BALL MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 Health Financial Systems This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interF@RM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPI RES 03-31-2022 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATIONPANDI der CCN: 15-0089 Peri od: Worksheet S From 01/01/2020 Parts I-III SETTLEMENT SUMMARY 12/31/2020 Date/Time Prepared: 7/15/2021 12:59 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 7/15/2021 Time: 12:59 pm] Manually prepared cost report use only 7] If this is an amended report enter the number of times the provider resubmitted this cost report] Medicare Utilization. Enter "F" for full or "L" for low. 6. Date Received: 7. Contractor No. 10. NPR Date: Contractor]Cost Report Status 11. Contractor's Vendor Code: (1) As Submitted use only (2) Settled without Audit 8. [N] Initial Report for this Provider CCN12. [O] If line 5, column 1 is 4: Enter (3) Settled with Audit 9. [N] Final Report for this Provider CCN | number of times reopened = 0-9. (3) Settled with Audit number of times reopened = 0-9.

PART II - CERTIFICATION

(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 THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTIONS 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 01/01/2020 and ending 12/31/2020 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.

[X]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 gned) JONATHAN VANATOR

Officer or Administrator of Provider(s)

CHIEF FINANCIAL OFFICER

Title

(Dated when report is electronically signed.)

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	843, 689	-853, 750	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	-74, 834	-3		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	768, 855	-853, 753	0	0	200. 00

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to compand review the information collection is estimated 673 hours per response, including the time to review instructions, search exist 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 I 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 R 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.

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 01/01/2020 Part I Date/Time Prepared: 12/31/2020 7/15/2021 12:59 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 2401 UNIVERSITY AVENUE 1.00 PO Box: 1.00 Zip Code: 47303-3428 County: DELAWARE 2.00 City: MUNCIE State: IN 2.00 Component Name CCN CBSA Provi der Date Payment System (P. Certi fied T, 0, or N) Number Number Type V XVIII XIX 1.00 2.00 3.00 4.00 5.00 6. 00 7. 00 8. 00 Hospital and Hospital-Based Component Identification: 3.00 BALL MEMORIAL HOSPITAL 150089 34620 1 07/01/1966 N 0 3.00 Hospi tal Subprovider - IPF 4.00 4.00 5.00 Subprovider - IRF BMH PHYSICAL REHAB 15T089 34620 5 07/01/1986 N Ρ 0 5.00 Subprovider - (Other) 6.00 6.00 Swing Beds - SNF Swing Beds - NF 7.00 7.00 8.00 8.00 9.00 Hospi tal -Based SNF 9.00 10.00 Hospi tal -Based NF 10.00 Hospi tal -Based OLTC 11.00 11.00 12.00 Hospi tal -Based HHA 12.00 13.00 Separately Certified ASC 13.00 14 00 Hospi tal -Based Hospi ce 14 00 15.00 Hospital -Based Health Clinic - RHC 15.00 16.00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital-Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: To: 1.00 2, 00 20.00 Cost Reporting Period (mm/dd/yyyy) 12/31/2020 01/01/2020 20 00 21.00 Type of Control (see instructions) 21.00 1. 00 2. 00 3.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for Ν 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. 22.01 Did this hospital receive interim uncompensated care payments for this reporting period? Enter in column 1, "Y" for yes or "N" for no for the 22.01 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 N N 22.02 payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to 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. 22.03 Did this hospital receive a geographic reclassification from urban to rural N Ν 22.03 as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period 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) 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. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? N 23.00 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 Medi cai d In-State In-State Out-of Out-of Other Medi cai d Medi cai d State State HMO days Medi cai d Medi cai d Medi cai d paid days eligible days unpai d days paid days el i gi bl e npaid days 1.00 2.00 3. 00 4.00 5. 00 6.00 24.00 If this provider is an IPPS hospital, enter the 3, 297 753 66 15, 104 24.00 in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.

Health Financial Systems BALL	_ MEMORIAL H	OSPI TAL			In Lieu	of Form	m CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION		Provi der C	CN: 15-0089	Peri od:	1	Vorkshe	eet S-2	
				From 01/0 To 12/3	31/2020 I			
	In-State	In-State	Out-of	Out-of	Medi cai		021 12: ther	59 pm
	Medi cai d	Medi cai d	State	State	HMO day	s Med	li cai d	
	paid days		Medicaid spaid days	Medicaid eligible		d	lays	
		unpara day		inpai d days	i			
25.00 If this provider is an IRF, enter the in-state Me	1.00	2.00	3.00	4. 00	5. 00	81 81	. 00	25. 00
paid days in column 1, the in-state Medicaid elig] ''		Ü	2	01		25.00
unpaid days in column 2, out-of-state Medicaid da	2							
column 3, out-of-state Medicaid eligible unpaid c column 4, Medicaid HMO paid and eligible but unpa								
days in column 5.								
				Urban/Ri	ural StDa	ate of 2.0		1
26.00 Enter your standard geographic classification (no		tus at the	begi nni ng o		1	2. 0	30	26. 00
reporting period. Enter "1" for urban or "2" for		tus at tho	and of the	cost	1			27. 00
27.00 Enter your standard geographic classification (no reporting period. Enter in column 1, "1" for urba					'			27.00
the effective date of the geographic reclassifica	ition in colu	umn 2.		1	_			
35.00 If this is a sole community hospital (SCH), enter in the cost reporting period.	the number	of periods	SCH status	in effect	O			35. 00
in the cost reporting period.				Begi nı	ni ng:	Endi		
36.00 Enter applicable beginning and ending dates of SC	'U ctatue Si	ıbserint Li	no 24 for n	1. (00	2. 0	00	36. 00
periods in excess of one and enter subsequent dat		abscript ii	116 30 101 11	ulliber of				30.00
37.00 If this is a Medicare dependent hospital (MDH), e	nter the nur	mber of per	iods MDH st	atu <mark>s is in</mark>	O			37. 00
effect in the cost reporting period. 37.01 Is this hospital a former MDH that is eligible for	or the MDH to	ransi ti onal	navment in					37. 01
accordance with FY 2016 OPPS final rule? Enter "Y								07.01
38.00 If line 37 is 1, enter the beginning and ending of								38. 00
than 1, subscript this line for the number of per dates.	Tods in exce	ess or one	and enter s	ubsequent				
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				Y/		Υ/		
39.00 Does this facility qualify for the inpatient hosp	ital navment	t adiustmon	t for low v	olume N		2. C		39. 00
hospitals in accordance with 42 CFR §412.101(b) (2					' l	IN		37.00
for yes or "N" for no. Does the facility meet the								
CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in co	orullii 2 Y I	or yes or	N TOT TIO.	(See				
40.00 Is this hospital subject to the HAC program reduc					ı	N		40. 00
for no in column 1, for discharges prior to Octob column 2, for discharges on or after October 1. (s or "N" fo	rnbin				
por amin 2, rec ar sonar gos en er ar ter setezer					V	XVIII	XIX	
Prospective Payment System (PPS)-Capital					1. 00	2. 00	3. 00	
45.00 Does this facility qualify and receive Capital pa	yment for di	sproporti o	nate share	in accorda	nce wNith	Υ	Υ	45. 00
42 CFR Section §412.320? (see instructions)								47 00
46.00 Is this facility eligible for additional payment to 42 CFR §412.348(f)? If yes, complete Wkst. L,						N	N	46. 00
47.00 Is this a new hospital under 42 CFR §412.300(b) F	PS capital?	Enter "Y	for yes or	"N" for no	. N	N	N	47. 00
48.00 Is the facility electing full federal capital pay Teaching Hospitals	ment? Enter	r "Y" for y	es or "N" f	or no.	N	N	N	48. 00
56.00 Is this a hospital involved in training residents	in approved	d GME progr	ams? Enter	"Y" for ye	s or YN"	Υ		56. 00
for no in column 1. If column 1 is "Y", are you i			r subsequen	t CR), MA	GME			
payment reduction? Enter "Y" for yes or "N" for 57.00 If line 56 is yes, is this the first cost reporti			resi dents	in approve	d GMEN			57. 00
programs trained at this facility? Enter "Y" for	yes or "N"	for no in	column 1. I	f column 1	is "Y"			
did residents start training in the first month on "N" for no in column 2. If column 2 is "Y", comp								
Wkst. D, Parts III & IV and D-2, Pt. II, if appli	cabl e.							
58.00 If line 56 is yes, did this facility elect cost r CMS Pub. 15-1, chapter 21, §2148? If yes, complet		, ,	cians' serv	ices as de	fihedNin			58. 00
59.00 Are costs claimed on line 100 of Worksheet A? If			-2, Pt. I.		N			59. 00
			NAHE 413.			ass-Th		
			Y/N	Line			cation on Code	
60.00 Are you claiming nursing and allied health educat	ion (NAHE) (note for a	1. 00 nv Y	2. Y		3. 0	00	60.00
programs that meet the criteria under 42 CFR 413.								00.00
Enter "Y" for yes or "N" for no in column 1. If					- 1			
impacted by CR 11642 (or subsequent CR) NAHE MA p "Y" for yes or "N" for no in column 2.	ayment adjus	stement? E	nter		- 1			
60.01 If line 60 is yes, complete columns 2 and 3 for e	ach program.	(see	1		23. 00	1		60. 01
i nstructi ons)					1			I

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 01/01/2020 Part I Date/Time Prepared: 12/31/2020 7/15/2021 12:59 pm Y/N IME Direct GME IME Direct GME 2.00 3. 00 1.00 4.00 5. 00 61.00 Did your hospital receive FTE slots under ACA section Y 12 00 12.00 61.00 5503? Enter "Y" for yes or "N" for no in column 1. nstructions) 61.01 Enter the average number of unweighted primary care 61.01 FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care 61.02 FTE count (excluding OB/GYN, general surgery FTEs, primary care FTEs added under section 5503 of ACA) (see instructions) 61.03 Enter the base line FTE count for primary care and/pr 61.03 general surgery residents, which is used for determining compliance with the 75% test. (see instructions) 61.04 Enter the number of unweighted primary care/or surgery 61.04 allopathic and/or osteopathic FTEs in the current cost reporting period (see instructions). 61.05 Enter the difference between the baseline primary 61.05 and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA §5503 award that is being used 61.06 for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program Code Unweighted IME Unweighted Program Name FTE Count Direct GME FT Count 1. 00 2.00 3.00 4.00 61.10 Of the FTEs in line 61.05, specify each new program 0 00 0 00 61 10 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter n column 4, the direct GME FTE unweighted count. 61.20 Of the FTEs in line 61.05, specify each expanded 0.00 0.00 61.20 program specialty, if any, and the number of FTE residents for each expanded program. (see instructi<mark>o</mark>ns) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which your 62.00 hospital received HRSA PCRE funding (see instructions) Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 62.01 0.00 62.01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter 63 00 for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions) Unwei ghted Unwei ghted Ratio (col. 17 FTEs FTEs in (col. 1 + col 2)) Nonprovi der Hospi tal Si te 3. 00 1.00 Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. 64.00 Enter in column 1, if line 63 is yes, or your facility trained residents in 2.75 15.74 0. 148729 64.00 the base year period, the number of unweighted non-primary care residen FTEs attributable to rotations occurring in all nonprovider settings. in column 2 the number of unweighted non-primary care resident FTEs tha trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)

In Lieu of Form CMS-2552-10 Health Financial Systems BALL MEMORIAL HOSPITAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0089 Peri od: Worksheet S-2 From 01/01/2020 Part I Date/Time Prepared: 12/31/2020 7/15/2021 12:59 pm Program Name Program Code Unwei ghted Unwei ghted Ratio (col. (col. 3 + colFTEs 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 FAMILY MEDICINE yes, or your facility trained 1350 3. 21 21. 04 0. 132371 65.00 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 ir column 4, the number of unweighted primary care residert FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) 65.01 INTERNAL MEDICINE 11400 13.76 0. 235980 Unwei ghted Unwei ghted Ratio (col. 1 FTĔs FTEs in (col. 1 + col Hospi tal Nonprovi der 2)) Si te 2.00 1.00 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 FTEs 1.67 8.33 0. 167000 66. 00 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 1.00 2. 00 4.00 5.00 3.00 67.00 Enter in column 1, the program FAMILY MEDICINE 1350 0.404419 12.08 17.79 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) 5.67 17.65 67.01 INT MEDICINE 1400 0. 243139 67. 01 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS 70.00 Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovide ? N 70.00 Enter "Y" for yes or "N" for no. 71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most Ν 0 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprov de\frac{\psi}{2} 75.00 Enter "Y" for yes and "N" for no.

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 Period:	Worksheet S	
To 12/	/01/2020 Part I /31/2020 Date/Time P	repared:
	7/15/2021 1:	2: 59 pm
76.00 If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the	1.00 2.00 3.00 most N N O	76. 00
recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N	" for no.	70.00
Column 2: Did this facility train residents in a new teaching program in accordance with 42 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indica		
program year began during this cost reporting period. (see instructions)	te will cil	
	1.00	
Long Term Care Hospital PPS 80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	80.00
81.00 Is this a LTCH co-located within another hospital for part or all of the cost reporting perifor yes and "N" for no.	iod? Enter "Y" N	81. 00
TEFRA Providers 85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "I	N" for no. N	85. 00
86.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §4		86. 00
Enter "Y" for yes and "N" for no. 87.00 Is this hospital an extended neoplastic disease care hospital classified under section 1886	(d)(1)(B)(vi)?N	87. 00
Enter "Y" for yes or "N" for no.	V XIX	
Title V and XIX Services	. 00 2. 00	
90.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes on "N" for no in the applicable column.	rN Y	90. 00
91.00 Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	rN N	91. 00
92.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.	N	92. 00
	N N	93. 00
94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	eN N	94. 00
95.00 If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	95. 00
96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	€N N	96. 00
	0.00 N Y	97. 00 98. 00
stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column		90.00
for title V, and in column 2 for title XIX. 98.01 Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C,	N Y	98. 01
Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		70.01
98.02 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed	N Y	98. 02
costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		
98.03 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH)	N N	98. 03
reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		
98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient		98. 04
services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		
98.05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2	.N Y	98. 05
for title XIX. 98.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I	N Y	98. 06
through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		
Rural Providers	N	105 00
105.00Does this hospital qualify as a CAH? 106.00 of this facility qualifies as a CAH, has it elected the all-inclusive method of payment for	N	105. 00 106. 00
	N	107. 00
training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train L&Rs in an approved		
medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes		
or "N" for no in column 2. (see instructions) 108.00 s this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR	N	108. 00
Section §412. 113(c). Enter "Y" for yes or "N" for no.		""

Health Financial Systems BALL MEMORIAL	L HOSPITAL		In Lieu	of Form CMS	S-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der C	CN: 15-0089 PG	eriod: rom 01/01/2020 o 12/31/2020	Worksheet S Part I Date/Time F 7/15/2021 1	Prepared:
	Physi cal 1.00	Occupational 2.00	Speech 3.00	Respirator 4.00	
109.00 If this hospital qualifies as a CAH or a cost provider, and therapy services provided by outside supplier? Enter "Y" of yes or "N" for no for each therapy.	e N	N N	N N	N N	109. 00
				1. 00	
110.00Did this hospital participate in the Rural Community Hospi Demonstration)for the current cost reporting period? Enter Worksheet E, Part A, Lines 200 through 218, and Worksheet	"Y" for yes	or "N" for no.	If yes, compl	N ete	110. 00
			1.00	2. 00	
111.00 f this facility qualifies as a CAH, did it participate in Integration Project (FCHIP) demonstration for this cost re or "N" for no in column 1. If the response to column 1 is the FCHIP demo in which this CAH is participating in column Ambulance services; "B" for additional beds; and/or "C" for	eporting perio Y, enter the nn 2. Enter al	od? Enter "Y" f integration pr I that apply:	or yes ong of		111.00
		1. 00	2. 00	3. 00	
112.00Did this hospital participate in the Pennsylvania Rural He demonstration for any portion of the current cost reportir "Y" for yes or "N" for no in column 1. If column 1 is "Y" 2, the date the hospital began participating in the demons column 3, enter the date the hospital ceased participation demonstration, if applicable. Miscellaneous Cost Reporting Information	ng period? En ', enter in co stration. In				112. 00
115.00 Is this an all-inclusive rate provider? Enter "Y" for yes column 1. If column 1 is yes, enter the method used (A, B, column 2. If column 2 is "E", enter in column 3 either "93 short term hospital or "98" percent for long term care (ir psychiatric, rehabilitation and long term hospitals provided inition in CMS Pub. 15-1, chapter 22, §2208.1.	or E only) i 3" percent for ncludes	n			0115.00
116.00 s this facility classified as a referral center? Enter "Y	Y" for yes or	'N" Y			116. 00
for no. 117.00 s this facility legally-required to carry malpractice ins	surance? Enter	"Y" N			117. 00
for yes or "N" for no. 118.00 s the malpractice insurance a claims-made or occurrence p		 1 if 1			118. 00
the policy is claim-made. Enter 2 if the policy is occurred to the pol	ence.	Premi ums	Losses	Insurance	
		1. 00	2.00	3. 00	_
118.01List amounts of malpractice premiums and paid losses:		544, 287	0	3.00	0118.01
			1.00	2. 00	
118.02 Are malpractice premiums and paid losses reported in a cos Administrative and General? If yes, submit supporting sch amounts contained therein.			N and		118. 02
119. 00D0 NOT USE THIS LINE 120. 00 Is this a SCH or EACH that qualifies for the Outpatient Ho and applicable amendments? (see instructions) Enter in col Is this a rural hospital with < 100 beds that qualifies for provision in ACA §3121 and applicable amendments? (see ins for yes or "N" for no. 121. 00Did this facility incur and report costs for high cost imp	umn 1, "Y" foor or the Outpati structions) En	or yes or "N" f ent Hold Harml iter in column	or no. ess 2, "Y"	N	119. 00 120. 00 121. 00
patients? Enter "Y" for yes or "N" for no.		· ·			
122.00Does the cost report contain healthcare related taxes as a Act?Enter "Y" for yes or "N" for no in column 1. If column Worksheet A line number where these taxes are included. Transplant Center Information				5. 06	122. 00
125.00 Does this facility operate a transplant center? Enter "Y"	for yes and "	N" for no. If	yes, N		125. 00
enter certification date(s) (mm/dd/yyyy) below. 126.00 f this is a Medicare certified kidney transplant center,		tification dat	e in		126. 00
column 1 and termination date, if applicable, in column 2. 127.00 f this is a Medicare certified heart transplant center, ϵ		ification date	in		127. 00
column 1 and termination date, if applicable, in column 2. 128.00 f this is a Medicare certified liver transplant center, ϵ		ification date	in		128. 00
column 1 and termination date, if applicable, in column 2. 129.00 of this is a Medicare certified lung transplant center, er					129. 00
column 1 and termination date, if applicable, in column 2. 130.00 f this is a Medicare certified pancreas transplant center					130.00
column 1 and termination date, if applicable, in column 2.					
in column 1 and termination date, if applicable, in column 132.00 old f this is a Medicare certified islet transplant center, column 1 and termination date, if applicable, in column 2.	n 2. enter the cert				131. 00 132. 00
				I	

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION	DATA Provider Co	CN: 15-0089	In Lieu Period:	Worksheet S-	
S. T.	2	2.1. 10 0007	From 01/01/2020	Part I	
			To 12/31/2020	Date/Time Pr 7/15/2021 12	repared 2:59 pm
22 AdDamarrad and recognised			1. 00	2. 00	122.0
33.00Removed and reserved 34.00If this is an organ procurement organization (OPO),	enter the OPO numbe	r in column	1 and		133. 0 134. 0
termination date, if applicable, in column 2.	circoi tilo di o riambo	i iii corumii	i dila		101.0
All Providers					
40.00 Are there any related organization or home office c				15H059	140. C
10? Enter "Y" for yes or "N" for no in column 1. If enter in column 2 the home office chain number. (se		e costs are	claimed,		
1. 00	2. 00		3. 00		
If this facility is part of a chain organization, e		rough 143 th		ess	
of the home office and enter the home office contra	actor name and contra	ctor number.			
41.00Name: INDIANA UNIVERISTY HEALTH INC Contractor's	Name: WPS	Contract	or's Number:0810)1	141. 0
42.00Street:340 W. 10TH STREET PO Box: 43.00City: INDIANAPOLIS State:	IN	Zi p Code	: 4620	12	142. 0 143. 0
33. OUCLITY: TNDI ANAPOLIS State:	I IN	Zip code	: 4020) <u>Z</u>	143. 0
				1. 00	_
4.00Are provider based physicians' costs included in Wo	orksheet A?			Υ	144. (
E OOLE costs for ropal corvisces are alaimed or Wist A	lino 74 one +bc ==	ctc for larg	1.00 tient Y	2. 00	1 A E . (
15.00 of costs for renal services are claimed on Wkst. A, services only? Enter "Y" for yes or "N" for no in c					145. C
dialysis facility include Medicare utilization for					
for yes or "N" for no in column 2.					
16.00 Has the cost allocation methodology changed from th					146. (
for yes or "N" for no in column 1. (See CMS Pub. 15	5-2, chapter 40, §402	0) If yes, e	nter the		
approval date (mm/dd/yyyy) in column 2.					
				1. 00	
17.00Was there a change in the statistical basis? Enter				N	147. (
18.00 Was there a change in the order of allocation? Ente			_	N	148. 0
19.00Was there a change to the simplified cost finding m				N Title XIX	149. 0
	Part A 1,00	Part B 2.00	Title V 3.00		_
				1 4 ()()	1
Does this facility contain a provider that qualifie				4. 00	
Does this facility contain a provider that qualific lower of costs or charges? Enter "Y" for yes or "N"	es for an exemption f	rom the appl	ication of the	•	
lower of costs or charges? Enter "Y" for yes or "N" (See 42 CFR §413.13)	es for an exemption f ' for no for each com	rom the appl ponent for P	ication of the Part A and Part E	3.	455
lower of costs or charges? Enter "Y" for yes or "N" (See 42 CFR §413.13) 55.00Hospital	es for an exemption f 'for no for each com	rom the appl ponent for P	ication of the Part A and Part E	3. N	
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lower of costs or charges? Enter "Y" for yes or "N" (See 42 CFR §413.13) 155.00 Hospital 166.00 Subprovider - IPF 17.00 Subprovider - IRF 18.00 SUBPROVIDER 19.00 SNF 19.00 OO HOME HEALTH AGENCY 19.00 CMHC 19.00 Multicampus 19.00 Sthis hospital part of a Multicampus hospital tha "Y" for yes or "N" for no. 19.00 Name 19.00 Na	es for an exemption f for no for each com N N N N N N N Comparison of the compariso	rom the applyponent for P N N N N N N N N N S mpuses in di	ication of the Part A and Part E N N N N N N N N P Therefore CBSAS?	N N N N N N 1.00	156. (157. (158. (159. (160. (161. (
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lower of costs or charges? Enter "Y" for yes or "N" (See 42 CFR §413.13) 15.00 Hospital 16.00 Subprovider - IPF 17.00 Subprovider - IRF 18.00 SUBPROVIDER 19.00 SNF 10.00 HOME HEALTH AGENCY 11.00 CMHC 12.00 Multicampus 15.00 Is this hospital part of a Multicampus hospital tha "Y" for yes or "N" for no. 18.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) 16.00 Health Information Technology (HIT) incentive in the provider is a CAH (line 105 is "Y") and is reasonable cost incurred for the HIT assets (see in the lift is provider is a CAH and is not a meaningful user under \$1886(n)? 18.00 If this provider is a CAH and is not a meaningful user under \$1886(n)? 18.00 If this provider is a CAH and is not a meaningful user under \$1886(n)? 18.00 If this provider is a CAH and is not a meaningful user under \$1886(n)? 18.00 If this provider is a CAH and is not a meaningful user under \$1886(n)?	es for an exemption for no for each come in the solution of the second o	mpuses in di State Zi 2.00 and Reinvest r "N" for no ine 167 is " der qualify ions)	ication of the Part A and Part E N N N N N N N N N N N N N N N N N N	N N N N N N N N N N N N N N N N N N N	156. (157. (158. (159. (160. (161. (————————————————————————————————————

Health Financial Systems	BALL MEMORIAL I	HOSPI TAL	In Lieu of Form CMS-2552-10			
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDE	NTIFICATION DATA		Peri od: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Pre 7/15/2021 12:	epared:	
			Begi nni ng	Endi ng		
			1. 00	2. 00		
170.00Enter in columns 1 and 2 the EHR beginn respectively (mm/dd/yyyy)	ing date and ending o	date for the reporting p	eri od		170. 00	
			1.00	0.00		
			1. 00	2. 00		
171.00 ffline 167 is "Y", does this provider 1876 Medicare cost plans reported on Wk "N" for no in column 1. If column 1 is in column 2. (see instructions)	st. S-3, Pt. I, line	2, col. 6? Enter "Y" fo	r yes and	1, 048	171. 00	

Health Financial Systems BALL MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 15-0089 Peri od: Worksheet S-2 From 01/01/2020 Part II Date/Time Prepared: 12/31/2020 7/15/2021 12:59 pm Y/N Date 1.00 2.00 General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format COMPLETED BY ALL HOSPITALS Provider Organization and Operation Has the provider changed ownership immediately prior to the beginning of the cost reportingN 1.00 1.00 period? If yes, enter the date of the change in column 2. (see instructions) Date V/I 1.00 2.00 3.00 2.00 Has the provider terminated participation in the Medicare Program? If yes, 2.00 N enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary. 3 00 Is the provider involved in business transactions, including managemen 3 00 contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? instructions) Y/N Date Type 1 00 2 00 3 00 Financial Data and Reports 4.00 Column 1: Were the financial statements prepared by a Certified Public Α 02/25/2021 4.00 Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues different from those 5.00 on the filed financial statements? If yes, submit reconciliation. Y/N Legal Oper 2.00 1.00 Approved Educational Activities 6.00 Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider s the N 6.00 legal operator of the program? 7.00 Are costs claimed for Allied Health Programs? If "Y" see instructions. 7.00 8.00 Were nursing school and/or allied health programs approved and/or renewed during the cost N 8.00 reporting period? If yes, see instructions. 9.00 Are costs claimed for Interns and Residents in an approved graduate medical education Υ 9.00 program in the current cost report? If yes, see instructions. Was an approved Intern and Resident GME program initiated or renewed in the current N 10.00 10.00 cost reporting period? If yes, see instructions. 11.00 Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching N 11.00 Program on Worksheet A? If yes, see instructions. Y/N 1.00 Bad Debts 12.00 Is the provider seeking reimbursement for bad debts? If yes, see instructions. 12.00 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period♡ 13.00 13.00 yes, submit copy. Iffline 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions. 14.00 Bed Complement 15.00 Did total beds available change from the prior cost reporting period? If yes, see instructions Υ 15<u>. 00</u> Part A Part B Y/N Date Y/N Date 1 00 2 00 3 00 4 00 PS&R Data 16.00 Was the cost report prepared using the PS&R Report only? If N N 16.00 either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see instructions) 17.00 Was the cost report prepared using the PS&R Report for tdtals 04/02/2021 Υ 04/02/2021 17.00 and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) 18.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not N 18.00 included on the PS&R Report used to file this cost report? If yes, see instructions. 19.00 If line 16 or 17 is yes, were adjustments made to PS&R Report Ν 19.00 data for corrections of other PS&R Report information? In yes, see instructions.

yes, see instructions 25.00 Have there been new capitalized leases entered into during the cost reporting period? If yes, see N 25.00 26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see N 26.00 27.00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy. N 27.00 28.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, submit copy. N 27.00 29.00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treatedN 28.00 29.00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treatedN 29.00 29.00 Has satisfing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions. N 30.00 20.00 Have changes or new agreements occurred in patient care services furnished through contractual N 31.00 20.00 Have changes or new agreements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions. 27.00 21.10 Are services furnished at the provider facility under an arrangement with provider-based physicians? If Y Yes, see instructions. 27.00 21.10 Are services furnished at the provider facility under an arrangement with the provider-based N 35.00 22.00 Home Office Costs 1.00 2.00 23.00 If line 36 is yes, were there new agreements or amended existing agreements with the provider-based N 35.00 23.00 If line 36 is yes, has a home office cost statement been prepared by the home office If Y Yes, see instructions. Y/N Date 1.00 2.00 23.00 If line 36 is yes, has a home office cost statement been prepared by the home office If Y 36.00 24.00 If line 36 is yes, as a home office cost statement been prepared by the home office If Y 36.00 25.00 If line 36 is yes, as a home office cost statement been prepared by the home office If Yes, see	Heal th	Financial Systems BALL MEMORIAL	. HOSPI TAL		In Lieu	of Form CM	S-2552-10		
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yes, see instructions. 38.00 If line 36 is yes, was the fiscal year end of the home office different from that of the N 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 Y 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 Enter the first name, last name and the title/position here RHONDA by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report preparer HEALTH 42.00 Enter the telephone number and email address of the cost 317-962-1093 RUTTER@IUHEALTH. ORG 43.00	36.00	Were home office costs claimed on the cost report?		h			36.00		
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 Y 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see Y 40.00 If line 36 is yes, did the provider render services to other chain components? If yes, see Y 40.00 If line 36 is yes, did the provider render services to other chain components? If yes, see Y 40.00 If line 36 is yes, did the provider render services to other chain components? If yes, see Y 40.00 If line 36 is yes, did the provider render services to other chain components? If yes, see Y 40.00 If line 36 is yes, did the provider render services to other chain components? If yes, see Y 40.00 If line 36 is yes, did the provider render services to other chain components? If yes, see Y 40.00 If line 36 is yes, did the provider render services to other chain components? If yes, see Y 40.00 If line 36 is yes, did the provider render services to other chain components? If yes, see Y 40.00 If line 36 is yes, did the provider render services to other chain components? If yes, see Y 40.00 If line 36 is yes, did the provider render services to other chain components? If yes, see Y 40.00 If line 36 is yes, did the provider render services to other chain components? If yes, see Y 40.00 If line 36 is yes, did the provider render services to other chain components? If yes, see Y 40.00 If line 36 is yes, did the provider services to other chain components? If yes, see Y 41.00 If line 36 i		yes, see instructions.							
instructions. 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 Cost Report Preparer Contact Information 41.00 Enter the first name, last name and the title/position heRMONDA by the cost report preparer in columns 1, 2, and 3, respectively. 42.00 Enter the employer/company name of the cost report preparety. HEALTH 42.00 Enter the telephone number and email address of the cost 317-962-1093 RUTTER@IUHEALTH. ORG 43.00		provider? If yes, enter in column 2 the fiscal year end of	the home of	fi ce.					
instructions. Cost Report Preparer Contact Information In 00 Cost Report Preparer Contact Information Enter the first name, last name and the title/position helder the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report preparety. HEALTH 42.00 Enter the telephone number and email address of the cost 317-962-1093 RUTTER@IUHEALTH. ORG 43.00		instructions.			´ `		40.00		
Cost Report Preparer Contact Information 41.00 Enter the first name, last name and the title/position heredondal by the cost report preparer in columns 1, 2, and 3, respectively. 42.00 Enter the employer/company name of the cost report prepared by HEALTH 43.00 Enter the telephone number and email address of the cost 317-962-1093 RUTTER@IUHEALTH. ORG 43.00									
41.00 Enter the first name, last name and the title/position heRbONDA by the cost report preparer in columns 1, 2, and 3, respectively. 42.00 Enter the employer/company name of the cost report preparbb. HEALTH 43.00 Enter the telephone number and email address of the cost 317-962-1093 RUTTER@IUHEALTH. ORG 43.00			1.	00	2.	00			
by the cost report preparer in columns 1, 2, and 3, respectively. 42.00 Enter the employer/company name of the cost report prepared HEALTH 43.00 Enter the telephone number and email address of the cost 317-962-1093 RUTTER@IUHEALTH. ORG 43.00			NIJONID A		LITTED		41.00		
42.00 Enter the employer/company name of the cost report prepared. HEALTH 43.00 Enter the telephone number and email address of the cost 317-962-1093 RUTTER@IUHEALTH. ORG 43.00	41.00	by the cost report preparer in columns 1, 2, and 3,	KIBUNDA		UTTER		41.00		
		Enter the employer/company name of the cost report prepare					42. 00		
			317-962-1093		RUTTER@I UHEALT	H. ORG	43. 00		

Health Financial Systems	BALL MEMORIA	In Lieu	In Lieu of Form CMS-2552-10			
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMEN	IT QUESTI ONNAI RE	Provi der CCN: 15-0089	Peri od:	Worksheet S-2		
			From 01/01/2020 To 12/31/2020	Part II Date/Time Pre	narod:	
			10 12/31/2020	7/15/2021 12:	59 pm	
		3. 00				
Cost Report Preparer Contact Information						
41.00 Enter the first name, last name and the	title/position he	DURECTOR, GOVERNMENT PROC	GRAN <mark>I</mark> S		41.00	
by the cost report preparer in columns	1, 2, and 3,					
respecti vel y.						
42.00 Enter the employer/company name of the	cost report prepar	er.			42.00	
43.00 Enter the telephone number and email ad	dress of the cost				43.00	
report preparer in columns 1 and 2, res	pecti vel y.					

Health Financial Systems BALL MEM HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA BALL MEMORIAL HOSPITAL

Period: Worksheet S-3
From 01/01/2020 Part I Provi der CCN: 15-0089

				Ţ	o 12/31/2020	Date/Time Pre 7/15/2021 12:	
						// Days / 0/P	
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
	oomponon:	Line Number	No. or bods	Avai I abl e	oran nour s	11 110 1	
		1.00	2.00	3.00	4. 00	5. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 an					0.00	1.00
	exclude Swing Bed, Observation Bed and Hosp		1	,2,202	0.00	Ü	
	days) (see instructions for col. 2 for the						
	portion of LDP room available beds)						
2.00	HMO and other (see instructions)	İ			i		2.00
3.00	HMO IPF Subprovider	1			i		3.00
4.00	HMO IRF Subprovider	1			i		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF				i	0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF				i	0	6.00
7.00	Total Adults and Peds. (exclude observation	n	252	92, 232	0.00	0	7. 00
	beds) (see instructions)			· ·			
8.00	INTENSIVE CARE UNIT	31.0	36	13, 176	0.00	0	8. 00
9.00	CORONARY CARE UNIT	32. 0		0	0. 00	0	9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT	İ			i		11.00
12.00	NEONATAL INTENSIVE CARE UNIT	35. 0	21	7, 686	0.00	0	12. 00
13.00	NURSERY	43. 0	o		1	0	13. 00
14.00	Total (see instructions)		309	113, 094	0.00	0	14. 00
15.00	CAH visits				1	0	15. 00
16.00	SUBPROVI DER - I PF	40. 0	o c	0	i i	0	16. 00
17.00	SUBPROVIDER - IRF	41. 0	16	5, 856		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
	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)	30. 0	O				24. 10
25.00	CMHC - CMHC						25. 00
	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 0				0	
	Total (sum of lines 14-26)	1	325	5			27. 00
28. 00	Observation Bed Days	1				0	
29. 00	Ambulance Trips	1					29. 00
30.00	Employee discount days (see instruction)						30.00
	Employee discount days - IRF						31. 00
	Labor & delivery days (see instructions)		8	2, 928			32.00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
	LTCH non-covered days						33.00
33. 01	LTCH site neutral days and discharges	I	1	l	I I		33. 01

					0 12/31/2020	7/15/2021 12:	
		I/P Days	/ O/P Visits	/ Tri ps	Full Time I	Equi val ents	J piii
	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 an	d 8 25, 550	1, 992	60, 983			1. 00
	exclude Swing Bed, Observation Bed and Hosp	i ce					
	days)(see instructions for col. 2 for the						
	portion of LDP room available beds)						
2.00	HMO and other (see instructions)	14, 998	14, 744				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	767	292				4.00
	Hospital Adults & Peds. Swing Bed SNF	0	0	C			5. 00
	Hospital Adults & Peds. Swing Bed NF		0	C			6. 00
7. 00	Total Adults and Peds. (exclude observation	25, 550	1, 992	60, 983			7. 00
	beds) (see instructions)						
	INTENSIVE CARE UNIT	4, 261	737	10, 017			8. 00
	CORONARY CARE UNIT	0	0	C			9. 00
10.00	BURN INTENSIVE CARE UNIT						10. 00
	SURGICAL INTENSIVE CARE UNIT						11. 00
	NEONATAL INTENSIVE CARE UNIT	0	392	3, 353			12. 00
	NURSERY		1, 412	2, 017			13. 00
	Total (see instructions)	29, 811	4, 533	76, 370	63. 19	1, 834. 72	
	CAH visits	0	0	C			15. 00
	SUBPROVI DER - I PF	0	0	C	0. 00		•
	SUBPROVI DER - I RF	2, 829	0	4, 489	0. 00	23. 79	
	SUBPROVI DER						18. 00
	SKILLED NURSING FACILITY						19. 00
	NURSING FACILITY						20.00
	OTHER LONG TERM CARE						21. 00
	HOME HEALTH AGENCY						22. 00
	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
	HOSPICE			010			24.00
	HOSPICE (non-distinct part)			912			24. 10
	CMHC - CMHC	-					25. 00 26. 00
	RURAL HEALTH CLINIC	0		0	0.00	0.00	
	FEDERALLY QUALIFIED HEALTH CENTER	U	0	C	0.00		
	Total (sum of lines 14-26) Observation Bed Days		166	7, 386	63. 19	1, 858. 51	27. 00 28. 00
	Ambul ance Tri ps	0	100	7, 380			29.00
	Employee discount days (see instruction)	U		0			30.00
	Employee discount days (see instruction)			0			30.00
	Labor & delivery days (see instructions)	0	53	1, 198			32.00
	Total ancillary labor & delivery room	U	55	1, 190			32. 00
JZ. U1	outpatient days (see instructions)			C			32.01
33 00	LTCH non-covered days	0					33. 00
	LTCH site neutral days and discharges	0					33. 01
55.51	i =	. 4	I			i I	

Health Financial Systems BALL MEN HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA BALL MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10

Provider CCN: 15-0089 Period: Worksheet S-3 From 01/01/2020 Part I To 12/31/2020 Date/Time Prepared:

			To	12/31/2020	Date/Time Pre 7/15/2021 12:	
	Full Time		Di sch	arges		
	Equi val ents					
Component	onpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
	11. 00	12. 00	13. 00	14. 00	15. 00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 ar		0	5, 482	519	15, 672	1. 00
exclude Swing Bed, Observation Bed and Hosp						
days)(see instructions for col. 2 for the						
portion of LDP room available beds)						
2.00 HMO and other (see instructions)			2, 491	2, 789		2.00
3.00 HMO IPF Subprovi der				0		3.00
4.00 HMO IRF Subprovi der				22		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	1					7.00
beds) (see instructions)						
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 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	5, 482	519	15, 672	14.00
15.00 CAH visits						15.00
16.00 SUBPROVI DER - I PF	0.00	0	0	0	0	16.00
17.00 SUBPROVI DER - I RF	0.00	0	209	0	341	17.00
18. 00 SUBPROVI DER						18. 00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21. 00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24. 00 HOSPI CE						24.00
24.10 HOSPICE (non-distinct part)						24. 10
25. 00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26. 00
26. 25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27.00 Total (sum of lines 14-26)	0.00					27. 00
28.00 Observation Bed Days						28. 00
29.00 Ambulance Trips						29. 00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room						32. 01
outpatient days (see instructions)						00.00
33.00 LTCH non-covered days			0			33. 00
33.01 LTCH site neutral days and discharges	1 1		0	l		33. 01

nearth Financial Systems		DALL WEWORTAL I	HUSPI IAL		III LI EL	I OI FOI III CIVIS-2	2332-10
HOSPITAL WAGE INDEX INFORMATION			Provi der (CCN: 15-0089	Peri od: From 01/01/2020 To 12/31/2020	Worksheet S-3 Part II Date/Time Pre	
						7/15/2021 12:	59 pm
	Wkst. A Line Amo	ount Reporte R ec	cl assi fi cati	Adjusted	Pai d Hours	Average Hourly	
	Number	pn	of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
		(Frank With	1/221 2 . 221	Calamiaa im	aal []	

Number Depth Dep								7/15/2021 12:	
PART 1 - 806E DATA 1.00 2.00 3.00 4.00 5.00 6.00 1.00				lmount Reporte				Average Hourly	
DART 1			Number						
Bart - Mace Bata - Mace Bata					7	l ' .			
1.00 Total sal arties (see 200.00 121,171,657 -565,337 120,666,370 3,865,689 87 31.70 1.0			1.00	2. 00	3. 00	4. 00	5. 00	6. 00	
1.00 Total salaries (see 200.00 121,171,697 -565,337 370,606,320 3,865,692 87 31.70 1.00									1
2. 00 Non-physician anesthetist Part	1. 00		200. 00	121, 171, 657	-565, 337	120, 606, 320	3, 865, 689, 87	31. 20	1.00
3.00 Non-physician anesthetist Part 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0									
4. 0. Physician-Part A – Administrative with the property of t	2. 00	Non-physician anesthetist Par	t	0	0	0	0. 00	0.00	2. 00
4. 0. Physician-Part A – Administrative with the property of t	3 00	A Non-physician anesthetist Par	+	0	0	0	0.00	0.00	3 00
4. 0 Amin in strative 1. 0 Physicians - Part A - Teaching 1. 0 Physicians - Part B for 1. 0 Physician and Mon 1. 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0.00	B	`		ĺ		0.00	0.00	0.00
4.01 Physicians - Part A - Teaching 57,350 0 57,350 0 0.0 0.00 0.00 0.00 5.00 Physician and Non	4. 00			0	0	0	0. 00	0. 00	4. 00
5.00 Physician and Mon Physician-Part B for hospital an-Part B for hospital-based RMC and FOMC 5.00 Non-physician-Part B for hospital-based RMC and FOMC 5.00 Non-physician part B for hospital-based RMC 5.00 Non-physician part B for Non-physician part B	4 01		,	E7 2E0	_	E7 2E0	2 144 00	24 75	4 01
6. Physician-Part B Non-physician-Part B For Nospi Tal-based RRC and FORC services are vices of the program of	5. 00		J	0 37, 330	0	0 0			•
nospital - based RHC and FOHC services nospital - based RHC and FOHC services nospital - based RHC and FOHC services nospital - based RHC and FOHC services nospital - based RHC and FOHC nospital - based RHC and RHC nospital - based RHC and RHC nospital - based RHC and RHC nospital - based RHC		3							
7. 00 Interms & residents (in an approved program) 7. 01 Contracted interms and approved program) 7. 01 Contracted interms and approved program approved progra	6.00			0	0	0	0. 00	0. 00	6. 00
Interns & residents (in an approved program)									
7. approved program) 7. approved program 8. color tractated interns and residents (in an approved programs) 8. color tome office and/or related on 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	7. 00		21. 00	0	4, 083, 556	4, 083, 556	137, 672. 00	29. 66	7. 00
residents (in an approved programs)		approved program)							1
8. 00 Home office and/or related one office and/or related organization personnel of Excluded area salaries (see	7. 01			0	0	0	0. 00	0.00	7. 01
Nome office and/or related organization personnel 44.00 0 0 0 0 0 0 0 0 0		` ''							
9.00 SNF 44.00 0 0 0 0 0.00 0.	8.00			0	0	0	0. 00	0.00	8.00
10.00 Excluded area salaries (see 6,440,319 1,571,756 8,012,075 230,005.35 34.83 10.00					_	_			
Instructions			44.00		0 1 571 756	0 8 012 075			
11.00 Contract labor: Direct Patient	10.00			0, 440, 317	1,371,730	0,012,073	230, 003. 33	34.03	10.00
Care Care									
12.00 Contract labor: Top level management and other management and other management and other management and other management and administrative services and administrative services and administrative services and administrative services and administrative services and administrative services and administrative services and administrative services and administrative services and administrative services and administrative services and administrative services and administrative services and administrative services and administrative services and administrative services and administrative services and administrative services and administrative services services and administrative services services and contract physicians part A - Teaching services services and services services and services services and services services and services services and services services and services services and services services services and services services and services services services and services services and services services and services services and services services services services services and services servic	11.00		t	3, 953, 614	0	3, 953, 614	60, 955. 96	64. 86	11.00
and administrative services 13.00 Contract labor: Physician-Part A - Administrative 14.00 Home office and/or related organization salaries and wage-related costs 14.01 Home office and/or related organization salaries 14.01 Home office and/or related organization salaries 15.601,005 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	12.00			0	0	0	0. 00	0.00	12. 00
13.00 Contract abor: Physician-Park 5,601,005 0 5,601,005 44,629.79 125.50 13.00 14.00 Home office and/or related organization salaries and wage-related costs 0 0 0 0 0 0 0 0 14.01 Home office and/or salaries and wage-related costs 36,955,190 0 36,955,190 991,275.91 37.28 14.00 14.02 Related organization salaries 0 0 0 0 0 0 0 0 0 15.00 Home office end Contract 0 0 0 0 0 0 0 0 0 16.01 Home office and Contract 0 0 0 0 0 0 0 0 16.01 Home office and Contract 0 0 0 0 0 0 0 0 16.01 Home office Physicians Part A - Teaching 0 0 0 0 0 0 0 0 16.02 Home office contract Physicians Part A - Teaching 0 0 0 0 0 0 0 17.00 Home office contract Physicians Part A - Teaching 0 0 0 0 0 0 0 18.00 Wage-related costs (core) (see 1 1 1 1 1 1 1 1 19.00 Wage-related costs (core) (see 1 1 1 1 1 1 1 19.00 Non-physician anesthetist Part 0 0 0 0 0 21.00 Non-physician Part A - Teaching 17,758 0 17,758 0 22.00 22.00 Physician Part A - Teaching 17,758 0 17,758 0 22.00 23.00 Physician Part A - Teaching 17,758 0 17,758 0 24.00 Wage-related costs (RHC/FOHC) 0 0 0 25.00 Interns & residents (in an approved program) 11,342,536 0 11,342,536 25.50 25.51 Home office wage-related (core) 11,342,536 0 0 25.52 Home office: Physician Part A - A A A A A A A A A			nt						
A - Admin istrative	12 00		_	F 401 00F		F 401 00F	44 620 70	125 50	12 00
14.00 Home office and/or related organization salaries and wage-related costs 36,955,190 0 36,955,190 991,275.91 37.28 14.01 14.02 Related organization salaries 36,955,190 0 36,955,190 991,275.91 37.28 14.01 14.02 Related organization salaries 0 0 0 0 0 0 0 0 0	13.00		L	5, 601, 005	0	5, 601, 005	44, 629. 79	125. 50	13.00
wage-related costs wage-related costs wage-related costs	14.00			0	0	0	0. 00	0.00	14. 00
Rel ated organization salaries 0 0 0 0 0 0 0 0 0	14 01	- C		36 955 190	0	36 955 190	991 275 91	37 28	14 01
Administrative				00, 700, 170	Ö	00, 700, 170			
Home office and Contract	15.00		-	0	0	0	0. 00	0. 00	15. 00
Physicians Part A - Teaching Home office Physicians Part A - 0 0 0 0 0 0 0 0 0	16 00			0	0	0	0.00	0.00	16 00
Home office Physicians Part A -	10.00						0.00	0.00	10.00
Home office contract Physicians 0 0 0 0 0 0 0 0 0	16. 01		-	0	0	0	0. 00	0. 00	16. 01
Part A - Teaching WAGE-RELATED COSTS	14 02		20	0			0.00	0.00	14 02
WAGE-RELATED COSTS Wage-rel ated costs (core) (see instructions) 17. 00 17. 00 18. 00 18. 00 18. 00 19.	16. 02		15	0		0	0.00	0.00	16.02
18.00 Wage-related costs (other) (see instructions) 18.00		WAGE-RELATED COSTS							
18.00 Wage-related costs (other) (see instructions) Excluded areas 2, 108, 861 0 2, 108, 861 19.00 Non-physician anesthetist Part A 21.00 Non-physician anesthetist Part B 22.00 Physician Part A - Administrative 22.01 Physician Part B 0 0 0 0 0 22.00 Wage-related costs (RHC/FQHC) 17, 758 0 0 0 0 0 0 23.00 24.00 Wage-related costs (RHC/FQHC) 11, 032, 031 approved program) 11, 032, 031 approved program 25.50 Home office wage-related (core) 25.52 Home office: Physician Part A - Administrative - Administrative - Administrative - 0 0 0 0 11, 032, 031 25.50 25.55	17. 00		e	30, 592, 370	0	30, 592, 370			17. 00
19.00 Excluded areas 2,108,861 0 2,108,861 19.00 20.00 Non-physician anesthetist Part 0 0 0 0 21.00 Non-physician anesthetist Part 0 0 0 0 0 22.00 0 0 0 0 0 0 0 0 0	18. 00		ee						18. 00
20.00 Non-physician anesthetist Part		, , ,							
A Non-physician anesthetist Part				2, 108, 861	0	2, 108, 861			19.00
B 22.00 Physician Part A - Administrative 22.01 Physician Part A - Teaching 23.00 Physician Part B 23.00 Wage-related costs (RHC/FQHC) 25.00 Interns & residents (in an approved program) 25.50 Home office wage-related (core) 25.51 Home office: Physician Part A - Administrative - wage-related	20.00	Non-physician anesthetist Pari	Ī	0	0	0			20.00
Administrative 22.01 Physician Part A - Teaching 23.00 Physician Part B 24.00 Wage-related costs (RHC/FQHC) 25.00 Interns & residents (in an approved program) 25.50 Home office wage-related (core) 26.51 Related organization 27.52 Home office: Physician Part A Administrative - wage-related	21.00	Non-physician anesthetist Par	t	0	0	0			21.00
Administrative 22.01 Physician Part A - Teaching 23.00 Physician Part B 24.00 Wage-related costs (RHC/FQHC) 25.00 Interns & residents (in an approved program) 25.50 Home office wage-related (core) 26.51 Related organization 27.52 Home office: Physician Part A Administrative - wage-related		В			_	_			
22. 01 Physician Part A - Teaching	22. 00			0	0	0			22. 00
23.00 Physician Part B 0 0 0 0 0 24.00 24.00 Wage-related costs (RHC/FQHC) 0 1 nterns & residents (in an approved program) 25.50 Home office wage-related (core) 26.51 Related organization wage-related (core) 27.52 Home office: Physician Part A - Administrative - wage-related	22. 01			17, 758	0	17, 758			22. 01
25. 00 Interns & residents (in an approved program) 1,032,031 0 1,032,031 25. 00 25. 50 Home office wage-related (core) 11,342,536 0 0 25. 51 Related organization 0 0 0 25. 52 Home office: Physician Part A - 0 0 0 Administrative - wage-related 25. 52	23.00	Physician Part B		0	0	0			23. 00
approved program) 25. 50 Home office wage-related (core) 11, 342, 536 25. 51 Related organization wage-related (core) 25. 52 Home office: Physician Part A - Administrative - wage-related				1 022 021	-	1 000 001			24.00
25. 50 Home office wage-related (core)	∠5.00			1, 032, 031	l 0	1, 032, 031			∠5.00
wage-related (core) 25.52 Home office: Physician Part A - 0 0 0 25.52 Administrative - wage-related	25. 50		e)	11, 342, 536	0	11, 342, 536			25. 50
25.52 Home office: Physician Part A - 0 0 0 25.52 Administrative - wage-related		Related organization		0	0	0			25. 51
Administrative - wage-related	25 52		_	_	_	_			25 52
	20.02								20.02

Hoal +h	Financial Systems		BALL MEMORIA	I HUSDITAI		In Lio	u of Form CMS 1	2552 10
	Financial Systems -AL WAGE INDEX INFORMATION		DALL MEMORIA			Period: From 01/01/2020	w of Form CMS-2 Worksheet S-3 Part II Date/Time Pre 7/15/2021 12:	3 epared:
		Wkst. A Line <i>l</i> Number	mount Reported	Reclassificati on of Salaries	,		Average Hourly Wage (col. 4 ÷	
				(from Wkst. A-6)	(col.2 ± col. 3)	Salaries in col. 4	col . 5)	
		1. 00	2.00	3. 00	4.00	5. 00	6.00	
25. 53	Home office: Physicians Part - Teaching - wage-related (core)	A	0	0		0		25. 53
	OVERHEAD COSTS - DIRECT SALAR	ES						
26.00	Employee Benefits Department	4. 00	36, 983	1, 540, 100	1, 577, 08	3 2, 080. 20	758. 14	26.00
27.00	Administrative & General	5. 00	10, 576, 200	-2, 089, 492	8, 486, 70	8 167, 036. 46	50. 81	27.00

	Wkst. A LineA	mount Reported	Reclassi ficati	Adjusted .	Paid Hours	Average Hourly	
	Number	·	on of Salaries	Sal ari es		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	
25.53 Home office: Physicians Part	Α	0	0	0			25. 53
- Teaching - wage-related							
(core)							
OVERHEAD COSTS - DIRECT SALAR							
26.00 Employee Benefits Department	4. 00	36, 983			2, 080. 20		
27.00 Administrative & General	5. 00	10, 576, 200	-2, 089, 492	8, 486, 708	167, 036. 46	50. 81	27. 00
28.00 Administrative & General unde	٢	144, 441	0	144, 441	652. 97	221. 21	28. 00
contract (see inst.)							
29.00 Maintenance & Repairs	6. 00	3, 288, 472	-78, 987	3, 209, 485	134, 461. 58		29. 00
30.00 Operation of Plant	7. 00		-65, 128	1, 559, 841	60, 784. 47	25. 66	30.00
31.00 Laundry & Linen Service	8. 00	0	0	0	0. 00	0.00	31.00
32. 00 Housekeepi ng	9. 00	2, 959, 065	-25, 654	2, 933, 411	196, 537. 30	14. 93	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, 744, 583	-1, 203, 963	1, 540, 620	82, 879. 80	18. 59	34.00
35.00 Dietary under contract (see		0	0	0	0. 00	0.00	35.00
i nstructi ons)							
36.00 Cafeteri a	11. 00	0	1, 183, 180	1, 183, 180	76, 448. 00	15. 48	36. 00
37.00 Maintenance of Personnel	12. 00	0	0	0	0. 00	0.00	37.00
38.00 Nursing Administration	13. 00	6, 075, 717	-238, 924	5, 836, 793	151, 274. 41	38. 58	38. 00
39.00 Central Services and Supply	14. 00	0	0	0	0. 00	0.00	39. 00
40.00 Pharmacy	15. 00	5, 528, 895	-418, 682	5, 110, 213	126, 496. 62	40. 40	40.00
41.00 Medical Records & Medical	16. 00	0	0	0	0.00	0.00	41.00
Records Li brary							
42.00 Social Service	17. 00	0	0	0	0. 00	0.00	42.00
43.00 Other General Service	18. 00	623, 885	-438	623, 447	44, 326. 28	14. 06	43.00

Heal th	Financial Systems		BALL MEMORIA	L HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPI 7	TAL WAGE INDEX INFORMATION			Provi der C		eriod: rom 01/01/2020	Worksheet S-3	
					į.		Date/Time Pre 7/15/2021 12:	
		Worksheet A	Amount Reporte	Reclassi ficati	Adj usted	Paid Hours	Average Hourly	
		Line Number		on of Salaries			Wage (col. 4 ÷	
				,	$(col.2 \pm col.$	Salaries in	col . 5)	
				Worksheet A-6)	_	col. 4		
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX							
1.00	Net salaries (see instruction	s)	121, 258, 748	-4, 648, 893	116, 609, 855	3, 726, 526. 84	31. 29	1. 00
2.00	Excluded area salaries (see		6, 440, 319	1, 571, 756	8, 012, 075	230, 005. 35	34.83	2.00
	instructions)							
3.00	Subtotal salaries (line 1 min	us	114, 818, 429	-6, 220, 649	108, 597, 780	3, 496, 521. 49	31.06	3.00
	line 2)							
4.00	Subtotal other wages & relate	d	46, 509, 809	0	46, 509, 809	1, 096, 861. 66	42. 40	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		41, 934, 906	0	41, 934, 906	0. 00	38. 61	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		203, 263, 144	-6, 220, 649	197, 042, 495	4, 593, 383. 15	42. 90	6.00
7.00	Total overhead cost (see		33, 603, 210		32, 205, 222	1, 042, 978. 09	30. 88	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: From 01/01/2020 Part IV To 12/31/2020 Date/Time Prepared:

	To 12/31/2020	Date/Time Pre 7/15/2021 12:	pared: 59 pm
		Amount	0 / p
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1. 00	401K Employer Contributions	4, 342, 598	1. 00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2. 00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	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. 02	Health Insurance (Self Funded with a Third Party Administrator)	18, 650, 054	
8. 03	Heal th Insurance (Purchased)	0	
9. 00	Prescription Drug Plan	0	9. 00
	Dental, Hearing and Vision Plan	543, 378	
	Life Insurance (If employee is owner or beneficiary)	55, 593	
	Accident Insurance (If employee is owner or beneficiary)	0	12.00
	Disability Insurance (If employee is owner or beneficiary)	720, 591	
	Long-Term Care Insurance (If employee is owner or beneficiary)	0	
	'Workers' Compensation Insurance	610, 210	
16. 00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106	Non 0	16. 00
	cumulative portion)		
	TAXES		
	FICA-Employers Portion Only	8, 725, 419	
	Medicare Taxes - Employers Portion Only	0	
	Unempl oyment I nsurance	0	. ,
20.00	State or Federal Unemployment Taxes	103, 178	20. 00
01 00	OTHER		01 00
21.00		see 0	21. 00
22.00	instructions))		00.00
	Day Care Cost and Allowances	0	00
	Tuition Reimbursement	0	
24.00	Total Wage Related cost (Sum of lines 1 -23)	33, 751, 021	∠4.00
25 00	Part B - Other than Core Related Cost		25 00
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	I	25. 00

Health Financial Systems	BALL MEMORIAL HOSPITAL	In Liou	of Form CMS-2	EE2 10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-0089		Worksheet S-3	
HOSFITAL CONTRACT LABOR AND BENEFIT COST	Frovider CCN. 13-0009		Part V	
		To 12/31/2020	Date/Time Pre	pared:
			7/15/2021 12:	59 pm
Cost Center Description		Contract Labor		
		1. 00	2. 00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital -Based Component Ident				
1.00 Total facility's contract labor and benefit	cost	3, 953, 614	33, 751, 021	1.00
2. 00 Hospi tal		3, 953, 614	33, 751, 021	2.00
3.00 Subprovi der - IPF		0	0	3. 00
4.00 Subprovi der - IRF		0	0	4.00
5.00 Subprovider - (Other)		0	0	5. 00
6.00 Swing Beds - SNF		0	0	6. 00
7.00 Swing Beds - NF		O	0	7. 00
8.00 Hospital-Based SNF				8. 00
9.00 Hospital-Based NF				9. 00
10.00 Hospital-Based OLTC				10. 00
11.00 Hospital-Based HHA				11. 00
12.00 Separately Certified ASC				12. 00
13.00 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	
18.00 Other		0	0	18. 00

	Financial Systems BALL MEMORIAL HO				of Form CMS-2	
HOSPI 1	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der (CCN: 15-0089	Period: From 01/01/2020	Worksheet S-1	10
				To 12/31/2020		epared:
					7/15/2021 12:	59 pm
					1. 00	
	Uncompensated and indigent care cost computation					
1. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 d Medicaid (see instructions for each line)	ivided by	line 202 col	umn 8)	0. 180046	1.00
2. 00	Net revenue from Medicaid				53, 395, 713	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?				Υ	3.00
4. 00	If line 3 is yes, does line 2 include all DSH and/or suppleme			li cai d?	Υ	4.00
5. 00 6. 00	If line 4 is no, then enter DSH and/or supplemental payments Medicaid charges	rrom Meai	card		0 344, 175, 577	
7. 00	Medicaid charges Medicaid cost (line 1 times line 6)				61, 967, 436	
8. 00	Difference between net revenue and costs for Medicaid program	(line 7	minus sum of	lines 2 and 5;	if < 8,571,723	•
	zero then enter zero)	,]
	Children's Health Insurance Program (CHIP) (see instructions	for each	line)		_	ļ
9.00	Net revenue from stand-alone CHIP				0	
11.00	Stand-alone CHIP charges Stand-alone CHIP cost (line 1 times line 10)				0	
	Difference between net revenue and costs for stand-alone CHIP	(Line 11	minus line 9	e if < zero the	_	
	zero)	`				
	Other state or local government indigent care program (see in	struction	s for each li	ne)]
	Net revenue from state or local indigent care program (Not in				108, 759	
	Charges for patients covered under state or local indigent ca State or local indigent care program cost (line 1 times line		m (Not includ	led in lines 6 o	r 10) 665,514 119,823	1
	Difference between net revenue and costs for state or local i		are program (line 15 minus L	· ·	
10.00	if < zero then enter zero)	nai gent e	are program i	TITIE 13 IIII III 3 I	1110 13, 11,004	10.00
	Grants, donations and total unreimbursed cost for Medicaid, C	HIP and s	tate/Local ir	idi gent care		1
	programs (see instructions for each line)					4
	Private grants, donations, or endowment income restricted to Government grants, appropriations or transfers for support of	9	,		0	
	Total unreimbursed cost for Medicaid, CHIP and state and loc			rams (sum of lin	_	•
. ,	and 16)	aa. go	oa. o p. og.	a (Sa S. 1111	00 0,0,1,002,707	'''
			Uni nsured	Insured	Total (col. 1	
			patients	pati ents	+ col . 2)	
	Uncompensated Care (see instructions for each line)		1.00	2. 00	3. 00	
20.00	Charity care charges and uninsured discounts for the entire f	acility (see 28, 691, 2	735, 373	29, 426, 624	20. OC
	i nstructi ons)					
21. 00	Cost of patients approved for charity care and uninsured disc instructions)	ounts (se	e 5, 165, 7	15 735, 373	5, 901, 118	21.00
22. 00	Payments received from patients for amounts previously writte	n off as		0 0	0	22. 00
23. 00	charity care Cost of charity care (line 21 minus line 22)		5, 165, 7	45	5, 901, 118	23. 00
					1.00	
24 00	Does the amount on line 20 column 2, include charges for pati	ont days	hovend a Lone	th of stay limi	1.00 t N	24.00
24.00	imposed on patients covered by Medicaid or other indigent car			Juli of Stay IIIII	L IV	24.00
25. 00	If line 24 is yes, enter the charges for patient days beyond limit			ıram's length of	stay 0	25. 00
26. 00	Total bad debt expense for the entire hospital complex (see i	nstructio	ns)		22, 380, 604	26.00
	Medicare reimbursable bad debts for the entire hospital compl				418, 518	•
27. 01	Medicare allowable bad debts for the entire hospital complex	•	,		643, 875	27. 01
	Non-Medicare bad debt expense (see instructions)				21, 736, 729	•
	Cost of non-Medicare and non-reimbursable Medicare bad debt e Cost of uncompensated care (line 23 column 3 plus line 29)	xpense (s	ee instructio	ons)	4, 138, 968	•
	Total unreimbursed and uncompensated care cost (line 19 plus	line 30)			10, 040, 086 18, 622, 873	•
	rotar am ormburoca and ancompensated care cost (fille 17 plus				10,022,073	1 51.00

Health Financial Systems	BALL MEMORIAL	. HOSPI TAL		In Lieu	of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provider CC	:N: 15-0089 P	eriod: rom 01/01/2020 o 12/31/2020	Worksheet A Date/Time Pre 7/15/2021 12:	epared:
Cost Center Description	Sal ari es	Other -		Reclassificati ons (See A-6)	Recl assi fi ed	59 piii
	1.00	2.00	3. 00	4. 00	5. 00	
GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT		3, 616, 672	3, 616, 672	20, 057, 477	23, 674, 149	1.00
3.00 00300 OTHER CAPITAL RELATED COSTS	24, 202	0	0	0	0	3.00
4.00 O0400 EMPLOYEE BENEFITS DEPARTMENT 5.01 O1160 COMMUNICATIONS	36, 983 511, 891	949, 188 276, 583	986, 171 788, 474	24, 475, 135 -202, 431	25, 461, 306 586, 043	4. 00 5. 01
5. 02 00550 DATA PROCESSING 5. 04 00570 ADMITTING	1 175 122	404 363	1 570 405	0 205 210	1 204 275	5. 02 5. 04
5. 05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	1, 175, 122 0	404, 363 0	1, 579, 485 0	-295, 210 0	1, 284, 275 0	5. 05
5.06 00590 OTHER ADMINISTRATIVE AND GENERAL 6.00 00600 MAINTENANCE & REPAIRS	8, 889, 187 3, 288, 472	87, 696, 222 14, 791, 748	96, 585, 409 18, 080, 220	-3, 888, 170 -7, 421, 355	92, 697, 239 10, 658, 865	5. 06 6. 00
7. 00 00700 OPERATION OF PLANT	1, 624, 969	5, 177, 684	6, 802, 653	229, 196	7, 031, 849	7. 00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG	0 2, 959, 065	0 2, 055, 865	0 5, 014, 930	1, 519, 354 -1, 540, 061	1, 519, 354 3, 474, 869	
10. 00 01000 DI ETARY	2, 744, 583	2, 696, 922	5, 441, 505	-3, 046, 702	2, 394, 803	
11. 00 O1100 CAFETERI A 13. 00 O1300 NURSI NG ADMINI STRATI ON	0 6, 075, 717	0 2, 626, 816	0 8, 702, 533	2, 174, 572 -1, 492, 257	2, 174, 572 7, 210, 276	
14.00 01400 CENTRAL SERVICES & SUPPLY	0, 073, 717	1, 218, 648	1, 218, 648	7, 642, 366	8, 861, 014	
15. 00 O1500 PHARMACY 16. 00 O1600 MEDI CAL RECORDS & LI BRARY	5, 528, 895	41, 632, 655	47, 161, 550	-40, 454, 962	6, 706, 588 0	15. 00 16. 00
18.00 01080 PATIENT TRANSPORTATION	623, 885	198, 058	821, 943	-147, 219	674, 724	18. 00
21.00 02100 1&R SERVICES-SALARY & FRINGES APPRVD 22.00 02200 1&R SERVICES-OTHER PRGM COSTS APPRVD	0 4, 268, 652	0 4, 434, 447	0 8, 703, 099	4, 083, 556 -5, 228, 130	4, 083, 556 3, 474, 969	
23.00 02300 PARAMED ED PRGM	95, 394	20, 196	115, 590	131, 723	247, 313	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	24, 629, 853	25, 795, 531	50, 425, 384	-9, 873, 814	40, 551, 570	30. 00
31.00 03100 INTENSIVE CARE UNIT	7, 075, 180	3, 593, 452	10, 668, 632	-2, 825, 766	7, 842, 866	31.00
32.00 O3200 CORONARY CARE UNIT 35.00 O2060 NEONATAL INTENSIVE CARE UNIT	0 2, 078, 487	0 2, 715, 556	0 4, 794, 043	0 -767, 923	0 4, 026, 120	32. 00 35. 00
40. 00 04000 SUBPROVI DER - PF	0	0	0	0	0	40. 00
41. 00 04100 SUBPROVI DER - IRF 43. 00 04300 NURSERY	1, 678, 532 0	683, 556 0	2, 362, 088 0	-451, 522 497, 789	1, 910, 566 497, 789	41. 00 43. 00
ANCILLARY SERVICE COST CENTERS	5 500 040	22 222 242	20 001 050			
50.00 05000 OPERATI NG ROOM 51.00 05100 RECOVERY ROOM	5, 582, 840 1, 437, 429	23, 238, 218 866, 518	28, 821, 058 2, 303, 947	-15, 554, 146 -764, 364	13, 266, 912 1, 539, 583	50. 00 51. 00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	1, 991, 175	1, 145, 698	3, 136, 873	-994, 572	2, 142, 301	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 57. 00 05700 CT SCAN	8, 893, 485 131, 417	14, 916, 260 65, 091	23, 809, 745 196, 508	-10, 706, 615 -48, 061	13, 103, 130 148, 447	54. 00 57. 00
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0 4/4 7/0	0	0 217 222	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	2, 101, 441 0	8, 464, 769 12, 660, 492	10, 566, 210 12, 660, 492	-8, 217, 222 -13, 560	2, 348, 988 12, 646, 932	
60. 01 06001 BLOOD LABORATORY	0	0	0	0	0	
63. 00 06300 BLOOD STORING, PROCESSING, & TRANS. 65. 00 06500 RESPIRATORY THERAPY	0 3, 439, 086	1, 317, 816 1, 895, 406	1, 317, 816 5, 334, 492	-1, 807 -1, 663, 825	1, 316, 009 3, 670, 667	65.00
65. 01 06501 SLEEP LAB	457, 604	367, 432	825, 036	-322, 401	502, 635	
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	4, 371, 759 765, 839	1, 683, 544 219, 784	6, 055, 303 985, 623	-1, 569, 163 -58, 483	4, 486, 140 927, 140	
68. 00 06800 SPEECH PATHOLOGY 68. 01 06801 AUDI OLOGY	515, 501	140, 977	656, 478	-45, 112	611, 366 0	
69. 00 06900 ELECTROCARDI OLOGY	1, 221, 392	1, 079, 553	2, 300, 945	-765, 546	1, 535, 399	68. 01 69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	11, 046, 559 11, 305, 027	11, 046, 559 11, 305, 027	71. 00 72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	40, 111, 517	40, 111, 517	
73.01 07301 HOSPITAL BASED RETAIL PHARMACIES 74.00 07400 RENAL DIALYSIS	1, 468, 882	6, 947, 042	8, 415, 924	-401, 005	8, 014, 919	
76. 00 03160 CARDI OPULMONARY	0	1, 492, 804 0	1, 492, 804 0	-76, 290 0	1, 416, 514 0	76.00
76. 97 07697 CARDIAC REHABILITATION 76. 98 07698 HYPERBARIC OXYGEN THERAPY	904, 300 494, 861	380, 733 1, 358, 942	1, 285, 033 1, 853, 803	-247, 199 -596, 548	1, 037, 834 1, 257, 255	
OUTPATIENT SERVICE COST CENTERS	494, 801	1, 336, 942	1, 633, 603	-390, 346	1, 257, 255	70. 90
90. 00 09000 CLI NI C 90. 01 09001 SUBSTANCE ABUSE CLI NI C	0 203, 279	0 515, 601	0 718, 880	0 -73, 002	0 645, 878	90.00
90. 01 09001 SUBSTANCE ABUSE CLINIC 90. 02 09002 PAIN CLINIC	203, 279 368, 755	742, 444	718, 880 1, 111, 199	-73,002 -307,577	645, 878 803, 622	90. 01 90. 02
90. 03 09003 0NCOLOGY CLI NI C 91. 00 09100 EMERGENCY	1, 224, 872	849, 151	2, 074, 023	-454, 326	1, 619, 697	90.03
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	7, 556, 586	6, 612, 539	14, 169, 125	-3, 239, 445	10, 929, 680	91. 00 92. 00
92.01 09201 OBSERVATION BEDS (DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	89, 894	156, 323	246, 217	-26, 634	219, 583	92. 01
95.00 09500 AMBULANCE SERVICES	0	0	0	0	0	95. 00
SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE		ol		0	0	113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	116, 505, 264	287, 701, 299	404, 206, 563		403, 698, 409	
NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	171, 845	351, 898	523, 743	-25, 635	498, 108	190. 00

<u>Health Financial Systems</u>	BALL MEMORIAL	HOSPI TAL		In Lieu	<u>ı of Form CMS-2</u>	<u> 2552-10</u>
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provi der CO	CN: 15-0089 F	eriod: Worksheet A		
				From 01/01/2020	1	
			[7	To 12/31/2020		
					7/15/2021 12:	59 pm
Cost Center Description	Sal ari es	0ther	Total (col. 1	Recl assi fi cati	Recl assi fi ed	
· ·			+ col . 2)	ons (See A-6)	Trial Balance	
				((col. 3 +-	
					col . 4)	
	1. 00	2.00	3. 00	4. 00	5. 00	
101 0010100 050540011						101 00
191. 0019100 RESEARCH	670, 931	198, 844	869, 775		· ·	
194. 0007950 OTHER NONREIMBURSABLE COST CENTERS	0	0	(0		194. 00
194.01 07951 BSU_PHARMACY	142, 330	41, 023	183, 353			
194. 02 <mark>07952 PAVILLION PHARMACY</mark>	788, 198	5, 299, 830	6, 088, 028	-54, 567	6, 033, 461	194. 02
194. 03 <mark>07953</mark> VENDI NG	0	0	(0	0	194. 03
194. 0407954 CARELI NE	0	0	(0	0	194. 04
194. 05 07955 WELLNESS CENTER	0	33, 798	33, 798	-33, 259	539	194. 05
194. 0607956 PHYSI CI AN PRACTI CE CLI NI CS	o o	00,770	(00,20,		194. 06
194. 0707957 PERINATAL CLINIC	0	0	(194. 07
194. 0807958 RENTAL PROPERTY	0	1, 611, 924	1 (11 02)	-871, 184		
	0	1, 011, 924	1, 611, 924	-8/1, 184		
194. 0907959 ADVERTI SI NG	0	0	(194. 09
194. 10 <mark>07960 I NTEGRA LTAC</mark>	0	0	(0 ا		194. 10
194. 1107961 IU HEALTH HOSPICE	0	426	426	-6		194. 11
194.1207962 POB MEDICAL PAVILLION CONDOS	0	0	(0		194. 12
194. 1307963 PEDI ATRI C THERAPI ES	1, 179, 829	416, 344	1, 596, 173	-193, 766	1, 402, 407	194. 13
194.1407964 NEW CASTLE ONCOLOGY	0	0	(ol o	0	194. 14
194. 1507965 MARKETING/PUBLIC RELATIONS	0	0	(0 0	0	194. 15
194. 1607966 JAY COUNTY HOSPITAL	364, 203	70, 002	434, 205	1, 016, 526		
194. 17 07967 CARDI NAL HEALTH CHOI CE	001, 200	70,002	101, 200	1,010,020		194. 17
194. 1807968 CHV CARDINAL HEALTH VENTURES		0				194. 17
•	0	0	(194. 16
194. 1907969 HEALTH CARE CONNECTIONS	0	0	(
194. 2007970 MEALS ON WHEELS	0	0	(0		194. 20
194. 21 07971 ST MARY'S SCHOOL	0	0	(0		194. 21
194. 2207972 THERAPIES TO OTHER ENTITIES	1, 232, 044	380, 479	1, 612, 523		1, 339, 269	194. 22
194. 23 07973 CANCER CENTER BOUTIQUE	15, 083	75, 315	90, 398	-398	90, 000	194. 23
194. 2407974 BOSC BALL OUTPATIENT SURGERY	0	0	(0	0	194. 24
194. 25 <mark>07975</mark> CARDI NAL BEHAVI ORAL HEALTH	0	167	167	7 -124	43	194. 25
194. 2607976 BLACKFORD COMMUNITY HOSPITAL	101, 930	40, 033	141, 963	1, 039, 257	1, 181, 220	194. 26
194. 2707977 MI DWEST HEALTH STRATEGIES	0	0	(0		194. 27
194. 2807978 CARDINAL SELECT RISK RETENTION GRP	Ŏ	Ŏ	Č	n o		194. 28
194. 2907979 HOME OFFICE CARDINAL HEALTH INITIATI		0				194. 29
194. 3007980 CARDI NAL HEALTH ALLI ANCE	0	0	(194. 29
	0	0	(
194. 31 07986 OTHER NONREI MBURSABLE COST CENTERS	0	0	(0		194. 31
194. 3207982 RENAL DI ALYSI S	0	0	(0		194. 32
194. 33 <mark>07983 LAB CORP</mark>	0	0	(0		194. 33
194.34 <mark>07984</mark> H.O. MATERIALS MGMT	0	0	(0	0	194. 34
194. 3507985 LEASED SPACE	0	0	(0	0	194. 35
200.00 TOTAL (SUM OF LINES 118 through 199)	121, 171, 657	296, 221, 382	417, 393, 039	9 0	417, 393, 039	200.00
	•			•	•	•

 Health Financial
 Systems
 BALL MEMORI

 RECLASSIFICATION
 AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES
 Peri od: From 01/01/2020 To 12/31/2020 Date/Ti me Prepared: 7/15/2021 12:59 pm Provi der CCN: 15-0089

				7/15/2021 12	!: 59 pm
	Cost Center Description		Net Expenses		
			For Allocation	1	
	Topico de la contraction de la	6. 00	7. 00		
1 00	GENERAL SERVICE COST CENTERS	E 174 0E0	00 040 007	ı	1 00
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	5, 174, 858			1.00
3.00	00300 OTHER CAPITAL RELATED COSTS	F20 103			3.00
4. 00 5. 01	00400 EMPLOYEE BENEFITS DEPARTMENT 01160 COMMUNI CATIONS	529, 183			4.00
5. 01	1	-112, 750			5. 01
	00550 DATA PROCESSING	18, 166, 907			5. 02
5. 04	OO570 ADMITTING	8, 911, 506			5.04
5. 05 5. 06	OO580 CASHI ERI NG/ACCOUNTS RECEI VABLE OO590 OTHER ADMI NI STRATI VE AND GENERAL	10, 742, 441			5. 05
		-51, 877, 419			5.06
6.00	00600 MAI NTENANCE & REPAI RS	-320, 654	· ·		6.00
7. 00 8. 00	00700 OPERATION OF PLANT	-216, 826			7.00
9. 00	00800 LAUNDRY & LINEN SERVICE	117 100	1, 519, 354		8.00
	00900 HOUSEKEEPI NG 01000 DI ETARY	-117, 180			9. 00 10. 00
11. 00	l l	-216, 243			1
	01100 CAFETERIA 01300 NURSING ADMINISTRATION	-1, 195, 180			11. 00 13. 00
	01400 CENTRAL SERVICES & SUPPLY	-23, 614	7, 186, 662 8, 861, 014		14. 00
	01500 PHARMACY	-537, 035			15. 00
	01600 MEDI CAL RECORDS & LI BRARY	-557, 055	0, 109, 555		16. 00
	01080 PATIENT TRANSPORTATION	-12, 400	662, 324		18. 00
	02100 &R SERVICES-SALARY & FRINGES APPRVD	-12, 400	4, 083, 556		21. 00
	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	-2, 800	3, 472, 169		22. 00
	02300 PARAMED ED PRGM	-2, 000	247, 313		23. 00
23.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	247, 313		25.00
30.00	03000 ADULTS & PEDIATRICS	-10, 880, 643	29, 670, 927		30.00
	03100 INTENSIVE CARE UNIT	0 000			31.00
	03200 CORONARY CARE UNIT	0	7, 042, 000		32.00
	02060 NEONATAL INTENSIVE CARE UNIT	-1, 542, 328		l control of the cont	35. 00
40. 00		-1, 342, 320 0	2,403,772		40.00
	04100 SUBPROVI DER - I RF	72, 273	-		41.00
	04300 NURSERY	72, 273	497, 789		43. 00
43.00	ANCILLARY SERVICE COST CENTERS	<u> </u>	471,107		T 43. 00
50.00	05000 OPERATI NG ROOM	-6, 041, 766	7, 225, 146		50.00
	05100 RECOVERY ROOM	0, 041, 700			51.00
	05200 DELIVERY ROOM & LABOR ROOM	0	2, 142, 301		52. 00
	05400 RADI OLOGY-DI AGNOSTI C	-515, 006			54.00
	05700 CT SCAN	-51, 682	96, 765		57. 00
58. 00		01,002	0		58.00
	05900 CARDI AC CATHETERI ZATI ON	-1, 800		l control of the cont	59.00
60.00	06000 LABORATORY	1, 000	12, 646, 932		60.00
	06001 BLOOD LABORATORY	0	0		60. 01
	06300 BLOOD STORING, PROCESSING, & TRANS.	0	1, 316, 009	•	63.00
65.00	06500 RESPI RATORY THERAPY	0	3, 670, 667		65. 00
	06501 SLEEP LAB	-18, 108			65. 01
	06600 PHYSI CAL THERAPY	-41, 539			66.00
	06700 OCCUPATI ONAL THERAPY	-90	· ·		67. 00
68. 00	06800 SPEECH PATHOLOGY	-389	610, 977		68. 00
	06801 AUDI OLOGY	0			68. 01
	06900 ELECTROCARDI OLOGY	-59, 303	1, 476, 096	l e e e e e e e e e e e e e e e e e e e	69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	11, 046, 559		71. 00
	07200 I MPL. DEV. CHARGED TO PATIENT	0	11, 305, 027		72.00
	07300 DRUGS CHARGED TO PATIENTS	0	40, 111, 517		73. 00
	07301 HOSPI TAL BASED RETAIL PHARMACIES	-620, 168	7, 394, 751		73. 01
	07400 RENAL DIALYSIS	320, .00 Ω	1, 416, 514		74.00
	03160 CARDI OPULMONARY	0	0		76. 00
	07697 CARDI AC REHABI LI TATI ON	-111, 950			76. 97
	07698 HYPERBARI C OXYGEN THERAPY	-48, 936	1, 208, 319		76. 98
, 5	OUTPATIENT SERVICE COST CENTERS	, 750	.,		7 / -
90. 00	09000 CLINIC	0	0		90.00
	09001 SUBSTANCE ABUSE CLINIC	-358, 000			90. 01
	09002 PAIN CLINIC	-393, 471	410, 151		90. 02
	09003 ONCOLOGY CLINIC	0	1, 619, 697		90. 03
91.00		-394, 409			91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	37., .07	, 555, 271		92.00
	09201 OBSERVATION BEDS (DISTINCT PART)	0	219, 583		92. 01
	OTHER REIMBURSABLE COST CENTERS		2.7,300		7
95.00	09500 AMBULANCE SERVICES	o	0		95. 00
. 5. 55	SPECIAL PURPOSE COST CENTERS				7
113. 00	11300 I NTEREST EXPENSE	0	0		113. 00
118. 00	•	-32, 114, 521			118.00
	NONREI MBURSABLE COST CENTERS	,	2. 1, 000, 000		1
190. 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	498, 108		190. 00
	19100 RESEARCH	Ö	742, 969		191.00
	07950 OTHER NONREIMBURSABLE COST CENTERS	Ö	0		194. 00
				•	· · · · · · · · · · · · · · · · · · ·

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

Provi der CCN: 15-0089

			10	7/15/	'2021 12:59 pm
Cost Center Description	Adjustments	Net Expenses	•	<u>. </u>	
	(See A-8) F	or Allocation			
	6. 00	7. 00			
194. 01 <mark>07951</mark> BSU PHARMACY	-177, 912	36, 811			194. 01
194.02 <mark>07952 PAVILLION PHARMACY</mark>	0	6, 033, 461			194. 02
194. 03 <mark>07953</mark> VENDI NG	0	0			194. 03
194. 04 <mark>07954</mark> CARELI NE	0	0			194. 04
194. 05 <mark>07955</mark> WELLNESS CENTER	0	539			194. 05
194.06 <mark>07956</mark> PHYSICIAN PRACTICE CLINICS	0	0			194. 06
194. 07 <mark>07957</mark> PERI NATAL CLI NI C	0	0			194. 07
194. 08 <mark>07958 RENTAL PROPERTY</mark>	0	740, 740			194. 08
194. 09 <mark>07959</mark> ADVERTI SI NG	0	0			194. 09
194. 10 <mark>07960 NTEGRA LTAC</mark>	0	0			194. 10
194. 11 <mark>07961 I U HEALTH HOSPICE</mark>	0	420			194. 11
194.1207962 POB MEDICAL PAVILLION CONDOS	0	0			194. 12
194. 13 07963 PEDI ATRI C THERAPI ES	0	1, 402, 407			194. 13
194.1407964 NEW CASTLE ONCOLOGY	0	0			194. 14
194. 15 07965 MARKETI NG/PUBLI C RELATI ONS	0	0			194. 15
194. 16 07966 JAY COUNTY HOSPITAL	-261, 969	1, 188, 762			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. 1907969 HEALTH CARE CONNECTIONS	0	0			194. 19
194.2007970 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, 339, 269	0			194. 22
194. 23 07973 CANCER CENTER BOUTIQUE	0	90, 000			194. 23
194. 2407974 BOSC BALL OUTPATIENT SURGERY	0	0			194. 24
194. 25 07975 CARDI NAL BEHAVI ORAL HEALTH	0	43			194. 25
194.2607976 BLACKFORD COMMUNITY HOSPITAL	-10, 962	1, 170, 258			194. 26
194. 2707977 MIDWEST HEALTH STRATEGIES	0	0			194. 27
194.28 <mark>07978 CARDINAL SELECT RISK RETENTION GRP</mark>	0	0			194. 28
194.2907979 HOME OFFICE CARDINAL HEALTH INITIATI	0	0			194. 29
194. 30 <mark>07980</mark> CARDI NAL HEALTH ALLI ANCE	0	0			194. 30
194. 31 07986 OTHER NONREIMBURSABLE COST CENTERS	0	0			194. 31
194. 32 <mark>07982 RENAL DIALYSIS</mark>	0	0			194. 32
194. 33 <mark>07983 LAB CORP</mark>	0	0			194. 33
194.34 <mark>07984</mark> H.O. MATERIALS MGMT	0	0			194. 34
194. 35 <mark>07985 LEASED SPACE</mark>	0	0			194. 35
200.00 TOTAL (SUM OF LINES 118 through 199)	-33, 904, 633	383, 488, 406			200. 00
		•			•

Period: Worksheet A-o From 01/01/2020 To 12/31/2020 Date/Time Prepared: 7/15/2021 12:59 pm

					7/15/2021 12:	59 pm
		Increases		0.11		
	Cost Center	Li ne #	Salary	Other		
	2.00	3. 00	4. 00	5. 00		
4 00	A - NON-BILLABLE SUPPLIES	44.00		0 407 040		4 00
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	8, 497, 943		1.00
2.00	NEW CAP REL COSTS-BLDG & FIX		0	2		2.00
3.00	COMMUNI CATI ONS	5. 01	0	2 242		3.00
4. 00	MAINTENANCE & REPAIRS	6. 00	0	3, 243		4.00
5. 00	NURSING ADMINISTRATION	13.00	- 1	38, 850		5.00
6. 00	I &R SERVICES-OTHER PRGM COST	S 22. 00	0	108		6. 00
7. 00	APPRVD PAVILLION PHARMACY	194. 02	0	169		7. 00
7. 00 8. 00	RENTAL PROPERTY	194. 02	0	541		1
9. 00	THERAPIES TO OTHER ENTITIES	194. 08	0	21		8.00
10.00	CANCER CENTER BOUTIQUE	194. 23	0	69		9.00
11. 00	CANCER CENTER BOUTTQUE	0.00	0	09		10. 00 11. 00
12.00		0.00	0	0		12.00
		0.00	o	0		13. 00
13.00	1					
14.00		0. 00 0. 00	0	0		14. 00 15. 00
15.00	1					16. 00
16. 00 17. 00	1	0. 00 0. 00	0	0		17. 00
18.00	1	0.00	0	0		18. 00
19. 00	1	0. 00	0	0		19. 00
20.00	1	0.00	0	0		20.00
21.00	1	0. 00	0	0		21. 00
22.00		0. 00	0	0		21.00
23. 00		0. 00	0	0		23. 00
24.00		0.00	0	0		24.00
25. 00	1	0. 00	0	0		25. 00
26. 00		0. 00	0	0		26. 00
27.00		0. 00	0	0		27. 00
28.00		0.00	0	0	l e	28. 00
29.00		0.00	Ö	0		29. 00
30.00		0. 00	0	0		30.00
31.00		0.00	0	0		31. 00
32.00		0.00	0	0	•	32.00
33.00		0.00	0	0	•	33. 00
34.00		0. 00	0	0	•	34. 00
35.00		0. 00	0	0	•	35. 00
36.00		0.00	o	0	•	36.00
37.00		0. 00	0	0	•	37. 00
			ŀ	-		1
38.00	1	0. 00 0. 00	0	0	•	38. 00
39. 00			— — — }	0 8, 540, 948	 	39. 00
	B - BILLABLE SUPPLIES		<u> </u>	0, 340, 940		
1. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	11, 046, 559		1. 00
1.00	PATIENTS	71.00	O .	11, 040, 339		1.00
2. 00	RENTAL PROPERTY	194. 08	0	245		2. 00
3. 00	KENTAL PROFERIT	0.00	0	0		3. 00
4. 00		0.00	Ö	0		4. 00
5. 00	1	0. 00	ő	o	1	5. 00
6. 00		0. 00	o	0		6. 00
7. 00	i i	0. 00	0	Ö		7. 00
8. 00		0. 00	Ö	0		8. 00
9. 00	i i	0. 00	Ö	Ö		9. 00
10.00	1	0. 00	ő	ő		10. 00
11. 00		0. 00	ő	Ö		11. 00
12. 00		0. 00	Ö	o		12. 00
13. 00		0. 00	ő	o		13. 00
14.00		0.00	0	0		14. 00
15. 00		0.00	0	0		15. 00
16. 00		0. 00	Ö	0		16. 00
17. 00		0. 00	Ö	0		17. 00
18. 00		0. 00	Ö	0		18. 00
19. 00		0. 00	Ö	0		19. 00
20.00		0. 00	Ö	0		20. 00
21.00		0. 00	0	0		21. 00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
24.00		0.00	0			24.00
			0	0		24. 00 25. 00
25. 00 26. 00		0. 00 0. 00	0	0		25. 00 26. 00
26. 00 27. 00		0.00	0	0	}	26. 00 27. 00
28.00		0.00		- 1		28.00
20.00	<u> </u>		— — o	<u>0</u> 11, 046, 804	 	20.00
	P I	ı	Ч	11,040,004	ı	ı

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

Provi der CCN: 15-0089 Peri od: From 01/01/2020 To 12/31/2020 Date/Ti me Prepared:

					7/15/2021 1	
		Increases				
	Cost Center	Li ne #	Salary	0ther		
	2.00 C - IMPLANTABLE DEVICES	3. 00	4. 00	5. 00		
1. 00	IMPL. DEV. CHARGED TO PATIEN	T 72.00	ol	11, 305, 027		1.00
2. 00	This E. BETT STRINGED TO TANTE.	0.00	ő	0		2. 00
3.00		0. 00	0	o		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	O	0		7.00
8. 00 9. 00		0. 00 0. 00	0	0		8. 00 9. 00
10.00		0.00	0	o		10.00
11. 00		0. 00	ő	Ö		11.00
12.00		0. 00	O	o		12. 00
13.00		0. 00	0	0		13. 00
14.00	<u> </u>	0.00	•	9		14. 00
	O DILLIADI E DOUGG		0	11, 305, 027		-
1. 00	D - BILLABLE DRUGS PHARMACY	15. 00	o	634, 738		1.00
2. 00	DRUGS CHARGED TO PATIENTS	73. 00	o	40, 111, 517		2. 00
3. 00		0. 00	o	0		3. 00
4.00		0. 00	O	o		4. 00
5.00		0. 00	0	0		5. 00
6. 00		0. 00	0	0		6. 00
7. 00		0.00	O	0		7. 00
8. 00 9. 00		0. 00 0. 00	0	0		8. 00 9. 00
10.00		0.00	ol	0		10.00
11. 00		0. 00	o	o		11. 00
12.00		0. 00	O	o		12. 00
13.00		0. 00	0	0		13. 00
14.00		0. 00	0	0		14. 00
15.00		0.00	0	0		15.00
16. 00 17. 00		0. 00 0. 00	0	0		16. 00 17. 00
18. 00		0.00	ol	0		18. 00
19. 00		0. 00	o	o		19. 00
20.00		0. 00	O	O		20.00
21.00		0. 00	0	0		21. 00
22. 00		0. 00	0	0		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	ol	ol		26. 00
27. 00		0. 00	o	O		27. 00
28.00		0. 00	0	0		28. 00
29. 00	<u> </u>	0.00	•	9		29. 00
	U E - INTERN & RESIDENT SALARI	FS	0	40, 746, 255		
1.00	I&R SERVICES-SALARY & FRINGE		4, 083, 556	0		1.00
	APPRVD			ļ		1
2. 00		0.00	0	o		2. 00
	F - CAFETERIA		4, 083, 556	<u> </u>		-
1. 00	CAFETERI A	11. 00	1, 183, 180	991, 392		1.00
	0 — — — — —		1, 183, 180	991, 392		
1 00	G - PHARMACY ADMIN COSTS	404.04	00.070	00.740		1
1. 00 2. 00	BSU PHARMACY PAVILLION PHARMACY	194. 01 194. 02	39, 873 39, 873	22, 748 22, 748		1. 00 2. 00
2.00	O PHARMACY	194.02	3 <u>9, 873</u> 79, 746	2 <u>2, 748</u> 45, 496		2.00
	H - AUTO & BUILDING INSURANC	E	77,710	10, 170		
1.00	NEW CAP REL COSTS-BLDG & FIX	T 1.00	0	<u>344, 0</u> 57		1.00
	0		0	344, 057		4
1. 00	I - REHAB ADMIN COSTS OCCUPATIONAL THERAPY	67. 00	75, 807	4, 598		1.00
2. 00	SPEECH PATHOLOGY	68. 00	51, 027	2, 950		2. 00
3. 00	PEDI ATRI C THERAPI ES	194. 13	116, 786	8, 711		3. 00
4. 00	THERAPIES TO OTHER ENTITIES	194. 22	1 <u>0, 8</u> 75	843		4. 00
	0		254, 495	17, 102		_
1 00	J - LAUNDRY	0.00	اه	1 510 254		1 00
1. 00 2. 00	LAUNDRY & LINEN SERVICE	8. 00 0. 00	0	1, 519, 354 0		1. 00 2. 00
3. 00		0.00	o	0		3. 00
4.00		0. 00	Ö	o		4. 00
5. 00		0. 00	0	0		5. 00
		·				· ·

BALL MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10

Health Financial Systems RECLASSIFICATIONS Peri od: From 01/01/2020 To 12/31/2020 Date/Ti me Prepared: 7/15/2021 12:59 pm Provi der CCN: 15-0089

					7/15/2021 12	2. 37 PIII
	0	Increases	Callanni	0.615		
	Cost Center 2.00	Li ne #	Sal ary	Other 5 00		
4 00	2. 00	3.00	4. 00	5. 00		4 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	0		11. 00
12.00		0. 00	0	0		12. 00
13.00		0. 00	0	0		13.00
14.00		0. 00	0	0		14. 00
15. 00		0. 00	0	0		15. 00
16. 00		0. 00	0	0		16. 00
17. 00		0. 00	0	0		17. 00
18. 00		0. 00	0	0		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		0. 00	0	0		22. 00
23.00		0. 00	0	0		23. 00
24.00		0. 00	0	0		24. 00
25.00		0. 00	0	0		25. 00
26.00		0. 00	0	0		26. 00
27.00		0. 00	0	0		27. 00
28.00		0. 00	0	0		28. 00
29.00		0. 00	0	0		29. 00
30.00		0. 00	0	0		30.00
31.00		0. 00	0	0		31.00
32.00		0. 00	0	0		32. 00
33.00		0.00	•	의		33. 00
	0		0	1, 519, 354		1
4 00	L - IRF AND PACU MEDSURG	00.00	07.404	10.00/		1
1.00	ADULTS & PEDIATRICS	30. 00	27, 131	13, 026		1.00
2. 00		0.00	$ \frac{9}{2}$	$ \frac{9}{12000}$		2. 00
	TOTALS Q - NURSERY		27, 131	13, 026		-
1. 00	NURSERY	43. 00	458, 820	38, 969		1.00
2. 00	NORSEKT		430, 620	30, 707		2.00
2.00	lacksquare — — — — —	— — <u> </u>	458, 820	38, 969		2.00
	S - EMPLOYEE BENEFITS					1
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	23, 032, 415		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	0		11. 00
12.00		0. 00	0	0		12. 00
13.00		0. 00	0	0		13. 00
14.00		0. 00	0	0		14. 00
15. 00		0. 00	0	0		15. 00
16.00		0. 00	0	0		16. 00
17.00		0. 00	0	0		17. 00
18.00		0. 00	0	0		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		0. 00	0	0		22. 00
23.00		0. 00	0	0		23. 00
24.00		0. 00	0	0		24. 00
25.00		0. 00	0	0		25.00
26.00		0. 00	0	0		26. 00
27.00		0. 00	0	0		27. 00
28.00		0. 00	0	0		28. 00
29.00		0. 00	0	0		29.00
30.00		0. 00	0	0		30.00
31.00		0.00	0	0		31.00
32.00		0.00	0	0		32.00
33.00		0.00	0	0		33.00
34. 00 35. 00		0.00	0	0		34. 00 35. 00
35. 00 36. 00		0. 00 0. 00	0	0		35. 00 36. 00
30.00		0.00	Ų	<u> </u>		30.00

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

Peri od: From 01/01/2020 To 12/31/2020 Date/Ti me Prepared: 7/15/2021 12:59 pm Provi der CCN: 15-0089

						7/15/2021 12	2: 59 pm
2.00		Coot Contor	Increases	Colory	Othor		
37.00	_						
38.00	37. 00	2.00					37. 00
40.00	38.00			0	o		38. 00
41.00				0			
42.00				0			
43 00				0			
44.00 46.00				0			
45.00 1.00				0	0		
46. 00				0			
1.00				0	Ö		
1.00 OTHER ADMINISTRATIVE AND 0.00 0 13,886 1.00 2.00 3 3 3 3 3 3 3 3 3		0 — — — — —		<u> </u>	23, 032, 415		_
CAMPAIL CAMP			1				
2.00 4.00 5.00 6.00 6.00 6.00 6.00 6.00 6.00 6	1.00		5. 06	0	13, 886		1.00
3.00 4.00 5.00 0.00 0.00 0.00 0.00 0.00 0	2 00	GENERAL	0.00	0	0		2 00
4. 00 6. 00					1		
6.00 8.00 9.00 1.00 1.00 1.00 1.00 1.00 1.00 1				0			
7.00 9.00 1	5.00		0. 00	0	o		5. 00
8.00				0	1 -1		
9.00 0				0	•		
1.00				0	· -1		
U - DEPRECIATION NEW CAP REL COSTS-BLDG & FIXT 1.00 0 18,699.025 1.00 2.00 3.00 4.00 0 0 0 0 3.00 4.00 6.00 0 0 0 0 0 6.00 6	7.00			— — <u> </u>			7.00
2 00		U - DEPRECIATION		_			
3.00 0.00 0.00 0 0 0 0 0		NEW CAP REL COSTS-BLDG & FIX					
4. 00 5. 00 6. 00 7. 00 6. 00 7. 00 8. 00 9. 00 9. 00 9. 00 9. 00 10. 00 9. 00 10. 00 11. 00				-	1 -1		
5. 00 6. 00 7. 00 8. 00 9. 00 9. 00 9. 00 10. 00 9. 00 11. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 11. 00 11. 00 10. 00 11.							
6. 00 7. 00 8. 00 9. 00 10. 00				-			
8. 00 9, 00 10, 00 11, 00 11, 00 12, 00 13, 00 14, 00 15, 00 16, 00 16, 00 16, 00 17, 00 18, 00 18, 00 19, 00 10, 00 10, 00 10, 00 10, 00 11,				0			
9.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 11.00 1	7.00			0			7. 00
10.00 11.00 12.00 12.00 12.00 13.00 14.00 14.00 15.00 0.00 0.00 0.00 0.00 0.00 14.00 15.00 16.00 17.00 18.00 17.00 18.00 19.00				-			
11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 16. 00 17. 00 18. 00 18. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 20. 00 21. 00 22. 00 23. 00 24. 00 24. 00 25. 00 26. 00 27. 00 26. 00 27. 00 28. 00 29. 00 29. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 29. 00 20. 00 20. 00 20. 00 21. 00 22. 00 23. 00 24. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 31. 00 31. 00 33. 00 34. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 00 00 00 00 00 00 00 00 00 00 00 00				-			
12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 00 10							
13.00				-			
15.00				-			
16.00 17.00 18.00 19.00	14.00		0. 00	0	o		14. 00
17.00				_	•		
18. 00				-			
19.00 19.00 20.00 20.00 20.00 20.00 21.00 22.00 22.00 23.00 24.00 25.00 26.00 24.00 25.00 26.00 27.00 28.00 27.00 28.00 27.00 28.00 27.00 28.00 29.00 30.00 30.00 31.00 32.00 33.0		•		-			
20. 00 21. 00 22. 00 22. 00 22. 00 22. 00 22. 00 23. 00 0. 0				_			
21. 00		'		-			
23. 00 24. 00 24. 00 24. 00 25. 00 0				0			
24. 00 25. 00 26. 00 27. 00 28. 00 27. 00 28. 00 29. 00 30. 00 30. 00 31. 00 32. 00 33. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 37. 00 38. 00 39. 00 41. 00 42. 00 30. 00 40. 00 40. 00 40. 00 41. 00 42. 00 42. 00 42. 00 42. 00 42. 00 42. 00 42. 00 42. 00 42. 00 42. 00 42. 00 42. 00 42. 00 42. 00 42. 00 44. 00 45. 00 46. 00 47. 00 48. 00 49. 00 40. 00 41. 00 42. 00 44. 00 45. 00 46. 00 47. 00 48. 00 49. 00 40. 00 41. 00 42. 00 44. 00 45. 00 46. 00 47. 00 48. 00 49. 00 40. 00 41. 00 41. 00 42. 00 43. 00 44. 00 45. 00 46. 00 47. 00 48. 00 49. 00 40. 00 40. 00 41. 00 41. 00 42. 00 44. 00 45. 00 46. 00 47. 00 48. 00 49. 00 49. 00 40. 00 41. 00 41. 00 42. 00 44. 00 45. 00 46. 00 47. 00 48. 00 49. 00 49. 00 40. 00 41. 00 41. 00 42. 00 44. 00 45. 00 46. 00 47. 00 48. 00 49. 00 49. 00 49. 00 40. 00 41. 00 41. 00 42. 00 44. 00 45. 00 46. 00 47. 00 48. 00 49. 00 49. 00 49. 00 49. 00 40. 00 40. 00 41. 00 41. 00 42. 00 43. 00 44. 00 44. 00 45. 00 46. 00 47. 00 48. 00 49. 00 49. 00 49. 00 40. 00 41. 00 41. 00 42. 00 44. 00 44. 00 45. 00 46. 00 47. 00 48. 00 49. 00 49. 00 49. 00 49. 00 49. 00 40. 00 40. 00 41. 00 41. 00 42. 00 42. 00 43. 00 44. 00 44. 00 45. 00 46. 00 47. 00 48. 00 49. 00 49. 00 49. 00 49. 00 49. 00 49. 00 49. 00 49. 00 40. 00 40. 00 40. 00 41. 00 42. 00 42. 00 43. 00 44. 00 45. 00 46. 00 47. 00 48. 00 49				0			
25. 00				-			
26. 00 27. 00 28. 00 29. 00 30. 00 30. 00 31. 00 32. 00 33. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 37. 00 38. 00 38. 00 39. 00 30		1		ŭ	1		
27. 00 28. 00 29. 00 30. 00 30. 00 30. 00 31. 00 32. 00 32. 00 33. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 37. 00 38. 00 37. 00 38. 00 37. 00 38. 00 37. 00 38. 00 37. 00 38. 00 37. 00 38. 00 37. 00 38. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00 10 10 10 10 10 10 10 10 10			0.00				
28. 00 29. 00 30. 00 0. 00 0. 00 0. 00 0. 00 31. 00 32. 00 33. 00 33. 00 33. 00 34. 00 35. 00 36. 00 37. 00 36. 00 37. 00 38. 00 37. 00 38. 00 39. 00 0. 00			0.00		Ö		
29, 00 30, 00 30, 00 31, 00 31, 00 32, 00 33, 00 33, 00 34, 00 35, 00 36, 00 37, 00 38, 00 38, 00 39, 00 40, 00 41, 00 42, 00 0 0 0 0 0 0 0 0 0 0 0 0			0. 00	0			28. 00
31.00 32.00 32.00 33.00 33.00 34.00 35.00 36.00 36.00 37.00 38.00 38.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 40.00 41.00 42.00 0			0. 00	0			
32.00 33.00 33.00 34.00 35.00 36.00 36.00 37.00 38.00 37.00 38.00 39.00 39.00 40.00 40.00 41.00 42.00 V - LEASE EXPENSE				0			
33.00 34.00 35.00 36.00 36.00 37.00 38.00 38.00 38.00 39.00 40.00 41.00 42.00 V - LEASE EXPENSE 1.00 0.00 0.00 0.00 0.00 0.00 0.00 0.				0			
34. 00 35. 00 36. 00 37. 00 38. 00 38. 00 39. 00 39. 00 40. 00 41. 00 42. 00 V - LEASE EXPENSE				0			
35. 00 36. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00 V - LEASE EXPENSE				ŭ			
36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00 V - LEASE EXPENSE NEW CAP REL COSTS-BLDG & FIXT 1. 00 2. 00 3. 00 3. 00 4. 00 4. 00 4. 00 4. 00 4. 00 4. 00 4. 00 5. 00 0.			0. 00	_			
37. 00 38. 00 39. 00 40. 00 41. 00 42. 00 V - LEASE EXPENSE 1. 00 2. 00 3. 00 3. 00 4. 00 5. 00 0. 0	36.00		0. 00	0			36. 00
39.00 40.00 41.00 42.00				0			
40.00 41.00 42.00 0 0 0 0 0 41.00 42.00 0 0 0 18,699,025 V - LEASE EXPENSE 1.00 NEW CAP REL COSTS-BLDG & FIXT 1.00 0 962,609 2.00 3.00 0 0 0 2.00 3.00 0 0 0 0 3.00 4.00 0 0 0 0 0 5.00				0	1		
41. 00 42. 00 0 0 0 1. 00 0 18, 699, 025 V - LEASE EXPENSE 1. 00 2. 00 3. 00 0. 00				0	1		
42.00 0 0 0 18,699,025 V - LEASE EXPENSE 1.00 NEW CAP REL COSTS-BLDG & FIXT 1.00 0 962,609 1.00 2.00 3.00 0 0 0 2.00 4.00 0 0 0 0 3.00 4.00 0 0 0 0 5.00				0			
0				0	0		
1. 00		0		<u>ō</u>	18, 699, 025		
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				<u> </u>			ļ ,
3. 00 0. 00 0 0 3. 00 4. 00 0. 00 0 0 4. 00 5. 00 0. 00 0 0 5. 00		NEW CAP REL COSTS-BLDG & FIX		_			
4.00 5.00 0.00 0 0 0 0 0 0 0 5.00					1		
5.00 0.00 0 0 5.00				_	1 -1		
			0. 00	-	1		
	6. 00		0. 00	0	0		6. 00

Peri od: From 01/01/2020 To 12/31/2020 Date/Ti me Prepared: 7/15/2021 12:59 pm

					7/15/2021 12: 59	pm
		Increases				
	Cost Center	Li ne #	Sal ary	Other 5		
	2.00	3.00	4.00	5. 00 962, 609		
	W - PTO USED AS STD	l	<u> </u>	902, 009		
1. 00	COMMUNI CATIONS	5. 01	0	2, 187	T 1	1. 00
2. 00	ADMI TTI NG	5. 04	0	4, 529		2. 00
3.00	OTHER ADMINISTRATIVE AND	5. 06	0	6, 158	·	3. 00
	GENERAL					
4.00	MAINTENANCE & REPAIRS	6. 00	0	11, 867		4. 00
5. 00	OPERATION OF PLANT	7. 00	0	1, 952		5. 00
6. 00	HOUSEKEEPI NG	9. 00	0	25, 654		5.00
7. 00 8. 00	DIETARY NURSING ADMINISTRATION	10. 00 13. 00	0	9, 570 39, 193	·	7. 00 3. 00
9. 00	PHARMACY	15. 00	0	38, 879	·	9. 00
10.00	PATIENT TRANSPORTATION	18. 00	0	438		0. 00
11.00	ADULTS & PEDIATRICS	30. 00	0	83, 219		1. 00
12.00	INTENSIVE CARE UNIT	31. 00	0	57, 874		2. 00
13.00	NEONATAL INTENSIVE CARE UNIT	35. 00	0	20, 550	13	3. 00
14.00	SUBPROVI DER - I RF	41. 00	0	2, 426		4. 00
15.00	OPERATING ROOM	50. 00	0	31, 218		5. 00
16.00	RECOVERY ROOM	51.00	0	14, 786	·	5.00
17. 00 18. 00	DELIVERY ROOM & LABOR ROOM RADIOLOGY-DIAGNOSTIC	52. 00 54. 00	0	22, 029 37, 868		7. 00 3. 00
19. 00	CT SCAN	57. 00	0	1, 904	•	9. 00
20.00	RESPIRATORY THERAPY	65. 00	0	22, 099		0. 00
21. 00	SLEEP LAB	65. 01	0	2, 121	·	1. 00
22.00	PHYSI CAL THERAPY	66. 00	0	37, 293	22	2. 00
23.00	OCCUPATI ONAL THERAPY	67. 00	0	2, 678	·	3. 00
24. 00	ELECTROCARDI OLOGY	69. 00	0	5, 376	· · · · · · · · · · · · · · · · · · ·	4. 00
25.00	CARDI AC REHABI LI TATI ON	76. 97	0	3, 380		5. 00
26. 00 27. 00	HYPERBARIC OXYGEN THERAPY SUBSTANCE ABUSE CLINIC	76. 98 90. 01	0	948		5. 00 7. 00
28. 00	PAIN CLINIC	90. 01	0	2, 185 1, 989	•	7. 00 3. 00
29. 00	ONCOLOGY CLINIC	90. 03	0	22, 097	·	9. 00
30.00	EMERGENCY	91. 00	Ö	25, 778	·	0. 00
31.00	GIFT, FLOWER, COFFEE SHOP &	190. 00	0	671		1. 00
	CANTEEN					
32.00	RESEARCH	191. 00	0	2, 216	·	2. 00
33.00	PEDIATRIC THERAPIES	194. 13	0	13, 971		3.00
34. 00	THERAPIES TO OTHER ENTITIES	194.22	— — <u> </u>	1 <u>0, 2</u> 34 565, 337		4. 00
	X - WASTE DISPOSAL		<u> </u>	303, 337		
1. 00	OPERATION OF PLANT	7. 00	0	427, 421	1	1. 00
2.00	i i	0. 00	0	0	!	2. 00
3.00		0. 00	0	0	3	3. 00
4.00		0. 00	0	0		4. 00
5. 00		0. 00	0	0	·	5. 00
6. 00	1	0.00	0	0	l	5.00
7. 00 8. 00	·	0. 00 0. 00	0	0	•	7. 00 3. 00
9. 00		0.00	0	0	·	9. 00
10.00		0. 00	0	0		0. 00
11.00		0. 00	0	0		1. 00
	0 — — — — —		₀	427, 421		
	Y - UTILITIES					
1.00	OPERATION OF PLANT	7. 00	0	588, 725		1.00
2. 00	OTHER ADMINISTRATIVE AND	5. 06	0	279	2	2. 00
3. 00	GENERAL	0. 00	0	0		3. 00
4. 00		0.00	0	0		4. 00
5. 00		0. 00	Ö	0		5. 00
6. 00		0. 00	0	0		5. 00
7.00		0. 00	0	0		7. 00
8.00		0. 00	0	0		3. 00
9. 00		0.00	0	0		9. 00
	O Z - BLACKFORD		0	589, 004	<u> </u>	
1 00	BLACKFORD COMMUNITY HOSPITAL	194. 26	672, 780	406, 361	1	1 00
1. 00 2. 00	BEACK OKE COMMON IT HOSPITAL	0.00	672, 780	406, 361 0		1. 00 2. 00
3. 00		0.00	o	O.		3. 00
4. 00		0. 00	Ö	ő		4. 00
5. 00		0. 00	o	O		5. 00
6. 00		0. 00	0	0		5. 00
7. 00		0.00	0	0	•	7. 00
8. 00		0.00	0	0		3.00
9. 00		0. 00	0	0	1 9	9. 00

Heal th Financial Systems

BALL MEMORIAL HOSPITAL

Provider CCN: 15-0089

Period:
From 01/01/2020
To 12/31/2020
Pate/Time Prepared:
7/15/2021 12: 59 pm

Cost Center

Line # Salary
Other

					To 12/31/2020 Date/Time Pro 7/15/2021 12	epared:
	Increases				1771372021 12	. 37 piii
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3.00	4. 00	5. 00		
10.00		0. 00	0	0		10.00
11.00		0. 00	0	0		11. 00
12.00		0. 00	0	0		12.00
13. 00		0.00	0	$ \frac{0}{100}$		13. 00
	O		672, 780	406, 361		-
1. 00	PARAMED ED PRGM	23. 00	133, 848	10, 239		1.00
1.00	O FROM		133, 848	10, 239		1.00
	AC - PROPERTY TAX		133, 040	10, 237		i
1. 00	NEW CAP REL COSTS-BLDG & FIX	Г 1.00	ol	171, 966		1.00
2. 00		0. 00	ō	0		2.00
			— — — 			
	AD - JAY HOSPITAL					
1.00	JAY COUNTY HOSPITAL	194. 16	674, 250	430, 651		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 8. 00	•	0. 00 0. 00	0	0		7. 00 8. 00
9. 00		0. 00	0	0		9.00
10. 00		0.00	Ö	0		10.00
11. 00		0. 00	ő	0		11. 00
12.00		0. 00	ő	Ö		12. 00
			674, 250	430, 651		
	AE - MALPRACTICE INSURANCE					
1.00	OTHER ADMINISTRATIVE AND	5. 06	0	100		1. 00
	GENERAL					
2. 00	I&R SERVICES-OTHER PRGM COST	5 22.00	0	250		2. 00
	<u>APPRVD</u>	+	+			
	O ACCOUED DTO		0	350		
1. 00	AF - ACCRUED PTO EMPLOYEE BENEFITS DEPARTMENT	4. 00	1, 540, 100	0		1.00
1.00	TOTALS	— 4. 00	1, 540, 100	— — —		1.00
500 00	Grand Total: Increases		9, 107, 906	119, 917, 694		500.00
500.00	Joi dila Totali. Tiloi cases	ļ	7, 107, 700	117, 717, 074	I	1000.00

Health Financial Systems RECLASSIFICATIONS Provi der CCN: 15-0089

					'	o 12/31/2020 Date/lime Pr 7/15/2021 12	
		Decreases	0.1	0.11			
	Cost Center 6.00	Li ne # 7.00	Sal ary 8. 00	0ther 9.00	Wkst. A-7 Ref. 10.00		
	A - NON-BILLABLE SUPPLIES	7.00	8.00	7.00	10.00		
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	2, 934	0		1.00
2.00	ADMI TTI NG	5. 04	0	· ·			2. 00
3. 00	OTHER ADMINISTRATIVE AND	5. 06	0	1, 506	0		3. 00
4. 00	GENERAL OPERATION OF PLANT	7. 00	0	83	0		4. 00
5. 00	HOUSEKEEPING	7. 00 9. 00	0	191, 641	0		5. 00
6. 00	DI ETARY	10. 00	0		0		6. 00
7.00	PHARMACY	15. 00	0		0		7. 00
8. 00	PATIENT TRANSPORTATION	18. 00	0		0		8. 00
9.00	ADULTS & PEDIATRICS	30.00	0		0		9.00
10. 00 11. 00	INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT	31. 00 35. 00	0	910, 733 153, 713	0		10. 00 11. 00
12.00	SUBPROVIDER - IRF	41. 00	0		Ŭ		12. 00
13.00	OPERATING ROOM	50. 00	0	· ·			13. 00
14.00	RECOVERY ROOM	51. 00	0				14.00
15.00	DELIVERY ROOM & LABOR ROOM	52. 00	0	'	0		15. 00
16.00	RADI OLOGY-DI AGNOSTI C	54. 00	0				16. 00
17.00	CT SCAN	57. 00	0		0		17. 00
18. 00 19. 00	CARDI AC CATHETERI ZATI ON RESPI RATORY THERAPY	59. 00 65. 00	0	363, 392 751, 122	0		18. 00 19. 00
20.00	SLEEP LAB	65. 00 65. 01	0	46, 051	0		20.00
21. 00	PHYSI CAL THERAPY	66. 00	0	49, 993			21. 00
22.00	OCCUPATI ONAL THERAPY	67. 00	0	6, 982	0		22. 00
23.00	SPEECH PATHOLOGY	68. 00	0	673			23. 00
24.00	ELECTROCARDI OLOGY	69.00	0				24. 00
25. 00	HOSPITAL BASED RETAIL PHARMACIES	73. 01	0	1, 531	0		25. 00
26. 00	RENAL DIALYSIS	74. 00	0	21, 941	0		26. 00
27. 00	CARDI AC REHABI LI TATI ON	76. 97	0	8, 098	-		27. 00
28.00	HYPERBARIC OXYGEN THERAPY	76. 98	0	141, 468	0		28. 00
29.00	SUBSTANCE ABUSE CLINIC	90. 01	0	3, 592	0		29. 00
30.00	PAIN CLINIC	90. 02	0				30.00
31.00	ONCOLOGY CLINIC	90. 03	0		0		31. 00 32. 00
32. 00 33. 00	EMERGENCY OBSERVATION BEDS (DISTINCT	91. 00 92. 01	0	928, 727 7, 512			32.00
33.00	PART)	72.01	O	7,312			33.00
34.00	GIFT, FLOWER, COFFEE SHOP &	190. 00	0	543	0		34.00
	CANTEEN						
35.00	RESEARCH	191. 00	0	239			35. 00
36.00	WELLNESS CENTER	194. 05	0	1, 119			36.00
37. 00 38. 00	PEDI ATRI C THERAPI ES CARDI NAL BEHAVI ORAL HEALTH	194. 13 194. 25	0	6, 125 124			37. 00 38. 00
39. 00	BLACKFORD COMMUNITY HOSPITAL		0	129			39. 00
	0		— — <u> </u>				1
	B - BILLABLE SUPPLIES						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	•			1.00
2.00	ADMITTING	5. 04	0	_	,		2.00
3. 00	OTHER ADMINISTRATIVE AND GENERAL	5. 06	0	758	0		3.00
4.00	DI ETARY	10. 00	0	39	0		4. 00
5. 00	NURSING ADMINISTRATION	13. 00	0	6	0		5. 00
6.00	CENTRAL SERVICES & SUPPLY	14. 00	0	387, 270	0		6. 00
7. 00	PHARMACY	15. 00	0	5, 758			7. 00
8.00	ADULTS & PEDIATRICS	30.00	0	114, 563			8.00
9. 00 10. 00	INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT	31. 00 35. 00	0	112, 170 24, 491	0		9. 00 10. 00
11. 00	SUBPROVI DER - I RF	41. 00	0		-		11. 00
12.00	OPERATING ROOM	50. 00	0				12. 00
13.00	RECOVERY ROOM	51. 00	0	8, 205	0		13. 00
14.00	DELIVERY ROOM & LABOR ROOM	52. 00	0	115, 117	0		14. 00
15.00	RADI OLOGY-DI AGNOSTI C	54. 00	0	, ,			15. 00
16.00	CARDI AC CATHETERI ZATI ON	59. 00	0	4, 046, 907	0		16.00
17.00	RESPIRATORY THERAPY	65. 00	0	20, 053			17. 00
18. 00 19. 00	PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	66. 00 67. 00	0	2, 428 88			18. 00 19. 00
20.00	ELECTROCARDI OLOGY	69. 00	0				20.00
21. 00	RENAL DIALYSIS	74. 00	0	2, 099			21. 00
22. 00	HYPERBARIC OXYGEN THERAPY	76. 98	0		0		22. 00
23.00	SUBSTANCE ABUSE CLINIC	90. 01	0	32			23. 00
24.00	PAIN CLINIC	90. 02	0				24. 00
25.00	ONCOLOGY CLINIC	90. 03	0				25. 00
26. 00	EMERGENCY	91. 00	0	88, 263	0	I	26. 00

Peri od: From 01/01/2020 To 12/31/2020 Date/Ti me Prepared: 7/15/2021 12:59 pm

						7/15/2021	
		Decreases					
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6.00	7. 00	8.00	9. 00	10.00		
27. 00	OBSERVATION BEDS (DISTINCT	92. 01	0	369	0		27. 00
20.00	PART)	104 22		107			20.00
28. 00	THERAPIES TO OTHER ENTITIES	1 <u>94.</u> 22	의		<u> </u>		28. 00
	O IMPLANTABLE DEVILORS		0	11, 046, 804			
1 00	C - IMPLANTABLE DEVICES	F 0/	ol	20	1 0	T	1 00
1. 00	OTHER ADMINISTRATIVE AND	5. 06	0	39	0		1.00
2 00	GENERAL CERVILOES & CURRLY	14.00					0.00
2.00	CENTRAL SERVICES & SUPPLY	14. 00	0	4 77/	0		2.00
3.00	ADULTS & PEDIATRICS	30. 00	0	4, 776			3.00
4. 00	INTENSIVE CARE UNIT	31. 00	0	3, 098	1		4.00
5. 00	NEONATAL INTENSIVE CARE UNIT	35. 00	0	106	0		5.00
6.00	OPERATING ROOM	50. 00	0	7, 357, 603	0		6.00
7. 00	RECOVERY ROOM	51. 00	U	147	0		7.00
8. 00	DELIVERY ROOM & LABOR ROOM	52. 00	0	4, 001	ĭ		8.00
9.00	RADI OLOGY-DI AGNOSTI C	54. 00	0	749, 238	0		9.00
10.00	CARDI AC CATHETERI ZATI ON	59. 00	0	3, 159, 081	0		10.00
11.00	PHYSI CAL THERAPY	66. 00	0	113	0		11.00
12.00	HYPERBARIC OXYGEN THERAPY PAIN CLINIC	76. 98	0	1, 275	0		12.00
13.00		90. 02	0	3, 750			13.00
14. 00	EMERGENCY	<u> </u>	— — 0	2 <u>1, 7</u> 98			14. 00
	D - BI LLABLE DRUGS		Ų	11, 305, 027			_
1. 00	PHARMACY	15. 00	O	39, 150, 473	0		1.00
2. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	94, 315			2.00
3. 00	ADMITTING	5. 04	0	94, 313			3. 00
4. 00	OTHER ADMINISTRATIVE AND	5. 04	0	2, 623			4.00
4.00	GENERAL	5.00	٥	2, 023	٥		4.00
5. 00	DI ETARY	10. 00	o	98	0		5. 00
6. 00	NURSING ADMINISTRATION	13. 00	o	15			6.00
7. 00	CENTRAL SERVICES & SUPPLY	14. 00	o	1, 393			7. 00
8. 00	ADULTS & PEDIATRICS	30. 00	o	183, 660	1		8. 00
9. 00	INTENSIVE CARE UNIT	31. 00	o	62, 920	0		9. 00
10.00	NEONATAL INTENSIVE CARE UNIT	35. 00	o	10, 347	0		10.00
11.00	SUBPROVI DER - I RF	41. 00	o	1, 877	0		11. 00
12.00	OPERATING ROOM	50.00	o	180, 097	0		12. 00
13. 00	RECOVERY ROOM	51. 00	ő	26, 906			13. 00
14. 00	DELIVERY ROOM & LABOR ROOM	52. 00	ő	18, 323	0		14. 00
15. 00	RADI OLOGY-DI AGNOSTI C	54. 00	ő	637, 508	ĺ		15. 00
16.00	CT SCAN	57. 00	ő	931	Ö		16. 00
17. 00	CARDI AC CATHETERI ZATI ON	59. 00	ő	67, 154	•		17. 00
18. 00	RESPI RATORY THERAPY	65. 00	ő	13, 351	0		18. 00
19. 00	PHYSI CAL THERAPY	66. 00	ő	82	0		19. 00
20.00	ELECTROCARDI OLOGY	69. 00	ő	336	Ö		20. 00
21.00	RENAL DIALYSIS	74. 00	ő	43, 473	0		21. 00
22. 00	CARDI AC REHABI LI TATI ON	76. 97	ő	275	Ö		22. 00
23. 00	HYPERBARI C OXYGEN THERAPY	76. 98	0	52, 208	l o		23. 00
24.00	PAIN CLINIC	90. 02	ő	1, 165	Ö		24. 00
	ONCOLOGY CLINIC	90. 03	ő	74, 509			25. 00
26.00	EMERGENCY	91. 00	ő	121, 225			26. 00
27. 00	OBSERVATION BEDS (DISTINCT	92. 01	0	721	0		27. 00
27.00	PART)	72.0.	آ	7	Ĭ		1 27.00
28. 00	RENTAL PROPERTY	194. 08	n	147	n		28. 00
29.00	CANCER CENTER BOUTIQUE	194. 23	o	55			29. 00
		+	— — -	40, 746, 255			
	E - INTERN & RESIDENT SALARI	ES					
1.00	OTHER ADMINISTRATIVE AND	5. 06	39, 600	0	0		1.00
	GENERAL						
2.00	I&R SERVICES-OTHER PRGM COST	S 22.00	4, 043, 956	0	0		2. 00
	APPRVD	1					
			4, 083, 556	<u> </u>			
	F - CAFETERIA						
1.00	DI ETARY	10. 00	<u>1, 183, 1</u> 80	991, 392	0		1. 00
	0		1, 183, 180	991, 392			
	G - PHARMACY ADMIN COSTS						
1.00	HOSPITAL BASED RETAIL	73. 01	79, 746	45, 496	0		1. 00
	PHARMACI ES						
2.00	L	<u>0.</u> 00	0	0	0		2. 00
	0		79, 746	45, 496			
	H - AUTO & BUILDING INSURANC						
1.00	OTHER ADMINISTRATIVE AND	5. 06	0	344, 057	12		1. 00
	GENERAL	↓	↓		L		1
	0		0	344, 057			

Period: Worksheet A-o From 01/01/2020 To 12/31/2020 Date/Time Prepared: 7/15/2021 12:59 pm

						7/15/2021 12	:59 pm
		Decreases					
	Cost Center	Li ne #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7. 00	8. 00	9. 00	10. 00		
1 00	I - REHAB ADMIN COSTS	// 00	054 405	17 100			1
1.00	PHYSI CAL THERAPY	66.00	254, 495	17, 102	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4. 00			— — — — <u>— — — — — — — — — — — — — — — </u>	17, 102	<u> </u>		4. 00
	U J - LAUNDRY		254, 495	17, 102			1
1 00	ADMITTING	5. 04	0	15	ol		1 100
1. 00 2. 00	OTHER ADMINISTRATIVE AND	5. 04	0	315			1. 00 2. 00
2.00	GENERAL	3.00	ď	313	O		2.00
3. 00	HOUSEKEEPI NG	9. 00	o	209, 717	0		3. 00
4. 00	DI ETARY	10. 00	o	16, 254	0		4. 00
5. 00	NURSING ADMINISTRATION	13. 00	o	10, 234	0		5.00
6. 00	CENTRAL SERVICES & SUPPLY	14. 00	o	418, 515	0		6.00
7. 00	PHARMACY	15. 00	0		0		7. 00
8. 00	PATIENT TRANSPORTATION	•	0	727	0		
		18. 00	0	3, 012	0		8.00
9.00	ADULTS & PEDIATRICS	30.00	-1	363, 281	0		9.00
	INTENSIVE CARE UNIT	31.00	0	83, 745	0		10.00
11.00	NEONATAL INTENSIVE CARE UNIT	35. 00	0	5, 649	0		11.00
	SUBPROVIDER - IRF OPERATING ROOM	41.00	0	19, 911	0		12.00
13.00	RECOVERY ROOM	50. 00 51. 00	0	108, 202	0		13.00
	DELIVERY ROOM & LABOR ROOM			21, 626	0		14.00
		52. 00 54. 00	0	21, 703	0		15.00
16.00	RADI OLOGY-DI AGNOSTI C		0	61, 893	0		16.00
17.00	CARDI AC CATHETERI ZATI ON	59.00	0	7, 292	0		17.00
18. 00	BLOOD STORING, PROCESSING, &	63. 00	U	1, 732	U		18. 00
10.00	TRANS.	45.00		252			10.00
19.00	RESPIRATORY THERAPY	65. 00	0	353	0		19.00
20.00	SLEEP LAB	65. 01	0	22, 995	0		20.00
21.00	PHYSI CAL THERAPY	66.00	0	22, 565	0		21.00
22.00	ELECTROCARDI OLOGY	69. 00	0	6, 417	0		22. 00
23. 00	HOSPITAL BASED RETAIL	73. 01	0	49	0		23. 00
04.00	PHARMACI ES	74.00		4 440			04.00
	RENAL DI ALYSI S	74.00	0	1, 113	0		24.00
	CARDI AC REHABI LI TATI ON	76. 97	0	5	0		25. 00
	HYPERBARI C OXYGEN THERAPY	76. 98	0	17, 806	0		26. 00
27. 00	SUBSTANCE ABUSE CLINIC	90. 01	0	101	0		27. 00
28. 00	PAIN CLINIC	90. 02	0	4, 862	0		28. 00
29. 00	ONCOLOGY CLINIC	90. 03	0	105	0		29. 00
30.00	EMERGENCY	91. 00	0	91, 893	0		30.00
31. 00	OBSERVATION BEDS (DISTINCT	92. 01	0	40	0		31. 00
22.00	PART)	104.05		4 000			22.00
32.00	WELLNESS CENTER	194. 05	0	4, 903	0		32.00
33. 00	PEDI ATRI C THERAPI ES	1 <u>94.</u> 13	— — — }	2, 434 1, 519, 354	<u> </u>		33. 00
	L - IRF AND PACU MEDSURG		<u> </u>	1, 519, 554			1
1. 00	SUBPROVI DER – I RF	41. 00	17, 026	6, 934	0		1.00
2. 00	RECOVERY ROOM	51. 00	10, 105	6, 092			2.00
2.00	TOTALS		27, 131	13, 026			2.00
	Q - NURSERY		2.7.10.1	.07 020			İ
1.00	ADULTS & PEDIATRICS	30. 00	442, 329	37, 544	0		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52. 00	16, 491	1, 425			2. 00
	$\overline{0}$ $\overline{}$ $\overline{}$ $\overline{}$ $\overline{}$		458, 820	38, 969			
	S - EMPLOYEE BENEFITS						
1. 00	COMMUNI CATI ONS	5. 01	0	202, 433			1. 00
2. 00	ADMITTING	5. 04	0	266, 521	0		2. 00
3. 00	OTHER ADMINISTRATIVE AND	5. 06	0	876, 821	0		3. 00
	GENERAL						
4. 00	MAINTENANCE & REPAIRS	6. 00	0	874, 851	0		4. 00
5. 00	OPERATION OF PLANT	7. 00	0	218, 975			5. 00
6. 00	HOUSEKEEPI NG	9. 00	0	1, 015, 894			6. 00
7. 00	DI ETARY	10. 00	0	755, 838			7. 00
8. 00	NURSING ADMINISTRATION	13. 00	0	1, 081, 229			8. 00
9. 00	PHARMACY	15. 00	0	941, 363			9. 00
10.00	PATIENT TRANSPORTATION	18. 00	0	127, 861	0		10. 00
11.00	I&R SERVICES-OTHER PRGM COST	S 22. 00	0	821, 020	0		11. 00
	APPRVD						
12.00	PARAMED ED PRGM	23. 00	0	12, 364	1		12.00
13.00	ADULTS & PEDIATRICS	30. 00	0	4, 469, 674	1		13. 00
	INTENSIVE CARE UNIT	31. 00	0	1, 237, 398			14. 00
15.00	NEONATAL INTENSIVE CARE UNIT	35. 00	0	473, 167	0		15. 00
16.00	SUBPROVI DER - I RF	41. 00	0	326, 359	1		16. 00
17.00	OPERATING ROOM	50. 00	0	1, 263, 698			17. 00
18. 00	RECOVERY ROOM	51. 00	0	289, 176	0		18. 00

Peri od: From 01/01/2020 To 12/31/2020 Date/Ti me Prepared: 7/15/2021 12:59 pm

		_				7/15/2021 12	:59 pm
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
10.00	6.00	7. 00	8.00	9. 00	10.00		40.00
19.00	DELIVERY ROOM & LABOR ROOM	52. 00	0				19.00
20.00	RADI OLOGY-DI AGNOSTI C	54.00	0				20.00
21.00	CT SCAN	57. 00	0				21.00
22.00	CARDI AC CATHETERI ZATI ON	59. 00	0				22.00
23.00	RESPIRATORY THERAPY	65. 00	0				23. 00
24.00	SLEEP LAB	65. 01	0				24.00
25.00	PHYSI CAL THERAPY	66. 00	0	•			25. 00
26.00	OCCUPATIONAL THERAPY	67. 00	0	, =			26. 00
27.00	SPEECH PATHOLOGY	68. 00	0				27. 00
	ELECTROCARDI OLOGY	69. 00	0				28. 00
29. 00	HOSPITAL BASED RETAIL	73. 01	0	224, 984	0		29. 00
20.00	PHARMACI ES	7/ 07		000 475			20.00
30.00	CARDI AC REHABI LI TATI ON	76. 97	0				30.00
	HYPERBARI C OXYGEN THERAPY	76. 98		· ·			31.00
	SUBSTANCE ABUSE CLINIC	90. 01	0	1,			32.00
33.00	PAIN CLINIC	90. 02	0		0		33.00
34.00	ONCOLOGY CLINIC	90. 03	0				34.00
35.00	EMERGENCY	91. 00	0	, , , , ,			35.00
36. 00	OBSERVATION BEDS (DISTINCT	92. 01	0	15, 743	0		36. 00
07.00	PART)	100.00					07.00
37. 00	GIFT, FLOWER, COFFEE SHOP &	190. 00	0	24, 839	0		37. 00
20.00	CANTEEN	404.00	_	407 451	_		20.00
38.00	RESEARCH	191. 00	0		0		38.00
39.00	BSU PHARMACY	194. 01	0		0		39.00
40.00	PAVILLION PHARMACY	194. 02	0	,	0		40.00
41.00	WELLNESS CENTER	194. 05	0		0		41.00
	PEDI ATRI C THERAPI ES	194. 13	0	257, 512			42.00
43.00	JAY COUNTY HOSPITAL	194. 16	0	,			43.00
44.00	THERAPIES TO OTHER ENTITIES	194. 22	0	,			44.00
45.00	CANCER CENTER BOUTIQUE	194. 23					45. 00
46. 00	BLACKFORD COMMUNITY HOSPITAL	1 <u>94.</u> 26	<u> </u>	 			46. 00
	U		0	23, 032, 415			-
1 00	T - CORPORATE TELEHPONE	12.00			1		1 00
1.00	NURSING ADMINISTRATION	13.00	0	•			1.00
2. 00	I &R SERVICES-OTHER PRGM COST	S 22.00	U	1, 082	0		2. 00
2 00	APPRVD ADULTS & PEDIATRICS	20.00	0	1 241			2 00
3. 00 4. 00	NEONATAL INTENSIVE CARE UNIT	30. 00 35. 00	0				3. 00 4. 00
5. 00	RADI OLOGY-DI AGNOSTI C		-	.,			5.00
	1	54. 00	0				
6. 00	CARDI AC CATHETERI ZATI ON	59. 00	0	263			6.00
7. 00	SUBSTANCE ABUSE CLINIC	90. 01 90. 02	0				7.00
8. 00 9. 00	PAIN CLINIC OBSERVATION BEDS (DISTINCT	90. 02 92. 01	0				8. 00 9. 00
9.00	PART)	92.01	U	2, 249	U		9.00
	<u> </u>	 	$$	13, 886	 		
	U - DEPRECIATION		0	13,000			1
1. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	28	9		1.00
2. 00	ADMITTING	5. 04		•			2.00
3. 00	OTHER ADMINISTRATIVE AND	5. 06	0				3. 00
0.00	GENERAL	0.00	· ·	207, 110	Ŭ		0.00
4.00	MAINTENANCE & REPAIRS	6. 00	0	6, 177, 710	0		4. 00
5. 00	OPERATION OF PLANT	7. 00	0				5. 00
6. 00	HOUSEKEEPI NG	9. 00	0				6.00
7. 00	DI ETARY	10. 00					7. 00
8. 00	NURSING ADMINISTRATION	13. 00	0				8.00
9. 00	CENTRAL SERVICES & SUPPLY	14. 00	0	, , , ,			9. 00
10.00	PHARMACY	15. 00	0				10.00
11. 00	PATIENT TRANSPORTATION	18. 00	0				11. 00
12.00	I&R SERVICES-OTHER PRGM COST		0				12. 00
.2.00	APPRVD	22.00	J.	002, 100			12.00
13.00	ADULTS & PEDIATRICS	30. 00	0	2, 245, 362	0		13.00
14. 00	INTENSIVE CARE UNIT	31. 00	0	,			14. 00
15. 00	NEONATAL INTENSIVE CARE UNIT	35. 00	0				15. 00
	SUBPROVI DER - I RF	41. 00	0				16. 00
17. 00	OPERATING ROOM	50. 00	0				17. 00
18. 00	RECOVERY ROOM	51. 00	0	,			18. 00
19. 00	DELIVERY ROOM & LABOR ROOM	52. 00	0				19. 00
20.00	RADI OLOGY-DI AGNOSTI C	54. 00	0				20.00
21. 00	CARDI AC CATHETERI ZATI ON	59. 00	0				21.00
22. 00	LABORATORY	60. 00	0	1			22. 00
23. 00	BLOOD STORING, PROCESSING, 8	63. 00	0	ľ			23. 00
_0.00	TRANS.	03.00			l ~		_5.00
24.00	RESPIRATORY THERAPY	65. 00	0	180, 251	0		24. 00
25. 00	SLEEP LAB	65. 01	0				25. 00
	•			, 3 . 0			

Peri od: From 01/01/2020 To 12/31/2020 Date/Ti me Prepared: 7/15/2021 12:59 pm

						7/15/2021	12: 59 pm
	0	Decreases	6-1	0.4.1	W 4 7 D. 6	ſ	
	Cost Center	Li ne #	Sal ary		Wkst. A-7 Ref.		
26. 00	6. 00 PHYSI CAL THERAPY	7. 00 66. 00	8. 00	9. 00 19, 433	10.00		26. 00
27. 00	OCCUPATIONAL THERAPY	67. 00	0	600	0		27. 00
28. 00	SPEECH PATHOLOGY	68. 00	Ö	1, 806	0		28. 00
29. 00	ELECTROCARDI OLOGY	69. 00	0	179, 118	0		29. 00
30.00	RENAL DIALYSIS	74. 00	0	7, 664	0		30.00
31.00	CARDIAC REHABILITATION	76. 97	0	4, 709	0		31. 00
32.00	HYPERBARIC OXYGEN THERAPY	76. 98	0	34, 138	0		32. 00
33.00	PAIN CLINIC	90. 02	0	75, 407	0		33. 00
34.00	ONCOLOGY CLINIC	90. 03	0	3, 372	0		34.00
35.00	EMERGENCY	91. 00	0	689, 755	0		35.00
36. 00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190. 00	U	253	U		36. 00
37. 00	RESEARCH	191. 00	0	111	0		37. 00
38. 00	WELLNESS CENTER	194. 05	Ö	27, 228	0		38. 00
39. 00	RENTAL PROPERTY	194. 08	o	161, 911	0		39. 00
40.00	IU HEALTH HOSPICE	194. 11	0	6	0		40.00
41.00	PEDIATRIC THERAPIES	194. 13	0	53, 192	0		41. 00
42.00	THERAPIES TO OTHER ENTITIES	1 <u>94.</u> 22	0	<u>1, 4</u> 87	0		42. 00
	0		0	18, 699, 025			
1 00	V - LEASE EXPENSE		اه	004 4/5	40		1 00
1. 00 2. 00	RADI OLOGY-DI AGNOSTI C SLEEP LAB	54. 00 65. 01	O ₁	391, 165	10 0		1. 00 2. 00
3. 00	PHYSI CAL THERAPY	66. 00	0	101, 548 237, 351	0		3.00
4. 00	HOSPITAL BASED RETAIL	73. 01	0	45, 328	0		4. 00
1. 00	PHARMACI ES	70.01	J	10, 020	Ŭ		1.00
5.00	ONCOLOGY CLINIC	90. 03	0	15, 454	0		5. 00
6.00	RENTAL PROPERTY	194. 08	o	<u>171, 7</u> 63	0		6. 00
	0		0	962, 609			
	W - PTO USED AS STD			-1	_		
1.00	COMMUNI CATI ONS	5. 01	2, 187	0	0		1.00
2.00	ADMITTING	5. 04	4, 529	0	0		2.00
3. 00	OTHER ADMINISTRATIVE AND GENERAL	5. 06	6, 158	U	U		3. 00
4. 00	MAINTENANCE & REPAIRS	6. 00	11, 867	0	0		4. 00
5. 00	OPERATION OF PLANT	7. 00	1, 952	0	0		5. 00
6.00	HOUSEKEEPI NG	9. 00	25, 654	0	0		6. 00
7.00	DI ETARY	10. 00	9, 570	0	0		7. 00
8. 00	NURSING ADMINISTRATION	13. 00	39, 193	0	0		8. 00
9. 00	PHARMACY	15. 00	38, 879	0	0		9. 00
10.00	PATIENT TRANSPORTATION	18. 00	438	0	0		10. 00
11.00	ADULTS & PEDIATRICS	30. 00	83, 219	0	0		11.00
12. 00 13. 00	INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT	31. 00 35. 00	57, 874	0	0		12. 00 13. 00
14.00	SUBPROVIDER - IRF	41. 00	20, 550 2, 426	0	0		14.00
15. 00	OPERATING ROOM	50. 00	31, 218	0	0		15. 00
16. 00	RECOVERY ROOM	51. 00	14, 786	0	0		16. 00
17.00	DELIVERY ROOM & LABOR ROOM	52. 00	22, 029	0	0		17. 00
18.00	RADI OLOGY-DI AGNOSTI C	54. 00	37, 868	0	0		18. 00
19.00	CT SCAN	57. 00	1, 904	0	0		19. 00
20.00	RESPI RATORY THERAPY	65. 00	22, 099	0	0		20. 00
21.00	SLEEP LAB	65. 01	2, 121	0	0		21.00
22.00	PHYSI CAL THERAPY	66. 00	37, 293	0	0		22.00
23. 00 24. 00	OCCUPATI ONAL THERAPY ELECTROCARDI OLOGY	67. 00 69. 00	2, 678 5, 376	0	0		23. 00 24. 00
25. 00	CARDI AC REHABI LI TATI ON	76. 97	3, 380	0	0		25. 00
26. 00	HYPERBARI C OXYGEN THERAPY	76. 98	948	0	0		26. 00
27. 00	SUBSTANCE ABUSE CLINIC	90. 01	2, 185	0	0		27. 00
28.00	PAIN CLINIC	90. 02	1, 989	0	0		28. 00
29.00	ONCOLOGY CLINIC	90. 03	22, 097	0	0		29. 00
30.00	EMERGENCY	91. 00	25, 778	0	0		30. 00
31. 00	GIFT, FLOWER, COFFEE SHOP &	190. 00	671	0	0		31. 00
00.00	CANTEEN	101 00	0.01/				
32.00	RESEARCH	191. 00	2, 216	0	0		32.00
33.00	PEDIATRIC THERAPIES	194. 13	13, 971	0	0		33.00
34.00	THERAPIES TO OTHER ENTITIES	1 <u>94.</u> 22	1 <u>0, 2</u> 34 565, 337	— — <u> </u>	<u> </u>		34.00
	X - WASTE DISPOSAL		303, 337	U U			
1. 00	NEW CAP REL COSTS-BLDG & FIX	T 1.00	0	22, 389	14		1.00
2. 00	MAINTENANCE & REPAIRS	6. 00	0	63, 391	0		2. 00
3.00	HOUSEKEEPI NG	9. 00	0	109, 167	0		3. 00
4.00	PHARMACY	15. 00	0	31, 262	0		4. 00
5. 00	OPERATING ROOM	50. 00	O	2, 156	0		5.00
6. 00	RADI OLOGY-DI AGNOSTI C	54. 00	0	494	0		6.00
7. 00	SLEEP LAB	65. 01	U	916	0		7. 00

BALL MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0089

					To	12/31/2020 Date/Time 7/15/2021	
		Decreases					
	Cost Center 6.00	Li ne # 7.00	Sal ary 8.00	0ther 9.00	Wkst. A-7 Ref. 10.00		
8. 00	PHYSI CAL THERAPY	66. 00	0.00	334	0		8. 00
9. 00	HOSPITAL BASED RETAIL	73. 01	0	3, 871	0		9. 00
40.00	PHARMACI ES	22.22		0.4.005			10.00
10. 00 11. 00	PAIN CLINIC	90. 02 194. 08	0	84, 985			10. 00 11. 00
11.00	RENTAL PROPERTY	194.08	 	10 <u>8, 4</u> 5 <u>6</u> 427, 421			11.00
	Y - UTILITIES		<u> </u>	127, 121	L .		
1.00	NEW CAP REL COSTS-BLDG & FIXT		0	97, 793			1.00
2.00	MAINTENANCE & REPAIRS	6. 00	0	36, 920			2. 00
3. 00 4. 00	OPERATING ROOM RADIOLOGY-DIAGNOSTIC	50. 00 54. 00	0	47 3, 586	0		3. 00 4. 00
5. 00	SLEEP LAB	65. 01	0	2, 161	0		5. 00
6. 00	PHYSI CAL THERAPY	66. 00	Ö	554	Ö		6. 00
7.00	HYPERBARIC OXYGEN THERAPY	76. 98	0	1, 647	0		7. 00
8. 00	RENTAL PROPERTY	194. 08	0	429, 693	0		8. 00
9. 00	BLACKFORD COMMUNITY HOSPITAL	1 <u>94.</u> 26		1 <u>6, 6</u> 03 589, 004	<u> </u>		9. 00
	Z - BLACKFORD		<u> </u>	389, 004			
1. 00	OTHER ADMINISTRATIVE AND	5. 06	250, 280	111, 230	0		1.00
	GENERAL]		
2.00	MAINTENANCE & REPAIRS	6. 00	36, 656	112, 346			2. 00
3. 00 4. 00	OPERATION OF PLANT DIETARY	7. 00 10. 00	31, 588	15, 392 2, 764			3. 00 4. 00
5. 00	NURSI NG ADMI NI STRATI ON	13. 00	5, 484 71, 290	43, 595			5. 00
6. 00	PHARMACY	15. 00	130, 477	46, 567	1		6. 00
7.00	RADI OLOGY-DI AGNOSTI C	54. 00	27, 969	43, 786	1		7. 00
8. 00	CARDI AC CATHETERI ZATI ON	59. 00	4, 684	1, 694			8. 00
9.00	RESPIRATORY THERAPY	65. 00	12, 097	6, 649	0		9. 00
10. 00 11. 00	PHYSI CAL THERAPY ELECTROCARDI OLOGY	66. 00 69. 00	39, 116 3, 051	8, 272 3, 419	0		10. 00 11. 00
12.00	CARDI AC REHABI LI TATI ON	76. 97	3, 263	1, 374			12. 00
13.00	JAY COUNTY HOSPITAL	194. 16	<u>56, 8</u> 25	<u>9, 2</u> 73			13. 00
	0		672, 780	406, 361			_
1 00	AB - PARAMEDICAL EDUCATION	15 00	122 040	10 220			1 1 00
1. 00	PHARMACY	1500	13 <u>3, 8</u> 48 133, 848	1 <u>0, 2</u> 39 10, 239			1.00
	AC - PROPERTY TAX		133, 040	10, 237			
1.00	OTHER ADMINISTRATIVE AND	5. 06	0	171, 426	13		1.00
	GENERAL						ļ
2. 00	RESPI RATORY THERAPY	<u>65.</u> 00		540			2. 00
	O		U_	171, 966			
1. 00	OTHER ADMINISTRATIVE AND	5. 06	246, 638	109, 376	0		1.00
	GENERAL			•			
2.00	MAINTENANCE & REPAIRS	6. 00	30, 464	92, 260	0		2. 00
3.00	OPERATION OF PLANT	7. 00	31, 588	15, 392	0		3.00
4. 00 5. 00	DI ETARY NURSI NG ADMI NI STRATI ON	10. 00 13. 00	5, 729 128, 441	2, 887 84, 390			4. 00 5. 00
6. 00	PHARMACY	15. 00	115, 478	41, 214			6. 00
7.00	RADI OLOGY-DI AGNOSTI C	54. 00	36, 373	56, 943			7. 00
8.00	CARDI AC CATHETERI ZATI ON	59. 00	3, 317	1, 199			8. 00
9. 00	RESPIRATORY THERAPY	65. 00	13, 842	7, 609	1		9.00
10. 00 11. 00	PHYSI CAL THERAPY ELECTROCARDI OLOGY	66. 00 69. 00	40, 858 8, 362	8, 641 9, 371	0		10. 00 11. 00
12.00	BLACKFORD COMMUNITY HOSPITAL	194. 26	13, 160	1, 369	1 -1		12. 00
	0 — — — — —		674, 250	430, 651			
	AE - MALPRACTICE INSURANCE						
1. 00	OTHER ADMINISTRATIVE AND	5. 06	0	250	0		1. 00
2. 00	GENERAL RADI OLOGY-DI AGNOSTI C	54. 00		100			2. 00
2.00	0		하				2.00
	AF - ACCRUED PTO						
1.00	OTHER ADMINISTRATIVE AND	5. 06	1, 540, 100	0	0		1. 00
	GENERAL — — — —	+		₀	├		
500 00	TOTALS Grand Total: Decreases		1, 540, 100 9, 673, 243	119, 352, 357			500.00
500.00	orana rotar. Decreases	l	7, 073, 243	117, 332, 337	1		1300.00

Health Financial Systems	BALL MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Period: Worksheet A-7

12/31/2020 Date/Time Prepared: 7/15/2021 12:59 pm Acqui si ti ons Begi nni ng Purchases Donati on Total Disposals and Retirements Bal ances 2.00 3.00 4.00 1.00 5.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 2, 924, 410 3, 148, 114 3, 148, 114 1.00 3, 630, 983 2.00 Land Improvements 17,010 17,010 218, 278 2.00 266, 944, 035 3.00 Buildings and Fixtures 15, 242, 412 15, 242, 412 323, 577 3.00 4.00 Building Improvements 68, 911, 312 14, 328, 883 14, 328, 883 5, 230 4.00 5.00 Fixed Equipment 5.00 6.00 117, 532, 439 Movable Equipment 7, 536, 437 7, 536, 437 913, 296 6.00 7.00 HIT designated Assets 0 7.00 8.00 Subtotal (sum of lines 1-7) 459, 943, 179 40, 272, 856 40, 272, 856 1, 460, 381 8.00 Reconciling Items 9.00 9.00 0 Total (line 8 minus line 9) 459, 943, 179 40, 272, 856 40, 272, 856 1, 460, 381 10.00 10.00 Endi ng Bal ance Fully Depreciated Assets 6.00 7.00 PART CHANGES IN CAPITAL ASSET BALANCES 1.00 6, 072, 524 1.00 Land 2.00 1, 292, 432 Land Improvements 3, 429, 715 2.00 3.00 Buildings and Fixtures 281, 862, 870 92,009,329 3.00 4.00 Building Improvements 909, 412 83, 234, 965 4.00 5.00 5 00 Fixed Equipment 57, 503, 326 6.00 Movable Equipment 124, 155, 580 6.00 7.00 HIT designated Assets 7.00 Subtotal (sum of lines 1-7) Reconciling Items 8.00 498, 755, 654 151, 714, 499 8.00 9.00 9.00 10.00 Total (line 8 minus line 9) 498, 755, 654 151, 714, 499 10.00

Health Financial Systems	BALL MEMORIAL HOSPITAL			In Lieu of Form CMS-2552-10		
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der C	CN: 15-0089	Peri od: From 01/01/2020	Worksheet A-7 Part II	,
					Date/Time Pre 7/15/2021 12:	
SUMMARY OF CAPITAL						
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 WO	ORKSHEET A, COL		and 2			
1.00 NEW CAP REL COSTS-BLDG & FLXT	2, 771, 512	9, 307		0	0	1.00
3.00 Total (sum of lines 1-2)	2, 771, 512	9, 307		0 0	0	3. 00
	SUMMARY 0	F CAPITAL				
Cost Center Description	Other	Total (1) (sum				
	Capi tal -Rel ate	of cols. 9				
	Costs (see	through 14)				
	instructions)					
	14. 00	15. 00				
PART II - RECONCILIATION OF AMOUNTS FROM W	DRKSHEET A, COL	UMN 2, LINES 1	and 2			
1.00 NEW CAP REL COSTS-BLDG & FLXT	835, 853	3, 616, 672				1.00
3.00 Total (sum of lines 1-2)	835, 853	3, 616, 672				3. 00

Health Financial Systems	BALL MEMORIA	L HOSPITAL		In Lieu	u of Form CMS-2	552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der C		eriod: rom 01/01/2020	Worksheet A-7	
					Date/Time Pre	pared:
				I	7/15/2021 12:	59 pm
	COMF	PUTATION OF RA	1108	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capitalized	Gross Assets	Ratio (see	Insurance	
3333 33333 F3, 33		Leases	for Ratio	instructions)		
			(col. 1 - col.	Í		
			2)			
	1. 00	2. 00	3. 00	4. 00	5. 00	
PART III - RECONCILIATION OF CAPITAL COSTS		-	· · · · · · · · · · · · · · · · · · ·		_	
1.00 NEW CAP REL COSTS-BLDG & FIXT	498, 755, 654		498, 755, 654			1.00
3.00 Total (sum of lines 1-2)	498, 755, 654		498, 755, 654			3.00
	ALLOCAT	TION OF OTHER (JAPITAL	SUMMARY U	F CAPITAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Rel ate	cols. 5	·		
		d Costs	through 7)			
	6. 00	7. 00	8. 00	9. 00	10. 00	
PART III - RECONCILIATION OF CAPITAL COSTS	CENTERS					
1.00 NEW CAP REL COSTS-BLDG & FLXT	0	0	C	29, 549, 161		1. 00
3.00 Total (sum of lines 1-2)	0	0	0	29, 549, 161	971, 916	3.00
		Su	MMARY OF CAPI	IAL		
Cost Center Description	Interest	nsurance (see	Taxes (see	Other	Total (2) (sum	
		instructions)	instructions)	Capi tal -Relate	of cols. 9	
				d Costs (see	through 14)	
				instructions)		
	11. 00	12. 00	13. 00	14. 00	15. 00	
PART III - RECONCILIATION OF CAPITAL COSTS	<u> </u>					
1.00 NEW CAP REL COSTS-BLDG & FLXT	-3, 201, 837					1.00
3.00 Total (sum of lines 1-2)	-3, 201, 837	344, 057	171, 966	1, 013, 744	28, 849, 007	3.00

				T	o 12/31/2020	Date/Time Pre	pared:
				Expense Classification on	Worksheet A	7/15/2021 12:	59 pm
				o/From Which the Amount is			
	Cost Center Description	1.00	Amount 2.00	Cost Center 3.00	Li ne # 4. 00	Wkst. A-7 Ref. 5.00	
1.00	Investment income - NEW CAP R			NEW CAP REL COSTS-BLDG & FI		11	1.00
2. 00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		0	*** Cost Center Deleted ***	2.00	0	2. 00
2.00	COSTS-MVBLE EQUIP (chapter 2)		U	cost center bereted	2. 00	U	2.00
3. 00	Investment income - other		0		0. 00	0	3. 00
4. 00	(chapter 2) Trade, quantity, and time		0		0. 00	0	4. 00
	discounts (chapter 8)						
5. 00	Refunds and rebates of expension (chapter 8)	es	0		0. 00	0	5. 00
6. 00	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
7.00	stations excluded) (chapter 2	1)	0		0.00	0	7.00
8. 00	Television and radio service		0		0. 00	0	8. 00
9. 00	(chapter 21) Parking Lot (chapter 21)		0		0. 00	0	9. 00
10.00	Provi der-based physician	A-8-2	-21, 829, 932			0	10. 00
11. 00	adjustment Sale of scrap, waste, etc.		0		0. 00	0	11. 00
	(chapter 23)						
12. 00	Related organization transactions (chapter 10)	A-8-1	45, 598, 906			0	12. 00
	Laundry and linen service		0		0. 00	0	
14. 00 15. 00	Cafeteria-employees and guest Rental of quarters to employe		-1, 195, 180	CAFETERI A	11. 00 0. 00	0	
13.00	and others		Ü		0.00	O	15.00
16.00	Sale of medical and surgical	+-	0		0. 00	0	16. 00
17. 00	supplies to other than patien Sale of drugs to other than	15	0		0. 00	0	17. 00
	pati ents		0		0.00		10.00
18.00	Sale of medical records and abstracts		U		0. 00	0	18. 00
19. 00	Nursing and allied health		0		0. 00	0	19. 00
	education (tuition, fees, books, etc.)						
	Vending machines		0		0. 00	0	
21. 00	Income from imposition of interest, finance or penalty		0		0. 00	0	21. 00
	charges (chapter 21)						
22. 00	Interest expense on Medicare	_	0		0. 00	0	22. 00
	overpayments and borrowings to repay Medicare overpayments						
23. 00	Adjustment for respiratory	A-8-3	0	RESPI RATORY THERAPY	65. 00		23. 00
	therapy costs in excess of limitation (chapter 14)						
24.00	Adjustment for physical thera		0	PHYSI CAL THERAPY	66. 00		24. 00
	costs in excess of limitation (chapter 14)						
25. 00	Utilization review -		0	*** Cost Center Deleted ***	114. 00		25. 00
	physicians' compensation (chapter 21)						
26. 00	Depreciation - NEW CAP REL		0	NEW CAP REL COSTS-BLDG & FI	(T 1.00	0	26. 00
27.00	COSTS-BLDG & FIXT		0	*** Cost Center Deleted ***	2.00	0	27. 00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		Ü	Cost Center Dereted	2. 00	0	27.00
	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19. 00		28. 00
	Physicians' assistant Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	0. 00 67. 00	0	29. 00 30. 00
	therapy costs in excess of		G				
30 99	limitation (chapter 14) Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30. 00		30. 99
	instructions)						
31. 00	Adjustment for speech patholocosts in excess of limitation		0	SPEECH PATHOLOGY	68. 00		31. 00
	(chapter 14)						
32. 00	CAH HIT Adjustment for Depreciation and Interest		0		0. 00	0	32. 00
33. 00	MI SCELLANEOUS INCOME	В	-42, 583	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33. 00

	Financial Systems		BALL MEMORIA			u of Form CMS-2	
ADJUST	MENTS TO EXPENSES			Provider CCN: 15-0089	eri od:	Worksheet A-8	3
					rom 01/01/2020 o 12/31/2020	Date/Time Pre	enared:
					0 12/31/2020	7/15/2021 12:	
				Expense Classification on	Worksheet A		
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description			Cost Center		Wkst. A-7 Ref.	
24.00	IMI COEL I ANEQUE I NICOME	1.00	2.00	3.00	4. 00	5. 00	24 00
	MISCELLANEOUS INCOME MISCELLANEOUS INCOME	B B		COMMUNICATIONS OTHER ADMINISTRATIVE AND	5. 01 5. 06	0	34. 00 35. 00
35. 00	MI SCELLANEOUS I NCOME	В	-293, 163	GENERAL	5.06	0	35.00
26 00	MISCELLANEOUS INCOME	В	220 654	MAINTENANCE & REPAIRS	6. 00	0	36. 00
	MI SCELLANEOUS I NCOME	В		OPERATION OF PLANT	7. 00		37. 00
	MI SCELLANEOUS I NCOME	В		HOUSEKEEPI NG	9.00		•
	MI SCELLANEOUS I NCOME	В	-216, 243		10. 00		
	MI SCELLANEOUS I NCOME	B		NURSING ADMINISTRATION	13. 00		40.00
	MI SCELLANEOUS I NCOME	B		PHARMACY	15. 00		
	MISCELLANEOUS INCOME	В		PATIENT TRANSPORTATION	18. 00		42. 00
	MISCELLANEOUS INCOME	B		I&R SERVICES-OTHER PRGM COS			43. 00
			_, -, -, -	APPRVD		_	
44.00	MISCELLANEOUS INCOME	В	-101, 896	OPERATING ROOM	50. 00	0	44.00
45.00	MISCELLANEOUS INCOME	В	-514, 875	RADI OLOGY-DI AGNOSTI C	54. 00	0	45. 00
46.01	MISCELLANEOUS INCOME	В	-51, 682	CT SCAN	57. 00	0	46. 01
46.02	MISCELLANEOUS INCOME	В		CARDIAC CATHETERIZATION	59. 00	0	46. 02
	MISCELLANEOUS INCOME	В		SLEEP LAB	65. 01	0	46. 04
	MISCELLANEOUS INCOME	В		PHYSI CAL THERAPY	66. 00		46. 05
	MISCELLANEOUS INCOME	В		OCCUPATI ONAL THERAPY	67. 00		46. 06
	MISCELLANEOUS INCOME	В		SPEECH PATHOLOGY	68. 00		10.07
	MISCELLANEOUS INCOME	В		ELECTROCARDI OLOGY	69. 00		46. 08
46. 09	MISCELLANEOUS INCOME	В		HOSPITAL BASED RETAIL	73. 01	0	46. 09
4/ 10	MI COEL LANGOUG LANGONE			PHARMACI ES	7, 07	_	4/ 10
	MI SCELLANEOUS I NCOME	В		CARDIAC REHABILITATION	76. 97		1
	MI SCELLANEOUS I NCOME	B B		SUBSTANCE ABUSE CLINIC	90. 01		46. 11
	MISCELLANEOUS INCOME	B R		EMERGENCY	91.00	0	
	MISCELLANEOUS INCOME MISCELLANEOUS INCOME	В		BSU PHARMACY JAY COUNTY HOSPITAL	194. 01 194. 16	Ĭ	
	MISCELLANEOUS INCOME	В		THERAPIES TO OTHER ENTITIES			46. 18
	MISCELLANEOUS INCOME	В		BLACKFORD COMMUNITY HOSPITA			
	NON-ALLOWABLE MARKETING	A		OTHER ADMINISTRATIVE AND	5.06		
70. 21	THOSE THE WARRENT NO		1, 300, 770	GENERAL	3.00		10.21
47 00	NON ALLOWADLE MADKETING		4 745	NUDCLAC ADMINISTRATION	12.00		47 22

-1, 745 NURSING ADMINISTRATION

-131 RADI OLOGY-DI AGNOSTI C

-13, 912 OTHER ADMINISTRATIVE AND

-23, 074, 001 EMPLOYEE BENEFITS DEPARTMENT

65, 699 SUBSTANCE ABUSE CLINIC

298, 071 NEW CAP REL COSTS-BLDG & FIXT

1,445 EMPLOYEE BENEFITS DEPARTMENT

-23, 955, 256 OTHER ADMINISTRATIVE AND

-60 CARDI AC REHABI LI TATI ON

-60 OPERATING ROOM

-120 PAIN CLINIC

GENERAL

GENERAL

-33, 904, 633

13.00

50.00

54.00

76. 97

90.02

5.06

4.00

5.06

1.00

90. 01

4.00

46.22

46. 23

46.24

46. 25

46. 26

46. 27

46. 28

46. 29

46.30

46. 31

46.32

50.00

14

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TOTAL (sum of lines 1 thru 49)

(Transfer to Worksheet A,

LOSS ON EXTINGUISHMENT OF DEB

ADDICTION AND PAIN CLINIC START

NON-ALLOWABLE MARKETING

NON-ALLOWABLE MARKETING

NON-ALLOWABLE MARKETING

NON-ALLOWABLE MARKETING

46. 25 NON-ALLOWABLE MARKETING

CORPORATE TELEPHONE

46. 28 EMPLOYEE BENEFITS OFFSET

PENSION EXPENSE

46. 22

46.23

46. 24

46.26

46.27

46.30

46.31

46.32

50.00

46. 29 HAF FEES

CARRY

LIP C

⁽²⁾ Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME Provider CCN: 15-0089 OFFICE COSTS

Peri od: From 01/01/2020 To 12/31/2020 Date/Time Prepare:

002	300.0			To 12/31/2020	Date/Time Pre 7/15/2021 12:	
	Li ne No.	Cost Center	Expense Items		mount Included	
				Allowable Cost		
					column 5	
	1. 00	2. 00	3. 00	4. 00	5. 00	
		MENTS REQUIRED AS A RESULT (OF TRANSACTIONS WITH RELATED	ORGANI ZATI ONS	OR	
1. 00	CLAIMED HOME OFFICE COSTS:	NEW CAP REL COSTS-BLDG & FIX	HOME OFFICE	8, 078, 624	0	1. 00
2. 00		EMPLOYEE BENEFITS DEPARTMENT		23, 644, 322	0	2. 00
3. 00			HOME OFFICE	18, 166, 907	0	3. 00
4. 00		ADMITTING	HOME OFFICE	8, 913, 006	0	4. 00
4. 00		CASHIERING/ACCOUNTS RECEIVAE		10, 742, 441	0	4. 00
4. 01		OTHER ADMINISTRATIVE AND GEN		29, 592, 611	53, 537, 913	4. 01
4. 02			HOME OFFICE	29, 592, 611	1, 092	4. 02
4. 03		NEW CAP REL COSTS-BLDG & FIX		3, 301	3, 301	4. 03
4. 05		EMPLOYEE BENEFITS DEPARTMENT		583, 128	583, 128	4. 05
4. 06		OTHER ADMINISTRATIVE AND GEN		1, 143, 695	1, 143, 695	4. 06
4. 07			RELATED PARTY	413, 989	413, 989	4. 07
4. 07	la contraction of the contractio	I&R SERVICES-OTHER PRGM COST		2, 279, 569	2, 279, 569	4. 07
4. 09			RELATED PARTY	10, 880, 643	10, 880, 643	4. 09
4. 10			RELATED PARTY	1, 500	1, 500	4. 10
4. 10		NEONATAL INTENSIVE CARE UNIT		1, 542, 328	1, 542, 328	4. 10
4. 12			RELATED PARTY	117, 680	117, 680	4. 12
4. 13			RELATED PARTY	6, 419, 510	6, 419, 510	4. 13
4. 14			RELATED PARTY	1, 663, 177	1, 663, 177	4. 14
4. 15			RELATED PARTY	30, 735	30, 735	4. 15
4. 16			RELATED PARTY	12, 514, 706	12, 514, 706	4. 16
4. 17			RELATED PARTY	101, 548	101, 548	4. 17
4. 18			RELATED PARTY	153, 435	153, 435	4. 18
4. 19		HOSPITAL BASED RETAIL PHARMA		45, 328	45, 328	4. 19
4. 20			RELATED PARTY	48, 936	48, 936	4. 20
4. 21			RELATED PARTY	420, 399	420, 399	4. 21
4. 22			RELATED PARTY	418, 269	418, 269	4. 22
4. 23			RELATED PARTY	310, 652	310, 652	4. 23
4. 24			RELATED PARTY	2, 635, 372	2, 635, 372	4. 24
4. 25			RELATED PARTY	6, 730	6, 730	4. 25
4. 26			RELATED PARTY	137, 292	137, 292	4. 26
4. 27		BLACKFORD COMMUNITY HOSPITAL		6, 160	6, 160	4. 27
5. 00	lo		o	141, 015, 993	95, 417, 087	5. 00
	amounts on lines 1-4 (and su	ubscripts as appropriate) are	transferred in detail to W		umn 6 lines a	S

* 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 look been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

			Related Organization(s) and.	or Home Office	
Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
1. 00	2. 00	3. 00	4. 00	5. 00	
B. INTERRELATIONSHIP TO RELA	TED ORGANIZATION(S) AND/OR	HOME OFFICE:			

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish 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 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 request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under tit XVIII.

6. 00	В	0. 00 I U HEALTH 100. 0	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.
- $\hbox{B. Corporation, partnership, or other organization has financial interest in provider}.$
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

	Financial Systems		BALL MEMORIAL H		In Lieu	of Form CMS-2552-	10
		RVICES FROM RELATE	ED ORGANIZATIONS AND HOME	Provider CCN: 15-0089	Peri od: From 01/01/2020	Worksheet A-8-1	
OFFI CE	C0515					Date/Time Prepare 7/15/2021 12:59 pt	d:
	Net AdjustmentsVkst	. A-7 Ref.				77 137 2021 12: 37 6	
	(col. 4 minus						
	col. 5)*						
	6. 00	7. 00					
	A. COSTS INCURRED CLAIMED HOME OFFICE		REQUIRED AS A RESULT OF T	RANSACTIONS WITH RELATE	ED ORGANIZATIONS	OR	
1.00	8, 078, 624	9				1. (00
2.00	23, 644, 322	o				2. (
3.00	18, 166, 907	o				3. 0	00
4.00	8, 913, 006	0				4. 0	00
4.01	10, 742, 441	0				4. 0	01
4. 02	-23, 945, 302	0				4. (
4. 03	-1, 092	0				4. 0	
4. 04	0	9				4. 0	
4. 05	0	0				4. (
4. 06	0	0				4. (
4. 07	0	0				4. (
4. 08	0	0				4. (
4. 09 4. 10		0				4. (
4. 10	0					4.	
4. 12						4.	
4. 13	0	ŏ				4.	
4. 14	0	ol				4.	
4. 15	0	o				4.	
4. 16	0	o				4.	
4. 17	0	o				4. *	17
4. 18	0	0				4. 1	
4. 19	0	0				4. 1	
4. 20	0	0				4.2	
4. 21	0	0				4.2	
4. 22	0	0				4.2	
4 23	ı ∩l	Οl				4	73

* 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 look been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

4. 25

4.26

4.27

5.00

Related Organization(s) and/or
Home Office

Type of Business

6.00

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish 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 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 request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under tit XVIII.

6. 00	HEALTHCARE		6.00
7. 00 8. 00 9. 00 10. 00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00]	100.00

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

4. 24 4. 25

4.26

4 27

0

45, 598, 906

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

PROVI DER BASED PHYSI CI AN ADJUSTMENT Provi der CCN: 15-0089 | Period: | Worksheet A-8-2 | From 01/01/2020 | To 12/31/2020 | Date/Time Prepared:

					T	o 12/31/2020	Date/Time Pr 7/15/2021 12	epared: ·59 pm
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount F	hysi ci an/Provi	
		I denti fi er	Remuneration	Component	Component		der Component	
				·	· ·		Hours	
	1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	7. 00	
1. 00	5. 04	ADMI TTI NG	1, 500	1, 500	0	211, 500	0	1.00
2.00	5. 06	OTHER ADMINISTRATIVE AND	2, 642, 788	2, 282, 788	360, 000	211, 500	5, 760	2. 00
		GENERAL						
3.00	30.00	ADULTS & PEDIATRICS	10, 880, 643	10, 880, 643	0	179, 000	0	3. 00
4.00		NEONATAL INTENSIVE CARE UNIT	1, 542, 328			169, 700		4. 00
5. 00		SUBPROVIDER - IRF	-72, 273			211, 500	•	5. 00
6. 00		OPERATING ROOM	5, 939, 810			246, 400		6. 00
7. 00		RADI OLOGY-DI AGNOSTI C	1, 209, 500		1, 209, 500	271, 900		
8. 00		HYPERBARIC OXYGEN THERAPY	48, 936			211, 500	1	0.00
9. 00	1	SUBSTANCE ABUSE CLINIC	420, 399	•		211, 501	0	7.00
10.00		PAIN CLINIC	393, 351			211, 500		10. 00
11.00	91.00	EMERGENCY	2, 001, 477		2, 001, 477	211, 500		
200.00			25, 008, 459					200.00
	Wkst. A Line #		Unadjusted RCE		Cost of	Provi der	Physician Cost	
		l denti fi er	Limit		Memberships &(
				Limit	Conti nui ng	of col. 12	Insurance	
	1.00	2.00	0.00	0.00	Educati on	10.00	14.00	
1. 00	1.00	2. 00	8.00	9. 00	12.00	13. 00	14. 00	1.00
2. 00		ADMITTING OTHER ADMINISTRATIVE AND	585, 692		-	0		
2.00	5.00	GENERAL	383, 692	29, 283	U	U	0	2.00
3. 00	30 00	ADULTS & PEDIATRICS	0	0	0	0	0	3. 00
4. 00	•	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	
5. 00		SUBPROVI DER - I RF	0	0	0	0	0	
6. 00		OPERATING ROOM		0	0	0	0	
7. 00		RADI OLOGY-DI AGNOSTI C	1, 291, 787	64, 589	Ö	0	Ö	0.00
8. 00		HYPERBARIC OXYGEN THERAPY	1,2,1,,0,	01,007	0	0	0	8. 00
9. 00		SUBSTANCE ABUSE CLINIC	ĺ	0	0	0	0	9. 00
10.00	•	PAIN CLINIC	0	0	0	0	0	10.00
11. 00		EMERGENCY	1, 609, 027	80, 451	0	0	Ö	
200. 00			3, 486, 506			0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
			component Share		Di sal I owance	•		
			of col. 14					
	1. 00	2. 00	15. 00	16.00	17. 00	18. 00		
1. 00		ADMI TTI NG	0		0	1, 500		1. 00
2. 00	5. 06	OTHER ADMINISTRATIVE AND	0	585, 692	0	2, 282, 788		2. 00
		GENERAL						
3. 00	•	ADULTS & PEDIATRICS	0	Ĭ	0	10, 880, 643		3. 00
4. 00	•	NEONATAL INTENSIVE CARE UNIT	0	0	0	1, 542, 328	ł	4. 00
5. 00		SUBPROVI DER – I RF	0	0	0	-72, 273		5. 00
6. 00	•	OPERATING ROOM	0		0	5, 939, 810		6. 00
7. 00		RADI OLOGY-DI AGNOSTI C	0	1, 291, 787	0	0		7. 00
8.00		HYPERBARIC OXYGEN THERAPY	0	0	0	48, 936		8.00
9.00		SUBSTANCE ABUSE CLINIC	0	0	0	420, 399		9.00
10.00	•	PAIN CLINIC]	1 (00 007	202 450	393, 351	1	10.00
11.00	•	EMERGENCY	0	.,,			1	11.00
200. 00	l		0	3, 486, 506	392, 450	21, 829, 932	I	200. 00

ealth Financial Systems OST ALLOCATION - GENERAL	SEDVICE COSTS	BALL MEMORIA	L HOSPITAL Provider C	CN: 15 0000 In	<u>In Lieu</u> eriod:	of Form CMS-2 Worksheet B	2552-1
OST ALLOCATION - GENERAL .	SERVICE COSTS		Provider C	EN. 15-0069 F	rom 01/01/2020		enared
			CAPI TAL		12, 01, 2020	7/15/2021 12:	59 pm
Ocat Ocaton Dec		Not Formand	RELATED COSTS	EMDLOVEE		DATA	
Cost Center Des	scription	Net Expenses for Cost	NEW BLDG & FLXT	EMPLOYEE BENEFITS	COMMUNI CATI ONS	DATA PROCESSI NG	
		Allocation (from Wkst A		DEPARTMENT			
		col. 7)	1.00	4.00	5.01		
GENERAL SERVICE COST		0	1.00	4.00	5. 01	5. 02	
00 00100 NEW CAP REL COS 00 00400 EMPLOYEE BENEFI		28, 849, 007 25, 990, 489	28, 849, 007 65, 408	26, 055, 897			1. 00 4. 00
01 01160 COMMUNI CATI ONS		473, 293	28, 814	111, 576			5.0
02 00550 DATA PROCESSING 04 00570 ADMITTING		18, 166, 907 10, 195, 781	0 111, 412	0 256, 246	0 6, 840	18, 166, 907 0	1
05 00580 CASHI ERI NG/ACCO		10, 742, 441	0	0	0	0	5. 0
06 00590 OTHER ADMINISTR		40, 819, 820 10, 338, 211	789, 924 14, 295, 657			0	
00 00700 OPERATION OF PL		6, 815, 023	706, 235	341, 454		0	
00 00800 LAUNDRY & LINE! 00 00900 HOUSEKEEPING	N SERVICE	1, 519, 354 3, 357, 689	0 195, 892	642, 132	0 31, 436	0	
. 00 01000 DI ETARY . 00 01100 CAFETERI A		2, 178, 560 979, 392	174, 922 216, 150			0	
.00 01300 NURSING ADMINIS		7, 186, 662	216, 672	1, 277, 691	24, 196	0	13. 0
. 00 01400 CENTRAL SERVI CE . 00 01500 PHARMACY	ES & SUPPLY	8, 861, 014 6, 169, 553	335, 516 116, 472		0 20, 234	0	
. 00 01600 MEDICAL RECORDS		0	0	0	0	0	16. 0
.00 01080 PATIENT TRANSPO .00 02100 & SERVICES-SA		662, 324 4, 083, 556	11, 355 0			0	
.00 02200 I&R SERVICES-0	THER PRGM COSTS APPRVD	3, 472, 169	661, 560	49, 187	2, 475	0	
.00 02300 PARAMED ED PRGM INPATIENT ROUTINE SE		247, 313	3, 084	50, 182	1, 058	0	23. 0
.00 03000 ADULTS & PEDIA00 03100 INTENSIVE CARE		29, 670, 927 7, 842, 866	2, 688, 274 437, 455		130, 620 33, 947	1, 969, 912 611, 033	
.00 03200 CORONARY CARE (JNI T	7, 042, 000	437, 433	1, 330, 107	0	0	32. 0
. 00 02060 NEONATAL I NTENS . 00 04000 SUBPROVI DER - I		2, 483, 792 0	161, 132 0	450, 489 0	9, 791 0	148, 053 0	1
. 00 04100 SUBPROVI DER - 1		1, 982, 839	158, 096			97, 756	41.0
. 00 04300 NURSERY ANCI LLARY SERVICE CO	ST CENTERS	497, 789	49, 167	100, 437	2, 162	29, 182	43.0
. 00 05000 OPERATING ROOM . 00 05100 RECOVERY ROOM		7, 225, 146 1, 539, 583	599, 236 130, 136		31, 096 7, 289	1, 523, 550 209, 283	•
00 05200 DELIVERY ROOM 8		2, 142, 301	203, 166	427, 442	9, 651	250, 743	52.0
00 05400 RADI OLOGY-DI AGN 00 05700 CT SCAN	NOSTI C	12, 588, 124 96, 765	988, 694 0			2, 357, 089 30, 008	
00 05800 MAGNETIC RESONA		0	0	0	0	0	58.0
. 00 05900 CARDI AC CATHETE . 00 06000 LABORATORY	ERIZATION	2, 347, 188 12, 646, 932	215, 059 283, 329		9, 302 14, 346	956, 414 811, 266	1
. 01 06001 BLOOD LABORATOR		0	0		0	76 042	
. 00 06300 BLOOD STORI NG, . 00 06500 RESPI RATORY THE		1, 316, 009 3, 670, 667	69, 520	742, 311	16, 614	76, 042 276, 341	
. 01 06501 SLEEP LAB . 00 06600 PHYSI CAL THERAF	ργ	484, 527 4, 444, 601	0 246, 418	99, 707 875, 611		54, 999 184, 637	1
. 00 06700 OCCUPATI ONAL TH	HERAPY	927, 050	38, 018	183, 653		68, 185	67.0
. 00 06800 SPEECH PATHOLOG . 01 06801 AUDI OLOGY	βY	610, 977 0	9, 093 0	124, 015	2, 452 0	38, 290 0	1
. 00 06900 ELECTROCARDI OLO		1, 476, 096	291, 568	263, 691	7, 908	505, 843	69.0
.00 07100 MEDICAL SUPPLIE .00 07200 MPL. DEV. CHAF		11, 046, 559 11, 305, 027	0	0	0	813, 584 973, 838	
.00 07300 DRUGS CHARGED	TO PATIENTS	40, 111, 517	0	0	0	3, 397, 324	73.0
. 01 07301 HOSPI TAL BASED . 00 07400 RENAL DI ALYSI S	RETAIL PHARMACTES	7, 394, 751 1, 416, 514	14, 043 46, 146		4, 631 0	69, 158 38, 260	•
. 00 03160 CARDI OPULMONAR		0	0	0	0	0	76. 0
. 97 07697 CARDI AC REHABI I . 98 07698 HYPERBARI C OXYO		925, 884 1, 208, 319	0 6, 563	.,0,000		39, 915 157, 769	•
OUTPATIENT SERVICE C . 00 09000 CLINIC			^			0	90. 0
. 01 09001 SUBSTANCE ABUSE	CLINIC	287, 878	100, 911	44, 020	1, 504	2, 808	•
OO TOOOOOT DALKE OF LAILO		410, 151 1, 619, 697	354, 920 45, 956			62, 455 358, 713	
			40.700	<u> </u>	5,4/9	JJO, / 13	1 70.0
. 02 09002 PAIN CLINIC . 03 09003 ONCOLOGY CLINIC . 00 09100 EMERGENCY		10, 535, 271	533, 749			2, 052, 277	
.03 09003 ONCOLOGY CLINI(.00 09100 EMERGENCY .00 09200 OBSERVATION BEI	OS (NON-DISTINCT PART)	10, 535, 271	533, 749	1, 648, 516	42, 132	2, 052, 277	92. 0
.03 09003 ONCOLOGY CLINIC	OS (NON-DISTINCT PART) OS (DISTINCT PART) OST CENTERS		533, 749 3, 985	1, 648, 516 19, 678	42, 132 323	2, 052, 277 2, 180	92. 0

371, 583, 888

25, 615, 014

24, 715, 388

113. 00

18, 166, 907 118. 00

599, 234

SPECIAL PURPOSE COST CENTERS

113.00 11300 INTEREST EXPENSE

118.00 SUBTOTALS (SUM OF LINES 1 through 117)

Health Financial Systems	BALL MEMORIAL HOSPITAL	-	In Lieu	of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COS	S Provi d	er CCN: 15-0089	From 01/01/2020	Worksheet B Part I Date/Time Prepared:

SECTION SELECTION	1		rom 01/01/2020	Part I		
			ĮT	o 12/31/2020	Date/Time Pre 7/15/2021 12:	epared:
		CAPI TAL			1/13/2021 12.	J9 pili
		RELATED COSTS				
Cost Center Description	Net Expenses	NEW BLDG &	EMPLOYEE	COMMUNICATIONS	DATA	
cost center bescription	for Cost	FLXT	BENEFITS	COMMONT CATTONS	PROCESSI NG	
	Allocation	1171	DEPARTMENT		1 KOCLSSI NO	
	(from Wkst A		DELAKTIVILINI			
	col. 7)					
	0	1.00	4. 00	5. 01	5. 02	
NONREI MBURSABLE COST CENTERS	Ŭ	1.00	1. 00	0.01	0.02	
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN	498, 108	0	37, 471	1, 717	0	190. 00
191. 00 19100 RESEARCH	742, 969	29, 573	146, 384	· ·		191.00
194. 0007950 OTHER NONREIMBURSABLE COST CENTERS	0	27, 070	0	0,720		194. 00
194. 0107951 BSU PHARMACY	36, 811	Ō	39, 885	659		194. 01
194. 0207952 PAVILLION PHARMACY	6, 033, 461	40, 168	181, 267	3, 240		194. 02
194. 0307953 VENDI NG	0	0	0	O		194. 03
194, 0407954 CARELI NE	0	o	0	o		194. 04
194. 0507955 WELLNESS CENTER	539	80, 226	0	o	0	194. 05
194.0607956 PHYSICIAN PRACTICE CLINICS	0	382, 643	0	o	0	194. 06
194. 0707957 PERINATAL CLINIC	0	0	0	o	0	194. 07
194. 0807958 RENTAL PROPERTY	740, 740	1, 432, 997	0	o		194. 08
194. 0907959 ADVERTI SI NG	0	, , , ,	0	o	0	194. 09
194. 1007960 I NTEGRA LTAC	0	186, 150	O	o	0	194. 10
194. 1107961 IU HEALTH HOSPICE	420	48, 091	O	o		194. 11
194.1207962 POB MEDICAL PAVILLION CONDOS	0	0	0	0	0	194. 12
194. 1307963 PEDI ATRI C THERAPI ES	1, 402, 407	105, 956	280, 775	0	0	194. 13
194.1407964 NEW CASTLE ONCOLOGY	0	0	0	0	0	194. 14
194. 1507965 MARKETING/PUBLIC RELATIONS	0	35, 171	0	0	0	194. 15
194. 1607966 JAY COUNTY HOSPITAL	1, 188, 762	79, 530	214, 881	2, 502	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. 1907969 HEALTH CARE CONNECTIONS	0	0	0	0	0	194. 19
194.20 <mark>07970</mark> MEALS ON WHEELS	0	0	0	0	0	194. 20
194. 2107971 ST MARY'S SCHOOL	0	0	0	0	0	194. 21
194.2207972 THERAPIES TO OTHER ENTITIES	0	0	269, 838	0	0	194. 22
194. 23 07973 CANCER CENTER BOUTIQUE	90, 000	13, 474	3, 302	180	0	194. 23
194. 2407974 BOSC BALL OUTPATIENT SURGERY	0	391, 119	0	0		194. 24
194. 25 07975 CARDI NAL BEHAVI ORAL HEALTH	43	0	0	0		194. 25
194. 2607976 BLACKFORD COMMUNITY HOSPITAL	1, 170, 258	60, 126	166, 706	2, 425		194. 26
194. 2707977 MI DWEST HEALTH STRATEGIES	0	0	0	0		194. 27
194.2807978 CARDINAL SELECT RISK RETENTION GRP	0	0	0	0		194. 28
194.2907979 HOME OFFICE CARDINAL HEALTH INITIATI	0	0	0	0		194. 29
194.3007980 CARDINAL HEALTH ALLIANCE	0	0	0	0		194. 30
194. 31 07986 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194. 31
194. 32 <mark>07982 RENAL DI ALYSI S</mark>	0	0	0	0		194. 32
194. 33 <mark>07983 LAB CORP</mark>	0	0	0	0		194. 33
194. 34 07984 H. O. MATERI ALS MGMT	0	0	0	0		194. 34
194. 35 <mark>07985</mark> LEASED SPACE	0	348, 769	0	0		194. 35
200.00 Cross Foot Adjustments		ļ				200. 00
201.00 Negative Cost Centers		0	0	0		201. 00
202.00 TOTAL (sum lines 118 through 201)	383, 488, 406	28, 849, 007	26, 055, 897	613, 683	18, 166, 907	202. 00

COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 15-0089

				I ^T	o 12/31/2020	Date/Time Pre 7/15/2021 12:	
	Cost Center Description	ADMI TTI NG	CASHI ERI NG/ACC			MAINTENANCE &	
			OUNTS RECEI VABLE		ADMI NI STRATI VE	REPAI RS	
		5. 04	5. 05	5A. 05	AND GENERAL 5.06	6. 00	
	GENERAL SERVICE COST CENTERS						
1. 00 4. 00	00100 NEW CAP REL COSTS-BLDG & FIXT 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 ADMI TTI NG	10, 570, 279					5. 04
5. 05 5. 06	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 00590 OTHER ADMINI STRATI VE AND GENERAL	0	10, 742, 441 0	43, 114, 303	43, 114, 303		5. 05 5. 06
6. 00	00600 MAI NTENANCE & REPAI RS	Ö	Ö	25, 357, 939		28, 569, 953	6. 00
7. 00	00700 OPERATION OF PLANT	0	0	7, 872, 433		1, 488, 229	7. 00
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	0	0	1, 519, 354 4, 227, 149		0 412, 797	8. 00 9. 00
10.00	· · · · · · · · · · · · · · · · · · ·	0	0	2, 703, 986		368, 608	10.00
11.00	01100 CAFETERI A	0	0	1, 466, 770		455, 487	11. 00
13.00	· · · · · · · · · · · · · · · · · · ·	0	0	8, 705, 221	1, 102, 664	456, 586	
14. 00 15. 00	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	O	0	9, 196, 530 7, 424, 900		707, 024 245, 439	14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	Ö	7,424,700	0	243, 437	16. 00
	01080 PATIENT TRANSPORTATION	0	0	817, 243		23, 927	18. 00
21.00		0	0	4, 999, 480		1 204 004	21. 00 22. 00
22. 00 23. 00	02300 PARAMED ED PRGM	0	0	4, 185, 391 301, 637	530, 151 38, 207	1, 394, 086 6, 498	
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	Ŭ.	5	331,7337	00/20/	57 175	20.00
30. 00 31. 00		1, 146, 131				5, 664, 922	30.00
	· · · · · · · · · · · · · · · · · · ·	355, 510 0	361, 320 0	11, 178, 240 0	1, 415, 914 0	921, 837 0	31. 00 32. 00
35.00	· · · · · · · · · · · · · · · · · · ·	86, 140	87, 548	3, 426, 945	434, 081	339, 549	
40.00		0	0	0	0	0	40.00
41. 00 43. 00	· · · · · · · · · · · · · · · · · · ·	56, 876 16, 979		2, 724, 466 712, 972	345, 100 90, 310	333, 150 103, 608	
43.00	ANCILLARY SERVICE COST CENTERS	10, 777			70, 310	103, 000	45.00
50.00		886, 429				1, 262, 752	50. 00
51. 00 52. 00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	121, 765 145, 887		2, 441, 020 3, 327, 461	309, 197 421, 480	274, 232 428, 127	51. 00 52. 00
54.00		1, 371, 397				2, 083, 448	
57.00	05700 CT SCAN	17, 459		191, 755		0	57. 00
58.00	1 1	0	0	0	0	452 107	58. 00
59. 00 60. 00		556, 459 472, 009		5, 108, 235 14, 707, 606		453, 187 597, 051	59. 00 60. 00
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
63.00		44, 243		1, 481, 260		0	63.00
65. 00 65. 01	06500 RESPI RATORY THERAPY 06501 SLEEP LAB	160, 780 31, 999		5, 099, 641 706, 319		146, 497 0	65. 00 65. 01
		107, 425		5, 985, 975		519, 271	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	39, 671	40, 320	1, 300, 490		80, 113	
	06800 SPEECH PATHOLOGY 06801 AUDI OLOGY	22, 278	22, 642	829, 747	105, 102	19, 162	
	06900 ELECTROCARDI OLOGY	294, 309	299, 119	3, 138, 534	397, 549	614, 414	68. 01 69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	473, 358	481, 095	12, 814, 596	1, 623, 186	0	71. 00
		566, 596		13, 421, 317	1, 700, 038	0	72.00
73. 00 73. 01	07300 DRUGS CHARGED TO PATIENTS 07301 HOSPITAL BASED RETAIL PHARMACIES	1, 977, 070 40, 237		47, 494, 698 7, 867, 801	6, 016, 147 996, 591	0 29, 593	73. 00 73. 01
	07400 RENAL DIALYSIS	22, 260	·	1, 545, 804		97, 242	
		0	0	0	0	0	
	07697 CARDIAC REHABILITATION 07698 HYPERBARIC OXYGEN THERAPY	23, 223 91, 793		1, 214, 308 1, 668, 478		0 13, 830	76. 97 76. 98
70. 70	OUTPATIENT SERVICE COST CENTERS	71, 773	73, 273	1,000,470	211, 341	13, 630	70. 70
	09000 CLI NI C	0	0	0	0	0	90.00
	09001 SUBSTANCE ABUSE CLINIC 09002 PAIN CLINIC	1, 634 36, 337		440, 415 983, 412		212, 647 747, 914	90. 01 90. 02
90. 02	· · · · · · · · · · · · · · · · · · ·	208, 705		2, 713, 957		96, 843	90. 02
91.00	09100 EMERGENCY	1, 194, 052				1, 124, 753	91. 00
	1 1 1	1 2/0	1 200	0	21 452	0.200	92.00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	1, 268	1, 289	248, 306	31, 452	8, 398	92. 01
95.00	09500 AMBULANCE SERVICES	0	0	11, 307	1, 432	23, 827	95. 00
112 0	SPECIAL PURPOSE COST CENTERS 011300 INTEREST EXPENSE						113. 00
118. 00		10, 570, 279	10, 742, 441	366, 994, 937	41, 025, 124	21, 755, 048	
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19100 RESEARCH	0	-	537, 296 922, 652		0 62, 318	190.00
	007950 OTHER NONREIMBURSABLE COST CENTERS	0		922, 652	1		191.00 194.00
	, , , , , , , , , , , , , , , , , , , ,	<u> </u>	<u> </u>		<u> </u>		

Health Financial Systems BALL MEMORIAL HOSPITAL

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0089

			T	o 12/31/2020	Date/Time Prepared: 7/15/2021 12:59 pm
Cost Center Description	ADMITTI NG	CASHI ERI NG/ACC	Subtotal	OTHER	MAI NTENANCE &
· ·		OUNTS		ADMI NI STRATI VE	REPAI RS
		RECEI VABLE		AND GENERAL	
	5. 04	5. 05	5A. 05	5. 06	6. 00
194. 01 07951 BSU PHARMACY	0	0	77, 355		0 194. 01
194.0207952 PAVILLION PHARMACY	0	0	6, 258, 136	792, 699	
194. 03 <mark>07953</mark> VENDI NG	0	0	0	0	0 194. 03
194. 04 <mark>07954</mark> CARELI NE	0	0	0	0	0 194. 04
194.0507955 WELLNESS CENTER	0	0	80, 765		169, 058 194. 05
194.0607956 PHYSICIAN PRACTICE CLINICS	0	0	382, 643	48, 468	806, 333 194. 06
194. 07 <mark>07957</mark> PERINATAL CLINIC	0	0	0	0	0 194. 07
194. 0807958 RENTAL PROPERTY	0	0	2, 173, 737	275, 341	3, 019, 715 194. 08
194. 0907959 ADVERTI SI NG	0	0	0	0	0 194. 09
194. 1007960 I NTEGRA LTAC	0	0	186, 150		
194. 11 <mark>07961 I U HEALTH HOSPI CE</mark>	0	0	48, 511	6, 145	101, 341 194. 11
194. 1207962 POB MEDICAL PAVILLION CONDOS	0	0	0	0	0 194. 12
194. 1307963 PEDI ATRI C THERAPI ES	0	0	1, 789, 138	226, 625	223, 278 194. 13
194.1407964 NEW CASTLE ONCOLOGY	0	0	0	0	0 194. 14
194. 1507965 MARKETI NG/PUBLI C RELATI ONS	0	0	35, 171		74, 115 194. 15
194. 1607966 JAY COUNTY HOSPI TAL	0	0	1, 485, 675	188, 186	167, 592 194. 16
194. 17 07967 CARDI NAL HEALTH CHOI CE	0	0	0	0	0 194. 17
194. 1807968 CHV CARDINAL HEALTH VENTURES	0	0	0	0	0 194. 18
194. 1907969 HEALTH CARE CONNECTIONS	0	0	0	0	0 194. 19
194. 2007970 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	269, 838		
194. 2307973 CANCER CENTER BOUTI QUE	0	0	106, 956		
194. 24 07974 BOSC BALL OUTPATIENT SURGERY	0	0	391, 119		824, 195 194. 24
194. 25 07975 CARDI NAL BEHAVI ORAL HEALTH	0	0	43		0 194. 25
194. 26 07976 BLACKFORD COMMUNITY HOSPITAL	0	0	1, 399, 515	177, 272	126, 702 194. 26
194. 27 07977 MI DWEST HEALTH STRATEGIES	0	0	0	0	0 194. 27
194. 2807978 CARDI NAL 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. 3207982 RENAL DI ALYSI S	0	0	0	0	0 194. 32
194. 3307983 LAB CORP	0	0	0	0	0 194. 33
194.3407984 H.O. MATERIALS MGMT 194.3507985 LEASED SPACE		0	240 740	44 170	0 194. 34 734, 950 194. 35
200.00 Cross Foot Adjustments	0	١	348, 769	44, 178	734, 950 194, 35
201.00 Regative Cost Centers	0		0	0	0 201. 00
202.00 TOTAL (sum lines 118 through 201)	10, 570, 279	10, 742, 441	383, 488, 406	12 114 202	
202. 04 TOTAL (Suil TITIES TTO LITTOUGH 201)	10, 570, 279	10, 742, 441	303, 400, 400	43, 114, 303	20, 009, 903 kuz. 00

| Period: | Worksheet B | From 01/01/2020 | Part | To 12/31/2020 | Date/Time Prepared:

				[10) 12/31/2020	Date/lime Pre 7/15/2021 12:	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	07 piii
		PLANT	LINEN SERVICE				
	GENERAL SERVICE COST CENTERS	7. 00	8. 00	9. 00	10. 00	11. 00	
1. 00	00100 NEW CAP REL COSTS-BLDG & FIXT	I			1		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 00600 MAINTENANCE & REPAIRS						5.06
6. 00 7. 00	00700 OPERATION OF PLANT	10, 357, 839					6. 00 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	10, 337, 037	1, 711, 806				8. 00
9. 00	00900 HOUSEKEEPI NG	157, 881	35				9. 00
10.00	01000 DI ETARY	140, 980	0	90, 091	3, 646, 171		10. 00
11.00	01100 CAFETERI A	174, 208	0	111, 325	0	2, 393, 581	11. 00
13.00	01300 NURSING ADMINISTRATION	174, 629	15	111, 593	0	114, 894	
	01400 CENTRAL SERVICES & SUPPLY	270, 413	0	172, 802	0	0	14.00
	01500 PHARMACY	93, 872	297	59, 987	0	96, 079	15.00
	01600 MEDICAL RECORDS & LIBRARY 01080 PATIENT TRANSPORTATION	0 9, 151	8, 156	5, 848	0	0 33, 664	16. 00 18. 00
21. 00	02100 &R SERVICES-SALARY & FRINGES APPRVD	7, 131	0, 130 0	3, 848	0	104, 563	
	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	533, 191	0	340, 726	Ö	11, 753	
	02300 PARAMED ED PRGM	2, 485	9	1, 588	Ō	5, 024	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	2, 166, 641	859, 906		2, 991, 899	620, 237	30.00
	03100 INTENSIVE CARE UNIT	352, 571	141, 704	225, 304	212, 095	161, 196	
32.00	03200 CORONARY CARE UNIT	100.0(0	0	0	0	32.00
35. 00 40. 00	02060 NEONATAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	129, 866	8, 899	82, 988	1, 193	46, 492 0	35. 00 40. 00
41. 00	04100 SUBPROVI DER - TPF	127, 419	57, 048	81, 425	230, 517	37, 582	41. 00
	04300 NURSERY	39, 626	14, 383	·	230, 317	10, 268	43. 00
10.00	ANCILLARY SERVICE COST CENTERS	07,020	11,000	20,020	<u>~</u>	10, 200	10.00
50.00	05000 OPERATING ROOM	482, 960	130, 254	308, 627	0	147, 658	50.00
51.00	05100 RECOVERY ROOM	104, 884	43, 913	67, 024	0	34, 612	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	163, 744	65, 079		0	45, 828	
54.00	05400 RADI OLOGY-DI AGNOSTI C	796, 848	100, 810	499, 576	0	187, 909	
57.00	05700 CT SCAN	0	0	0	0	6, 777	57. 00
58. 00 59. 00	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION	173, 329	21, 623	110, 763	0	0 44, 169	58. 00 59. 00
60.00	06000 LABORATORY	228, 352	21, 023	144, 523	0	68, 118	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0	0	00,110	60. 01
63. 00	06300 BLOOD STORING, PROCESSING, & TRANS.	Ö	383	Ö	Ö	0	63. 00
65.00	06500 RESPI RATORY THERAPY	56, 030	227	35, 805	0	78, 892	65. 00
65. 01	06501 SLEEP LAB	0	172	0	0	12, 180	65. 01
66.00	06600 PHYSI CAL THERAPY	198, 603	8, 200		0	85, 953	
67.00	06700 OCCUPATI ONAL THERAPY	30, 641	0	19, 580	0	17, 061	
68.00	06800 SPEECH PATHOLOGY 06801 AUDI OLOGY	7, 329	0	4, 683	0	11, 643	
68. 01	06900 ELECTROCARDI OLOGY	234, 992	17, 376	150, 168	0	0 37, 550	68. 01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	234, 772	17, 370	130, 108	0		71.00
	07200 IMPL. DEV. CHARGED TO PATIENT	Ö	0	Ö	ő	0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	0	0	Ō	0	73. 00
	07301 HOSPITAL BASED RETAIL PHARMACIES	11, 318	149	0	0	21, 990	73. 01
	07400 RENAL DIALYSIS	37, 192	2, 535	23, 767	0	0	74.00
	03160 CARDI OPULMONARY	0	0	0	0	0	76. 00
	07697 CARDI AC REHABI LI TATI ON	0	0	0	0	24, 612	
76. 98	07698 HYPERBARIC OXYGEN THERAPY OUTPATIENT SERVICE COST CENTERS	5, 289	0	3, 380	0	12, 448	76. 98
00.00	09000 CLINIC	1 0	0	1 0	٥	0	90. 00
	09001 SUBSTANCE ABUSE CLINIC	81, 330	0	51, 973	0		90.00
	09002 PAIN CLINIC	286, 052	0	182, 796	Ö	11, 074	
	09003 ONCOLOGY CLINIC	37, 039	686		ō	26, 018	
91.00	09100 EMERGENCY	430, 180			0	200, 057	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	3, 212	5	2, 053	0	1, 532	92. 01
05.55	OTHER REIMBURSABLE COST CENTERS		-	=	-1		05.65
95.00	09500 AMBULANCE SERVICES	9, 113	0	5, 824	0	0	95. 00
112 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE				- 1		113. 00
113.00		7, 751, 370	1, 702, 301	4, 735, 254	3, 435, 704	2, 324, 973	
	NONREI MBURSABLE COST CENTERS	7,751,570	1, 102, 301	1, 755, 254	3, 133, 704	2,027,710	. 10. 00
190. 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	0	O	0	8, 151	190. 00
191. 00	19100 RESEARCH	23, 834	0	15, 231	Ó	17, 693	191. 00
	07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194. 00
194. 01	07951 BSU PHARMACY	0	0	j 0	0	3, 128	194. 01

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS BALL MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10

Provi der CCN: 15-0089 Period: Worksheet B From 01/01/2020 Part I To 12/31/2020 Date/Time Prepared:

			To	12/31/2020	Date/Time Prepa 7/15/2021 12:59	ared:
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	9 DIII
cost center beservetron		LINEN SERVICE	HOOSEKEELLING	DILIMI	ONIETEKIN	
	7. 00	8. 00	9. 00	10. 00	11. 00	
194. 0207952 PAVILLION PHARMACY	32, 374	154	20, 688	0	15, 387 19	94. 02
194. 03 07953 VENDI NG	0	0	0	0		94. 03
194. 0407954 CARELI NE	0	0	0	0	019	94. 04
194. 05 07955 WELLNESS CENTER	64, 659	9, 239	41, 319	0	019	94. 05
194.0607956 PHYSICIAN PRACTICE CLINICS	308, 395		76, 880	0	019	94.06
194. 07 07957 PERINATAL CLINIC	0	0	0	0	0 19	94. 07
194. 08 07958 RENTAL PROPERTY	1, 154, 938	112	340, 294	0	019	94. 08
194. 09 07959 ADVERTI SI NG	0	0	0	0	019	94. 09
194. 1007960 INTEGRA LTAC	150, 030	0	0	178, 658	019	94. 10
194. 1107961 IU HEALTH HOSPICE	38, 760	0	24, 769	0	0 19	94. 11
194.1207962 POB MEDICAL PAVILLION CONDOS	0	0	0	0	0 19	94. 12
194. 13 07963 PEDI ATRI C THERAPI ES	85, 396	0	0	0	0 19	94. 13
194. 14 07964 NEW CASTLE ONCOLOGY	0	0	0	0	0 19	94. 14
194. 15 07965 MARKETI NG/PUBLI C RELATI ONS	28, 346	0	0	0	0 19	94. 15
194. 1607966 JAY COUNTY HOSPITAL	64, 098	0	40, 961	0	11, 880 19	94. 16
194. 1707967 CARDINAL HEALTH CHOICE	0	0	0	0	0 19	94. 17
194. 1807968 CHV CARDINAL HEALTH VENTURES	0	0	0	0	0 19	94. 18
194. 1907969 HEALTH CARE CONNECTIONS	0	0	0	0	0 19	94. 19
194.2007970 MEALS ON WHEELS	0	0	0	0	0 19	94. 20
194. 21 <mark>07971</mark> ST MARY'S SCHOOL	0	0	0	0	0 19	94. 21
194. 2207972 THERAPIES TO OTHER ENTITIES	0	0	0	0	0 19	94. 22
194. 23 07973 CANCER CENTER BOUTIQUE	10, 859	0	6, 939	0	853 19	94. 23
194. 24 07974 BOSC BALL OUTPATIENT SURGERY	315, 227	0	0	0	0 19	94. 24
194. 25 07975 CARDI NAL BEHAVI ORAL HEALTH	0	0	0	31, 809	0 19	94. 25
194. 2607976 BLACKFORD COMMUNITY HOSPITAL	48, 459	0	30, 967	0	11, 516 19	94. 26
194. 2707977 MIDWEST HEALTH STRATEGIES	0	0	0	0	0 19	94. 27
194.2807978 CARDINAL SELECT RISK RETENTION GRP	0	0	0	0	0 19	94. 28
194.2907979 HOME OFFICE CARDINAL HEALTH INITIATI	0	0	0	0		94. 29
194.3007980 CARDINAL HEALTH ALLIANCE	0	0	0	0		94. 30
194. 31 07986 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		94. 31
194. 32 <mark>07982</mark> RENAL DI ALYSI S	0	0	0	0		94. 32
194. 33 <mark>07983</mark> LAB CORP	0	0	0	0		94. 33
194. 3407984 H. O. MATERIALS MGMT	0	0	0	0		94. 34
194. 35 <mark>07985</mark> LEASED SPACE	281, 094	0	0	0		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)	10, 357, 839	1, 711, 806	5, 333, 302	3, 646, 171	2, 393, 581 20	02.00

Health Financial Systems BALL MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - GENERAL SERVICE COSTS

Peri od: Worksheet B From 01/01/2020 Part I To 12/31/2020 Date/Ti me Prepared: 7/15/2021 12:59 pm Provi der CCN: 15-0089

						7/15/2021 12:	59 pm
						OTHER GENERAL SERVI CE	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	PATI ENT	
		ADMINI STRATI ON	SERVICES & SUPPLY		RECORDS & LI BRARY	TRANSPORTATI ON	
		13. 00	14. 00	15. 00	16. 00	18. 00	
	GENERAL SERVICE COST CENTERS						
1. 00 4. 00	00100 NEW CAP REL COSTS-BLDG & FLXT						1.00
5. 01	00400 EMPLOYEE BENEFITS DEPARTMENT 01160 COMMUNICATIONS						4. 00 5. 01
5. 02	00550 DATA PROCESSING						5. 02
5.04	00570 ADMI TTI NG						5. 04
5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 00590 OTHER ADMI NI STRATI VE AND GENERAL						5. 05
5. 06 6. 00	00600 MAINTENANCE & REPAIRS						5. 06 6. 00
7. 00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY						9. 00 10. 00
	01100 CAFETERI A						11. 00
13.00	01300 NURSING ADMINISTRATION	10, 665, 602		<u>.</u>			13. 00
	01400 CENTRAL SERVICES & SUPPLY	0	11, 511, 666				14.00
	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	0	99, 482 0	8, 960, 546	0		15. 00 16. 00
	01080 PATIENT TRANSPORTATION	o o	232	Ö	0	1, 001, 739	
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21. 00
	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0	37	0	0	0	22. 00
23.00	02300 PARAMED ED PRGM INPATIENT ROUTINE SERVICE COST CENTERS	l U	0	U	0	0	23. 00
30.00	03000 ADULTS & PEDIATRICS	5, 066, 998	794, 305	40, 166	0	108, 685	30. 00
	03100 I NTENSI VE CARE UNIT	1, 331, 949	348, 694	13, 752	0	33, 712	31.00
	03200 CORONARY CARE UNIT 02060 NEONATAL INTENSIVE CARE UNIT	0 373, 240	0 58, 035	0 2, 221	0	0 8, 168	32. 00 35. 00
	04000 SUBPROVI DER - I PF	373, 240	0.033	2, 221	0	0, 100	40. 00
	04100 SUBPROVI DER - I RF	304, 509	22, 565	395	0	5, 393	
43.00	04300 NURSERY	83, 744	0	0	0	1, 610	43. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	394, 286	690, 882	15, 285	0	84, 058	50. 00
	05100 RECOVERY ROOM	306, 275	46, 965	5, 876	0	11, 547	51. 00
	05200 DELIVERY ROOM & LABOR ROOM	359, 258	107, 926	3, 661	0	13, 834	
	05400 RADI OLOGY-DI AGNOSTI C 05700 CT SCAN	275, 515	282, 519 524	6, 476 0	0	130, 046	54. 00 57. 00
	05800 MAGNETIC RESONANCE I MAGING (MRI)		0	0	0	1, 656 0	58. 00
	05900 CARDI AC CATHETERI ZATI ON	204, 134	202, 926	4, 153	0	52, 768	
	06000 LABORATORY	0	0	0	0	44, 760	*
	06001 BLOOD LABORATORY 06300 BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0 4, 195	60. 01 63. 00
	06500 RESPIRATORY THERAPY	41, 798	273, 572	1, 544	0	15, 246	
	06501 SLEEP LAB	442	16, 598	0	0	3, 034	
	06600 PHYSI CAL THERAPY	0	18, 790		0	10, 187	
	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	2, 563 255	0	0		67. 00 68. 00
68.01	06801 AUDI OLOGY	Ö	0	Ö	Ō	2, 110	68. 01
	06900 ELECTROCARDI OLOGY	0	11, 216	0	0	27, 909	•
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	0	3, 981, 257 4, 074, 408	0	0	44, 887 53, 729	71. 00 72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	4, 074, 400	8, 821, 312	0	186, 865	
	07301 HOSPITAL BASED RETAIL PHARMACIES	0	741	0	0		73. 01
	07400 RENAL DI ALYSI S	0	8, 433 0	2, 404	0		74.00
	03160 CARDI OPULMONARY 07697 CARDI AC REHABI LI TATI ON	8, 978	3, 098	0	0	0 2, 202	76. 00 76. 97
	07698 HYPERBARIC OXYGEN THERAPY	93, 310	53, 089	285	Ö	· ·	76. 98
	OUTPATIENT SERVICE COST CENTERS	1	al				00.00
	09000 CLINIC 09001 SUBSTANCE ABUSE CLINIC	0 11, 333	0 1, 518	0	0	0 155	90. 00 90. 01
	09002 PAIN CLINIC	39, 738	11, 747	95	0	3, 446	
	09003 ONCOLOGY CLINIC	212, 229	36, 294	16, 311	0	19, 791	90. 03
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 466, 616	356, 916	26, 407	0	113, 229	91.00
	09201 OBSERVATION BEDS (NON-DISTINCT PART)	14, 276	2, 707	159	0	120	92. 00 92. 01
	OTHER REIMBURSABLE COST CENTERS						
95. 00	09500 AMBULANCE SERVICES	0	0	0	0	0	95. 00
113 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE						113. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	10, 588, 628	11, 508, 294	8, 960, 502	0		
100 ==	NONREI MBURSABLE COST CENTERS			-1			100 0=
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	209	0	0	0	190. 00

Health Financial Systems BALL MEMORIAL HOSPITAL

COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 15-0089

				10 12/31/202	7/15/2021 12: 59 pm
			1		OTHER GENERAL
					SERVI CE
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	PATI ENT
	ADMI NI STRATI ON	SERVICES &		RECORDS &	TRANSPORTATI ON
		SUPPLY		LI BRARY	
	13. 00	14. 00	15. 00	16. 00	18. 00
191. 00 19100 RESEARCH	74, 030	120	(0 (0 191. 00
194.0007950 OTHER NONREIMBURSABLE COST CENTERS	0	0			0 194.00
194. 0107951 BSU PHARMACY	0	0			0 194. 01
194. 0207952 PAVILLION PHARMACY	0	194			0 194. 02
194. 0307953 VENDI NG	0	0	ĺ		0 194. 03
194. 0407954 CARELI NE	0	o o		ol i	0194.04
194. 0507955 WELLNESS CENTER	0	436	i	ol i	0 194. 05
194. 0607956 PHYSICIAN PRACTICE CLINICS	Ö	0			0194.06
194. 07 07957 PERI NATAL CLI NI C	Ö	Õ		Ď i	0194.07
194. 0807958 RENTAL PROPERTY	0	0	3:		0194.08
194. 0907759 ADVERTI SI NG	0	0	3.		0194.09
194. 1007960 NTEGRA LTAC	0	0			0194.10
194. 1107961 I U HEALTH HOSPI CE	0	0			0194.10
194. 1207962 POB MEDICAL PAVILLION CONDOS	0	0			0194.11
194. 1307963 PEDI ATRI C THERAPI ES	0	2, 311			0194.12
194. 1407964 NEW CASTLE ONCOLOGY	0	2, 311			0194.13
194. 1507965 MARKETI NG/PUBLI C RELATIONS	0	0			0194.14
194. 1607966 JAY COUNTY HOSPITAL	0	0			0194.15
194. 1707967 CARDI NAL HEALTH CHOI CE	0	0			0194.10
194. 1807968 CHV CARDINAL HEALTH VENTURES	0	0			0194.17
194. 1907969 HEALTH CARE CONNECTIONS	0	0			0194.10
194. 2007970 MEALS ON WHEELS	0	0			0 194. 19
194. 2107971 ST MARY'S SCHOOL	0	0			0 194. 20
194. 210797131 WART 3 3CHOOL 194. 2207972 THERAPIES TO OTHER ENTITIES	2, 944	0			0 194. 21
194. 2307973 CANCER CENTER BOUTLQUE	2, 944	0	1:		0 194. 22
194. 2407974 BOSC BALL OUTPATIENT SURGERY	0	0	1.	2	0194.23
194. 2507975 CARDI NAL BEHAVI ORAL HEALTH	0	47			0194.24
194. 2607976 BLACKFORD COMMUNITY HOSPITAL	0	47			0194.25
194. 2707976 BLACKFORD COMMONTH HOSPITAL 194. 2707977 MI DWEST HEALTH STRATEGIES	0	47			0194.20
194. 2807978 CARDINAL SELECT RISK RETENTION GRP	0	0			0194.27
194. 2907976 CARDINAL SELECT RISK RETENTION GRP	0	0			0194.29
194. 3007980 CARDINAL HEALTH ALLIANCE	0	0			0194. 29
194. 3107986 OTHER NONREIMBURSABLE COST CENTERS	0	0			0194.30
	0	0			
194. 32 07982 RENAL DI ALYSI S		0		J ,	0 194. 32 0 194. 33
194. 33 07983 LAB CORP		0		J ,	
194. 34 07984 H. O. MATERI ALS MGMT	0	0)	0 194. 34
194. 35 07985 LEASED SPACE	0	0	(1	0 194. 35
200.00 Cross Foot Adjustments					200.00
201.00 Negative Cost Centers	10 //5 /00	0	0.040.51	<u>'</u>	0 201. 00
202.00 TOTAL (sum lines 118 through 201)	10, 665, 602	11, 511, 666	8, 960, 54	ol (1, 001, 739 202. 00

Health Financial Systems	BALL MEMORIAL		ON 45 0000 T-		of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der C	CN: 15-0089 F F T	Period: From 01/01/2020 To 12/31/2020	Worksheet B Part I Date/Time Pre	pared:
	I NTERNS &	I RESI DENTS			7/15/2021 12:	59 pm
Cost Center Description	SERVICES-SALARS & FRINGES	SERVICES-OTHER PRGM COSTS	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown	
	21. 00	22. 00	23. 00	24. 00	Adjustments 25.00	
GENERAL SERVICE COST CENTERS 1. 00 1000 NEW CAP REL COSTS-BLDG & FIXT 4. 00 200400 EMPLOYEE BENEFITS DEPARTMENT 5. 01 5. 01 5. 02 00550 DATA PROCESSING 5. 04 00570 ADMITTING 5. 05 00580 CASHIERING/ACCOUNTS RECEIVABLE 6. 00 00600 MAINTENANCE & REPAIRS 7. 00 00700 OPERATION OF PLANT 8. 00 00800 LAUNDRY & LINEN SERVICE 9. 00 00900 HOUSEKEEPING 10. 00 11. 00 01000 DIETARY 11. 00	PPRVD 5, 737, 312	6, 995, 335			23.00	1. 00 4. 00 5. 01 5. 02 5. 04 5. 05 5. 06 6. 00 7. 00 8. 00 9. 00 11. 00 13. 00 14. 00 15. 00 16. 00 18. 00 21. 00 22. 00 23. 00
30.00 O3000 ADULTS & PEDIATRICS	3, 393, 939	4, 138, 131	C	.,	-7, 532, 070	30. 00
31. 00 03100 INTENSI VE CARE UNIT 32. 00 03200 CORONARY CARE UNIT	757, 807 0	923, 972 0		18, 018, 747	-1, 681, 779 0	31. 00 32. 00
35.00 02060 NEONATAL INTENSIVE CARE UNIT	44, 043	53, 701	C	5, 009, 421	-97, 744	35.00
40. 00 04000 SUBPROVI DER - I PF 41. 00 04100 SUBPROVI DER - I RF	0	0	(.,,	0	40. 00 41. 00
43. 00 O4300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	0		1, 081, 844	0	43. 00
50. 00 05000 OPERATI NG ROOM 51. 00 05100 RECOVERY ROOM 52. 00 05200 DELI VERY ROOM & LABOR ROOM 54. 00 05400 RADI OLOGY-DI AGNOSTI C 57. 00 05700 CT SCAN	343, 280 0 0 0 181, 356	418, 551 0 0 221, 121 0	C	3, 645, 545 5, 041, 036	-761, 831 0 0 -402, 477 0	54. 00 57. 00
58. 00	0 0 0	0 0 0 0 0 202, 168 0 0		7, 022, 332 17, 653, 378 0 1, 673, 465 6, 763, 187 828, 212 7, 613, 157 1, 618, 939 980, 034	0 0 0 0 0 -367, 979 0 0	63. 00 65. 00 65. 01 66. 00 67. 00 68. 00
68. 01 06801 AUDI OLOGY 69. 00 06900 ELECTROCARDI OLOGY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI 72. 00 07200 MPL. DEV. CHARGED TO PATI ENT	0 255, 193 ENTS 0 0	0 311, 149 0 0		0 5, 196, 050 18, 463, 926 19, 249, 492	0 -566, 342 0 0	69. 00

32. 00 03200 CORONARY CARE UNI I	O	0	O	O		32.00
35.00 02060 NEONATAL INTENSIVE CARE UNIT	44, 043	53, 701	0	5, 009, 421	-97, 744	35.00
40. 00 04000 SUBPROVI DER - 1 PF	ol	0	0	0	0	40.00
41. 00 04100 SUBPROVI DER - RF	0	0	0	4, 269, 569	0	
43. 00 04300 NURSERY	ă	0	0	1, 081, 844	0	43. 00
	<u> </u>	U	Ч	1, 081, 844	U	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	343, 280	418, 551	0	18, 228, 578	-761, 831	50.00
51.00 05100 RECOVERY ROOM	0	0	0	3, 645, 545	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	ol	o	0	5, 041, 036	0	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	181, 356	221, 121	0	28, 046, 084	-402, 477	
57. 00 05700 CT SCAN	101, 330		0			
	o _l	0	U	225, 001	0	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	O	0	0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0	7, 022, 332	0	59. 00
60. 00 06000 LABORATORY	o	0	0	17, 653, 378	0	60.00
60. 01 06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0	آم	0	1, 673, 465	0	63. 00
65. 00 06500 RESPIRATORY THERAPY	165, 811	202, 168	0		-367, 979	65.00
	105, 811		U	6, 763, 187		
65. 01 06501 SLEEP LAB	O	0	O	828, 212	0	65. 01
66. 00 06600 PHYSI CAL THERAPY	0	0	0	7, 613, 157	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	1, 618, 939	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0	0	980, 034	0	68. 00
68. 01 06801 AUDI OLOGY	0	آم	0	0	0	68. 01
69. 00 06900 ELECTROCARDI OLOGY	255, 193	211 140	0	5, 196, 050	-566, 342	69. 00
	255, 193	311, 149	U			
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	O	18, 463, 926	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	19, 249, 492	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	355, 448	62, 874, 470	0	73.00
73.01 07301 HOSPITAL BASED RETAIL PHARMACIES	0	0	0	8, 931, 999	0	73. 01
74.00 07400 RENAL DIALYSIS	0	0	0	1, 915, 290	0	74. 00
76. 00 03160 CARDI OPULMONARY	Õ	0	ŏ	1, 710, 270	0	76.00
	0	0	0	1 407 011		
76. 97 O7697 CARDI AC REHABI LI TATI ON	0	0	0	1, 407, 011	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	24, 613	30, 009	0	2, 124, 777	-54, 622	76. 98
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0	0	0	0	90.00
90. 01 09001 SUBSTANCE ABUSE CLINIC	0	0	0	862, 297	0	90. 01
90. 02 09002 PAIN CLINIC	102, 336	124, 776	0	2, 617, 952	-227, 112	
90. 03 09003 ONCOLOGY CLINIC	55, 702	67, 916	0		-123, 618	
			U	3, 650, 224		
91. 00 09100 EMERGENCY	401, 573	489, 626	0	24, 505, 408	-891, 199	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	312, 220	0	92. 01
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0	0	0	51, 503	0	95. 00
SPECIAL PURPOSE COST CENTERS	<u> </u>	<u> </u>	<u> </u>	31, 303		75.00
						110 00
113. 00 11300 NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	5, 725, 653	6, 981, 120	355, 448	354, 491, 492	-12, 706, 773	118. 00
MCRI F32 - 16. 10. 172. 3						
						,

Health Financial Systems	BALL MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Peri od: Worksheet B From 01/01/2020 Part I To 12/31/2020 Date/Time Prepared: 7/15/2021 13.50 pm

COST ALLOCA	ITON - GENERAL SERVICE COSTS		Provider C	CN: 15-0089	eriod: rom 01/01/2020	Worksheet B Part	
					o 12/31/2020	Date/Time Pre	epared:
						7/15/2021 12:	59 pm
		INTERNS &	RESI DENTS				
	Onet Oreton December 1	CEDVI OEC CALAD	TED // OEC OTHER	DADAMED ED	College	L t	
	Cost Center Description	SERVI CES-SALAR			Subtotal	Intern &	
		& FRINGES	PRGM COSTS	PRGM		Residents Cost	
						& Post Stepdown	
						Adjustments	
		21. 00	22. 00	23. 00	24. 00	25. 00	
NONRE	IMBURSABLE COST CENTERS	21.00	22.00	23.00	24.00	23.00	
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C	613, 714	0	190. 00
191. 00 19100		11, 659	14, 215	Č	1, 258, 622	-25, 874	
	OTHER NONREIMBURSABLE COST CENTERS	0	0	Ċ	0		194. 00
	BSU PHARMACY	Ó	0	C	90, 281		194. 01
194. 02 07952	PAVILLION PHARMACY	0	0	C	7, 204, 278		194. 02
194. 03 07953	VENDI NG	0	0	C	0	0	194. 03
194. 04 07954	CARELINE	0	0	C	0	0	194. 04
194. 05 07955	WELLNESS CENTER	0	0	C	375, 706	0	194. 05
194. 06 07956	PHYSICIAN PRACTICE CLINICS	0	0	C	1, 622, 719	0	194. 06
194. 07 07957	PERINATAL CLINIC	0	0	C	0	0	194. 07
	RENTAL PROPERTY	0	0	C	6, 964, 169		194. 08
	ADVERTI SI NG	0	0	C	0		194. 09
	INTEGRA LTAC	0	0	C	930, 686		194. 10
	IU HEALTH HOSPICE	0	0	C	219, 526		194. 11
	POB MEDICAL PAVILLION CONDOS	0	0	C	0		194. 12
	PEDI ATRI C THERAPI ES	0	0		2, 326, 748		194. 13
	NEW CASTLE ONCOLOGY	0	0		142 007		194. 14 194. 15
	MARKETING/PUBLIC RELATIONS JAY COUNTY HOSPITAL	0	0		142, 087 1, 958, 392		194. 15 194. 16
	CARDI NAL HEALTH CHOICE	0	0		1, 730, 372		194. 10
	CHV CARDINAL HEALTH VENTURES	0	0				194. 17
	HEALTH CARE CONNECTIONS	o o	0	,	Ö		194. 19
	MEALS ON WHEELS	Ö	0	Č	Ö		194. 20
	ST MARY'S SCHOOL	ō	0	Ċ	Ö		194. 21
	THERAPIES TO OTHER ENTITIES	o	0	C	306, 962	0	194. 22
	CANCER CENTER BOUTIQUE	0	0	C	167, 568	0	194. 23
194. 24 07974	BOSC BALL OUTPATIENT SURGERY	0	0	C	1, 580, 083	0	194. 24
194. 25 07975	CARDINAL BEHAVIORAL HEALTH	0	0	C	31, 904	0	194. 25
	BLACKFORD COMMUNITY HOSPITAL	0	0	C	1, 794, 478	0	194. 26
	MIDWEST HEALTH STRATEGIES	0	0	C	0		194. 27
	CARDINAL SELECT RISK RETENTION GRP	0	0	C	0		194. 28
	HOME OFFICE CARDINAL HEALTH INITIATI	0	0	C	0		194. 29
	CARDINAL HEALTH ALLIANCE	0	0	C	0		194. 30
	OTHER NONREIMBURSABLE COST CENTERS	0	0	C	0		194. 31
	RENAL DI ALYSI S	0	0	<u> </u>	0		194. 32
194. 33 07983		0	0				194. 33
	H.O. MATERIALS MGMT		0		1 400 001		194. 34 194. 35
200. 00	LEASED SPACE Cross Foot Adjustments		0		1, 408, 991		194. 35 200. 00
200.00	Negative Cost Centers	0	0				200.00
	TOTAL (sum lines 118 through 201)	5, 737, 312	6, 995, 335	355, 448	383, 488, 406		
	() () () () () () () () () ()	-, ,	2, 2, 000		,,,	. = , = ,	,

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

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0089 Period: From 01/01/2020 Part I

Date/Time Prepared: 12/31/2020 7/15/2021 12:59 pm Cost Center Description Total 26. 00 GENERAL SERVICE COST CENTERS 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 00550 DATA PROCESSING 5.02 5 02 5.04 00570 ADMITTING 5.04 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.05 5.05 5.06 00590 OTHER ADMINISTRATIVE AND GENERAL 5.06 00600 MAINTENANCE & REPAIRS 6.00 6.00 7.00 7.00 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9 00 00900 HOUSEKEEPI NG 9 00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 13.00 01300 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 01080 PATIENT TRANSPORTATION 18 00 18 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 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 67, 078, 274 30.00 03100 INTENSIVE CARE UNIT 16, 336, 968 31.00 31.00 32.00 03200 CORONARY CARE UNIT 32.00 02060 NEONATAL INTENSIVE CARE UNIT 35 00 4, 911, 677 35 00 40.00 04000 SUBPROVIDER - IPF 40.00 04100 SUBPROVI DER - I RF 41.00 4, 269, 569 41.00 04300 NURSERY 1.081.844 43.00 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 17, 466, 747 50.00 05100 RECOVERY ROOM 51.00 3, 645, 545 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 5.041.036 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 27, 643, 607 54.00 57.00 05700 CT SCAN 225, 001 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 59.00 05900 CARDIAC CATHETERIZATION 7, 022, 332 59.00 60.00 06000 LABORATORY 17, 653, 378 60.00 60.01 06001 BLOOD LABORATORY 60.01 06300 BLOOD STORING, PROCESSING, & TRANS. 1, 673, 465 63.00 63.00 06500 RESPIRATORY THERAPY 65.00 6, 395, 208 65.00 06501 SLEEP LAB 828, 212 65.01 65.01 06600 PHYSI CAL THERAPY 66.00 7, 613, 157 66.00 06700 OCCUPATIONAL THERAPY 1, 618, 939 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 980, 034 68.00 06801 AUDI OLOGY 68.01 68.01 69.00 06900 ELECTROCARDI OLOGY 4, 629, 708 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71 00 18, 463, 926 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 19, 249, 492 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 62, 874, 470 73.00 07301 HOSPITAL BASED RETAIL PHARMACIES 8, 931, 999 73 01 73 01 74.00 07400 RENAL DIALYSIS 1, 915, 290 74.00 76.00 03160 CARDI OPULMONARY 76.00 07697 CARDIAC REHABILITATION 76.97 1, 407, 011 76.97 07698 HYPERBARIC OXYGEN THERAPY 2, 070, 155 76. 98 76 98 OUTPATIENT SERVICE COST CENTERS 90.00 90.00 09000 CLI NI C 90.01 09001 SUBSTANCE ABUSE CLINIC 862, 297 90.01 09002 PAIN CLINIC 90 02 2, 390, 840 90 02 90.03 09003 ONCOLOGY CLINIC 3, 526, 606 90.03 09100 EMERGENCY 91.00 23, 614, 209 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 092<u>01 OBSERVATION BEDS (DISTINCT PART)</u> 312, 220 92.01 92.01 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 95.00 51, 503 95.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 341, 784, 719 118.00 NONREI MBURSABLE COST CENTERS 190.00 190, 00 19000 GLFT, FLOWER, COFFEE SHOP & CANTEEN 613, 714 191. 00 19100 RESEARCH 1, 232, 748 191. 00 194. 00 07950 OTHER NONREIMBURSABLE COST CENTERS 194. 00 194. 0107951 BSU PHARMACY 90, 281 194. 01 194. 02 07952 PAVILLION PHARMACY 194. 02 7, 204, 278

Health Financial Systems

BALL MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0089
Form 01/01/2020
From 01/01/2020
For 12/31/2020
 | | To 12/31/2020 Date/Time Prepared: 7/15/2021 12: 59 pm | |
|---|---|---|
| Cost Center Description | Total | 77 137 2021 12. 37 5111 |
| · · · · · · · · · · · · · · · · · · · | 26. 00 | |
| 194. 03 07953 VENDI NG | 0 | 194. 03 |
| 194. 04 07954 CARELI NE | 0 | 194. 04 |
| 194. 05 07955 WELLNESS CENTER | 375, 706 | 194. 05 |
| 194.0607956 PHYSICIAN PRACTICE CLINICS | 1, 622, 719 | 194. 06 |
| 194. 07 <mark>07957 PERINATAL CLINIC</mark> | 0 | 194. 07 |
| 194. 08 07958 RENTAL PROPERTY | 6, 964, 169 | 194. 08 |
| 194. 0907959 ADVERTI SI NG | 0 | 194. 09 |
| 194. 10 <mark>07960</mark> I NTEGRA LTAC | 930, 686 | 194. 10 |
| 194. 11 <mark>07961 IU HEALTH HOSPICE</mark> | 219, 526 | 194. 11 |
| 194.12 <mark>07962</mark> POB MEDICAL PAVILLION CONDOS | 0 | 194. 12 |
| 194. 13 <mark>07963</mark> PEDIATRIC THERAPIES | 2, 326, 748 | 194. 13 |
| 194.1407964 NEW CASTLE ONCOLOGY | 0 | 194. 14 |
| 194. 15 07965 MARKETING/PUBLIC RELATIONS | 142, 087 | 194. 15 |
| 194. 16 <mark>07966 JAY COUNTY HOSPITAL</mark> | 1, 958, 392 | 194. 16 |
| 194. 1707967 CARDINAL HEALTH CHOICE | 0 | 194. 17 |
| 194. 18 <mark>07968 CHV CARDINAL HEALTH VENTURES</mark> | 0 | 194. 18 |
| 194. 1907969 HEALTH CARE CONNECTIONS | 0 | 194. 19 |
| 194.2007970 MEALS ON WHEELS | 0 | 194. 20 |
| 194. 21 <mark>07971</mark> ST MARY'S SCHOOL | 0 | 194. 21 |
| 194. 2207972 THERAPIES TO OTHER ENTITIES | 306, 962 | 194. 22 |
| 194. 23 07973 CANCER CENTER BOUTI QUE | 167, 568 | 194. 23 |
| 194. 24 07974 BOSC BALL OUTPATIENT SURGERY | 1, 580, 083 | 194. 24 |
| 194. 25 07975 CARDI NAL BEHAVI ORAL HEALTH | 31, 904 | 194. 25 |
| 194. 26 07976 BLACKFORD COMMUNITY HOSPITAL | 1, 794, 478 | 194. 26 |
| 194. 27 07977 MI DWEST HEALTH STRATEGIES | 0 | 194. 27 |
| 194. 28 07978 CARDINAL SELECT RISK RETENTION GRP | 0 | 194. 28 |
| 194.2907979 HOME OFFICE CARDINAL HEALTH INITIATI | 0 | 194. 29 |
| 194. 3007980 CARDINAL HEALTH ALLIANCE | 0 | 194. 30 |
| 194. 31 07986 OTHER NONREI MBURSABLE COST CENTERS | 0 | 194. 31 |
| 194. 3207982 RENAL DI ALYSI S | 0 | 194. 32 |
| 194. 33 07983 LAB CORP | 0 | 194. 33 |
| 194. 3407984 H. O. MATERI ALS MGMT | 0 | 194. 34 |
| 194. 3507985 LEASED SPACE | 1, 408, 991 | 194. 35 |
| 200.00 Cross Foot Adjustments | 0 | 200.00 |
| 201.00 Negative Cost Centers | 0 | 201. 00 |
| 202.00 TOTAL (sum lines 118 through 201) | 370, 755, 759 | 202.00 |

				T	o 12/31/2020	Date/Time Pre 7/15/2021 12:	epared:
			CAPI TAL			77 137 2021 12.	J Pill
	Cost Center Description	Di rectly	RELATED COSTS NEW BLDG &	Subtotal	EMPLOYEE	COMMUNI CATI ONS	
	cost center bescription	Assigned New	FIXT	Subtotal	BENEFITS	COMMON CATTONS	
		Capital Related	ł		DEPARTMENT		
		Costs 0	1. 00	2A	4. 00	5. 01	
	GENERAL SERVICE COST CENTERS		1. 00		1. 00	0.01	
1.00	00100 NEW CAP REL COSTS-BLDG & FLXT		/F 400	45.400	45.400		1.00
4. 00 5. 01	00400 EMPLOYEE BENEFITS DEPARTMENT 01160 COMMUNI CATIONS	0	65, 408 28, 814	65, 408 28, 814	65, 408 280	29, 094	4. 00 5. 01
5. 02	00550 DATA PROCESSING	0	0	0	0	0	5. 02
5. 04	00570 ADMITTING	0	111, 412	111, 412	644	324	5. 04
5. 05 5. 06	OO580 CASHI ERI NG/ACCOUNTS RECEI VABLE OO590 OTHER ADMINI STRATI VE AND GENERAL	0	789, 924	789, 924	3,744	0 693	5. 05 5. 06
6. 00	00600 MAINTENANCE & REPAIRS	0	14, 295, 657	14, 295, 657	1, 765	1, 020	6. 00
7. 00	00700 OPERATION OF PLANT	0	706, 235	706, 235	858		7.00
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	0	195, 892	195, 892	1, 613	0 1, 490	8. 00 9. 00
10.00	01000 DI ETARY	O	174, 922	174, 922	847	629	1
11.00	01100 CAFETERI A	0	216, 150	1		580	1
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	0	216, 672 335, 516	216, 672 335, 516	3, 210 0	1, 147 0	13. 00 14. 00
15.00	01500 PHARMACY	0	116, 472	116, 472	2, 811	959	•
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	11 255	0	0	0	16.00
18. 00 21. 00	O1080 PATIENT TRANSPORTATION O2100 L&R SERVICES-SALARY & FRINGES APPRVD	0	11, 355 0	11, 355 0	343 2, 246	336 1, 044	•
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	661, 560	661, 560	124	117	1
23. 00	02300 PARAMED ED PRGM	0	3, 084	3, 084	126	50	23. 00
30.00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	0	2, 688, 274	2, 688, 274	13, 214	6, 191	30.00
31.00	03100 INTENSIVE CARE UNIT	0	437, 455	437, 455	3, 860	1, 609	31. 00
32. 00 35. 00	03200 CORONARY CARE UNIT	0	141 122	141 122	0	0	32.00
40.00	02060 NEONATAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	0	161, 132 0	161, 132 0	1, 132 0	464 0	35. 00 40. 00
41.00	04100 SUBPROVI DER - I RF	0	158, 096	158, 096		375	41.00
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	49, 167	49, 167	252	103	43.00
50.00	05000 OPERATI NG ROOM	0	599, 236	599, 236	3, 053	1, 474	50. 00
51.00	05100 RECOVERY ROOM	0	130, 136	130, 136		346	
52. 00 54. 00	O5200 DELI VERY ROOM & LABOR ROOM O5400 RADI OLOGY-DI AGNOSTI C	0	203, 166 988, 694	203, 166 988, 694		458 1, 876	•
57.00	05700 CT SCAN		700, 074	0	71	68	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58. 00
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	215, 059 283, 329	215, 059 283, 329		441 680	1
60.01	06001 BLOOD LABORATORY		203, 327	203, 327	0	000	60.01
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
65. 00 65. 01	06500 RESPI RATORY THERAPY 06501 SLEEP LAB	0	69, 520 0	69, 520 0	1, 865 251		65. 00 65. 01
	06600 PHYSI CAL THERAPY	Ö	246, 418	246, 418			66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	38, 018			170	
68. 00 68. 01	06800 SPEECH PATHOLOGY 06801 AUDI OLOGY	0	9, 093 0	9, 093 0	312 0	116 0	1
69.00	06900 ELECTROCARDI OLOGY	O	291, 568	291, 568	663	375	
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0	0	0	0	•
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	72. 00 73. 00
73. 01	07301 HOSPITAL BASED RETAIL PHARMACIES	O	14, 043	14, 043	764	220	
	07400 RENAL DI ALYSI S	0	46, 146	46, 146	0	0	•
	03160 CARDI OPULMONARY 07697 CARDI AC REHABI LI TATI ON	0	0	0	494	0 246	76. 00 76. 97
	07698 HYPERBARIC OXYGEN THERAPY	0	6, 563	6, 563	272	124	•
00.00	OUTPATIENT SERVICE COST CENTERS		0		0		00 00
90.00	09000 CLINIC 09001 SUBSTANCE ABUSE CLINIC	0	0 100, 911	100, 911	0 111	0 71	90. 00 90. 01
	09002 PAIN CLINIC	O	354, 920				•
90.03	09003 ONCOLOGY CLINIC	0	45, 956	1		260	•
91.00 92.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	533, 749	533, 749 0	4, 142	1, 997	91. 00 92. 00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	0	3, 985	3, 985	49	15	1
05 00	OTHER REIMBURSABLE COST CENTERS		14 007	14 007			05 00
95.00	09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	0	11, 307	11, 307	0	0	95. 00
	11300 INTEREST EXPENSE						113. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)) 0	25, 615, 014	25, 615, 014	62, 041	28, 408	n 18. 00

From 01/01/2020 Part II 12/31/2020 Date/Time Prepared: 7/15/2021 12:59 pm CAPI TAL RELATED COSTS Di rectly **EMPLOYEE** Cost Center Description NEW BLDG & Subtotal COMMUNICATIONS Assigned New FIXT **BENEFITS** apital Related **DEPARTMENT** Costs 1.00 2A 4. 00 5. 01 Ω NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 81 190. 00 191. 0019100 RESEARCH 177 191.00 29. 573 29, 573 368 194. 0007950 OTHER NONREIMBURSABLE COST CENTERS 0 194.00 194. 01 07951 BSU PHARMACY 100 31 194. 01 194. 02 07952 PAVILLION PHARMACY 154 194. 02 40, 168 40, 168 455 194. 03 07953 VENDI NG 194. 04 07954 CARELI NE 0 0 194. 03 0 194.04 0 194. 05 07955 WELLNESS CENTER 80, 226 80, 226 0 194. 05 194.0607956 PHYSICIAN PRACTICE CLINICS 194.0707957 PERINATAL CLINIC 0 382, 643 382, 643 0 194. 06 0 0 194. 07 1, 432, 997 194. 08 07958 RENTAL PROPERTY 1, 432, 997 0 194.08 0 194. 0907959 ADVERTI SI NG 0 194. 09 194. 1007960 INTEGRA LTAC 186, 150 186, 150 0194.10 194. 1107961 IU HEALTH HOSPICE 194. 1207962 POB MEDICAL PAVILLION CONDOS 0 194. 11 0 48, 091 48, 091 0 194. 12 194. 1307963 PEDIATRIC THERAPIES 0 194. 13 0 105, 956 105, 956 705 194. 14 07964 NEW CASTLE ONCOLOGY 194. 15 07965 MARKETI NG/PUBLI C RELATI ONS 0 194, 14 0 35, 171 35, 171 0194.15 194. 16 07966 JAY COUNTY HOSPITAL 79, 530 79, 530 540 119 194. 16 194. 1707967 CARDI NAL HEALTH CHOI CE 194. 1807968 CHV CARDI NAL HEALTH VENTURES 0 0 194. 17 0194.18 0 194. 1907969 HEALTH CARE CONNECTIONS 0 194. 19 194. 2007970 MEALS ON WHEELS 0 0 194. 20 194. 2107971 ST MARY'S SCHOOL 0 0 194. 21 194. 22 07972 THERAPI ES TO OTHER ENTITIES 0194.22 678 194. 23 07973 CANCER CENTER BOUTI QUE 13, 474 13, 474 9 194. 23 194. 24 07974 BOSC BALL OUTPATIENT SURGERY 391, 119 391, 119 0 194. 24 194. 25 07975 CARDI NAL BEHAVI ORAL HEALTH 0 194. 25 194. 26 07976 BLACKFORD COMMUNITY HOSPITAL 60, 126 115 194. 26 60, 126 419 194. 27 07977 MI DWEST HEALTH STRATEGIES 0 194. 27 194. 28 07978 CARDINAL SELECT RISK RETENTION GRP 0 194. 28 0 194. 2907979 HOME OFFICE CARDINAL HEALTH INITIATI 0194.29 194. 30 07980 CARDINAL HEALTH ALLIANCE 0 194.30 194. 31 07986 OTHER NONREIMBURSABLE COST CENTERS 0 194. 31 194. 3207982 RENAL DIALYSIS 0 194. 32 0 194. 33 194. 33 07983 LAB CORP 194. 34 07984 H. O. MATERIALS MGMT 0 194. 34 194. 35 07985 LEASED SPACE 0 194. 35 348, 769 348, 769 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 201.00

28, 849, 007

28, 849, 007

65, 408

29, 094 202. 00

202.00

TOTAL (sum lines 118 through 201)

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS BALL MEMORIAL HOSPITAL Provi der CCN: 15-0089

Control Center Description September Septe					'	0 12/31/2020	Date/lime Pre 7/15/2021 12:	
RECEIVANDE AND STREETS S. 92 S. 04 S. 95 S. 06 S. 00 S. 00		Cost Center Description	ATA PROCESSING	ADMI TTI NG	CASHI ERI NG/ACC	OTHER	MAINTENANCE &	
							REPAI RS	
DESIRENT SERVICE COST CENTERS 1			5.02	5.04			6.00	
1.00 ODIOO INCEPT COSTS-SUDG & FIXT		GENERAL SERVICE COST CENTERS	3.02	3.04	3.03	3.00	0.00	
5.01 0.1140 COMMANICATIONS	1.00							1.00
5.02 0.0056 DATA PROCESSING		•						•
5.04 0.0076 JAMITTING 0.00		•						•
5.05 0.0580 CASHLERIN RAZACCIUNTS RECTURBLE 0 0 0 794, 361 1, 357, 672 5, 56 6.0590 O.0500 MAINTFAMECT & REPAIL RS 0 0 0 0 0 1, 277, 897 8, 00 0 0 0 0 0 0 0 0 0				112 380				•
5.6-6 00 00000 MINTERMAN INSTRATIVE AND GENERAL 0 0 0 0 19 794, 361		•	l ö	_	_			•
0 00 000 DOTOGO DEREATION OF PLANT 0 0 00 00 1,3,546 0 0 0000 DALABION STRUCE 0 0 0 0 0 3,546 0 0 000 DALABION STRUCE 0 0 0 0 0 0 0,3,546 0 0 0 0 0 1,3,546 0 0 0 0 0 0 0,3,546 1 10 20 0 1 10 1 1 1 1 1 1 1 1 1 1 1 1 1		•	0	0	0	794, 361		5. 06
8.00 00000 LAURIGHY & LINEN SERVICE 0 0 0 0 0 0 0 0 0			0	0	0			•
9.00 00000 MUSISKEEPING		•	0	0	0			•
19.00 01000 DETARY				0				•
13.00 0300 MURSING ADMINISTRATION 0 0 0 20, 318 229, 464 13.00		•	O	0	0			•
14.00 01400 CENTRAL SERVICES & SUPPLY 0 0 0 21,465 355,310 14.00 10.0		•	0	0	0			1
15.00 01500 PHARMACY 0 0 0 17,330 123,344 15.00 16.0			0	0	0			1
16.00 01-000 MEDI CAL RECORDS & LIBRARY 0 0 0 0 10 00 0 10 00 10 00 11 00 11 00 01 00 01 00 01 00 01 01 00 11 00 01 01 00 01 01 00 01 01 01 00 01				0				1
21.00 0 2010 AR SERVICES-SALARY & FRINCES APPRVD 0 0 0 9,769 0,70588 22 00 220 00 2200 ARS SERVICES-COTHER PROM COSTS APPRVD 0 0 0 0 704 3,266 23 00		•	Ö	0	Ö	0		1
22.00 0.2000 IAR SERVICES-OTHER PROM COSTS APPRVD 0 0 0 7,69 700,588 22.00 700 700 700 700 700 700 3,266 23.00 23.			0	0	0	1, 907	12, 025	18. 00
23.00		•	0	0				•
INPATI_ENT_ROUTINE_SERVICE_COST_CENTERS 0			0	0			,	•
0.000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.	23.00		<u> </u>			704	3, 200	25.00
32 00 33200 COROMARY CARE UNIT 0 0 0 0 0 0 0 0 0			0	12, 145	0	98, 152	2, 846, 866	30.00
35. 00		•	0		1	26, 090		
40.00 04000 SUBPROVI DER - I PF 0 603 0 5,55 167,422 41.00 41.00 04100 SUBPROVI DER - I RF 0 663 0 6,355 167,422 41.00 41.00 41.00 04100 SUBPROVI DER - I RF 0 180 0 1,664 52,067 43.00 43			0			7 998		•
1.0 0.100 SUBPROVI DER - I RF					1		_	
ANCILLARY SERVICE COST CENTERS		•	0	603	O	6, 359		•
50.00	43.00		0	180	0	1, 664	52, 067	43. 00
51.00	50.00		I ol	0.202	1 0	20 000	624 507	50 00
52.00 0520		•			1			•
57.00 05700 CT SCAN 0 185 0 448 0 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 0 0 0 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 0 0 0 0 59.00 05900 CARDINAC CATHETERIZATION 0 5,896 0 11,923 227,746 59.00 06.00 06000 LABORATORY 0 0 0 0 0 0 0 0 0			Ö		1			•
58.00 OSBOO MAGNETI C RESONANCE I MAGING (MRI) 0 0 58.00 0 19.23 227, 746 59.00 59.00 059.00 CARDIAC CATHETERI ZATION 0 5.806 0 11.923 227, 746 59.00 60.00 0 0 0 0 0 0 0 0 0			0		1			•
59, 00 05900 CARDI AC CATHETER ZATION 0 5, 896 0 11, 923 227, 746 59, 00			0		1			•
60 00 0.0000 LABDRATORY 0 5,002 0 34,328 300,044 60.00 0 0 0 0 0 0 0 0 0								
63.00 06300 BLOOD STORI NG, PROCESSI NG, & TRANS. 0 469 0 3, 457 0 63.00		•	o		1			1
65. 00 06500 RESPI RATORY THERAPY 0 1.704 0 11.903 73,621 65. 00	60. 01		0	0	0	0	0	60. 01
65.01 06501 SLEEP LAB			0		1			1
66.00 06600 PHYSI CAL THERAPY 0 1,138 0 13,971 260,956 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0 420 0 3,035 40,260 67.00 68.01 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 68.01 06801 AUDI OLOGY 0 0 0 0 0 0 0 68.01 06801 AUDI OLOGY 0 0 0 0 0 0 68.01 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 0 68.01 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 68.01 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 68.01 06801 AUDI OLOGY 0 0 0 0 0 0 68.01 06800 SPEECH PATHOLOGY 0 0 0 0 0 68.01 06800 SPEECH PATHOLOGY 0 0 0 0 69.00 06900 ELECTROCARDI OLOGY 0 0 0 0 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 5,016 0 29,909 0 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 5,016 0 29,909 0 71.00 71.00 07300 O7300 DRUGS CHARGED TO PATI ENTS 0 2,1324 0 110,783 0 73.00 73.01 07301 HOSPI TAL BASED RETAI L PHARMACI ES 0 426 0 18,363 14,872 73.01 74.00 07400 RENAL DI ALYSI S 0 236 0 3,608 48,869 74.00 76.00 03160 CARDI OPULMONARY 0 0 0 0 0 0 0 76.97 07697 CARDI AC REHABI LI TATI ON 0 246 0 2,834 0 76.97 76.98 07698 HYPERBARI C DXYGEN THERAPY 0 973 0 3,894 6,950 76.98 07698 HYPERBARI C DXYGEN THERAPY 0 0 385 0 2,295 375,859 90.02 76.00 09000 CLI NI C 0 385 0 2,295 375,859 90.02 76.00 09000 DRUGSTANTE ON BEDS (NON-DI STI NCT PART) 0 12,652 0 40,190 565,237 91.00 77.00 09000 DRUGSERVATI ON BEDS (DI STI NCT PART) 0 12,652 0 40,190 565,237 91.00 77.00 09000 DRUGSERVATI ON BEDS (DI STI NCT PART) 0 12,652 0 40,190 565,237 91.00 77.00 09000 DRUGSRABLE COST CENTERS 113.00 78.00 09000 09000 09000 09000 09000 09000 09000 09000 09000 78.00 09000 09000 09000 09000 09000 09000 09000 09000 09000			0		1			
67:00 06700 06CUPATI ONAL THERAPY 0 420 0 3, 035 40, 260 67:00 68:01 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 69:00 06900 ELECTROCARDI OLOGY 0 0 3, 119 0 7, 325 308, 769 69:00 71:00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 5, 116 0 29;909 0 71:00 72:00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 6,004 0 31, 325 0 72:00 73:00 07300 RUGS CHARGED TO PATI ENTS 0 21, 324 0 110, 783 0 73:00 73:01 07301 HOSPI TAL BASED RETAIL PHARMACI ES 0 246 0 18, 363 14, 872 73:01 74:00 07400 RENAL DI ALYSIS 0 236 0 3, 608 48, 869 74:00 76:00 03160 CARDI OPULMONARY 0 0 0 0 0 0 76:97 07697 CARDI ACREMABI LI TATTI ON 0 246 0 2, 834 0 76:97 76:97 07697 CARDI ACREMABI LI TATTI ON 0 246 0 2, 834 0 76:97 76:00 07600 CLINIC 0 973 0 3, 894 6, 950 76:00 09000 CLINIC 0 375 305 305 305 305 305 76:00 09000 00000 00000 00000 76:00 09000 00000 00000 76:00 09000 00000 00000 76:00 09000 00000 00000 76:00 09000 00000 00000 76:00 09000 00000 76:00 09000 00000 76:00 09000 00000 76:00 09000 00000 76:00 09000 00000 76:00 09000 00000 76:00 09000 00000 76:00 09000 00000 76:00 09000 00000 76:00 09000 76:00 09000 00000 76:00 09000 00000 76:00 09000 76:00 09000 00000 76:00 09000 76:00 09000 00000 76:00 09000					1			1
68.01 06801 AUDI OLOGY		06700 OCCUPATI ONAL THERAPY	0		1	3, 035	40, 260	
69.00 06900 ELECTROCARDI OLOGY 0 3, 119 0 7, 325 308,769 69.00			0					
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 5, 016 0 29, 909 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENT 0 6, 004 0 31, 325 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 21, 324 0 110, 783 0 73. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 21, 324 0 110, 783 0 73. 00 73. 01 07301 HOSPI TAL BASED RETAIL PHARMACIES 0 426 0 18, 363 14, 872 73. 01 74. 00 07400 RENAL DIALYSIS 0 0 0 0 0 0 0 0 0			0	O	1			
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT 0 6, 004 0 31, 325 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 21, 324 0 110, 783 0 73. 00 73. 01 O7301 HOSPI TAL. BASED RETAIL PHARMACI ES 0 426 0 18, 363 14, 872 73. 01 74. 00 07400 RENAL DI ALYSI S 0 236 0 3, 608 48, 869 74. 00 76. 00 0 0 0 0 0 0 0 0 0			l ö		1			
73. 01 07301 HOSPITAL BASED RETAIL PHARMACIES 0 426 0 18, 363 14, 872 73. 01 74. 00 07400 RENAL DIALYSIS 0 236 0 3, 608 48, 869 74. 00 07400 RENAL DIALYSIS 0 0 236 0 3, 608 48, 869 74. 00 03 60 CARDIO PULMONARY 0 0 0 0 0 0 0 0 0 76. 00 76. 00 76. 00 76. 97 76. 97 76. 97 76. 98 07697 CARDIA C REHABILITATION 0 246 0 2, 834 0 76. 97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 973 0 3, 894 6, 950 76. 98 07409 HYPERBARI C OXYGEN THERAPY 0 973 0 0 3, 894 6, 950 76. 98 07409 HYPERBARI C OXYGEN THERAPY 0 973 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0					
74. 00 07400 RENAL DI ALYSI S 0 236 0 3,608 48,869 74.00 76.00 3160 CARDI OPULMONARY 0 0 0 0 0 0 76.00 76.00 76.97 76.97 76.97 76.97 76.97 CARDI AC REHABI LI TATI ON 0 246 0 2,834 0 76.97 76.98 MYPERBARI C OXYGEN THERAPY 0 973 0 3,894 6,950 76.98 MYPERBARI C OXYGEN THERAPY 0 973 0 3,894 6,950 76.98 MYPERBARI C OXYGEN THERAPY 0 973 0 0 0 0 0 0 0 0 0			0		1			
76. 00 03160 CARDI OPULMONARY 0 0 0 0 0 76. 00 76. 00 76. 00 76. 97 76. 97 76. 97 76. 97 76. 98 7			0					
76. 97					1	3,008		
OUTPATIENT SERVICE COST CENTERS OUTPATIENT SERVICE COST CENTERS OUTPATIENT SERVICE COST CENTERS OUTPATIENT SERVICE COST CENTERS OUTPATIENT SERVICE COST CENTERS OUTPATIENT SERVICE COST CENTERS OUTPATIENT SERVICE COST CENTERS OUTPATIENT SERVICE COST CENTERS OUTPATIENT SERVICE COST CENTERS OUTPATIENT SERVICE COST CENTERS OUTPATIENT SERVICE COST CENTERS OUTPATIENT SERVICE COST CENTERS OUTPATIENT SERVICE COST CENTERS OUTPATIENT SERVICE COST CENTERS OUTPATIENT SERVICE SERVICE S ICE SERVICE S OUTPATIENT SERVICE SER			Ö			2, 834		•
90. 00	76. 98		0	973	0	3, 894	6, 950	76. 98
90. 01	00 00		1 0	0	1 0	0		00 00
90. 02								•
91. 00	90.02	09002 PAIN CLINIC	Ö		l e			
92. 00			0					
92. 01			0	12, 652	0	40, 190	565, 237	•
OTHER REIMBURSABLE COST CENTERS O O O O O O O O O O O O O O O O O O				13		580	4 220	•
95. 00	72.01		<u> </u>	13	<u> </u>	300	4, 220	72.01
113. 00	95.00	09500 AMBULANCE SERVICES	0	0	0	26	11, 974	95. 00
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 0 112, 380 0 755, 865 10, 932, 846 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 1, 254 0 190. 00 191. 0	110 01				1			112 00
NONREI MBURSABLE COST CENTERS 0 0 1, 254 0 190. 00 190. 00 19100 RESEARCH 0 0 0 2, 153 31, 317 191. 00				112 380	0	755 865	10, 932, 846	
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 1, 254 0 190. 00 191. 00 191. 00 191. 00 191. 00 0 0 2, 153 31, 317 191. 00	. 10. 00		, J	112, 300		, , , , , , , , , , , , , , , , , , , ,	10, 702, 040	1
		19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		l			
194. 00 01 01 01 0 194. 00			o o					
	194.00	MO1430 OTHER MONKET MONKSARTE COST CENTERS	<u> </u>	0	<u> </u>	<u> </u>	<u> </u>	194.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS BALL MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 01/01/2020 Part II
To 12/31/2020 Date/Time Prepared: Provi der CCN: 15-0089

			Т	o 12/31/2020	Date/Time Prepared: 7/15/2021 12:59 pm
Cost Center Description	DATA PROCESSING	ADMI TTI NG	CASHI ERI NG/ACC	OTHER	MAINTENANCE &
			OUNTS	ADMI NI STRATI VE	
			RECEI VABLE	AND GENERAL	
	5. 02	5. 04	5. 05	5. 06	6. 00
194. 01 07951 BSU PHARMACY	0	0	C	181	0 194. 01
194.0207952 PAVILLION PHARMACY	0	0	C	14, 606	42, 538 194. 02
194. 03 <mark>07953 VENDI NG</mark>	0	0	C	0	0 194. 03
194. 04 <mark>07954</mark> CARELI NE	0	0	C	0	0 194. 04
194. 05 07955 WELLNESS CENTER	0	0	C	189	84, 959 194. 05
194.06 <mark>07956 PHYSICIAN PRACTICE CLINICS</mark>	0	0	C	893	405, 217 194. 06
194. 07 <mark>07957</mark> PERINATAL CLINIC	0	0	C	0	0 194. 07
194. 08 <mark>07958 RENTAL PROPERTY</mark>	0	0	C	5, 074	1, 517, 536 194. 08
194. 09 <mark>07959</mark> ADVERTI SI NG	0	0	C	0	0 194. 09
194. 10 <mark>07960 INTEGRA LTAC</mark>	0	0	C	434	197, 132 194. 10
194. 11 07961 IU HEALTH HOSPICE	0	0	C	113	50, 928 194. 11
194.1207962 POB MEDICAL PAVILLION CONDOS	0	0	C	0	0 194. 12
194. 13 <mark>07963</mark> PEDI ATRI C THERAPI ES	0	0	C	4, 176	112, 207 194. 13
194.1407964 NEW CASTLE ONCOLOGY	0	0	C	0	0 194. 14
194. 1507965 MARKETING/PUBLIC RELATIONS	0	0	C	82	37, 246 194. 15
194. 1607966 JAY COUNTY HOSPITAL	0	0	C	3, 468	84, 222 194. 16
194. 1707967 CARDI NAL HEALTH CHOICE	0	0	C	0	0 194. 17
194. 1807968 CHV CARDINAL HEALTH VENTURES	0	0	C	0	0 194. 18
194. 1907969 HEALTH CARE CONNECTIONS	0	0	C	0	0 194. 19
194. 2007970 MEALS ON WHEELS	0	0	C	0	0 194. 20
194. 21 07971 ST MARY'S SCHOOL	0	0	O	0	0 194. 21
194. 2207972 THERAPIES TO OTHER ENTITIES	0	0	0	630	0 194. 22
194. 2307973 CANCER CENTER BOUTI QUE	0	0	0	250	14, 269 194. 23
194. 24 07974 BOSC BALL OUTPATIENT SURGERY	0	0	0	913	414, 193 194. 24
194. 25 07975 CARDI NAL BEHAVI ORAL HEALTH	0	0		0	0 194. 25
194. 26 07976 BLACKFORD COMMUNITY HOSPITAL	0	0		3, 266	63, 673 194. 26
194. 27 07977 MI DWEST HEALTH STRATEGIES	0	0		0	0 194. 27
194. 28 07978 CARDI NAL SELECT RISK RETENTION GRP	0	0		0	0 194. 28
194. 2907979 HOME OFFICE CARDINAL HEALTH INITIATI 194. 3007980 CARDINAL HEALTH ALLIANCE	0	0		0	0 194. 29 0 194. 30
194. 3107986 OTHER NONREIMBURSABLE COST CENTERS		0		0	0194.30
194. 3207982 RENAL DI ALYSI S		0		0	0194.31
194. 3307983 LAB CORP		0		0	0194.32
194. 3407983 LAB CORP 194. 3407984 H. O. MATERI ALS MGMT		0		0	0194.33
194. 3507985 LEASED SPACE		0		814	369, 344 194. 35
200.00 Cross Foot Adjustments	1	U	l '	014	200.00
201.00 Negative Cost Centers		0		0	0 201. 00
202.00 TOTAL (sum lines 118 through 201)		112, 380		794, 361	
202. 09 TOTAL (Suil TITIES TTO LITTOUGH 201)	1 9	112, 300	ı	1 74, 301	17, 337, 027 202.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 15-0089

						7/15/2021 12:	59 pm
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		PLANT 7. 00	8.00	9.00	10. 00	11. 00	
	GENERAL SERVICE COST CENTERS	7.00	8.00	9.00	10.00	11.00	
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 MAINTENANCE & REPAIRS						6. 00
7. 00	00700 OPERATION OF PLANT	1, 473, 827					7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	0	3, 546				8.00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	22, 465 20, 060	0	,	395, 422		9. 00 10. 00
	01100 CAFETERI A	24, 788	0	7, 412 9, 159	393, 422	483, 653	
	01300 NURSING ADMINISTRATION	24, 848	0	9, 181	o	23, 216	
	01400 CENTRAL SERVICES & SUPPLY	38, 477	0	1	0	0	14. 00
	01500 PHARMACY	13, 357	1	4, 935	0	19, 414	
	01600 MEDI CAL RECORDS & LI BRARY	0	0	0	0	0	16.00
	01080 PATIENT TRANSPORTATION 02100 &R SERVICES-SALARY & FRINGES APPRVD	1, 302	17 0	481	0	6, 802 21, 128	
	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	75, 868	0	1	0	2, 375	
	02300 PARAMED ED PRGM	354	0		Ö	1, 015	
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDI ATRI CS	308, 295	1, 782	1	324, 468	125, 328	
	03100 INTENSIVE CARE UNIT	50, 168	294		23, 001	32, 572	31.00
	03200 CORONARY CARE UNIT 02060 NEONATAL INTENSIVE CARE UNIT	18, 479	0 18	1	129	0 9, 394	32. 00 35. 00
	04000 SUBPROVI DER - I PF	10, 479	0		127	9, 374	40.00
	04100 SUBPROVI DER – I RF	18, 131	118	1	24, 999	7, 594	
	04300 NURSERY	5, 638	30		0	2, 075	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM 05100 RECOVERY ROOM	68, 721	270		0	29, 836	
51. 00 52. 00	05200 DELIVERY ROOM & LABOR ROOM	14, 924 23, 299	91 135		0	6, 994 9, 260	
	05400 RADI OLOGY-DI AGNOSTI C	113, 384	209		0	37, 969	
	05700 CT SCAN	0	0		0	1, 369	
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	· ·	0	0	58. 00
	05900 CARDI AC CATHETERI ZATI ON	24, 663	45		0	8, 925	
	06000 LABORATORY	32, 492	0	' - 1	0	13, 764	60.00
	06001 BLOOD LABORATORY 06300 BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	60. 01 63. 00
	06500 RESPIRATORY THERAPY	7, 973	0	2, 946	0	15, 941	65. 00
	06501 SLEEP LAB	0	0	1	Ö	2, 461	65. 01
	06600 PHYSI CAL THERAPY	28, 259	17	2, 300	0	17, 368	66. 00
	06700 OCCUPATI ONAL THERAPY	4, 360			0	3, 447	
	06800 SPEECH PATHOLOGY	1, 043	0		0	2, 353	
	06801 AUDI OLOGY 06900 ELECTROCARDI OLOGY	0 33, 437	0 36		0	7 588	68. 01 69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0 0	0	,	0		71. 00
	07200 IMPL. DEV. CHARGED TO PATIENT	o	0	Ö	0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
	07301 HOSPI TAL BASED RETAIL PHARMACIES	1, 610	0	0	0		73. 01
	07400 RENAL DI ALYSI S	5, 292	5	1, 955	0		74.00
	03160 CARDI OPULMONARY 07697 CARDI AC REHABI LI TATI ON	0	0	0	0	0 4 973	76. 00 76. 97
	07698 HYPERBARI C OXYGEN THERAPY	753	0	278	0		76. 97 76. 98
70.70	OUTPATIENT SERVICE COST CENTERS	, 55		2,0	<u> </u>	2,0.0	70.70
	09000 CLINIC	0	0	0	0	0	90. 00
	09001 SUBSTANCE ABUSE CLINIC	11, 573	0	4, 276	0	1, 443	
	09002 PAIN CLINIC	40, 703		15, 039	0		90. 02
	09003 ONCOLOGY CLINIC 09100 EMERGENCY	5, 270 61, 211	457	1, 947 22, 616	0	5, 257 40, 424	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	01, 211	437	22,010	o i	40, 424	92.00
	09201 OBSERVATION BEDS (DISTINCT PART)	457	0	169	0	310	92. 01
	OTHER REIMBURSABLE COST CENTERS				•		
95.00	09500 AMBULANCE SERVICES	1, 297	0	479	0	0	95. 00
440.00	SPECIAL PURPOSE COST CENTERS	· · · · · · · · · · · · · · · · · · ·		1	-		140 00
113. 00 118. 00	11300 INTEREST EXPENSE	1 100 051	2 527	200 570	272 507	440 701	113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	1, 102, 951	3, 527	389, 572	372, 597	469, 791	110.00
190. 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	O	ol	1.647	190. 00
191.00	19100 RESEARCH	3, 391	0	1, 253	Ö	3, 575	191. 00
	07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194. 00
194. 01	07951 BSU PHARMACY	0	0	0	0	632	194. 01

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Period: Worksheet B From 01/01/2020 Part II To 12/31/2020 Date/Time Prepar Provi der CCN: 15-0089

			To	12/31/2020	Date/Time Pre 7/15/2021 12:	
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	O 7 DIII
· ·	PLANT	LINEN SERVICE				
	7. 00	8. 00	9. 00	10. 00	11. 00	
194. 0207952 PAVILLION PHARMACY	4, 607	0	1, 702	0	3, 109	194. 02
194. 03 07953 VENDI NG	0	0	0	0	0	194. 03
194. 04 <mark>07954</mark> CARELI NE	0	0	0	0	0	194. 04
194. 05 <mark>07955</mark> WELLNESS CENTER	9, 200	19	3, 399	0	0	194. 05
194.0607956 PHYSICIAN PRACTICE CLINICS	43, 882	0	6, 325	0		194. 06
194. 07 <mark>07957 PERINATAL CLINIC</mark>	0	0	0	0	0	194. 07
194.08 <mark>07958</mark> RENTAL PROPERTY	164, 337	0	27, 996	0	0	194. 08
194. 09 <mark>07959</mark> ADVERTI SI NG	0	0	0	0	0	194. 09
194. 10 <mark>07960 NTEGRA LTAC</mark>	21, 348	0	0	19, 375	0	194. 10
194. 11 <mark>07961 I U HEALTH HOSPI CE</mark>	5, 515	0	2, 038	0	0	194. 11
194.1207962 POB MEDICAL PAVILLION CONDOS	0	0	0	0	0	194. 12
194. 13 <mark>07963</mark> PEDIATRIC THERAPIES	12, 151	0	0	0		194. 13
194.1407964 NEW CASTLE ONCOLOGY	0	0	0	0	0	194. 14
194. 15 07965 MARKETI NG/PUBLIC RELATIONS	4, 033	0	0	0	0	194. 15
194. 16 07966 JAY COUNTY HOSPITAL	9, 121	0	3, 370	0	2, 400	194. 16
194. 1707967 CARDINAL HEALTH CHOICE	0	0	0	0	0	194. 17
194. 1807968 CHV CARDINAL HEALTH VENTURES	0	0	0	0	0	194. 18
194. 1907969 HEALTH CARE CONNECTIONS	0	0	0	0	0	194. 19
194.2007970 MEALS ON WHEELS	0	0	0	0	0	194. 20
194. 21 <mark>07971</mark> ST MARY'S SCHOOL	0	0	0	0	0	194. 21
194. 2207972 THERAPIES TO OTHER ENTITIES	0	0	0	0	0	194. 22
194. 23 07973 CANCER CENTER BOUTIQUE	1, 545	0	571	0	172	194. 23
194. 24 07974 BOSC BALL OUTPATIENT SURGERY	44, 854	0	0	0	0	194. 24
194. 25 07975 CARDI NAL BEHAVI ORAL HEALTH	0	0	0	3, 450	0	194. 25
194.2607976 BLACKFORD COMMUNITY HOSPITAL	6, 895	0	2, 548	0	2, 327	194. 26
194. 2707977 MIDWEST HEALTH STRATEGIES	0	0	0	0	0	194. 27
194.28 <mark>07978</mark> CARDINAL SELECT RISK RETENTION GRP	0	0	0	0	0	194. 28
194.2907979 HOME OFFICE CARDINAL HEALTH INITIATI	0	0	0	0	0	194. 29
194. 3007980 CARDINAL HEALTH ALLIANCE	0	0	0	0	0	194. 30
194. 31 07986 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194. 31
194. 32 <mark>07982</mark> RENAL DI ALYSI S	0	0	0	0		194. 32
194. 33 <mark>07983 LAB CORP</mark>	0	0	0	0		194. 33
194.34 <mark>07984</mark> H.O. MATERIALS MGMT	0	0	0	0		194. 34
194. 35 <mark>07985</mark> LEASED SPACE	39, 997	0	0	0		194. 35
200.00 Cross Foot Adjustments			l l			200. 00
201.00 Negative Cost Centers	0	0	0	0		201. 00
202.00 TOTAL (sum lines 118 through 201)	1, 473, 827	3, 546	438, 774	395, 422	483, 653	202. 00

Provi der CCN: 15-0089

			To		Date/Time Pre 7/15/2021 12:	
					OTHER GENERAL SERVICE	
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	PATI ENT	
	ADMI NI STRATI	ON SERVICES & SUPPLY		RECORDS & LI BRARY	TRANSPORTATI ON	
	13. 00	14. 00	15. 00	16. 00	18. 00	
GENERAL SERVICE COST CENTERS	FLVT					1 00
1.00 O0100 NEW CAP REL COSTS-BLDG & 4.00 O0400 EMPLOYEE BENEFITS DEPARTM						1. 00 4. 00
5. 01 01160 COMMUNI CATI ONS						5. 01
5. 02 00550 DATA PROCESSING 5. 04 00570 ADMITTING						5. 02
5. 04 00570 ADMI TTI NG 5. 05 00580 CASHI ERI NG/ACCOUNTS RECEI	VABLE					5. 04 5. 05
5.06 00590 OTHER ADMINISTRATIVE AND						5. 06
6.00 00600 MAINTENANCE & REPAIRS						6. 00
7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE						7. 00 8. 00
9. 00 00900 HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERIA 13. 00 01300 NURSING ADMINISTRATION	528, 0	16				11. 00 13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY		0 764, 985	5			14. 00
15. 00 01500 PHARMACY		0 6, 611				15. 00
16.00 01600 MEDICAL RECORDS & LIBRAR' 18.00 01080 PATIENT TRANSPORTATION	(0 0	1 1	0	34, 583	16. 00 18. 00
21. 00 02100 I &R SERVICES-SALARY & FRI	NGES APPRVD	0 0	1	0	34, 363	21. 00
22.00 02200 &R SERVICES-OTHER PRGM (0 2	0	0	0	22. 00
23.00 O2300 PARAMED ED PRGM INPATIENT ROUTINE SERVICE COST	CENTERS	0 0) 0	0	0	23. 00
30. 00 03000 ADULTS & PEDIATRICS	250, 8 ₁	52, 784	1, 368	0	3, 705	30. 00
31.00 03100 INTENSIVE CARE UNIT	65, 9		468	0	1, 149	31. 00
32.00 03200 CORONARY CARE UNIT 35.00 02060 NEONATAL INTENSIVE CARE U	JNI T 18, 4	0	71 Y	0	0 278	32. 00 35. 00
40. 00 04000 SUBPROVI DER - I PF	10, 4	0 0		0	0	40. 00
41. 00 04100 SUBPROVI DER - I RF	15, 0			0	184	41.00
43.00 O4300 NURSERY ANCILLARY SERVICE COST CENTERS	4, 1	16 C		0	55	43. 00
50. 00 05000 OPERATING ROOM	19, 5:	21 45, 911	521	0	2, 866	50.00
51. 00 05100 RECOVERY ROOM	15, 1			0	394	51.00
52. 00 05200 DELI VERY ROOM & LABOR ROO 54. 00 05400 RADI OLOGY-DI AGNOSTI C	DM 17, 78			0	472 4, 433	52. 00 54. 00
57. 00 05700 CT SCAN	10,0	0 35		Ö	56	57. 00
58. 00 05800 MAGNETIC RESONANCE I MAGIN		0 0	-	0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	10, 10	07 13, 485 0 0		0	1, 799 1, 526	59. 00 60. 00
60.01 06001 BLOOD LABORATORY		0	0	O	0	60. 01
63.00 06300 BLOOD STORING, PROCESSING 65.00 06500 RESPIRATORY THERAPY		0 10 100	0 53	0	143	63.00
65. 00 06500 RESPI RATORY THERAPY 65. 01 06501 SLEEP LAB	2, 0	59 18, 180 22 1, 103	1	0	520 103	65. 00 65. 01
66.00 06600 PHYSI CAL THERAPY		0 1, 249		O	347	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		0 170		0		67.00
68. 00 06800 SPEECH PATHOLOGY 68. 01 06801 AUDI OLOGY		0 17	1	0	0	68. 00 68. 01
69. 00 06900 ELECTROCARDI OLOGY		0 745	0	O	951	69. 00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED		0 264, 565		0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATENTS		0 270, 758 0 0		0	1, 832 6, 805	72. 00 73. 00
73. 01 07301 HOSPITAL BASED RETAIL PHA		0 49		0		73. 01
74.00 07400 RENAL DI ALYSIS 76.00 03160 CARDI OPULMONARY		0 560	1	0	72	
76. 97 07697 CARDI AC REHABI LI TATI ON	4.	0 14 206	1	0	0 75	76. 00 76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAP	4, 6			0	297	76. 98
OUTPATIENT SERVICE COST CENTER 90.00 09000 CLINIC	S	ol c	0	ol	0	90. 00
90. 01 09001 SUBSTANCE ABUSE CLINIC	5.	101	1	0	5	90. 01
90. 02 09002 PAIN CLINIC	1, 9	•		0	117	90. 02
90. 03 09003 0NCOLOGY CLINIC 91. 00 09100 EMERGENCY	10, 50 72, 6	1		0	675 3 860	90. 03 91. 00
92. 00 09200 OBSERVATION BEDS (NON-DIS		25,710	,	J	3, 000	92. 00
92. 01 09201 OBSERVATION BEDS (DISTING		07 180	5	0	4	92. 01
OTHER REIMBURSABLE COST CENTER 95.00 09500 AMBULANCE SERVICES	o	0 0	0	o	0	95. 00
SPECIAL PURPOSE COST CENTERS				-1		
113.0011300 INTEREST EXPENSE 118.00 SUBTOTALS (SUM OF LINES	l through 117) 524,2	35 764, 760	305, 233	0	34, 583	113. 00 118. 00
NONREI MBURSABLE COST CENTERS	-					
190. 00 19000 GIFT, FLOWER, COFFEE SHOP	& CANIEEN	0 14	0	0	0	190. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 15-0089

				10 12/31/2020	7/15/2021 12: 59	
		•			OTHER GENERAL	
					SERVI CE	
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	PATI ENT	
cost center bescription			FHARWACI			
	ADMINI STRATION	SERVICES &		RECORDS &	TRANSPORTATI ON	
	12.00	SUPPLY	15.00	LI BRARY	10.00	
101 0010100 05051000	13. 00	14. 00	15. 00	16. 00	18. 00	
191. 00 19100 RESEARCH	3, 665	8	(0 191	
194. 0007950 OTHER NONREIMBURSABLE COST CENTERS	0	0	(0	0 194	
194.0107951 BSU PHARMACY	0	0	(0	0 194	
194.02 07952 PAVILLION PHARMACY	0	13		0	0 194	1. 02
194. 03 <mark>07953</mark> VENDI NG	0	0			0 194	1. 03
194. 0407954 CARELI NE	0	0	(0 194	1. 04
194.0507955 WELLNESS CENTER	0	29	l	ol c	0 194	. 05
194.0607956 PHYSICIAN PRACTICE CLINICS	0	0	l (0 194	
194. 07/07957 PERINATAL CLINIC	0	0			0194	
194. 0807958 RENTAL PROPERTY	0	0		1	0194	
194. 0907959 ADVERTI SI NG		0	1		0194	
, , , , , , , , , , , , , , , , , , ,	0	0			1	
194. 1007960 I NTEGRA LTAC	U	U	<u>'</u>		0 194	
194. 11 07961 I U HEALTH HOSPI CE	0	0	(0 194	
194.1207962 POB MEDICAL PAVILLION CONDOS	0	0	(0	0 194	
194. 1307963 PEDI ATRI C THERAPI ES	0	154	(0	0 194	l. 13
194.1407964 NEW CASTLE ONCOLOGY	0	0		0	0 194	1. 14
194.1507965 MARKETING/PUBLIC RELATIONS	0	0			0 194	l. 15
194.1607966 JAY COUNTY HOSPITAL	0	0	(0 194	1. 16
194. 1707967 CARDINAL HEALTH CHOICE	0	0			0 194	1. 17
194. 1807968 CHV CARDINAL HEALTH VENTURES	0	0	l (ol d	0 194	1. 18
194. 1907969 HEALTH CARE CONNECTIONS	0	0	l (ol d	0 194	1. 19
194. 2007970 MEALS ON WHEELS	0	0			0 194	
194. 2107971 ST MARY'S SCHOOL	0	0	1		0194	
194. 2207972 THERAPIES TO OTHER ENTITIES	146	0	l i		0194	
194. 2307973 CANCER CENTER BOUTIQUE	140	1	l '		0194	
194. 2407974 BOSC BALL OUTPATIENT SURGERY	0	1			0194	
	0	0			1	
194. 25 07975 CARDI NAL BEHAVI ORAL HEALTH	U	3	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		0 194	
194. 26 07976 BLACKFORD COMMUNITY HOSPITAL	0	3	·		0 194	
194. 27 07977 MI DWEST HEALTH STRATEGIES	0	0	(0	0 194	
194.2807978 CARDINAL SELECT RISK RETENTION GRP	0	0	(0	0 194	
194.2907979 HOME OFFICE CARDINAL HEALTH INITIATI	0	0	(0	0 194	1. 29
194. 30 <mark>07980</mark> CARDINAL HEALTH ALLIANCE	0	0		0	0 194	1. 30
194. 31 07986 OTHER NONREIMBURSABLE COST CENTERS	0	0			0 194	1. 31
194. 32 <mark>07982 RENAL DI ALYSI S</mark>	0	0	i		0 194	1. 32
194. 3307983 LAB CORP	l o	0			0 194	1. 33
194. 3407984 H. O. MATERIALS MGMT	0	0	l	ol c	0 194	
194. 3507985 LEASED SPACE	0	0			0194	
200.00 Cross Foot Adjustments	I	O	l '	1	1). 00
201.00 Negative Cost Centers		0	,		0201	
1 1 3	528, 046	764, 985	305, 23	4		
202.00 TOTAL (sum lines 118 through 201)	320, 040	104, 985	J 300, 23	+1	η 34, 303 <u>2</u> 02	. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS BALL MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 Peri od: Worksheet B From 01/01/2020 Part II To 12/31/2020 Date/Time Prepared: 7/15/2021 12:59 pm Provi der CCN: 15-0089

	I NTEDNO 0	DECLIDENTS			//15/2021 12: 	59 pm
	I INTERNS &	RESI DENTS				
Cost Contor Description	SERVI CES-SALAR	KEDVICES OTHER	PARAMED ED	Subtotal	Intorn &	
Cost Center Description	& FRINGES	PRGM COSTS	PRGM		Intern & Residents Cost	
	α FRINGES	PROW COSTS	PRGIVI		& Post	
					Stepdown	
					Adjustments	
	21. 00	22. 00	23. 00	24. 00	25. 00	
GENERAL SERVICE COST CENTERS	21.00	22.00	20.00	21.00	20.00	
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 PROCESSING						5. 02
5. 04 00570 ADMITTING					ļ	5. 04
5. 05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 05
5.06 00590 OTHER ADMINISTRATIVE AND GENERAL					1	5. 06
6.00 00600 MAINTENANCE & REPAIRS						6. 00
7.00 O0700 OPERATION OF PLANT						7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG		•			·	9.00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A						10.00
13.00 O1300 NURSING ADMINISTRATION	1	•			·	11. 00 13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY		1			i	14. 00
15. 00 01500 PHARMACY		•			i	15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY						16. 00
18. 00 01080 PATI ENT TRANSPORTATION						18. 00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	36, 087					21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD		1, 478, 435				22. 00
23.00 02300 PARAMED ED PRGM			8, 730			23. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS				6, 847, 341		30. 00
31.00 03100 INTENSIVE CARE UNIT				1, 151, 348		31.00
32. 00 03200 CORONARY CARE UNIT				0	0	32.00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT				399, 815		35. 00
40. 00 04000 SUBPROVI DER - I PF 41. 00 04100 SUBPROVI DER - I RF		•		408, 080	0	40. 00 41. 00
43. 00 04300 NURSERY				117, 460		43.00
ANCI LLARY SERVI CE COST CENTERS				117, 400	<u> </u>	43.00
50. 00 05000 OPERATI NG ROOM				1, 469, 679	0	50.00
51.00 05100 RECOVERY ROOM				322, 460		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	I			496, 021	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C				2, 334, 918	0	54.00
57.00 05700 CT SCAN				2, 232		57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)				0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON				530, 494		59. 00
60. 00 06000 LABORATORY		•		683, 055		60.00
60. 01 06001 BLOOD LABORATORY 63. 00 06300 BLOOD STORI NG, PROCESSI NG, & TRANS.		•		4 070	0	60. 01 63. 00
65. 00 06500 RESPIRATORY THERAPY		•		4, 070 207, 083		65. 00
65. 01 06501 SLEEP LAB				6, 050		65. 01
66. 00 06600 PHYSI CAL THERAPY				575, 081		
67. 00 06700 OCCUPATI ONAL THERAPY				92, 080		
68.00 06800 SPEECH PATHOLOGY				25, 194		68. 00
68. 01 06801 AUDI OLOGY				0	0	68. 01
69. 00 06900 ELECTROCARDI OLOGY				666, 930	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS			j l	301, 020		71. 00
72.00 07200 I MPL. DEV. CHARGED TO PATIENT				309, 919		72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS				439, 404		73. 00
73. 01 07301 HOSPITAL BASED RETAIL PHARMACIES				54, 920		73. 01
74. 00 07400 RENAL DI ALYSI S				106, 825		74.00
76. 00 03160 CARDI OPULMONARY 76. 97 07697 CARDI AC REHABI LI TATI ON				0 510	0	76. 00 76. 97
76. 98 O7698 HYPERBARI C OXYGEN THERAPY				9, 518 30, 777		76. 97 76. 98
OUTPATIENT SERVICE COST CENTERS				30,111	. 0	70.70
90. 00 09000 CLINIC				0	0	90. 00
90. 01 09001 SUBSTANCE ABUSE CLINIC				226, 961	1	90. 01
90. 02 09002 PAIN CLINIC		1		794, 620	1	90. 02
90. 03 09003 ONCOLOGY CLINIC				130, 716		90. 03
91.00 09100 EMERGENCY			l l	1, 383, 763		91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
92. 01 09201 OBSERVATION BEDS (DISTINCT PART)				10, 694	0	92. 01
OTHER REIMBURSABLE COST CENTERS	1	1	1	0= 0=		05.00
95. 00 09500 AMBULANCE SERVICES				25, 083	0	95. 00
SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE	1	I				113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 11	7) 0	0	0	20, 163, 611		113.00 118.00
34 TOOSTOTIVES (SOM OF ETIMES I THE OUGH IT	· /1 0		<u> </u>	20, 100, 011		. 10. 00

Health Financial Systems	BALL MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS	Provi der CCN: 15-0089	Period: Worksheet B From 01/01/2020 Part II To 12/31/2020 Date/Time Prepared: 7/15/2021 12:59 pm

ALLOCATION OF	- CAPITAL RELATED COSTS		Provider C	CN: 15-0089	From 01/01/2020 To 12/31/2020	Part II Date/Time Prepared: 7/15/2021 12:59 pm
		INTERNS &	RESI DENTS			
C	Cost Center Description	SERVI CES-SALARY			Subtotal	Intern &
		& FRINGES	PRGM COSTS	PRGM		Residents Cost
						& Post
						Stepdown
		21. 00	22. 00	23. 00	24. 00	Adjustments 25.00
NONDELL	MBURSABLE COST CENTERS	21.00	22.00	23.00	24.00	25.00
	GIFT, FLOWER, COFFEE SHOP & CANTEEN				3, 090	0190.00
191. 00 19100 F					75, 480	0191.00
	OTHER NONREIMBURSABLE COST CENTERS				0	0 194. 00
194. 01 07951 E					944	0 194. 01
	PAVILLION PHARMACY				107, 352	0 194. 02
194. 0307953 V					0	0 194. 03
194. 04 07954 0	CARELINE				0	0 194. 04
194. 05 07955 W	VELLNESS CENTER				178, 021	0 194. 05
194. 06 07956 F	PHYSICIAN PRACTICE CLINICS				838, 960	0 194. 06
194. 07 07957 F	PERINATAL CLINIC				0	0 194. 07
	RENTAL PROPERTY				3, 147, 941	0 194. 08
194. 09 07959 A					0	0 194. 09
194. 10 <mark>07960</mark> I					424, 439	0 194. 10
	U HEALTH HOSPICE				106, 685	0 194. 11
	POB MEDICAL PAVILLION CONDOS				0	0 194. 12
	PEDI ATRI C THERAPI ES				235, 349	0 194. 13
	NEW CASTLE ONCOLOGY				0	0 194. 14
	MARKETI NG/PUBLI C RELATIONS				76, 532	0 194. 15
	JAY COUNTY HOSPI TAL				182, 770	0 194. 16
	CARDINAL HEALTH CHOICE CHV CARDINAL HEALTH VENTURES				0	0 194. 17
	HEALTH CARE CONNECTIONS				0	0 194. 18 0 194. 19
	MEALS ON WHEELS				0	0194.19
	ST MARY'S SCHOOL				0	0194. 21
	THERAPIES TO OTHER ENTITIES				1, 454	0194. 22
	CANCER CENTER BOUTI QUE				30, 299	0194.23
	BOSC BALL OUTPATIENT SURGERY				851, 079	
	CARDINAL BEHAVIORAL HEALTH				3, 453	
	BLACKFORD COMMUNITY HOSPITAL				139, 372	0194.26
	NI DWEST HEALTH STRATEGIES				0	0 194. 27
	CARDINAL SELECT RISK RETENTION GRP				0	0 194. 28
194. 29 07979 H	HOME OFFICE CARDINAL HEALTH INITIATI				0	0 194. 29
194. 30 <mark>07980</mark> 0	CARDINAL HEALTH ALLIANCE				0	0 194. 30
	OTHER NONREIMBURSABLE COST CENTERS				0	0 194. 31
	RENAL DIALYSIS				0	0 194. 32
194. 3307983 L					0	0 194. 33
	H.O. MATERIALS MGMT				0	0 194. 34
194. 35 07985 L			, .=	_ = -	758, 924	0 194. 35
1 1	Cross Foot Adjustments	36, 087	1, 478, 435	8, 73	1, 523, 252	0 200. 00
	Vegative Cost Centers	24 007	1 470 405	0.70	0	0 201. 00
202. 00 T	「OTAL (sum lines 118 through 201)	36, 087	1, 478, 435	8, 73	28, 849, 007	0 202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS BALL MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 Provi der CCN: 15-0089

| Peri od: | Worksheet B | From 01/01/2020 | Part II | Date/Time | Prepared: | 7/15/2021 | 12: 59 pm

	Cost Center Description	Total	7/13/2021 12	. 37 piii
	CENEDAL CEDVICE COCT CENTEDS	26. 00		
	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT			1.00
	00400 EMPLOYEE BENEFITS DEPARTMENT			4. 00
	01160 COMMUNI CATI ONS			5. 01
	00550 DATA PROCESSING			5. 02
	00570 ADMI TTI NG			5. 04 5. 05
	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 00590 OTHER ADMINI STRATI VE AND GENERAL			5. 06
	00600 MAINTENANCE & REPAIRS			6. 00
	00700 OPERATION OF PLANT			7. 00
	00800 LAUNDRY & LINEN SERVICE			8.00
	00900 HOUSEKEEPI NG 01000 DI ETARY			9. 00 10. 00
	01100 CAFETERI A			11. 00
13. 00	01300 NURSING ADMINISTRATION			13. 00
	01400 CENTRAL SERVI CES & SUPPLY			14.00
	01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY			15. 00 16. 00
	01080 PATIENT TRANSPORTATION			18. 00
	02100 &R SERVICES-SALARY & FRINGES APPRVD			21.00
	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD			22. 00
	02300 PARAMED ED PRGM INPATIENT ROUTINE SERVICE COST CENTERS			23. 00
	03000 ADULTS & PEDIATRICS	6, 847, 341		30.00
31.00	03100 INTENSIVE CARE UNIT	1, 151, 348		31.00
	03200 CORONARY CARE UNIT	0		32.00
	02060 NEONATAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	399, 815		35. 00 40. 00
	04100 SUBPROVIDER - IRF	408, 080		41.00
43.00	04300 NURSERY	117, 460		43.00
	ANCILLARY SERVICE COST CENTERS	4 4/0 (70		
	05000 OPERATING ROOM 05100 RECOVERY ROOM	1, 469, 679 322, 460		50. 00 51. 00
	05200 DELIVERY ROOM & LABOR ROOM	496, 021		52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 334, 918		54.00
	05700 CT SCAN	2, 232		57.00
	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION	0 530, 494		58. 00 59. 00
	06000 LABORATORY	683, 055		60.00
	06001 BLOOD LABORATORY	0		60. 01
	06300 BLOOD STORING, PROCESSING, & TRANS.	4, 070		63. 00
	06500 RESPI RATORY THERAPY	207, 083		65.00
	06501 SLEEP LAB 06600 PHYSI CAL THERAPY	6, 050 575, 081		65. 01 66. 00
	06700 OCCUPATI ONAL THERAPY	92, 080		67. 00
	06800 SPEECH PATHOLOGY	25, 194		68. 00
	06801 AUDI OLOGY 06900 ELECTROCARDI OLOGY	644 020		68. 01 69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	666, 930 301, 020		71.00
	07200 IMPL. DEV. CHARGED TO PATIENT	309, 919		72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	439, 404		73. 00
	07301 HOSPITAL BASED RETAIL PHARMACIES 07400 RENAL DIALYSIS	54, 920		73. 01
	03160 CARDI OPULMONARY	106, 825 0		74. 00 76. 00
76. 97	07697 CARDIAC REHABILITATION	9, 518		76. 97
	07698 HYPERBARI C OXYGEN THERAPY	30, 777		76. 98
	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC	ol		90.00
	09000 CLINIC 09001 SUBSTANCE ABUSE CLINIC	226, 961		90. 00 90. 01
90. 02	09002 PAIN CLINIC	794, 620		90. 02
	09003 ONCOLOGY CLINIC	130, 716		90. 03
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 383, 763		91. 00 92. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART) 09201 OBSERVATION BEDS (DISTINCT PART)	10, 694		92.00
	OTHER REIMBURSABLE COST CENTERS	13, 374]
	09500 AMBULANCE SERVICES	25, 083		95. 00
	SPECIAL PURPOSE COST CENTERS	-		112 00
113.00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	20, 163, 611		113. 00 118. 00
	NONREI MBURSABLE COST CENTERS	20, 700, 011]
190. 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	3, 090		190. 00
	19100 RESEARCH	75, 480		191.00
	07950 OTHER NONREIMBURSABLE COST CENTERS 07951 BSU PHARMACY	0 944		194. 00 194. 01
	07952 PAVILLION PHARMACY	107, 352		194. 02

Health Financial Systems

BALL MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0089 | Period: From 01/01/2020 | Part II

		To 12/31/2020 Date/Time Prepared: 7/15/2021 12: 59 pm
Cost Center Description	Total	77 107 2021 12. 07 pm
· ·	26. 00	
194. 03 07953 VENDI NG	0	194. 03
194. 0407954 CARELI NE	0	194. 04
194.0507955 WELLNESS CENTER	178, 021	194. 05
194.0607956 PHYSICIAN PRACTICE CLINICS	838, 960	194. 06
194. 0707957 PERINATAL CLINIC	0	194. 07
194. 0807958 RENTAL PROPERTY	3, 147, 941	194. 08
194. 0907959 ADVERTI SI NG	0	194. 09
194. 1007960 I NTEGRA LTAC	424, 439	194. 10
194. 1107961 I U HEALTH HOSPICE	106, 685	194. 11
194. 1207962 POB MEDICAL PAVILLION CONDOS	0	194. 12
194. 1307963 PEDI ATRI C THERAPI ES	235, 349	194. 13
194.1407964 NEW CASTLE ONCOLOGY	0	194. 14
194. 15 07965 MARKETI NG/PUBLI C RELATI ONS	76, 532	194. 15
194. 1607966 JAY COUNTY HOSPITAL	182, 770	194. 16
194. 1707967 CARDI NAL HEALTH CHOI CE	0	194. 17
194. 1807968 CHV CARDINAL HEALTH VENTURES	0	194. 18
194. 1907969 HEALTH CARE CONNECTIONS	0	194. 19
194.2007970 MEALS ON WHEELS	0	194. 20
194. 2107971 ST MARY'S SCHOOL	0	194. 21
194. 2207972 THERAPIES TO OTHER ENTITIES	1, 454	194. 22
194. 2307973 CANCER CENTER BOUTIQUE	30, 299	194. 23
194. 2407974 BOSC BALL OUTPATIENT SURGERY	851, 079	194. 24
194. 25 07975 CARDI NAL BEHAVI ORAL HEALTH	3, 453	194. 25
194. 2607976 BLACKFORD COMMUNITY HOSPITAL	139, 372	194. 26
194. 27 07977 MIDWEST HEALTH STRATEGIES	0	194. 27
194.2807978 CARDINAL SELECT RISK RETENTION GRP	0	194. 28
194.2907979 HOME OFFICE CARDINAL HEALTH INITIATI	0	194. 29
194. 3007980 CARDINAL HEALTH ALLIANCE	0	194. 30
194.31 07986 OTHER NONREIMBURSABLE COST CENTERS	0	194. 31
194. 32 <mark>07982 RENAL DI ALYSI S</mark>	0	194. 32
194. 33 07983 LAB CORP	0	194. 33
194.34 <mark>07984</mark> H.O. MATERIALS MGMT	0	194. 34
194. 35 <mark>07985 LEASED SPACE</mark>	758, 924	194. 35
200.00 Cross Foot Adjustments	1, 523, 252	200. 00
201.00 Negative Cost Centers	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	28, 849, 007	202. 00

	Financial Systems LLOCATION - STATISTICAL BASIS	BALL MEMORIAL		CN: 15-0089 P	In Lieu eriod:	of Form CMS-2 Worksheet B-1	
0001 7	ELEGONT ON STATE BASIS		Trovider o	F T	rom 01/01/2020	Date/Time Pre	
		CAPITAL RELATED)			7/15/2021 12:	59 pm
	Cost Contar Decement on	COSTS NEW BLDG & FIXT	EMPLOYEE	COMMUNICATIONS	DATA	ADMI TTI NG	
	Cost Center Description	NEW BLDG & FIXI	EMPLOYEE BENEFITS	COMMUNI CATI ONS (FTE'S)	DATA PROCESSI NG	(GROSS	
		(SQUARE FEET)	DEPARTMENT (GROSS		(GROSS CHARGES)	CHARGES)	
		ŕ	SALARI ES)		ŕ		
	GENERAL SERVICE COST CENTERS	1.00	4. 00	5. 01	5. 02	5. 04	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	1, 824, 235	110 000 007				1.00
4. 00 5. 01	00400 EMPLOYEE BENEFITS DEPARTMENT 01160 COMMUNICATIONS	4, 136 1, 822	119, 029, 237 509, 704	184, 462			4. 00 5. 01
5. 02 5. 04	00550 DATA PROCESSI NG 00570 ADMI TTI NG	0 7 045	1 170 502	0 054	1, 898, 319, 861 0	1 000 210 041	5. 02 5. 04
5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	7, 045 0	1, 170, 593 0	2, 056 0	0	1, 898, 319, 861 0	5. 05
5. 06 6. 00	00590 OTHER ADMINISTRATIVE AND GENERAL 00600 MAINTENANCE & REPAIRS	49, 950 903, 970	6, 806, 411 3, 209, 485	4, 393 6, 464	0	0	5. 06 6. 00
7. 00	00700 OPERATION OF PLANT	44, 658	1, 559, 841		0	0	7. 00
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	0 12, 387	0 2, 933, 411	0 9, 449	0	0	8. 00 9. 00
10.00	01000 DI ETARY	11, 061	1, 540, 620		o o	0	10.00
	01100 CAFETERIA 01300 NURSING ADMINISTRATION	13, 668 13, 701	1, 183, 180 5, 836, 793		0	0	11. 00 13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	21, 216	0, 030, 773	7,273	o o	0	14. 00
	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	7, 365	5, 110, 213	6, 082	0	0	15. 00 16. 00
	01080 PATIENT TRANSPORTATION	718	623, 447	2, 131	0	0	18. 00
	02100 &R SERVICES-SALARY & FRINGES APPRVD 02200 &R SERVICES-OTHER PRGM COSTS APPRVD	0 41, 833	4, 083, 556 224, 696		0	0	21. 00 22. 00
	02300 PARAMED ED PRGM	195	229, 242	318	0	0	23. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	169, 990	24, 131, 436	39, 262	205, 842, 412	205, 842, 412	30. 00
31.00	03100 INTENSIVE CARE UNIT	27, 662	7, 017, 306		63, 848, 782	63, 848, 782	31. 00
	03200 CORONARY CARE UNIT 02060 NEONATAL INTENSIVE CARE UNIT	0 10, 189	0 2, 057, 937	0 2, 943	0 15, 470, 534	0 15, 470, 534	32. 00 35. 00
40.00	04000 SUBPROVI DER - I PF	0	0	0	0	0	40. 00
	04100 SUBPROVI DER - RF 04300 NURSERY	9, 997 3, 109	1, 659, 080 458, 820		10, 214, 820 3, 049, 327	10, 214, 820 3, 049, 327	41. 00 43. 00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM 05100 RECOVERY ROOM	37, 892 8, 229	5, 551, 622 1, 412, 538	9, 347 2, 191	159, 200, 605 21, 868, 641	159, 200, 605 21, 868, 641	50. 00 51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	12, 847	1, 952, 655	2, 901	26, 200, 945	26, 200, 945	52. 00
54. 00 57. 00	05400 RADI OLOGY-DI AGNOSTI C 05700 CT SCAN	62, 519 0	8, 791, 275 129, 513		246, 299, 807 3, 135, 633	246, 299, 807 3, 135, 633	54. 00 57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58. 00
	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	13, 599 17, 916	2, 093, 440 0			99, 938, 747 84, 771, 790	
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
63. 00 65. 00	06300 BLOOD STORING, PROCESSING, & TRANS. 06500 RESPIRATORY THERAPY	4, 396	3, 391, 048	4, 994	7, 945, 912 28, 875, 744	7, 945, 912 28, 875, 744	63. 00 65. 00
65. 01	06501 SLEEP LAB	0	455, 483		5, 747, 012	5, 747, 012	65. 01
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	15, 582 2, 404	3, 999, 997 838, 968	5, 441 1, 080	19, 293, 321 7, 124, 866	19, 293, 321 7, 124, 866	
68.00	06800 SPEECH PATHOLOGY	575	566, 528		4, 001, 003	4, 001, 003	68. 00
	06801 AUDI OLOGY 06900 ELECTROCARDI OLOGY	0 18, 437	1, 204, 603	0 2, 377	52, 857, 178	0 52, 857, 178	68. 01 69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	85, 014, 053	85, 014, 053 101, 759, 409	71.00
	07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS	0	0	0	101, 759, 409 354, 998, 924	354, 998, 924	72. 00 73. 00
	07301 HOSPITAL BASED RETAIL PHARMACIES	888	1, 389, 136	1, 392	7, 226, 550	7, 226, 550	
	07400 RENAL DI ALYSI S 03160 CARDI OPULMONARY	2, 918 0	0	0	3, 997, 884 0	3, 997, 884 0	74. 00 76. 00
76. 97	07697 CARDIAC REHABILITATION	0	897, 657			4, 170, 826	76. 97
	07698 HYPERBARI C OXYGEN THERAPY OUTPATIENT SERVICE COST CENTERS	415	493, 913	788	16, 485, 801	16, 485, 801	76. 98
90. 00 90. 01	09000 CLINIC 09001 SUBSTANCE ABUSE CLINIC	0 6, 381	0 201, 094	0 452	0 293, 425	0 293, 425	90. 00 90. 01
	09002 PAIN CLINIC	22, 443	366, 766		6, 526, 106	6, 526, 106	90.01
	09003 ONCOLOGY CLINIC 09100 EMERGENCY	2, 906	1, 202, 775		37, 483, 021	37, 483, 021	90. 03
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	33, 751	7, 530, 808	12, 664	214, 448, 979	214, 448, 979	91. 00 92. 00
	09201 OBSERVATION BEDS (DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	252	89, 894	97	227, 804	227, 804	92. 01
95. 00	09500 AMBULANCE SERVICES	715	0	0	0	0	95. 00
113 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE	T T					113. 00
118. 00		1, 619, 737	112, 905, 484	180, 119	1, 898, 319, 861	1, 898, 319, 861	

<u>leal th Financia</u>		BALL MEMORIAL				<u>of Form CMS-</u>	
COST ALLOCATION	I - STATISTICAL BASIS		Provi der C	CN: 15-0089	Period: From 01/01/2020	Worksheet B-	1
					To 12/31/2020	Date/Time Pr 7/15/2021 12	epared: :59 pm
		APITAL RELATED					
Cos	t Center Description	COSTS NEW BLDG & FLX	EMPLOYEE	COMMUNICATION	S DATA	ADMI TTI NG	
COS	t center bescription	ILW DLDG & TIA	BENEFITS	(FTE'S)	PROCESSI NG	(GROSS	
		(SQUARE	DEPARTMENT		(GROSS	CHARGES)	
		FEET)	(GROSS		CHARGES)		
		1.00	SALARI ES) 4. 00	5. 01	5. 02	5. 04	
NONREI MBU	JRSABLE COST CENTERS		11.00	0,0,	0102	0.01	
	T, FLOWER, COFFEE SHOP & CANTEEN	0	171, 174	1			190. 00
191. 00 19100 RES	EARCH ER NONREIMBURSABLE COST CENTERS	1, 870	668, 715	1			191.00
194. 0007950 01H 194. 0107951 BSU			0 182, 203		- 1		194. 00 194. 01
	ILLION PHARMACY	2, 540	828, 071	l .			194. 02
194. 03 <mark>07953</mark> VEN		0	0	(0		194. 03
194. 04 07954 CAR		0	0	9	0		194.04
194. 05 07955 WEL	SICIAN PRACTICE CLINICS	5, 073 24, 196	0				194. 05 194. 06
194. 0707957 PER		0	0		o o		194. 07
194. 08 07958 REN		90, 614	0	(0		194. 08
194. 0907959 ADV		0	0	(0		194. 09
194. 10 07960 NT 194. 11 07961 U		11, 771 3, 041	0				194. 10 194. 11
	MEDICAL PAVILLION CONDOS	0	0		o o		194. 12
194. 13 <mark>07963</mark> PED	I ATRI C THERAPI ES	6, 700	1, 282, 644		0		194. 13
	CASTLE ONCOLOGY	0	0	(0		194. 14
	KETING/PUBLIC RELATIONS COUNTY HOSPITAL	2, 224 5, 029	981, 628	l .			194. 15 194. 16
	DINAL HEALTH CHOICE	3,029	901, 020	l			194. 10
	CARDINAL HEALTH VENTURES	0	0	(0		194. 18
	LTH CARE CONNECTIONS	0	0	(0		194. 19
194. 20 <mark>07970 MEA</mark> 194. 2107971 ST		0	0				194. 20 194. 21
	RAPIES TO OTHER ENTITIES		1, 232, 685				194. 21
	CER CENTER BOUTIQUE	852	15, 083	1	4 0		194. 23
	C BALL OUTPATIENT SURGERY	24, 732	0		-		194. 24
	DINAL BEHAVIORAL HEALTH CKFORD COMMUNITY HOSPITAL	3, 802	761, 550	729	- 1		194. 25 194. 26
	WEST HEALTH STRATEGIES	3, 802	701, 550	1			194. 20
194. 28 <mark>07978</mark> CAR	DINAL SELECT RISK RETENTION GRP	Ö	0	(0		194. 28
	E OFFICE CARDINAL HEALTH INITIATI	0	0	(0		194. 29
	DI NAL HEALTH ALLI ANCE	0	0				194. 30 194. 31
194. 3107986 016 194. 3207982 REN	ER NONREIMBURSABLE COST CENTERS		0				194. 31
194. 33 <mark>07983</mark> LAB	CORP	Ö	0		o o		194. 33
	. MATERIALS MGMT	0	0	(0		194. 34
194. 35 07985 LEA		22, 054	0	(0	(194. 35
	ss Foot Adjustments ative Cost Centers	1		ł			200. 00 201. 00
	t to be allocated (per Wkst. B, Pa	t 28, 849, 007	26, 055, 897	613, 683	18, 166, 907	10, 570, 279	
1)	•						1
	t cost multiplier (Wkst. B, Part I)		0. 218903			0. 005568	
	t to be allocated (per Wkst. B, Pa	1 ^t	65, 408	29, 094	٩ ٥	112, 380	204. 00
205. 00 Uni	t cost multiplier (Wkst. B, Part I)	<u> </u>	0. 000550	0. 157724	0. 000000	0. 000059	205.00
	E adjustment amount to be allocated		2. 000000]	1.000000	2. 00000	206.00
1 1 2	r Wkst. B-2)						
207. 00 NAH	E unit cost multiplier (Wkst. D,			1	1	1	207.00

alth Financial Systems ST ALLOCATION - STATISTICAL BASIS		BALL MEMORIAL	Provi der C	CN: 15-0089 Po	eriod:	of Form CMS-2 Worksheet B-1	
THE BISTONE BISTONE BISTO				F T	rom 01/01/2020	Date/Time Pre	
		T ==				7/15/2021 12:	59
Cost Center Description		CASHIERING/ACCO UNTS RECEIVABLE	Reconciliation	OTHER ADMI NI STRATI VE	MAINTENANCE & REPAIRS	OPERATION OF PLANT	
		ONTO RECEIVABLE		AND GENERAL	(SQUARE	(SQUARE	
		(GROSS CHARGES)		(ACCUM.	FEET)	FEET)	
		5. 05	5A. 06	COST) 5. 06	6. 00	7. 00	\vdash
GENERAL SERVICE COST CENTERS							Г
00 00100 NEW CAP REL COSTS-BLDG & 00400 EMPLOYEE BENEFITS DEPART							1
01160 COMMUNICATIONS	WEIV!						
02 00550 DATA PROCESSING							
04 00570 ADMI TTI NG 05 00580 CASHI ERI NG/ACCOUNTS RECE	LVARLE	1, 898, 319, 861					5
06 00590 OTHER ADMINISTRATIVE AND		0	-43, 114, 303	340, 374, 103			į
00600 MAINTENANCE & REPAIRS		0	0	25, 357, 939	857, 312		1
00 00700 OPERATION OF PLANT 00 00800 LAUNDRY & LINEN SERVICE		0	0	7, 872, 433	44, 658 0	812, 654 0	1
00 00900 HOUSEKEEPI NG		0	0	1, 519, 354 4, 227, 149	12, 387	12, 387	
00 01000 DI ETARY		Ö	Ō	2, 703, 986	11, 061	11, 061	
00 01100 CAFETERI A		0	0	1, 466, 770	13, 668	13, 668	1
00 01300 NURSING ADMINISTRATION 00 01400 CENTRAL SERVICES & SUPPL	٧	0	0	8, 705, 221 9, 196, 530	13, 701 21, 216	13, 701 21, 216	
00 01500 PHARMACY		Ö	0	7, 424, 900	7, 365	7, 365	
00 01600 MEDICAL RECORDS & LIBRAR	Υ	0	0	0	0	0	
00 01080 PATIENT TRANSPORTATION 00 02100 I&R SERVICES-SALARY & FR	INCES ADDDVD	0	0	817, 243 4, 999, 480	718	718 0	1 -
00 0210011 &R SERVICES-SALARI & FR		0	0	4, 999, 480 4, 185, 391	41, 833	41, 833	
00 02300 PARAMED ED PRGM		0	0	301, 637	195	195	
INPATIENT ROUTINE SERVICE COST OO 03000 ADULTS & PEDIATRICS	CENTERS	205 042 412		42 OF 2 200	160,000	160,000	١,,
00 03100 INTENSIVE CARE UNIT		205, 842, 412 63, 848, 782	0		169, 990 27, 662	169, 990 27, 662	
00 03200 CORONARY CARE UNIT		0	Ō	0	0	0	1
00 02060 NEONATAL INTENSIVE CARE	UNI T	15, 470, 534	0	3, 426, 945	10, 189	10, 189	
. 00 04000 SUBPROVI DER - 1 PF . 00 04100 SUBPROVI DER - 1 RF		10, 214, 820	0	0 2, 724, 466	0 9, 997	0 9, 997	
00 04300 NURSERY		3, 049, 327	0	712, 972	3, 109	3, 109	
ANCILLARY SERVICE COST CENTERS	S	150 200 (05		10 201 / 40	27,000	27,002	۱.,
00 05000 OPERATING ROOM 00 05100 RECOVERY ROOM		159, 200, 605 21, 868, 641	0	12, 381, 640 2, 441, 020	37, 892 8, 229	37, 892 8, 229	
00 05200 DELIVERY ROOM & LABOR RO	OM	26, 200, 945	0	3, 327, 461	12, 847	12, 847	
00 05400 RADI OLOGY-DI AGNOSTI C		246, 299, 807	0	20, 663, 124	62, 519	62, 519	
00 05700 CT SCAN 00 05800 MAGNETIC RESONANCE I MAGI	NG (MRI)	3, 135, 633 0	0	191, 755 0	0	0	
00 05900 CARDI AC CATHETERI ZATI ON	NO (MICE)	99, 938, 747	0	-	13, 599	13, 599	
00 06000 LABORATORY		84, 771, 790	0	14, 707, 606	17, 916	17, 916	
01 06001 BLOOD LABORATORY 00 06300 BLOOD STORING, PROCESSIN	C 0 TDANS	0 7, 945, 912	0	1 401 240	0	0	
00 06500 RESPIRATORY THERAPY	G, & TRANS.	28, 875, 744	0	1, 481, 260 5, 099, 641	4, 396	4, 396	
01 06501 SLEEP LAB		5, 747, 012	0	706, 319	0	0	1
00 06600 PHYSI CAL THERAPY		19, 293, 321	0	5, 985, 975	15, 582	15, 582	
00 06700 OCCUPATI ONAL THERAPY 00 06800 SPEECH PATHOLOGY		7, 124, 866 4, 001, 003	0	1, 300, 490 829, 747	2, 404 575	2, 404 575	
01 06801 AUDI OLOGY		0	0	027,717	0	0	1
00 06900 ELECTROCARDI OLOGY		52, 857, 178	0	3, 138, 534	18, 437	18, 437	
00 07100 MEDICAL SUPPLIES CHARGED 00 07200 IMPL. DEV. CHARGED TO PA		85, 014, 053 101, 759, 409	0	12, 814, 596 13, 421, 317	0	0	
00 07300 DRUGS CHARGED TO PATIENT		354, 998, 924	0	47, 494, 698	0	0	
01 07301 HOSPITAL BASED RETAIL PH		7, 226, 550	0	7, 867, 801	888	888	73
00 07400 RENAL DIALYSIS		3, 997, 884	0	1, 545, 804	2, 918	2, 918	
00 03160 CARDI OPULMONARY 97 07697 CARDI AC REHABI LI TATI ON		4, 170, 826	0	1, 214, 308	0	0	
98 07698 HYPERBARI C OXYGEN THERAP	Υ	16, 485, 801	0	1, 668, 478	415	415	
OUTPATIENT SERVICE COST CENTER							
00 09000 CLINIC		203 425	0	440 415	0 4 201	0 6 381	
01 09001 SUBSTANCE ABUSE CLINIC 02 09002 PAIN CLINIC		293, 425 6, 526, 106	0	440, 415 983, 412	6, 381 22, 443	6, 381 22, 443	•
03 09003 ONCOLOGY CLINIC		37, 483, 021	Ö	2, 713, 957	2, 906	2, 906	
00 09100 EMERGENCY		214, 448, 979	0	17, 219, 564	33, 751	33, 751	
00 09200 OBSERVATION BEDS (NON-DI		227 004	^	240 204	353	252	92
O1 O9201 OBSERVATION BEDS (DISTIN		227, 804	0	248, 306	252	252	92
LINE HELIMOSHOLDEL GOOT GENTER							4
00 09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS		0	0	11, 307	715	715	9!

0

0

-43, 114, 303

323, 880, 634

537, 296

0

652, 814

0 190. 00

113. 00 608, 156 118. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS In Lieu of Form CMS-2552-10
Worksheet B-1 Peri od: From 01/01/2020 Provi der CCN: 15-0089

				o 12/31/2020	Date/Time Pre 7/15/2021 12:	
Cost Center Description	¢ASHI ERI NG∕ACC®Reo			MAINTENANCE &	OPERATION OF	
	UNTS RECEIVABLE		ADMINI STRATI VE		PLANT	
			AND GENERAL	(SQUARE	(SQUARE	
	(GROSS CHARGES)		(ACCUM.	FEET)	FEET)	
	5. 05	5A. 06	COST) 5. 06	6. 00	7. 00	
191. 0019100 RESEARCH	0	0	922, 652	1, 870		191. 00
194. 00 07950 OTHER NONREIMBURSABLE COST CENTERS	6 0	0	0	0	0	194. 00
194.0107951 BSU PHARMACY	0	0	77, 355	0		194. 01
194. 0207952 PAVILLION PHARMACY	0	0	6, 258, 136	2, 540	· ·	194. 02
194. 0307953 VENDI NG	0	0	0	0		194. 03
194. 0407954 CARELINE 194. 0507955 WELLNESS CENTER	0	0	00.7/5	0		194. 04
194.0607956 PHYSICIAN PRACTICE CLINICS		0	80, 765 382, 643	5, 073 24, 196	24, 196	194. 05
194. 07/07957 PERINATAL CLINIC		0	302, 043	24, 190		194. 00
194. 0807958 RENTAL PROPERTY	Ö	0	2, 173, 737	90, 614	90, 614	
194. 0907959 ADVERTI SI NG	O	0	0	0	· ·	194. 09
194. 1007960 I NTEGRA LTAC	O	0	186, 150	11, 771	11, 771	194. 10
194. 11 07961 I U HEALTH HOSPI CE	0	0	48, 511	3, 041	· ·	194. 11
194. 1207962 POB MEDICAL PAVILLION CONDOS	0	0	0	0		194. 12
194. 1307963 PEDI ATRI C THERAPI ES	0	0	1, 789, 138	6, 700	· ·	194. 13
194. 14 07964 NEW CASTLE ONCOLOGY	0	0	0 35, 171	0		194. 14 194. 15
194. 1507965 MARKETING/PUBLIC RELATIONS 194. 1607966 JAY COUNTY HOSPITAL		0		2, 224 5, 029	· ·	194. 15
194. 1707967 CARDI NAL HEALTH CHOI CE		0	1,465,675	3,027		194. 10
194. 1807968 CHV CARDINAL HEALTH VENTURES	Ö	0	0	Ö		194. 18
194. 1907969 HEALTH CARE CONNECTIONS	O	0	0	0	0	194. 19
194.2007970 MEALS ON WHEELS	0	0	0	0	0	194. 20
194. 21 07971 ST MARY'S SCHOOL	0	0	0	0		194. 21
194. 2207972 THERAPIES TO OTHER ENTITIES	0	0	269, 838			194. 22
194. 2307973 CANCER CENTER BOUTI QUE	0	0	106, 956	1		194. 23
194. 2407974 BOSC BALL OUTPATIENT SURGERY 194. 2507975 CARDINAL BEHAVIORAL HEALTH	0	0	391, 119 43		24, 732	194. 24 194. 25
194. 2607976 BLACKFORD COMMUNITY HOSPITAL		0	1, 399, 515			194. 25 194. 26
194. 2707977 MI DWEST HEALTH STRATEGIES		0	1,377,319	0,002	· ·	194. 27
194. 2807978 CARDINAL SELECT RISK RETENTION GRE		0	Ö	Ö		194. 28
194. 2907979 HOME OFFICE CARDINAL HEALTH INITIA		0	0	0	0	194. 29
194. 3007980 CARDINAL HEALTH ALLIANCE	0	0	0	0		194. 30
194. 31 07986 OTHER NONREI MBURSABLE COST CENTERS	6 0	0	0	0		194. 31
194. 32 07982 RENAL DI ALYSI S	0	0	0	0		194. 32
194. 33 07983 LAB_CORP 194. 34 07984 H. O. MATERI ALS_MGMT	0	0	0	0		194. 33 194. 34
194. 3507985 LEASED SPACE		0	348, 769	22, 054	22, 054	
200.00 Cross Foot Adjustments		O	340,707	22,054		200. 00
201.00 Negative Cost Centers			•			201. 00
202.00 Cost to be allocated (per Wkst. B,	Part 10, 742, 441		43, 114, 303	28, 569, 953	10, 357, 839	202. 00
1)					i l	
203.00 Unit cost multiplier (Wkst. B, Par	rt I) 0. 005659		0. 126667			
204.00 Cost to be allocated (per Wkst. B,	Part 0		794, 361	14, 357, 627	1, 473, 827	204. 00
205.00 Unit cost multiplier (Wkst. B, Par	-t II) 0.000000		0. 002334	16. 747260	1. 813597	205 00
206.00 NAHE adjustment amount to be alloc			0.002334	10.747200		205. 00 206. 00
(per Wkst. B-2)						200.00
207.00 NAHE unit cost multiplier (Wkst. [),		•			207. 00
Parts III and IV)					1	

				To	com 01/01/2020 12/31/2020	Date/Time Pre	
	Cost Center Description I	AUNDRY & LINE		DI ETARY	CAFETERI A	7/15/2021 12: NURSI NG	59 pm
		SERVI CE	(SQUARE FEET -		(FTE' S)	ADMINI STRATI ON	
		(POUNDS OF LAUNDRY)	HOUSEKEEPI NG)	SERVED)		(DI RECT NURS. HRS.)	
	January and an analysis and an	8. 00	9. 00	10.00	11. 00	13. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT	ı					1. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	01160 COMMUNI CATI ONS						5. 01
5. 02 5. 04	00550 DATA PROCESSI NG 00570 ADMI TTI NG						5. 02 5. 04
5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 05
5. 06 6. 00	00590 OTHER ADMINISTRATIVE AND GENERAL 00600 MAINTENANCE & REPAIRS						5. 06 6. 00
7. 00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	1, 363, 966					8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	28	654, 802 11, 061	1			9. 00 10. 00
11. 00	1 I	Ö	13, 668	1	151, 518		11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	12	13, 701	0	7, 273	1	
15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	237	21, 216 7, 365	1	6, 082	0	14. 00 15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16. 00
18.00	01080 PATIENT TRANSPORTATION 02100 I&R SERVICES-SALARY & FRINGES APPRVD	6, 499	718 0	1	2, 131 6, 619	0	18. 00 21. 00
	02200 &R SERVICES-OTHER PRGM COSTS APPRVD	0	41, 833	1 -1	744	Ö	22. 00
23. 00		7	195	0	318	0	23. 00
30. 00	O3000 ADULTS & PEDIATRICS	685, 171	169, 990	158, 020	39, 262	34, 428	30. 00
31.00	03100 INTENSIVE CARE UNIT	112, 910	· ·		10, 204	9, 050	31. 00
32. 00 35. 00	03200 CORONARY CARE UNIT	0 7, 091	10 190	0	2 043	0	32.00
40.00	02060 NEONATAL INTENSIVE CARE UNIT 04000 SUBPROVI DER - PF	7,091	10, 189 0	63 0	2, 943 0	2, 536 0	35. 00 40. 00
41.00	04100 SUBPROVI DER - I RF	45, 456	· ·		2, 379	1	41. 00
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	11, 460	3, 109	0	650	569	43. 00
50.00	05000 OPERATING ROOM	103, 786		0	9, 347	2, 679	50. 00
51. 00 52. 00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	34, 990 51, 855	· ·		2, 191 2, 901		51. 00 52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	80, 325	61, 336		11, 895	1	54. 00
57.00	05700 CT SCAN	0	0	1	429	1	57. 00
58. 00 59. 00	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION	0 17, 229	0 13, 599	·	0 2, 796	ı	58. 00 59. 00
60.00	1 I	0	17, 744	1	4, 312	0	60.00
60. 01	06001 BLOOD LABORATORY	0 305	0	0	0	-	60. 01
63. 00 65. 00	06300 BLOOD STORING, PROCESSING, & TRANS. 06500 RESPIRATORY THERAPY	181	4, 396	0	4, 994	0 284	63. 00 65. 00
65. 01	06501 SLEEP LAB	137	0	0	771	3	65. 01
	06600 PHYSICAL THERAPY 06700 OCCUPATIONAL THERAPY	6, 534 0	3, 432 2, 404	1	5, 441 1, 080		66. 00 67. 00
	06800 SPEECH PATHOLOGY	Ö	575	ı "ı	737		68. 00
	06801 AUDI OLOGY 06900 ELECTROCARDI OLOGY	12 945	19 427	1	2 277	0	68. 01 69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	13, 845 0	18, 437 0	0	2, 377 0	0	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72. 00
	07300 DRUGS CHARGED TO PATIENTS 07301 HOSPITAL BASED RETAIL PHARMACIES	0 119	0	0	0 1, 392	0	73. 00 73. 01
74.00	07400 RENAL DIALYSIS	2, 020	2, 918	ő	0	ő	74. 00
	03160 CARDI OPULMONARY	0	0	0	1 550	0	76.00
	07697 CARDI AC REHABI LI TATI ON 07698 HYPERBARI C OXYGEN THERAPY		415	0	1, 558 788		76. 97 76. 98
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLINIC 09001 SUBSTANCE ABUSE CLINIC	0	0 6, 381	1	0 452	0 77	90. 00 90. 01
	09002 PAIN CLINIC	0	22, 443		701		
	09003 ONCOLOGY CLINIC	547	2, 906		1, 647		
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	175, 644	33, 751	U	12, 664	9, 965	91. 00 92. 00
	09201 OBSERVATION BEDS (DISTINCT PART)	4	252	0	97	97	
05 00	OTHER REIMBURSABLE COST CENTERS	0	715		0	0	05 00
70. UU	09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	0	715	0	0	0	95. 00
	11300 INTEREST EXPENSE	1 05 (000	F04 0=1	404 4/5	447 4		113.00
118. 0	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	1, 356, 392	581, 376	181, 460	147, 175	71, 945	i i8.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			516		190. 00
191.0	19100 RESEARCH	0	1, 870	0	1, 120	503	191. 00

Provi der CCN: 15-0089

			["	0 12/31/2020	7/15/2021 12:59	
Cost Center Description L	AUNDRY & LINE	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	
	SERVI CE	(SQUARE FEET -	(MEALS	(FTE' S)	ADMINI STRATION	
	(POUNDS OF	HOUSEKEEPI NG)	SERVED)		(DI RECT NURS.	
	LAUNDRY)				HRS.)	
	8. 00	9. 00	10. 00	11. 00	13. 00	
194. 0007950 OTHER NONREIMBURSABLE COST CENTERS	0	-	0	0	ı " " " " " " " " " " " " " " " " " " "	
194. 0107951 BSU PHARMACY	0	ı -	0	198		
194. 02 07952 PAVILLION PHARMACY	123	· ·	0	974		
194. 03 07953 VENDI NG	0	Ĭ	0	0	0 194	
194. 0407954 CARELINE	7 2/2	ı	0	0	0 194 0 194	
194. 0507955 WELLNESS CENTER 194. 0607956 PHYSICIAN PRACTICE CLINICS	7, 362	5, 073 9, 439	0	0	01194	
194. 0707957 PERINATAL CLINIC	0	1	0	0	0194	
194. 0807958 RENTAL PROPERTY	89	_	0	0	0194	
194. 0907959 ADVERTI SI NG	0,	41, 700	0	0	0194	
194. 1007960 I NTEGRA LTAC	0	Ö	9, 436	0	0194	
194. 1107961 I U HEALTH HOSPI CE	0	3, 041	,, .55	0	0194	
194. 1207962 POB MEDICAL PAVILLION CONDOS	0	0	0	0	0194	
194. 1307963 PEDI ATRI C THERAPI ES	Ö	Ō	0	0	0194	
194.1407964 NEW CASTLE ONCOLOGY	0	0	0	0	0 194	1. 14
194. 1507965 MARKETING/PUBLIC RELATIONS	0	0	0	0	0 194	1. 15
194. 1607966 JAY COUNTY HOSPITAL	0	5, 029	0	752	0 194	1. 16
194. 1707967 CARDINAL HEALTH CHOICE	0	0	0	0	0 194	
194. 1807968 CHV CARDINAL HEALTH VENTURES	0	0	0	0	0 194	
194. 1907969 HEALTH CARE CONNECTIONS	0	0	0	0	0 194	
194. 2007970 MEALS ON WHEELS	0	0	0	0	0 194	
194. 21 07971 ST_MARY' S_SCHOOL	0	0	0	0	0 194	
194. 2207972 THERAPIES TO OTHER ENTITIES	0	0	0		20 194 0 194	
194. 2307973 CANCER CENTER BOUTLOUE 194. 2407974 BOSC BALL OUTPATLENT SURGERY	0	852	0	54	0194	
194. 2507975 CARDI NAL BEHAVI ORAL HEALTH	0	0	1, 680	0	0194	
194. 2607976 BLACKFORD COMMUNITY HOSPITAL	0	3, 802	1,000	729		
194. 2707977 MI DWEST HEALTH STRATEGIES	0	0,002	0	, 2,	0194	
194. 2807978 CARDINAL SELECT RISK RETENTION GRP	0	0	0	0	0194	
194. 2907979 HOME OFFICE CARDINAL HEALTH INITIATI	0	0	0	0	0194	1. 29
194. 3007980 CARDINAL HEALTH ALLIANCE	0	0	0	0	0 194	1. 30
194.3107986 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0 194	1. 31
194. 32 <mark>07982</mark> RENAL DI ALYSI S	0	0	0	0	0 194	1. 32
194. 33 <mark>07983 LAB CORP</mark>	0	0	0	0	0 194	
194. 34 07984 H. O. MATERI ALS MGMT	0	0	0	0	0 194	
194. 3507985 LEASED SPACE	0	0	0	0	0 194	
200.00 Cross Foot Adjustments						0.00
201.00 Negative Cost Centers	1 711 00/	F 000 000	0 (4(171	0 000 501	F**	1.00
202.00 Cost to be allocated (per Wkst. B, Par	t 1, 711, 806	5, 333, 302	3, 646, 171	2, 393, 581	10, 665, 602 202	2. 00
203.00 Unit cost multiplier (Wkst. B, Part I)	1. 255021	8. 144908	18. 933673	15. 797338	147. 176712 203	2 00
204.00 Cost to be allocated (per Wkst. B, Par		4	395, 422	483, 653	•	
204.00 Cost to be allocated (per wkst. B, Par	3, 540	430, 774	373, 422	400,000	320, 040 204	t. UU
205.00 Unit cost multiplier (Wkst. B, Part II) 0. 002600	0. 670087	2. 053330	3. 192050	7. 286609 205	5 00
206.00 NAHE adjustment amount to be allocated		0.073007	2. 000000	0. 1,2000	1 1	5. 00
(per Wkst. B-2)					[[
207.00 NAHE unit cost multiplier (Wkst. D,					207	7. 00
Parts III and IV)						
		-			•	

	Financial Systems LLOCATION - STATISTICAL BASIS	BALL MEMORIAL	Provi der C	CN: 15-0089 ID	<u>In Lieu</u> Period:	u of Form CMS-2 Worksheet B-1	
5031 F	ELUCATION - STATISTICAL BASIS		FI OVI del Ci	F	rom 01/01/2020 o 12/31/2020		epared:
	Cost Center Description	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S.)	PHARMACY (COSTED REQUI S.)	MEDI CAL RECORDS & LI BRARY (GROSS CHARGES)	OTHER GENERAL SERVI CE PATI ENT TRANSPORTATI ON (GROSS CHARGES)	I NTERNS & RESI DENTS SERVI CES-SALAR	
		14. 00	15. 00	16. 00	18. 00	21. 00	
1 00	GENERAL SERVICE COST CENTERS				1		1 00
13. 00 14. 00 15. 00 16. 00 18. 00 21. 00 22. 00	00100 NEW CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT 01160 COMMUNI CATIONS 00550 DATA PROCESSING 00570 ADMITTING 00580 CASHIERING/ACCOUNTS RECEIVABLE 00590 OTHER ADMINISTRATIVE AND GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01080 PATIENT TRANSPORTATION 02100 I&R SERVICES-SALARY & FRINGES APPRVD 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	31, 940, 741 276, 027 0 644 0 104	40, 744, 638 0 0 0 0	1, 898, 319, 861 C C	1, 898, 319, 861 0 0	4, 429	1. 00 4. 00 5. 0' 5. 0' 5. 0' 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 13. 00 14. 00 18. 00 21. 00 22. 00 23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				<u> </u>		1
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	2, 203, 910 967, 500	182, 641 62, 531	205, 842, 412 63, 848, 782		2, 620 585	•
	03200 CORONARY CARE UNIT	0	0	03, 040, 702	03, 040, 702	0	1
5.00	02060 NEONATAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	161, 025	10, 099	15, 470, 534	15, 470, 534	34 0	35. 00 40. 00
1. 00	04100 SUBPROVIDER - TPF	62, 609	1, 794	10, 214, 820	10, 214, 820	0	41. 00
3. 00	04300 NURSERY	0	0	3, 049, 327	3, 049, 327	0	43.00
0. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	1, 916, 949	69, 504	159, 200, 605	159, 200, 605	265	50.00
	05100 RECOVERY ROOM	130, 310	26, 717	21, 868, 641		0	ł
2.00	05200 DELIVERY ROOM & LABOR ROOM	299, 456	16, 648	26, 200, 945		0	52. 0
	05400 RADI OLOGY-DI AGNOSTI C 05700 CT SCAN	783, 888 1, 454	29, 448 0	246, 299, 807 3, 135, 633		140 0	1
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	3, 133, 033	3, 133, 033	0	1
9. 00	05900 CARDI AC CATHETERI ZATI ON	563, 046	18, 885	99, 938, 747		0	59. 0
	06000 LABORATORY	0	0	84, 771, 790	84, 771, 790	0	60.0
	06001 BL00D LABORATORY 06300 BL00D STORING, PROCESSING, & TRANS.	0	0	7, 945, 912	7, 945, 912	0	60.0
5. 00	06500 RESPIRATORY THERAPY	759, 065	7, 023	28, 875, 744	28, 875, 744	128	
	06501 SLEEP LAB 06600 PHYSI CAL THERAPY	46, 053 52, 136	0	5, 747, 012 19, 293, 321		0	65. 0 66. 0
7. 00	06700 OCCUPATI ONAL THERAPY	7, 112	0	7, 124, 866		0	67.0
	06800 SPEECH PATHOLOGY	708	0	4, 001, 003	4, 001, 003	0	68. 0
	06801 AUDI OLOGY 06900 ELECTROCARDI OLOGY	0 31, 120	0	52, 857, 178	0 52, 857, 178	0 197	68. 0 69. 0
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	11, 046, 559	0	85, 014, 053		0	1
	07200 IMPL. DEV. CHARGED TO PATIENT	11, 305, 027	0	101, 759, 409	101, 759, 409	0	
	07300 DRUGS CHARGED TO PATIENTS 07301 HOSPITAL BASED RETAIL PHARMACIES	0 2, 055	40, 111, 520	354, 998, 924 7, 226, 550		0	73. 0 73. 0
	07400 RENAL DI ALYSI S	23, 398	10, 932	3, 997, 884		0	74.0
5. 00	03160 CARDI OPULMONARY	0	0	C	0	0	76. 0
	07697 CARDI AC REHABI LI TATI ON	8, 595	1 205	4, 170, 826		0	76. 9
5. 98	07698 HYPERBARIC OXYGEN THERAPY OUTPATIENT SERVICE COST CENTERS	147, 303	1, 295	16, 485, 801	16, 485, 801	19	76. 9
0.00	09000 CLINIC	0	0	C	0	0	90.00
0. 01	09001 SUBSTANCE ABUSE CLINIC	4, 211	0	293, 425		0	
	09002 PAIN CLINIC 09003 ONCOLOGY CLINIC	32, 593 100, 704	433 74, 170	6, 526, 106 37, 483, 021		79 43	1
	09100 EMERGENCY	990, 315	120, 075	214, 448, 979			•
2. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	· ·					92.00
2. 01	09201 OBSERVATION BEDS (DISTINCT PART)	7, 512	721	227, 804	227, 804	0	92.0
- 00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	ol	0	C	l ol	0	95.00
). UU							
	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE	-					113. O

Health Financial Systems	BALL MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10	į
COST ALLOCATION - STATISTICAL BASIS	Provi der CCN: 15-0089	Period: Worksheet B-1	
		From 01/01/2020	

COST ALLOCATION - STATISTICAL DASIS		Triovider c		From 01/01/2020	Worksheet B-1	
			[To 12/31/2020	Date/Time Pre	pared:
				OTHER GENERAL	7/15/2021 12: I NTERNS &	59 pili
				SERVI CE	RESI DENTS	ĺ
Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	PATI ENT	SERVI CES-SALAR	
	SERVICES &	(COSTED	RECORDS &	TRANSPORTATI ON		
	SUPPLY	REQUIS.)	LI BRARY	(GROSS	(ASSI GNED	
	(COSTED	,	(GROSS	CHARGES)	TIME)	
	REQUIS.)		CHARGES)		ĺ	
	14. 00	15. 00	16.00	18. 00	21.00	
NONREI MBURSABLE COST CENTERS						ĺ
190. OQ 1900O GI FT, FLOWER, COFFEE SHOP & CANTEEN	579	0	l .	0		190. 00
191. 0019100 RESEARCH	332	0	(0		191. 00
194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS	0	0	9	0		194. 00
194. 01 07951 BSU_PHARMACY	0	0	9	0		194. 01
194. 02 07952 PAVI LLI ON PHARMACY	537	0	9	0		194. 02
194. 03 07953 VENDI NG	0	0)			194. 03
194. 0407954 CARELI NE	1 200	0				194. 04
194. 0507955 WELLNESS CENTER	1, 209	0				194. 05
194. 0607956 PHYSI CLAN PRACTI CE CLINI CS 194. 0707957 PERI NATAL CLINI C		0				194. 06 194. 07
194. 0807958 RENTAL PROPERTY		147] ;			194. 07
194. 0907959 ADVERTI SI NG	0	0)			194. 09
194. 1007960 NTEGRA LTAC	0	0				194. 09
194. 1107961 I U HEALTH HOSPI CE	0	0				194. 11
194. 1207962 POB MEDICAL PAVILLION CONDOS	0	0)			194. 12
194. 1307963 PEDI ATRI C THERAPI ES	6, 413	0			1 1	194. 13
194. 1407964 NEW CASTLE ONCOLOGY	0, 110	0			1	194. 14
194. 1507965 MARKETI NG/PUBLI C RELATIONS	0	0				194. 15
194. 1607966 JAY COUNTY HOSPI TAL	0	0		o o		194. 16
194. 1707967 CARDI NAL HEALTH CHOICE	0	0	(0	0	194. 17
194. 1807968 CHV CARDINAL HEALTH VENTURES	0	0	(0	0	194. 18
194. 1907969 HEALTH CARE CONNECTIONS	0	0	(0	0	194. 19
194.20 <mark>07970</mark> MEALS ON WHEELS	0	0	(0	0	194. 20
194. 21 07971 ST MARY'S SCHOOL	0	0	(0	0	194. 21
194. 2207972 THERAPIES TO OTHER ENTITIES	0	0		0		194. 22
194. 23 07973 CANCER CENTER BOUTI QUE	21	55	h .	0		194. 23
194. 2407974 BOSC BALL OUTPATIENT SURGERY	0	0	1	0		194. 24
194. 25 07975 CARDI NAL BEHAVI ORAL HEALTH	131	0	(0		194. 25
194. 2607976 BLACKFORD COMMUNITY HOSPITAL	131	0	9	0		194. 26
194. 2707977 MI DWEST HEALTH STRATEGIES	0	0	9	0		194. 27
194. 2807978 CARDI NAL SELECT RISK RETENTION GRP	0	0				194. 28
194. 2907979 HOME OFFICE CARDINAL HEALTH INITIATI	0	0				194. 29
194. 3007980 CARDI NAL HEALTH ALLI ANCE	0	0				194. 30 194. 31
194. 31 07986 OTHER NONREIMBURSABLE COST CENTERS 194. 32 07982 RENAL DIALYSIS	0	0	}			194. 31
194. 3307983 LAB CORP	0	0)			194. 32
194. 3407984 H. O. MATERI ALS MGMT	0	0				194. 34
194. 3507985 LEASED SPACE	0	0				194. 35
200.00 Cross Foot Adjustments	ų –	O	`			200.00
201.00 Negative Cost Centers			Ì		1 1	201.00
202.00 Cost to be allocated (per Wkst. B, Par	t 11,511,666	8, 960, 546	1	1, 001, 739	1 1	1
1)	11,011,000	0, 700, 010	`	1,001,707	0,707,012	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	0. 360407	0. 219920	0. 000000	0. 000528	1, 295. 396704	203.00
204.00 Cost to be allocated (per Wkst. B, Par		305, 234		34, 583		
]	222, 201]		1	
205.00 Unit cost multiplier (Wkst. B, Part II) 0. 023950	0. 007491	0. 000000	0. 000018	8. 147889	205. 00
206.00 NAHE adjustment amount to be allocated						206. 00
(per Wkst. B-2)			1			1
207.00 NAHE unit cost multiplier (Wkst. D,						207. 00
Parts III and IV)						ĺ

Health Financial Systems BALL MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0089 Peri od: Worksheet B-1 From 01/01/2020 12/31/2020 Date/Time Prepared: 7/15/2021 12:59 pm INTERNS & **RESI DENTS** Cost Center Description SERVI CES-OTHER PARAMED ED PRGM COSTS **PRGM** ASSIGNED TIME (100% PHARMACY DRUGS) 22.00 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 5.01 01160 COMMUNI CATI ONS 5.01 5.02 00550 DATA PROCESSING 5.02 5 04 00570 ADMITTING 5 04 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.05 5.05 00590 OTHER ADMINISTRATIVE AND GENERAL 5.06 5.06 6.00 00600 MAINTENANCE & REPAIRS 6.00 00700 OPERATION OF PLANT 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI FTARY 10 00 10 00 11.00 01100 CAFETERI A 11.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 15 00 15 00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 01080 PATIENT TRANSPORTATION 18.00 18.00 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 21.00 02200 | &R SERVICES-OTHER PRGM COSTS APPRVD 22 00 4.429 22 00 23.00 02300 PARAMED ED PRGM 100 23.00 NPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 30.00 2,620 31 00 03100 INTENSIVE CARE UNIT 585 C 31.00 32.00 03200 CORONARY CARE UNIT C 32.00 35 00 02060 NEONATAL INTENSIVE CARE UNIT 34 0 35.00 04000 SUBPROVIDER - IPF 40.00 0 C 40.00 04100 SUBPROVIDER - IRF 41.00 0 C 41 00 04300 NURSERY 43.00 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 265 50.00 51.00 05100 RECOVERY ROOM C 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 52.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 0 140 54.00 57.00 05700 CT SCAN 0 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 59.00 60.00 06000 LABORATORY 0 0 60.00 60.01 06001 BLOOD LABORATORY 0 C 60.01 06300 BLOOD STORING, PROCESSING, & TRANS. 63.00 63.00 06500 RESPIRATORY THERAPY 0 65.00 128 65.00 06501 SLEEP LAB 65.01 C 65.01 66.00 06600 PHYSI CAL THERAPY 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 0 67.00 06800 SPEECH PATHOLOGY 68 00 0 0 68 00 06801 AUDI OLOGY 0 68.01 68.01 69.00 06900 ELECTROCARDI OLOGY 197 C 69.00 71.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT 0 72 00 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 100 73.00 73.01 07301 HOSPITAL BASED RETAIL PHARMACIES 73.01 74.00 07400 RENAL DIALYSIS 0 0 74.00 03160 CARDI OPULMONARY 0 76 00 0 76 00 76.97 07697 CARDIAC REHABILITATION C 76.97 07698 HYPERBARIC OXYGEN THERAPY 76.98 76.98 OUTPATIENT SERVICE COST CENTERS 90.00 C 90 00 09000 CLI NI C 0 90.01 09001 SUBSTANCE ABUSE CLINIC 0 90.01 90.02 09002 PAIN CLINIC 79 C 90.02 09003 ONCOLOGY CLINIC 90.03 43 90 03 C 91.00 09100 EMERGENCY 310 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 09201 OBSERVATION BEDS (DISTINCT PART)
OTHER REIMBURSABLE COST CENTERS

0

4.420

0

100

92.01

95.00

113.00

118. 00

09500 AMBULANCE SERVICES

113.0011300 INTEREST EXPENSE

SPECIAL PURPOSE COST CENTERS

SUBTOTALS (SUM OF LINES 1 through 117)

92.01

95.00

118.00

Health Financial Systems	BALL MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Provi der CCN: 15-0089	Period: Worksheet B-1 From 01/01/2020
		To 12/31/2020 Date/Time Prenared:

				e Prepared:
Cost Center Description	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS ASSIGNED TIME)	PARAMED ED PRGM (100% PHARMACY DRUGS)	7/15/202	1 12:59 pm
	22. 00	23. 00		
NONRELMBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 191. 00 19100 RESEARCH 194. 00 07950 OTHER NONRELMBURSABLE COST CENTERS 194. 01 07951 BSU PHARMACY 194. 02 07952 PAVI LLI ON PHARMACY 194. 03 07953 VENDI NG 194. 04 07954 CARELI NE 194. 05 07955 WELLNESS CENTER 194. 06 07956 PHYSI CI AN PRACTI CE CLI NI CS 194. 07 07957 PERI NATAL CLI NI C 194. 08 07958 RENTAL PROPERTY 194. 09 07959 ADVERTI SI NG 194. 10 07960 I NTEGRA LTAC 194. 11 07961 I U HEALTH HOSPI CE 194. 12 07962 POB MEDI CAL PAVI LLI ON CONDOS 194. 13 07963 PEDI ATRI C THERAPI ES 194. 14 07964 NEW CASTLE ONCOLOGY 194. 15 07965 MARKETI NG/PUBLI C RELATI ONS 194. 16 07966 ATRIC CARDI NAL HEALTH CHOI CE 194. 18 07968 CARDI NAL HEALTH CHOI CE 194. 19 07969 HEALTH CARE CONNECTI ONS 194. 20 07970 MEALS ON WHEELS 194. 20 07970 MEALS ON WHEELS 194. 23 07973 CANCER CENTER BOUTI QUE 194. 24 07974 BOSC BALL OUTPATI ENT SURGERY 194. 25 07975 CARDI NAL BEHAVI ORAL HEALTH 194. 26 07976 BLACKFORD COMMUNI TY HOSPI TAL 194. 26 07976 BLACKFORD COMMUNI TY HOSPI TAL 194. 26 07976 BLACKFORD COMMUNI TY HOSPI TAL 194. 27 07977 MI DWEST HEALTH STRATEGI ES 194. 29 07979 HOME OFFI CE CARDI NAL HEALTH I NI TI ATI 194. 30 07980 CARDI NAL HEALTH ALLI ANCE 194. 31 07986 OTHER NONREI MBURSABLE COST CENTERS 22.00 0 9 9 0 0 0 0 0 0 0 0 0 0 0 0 0	23. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		190. 00 191. 00 194. 00 194. 01 194. 02 194. 03 194. 04 194. 05 194. 06 194. 07 194. 10 194. 11 194. 12 194. 13 194. 14 194. 15 194. 15 194. 16 194. 17 194. 18 194. 19 194. 20 194. 21 194. 22 194. 23 194. 24 194. 25 194. 25 194. 27 194. 27 194. 29 194. 30 194. 31	
194. 3207982 RENAL DIALYSIS 194. 3307983 LAB CORP 194. 3407984 H.O. MATERIALS MGMT 194. 3507985 LEASED SPACE 200. 00 Cross Foot Adjustments 201. 00 Negative Cost Centers 202. 00 Cost to be allocated (per Wkst. B, Par	0 0 0 0 t 6, 995, 335	0 0 0 0 355, 448		194. 32 194. 33 194. 34 194. 35 200. 00 201. 00 202. 00
203.00 Unit cost multiplier (Wkst. B, Part I) 204.00 Cost to be allocated (per Wkst. B, Par	1, 579. 438925	3, 554. 480000 8, 730		203. 00 204. 00
205.00 Unit cost multiplier (Wkst. B, Part II 206.00 NAHE adjustment amount to be allocated) 333. 807857	87. 300000 0	1	205. 00 206. 00
(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, Parts III and IV)		0. 000000		207. 00

	Financial Systems ATION OF RATIO OF COSTS TO CHARGES	BALL MEMORIA		CN: 15-0089	Peri od:	<u>of Form CMS-2</u> Worksheet C	2332-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider		From 01/01/2020	Part I	
					To 12/31/2020	Date/Time Pre 7/15/2021 12:	epared: 59 pm
			Title	XVIII	Hospi tal	PPS	0 / p
				T	Costs		
	Cost Center Description	Total Cost (from Wkst. B,	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		Part I, col.	Auj .		Di Sai i Owance		
		26)					
		1.00	2.00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	67, 078, 274		67, 078, 27		67, 078, 274	
	03100 INTENSIVE CARE UNIT	16, 336, 968		16, 336, 96	8 0	16, 336, 968	
	03200 CORONARY CARE UNIT	0			0	0	32.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT	4, 911, 677		4, 911, 67	7 0	4, 911, 677	
	04000 SUBPROVI DER - I PF	4 2/0 5/0		4 0/0 5/	0	0	
	04100 SUBPROVI DER - I RF 04300 NURSERY	4, 269, 569 1, 081, 844		4, 269, 56 1, 081, 84		4, 269, 569 1, 081, 844	
43.00	ANCILLARY SERVICE COST CENTERS	1,001,044		1,001,04	4 0	1,001,044	43.00
50.00	05000 OPERATING ROOM	17, 466, 747		17, 466, 74	7 0	17, 466, 747	50.00
	05100 RECOVERY ROOM	3, 645, 545		3, 645, 54		3, 645, 545	•
	05200 DELIVERY ROOM & LABOR ROOM	5, 041, 036		5, 041, 03		5, 041, 036	
	05400 RADI OLOGY-DI AGNOSTI C	27, 643, 607		27, 643, 60		27, 643, 607	54.00
	05700 CT SCAN	225, 001		225, 00	1 0	225, 001	57. 00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0			0	0	
	05900 CARDI AC CATHETERI ZATI ON	7, 022, 332		7, 022, 33		7, 022, 332	
	06000 LABORATORY	17, 653, 378		17, 653, 37	8 0	17, 653, 378	•
	06001 BLOOD LABORATORY	1 (72 4/5	1	1 (70 4/	0	0	
	06300 BLOOD STORING, PROCESSING, & TRANS. 06500 RESPIRATORY THERAPY	1, 673, 465 6, 395, 208		1, 673, 46 6, 395, 20		1, 673, 465 6, 395, 208	
	06501 SLEEP LAB	828, 212		828, 21		828, 212	
	06600 PHYSI CAL THERAPY	7, 613, 157				7, 613, 157	
	06700 OCCUPATI ONAL THERAPY	1, 618, 939		1, 618, 93		1, 618, 939	
	06800 SPEECH PATHOLOGY	980, 034		980, 03		980, 034	
	06801 AUDI OLOGY	0	O		0 0	0	68. 01
69.00	06900 ELECTROCARDI OLOGY	4, 629, 708		4, 629, 70	8 0	4, 629, 708	69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	18, 463, 926		18, 463, 92	6 0	18, 463, 926	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENT	19, 249, 492		19, 249, 49		19, 249, 492	•
	07300 DRUGS CHARGED TO PATIENTS	62, 874, 470		62, 874, 47		62, 874, 470	
	07301 HOSPITAL BASED RETAIL PHARMACIES	8, 931, 999		8, 931, 99		8, 931, 999	
	07400 RENAL DI ALYSI S	1, 915, 290		1, 915, 29	0	1, 915, 290	
	03160 CARDI OPULMONARY	1 407 011		1 407 01	0	1 407 011	76.00
	07697 CARDIAC REHABILITATION 07698 HYPERBARIC OXYGEN THERAPY	1, 407, 011 2, 070, 155	•	1, 407, 01 2, 070, 15		1, 407, 011 2, 070, 155	
70. 90	OUTPATIENT SERVICE COST CENTERS	2,070,155		2,070,13	<u> </u>	2,070,133	70. 90
90.00	09000 CLINIC	0		1	0 0	0	90.00
	09001 SUBSTANCE ABUSE CLINIC	862, 297	•	862, 29	7	862, 297	1
	09002 PAIN CLINIC	2, 390, 840		2, 390, 84		2, 390, 840	
	09003 ONCOLOGY CLINIC	3, 526, 606		3, 526, 60		3, 526, 606	
	09100 EMERGENCY	23, 614, 209		23, 614, 20			1
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	7, 246, 552		7, 246, 55		7, 246, 552	
	00201 OBSEDVATION BEDS (DISTINCT DADT)	212 220		212 22			02 01

312, 220

51, 503

349, 031, 271

341, 784, 719

7, 246, 552

312, 220

51, 503

349, 031, 271 7, 246, 552 341, 784, 719

0

312, 220

51, 503

349, 423, 721 200. 00 7, 246, 552 201. 00 342, 177, 169 202. 00

0

392, 450

392, 450

92. 01

95.00

113. 00

92. 01 09201 OBSERVATION BEDS (DISTINCT PART)

OTHER REIMBURSABLE COST CENTERS
09500 AMBULANCE SERVICES

Less Observation Beds Total (see instructions)

Subtotal (see instructions)

SPECIAL PURPOSE COST CENTERS

113. 00 | INTEREST EXPENSE 200. 00 | Subtotal (see instance) 201. 00 | Less Observation 202. 00 | Total (see instance)

95.00

Health Financial Systems	BALL MEMORIA				of Form CMS-2	<u> 2552-10</u>
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der C	CN: 15-0089	Period: From 01/01/2020	Worksheet C Part I	
				To 12/31/2020	Date/Time Pre 7/15/2021 12:	epared:
						59 pm
			XVIII	Hospi tal	PPS	
Cost Center Description	Inpatient	Charges Outpatient	Total (col	6 Cost or Other	TEFRA	
cost center bescription	Tilpati ent	outpatrent	+ col . 7)	Ratio	Inpatient	
			1 001. 7)	Ratio	Ratio	
	6. 00	7. 00	8. 00	9, 00	10. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	170, 283, 881		170, 283, 88	31		30.00
31.00 03100 INTENSIVE CARE UNIT	63, 848, 782		63, 848, 78	32		31.00
32. 00 03200 CORONARY CARE UNIT	0			0		32. 00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT	15, 470, 534		15, 470, 53	34		35. 00
40. 00 04000 SUBPROVI DER - I PF	0		10 014 0	0		40.00
41. 00 04100 SUBPROVI DER - IRF 43. 00 04300 NURSERY	10, 214, 820 3, 049, 327		10, 214, 82 3, 049, 32			41. 00 43. 00
43.00 04300 NURSERY ANCILLARY SERVICE COST CENTERS	3,049,327		3,049,3	27		43.00
50. 00 05000 OPERATI NG ROOM	87, 857, 056	71, 343, 549	159, 200, 60	0. 109715	0. 000000	50.00
51. 00 05100 RECOVERY ROOM	7, 887, 607	13, 981, 034			0. 000000	
52.00 05200 DELIVERY ROOM & LABOR ROOM	22, 511, 534	3, 689, 411			0. 000000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	60, 296, 787	186, 003, 020			0. 000000	
57.00 05700 CT SCAN	1, 643, 931	1, 491, 702			0. 000000	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0. 000000	0. 000000	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	43, 859, 800	56, 078, 947	99, 938, 74	47 0. 070266	0. 000000	
60. 00 06000 LABORATORY	44, 333, 162	40, 438, 628	84, 771, 79		0. 000000	
60. 01 06001 BL00D LABORATORY	0	0		0.000000	0. 000000	
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	6, 069, 187	1, 876, 725			0. 000000	
65. 00 06500 RESPIRATORY THERAPY	26, 294, 615	2, 581, 129			0. 000000	
65. 01 06501 SLEEP LAB 66. 00 06600 PHYSI CAL THERAPY	5, 520 9, 266, 078	5, 741, 492 10, 027, 243			0. 000000 0. 000000	
67. 00 06700 OCCUPATI ONAL THERAPY	7, 036, 802	88, 064			0. 000000	
68. 00 06800 SPEECH PATHOLOGY	3, 713, 588	287, 415			0. 000000	
68. 01 06801 AUDI OLOGY	0, 710, 000	207, 110		0.000000	0. 000000	
69. 00 06900 ELECTROCARDI OLOGY	32, 676, 189	20, 180, 989	52, 857, 1 ⁻		0. 000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	37, 746, 328	47, 267, 725			0. 000000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	62, 099, 645	39, 659, 764	101, 759, 40	0. 189167	0. 000000	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	111, 315, 588	243, 683, 336	354, 998, 92	24 0. 177112	0. 000000	73. 00
73.01 07301 HOSPITAL BASED RETAIL PHARMACIES	0	7, 226, 550	7, 226, 5	50 1. 235998	0. 000000	73. 01
74.00 07400 RENAL DI ALYSI S	3, 806, 930	190, 954			0. 000000	
76. 00 03160 CARDI OPULMONARY	0	0		0. 000000	0. 000000	
76. 97 07697 CARDI AC REHABI LI TATI ON	1, 004, 003	3, 166, 823			0. 000000	
76. 98 O7698 HYPERBARI C OXYGEN THERAPY	58, 782	16, 427, 019	16, 485, 80	0. 125572	0. 000000	76. 98
90. 00 09000 CLINIC	O	0	1	0 000000	0.000000	90.00
90. 00 09000 CLINIC 90. 01 09001 SUBSTANCE ABUSE CLINIC	296	293, 129		0, 000000	0. 000000 0. 000000	
90. 01 09001 SUBSTANCE ABUSE CLINIC 90. 02 09002 PAIN CLINIC	11, 223	6, 514, 883			0. 000000	
90. 03 09003 ONCOLOGY CLINIC	374, 827	37, 108, 194			0. 000000	
01 00 1001001 EMEDICENTY	70 247 212				0.000000	

0

70, 367, 313

1, 193, 917 18, 244

904, 316, 296

904, 316, 296

144, 081, 666

34, 364, 614 209, 560

0

994, 003, 565 1, 898, 319, 861

994, 003, 565 1, 898, 319, 861

214, 448, 979 35, 558, 531

227, 804

0

0. 110116

0. 203792

1. 370564

0.000000

0.000000

0.000000

0.000000

0. 000000

91.00

92.00

92.01

95.00

113. 00

200.00

201.00 202. 00

91.00

92.00

92.01

95.00

09100 EMERGENCY

113. 00 11300 | INTEREST EXPENSE 200. 00 | Subtotal (see instantial substitution of the control

09200 OBSERVATION BEDS (NON-DISTINCT PART) 09201 OBSERVATION BEDS (DISTINCT PART)

Subtotal (see instructions)

OTHER REIMBURSABLE COST CENTERS
09500 AMBULANCE SERVICES
SPECIAL PURPOSE COST CENTERS

Less Observation Beds

Total (see instructions)

Health Financial Systems	BALL MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0089	Period: From 01/01/2020 To 12/31/2020 Worksheet C Part I Date/Time Prepared: 7/15/2021 12:59 pm

Cost Center Description					7/15/2021 12: 59 p
Ratio 11.00		lass i ii il	Title XVIII	Hospi tal	PPS
NPATIENT ROUTINE SERVICE COST CENTERS	Cost Center Description				
INPATE INT ROUTINE SERVICE COST CENTERS 31.00 0.3100 ADULTS & PEDIATRIC S 31.00 0.3100 ADULTS & PEDIATRIC S 32.00 0.3200 ADULTS & PEDIATRIC S 32.00 0.3200 CRONARY CARE UNIT 33.50 0.00 20.00 SUBPROVI DER - I PF 44.10 0.00 4100 SUBPROVI DER - I PF 44.10 0.00 410 SUBPR					
30. 00 30000 ADULTS & PEDI ATRI CS 31 32 32 33 30 03200 ORROMARY CARE UNIT 33 32 30 03200 ORROMARY CARE UNIT 33 33 30 03200 ORROMARY CARE UNIT 33 30 03200 ORROMARY CARE UNIT 34 40 40 04000 SUBPROVI DER - I PF 44 43 40 04 04 00 AUROUS SUBPROVI DER - I RF 44 43 00 04300 SUBPROVI DER - I RF 44 45 00 04300 MURSERY 45 05 05 05 05 05 05 05		11. 00			
31.00 03100 INTERSIVE CARE UNIT 33 35.00 03200 ORDMAPK CARE UNIT 33 35.00 03200 ORDMAPK CARE UNIT 33 35.00 03200 ORDMAPK CARE UNIT 34 36.00 04200 SUBPROVI DER - I PF 44 41.00 04100 SUBPROVI DER - I PF 44 41.00 05100 SUBPROVI DER - I PF 44.00 05					
32.00 0320					30.
35. 00 02060 NEOMATAL INTENSIVE CARE UNIT	31.00 03100 INTENSIVE CARE UNIT				31.
40. 00 04000 SUBPROVI DER - 1 IPF 41 43. 00 04300 SUBPROVI DER - 1 IPF 44. 00 04300 SUBPROVI DER - 1 IPF 45. 00 04300 SUBPROVI DER - 1 IPF 45. 00 04300 SUBPROVI DER - 1 IPF 45. 00 05000 OFFART ING ROOM 0. 109715 55. 00 05000 OFFART ING ROOM 0. 106702 55. 00 05000 OFFART ING ROOM 0. 106702 55. 00 05000 OFFART ING ROOM 0. 106702 55. 00 05000 OFFART ING ROOM 0. 109715 55. 00 05000 OFFART ING ROOM 0. 109715 55. 00 O5400 OFFART ING ROOM 0. 109715 55. 00 O5700 OFFART ING ROOM 0. 109715 55. 00 O5700 OFFART ING ROOM 0. 109715 55. 00 O5700 OFFART ING ROOM 0. 007175 56. 00 O5800 MAGNETI C RESONANCE IMAGI ING (MRI) 0. 000000 0. 05000 OARDI ACCATHETERI ZATI ON 0. 070266 55. 00 O5900 OARDI ACCATHETERI ZATI ON 0. 000000 0. 000000 0. 00000 0. 00000 0. 00000 0. 00000 0. 00000 0. 00000 0. 00000 0. 00000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 00000000	32. 00 03200 CORONARY CARE UNIT				32.
11.00 04100 SUBPROVI DER - I IRF	35.00 02060 NEONATAL INTENSIVE CARE UNIT				35.
A3.00 04300 NURSERY 44	40. 00 04000 SUBPROVI DER - 1 PF				40.
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OUTPATI ENT SERVI CE COST CENTERS O. 000000 O. 000000 O. 0000000 O. 0000000 O. 000000000 O. 000000000 O. 000000000 O. 0000000000					76.
90. 00					
90. 01 09001 SUBSTANCE ABUSE CLINIC 2. 938731 90. 02 09002 PAIN CLINIC 0. 366350 90. 03 09003 0NCOLOGY CLINIC 0. 094085 90. 09100 EMERGENCY 0. 111946 91. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0. 203792 92. 01 09201 0BSERVATION BEDS (DISTINCT PART) 1. 370564 92. 00 09200 0BSERVATION BEDS (DISTINCT PART) 0. 203792 92. 01 09201 0BSERVATION BEDS (DISTINCT PART) 0. 203792 93. 00 09201 09301		0. 000000			90.
90. 02					90.
90. 03					90.
91. 00 09100 EMERGENCY 0. 111946 91 92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 0. 203792 92 92. 01 09201 0BSERVATI ON BEDS (DISTINCT PART) 1. 370564 92 95. 00 09500 AMBULANCE SERVICES 0. 000000 95 SPECIAL PURPOSE COST CENTERS	· · · · · · · · · · · · · · · · · · ·				90.
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 0. 203792 92. 01 09201 0BSERVATI ON BEDS (DISTINCT PART) 1. 370564 92. 01 071 072 073 074 0					91.
92. 01 09201 085ERVATI ON BEDS (DISTINCT PART) 1.370564 92 OTHER REIMBURSABLE COST CENTERS 0.000000 95 SPECIAL PURPOSE COST CENTERS 95 OFFICIAL PURPOSE COST CENTERS 95 OFFI					92.
OTHER REIMBURSABLE COST CENTERS 95. 00 O9500 AMBULANCE SERVICES 0. 0000000 95 SPECIAL PURPOSE COST CENTERS					
95. 00 O9500 AMBULANCE SERVICES 0. 000000 95 SPECIAL PURPOSE COST CENTERS		1. 370304			92.
SPECIAL PURPOSE COST CENTERS		0.000000			95.
		0. 000000			95.
		1			110
	113. 00 11300 I NTEREST EXPENSE				113.
	` ,				200.
					201.
202.00 Total (see instructions)	202. Uq Total (see Instructions)	I I			202.

Heal th	Financial Systems	BALL MEMORIA	L HOSPITAL		In Lieu	ı of Form CMS-2	2552-10
	ATION OF RATIO OF COSTS TO CHARGES		Provi der C	CN: 15-0089 F	Peri od:	Worksheet C	
				<u> </u>	From 01/01/2020 To 12/31/2020	Part I	narad.
					10 12/31/2020	Date/Time Pre 7/15/2021 12:	59 pm
			Ti tl	e XIX	Hospi tal	Cost	о / р
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2. 00	3. 00	4. 00	5. 00	
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	(7.070.074		(7.070.07	41 0	(7.070.074	20 00
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	67, 078, 274		67, 078, 274		67, 078, 274	
		16, 336, 968		16, 336, 968	0	16, 336, 968	31.00
	03200 CORONARY CARE UNIT 02060 NEONATAL INTENSIVE CARE UNIT	4, 911, 677		4, 911, 67	7	0 4, 911, 677	
	04000 SUBPROVI DER - I PF	4, 711, 0//		4, 711, 07		4, 911, 077	40.00
	04100 SUBPROVI DER - I RF	4, 269, 569		4, 269, 569		4, 269, 569	
	04300 NURSERY	1, 081, 844		1, 081, 844		1, 081, 844	
	ANCILLARY SERVICE COST CENTERS	1,001,011		1,001,01	· <u>I</u>	1,001,011	10.00
	05000 OPERATING ROOM	17, 466, 747		17, 466, 747	7 0	17, 466, 747	50.00
51.00	05100 RECOVERY ROOM	3, 645, 545		3, 645, 545	0	3, 645, 545	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	5, 041, 036		5, 041, 036	6	5, 041, 036	52.00
	05400 RADI OLOGY-DI AGNOSTI C	27, 643, 607		27, 643, 607	7 0	27, 643, 607	54.00
	05700 CT SCAN	225, 001		225, 001	0	225, 001	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0		(0	0	58. 00
	05900 CARDI AC CATHETERI ZATI ON	7, 022, 332		7, 022, 332		7, 022, 332	•
	06000 LABORATORY	17, 653, 378		17, 653, 378	0	17, 653, 378	
	06001 BLOOD LABORATORY	0		1 (70 4(0	60. 01
	06300 BLOOD STORING, PROCESSING, & TRANS. 06500 RESPIRATORY THERAPY	1, 673, 465 6, 395, 208	0	1, 673, 465 6, 395, 208		1, 673, 465 6, 395, 208	
	06501 SLEEP LAB	828, 212	0	828, 212		828, 212	•
	06600 PHYSI CAL THERAPY	7, 613, 157	0		1	7, 613, 157	1
	06700 OCCUPATI ONAL THERAPY	1, 618, 939	-	.,		1, 618, 939	•
	06800 SPEECH PATHOLOGY	980, 034				980, 034	
	06801 AUDI OLOGY	0	0	700,00	o o	0	68. 01
	06900 ELECTROCARDI OLOGY	4, 629, 708	Ŭ	4, 629, 708	o o	4, 629, 708	•
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	18, 463, 926		18, 463, 926		18, 463, 926	•
	07200 IMPL. DEV. CHARGED TO PATIENT	19, 249, 492		19, 249, 492	0	19, 249, 492	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	62, 874, 470		62, 874, 470	0	62, 874, 470	73. 00
73.01	07301 HOSPITAL BASED RETAIL PHARMACIES	8, 931, 999		8, 931, 999	9 0	8, 931, 999	73. 01
	07400 RENAL DIALYSIS	1, 915, 290		1, 915, 290	0	1, 915, 290	74. 00
	03160 CARDI OPULMONARY	0		(0	0	76. 00
	07697 CARDIAC REHABILITATION	1, 407, 011		1, 407, 011		1, 407, 011	
76. 98	07698 HYPERBARIC OXYGEN THERAPY	2, 070, 155		2, 070, 155	0	2, 070, 155	76. 98
00	OUTPATIENT SERVICE COST CENTERS	-		1	.1 -		
	09000 CLINIC	0		0,000	0	0	90.00
90. 01	09001 SUBSTANCE ABUSE CLINIC	862, 297		862, 297	0	862, 297	90. 01

Health Financial Systems	BALL MEMORIA				of Form CMS-2	<u> 2552-10</u>
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der C	CN: 15-0089	Peri od: From 01/01/2020 To 12/31/2020		epared:
		Ti +I	e XIX	Hospi tal	Cost	39 piii
		Charges	C XIX	nospi tui	0031	
Cost Center Description	I npati ent	Outpati ent	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA I npati ent Rati o	
	6. 00	7. 00	8. 00	9, 00	10. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	170, 283, 881		170, 283, 88	31		30. 00
31.00 03100 INTENSIVE CARE UNIT	63, 848, 782		63, 848, 78	32		31.00
32.00 03200 CORONARY CARE UNIT	0			0		32.00
35.00 02060 NEONATAL INTENSIVE CARE UNIT	15, 470, 534		15, 470, 53	34		35. 00
40. 00 04000 SUBPROVI DER - 1 PF	0			0		40.00
41.00 04100 SUBPROVI DER - I RF	10, 214, 820		10, 214, 82			41.00
43. 00 04300 NURSERY	3, 049, 327		3, 049, 32	27		43. 00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	87, 857, 056	71, 343, 549			0. 000000	
51. 00 05100 RECOVERY ROOM	7, 887, 607	13, 981, 034			0. 000000	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	22, 511, 534	3, 689, 411			0. 000000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	60, 296, 787	186, 003, 020			0. 000000	
57.00 05700 CT SCAN 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	1, 643, 931 0	1, 491, 702	3, 135, 63	0. 071756 0 0. 000000	0. 000000 0. 000000	
59. 00 05900 CARDI AC CATHETERI ZATI ON	43, 859, 800	56, 078, 947	99, 938, 74		0. 000000	
60. 00 106000 LABORATORY	44, 333, 162	40, 438, 628			0. 000000	
60. 01 06001 BLOOD LABORATORY	14, 333, 102	40, 430, 020	04,771,72	0 0.000000	0. 000000	
63. 00 06300 BLOOD STORING, PROCESSING, & TRANS.	6, 069, 187	1, 876, 725	7, 945, 91		0. 000000	
65. 00 06500 RESPI RATORY THERAPY	26, 294, 615	2, 581, 129			0. 000000	
65. 01 06501 SLEEP LAB	5, 520	5, 741, 492			0. 000000	
66. 00 06600 PHYSI CAL THERAPY	9, 266, 078	10, 027, 243			0. 000000	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	7, 036, 802	88, 064			0. 000000	67.00
68.00 06800 SPEECH PATHOLOGY	3, 713, 588	287, 415	4, 001, 00	0. 244947	0. 000000	68. 00
68. 01 06801 AUDI OLOGY	0	0		0. 000000	0. 000000	
69. 00 06900 ELECTROCARDI OLOGY	32, 676, 189	20, 180, 989	52, 857, 17		0. 000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	37, 746, 328	47, 267, 725			0. 000000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	62, 099, 645	39, 659, 764			0. 000000	
73.00 07300 DRUGS CHARGED TO PATIENTS	111, 315, 588	243, 683, 336			0. 000000	
73.01 07301 HOSPITAL BASED RETAIL PHARMACIES	0	7, 226, 550			0. 000000	
74.00 07400 RENAL DIALYSIS	3, 806, 930	190, 954	3, 997, 88		0. 000000	
76. 00 03160 CARDI OPULMONARY	0	0		0.000000	0. 000000	
76. 97 O7697 CARDI AC REHABI LI TATI ON	1, 004, 003	3, 166, 823			0. 000000	
76. 98 07698 HYPERBARI C OXYGEN THERAPY	58, 782	16, 427, 019	16, 485, 80	0. 125572	0. 000000	76. 98
OUTPATIENT SERVICE COST CENTERS	1 2			0 000000	0.000000	00 00
90. 00 09000 CLINIC 90. 01 09001 SUBSTANCE ABUSE CLINIC	0	202 422	202 46	0.000000	0. 000000	
90.02 109002 PAIN CLINIC	296 11 223	293, 129 6, 514, 883			0. 000000	

0

11, 223

374, 827

70, 367, 313

1, 193, 917 18, 244

904, 316, 296

904, 316, 296

0

994, 003, 565 1, 898, 319, 861

994, 003, 565 1, 898, 319, 861

6, 514, 883

37, 108, 194

144, 081, 666 34, 364, 614 209, 560

227, 804

0

0. 366350

0.094085

0. 110116

0. 203792 1. 370564

0.000000

6, 526, 106

37, 483, 021

214, 448, 979 35, 558, 531

0.000000

0.000000

0. 000000

0. 000000

0.000000

0. 000000

90.02

90.03

91.00

92.00

92.01

95.00

113. 00

200.00 201. 00

202. 00

90. 02 09002 PAIN CLINIC

09100 EMERGENCY

113. 00 11300 I NTEREST EXPENSE

09003 ONCOLOGY CLINIC

09200 OBSERVATION BEDS (NON-DISTINCT PART) 09201 OBSERVATION BEDS (DISTINCT PART)

Subtotal (see instructions)

OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS

Less Observation Beds

Total (see instructions)

90.03

91.00

92.00

92.01

95.00

200. 00 201. 00 202. 00

Health Financial Systems	BALL MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0089	Peri od: Worksheet C From 01/01/2020 Part I To 12/31/2020 Date/Time Prepared: 7/15/2021 12:59 pm

				7/15/2021 12:59 pm
		Title XIX	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
32.00 03200 CORONARY CARE UNIT				32. 00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT				35. 00
40. 00 04000 SUBPROVI DER - PF				40.00
41. 00 04100 SUBPROVI DER - RF				41. 00
43. 00 04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS				45.00
50. 00 05000 OPERATING ROOM	0. 000000			50.00
51. 00 05100 RECOVERY ROOM	0.000000			51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0.000000			52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
57. 00 05700 CT SCAN	0. 000000			57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000			58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000			59. 00
60. 00 06000 LABORATORY	0. 000000			60.00
60. 01 06001 BLOOD LABORATORY	0. 000000			60. 01
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0. 000000			63. 00
65. 00 06500 RESPIRATORY THERAPY	0. 000000			65. 00
65. 01 06501 SLEEP LAB	0. 000000			65. 01
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67. 00
68.00 06800 SPEECH PATHOLOGY	0. 000000			68. 00
68. 01 06801 AUDI OLOGY	0. 000000			68. 01
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73. 00
73.01 07301 HOSPITAL BASED RETAIL PHARMACIES	0. 000000			73. 01
74.00 07400 RENAL DIALYSIS	0. 000000			74.00
76. 00 03160 CARDI OPULMONARY	0. 000000			76. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000			76. 97
76. 98 07698 HYPERBARIC OXYGEN THERAPY	0. 000000			76. 98
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	0. 000000			90.00
90. 01 09001 SUBSTANCE ABUSE CLINIC	0. 000000			90. 01
90. 02 09002 PAIN CLINIC	0. 000000			90. 02
90. 03 09003 ONCOLOGY CLINIC	0. 000000			90. 03
91. 00 09100 EMERGENCY	0. 000000			91. 00
	0. 000000			92. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)				
92. 01 09201 OBSERVATION BEDS (DISTINCT PART)	0. 000000			92. 01
OTHER REIMBURSABLE COST CENTERS	0.000000			05.00
95. 00 09500 AMBULANCE SERVICES	0. 000000			95. 00
SPECIAL PURPOSE COST CENTERS				112 00
113. 0011300 NTEREST EXPENSE				113.00
200.00 Subtotal (see instructions)				200.00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)	1			202.00

Health Financial Systems	BALL MEMORIA	L HOSPITAL		In Lieu	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPIT		Provi der C		Period: From 01/01/2020	Worksheet D Part I Date/Time Pro 7/15/2021 12:	epared:
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capital Related	Swing Bed	Reduced	Total Patient	Per Diem (col.	
·	Cost (from	Adjustment	Capi tal	Days	3 / col. 4)	
	Wkst. B, Part		Related Cost		,	
	II, col. 26)		(col. 1 - col			
			2)			
	1.00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS				•		
30.00 ADULTS & PEDIATRICS	6, 847, 341	0	6, 847, 34	1 68, 369	100. 15	30.00
31.00 INTENSIVE CARE UNIT	1, 151, 348		1, 151, 348	10, 017	114. 94	31.00
32.00 CORONARY CARE UNIT	0			ol o	0. 00	32. 00
35.00 NEONATAL INTENSIVE CARE UNIT	399, 815		399, 81	3, 353	119. 24	35. 00
40. 00 SUBPROVI DER - I PF	0	0		ol	0.00	40.00
41.00 SUBPROVI DER - I RF	408, 080	0	408, 080	4, 489	90. 91	41.00
43.00 NURSERY	117, 460		117, 460			43.00
200.00 Total (lines 30 through 199)	8, 924, 044		8, 924, 04			200.00
Cost Center Description	Inpatient	Inpatient	-, -, -, -, -, -, -, -, -, -, -, -, -, -			
'	Program days	Program				
	1 - 1 - 3	Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS					-	
30.00 ADULTS & PEDIATRICS	25, 550	2, 558, 833				30.00
31.00 INTENSIVE CARE UNIT	4, 261	489, 759				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, 829	257, 184				41.00
43. 00 NURSERY	2, 027	207, 101				43. 00
200.00 Total (lines 30 through 199)	32, 640	3, 305, 776				200. 00

Health Financial Systems	BALL MEMORIA	AL HOSPITAL		In Lieu	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPI	TAL COSTS	Provi der C		Period: From 01/01/2020 To 12/31/2020	Worksheet D Part II	epared:
		Title	: XVIII	Hospi tal	PPS	
Cost Center Description	apital Related	Total Charges	Ratio of Cost	Inpatient	Capital Costs	
	Cost (from	(from Wkst. C,	to Charges	Program	(column 3 x	
	Wkst. B, Part	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	II, col. 26)	8)	2)		ŕ	
	1.00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS		•		•		
50. 00 05000 OPERATING ROOM	1, 469, 679	159, 200, 605	0. 00923	2 36, 601, 531	337, 905	50.00
51.00 05100 RECOVERY ROOM	322, 460	21, 868, 641	0. 01474	5 3, 453, 247	50, 918	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	496, 021	26, 200, 945	0. 01893	1 68, 590	1, 298	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 334, 918	246, 299, 807	0. 00948	26, 736, 503	253, 462	54.00
57.00 05700 CT SCAN	2, 232	3, 135, 633	0. 00071	766, 646	546	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0. 00000	0	0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	530, 494	99, 938, 747	0. 00530	17, 563, 959	93, 229	59.00
60. 00 06000 LABORATORY	683, 055	84, 771, 790	0. 00805	17, 327, 111	139, 622	60.00
60. 01 06001 BLOOD LABORATORY	0	0	0. 00000	0	0	60. 01
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	4, 070	7, 945, 912	0. 00051	2, 906, 101	1, 488	63.00
65.00 06500 RESPIRATORY THERAPY	207, 083	28, 875, 744	0. 00717	2 10, 718, 587	76, 874	65.00
65. 01 06501 SLEEP LAB	6, 050	5, 747, 012	0. 00105	5, 520	6	65. 01
66. 00 06600 PHYSI CAL THERAPY	575, 081			7 2, 811, 028	83, 788	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	92, 080	7, 124, 866	0. 01292	4 1, 132, 539	14, 637	67.00
68.00 06800 SPEECH PATHOLOGY	25, 194	4, 001, 003	0. 00629	7 1, 038, 888	6, 542	68. 00
68. 01 06801 AUDI OLOGY	0	0	0. 00000	0	0	68. 01
69. 00 06900 ELECTROCARDI OLOGY	666, 930			15, 367, 818	193, 911	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	301, 020	85, 014, 053	0. 00354		58, 791	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	309, 919				86, 491	
73.00 07300 DRUGS CHARGED TO PATIENTS	439, 404	354, 998, 924			52, 759	
73.01 07301 HOSPITAL BASED RETAIL PHARMACIES	54, 920				0	
74.00 07400 RENAL DIALYSIS	106, 825	3, 997, 884		,	55, 847	74. 00
76. 00 03160 CARDI OPULMONARY	0	0	0. 00000		0	76. 00
76. 97 O7697 CARDIAC REHABILITATION	9, 518				1, 021	•
76. 98 07698 HYPERBARIC OXYGEN THERAPY	30, 777	16, 485, 801	0. 00186	7 40, 221	75	76. 98
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0				0	
90. 01 09001 SUBSTANCE ABUSE CLINIC	226, 961				0	
90. 02 09002 PAIN CLINIC	794, 620				1, 354	
90. 03 09003 ONCOLOGY CLINIC	130, 716					
91. 00 09100 EMERGENCY	1, 383, 763					•
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	739, 728					•
92. 01 09201 OBSERVATION BEDS (DISTINCT PART)	10, 694	227, 804	0. 04694	4 6, 852	322	92. 01
OTHER REIMBURSABLE COST CENTERS			1			05.00
95. 00 09500 AMBULANCE SERVICES	11 054 010	1 /05 450 517		257 700 005	1 71/ 575	95. 00
200.00 Total (lines 50 through 199)	11, 954, 212	1, 635, 452, 517	I	257, 739, 295	1, 716, 575	K00.00

Health Financial Systems	BALL MEMORIA	I HOSDITAI		Inlia	u of Form CMS-:	2552_10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER			F	Period: From 01/01/2020 To 12/31/2020	Worksheet D	epared:
-		Title	: XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School			Allied Health		
· ·	Post-Stepdown	3	Post-Stepdown		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	30. 00
31.00 03100 INTENSIVE CARE UNIT	0	0	C	0	0	31.00
32.00 03200 CORONARY CARE UNIT	0	0	C	0	0	32.00
35.00 02060 NEONATAL INTENSIVE CARE UNIT	0	0	C	0	0	35.00
40. 00 04000 SUBPROVI DER - 1 PF	0	0	C	0	0	40.00
41.00 04100 SUBPROVI DER - I RF	0	0	(0	0	
43. 00 04300 NURSERY	0	0	C	0	0	
200.00 Total (lines 30 through 199)	0	0	C	0		200. 00
Cost Center Description	Swi ng-Bed	Total Costs		Per Diem (col.		
		(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
	instructions)	minus col. 4)				
	4. 00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			,			
30. 00 03000 ADULTS & PEDIATRICS	0	0	68, 369			
31.00 03100 INTENSIVE CARE UNIT		0	10, 017			
32. 00 03200 CORONARY CARE UNIT		0		0.00		
35.00 02060 NEONATAL INTENSIVE CARE UNIT		0	3, 353			
40. 00 04000 SUBPROVI DER - 1 PF	0	0		0.00		
41. 00 04100 SUBPROVI DER - RF	0	0	4, 489			41.00
43. 00 04300 NURSERY		0	2, 017			
200.00 Total (lines 30 through 199)		0	88, 245		32, 640	200. 00
Cost Center Description	Inpatient					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS	9.00					
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
31. 00 03100 NTENSI VE CARE UNIT						31.00
32. 00 03200 CORONARY CARE UNIT						32.00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT						35. 00
40. 00 04000 SUBPROVI DER - PF						40. 00
41. 00 04100 SUBPROVI DER - RF						41. 00
43. 00 04300 NURSERY						43. 00
200.00 Total (lines 30 through 199)						200. 00
200.00 [10tal (111105 00 till oagh 177)	ı "					F 50. 00

Health Financial Systems	BALL MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCI LLARY SERVI CE OTHER PASS Provi der CCN: 15-0089	Peri od: Worksheet D From 01/01/2020 Part IV To 12/31/2020 Date/Time Prepared: 7/15/2021 13:50 pm

			[''	0 12/31/2020	7/15/2021 12:	epared: 59 pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician Nu	ırsing School	Nursing School	Allied Health	Allied Health	
	Anesthetist Po	ost-Stepdown	•	Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1. 00	2A	2. 00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	54.00
57.00 05700 CT SCAN	0	0	0	0	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	0	0	0	0	0	59. 00
60. 00 06000 LABORATORY	0	0	0	0	0	60.00
60. 01 06001 BL00D LABORATORY	0	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	0	0	0	0	0	65. 00
65. 01 06501 SLEEP LAB	0	0	0	0	0	65. 01
66.00 06600 PHYSI CAL THERAPY	0	0	0	0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67. 00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68. 00
68. 01 06801 AUDI OLOGY	0	0	0	0	0	68. 01
69. 00 06900 ELECTROCARDI OLOGY	0	0	0	0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	355, 448	
73.01 07301 HOSPITAL BASED RETAIL PHARMACIES	0	0	0	0	0	73. 01
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	74. 00
76. 00 03160 CARDI OPULMONARY	0	0	0	0	0	76. 00
76. 97 O7697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	76. 97
76. 98 O7698 HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76. 98
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0	0	0	0	70.00
90.01 09001 SUBSTANCE ABUSE CLINIC	0	0	0	0	0	90. 01
90. 02 09002 PAIN CLINIC	0	0	0	0	0	90. 02
90. 03 09003 ONCOLOGY CLINIC	0	0	0	0	0	90. 03
91. 00 09100 EMERGENCY	0	0	0	0	0	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92. 00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92. 01
OTHER REIMBURSABLE COST CENTERS				-		
95. 00 09500 AMBULANCE SERVICES		_	_	_		95. 00
200.00 Total (lines 50 through 199)	0	0	0	0	355, 448	200.00

Heal th Financial	Systems		BALL MEMORIA	L HOSPITAL		In Lieu	u of Form CMS-2	2552-10
APPORTI ONMENT OF THROUGH COSTS	I NPATI ENT/OUTPATI ENT	ANCI LLARY	SERVI CE OTHER PA	ASS Provider (Period: From 01/01/2020 To 12/31/2020	Worksheet D Part IV Date/Time Pre 7/15/2021 12:	epared: 59 pm
				Title	e XVIII	Hospi tal	PPS	
Cost	Center Description		All Other	Total Cost	Total	Total Charges		
			Medi cal	(sum of cols.		(from Wkst. C,		
			Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
				4)	col s. 2, 3,	8)	7)	
					and 4)		(see	
							instructions)	

	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	•	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
		Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
			_	and 4)	_	(see	
				,		instructions)	
		4.00	5. 00	6. 00	7. 00	8. 00	
A	NCILLARY SERVICE COST CENTERS	•					
50.00	5000 OPERATING ROOM	0	0	0	159, 200, 605	0. 000000	50.00
51.00 0	5100 RECOVERY ROOM	0	0	0	21, 868, 641	0. 000000	51. 00
52.00 0	5200 DELIVERY ROOM & LABOR ROOM	0	0	0	26, 200, 945	0. 000000	52.00
54.00 0	5400 RADI OLOGY-DI AGNOSTI C	0	0	0	246, 299, 807	0. 000000	54.00
57.00 0	5700 CT SCAN	0	0	0	3, 135, 633	0. 000000	57. 00
58. 00 0	5800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0. 000000	58. 00
59.00 0	5900 CARDIAC CATHETERIZATION	0	0	0	99, 938, 747	0. 000000	59. 00
60.00 0	6000 LABORATORY	0	0	0	84, 771, 790	0. 000000	60.00
60. 01 0	6001 BLOOD LABORATORY	0	0	0	0	0. 000000	60. 01
63.00 0	6300 BLOOD STORING, PROCESSING, & TRANS.	0	0	0	7, 945, 912	0. 000000	63.00
65.00 0	6500 RESPIRATORY THERAPY	0	0	0	28, 875, 744	0. 000000	65. 00
65. 01 0	6501 SLEEP LAB	0	0	0	5, 747, 012		65. 01
	6600 PHYSI CAL THERAPY	0	0	Ó	19, 293, 321		
	6700 OCCUPATI ONAL THERAPY	0	0	Ó	7, 124, 866		
	6800 SPEECH PATHOLOGY	0	Ó	0	4, 001, 003		
	6801 AUDI OLOGY	0	0	Ó	0	0. 000000	
	6900 ELECTROCARDI OLOGY	0	0	Ó	52, 857, 178		
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	Ó	85, 014, 053		
	7200 IMPL. DEV. CHARGED TO PATIENT	0	Ó	0	101, 759, 409		
	7300 DRUGS CHARGED TO PATIENTS	0	355, 448	355, 448			73. 00
73. 01 0	7301 HOSPITAL BASED RETAIL PHARMACIES	0	0	0	7, 226, 550		73. 01
	7400 RENAL DIALYSIS	0	0	0	3, 997, 884		74.00
	3160 CARDI OPULMONARY	0	0	0	0	0. 000000	76. 00
76. 97 0	7697 CARDIAC REHABILITATION	0	0	0	4, 170, 826	0. 000000	76. 97
76. 98 0	7698 HYPERBARIC OXYGEN THERAPY	0	0	0	16, 485, 801	0. 000000	76. 98
	UTPATIENT SERVICE COST CENTERS						
90.00 0	9000 CLI NI C	0	0	0	0	0.000000	90.00
90. 01 0	9001 SUBSTANCE ABUSE CLINIC	0	0	0	293, 425	0. 000000	90. 01
90. 02 0	9002 PAIN CLINIC	0	0	0	6, 526, 106	0. 000000	90. 02
90. 03 0	9003 ONCOLOGY CLINIC	0	0	0	37, 483, 021	0. 000000	90. 03
91.00 0	9100 EMERGENCY	0	0	0	214, 448, 979	0. 000000	91. 00
92.00 0	9200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	35, 558, 531	0. 000000	92.00
92. 01 0	9201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	227, 804		92. 01
0	THER REIMBURSABLE COST CENTERS						
	9500 AMBULANCE SERVICES						95. 00
200. 00	Total (lines 50 through 199)	0	355, 448	355, 448	1, 635, 452, 517	l	200. 00

Health Financial Systems	BALL MEMORIAL F	HOSPI TAL	In Lieu	of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCI LLARY SERVI CE OTHER PASS		From 01/01/2020	Worksheet D Part IV Date/Time Prepared: 7/15/2021 12:59 pm

THROUGH COSTS			Ţ	o 12/31/2020	Date/Time Pre 7/15/2021 12:	epared: 59 pm
		Title	xVIII	Hospi tal	PPS	
Cost Center Description	Outpati ent	Inpatient	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		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	36, 601, 531		18, 310, 303	0	00.00
51.00 05100 RECOVERY ROOM	0. 000000	3, 453, 247		4, 372, 446		51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	68, 590		10, 146		52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	26, 736, 503	b .	60, 541, 764	0	54. 00
57.00 05700 CT SCAN	0. 000000	766, 646	0	392, 857	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	17, 563, 959		20, 486, 276	0	59. 00
60. 00 06000 LABORATORY	0. 000000	17, 327, 111	0	5, 060, 001	0	00.00
60. 01 06001 BL00D LABORATORY	0. 000000	0	0	0	0	60. 01
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0. 000000	2, 906, 101	0	782, 323		63.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	10, 718, 587	0	495, 312	0	65.00
65. 01 06501 SLEEP LAB	0. 000000	5, 520	0	1, 316, 679	0	65. 01
66. 00 06600 PHYSI CAL THERAPY	0. 000000	2, 811, 028	0	219, 135	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	1, 132, 539		610	0	67. 00
68.00 06800 SPEECH PATHOLOGY	0. 000000	1, 038, 888	0	14, 645	0	68. 00
68. 01 06801 AUDI OLOGY	0. 000000	0	·	0	0	68. 01
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	15, 367, 818	0	5, 665, 077	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	16, 602, 941		17, 239, 657		71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000	28, 394, 979	0	14, 223, 909		
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 001001	42, 616, 007	42, 659	97, 240, 880	97, 338	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, 090, 090	0	103, 360	0	74. 00
76. 00 03160 CARDI OPULMONARY	0. 000000	0	0	0	0	76. 00
76. 97 O7697 CARDI AC REHABI LI TATI ON	0. 000000	447, 393	0	1, 273, 510	0	76. 97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0. 000000	40, 221	0	6, 493, 831	0	76. 98
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0. 000000	0	0	0	0	90.00
90.01 09001 SUBSTANCE ABUSE CLINIC	0. 000000	0	0	11, 554		90. 01
90.02 09002 PAIN CLINIC	0. 000000	11, 121		2, 204, 540		90. 02
90. 03 09003 0NCOLOGY CLINIC	0. 000000	197, 949	0	14, 837, 955	0	90. 03
91.00 09100 EMERGENCY	0. 000000	30, 413, 479	0	23, 110, 437		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	420, 195		6, 885, 407	0	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0. 000000	6, 852	0	38, 551	0	92. 01
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	1 1	257, 739, 295	42, 659	301, 331, 165	97, 338	200.00

Health Financial Systems	BALL MEMORIAL H	IOSPI TAL	In Lieu	of Form CMS-2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SE	ERVICES AND VACCINE COST	Provi der CCN: 15-0089	From 01/01/2020	Worksheet D Part V Date/Time Prepared: 7/15/2021 12:59 pm
		Title XVIII	Hospi tal	PPS

				-	Γο 12/31/2020	Date/Time Pre 7/15/2021 12:	epared:
			Title	XVIII	Hospi tal	PPS	07 piii
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Servi ces	
	, , , , , , , , , , , , , , , , , , ,		Services (see		Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Servi ces Not	(,,	
		Part I, col. 9		Subject To	Subject To		
		,					
				(see inst.)	(see inst.)		
		1.00	2. 00	3.00	4.00	5. 00	
ANCIL	LARY SERVICE COST CENTERS	11.00	2, 00	0.00	11 00	0.00	
	OPERATING ROOM	0. 109715	18, 310, 303	(0	2, 008, 915	50.00
	RECOVERY ROOM	0. 166702				728, 895	
•	DELIVERY ROOM & LABOR ROOM	0. 192399		10		1, 952	10
	RADI OLOGY-DI AGNOSTI C	0. 112236	· ·			6, 794, 965	10
	CT SCAN	0. 071756		1		28, 190	
	MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	· ·)		0	•
	CARDI AC CATHETERI ZATI ON	0. 070266		1	o o	1, 439, 489	(A)
	LABORATORY	0. 208246		b		1, 053, 725	•
	BLOOD LABORATORY	0. 000000		1		1,033,723	1
	BLOOD STORING, PROCESSING, & TRANS.	0. 210607	782, 323			164, 763	
	RESPIRATORY THERAPY	0. 221473	495, 312	1		109, 698	
	SLEEP LAB	0. 221473	1, 316, 679	1		189, 749	
	PHYSI CAL THERAPY	0. 394601	219, 135			86, 471	•
•	OCCUPATIONAL THERAPY	0. 394601	219, 133	1		139	•
	SPEECH PATHOLOGY	0. 227224		1		3, 587	•
•			14, 645			•	•
	AUDI OLOGY	0.000000				0	
	ELECTROCARDI OLOGY	0. 087589		1		496, 198	
	MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 217187	17, 239, 657			3, 744, 229	10
	IMPL. DEV. CHARGED TO PATIENT	0. 189167	14, 223, 909	1	105 104	2, 690, 694	
	DRUGS CHARGED TO PATIENTS	0. 177112	· · ·		105, 126	· · ·	10
	HOSPITAL BASED RETAIL PHARMACIES	1. 235998				0	
•	RENAL DI ALYSI S	0. 479076	· ·	1	0	•	74.00
	CARDI OPULMONARY	0. 000000			0	0	
	CARDI AC REHABI LI TATI ON	0. 337346			0	429, 614	•
	HYPERBARI C OXYGEN THERAPY	0. 125572	6, 493, 831	1, 63!	0	815, 443	76. 98
	TIENT SERVICE COST CENTERS	0.000000					00.00
90.00 09000		0. 000000		•	0	0	
	SUBSTANCE ABUSE CLINIC	2. 938731	11, 554		0	33, 954	
	PAIN CLINIC	0. 366350			0	807, 633	•
	ONCOLOGY CLINIC	0. 094085			0	1, 396, 029	
91.00 09100		0. 110116			0	2, 544, 829	
	OBSERVATION BEDS (NON-DISTINCT PART)	0. 203792			0	1, 403, 191	
	OBSERVATION BEDS (DISTINCT PART)	1. 370564	38, 551		0	52, 837	92. 01
	REIMBURSABLE COST CENTERS			1	.1		
•	AMBULANCE SERVICES	0. 000000		(]		95. 00
200. 00	Subtotal (see instructions)		301, 331, 165	1, 63!	105, 126	44, 297, 233	11
201. 00	Less PBP Clinic Lab. Services-Program				이 이		201. 00
	Only Charges						
202. 00	Net Charges (line 200 - line 201)	l	301, 331, 165	1, 63	105, 126	44, 297, 233	202. OO

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES A	AND VACCINE COST	Provi der CCN:	: 15-0089	Peri od: From 01/01/2020 To 12/31/2020		repared: 2:59 pm
		Title X	VIII	Hospi tal	PPS	
	Cos					
Cost Center Description	Cost Reimbursed					
	Servi ces	Rei mbursed				
	Subject To Ded.					
	& Coins. (see inst.)	Subject To Ded. & Coins.				
	I IISt.)	(see inst.)				
	6.00	7.00				
ANCILLARY SERVICE COST CENTERS	0.00	7.00				
50. 00 05000 OPERATING ROOM	0	0				T 50. 00
51. 00 05100 RECOVERY ROOM		Ö				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	o				52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
57.00 05700 CT SCAN	0	O				57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0				58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0				59. 00
60. 00 06000 LABORATORY	0	0				60.00
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	0	0				65. 01
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY		0				66. 00 67. 00
68. 00 06800 SPEECH PATHOLOGY		0				68.00
68. 01 06801 AUDI OLOGY		0				68. 01
69. 00 06900 ELECTROCARDI OLOGY	0	Ö				69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	o				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	O				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	18, 619				73.00
73.01 07301 HOSPITAL BASED RETAIL PHARMACIES	0	0				73. 01
74.00 07400 RENAL DIALYSIS	0	0				74. 00
76. 00 03160 CARDI OPULMONARY	0	0				76. 00
76. 97 O7697 CARDI AC REHABI LI TATI ON	0	0				76. 97
76. 98 O7698 HYPERBARI C OXYGEN THERAPY	205	0				76. 98
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINI C	0	0				90.00
90.01 09001 SUBSTANCE ABUSE CLINIC 90.02 09002 PAIN CLINIC	0	0				90. 01 90. 02
90. 02 09002 PATN CETNIC 90. 03 09003 0NCOLOGY CLINIC		0				90.02
91. 00 09100 EMERGENCY		o				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0				92. 00
92. 01 09201 OBSERVATION BEDS (DISTINCT PART)		0				92. 01
OTHER REIMBURSABLE COST CENTERS	<u> </u>	<u> </u>				7
95. 00 09500 AMBULANCE SERVICES	0					95. 00
200.00 Subtotal (see instructions)	205	18, 619				200.00

205

205

18, 619

18, 619

95. 00 200. 00 201. 00

202.00

95. 00 200. 00 201. 00

202.00

Subtotal (see instructions)
Less PBP Clinic Lab. Services-Program
Only Charges
Net Charges (line 200 - line 201)

Health Financial Systems	BALL MEMORIA	AL HOSPITAL		In Lieu	u of Form CMS-2	<u> 2552-10</u>
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPI	TAL COSTS	Provi der C	CN: 15-0089	Peri od:	Worksheet D	
				From 01/01/2020	Part II	
		Component	CCN: 15-T089	Го 12/31/2020	Date/Time Pre 7/15/2021 12:	epareu: 59 nm
		Title	XVIII \$u	ıbprovi der - IR	PPS	37 piii
Cost Center Description	apital Relate				Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
		Part I, col.		Charges	column 4)	
	II, col. 26)	8)	2)	3 1 3 1	,	
	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	1, 469, 679	159, 200, 605	0. 009232	96, 295	889	50.00
51.00 05100 RECOVERY ROOM	322, 460			18, 544	273	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	496, 021	26, 200, 945	0. 01893 ⁻		0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 334, 918	246, 299, 807	0. 009480	250, 695	2, 377	54.00
57.00 05700 CT SCAN	2, 232	1		14, 380	10	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	1	0. 000000		0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	530, 494	99, 938, 747	0. 005308	0	0	59. 00
60. 00 06000 LABORATORY	683, 055	84, 771, 790	0. 008058	416, 885	3, 359	60.00
60. 01 06001 BLOOD LABORATORY	0	0	0. 000000		0	60. 01
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	4, 070	7, 945, 912	0. 000512	84, 223	43	63.00
65. 00 06500 RESPIRATORY THERAPY	207, 083				848	65.00
65. 01 06501 SLEEP LAB	6, 050				0	
66. 00 06600 PHYSI CAL THERAPY	575, 081				61, 202	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	92, 080	7, 124, 866	0. 012924	2, 577, 629	33, 313	67. 00
68.00 06800 SPEECH PATHOLOGY	25, 194	4, 001, 003	0. 00629	638, 741	4, 022	68. 00
68. 01 06801 AUDI OLOGY	0	0	0. 000000	0	0	68. 01
69. 00 06900 ELECTROCARDI OLOGY	666, 930	52, 857, 178	0. 012618	44, 212	558	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	301, 020	85, 014, 053	0. 00354 ²	85, 710	303	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	309, 919	101, 759, 409	0. 003046	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	439, 404	354, 998, 924	0. 001238	1, 106, 729	1, 370	73. 00
73.01 07301 HOSPITAL BASED RETAIL PHARMACIES	54, 920	7, 226, 550	0. 007600	0	0	73. 01
74.00 07400 RENAL DIALYSIS	106, 825	3, 997, 884	0. 026720	126, 567	3, 382	74.00
76.00 03160 CARDI OPULMONARY	0	0		0	0	76. 00
76.97 07697 CARDIAC REHABILITATION	9, 518	4, 170, 826	0. 002282	0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	30, 777	16, 485, 801	0. 00186	7 0	0	76. 98
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0	0. 000000	0	0	90.00
90. 01 09001 SUBSTANCE ABUSE CLINIC	226, 961	293, 425	0. 773489	9 0	0	90. 01
90.02 09002 PAIN CLINIC	794, 620				0	
90. 03 09003 ONCOLOGY CLINIC	130, 716				0	
91. 00 09100 EMERGENCY	1, 383, 763				0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0				0	
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	10, 694	227, 804	0. 04694	1 0	0	92. 01
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50 through 199)	11, 214, 484	1, 635, 452, 517		7, 632, 134	111, 949	200.00

Health Financial Systems	BALL MEMORIAL H	HOSPI TAL	In Lieu	of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 15-0089	Peri od: From 01/01/2020	Worksheet D Part IV
1111100011 00313		Component CCN: 15-T089	To 12/31/2020	Date/Time Prepared: 7/15/2021 12:59 pm
		Ti +l \(\text{YVIII}	Subprovider - IPE	DDS

Title XVIII Subprovider - IR\$ PPS			Component	CCN: 15-1089 1	0 12/31/2020	7/15/2021 12:	
Cost Center Description			Title	XVIII \$u	bprovider - IRI		0 7 Pill
Anesthetist Cost	Cost Center Description	Non Physician					
ANCILLARY SERVICE COST CENTERS 1.00 2A 2.00 3A 3.00				3			
ANCILLARY SERVICE COST CENTERS							
50.00 050000 050000 05000 050000 050000 050000 050000 050000 05000				2. 00		3. 00	
51.00 05.100 RECOVERY ROOM 0 0 0 0 0 0 0 0 0	ANCILLARY SERVICE COST CENTERS						
52.00 05.200 DELI VERY ROOM & LABOR ROOM 0 0 0 0 52.00	50. 00 05000 OPERATI NG ROOM	0	0	0	0	0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 0 0 54. 40 57. 00 05700 CT SCAN 0 0 0 0 0 0 57. 00 58. 00 05800 MAGNETI C RESONANCE IMAGI NG (MRI) 0 0 0 0 0 0 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 0 0 60. 00 60000 LABDRATORY 0 0 0 0 0 0 0 60. 01 06000 LABDRATORY 0 0 0 0 0 0 0 61. 00 06000 LABDRATORY 0 0 0 0 0 0 0 62. 00 06500 RESPI RATORY THERAPY 0 0 0 0 0 0 0 65. 01 06500 RESPI RATORY THERAPY 0 0 0 0 0 0 0 65. 01 06501 SLEEP LAB 0 0 0 0 0 0 0 66. 01 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 0 67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0 0 0 68. 01 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 69. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 0 75. 00 07597 CARDI ACRES TO PATI ENTS 0 0 0 0 0 76. 09 07698 HYPERBARI C DAYGEN THERAPY 0 0 0 0 0 0 76. 90 07698 HYPERBARI C DAYGEN THERAPY 0 0 0 0 0 76. 90 07698 HYPERBARI C DAYGEN THERAPY 0 0 0 0 0 76. 90 07698 HYPERBARI C DAYGEN THERAPY 0 0 0 0 0 76. 90 07698 HYPERBARI C DAYGEN THERAPY 0 0 0 0 0 76. 90 07698 HYPERBARI C DAYGEN THERAPY 0 0 0 0 0 76. 90 07699 CARDI ACRES TRUCE COST CENTERS 79. 00 09000 CLINIC 0 0 0 0 0 0 70. 01 09001 SUBSTANCE ABUSE CLINIC 0 0 0 0 0 79. 01 09001 SUBSTANCE ABUSE CLINIC 0 0 0 0 0 79. 00 07000 0000000000000000000000000	51.00 05100 RECOVERY ROOM	o	О	0	О	0	51.00
57. 00 05700 CT SCAN 0 0 0 0 0 0 57. 00 58. 00 05800 MARNETI C RESONANCE I MAGI NG (MRI) 0 0 0 0 0 0 58. 00 59. 00 05900 CARDIAC CATHETERI ZATI ON 0 0 0 0 0 0 60. 00 06000 LABORATORY 0 0 0 0 0 0 60. 01 06000 LABORATORY 0 0 0 0 0 60. 01 06000 BLODD LABORATORY 0 0 0 0 0 63. 00 06300 BLODD STORI NG , PROCESSI NG & TRANS. 0 0 0 0 0 65. 00 06500 RESPIRATORY THERAPY 0 0 0 0 0 65. 01 06501 SLEEP LAB 0 0 0 0 0 66. 00 06500 PHYSI CAL THERAPY 0 0 0 0 0 67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 0 68. 00 06800 SPECCH PATHOLOGY 0 0 0 0 68. 01 06801 AUDI OLOGY 0 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 75. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 76. 97 07697 CARDI LA BASED RETAIL PHARMACI ES 0 0 0 0 76. 97 07697 CARDI LA CREHABI LI TATI ON 0 0 0 0 76. 98 07698 MYPERBARI C OXYCOR THERAPY 0 0 0 0 0 76. 99 07698 MYPERBARI C OXYCOR THERAPY 0 0 0 0 0 76. 90 07699 CARDI LA C REHABI LI TATI ON 0 0 0 0 76. 90 07699 CARDI LA C REHABI LI TATI ON 0 0 0 0 76. 90 07699 CARDI LA C REHABI LI TATI ON 0 0 0 0 76. 90 07699 OSSENAVI ON BEDS (DISTINCT PART) 0 0 0 0 0 90. 01 90000 CLINIC 0 0 0 0 0 90. 02 90000 SBESTANCE ABUSE CLINIC 0 0 0 0 90. 01 90010 BUSSTANCE ABUSE CLINIC 0 0 0 0 90. 01 90010 BUSSTANCE ABUSE CLINIC 0 0 0 0 90. 01 90010 DRIFFIENT 0 0 0 0 90. 01 90010 DRIFFIENT 0 0 0 0 90. 02 90000 DRIFFIENT 0 0 0 0 90. 01 90010 DRIFFIENT 0	52.00 05200 DELIVERY ROOM & LABOR ROOM	o	0	0	О	0	52.00
57. 00 05700 CT SCAN 0 0 0 0 0 0 57. 00 58. 00 05800 MARNETI C RESONANCE I MAGI NG (MRI) 0 0 0 0 0 0 58. 00 59. 00 05900 CARDIAC CATHETERI ZATI ON 0 0 0 0 0 0 60. 00 06000 LABORATORY 0 0 0 0 0 0 60. 01 06000 LABORATORY 0 0 0 0 0 60. 01 06000 BLODD LABORATORY 0 0 0 0 0 63. 00 06300 BLODD STORI NG , PROCESSI NG & TRANS. 0 0 0 0 0 65. 00 06500 RESPIRATORY THERAPY 0 0 0 0 0 65. 01 06501 SLEEP LAB 0 0 0 0 0 66. 00 06500 PHYSI CAL THERAPY 0 0 0 0 0 67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 0 68. 00 06800 SPECCH PATHOLOGY 0 0 0 0 68. 01 06801 AUDI OLOGY 0 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 75. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 76. 97 07697 CARDI LA BASED RETAIL PHARMACI ES 0 0 0 0 76. 97 07697 CARDI LA CREHABI LI TATI ON 0 0 0 0 76. 98 07698 MYPERBARI C OXYCOR THERAPY 0 0 0 0 0 76. 99 07698 MYPERBARI C OXYCOR THERAPY 0 0 0 0 0 76. 90 07699 CARDI LA C REHABI LI TATI ON 0 0 0 0 76. 90 07699 CARDI LA C REHABI LI TATI ON 0 0 0 0 76. 90 07699 CARDI LA C REHABI LI TATI ON 0 0 0 0 76. 90 07699 OSSENAVI ON BEDS (DISTINCT PART) 0 0 0 0 0 90. 01 90000 CLINIC 0 0 0 0 0 90. 02 90000 SBESTANCE ABUSE CLINIC 0 0 0 0 90. 01 90010 BUSSTANCE ABUSE CLINIC 0 0 0 0 90. 01 90010 BUSSTANCE ABUSE CLINIC 0 0 0 0 90. 01 90010 DRIFFIENT 0 0 0 0 90. 01 90010 DRIFFIENT 0 0 0 0 90. 02 90000 DRIFFIENT 0 0 0 0 90. 01 90010 DRIFFIENT 0	54. 00 05400 RADI OLOGY-DI AGNOSTI C	o	0	0	О	0	54.00
59, 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 0 59. 000		О	0	0	0	0	57.00
60. 00 6000 LABORATORY	58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0	0	0	0	0	58.00
60. 01 6001 BLOOD LABORATORY 63. 00 06500 BLOOD STORING, PROCESSING, & TRANS. 0 0 0 0 0 0 0 0 0 0 0 65. 00 65. 00 06500 RESPIRATORY THERAPY 0 0 0 0 0 0 0 0 65. 00 65. 01 06501 SLEEP LAB 0 0 0 0 0 0 0 0 0 0 65. 00 66. 01 06501 SLEEP LAB 0 0 0 0 0 0 0 0 0 65. 01 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 0 0 0 66. 00 67. 00 06700 COCUPATI ONAL THERAPY 0 0 0 0 0 0 0 0 66. 00 68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 0 0 68. 01 68. 01 06801 AUDI OLOGY 0 0 0 0 0 0 0 0 68. 01 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 0 68. 01 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 0 0 0 68. 01 69. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59.00
63. 00 06300 BLOOD STORING, PROCESSING, & TRANS. 0 0 0 0 0 0 63. 00 65. 00 06500 RESPIRATORY THERAPY 0 0 0 0 0 0 0 65. 01 06501 SLEEP LAB 0 0 0 0 0 0 66. 01 06501 SLEEP LAB 0 0 0 0 0 0 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 67. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 68. 01 06600 OCCUPATI ONAL THERAPY 0 0 0 0 0 0 68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 69. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 69. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 69. 00 06801 AUDI OLOGY 0 0 0 0 0 69. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENT 0 0 0 0 0 73. 01 07301 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 73. 01 07301 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 75. 00 07697 CARDI AC REHABI LI TATI ON 0 0 0 0 0 76. 97 07697 CARDI AC REHABI LI TATI ON 0 0 0 0 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 70. 00 09000 CLI NI C 0 0 0 0 70. 01 09001 SUBSTANCE ABUSE CLI NI C 0 0 0 0 70. 02 09002 PAIN CLI NI C 0 0 0 0 70. 03 09003 ONCOLOGY CLI NI C 0 0 0 0 70. 04 09000 DESERVATI ON BEDS (DI STI NCT PART) 0 0 0 70. 07 07500 AMBURJANCE SERVI CES 95. 00 75. 00 09000 AMBURJANCE SERVI CES	60. 00 06000 LABORATORY	О	0	0	0	0	60.00
65. 00 06500 RESPIRATORY THERAPY 0 0 0 0 0 0 0 0 0	60. 01 06001 BLOOD LABORATORY	О	0	0	0	0	60. 01
65. 01 06501 SLEEP LAB 0 0 0 0 0 0 0 0 65. 01 66. 00 67.00 0 0 0 0 0 0 0 0 65. 01 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 0 66. 00 67.00 0CUPATI ONAL THERAPY 0 0 0 0 0 0 0 66. 00 67.00 0CUPATI ONAL THERAPY 0 0 0 0 0 0 0 0 68. 00 68. 00 68. 00 68. 00 68. 01 06801 AUDI OLOGY 0 0 0 0 0 0 0 0 68. 01 69. 00 0 0 0 0 0 0 0 68. 01 69. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	63.00 06300 BLOOD STORING, PROCESSING, & TR	RANS. 0	0	0	0	0	63.00
66.00 06600 PHYSICAL THERAPY 0 0 0 0 0 0 0 66.00 67.00 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0 0 0 66.00 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 68.00 68.01 06801 AUDI OLOGY 0 0 0 0 0 0 0 0 68.01 06801 AUDI OLOGY 0 0 0 0 0 0 0 0 68.01 69.00 69.00 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 0 68.01 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 0 0 0 72.00 072.00 1 MPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 0 0 72.00 1 MPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 0 355, 448 73.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 355, 448 73.00 73.01 07301 HOSPI TAL BASED RETAIL PHARMACI ES 0 0 0 0 0 355, 448 73.00 74.00 07400 RENAL DI ALYSI S 0 0 0 0 0 0 74.00 76.00 03160 CARDI OPULMONARY 0 0 0 0 0 0 76.00 76.90 76.90 07697 CARDI AC REHABI LI TATI ON 0 0 0 0 0 0 76.90 76.90 76.98 PYPERBARI C OXYGEN THERAPY 0 0 0 0 0 0 0 0 76.90 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	65. 00 06500 RESPIRATORY THERAPY	О	0	0	0	0	65.00
67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 0 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 68. 00 68. 01 06801 AUDI OLOGY 0 0 0 0 0 0 68. 01 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 73. 01 07301 HOSPI TAL BASED RETAIL PHARMACI ES 0 0 0 0 0 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 75. 00 07697 CARDI AC REHABI LI TATI ON 0 0 0 0 76. 97 07697 07697 CARDI AC REHABI LI TATI ON 0 0 0 0 76. 98 OUTPATI ENT SERVI CE COST CENTERS 0 0 0 0 0 90. 01 09000 CLI NI C 0 0 0 0 90. 02 09002 PAIN CLI NI C 0 0 0 0 90. 03 09003 ONCOLOGY CLI NI C 0 0 0 0 90. 04 09200 OSERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 0 90. 00 09200 OSERVATI ON BEDS (DISTINCT PART) 0 0 0 0 90. 00 OTHER REI MBURSABLE COST CENTERS 95. 00 OSE 95. 00 OSE 95. 00 OSE 95. 00 OSE OSE OSE OSE OSE OSE OSE OSE OSE 95. 00 OSE 95. 00 OSE 95. 00 OSE 95. 00 OSE	65. 01 06501 SLEEP LAB	o	0	0	О	0	65. 01
68. 00	66. 00 06600 PHYSI CAL THERAPY	О	0	0	0	0	66.00
68. 01 06801 AUDI OLOGY 0 0 0 0 0 0 0 0 0 68. 01 69. 00 6900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 0 0 69. 00 71. 00 71. 00 771. 00 771. 00 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 72. 00	67. 00 06700 OCCUPATI ONAL THERAPY	o	0	0	О	0	67.00
69. 00 06900 ELECTROCARDI OLOGY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 0 0 0 0 0 0 71. 00 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENT 0 0 0 0 0 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 0 355, 448 73. 00 73. 01 07301 HOSPI TAL BASED RETAIL PHARMACI ES 0 0 0 0 0 0 0 73. 01 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 0 0 0 74. 00 76. 00 03160 CARDI OPULMONARY 0 0 0 0 0 0 0 0 0 0 76. 00 76. 97 07697 CARDI AC REHABI LI TATI ON 0 076. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 90. 01 09001 SUBSTANCE ABUSE CLINI C 0 0 0 0 0 0 0 0 0 0 0 0 0 0 90. 01 09001 SUBSTANCE ABUSE CLINI C 0 0 0 0 0 0 0 0 0 0 0 0 0 0 91. 00 09000 PAIN CLINI C 0 0 0 0 0 0 0 0 0 0 0 0 0 0 92. 00 09200 DESERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 92. 01 071ER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES	68.00 06800 SPEECH PATHOLOGY	О	0	0	o	0	68.00
71. 00	68. 01 06801 AUDI OLOGY	О	0	0	o	0	68. 01
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT 0 0 0 0 0 0 0 72. 00 73300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 355, 448 73. 00 73. 01 07301 HOSPI TAL BASED RETAIL PHARMACIES 0 0 0 0 0 0 73. 01 74. 00 07400 RENAL DIALYSIS 0 0 0 0 0 0 0 0 0 74. 00 76. 00 0 3160 CARDI OPULMONARY 0 0 0 0 0 0 0 0 0 76. 00 76. 00 76. 97 076. 97 CARDI AC REHABI LI TATI ON 0 0 0 0 0 0 0 0 0 0 76. 97 76. 98 07698 HYPERBARI C 0XYGEN THERAPY 0 0 0 0 0 0 0 0 0 0 76. 98 076. 98 HYPERBARI C 0XYGEN THERAPY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	69. 00 06900 ELECTROCARDI OLOGY	o	0	0	o	0	69.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 355, 448 73. 00 73. 01 07301 HOSPITAL BASED RETAIL PHARMACIES 0 0 0 0 0 0 73. 01 74. 00 07400 RENAL DI ALYSIS 0 0 0 0 0 0 0 0 74. 00 76. 00 03160 CARDI OPULMONARY 0 0 0 0 0 0 0 0 0	71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	TENTS 0	0	0	o	0	71. 00
73. 01 07301 HOSPI TAL BASED RETAIL PHARMACIES 0 0 0 0 0 0 73. 01 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 0 0 74. 00 76. 00 03160 CARDI OPULMONARY 0 0 0 0 0 0 0 76. 00 76. 00 76. 97 07697 CARDI AC REHABI LI TATI ON 0 0 0 0 0 0 0 76. 97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 0 0 0 76. 98 0000 CLI NI C 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	72.00 07200 IMPL. DEV. CHARGED TO PATIENT	o	0	0	o	0	72.00
74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 0 74. 00 76. 00 03160 CARDI OPULMONARY 0 0 0 0 0 0 0 0 0	73.00 07300 DRUGS CHARGED TO PATIENTS	О	0	0	o	355, 448	73. 00
76. 00 03160 CARDI OPULMONARY 0 0 0 0 0 0 76. 00 76. 97 76. 97 76. 97 76. 97 76. 98 07697 CARDI AC REHABI LI TATI ON 0 0 0 0 0 0 0 76. 97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 0 0 0 0	73.01 07301 HOSPITAL BASED RETAIL PHARMACIE	S 0	0	0	0	0	73. 01
76. 97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 0 0 0 76. 97 76. 98 00UTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	74.00 07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 0 76. 98	76.00 03160 CARDI OPULMONARY	0	0	0	0	0	76. 00
OUTPATIENT SERVICE COST CENTERS 90.00 O O O O O O O O O	76.97 07697 CARDIAC REHABILITATION	0	0	0	0	0	76. 97
90. 00 09000 CLINIC 0 0 0 0 0 0 90. 00 90. 00 90. 01 09001 SUBSTANCE ABUSE CLINIC 0 0 0 0 0 0 0 90. 01 90. 02 09002 PAIN CLINIC 0 0 0 0 0 0 0 0 0	76. 98 07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0	. 0	76. 98
90. 01 09001 SUBSTANCE ABUSE CLINIC 0 0 0 0 0 90. 01 90. 02 09002 PAIN CLINIC 0 0 0 0 0 0 90. 03 09003 ONCOLOGY CLINIC 0 0 0 0 0 0 91. 00 09100 EMERGENCY 0 0 0 0 0 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 92. 01 OTHER REIMBURSABLE COST CENTERS 95. 00 OSTOR AMBULANCE SERVICES 95. 00	OUTPATIENT SERVICE COST CENTERS						
90. 02 09002 PAIN CLINIC 0 0 0 0 0 0 90. 02 90. 03 09003 0NCOLOGY CLINIC 0 0 0 0 0 0 0 0 90. 03 91. 00 09100 EMERGENCY 0 0 0 0 0 0 0 0 91. 00 92. 00 92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 0 0 0 0 92. 00 09201 0BSERVATION BEDS (DISTINCT PART) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	90. 00 09000 CLINIC	0	0	0	0	0	90.00
90. 03 09003 0NCOLOGY CLINIC 0 0 0 0 90. 03 91. 00 91. 00 92. 00 92. 00 92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 0 92. 00 92. 01 09201 0BSERVATION BEDS (DISTINCT PART) 0 0 0 0 0 92. 01 0THER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95. 00	90.01 09001 SUBSTANCE ABUSE CLINIC	0	0	0	0	0	90. 01
91. 00 09100 EMERGENCY 0 0 0 0 91. 00 92. 00 92. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 0 92. 00 92. 01 09201 OBSERVATION BEDS (DISTINCT PART) 0 0 0 0 0 92. 01 07 07 07 07 07 07 07	90.02 09002 PAIN CLINIC	0	0	0	0	0	90. 02
92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0 0 0 92. 00 92. 01 09201 0BSERVATION BEDS (DISTINCT PART) 0 0 0 0 92. 01 0 0 0 0 0 0 0 0 0	90.03 09003 ONCOLOGY CLINIC	0	0	0	0	0	90. 03
92. 01 09201 0BSERVATION BEDS (DISTINCT PART) 0 0 0 0 92. 01 0THER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95. 00	91. 00 09100 EMERGENCY	0	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95. 00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT	PART) 0		0		0	92.00
95. 00 09500 AMBULANCE SERVICES 95. 00	92.01 09201 OBSERVATION BEDS (DISTINCT PART	0	0	0	0	. 0	92. 01
200.00 Total (lines 50 through 199) 0 0 0 355,448 200.00							
	200.00 Total (lines 50 through 199)	0	0	0	0	355, 448	200. 00

	DALL MEMORIA				6.5. 040.4	
Health Financial Systems	BALL MEMORIA		ON 45 0000 Is		u of Form CMS-2	<u> 2552-10</u>
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY S THROUGH COSTS	ERVICE OTHER P.	ASS Provider C		Period: From 01/01/2020	Worksheet D	
THROUGH COSTS		Component		o 12/31/2020	Date/Time Pre 7/15/2021 12:	epared:
					7/15/2021 12:	59 pm
				ibprovider - IR		
Cost Center Description	All Other	Total Cost	Total	Total Charges		
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
	Education Cost			Part I, col.		
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see	
					instructions)	
ANOLILIADY OF DUT OF CONTROL	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS			1	150 000 (05	0.00000	F0 00
50. 00 05000 OPERATING ROOM	0	0	_	107/200/000		
51. 00 05100 RECOVERY ROOM	0	0	_	,		
52.00 O5200 DELI VERY ROOM & LABOR ROOM 54.00 O5400 RADI OLOGY-DI AGNOSTI C	0			26, 200, 945 246, 299, 807		
57. 00 05700 CT SCAN	0					
58.00 05700 CT SCAN 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)				3, 135, 633	0.00000	
59. 00 05900 CARDI AC CATHETERI ZATI ON				-		
60. 00 1060001 LABORATORY				84, 771, 790		
60. 01 106001 BLOOD LABORATORY				04, 771, 790	0.000000	•
63. 00 06300 BLOOD STORING, PROCESSING, & TRANS.				7, 945, 912		
65. 00 06500 RESPIRATORY THERAPY				28, 875, 744		
65. 01 06501 SLEEP LAB						
66. 00 06600 PHYSI CAL THERAPY				19, 293, 321		
67. 00 06700 OCCUPATI ONAL THERAPY	0		7	7, 124, 866		
68. 00 06800 SPEECH PATHOLOGY	1 0		7	4, 001, 003		
68. 01 06801 AUDI OLOGY	0		ď	0	0. 000000	
69. 00 06900 ELECTROCARDI OLOGY	0	i	ď	52, 857, 178		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	ĺ	d			
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		101, 759, 409		
73.00 07300 DRUGS CHARGED TO PATIENTS	0	355, 448	355, 448			
73.01 07301 HOSPITAL BASED RETAIL PHARMACIES	0	0	C	7, 226, 550		73. 01
74.00 07400 RENAL DIALYSIS	0	0	l c	3, 997, 884	0. 000000	74. 00
76. 00 03160 CARDI OPULMONARY	0	0	C	0	0. 000000	76. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	C	4, 170, 826	0. 000000	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	c			76. 98
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLI NI C	0	0	C	0	0. 000000	
90.01 09001 SUBSTANCE ABUSE CLINIC	0	0				
au us juanus bain ciinic	1	1		6 526 106	0 000000	90 02

227, 804

6, 526, 106

37, 483, 021 214, 448, 979 35, 558, 531

355, 448 1, 635, 452, 517

0

355, 448

90.02

90. 03 91.00

92.00

92.01

95.00

200.00

0.000000

0.000000

0. 000000

0.000000

0.000000

200.00

90. 02 09002 PAIN CLINIC

90. 03 09003 ONCOLOGY CLINIC 91. 00 09100 EMERGENCY

95.00 09500 AMBULANCE SERVICES

92. 00 | 09200 | 0BSERVATION BEDS (NON-DISTINCT PART) 92. 01 | 09201 | 0BSERVATION BEDS (DISTINCT PART)

Total (lines 50 through 199)

OTHER REIMBURSABLE COST CENTERS

Health Financial Systems	BALL MEMORIA				u of Form CMS-2	<u> 2552-10</u>
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY S	ERVICE OTHER PA	ASS Provi der C	CN: 15-0089	Period: From 01/01/2020	Worksheet D	
THROUGH COSTS		Component		To 12/31/2020	Date/Time Pre 7/15/2021 12:	epared:
					7/15/2021 12:	59 pm
	1 0 1 11 1			ıbprovi der - IR		
Cost Center Description	Outpati ent	Inpatient	Inpatient	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.		Costs (col. 8		Costs (col. 9	
	7)		x col . 10)		x col . 12)	
ANOLLI ADV. CEDVI OF COCT. CENTEDO	9. 00	10. 00	11. 00	12. 00	13. 00	
ANCILLARY SERVICE COST CENTERS		24 225	1			
50. 00 05000 OPERATING ROOM	0. 000000	96, 295			0	00.00
51. 00 05100 RECOVERY ROOM	0. 000000	18, 544	h .	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0	`	0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	250, 695		0	0	54.00
57. 00 05700 CT SCAN	0. 000000	14, 380	1	0	0	57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000	0	(0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	0	(0	0	59. 00
60. 00 06000 LABORATORY	0. 000000	416, 885	(0	0	60.00
60. 01 06001 BL00D LABORATORY	0. 000000	0	(0	0	60. 01
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0. 000000	84, 223		0	0	63. 00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	118, 263	(0	0	65.00
65. 01 06501 SLEEP LAB	0. 000000	0	(0	0	65. 01
66. 00 06600 PHYSI CAL THERAPY	0. 000000	2, 053, 261		0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	2, 577, 629	(0	0	67. 00
68.00 06800 SPEECH PATHOLOGY	0. 000000	638, 741	(0	0	68. 00
68. 01 06801 AUDI OLOGY	0. 000000	0	`	0	0	
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	44, 212	(0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	85, 710	(0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000	0	(0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 001001	1, 106, 729	1, 108	3 0	0	73. 00
73.01 07301 HOSPITAL BASED RETAIL PHARMACIES	0. 000000	0	(0	0	73. 01
74.00 07400 RENAL DIALYSIS	0. 000000	126, 567	(0	0	74.00
76.00 03160 CARDI OPULMONARY	0. 000000	0	(0	0	76. 00
76.97 O7697 CARDIAC REHABILITATION	0. 000000	0	(0	0	76. 97
76. 98 07698 HYPERBARIC OXYGEN THERAPY	0. 000000	0	(0	0	76. 98
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0. 000000	0	(0	0	90.00
90. 01 09001 SUBSTANCE ABUSE CLINIC	0. 000000	0	(0	0	90. 01
90. 02 09002 PALN CLINIC	0. 000000	0	(0	0	90. 02
90 03 09003 0NCOLOGY CLINIC	0,000000	0	d c	ol o	ما ا	90 03

0. 000000

0. 000000

0. 000000 0. 000000

1, 108

7, 632, 134

0 91.00

89

89

90.03 0

92.00 0 0 92.01

95. 00 0 200. 00

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

Health Financial Systems	BALL MEMORIAL	HOSPI TAL	In Lieu	u of Form CMS-2	552-10
APPORTI ONMENT OF MEDICAL, OTHER HEALTH	SERVICES AND VACCINE COST	Provi der CCN: 15-0089	Peri od: From 01/01/2020	Worksheet D Part V	
		Component CCN: 15-T089			
		Title XVIII	\$ubprovider - IR	F PPS	
		Charges		Costs	
Cost Center Description	Cost to ChargePP	S Reimbursed Cost	Cost	PPS Services	

					7/15/2021 12:	59 pm
		Title	: XVIII \$u	ıbprovi der - IR		
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
·	Ratio From	Services (see	Rei mbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Servi ces Not	` ,	
	Part I, col. 9	Í	Subject To	Subject To		
	, , , , , , , , , , , , , , , , , , , ,		, ,	Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2. 00	3.00	4.00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0. 109715	0	C	0	0	50.00
51.00 05100 RECOVERY ROOM	0. 166702	0		o	0	•
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 192399	0		0	0	•
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 112236	0	l d	0	0	54.00
57. 00 05700 CT SCAN	0. 071756	0	l d	0	0	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0		0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 070266	0	l c	0	0	•
60. 00 06000 LABORATORY	0. 208246	0	·	o o	0	60.00
60. 01 06001 BLOOD LABORATORY	0. 000000	0	1	o o	0	
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0. 210607	0		o o	0	63. 00
65. 00 06500 RESPIRATORY THERAPY	0. 221473	0	1	o o	0	1
65. 01 06501 SLEEP LAB	0. 144112	0	1	o o	0	65. 01
66. 00 06600 PHYSI CAL THERAPY	0. 394601	0	1		0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 227224	0			0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 244947	0			0	68. 00
68. 01 06801 AUDI OLOGY	0. 000000	0	1		0	68. 01
69. 00 06900 ELECTROCARDI OLOGY	0. 087589	0			0	69. 00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0. 217187	0			0	71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 189167	0			0	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 177112	0		141	0	73. 00
73. 01 07301 HOSPITAL BASED RETAIL PHARMACIES	1. 235998	0			0	73. 00
74. 00 07400 RENAL DI ALYSI S	0. 479076	0		o o	0	74. 00
76. 00 03160 CARDI OPULMONARY	0. 000000	0		o o	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 337346	0	1	S O	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 125572	0		o o	0	1
OUTPATIENT SERVICE COST CENTERS	0. 125572			<u>, </u>	0	70.70
90. 00 09000 CLINIC	0. 000000	0		0	0	90. 00
90. 01 09001 SUBSTANCE ABUSE CLINIC	2. 938731	0	1	o o	0	90. 01
90. 02 09002 PAIN CLINIC	0. 366350	0	Č	o o	0	1
90. 03 09003 ONCOLOGY CLINIC	0. 094085	0		o o	0	
91. 00 09100 EMERGENCY	0. 110116	89			10	(4)
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 203792	0			0	
92. 01 09201 OBSERVATION BEDS (DISTINCT PART)	1. 370564	0	1		0	•
OTHER REIMBURSABLE COST CENTERS	1. 370304			<u>, </u>	0	72.01
95. 00 09500 AMBULANCE SERVICES	0. 000000					95. 00
200.00 Subtotal (see instructions)	0.000000	89		141	10	200.00
201. 00 Less PBP Clinic Lab. Services-Program	,	07				201.00
Only Charges	'			1		_01.00
202.00 Net Charges (line 200 - line 201)		89	c	141	10	202. 00
202. 09 met onarges (11116-201)	1 1	07		1	10	202.00

Health Financial Systems BALL MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provi der CCN: 15-0089 Peri od: Worksheet D From 01/01/2020 Part V Component CCN: 15-T089 12/31/2020 Date/Time Prepared: To 7/15/2021 12:59 pm Title XVIII \$ubprovider - IRF PPS Costs Cost Center Description ost Reimbursed Cost Servi ces Rei mbursed ubject To Ded. Services Not & Coins. (see inst.) Subject To Ded. & Coins (see inst.) 6.00 7.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 51.00 05100 RECOVERY ROOM C 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 0 52.00 54 00 lo5400 RADI OLOGY-DI AGNOSTI C 0 54 00 57.00 05700 CT SCAN C 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 59.00 05900 CARDIAC CATHETERIZATION 0 0 59.00 0 60.00 06000 LABORATORY 0 60.00 60.01 06001 BLOOD LABORATORY 60.01 63.00 06300 BLOOD STORING, PROCESSING, & TRANS. 0000000 63.00 06500 RESPIRATORY THERAPY 65 00 65 00 06501 SLEEP LAB 65.01 0 65.01 66.00 06600 PHYSI CAL THERAPY 66.00 06700 OCCUPATI ONAL THERAPY 67.00 67.00 68 00 06800 SPEECH PATHOLOGY 0 68 00 68.01 06801 AUDI OLOGY 0 68.01 69.00 06900 ELECTROCARDI OLOGY 69.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 72.00 72 00 C 73.00 07300 DRUGS CHARGED TO PATIENTS 25 73.00 07301 HOSPITAL BASED RETAIL PHARMACIES 0 0 73.01 73.01 07400 RENAL DIALYSIS 74.00 0 74.00 03160 CARDI OPULMONARY 76 00 0 0 76.00 76.97 07697 CARDIAC REHABILITATION 76.97 76.98 07698 HYPERBARIC OXYGEN THERAPY 76.98 OUTPATIENT SERVICE COST CENTERS 90.00 90.00 09000 CLINIC 0 C 90.01 09001 SUBSTANCE ABUSE CLINIC 90.01 90.02 09002 PAIN CLINIC 0 0 90.02 90.03 09003 ONCOLOGY CLINIC 90.03 C

C

25

25

91.00

92.00

92.01

95.00

200.00

201. 00

202.00

91.00

92.00

92.01

95.00

200.00

201.00

202.00

09100 EMERGENCY

09200 OBSERVATION BEDS (NON-DISTINCT PART)

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

09201 OBSERVATION BEDS (DISTINCT PART)

Subtotal (see instructions)

OTHER REIMBURSABLE COST CENTERS

09500 AMBULANCE SERVICES

Only Charges

llool +b	Financial Systems PALL MEMORIAL HOSPITAL		la li ou	of Form CM	2 2552 10
	Financial Systems BALL MEMORIAL HOSPITAL FATION OF INPATIENT OPERATING COST Provide	r CCN: 15-0089	Peri od:	of Form CM Worksheet I	
			From 01/01/2020	Date/Time I	
				7/15/2021	12:59 pm
	Cost Center Description	tle XVIII	Hospi tal	PPS	
				1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1. 00	Inpatient days (including private room days and swing-bed days, excl	udi ng newborn)	1	68, 3	69 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and	d newborn days))	68, 3	69 2.00
3. 00	Private room days (excluding swing-bed and observation bed days). If not complete this line.	you have only	pri vate room da	ys, do	0 3.00
4. 00	Semi-private room days (excluding swing-bed and observation bed days	s)		60, 9	83 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days	;) through Decer	mber 31 of the c	ost	0 5.00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private room days	s) after Decembe	er 31 of the cos	t	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 days) reporting period	through Decemb	per 31 of the co	st	0 7.00
8. 00	Total swing-bed NF type inpatient days (including private room days)	after December	r 31 of the cost		0 8.00
0.00	reporting period (if calendar year, enter 0 on this line)				
9. 00	Total inpatient days including private room days applicable to the F newborn days) (see instructions)	'rogram (excludi	ng swing-bed an	d 25, 5	50 9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (in	ncluding private	e room days) thr	ough	0 10.00
11. 00	December 31 of the cost reporting period (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII only (in	actudina nrivat	room days) aft	ar.	0 11.00
11.00	December 31 of the cost reporting period (if calendar year, enter 0	on this line)	e room days) arti	31	0 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only		vate room days)	through	0 12.00
13. 00	December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX only	(including priv	vate room days)	after	0 13.00
	December 31 of the cost reporting period (if calendar year, enter 0	on this line)	-		
	Medically necessary private room days applicable to the Program (exc Total nursery days (title V or XIX only)	:luding swing-be	ed days)		0 14.00 0 15.00
	Nursery days (title V or XIX only)				0 16.00
	SWING BED ADJUSTMENT				17.00
17.00	Medicare rate for swing-bed SNF services applicable to services through period	ough December 3	of the cost re	porting 0.	00 17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to services after	er December 31 d	of the cost repo	rting 0.	00 18. 00
10 00	period Medicaid rate for swing-bed NF services applicable to services through	igh December 31	of the cost ren	ortina 216	05 10 00
17.00	period	igii becember 31	or the cost rep	of tring 210.	73 17.00
20.00	Medicaid rate for swing-bed NF services applicable to services after	December 31 of	f the cost repor	ting 0.	00 20.00
21. 00	period Total general inpatient routine service cost (see instructions)			67, 078, 2	74 21.00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of	of the cost repo	orting period (I	ne 5 x	0 22.00
23 00	line 17) Swing-bed cost applicable to SNF type services after December 31 of	the cost renor	ting period (lin	- 6 x	0 23.00
25.00	line 18)	the cost report	tring period (irin		0 25.00
24. 00	Swing-bed cost applicable to NF type services through December 31 of line 19)	the cost repor	rting period (li	ne 7 x	0 24.00
25. 00	Swing-bed cost applicable to NF type services after December 31 of t	he cost reporti	ng period (line	8 x	0 25.00
	line 20)	•	•		
	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 2	21 minus line 20	5)	67, 078, 2	0 26.00 74 27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			57,070,2	
	General inpatient routine service charges (excluding swing-bed and of	bservation bed	charges)		0 28.00 0 29.00
	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)		ł		0 29.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line	28)		0. 0000	00 31.00
	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)		ļ		00 32.00 00 33.00
	Average per diem private room charge differential (line 32 minus line)	ne 33)(see instr	ructions)		00 33.00
35.00	Average per diem private room cost differential (line 34 x line 31)		·		00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)				0 36.00

	Inpatient days (including private room days, excluding swing-bed and newborn days) Private room days (excluding swing-bed and observation bed days). If you have only private room days	1 6	58, 369	2.00
3. 00	not complete this line.	ys, do	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		50, 983	4.00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the creporting period	pst	0	5.00
6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cos	t	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 days) through December 31 of the co	st	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private room 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 an	d 2	25, 550	9. 00
10.00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) thr December 31 of the cost reporting period (see instructions)	ough	0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) aft December 31 of the cost reporting period (if calendar year, enter 0 on this line)	er	0	11. 00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) December 31 of the cost reporting period	through	0	12. 00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) December 31 of the cost reporting period (if calendar year, enter 0 on this line)	after	0	13. 00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14. 00
	Total nursery days (title V or XIX only)		0	15.00
16. 00	Nursery days (title V or XLX only) SWING BED ADJUSTMENT	<u> </u>	0	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reperiod	porti ng	0. 00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost repo period	rti ng	0. 00	18. 00
19. 00	Medicald rate for swing-bed NF services applicable to services through December 31 of the cost rep period	orting 2	216. 95	19. 00
20. 00	Medicald rate for swing-bed NF services applicable to services after December 31 of the cost repor period	ti ng	0. 00	20. 00
21. 00 22. 00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 17)		78, 274 0	21. 00 22. 00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (lin line 18)	e 6 x	0	23. 00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (li line 19)	ne 7 x	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line line 20)	8 x	0	25. 00
26.00	Total swing-bed cost (see instructions)			26.00
	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	67, 07	78, 274	
	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28. 00
	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)		0	29. 00 30. 00
	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. (000000	
	Average private room per diem charge (line 29 ÷ line 3)			32. 00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0. 00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	1		34.00
	Average per diem private room cost differential (line 34 x line 31)		0. 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 differential (I minus line 36)	ne 27 , 07	78, 274	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY			
00.55	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		204 17	
	Adjusted general inpatient routine service cost per diem (see instructions)	4	981. 12	
	Program general inpatient routine service cost (line 9 x line 38)	25, 06	57, 616	
	Medically necessary private room cost applicable to the Program (line 14 x line 35) Total Program general inpatient routine service cost (line 39 + line 40)	25.0/	0 67, 616	40. 00 41. 00
11.00	Total	20,00	., 510	11.00

CORDITION OF LIMBOTHER OF DEPOLITION COST Provider COX. 15-0009 Portion		Financial Systems	BALL MEMORIA				of Form CMS-	
Cost Center Description	COMPUTA	TION OF INPATIENT OPERATING COST		Provi der CCN	F	rom 01/01/2020	1	
Cost Center Description							7/15/2021 12	epared: :59 pm
Col.		Cost Center Description	otal Inpatien					
1.00			Cost	Inpatient DaysDi			`	
Intensive Care Type Inpatient Hospital Juli 15 10,336,968 10,017 1,630.92 4,201 6,949,500 43,00 MINESTRE CARE UNIT 10,336,968 10,017 1,630.92 4,201 6,949,500 44,00 Sies Color Liver Section 1 4,911,677 3,353 1,464.80 0 47,00 47,00 47,00 47,00 5,000 1,00					3. 00		5. 00	
				0	0.00	0		42.00
45.00 BIRN INTENSIVE CARE UNIT	43. 00 I	NTENSI VE CARE UNI T		1				
## PROMATAL INTERSIVE CARE UNIT			0	O O	0.00	0	(
Cost Center Description			4 011 477	2 252	1 444 04	0		
48.00 Program inpatient ancillary service cost (Wisst. D-3, col. 3, line 200) 39, 661,402 88.00 Post Program inpatient costs (sum of flines 41 through 48) (sue instructions) 71,678,458 49.00 79.00 Fort Program inpatient costs (sum of flines 41 through 48) (sue instructions) 71,678,458 49.00 79	47.00		4, 911, 677	3, 333	1, 404. 80	0		47.00
10.15a Program inpatient costs (sum of lines 41 through 48) (see instructions)	48 00 F	Program inpatient ancillary service cost (Wkst D-3 col	3 Line 200)				2 48 00
Pass through costs applicable to Program inpatient routine services (from West. D. sum of Parts Ind 13 748, 522 50.00	49. 00 1	Total Program inpatient costs (sum of lines			ons)			•
17 17			npatient routir	ne services (fro	m Wkst. D, si	um of Parts I	and 181048,592	50.00
10 10 10 10 10 10 10 10	51.00 F	Pass through costs applicable to Program in	•	,			. , .	•
education costs (il ne 49 minus line 52)	52.00 1	Total Program excludable cost (sum of lines						
TARCET ANDUNT AND LIMIT COMPUTATION 54.00 FORT and discharge 0.00 55.00 Target amount per discharge 0.00 55.00 Target amount per discharge 0.00 55.00 55.00 Target amount per discharge 0.00 55.00 55.00 Target amount (line 54 x line 55) 0.56.00 55.00 Target amount (line 54 x line 55) 0.56.00 55.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 0.50.00 56.0			udi ng capi tal	related, non-ph	ysician anes	thetist, and m	edi c á 6, 870, 632	53.00
55.00 Target amount per discharge 6.00 Target amount (line 54 x line 55) 6.00 Target amount (line 54 x line 55) 6.00 Target amount (line 54 x line 55) 6.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 6.00 Bolls payment (see instructions) 6.00 Lesser of Ilnes 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by he market basket 6.00 Lesser of Ilnes 53/54 or 55 from prior year cost report, updated by the market basket 6.00 Inches 53/54 is less than the lower of Ilnes 55,50 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56) otherwise enter zero (see instructions) 6.20 Rel left payment (see instructions) 6.20 Melief payment (see instructions) 6.30 Allowable Inpatient cost plus incentive payment (see instructions) 6.40 Medicare swin q-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (Ititle XVIII only) 6.50 Medicare swin q-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH 6.70 Total Medicare swin q-bed NF inpatient routine costs through December 31 of the cost reporting period (See instructions) 6.70 Total Medicare swin q-bed NF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH 6.70 Total Medicare swin q-bed NF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH 6.70 Total Medicare swing-bed NF inpatient routine costs (line 67 + line 68) 6.70 Total field oursing facility/other nursing facility/other program (line 14 x line 35) 6.70 Total field oursing facility/other nursing facility/	Т	ARGET AMOUNT AND LIMIT COMPUTATION						
56.00 Target amount (line 54 x line 55) 57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 58.00 Bonus payment (see Instructions) 59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by market basket 60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 61.00 Lesser of lines 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see Instructions) 62.00 Relief payment (see instructions) 63.00 Allowable Inpatient cost plus incentive payment (see instructions) 64.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See Instructions) (rine 40 x 10 x 10 x 10 x 10 x 10 x 10 x 10 x		3						
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76.00 77.00 77.00 78.00 79.00 Regregate charges to beneficiaries for excess costs (from provider records) 79.00 81.00 1 Inpatient routine service cost (line 74 minus line 77) 80.00 1 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 82.00 1 Inpatient routine service cost per diem limitation 82.00 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 85.00 86.00 1 Total Program inpatient operating costs (see instructions) 87.00 88.00 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 76.00 77.00 78.00 78.00 79.00 80.00 79.00 80			t routine servi	ce costs (from	Worksheet B,	Part II, colu	mn 26,	
78.00 Inpatient routine service cost (line 74 minus line 77) 78.00 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 80.00 81.00 Inpatient routine service cost per diem limitation 81.00 82.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 83.00 Reasonable inpatient routine service costs (see instructions) 83.00 84.00 Program inpatient ancillary services (see instructions) 84.00 Utilization review - physician compensation (see instructions) 85.00 Total Program inpatient operating costs (sum of lines 83 through 85) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 7,386 87.00 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 981.12 88.00		·	ine 2)					76. 00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Reasonable inpatient routine service costs (see instructions) 79.00 Reasonable inpatient routine services (see instructions) 79.00 Reasonable inpatient routine service cost (see instructions) 81.00 Reasonable inpatient routine services (see instructions) 82.00 Reasonable inpatient routine services (see instructions) 83.00 Reasonable inpatient ancillary services (see instructions) 84.00 Program inpatient encorpation (see instructions) 85.00 Total Program inpatient operating costs (sum of lines 83 through 85) 87.00 Reasonable inpatient operating costs (sum of lines 83 through 85) 87.00 Reasonable inpatient operating costs (sum of lines 83 through 85) 87.00 Reasonable inpatient operating costs (sum of lines 83 through 85) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Reasonable inpatient routine service costs (see instructions) 89.00 Reasonable inpatient routine service cost (see instructions) 80.00 Reasonable inpatient routine service cost (see instructions) 81.00 Reasonable inpatient routine service cost (see instructions) 82.00 Reasonable inpatient routine service cost (see instructions) 84.00 Reasonable inpatient routine service cost (see instructions) 85.00 Reasonable inpatient routine service cost (see instructions) 86.00 Reasonable inpatient routine service cost (see instructions) 87.00 Reasonable inpatient routine service cost (see instructions) 88.00 Reasonable inpatient routine service cost (see instructions) 89.00 Reasonable inpatient routine service cost (see		9 ,						
81.00 Inpatient routine service cost per diem limitation 81.00 82.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 83.00 Reasonable inpatient routine service costs (see instructions) 83.00 Program inpatient ancillary services (see instructions) 84.00 85.00 Utilization review - physician compensation (see instructions) 85.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 7,386 87.00 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 981.12 88.00	79. 00 A	Aggregate charges to beneficiaries for exce	ess costs (from	•				79. 00
82.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 83.00 Reasonable inpatient routine service costs (see instructions) 83.00 Program inpatient ancillary services (see instructions) 84.00 85.00 Itization review - physician compensation (see instructions) 85.00 Total Program inpatient operating costs (sum of lines 83 through 85) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 7,386 87.00 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 981.12 88.00		•	•	e cost limitatio	n (line 78 mi	nus line 79)		•
84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 85.00 Total Program inpatient operating costs (sum of lines 83 through 85) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Results of the program inpatient operation operation of the program inpatient operation of the program inpatient operation operation of the program inpatient operation operati	82. 00 I	npatient routine service cost limitation	(line 9 x line					82. 00
85.00 Utilization review - physician compensation (see instructions) 85.00 Total Program inpatient operating costs (sum of lines 83 through 85) 87.00 Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 87.00 Results (sum of lines 83 through 85) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Results (sum of lines 83 through 85) 89.00 Results (sum of lin				UHS)				•
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 981.12 88.00	85. 00 L	Jtilization review - physician compensation	n (see instruct					1
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 981.12 88.00	P	ART IV - COMPUTATION OF OBSERVATION BED PA	SS THROUGH COS					
				/ ÷ line 2)				1
								1

Health Financial Systems	BALL MEMORIA	L HOSPITAL		In Lieu	of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der Co		Peri od:	Worksheet D-1	
				From 01/01/2020 To 12/31/2020	Date/Time Pre 7/15/2021 12:	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capi tal -related cost	6, 847, 341	67, 078, 274	0. 10208	0 7, 246, 552	739, 728	90.00
91.00 Nursing School cost	0	67, 078, 274	0. 00000	0 7, 246, 552	0	91.00
92.00 Allied health cost	0	67, 078, 274	0. 00000	0 7, 246, 552	0	92.00
93.00 All other Medical Education	0	67, 078, 274	0. 00000	0 7, 246, 552	0	93. 00

Health Financial Systems	BALL MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0089	Peri od: Worksheet D-1
	Component CCN: 15-T089	To 12/31/2020 Date/Time Prepared: 7/15/2021 12:59 pm
	Title XVIII	Subprovider - IRF PPS

		Title XVIII	 \$ubprovider - IR	7/15/2021 RF P	1 12: PS	59 pm
	Cost Center Description	THE WITH	pubpi ovi dei - i i			
	DADT I ALL DOOM DED COMPONENTS			1. 00		
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days			4	, 489	1. 00
2.00	Inpatient days (including private room days, excluding swing				, 489	2.00
3. 00	Private room days (excluding swing-bed and observation bed on not complete this line.	days). If you have only	private room da	ys, do	0	3. 00
4. 00	Semi-private room days (excluding swing-bed and observation	bed days)		4	, 489	4. 00
5.00	Total swing-bed SNF type inpatient days (including private m		mber 31 of the c		0	5. 00
	reporting period			L		
6. 00	Total swing-bed SNF type inpatient days (including private reporting period (if calendar year, enter 0 on this line)	room days) after Decemb	er 31 of the cos	t	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private ro	oom days) through Decem	ber 31 of the co	st	0	7. 00
	reporting period	3 ,				
8. 00	Total swing-bed NF type inpatient days (including private ro	oom days) after Decembe	r 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 (exclud	ing swing-bed an	Н 2	, 829	9. 00
7. 00	newborn days) (see instructions)	to the frogram (exerua	ing swing bed di		, 02 /	7. 00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII	only (including private	e room days) thr	bugh	0	10. 00
11 00	December 31 of the cost reporting period (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII	anly (including privat	a room dova) aft		0	11. 00
11.00	December 31 of the cost reporting period (if calendar year,	enter 0 on this line)	e room days) art	ei	U	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or)		vate room days)	through	0	12. 00
	December 31 of the cost reporting period					
13.00	Swing-bed NF type inpatient days applicable to titles V or December 31 of the cost reporting period (if calendar year,		vate room days)	after	0	13. 00
14.00	Medically necessary private room days applicable to the Proc		ed davs)		0	14. 00
	Total nursery days (title V or XIX only)	y (1	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 servi	ces through December 3	1 of the cost re	borting	0.00	17. 00
17.00	period	ces through becember 5	i or the cost re	por tring	3. 00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to servi	ces after December 31	of the cost repo	rting	0. 00	18. 00
10.00	period	and there was December 21	a£ +ba aaa+ waw	1	, or	10.00
19.00	Medicaid rate for swing-bed NF services applicable to service period	ces through becember 31	of the cost rep	pring 21	5. 95	19.00
20.00	Medicaid rate for swing-bed NF services applicable to service	ces after December 31 o	f the cost repor	ting	0. 00	20. 00
	peri od					
	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through December 1.		orting ported (21. 00 22. 00
22.00	line 17)	liber 31 of the cost rep	or tring period (i	The 5 X	U	22.00
23.00	Swing-bed cost applicable to SNF type services after December	er 31 of the cost repor	ting period (lin	e 6 x	0	23. 00
04.00	line 18)	01 -6 -11	attana analah 711			04.00
24.00	Swing-bed cost applicable to NF type services through Decembline 19)	per 31 of the cost repo	rting period (ii	ne / x	0	24. 00
25.00	Swing-bed cost applicable to NF type services after December	31 of the cost report	ing period (line	8 x	0	25. 00
	line 20)					
	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	t (lino 21 minus lino 2	4)	1 260		26. 00 27. 00
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	L (TITIE ZI IIIIIUS TITIE Z	<i></i>	4, 209	, 509	21.00
	General inpatient routine service charges (excluding swing-	oed and observation bed	charges)		0	28. 00
	Pri vate room charges (excluding swing-bed charges)				0	
30.00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 2)	7 ÷ line 28)		0.00	0	30. 00 31. 00
32.00	Average private room per diem charge (line 29 ÷ line 3)	7 + 11116 20)		1	0. 00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4))		1		33. 00
	Average per diem private room charge differential (line 32 m		ructions)	1		34.00
	Average per diem private room cost differential (line 34 x l Private room cost differential adjustment (line 3 x line 35)			· '	0.00	35. 00 36. 00
	General inpatient routine service cost net of swing-bed cost		differential (I	ne 24, 269	-	
	minus line 36)			<u> </u>		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	LUCTMENTS				
38 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD Adjusted general inpatient routine service cost per diem (se			95	1, 12	38. 00
39.00	Program general inpatient routine service cost (line 9 x lir	ne 38)		1		39. 00
	Medically necessary private room cost applicable to the Prod)			40.00
41.00	Total Program general inpatient routine service cost (line 3	39 + IINE 4U)		1 2, 690	, /18	41. 00

Heal th	Financial Systems	BALL MEMORIA	AL HOSPITAL		In Lieu	ı of Form CMS	-2552-10
	TATION OF INPATIENT OPERATING COST				eriod: rom 01/01/2020	Worksheet D	
			Component	CCN: 15-T089		Date/Time P 7/15/2021 1	repared: 2:59 pm
	Cost Center Description	otal Inpatien			provider - IR Program Days		
	cost center bescription	Cost		Diem (col. 1 ÷	11 Ogi alli Days	(col. 3 x col	
		1.00	2.00	col . 2) 3.00	4. 00	4) 5. 00	
42.00	NURSERY (title V & XIX only)	C			0		0 42.00
43. 00	Intensive Care Type Inpatient Hospital Unit INTENSIVE CARE UNIT			0.00	0		0 43.00
	CORONARY CARE UNIT	C	C	0.00	0		0 44.00
	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT		1				45. 00 46. 00
47. 00	NEONATAL INTENSIVE CARE UNIT Cost Center Description	C		0.00	0		0 47.00
	·					1. 00	
	Program inpatient ancillary service cost (V Total Program inpatient costs (sum of lines					2, 005, 08 4, 695, 80	
	PASS THROUGH COST ADJUSTMENTS	v	,	ĺ			
50. 00 51. 00	Pass through costs applicable to Program in Pass through costs applicable to Program in					and III2)57,18 II and 113.05	
F2 00	IV)	. 50 and 51)	,			270 24	1 52 00
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost excl		related, non-	physician anest	hetist, and m	370, 24 edi ca 4 , 325, 56	
	education costs (line 49 minus line 52) TARGET AMOUNT AND LIMIT COMPUTATION			· -			-
	Program di scharges						0 54.00
	Target amount per discharge Target amount (line 54 x line 55)						0 55.00 0 56.00
57.00	Difference between adjusted inpatient opera	ating cost and	target amount	(line 56 minus	s line 53)		0 57.00
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost r	reporting perio	nd ending 1996	undated and o	compounded by		0 58.00 0 59.00
	market basket		· ·				
	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of lir					0.0 y which	0 60.00 0 61.00
	operating costs (line 53) are less than exp	ected costs (I					
62.00	56), otherwise enter zero (see instructions Relief payment (see instructions)	s)					0 62.00
63. 00	63.00 Allowable Inpatient cost plus incentive payment (see instructions) PROGRAM INPATIENT ROUTINE SWING BED COST						
64. 00	Medicare swing-bed SNF inpatient routine co	sts through De	ecember 31 of	the cost report	ing period (S	ee	0 64. 00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine co</pre>	osts after Dece	ember 31 of th	e cost reportir	ng period (See		0 65.00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient rout	ine costs (lir	ne 64 nlus lin	a 65) (titla XVI	II only) For	CVH	0 66.00
	(see instructions)	•	·	, ,	3,		
67. 00	Title V or XIX swing-bed NF inpatient routi 12 x line 19)	ne costs throu	ugh December 3	1 of the cost i	reporting peri	bd (line	0 67.00
68. 00	Title V or XIX swing-bed NF inpatient routi 13 x line 20)	ne costs after	December 31	of the cost rep	orting period	(line	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 Skilled nursing facility/other nursing faci				")		70. 00
71.00	Adjusted general inpatient routine service	cost per diem		,			71. 00
	Program routine service cost (line 9 x line Medically necessary private room cost appli		am (line 14 x	line 35)			72. 00 73. 00
	Total Program general inpatient routine ser Capital-related cost allocated to inpatient				Dort II oolu	nn 24	74. 00
75.00	line 45)	. Toutine servi	ce costs (110	iii woi ksheet b,	Part II, Coru	III1 20,	75. 00
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ 1 Program capital-related costs (line 9 x lir						76. 00 77. 00
78.00	Inpatient routine service cost (line 74 mir	nus line 77)					78. 00
	Aggregate charges to beneficiaries for excellational Program routine service costs for con	•	•	•	nus line 79)		79. 00 80. 00
81.00	Inpatient routine service cost per diem lim	ni tati on			,		81. 00
	Inpatient routine service cost limitation (Reasonable inpatient routine service costs	•					82. 00 83. 00
84.00	Program inpatient ancillary services (see i	nstructions)	ŕ				84. 00
	Utilization review - physician compensation Total Program inpatient operating costs (su						85. 00 86. 00
	PART IV - COMPUTATION OF OBSERVATION BED PA	SS THROUGH COS					
	Total observation bed days (see instruction Adjusted general inpatient routine cost per	diem (line 27					0 87.00 0 88.00
89. 00	Observation bed cost (line 87 x line 88) (s	see instruction	ns)				0 89. 00

Health Financial Systems	BALL MEMORIA	L HOSPITAL		In Lieu	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der C	CN: 15-0089	Peri od:	Worksheet D-1	
		'	CCN: 15-T089	From 01/01/2020 Fo 12/31/2020	Date/Time Pre 7/15/2021 12:	
		Title	XVIII \$t	ubprovider - IR	F 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 Capi tal -related cost	408, 080	4, 269, 569	0. 095579	9 0	0	90.00
91.00 Nursing School cost	0	4, 269, 569	0. 000000	0	0	91. 00
92.00 Allied health cost	0	4, 269, 569	0. 000000	0	0	92.00
93.00 All other Medical Education	0	4, 269, 569	0. 000000	0	0	93. 00

Heal th	Financial Systems BALL MEMORIAL	HOSPI TAI	In lieu	ı of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0089	Peri od: From 01/01/2020	Worksheet D-1 Date/Time Pre	1 epared:
		Title XIX	Hospi tal	7/15/2021 12: Cost	59 pm
	Cost Center Description	THE ALA	nospi tai		
	DART L ALL PROVERED COMPONENTS			1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				1
1. 00 2. 00 3. 00	Inpatient days (including private room days and swing-bed of Inpatient days (including private room days, excluding swir Private room days (excluding swing-bed and observation bed	ng-bed and newborn days)		68, 369 68, 369 ys, do 0	2. 00
4. 00 5. 00	not complete this line. Semi-private room days (excluding swing-bed and observatior Total swing-bed SNF type inpatient days (including private		nber 31 of the c	60, 983 ost 0	
6. 00	reporting period Total swing-bed SNF type inpatient days (including private reporting period (if calendar year, enter 0 on this line)	room days) after December	er 31 of the cos	t 0	6. 00
7. 00	Total swing-bear NF type inpatient days (including private r reporting period	room days) through Decemb	oer 31 of the co	st 0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private reporting period (if calendar year, enter 0 on this line)	•		0	
9. 00 10. 00	Total inpatient days including private room days applicable newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII	_			
	December 31 of the cost reporting period (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII	only (including private	,	· ·	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, Swing-bed NF type inpatient days applicable to titles V or December 31 of the cost reporting period		vate room days)	through 0	12. 00
	Swing-bed NF type inpatient days applicable to titles V or December 31 of the cost reporting period (if calendar year,	enter 0 on this line)	• •	after 0	13. 00
15.00	Medically necessary private room days applicable to the Pro Total nursery days (title V or XIX only)	ogram (excluding swing-be	ed days)		15. 00
16.00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT		l l	1,412	16. 00
	Medicare rate for swing-bed SNF services applicable to serveriod	G		Ü	17. 00
	Medicare rate for swing-bed SNF services applicable to services of period Medicaid rate for swing-bed NF services applicable to services.		·	3	18.00
	period Medicaid rate for swing-bed NF services applicable to servi	9	`	Ü	20. 00
21. 00	period Total general inpatient routine service cost (see instructi			67, 078, 274	
22. 00	Swing-bed cost applicable to SNF type services through Dece line 17) Swing-bed cost applicable to SNF type services after Decemb	·	` '		22. 00
	Line 18) Swing-bed cost applicable to NF type services through December 18				
25. 00	line 19) Swing-bed cost applicable to NF type services after December	er 31 of the cost reporti	ng period (line	8 x 0	25. 00
26. 00 27. 00	line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cos	st (line 21 minus line 26	5)	0 67, 078, 274	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
	General inpatient routine service charges (excluding swing- Private room charges (excluding swing-bed charges)	bed and observation bed	charges)	0	
30.00	Semi-private room charges (excluding swing-bed charges)		İ	0	30. 00
	General inpatient routine service cost/charge ratio (line 2	27 ÷ line 28)	ļ	0. 000000	
	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4	1)	ļ		32. 00 33. 00
	Average per diem private room charge differential (line 32		ructions)		34.00
35.00	Average per diem private room cost differential (line 34 x Private room cost differential adjustment (line 3 x line 35	line 31)	ŕ	0. 00	35. 00 36. 00
30 UU	ren vare room cost orrierentral adrustment (1996 3 × 1984 3º	1 /	I	()	יוט טכ.

Heal th	Financial Systems BALL MEMORIAL HOSPITAL In Lieu	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST Provider CCN: 15-0089 Period: From 01/01/2020	Worksheet D-1	1
		Date/Time Pre 7/15/2021 12:	pared: 59 pm
	Cost Center Description Total Inpatient Total Average Per Program Days	Program Cost	
	Cost npatient DaysDiem (col. 1 ÷	(col. 3 x col.	
	1.00 2.00 3.00 4.00	4) 5. 00	
42. 00	NURSERY (title V & XIX only) 1,081,844 2,017 536.36 1,412 Intensive Care Type Inpatient Hospital Units	757, 340	42. 00
	INTENSI VE CARE UNIT 16, 336, 968 10, 017 1, 630. 92 737	1, 201, 988	•
	CORONARY CARE UNIT 0 0 0.00 0 BURN INTENSIVE CARE UNIT	0	44. 00 45. 00
46.00	SURGICAL INTENSIVE CARE UNIT	574 005	46. 00
47.00	NEONATAL INTENSIVE CARE UNIT	574, 225	47.00
49, 00		1.00	40,00
	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200) Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1, 884, 720 6, 372, 664	•
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I	and III) 0	50.00
	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts		
52. 00	IV) Total Program excludable cost (sum of lines 50 and 51)	0	52. 00
	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and m	_	53. 00
	education costs (line 49 minus line 52) TARGET AMOUNT AND LIMIT COMPUTATION		
	Program di scharges	0	
	Target amount per discharge Target amount (line 54 x line 55)	0.00	1
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	
	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by	the 0.00	00.00
60. 00	market basket Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount b	y which 0	
	operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount 56), otherwise enter zero (see instructions)	(line	
	Relief payment (see instructions)	0	
63.00	Allowable Inpatient cost plus incentive payment (see instructions) PROGRAM INPATIENT ROUTINE SWING BED COST	0	63. 00
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (Sinstructions)(title XVIII only)	ee 0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See	0	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For	CAH 0	66. 00
	(see instructions) Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting peri		67. 00
67.00	12 x line 19)	ba (Title 0	67.00
68. 00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period 13 x line 20)	(line 0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70. 00
	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) Program routine service cost (line 9 x line 71)		71. 00 72. 00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73. 00
	Total Program general inpatient routine service costs (line 72 + line 73) Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, colu	mn 26.	74. 00 75. 00
	line 45)	,	
	Per diem capital-related costs (line 75 ÷ line 2) Program capital-related costs (line 9 x line 76)		76. 00 77. 00
	Inpatient routine service cost (line 74 minus line 77)		78. 00 79. 00
	Aggregate charges to beneficiaries for excess costs (from provider records) Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
	Inpatient routine service cost per diem limitation Inpatient routine service cost limitation (line 9 x line 81)		81. 00 82. 00
83.00	Reasonable inpatient routine service costs (see instructions)		83. 00
	Program inpatient ancillary services (see instructions) Utilization review - physician compensation (see instructions)		84. 00 85. 00
	Total Program inpatient operating costs (sum of lines 83 through 85)		86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions)	7, 386	87. 00
88. 00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	981. 12	88. 00
87.00	Observation bed cost (line 87 x line 88) (see instructions)	7, 246, 552	I αλ. 00

Health Financial Systems	BALL MEMORIA	L HOSPITAL		In Lieu	of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der Co		Peri od:	Worksheet D-1	
				From 01/01/2020 To 12/31/2020	Date/Time Pre 7/15/2021 12:	
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capi tal -related cost	6, 847, 341	67, 078, 274	0. 10208	0 7, 246, 552	739, 728	90.00
91.00 Nursing School cost	0	67, 078, 274	0. 00000	0 7, 246, 552	0	91.00
92.00 Allied health cost	0	67, 078, 274	0. 00000	0 7, 246, 552	0	92.00
93.00 All other Medical Education	0	67, 078, 274	0. 00000	7, 246, 552	0	93. 00

Health Financial Systems	BALL MEMORIAL HOSPITAL	In Lieu (of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0089	Peri od: \\From \01/01/2020	Worksheet D-1
	Component CCN: 15-T089	To 12/31/2020 [Date/Time Prepared: 7/15/2021 12:59 pm
	Title XIX	\$ubprovider - IRF	Cost

		Component CCN. 15-1089	12/31/2020	7/15/2021 12				
		Title XIX	\$ubprovider - IR					
	Cost Center Description							
				1.00				
	PART I - ALL PROVIDER COMPONENTS							
4 00	I NPATI ENT DAYS				1 00			
1.00	Inpatient days (including private room days and swing-bed days		`	4, 489				
2.00	Inpatient days (including private room days, excluding swing			4, 489	•			
3. 00	Private room days (excluding swing-bed and observation bed	days). II you have only	private room da	lys, do C	3.00			
4. 00	not complete this line. Semi-private room days (excluding swing-bed and observation	had days)		4, 489	4.00			
5. 00			mbor 21 of the c					
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cbst 0 reporting period							
6. 00	Total swing-bed SNF type inpatient days (including private	room days) after Decemb	er 31 of the cos	t c	6.00			
0.00	reporting period (if calendar year, enter 0 on this line)	dom days) arter becemb	er or the cos		0.00			
7. 00	Total swing-bed NF type inpatient days (including private re	oom days) through Decem	ber 31 of the co	st C	7.00			
	reporting period	y-,g						
8.00	Total swing-bed NF type inpatient days (including private re	oom days) after Decembe	r 31 of the cost	ď	8.00			
	reporting period (if calendar year, enter 0 on this line)	3 /						
9.00	Total inpatient days including private room days applicable	to the Program (exclud	ing swing-bed an	d c	9.00			
	newborn days) (see instructions)							
10.00	Swing-bed SNF type inpatient days applicable to title XVIII	only (including private	e room days) thr	bugh C	10.00			
	December 31 of the cost reporting period (see instructions)							
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII		e room days) aft	er C	11. 00			
	December 31 of the cost reporting period (if calendar year,							
12. 00	Swing-bed NF type inpatient days applicable to titles V or X	KIX only (including pri	vate room days)	through C	12. 00			
	December 31 of the cost reporting period							
13.00	Swing-bed NF type inpatient days applicable to titles V or X		vate room days)	after C	13. 00			
14 00	December 31 of the cost reporting period (if calendar year,		- d - d \		14 00			
	Medically necessary private room days applicable to the Programme days (title V and VIV and VIV)	gram (excluding swing-b	ed days)	2 017				
	Total nursery days (title V or XIX only)				15.00			
16.00	Nursery days (title V or XLX only) SWING BED ADJUSTMENT			1,412	16. 00			
17 00	Medicare rate for swing-bed SNF services applicable to servi	cos through Docombor 2	1 of the cost re	borting 0.00	17. 00			
17.00	period	ces through becember 5	i or the cost re	por tring 0.00	17.00			
18 00	Medicare rate for swing-bed SNF services applicable to servi	ces after December 31	of the cost repo	rtina 0.00	18. 00			
	peri od	oce area pecamber or	oo ooot .opo	19	10.00			
19.00	Medicaid rate for swing-bed NF services applicable to servi	ces through December 31	of the cost rep	orting 216.95	19.00			
	peri od	· ·	·					
20.00	Medicaid rate for swing-bed NF services applicable to servi	ces after December 31 o	f the cost repor	ting 0.00	20.00			
	peri od							
	Total general inpatient routine service cost (see instruction			4, 269, 569				
22. 00	Swing-bed cost applicable to SNF type services through Dece	mber 31 of the cost rep	orting period (I	ne 5 x C	22. 00			
	line 17)							
23. 00	Swing-bed cost applicable to SNF type services after December	er 31 of the cost repor	ting period (lin	le 6 x C	23. 00			
04.00	line 18)	21 .C th			04 00			
24.00	Swing-bed cost applicable to NF type services through December 100	per 31 of the cost repo	rting perioa (ii	ne / x	24. 00			
25 00	line 19)	c 21 of the cost report	ing ported (Line		25 00			
25.00	Swing-bed cost applicable to NF type services after December line 20)	31 of the cost report	ing period (iffie	10 x	25. 00			
26 00	Total swing-bed cost (see instructions)			_	26. 00			
	General inpatient routine service cost net of swing-bed cos	t (line 21 minus line 2	6)	4, 269, 569				
_,.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	21	-,	.,207,007	1 55			
28. 00	General inpatient routine service charges (excluding swing-	oed and observation bed	charges)	C	28. 00			
	Private room charges (excluding swing-bed charges)		3 /		10			
	Semi-private room charges (excluding swing-bed charges)			j	•			
	General inpatient routine service cost/charge ratio (line 2	7 ÷ line 28)		0. 000000				
	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.00			
	Average semi-private room per diem charge (line 30 ÷ line 4)				33. 00			
	Average per diem private room charge differential (line 32 m		ructions)	1	34.00			
35.00	Average per diem private room cost differential (line 34 x	ine 31)		0. 00	•			
	Private room cost differential adjustment (line 3 x line 35)			C				
37. 00	General inpatient routine service cost net of swing-bed cos	t and private room cost	differential (I	ne 24, 269, 569	37. 00			
	minus line 36)				4			
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	LUCTMENTS			+			
30 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AN			051 10	20 00			
	Adjusted general inpatient routine service cost per diem (so			951. 12 0	38.00			
	Program general inpatient routine service cost (line 9 x limedically necessary private room cost applicable to the Program)		•			
	Total Program general inpatient routine service cost (line 3		,		41.00			
- 1.00	Trotal Trogram general impatrent routine service cost (ITHE	5, , IIIIC 1 0)		1	1 -1.00			

Heal th	Financial Systems	BALL MEMORIA	AL HOSPITAL		In Lieu	of Form C	MS-25	552-10
	ATION OF INPATIENT OPERATING COST				eriod: rom 01/01/2020	Worksheet		
			Componen		o 12/31/2020	Date/Time 7/15/2021		
					bprovider - IRF	Co	st	D9 DIII
	Cost Center Description	otal Inpatien Cost		Average Per ysDiem (col. 1 ÷		Program Co col. 3 x c		
				col. 2)	Ì	4)	.01 .	
42.00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5. 00		42. 00
	Intensive Care Type Inpatient Hospital Unit			0, 00	O ₁		0	42.00
	INTENSIVE CARE UNIT CORONARY CARE UNIT	0	1	0.00	0			43. 00 44. 00
	BURN INTENSIVE CARE UNIT		1	0.00	٥			45. 00
	SURGICAL INTENSIVE CARE UNIT	0		0 0.00	0			46. 00 47. 00
47.00	NEONATAL INTENSIVE CARE UNIT Cost Center Description		'1	0, 00	U			47.00
49.00	Program inpatient ancillary service cost (W	lkst D 2 col	2 Line 200	1)		1. 00		48. 00
	Total Program inpatient costs (sum of lines							49. 00
FO 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program in	notiont routin	as sorul oss (from Wkot D. o.	m of Dorto I b	nd III)	0	FO 00
	Pass through costs applicable to Program in					nd III) I and	- 1	50. 00 51. 00
F0 00	IV)	. 50 (51)						F0 00
	Total Program excludable cost (sum of lines Total Program inpatient operating cost excl		related, nor	n-physician anes	thetist, and me	di cal		52. 00 53. 00
	education costs (line 49 minus line 52)							
54.00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges				I		0	54. 00
	Target amount per discharge					C		55. 00
	Target amount (line 54 x line 55) Difference between adjusted inpatient opera	iting cost and	target amour	nt (line 56 minu	s line 53)			56. 00 57. 00
58.00	Bonus payment (see instructions)	· ·	o .	•			- 1	58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost r market basket	eporting perio	od ending 199	6, updated and	compounded by t	ne 0). 00	59. 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 lir operating costs (line 53) are less than exp						0	61. 00
40.00	56), otherwise enter zero (see instructions	5)				•		(0.00
	Relief payment (see instructions) Allowable Inpatient cost plus incentive pay	ment (see inst	tructions)					62. 00 63. 00
	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine co	ata theatimh Da			*!	_		(4.00
64. 00	instructions)(title XVIII only)	ists through be	ecember 31 01	the cost repor	tring period (se	е	ا	64. 00
65.00	Medicare swing-bed SNF inpatient routine coinstructions)(title XVIII only)	sts after Dece	ember 31 of t	he cost reporti	ng period (See		0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient rout	ine costs (lir	ne 64 plus li	ne 65)(title XV	III only). For	CAH	0	66. 00
67. 00	(see instructions) Title V or XIX swing-bed NF inpatient routi	no costo throu	iah Dooombor	21 of the cost	ronorting norih	d (line		67. 00
67.00	12 x line 19)	THE COSTS THEOL	agri becember	31 Of the Cost	reporting perio	u (IIIIe	ď	67.00
68. 00	Title V or XIX swing-bed NF inpatient routi 13 x line 20)	ne costs after	December 31	of the cost re	porting period	(line	0	68. 00
69.00	Total title V or XIX swing-bed NF inpatient	routine costs	s (line 67 +	line 68)			0	69. 00
	PART III - SKILLED NURSING FACILITY, OTHER Skilled nursing facility/other nursing faci				7)			70. 00
71.00	Adjusted general inpatient routine service	cost per diem		•	,,			71. 00
	Program routine service cost (line 9 x line Medically necessary private room cost appli		cam (lino 14	v lino 35)				72. 00 73. 00
	Total Program general inpatient routine ser						1	74.00
75. 00	Capital-related cost allocated to inpatient line 45)	routine servi	ce costs (fr	om Worksheet B,	Part II, colum	n 26,		75. 00
76.00	Per diem capital-related costs (line 75 ÷ l	ine 2)						76. 00
	Program capital-related costs (line 9 x lir Inpatient routine service cost (line 74 mir							77. 00 78. 00
	Aggregate charges to beneficiaries for exce	,	m provider re	ecords)				79. 00
	Total Program routine service costs for com Inpatient routine service cost per diem lim	•	e cost limita	ition (line 78 m	inus line 79)			80. 00 81. 00
	Inpatient routine service cost per drem in Inpatient routine service cost limitation (81)					82. 00
	Reasonable inpatient routine service costs	•	ons)					83. 00 84. 00
	Program inpatient ancillary services (see i Utilization review - physician compensation		tions)					85.00
	Total Program inpatient operating costs (su	m of lines 83	through 85)		1			86. 00
87. 00	<u>PART IV - COMPUTATION OF OBSERVATION BED PA</u> Total observation bed days (see instruction)		1		0	87. 00
88.00	Adjusted general inpatient routine cost per	diem (line 27	,		1	C	0. 00	88. 00
89.00	Observation bed cost (line 87 x line 88) (s	ee instructior	15)		ı		υĮ	89. 00

Health Financial Systems	BALL MEMORIA	L HOSPITAL		In Lieu	of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der Co	CN: 15-0089	Peri od:	Worksheet D-1	
		Component		From 01/01/2020 To 12/31/2020		
		Titl	e XIX 💲 \$ι	ıbprovi der - IR	₱ Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1. 00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	408, 080	4, 269, 569	0. 095579	0	0	90.00
91.00 Nursing School cost	0	4, 269, 569	0. 000000	0	0	91. 00
92.00 Allied health cost	0	4, 269, 569	0. 000000	0	0	92.00
93.00 All other Medical Education	0	4, 269, 569	0. 000000	0	0	93. 00

Health Financial Systems BALL MEMORIAL HOSPI	IAL		In Lie	u of Form CMS-2	<u> 2552-10</u>
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT Pro	vider C	CN: 15-0089	Period: Worksheet D- From 01/01/2020		3
			To 12/31/2020	Date/Time Pre	epared:
	Ti +l c	xVIII	Hospi tal	7/15/2021 12: PPS	59 pm
Cost Center Description	11 (1)	Ratio of Cos		Inpati ent	·
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
INDATIENT DOUTINE SERVICE COST SENTERS		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS 30. 00 03000 ADULTS & PEDIATRICS		l	72, 157, 773	İ	30.00
31. 00 03100 NTENSI VE CARE UNIT			26, 366, 996		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 - 1 PF			0		40. 00
41. 00 04100 SUBPROVI DER - RF			0		41.00
43. 00 O4300 NURSERY					43. 00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM		0. 10971	15 36, 601, 531	4, 015, 737	50.00
51. 00 05100 RECOVERY ROOM		0. 16670		575, 663	
52. OO O5200 DELI VERY ROOM & LABOR ROOM		0. 19239			
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 11223			•
57. 00 05700 CT SCAN		0. 07175	766, 646	55, 011	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 00000		0	
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 07026			
60. 00 06000 LABORATORY		0. 20824		3, 608, 302	
60. 01 06001 BLOOD LABORATORY		0. 00000		(12.045	
63. 00 06300 BLOOD STORING, PROCESSING, & TRANS. 65. 00 06500 RESPIRATORY THERAPY		0. 21060 0. 22147		612, 045 2, 373, 878	
65. 01 06501 SLEEP LAB		0. 22147			1
66. 00 06600 PHYSI CAL THERAPY		0. 39460		1	•
67. 00 06700 OCCUPATI ONAL THERAPY		0. 22722		1	
68. 00 06800 SPEECH PATHOLOGY		0. 24494			1
68. 01 06801 AUDI OLOGY		0. 00000		0	68. 01
69. 00 06900 ELECTROCARDI OLOGY		0. 08758			
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS		0. 21718		3, 605, 943	•
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 18916			
73.00 O7300 DRUGS CHARGED TO PATIENTS 73.01 O7301 HOSPITAL BASED RETAIL PHARMACIES		0. 17711 1. 23599		7, 547, 806 0	
74. 00 07400 RENAL DI ALYSI S		0. 47907			
76. 00 03160 CARDI OPULMONARY		0. 00000		0	•
76. 97 07697 CARDI AC REHABI LI TATI ON		0. 33734			•
76.98 O7698 HYPERBARIC OXYGEN THERAPY		0. 12557	72 40, 221	5, 051	76. 98
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC		0. 00000			
90. 01 09001 SUBSTANCE ABUSE CLINIC		2. 93873			
90. 02 09002 PAIN CLINIC		0. 36635		4, 074	
90. 03 09003 0NCOLOGY CLINIC 91. 00 09100 EMERGENCY		0. 09408 0. 11194			•
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 11192			1
92.01 09201 OBSERVATION BEDS (NON-DISTINCT PART)		1. 37056		9, 391	
OTHER REIMBURSABLE COST CENTERS			27002	., 0,,	1
95. 00 09500 AMBULANCE SERVICES					95. 00
200.00 Total (sum of lines 50 through 94 and 96 through 98)		ļ	257, 739, 295	39, 661, 492	
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61)	1 0	l	201. 00
202.00 Net charges (line 200 minus line 201)		1	257, 739, 295	1	202. 00

Health Financial Systems BALL MEMORIAL	HOSPI TAL		In Lieu	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der (CCN: 15-0089 F	Peri od:	Worksheet D-3	3
	Component		From 01/01/2020 Fo 12/31/2020	Date/Time Pre 7/15/2021 12:	epared: 59 pm
	Ti tl e	e XVIII 💲 \$ι	ıbprovi der - IR	F PPS	
Cost Center Description		Ratio of Cost	Inpati ent	Inpatient	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
LANDATI FAIT DOUTLAGE OFFILIAGE OFFILIAGE		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		1	1 0	I	20 00
30. 00 03000 ADULTS & PEDI ATRI CS			0		30.00
31.00 03100 INTENSIVE CARE UNIT 32.00 03200 CORONARY CARE UNIT					31. 00 32. 00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT					35.00
40. 00 04000 SUBPROVI DER - PF					40.00
41. 00 04100 SUBPROVI DER			6, 404, 790		41.00
43. 00 04300 NURSERY			0,404,770		43.00
ANCI LLARY SERVI CE COST CENTERS		<u> </u>	<u> </u>	l	43.00
50. 00 05000 OPERATING ROOM		0. 109715	96, 295	10, 565	50.00
51. 00 05100 RECOVERY ROOM		0. 166702	1		
52.00 O5200 DELIVERY ROOM & LABOR ROOM		0. 192399		0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 112236		28, 137	54.00
57. 00 05700 CT SCAN		0. 071756			•
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 000000		0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 070266	6 0	0	59. 00
60. 00 06000 LABORATORY		0. 208246	416, 885	86, 815	60.00
60. 01 06001 BLOOD LABORATORY		0. 000000	0	0	60. 01
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.		0. 210607	84, 223	17, 738	
65. 00 06500 RESPI RATORY THERAPY		0. 221473	1	26, 192	•
65. 01 06501 SLEEP LAB		0. 144112	1	0	65. 01
66.00 06600 PHYSI CAL THERAPY		0. 394601		810, 219	
67.00 06700 OCCUPATI ONAL THERAPY		0. 227224		1	1
68. 00 06800 SPEECH PATHOLOGY		0. 244947		156, 458	
68. 01 06801 AUDI OLOGY		0. 000000		0	68. 01
69. 00 06900 ELECTROCARDI OLOGY		0. 087589	1	3, 872	•
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS		0. 217187		1	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 189167		10/ 015	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS 73.01 07301 HOSPITAL BASED RETAIL PHARMACIES		0. 177112	1	196, 015 0	•
73. 01 07301 HOSPITAL BASED RETAIL PHARMACIES 74. 00 07400 RENAL DIALYSIS		1. 235998		-	73. 01
74. 00 07400 RENAL DI ALYSI S 76. 00 03160 CARDI OPULMONARY		0. 479076 0. 000000		60, 635 0	74. 00 76. 00
76. 97 07697 CARDI AC REHABI LI TATI ON		0. 337346	1	0	76.00
76. 98 O7698 HYPERBARI C OXYGEN THERAPY		0. 337340			
OUTPATIENT SERVICE COST CENTERS		0. 120072			70.70
90. 00 09000 CLINI C		0. 000000	0	0	90. 00
90. 01 09001 SUBSTANCE ABUSE CLINIC		2. 93873	1	0	
90. 02 09002 PAIN CLINIC		0. 366350	1		
90 03 09003 0NCOLOGY CLINIC		0.094085		-	

0.094085

0. 111946

0. 203792 1. 370564

7, 632, 134

7, 632, 134

90.03

91.00

95.00

202. 00

0

0 92.00 92.01

2, 005, 083 200. 00 201. 00

90.03

91.00

95. 00 200. 00 201. 00 202. 00

09003 ONCOLOGY CLINIC

09500 AMBULANCE SERVICES

92. 00 | 09200 | 0BSERVATION BEDS (NON-DISTINCT PART) 92. 01 | 09201 | 0BSERVATION BEDS (DISTINCT PART)

Net charges (line 200 minus line 201)

Total (sum of lines 50 through 94 and 96 through 98)
Less PBP Clinic Laboratory Services-Program only charges (line 61)

OTHER REIMBURSABLE COST CENTERS

09100 EMERGENCY

Health Financial Systems BALL MEMORIAL HOSPITAL	_	In Lieu	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT Provide	er CCN: 15-0089	Period:	Worksheet D-3	3
		From 01/01/2020 To 12/31/2020		nared.
		10 127 317 2020	7/15/2021 12:	
	Title XIX	Hospi tal	Cost	
Cost Center Description	Ratio of Co	•	Inpatient	
	To Charges		Program Costs	
		Charges	(col. 1 x col. 2)	
	1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDI ATRI CS		4, 235, 628		30. 00
31.00 03100 INTENSIVE CARE UNIT		1, 261, 868		31.00
32. 00 O3200 CORONARY CARE UNIT		0		32. 00
35.00 02060 NEONATAL INTENSIVE CARE UNIT		1, 575, 725		35. 00
40. 00 04000 SUBPROVI DER - I PF		0		40.00
41. 00 04100 SUBPROVI DER - RF		0		41.00
43. 00 O4300 NURSERY ANCI LLARY SERVI CE COST CENTERS		210, 895		43. 00
50. 00 05000 OPERATING ROOM	0. 1097	1, 195, 006	131, 110	50.00
51. 00 05100 RECOVERY ROOM	0. 1667		18, 036	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 1923		145, 175	•
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 1122		114, 746	
57. 00 05700 CT SCAN	0. 0717	56 22, 200	1, 593	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 0000	00 0	0	
59.00 O5900 CARDIAC CATHETERIZATION	0. 0702		7, 739	
60. 00 06000 LABORATORY	0. 2082		220, 479	
60. 01 06001 BLOOD LABORATORY	0.0000		0	
63. 00 06300 BLOOD STORI NG, PROCESSI NG, & TRANS.	0. 2106		20, 015	
65. 00 06500 RESPI RATORY THERAPY 65. 01 06501 SLEEP LAB	0. 2214 0. 1441		150, 422 0	1
66. 00 06600 PHYSI CAL THERAPY	0. 3946			•
67. 00 06700 OCCUPATI ONAL THERAPY	0. 2272		16, 100	1
68. 00 06800 SPEECH PATHOLOGY	0. 2449		25, 852	1
68. 01 06801 AUDI OLOGY	0. 0000		0	1
69. 00 06900 ELECTROCARDI OLOGY	0. 0875		49, 903	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 2171	87 511, 581	111, 109	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 1891		104, 107	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 1771			•
73. 01 07301 HOSPITAL BASED RETAIL PHARMACIES	1. 2359		0	
74. 00 07400 RENAL DI ALYSI S	0. 4790		29, 742	
76. 00 03160 CARDI OPULMONARY 76. 97 07697 CARDI AC REHABI LI TATI ON	0.0000		0 E 150	
76. 98 O7698 HYPERBARI C OXYGEN THERAPY	0. 3373 0. 1255		5, 150 0	
OUTPATIENT SERVICE COST CENTERS	0. 1233	72 0	0	70. 70
90. 00 09000 CLINIC	0.0000	00 0	0	90.00
90. 01 09001 SUBSTANCE ABUSE CLINIC	2. 9387		0	•
90. 02 09002 PAIN CLINIC	0. 3663	50 0	0	90. 02
90. 03 09003 0NCOLOGY CLINIC	0. 0940	85 8, 673	816	90. 03
91. 00 09100 EMERGENCY	0. 1101		165, 626	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 2037		8, 268	•
92. 01 09201 OBSERVATION BEDS (DISTINCT PART)	1. 3705	64 0	0	92. 01
OTHER REIMBURSABLE COST CENTERS				05 00
95.00 O9500 AMBULANCE SERVICES 200.00 Total (sum of lines 50 through 94 and 96 through 98)		11 474 440	1 004 700	95.00
200.00 Total (sum of lines 50 through 94 and 96 through 98) 201.00 Less PBP Clinic Laboratory Services-Program only charges (line	e 61	11, 476, 662	1, 884, 720	200.00
202.00 Net charges (line 200 minus line 201)		11, 476, 662		201.00
	1	, 170, 302	1	

Health Financial Systems	BALL MEMORIAL H	HOSPI TAL	In Lieu	of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 15-0089	From 01/01/2020	Worksheet E Part A Date/Time Prepared: 7/15/2021 12:59 pm
		Title XVIII	Hospi tal	PPS

				7/15/2021 12	: 59 pm
		Title XVIII	Hospi tal	PPS	
				1. 00	
1 00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				1 00
1.00	DRG Amounts Other than Outlier Payments	ant an anal and the Oataban a	(t	(
1. 01	DRG amounts other than outlier payments for discharges occur				
1. 02	DRG amounts other than outlier payments for discharges occur DRG for federal specific operating payment for Model 4 BPCI				
1. 03	1 3 3	Tor discharges occurrin	ig prior to octo	ber i	1. 03
1 04	(see instructions)	for discharges ecourris	on or ofter O	otobor 1 (1.04
1. 04	DRG for federal specific operating payment for Model 4 BPCI (see instructions)	Tor discharges occurrin	ig on or arter o	ctober i (1.04
2. 00	Outlier payments for discharges. (see instructions)				2. 00
2. 00	Outlier reconciliation amount			,	2.00
2. 02	Outlier payment for discharges for Model 4 BPCI (see instruc	stions)			2.01
2. 02	Outlier payments for discharges occurring prior to October	•		1, 071, 740	
2. 04	Outlier payments for discharges occurring on or after October			166, 429	•
3. 00	Managed Care Simulated Payments	(300 111311 4011 6113)		26, 899, 846	
4. 00	Bed days available divided by number of days in the cost rep	porting period (see inst	ructions)	294. 33	1
1. 00	Indirect Medical Education Adjustment	borting perrou (see riist	i do ti ons)	271.00	1.00
5. 00	FTE count for allopathic and osteopathic programs for the mo	ost recent cost reportir	na period endina	on or 50.70	5.00
0.00	before 12/31/1996. (see instructions)	out resent each reportin	ig port ou onaring	0 0. 00. 7.	0.00
6.00	FTE count for allopathic and osteopathic programs that meet	the criteria for an add	l-on to the cap	for new 0.00	6.00
	programs in accordance with 42 CFR 413.79(e)				
7.00	MMA Section 422 reduction amount to the IME cap as specified	d under 42 CFR §412.105(f)(1)(iv)(B)(1)	0. 00	7.00
7. 01	ACA § 5503 reduction amount to the IME cap as specified under	er 42 CFR §412.105(f)(1)	(iv)(B)(2) If t	ne cost 0.00	7. 01
	report straddles July 1, 2011 then see instructions.		, , , , , ,		
8.00	Adjustment (increase or decrease) to the FTE count for allow	oathic and osteopathic p	rograms for aff	liated 0.00	8.00
	programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(i				
	50069 (August 1, 2002).	_			1
8. 01	The amount of increase if the hospital was awarded FTE cap s	slots under § 5503 of th	ne ACA. If the c	ost 12.00	8. 01
	report straddles July 1, 2011, see instructions.				1
8. 02	The amount of increase if the hospital was awarded FTE cap s	slots from a closed tead	ching hospital u	nder § 0.00	8. 02
	5506 of ACA. (see instructions)				
9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus li				•
	FTE count for allopathic and osteopathic programs in the cu	rrent year from your red	cords		10.00
	FTE count for residents in dental and podiatric programs.				11.00
	Current year allowable FTE (see instructions)				12.00
13.00	Total allowable FTE count for the prior year.			62. 48	•
14.00	Total allowable FTE count for the penultimate year if that y	ear ended on or after s	September 30, 19	97, 62.34	14.00
15 00	otherwise enter zero.			(0.5	15 00
	Sum of lines 12 through 14 divided by 3.				15.00
	Adjustment for residents in initial years of the program				16.00
	Adjustment for residents displaced by program or hospital cl	osure			17.00
	Adjusted rolling average FTE count	4)			18.00
	Current year resident to bed ratio (line 18 divided by line	4).		0. 21238	
	Prior year resident to bed ratio (see instructions)			0. 214715	
	Enter the lesser of lines 19 or 20 (see instructions) IME payment adjustment (see instructions)			0. 21238° 6, 076, 70°	
	IME payment adjustment - Managed Care (see instructions)			2, 945, 856	
22.01	Indirect Medical Education Adjustment for the Add-on for § 4	122 of the MMA		2, 745, 650	22.01
23 NO	Number of additional allopathic and osteopathic IME FTE resi		CER 412 105	4 00	23. 00
20.00	(f)(1)(iv)(C).	dent cap sivis under 42	. OFR 412, 100	4.00	7 23.00
24 00	IME FTE Resident Count Over Cap (see instructions)			0.20	24.00
	If the amount on line 24 is greater than -0-, then enter the	Nower of line 23 or li	ne 24 (see		25.00
23.00	instructions)	c rower or rine 25 or ri	116 24 (366	0. 20	25.00
26 00	Resident to bed ratio (divide line 25 by line 4)			0. 000680	26.00
	IME payments adjustment factor. (see instructions)			0. 000182	
	IME add-on adjustment amount (see instructions)			10, 099	
	IME add-on adjustment amount - Managed Care (see instruction	าร)			28. 01
	Total IME payment (sum of lines 22 and 28)	:=/		6, 086, 806	
	Total IME payment - Managed Care (sum of lines 22.01 and 28.	01)		2, 950, 752	
27.01	Disproporti onate Share Adjustment			2, 700, 702	7
30.00	Percentage of SSI recipient patient days to Medicare Part A	patient days (see instr	ructions)	5. 10	30.00
	Percentage of Medicaid patient days (see instructions)	, 1 2 22,2 (333 1.131)	· · · · · · · · · · · · · · · · · · ·		2 31.00
	Sum of lines 30 and 31				2 32.00
	Allowable disproportionate share percentage (see instruction	ns)			33.00
	Disproportionate share adjustment (see instructions)			1, 939, 339	
	• • • • • • • • • • • • • • • • • • • •		'	•	•

	Financial Systems BALL MEMORIAL			of Form CMS-2	2552-10
CALCUL	LATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0089	Peri od: From 01/01/2020	Worksheet E Part A	
			To 12/31/2020	Date/Time Pre	
		Title XVIII	Hospi tal	7/15/2021 12: PPS	59 pm
		1110 XVIII	Prior to 10/1		
			1.00	2. 00	
05.00	Uncompensated Care Adjustment		10.050.500.00/	0.000.014.501	05 00
	Total uncompensated care amount (see instructions) Factor 3 (see instructions)		8, 350, 599, 096 0. 000376569	8, 290, 014, 521 0. 000362015	
	Hospital uncompensated care payment (If line 34 is zero, o	enter zero on this line)	1	3, 001, 111	
00.02	instructions)	o	(5)5 5, 11, 75, 1	0,001,111	00.02
	Pro rata share of the hospital uncompensated care payment			756, 445	
36. 00	Total uncompensated care (sum of columns 1 and 2 on line 3		3, 110, 580		36. 00
40 00	Additional payment for high percentage of ESRD beneficiary Total Medicare discharges, excluding MS-DRGs 652, 682, 683				40. 00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682		0		41.00
	instructions)	,,			
41.01	Total ESRD Medicare covered and paid discharges excluding	MS-DRGs 652, 682, 683,	68 4 an 0		41. 01
42.00	685. (see instructions)		0.00		42 00
42.00	Divide line 41 by line 40 (if less than 10%, you do not que Total Medicare ESRD inpatient days excluding MS-DRGs 652,		0.00		42. 00 43. 00
43.00	linstructions)	, 002, 003, 004 an 003. (366 0		43.00
	Ratio of average length of stay to one week (line 43 divid				44.00
	Average weekly cost for dialysis treatments (see instructi		0.00		45. 00
	Total additional payment (line 45 times line 44 times line	e 41.01)	(7.0/2.051		46.00
	Subtotal (see instructions) Hospital specific payments (to be completed by SCH and MDI	H small rural hosnitals	67, 863, 851		47. 00 48. 00
40.00	instructions)	ii, siiai i turui nospi tars	on y. (see		40.00
				Amount	
40.00	Total assument for impations assume (one impartment)	1)		1. 00	40.00
50.00	Total payment for inpatient operating costs (see instructing Payment for inpatient program capital (from Wkst. L, Pt.		اه)	70, 814, 603 5, 035, 849	1
	Exception payment for inpatient program capital (Wkst. L,			0,000,017	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4,			2, 502, 258	52. 00
	Nursing and Allied Health Managed Care payment			21, 539	
	Special add-on payments for new technologies Islet isolation add-on payment			223, 647 0	
	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, Iii	ne 69)		0	
56.00	Cost of physicians' services in a teaching hospital (see			0	56.00
	Routine service other pass through costs (from Wkst. D, P		0 through 35).	0	
58.00	Ancillary service other pass through costs from Wkst. D, I	Pt. IV, col. 11 line 200)		42, 659	
	Total (sum of amounts on lines 49 through 58) Primary payer payments			78, 640, 555 31, 133	
00.00	Total amount payable for program beneficiaries (line 59 mi	inus line 60)		78, 609, 422	
	Deductibles billed to program beneficiaries	,		5, 500, 792	
61.00	l =			325, 457	63.00
61. 00 62. 00 63. 00	Coinsurance billed to program beneficiaries				
61. 00 62. 00 63. 00 64. 00	Allowable bad debts (see instructions)			704, 773	1
61.00 62.00 63.00 64.00 65.00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)	instructions)		704, 773 458, 102	65. 00
61. 00 62. 00 63. 00 64. 00 65. 00 66. 00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see i	i nstructi ons)		704, 773 458, 102 249, 949	65. 00 66. 00
61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)		(see instructio	704, 773 458, 102 249, 949 73, 241, 275	65. 00 66. 00 67. 00
61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see is Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices outlier payments reconciliation (sum of lines 93, 95 and 65)	for applicable to MS-DRGs	1	704, 773 458, 102 249, 949 73, 241, 275 ns) 0	65. 00 66. 00 67. 00 68. 00 69. 00
61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see insubstated line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices of Outlier payments reconciliation (sum of lines 93, 95 and OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	for applicable to MS-DRGs 96).(For SCH see instruct	i ons)	704, 773 458, 102 249, 949 73, 241, 275 ns) 0 0	65. 00 66. 00 67. 00 68. 00 69. 00 70. 00
61.00 62.00 63.00 64.00 65.00 66.00 67.00 68.00 69.00 70.00 70.50	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see insubstations) Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices outlier payments reconciliation (sum of lines 93, 95 and 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demo	for applicable to MS-DRGs 96).(For SCH see instruct onstration) adjustment (s	i ons)	704, 773 458, 102 249, 949 73, 241, 275 ns) 0 0	65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 70. 50
61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 70. 50 70. 87	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see insubstated line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices of Outlier payments reconciliation (sum of lines 93, 95 and OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	for applicable to MS-DRGs 96).(For SCH see instruct onstration) adjustment (s ion	i ons)	704, 773 458, 102 249, 949 73, 241, 275 ns) 0 0	65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 70. 50 70. 87
61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 70. 00 70. 50 70. 87 70. 88 70. 89	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Credits received from manufacturers for replaced devices outlier payments reconciliation (sum of lines 93, 95 and other ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonstration payment adjustment amount before sequestration of MDH volume decrease adjustment (contractor use only Pioneer ACO demonstration payment adjustment amount (see	for applicable to MS-DRGs 96).(For SCH see instruct onstration) adjustment (s ion y) instructions)	i ons)	704, 773 458, 102 249, 949 73, 241, 275 ns) 0 0 0 0	65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 70. 50 70. 87
61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 70. 00 70. 50 70. 87 70. 88 70. 89 70. 90	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Credits received from manufacturers for replaced devices outlier payments reconciliation (sum of lines 93, 95 and of OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonstration payment adjustment amount before sequestration of MDH volume decrease adjustment (contractor use only Pioneer ACO demonstration payment adjustment amount (see instructions)	for applicable to MS-DRGs 96).(For SCH see instruct onstration) adjustment (s ion y) instructions) s)	i ons)	704, 773 458, 102 249, 949 73, 241, 275 ns) 0 0 0 0 0	65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 70. 50 70. 87 70. 88 70. 89 70. 90
61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 70. 50 70. 87 70. 88 70. 89 70. 90 70. 91	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see is subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices outlier payments reconciliation (sum of lines 93, 95 and OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonstration payment adjustment amount before sequestration of MDH volume decrease adjustment (contractor use only Pioneer ACO demonstration payment adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions)	for applicable to MS-DRGs 96).(For SCH see instruct onstration) adjustment (s ion y) instructions) s)	i ons)	704, 773 458, 102 249, 949 73, 241, 275 ns) 0 0 0 0 0	65. 00 66. 00 67. 00 68. 00 70. 00 70. 50 70. 87 70. 88 70. 89 70. 90 70. 91
61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 69. 00 70. 50 70. 87 70. 88 70. 89 70. 90 70. 91	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see insubstant (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices outlier payments reconciliation (sum of lines 93, 95 and OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demo Demonstration payment adjustment amount before sequestration Componer ACO demonstration payment adjustment (contractor use only Pioneer ACO demonstration payment adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)	for applicable to MS-DRGs 96).(For SCH see instruct onstration) adjustment (s ion y) instructions) s)	i ons)	704, 773 458, 102 249, 949 73, 241, 275 1s) 0 0 0 0 0	65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 70. 50 70. 87 70. 88 70. 89 70. 90 70. 91
61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 70. 50 70. 87 70. 88 70. 89 70. 91 70. 92 70. 93	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see is subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices outlier payments reconciliation (sum of lines 93, 95 and OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonstration payment adjustment amount before sequestration of MDH volume decrease adjustment (contractor use only Pioneer ACO demonstration payment adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions)	for applicable to MS-DRGs 96).(For SCH see instruct onstration) adjustment (s ion y) instructions) s)	i ons)	704, 773 458, 102 249, 949 73, 241, 275 ns) 0 0 0 0 0 0 0 0 -263, 438 -44, 002	65. 00 66. 00 67. 00 68. 00 70. 00 70. 50 70. 87 70. 88 70. 99 70. 90 70. 91 70. 92 70. 93

	Financial Systems BALL MEMORIAL TION OF REIMBURSEMENT SETTLEMENT	Provi der C		Peri od: From 01/01/2020	worksheet E Part A Date/Time Pre	
		T: +1.0	XVIII		7/15/2021 12: PPS	
		<u> </u>		Hospi tal (yyyy)	Amount	
				0	1. 00	
	ow volume adjustment for federal fiscal year (yyyy) (Enter	in column () the	0	0	70. 9
	corresponding federal year for the period prior to 10/1)				_	
	ow volume adjustment for federal fiscal year (yyyy) (Enter) the	0	0	70. 9
	corresponding federal year for the period ending on or afte .ow Volume Payment-3	er 10/1)			0	70. 9
	IAC adjustment amount (see instructions)				0	
	mount due provider (line 67 minus lines 68 plus/minus line	es 69 & 70)			72, 933, 835	
	Sequestration adjustment (see instructions)	,			481, 363	•
1.02	Demonstration payment adjustment amount after sequestration	า			0	71.0
	Sequestration adjustment-PARHM pass-throughs					71.0
	nterim payments				71, 608, 783	
	nterim payments-PARHM				0	72.0
	entative settlement (for contractor use only) entative settlement-PARHM (for contractor use only)				0	73. 0
	Balance due provider/program (line 71 minus lines 71.01, 71	1. 02. 72. and	73)		843, 689	
	Balance due provider/program-PARHM (see instructions)	52, 72, and	,		545, 567	74.0
	Protested amounts (nonallowable cost report items) in accor	dance with	MS		1, 870, 468	75. O
	Pub. 15-2, chapter 1, §115.2]
	O BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
	Operating outlier amount from Wkst. E, Pt. A, line 2, or su	um of 2.03 pl	us		0	90.0
	2.04 (see instructions) Capital outlier from Wkst. L, Pt. I, line 2				0	91. 0
	perating outlier reconciliation adjustment amount (see ins	structions)			0	
	Capital outlier reconciliation adjustment amount (see instr				Ö	•
	The rate used to calculate the time value of money (see ins					94. 0
5. 00 1	ime value of money for operating expenses (see instruction	ns)			0	
6.00 1	ime value of money for capital related expenses (see instr	ructions)		To 1 10 11	0	96. 0
				Prior to 10/1 1.00	0n/After 10/1 2.00	
Н	SP Bonus Payment Amount			1.00	2.00	
	ISP bonus amount (see instructions)			0	0	100.0
	VBP Adjustment for HSP Bonus Payment					
	IVBP adjustment factor (see instructions)			0. 0000000000		
	IVBP adjustment amount for HSP bonus payment (see instructi	ons)		0	0	102. 0
	RR Adjustment for HSP Bonus Payment IRR adjustment factor (see instructions)				0.0000	
DIS COULT	inn aufustiliett ractor (see riistructrons)			0 0000		מות ליות
	IRR adjustment amount for HSP bonus payment (see instruction	ons)		0.0000		•
04.00 F	IRR adjustment amount for HSP bonus payment (see instruction ural Community Hospital Demonstration Project (§410A Demon	ons) nstration) Ad	ljustment	0. 0000		103. 0 104. 0
04. 00 <u>F</u> 00. 00 I	ural Community Hospital Demonstration Project (§410A Demon s this the first year of the current 5-year demonstration	nstration) Ad	ljustment the 21st Ce	0	0	104. 0
04. 00 <u>F</u> 00. 00 I	ural Community Hospital Demonstration Project (§410A Demons this the first year of the current 5-year demonstration cures Act? Enter "Y" for yes or "N" for no.	nstration) Ad	ljustment the 21st Ce	0	0	104. 0
04. 00 <u>F</u> 00. 00 I <u>C</u>	ural Community Hospital Demonstration Project (§410A Demon s this the first year of the current 5-year demonstration cures Act? Enter "Y" for yes or "N" for no. ost Reimbursement	nstration) Ad period under	ijustment the 21st Ce	0	0	104. 0 200. 0
04. 00 F R 00. 00 I C 01. 00 M	ural Community Hospital Demonstration Project (§410A Demons this the first year of the current 5-year demonstration cures Act? Enter "Y" for yes or "N" for no. ost Reimbursement ledicare inpatient service costs (from Wkst. D-1, Pt. II, I	nstration) Ad period under	ljustment - the 21st Ce	0	0	104. 0 200. 0 201. 0
04. 00 F R 00. 00 F C 01. 00 M 02. 00 M	ural Community Hospital Demonstration Project (§410A Demons this the first year of the current 5-year demonstration cures Act? Enter "Y" for yes or "N" for no. ost Reimbursement ledicare inpatient service costs (from Wkst. D-1, Pt. II, I ledicare discharges (see instructions)	nstration) Ad period under	ljustment the 21st Ce	0	0	104. 0 200. 0 201. 0 202. 0
04. 00 <u>F</u> 00. 00 I 00. 00 I 00. 00 M 02. 00 M 03. 00 0	ural Community Hospital Demonstration Project (§410A Demons this the first year of the current 5-year demonstration cures Act? Enter "Y" for yes or "N" for no. oost Reimbursement ledicare inpatient service costs (from Wkst. D-1, Pt. II, I ledicare discharges (see instructions) case-mix adjustment factor (see instructions)	nstration) Ad period under ine 49)	the 21st Ce	o ntury	0	104. 0 200. 0 201. 0 202. 0
04. 00 H R 00. 00 I C 01. 00 M 02. 00 M 03. 00 C	ural Community Hospital Demonstration Project (§410A Demons this the first year of the current 5-year demonstration cures Act? Enter "Y" for yes or "N" for no. Ost Reimbursement ledicare inpatient service costs (from Wkst. D-1, Pt. II, I ledicare discharges (see instructions) case-mix adjustment factor (see instructions) computation of Demonstration Target Amount Limitation (N/A)	nstration) Ad period under ine 49)	the 21st Ce	o ntury	0	104. 0 200. 0 201. 0 202. 0
04. 00 H R 00. 00 I C 01. 00 M 02. 00 M 03. 00 C d 04. 00 M	ural Community Hospital Demonstration Project (§410A Demons this the first year of the current 5-year demonstration cures Act? Enter "Y" for yes or "N" for no. ost Reimbursement ledicare inpatient service costs (from Wkst. D-1, Pt. II, I ledicare discharges (see instructions) case-mix adjustment factor (see instructions) computation of Demonstration Target Amount Limitation (N/A emonstration period) ledicare target amount	nstration) Ad period under ine 49)	the 21st Ce	o ntury	0	104. 0 200. 0 201. 0 202. 0 203. 0
04. 00 H R R OO. 00 I OO N OO I OO N OO I OO N OO I OO N OO OO N OO OO OO OO OO OO OO OO OO	ural Community Hospital Demonstration Project (§410A Demons this the first year of the current 5-year demonstration cures Act? Enter "Y" for yes or "N" for no. ost Reimbursement ledicare inpatient service costs (from Wkst. D-1, Pt. II, I ledicare discharges (see instructions) case-mix adjustment factor (see instructions) computation of Demonstration Target Amount Limitation (N/A emonstration period) ledicare target amount case-mix adjusted target amount (line 203 times line 204)	nstration) Ad period under ine 49) in first yea	the 21st Ce	o ntury	0	200. 0 201. 0 202. 0 203. 0 204. 0 205. 0
04. 00 R R R C C C C C C C	ural Community Hospital Demonstration Project (§410A Demons this the first year of the current 5-year demonstration cures Act? Enter "Y" for yes or "N" for no. Sost Reimbursement ledicare inpatient service costs (from Wkst. D-1, Pt. II, I ledicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A emonstration period) Ledicare target amount Case-mix adjusted target amount (line 203 times line 204) Ledicare inpatient routine cost cap (line 202 times line 204)	nstration) Ad period under ine 49) in first yea	the 21st Ce	o ntury	0	200. 0 201. 0 202. 0 203. 0 204. 0 205. 0
04. 00 R R R C C C C C C C	ural Community Hospital Demonstration Project (§410A Demons this the first year of the current 5-year demonstration cures Act? Enter "Y" for yes or "N" for no. Sost Reimbursement ledicare inpatient service costs (from Wkst. D-1, Pt. II, I ledicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A emonstration period) Ledicare target amount case-mix adjusted target amount (line 203 times line 204) Ledicare inpatient routine cost cap (line 202 times line 204) Ledicare inpatient routine cost cap (line 202 times line 204) Ledicare inpatient routine cost cap (line 202 times line 204) Ledicare inpatient routine cost cap (line 202 times line 204)	ine 49) in first yea	the 21st Ce	o ntury	0	200. 0 201. 0 202. 0 203. 0 204. 0 205. 0 206. 0
04. 00 R R R O O O O O O O	ural Community Hospital Demonstration Project (§410A Demons this the first year of the current 5-year demonstration cures Act? Enter "Y" for yes or "N" for no. Ost Reimbursement ledicare inpatient service costs (from Wkst. D-1, Pt. II, I ledicare discharges (see instructions) case-mix adjustment factor (see instructions) computation of Demonstration Target Amount Limitation (N/A memonstration period) ledicare target amount case-mix adjusted target amount (line 203 times line 204) ledicare inpatient routine cost cap (line 202 times line 204) ledicare inpatient to Medicare Part A Inpatient Reimbursement program reimbursement under the §410A Demonstration (see in	ine 49) in first yea 25)	the 21st Ce	o ntury	0	200. 0 201. 0 202. 0 203. 0 204. 0 205. 0 206. 0
04. 00 R R R R R R R R R	ural Community Hospital Demonstration Project (§410A Demons this the first year of the current 5-year demonstration as this the first year of the current 5-year demonstration are Act? Enter "Y" for yes or "N" for no. OST Reimbursement ledicare inpatient service costs (from Wkst. D-1, Pt. II, I ledicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A emonstration period) Ledicare target amount case-mix adjusted target amount (line 203 times line 204) Ledicare inpatient routine cost cap (line 202 times line 204) Ledicare inpatient routine cost cap (line 207 times line 208) Ledicare inpatient routine cost cap (line 208 times line 208) Ledicare inpatient routine cost cap (line 209 times line 208) Ledicare line bursement under the §410A Demonstration (see in ledicare Part A inpatient service costs (from Wkst. E, Pt.	ine 49) in first yea 25)	the 21st Ce	o ntury	0	200. 0 201. 0 202. 0 203. 0 204. 0 205. 0 206. 0 207. 0 208. 0
04. 00 R R R R R R R R R	ural Community Hospital Demonstration Project (§410A Demons this the first year of the current 5-year demonstration cures Act? Enter "Y" for yes or "N" for no. Ost Reimbursement ledicare inpatient service costs (from Wkst. D-1, Pt. II, I ledicare discharges (see instructions) case-mix adjustment factor (see instructions) computation of Demonstration Target Amount Limitation (N/A memonstration period) ledicare target amount case-mix adjusted target amount (line 203 times line 204) ledicare inpatient routine cost cap (line 202 times line 204) ledicare inpatient to Medicare Part A Inpatient Reimbursement program reimbursement under the §410A Demonstration (see in	ine 49) in first yea 25)	the 21st Ce	o ntury	0	201. 0 201. 0 202. 0 203. 0 204. 0 205. 0 206. 0 207. 0 208. 0 209. 0
04. 00 R R O O O O O O O O	ural Community Hospital Demonstration Project (§410A Demons this the first year of the current 5-year demonstration bures Act? Enter "Y" for yes or "N" for no. OST Reimbursement ledicare inpatient service costs (from Wkst. D-1, Pt. II, I ledicare discharges (see instructions) lease-mix adjustment factor (see instructions) computation of Demonstration Target Amount Limitation (N/A emonstration period) ledicare target amount (line 203 times line 204) ledicare inpatient routine cost cap (line 202 times line 204) ledicare inpatient routine cost cap (line 202 times line 204) ledicare inpatient routine cost cap (line 207 times line 208) roogram reimbursement under the §410A Demonstration (see in ledicare Part A inpatient service costs (from Wkst. E, Pt. adjustment to Medicare IPPS payments (see instructions)	ine 49) in first yea 05) astructions) A, line 59)	the 21st Ce	o ntury	0	•
04. 00 R R R R R R R R R	ural Community Hospital Demonstration Project (§410A Demons this the first year of the current 5-year demonstration sures Act? Enter "Y" for yes or "N" for no. Outs Reimbursement Idedicare inpatient service costs (from Wkst. D-1, Pt. II, I ledicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A emonstration period) Idedicare target amount Case-mix adjusted target amount (line 203 times line 204) Idedicare inpatient routine cost cap (line 202 times line 204) Idedicare inpatient routine cost cap (line 207 times line 208) Idedicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see in ledicare Part A inpatient service costs (from Wkst. E, Pt. adjustment to Medicare IPPS payments (see instructions) Reserved for future use local adjustment to Medicare IPPS payments (see instruction comparision of PPS versus Cost Reimbursement	ine 49) in first yea 25) structions) A, line 59)	the 21st Ce	o ntury	0	201. 0 202. 0 203. 0 204. 0 205. 0 206. 0 207. 0 208. 0 209. 0 211. 0
04. 00 R R R R R R R R R	ural Community Hospital Demonstration Project (§410A Demons this the first year of the current 5-year demonstration bures Act? Enter "Y" for yes or "N" for no. Ost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, I ledicare discharges (see instructions) Mase-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A emonstration period) Medicare target amount Mase-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 204) Medicare inpatient routine cost cap (line 202 times line 204) Medicare Part A Inpatient Reimbursement Medicare Part A inpatient service costs (from Wkst. E, Pt. Adjustment to Medicare IPPS payments (see instructions) Medicare discharge (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. Adjustment to Medicare IPPS payments (see instructions) Medicare discharges (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. Adjustment to Medicare IPPS payments (see instructions) Medicare IPPS versus Cost Reimbursement Medicare IPPS payments (see instructions)	ine 49) in first yea 25) structions) A, line 59)	the 21st Ce	o ntury	0	201. 0 202. 0 203. 0 203. 0 204. 0 205. 0 206. 0 207. 0 208. 0 210. 0 211. 0
04. 00 R R R R R R R R R	ural Community Hospital Demonstration Project (§410A Demons this the first year of the current 5-year demonstration sures Act? Enter "Y" for yes or "N" for no. Outs Reimbursement Idedicare inpatient service costs (from Wkst. D-1, Pt. II, I ledicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A emonstration period) Idedicare target amount Case-mix adjusted target amount (line 203 times line 204) Idedicare inpatient routine cost cap (line 202 times line 204) Idedicare inpatient routine cost cap (line 207 times line 208) Idedicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see in ledicare Part A inpatient service costs (from Wkst. E, Pt. adjustment to Medicare IPPS payments (see instructions) Reserved for future use local adjustment to Medicare IPPS payments (see instruction comparision of PPS versus Cost Reimbursement	ine 49) in first yea 25) astructions) A, line 59) as 211)	r the 21st Ce	ntury rent 5-year	0	201. 0 201. 0 202. 0 203. 0 204. 0 205. 0 206. 0 207. 0 209. 0 210. 0 211. 0

						12/01/2020	7/15/2021 12:	
		W (0 F D) A	I		XVIII	Hospi tal	PPS	
		W/S E, Part A	Amounts (from	Pre/Post	Period Prior to 10/01	Peri od On/After 10/01	Total (Col 2	
		0	E, Part A) 1.00	Entitlement 2.00	3.00	4. 00	through 4) 5.00	
1. 00	DRG amounts other than outlie		0	0	3.00		0.00	1.00
	payments						1	
1. 01	DRG amounts other than outlie	1.01	39, 025, 411	0	39, 025, 411		39, 025, 411	1. 01
	payments for discharges occurring prior to October 1							
1. 02	DRG amounts other than outlie	1.02	16, 463, 546	0		16, 463, 546	16, 463, 546	1. 02
02	payments for discharges	1 52	107 1007 0 10	Ü		107 1007 0 10	10, 100, 010	
	occurring on or after October	•						
1. 03	DRG for Federal specific	1. 03	0	0	C)	0	1. 03
	operating payment for Model 4							
	BPCI occurring prior to Octob	er I						
1. 04	DRG for Federal specific	1. 04	0	0	•	0	0	1. 04
	operating payment for Model 4							
	BPCI occurring on or after							
2 00	October 1	2.00					1	2 00
2. 00	Outlier payments for discharg (see instructions)	es 2.00						2. 00
2. 01	Outlier payments for discharg	es 2.02	0	0	d	o	0	2. 01
	for Model 4 BPCI			-				
2. 02	Outlier payments for discharg	es 2.03	1, 071, 740	0	1, 071, 740		1, 071, 740	2. 02
	occurring prior to October 1							
2. 03	(see instructions) Outlier payments for discharg	es 2.04	166, 429	0		166, 429	166, 429	2. 03
2.03	occurring on or after October		100, 427	O		100, 427	100, 427	2.03
	(see instructions)							
3.00	Operating outlier	2. 01	0	0	C	0	0	3. 00
4 00	reconciliation	2.00	0/ 000 04/	0	10 000 /7-	0.0/0.1/0	04 000 044	4 00
4. 00	Managed care simulated paymen Indirect Medical Education Ad		26, 899, 846	0	18, 830, 677	8, 069, 169	26, 899, 846	4. 00
5. 00	Amount from Worksheet E, Part		0. 212381	0. 212381	0. 212381	0. 212381		5. 00
	A, line 21 (see instructions)							
6. 00	IME payment adjustment (see	22. 00	6, 076, 707	0	4, 273, 751	1, 802, 956	6, 076, 707	6. 00
/ 01	instructions)	22.01	2 045 05/	0	2 0/2 105	002 /71	2 045 05/	/ 01
6. 01	IME payment adjustment for managed care (see instruction	22. 01	2, 945, 856	0	2, 062, 185	883, 671	2, 945, 856	6. 01
	Indirect Medical Education Ad		he Add-on for	Section 422 of	the MMA			
7. 00	IME payment adjustment factor		0. 000182	0. 000182	0. 000182	0. 000182		7. 00
	(see instructions)							
8. 00	IME adjustment (see	28. 00	10, 099	0	7, 103	2, 996	10, 099	8. 00
8. 01	instructions) IME payment adjustment add on	28. 01	4, 896	0	3, 427	1, 469	4, 896	8. 01
0.01	for managed care (see	20.01	4, 070	O	5, 427	1,407	4, 070	0.01
	instructions)							
9. 00	Total IME payment (sum of lin	es 29.00	6, 086, 806	0	4, 280, 854	1, 805, 952	6, 086, 806	9. 00
0.01	6 and 8)	20.01	2 050 752	0	2 045 413	005 140	2 050 752	0.01
9. 01	Total IME payment for managed care (sum of lines 6.01 and	29. 01	2, 950, 752	0	2, 065, 612	885, 140	2, 950, 752	9. 01
	8. 01)							
	Disproportionate Share Adjusti							[
10.00	Allowable disproportionate	33. 00	0. 1398	0. 1398	0. 1398	0. 1398		10. 00
	share percentage (see instructions)							
11 00	Di sproporti onate share	34. 00	1, 939, 339	0	1, 363, 938	575, 401	1, 939, 339	11 00
	adjustment (see instructions)		1,707,007	Ü	., 000, 700	7	1,707,007	
11. 01	Uncompensated care payments	36. 00	3, 110, 580	0	2, 354, 135	756, 445	3, 110, 580	11. 01
40.00	Additional payment for high po	ercentage of E	SRD beneficiar					10.00
12.00	Total ESRD additional payment (see instructions)	46. 00	0	0	C) O	0	12. 00
13. 00	Subtotal (see instructions)	47. 00	67, 863, 851	0	48, 096, 078	19, 767, 773	67, 863, 851	13 00
14.00	Hospital specific payments	48. 00	0	0	(0	0	14. 00
	(completed by SCH and MDH,							
	small rural hospitals only.)							
15 00	(see instructions) Total payment for inpatient	40.00	70 014 602	0	EO 141 400	20 452 012	70 014 402	15 00
15.00	operating costs (see	49. 00	70, 814, 603	0	50, 161, 690	20, 652, 913	70, 814, 603	15.00
	instructions)							
16.00	Payment for inpatient program		5, 035, 849	0	3, 612, 330	1, 423, 519	5, 035, 849	16. 00
	capital (from Wkst. L, Pt. I,							
17.00	if applicable)	L 54.00	200 / :-	<u>.</u>	_	000 (:-	000 (:=	17.00
17.00	Special add-on payments for n technologies	ew 54.00	223, 647	0	C	223, 647	223, 647	17.00
17. 01	Net organ aquisition cost							17. 01
		1			<u> </u>	1		

Heal th	Financial Systems		BALL MEMORIA	L HOSPITAL		In Lieu	u of Form CMS-2	2552-10
LOW VOLUME CALCULATION EXHIBIT 4				Provi der C		Period: From 01/01/2020 To 12/31/2020		pared:
					XVIII	Hospi tal	PPS	
			Amounts (from		Period Prior		Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01		
		0	1.00	2. 00	3. 00	4. 00	5. 00	
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRG	68. 00	0	0	(0	0	17. 02
18. 00	Capital outlier reconciliation adjustment amount (see		0	0	,	0	0	18. 00
19. 00	instructions) SUBTOTAL			0	53, 774, 02	22, 300, 079	76, 074, 099	19. 00
		W/S L, line	(Amounts from L)					
		0	1. 00	2. 00	3. 00	4. 00	5. 00	
	Capital DRG other than outlie Model 4 BPCI Capital DRG othe		4, 318, 257 0	0	, ,	1, 227, 011 0 0	4, 318, 257 0	t .
	than outlier Capital DRG outlier payments Model 4 BPCI Capital DRG	2. 00 2. 01	60, 353 0	0	50, 59	9, 757 0 0	60, 353 0	
22. 00	outlier payments Indirect medical education percentage (see instructions)	5. 00	0. 0895	0. 0895	0. 089	0. 0895		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	386, 484	0	276, 66	7 109, 817	386, 484	23. 00
24.00	Allowable disproportionate share percentage (see instructions)	10. 00	0. 0627	0. 0627	0. 062	0. 0627		24.00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	270, 755	0	193, 82	76, 934	270, 755	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	5, 035, 849	0	3, 612, 33	1, 423, 519	5, 035, 849	26. 00
		W/S E, Part A	(Amounts to E ,					
		line	Part A)					
		0	1. 00	2. 00	3. 00	4. 00	5. 00	
	Low volume adjustment factor Low volume adjustment (transformation amount to Wkst. E, Pt. A, line				0. 00000	0.000000	0	27. 00 28. 00
29. 00	Low volume adjustment (transfi amount to Wkst. E, Pt. A, lin	r 70. 97				0	0	29. 00
100. 00	Transfer low volume adjustmen to Wkst. E, Pt. A.		Υ					100. 00

				[o 12/31/2020	Date/Time Pre	pared:
			Title	XVIII	Hospi tal	7/15/2021 12: PPS	59 pm
		kst. E, Pt. A		Peri od to		Total (cols. 2	
		line	Wkst. E, Pt.	10/01	after 10/01	and 3)	
		0	A) 1.00	2. 00	3. 00	4. 00	
1. 00	DRG amounts other than outlier payments	1. 00	1.00	2.00	3.00	4.00	1. 00
1. 01	DRG amounts other than outlier payments for		39, 025, 411	39, 025, 411		39, 025, 411	1. 01
1. 02	discharges occurring prior to October 1 DRG amounts other than outlier payments for	1. 02	16, 463, 546		16, 463, 546	16, 463, 546	1. 02
1.02	discharges occurring on or after October 1	1.02	10, 403, 540		10, 403, 340	10, 403, 540	1.02
1. 03	DRG for Federal specific operating payment Model 4 BPCI occurring prior to October 1	for 1.03	0	0		0	1. 03
1. 04	DRG for Federal specific operating payment Model 4 BPCI occurring on or after October	for 1.04 1	0		0	0	1. 04
2. 00	Outlier payments for discharges (see instructions)	2. 00					2. 00
2. 01	Outlier payments for discharges for Model 4	2. 02	0	0	0	0	2. 01
2. 02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2. 03	1, 071, 740	1, 071, 740		1, 071, 740	2. 02
2. 03	Outlier payments for discharges occurring o or after October 1 (see instructions)	n 2.04	166, 429		166, 429	166, 429	2. 03
3. 00	Operating outlier reconciliation	2. 01	0	0	0	0	3. 00
4. 00	Managed care simulated payments	3. 00	26, 899, 846	18, 830, 677	8, 069, 169	26, 899, 846	4. 00
5. 00	Indirect Medical Education Adjustment Amount from Worksheet E, Part A, line 21 (s	ee 21.00	0. 212381	0. 212381	0. 212381		5. 00
6. 00	instructions) IME payment adjustment (see instructions)	22. 00	6, 076, 707	4, 273, 751	1, 802, 956	6, 076, 707	6. 00
6. 01	IME payment adjustment for managed care (se		2, 945, 856			2, 945, 856	6. 01
	instructions) Indirect Medical Education Adjustment for th		Cootian 122 of				
7. 00	IME payment adjustment factor (see	27. 00	0. 000182	0. 000182	0. 000182		7. 00
	instructions)						
8.00	IME adjustment (see instructions)	28.00	10, 099	7, 103			8. 00 8. 01
8. 01	<pre>IME payment adj ustment add on for managed c (see instructions)</pre>	are 28.01	4, 896	3, 427	1, 469	4, 896	8.01
9. 00	Total IME payment (sum of lines 6 and 8)	29. 00	6, 086, 806	4, 280, 854			9. 00
9. 01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	2, 950, 752	2, 065, 612	885, 140	2, 950, 752	9. 01
	Di sproporti onate Share Adjustment						
10.00	Allowable disproportionate share percentage	33. 00	0. 1398	0. 1398	0. 1398		10.00
11. 00	(see instructions) Disproportionate share adjustment (see	34. 00	1, 939, 339	1, 363, 938	575, 401	1, 939, 339	11. 00
11.00	instructions)	34.00	1, 737, 337	1, 303, 730	373, 401	1, 737, 337	11.00
11. 01	Uncompensated care payments	36.00	3, 110, 580	2, 354, 135	756, 445	3, 110, 580	11. 01
12 00	Additional payment for high percentage of EST Total ESRD additional payment (see	SRD beneficiar 46.00	ry discharges	0	0	0	12. 00
12.00	instructions)	40.00		0	U	U	12.00
	Subtotal (see instructions)	47. 00	67, 863, 851	48, 096, 078	19, 767, 773		
14. 00	Hospital specific payments (completed by SC	H 48. 00	0	0	0	0	14. 00
	and MDH, small rural hospitals only.) (see instructions)						
15. 00	Total payment for inpatient operating costs	49. 00	70, 814, 603	50, 161, 690	20, 652, 913	70, 814, 603	15. 00
16. 00	(see instructions) Payment for inpatient program capital (from	50. 00	5, 035, 849	3, 612, 330	1, 423, 519	5, 035, 849	16 00
10.00	Wkst. L, Pt. I, if applicable)	30.00	3, 033, 647	3,012,330	1, 423, 319	5, 035, 647	10.00
17.00	Special add-on payments for new technologie	s 54.00	223, 647	0	223, 647	223, 647	
	Net organ acquisition cost Credits received from manufacturers for	68. 00	n	n	0	0	17. 01 17. 02
	replaced devices for applicable MS-DRGs		 				
18. 00	Capital outlier reconciliation adjustment amount (see instructions)	93. 00	0	0	0	0	18. 00
19. 00	SUBTOTAL			53, 774, 020	22, 300, 079	76, 074, 099	19. 00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCUI	LATION EXHIBIT	5 Provider C		Period: From 01/01/2020 To 12/31/2020	worksheet E Part A Exhibi Date/Time Pre 7/15/2021 12:	t 5 epared:
			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	4, 318, 257	3, 091, 24	6 1, 227, 011	4, 318, 257	
20.01 Model 4 BPCI Capital DRG other than outlier		0		0	0	
21.00 Capital DRG outlier payments	2.00	60, 353	50, 59	6 9, 757	60, 353	
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. 0895	0. 089	5 0. 0895		22. 00
23.00 Indirect medical education adjustment (see instructions)	6. 00	386, 484	276, 66	7 109, 817	386, 484	23. 00
24.00 Allowable disproportionate share percentage (see instructions)	10. 00	0. 0627	0. 062	7 0. 0627		24. 00
25.00 Disproportionate share adjustment (see instructions)	11. 00	270, 755	193, 82	1 76, 934	270, 755	25. 00
26.00 Total prospective capital payments (see instructions)	12. 00	5, 035, 849	3, 612, 33	0 1, 423, 519	5, 035, 849	26. 00
	kst. E, Pt. A	(Amt. from				
	line	Wkst. E, Pt. A)				
	0	1.00	2.00	3. 00	4. 00	
27. 00						27.00
28.00 Low volume adjustment prior to October 1	70. 96	0		0	0	28.00
29.00 Low volume adjustment on or after October 1	70. 97	0		0	0	29.00
30.00 HVBP payment adjustment (see instructions)	70. 93	-263, 438	-178, 59	7 -84, 841	-263, 438	30.00
30.01 HVBP payment adjustment for HSP bonus payme (see instructions)	nt 70.90	0		0	0	30. 01
31.00 HRR adjustment (see instructions)	70. 94	-44, 002	-27, 31	5 -16, 687	-44, 002	31.00
31.01 HRR adjustment for HSP bonus payment (see instructions)	70. 91	0		0	0	31. 01
					(Amt. to Wkst. E, Pt. A)	
	0	1.00	2. 00	3. 00	4. 00	
32.00 HAC Reduction Program adjustment (see instructions)	70. 99			0 0	0	32. 00
100.00 Transfer HAC´Reduction Program adjustment t Wkst. E, Pt. A.	О	N				100. 00

Health Financial Systems	BALL MEMORIAL HOSPITAL	In Lieu	of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0089	From 01/01/2020 To 12/31/2020	Worksheet E Part B Date/Time Prepared: 7/15/2021 12:59 pm
	Ti +Lo VVIII	Hospi tal	DDC

	Title XVIII Hospital	7/15/2021 12: PPS	59 pm
	II ti e Avii i nospi tai	FF3	
	DADT D. MEDICAL AND OTHER HEALTH CERVICES	1. 00	
1. 00 2. 00 3. 00	PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instructions) OPPS payments OPPS payments Outblies payments	18, 824 44, 199, 895 39, 735, 915	2. 00 3. 00
4. 00 4. 01 5. 00	Outlier payment (see instructions) Outlier reconciliation amount (see instructions) Enter the hospital specific payment to cost ratio (see instructions)	194, 790 0 0. 000	4. 01
6. 00 7. 00	Line 2 times line 5 Sum of lines 3, 4, and 4.01, divided by line 6	0.000	6.00
8. 00 9. 00	Transitional corridor payment (see instructions) Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	97, 338	8. 00
	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)	0 18, 824	
	COMPUTATION OF LESSER OF COST OR CHARGES		ļ
12.00	Reasonable charges Ancillary service charges	106, 761	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69) Total reasonable charges (sum of lines 12 and 13)	106, 761	13. 00
	Customary charges		
15. 00 16. 00	Aggregate amount actually collected from patients liable for payment for services on a charge basi Amounts that would have been realized from patients liable for payment for services on a chargebas such payment been made in accordance with 42 CFR §413.13(e)	s 0 s had 0	
	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions)	0. 000000 106, 761	1
	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	87, 937	
20. 00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20. 00
	Lesser of cost or charges (see instructions) Interns and residents (see instructions)	18, 824 0	1
	Cost of physicians' services in a teaching hospital (see instructions) Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0 40, 028, 043	23. 00 24. 00
25. 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance amounts (for CAH, see instructions)	0	25. 00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions) Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	6, 835, 787 33, 211, 080	26. 00
	Direct graduate medical education payments (from Wkst. E-4, line 50) ESRD direct medical education costs (from Wkst. E-4, line 36)	1, 451, 949 0	1
30.00	Subtotal (sum of lines 27 through 29)	34, 663, 029	30.00
	Primary payer payments Subtotal (line 30 minus line 31)	17, 529 34, 645, 500	
33 00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	-62, 884	1
	Adjusted reimbursable bad debts (see instructions)	-40, 875	1
	Allowable bad debts for dual eligible beneficiaries (see instructions) Subtotal (see instructions)	-428, 786 34, 604, 625	
	MSP-LCC reconciliation amount from PS&R	-328	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	1
	Pioneer ACO demonstration payment adjustment (see instructions)		39. 50
	Demonstration payment adjustment amount before sequestration	0	
	Partial or full credits received from manufacturers for replaced devices (see instructions) RECOVERY OF ACCELERATED DEPRECIATION	0	1 1 1 1 1 1
	Subtotal (see instructions)	34, 604, 953	
	Sequestration adjustment (see instructions)	228, 393	
	Demonstration payment adjustment amount after sequestration	0	
	Sequestration adjustment-PARHM pass-throughs		40. 03
41.00	Interim payments	35, 230, 310	41. 00
	Interim payments-PARHM		41. 01
	Tentative settlement (for contractors use only)	0	
	Tentative settlement-PARHM (for contractor use only)	050 750	42. 01
	Balance due provider/program (see instructions)	-853, 750	
	Balance due provider/program-PARHM (see instructions) Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §1 TO BE COMPLETED BY CONTRACTOR	15. 2 9, 736	43. 01
90.00	Original outlier amount (see instructions)	0	90.00
	Outlier reconciliation adjustment amount (see instructions)	0	1
	The rate used to calculate the Time Value of Money	1	92.00
	Time Value of Money (see instructions)	0	
94.00	Total (sum of lines 91 and 93)	0	94.00

Health Financial Systems	BALL MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Period: Worksheet E
		From 01/01/2020 Part B
	Component CCN: 15-T089	
	·	7/15/2021 12:59 pm
	T: +1 - \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	Andrews and deep LDF DDC

	Title XVIII \$ubprovider - IF	7/15/2021 12: PPS	59 pm
	THE AVITT GASPIOVING IT	113	
		1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1. 00 2. 00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instructions)	25 10	
3. 00	OPPS payments	37	
4. 00	Outlier payment (see instructions)	0	
4. 01	Outlier reconciliation amount (see instructions)	0	4. 01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	
6.00	Line 2 times line 5	0.00	
7. 00 8. 00	Sum of lines 3, 4, and 4.01, divided by line 6 Transitional corridor payment (see instructions)	0.00	•
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	Ö	
	Organ acqui si ti ons	0	1
11. 00	Total cost (sum of lines 1 and 10) (see instructions)	25	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES		
12 00	Reasonable charges Ancillary service charges	1./1	12. 00
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	1
	Total reasonable charges (sum of lines 12 and 13)	141	10
	Customary charges		
	Aggregate amount actually collected from patients liable for payment for services on a charge basi		
16. 00	Amounts that would have been realized from patients liable for payment for services on a chargebas	s had 0	16. 00
17 00	such payment been made in accordance with 42 CFR §413.13(e) Ratio of line 15 to line 16 (not to exceed 1.000000)	0. 000000	17 00
	Total customary charges (see instructions)	1	18. 00
	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see		19. 00
	instructions)		
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see	0	20. 00
21 00	instructions) Lesser of cost or charges (see instructions)	25	21. 00
	Interns and residents (see instructions)	0	1
	Cost of physicians' services in a teaching hospital (see instructions)	l ő	1
	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	37	•
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
	Deductibles and coinsurance amounts (for CAH, see instructions)	0	
	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions) Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see	0 62	
27.00	instructions)	02	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28. 00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29. 00
	Subtotal (sum of lines 27 through 29)	62	10
	Primary payer payments	0	
32.00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	62	32. 00
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33. 00
	Allowable bad debts (see instructions)	0	•
	Adjusted reimbursable bad debts (see instructions)	0	35. 00
	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	
	Subtotal (see instructions)	62	1
	MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	•
	Pioneer ACO demonstration payment adjustment (see instructions)	Ĭ	39. 50
	Demonstration payment adjustment amount before sequestration	0	•
	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	
	RECOVERY OF ACCELERATED DEPRECIATION	0	
	Subtotal (see instructions)	62	•
	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration	0	
	Sequestration adjustment-PARHM pass-throughs		40. 02
	Interim payments	65	10
41.01	Interim payments-PARHM		41. 01
	Tentative settlement (for contractors use only)	0	
	Tentative settlement-PARHM (for contractor use only)	2	42. 01
	Balance due provider/program (see instructions) Balance due provider/program-PARHM (see instructions)	-3	43. 00 43. 01
	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §1	15. 2 0	10
55	TO BE COMPLETED BY CONTRACTOR]
90.00	Original outlier amount (see instructions)	0	90. 00
	Outlier reconciliation adjustment amount (see instructions)	0	
	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)	1	92.00
	Time Value of Money (see instructions) Total (sum of lines 91 and 93)	0	93. 00 94. 00
, 4. 00	1,000. (cam of 1,100 /) and /0/		1 / 1. 00

Health Financial Systems BALL MEMORIA	AL HOSPITAL		In Lieu	ı of Form CMS-2	2552-10
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provi der C		Period: From 01/01/2020 To 12/31/2020	Worksheet E-1 Part I Date/Time Pre 7/15/2021 12:	pared:
	Title	: XVIII	Hospi tal	PPS	
	I npati en	it Part A	Par	t B	
	mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
	1 22	2.00	3.00	4, 00	
	1.00	2.00	3.00	4.00	
1.00 Total interim payments paid to provider	1.00	71, 608, 78		35, 159, 110	1. 00

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4.00	
00	Total interim payments paid to provider		71, 608, 783		35, 159, 110	1.
00	Interim payments payable on individual bills, either		0		0	2.
00	submitted or to be submitted to the contractor for service	es	Ğ		Ĭ	
	rendered in the cost reporting period. If none, write "N					
		ONE				
00	or enter a zero	١.				
00	List separately each retroactive lump sum adjustment amou					3.
	based on subsequent revision of the interim rate for the					
	reporting period. Also show date of each payment. If none	,				
	write "NONE" or enter a zero. (1)					
	Program to Provider					1
01	ADJUSTMENTS TO PROVIDER		0	09/02/2020	71, 200	3.
02	THE SOUTHERT OF THE TROUBER	1	0	077 027 2020	0	
			0			
03			U		1 -1	-
04			0		0	
05			0		0	3
	Provider to Program					
50	ADJUSTMENTS TO PROGRAM		0		0	3.
51			0		0	3
52		1	0		o	3
53		1	0		ő	
			0		0	
54			U		1 -1	
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0		71, 200	3
	3. 50-3. 98)					l
00	Total interim payments (sum of lines 1, 2, and 3.99)		71, 608, 783		35, 230, 310	4
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					1
00	List separately each tentative settlement payment after of	esk				5
00	review. Also show date of each payment. If none, write "N					ľ
	1 3	ONL				
	or enter a zero. (1)					ł
	Program to Provider	1				_
01	TENTATI VE TO PROVI DER		0		0	
02			0		0	
03			0		0	5
	Provider to Program					I
50	TENTATI VE TO PROGRAM		0		0	1 5
51		1	0		0	5
52		1	0		l o	
	Cubtotal (our of lines 5 01 5 40 minus our of lines	1	0			
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		U		0	5
	5. 50-5. 98)					
00	Determined net settlement amount (balance due) based on t	he				6
	cost report. (1)					1
01	SETTLEMENT TO PROVIDER		843, 689		0	6
02	SETTLEMENT TO PROGRAM		0		853, 750	6
00	Total Medicare program liability (see instructions)		72, 452, 472		34, 376, 560	
50	Trotal modification program traditity (See Thistractions)		12, 732, 712	Contractor	NPR Date	
					1 1 1	
				Number	(Mo/Day/Yr)	
		l)	1. 00	2. 00	
00	Name of Contractor	9				8

Health Financial Systems	BALL MEMORIAL I	HOSPI TAL	In Lieu	of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO PROVIDERS FOR	SERVICES RENDERED	Provider CCN: 15-0089 Component CCN: 15-T089	From 01/01/2020	
		Component CCN. 13-1069	10 12/31/2020	Date/ITille Prepareu.

		Component	CCN: 15-T089	Γο 12/31/2020	Date/Time Pre 7/15/2021 12:	pared:
		Title	x XVIII \$u	ıbprovider - IR		59 piii
			t Part A		t B	
		mm/dd/yyyy 1.00	Amount 2.00	mm/dd/yyyy 3.00	Amount 4.00	
1. 00 Tot	al interim payments paid to provider	1.00	4, 343, 67		4.00	1. 00
	erim payments payable on individual bills, either		4, 343, 07	<u> </u>	0	
	omitted or to be submitted to the contractor for service	es				
ren	ndered in the cost reporting period. If none, write "N	ONE"				
	enter a zero					l
	st separately each retroactive lump sum adjustment amou					3.00
	sed on subsequent revision of the interim rate for the					
	porting period. Also show date of each payment. If none	•				
	te "NONE" or enter a zero. (1) gram to Provider					ł
	JUSTMENTS TO PROVIDER				0	3. 01
3. 02	Sermente la literation				l o	3. 02
3. 03					0	3. 03
3. 04			(0	3. 04
3. 05			(0	3. 05
	vider to Program		1	.1	1	
	JUSTMENTS TO PROGRAM				0	
3. 51 3. 52			(0	
3. 52					0	3. 52
3. 54					0	
•	ototal (sum of lines 3.01–3.49 minus sum of lines				Ö	3. 99
3. 5	50-3. 98)					
	cal interim payments (sum of lines 1, 2, and 3.99)		4, 343, 67	1	65	4.00
,	ransfer to Wkst. E or Wkst. E-3, line and column as					
	propri ate)					ļ
	BE COMPLETED BY CONTRACTOR	ook	ı	1	ı	E 00
	st separately each tentative settlement payment after d /iew. Also show date of each payment. If none, write "N					5.00
	enter a zero. (1)	OIVL				
	gram to Provider					1
5. 01 TEN	ITATI VE TO PROVI DER		(0	5. 01
5. 02			(1	0	5. 02
5. 03			(0	5. 03
	vider to Program		1 /	- I	1	
5. 50 TEN 5. 51	ITATIVE TO PROGRAM		(0	
5. 52					0	
	ototal (sum of lines 5.01-5.49 minus sum of lines				0	5. 99
	50-5. 98)		l `	1		0. ,,
	ermined net settlement amount (balance due) based on t	he			1	6.00
cos	st report. (1)					l
	TLEMENT TO PROVIDER		(0	
	TLEMENT TO PROGRAM		74, 834		3	
7. 00 Tot	al Medicare program liability (see instructions)		4, 268, 83		NPR Date	7. 00
				Contractor Number	(Mo/Day/Yr)	
		()	1. 00	2. 00	
8. 00 Nam	ne of Contractor				2.00	8. 00
1				•	•	,

Heal th	ealth Financial Systems BALL MEMORIAL HOSPITAL In Lieu			of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0089	Peri od: From 01/01/2020	Worksheet E-	1
				Date/Time Pr	
				7/15/2021 12	:59 pm
		Title XVIII	Hospi tal	PPS	
				1 00	
	TO BE COMPLETED BY CONTRACTOR FOR MONOTANDARD COOT REPORTS			1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS	DAI.			4
1 00	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		1 11		1 00
1.00	Total hospital discharges as defined in AARA §4102 from Wks	The state of the s	The 14		1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1,	8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	0.10			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1,	8-12			4.00
5. 00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00
6. 00	Total hospital charity care charges from Wkst. S-10, col. 3				6.00
7. 00	CAH only - The reasonable cost incurred for the purchase of 168	certified HII technolo	gy WKSt. S-2, Pt.	l line	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	n (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
	Balance due provider (line 8 (or line 10) minus line 30 and	line 31) (see instruct	i ons)		32.00
			•		

Health Financial Systems	BALL MEMORIAL I	HOSPI TAL		In Lieu	of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 15-00	89 Peri	od: 01/01/2020	Worksheet E-3
		Component CCN: 15-T			Date/Time Prepared: 7/15/2021 12:59 pm
		Ti +Lo VVIII	\$uhnr.	ovidor IDI	DDC

		Title XVIII	 \$ubprovider - IR	7/15/2021 12: PPS	59 pm
		I II LI E XVIII	pubprovider - ik	л PPS	
				1. 00	
	PART III - MEDICARE PART A SERVICES - IRF PPS			1, 00	
1.00	Net Federal PPS Payment (see instructions)			4, 076, 771	1. 00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0. 0169	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			103, 142	3.00
4.00	Outlier Payments			159, 239	4.00
5.00	Unweighted intern and resident FTE count in the most recent	cost reporting period	ending on or pr	or to 0.00	5. 00
	November 15, 2004 (see instructions)				
5. 01	Cap increases for the unweighted intern and resident FTE cou				5. 01
	program or hospital closure, that would not be counted with	out a temporary cap adj	ustment under 42	CFR	
	§412.424(d)(1)(iii)(F)(1) or (2) (see instructions)				
6. 00	New Teaching program adjustment. (see instructions)			0. 00	
7. 00	Current year's unweighted FTE count of I&R excluding FTEs in	n the new program growt	h period of a "n	ew 0.00	7. 00
0.00	teaching program" (see instructions)			0.00	0.00
8. 00	Current year's unweighted I&R FTE count for residents within	n the new program growt	n period of a "n	ew 0.00	8. 00
0.00	teaching program" (see instructions)		,	0.00	0.00
9.00	Intern and resident count for IRF PPS medical education adju	ustment (see instructio	ns)	0.00	
10.00	1 1 3 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			12. 265027	
	Teaching Adjustment Factor (see instructions)			0. 000000	
	Teaching Adjustment (see instructions)				12.00
13.00	,	ati an)		4, 339, 152	
	Nursing and Allied Health Managed Care payments (see instruc	ction)		0	14. 00 15. 00
	Organ acquisition (DO NOT USE THIS LINE) Cost of physicians' services in a teaching hospital (see ins	structions)		0	
	Subtotal (see instructions)	structions)		4, 339, 152	
	Pri mary payer payments				18.00
	Subtotal (line 17 less line 18).			4, 339, 152	
	Deducti bl es			16, 896	
	Subtotal (line 19 minus line 20)			4, 322, 256	
	Coi nsurance			27, 456	
	Subtotal (line 21 minus line 22)			4, 294, 800	
	Allowable bad debts (exclude bad debts for professional serv	vices) (see instruction	s)		24. 00
	Adjusted reimbursable bad debts (see instructions)	, (, , , , , , , , , , , , , , , , , ,	- /	1, 291	
26.00	Allowable bad debts for dual eligible beneficiaries (see ins	structions)			26. 00
27.00	Subtotal (sum of lines 23 and 25)			4, 296, 091	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, 108	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 instruction	ons)		0	31. 50
	Demonstration payment adjustment amount before sequestration	า			31. 99
	Total amount payable to the provider (see instructions)			4, 297, 199	32.00
	Sequestration adjustment (see instructions)			28, 362	
	Demonstration payment adjustment amount after sequestration			0	
	Interim payments			4, 343, 671	
	Tentative settlement (for contractor use only)	00 00 101		0	
	Balance due provider/program (line 32 minus lines 32.01, 32.		0 -1 1 C1	-74, 834	
36.00	Protested amounts (nonallowable cost report items) in accord	uance with CMS Pub. 15-	z, cnapter 1, §1	15. 2 23, 645	36. 00
EO 00	TO BE COMPLETED BY CONTRACTOR			150,000	EO 00
	Original outlier amount from Wkst. E-3, Pt. III, line 4			159, 239	
	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money				51. 00 52. 00
	Time Value of Money (see instructions)				52.00
55.00	Trimo variae or money (see tristructions)			,	1 33.00

Heal th	Financial Systems BALL MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
DI RECT	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provi der C		Peri od: From 01/01/2020	Worksheet E-4	
MEDI CA	L EDUCATION COSTS				Date/Time Pre	
		Title	· XVIII	Hospi tal	7/15/2021 12: PPS	59 pm
		1 1110	7,7,111	nospi tui	1.00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT				1.00	
1. 00	Unweighted resident FTE count for allopathic and osteopathi or before December 31, 1996.	c programs 1	for cost repo	rting periods e	ndi ng on 57. 92	1. 00
2.00	Unweighted FTE resident cap add-on for new programs per 42		e)(1) (see in	structions)	0.00	2.00
3. 00 3. 01	Amount of reduction to Direct GME cap under section 422 of Direct GME cap reduction amount under ACA §5503 in accordance (ACA §5503)		CFR §413.79 (m). (see instru	0.00 cti ons 0.00	3. 00 3. 01
4. 00	for cost reporting periods straddling 7/1/2011) Adjustment (plus or minus) to the FTE cap for allopathic an affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))	nd osteopathi	c programs d	ue to a Medicar	e GME 0.00	4. 00
4. 01	ACA Section 5503 increase to the Direct GME FTE Cap (see in straddling 7/1/2011)	structions 1	for cost repo	rting periods	12. 00	4. 01
4. 02	ACA Section 5506 number of additional direct GME FTE cap sl periods straddling 7/1/2011)	ots (see in	nstructions f	or cost reporti	ng 0.00	4. 02
5. 00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus applicable subscripts	plus or minu	us line 4 plu	s lines 4.01 an	d 4. 02 69. 92	5. 00
6. 00	Unweighted resident FTE count for allopathic and osteopathirecords (see instructions)	c programs 1	for the curre	nt year from yo	ur 63.19	6. 00
7. 00	Enter the lesser of line 5 or line 6		1		63. 19	7. 00
			Primary Care	0ther 2.00	Total 3. 00	
8. 00	Weighted FTE count for physicians in an allopathic and oste for the current year.	eopathic prog				8. 00
9. 00	If line 6 is less than 5 enter the amount from line 8, othe line 8 times the result of line 5 divided by the amount on		pl y 53. 1	9 10.00	63. 19	9. 00
	Weighted dental and podiatric resident FTE count for the cu	ırrent year		0. 00	1	10. 00
	Unweighted dental and podiatric resident FTE count for the Total weighted FTE count	current year	53. 1	0. 00 9 10. 00		10. 01 11. 00
12. 00	Total weighted resident FTE count for the prior cost report instructions)	ing year (se				12. 00
13.00	Total weighted resident FTE count for the penultimate cost (see instructions)	reporting ye	ar 53.7	10.00		13. 00
	Rolling average FTE count (sum of lines 11 through 13 divid	led by 3).	53. 5			14.00
	Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new	, programe	0. C 0. C			15. 00 15. 01
	Adjustment for residents displaced by program or hospital o		0.0			16. 00
	Unweighted adjustment for residents displaced by program or					16. 01
	Adjusted rolling average FTE count		53. 5	7 10.00		17. 00
	Per resident amount		106, 140. 6			18. 00
19. 00	Approved amount for resident costs		5, 685, 95	7 1, 005, 059	6, 691, 016	19. 00
					1. 00	
	Additional unweighted allopathic and osteopathic direct GME 413.79(c)(4)		nt cap slots	received under	42 Sec. 4.00	20. 00
	Direct GME FTE unweighted resident count over cap (see inst					21.00
	Allowable additional direct GME FTE Resident Count (see ins			`		22. 00
	Enter the locality adjustment national average per resident	amount (see	e instruction	S)	104, 570. 91	
	Multiply line 22 time line 23 Total direct GME amount (sum of lines 19 and 24)				6, 691, 016	24.00
25.00	Total direct GWL amount (Sum of Titles 17 and 24)		npatient Par	t Managed Care	Total	25.00
			. A	2.00	2.00	
	COMPUTATION OF PROGRAM PATIENT LOAD		1. 00	2. 00	3. 00	
26. 00	Inpatient Days (see instructions) (Title XIX - see S-2 Part column 2)	IX, line 3.	02, 32, 64	0 15, 765		26. 00
27.00	Total Inpatient Days (see instructions)		80, 04	0 80, 040		27. 00
	Ratio of inpatient days to total inpatient days		0. 40779		1	28. 00
	Program di rect GME amount		2, 728, 57			
	Percent reduction for MA DGME			7.00	1	29. 01
	Reduction for direct GME payments for Medicare Advantage Net Program direct GME amount			92, 252	92, 252 3, 954, 207	
	. •		•	•		

Health Financial Systems BALL MEMORI	AL HOSPITAL	In Lieu	of Form CMS-2	2552-10
DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRE	CT Provi der CCN: 15-0089	Peri od:	Worksheet E-4	ļ
MEDICAL EDUCATION COSTS		From 01/01/2020 To 12/31/2020	Date/Time Pre 7/15/2021 12:	
	Title XVIII	Hospi tal	PPS	
DIDECT MEDICAL EDUCATION COCTO FOR FORD COMPOCITE DATE	TITLE WHILL ONLY (NUDCING	CCHOOL AND	1. 00	
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - PARAMEDICAL EDUCATION COSTS)	`			
32.00 Renal dialysis direct medical education costs (from Wks	t. B, Pt. I, sum of col. 20	and 23, lines 7	4 and 0	32. 00
33.00 Renal dialysis and home dialysis total charges (Wkst. C	Pt. I, col. 8, sum of lin	nes 74 and 94)	3, 997, 884	33.00
34.00 Ratio of direct medical education costs to total charges	s (line 32 ÷ line 33)	·	0. 000000	34.00
35.00 Medicare outpatient ESRD charges (see instructions)			0	35. 00
36.00 Medicare outpatient ESRD direct medical education costs (line 34 x line 35)				36. 00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE	XVIII ONLY			
Part A Reasonable Cost			7/ 07/ 050	07.00
37.00 Reasonable cost (see instructions) 38.00 Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, lii	20. (0)		76, 374, 259 0	•
39.00 Cost of physicians' services in a teaching hospital (see			0	
40.00 Primary payer payments (see instructions)	e matructions)		31, 133	
41.00 Total Part A reasonable cost (sum of lines 37 through 39	minus line 40)		76, 343, 126	
Part B Reasonable Cost			7070107120	
42.00 Reasonable cost (see instructions)			44, 316, 092	42. 00
43.00 Primary payer payments (see instructions)			17, 529	43.00
44.00 Total Part B reasonable cost (line 42 minus line 43)			44, 298, 563	44.00
45.00 Total reasonable cost (sum of lines 41 and 44)			120, 641, 689	
46.00 Ratio of Part A reasonable cost to total reasonable cos			0. 632809	•
47.00 Ratio of Part B reasonable cost to total reasonable cos			0. 367191	47. 00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A A	AND PARI B	1	2 054 207	40.00
48.00 Total program GME payment (line 31) 49.00 Part A Medicare GME payment (line 46 x 48) (title XVIII	only) (see instructions)		3, 954, 207 2, 502, 258	
50.00 Part B Medicare GME payment (line 46 x 48) (title XVIII			2, 502, 258 1, 451, 949	
30.00 prart b wedicare dwil payment (Time 47 x 40) (title xviii	only) (see Thistructions)	ı	1, 451, 949	1 30.00

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

BALANCE SHEET (If you are nonproprietary and do not maintain fund-typevider CCN: 15-0089 | Period: From 01/01/2020 | To 12/31/2020 | Date/Time Prepared: 7/15/2021 12:59 pm

			'	0 12/31/2020	7/15/2021 12:	
		General Fund	Speci fi c	Endowment Fund		
			Purpose Fund			
	AUDDENT ACCETO	1. 00	2. 00	3. 00	4. 00	
1. 00	CURRENT ASSETS Cash on hand in banks	325, 087, 965	1 0	O	0	1.00
2. 00	Temporary investments	323, 067, 9 03	0	0	0	
3. 00	Notes receivable	0	Ö	ő	0	
4. 00	Accounts receivable	51, 289, 647	Ō	Ō	0	•
5.00	Other recei vable	-12, 057, 955	0	0	0	5. 00
6.00	Allowances for uncollectible notes and accounts receivabl		0	0	0	
7. 00	Inventory	13, 073, 960	1	0	0	
8. 00	Prepai d expenses	1, 773, 171	0	0	0	
9. 00 10. 00	Other current assets Due from other funds	0	0	0	0	
11.00	Total current assets (sum of lines 1-10)	379, 166, 788		0	0	
11.00	FIXED ASSETS	677, 100, 700		<u> </u>		1 00
12.00	Land	6, 072, 523	0	0	0	12. 00
13.00	Land improvements	3, 429, 715	0	0	0	13. 00
	Accumulated depreciation	-3, 046, 244		0	0	
	Bui I di ngs	364, 668, 716		0	0	
	Accumulated depreciation	-212, 292, 990		0	0	
	Leasehold improvements Accumulated depreciation	429, 120 -339, 883	1	0	0	
	Fixed equipment	-337, 003 O		0	0	1
	Accumulated depreciation	0	Ö	ő	0	1
	Automobiles and trucks	0	Ō	Ō	0	1
	Accumulated depreciation	0	0	0	0	22. 00
	Major movable equipment	124, 155, 579		0	0	
	Accumulated depreciation	-86, 739, 241	0	0	0	
	Minor equipment depreciable	0	0	0	0	
	Accumulated depreciation	0	0	0	0	
	HIT designated Assets Accumulated depreciation	0	0	0	0	•
	Mi nor equi pment-nondepreci abl e	0		0	0	1
	Total fixed assets (sum of lines 12-29)	196, 337, 295	Ö	ő	0	•
	OTHER ASSETS					
	Investments	22, 378, 711	0	0	0	
	Deposits on Leases	0	0	0	0	
	Due from owners/officers	12 042 700	0	0	0	
	Other assets Total other assets (sum of lines 31-34)	12, 843, 798 35, 222, 509	b .	0	0	
36.00	Total assets (sum of lines 11, 30, and 35)	610, 726, 592		0	0	
00.00	CURRENT LIABILITIES	0.077207072	<u> </u>	<u> </u>		00.00
37.00	Accounts payable	9, 029, 185	0	0	0	37. 00
	Salaries, wages, and fees payable	13, 235, 879	0	0	0	
	Payroll taxes payable	594, 237	1	0	0	
	Notes and Loans payable (short term)	177, 586	0	0	0	
	Deferred income	U FF 010 010	0	O	0	
	Accelerated payments Due to other funds	55, 919, 210 9, 812, 103	1	0	0	42. 00 43. 00
	Other current liabilities	9, 012, 103		Ö		44. 00
	Total current liabilities (sum of lines 37 thru 44)	88, 768, 200		Ö		45. 00
	LONG TERM LIABILITIES					
	Mortgage payable	0	0	0	0	46. 00
	Notes payable	0	0	0	0	
	Unsecured Loans	0	0	0	0	
	Other long term liabilities	1, 854, 138	1	0	0	•
	Total long term liabilities (sum of lines 46 thru 49) Total liabilities (sum of lines 45 and 50)	1, 854, 138 90, 622, 338	1	0	0	•
31.00	CAPITAL ACCOUNTS	70, 022, 330	· · · · · · · · ·	<u> </u>		31.00
52.00	General fund balance	520, 104, 254				52. 00
53.00	Specific purpose fund		0			53. 00
	Donor created - endowment fund balance - restricted			0		54. 00
	Donor created - endowment fund balance - unrestricted			0		55.00
	Governing body created - endowment fund balance			0	^	56.00
	Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement,				0	
50.00	replacement, and expansion				U	30.00
59. 00	Total fund balances (sum of lines 52 thru 58)	520, 104, 254	0	0	0	59. 00
	Total liabilities and fund balances (sum of lines 51 and			Ö		60.00
				•		

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES In Lieu of Form CMS-2552-10
Worksheet G-1 BALL MEMORIAL HOSPITAL Provi der CCN: 15-0089

Peri od: From 01/01/2020

					To	12/31/2020	Date/Time Pr 7/15/2021 12	epared: :59 pm
		General	Fund	Speci al	Pui	rpose Fund	Endowment Fun	d
1 00		1.00	2.00	3.00	_	4. 00	5. 00	1 00
1. 00 2. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29)		506, 087, 332		ŀ	0		1.00
3. 00	Total (sum of line 1 and line 2)		59, 636, 468 565, 723, 800		ł	0		2. 00 3. 00
4. 00	Additions (credit adjustments) (specify)	0	303, 723, 000	1	0	0	1	4.00
5. 00	That there (ereal trady detiments) (epecing)	Ö		1	0			5.00
6.00		0		İ	0			6.00
7.00		0			0			7.00
8. 00		0			0		1	8.00
9.00	Total additions (sum of line 4-9)	O	0	}	O	0	1	9.00
	Subtotal (line 3 plus line 10)		0 565, 723, 800	I .		0		11. 00
12. 00	Deductions (debit adjustments) (specify)	0	303, 723, 000	1	0	O	1	12.00
	UNRESTRICTED FUND BALANCE	34, 076, 172		ľ	0			13.00
14.00	RESTRICTED FUND BALANCE	11, 543, 370		İ	0			14. 00
	ROUNDI NG	4			0		•	15. 00
16.00		0			0		1	16.00
17.00	Total deductions (sum of lines 12-17)	O	45, 619, 546	}	O	0	·	17.00
	Fund balance at end of period per balance		520, 104, 254	l .	ł	0		19.00
17.00	sheet (line 11 minus line 18)		020, 101, 201			· ·		17.00
		Endowment Fund	PI ant	Fund				
		6. 00	7. 00	8. 00				
1. 00	Fund balances at beginning of period	0.00	7.00	0.00	0		-	1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)							2. 00
3.00	Total (sum of line 1 and line 2)	0		,	0			3. 00
4.00	Additions (credit adjustments) (specify)		0	1	ŀ			4.00
5. 00 6. 00			0	}	ł			5. 00 6. 00
7. 00			0		ł			7.00
8. 00			0		ı			8.00
9.00			0	İ	l			9. 00
	Total additions (sum of line 4-9)	0			0			10. 00
	Subtotal (line 3 plus line 10)	0	_		0			11. 00
	Deductions (debit adjustments) (specify)		0		ŀ			12. 00 13. 00
14.00	UNRESTRICTED FUND BALANCE RESTRICTED FUND BALANCE		0		H			14. 00
	ROUNDI NG		0					15. 00
16. 00			0					16. 00
17.00			0					17. 00
	Total deductions (sum of lines 12-17)	0			0			18. 00
19. 00	Fund balance at end of period per balance	0			0			19. 00
	sheet (line 11 minus line 18)	l l		I	I			l

Health Financial Systems BALL MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0089 Period: Worksheet G-2

Worksheet G-2 Parts I & II Date/Time Prepared: STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0089 Peri od: From 01/01/2020 12/31/2020 7/15/2021 12:59 pm Cost Center Description Outpati ent I npati ent Total 1.00 2.00 3.00 PART I - PATIENT REVENUES <u>General Inpatient Routine Services</u> 1.00 Hospi tal 175, 404, 648 175, 404, 648 2.00 SUBPROVIDER - IPF 2.00 SUBPROVIDER - IRF 7, 987, 980 7, 987, 980 3.00 3.00 4.00 SUBPROVI DER 4.00 5.00 Swing bed - SNF 0 5.00 Swing bed - NF 6.00 6.00 0 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) 183, 392, 628 183, 392, 628 10.00 Intensive Care Type Inpatient Hospital Services 11.00 INTENSIVE CARE UNIT 63, 848, 782 63, 848, 782 11.00 12.00 CORONARY CARE UNIT 0 12.00 BURN INTENSIVE CARE UNIT 13.00 13.00 14.00 SURGICAL INTENSIVE CARE UNIT 14.00 15.00 NEONATAL INTENSIVE CARE UNIT 15, 470, 534 15, 470, 534 15.00 Total intensive care type inpatient hospital services (sum of lines 11 15)79,319,316 79, 319, 316 16 00 16 00 17.00 Total inpatient routine care services (sum of lines 10 and 16) 262, 711, 944 262, 711, 944 17.00 18.00 Ancillary services 569, 638, 533 771, 431, 519 1, 341, 070, 052 18.00 19.00 Outpatient services 71, 965, 820 222, 572, 046 294, 537, 866 19.00 20.00 RURAL HEALTH CLINIC 20 00 21.00 FEDERALLY QUALIFIED HEALTH CENTER 0 21.00 22.00 HOME HEALTH AGENCY 22.00 23.00 AMBULANCE SERVICES 0 23.00 24.00 CMHC 24.00 25.00 AMBULATORY SURGICAL CENTER (D.P.) 25.00 HOSPI CE 26.00 26.00 8, 396, 680 PAVILLION PHARMACY AND PHYSICIAN 8, 396, 680 27.00 27.00 28.00 Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-**3**04, 316, 297 1, 002, 400, 245 1, 906, 716, 542 28.00 PART II - OPERATING EXPENSES Operating expenses (per Wkst. A, column 3, line 200) 29.00 417, 393, 039 29.00 30.00 ADD (SPECIFY) 30.00 31.00 31.00 32.00 32.00 33.00 33.00 34.00 34.00 35.00 35.00 Total additions (sum of lines 30-35) 36, 00 36,00 37.00 DEDUCT (SPECIFY) 37.00

38.00

39.00

40.00

41.00

42.00

43.00

417, 393, 039

38.00

39.00

40.00

41.00

42.00

43.00

Total deductions (sum of lines 37-41)

Wkst. G-3, line 4)

Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to

Heal th	Financial Systems	BALL MEMORIAL HOSPITAL		In Lieu	of Form CMS-2	2552-10
	MENT OF REVENUES AND EXPENSES	Provi der CC	N: 15-0089 Per	ri od:	Worksheet G-3	
			Fro To	om 01/01/2020 12/31/2020	Date/Time Pre	
					7/15/2021 12:	59 DIII
				<u> </u>	1. 00	
1. 00	Total patient revenues (from Wkst. G-2, Pa	rt L. column 3. line 28)			1, 906, 716, 542	1. 00
2.00	Less contractual allowances and discounts				1, 467, 721, 224	2. 00
3.00	Net patient revenues (line 1 minus line 2)	•			438, 995, 318	3. 00
4.00	Less total operating expenses (from Wkst.	G-2, Part II, line 43)			417, 393, 039	4.00
5.00	Net income from service to patients (line	3 minus line 4)			21, 602, 279	5. 00
	OTHER I NCOME	•				
6.00	Contributions, donations, bequests, etc				0	6.00
7.00	Income from investments				0	
8.00	Revenues from telephone and other miscella	neous communication services			0	
9.00	Revenue from television and radio service				0	
10.00	Purchase di scounts				0	10.00
	Rebates and refunds of expenses					11. 00
	Parking Lot receipts					12.00
	Revenue from Laundry and Linen service					13.00
	Revenue from meals sold to employees and g	uests			0	14.00
	Revenue from rental of living quarters				0	
	Revenue from sale of medical and surgical		ts		0	
	Revenue from sale of drugs to other than p					17. 00
	Revenue from sale of medical records and a					18. 00
	Tuition (fees, sale of textbooks, uniforms	,				19. 00
	Revenue from gifts, flowers, coffee shops,	and canteen				20.00
	Rental of vending machines				-	21. 00
	Rental of hospital space				0	
	Governmental appropriations				0	_0.00
	MISCELLANEOUS INCOME				24, 356, 728	
	COVI D-19 PHE Fundi ng				13, 677, 461	
	Total other income (sum of lines 6-24)				38, 034, 189	
	Total (line 5 plus line 25)				59, 636, 468	
	OTHER EXPENSES (SPECIFY)				0	
	Total other expenses (sum of line 27 and s				0	28. 00
29. 00	Net income (or loss) for the period (line	26 minus line 28)		l	59, 636, 468	29. 00

Heal th	Financial Systems BALL MEMORIAL	HOSPI TAL	In Lieu	u of Form CMS-:	2552-10
	ATION OF CAPITAL PAYMENT	Provi der CCN: 15-0089	Peri od:	Worksheet L	
			From 01/01/2020 To 12/31/2020		onarod.
			10 12/31/2020	7/15/2021 12:	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD			1.00	
	CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier			4, 318, 257	•
1. 01 2. 00	Model 4 BPCI Capital DRG other than outlier Capital DRG outlier payments			60, 353	
2. 00	Model 4 BPCI Capital DRG outlier payments			00, 353	•
3. 00	Total inpatient days divided by number of days in the cost	reporting period (see i	nstructions)	206. 42	
4. 00	Number of interns & residents (see instructions)		,	62. 71	•
5.00	Indirect medical education percentage (see instructions)			8. 95	5.00
6.00	Indirect medical education adjustment (multiply line 5 by	the sum of lines 1 and 1	.01, columns 1 a	hd 386, 484	6.00
7 00	1.01)(see instructions)			5.40	7 00
7. 00	Percentage of SSI recipient patient days to Medicare Part (see instructions)	A patient days (Workshee	t E, part A line	30) 5. 10	7. 00
8. 00	Percentage of Medicaid patient days to total days (see ins	structions)		24. 92	8.00
9. 00	Sum of lines 7 and 8			30. 02	
10.00	Allowable disproportionate share percentage (see instructi	ons)		6. 27	10.00
	Disproportionate share adjustment (see instructions)			270, 755	
12.00	Total prospective capital payments (see instructions)			5, 035, 849	12.00
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST			1.00	
1.00	Program inpatient routine capital cost (see instructions)			0	1.00
2.00	Program inpatient ancillary capital cost (see instructions	5)		0	
3.00	Total inpatient program capital cost (line 1 plus line 2)			0	
4. 00 5. 00	Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line 4)			0	
3.00	Trotal impatrent program capital cost (fine 3 x fine 4)		_	0	3.00
				1. 00	
1 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS			I 0	1 00
1. 00 2. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumst	ances (see instructions)			
3. 00	Net program inpatient capital costs (line 1 minus line 2)	tances (see Thisti detrons)		1 0	
4. 00	Applicable exception percentage (see instructions)			0.00	
5.00	Capital cost for comparison to payments (line 3 x line 4)			0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see	,		0. 00	
7. 00	Adjustment to capital minimum payment level for extraordin	nary circumstances (line	2 x line 6)	0	
8.00	Capital minimum payment level (line 5 plus line 7)	anli achi a)		0	
9. 00 10. 00	Current year capital payments (from Part I, line 12, as ap Current year comparison of capital minimum payment level t		8 Lace lina 0)		
11. 00	Carryover of accumulated capital minimum payment level over				
50	Part III, line 14)		Joanor Ko		
	Net comparison of capital minimum payment level to capital			0	
	Current year exception payment (if line 12 is positive, er			0	
14. 00	Carryover of accumulated capital minimum payment level over	er capital payment for th	e following peri	pd (if 0	14. 00
15 00	line 12 is negative, enter the amount on this line) Current year allowable operating and capital payment (see	instructions)		0	15. 00
	Current year operating and capital costs (see instructions	,			
	Current year exception offset amount (see instructions)	-,		ĺ	
				•	•