H FTF 1 1 (4.05	6 1		1. 00	2. 00	3.00	4.00	(4.40
	Of the FTEs in line 61.05, speci specialty, if any, and the numbe for each new program. (see instroclumn 1, the program name. Ente program code. Enter in column 3, unweighted count. Enter in colum FTE unweighted count.	r of FTE residents uctions) Enter in r in column 2, the the IME FTE				0.00	0.00	61. 10
61. 20	of the FTEs in line 61.05, speci program specialty, if any, and t residents for each expanded prog instructions) Enter in column 1, Enter in column 2, the program c 3, the IME FTE unweighted count. the direct GME FTE unweighted co	he number of FTE ram. (see the program name. ode. Enter in column Enter in column 4,				0.00	0.00	61. 20
							1.00	
62. 00	ACA Provisions Affecting the Hea Enter the number of FTE resident your hospital received HRSA PCRE	s that your hospital	trai nec			riod for which	0.00	62. 00
62. 01	Enter the number of FTE resident during in this cost reporting pe Teaching Hospitals that Claim Re	s that rotated from a riod of HRSA THC prog	n Teachi gram. (s	<u>see instructio</u>		o your hospital	0.00	62. 01
	Has your facility trained reside "Y" for yes or "N" for no in col	nts in nonprovider se	ettings	during this c			Y	63. 00
	,	,			Unwei ghted FTEs Nonprovi der	Unweighted FTEs in	Ratio (col. 1/ (col. 1 + col. 2))	
					Si te	0.00	2.00	
	Section 5504 of the ACA Base Yea	r FTE Residents in No	onprovi o	der Settings	1.00 This base vea	2.00 ar is vour cost r	3.00 reporting	
	period that begins on or after J	uly 1, 2009 and befor	e June	30, 2010.				
	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	ber of unweighted nor tations occurring in	n-primar all nor	ry care nprovi der	2.	75 15. 74	0. 148729	64.00
	resident FTEs that trained in yo of (column 1 divided by (column	ur hospital. Enter ir	n column	n 3 the ratio				
	or (corumn r arvided by (corumn	Program Name		ogram Code	Unwei ghted FTEs Nonprovi der	FTEs in	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00		2.00	Si te	4.00	F 00	
		1. 00		2.00	3. 00	4. 00	5.00	

Health Financial Systems BALL MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0089 Peri od: Worksheet S-2 From 01/01/2017 Part I 12/31/2017 Date/Time Prepared: 5/24/2018 5:05 pm Ratio (col. 3/ Program Name Program Code Unwei ghted Unwei ghted Ratio (col. (col. 3 + col FTEs FTEs in Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 is yes, or your facility FAMILY MEDICINE 3. 21 21. 04 0. 132371 65. 00 trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) <u>6</u>5. 01 0. 235980 65. 01 INTERNAL MEDICINE 1400 4.25 13. 76 Ratio (col. Unwei ghted Unwei ghted FTEs FTEs in (col. 1 + col Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 66.00 Enter in column 1 the number of unweighted non-primary care resident 2. 34 7.66 0. 234000 66. 00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Unwei ghted Program Name Program Code Unwei ghted Ratio (col. 3/ FTEs FTEs in (col. 3 + colNonprovi der Hospi tal 4)) Si te 3. 00 1.00 2.00 4.00 5.00 67.00 Enter in column 1, the program FAMILY MEDICINE 1350 10.59 18. 98 0. 358133 67. 00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)

	4)). (See Histiactions)			I					
67. 01		INT MEDICINE	1400	3. 27		20. 73	0.	136250	67. 01
						1. 00	2. 00	3.00	
	Inpatient Psychiatric Facility F	PPS							
70.00	Is this facility an Inpatient Ps	sychiatric Facility (IPF), or does it conta	ain an IPF subp	rovi der?	N			70.00
	Enter "Y" for yes or "N" for no).							
71.00	If line 70 is yes: Column 1: Dic					N		0	71.00
	recent cost report filed on or b	oefore November 15, 20	004? Enter "Y" for ye	es or "N" for n	o. (see				
	42 CFR 412.424(d)(1)(iii)(c)) Co								
	program in accordance with 42 CF								
	Column 3: If column 2 is Y, indi	cate which program ye	ear began during this	cost reporting	peri od.				
	(see instructions)								
	Inpatient Rehabilitation Facilit	ty PPS							
75.00	Is this facility an Inpatient Re	ehabilitation Facility	y (IRF), or does it co	ontain an IRF		Y			75.00
	subprovider? Enter "Y" for yes	and "N" for no.							

106.00

107.00

108.00

Ν

N

106.00 If this facility qualifies as a CAH, has it elected the all-inclusive method of payment

107.00 If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If

108.00 Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.

yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost

for outpatient services? (see instructions)

reimbursed. If yes complete Wkst. D-2, Pt. II.

are claimed, enter in column 2 the home office chain number. (see instructions)

Health Financial Systems BALL MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0089 Peri od: Worksheet S-2 From 01/01/2017 Part I 12/31/2017 Date/Time Prepared: To 5/24/2018 5:05 pm 3.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number

Name: INDIANA UNIVERISTY HEALTH INC | Contractor's Name: WPS 141. 00 Name: INDIANA UNIVERISTY HEALTH INC Contractor's Number: 08101 141 00 142.00 Street: 340 W. 10TH STREET PO Box: 142.00 143.00 City: INDIANAPOLIS 143. 00 State: Zip Code: 1.00 144.00 Are provider based physicians' costs included in Worksheet A? γ 144. 00 1. 00 2.00 145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for 145.00 inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost allocation methodology changed from the previously filed cost report? 146.00 Ν Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, \$4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. 1.00 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. 147. 00 Ν N 148 00 149.00Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no Ν 149.00 Part A Part B Title V Title XIX 1.00 2.00 3.00 4.00 Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) 155.00 Hospi tal Ν N 155.00 156.00 Subprovider - IPF Ν Ν Ν Ν 156.00 157.00 Subprovi der - IRF 157 00 N Ν Ν N 158. 00 SUBPROVI DER 158. 00 159.00 SNF Ν Ν Ν Ν 159. 00 160.00 HOME HEALTH AGENCY 160. 00 Ν Ν Ν Ν 161.00 CMHC Ν Ν N 161. 00 1.00 Multicampus 165.00 s this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? N 165.00 Enter "Y" for yes or "N" for no. Name County State Zip Code CBSA FTE/Campus 0 1.00 2.00 3.00 4.00 5.00 166.00 If line 165 is yes, for each 0.00 166.00 campus enter the name in column O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) 1.00 Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act 167.00 s this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no. 167 00 168.00 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the

reasonable cost incurred for the HIT assets (see instructions)			
168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a	hardshi p		168. 01
exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)			
169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N	l"), enter the	9. 99	169. 00
transition factor. (see instructions)			
	Begi nni ng	Endi ng	
	1. 00	2. 00	
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting	04/01/2017	06/30/2017	170. 00
period respectively (mm/dd/yyyy)			
	1. 00	2.00	
171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in	Y	1, 802	171. 00
section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter			
"Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section			
1876 Medicare days in column 2. (see instructions)			

0168.00

SPI I	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-0089	Peri od: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part II Date/Time Pro 5/24/2018 5:0	epared:
				Y/N 1. 00	Date	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	lfor all NO re	esponses. Ente		2.00 The	
0	Provider Organization and Operation Has the provider changed ownership immediately prior to the	hoginning of	the cost	N		1.00
00	reporting period? If yes, enter the date of the change in a	column 2. (see	instructions			1.00
	Topo one grant and the second of the second		Y/N	Date	V/I	
			1.00	2. 00	3. 00	
00	Has the provider terminated participation in the Medicare F yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary. Is the provider involved in business transactions, including	nn 3, "V" for	N Y			3.00
	contracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members of directors through ownership, control, or family and other relationships? (see instructions)	offices, drug der or its of the board				
			Y/N	Type	Date	
	Financial Data and Reports		1.00	2. 00	3. 00	
	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" for "R" for Reviewed. Submit complete copy or enter date avacolumn 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 diffe		N			5. 00
	those on the filed financial statements? If yes, submit rec	conciliation.		Y/N	Legal Oper.	
				1. 00	2. 00	
	Approved Educational Activities					
00	Column 1: Are costs claimed for nursing school? Column 2:	If yes, is th	ne provider is	s N		6. 00
	the legal operator of the program?	actouctions		Y		7 00
00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.	and/or renewed	Ü	N		7. 00 8. 00
00	Are costs claimed for Interns and Residents in an approved		cal education	Y		9. 00
00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.		the current	N		10.00
00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	N		11. 00
					Y/N 1. 00	
	Bad Debts				1.00	
00	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p			ost reporting	Y N	12. 00 13. 00
	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	ents waived? If	fyes, see ins	structi ons.	N	14. 00
	Did total beds available change from the prior cost reporti	1 -	yes, see inst	tructions.	Y t B	15. 00
		Y/N	Date	Y/N	Date	
	DCAD D I	1.00	2. 00	3. 00	4. 00	
	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see	N		N		16. 00
00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Y	04/04/2018	Υ	04/04/2018	17.00
00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions	N		N		18.00
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	N		N		19. 00

	Heal th	Financial Systems BALL MEMORIA	AL HOSPITAL		In Lie	u of Form CM	S-2552-10		
Description Y/N Y/N	HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider Co	CN: 15-0089	From 01/01/2017	Part II Date/Time P	repared:		
Report data for Other? Describ the other adjustments andle to PSAR Report data for Other? Describ the other adjustments: Y/N Dato Y/N Da			Descri	pti on	Y/N				
Report data for Other? Describe the other adjustments: Y/R Date Y/R Date			()					
21.00 Was the cost report prepared only using the provider's N 2.00 3.00 4.00 2.00 1.00 1.00 1.00 1.00 1.00 1.00 1	20. 00				N	N	20. 00		
21.00 Was the cost report prepared only using the provider's N N 2.00 COMPLETED BY COST RETINBURSED AND TEERA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) 1.00		report data for other: bescribe the other adjustments.	Y/N	Date	Y/N	Date			
COMPLETED BY COST RELIBRIESED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) Sepital Related Cost Sepital Related Sepital									
Completed BY COST RELIBURSED AND TERRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) Capital Related Cost Capital Related Cost 22.00 Have assets been reliar for Medicare purposes? If yes, see instructions 23.00 Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions. 16 yes, see instructions 25.00 Have men leaves and/or amendments to existing leaves entered into during this cost reporting period? 26 yes, see instructions 26.00 Were assets subject to Sec 2314 of DEFRA acquired during the cost reporting period? If yes, see 27.00 Has the provider's capitalization policy changed during the cost reporting period? If yes, see instructions. 28.00 Were neaves subject to Sec 2314 of DEFRA acquired during the cost reporting period? If yes, submit N N N N N N N N N N N N N N N N N N N	21. 00		N		N		21. 00		
Completed BY COST RELIBURSED AND TERRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) Capital Related Cost Capital Related Cost 22.00 Have assets been reliar for Medicare purposes? If yes, see instructions 23.00 Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions. 16 yes, see instructions 25.00 Have men leaves and/or amendments to existing leaves entered into during this cost reporting period? 26 yes, see instructions 26.00 Were assets subject to Sec 2314 of DEFRA acquired during the cost reporting period? If yes, see 27.00 Has the provider's capitalization policy changed during the cost reporting period? If yes, see instructions. 28.00 Were neaves subject to Sec 2314 of DEFRA acquired during the cost reporting period? If yes, submit N N N N N N N N N N N N N N N N N N N						1.00			
Capital Related Cost 2.0 Ol Have essets been relifed for Medicare purposes? If yes, see instructions 3.0 Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost N 23.00 Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost N 23.00 Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost N 24.00 Were new Leases and/or amendments to existing leases entered into during this cost reporting period? Y 24.00 Have there been new capitalized leases entered into during the cost reporting period? If yes, see Y 25.00 Have there seen new capitalized leases entered into during the cost reporting period? If yes, see N 26.00 Were assets sudject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see N 26.00 Were new Leans, mortgage agreements or letters of credit entered into during the cost reporting N 27.00 Has the provider's capitalization policy changed during the cost reporting period? If yes, see instructions Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) N 29.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see N 30.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see N 31.00 Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions 32.00 Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. 9.00 Her beaded Physicians 1.00 Have changes or new agreements or amended existing agreements with the provider-based N 35.00 Filine 32 is yes, were there new agreements or amended existing agreements with the provider-based N 36.00 Fire home office costs 1.00 Have changes or provider? If yes, see instructions. 9.00 His instructions. 9.00 His in		COMPLETED BY COST DELMBLIDSED AND TEEDA HOSDITALS ONLY (EYCE	DT CHILDDENS H	OSDI TAI S)		1.00			
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30.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see	29. 00	Did the provider have a funded depreciation account and/or	N	29. 00					
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34.00 Are services furnished at the provider facility under an arrangement with provider-based physicians? 35.00 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based N 35.00 physicians during the cost reporting period? If yes, see instructions. Home Office Costs									
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Home Office Costs 36.00 Were home office costs claimed on the cost report? 37.00 If line 36 is yes, has a home office cost statement been prepared by the home office? 38.00 If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office. 39.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 instructions. Cost Report Preparer Contact Information 41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 42.00 Enter the employer/company name of the cost report IU HEALTH Enter the telephone number and email address of the cost 317-962-1093 RUTTER@IUHEALTH. ORG 43.00		personal during the coot reporting person in year see in	1011 4011 01101		Y/N	Date			
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40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 instructions. 1.00 2.00	39. 00	If line 36 is yes, did the provider render services to other			, Ү		39. 00		
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41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 42.00 Enter the employer/company name of the cost report preparer. 43.00 Enter the telephone number and email address of the cost 317-962-1093 RUTTER@IUHEALTH. ORG 43.00			1.	00	2.	00			
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43.00 Enter the telephone number and email address of the cost 317-962-1093 RUTTER@IUHEALTH.ORG 43.00	42. 00	Enter the employer/company name of the cost report	IU HEALTH				42. 00		
	43. 00	Enter the telephone number and email address of the cost	317-962-1093		RUTTER@I UHEALTI	H. ORG	43. 00		

Heal th	Financial Systems BALL MEM	ORIAL F	IOSPI TAL		In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-00	F	eriod: rom 01/01/2017		
					o 12/31/2017	Date/Time Pre 5/24/2018 5:0	pared: 05 pm
			3. 00				
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title/position		RECTOR, GOVERNMENT				41.00
	held by the cost report preparer in columns 1, 2, and 3	, PRO)GRAMS				
	respecti vel y.						
42.00	Enter the employer/company name of the cost report						42. 00
	preparer.						
43.00	Enter the telephone number and email address of the cos	t					43.00
	report preparer in columns 1 and 2, respectively.						

| Period: | Worksheet S-3 | From 01/01/2017 | Part | To 12/31/2017 | Date/Time Prepared:
 Heal th Financial
 Systems
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 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX
 STATISTICAL DATA
 Provider CCN: 15-0089

					Т	o 12/31/2017	Date/Time Pre 5/24/2018 5:0	
							I/P Days / 0/P	J pili
							Visits / Trips	
	Component	Worksheet A	No.	of Beds	Bed Days	CAH Hours	Title V	
	'	Line Number			Avai I abl e			
		1. 00		2.00	3.00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		263	95, 995	0.00	0	1. 00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2. 00
3.00	HMO 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			263	95, 995	0.00	0	7. 00
	beds) (see instructions)							
8.00	INTENSIVE CARE UNIT	31. 00		36	13, 140	0.00	0	8. 00
9.00	CORONARY CARE UNIT	32. 00		0	C	0.00	0	9. 00
10.00	BURN INTENSIVE CARE UNIT							10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT							11. 00
12.00	NEONATAL INTENSIVE CARE UNIT	35. 00		23	8, 395	0.00	0	12. 00
13.00	NURSERY	43. 00					0	13. 00
14.00	Total (see instructions)			322	117, 530	0.00	0	14. 00
15. 00	CAH visits						0	15. 00
16.00	SUBPROVI DER - I PF	40. 00		0			0	16. 00
17. 00	SUBPROVI DER - I RF	41. 00		16	5, 840		0	17. 00
18.00	SUBPROVI DER							18. 00
19. 00	SKILLED NURSING FACILITY							19. 00
20.00	NURSING FACILITY							20. 00
21.00	OTHER LONG TERM CARE							21. 00
22. 00	HOME HEALTH AGENCY							22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)							23. 00
24.00	HOSPI CE							24. 00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25.00	CMHC - CMHC							25. 00
26.00	RURAL HEALTH CLINIC							26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	26. 25
27.00	Total (sum of lines 14-26)			338				27. 00
28. 00	Observation Bed Days						0	28. 00
29. 00	Ambul ance Tri ps							29. 00
30.00	Employee discount days (see instruction)							30. 00
31.00	Employee discount days - IRF							31. 00
32.00	Labor & delivery days (see instructions)			8	2, 920			32. 00
32. 01	Total ancillary labor & delivery room							32. 01
	outpatient days (see instructions)							
33. 00	LTCH non-covered days							33. 00
33. 01	LTCH site neutral days and discharges							33. 01

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 HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

| Peri od: | Worksheet S-3 | From 01/01/2017 | Part I | To 12/31/2017 | Date/Time Prepared:

				1	0 12/31/2017	5/24/2018 5:0	
		I/P Days	/ O/P Visits	/ Trips	Full Time I	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
				Pati ents	& Residents	Payrol I	
		6.00	7. 00	8. 00	9. 00	10.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	33, 515	1, 119	67, 343			1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2. 00	HMO and other (see instructions)	10, 078	17, 183				2. 00
3.00	HMO IPF Subprovider	0	0				3. 00
4.00	HMO IRF Subprovider	283	249				4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5. 00
6. 00	Hospital Adults & Peds. Swing Bed NF		0	0			6. 00
7. 00	Total Adults and Peds. (exclude observation	33, 515	1, 119	67, 343			7. 00
0.00	beds) (see instructions)	F 400	540	40 740			0.00
8.00	INTENSIVE CARE UNIT	5, 430	518	10, 712			8. 00
9.00	CORONARY CARE UNIT	O O	U	0			9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT	0	400	2 242			11.00
12.00	NEONATAL INTENSIVE CARE UNIT	U	422	3, 342			12. 00 13. 00
13.00	NURSERY	20 045	1, 639	2, 539		1 024 44	
14.00	Total (see instructions)	38, 945	3, 698	83, 936		1, 834. 44	
15.00	CAH visits	0	0	0		0.00	15. 00
16. 00 17. 00	SUBPROVIDER - I PF	2, 944	23	4, 174	0.00	0. 00 23. 46	1
18.00	SUBPROVI DER - I RF SUBPROVI DER	2, 944	23	4, 1/4	0.00	23. 40	18.00
19. 00	SKILLED NURSING FACILITY						19.00
20. 00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY						22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)	٥	0	507			24. 10
25. 00	CMHC - CMHC	٩	Ĭ	007			25. 00
26. 00							26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	ol	0	0	0.00	0.00	
27. 00		١	Ĭ	· ·	63. 57		
28. 00	Observation Bed Days		161	7, 350		1,007.70	28. 00
29. 00	Ambul ance Trips	1, 641		,, 000			29. 00
30. 00	· ·	.,		0			30.00
31. 00				0			31.00
32. 00	, ,	l ol	31	642			32. 00
32. 01	Total ancillary labor & delivery room		0.	0.2			32. 01
	outpatient days (see instructions)			· ·			
33. 00	LTCH non-covered days	o					33. 00
33. 01	LTCH site neutral days and discharges	o					33. 01

| Peri od: | Worksheet S-3 | From 01/01/2017 | Part I | To 12/31/2017 | Date/Time Prepared:

				10	12/31/201/	5/24/2018 5:0	
		Full Time		Di scha	arges	0,21,2010 010	J
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11.00	12.00	13.00	14. 00	15. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	7, 209	263	16, 938	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2. 00	HMO and other (see instructions)			1, 678	3, 071		2. 00
3. 00	HMO IPF Subprovider				0		3. 00
4. 00	HMO IRF Subprovider				17		4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF						5. 00
6. 00	Hospital Adults & Peds. Swing Bed NF						6. 00
7. 00	Total Adults and Peds. (exclude observation						7. 00
0.00	beds) (see instructions)						0.00
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	NEONATAL INTENSIVE CARE UNIT						12. 00 13. 00
13.00	NURSERY	0.00	0	7, 209	24.2	16, 938	
14.00	Total (see instructions)	0.00	Ü	7, 209	263	10, 938	
15. 00 16. 00	CAH visits SUBPROVIDER - IPF	0. 00	0	0	o	0	15. 00 16. 00
17. 00	SUBPROVIDER - I FF	0.00	0	215	0	305	
18. 00		0.00	U	213	4	303	18.00
19. 00	SKILLED NURSING FACILITY						19.00
20. 00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY						22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24. 00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC						25. 00
26. 00							26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0. 00					26. 25
27. 00		0. 00					27. 00
28. 00	Observation Bed Days	0.00					28. 00
29. 00	Ambul ance Trips						29. 00
30. 00	Employee discount days (see instruction)						30.00
31. 00							31.00
32. 00	, ,				ļ		32. 00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33. 00	LTCH non-covered days			0			33. 00
33. 01	LTCH site neutral days and discharges			0			33. 01

| Period: | Worksheet S-3 | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared: Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0089

Wkst. A Line Amount Reclassificati Adjusted Salaries Related to Salaries (from Wkst. A-6) 3) col. 4	6. 00 6. 00 00 0. 00 00 0. 00	1.00
A-6 3 COI. 4	6. 00 6. 00 00 0. 00 00 0. 00	
PART II - WAGE DATA SALARIES 1. 00 Total salaries (see 200.00 105, 924, 436 -531, 881 105, 392, 555 3, 864, 421.6 instructions)	27. 27 00 0. 00 00 0. 00	
1.00 Total salaries (see 200.00 105, 924, 436 -531, 881 105, 392, 555 3, 864, 421. 6 instructions)	0.00	
instructions)	0.00	
2.00 Non-physician anesthetist Part 0 0 0 0.0	0. 00	2. 00
3.00 Non-physician anesthetist Part 0 0 0 0.0	0. 00	3. 00
4.00 Physician-Part A - 0 0 0 0.0		4. 00
Administrative	l l	
Physician-Part B		
6.00 Non-physician-Part B for 0 0 0 0.0 hospital-based RHC and FQHC services	0.00	6. 00
7.00 Interns & residents (in an 21.00 0 3,732,024 3,732,024 138,947.0 approved program)	26. 86	7. 00
7.01 Contracted interns and residents (in an approved 0 0 0 0.0	0. 00	7. 01
programs) 8.00 Home office and/or related 0 0 0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0	0. 00	8. 00
9.00 SNF 44.00 0 0 0 0.0	•	1
10. 00 Excluded area salaries (see 6, 363, 479 146, 009 6, 509, 488 229, 550. 1	8 28.36	10.00
OTHER WAGES & RELATED COSTS 11. 00 Contract Labor: Direct Patient 9, 107, 385 0 9, 107, 385 123, 854. 1	5 73. 53	11. 00
Care	0. 00	12. 00
management and other management and administrative		
services 13. 00 Contract Labor: Physician-Part 4,429,750 0 4,429,750 60,360.1	5 73. 39	13. 00
14.00 Home office and/or related 0 0 0 0.0 organization salaries and	0. 00	14. 00
wage-related costs	5 38. 11	14. 01
14.02 Related organization salaries 0 0 0.0		
15.00 Home office: Physician Part A 0 0 0 0.0	0.00	15. 00
16.00 Home office and Contract 0 0 0 0.0 Physicians Part A - Teaching	0.00	16. 00
WAGE-RELATED COSTS 17. 00 Wage-rel ated costs (core) (see 46, 319, 623 0 46, 319, 623		17. 00
instructions) 18.00 Wage-related costs (other) 0 0		18. 00
(see instructions) 19. 00 Excluded areas 3, 125, 369 0 3, 125, 369		19. 00
20. 00 Non-physician anesthetist Part 0 0 0 0		20. 00
21.00 Non-physician anesthetist Part 0 0 0		21. 00
22.00 Physician Part A - 0 0 0 Administrative		22. 00
22. 01 Physician Part A - Teaching 0 0 0		22. 01
23. 00 Physician Part B		23. 00 24. 00
25. 00 Interns & residents (in an approved program) 897, 395 0 897, 395		25. 00
25.50 Home office wage-related 0 0 0 0 (core)		25. 50
25. 51 Related organization 0 0 0 0 0 wage-related (core)		25. 51
25.52 Home office: Physician Part A 0 0 0 0 - Administrative -		25. 52
wage-related (core) 25.53 Home office & Contract 0 0 0		25. 53
Physicians Part A - Teaching - wage-related (core)		
OVERHEAD COSTS - DIRECT SALARIES 26.00 Employee Benefits Department 4.00 36,084 -215 35,869 2,067.4	17 25	26. 00
27. 00 Admi ni strati ve & General 5. 00 7, 196, 622 -23, 499 7, 173, 123 186, 320.		27. 00

| Peri od: | Worksheet S-3 | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared:

							5/24/2018 5: 0	
		Wkst. A Line	Amount	Recl assi fi cati	Adj usted	Paid Hours	Average Hourly	
		Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col.	Salaries in	col . 5)	
				A-6)	3)	col. 4		
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
28. 00	Administrative & General under		9, 982	0	9, 982	67. 54	147. 79	28. 00
	contract (see inst.)							
29. 00	Maintenance & Repairs	6. 00						29. 00
30.00	Operation of Plant	7. 00		-1, 794	1, 248, 576	50, 793. 83	24. 58	30.00
31. 00	Laundry & Linen Service	8. 00		0	0	0.00		31. 00
32.00	Housekeepi ng	9. 00	2, 602, 065	-12, 916	2, 589, 149	195, 865. 25	13. 22	32.00
33.00	Housekeeping under contract		0	0	0	0. 00	0.00	33.00
	(see instructions)							
34.00	Di etary	10. 00	2, 548, 163	-1, 198, 840	1, 349, 323	81, 709. 78	16. 51	34.00
35.00	Di etary under contract (see		0	0	0	0. 00	0.00	35.00
	instructions)							
36. 00	Cafeteri a	11. 00		1, 184, 318	1, 184, 318	87, 102. 00	13. 60	36.00
37.00	Maintenance of Personnel	12. 00	0	0	0	0. 00	0.00	37.00
38. 00	Nursing Administration	13. 00	5, 432, 085	-25, 610	5, 406, 475	159, 580. 50	33. 88	38.00
39.00	Central Services and Supply	14. 00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15. 00	4, 880, 485	-80, 593	4, 799, 892	131, 836. 41	36. 41	40.00
41.00	Medical Records & Medical	16. 00	0	0	0	0.00	0.00	41.00
	Records Library							
42.00	Soci al Servi ce	17. 00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18. 00	0	0	0	0.00	0.00	43.00

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION BALL MEMORIAL HOSPITAL

| Peri od: | Worksheet S-3 | From 01/01/2017 | Part III | To 12/31/2017 | Date/Time Prepared: | Peri od: | Per Provider CCN: 15-0089

							5/24/2018 5:05	5 pm
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col . 5)	
				Worksheet A-6)	3)	col. 4		
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		105, 934, 418	-4, 263, 905	101, 670, 513	3, 725, 542. 18	27. 29	1.00
	instructions)							
2.00	Excluded area salaries (see		6, 363, 479	146, 009	6, 509, 488	229, 550. 18	28. 36	2.00
	instructions)							
3.00	Subtotal salaries (line 1		99, 570, 939	-4, 409, 914	95, 161, 025	3, 495, 992. 00	27. 22	3.00
	minus line 2)							
4.00	Subtotal other wages & related		45, 954, 825	0	45, 954, 825	1, 034, 897. 45	44. 41	4. 00
	costs (see inst.)							
5.00	Subtotal wage-related costs		46, 319, 623	0	46, 319, 623	0.00	48. 67	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		191, 845, 387	-4, 409, 914	187, 435, 473	4, 530, 889. 45	41. 37	6.00
7.00	Total overhead cost (see		26, 843, 658	-159, 544	26, 684, 114	1, 026, 877. 64	25. 99	7.00
	instructions)							

Health Financial Systems	BALL MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0089	Peri od: Worksheet S-3
		From 01/01/2017 Part IV
		T- 10/01/0017 D-+-/T: D

	To 12/31/2017	Date/Time Prep 5/24/2018 5:0	
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	4, 673, 614	1. 00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2. 00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	20, 595, 023	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5. 00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6. 00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST	•	
8.00	Health Insurance (Purchased or Self Funded)	0	8. 00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	15, 358, 840	8. 02
8. 03	Health Insurance (Purchased)	0	8. 03
9. 00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	478, 481	10.00
	Life Insurance (If employee is owner or beneficiary)	59, 727	11. 00
	Accident Insurance (If employee is owner or beneficiary)	0	12.00
	Disability Insurance (If employee is owner or beneficiary)	689, 669	13. 00
	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
	'Workers' Compensation Insurance	575, 547	15. 00
16. 00	'	0	16. 00
	Non cumulative portion)		
	TAXES	•	
17.00	FICA-Employers Portion Only	7, 605, 318	17. 00
18.00	Medicare Taxes - Employers Portion Only	0	18. 00
	Unempl oyment Insurance	0	19. 00
20.00	State or Federal Unemployment Taxes	12, 711	20. 00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see	0	21. 00
	instructions))		
22.00	Day Care Cost and Allowances	0	22. 00
	Tuition Reimbursement	293, 455	23. 00
24.00	Total Wage Related cost (Sum of lines 1 -23)	50, 342, 385	24. 00
	Part B - Other than Core Related Cost		
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25. 00
			•

Health Financial Systems	BALL MEMORIAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	F	From 01/01/2017	Worksheet S-3 Part V Date/Time Pre 5/24/2018 5:0	pared:
Cost Center Description		Contract Labor	Benefit Cost	
		1. 00	2. 00	

		 	5/24/2018 5:0	
	Cost Center Description	Contract Labor	Benefit Cost	
		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	9, 107, 385	50, 342, 385	1. 00
2.00	Hospi tal	9, 107, 385	50, 342, 385	2. 00
3.00	Subprovi der - I PF	0	0	3. 00
4.00	Subprovi der - I RF	0	0	4. 00
5.00	Subprovi der - (Other)	0	0	5. 00
6.00	Swing Beds - SNF	0	0	6. 00
7.00	Swing Beds - NF	0	0	7. 00
8.00	Hospi tal -Based SNF			8. 00
9.00	Hospi tal -Based NF			9. 00
10. 00	Hospi tal -Based OLTC			10. 00
11. 00	Hospi tal -Based HHA			11. 00
12. 00	Separately Certified ASC			12. 00
13. 00	Hospi tal -Based Hospi ce			13. 00
14.00	Hospital-Based Health Clinic RHC			14. 00
15. 00	Hospital-Based Health Clinic FQHC			15. 00
16. 00	Hospi tal -Based-CMHC			16. 00
17. 00	Renal Dialysis	0	0	17. 00
18. 00	Other	0	0	18. 00

Health Financial Systems BALL MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10			
HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CC	N: 15-0089	Peri od:	Worksheet S-10				
			From 01/01/2017 To 12/31/2017	Date/Time Prep 5/24/2018 5:05				
					,			
				1. 00				
Uncompensated and indigent care cost computation 1.00 Cost to charge ratio (Worksheet C, Part I line 202 column	2 divided by Lin	20.2 column	. 01	0. 161552	l 1. 00			
Medicaid (see instructions for each line)	3 divided by iii	ie 202 Coruiiii	0)	0. 101552	1.00			
2.00 Net revenue from Medicaid				45, 383, 547	2.00			
3.00 Did you receive DSH or supplemental payments from Medicaid	l?			Υ	3.00			
4.00 If line 3 is yes, does line 2 include all DSH and/or suppl	, ,		i d?	Y	4.00			
5.00 If line 4 is no, then enter DSH and/or supplemental paymen	nts from Medicaic	d		0				
6.00 Medicaid charges 7.00 Medicaid cost (line 1 times line 6)				344, 567, 130 55, 665, 509	6. 00 7. 00			
8.00 Difference between net revenue and costs for Medicaid prog	ıram (line 7 minu	ıs sum of lin	es 2 and 5 if	10, 281, 962				
<pre>< zero then enter zero)</pre>	ji dili (11110 7 lili1110	as sam or rrn	ico 2 una o, 11	10, 201, 702	0.00			
Children's Health Insurance Program (CHIP) (see instruction	ns for each line	e)						
9.00 Net revenue from stand-alone CHIP				0				
10.00 Stand-alone CHIP charges				0				
11.00 Stand-alone CHIP cost (line 1 times line 10) 12.00 Difference between net revenue and costs for stand-alone C	`UID (lino 11 min	aus lino 0: i	f < zoro thon	0				
enter zero)	JIIF (IIIIE II IIIII	ius IIIIe 9, I	i < Zero tileli	U	12.00			
Other state or local government indigent care program (see	instructions fo	or each line)			İ			
13.00 Net revenue from state or local indigent care program (Not				-	13.00			
14.00 Charges for patients covered under state or local indigent	care program (N	Not included	in lines 6 or	0	14.00			
10) 15.00 State or Local indigent care program cost (line 1 times li	no 14)			0	15. 00			
15.00 State or local indigent care program cost (line 1 times li 16.00 Difference between net revenue and costs for state or loca		nrogram (lin	e 15 minus line					
13; if < zero then enter zero)	ii iiidi gent edile	program (TT	ic to illitius title	Ĭ	10.00			
Grants, donations and total unreimbursed cost for Medicaid instructions for each line)	, CHIP and state	e/Local indig	ent care program	is (see				
17.00 Private grants, donations, or endowment income restricted	to funding chari	ty care		0	17. 00			
18.00 Government grants, appropriations or transfers for support				0				
19.00 Total unreimbursed cost for Medicaid , CHIP and state and 8, 12 and 16)	local indigent o	care programs	(sum of lines	10, 281, 962	19.00			
o, 12 and 10)		Uni nsured	Insured	Total (col. 1				
		pati ents	pati ents	+ col. 2)				
		1. 00	2. 00	3. 00				
Uncompensated Care (see instructions for each line) 20.00 Charity care charges and uninsured discounts for the entir	o fooility	39, 166, 02	2, 681, 056	41, 847, 083	20 00			
(see instructions)	e racifity	39, 100, 02	2,001,000	41, 047, 003	20.00			
21.00 Cost of patients approved for charity care and uninsured d	liscounts (see	6, 327, 35	2, 681, 056	9, 008, 406	21.00			
instructions)								
22.00 Payments received from patients for amounts previously wri	tten off as	291, 26	0	291, 269	22. 00			
charity care 23 00 (cast of charity care (line 31 minus line 32)		6, 036, 08	2, 681, 056	0 717 127	22 00			
23.00 Cost of charity care (line 21 minus line 22)		0, 030, 00	2,001,000	8, 717, 137	23.00			
				1.00				
24.00 Does the amount on line 20 column 2, include charges for p		ond a Length	of stay limit		24.00			
imposed on patients covered by Medicaid or other indigent 25.00 If line 24 is yes, enter the charges for patient days beyo		care program	's length of	0	25. 00			
stay limit 26.00 Total bad debt expense for the entire hospital complex (se	o inctruction=\			22 271 504	26. 00			
· ·								
27.01 Medicare allowable bad debts for the entire hospital compl	`	•		19, 974, 799 4, 380, 848				
27.01 Medicare allowable bad debts for the entire hospital compl 28.00 Non-Medicare bad debt expense (see instructions)	ot expense (see i	•			29. 00 30. 00			

		icial Systems ATION AND ADJUSTMENTS OF TRIAL BALANCE OF	BALL MEMORIAL	Provi der Co	N: 15 0000 D	eri od:	wof Form CMS-2 Worksheet A	2552-10
RECLAS	531 F1 G	ATTON AND ADJUSTMENTS OF TRIAL BALANCE OF	EXPENSES	Provider Co	F	rom 01/01/2017		
					Т	o 12/31/2017	Date/Time Pre 5/24/2018 5:0	pared:
		Cost Center Description	Sal ari es	Other	Total (col 1	Recl assi fi cati		5 pili
		Successive Superior	00.0	0 (1.10)	+ col . 2)	ons (See A-6)	Trial Balance	
							(col. 3 +-	
							col . 4)	
	CENED	AL SERVICE COST CENTERS	1.00	2.00	3. 00	4. 00	5. 00	
1. 00		NEW CAP REL COSTS-BLDG & FIXT		4, 884, 336	4, 884, 336	19, 976, 998	24, 861, 334	1.00
3.00		OTHER CAPITAL RELATED COSTS		0			0	1
4.00		EMPLOYEE BENEFITS DEPARTMENT	36, 084	1, 638, 144	1, 674, 228	19, 945, 327	21, 619, 555	4. 00
5. 01		COMMUNI CATI ONS	512, 947	326, 497	839, 444	-189, 818	1	1
5. 02		DATA PROCESSING ADMITTING	050 422	252.003	1 212 404	2/1 007	1 051 400	
5. 04 5. 05		CASHI ERI NG/ACCOUNTS RECEI VABLE	959, 423	353, 983	1, 313, 406	-261, 997	1, 051, 409 0	
5. 06		OTHER ADMINISTRATIVE AND GENERAL	5, 724, 252	73, 880, 645	79, 604, 897	-1, 548, 846	1	5. 06
6.00		MAINTENANCE & REPAIRS	2, 887, 802	14, 801, 873			8, 794, 814	
7.00		OPERATION OF PLANT	1, 250, 370	4, 869, 101				1
8.00		LAUNDRY & LINEN SERVICE	0	0	1	.,,		1
9. 00 10. 00		HOUSEKEEPI NG DI ETARY	2, 602, 065 2, 548, 163	1, 813, 160 2, 555, 886			2, 932, 902 2, 121, 767	1
11. 00		CAFETERI A	2, 340, 103	2, 333, 000	3, 104, 047	2, 181, 412		
13. 00		NURSING ADMINISTRATION	5, 432, 085	2, 589, 110	8, 021, 195			1
14. 00		CENTRAL SERVICES & SUPPLY	0	1, 618, 497				1
15.00		PHARMACY	4, 880, 485	27, 970, 538				1
16. 00 21. 00		MEDICAL RECORDS & LIBRARY I&R SERVICES-SALARY & FRINGES APPRVD	0	0		-	0 3, 732, 024	
22. 00		I &R SERVICES-SALARY & FRINGES APPRVD	3, 980, 479	4, 325, 112	1		3, 732, 024	
23. 00		PARAMED ED PRGM	68, 973	14, 828				1
	I NPAT	IENT ROUTINE SERVICE COST CENTERS						
30.00		ADULTS & PEDIATRICS	21, 383, 173	13, 403, 651				
31.00		INTENSIVE CARE UNIT	6, 677, 543	3, 670, 583		-2, 371, 884	1	1
32. 00 35. 00		CORONARY CARE UNIT NEONATAL INTENSIVE CARE UNIT	1, 772, 864	0 835, 748	· ·	-592, 545	0 2, 016, 067	
40. 00		SUBPROVIDER - I PF	1, 772, 804	033, 740		-572, 545	2,010,007	1
41. 00		SUBPROVIDER - IRF	1, 511, 421	894, 426	2, 405, 847	-350, 133	2, 055, 714	1
43.00		NURSERY	0	0	C	625, 770	625, 770	43. 00
F0 00		LARY SERVICE COST CENTERS	4 040 (0)	40.0/7./70	04.000.057	40.000.000	/ //0 540	
50. 00 51. 00	1	OPERATING ROOM RECOVERY ROOM	4, 940, 686 1, 469, 636	19, 967, 670 706, 651				
52. 00		DELIVERY ROOM & LABOR ROOM	1, 894, 022	1, 011, 327				1
54.00		RADI OLOGY-DI AGNOSTI C	8, 443, 335	14, 133, 633				1
57. 00		EKG AND EEG	158, 391	56, 206	1		1	1
58.00	1	MAGNETIC RESONANCE IMAGING (MRI)	0	0 425 722	1	-	0	
59. 00 60. 00		CARDI AC CATHETERI ZATI ON LABORATORY	1, 724, 054	8, 425, 723 9, 717, 096				1
60. 01		BLOOD LABORATORY	Ö	0,717,070	7,717,070	27, 323	0	1
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	О	1, 248, 663	1, 248, 663	-1, 630	1, 247, 033	63. 00
65.00		RESPI RATORY THERAPY	3, 142, 922	1, 102, 349				1
65. 01		SLEEP LAB	437, 799	512, 794				1
66. 00 67. 00		PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	4, 774, 463 741, 266	1, 885, 976 216, 889			5, 168, 028 857, 096	1
68. 00		SPEECH PATHOLOGY	386, 820	115, 856			l	
68. 01		AUDI OLOGY	0	0	· c	_	0	1
69. 00		ELECTROCARDI OLOGY	1, 224, 810	859, 377	2, 084, 187			
71.00		MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	10, 003, 772	10, 003, 772	1
72. 00 73. 00	1	IMPL. DEV. CHARGED TO PATIENT DRUGS CHARGED TO PATIENTS	0	0	0	13, 844, 516 27, 589, 201	13, 844, 516 27, 589, 201	
73. 00		HOSPITAL BASED RETAIL PHARMACIES	1, 680, 377	8, 665, 797	10, 346, 174		9, 929, 792	1
74. 00	07400	RENAL DIALYSIS	0	1, 346, 503				1
76. 00	1	CARDI OPULMONARY	o	0		0	0	
76. 97		CARDI AC REHABI LI TATI ON	519, 398	257, 887			632, 334	
76. 98		HYPERBARIC OXYGEN THERAPY TIENT SERVICE COST CENTERS	506, 115	1, 209, 293	1, 715, 408	-489, 651	1, 225, 757	76. 98
90. 00		CLINIC	0	0	C	0	0	90.00
90. 02	1	PAIN CLINIC	397, 338	586, 515	983, 853	-538, 723	445, 130	1
90. 03		ONCOLOGY CLINIC	673, 749	399, 655				1
91.00		EMERGENCY	5, 798, 041	6, 930, 081	12, 728, 122	-2, 862, 628	9, 865, 494	1
92. 00 92. 01		OBSERVATION BEDS (NON-DISTINCT PART) OBSERVATION BEDS (DISTINCT PART)	0	0	l c	0	0	92. 00 92. 01
92. UT		REIMBURSABLE COST CENTERS	······································	0		ı o	0	72.01
95.00		AMBULANCE SERVICES	1, 448, 328	854, 384	2, 302, 712	-506, 897	1, 795, 815	95. 00
	SPECI	AL PURPOSE COST CENTERS						
		INTEREST EXPENSE	100 505 :=	0			l	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	102, 589, 679	240, 656, 443	343, 246, 122	1, 594, 950	344, 841, 072	1118.00
190 00		IMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN	138, 257	620, 537	758, 794	-44, 572	714, 222	190 00
		RESEARCH	637, 542	232, 427				
		OTHER NONREIMBURSABLE COST CENTERS	0	0				194. 00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES Provider CCN: 15-0089 Peri od: Worksheet A From 01/01/2017 12/31/2017 Date/Time Prepared: 5/24/2018 5:05 pm Cost Center Description Sal ari es 0ther Total (col. 1 Reclassi fi cati Recl assi fi ed + col . 2) ons (See A-6) Trial Balance (col. 3 +-4) col. 4.00 1.00 2.00 3.00 5.00 194.01 07951 BSU PHARMACY 206, 635 56, 151 262, 786 -19, 314 243, 472 194. 01 194. 02 07952 PAVILLION PHARMACY 673, 976 6, 417, 525 194. 02 5, 829, 991 6, 503, 967 -86, 442 194. 03 07953 VENDI NG 0 194. 03 0 0 194. 04 07954 CARELI NE 0 0 0 194 04 194. 05 07955 WELLNESS CENTER 28, 904 76, 256 105, 160 -64, 433 40, 727 194. 05 194.06 07956 PHYSICIAN PRACTICE CLINICS 16, 403 194. 06 0 28, 160 28, 160 -11, 757 194. 07 07957 PERINATAL CLINIC 0 194, 07 0 194. 08 07958 RENTAL PROPERTY 0 1, 599, 203 -989, 627 609, 576 194. 08 1, 599, 203 0 194. 09 194. 09 07959 ADVERTI SI NG 0 194. 10 07960 I NTEGRA LTAC 0 194. 10 3, 435 194. 11 194. 11 07961 I U HEALTH HOSPICE 7, 261 7, 261 -3,826194. 12 07962 POB MEDICAL PAVILLION CONDOS 0 0 194. 12 194. 13 07963 EXECUTI VE PHYSI CAL 0 0 0 194. 13 0 194. 14 07964 NEW CASTLE ONCOLOGY 0 0 0 194. 14 C 194. 15 07965 MARKETI NG/PUBLIC RELATIONS 0 194, 15 0 Ω 194. 16 07966 JAY COUNTY HOSPITAL 212, 263 32, 804 245, 067 -22, 001 223, 066 194. 16 194. 17 07967 CARDI NAL HEALTH CHOICE 0 194. 17 0 194. 18 07968 CHV CARDI NAL HEALTH VENTURES 0 194, 18 0 0 0 194. 19 07969 HEALTH CARE CONNECTIONS 0 194. 19 0 C 0 0 194. 20 07970 MEALS ON WHEELS 0 C 0 0 0 194. 20 194. 21 07971 ST MARY'S SCHOOL 0 194. 21 0 194. 22 07972 THERAPIES TO OTHER ENTITIES 1, 256, 107 1, 419, 914 194. 22 367, 791 1, 623, 898 -203 984 194. 23 07973 CANCER CENTER BOUTIQUE 14, 251 108, 223 122, 474 -1, 948 120, 526 194. 23 194. 24 07974 BOSC BALL OUTPATIENT SURGERY 0 194. 24 194, 25 07975 CARDI NAL BEHAVI ORAL HEALTH 270 270 -149 121 194. 25 194. 26 07976 BLACKFORD COMMUNITY HOSPITAL 200, 355 180, 421 194. 26 166, 822 33, 533 -19, 934 194. 27 07977 MIDWEST HEALTH STRATEGIES 0 194. 27 194. 28 07978 CARDINAL SELECT RISK RETENTION GRP 0 0 194. 28 0 0 0 0 0 194. 29 07979 HOME OFFICE CARDINAL HEALTH INITIATI 0 194, 29 Ω 0 194. 30 07980 CARDI NAL HEALTH ALLI ANCE 69 194. 30 69 69 194. 31 07986 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 194. 31 0 0 0 0 194. 32 07982 RENAL DIALYSIS 0 194. 32 0 0 194. 33 07983 LAB CORP 0 0 0 194. 33 194. 34 07984 H. O. MATERIALS MGMT 0 C 0 0 194. 34 194. 35 07985 LEASED SPACE 0 194. 35 200.00 TOTAL (SUM OF LINES 118 through 199) 105, 924, 436 249, 649, 119 355, 573, 555 355, 573, 555 200. 00

Peri od: From 01/01/2017 To 12/31/2017 Date/Time Prepared: 5/24/2018 5:05 pm

Belleran Emiric Description Algustiments Sear Pub For A Description					5/24/2018 5:0)5 pm
		Cost Center Description	Adjustments	Net Expenses		
CREMENT SERVICE COST CENTERS 207,790			(See A-8)			
1.00 001000 MAR CAP REL COSTS-SELEG & FIXT -207,200 24, 696,046 3.00 0010000 0010000 0010000 0010000 00100000 00100000 00100000 00100000 00100000000			6. 00	7. 00		
3.00 00000 INTERCEPT ALL RELATION COSTS 0 0 0 0 0 0 0 0 0		GENERAL SERVICE COST CENTERS				
4.00 0.000 DEPRIOYPE PRIFEITS DEPARTMENT -3, 996, 737 17, 072, 181 5.01 1160 0.000	1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	-207, 290	24, 654, 044		1.00
11	3.00	00300 OTHER CAPITAL RELATED COSTS	0	0		3. 00
11,797,428 11,797,428 12,774,599 5,04 5,05 5,06 5,05 5,0	4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-3, 996, 737	17, 622, 818		4. 00
0.0570 JAMINTH INC 0.0570	5. 01	01160 COMMUNI CATI ONS	-116, 650	532, 976		5. 01
Do. STO JAMAN LT IN STORY OF	5.02	00550 DATA PROCESSING	11, 797, 428	11, 797, 428		5. 02
5.05 DOSHO CASHLER MRYACCIONINS SECTUMENT 5.06 DOSHO GIRT AGMINISTRATION MIGHTAN 4.07 DOSHO CASHLER MRYACCIONINS SECTUMENT 6.00 DOSHO CONDON MINITARANCE & REPOLIES SUPPLY 6.00 DOSHO CONDON MINITARANCE & REPOLIT				1		
D.D. D.D. D.D. D.D. D.D.						1
0.000 0.0000 MATERIANCE & REPAIR S				1		1
1.00						1
0.00 0.000						1
0.000 0.0000 0.0000 0.000000 0.000000 0.00000000				l		1
10.00 01000 DETARY -4.49, 101 1, 672, 666 10.00 11.00 1100 CAFETERIA -1, 315, 188 866, 224 11.00 13.00 01300 MIRSI NG ADMINISTRATION -226, 752 6, 556, 657 13.00 13.00 13.00 01300 MIRSI NG ADMINISTRATION -226, 752 6, 556, 657 13.00 13.00 13.00 01300 MIRSI NG ADMINISTRATION -8.72, 88 4, 913, 465 13.00 13.00 01300 MIRSI NG ADMINISTRATION -8.72, 88 4, 913, 465 13.00 01300 MIRSI NG MIRCORDS & LIBRADY -8.72, 88 4, 913, 465 13.00 01300 MIRSI NG USS & LIBRADY -5.70, 80 3, 335, 969 22.00 0200 NR SERVICES DESTRUE SERVICES OST CENTERS -6.3, 245 27, 059, 117 23.00 01300 MIRCORD NEW MIRCORD & -6.72, 77 7, 954, 265 33.00 01300 MIRCORD NEW MIRCORD & -6.72, 77 7, 954, 265 33.00 01300 MIRCORD NEW MIRCORD & -6.72, 77 7, 954, 265 33.00 01300 MIRCORD NEW MIRCORD & -6.72, 77 7, 954, 265 33.00 01300 MIRCORD NEW MIRCORD & -6.72, 77 7, 954, 265 33.00 01300 MIRCORD NEW MIRCORD & -6.72, 77 7, 954, 265 33.00 01300 MIRCORD NEW MIRCORD & -6.72, 77 7, 954, 265 33.00 01300 MIRCORD NEW MIRCORD & -6.72, 77 7, 954, 265 33.00 01300 MIRCORD NEW MIRCORD & -6.72, 77 7, 954, 265 33.00 01300 MIRCORD NEW MIRCORD & -6.72, 77 7, 954, 265 33.00 01300 MIRCORD NEW MIRCORD & -6.72, 77 7, 954, 265 33.00 01300 MIRCORD NEW MIRCORD & -6.72, 77 7, 954, 265 33.00 01300 MIRCORD NEW MIRCORD & -6.72, 77 7, 954, 265 33.00 01300 MIRCORD NEW MIRCORD & -6.72, 77 7, 954, 265 33.00 01300 MIRCORD NEW MIRCORD & -7.72, 77 7, 954, 265 33.00 01300 MIRCORD NEW MIRCORD & -7.72, 77 7, 954, 265 33.00 01300 MIRCORD NEW MIRCORD & -7.72, 77 7, 954, 265 33.00 01300 MIRCORD NEW MIRCORD NEW MIRCORD & -7.72, 77 7, 954, 265 33.00 01300 MIRCORD NEW MIR			-	1		1
11.00 0 1100 CAFETERIA				1		1
13.00 10300 NURSING ADMINISTRATION -22, 752 6,556,667 13.00 14.0						
14.00 014000 [CHITMAL SERVICES & SUPPLY				1		
15.00 10500 PHANMACY 10.00 10500 PHANMACY 10.00	13. 00	01300 NURSI NG ADMINISTRATION	-226, 752	6, 556, 657		13. 00
16.00 16.00 MEDICAL RECORDS & LIBRARY 0 0 3,732 024 22.00 22	14. 00	01400 CENTRAL SERVICES & SUPPLY	-3			14. 00
21.00	15.00	01500 PHARMACY	-872, 288	4, 913, 465		15. 00
22.00	16.00	01600 MEDICAL RECORDS & LIBRARY	0	O		16. 00
22.00 02200 FAR SERVICES-OTHER PROM OSTS APPRVD -57,00 3,355,969 22.00 147,471 22.00 22.00 24	21. 00	02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	3, 732, 024		21. 00
23.00	22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	-57, 050			22. 00
INPATI ENT ROUTI NE SERVICE COST CENTERS -63, 248 27,059,117 30,00 31.00 300,00 3010 ADULTS & PEDIATRICS -63, 248 27,059,117 0 32.00		1 1		1		
30.00	20.00			, ,		1 20.00
31.00 03100 INTENSIVE CARE UNIT	30 00		-63 2/15	27 059 117		30 00
32.00 03200 CORDMARY CARE UNIT 0.0 0.0 32.00 0.						
1.5 0.0 02060 NEONATAL INTENSIVE CARE UNIT -85, 213 1, 930, 854 41.00 40.00 0400 SUBPROVIDER - IPF 0 0 0 0 40.00 0400 04100 SUBPROVIDER - IPF 0 0 0 0 05.00		1				
40, 00 04000 SUBPROVI DER - I PF 0 42, 00		1				1
14. 00 04100 SUBPROVIDER - I F -276 2, 055, 438 41. 00 A30 04300 MURSERY 0 0.525, 770 43. 00 A30 04300 MURSERY 0 0.525, 770 43. 00 A30 04300 MURSERY 0 0.500 MURSERY 0 0.500 MEDICAL RAY SERVICE COST CENTERS 50. 00 50.00 OFFERT IN S. ROOM -5, 636 1, 591, 732 51. 00 52. 00 52.00 05200 DELI VERY ROOM & LABOR ROOM -12, 710 2, 09, 536 52. 00 53.00 DELI VERY ROOM & LABOR ROOM -12, 710 2, 09, 536 52. 00 53.00 DELI VERY ROOM & LABOR ROOM -12, 775, 625 10, 737, 579 53. 00 53.00 05300 MEDICAL CENTER REPORT 0.500						1
A3. 00 O-3000 FURSERY COST CENTERS				١		1
ANCILLARY SERVICE COST CENTERS 50.00		l i				1
50.00	43.00	04300 NURSERY	0	625, 770		43. 00
51.00 05100 RECOVERY ROOM -5.636 1.591, 732 51.00 52.00 52.00 05200 DELIVERY ROOM & LABOR ROOM -1.2, 710 2.029, 536 52.00 53.00 05800 RAGNETI C RESONANCE I MAGING (MRI) -93.866 75.537 57.00 58.00 05800 MAGNETI C RESONANCE I MAGING (MRI) -35.265 2.010, 417 59.00 05900 CARDI AC. CAITHETERI ZATI ON -35.265 2.010, 417 59.00 05900 CARDI AC. CAITHETERI ZATI ON -35.265 2.010, 417 59.00 05900 CARDI AC. CAITHETERI ZATI ON -35.265 2.010, 417 59.00 05.00 05900 CARDI AC. CAITHETERI ZATI ON -0.00 0.		ANCILLARY SERVICE COST CENTERS				
S2.00 05200 05200 DELLUFENY ROOM & LABOR ROOM -1, 7, 76, 282 0, 73, 75, 79 54, 00 54, 00 5400 RADIO LABOR TOOM -1, 756, 282 7, 737, 579 57, 00 58, 00 5800 MAGNETI C RESONANCE IMAGING (MRI) 0 0 0, 88, 00 0, 00	50.00	05000 OPERATING ROOM	-402, 881	6, 266, 637		50.00
54.00 05400 RADI OLOGY-DI ACNOSTIC -1,756, 282 10,737, 579 57.00 58.00 05500 EGG MEC AND EGG -93,866 75,537 57.00 58.00 05500 MAGMETIC RESONANCE IMAGING (MRI) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	51.00	05100 RECOVERY ROOM	-5, 636	1, 591, 732		51.00
54.00 05400 RADI OLGCY-DI ACMOSTIC -1,756, 282 10,737, 579 55.00 57.00 58.00 05800 MAGMETI C RESONANCE I I IMAGI NG (MRI) -93,866 75,537 57.00 58.00 05800 MAGMETI C RESONANCE I I I I I I I I I I I I I I I I I I I	52.00	05200 DELIVERY ROOM & LABOR ROOM	-12, 710	2, 029, 536		52. 00
S7. 00 03280 EKG AND EEC S7. 00 S8. 00 S8. 00 C8. 00 C8. 00 S9. 00 C9.						1
SBS 00 OSBOO MAGNETIC RESONANCE IMACING (MRI) 0 0 58.00						1
59.00 05900 CARDIAC CATHETERI ZATION -35, 265 2, 010, 417 60.00				l		
60.0 06000 06000 LABORATORY 0 0, 687, 571 0 0 0 0 0 0 0 0 0			-	· ·		
60.01 0600				1		1
63.00 06300 BLOOD STORING, PROCESSING, & TRANS. 0 1, 247, 033 65.00 65.00 06500 RESPIRATORY THERAPY -27, 678 3, 362, 438 65.00 65.01 06501 SLEEP LAB -73, 245 411, 594 66.00 66.00 06600 PHYSI CAL THERAPY -1, 562, 232 3, 605, 796 66.00 66.00 06600 PHYSI CAL THERAPY -71, 331 785, 765 67.00 66.00 06800 SPECH PATHOLOGY -53, 780 391, 283 68.00 68.01 06801 006801 AUDI OLOGY -53, 780 391, 283 68.00 69.00 06801 AUDI OLOGY 0 0 68.01 06801 AUDI OLOGY -84, 119 1, 168, 072 69.00 69.00 07100 AUDI CAL SUPPLIES CHARGED TO PATI ENTS 0 10, 003, 772 71.00 AUDI CAL SUPPLIES CHARGED TO PATI ENTS 0 13, 844, 516 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 27, 589, 201 73.00 73.01 73.01 7301 MOST) HASPEN BETAIL PHARMACIES -587, 726 9, 342, 066 73.01 74.00 07400 RENAL DI ALYSIS 0 1, 278, 417 74.00 76.00				1		1
65. 00 06500 RESPI RATORY THERAPY -27, 678 3, 362, 438 65. 00 65. 01 06501 SLEEP LAB -73, 245 411, 594 65. 01 66. 00 06600 PHYSI CAL THERAPY -1, 562, 232 3, 050, 796 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY -71, 331 785, 765 67. 00 68. 00 06800 SPECET PATHOLOGY -53, 780 391, 283 68. 00 68. 01 06801 AUDI OLOGY 0 0 0 68. 01 69. 00 06900 ELECTROCARDI OLOGY -84, 119 1, 168, 072 71. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 10, 003, 772 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 27, 589, 201 73. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 27, 589, 201 73. 00 73. 01 07301 HOSPI TAL BASED RETAI L. PHARMACI ES -587, 726 9, 342, 066 73. 01 74. 00 07400 RENAL DI LAYSI S 0 1, 278, 417 74. 00 76. 00 03160 CARDI OPULLMONARY 0 0 0 76. 97 07697 CARDI AC REHABI LI TATI ON -48, 206 584, 128 76. 98 76. 98 07698 HYPERBARI C D XYGEN THERAPY -3, 474 1, 222, 283 76. 98 79. 00 09000 CLINIC 0 445, 130 90. 00 79. 0. 00 09000 CLINIC 0 445, 130 90. 00 79. 0. 00 09000 ELERGENCY -126, 542 9, 738, 952 91. 00 79. 00 09000 OTTO OTTO OTTO OTTO OTTO OTTO OTTO			-	-		
65. 01 06501 SLEEP LAB -7.3, 245 411, 594 66. 00 06600 PHYSI CAL THERAPY -1.562, 232 3, 605, 796 66. 00 06700 OCCUPATI ONAL THERAPY -7.1, 331 785, 765 67. 00 0680. 00 06800 SPEECH PATHOLOGY -53, 780 391, 283 68. 00 68. 01 06801 AUDI OLOGY 0 0 0 06. 80. 01 06801 AUDI OLOGY -7.1, 331 785, 765 67. 00 0 0 06. 00 0 0 0 0 0 0 0 0 0			-	1		1
66. 00 06600 PHYSI CAL THERAPY		1		1		
67. 00 06700 OCCUPATI ONAL THERAPY	65. 01		-73, 245	411, 594		65. 01
68. 00 06800 SPECH PATHOLOGY -53, 780 391, 283 68. 00 06801 AUDI OLOGY 0 0 0 0 68. 01 69. 01 06801 AUDI OLOGY 0 0 0 0 0 68. 01 69. 00 06900 ELECTROCARDI OLOGY -84, 119 1, 168, 072 71. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 10, 003, 772 77. 00 72. 00 07200 IMPL DEV. CHARGED TO PATIENTS 0 13, 844, 516 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 27, 589, 201 73. 00 73. 01 07301 HOSPITAL BASED RETAIL PHARMACIES -587, 726 9, 342, 066 73. 01 74. 00 07400 RENAL DI ALYSIS 0 0 0 76. 00 76. 97 07697 CARDI AC REHABILLITATI ON -48, 206 584, 128 76. 97 76. 98 07698 HYPERBARI C OXYGEN THERAPY -3, 474 1, 222, 283 76. 98 00 07000 CLINI C 0 0 0 0 09. 02 090002 PAIN CLINI C 0 445, 130 90. 02 09. 03 09003 ONCOLOGY CLINI C 0 445, 130 90. 02 09. 04 09002 PAIN CLINI C 0 445, 130 90. 02 09. 05 09002 OSSERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 09. 01 09200 0SSERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 09. 02 09500 AMBULANCE SERVI CES -12, 324 1, 783, 491 95. 00 113. 00 113. 00 INTEREST EXPENSE 5 113. 00 114. 00 NONREI MBURSABLE COST CENTERS 95. 00 115. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 191. 00 019000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 191. 00 019000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 191. 00 019000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 191. 00 019000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 191. 00 019000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 191. 00 019000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 191. 00 019000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 191. 00 019000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 191. 00 019000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 191. 00 019000 GIFT, FLOWER, COF	66. 00	06600 PHYSI CAL THERAPY	-1, 562, 232	3, 605, 796		66. 00
68.01 06801 AUDI OLOGY	67.00	06700 OCCUPATI ONAL THERAPY	-71, 331	785, 765		67. 00
68. 01 06801 AUDI OLOGY	68. 00	06800 SPEECH PATHOLOGY	-53, 780	391, 283		68. 00
69.00 6900 ELECTROCARDI OLOGY	68. 01	06801 AUDI OLOGY	0	1		68. 01
71. 00		1 1	-84. 119	1, 168, 072		1
72. 00 07200 IMPL DEV. CHARGED TO PATIENT 0 13, 844, 516 72. 00 73. 00 73.00 DRUGS CHARGED TO PATIENTS 0 27, 589, 201 73. 00 73. 01 105PI TAL BASED RETAIL PHARMACI ES -587, 726 9, 342, 066 73. 01 74. 00 07400 RENAL DI ALYSIS 0 1, 278, 417 74. 00 07600 07						
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74. 00 07400 RENAL DIALYSIS 0 1,278,417 0 76. 00 76. 00 03160 CARDI OPULMONARY 0 0 0 0 76. 97 07697 CARDI AC REHABI LI TATI ON -48, 206 584, 128 76. 97 76. 98 07698 HYPERBARI C OXYGEN THERAPY -3,474 1,222,283 76. 98 OUTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C 0 0 445, 130 90. 02 90. 02 09002 PAIN CLINI C 0 445, 130 90. 02 90. 03 09003 ONCOLOGY CLINI C 0 942, 386 90. 03 91. 00 09000 EMERGENCY -126, 542 9, 738, 952 91. 00 92. 01 09200 DBSERVATI ON BEDS (NON-DISTI NCT PART) 92. 00 92. 01 09201 DBSERVATI ON BEDS (DISTINCT PART) 0 0 0 0 95. 00 09500 AMBULANCE SERVI CES 1-12, 324 1, 783, 491 95. 00 95. 00 09500 AMBULANCE SERVI CES 1-12, 324 1, 783, 491 95. 00 113. 00 11300 INTEREST EXPENSE 0 0 0 0 113. 00 118. 00 NONEEI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 714, 222 19. 00 191. 00 07950 JRTER NONEEI MBURSABLE COST CENTERS 190. 00 19000 RESEARCH -2, 119 740, 887 191. 00 194. 01 07951 BSU PHARMACY -258, 294 -14, 822 194. 01			F07 72/	1		
76. 00 03160 CARDI OPULMONARY 0 0 0 76. 00 76. 70 76. 77 76. 77 76. 77 76. 77 76. 77 76. 77 76. 78						
76. 97						
76. 98 O7698 HYPERBARI C OXYGEN THERAPY			_	-		
OUTPATIENT SERVICE COST CENTERS O				1		
90. 00 09000 CLINIC 0 0 0 0 9000 90	76. 98		-3, 474	1, 222, 283		J 76. 98
90. 02						
90. 03			0	0		90.00
90. 03	90. 02	09002 PAIN CLINIC	0	445, 130		90. 02
91. 00			0	1		
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 0 0 0 0 0 0			-126, 542			
92. 01 09201 0BSERVATI ON BEDS (DI STINCT PART) 0 0 0 0 0 0 0 0 0			0, 012			1
OTHER REI MBURSABLE COST CENTERS 95. 00 9500 AMBULANCE SERVI CES -12, 324 1, 783, 491 95. 00 SPECI AL PURPOSE COST CENTERS 0 0 113. 00 INTEREST EXPENSE 0 0 118. 00 SUBTOTALS (SUM OF LI NES 1 through 117) -35, 400, 418 309, 440, 654 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 2, 119 740, 887 191. 00 194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS 0 0 194. 00 194. 01 07951 BSU PHARMACY -258, 294 -14, 822 194. 01			^			1
95. 00	72.01			ı U		1 /2.01
SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	05 00		10 224	1 702 401		0F 00
113. 00	95. UU		- 12, 324	1, /83, 491		45.00
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) -35, 400, 418 309, 440, 654 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN -2, 119 740, 887 191. 00 194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS 0 0 194. 00 194. 01 07951 BSU PHARMACY -258, 294 -14, 822 194. 01	140 0-		-			110 00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 714, 222 190. 00 191. 00 19100 RESEARCH -2, 119 740, 887 191. 00 194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS 0 0 194. 00 194. 01 07951 BSU PHARMACY -258, 294 -14, 822 194. 01		1				
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 714, 222 190. 00 191. 00 19100 RESEARCH -2, 119 740, 887 191. 00 194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS 0 0 194. 00 194. 01 07951 BSU PHARMACY -258, 294 -14, 822 194. 01	118. 00		-35, 400, 418	309, 440, 654		<u>_</u> 1118. 00
191. 00 19100 RESEARCH						
194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS 0 0 194. 01 07951 BSU PHARMACY -258, 294 -14, 822 194. 01	190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	714, 222		190. 00
194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS 0 0 194. 01 07951 BSU PHARMACY -258, 294 -14, 822 194. 01			-2, 119	740, 887		191. 00
194. 01 07951 BSU PHARMACY -258, 294 -14, 822 194. 01	194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	0	0		194.00
			-258, 294	-14, 822		
10000				l		
		· · · · · · · · · · · · · · · · · · ·	., ., ,			1

 Health Financial
 Systems
 BALL MEMORITY

 RECLASSIFICATION
 AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES
 BALL MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10

Provider CCN: 15-0089

			3 5: 05 pm
Cost Center Description		Net Expenses	
		or Allocation	
	6.00	7. 00	
194. 03 07953 VENDI NG	0	0	194. 03
194. 04 07954 CARELI NE	0	0	194. 04
194.05 07955 WELLNESS CENTER	0	40, 727	194. 05
194.06 07956 PHYSICIAN PRACTICE CLINICS	0	16, 403	194. 06
194. 07 07957 PERI NATAL CLI NI C	0	0	194. 07
194. 08 07958 RENTAL PROPERTY	0	609, 576	194. 08
194. 09 07959 ADVERTI SI NG	0	0	194. 09
194. 10 07960 INTEGRA LTAC	0	0	194. 10
194. 11 07961 I U HEALTH HOSPI CE	-7, 066	-3, 631	194. 11
194.12 07962 POB MEDICAL PAVILLION CONDOS	0	0	194. 12
194. 13 07963 EXECUTI VE PHYSI CAL	0	0	194. 13
194.14 07964 NEW CASTLE ONCOLOGY	0	0	194. 14
194. 15 07965 MARKETI NG/PUBLI C RELATIONS	0	0	194. 15
194. 16 07966 JAY COUNTY HOSPITAL	0	223, 066	194. 16
194. 17 07967 CARDI NAL HEALTH CHOI CE	0	0	194. 17
194. 18 07968 CHV CARDINAL HEALTH VENTURES	0	0	194. 18
194. 19 07969 HEALTH CARE CONNECTIONS	0	0	194. 19
194.20 07970 MEALS ON WHEELS	0	0	194. 20
194. 21 07971 ST MARY'S SCHOOL	0	0	194. 21
194.22 07972 THERAPIES TO OTHER ENTITIES	-1, 038, 889	381, 025	194. 22
194. 23 07973 CANCER CENTER BOUTIQUE	0	120, 526	194. 23
194. 24 07974 BOSC BALL OUTPATIENT SURGERY	0	0	194. 24
194. 25 07975 CARDI NAL BEHAVI ORAL HEALTH	0	121	194. 25
194.26 07976 BLACKFORD COMMUNITY HOSPITAL	-180, 421	0	194. 26
194.27 07977 MIDWEST HEALTH STRATEGIES	0	0	194. 27
194.28 07978 CARDINAL SELECT RISK RETENTION GRP	0	0	194. 28
194.29 07979 HOME OFFICE CARDINAL HEALTH INITIATI	0	0	194. 29
194. 30 07980 CARDI NAL HEALTH ALLI ANCE	0	69	194. 30
194.31 07986 OTHER NONREIMBURSABLE COST CENTERS	0	0	194. 31
194. 32 07982 RENAL DIALYSIS	0	0	194. 32
194. 33 07983 LAB CORP	0	0	194. 33
194.34 07984 H.O. MATERIALS MGMT	0	0	194. 34
194. 35 07985 LEASED SPACE	0	0	194. 35
200.00 TOTAL (SUM OF LINES 118 through 199)	-36, 889, 146	318, 684, 409	200. 00

In Lieu of Form CMS-2552-10
Worksheet A-6 Peri od: From 01/01/2017 To 12/31/2017

Date/Time Prepared: 5/24/2018 5:05 pm

		Increases			5/24/2018 5:0)3 piii
	Cost Center	Increases Line #	Sal ary	Other		
	2. 00	3.00	4. 00	5. 00		
	A - NON-BILLABLE SUPPLIES					
1.00	CENTRAL SERVICES & SUPPLY	14.00	C	9, 189, 329		1.00
	OTHER ADMINISTRATIVE AND	5. 06	0	331, 738		2. 00
	GENERAL	50.00		470 505		
	CARDI AC CATHETERI ZATI ON	59.00	0			3.00
4. 00 5. 00	RENTAL PROPERTY	194. 08 0. 00	0			4. 00 5. 00
6. 00		0.00	0			6. 00
7. 00		0.00	0			7. 00
8.00		0.00	O			8. 00
9.00		0.00	0	0		9. 00
10.00		0.00	0			10. 00
11. 00		0.00	0			11. 00
12.00		0.00	0			12.00
13. 00 14. 00		0. 00 0. 00	0			13. 00 14. 00
15. 00		0.00	0			15. 00
16. 00		0.00	Ö			16. 00
17. 00		0.00	0			17. 00
18. 00		0.00	O			18. 00
19. 00		0.00	0			19. 00
20. 00		0.00	0			20. 00
21. 00		0.00	0			21.00
22. 00 23. 00		0. 00 0. 00	0			22. 00 23. 00
24. 00		0.00	0			24. 00
25. 00		0.00	Ö			25. 00
26. 00		0.00	0			26. 00
27.00		0.00	0			27. 00
28. 00		0.00	0			28. 00
29. 00		0.00	0			29. 00
30.00		0.00	0			30.00
31. 00 32. 00		0. 00 0. 00	0			31. 00 32. 00
33. 00		0.00	0			33. 00
34. 00		0.00	Ö			34. 00
35. 00		0.00	0			35. 00
36.00		0.00	0	0		36. 00
37.00		0.00	0			37. 00
38. 00		0.00	0			38. 00
39. 00		0.00	0			39. 00
40. 00		0.00	0			40. 00
	B - BILLABLE SUPPLIES			7, 077, 015		
	MEDICAL SUPPLIES CHARGED TO	71.00	C	10, 003, 772		1. 00
	PATI ENTS					
	OPERATION OF PLANT	7. 00	0			2. 00
3.00		0.00	0			3. 00
4.00		0.00	0	1		4. 00
5. 00 6. 00		0. 00 0. 00	0			5. 00 6. 00
7. 00		0.00	0			7. 00
8. 00		0.00	0			8. 00
9.00		0.00	O			9. 00
10.00		0.00	0	0		10. 00
11. 00		0.00	0			11. 00
12.00		0.00	0			12.00
13.00		0.00	0			13.00
14. 00 15. 00		0. 00 0. 00	0			14. 00 15. 00
16. 00		0.00	0			16. 00
17. 00		0.00	0			17. 00
18. 00		0.00	0			18. 00
19. 00		0.00	Ö			19. 00
20. 00		0.00	0			20. 00
21. 00		0.00	0			21. 00
22.00		0.00	0	0		22. 00
23. 00		0.00	0			23. 00
24. 00		0.00	0			24. 00
25. 00		0.00	0			25. 00
26. 00	0 — — — — —	0.00	— — <u> </u>	10, 006, 972		26. 00
	I=	ı I	0	1 .5,000,772	l	1

Health Financial Systems RECLASSIFICATIONS BALL MEMORIAL HOSPITAL Provider CCN: 15-0089

Peri od: From 01/01/2017 To 12/31/2017 Date/Time Prepared: 5/24/2018 5:05 pm

					5/24/2018 5	: 05 pm
	Cost Center	Increases Line #	Salary	Other		
	2. 00	3. 00	4. 00	5. 00		
	C - IMPLANTABLE DEVICES					
1.00	IMPL. DEV. CHARGED TO	72. 00	0	13, 844, 516		1. 00
2. 00	PATI ENT	0.00	o	0		2. 00
3.00		0.00	o	0		3. 00
4. 00		0.00	o	Ö		4. 00
5.00		0.00	0	0		5. 00
6.00		0.00	0	0		6. 00
7.00		0.00	0	0		7. 00
8. 00 9. 00		0. 00 0. 00	0	0		8. 00 9. 00
10. 00		0.00	Ö	0		10.00
11. 00		0.00	ō	0		11. 00
12.00		0.00	0	0		12. 00
13.00		0.00	0	0		13.00
14. 00 15. 00		0. 00 0. 00	0	0		14. 00 15. 00
13.00				13, 844, 516		13.00
	D - BILLABLE DRUGS	<u>'</u>	- 1	.,		
1.00	DRUGS CHARGED TO PATIENTS	73. 00	0	27, 589, 201		1. 00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	22, 391		2.00
3. 00 4. 00	PHARMACY	15. 00 0. 00	0	652, 512 0		3. 00 4. 00
5. 00		0.00	o	ő		5. 00
6.00		0.00	O	0		6. 00
7.00		0.00	0	0		7. 00
8.00		0.00	0	0		8. 00
9. 00 10. 00		0. 00 0. 00	0	0		9. 00 10. 00
11. 00		0.00	o	0		11.00
12. 00		0.00	Ö	Ö		12. 00
13.00		0.00	0	0		13. 00
14.00		0.00	0	0		14. 00
15.00		0.00	0	0		15. 00
16. 00 17. 00		0. 00 0. 00	ol Ol	0		16. 00 17. 00
18. 00		0.00	o	o		18. 00
19.00		0.00	0	0		19. 00
20.00		0.00	0	0		20. 00
21. 00		0.00	0	0		21. 00
22. 00 23. 00		0. 00 0. 00	0	0		22. 00 23. 00
24. 00		0.00	o	Ö		24. 00
25. 00		0.00	О	0		25. 00
26.00		0.00	0	0		26. 00
27. 00 28. 00		0. 00 0. 00	0	0		27. 00 28. 00
29. 00		0.00	0	0		29. 00
				28, 264, 104		
	E - INTERN & RESIDENT SALARIE					
1.00	I &R SERVICES-SALARY &	21. 00	3, 732, 024	0		1. 00
	FRI NGES APPRVD		3, 732, 024	₀		
	F - CAFETERIA		3, 732, 024	<u> </u>		
1.00	CAFETERI A	11. 00	1, 184, 318	997, 094		1.00
	0		1, 184, 318	997, 094		
1 00	G - PHARMACY ADMIN COSTS BSU PHARMACY	194. 01	18, 660	2 524		1 00
1. 00 2. 00	PAVILLION PHARMACY	194.01	18, 660	3, 526 3, 526		1. 00 2. 00
2.00	0	174.02	37, 320	7, 052		2.00
	H - AUTO & BUILDING INSURANCE					
1.00	NEW CAP REL COSTS-BLDG &	1.00	0	370, 382		1. 00
	FIXT — — — — —	+				ŀ
	I - REHAB ADMIN COSTS		U	370, 382		_
1.00	OCCUPATI ONAL THERAPY	67. 00	52, 994	3, 681		1.00
2.00	SPEECH PATHOLOGY	68. 00	27, 654	1, 966		2. 00
3.00	THERAPIES TO OTHER ENTITIES	194. 22	60, 232	4, 511		3. 00
	O L LAUNDDY		140, 880	10, 158		\dashv
1. 00	J - LAUNDRY LAUNDRY & LINEN SERVICE	8. 00	O	1, 360, 655		1. 00
2.00	LINEN SERVICE	0.00	o	1, 300, 033		2. 00
3. 00		0.00	ō	0		3. 00
4. 00	<u> </u>	0.00	o	0		4. 00

Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10
Worksheet A-6 Peri od: From 01/01/2017 To 12/31/2017 Provider CCN: 15-0089 Date/Time Prepared: 5/24/2018 5:05 pm

		Increases			3, 2, 1	
	Cost Center	Li ne #	Sal ary	Other 5		
5. 00	2. 00	3.00	4.00	5. 00 0		5. 00
6.00		0.00	o	Ö		6. 00
7.00		0.00	0	0		7. 00
8.00		0.00	0	0		8. 00
9.00		0.00	0	0		9.00
10. 00 11. 00		0. 00 0. 00	0	0		10. 00 11. 00
12. 00		0.00	o	Ö		12. 00
13.00		0.00	0	0		13. 00
14.00		0.00	0	0		14.00
15. 00 16. 00		0. 00 0. 00	0	0		15. 00 16. 00
17. 00		0.00	Ö	Ö		17. 00
18.00		0.00	0	0		18. 00
19. 00		0.00	0	0		19.00
20. 00 21. 00		0. 00 0. 00	0	0		20. 00 21. 00
22. 00		0.00	Ö	Ö		22. 00
23. 00		0.00	0	0		23. 00
24. 00 25. 00		0. 00 0. 00	0	0		24. 00 25. 00
26. 00		0.00	0	0		26. 00
27. 00		0.00	Ö	0		27. 00
28. 00		0.00	0	0		28. 00
29. 00		0.00	0	0		29. 00
30. 00		0.00		1, 360, 655		30. 00
	L - MISC PROPERTIES			17 0007 000		
1.00		0.00		0		1.00
	M - OP ONCOLOGY INFUSION		U	U		1
1.00	ONCOLOGY CLINIC	90.03	194, 118	17, 243		1.00
	0		194, 118	17, 243		
1. 00	P - LEGAL FEES OTHER ADMINISTRATIVE AND	5. 06	O	1, 151		1.00
1.00	GENERAL	3.00		1, 101		1.00
2.00		0.00		0		2. 00
	Q - NURSERY		0	1, 151		1
1.00	NURSERY	43.00	571, 125	54, 645		1.00
2.00		0.00	0	0		2.00
3. 00		0.00	571, 125	<u></u> 0 54, 645		3. 00
	R - OBSERVATION		37.17.120			1
1.00		0.00	0_	0		1.00
	S - EMPLOYEE BENEFITS		<u> </u>	U		1
	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	20, 010, 143		1.00
2.00		0.00	0	0		2.00
3. 00 4. 00		0. 00 0. 00	0	0		3. 00 4. 00
5. 00		0.00	o	0		5. 00
6.00		0.00	0	0		6. 00
7.00		0.00	0	0		7.00
8. 00 9. 00		0. 00 0. 00	0	0 0		8. 00 9. 00
10. 00		0.00	o	0		10.00
11.00		0.00	0	0		11. 00
12.00		0.00	0	0		12.00
13. 00 14. 00		0. 00 0. 00	0	0		13. 00 14. 00
15. 00		0.00	0	0		15. 00
16.00		0.00	0	0		16. 00
17. 00		0.00	0	0		17. 00
18. 00 19. 00		0. 00 0. 00	0	0		18. 00 19. 00
20. 00		0.00	0	0		20.00
21.00		0.00	0	0		21. 00
22. 00		0.00	0	0		22. 00
23. 00 24. 00		0. 00 0. 00	0	0		23. 00 24. 00
25. 00		0.00	o	0		25. 00
26.00		0.00	o	0		26. 00
27. 00		0.00	0	0		27. 00

In Lieu of Form CMS-2552-10

Period:
From 01/01/2017
To 12/31/2017
Date/Time Prepared:
5/24/2018 5:05 pm Health Financial Systems RECLASSIFICATIONS BALL MEMORIAL HOSPITAL Provider CCN: 15-0089

					5/24/2018 5:	
	2 1 2 1	Increases				
	Cost Center 2.00	Li ne # 3.00	Sal ary 4. 00	0ther 5.00		
28. 00	2. 00	0.00	4.00	5.00		28. 00
29. 00		0.00	0	0		29. 00
30.00		0.00	0			30. 00
31. 00		0.00	0			31. 00
32. 00 33. 00		0. 00 0. 00	0			32. 00 33. 00
34. 00		0.00	0			34.00
35. 00		0.00	0	o		35. 00
36. 00		0.00	0			36. 00
37. 00		0.00	0			37. 00
38. 00 39. 00		0. 00 0. 00	0			38. 00 39. 00
40. 00		0.00	0			40. 00
41. 00		0.00	0			41. 00
42. 00		0.00	0			42. 00
43. 00	<u> </u>	0.00	— — — ⁰	20, 010, 143		43. 00
	T - CORPORATE TELEHPONE			20,010,143		
1.00	OTHER ADMINISTRATIVE AND	5. 06	0	10, 236		1. 00
0.00	GENERAL	0.00				0.00
2. 00 3. 00		0. 00 0. 00	0	1		2. 00 3. 00
4. 00		0.00	0			4. 00
5.00		0.00	0	1		5. 00
6.00		0.00	0			6. 00
7.00		0.00	0	0		7. 00
8. 00	<u> </u>	0.00	0	10, 236		8. 00
	U - DEPRECIATION			10,200		
1.00	NEW CAP REL COSTS-BLDG &	1. 00	0	17, 761, 971		1. 00
2. 00	FLXT	0.00	0	0		2. 00
3.00		0.00	0	1		3. 00
4.00		0.00	0			4. 00
5.00		0.00	0			5. 00
6.00		0.00	0			6. 00
7. 00 8. 00		0. 00 0. 00	0			7. 00 8. 00
9. 00		0.00	0			9. 00
10.00		0.00	0	o		10.00
11. 00		0.00	0			11. 00
12.00		0.00	0			12.00
13. 00 14. 00		0. 00 0. 00	0			13. 00 14. 00
15. 00		0.00	0			15. 00
16. 00		0.00	0	0		16. 00
17. 00		0.00	0			17. 00
18. 00 19. 00		0. 00 0. 00	0			18. 00 19. 00
20. 00		0.00	0			20. 00
21. 00		0.00	0			21. 00
22. 00		0.00	0	0		22. 00
23. 00		0.00	0			23. 00
24. 00 25. 00		0. 00 0. 00	0			24. 00 25. 00
26. 00		0.00	0			26. 00
27. 00		0.00	0			27. 00
28. 00		0.00	0			28. 00
29. 00		0.00	0			29. 00
30. 00 31. 00		0. 00 0. 00	0			30. 00 31. 00
32. 00		0.00	0			32.00
33.00		0.00	0	0		33. 00
34.00		0.00	0	0		34.00
35. 00		0.00	0			35. 00
36. 00 37. 00		0. 00 0. 00	0			36. 00 37. 00
38. 00		0.00	0			38. 00
39.00		0.00	0	0		39. 00
40. 00		0.00	0			40. 00
41. 00		0.00	0			41.00
42. 00	<u> </u>	0.00	0	17, 761, 971		42. 00
	ľ	ı l	U	11,101,711		Į.

Peri od: From 01/01/2017 To 12/31/2017 Date/Time Prepared: 5/24/2018 5:05 pm

					5/24/2018 5:0	15 pm
	Cost Contor	Increases	Calamy	O+box		
	Cost Center 2.00	Li ne # 3.00	Sal ary 4.00	0ther 5.00		
	V - LEASE EXPENSE	3.00	4.00	5.00		
1.00	NEW CAP REL COSTS-BLDG &	1.00	0	1, 397, 071		1. 00
1.00	FIXT	1.00	٥	1, 377, 071		1.00
2.00		0.00	О	0		2. 00
3.00		0.00	o	0		3. 00
4.00		0.00	0	0		4.00
5.00		0.00	o	0		5.00
6.00		0.00	o	0		6.00
7.00		0.00	О	0		7. 00
8.00		0.00	О	0		8.00
9.00		0.00	О	0		9.00
	0 — — — — —			1, 397, 071		
	W - PTO USED AS STD	<u> </u>				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	215		1.00
2.00	COMMUNI CATI ONS	5. 01	О	12, 038		2.00
3.00	ADMI TTI NG	5. 04	0	4, 083		3.00
4.00	OTHER ADMINISTRATIVE AND	5. 06	0	7, 378		4.00
	GENERAL					
5.00	MAINTENANCE & REPAIRS	6. 00	0	395		5.00
6.00	OPERATION OF PLANT	7. 00	0	1, 794		6. 00
7. 00	HOUSEKEEPI NG	9. 00	0	12, 916		7. 00
8.00	DI ETARY	10. 00	0	14, 522		8.00
9.00	NURSING ADMINISTRATION	13. 00	0	25, 610		9. 00
10. 00	PHARMACY	15. 00	0	13, 417		10. 00
11. 00	ADULTS & PEDIATRICS	30. 00	0	164, 047		11. 00
12.00	INTENSIVE CARE UNIT	31. 00	0	67, 245		12.00
13.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	13, 557		13.00
14.00	SUBPROVI DER - I RF	41. 00	0	7, 861		14. 00
15. 00	OPERATING ROOM	50.00	0	24, 153		15. 00
16.00	RECOVERY ROOM	51. 00	0	9, 323		16. 00
17. 00	DELIVERY ROOM & LABOR ROOM	52. 00	0	10, 688		17. 00
18. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	48, 941		18. 00
19. 00	EKG AND EEG	57. 00	0	1, 215		19. 00
20.00	RESPIRATORY THERAPY	65.00	0	2, 592		20.00
21. 00	SLEEP LAB	65. 01	0	4, 502		21. 00
22. 00	PHYSI CAL THERAPY	66.00	0	26, 438		22. 00
23. 00	OCCUPATI ONAL THERAPY	67. 00	0	1, 050		23. 00
24. 00	SPEECH PATHOLOGY	68. 00	0	7, 874		24. 00
25. 00	ELECTROCARDI OLOGY	69. 00	0	10, 225		25. 00
26. 00	HYPERBARIC OXYGEN THERAPY	76. 98	0	2, 077		26. 00
27. 00	PAIN CLINIC	90. 02	0	466		27. 00
28. 00	ONCOLOGY CLINIC	90. 03	0	1, 503		28. 00
29. 00	EMERGENCY	91. 00	0	24, 898		29. 00
30.00	AMBULANCE SERVICES	95. 00	0	786		30. 00
31. 00	GIFT, FLOWER, COFFEE SHOP &	190. 00	0	1, 306		31. 00
	CANTEEN					
32. 00	RESEARCH	191. 00	0	6, 719		32. 00
33. 00	THERAPIES TO OTHER ENTITIES	<u> </u>	•	2,047		33. 00
	0		0	531, 881		
	X - WASTE DI SPOSAL	7 00	al	077 077		
1.00	OPERATION OF PLANT	7. 00	0	277, 977		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5. 00
6.00		0.00	0	0		6. 00
7.00		0.00	0	0		7. 00
8.00		0.00	0	0		8. 00
9.00		0.00	0	0		9. 00
10. 00		0.00	4	0		10. 00
	V UTILLITIES		0	277, 977		
1 00	Y - UTILITIES			F/C / C-		4 00
1.00	OPERATION OF PLANT	7. 00	0	562, 683		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6. 00
7.00		0.00	0	0		7. 00
8.00		0.00	0	0		8. 00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11. 00		0.00		0		11. 00
	0	I_	0	562, 683		

Health Financial Systems

BALL MEMORIAL HOSPITAL

Provider CCN: 15-0089
Period:
From 01/01/2017
To 12/31/2017
Prepared:

					5/24/2018 5:0	epared: 05 pm
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3.00	4.00	5. 00		
	Z - BLACKFORD					
1.00		0.00	0	0		1. 00
	0		0	0		
	AA - INTEREST EXPENSE					
1.00	NEW CAP REL COSTS-BLDG &	1. 00	0	1, 397		1. 00
	FI XT					
2.00		0. 00	0	0		2. 00
3.00		0.00	•	0		3. 00
	0		0	1, 397		
	AB - PARAMEDICAL EDUCATION					
1.00	PARAMED ED PRGM	23. 00	67, 176	<u>5, 1</u> 39		1. 00
	TOTALS		67, 176	5, 139		_
	AC - PROPERTY TAX					
1. 00	NEW CAP REL COSTS-BLDG &	1. 00	0	556, 750		1. 00
	FIXT					
2.00		0.00	0	0		2. 00
	TOTALS		0	556, 750		
500. 00	Grand Total: Increases		5, 926, 961	105, 748, 835		500.00

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0089

						From 01/01/2017 To 12/31/2017	Date/Time Prep	
		Decreases					5/24/2018 5: 05	j pm
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.			
	6. 00	7. 00	8.00	9. 00	10. 00			
1. 00	A - NON-BILLABLE SUPPLIES EMPLOYEE BENEFITS DEPARTMENT	4.00	O	3, 449				1. 00
2.00	COMMUNI CATI ONS	5. 01	Ö	28				2. 00
3.00	ADMI TTI NG	5. 04	0	32, 374	(3. 00
4. 00 5. 00	MAINTENANCE & REPAIRS OPERATION OF PLANT	6. 00 7. 00	0	31, 897 724				4. 00 5. 00
6. 00	HOUSEKEEPI NG	9. 00	0	139, 293				6. 00
7. 00	DI ETARY	10.00	O	8, 313				7. 00
8.00	NURSI NG ADMI NI STRATI ON	13. 00	0	3, 057				8. 00
9. 00 10. 00	PHARMACY I &R SERVICES-OTHER PRGM	15. 00 22. 00	0	158, 290 1, 465				9. 00 10. 00
10.00	COSTS APPRVD	22.00	o o	1, 403				10.00
11.00	ADULTS & PEDIATRICS	30. 00	0	1, 984, 653	(11.00
12.00	INTENSIVE CARE UNIT	31.00	0	842, 162				12.00
13. 00 14. 00	NEONATAL INTENSIVE CARE UNIT	35. 00 41. 00	0	117, 657 46, 703)		13. 00 14. 00
15. 00	OPERATING ROOM	50.00	ő	3, 462, 739				15. 00
16.00	RECOVERY ROOM	51.00	0	182, 197				16.00
17. 00	DELIVERY ROOM & LABOR ROOM	52.00	0	203, 435				17. 00
18. 00 19. 00	RADI OLOGY-DI AGNOSTI C EKG AND EEG	54. 00 57. 00	0	543, 205 3, 963				18. 00 19. 00
20. 00	RESPIRATORY THERAPY	65. 00	o	284, 178				20. 00
21. 00	SLEEP LAB	65. 01	0	45, 370				21. 00
22. 00	PHYSI CAL THERAPY	66.00	0	39, 043				22. 00
23. 00 24. 00	OCCUPATI ONAL THERAPY SPEECH PATHOLOGY	67. 00 68. 00	0	18, 779 1, 205				23. 00 24. 00
25. 00	ELECTROCARDI OLOGY	69. 00	o	21, 281				25. 00
26.00	HOSPITAL BASED RETAIL	73. 01	0	563	(26. 00
27.00	PHARMACI ES	74.00		10.015				27.00
27. 00 28. 00	RENAL DIALYSIS CARDIAC REHABILITATION	74. 00 76. 97	0	18, 815 8, 689				27. 00 28. 00
29. 00	HYPERBARI C OXYGEN THERAPY	76. 98	ő	97, 851				29. 00
30.00	PAIN CLINIC	90. 02	0	91, 246				30.00
31.00	ONCOLOGY CLINIC	90. 03	0	181, 775				31.00
32. 00 33. 00	EMERGENCY AMBULANCE SERVICES	91. 00 95. 00	0	1, 062, 846 56, 360				32. 00 33. 00
34. 00	GIFT, FLOWER, COFFEE SHOP &	190.00	o	1, 277				34. 00
	CANTEEN							
35. 00 36. 00	RESEARCH PAVILLION PHARMACY	191. 00 194. 02	0	652 2, 877	(35. 00 36. 00
37. 00	WELLNESS CENTER	194. 02	o	246				37. 00
38. 00	IU HEALTH HOSPICE	194. 11	О	183	(38. 00
39.00	CANCER CENTER BOUTIQUE	194. 23	0	753				39.00
40. 00	CARDI NAL BEHAVI ORAL HEALTH	1 <u>94.</u> 25	0	2 <u>2</u> 9, 699, 615		<u>)</u>		40. 00
	B - BILLABLE SUPPLIES		<u> </u>	7, 077, 010				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	5				1. 00
2. 00 3. 00	ADMITTING OTHER ADMINISTRATIVE AND	5. 04 5. 06	0	40 1, 939))		2. 00 3. 00
3.00	GENERAL	5.00	o o	1, 939		1		3.00
4.00	MAINTENANCE & REPAIRS	6. 00	0	461	(4. 00
5.00	NURSING ADMINISTRATION	13.00	0	157				5.00
6. 00 7. 00	CENTRAL SERVICES & SUPPLY PHARMACY	14. 00 15. 00	0	134, 008 6, 687				6. 00 7. 00
8. 00	I&R SERVICES-OTHER PRGM	22. 00	0	517				8. 00
	COSTS APPRVD							
9.00	ADULTS & PEDIATRICS	30.00	0	20, 800				9.00
10. 00 11. 00	INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT	31. 00 35. 00	0	82, 929 11, 020				10. 00 11. 00
12. 00	SUBPROVI DER - I RF	41.00	ő	484				12. 00
13.00	OPERATING ROOM	50.00	0	2, 716, 675	(13.00
14.00	RECOVERY ROOM	51.00	0	168				14.00
15. 00 16. 00	DELIVERY ROOM & LABOR ROOM RADIOLOGY-DIAGNOSTIC	52. 00 54. 00	0	99, 028 2, 823, 330		ار		15. 00 16. 00
17. 00	CARDI AC CATHETERI ZATI ON	59. 00	o	3, 749, 967				17. 00
18. 00	RESPI RATORY THERAPY	65. 00	O	265	(18. 00
19.00	PHYSI CAL THERAPY	66.00	0	4, 245				19.00
20. 00 21. 00	RENAL DI ALYSIS	69. 00 74. 00	0	93, 312 605		ار		20. 00 21. 00
22. 00	CARDIAC REHABILITATION	76. 97	ol	77		o		22. 00
23. 00	HYPERBARIC OXYGEN THERAPY	76. 98	0	222, 484	(23. 00
24. 00	PAIN CLINIC	90.02	0	612				24. 00
25. 00 26. 00	EMERGENCY AMBULANCE SERVICES	91. 00 95. 00	0	35, 709 1, 448) 		25. 00 26. 00
		75. 00	<u> </u>	1, 740	1	-1		

Date/Ti me	Prepared:
5/24/2018	F. OF nm

		Doorsoos				5/24/2018 5:	05 pm
	Coat Conton	Decreases	Coloru	0+box	Wkat A 7 Daf	1	
	Cost Center 6.00	Li ne # 7.00	Sal ary 8.00	0ther 9.00	Wkst. A-7 Ref. 10.00		
	0.00	7.00	8.00	10, 006, 972			_
	C - IMPLANTABLE DEVICES		<u> </u>	10,000,772			
1. 00	OTHER ADMINISTRATIVE AND	5. 06	0	164	0		1.00
	GENERAL	0.00	Ĭ				
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	216	0		2. 00
3.00	PHARMACY	15. 00	0	30	0		3. 00
4.00	ADULTS & PEDIATRICS	30.00	0	429	0		4. 00
5.00	INTENSIVE CARE UNIT	31.00	0	818	0		5. 00
6.00	OPERATING ROOM	50.00	0	9, 342, 155	0		6. 00
7.00	DELIVERY ROOM & LABOR ROOM	52.00	0	3, 398	0		7. 00
8.00	RADI OLOGY-DI AGNOSTI C	54.00	0	611, 025	0		8. 00
9.00	CARDIAC CATHETERIZATION	59.00	0	3, 863, 197	0		9. 00
10.00	PHYSI CAL THERAPY	66.00	0	20	0		10.00
11. 00	OCCUPATI ONAL THERAPY	67.00	0	137	0	l .	11. 00
12.00	SPEECH PATHOLOGY	68. 00	0	298	0		12. 00
13.00	CARDIAC REHABILITATION	76. 97	0	254		l .	13. 00
14.00	PAIN CLINIC	90. 02	0	60		l .	14. 00
15. 00	EMERGENCY	91.00	0	2 <u>2, 3</u> 15			15. 00
	0		0	13, 844, 516			_
	D - BILLABLE DRUGS	1	_1		_		4
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	59, 475		ł czaracza w czaracza	1.00
2.00	ADMITTING	5. 04	0	106		ł czaracza w czaracza	2. 00
3. 00	OTHER ADMINISTRATIVE AND	5. 06	0	77	0		3. 00
4 00	GENERAL DEPARTS	, 00	0	100			4 00
4.00	MAINTENANCE & REPAIRS	6.00	0	199		l .	4. 00
5.00	NURSI NG ADMI NI STRATI ON	13.00	0	35		l .	5. 00
6.00	PHARMACY	15.00	0	26, 331, 568 208, 842	0	l .	6.00
7. 00 8. 00	ADULTS & PEDIATRICS	30.00	0	•	_	l .	7.00
9. 00	INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT	31. 00 35. 00	0	55, 310 6, 877	0	l .	8. 00 9. 00
10. 00	SUBPROVIDER - IRF	41.00	0	3, 206	_	l .	10.00
11. 00	OPERATING ROOM	50.00	o	223, 762	0	l .	11.00
12. 00	RECOVERY ROOM	51.00	o	40, 071	0	l .	12. 00
13. 00	DELIVERY ROOM & LABOR ROOM	52.00	0	20, 080	0	l .	13. 00
14. 00	RADI OLOGY-DI AGNOSTI C	54.00	o	708, 158	_	l .	14. 00
15. 00	EKG AND EEG	57.00	o	3	0	l .	15. 00
16. 00	CARDIAC CATHETERIZATION	59.00	o	69, 997	_	l .	16.00
17. 00	RESPIRATORY THERAPY	65.00	o	5, 212	0	l .	17. 00
18. 00	PHYSI CAL THERAPY	66.00	0	414	_	l .	18. 00
19. 00	OCCUPATI ONAL THERAPY	67.00	o	34		l .	19. 00
20. 00	ELECTROCARDI OLOGY	69.00	0	5, 436			20.00
21. 00	RENAL DI ALYSI S	74.00	0	39, 300	0	l .	21. 00
22. 00	CARDIAC REHABILITATION	76. 97	o	4	0	l .	22. 00
23. 00	HYPERBARI C OXYGEN THERAPY	76. 98	o	34, 567	0		23. 00
24.00	PAIN CLINIC	90. 02	0	251, 168	0		24. 00
25.00	ONCOLOGY CLINIC	90. 03	0	29, 109			25. 00
26.00	EMERGENCY	91.00	0	157, 906			26. 00
27. 00	AMBULANCE SERVICES	95.00	0	13, 035	0		27. 00
28.00	RESEARCH	191.00	0	26	0		28. 00
29.00	CARDINAL BEHAVIORAL HEALTH	194. 25	0	127	0		29. 00
	0			28, 264, 104			
	E - INTERN & RESIDENT SALARIE						4
1.00	I&R SERVICES-OTHER PRGM	22. 00	3, 732, 024	0	0		1. 00
	COSTS APPRVD						
	0		3, 732, 024	0			4
4.05	F - CAFETERIA			00= -			4
1. 00	DI ETARY	1000	<u>1, 184, 318</u>	997, 094			1. 00
	C DHADMACY ADMIN COSTS		1, 184, 318	997, 094			-
1.00	G - PHARMACY ADMIN COSTS HOSPITAL BASED RETAIL	73. 01	37, 320	7, 052	0		1. 00
1.00	PHARMACIES	73.01	37, 320	7,032	0		1.00
2.00	FHARMACIES	0.00	0	0	0		2. 00
2.00	<u> </u>		37, 320				2.00
	H - AUTO & BUILDING INSURANCE	<u> </u>	0., ===1	.,, .,.	<u>I</u>	I	
1.00	OTHER ADMINISTRATIVE AND	5. 06	0	370, 382	12		1.00
	GENERAL		٦	2.2,302			
				370, 382			
	I - REHAB ADMIN COSTS						
1.00	PHYSI CAL THERAPY	66.00	140, 880	10, 158	0		1.00
2.00		0.00	0	0	0		2. 00
3.00	<u> </u>	0.00	0	0	0		3. 00
	0		140, 880	10, 158			

Peri od: From 01/01/2017 To 12/31/2017 Date/Time Prepared: 5/24/2018 5:05 pm

		Decreases				5/24/2018 5:0)5 pm
	Cost Center	Li ne #	Salary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8.00	9. 00	10.00		
	J - LAUNDRY						
1.00	ADMITTING	5. 04	0	3, 557	0		1.00
2.00	OTHER ADMINISTRATIVE AND	5. 06	0	523	0		2. 00
3.00	GENERAL MAINTENANCE & REPAIRS	6. 00	0	22	o		3. 00
4.00	HOUSEKEEPI NG	9. 00	o	224, 295			4. 00
5. 00	DI ETARY	10.00	o	15, 759			5. 00
6.00	CENTRAL SERVICES & SUPPLY	14. 00	O	446, 503			6. 00
7.00	ADULTS & PEDIATRICS	30.00	0	292, 016	0		7. 00
8.00	INTENSIVE CARE UNIT	31.00	0	56, 261	0		8. 00
9.00	NEONATAL INTENSIVE CARE UNIT	35. 00	0	6, 857	0		9. 00
10.00	SUBPROVI DER – I RF	41. 00	0	14, 918			10.00
11.00	OPERATING ROOM RECOVERY ROOM	50.00	0	52, 980	0		11.00
12. 00 13. 00	DELIVERY ROOM & LABOR ROOM	51. 00 52. 00	0	13, 741 24, 592			12. 00 13. 00
14. 00	RADI OLOGY-DI AGNOSTI C	54.00	o	47, 695			14. 00
15. 00	EKG AND EEG	57. 00	o	12			15. 00
16.00	CARDIAC CATHETERIZATION	59. 00	О	8, 445	o		16. 00
17. 00	RESPIRATORY THERAPY	65.00	0	404			17. 00
18. 00	SLEEP LAB	65. 01	0	20, 705	1		18. 00
19. 00	PHYSI CAL THERAPY	66.00	0	16, 846	1		19.00
20. 00 21. 00	ELECTROCARDI OLOGY RENAL DI ALYSI S	69. 00 74. 00	0	8, 128	1		20. 00 21. 00
22. 00	CARDIAC REHABILITATION	74.00 76.97	0	1, 188 75			22.00
23. 00	PAIN CLINIC	90. 02	o	8, 263			23. 00
24. 00	ONCOLOGY CLINIC	90. 03	o	23	1		24. 00
25. 00	EMERGENCY	91.00	О	87, 936			25. 00
26. 00	PAVILLION PHARMACY	194. 02	0	8	0		26. 00
27. 00	WELLNESS CENTER	194. 05	0	8, 827	0		27. 00
28. 00	RENTAL PROPERTY	194. 08	0	28			28. 00
29. 00	I U HEALTH HOSPI CE	194. 11	0	20			29. 00
30. 00	CANCER CENTER BOUTIQUE	194. 23		28 1, 360, 655			30. 00
	L - MISC PROPERTIES		<u> </u>	1, 300, 033			
1.00		0.00	0	0	0		1. 00
	0		0	0			
1 00	M - OP ONCOLOGY INFUSION	30.00	194, 118	17 242			1 00
1. 00	ADULTS & PEDIATRICS	30.00	194, 118	1 <u>7, 2</u> 43 17, 243			1. 00
	P - LEGAL FEES		1717110	.,, 2.10	ll		1
1.00	PHARMACY	15. 00	0	757	0		1.00
2.00	PHYSICAL THERAPY	66.00	0		0		2. 00
	0 AUDOEDV		0	1, 151			-
1.00	Q - NURSERY ADULTS & PEDIATRICS	30.00	539, 762	51, 615	O		1.00
2.00	NEONATAL INTENSIVE CARE UNIT	35. 00	252	31, 013	1		2.00
3. 00	DELIVERY ROOM & LABOR ROOM	52.00	31, 111	2, 995			3.00
	0 = = = = = =		571, 125	54, 645			
	R - OBSERVATION						
1. 00		0.00	•	0			1.00
	S - EMPLOYEE BENEFITS		0	0			1
1.00	COMMUNI CATIONS	5. 01	0	189, 790	O		1.00
2.00	ADMI TTI NG	5. 04	O	215, 563			2. 00
3.00	OTHER ADMINISTRATIVE AND	5. 06	0	599, 357	O		3. 00
	GENERAL						
4.00	MAINTENANCE & REPAIRS	6. 00	0	709, 014			4. 00
5.00	OPERATION OF PLANT	7. 00 9. 00	0	184, 328 962, 929			5.00
6. 00 7. 00	HOUSEKEEPI NG DI ETARY	10. 00	0	684, 471			6. 00 7. 00
8. 00	NURSING ADMINISTRATION	13. 00	o	1, 103, 740			8.00
9. 00	PHARMACY	15. 00	o	834, 303			9. 00
10.00	I&R SERVICES-OTHER PRGM	22. 00	О	802, 944			10.00
	COSTS APPRVD						
11.00	PARAMED ED PRGM	23. 00	0	8, 645			11.00
12.00	ADULTS & PEDIATRICS	30.00	0	3, 933, 477			12.00
13. 00 14. 00	INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT	31. 00 35. 00	0	1, 228, 666 369, 212			13. 00 14. 00
15. 00	SUBPROVIDER - IRF	41. 00	0	264, 620			15. 00
16. 00	OPERATING ROOM	50.00	o	978, 828	1		16. 00
17. 00	RECOVERY ROOM	51. 00	o	230, 934			17. 00
18. 00	DELIVERY ROOM & LABOR ROOM	52. 00	О	372, 515	o		18. 00
19. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	1, 449, 086			19. 00
20. 00	EKG AND EEG	57. 00	0	40, 751	0		20. 00

Peri od: From 01/01/2017 To 12/31/2017

Date/Time Prepared: 5/24/2018 5:05 pm

		D				5/24/2018 5:	US PIII
		Decreases				I	
	Cost Center	Li ne #	Sal ary		Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
21. 00	CARDI AC CATHETERI ZATI ON	59. 00	0	297, 794	0		21. 00
22.00	RESPIRATORY THERAPY	65. 00	0	448, 034	0		22. 00
23.00	SLEEP LAB	65. 01	0	113, 721	0		23. 00
24.00	PHYSI CAL THERAPY	66.00	0	925, 945	0		24. 00
25. 00	OCCUPATI ONAL THERAPY	67. 00	0	138, 122	0	l	25. 00
26. 00	SPEECH PATHOLOGY	68. 00	Ö	1	0	l	26. 00
	1		0				4
27. 00	ELECTROCARDI OLOGY	69. 00	U	310, 446	0		27. 00
28. 00	HOSPITAL BASED RETAIL	73. 01	0	277, 688	0		28. 00
	PHARMACI ES						
29. 00	CARDIAC REHABILITATION	76. 97	0	131, 724	0	l e	29. 00
30.00	HYPERBARIC OXYGEN THERAPY	76. 98	0	97, 605	0		30.00
31.00	PAIN CLINIC	90. 02	0	109, 933	0		31.00
32. 00	ONCOLOGY CLINIC	90. 03	0	1	0	l e	32. 00
33. 00	EMERGENCY	91.00	0	901, 585	0		33. 00
	1		0				4
34.00	AMBULANCE SERVICES	95.00	U	252, 171	0		34. 00
35. 00	GIFT, FLOWER, COFFEE SHOP &	190. 00	Ü	39, 501	0		35. 00
	CANTEEN						
36. 00	RESEARCH	191. 00	0	125, 878	0		36. 00
37.00	BSU PHARMACY	194. 01	0	41, 500	0		37. 00
38.00	PAVILLION PHARMACY	194. 02	0	105, 743	0		38. 00
39.00	WELLNESS CENTER	194. 05	0	22, 563	0		39. 00
40. 00	JAY COUNTY HOSPITAL	194. 16	0	22, 001	0		40. 00
41. 00		194. 22	0		0		41. 00
	THERAPIES TO OTHER ENTITIES		U				1
42. 00	CANCER CENTER BOUTIQUE	194. 23	Ü	1, 104	0		42. 00
43.00	BLACKFORD COMMUNITY HOSPITAL	1 <u>94.</u> 26	0	<u> </u>	0		43. 00
	0		0	20, 010, 143			
	T - CORPORATE TELEHPONE						
1.00	ADMI TTI NG	5. 04	0	17	0		1.00
2.00	INTENSIVE CARE UNIT	31. 00	0	•	0	l e e e e e e e e e e e e e e e e e e e	2. 00
3. 00	NEONATAL INTENSIVE CARE UNIT	35.00	0	93	0	l e e e e e e e e e e e e e e e e e e e	3. 00
			0		0		1
4.00	OPERATING ROOM	50.00	0	326	0		4. 00
5.00	DELIVERY ROOM & LABOR ROOM	52. 00	0	595	0		5. 00
6.00	RADI OLOGY-DI AGNOSTI C	54. 00	0	679	0		6. 00
7.00	CARDIAC CATHETERIZATION	59. 00	0	760	0		7. 00
8.00	EMERGENCY	91.00	0	6, 261	0		8. 00
		1					
	U - DEPRECIATION			•	I.		1
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1, 887	9		1.00
2.00	ADMITTING	5. 04	0	1	0	l l	2. 00
3. 00	OTHER ADMINISTRATIVE AND		0	1	-	l I	3. 00
3.00	I I	5. 06	U	303, 103	U		3.00
	GENERAL	, , ,					
4.00	MAINTENANCE & REPAIRS	6. 00	0	1 -, ,	0		4. 00
5.00	OPERATION OF PLANT	7. 00	0	502, 171	0		5. 00
6.00	HOUSEKEEPI NG	9. 00	0	7, 005	0		6. 00
7.00	DI ETARY	10.00	0	92, 327	0		7. 00
8.00	NURSING ADMINISTRATION	13. 00	0	130, 797	0		8. 00
9.00	CENTRAL SERVICES & SUPPLY	14.00	0	54, 481	0		9. 00
10. 00	PHARMACY	15. 00	0	1	0		10.00
			0			l	1
11.00	I &R SERVICES-OTHER PRGM	22. 00	U	360, 185	U		11. 00
	COSTS APPRVD		_		_		
12. 00	ADULTS & PEDIATRICS	30. 00	0		0	l e	12. 00
13.00	INTENSIVE CARE UNIT	31. 00	0		0	l e e e e e e e e e e e e e e e e e e e	13. 00
14.00	NEONATAL INTENSIVE CARE UNIT	35. 00	0	80, 542	0		14. 00
15.00	SUBPROVI DER - I RF	41. 00	0	20, 202	0		15. 00
16.00	OPERATING ROOM	50.00	0	1, 460, 294	0		16. 00
17. 00	RECOVERY ROOM	51.00	0	111, 808	0		17. 00
18. 00	DELIVERY ROOM & LABOR ROOM	52.00	Ö		0	l	18. 00
			0		0	l e e e e e e e e e e e e e e e e e e e	
19. 00	RADI OLOGY-DI AGNOSTI C	54.00	U	3, 444, 604			19. 00
20. 00	EKG AND EEG	57. 00	Ü	465	0		20. 00
21. 00	CARDIAC CATHETERIZATION	59. 00	0	,	0		21. 00
22.00	LABORATORY	60.00	0	23, 644	0		22. 00
23.00	BLOOD STORING, PROCESSING, &	63.00	0	1, 630	0		23. 00
	TRANS.						1
24.00	RESPIRATORY THERAPY	65.00	0	117, 062	0		24. 00
25. 00	SLEEP LAB	65. 01	Ö	1	0	l .	25. 00
26. 00	PHYSI CAL THERAPY	66.00	0		0	l e e e e e e e e e e e e e e e e e e e	26. 00
			0	1		l e e e e e e e e e e e e e e e e e e e	
27. 00	OCCUPATIONAL THERAPY	67.00	Ü	662	0	l e e e e e e e e e e e e e e e e e e e	27. 00
28. 00	SPEECH PATHOLOGY	68. 00	0	2, 408	0	l I	28. 00
29. 00	ELECTROCARDI OLOGY	69. 00	0	393, 393	0		29. 00
30.00	RENAL DIALYSIS	74.00	0	8, 178	0		30. 00
31.00	CARDIAC REHABILITATION	76. 97	0	4, 128	0		31. 00
32.00	HYPERBARIC OXYGEN THERAPY	76. 98	n	35, 251	0		32. 00
33. 00	PAIN CLINIC	90. 02	Ö	1		l	33. 00
34. 00	ONCOLOGY CLINIC	90. 02	0			l control of the cont	34. 00
J4. UU	ONCOLOGI CLINIC	90.03		n 5, 292	ı	<u> </u>	1 34.00

RECLASSI FI CATI ONS

Provider CCN: 15-0089

Peri od: Worksheet A-6 From 01/01/2017 To 12/31/2017 Date/Time Prepared:

5/24/2018 5:05 pm

Decreases Wkst. A-7 Ref. Cost Center Sal ary 0ther Line # 6.00 7.00 8.00 9.00 10.00 **EMERGENCY** 35.00 91.00 588.070 0 35 00 95.00 36, 00 AMBULANCE SERVICES 154, 532 0 36.00 0 GIFT, FLOWER, COFFEE SHOP & 190.00 0 3, 794 37.00 37.00 CANTEEN 191 00 38 00 RESEARCH 407 0 38 00 39.00 WELLNESS CENTER 194.05 0 32, 797 0 39.00 194.08 RENTAL PROPERTY o 40.00 166,060 0 40.00 41.00 IU HEALTH HOSPICE 194.11 0 0 41.00 17 CANCER CENTER BOUTIQUE 42.00 194.23 63 0 42.00 Ō 17, 761, 971 V - LEASE EXPENSE I&R SERVICES-OTHER PRGM 0 1.00 22.00 15.337 10 1.00 COSTS APPRVD 2.00 RADI OLOGY-DI AGNOSTI C 54.00 0 451, 046 0 2.00 3.00 LABORATORY 60.00 0 5,881 0 3.00 4.00 SLEEP LAB 65.01 0 0 164.041 4.00 329, 232 PHYSICAL THERAPY 0 5.00 66.00 0 5.00 6.00 HOSPITAL BASED RETAIL 73.01 0 89, 709 0 6.00 PHARMACI ES 7.00 ONCOLOGY CLINIC 90.03 0 14, 251 0 7.00 AMBULANCE SERVICES 8.00 8 00 95 00 0 26, 868 0 9.00 RENTAL PROPERTY 194.08 300, 706 0 9.00 1, 397, 071 W - PTO USED AS STD 1.00 EMPLOYEE BENEFITS DEPARTMENT 215 0 4.00 0 1.00 2.00 COMMUNICATIONS 5.01 12,038 0 0 2.00 0 3.00 ADMITTI NG 5.04 4,083 0 3.00 OTHER ADMINISTRATIVE AND 4.00 5.06 7, 378 0 0 4.00 GENERAL 5.00 MAINTENANCE & REPAIRS 6.00 395 0 0 5.00 OPERATION OF PLANT 1, 794 0 6.00 7.00 0 6.00 0 7.00 HOUSEKEEPI NG 9.00 12, 916 0 7.00 10.00 14, 522 0 0 8.00 DI FTARY 8.00 9.00 NURSING ADMINISTRATION 13.00 25, 610 0 0 9.00 0 10.00 PHARMACY 15.00 13, 417 0 10.00 ADULTS & PEDIATRICS 0 11 00 30.00 164 047 O 11 00 0| 0 12.00 INTENSIVE CARE UNIT 31.00 67, 245 12.00 13.00 NEONATAL INTENSIVE CARE UNIT 35.00 13, 55 0 0 13.00 14.00 SUBPROVIDER - IRF 41.00 7, 861 0 0 14.00 0 OPERATING ROOM 50 00 0 15 00 24, 153 15 00 0 16.00 RECOVERY ROOM 51.00 9, 323 0 16.00 17.00 DELIVERY ROOM & LABOR ROOM 52.00 10, 688 0 0 17.00 0 RADI OLOGY-DI AGNOSTI C 54.00 48, 941 0 18.00 18.00 lekg and eeg 57 00 1, 215 0 0 19 00 19 00 20.00 RESPIRATORY THERAPY 65.00 2, 592 0 0 20.00 SLEEP LAB 0 21.00 65.01 4, 502 0 21.00 PHYSICAL THERAPY 0 0 22.00 66, 00 26, 438 22.00 0 23.00 OCCUPATIONAL THERAPY 67.00 1,050 0 23.00 24.00 SPEECH PATHOLOGY 68.00 7,874 0 0 24.00 ELECTROCARDI OLOGY 0 25.00 69.00 10, 225 0 25.00 0 HYPERBARIC OXYGEN THERAPY 76.98 2,077 26,00 0 26,00 27.00 PAIN CLINIC 90.02 466 0 0 27.00 ONCOLOGY CLINIC 0 28.00 90.03 1,503 0 28.00 EMERGENCY 91.00 24, 898 0 29.00 0 29.00 AMBULANCE SERVICES 30 00 95.00 786 0 0 30.00 GIFT, FLOWER, COFFEE SHOP & 190.00 1, 306 0 0 31.00 31.00 CANTEEN 32.00 RESEARCH 191.00 6,719 0 32.00 33 00 THERAPIES TO OTHER ENTITIES 194.22 2, 047 0 33 00 531, 881 \cap X - WASTE DISPOSAL 1.00 NEW CAP REL COSTS-BLDG & 1.00 0 18, 720 14 1.00 FLXT MAINTENANCE & REPAIRS 2 00 20.202 6.00 0 0 2 00 3.00 HOUSEKEEPI NG 9.00 0 148, 801 0 3.00 4.00 OPERATING ROOM 50.00 o 1,079 0 4.00 RADI OLOGY-DI AGNOSTI C 0 0 5.00 54.00 378 5.00 6.00 SLEEP LAB 65.01 0 897 0 6 00 66.00 7.00 PHYSICAL THERAPY 0 304 0 7.00 8.00 HOSPITAL BASED RETAIL 73.01 0 3, 724 0 8.00 PHARMACI ES 9 00 PAIN CLINIC 90 02 0 9 00 1.068 10.00 RENTAL PROPERTY 194.08 82, 804 10.00 0 277, 977

Health Financial Systems RECLASSIFICATIONS BALL MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10

Peri od: Worksheet A-6 From 01/01/2017 To 12/31/2017 Date/Time Pres Provider CCN: 15-0089

					Т	o 12/31/2017	Date/Time Prepared: 5/24/2018 5:05 pm
		Decreases				. 1	972 17 20 10 01 00 pm
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6, 00	7. 00	8.00	9, 00	10, 00		
	Y - UTILITIES				<u> </u>		
1. 00	NEW CAP REL COSTS-BLDG & FLXT	1. 00	0	91, 853	14		1.00
2.00	MAINTENANCE & REPAIRS	6.00	O	3, 239	0		2.00
3. 00	I&R SERVICES-OTHER PRGM COSTS APPRVD	22. 00	0	100	0		3. 00
4.00	RADI OLOGY-DI AGNOSTI C	54.00	O	3, 901	0		4.00
5.00	SLEEP LAB	65. 01	O	3, 406	0		5. 00
6.00	PHYSI CAL THERAPY	66.00	O	411	0		6. 00
7.00	HYPERBARIC OXYGEN THERAPY	76. 98	O	1, 893	0		7. 00
8.00	AMBULANCE SERVICES	95.00	O	2, 465	0		8. 00
9.00	PHYSICIAN PRACTICE CLINICS	194. 06	O	11, 757	0		9. 00
10.00	RENTAL PROPERTY	194. 08	O	440, 052	0		10.00
11.00	IU HEALTH HOSPICE	194. 11	O	3, 606	0		11.00
	0 — — — — —			562, 683			
	Z - BLACKFORD						
1.00		0.00	0	0	0		1. 00
	0						
	AA - INTEREST EXPENSE						
1.00	OPERATION OF PLANT	7. 00	0	30	11		1. 00
2.00	PHARMACY	15. 00	0	1, 349	0		2. 00
3.00	AMBULANCE SERVICES	95.00	0	18			3. 00
	0		0	1, 397			
	AB - PARAMEDICAL EDUCATION						
1.00	PHARMACY	15. 00	67, 176	5, 139	0		1. 00
	TOTALS		67, 176	5, 139			
	AC - PROPERTY TAX						
1. 00	OTHER ADMINISTRATIVE AND GENERAL	5. 06	0	556, 424	13		1.00
2.00	HOSPITAL BASED RETAIL	73. 01	О	326	O		2. 00
	PHARMACI ES	+	+	556, 750	$oxed{oldsymbol{arphi}}$		
500 00	Grand Total: Decreases		6, 458, 842	105, 216, 954			500.00
500.00	pi anu rotar. Decreases	ı	0, 458, 842	100, 216, 954			500.00

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS BALL MEMORIAL HOSPITAL

Provider CCN: 15-0089

				-	Го 12/31/2017	Date/Time Prep 5/24/2018 5:09	
			<u> </u>	Acqui si ti ons			
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
						Retirements	
		1.00	2. 00	3.00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	2, 924, 410	0	(0	0	1. 00
2.00	Land Improvements	3, 630, 983	0	(0	0	2. 00
3.00	Buildings and Fixtures	268, 259, 948	0	(0	15, 513	3. 00
4.00	Building Improvements	20, 766, 697	16, 701, 884	(16, 701, 884	0	4. 00
5.00	Fixed Equipment	0	0	(0	0	5. 00
6.00	Movable Equipment	161, 188, 378	16, 070, 698	(16, 070, 698	7, 929, 461	6. 00
7.00	HIT designated Assets	0	0	(0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	456, 770, 416	32, 772, 582	(32, 772, 582	7, 944, 974	8. 00
9.00	Reconciling Items	0	0	(0	0	9. 00
10.00	Total (line 8 minus line 9)	456, 770, 416	32, 772, 582	(32, 772, 582	7, 944, 974	10.00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6.00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	2, 924, 410	0				1. 00
2.00	Land Improvements	3, 630, 983	0				2. 00
3.00	Buildings and Fixtures	268, 244, 435	0				3. 00
4.00	Building Improvements	37, 468, 581	0				4. 00
5.00	Fixed Equipment	0	0				5. 00
6.00	Movable Equipment	169, 329, 615	0				6. 00
7.00	HIT designated Assets	0	0				7. 00
8.00	Subtotal (sum of lines 1-7)	481, 598, 024	0				8. 00
9.00	Reconciling Items	0	0				9. 00
10.00	Total (line 8 minus line 9)	481, 598, 024	0				10. 00

Heal th	Financial Systems	BALL MEMORIAL HOSPITAL			In Lieu of Form CMS-2552-10		
RECONG	CILIATION OF CAPITAL COSTS CENTERS		Provi der CO		Peri od:	Worksheet A-7	
					From 01/01/2017 To 12/31/2017	Part II Date/Time Pre	pared:
						5/24/2018 5:0	
			SU	JMMARY OF CAPI	TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
					instructions)		
		9. 00	10.00	11. 00	12. 00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	NEW CAP REL COSTS-BLDG & FLXT	1, 676, 934	242, 649	2, 280, 01	1 0	0	1.00
3.00	Total (sum of lines 1-2)	1, 676, 934	242, 649	2, 280, 01	1 0	0	3. 00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
	·	Capi tal -Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)	Ů,				
		14.00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	684, 742					1.00
3.00	Total (sum of lines 1-2)	684, 742					3. 00

Health Financial Systems		BALL MEMORIAL HOSPITAL			In Lieu of Form CMS-2552-10		
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provi der CO		Peri od:	Worksheet A-7	
					From 01/01/2017 Fo 12/31/2017	Part III Date/Time Prep	nared:
						5/24/2018 5: 05	
		COMI	PUTATION OF RAT	TI 0S	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description		Capitalized	Gross Assets	Ratio (see	Insurance	
	cost center bescription	Gross Assets	Leases	for Ratio	instructions)	Trisul ance	
			Leases	(col. 1 - col.			
				2)			
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE						
1.00	NEW CAP REL COSTS-BLDG & FLXT	481, 598, 025	l .	, ,		0	1. 00
3.00	Total (sum of lines 1-2)	481, 598, 025		481, 598, 02!			3. 00
		ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL					
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Relate	cols. 5			
			d Costs	through 7)			
		6. 00	7. 00	8. 00	9. 00	10. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	ENTERS	1				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	(21, 170, 026		1. 00
3. 00	Total (sum of lines 1-2)	0	0	(21, 170, 026	-432, 263	3. 00
			SL	JMMARY OF CAPI	IAL		
	Cost Center Description	Interest	Insurance (see	,		Total (2) (sum	
			instructions)	instructions)	Capi tal -Rel ate		
					d Costs (see	through 14)	
					instructions)		
	DADT 111 DECONOLITATION OF CARLEY COOTS OF	11.00	12. 00	13. 00	14. 00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE		070.000			04 (54 044	
1.00	NEW CAP REL COSTS-BLDG & FIXT	1, 627, 507		1			1. 00
3.00	Total (sum of lines 1-2)	1, 627, 507	370, 382	556, 750	1, 361, 642	24, 654, 044	3. 00

				To	Date/Time Pre		
				Expense Classification on To/From Which the Amount is		5/24/2018 5: 0	5 piii
				TO/TTOM WITH CIT THE /WINGGITT TS	to be haj usteu		
	Cost Center Description		Amount	Cost Center		Wkst. A-7 Ref.	
1.00	Investment income - NEW CAP	1. 00 B	2. 00 -653, 901	3.00 NEW CAP REL COSTS-BLDG &	4. 00	5. 00 11	1. 00
	REL COSTS-BLDG & FLXT (chapter 2)			FIXT			
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	2. 00	0	2. 00
3.00	Investment income - other (chapter 2)		0		0.00	0	3. 00
4. 00	Trade, quantity, and time		0		0.00	0	4. 00
5. 00	discounts (chapter 8) Refunds and rebates of		0		0.00	0	5. 00
6. 00	expenses (chapter 8) Rental of provider space by		0		0.00	0	6. 00
7. 00	suppliers (chapter 8) Telephone services (pay		0		0.00	0	7. 00
	stations excluded) (chapter 21)						
8.00	Television and radio service (chapter 21)		0		0.00	0	8. 00
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	0 -919, 124		0.00	0	
	adjustment	A-0-2					
11. 00	Sale of scrap, waste, etc. (chapter 23)		0		0. 00	0	
12. 00	Related organization transactions (chapter 10)	A-8-1	18, 164, 311			0	12.00
13. 00 14. 00	Laundry and linen service Cafeteria-employees and guests	В	0 -1, 315, 188	CAFETERI A	0. 00 11. 00	0	
15. 00	Rental of quarters to employee and others		0		0.00	0	15. 00
16. 00	Sale of medical and surgical supplies to other than		0		0.00	0	16. 00
17. 00	patients Sale of drugs to other than		0		0. 00	0	17. 00
	patients		0				
18. 00	Sale of medical records and abstracts		0		0. 00	0	
19. 00	Nursing and allied health education (tuition, fees,		0		0.00	0	19. 00
20. 00	books, etc.) Vending machines		0		0.00	0	20. 00
21. 00	Income from imposition of interest, finance or penalty		0		0.00	0	21. 00
22 00	charges (chapter 21) Interest expense on Medicare		0		0. 00	0	22. 00
22.00	overpayments and borrowings to repay Medicare overpayments		, and the second		0.00	J	22.00
23. 00	Adjustment for respiratory	A-8-3	0	RESPI RATORY THERAPY	65.00		23. 00
04.00	therapy costs in excess of limitation (chapter 14)		0	DUNCH OAL THEDADY	// 00		04.00
24. 00	Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
25. 00	limitation (chapter 14) Utilization review -		0	*** Cost Center Deleted ***	114. 00		25. 00
	physicians' compensation (chapter 21)						
26. 00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT			NEW CAP REL COSTS-BLDG & FIXT	1. 00	0	26. 00
27. 00	Depreciation - CAP REL COSTS-MVBLE EQUIP			*** Cost Center Deleted ***	2. 00	0	27. 00
28. 00 29. 00	Non-physician Anesthetist Physicians' assistant		0	*** Cost Center Deleted ***	19. 00 0. 00	0	28. 00 29. 00
30. 00	Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	67. 00		30.00
20.00	therapy costs in excess of limitation (chapter 14)		•	ADULTO A DEDLATRACE	20.22		20.00
30. 99	Hospice (non-distinct) (see instructions)			ADULTS & PEDIATRICS	30. 00		30. 99
31. 00	Adjustment for speech pathology costs in excess of	A-8-3	0	SPEECH PATHOLOGY	68. 00		31.00
32. 00	limitation (chapter 14) CAH HIT Adjustment for		0		0.00	0	32. 00
	Depreciation and Interest						

From 01/01/2017

Description					To	om 01/01/2017 12/31/2017	Date/Time Prep	
Cost Center Description Spit M/Code (2) Appoint Cost Center Line # Most A-7 Ref.							372472018 5.03	3 pili
1.00 2.03 3.00 M. SCELLANEOUS INCOME 8 -2.071, 99 NRY CAP RELATED 8 1.00 0 3.00					To/From Which the Amount is 1 	to be Adjusted		
1.00 2.00 3.00 4.00 5.00								
1.00 2.00 3.00 M. SCELLANEOUS INCOME								
10 10 10 10 10 10 10 10		Cost Center Description						
1.0 MI SCELLANEOUS INCOME 8	33. 00	MISCELLANEOUS INCOME						33. 00
1.00 MI SCELLARGOUS INCOME B -116, 6500 CAMAUNICATIONS 5 01 0 35,00 0 35					FIXT			
30.00 MI SCELLARGUS INCOME B -29, 355/AMITTIN KO 5.04 0.30, 00 37.00 37.00 MI SCELLARGUS INCOME B -2,51, 190/DITHER NUMERISTRATIVE AND 5.06 0.37.00 37.00 38.00		1						
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45.07 MISCELLANEOUS INCOME B -1,562,232]PHYSICAL THERAPY 67.00 0.45,07							-	
45.00 M SCELLANEOUS NCOME B -53, 780 SPEECH PATHOLOGY 69, 00 0 45, 00 65, 10 M SCELLANEOUS NCOME B -84, 109 LECTROCARD 0.00 0 45, 11 PHARMACIES 73, 01 0 45, 12 PHARMACIES 73, 01 PHARMACIES 74, 01		1						
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45. 14 MISCELLANEOUS INCOME B -1.2, 324 AMBULANCE SERVI CES 95. 00 0 45. 14		1			1			
45.15 NON-ALLOWABLE MARKETING A -1,593, 238 OTHER ADMINI STRATIVE AND GENERAL CORPORATE TELEPHONE A -10,236 OTHER ADMINI STRATIVE AND 5.06 0 45.16		1					0	
A5. 16 NON-ALLOWABLE MARKETING A -44 SLEEP LAB 65. 01 0 45. 16		1	1				Ö	
45. 17 CORPORATE TELEPHONE A					1		_	
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45. 23 NON-ALLOWABLE MARKETING A -100 NURSING ADMINISTRATION 13. 00 0 45. 23 45. 24 LOSS ON EXTINGUISHMENT OF DEBT CARRY 1.00 14 45. 24 787, 473 NEW CAP REL COSTS-BLDG & 1. 00 14 45. 24 65. 24 65. 25 MI SCELLANEOUS I NCOME B -258, 294 BSU PHARMACY 194. 01 0 45. 25 45. 26 MI SCELLANEOUS I NCOME B -7, 066 IU HEALTH HOSPI CE 194. 11 0 45. 26 45. 27 MI SCELLANEOUS I NCOME B -2, 119RESEARCH 191. 00 0 45. 27 45. 28 MI SCELLANEOUS I NCOME B -1, 038, 889 THERAPI ES TO OTHER ENTITIES 194. 22 0 45. 28 45. 29 MI SCELLANEOUS I NCOME B -2, 119PI NTENSI VE CARE UNIT 31. 00 0 45. 30 MI SCELLANEOUS I NCOME B -21, 197I NTENSI VE CARE UNIT 31. 00 0 45. 30 MI SCELLANEOUS I NCOME B -21, 230 RECOVERY ROOM 51. 00 0 45. 30 MI SCELLANEOUS I NCOME B -22, 236 RECOVERY ROOM 51. 00 0 45. 31 45. 32 MI SCELLANEOUS I NCOME B -22, 236 RECOVERY ROOM 51. 00 0 45. 32 45. 33 MI SCELLANEOUS I NCOME B -10, 213 NEONATAL I NTENSI VE CARE UNIT 35. 00 0 45. 32 45. 33 MI SCELLANEOUS I NCOME B -22, 236 RECOVERY ROOM 51. 00 0 45. 34 45. 35 MI SCELLANEOUS I NCOME B -180, 421 BLACKFORD COMMUNITY HOSPITAL 194. 26 0 45. 34 45. 35 MI SCELLANEOUS I NCOME B -180, 421 BLACKFORD COMMUNITY HOSPITAL 194. 26 0 45. 35 45. 36 MI SCELLANEOUS I NCOME B -276 SUBPROVI DER -1 RF 41. 00 0 45. 35 45. 36 MI SCELLANEOUS I NCOME B -276 SUBPROVI DER -1 RF 41. 00 0 45. 36 45. 36 MI SCELLANEOUS I NCOME B -276 SUBPROVI DER -1 RF 41. 00 0 45. 36 45. 36 MI SCELLANEOUS I NCOME B -276 SUBPROVI DER -1 RF 41. 00 0 45. 36 45. 36 MI SCELLANEOUS I NCOME B -276 SUBPROVI DER -1 RF 41. 00 0 45. 36 45. 36 MI SCELLANEOUS I NCOME B -276 SUBPROVI DER -1 RF 41. 00 0 45. 36 45. 36 MI SCELLANEOUS I NCOME B -276 SUBPROVI DER -1 RF 41. 00 0 45. 36 45. 36 MI SCELLANEOUS I NCOME B -276 SUBPROVI DER -1 RF 41. 00 0 45. 36 45. 36 MI SCELLANEOUS I NCOME B -276 SUBPROVI DER -1 RF 41. 00 0 45. 36 45. 36 MI SCELLANEOUS I NCOME B -276 SUBPROVI DER -1 RF 41. 00 0 45. 36 45. 36 MI SCELLANEOUS I NCOME B -276 SUBPROVI DER -1 RF 41. 00 0 45. 36 MI SCELLANEOUS I NCOME B -276 SUBPROVI DER -1 RF 41. 00 0 45. 38 MI SCELLA	45. 22	PTO ACCRUAL	A	-378, 914		5. 06	0	45. 22
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45. 32 MI SCELLANEOUS I NCOME 45. 33 MI SCELLANEOUS I NCOME 45. 34 MI SCELLANEOUS I NCOME 45. 35 MI SCELLANEOUS I NCOME 45. 36 MI SCELLANEOUS I NCOME 45. 37 MI SCELLANEOUS I NCOME 45. 38 NON-ALLOWABLE MARKETING 45. 38 NON-ALLOWABLE MARKETING 45. 39 NON-ALLOWABLE PATIENT 45. 30 NON-ALLOWABLE PATIENT 46. 30 NON-ALLOWABLE PATIENT 47. 30 NON-ALLOWABLE PATIENT 48. 30 NON-ALLOWABLE PATIENT 49. 30 NON-ALLOWABLE PATIENT 49		1					· ·	
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45. 34 MI SCELLANEOUS INCOME B -180, 421 BLACKFORD COMMUNITY HOSPITAL 194. 26 0 45. 34 45. 35 MI SCELLANEOUS INCOME B -276 SUBPROVIDER - IRF 41. 00 0 45. 35 45. 36 MI SCELLANEOUS INCOME B -27, 078 RESPIRATORY THERAPY 65. 00 0 45. 36 45. 37 MI SCELLANEOUS INCOME B -3, 474 HYPERBARIC OXYGEN THERAPY 76. 98 0 45. 37 45. 38 NON-ALLOWABLE MARKETING A 257 HOSPITAL BASED RETAIL 73. 01 0 45. 38 PHARMACIES 45. 39 NON-ALLOWABLE PATIENT A -3, 400 RECOVERY ROOM 51. 00 0 45. 39 REIMBURSEMENT 70TAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		1						
45. 35 MI SCELLANEOUS INCOME B -276 SUBPROVIDER - IRF 41. 00 0 45. 35 45. 36 MI SCELLANEOUS INCOME B -27, 078 RESPIRATORY THERAPY 65. 00 0 45. 36 45. 37 MI SCELLANEOUS INCOME B -3, 474 HYPERBARIC OXYGEN THERAPY 76. 98 0 45. 37 45. 38 NON-ALLOWABLE MARKETING A 257 HOSPITAL BASED RETAIL 73. 01 0 45. 38 45. 39 NON-ALLOWABLE PATIENT A -3, 400 RECOVERY ROOM 51. 00 45. 39 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		1			1		-	
45. 37 MI SCELLANEOUS INCOME B -3, 474 HYPERBARIC OXYGEN THERAPY 76. 98 0 45. 37 45. 38 NON-ALLOWABLE MARKETING A 257 HOSPITAL BASED RETAIL 73. 01 0 45. 38 45. 39 NON-ALLOWABLE PATIENT A -3, 400 RECOVERY ROOM 51. 00 0 45. 39 REIMBURSEMENT TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)	45. 35	MI SCELLANEOUS I NCOME	В	-276	SUBPROVI DER - I RF	41. 00	0	
45. 38 NON-ALLOWABLE MARKETING A 257 HOSPITAL BASED RETAIL 73. 01 0 45. 38 PHARMACIES 45. 39 NON-ALLOWABLE PATIENT A -3, 400 RECOVERY ROOM 51. 00 0 45. 39 REIMBURSEMENT TOTAL (sum of lines 1 thru 49) -36, 889, 146 (Transfer to Worksheet A, column 6, line 200.)		1	1					
45. 39 NON-ALLOWABLE PATIENT A -3, 400 RECOVERY ROOM 51. 00 0 45. 39 REIMBURSEMENT TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		1						
REIMBURSEMENT TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.) REIMBURSEMENT -36,889,146 50.00	40.00	NON ALLOWADLE WARKETING		257		73.01		40.00
50.00 TOTAL (sum of lines 1 thru 49)	45. 39	II	A	-3, 400	RECOVERY ROOM	51. 00	0	45. 39
(Transfer to Worksheet A, column 6, line 200.)	50. 00	1		-36, 889, 146				50. 00
		(Transfer to Worksheet A,		,				
LIN HOSCIENTION - ALL CHANTAE PATAPANCAS IN THIS COLUMN NORTHIN TO CMS DUN TH T	(1) 5				OMC Duk. 15 1			

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

Health Financial Systems		BALL MEMORIA	L HOSPITAL	In Lieu of Form CMS-2552-1		
ADJUSTMENTS TO EXPENSES				Peri od:	Worksheet A-8	
				From 01/01/2017		
				To 12/31/2017	Date/Time Pre 5/24/2018 5:0	
			Expense Classification o To/From Which the Amount is			J piii
Cost Center Description	Rasis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
oost conter bescriptron	1.00	2.00	3.00	4. 00	5. 00	

- A. Costs if cost, including applicable overhead, can be determined.

 B. Amount Received if cost cannot be determined.

 (3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 15-0089 Period: From 01/01/2017 To 12/31/2017 Date/Time Prepared:

				To 12/31/2017	Date/Time Pre 5/24/2018 5:0	
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	У РІІІ
		5551 5511151	Expense i teme	Allowable Cost		
					Wks. A, column	
					5	
	1. 00 2. 00		3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUSTM	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OR	GANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:					
1.00		NEW CAP REL COSTS-BLDG & FIX		4, 552, 126	2, 820, 044	1.00
2.00		EMPLOYEE BENEFITS DEPARTMENT		16, 805, 875	413, 031	2.00
3.00			HOME OFFICE	11, 797, 428	0	3.00
4.00			HOME OFFICE	6, 705, 405	0	4.00
4. 01		CASHIERING/ACCOUNTS RECEIVAB		5, 464, 842	0	4. 01
4.02	5. 06	OTHER ADMINISTRATIVE AND GEN	HOME OFFICE	23, 706, 639	47, 634, 929	4. 02
4.03			RELATED PARTY	370, 944	370, 944	4. 03
4.04	22. 00	I&R SERVICES-OTHER PRGM COST	RELATED PARTY	2, 083, 407	2, 083, 407	4.04
4.05	30.00	ADULTS & PEDIATRICS	RELATED PARTY	12, 087	12, 087	4. 05
4.06	31.00	INTENSIVE CARE UNIT	RELATED PARTY	2, 034	2, 034	4.06
4.07	35. 00	NEONATAL INTENSIVE CARE UNIT	RELATED PARTY	75, 000	75, 000	4. 07
4.08			RELATED PARTY	360, 030	360, 030	4. 08
4.09	50.00	OPERATING ROOM	RELATED PARTY	409, 496	409, 496	4. 09
4. 10	54.00	RADI OLOGY-DI AGNOSTI C	RELATED PARTY	2, 216, 178	2, 216, 178	4. 10
4. 11	59. 00	CARDIAC CATHETERIZATION	RELATED PARTY	20, 191	20, 191	4. 11
4. 12	60.00	LABORATORY	RELATED PARTY	9, 563, 414	9, 563, 414	4. 12
4. 13	65. 01	SLEEP LAB	RELATED PARTY	164, 041	164, 041	4. 13
4. 14	66.00	PHYSI CAL THERAPY	RELATED PARTY	247, 860	247, 860	4. 14
4. 15	69. 00	ELECTROCARDI OLOGY	RELATED PARTY	7, 200	7, 200	4. 15
4. 16	73. 01	HOSPITAL BASED RETAIL PHARMA	RELATED PARTY	172, 911	172, 911	4. 16
4. 17	90. 02	PAIN CLINIC	RELATED PARTY	24, 827	24, 827	4. 17
4. 18	91.00	EMERGENCY	RELATED PARTY	2, 322, 247	2, 322, 247	4. 18
4. 19	95. 00	AMBULANCE SERVICES	RELATED PARTY	107, 448	107, 448	4. 19
4. 20	191.00	RESEARCH	RELATED PARTY	7, 444	7, 444	4. 20
4. 21	194. 08	RENTAL PROPERTY	RELATED PARTY	268, 837	268, 837	4. 21
5.00	0		0	87, 467, 911	69, 303, 600	5. 00

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

1100 110 0	the been posted to we kender h, cordina i and or 2, the amount arrowable should be marked in cordinar or this part.								
				Related Organization(s) and/	or Home Office	i			
						i			
						i			
						i			
	Symbol (1)	Name	Percentage of	Name	Percentage of	í			
	-		Ownershi p		Ownershi p				
	1. 00	2.00	3. 00	4. 00	5. 00				
	B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HO	ME OFFICE:						

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

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

6. 00	В	0.00 IU HEALTH 100.00	6. 00
7.00		0.00	7. 00
8.00		0.00	8. 00
9.00		0.00	9. 00
10.00		0.00	10.00
100.00	G. Other (financial or		100.00
	non-financial) specify:		

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provide $ilde{ ext{r}}.$
- 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.

					To 12/31/2017	Date/Time Prepared 5/24/2018 5:05 pm	
	Net	Wkst. A-7 Ref.					
	Adjustments						
	(col. 4 minus						
	col. 5)*						
	6. 00	7. 00					
			MENTS REQUIRED AS A RESULT OF TRAI	NSACTIONS WITH RELATED O	RGANIZATIONS OR (CLAI MED	
	HOME OFFICE CO						
1.00	1, 732, 082						00
2.00	16, 392, 844	0				2.0	00
3.00	11, 797, 428	0				3.0	00
4.00	6, 705, 405					4.0	
4.01	5, 464, 842	0				4.0	01
4.02	-23, 928, 290	0				4.0	
4.03	0	0				4.0	03
4.04	0	0				4.0	04
4.05	0	0				4. (05
4.06	0	0				4. (06
4.07	0	0				4. (07
4.08	0	0				4. (80
4.09	0	0				4. (09
4. 10	0	0				4. 1	10
4. 11	0	0				4. 1	11
4. 12	0	0				4. 1	12
4. 13	0	0				4. 1	13
4.14	0	0				4. 1	14
4. 15	0	0				4. 1	15
4. 16	0	0				4. 1	16
4. 17	0	0				4. 1	17
4. 18		0				4.	18
4. 19	0	0				4. 1	19
4. 20	0	0				4. 2	20
4. 21		0				4. 2	21
5.00	18, 164, 311					5. (00

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

1100 110 0	boon pooted to normanost m	cordinate a dray or 2, the dimedrit difference should be that cated in cordinate of this part.						
	Rel ated Organization(s)							
	and/or Home Office							
	Type of Business							
	31							
	6. 00							
	B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HOME OFFICE:						
	B. THYERREE THOUGHT TO REELITED GROWN ENTITION (3) THEO OR HOME OF THE							

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

Termbursement under title AVIII.						
		HEALTHCARE		. 00		
	7.00		7.	. 00		
	8.00			. 00		
	9.00		9.	. 00		
	10. 00 100. 00		10.	. 00		
	100.00		100.	. 00		

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- 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.

In Lieu of Form CMS-2552-10
Period: Worksheet A-8-2
From 01/01/2017
To 12/21/2017 Pate/Time Propagate Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 15-0089

						To 12/31/2017		
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		l denti fi er	Remuneration	Component	Component		ider Component	
	1.00	2.00	2.00	4.00	F 00	/ 00	Hours	
1. 00	1.00	2.00 EMPLOYEE BENEFITS DEPARTMENT	3.00	4. 00 883	5. 00	6. 00	7. 00	1. 00
2. 00		OTHER ADMINISTRATIVE AND	519, 133			1	_	
2.00		GENERAL	317, 133	130, 020	303, 113	211,300	3,701	2.00
3.00		NEONATAL INTENSIVE CARE UNIT	75, 000	75, 000	0	0	0	3. 00
4.00		RADI OLOGY-DI AGNOSTI C	1, 936, 621	686, 621	1, 250, 000	271, 900	17, 520	4. 00
5.00	65. 00	RESPI RATORY THERAPY	600	600	0	0	0	5. 00
6.00		EMERGENCY	2, 184, 519	0	2, 184, 519	211, 500	33, 945	6. 00
7.00	0. 00		0	0	0	0	0	7. 00
8.00	0. 00		0	0	0	0	0	8. 00
9.00	0. 00		0	0	0	0	0	9. 00
10.00	0. 00		0	0	0	0	0	10.00
200.00	WI+ A I : //	Cook Cook or (Dharei ei ee	4, 716, 756					200. 00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit		Cost of Memberships &	Provi der	Physician Cost of Malpractice	
		rdentiffer	LIIIII	Limit	Continuing	Component Share of col.	Insurance	
					Education	12	Trisul dilec	
	1. 00	2.00	8. 00	9. 00	12. 00	13.00	14.00	
1. 00	4. 00	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	1. 00
2.00	5. 06	OTHER ADMINISTRATIVE AND	587, 828	29, 391	0	0	0	2. 00
		GENERAL						
3.00		NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	0.00
4.00		RADI OLOGY-DI AGNOSTI C	2, 290, 235	114, 512	0	0	0	
5.00		RESPIRATORY THERAPY	0 451 (10	170 501	0	0		5. 00
6. 00 7. 00	0.00	EMERGENCY	3, 451, 619	172, 581	0	0	0	6. 00 7. 00
8.00	0.00		0					8.00
9. 00	0.00		0		0			
10. 00	0.00		0	0	0		0	
200. 00	0.00		6, 329, 682	316, 484	0	ĺ	Ö	200. 00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		l denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1.00		14	1/ 00	17.00	10.00		
1 00	1.00	2.00	15. 00	16. 00	17. 00	18. 00		1 00
1. 00 2. 00		EMPLOYEE BENEFITS DEPARTMENT	0	· ·	_		1	1. 00 2. 00
2.00		OTHER ADMINISTRATIVE AND GENERAL	0	307, 020	o o	130,020		2.00
3.00		NEONATAL INTENSIVE CARE UNIT	0	0	0	75, 000		3. 00
4. 00		RADI OLOGY-DI AGNOSTI C	l o	2, 290, 235	Ö	686, 621		4. 00
5.00		RESPI RATORY THERAPY	0	0	0	600		5. 00
6.00	91.00	EMERGENCY	0	3, 451, 619	0	0		6. 00
7.00	0.00		0	0	0	0		7. 00
8.00	0. 00		0	0	0	0		8. 00
9.00	0.00		0	0	0	0		9. 00
10.00	0. 00		0	0	0	0		10.00
200.00			0	6, 329, 682	0	919, 124		200. 00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2017 | Part | To 12/31/2017 | Date/Time Prepared: | From 12/31/2017 | Period: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0089

					1	o 12/31/2017	Date/lime Pre 5/24/2018 5:0	
	,	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	COMMUNI CATI ONS	DATA PROCESSI NG	<u> Э</u> рііі
			0	1.00	4. 00	5. 01	5. 02	
		L SERVICE COST CENTERS						
1. 00 4. 00 5. 01 5. 02 5. 04	00400 01160 00550	NEW CAP REL COSTS-BLDG & FIXT EMPLOYEE BENEFITS DEPARTMENT COMMUNI CATIONS DATA PROCESSING ADMITTING	24, 654, 044 17, 622, 818 532, 976 11, 797, 428 7, 727, 459	75, 000 20, 867 0	17, 697, 818 84, 143 0	637, 986 0	11, 797, 428 0	1. 00 4. 00 5. 01 5. 02 5. 04
5. 05 5. 06 6. 00	00580 00590 00600	CASHIERING/ACCOUNTS RECEIVABLE OTHER ADMINISTRATIVE AND GENERAL MAINTENANCE & REPAIRS OPERATION OF PLANT	5, 464, 842 32, 496, 496 7, 681, 382	0 811, 679 12, 475, 555	960, 320 485, 027	0 14, 730 21, 944	0 0 0	5. 05 5. 06 6. 00 7. 00
7. 00 8. 00 9. 00 10. 00	00800	DECRATION OF PLANT LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY	6, 056, 223 1, 360, 655 2, 856, 075 1, 672, 666	0 211, 445	0 434, 925	0 32, 676	0	8. 00 9. 00 10. 00
11. 00 13. 00 14. 00	01100 01300 01400	CAFETERIA NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	866, 224 6, 556, 657 10, 195, 006	200, 203 243, 847 223, 300	198, 942 908, 180 0	14, 532 26, 621 0	0 0	11. 00 13. 00 14. 00
15. 00 16. 00 21. 00 22. 00	01600 02100	PHARMACY MEDICAL RECORDS & LIBRARY I&R SERVICES-SALARY & FRINGES APPRVD I&R SERVICES-OTHER PRGM COSTS APPRVD	4, 913, 465 0 3, 732, 024 3, 335, 969	0	0 626, 905	0 23, 179	0 0 0	15. 00 16. 00 21. 00 22. 00
23. 00	02300 I NPATI	PARAMED ED PRGM ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	147, 471 27, 059, 117	1, 351	22, 870	531	1, 411, 326	23. 00
31. 00 32. 00 35. 00	03200 02060	INTENSIVE CARE UNIT CORONARY CARE UNIT NEONATAL INTENSIVE CARE UNIT	7, 954, 263 0 1, 930, 854	0	0	0	394, 309 0 98, 329	31. 00 32. 00 35. 00
40. 00 41. 00 43. 00	04100 04300	SUBPROVIDER - IPF SUBPROVIDER - IRF NURSERY ARY SERVICE COST CENTERS	0 2, 055, 438 625, 770	l			72, 206 41, 214	40. 00 41. 00 43. 00
50. 00		OPERATING ROOM	6, 266, 637	454, 957	825, 879	30, 653	1, 079, 832	50. 00
51. 00 52. 00	05100	RECOVERY ROOM DELIVERY ROOM & LABOR ROOM	1, 591, 732 2, 029, 536	113, 391	245, 303	8, 484	126, 600 189, 876	51. 00
54. 00 57. 00 58. 00	03280	RADIOLOGY-DIAGNOSTIC EKG AND EEG MAGNETIC RESONANCE IMAGING (MRI)	10, 737, 579 75, 537 0	853, 177 0 0	26, 402		1, 549, 838 24, 248 0	
59. 00 60. 00 60. 01	05900 06000 06001	CARDI AC CATHETERI ZATI ON LABORATORY BLOOD LABORATORY	2, 010, 417 9, 687, 571 0	44, 548 0	0	8, 481 19, 654 0	655, 356 702, 866 0	59. 00 60. 00 60. 01
63. 00 65. 00 65. 01 66. 00	06500 06501	BLOOD STORING, PROCESSING, & TRANS. RESPIRATORY THERAPY SLEEP LAB PHYSICAL THERAPY	1, 247, 033 3, 362, 438 411, 594 3, 605, 796	64, 789 0	72, 785	2, 793	44, 116 145, 164 57, 434 125, 644	65. 00 65. 01
67. 00 68. 00	06700 06800	OCCUPATIONAL THERAPY SPEECH PATHOLOGY AUDIOLOGY	785, 765 391, 283	33, 488	133, 243 68, 301	3, 994	40, 620 20, 015 0	67. 00 68. 00
68. 01 69. 00 71. 00 72. 00 73. 00	06900 07100 07200	MODIOLOGY MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENT DRUGS CHARGED TO PATIENT	1, 168, 072 10, 003, 772 13, 844, 516 27, 589, 201	256, 899 0	204, 026 0	0	351, 527 356, 756 731, 958 1, 544, 157	72. 00
73. 01 74. 00 76. 00	07301 07400 03160	HOSPITAL BASED RETAIL PHARMACIES RENAL DIALYSIS CARDIOPULMONARY	9, 342, 066 1, 278, 417 0	0 40, 648 0	276, 001 0	6, 839 0 0	60, 930 26, 083 0	73. 01 74. 00 76. 00
76. 97 76. 98	07698 0UTPAT	CARDIAC REHABILITATION HYPERBARIC OXYGEN THERAPY IENT SERVICE COST CENTERS	584, 128 1, 222, 283	1, 045	84, 668	2, 807	26, 953 103, 218	
90.00	1 1	CLINIC	0 445 120	-	1		0 55 604	90.00
90. 02 90. 03		PAIN CLINIC ONCOLOGY CLINIC	445, 130 942, 386				55, 604 209, 057	90. 02 90. 03
90. 03		EMERGENCY	942, 386 9, 738, 952	l			1, 495, 491	90.03
92. 00 92. 01	09200 09201	OBSERVATION BEDS (NON-DISTINCT PART) OBSERVATION BEDS (DISTINCT PART)	0				0	92. 00
95. 00	09500	REIMBURSABLE COST CENTERS AMBULANCE SERVICES IL PURPOSE COST CENTERS	1, 783, 491	41, 651	243, 158	11, 715	56, 701	95. 00
113. 00 118. 00	11300	INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	309, 440, 654	21, 625, 404	17, 122, 950	620, 425	11, 797, 428	113. 00 118. 00
190.00		MBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN	714, 222	0	23, 005	1, 558	0	190. 00
			·					

| Peri od: | Worksheet B | From 01/01/2017 | Part | To 12/31/2017 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0089

			T	o 12/31/2017	Date/Time Prepare 5/24/2018 5:05 pm	
		CAPI TAL			07 2 17 20 10 0. 00 pin	
		RELATED COSTS				
Cost Center Description	Net Expenses	NEW BLDG &	EMPLOYEE	COMMUNI CATI ONS	DATA	
	for Cost	FLXT	BENEFITS		PROCESSI NG	
	Allocation		DEPARTMENT			
	(from Wkst A					
	col . 7)					
	0	1.00	4. 00	5. 01	5. 02	
191. 00 19100 RESEARCH	740, 887	21, 620			0 191.	
194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS	0	0		0	0 194.	
194. 01 07951 BSU_PHARMACY	-14, 822		37, 845		0 194.	
194. 02 07952 PAVILLION PHARMACY	6, 415, 586	39, 478	116, 349	3, 411	0 194.	
194. 03 07953 VENDI NG	0	0	0	0	0 194.	
194. 04 07954 CARELI NE	0	0	0	0	0 194.	
194. 05 07955 WELLNESS CENTER	40, 727	70, 667	4, 855	291	0 194.	
194. 06 07956 PHYSICIAN PRACTICE CLINICS	16, 403	282, 781	0	0	0 194.	
194. 07 07957 PERI NATAL CLI NI C	0	0	0	0	0 194.	
194. 08 07958 RENTAL PROPERTY	609, 576	1, 853, 428	0	0	0 194.	
194. 09 07959 ADVERTI SI NG	0	0	0	0	0 194.	
194. 10 07960 I NTEGRA LTAC	0	163, 971	0	0	0 194.	
194. 11 07961 I U HEALTH HOSPI CE	-3, 631	53, 770	0	0	0 194.	
194. 12 07962 POB MEDICAL PAVILLION CONDOS	0	0	0	0	0 194.	
194. 13 07963 EXECUTI VE PHYSI CAL	0	0	0	0	0 194.	
194. 14 07964 NEW CASTLE ONCOLOGY	0	0	0	0	0 194.	
194. 15 07965 MARKETI NG/PUBLI C RELATI ONS	0	62, 769		0	0 194.	
194. 16 07966 JAY COUNTY HOSPI TAL	223, 066	0	35, 656	0	0 194.	
194. 17 07967 CARDI NAL HEALTH CHOI CE	0	0	0	0	0 194.	
194. 18 07968 CHV CARDINAL HEALTH VENTURES	0	0	0	0	0 194.	
194. 19 07969 HEALTH CARE CONNECTIONS	0	0	0	0	0 194.	
194. 20 07970 MEALS ON WHEELS	0	0	0	0	0 194.	
194. 21 07971 ST MARY'S SCHOOL	0	0	0	0	0 194.	
194. 22 07972 THERAPIES TO OTHER ENTITIES	381, 025		,		0 194.	
194. 23 07973 CANCER CENTER BOUTLQUE	120, 526			208	0 194.	
194. 24 07974 BOSC BALL OUTPATIENT SURGERY	0	344, 965		0	0 194.	
194. 25 07975 CARDI NAL BEHAVI ORAL HEALTH	121	123, 323		0	0 194.	
194. 26 07976 BLACKFORD COMMUNITY HOSPITAL	0	0	28, 023		0 194.	
194. 27 07977 MIDWEST HEALTH STRATEGIES	0	0	0	0	0 194.	
194. 28 07978 CARDINAL SELECT RISK RETENTION GRP	0	0	0	0	0 194.	
194.29 07979 HOME OFFICE CARDINAL HEALTH INITIATI	0	0	0	0	0 194.	
194. 30 07980 CARDI NAL HEALTH ALLI ANCE	69	0	0	0	0 194.	
194.31 07986 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0 194.	
194. 32 07982 RENAL DI ALYSI S	0	0	0	0	0 194.	
194. 33 07983 LAB CORP	0	0	0	0	0 194.	
194. 34 07984 H.O. MATERIALS MGMT	0	0	0	0	0 194.	
194. 35 07985 LEASED SPACE	0	0	0	0	0 194.	
200.00 Cross Foot Adjustments					200.	
201.00 Negative Cost Centers		0	0	0	0 201.	
202.00 TOTAL (sum lines 118 through 201)	318, 684, 409	24, 654, 044	17, 697, 818	637, 986	11, 797, 428 202.	00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2017 Part I
To 12/31/2017 Date/Time Prepared: 5/24/2018 5:05 pm

			'	0 12/31/201/	5/24/2018 5:0	
Cost Center Description	ADMI TTI NG	CASHI ERI NG/ACC	Subtotal	OTHER	MAINTENANCE &	,
		OUNTS		ADMI NI STRATI VE	REPAI RS	
	F 04	RECEI VABLE	EA OF	AND GENERAL	/ 00	
GENERAL SERVICE COST CENTERS	5. 04	5. 05	5A. 05	5. 06	6. 00	
1. 00 00100 NEW CAP REL COSTS-BLDG & FLXT						1.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01 01160 COMMUNI CATI ONS						5. 01
5. 02 00550 DATA PROCESSING						5. 02
5. 04 00570 ADMI TTI NG	7, 959, 848					5. 04
5. 05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	5, 464, 842				5. 05
5.06 00590 OTHER ADMINISTRATIVE AND GENERAL	0	o	34, 283, 225	34, 283, 225		5. 06
6.00 00600 MAINTENANCE & REPAIRS	0	0	20, 663, 908	2, 490, 931	23, 154, 839	6. 00
7.00 00700 OPERATION OF PLANT	0	0	7, 198, 709		1, 909, 245	7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	0	0	1, 360, 655		0	8. 00
9. 00 00900 HOUSEKEEPI NG	0	0	3, 535, 121		436, 775	9. 00
10. 00 01000 DI ETARY	0	0	2, 057, 229		298, 022	10.00
11. 00 01100 CAFETERI A	0	0	1, 279, 901	154, 286	413, 553	11.00
13. 00 01300 NURSI NG ADMINI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY	0	0	7, 735, 305 10, 418, 306		503, 705 461, 262	13. 00 14. 00
15. 00 01500 PHARMACY	0		5, 836, 314		195, 353	15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0		0, 630, 314	703, 536	175, 353	16.00
21. 00 02100 &R SERVI CES-SALARY & FRI NGES APPRVD	Ö		4, 382, 108	528, 241	0	21.00
22. 00 02200 &R SERVI CES-OTHER PRGM COSTS APPRVD	Ö	1	3, 636, 996		529, 977	22. 00
23.00 02300 PARAMED ED PRGM	0	o	172, 223		2, 791	23. 00
INPATIENT ROUTINE SERVICE COST CENTERS		<u>'</u>		· · · · ·		
30. 00 03000 ADULTS & PEDI ATRI CS	952, 265	653, 813	35, 755, 746	4, 310, 262	4, 357, 129	30. 00
31.00 03100 INTENSIVE CARE UNIT	266, 052		10, 330, 241	1, 245, 259	800, 662	31.00
32. 00 03200 CORONARY CARE UNIT	0	1	0	0	0	32. 00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT	66, 346		2, 517, 075	303, 421	148, 162	35. 00
40. 00 04000 SUBPROVI DER - 1 PF	0	1	0 (00 701	214 504	0	40.00
41. 00 04100 SUBPROVI DER - RF 43. 00 04300 NURSERY	48, 720 27, 808		2, 609, 781	314, 596 104, 494	287, 663	41. 00 43. 00
ANCI LLARY SERVI CE COST CENTERS	27,000	19,093	866, 846	104, 494	111, 704	43.00
50. 00 05000 OPERATI NG ROOM	728, 596	500, 245	9, 886, 799	1, 191, 804	939, 789	50.00
51. 00 05100 RECOVERY ROOM	85, 421	58, 649	2, 229, 580		234, 228	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	128, 115		2, 933, 954		366, 995	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 045, 481		16, 356, 189		1, 762, 378	54.00
57.00 03280 EKG AND EEG	16, 361	11, 233	155, 509	18, 746	0	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	442, 189		3, 905, 230		404, 000	59. 00
60. 00 06000 LABORATORY	474, 245	325, 611	11, 254, 495	1, 356, 673	92, 022	60.00
60. 01 06001 BLOOD LABORATORY	0	0 407	0	0	0	60. 01
63.00 06300 BLOOD STORING, PROCESSING, & TRANS. 65.00 06500 RESPIRATORY THERAPY	29, 767	20, 437	1, 341, 353		122 022	63.00
65. 00 06500 RESPI RATORY THERAPY 65. 01 06501 SLEEP LAB	97, 947 38, 753		4, 282, 647 609, 966		133, 832 0	65. 00 65. 01
66. 00 06600 PHYSI CAL THERAPY	84, 776		4, 715, 032		89, 174	
67. 00 06700 OCCUPATI ONAL THERAPY	27, 408		1, 043, 336		69, 175	67.00
68. 00 06800 SPEECH PATHOLOGY	13, 505		512, 416		16, 546	68. 00
68. 01 06801 AUDI OLOGY	0		0		0	68. 01
69. 00 06900 ELECTROCARDI OLOGY	237, 186	162, 849	2, 389, 428	288, 034	530, 667	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	240, 714		10, 766, 513	1, 297, 849	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	493, 875		15, 409, 437	1, 857, 531	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 041, 891		30, 890, 598		0	73. 00
73. 01 07301 HOSPITAL BASED RETAIL PHARMACIES	41, 111		9, 755, 174		0	73. 01
74. 00 07400 RENAL DI ALYSI S	17, 599		1, 374, 830		83, 965	74.00
76. 00 03160 CARDI OPULMONARY	0	1	722 (12		0	76.00
76. 97 O7697 CARDI AC REHABI LI TATI ON 76. 98 O7698 HYPERBARI C OXYGEN THERAPY	18, 186		732, 613		0	76. 97 76. 98
76. 98 O7698 HYPERBARI C OXYGEN THERAPY OUTPATIENT SERVICE COST CENTERS	69, 644	47,817	1, 531, 482	184, 612	2, 158	70.98
90. 00 09000 CLI NI C	0	ا ا	0	ام	0	90.00
90. 02 09002 PAIN CLINIC	37, 518	25, 759	946, 156	114, 054	645, 796	90. 02
90. 03 09003 0NCOLOGY CLINIC	141, 057		1, 554, 181	187, 349	30, 703	90. 03
91. 00 09100 EMERGENCY	1, 009, 054		14, 401, 737		955, 213	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0	O	0	0	0	92. 01
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	38, 258	26, 267	2, 201, 241	265, 349	86, 037	95. 00
SPECIAL PURPOSE COST CENTERS		T				112 00
113.00 11300 INTEREST EXPENSE 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	7 050 040	E 464 043	30E 010 E0E	20 720 424	16 000 401	113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	7, 959, 848	5, 464, 842	305, 819, 585	32, 732, 436	16, 898, 681	1110.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	n	738, 785	89, 057	n	190. 00
191. 00 19100 RESEARCH	0		872, 266		44, 659	
194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS	Ö	1	0	0		194. 00
194. 01 07951 BSU PHARMACY	0	0	23, 977	2, 890	0	194. 01
194.02 07952 PAVILLION PHARMACY	0	o	6, 574, 824	792, 562	81, 548	194. 02

			'	0 12/31/2017	5/24/2018 5:0	
Cost Center Description	ADMITTING	CASHI ERI NG/ACC	Subtotal	OTHER	MAINTENANCE &	
		OUNTS		ADMI NI STRATI VE	REPAI RS	
		RECEI VABLE		AND GENERAL		
	5. 04	5. 05	5A. 05	5. 06	6. 00	
194. 03 07953 VENDI NG		0	C	0		194. 03
194. 04 07954 CARELI NE		0	C	0	0	194. 04
194. 05 07955 WELLNESS CENTER		0	116, 540	14, 048	145, 975	194. 05
194.06 07956 PHYSICIAN PRACTICE CLINICS		0	299, 184	36, 065	584, 131	194. 06
194. 07 07957 PERINATAL CLINIC	(0	C	0	0	194. 07
194.08 07958 RENTAL PROPERTY	(0	2, 463, 004	296, 903	3, 828, 562	194. 08
194. 09 07959 ADVERTI SI NG	(0	C	0	0	194. 09
194. 10 07960 INTEGRA LTAC	(0	163, 971	19, 766	338, 710	194. 10
194. 11 07961 I U HEALTH HOSPI CE	(0	50, 139	6, 044	111, 071	194. 11
194.12 07962 POB MEDICAL PAVILLION CONDOS	(0	C	0	0	194. 12
194. 13 07963 EXECUTI VE PHYSI CAL	(0	C	0	0	194. 13
194.14 07964 NEW CASTLE ONCOLOGY	(0	C	0	0	194. 14
194. 15 07965 MARKETING/PUBLIC RELATIONS	(0	62, 769	7, 566	129, 660	194. 15
194. 16 07966 JAY COUNTY HOSPITAL	(0	258, 722	31, 188	0	194. 16
194. 17 07967 CARDI NAL HEALTH CHOI CE		0	C	0		194. 17
194. 18 07968 CHV CARDINAL HEALTH VENTURES		이	C	0		194. 18
194. 19 07969 HEALTH CARE CONNECTIONS		이	C	0		194. 19
194.20 07970 MEALS ON WHEELS		이	C	0		194. 20
194.21 07971 ST MARY'S SCHOOL		이	C	0	•	194. 21
194. 22 07972 THERAPIES TO OTHER ENTITIES		이	608, 646			194. 22
194. 23 07973 CANCER CENTER BOUTIQUE		이	134, 996			194. 23
194. 24 07974 BOSC BALL OUTPATIENT SURGERY	(이	344, 965			
194. 25 07975 CARDI NAL BEHAVI ORAL HEALTH	(이	123, 444		254, 744	
194. 26 07976 BLACKFORD COMMUNITY HOSPITAL	(이	28, 523	3, 438		194. 26
194. 27 07977 MI DWEST HEALTH STRATEGIES	(이	C	0		194. 27
194.28 07978 CARDINAL SELECT RISK RETENTION GRP	(이	C	0		194. 28
194.29 07979 HOME OFFICE CARDINAL HEALTH INITIATI	(이	C	0		194. 29
194.30 07980 CARDI NAL HEALTH ALLI ANCE	(이	69	8		194. 30
194.31 07986 OTHER NONREIMBURSABLE COST CENTERS		이	C	0	l .	194. 31
194. 32 07982 RENAL DI ALYSI S	(이	C	0		194. 32
194. 33 07983 LAB CORP	(이	C	0		194. 33
194.34 07984 H.O. MATERIALS MGMT	(이	C	0		194. 34
194. 35 07985 LEASED SPACE		이	C	0	0	194. 35
200.00 Cross Foot Adjustments			C)		200. 00
201.00 Negative Cost Centers	(0	C	0		201.00
202.00 TOTAL (sum lines 118 through 201)	7, 959, 848	5, 464, 842	318, 684, 409	34, 283, 225	23, 154, 839	202. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2017 | Part I | To 12/31/2017 | Date/Time Prepared: | 5/24/2018 5:05 pm

	005047104105	L ALINDRY &	Luguerreen	DI ETADY	5/24/2018 5:0	5 pm
Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
	7.00	8.00	9. 00	10.00	11. 00	
GENERAL SERVICE COST CENTERS						
1.00 O0100 NEW CAP REL COSTS-BLDG & FIXT						1. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01 01160 COMMUNI CATI ONS						5. 01
5. 02 00550 DATA PROCESSI NG						5. 02
5. 04 00570 ADMI TTI NG						5. 04
5. 05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 05
5. 06 00590 OTHER ADMINISTRATIVE AND GENERAL 6. 00 00600 MAINTENANCE & REPAIRS						5. 06 6. 00
7.00 OO700 OPERATION OF PLANT	9, 975, 722					7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE	0, 773, 722					8. 00
9. 00 00900 HOUSEKEEPI NG	205, 085		4, 603, 143			9. 00
10. 00 01000 DI ETARY	139, 934		8, 922	2, 752, 127		10.00
11. 00 01100 CAFETERI A	194, 181	44	47, 159	0	2, 089, 124	11. 00
13.00 01300 NURSING ADMINISTRATION	236, 511	0	18, 800	0	106, 615	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	216, 582	О	19, 756	0	0	14. 00
15. 00 01500 PHARMACY	91, 727	245	22, 305	0	88, 077	15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16. 00
21.00 02100 1 &R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	92, 830	21. 00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	248, 847	0	4, 461	0	10, 923	
23. 00 O2300 PARAMED ED PRGM	1, 311	0	0	0	2, 126	23. 00
INPATIENT ROUTINE SERVICE COST CENTERS			0.074.540	0.445.400	E4E 04/	
30. 00 03000 ADULTS & PEDI ATRI CS	2, 045, 862		2, 071, 510	2, 145, 638		30.00
31. 00 03100 INTENSIVE CARE UNIT 32. 00 03200 CORONARY CARE UNIT	375, 945	127, 601	340, 313	206, 763		31.00
32. 00 03200 CORONARY CARE UNIT 35. 00 02060 NEONATAL INTENSIVE CARE UNIT	69, 568	12 205	0 16, 570	0	0 35, 172	32.00
40. 00 04000 SUBPROVI DER - PF	09, 300	12, 395	16, 570	0	35, 1/2	35. 00 40. 00
41. 00 04100 SUBPROVI DER - 1 FF	135, 070	34, 427	208, 234	138, 469		41.00
43. 00 04300 NURSERY	52, 450			130, 407		43.00
ANCI LLARY SERVI CE COST CENTERS	32, 430	14, 250	47, 707		11,770	43.00
50. 00 05000 OPERATING ROOM	441, 272	116, 578	257, 465	0	122, 763	50.00
51.00 05100 RECOVERY ROOM	109, 980		15, 295	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	172, 320		244, 719	0	38, 702	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	827, 512	108, 348	225, 123	0	170, 192	54.00
57.00 03280 EKG AND EEG	0	12	0	0	6, 921	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	189, 695	22, 414	117, 899	0	33, 963	59. 00
60. 00 06000 LABORATORY	43, 208	0	115, 987	0	78, 711	60. 00
60. 01 06001 BLOOD LABORATORY	0		0	0	0	60. 01
63. 00 06300 BLOOD STORING, PROCESSING, & TRANS.	0	582	0	0	0	63.00
65. 00 06500 RESPIRATORY THERAPY	62, 840		18, 481	0	70, 275	
65. 01 06501 SLEEP LAB	41 071	10	75 027	0	11, 187	65. 01
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	41, 871		75, 837	0	94, 247	
67. 00 06700 0CCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	32, 481 7, 769		4, 461 4, 461	0	15, 995 8, 130	
68. 00 06800 SPEECH PATHOLOGY 68. 01 06801 AUDI OLOGY	7, 769	0	4, 461	0	0, 130	68. 01
69. 00 06900 ELECTROCARDI OLOGY	249, 171	20, 198	_	0	35, 520	69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	247, 171			0	0	71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	0	0	0	0	o o	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	o	o	0	Ö	73. 00
73. 01 07301 HOSPITAL BASED RETAIL PHARMACIES	0	0	8, 922	0	27, 390	73. 01
74.00 07400 RENAL DIALYSIS	39, 425	2, 755	0	0	0	74. 00
76. 00 03160 CARDI OPULMONARY	0	0	0	0	0	76. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	128	36, 326	0	14, 466	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	1, 013	0	0	0	11, 242	76. 98
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0	0	0	0	90. 00
90. 02 09002 PAIN CLINIC	303, 229		4, 461	0	11, 395	90. 02
90. 03 09003 ONCOLOGY CLINIC	14, 416			0	17, 774	90. 03
91. 00 09100 EMERGENCY	448, 513	239, 545	550, 618	0	133, 116	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
92. 01 09201 OBSERVATI ON BEDS (DI STINCT PART) OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	92. 01
95. 00 09500 AMBULANCE SERVICES	40, 398	0	0	0	46, 915	95. 00
SPECIAL PURPOSE COST CENTERS	40, 370	U	U _I		40, 715	75.00
113. 00 11300 NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	7, 038, 186	1, 506, 109	4, 487, 794	2, 490, 870	2, 018, 793	
NONREI MBURSABLE COST CENTERS	7,030,100	1, 300, 107	4, 407, 774	2, 470, 070	2,010,773	1110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	Ω	6. 240	190. 00
191. 00 19100 RESEARCH	20, 969	l o	ا	0	15, 189	
194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS	0		37, 600	0	0	194. 00
194.01 07951 BSU PHARMACY	0	0	0	0		194. 01
194.02 07952 PAVILLION PHARMACY	38, 290	0	0	0	13, 660	194. 02
194. 03 07953 VENDI NG	0	0	0	0	0	194. 03

| Peri od: | Worksheet B | From 01/01/2017 | Part | To 12/31/2017 | Date/Time Prepared: | From 01/01/2017 | Part | Prepared: | From 01/2017 | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | P

			10	12/31/201/	5/24/2018 5:05 p	
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
·	PLANT	LINEN SERVICE				
	7. 00	8. 00	9. 00	10. 00	11. 00	
194. 04 07954 CARELI NE	0	0	0	0	0 19	94. 04
194. 05 07955 WELLNESS CENTER	68, 542	18, 520	50, 983	0	1, 167 19	4. 05
194.06 07956 PHYSICIAN PRACTICE CLINICS	274, 275	0	8, 922	0	0 19	94. 06
194. 07 07957 PERINATAL CLINIC	0	0	0	0	0 19	94. 07
194. 08 07958 RENTAL PROPERTY	1, 797, 675	0	0	0	0 19	94. 08
194. 09 07959 ADVERTI SI NG	0	0	0	0	0 19	4. 09
194. 10 07960 INTEGRA LTAC	159, 039	0	0	141, 281	0 19	94. 10
194. 11 07961 I U HEALTH HOSPICE	52, 153	46	17, 844	0	0 19	94. 11
194.12 07962 POB MEDICAL PAVILLION CONDOS	0	0	0	0	0 19	94. 12
194. 13 07963 EXECUTI VE PHYSI CAL	0	0	0	0	0 19	94. 13
194.14 07964 NEW CASTLE ONCOLOGY	0	0	0	0	0 19	94. 14
194. 15 07965 MARKETING/PUBLIC RELATIONS	60, 881	0	O	0	0 19	4. 15
194. 16 07966 JAY COUNTY HOSPITAL	0	0	O	0	0 19	94. 16
194. 17 07967 CARDI NAL HEALTH CHOI CE	0	0	O	0	0 19	94. 17
194. 18 07968 CHV CARDINAL HEALTH VENTURES	0	0	0	0	0 19	94. 18
194. 19 07969 HEALTH CARE CONNECTIONS	0	0	0	0	0 19	94. 19
194.20 07970 MEALS ON WHEELS	0	0	0	0	0 19	4. 20
194. 21 07971 ST MARY'S SCHOOL	0	0	0	0	0 19	94. 21
194.22 07972 THERAPIES TO OTHER ENTITIES	0	0	0	0	27, 418 19	94. 22
194. 23 07973 CANCER CENTER BOUTIQUE	11, 511	0	0	0	834 19	94. 23
194. 24 07974 BOSC BALL OUTPATIENT SURGERY	334, 588	0	0	0	0 19	94. 24
194. 25 07975 CARDI NAL BEHAVI ORAL HEALTH	119, 613	0	0	119, 976	0 19	4. 25
194.26 07976 BLACKFORD COMMUNITY HOSPITAL	0	0	0	0	2, 001 19	94. 26
194.27 07977 MIDWEST HEALTH STRATEGIES	0	0	0	0	0 19	94. 27
194.28 07978 CARDINAL SELECT RISK RETENTION GRP	0	0	0	0		4. 28
194.29 07979 HOME OFFICE CARDINAL HEALTH INITIATI	0	0	0	0		94. 29
194. 30 07980 CARDI NAL HEALTH ALLI ANCE	0	0	0	0	0 19	94. 30
194.31 07986 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		94. 31
194. 32 07982 RENAL DI ALYSI S	0	0	0	0	0 19	94. 32
194. 33 07983 LAB_CORP	0	0	0	0	0 19	94. 33
194.34 07984 H.O. MATERIALS MGMT	0	0	0	0	0 19	94. 34
194. 35 07985 LEASED SPACE	0	0	0	0	0 19	94. 35
200.00 Cross Foot Adjustments						00.00
201.00 Negative Cost Centers	0	0	0	0		1. 00
202.00 TOTAL (sum lines 118 through 201)	9, 975, 722	1, 524, 675	4, 603, 143	2, 752, 127	2, 089, 124 20	2. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2017 | Part | To 12/31/2017 | Date/Time Prepared: | From 12/31/2017 | Period:
				lo	12/31/2017	Date/lime Prep 5/24/2018 5:0	
	Cost Center Description	NURSI NG ADMI NI STRATI ON 13. 00	CENTRAL SERVI CES & SUPPLY 14.00	PHARMACY	MEDI CAL RECORDS & LI BRARY	I NTERNS & RESI DENTS SERVI CES-SALAR Y & FRI NGES	
	GENERAL SERVICE COST CENTERS	13.00	14.00	15.00	16. 00	21.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	01160 COMMUNI CATI ONS						5. 01
5. 02 5. 04	00550 DATA PROCESSING 00570 ADMITTING						5. 02 5. 04
5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 05
5.06	00590 OTHER ADMINISTRATIVE AND GENERAL						5. 06
6.00	00600 MAI NTENANCE & REPAI RS						6. 00
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG						9. 00
10.00							10. 00
11.00		0 522 200					11.00
13. 00 14. 00		9, 533, 388	12, 371, 781				13. 00 14. 00
15. 00		o	56, 937				15. 00
16. 00		0	0		0		16. 00
21. 00		0	0	- 1	0	5, 003, 179	21. 00
22. 00 23. 00	1	0	524 0	0	0		22. 00 23. 00
23.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	<u> </u>		<u> </u>			23.00
30.00	03000 ADULTS & PEDIATRICS	4, 587, 646	710, 752	50, 894	0	2, 829, 668	30. 00
31.00		1, 278, 711	301, 529	13, 613	0	615, 145	31.00
32. 00 35. 00	1	311, 821	0 42, 127	0 1, 601	0	82, 019 0	32. 00 35. 00
40. 00	1	0	42, 127	0	0		40. 00
41.00	04100 SUBPROVI DER - I RF	287, 746	16, 735	791	0	0	41. 00
43.00		104, 517	0	0	0	0	43. 00
50. 00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM	374, 099	1, 253, 048	19, 546	0	272, 714	50. 00
51. 00	1	341, 662	65, 230		0	0	51. 00
52.00	1	321, 624	72, 819		0	0	52. 00
54.00		261, 653	196, 513		0	137, 382	54. 00
57. 00 58. 00		0	1, 418 0		0	0	57. 00 58. 00
59. 00		186, 112	15, 797	4, 267	0		59. 00
60.00		0	0	0	0	0	60. 00
60. 01	06001 BLOOD LABORATORY	0	412 120	0	0	0	60. 01
63. 00 65. 00			413, 128 101, 681	0 241	0	0 174, 291	63. 00 65. 00
65. 01		o	16, 233		0	0	65. 01
66.00		1, 153	13, 980		0	0	66. 00
67. 00		0	6, 719		0	0	
68. 00 68. 01	1		431 0	- 1	0	0	
69. 00	1	O	7, 623		0	246, 058	69. 00
71. 00		0	3, 579, 370		0	0	71. 00
72. 00 73. 00	1	0	4, 953, 603 0		0	0	72. 00 73. 00
73. 00	1	0	201	0, 027, 370	0		73.00
74. 00	1	0	6, 740	2, 262	0	Ö	74. 00
76. 00	1	0	0		0	0	76. 00
76. 97 76. 98	1	8, 506 92, 119	3, 109 35, 031	1 10	0	0	76. 97 76. 98
70. 90	OUTPATIENT SERVICE COST CENTERS	92, 119	33, 031	10	0	0	70. 90
90.00		0	0	0	0	0	90. 00
90. 02		49, 159	32, 649		0	126, 105	90. 02
90. 03		148, 630	65, 048		0	98, 423 415, 223	90. 03
91. 00 92. 00		1, 095, 482	380, 490	38, 666	Ü	415, 225	91. 00 92. 00
92. 01		0	0	О	0	0	
	OTHER REIMBURSABLE COST CENTERS					_	
95. 00	09500 AMBULANCE SERVI CES SPECIAL PURPOSE COST CENTERS	0	20, 166	301	0	0	95. 00
113. 00	0 11300 I NTEREST EXPENSE						113. 00
118.00	O SUBTOTALS (SUM OF LINES 1 through 117)	9, 450, 640	12, 369, 631	6, 994, 487	0		
100.00	NONREI MBURSABLE COST CENTERS		,I	-			100.00
	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 19100 RESEARCH	76, 405	457 233		0		190. 00 191. 00
	007950 OTHER NONREIMBURSABLE COST CENTERS	70, 403	0		0		194. 00
	<u> </u>		- 1				

S724/2018 5:05 pm
NURSI NG ADMINI STRATI ON SERVI CES & SUPPLY SUPPLY SUPPLY SERVI CES & SERVI CES SALAR Y & FRI NGES SERVI CES & SUPPLY SERVI CES & SUPPLY SERVI CES & SUPPLY SERVI CES & SERVI
NURSI NG ADMINI STRATI ON SERVI CES & SUPPLY SUPPLY SUPPLY SERVI CES & SERVI CES SALAR Y & FRI NGES SERVI CES & SUPPLY SERVI CES & SUPPLY SERVI CES & SUPPLY SERVI CES & SERVI
SUPPLY LI BRARY
13. 00 14. 00 15. 00 16. 00 21. 00 194. 01 07951 BSU PHARMACY 0 0 0 0 0 194. 01
194. 01 07951 BSU PHARMACY 0 0 0 0 0 194. 01
104 00 070 070 070 070 070 070 070 070 07
194. 02 07952 PAVI LLI ON PHARMACY 0 1, 029 0 0 0 194. 02
194. 03 07953 VENDI NG 0 0 0 0 0 194. 03
194. 04 07954 CARELINE 0 0 0 0 0 0 194. 04
194. 05 07955 WELLNESS CENTER 0 89 0 0 0 194. 05
194. 06 07956 PHYSI CI AN PRACTI CE CLI NI CS 0 0 0 0 0 194. 06
194. 07 07957 PERINATAL CLINIC 0 0 0 0 0 194. 07
194. 08 07958 RENTAL PROPERTY 0 0 0 0 0 194. 08
194. 09 07959 ADVERTI SI NG 0 0 0 0 0 194. 09
194. 10 07960 I NTEGRA LTAC 0 0 0 0 0 194. 10
194. 11 07961 I U HEALTH HOSPI CE 0 65 0 0 0 194. 11
194. 12 07962 POB MEDICAL PAVILLION CONDOS 0 0 0 0 194. 12
194. 13 07963 EXECUTI VE PHYSI CAL 0 0 0 0 0 194. 13
194. 14 07964 NEW CASTLE ONCOLOGY 0 0 0 0 194. 14
194. 15 07965 MARKETI NG/PUBLI C RELATI ONS 0 0 0 0 194. 15
194. 16 07966 JAY COUNTY HOSPITAL 0 0 0 0 0 194. 16
194. 17 07967 CARDI NAL HEALTH CHOI CE 0 0 0 0 0 194. 17
194. 18 07968 CHV CARDI NAL HEALTH VENTURES 0 0 0 0 0 194. 18
194.19 07969 HEALTH CARE CONNECTIONS 0 0 0 0 0 194.19
194. 20 07970 MEALS ON WHEELS 0 0 0 0 0 194. 20
194. 21 07971 ST MARY'S SCHOOL 0 0 0 0 194. 21
194. 22 07972 THERAPIES TO OTHER ENTITIES 0 0 0 0 0 194. 22
194. 23 07973 CANCER CENTER BOUTI QUE 0 269 0 0 0 194. 23
194. 24 07974 BOSC BALL OUTPATIENT SURGERY 0 0 0 0 0 194. 24
194. 25 07975 CARDI NAL BEHAVI ORAL HEALTH 0 8 3 0 0 194. 25
194. 26 07976 BLACKFORD COMMUNI TY HOSPI TAL 6, 343 0 0 0 0 194. 26
194. 27 07977 MI DWEST HEALTH STRATEGI ES 0 0 0 0 0 194. 27
194. 28 07978 CARDINAL SELECT RISK RETENTION GRP 0 0 0 0 0 194. 28
194.29 07979 HOME OFFICE CARDINAL HEALTH INITIATI 0 0 0 0 0 0 194.29
194. 30 07980 CARDI NAL HEALTH ALLI ANCE 0 0 0 0 0 194. 30
194. 31 07986 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 194. 31
194. 32 07982 RENAL DI ALYSI S 0 0 0 0 0 194. 32
194. 33 07983 LAB CORP 0 0 0 0 194. 33
194. 34 07984 H. O. MATERI ALS MGMT 0 0 0 0 0 194. 34
194. 35 07985 LEASED SPACE 0 0 0 0 194. 35
200.00 Cross Foot Adjustments 0 200.00
201.00 Negative Cost Centers 0 0 0 0 201.00
202.00 TOTAL (sum lines 118 through 201) 9,533,388 12,371,781 6,994,496 0 5,003,179 202.00

	Financial Systems	BALL MEMORI AI		N 45 0000 D		u of Form CMS-:	2552-10
COST	ALLOCATION - GENERAL SERVICE COSTS		Provi der CC		eriod: rom 01/01/2017	Worksheet B Part I	
					o 12/31/2017	Date/Time Pre	pared:
		INTERNS &				5/24/2018 5:0	5 pm
		RESI DENTS					
	Cost Center Description	SERVI CES-OTHER	PARAMED ED	Subtotal	Intern &	Total	
	·	PRGM COSTS	PRGM		Residents Cost		
					& Post		
					Stepdown		
		22.00	23. 00	24. 00	Adjustments 25.00	26. 00	
	GENERAL SERVICE COST CENTERS	22.00	23.00	24.00	25.00	20.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	01160 COMMUNI CATI ONS						5. 01
5. 02	00550 DATA PROCESSI NG						5. 02
5. 04 5. 05	OO570 ADMITTING OO580 CASHIERING/ACCOUNTS RECEIVABLE						5. 04 5. 05
5. 06	00590 OTHER ADMINISTRATIVE AND GENERAL						5. 06
6.00	00600 MAINTENANCE & REPAIRS		•				6. 00
7.00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A						10.00
13. 00	01300 NURSI NG ADMI NI STRATI ON						13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY						14. 00
15.00	01500 PHARMACY						15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY						16. 00
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRVD	4 070 450					21. 00
22. 00 23. 00	O2200 I &R SERVICES-OTHER PRGM COSTS APPRVD O2300 PARAMED ED PRGM	4, 870, 150	199, 212				22. 00 23. 00
23.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		177, 212				23.00
30. 00	03000 ADULTS & PEDI ATRI CS	2, 754, 427	0	62, 830, 895	-5, 584, 095	57, 246, 800	30.00
31.00	03100 INTENSIVE CARE UNIT	598, 789	0	16, 374, 524		15, 160, 590	1
32. 00	03200 CORONARY CARE UNIT	79, 839	0	161, 858		0	32. 00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	0	0	3, 457, 912		3, 457, 912	
40. 00 41. 00	04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF	0 0	0	4, 066, 114	١	4, 066, 114	40.00
43.00	04300 NURSERY	0	0	1, 315, 774	l .	1, 315, 774	1
10.00	ANCI LLARY SERVI CE COST CENTERS	<u> </u>	<u> </u>	1,010,771	<u> </u>	1,010,771	10.00
50.00	05000 OPERATING ROOM	265, 463	0	15, 141, 340	-538, 177	14, 603, 163	50. 00
51.00	05100 RECOVERY ROOM	0	0	3, 345, 626	l .	3, 345, 626	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	122 720	0	4, 571, 782	l .	4, 571, 782	
54. 00 57. 00	05400 RADI OLOGY-DI AGNOSTI C 03280 EKG AND EEG	133, 730	0	22, 163, 335 182, 607		21, 892, 223 182, 607	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	102, 007	o o	102, 007	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	o	O	5, 350, 133		5, 350, 133	
60.00	06000 LABORATORY	o	О	12, 941, 096	0	12, 941, 096	60.00
60. 01	06001 BLOOD LABORATORY	0	0	C	0	0	
	06300 BLOOD STORING, PROCESSING, & TRANS.	0	0	1, 916, 756	l l	1, 916, 756	
65. 00 65. 01	06500 RESPI RATORY THERAPY 06501 SLEEP LAB	169, 657	0	5, 530, 705 710, 924		5, 186, 757 710, 924	
66. 00	06600 PHYSI CAL THERAPY	0	0	5, 604, 976		5, 604, 976	
67. 00	06700 OCCUPATI ONAL THERAPY	Ö	O	1, 297, 944		1, 297, 944	
68. 00	06800 SPEECH PATHOLOGY	0	0	611, 522	O	611, 522	68. 00
68. 01	06801 AUDI OLOGY	0	0		0	0	
69. 00	06900 ELECTROCARDI OLOGY	239, 516	0	4, 006, 217		3, 520, 643	1
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT		0	15, 643, 732 22, 220, 571	I	15, 643, 732 22, 220, 571	
73. 00	07300 DRUGS CHARGED TO PATIENTS		199, 212	41, 641, 093	I	41, 641, 093	
73. 01	07301 HOSPITAL BASED RETAIL PHARMACIES	0	O	10, 967, 624	I	10, 967, 624	
74.00	07400 RENAL DIALYSIS	0	0	1, 675, 706	0	1, 675, 706	74. 00
76. 00	03160 CARDI OPULMONARY	0	0	0	0	0	
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	883, 462	l	883, 462	1
76. 98	O7698 HYPERBARI C OXYGEN THERAPY OUTPATIENT SERVICE COST CENTERS	l d	U _I	1, 857, 667	0	1, 857, 667	76. 98
90. 00	09000 CLINIC	O	0	C	ol	0	90.00
90. 02	09002 PAIN CLINIC	122, 752	0	2, 355, 990		2, 107, 133	
90. 03	09003 ONCOLOGY CLINIC	95, 806	0	2, 225, 418		2, 031, 189	
91. 00	09100 EMERGENCY	404, 183	0	20, 798, 843		19, 979, 437	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				0	0	92.00
92. 01	O9201 OBSERVATION BEDS (DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	0	ΟĮ		0	0	92. 01
95. 00	09500 AMBULANCE SERVICES	0	0	2, 660, 407	O	2, 660, 407	95. 00
	SPECIAL PURPOSE COST CENTERS		<u> </u>	, , , , , , , , , , , , , , , , , , , ,		, , , , , , , ,]
	11300 I NTEREST EXPENSE						113. 00
118. 00	9 /	4, 864, 162	199, 212	294, 512, 553	-9, 861, 190	284, 651, 363	1118. 00
190 00	NONREIMBURSABLE COST CENTERS 1900 GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	0	834, 539	O	834, 539	190 00
1 70. 00	TITOGO OTTI, I LONEIN, COLLECTION & CANTLEN	<u>, </u>	- VI	034, 039	<u> </u>	034, 039	1170.00

| Period: | Worksheet B | From 01/01/2017 | Part | To 12/31/2017 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0089

			Т	o 12/31/2017	Date/Time Prepared: 5/24/2018 5:05 pm
	INTERNS &				372472018 3.03 piii
	RESI DENTS				
Cost Center Description	SERVI CES-OTHER	PARAMED ED	Subtotal	Intern &	Total
	PRGM COSTS	PRGM		Residents Cost	
				& Post	
				Stepdown	
	22.22	22.22	24.22	Adjustments	04.00
191. 00 19100 RESEARCH	22. 00 5, 988	23. 00	24. 00 1, 147, 013	25. 00 -12, 139	26. 00 1, 134, 874 191. 00
191. 00 19100 RESEARCH 194. 00 07950 OTHER NONREIMBURSABLE COST CENTERS	3, 900	0	37, 600		37, 600 194. 00
194. 01 07951 BSU PHARMACY		0	30, 689		30, 689 194. 01
194. 02 07952 PAVI LLI ON PHARMACY		0	7, 501, 913		7, 501, 913 194. 02
194. 03 07953 VENDI NG		0	7, 301, 913	0	0 194. 03
194. 04 07954 CARELI NE		0		0	0 194.04
194. 05 07955 WELLNESS CENTER	0	0	415, 864	0	415, 864 194. 05
194. 06 07956 PHYSI CLAN PRACTICE CLINICS	0	0	1, 202, 577		1, 202, 577 194. 06
194. 07 07957 PERINATAL CLINIC	0	0	0	o	0 194.07
194. 08 07958 RENTAL PROPERTY	0	0	8, 386, 144	O	8, 386, 144 194. 08
194. 09 07959 ADVERTI SI NG	o	0	0	o	0 194. 09
194. 10 07960 INTEGRA LTAC	o	0	822, 767	o	822, 767 194. 10
194. 11 07961 IU HEALTH HOSPICE	0	0	237, 362	o	237, 362 194. 11
194.12 07962 POB MEDICAL PAVILLION CONDOS	0	0	0	0	0 194. 12
194. 13 07963 EXECUTI VE PHYSI CAL	0	0	0	0	0 194. 13
194.14 07964 NEW CASTLE ONCOLOGY	0	0	0	0	0 194. 14
194.15 07965 MARKETING/PUBLIC RELATIONS	0	0	260, 876		260, 876 194. 15
194.16 07966 JAY COUNTY HOSPITAL	0	0	289, 910	0	289, 910 194. 16
194. 17 07967 CARDI NAL HEALTH CHOI CE	0	0	0	0	0 194. 17
194. 18 07968 CHV CARDINAL HEALTH VENTURES	0	0	0	0	0 194. 18
194. 19 07969 HEALTH CARE CONNECTIONS	0	0	0	0	0 194. 19
194. 20 07970 MEALS ON WHEELS	0	0	0	0	0 194. 20
194. 21 07971 ST MARY'S SCHOOL	0	0	700 400	0	0 194. 21
194. 22 07972 THERAPI ES TO OTHER ENTITIES	0	0	709, 433		709, 433 194. 22
194. 23 07973 CANCER CENTER BOUTIQUE 194. 24 07974 BOSC BALL OUTPATIENT SURGERY	0	0	188, 399		188, 399 194. 23
194. 25 07974 BOSC BALL OUTPATTENT SURGERT	0	0	1, 433, 719 632, 669		1, 433, 719 194. 24 632, 669 194. 25
194. 26 07976 BLACKFORD COMMUNITY HOSPITAL	0	0	40, 305		40, 305 194. 26
194. 27 07977 MI DWEST HEALTH STRATEGIES	0	0	40, 303	0	0 194. 27
194. 28 07978 CARDI NAL SELECT RISK RETENTION GRP		0		0	0 194. 28
194. 29 07979 HOME OFFICE CARDINAL HEALTH INITIATI		0		0	0 194. 29
194. 30 07980 CARDI NAL HEALTH ALLI ANCE		0	77		77 194. 30
194. 31 07986 OTHER NONREI MBURSABLE COST CENTERS		0	, , ,		0 194. 31
194. 32 07982 RENAL DI ALYSI S	0	0		0	0 194. 32
194. 33 07983 LAB CORP	0	0	ا م	o o	0 194. 33
194. 34 07984 H. O. MATERI ALS MGMT	ام	0	l o	l ol	0 194. 34
194. 35 07985 LEASED SPACE	l	0	0	o	0 194. 35
200.00 Cross Foot Adjustments	o	0	0	o	0 200. 00
201.00 Negative Cost Centers	o	0	0	o	0 201. 00
202.00 TOTAL (sum lines 118 through 201)	4, 870, 150	199, 212	318, 684, 409	-9, 873, 329	308, 811, 080 202. 00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared: | From 12/31/2017 | Part II | Prepared: | Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0089

Cost Center Description Directly RELATED COSTS NEW BLDG & Subtotal EMPLOYEE BENEFITS DEPARTMENT	1. 00 4. 00 5. 01 5. 02 5. 04 5. 05
0 1.00 2A 4.00 5.01 GENERAL SERVICE COST CENTERS	4. 00 5. 01 5. 02 5. 04 5. 05
1.00 O0100 NEW CAP REL COSTS-BLDG & FIXT	4. 00 5. 01 5. 02 5. 04 5. 05
	4. 00 5. 01 5. 02 5. 04 5. 05
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 01 /5.0001 /5.0001 /5.0001	5. 01 5. 02 5. 04 5. 05
5. 01 01160 COMMUNI CATI ONS 0 20, 867 20, 867 357 21, 22-	5. 02 5. 04 5. 05
5. 01 OTTOO COMMONT CATTONS 0 20, 867 20, 867 357 21, 227 25, 867 20	5. 04 5. 05
5. 04 00570 ADMI TTI NG 0 61, 557 61, 557 680 34	5. 05
5. 05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 0 0 0 0 0	5. 06
5. 06 00590 OTHER ADMINISTRATIVE AND GENERAL 0 811, 679 811, 679 4, 070 490	
6. 00 00600 MAI NTENANCE & REPAI RS 0 12, 475, 555 12, 475, 555 2, 056 730	•
7. 00 00700 OPERATI ON OF PLANT 0 924, 276 924, 276 889 28.	7. 00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 0 0 0 0 0 0 0 0 0	8. 00 9. 00
10. 00 01000 DI ETARY	•
11.00 01100 CAFETERI A 0 200, 203 200, 203 843 48:	•
13. 00 01300 NURSING ADMINISTRATION 0 243, 847 243, 847 3, 849 886	13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY 0 223, 300 223, 300 0	14. 00
15. 00 01500 PHARMACY 0 94, 571 94, 571 3, 418 73	•
16. 00 01600 MEDI CAL RECORDS & LI BRARY 0 0 0 0 0 0 0 0 0 21. 00 02100 1 &R SERVI CES-SALARY & FRI NGES APPRVD 0 0 0 2, 657 77	16. 00 21. 00
22. 00 02200 1 &R SERVI CES-OTHER PRGM COSTS APPRVD 0 256, 565 256, 565 177 9	22. 00
23. 00 02300 PARAMED ED PRGM 0 1, 351 1, 351 97 18	1
INPATIENT ROUTINE SERVICE COST CENTERS	
30. 00 03000 ADULTS & PEDI ATRI CS 0 2, 109, 311 2, 109, 311 14, 568 4, 28	30.00
31. 00 03100 I NTENSI VE CARE UNI T	1
35. 00 02060 NEONATAL INTENSIVE CARE UNIT 0 71,726 71,726 1,252 29.	
40. 00 04000 SUBPROVI DER - PF 0 0 0 0	40.00
41. 00 04100 SUBPROVI DER - I RF 0 139, 259 139, 259 1, 071 27	41. 00
43. 00 04300 NURSERY 0 54, 077 54, 077 407 98	43. 00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM 0 454, 957 454, 957 3, 501 1, 020	50. 00
51. 00 05100 RECOVERY ROOM 0 113, 391 1, 040 28	51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 0 177, 665 177, 665 1, 319 32	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 853, 177 853, 177 5, 977 1, 41-	1
57. 00 03280 EKG AND EEG	57. 00
58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI)	58. 00 59. 00
60. 00 06000 LABORATORY 0 44, 548 44, 548 0 65-	60.00
60. 01 06001 BLOOD LABORATORY 0 0 0 0	60. 01
63.00 06300 BLOOD STORING, PROCESSING, & TRANS. 0 0 0 0 0	63. 00
65. 00 06500 RESPI RATORY THERAPY	
66. 00 06600 PHYSI CAL THERAPY	•
	67. 00
68. 00 06800 SPEECH PATHOLOGY 0 8, 010 8, 010 289 66	68. 00
68. 01 06801 AUDI OLOGY 0 0 0 0	68. 01
69. 00 06900 ELECTROCARDI OLOGY	69. 00 71. 00
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0	
73.01 07301 HOSPITAL BASED RETAIL PHARMACIES 0 0 0 1,170 229	
74. 00 07400 RENAL DI ALYSI S 0 40, 648 40, 648 0 0	1
76. 00 03160 CARDI OPULMONARY 0 0 0 0 0 0 0 0 0	76. 00 76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 1, 045 1, 045 359 95	•
OUTPATIENT SERVICE COST CENTERS	
90. 00 09000 CLI NI C 0 0 0 0	
90. 02 09002 PAIN CLINIC 0 312, 633 312, 633 283 99 90. 03 09003 0NCOLOGY CLINIC 0 14, 863 14, 863 617 149	•
90. 03 09003 0NCOLOGY CLINIC 0 14, 863 14, 863 617 146 14, 100 14, 1	1
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART)	92.00
92.01 09201 0BSERVATI ON BEDS (DI STI NCT PART) 0 0 0 0	92. 01
OTHER REI MBURSABLE COST CENTERS	
95. 00 09500 AMBULANCE SERVI CES 0 41, 651 41, 651 1, 031 396 SPECI AL PURPOSE COST CENTERS	95. 00
113. 00 11300 I NTEREST EXPENSE	113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 0 21,625,404 21,625,404 72,563 20,639	118. 00
NONREI MBURSABLE COST CENTERS	
	190. 00 191. 00
1 0 21,020 21,020 447 121	1171.00

| Peri od: | Worksheet B | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0089

			To	12/31/2017	Date/Time Prep 5/24/2018 5:09	
Cost Center Description	Directly Assigned New	CAPITAL RELATED COSTS NEW BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS	COMMUNI CATI ONS	σ piii
	Capi tal			DEPARTMENT		
	Related Costs					
	0	1. 00	2A	4. 00	5. 01	
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194. 00
194. 01 07951 BSU PHARMACY	0	0	0	160	l .	194. 01
194. 02 07952 PAVILLION PHARMACY	0	39, 478	39, 478	493		194. 02
194. 03 07953 VENDI NG 194. 04 07954 CARELI NE	0	0	0	0	l	194. 03 194. 04
194. 04 07954 CARELI NE 194. 05 07955 WELLNESS CENTER	0	70, 667	70, 667	21		194. 04
194. 06 07956 PHYSI CLAN PRACTICE CLINICS	0	282, 781		0		194. 05
194. 07 07957 PERINATAL CLINIC	0	202, 781		0		194. 00
194. 08 07958 RENTAL PROPERTY	0	1, 853, 428	· ·	0		194. 07
194. 09 07959 ADVERTI SI NG	0	1,033,420	1, 033, 420	0	l .	194. 09
194. 10 07960 I NTEGRA LTAC	0	163, 971	163, 971	0	l .	194. 10
194. 11 07961 I U HEALTH HOSPI CE	0	53, 770	·	0	l .	194. 11
194. 12 07962 POB MEDICAL PAVILLION CONDOS	0	0	0	0	l .	194. 12
194. 13 07963 EXECUTI VE PHYSI CAL	0	0	0	0	o	194. 13
194.14 07964 NEW CASTLE ONCOLOGY	0	0	0	0	o	194. 14
194. 15 07965 MARKETING/PUBLIC RELATIONS	0	62, 769	62, 769	0	0	194. 15
194.16 07966 JAY COUNTY HOSPITAL	0	0	0	151	ol	194. 16
194. 17 07967 CARDI NAL HEALTH CHOI CE	0	0	0	0	0	194. 17
194. 18 07968 CHV CARDINAL HEALTH VENTURES	0	0	0	0		194. 18
194. 19 07969 HEALTH CARE CONNECTIONS	0	0	0	0		194. 19
194.20 07970 MEALS ON WHEELS	0	0	0	0		194. 20
194. 21 07971 ST MARY'S SCHOOL	0	0	0	0		194. 21
194. 22 07972 THERAPIES TO OTHER ENTITIES	0	0	0	936		194. 22
194. 23 07973 CANCER CENTER BOUTI QUE	0	11, 868		10		194. 23
194. 24 07974 BOSC BALL OUTPATIENT SURGERY	0	344, 965		0		194. 24
194. 25 07975 CARDI NAL BEHAVI ORAL HEALTH 194. 26 07976 BLACKFORD COMMUNI TY HOSPI TAL	0	123, 323	123, 323	0 119		194. 25 194. 26
194. 27 07977 MIDWEST HEALTH STRATEGIES	0	0	0	119		194. 26
194. 28 07978 CARDINAL SELECT RISK RETENTION GRP	0	0	0	0		194. 27
194. 29 07979 HOME OFFICE CARDINAL HEALTH INITIATI	0	0	0	0		194. 29
194. 30 07980 CARDI NAL HEALTH ALLI ANCE	0	0	0	0		194. 30
194. 31 07986 OTHER NONREI MBURSABLE COST CENTERS	0	0	0	0		194. 31
194. 32 07982 RENAL DI ALYSI S	0	0	Ö	0		194. 32
194. 33 07983 LAB CORP	0	١	0	0		194. 33
194. 34 07984 H. O. MATERI ALS MGMT	0	0	0	0		194. 34
194. 35 07985 LEASED SPACE	0	Ö	o	0	l .	194. 35
200.00 Cross Foot Adjustments			0			200. 00
201.00 Negative Cost Centers		0	0	0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	0	24, 654, 044	24, 654, 044	75, 000	21, 224	202. 00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2017 Part II
To 12/31/2017 Date/Time Prepared: 5/24/2018 5:05 pm

					0 12/31/201/	5/24/2018 5:0	
	Cost Center Description	DATA	ADMI TTI NG	CASHI ERI NG/ACC	-	MAINTENANCE &	
		PROCESSI NG		OUNTS RECEI VABLE	ADMINISTRATIVE AND GENERAL	REPAI RS	
		5. 02	5. 04	5. 05	5. 06	6. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT					I	1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					I	4. 00
5. 01	01160 COMMUNI CATI ONS					I	5. 01
5. 02 5. 04	OO550 DATA PROCESSING OO570 ADMITTING	0	62, 581			I	5. 02 5. 04
5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	02, 361			I	5. 04
5. 06	00590 OTHER ADMINISTRATIVE AND GENERAL	0	0		816, 239	I	5. 06
6. 00	00600 MAINTENANCE & REPAIRS	o	0	o o	59, 305	12, 537, 646	1
7.00	00700 OPERATION OF PLANT	O	O	0	20, 660	1, 033, 799	
8.00	00800 LAUNDRY & LINEN SERVICE	0	0	0	3, 905	0	8. 00
9.00	00900 HOUSEKEEPI NG	0	0	0	10, 146	236, 500	9. 00
10. 00	01000 DI ETARY	0	0	0	5, 904	161, 370	
11.00	01100 CAFETERI A	0	0	0	3, 673	223, 927	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	0	0	22, 200	272, 741	13.00
14. 00 15. 00	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY		0	1	29, 901 16, 750	249, 759 105, 778	ı
	01600 MEDICAL RECORDS & LIBRARY		0		10, 730	0 0	ı
21. 00	02100 I &R SERVI CES-SALARY & FRI NGES APPRVD	o	0	o o	12, 577	Ö	
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	O	O	o o	10, 438	286, 966	1
23.00	02300 PARAMED ED PRGM	0	0	0	494	1, 511	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS			,			
30. 00	03000 ADULTS & PEDI ATRI CS	0	7, 588		102, 629		1
31. 00	03100 NTENSI VE CARE UNI T	0	2, 120		29, 648	433, 534	1
32. 00	03200 CORONARY CARE UNIT	0	O F30	1	7 224	0 225	
35. 00 40. 00	02060 NEONATAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	0	529 0		7, 224 0	80, 225 0	35. 00 40. 00
41. 00	04100 SUBPROVI DER – TPF	0	388	1	7, 490	_	1
43. 00	04300 NURSERY		222		2, 488	60, 484	1
10.00	ANCILLARY SERVICE COST CENTERS	٥١			27 100	307 101	10.00
50.00	05000 OPERATI NG ROOM	0	5, 806	0	28, 375	508, 867	50.00
51.00	05100 RECOVERY ROOM	0	681	0	6, 399	126, 827	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	1, 021	0	8, 420	198, 717	52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	7, 485	1	46, 942	954, 274	54.00
57. 00	03280 EKG AND EEG	0	130	1	446	0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	2 522	1	11 200	0	58. 00
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	3, 523 3, 779	1	11, 208 32, 300	218, 754 49, 827	59. 00 60. 00
60. 00	06001 BLOOD LABORATORY	0	3, 779	1	32, 300 0	49, 627	60. 00
63. 00	06300 BLOOD STORING, PROCESSING, & TRANS.	0	237	1	3, 850	0	63. 00
65. 00	06500 RESPI RATORY THERAPY	o	780	1	12, 291	72, 466	1
65. 01	06501 SLEEP LAB	0	309	0	1, 751	0	65. 01
66.00	06600 PHYSI CAL THERAPY	O	676	0	13, 532	48, 285	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	218		2, 994	37, 456	
68. 00	06800 SPEECH PATHOLOGY	0	108	1	1, 471	8, 959	1
68. 01	06801 AUDI OLOGY	0	1 000	1	(050	0	
69. 00 71. 00	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	1, 890 1, 918		6, 858 30, 900	287, 340 0	1
71.00	07200 I MPL. DEV. CHARGED TO PATIENT	0	3, 935		44, 225	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	8, 302		88, 656	_	73. 00
	07301 HOSPI TAL BASED RETAIL PHARMACIES	Ö	328		27, 997	Ö	73. 01
	07400 RENAL DIALYSIS	0	140		3, 946	45, 465	
76.00	03160 CARDI OPULMONARY	0	0	0	0	0	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	145		2, 103	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	555	0	4, 395	1, 169	76. 98
00.00	OUTPATIENT SERVICE COST CENTERS						00.00
90.00	09000 CLI NI C	0	299		0 715	240 (70	
90. 02	O9002 PAIN CLINIC O9003 ONCOLOGY CLINIC	0	1, 124		2, 715 4, 460	349, 679 16, 625	
91. 00	09100 EMERGENCY	0	8, 040	1	41, 333	517, 219	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	J	0,010		11, 000	1	92. 00
	09201 OBSERVATION BEDS (DISTINCT PART)	o	0	0	0	0	1
	OTHER REIMBURSABLE COST CENTERS				,		
95. 00	09500 AMBULANCE SERVI CES	0	305	0	6, 318	46, 586	95. 00
	SPECIAL PURPOSE COST CENTERS						
	11300 I NTEREST EXPENSE	_		_			113. 00
118. 00	, J ,	0	62, 581	0	779, 317	9, 150, 126	118.00
100 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	ol	0	0	2, 120		190. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		0	1	2, 120 2, 503		190.00
	07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	1	2, 303		194. 00
	07951 BSU PHARMACY	o	0	1	69		194. 01
	07952 PAVILLION PHARMACY	o	0	0			194. 02
	•	, , , , , , , , , , , , , , , , , , ,					

| Period: | Worksheet B | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0089

			T	o 12/31/2017	Date/Time Pre 5/24/2018 5:0	
Cost Center Description	DATA	ADMI TTI NG	CASHI ERI NG/ACC	OTHER	MAINTENANCE &	J pili
oost conten boschiptron	PROCESSI NG	7.0 111110		ADMI NI STRATI VE	REPAI RS	
	11.002001110		RECEI VABLE	AND GENERAL		
	5. 02	5. 04	5. 05	5. 06	6. 00	
194. 03 07953 VENDI NG	0	C	0	0	0	194. 03
194. 04 07954 CARELI NE	0	0	0	0	0	194. 04
194. 05 07955 WELLNESS CENTER	0	0	0	334	79, 041	194. 05
194.06 07956 PHYSICIAN PRACTICE CLINICS	0	0	0	859	316, 289	194. 06
194. 07 07957 PERINATAL CLINIC	0	0	0	0	0	194. 07
194. 08 07958 RENTAL PROPERTY	0	0	0	7, 069	2, 073, 050	194. 08
194. 09 07959 ADVERTI SI NG	0	0	0	0	0	194. 09
194. 10 07960 INTEGRA LTAC	0	0	0	471	183, 401	194. 10
194. 11 07961 I U HEALTH HOSPI CE	0	0	0	144	60, 142	194. 11
194.12 07962 POB MEDICAL PAVILLION CONDOS	0	0	0	0	0	194. 12
194. 13 07963 EXECUTI VE PHYSI CAL	0	0	0	0	0	194. 13
194.14 07964 NEW CASTLE ONCOLOGY	0	0	0	0	0	194. 14
194. 15 07965 MARKETING/PUBLIC RELATIONS	0	0	0	180	70, 207	194. 15
194. 16 07966 JAY COUNTY HOSPITAL	0	0	0	743	0	194. 16
194. 17 07967 CARDI NAL HEALTH CHOI CE	0	0	0	0	0	194. 17
194. 18 07968 CHV CARDINAL HEALTH VENTURES	0	0	0	0	0	194. 18
194. 19 07969 HEALTH CARE CONNECTIONS	0	0	0	0	0	194. 19
194.20 07970 MEALS ON WHEELS	0	0	0	0	0	194. 20
194. 21 07971 ST MARY'S SCHOOL	0	0	0	0	0	194. 21
194.22 07972 THERAPIES TO OTHER ENTITIES	0	0	0	1, 747		194. 22
194. 23 07973 CANCER CENTER BOUTIQUE	0	0	0	387	13, 275	194. 23
194. 24 07974 BOSC BALL OUTPATIENT SURGERY	0	0	0	990	385, 842	194. 24
194. 25 07975 CARDI NAL BEHAVI ORAL HEALTH	0	0	0	354	137, 936	
194.26 07976 BLACKFORD COMMUNITY HOSPITAL	0	0	0	82		194. 26
194. 27 07977 MI DWEST HEALTH STRATEGIES	0	0	0	0		194. 27
194.28 07978 CARDINAL SELECT RISK RETENTION GRP	0	0	0	0		194. 28
194.29 07979 HOME OFFICE CARDINAL HEALTH INITIATI	0	0	0	0	0	194. 29
194.30 07980 CARDINAL HEALTH ALLIANCE	0	0	0	0		194. 30
194.31 07986 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194. 31
194. 32 07982 RENAL DI ALYSI S	0	0	0	0		194. 32
194. 33 07983 LAB CORP	0	0	0	0	0	194. 33
194.34 07984 H.O. MATERIALS MGMT	0	0	0	0		194. 34
194. 35 07985 LEASED SPACE	0	0	0	0		194. 35
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0	0	0		201. 00
202.00 TOTAL (sum lines 118 through 201)	0	62, 581	0	816, 239	12, 537, 646	202. 00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2017 Part II
To 12/31/2017 Date/Time Prepared: 5/24/2018 5:05 pm

) 12/31/201/	5/24/2018 5:0	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	·
		PLANT	LINEN SERVICE				
	CENEDAL CEDVICE COCT CENTEDO	7. 00	8. 00	9. 00	10. 00	11. 00	
1. 00	GENERAL SERVICE COST CENTERS O0100 NEW CAP REL COSTS-BLDG & FIXT						1.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	01160 COMMUNI CATI ONS						5. 01
5. 02	00550 DATA PROCESSING						5. 02
5. 04	00570 ADMITTING						5. 04
5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 05
5.06	00590 OTHER ADMINISTRATIVE AND GENERAL						5. 06
6.00	00600 MAINTENANCE & REPAIRS						6. 00
7.00	00700 OPERATION OF PLANT	1, 979, 906					7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	3, 905				8. 00
9.00	00900 HOUSEKEEPI NG	40, 704	0	501, 725			9. 00
10. 00	01000 DI ETARY	27, 773	0	972	341, 707		10. 00
11.00	01100 CAFETERI A	38, 540	0	5, 140	0	472, 809	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	46, 941	0	2, 049	0	24, 129	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	42, 986	0	2, 153	U	10.034	14.00
15. 00 16. 00	+ I	18, 205 0	1	2, 431 0	0	19, 934 0	15. 00 16. 00
21. 00	+ I	0	0	0	0	21, 009	21. 00
22. 00	+ I	49, 389	0	486	0	2, 472	22.00
23. 00	+ +	260	0	0	ol	481	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	= 3.51	-	-1	-1		
30.00	03000 ADULTS & PEDIATRICS	406, 043	1, 781	225, 792	266, 404	116, 736	30. 00
31.00	I I	74, 615	327	37, 093	25, 672	31, 674	31.00
32. 00	03200 CORONARY CARE UNIT	0	0		o	0	32. 00
35. 00	+ I	13, 807	32	1, 806	0	7, 960	35. 00
40. 00	04000 SUBPROVI DER - I PF	0	0	- 1	0	0	40. 00
41. 00	04100 SUBPROVI DER – I RF	26, 808	88		17, 193	7, 378	41.00
43. 00		10, 410	37	5, 418	0	2, 670	43. 00
50. 00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM	87, 580	299	28, 063	O	27, 784	50.00
51. 00	05100 RECOVERY ROOM	21, 828	95	· ·	0	7, 690	51.00
52. 00	1 1	34, 201	159	· ·	Ö	8, 759	52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	164, 238	278		ol	38, 518	54.00
57. 00	1 1	0	0		o	1, 566	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	o	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	37, 649	57	12, 850	o	7, 687	59. 00
60.00	06000 LABORATORY	8, 576	0	12, 642	o	17, 814	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0	1	0	0	0	63. 00
65. 00	06500 RESPI RATORY THERAPY	12, 472	1	2, 014	0	15, 905	65. 00
65. 01	06501 SLEEP LAB	0	0	-	0	2, 532	65. 01
66.00	06600 PHYSI CAL THERAPY	8, 310	14		0	21, 330	66.00
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	6, 447	0	486 486	U O	3, 620	67. 00 68. 00
68. 01	06801 AUDI OLOGY	1, 542	0	460	0	1, 840 0	68. 00
69. 00	+ + +	49, 454	52	-	0	8, 039	69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		ol	0, 007	71. 00
72. 00	1 1	O	Ö	Ö	ol	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	o	0	73. 00
73. 01	07301 HOSPITAL BASED RETAIL PHARMACIES	0	0	972	o	6, 199	73. 01
74.00		7, 825	7	0	o	0	74.00
76. 00		0	0	0	0	0	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	3, 959	0	3, 274	76. 97
76. 98		201	0	0	0	2, 544	76. 98
00.00	OUTPATIENT SERVICE COST CENTERS		^		ما		00.00
90. 00 90. 02		60, 183	0	104	0	0 2 570	90. 00 90. 02
90. 02		2, 861	15	486	0	2, 579 4, 023	90. 02
91.00	I I	89, 018	614	1	0	30, 127	91.00
92. 00	1 1	07,010	011	00,010	Ĭ	00, 127	92. 00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	o	o	0	92. 01
	OTHER REIMBURSABLE COST CENTERS	-,	<u> </u>	-1	-,		
95.00	09500 AMBULANCE SERVICES	8, 018	0	0	0	10, 618	95. 00
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE					-	113. 00
118. 00		1, 396, 884	3, 858	489, 153	309, 269	456, 891	118. 00
100.0	NONREI MBURSABLE COST CENTERS		^		ام	1 410	100.00
	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1 1/3	0	0	O		190.00
	0 19100 RESEARCH 0 07950 OTHER NONREIMBURSABLE COST CENTERS	4, 162 0	0	4, 098	O ₁		191. 00 194. 00
	107950 OTHER NONRETMBURSABLE COST CENTERS	0	0	4,098	O A		194. 00
194. 0	2 07952 PAVILLION PHARMACY	7, 600	0	0	0		194. 01
	3 07953 VENDI NG	0	n	ا	ol Ol		194. 02
	i I	, 9		٠	<u> </u>		

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared: | From 12/31/2017 | Part II | Prepared: |

				, 12,01,201,	5/24/2018 5:0	
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
	PLANT	LINEN SERVICE				
	7.00	8. 00	9. 00	10.00	11. 00	
194. 04 07954 CARELI NE	0	0	0	0		194. 04
194. 05 07955 WELLNESS CENTER	13, 604	47	5, 557	0	264	194. 05
194.06 07956 PHYSICIAN PRACTICE CLINICS	54, 436	0	972	0	0	194. 06
194. 07 07957 PERINATAL CLINIC	0	0	0	0	0	194. 07
194.08 07958 RENTAL PROPERTY	356, 789	0	0	0	0	194. 08
194. 09 07959 ADVERTI SI NG	0	0	0	0	0	194. 09
194. 10 07960 I NTEGRA LTAC	31, 565	0	0	17, 542	0	194. 10
194. 11 07961 I U HEALTH HOSPI CE	10, 351	0	1, 945	0	0	194. 11
194.12 07962 POB MEDICAL PAVILLION CONDOS	0	0	0	0	0	194. 12
194. 13 07963 EXECUTI VE PHYSI CAL	0	0	0	0	0	194. 13
194.14 07964 NEW CASTLE ONCOLOGY	0	0	0	0	0	194. 14
194. 15 07965 MARKETING/PUBLIC RELATIONS	12, 083	0	0	0	0	194. 15
194. 16 07966 JAY COUNTY HOSPITAL	0	0	0	0	0	194. 16
194. 17 07967 CARDI NAL HEALTH CHOI CE	0	0	0	0	0	194. 17
194. 18 07968 CHV CARDINAL HEALTH VENTURES	0	0	0	0	0	194. 18
194. 19 07969 HEALTH CARE CONNECTIONS	0	0	0	0	0	194. 19
194.20 07970 MEALS ON WHEELS	0	0	0	0	0	194. 20
194. 21 07971 ST MARY'S SCHOOL	0	0	0	0	0	194. 21
194.22 07972 THERAPIES TO OTHER ENTITIES	0	0	0	0	6, 205	194. 22
194. 23 07973 CANCER CENTER BOUTIQUE	2, 285	0	0	0	189	194. 23
194. 24 07974 BOSC BALL OUTPATIENT SURGERY	66, 407	0	0	0	0	194. 24
194. 25 07975 CARDI NAL BEHAVI ORAL HEALTH	23, 740	0	0	14, 896	0	194. 25
194.26 07976 BLACKFORD COMMUNITY HOSPITAL	0	0	0	0	453	194. 26
194. 27 07977 MIDWEST HEALTH STRATEGIES	0	0	0	0	0	194. 27
194.28 07978 CARDINAL SELECT RISK RETENTION GRP	0	0	0	0	0	194. 28
194.29 07979 HOME OFFICE CARDINAL HEALTH INITIATI	0	0	0	0	0	194. 29
194. 30 07980 CARDI NAL HEALTH ALLI ANCE	0	0	0	0	0	194. 30
194.31 07986 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194. 31
194. 32 07982 RENAL DIALYSIS	0	0	0	0	0	194. 32
194. 33 07983 LAB CORP	0	0	0	0	0	194. 33
194.34 07984 H.O. MATERIALS MGMT	0	0	0	0	0	194. 34
194. 35 07985 LEASED SPACE	0	0	0	0	0	194. 35
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0	0	0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	1, 979, 906	3, 905	501, 725	341, 707		

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared: | From 12/31/2017 | Part II | Prepared: | Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0089

COST CENTER DESCRIPTION					lo	12/31/2017	Date/lime Prep 5/24/2018 5:09	
DEBARMAL SERVICE LOST CENTERS 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		Cost Center Description	ADMI NI STRATI ON	SERVICES & SUPPLY		RECORDS & LI BRARY	I NTERNS & RESI DENTS SERVI CES-SALAR Y & FRI NGES	
4 - 0.0 0.0000 DEPLOYEE SIREFITS DEPARTMENT		GENERAL SERVICE COST CENTERS						
0.1146 COMMANICATIONS		1						
0.0000 0.00000 0.000000 0.000000 0.000000 0.000000 0.00000000		1						
5.04 0.0076/J.CANN TILKO 5.05 0.0080/C.SCH ENING/ACCURTS RECEIVABLE 5.06 0.0080/C.SCH ENING/ACCURTS RECEIVABLE 5.06 0.0090/C.SCH ENING/ACCURTS RECEIVABLE 5.07 0.0090/C.SCH ENING/ACCURTS RECEIVABLE 6.00 0.0090/C.SCH ENING/ACCURTS RECEI		1						
5.05		1						
0.00 DOCOGO MAINTENANCE & REPAIRS								
0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.000000 0.00000000		00590 OTHER ADMINISTRATIVE AND GENERAL						5.06
8.00 00000 LAMINORY & LINEN SERVICE								
9.00 0.0900 MULSEKEFEP ING 9.00 11.00								
10.00 01000 DETARY								
13.00 01300 NURSING ADMINISTRATION 616, 642 548,000 113,00 14.00 1400 01400 CENTRAL SERVICE SE SUPPLY 0 0,252 264,342 115,00 16.								
14.00 01400 CRITTAL SERVICES & SUPPLY 0 548,009 14.00 15.00 01500 PHARMACY 0 2,522 264,342 15.00 16.00 01600 PHARMACY 0 0 0 0 0 37.014 16.00 01600 PHARMACY 0 0 0 0 0 37.014 17.00 02100 188 SERVICES-SALARY & FIRINGS APPRVID 0 0 0 0 0 37.014 17.00 02100 188 SERVICES-SALARY & FIRINGS APPRVID 0 0 0 0 0 37.014 17.00 02100 188 SERVICES-SALARY & FIRINGS APPRVID 0 0 0 0 0 0 17.00 02100 188 SERVICES-SALARY & FIRINGS APPRVID 0 0 0 0 0 0 17.00 03000 ADULTS & PERSENUE COST CENTERS 296,741 31,487 1,924 0 30.00 18.00 03000 ADULTS & PERSENUE COST CENTERS 296,741 31,487 1,924 0 30.00 18.00 03000 ADULTS & PERSENUE COST CENTERS 296,741 31,487 1,924 0 0 0 0 0 18.00 03200 COROMARY CARE UNIT 0 0 0 0 0 0 32.00 18.00 03200 COROMARY CARE UNIT 20,1699 1,866 61 0 0 0 0 0 0 0 18.00 03200 SUBPROVI DER - IFFE 0 0 0 0 0 0 0 0 0	11. 00	01100 CAFETERI A						11. 00
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16.00 01000 NEDICAL RECORDS & LIBRARY 0 0 0 0 37.014 71.00 22.00 0200 188 SERVICES-STALRY & FRINCES APPRVD 0 0 0 0 0 0 22.00 23.00 2			0					
21.00			0			0		
22.00 0200 187 SERVICES-OTHER PROXI COSTS APPRIVD 0 0 0 0 0 22.00			0			Ö	37, 014	
INPATI FUT ROUTH NE SERVICE COST CENTERS			0	-		Ö	21, 211	
30.00	23. 00		0	0	0	0		23. 00
31.00			001 711	04 40-		ام		
32.00						-1		
15.00 02060 NEONATAL INTENSIVE CARE UNIT 20, 169 1, 866 61 0 35, 00 40.00 000 CSUBPROVIDER - IPF 0 0 0 0 0 0 40.00 000 CSUBPROVIDER - IPF 18, 612 741 30 0 41.00		1	82,710			0		
1.0 0.4100 SUBPROVIDER - IRF 18, 612 741 30 0 41.00		1	20, 169	-		o		
43. 00 04300 NURSERY 6, 760 0 0 0 43. 00	40.00	04000 SUBPROVI DER - I PF	0			О		
ANCILLARY SERVICE COST CENTERS		1	1			- 1		
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57. 00 03280 EKG AND EEG 0 63 0 0 57. 00	52.00	05200 DELIVERY ROOM & LABOR ROOM	20, 803	3, 226	181	О		52.00
58. 00 OSBOO MAGNETI C RESONANCE I MAGI NG (MRI)			1			0		
59, 00 05900 CARDIA C CATHETERI ZATI ON 12,038 700 161 0 59,000 60,000 6000 ABDORATORY 0 0 0 0 0 0 60,000 60,000 ABDORATORY 0 0 0 0 0 0 60,000 60,001 63,000 63000 BLOOD LABORATORY 67,000 60,001 63,000 63000 85,000 65,0			0			0		
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69. 00 06900 ELECTROCARDI OLOGY 0 338 0 0 69. 00 71. 00 771. 00 771. 00 771. 00 771. 00 771. 00 771. 00 771. 00 771. 00 772. 00 772. 00 772. 00 773. 01 773. 01 773. 01 773. 01 773. 01 773. 01 140SPI TAL BASED RETAIL PHARMACIES 0 299 86 0 73. 01 774. 00 774. 00			0	19	0	О		
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 158,570 0 0 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENT 0 219,466 0 0 0 72. 00 73. 00 73. 00 73. 00 73. 00 73. 01		1	0	-		0		
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73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 258,034 0 73. 00 73. 01 73. 01 07301 HOSPITAL BASED RETAIL PHARMACIES 0 9 0 0 0 73. 01 73. 01 73. 01 07400 RENAL DI ALYSIS 0 299 86 0 74. 00 76. 00 03160 CARDI OPULMONARY 0 0 0 0 0 0 0 0 0			0			0		
74. 00		1	O			o		
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76. 98 O7698 HYPERBARI C OXYGEN THERAPY 5, 958 1, 552 0 0 0 76. 98 OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINI C 0 0 0 0 0 90. 00 90. 02 09002 PAIN CLINI C 3, 180 1, 446 9 0 90. 02 90. 03 09003 0NCOLOGY CLINI C 9, 614 2, 882 269 0 90. 03 91. 00 09100 EMERGENCY 70, 858 16, 856 1, 461 0 91. 00 92. 01 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 92. 00 92. 01 09200 OBSERVATI ON BEDS (DISTINCT PART) 0 0 0 0 0 92. 01 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 0 893 11 0 95. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113. 00 11300 INTEREST EXPENSE 114. 00 NONREI MBURSABLE COST CENTERS 115. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 90. 00 191. 00 191. 00 19100 RESEARCH 0 90. 00 191. 00 191. 00 19100 RESEARCH			0	-	-	0		
OUTPATI ENT SERVI CE COST CENTERS O O O O O O O O O			1 1			0		
90. 02	70. 70		0, 700	1,002	o _l	₀		70. 70
90. 03	90.00		0	0	0	0		90.00
91. 00			1			0		
92. 00 92. 01 93. 02 94. 04 94			1			0		
92. 01			70, 636	10, 630	1, 401	U		
95. 00			0	0	0	О		
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 611,290 548,004 264,342 0 0 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 20 0 0 190.00 191			,					
113. 00 11300 INTEREST EXPENSE 118. 00	95. 00		0	893	11	0		95. 00
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 611, 290 548, 004 264, 342 0 0 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 20 0 0 190. 00 191. 00 19100 RESEARCH 4, 942 10 0 0 191. 00	112 0							113 00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 20 0 0 190. 00 191. 00 191. 00 19100 RESEARCH 4, 942 10 0 0 191. 00			611. 290	548. 004	264. 342	0		
191. 00 19100 RESEARCH 4, 942 10 0 0 191. 00			, 0	,	,	5		
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194. 00 07950 0THER NONREIMBURSABLE COST CENTERS 0 0 0 0 194. 00		0 19100 RESEARCH 0 07950 OTHER NONREIMBURSABLE COST CENTERS	1					
194. 00 07950 0THER NONREIMBURSABLE COST CENTERS 0 0 0 0 194. 00	174.00	0/07/20/01THEN MONNET WIDDNSADEL COST CENTERS	ı U	U	١	·		174.00

| Peri od: | Worksheet B | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0089

				То	12/31/2017	Date/Time Pre 5/24/2018 5:0	
						INTERNS &	J pili
						RESI DENTS	
Cost Center Description	NURSI NG	CENTRAL	PHARMACY		MEDI CAL	SERVI CES-SALAR	
	ADMI NI STRATI ON	SERVICES &			RECORDS &	Y & FRINGES	
		SUPPLY			LI BRARY		
	13. 00	14.00	15. 00		16. 00	21. 00	
194. 01 07951 BSU PHARMACY	0	0		0	0		194. 01
194.02 07952 PAVILLION PHARMACY	0	46		0	0		194. 02
194. 03 07953 VENDI NG	0	0		0	0		194. 03
194. 04 07954 CARELI NE	0	0		0	0		194. 04
194.05 07955 WELLNESS CENTER	0	4		0	0		194. 05
194.06 07956 PHYSICIAN PRACTICE CLINICS	0	0		0	0		194. 06
194. 07 07957 PERINATAL CLINIC	0	0		0	0		194. 07
194.08 07958 RENTAL PROPERTY	0	0		0	0		194. 08
194. 09 07959 ADVERTI SI NG	0	0		0	0		194. 09
194. 10 07960 INTEGRA LTAC	0	0		0	0		194. 10
194. 11 07961 IU HEALTH HOSPICE	0	3		0	0		194. 11
194.12 07962 POB MEDICAL PAVILLION CONDOS	0	0		0	0		194. 12
194. 13 07963 EXECUTI VE PHYSI CAL	0	0		0	0		194. 13
194.14 07964 NEW CASTLE ONCOLOGY	0	0		0	0		194. 14
194. 15 07965 MARKETI NG/PUBLI C RELATI ONS	0	0		0	0		194. 15
194. 16 07966 JAY COUNTY HOSPITAL	0	0		0	0		194. 16
194. 17 07967 CARDI NAL HEALTH CHOI CE	0	0		0	0		194. 17
194. 18 07968 CHV CARDINAL HEALTH VENTURES	0	0		0	0		194. 18
194. 19 07969 HEALTH CARE CONNECTIONS	0	0		0	0		194. 19
194.20 07970 MEALS ON WHEELS	0	0		0	0		194. 20
194.21 07971 ST MARY'S SCHOOL	0	0		0	0		194. 21
194.22 07972 THERAPIES TO OTHER ENTITIES	0	0		0	0		194. 22
194. 23 07973 CANCER CENTER BOUTIQUE	0	12		0	0		194. 23
194. 24 07974 BOSC BALL OUTPATIENT SURGERY	0	0		0	0		194. 24
194. 25 07975 CARDI NAL BEHAVI ORAL HEALTH	0	0		0	0		194. 25
194. 26 07976 BLACKFORD COMMUNITY HOSPITAL	410	0		0	0		194. 26
194. 27 07977 MI DWEST HEALTH STRATEGIES	0	0		0	0		194. 27
194. 28 07978 CARDINAL SELECT RISK RETENTION GRP	0	0		0	0		194. 28
194. 29 07979 HOME OFFICE CARDINAL HEALTH INITIATI	0	0		0	0		194. 29
194. 30 07980 CARDI NAL HEALTH ALLI ANCE	0	0		0	0		194. 30
194. 31 07986 OTHER NONREI MBURSABLE COST CENTERS	0	0		0	0		194. 31
194. 32 07982 RENAL DI ALYSI S	0	0		0	0		194. 32
194. 33 07983 LAB CORP	0	0		0	0		194. 33
194. 34 07984 H. O. MATERI ALS MGMT	0	0		U	0		194. 34
194. 35 07985 LEASED SPACE	0	0		U	0	07.01.	194. 35
200.00 Cross Foot Adjustments		-			-	37, 014	
201.00 Negative Cost Centers	0	0		0	0		201. 00
202.00 TOTAL (sum lines 118 through 201)	616, 642	548, 099	264, 3	42	0	37, 014	J202. 00

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0089 Peri od: Worksheet B From 01/01/2017 Part II Date/Time Prepared: 12/31/2017 5/24/2018 5:05 pm INTERNS & **RESI DENTS** Cost Center Description SERVI CES-OTHER PARAMED ED Subtotal Intern & Total PRGM COSTS **PRGM** Residents Cost & Post Stepdown Adjustments 22.00 23.00 24.00 25.00 26.00 GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 1 00 1 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4 00 5.01 01160 COMMUNI CATI ONS 5.01 00550 DATA PROCESSING 5 02 5 02 5.04 00570 ADMITTING 5.04 5.05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.05 00590 OTHER ADMINISTRATIVE AND GENERAL 5.06 5.06 00600 MAINTENANCE & REPAIRS 6 00 6 00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 00900 HOUSEKEEPI NG 9.00 9.00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 15 00 01500 PHARMACY 15 00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 22.00 606, 607 22.00 02300 PARAMED ED PRGM 23.00 4, 212 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 5, 944, 542 5, 944, 542 30.00 31.00 03100 INTENSIVE CARE UNIT 1, 124, 740 0 1, 124, 740 31.00 32.00 03200 CORONARY CARE UNIT 0 32.00 Λ 02060 NEONATAL INTENSIVE CARE UNIT 0 35.00 206, 949 206, 949 35.00 04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF o 40.00 C 40.00 0 0 41.00 397, 787 397, 787 41.00 04300 NURSERY 43.00 143,071 143, 071 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 1, 226, 700 0 1, 226, 700 0 51.00 05100 RECOVERY ROOM 305, 265 305, 265 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 481, 465 0 481, 465 52.00 05400 RADI OLOGY-DI AGNOSTI C 2, 122, 948 2, 122, 948 54.00 54.00 03280 EKG AND EEG 57.00 2, 374 2, 374 57.00 0 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 501, 716 0 0 0 501, 716 59.00 06000 LABORATORY 60 00 170, 140 170, 140 60 00 60.01 06001 BLOOD LABORATORY 60.01 63.00 06300 BLOOD STORING, PROCESSING, & TRANS. 22, 390 22, 390 63.00 65.00 06500 RESPIRATORY THERAPY 188, 052 0 188, 052 65.00 06501 SLEEP LAB 5.713 5.713 65 01 65 01 66.00 06600 PHYSI CAL THERAPY 148, 339 148, 339 66.00 06700 OCCUPATIONAL THERAPY 85, 705 0 0 0 0 0 0 0 0 0 85, 705 67.00 67.00 22, 792 68.00 06800 SPEECH PATHOLOGY 22, 792 68.00 06801 AUDI OLOGY 68.01 C0 68 01 69.00 06900 ELECTROCARDI OLOGY 612,030 612, 030 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 191, 388 191, 388 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 72.00 267, 626 267, 626 72.00 07300 DRUGS CHARGED TO PATIENTS 354, 992 73.00 354, 992 73.00 73. 01 07301 HOSPITAL BASED RETAIL PHARMACIES 36, 903 36, 903 73.01 07400 RENAL DIALYSIS 74 00 98, 416 98, 416 74.00 03160 CARDI OPULMONARY 76.00 76.00 0 0 76. 97 07697 CARDIAC REHABILITATION 10,659 10, 659 76.97 07698 HYPERBARIC OXYGEN THERAPY 0 76.98 17,871 17,871 76.98 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 0 90 00 90.02 09002 PAIN CLINIC 733, 587 0 733, 587 90.02 09003 ONCOLOGY CLINIC 0 90.03 57, 501 57, 501 90.03 0 09100 EMERGENCY 1, 303, 181 91.00 91.00 1, 303, 181 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92 00 0 92 00 09201 OBSERVATION BEDS (DISTINCT PART) 92.01 92.01 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 0 95.00 95.00 115, 821 115, 821 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 0 0 16, 900, 663 16, 900<u>, 663</u> 118. 00 118.00 0 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 3, 702 0 3, 702 190. 00

| Peri od: | Worksheet B | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0089

				0 12/31/201/	5/24/2018 5:0	
	INTERNS &				0,21,2010 010	, p
	RESI DENTS					
Cost Center Description	SERVI CES-OTHER	PARAMED ED	Subtotal	Intern &	Total	
,	PRGM COSTS	PRGM		Residents Cost		
				& Post		
				Stepdown		
				Adjustments		
	22. 00	23. 00	24. 00	25. 00	26. 00	
191. 00 19100 RESEARCH			61, 431	0	61, 431	191. 00
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS			4, 098	0	4, 098	194. 00
194.01 07951 BSU PHARMACY			1, 126	0	1, 126	194. 01
194.02 07952 PAVILLION PHARMACY			113, 848	0	113, 848	194. 02
194. 03 07953 VENDI NG			C	0	0	194. 03
194. 04 07954 CARELI NE			C	0	0	194. 04
194. 05 07955 WELLNESS CENTER			169, 549	0	169, 549	194. 05
194.06 07956 PHYSICIAN PRACTICE CLINICS			655, 337	0	655, 337	194. 06
194. 07 07957 PERI NATAL CLI NI C			C	0	0	194. 07
194. 08 07958 RENTAL PROPERTY			4, 290, 336	0	4, 290, 336	194. 08
194. 09 07959 ADVERTI SI NG			C	0	0	194. 09
194. 10 07960 I NTEGRA LTAC			396, 950	0	396, 950	194. 10
194. 11 07961 IU HEALTH HOSPICE			126, 355	0	126, 355	194. 11
194.12 07962 POB MEDICAL PAVILLION CONDOS			· c			194. 12
194. 13 07963 EXECUTI VE PHYSI CAL			C	0	0	194. 13
194.14 07964 NEW CASTLE ONCOLOGY			C	0	0	194. 14
194. 15 07965 MARKETI NG/PUBLI C RELATI ONS			145, 239	0	145, 239	194. 15
194. 16 07966 JAY COUNTY HOSPITAL			894			194. 16
194. 17 07967 CARDI NAL HEALTH CHOI CE			C	0		194. 17
194. 18 07968 CHV CARDINAL HEALTH VENTURES			C	0	0	194. 18
194. 19 07969 HEALTH CARE CONNECTIONS			C	0	0	194. 19
194.20 07970 MEALS ON WHEELS			C	0	0	194. 20
194. 21 07971 ST MARY'S SCHOOL			C	0	0	194. 21
194. 22 07972 THERAPIES TO OTHER ENTITIES			9, 116	0	9, 116	194. 22
194. 23 07973 CANCER CENTER BOUTLQUE			28, 033		28, 033	194. 23
194. 24 07974 BOSC BALL OUTPATIENT SURGERY			798, 204		798, 204	
194. 25 07975 CARDI NAL BEHAVI ORAL HEALTH			300, 249	0	300, 249	194. 25
194. 26 07976 BLACKFORD COMMUNITY HOSPITAL			1, 081			194. 26
194. 27 07977 MI DWEST HEALTH STRATEGIES			C			194, 27
194. 28 07978 CARDINAL SELECT RISK RETENTION GRP			C	0	0	194. 28
194.29 07979 HOME OFFICE CARDINAL HEALTH INITIATI			C	0	0	194, 29
194. 30 07980 CARDI NAL HEALTH ALLI ANCE			C	0	0	194. 30
194. 31 07986 OTHER NONREIMBURSABLE COST CENTERS			C	0	0	194. 31
194. 32 07982 RENAL DI ALYSI S			i a	o o		194. 32
194. 33 07983 LAB CORP	1		o o	o o		194. 33
194. 34 07984 H. O. MATERI ALS MGMT			o o	o o		194. 34
194. 35 07985 LEASED SPACE			d	o		194. 35
200.00 Cross Foot Adjustments	606, 607	4, 212	647, 833	Ö	647, 833	
201.00 Negative Cost Centers	0	0	0	Ö		201. 00
202.00 TOTAL (sum lines 118 through 201)	606, 607	4, 212	24, 654, 044	. 0	24, 654, 044	
				1		•

	ALLOCATION - STATISTICAL BASIS	DALL WEWORTAL	Provi der Co	CN: 15-0089 P	eri od:	Worksheet B-1	
				F	rom 01/01/2017 o 12/31/2017	Data /Tima Dra	
				''	0 12/31/201/	Date/Time Pre 5/24/2018 5:0	pareu: 5 pm
		CAPI TAL					·
	0 1 0 1 0 1	RELATED COSTS	EMDL OVEE		DATA	ADMITTING	
	Cost Center Description	NEW BLDG & FLXT	EMPLOYEE BENEFITS	COMMUNI CATI ONS	DATA PROCESSING	ADMITTING (GROSS	
		(SQUARE	DEPARTMENT	(FTE' S)	(GROSS	CHARGES)	
		FEET)	(GROSS	(112 3)	CHARGES)	CHARGES)	
			SALARI ES)				
	T	1.00	4. 00	5. 01	5. 02	5. 04	
1 00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT	1 7/0 020					1 00
1. 00 4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 769, 839 5, 384	105, 356, 686				1. 00 4. 00
5. 01	01160 COMMUNI CATI ONS	1, 498	500, 909				5. 01
5. 02	00550 DATA PROCESSING	0	0		1, 761, 976, 342		5. 02
5.04	00570 ADMI TTI NG	4, 419	955, 340	2, 984	0	1, 761, 976, 342	5. 04
5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	0		0	0	5. 05
5.06	00590 OTHER ADMINISTRATIVE AND GENERAL	58, 268	5, 716, 874	4, 245	0	0	5. 06
6. 00 7. 00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT	895, 582 66, 351	2, 887, 407 1, 248, 576	6, 324 2, 442		0	6. 00 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	00, 331	1, 240, 370	2, 442	0	0	8.00
9. 00	00900 HOUSEKEEPI NG	15, 179	2, 589, 149	_	0	0	9. 00
10.00	01000 DI ETARY	10, 357	1, 349, 323	3, 928	0	0	10. 00
11. 00	01100 CAFETERI A	14, 372	1, 184, 318			0	11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	17, 505	5, 406, 475		0	0	13.00
14. 00 15. 00	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	16, 030 6, 789	4, 799, 892	6 220	0	0	14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0, 789	4, 799, 692 N	6, 338	0	0	16. 00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD		3, 732, 024	6, 680	Ö	0	21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	18, 418	248, 455			0	22. 00
23. 00	02300 PARAMED ED PRGM	97	136, 149	153	0	0	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	154 404	00 105 017	07.440		010 771 151	
30.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	151, 421	20, 485, 246			210, 771, 456	
31. 00 32. 00	03200 CORONARY CARE UNIT	27, 825	6, 610, 298	10, 071	58, 887, 224	58, 887, 224 0	
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	5, 149	1, 759, 055	2, 531	14, 684, 782	14, 684, 782	
40. 00	04000 SUBPROVI DER - I PF	0	0	0	0	0	
41.00	04100 SUBPROVI DER - I RF	9, 997	1, 503, 560	2, 346	10, 783, 458	10, 783, 458	41. 00
43.00	04300 NURSERY	3, 882	571, 125	849	6, 155, 032	6, 155, 032	43. 00
FO 00	ANCI LLARY SERVI CE COST CENTERS	22.770	4 01/ 522	0.024	1/1 2/5 1//	1/1 2/5 1//	F0 00
50. 00 51. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM	32, 660 8, 140	4, 916, 533 1, 460, 313			161, 265, 166 18, 906, 878	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	12, 754	1, 852, 223			28, 356, 631	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	61, 247	8, 394, 394	12, 247		231, 571, 886	54.00
57. 00	03280 EKG AND EEG	0	157, 176	498	3, 621, 216	3, 621, 216	
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0	0	58. 00
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	14, 040	1, 724, 054			97, 872, 727	
60. 00	06000 LABORATORY	3, 198	0	5, 664 0	104, 967, 986	104, 967, 986 0	
63. 00			0	ő	6, 588, 426		
	06500 RESPIRATORY THERAPY	4, 651	3, 140, 330	5, 057		21, 679, 245	
65. 01	06501 SLEEP LAB	0	433, 297		8, 577, 376	8, 577, 376	65. 01
66. 00	06600 PHYSI CAL THERAPY	3, 099	4, 607, 145			18, 764, 017	
67. 00	06700 OCCUPATIONAL THERAPY	2, 404	793, 210		6, 066, 332	6, 066, 332	
68. 00 68. 01	06800 SPEECH PATHOLOGY 06801 AUDI OLOGY	575	406, 600	585 0		2, 989, 114 0	68. 00 68. 01
69. 00	06900 ELECTROCARDI OLOGY	18, 442	1, 214, 585	_	-	52, 498, 004	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	53, 278, 902	53, 278, 902	
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	109, 312, 655	109, 312, 655	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	230, 608, 929	230, 608, 929	
73. 01	07301 HOSPITAL BASED RETAIL PHARMACIES	0	1, 643, 057	1, 971	9, 099, 452	9, 099, 452	
74. 00 76. 00	07400 RENAL DI ALYSI S 03160 CARDI OPULMONARY	2, 918	0	0	3, 895, 337 0	3, 895, 337 0	74. 00 76. 00
76. 00	07697 CARDI AC REHABI LI TATI ON		519, 398	1, 041	4, 025, 226	4, 025, 226	
76. 98	07698 HYPERBARI C OXYGEN THERAPY	75	504, 038		15, 414, 873	15, 414, 873	
	OUTPATIENT SERVICE COST CENTERS		·				
90.00	09000 CLI NI C	0	0			0	
90. 02	09002 PAIN CLINIC	22, 443	396, 872			8, 304, 023	
90. 03 91. 00	09003 ONCOLOGY CLINIC 09100 EMERGENCY	1, 067	866, 364 5, 773, 143			31, 221, 111 223, 340, 968	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	33, 196	5, 775, 145	7, 3/7	223, 340, 700	223, 340, 700	92.00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	О	0	0	
	OTHER REIMBURSABLE COST CENTERS	· ·			-1		
95. 00	09500 AMBULANCE SERVICES	2, 990	1, 447, 542	3, 376	8, 467, 910	8, 467, 910	95. 00
110 -	SPECIAL PURPOSE COST CENTERS			ı			110 00
113. 00 118. 00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	1 552 422	101, 934, 449	170 000	1 761 074 242	1 761 074 242	113.00
110.00	NONREIMBURSABLE COST CENTERS	1, 552, 422	101, 734, 449	1 178,800	1, 101, 910, 342	1, 761, 976, 342	1110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	136, 951	449	0	0	190. 00
-	·	·		'	·		

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0089

				To	12/31/2017	Date/Time Pre 5/24/2018 5:0	
		CAPI TAL					ļ
		RELATED COSTS					
Cos	st Center Description	NEW BLDG &	EMPLOYEE	COMMUNI CATI ONS	DATA	ADMI TTI NG	
		FIXT (SQUARE	BENEFITS DEPARTMENT	(FTE'S)	PROCESSING (GROSS	(GROSS CHARGES)	
		FEET)	(GROSS	(FIE 3)	CHARGES)	CHARGES)	
		1661)	SALARI ES)		CHARGES)		
		1. 00	4. 00	5. 01	5. 02	5. 04	
191. 00 19100 RES		1, 552	630, 823		0		191. 00
	HER NONREIMBURSABLE COST CENTERS	0	0		0		194. 00
194. 01 07951 BSU		0	225, 295		0		194. 01
	/ILLION PHARMACY	2, 834	692, 636	1	0		194. 02
194. 03 07953 VEN		0	0	_	0		194. 03 194. 04
194. 04 07954 CAR 194. 05 07955 WEL		5, 073	28, 904		U O		194. 04
	SICIAN PRACTICE CLINICS	20, 300	20, 904 0	04	0		194. 05
194. 07 07957 PER		20, 300	0		0		194. 07
194. 08 07958 REN		133, 052	0	- 1	ol		194. 08
194. 09 07959 ADV		0	0	- 1	ol		194. 09
194. 10 07960 I NT		11, 771	0		o		194. 10
194. 11 07961 I U	HEALTH HOSPICE	3, 860	0	0	o	0	194. 11
194. 12 07962 POB	B MEDICAL PAVILLION CONDOS	0	0	0	0	0	194. 12
	ECUTI VE PHYSI CAL	0	0		0		194. 13
	V CASTLE ONCOLOGY	0	0	- 1	0		194. 14
	RKETING/PUBLIC RELATIONS	4, 506	0		0		194. 15
	COUNTY HOSPITAL	0	212, 263		0		194. 16
	RDI NAL HEALTH CHOI CE	0	0	- 1	0		194. 17
	/ CARDINAL HEALTH VENTURES ALTH CARE CONNECTIONS	0	0	_	0		194. 18 194. 19
194. 19 07 969 HEA		0	0		0		194. 19
194. 21 07971 ST		0	0	-	0		194. 21
	ERAPIES TO OTHER ENTITIES	Ö	1, 314, 292		ol		194. 22
	ICER CENTER BOUTIQUE	852	14, 251		ol		194. 23
194. 24 07974 BOS	SC BALL OUTPATIENT SURGERY	24, 764	0		o	0	194. 24
	RDI NAL BEHAVI ORAL HEALTH	8, 853	0	0	o	0	194. 25
194. 26 07976 BLA	ACKFORD COMMUNITY HOSPITAL	0	166, 822	144	0	0	194. 26
	DWEST HEALTH STRATEGIES	0	0	_	0		194. 27
	RDINAL SELECT RISK RETENTION GRP	0	0	_	0		194. 28
	ME OFFICE CARDINAL HEALTH INITIATI	0	0	0	0		194. 29
	RDI NAL HEALTH ALLI ANCE	0	0	_	0		194. 30
	HER NONREIMBURSABLE COST CENTERS	0	0	0	O O		194. 31
194. 32 07982 REN 194. 33 07983 LAB		0	0	- 1	0		194. 32 194. 33
	D. MATERIALS MGMT	0	0	1	0		194. 34
194. 35 07985 LEA		0	0	_	0		194. 35
	oss Foot Adjustments	Ŭ.	O		Ĭ	O	200.00
	pative Cost Centers						201. 00
	st to be allocated (per Wkst. B,	24, 654, 044	17, 697, 818	637, 986	11, 797, 428	7, 959, 848	
Par	rt I)						
	t cost multiplier (Wkst. B, Part I)	13. 930106	0. 167980	1	0. 006696	0. 004518	1
	st to be allocated (per Wkst. B,		75, 000	21, 224	0	62, 581	204. 00
	rt II)			0.445405			
	t cost multiplier (Wkst. B, Part		0. 000712	0. 115435	0. 000000	0. 000036	205.00
206. 00 NAH	HE adjustment amount to be allocated						206. 00
	er Wkst. B-2)						
	HE unit cost multiplier (Wkst. D,						207. 00
Par	rts III and IV)			1	l		

Heal th	Financial Systems	BALL MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-	2552-10
	ALLOCATION - STATISTICAL BASIS		Provi der CO		Peri od:	Worksheet B-1	
					From 01/01/2017 Fo 12/31/2017	Date/Time Pre	pared:
				071150		5/24/2018 5:0	5 pm
	Cost Center Description	CASHI ERI NG/ACCR OUNTS		OTHER ADMI NI STRATI VI	MAINTENANCE & REPAIRS	OPERATION OF PLANT	
		RECEI VABLE		AND GENERAL	(SQUARE	(SQUARE	
		(GROSS		(ACCUM.	FEET)	FEET)	
		CHARGES)		COST)	,	<u> </u>	
	I	5. 05	5A. 06	5. 06	6. 00	7. 00	
1 00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT			T			1 00
1. 00 4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						1. 00 4. 00
5. 01	01160 COMMUNI CATI ONS						5. 01
5. 02	00550 DATA PROCESSING						5. 02
5.04	00570 ADMITTING						5. 04
5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	1, 761, 976, 342					5. 05
5.06	00590 OTHER ADMINISTRATIVE AND GENERAL	0	-34, 283, 225				5. 06
6. 00 7. 00	00600 MAINTENANCE & REPAIRS	0	0	20, 663, 90		720 227	6.00
8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE		0	7, 198, 70 1, 360, 65		738, 337 0	1
9. 00	00900 HOUSEKEEPING		0	3, 535, 12			•
10.00	01000 DI ETARY	o	0	2, 057, 22		10, 357	1
11. 00	01100 CAFETERI A	0	0	1, 279, 90	1 14, 372	14, 372	11. 00
13. 00	01300 NURSING ADMINISTRATION	0	0	7, 735, 30		17, 505	1
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	0	10, 418, 30		16, 030	
15. 00	01500 PHARMACY	0	0	5, 836, 31	6, 789	6, 789	
16. 00 21. 00	01600 MEDICAL RECORDS & LIBRARY 02100 I&R SERVICES-SALARY & FRINGES APPRVD		0	4, 382, 10		0	
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD		0	3, 636, 99		18, 418	1
23. 00	02300 PARAMED ED PRGM		0	172, 22		97	1
	INPATIENT ROUTINE SERVICE COST CENTERS	-1					
30.00	03000 ADULTS & PEDIATRICS	210, 771, 456	0	35, 755, 74	5 151, 421	151, 421	30.00
31. 00		58, 887, 224	0	10, 330, 24		27, 825	
32. 00	03200 CORONARY CARE UNIT	0	0	0 547 07	0	0	
35. 00 40. 00	02060 NEONATAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	14, 684, 782	0	2, 517, 07	5, 149	5, 149	35. 00 40. 00
41. 00	04100 SUBPROVI DER – TFF	10, 783, 458	0	2, 609, 78	1 9, 997	9, 997	1
43. 00	04300 NURSERY	6, 155, 032	0	866, 84		3, 882	1
	ANCILLARY SERVICE COST CENTERS			·		·]
50. 00	05000 OPERATING ROOM	161, 265, 166	0	,			1
51. 00	05100 RECOVERY ROOM	18, 906, 878	0	2, 229, 580		8, 140	
52.00	05200 DELIVERY ROOM & LABOR ROOM	28, 356, 631	0	2, 933, 95		12, 754	1
54. 00 57. 00	05400 RADI OLOGY-DI AGNOSTI C 03280 EKG AND EEG	231, 571, 886 3, 621, 216	0	16, 356, 18 ⁹ 155, 50 ⁹		61, 247 0	1
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	3,021,210	0	155, 50	0	0	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	97, 872, 727	0	3, 905, 23	14, 040	14, 040	•
60.00	06000 LABORATORY	104, 967, 986	0	11, 254, 49		3, 198	60.00
60. 01	06001 BLOOD LABORATORY	0	0	(0	0	
63. 00	06300 BLOOD STORING, PROCESSING, & TRANS.	6, 588, 426	0	1, 341, 35		0	
65. 00	06500 RESPIRATORY THERAPY	21, 679, 245	0	4, 282, 64			65. 00
	06501 SLEEP LAB 06600 PHYSI CAL THERAPY	8, 577, 376 18, 764, 017	0	609, 96, 4, 715, 03:		3 000	65. 01 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	6, 066, 332	0	1, 043, 33			67. 00
68. 00	06800 SPEECH PATHOLOGY	2, 989, 114	0	512, 41		575	1
68. 01	06801 AUDI OLOGY	0	0		0	0	68. 01
69. 00	06900 ELECTROCARDI OLOGY	52, 498, 004	0	2, 389, 42		18, 442	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	53, 278, 902	0	10, 766, 51		0	
72.00		109, 312, 655	0	15, 409, 43		0	
73. 00 73. 01	07300 DRUGS CHARGED TO PATIENTS 07301 HOSPITAL BASED RETAIL PHARMACIES	230, 608, 929 9, 099, 452	0	30, 890, 598 9, 755, 17		0	73. 00 73. 01
74. 00	07400 RENAL DIALYSIS	3, 895, 337	0	1, 374, 830		2, 918	1
76. 00	· ·	0	0	1, 21 1, 22	0	0	1
76. 97	07697 CARDIAC REHABILITATION	4, 025, 226	0	732, 61	3 0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	15, 414, 873	0	1, 531, 48:	2 75	75	76. 98
00.00	OUTPATIENT SERVICE COST CENTERS						00.00
90. 00 90. 02	09000	8, 304, 023	0	946, 15	5 22, 443	0	
90. 02	09003 ONCOLOGY CLINIC	31, 221, 111	0	1, 554, 18		22, 443 1, 067	1
	09100 EMERGENCY	223, 340, 968	0	14, 401, 73		33, 196	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	(0	0	92. 01
	OTHER REIMBURSABLE COST CENTERS		-		.1		
9 5. 00	09500 AMBULANCE SERVICES	8, 467, 910	0	2, 201, 24	1 2, 990	2, 990	95. 00
113 00	SPECIAL PURPOSE COST CENTERS 11300 NTEREST EXPENSE						113. 00
113.00		1, 761, 976, 342	-34, 283, 225	271, 536, 36	587, 271	520, 920	
	NONREI MBURSABLE COST CENTERS	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,		337,271	525, 720	1
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	738, 78			190. 00
	19100 RESEARCH	0	0	872, 26			191. 00
194.00	0 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0		0	0	194. 00

Peri od: From 01/01/2017 To 12/31/2017 Date/Time Prepared:

					5/24/2018 5:0	5 pm
Cost Center Description	CASHI ERI NG/ACC	Reconciliation	OTHER	MAINTENANCE &	OPERATION OF	
	OUNTS		ADMI NI STRATI VE	REPAI RS	PLANT	
	RECEI VABLE		AND GENERAL	(SQUARE	(SQUARE	
	(GROSS		(ACCUM.	FEET)	FEET)	
	CHARGES)		COST)			
	5. 05	5A. 06	5.06	6. 00	7. 00	
194. 01 07951 BSU PHARMACY	0	0	23, 977	0	0	194. 01
194.02 07952 PAVILLION PHARMACY	0	0	6, 574, 824	2, 834	2, 834	194. 02
194. 03 07953 VENDI NG	0	0	C	0	0	194. 03
194. 04 07954 CARELI NE	0	0	C	0	0	194. 04
194.05 07955 WELLNESS CENTER	0	0	116, 540	5, 073	5, 073	194. 05
194.06 07956 PHYSICIAN PRACTICE CLINICS	o	0	299, 184	20, 300	20, 300	194. 06
194. 07 07957 PERI NATAL CLI NI C	ol	0	l c	0	0	194. 07
194. 08 07958 RENTAL PROPERTY	ol	0	2, 463, 004	133, 052	133, 052	194. 08
194. 09 07959 ADVERTI SI NG	o	0		0	0	194. 09
194. 10 07960 I NTEGRA LTAC	l ol	0	163, 971	11, 771	11, 771	194, 10
194. 11 07961 IU HEALTH HOSPICE	ol	0	50, 139			194. 11
194. 12 07962 POB MEDICAL PAVILLION CONDOS	O	0	0	0		194, 12
194. 13 07963 EXECUTI VE PHYSI CAL	l ol	0	0	0		194. 13
194.14 07964 NEW CASTLE ONCOLOGY	l ol	0		0	0	
194. 15 07965 MARKETI NG/PUBLI C RELATI ONS		0	62, 769	4, 506		194. 15
194. 16 07966 JAY COUNTY HOSPITAL		0	258, 722		· ·	194. 16
194. 17 07967 CARDI NAL HEALTH CHOI CE	j o	0	200, 722	o o		194. 17
194. 18 07968 CHV CARDI NAL HEALTH VENTURES	Ö	0		0		194. 18
194. 19 07969 HEALTH CARE CONNECTIONS	o o	0		0		194. 19
194. 20 07970 MEALS ON WHEELS		0		0		194. 19
194. 21 07971 ST MARY'S SCHOOL	l ö	0		0		194. 21
194. 22 07972 THERAPIES TO OTHER ENTITIES		0	608, 646	0		194. 22
194. 23 07973 CANCER CENTER BOUTLQUE		0	134, 996			194. 22
194. 24 07974 BOSC BALL OUTPATIENT SURGERY	l ö	0	344, 965			194. 24
194. 25 07975 CARDI NAL BEHAVI ORAL HEALTH		0	123, 444			194. 25
194. 26 07976 BLACKFORD COMMUNITY HOSPITAL	٥	0	28, 523	·		194. 26
194. 27 07977 MI DWEST HEALTH STRATEGIES		0	20, 323			194. 27
194. 28 07978 CARDINAL SELECT RISK RETENTION	_	0		_		194. 27
194. 29 07979 HOME OFFICE CARDINAL HEALTH IN		0				194. 29
194. 30 07980 CARDI NAL HEALTH ALLI ANCE	0	0	69	_		194. 30
194. 31 07986 OTHER NONREIMBURSABLE COST CEN	-	0	0,7	0		194. 31
194. 32 07982 RENAL DI ALYSI S	VIERS 0	0		0		194. 31
194. 33 07983 LAB CORP		0		0		194. 32
194. 34 07984 H. O. MATERI ALS MGMT		0		0		194. 34
194. 35 07985 LEASED SPACE		0		0		194. 34
200.00 Cross Foot Adjustments	١	U		U	U	200.00
201.00 Negative Cost Centers						200.00
	- D = 4/4 043		24 202 225	22 154 020	0 075 700	
· · · · · · · · · · · · · · · · · · ·	t. B, 5, 464, 842		34, 283, 225	23, 154, 839	9, 975, 722	202.00
Part I) 203.00 Unit cost multiplier (Wkst. B.	Part I) 0.003102		0. 120545	28. 774928	13. 511069	202 00
204.00 Cost to be allocated (per Wksi	и. в,		816, 239	12, 537, 646	1, 979, 906	204.00
205.00 Unit cost multiplier (Wkst. B,	Part 0.000000		0.002870	15. 580754	2. 681575	205 00
205.00 Office Cost multiprier (wkst. B,	Par t 0.000000		0.002670	13. 360/34	2.001373	205.00
206.00 NAHE adjustment amount to be a	allocated					206. 00
(per Wkst. B-2)	ii i ocateu					200.00
207.00 NAHE unit cost multiplier (Wks	st D					207. 00
Parts III and IV)						[
1 (1. co and)	1 1		ı	1		1

Health Financial Systems COST ALLOCATION - STATISTICAL BASIS	BALL MEMORIA	L HOSPITAL Provider CC		In Lie eriod: com 01/01/2017	u of Form CMS-2 Worksheet B-1	2552-10
			To		Date/Time Pre 5/24/2018 5:0	
Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING (HOURS OF	DI ETARY (MEALS	CAFETERI A (FTE' S)	NURSI NG ADMI NI STRATI ON	
	(POUNDS OF LAUNDRY)	SERVI CE)	SERVED)	, ,	(DIRECT NURS.	
		0.00	10.00	11 00	HRS.)	
GENERAL SERVI CE COST CENTERS	8. 00	9. 00	10. 00	11.00	13. 00	
1.00 OO100 NEW CAP REL COSTS-BLDG & FIXT 4.00 OO400 EMPLOYEE BENEFITS DEPARTMENT						1. 00 4. 00
5. 01 01160 COMMUNI CATI ONS 5. 02 00550 DATA PROCESSI NG						5. 01 5. 02
5. 04 00570 ADMI TTI NG						5. 04
5. 05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5. 06 00590 OTHER ADMINI STRATI VE AND GENERAL						5. 05 5. 06
6.00 00600 MAINTENANCE & REPAIRS 7.00 00700 OPERATION OF PLANT						6. 00 7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	1, 565, 174					8. 00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY	22 32	28, 892 56	254, 484			9. 00 10. 00
11. 00 01100 CAFETERIA 13. 00 01300 NURSI NG ADMINISTRATION	45	296 118	0	150, 333 7, 672	66, 130	11. 00 13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	0	124	0	7, 672	00, 130	14. 00
15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY	251	140 0	0	6, 338 0	0	15. 00 16. 00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	6, 680	0	21. 00
22. 00 02200 1 &R SERVICES-OTHER PRGM COSTS APPRVD	0	28 0	0 0	786 153	0	22. 00 23. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	714, 022	13, 002	198, 403	37, 118	31, 823	30. 00
31.00 03100 INTENSIVE CARE UNIT	130, 990	2, 136	19, 119	10, 071	8, 870	31. 00
32.00 03200 CORONARY CARE UNIT 35.00 02060 NEONATAL INTENSIVE CARE UNIT	12, 724	104	0	2, 531	0 2, 163	
40. 00 04000 SUBPROVI DER - 1 PF 41. 00 04100 SUBPROVI DER - 1 RF	0 35, 341	0 1, 307	0 12, 804	0 2, 346	0 1, 996	40. 00 41. 00
43. 00 04300 NURSERY	14, 635	312	0	849	725	43. 00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	119, 675	1, 616	0	8, 834	2, 595	50. 00
51. 00 05100 RECOVERY ROOM 52. 00 05200 DELIVERY ROOM & LABOR ROOM	37, 983 63, 836	96 1, 536	0	2, 445 2, 785	2, 370 2, 231	51. 00 52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	111, 226	1, 413	0	12, 247	1, 815	54. 00
57.00 03280 EKG AND EEG 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	12	0	0	498 0	0	57. 00 58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	23, 009	740 728	0	2, 444 5, 664	1, 291 0	59. 00 60. 00
60. 01 06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
63. 00 06300 BLOOD STORING, PROCESSING, & TRANS. 65. 00 06500 RESPIRATORY THERAPY	597 522	0 116	0	0 5, 057	0	63. 00 65. 00
65. 01 06501 SLEEP LAB 66. 00 06600 PHYSI CAL THERAPY	10 5, 445	0 476	0	805 6, 782	0	65. 01 66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	28	0	1, 151	0	67. 00
68. 00 06800 SPEECH PATHOLOGY 68. 01 06801 AUDI OLOGY	0	28 0	0	585 0	0	68. 00 68. 01
69.00 06900 ELECTROCARDIOLOGY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	20, 734	0	0	2, 556 0	0	69. 00 71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS 73.01 07301 HOSPITAL BASED RETAIL PHARMACIES	0	56	0	0 1, 971	0	73. 00 73. 01
74. 00 07400 RENAL DI ALYSI S 76. 00 03160 CARDI OPULMONARY	2, 828	0	0	0	0	74. 00 76. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	131	228	o	1, 041	59	76. 97
76. 98 O7698 HYPERBARI C OXYGEN THERAPY OUTPATIENT SERVICE COST CENTERS	0	0	0	809	639	76. 98
90. 00 09000 CLI NI C 90. 02 09002 PAI N CLI NI C	0	0 28	0	0 820	0 341	90. 00 90. 02
90. 03 09003 ONCOLOGY CLINIC	6, 137	0	Ö	1, 279	1, 031	90. 03
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	245, 908	3, 456	0	9, 579	7, 599	91. 00 92. 00
92. 01 09201 OBSERVATION BEDS (DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	92. 01
95. 00 09500 AMBULANCE SERVICES	0	0	0	3, 376	0	95. 00
SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	1, 546, 115	28, 168	230, 326	145, 272	65, 556	118. 00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	449		190. 00
191.00 19100 RESEARCH 194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0 0	0 236	0 0	1, 093 0		191. 00 194. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provi der CCN: 15-0089

			То	12/31/2017	Date/Time Prep 5/24/2018 5:05	
Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG) рііі
	LINEN SERVICE	(HOURS OF	(MEALS		ADMI NI STRATI ON	
	(POUNDS OF	SERVI CE)	SERVED)			
	LAUNDRY)				(DI RECT NURS.	
					HRS.)	
	8. 00	9. 00	10.00	11. 00	13. 00	
194. 01 07951 BSU PHARMACY	0	0	-	275		194. 01
194. 02 07952 PAVILLION PHARMACY	0	0		983		194. 02
194. 03 07953 VENDI NG	0	0	i l	0		194. 03 194. 04
194. 04 07954 CARELI NE 194. 05 07955 WELLNESS CENTER	19, 012	320	-	0 84		194. 04 194. 05
194. 06 07956 PHYSI CI AN PRACTI CE CLINI CS	19,012	56	i l	04		194. 05
194. 07 07957 PERINATAL CLINIC	0	0	i I	0		194. 00
194. 08 07958 RENTAL PROPERTY	0	0		0		194. 08
194. 09 07959 ADVERTI SI NG	0	0	-	0		194. 09
194. 10 07960 I NTEGRA LTAC	0	0	- 1	0		194. 10
194. 11 07961 I U HEALTH HOSPICE	47	112	0	0	0	194. 11
194.12 07962 POB MEDICAL PAVILLION CONDOS	0	0	0	0	0	194. 12
194. 13 07963 EXECUTI VE PHYSI CAL	0	0	0	0	0	194. 13
194.14 07964 NEW CASTLE ONCOLOGY	0	0		0		194. 14
194.15 07965 MARKETING/PUBLIC RELATIONS	0	0	0	0		194. 15
194. 16 07966 JAY COUNTY HOSPITAL	0	0	0	0		194. 16
194. 17 07967 CARDI NAL HEALTH CHOI CE	0	0	-	0		194. 17
194. 18 07968 CHV CARDI NAL HEALTH VENTURES	0	0	0	0		194. 18
194. 19 07969 HEALTH CARE CONNECTIONS	0	0	0	0		194. 19
194.20 07970 MEALS ON WHEELS 194.21 07971 ST MARY'S SCHOOL	0	0	_	0		194. 20 194. 21
194. 22 07972 THERAPIES TO OTHER ENTITIES	0	0		1, 973		194. 21
194. 23 07973 CANCER CENTER BOUTLQUE	0	0		1, 4/3		194. 22
194. 24 07974 BOSC BALL OUTPATIENT SURGERY	0	0		0		194. 24
194. 25 07975 CARDI NAL BEHAVI ORAL HEALTH	l o	0	-	0		194. 25
194. 26 07976 BLACKFORD COMMUNITY HOSPITAL	0	0		144		194. 26
194.27 07977 MIDWEST HEALTH STRATEGIES	0	0	0	0	0	194. 27
194.28 07978 CARDINAL SELECT RISK RETENTION GRP	0	0	0	0	0	194. 28
194.29 07979 HOME OFFICE CARDINAL HEALTH INITIATI	0	0	0	0		194. 29
194. 30 07980 CARDI NAL HEALTH ALLI ANCE	0	0	0	0		194. 30
194. 31 07986 OTHER NONREI MBURSABLE COST CENTERS	0	0	0	0		194. 31
194. 32 07982 RENAL DI ALYSI S	0	0	0	0		194. 32
194. 33 07983 LAB CORP	0	0	0	0		194. 33
194.34 07984 H.O. MATERIALS MGMT 194.35 07985 LEASED SPACE	0	0	0	0		194. 34 194. 35
200.00 Cross Foot Adjustments	l o	U		U		200. 00
201.00 Negative Cost Centers						200. 00
202.00 Cost to be allocated (per Wkst. B,	1, 524, 675	4, 603, 143	2, 752, 127	2, 089, 124		
Part I)	1,021,070	1,000,110	2, 702, 127	2,007,121	7, 000, 000	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	0. 974125	159. 322408	10. 814538	13. 896643	144. 161319	203. 00
204.00 Cost to be allocated (per Wkst. B,	3, 905	501, 725	341, 707	472, 809	616, 642	204. 00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part	0. 002495	17. 365534	1. 342745	3. 145078	9. 324694	205. 00
206.00 NAHE adjustment amount to be allocated						206. 00
(per Wkst. B-2)].	207 00
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00
i parts in and iv)	1		1		ı	

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS In Lieu of Form CMS-2552-10
Worksheet B-1 Peri od: Worksheet B-1 From 01/01/2017 To 12/31/2017 Date/Time Prepared: 5/24/2018 5:05 pm Provider CCN: 15-0089

				10		5/24/2018 5:0	
					INTERNS &	RESI DENTS	
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SERVI CES-SALAR	SERVI CES-OTHER	
	Sect Control Boson Peron	SERVICES &	(COSTED	RECORDS &	Y & FRINGES	PRGM COSTS	
		SUPPLY	REQUIS.)	LI BRARY	(ASSI GNED	(ASSI GNED	
		(COSTED		(GROSS CHARGES)	TIME)	TIME)	
		REQUIS.) 14. 00	15. 00	16. 00	21. 00	22. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
4. 00 5. 01	00400 EMPLOYEE BENEFITS DEPARTMENT 01160 COMMUNI CATIONS						4. 00 5. 01
5. 02	00550 DATA PROCESSING						5. 02
5. 04	00570 ADMITTING						5. 04
5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 05
5.06	00590 OTHER ADMINISTRATIVE AND GENERAL						5.06
6. 00 7. 00	O0600 MAINTENANCE & REPAIRS O0700 OPERATION OF PLANT						6. 00 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10.00
11. 00 13. 00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON						11. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	34, 577, 156					14. 00
15.00	01500 PHARMACY	159, 131	28, 263, 707				15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	0				16. 00
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRVD	0	0	_	.,		21. 00
22. 00 23. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD 02300 PARAMED ED PRGM	1, 465	0	0		4, 880	22. 00 23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	-1	•				
30.00	03000 ADULTS & PEDIATRICS	1, 986, 440	205, 656				30.00
31. 00 32. 00	03100 I NTENSI VE CARE UNI T	842, 726	55, 009 0				31. 00 32. 00
35. 00	03200 CORONARY CARE UNIT 02060 NEONATAL INTENSIVE CARE UNIT	117, 737	6, 470		0		35.00
40. 00	04000 SUBPROVI DER - I PF	0	0	0	0		40. 00
41. 00	04100 SUBPROVI DER - I RF	46, 772	3, 197				41. 00
43. 00	04300 NURSERY ANCILLARY SERVICE COST CENTERS	0	0	6, 155, 032	0	0	43. 00
50.00	05000 OPERATING ROOM	3, 502, 072	78, 981	161, 265, 166	266	266	50.00
51.00	05100 RECOVERY ROOM	182, 308	40, 041			0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	203, 518	19, 362		0	0	52.00
54. 00 57. 00	05400 RADI OLOGY-DI AGNOSTI C 03280 EKG AND EEG	549, 224 3, 963	51, 149 3	1		134 0	54. 00 57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	1	_	-	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	44, 150	17, 241		0	-	59. 00
60.00	06000 LABORATORY 06001 BLOOD LABORATORY	0	0		0	-	60.00
60. 01 63. 00	06300 BLOOD STORING, PROCESSING, & TRANS.	1, 154, 627	0	0 6, 588, 426	0	_	60. 01 63. 00
65. 00	06500 RESPI RATORY THERAPY	284, 181	974		170	-	65. 00
65. 01	06501 SLEEP LAB	45, 370	0				
	06600 PHYSI CAL THERAPY	39, 071	17		0	_	
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	18, 779 1, 205	34		0		67. 00 68. 00
68. 01	06801 AUDI OLOGY	0	0	l	0		68. 01
69. 00	06900 ELECTROCARDI OLOGY	21, 306	10		240		1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	10, 003, 772	0		0		71. 00 72. 00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS	13, 844, 516	0 27, 589, 201			0	72.00
73. 01	07301 HOSPITAL BASED RETAIL PHARMACIES	563	0			0	73. 01
74.00	07400 RENAL DIALYSIS	18, 836	9, 142	3, 895, 337	0	0	74. 00
76.00	03160 CARDI OPULMONARY	0	0			0	76.00
76. 97 76. 98	07697 CARDI AC REHABI LI TATI ON 07698 HYPERBARI C OXYGEN THERAPY	8, 689 97, 906	41	4, 025, 226 15, 414, 873	0		76. 97 76. 98
70. 70	OUTPATIENT SERVICE COST CENTERS	77,700		10, 111, 070	<u> </u>	<u> </u>	70.70
90.00	09000 CLI NI C	0	0				90. 00
90. 02 90. 03	O9002 PAIN CLINIC O9003 ONCOLOGY CLINIC	91, 248 181, 800	946 28, 732		123 96		1
91.00	09100 EMERGENCY	1, 063, 409	156, 245				
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		,	, , , , , , , ,	,55	,,,,	92. 00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92. 01
95. 00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	56, 360	1, 215	8, 467, 910	0	0	95. 00
,J. 00	SPECIAL PURPOSE COST CENTERS	30, 300	1, 213	0,407,710	0	U	, 73.00
	11300 INTEREST EXPENSE						113. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	34, 571, 144	28, 263, 670	1, 761, 976, 342	4, 874	4, 874	118. 00
190. 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 277	0	0	0	0	190. 00
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Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Peri od: Worksheet B-1 From 01/01/2017 To 12/31/2017 Date/Time Prepared: 5/24/2018 5:05 pm Provider CCN: 15-0089

					0 12/31/2017	5/24/2018 5:0	5 pm
					INTERNS &	RESI DENTS	
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SERVI CES-SALAR	SERVI CES-OTHER	
		SERVICES &	(COSTED	RECORDS &	Y & FRINGES	PRGM COSTS	
		SUPPLY	REQUI S.)	LI BRARY	(ASSI GNED	(ASSI GNED	
		(COSTED		(GROSS	TI ME)	TIME)	
		REQUI S.) 14. 00	15. 00	CHARGES) 16. 00	21.00	22.00	
191. 00 19100	RESEARCH	652	26	0			191. 00
	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194. 00
	BSU PHARMACY	0	0	0	-		194. 01
	PAVILLION PHARMACY	2, 877	0	0	-		194. 02
194. 03 07953		0	0	0	_		194. 03
194. 04 07954	WELLNESS CENTER	248	0	0	_		194. 04 194. 05
	PHYSICIAN PRACTICE CLINICS	240	0	0			194. 06
	PERINATAL CLINIC	o	o	0			194. 07
	RENTAL PROPERTY	0	О	0	0	0	194. 08
	ADVERTI SI NG	0	0	0			194. 09
	INTEGRA LTAC	0	0	0	-		194. 10
	IU HEALTH HOSPICE	183	0	0			194. 11
	POB MEDICAL PAVILLION CONDOS EXECUTIVE PHYSICAL	0	0	0			194. 12 194. 13
	NEW CASTLE ONCOLOGY	0	0	0			194. 13
	MARKETI NG/PUBLI C RELATIONS	o	o	0	-		194. 15
194. 16 07966	JAY COUNTY HOSPITAL	0	О	0	0	0	194. 16
	CARDINAL HEALTH CHOICE	0	0	0	-		194. 17
	CHV CARDINAL HEALTH VENTURES	0	0	0			194. 18
	HEALTH CARE CONNECTIONS	0	0	0	-		194. 19
	MEALS ON WHEELS ST MARY'S SCHOOL	0	0	0	-		194. 20 194. 21
	THERAPIES TO OTHER ENTITIES	o	0	0	-		194. 21
	CANCER CENTER BOUTIQUE	753	ő	0			194. 23
	BOSC BALL OUTPATIENT SURGERY	0	0	0	0	0	194. 24
	CARDI NAL BEHAVI ORAL HEALTH	22	11	0	0	0	194. 25
	BLACKFORD COMMUNITY HOSPITAL	0	0	0			194. 26
	MI DWEST HEALTH STRATEGIES	0	0	0			194. 27
	CARDINAL SELECT RISK RETENTION GRP HOME OFFICE CARDINAL HEALTH INITIATI	0	0	0	-		194. 28 194. 29
	CARDINAL HEALTH ALLIANCE	0	0	0	-		194. 29
	OTHER NONREIMBURSABLE COST CENTERS	o o	ő	0	-		194. 31
	RENAL DIALYSIS	0	O	0	0		194. 32
194. 33 07983		O	o	0	0		194. 33
	H.O. MATERIALS MGMT	0	0	0	0		194. 34
	LEASED SPACE	0	0	0	0		194. 35
200. 00 201. 00	Cross Foot Adjustments Negative Cost Centers						200. 00 201. 00
202.00	Cost to be allocated (per Wkst. B,	12, 371, 781	6, 994, 496	0	5, 003, 179		
202.00	Part I)	12, 371, 701	0, 7,7, 4,70	O	3,003,177	4, 070, 130	202.00
203. 00	Unit cost multiplier (Wkst. B, Part I)	0. 357802	0. 247473	0.000000	1, 025. 241598	997. 981557	203. 00
204. 00	Cost to be allocated (per Wkst. B,	548, 099	264, 342	0	37, 014	606, 607	204. 00
005 60	Part II)	0 01-0-	0 0000==	0 0005	7 50.05	404 0047:-	005 00
205. 00	Unit cost multiplier (Wkst. B, Part II)	0. 015851	0. 009353	0. 000000	7. 584836	124. 304713	205. 00
206. 00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)		l				

Health Financial Systems BALL MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0089 Period: Worksheet B-1

From 01/01/2017 12/31/2017 Date/Time Prepared: 5/24/2018 5:05 pm Cost Center Description PARAMED ED PRGM (100% **PHARMACY** DRUGS) 23.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 01160 COMMUNI CATI ONS 5.01 5.01 00550 DATA PROCESSING 5.02 5.02 00570 ADMITTING 5.04 5.04 5.05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.05 5.06 00590 OTHER ADMINISTRATIVE AND GENERAL 5.06 6.00 00600 MAINTENANCE & REPAIRS 6.00 00700 OPERATION OF PLANT 7 00 7 00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 01100 CAFETERIA 11 00 11 00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 15. 00 01500 PHARMACY 15 00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD 21.00 21.00 22. 00 02200 I &R SERVICES-OTHER PRGM COSTS APPRVD 22.00 02300 PARAMED ED PRGM 23.00 100 23 00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 30.00 0 31.00 03100 INTENSIVE CARE UNIT 0 0 0 31.00 03200 CORONARY CARE UNIT 32 00 32 00 35.00 02060 NEONATAL INTENSIVE CARE UNIT 35.00 04000 SUBPROVIDER - IPF 40.00 40.00 0 04100 SUBPROVI DER - I RF 41.00 41.00 04300 NURSERY 43.00 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 0 50 00 51.00 05100 RECOVERY ROOM 000000000000000000 51.00 05200 DELIVERY ROOM & LABOR ROOM 52 00 52 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 03280 EKG AND EEG 57.00 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 58.00 59.00 05900 CARDIAC CATHETERIZATION 59.00 60.00 06000 LABORATORY 60.00 06001 BLOOD LABORATORY 60.01 60.01 63.00 06300 BLOOD STORING, PROCESSING, & TRANS. 63.00 65.00 06500 RESPIRATORY THERAPY 65.00 65.01 06501 SLEEP LAB 65.01 06600 PHYSI CAL THERAPY 66.00 66.00 67.00 06700 OCCUPATIONAL THERAPY 67.00 68.00 06800 SPEECH PATHOLOGY 68.00 06801 AUDI OLOGY 68.01 68.01 06900 ELECTROCARDI OLOGY 69 00 69 00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 72.00 72.00 73. 00 07300 DRUGS CHARGED TO PATIENTS 100 73.00 07301 HOSPITAL BASED RETAIL PHARMACIES 0 73.01 73.01 74.00 07400 RENAL DIALYSIS 0 74.00 0 03160 CARDI OPULMONARY 76.00 76.00 76 97 07697 CARDIAC REHABILITATION 76 97 07698 HYPERBARI C OXYGEN THERAPY 76.98 0 76.98 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 90.00 09002 PAIN CLINIC 0 90 02 90 02 90.03 09003 ONCOLOGY CLINIC 0 90.03 09100 EMERGENCY 0 91.00 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 09201 OBSERVATION BEDS (DISTINCT PART) 0 92.01 92.01 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 0 95.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 100 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190.00 0 191. 00 19100 RESEARCH 0 191.00 194. 00 07950 OTHER NONREIMBURSABLE COST CENTERS 0 194.00

Health Financial Systems

BALL MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0089

Period: Worksheet B-1

From 01/01/2017 12/31/2017 Date/Time Prepared: 5/24/2018 5:05 pm Cost Center Description PARAMED ED PRGM (100% **PHARMACY** DRUGS) 23.00 194. 01 07951 BSU PHARMACY 194. 01 194. 02 07952 PAVILLION PHARMACY 194. 02 194. 03 07953 VENDI NG 194. 03 194. 04 07954 CARELI NE 194. 04 194. 05 07955 WELLNESS CENTER 194. 05 194.06 07956 PHYSICIAN PRACTICE CLINICS 194. 06 194. 07 07957 PERINATAL CLINIC 194. 07 194. 08 07958 RENTAL PROPERTY 194. 08 194. 09 07959 ADVERTI SI NG 194. 09 194. 10 07960 INTEGRA LTAC 194. 10 194. 11 07961 IU HEALTH HOSPICE 194. 11 194. 12 07962 POB MEDICAL PAVILLION CONDOS 194. 12 194. 13 07963 EXECUTI VE PHYSI CAL 194. 13 194. 14 07964 NEW CASTLE ONCOLOGY 194, 14 194. 15 194. 15 07965 MARKETI NG/PUBLI C RELATIONS 194. 16 07966 JAY COUNTY HOSPITAL 194. 16 194. 17 07967 CARDI NAL HEALTH CHOICE 194. 17 194. 18 07968 CHV CARDINAL HEALTH VENTURES 194. 18 194. 19 07969 HEALTH CARE CONNECTIONS 194. 19 194. 20 07970 MEALS ON WHEELS 194. 20 194. 21 07971 ST MARY'S SCHOOL 194. 22 07972 THERAPIES TO OTHER ENTITIES 194, 21 194. 22 194. 23 07973 CANCER CENTER BOUTIQUE 194. 23 194. 24 07974 BOSC BALL OUTPATIENT SURGERY 194. 24 194. 25 07975 CARDI NAL BEHAVI ORAL HEALTH 194 25 194. 26 07976 BLACKFORD COMMUNITY HOSPITAL 194. 26 194. 27 07977 MI DWEST HEALTH STRATEGIES 194. 27 194. 28 07978 CARDINAL SELECT RISK RETENTION GRP 194. 28 194. 29 07979 HOME OFFICE CARDINAL HEALTH INITIATI 194. 29 194. 30 07980 CARDI NAL HEALTH ALLI ANCE 194. 30 194. 31 07986 OTHER NONREIMBURSABLE COST CENTERS 194. 31 194. 32 07982 RENAL DIALYSIS 194. 32 194. 33 07983 LAB CORP 194 33 194. 34 07984 H. O. MATERIALS MGMT 0 194. 34 194. 35 07985 LEASED SPACE 0 194. 35 Cross Foot Adjustments 200. 00 200.00 201.00 Negative Cost Centers 201. 00 202.00 Cost to be allocated (per Wkst. B, 199, 212 202.00 Part I)

1, 992, 120000

4, 212

0

42. 120000

0.000000

203. 00

204. 00

205.00

206.00

207.00

203.00

204.00

205.00

206.00

207.00

Unit cost multiplier (Wkst. B, Part I)

NAHE adjustment amount to be allocated

Cost to be allocated (per Wkst. B,

Unit cost multiplier (Wkst. B, Part

NAHE unit cost multiplier (Wkst. D,

Part II)

(per Wkst. B-2)

Parts III and IV)

11)

| In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2017 | Part | To 12/31/2017 | Date/Time Prepared: | 5/24/2018 5:05 pm Provider CCN: 15-0089

Total Cost Tot							5/24/2018 5:0	5 pm
Total Cost Forward F				Title	XVIII	Hospi tal	PPS	
Total Cost Forward F		·		<u>'</u>			•	
INPATIENT ROUTINE SERVICE COST CENTERS Adj Disallowance Part 1, cot 26,0		Cost Contor Doscription	Total Cost	Thorany Limit	Total Costs		Total Costs	
Part I. col. 260 2.00 3.00 4.00 5.00		cost center bescription			10101 00313		10101 00313	
IMPATI ENT ROUTINE SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00				Auj .		DI Sai i Owance		
INPATI ENT ROUTINE SERVICE COST CENTERS 1, 100 2, 00 3, 00 4, 00 5, 00								
INPATI ENT ROUTINE SERVICE COST CENTERS								
30.00			1.00	2. 00	3. 00	4. 00	5. 00	
30.00		INPATIENT ROUTINE SERVICE COST CENTERS						
31. 00 03100 INTENSIVE CARE UNIT 15, 160, 990 0 15, 160, 590 31. 00 32. 00 32. 00 32. 00 03200 02000 CROMANY CARE UNIT 3, 457, 912 3, 457, 912 0 3, 457, 912 0 35. 00 041. 00 02000 CROMANY CARE UNIT 3, 457, 912 0 3, 457, 912 35. 00 041. 00	30.00		57, 246, 800		57, 246, 800	0	57, 246, 800	30.00
32.00 03200 CORONARY CARE UNIT 0 0 0 3.5 7.912 0.3 4.57, 912 0.3 4.571, 912 0.3 4.5	31 00							
3. 457, 912 3. 457, 912 3. 457, 912 3. 457, 912 3. 600 0. 0			10,100,070					
40. 00 04000 SUBPROVI DER - I PF			2 457 013					
11.00 04100 SUBPROVI DER - 1 RF			3, 457, 912		3, 457, 912			
A3. 00 04300 NURSERY			0		(1	_	
ANCILLARY SERVICE COST CENTERS								
50.00 05000 05000 0FEATI NG ROOM 14, 603, 163 14, 603, 163 0 14, 603, 163 50.00 51.00 05100 RECOVERY ROOM 3, 345, 626 51.00 05200 05200 DELIVERY ROOM 4, 571, 782 4, 571, 782 0 4, 571, 782 20.00 52.00 05200 DELIVERY ROOM 6, 4571, 782 22.00 21, 892, 223 223 54.00 05400 RADIOLOGY-DIAGNOSTIC 182, 607 0 182, 607 0 182, 607 0 0 0 0 0 0 0 0 0	43.00	04300 NURSERY	1, 315, 774		1, 315, 774	0	1, 315, 774	43.00
50.00 05000 05000 0FEATI NG ROOM 14, 603, 163 14, 603, 163 0 14, 603, 163 50.00 51.00 05100 RECOVERY ROOM 3, 345, 626 51.00 05200 05200 DELIVERY ROOM 4, 571, 782 4, 571, 782 0 4, 571, 782 20.00 52.00 05200 DELIVERY ROOM 6, 4571, 782 22.00 21, 892, 223 223 54.00 05400 RADIOLOGY-DIAGNOSTIC 182, 607 0 182, 607 0 182, 607 0 0 0 0 0 0 0 0 0		ANCILLARY SERVICE COST CENTERS						
S1 00 05100 RECOVERY ROOM A S71 / R82 4 S71 / R82 5 0 0 3 345 626 5 1 00 52 00 05200 DEL IVERY ROOM A LABOR ROOM A S71 / R82 5 2 0 05400 RADIO LOCY-DI AGNOSTI C 21 , 892 , 223 21 , 892 , 223 0 21 , 892 , 223 5 4 00 5 00 0 0 0 0 0 0	50.00		14, 603, 163		14, 603, 163	0	14, 603, 163	50.00
S2.00 05200 DELIVERY ROOM & LABOR ROOM 4,571,782 4,571,782 0 4,571,782 52.00								
54.00 05400 RADIOLOGY-DIACNOSTIC 21,892,223 21,892,223 0 21,892,223 54.00 557.00 03520 EKG AND EEG 182,607 182,607 182,607 0 0 0 0 557.00 58.00 055900 OS5900 CARDIAC CATHETERIZATION 5,350,133 5,350,133 0 5,350,133 0 5,800 59.00 055900 CARDIAC CATHETERIZATION 5,350,133 5,350,133 0 5,350,133 0 5,350,133 0 60.00 06000 LABORATORY 0 0 0 0 0 0 60.01 06001 BLODO LABORATORY 0 0 0 0 0 0 60.01 06001 BLODO LABORATORY 0 0 0 0 0 60.01 06001 DECORDING, PROCESSING, & TRANS. 1,916,756 1,916,756 0 1,916,756 63.00 65.00 065900 RESPIRATORY THERAPY 5,186,757 0 5,186,757 0 5,186,757 0 65.01 06501 SLEEP LAB 710,924 0 710,924 0 710,924 0 710,924 65.01 66.00 06600 06600 PHYSI CAL THERAPY 5,604,976 0 5,604,976 0 5,604,976 0 5,604,976 0 611,522 0 67.00 06700 0CCUPATI ONAL THERAPY 1,297,944 0 1,297,944 0 1,297,944 0 1,297,944 0 1,297,944 0 0 0 0 0 0 0 68.01 06801 AUDIOLOGY 611,522 0 611,522		05200 DELLVERY POOM & LABOR POOM						52.00
182,607 03280 EKG AND EEG 182,607 0 182,607 0 0 0 0 0 0 0 0 0								
S8. 00 OSBOO MARNETIC RESONANCE I MAGI NG (MRI)								
59.00 05900 CARDIA C CATHETERI ZATI ON 5, 350, 133 5, 350, 133 0 12, 941, 096 60.00 60.00 LABORATORY 12, 941, 096 12, 941, 096 60.00 60.01 60.01 60.01 60.01 60.01 60.01 60.01 60.01 60.01 60.01 60.01 60.01 60.00			182, 607					
60.00 06000 LABORATORY 12, 941, 096 0 12, 941, 096 0 0 0 0 0 0 0 0 0			0		[
60.01 06001 BLOOD LABORATORY 0 0 0 0 0 0 60.01 63.00 06300 BLOOD STORI NG, PROCESSING, & TRANS. 1,916,756 1,916,756 0 65.00 06500 RESPIRATORY THERAPY 5,186,757 0 5,186,757 0 65.01 06501 SLEEP LAB 710,924 0 710,924 0 66.00 06600 PRISTICAL THERAPY 5,604,976 0 5,604,976 0 66.00 06600 PRISTICAL THERAPY 1,297,944 0 1,297,944 0 1,297,944 0 66.01 06600 DRISTICAL THERAPY 1,297,944 0 1,297,944 0 1,297,944 0 1,297,944 0 67.00 06700 05CUPATI ONAL THERAPY 1,297,944 0 1,297,944 0 1,297,944 0 1,297,944 0 1,297,944 0 1,297,944 0 0 0 0 0 68.01 06801 AUDI OLOGY 0 0 0 0 0 0 0 0 0	59.00	05900 CARDI AC CATHETERI ZATI ON	5, 350, 133		5, 350, 133	0	5, 350, 133	59. 00
60.01 06001 BLOOD LABORATORY 0 0 0 0 0 0 60.01 63.00 06300 BLOOD STORI NG, PROCESSING, & TRANS. 1,916,756 1,916,756 0 65.00 06500 RESPIRATORY THERAPY 5,186,757 0 5,186,757 0 65.01 06501 SLEEP LAB 710,924 0 710,924 0 66.00 06600 PRISTICAL THERAPY 5,604,976 0 5,604,976 0 66.00 06600 PRISTICAL THERAPY 1,297,944 0 1,297,944 0 1,297,944 0 66.01 06600 DRISTICAL THERAPY 1,297,944 0 1,297,944 0 1,297,944 0 1,297,944 0 67.00 06700 05CUPATI ONAL THERAPY 1,297,944 0 1,297,944 0 1,297,944 0 1,297,944 0 1,297,944 0 1,297,944 0 0 0 0 0 68.01 06801 AUDI OLOGY 0 0 0 0 0 0 0 0 0	60.00	06000 LABORATORY	12, 941, 096		12, 941, 096	ol ol	12, 941, 096	60.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS. 1, 916, 756 0 1, 916, 756 0 0.06500 RESPI RATORY THERAPY 5, 186, 757 0 5, 186, 757 0 0.06500 RESPI RATORY THERAPY 5, 604, 976 0 710, 924 0 10, 970, 920 0 710, 924 0 710, 924 0 710, 924 0 10, 970, 921 0 710, 924 0 710, 924 0 710, 924 0 10, 970, 921 0 710, 924 0 710, 924 0 710, 924 0 10, 970, 921 0 710, 920 0 710, 920 0 710, 920 0 710, 920 0 710, 920 0 710, 920 0 710, 920 0 710,	60. 01	06001 BLOOD LABORATORY	0		(ol ol	0	60. 01
65. 00 06500 RESPIRATORY THERAPY 5, 186, 757 0 5, 186, 757 0 5, 186, 757 0 5, 186, 757 0 5, 186, 757 0 5, 186, 757 0 5, 186, 757 0 5, 186, 757 0 5, 186, 757 0 5, 186, 757 0 5, 186, 757 0 5, 186, 757 0 5, 004, 976 0 5, 004, 976 0 5, 004, 976 0 5, 004, 976 0 5, 004, 976 0 5, 004, 976 0 5, 004, 976 0 5, 004, 976 0 5, 004, 976 0 5, 004, 976 0 5, 004, 976 0 5, 004, 976 0 5, 004, 976 0 0 0 1, 297, 944 0 1, 297, 944 0 1, 297, 944 0 1, 297, 944 0 1, 297, 944 0 1, 297, 944 0 1, 297, 944 0 1, 297, 944 0 1, 297, 944 0 1, 297, 944 0 1, 297, 944 0 0 0 0 0 0 0 0 0			1 916 756				1 916 756	
65. 01 06501 SLEEP LAB 770, 924 0 710, 924 0 710, 924 65. 01 66. 00 06600 PHYSI CAL THERAPY 5, 604, 976 0 5, 604, 976 0 5, 604, 976 66. 00 6700 0CCUPATI ONAL THERAPY 1, 297, 944 0 1, 297, 944 0 1, 297, 944 67. 00 06700 0CCUPATI ONAL THERAPY 1, 297, 944 0 1, 297, 944 0 1, 297, 944 67. 00 06700 0CCUPATI ONAL THERAPY 1, 297, 944 0 1, 297, 944 67. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								
66. 00 06600 PHYSICAL THERAPY 5, 604, 976 0 5, 604, 976 0 0, 600 0 0 0 0 0 0 0 0 0								
67.00 06700 OCCUPATIONAL THERAPY 1, 297, 944 0 1, 297, 944 0 1, 297, 944 67.00 68.00 06800 SPECH PATHOLOGY 611, 522 0 611, 522 0 69.00 06900 SPECH PATHOLOGY 0 0 0 0 69.01 06900 CELCTROCARDIOLOGY 3, 520, 643 3, 520, 643 0 3, 520, 643 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 15, 643, 732 15, 643, 732 0 15, 643, 732 0 72. 00 07200 MEDI CAL SUPPLIES CHARGED TO PATIENTS 15, 643, 732 15, 643, 732 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 22, 220, 571 22, 220, 571 0 22, 220, 571 72. 00 73. 00 07301 HOSPI TAL BASED RETAIL PHARMACIES 10, 967, 624 10, 967, 624 0 74. 00 07400 RENAL DI ALYSIS 1, 675, 706 1, 675, 706 0 76. 700 76. 90 07400 RENAL DI ALYSIS 1, 675, 706 0 0 0 76. 97 07697 CARDI AC REHABILLITATION 883, 462 883, 462 0 76. 98 07698 HYDERBARIC OXYGEN THERAPY 1, 857, 667 0 79. 00 09000 CLINIC 0 0 0 0 79. 00 09000 CLINIC 0 0 0 79. 00 09000 CLINIC 0 0 0 79. 00 09000 CLINIC 2, 107, 133 2, 107, 133 0 2, 107, 133 0 79. 00 09000 CLINIC 2, 031, 189 2, 031, 189 0 2, 031, 189 79. 00 09000 CLINIC 2, 031, 189 2, 031, 189 0 2, 031, 189 79. 00 09000 CLINIC 2, 031, 189 2, 031, 189 0 2, 031, 189 79. 00 09000 CLINIC 2, 031, 189 2, 031, 189 0 2, 031, 189 79. 00 09000 CLINIC 2, 031, 189 2, 031, 189 0 2, 031, 189 79. 00 09000 CLINIC 2, 031, 189 2, 031, 189 0 2, 031, 189 79. 00 09000 CLINIC 5, 633, 261 5, 633, 261 5, 633, 261 79. 00 09000 DERREGENCY 19, 979, 437 19, 979, 437 0 79. 00 09000 DERREGENCY 19, 979, 437 19, 979, 437 0 79. 00 09000 DERREGENCY 19, 979, 437 19, 979, 437 0 79. 00 09000 DERREGENCY 19, 133, 20 2, 660, 407 0 2, 660, 407 0 70. 00 09000 DERREGENCY 19, 100 1300 100 100 100 100 100 100 100 100 100 100 100 100 100								
68. 00 06800 SPEECH PATHOLOGY 611, 522 0 611, 522 0 68. 01 68. 01 06801 AUDI OLOGY 0 0 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 3, 520, 643 3, 520, 643 0 3, 520, 643 69. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 15, 643, 732 15, 643, 732 0 15, 643, 732 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 22, 220, 571 22, 220, 571 0 22, 220, 571 72. 00 73. 01 07301 DRUGS CHARGED TO PATI ENTS 41, 641, 093 41, 641, 093 0 41, 641, 093 0 74. 00 07400 RENAL DI ALYSI S 1, 675, 706 1, 675, 706 0 10, 967, 624 10, 967, 624 0 10, 967, 624 73. 01 74. 00 07400 RENAL DI ALYSI S 1, 675, 706 0 1, 675, 706 0 0 0 0 76. 97 07697 CARDI AC REHABI LI TATI ON 883, 462 883, 462 0 883, 462 0 76. 98 07698 HYPERBARI C OXYGEN THERAPY 1, 857, 667 0 1, 857, 667 0 79. 02 09002 CLI NI C 0 0 0 0 0 0 79. 03 09003 ONCOLOGY CLI NI C 2, 031, 189 2, 031, 189 0 79. 00 09000 CLI NI C 2, 031, 189 2, 031, 189 0 79. 00 09000 DEMERGENCY 19, 979, 437 19, 979, 437 0 19, 979, 437 19, 979, 437 0 79. 00 09200 DESERVATI ON BEDS (IOISTI NCT PART) 5, 633, 261 5, 633, 261 20. 00 70. 00 00 00 00 00 00 00 0								
68.01 06801 AUDI OLOGY 0 0 0 0 0 0 0 0 68.01 69.00 06900 ELECTROCARDI OLOGY 3,520,643 3,520,643 0 3,520,643 0 3,520,643 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 15,643,732 15,643,732 0 15,643,732 72.00 07200 IMPL. DEV. CHARGED TO PATI ENT 22,220,571 22,220,571 0 22,220,571 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 41,641,093 41,641,093 0 41,641,093								
69. 00 06900 ELECTROCARDI OLOGY 3,520,643 3,520,643 0 3,520,643 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 15,643,732 15,643,732 0 15,643,732 71. 00 72. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENT 22,220,571 22,220,571 0 22,220,571 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 41,641,093 41,641,093 0 41,641,093 73. 00 73. 01 07301 HOSPI TAL BASED RETAI L PHARMACI ES 10,967,624 10,967,624 0 10,967,624 73. 01 74. 00 0 0 0 0 0 0 0 0 0	68. 00	06800 SPEECH PATHOLOGY	611, 522	0	611, 522	2 0	611, 522	68. 00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 15, 643, 732 15, 643, 732 0 15, 643, 732 71, 00 7200 1MPL. DEV. CHARGED TO PATIENT 22, 220, 571 22, 220, 571 0 22, 220, 571 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 41, 641, 093 41, 641, 093 0 41, 641, 093 73. 00 73. 01 74. 00 07400 RENAL DIALYSIS 1, 675, 706 1, 675, 706 0 1, 675, 706 74. 00 76. 00 0 0 0 0 0 0 0 0 0	68. 01	06801 AUDI OLOGY	0	0	(0	0	68. 01
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 15, 643, 732 15, 643, 732 0 15, 643, 732 71, 00 7200 1MPL. DEV. CHARGED TO PATIENT 22, 220, 571 22, 220, 571 0 22, 220, 571 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 41, 641, 093 41, 641, 093 0 41, 641, 093 73. 00 73. 01 74. 00 07400 RENAL DIALYSIS 1, 675, 706 1, 675, 706 0 1, 675, 706 74. 00 76. 00 0 0 0 0 0 0 0 0 0	69.00	06900 ELECTROCARDI OLOGY	3, 520, 643		3, 520, 643	ol	3, 520, 643	69. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT 22, 220, 571 22, 220, 571 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 41, 641, 093 41, 641, 093 0 41, 641, 093 30 07301 07301 HOSPI TAL BASED RETAIL PHARMACI ES 10, 967, 624 10, 967, 624 0 10, 967, 624 73. 01 73. 01 07301 HOSPI TAL BASED RETAIL PHARMACI ES 10, 967, 624 10, 967, 624 0 10, 967, 624 73. 01 07400 RENAL DI ALYSI S 1, 675, 706 1, 675, 706 0 1, 675, 706 74. 00 0 0 0 0 0 0 0 0 0	71 00							
73. 00 07300 DRUGS CHARGED TO PATIENTS 41, 641, 093 41, 641, 093 73. 00 73. 01 07301 HOSPITAL BASED RETAIL PHARMACIES 10, 967, 624 10, 967, 624 0 10, 967, 624 73. 01 74. 00 77400 RENAL DIALYSIS 1, 675, 706 1, 675, 706 0 1, 675, 706 74. 00 76. 00 0 0 0 0 0 0 0 0 0								
73. 01 07301 HOSPI TAL BASED RETAIL PHARMACI ES 10, 967, 624 10, 967, 624 0 10, 967, 624 73. 01 74. 00 07400 RENAL DIALYSI S 1, 675, 706 1, 675, 706 0 1, 675, 706 74. 00 0 0 0 0 0 76. 00 0 0 0 76. 00 0 0 0 0 76. 00 0 0 0 0 76. 00 0 0 0 0 76. 00 0 0 0 0 76. 00 0 0 0 0 76. 00 0 0 0 0 76. 00 0 0 0 0 76. 00 0 0 0 0 76. 00 0 0 0 0 76. 00 0 0 0 0 76. 00 0 0 0 0 76. 00 0 0 0 0 0 0 76. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								
74. 00								
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76. 97			1,6/5,706					
76. 98 07698 HYPERBARI C 0XYGEN THERAPY 1,857,667 1,857,667 0 1,857,667 76. 98 000			0					
OUTPATIENT SERVICE COST CENTERS O	76. 97		883, 462		883, 462	2 0	883, 462	76. 97
90. 00	76. 98	07698 HYPERBARI C OXYGEN THERAPY	1, 857, 667		1, 857, 667	0	1, 857, 667	76. 98
90. 02		OUTPATIENT SERVICE COST CENTERS						1
90. 02	90.00	09000 CLI NI C	0		(0	0	90.00
90. 03			2 107 133		2 107 133		2 107 133	
91. 00								
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OTHER REI MBURSABLE COST CENTERS 95. 00								
95. 00 09500 AMBULANCE SERVICES 2, 660, 407 2, 660, 407 0 2, 660, 407 95. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113. 00 290, 284, 624 0 290, 284, 624 0 290, 284, 624 200. 00 201. 00 Less Observation Beds 5, 633, 261 5, 633, 261 201. 00	92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	0			0	0	92. 01
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 290, 284, 624 0 290, 284, 624 200.00 201.00 Less Observation Beds 5, 633, 261 5, 633, 261 201.00		OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 290, 284, 624 0 290, 284, 624 200.00 201.00 Less Observation Beds 5, 633, 261 5, 633, 261 201.00	95.00	09500 AMBULANCE SERVI CES	2, 660, 407		2, 660, 407	0	2, 660, 407	95. 00
113. 00		SPECIAL PURPOSE COST CENTERS						1
200. 00 Subtotal (see instructions) 290, 284, 624 0 290, 284, 624 0 290, 284, 624 0 290, 284, 624 200. 00 290, 284, 624 5, 633, 261 5, 633, 261 201. 00	113 00							113 00
201.00 Less Observation Beds 5, 633, 261 5, 633, 261 5, 633, 261 201.00		1 1	200 204 424		200 204 424	_	200 204 424	
				1				
202.00 101a (See Instructions) 284,651,363 0 284.651,363 0 284.651,363				_				
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Provider CCN: 15-0089

					10 12/31/2017	5/24/2018 5:0	
			Title	· XVIII	Hospi tal	PPS	<u> </u>
	<u> </u>		Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col.	Cost or Other	TEFRA	
				+ col. 7)	Ratio	I npati ent	
						Ratio	
		6. 00	7. 00	8. 00	9. 00	10. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	105 050 044		105.050.04	.1		
30.00	03000 ADULTS & PEDIATRICS	185, 050, 846		185, 050, 84			30.00
31.00	03100 I NTENSI VE CARE UNI T	58, 887, 224		58, 887, 22			31.00
32.00	03200 CORONARY CARE UNIT	0			0		32.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT	14, 684, 782		14, 684, 78			35.00
40.00	04000 SUBPROVI DER - I PF	10 700 150			0		40.00
41.00	04100 SUBPROVI DER – I RF	10, 783, 458		10, 783, 45			41.00
43. 00	04300 NURSERY ANCILLARY SERVICE COST CENTERS	6, 155, 032		6, 155, 03	2		43. 00
50. 00	05000 OPERATING ROOM	104, 371, 979	56, 893, 187	161, 265, 16	6 0. 090554	0. 000000	50.00
51. 00	05100 RECOVERY ROOM	104, 371, 979	8, 305, 415			0. 000000	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	23, 818, 718	4, 537, 913			0. 000000	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	58, 912, 408	172, 659, 478			0. 000000	1
57. 00	03280 EKG AND EEG	1, 779, 198	1, 842, 018			0. 000000	1
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	1, 777, 170	1, 042, 010		0.000000	0. 000000	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	47, 462, 365	50, 410, 362			0. 000000	1
60. 00	06000 LABORATORY	55, 275, 984	49, 692, 002			0. 000000	1
60. 01	06001 BLOOD LABORATORY	00, 270, 704	47, 072, 002	1	0. 000000	0. 000000	
63. 00	06300 BLOOD STORING, PROCESSING, & TRANS.	5, 137, 015	1, 451, 411			0. 000000	
65. 00	06500 RESPIRATORY THERAPY	19, 457, 151	2, 222, 094			0. 000000	
65. 01	06501 SLEEP LAB	6, 547	8, 570, 829			0. 000000	
66. 00	06600 PHYSI CAL THERAPY	8, 659, 173	10, 104, 844			0. 000000	1
67. 00	06700 OCCUPATI ONAL THERAPY	5, 583, 648	482, 684			0. 000000	
68. 00	06800 SPEECH PATHOLOGY	2, 683, 776	305, 338			0. 000000	1
68. 01	06801 AUDI OLOGY	0	0		0. 000000	0.000000	68. 01
69.00	06900 ELECTROCARDI OLOGY	36, 786, 379	15, 711, 625	52, 498, 00	4 0. 067062	0.000000	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	26, 389, 338	26, 889, 564	53, 278, 90	2 0. 293620	0.000000	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	82, 053, 086	27, 259, 569	109, 312, 65	5 0. 203275	0.000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	106, 048, 729	124, 560, 200	230, 608, 92	9 0. 180570	0.000000	73. 00
73. 01	07301 HOSPITAL BASED RETAIL PHARMACIES	0	9, 099, 452	9, 099, 45	2 1. 205306	0.000000	73. 01
74.00	07400 RENAL DIALYSIS	3, 782, 360	112, 977	3, 895, 33		0. 000000	
76. 00	03160 CARDI OPULMONARY	0	0		0. 000000	0. 000000	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	982, 730	3, 042, 496			0. 000000	
76. 98	07698 HYPERBARI C OXYGEN THERAPY	100, 050	15, 314, 823	15, 414, 87	0. 120511	0. 000000	76. 98
	OUTPATIENT SERVICE COST CENTERS	,					
90.00	09000 CLI NI C	0	0	1	0. 000000	0. 000000	
90. 02	09002 PAIN CLINIC	28, 546	8, 275, 477			0. 000000	1
90. 03	09003 ONCOLOGY CLINIC	215, 209	31, 005, 902			0. 000000	1
91. 00	09100 EMERGENCY	65, 426, 293	157, 914, 675			0. 000000	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 386, 193	23, 334, 417			0. 000000	
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0		0.00000	0. 000000	92. 01
05 00	OTHER REIMBURSABLE COST CENTERS	14 7/1	0.452.140	0.4/7.01	0 214175	0.000000	05 00
95. 00	09500 AMBULANCE SERVICES	14, 761	8, 453, 149	8, 467, 91	0. 314175	0. 000000	95. 00
112 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE						113. 00
200.00		943, 524, 441	Q1Q /51 001	1, 761, 976, 34	2		200. 00
200.00	()	743, 324, 441	010, 401, 701	1, 701, 770, 34	-		200.00
201.00		943, 524, 441	818 451 901	1, 761, 976, 34	2		202.00
202.00	1.0141 (300 111311 4011 0113)	, 10, 024, 441	515, 451, 701	1 ., , 5 ., , , 6, 54	-1	l	1-02.00

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES BALL MEMORIAL HOSPITAL Provider CCN: 15-0089

| In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2017 | Part | To 12/31/2017 | Date/Time Prepared: | 5/24/2018 5:05 pm

				5/24/2018 5:05 pm
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
31. 00 03100 I NTENSI VE CARE UNI T				31.00
32. 00 03200 CORONARY CARE UNIT				32.00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT				35.00
40. 00 04000 SUBPROVI DER - 1 PF				40. 00
41. 00 04100 SUBPROVI DER - RF				41. 00
43. 00 04300 NURSERY				43. 00
ANCI LLARY SERVI CE COST CENTERS				101.00
50. 00 05000 OPERATI NG ROOM	0. 090554			50.00
51. 00 05100 RECOVERY ROOM	0. 176953			51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 161224			52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 094537			54.00
57. 00 03280 EKG AND EEG	0. 050427			57. 00
58. 00 05800 MAGNETIC RESONANCE MAGING (MRI)	0. 000000			58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 054664			59. 00
60. 00 06000 LABORATORY	0. 123286			60.00
60. 01 06001 BLOOD LABORATORY	0. 000000			60. 01
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0. 290928			63. 00
65. 00 06500 RESPI RATORY THERAPY	0. 239250			65. 00
65. 01 06501 SLEEP LAB	0. 082884			65. 01
66. 00 06600 PHYSI CAL THERAPY	0. 298709			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 213959			67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 204583			68. 00
68. 01 06801 AUDI OLOGY	0. 000000			68. 01
69. 00 06900 ELECTROCARDI OLOGY	0. 067062			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 293620			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 203275			72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 180570			73.00
73. 01 07301 HOSPITAL BASED RETAIL PHARMACIES	1. 205306			73. 01
74. 00 07400 RENAL DIALYSIS	0. 430183			74. 00
76. 00 03160 CARDI OPULMONARY	0. 000000			76. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 219481			76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 120511			76. 98
OUTPATIENT SERVICE COST CENTERS	0. 120011			76. 76
90. 00 09000 CLINIC	0. 000000			90.00
90. 02 09000 PAIN CLINIC	0. 253748			90.00
90. 02 09002 PATN CETNIC 90. 03 09003 0NCOLOGY CLINIC	0. 253748			90. 02
91. 00 09100 EMERGENCY	0. 089457			91. 00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0. 219017			92.00
92. 01 09201 OBSERVATION BEDS (DISTINCT PART)	0. 000000			92. 01
OTHER REIMBURSABLE COST CENTERS				
95. 00 09500 AMBULANCE SERVI CES	0 0444			
SPECIAL PURPOSE COST CENTERS	0. 314175			95. 00
113. 00 11300 I NTEREST EXPENSE	0. 314175			
	0. 314175			113. 00
200.00 Subtotal (see instructions)	0. 314175			113. 00 200. 00
	0. 314175			113. 00

From 01/01/2017 Part I Date/Time Prepared: 12/31/2017 5/24/2018 5:05 pm Title XIX Hospi tal Cost Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs from Wkst. B, Adj Di sal I owance Part I, col. 26) 1.00 2.00 3.00 4.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 57, 246, 800 57, 246, 800 57, 246, 800 30.00 03100 INTENSIVE CARE UNIT 0 31.00 31.00 15, 160, 590 15, 160, 590 15, 160, 590 03200 CORONARY CARE UNIT 0 32.00 32.00 02060 NEONATAL INTENSIVE CARE UNIT 0 3, 457, 912 35.00 3, 457, 912 35, 00 3, 457, 912 04000 SUBPROVI DER - I PF 0 40.00 C Λ 40.00 41.00 04100 SUBPROVIDER - IRF 4,066,114 4, 066, 114 0 4, 066, 114 41.00 04300 NURSERY 1, 315, 774 1, 315<u>,</u> 774 <u>1, 315,</u> 774 43.00 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 14, 603, 163 14, 603, 163 0 14, 603, 163 50.00 51.00 05100 RECOVERY ROOM 3, 345, 626 3, 345, 626 0 3, 345, 626 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 4, 571, 782 4, 571, 782 0 4, 571, 782 52.00 05400 RADI OLOGY-DI AGNOSTI C 21, 892, 223 54.00 21, 892, 223 21, 892, 223 54.00 57.00 03280 EKG AND EEG 182, 607 182, 607 182, 607 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 0 0 0 0 0 0 58.00 5, 350, 133 05900 CARDIAC CATHETERIZATION 5, 350, 133 5, 350, 133 59 00 59 00 60.00 06000 LABORATORY 12, 941, 096 12, 941, 096 12, 941, 096 60.00 06001 BLOOD LABORATORY 60.01 60.01 06300 BLOOD STORING, PROCESSING, & TRANS. 63.00 1, 916, 756 1, 916, 756 1, 916, 756 63.00 06500 RESPIRATORY THERAPY 5, 186, 757 65 00 5, 186, 757 5, 186, 757 65 00 65.01 06501 SLEEP LAB 710, 924 710, 924 710, 924 65.01 06600 PHYSI CAL THERAPY 66.00 5, 604, 976 5, 604, 976 0 5, 604, 976 66.00 06700 OCCUPATIONAL THERAPY 67 00 1, 297, 944 1, 297, 944 1, 297, 944 67 00 68.00 06800 SPEECH PATHOLOGY 611, 522 611, 522 611, 522 68.00 0 06801 AUDI OLOGY 68.01 68.01 69.00 06900 ELECTROCARDI OLOGY 3, 520, 643 3, 520, 643 0 3, 520, 643 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 15, 643, 732 15, 643, 732 15, 643, 732 71 00 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 22, 220, 571 22, 220, 571 22, 220, 571 72.00 07300 DRUGS CHARGED TO PATIENTS 41, 641, 093 0 0 41, 641, 093 41, 641, 093 73.00 73.01 07301 HOSPITAL BASED RETAIL PHARMACIES 10, 967, 624 10, 967, 624 10, 967, 624 73.01 07400 RENAL DIALYSIS 1, 675, 706 1, 675, 706 74 00 1, 675, 706 74 00 76.00 03160 CARDI OPULMONARY 0 0 76.00 883, 462 883, 462 07697 CARDIAC REHABILITATION 76.97 883, 462 76.97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 1, 857, 667 1, 857, 667 1, 857, 667 76. 98 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 90.00 0 90 02 09002 PAIN CLINIC 2, 107, 133 2, 107, 133 0 2, 107, 133 90 02 09003 ONCOLOGY CLINIC 0 90.03 90.03 2.031.189 2.031.189 2, 031, 189 0 91.00 09100 EMERGENCY 19, 979, 437 19, 979, 437 19, 979, 437 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 5, 633, 261 5, 633, 261 5, 633, 261 92.00 09201 OBSERVATION BEDS (DISTINCT PART) 92.01 92.01

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290, 284, 624 200. 00

284, 651, 363 202. 00

5, 633, 261 201. 00

95.00

113.00

2, 660, 407

290, 284, 624

284, 651, 363

5, 633, 261

0

OTHER REIMBURSABLE COST CENTERS
09500 AMBULANCE SERVICES

Less Observation Beds

Total (see instructions)

Subtotal (see instructions)

SPECIAL PURPOSE COST CENTERS

113. 00 11300 | INTEREST EXPENSE

95.00

200.00

201.00

202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0089 Peri od: Worksheet C From 01/01/2017 Part I Date/Time Prepared: 12/31/2017 5/24/2018 5:05 pm Title XIX Hospi tal Cost Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other **TFFRA** + col . 7) Ratio Inpati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 185, 050, 846 185, 050, 846 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 58, 887, 224 58, 887, 224 31.00 03200 CORONARY CARE UNIT 32.00 32.00 35.00 02060 NEONATAL INTENSIVE CARE UNIT 14.684.782 14, 684, 782 35.00 04000 SUBPROVIDER - IPF 40.00 40.00 41.00 04100 SUBPROVIDER - IRF 10, 783, 458 10, 783, 458 41.00 43.00 04300 NURSERY 6, 155, 032 6, 155, 032 43 00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 104, 371, 979 56, 893, 187 161, 265, 166 0.090554 0.000000 50.00 51.00 05100 RECOVERY ROOM 10, 601, 463 8, 305, 415 18, 906, 878 0.176953 0.000000 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 23, 818, 718 4, 537, 913 28, 356, 631 0.161224 0.000000 52.00 58, 912, 408 05400 RADI OLOGY-DI AGNOSTI C 231, 571, 886 0.094537 0.000000 54.00 172, 659, 478 54.00 0.050427 57.00 03280 EKG AND EEG 1, 779, 198 1,842,018 3, 621, 216 0.000000 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0.000000 0.000000 58.00 59.00 05900 CARDIAC CATHETERIZATION 47, 462, 365 50, 410, 362 97, 872, 727 0.054664 0.000000 59.00 06000 LABORATORY 60.00 55, 275, 984 49, 692, 002 104, 967, 986 0.123286 0.000000 60 00 60.01 06001 BLOOD LABORATORY 0.000000 0.000000 60.01 06300 BLOOD STORING, PROCESSING, & TRANS. 0. 290928 63.00 5, 137, 015 1, 451, 411 6, 588, 426 0.000000 63.00 19, 457, 151 06500 RESPIRATORY THERAPY 2, 222, 094 21, 679, 245 0.239250 0.000000 65.00 65.00 8, 570, 829 8, 577, 376 65.01 06501 SLEEP LAB 6,547 0.082884 0.000000 65.01 66.00 66.00 06600 PHYSI CAL THERAPY 8, 659, 173 10, 104, 844 18, 764, 017 0.298709 0.000000 06700 OCCUPATIONAL THERAPY 67.00 5, 583, 648 482, 684 6, 066, 332 0. 213959 0.000000 67.00 2, 989, 114 06800 SPEECH PATHOLOGY 2, 683, 776 305, 338 0 204583 0 000000 68 00 68 00 68.01 06801 AUDI OLOGY 0.000000 0.000000 68.01 15, 711, 625 06900 ELECTROCARDI OLOGY 36, 786, 379 52, 498, 004 0.067062 0.000000 69.00 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 26, 389, 338 26, 889, 564 53, 278, 902 0.293620 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 27, 259, 569 109, 312, 655 72.00 82, 053, 086 0.203275 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 106, 048, 729 124, 560, 200 230, 608, 929 0. 180570 0.000000 73.00 9, 099, 452 73. 01 07301 HOSPITAL BASED RETAIL PHARMACIES 9, 099, 452 1.205306 0.000000 73.01 0 74 00 07400 RENAL DIALYSIS 3 782 360 112, 977 3, 895, 337 0 430183 0 000000 74 00 03160 CARDI OPULMONARY 76.00 0.000000 0.000000 76.00 76. 97 07697 CARDIAC REHABILITATION 982, 730 3, 042, 496 4, 025, 226 0.219481 0.000000 76. 97 100,050 76.98 07698 HYPERBARI C OXYGEN THERAPY 15, 314, 823 15, 414, 873 0.120511 0.000000 76.98 OUTPATIENT SERVICE COST CENTERS 09000 CLI NI C 90.00 0.000000 0.000000 90.00 09002 PAIN CLINIC 28, 546 8, 275, 477 8, 304, 023 90.02 0.253748 0.000000 90.02 90.03 09003 ONCOLOGY CLINIC 215, 209 31,005,902 31, 221, 111 0.065058 0.000000 90.03 157, 914, 675 91 00 09100 EMERGENCY 223, 340, 968 0.089457 91 00 65, 426, 293 0.000000 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 2, 386, 193 23, 334, 417 25, 720, 610 0.219017 0.000000 92.00

OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 14, 761 8, 453, 149 8, 467, 910 0.314175 0.000000 95.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 200.00 Subtotal (see instructions) 943, 524, 441 818, 451, 901 1, 761, 976, 342 200. 00 201.00 Less Observation Beds 201. 00 202.00 818, 451, 901 1, 761, 976, 342 Total (see instructions) 943, 524, 441 202.00

0.000000

0.000000

92.01

92.01

09201 OBSERVATION BEDS (DISTINCT PART)

Health Financial Systems BALL MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0089 Period: From 01/01/2017 Part I

12/31/2017 Date/Time Prepared: 5/24/2018 5:05 pm Title XIX Hospi tal Cost PPS Inpatient Cost Center Description Ratio 11 00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 30.00 03100 INTENSIVE CARE UNIT 31.00 31.00 32.00 03200 CORONARY CARE UNIT 32.00 35.00 02060 NEONATAL INTENSIVE CARE UNIT 35.00 40. 00 | 04000 | SUBPROVI DER - I PF 40.00 04100 SUBPROVI DER - I RF 41.00 41.00 04300 NURSERY 43.00 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 000000 50.00 51. 00 05100 RECOVERY ROOM 0.000000 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 0.000000 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 54.00 57.00 03280 EKG AND EEG 0.000000 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58. 00 0.000000 58.00 59.00 05900 CARDIAC CATHETERIZATION 0.000000 59.00 06000 LABORATORY 0.000000 60.00 60.00 06001 BLOOD LABORATORY 0.000000 60.01 60.01 06300 BLOOD STORING, PROCESSING, & TRANS. 0.000000 63.00 63 00 65.00 06500 RESPIRATORY THERAPY 0.000000 65.00 06501 SLEEP LAB 65.01 0.000000 65.01 06600 PHYSI CAL THERAPY 0.000000 66.00 66.00 06700 OCCUPATIONAL THERAPY 67.00 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 0.000000 68.00 06801 AUDI OLOGY 68. 01 0.000000 68.01 06900 ELECTROCARDI OLOGY 0.000000 69.00 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 0.000000 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0.000000 73.00 07301 HOSPITAL BASED RETAIL PHARMACIES 0.000000 73.01 73.01 74. 00 07400 RENAL DIALYSIS 0.000000 74.00 03160 CARDI OPULMONARY 0.000000 76.00 76.00 07697 CARDIAC REHABILITATION 76. 97 0.000000 76. 97 07698 HYPERBARI C OXYGEN THERAPY 76. 98 0.000000 76. 98 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0.000000 90.00 90. 02 0.000000 09002 PAIN CLINIC 90.02 90.03 09003 ONCOLOGY CLINIC 0.000000 90.03 09100 EMERGENCY 91.00 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)
09201 OBSERVATION BEDS (DISTINCT PART) 92.00 0.000000 92.00 92.01 0.000000 92.01 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES
SPECIAL PURPOSE COST CENTERS 95.00 0.000000 95.00 113.00 11300 I NTEREST EXPENSE 113.00 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201. 00

202.00

202.00

Total (see instructions)

Health Financial Systems	BALL MEMORIA	L HOSPITAL		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL		Provi der C		Period: From 01/01/2017 To 12/31/2017	Worksheet D Part I	pared:
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	5, 944, 542	0	5, 944, 54	2 74, 693	79. 59	30.00
31.00 INTENSIVE CARE UNIT	1, 124, 740		1, 124, 74	0 10, 712	105.00	31.00
32.00 CORONARY CARE UNIT	0			0 0	0.00	32.00
35.00 NEONATAL INTENSIVE CARE UNIT	206, 949		206, 94	9 3, 342	61. 92	35.00
40. 00 SUBPROVI DER - I PF	0	0		0	0.00	40.00
41. 00 SUBPROVI DER - I RF	397, 787	0	397, 78	7 4, 174	95. 30	41.00
43. 00 NURSERY	143, 071		143, 07	1 2, 539	56. 35	43.00
200.00 Total (lines 30 through 199)	7, 817, 089		7, 817, 08	95, 460		200.00
Cost Center Description	Inpati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	33, 515	2, 667, 459)			30.00
31.00 INTENSIVE CARE UNIT	5, 430	570, 150				31.00
32. 00 CORONARY CARE UNIT	0	0				32.00
35.00 NEONATAL INTENSIVE CARE UNIT	0	0				35. 00
40. 00 SUBPROVI DER - I PF	0	0				40.00
41. 00 SUBPROVI DER - I RF	2, 944	280, 563				41.00
43. 00 NURSERY	0	0				43.00
200.00 Total (lines 30 through 199)	41, 889	3, 518, 172	2			200. 00

Heal th	Financial Systems	BALL MEMORIA	L HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORT	TIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der C	CN: 15-0089	Peri od:	Worksheet D	
					From 01/01/2017	Part II	
					To 12/31/2017	Date/Time Pre 5/24/2018 5:0	parea: 5 nm
			Ti tl e	xVIII	Hospi tal	PPS	<u> Э</u> рііі
	Cost Center Description	Capi tal	Total Charges			Capital Costs	
	5051 5011101 50501 1 pt 1 011		(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,				column 4)	
		Part II, col.	8)	2)	3.1	,	
		26)	Í	· ·			
		1.00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	1, 226, 700	161, 265, 166	0. 00760	97 49, 189, 302	374, 183	50.00
51.00	05100 RECOVERY ROOM	305, 265	18, 906, 878	0. 01614	4, 903, 104	79, 166	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	481, 465	28, 356, 631	0. 01697	186, 389	3, 165	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 122, 948	231, 571, 886	0. 00916	30, 998, 699	284, 196	54.00
57.00	03280 EKG AND EEG	2, 374	3, 621, 216	0.00065	993, 171	652	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0. 00000	00	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	501, 716	97, 872, 727	0. 00512	26 23, 157, 625	118, 706	59. 00
60.00	06000 LABORATORY	170, 140	104, 967, 986	0. 00162	21 25, 302, 003	41, 015	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0. 00000	00	0	60. 01
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	22, 390	6, 588, 426	0. 00339	3, 016, 121	10, 249	63.00
65.00	06500 RESPIRATORY THERAPY	188, 052	21, 679, 245	0.00867	74 10, 301, 230	89, 353	65.00
65. 01	06501 SLEEP LAB	5, 713	8, 577, 376	0.00066	56 0	0	65. 01
66.00	06600 PHYSI CAL THERAPY	148, 339	18, 764, 017	0.00790	3, 266, 521	25, 825	66.00
67.00	06700 OCCUPATI ONAL THERAPY	85, 705	6, 066, 332	0. 01412	28 1, 110, 724	15, 692	67.00
68.00	06800 SPEECH PATHOLOGY	22, 792			25 876, 338	6, 682	68. 00
68. 01	06801 AUDI OLOGY	0	0	0. 00000	00	0	68. 01
69.00	06900 ELECTROCARDI OLOGY	612, 030	52, 498, 004	0. 01165	58 20, 748, 376	241, 885	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	191, 388	53, 278, 902	0.00359	13, 272, 185	47, 674	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	267, 626	109, 312, 655	0.00244	41, 426, 635	101, 412	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	354, 992	230, 608, 929	0. 00153	49, 200, 806	75, 720	73. 00
73. 01	07301 HOSPITAL BASED RETAIL PHARMACIES	36, 903	9, 099, 452	0.00405	56 0	0	73. 01
74.00	07400 RENAL DIALYSIS	98, 416	3, 895, 337	0. 02526	2, 580, 371	65, 193	74.00
76.00	03160 CARDI OPULMONARY	0	0	0.00000	00	0	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	10, 659	4, 025, 226	0. 00264	18 547, 076	1, 449	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	17, 871	15, 414, 873	0. 00115	59 79, 777	92	76. 98
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0				0	
	09002 PAIN CLINIC	733, 587					90. 02
00 02	00003 ONCOLOCY CLINIC	E7 E01	21 221 111	0 0010/	112 114	1 207	00 02

57, 501

584, 963

9, 552, 716 1, 477, 947, 090

1, 303, 181

31, 221, 111

223, 340, 968

25, 720, 610

0.001842

0.005835

0.022743

0.000000

112, 146

34, 038, 787

1, 155, 367

316, 484, 010

198, 616

26, 277

207

1, 809, 287 200. 00

90.03

91.00

92.00

92.01

95.00

90. 03 09003 ONCOLOGY CLINIC

91.00

92.00

92.01

09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)

09201 OBSERVATION BEDS (DISTINCT PART)
OTHER REIMBURSABLE COST CENTERS

95. 00 09500 AMBULANCE SERVICES 200. 00 Total (lines 50 through 199)

Health Financial Systems	BALL MEMORIA	L HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COS	TS Provider C		Period: From 01/01/2017 To 12/31/2017	Worksheet D Part III Date/Time Pre 5/24/2018 5:0	pared: 5 pm
		Title	: XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	Nursing School	Allied Health	Allied Health	All Other	
	Post-Stepdown		Post-Stepdowr	n Cost	Medi cal	
	Adjustments		Adjustments		Education Cost	
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	0	0		0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0)	0	0	31.00
32. 00 03200 CORONARY CARE UNIT	0	0	1	0 0	0	32.00
35.00 02060 NEONATAL INTENSIVE CARE UNIT	0	0	1	0 0	0	35. 00
10. 00 04000 SUBPROVI DER - 1 PF	0	0)	0 0	0	40.00
11. 00 04100 SUBPROVI DER - I RF	0	0)	0 0	0	41.00
3. 00 04300 NURSERY		0		o o	0	43.00
	1	1	I	1		

		Title	: XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	Nursing School	Allied Health	Allied Health	All Other	
· ·	Post-Stepdown	Ü	Post-Stepdown	Cost	Medi cal	
	Adjustments		Adjustments		Education Cost	
	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31. 00 03100 NTENSI VE CARE UNI T	0	0		0	i o	31. 00
32. 00 03200 CORONARY CARE UNIT	0	0		0	0	32. 00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT		0		0	0	1
	0	0		0	1	
40. 00 04000 SUBPROVI DER - PF	0	0	0	0	0	1 .0.00
41. 00 04100 SUBPROVI DER - RF	0	0	0	0	0	41.00
43. 00 04300 NURSERY	0	0	0	0	0	1 .0.00
200.00 Total (lines 30 through 199)	0	0	0	0		200. 00
Cost Center Description	Swi ng-Bed	Total Costs		Per Diem (col.	Inpati ent	
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
		minus col. 4)				
	4. 00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	74, 693			30.00
31.00 03100 INTENSIVE CARE UNIT		0	10, 712	0.00	5, 430	31.00
32. 00 03200 CORONARY CARE UNIT		0	0	0.00	0	32. 00
35.00 02060 NEONATAL INTENSIVE CARE UNIT		0	3, 342	0.00	0	35. 00
40. 00 04000 SUBPROVI DER - I PF	0	0	l	0.00	l 0	40.00
41. 00 04100 SUBPROVI DER - I RF	0	0	4, 174	0.00	2, 944	41.00
43. 00 04300 NURSERY		0				1
200.00 Total (lines 30 through 199)		0			41, 889	1
Cost Center Description	I npati ent	Ü	70, 100		11,007	200.00
oost conten bescriptron	Program					
	Pass-Through					
	Cost (col. 7 x					
	cost (cor. 7 x					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS	7.00					
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
31. 00 03100 NTENSI VE CARE UNI T	0					31.00
	0					1
32. 00 03200 CORONARY CARE UNIT	0					32. 00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT	0					35. 00
40. 00 04000 SUBPROVI DER - PF	0					40.00
41. 00 04100 SUBPROVI DER - I RF	0					41. 00
43. 00 04300 NURSERY	0					43. 00
200.00 Total (lines 30 through 199)	0					200. 00

Health Financial Systems	BALL MEMORIAL H	IOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0089	Peri od:	Worksheet D
THROUGH COSTS			From 01/01/2017	Part IV

To 12/31/2017 Date/Time Prepared: 5/24/2018 5:05 pm Title XVIII Hospi tal PPS Cost Center Description Non Physician Nursing School Nursing School Allied Health Allied Health Anesthetist Post-Stepdown Post-Stepdown Cost Adjustments Adjustments 1.00 2.00 3. 00 2A 3A ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 51.00 05100 RECOVERY ROOM 000000000000000000000000000 0 0 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 0 0 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 0 0 57.00 03280 EKG AND EEG 0 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 58.00 58.00 0 0 59.00 05900 CARDI AC CATHETERI ZATI ON 0 59.00 60.00 06000 LABORATORY 0 0 60.00 06001 BLOOD LABORATORY 0 60.01 0 60.01 0 06300 BLOOD STORING, PROCESSING, & TRANS. 0 63.00 Λ 63.00 65.00 06500 RESPIRATORY THERAPY 0 0 0 65.00 65.01 06501 SLEEP LAB 65.01 06600 PHYSI CAL THERAPY 66.00 0 0 66.00 0 06700 OCCUPATI ONAL THERAPY 0 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 68.00 06801 AUDI OLOGY 0 0 68.01 68.01 0 06900 ELECTROCARDI OLOGY 69.00 69.00 Ω 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 72.00 72.00 0 07300 DRUGS CHARGED TO PATIENTS 0 199, 212 73.00 73.00 07301 HOSPITAL BASED RETAIL PHARMACIES 0 73.01 0 0 73.01 0 74.00 07400 RENAL DIALYSIS 0 0 74.00 03160 CARDI OPULMONARY 0 76.00 0 76.00 0 76 97 07697 CARDIAC REHABILITATION 0 Ω 76. 97 07698 HYPERBARI C OXYGEN THERAPY 0 0 76. 98 0 0 76.98 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 0 0 0 0 90.00 09002 PAIN CLINIC 0 0 90.02 90.02 C 0 09003 ONCOLOGY CLINIC 90.03 0 0 0 90.03 0 09100 EMERGENCY 0 0 91.00 91.00 0 0 92 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 09201 OBSERVATION BEDS (DISTINCT PART) 0 92.01 0 92.01 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 95.00 0

0

0

0

199, 212 200. 00

200.00

Total (lines 50 through 199)

Health Financial Systems	BALL MEMORIAL H	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0089	Peri od:	Worksheet D
THROUGH COSTS			From 01/01/2017	Part IV

THROUGH COSTS 12/31/2017 Date/Time Prepared: 5/24/2018 5:05 pm Hospi tal Title XVIII Cost Center Description All Other Total Cost Total Total Charges Ratio of Cost to Charges Medi cal (from Wkst. C, (sum of col 1 Outpati ent Education Cost through col Cost (sum of Part I, col. (col. 5 ÷ col col. 2, 3 and 4) 8) 7) 4.00 5.00 6.00 7.00 8.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 161, 265, 166 0.000000 50.00 00000000000000000000000 51.00 05100 RECOVERY ROOM 18, 906, 878 0.00000051.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 28, 356, 631 0.000000 52.00 52.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 231, 571, 886 0.000000 54.00 54.00 0 03280 EKG AND EEG 3, 621, 216 0.000000 57.00 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 0 0.000000 58.00 59.00 05900 CARDIAC CATHETERIZATION 97, 872, 727 0.000000 59.00 06000 LABORATORY 0 0 0.000000 60 00 104, 967, 986 60 00 06001 BLOOD LABORATORY 0 60.01 0.000000 60.01 63.00 06300 BLOOD STORING, PROCESSING, & TRANS. 6, 588, 426 0.000000 63.00 06500 RESPIRATORY THERAPY 65.00 21, 679, 245 0.000000 65.00 06501 SLEEP LAB 8, 577, 376 0 000000 65 01 65 01 66.00 06600 PHYSI CAL THERAPY 18, 764, 017 0.000000 66.00 06700 OCCUPATIONAL THERAPY 0.000000 67.00 6, 066, 332 67.00 06800 SPEECH PATHOLOGY 68 00 2, 989, 114 0.000000 68 00 68.01 06801 AUDI OLOGY 0.000000 68.01 69.00 06900 ELECTROCARDI OLOGY 52, 498, 004 0.000000 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 53, 278, 902 0.000000 71.00 07200 I MPL. DEV. CHARGED TO PATIENT O 109, 312, 655 0.000000 72 00 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 199, 212 199, 212 230, 608, 929 0.000864 73.00 07301 HOSPITAL BASED RETAIL PHARMACIES 9, 099, 452 0.000000 73.01 74.00 07400 RENAL DIALYSIS 0 0 0 0 3, 895, 337 0.000000 74.00 03160 CARDI OPULMONARY 0 76.00 Ω 0.000000 76.00 76.97 07697 CARDIAC REHABILITATION C 4, 025, 226 0.000000 76.97 07698 HYPERBARI C OXYGEN THERAPY 15, 414, 873 0.000000 76. 98 76.98 OUTPATIENT SERVICE COST CENTERS 90.00 90 00 09000 CLI NI C 0 0.000000 0 90.02 09002 PAIN CLINIC 0 0 8, 304, 023 0.000000 90.02 09003 ONCOLOGY CLINIC 90.03 0 31, 221, 111 0.000000 90.03 0 91.00 09100 EMERGENCY 0 0 223, 340, 968 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 92.00 r 25, 720, 610 0.000000 92 00 09201 OBSERVATION BEDS (DISTINCT PART) 0.000000 92.01 92.01 OTHER REIMBURSABLE COST CENTERS 95.00 95.00 09500 AMBULANCE SERVICES o 199, 212 1, 477, 947, 090 199, 212 200.00 Total (lines 50 through 199) 200.00

Health Financial Systems	BALL MEMORIAL HOSPITAL				In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT/OUTPATIENT AN THROUGH COSTS	ICI LLARY SERVI CE OTHER PASS	Provider CO		Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Pre 5/24/2018 5:0		
		Title	: XVIII	Hospi tal	PPS		
Cost Center Description	Outpati ent	I npati ent	Inpatient	Outpati ent	Outpati ent		
	Ratio of Cost	Program	Program	Program	Program		
	to Charges	Charges	Pass-Through	Charges	Pass-Through		
	(col. 6 ÷ col.		Costs (col. 8	3	Costs (col. 9		
	7\		! 10)		1 10)		

					5/24/2018 5:0	5 pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷ col.	Ü	Costs (col. 8	ŭ	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	49, 189, 302	0	17, 634, 618	0	50.00
51.00 05100 RECOVERY ROOM	0. 000000	4, 903, 104	0	2, 765, 116	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	186, 389		8, 239		52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	30, 998, 699	0	69, 915, 584	0	54.00
57. 00 03280 EKG AND EEG	0. 000000	993, 171	0	620, 373	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0	0	0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	23, 157, 625	0	21, 278, 489	0	59.00
60. 00 06000 LABORATORY	0. 000000	25, 302, 003		7, 068, 360		60.00
60. 01 06001 BLOOD LABORATORY	0. 000000	0	o	0	0	60, 01
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0. 000000	3, 016, 121	o	461, 755	0	63.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	10, 301, 230	0	613, 548	0	65. 00
65. 01 06501 SLEEP LAB	0. 000000	0	0	2, 631, 118		65. 01
66. 00 06600 PHYSI CAL THERAPY	0. 000000	3, 266, 521	0	132, 819		66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	1, 110, 724	0	38, 960		67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	876, 338		10, 151	0	68. 00
68. 01 06801 AUDI OLOGY	0. 000000	0	0	0	0	68. 01
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	20, 748, 376	0	5, 996, 353	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	13, 272, 185		12, 611, 005		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000	41, 426, 635		13, 389, 309		72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000864	49, 200, 806		49, 915, 272		73. 00
73. 01 07301 HOSPITAL BASED RETAIL PHARMACIES	0. 000000	0	0	0	0	73. 01
74. 00 07400 RENAL DIALYSIS	0. 000000	2, 580, 371	0	63, 796	0	74. 00
76. 00 03160 CARDI OPULMONARY	0. 000000	0	0	0	0	76. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	547, 076	0	1, 580, 374	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000	79, 777		6, 206, 108		76. 98
OUTPATIENT SERVICE COST CENTERS	<u>'</u>	•	'			
90. 00 09000 CLI NI C	0. 000000	0	0	0	0	90.00
90. 02 09002 PAIN CLINIC	0. 000000	21, 257	0	3, 346, 341	0	90. 02
90. 03 09003 0NCOLOGY CLINIC	0. 000000	112, 146	0	12, 790, 152	0	90. 03
91. 00 09100 EMERGENCY	0. 000000	34, 038, 787	o	32, 521, 279		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	1, 155, 367	o	7, 603, 039		92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0. 000000	0	o	0	l	92. 01
OTHER REIMBURSABLE COST CENTERS						İ
95. 00 09500 AMBULANCE SERVI CES						95. 00
200.00 Total (lines 50 through 199)		316, 484, 010	42, 509	269, 202, 158	43, 127	
	'				'	'

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0089 Peri od: Worksheet D From 01/01/2017 Part V Date/Time Prepared: 12/31/2017 5/24/2018 5:05 pm Title XVIII Hospi tal Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Ratio From Services (see Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1. 00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.090554 17, 634, 618 742 1, 596, 885 50.00 51.00 05100 RECOVERY ROOM 0.176953 2, 765, 116 3, 376 0 489, 296 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 52 00 0 161224 8, 239 1, 328 0 52 00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.094537 69, 915, 584 0 6,609,610 54.00 57.00 03280 EKG AND EEG 0.050427 620, 373 0 0 31, 284 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0.000000 0 0 0 58 00 05900 CARDIAC CATHETERIZATION 59.00 0.054664 21, 278, 489 0 1, 163, 167 59.00 60.00 06000 LABORATORY 0. 123286 7,068,360 366 871, 430 60.00 60.01 06001 BLOOD LABORATORY 0.000000 0 0 60.01 0 06300 BLOOD STORING, PROCESSING, & TRANS. 0 290928 461, 755 134, 337 63 00 0 63 00 65.00 06500 RESPIRATORY THERAPY 0.239250 613, 548 0 146, 791 65.00 06501 SLEEP LAB 0.082884 2, 631, 118 0 218, 078 65.01 65.01 06600 PHYSI CAL THERAPY 0. 298709 132, 819 0 39, 674 66.00 0 66,00 06700 OCCUPATIONAL THERAPY O 8, 336 67.00 0.213959 38, 960 67.00 68.00 06800 SPEECH PATHOLOGY 0. 204583 10, 151 0 2,077 68.00 06801 AUDI OLOGY 0.000000 68.01 0 68.01 5, 996, 353 06900 ELECTROCARDI OLOGY 0.067062 0 402, 127 69.00 69.00 334 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 3, 702, 843 71.00 0. 293620 12, 611, 005 0 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0. 203275 13, 389, 309 0 2, 721, 712 72.00 07300 DRUGS CHARGED TO PATIENTS 132, 821 73.00 0.180570 49, 915, 272 398 9, 013, 201 73.00 07301 HOSPITAL BASED RETAIL PHARMACIES 73.01 1. 205306 73.01 C 0 0 07400 RENAL DIALYSIS 0 0 74.00 0.430183 63.796 27.444 74 00 03160 CARDI OPULMONARY 0.000000 0 0 76.00 76.00 0 07697 CARDIAC REHABILITATION o 76. 97 0. 219481 1,580,374 0 346, 862 76. 97 76. 98 07698 HYPERBARIC OXYGEN THERAPY 6<u>, 206, 108</u> 0 747, 904 0.120511 0 76.98 OUTPATIENT SERVICE COST CENTERS 09000 CLI NI C 0.000000 90.00 0 90.00 0 90.02 09002 PAIN CLINIC 0. 253748 3, 346, 341 0 849, 127 90.02 09003 ONCOLOGY CLINIC 0.065058 12, 790, 152 0 0 90 03 832, 102 90.03 91.00 09100 EMERGENCY 0.089457 32, 521, 279 0 57 2, 909, 256 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0. 219017 7, 603, 039 1,725 0 1, 665, 195 92.00 09201 OBSERVATION BEDS (DISTINCT PART) 92.01 0.000000 92.01 0 0 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0.314175 200.00 Subtotal (see instructions) 269, 202, 158 6, 941 132, 878 34, 530, 066 200. 00 Less PBP Clinic Lab. Services-Program 201.00 201.00 Only Charges 202.00 Net Charges (line 200 - line 201) 269, 202, 158 6, 941 132, 878 34, 530, 066 202. 00

Health Financial Systems BALL MEMORIA APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST BALL MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10

| Period: | Worksheet D |
| From 01/01/2017 | Part V |
| To 12/31/2017 | Date/Time Prepared: | 5/24/2018 5:05 pm | Provider CCN: 15-0089

						5/24/2018 5:0	5 pm
			Title	XVIII	Hospi tal	PPS	
		Cos	sts				
	Cost Center Description	Cost	Cost				
		Rei mbursed	Rei mbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
		6. 00	7. 00				
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATI NG ROOM	67	0				50. 00
	05100 RECOVERY ROOM	597	0				51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0				52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
57. 00	03280 EKG AND EEG	0	0				57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0				58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0				59. 00
60.00	06000 LABORATORY	45	0				60.00
60. 01	06001 BLOOD LABORATORY	0	0				60. 01
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0	0				63.00
65. 00	06500 RESPI RATORY THERAPY	0	0				65.00
65. 01	06501 SLEEP LAB	O	0				65. 01
66. 00	06600 PHYSI CAL THERAPY	O	0				66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	O	0				67. 00
68. 00	06800 SPEECH PATHOLOGY	o	0				68. 00
68. 01	06801 AUDI OLOGY	o	0				68. 01
69. 00	06900 ELECTROCARDI OLOGY	22	0				69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	0				71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENT	O	0				72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	72	23, 983				73. 00
73. 01	07301 HOSPITAL BASED RETAIL PHARMACIES	0	0				73. 01
74. 00	07400 RENAL DIALYSIS	0	0				74.00
	03160 CARDI OPULMONARY	o	0				76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	o	0				76. 97
	07698 HYPERBARI C OXYGEN THERAPY	o	0				76. 98
	OUTPATIENT SERVICE COST CENTERS	,		·			
	09000 CLI NI C	0	0				90.00
90. 02	09002 PAIN CLINIC	O	0				90. 02
90. 03	09003 ONCOLOGY CLINIC	0	0				90. 03
	09100 EMERGENCY	0	5				91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	378	0				92. 00
	09201 OBSERVATION BEDS (DISTINCT PART)	0	Ö				92. 01
	OTHER REIMBURSABLE COST CENTERS			'			
	09500 AMBULANCE SERVICES	0					95. 00
200.00	Subtotal (see instructions)	1, 181	23, 988				200.00
201.00	Less PBP Clinic Lab. Services-Program	0					201. 00
	Only Charges						
202. 00	Net Charges (line 200 - line 201)	1, 181	23, 988				202. 00

Heal th	Financial Systems	BALL MEMORIA	AL HOSPITAL		In Lie	eu of Form CMS	2552-10
APPORT	TONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der C	CN: 15-0089	Period: From 01/01/2017	Worksheet D Part II	
			· ·	CCN: 15-T089	To 12/31/2017	Date/Time Pre 5/24/2018 5:0	
			Title	· XVIII	Subprovi der - I RF	PPS	
	Cost Center Description	Capi tal	Total Charges			Capital Costs	
			(from Wkst. C,	to Charges	Program	(column 3 x	
		(from Wkst. B,		(col. 1 + col	. Charges	column 4)	
		Part II, col.	8)	2)			
		26)	0.00	0.00	4.00	F 00	
	ANOLILIADY CEDYLOG COCT CENTERS	1.00	2.00	3. 00	4. 00	5. 00	
F0 00	ANCILLARY SERVICE COST CENTERS	4 00/ 700	4/4 0/5 4//	0.007//	77 //4	F04	
50.00	05000 OPERATI NG ROOM	1, 226, 700		l .		591	50.00
51.00	05100 RECOVERY ROOM	305, 265					1
52.00	05200 DELIVERY ROOM & LABOR ROOM	481, 465		l .		0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 122, 948		1		1, 863	1
57. 00	03280 EKG AND EEG	2, 374				8	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	1			0	
59. 00	05900 CARDI AC CATHETERI ZATI ON	501, 716				. 0	
60.00	06000 LABORATORY	170, 140	i e	l .			
60. 01	06001 BLOOD LABORATORY	0	1	0.0000		0	
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	22, 390				41	63. 00
65. 00	06500 RESPI RATORY THERAPY	188, 052		l .			
65. 01	06501 SLEEP LAB	5, 713		1			
66. 00	06600 PHYSI CAL THERAPY	148, 339		•			
67. 00	06700 OCCUPATI ONAL THERAPY	85, 705					
68. 00	06800 SPEECH PATHOLOGY	22, 792	1 ' '				
68. 01	06801 AUDI OLOGY	0	1 -				
69. 00	06900 ELECTROCARDI OLOGY	612, 030					
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	191, 388					
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	267, 626		l .		7	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	354, 992				2, 116	
73. 01	07301 HOSPI TAL BASED RETAIL PHARMACI ES	36, 903		l .		0	
74.00	07400 RENAL DIALYSIS	98, 416					
76. 00	03160 CARDI OPULMONARY	0	1			0	
76. 97	07697 CARDI AC REHABI LI TATI ON	10, 659					
76. 98	07698 HYPERBARI C OXYGEN THERAPY	17, 871	15, 414, 873	0. 0011	59 0	0	76. 98
	OUTPATIENT SERVICE COST CENTERS		1	1		1	
90. 00	09000 CLI NI C	0				1	
90. 02	09002 PAIN CLINIC	733, 587		l .			
90. 03	09003 ONCOLOGY CLINIC	57, 501		l .		0	
91.00	09100 EMERGENCY	1, 303, 181		l .			
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0					
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0.00000	00 0	0	92. 01
05.00	OTHER REIMBURSABLE COST CENTERS					1	05.00
95.00	09500 AMBULANCE SERVICES	0.047.750	1 477 047 000		7 500 005	/ 4 005	95. 00
200.00	Total (lines 50 through 199)	8, 967, 753	1, 477, 947, 090	1	7, 503, 005	64, 395	200. 00

Health Financial Systems	IOSPI TAL	In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0089 Component CCN: 15-T089	Peri od: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Prepared: 5/24/2018 5:05 pm
		Title XVIII	Subprovi der -	PPS

		Ti tl e	e XVIII	Subprovi der -	PPS	<u> </u>
Cost Center Description	Non Physician	Nursing School	Nursing School	IRF Allied Health	Allied Health	
3031 3011131 B3301 1 p11 011	Anesthetist	Post-Stepdown	landing conto	Post-Stepdown	7 11 od 11odi til	
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0	0	(0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	(0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	(0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	(0	0	54.00
57.00 03280 EKG AND EEG	0	0	(0	0	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	(0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	(0	0	59. 00
60. 00 06000 LABORATORY	0	0) c	0	0	60. 00
60. 01 06001 BLOOD LABORATORY	0	0	(0	0	60. 01
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0	0	(0	0	63. 00
65. 00 06500 RESPI RATORY THERAPY	0	0	(0	0	65. 00
65. 01 06501 SLEEP LAB	0	0	(0	0	65. 01
66. 00 06600 PHYSI CAL THERAPY	0	0	(0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	(0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	(0	0	68. 00
68. 01 06801 AUDI OLOGY	0	0	(0	0	68. 01
69. 00 06900 ELECTROCARDI OLOGY	0	0	(0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	(0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	(0	199, 212	73. 00
73. 01 07301 HOSPITAL BASED RETAIL PHARMACIES	0	0	(0	0	73. 01
74. 00 07400 RENAL DI ALYSI S	0	0	(0	0	74. 00
76. 00 03160 CARDI OPULMONARY	0	0	(0	0	76. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	() 0	0	76. 98
OUTPATIENT SERVICE COST CENTERS		1	1			
90. 00 09000 CLI NI C	0	0		0	0	
90. 02 09002 PAIN CLINIC	0	0		0	0	90. 02
90. 03 09003 0NCOLOGY CLINIC	0			0	0	90. 03
91. 00 09100 EMERGENCY	0		1	0	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0				0	92.00
92. 01 09201 OBSERVATI ON BEDS (DI STI NCT PART)	0	0	1 (0	0	92. 01
95.00 OTHER REIMBURSABLE COST CENTERS 95.00 O9500 AMBULANCE SERVICES			1			05 00
95.00 09500 AMBULANCE SERVICES 200.00 Total (lines 50 through 199)	0	o		0	199, 212	95.00
200.00 Total (Tries 50 through 199)	1	'I	ıl C	الم	177, 212	₁ 200.00

Health Financial Systems	BALL MEMORIA	J HOSPITAL		In lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE			CN: 15-0089	Peri od:	Worksheet D	
THROUGH COSTS			2011 45 7000	From 01/01/2017		
		Component	CCN: 15-T089	To 12/31/2017	Date/Time Pre 5/24/2018 5:0	
		Title	XVIII	Subprovi der -	PPS	.о р
Cook Cooker Doors' at lan	A11 O+b	T-+-1 C+	T-+-1	I RF	D-+:€ C+	
Cost Center Description	All Other Medical	Total Cost (sum of col 1	Total Outpatient	Total Charges (from Wkst. C,	Ratio of Cost to Charges	
	Education Cost		Cost (sum of	,	(col. 5 ÷ col.	
	Ludcati on cost	4)	col. 2, 3 an		7)	
		"/	4)	0)	,,	
	4.00	5. 00	6.00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS	_					
50. 00 05000 OPERATING ROOM	0			0 161, 265, 166	1	1
51. 00 05100 RECOVERY ROOM	0	0		0 18, 906, 878	0. 000000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 28, 356, 631	0. 000000	•
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 231, 571, 886	0. 000000	•
57. 00 03280 EKG AND EEG	0	0		0 3, 621, 216	0. 000000	•
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0	0. 000000	•
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 97, 872, 727	0. 000000	
60. 00 06000 LABORATORY	0	0		0 104, 967, 986	0. 000000	•
60. 01 06001 BL00D LABORATORY	0	0		0	0. 000000	
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0	0		0 6, 588, 426	0. 000000	1
65. 00 06500 RESPIRATORY THERAPY	0	0		0 21, 679, 245	0. 000000	1
65. 01 06501 SLEEP LAB	0	0		0 8, 577, 376	0.000000	1
66. 00 06600 PHYSI CAL THERAPY	0	0		0 18, 764, 017	0.000000	
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0 6, 066, 332	0.000000	1
68. 00 06800 SPEECH PATHOLOGY	0	0		0 2, 989, 114		
68. 01 06801 AUDI OLOGY	0	0		0 0	0.000000	
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 52, 498, 004	0.000000	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 53, 278, 902	0.000000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT 73.00 07300 DRUGS CHARGED TO PATIENTS	0	100 212		0 109, 312, 655	0.000000	
73. 00 07300 DRUGS CHARGED TO PATLENTS 73. 01 07301 HOSPITAL BASED RETAIL PHARMACIES	0	199, 212 0	199, 21	2 230, 608, 929 0 9, 099, 452	0. 000864 0. 000000	
74. 00 07400 RENAL DIALYSIS	0			0 3, 895, 337	0.00000	
74. 00 07400 RENAL DI ALTSIS 76. 00 03160 CARDI OPULMONARY	0			0 3, 693, 337	0.00000	
76. 97 07697 CARDI AC REHABI LI TATI ON				0 4, 025, 226	0.00000	
76. 98 07698 HYPERBARI C OXYGEN THERAPY		_		0 15, 414, 873	0.00000	
OUTPATIENT SERVICE COST CENTERS				0 13, 414, 673	0.00000	70. 70
90. 00 09000 CLINIC	0	0		0 0	0.000000	90.00
90. 02 09002 PAIN CLINIC	Ö			0 8, 304, 023	0. 000000	•
90. 03 09003 0NCOLOGY CLINIC	0			0 31, 221, 111	0. 000000	•
91. 00 09100 EMERGENCY	1 0	1 0		0 223, 340, 968	l	1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	Ö	ĺ		0 25, 720, 610	0. 000000	1
92. 01 09201 OBSERVATION BEDS (DISTINCT PART)	Ö			0 0	0. 000000	1
OTHER REIMBURSABLE COST CENTERS						1
95. 00 09500 AMBULANCE SERVI CES						95. 00
75. 00 07500 AMBOLANCE SERVI CES						

llool +b	Financial Cystems	DALL MEMODIAL	HOCDI TAI		المانما	u of Form CMC	2552 10
	Financial Systems TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	BALL MEMORIAL	Provider CO	N. 1E 0000	Period:	eu of Form CMS-: Worksheet D	2552-10
	CH COSTS	WICE UTILK PASS	Frovider Co	JN. 13-0009	From 01/01/2017	Part IV	
			· ·		To 12/31/2017	Date/Time Pre 5/24/2018 5:0	
				XVIII	Subprovi der – I RF	PPS	
	Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through		Pass-Through	
		(col. 6 ÷ col.		Costs (col.	3	Costs (col. 9	
		7)	40.00	x col. 10)	10.00	x col . 12)	
	ANCILLARY SERVICE COST CENTERS	9. 00	10. 00	11.00	12.00	13.00	
50. 00	05000 OPERATING ROOM	0. 000000	77 441		0 0	0	50.00
51. 00	1 1	0. 000000	77, 661		0 0		51.00
	05100 RECOVERY ROOM		9, 843 0		0 0	1	
52. 00 54. 00	O5200 DELI VERY ROOM & LABOR ROOM O5400 RADI OLOGY-DI AGNOSTI C	0.000000	-		0 0	0	52. 00 54. 00
54.00			203, 245		-	1	
58.00	03280 EKG AND EEG	0. 000000 0. 000000	11, 753 0		0 0	0	57. 00
59.00	05800 MAGNETIC RESONANCE I MAGING (MRI)		0		-	1	58. 00
	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0. 000000 0. 000000	469, 990		0 0	0	59.00
60. 00 60. 01	06001 BLOOD LABORATORY	0. 000000	469, 990		0 0	0	60.00
63. 00	1 1	0. 000000	12.040		0 0	0	63.00
65. 00	06300 BLOOD STORI NG, PROCESSI NG, & TRANS. 06500 RESPI RATORY THERAPY	0.000000	12, 069		0 0	0	65.00
65. 00	06501 SLEEP LAB	0. 000000	129, 069		0 0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0.000000	1, 974, 160		0 0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	2, 389, 926		0 0	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	638, 206		0 0	0	68. 00
68. 01	06801 AUDI OLOGY	0. 000000	030, 200		0 0	0	68. 01
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	37, 765		0	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	55, 746		0 0	0	71.00
71.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	2, 911		0 0	0	71.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0.000864	1, 374, 907	1, 18	-1	0	73.00
73. 00	07301 HOSPITAL BASED RETAIL PHARMACIES	0. 000004	1,374,707	1, 10	0 0	0	73. 00
74. 00	07400 RENAL DIALYSIS	0. 000000	111, 836		0 0	0	74.00
76. 00	03160 CARDI OPULMONARY	0. 000000	111, 030		0 0	0	76.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0. 000000	0		0 0	Ö	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0		0 0	0	76. 98
70. 70	OUTPATIENT SERVICE COST CENTERS	0.000000			0 0		70.70
90.00	09000 CLINI C	0. 000000	0		0 0	0	90.00
90. 02	09002 PAIN CLINIC	0. 000000	0		0 0	Ö	90. 02
90. 03	09003 ONCOLOGY CLINIC	0. 000000	0		0 0	0	90. 03
91. 00	09100 EMERGENCY	0. 000000	3, 918		0 0	o o	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0, 710		0 0	Ö	92. 00
92. 01	09201 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0 0	0	
72.01	OTHER REIMBURSABLE COST CENTERS	0.000000			<u> </u>	0	1 /2.01
95. 00	09500 AMBULANCE SERVICES						95. 00
200.00	1 1		7, 503, 005	1, 18	8 0	0	200.00
	1 1 2 2 2 2 2 2 2 2 3 2 2 3 2 2 3 2 3 2	1	.,, 000	., .,	-1		

Health Financial Systems	BALL MEMORIA	In Lie	u of Form CMS-2552-10	
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0089	Peri od: From 01/01/2017	Worksheet D
		Component CCN: 15-T089		
		Title XVIII	Subprovi der -	PPS
			l RF	

						5/24/2018 5:0	5 pm
			Title	XVIII	Subprovi der -	PPS	
					I RF		
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	·	Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not	,	
		Part I, col. 9	,	Subject To	Subject To		
				Ded. & Coins.	Ded. & Coins.		
				(see inst.)	(see inst.)		
		1.00	2. 00	3.00	4. 00	5. 00	
ANCLLI	ARY SERVICE COST CENTERS						
	OPERATI NG ROOM	0. 090554	0		0	0	50.00
1 1	RECOVERY ROOM	0. 176953	0		0	0	51. 00
1 1	DELIVERY ROOM & LABOR ROOM	0. 161224	0	1	0	0	52. 00
1 1	RADI OLOGY-DI AGNOSTI C	0. 094537	0			0	54.00
1 1	EKG AND EEG	0. 050427	0			0	57.00
1 1		0.000000	0			0	58.00
1 1	MAGNETIC RESONANCE IMAGING (MRI)	1	0			_	•
1 1	CARDI AC CATHETERI ZATI ON	0. 054664	0		ا	0	59.00
	LABORATORY	0. 123286	0		0	0	60.00
1 1	BLOOD LABORATORY	0. 000000	0		0	0	60. 01
1 1	BLOOD STORING, PROCESSING, & TRANS.	0. 290928	0		0	0	63. 00
1 1	RESPI RATORY THERAPY	0. 239250	0		0	0	65. 00
	SLEEP LAB	0. 082884	0	1	0	0	65. 01
66. 00 06600	PHYSI CAL THERAPY	0. 298709	0		0	0	66. 00
67. 00 06700	OCCUPATI ONAL THERAPY	0. 213959	0		0	0	67. 00
68. 00 06800	SPEECH PATHOLOGY	0. 204583	0		0	0	68. 00
68. 01 06801	AUDI OLOGY	0.000000	0		0	0	68. 01
69. 00 06900	ELECTROCARDI OLOGY	0. 067062	0		0	0	69. 00
71. 00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 293620	0		0	0	71. 00
72. 00 07200	IMPL. DEV. CHARGED TO PATIENT	0. 203275	0		0	0	72. 00
73. 00 07300	DRUGS CHARGED TO PATIENTS	0. 180570	0		866	0	73. 00
	HOSPITAL BASED RETAIL PHARMACIES	1. 205306	0		0	0	73. 01
	RENAL DIALYSIS	0. 430183	0		0	0	74. 00
	CARDI OPULMONARY	0. 000000	0		0	0	76. 00
	CARDI AC REHABI LI TATI ON	0. 219481	0		0	0	76. 97
	HYPERBARI C OXYGEN THERAPY	0. 120511	0			0	76. 98
	TIENT SERVICE COST CENTERS	0. 120311			<u>J</u>	U	70. 70
	CLINIC	0. 000000	0		0 0	0	90.00
1 1	PAIN CLINIC	0. 253748	0	1		0	90.00
1 1		1	0				•
1 1	ONCOLOGY CLINIC	0. 065058	0		ا	0	90. 03
	EMERGENCY	0. 089457	0	1	0	0	91.00
1 1	OBSERVATION BEDS (NON-DISTINCT PART)	0. 219017	0	•	0	0	92.00
	OBSERVATION BEDS (DISTINCT PART)	0. 000000	0		0	0	92. 01
	REIMBURSABLE COST CENTERS			1	-1		
1 1	AMBULANCE SERVICES	0. 314175		•	D .		95. 00
1 1	Subtotal (see instructions)		0		866	0	200. 00
	Less PBP Clinic Lab. Services-Program			[0		201. 00
1 1	Only Charges						
202.00	Net Charges (line 200 - line 201)		0		866	0	202. 00

Health Financial Systems	L HOSPI TAL		In Lieu of Form CMS-2552-10			
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	'	CN: 15-0089 CCN: 15-T089	Peri od: From 01/01/2017 To 12/31/2017 Subprovi der -	Worksheet D Part V Date/Time Pre 5/24/2018 5:0 PPS	
Cost Center Description	Cost	sts Cost				
·	Reimbursed Services	Reimbursed Services Not				

				INI	
		Cos	sts		
	Cost Center Description	Cost	Cost		
	oost center bescription				
		Rei mbursed	Rei mbursed		
		Servi ces	Services Not		
		Subject To	Subject To		
			Ded. & Coins.		
		(see inst.)	(see inst.)		
		6. 00	7. 00		
ΔN	CILLARY SERVICE COST CENTERS	'			
	OOO OPERATING ROOM	0			50.00
51.00 05	100 RECOVERY ROOM	0	0		51.00
52. 00 05	200 DELIVERY ROOM & LABOR ROOM	1	0		52. 00
	4400 RADI OLOGY-DI AGNOSTI C				54.00
		0	1		
57. 00 03	280 EKG AND EEG] 0	0		57. 00
58. 00 05	800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58. 00
	1900 CARDI AC CATHETERI ZATI ON	1	0		59. 00
		0			•
	000 LABORATORY	0	0		60. 00
60. 01 06	001 BLOOD LABORATORY	0	0		60. 01
	300 BLOOD STORING, PROCESSING, & TRANS.	1	o		63. 00
	500 RESPI RATORY THERAPY	0	ų o		65. 00
65. 01 06	501 SLEEP LAB	0	0		65. 01
66. 00 06	600 PHYSI CAL THERAPY	1	0		66. 00
1			0		67. 00
	700 OCCUPATI ONAL THERAPY	0	_		
68. 00 06	800 SPEECH PATHOLOGY	0	0		68. 00
68. 01 06	801 AUDI OLOGY	0	0		68. 01
	900 ELECTROCARDI OLOGY	1	0		69. 00
		0		l .	
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	l .	71. 00
72.00 07	200 IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73. 00 07	300 DRUGS CHARGED TO PATIENTS	1	156		73. 00
1	1				
1	301 HOSPITAL BASED RETAIL PHARMACIES	0	0	l .	73. 01
74. 00 07	400 RENAL DIALYSIS	0	0		74.00
76. 00 03	160 CARDI OPULMONARY	0	0		76. 00
1	697 CARDI AC REHABI LI TATI ON		o	l .	76. 97
		0			
	698 HYPERBARI C OXYGEN THERAPY	0	0		76. 98
OU	TPATIENT SERVICE COST CENTERS				
	000 CLI NI C	0	0		90. 00
	0002 PAIN CLINIC	0	0	•	90. 02
90. 03 09	003 ONCOLOGY CLINIC	0	0		90. 03
91.00 09	100 EMERGENCY	0	0		91.00
	· ·				
	200 OBSERVATION BEDS (NON-DISTINCT PART)	1	0	l .	92. 00
92. 01 09	201 OBSERVATION BEDS (DISTINCT PART)	0	0		92. 01
OT	HER REIMBURSABLE COST CENTERS				
	500 AMBULANCE SERVICES	0			95. 00
	· ·				
200.00	Subtotal (see instructions)	0	156		200. 00
201.00	Less PBP Clinic Lab. Services-Program	0			201.00
	Only Charges				1
202. 00	Net Charges (line 200 - line 201)	0	156		202. 00
202.00	INEL GIRLIGES (TITLE 200 - TITLE 201)	1	130	I	1202.00

Health Financial Systems	BALL MEMORIAL HOSPITAL			In Li	MS-255	52-10			
COMPUTATION OF INPATIENT	OPERATI NG COST		Provi der	CCN: 1		Period: From 01/01/2017 To 12/31/2017	Worksheet Date/Time 5/24/2018	Prepa	
			Ti tl	le XVI	111	Hospi tal	PPS	S	

		Title XVIII	Hospi tal	5/24/2018 5: 0 PPS	5 pm		
	Cost Center Description			1. 00			
	PART I - ALL PROVIDER COMPONENTS			1.00			
1 00	I NPATI ENT DAYS			74 (02	1 00		
1. 00 2. 00	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-b			74, 693 74, 693	1. 00 2. 00		
3.00	Private room days (excluding swing-bed and observation bed day		vate room days,	74, 073	3.00		
	do not complete this line.	, , ,					
4.00	Semi-private room days (excluding swing-bed and observation be		24 6 11	67, 343	4. 00		
5. 00	Total swing-bed SNF type inpatient days (including private rooreporting period	om days) through December	r 31 of the cost	0	5. 00		
6. 00	Total swing-bed SNF type inpatient days (including private roo	om days) after December :	31 of the cost	0	6. 00		
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room	n days) through December	31 of the cost	0	7. 00		
0.00	reporting period		1 -6	0	0.00		
8. 00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	n days) after December 3	or the cost	0	8. 00		
9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	33, 515	9. 00		
10. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII or		oom days)	0	10.00		
11. 00	through December 31 of the cost reporting period (see instruct Swing-bed SNF type inpatient days applicable to title XVIII or		nom dovo) often	0	11.00		
11.00	December 31 of the cost reporting period (if calendar year, er		John days) arter	U	11.00		
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI)		e room days)	0	12. 00		
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI)	Conty (including private	e room days)	0	13. 00		
	after December 31 of the cost reporting period (if calendar ye	ear, enter O on this line	e)	_			
14.00	Medically necessary private room days applicable to the Progra	am (excluding swing-bed o	days)	0	14. 00 15. 00		
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	16.00		
10.00	SWING BED ADJUSTMENT				10.00		
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 o	f the cost	0. 00	17. 00		
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18. 00		
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	0.00	19. 00				
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	0. 00	20. 00				
21. 00	reporting period Total general inpatient routine service cost (see instructions	57, 246, 800	21. 00				
22. 00	Swing-bed cost applicable to SNF type services through December		ng period (line	0 0	22.00		
	5 x line 17)	·					
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	g period (line 6	0	23. 00		
24. 00	Swing-bed cost applicable to NF type services through December 7×1 ine 19)	31 of the cost reporti	ng period (line	0	24. 00		
25. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)	31 of the cost reporting	period (line 8	0	25. 00		
26. 00	Total swing-bed cost (see instructions)			0	26. 00		
27. 00	General inpatient routine service cost net of swing-bed cost (PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		57, 246, 800			
28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed cha	arges)	0	28. 00		
29. 00	Private room charges (excluding swing-bed charges)		,	0	29. 00		
30. 00	Semi-private room charges (excluding swing-bed charges)			0	30.00		
31. 00	General inpatient routine service cost/charge ratio (line 27 -	· line 28)		0.000000	31.00		
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.00		
33. 00 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mir	nus line 33)(see instruct	tions)	0. 00 0. 00	1		
35. 00	Average per diem private room cost differential (line 34 x line		LI OHS)	0.00	1		
36. 00	Private room cost differential adjustment (line 3 x line 35)	ic 31)		0.00	36.00		
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	57, 246, 800	37. 00		
	27 minus line 36)						
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	ICTMENTS					
20.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU		Т	7// 40	20.00		
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see	•		766. 43	1		
40. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Program	•		25, 686, 901 0	39. 00 40. 00		
	Total Program general inpatient routine service cost (line 39	,		25, 686, 901	1		
	, 5 5 ,	• /	1	., = 1 . 3 .			

	Financial Systems	BALL MEMORIAL		N. 1E 0000		workshoot D 1	
COMPUI	ATION OF INPATIENT OPERATING COST		Provi der Co	JN: 15-0089	Peri od: From 01/01/2017	Worksheet D-1	
					To 12/31/2017	Date/Time Pre 5/24/2018 5:0	
	Cost Center Description	Total	Ti tl e	XVIII	Hospi tal	PPS Program Cost	
	Cost Center Description	Total Inpatient Cost		Average Per Diem (col. 1		Program Cost (col. 3 x col.	
		1 00	2.00	col . 2)	4.00	4)	
42. 00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4. 00 00 0	5. 00	42. 00
	Intensive Care Type Inpatient Hospital Units						
43. 00 44. 00	INTENSIVE CARE UNIT	15, 160, 590 0	10, 712 0			7, 685, 025 0	
45. 00	BURN INTENSIVE CARE UNIT		0	0.		Ĭ	45. 00
46.00		2 457 012	2 242	1 024	68 0		46.00
47.00	NEONATAL INTENSIVE CARE UNIT Cost Center Description	3, 457, 912	3, 342	1, 034.	08 0	0	47. 00
	·					1. 00	
48. 00 49. 00	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines			ns)		44, 596, 608 77, 968, 534	
17.00	PASS THROUGH COST ADJUSTMENTS	<u> </u>		•			17.00
50. 00	Pass through costs applicable to Program inp.	atient routine	services (from	Wkst. D, su	m of Parts I and	3, 237, 609	50.00
51. 00	Pass through costs applicable to Program inp	atient ancillar	y services (fr	om Wkst. D,	sum of Parts II	1, 851, 796	51.00
	and IV)	>					
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu-		lated non-phy	sician anesti	hetist and	5, 089, 405 72, 879, 129	
	medical education costs (line 49 minus line					,	
54 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
	Target amount per discharge						55. 00
56.00	Target amount (line 54 x line 55)			! -	1: 52)	l e	56.00
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	rget amount (i	ine 56 minus	11 ne 53)	0	
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996, u	pdated and c	ompounded by the		59. 00
60. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost report up	dated by the m	arket basket		0.00	60.00
61. 00	If line 53/54 is less than the lower of line	s 55, 59 or 60	enter the less	er of 50% of	the amount by	0	
	which operating costs (line 53) are less tha amount (line 56), otherwise enter zero (see		s (lines 54 x	60), or 1% o	f the target		
62. 00	Relief payment (see instructions)	riisti ucti olis)				0	62. 00
63. 00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	ctions)			0	63.00
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of the	cost report	ing period (See	0	64. 00
/ F 00	instructions) (title XVIII only)	to often Decemb	or 21 of the o	aat ranamtin	a norted (Coo	0	4 F 00
65. 00	Medicare swing-bed SNF inpatient routine cos instructions) (title XVIII only)	ts after beceilib	er 31 of the C	ost reportin	g perrod (see		65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 6	5)(title XVI	II only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing	e costs through	December 31 o	f the cost r	eporting period	0	67. 00
	(line 12 x line 19)	· ·					
68. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	e costs after D	ecember 31 of	the cost rep	orting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facil)		70.00
71. 00	Adjusted general inpatient routine service of	9		•	,		71.00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic		(line 14 v li	no 3E)			72. 00 73. 00
74. 00	Total Program general inpatient routine serv						74.00
75. 00	Capital -related cost allocated to inpatient	routine service	costs (from W	orksheet B, I	Part II, column		75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00	Program capital-related costs (line 9 x line	76)					77. 00
78. 00 79. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		rovider record	s)			78. 00 79. 00
80.00	Total Program routine service costs for comp	arison to the c			nus line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I)				81. 00 82. 00
83. 00	Reasonable inpatient routine service costs (83. 00
84. 00	Program inpatient ancillary services (see in	structions)					84. 00
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85. 00 86. 00
	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST					
07 00	Total observation bed days (see instructions)				7, 350	87. 00
87. 00 88. 00	Adjusted general inpatient routine cost per	diem (line 27 ±	line 2)			766 42	88. 00

Health Financial Systems	BALL MEMORIA	L HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2017 Fo 12/31/2017	Date/Time Pre 5/24/2018 5:0	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital -related cost	5, 944, 542	57, 246, 800	0. 10384	1 5, 633, 261	584, 963	90.00
91.00 Nursing School cost	0	57, 246, 800	0.00000	5, 633, 261	0	91.00
92.00 Allied health cost	0	57, 246, 800	0.00000	5, 633, 261	0	92.00
93.00 All other Medical Education	0	57, 246, 800	0. 000000	5, 633, 261	0	93. 00

Health Financial Systems	BALL MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0089	Period: From 01/01/2017	Worksheet D-1
	Component CCN: 15-T089		
	Title XVIII	Subprovi der -	PPS
		LDE	

		litie XVIII	I RF	PPS	
	Cost Center Description				
	T			1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days	s excluding newborn)		4, 174	1. 00
2. 00	Inpatient days (including private room days, excluding swing-l			4, 174	2. 00
3.00	Private room days (excluding swing-bed and observation bed day		ivate room days,	0	3.00
	do not complete this line.				
4.00	Semi-private room days (excluding swing-bed and observation be		. 21 -6 +6	4, 174	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roof reporting period	om days) through becembe	a 31 of the cost	0	5. 00
6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December	31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)	•			
7.00	Total swing-bed NF type inpatient days (including private room	n days) through December	31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private room	n days) after December 3	1 of the cost	0	8. 00
8.00	reporting period (if calendar year, enter 0 on this line)	ii days) ai tei beceilibei 3	i or the cost	U	0.00
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	2, 944	9. 00
	newborn days)				
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII on through December 31 of the cost reporting period (see instructions)		oom days)	0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		oom days) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, en			_	
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including privat	e room days)	0	12.00
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX	/ calv (i actudi ac acivot	a maam daysa)	0	13. 00
13.00	after December 31 of the cost reporting period (if calendar ye			U	13.00
14. 00	Medically necessary private room days applicable to the Progra			0	14. 00
15. 00	Total nursery days (title V or XIX only)			0	15.00
16. 00	Nursery days (title V or XIX only)			0	16. 00
17. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service	os through Docombor 21 o	f the cost	0.00	17. 00
17.00	reporting period	es thi dugit becember 51 c	the cost	0.00	17.00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18.00
40.00	reporting period				40.00
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s through December 31 of	the cost	0.00	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of t	he cost	0.00	20. 00
	reporting period				
21.00	Total general inpatient routine service cost (see instructions			4, 066, 114	
22. 00	Swing-bed cost applicable to SNF type services through December 5×1 ine 17)	er 31 of the cost report	ing period (line	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	a period (line 6	0	23. 00
	x line 18)				
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24. 00
25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December 3	21 of the cost reporting	poriod (line 9	0	25. 00
25.00	x line 20)	of the cost reporting	perrou (Trile 6	U	25.00
26. 00	Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		4, 066, 114	27. 00
20 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	d and observation had sh	argos)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	a and observation bed cr	lai yes)	0	
30.00	Semi -pri vate room charges (excluding swing-bed charges)			0	30.00
31. 00	General inpatient routine service cost/charge ratio (line 27	: line 28)		0.000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
33. 00 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 min	ous line 33)(see instruc	tions)	0. 00 0. 00	
35. 00	Average per diem private room cost differential (line 34 x line)		111 0113)	0.00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	,		0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	4, 066, 114	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			974. 15	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line			2, 867, 898	
40.00	Medically necessary private room cost applicable to the Progra	•		0	
41. 00	Total Program general inpatient routine service cost (line 39	+ IIne 40)		2, 867, 898	41.00

	Financial Systems ATION OF INPATIENT OPERATING COST	BALL MEMORIAL	HOSPITAL Provider CCN	. 15_0080	In Lie Period:	u of Form CMS-2 Worksheet D-1	
OWPUI	ATION OF INPATIENT OPERATING COST		Component CC		From 01/01/2017 To 12/31/2017	Date/Time Pre	pared:
			Title	(VIII	Subprovi der -	5/24/2018 5: 05 PPS	5 pm
	Cost Center Description	Total		Average Per	IRF Program Days	Program Cost	
		Inpatient Cost I	npatient DaysD	em (col. 1 col. 2)	÷	(col. 3 x col. 4)	
		1.00	2.00	3.00	4. 00	5. 00	
2. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0.0	0 0	0	42.0
3. 00	INTENSIVE CARE UNIT	0	0	0.0	0 0	0	43.0
4. 00	CORONARY CARE UNIT	0	o	0.0	0 0	0	
5. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. (46. (
	NEONATAL INTENSIVE CARE UNIT	0	0	0.0	0 0	0	47. 0
	Cost Center Description					1. 00	
8. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3,	line 200)			1, 668, 747	48. 0
9. 00	Total Program inpatient costs (sum of lines	41 through 48)(s	ee instructions	s)		4, 536, 645	49. (
0. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp.	atient routine s	ervices (from \	Vkst. D. sum	of Parts I and	280, 563	50. (
	111)		•				
1. 00	Pass through costs applicable to Program inpland IV)	atient ancillary	services (from	ıwkst. D, s	um or Parts II	65, 583	51.0
2. 00	Total Program excludable cost (sum of lines					346, 146	1
3. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		ated, non-physi	ci an anesth	etist, and	4, 190, 499	53.0
	TARGET AMOUNT AND LIMIT COMPUTATION	02)					1
	Program discharges Target amount per discharge					0 0. 00	
6. 00	Target amount (line 54 x line 55)					0.00	1
	Difference between adjusted inpatient operat	ing cost and tar	get amount (li	ne 56 minus	line 53)	0	1 -
8. 00 9. 00	Bonus payment (see instructions)	norting period e	ndina 1996 una	dated and co	mnounded by the	0 0. 00	
7. 00	O Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						
0.00	Lesser of lines 53/54 or 55 from prior year of line 53/54 is less than the lower of line				the amount by	0. 00 0	1
11.00	which operating costs (line 53) are less tha	n expected costs					01.0
2. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)				0	62. (
3. 00	, , , , , , , , , , , , , , , , , , , ,	ent (see instruc	tions)				63.0
4. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dosom	har 21 of the	act reporti	ng poriod (Soo	0	64. (
14.00	instructions)(title XVIII only)	3		'	5 1 (ı	04. (
5. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decembe	r 31 of the co	st reporting	period (See	0	65.0
6. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line 6	4 plus line 65)	(title XVII	l only). For	0	66. (
7 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing	a costs through l	December 31 of	the cost re	norting period		67. 0
7.00	(line 12 x line 19)	e costs till ough i	becember 31 or	the cost re	portring perrod		07.0
8. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	e costs after De	cember 31 of t	ne cost repo	rting period	0	68. 0
9. 00	Total title V or XIX swing-bed NF inpatient	routine costs (li	ine 67 + line (58)		0	69. (
0.00	PART III - SKILLED NURSING FACILITY, OTHER NI						70.
0. 00 1. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service contents.						70.0
2. 00	Program routine service cost (line 9 x line						72.
3. 00 4. 00	Medically necessary private room cost application. Total Program general inpatient routine serv	•	•	9 35)			73. (
5. 00	Capital -related cost allocated to inpatient	•		ksheet B, P	art II, column		75.0
6. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	no 2)					76. (
7. 00	Program capital -related costs (line 9 x line						77. (
8.00	1	,	ovidor rosset-				78. (
9. 00 0. 00	00 0				us line 79)		79. (80. (
1. 00	Inpatient routine service cost per diem limi	tati on			,		81. (
2. 00 3. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs ()				82.0
4. 00			,				84. (
5. 00	Utilization review - physician compensation	(see instructions					85. 0
			ough 85)				86. (
6. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS	ו בינול חגונוטאדון כ					
7. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions Adjusted general inpatient routine cost per)				0 0. 00	

Health Financial Systems	BALL MEMORIA	L HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
		Component (From 01/01/2017 To 12/31/2017		
		Title	XVIII	Subprovi der – I RF	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	397, 787	4, 066, 114	0. 09783	0 0	0	90.00
91.00 Nursing School cost	0	4, 066, 114	0.00000	0	0	91.00
92.00 Allied health cost	0	4, 066, 114	0. 00000	0 0	0	92. 00
93.00 All other Medical Education	0	4, 066, 114	0. 00000	0 0	0	93. 00

Health Financial Systems	BALL MEMORIAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0089	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Pre 5/24/2018 5:0	pared:
	Title XIX	Hospi tal	Cost	

Digital - All PRODUCER COMPONENTS 1.00 Page 1			Title XIX	Hospi tal	5/24/2018 5:0 Cost	5 pm
INPATIENT DAYS INPA		Cost Center Description			1 00	
Inpatt ent days (including private room days, and saving-bed days, excluding needed in Control (1998) 74,693 2.00		PART I - ALL PROVIDER COMPONENTS			1.00	
Impact ent days (including private room days, excluding swing-bed and newborn days) 74,693 2,00 2,0						
Private room days (excluding swing-bed and observation bed days). It you have only private room days. 67,343 4.00 Sonit-private room days (excluding swing-bed and observation bed days) 80,700 Sonit-private room days (excluding swing-bed and observation bed days) 81,000 Sonit-private room days (excluding swing-bed and observation bed days) 82,000 Sonit-private room days (excluding swing-bed with the cost room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this 1 line) 92,001 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this 1 line) 93,001 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this 1 line) 94,001 Total lapatient days including private room days applicable to the Program (excluding swing-bed and newborn days) 95,002 Swing-bed SNF type inpatient days applicable to 11 to XVII 1 only (including private room days) 11,003 Swing-bed SNF type inpatient days applicable to 11 to XVII 1 only (including private room days) 12,003 Swing-bed SNF type inpatient days applicable to 11 to XVII 1 only (including private room days) 13,003 Swing-bed SNF type inpatient days applicable to 11 to XVII 1 only (including private room days) 14,004 Medically including private room days after December 31 of the cost reporting period (if calendar year, enter 0 on this 1 line) 15,000 Total nursery days (title v or XIX only) 16,001 Westerd (including private room days) 17,001 Total nursery days (title v or XIX only) 18,001 Westerd (including private room days) 18,002 Westerd (including private room days) 18,003 Westerd (including private room days) 19,004 Westerd (including private room days) 19,005 Westerd (including private room days) 10,006 Westerd (including private room days) 10,007 Westerd (including private room days) 10,008 Westerd (including private room days) 11,009 West						
do not complete this line. 4. OS Self-private room days (excluding swing-bed and observation bed days) 5. Did Total swing-bed SW type inpattent days (including private room days) after December 31 of the cost period period period period period period (if calendar year, enter 0 on this line) 7. Did Swing-bed SW type inpattent days (including private room days) through December 31 of the cost period (if calendar year, enter 0 on this line) 7. Did Total swing-bed W type inpattent days (including private room days) through December 31 of the cost period traperiod (if calendar year, enter 0 on this line) 8. Did Total swing-bed W type inpattent days (including private room days) after December 31 of the cost period (if calendar year, enter 0 on this line) 9. Did Total inpattent days including private room days) after December 31 of the cost period (if calendar year, enter 0 on this line) 10. Did Impattent days including private room days) after December 31 of the cost period (if calendar year, enter 0 on this line) 10. Did Impattent days including private room days after December 31 of the cost period (if calendar year, enter 0 on this line) 10. Did Swing-bed SW type inpattent days applicable to title sW including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 10. Did December 31 of the cost reporting period (if calendar year, enter 0 on this line) 11. Did Swing-bed NF type inpattent days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12. Did Total provider type independent of the provider period (if calendar year, enter 0 on this line) 13. Did Total provider type independent of the provider type independent of the cost reporting period (in calendar year, enter 0 on this line) 14. Did Total provider type independent of the provider type independent of the cost reporting period (in calendar year, enter 0 on this line) 15. Did Total provider			vate room days	· ·		
Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost of Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line) reporting period (if callendar year, enter 0 on this line) reporting period (if callendar year, enter 0 on this line) reporting period (if callendar year, enter 0 on this line) so with the private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line) reporting pe	0.00		ys). It you have only pri	vate room days,	· ·	0.00
reporting period (1 cal cadar year, enter 0 on this line) 7. 00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (1 cal cadar year, enter 0 on this line) 8. 00 reporting period (1 cal cadar year, enter 0 on this line) 8. 00 reporting period (1 cal cadar year, enter 0 on this line) 9. 00 Total inpatient days (including private room days) after December 31 of the cost reporting period (1 cal endar year, enter 0 on this line) 10. 00 Swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (1 cal endar year, enter 0 on this line) 10. 00 Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and including private room days) after on through December 31 of the cost reporting period (see instructions) 10. 00 Swing-bed SNF type inpatient days applicable to till to XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions) 10. 00 Swing-bed SNF type inpatient days applicable to till to XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions) 10. 00 Swing-bed SNF type inpatient days applicable to till to XVIII only (including private room days) after December 31 of the cost reporting period (see instructions) 10. 00 Swing-bed NF type inpatient days applicable to tilles V or XIX only (including private room days) 10. 00 Swing-bed NF type inpatient days applicable to tilles V or XIX only (including private room days) 10. 00 Swing-bed NF type inpatient days applicable to tilles V or XIX only (including private room days) 10. 00 Swing-bed NF type inpatient days applicable to tilles V or XIX only (including private room days) 10. 00 Swing-bed NF type inpatient days applicable to services after December 31 of the cost reporting period (including private room days) 10. 00 Swing-bed cost applicable to SNF services applicable to services after December 31 of						
Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost roporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9.00 Total inpatient days including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 10.00 Swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting december 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December	5. 00		om days) through December	31 of the cost	0	5. 00
reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed MF type inpatient days (including private room days) through December 31 of the cost 1 of t	6 00		om days) after December (21 of the cost	0	6.00
reporting period 8. 00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9. 00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) 10. 00 Sking-bed SMb type inpatient days applicable to title XVIII only (including private room days) 11. 00 Swing-bed SMb type inpatient days applicable to title XVIII only (including private room days) after 0 flower the cost reporting period (including private room days) after 0 flower the cost reporting period (including private room days) after 0 flower through December 31 of the cost reporting period (including private room days) 0 flower through December 31 of the cost reporting period (including private room days) 0 flower of the December 31 of the cost reporting period (including private room days) 0 flower of the December 31 of the cost reporting period (including private room days) 0 flower of the December 31 of the cost reporting period (including private room days) 0 flower of the December 31 of the cost reporting period (including private room days) 0 flower of the December 31 of the cost reporting period (including private room days) 0 flower of the December 31 of the cost reporting period (including private room days) 1 flower private room days 0 flower private	0.00		on days) at tel becember .	or the cost	O	0.00
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25. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26. 00 Total swing-bed cost (see instructions) 27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29. 00 Private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 30. 00 General inpatient routine service cost/charge ratio (line 27 ± line 28) 30. 00 Average private room per diem charge (line 29 ± line 3) 30. 00 Average semi-private room per diem charge (line 30 ± line 4) 30. 00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 30. 00 Average per diem private room cost differential (line 32 minus line 33) 30. 00 Private room cost differential adjustment (line 3 x line 35) 31. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 57, 246, 800 and 57, 246,	24. 00	1 3 11 31	r 31 of the cost reporti	ng period (line	0	24. 00
Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 27.00 PRI VATE ROOM DIFFERENTI AL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Pri vate room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 30.00 Average private room per diem charge (line 29 + line 3) 30.00 Average semi-private room per diem charge (line 30 + line 4) 30.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions) 34.00 Average per diem private room cost differential (line 34 x line 31) 35.00 Average per diem private room cost differential (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	25. 00		31 of the cost reporting	period (line 8	0	25. 00
27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges) Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 + line 28) Average private room per diem charge (line 29 + line 3) Average semi-private room per diem charge (line 30 + line 4) Average per diem private room charge differential (line 32 minus line 33) (see instructions) Average per diem private room cost differential (line 34 x line 31) Average per diem private room cost differential (line 34 x line 31) Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line 37, 246, 800) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38) Program general inpatient routine service cost (line 9 x line 38) B87, 635 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) O 40.00	0, 00					
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 57, 246, 800 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 38.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 28.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 20.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 32.			(line 21 minus line 26)			
29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 57, 246, 800 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 29.00 29.00 30.00 30.00 30.00 30.00 30.00 31.00 32	27.00		(TITIC 21 IIITIGS TITIC 20)		37, 240, 000	27.00
30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 57, 246, 800 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	28. 00		d and observation bed cha	arges)		
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 57, 246, 800 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 000 000 000 000 000 000 000 000 0						
32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 57, 246, 800) 27 minus line 36) PART II - HOSPITAL AND SUBPROVI DERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			line 20)			
33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 57, 246, 800) 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 766.43 38.00 Program general inpatient routine service cost (line 9 x line 38) 857,635 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)			Firme 28)			
34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 57, 246, 800) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 766.43 38.00 Program general inpatient routine service cost (line 9 x line 38) Wedically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 34.00 34.00						
35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 57, 246, 800 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 766.43 38.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00			aus lino 22) (soo instruc	tions)		
36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 57, 246, 800 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 36.00 37.00 3				11 0115)		
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27, 246, 800 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 37.00 Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)			IC 31)			
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 766.43 38.00 Program general inpatient routine service cost (line 9 x line 38) 857,635 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00			and private room cost di	Fforential (line		
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 766.43 38.00 Program general inpatient routine service cost (line 9 x line 38) 857,635 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	37.00		and private room cost dr	referrial (TINE	37, 240, 800	37.00
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 766.43 38.00 Program general inpatient routine service cost (line 9 x line 38) 857,635 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00						
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 857,635 39.00 40.00		PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	JSTMENTS			
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	38.00	Adjusted general inpatient routine service cost per diem (see	instructions)		766. 43	38. 00
	39. 00		•		857, 635	
41.00 Total Program general inpatient routine service cost (line 39 + line 40) 857,635 41.00			,			
	41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		857, 635	41.00

Heal th	h Financial Systems BALL MEMORIAL HOSPITAL	In Lie	eu of Form CMS-2	2552-10
COMPUT		iod: om 01/01/2017	Worksheet D-1	
	To	12/31/2017	Date/Time Prep 5/24/2018 5:09	
	Title XIX	Hospi tal	Cost	
	Cost Center Description Total Total Average Per Inpatient Cost Inpatient Days Diem (col. 1 ÷	Program Days	Program Cost	
	col. 2)		4)	
42 00	1.00 2.00 3.00 NURSERY (title V & XIX only) 1,315,774 2,539 518.23	4. 00 1, 639	5. 00 849, 379	42 00
	Intensive Care Type Inpatient Hospital Units		·	
43. 00 44. 00		518 0	733, 120 0	43. 00 44. 00
45. 00		0		45. 00
46. 00 47. 00	SURGICAL INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT 3,457,912 3,342 1,034.68	422	436, 635	46. 00 47. 00
47.00	Cost Center Description	722		47.00
48. 00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		1. 00 1, 762, 714	48. 00
	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		4, 639, 483	
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of	Parts L and	0	50. 00
	111)	raits i aliu		
51. 00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum and IV)	of Parts II	0	51. 00
52.00	Total Program excludable cost (sum of lines 50 and 51)		0	52.00
53. 00	Total Program inpatient operating cost excluding capital related, non-physician anestheti medical education costs (line 49 minus line 52)	st, and	0	53. 00
	TARGET AMOUNT AND LIMIT COMPUTATION			
54. 00 55. 00	Program discharges Target amount per discharge		0.00	54. 00 55. 00
56. 00			0.00	56. 00
57. 00		ne 53)	0	57. 00
58. 00 59. 00		nunded by the	0.00	58. 00 59. 00
37.00	market basket	dided by the		37.00
60. 00 61. 00		amount by	0.00	60. 00 61. 00
01.00	which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the			01.00
62. 00	amount (line 56), otherwise enter zero (see instructions) Relief payment (see instructions)		0	62. 00
63. 00			0	63. 00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting	pariod (Saa	0	64. 00
04.00	instructions)(title XVIII only)			
65. 00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting pe instructions)(title XVIII only)	eriod (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII c	only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost repor	ting period	0	67. 00
49.00	(line 12 x line 19)	na pori od		49.00
68. 00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporti (line 13 x line 20)	ng perrou		68. 00
69. 00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		0	69. 00
70. 00				70. 00
71.00				71. 00
72. 00 73. 00				72. 00 73. 00
74. 00				74.00
75. 00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part 26, line 45)	II, column		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ line 2)			76. 00
77. 00 78. 00				77. 00 78. 00
79. 00	, ,			79. 00
80.00		line 79)		80.00
81. 00 82. 00	· ·			81. 00 82. 00
83. 00				83. 00
84. 00	Program inpatient ancillary services (see instructions)			84.00
85.00				85. 00
86. 00	Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST			86. 00
87. 00	Total observation bed days (see instructions)		7, 350	87. 00
88. 00 89. 00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) Observation bed cost (line 87 x line 88) (see instructions)		766. 43 5, 633, 261	
57.00	, passer tall on sour cost (Title or A Title ob) (see Thati deliving)		0,000,201	37.00

Health Financial Systems	BALL MEMORIAL	_ HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2017	D 1 /T' D	
				To 12/31/2017	Date/Time Prep 5/24/2018 5:09	
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	5, 944, 542	57, 246, 800	0. 10384	1 5, 633, 261	584, 963	90.00
91.00 Nursing School cost	0	57, 246, 800	0.00000	5, 633, 261	0	91.00
92.00 Allied health cost	0	57, 246, 800	0.00000	5, 633, 261	0	92.00
93.00 All other Medical Education	0	57, 246, 800	0.00000	0 5, 633, 261	0	93. 00

Health Financial Systems	BALL MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0089	Peri od: From 01/01/2017	Worksheet D-1
	Component CCN: 15-T089	To 12/31/2017	Date/Time Prepared: 5/24/2018 5:05 pm
	Title XIX	Subprovi der -	Cost

		TI LIE XIX	I RF	COST	
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days	s, excluding newborn)		4, 174	1. 00
2.00	Inpatient days (including private room days, excluding swing-b			4, 174	2. 00
3. 00	Private room days (excluding swing-bed and observation bed day	(s). If you have only pri	vate room days,	0	3. 00
4.00	do not complete this line. Semi-private room days (excluding swing-bed and observation be	ed days)		4, 174	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private roo		31 of the cost	0	5. 00
	reporting period			_	
6. 00	Total swing-bed SNF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line)	om days) after December 3	1 of the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	0	7. 00
	reporting period	, .,		_	
8.00	Total swing-bed NF type inpatient days (including private room	n days) after December 31	of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	the Program (excluding	swing_bed and	23	9. 00
7.00	newborn days)	the riogram (excluding	swifig-bed and	23	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII or		om days)	0	10.00
11 00	through December 31 of the cost reporting period (see instruct			0	11 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or December 31 of the cost reporting period (if calendar year, er	nter 0 on this line)	om days) arter	0	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI)		room days)	0	12. 00
	through December 31 of the cost reporting period				
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI) after December 31 of the cost reporting period (if calendar ve			0	13. 00
14. 00	Medically necessary private room days applicable to the Progra	· ·	, I	0	14. 00
15. 00	Total nursery days (title V or XIX only)	(ener during eming zeu d	1	- 1	15. 00
16. 00	Nursery days (title V or XIX only)			1, 639	16. 00
47.00	SWING BED ADJUSTMENT			2 22	47.00
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 of	the cost	0.00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of t	he cost	0. 00	18. 00
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0. 00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	s after December 31 of th	e cost	0.00	20. 00
20.00	reporting period			0.00	20.00
21. 00	Total general inpatient routine service cost (see instructions			4, 066, 114	
22. 00	Swing-bed cost applicable to SNF type services through December 5×1 ine 17)	er 31 of the cost reporti	ng period (line	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	period (line 6	0	23. 00
	x line 18)	3			
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reportin	g period (line	0	24. 00
25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December 3	21 of the cost reporting	nariod (lina 8	0	25. 00
25.00	x line 20)	or the cost reporting	perroa (rriie o	O	23.00
26. 00	Total swing-bed cost (see instructions)			0	
27. 00	General inpatient routine service cost net of swing-bed cost ((line 21 minus line 26)		4, 066, 114	27. 00
28. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	d and observation bed cha	rges)	0	28. 00
29. 00	Pri vate room charges (excluding swing-bed charges)	. and obeen rathern bear one	. gooy	0	
30.00	Semi -private room charges (excluding swing-bed charges)			0	30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27 =	- line 28)		0. 000000	
32. 00 33. 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00 0. 00	
34. 00	Average per diem private room charge differential (line 32 mir	ous line 33)(see instruct	ions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x lin		1 0113)	0.00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	•		0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost dif	ferential (line	4, 066, 114	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			974. 15	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line			22, 405	
40.00	Medically necessary private room cost applicable to the Progra	*		0	40.00
41. 00	Total Program general inpatient routine service cost (line 39	+ ITHE 40)		22, 405	41.00

Heal th	Financial Systems	BALL MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2	<u>2552</u> -10
	ATION OF INPATIENT OPERATING COST		Provider CCN: 15-0089 Component CCN: 15-T089	Peri od: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Pre	
			Title XIX	Subprovi der -	5/24/2018 5: 0 Cost	
	Cost Center Description	Total	Total Average Pe	IRF	Program Cost	
			patient Days Diem (col. col. 2)		(col. 3 x col. 4)	
10.00	Indipositive to the second	1.00	2.00 3.00	4.00	5. 00	10.00
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0 0	. 00 0	0	42. 00
43. 00 44. 00	INTENSIVE CARE UNIT	0	i i	. 00 0	0	43. 00 44. 00
45.00	BURN INTENSIVE CARE UNIT	Ĭ		. 00		45. 00
46. 00 47. 00	SURGICAL INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT	o	0 0	. 00 0	0	46. 00 47. 00
	Cost Center Description					
48. 00	Program inpatient ancillary service cost (Wk:				1. 00 30, 553	48. 00
49. 00	Total Program inpatient costs (sum of lines - PASS THROUGH COST ADJUSTMENTS	41 through 48)(se	e instructions)		52, 958	49. 00
50. 00	Pass through costs applicable to Program inpa	atient routine se	rvices (from Wkst. D, s	um of Parts I and	0	50. 00
51. 00		atient ancillary	services (from Wkst. D,	sum of Parts II	0	51. 00
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)			0	52. 00
53. 00	Total Program inpatient operating cost exclu	ding capital rela	ted, non-physician anes	thetist, and	0	
	medical education costs (line 49 minus line ! TARGET AMOUNT AND LIMIT COMPUTATION	52)				
54. 00 55. 00	Program discharges Target amount per discharge					54. 00 55. 00
56.00	Target amount (line 54 x line 55)			>	0	56. 00
57. 00 58. 00	Difference between adjusted inpatient operations payment (see instructions)	0				
59. 00	Lesser of lines 53/54 or 55 from the cost remarket basket	0.00	59. 00			
60.00	Lesser of lines 53/54 or 55 from prior year		60.00			
61. 00	If line 53/54 is less than the lower of line: which operating costs (line 53) are less than	n expected costs			0	61. 00
62. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	nstructions)			0	62. 00
	Allowable Inpatient cost plus incentive payme	0	1			
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cost	0	64. 00			
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	0	65. 00			
66. 00	instructions)(title XVIII only)					66. 00
	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					
67. 00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					67. 00
68. 00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					68. 00
69. 00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) VART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY				0	69. 00
70. 00	Skilled nursing facility/other nursing facility			7)		70. 00
71. 00 72. 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		e 70 ÷ line 2)			71. 00 72. 00
73. 00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73. 00
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient	•		Part II, column		74. 00 75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)				76. 00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus					77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for excess costs (from provider records)					79. 00
80. 00 81. 00						80. 00 81. 00
82. 00	Inpatient routine service cost limitation (line 9 x line 81)					
83. 00 84. 00	0 Program inpatient ancillary services (see instructions)					
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum					85. 00 86. 00
	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST	-g., 00)		-	1
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per	diem (line 27 ÷ l	ine 2)			88. 00
89. 00	Observation bed cost (line 87 x line 88) (see	e instructions)			0	89. 00

Health Financial Systems	BALL MEMORIAL HOSPITAL			In Lieu of Form CMS-2552-10			
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0089		Peri od:	Worksheet D-1		
				From 01/01/2017 To 12/31/2017 Date/Time Pro 5/24/2018 5:0			
		Ti tl	e XIX	Subprovi der - I RF	Cost		
Cost Center Description	Cost 1.00	Routine Cost (from line 21)	col umn 1 ÷ col umn 2	Total Observation Bed Cost (from	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions) 5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90. 00 Capital -related cost	397, 787	4, 066, 114	0. 09783	0 0	0	90. 00	
91.00 Nursing School cost	0	4, 066, 114	0. 00000	0 0	0	91.00	
92.00 Allied health cost	0	4, 066, 114	0.00000	0 0	0	92. 00	
93.00 All other Medical Education	0	4, 066, 114	0. 00000	0 0	0	93. 00	

Health Financial Systems	BALL MEMORIAL H	IOSPI TAI		In lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	DALE MEMORIAL I	Provi der CCN: 15-0089		Peri od: From 01/01/2017	Worksheet D-3	
					Date/Time Pre 5/24/2018 5:0	pared: 5 pm
		Ti tl e	: XVIII	Hospi tal	PPS	
Cost Center Description			Ratio of Cos	t Inpatient	Inpati ent	
·			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS				91, 040, 137		30.00
31. 00 03100 INTENSIVE CARE UNIT				29, 614, 362		31.00
22 OO O2200 CORONARY CARE HALT			1	0		22 00

	Cost Center Description	To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	0.00	2)	
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1. 00	2. 00	3. 00	
30. 00	03000 ADULTS & PEDIATRICS		91, 040, 137		30. 00
31. 00	03100 I NTENSI VE CARE UNIT		29, 614, 362		31.00
32. 00	03200 CORONARY CARE UNIT	•	27, 014, 302		32. 00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	•	0		35. 00
40. 00	04000 SUBPROVI DER - I PF		0		40. 00
41. 00	04100 SUBPROVI DER - I RF		0		41. 00
43. 00	04300 NURSERY		O		43. 00
43.00	ANCI LLARY SERVI CE COST CENTERS				45.00
50. 00	05000 OPERATI NG ROOM	0. 090554	49, 189, 302	4, 454, 288	50. 00
51. 00	05100 RECOVERY ROOM	0. 176953	4, 903, 104		
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 161224	186, 389		52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 094537	30, 998, 699		54.00
57. 00	03280 EKG AND EEG	0. 050427	993, 171		
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0.000000	0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 054664	23, 157, 625	1, 265, 888	59. 00
60.00	06000 LABORATORY	0. 123286	25, 302, 003	3, 119, 383	60. 00
60. 01	06001 BLOOD LABORATORY	0.000000	0	0	60. 01
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0. 290928	3, 016, 121	877, 474	63.00
65.00	06500 RESPI RATORY THERAPY	0. 239250	10, 301, 230	2, 464, 569	65. 00
65. 01	06501 SLEEP LAB	0. 082884	0	0	65. 01
66.00	06600 PHYSI CAL THERAPY	0. 298709	3, 266, 521	975, 739	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 213959	1, 110, 724	237, 649	67.00
68. 00	06800 SPEECH PATHOLOGY	0. 204583	876, 338	179, 284	68. 00
68. 01	06801 AUDI OLOGY	0.000000	0	0	68. 01
69. 00	06900 ELECTROCARDI OLOGY	0. 067062	20, 748, 376		69. 00
71. 00		0. 293620	13, 272, 185		71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0. 203275	41, 426, 635		
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 180570	49, 200, 806	8, 884, 190	73. 00
73. 01	07301 HOSPITAL BASED RETAIL PHARMACIES	1. 205306	0	0	73. 01
74.00	07400 RENAL DI ALYSI S	0. 430183	2, 580, 371	1, 110, 032	74. 00
76. 00	03160 CARDI OPULMONARY	0.000000	0	0	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0. 219481	547, 076		76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0. 120511	79, 777	9, 614	76. 98
	OUTPATIENT SERVICE COST CENTERS			1	
90.00	09000 CLI NI C	0.000000	0	0	90.00
90. 02	09002 PAIN CLINIC	0. 253748	21, 257		90. 02
90. 03	09003 ONCOLOGY CLINIC	0. 065058	112, 146		90. 03
91.00	09100 EMERGENCY	0. 089457	34, 038, 787		
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 219017	1, 155, 367	253, 045	
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	0. 000000	0	0	92. 01
95. 00	OTHER REI MBURSABLE COST CENTERS O9500 AMBULANCE SERVI CES				95. 00
95. 00 200. 00			216 404 010	44, 596, 608	
200.00			316, 484, 010	44, 370, 608	200.00
201.00			316, 484, 010		201.00
202.00	net charges (True 200 illinius True 201)	1	310, 404, 010	I	1202.00

INPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT			Period: From 01/01/2017 To 12/31/2017	Worksheet D-3 Date/Time Pre 5/24/2018 5:0	pared:
		Ti tl	e XVIII	Subprovider -	PPS	о ріп
	Cost Center Description		Ratio of Cost To Charges		Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 31. 00 32. 00 35. 00 40. 00 41. 00 43. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT 02060 NEONATAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF 04300 NURSERY			0 0 0 0 7, 536, 696		30. 00 31. 00 32. 00 35. 00 40. 00 41. 00 43. 00
	ANCILLARY SERVICE COST CENTERS					
50. 00 51. 00	O5000 OPERATING ROOM O5100 RECOVERY ROOM		0. 09055 0. 17695	· ·	7, 033 1, 742	
52. 00	05200 DELIVERY ROOM & LABOR ROOM		0. 16122		0	
	05400 RADI OLOGY-DI AGNOSTI C		0. 09453		19, 214	•
57. 00	03280 EKG AND EEG		0. 05042	·	593	
58. 00 59. 00	05800 MAGNETI C RESONANCE I MAGI NG (MRI) 05900 CARDI AC CATHETERI ZATI ON		0.00000		0	58. 0 59. 0
60.00	06000 LABORATORY		0. 05466 0. 12328		0 57, 943	
60. 00	06001 BL00D LABORATORY		0. 00000		0 37, 943	60.0
63. 00	06300 BLOOD STORING, PROCESSING, & TRANS.		0. 29092		3, 511	1
65. 00	06500 RESPI RATORY THERAPY		0. 23925		30, 880	
65. 01	06501 SLEEP LAB		0. 08288	·	0	65. 0
66. 00	06600 PHYSI CAL THERAPY		0. 29870		589, 699	66.0
67. 00	06700 OCCUPATI ONAL THERAPY		0. 21395	9 2, 389, 926	511, 346	67.0
68. 00	06800 SPEECH PATHOLOGY		0. 20458	3 638, 206	130, 566	68. 0
68. 01	06801 AUDI OLOGY		0.00000	0	0	68. 0
69. 00	06900 ELECTROCARDI OLOGY		0. 06706		2, 533	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 29362		16, 368	
	07200 I MPL. DEV. CHARGED TO PATIENT		0. 20327		592	
73.00	07300 DRUGS CHARGED TO PATIENTS		0. 18057		248, 267	
	07301 HOSPI TAL BASED RETAIL PHARMACIES		1. 20530		0	
	07400 RENAL DI ALYSI S		0. 43018		48, 110	
76.00	03160 CARDI OPULMONARY		0.00000		0	
76. 97 76. 98	O7697 CARDI AC REHABI LI TATI ON O7698 HYPERBARI C OXYGEN THERAPY		0. 21948 0. 12051		0	
10. 90	OUTPATIENT SERVICE COST CENTERS		0. 12051	11 0	0	1 /0. 9
90. 00	09000 CLINIC		0.00000	0 0	0	90.0
90.00	09002 PAIN CLINIC		0. 25374		0	
90. 02	09003 ONCOLOGY CLINIC		0. 06505		0	90.0
91. 00	09100 EMERGENCY		0. 08945	-	350	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 21901		0	1
02 01	00201 ORSEDVATION REDS (DISTINCT DAPT)		0.00000		0	

0.000000

7, 503, 005

7, 503, 005

92. 01 95.00

201. 00 202. 00

1, 668, 747 200. 00

200.00

201.00 202.00 Total (sum of lines 50 through 94 and 96 through 98)

Less PBP Clinic Laboratory Services-Program only charges (line 61) Net charges (line 200 minus line 201)

92. 01 09201 OBSERVATION BEDS (MON-DISTINCT PART)
OTHER REIMBURSABLE COST CENTERS
95. 00 09500 AMBULANCE SERVICES

Health Financial Systems	BALL MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der CCN: 15-0089	Period: Worksheet D-3

Health Financial Systems BALL MEMORIAL HO	JSPI TAL		In Lie	eu of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0089	Peri od:	Worksheet D-3	
			From 01/01/2017 To 12/31/2017	Date/Time Pre	nared:
			10 12/31/2017	5/24/2018 5:0	
	Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos	t Inpatient	Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			4, 246, 821		30. 00
31. 00 03100 I NTENSI VE CARE UNIT			2, 448, 294		31.00
32. 00 03200 CORONARY CARE UNIT			0		32. 00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT			1, 894, 931		35. 00
40. 00 04000 SUBPROVI DER - I PF			0		40. 00
41. 00 04100 SUBPROVI DER - I RF			143, 472		41.00
43. 00 04300 NURSERY			270, 193		43. 00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATI NG ROOM		0. 09055	1, 234, 251	111, 766	
51.00 05100 RECOVERY ROOM		0. 17695	128, 686		
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 16122		97, 560	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 09453	7 1, 052, 819	99, 530	54.00
57. 00 03280 EKG AND EEG		0. 05042	7 32, 193	1, 623	57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0.00000	0 0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0.05466	393, 554	21, 513	59. 00
60. 00 06000 LABORATORY		0. 12328	1, 312, 039	161, 756	60.00
60. 01 06001 BLOOD LABORATORY		0.00000	0 0	0	60. 01
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.		0. 29092	117, 739	34, 254	63.00
65. 00 06500 RESPI RATORY THERAPY		0. 23925	0 712, 599	170, 489	65. 00
65. 01 06501 SLEEP LAB		0. 08288	4 0	0	65. 01
66. 00 06600 PHYSI CAL THERAPY		0. 29870	120, 279	35, 928	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 21395	9 108, 965	23, 314	67.00
68.00 06800 SPEECH PATHOLOGY		0. 20458	3 113, 916	23, 305	68. 00
68. 01 06801 AUDI OLOGY		0.00000	0 0	0	68. 01
69. 00 06900 ELECTROCARDI OLOGY		0.06706	2 595, 842	39, 958	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 29362	0 379, 049	111, 296	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 20327	5 727, 515	147, 886	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 18057	0 2, 657, 451	479, 856	73.00
73. 01 07301 HOSPITAL BASED RETAIL PHARMACIES		1. 20530	0	0	73. 01
74.00 07400 RENAL DIALYSIS		0. 43018	3 123, 050	52, 934	74.00
76. 00 03160 CARDI OPULMONARY		0.00000	0	0	76. 00
76. 97 07697 CARDI AC REHABI LI TATI ON		0. 21948		996	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY		0. 12051		0	76. 98
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C		0.00000	0 0	0	90.00
90. 02 09002 PAIN CLINIC		0. 25374		0	90. 02
90. 03 09003 ONCOLOGY CLINIC		0.06505		300	90. 03
91. 00 09100 EMERGENCY		0. 08945		116, 184	1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 21901		9, 495	
92. 01 09201 OBSERVATION BEDS (DISTINCT PART)		0.00000		0	
OTHER REI MBURSABLE COST CENTERS		1.23000		·	1
95. 00 09500 AMBULANCE SERVI CES					95. 00
200.00 Total (sum of lines 50 through 94 and 96 through 98)			11, 766, 333	1, 762, 714	
201.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0	1,	201. 00
202.00 Net charges (line 200 minus line 201)	() / /		11, 766, 333		202. 00
		1	,,	I	1-32. 00

		ALL MEMORIAL HOSPITAL	ON 45 0000		u of Form CMS-2	
INPAII	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provider (CCN: 15-0089	Peri od: From 01/01/2017	Worksheet D-3	
		Component	CCN: 15-T089	To 12/31/2017	Date/Time Pre 5/24/2018 5:0	
		Ti t	le XIX	Subprovi der – I RF	Cost	•
	Cost Center Description		Ratio of Cos To Charges	t Inpatient Program Charges	Inpatient Program Costs (col. 1 x col.	
			1.00	2. 00	2)	
	INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00	03000 ADULTS & PEDI ATRI CS			0		30.00
31.00	03100 INTENSIVE CARE UNIT			0		31.00
32.00	03200 CORONARY CARE UNIT			0		32.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT			0		35.00
40.00	04000 SUBPROVI DER - I PF			0		40.00
41.00	04100 SUBPROVI DER - I RF			143, 472		41.00
43.00	04300 NURSERY			0		43. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 0PERATING ROOM		0. 0905	54 0	0	50.00
51.00	05100 RECOVERY ROOM		0. 1769!		0	
	05200 DELIVERY ROOM & LABOR ROOM		0. 16122		Ö	
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 09453		131	
57. 00	03280 EKG AND EEG		0. 05042		0	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)		0.00000		0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON		0. 05466	64 0	0	59.00
60.00	06000 LABORATORY		0. 12328	86 6, 967	859	60.00
60. 01	06001 BLOOD LABORATORY		0.00000		0	
63. 00	06300 BLOOD STORING, PROCESSING, & TRANS.		0. 29092		0	
65. 00	06500 RESPI RATORY THERAPY		0. 23925		89	
65. 01	06501 SLEEP LAB		0. 08288		0	
66.00	06600 PHYSI CAL THERAPY		0. 29870		10, 014	
67.00	06700 OCCUPATI ONAL THERAPY		0. 21395		10, 706	
68. 00 68. 01	O6800 SPEECH PATHOLOGY O6801 AUDI OLOGY		0. 20458	· ·	4, 901 0	1
	06900 ELECTROCARDI OLOGY		0.0670		0	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 29362		660	1
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT		0. 2032		0	1
	07300 DRUGS CHARGED TO PATIENTS		0. 1805		3, 193	
73. 01	07301 HOSPI TAL BASED RETAIL PHARMACIES		1. 20530	· ·	0	
74. 00	07400 RENAL DIALYSIS		0. 43018		0	1
76.00	03160 CARDI OPULMONARY		0.00000	00	0	76. 00
76. 97	07697 CARDI AC REHABILITATION		0. 21948	81 0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY		0. 1205	11 0	0	76. 98
00.00	OUTPATIENT SERVICE COST CENTERS		0.0000	20	^	00.00
90. 00 90. 02	09000 CLINIC		0.00000		0	
90. 02	O9002 PAIN CLINIC O9003 ONCOLOGY CLINIC		0. 25374 0. 06509		0	
90. 03	09100 EMERGENCY		0. 08945		0	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 2190		_	1
02.00	00200 OBSERVATION DEDS (NON DISTINCT TART)		0.2170		0	

0.000000

136, 177

136, 177

92.01

95.00

201. 00 202. 00

30, 553 200. 00

92.00 92. 01

200.00

201.00 202.00 Total (sum of lines 50 through 94 and 96 through 98)

Less PBP Clinic Laboratory Services-Program only charges (line 61) Net charges (line 200 minus line 201)

09201 OBSERVATION BEDS (DISTINCT PART)

OTHER REIMBURSABLE COST CENTERS

95. 00 09500 AMBULANCE SERVICES

Health Financial Systems	BALL MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0089	Peri od: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Prepared: 5/24/2018 5:05 pm

		T' II WIII		5/24/2018 5:0	5 pm
		Title XVIII	Hospi tal	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 instructions)	g prior to October 1 (s	see	0 47, 913, 182	1. 00 1. 01
1. 02	DRG amounts other than outlier payments for discharges occurring instructions)	g on or after October	l (see	16, 091, 275	1. 02
1. 03	DRG for federal specific operating payment for Model 4 BPCI for 1 (see instructions)	discharges occurring p	orior to October	0	1. 03
1. 04	DRG for federal specific operating payment for Model 4 BPCl for October 1 (see instructions)	discharges occurring	on or after	0	1. 04
2. 00 2. 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			784, 968 0	2. 00 2. 01
2. 02	Outlier payment for discharges for Model 4 BPCI (see instruction	ns)		0	2. 02
3. 00 4. 00	Managed Care Simulated Payments Bed days available divided by number of days in the cost reporti	ng period (see instru	ctions)	15, 600, 866 308. 47	3. 00 4. 00
5. 00	Indirect Medical Education Adjustment FTE count for allopathic and osteopathic programs for the most r	recent cost reporting p	period ending on	50. 70	5. 00
6. 00	or before 12/31/1996. (see instructions) FTE count for allopathic and osteopathic programs which meet the for new programs in accordance with 42 CFR 413.79(e)	e criteria for an add-o	on to the cap	0.00	6. 00
7. 00	MMA Section 422 reduction amount to the IME cap as specified unc	der 42 CFR §412.105(f)	(1) (i v) (B) (1)	0.00	7. 00
7. 01	ACA § 5503 reduction amount to the IME cap as specified under 42 cost report straddles July 1, 2011 then see instructions.			0.00	7. 01
8. 00	Adjustment (increase or decrease) to the FTE count for allopathi affiliated programs in accordance with 42 CFR 413.75(b), 413.79(1998), and 67 FR 50069 (August 1, 2002).			0.00	8. 00
8. 01	The amount of increase if the hospital was awarded FTE cap slots report straddles July 1, 2011, see instructions.	s under § 5503 of the A	ACA. If the cost	12. 00	8. 01
8. 02	The amount of increase if the hospital was awarded FTE cap slots under § 5506 of ACA. (see instructions)	s from a closed teachi	ng hospital	0. 00	8. 02
9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines instructions)	(8, 8,01 and 8,02) (9	see	62. 70	9. 00
10. 00 11. 00	FTE count for allopathic and osteopathic programs in the current FTE count for residents in dental and podiatric programs.	t year from your record	ds	62. 14 0. 00	
12. 00	Current year allowable FTE (see instructions)			62. 14	
13. 00 14. 00	Total allowable FTE count for the prior year. Total allowable FTE count for the penultimate year if that year	ended on or after Sep	tember 30, 1997,	62. 70 61. 03	
15. 00	otherwise enter zero. Sum of lines 12 through 14 divided by 3.			61. 96	15. 00
16.00	Adjustment for residents in initial years of the program			0.00	16. 00
17. 00	Adjustment for residents displaced by program or hospital closur	re			17. 00
18.00	Adjusted rolling average FTE count			61. 96	
19. 00 20. 00	Current year resident to bed ratio (line 18 divided by line 4). Prior year resident to bed ratio (see instructions)			0. 200862 0. 209685	
21. 00	Enter the lesser of lines 19 or 20 (see instructions)			0. 200862	
22. 00	IME payment adjustment (see instructions)			6, 648, 783	
22. 01	IME payment adjustment - Managed Care (see instructions)			1, 620, 618	
	Indirect Medical Education Adjustment for the Add-on for § 422 c				
23. 00	Number of additional allopathic and osteopathic IME FTE resident $(f)(1)(iv)(C)$.	t cap slots under 42 Cl	-R 412.105	4.00	23. 00
24.00	IME FTE Resident Count Over Cap (see instructions)			-0. 56	24. 00
25. 00	If the amount on line 24 is greater than -O-, then enter the low instructions)	wer of line 23 or line	24 (see	0.00	25. 00
26.00	Resident to bed ratio (divide line 25 by line 4)			0.000000	26. 00
27. 00	IME payments adjustment factor. (see instructions)			0.000000	27. 00
28. 00	IME add-on adjustment amount (see instructions)			0	28. 00
28. 01	IME add-on adjustment amount - Managed Care (see instructions)			0	28. 01
29.00	Total IME payment (sum of lines 22 and 28)			6, 648, 783	29. 00
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment			1, 620, 618	29. 01
30.00	Percentage of SSI recipient patient days to Medicare Part A pati	ent days (see instruct	tions)	6. 40	30. 00
31. 00	Percentage of Medicaid patient days (see instructions)	3 (1111 1711	´		31. 00
32.00	Sum of lines 30 and 31			31. 13	
	Allowable disproportionate share percentage (see instructions)			14. 90	33. 00
34. 00	Disproportionate share adjustment (see instructions)			2, 384, 166	34.00

LCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0089	Peri od: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Prep 5/24/2018 5:09	
		Title XVIII	Hospi tal	PPS	
			Prior to 10/1		
	Uncompensated Care Adjustment		1. 00	2. 00	
. 00	Total uncompensated care amount (see instructions)		5, 977, 483, 147	6, 766, 695, 164	35.0
. 01	Factor 3 (see instructions)		0. 000541810	0. 000725628	
. 02	Hospital uncompensated care payment (If line 34 is zero, enterinstructions) $$, ,		4, 910, 101	35. C
. 03 . 00	Pro rata share of the hospital uncompensated care payment amount of the land the lan	03)	2, 422, 340 3, 659, 956	1, 237, 616	35. 0 36. 0
. 00	Additional payment for high percentage of ESRD beneficiary di Total Medicare discharges on Worksheet S-3, Part I excluding		gh 46) 0		40. C
. 00	652, 682, 683, 684 and 685 (see instructions) Total ESRD Medicare discharges excluding MS-DRGs 652, 682, (instructions)	683, 684 an 685. (see	0		41. C
. 01	Total ESRD Medicare covered and paid discharges excluding MS- an 685. (see instructions)	-DRGs 652, 682, 683, 684	0		41. C
. 00	Divide line 41 by line 40 (if less than 10%, you do not quality Total Medicare ESRD inpatient days excluding MS-DRGs 652, 68 instructions)		0.00		42. C
. 00	Ratio of average length of stay to one week (line 43 divided days)	by line 41 divided by 7	0. 000000		44. 0
. 00	Average weekly cost for dialysis treatments (see instructions		0.00		45. 0
. 00	Total additional payment (line 45 times line 44 times line 47	1. 01)	0		46. (
. 00	Subtotal (see instructions)		77, 482, 330		47.
. 00	Hospital specific payments (to be completed by SCH and MDH, sonly, (see instructions)	smail rurai nospitais	0		48.
	only. (See Tristractions)			Amount	
				1. 00	
. 00	Total payment for inpatient operating costs (see instructions			79, 102, 948	
. 00	Payment for inpatient program capital (from Wkst. L, Pt. I am			5, 988, 960	
. 00	Exception payment for inpatient program capital (Wkst. L, Pt.			0 2 422 114	51.
. 00	Direct graduate medical education payment (from Wkst. E-4, li Nursing and Allied Health Managed Care payment	The 49 See Thistructions).		2, 622, 116 0	52. 53.
. 00	Special add-on payments for new technologies			13, 497	
. 01	Islet isolation add-on payment			0	54.
. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6	69)		Ö	55.
. 00	Cost of physicians' services in a teaching hospital (see intr	•		0	56.
. 00	Routine service other pass through costs (from Wkst. D, Pt. I	III, column 9, lines 30 t	hrough 35).	0	57.
00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 11 line 200)		42, 509	
00	Total (sum of amounts on lines 49 through 58)			87, 770, 030	
00	Primary payer payments	- 1: (0)		44, 347	
00	Total amount payable for program beneficiaries (line 59 minus	s rine 60)		87, 725, 683	
00	Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries			6, 673, 688 227, 570	
	. 9			1, 426, 334	
	Adjusted reimbursable bad debts (see instructions)			927, 117	
. 00	Allowable bad debts for dual eligible beneficiaries (see inst	tructions)		267, 433	
. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	,		81, 751, 542	
00	Credits received from manufacturers for replaced devices for	applicable to MS-DRGs (s	ee instructions)	0	68.
00	Outlier payments reconciliation (sum of lines 93, 95 and 96).	(For SCH see instruction	s)	0	69.
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70.
. 50	Rural Community Hospital Demonstration Project (§410A Demonst		ınstructions)	0	70.
. 87	Demonstration payment adjustment amount before sequestration			0	70.
. 88 . 89	SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration nayment adjustment amount (see inst	tructions)		0	70. 70.
. 89 . 90	Pioneer ACO demonstration payment adjustment amount (see inst HSP bonus payment HVBP adjustment amount (see instructions)	ti ucti ulis <i>j</i>		0	70. 70.
. 90 . 91	HSP bonus payment HRR adjustment amount (see instructions)			0	70. 70.
	Bundled Model 1 discount amount (see instructions)			0	70.
. 92				ŭ,	
). 92). 93	HVBP payment adjustment amount (see instructions)			-76, 355	70.

	Financial Systems BALL MEMORIAL F				u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der C		Peri od:	Worksheet E	
				From 01/01/2017 To 12/31/2017		norod:
				10 12/31/201/	5/24/2018 5:0	pareu: 15 nm
		Ti tl e	e XVIII	Hospi tal	PPS	о ріп
		11 616		(уууу)	Amount	
				0	1. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in	n column O		0	0	70. 96
	the corresponding federal year for the period prior to 10/1)			-	_	
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in	n column 0		0	0	70. 97
	the corresponding federal year for the period ending on or aft					
70. 98	Low Volume Payment-3				0	70. 98
70. 99	HAC adjustment amount (see instructions)				0	70. 99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 6	59 & 70)			81, 464, 110	71.00
71. 01	Sequestration adjustment (see instructions)	ŕ			1, 629, 282	71. 01
71. 02	Demonstration payment adjustment amount after sequestration				0	71. 02
72.00	Interim payments				79, 107, 989	72.00
73.00	Tentative settlement (for contractor use only)				0	73.00
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02	2, 72, and			726, 839	74.00
	73)					
75.00	Protested amounts (nonallowable cost report items) in accordan	nce with			1, 408, 371	75.00
	CMS Pub. 15-2, chapter 1, §115.2					
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
	Operating outlier amount from Wkst. E, Pt. A, line 2 (see inst	tructions)			0	
91. 00					0	1 / 00
92. 00	Operating outlier reconciliation adjustment amount (see instru				0	72.00
	Capital outlier reconciliation adjustment amount (see instruct				0	1
	The rate used to calculate the time value of money (see instru	uctions)			0. 00	
95.00	Time value of money for operating expenses (see instructions)				0	
96. 00	Time value of money for capital related expenses (see instruct	tions)			0	96. 00
					On/After 10/1	
	The second secon			1. 00	2. 00	
	HSP Bonus Payment Amount					1
100.00	HSP bonus amount (see instructions)			0	0	100. 00
	HVBP Adjustment for HSP Bonus Payment					1
	HVBP adjustment factor (see instructions)			0. 0000000000		
102.00	HVBP adjustment amount for HSP bonus payment (see instructions	5)		0	0	102.00
	HRR Adjustment for HSP Bonus Payment					
	HRR adjustment factor (see instructions)			0.0000	0. 0000	
104.00	HRR adjustment amount for HSP bonus payment (see instructions)			0	0	104.00
	Rural Community Hospital Demonstration Project (§410A Demonstr					
200.00	Is this the first year of the current 5-year demonstration per	riod under t	the 21st			200. 00
	Century Cures Act? Enter "Y" for yes or "N" for no.					J

	THE adjustment amount (see this tructions)	1		70.99
71. 00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		81, 464, 110	71. OC
71. 01	Sequestration adjustment (see instructions)		1, 629, 282	2 71. 01
71. 02	Demonstration payment adjustment amount after sequestration		0	71. 02
72.00	Interim payments		79, 107, 989	72.00
	Tentative settlement (for contractor use only)		0	73.00
74. 00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and		726, 839	
74.00	73)		720,037	74.00
75. 00			1 400 271	75. 00
75.00	Protested amounts (nonallowable cost report items) in accordance with		1, 408, 371	/5.00
	CMS Pub. 15-2, chapter 1, §115.2			-
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			4
90. 00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0	
91. 00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94. 00	The rate used to calculate the time value of money (see instructions)		0.00	
95. 00				
	Time value of money for operating expenses (see instructions)		0	
96.00	Time value of money for capital related expenses (see instructions)	1	0	96.00
		Prior to 10/1		
		1. 00	2. 00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)	0	0	100. 00
	HVBP Adjustment for HSP Bonus Payment			
101 00	HVBP adjustment factor (see instructions)	0.000000000	0. 0000000000	1101 00
	HVBP adjustment ractor (see instructions)	0.000000000		
102.00		<u> </u>	0	102.00
	HRR Adjustment for HSP Bonus Payment			4
	HRR adjustment factor (see instructions)	0.0000	0.0000	
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	0 104.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st			200.00
	Century Cures Act? Enter "Y" for yes or "N" for no.			
	Cost Reimbursement	1		
201 00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201. 00
				202. 00
	Medicare discharges (see instructions)			
203.00	Case-mix adjustment factor (see instructions)			203. 00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current	: 5-year demonst	ration	
	peri od)			
204.00	Medicare target amount			204. 00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205. 00
	Medicare inpatient routine cost cap (line 202 times line 205)			206. 00
	Adjustment to Medicare Part A Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207. 00
	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208. 00
	Adjustment to Medicare IPPS payments (see instructions)			209. 00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211. 00
	Comparision of PPS versus Cost Reimbursement			
212 00				212. 00
				213. 00
218.00	, ,			218. 00
	(line 212 minus line 213) (see instructions)			1
213.00	Total adjustment to Medicare Part A IPPS payments (from line 211) Low-volume adjustment (see instructions) Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			ı

| In Lieu of Form CMS-2552-10 | Period: | Worksheet E | From 01/01/2017 | Part A Exhibit 4 | To 12/31/2017 | Date/Time Prepared: | 5/24/2018 5:05 pm Provider CCN: 15-0089

					VVIIII	Haani tal	DDC	
	·	W/S F Part A	Amounts (from	Pre/Post	XVIII Period Prior	Hospi tal Peri od	PPS Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
1 00	Inno.	0	1.00	2. 00	3. 00	4. 00	5. 00	4 00
1. 00	DRG amounts other than outlier payments	1. 00	0	0	0	0	0	1. 00
1. 01	DRG amounts other than outlier payments for discharges	1. 01	47, 913, 182	O	47, 913, 182		47, 913, 182	1. 01
1. 02	occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	16, 091, 275	0		16, 091, 275	16, 091, 275	1. 02
1. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1. 03	0	O [°]	0		0	1. 03
1. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0	0		0	0	1. 04
2. 00	Outlier payments for discharges (see instructions)	2. 00	784, 968	0	628, 643	156, 325	784, 968	2. 00
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	0	0	0	0	0	2. 01
3. 00	Operating outlier	2. 01	0	0	0	0	0	3. 00
4. 00	Managed care simulated payments	3. 00	15, 600, 866	0	11, 462, 464	4, 138, 401	15, 600, 865	4. 00
	Indirect Medical Education Adju							[
5.00	Amount from Worksheet E, Part	21. 00	0. 200862	0. 200862	0. 200862	0. 200862		5. 00
6. 00	A, line 21 (see instructions) IME payment adjustment (see	22. 00	6, 648, 783	0	4, 977, 221	1, 671, 562	6, 648, 783	6. 00
6. 01	instructions) IME payment adjustment for	22. 01	1, 620, 618	0	1, 620, 618	0	1, 620, 618	6. 01
	managed care (see instructions)	votment for the	Add on for Coo	ation 422 of t	bo MMA			
7. 00	Indirect Medical Education Adju IME payment adjustment factor	27. 00	0. 000000	0. 000000		0. 000000		7.00
8. 00	(see instructions) IME adjustment (see	28. 00	0. 000000	0. 000000	0.00000	0. 000000	0	8. 00
8. 01	instructions) IME payment adjustment add on	28. 01	0	0	0	0	0	8. 01
	for managed care (see instructions)							
9. 00	Total IME payment (sum of lines 6 and 8)	29. 00	6, 648, 783	0	4, 977, 221			
9. 01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	1, 620, 618	0	1, 620, 618	O	1, 620, 618	9. 01
40.00	Disproportionate Share Adjustme		0.4400	0.4400	0.4400	0.4400		1 40 00
10. 00	Allowable disproportionate share percentage (see	33. 00	0. 1490	0. 1490	0. 1490	0. 1490		10. 00
11. 00	i nstructi ons) Di sproporti onate share	34. 00	2, 384, 166	0	1, 784, 766	599, 400	2, 384, 166	11. 00
11. 01	adjustment (see instructions) Uncompensated care payments	36.00	3, 659, 956	0	2, 422, 340	1, 237, 616	3, 659, 956	11. 01
12. 00	Additional payment for high per Total ESRD additional payment	centage of ESR 46.00	RD beneficiary o	di scharges 0	0	0	0	12. 00
	(see instructions)							
13. 00 14. 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	47. 00 48. 00	77, 482, 330 0	0	57, 726, 152 0	19, 756, 178 0	77, 482, 330 0	13. 00 14. 00
15. 00	(see instructions) Total payment for inpatient operating costs (see	49. 00	79, 102, 948	O	59, 346, 770	19, 756, 178	79, 102, 948	15. 00
16. 00	instructions) Payment for inpatient program capital (from Wkst. L, Pt. I,	50. 00	5, 988, 960	0	4, 480, 601	1, 508, 359	5, 988, 960	16. 00
17. 00	if applicable) Special add-on payments for	54. 00	13, 497	O	8, 286	5, 211	13, 497	17. 00
17. 01 17. 02	new technologies Net organ aquisition cost Credits received from manufacturers for replaced devices for applicable MS-DRGs	68. 00	0	0	0	0	0	17. 01 17. 02

					Т	o 12/31/2017	Date/Time Pre 5/24/2018 5:0	pared:
				Title	XVIII	Hospi tal	PPS	
		W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
		0	1.00	2.00	3. 00	4. 00	5. 00	
18.00	Capital outlier reconciliation	93. 00	0	0	C	0	0	18. 00
	adjustment amount (see							
	instructions)							
19.00	SUBTOTAL			0	63, 835, 657	21, 269, 748	85, 105, 405	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		5, 191, 242	0	3, 880, 478	1, 310, 764	5, 191, 242	
20. 01	Model 4 BPCI Capital DRG other	1. 01	0	0	(0	0	20. 01
	than outlier							
21. 00	Capital DRG outlier payments	2. 00	40, 316	0	33, 962	6, 354	40, 316	21. 00
21. 01	Model 4 BPCI Capital DRG	2. 01	0	0	(0	0	21. 01
	outlier payments							
22. 00	Indirect medical education	5. 00	0. 0809	0. 0809	0. 0809	0. 0809		22. 00
	percentage (see instructions)							
23. 00	Indirect medical education	6. 00	419, 971	0	313, 930	106, 041	419, 971	23. 00
	adjustment (see instructions)							
24. 00	Allowable disproportionate	10. 00	0. 0650	0. 0650	0. 0650	0. 0650		24. 00
	share percentage (see							
	instructions)							
25. 00	Di sproporti onate share	11. 00	337, 431	0	252, 231	85, 200	337, 431	25. 00
	adjustment (see instructions)							
26. 00	Total prospective capital	12. 00	5, 988, 960	0	4, 480, 601	1, 508, 359	5, 988, 960	26. 00
	payments (see instructions)							
			(Amounts to E,					
		line	Part A)	0.00				
07.00	1	0	1. 00	2. 00	3.00	4. 00	5. 00	07.00
27. 00	Low volume adjustment factor				0. 000000	0. 000000	_	27. 00
28. 00	Low volume adjustment	70. 96)	0	28. 00
	(transfer amount to Wkst. E,							
	Pt. A, line)	70.07						
29. 00	Low volume adjustment	70. 97				0	0	29. 00
	(transfer amount to Wkst. E,							
400.00	Pt. A, line)							100.00
100.00	Transfer low volume		N					100. 00
	adjustments to Wkst. E, Pt. A.	I						

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 Provider CCN: 15-0089 Peri od: Worksheet E From 01/01/2017 Part A Exhibit 5 Date/Time Prepared: 12/31/2017 5/24/2018 5:05 pm Hospi tal Title XVIII PPS Period to Total (cols. 2 Wkst. E, Pt. Amt. from Peri od on Wkst. E, Pt. 10/01 A. line after 10/01 and 3) A) 2.00 3. 00 0 4.00 1.00 1.00 DRG amounts other than outlier payments 1.00 1. 00 DRG amounts other than outlier payments for 47, 913, 182 47, 913, 182 1.01 1.01 47, 913, 182 1.01 discharges occurring prior to October 1 DRG amounts other than outlier payments for 1.02 1.02 16, 091, 275 16, 091, 275 16, 091, 275 1.02 discharges occurring on or after October 1 1.03 DRG for Federal specific operating payment 1.03 0 1.03 for Model 4 BPCI occurring prior to October DRG for Federal specific operating payment 1.04 1.04 1.04 0 0 for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for discharges (see 2.00 784, 968 628, 643 156, 325 784, 968 2.00 instructions) 2.01 Outlier payments for discharges for Model 4 2.02 2.01 Operating outlier reconciliation 3 00 2 01 3 00 4.00 Managed care simulated payments 3.00 15, 600, 866 11, 462, 464 4, 138, 401 15, 600, 865 4.00 Indirect Medical Education Adjustment 5.00 Amount from Worksheet E, Part A, line 21 21.00 0. 200862 0. 200862 0. 200862 5.00 (see instructions) 6 00 IME payment adjustment (see instructions) 22 00 6, 648, 783 4, 977, 221 1, 671, 562 6, 648, 783 6 00 IME payment adjustment for managed care (see 1, 190, 721 429, 897 1, 620, 618 6.01 22.01 1,620,618 6.01 instructions) Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 7.00 0.000000 0.000000 IME payment adjustment factor (see 27.00 0.000000 7.00 instructions) 8.00 IME adjustment (see instructions) 28.00 8.00 8.01 IME payment adjustment add on for managed 28.01 8.01 care (see instructions) Total IME payment (sum of lines 6 and 8) 4, 977, 221 9.00 29.00 6, 648, 783 6, 648, 783 1, 671, 562 9.00 9.01 Total IME payment for managed care (sum of 29.01 1,620,618 1, 190, 721 429, 897 1, 620, 618 9.01 lines 6.01 and 8.01) Disproportionate Share Adjustment 10.00 Allowable disproportionate share percentage 33.00 0.1490 0.1490 10.00 0.1490 (see instructions) 11.00 Disproportionate share adjustment (see 34.00 2, 384, 166 1, 784, 766 599, 400 2, 384, 166 11.00 instructions) 11.01 Uncompensated care payments 36.00 3, 659, 956 2, 422, 340 1, 237, 616 3, 659, 956 11.01 Additional payment for high percentage of ESRD beneficiary discharges Total ESRD additional payment (see 12 00 O 0 12 00 46 00 instructions) 13.00 Subtotal (see instructions) 47.00 77, 482, 330 57, 726, 152 19, 756, 178 77, 482, 330 13.00 14.00 Hospital specific payments (completed by SCH 48.00 14.00 and MDH, small rural hospitals only.) (see

49.00

50.00

54.00

68.00

93.00

79, 102, 948

5, 988, 960

13, 497

58, 916, 873

4, 480, 601

63, 405, 760

8, 286

0

20, 186, 075

1, 508, 359

21, 699, 645

5, 211

0

79, 102, 948

5, 988, 960

13, 497

0 17.02

85, 105, 405 19. 00

15.00

16.00

17.00

17.01

18.00

instructions)

(see instructions)

15.00

16.00

17.00

17.01

17.02

18.00

19.00 SUBTOTAL

Total payment for inpatient operating costs

Payment for inpatient program capital (from

Special add-on payments for new technologies

Credits received from manufacturers for

replaced devices for applicable MS-DRGs

Capital outlier reconciliation adjustment

Wkst. L, Pt. I, if applicable)

Net organ acquisition cost

amount (see instructions)

Heal th	Financial Systems	BALL MEMORIA	L HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
HOSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provider Co		Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Exhibi Date/Time Pre 5/24/2018 5:0	pared:
			Title	· XVIII	Hospi tal	PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3. 00	4. 00	
20.00	Capital DRG other than outlier	1.00	5, 191, 242	3, 880, 47	8 1, 310, 764	5, 191, 242	20. 00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0		0	0	20. 01
21.00	Capital DRG outlier payments	2.00	40, 316	33, 96	2 6, 354	40, 316	21. 00
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0		0 0	0	21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0809	0.080	9 0. 0809		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	419, 971	313, 93	0 106, 041	419, 971	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10.00	0. 0650	0. 065	0. 0650		24. 00
25. 00	Disproportionate share adjustment (see instructions)	11.00	337, 431	252, 23	1 85, 200	337, 431	25. 00
26. 00	Total prospective capital payments (see instructions)	12.00	5, 988, 960	4, 480, 60	1 1, 508, 359	5, 988, 960	26. 00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt.				
		0	A) 1. 00	2.00	3. 00	4.00	
27. 00		U	1.00	2.00	3.00	4.00	27. 00
28.00	Low volume adjustment prior to October 1	70, 96	_		0	0	28.00
29. 00	Low volume adjustment on or after October 1	70. 96	0		٥	0	29.00
30.00	HVBP payment adjustment (see instructions)	70. 97	74 255	-126, 80	0 50, 445	1	
30. 00	HVBP payment adjustment for HSP bonus	70. 93	-76, 355	- 120, 80	0 50, 445	-76,355	30.00
	payment (see instructions)		0		0		
31. 00	HRR adjustment (see instructions)	70. 94	-211, 077	-182, 10	3 -28, 974		31. 00
31. 01	HRR adjustment for HSP bonus payment (see	70. 91	0		0 0	0	31. 01

0

70. 99

100.00

0 32. 00

(Amt. to Wkst. E, Pt. A) 4.00

3. 00

2.00

1.00

Ν

instructions)

32.00 HAC Reduction Program adjustment (see

instructions)

100.00 Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.

Health Financial Systems	BALL MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0089	Peri od: Worksheet E From 01/01/2017 Part B To 12/31/2017 Date/Time Prepared:

MART 8 - NEDICAL AND OTHER HEALTH SERVICES 1.00			1	0 12/31/201/	5/24/2018 5:0	
Name			Title XVIII	Hospi tal		<u> </u>
Name						
Modical and other services (see instructions) 25, 169 1.00					1. 00	
Medical and other services relaburated under other (see Instructions) 34, 446, 339 2, 30 00 Physpopements 38, 421, 663 2, 30 00 Physpopement (see Instructions) 178, 67 4, 00 178, 67 4, 00 178, 67 4, 00 178, 67 4, 00 178, 67 4, 00 178, 67 4, 00 178, 67 4, 00 178, 67 4, 00 178, 67 4, 00 178, 67 4, 00 178, 67 4, 00 188, 67						
2.00 OPPS payments						1
0.00 1.00		· ·	tions)			•
Action Content Conte						1
Enter the hospit tal specific payment to cost ratio (see instructions)						1
Line 2 times Line 5 0.00 0.00		, , , , , , , , , , , , , , , , , , ,				1
Sum of Fines 3, 4, and 4, 01, divided by Fine 6 0.00 7.00			ctions)			•
Transit tional corridor payment (see instructions) 3 0 0 0 0 0 0 0 0 0 0						1
Ancil lary service other pass through costs from West. D. Pt. IV, col. 13, line 200 43, 127 9, 00 10, 00 00 00 00 00 00						1
10,00 Organ acquist from 10,00 Department			V and 12 lime 200		_	1
1.00 Orall cost (sum of lines 1 and 10) (see instructions) 1.00 Orall cost (sum of lines 1 and 10) (see instructions) 1.00 Orall cost (sum of lines 1 and 10) (see instructions) 1.00 Orall cost (sum of lines 1 and 10) Orall cost (sum of lines 1 and 10) Orall cost (sum of lines 1 and 10) Orall cost (sum of li			v, cor. 13, Trie 200			1
Communication of Lesser of Cost or Charges 139, 819 12, 00 130, 00		,			_	
Reasonable charges 12,00 Ancil lary service charges 139, 819 12,00 20 20 20 20 20 20 20	11.00				25, 109	11.00
12.00 Ancillary service charges 139, 819 12, 00 12						<u> </u>
13.00 Organ acquisition charges (From Wist. D.4, Pt. III, col. 4, Iline 69) 0 13.00	12 00				130 810	12 00
14.00 Total reasonable charges (sum of lines 12 and 13) 14.00 14.00 15.00 15.00 20.00			ne 69)			1
Display Disp			116 07)			1
15.00 Aggregate amount actually collected from patients Iable for payment for services on a charge basis 0 16.00 Amounts that would have been realized from patients Iable for payment for services on a chargebasis 0 16.00 Amounts that would have been realized from patients Iable for payment for services on a chargebasis 0 16.00 Amounts that would have been realized from patients Iable for payment for services on a chargebasis 0 16.00 Amounts 17.00 Total customary charges (see instructions) 139, 819 18.00 19.00 Excess of customary charges (see instructions) 139, 819 18.00 19.00 Excess of customary charges (or reasonable cost (complete only if line 18 exceeds line 11) (see 1114,650 19.00 15	00				107/017	
16.00 Amounts that would have been realized from patients liable for payment for services on a chargebasis A	15. 00		payment for services on a	charge basis	0	15. 00
had such payment been made in accordance with 42 CFR \$413.13(e)		,	3	9	0	•
17.00 Ratio of line 15 to line 16 (not to exceed 1.000000) 17.00 18.00 Total customary charges (see instructions) 139,819 18.00 18.00 Total customary charges (see instructions) 19.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see 114,650 19.00 114,650 19.00 114,650 19.00 114,650 19.00 114,650 19.00 114,650 19.00 114,650 19.00 114,650 19.00 114,650 19.00 114,650 19.00 114,650 19.00 114,650 19.00 114,650 19.00 114,650 19.00 114,650 19.00 114,650 19.00 114,650 19.00 114,65		·	. ,	3		
19.00 Excess of customary Charges over reasonable cost (complete only if line 18 exceeds line 11) (see 114,650 19.00 114,650	17.00				0.000000	17. 00
Instructions	18.00	Total customary charges (see instructions)			139, 819	18. 00
20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see 0 20.00	19.00	Excess of customary charges over reasonable cost (complete onl	y if line 18 exceeds line	11) (see	114, 650	19. 00
Instructions		instructions)				
21.00 Lesser of cost or charges (see instructions) 0 22.00 22.00 23.00 20.00 23.00 22.00 23.00 25.00 2	20.00		y if line 11 exceeds line	18) (see	0	20. 00
22.00 Interns and residents (see instructions) 0 22.00 23.00						
23. 00 Cost of physicians' services in a teaching hospital (see instructions) 0 23. 00 38. 643.657 24. 00 Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) 38. 643.657 24. 00 25. 00 Deductibles and coinsurance (for CAH, see instructions) 0 25. 00 26. 00 Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions) 6, 996, 724 26. 00 27. 00 Subtotal ([(ines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see 1.672, 102 27. 00 Instructions) 1, 098.654 28. 00 29. 00 29. 00 28. 00 29.		g ,				1
Total prospective payment (sum of lines 3, 4, 4, 01, 8 and 9) 38, 643, 657 24. 00		· · · · · · · · · · · · · · · · · · ·			_	
COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance (for CAH, see instructions) Deductibles and coinsurance (for CAH, see instructions) 6, 996, 724 26 00 25. 00 Deductibles and coinsurance relating to amount on line 24 (for CAH, see instructions) 6, 996, 724 26 00 27. 00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see 31, 672, 102 27. 00 28. 00 Direct graduate medical education payments (from Wkst. E-4, line 50) 1,098, 654 28. 00 29. 00 ESRD direct medical education costs (from Wkst. E-4, line 36) 0,29. 00 30. 00 Subtotal (sum of lines 27 through 29) 32,770, 756 30. 00 30. 00 Subtotal (sum of lines 27 through 29) 32,770, 756 30. 00 31. 00 Company payments 4,677 31. 00 32. 00 Subtotal (line 30 minus line 31) 32,766,079 32. 00 33. 00 Composite rate ESRD (from Wkst. I-5, line 11) 32,766,079 32. 00 34. 00 Allowable bad debts (see instructions) 1,862,599 34. 00 35. 00 Allowable bad debts (see instructions) 1,210,689 35. 00 36. 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 1,004,601 36. 00 37. 00 Subtotal (see instructions) 33,976,768 37. 00 38. 00 MSP-LCC reconciliation amount from PS&R -490 38. 00 39. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0,39,95 39. 97 Demonstration payment adjustment (see instructions) 33,977,288 40. 01 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 0,39,97 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 0,39,97 30. 00 The rate used to calculate the Time Value of Money (see instructions) 0,00 0,00 30. 00 The rate used to calculate the Time Value of Money (see instructions) 0,00 0,00 30. 01 The rate used to calculate the Time Value of Money (see instructions) 0,00 0,00 30. 00 The rate used to calculate the Time Value of Money (see instructions) 0,00 0,00 30. 00 The Value of Money (see instructions) 0,00 0,00 30. 00		, , , , , , , , , , , , , , , , , , , ,	ructions)		_	1
25.00 Deductible sand coinsurance (for CAH, see instructions) 0, 696,724 26.00 27.00 28.00 29.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions) 1, 098,654 28.00 29.00	24.00				38, 643, 657	24.00
26. 00 Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions) 5,996,724 26. 00	25 00				0	25 00
27. 00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions) 1,098,654 28. 00 10 rect graduate medical education payments (from Wkst. E-4, line 50) 1,098,654 28. 00 29. 00 25RD direct medical education costs (from Wkst. E-4, line 36) 29. 00 23,770,756 30. 00 29. 00 32,770,756 30. 00 29. 00 32,770,756 30. 00 29. 00 32,770,756 30. 00 29. 00 32,770,756 30. 00 29. 00 32,770,756 30. 00 29. 00 32,770,756 30. 00 29. 00 32,770,756 30. 00 29. 00 32,770,756 30. 00 29. 00 32,770,756 30. 00 29. 00 32,770,756 30. 00 29. 00 32,770,756 30. 00 29. 00 32,770,756 30. 00 29. 00 32,770,756 30. 00 29. 00 32,770,756 30. 00 29. 00 32,770,756 30. 00 29. 00 32,770,756 30. 00 29. 00 32,770,756 30. 00 29. 00 32,770,756 30. 00 29. 00 32,770,756 30. 00 32,770,756 30. 00 32,770,756 30. 00 32,770,756 30. 00 32,770,756 30. 00 32,770,756 30. 00 32,770,756 30. 00 32,770,756 30. 00 32,770,756 30. 00 32,770,756 30. 00 32,770,756 30. 00 32,770,756 30. 00 32,770,756 30. 00 32,770,756 30. 00 32,770,756 30. 00 32,770,756 30. 00 32,770,756 30. 00 32,770,756 30. 00 32,970,758 32. 00 32,970,758 32. 00 32,970,758 32. 00 32,970,758 32. 00 32,970,758 32. 00 32,970,758			c CAH coo instructions)			•
Instructions				nd 23] (see		1
28. 00 Direct graduate medical education payments (from Wkst. E-4, line 50) 1,098,654 28. 00 29. 00 ESRD direct medical education costs (from Wkst. E-4, line 36) 29. 00	27.00		ords the sum of filles 22 a	iiu 23] (366	31,072,102	27.00
9.9 00 ESRD direct medical education costs (from Wkst. E-4, line 36) 29, 00 30. 00 Subtotal (sum of lines 27 through 29) 32, 770, 756 30. 00 31. 00 Primary payer payments 4, 677 31. 00 32. 00 Aubtotal (line 30 minus line 31) 32, 766, 079 32. 00 33. 00 Composite rate ESRD (from Wkst. I-5, line 11) 0 33. 00 34. 00 All lowable bad debts (see instructions) 1, 862,599 34. 00 35. 00 All lowable bad debts (see instructions) 1, 210,689 35. 00 36. 00 All lowable bad debts for dual eligible beneficiaries (see instructions) 1, 004,601 36. 00 36. 00 All lowable bad debts for dual eligible beneficiaries (see instructions) 33, 976,768 37. 00 38. 00 MSP-LCC reconciliation amount from PS&R -490 38. 00 39. 01 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39. 90 39. 90 Ponoer-ACO demonstration payment adjustment (see instructions) 61.687 39. 90 39. 99 Partial or full credits received from amurfacturers for replaced devices (see instructions) 679,545	28 00		ne 50)		1 098 654	28 00
Subtotal (sum of lines 27 through 29) 32, 770, 756 30, 00 31. 00 31. 00 32, 770, 756 30, 00 31. 00 32, 766, 079 32, 00 32, 06, 079 32, 06, 079 32, 06, 079 32, 06, 079 32, 00 32, 00 32, 00 32, 00 32, 00 32, 00 33, 00 34,						1
31.00 Primary payer payments 3.00 Subtotal (line 30 minus line 31) 32.00 Subtotal (soe instructions) 33.00 Subtotal (soe instructions) 33.00 Subtotal (soe instructions) 33.00 Subtotal (soe instructions) 33.976, 688 35.00 Subtotal (soe instructions) 33.976, 688 37.00 Subtotal (soe instructions) 33.976, 788 37.00 Subtotal (soe instructions) 33.976, 788 37.00 Subtotal (soe instructions) 33.976, 788 39.00 Subtotal (soe instructions) 39.00 Subtotal (soe instructions) 39.00 Subtotal (soe instructions) 39.97 Subtotal (1
32.00		,				ı
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34.00		ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	CES)			
35.00 Adj usted reimbursable bad debts (see instructions) 1, 210, 689 35.00 36.00 All owable bad debts for dual eligible beneficiaries (see instructions) 1, 004, 601 36.00 37.00 Subtotal (see instructions) 33, 976, 768 37.00 38.00 MSP-LCC reconciliation amount from PS&R -490 38.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPEIFY) 0 39.00 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.50 Partial or full credits received from manufacturers for replaced devices (see instructions) 61, 687 39.98 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 40.00 Subtotal (see instructions) 679, 545 40.00 40.01 50.00 40.02 41.00 1nterim payment adjustment amount after sequestration 679, 545 40.00 41.00 1nterim payment adjustment amount after sequestration 679, 545 40.00 41.00 1nterim payment adjustment (see instructions) 30.99 41.00 41	33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0	33. 00
36. 00	34.00	Allowable bad debts (see instructions)			1, 862, 599	34. 00
33, 976, 768 37, 00 38, 00 MSP-LCC reconciliation amount from PS&R -490 38, 00 39, 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 9, 00 9, 00 9, 00 9, 00 93, 00 9, 00 93, 00 9, 00 93, 00 9, 00 93, 00 9, 00 93, 00 9, 00 9, 00 93, 00 9, 00 9, 00 9, 00 9, 00 93, 00 9, 00 0, 00 9, 00 9, 00 0, 00 9, 00 0, 00 9, 00 0, 00	35.00	Adjusted reimbursable bad debts (see instructions)			1, 210, 689	35. 00
38.00 MSP-LCC reconciliation amount from PS&R -490 38.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.00 39.97 Demonstration payment adjustment amount before sequestration 0 39.97 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 61,687 39.98 39.99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 40.01 Subtotal (see instructions) 33,977,258 40.00 40.02 Demonstration adjustment (see instructions) 679,545 40.01 40.02 Demonstration payment adjustment amount after sequestration 0 40.02 41.00 Interim payments 32,989,201 41.00 42.00 Tentative settlement (for contractors use only) 0 42.00 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5,240 5,240 41.5.2. TO BE COMPLETED BY CONTRACTOR 0 90.00 90.00 Original outlier amount (see instructions) 0 90.00			ructions)			1
39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.50 9.00 39.50 9.00 39.50 9.00 39.50 9.00 39.50 9.00 39.50 9.00 39.50 9.00 39.50 9.00 39.50 9.00 39.50 9.00 39.50 9.00 39.90 9.00 39.90 9.00 39.90 9.00 39.90 9.00 39.90 9.00 39.90 9.00	37. 00	Subtotal (see instructions)				1
39.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.97 Demonstration payment adjustment amount before sequestration 39.97 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.99 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.99 RECOVERY OF ACCELERATED DEPRECIATION 39.99 Subtotal (see instructions) 30.00 Subtotal (see instructions) 30.00 Subtotal (see instructions) 30.00 Demonstration adjustment (see instructions) 30.00 Demonstration payment adjustment amount after sequestration 30.00 Linterim payments 30.00 Tentative settlement (for contractors use only) 30.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5, 240 Fig. 15.2 TO BE COMPLETED BY CONTRACTOR 30.00 Original outlier amount (see instructions) 30.00 Original outlier amount (see instructions) 30.00 The rate used to calculate the Time Value of Money 30.00 Time Value of Money (see instructions) 30.00 Og3.00						1
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40.00 Subtotal (see instructions) 33, 977, 258 40.00 40.01 Sequestration adjustment (see instructions) 679, 545 40.01 40.02 Demonstration payment adjustment amount after sequestration 0 40.02 41.00 Interim payments 32, 989, 201 41.00 42.00 Tentative settlement (for contractors use only) 0 42.00 43.00 Balance due provider/program (see instructions) 308, 512 43.00 44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5, 240 5, 240 44.00 90.00 Original outlier amount (see instructions) 0 90.00 90.00 91.00 Outlier reconciliation adjustment amount (see instructions) 0 91.00 92.00 The rate used to calculate the Time Value of Money 0.00 92.00 93.00 Time Value of Money (see instructions) 0 93.00		!	ced devices (see instructi	ons)		•
40. 01 Sequestration adjustment (see instructions) 40. 02 Demonstration payment adjustment amount after sequestration 0 40. 02 41. 00 Interim payments 32, 989, 201 41. 00 42. 00 Tentative settlement (for contractors use only) 43. 00 Balance due provider/program (see instructions) 44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5, 240 44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5, 240 90. 00 Original outlier amount (see instructions) 91. 00 Outlier reconciliation adjustment amount (see instructions) 92. 00 The rate used to calculate the Time Value of Money 93. 00 Time Value of Money (see instructions) 93. 00 Time Value of Money (see instructions)					_	•
40.02 Demonstration payment adjustment amount after sequestration 0 40.02 41.00 Interim payments 32,989,201 41.00 42.00 Tentative settlement (for contractors use only) 0 42.00 43.00 Balance due provider/program (see instructions) 308,512 43.00 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5,240 44.00 90.00 Original outlier amount (see instructions) 0 90.00 91.00 Outlier reconciliation adjustment amount (see instructions) 0 91.00 92.00 The rate used to calculate the Time Value of Money 0.00 92.00 93.00 Time Value of Money (see instructions) 0 93.00						1
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42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5, 240 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 94.00 Value of Money (see instructions) 95.00 Outlier reconciliation adjustment amount (see instructions) 96.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions) 98.00 Outlier reconciliation adjustment amount (see instructions) 99.00 Outlier reconciliation adjustment amount (see instructions)						•
43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5,240 44.00 \$\frac{\fra		' '				1
44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 95.240 Outlier 1, 5, 240					1	
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TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 95.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions)	- 00		ISS WITH SMS FUD. 13-2, CIN	aptor I,	5, 240	1 00
90.00Original outlier amount (see instructions)090.0091.00Outlier reconciliation adjustment amount (see instructions)091.0092.00The rate used to calculate the Time Value of Money0.0092.0093.00Time Value of Money (see instructions)093.00						
91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 91.00 92.00 93.00 Time Value of Money (see instructions)	90. 00				0	90.00
92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0.00 92.00 0.00 93.00		,				•
93.00 Time Value of Money (see instructions) 0 93.00		· · · · · · · · · · · · · · · · · · ·				
	94.00				0	94.00

Health Financial Systems	BALL MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Peri od:	Worksheet E
	Component CCN: 15-T089	From 01/01/2017 To 12/31/2017	Date/Time Prepared:
			5/24/2018 5:05 pm
	Ti tla YVIII	Subprovi der -	DDC

Name			Title XVIII	Subprovi der – I RF	PPS	
Natl B - MBDICAL AND OTHER REALTH SERVICES 100 Model and other services (see instructions) 156 1 00 Model and other services (see instructions) 156 1 00 2 00				INI	1.00	
Modical and other services (see Instructions) 156 1,00 1,		PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
0 0PPS payments	1.00				156	1. 00
Duti in Payment (See Instructions)			tions)			
0.01 content						
Enter the hospital specific payment to cost ratio (see instructions) 0.000 5.00						
		,	ctions)		0. 000	
Transitional corridor payment (see instructions) 8.00						
Ancil lary service other pass through costs from Wist. D. Pt. IV, col. 13, line 200 0, 9, 00						
0.00 Organ acquist from 0.10 0.00			IV col 13 line 200			
Total cost (sun of lines 1 and 10) (see instructions) 150 11.00			1 v, cor. 13, 1111e 200			
Reasonable charges 12.00 Another preserving 12.00 Another preser		1 9 1			156	
12.00 Ancil lary service charges 666 12.00 13.00 13.00 14.00 15.00 1						
13.00 Organ acquisition charges (From West. D -4, Pt. III, col. 4, line 69)	12 00				044	12.00
14.00 Total reasonable charges (sum of lines 12 and 13) 15.00 Aggregate amount actually collected from patients Itale for payment for services on a charge basis 0 15.00 Aggregate amount actually collected from patients Itale for payment for services on a chargebasis 0 16.00 Amounts that would have been real ized from patients Itale for payment for services on a chargebasis 0 16.00 Amounts that would have been real ized from patients Itale for payment for services on a chargebasis 0 16.00 Amounts 1			ne 69)			•
15.00 Aggregate amount actually collected from patients Iable for payment for services on a charge basis 0 16.00 Abouts that would have been realized from patients Iable for payment for services on a chargebasis 0 16.00 Abouts that would have been realized from patients Iable for payment for services on a chargebasis 0 16.00 Abouts that would have been realized from patients Iable for payment for services on a chargebasis 0 16.00 Abouts that would have been realized from patients 16.00 16.00 About for Illina 16.00			07)			
16.00		Customary charges				
had such payment been made in accordance with 42 CFR \$413.13(e)*						
17.00 Ratio of line 15 to line 16 (not to exceed 1.000000) 0.000000 17.00	16.00			n a cnargebasis	١	16.00
18.00 Total customary charges (see instructions) 866 18.00 19.00 1	17. 00		2)		0. 000000	17. 00
instructions 20.00	18. 00				866	18. 00
20. 00 Excess of reasonable cost over customarry charges (complete only if line 11 exceeds line 18) (see 0 20. 00 15. 0	19. 00		y if line 18 exceeds li	ne 11) (see	710	19. 00
instructions 156 21. 00	20 00		ly if line 11 exceeds li	na 18) (saa		20 00
1.00 Lesser of cost or charges (see instructions) 156 21.00 22.00 1	20.00		Ty IT TITLE IT EXCEEDS IT	10) (366	Ĭ	20.00
23. 00 Cost of physicians' services in a teaching hospital (see instructions) 0 23. 00 24. 00 COMPUTATION OF REIMBURSEMENT SETILEMENT 0 24. 00 COMPUTATION OF REIMBURSEMENT SETILEMENT 0 25. 00 Deductibles and coinsurance (for CAH, see instructions) 0 26. 00 26. 00 26. 00 26. 00 26. 00 Deductibles and coinsurance relating to amount on line 24 (for CAH, see instructions) 0 26. 00 26. 00 27. 00 Subtotal ([(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see 156 27. 00 157 157 158	21. 00				156	21. 00
Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) 24.00		1				
COMPUTATION OF RELIBIDIRSEMENT SETTLEMENT Deductibles and coinsurance (for CAH, see instructions) Deductibles and coinsurance (for CAH, see instructions) O 25.00			ructions)			
25.00 Deductible and coinsurance (for CAH, see instructions) 0 25.00	24.00				- 0	24.00
27.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	25.00				0	25. 00
Instructions						
28.00 Direct graduate medical education payments (From Wkst. E-4, line 50) 28.00 ESRD direct medical education costs (From Wkst. E-4, line 36) 29.00	27. 00		olus the sum of lines 22	and 23] (see	156	27. 00
29.00 ESRD direct medical education costs (from Wkst. E-4, line 36) 0 29.00 30.00 Subtotal (sum of lines 27 through 29) 156 30.00 30.00 Subtotal (sum of lines 27 through 29) 156 30.00 31.0	28. 00		ne 50)		0	28. 00
31.00 Primary payer payments 0 31.00 Subtotal (line 30 minus line 31) 156 32.00 ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 32.00 ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 33.00 Composite rate ESRD (from Wkst. 1-5, line 11) 0 33.00 34.00 All lowable bad debts (see instructions) 0 34.00 All lowable bad debts (see instructions) 0 35.00 Adjusted reimbursable bad debts (see instructions) 0 36.00 All lowable bad debts for dual eligible beneficiaries (see instructions) 156 37.00 Subtotal (see instructions) 156 37.00 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 MSP-LCC reconciliation amount from PS&R 0 39.00 99.00			,		o	
Subtotal (ine 30 minus line 31)		,				
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 33.00						
33.00 Composite rate ESRD (from Wkst. I-5, line 11) 33.00 Allowable bad debts (see instructions) 0 34.00 35.00 Adjusted reimbursable bad debts (see instructions) 0 35.00 Adjusted reimbursable bad debts (see instructions) 0 36.00 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 156 37.00 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.90 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.50 99.90 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.97 Other ACO demonstration payment adjustment (see instructions) 0 39.97 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.98 40.00 Subtotal (see instructions) 156 40.00 40.01 Sequestration adjustment (see instructions) 156 40.00 40.01 Sequestration adjustment (see instructions) 3 40.01 40.02 Demonstration payment adjustment amount after sequestration 41.00 Interim payments 41.00 41.00 Interim payments 41.00 42.00 Tentative settlement (for contractors use only) 41.00 Frotested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 43.00 44.00 Frotested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 44.00 44.00 Frotested amounts (see instructions) 0 90.00	32.00		CFS)		150	32.00
35.00 Adjusted reimbursable bad debts (see instructions) 0 35.00 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 0 36.00 37.00 Subtotal (see instructions) 156 37.00 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPEIFY) 0 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.97 Demonstration payment adjustment amount before sequestration 99.97 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.98 99.98 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 40.00 Subtotal (see instructions) 156 40.00	33. 00		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		0	33. 00
36. 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 0 36. 00 37. 00 Subtotal (see instructions) 156 37. 00 38. 00 MSP-LCC reconciliation amount from PS&R 0 38. 00 39. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39. 00 39. 50 Pioneer ACO demonstration payment adjustment (see instructions) 39. 50 39. 97 Demonstration payment adjustment amount before sequestration 0 39. 97 39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39. 97 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 0 39. 98 40. 01 Sequestration adjustment (see instructions) 156 40. 00 40. 02 Demonstration payment adjustment amount after sequestration 0 40. 01 40. 02 Interim payments 170 41. 00 42. 00 Tentative settlement (for contractors use only) 42. 00 43. 00 Bal ance due provi der/program (see instructions) -17 43. 00 44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 10 44. 00		,				
37.00 Subtotal (see instructions) 156 37.00 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.50 39.50 39.97 Pioneer ACO demonstration payment adjustment (see instructions) 0 39.97 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.99 40.00 Subtotal (see instructions) 156 40.00 40.00 40.01 Sequestration adjustment (see instructions) 3 40.01 40.02 Demonstration payment adjustment amount after sequestration 0 40.02 40.00 1		, , , , , , , , , , , , , , , , , , , ,				
38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.50 39.97 Demonstration payment adjustment amount before sequestration 0 39.97 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.99 40.01 Sequestration adjustment (see instructions) 0 39.99 40.01 Sequestration adjustment (see instructions) 3 40.01 40.02 Demonstration payment adjustment amount after sequestration 0 40.01 40.02 Demonstration payment adjustment amount after sequestration 0 40.01 40.02 Interim payments 170 41.00 42.00 Tentative settlement (for contractors use only) 0 42.00 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 §115.2 TO BE COMPLETED BY CONTRACTOR 0 40.00 91.00 Outlier reconciliation adjustment amount (see instructions) 0 91.0		· ·	ructions)			
39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.50 39.00 39.50 91 oneer ACO demonstration payment adjustment (see instructions) 39.50 39.50 39.97 39.98 39.99 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.98 39.99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 40.00 Subtotal (see instructions) 156 40.00 40.01 Sequestration adjustment (see instructions) 156 40.00 40.01 Demonstration payment adjustment amount after sequestration 0 40.02 41.00 Interim payments 170 41.00 42.00 43.00 Bal ance due provider/program (see instructions) -17 43.00 44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 10 BE COMPLETED BY CONTRACTOR 90.00 The rate used to calculate the Time Value of Money (see instructions) 0 93.00 93.00 Time Value of Money (see instructions) 0 93.00 93.00 10 10 10 10 10 10 10						
39. 97 39. 98 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 40. 00 Subtotal (see instructions) Sequestration payment adjustment amount after sequestration 40. 01 Demonstration payment (see instructions) Sequestration adjustment (see instructions) 156 40. 02 41. 00 Interim payments Tentative settlement (for contractors use only) Balance due provider/program (see instructions) 42. 00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 1, 00 Second Time Value of Money (see instructions) 90. 00 Time Value of Money (see instructions) 13. 99. 97 39. 98 RECOVERY OF ACCELERATED DEPRECIATION 0 39. 98 RECOVERY OF ACCELERATED DEPRECIATION 0 39. 99 39. 99 39. 99 39. 99 15 40. 00 39. 99 39					0	
39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 40. 00 Subtotal (see instructions) 50 Sequestration adjustment (see instructions) 40. 01 Demonstration payment adjustment amount after sequestration 40. 02 Demonstration payment adjustment amount after sequestration 41. 00 Interim payments 42. 00 Tentative settlement (for contractors use only) 43. 00 Balance due provider/program (see instructions) 44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, or 44. 00 90. 00 Original outlier amount (see instructions) 91. 00 Outlier reconciliation adjustment amount (see instructions) 92. 00 The rate used to calculate the Time Value of Money 10 Subtractions 10 Sequestration adjustment amount (see instructions) 11 Option and the provider of the provider o			s)		_	
39. 99 RECOVERY OF ACCELERATED DEPRECIATION 0 39. 99 40. 00 Subtotal (see instructions) 156 40. 00 40. 01 Sequestration adjustment (see instructions) 3 40. 01 40. 02 41. 00 Interim payment adjustment amount after sequestration 0 40. 02 41. 00 Interim payments 170 41. 00 42. 00 43. 00 Balance due provider/program (see instructions) -17 43. 00 44. 00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44. 00 44. 00 45. 00			and dovines (see instruc	tions)		
40.00 Subtotal (see instructions) 156 40.00 40.01 Sequestration adjustment (see instructions) 3 40.01 40.02 40.00 40.02 41.00 41.00 41.00 41.00 41.00 42.00 42.00 43.00 44.00		· ·	Led devices (see Ilistide	ti ons)		
40.02 Demonstration payment adjustment amount after sequestration 41.00 Interim payments Tentative settlement (for contractors use only) 43.00 Bal ance due provider/program (see instructions) 44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, provided amounts (nonal lowable cost report items) 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 94.00 Og 40.00 95.00 Og 40.00 96.00 Og 90.00 97.00 Og 90.00						
41.00 Interim payments 170 41.00 42.00 42.00 43.00 Balance due provider/program (see instructions) -17 43.00 44.00 Frotested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 691.00 0 0 0 0 0 0 0 0 0						
Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 79.00 The rate used to calculate the Time Value of Money 70 Time Value of Money (see instructions) 70 To BE COMPLETED BY CONTRACTOR 71 To BE COMPLETED BY CONTRACTOR 72 To BE COMPLETED BY CONTRACTOR 73 To BE COMPLETED BY CONTRACTOR 74 To BE COMPLETED BY CONTRACTOR 75 To BE COMPLETED BY CONTRACTOR 76 To BE COMPLETED BY CONTRACTOR 77 To BE COMPLETED BY CONTRACTOR 78 To BE COMPLETED BY CONTRACTOR 79 To BE COMPLETED BY C		, , , ,				
43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions)						
\$115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 0 Outlier reconciliation adjustment amount (see instructions) 0 Utlier reconciliation adjustment amount (see instructions) 0 P1.00 1 The rate used to calculate the Time Value of Money 0.00 P2.00 1 Time Value of Money (see instructions) 0 P3.00		,				
TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 95.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions) 98.00 Outlier reconciliation adjustment amount (see instructions) 99.00 Outlier reconciliation adjustment amount (see instructions)	44.00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub. 15-2,	chapter 1,	o	
90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 90.00 91.00 92.00 93.00						
91. 00 Outlier reconciliation adjustment amount (see instructions) 92. 00 The rate used to calculate the Time Value of Money 93. 00 Time Value of Money (see instructions) 0 91. 00 92. 00 93. 00	90 00				0	90 00
92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0.00 92.00 93.00						
		1			0.00	92. 00
94. UU TOTAL (SUM OF LINES 91 AND 93)						
	94.00	Tiotai (sum of lines 91 and 93)		l	0	94.00

Health Financial Systems BAANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Peri od: | Worksheet E-1 | From 01/01/2017 | Part I | To 12/31/2017 | Date/Time Prepared: Provider CCN: 15-0089

				10 12/31/201/	5/24/2018 5: 05	
		Ti tl	e XVIII	Hospi tal	PPS	•
		Inpatie	nt Part A	Pai	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		79, 040, 88	9	32, 751, 201	1. 00
2.00	Interim payments payable on individual bills, either			ol	0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider				•	
3.01	ADJUSTMENTS TO PROVIDER	07/24/2017	67, 10	0 07/24/2017	238, 000	3. 01
3.02				o	o	3. 02
3.03				o	0	3. 03
3.04				ol	l ol	3. 04
3. 05				o	ol	3. 05
	Provider to Program	'	•	-		
3.50	ADJUSTMENTS TO PROGRAM			0	0	3. 50
3.51				o	0	3. 51
3.52				o	0	3. 52
3.53				o	o	3. 53
3.54				o	o	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		67, 10	o	238, 000	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		79, 107, 98	9	32, 989, 201	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER			0	0	5. 01
5.02				0	0	5. 02
5.03				0	0	5. 03
	Provider to Program					
5.50	TENTATI VE TO PROGRAM			0	0	5. 50
5. 51			1	0	0	5. 51
5.52				0	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on		1			6. 00
	the cost report. (1)		1			
6. 01	SETTLEMENT TO PROVIDER		726, 83	9	308, 512	6. 01
6.02	SETTLEMENT TO PROGRAM		1	0	0	6. 02
7.00	Total Medicare program liability (see instructions)		79, 834, 82		33, 297, 713	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
	Turn Caracteristics		0	1. 00	2. 00	
8.00	Name of Contractor					8. 00

Health Financial Systems BAANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Peri od: From 01/01/2017 To 12/31/2017 Provider CCN: 15-0089 Component CCN: 15-T089

		Title	XVIII	Subprovider - IRF	PPS	
		Inpatien	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		3, 944, 94		170	1. 00
2.00	Interim payments payable on individual bills, either			0	0	2. 00
	submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1) Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER			ol	0	3. 01
3. 02	THE STATE OF THE TREET.			o	Ö	3. 02
3.03				О	0	3. 03
3.04				0	0	3. 04
3. 05				0	0	3. 05
3. 50	Provider to Program ADJUSTMENTS TO PROGRAM		Γ	ol	0	3. 50
3. 50	ADJUSTMENTS TO PROGRAM			0	0	3. 50
3. 52				o	Ö	3. 52
3.53				O	0	3. 53
3.54				0	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3. 99
4. 00	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99)		3, 944, 94	4	170	4. 00
4.00	(transfer to Wkst. E or Wkst. E-3, line and column as		3, 944, 94	0	170	4.00
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER			0	0	5. 01
5.02				О	0	5. 02
5.03				0	0	5. 03
F F0	Provider to Program TENTATIVE TO PROGRAM				0	F F0
5. 50 5. 51	TENTATIVE TO PROGRAM			0	0	5. 50 5. 51
5. 52				o	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			Ö	Ö	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6. 00
6. 01	the cost report. (1) SETTLEMENT TO PROVIDER		24, 22	1	o	6. 01
6. 02	SETTLEMENT TO PROVIDER		24, 22	0	17	6. 02
7. 00	Total Medicare program liability (see instructions)		3, 969, 16	7	153	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
8. 00	Name of Contractor	()	1. 00	2. 00	0.00
8.00	Name of Contractor			1		8. 00

Heal th	Financial Systems BALL MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-	2552-10	
CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-0089 Period: From 01/01/2017 To 12/31/2017 From 01/01/2017 From					
		Title XVIII	Hospi tal	PPS		
				1. 00		
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS					
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION					
1.00	.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14					
2.00	2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12					
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3. 00	
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	-12			4. 00	
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5. 00	
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 I	ine 20			6. 00	
7. 00						
8.00	Calculation of the HIT incentive payment (see instructions)				8. 00	
9.00	Sequestration adjustment amount (see instructions)				9. 00	
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00	
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				1	
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00	
	Other Adjustment (specify)				31.00	
	00 Palance due provider (line 9 (or line 10) minus line 20 and line 21) (see instructions)					

32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)

30. 00 31. 00 32. 00

Health Financial Systems	BALL MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0089	Peri od: From 01/01/2017	Worksheet E-3
	Component CCN: 15-T089		Date/Time Prepared: 5/24/2018 5:05 pm
	Title XVIII	Subprovi der -	PPS
		IRF	

	IRF		
		1. 00	
4 00	PART III - MEDICARE PART A SERVICES - IRF PPS	0.000.004	4 00
1.00	Net Federal PPS Payment (see instructions)	3, 808, 034	1. 00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0. 0294	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	110, 814	3. 00
4.00	Outlier Payments	148, 712	4. 00
5. 00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	62. 51	5. 00
5. 01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	5. 01
6.00	New Teaching program adjustment. (see instructions)	0.00	6. 00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new	0.00	7.00
	teaching program" (see instructions)		
8. 00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0. 00	8. 00
9. 00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9. 00
10. 00	Average Daily Census (see instructions)	11. 435616	
11. 00	Teaching Adjustment Factor (see instructions)	0. 000000	
12. 00	Teaching Adjustment (see instructions)	0.000000	12. 00
13. 00	Total PPS Payment (see instructions)	4, 067, 560	
14. 00	Nursing and Allied Health Managed Care payments (see instruction)	4, 007, 300	
15. 00	Organ acquisition (DO NOT USE THIS LINE)	ŭ	15. 00
16. 00	Cost of physicians' services in a teaching hospital (see instructions)	0	
17. 00	Subtotal (see instructions)	4, 067, 560	
18. 00	Primary payer payments	0	18. 00
19. 00	Subtotal (line 17 less line 18).	4, 067, 560	
20. 00	Deducti bl es	21, 056	
21. 00	Subtotal (line 19 minus line 20)	4, 046, 504	
22. 00	Coinsurance	2, 632	
23. 00	Subtotal (line 21 minus line 22)	4, 043, 872	
24. 00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	7, 862	
25.00	Adjusted reimbursable bad debts (see instructions)	5, 110	
26. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)	2, 632	26. 00
27. 00	Subtotal (sum of lines 23 and 25)	4, 048, 982	27. 00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28. 00
29.00	Other pass through costs (see instructions)	1, 188	29. 00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31. 50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31. 50
31. 99	Demonstration payment adjustment amount before sequestration	0	31. 99
32.00	Total amount payable to the provider (see instructions)	4, 050, 170	32.00
32. 01	Sequestration adjustment (see instructions)	81, 003	32. 01
32. 02	Demonstration payment adjustment amount after sequestration	0	32. 02
33.00	Interim payments	3, 944, 946	
34. 00	Tentative settlement (for contractor use only)	0	34.00
35. 00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	24, 221	
36. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	26, 656	36. 00
	§115. 2 TO BE COMPLETED BY CONTRACTOR		
50 00	Original outlier amount from Wkst. E-3, Pt. III, line 4	148, 712	50. 00
51.00	Outlier reconciliation adjustment amount (see instructions)	140, 712	51. 00
52. 00	The rate used to calculate the Time Value of Money		52. 00
	Time Value of Money (see instructions)		53. 00
	1	۰۱	

1FDI CΔ	Financial Systems GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provi der Co		Peri od:	u of Form CMS-2 Worksheet E-4	
ILDI OF	AL EDUCATION COSTS			From 01/01/2017 To 12/31/2017	Date/Time Pre	oared:
			20011		5/24/2018 5:0	5 pm
		litle	XVIII	Hospi tal	PPS	
					1. 00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT					
. 00	Unweighted resident FTE count for allopathic and osteopathic ending on or before December 31, 1996.	programs for	cost reporti	ng periods	57. 92	1. 00
00	Unweighted FTE resident cap add-on for new programs per 42 CF		(1) (see instr	uctions)	0.00	2. 0
00 01	Amount of reduction to Direct GME cap under section 422 of MN Direct GME cap reduction amount under ACA §5503 in accordance		8 §413.79 (m).	(see	0. 00 0. 00	3. 0 3. 0
00	instructions for cost reporting periods straddling 7/1/2011) Adjustment (plus or minus) to the FTE cap for allopathic and		programs due	to a Medicare	0. 00	4. 0
. 01	GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f) ACA Section 5503 increase to the Direct GME FTE Cap (see inst		cost reporti	ng periods	12. 00	4. 0°
. 02	straddling 7/1/2011) ACA Section 5506 number of additional direct GME FTE cap slot periods straddling 7/1/2011)	ts (see inst	ructions for	cost reporting	0. 00	4. 0
5. 00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 pl 4.02 plus applicable subscripts	us or minus	line 4 plus l	ines 4.01 and	69. 92	5. 00
. 00	Unweighted resident FTE count for allopathic and osteopathic records (see instructions)	programs for	the current	year from your	63. 57	6. 00
. 00	Enter the lesser of line 5 or line 6				63. 57	7. 00
			Primary Care		Total	
. 00	Weighted FTE count for physicians in an allopathic and osteop	oathi c	1. 00 53. 3	2. 00	3. 00 63. 32	8. 00
00	program for the current year. If line 6 is less than 5 enter the amount from line 8, otherw		53. 3			9. 0
	multiply line 8 times the result of line 5 divided by the amo	ount on line				
0. 00	Weighted dental and podiatric resident FTE count for the curr	,		0.00		10. 0
0. 01	Unweighted dental and podiatric resident FTE count for the cu	ırrent year	F2 2	0.00		10.0
1. 00 2. 00	Total weighted FTE count Total weighted resident FTE count for the prior cost reportir instructions)	ng year (see	53. 3 54. 2			11. 0 12. 0
3. 00	Total weighted resident FTE count for the penultimate cost revear (see instructions)	eporti ng	52.0	10. 49		13. 0
4. 00	Rolling average FTE count (sum of lines 11 through 13 divided	d by 3).	53. 1	9 10. 16		14. 0
5. 00	Adjustment for residents in initial years of new programs		0.0			15. 0
5. 01	Unweighted adjustment for residents in initial years of new p		0.0			15. 0
6. 00 6. 01	Adjustment for residents displaced by program or hospital clounweighted adjustment for residents displaced by program or h		0. 0 0. 0			16. 0 16. 0
7. 00	closure Adjusted rolling average FTE count		53. 1	9 10. 16		17. 00
8. 00	Per resident amount		100, 560. 7			18. 00
9. 00	Approved amount for resident costs		5, 348, 82	967, 458	6, 316, 285	19. 0
					1 00	
0. 00	Additional unweighted allopathic and osteopathic direct GME F Sec. 413.79(c)(4)	TE resident	cap slots rec	eived under 42	1.00	20. 0
	Direct GME FTE unweighted resident count over cap (see instru	uctions)			0. 00	21. 0
1. 00	Allowable additional direct GME FTE Resident Count (see instr				0. 00	
	Allowable additional direct GME FIE Resident Count (see Insti		structions)		99, 073. 51	23. 0
2. 00 3. 00	Enter the locally adjustment national average per resident am	nount (see in				24. 0
2. 00 3. 00 4. 00	Enter the locally adjustment national average per resident an Multiply line 22 time line 23	nount (see in	,		0	25 0
2. 00 3. 00 4. 00	Enter the locally adjustment national average per resident an Multiply line 22 time line 23	nount (see in	,	t Managed care	0 6, 316, 285	25. 0
2. 00 3. 00 4. 00	Enter the locally adjustment national average per resident an Multiply line 22 time line 23	nount (see in	Inpatient Par A	t Managed care	6, 316, 285	25. 0
2. 00 3. 00 4. 00	Enter the locally adjustment national average per resident an Multiply line 22 time line 23 Total direct GME amount (sum of lines 19 and 24)	nount (see in	Inpatient Par	Managed care		25. 0
2. 00 3. 00 4. 00 5. 00	Enter the locally adjustment national average per resident an Multiply line 22 time line 23	nount (see in	Inpatient Par A	2.00	6, 316, 285	
2. 00 3. 00 4. 00 5. 00	Enter the locally adjustment national average per resident an Multiply line 22 time line 23 Total direct GME amount (sum of lines 19 and 24) COMPUTATION OF PROGRAM PATIENT LOAD	nount (see in	Inpatient Par A 1.00	2. 00	6, 316, 285 3. 00	26. 00
11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00	Enter the locally adjustment national average per resident an Multiply line 22 time line 23 Total direct GME amount (sum of lines 19 and 24) COMPUTATION OF PROGRAM PATIENT LOAD Inpatient Days (see instructions) Total Inpatient Days (see instructions) Ratio of inpatient days to total inpatient days	nount (see in	Inpati ent Par A 1.00 41,88 86,21 0.48587	2. 00 2. 00 19 10, 361 3 86, 213 8 0. 120179	6, 316, 285 3. 00	26. 00 27. 00 28. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	Enter the locally adjustment national average per resident an Multiply line 22 time line 23 Total direct GME amount (sum of lines 19 and 24) COMPUTATION OF PROGRAM PATIENT LOAD Inpatient Days (see instructions) Total Inpatient Days (see instructions)	nount (see in	Inpati ent Par A 1.00 41,88 86,21	2. 00 2. 00 19 10, 361 3 86, 213 8 0. 120179	6, 316, 285 3. 00	26. 0 27. 0

111 41-	Financial Customs	JOCOL TAI	1-11-	u of Form CMS-2	2552 40		
	y .						
	AL EDUCATION COSTS	Trovider cent. 13 coo?	From 01/01/2017	Worksheet E-4			
			To 12/31/2017	Date/Time Prep 5/24/2018 5:09			
		Title XVIII	Hospi tal	PPS	о ріп		
				1. 00			
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE EDUCATION COSTS)	E XVIII ONLY (NURSING SC	HOOL AND PARAMEDI	CAL			
32.00	,	Pt. I, sum of col. 20 an	d 23, lines 74	0	32. 00		
	and 94)						
33.00			74 and 94)	3, 895, 337	33. 00		
	Ratio of direct medical education costs to total charges (line		0.000000				
	Medicare outpatient ESRD charges (see instructions)	0	35. 00 36. 00				
36. 00	00 Medicare outpatient ESRD direct medical education costs (line 34 x line 35)						
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY						
	Part A Reasonable Cost						
37. 00	1			82, 505, 179			
38. 00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)			0	38. 00		
	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	39. 00		
40. 00	1 3 1 3 1 1 3 1 1 1 1 1 1 1 1 1 1 1 1 1	44, 347					
41. 00	00 Total Part A reasonable cost (sum of lines 37 through 39 minus line 40) 82,460,832						
40.00	Part B Reasonable Cost			04 555 004			
	Reasonable cost (see instructions)			34, 555, 391			
	Primary payer payments (see instructions)			4, 677			
44. 00				34, 550, 714 117, 011, 546			
45. 00 46. 00							
	00 Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45) 00 Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)						
47.00	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PA			0. 295276	47.00		
10 00	Total program GME payment (line 31)	KI D		3, 720, 770	40 00		
	Part A Medicare GME payment (line 46 x 48) (title XVIII only)	(see instructions)		2, 622, 116			
	Part B Medicare GME payment (line 47 x 48) (title XVIII only)			1, 098, 654			
30. 00	Trait & modificate one payment (Tritle 47 x 40) (Tritle XVIII offin)	(300 111311 4011 0113)	ļ	1, 070, 054	1 30.00		

Health Financial Systems BALL MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10

Health Financial Systems

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

Worksheet G
7
7 Date/Time Prepared: 5/24/2018 5:05 pm

		General Fund	Speci fi c	Fradoumon+ Fund	DI + C I	
		deneral rana		Endowment Fund	Plant Fund	
		1.00	Purpose Fund 2.00	3. 00	4. 00	
	CURRENT ASSETS	1.00	2.00	3. 00	1 4.00	
1.00	Cash on hand in banks	171, 997, 243	0	0		
2.00	Temporary investments	0	0	0		
3.00	Notes receivable	0	0	0	0	
4.00	Accounts receivable	52, 739, 810		0	0	
5.00	Other receivable	-5, 065, 528	0	0	0	
6.00	Allowances for uncollectible notes and accounts receivable	7 020 545	0	0	0	
7. 00 8. 00	Inventory Prepaid expenses	7, 920, 545 2, 347, 532		0	0	
9. 00	Other current assets	2, 347, 332	0	0	0	
10.00	Due from other funds	0	0	0	Ö	
11. 00	Total current assets (sum of lines 1-10)	229, 939, 602	0	0	1	
	FIXED ASSETS	, , , , , , , , , , , , , , , , , , , ,				
12.00	Land	2, 924, 410	0	0	0	12. 00
13.00	Land improvements	3, 630, 983		0		
14. 00	Accumulated depreciation	-2, 940, 462		0		1
15. 00	Bui I di ngs	305, 390, 684		0	"	
16.00	Accumulated depreciation	-169, 346, 036		0	0	
17. 00	Leasehold improvements	322, 332		0	0 0	1
18. 00 19. 00	Accumulated depreciation Fixed equipment	-282, 839	0	0	0	
20. 00	Accumulated depreciation		0	0		
21. 00	Automobiles and trucks		0	0	0	
22. 00	Accumulated depreciation	0	l ő	0	Ö	
23. 00	Major movable equipment	169, 329, 616	Ō	0	Ō	
24.00	Accumul ated depreciation	-130, 889, 560		0	0	24. 00
25.00	Mi nor equi pment depreci abl e	0	0	0	0	25. 00
26. 00	Accumul ated depreciation	0	0	0	0	26. 00
27. 00	HIT designated Assets	0	0	0	0	
28. 00	Accumulated depreciation	0	0	0	0	
29. 00	Mi nor equi pment-nondepreci abl e	0	0	0		
30. 00	Total fixed assets (sum of lines 12-29)	178, 139, 128	0	0	0	30.00
31. 00	OTHER ASSETS Investments	30, 849, 824	0	0	0	31. 00
32. 00	Deposits on Leases	30, 644, 624	0	0	1	
33. 00	Due from owners/officers		0	0	0	
34. 00	Other assets	18, 919, 022	_	0	0	
35. 00	Total other assets (sum of lines 31-34)	49, 768, 846		0	Ō	
36.00	Total assets (sum of lines 11, 30, and 35)	457, 847, 576	0	0	0	36. 00
	CURRENT LIABILITIES					
37. 00	Accounts payable	17, 261, 255		0		
38. 00	Salaries, wages, and fees payable	11, 613, 164	0	0		
39. 00	Payroll taxes payable	0	0	0	0	
40.00	Notes and Loans payable (short term)	7, 717, 333	0	0	0 0	1
41. 00 42. 00	Deferred income Accelerated payments	0	0	0	U	41. 00 42. 00
43. 00	Due to other funds	6, 005, 736	0	0	0	1
44. 00	Other current liabilities	0,003,730	0	0	Ö	
45. 00	Total current liabilities (sum of lines 37 thru 44)	42, 597, 488	_	0	l .	1
	LONG TERM LIABILITIES					1
46.00	Mortgage payable	0	0	0	0	46. 00
47.00	Notes payable	69, 068, 724	0	0	0	47. 00
48.00	Unsecured Loans	0	0	0		1
49. 00	Other long term liabilities	3, 239, 474		0	1	
50.00	Total long term liabilities (sum of lines 46 thru 49)	72, 308, 198			1	
51. 00	Total liabilities (sum of lines 45 and 50)	114, 905, 686	0	0	0	51.00
E2 00	CAPITAL ACCOUNTS General fund balance	242 041 000				F2 00
52. 00 53. 00	Specific purpose fund	342, 941, 890	0			52. 00 53. 00
54. 00	Donor created - endowment fund balance - restricted		0	0		54.00
55. 00	Donor created - endowment fund balance - unrestricted			0		55. 00
56. 00	Governing body created - endowment fund balance			0		56. 00
57. 00	Plant fund balance - invested in plant			· ·	0	
58. 00	Plant fund balance - reserve for plant improvement,				Ö	
JJ. JU	replacement, and expansion					
55. 50			1	_	1	1
59. 00	Total fund balances (sum of lines 52 thru 58)	342, 941, 890	0	0	0	
		342, 941, 890 457, 847, 576		0	0	

Health Financial Systems

BALL MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10

STATEMENT OF CHANGES IN FUND BALANCES

Fund balance at end of period per balance

sheet (line 11 minus line 18)

Provider CCN: 15-0089

Peri od: Worksheet G-1 From 01/01/2017

12/31/2017 Date/Time Prepared: 5/24/2018 5:05 pm General Fund Special Purpose Fund Endowment Fund 1.00 2.00 3.00 4. 00 5. 00 1.00 Fund balances at beginning of period 315, 622, 675 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 29) 66, 249, 525 2.00 3.00 Total (sum of line 1 and line 2) 381, 872, 200 0 3.00 4.00 DONATED PP&E 5, 657 0 0 4.00 0 5.00 0 5.00 6.00 6.00 0 0 7.00 0 7.00 0 8.00 0 8.00 0 0 9.00 0 9.00 10.00 Total additions (sum of line 4-9) 5, 657 10.00 Subtotal (line 3 plus line 10) 381, 877, 857 11.00 0 11.00 UNRESTRICTED FUND BALANCE 12.00 38, 377, 863 0 12.00 13.00 PENSI ON 558, 101 13.00 14.00 ROUNDI NG 0 14.00 3 0 15.00 15.00 0 16.00 0 0 16.00 17.00 0 17.00 18.00 Total deductions (sum of lines 12-17) 38, 935, 967 18.00 Fund balance at end of period per balance 342, 941, 890 19.00 19.00 sheet (line 11 minus line 18) Endowment Fund Plant Fund 7. 00 8.00 6. 00 1.00 Fund balances at beginning of period 0 0 1.00 Net income (loss) (from Wkst. G-3, line 29) 2.00 2.00 Total (sum of line 1 and line 2) 3.00 0 0 3.00 DONATED PP&E 4.00 4.00 5.00 0 5.00 0 6.00 6.00 7.00 0 7 00 8.00 0 8.00 9.00 0 9.00 10.00 Total additions (sum of line 4-9) 0 0 10.00 0 0 11.00 Subtotal (line 3 plus line 10) 11.00 12.00 UNRESTRICTED FUND BALANCE 12.00 13.00 PENSI ON 13.00 14.00 ROUNDI NG 0 14.00 0 15.00 15.00 16.00 16.00 17.00 17.00 Total deductions (sum of lines 12-17) 18.00 18.00 0

0

0

19.00

19.00

Health Financial Systems
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0089

			10	12/31/201/	5/24/2018 5:05	pared: 5 nm
	Cost Center Description	Inpati en	t	Outpati ent	Total	у ріп
		1.00		2. 00	3. 00	
	PART I - PATIENT REVENUES	·				
	General Inpatient Routine Services					
1.00	Hospi tal	191, 205,	878		191, 205, 878	1.00
2.00	SUBPROVI DER - I PF		0		0	2.00
3.00	SUBPROVI DER - I RF	10, 783,	458		10, 783, 458	3.00
4.00	SUBPROVI DER					4.00
5.00	Swing bed - SNF		0		0	5.00
6.00	Swing bed - NF		0		0	6.00
7.00	SKILLED NURSING FACILITY					7. 00
8.00	NURSING FACILITY					8. 00
9.00	OTHER LONG TERM CARE					9. 00
10. 00	Total general inpatient care services (sum of lines 1-9)	201, 989,	336		201, 989, 336	10. 00
	Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	58, 887,	224		58, 887, 224	11. 00
12.00	CORONARY CARE UNIT		O		0	12.00
13.00	BURN INTENSIVE CARE UNIT					13.00
14.00	SURGICAL INTENSIVE CARE UNIT	14 (04	700		44 (04 700	14.00
15.00	NEONATAL INTENSIVE CARE UNIT	14, 684,			14, 684, 782	15. 00
16. 00	Total intensive care type inpatient hospital services (sum of	i nes 73, 572,	006		73, 572, 006	16. 00
17. 00	11-15) Total inpatient routine care services (sum of lines 10 and 16)	275, 561,	242		275, 561, 342	17. 00
18. 00	Ancillary services	599, 892,		500 460 270	1, 189, 360, 377	18. 00
19. 00	Outpatient services	68, 056,		220, 530, 471	288, 586, 712	19. 00
20. 00	RURAL HEALTH CLINIC	08, 030,	0	220, 330, 471	200, 300, 712	20. 00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	ol	0	21. 00
22. 00	HOME HEALTH AGENCY		٦	ĭ	Ĭ	22. 00
23. 00	AMBULANCE SERVI CES	14	761	8, 453, 149	8, 467, 910	23. 00
24. 00	CMHC	1	,	0, 100, 117	0, 10,, 7.0	24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)					25. 00
26. 00	HOSPI CE					26. 00
27. 00	OTHER (RETAIL PHARMACY)		0	6, 516, 317	6, 516, 317	27. 00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst. 943, 524,	442	824, 968, 216	1, 768, 492, 658	28.00
	G-3, line 1)					
	PART II - OPERATING EXPENSES					
29. 00	Operating expenses (per Wkst. A, column 3, line 200)			355, 573, 555		29. 00
30.00	ADD (SPECIFY)		0			30.00
31. 00			0			31.00
32. 00			0			32. 00
33. 00			0			33.00
34. 00			0			34. 00
35. 00			0	_		35. 00
36. 00	Total additions (sum of lines 30-35)			0		36. 00
37. 00	DEDUCT (SPECIFY)		0			37. 00
38. 00		•	0			38. 00
39.00			0			39. 00
40. 00 41. 00			0			40. 00 41. 00
41.00	Total deductions (sum of lines 37-41)		U			41.00
42.00	Total operating expenses (sum of lines 29 and 36 minus line 42)	(transfer		355, 573, 555		42.00
43.00	to Wkst. G-3, line 4)	(Cranster		333, 373, 333		43.00
	10 mot. 0 0, 1110 T/	ı	1	ı	ı	

Heal th	Financial Systems BALL MEMORIAL	HOSPI TAI	In lie	u of Form CMS-2	2552-10
	ENT OF REVENUES AND EXPENSES	Provi der CCN: 15-0089	Period: From 01/01/2017 To 12/31/2017	Worksheet G-3	
			12,01,201,	5/24/2018 5:0	
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, li			1, 768, 492, 658	1. 00
2.00	Less contractual allowances and discounts on patients' accou	nts		1, 368, 865, 216	2. 00
3.00	Net patient revenues (line 1 minus line 2)	>		399, 627, 442	3. 00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		355, 573, 555	
5.00	Net income from service to patients (line 3 minus line 4)			44, 053, 887	5. 00
	OTHER I NCOME				,
6.00	Contributions, donations, bequests, etc			0	
7.00	Income from investments			0	7. 00
8.00	Revenues from telephone and other miscellaneous communication	n services		0	
9.00	Revenue from television and radio service			0	9. 00
10.00	Purchase di scounts			0	10.00
11. 00	Rebates and refunds of expenses			0	11. 00
12.00	Parking lot receipts			0	12.00
13.00	Revenue from laundry and linen service			0	13. 00 14. 00
14. 00 15. 00	Revenue from meals sold to employees and guests			0	15.00
	Revenue from rental of living quarters Revenue from sale of medical and surgical supplies to other	than nationta		0	
16. 00 17. 00	Revenue from sale of drugs to other than patients	than patrents		0	16. 00 17. 00
18. 00	Revenue from sale of medical records and abstracts			-	
19. 00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	
20. 00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
21. 00	Rental of vending machines			0	
21.00	Rental of hospital space			0	21.00
23. 00	Governmental appropriations			0	23. 00
24. 00	MISCELLANEOUS INCOME			22, 195, 638	
25. 00	Total other income (sum of lines 6-24)			22, 195, 638	
26. 00	Total (line 5 plus line 25)			66, 249, 525	
27. 00	OTHER EXPENSES (SPECIFY)			00, 249, 525	27. 00
28. 00	Total other expenses (sum of line 27 and subscripts)			0	28.00
	Net income (or loss) for the period (line 26 minus line 28)			66, 249, 525	
27.00	mot modific (or 1033) for the period (time 20 millius fille 20)			00, 247, 323	27.00

PART I - FULLY PROSPECTIVE METHOD CAPITAL FEDERAL AMOUNT 1.00 Capital DRG other than outlier 1.01 Model 4 BPCI Capital DRG other than outlier 2.00 Capital DRG outlier payments 2.01 Model 4 BPCI Capital DRG outlier payments 3.00 Total inpatient days divided by number of days in the cost reporting period (see instructions) 4.00 Number of interns & residents (see instructions) 5.00 Indirect medical education percentage (see instructions) 6.00 Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1.01) (see instructions) 7.00 Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A I 30) (see instructions) 8.00 Percentage of Medicaid patient days to total days (see instructions) 9.00 Sum of lines 7 and 8 10.00 Allowable disproportionate share percentage (see instructions)	1 and	2018 5: 01 PPS .000 , 191, 242 0 40, 316 0 224. 76 61. 96 8. 09 419, 971 6. 40 24. 73	1. 00 1. 01 2. 00 2. 01 3. 00 4. 00 5. 00
PART I - FULLY PROSPECTIVE METHOD CAPITAL FEDERAL AMOUNT 1.00 Capital DRG other than outlier 1.01 Model 4 BPCI Capital DRG other than outlier 2.00 Capital DRG outlier payments 2.01 Model 4 BPCI Capital DRG outlier payments 3.00 Total inpatient days divided by number of days in the cost reporting period (see instructions) 4.00 Number of interns & residents (see instructions) 5.00 Indirect medical education percentage (see instructions) 6.00 Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1.01) (see instructions) 7.00 Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A I 30) (see instructions) 8.00 Percentage of Medicaid patient days to total days (see instructions) 9.00 Sum of lines 7 and 8 10.00 Allowable disproportionate share percentage (see instructions)	1. 5,	, 191, 242 0 40, 316 0 224. 76 61. 96 8. 09 419, 971 6. 40	1. 01 2. 00 2. 01 3. 00 4. 00 5. 00
CAPITAL FEDERAL AMOUNT 1.00 Capital DRG other than outlier Model 4 BPCI Capital DRG other than outlier Capital DRG outlier payments Model 4 BPCI Capital DRG outlier payments Total inpatient days divided by number of days in the cost reporting period (see instructions) Mumber of interns & residents (see instructions) Indirect medical education percentage (see instructions) Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1.01) (see instructions) Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A I 30) (see instructions) Percentage of Medicaid patient days to total days (see instructions) Sum of lines 7 and 8 Allowable disproportionate share percentage (see instructions)	1 and	, 191, 242 0 40, 316 0 224. 76 61. 96 8. 09 419, 971 6. 40	1. 01 2. 00 2. 01 3. 00 4. 00 5. 00
CAPITAL FEDERAL AMOUNT 1.00 Capital DRG other than outlier 1.01 Model 4 BPCI Capital DRG other than outlier 2.00 Capital DRG outlier payments Model 4 BPCI Capital DRG outlier payments 3.00 Total inpatient days divided by number of days in the cost reporting period (see instructions) 4.00 Number of interns & residents (see instructions) Indirect medical education percentage (see instructions) Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1.01) (see instructions) Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A I 30) (see instructions) Percentage of Medicaid patient days to total days (see instructions) Sum of lines 7 and 8 Allowable disproportionate share percentage (see instructions)	1 and	0 40, 316 0 224. 76 61. 96 8. 09 419, 971 6. 40	1. 0° 2. 00 2. 0° 3. 00 4. 00 5. 00
Capital DRG other than outlier Model 4 BPCI Capital DRG other than outlier Capital DRG outlier payments Model 4 BPCI Capital DRG outlier payments Total inpatient days divided by number of days in the cost reporting period (see instructions) Number of interns & residents (see instructions) Indirect medical education percentage (see instructions) Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1.01) (see instructions) Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A I 30) (see instructions) Percentage of Medicaid patient days to total days (see instructions) Sum of lines 7 and 8 Allowable disproportionate share percentage (see instructions)	1 and	0 40, 316 0 224. 76 61. 96 8. 09 419, 971 6. 40	1. 0° 2. 00 2. 0° 3. 00 4. 00 5. 00
Model 4 BPCI Capital DRG other than outlier Capital DRG outlier payments Model 4 BPCI Capital DRG outlier payments Total inpatient days divided by number of days in the cost reporting period (see instructions) Number of interns & residents (see instructions) Indirect medical education percentage (see instructions) Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1.01)(see instructions) Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A I 30) (see instructions) Percentage of Medicaid patient days to total days (see instructions) Sum of lines 7 and 8 Allowable disproportionate share percentage (see instructions)	1 and	0 40, 316 0 224. 76 61. 96 8. 09 419, 971 6. 40	1. 0° 2. 00 2. 0° 3. 00 4. 00 5. 00
Capital DRG outlier payments Model 4 BPCI Capital DRG outlier payments Total inpatient days divided by number of days in the cost reporting period (see instructions) Number of interns & residents (see instructions) Indirect medical education percentage (see instructions) Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1.01) (see instructions) Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A I 30) (see instructions) Percentage of Medicaid patient days to total days (see instructions) Sum of lines 7 and 8 Allowable disproportionate share percentage (see instructions)		40, 316 0 224. 76 61. 96 8. 09 419, 971 6. 40	2. 00 2. 0 3. 00 4. 00 5. 00
Model 4 BPCI Capital DRG outlier payments Total inpatient days divided by number of days in the cost reporting period (see instructions) Number of interns & residents (see instructions) Indirect medical education percentage (see instructions) Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1.01)(see instructions) Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A I 30) (see instructions) Percentage of Medicaid patient days to total days (see instructions) Sum of lines 7 and 8 Allowable disproportionate share percentage (see instructions)		0 224. 76 61. 96 8. 09 419, 971 6. 40	2. 0° 3. 00 4. 00 5. 00 6. 00
Total inpatient days divided by number of days in the cost reporting period (see instructions) Number of interns & residents (see instructions) Indirect medical education percentage (see instructions) Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1.01) (see instructions) Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A I 30) (see instructions) Percentage of Medicaid patient days to total days (see instructions) Sum of lines 7 and 8 Allowable disproportionate share percentage (see instructions)		224. 76 61. 96 8. 09 419, 971 6. 40	3. 00 4. 00 5. 00 6. 00
Number of interns & residents (see instructions) Indirect medical education percentage (see instructions) Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1.01) (see instructions) Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A I 30) (see instructions) Percentage of Medicaid patient days to total days (see instructions) Sum of lines 7 and 8 Allowable disproportionate share percentage (see instructions)		61. 96 8. 09 419, 971 6. 40	4. 00 5. 00 6. 00
Indirect medical education percentage (see instructions) Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1.01) (see instructions) Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A I 30) (see instructions) Percentage of Medicaid patient days to total days (see instructions) Sum of lines 7 and 8 Allowable disproportionate share percentage (see instructions)		8. 09 419, 971 6. 40	5. 00 6. 00
Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1.01) (see instructions) Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A I 30) (see instructions) Percentage of Medicaid patient days to total days (see instructions) Sum of lines 7 and 8 Allowable disproportionate share percentage (see instructions)		419, 971 6. 40	6. 00
1.01)(see instructions) Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A I 30) (see instructions) Percentage of Medicaid patient days to total days (see instructions) Sum of lines 7 and 8 10.00 Allowable disproportionate share percentage (see instructions)		6. 40	
Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A I 30) (see instructions) Percentage of Medicaid patient days to total days (see instructions) Sum of lines 7 and 8 10.00 Allowable disproportionate share percentage (see instructions)	i ne		7. 00
2.00 Sum of lines 7 and 8 10.00 Allowable disproportionate share percentage (see instructions)		24 73	
10.00 Allowable disproportionate share percentage (see instructions)		21.70	8.00
3. (31. 13	9.00
11 00 Diangapartianata ahara adiyatmant (asa inatro-t')		6. 50	
I1.00 Disproportionate share adjustment (see instructions)	•	337, 431	
12.00 Total prospective capital payments (see instructions)	5,	, 988, 960	12.00
	1.	. 00	
PART II - PAYMENT UNDER REASONABLE COST			
1.00 Program inpatient routine capital cost (see instructions)		0	1.00
2.00 Program inpatient ancillary capital cost (see instructions)		0	
3.00 Total inpatient program capital cost (line 1 plus line 2)		0	
4.00 Capital cost payment factor (see instructions)		0	
5.00 Total inpatient program capital cost (line 3 x line 4)		0	5. 00
	1.	. 00	
PART III - COMPUTATION OF EXCEPTION PAYMENTS			
1.00 Program inpatient capital costs (see instructions)	-	0	1.00
2.00 Program inpatient capital costs for extraordinary circumstances (see instructions) 3.00 Net program inpatient capital costs (line 1 minus line 2)		0	
4.00 Applicable exception percentage (see instructions)	-	0. 00	
5.00 Capital cost for comparison to payments (line 3 x line 4)		0.00	
6.00 Percentage adjustment for extraordinary circumstances (see instructions)		0. 00	
7.00 Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0.00	
3.00 Capital minimum payment level (line 5 plus line 7)		0	
2.00 Current year capital payments (from Part I, line 12, as applicable)		0	
10.00 Current year comparison of capital minimum payment level to capital payments (line 8 less line	9)	0	10.00
1.00 Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11. 00
2.00 Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00 Current year exception payment (if line 12 is positive, enter the amount on this line)		0	
4.00 Carryover of accumulated capital minimum payment level over capital payment for the following payment (if line 12 is negative, enter the amount on this line)	eri od	0	
5.00 Current year allowable operating and capital payment (see instructions)		0	15. 0
16.00 Current year operating and capital costs (see instructions)		0	
17.00 Current year exception offset amount (see instructions)	I	0	17